

Liverpool Heart and Chest Hospital 
NHS Foundation Trust

Strategic Oversight Framework

March 2025

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Icon Definitions

Variation			Assurance		
	 	 			
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

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



Change Control

Board Governance of LHCH Strategic Oversight Framework change control

- At the start of the year the Board will sign off the SOF (Strategic Outcomes Framework) and any associated targets (metrics).
- Each metric will be assigned to a Trust Committee.
- Throughout the year the committees will fulfil their wider assurance functions and additionally have opportunity to explore more fully the drivers and any issues or mitigations associated with particular areas of performance falling with their remit.
- Overall performance will continue to be reported to the Board at each meeting. A summary will be provided by the lead executive to each Board meeting but the Board may choose to secure supplementary updates from Committee Chairs based on the experience of the committee they lead – as appropriate.
- No later than Q4 of each year it is envisaged that each committee will allocate time to review the SOF and consider, the need for any amendment, changes or alteration to the current measures. Issues considered may relate to changing operating environment, performance, or changing focus of the organisation. Proposals may be brought forward by the responsible operational team but the committee might equally make proposals, for response, to operational colleagues.
- No later than Q1 the Board will be presented with proposals for the organisational SOF for that operational year. These proposals will represent the combined view of the executive and the committees and reflect the experience of the previous year but also NHS planning considerations.
- In year – any changes to either metrics or performance coverage should first be discussed with the relevant board committee who will form a view and either propose a discussion at Board or make a recommendation to support a change having fully explored the issues under focus.



Operational Performance

SRO: Jonathan Mathews, Chief Operating Officer

Highlights:

At the end of M12 6 standards show below the required target or some statistical variance, however all of these are expected or show levels of improvement based on mitigation plans in place. All of these indicators were monitored and closely aligned against any clinical risk. For 25/26 we are reviewing all indicators against the regional and national ambitions.

Elective activity was at 8% above plan in month, with case mix & non elective demand shown within our financial reporting.

Cancer Performance is reported a month in arrears. In February the FDT standard was non compliant. however the 31and 62 day positions were compliant.

We were unable to achieve a zero position for 65 weeks by the end of March, however the remaining numbers are due to complexity or patient choice, however the Surgery Division have done an amazing job on moving us to very small numbers within this cohort. Our 52 week position has raised in month due to mutual aid we continue to provide for Mid Cheshire Hospital for Cardiology.

DM01 (Diagnostics) has shown significant improvement over the last few months and is now back to DMO1 compliant.

Areas of Concern:

Diagnostics continue to have specific capacity constraints on Stress MRI, Congenital and pacemaker patients. Sustainable recovery is being reviewed in conjunction with the ICS and CAMRIN colleagues. Additional sessions and mutual aid from University Hospital Liverpool Group continue to support recovery, however the specialist skills are not readily available in C&M and a sustainable long term plan needs to be created.

The FDS diagnostic wait times continue to remain a challenge as although we have a small number of breaches the denominator does not allow for significant slippage against the percentage performance. No Clinical Harm has been identified when the pathways have been reviewed and performance is monitored weekly in the Cancer teams.




As a Trust Cardiac Surgical Waiting Lists continue to be pressured with non elective demand and specific service line pressures (Mitral and ACHD) which continue to pose risk due to the workforce shortfall and capacity deficit going in to 25/26.

Non Elective Activity continues to be actively monitored with overall impact on Elective capacity and will be a discussion for 25/26 commissioning and contracting.

Forward Look (with actions):

- *Annual Planning is now coming to a close with an understanding of Targets for 25/26, which are detailed in a separate paper.
- * Activity will continue to be monitored weekly, with increased data being reviewed to understand case mix and non elective demand given contracting changes. Additional sessions and capacity will be explored as required.
- * FDS although not expected to be sustainable, has been able to achieve in in 24/25, this will continue to be an area of focus for 25/26. The 62 standards is compliant, however sustained achievement will align with the FDS capacity. The Cancer Alliance are sighted on our current action plan and will be joining Cancer Board to provide support to any areas of concern
- * A Cardiac MRI capacity and demand task & finish is in place (working with regional colleagues) to look at closing the MRI capacity gap. UHLG (University Hospital Liverpool Group) support continues into Q1.
- * Overall Waiting List Size & 35 weeks has shown increases, however no concerns have been raised at this stage. The Divisions will be looking at waiting list processes through the Safe Waiting List Management Group and a forecast against the return to RTT standards.

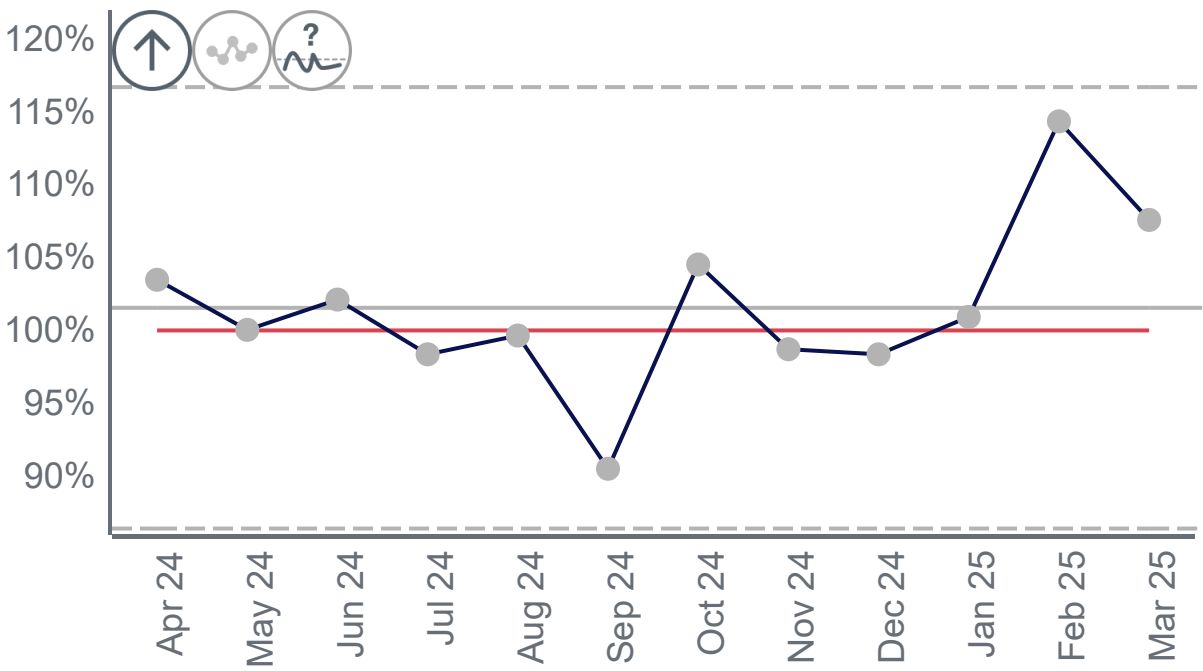
Operational Performance - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
Bed Occupancy	Mar-25	81.3	>=80%	80		
Cancelled Operations for non-clinical reasons	Mar-25	4.9	<=2%	2		
Outpatient activity delivered remotely via telephone or video consultation	Mar-25	30.1	25%	28		
Elective Activity Levels	Mar-25	107.6	100%	102		
Maximum 6-week wait for diagnostic procedures	Mar-25	96.12	>=95%	87		
Overall Size of Waiting List	Mar-25	6487		6397		
Incomplete Pathways 35+ Weeks	Mar-25	374		314		
Referral to treatment - Incomplete Pathways 52+ weeks	Mar-25	56		63		
Referral to Treatment - Incomplete Pathways 65+ weeks	Mar-25	4.0		14		
PIFU Pathway	Mar-25	1818	113	1495		
Letters waiting to be typed over 7 days	Mar-25	128	0	273		
Non-Criteria to Reside Occupied beds as a proportion of total occupied beds	Mar-25	7.3		4		
Patients not booked in within 28 days (non clinical cancellations)	Mar-25	0.0	0	1		
Cancer Patients meeting the Faster Diagnosis Target (FDT)	Feb-25	70	>=75%	62.4		
Cancer: 31-day decision to treat to treatment standard	Feb-25	100	>=96%	93.1		
Cancer: 62-day referral to treatment standard	Feb-25	85.2	>=85%	74.4		



Operational Performance - Drive Metrics

Elective Activity Levels



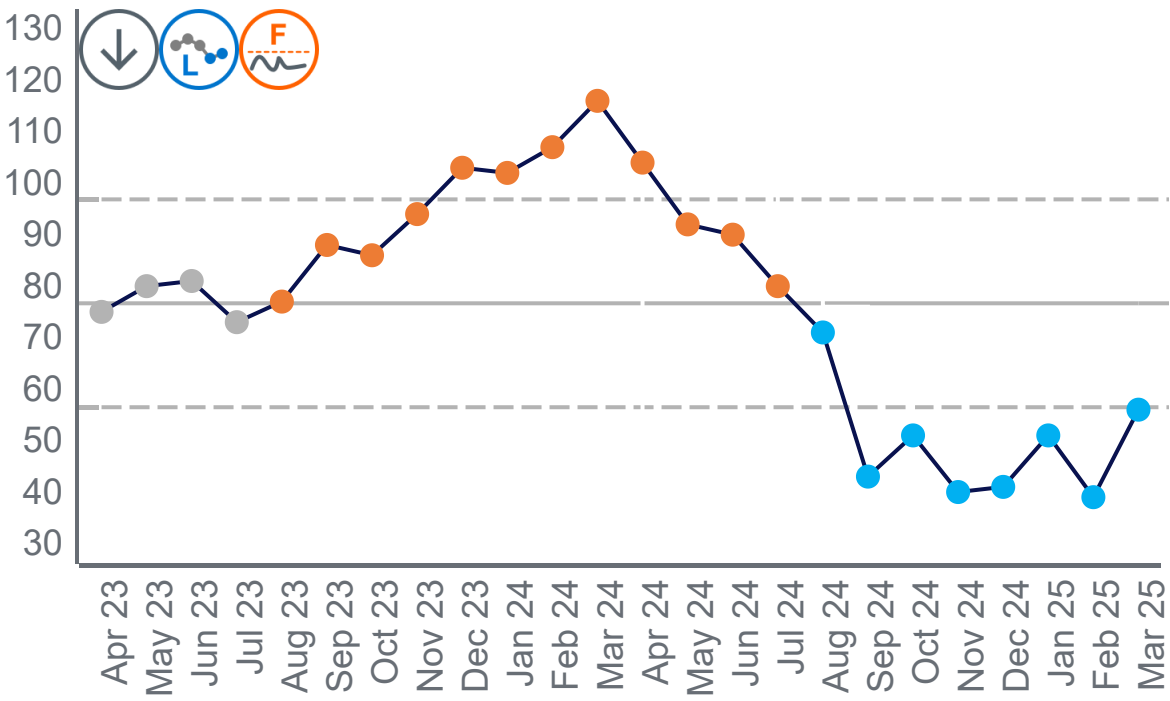
Technical Analysis:

Performance within Mar-25 was 108% achieving the target of 100%. 2024/25 is demonstrating common cause variation and continually passing and failing the target.

Actions:

- *Surgery NE demand forms a significant part of commissioning and contracting for 25/26
- *Weekly and Monthly monitoring continues through both Division and Trust Performance meetings.

Referral to treatment - Incomplete Pathways 52+ weeks



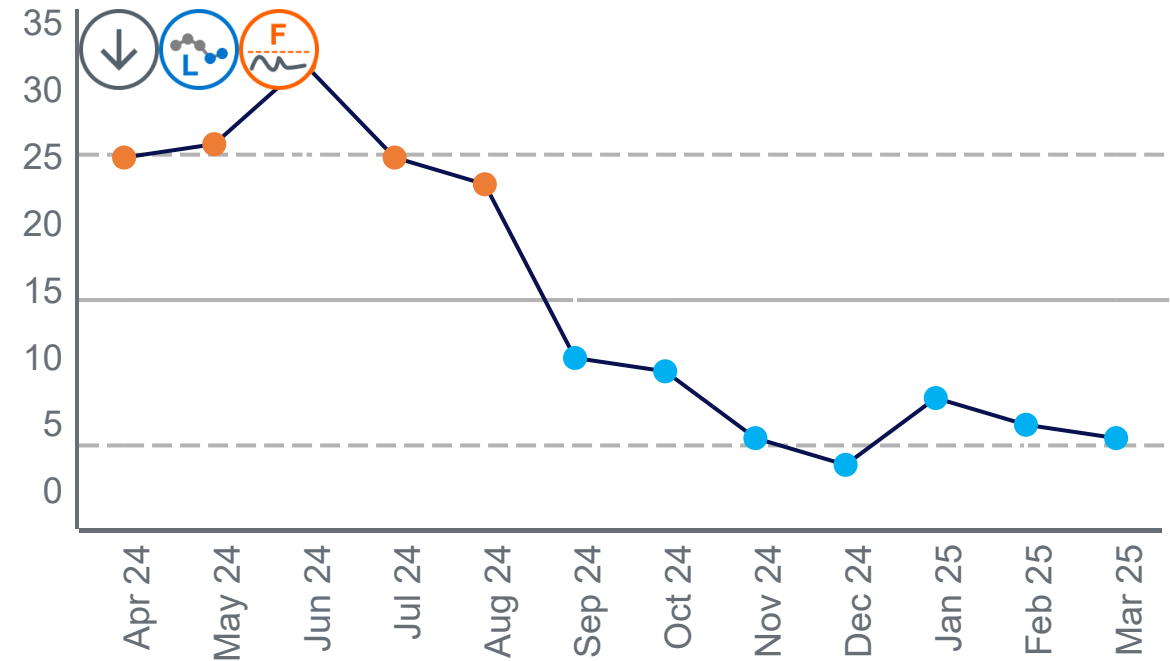
Technical Analysis:

Current performance is displaying special improvement as the trust closes the gap on achieving the target. 2024/25 has shown a reduction but has stabilised over recent months. Surgery patients remain the most significant contributors to volumes. Further work required to achieve target.

Actions:

- *Pathway RCAs undertaken for every patient which tips over 52 weeks.
- *Trajectory and plans in place in line with national ambition of only 1% of 52 week patients against total waiting list size in 25/26.

Referral to Treatment - Incomplete Pathways 65+ weeks



Technical Analysis:

Performance across 2024/25 is displaying special cause improvement. The trust failed to meet the target in Mar-25. Recent months has shown improvement but further work required to close the gap.

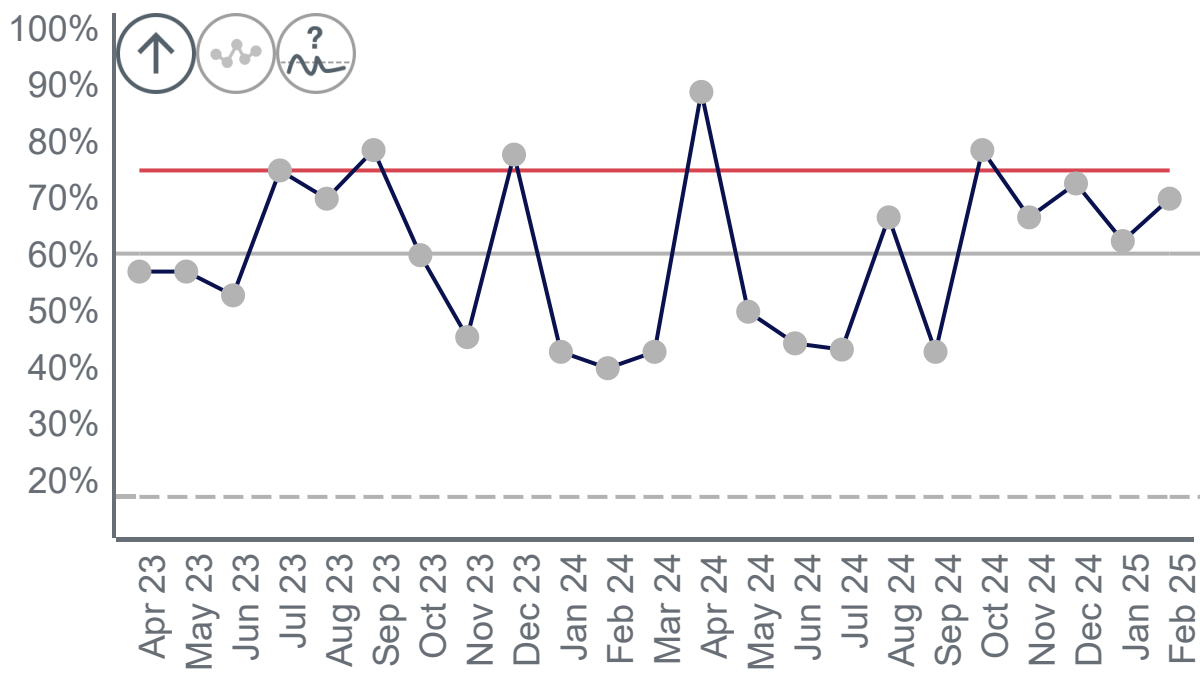
Actions:

- *Mini Mitral Service line remains closed to Referrals
- *Micro management of the PTL undertaken by the Surgery Divisional Team.



Operational Performance - Drive Metrics

Cancer Patients meeting the Faster Diagnosis Target (FDT)



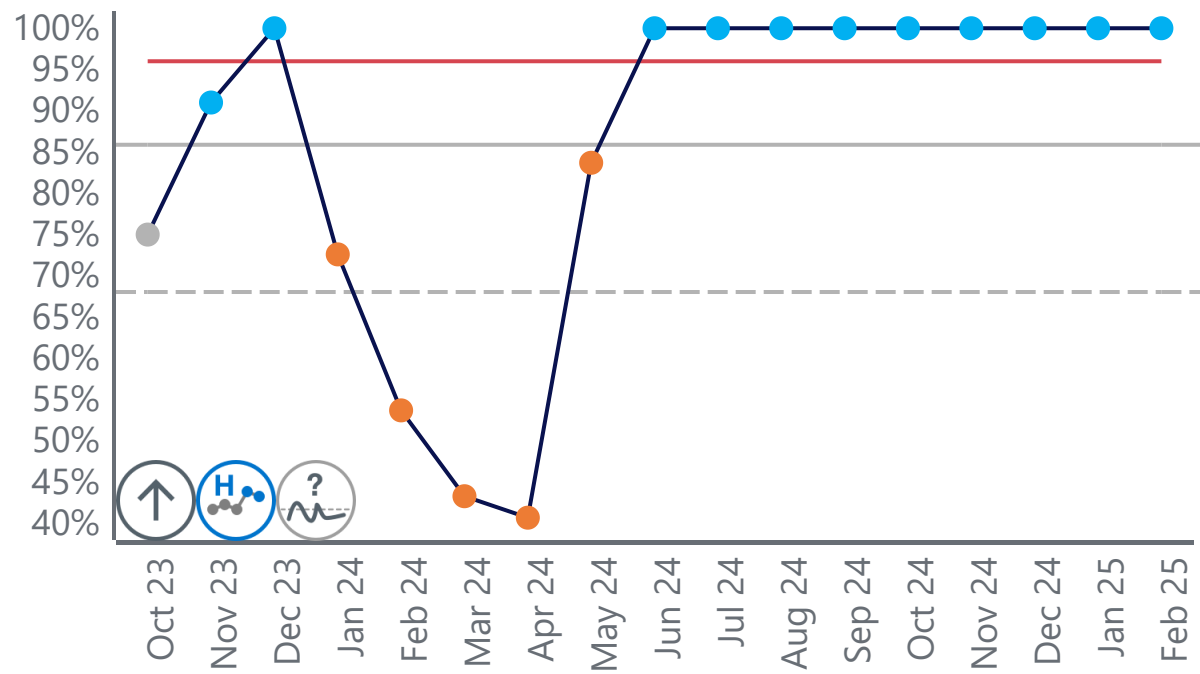
Technical Analysis:

The target was not achieved in February. Performance continues to display common cause variation of passing and failing the target inconsistently. Improvement Required to consistently achieve Cancer FDT.

Actions:

- *Additional sessions continue to be requested to support wait times in CT guided biopsy & EBUS.
- *EBUS Joint Consultants now in place.
- *CT guided biopsy breaches being reviewed against MDS information.

Cancer: 31-day decision to treat to treatment standard



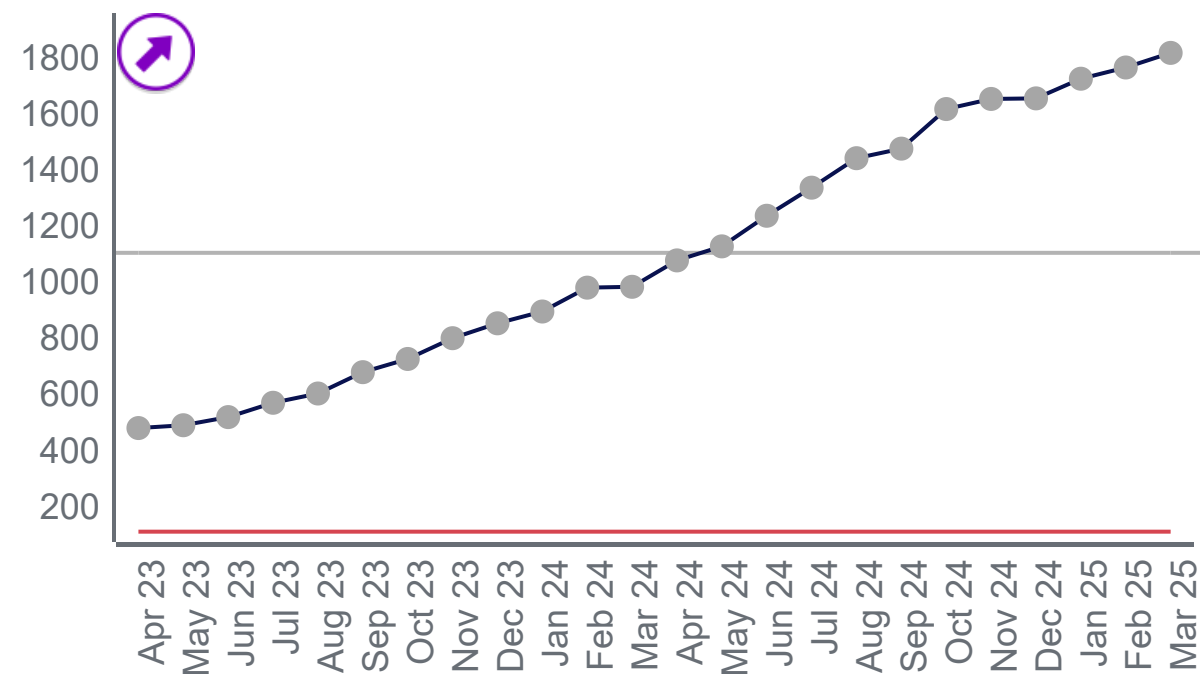
Technical Analysis:

Performance is displaying special cause improvement having achieved the target for the last 9 months.

Actions:

- * Surgical wait times have now reduced under 7 days with increased capacity put in place.

PIFU Pathway



Technical Analysis:

There has been slow growth to active patient numbers on PIFU pathways in March. Numbers added each month needs to increase to achieve the 2% target.

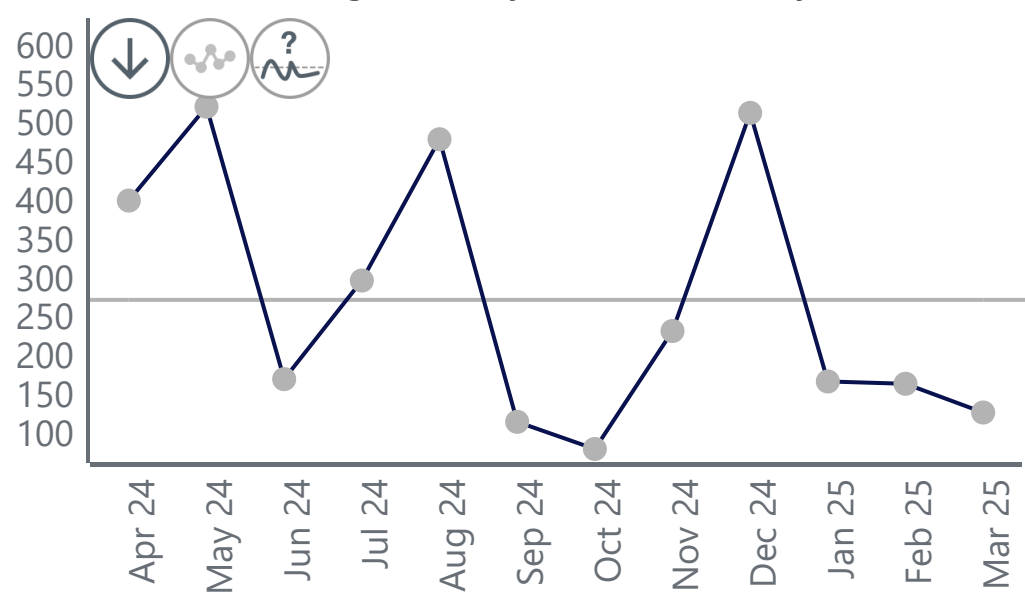
Actions:

- *The Outpatient Transformation Group (OTG) continues to drive the use of Patient Initiated Follow Ups within LHCH.
- *Service lines have been reviewed and targeted for onboarding based on appropriate clinical pathways.

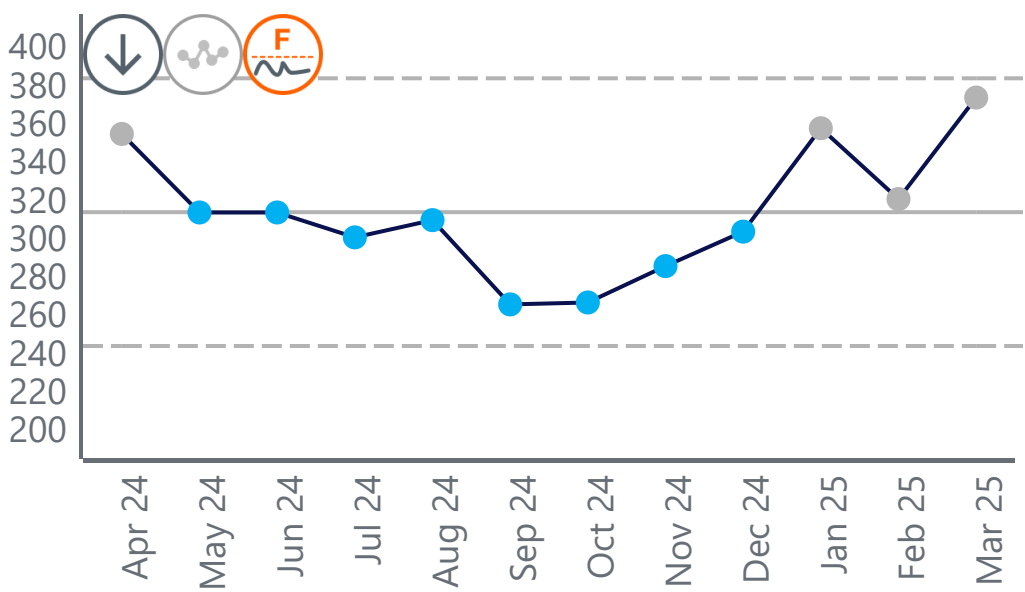


Operational Performance - Watch Metrics

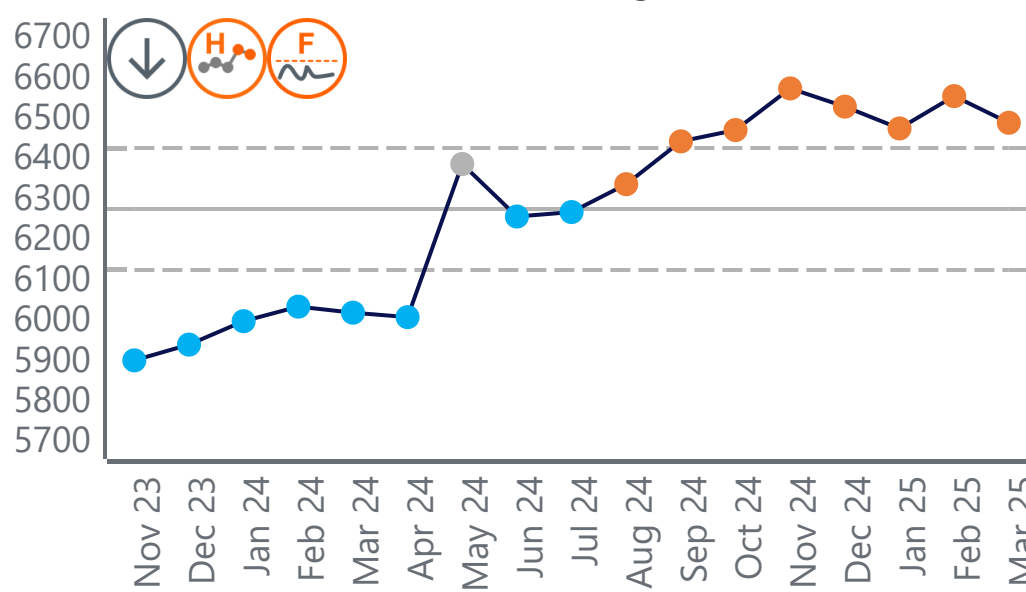
Letters waiting to be typed over 7 days



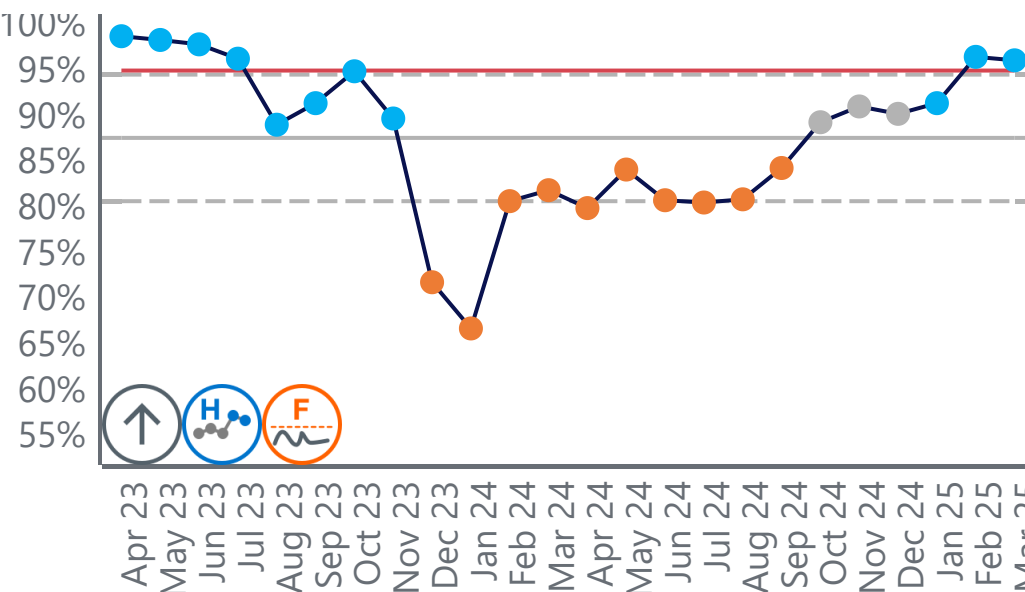
Incomplete Pathways 35+ Weeks



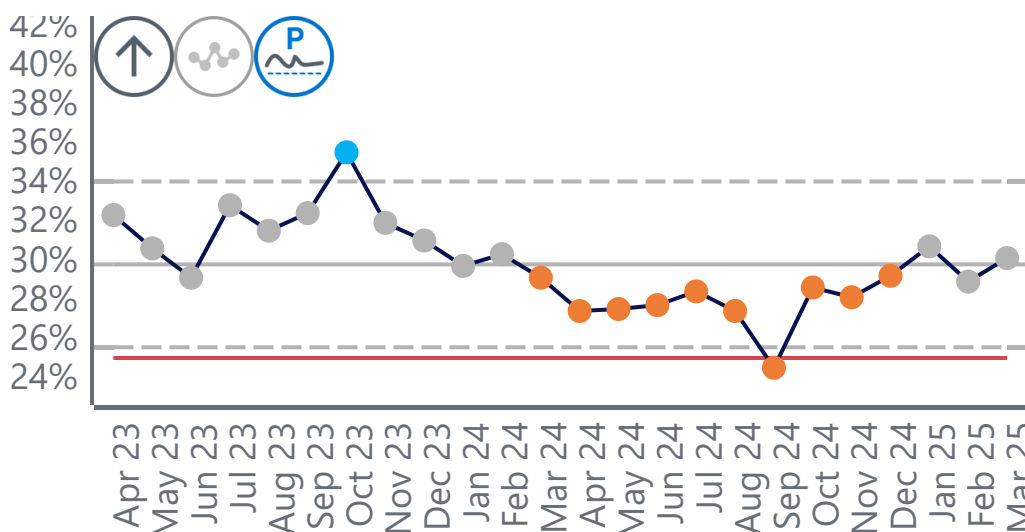
Overall Size of Waiting List



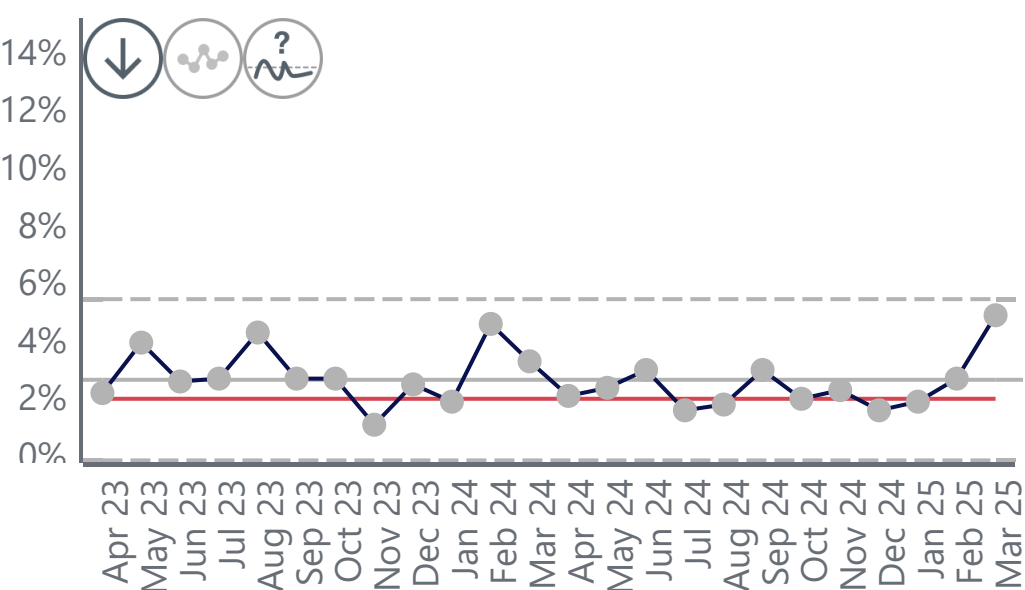
Maximum 6-week wait for diagnostic procedures



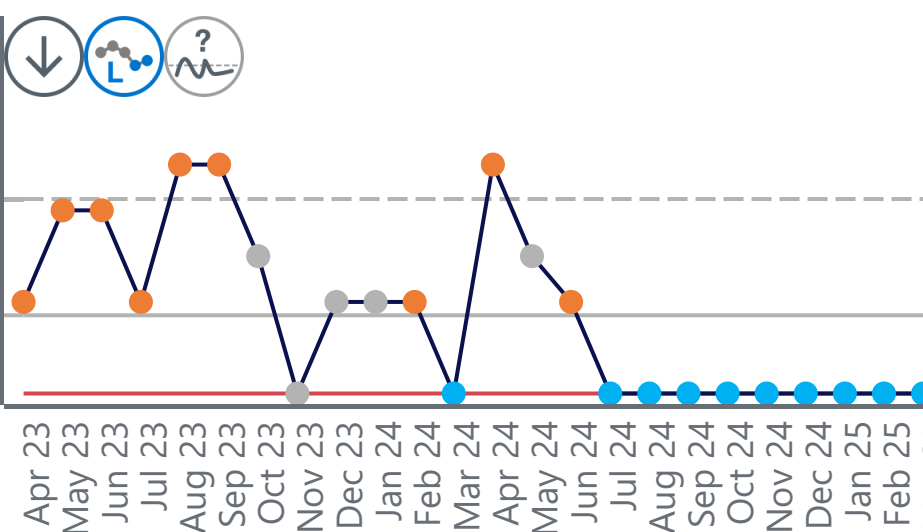
Outpatient activity delivered remotely via telephone or video consultation



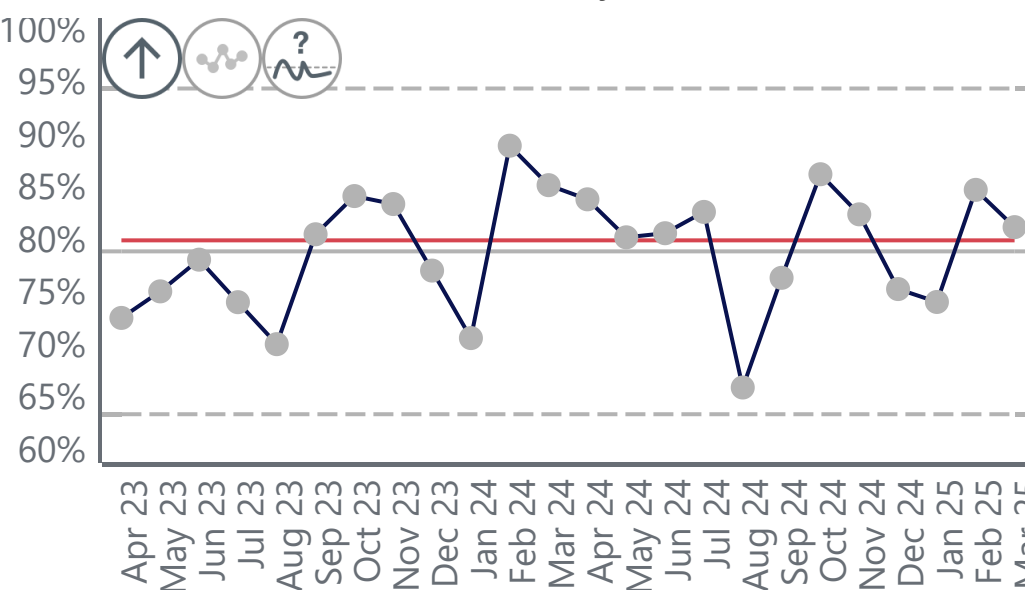
Cancelled Operations for non-clinical reasons



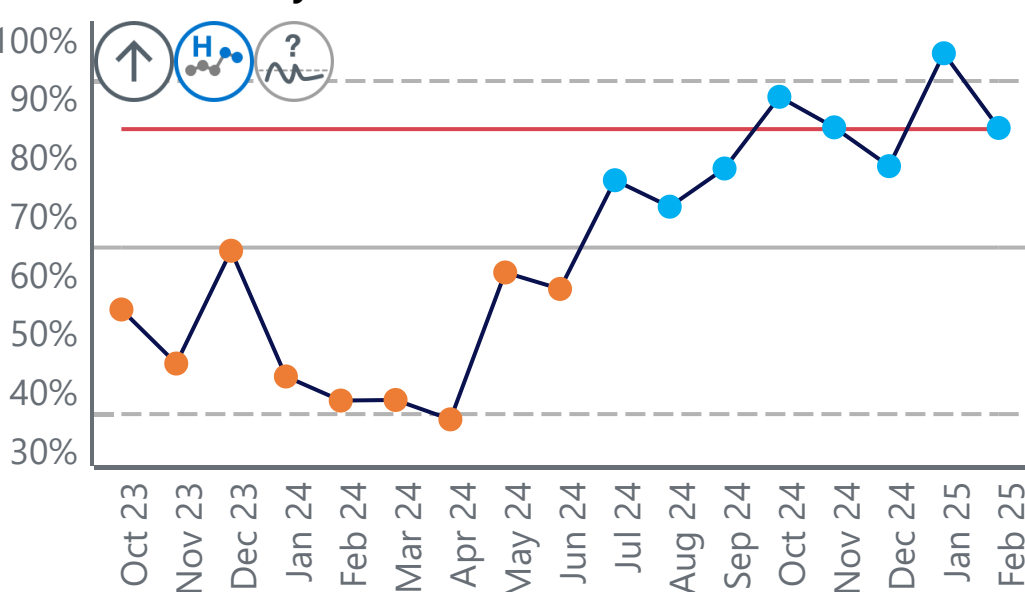
Patients not booked in within 28 days (non clinical cancellations)



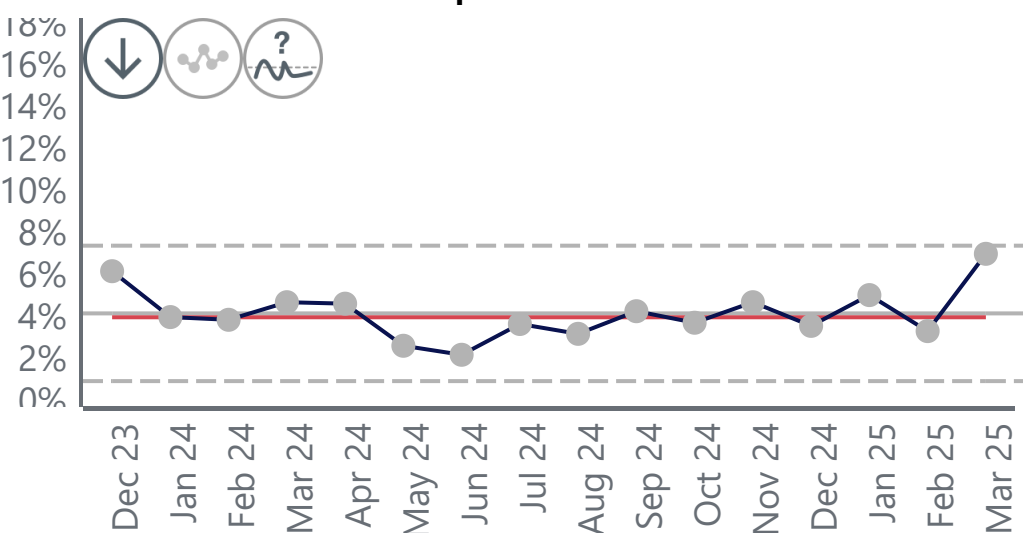
Bed Occupancy



Cancer: 62-day referral to treatment standard



Non-Criteria to Reside Occupied beds as a proportion of total occupied beds



Productivity

SRO: Ben Davies, Associate Director of Transformation

Highlights:

Overdue follow-up performance has continued to achieve the 25% target for the 8th month in a row, which is a fantastic result by the teams. Service lines are currently reviewing their under-utilised clinics, and this is now fed back to the medicine divisional director in the newly implemented 6:4:2 weekly scheduling meeting. The team have also removed the 0% utilised and emergency clinics to improve data accuracy.

The overall Diagnostic DNA rate has reduced again this month from 6% to 4%, with work continuing within CT & MRI, calling patients 48 hrs before their appointment, which the team feels has had the greatest impact on DNA rates. A standard letter template is now in place for Echo clinics, along with the correct patient leaflets being sent.

The Theatre and Cath Lab combined utilisation performance remains slightly below 85%, however, we have seen more patients arriving in theatres on time. For the 3rd successive month, there has been an improvement in % of core sessions delivered in theatres. There has also been a reduction in the number of avoidable cancellations again for this reporting period.

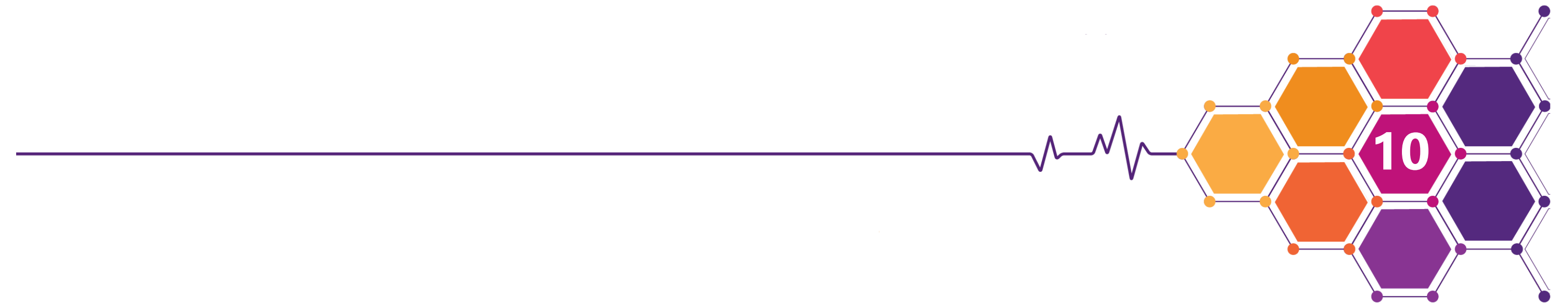
Overall, the 3 drive metrics continue to maintain a positive trajectory, and this is also reflected in the watch metric performance figures. Work continues with the teams to understand and identify areas for improvement and how we can replicate work done in other areas to recognise similar benefits to patient experience and performance.

Areas of Concern:













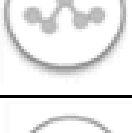

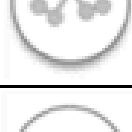

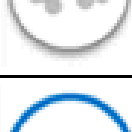






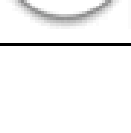
- * Whilst Echo & Sleep DNA rates position has improved over the last couple of months they remain above target. Process mapping sessions are planned with the teams to better understand processes and identify areas for improvement.
- * Work is ongoing to review and update ENVOY, our text reminder service, and Health Care Comm's letters for Sleep patients as they do not reflect the service's requirements, which is hindering DNA rates for this service.

Forward Look (with actions):

- * The theatre programme continues to work on improving theatre session utilisation with a focus on how we can improve our knife-to-skin performance against the agreed metric.
- * Work is underway to look at the potential of creating a 'pooled' waiting list of patients to improve theatre utilisation and productivity. The team are also collecting data to determine how we can maximise theatre slot utilisation by ensuring lists are planned and filled accordingly.
- * A review is to be conducted for Sleep letters and attachments to ensure a standard template is being utilised with the correct information and leaflets being provided to improve DNA rates.
- * A project refresh is underway to review and realign the workstreams within Diagnostic Delivery to aid with productivity overall due to crossover between utilisation, DNA's, etc.



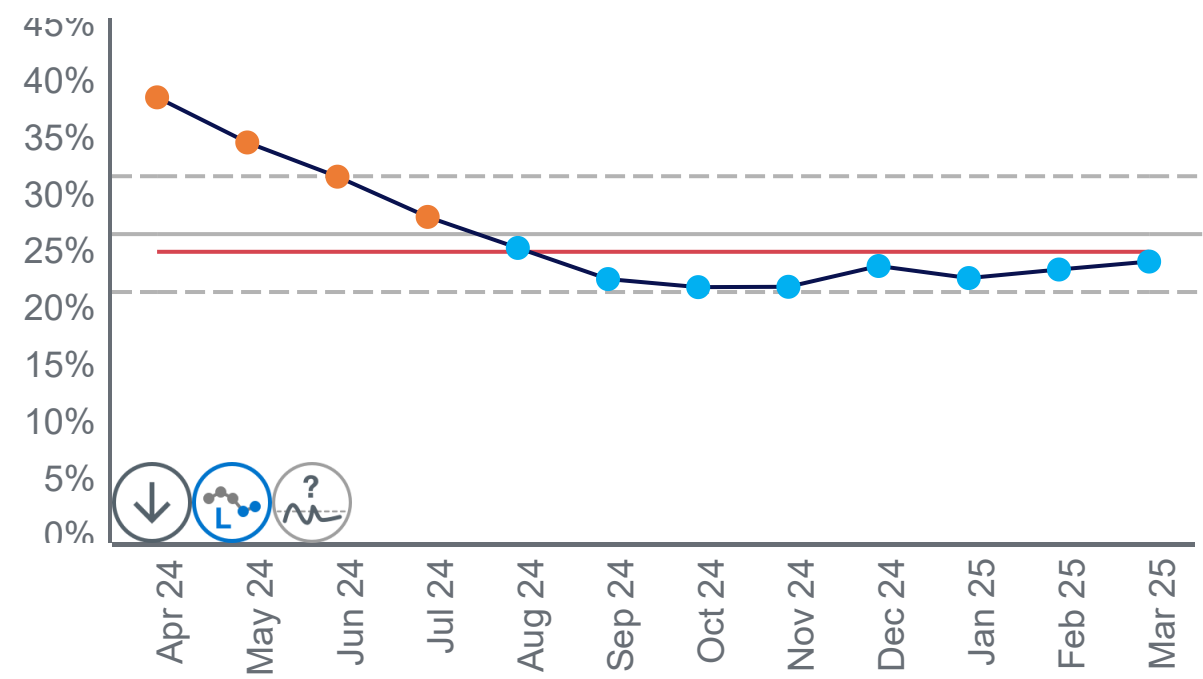
Productivity - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
% Avoidable Cancellations (Theatres)	Feb-25	0.4	1%	1.4		
% Core Session Delivery (Theatres)	Mar-25	99.0	95%	97.6		
% Session Utilisation (Theatres)	Mar-25	78.7	85%	82.8		
Diagnostic DNA Rate	Mar-25	4.0	3%	6.4		
CT DNA Rate	Mar-25	3.0	3%	4.3		
MRI DNA Rate	Mar-25	4	3%	4.8		
Echo DNA Rate	Mar-25	9	3%	8.7		
Sleep DNA Rate	Mar-25	19	3%	18.0		
% Patients on PIFU	Mar-25	1.9	2%	1.6		
Overdue Follow Ups	Mar-25	24.14	25%	26.6		
Slot Utilisation	Mar-25	39.7	85%	33.7		
Theatre and Cath Lab Utilisation Combined	Mar-25	82.65	85%	85.1		



Productivity - Drive Metrics

Overdue Follow Ups



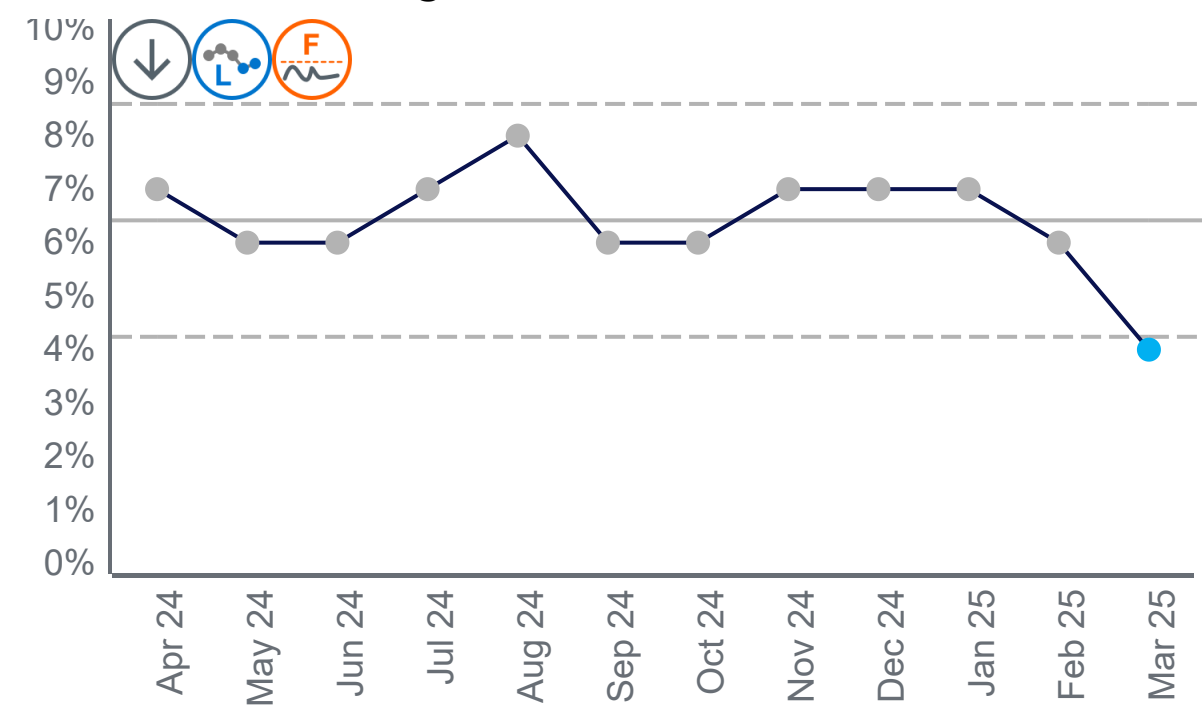
Technical Analysis:

Currently the target of 25% is being achieved. Over the recent months performance has shown improvement. Further consistency required to ensure recent performance is maintained.

Actions:

* Reviewing data and a refresh of metrics for next year to provide oversight of not only volume of overdue follow ups but also the time patients are waiting to improve patient experience.

Diagnostic DNA Rate



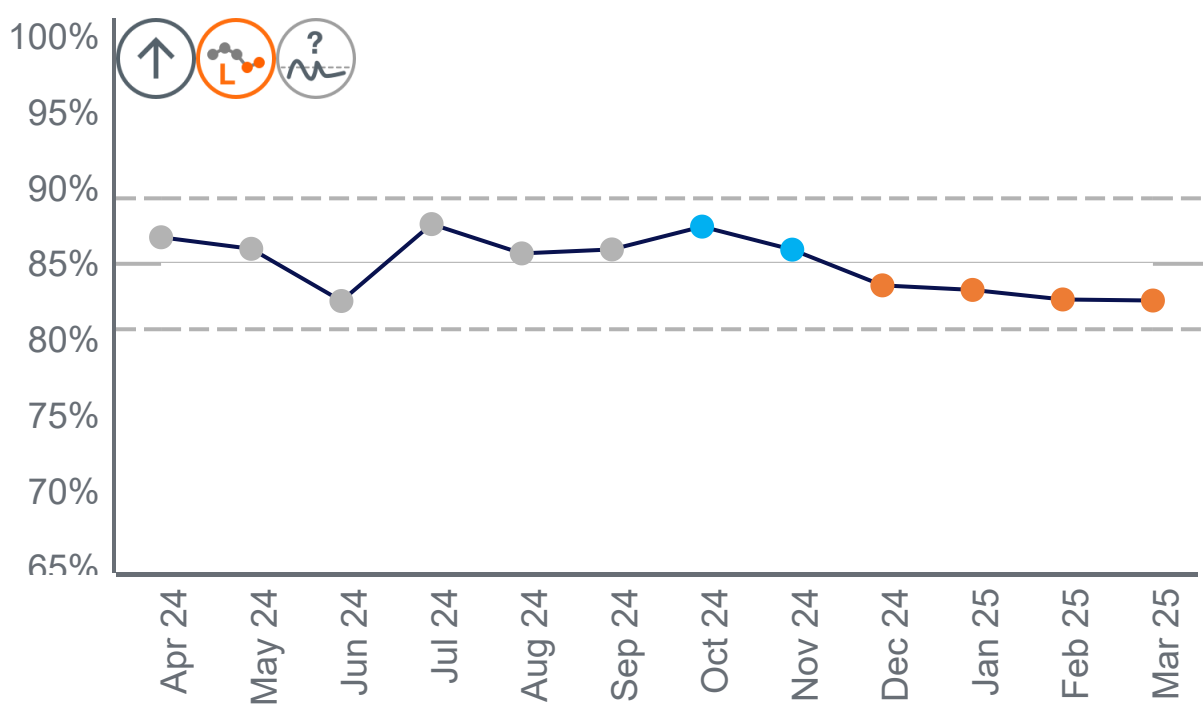
Technical Analysis:

Current performance is displaying special cause improvement. Further work required to achieve the target consistently.

Actions:

* Completion of the process mapping sessions for the remaining area to be conducted.
* Review of the Sleep letters and leaflets to be completed and implementation of a standardised template.

Theatre and Cath Lab Utilisation Combined



Technical Analysis:

Current performance is demonstrating common cause variation but remains consistently below the target. Further action is required to consistently achieve the target.

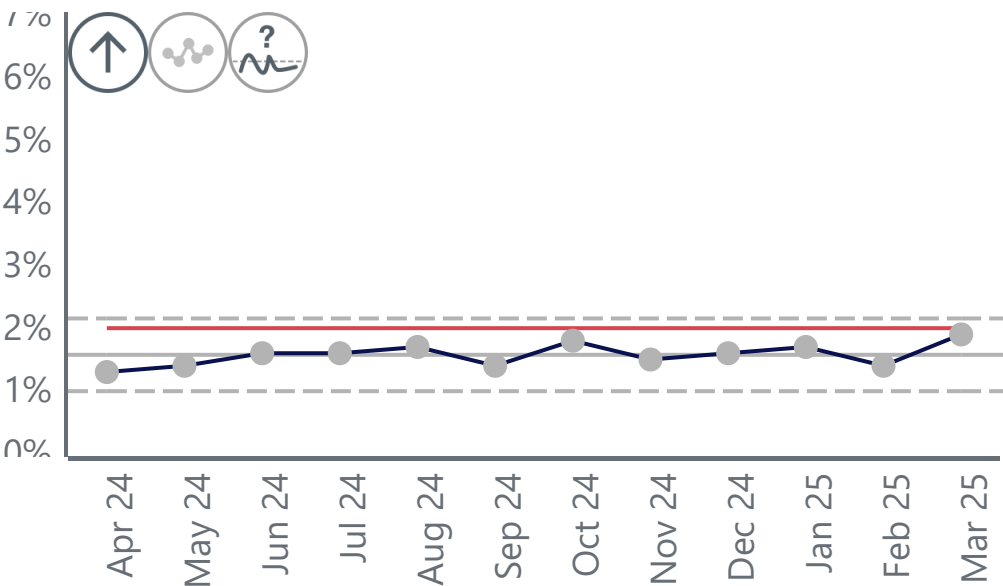
Actions:

* Work continues to track and monitor the cause of delays to improve theatre list start times
* List planning 'check & challenge' process continues to ensure lists are realistic and achievable.
* Pooled patient list is being worked up to ensure we maximise theatre slot utilisation.

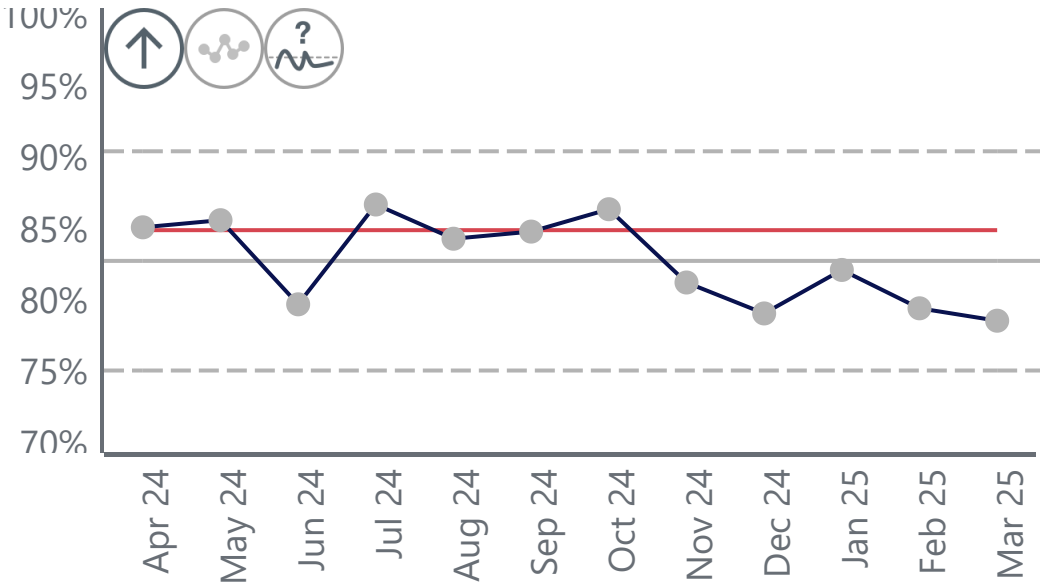


Productivity - Watch Metrics

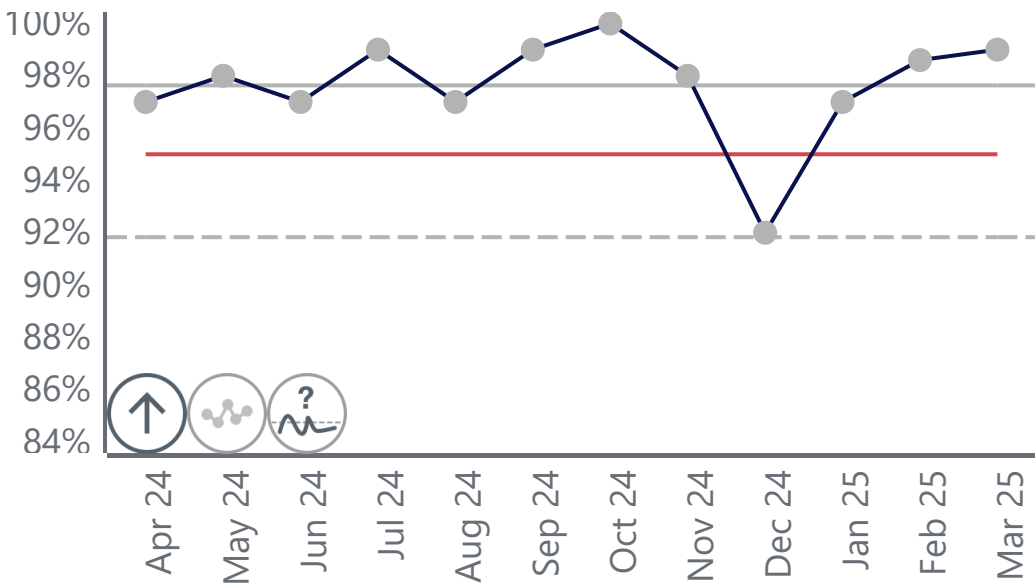
% Patients on PIFU



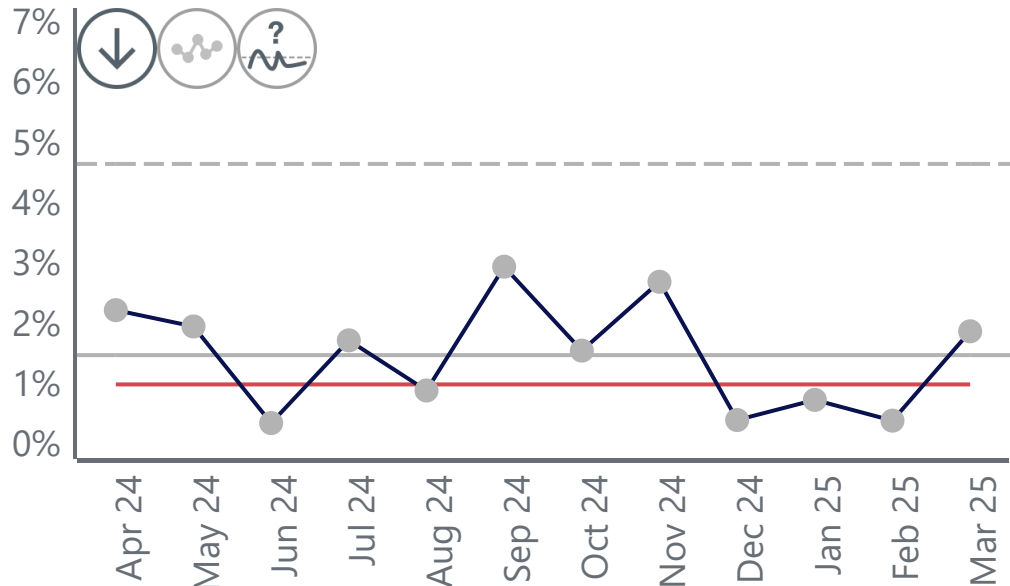
% Session Utilisation (Theatres)



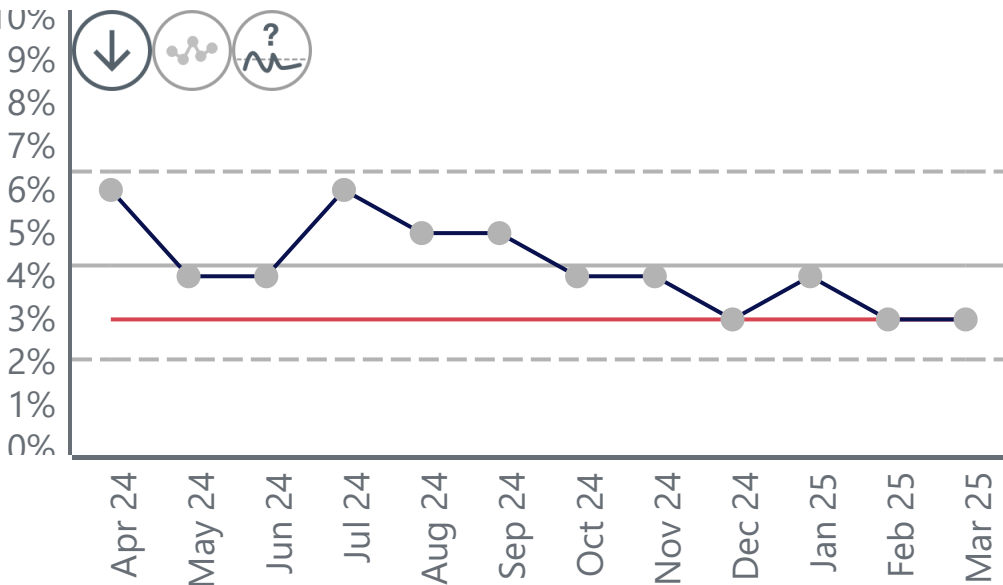
% Core Session Delivery (Theatres)



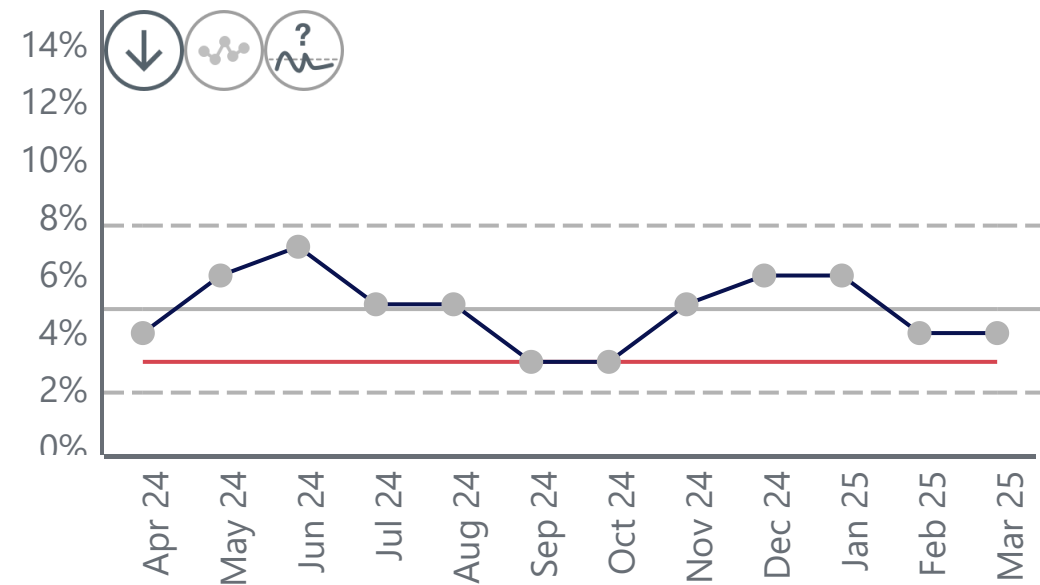
% Avoidable Cancellations (Theatres)



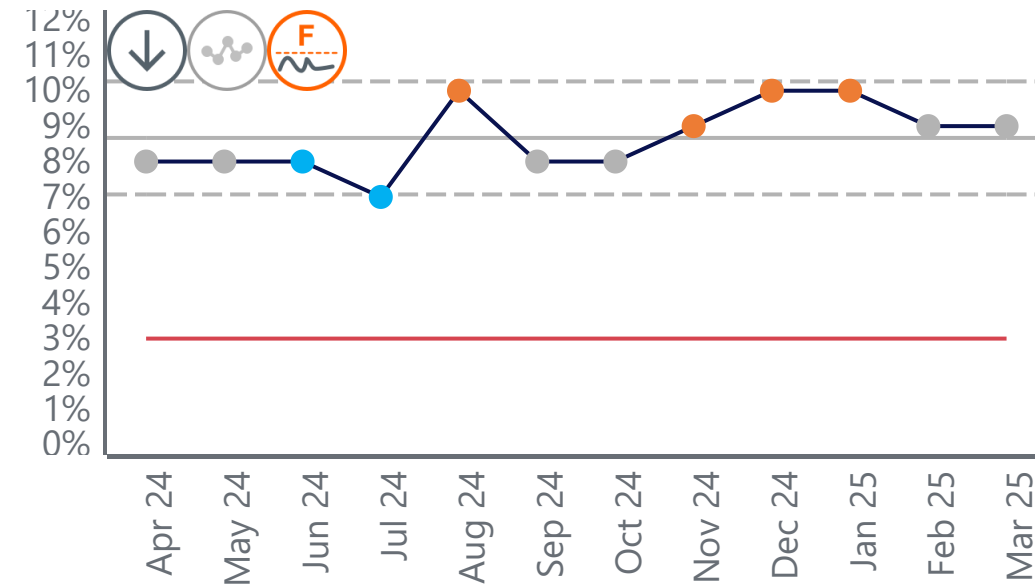
CT DNA Rate



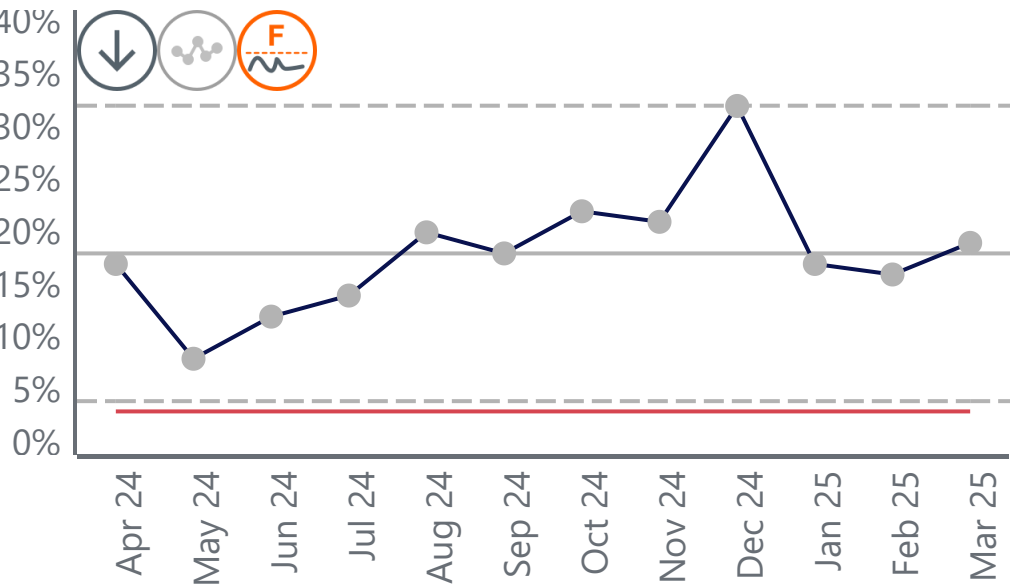
MRI DNA Rate



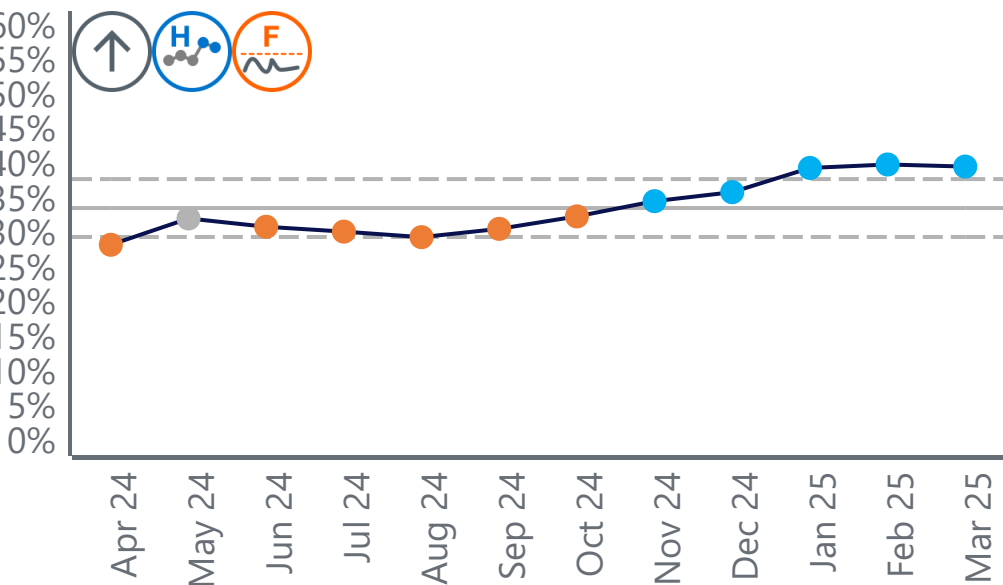
Echo DNA Rate



Sleep DNA Rate



Slot Utilisation



Quality of Care

SRO: Joan Mathews, Director of Nursing, Quality & Safety
Mr Manoj Kuduvalli, Medical Director
Ben Vinter, Director of Risk and Corporate Governance

Highlights:

- *The Sepsis target for 1 hour antibiotics has continued to consistently perform at or above the 90% target, with performance above.
- *There was one Never Event. There were no serious incidents or Grade 2 or above pressure ulcers observed due to lapses in care in the month.
- *Excellent performance continues in Dementia and Delirium.
- *Discharge summary on the day of discharge metric continues to perform above target
- * Referrals to a dietician for patients scoring high risk has improved with performance above the target of 90% in month
- *Good performance against the range of watch metrics with the majority achieving target and remaining in expected parameters.
- *Number of falls continues to be within the expected variation. As previously reported additional measures have been taken with an aim to reduce this consistently (e.g. increased Rambleguard equipment across all ward areas and continued bathroom watch).
- *Numbers of formal complaints continue to be low.
- *VTE performance has been variable in recent months. Ongoing improvement plans including better documentation.
- * Slight recovery in Family and Friends Test (FFT) metric performance. The data continues to be reviewed with the analytical team and ward teams granular level results continue to look positive.
- *PPCI Door to Balloon watch metric of 75% within 60 minutes (national target) continues to perform mostly above target. Call to balloon time continues to consistently fail it's target due to national and regional issues. This includes categorisation of chest pain as a category 2 call, leading to delays in ambulance arrival and transfer times (including self presenters to A&E requiring transfer to LHCH). There has however been consistent improved performance since Dec 2023.
- *Surgical Site Infection shows sustained improving trends in recent months.

Areas of Concern:

- *Number of falls remain failry static albeit still low numbers. All falls are subject to an MDT review, nevertheless this will be kept under close review.
- *Radiology Alerts Response (RAR) documents audit continues to perform below the target.

Forward Look (with actions):

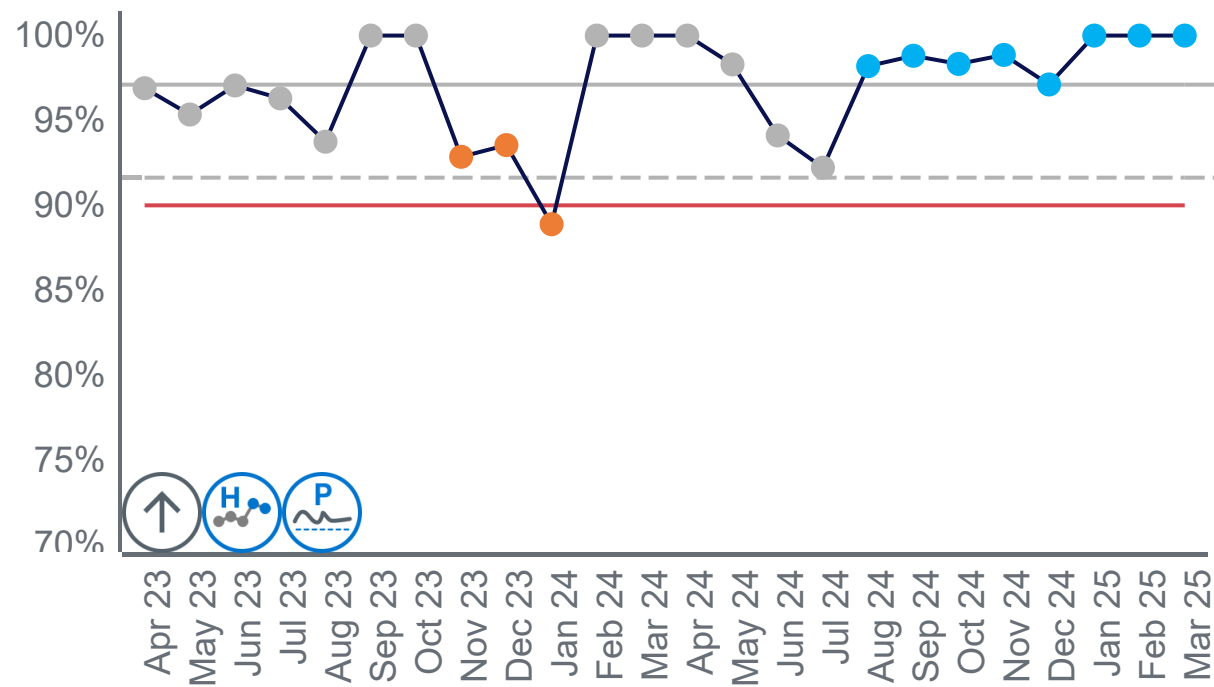
- *Radiology Alert Response (RAR) dashboard is regularly used by Divisions to improve compliance. Ongoing work to improve data quality of the audit tool, which is more likely the issue. Work on this is planned to be completed within Q1 of 2025-26. Retrospective audit of incomplete RARs to be completed once data quality of audit is assured. Education module and SOP for users also being developed to improve compliance.
- *Patients receiving their discharge summary on day of discharge - improvement continues to be made. This remains a focus within the Divisional teams to maintain consistency.
- *Improvement strategy for VTE assessment documentation ongoing.

Quality of Care - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
% of radiological alerts with a response document	Mar-25	77.6	>=95%	85.7		
95% of all patients to receive a copy of their Discharge Summary on day of discharge	Mar-25	96.7	>=95%	93.8		
Clostridium Difficile	Mar-25	0.0	0	0.3		
Delirium Risk Assessment to be completed on Admission and once a day	Mar-25	99.5	>=90%	98.8		
Delivery of at least one sepsis antibiotic within one hour of prescription (LHCH target)	Mar-25	100.0	>=90%	98.0		
Dementia - Find	Mar-25	100	>=90%	96.1		
FFT: REPUTATION	Mar-25	99.2	>=95%	98.5		
Gram Negative Bacteraemias	Mar-25	1	0	1.3		
Incidents - Serious incidents, Never Events, Adverse Events (Red)	Mar-25	0	0	0.2		
MRSA Bacteraemias	Mar-25	0	0	0.2		
MSSA Bacteraemias	Mar-25	1	0	0.9		
Number of Falls	Mar-25	13		7.3		
Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care)	Mar-25	0	<=0.5	0.1		
Number of LHCH acquired grade 3+ pressure ulcers (due to lapses in care)	Mar-25	0.0	<=0	0.1		
Nutrition - Patients scoring high risk (2 or more) are referred to dietician	Mar-25	95.35	>=90%	90.7		
Occurrence of any Never Events	Mar-25	0.0	0	0.0		
Primary PCI - 60 minute 'Door-to-balloon' (national target)	Mar-25	78.7	>=75%	81.2		
Primary PCI - 150 minute 'Call-to-balloon' (national target)	Mar-25	81.0	>=95%	69.7		
Quantity of complaints	Mar-25	0	<=6	1.3		
Venous thromboembolism (VTE) risk assessment	Mar-25	93.6	95%	93.6		
Number of Incidents No Harm and Near Miss	Mar-25	107	143	111.5		
Number of Incidents rated Minor Harm or Above	Mar-25	25	25	28.3		
Incident Closures within 28 days	Feb-25	74.0	0	64.4		
Surgical Site Infections	Jan-25	3	0%	7.1		

Quality of Care - Drive Metrics

Delivery of at least one sepsis antibiotic within one hour of prescription (LHCH target)



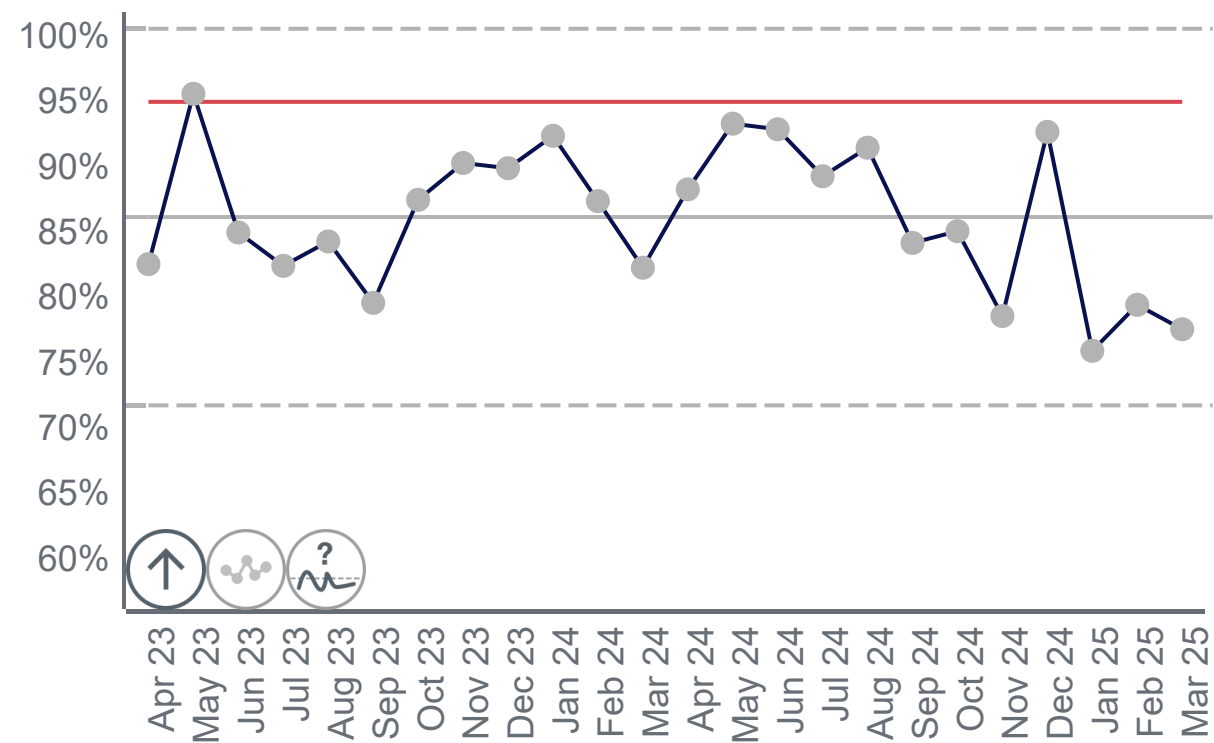
Technical Analysis:

Performance of the one hour Target remains above the target. This displays positive consistency for Sepsis identification and treatment. Over the most recent 18 month period the trust has failed this target only once.

Actions:

Maintain weekly feedback to clinicians if this metric is missed.

% of radiological alerts with a response document



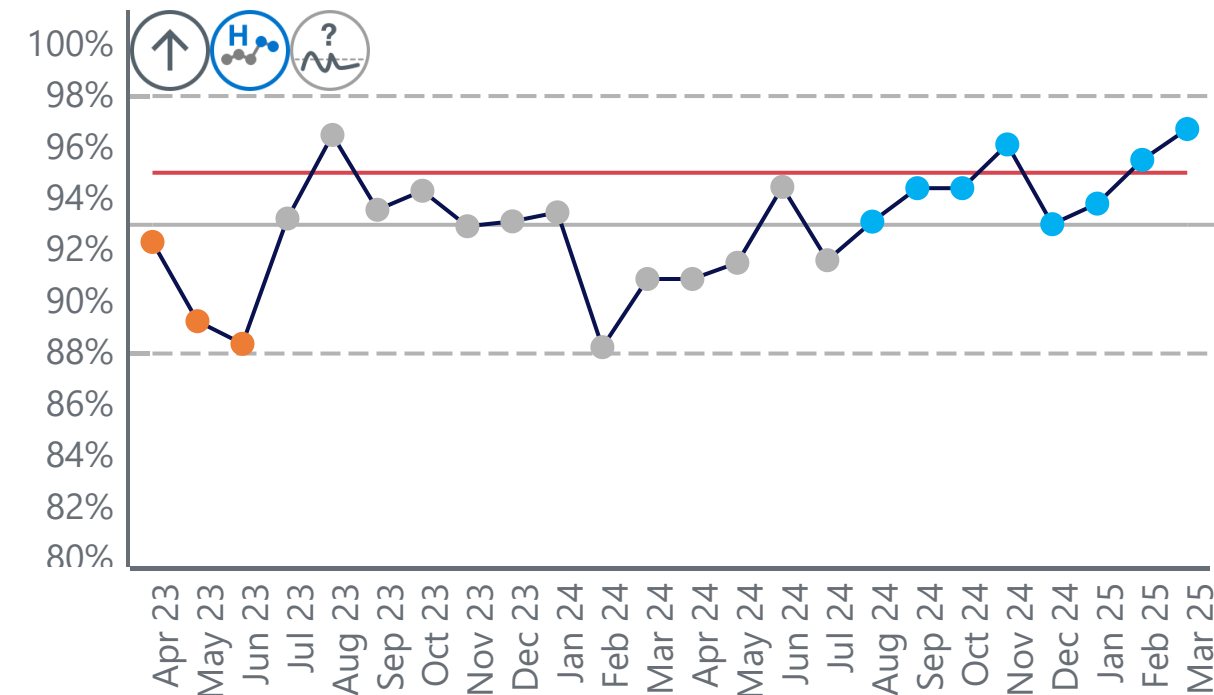
Technical Analysis:

March performance remains consistent with previous months displaying common cause variation. Improvement is required to achieve target on a consistent basis. The target has not been achieved since May-23.

Actions:

The existing dashboard has been repointed with the addition of long standing records with no RAR. Divisions continue to use the existing dashboard to improve compliance. Ongoing work to improve data quality of the audit which is more likely the issue. Work on this planned to be completed within Q1 of 2025-26.

95% of all patients to receive a copy of their Discharge Summary on day of discharge



Technical Analysis:

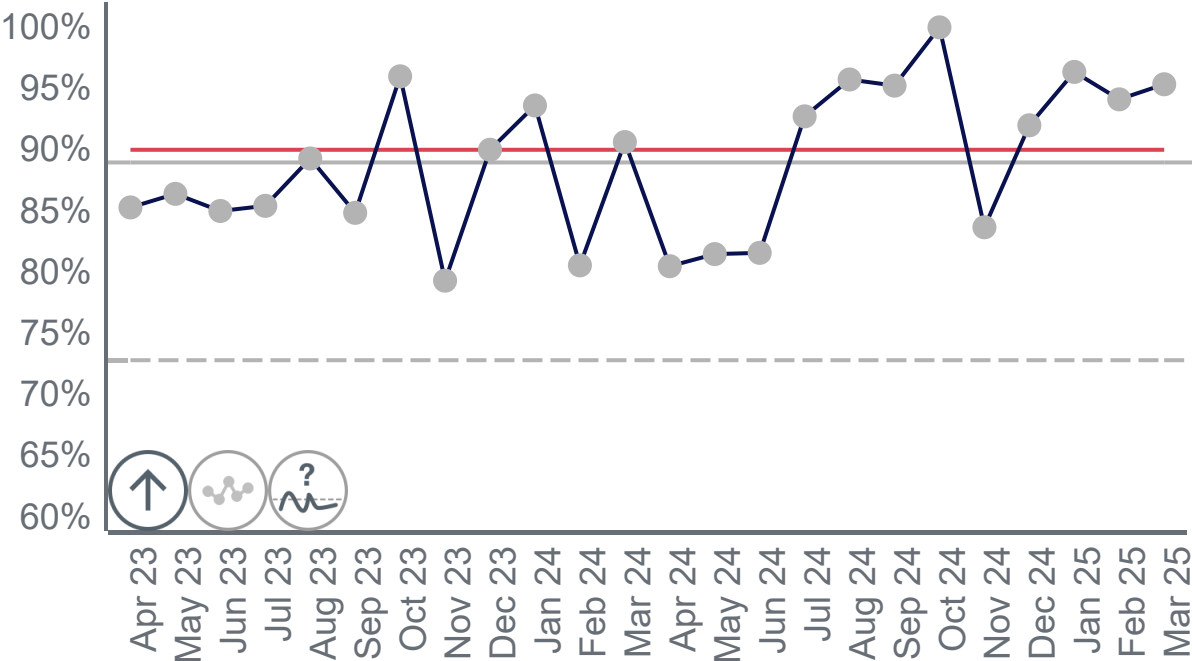
Performance in March is above the target of 95% and showing special cause Improvement. Continual work required to consistently achieve target with the metric displaying inconsistency of passing and falling short of the target.

Actions:

Continued focus on keeping up recent improvement.

Quality of Care - Drive Metrics

Nutrition - Patients scoring high risk (2 or more) are referred to dietician



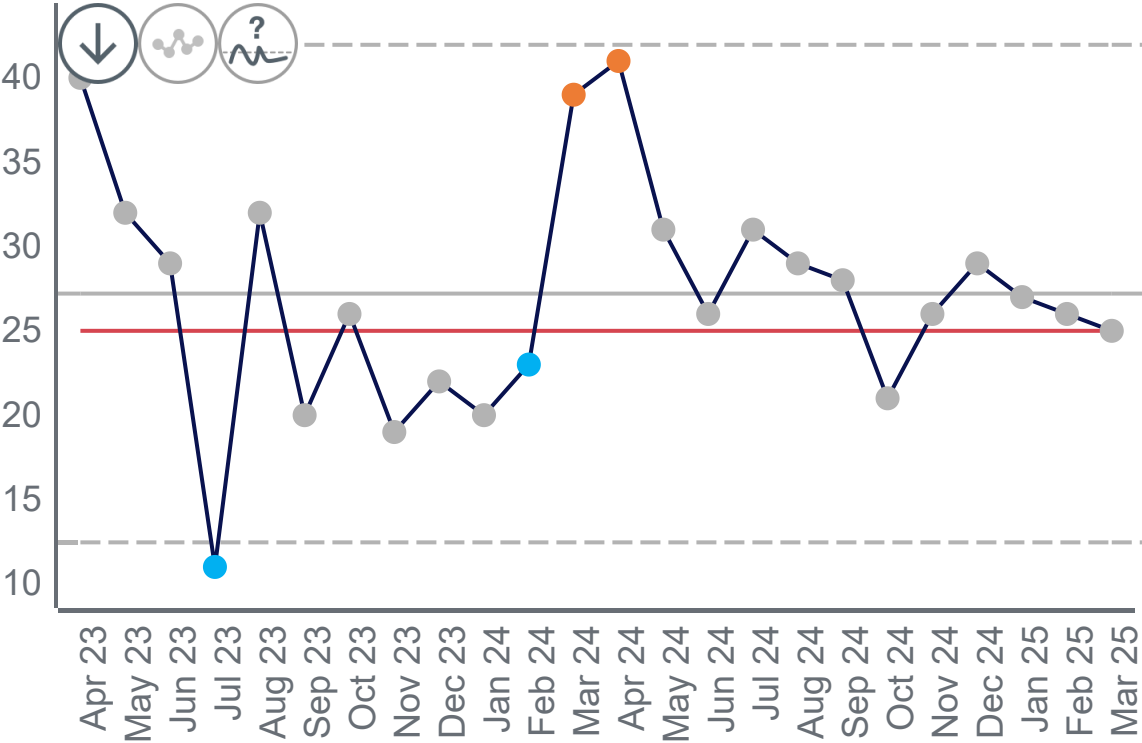
Technical Analysis:

Performance within March was 95%, which is above the target of 90%. Continued improvement required to provide consistency which will see the metric move away from common cause variation of passing and failing the target.

Actions:

Nutritional Risk Assessments for patients requiring Dietetic involvement are positively consistent.

Number of Incidents rated Minor Harm or Above



Technical Analysis:

Performance is showing common cause variation of passing and failing the targeted. A period of increase in the number of Harms has shown a consistent reduction to levels seen in Q4 of 2023/24. Further improvement required to consistently achieve the target.

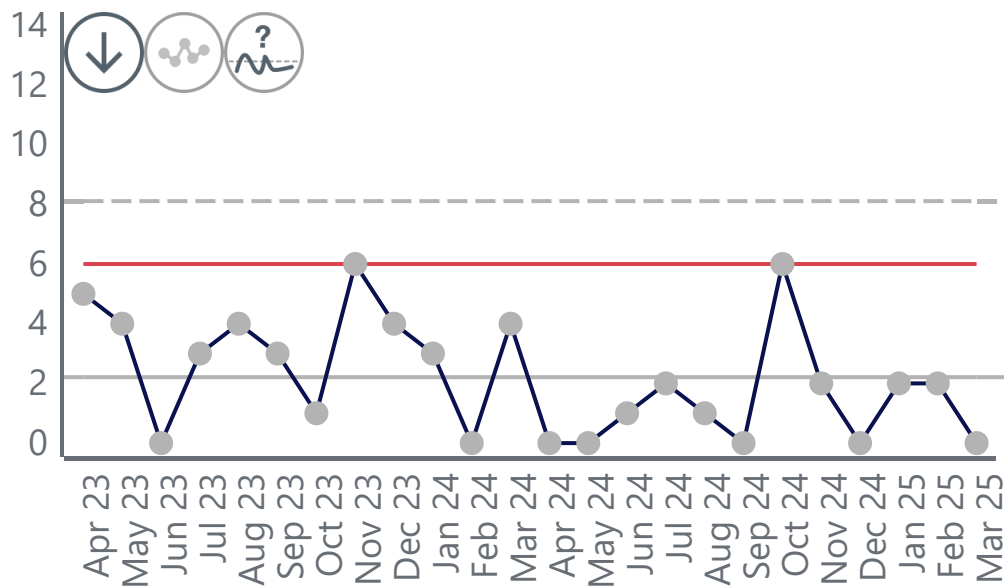
Actions:

Strong reporting culture and learning from incidents. Reviews continue via safety surveillance and hasn't identified recurrent themes. A weekly patient safety meeting is now in place to review all moderate and above incidents, including action and learning. Further refinement of the KPI is needed and closely monitored.

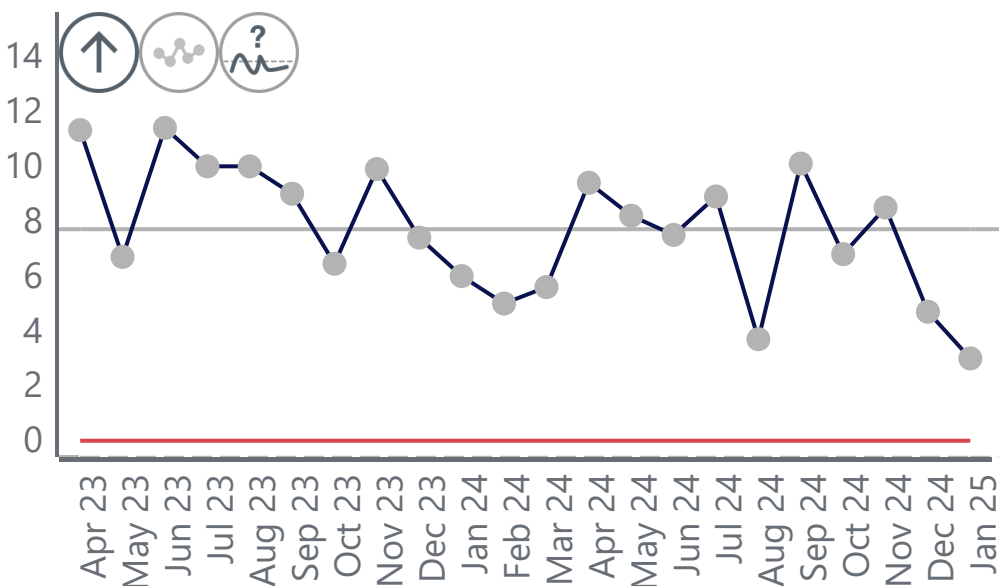


Quality of Care - Watch Metrics

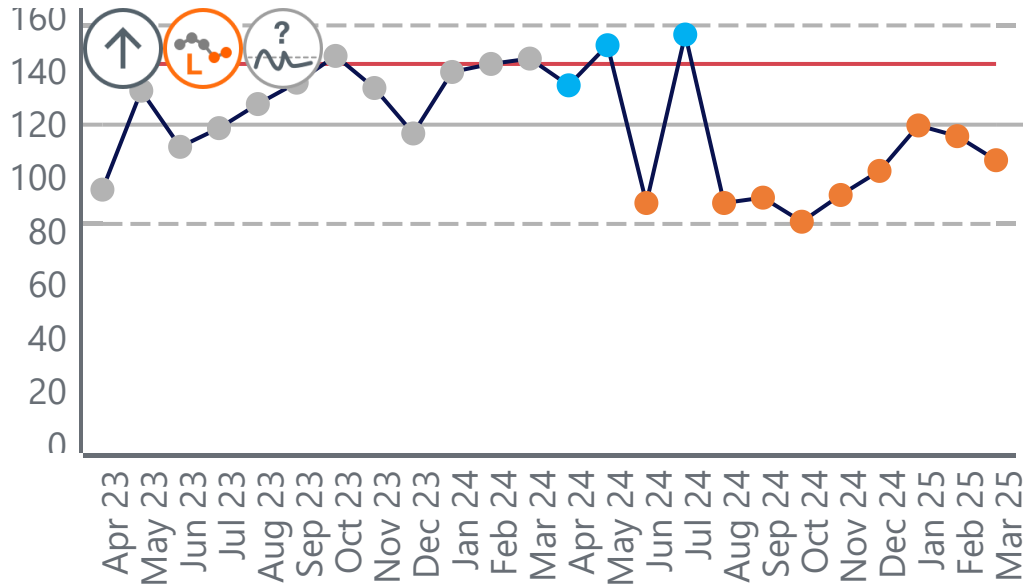
Quantity of complaints



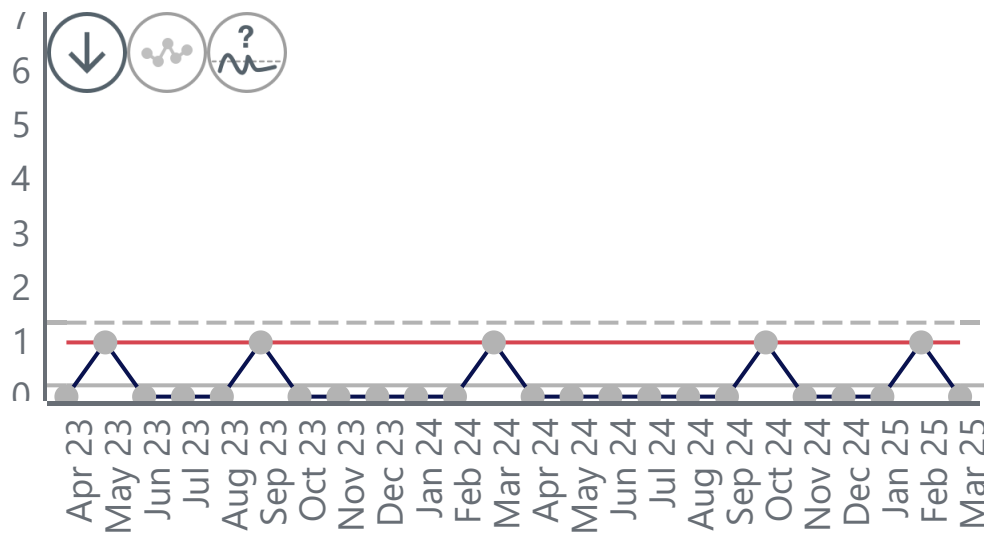
Surgical Site Infections



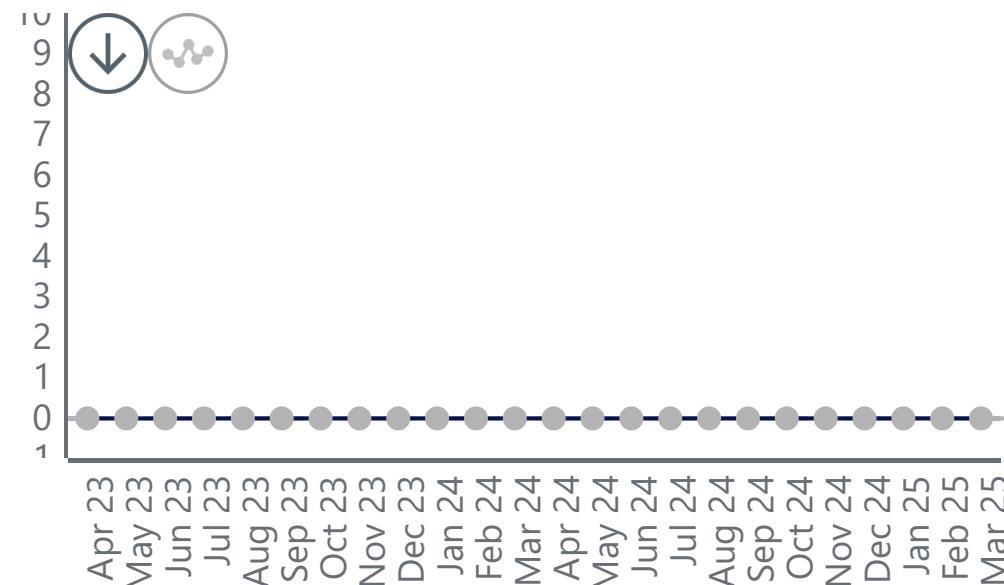
Number of Incidents No Harm and Near Miss



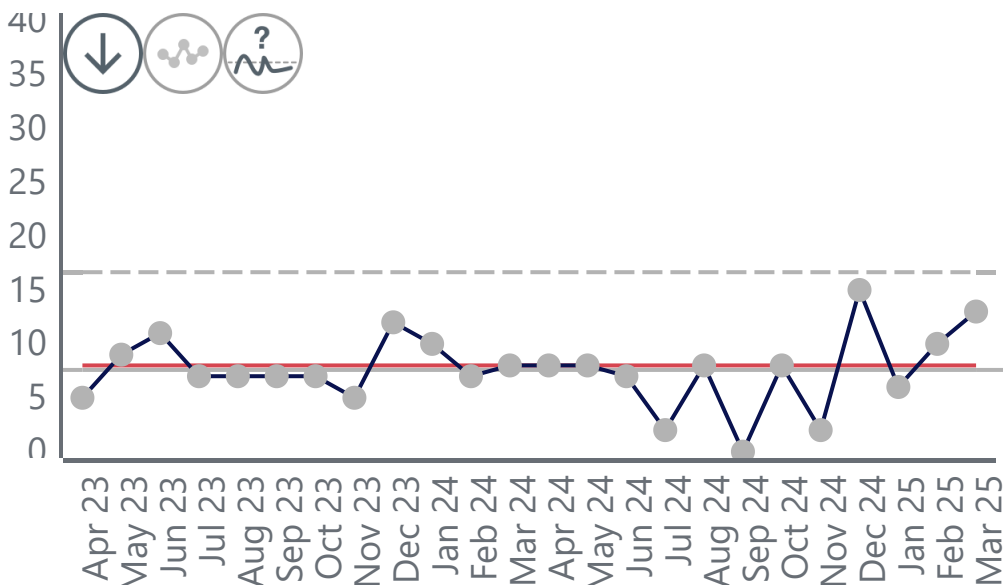
Incidents - Serious incidents, Never Events, Adverse Events (Red)



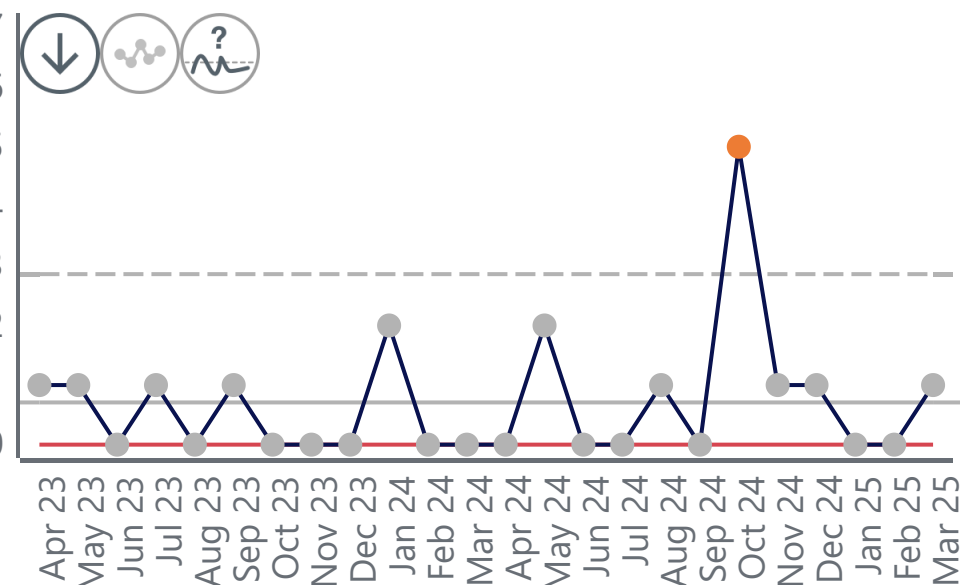
Occurrence of any Never Events



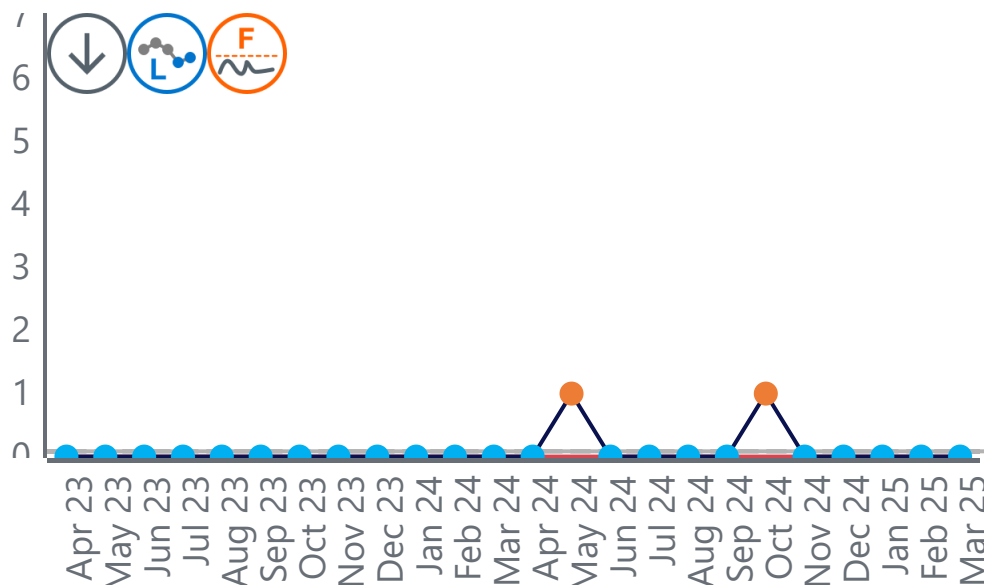
Number of Falls



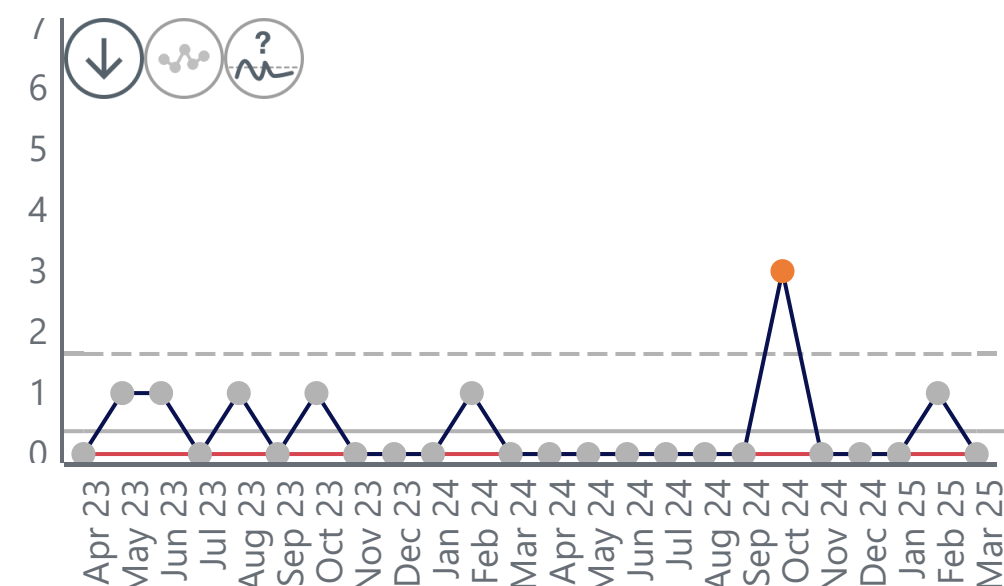
MSSA Bacteraemias



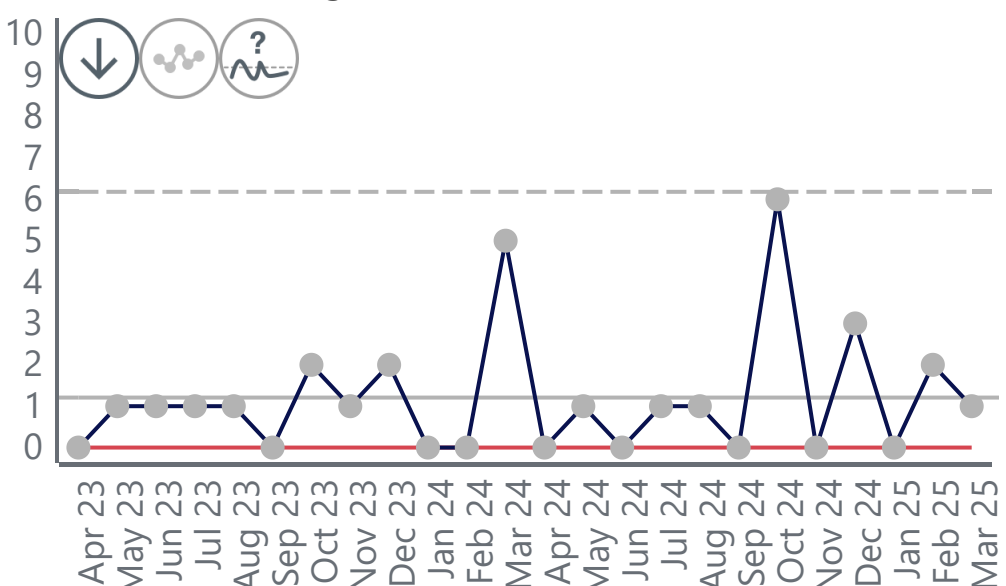
MRSA Bacteraemias



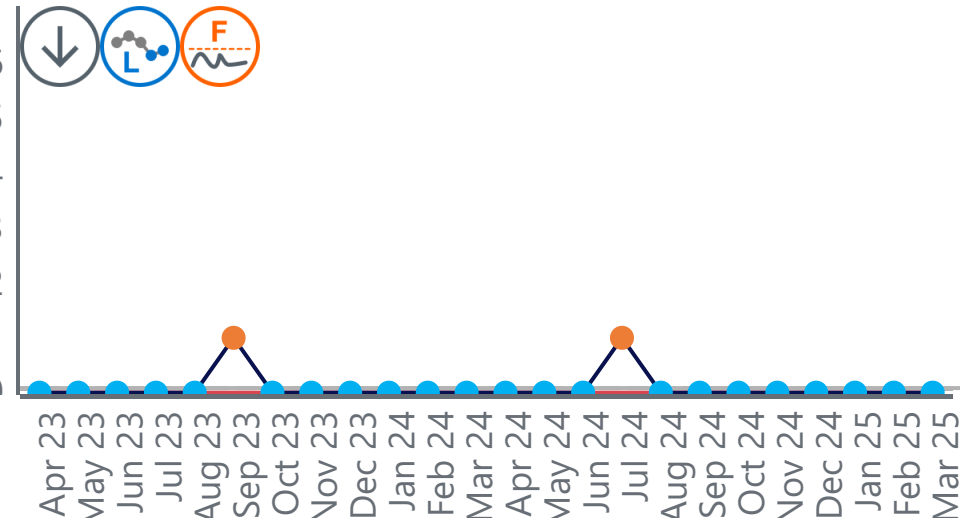
Clostridium Difficile



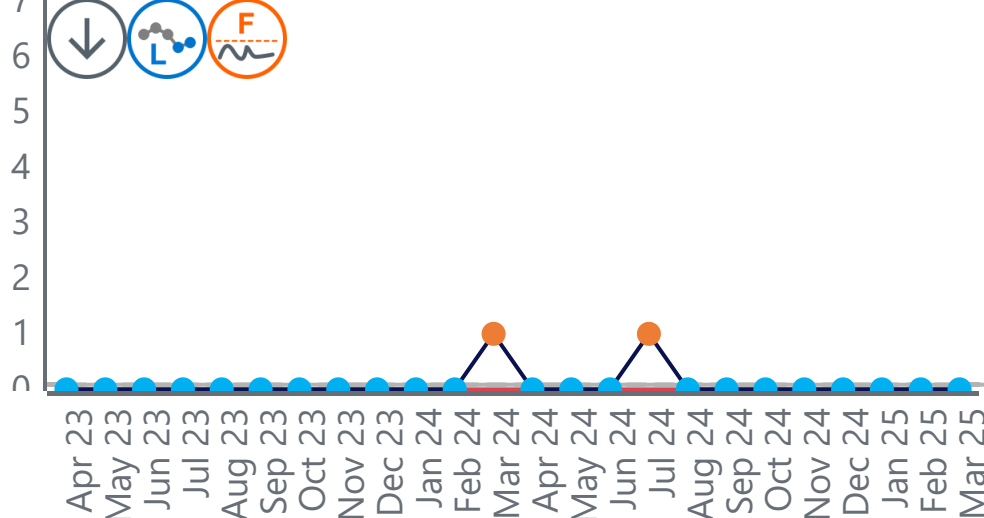
Gram Negative Bacteraemias



Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care)

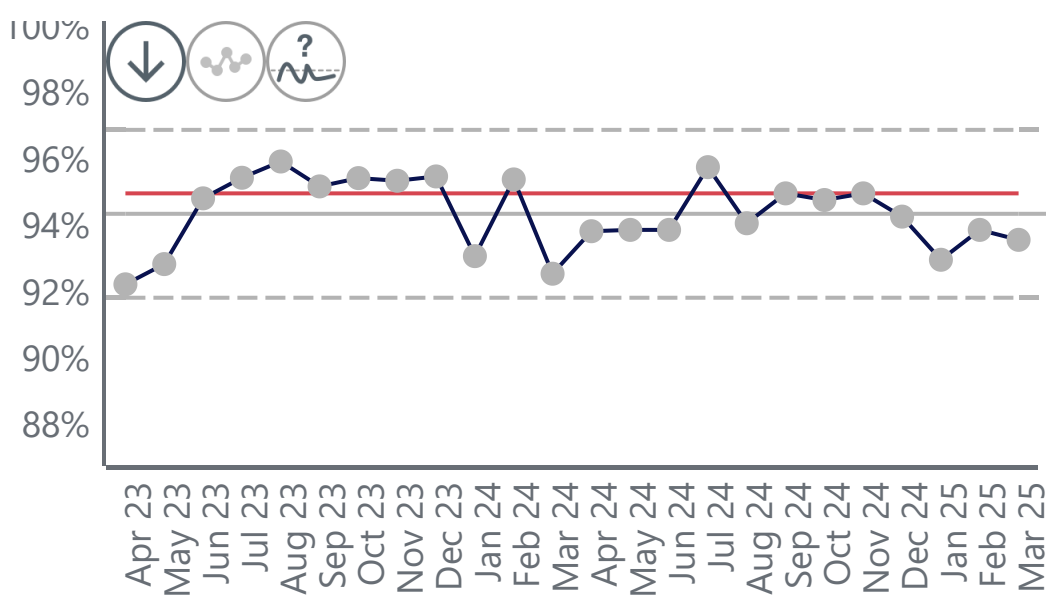


Number of LHCH acquired grade 3+ pressure ulcers (due to lapses in care)

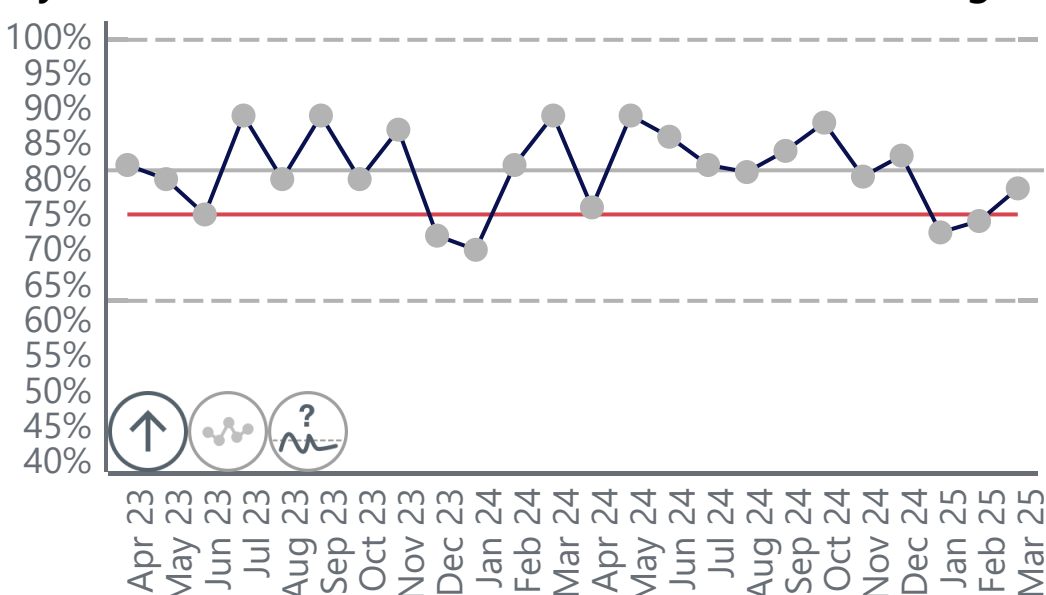


Quality of Care - Watch Metrics

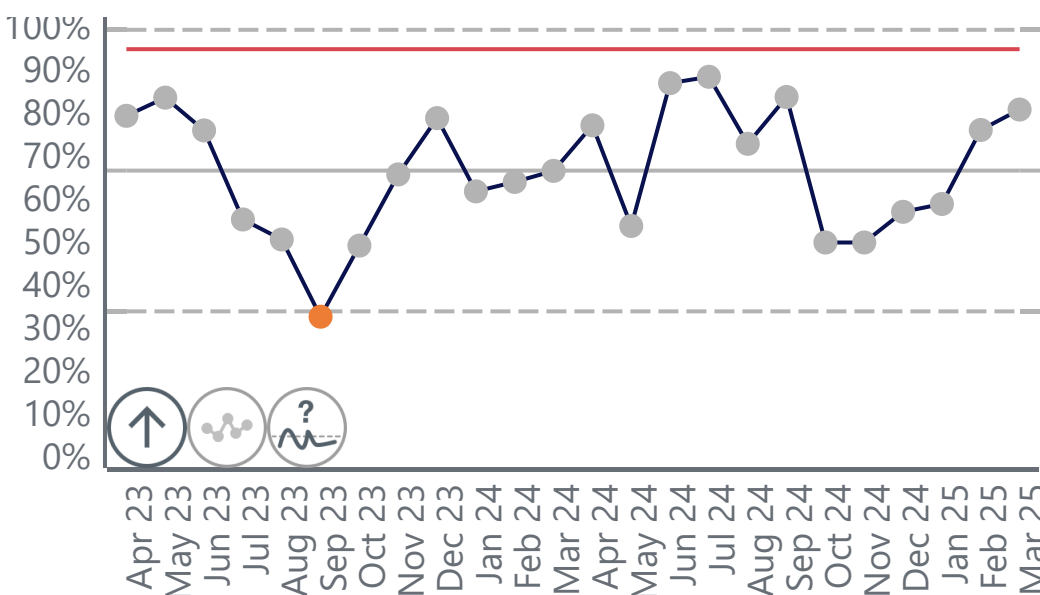
Venous thromboembolism (VTE) risk assessment



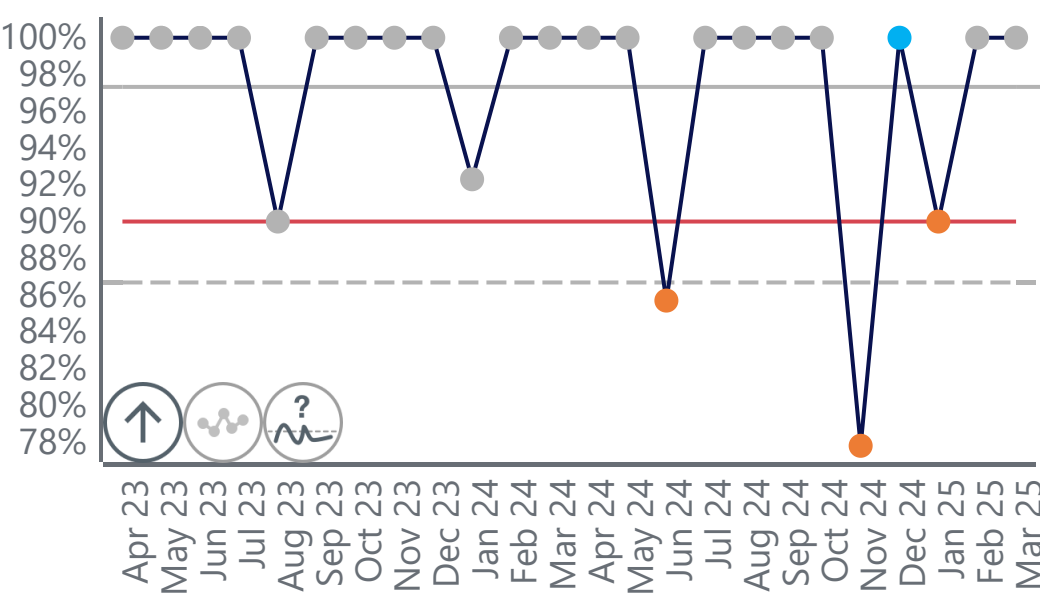
Primary PCI - 60 minute 'Door-to-balloon' (national target)



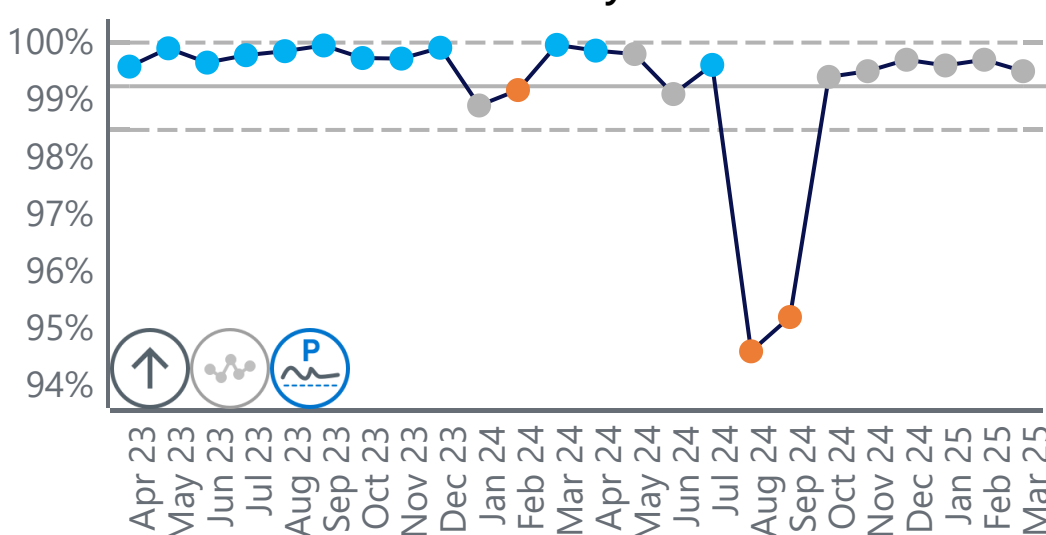
Primary PCI - 150 minute 'Call-to-balloon' (national target)



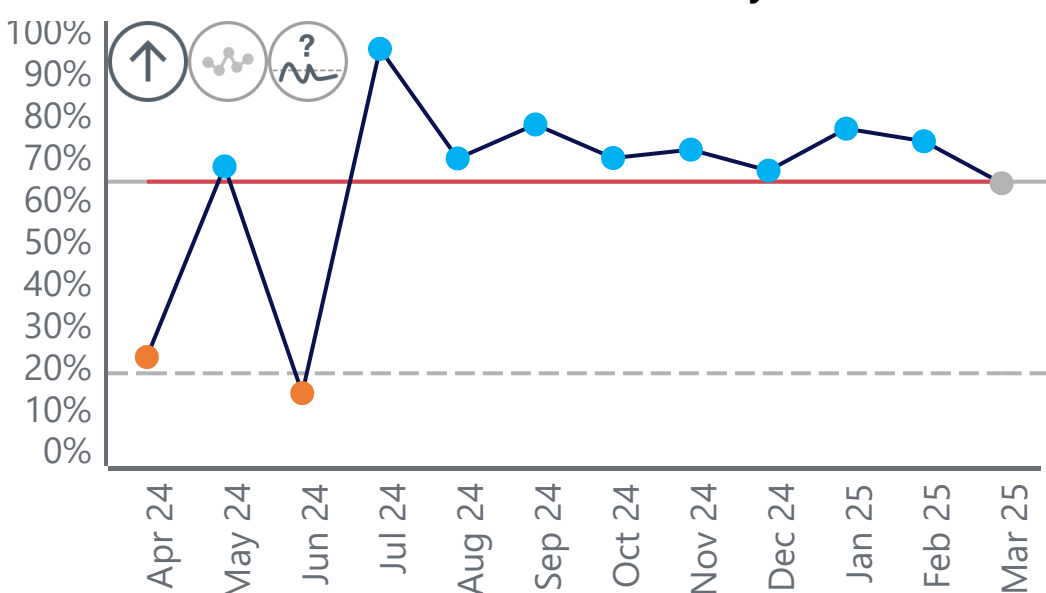
Dementia - Find



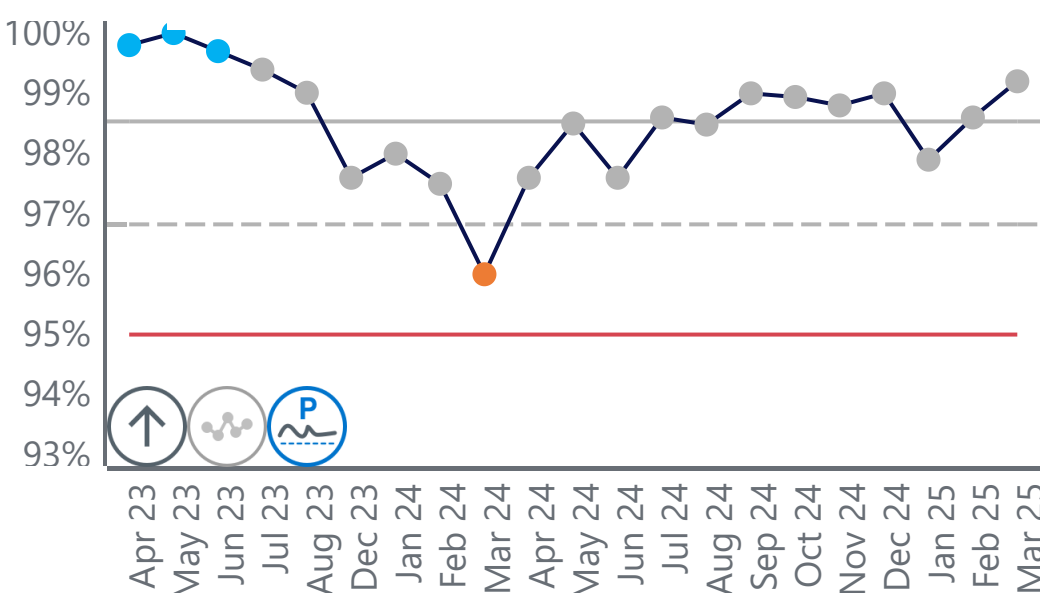
Delirium Risk Assessment to be completed on Admission and once a day



Incident Closures within 28 days



FFT: REPUTATION



Finance

SRO: James Thomson, Chief Finance Officer

Highlights:

The 2024/25 full-year position is a £14,185k surplus. This is £44k better than plan. This has been achieved through a strong income performance in a range of areas:

- the contract with Wales follows a cost per case arrangement, and the over-performance is reflected in the financial position.
- under-performance in surgical elective activity has been partially offset by growth in outpatients and radiology .
- Private patient income has risen in 2024/25.
- Non-recurrent income associated with prior year ERF and cost pressure support.
- Interest income from high cash balances and high interest rates.

Delays in the phase 4 expansion of the Lung Cancer Screening programme resulted in an income shortfall at the beginning of the year. The programme is now fully operational and recovered some of the shortfall from the opening months of the year. The net position at the end of the year was an adverse variance of £359k, marginally ahead of the forecast calculated previously. Pay costs are fairly stable, with low levels of agency spend. However, costs for the medical workforce remain higher than budget with additional session payments for consultants the main contributor of the overspend. In addition, the stretch target linked to workforce reduction (issued by the ICB) was not delivered, and this placed pressure on the overall Trust pay budget. There are non-pay budgetary pressures driven by overspends in theatres and cath labs, driven in part by emergency surgery activity and higher prices. Drugs price inflation is also contributing to the overspend. There remains some slippage against the CIP target. 94% of the annual target was delivered.

Areas of Concern:

Slippage against the CIP plan created a financial pressure in the year. The Divisions had a 3% target which is added to undelivered CIP from previous years giving a total Divisional CIP of £4,811k for the year. Other central schemes (both recurrent and non-recurrent) were also added to the CIP target, giving a Trust total of £10,644k. The Trust delivered 94% of the annual CIP target in 2024/25.

The rising costs of clinical consumables and drugs is an area of concern, with overspends in cath labs, theatres and drugs identified as key pressures throughout the year.

The significant over-performance in emergency surgery has resulted in reduced elective activity and increased non-pay costs. The delay in the roll out of Targeted Lung into new areas was a temporary financial pressure. This improved in late Summer, and has recovered much of the shortfall from the opening months.

The Trust failed to deliver the WTE and associated pay cost reduction which was part of the stretch target given by the ICB.

Forward Look (with actions):













The Trust achieved the financial target agreed with the Integrated Care Board for 2024/25. The focus now shifts to delivering the challenging target in 2025/26. The target surplus currently stands at £7.4m, but this could increase as the Cheshire and Mersey system plan is not currently in line with the control total issued by NHS England.

The financial framework for next year has been published, and the efficiency/productivity requirements on the NHS are greater than they have been in recent years. Delivering the financial targets in 25/26 will require fiscal discipline, management of risks, and unlocking significant savings (e.g. from collaboration in the Group model and delivering transformation).

The Trust has reviewed the transformation programmes in place and agreed a number of working groups to drive the improvements forward.

The Trust is also working closely with system partners to ensure the financial controls in place are strong and fit for purpose. In addition, working groups to support closer working across Liverpool providers are in place and tasked with identifying opportunities for collaboration and efficiency.

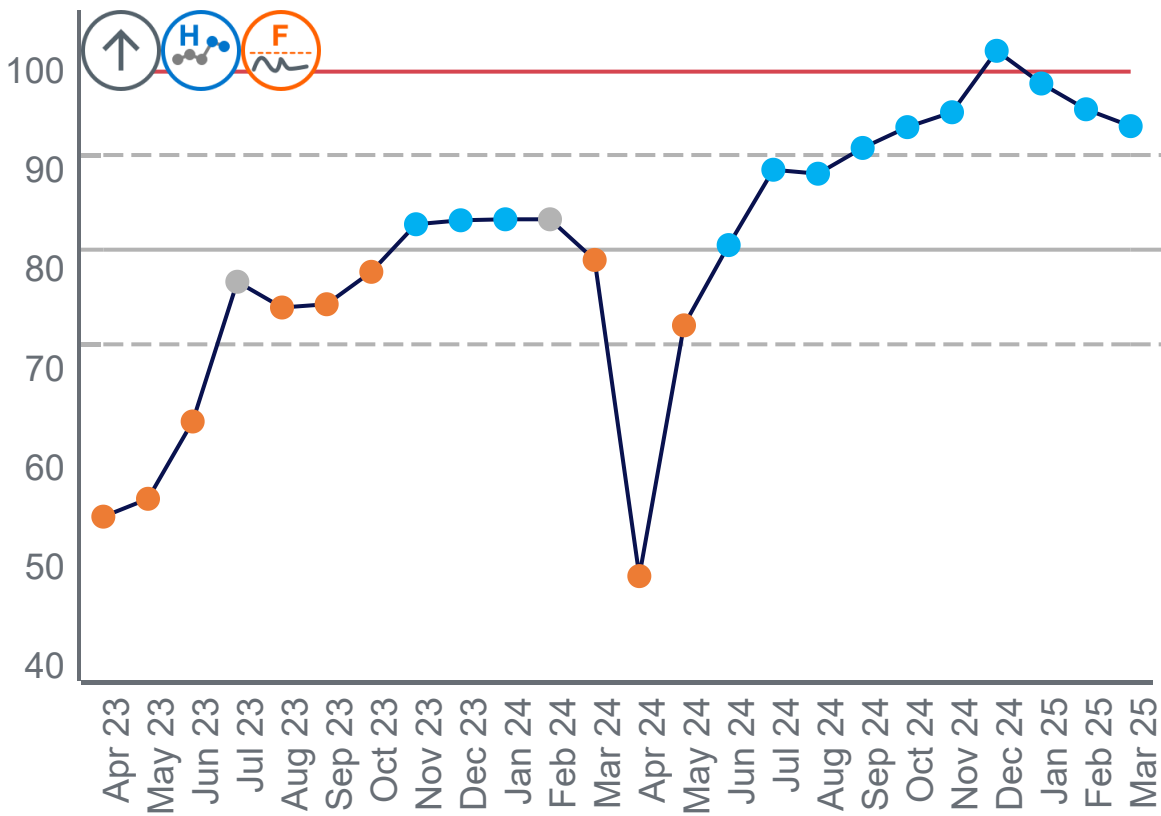
Finance - Metric Summary

Metric Name	Month	Performance	Target	Average / Cumulative	Variation	Assurance
I & E distance from target (cumulative) - £,000	Mar-25	44	0	-715		
Liquidity (days)	Mar-25	37		30		
Recurrent CIP identified	Mar-25	95	100	88		
Capital Expenditure (Trust Level)	Mar-25	8207000.0	7451000	3184513.0		
Cash in Bank (Trust Level)	Mar-25	49376000		43225183		
Pay Spend v Budget	Mar-25	15894	15866	10086		
WTE versus establishment	Mar-25	1939	1898	1902		



Finance - Drive Metrics

Recurrent CIP identified



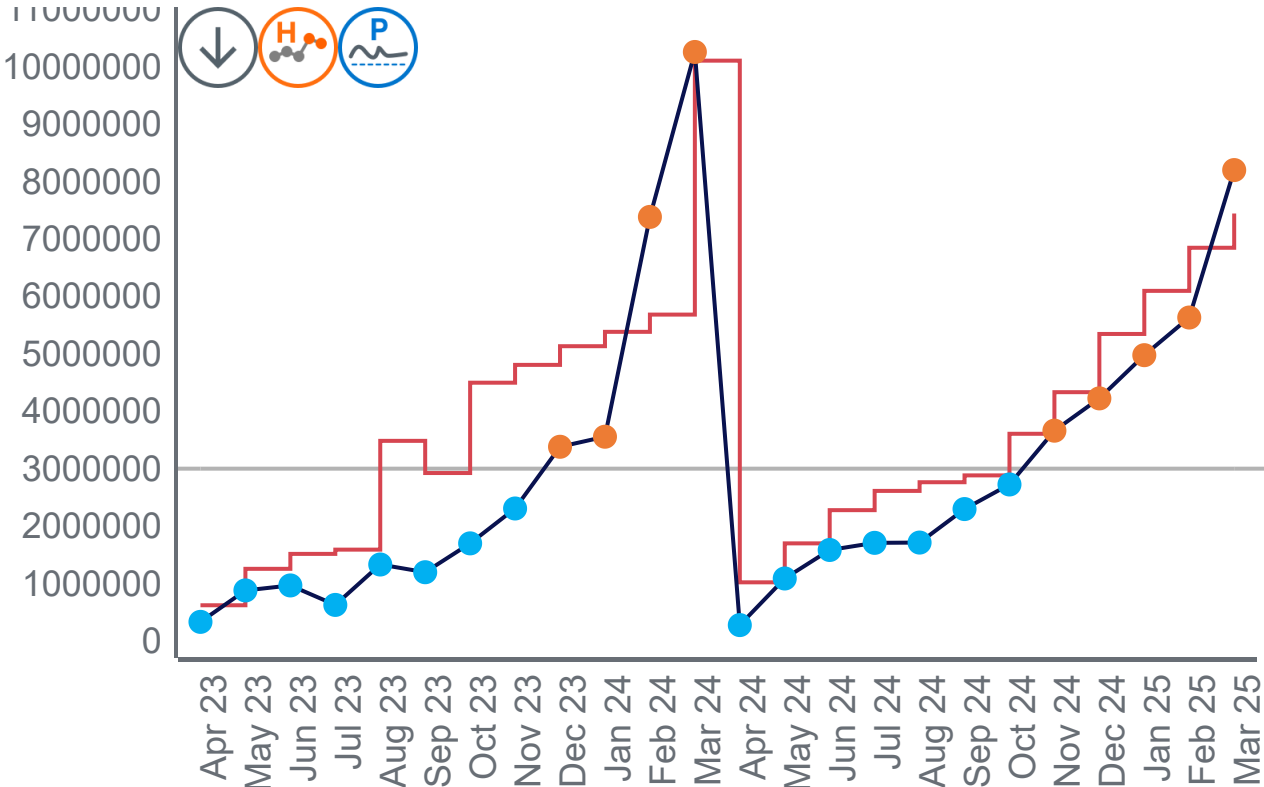
Technical Analysis:

CIP has made significant improvement and is ahead of the same period in 2023/24. As 2024/25 closes performance has demonstrated special cause improvement but has falling short of the target.

Actions:

Monthly monitoring of progress through gateways and identification of schemes against the target is in place. Trust wide CIP workshop held in February. The Divisions continue to review opportunities for CIP and progress ideas. Revised transformation projects and governance arrangements to support delivery.

Capital Expenditure (Trust Level)



Technical Analysis:

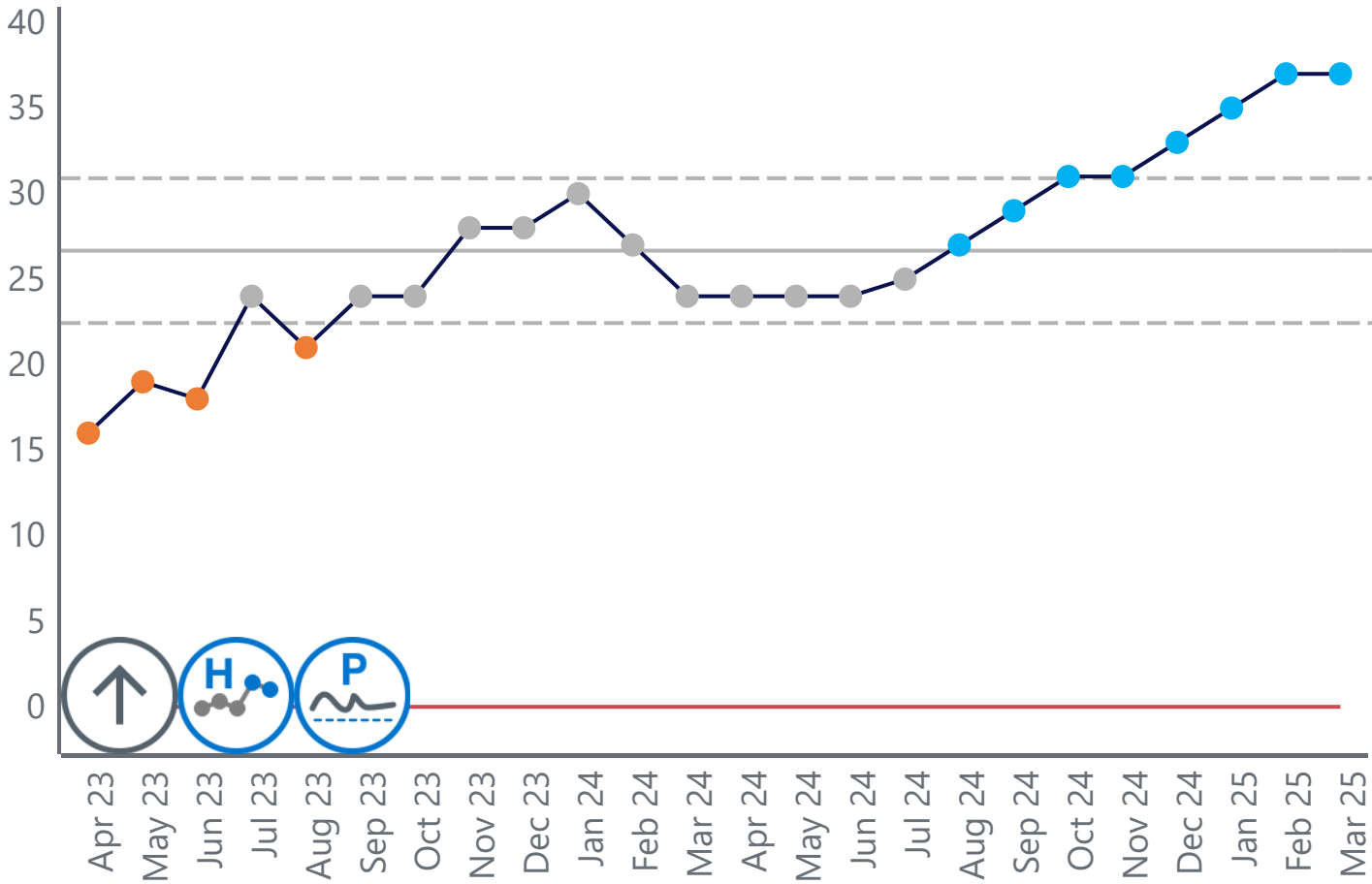
Expenditure is displaying cause for concern within performance variation as the Trust closes 2024/25.

Actions:

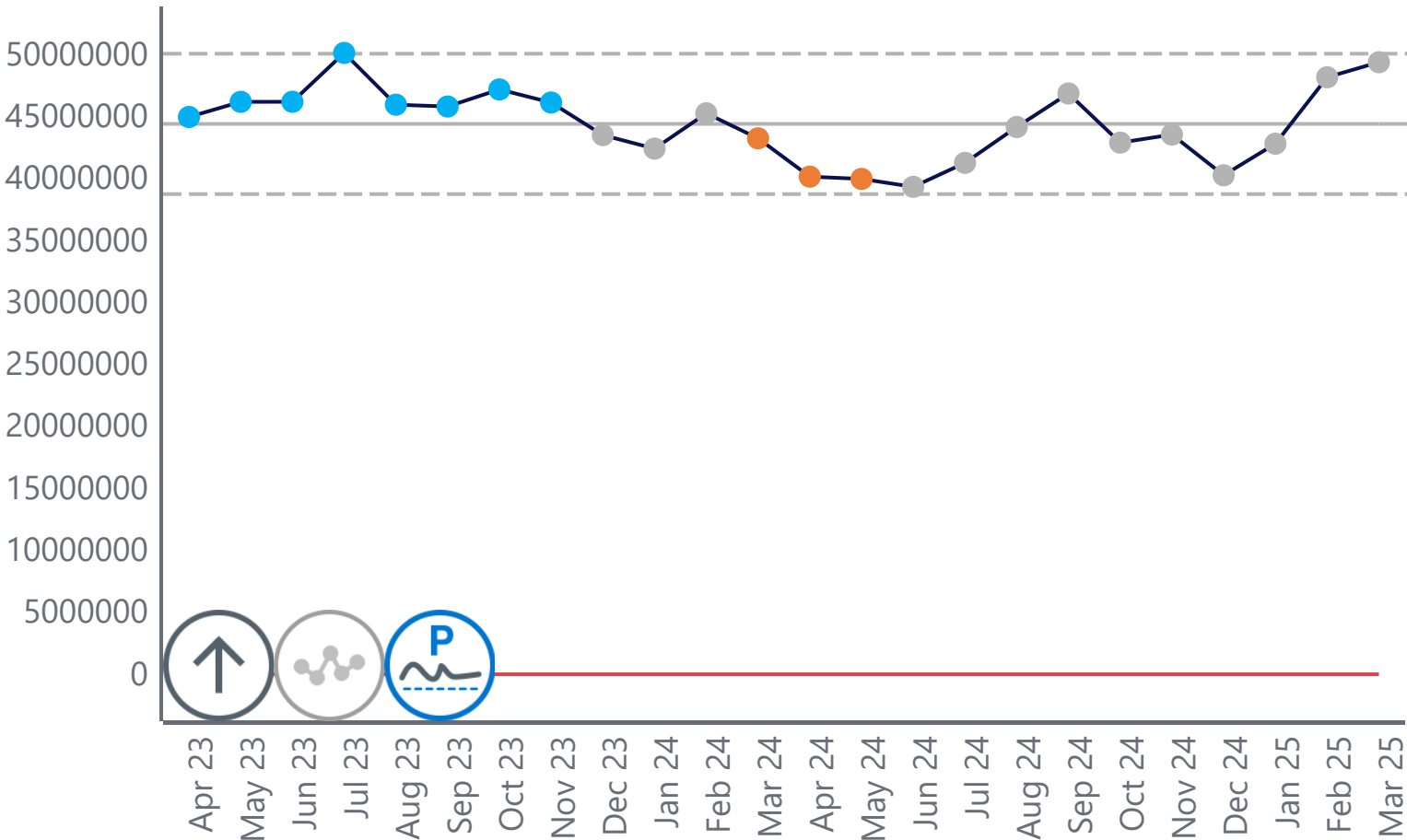
Capital commitments are monitored by the Capital Management Group. Capital spend in 2024/25 was consistent with the capital funding allocation agreed with the ICB.

Finance - Watch Metrics

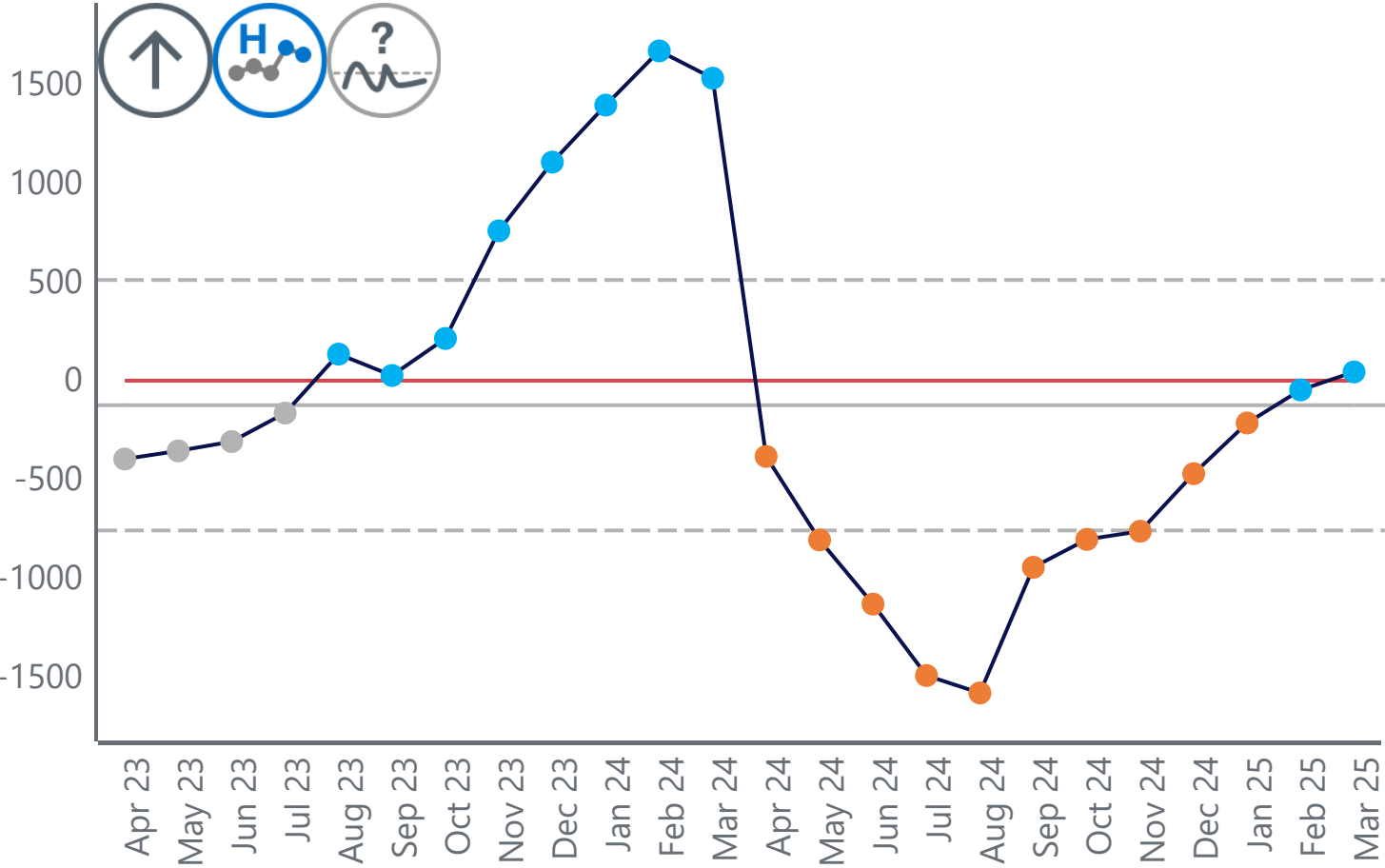
Liquidity (days)



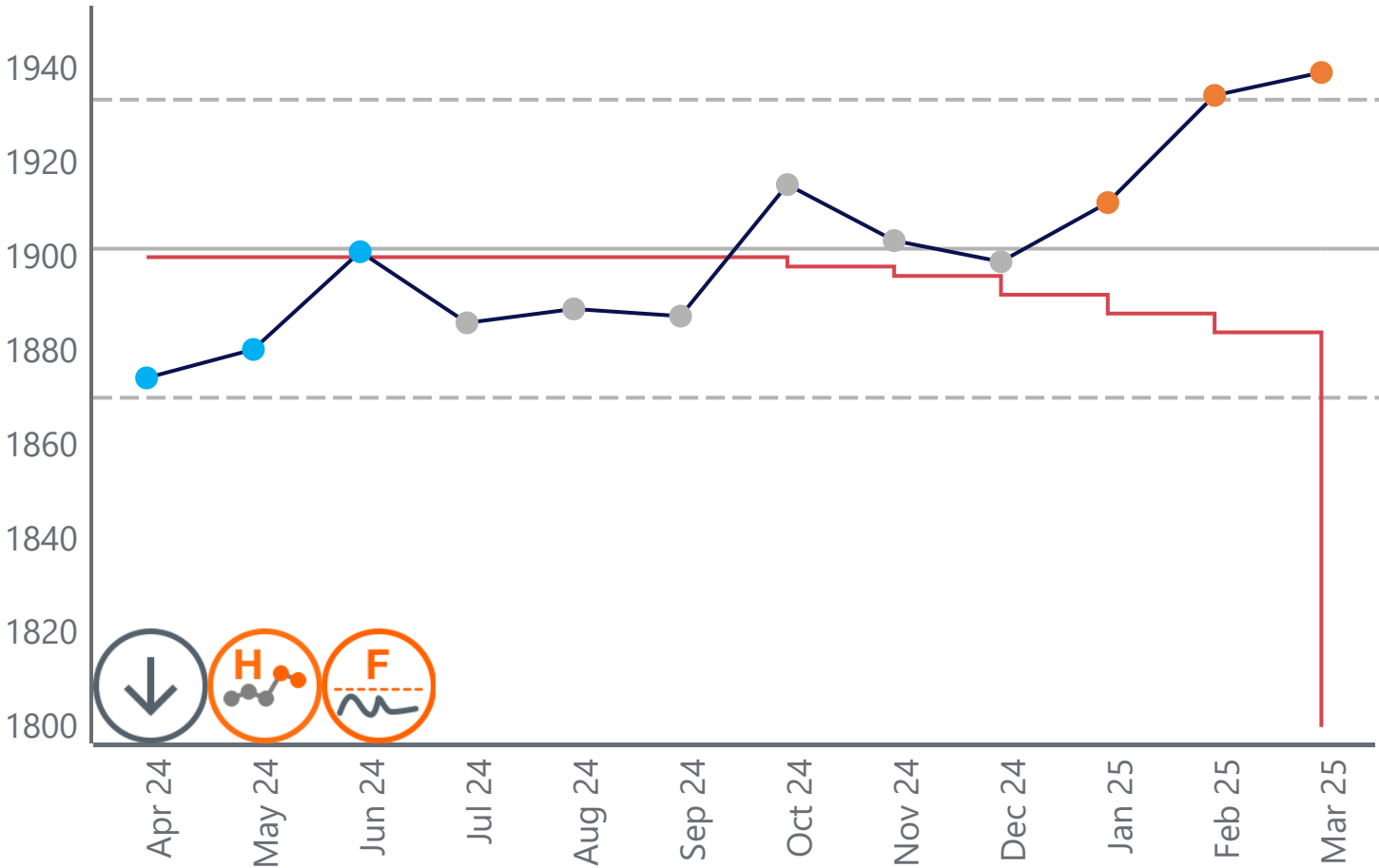
Cash in Bank (Trust Level)



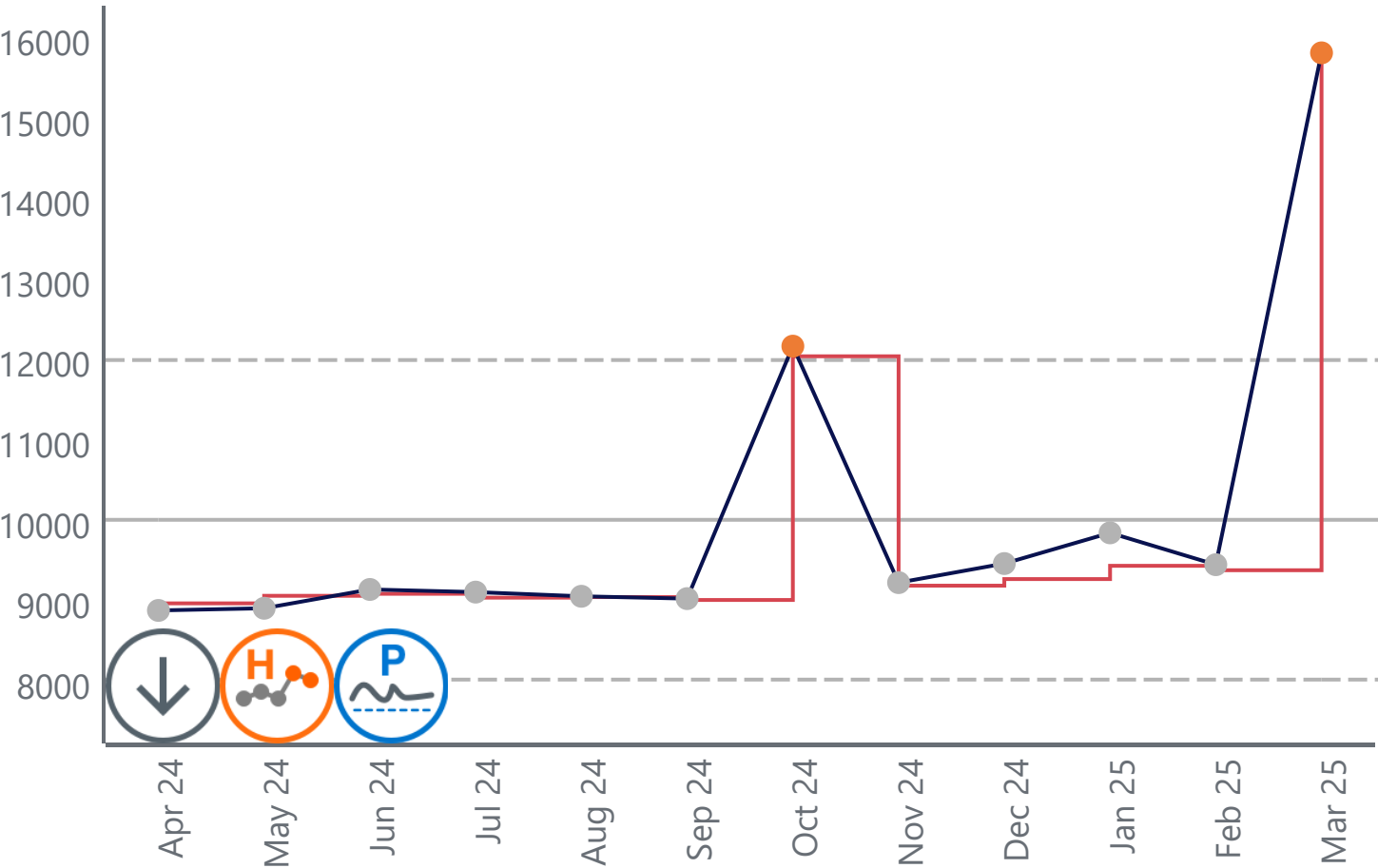
I & E distance from target (cumulative) - £,000



WTE versus establishment



Pay Spend v Budget



People

SRO: Jane Royds, Chief People Officer

Highlights:

Voluntary turnover continues on a downward trajectory, reflecting improved staff retention across the organisation.

National Staff Survey results have been published and presented to the Board in March. LHCH has been rated the best in the country across all People Promise themes. We are also pleased to have received the highest overall ratings for being a great place to work and to receive treatment, demonstrating our commitment to creating a compassionate and high-quality working environment. Formal acknowledgement was received from NHS England, highlighting our continued commitment to staff engagement and experience.

Areas of Concern:

The overall sickness absence rate has seen a marginal increase of 0.37%, bringing the current rate to 4.85%.

There has been a marked improvement in the management of long-term sickness cases, with a number of employees successfully returning to work. Several Stage 4 hearings have also taken place, supporting progress in resolving ongoing cases. As a result, long-term sickness has reduced during March. However, this has been offset by an increase in short-term sickness, which accounts for the overall rise in the absence rate this month.

Continued efforts are being made to ensure that managers feel confident and competent in managing sickness absence while providing appropriate support to staff. The new Managing Attendance Policy has now been ratified, and the HR team will be rolling out bitesize training sessions for managers. In addition, a comprehensive policy toolkit is being developed, offering a range of helpful resources to support the effective management of sickness absence.

Forward Look (with actions):















Key priorities include effective planning and communication for the upcoming launch of the new Appraisal window on 1st May.

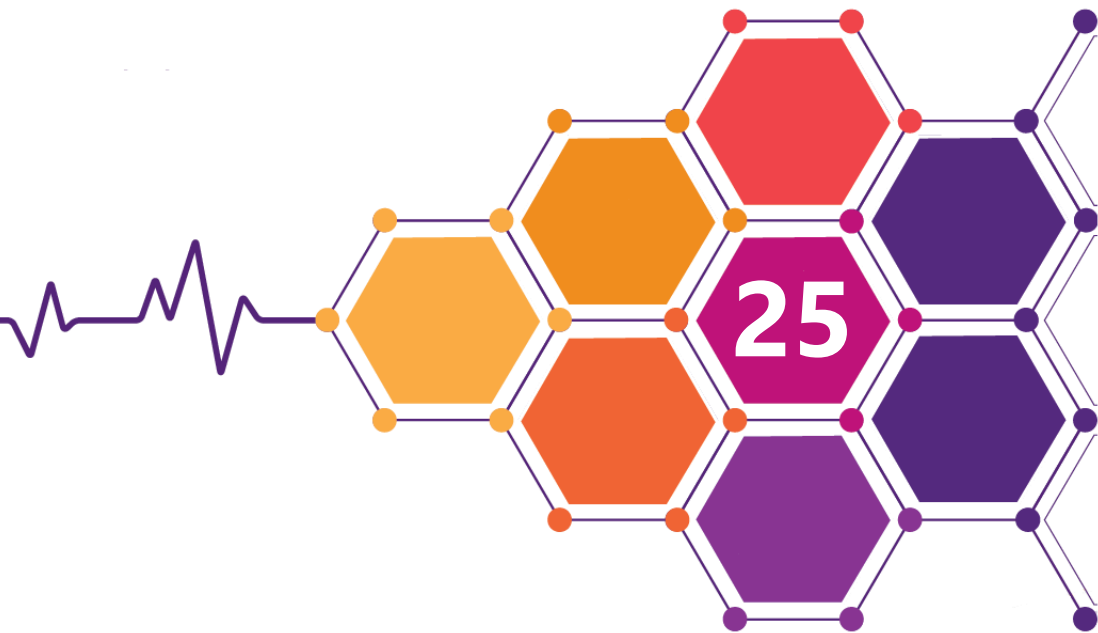
Divisional Staff Survey action plans are currently in development to address local feedback and drive meaningful change.

Additionally, there is a renewed focus on improving Mandatory Training (MT) compliance, with targeted support and collaboration with divisions underway to ensure sustained progress.



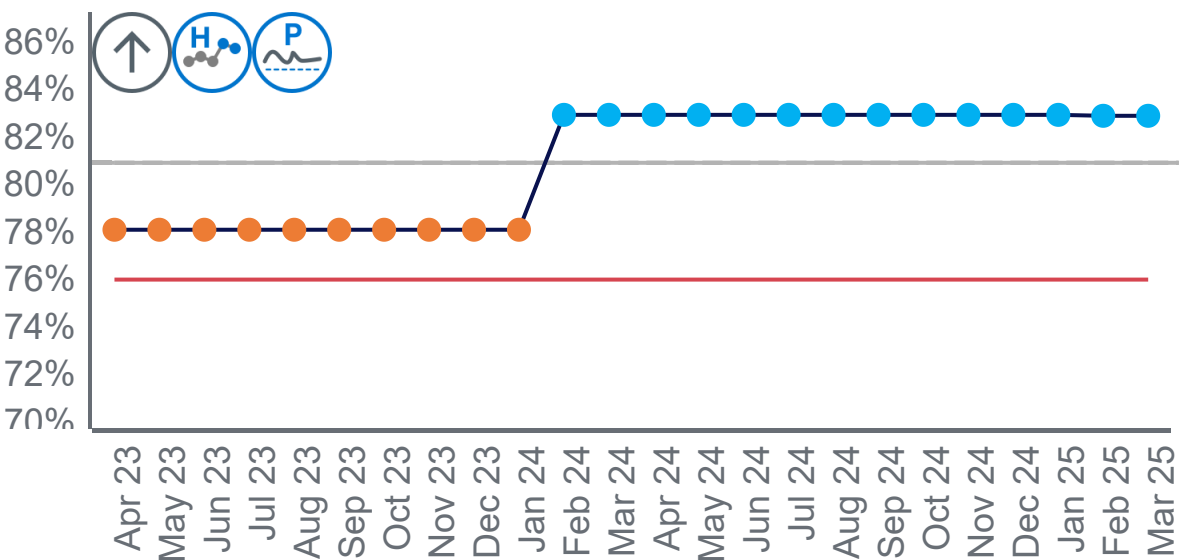
People - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
Appraisals Compliance	Mar-25	85.1	>=90%	82.5		
Mandatory Training Compliance	Mar-25	93.2	>=95%	93.2		
NHS Staff Survey - Staff recommendation of the organisation as a place to work	Mar-25	82.9	>=76%	82.9		
Staff Turnover	Mar-25	8.9	<=10%	9.9		
Staff Sickness (All Staff)	Mar-25	4.85	<=4.5%	5.2		
Long Term Sickness	Mar-25	2.75	<=4.5%	3.4		
Short Term Sickness	Mar-25	2.1	<=4.5%	1.8		



People - Drive Metrics

NHS Staff Survey - Staff recommendation of the organisation as a place to work



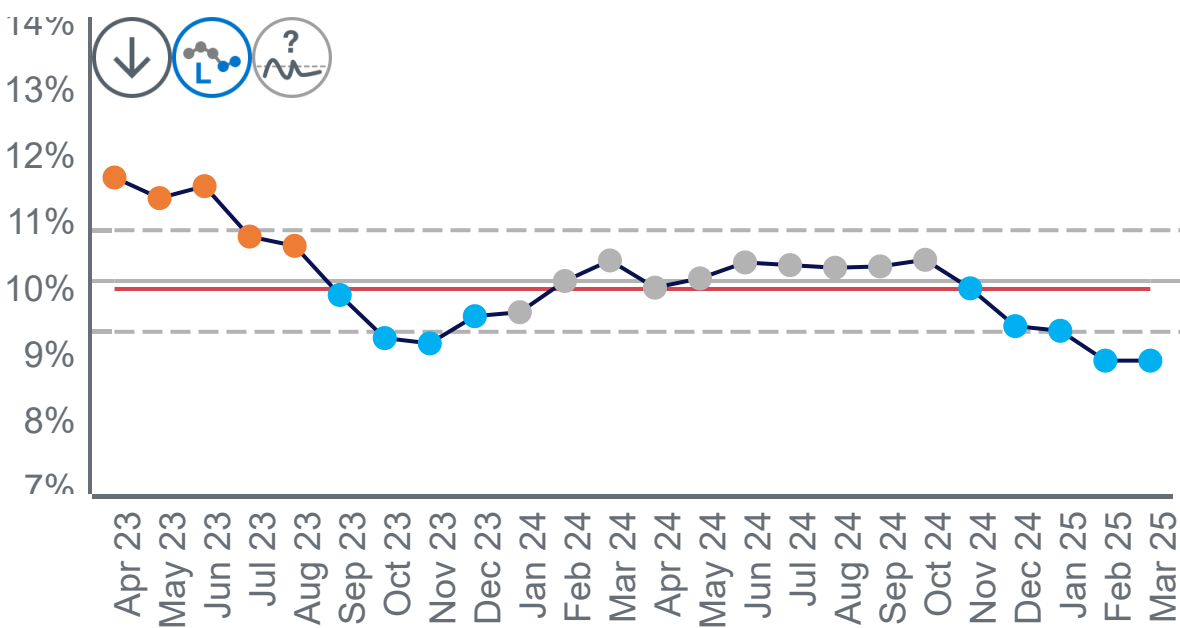
Technical Analysis:

2024/25 is demonstrating positive improvement against the 2023/24 performance achieving 83% against the target of 76%. This is an annual indicator.

Actions:

Strong performance - LHCH ranked top in the country for a Place to Work.

Staff Turnover



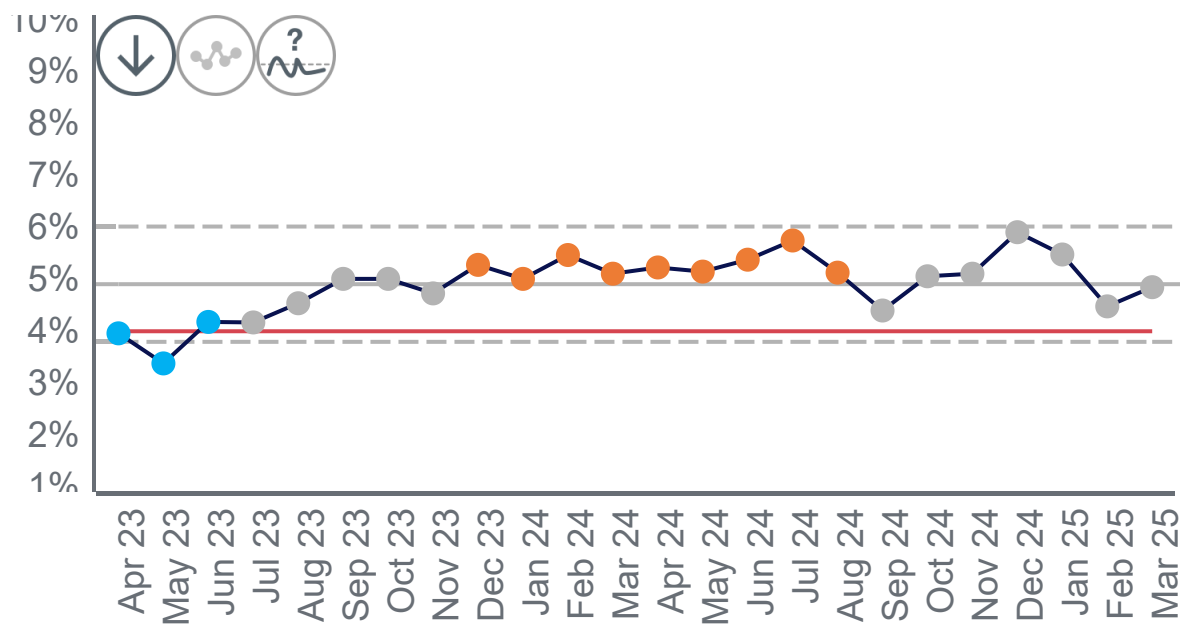
Technical Analysis:

Staff Turnover is displaying special cause improvement with a continual reduction over the last 5 months.

Actions:

Voluntary turnover is demonstrating a downward trend over the last 5 months.

Staff Sickness (All Staff)



Technical Analysis:

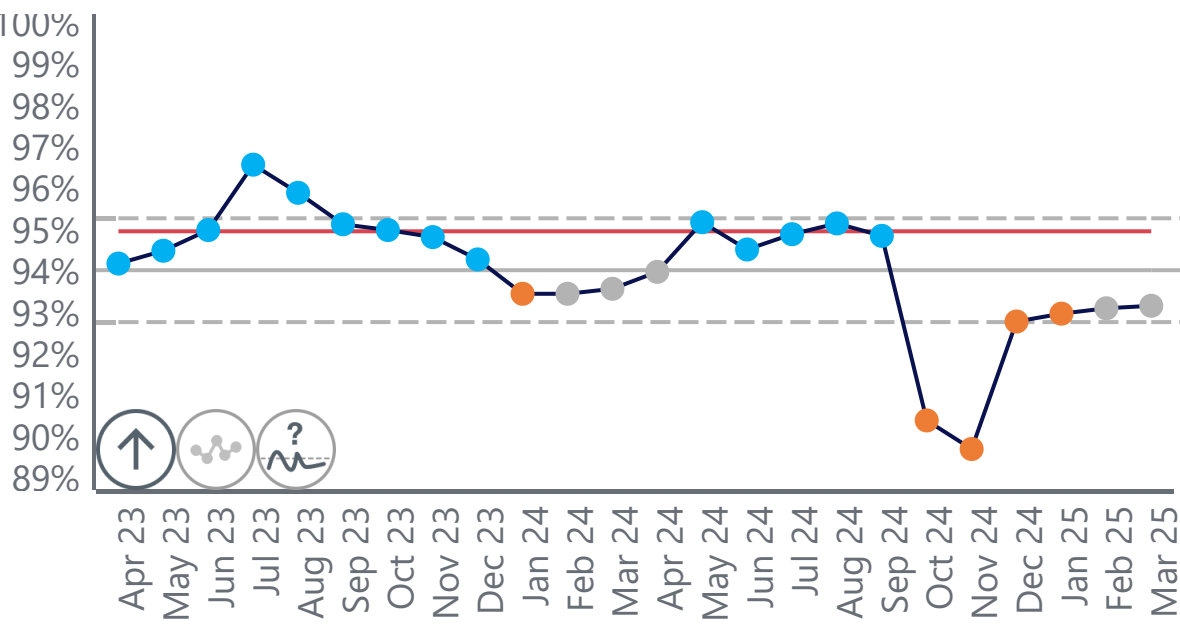
Total absence in March was 5%, this is above the target of 4.5%. Current performance is displaying inconsistency to achieve the target and common cause variation monthly. Further work required to close the gap on the target.

Actions:

Long-term sickness has reduced during March. However, this has been offset by an increase in short-term sickness, which accounts for the overall rise in the absence rate this month.

See summary for actions.

Mandatory Training Compliance



Technical Analysis:

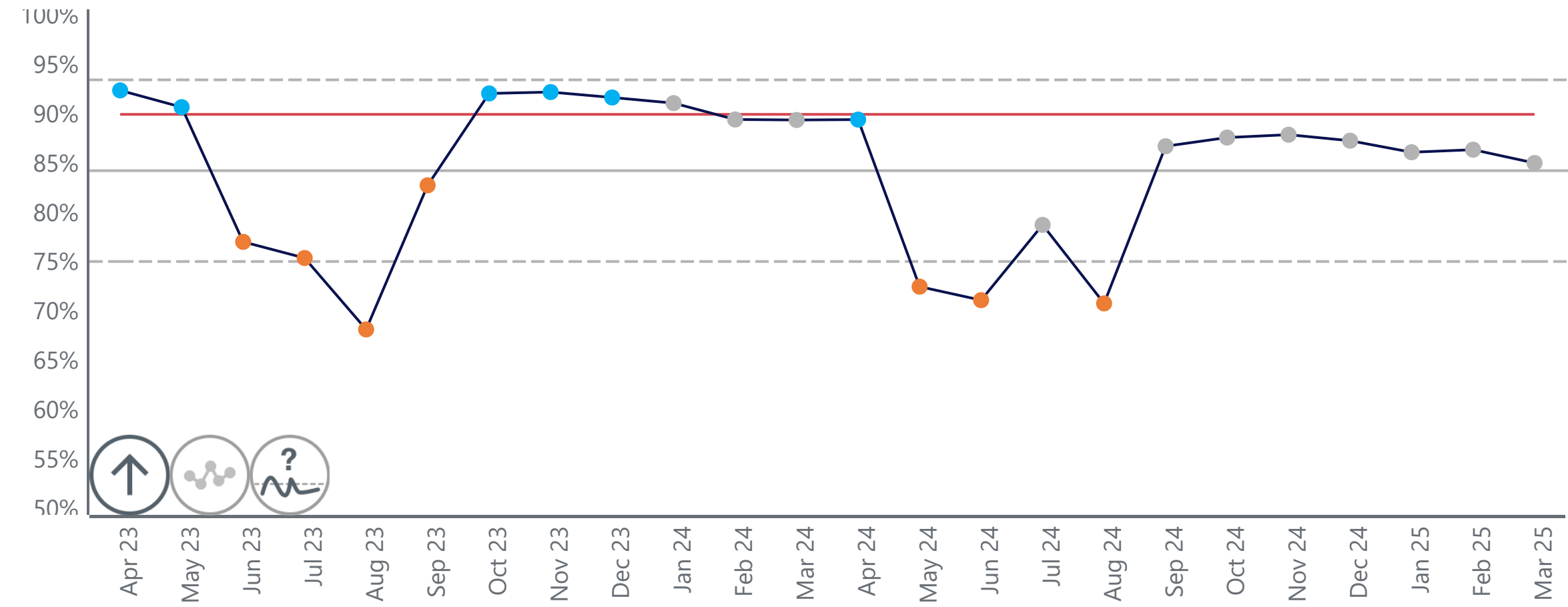
Performance seen a noticeable drop post Sep-24. Mar-25 has performed similar to the previous three months which is an improvement on the dip within Oct-24 and Nov-24. All divisions contributing and performance showing no significant change to improve.

Actions:

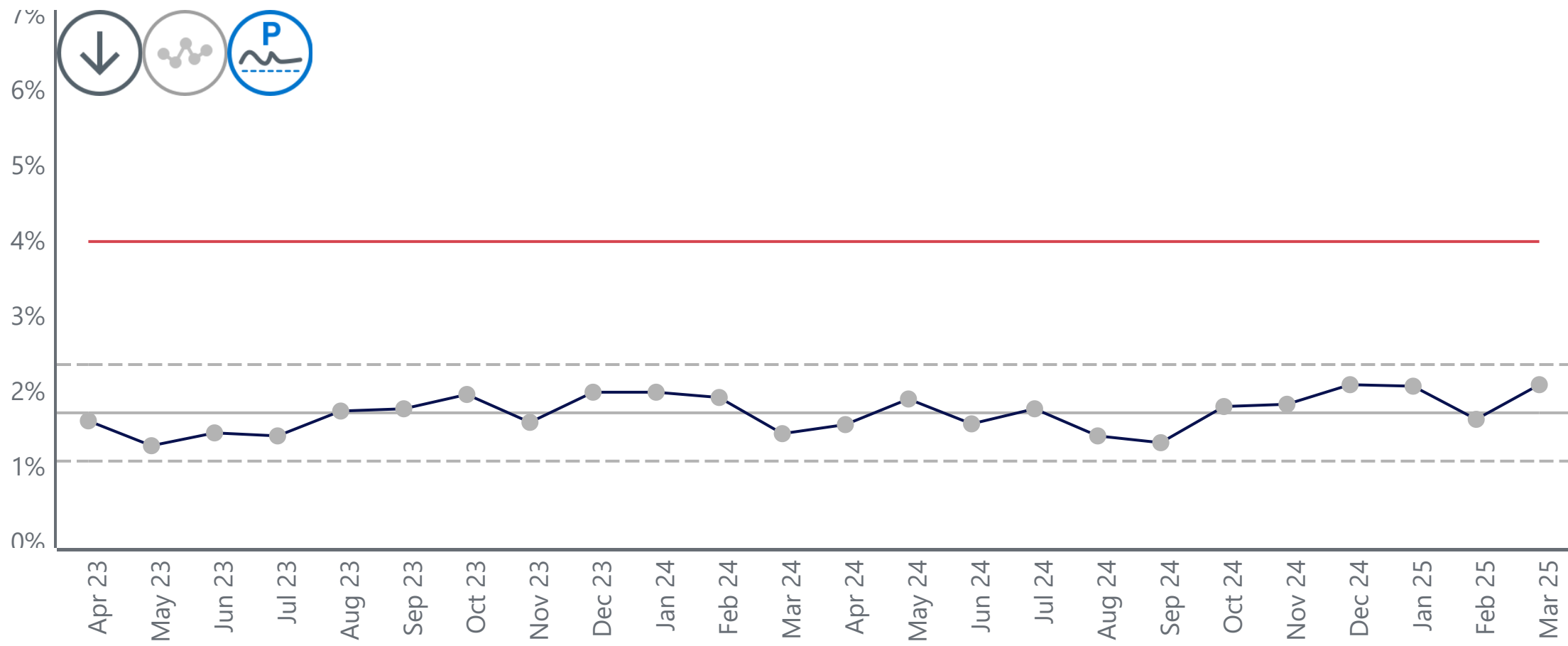
Targeted support and collaboration with divisions underway to ensure sustained progress.

People - Watch Metrics

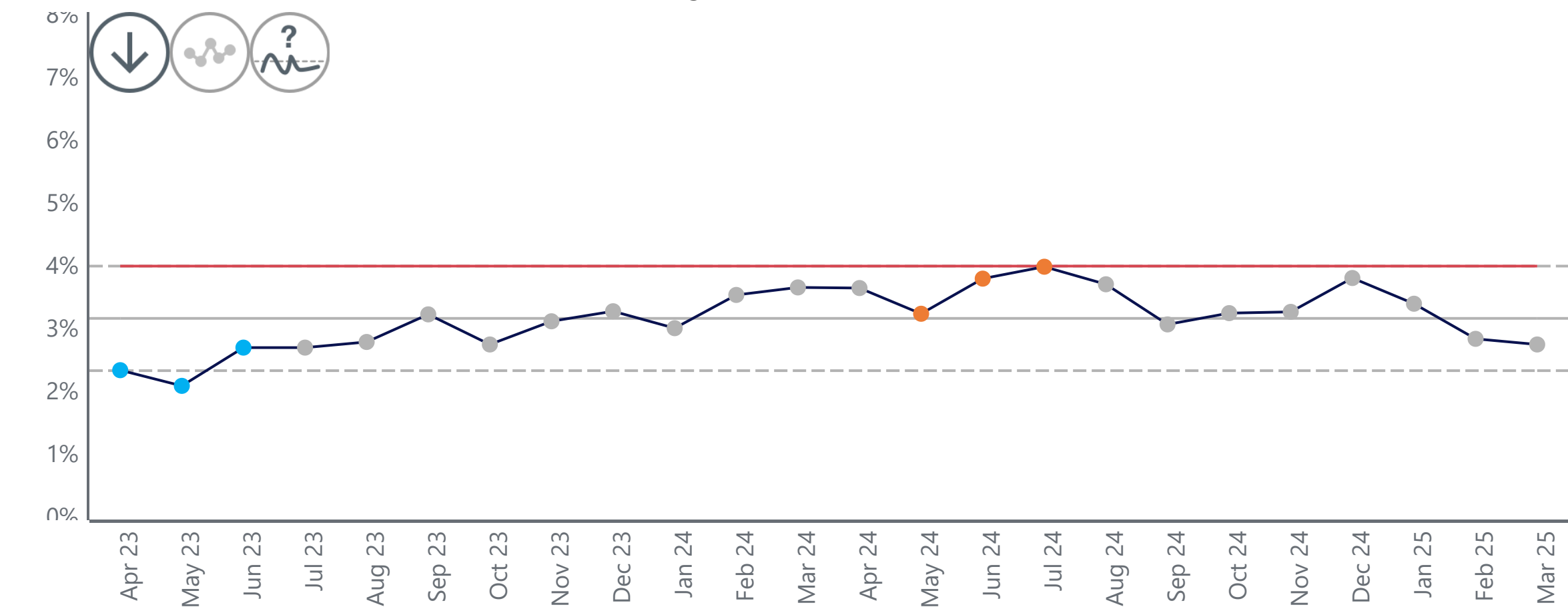
Appraisals Compliance



Short Term Sickness



Long Term Sickness





Key Contacts:

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Analytics@lhch.nhs.uk

