

PUBLIC – Board of Directors
29th July 2025

Report	Agenda Item 16.	Integrated Performance Report (IPR) – June 2025					
Purpose of the Report	Decision		Ratification		Assurance	X	Information
Accountable Executive	Cathy Chadwick Sue Pemberton Nigel Scawn Karen Edge Vicki Wilson			Chief Operating Officer Director of Nursing/Deputy CEO Medical Director Chief Finance Officer Chief People Officer			
Author(s)	Dan Nash			Director of Performance			
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			X X X X X	This report covers 5 areas of the BAF and therefore changes in performance in any of the areas can affect risk score on the BAF.		
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						X X X X X X
CQC Domains	Safe Effective Caring Responsive Well led						X X X X X
Previous considerations	Not applicable						
Executive summary	The purpose of this report is to: - Summarise the key performance indicators. - Assure the Board of the monthly oversight of Trust priorities against agreed targets. - Highlight areas of high or low performance such as: Areas of positive assurance: - A sustained reduction in ambulance turnaround times over 60 minutes - A reduction in the number of patients receiving care on the Emergency Department corridor 0 never Events 0 Steis reportable incidents in June						

	• Improvements in the compliance for Braden, MUST and falls risk assessments. • Exceeded the target for annual appraisal compliance • Exceeded the target for mandatory training compliance Areas requiring improvement: • Patient feedback – complaints open at month end • Emergency Medicine Performance • Sickness Absence Compliance • Total size of waiting list • 18-week RTT compliance
Recommendations	The Board of Directors is asked to consider and note the contents of the Report.

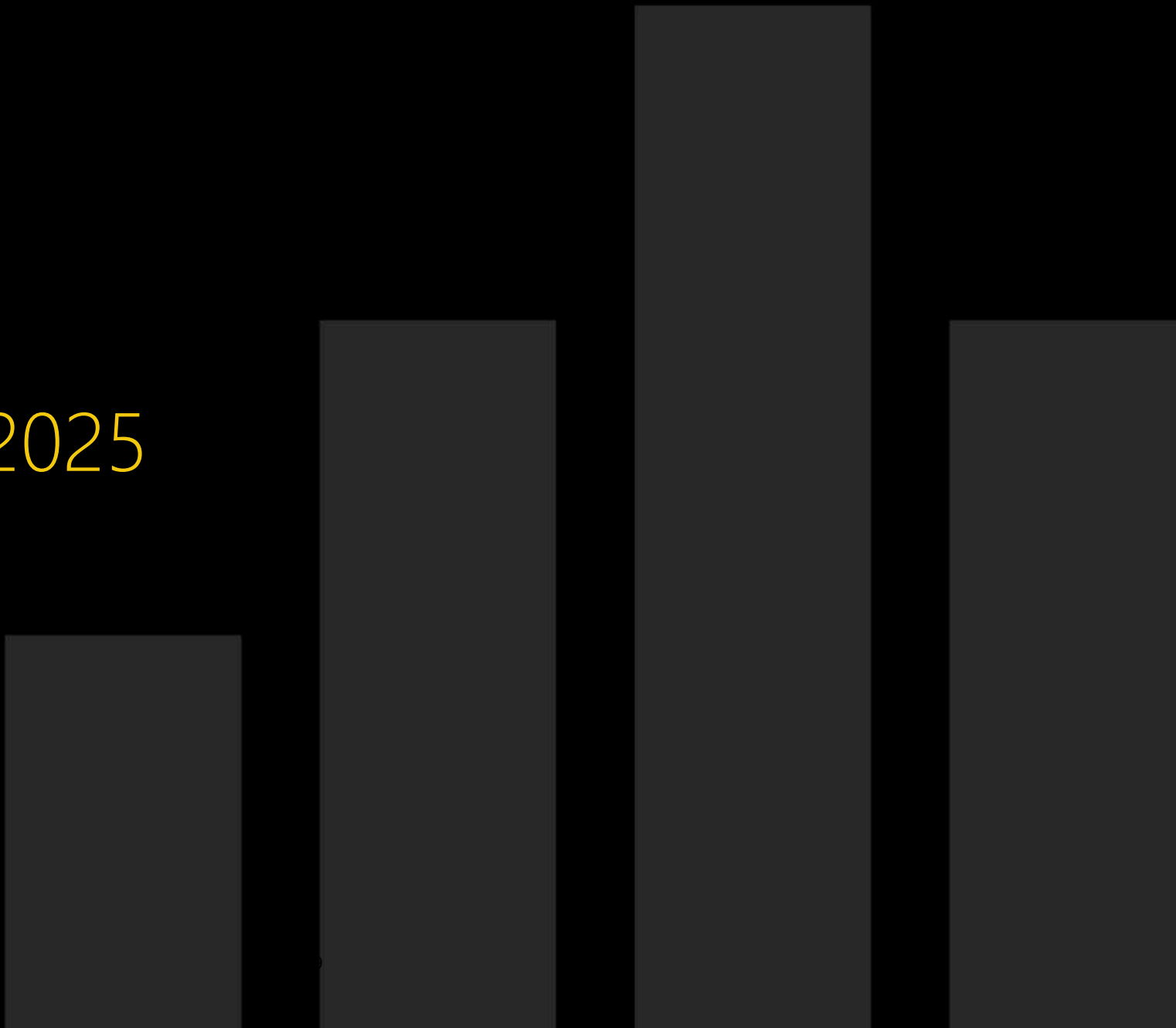
Corporate Impact Assessment	
Statutory/regulatory requirements	Monitors performance against key targets both quality and performance measures.
Risk	Report relates to 5 areas of the BAF risks
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

COCH IPR Jun 2025

[View in Power BI](#) ↗

Last data refresh:
18/07/2025 15:45:41 UTC

Downloaded at:
18/07/2025 15:50:03 UTC



COCH Integrated Performance Report



A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart

The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits

In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.

The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:

- a point beyond the process limits
- a run of points all above or all below the mean
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator

Recalculations

After a sustained change, a recalculation may be added. This splits the chart with the mean and process limits calculated separately using the data before and after. This gives a more accurate reflection on the system as it currently stands.

Baselines

Baselines are commonly set as part of an improvement project, which are shown with solid line process limits. The mean and process limits are calculated from the data in this period and fixed in place for the data points afterwards. This will more easily show if a change has occurred. If a recalculation is later added, the fixed mean and process limits end and are recalculated from the data starting at this point.

Summary icons

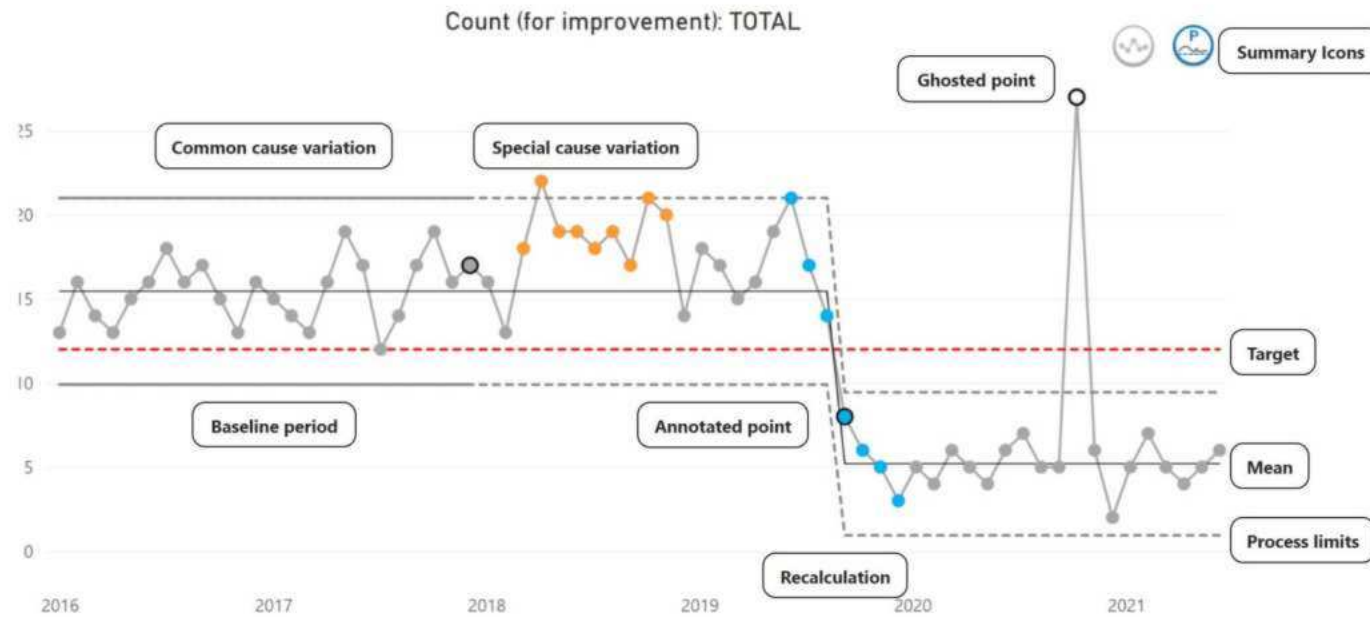
Summary icons are shown in the top-right of the chart and explained on the *Icon Descriptions* page.

Ghosting

There is sometimes a need to remove a data point from the chart because it is a known anomaly – for example, a high referral count after a one-off migration – and will skew the data to render the chart meaningless. An alternative is to ghost the data point. The data point remains visible on the chart as a white dot but is excluded from all calculations.

Annotations

If a dot has a black circle around it, there is an annotation that can be viewed in a tooltip by placing the mouse cursor over it in the interactive version of the report.



Not enough data points?

An SPC chart requires enough data for a robust analysis. If there are too few data points, the SPC elements are not displayed.



Purple dots

It is not always possible to say that higher values are better or worse, for which purple is used instead of blue and orange.



Variance - Is the measure getting better/worse?

		Assurance - Can the target be consistently achieved?			
		Consistently hits target 	Target not consistently achieved or failed 	Consistently fails target 	No target set / insufficient data points 
Variance - Is the measure getting better/worse?	Special Cause Improvement  		STeIS Reported Incidents FFT OP Response Rate Registered Staffing Fill Rates % Sickness Absence Rate Annual Appraisal Compliance Medical & Dental Reduction in Agency Shifts over Cap Rates	ED 4 Hour Wait Standard % Of ED Patients Waiting Over 12 Hours Ambulance Handovers 60+ minutes Patient Initiated Follow Up (%) E-Discharge Overall Compliance (%) Mandatory Training Compliance	SHMI - <i>no target, but indicator is "as expected"</i> Hospital Standardised Mortality Ratio (HSMR) - <i>no target, but indicator banding is "as expected"</i>
	Common Cause Variation 	Patient Feedback: Complaints Opened In Month Eclampsia Maternal Deaths Nursing & Midwifery Reduction in Agency Shifts over Cap Rates	RTT Incomplete Pathways Waiting Over 78 Weeks RTT Incomplete Pathways Waiting Over 104 Weeks Cancer Treatments: 28 Day FDS Cancer Treatments: 31 Day Standard Cancer Treatments: 62 Day Standard Never Events MSA Incidents All Incidents All Incidents: Moderate Harm and Above Medication Incidents Medication Incidents With Harm Falls Rate Per 1000 Bed Days Falls With Harm Rate Per 1000 Bed Days Hospital Acquired Pressure Ulcers Rate Per 1000 Bed Days Infection Control - C.Difficile Cases Infection Control - MRSA Cases Patient Feedback: Concerns Opened In Month FFT IP Response Rate VTE - Assessment Completed Compliance Unregistered Staffing Fill Rates % Sepsis Screening Sepsis Treatment Term Admission Rate Sections Rate PPH rate per 1000 births Tears rate per 1000 births Stillbirths Neonatal Deaths Better Payment Practice Code (value)	ED 4 Hour Wait Standard - Type 1 ED Patients Waiting Over 12 hours 12 Hour ED DTA Breaches RTT Incomplete Pathways Waiting Over 65 Weeks Diagnostics Test Exceeding 6 Weeks Waiting Time (DM01) VTE - 14 Hour Compliance	Mortality - Total Inpatient Deaths - <i>no target, but value is in the normal range</i> Present On Admission Pressure Ulcers Rate Per 1000 Bed Days - <i>target to be identified</i> Patient Feedback: Concerns Open At Month End - <i>target to be identified</i> FFT - A&E Positive Rate - <i>Insufficient data points for assurance</i> FFT - IP Positive Rate - <i>Insufficient data points for assurance</i> FFT - OP Positive Rate - <i>Insufficient data points for assurance</i> Women Delivered - <i>no target, but value is in the normal range</i> Live Births - <i>no target, but value is in the normal range</i> Births in Co-located MLU - <i>no target, but value is in the normal range</i> Other Reduction in Agency Shifts over Cap Rates - <i>target to be identified</i>
	Special Cause Concern  	Staff Turnover Percentage	FFT A&E Response Rate Better Payment Practice Code (number)	Ambulance Handovers 30-60 minutes 18 Week Referral To Treatment (RTT) Incomplete Pathways Total 18 Week RTT Incomplete Pathways RTT Incomplete Pathways Waiting Over 52 Weeks % of Pathways over 52 weeks RTT Wait for 1st OP Appt - % waiting <18 weeks NC2R: Total Delayed Days Patient Feedback: Complaints Open At Month End	

172

Operational Metrics	Latest Date	Value	Variation	Assurance	Target
ED 4 Hour Wait Standard	Jun-25	63.7%			78%
ED 4 Hour Wait Standard - Type 1	Jun-25	50.9%			78%
ED Patients Waiting Over 12 hours	Jun-25	1175			0
12 Hour ED DTA Breaches	Jun-25	580			0
Ambulance Handovers 30-60 minutes	Jun-25	522			0
Ambulance Handovers 60+ minutes	Jun-25	68			0
18 Week Referral To Treatment (RTT) Incomplete Pathways	Jun-25	48.5%			60%
Total 18 Week RTT Incomplete Pathways	Jun-25	34250			26110
RTT Incomplete Pathways Waiting Over 52 Weeks	Jun-25	2837			0
RTT Incomplete Pathways Waiting Over 65 Weeks	Jun-25	218			0
RTT Incomplete Pathways Waiting Over 78 Weeks	Jun-25	15			0
RTT Incomplete Pathways Waiting Over 104 Weeks	Jun-25	0			0
RTT Wait for 1st OP Appt - % waiting <18 weeks	Jun-25	47.2%			67%
Patient Initiated Follow Up (%)	Jun-25	4.5%			5%
Diagnostics Test Exceeding 6 Weeks Waiting Time (DM01)	Jun-25	18.4%			1%
Cancer Treatments: 28 Day FDS	May-25	75.6%			77%
Cancer Treatments: 31 Day Standard	May-25	94.8%			96%
Cancer Treatments: 62 Day Standard	May-25	77.9%			85%
NC2R: Total Delayed Days	Jun-25	3612			1740
E-Discharge Overall Compliance (%)	Jun-25	74%			95%

Maternity Metrics	Latest Date	Value	Variation	Assurance	Target
Women Delivered	Jun-25	140			
Live Births	Jun-25	139			
Births in Co-located MLU	Jun-25	8			
Term Admission Rate	Jun-25	4.3%			4.8%
Sections Rate	Jun-25	43%			45%
PPH rate per 1000 births	Jun-25	36			30
Tears rate per 1000 births	Jun-25	28.6			28
Eclampsia	Jun-25	0			0
Maternal Deaths	Jun-25	0			0
Stillbirths	Jun-25	1			0
Neonatal Deaths	Jun-25	0			0

Q&S Metrics	Latest Date	Value	Variation	Assurance	Target
SHMI	Feb-25	91.1			
Mortality - Total Inpatient Deaths	Jun-25	93			
STeIS Reported Incidents	Jun-25	0			0
Never Events	Jun-25	0			0
MSA Incidents	Jun-25	2			0
All Incidents	Jun-25	1253			1155
All Incidents: Moderate Harm and Above	Jun-25	70			40
Medication Incidents	Jun-25	126			108
Medication Incidents With Harm	Jun-25	2			0
Falls Rate Per 1000 Bed Days	Jun-25	4.30			4.87
Falls With Harm Rate Per 1000 Bed Days	Jun-25	0.061			0.1
Hospital Acquired Pressure Ulcers Rate Per 1000 Bed Days	Jun-25	2.33			1.22
Present On Admission Pressure Ulcers Rate Per 1000 Bed Days	Jun-25	3.25			
Infection Control - C.Difficile Cases	Jun-25	8			4
Infection Control - MRSA Cases	Jun-25	0			0
Patient Feedback: Complaints Opened In Month	Jun-25	11			40
Patient Feedback: Complaints Open At Month End	Jun-25	27			7
Patient Feedback: Concerns Opened In Month	Jun-25	292			229
Patient Feedback: Concerns Open At Month End	Jun-25	75			
FFT A&E Positive Rate	Jun-25	76.7%			95%
FFT IP Positive Rate	Jun-25	93.9%			95%
FFT OP Positive Rate	Jun-25	93.3%			95%
VTE - Assessment Completed Compliance	Jun-25	90.8%			95%
VTE - 14 Hour Compliance	Jun-25	77.4%			95%

HR / Finance Metrics	Latest Date	Value	Variation	Assurance	Target
Sickness Absence Rate	Jun-25	5.05%			5%
Staff Turnover Percentage	Jun-25	9.82%			10%
Annual Appraisal Compliance	Jun-25	81.6%			80%
Mandatory Training Compliance	Jun-25	90.9%			90%
Medical & Dental Reduction in Agency Shifts over Cap Rates	Jun-25	116			120
Nursing & Midwifery Reduction in Agency Shifts over Cap Rates	Jun-25	154			1200
Other Reduction in Agency Shifts over Cap Rates	Jun-25	214			
Better Payment Practice Code (value)	Jun-25	95.3%			95%
Better Payment Practice Code (number)	Jun-25	91.5%			95%

Highlights:

In June, we delivered our highest 4-hour performance that we have recorded over the past 2 years at 63.7% (a 3% improvement from May) and delivered our lowest percentage of patients waiting longer than 12 hours in the same time period, these were both delivered despite seeing our daily attendances sustained at significantly higher volumes when compared to previous years. We have sustained the improvements seen across our ambulance handover time metrics and significantly reduced our use of corridor care.

Sustained level of performance in 62 day and 31 day CWT standards however we have seen a deterioration in our 28 FDS performance driven by a deterioration in performance within the skin tumour group.

DM01 performance saw a marginal improvement in month to 81.6%, the challenges within the Echocardiography and Non-obstetric ultrasound modalities remain with recovery plans beginning to show impact.

The Trust saw improvements in 18 week RTT, wait to first appointment and PIFU performance, however due to a reduction in the volume of referrals received in month the percentage of patients above 52 weeks did increase.

Areas of Concern:

Despite improvement in our ED performance, UEC KPIs continues to be a concern. The Patient Flow steering group continues to meet on an alternate weekly basis, with all workstreams provided updates with agreed action plans.

The deterioration in our 28 day FDS performance, this is largely driven by our reduced performance in skin. A robust action plan has been developed to recover the position however it is not expected to fully recover until September due to the large volumes in referrals within the tumour group expected as usual over summer period, and the size of backlog to clear.

RTT forecasts within annual planning cycle raised concerns for multiple specialties which are being borne out in our performance, improvements trajectories being developed for each, with weekly tracking and reporting at ODG. We are slightly off trajectory compared to plan with the majority of initiatives to deliver RTT improvement due to start in July.

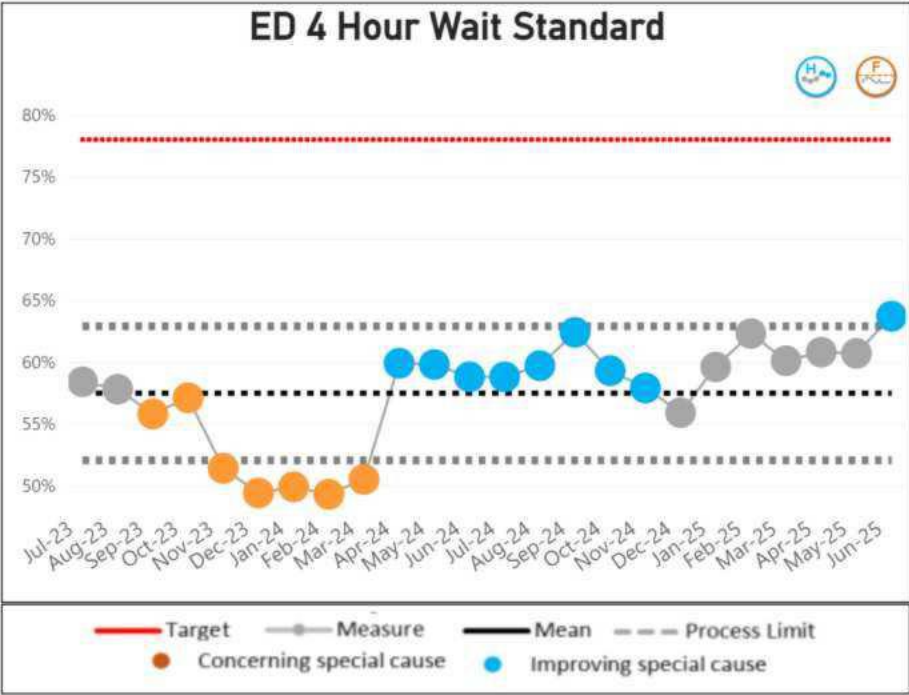
Forward Look (with action)

On-going engagement with C&M ICB in relation to the regional varicose veins clinical guidance and community initiatives within ENT

Commencement of consultant connect engagement within ENT, Dermatology and Vascular specialties in July

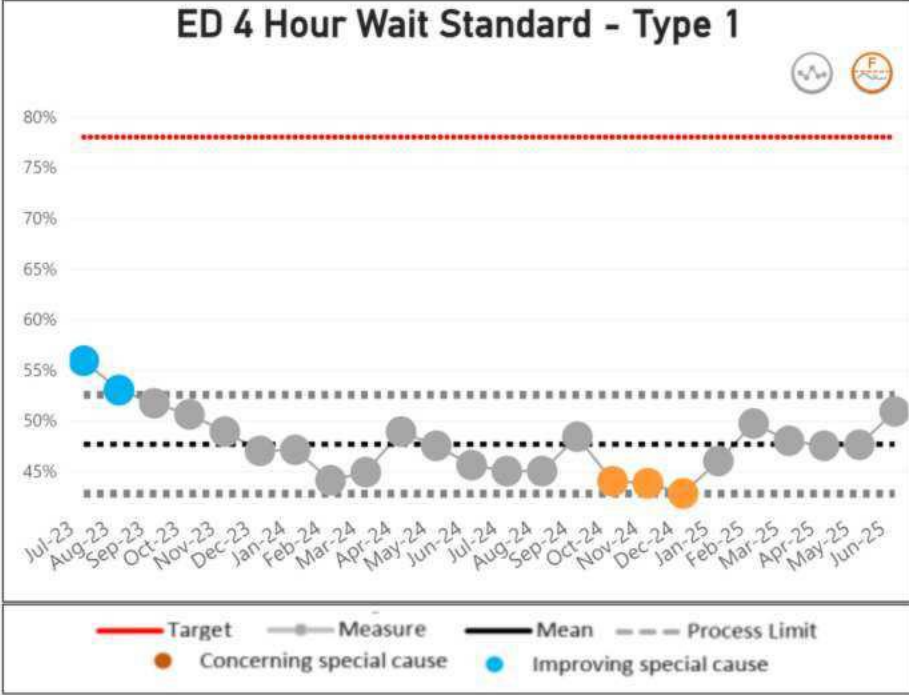
Use of Paddington CDC to support with mutual aid for Non-obstetric ultrasound DM01 backlog clearance, and WLI's to support improvements in Echocardiography

Jun-25
63.7%
Variance
Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.
Target
78%

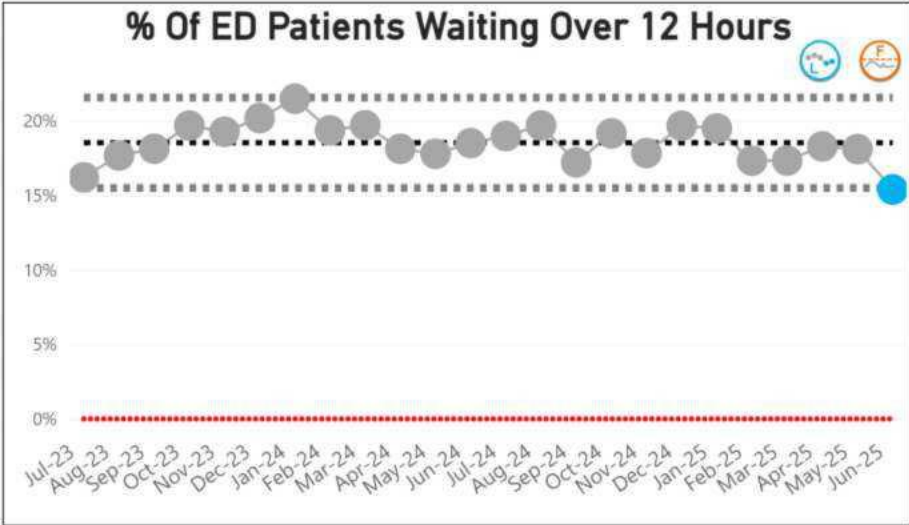


Jun-25
50.9%
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
78%

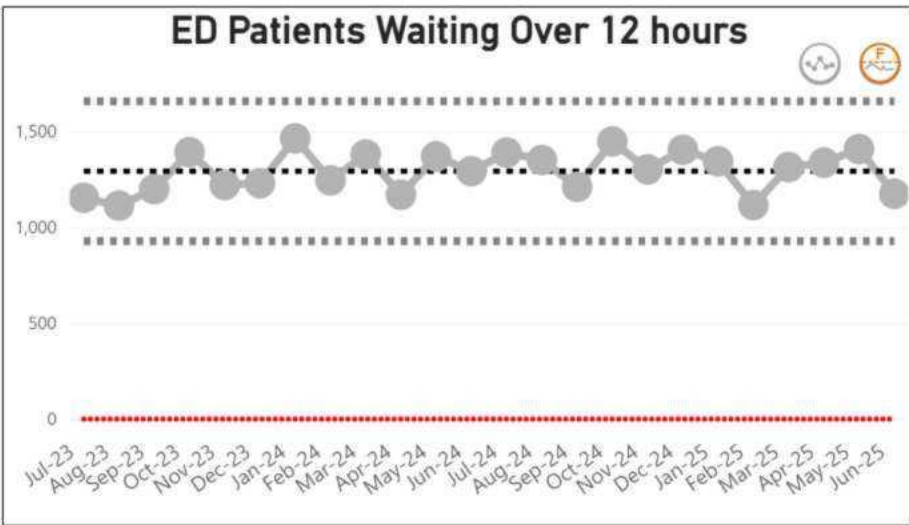
The latest National Comparator for ED 4hr Wait Standard is 75.5% (June 25), Type 1 was 61.7% nationally.



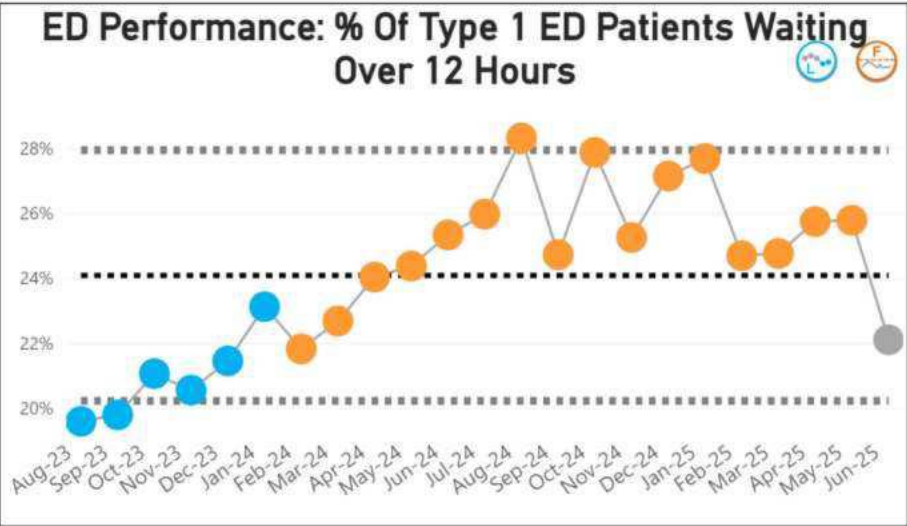
Jun-25
15.4%
Variance
Special cause variation of an IMPROVING nature where the measure is significantly LOWER.
Target
0%



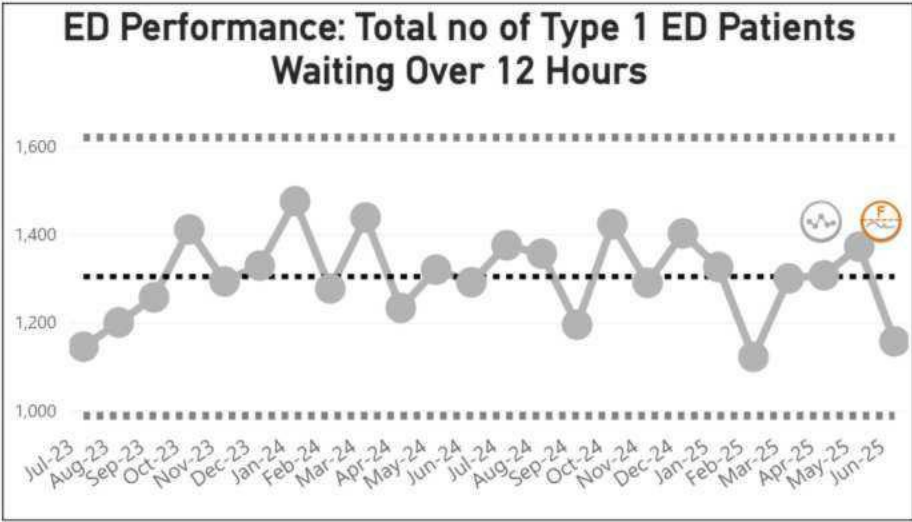
Jun-25
1175
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
0



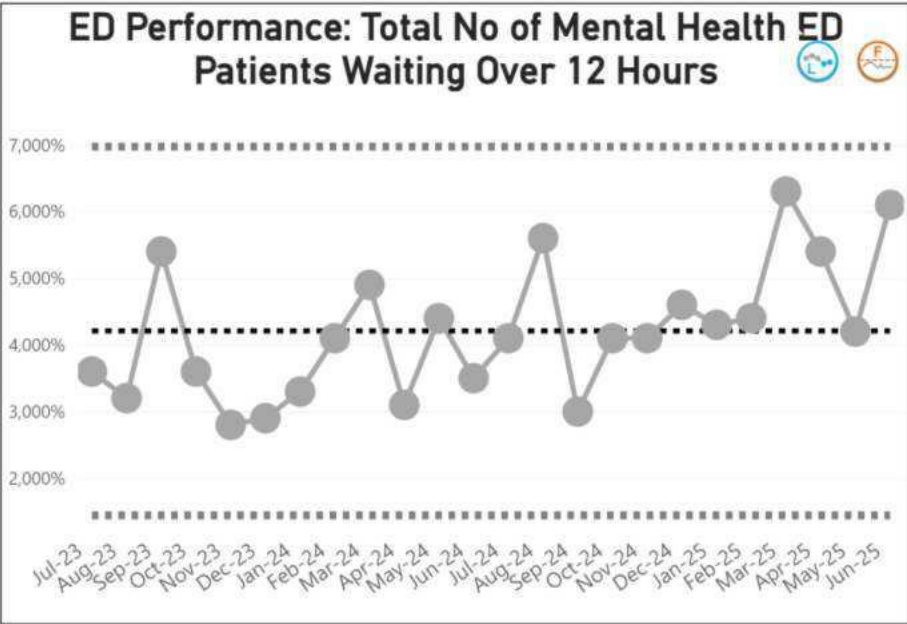
Jun-25
22.1%
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target



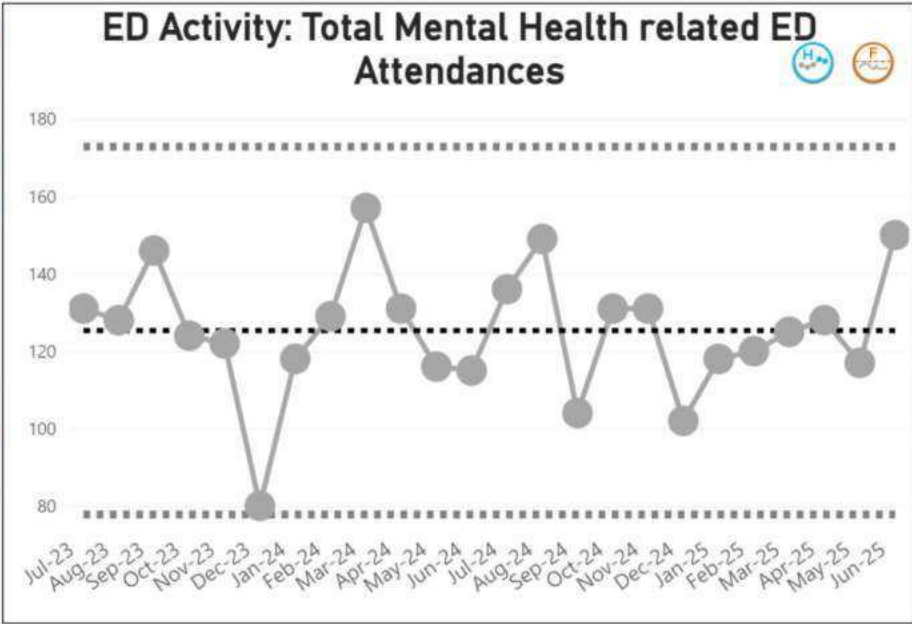
Jun-25
1157
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
0



Jun-25
61
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target



Jun-25
150
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target



Jun-25

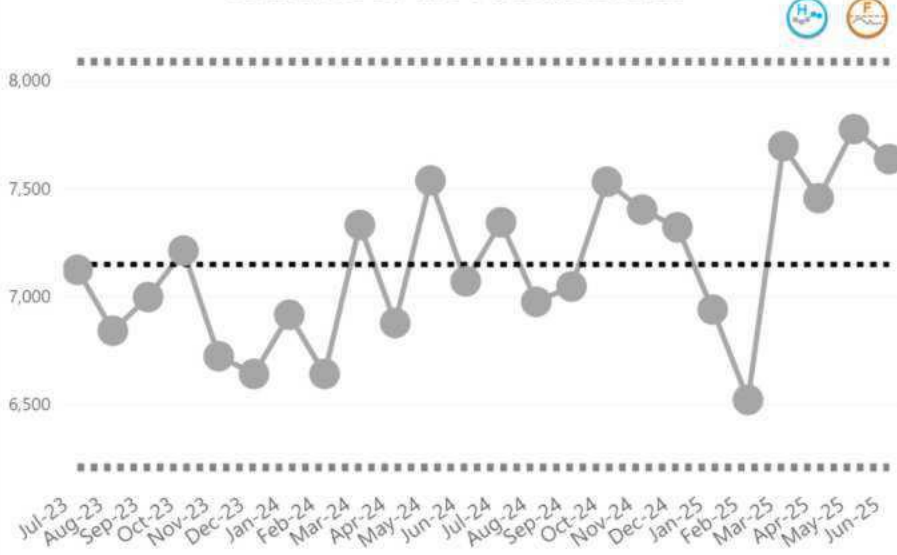
7635

Variance

Special cause variation of an
IMPROVING nature where
the measure is significantly
HIGHER.

Target

Total No of ED Attendances



Jun-25

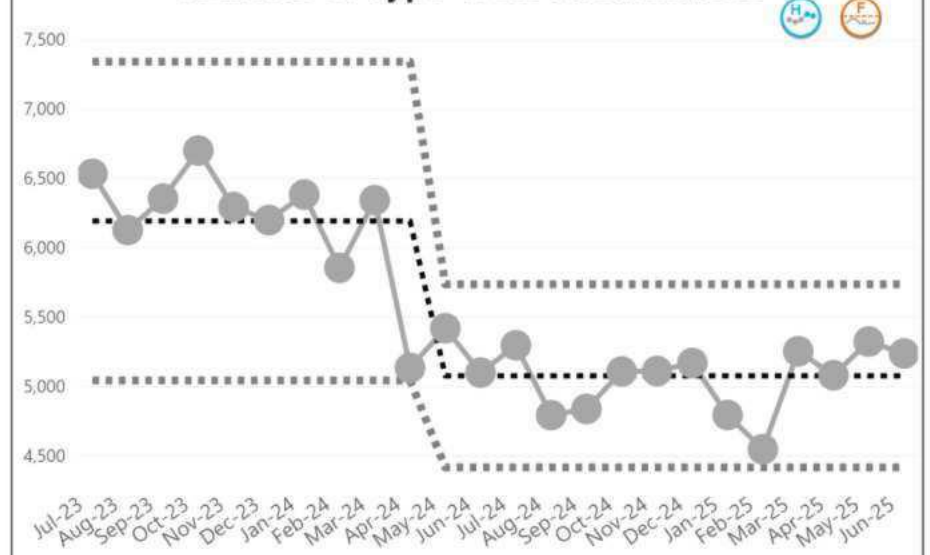
5235

Variance

Common cause variation,
NO SIGNIFICANT CHANGE.

Target

Total No of Type 1: ED Attendances



Jun-25

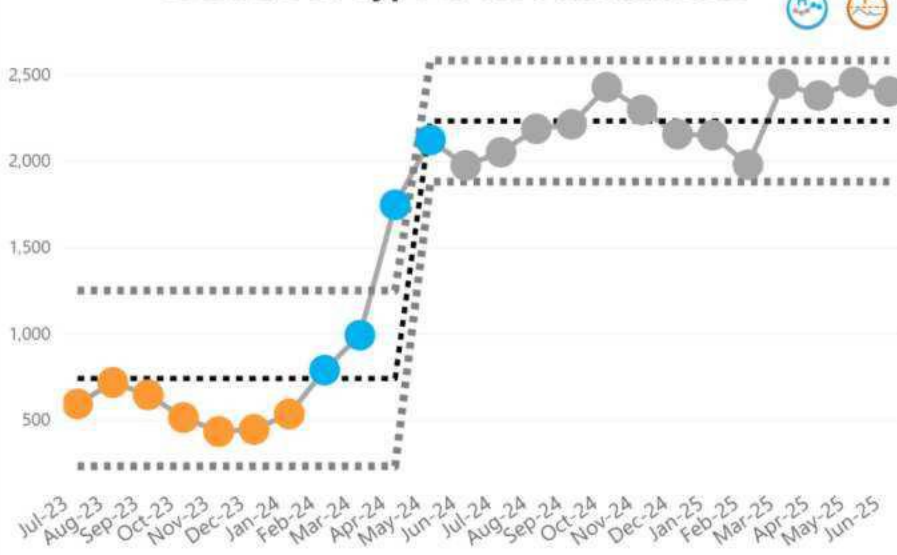
2400

Variance

Special cause variation of an
IMPROVING nature where
the measure is significantly
HIGHER.

Target

Total No of Type 3: ED Attendances



Jun-25

580

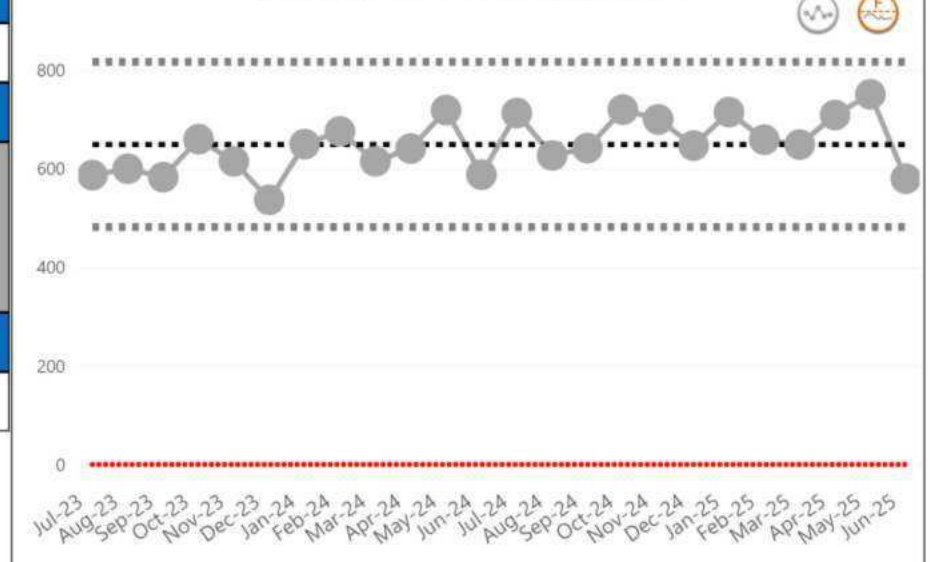
Variance

Common cause variation, NO
SIGNIFICANT CHANGE.

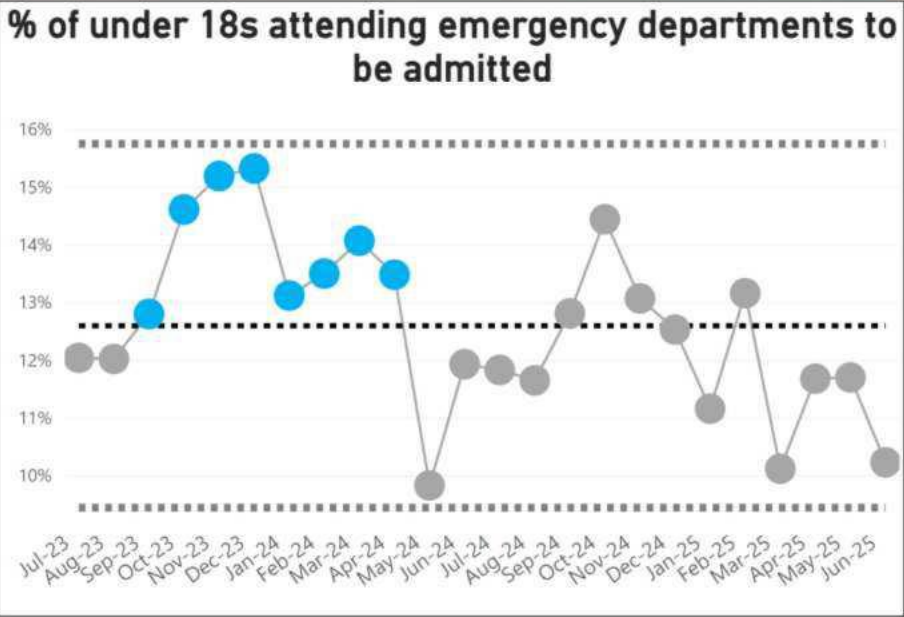
Target

0

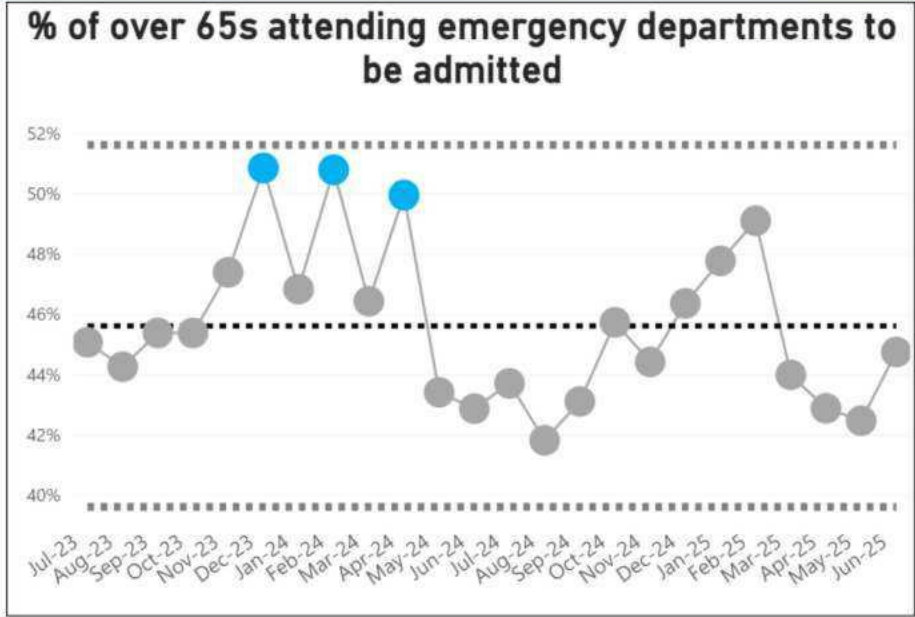
12 Hour ED DTA Breaches



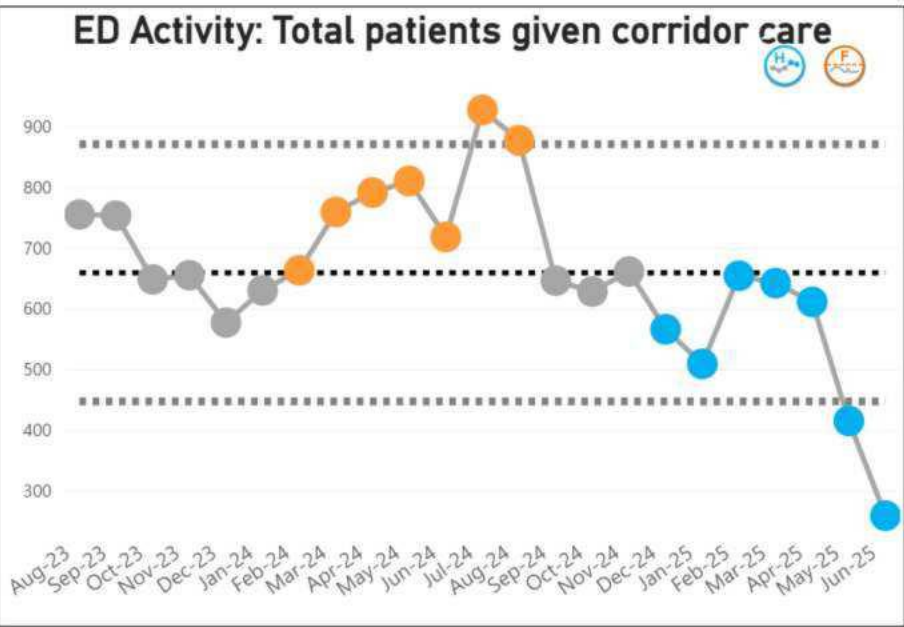
Jun-25
10.2%
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target



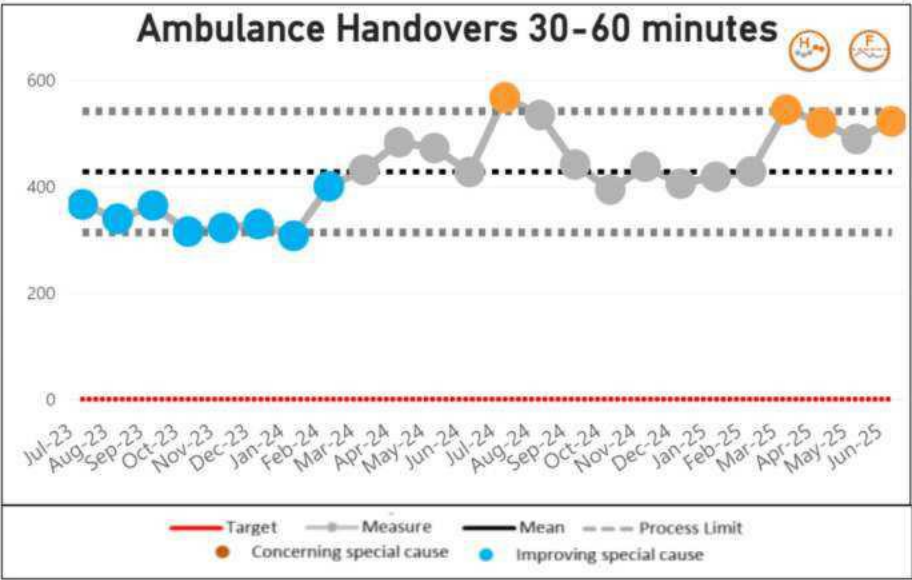
Jun-25
44.8%
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target



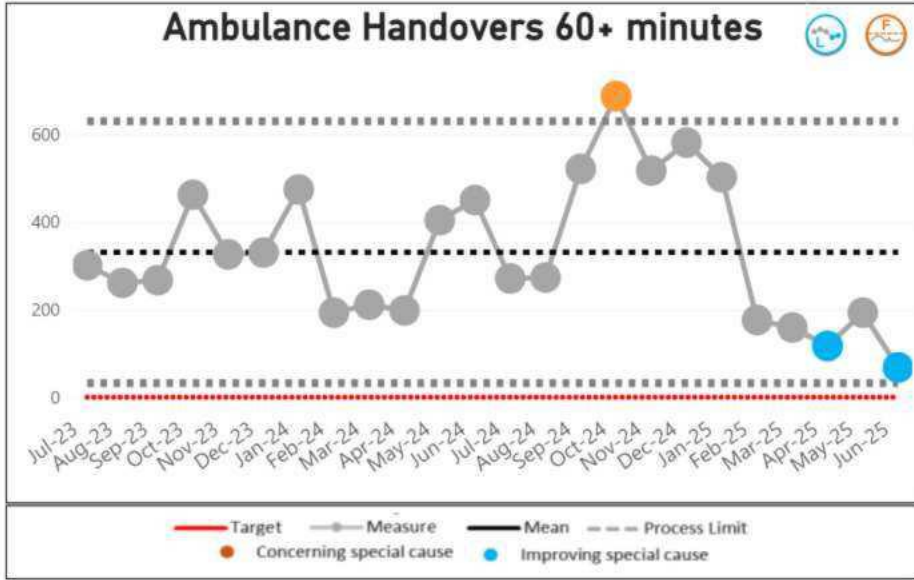
Jun-25
259
Variance
Special cause variation of an IMPROVING nature where the measure is significantly LOWER.
Target



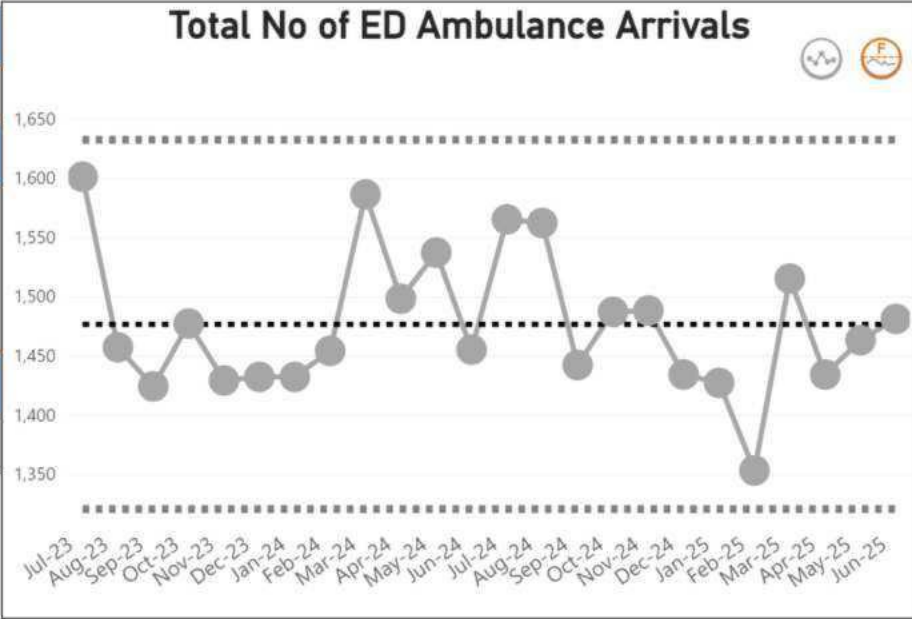
Jun-25
522
Variance
Special cause variation of an CONCERNING nature where the measure is significantly ...
Target
0



Jun-25
68
Variance
Special cause variation of an IMPROVING nature where the measure is significantly L...
Target
0



Jun-25
580
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
0



Supplementary ED Narrative

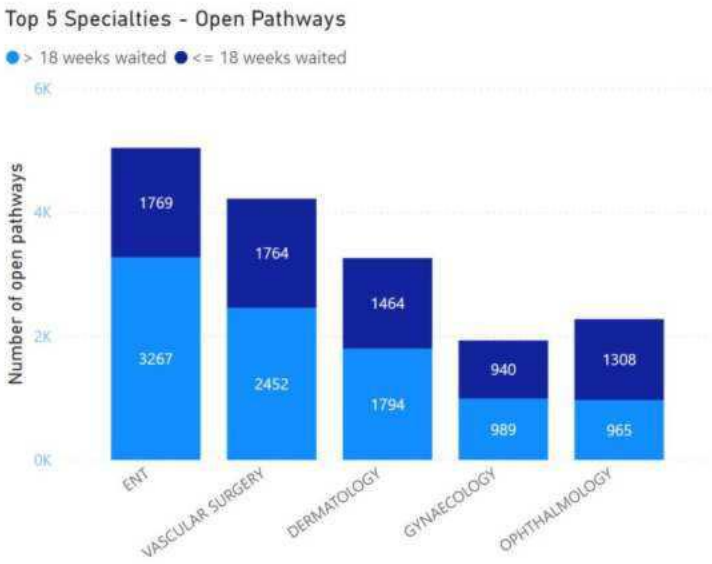
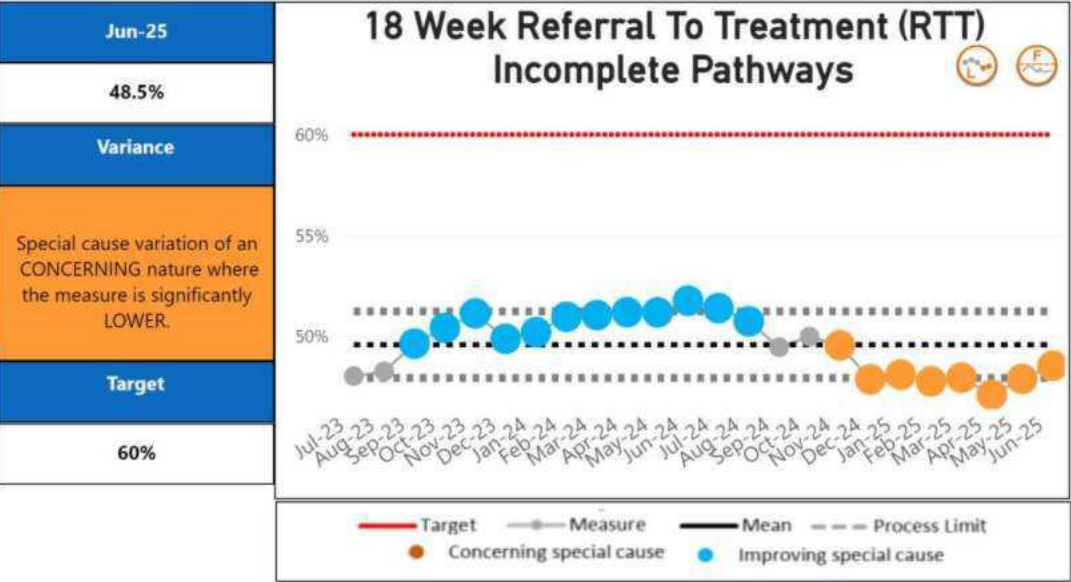
ED attendances decreased by 2% in June (7614) compared to 7748 in May. Our average daily attends in June were 254 compared to 250 in May. There remains variation within the number of daily attendances, the lowest day in month was 215 and the highest 335. The number of days in which we had over 240 attends remained consistent, in June we had 20 which was the same figure (20) in May.

Ambulance arrivals for June were 1474 compared to May which was 1450. There is significant variation in daily ambulance arrivals, our lowest day in June was 36 and highest day 61. Last month we have seen a significant decrease in the number of >25-minute breaches in comparison to previous months, in March we saw 700, in April we saw 634, in May it dropped to 626, and in June this dropped to 484. The Trust has seen significant improvements in ambulance handover times, particularly when it comes to delays of 60 minutes +. Ambulance handover is a priority for the trust, and we continue to work closely with system partners such as Nwas to improve this which, includes commencing call before convey, the age criteria for which has recently reduced.

Overall, 4-hour performance for June was 63.8% compared to May which was 61%, this means that 4-hour performance has been 60% + each month since Jan 25, with our previous month (June) being the best performing month YTD. Admitted 4-hour performance was 26.3% which is a 0.8% decrease in improvement from previous month. Non admitted performance was 74.5%, this is an improvement of 4.1% when compared to previous month and was our best non-admitted performance year to date. There continues to be a sustained focus on protecting 'see and treat' capacity within the Emergency Department to support flow throughout the department, as well as creating a sustainable and successful streaming model within initial assessment so patients are seen, treated and discharged in the most appropriate setting.

We continue to focus on 4-hour quality, which supports the daily decongestion of the Emergency Department. In June we saw 2400 patient streamed up to our UTC, which was 32% of our overall UTC take.

In June 2453 patients were streamed to the UTC which is 32% of the Emergency Department take, this figure was the highest number of patient streamed to the UTC YTD. Streaming patients to SDEC services also remains a priority for the ED, with 326 patients being streamed from ED to SDEC in June.



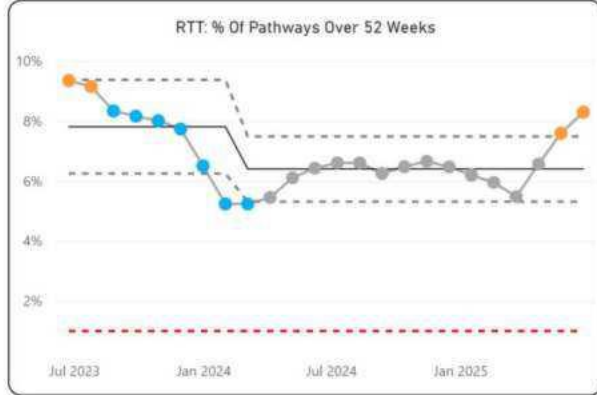
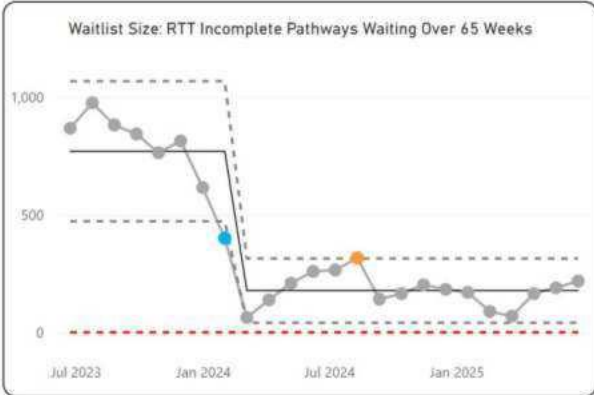
RTT Narrative

The target for total incomplete pathways sits at 26110, as this is the target for the end of the 25/26 Financial Year.

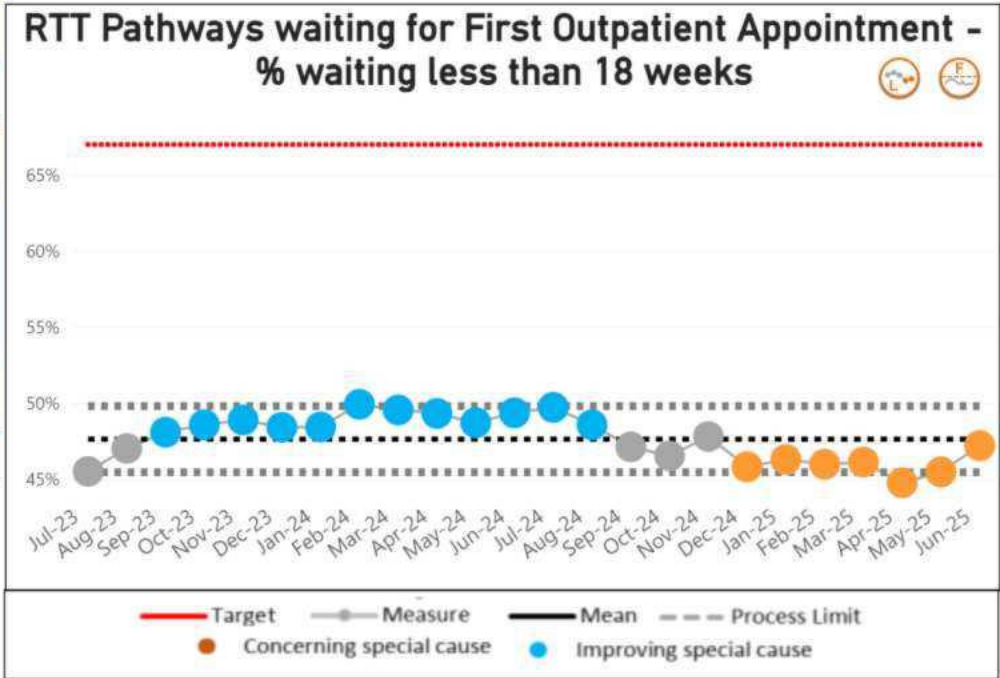
The Trust continued to ensure that there are minimal RTT pathways waiting longer than 78 weeks. In addition, Divisions are managing their waiting times with the aim of reducing long waits to have no pathways greater than 65 weeks on a month to month basis.

The latest National Comparator for 18 week RTT Incomplete pathways is 60.9% (May 25)

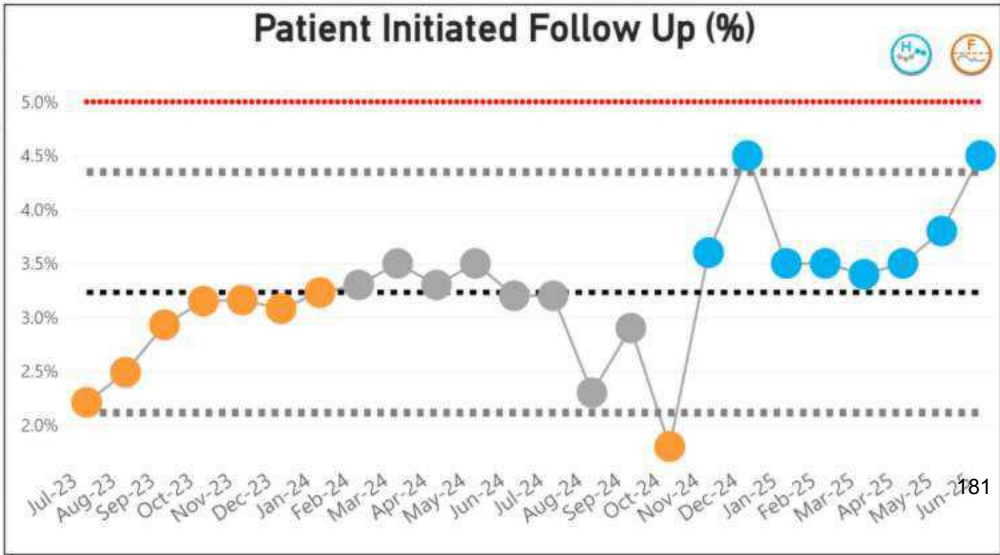
Group	Latest Date	Value	Variation	Assurance	Target
Total 18 Week RTT Incomplete Pathways	Jun-25	34250			26110
% Of Pathways Over 52 Weeks	Jun-25	8.28%			1%
RTT Incomplete Pathways Waiting Over 52 Weeks	Jun-25	2837			0
RTT Incomplete Pathways Waiting Over 65 Weeks	Jun-25	218			0
RTT Incomplete Pathways Waiting Over 78 Weeks	Jun-25	15			0
RTT Incomplete Pathways Waiting Over 104 Weeks	Jun-25	0			0

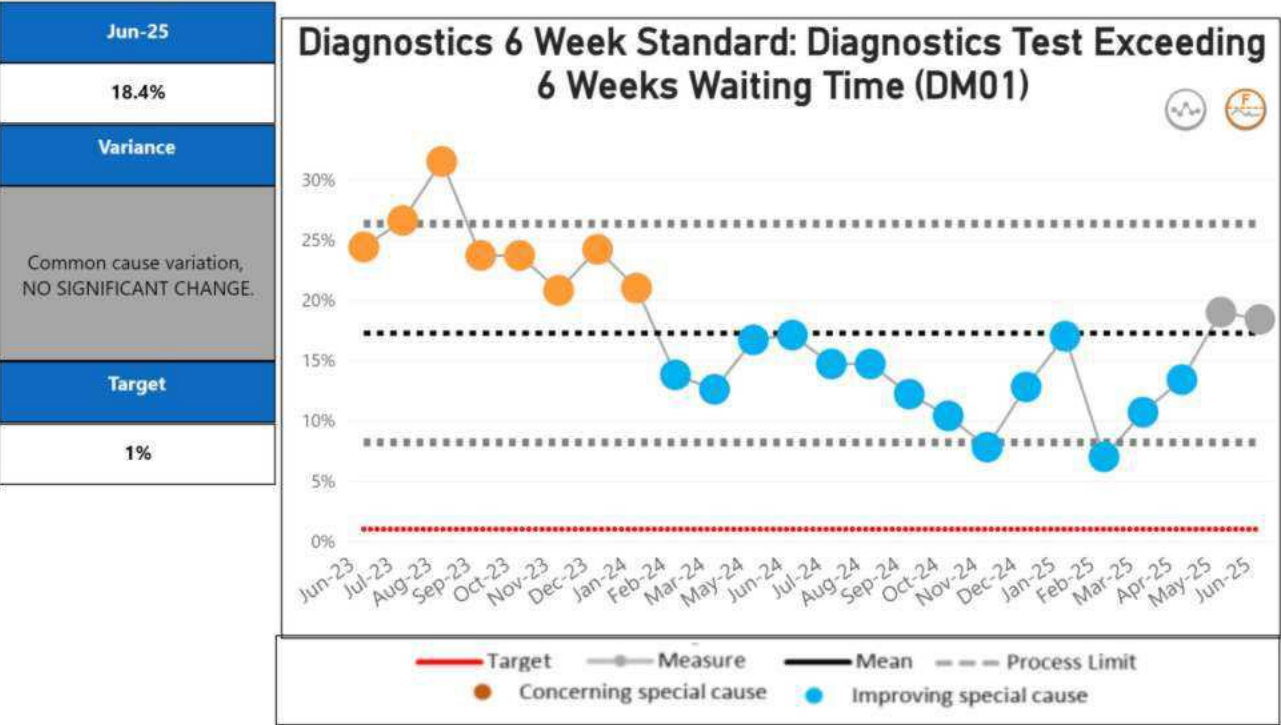


Jun-25
47.2%
Variance
Special cause variation of an CONCERNING nature where the measure is significantly LOWER.
Target
67%



Jun-25
4.5%
Variance
Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.
Target
5%





English - Number of exams >6 weeks

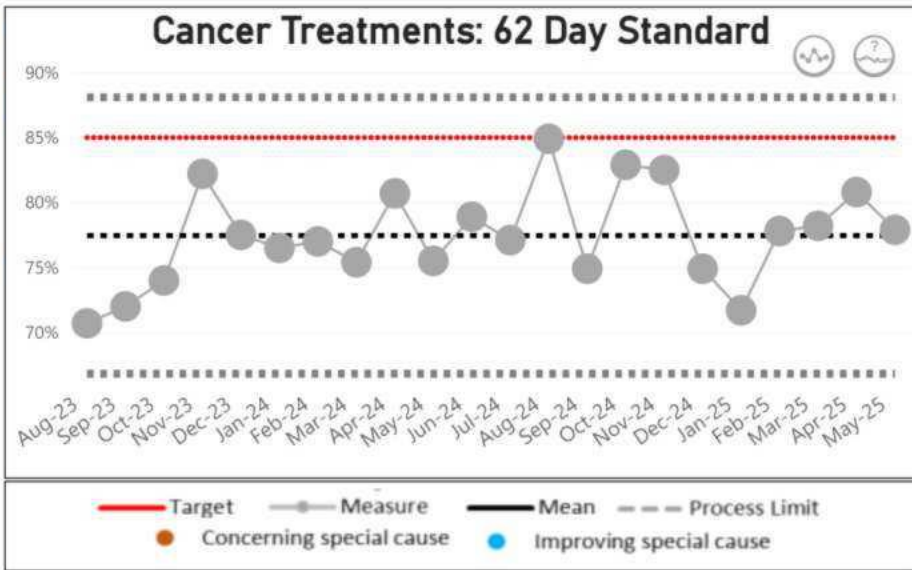
Month End Snapshot	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Magnetic Resonance Imaging	8	2	4	2	7	14	13	15	6	8	4	20	52
Computed Tomography	0	0	4	0	2	8	14	22	3	13	24	26	14
Non-obstetric ultrasound	1	0	7	6	115	49	311	404	31	68	184	410	366
Barium Enema	0	0	0	0	0	0	0	0	0	0	0	0	0
DEXA Scan												0	1
Audiology - Audiology Assessments	169	103	70	61	40	36	74	92	51	99	108	82	49
Cardiology - echocardiography	340	203	215	112	30	36	62	191	161	264	221	417	505
Respiratory physiology - sleep studies	3	0	3	4	7	2	6	17	6	3	5	9	15
Colonoscopy	198	213	165	132	83	44	54	58	28	84	85	96	118
Flexi sigmoidoscopy	6	7	11	6	3	5	8	14	1	3	3	1	4
Cystoscopy	10	17	19	82	52	24	5	1	6	5	12	9	29
Gastroscopy	232	272	267	305	273	224	211	228	140	159	177	169	158
Total patients waiting	5645	5543	5198	5822	5903	5660	5916	6141	6159	6574	6142	6506	7117
Total breaches	967	817	765	710	612	442	758	1042	433	706	823	1239	1311
% > Threshold	17.1%	14.7%	14.7%	12.2%	10.4%	7.8%	12.8%	17.0%	7.0%	10.7%	13.4%	19.0%	18.4%

The latest National Comparator for DM01 is 22.0% (May 25)

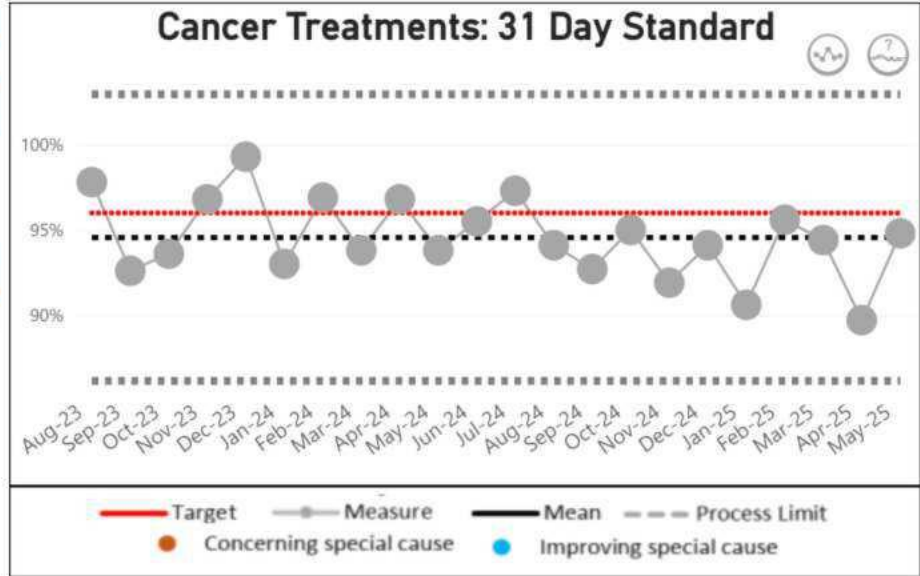
DM01 Narrative

- Echo – significant sickness absence in the team meant our capacity was reduced to 50% normal which caused steep decline.
- Respiratory – continued sickness absence of B6 staff has reduced reporting capacity, managing accordingly.
- Audiology - The reduction in DM01 for paediatric audiology assessments was expected due to an unfilled maternity vacancy.

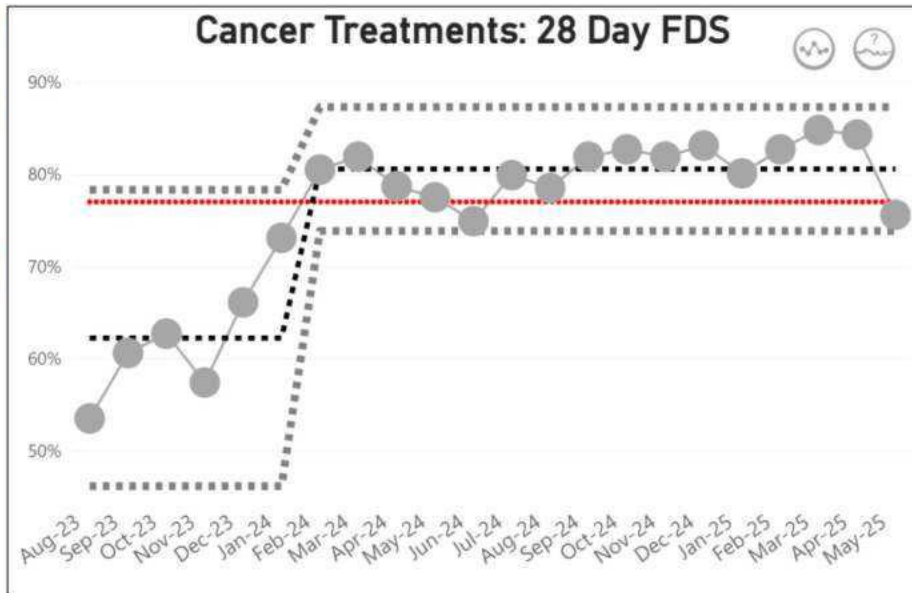
May-25
77.9%
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
85%



May-25
94.8%
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
96%



May-25
75.6%
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
77%

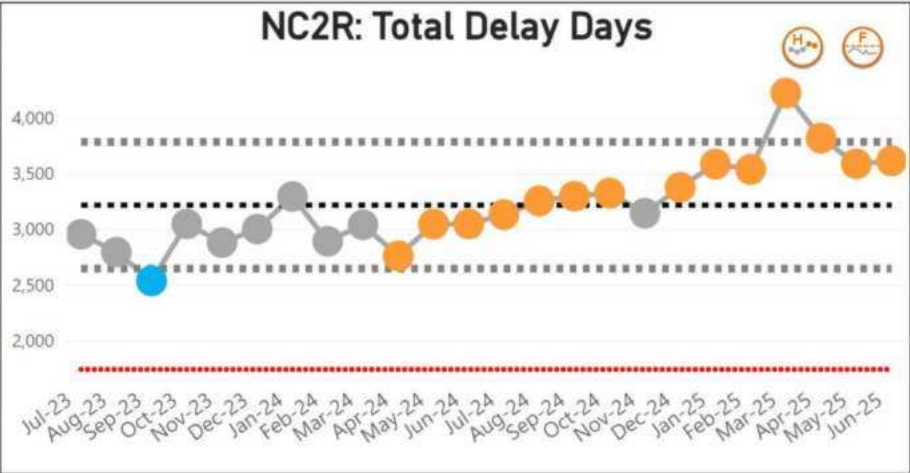


Cancer National Comparator

The latest National Comparator for the Cancer 62 Day Standard is 67.8% (May 25)
The latest National Comparator for the Cancer 31 Day Standard is 91.0% (May 25)
The latest National Comparator for the Cancer 28 Day Standard is 74.8% (May 25)

ICB	Organisation Name	Number of providers submitting acceptable data	Number of patients discharged in total	Total bed days lost due to delayed discharge	% of patients discharged where		Number of patients discharged where, between the Discharge Ready Date and Discharge Date, there is -							% patients discharged where, between the Discharge Ready Date and Discharge Date, there is -							Average days from Discharge Ready Date to date of discharge (inc 0 day delays)	Average days from Discharge Ready Date to date of discharge (exc 0 day delays)
					Date of discharge is same as Discharge Ready Date	Date of Discharge is 1+ days after Discharge Ready Date	No delay	1 day delay	2-3 day delay	4-6 day delay	7-13 day delay	14-20 day delay	21 days or more	No delay	1 day delay	2-3 day delay	4-6 day delay	7-13 day delay	14-20 day delay	21 days or more		
National	ENGLAND	128	360,167	301,996	86.1%	13.9%	310,146	16,927	11,734	7,999	7,817	2,702	2,842	86.1%	4.7%	3.3%	2.2%	2.2%	0.8%	0.8%	0.8	6.0
Regional	NORTH WEST	21	47,158	45,656	86.6%	13.4%	40,860	1,815	1,376	1,088	1,127	404	488	86.6%	3.8%	2.9%	2.3%	2.4%	0.9%	1.0%	1.0	7.2
Cheshire & Merseyside	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	Acceptable	36	-	100.0%	0.0%	36	-	-	-	-	-	-	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-	-
Cheshire & Merseyside	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	Acceptable	1,633	2,738	89.4%	10.6%	1,460	22	37	25	28	16	45	89.4%	1.3%	2.3%	1.5%	1.7%	1.0%	2.8%	1.7	15.8
Cheshire & Merseyside	LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	Acceptable	645	74	98.0%	2.0%	632	1	3	5	3	1	-	98.0%	0.2%	0.5%	0.8%	0.5%	0.2%	0.0%	0.1	5.7
Cheshire & Merseyside	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Acceptable	4,800	6,098	83.8%	16.2%	4,024	233	154	150	114	51	74	83.8%	4.9%	3.2%	3.1%	2.4%	1.1%	1.5%	1.3	7.9
Cheshire & Merseyside	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	Acceptable	222	40	87.8%	12.2%	195	20	6	1	-	-	-	87.8%	9.0%	2.7%	0.5%	0.0%	0.0%	0.0%	0.2	1.5
Cheshire & Merseyside	MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	Acceptable	4,368	3,686	91.6%	8.4%	4,003	84	61	59	71	32	58	91.6%	1.9%	1.4%	1.4%	1.6%	0.7%	1.3%	0.8	10.1
Cheshire & Merseyside	THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	Acceptable	159	42	95.0%	5.0%	151	1	2	3	2	-	-	95.0%	0.6%	1.3%	1.9%	1.3%	0.0%	0.0%	0.3	5.3
Cheshire & Merseyside	THE WALTON CENTRE NHS FOUNDATION TRUST	Acceptable	322	-	100.0%	0.0%	322	-	-	-	-	-	-	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-	-
Cheshire & Merseyside	WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	Acceptable	1,628	2,636	82.4%	17.6%	1,342	45	61	54	66	25	35	82.4%	2.8%	3.7%	3.3%	4.1%	1.5%	2.1%	1.6	9.2
Cheshire & Merseyside	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	Acceptable	2,394	1,508	89.4%	10.6%	2,140	67	76	46	40	13	12	89.4%	2.8%	3.2%	1.9%	1.7%	0.5%	0.5%	0.6	5.9
Cheshire & Merseyside	EAST CHESHIRE NHS TRUST	Unacceptable	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cheshire & Merseyside	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	Unacceptable	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

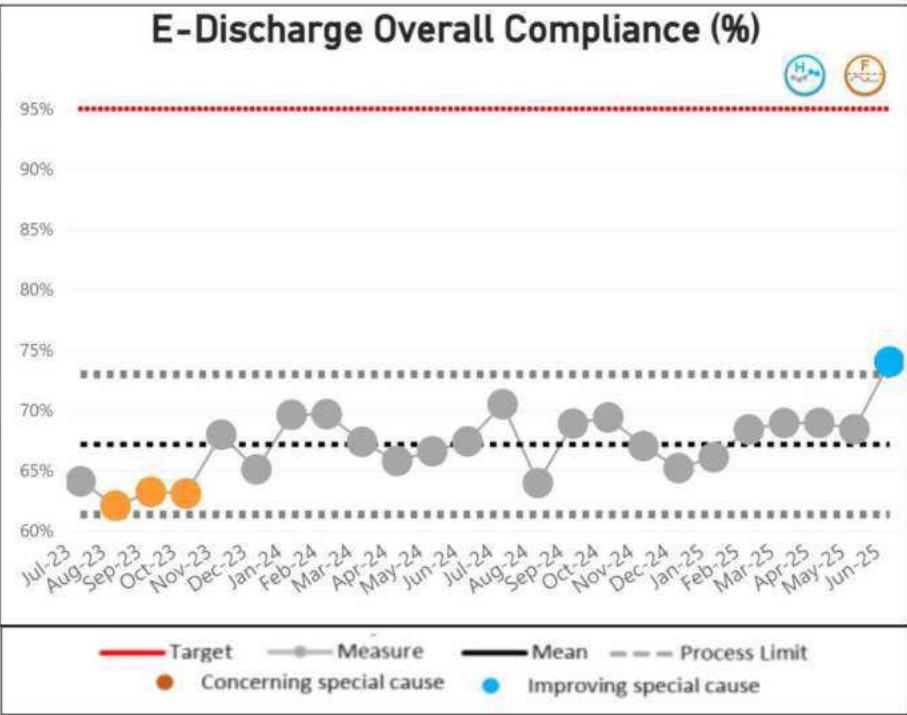
Jun-25
3612
Variance
Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.
Target
1740



Discharge Ready Date Narrative

The metric *Average days from Discharge from Ready Date* to date of discharge has been added to the National Oversight framework and will be monitored closely.

Table with 2 columns: Category, Value. Rows include Jun-25 (74%), Variance, Special cause variation of an IMPROVING nature where the measure is significantly HIGHER, Target (95%).



Planned Care E-Discharge

Table with 17 columns (Divisions, Apr 24, May 24, Jun 24, Jul 24, Aug 24, Sep 24, Oct 24, Nov 24, Dec 24, Jan 25, Feb 25, Mar 25, Apr 25, May 25, Jun 25) and 5 rows of data: Discharges added, Letters sent, Backlog size, Incomplete remaining, Within 24hr %.

Urgent Care E-Discharge

Table with 17 columns (Divisions, Apr 24, May 24, Jun 24, Jul 24, Aug 24, Sep 24, Oct 24, Nov 24, Dec 24, Jan 25, Feb 25, Mar 25, Apr 25, May 25, Jun 25) and 5 rows of data: Discharges added, Letters sent, Backlog size, Incomplete remaining, Within 24hr %.

W&C E-Discharge

Table with 17 columns (Divisions, Apr 24, May 24, Jun 24, Jul 24, Aug 24, Sep 24, Oct 24, Nov 24, Dec 24, Jan 25, Feb 25, Mar 25, Apr 25, May 25, Jun 25) and 5 rows of data: Discharges added, Letters sent, Backlog size, Incomplete remaining, Within 24hr %.

Highlights:

- Consistent incident reporting including moderate and above harm incidents
- Zero Steis reportable incidents in June
- Within trajectory for 5% reduction in CDIFF- end of quarter one – 17 cases – improvements and themes identified
- Reduction in falls and falls with harm in June
- ‘Striving for Excellence’ ward accreditation framework continues
- Continued Trust wide focus on deconditioning work to start getting patients safely mobilised and sitting out and getting dressed
- Continued Trust wide focus on patient flow
- Improvements in the compliance of Braden, MUST and falls risk assessments.
- Friends and Family Test – just under the national positive response rate – ED positive response 76.7% (78%), Inpatient 93.9% (94%), Outpatient 93.3% (94%)

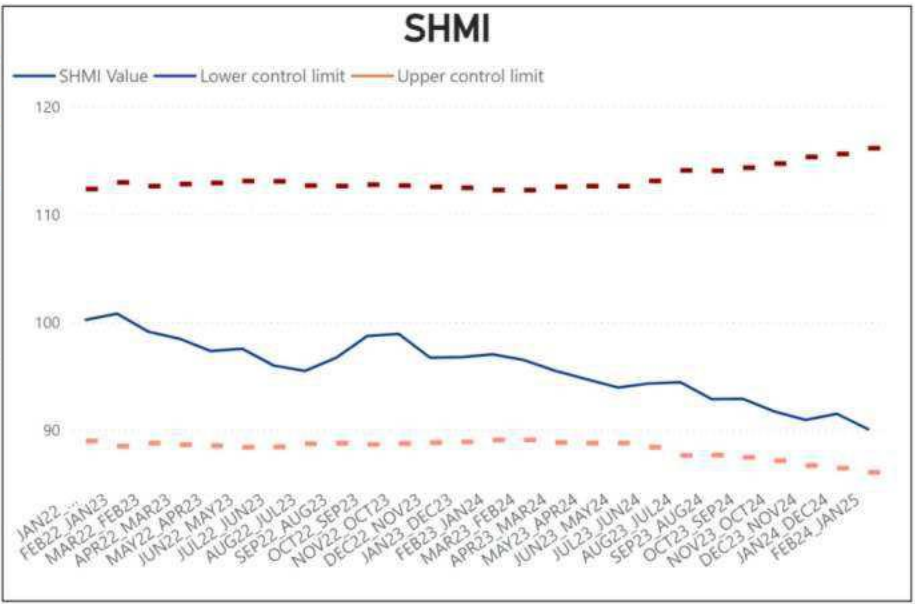
Areas of Concern:

- Sepsis Screening compliance – new screening tool (pop up) and dashboard development to support improving compliance
- Patient Flow and Emergency Department performance and quality indicators - Strengthening the leadership in the emergency department – CQC Inspection
- E-Discharge compliance demonstrating some improvement – Task and Finish group
- E.coli – at end of quarter one we have exceeded trajectory for a 5% decrease – improvements and themes identified
- New Pressure Ulcers (Cat 2 and Cat 3) continue to be a concern- weekly review and actions and initiatives ongoing
- Timely closure of complaints and concerns – increase in open complaints – with 6 overdue – challenges in complex complaints and waiting for family meetings

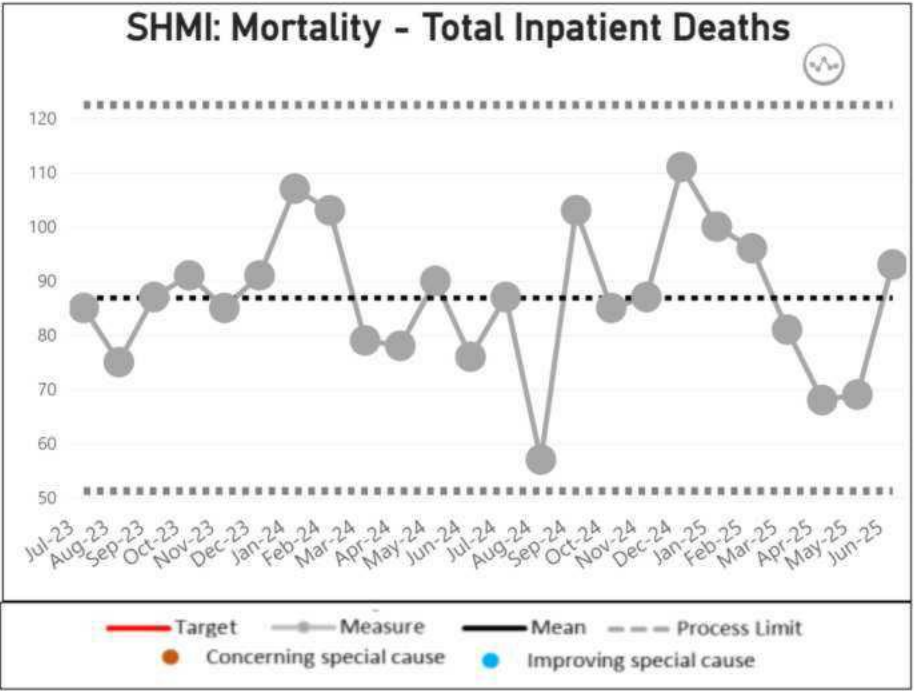
Forward Look (with actions):

- Quality, Safety and Experience Strategy ratified – driving standards
- PSIRF policy and plan for 2025/26 – ICB sign off completed
- Renew and Refresh of Patient Experience group – first meeting held
- Friends and Family Test Improvements – working with external partners and BI

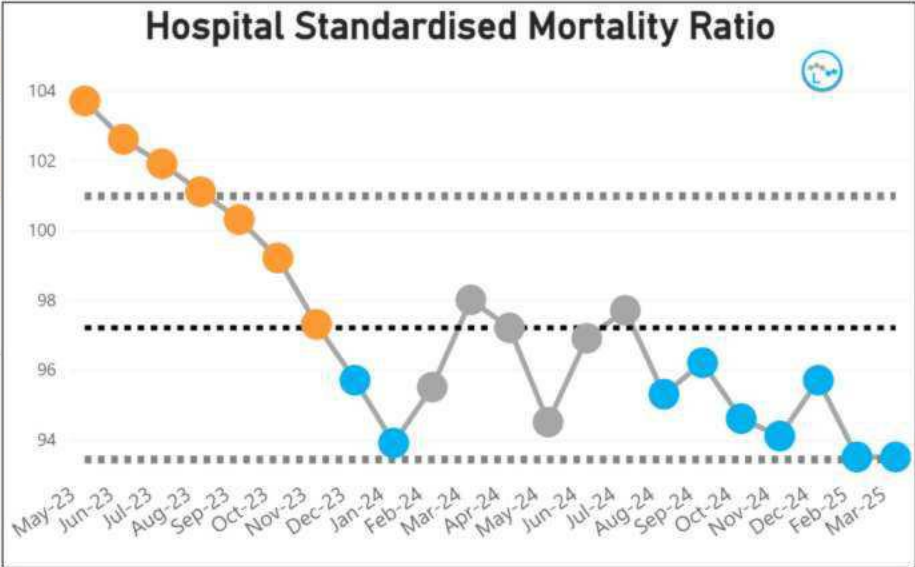
FEB24_JAN25
90.08
Banding
As expected



Feb-25
93
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target



Mar-25
93.5
Banding
As expected



HSMR Narrative

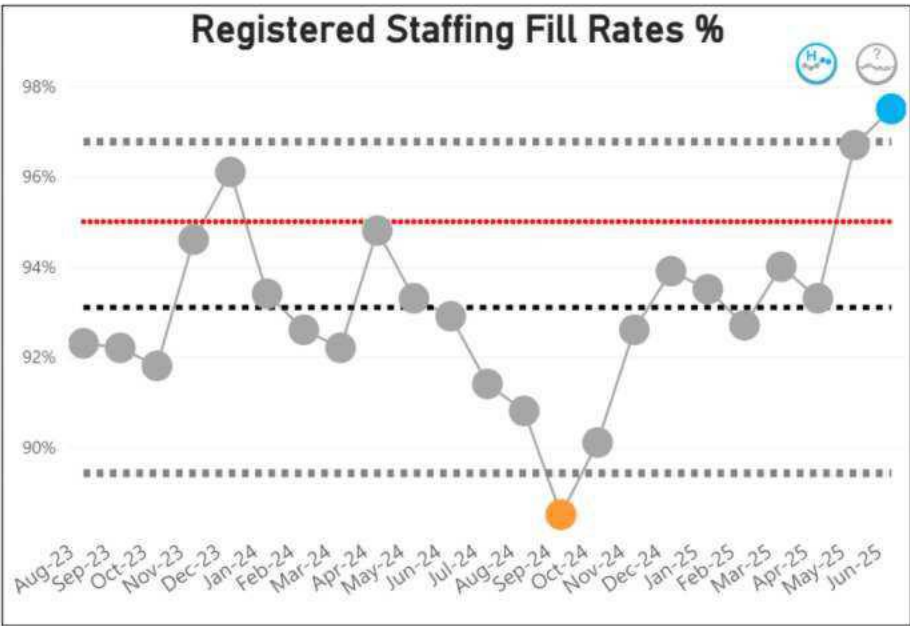
The current HSMR (to March 25) is 93.5 which was the same figure as February 25 and a reduction from January 25. From April - 23 onward, we are showing a statistically significant decrease in our HSMR score. As the reporting period now excludes most of the aftermath of the Cerner implementation the mean has dropped, and we now see that the current reporting figure is below the Lower Control Limit, showing an improved performance in this metric.

SHMI Narrative

The current SHMI remains sub 100 which is on par with previous periods and remains within the expected range. The figures are now showing a 7 point below the mean improvement with recent months being below the Lower Control Limit, demonstrating a continued increase in performance.

We have added the total number of Inpatient deaths into the IPR as supplementary to our HSMR and SHMI being a few months behind.

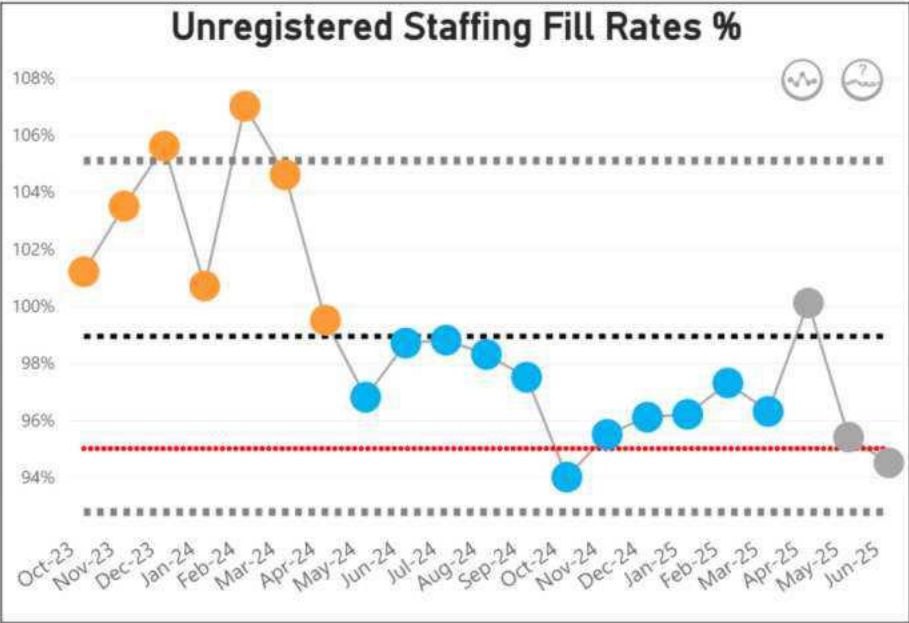
Jun-25
97.5%
Variance
Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.
Target
95%



Registered Nursing Narrative

The significant reduction in registered nurse fill rates had correlated with the establishment work completed earlier in the year, when Planned nursing numbers were increased within wards and departments in response to the acuity and dependency commonly seen in the area. This has resulted in a vacancy, which is actively being recruited to and there is a strong pipeline in place. However, the Trusts is experiencing a higher-than-expected number of registered nurses unavailable for work and although a % of this is planned for in the establishment headroom (23%), current sickness and absence has exceeded this. A detailed analysis has been undertaken and this is largely being driven by stress and anxiety which triangulates with staff redeployment day to day to maintain staffing levels. Immediate actions have been put into place in the emergency department and SDEC (where staff are currently being redeployed to) to reduce the need for staff moves. These actions include redeploying interested staff for a period of time (rather than day to day) and increasing temporary staffing requests, in advance, on blocks contracts, where possible for continuity. This metric will continue to be closely monitored by the senior nursing team.

Jun-25
94.5%
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
95%



Unregistered Nursing Narrative

There still remains issues with the complexity of patients, with multiple wards and departments operationalising 'zoned bays' and nursing patients required on-to-one.

There has been a drop in both metrics this calendar year but unregistered staffing now appears as being more stable and close to the 95% target.

Safer Staffing Levels - Jun 25

Ward Information			Staffing Rates								CHPPD				Falls		Skin Integrity	Medication	Staffing		Friends & Family		
Directorate	Ward	Occupancy	Total Reg	Total Unreg	Day Reg	Day Unreg	Night Reg	Night Unreg	Reg	Non-Reg	Actual	Planned	Nat Avg	Total	With Harm	HAPU	Admin Incs	Incidents	With Harm	Positive	Negative	Response	
Urgent Care	Acute Medical Unit	50	96.50%	96.27%	95.92%	99.41%	97.56%	92.23%	4.3	3.8	8.1	8.4	9.7	8	0	0	1	10	6	0	85.00%	15.00%	11.36%
	Ward 33 Trinity Ward	34	93.68%	91.23%	84.85%	96.74%	104.42%	88.43%	3.3	3.5	6.8	7.4	27.0	3	0	0	4	1	0	0	0	0	
	Ward 40	11	103.40%	94.74%	95.93%	100.00%	123.41%	90.07%	3.5	3.7	7.2	7.3	15.9	0	0	2	0	0	0	0.00%	0.00%	0.00%	
	Ward 42	16	96.67%	90.95%	96.67%	100.00%	96.67%	85.55%	5.0	5.5	10.5	11.2	15.0	2	0	2	0	2	0	100.00%	0.00%	26.09%	
	Ward 43 Meadows Ward	16	100.22%	96.29%	99.38%	97.78%	103.41%	94.95%	3.3	4.2	7.5	7.7	8.0	0	0	0	0	1	0	85.71%	14.29%	18.92%	
	Ward 44	28	95.07%	90.98%	90.26%	97.16%	101.56%	86.71%	3.6	3.6	7.2	7.8	13.7	5	0	2	5	0	0	75.00%	25.00%	8.51%	
	Ward 45 Palace	25	104.70%	100.01%	97.96%	103.33%	115.28%	97.79%	3.4	3.2	6.6	6.5	8.1	4	0	1	1	0	0	85.71%	0.00%	11.11%	
	Ward 50	28	95.43%	96.86%	88.36%	100.23%	103.20%	95.37%	3.9	3.7	7.6	7.9	8.7	2	0	1	2	0	0	50.00%	50.00%	6.25%	
	Ward 51	28	95.10%	95.43%	89.73%	100.51%	100.44%	93.20%	3.7	3.6	7.3	7.7	8.1	7	0	3	2	1	0	75.00%	25.00%	9.52%	
	Cardiology Unit	16	89.00%	93.23%	85.56%	95.91%	97.46%	88.37%	4.0	3.8	7.8	8.5	8.3	1	0	1	1	1	0	100.00%	0.00%	13.56%	
	Respiratory Unit	38	95.61%	94.93%	95.84%	100.12%	95.27%	89.19%	4.2	4.0	8.2	8.6	7.1	9	0	3	4	2	0	75.00%	25.00%	16.00%	
	Modular	20	96.42%	99.36%	91.18%	100.00%	109.20%	98.79%	3.2	3.0	6.2	6.3	8.1	1	0	1	2	0	0	0.00%	0.00%	0.00%	
Planned Care	Emergency Dept Team		93.85%	96.29%	92.11%	96.47%	98.39%	95.88%	#N/A	#N/A	#N/A	#N/A	#N/A	6	0	0	5	10	0	71.90%	17.15%	10.60%	
	Ward 60 Haematology Oncology Suite		94.80%	67.93%	94.80%	100.00%	100.00%	67.93%	#N/A	#N/A	#N/A	#N/A	#N/A	0	0	0	0	0	0	91.11%	0.00%	10.56%	
	Renal Unit (Care)		91.87%	100.48%	91.87%	100.00%	100.00%	100.48%	#N/A	#N/A	#N/A	#N/A	#N/A	0	0	0	0	0	0	0	0	0	
	Ward 41	29	95.99%	93.14%	92.03%	101.11%	100.87%	89.57%	3.4	3.6	7.0	7.4	8.1	1	0	8	3	0	0	100.00%	0.00%	16.00%	
	Ward 52	28	97.21%	108.10%	91.78%	101.24%	104.38%	114.18%	3.3	2.8	6.1	6.0	8.7	3	0	3	1	3	0	66.67%	20.00%	17.86%	
	Ward 53	28	97.68%	90.87%	97.37%	98.03%	98.18%	86.12%	3.5	3.1	6.6	7.0	8.1	8	1	3	2	1	0	100.00%	0.00%	19.35%	
	Ward 54	28	98.72%	97.62%	90.13%	102.32%	120.00%	94.05%	3.0	3.0	5.9	6.0	9.1	1	0	1	0	0	0				
W&C TICC	Ward 56	28	126.11%	97.74%	98.61%	100.00%	200.08%	95.76%	4.1	3.7	7.9	7.1	6.2	0	0	0	4	0	0	80.00%	20.00%	23.81%	
	Critical Care	15	97.26%	95.98%	97.07%	96.50%	100.00%	89.86%	#N/A	#N/A	#N/A	#N/A	#N/A	0	0	0	2	4	0				
	Bluebell Unit	24	96.59%	97.27%	93.82%	100.00%	99.95%	96.29%	3.0	3.4	6.3	6.5	8.1	1	0	1	0	0	0	93.33%	0.00%	88.24%	
	EPH Stroke Rehab Unit Team	17	97.88%	98.49%	95.50%	100.00%	100.00%	97.95%	3.7	4.8	8.5	8.7	8.7	1	0	1	0	2	0	87.50%	12.50%	80.00%	
W&C	Poppy Unit	19	75.43%	111.12%	97.27%	95.1%	46.7%	94.19%	1.8	4.4	2.4	3.9	8.0	3	1	1	0	0	0	66.67%	16.67%	50.00%	
	Maternity Suite		93.92%	68.99%	93.78%	69.0%	94.2%	54.14%	33.1	1.9	35.2	2.7	9.0	0	0	0	0	0	0	0	0	0	
	NNU		94.03%	100.00%	105.05%	100.0%	79.1%	100.00%	20.9	0.0	22.2	0.0	8.7	0	0	0	0	0	0				
	Ward 29 & 30 Childrens' Unit	22	94.00%	110.93%	94.80%	123.2%	93.0%	106.77%	2.4	0.7	2.6	0.7	8.3	0	0	0	0	1	0				

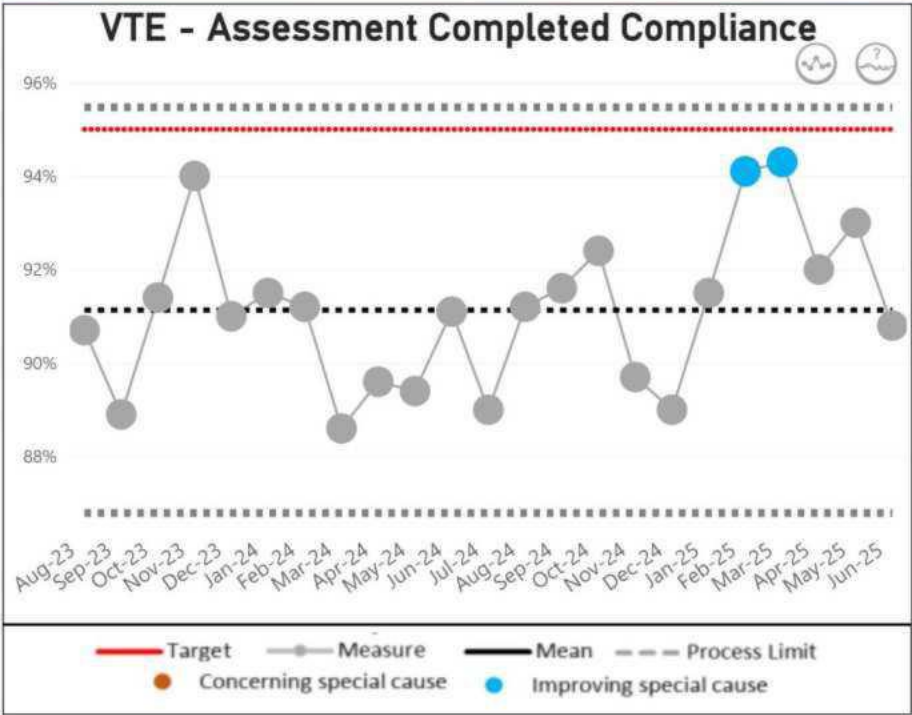
Nurse Staffing Breakdown

We have added this page to give further insight into our staffing levels as well as metrics effected by staffing levels. Each Ward area has a breakdown of their registered and unregistered staffing, as well as the breakdown of these figures for Day and Night. The Care Hours Per Patient Day (CHPPD) is also displayed, the national average is taken from the average CHPPD for the wards speciality.

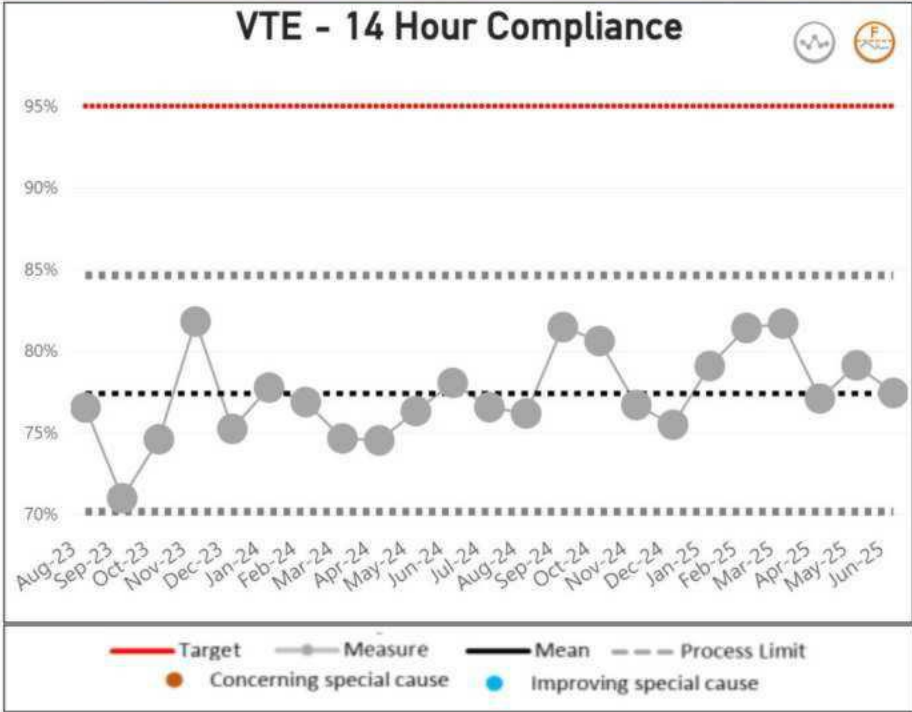
FFT Breakdowns for positive, negative and response rate are also given. This is based on the patient's discharge ward, i.e. the last ward of treatment. Our average response rate for Inpatient FFT is 20%, so there can be some wards/areas that do not get many responses, you also see a few patients responding multiple times, so that shows for some of the EPH areas where the response rate is over 100%.

FFT is split into 6 options, very good, good, neither, poor, very poor and "don't know", for positive we look at very good and good, and negative is poor and very poor, thus you can see that some of the % do not total 100%.

Jun-25
90.8%
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
95%



Jun-25
77.4%
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
95%



VTE Narrative

Following the return of the national submission for VTE, a review of the data capture and definitions was undertaken. Following this it was identified that in order for a VTE assessment to be classed as valid, the result of a patient being at risk must be finalised on the system. This has resulted in a drop in compliance but is a more accurate reflection of patient care. Compliance is closely monitored on weekly reports