NHS
Royal Cornwall Hospitals
NHS Trust

Integrated Performance Report

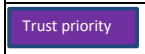
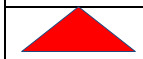




June 2025

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

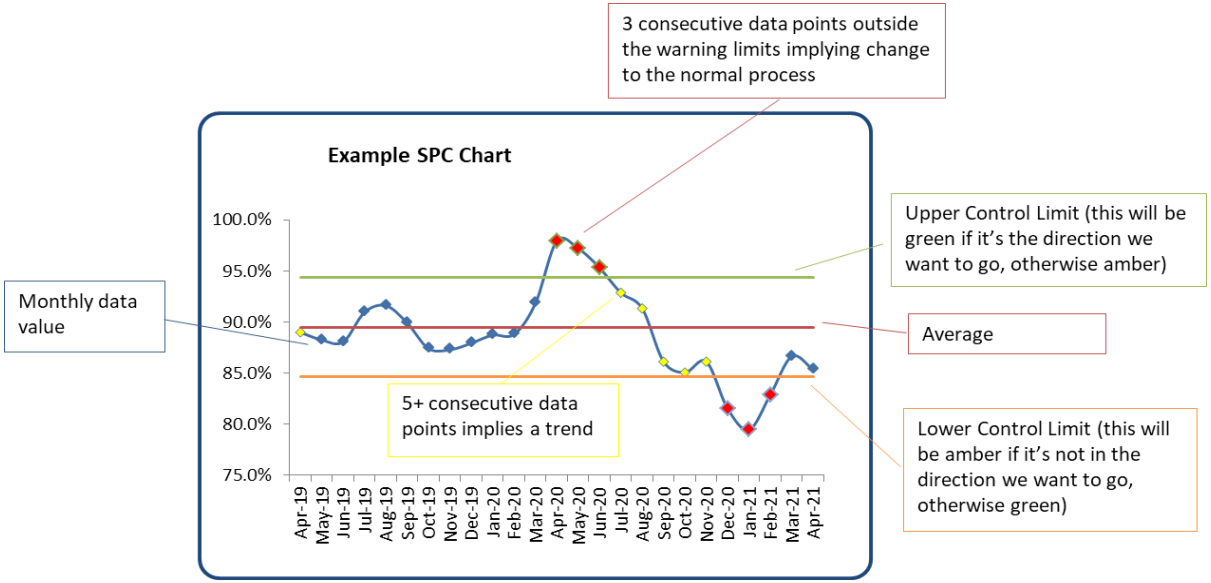
Within the Integrated Performance Report (IPR), statistical process control (SPC) charts are used where approriate.

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 changing 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, straight 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 the 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	Mar-25	Apr-25	May-25	Jun-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	50.86%	44.24%	43.92%	47.29%	49.53%	49.08%	43.43%	-5.65%	43.43%	
	RCHT Delayed Patients (P0-P3)	42			96	82	81	83	+2.26	83	
	Inpatient Elective Activity	100%			105.21%	105.18%	108.32%	101.20%		101.20%	
	Total general and acute (G&A) bed occupancy (%)	93.98%			95.54%	95.35%	94.95%	94.91%	-0.04%	94.91%	
	Infection control: C-difficile cases	19	98	115	11	6	5	9	+4	20	
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%	37.88%	37.88%	37.88%	0.00%	37.88%	
	% Appraisals completed of eligible staff	85%	72.32%	75.41%	77.61%	77.30%	76.13%	75.94%	-0.19%	75.94%	
	% Sickness absence	3.75%	5.00%	4.96%	4.57%	4.44%	4.67%	4.58%	-0.09%	4.58%	
	Staff turnover	7-15%	9.38%		8.48%	8.50%	8.44%	8.31%	-0.13%	8.31%	
Journey of Improvement (Reviewed by Finance and Performance Committee)	Monthly financial position (£m)	1.35			-0.90	2.12	1.98	1.38	-0.6		
	Year to date financial position	5.53			-0.09	2.12	4.11	5.49	+1.4		
	Monthly agency spend (£m)	0.77	22.53		0.94	0.71	0.83	0.67	-0.16		
	Capital spend against plan (£m)	7.93	44.10		56.54	1.21	3.18	4.34	+1.16		
	CIP % delivery at year end	100%	100.00%		100%	91%	92%	100%	8%		
	Forecast recurrent CIP (%)	75%	41.00%		45%	75%	75%	75%	0%		

Safe, High Quality Care

Urgent Emergency Care

Metric Highlights:

ED and MIU 4 hour arrival to discharge, admission or transfer dropped below the mean to the lowest performance since October 2024 at 76.28% in June, with Treliske ED 4 hour performance also falling below the mean to 43.43%, both below the standard and operational plan trajectory. All Emergency Department and ambulance metrics remained within control limits in June.

All stroke metrics remained within control limits in June 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 dropped to 23% in June, the lowest since October 2024, against a standard of 70%.

From a patient flow perspective, super stranded patients with a length of stay above 21 days remained the lowest since October 2021 with 90 in June, close to the lower control limit, and the lowest number of delayed discharges per pathway since May 2024. For the first time since April 2024, net emergency readmissions within 30 days met the target, and for the second consecutive month average length of stay met the target and remains close to the lower control limit.

Stroke:

Implementation of an Escalation Plan to protect Hyper Acute Stroke Unit beds and access to the unit brought dramatic improvements in June to 90% stay on the Acute Stroke Unit for stroke patients (86.7%). 4-hour access to the Acute Stroke Unit performance was 50% in June and although a slight decline from previous month, remains above our average to date (40%). In response, all 4-hour breaches are being rapidly reviewed to ensure the escalation plan is being followed and reasons for breaches, led by Service Manager. Stroke Mortality in June was 9.6% and remained below the target of 10% for the second month consistently. This is rated an extreme risk which will be reduced if this can be sustained. A full action plan in response to the RCP peer review recommendations has been written and is being approved by Quality Assurance Committee (QAC) on 17 July. This will report monthly to the QAC for assurance.

Thrombolysis rates in June increased to 11% (just below target of 12%) and this is attributed to the switch from administering Alteplase to Tenectoplase, and Stroke Consultant input. The goal is to move to Stroke 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, to release consultants to Stroke Unit and for thrombolysis. Therapy levels remain below guideline levels with gaps in OT and Physio.The 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, which will in turn improve outcomes and mortality for Stroke patients. Therapy staffing levels in the community are also impacting the service, due to insufficient therapists able to provide immediate intense therapy for patients at home. The lack of Early Supported Discharge (ESD) service for stroke results in patients remaining on the unit when they no longer require specialist stoke unit care, and a plan for onward care is required in order to deliver the planned changes to the stroke unit bed base. We are commencing a deep dive into stroke, recognising we are not seeing the expected improvement, and we have also reached out to ECIST for support.

Fractured Neck of Femur Pathway

June NOF performance was 23 % based on discharge date. In real time based on admission data 35% of NOFs made it to theatre within 36 hours in June 2025. We had 9 periprosthetic fractures, 3 femur fractures and 59 NOFs present in June, a total of 71 fragility fractures. As the whiteboard numbers increase and the ask from other services to utilise trauma theatre capacity, we see a drop in our NOF performance.

White board number exceeded the normal range expected in June – 75 . As expected, the number of 'outstanding NOFs' directly correlates with the whiteboard total i.e. when we have the most outstanding NOFs, our whiteboard number is the highest.

As agreed with the medical director, we will aim to focus our fragility fractures primarily in Theatre 10 and ensure a minimum of 3 NOFs are listed per day.

We will also utilise the trauma surge Standard Operating Procedure when the whiteboard number exceed the normal range of 65 to 70 on the board.

Kingsgate review of trauma and elective capacity is going. There has been no agreement across the services (theatre staff and Anaesthetist) to change our current modelling in theatres.

We are continuing with our daily monitoring of our NOF position and have initiated the use of the nerve centre NOF tracking board.

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

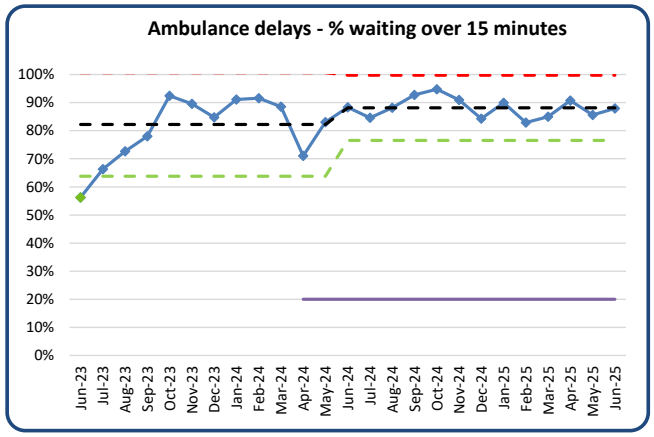
RCHT and SWASFT continued operating the Timely Handover Protocol (THP) for 60 minutes between 8.00 am and 6.00 pm daily, with the Internal Professional Standards (IPS) circulated and embedded, patient flow continued to impact against achieving them. In the Clinical Vision of Flow, the Acute Medical and Frailty Unit (AMFU) flow programme saw increased traction with General Manager and Deputy Head of Nursing involvement to expedite the timeline for the Medical Rapid Assessment and Triage opening. There continues to be challenges with long waits to be seen in ED, especially overnight, but with the actions of the AMFU flow programme the trajectory of ED crowding is set to reduce, allowing clinicians the time and space to see their patients. Environmental works in the Acute Medical Unit (AMU) to create an admitting area so the Medical Take can be removed from ED completed on the 9th July and first indications of the success of the project are overwhelmingly positive, but more time is needed to ensure that the take remains on the unit and ED crowding continues on a downward trajectory. RCHT intend to implement the 45 minute maximum handover (“release to rescue”) on the 16th July to ensure that ambulances can respond to emergencies in the community.

During July there will be dedicated focus on improving non-admitted 4h ED performance.

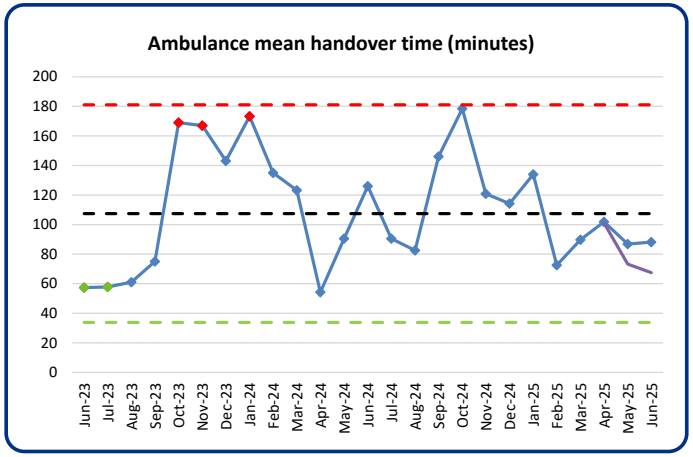
A contemporaneous UEC updae is provided to Board on a weekly basis, and a focussed paper on UEC performance is provided to Trust Board and QAC on a monthly basis.

Safe, High Quality Care

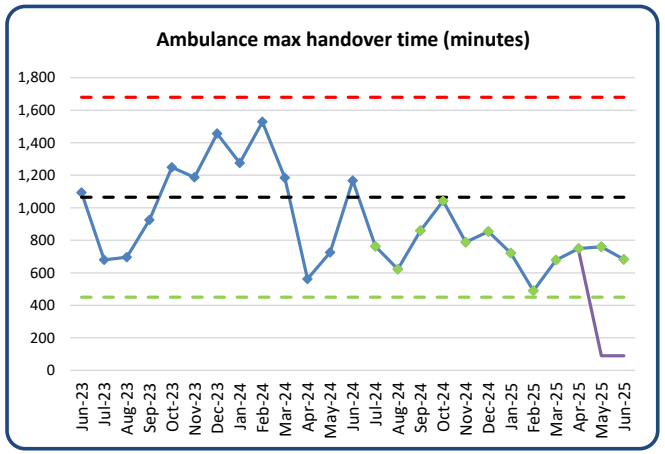
Improving urgent and emergency care performance. By March 2026: improve system 4hr performance to 85.8%(ED to 62.9%), reduce ambulance holds to an avg of 27 mins, reduce waits over 12hrs in ED to 5%



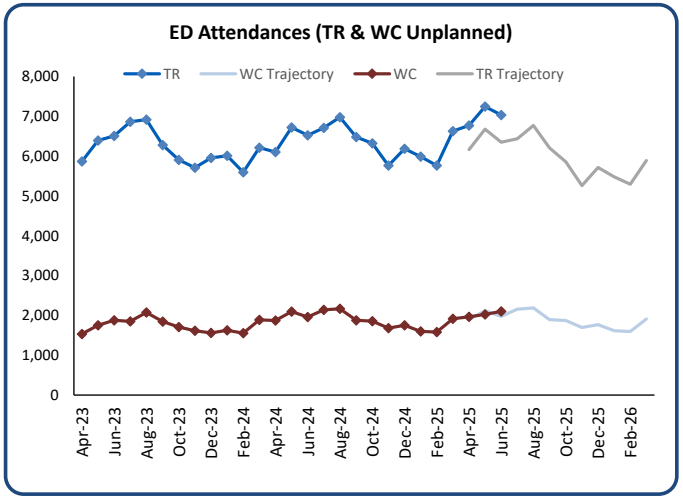
Jun-25
87.97%



Jun-25
88



Jun-25
682.22

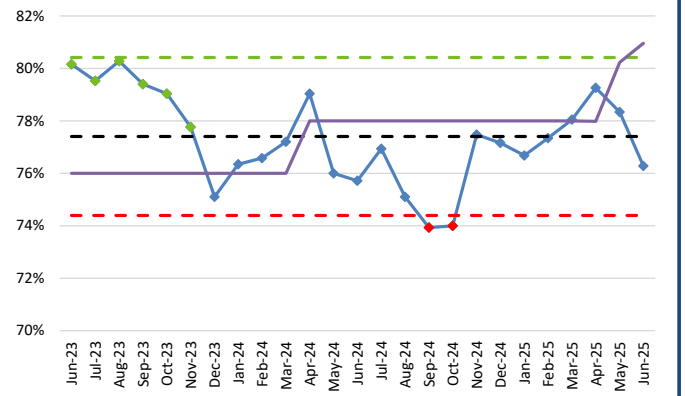


Jun-25	
TR	7034
WC	2100

Safe, High Quality Care

Trust priority

ED & MIU attenders - 4 hours arrival to discharge, admission or transfer



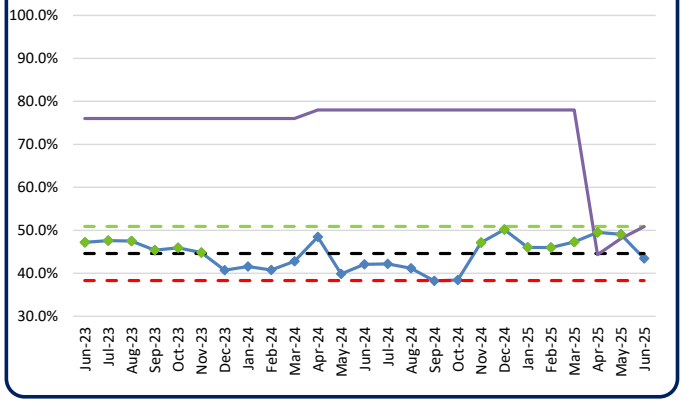
Jun-25

76.28%

NHS PAF

Trust priority

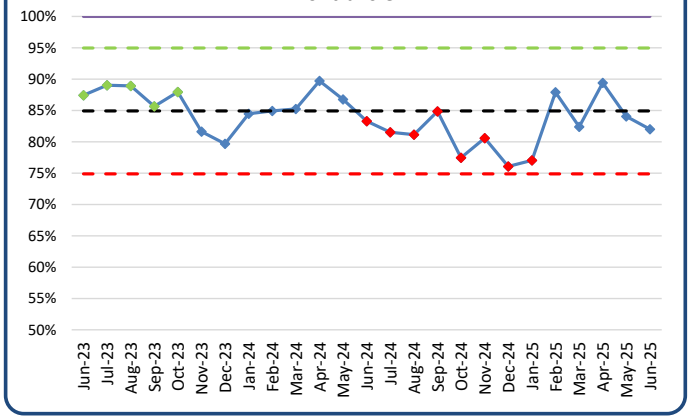
TR ED attenders - 4 hours arrival to discharge, admission or transfer



Jun-25

43.43%

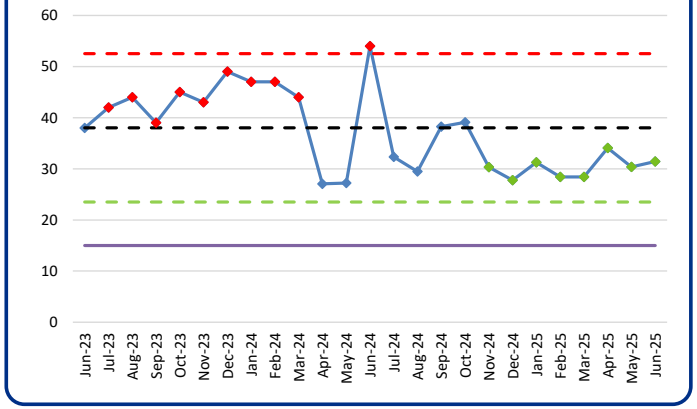
WC ED attenders - 4 hours arrival to discharge, admission or transfer



Jun-25

81.57%

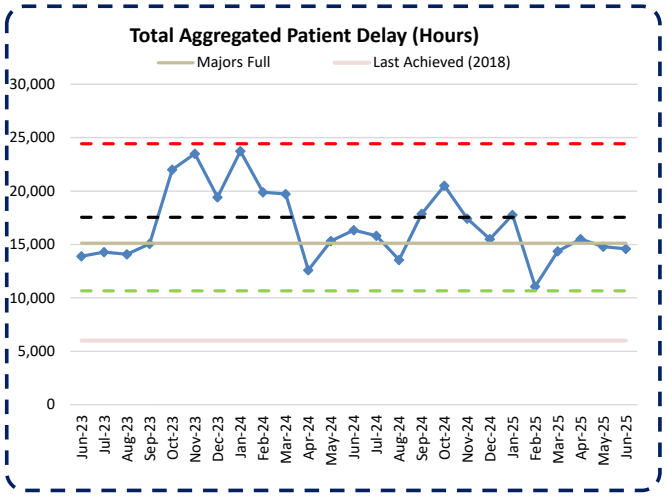
95th percentile, time to initial assessment (mins)



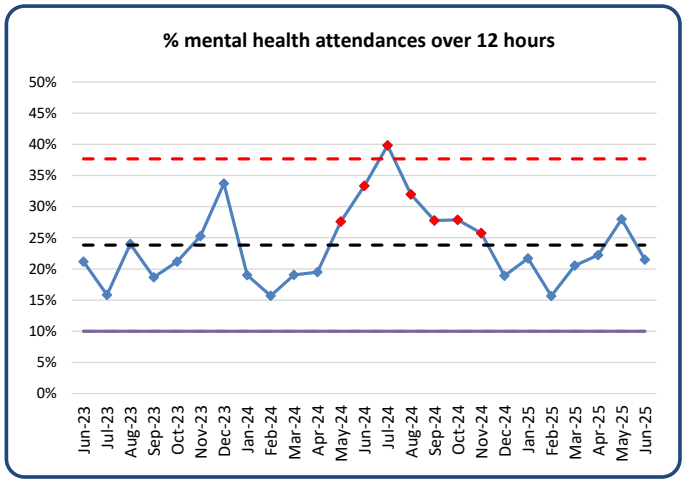
Jun-25

31

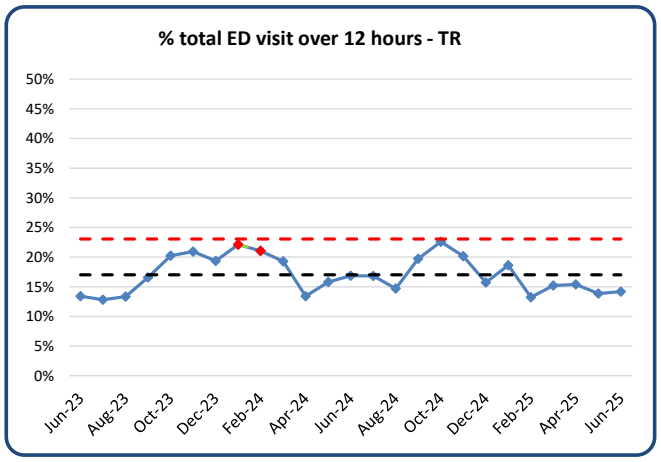
Safe, High Quality Care



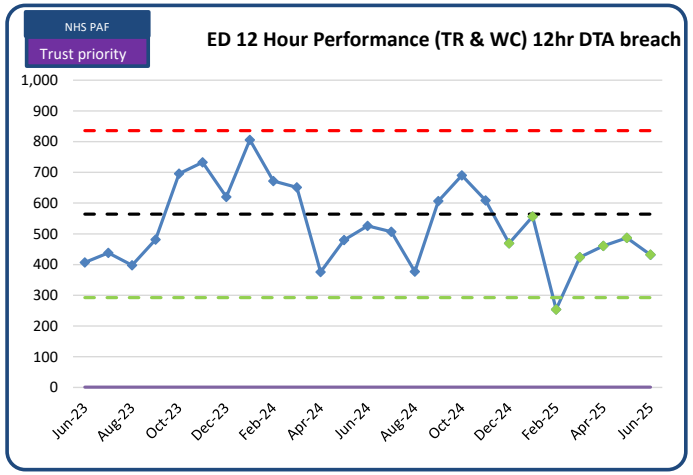
Jun-25
14,596



Jun-25
21%

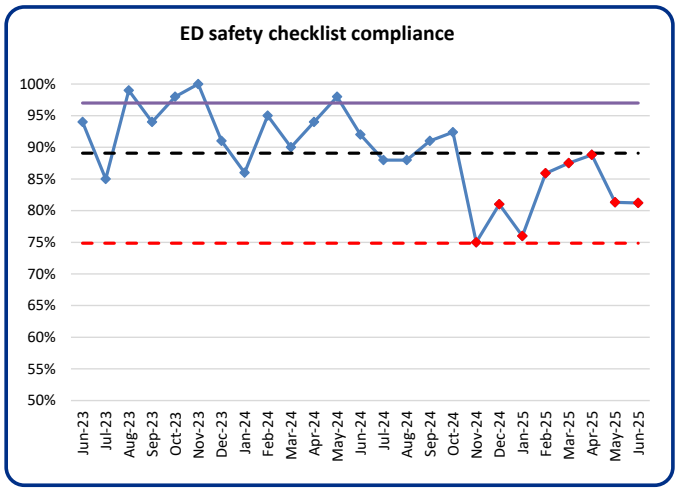


Jun-25
14.16%

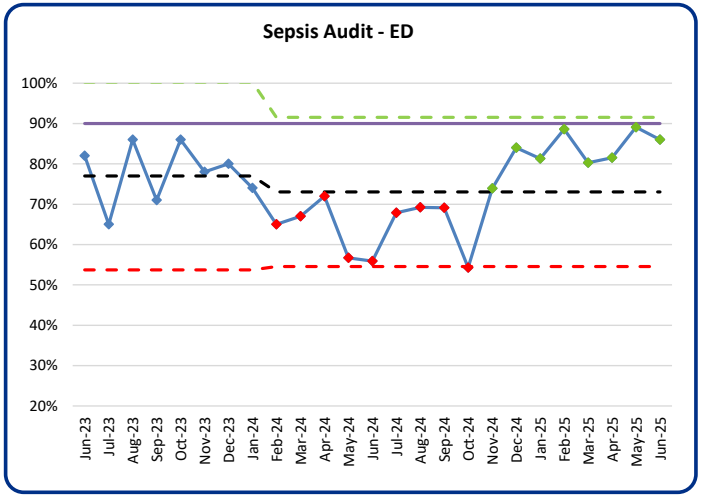


Jun-25	
Breaches	432

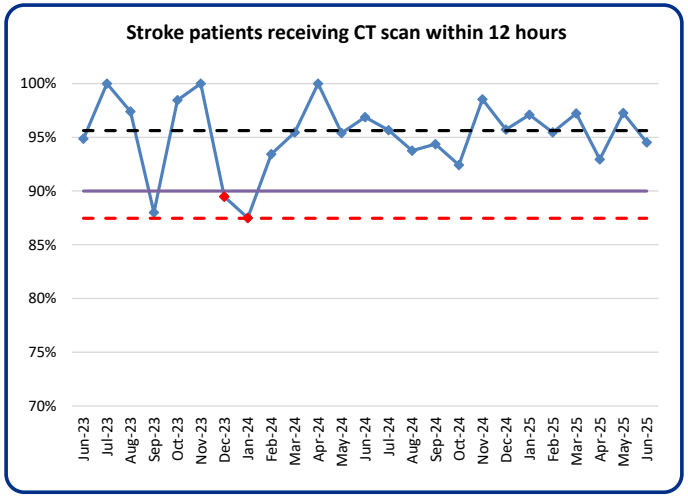
Safe, High Quality Care



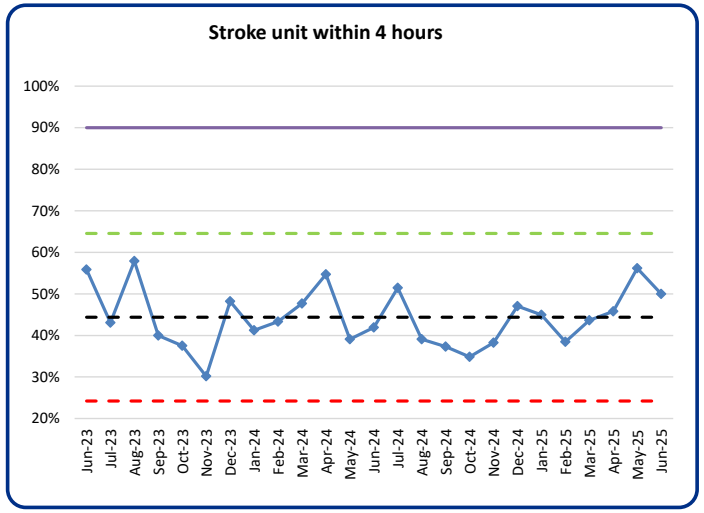
Jun-25
81.20%



Jun-25	
Antibiotics within 1 hr	86.00%



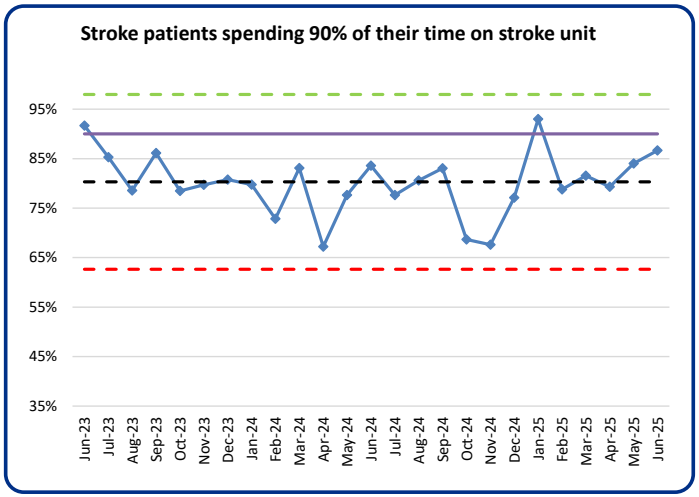
Jun-25
94.52%



Jun-25
50.00%

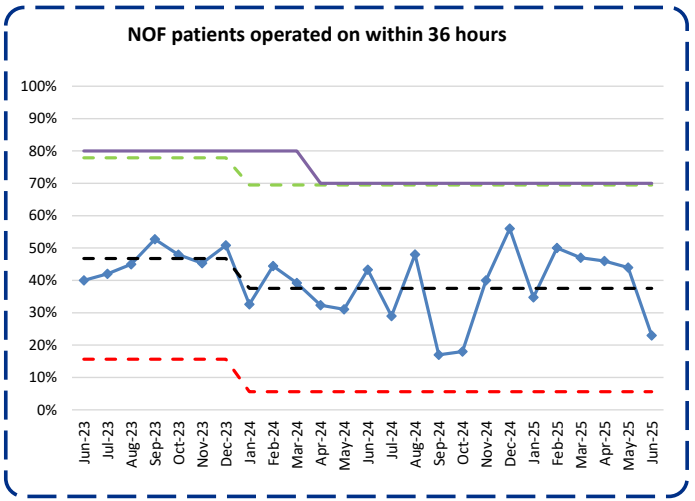
Safe, High Quality Care

Stroke patients spending 90% of their time on stroke unit



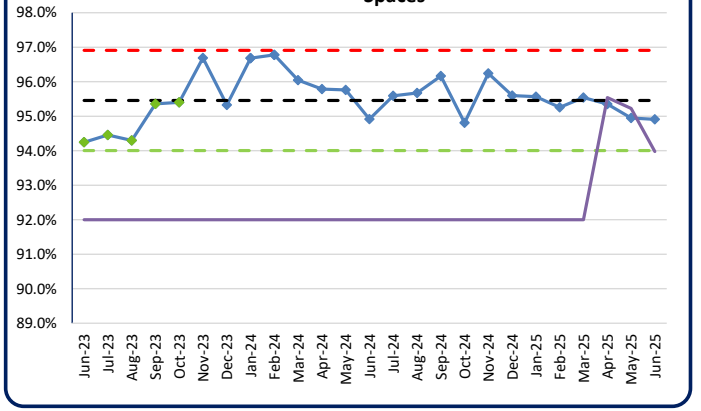
Jun-25
86.67%

NOF patients operated on within 36 hours



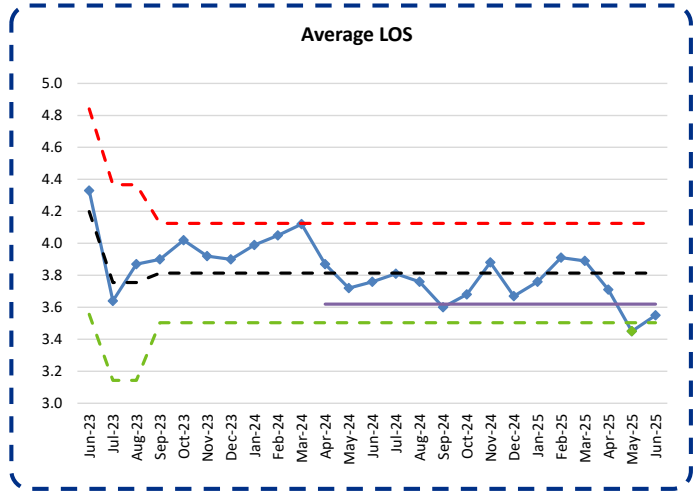
Jun-25
23.00%

Total General & Acute Bed Occupancy Including Escalation Spaces



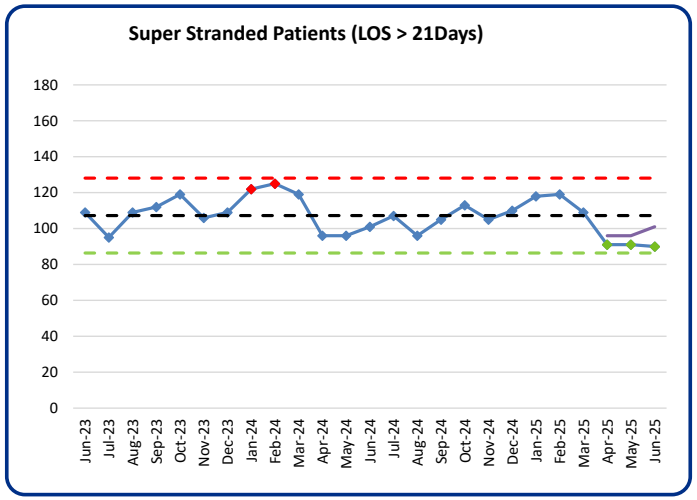
Jun-25
94.91%

Average LOS

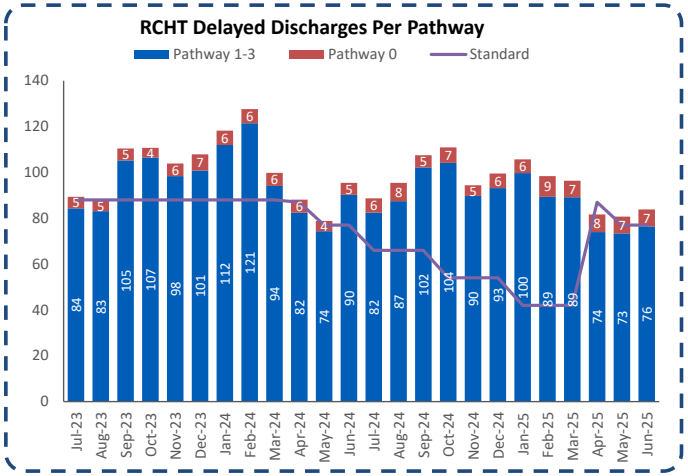


Jun-25
3.55

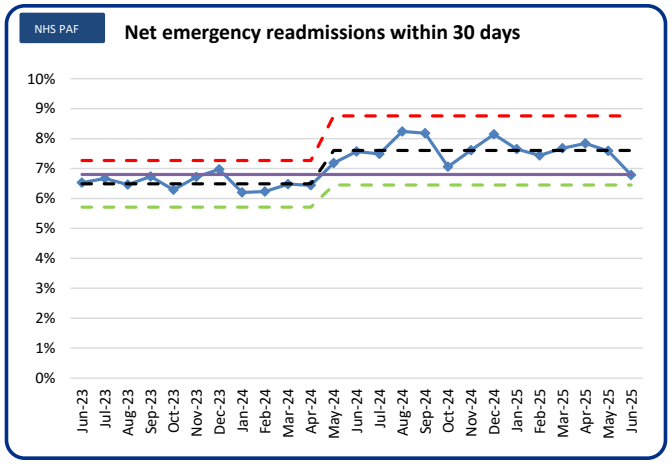
Safe, High Quality Care



Jun-25
90



Jun-25	
Pathway 0	7
Pathway 1-3	76
Total	83



Jun-25
6.78%

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. At the time of writing there were 13 65 week wait pathways for June, this is expected to improve further at final submission. All bar one were within Orthopaedics, with 1 Oral Surgery patient who has since been treated. 52 week waits increased month on month to 429 (vs 381 in May and trajectory of 381), with 22 treatment functions reporting these long waits. 35% of 52 week waits were in Trauma and Orthopaedics, with the next highest Gynaecology (13%), Dermatology (11%) and Ear Nose and Throat (ENT) (9%). 24 patients within the 52 week cohort are aged under 18 years. Incomplete pathway performance was 71.6% within 18 weeks in June, with Model Hospital weekly benchmarking (06/07/25) placing the Trust 12th in the country, and best in the southwest for this metric. Completed RTT pathway activity for both non-admitted and admitted pathways were below trajectory in June (both 97 below).

Total inpatient elective activity continued to meet the 2025/26 target in June. The outpatient follow up waiting list increased to 121,728 (+349). The follow-up waiting list backlog (more than 1 month overdue not booked) reduced to 16,197 (-101) – the most overdue remains in Cardiology at 31 months.

Diagnostic performance against the 6 week wait standard was 89.51% in June, up from 88.18% in May, against a standard of 99%. The number over 13 weeks increased to 217 in June (145 in May) with the maximum wait 89 weeks.

Elective touchtime theatres activity improved to 86% in June meeting the 85% target, the best performance in over 3 years, and the highest number of elective operations completed. Elective session utilisation improved to 92%, close to the target of 92.8%. 28 day re-booking breaches increased to 26 in June (+2) and continues to adversely exceed the target of 7. There were 103 cancellations in June, 26 more than the previous month. Percentage of cancellations on the same day is reported one month in arrears, and in May remained positively below the mean at 1.09% but did not meet the 0.8% target. The Trust met the target for the Outpatient Transformation key performance metrics in June, with the percentage of outpatients follow up without a procedure reaching the lower control limit, the best position since October 2023. The Trust continues to perform well in patient initiated follow-up (PIFU), meeting the national target and operational plan trajectory, with Model Hospital benchmarking showing the Trust to be the 5th highest Trust in the country in the most recent benchmarking from May 2025.

Actions and Progress Achieved - Elective Recovery Programme:

RTT Performance: The RCHT Operational Plan for 2025/26 aims to achieve 74% RTT performance by March 2026. Performance improved from 70% in April, 71% in May to 72% in June. Ongoing actions focus on improving non-admitted performance across all specialties, with targeted plans in high-demand areas.

Enhanced scrutiny: Work continues across all specialties to identify productivity gains.

Planned Care Improvements: The new WCH Outpatient department went live on the 3rd June with an increased range of specialities using the space**;** Medical Day Unit has vacated the Ground floor Tremenel, with WARM using the space, with Eye Emergency Clinic along with additional procedure rooms to undertake minor operations expected Qtr 3.

52-Week Waits: Provisional trajectory targets set zero 52ww by March 2026. With the increase in 52ww between April and June; the Care Groups have subsequently presented recovery plans to come back to zero 52ww by March 2026. Additional actions supporting both 52ww and 65ww are: mobilisation of a theatre template from the 1st Sept, a business case supported by St Michael's Hospital (SMH) constitutional standards capital funding to increase elective capacity, additional locum capacity, exploration if Gynae can use vacant theatre sessions at SMH as well as non-admitted sprints.

Outpatient Utilisation - A two-week audit on outpatient space utilisation has been completed, with the outcomes and data (available space) shared on the with the care groups. The agreed actions are for care groups to feedback to the clinical teams underutilised outpatient space, maximising the use of the booking system across all outpatient areas and to implement an outpatient scheduling process similar to existing theatre processes.

Outpatient Transformation – Trust continues to benchmark favourably across key indicators. Actions - clinic template levelling up continues to ensure the ratio of new to follow-up appointments is aligned with recovery plans. PIFU (patient-initiated follow-up) work continues with actions focused on the small number of specialities not in upper quartile and considered to have remaining opportunity. Technical and administrative waiting list validation continues, with 98% achieved for 12 week validation (patients are contacted at 12 weeks and then every 12 weeks thereafter), compared with the 90% target. Clinical validation opportunities using artificial intelligence solutions are being explored.

Theatre Performance: The trust continues to see improvements in session utilisation, cancellations, and overall theatre performance for June. (noting July and Aug are periodically challenging months for theatre performance). The new theatre template commences from the 1st of Sept, to increase SASH (St Austell Surgical Hub) utilisation, activity, performance and income. Work continues with the constitutional standards capital funding bid for additional theatre capacity at SMH. Ongoing focus remains on booking, session planning, and reducing cancellations both on the day and within 72 hours.

Activity Repatriation – Work continues with planning and mobilisation of repatriation of higher-cost insourced and outsourced activity**.**

Diagnostic Performance: Overall DMO1 diagnostic performance increased from 88% to 90% in June, however there is a risk that gains in other specialties may be offset by capacity challenges in CT in July. The main underperformance is in CT due to a complexity of issues. The actions to improve this include addressing CT staffing plans, CT Agency and increasing non-contrast scans via ICB-commissioned CDC (Community Diagnostic Centre) vans. Echo performance is improving through insourcing, with all echocardiographer positions filled with staff due to be in place via late summer. Respiratory physiology sleep studies remain low at 39% but improved from 34%, with improvement plans underway supported by the purchase of 10 additional sleep study machines. The ICB-contracted Camborne Redruth CDC is expected to go live in November 2025, with modular buildings arriving on site in September.

Potential Risks/Identified Risks:

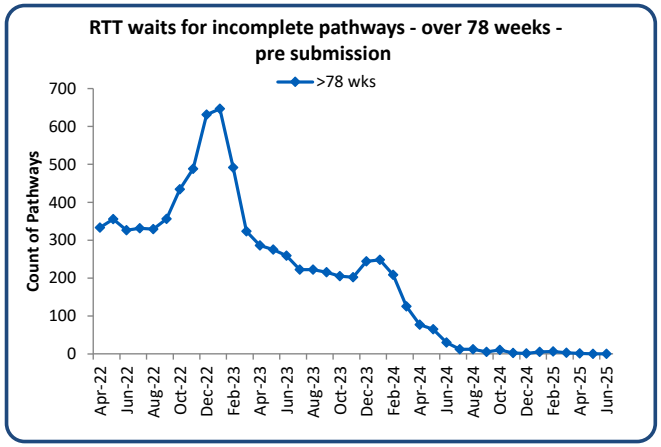
eCare Implementation Risks: Potential impacts of eCare on 2025/26 elective activity, or resources may be diverted from planned care to eCare impacting performance

Operational Efficiency Risks: The 2025/26 operational plan assumes continued activity at 2024/25 levels, including premium cost activity, which RCHT aims to reduce through operational efficiencies. There is a risk that efficiencies may take longer to realize or be insufficient, potentially causing capacity shortfalls and affecting planned care recovery. Whilst we're seeing a reduction in PTL, we are not seeing an RTT performance increase.

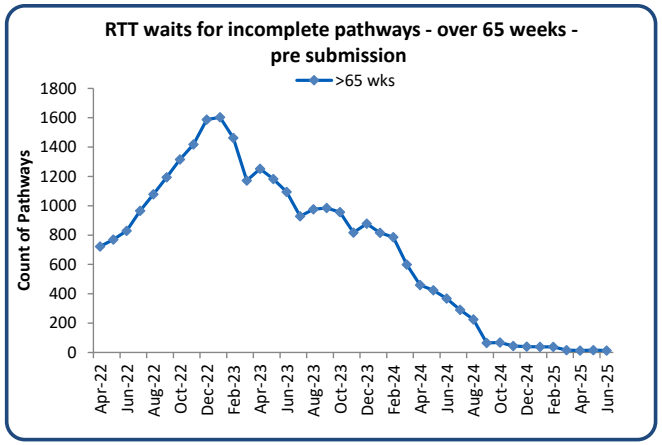
realize or be insufficient, potentially causing capacity shortfalls and affecting planned care recovery. Whilst we're seeing a reduction in FTE, we are not seeing an RTT performance increase.

Safe, High Quality Care

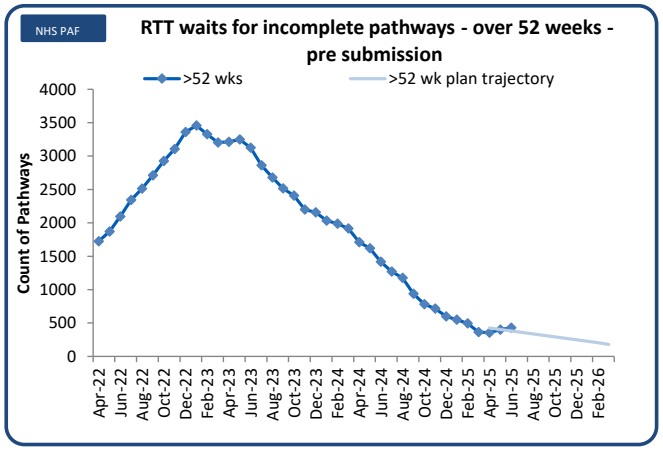
Improving access to elective services. By March 2026: 74% of patients waiting no more than 18 weeks for their elective treatment.



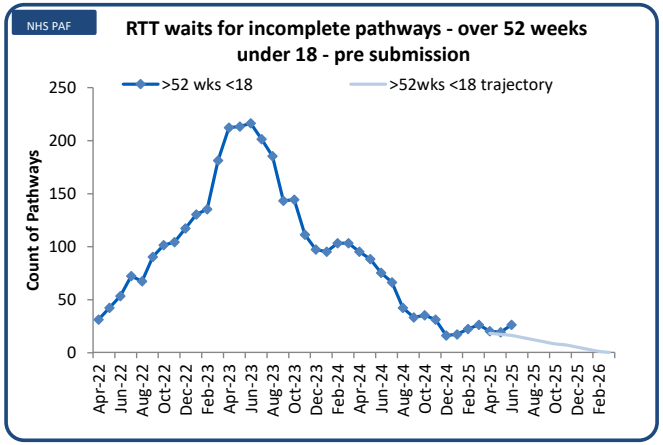
Jun-25	
Over 78 wks	0



Jun-25	
Over 65 wks	13

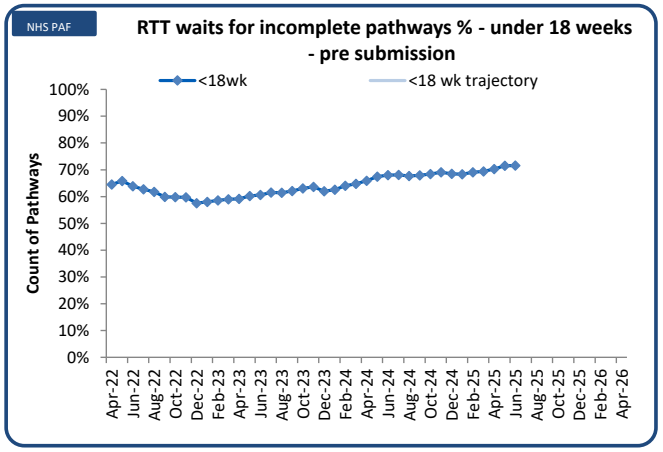


Jun-25	
Over 52 wks	429

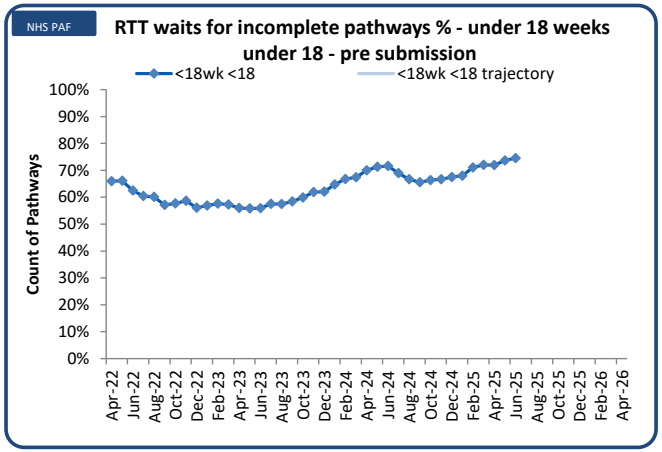


Jun-25	
Over 52 wks <18	26

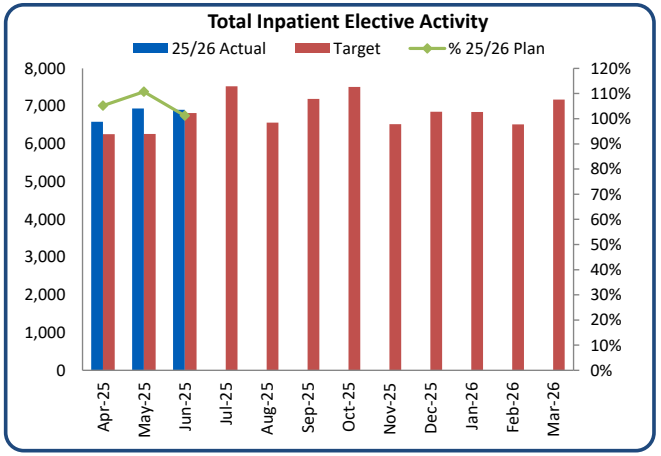
Safe, High Quality Care



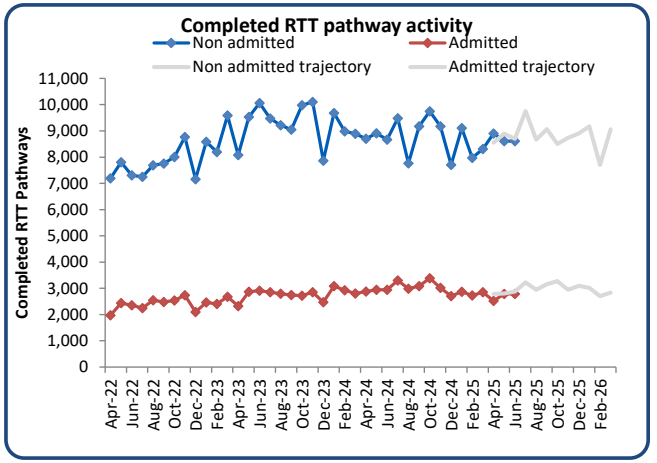
Jun-25	
Under 18 wks	71.57%



Jun-25	
Under 18wks <18	74.52%

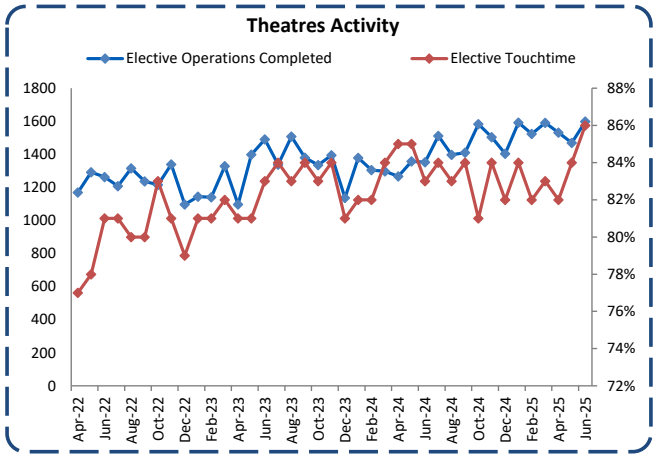


Jun-25	
Target	6819
25/26 Actual	6,901
25/26 Plan %	101%

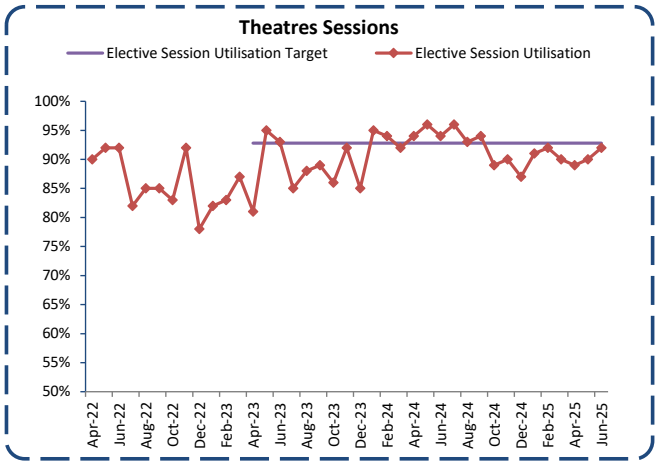


Jun-25	
Admitted	2784
Non admitted	8607

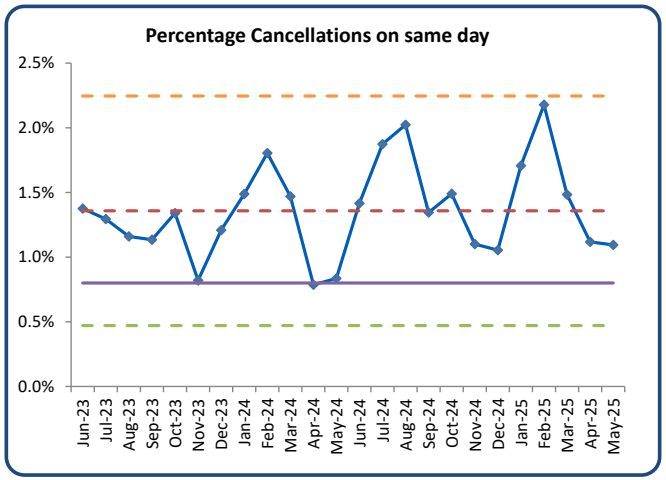
Safe, High Quality Care



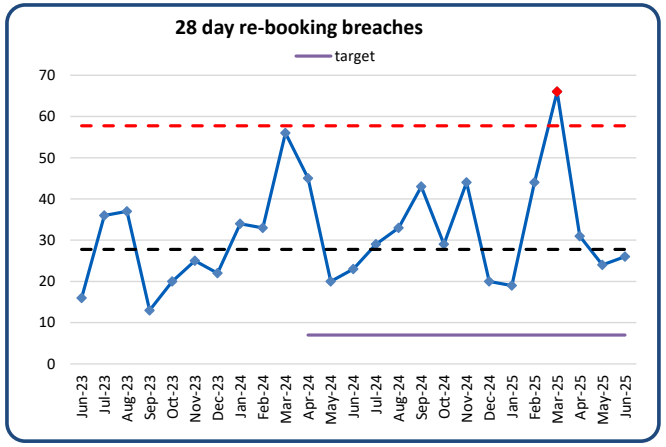
Jun-25	
Elective Operations Completed	1598
Elective Touchtime	86.00%



Jun-25	
Elective Session Utilisation	92.00%

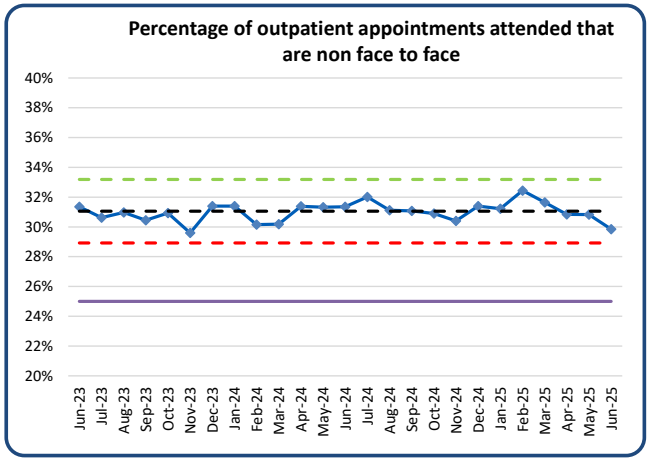


May-25
1.09%

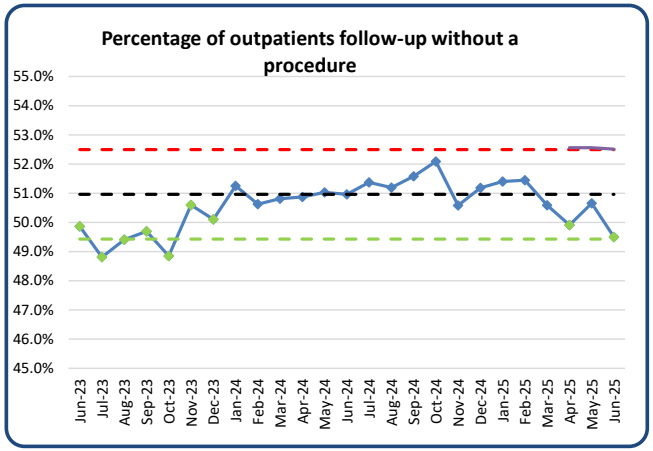


Jun-25
26

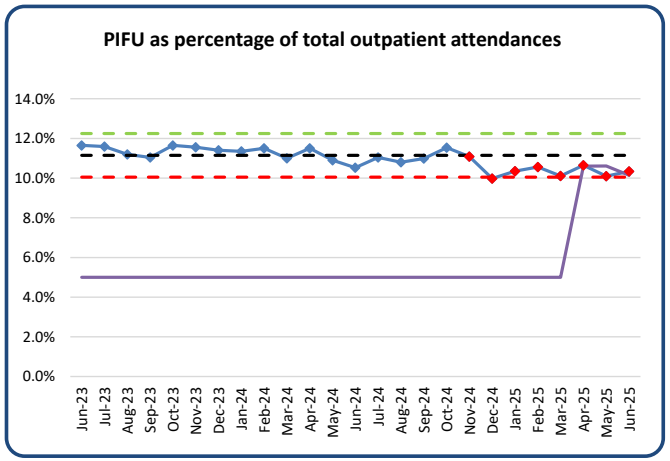
Safe, High Quality Care



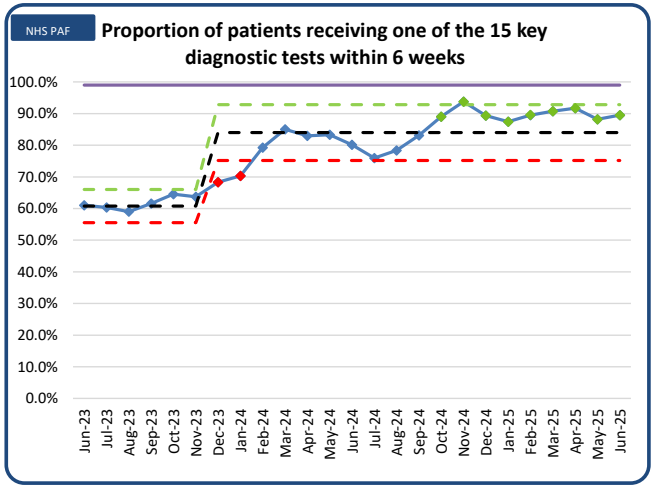
Jun-25
29.85%



Jun-25
49.50%

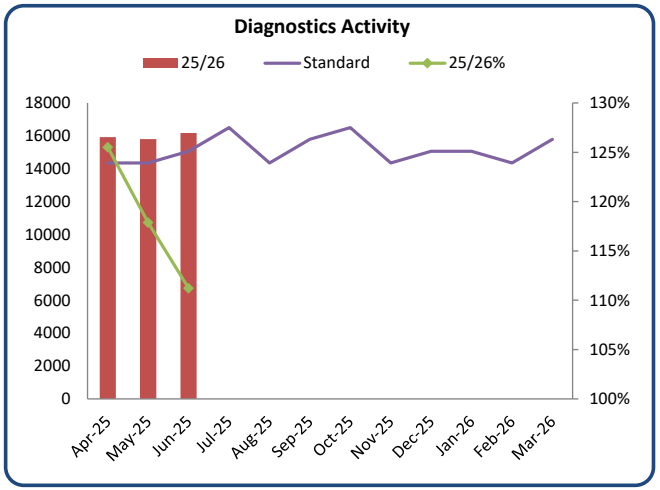


Jun-25
10.34%



Jun-25
89.51%

Safe, High Quality Care



Jun-25	
25/26	16,169
25/26%	111.23%

Safe, High Quality Care

Cancer

Metric Highlights:

In the combined 62-day target for May, there were 63.5 breaches giving a performance of 81.1%. This is a rise from April which reported 69.5 breaches and performance below 80%. It is still above the nationally set interim of 70% but under the actual target of 85%.

Both breast and lung are continuing to work on improving pathway steps and performance which will be shared with the ICB and Peninsula Cancer Alliance monthly. These will be monitored internally and concerns escalated. In May, breast 62-day was 73.2% up from 64.3% in April, and lung was 68.1% up from 67.4% in April.

This compares to an England average of 67.8% putting the Trust 19th in England. Breast reported 15 breaches which accounted for 24% of all 62-day breaches, 23% were with urology (14.5 breaches), 14% with colorectal (9 breaches) and the remaining breaches being spread across tumour sites. Head and Neck were the only site to be below England average but these are small numbers (less than 10 patients) so can be easily distorted.

Combined 31-day performance remained above 90% in May at 94.3% which is up from April's performance of 92%. Performance was above the England average of 90.9%, but short of achieving the national standard of 96%. The breach numbers were lower again in May at 39 which is down from 52 in April and considerably lower compared to nearly 70 in March and February. Half the breaches 19 out of 39 were within breast which covers breast surgery, skin oncoplastics surgery and radiotherapy. The Trust ranked 71st out of 135 providers in England.

Workforce shortages in oncology continue to be a considerable risk with potentially one of the two locums departing in July which would leave a shortfall in capacity creating a waiting list to be seen. There is also a new NICE approved drug for breast due for release in late July/early August which will add new demand. There is potential for external support to manage the additional demand which is being progressed through Trust investment committee.

Combined 28-day performance for May was 81.3% which is no change to April at 81.3%. This is above the external stretch target of 80% but short of the internal stretch target of 85%. This compares to an England average performance of 74.7%. There will be a performance downturn over the summer as breast capacity is below demand and the booking window will stretch out beyond 28 days in July without additional capacity.

Quarter one early stage diagnosis will be published in June. The Trust is benefitting from early adoption initiatives such as lung screening and embedding of FIT (faecal immunochemical test) which aim to pick up cancers before symptoms are noticeable. The capture of cancer staging which informs early diagnosis is carried out at MDT with support from Cancer Services. Specialty teams and cancer services work on filling the data gap which is then reported quarterly in arrears to ensure data completeness and accuracy.

Actions and Progress Achieved

Combined 28 day and Turnaround Time

Histology 10-day turnaround dropped from 87.1% in May to 79.1% in June. The number going through was still lower at just under 190 compared to 200+. To deliver strong histology turnaround times actively supports the 28 day pathway as this can account for a third of the allotted pathway time.

Endoscopy turnaround continued to be over 70% in June at 75.6% up slightly from May. Nearly 550 suspected cancer procedures were carried out. The average wait was just under 10 days again in June at 9.93 which is essential to ensure any histology can be processed within the 28 day window.

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. At present the Trust is reporting just under 10 days for diagnostic procedures and the majority of histology reports are available within 10 days which allows one week to inform the patient of a diagnosis or no cancer found.

Combined 31 day and 62 days.

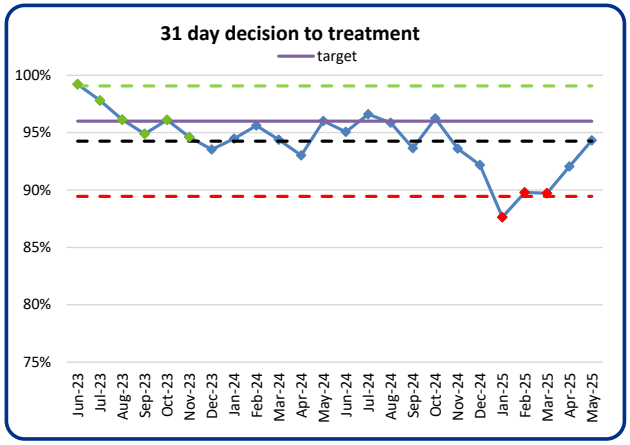
Breast surgery performance improved for 62 day and 31 day in May with very similar activity to April but fewer breaches. The 31 day has improved over the last couple of months and is now above the England average whereas before it tracked consistently below. For 62 day performance there is a clear margin between national performance and the Trust with around 15% higher performance by the Trust. There is ongoing work on a recovery plan for breast including radiology and surgery to review the entire pathway and how performance can be sustainably recovered. There is a high risk of further deterioration as capacity for the first new patient appointment is moving out and will start to be outside of 28 days mid-June where any referral received will be booked beyond 28 days into July and August. Early actions taken have mitiga ted impact and patients are now being seen within the 28 day target. Work continues to implement a single pathway for all breast patients. Ongoing recruitment in radiology to provide sustainable capacity, alongside surgery.

Oncology continues to have a high-risk gap in breast oncology with workforce shortages in consultants. Two locums are in post and the Trust is out to advert for replacements. One locum is likely to leave the organisation in July which will further exacerbate the capacity shortfall. The team are reviewing potential locums to bridge the gap to recruitment.

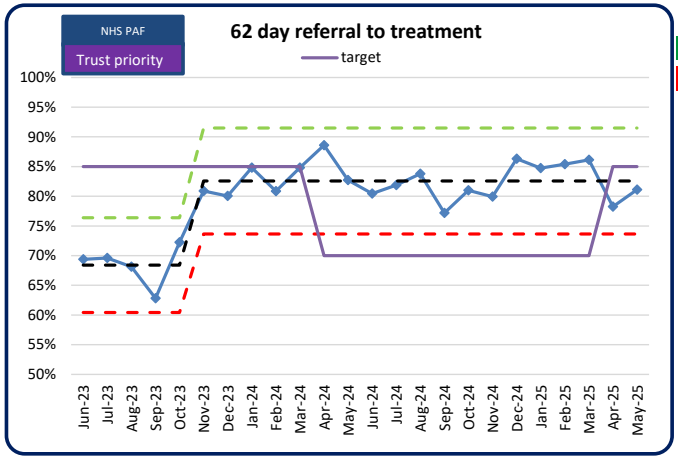
Most tumour sites maintained or slightly improved their 31 and 62 day performance in May compared to April. At the end of quarter one (June data), it is anticipated that trajectories will be upwards in order to reach the national targets of 96% and 85% stretching beyond interim national targets to meet the internal stretch targets.

Safe, High Quality Care

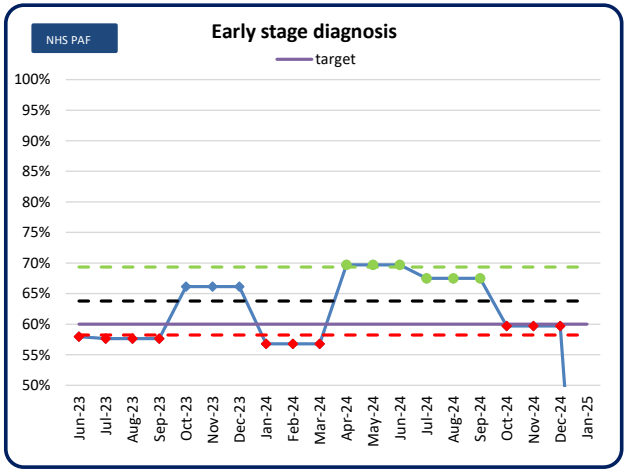
Improving access to elective services. By March 2026: 84.8% patients to receive treatment within 62 days, 83% patients to receive a diagnosis within 28 days



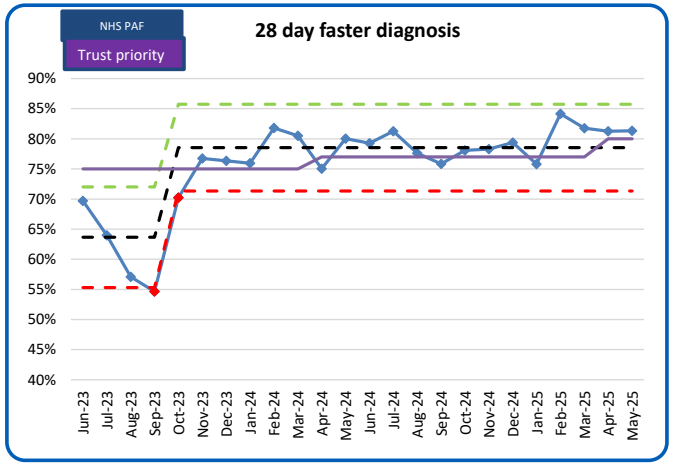
May-25
94.32%



May-25
81.10%



Dec-24
59.71%



May-25	
Faster Diagnosis	81.34%

Safe, High Quality Care

Safety and Quality

Metric Highlights:

Rate of inpatients to suffer a new pressure ulcer per 1000 bed days remains high at 1.4 in June, although dropped just below the upper control limit having exceeded the upper control limit last month. For the fourth consecutive month moderate/severe harm falls per 1000 bed days reduced to the lowest level since April 2024. The total number of formal complaints received was the highest in over 2 years with 40 received in June. Combined, June saw the most complaints received since October 2024. Duty of Candour compliance saw the best performance in over 2 years at 67%, although remains a way off the target of 100%.

HSMR (Hospital Standardised Mortality Ratio) and Mortality: The HSMR (Hospital Standardised Mortality Ratio) (12 months rolling year to March 2025) is 96.26. There is currently 1 HSMR alert for RCHT: Fractured neck of femur: 122.50 – a slight increase from 118.92 . There are 76 patients in 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: Deficiency and other anaemia 96.27, Acute Cerebrovascular Disease (Stroke) 95.89, Renal Failure 60.26, Congestive cardiac failure 85.17, Other Fractures 57.27 and other Liver disease at 44.78

RCHT's SHMI is currently at 106.69. This is well within the benchmarked confidence levels. Upper 95% confidence level of 117 and lower 95% confidence level of 87. There has been a slowly increasing trend over the last 6 months which is being monitored. An increase in SHMI can signal issues and changes in a number of areas. Clinical Care: Increase in patient acuity/severity – Sicker patients being admitted may have higher mortality risks not fully captured in the SHMI model. Increase in emergency admissions – Emergency admissions have a higher overall mortality than planned admissions. End of life care post disch arge – Patients dying within 30days of hospital discharge are included in the SHMI model and changes in end of life care will affect the index. Suboptimal clinical care – Diagnosis and treatment delays, service changes suboptimal handovers, patient flow, staffing and skill mix.

Data and coding: Inaccurate data entry for patient comorbidity will mean expected deaths are underestimated, increasing SHMI. Inaccurate primary diagnosis coding will affect risk adjustment in the SHMI model and affect mortality rates. Poor quality discharge data/incomplete follow up will affect SHMI. Systemic/External Factors: Pandemic/seasonal illness. Change in population demographic – for example increase in age and frailty.Discharge to inappropriate care settings – for example community care capacity not matching demand will increase HSMI. We are monitoring the gradual rise in RCHT SHMI in this context, despite the rise being well inside control limits.

Falls: In June, there were a total of 79 inpatient falls reported which means the Trust target of 7.5% reduction (5.32) was met. The observed decrease in falls may be attributed to the alterations in reporting where now only those areas with occupied bed day data are included in the numbers, all other falls will still be acknowledged as part of the monthly reporting. The new Multifactorial Assessment to optimise Safe Activity (MASA) assessment which became operational in May, as well as the availability of decaffeinated beverages as a standard choice for patients prompted by the significant link between falls and lower urinary tract symptoms in hospital settings, may have also attributed to the decrease in numbers seen this month. There was 1 reported inpatient fall that resulted in moderate or greater harm, successfully achieving a 10% reduction in falls leading to injury. The incident occurred on Kerensa ward and was classified as severe harm resulting in a fractured neck of femur. Over the past three months, Kerensa has experienced 4 inpatient falls resulting in moderate or greater harm. Currently, a thematic review is being conducted to develop a strategy aimed at minimising patient harm in this area.

Infection Control: By June's end there has been 20 hospital onset, hospital associated (HOHA) C.diff infections with 9 occurring in June. The Trust is 1 above expected tolerance for HOHA at this stage. There have been 2 C.diff community onset, hospital associated cases in June bringing the total to 6, 1 below expected tolerance at this stage. In June there were 3 periods of increased incidence identified in regard to C.diff, this is 2 or more cases on the same ward within a 28 day period. Trauma 1 and Zennor have been reviewed and no link has been found. GLU is under further investigation with samples being sent for genetic grouping. Additional actions such as enhanced cleaning, auditing and antimicrobial review are underway.There has been no cases of MRSA reported so far this financial year, the tolerance for MRSA is '0', last year the Trust reported 1 MRSA case. During June there were 4 cases of E.coli HOHA reported, bringing the current 2025/26 total to 10 cases. E.coli HOHA is currently 11 cases below the tolerance envisioned by June's end, this is positive and will be an area that the IPAC team are looking for themes due to an increase in cases in 2024/25. 1 E.coli has been reported at a moderate harm level in June, a PSR1 is outstanding for this case. A case of ESBL resistance was also reported at a level of moderate har m in June, the PSR1 is underway. All other healthcare associated infections that the IPC service tracks have been reviewed as no - minor harm. Outbreak activity has been low with one Covid-19 outbreak reported in June on Phoenix. In recent years a rise in cases has been seen during July into early August, however latest epidemiology suggests that we have already seen a small peak and that cases are on a downward trajectory across the South West. The IPAC team will continue to monitor this.

Complaints, Duty of Candour, PSII and Never Events: Complaints acknowledged within three working days remained at 100%, reflecting the team's continued high performance and commitment to timely communication. This month has seen an increase in the number of formal complaints, marking the highest figures in the past 12 months. The team continues to focus on early escalation and effective coordination to ensure responses are managed within the required timeframe.

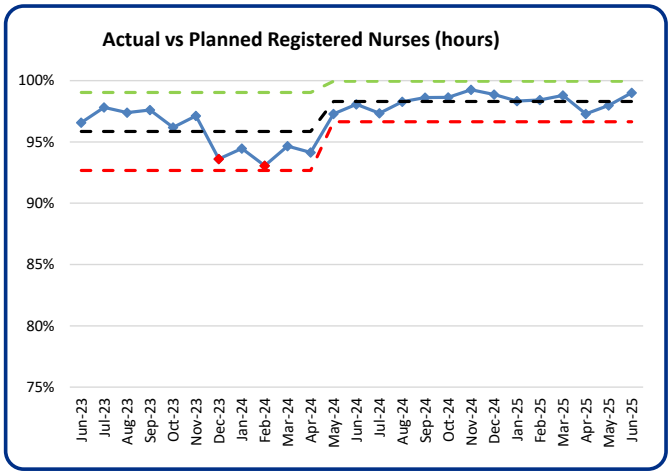
Never Event declared following an anaesthetic block incident which was incorrectly administered to the right side for a left side procedu re (wrong side block). Declared on the 13/06/2025. Duty of Candour complete. Terms of Reference for the Patients Safety Learning Investigation agreed. No harm to patient.

Quarterly Duty of Candour audit is in progress. The Duty of Candour improvement project working group commenced 11th July 2025 and are moving into the first element of the deliver plan, the Associate Director of Quality Governance is the SRO. There is a review of the Duty of Candour Patient Information Leaflet which is currently in progress.

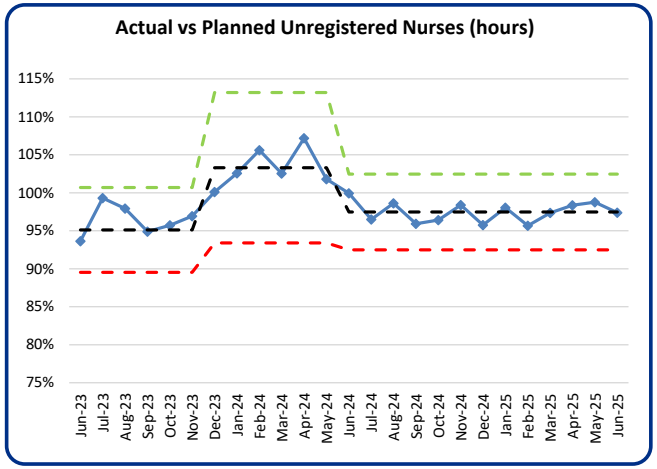
Pressure Ulcers: The incidence of hospital acquired pressure ulcers has reduced slightly this month, from 1.7 in May to 1.4 in June. Even thou gh there has been a slight decrease in overall numbers, the level of harm has increased. 10 category 3 or above incidents were reported in June. Using the pre-PSR 1 checklist, 7 of these were confirmed as true moderate harms. This is a significant increase from the 2 moderate harms confirmed in May. The themes within these incidents is similar to previous investigations, with documentation not completed accurately or according to the risk assessment and equipment not being in place in a timely manner.

There is a new risk on the risk register concerning workforce issues within the Tissue Viability team. This may have an impact on the number of pressure ulcer incidents due to lack of education and support for wards.

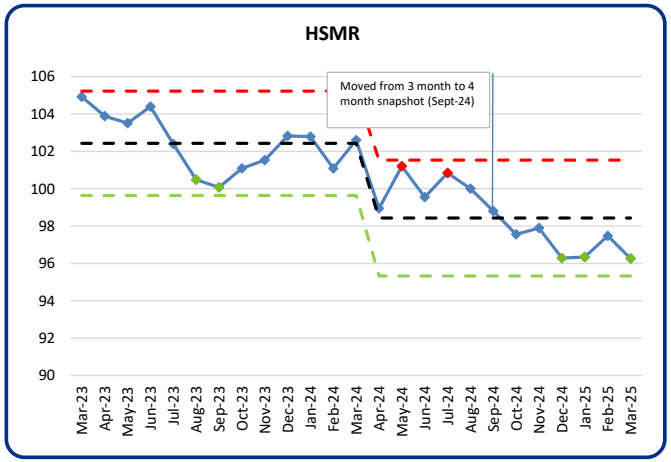
Safe, High Quality Care



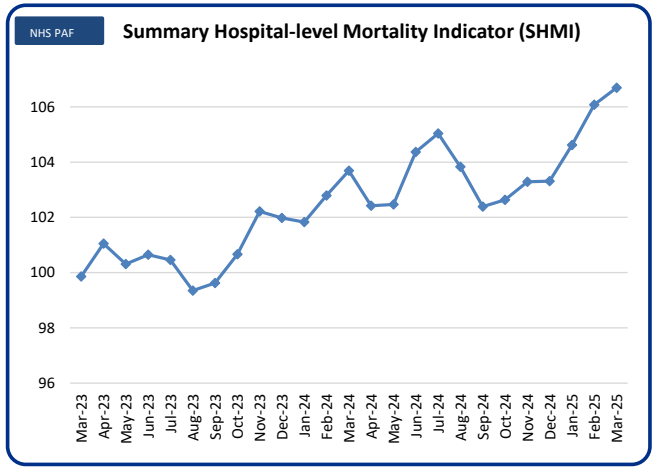
Jun-25	
Actual vs Planned	99.02%



Jun-25	
Actual vs Planned	97.40%



Mar-25	
HSMR	96.26

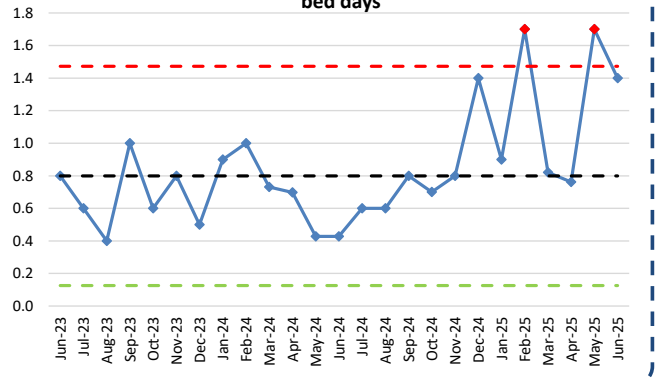


Mar-25
106.69
(Expected range)

Safe, High Quality Care

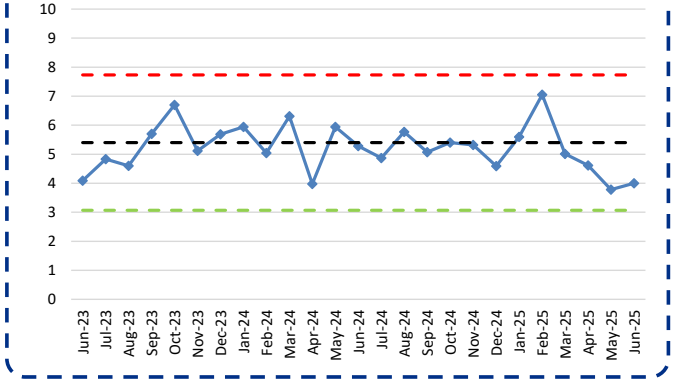
NHS PAF

Rate of inpatients to suffer a new pressure ulcer per 1000 bed days



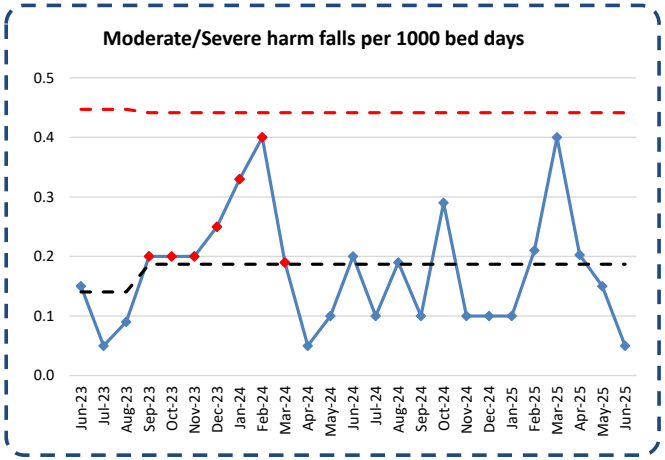
Jun-25
1.40

All patient falls per 1000 bed days



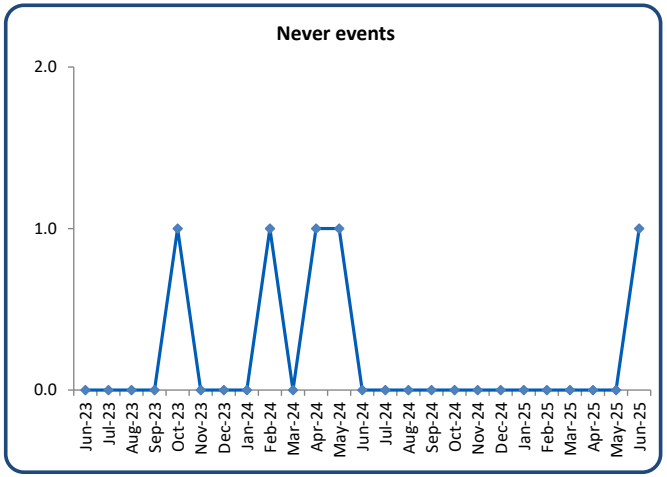
Jun-25
4.00

Moderate/Severe harm falls per 1000 bed days



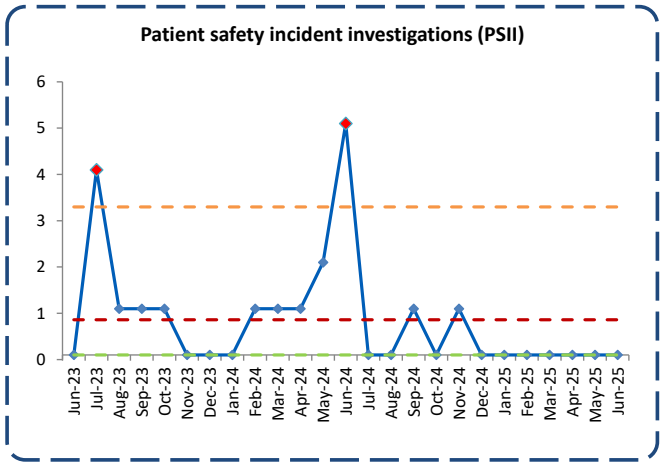
Jun-25
0.05

Never events

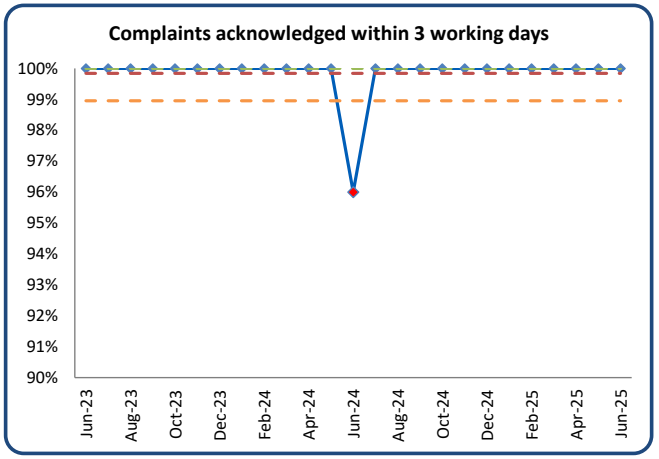


Jun-25
1

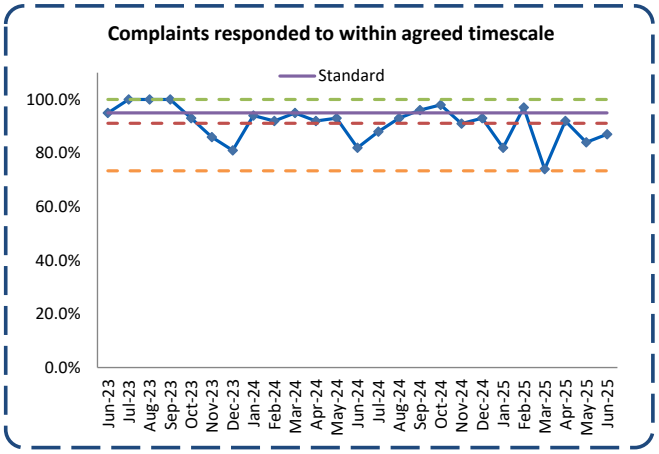
Safe, High Quality Care



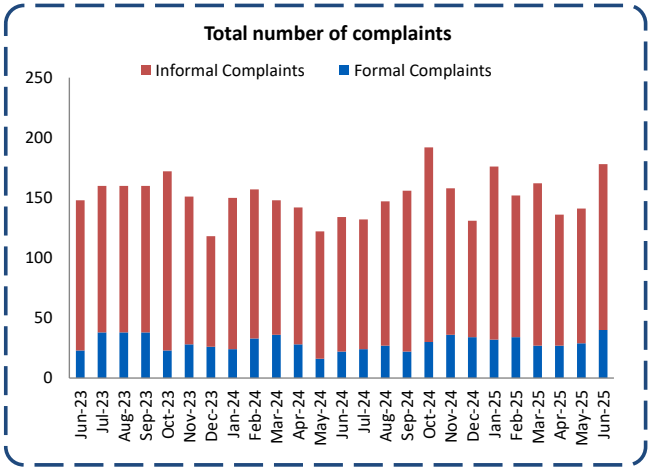
Jun-25
0



Jun-25
100.00%

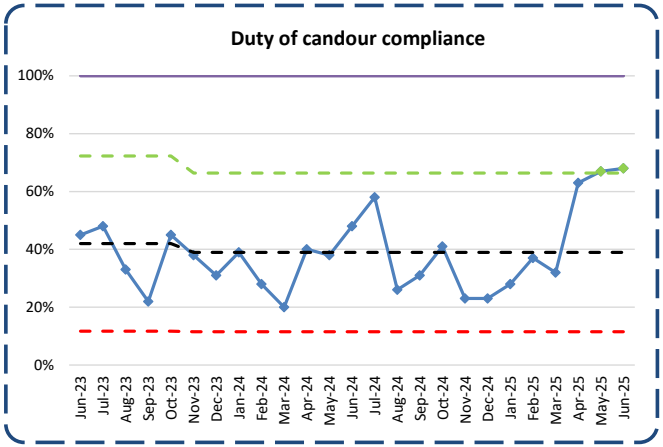


Jun-25
87.00%



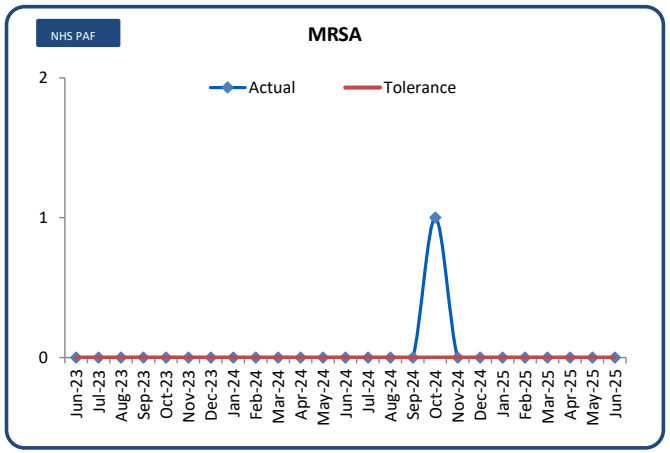
Jun-25	
Formal complaints	40
Informal complaints	138

Safe, High Quality Care

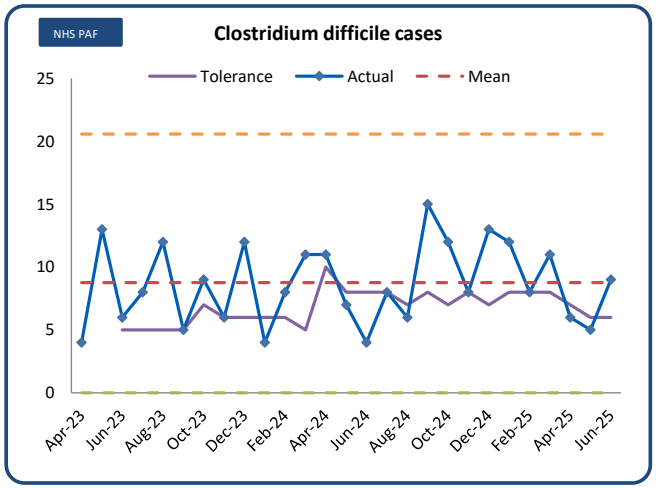


Jun-25
67.00%

Duty of Candour (All Incidents)	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Incident Graded Moderate or Above	14	17	28	10	18	19
Duty of Candour Complete	13	12	9	16	17	18
% Compliance with Duty of Candour	**28%**	**37%**	**32%**	**63%**	**63%**	**68%**

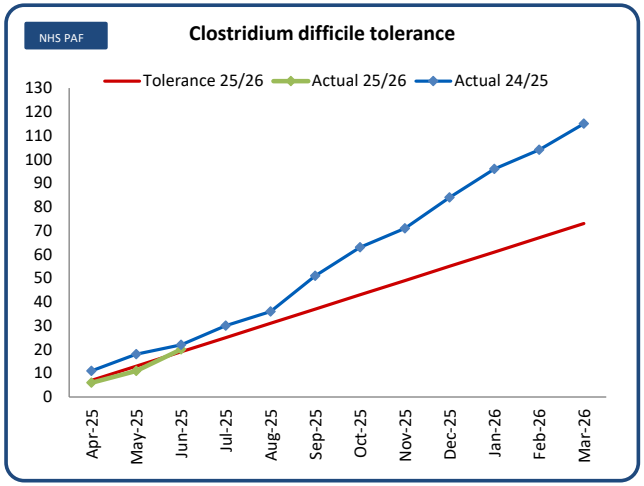


Jun-25
0

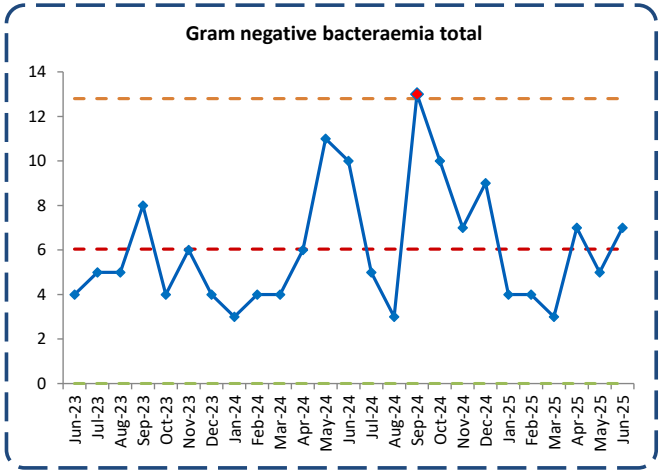


Jun-25	
Cdiff Cases	9
Tolerance	6

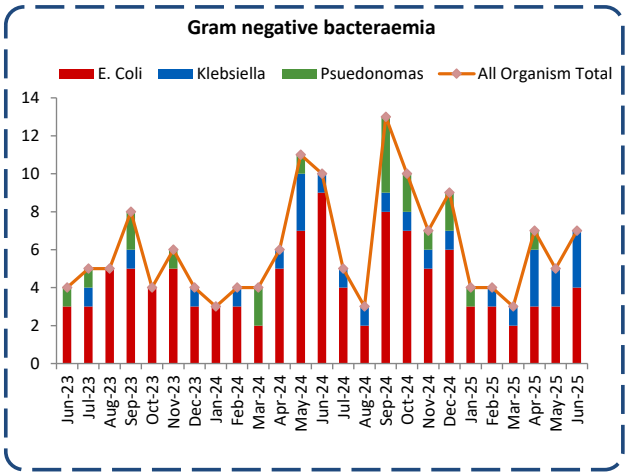
Safe, High Quality Care



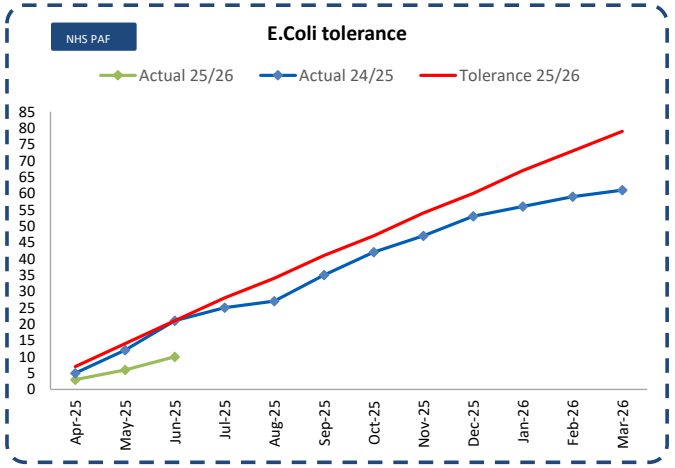
Jun-25	
Cdiff cumulative	20
Tolerance	19



Jun-25
7

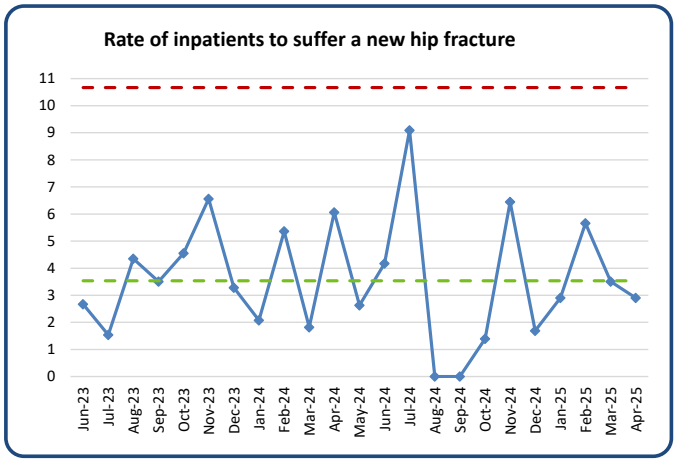


Jun-25	
E.coli	4
Klebsiella	3
Pseudomonas	0
All Organism Total	7



Jun-25	
E. Coli cumulative	10
Tolerance	21

Safe, High Quality Care



Apr-25
2.90

Supported and Valued People

People

Metric Highlights:

Stress related absence increased to 26.5% in June, up from 25.3% in May, but remains below the trajectory, and overall staff sickness improved slightly to 4.58% from 4.67% in May, above the target of 3.75%. Staff turnover has remained stable in June with a 0.1% reduction on last month, and vacancy rate across the Trust reduced to 10.3% from 10.7% last month. Appraisal compliance remained favourably above the mean at 75.9%, but below the target of 85%. Statutory and Mandatory training compliance flagged as a concern special cause variation on the statistical process chart (SPC) in June and was at the lower control limit with 79.1% performance against a target of 90%. Staff friends and family survey – recommend the Trust as a place to work, and recommend the Trust as a place to receive care, and pulse survey – I feel secure raising concerns or speaking up all triggered as an SPC exception concern again in June (quarterly data) with the lowest results in 2 years.

Key Exceptions: Performance on statutory and essential 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 June 25 has decreased to 10.3% and turnover has reduced slightly to 84.3%. This metric is likely to plateau or decrease given the Trust's current position and workforce interventions. We may see turnover remain static over coming months given there are schemes such as MARS running. Total Registered Nursing & Midwifery vacancy rate is 9.74% with the vacancy rate for Band 5 RNs increasing slightly to 8.22% which equates to 74 WTE. Medical staff vacancy rate has increased slightly from 7.64% to 7.94%. 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. Targeted support continues to recruit to hard to fill roles with some success for AEM consultant vacancies recently.

Recruitment: The current default position is no recruitment to vacancies. Where a role is essential to be filled, it is being held for redeployment where possible ahead of organisational change.

Variable Pay costs: Agency spend decreased in June from 829k to £671 and remains within planned spend. The South West region continues to lead the way in price cap compliance and agency spend reduction. Pending industrial action by Resident Doctors is a risk to managing premium spend.

Sickness Absence The overall annual sickness absence rate has decreased very slightly from 4.67% in May to 4.58% in June. The proportion of sickness related to stress and anxiety has increased slightly from last month to 26.5%. This is the 4th month of sickness under 28%. Working with the OH team we are promoting proactively the Employee Assistance Programme (EAP) and other support networks such as Workwell.

Appraisal Compliance: The appraisal rate remained reduced slightly this month at 76.1%%. There is a continued focus on appraisal completion and promotion of the blended approach to appraisal.

Statutory and Essential Training: Mandatory training compliance remains below the Trust target of 90%. However, it increased slightly from 78.8% in May 2025 to 79.1% in June. In April 2025 safeguarding adults level 3 training was added to the reporting framework and, as this training is still fairly new, the overall trust compliance level is still only at 27.2%%. This will have a negative impact on our overall compliance rate. 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. Subjects where participants are most 'out of date' are prioritised to build a bespoke programme addressing areas of highest risk and impact. We have been participating on the national project to streamline statutory and mandatory training. We complete our first training cluster review of requests for training to be mandated locally and have made recommendations to the strategic workforce group meeting in May 2025. We are also reviewing all locally mandated training and expect to recommend some reductions in the requirements. Nationally mandated topics, which make up the overall trust compliance figure, are being reviewed nationally. However, we have made changes to refresher frequencies in line with the national Core Skills Training Framework Compliance for Health and Safety training has increased from 76.7% to 78.4% in June 2025.

Equality, Diversity and Inclusion: A Task Force is being developed to consider why 50% of our ethnic minority colleagues have stated in the staff survey that they are considering leaving the Trust. This is outlined in the Annual Equality Report for 2025

Staff and Pulse Survey: I would recommend the organisation as a place to work

The national and local financial position has impacted performance in this quarter. This is supported by the comments coming from the pulse survey. The things we can impact that prevents staff recommending RCHT 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'; Trust is only concerned with saving money, not staff wellbeing; slow processes get in the way of implementing changes.The trust continues to work on the staff survey with all care groups and the trust forming action plans in response to staff voice. Updates are being submitted in July and will form the basis for comms campaign. Both the LEAD and Safe and compassionate leadership programme are paused from August due to capacity reductions.

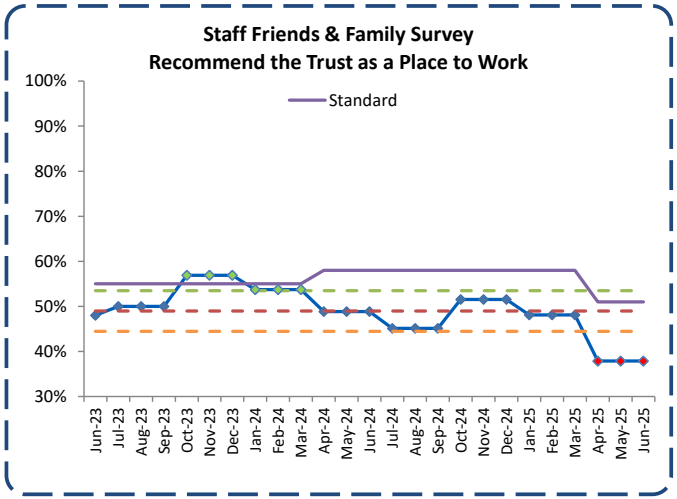
Staff and Pulse Survey: % of people would be happy with the standard of care provided If a friend or relative needed treatment

Staff are being impacted by the local and national financial position. 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; slow processes get in the way of implementing changes

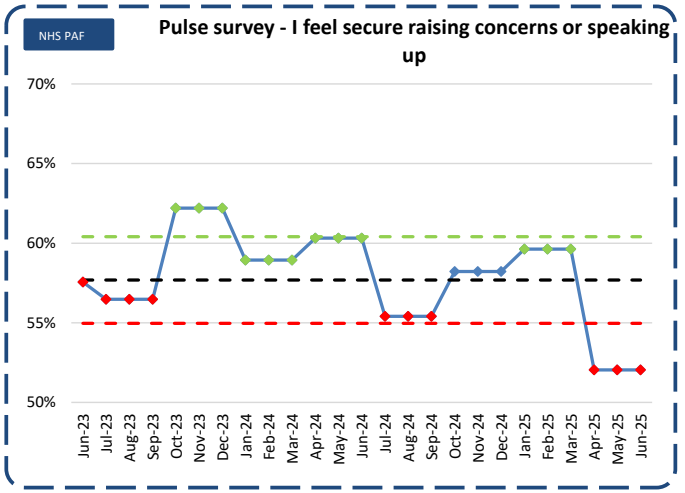
Organisational Development: LEAD programme scheduled until end of August 25 – nothing scheduled thereafter pending review of the OD programme. Safe and Compassionate Leadership programme – cohort in May but no further chohort scheduled pending review of programme for 25/26. Insights programme and bespoke OD interventions for teams continue. Work is underway to develop a 'We are RCHT' culture programme for RCHT, bringing together key elements of Organisational Development, Quality Improvement and Patient Safety.

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; impact of organisational change.

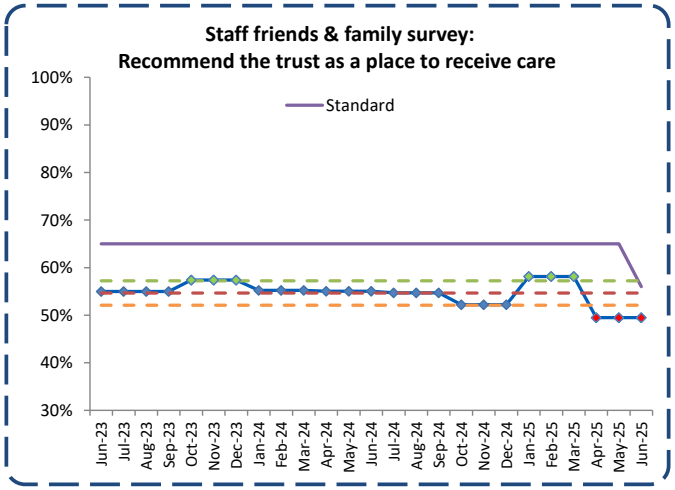
Supported and Valued People



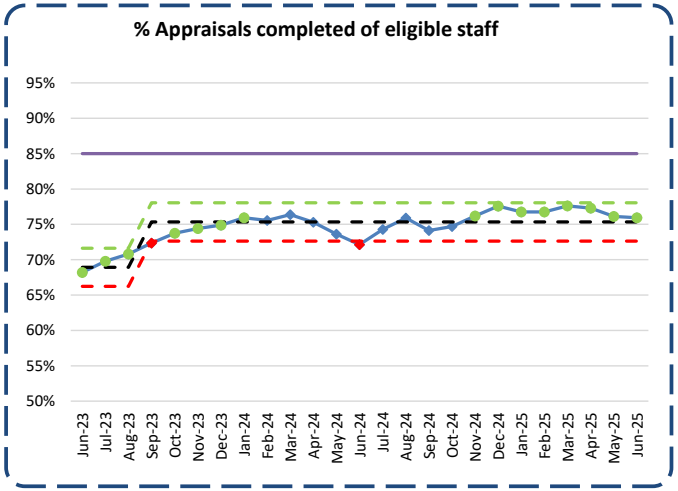
Jun-25
38%



Jun-25
52.04%

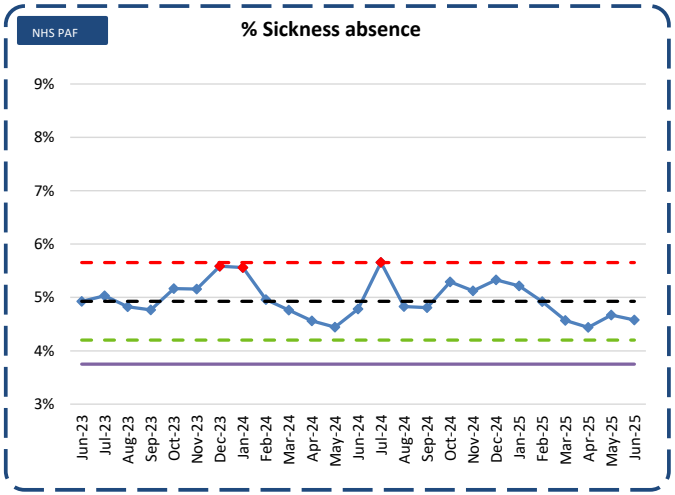


Jun-25
49%

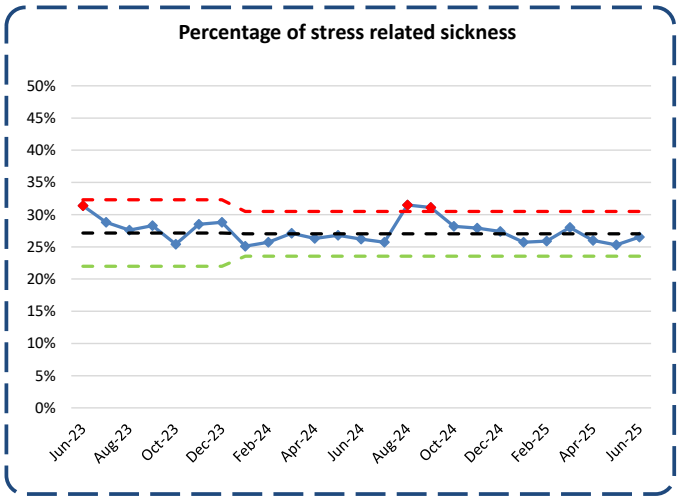


Jun-25
75.9%

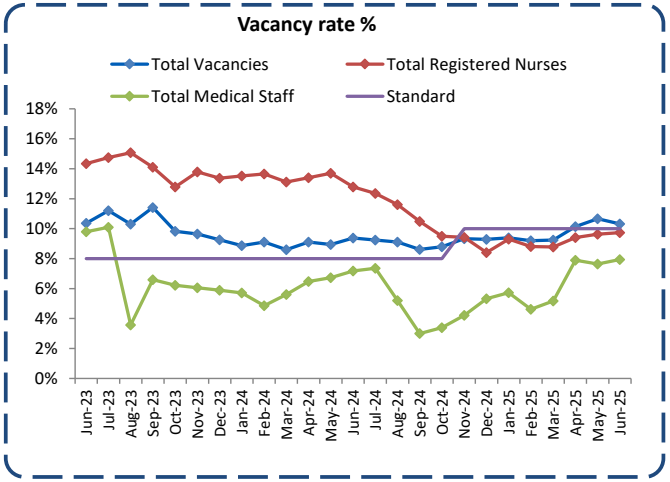
Supported and Valued People



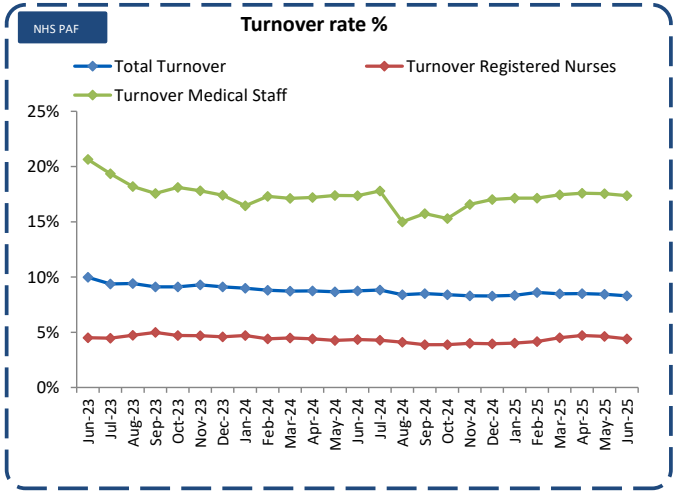
Jun-25
4.58%



Jun-25
26.50%

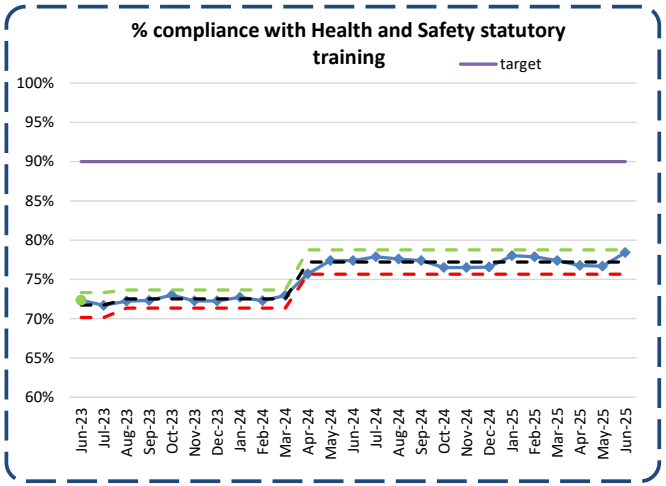


Jun-25	
Total vacancies	10.3%
Total registered nurses	9.7%
Total medical staff	7.9%

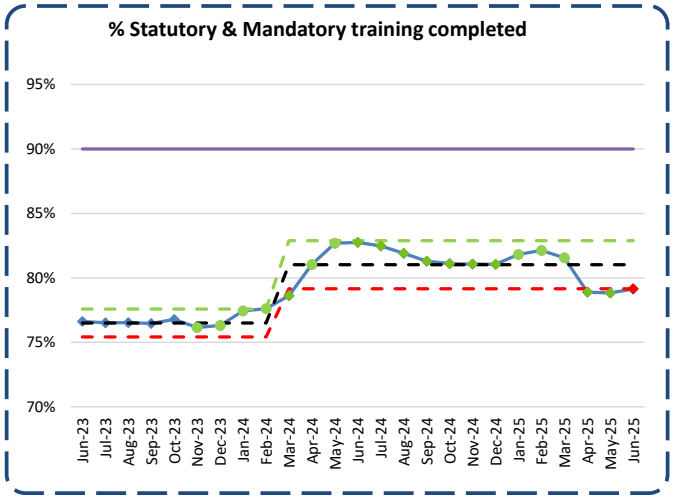


Jun-25	
Total turnover	8.3%
Total registered nurses	4.4%
Total medical staff	17.4%

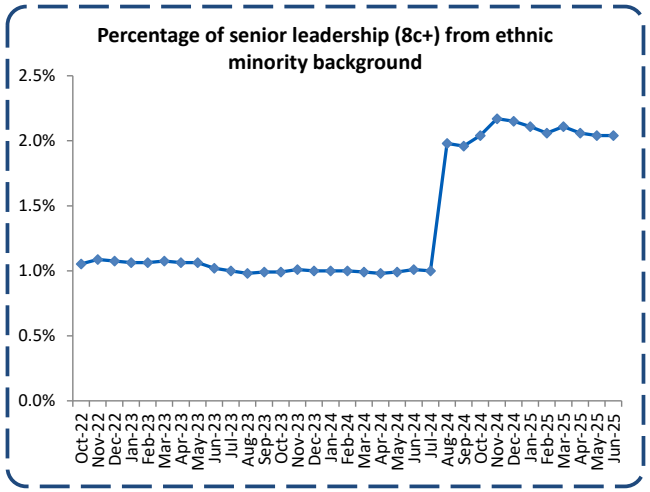
Supported and Valued People



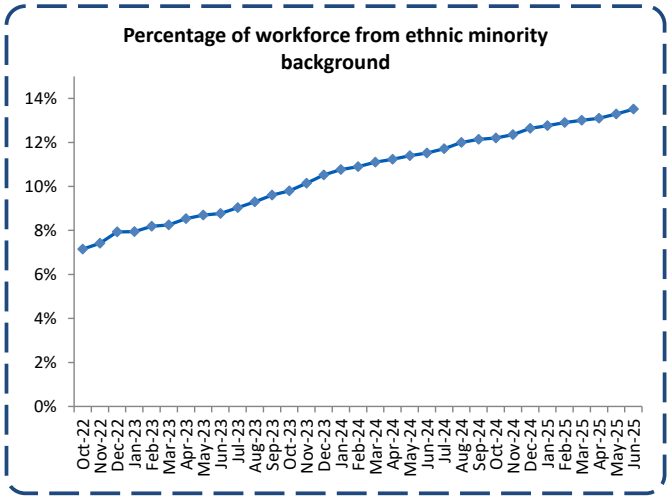
Jun-25
78.43%



Jun-25
79.1%



Jun-25
2.04%



Jun-25
13.51%

Journey of Improvement

Finance

The in-month (June) position was a £1.38m deficit, against the planned deficit of £1.35m, resulting in an adverse variance to plan of £0.03m. This decreased the cumulative positive variance from months 1-2 to a £0.04m surplus (£5.49m actual vs £5.53m deficit plan). The clinical care groups were off plan in June by £0.81m in June with a YTD position of £1.27m over budget. Though pay controls were not met in June the cumulative variance remains close to budget at a £0.08m deficit with mixed performance across care groups. Corporate departments have consistently reported underspends and in June this equated to £0.13m increasing the cumulative position for Q1 to a £0.42m surplus. The releasing of reserve underspends was necessary in June to achieve a near balanced position for the month as well as to meet CIP requirements.

Subjective Variances (Pay / Non-Pay / Income):
Pay in June pay was £0.17m over budget and has includes retrospective back payments of c.£0.2m, which partially accounts for the increase since May. These payments were across all staff groups but in particular medical staffing for back dated job plan payments.
Non-Pay was £0.73m over budget in June and £1.04m cumulatively. There is significant pressure on clinical non-pay budgets which contributes 94% / £1.2m of the overspend and relates in the main to clinical supplies and drug and blood expenditure. A proportion of this overspend is attributable to increases in operational activity and the transition from outsourcing being implemented as part of the cost improvement programme (CIP).
Income at month 3 is £523k overachieved which is mainly due to an over performance on ERF of £613k partially offset by Care Group income.

Capital:
Capital expenditure is currently £3.60m behind plan, the majority of this variance is linked to externally funded projects such as the Women & Children's Hospital and eCare which are currently behind plan. It is however expected that both projects will catch-up to the plan as the year progresses and spend their funding allocations in-full.
A handful of the Trust's larger internally funded projects have also fallen behind plan, including the refurbishment of the Sterile Services Department and the Tower Block. Work on Sterile Services is expected to catch-up later in the year whilst alternative arrangements are being made to make use of the funding currently allocated to investment in the Tower Block.

CIP:
The financial plan included a total savings target of £49.3m for 2025/26. Delivery in June was £2.73m, against a £2.77m requirement. The year-to-date position is a shortfall of £0.34m.
Recurrent CIP delivery up to M3 was £2.05m (31.7%) and a full year value of £8.6m. The forecast CIP remains at £49.3m with £0.94m unidentified but this assumes further opportunities that are yet to be fully tested to fulfil potential.

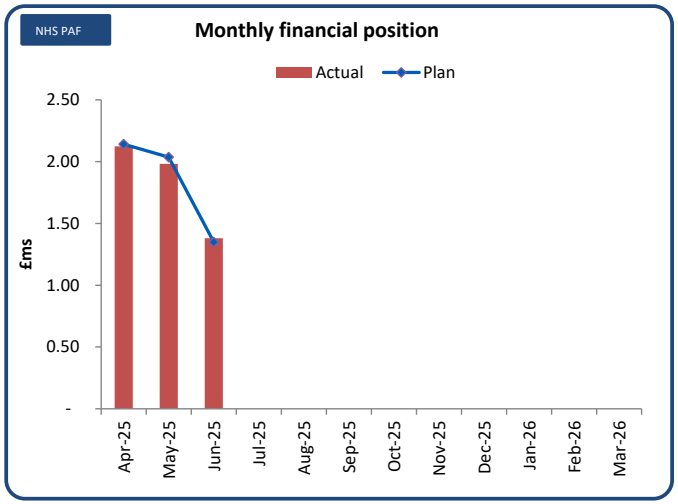
Cash:
The Trust ended June 2025 with a cash balance of £25.8m (31 May 2025 £31.2m) compared with a planned cash balance of £16.8m, resulting in a £9.0m/2.3 days of favourable variance to plan.

Agency:
Expenditure for the month was £0.1m below plan across both medical and non-medical. Cumulatively, Q1 expenditure is £0.31m below expected levels. These underspends have been most pronounced in the Acute and Emergency Medicine care group and are reflected across all staff groups, with the most significant in nursing and consultants.

Journey of Improvement

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

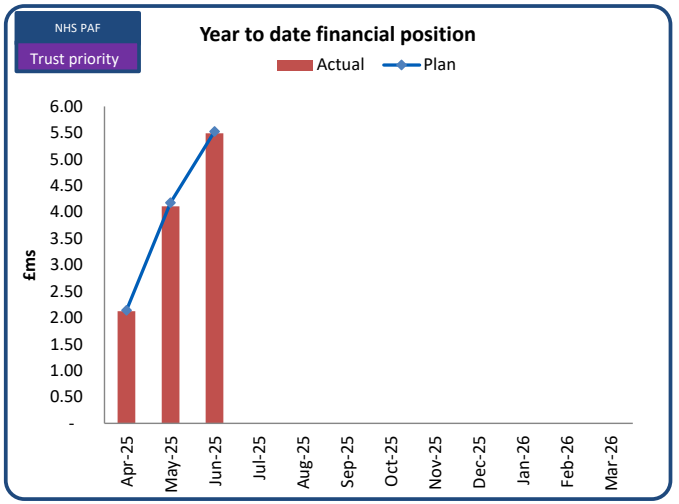
NHS PAF



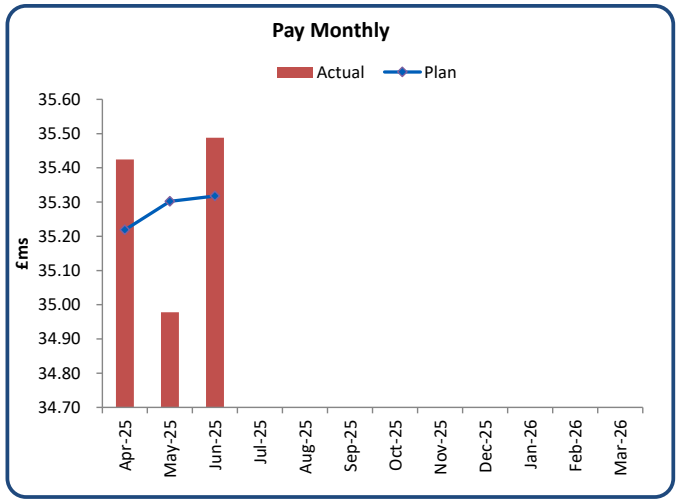
Jun-25
1.38

NHS PAF

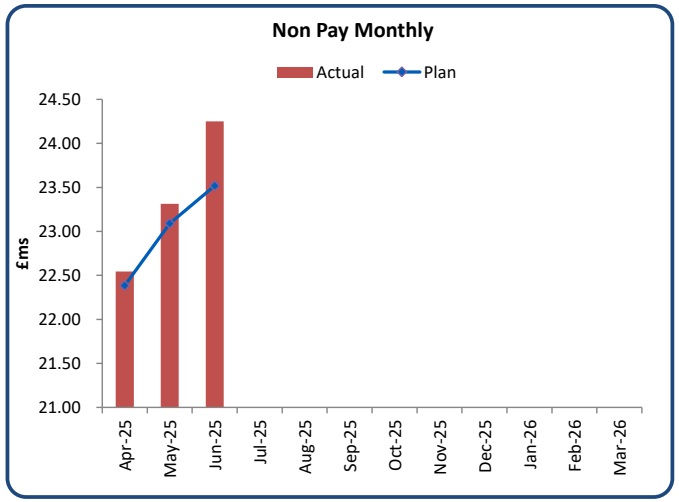
Trust priority



	Jun-25
Actual	5.49
Variance	-0.04

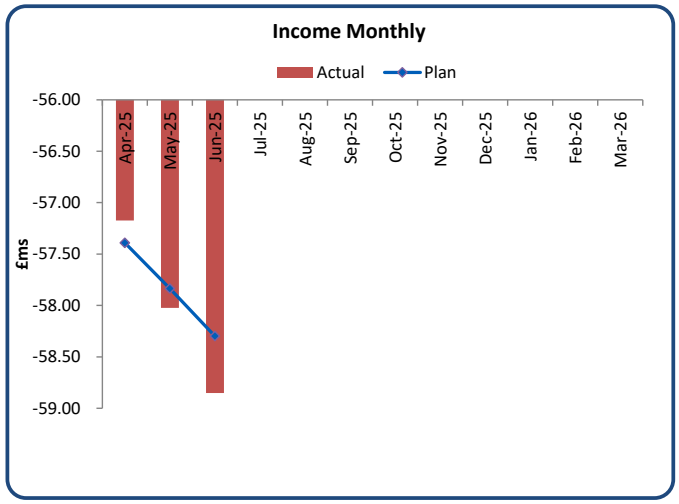


Jun-25
35.49

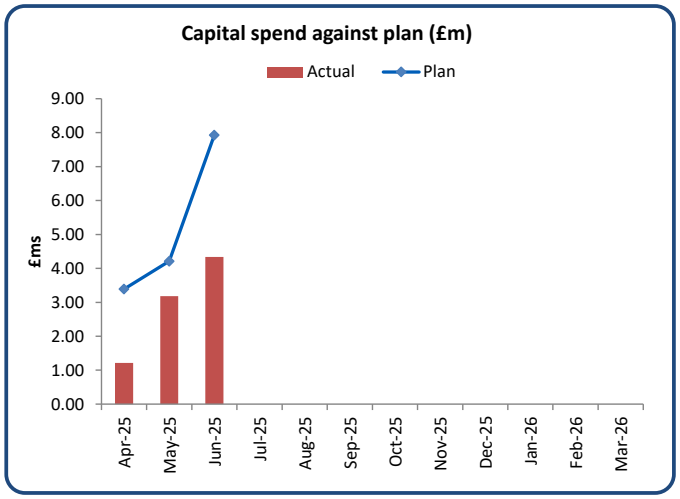


Jun-25
24.25

Journey of Improvement

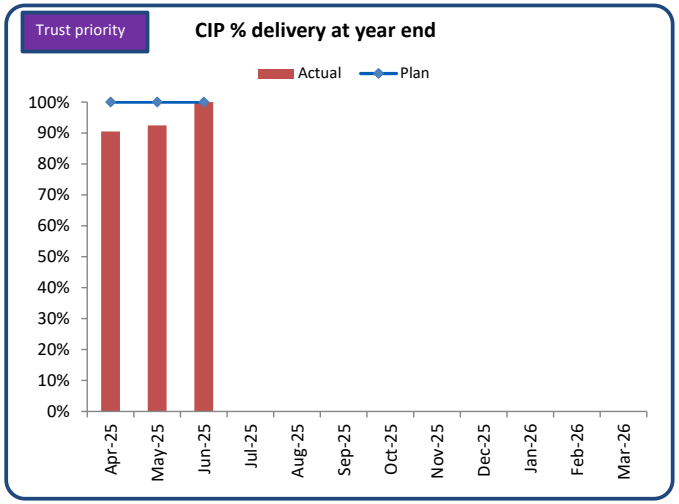


	Jun-25
	-58.85

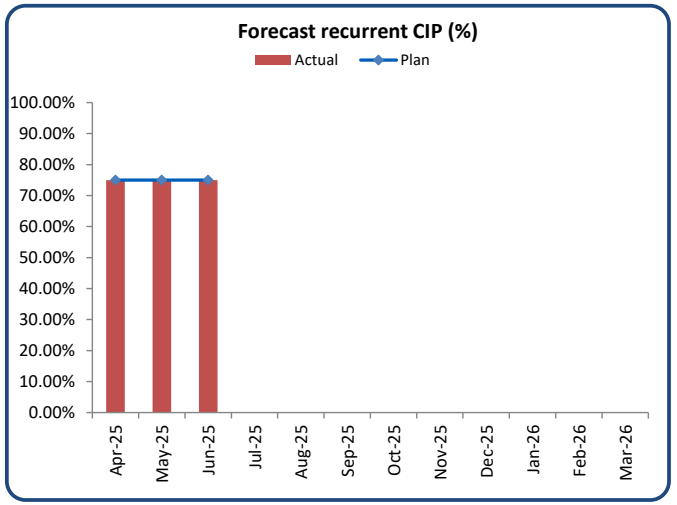


	Jun-25
	4.34

Trust priority

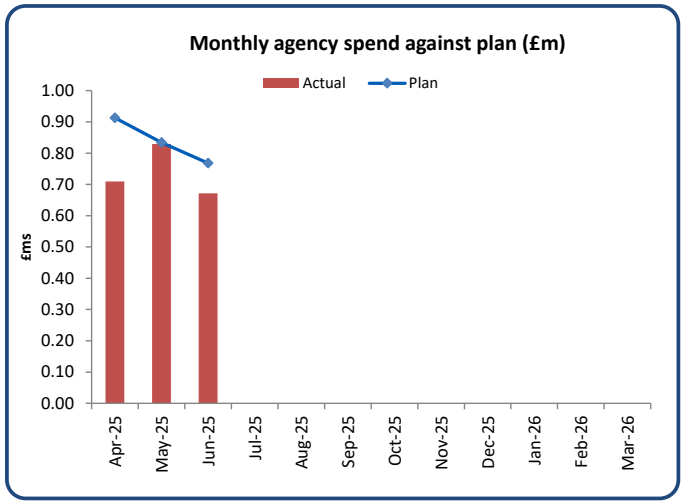


	Jun-25
Delivery %	100.00%
Delivery £	49.30
Plan £	49.30
Variance	-

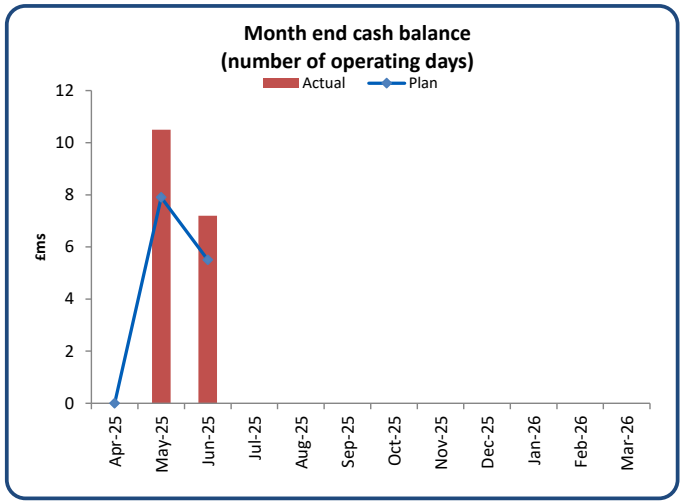


	Jun-25
	75.00%

Journey of Improvement



Jun-25
0.67



Jun-25
7.20

Appendix 1: Safe, High Quality Care Summary Dashboard

Metric	25/26 Target/ Standard	24/25	Mar-25	Apr-25	May-25	Jun-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%	86.19%	85.00%	90.70%	85.58%	87.97%	+2.39%	87.97%	
Ambulance mean handover time (minutes)	67.50		89.83	101.87	86.79544885	88.18	1.38	88.18	
Ambulance max handover time (minutes)	90		679	749	760	682	-78	682	
ED Attendances (TR unplanned)	6351		6629	6767	7244	7034	-210	7034	
ED Attendances (WC unplanned)	1978		1915	1963	2027	2100	+73	2100	
ED & MIU attenders - 4 hours arrival to discharge, admission or transfer	80.96%	76.45%	78.05%	79.26%	78.34%	76.28%	-2.06%	76.28%	
Treliske ED attenders - 4 hours arrival to discharge, admission or transfer	50.86%	43.92%	47.29%	49.53%	49.08%	43.43%	-5.65%	43.43%	
WC ED attenders - 4 hours arrival to discharge, admission or transfer			82.40%	89.40%	84.07%	82.00%	-2.07%	82.00%	
95th percentile, time to initial assessment (mins)	15	33	28	34	30	31	+1	31	
Aggregated Patient Delay (hours)			14371	15515	14801	14596	-204	14596	
% mental health patients spending over 12 hours in A&E			21%	22%	28%	21%	-6%	72%	
% total ED visit over 12 hours (TR)			15.21%	15.40%	13.85%	14.16%	0%	14%	
ED over 12 hours in department (TR&WC)		12978	1013	1043	1003	997	-6	997	
ED safety checklist	97.00%	87.40%	87.50%	88.80%	81.30%	81.20%	-0.10%	81.20%	
Sepsis patients who met the criteria and received antibiotics within an hour - ED	90.00%	71.10%	80%	82%	89%	86%	-3.10%	86%	
Stroke unit within 4 hours	90.00%	42.49%	43.66%	45.78%	56.16%	50.00%	-6.16%	50.00%	
Stroke patients receiving CT scan within 12 hours	90.00%	96.03%	97.22%	92.94%	97.26%	94.52%	-2.74%	94.52%	
Stroke patients spending 90% of their time on stroke unit	90.00%	77.79%	81.54%	79.31%	84.00%	86.67%	+2.67%	86.67%	
NOF patients operated on within 36 hours	70.00%	37.20%	47.00%	46.00%	44.00%	23.00%	-21.00%	23.00%	
Total general and acute (G&A) bed occupancy (%)	93.98%		95.54%	95.35%	94.95%	94.91%	-0.04%	94.91%	

Appendix 1: Safe, High Quality Care Summary Dashboard

Metric	25/26 Target/ Standard	24/25	Mar-25	Apr-25	May-25	Jun-25	Variation	YTD 25/26	Sparkline
Average LOS	3.62	3.78	3.89	3.71	3.45	3.55	+0.10	3.55	
Super stranded patients (21+ day LOS)	122	106	109	91	91	90	-1	90	
RCHT Delayed Patients	42		96	82	81	83	+2	83	
Net emergency readmissions within 30 days	6.80%	7.56%	7.68%	7.84%	7.59%	6.78%	-0.81%	6.78%	
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 for incomplete pathways- over 78 weeks - pre submission	0	3	3	1	0	0	0	0	
RTT waits for incomplete pathways- over 65 weeks - pre submission	0	16	16	13	16	13	-3	13	
RTT waits for incomplete pathways- over 52 weeks - pre submission	381	365	365	355	400	429	+29	429	
RTT waits for incomplete pathways- over 52 weeks under 18 - pre submission	16		26	20	19	26	+7	26	
RTT waits for incomplete pathways % - under 18 weeks - pre submission			69.41%	70.27%	71.52%	71.57%	+0	71.57%	
RTT waits for incomplete pathways % - under 18 weeks under 18 - pre submission	2252		71.99%	71.92%	73.59%	74.52%	+0	74.52%	
Inpatient Elective Activity	100.00%		105.21%	105.18%	108.32%	101.20%	-7.12%	101.20%	
Completed RTT pathway activity - admitted	#N/A		2856	2520	2784	2784	0	2784	
Completed RTT pathway activity - non admitted	#N/A		8315	8896	8607	8607	0	8607	
Elective Operations Completed			1590	1531	1470	1598	+128	1598.00	
Elective Touchtime	85.00%		83.00%	82.00%	84.00%	86.00%	2.00%	86.00%	
Elective Session Utilisation	92.80%		90.00%	89.00%	90.00%	92.00%	2.00%	92.00%	
Percentage of cancellations on the same day	0.80%	1.44%	1.48%	1.12%	1.09%	in arrears		in arrears	
28 day re-booking breaches	7	35	66	31	24	26	+2	35	
Percentage of outpatient appointments attended that are non F2F	25%	31.35%	31.65%	30.85%	30.83%	29.85%	-0.98%	29.85%	
Percentage of outpatient follow-up without a procedure	53%		50.59%	49.91%	50.66%	49.50%	-1.16%	49.50%	
PIFU as percentage of total outpatient attendances	10.14%		10.11%	10.65%	10.10%	10.34%	0.24%	10.34%	
Proportion of patients receiving one of the 15 key diagnostic tests within 6 weeks	99.00%	85.30%	90.76%	91.71%	88.18%	89.51%	+1.33%	89.51%	
Diagnostic activity	110.60%		152.11%	125.53%	117.89%	111.23%	-6.66%	111.23%	
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									

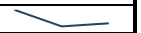
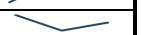
Appendix 1: Safe, High Quality Care Summary Dashboard

Metric	25/26 Target/ Standard	24/25	Mar-25	Apr-25	May-25	Jun-25	Variation	YTD 25/26	Sparkline
Combined 31 day decision to treament	96.00%		#N/A	92.05%	94.32%	in arrears	+2.27%	in arrears	
Combined 62 day referral to treament	70.00%		#N/A	78.25%	81.10%	in arrears	+2.85%	in arrears	
Early stage diagnosis	60.00%		in arrears	in arrears	in arrears	in arrears		in arrears	
28 day faster diagnosis	77.00%		81.78%	81.26%	81.34%	in arrears	0.08%	in arrears	
Safety and Quality									
Actual vs Planned Registered Nurses (hours)		98.01%	98.80%	97.28%	97.98%	99.02%	+1.04%	99.02%	
Actual vs Planned Unregistered Nurses (hours)		98.47%	97.35%	98.36%	98.77%	97.40%	-1.38%	97.40%	
Rolling 12 month HSMR		98.63	96.26	in arrears	in arrears	in arrears		in arrears	
SHMI			106.69	in arrears	in arrears	in arrears		in arrears	
Number of pressure ulcers per 1000 bed days			0.82	0.76	1.70	1.40	-0.30	1.40	
All patient falls per 1000 bed days			5.01	4.61	3.78	4.00	+0.22	4.00	
Moderate/Severe harm falls per 1000 bed days			0.40	0.20	0.15	0.05	-0.10	0.05	
Never events	0	2	0	0	0	1	+1	1	
Patient safety incident investigations (PSII)		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%	89.92%	74.00%	92.00%	84.00%	87.00%	+3.00%	87.00%	
Total number of formal complaints	30	28	27	27	29	40	+11	40	
Total number of informal complaints		123	135	109	112	138	+26	138	
Duty of candour compliance	100.00%	35.42%	32.00%	63.00%	63.00%	67.00%	+4.00%	35.42%	
Infection control: MRSA	0	1	0	0	0	0	0	0	
Infection control: C-difficile cases	19	115	11	6	5	9	+4	20	
Gram negative bacteraemia total		85	3	7	5	7	+2	7	
E.Coli cumulative			56	59	6	10		10	

Appendix 2: Supported and Valued People Summary Dashboard

Metric	25/26 Target/ Standard	24/25	Mar-25	Apr-25	May-25	Jun-25	Variation	YTD 25/26	Sparkline
Recommend the Trust as a Place to Work	51.00%	48.41%	48.13%	37.88%	37.88%	37.88%	0.00%	+37.88%	
Pulse survey – I feel secure raising concerns or speaking up	59.00%	58.39%	59.63%	52.04%	52.04%	52.04%	0.00%	+52.04%	
Recommend the trust as a place to receive care	56.00%	55.02%	58.13%	49.49%	49.49%	49.49%	0.00%	+49.49%	
% Appraisals completed of eligible staff	85.00%	75.41%	77.61%	77.30%	76.13%	75.94%	-0.19%	+75.94%	
% Sickness absence	3.75%	4.96%	4.57%	4.44%	4.67%	4.58%	-0.09%	4.63%	
Percentage of stress related sickness	28.50%	27.56%	28.00%	26.00%	25.30%	26.50%	1.20%	25.90%	
Vacancy rate %	9.00%	9.14%	9.24%	10.13%	10.67%	10.32%	-0.35%	10.49%	
Turnover rate %	7-15%	8.52%	8.48%	8.50%	8.44%	8.31%	-0.13%	8.37%	
% compliance with Health and Safety Statutory training	90.00%	81.74%	77.39%	76.77%	76.69%	78.43%	1.74%	78.43%	
% Statutory and Mandatory training completed	90.00%	81.74%	81.55%	78.90%	78.83%	79.15%	0.32%	79.15%	
Percentage of senior leadership (8c+) from ethnic minority background		1.71%	2.11%	2.06%	2.04%	2.04%	0.00%	2.04%	
Percentage of workforce from ethnic minority background		12.16%	13.01%	13.10%	13.29%	13.51%	+0.22%	13.51%	

Appendix 3: Journey of Improvement Summary Dashboard

Metric	25/26 Target/ Standard	Mar-25	Apr-25	May-25	Jun-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)	1.35	-0.90	2.12	1.98	1.38			
Year to date financial position (£m)	5.53	-0.09	2.12	4.11	5.49			
Pay monthly (£m)	35.32	68.92	35.42	34.98	35.49			
Non pay monthly (£m)	23.52	26.51	22.54	23.31	24.25			
Income monthly (£m)	-58.30	-96.20	-57.17	-58.02	-58.85			
Capital spend against plan (£m)	7.93	56.54	1.21	3.18	4.34			
CIP % delivery at year end (%)	100%	100%	91%	92%	100%			
Forecast recurrent CIP (%)	75%	45%	75%	75%	75%			
Monthly agency spend against plan (£m)	0.77	0.94	0.71	0.83	0.67			
Month End Cash balance (number operating days)	6			11	7			