

Liverpool Heart and Chest Hospital   
NHS Foundation Trust

# Strategic Oversight Framework

April 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 beginning of the financial year, we have refreshed the KPIs against the 25/26 targets. Some of the SPCC charts will not show statistical trends until we get 6 data points. At the end of M1 4 standards show below the required target or some statistical variance, these have been reviewed and mitigation plans in place where possible. All of these indicators are monitored and closely aligned against any clinical risk.

Elective activity was below plan in month at 94%, with case mix & non elective demand shown within our financial reporting.

Cancer Performance is reported a month in arrears. In March both the Faster Diagnosis and 62 Day pathway targets were compliant.

For long waiters we have now moved to monitoring the 52 week position; in month this has reduced and we are micromanaging the position. Mutual aid continues to be provided for Mid Cheshire Hospital for Cardiology.

DM01 (Diagnostics) has shown significant improvement over the last few months and is now back to DM01 compliant. To note MRI is also now forecast to be individually compliant for May.

Areas of Concern:

Elective activity was below plan in April and has been impacted by annual leave and sickness during bank holiday periods. Scheduling and Critical Care staffing is being monitored for May with cancellations foreseen with staffing levels and activity increases.

Additional sessions and mutual aid from University Hospital Liverpool Group continue to support capacity for MRI. Specialist skills continue to be a shortfall in C&M and a sustainable diagnostic planning is ongoing.

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 still to be finalised to complete a triangulation of finance and operational targets for C&M.

\* 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, in line with financial controls.

\* 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

\* Validation sprint work is being funded nationally and overall waiting list size & 18 week backlog is being targeted for Q1. The Divisions will be looking at waiting list processes through the Safe Waiting List Management Group and monitoring against RTT standards.

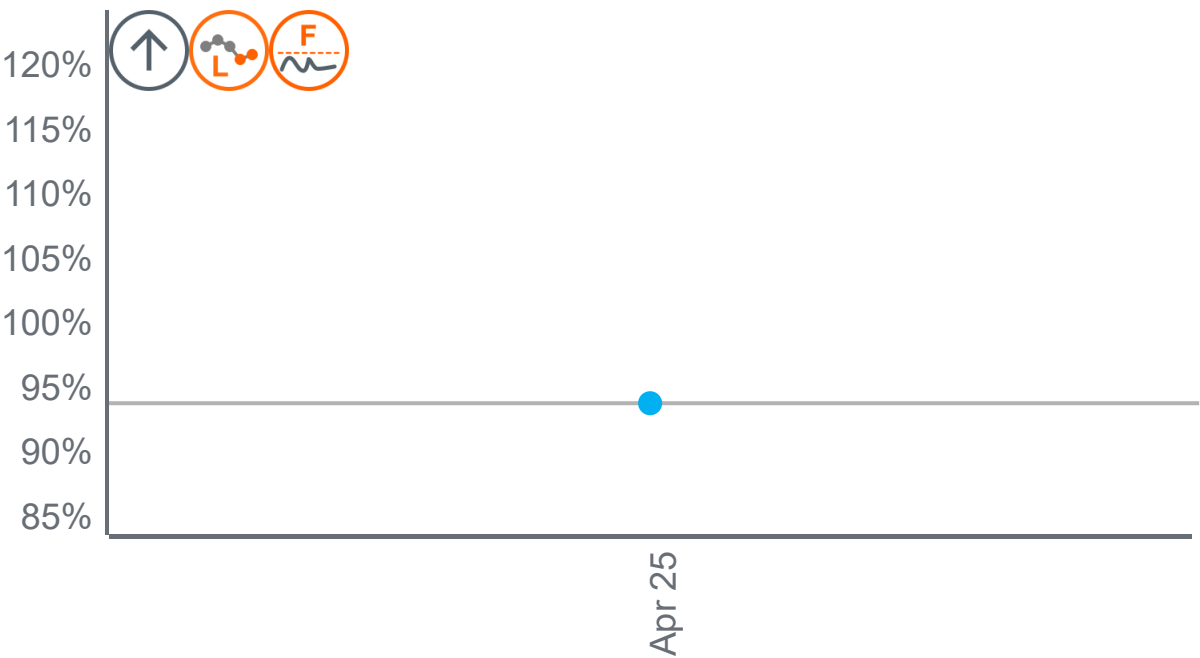
Operational Performance - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
Bed Occupancy	Apr-25	74.3	>=80%	74		
Cancelled Operations for non-clinical reasons	Apr-25	3.0	<=2%	3		
DNA Rate for most deprived areas	Apr-25	15.7	<=5%	16		
Elective Activity Levels	Apr-25	100.9	100%	101		
Letters waiting to be typed over 7 days	Apr-25	136	0	136		
Maximum 6-week wait for diagnostic procedures	Apr-25	97.9	>=95%	98		
Non-Criteria to Reside Occupied beds as a proportion of total occupied beds	Apr-25	98.1		98		
Overall Size of Waiting List	Apr-25	6201		6201		
Patients not booked in within 28 days (non clinical cancellations)	Apr-25	5.0	0	5		
RTT 18 weeks in aggregate - Incomplete Pathways	Apr-25	68.5	92%	68		
Referral to treatment - Incomplete Pathways 52+ weeks	Apr-25	50		50		
RTT 18 Week Backlog	Apr-25	1730		1705		
RTT Open Pathways - Percentage Without an Ethnicity Status	Apr-25	51.7	<=35%	52		
RTT Pathway Waiters (52+ weeks) for the most deprived areas	Apr-25	80.0	0%	80		
Time to First Appointment	Apr-25	79.0	5%	79.0		
Cancer Patients meeting the Faster Diagnosis Target (FDT)	Apr-25	87	>=75%	64.5		
Cancer: 62-day referral to treatment standard	Apr-25	85.5	>=85%	75.3		



Operational Performance - Drive Metrics

Elective Activity Levels



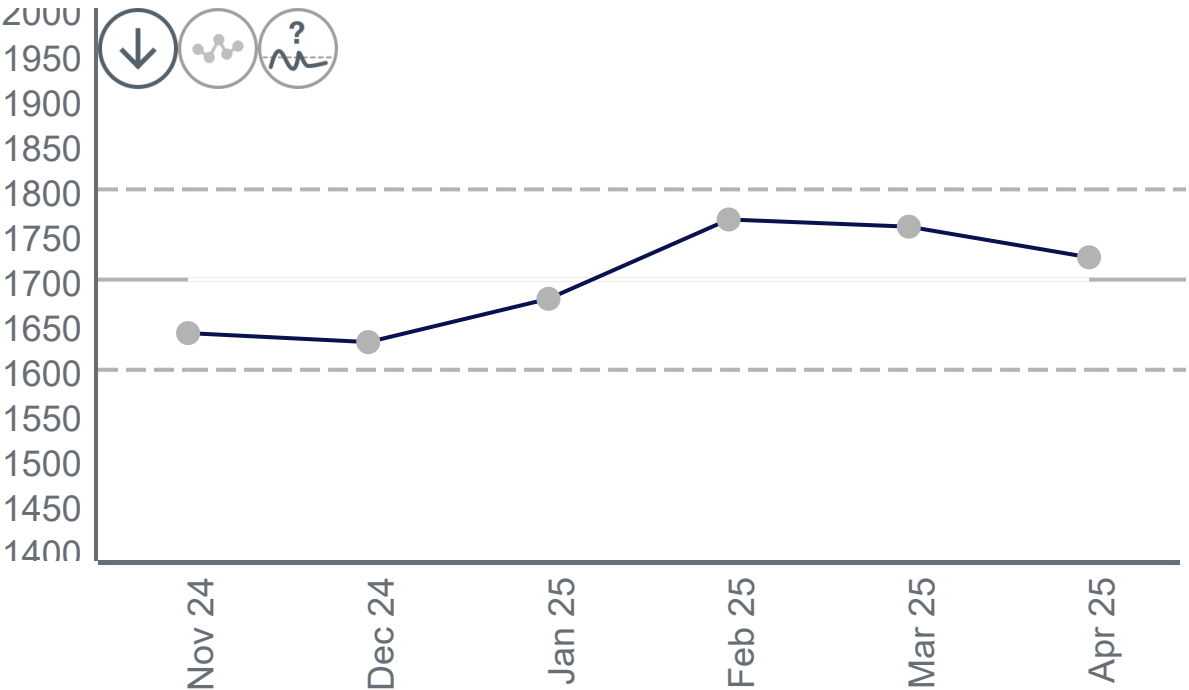
Technical Analysis:

Performance within Apr-25 failed to achieve the target of 100%. Further work required across divisions to close gap on target consistently.

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.

RTT 18 Week Backlog



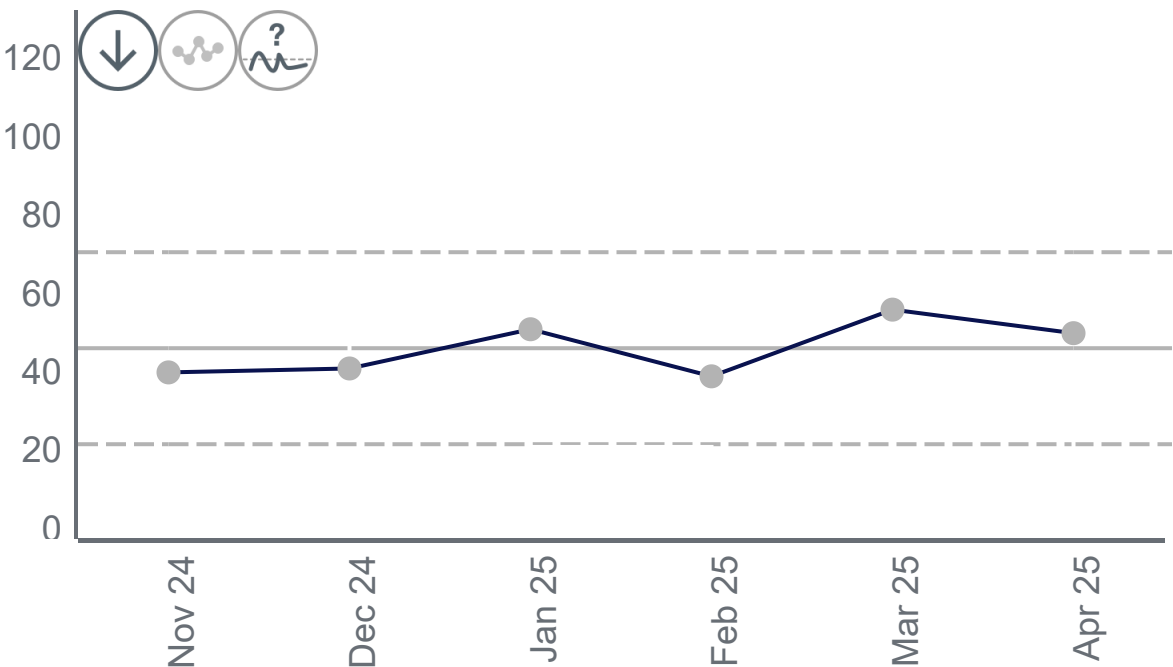
Technical Analysis:

Performance over recent months has shown a minor increase in backlog numbers. Further work required to reduce RTT backlog.

Actions:

- \* Validation bank and overtime in line with national validation funding
- \*Weekly PTL monitoring meetings via Divisional Leadership team
- \*Bi weekly performance meeting chaired by the COO

Referral to treatment - Incomplete Pathways 52+ weeks



Technical Analysis:

Current performance is displaying common cause variation with no significant change. Surgery patients remain the most significant contributors to volumes. Further work required to achieve target.

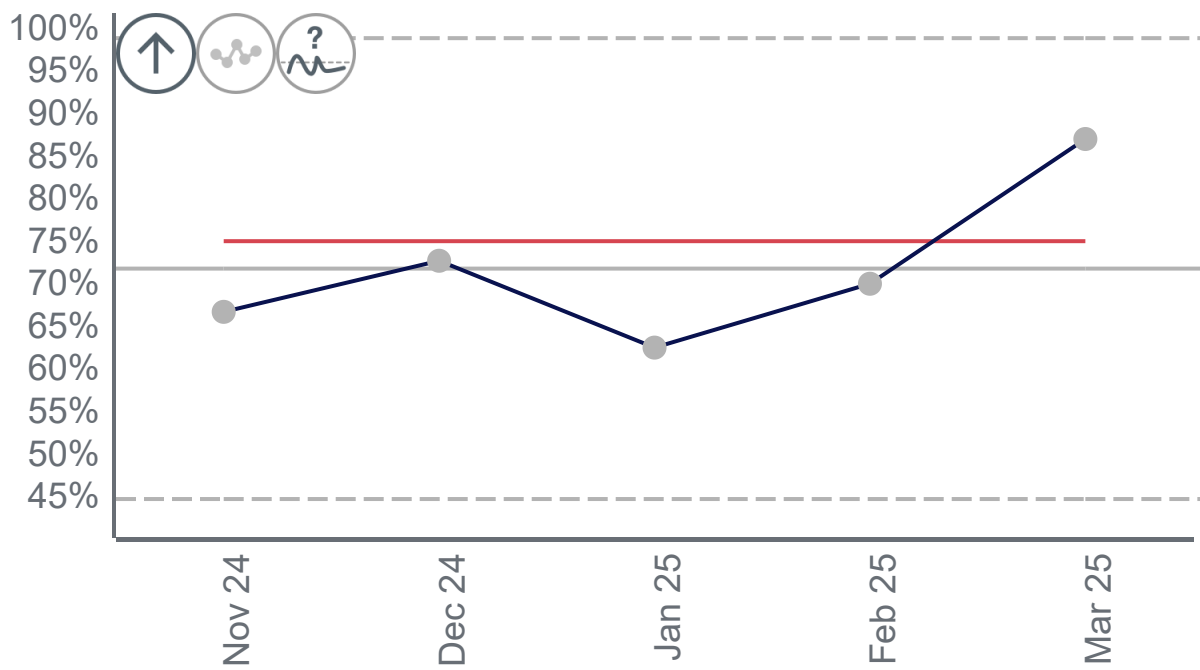
Actions:

- \*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.



Operational Performance - Drive Metrics

Cancer Patients meeting the Faster Diagnosis Target (FDT)



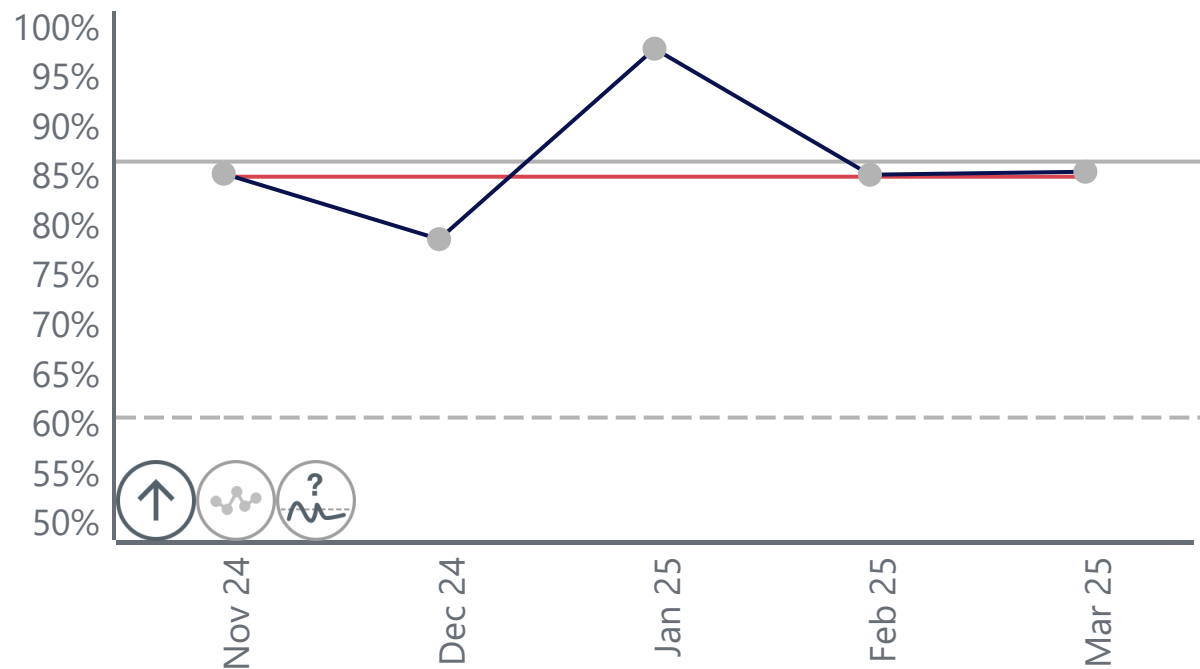
Technical Analysis:

The target was achieved in Mar-25 for the first time since Oct-24. 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: 62-day referral to treatment standard



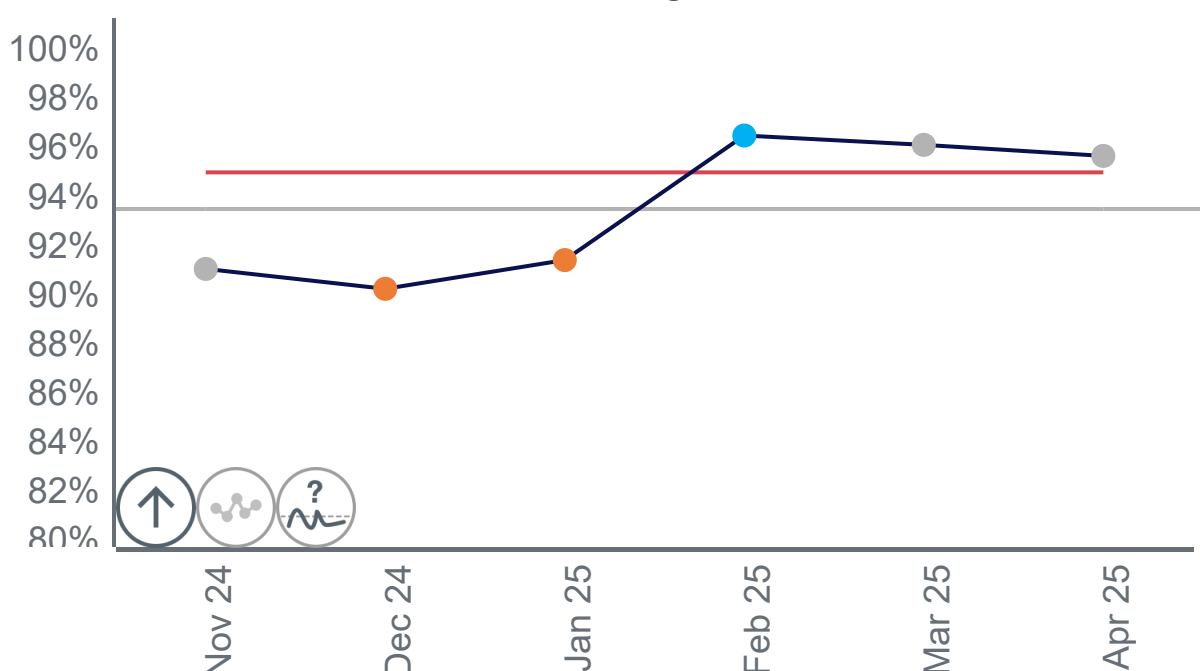
Technical Analysis:

Performance of the 62 day Cancer standard is displaying common cause variation. Further work required to consistently achieve the Target.

Actions:

- \* Weekly Multi-disciplinary PTL meetings undertaken per week.
- \*Breach analysis and learning monitored through Cancer Board.

Maximum 6-week wait for diagnostic procedures



Technical Analysis:

Performance of the 6 week target has shown common cause variation and has achieved the target for the last 3 months. Continued work to consistently achieve the target.

Actions:

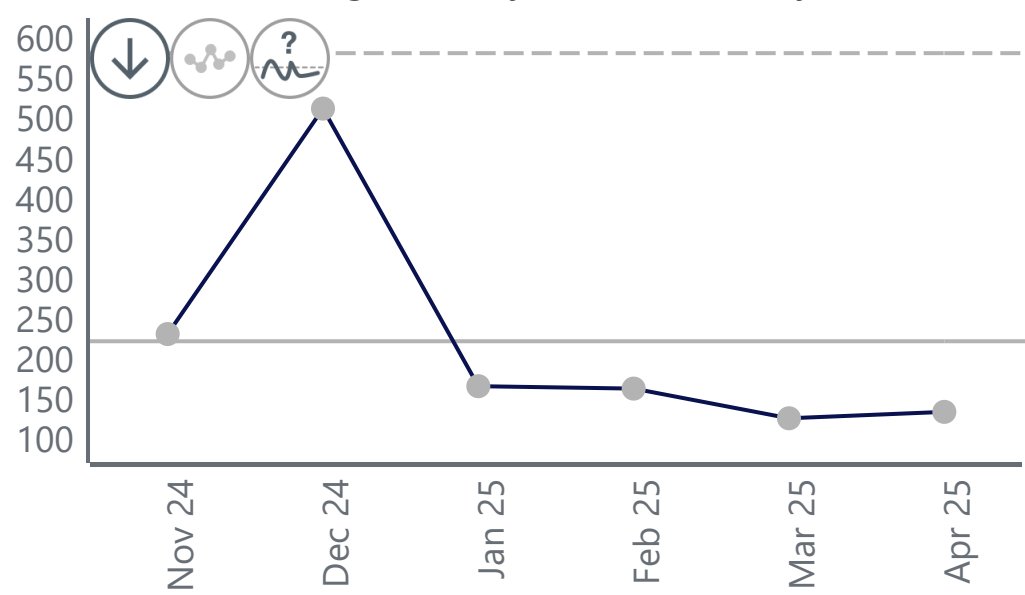
- \*Divisional Director runs weekly PTL meetings.
- \*MRI mutual aid continues via LUFT to support capacity.



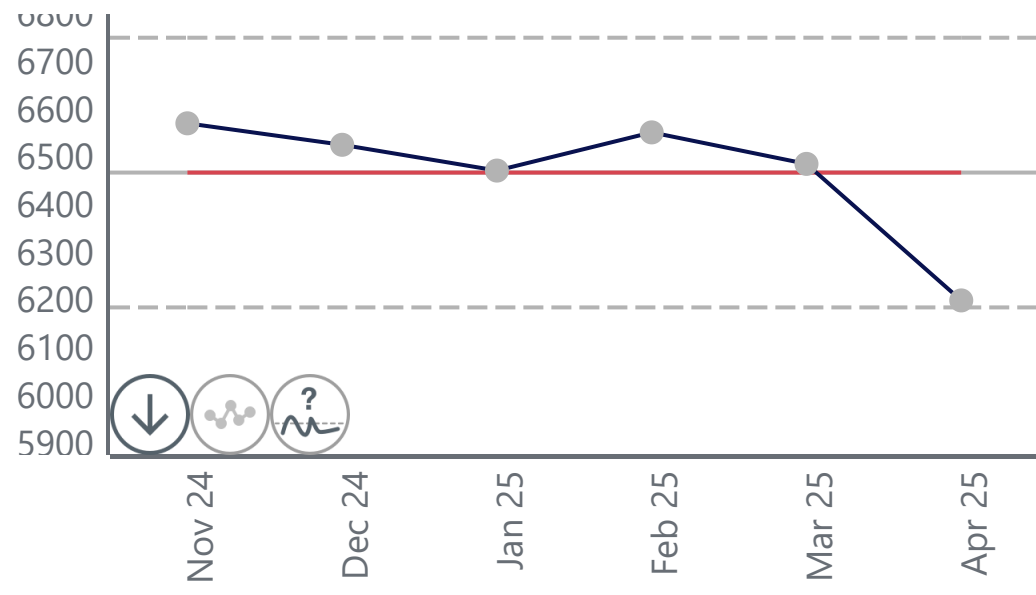


Operational Performance - Watch Metrics

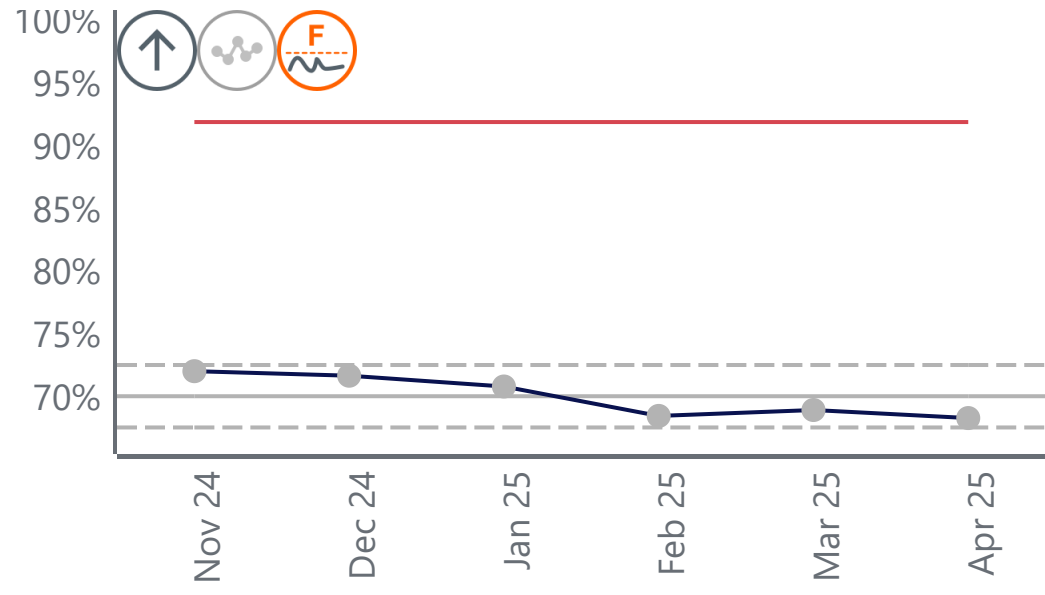
Letters waiting to be typed over 7 days



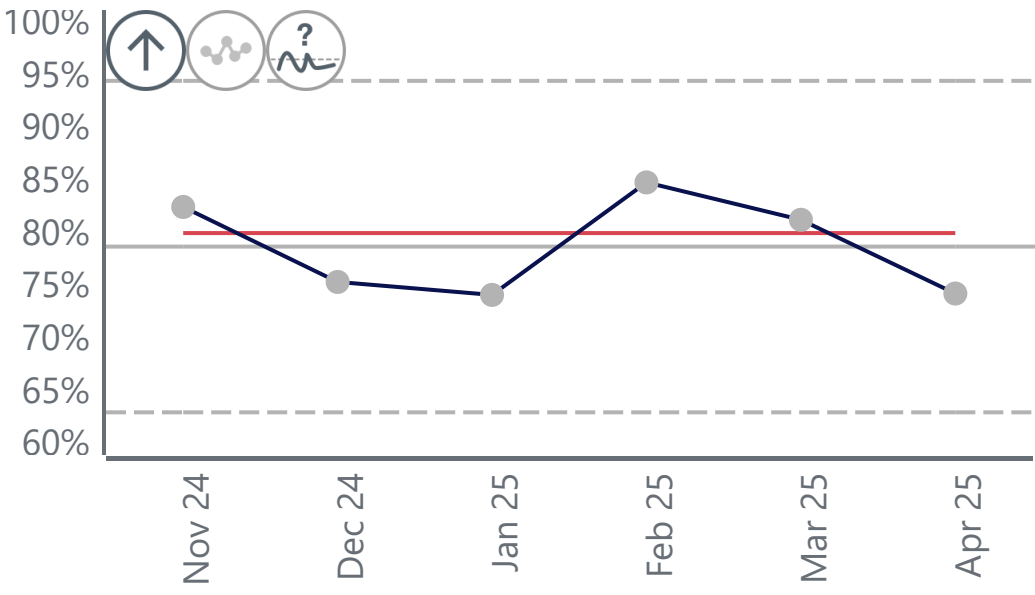
Overall Size of Waiting List



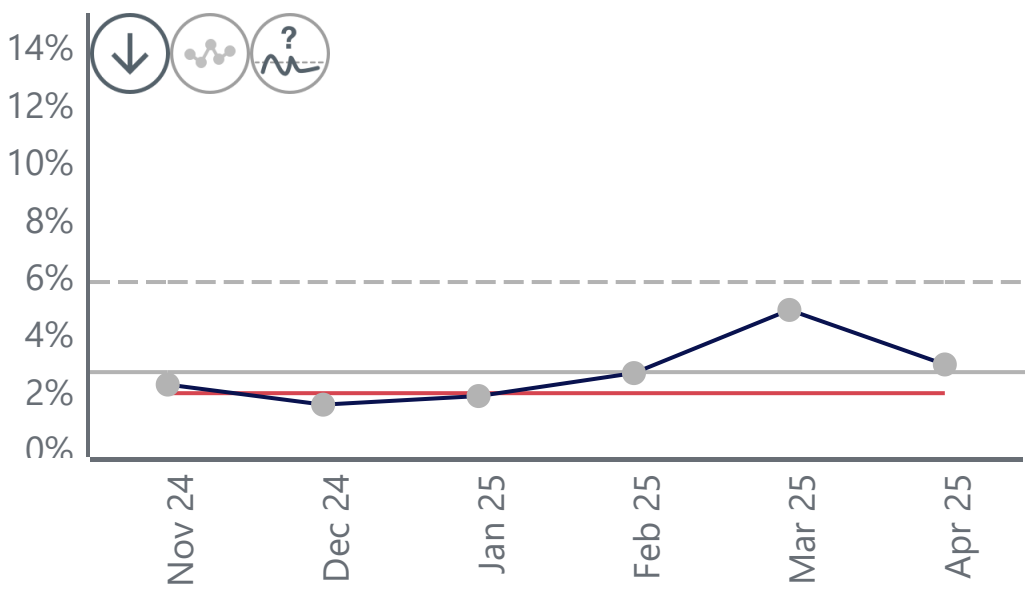
RTT 18 weeks in aggregate - Incomplete Pathways



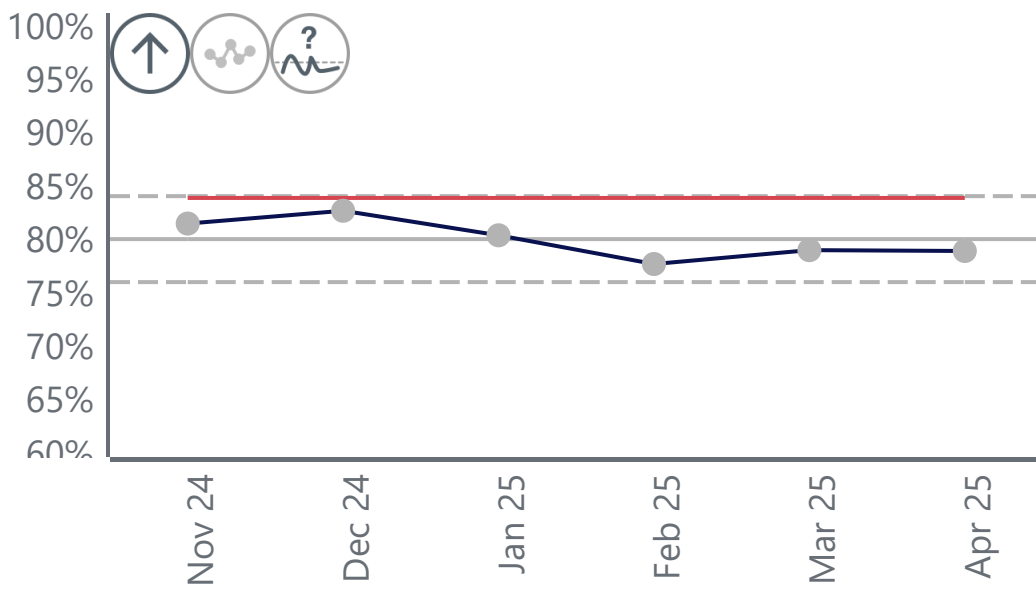
Bed Occupancy



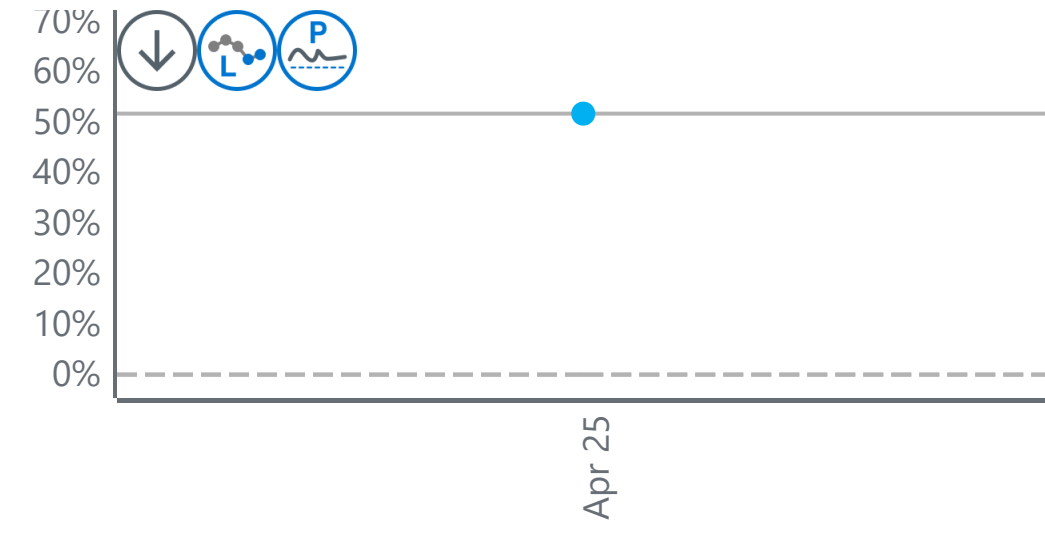
Cancelled Operations for non-clinical reasons



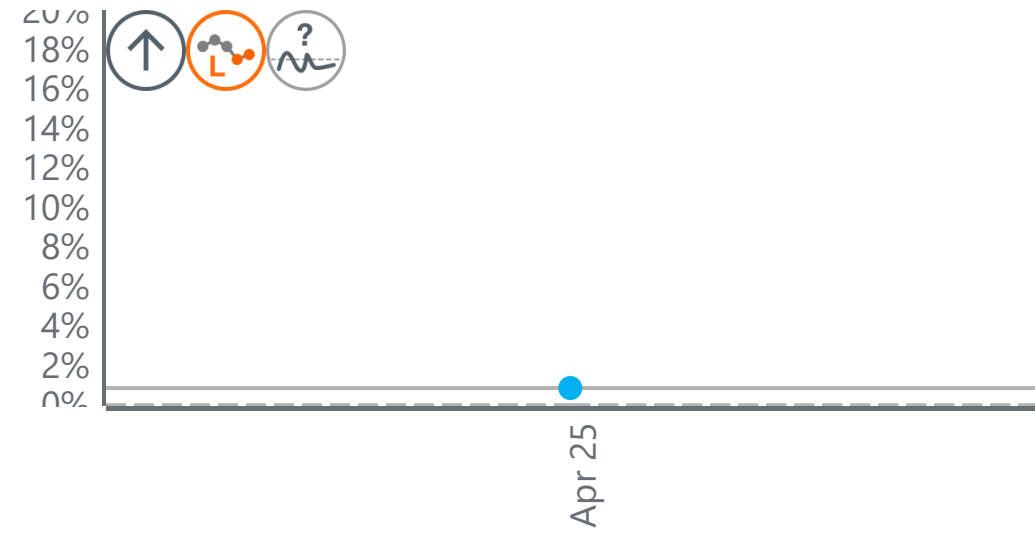
Time to First Appointment



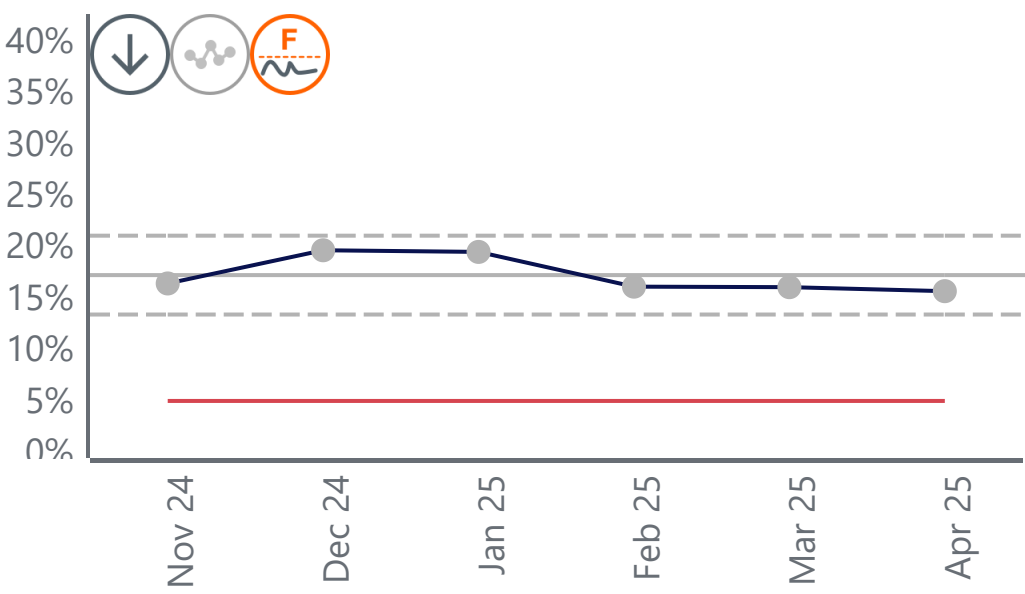
RTT Open Pathways - Percentage without an Ethnicity Status



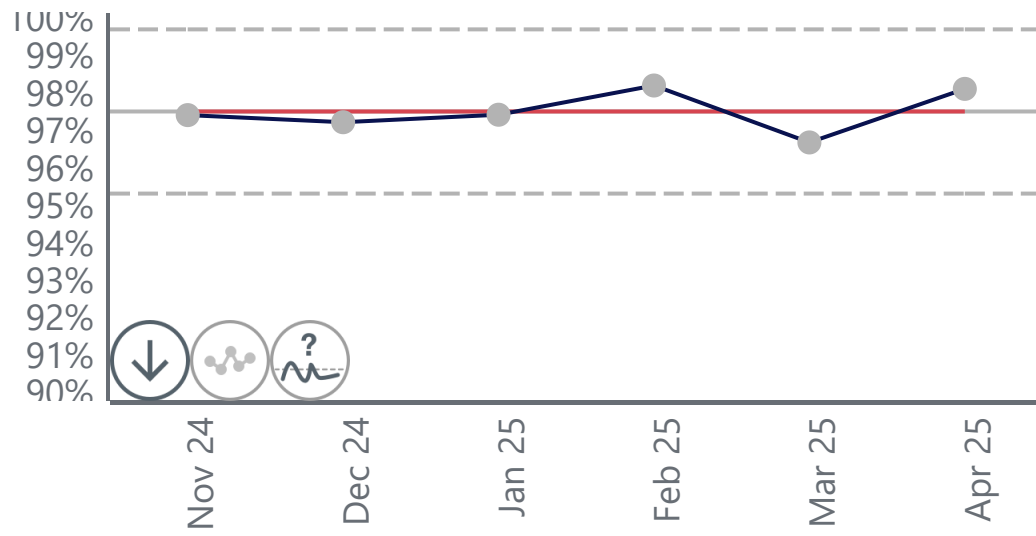
RTT Pathway Waiters (52+ weeks) for the most deprived areas



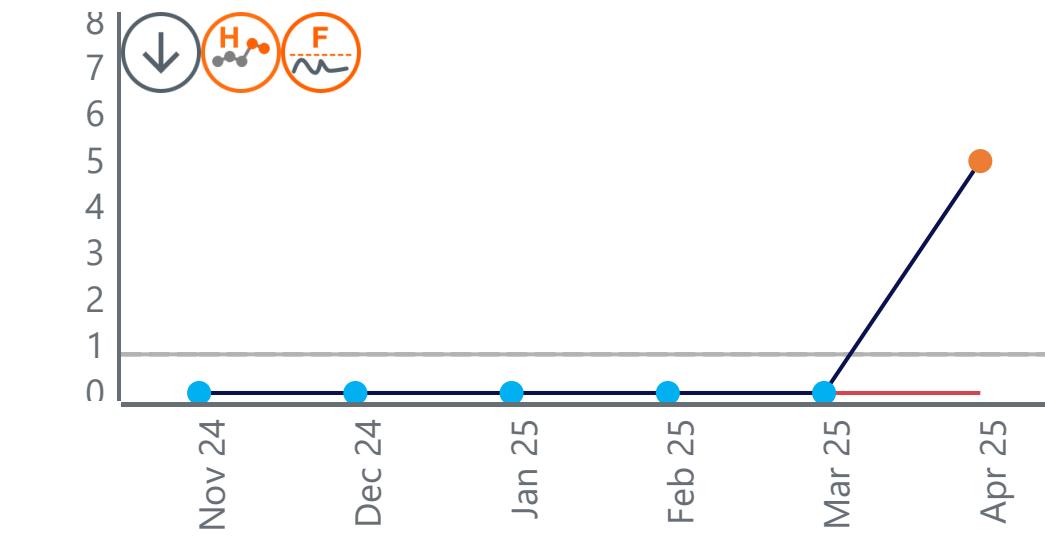
DNA Rate for most deprived areas



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



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



Productivity

**SRO: Ben Davies, Associate Director of Transformation**

**Highlights:**

This month we have amended the drive metric for Overdue Follow Ups to provide more assurance that those patients who are overdue are being seen in a more timely manner. The metric reports on those patients who are waiting to be seen that are more than 25% overdue of the time of their follow-up appointment. As the data demonstrates over the last 12 months we have seen the amount of patients waiting go from 25% to 16%. This has been enabled through the work undertaken by the Safer Waiting List programme of work being led by Lucy Currie. Overdue follow ups continues to be monitored under the watch metrics and we remain on target for the 9th month in a row.

Patient Initiated Follow-up (PIFU) performance has dipped slightly this month and did not achieve the set target of 2%. ICC have commenced the roll out of PIFU, which will allow for patients to be more in control of their appointment and create capacity. Work is ongoing with the teams to improve our position, with the SOP in the process of being signed off by the triumvirate.

The overall Diagnostic DNA rate has increased this month which is due to an increase in Echo DNA rates. Sleep DNA rates have improved again this month, with CT and MRI rates staying consistent. There are still ongoing issues with the text reminders and letters that are being worked on by the teams. Staff are trialling calling patients 7 days in advance of their appointment to confirm attendance which other areas have seen benefits implementing.

**Areas of Concern:**

- \* Short notice cancellations have adversely impacted on theatre utilisation. 11 lists were lost this month which has impacted the core session delivery.
- \* Whilst Sleep DNA rate has improved over the last months, it remains above target. The increase in Echo DNA rate is specifically related to Cardio-oncology diagnostics. There are ongoing issues with text messages and letters.
- \* Work is ongoing to review and update ENVOY, our text reminder service, and Health Care Comms letters for Echo & Sleep patients as they do not reflect the service's requirements, which is hindering DNA rates for this service.

**Forward Look (with actions):**

- \* Theatre teams are flexing between Thoracic and Cardiac to maximise productivity within theatres whilst also working with POCCU regarding cancellations due to staffing issues.
- \* To improve theatre utilisation 4 key actions are underway to improve start times:
  - \* Developing a policy for automatic sending for all morning cases
  - \* Team Brief at 08:05
  - \* Surgeon scrubbed at 09:00
  - \* Trial of admitting DOSA patients directly to theatres
- \* Trial underway to improve Echo DNA rates with staff calling patients 7 days prior to their procedure to remind and confirm they are still attending their appointment.



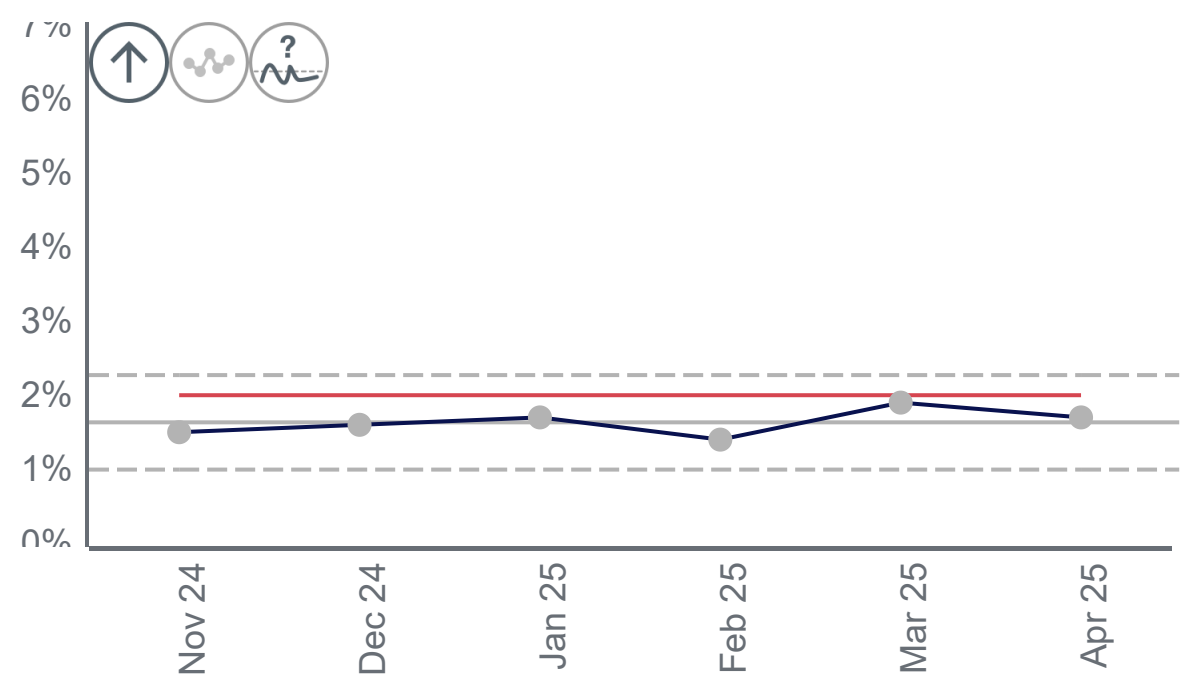
Productivity - Metric Summary

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Productivity - Drive Metrics

% Patients on PIFU



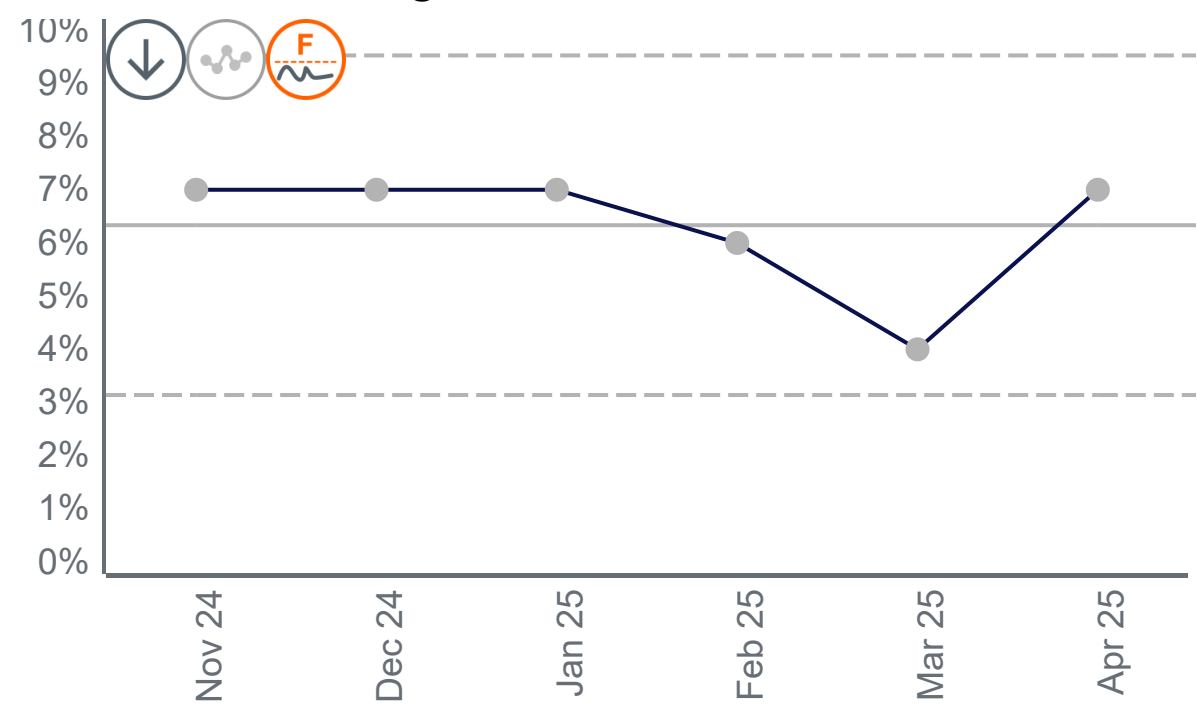
Technical Analysis:

The trust failed to achieve the 2% target across 2024/25. Performance has routinely shown common cause variation with improvement required to achieve the target consistently.

Actions:

- \* SOPs are with the triumvirate for sign off.
- \* ICC have commenced with implementation of PIFU which will create capacity.
- \* Discussions to be held with service lines regarding PIFU follow-ups no longer being used.
- \*Continue to promote and drive PIFU uptake.

Diagnostic DNA Rate



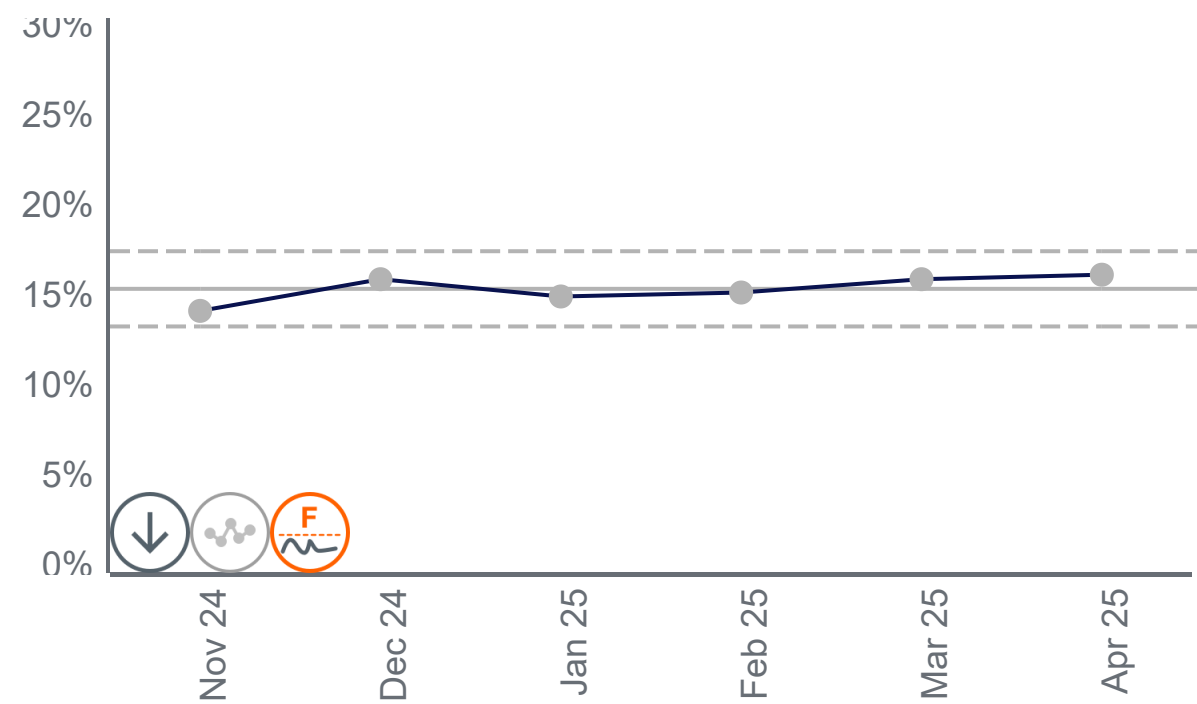
Technical Analysis:

Current performance is displaying common cause variation. Further work required to achieve target consistently.

Actions:

- \* The decrease in performance is specifically within Echo Cardio-oncology diagnostics.
- \* Ongoing issues with patients not receiving texts & letters.
- \* Staff are testing ringing patients in the 7 days before their appointment to confirm attendance.

Risk stratified Overdue Follow Ups (>25% overdue)



Technical Analysis:

Performance is showing common cause variation with no significant change. Further work required as the Trust continues to fail to meet the target.

Actions:

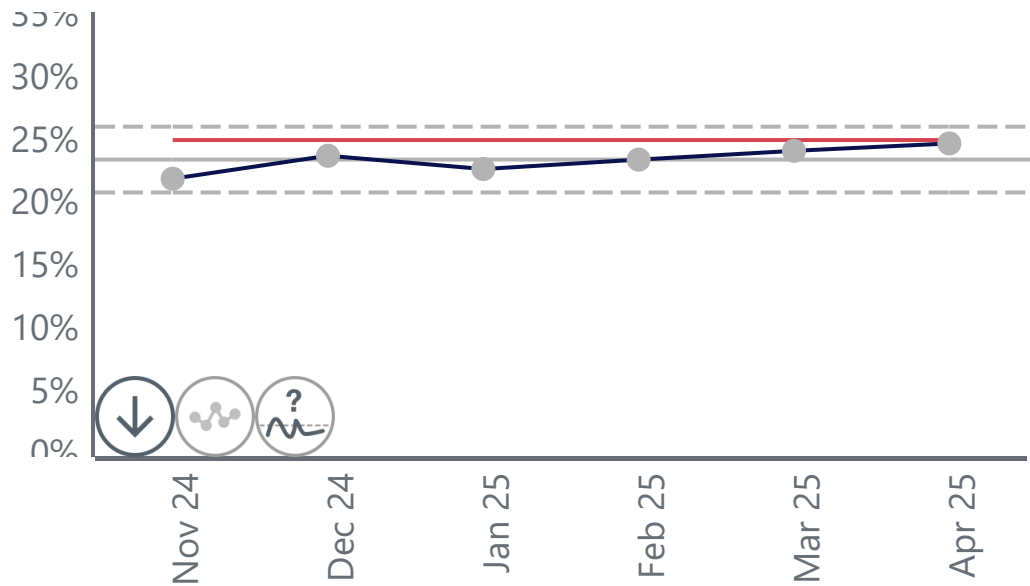
- \* Safer waiting list management group well established.
- \* Work underway regarding out patient care records follow ups to ensure all patients safe and captured.
- \* SOP is being developed with regards to the management of patients on the FOWL who are overdue.



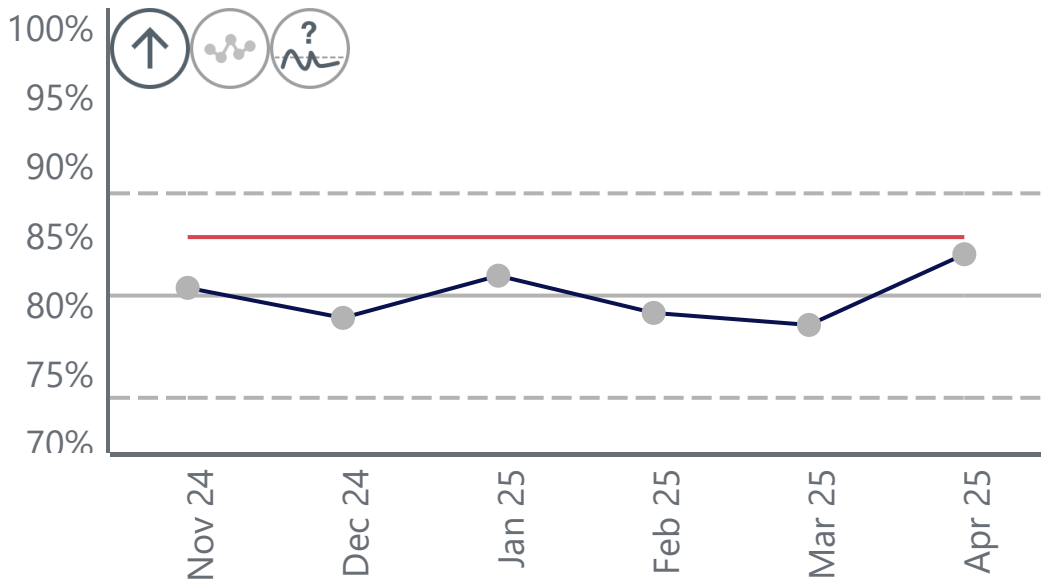


Productivity - Watch Metrics

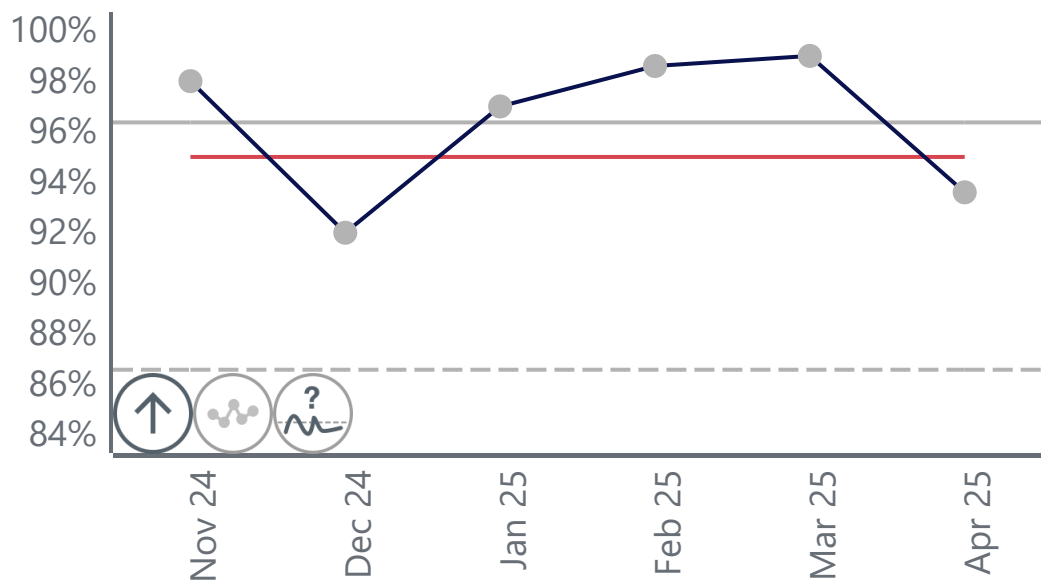
Overdue Follow Ups



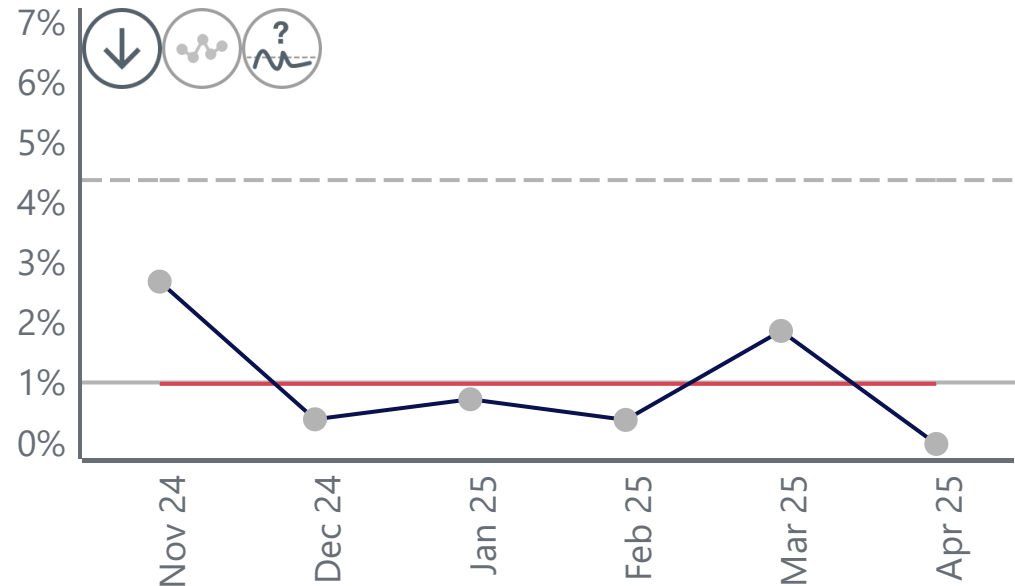
% Session Utilisation (Theatres)



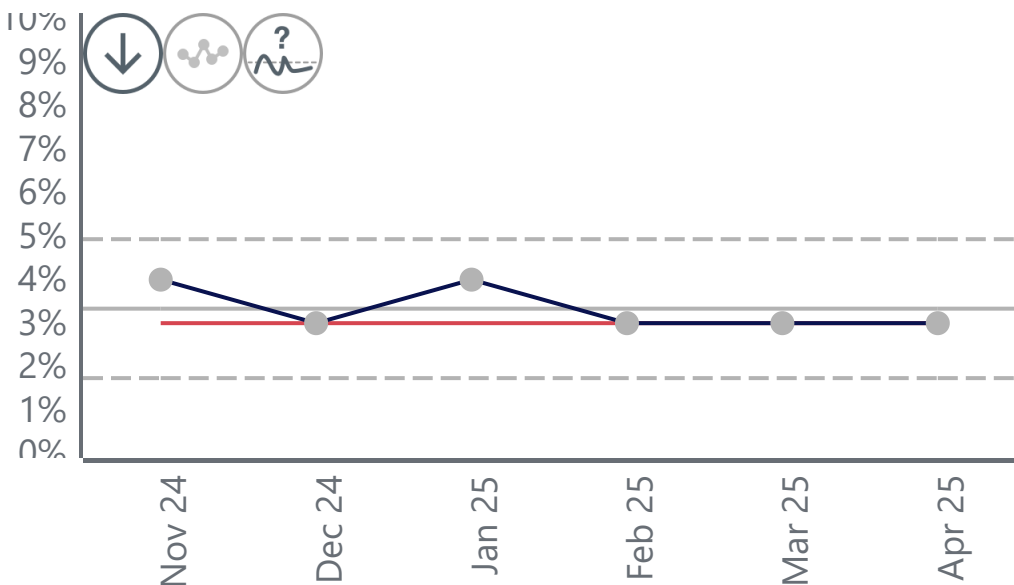
% Core Session Delivery (Theatres)



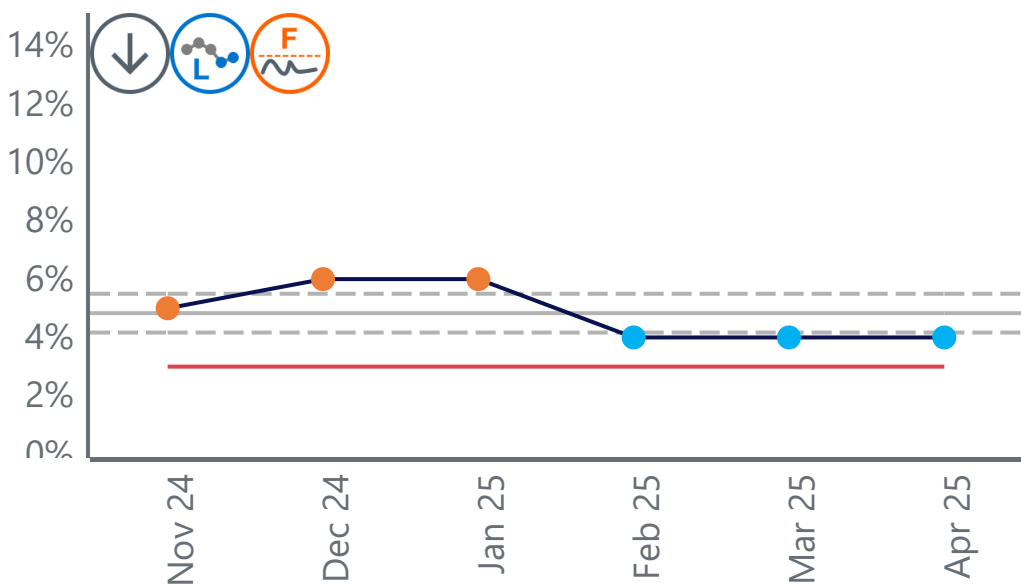
% Avoidable Cancellations (Theatres)



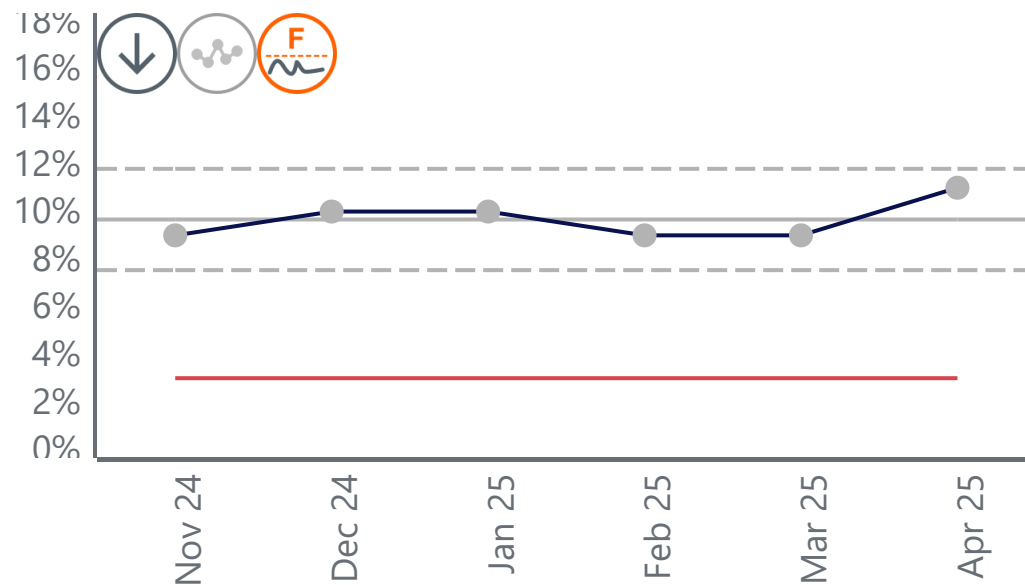
CT DNA Rate



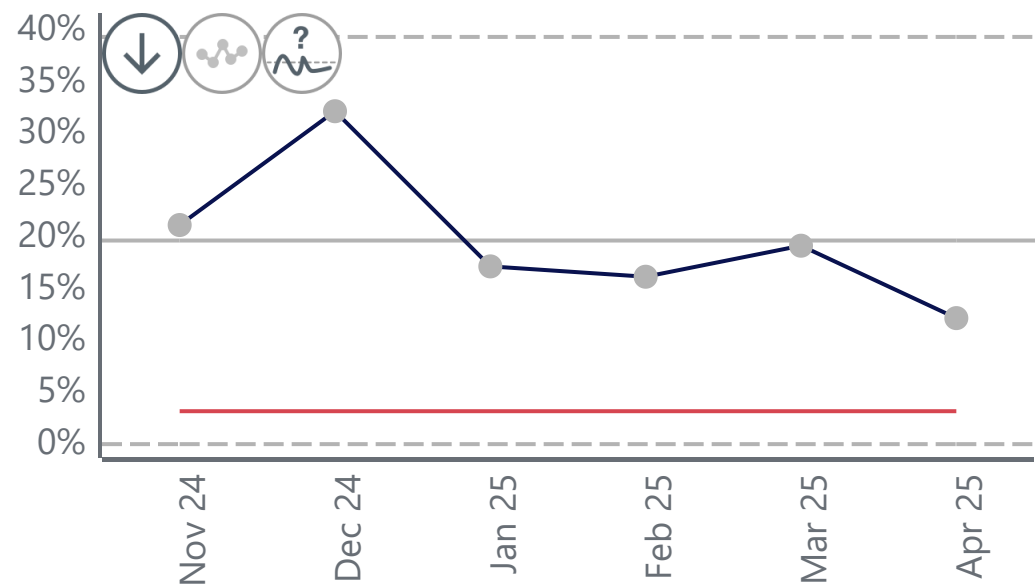
MRI DNA Rate



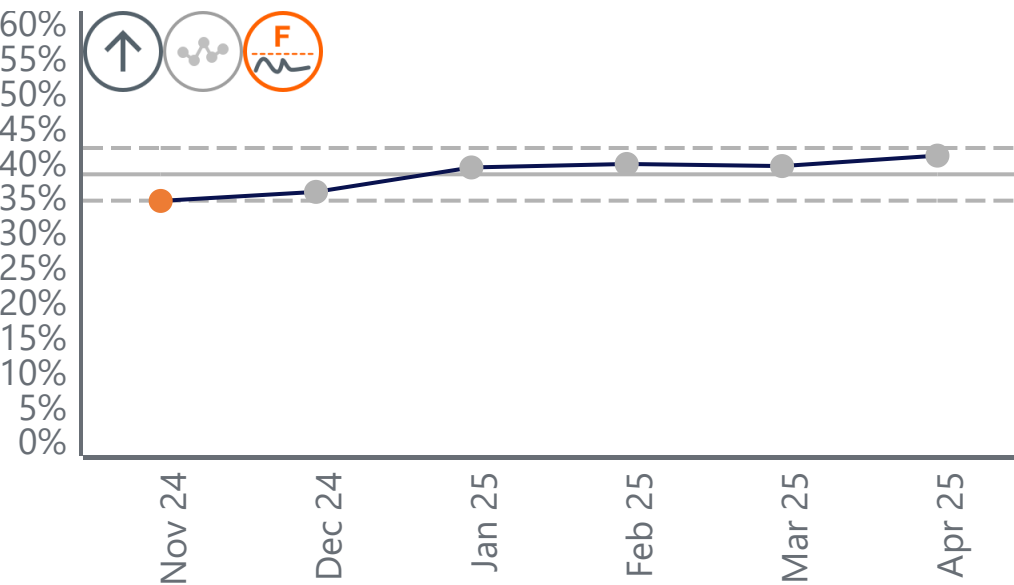
Echo DNA Rate



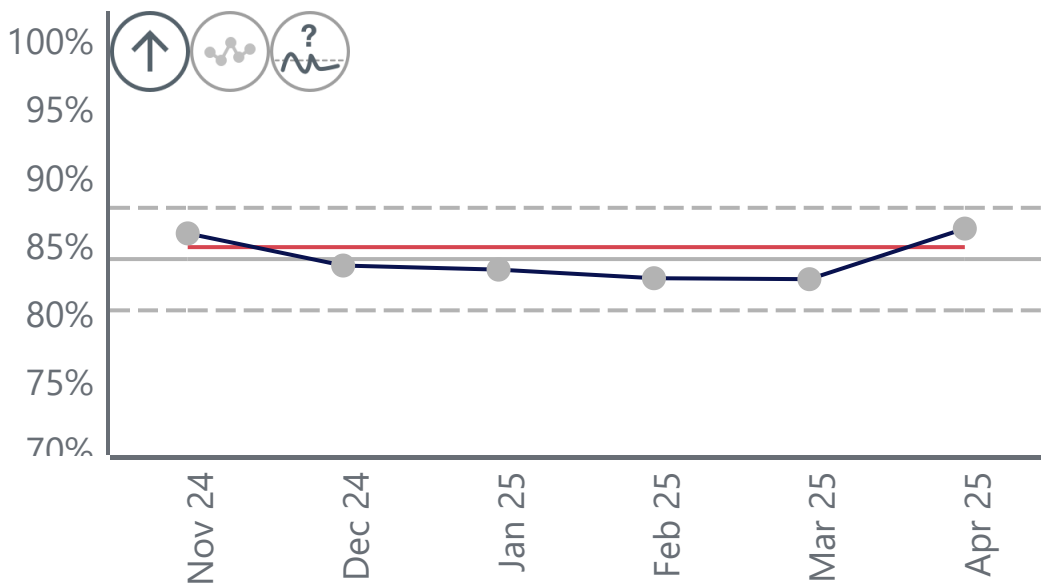
Sleep DNA Rate



Slot Utilisation



Theatre and Cath Lab Utilisation Combined



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 fairly 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.



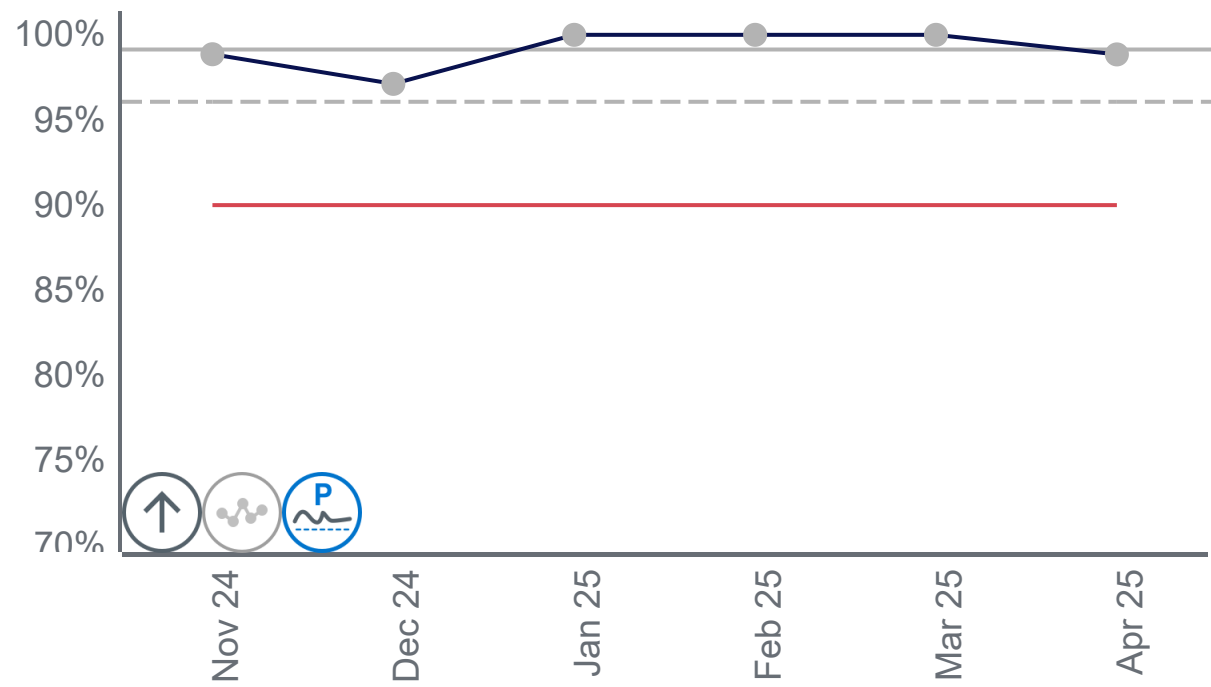
Quality of Care - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
% of radiological alerts with a response document	Apr-25	78.9	>=95%	78.9		
95% of all patients to receive a copy of their Discharge Summary on day of discharge	Apr-25	96.1	>=95%	96.1		
Clostridium Difficile	Apr-25	0.0	0	0.0		
Delirium Risk Assessment to be completed on Admission and once a day	Apr-25	99.6	>=90%	99.6		
Delivery of at least one sepsis antibiotic within one hour of prescription (LHCH target)	Apr-25	98.9	>=90%	98.9		
Dementia - Find	Apr-25	100	>=90%	100.0		
Gram Negative Bacteraemias	Apr-25	2	0	2.0		
Incidents - Serious incidents, Never Events, Adverse Events (Red)	Apr-25	0	0	0.0		
MRSA Bacteraemias	Apr-25	0	0	0.0		
MSSA Bacteraemias	Apr-25	1	0	1.0		
Number of Falls	Apr-25	13		13.0		
Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care)	Apr-25	0	<=0.5	0.0		
Number of LHCH acquired grade 3+ pressure ulcers (due to lapses in care)	Apr-25	0.0	<=0	0.0		
Nutrition - Patients scoring high risk (2 or more) are referred to dietician	Apr-25	93.75	>=90%	93.8		
Occurrence of any Never Events	Apr-25	0.0	0	0.0		
Primary PCI - 60 minute 'Door-to-balloon' (national target)	Apr-25	73.5	>=75%	73.5		
Primary PCI - 150 minute 'Call-to-balloon' (national target)	Apr-25	73.1	>=95%	73.1		
Quantity of complaints	Apr-25	2	<=6	2.0		
Venous thromboembolism (VTE) risk assessment	Apr-25	93.3	95%	93.3		
Number of Incidents No Harm and Near Miss	Apr-25	112	143	112.0		
Number of Incidents rated Minor Harm or Above	Apr-25	24	25	24.0		
FFT: REPUTATION	Apr-25	98.0	>=95%	98.0		
FFT: AFTER STAY	Apr-25	96.4	>=95%	96.4		
FFT: ARRIVAL	Apr-25	100.0	>=90%	100.0		
FFT: PATIENT CONTRACT	Apr-25	99.4	>=95%	99.4		
FFT: STAY	Apr-25	100.0	>=95%	100.0		
FFT: TREATMENT	Apr-25	98.9	>=90%	98.9		
Incident Closures within 28 days	Apr-25	51.0	0	51.0		
Surgical Site Infections	Feb-25	7.7	0%	7.1		



Quality of Care - Drive Metrics

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



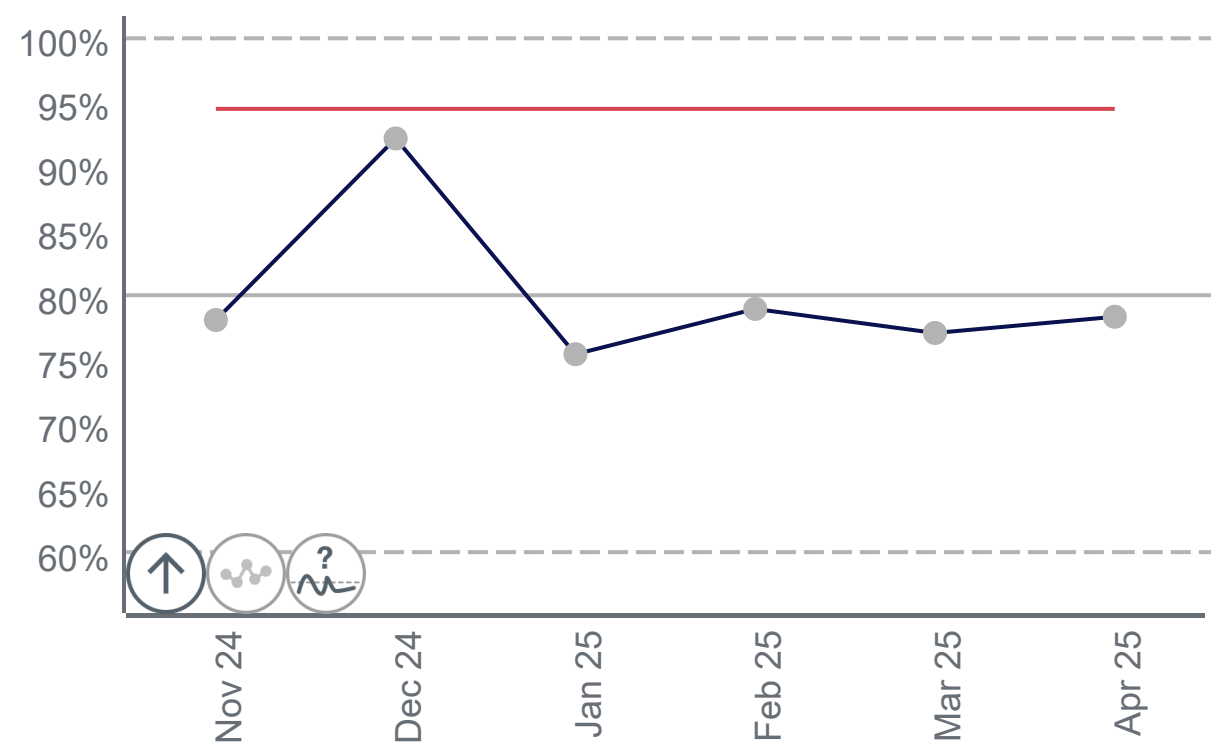
Technical Analysis:

Performance of the one hour Target remains above 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



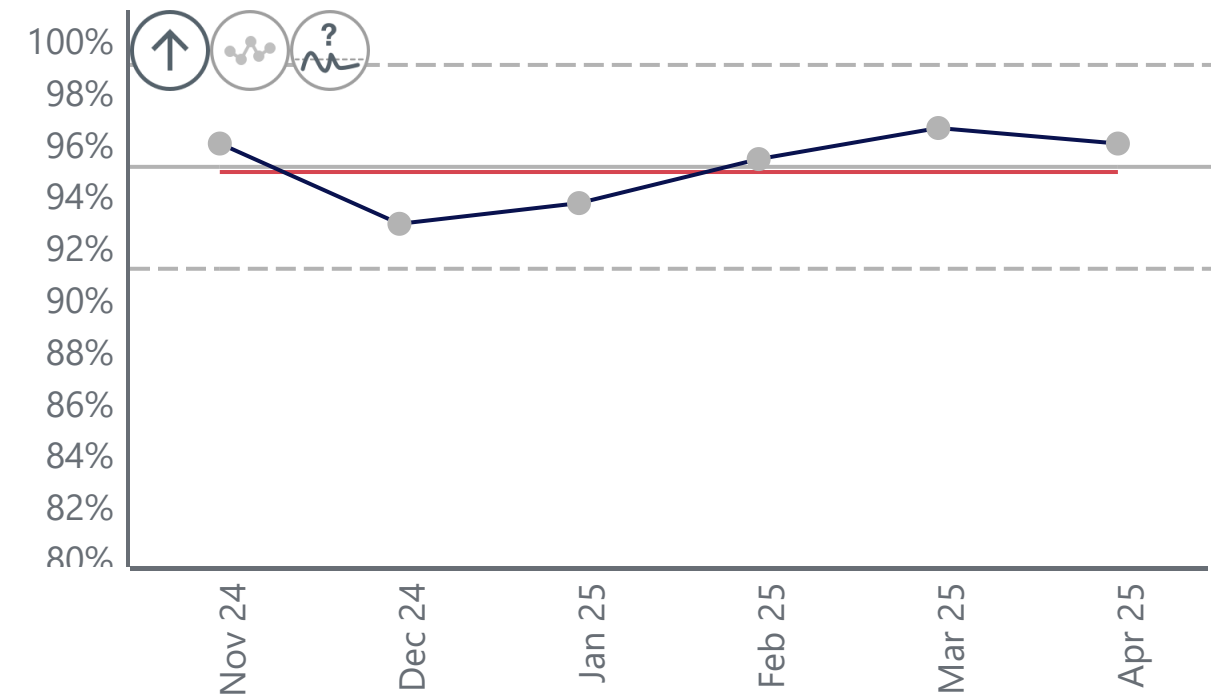
Technical Analysis:

April 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 April is above the target of 95% for the third consecutive month. Continual work required to consistently achieve target with the metric displaying inconsistency of passing and falling short of the target.

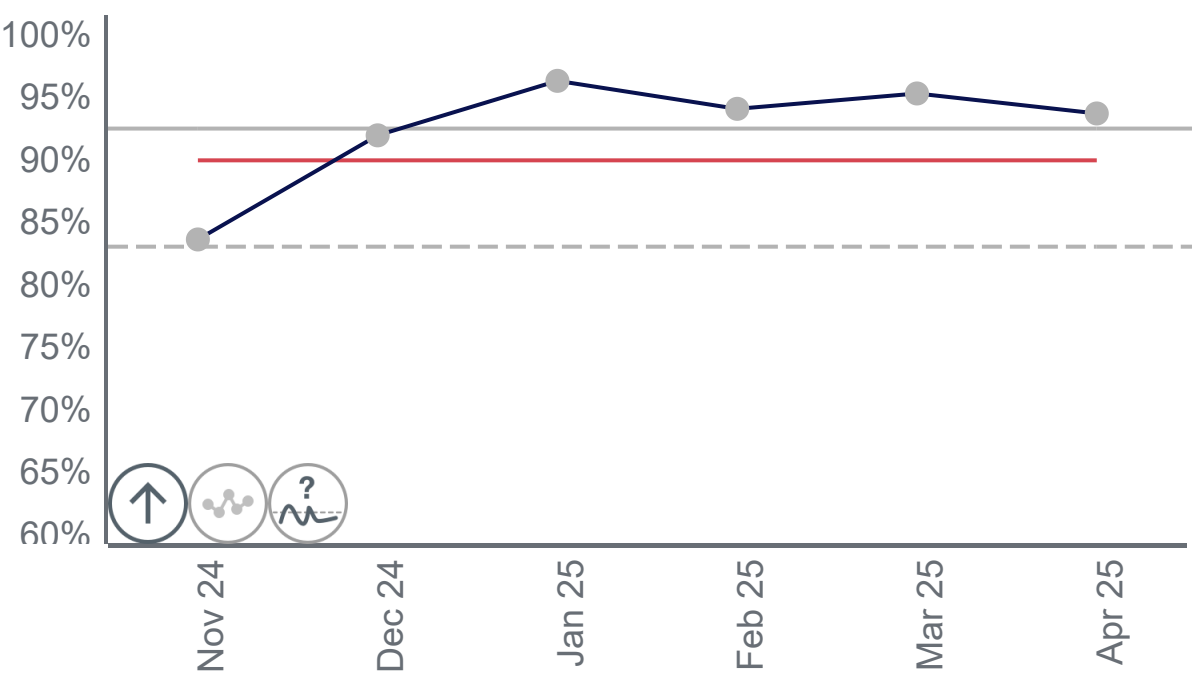
Actions:

Continued focus on keeping up recent improvement.



Quality of Care - Drive Metrics

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



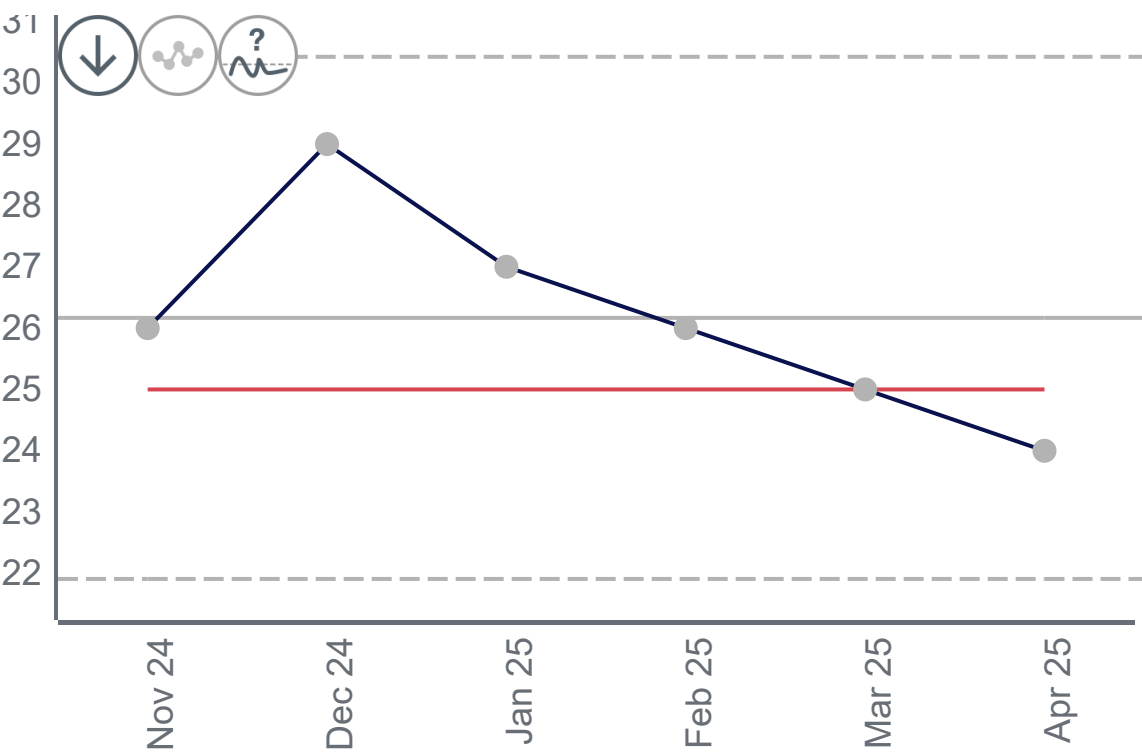
Technical Analysis:

Performance within April was 94%, 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. The target has been achieved across the last 5 months.

Actions:

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

Number of Incidents rated Minor Harm or Above



Technical Analysis:

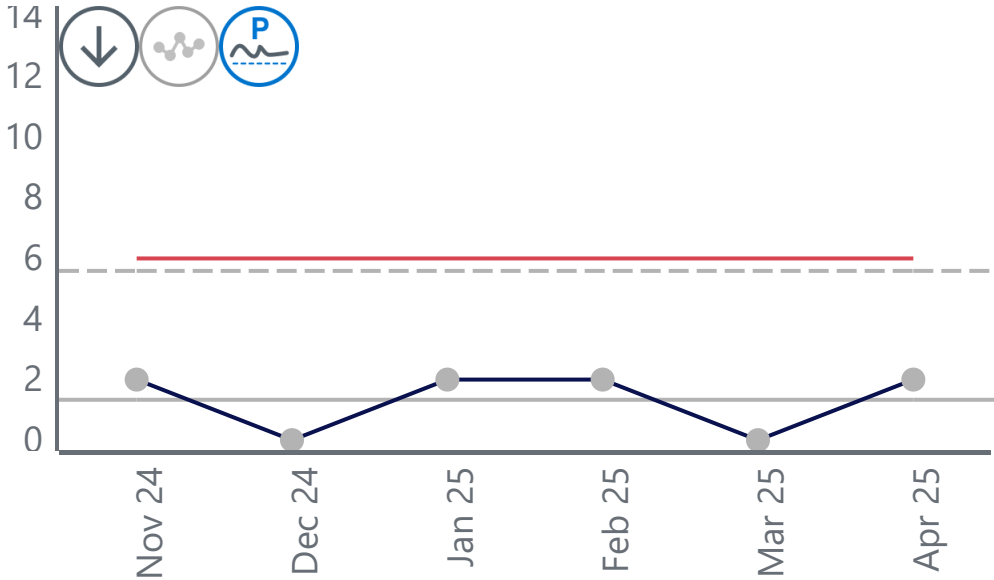
Performance is showing common cause variation of passing and failing the targeted. A period of increase in the number of Harms has shown a consistent reduction over the last 4 months. Further improvement required to consistently achieve the target.

Actions:

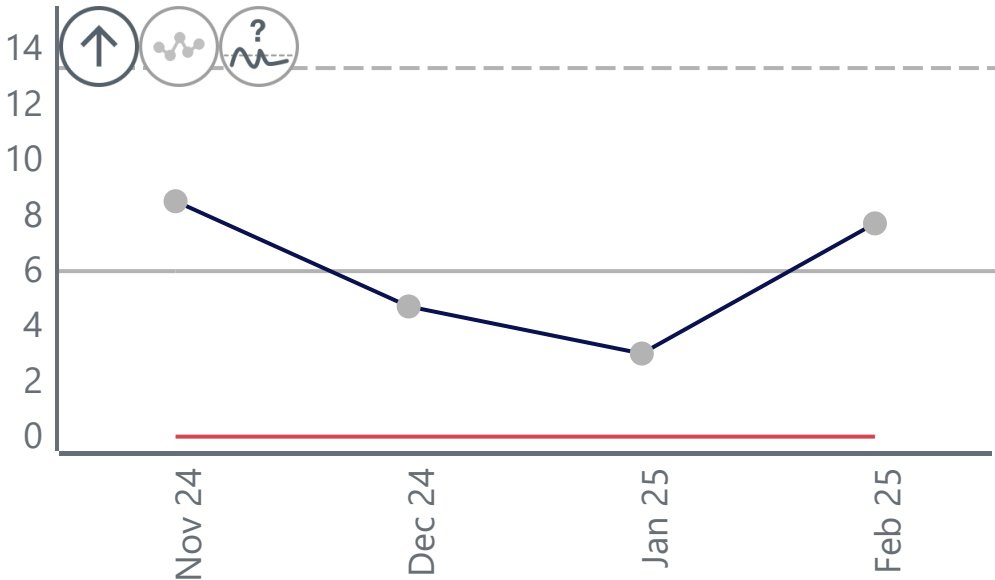
Strong reporting culture and learning from incidents. Reviews continue via safety surveillance and hasn't identified recurrent themes. A weekly patient safety meeting is now in place to review all moderate and above incidents, including action and learning. Further refinement of the KPI is needed and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

Quality of Care - Watch Metrics

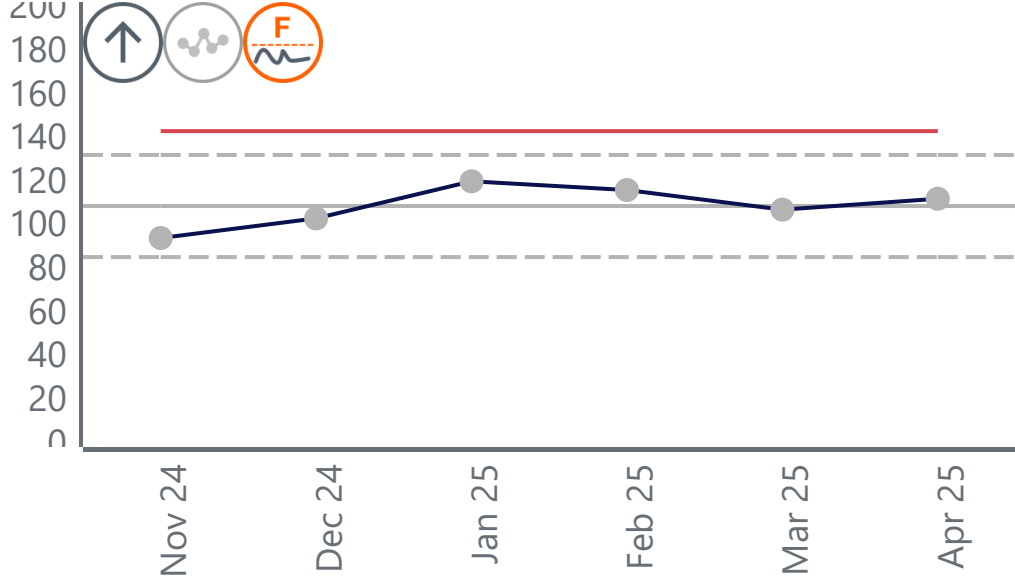
Quantity of complaints



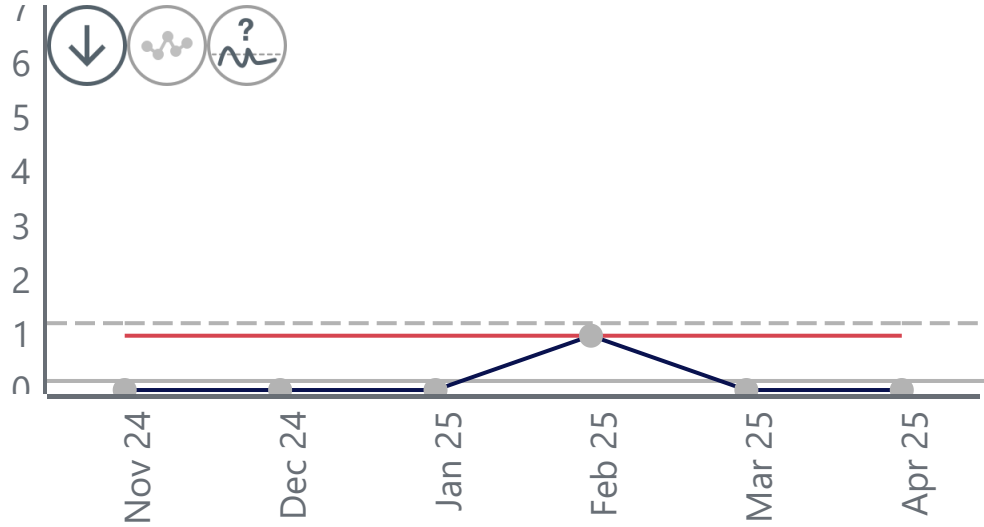
Surgical Site Infections



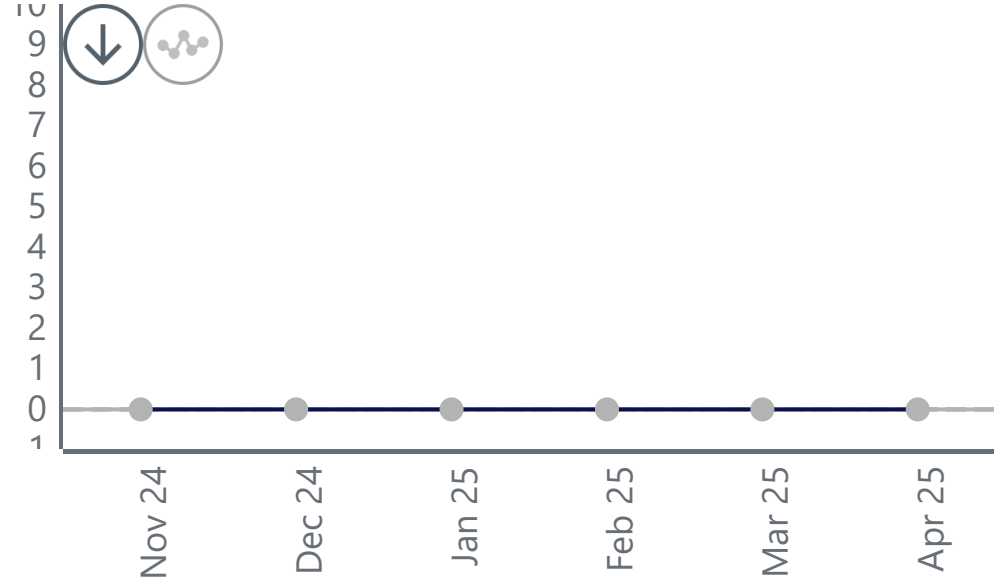
Number of Incidents No Harm and Near Miss



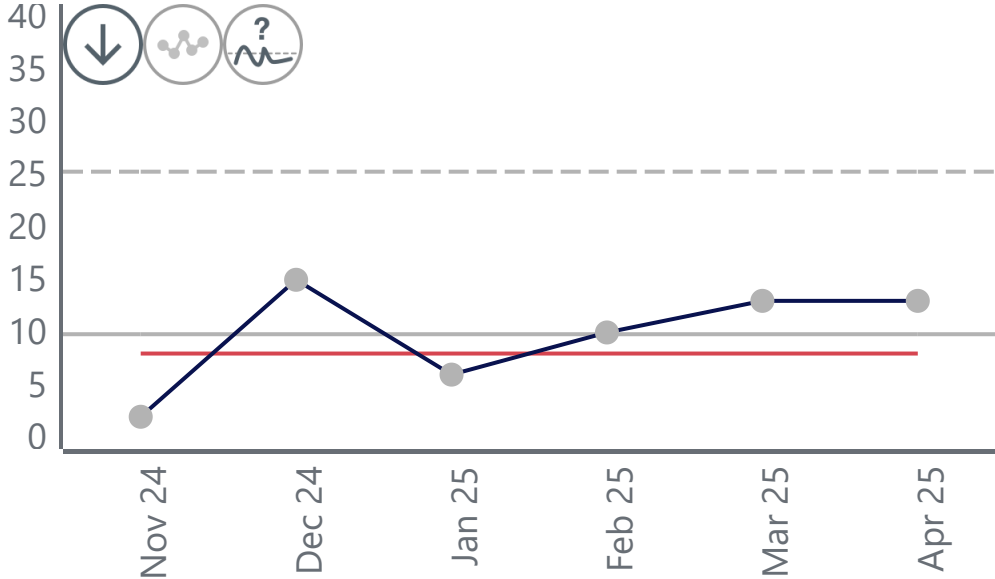
Incidents - Serious incidents, Never Events, Adverse Events (Red)



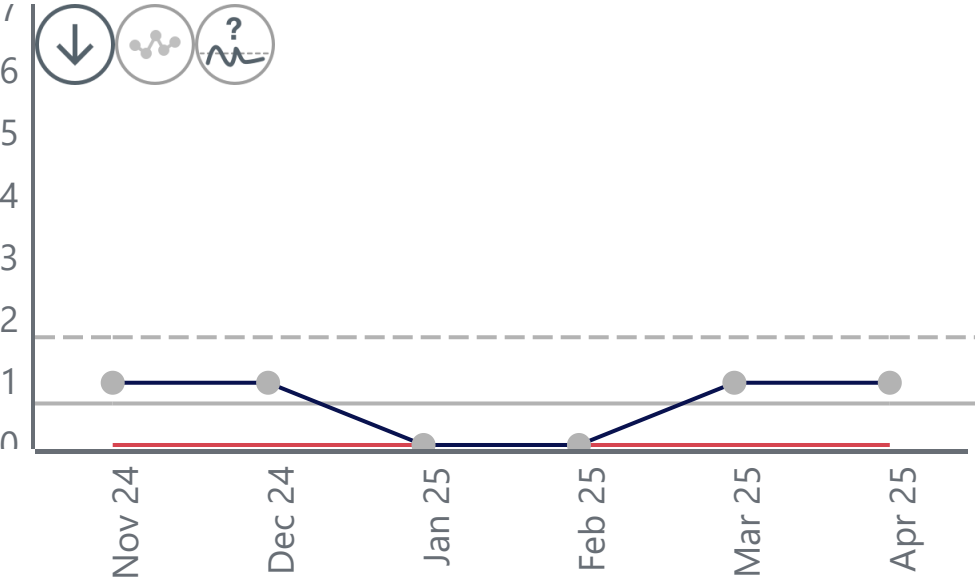
Occurrence of any Never Events



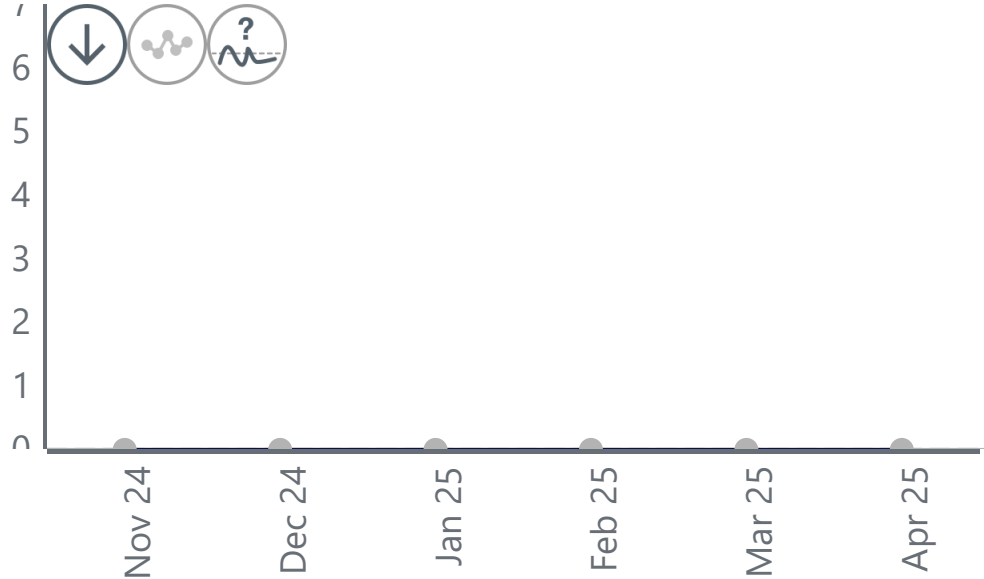
Number of Falls



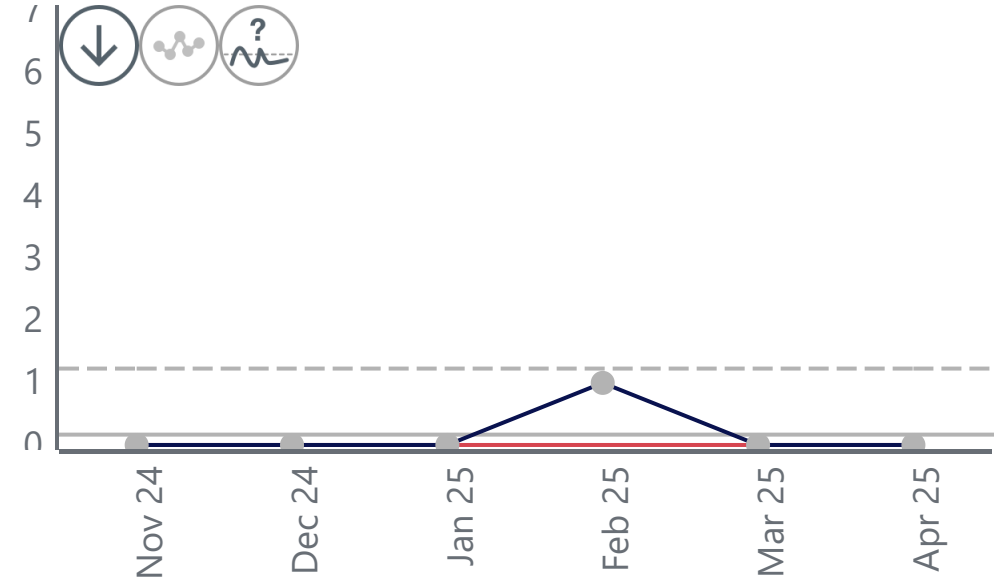
MSSA Bacteraemias



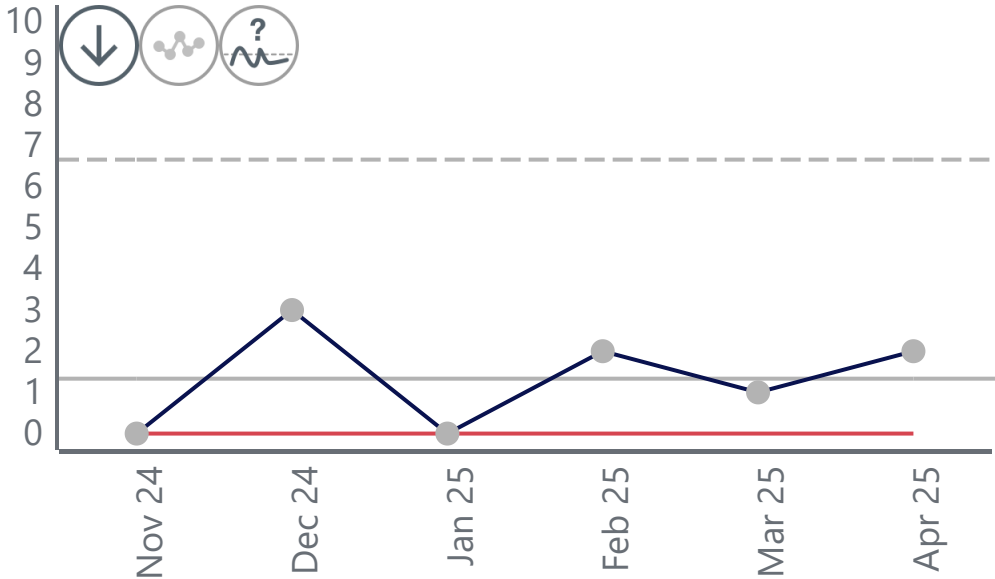
MRSA Bacteraemias



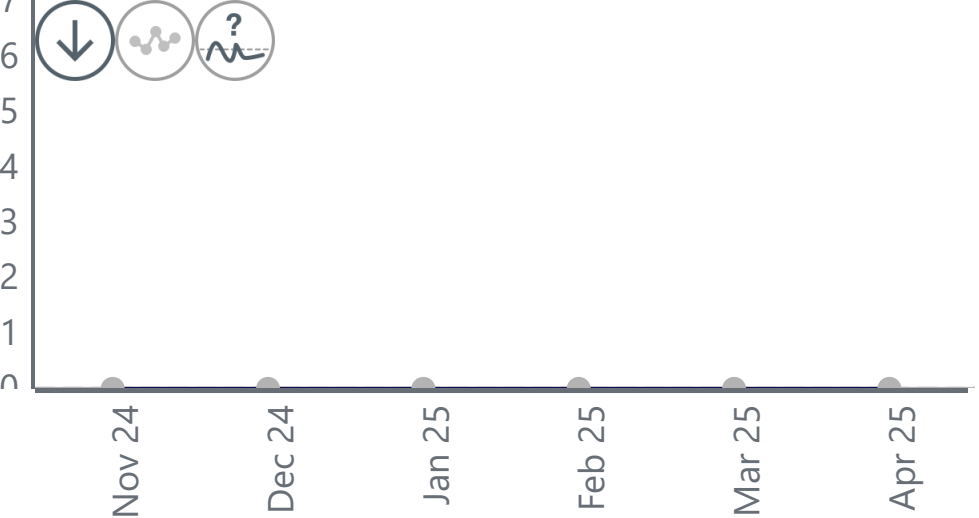
Clostridium Difficile



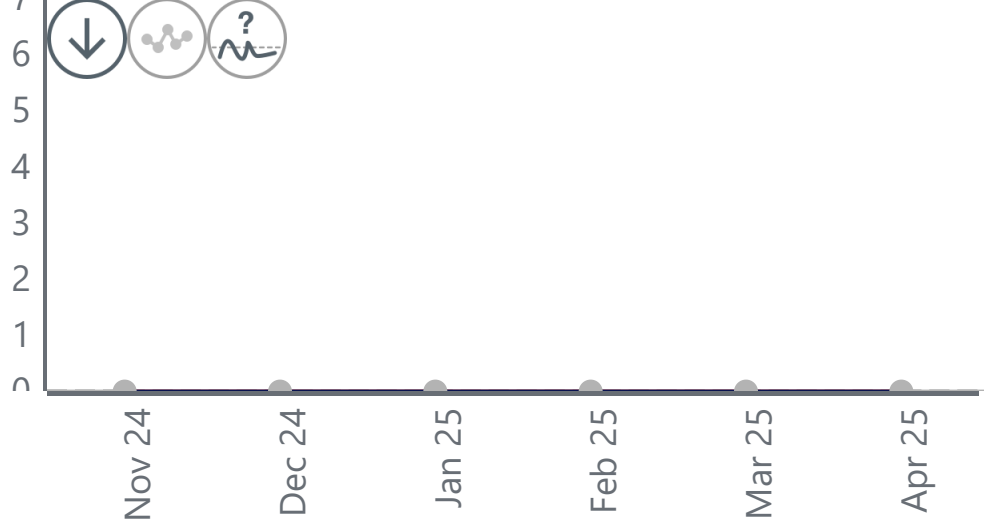
Gram Negative Bacteraemias



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

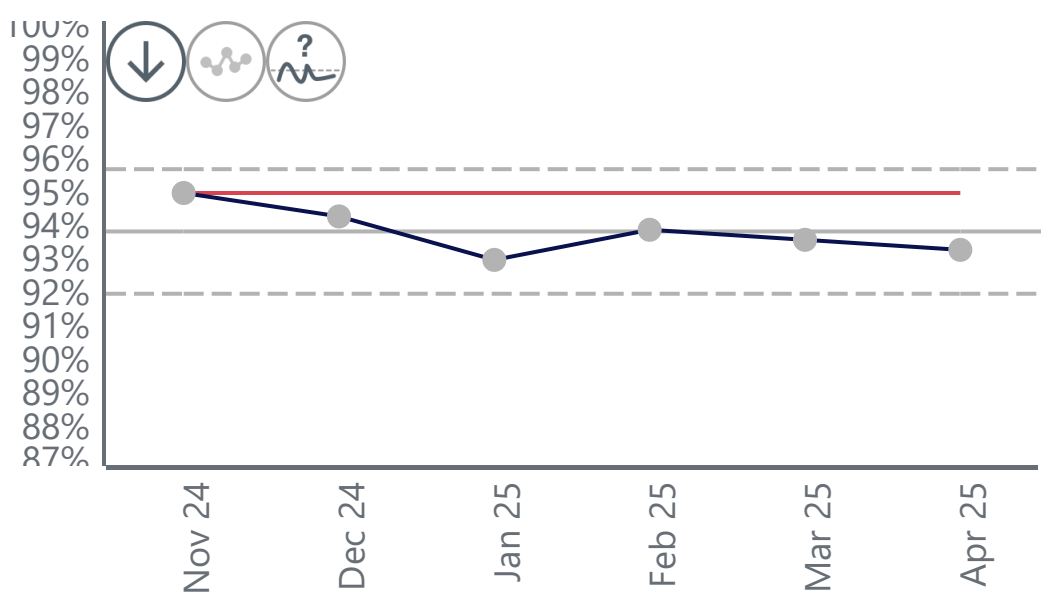


Number of LHCH acquired grade 3+ pressure ulcers (due to lapses in care)

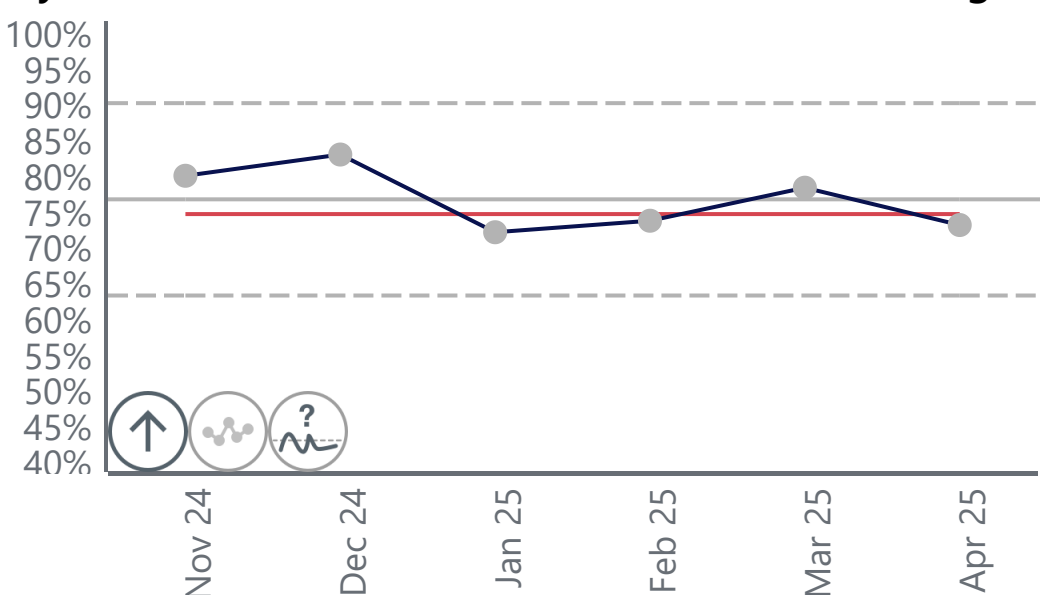


Quality of Care - Watch Metrics

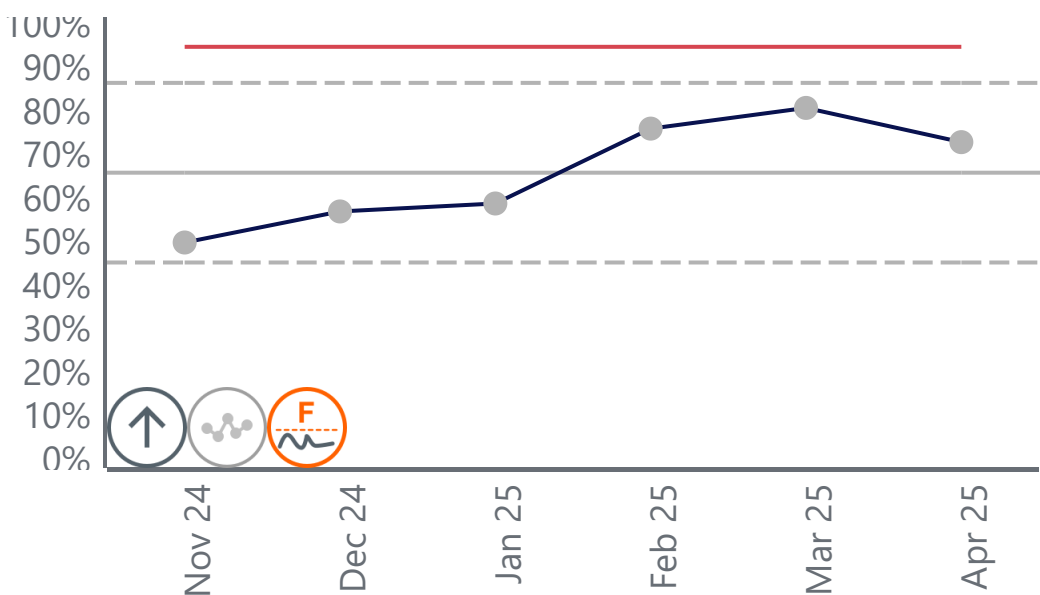
Venous thromboembolism (VTE) risk assessment



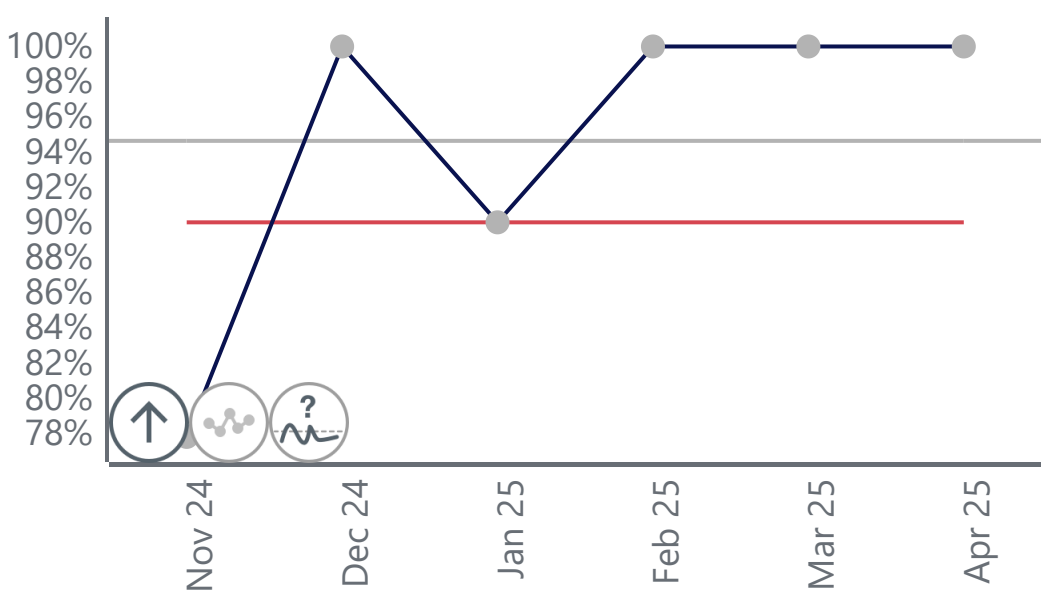
Primary PCI - 60 minute 'Door-to-balloon' (national target)



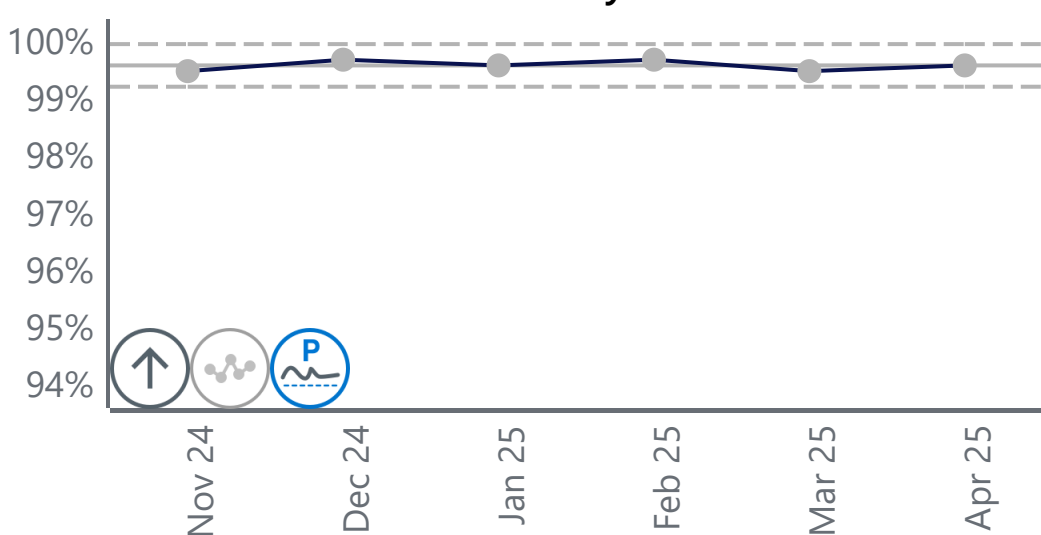
Primary PCI - 150 minute 'Call-to-balloon' (national target)



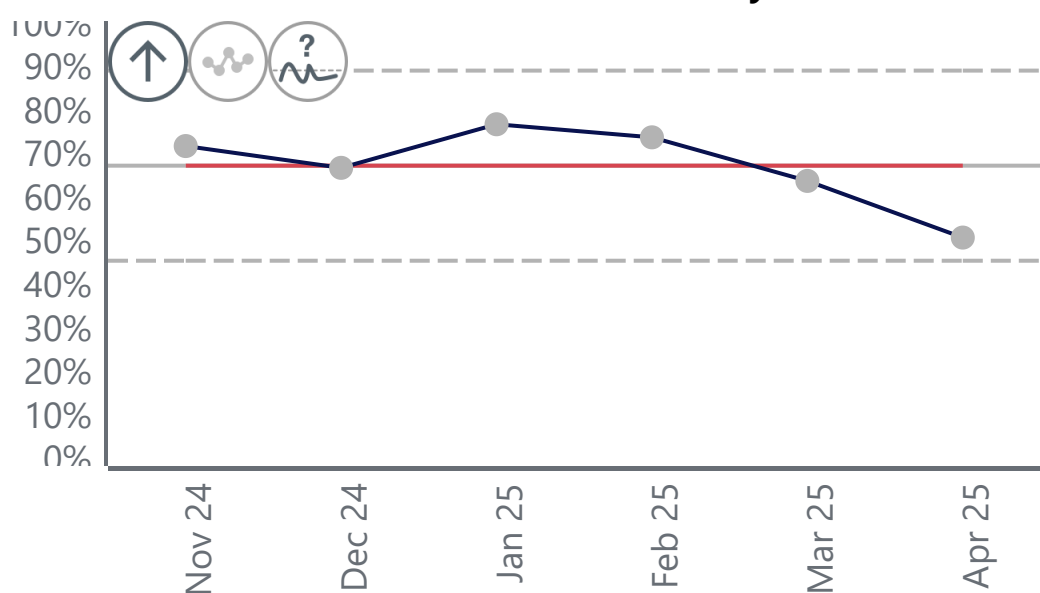
Dementia - Find



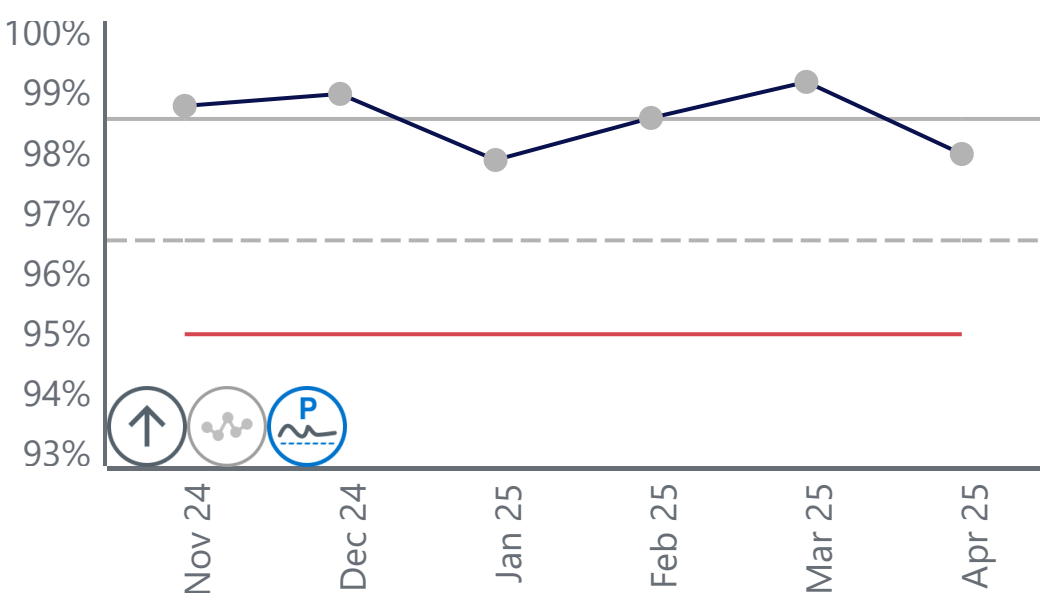
Delirium Risk Assessment to be completed on Admission and once a day



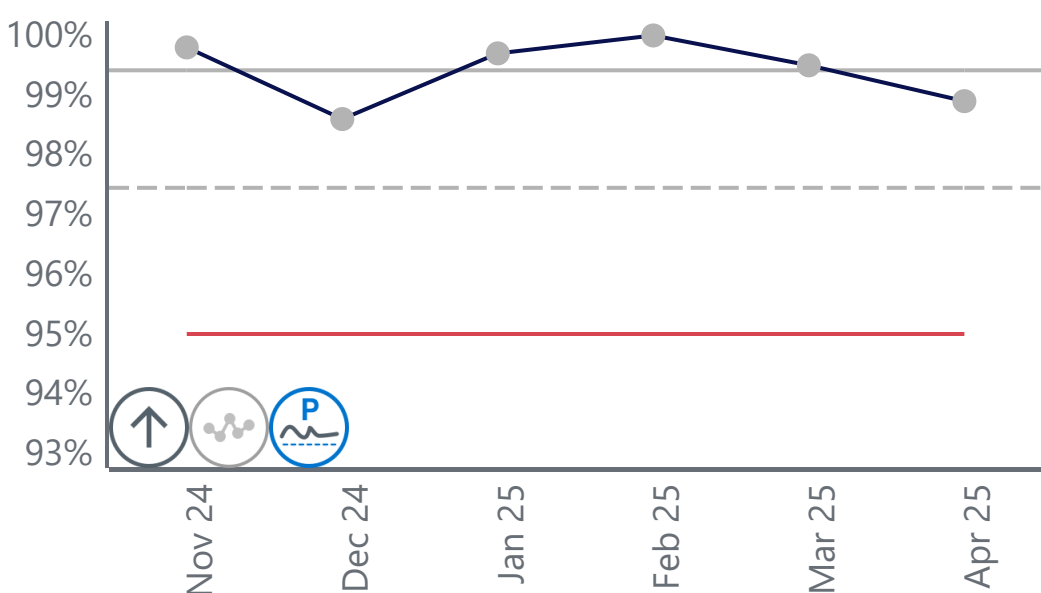
Incident Closures within 28 days



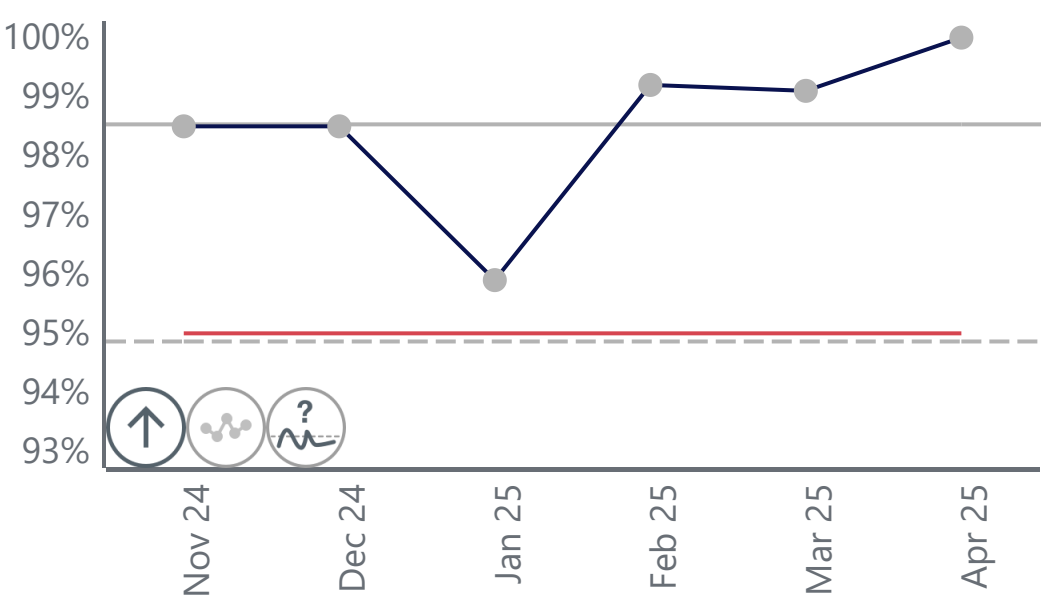
FFT: REPUTATION



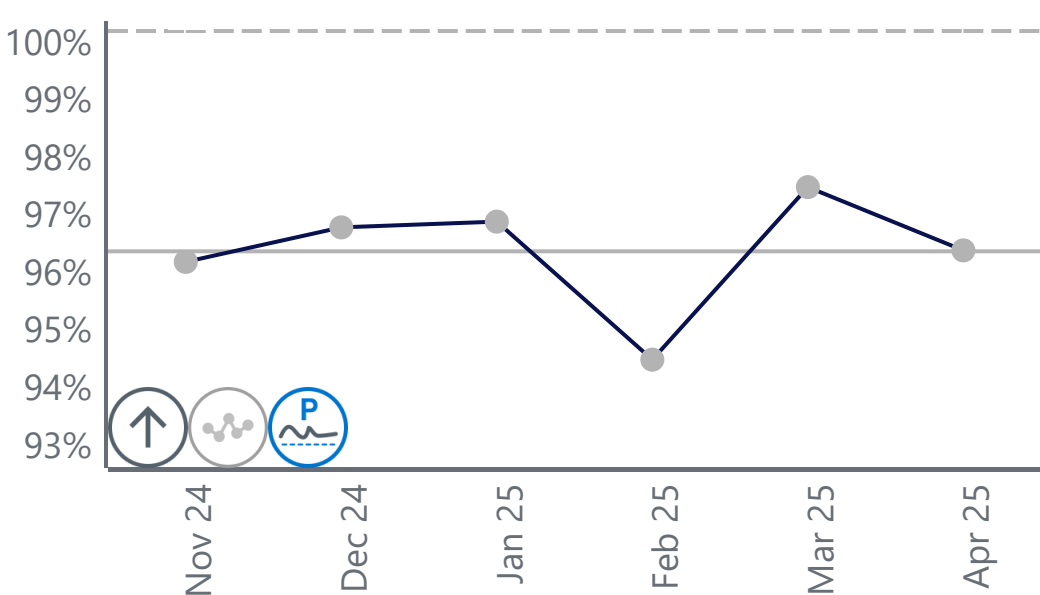
FFT: TREATMENT



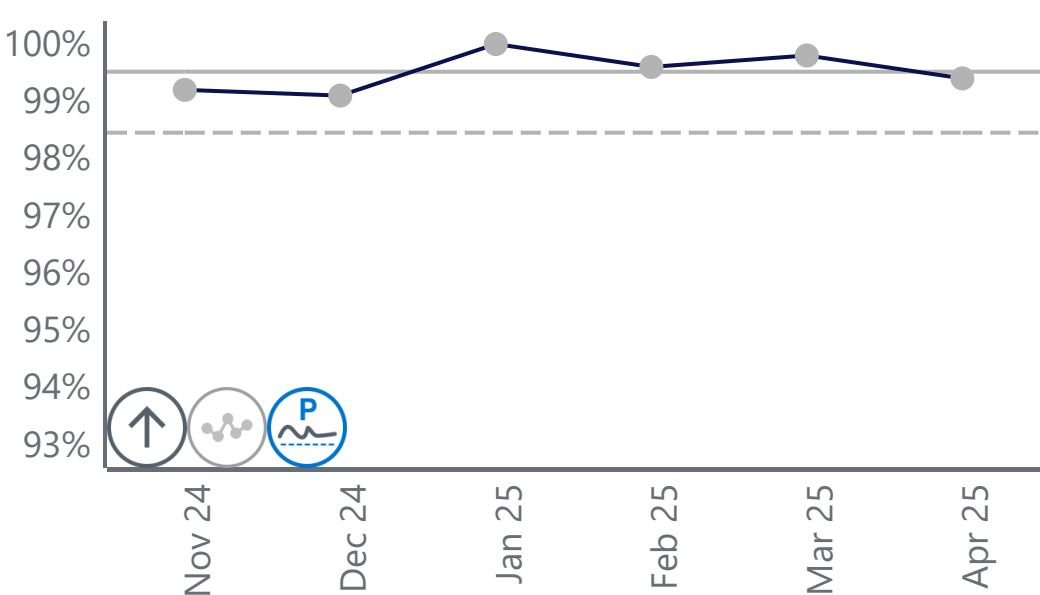
FFT: ARRIVAL



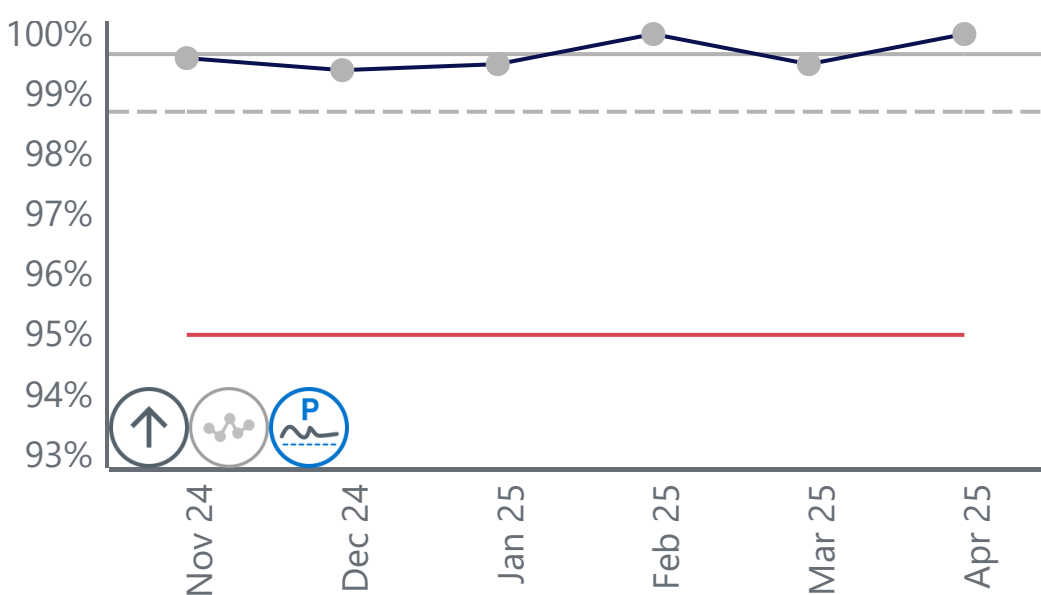
FFT: AFTER STAY



FFT: PATIENT CONTRACT



FFT: STAY



Finance

SRO: James Thomson, Chief Finance Officer

Highlights:

Month 1 financial performance matches to the plan (£579k surplus).  
There were a number of shortfalls in income, most notably IOM, Private Patients and income for Wales. Income for the core contracts with Spec Comm and the ICB have been matched to plan.  
A shortfall in CIP delivery was the largest budgetary pressure in month 1, with very little divisional CIP transacted. Confirm and Challenge sessions have been held with each division, and improvements are scheduled for month 2.  
- 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 of £0.7m in April. The annual target for the Trust is £13.5m.  
The divisional CIP targets are significantly higher than previous years in response to the additional stretch across the system and higher efficiency targets across the wider NHS. The central Trust CIP schemes have all been transacted, but divisional performance will need a marked improvement in order to recover the shortfall in month 1, and keep up with the targets in future months.  
The investment in cath lab 7 is predicated on additional income from commissioners. The ICB have added a portion of the income needed to the contract, but Specialised Commissioning is yet to commit to the additional activity. This remains a risk, and has been raised through contract meetings, and activity projections shared with commissioners.  
Emergency surgery continues to be a risk, with the knock-on impact of reduced elective activity and income.






Forward Look (with actions):

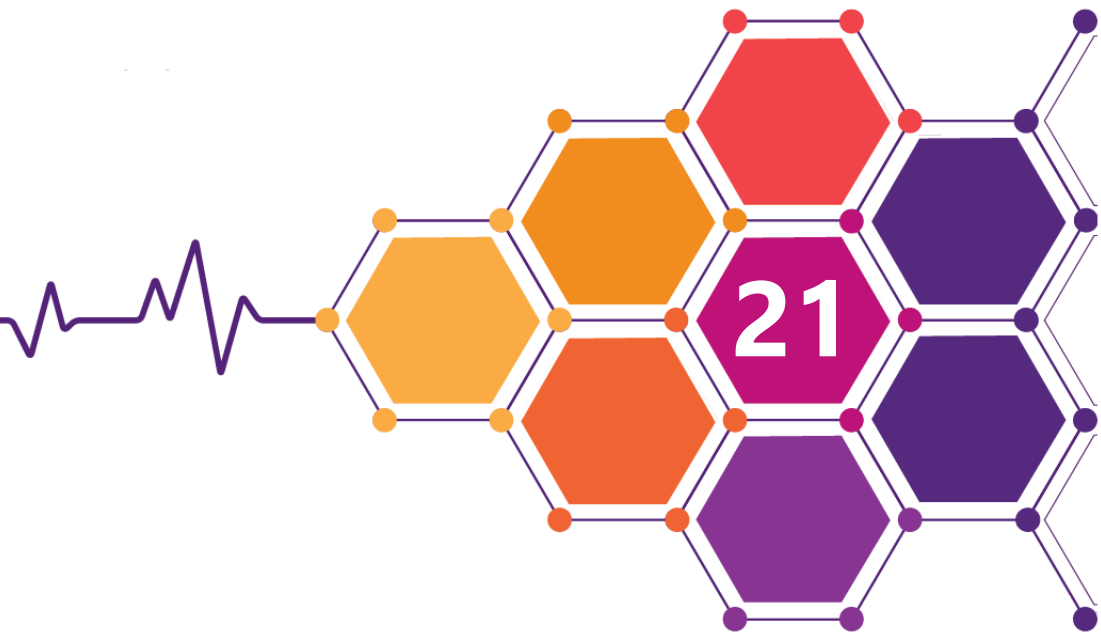
The Trust has a challenging financial target, with a planned surplus of £9.6m.  
  
Achievement of the surplus is dependent on delivering a larger CIP programme than previous years, and the careful management of other cost pressures and risks. The Trust has amended its governance programmes to respond to the challenge, with a larger focus on cross-divisional CIP schemes. A heightened focus on CIP delivery and cost control is in place across the system.



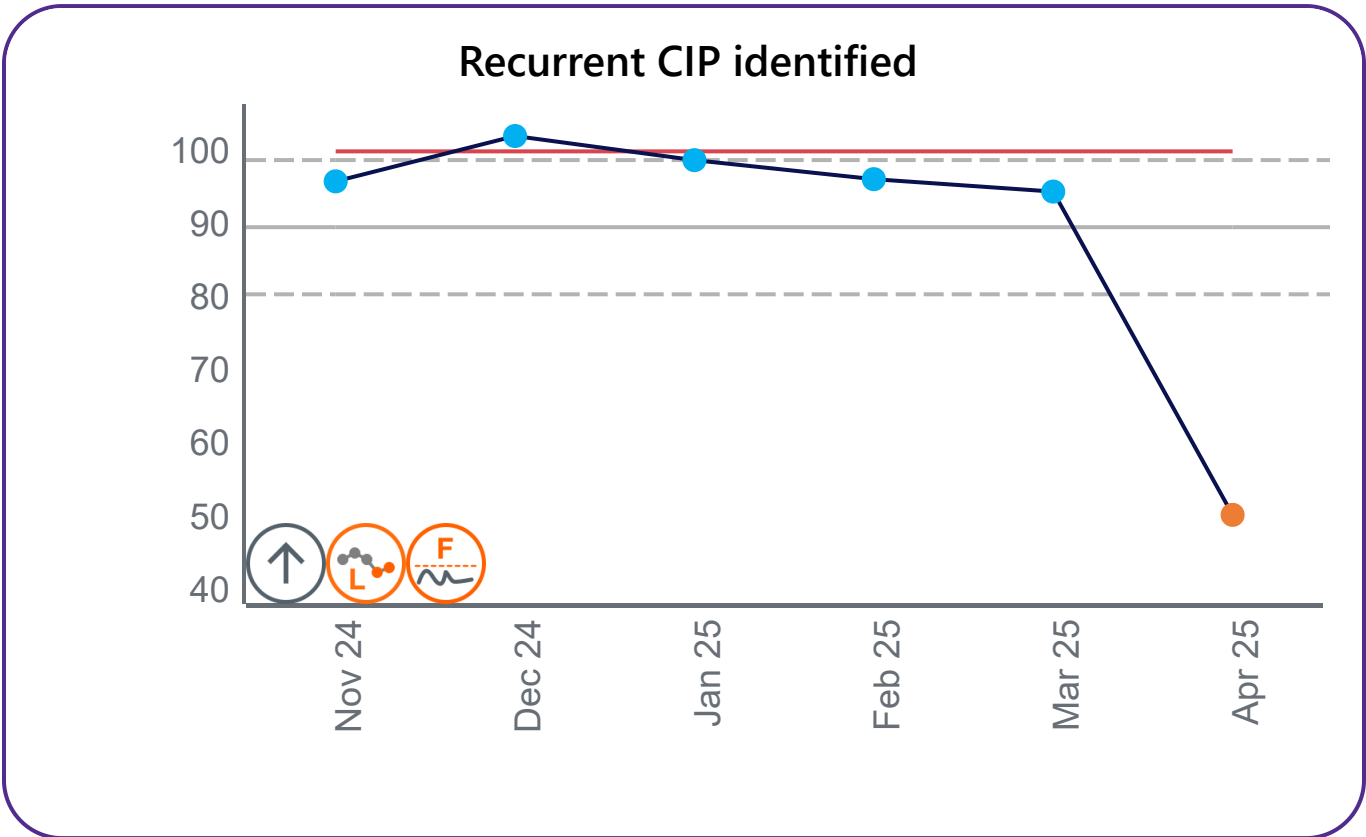


Finance - Metric Summary

Metric Name	Month	Performance	Target	Average / Cumulative	Variation	Assurance
I & E distance from target (cumulative) - £,000	Apr-25	579	0	579		
Liquidity (days)	Apr-25	39		39		
Recurrent CIP identified	Apr-25	50	100	50		
Capital Expenditure (Trust Level)	Apr-25	199000.0	844000	199000.0		
Cash in Bank (Trust Level)	Apr-25	49923000		49923000		
Pay Spend v Budget	Apr-25	10306	10495	10306		
WTE vs Workforce Plan	Apr-25	1967	1898	1967		

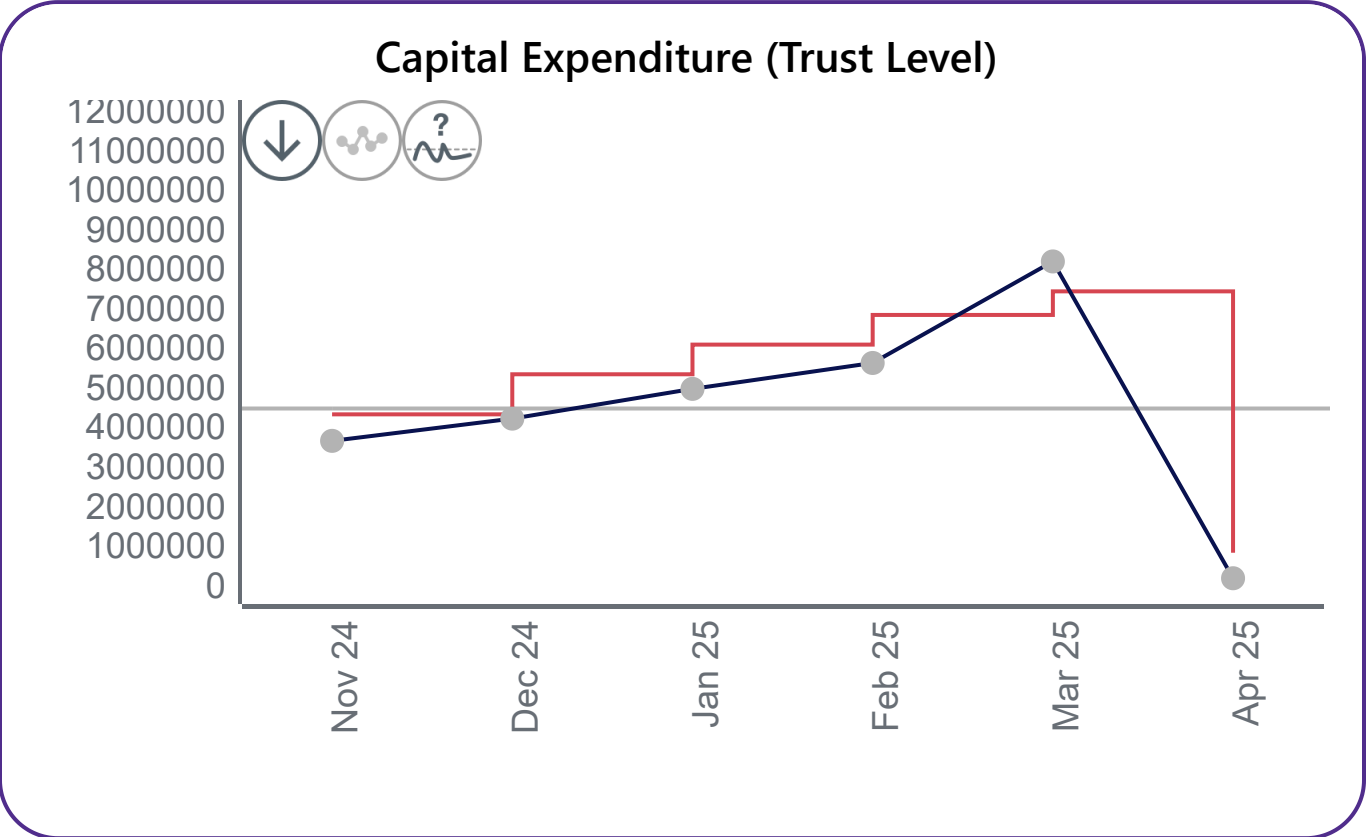


Finance - Drive Metrics



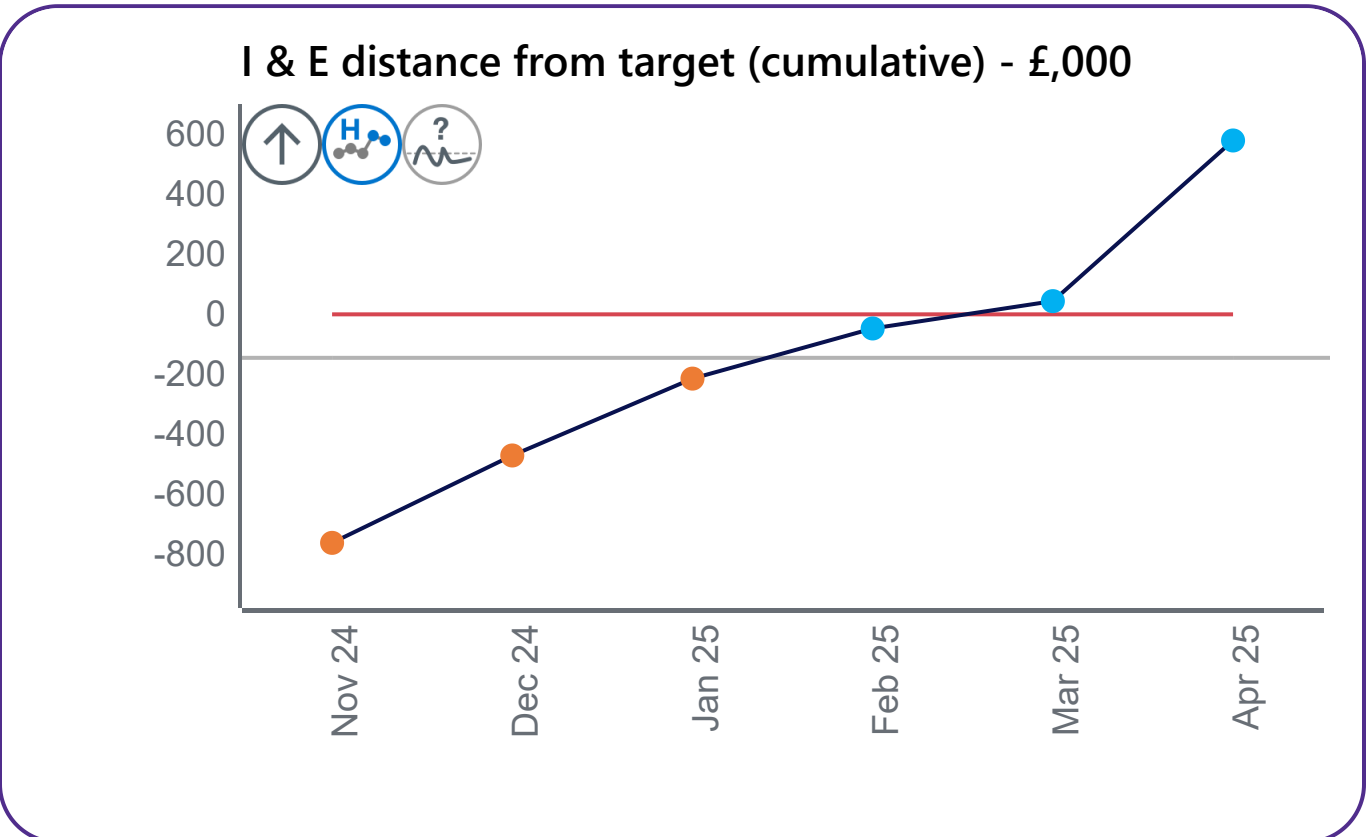
**Technical Analysis:**  
CIP is currently falling short as the trust opens up on 2025/26. Significant work required to work towards achieving the target.

**Actions:**  
Monthly monitoring of progress through gateways and identification of schemes against the target is in place. Trust wide CIP workshop held in February. Revised transformation projects and governance arrangements to support delivery. Confirm and challenge sessions have been held and are scheduled.



**Technical Analysis:**  
Expenditure is displaying common cause variation within performance across the last 6 months as the trust commences into 2025/26.

**Actions:**  
Capital commitments are monitored by the Capital Management Group. Capital spend in 2025/26 is consistent with the capital funding allocation agreed with the ICB.



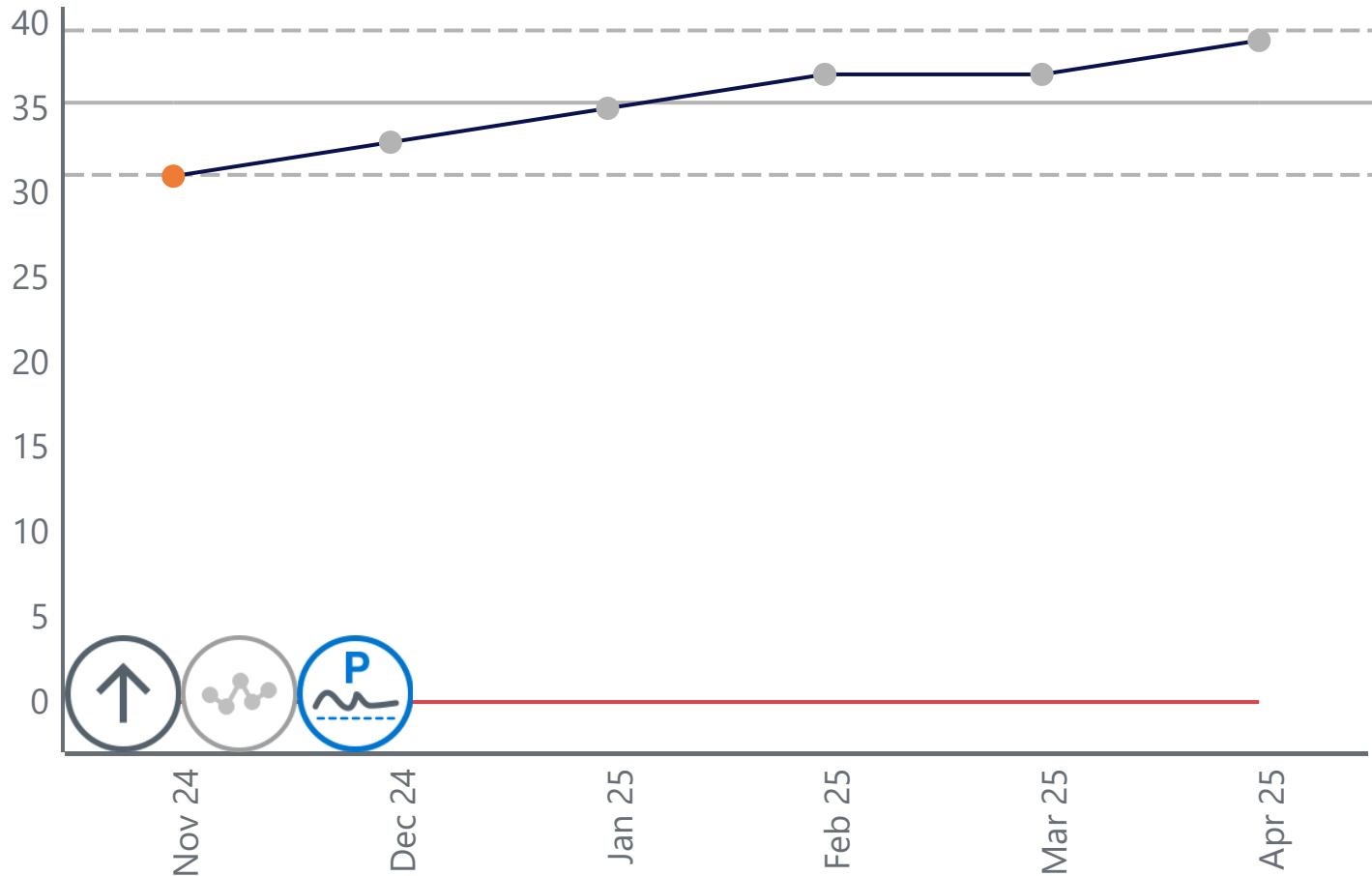
**Technical Analysis:**  
Performance is displaying special cause improvement with the target being met within April 2025.

**Actions:**  
The Trust needs to expedite CIP delivery to ensure it remains on track to deliver the planned surplus. Management of other risks, most notably delivering, and being paid for, elective activity.

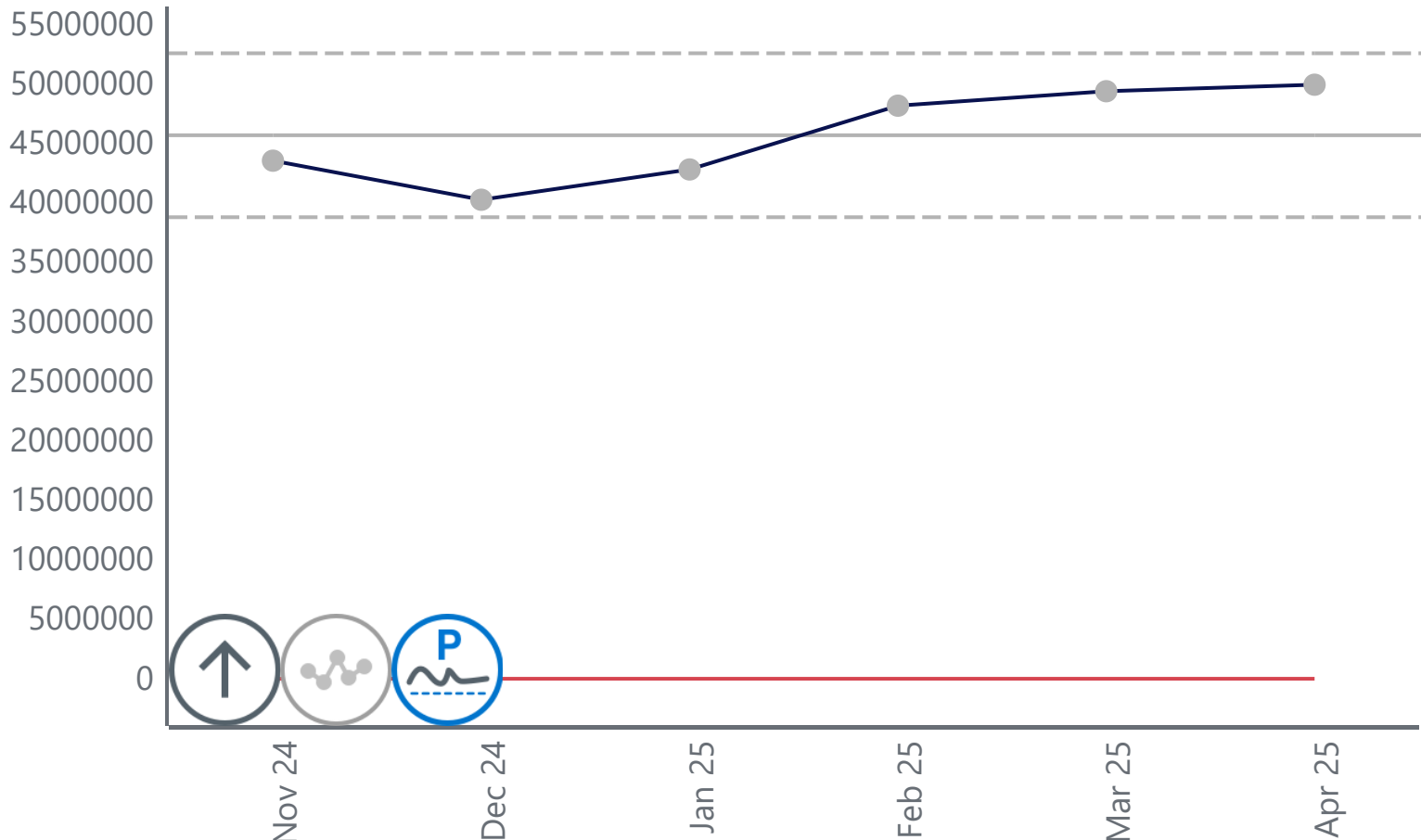


Finance - Watch Metrics

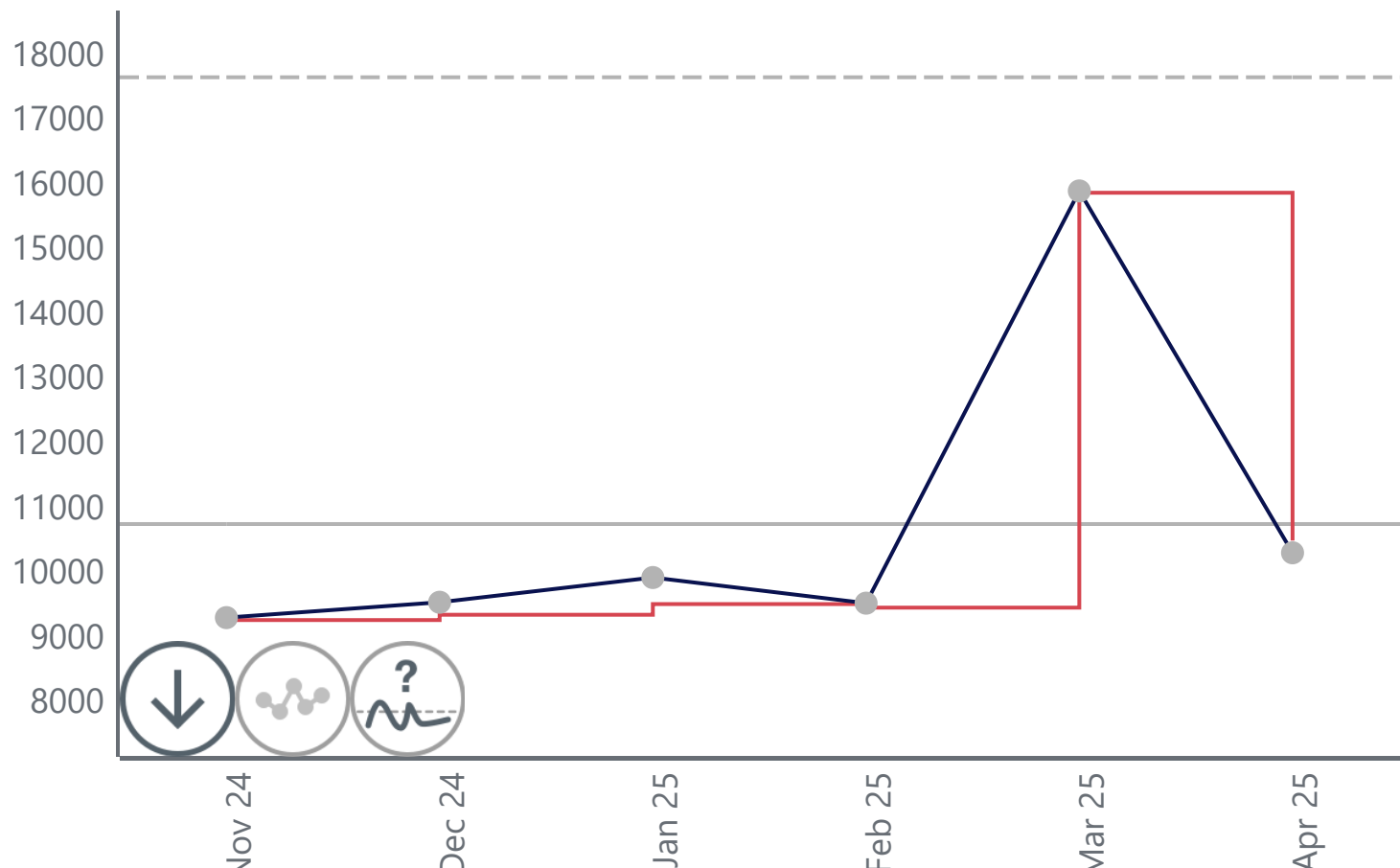
Liquidity (days)



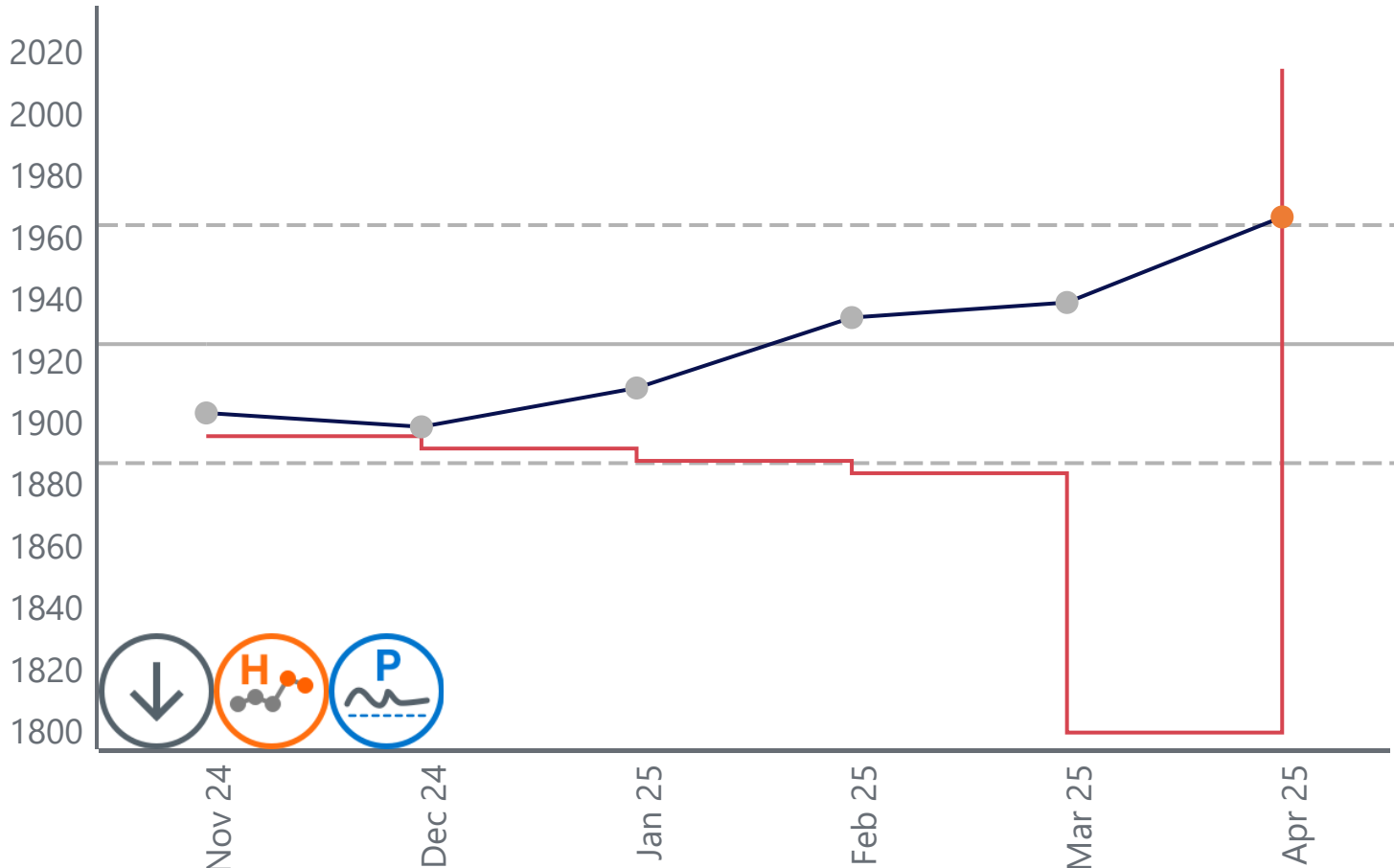
Cash in Bank (Trust Level)



Pay Spend v Budget



WTE vs Workforce Plan



People

SRO: Jane Royds, Chief People Officer

Highlights:

We continue to see positive progress in key workforce metrics, with a sustained reduction in turnover and a favourable variance in both bank and agency usage and spend. These improvements reflect ongoing efforts to stabilise the workforce and manage resources more effectively.

As part of the governance cycle, each division has now presented its Staff Survey Action Plan to the People Delivery Group. These presentations demonstrated a strong understanding of local survey results and outlined clear, targeted actions to support improvement.

We are also in the final stages of preparation to launch the 2024/25 appraisal window on 1st May, supporting our focus on performance and development.

Areas of Concern:

The Trust’s sickness absence rate has remained relatively stable from March to April, with a slight increase of 0.02%. The balance between long-term and short-term sickness, with a decrease in long-term cases and a modest increase in short-term cases, suggests that there are no drastic shifts but highlights areas for further attention, particularly in managing gastrointestinal and musculoskeletal issues.

The increase in musculoskeletal cases warrants further exploration, as it may indicate a trend that could require targeted interventions or preventive measures. Additionally, the rise in short-term sickness due to gastrointestinal problems highlights a need for ongoing vigilance and possibly tailored support for staff facing these health challenges.

Robust monthly reporting of all sickness absence remains in place. Continued efforts are being made to ensure that managers feel confident and competent in managing sickness absence while providing appropriate support to staff. In line with the ratification of the new Managing Attendance Policy, the HR team will be delivering bitesize training sessions over the coming weeks which will allow for further support for managers to help them navigate complex cases.

Compliance declined in the Corporate Division is largely due to the recent integration of the Digital Systems Team who joined the Trust in April. Not all their training records have been automatically matched with our compliance system. We expect a significant improvement in this area next month as data reconciliation progresses.

Forward Look (with actions):











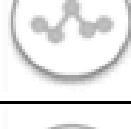







Planning is underway for our next Live Well, Work Well event this summer, with a focus on supporting staff health and wellbeing.

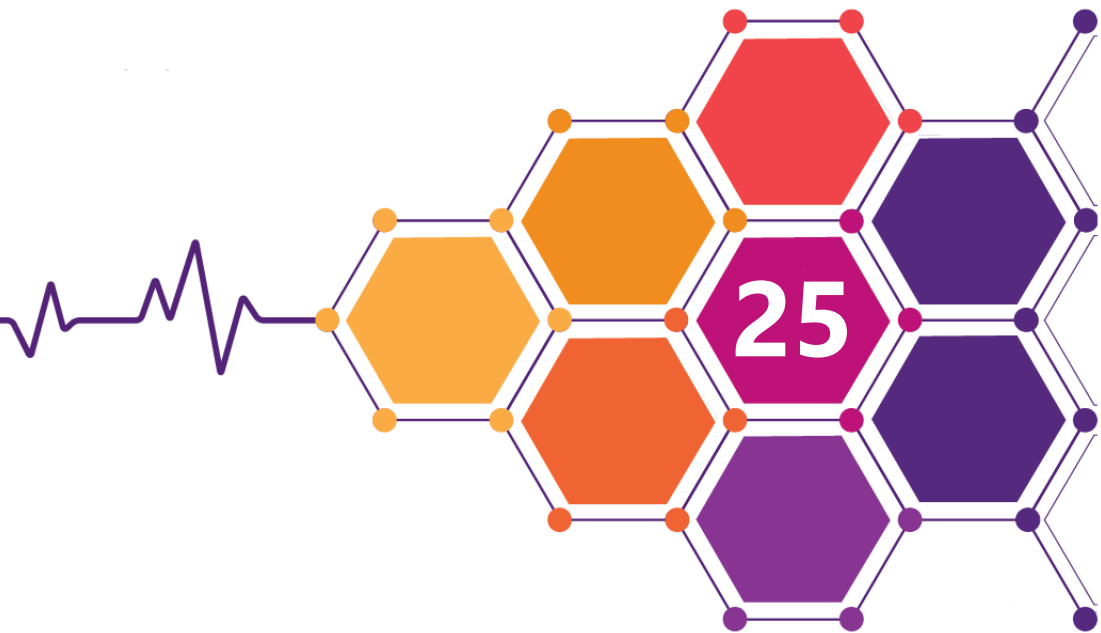
The launch of the appraisal window is planned for 1st May 25.





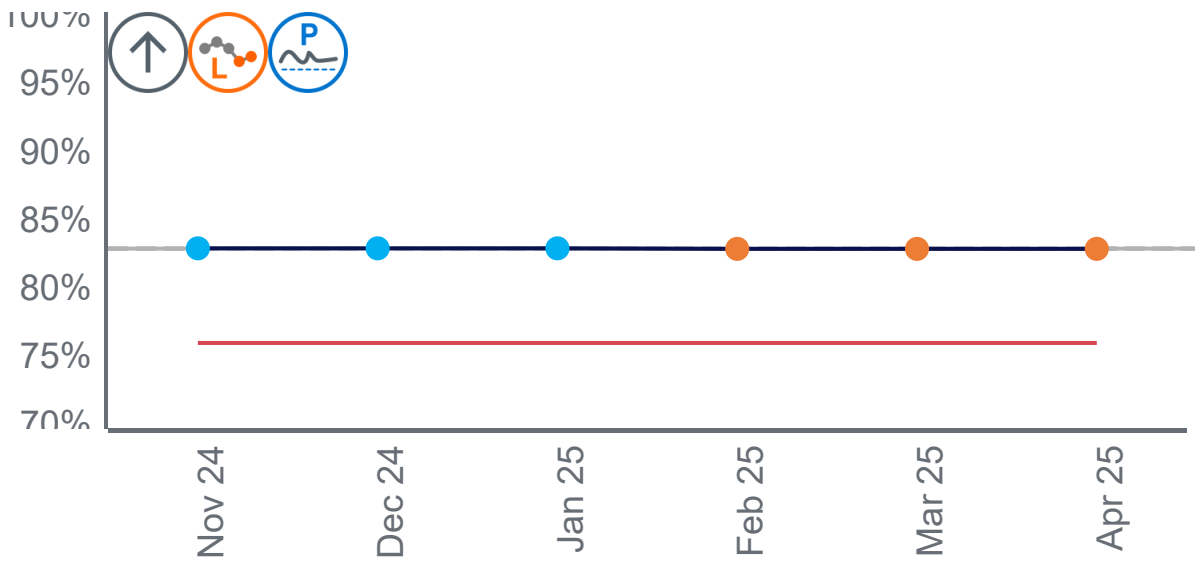
People - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
Appraisals Compliance	Apr-25	81.9	>=90%	81.9		
Mandatory Training Compliance	Apr-25	94.3	>=95%	94.3		
NHS Staff Survey - Staff recommendation of the organisation as a place to work	Apr-25	82.9	>=76%	82.9		
Staff Turnover	Apr-25	7.9	<=10%	7.9		
Staff Sickness (All Staff)	Apr-25	4.88	<=4.5%	4.9		
Long Term Sickness	Apr-25	2.88	<=4.5%	2.9		
Short Term Sickness	Apr-25	2	<=4.5%	2.0		
EDI: Bullying and Harassment of Staff by Patient and Relatives	Apr-25	11.5		11.5		
EDI: My Organisation Treats me fairly	Apr-25	68.8		68.8		



People - Drive Metrics

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



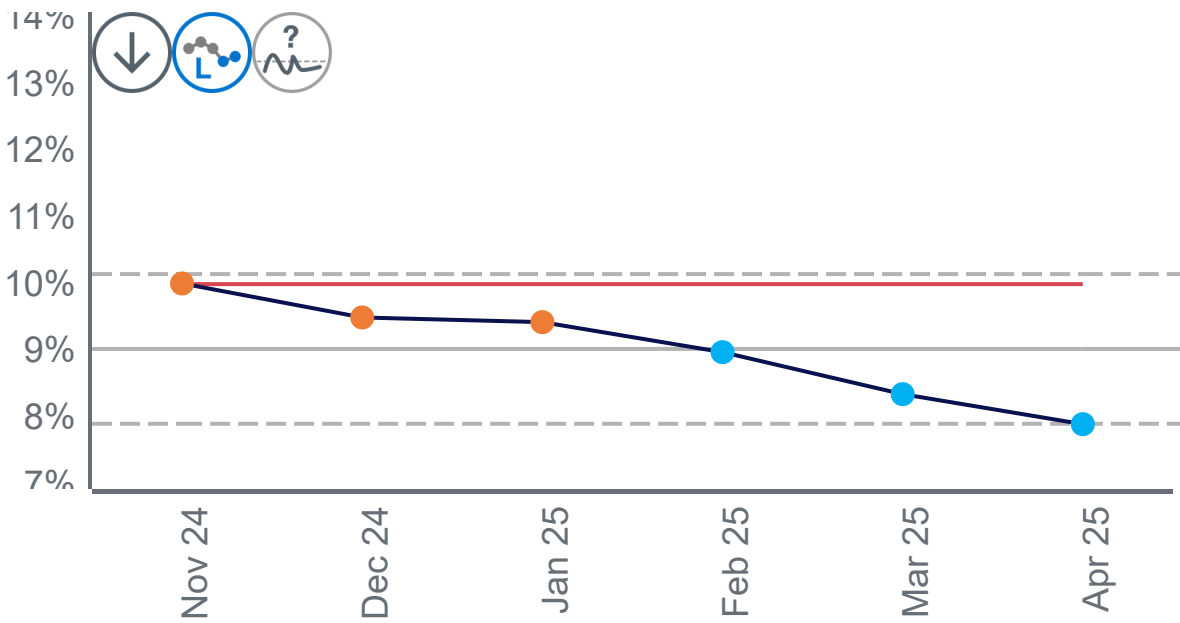
Technical Analysis:

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



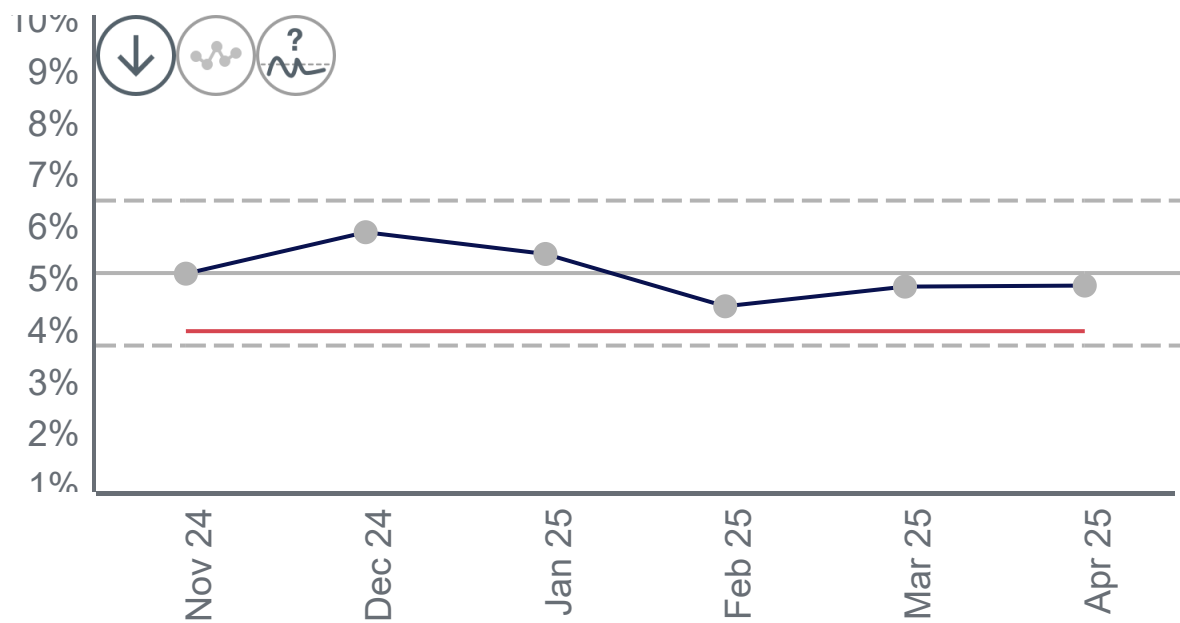
Technical Analysis:

Staff Turnover is displaying special cause improvement with a continual reduction over the last 6 months.

Actions:

Continued downward trend

Staff Sickness (All Staff)



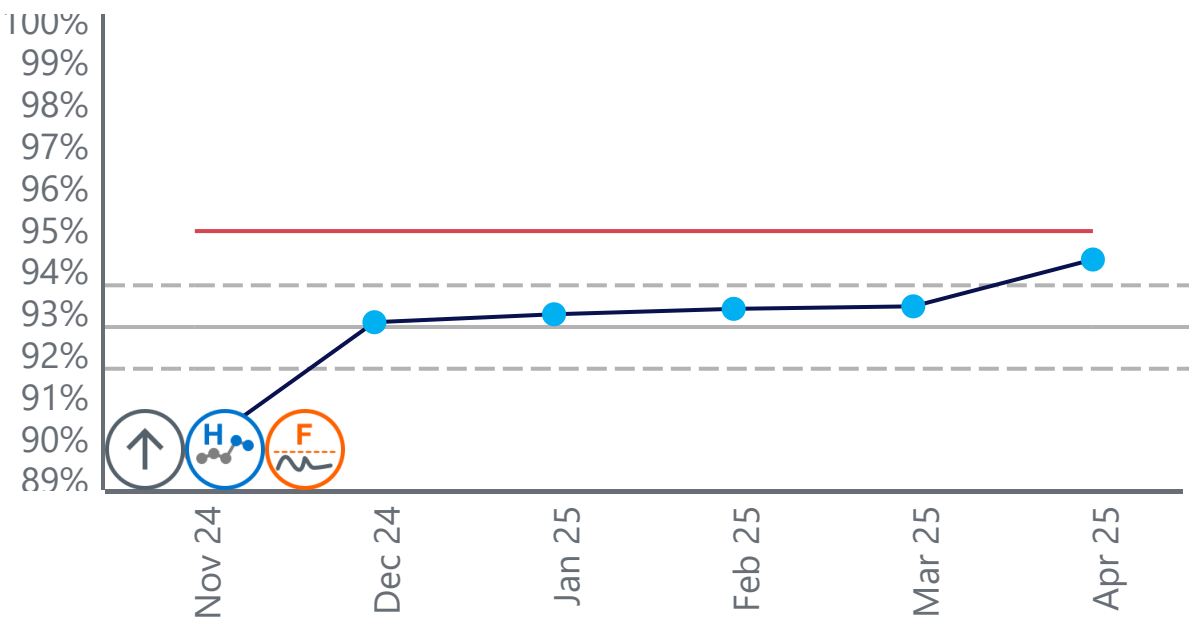
Technical Analysis:

Total absence in April 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:

Review of all cases by Business HR Team - deep dive into short terms sickness  
  
Planning Implementation of the Managing Sickness and Wellbeing Policy.

Mandatory Training Compliance



Technical Analysis:

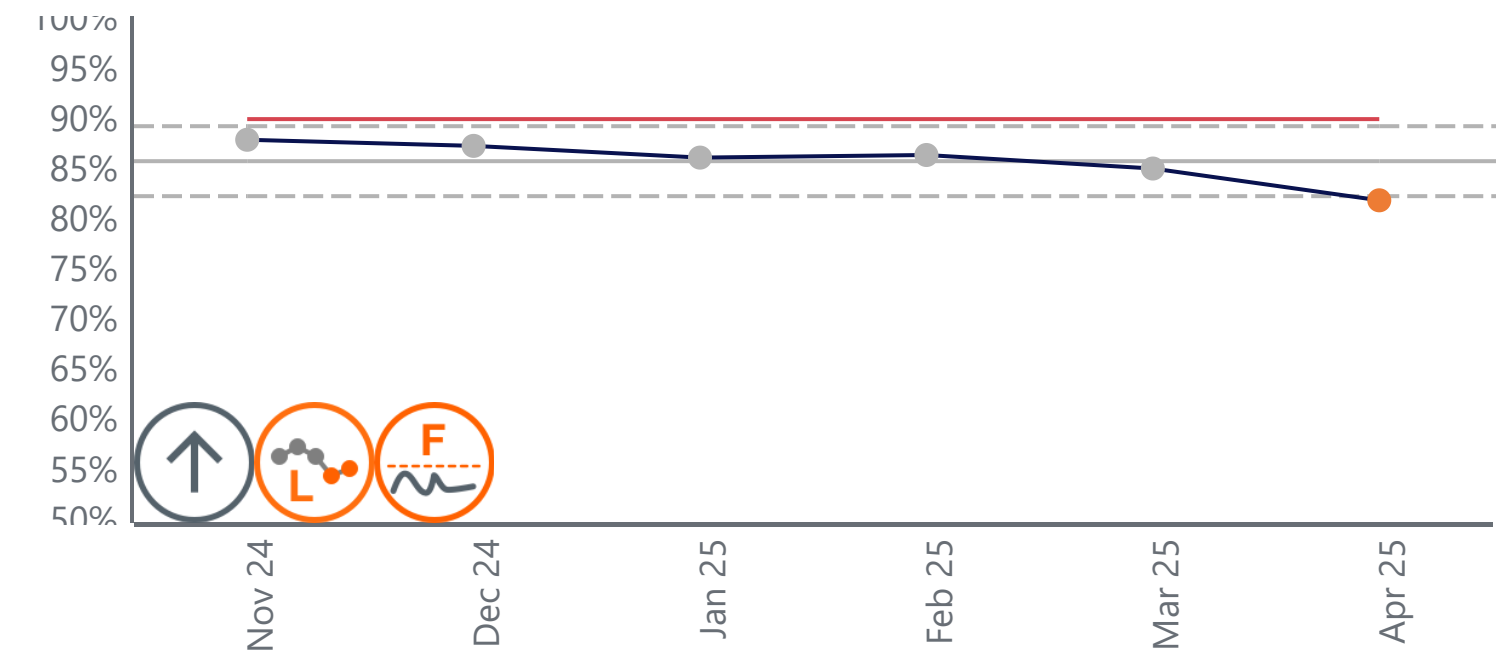
Performance has shown special cause improvement over the last 6 months. Continued work will see the gap close on achieving the target.

Actions:

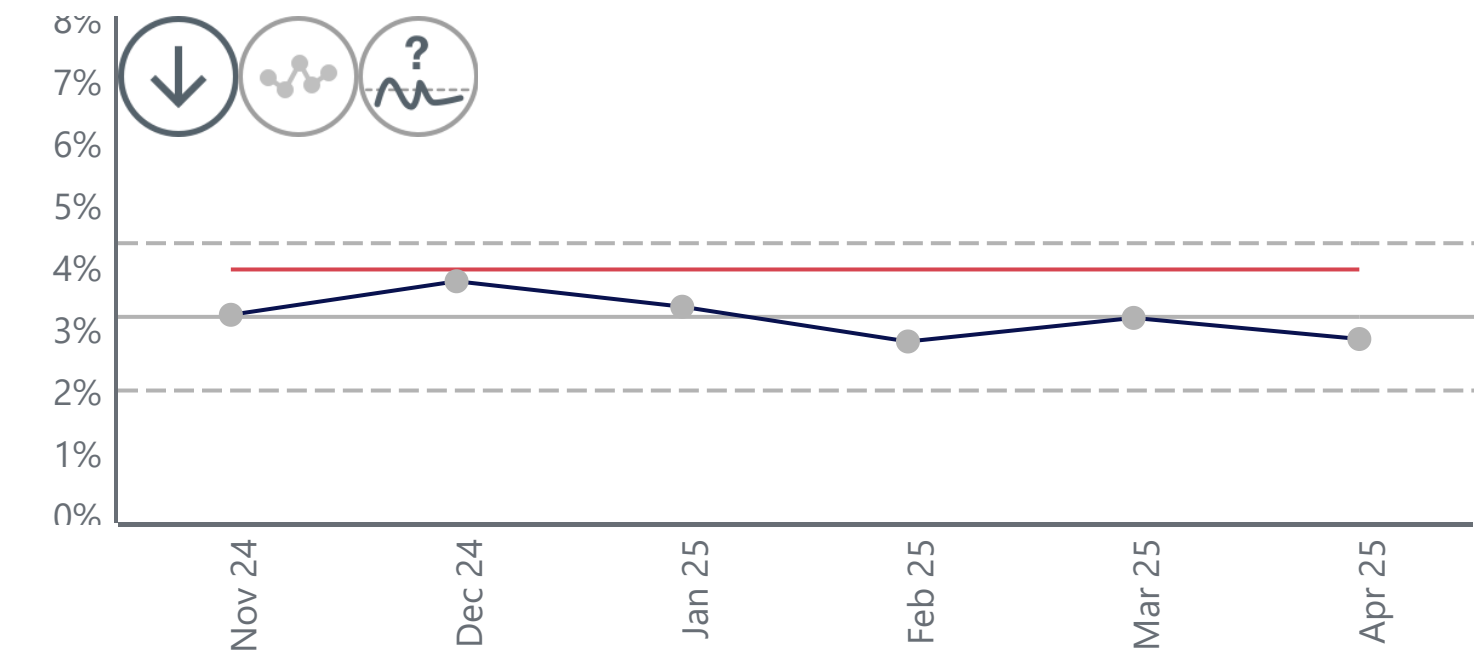
Compliance reported through Divisional Board.  
Reconciliation of Digital Services records to drive up Corporate compliance.

People - Watch Metrics

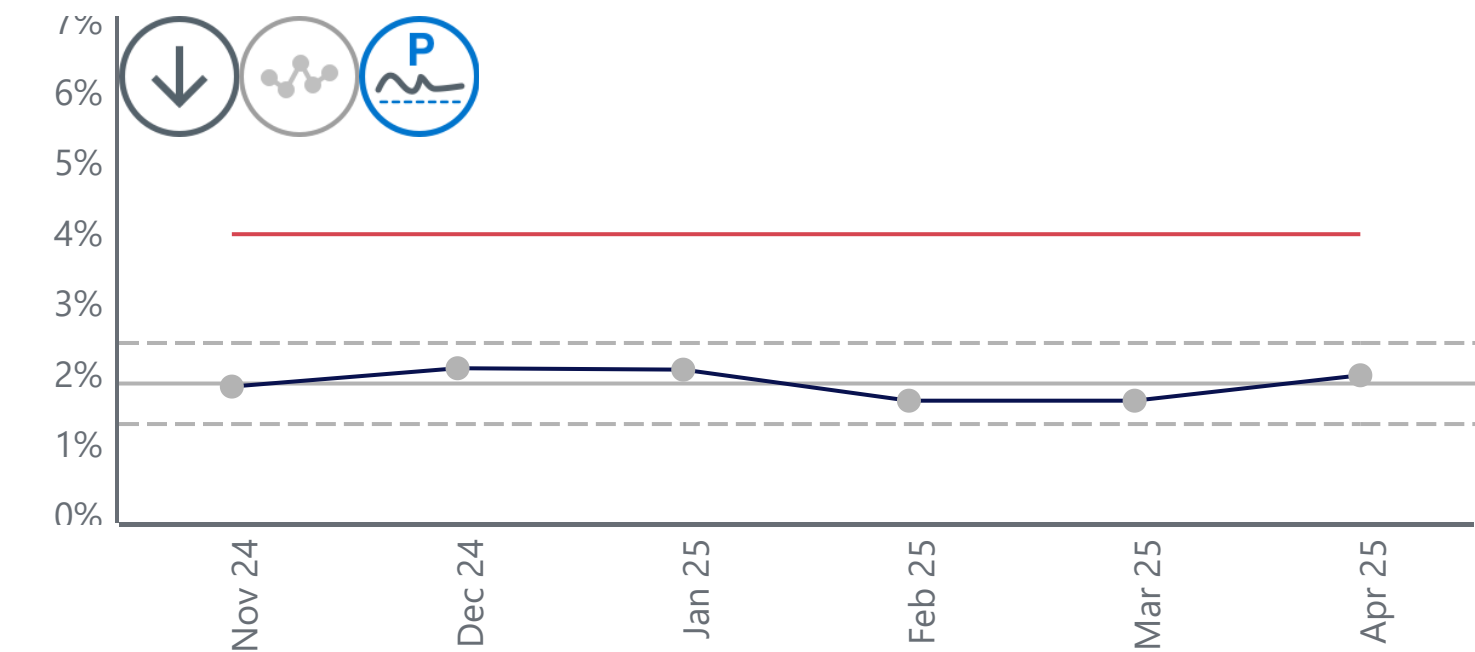
Appraisals Compliance



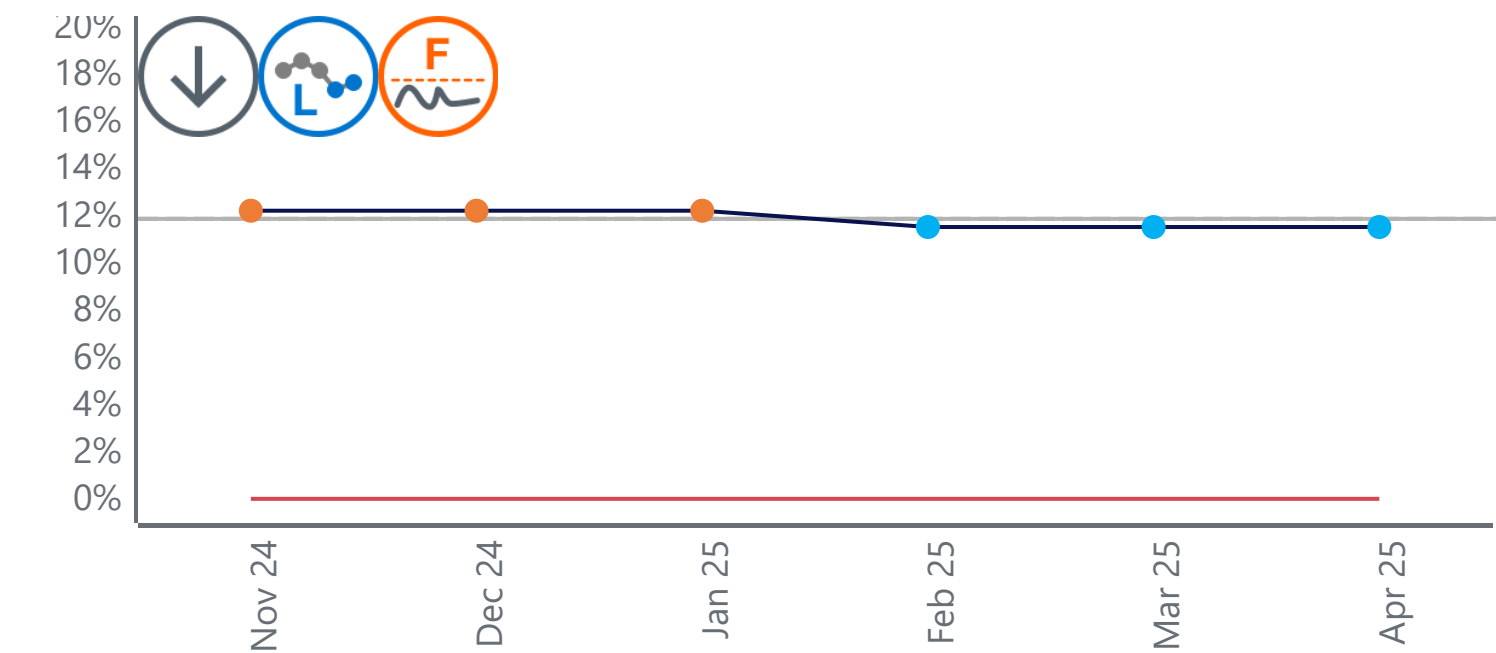
Long Term Sickness



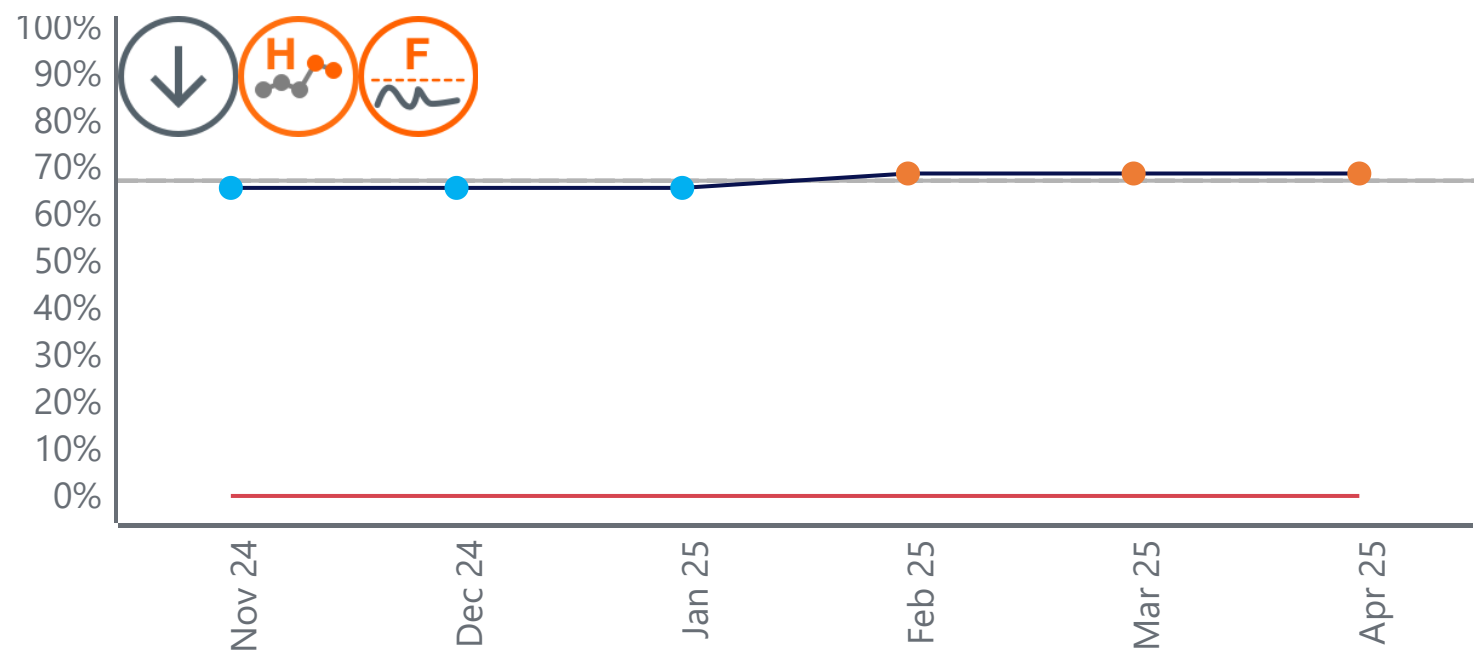
Short Term Sickness



EDI: Bullying and Harassment of Staff by Patient and Relatives



EDI: My Organisation Treats me fairly





Research

SRO: Shirley Pringle, Director of Research Operations

Highlights:

Set up time for studies has considerably improved from 185 days to 55 days - now meeting 100 day target.

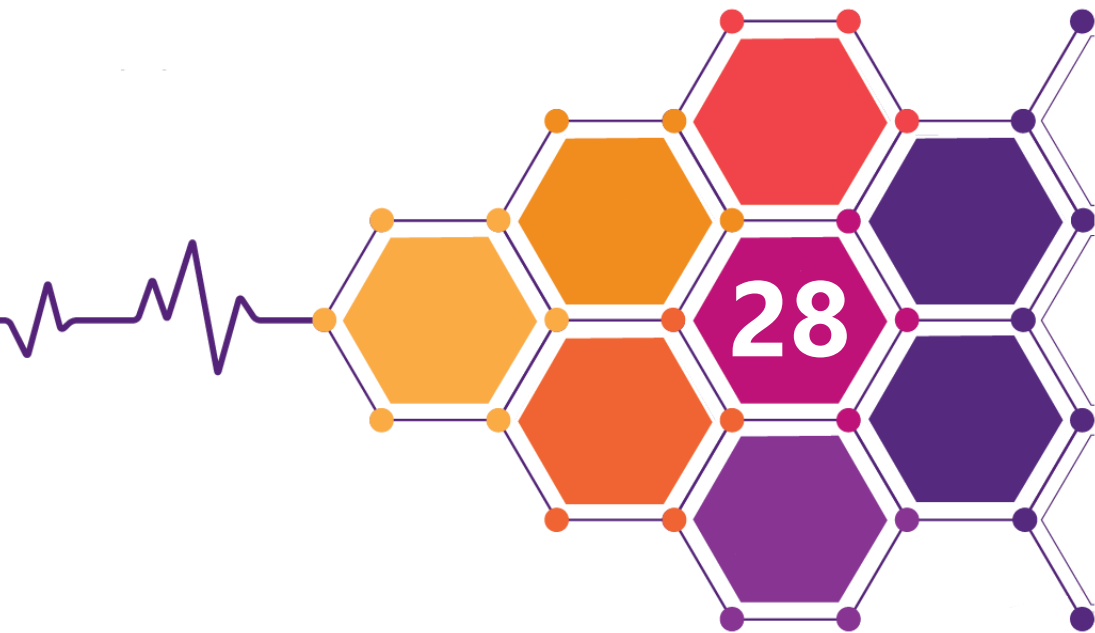
Requirement for trust to achieve 80% time to target recruitment for studies that close to recruitment - target currently being met 80% for commercial studies and 80% for non-commercial studies.

Areas of Concern:















- \*Current open studies below target recruitment expected 80% recruitment for all studies.
- Commercial time to target is 75%      Non- commercial time to target is 68.3%
- \*Target of 3 for successful grants has not been met currently no successful grant applications.
- \* The research department is a self funding directorate and is required by the trust to maintain a break even financial position - this has required a transfer of 200k YTD from research deferred accounts to break even.

Forward Look (with actions):

- \*Improve research set up times - named nurse to be identified for studies in the approvals stage. Head of governance working with team to identify any efficiencies for the process..
- \* Improve time to target for open and recruiting studies - Weekly review of RAG status for all studies - highlighting concerns with PI's if recruitment falls to offer support. Research matron to work with teams to establish recruitment strategies.
- \* Improve grant success - early introduction to LHP JRO for contract and application support - feedback for unsuccessful grants to identify if any support can be provided for future awards.
- \* Financial review and improvement of invoicing for activity - currently working with research delivery team to add all activity on EDGE - member of staff now responsible for invoicing sponsor. Working with finance to understand trends and measure improvements.



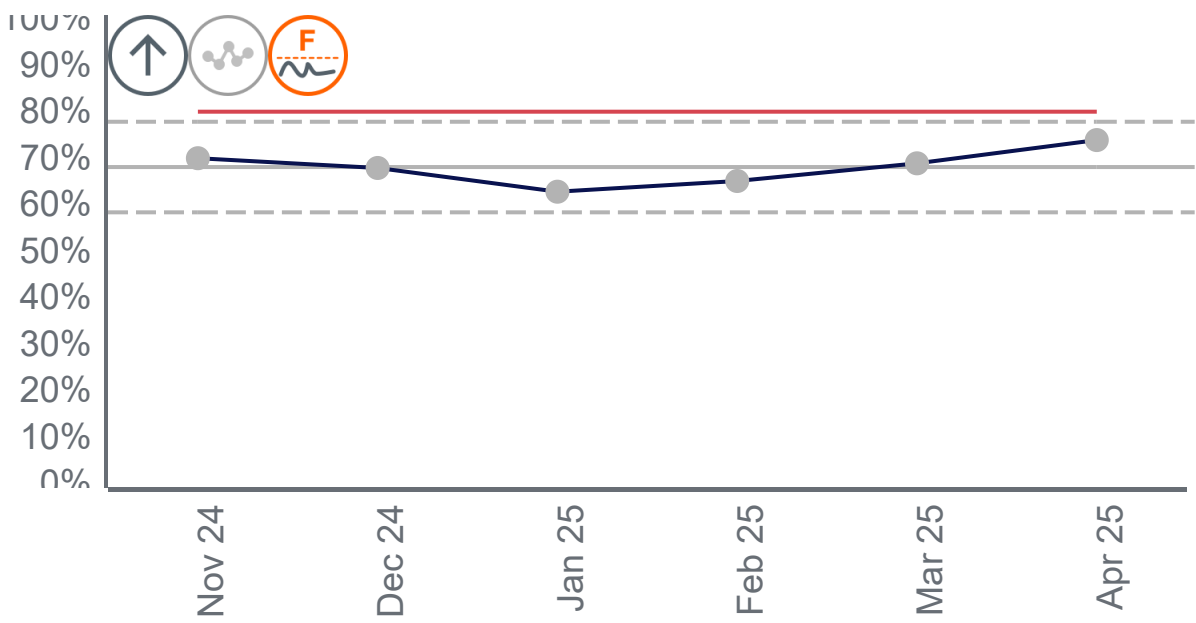
Research - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
Recruitment to all studies	Apr-25	102.0	70	102.0		
Number of studies open	Apr-25	55.0	40	55.0		
Recruitment to time and target for all research	Apr-25	73.9	80%	73.9		
Average set up time for Research	Apr-25	55	100 day avg	55.0		
Number of successful NIHR Grants	Apr-25	0.0	3 per annum	0.0		
Number of active PI's	Apr-25	33	39	33.0		
Number of AHP/CNS/ Clinical Scientist PI's	Apr-25	2	5	2.0		



Research - Drive Metrics

Recruitment to time and target for all research



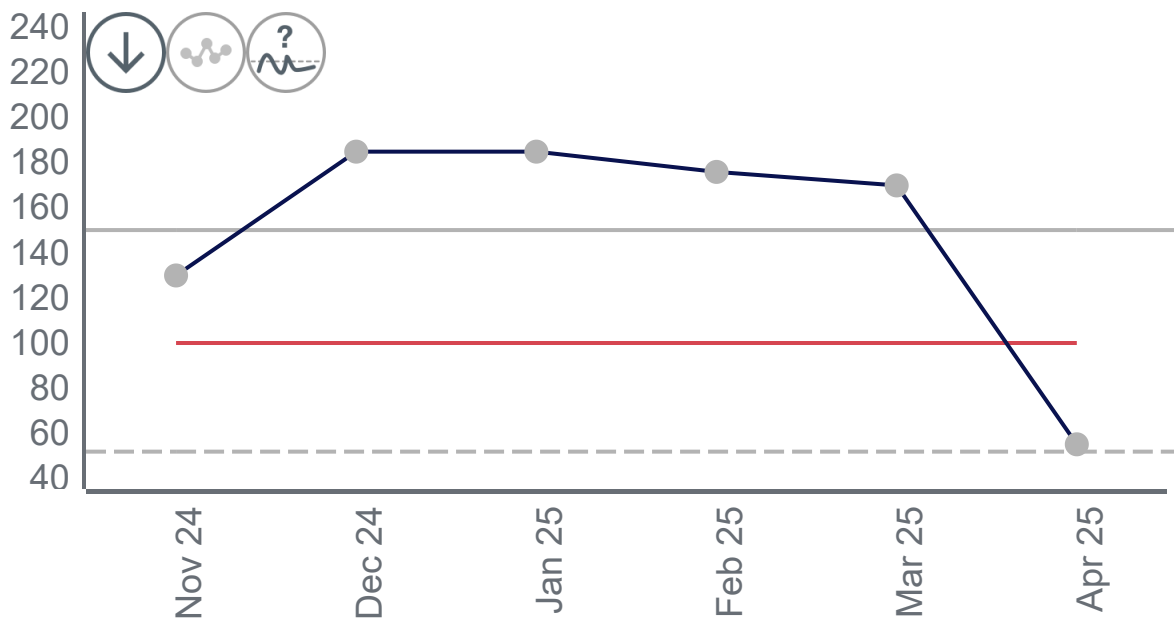
Technical Analysis:

Performance across 2024/25 and into 2025/26 has consistently below the target of 80% with no significant change shown. Improvement required to achieve the target consistently.

Actions:

\*EDGE database now continually reviewed to ensure recruitment is updated. \*Research team working with PI's to ensure recruitment figures are added to EDGE - support offered to add this info. Discussion between R&I and PIs to set target during set up to ensure target can be met.

Average set up time for Research



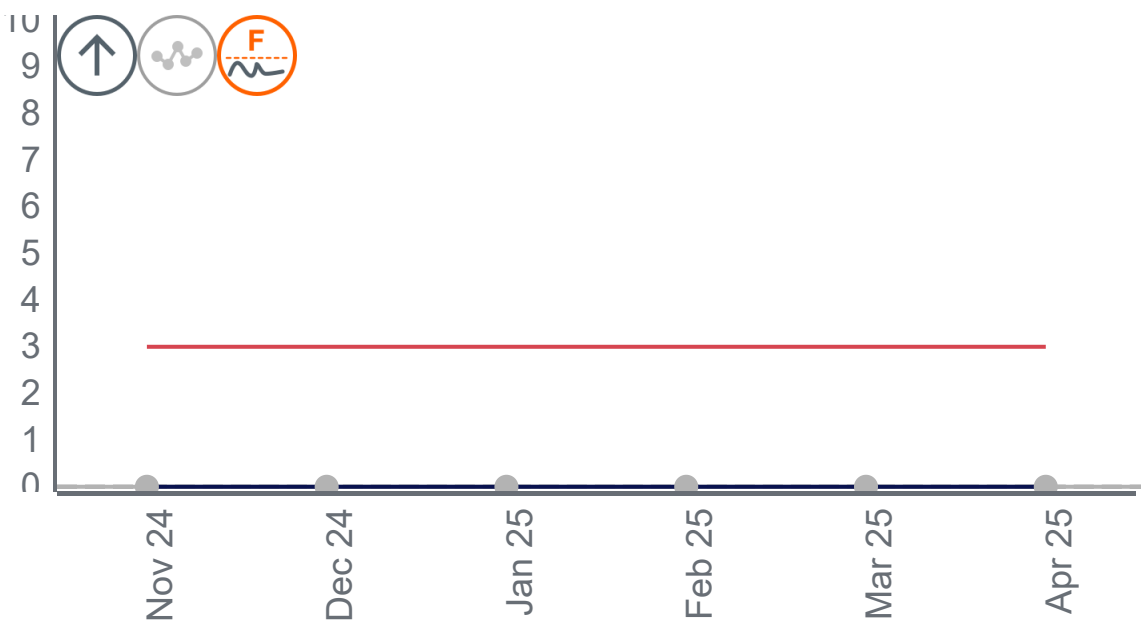
Technical Analysis:

Performance in Apr-25 has significantly dropped to levels seen within early 2024/25. Improvement required to maintain current setup time.

Actions:

\*Set up time impacted with increase of new studies. \*Research nurses now will support study set up and will liaise with research governance teams, sponsor and PI's to reduce time addressing queries.

Number of successful NIHR Grants



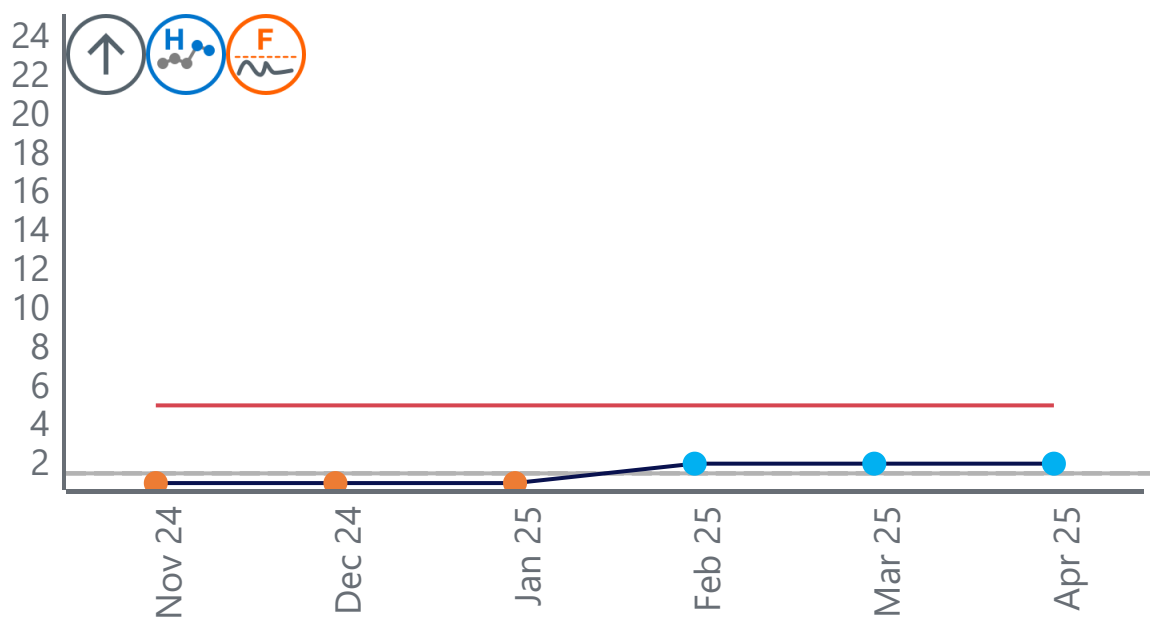
Technical Analysis:

The trust failed to meet the target of 3 grants per annum for 2024/25. Improvement required as 2025/26 commences.

Actions:

\*LHP JRO providing support for grant submission. \*Rod Stables will provide training and support for new applications via the research café.

Number of AHP/CNS/ Clinical Scientist PI's



Technical Analysis:

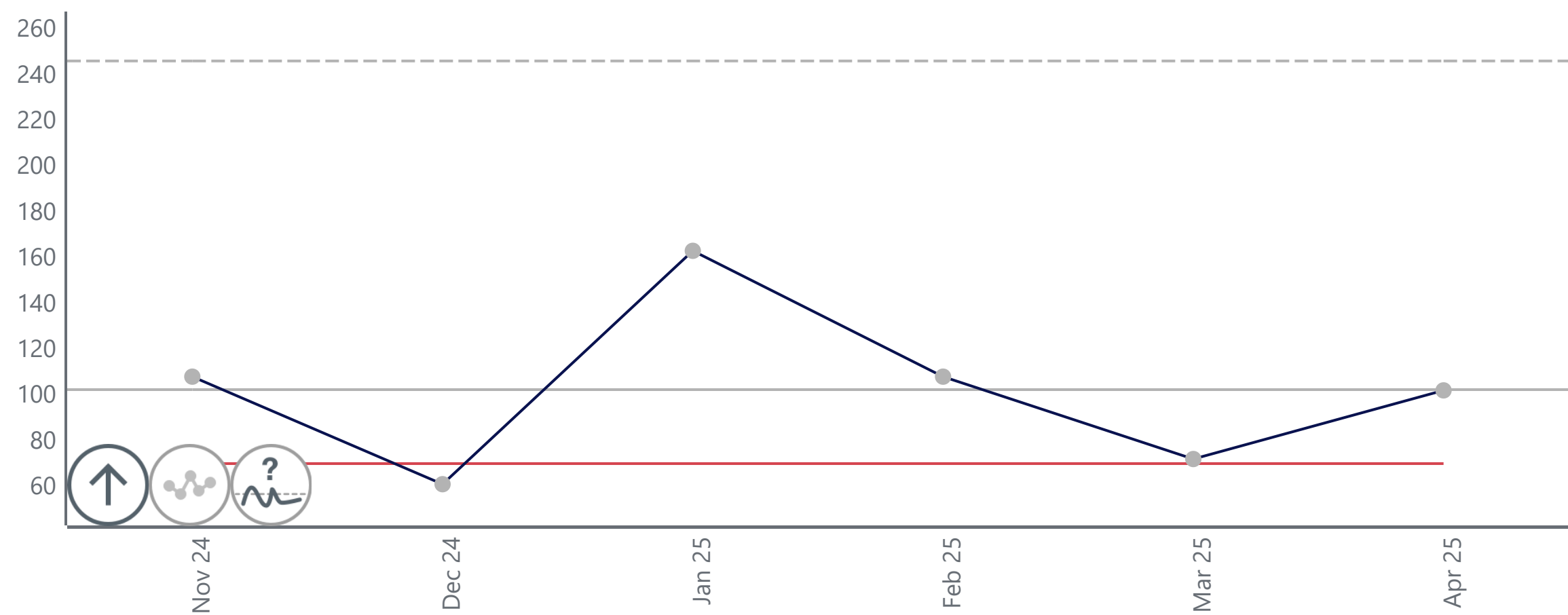
The trust has failed to meet the target of 5 PI's. Improvement required to consistently achieve the target.

Actions:

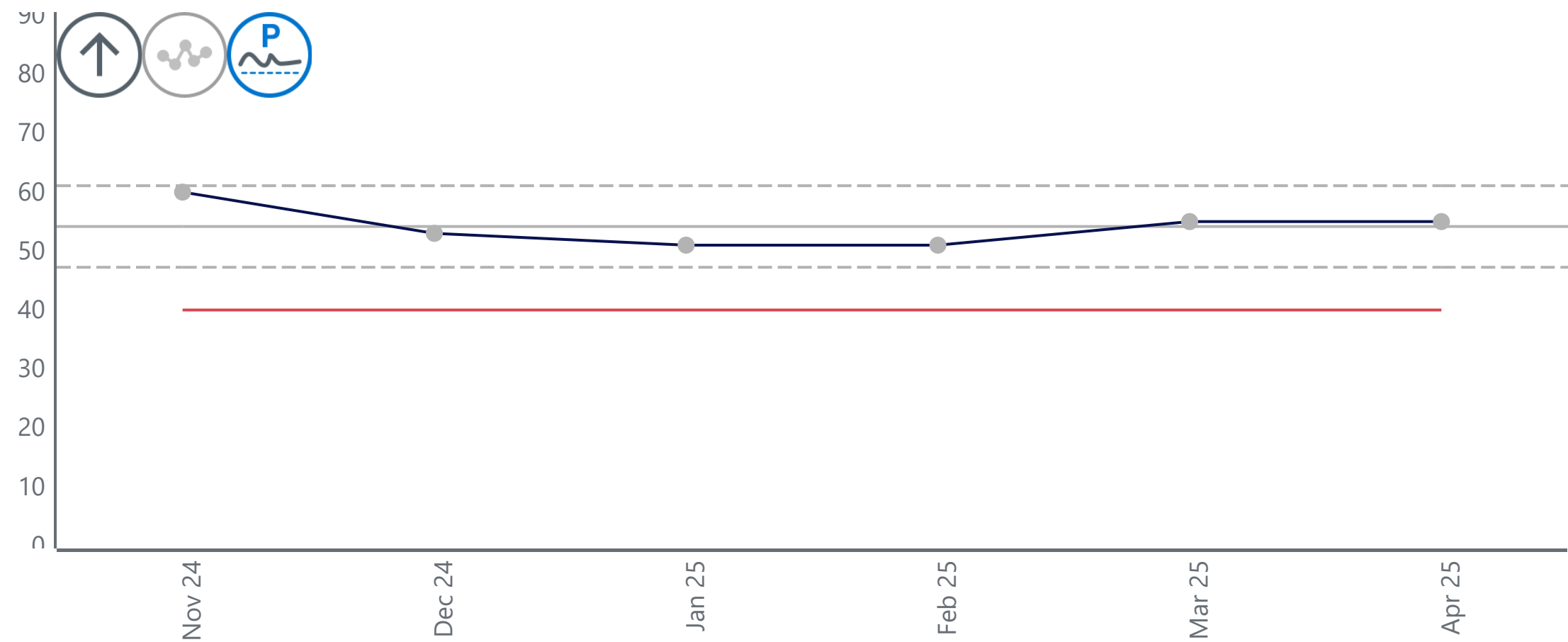
\* Senior research team working on plans for research support mechanism for AHP/CNS and Clinical Scientist. \*Research ambassadors within in clinical areas to be identified.

Research - Watch Metrics

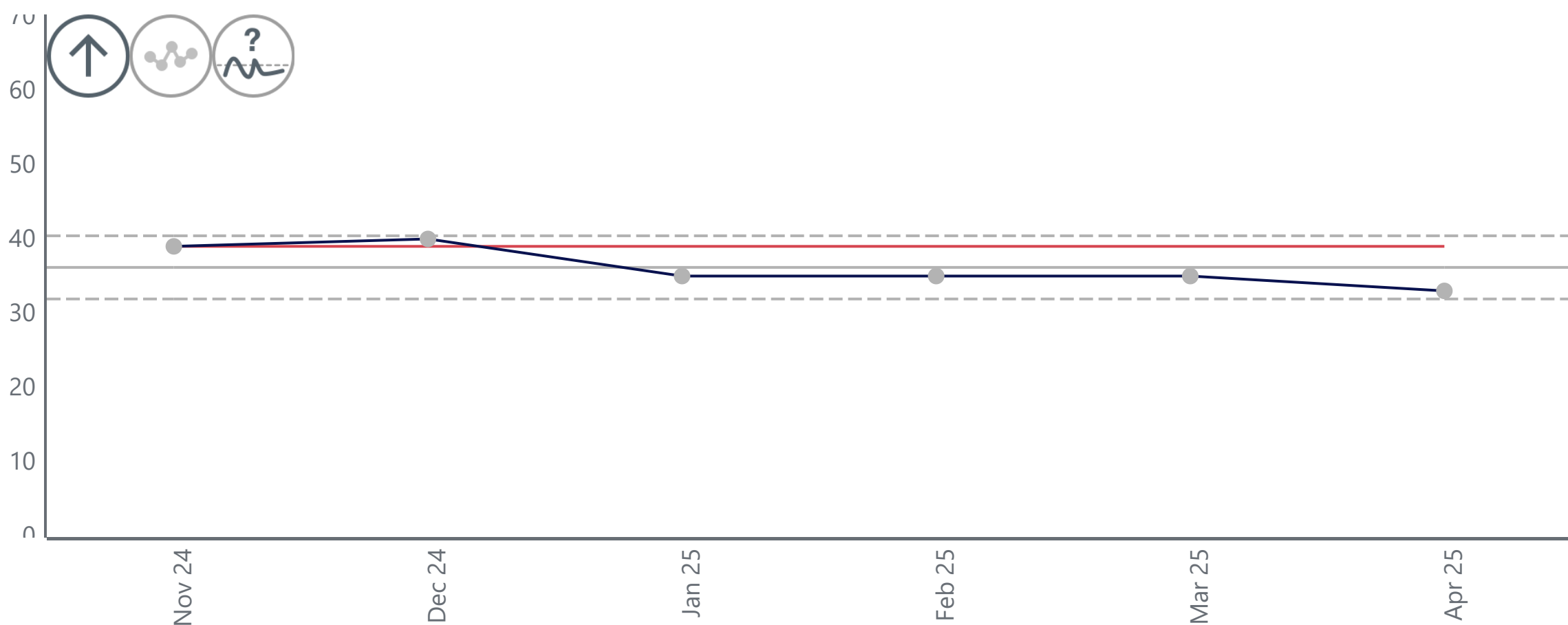
Recruitment to all studies



Number of studies open



Number of active PI's





Risk Summary

Executive Summary

The Corporate Risk Register contains significant risks identified as having potential impact on the trust corporate objectives, including risks identified and escalated by Divisions. Risks are reviewed monthly at each Divisional Governance meeting and quarterly by the Risk Management Committee.

This report provides an update of risks with residual scores of 12 or higher along with the controls in place to control and/or mitigate them.

The Risk Management Committee continues to receive highlight reports including health and safety and fire safety, which provide assurance on the wider controls in place, and any significant gaps would be escalated to the Operational Board as required.

The information provided in this report is accurate as of 12th May 2025. Any further changes to the risk registers will be included in subsequent reports.

Key Risks

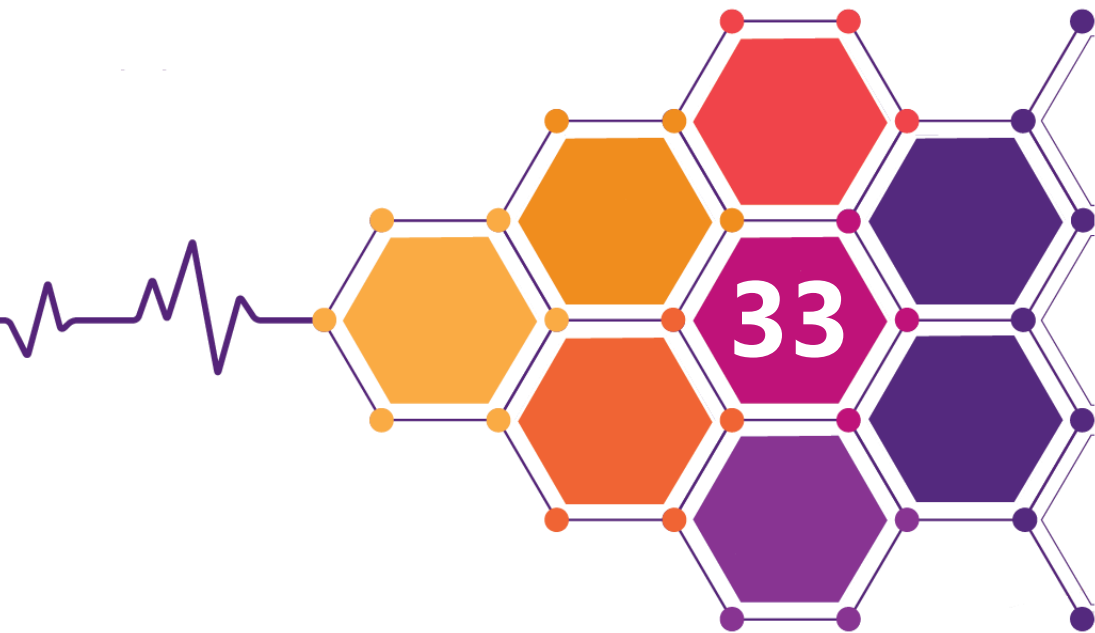
Currently there are 353 risks managed and mitigated below a residual score of 12. This leaves a total of 37 risks scoring 12 or over. Of these 36 have been reviewed within the last quarter (3 months).

division	1	2	3	4	5	6	8	9	10	12	16	Total
Medicine	1		7	18		31	9	19	3	5		93
Clinical Services	1	9	5	12		20	5	7		5		64
Corporate Services	17	23	9	23	3	25	21	21	4	15	4	165
Surgery	1	1	9	15		17	6	11		7	1	68
Total	20	33	30	68	3	93	41	58	7	32	5	390



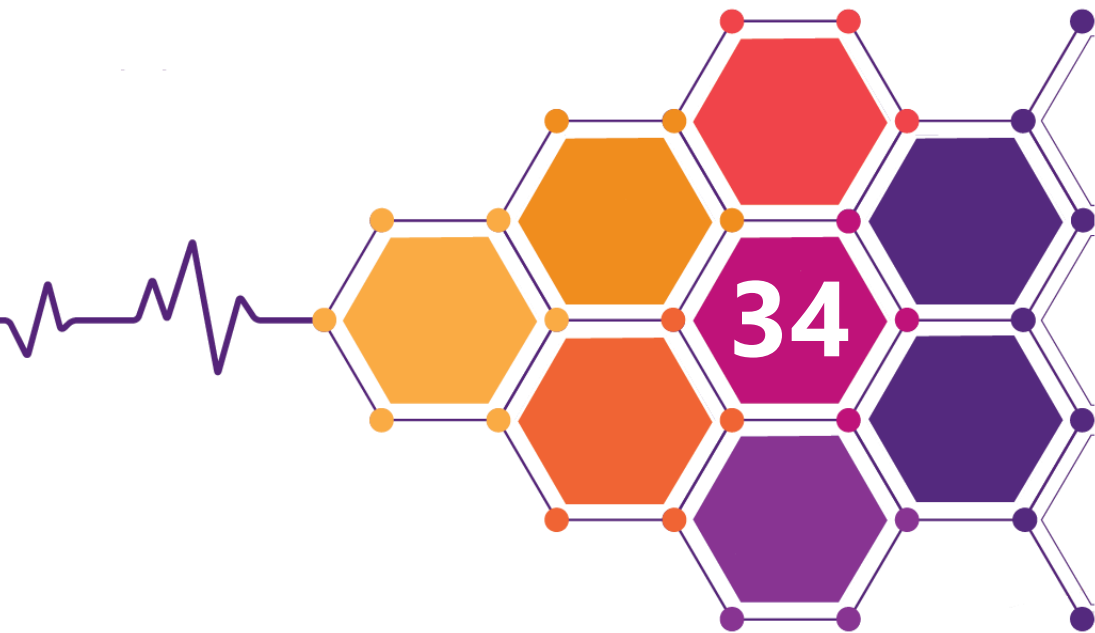
Risk - Divisional

Risk ID	Risk Descripton	Current Score	CurrentControls	FurtherMitigatingActions
1067	Surgical corridor - defective concrete slab and steel	16	[structural inspection carried out June/July 2021. TDE appointed as contractor and have completed propping works to rectify the issue.] [follow up inspection completed in 2024 to review current controls and check for any further deterioration. further works now required to install additional structural supports following receipt of report. risk increased to 16 until structural works are completed. funding for works approved at Jan 25 CMG for completion April 25]	[annual assessments by structural engineer]
1944	Clinical Letters Process	16	[Weekly report on the known letters in EPRO being sent to Operational teams to allow for a review of patients in the system *Additional review/metrics in the report now updated] [Weekly task & finish group established with Digital and EPRO colleagues to identify any gaps in Letter Flow] [Senior Leadership restarted in the Trust (since a further issues was identified) to look at options for recovery (with the number of letters that haven't been sent out the Trust)]	[Further training of administration staff on EPRO processes and develop SOP's to support ongoing management of the system] [Risk review to be completed in line with Trust Risk & Governance Policy] [Ops Team and Admin team meeting held to share the current position on the letter issues] [Reviewed training plan with EPRO to be agreed in support of the Admin teams] [A second EPRO linked audit tool to be created for the clinical teams] [All letters sent out from Mar 25] [Technical updates to EPRO actioned] [Final PSIRF Closure Report] [Smaller Task & Finish Group in place] [Upgrade of EPRO system following task & finish group
0155	additional theatres, lack of perfusion staff	15	[Use of agency staff may be available only if necessary / ongoing workforce planning to account for departmental age demographics,] [Current establishment of 12 WTE. Two trainees recruited and due to qualify Sept 25 and Sept 26 respectively. Current, vacancy rate of 2 x WTE plus 1 x WTE of maternity leave. Additional 2 x WTE unplanned absence due to illness. Potential for medium to long term. Current demographics mean that further retirements could happen in coming years. Advertised for replacements in January 2025 with no success, current perfusion job vacancy rate high nationally. Further advertising planned including for a	[Trainee appointed September 2023 who will qualify September 2025. With further trainee appointed September 2024 , qualifying September 2026.] [Use of locum perfusionists.]



Risk - High Risks

Risk ID	Risk Description	Current Score	CurrentControls	FurtherMitigatingActions
2038	Isilon Capacity, Replication and Resilience	16	[Controls from risk #2046 31/7/24 In the short term, the trust IT support team have looked at various methods to reduce existing stored data or expand the available storage. This has included removing unused and unneeded data and removing the storage replication, freeing up additional space for data storage.] [Controls from risk #2046 31/7/24 An overarching infrastructure strategy is in production which will look to provide a long term solution which matches the trusts future storage requirements.] [IT are reviewing options with suppliers and hope to have them together by end of mid-Feb. Head of IT will be working up a business case once requirements and costs are finalised.] [IT have been provided with options from their supplier CDW which they are currently reviewing (Jan 2025). A business case will be generated and signed off by the end with the expectation of implementation in March.] [27/01/2025 Awaiting confirmation that business case has been approved to enable the procurement of a storage solution] [13/03/2025 review of the archives by PACS	[In light of the INC cyber incident IT have been asked to take the ISCV archives offline until all remediation activities are complete and NHSE/KPMG report that no threat actors are present on the network.] [10/02/2025 In light of the disengagement of LHCH from iDigital this piece of work is unlikely to be commenced before 1st April] [08/04/2025: A new solution is in the final stages of design. This will be a latest generation solution, replicated between two diverse datacentres and data tiering into Cloud.]
2063	Inadequate Backup Capacity - Risk of losing patient and clinical data	16	[Regular Testing and Monitoring: - Verifying Backups and their Integrity through regularly testing backups. - - Monitor backup processes to detect and address any issues promptly.]	[Mitigation Plan: Enhance Backup Retention: Increase Retention Periods: Extend the retention periods for both EPR and other critical systems to ensure data is available for longer recovery windows. Implement Offsite Backups: Replicate Data Offsite: Ensure that backups are stored in multiple locations, including offsite or cloud-based solutions, to protect against site-specific disasters. Adopt Comprehensive Backup Solutions: Utilise Advanced Features: Leverage Rubrik's advanced (Enterprise) features, such as automated backup verification and ransomware detection, to enhance data protection and recovery capabilities. Business case scoped to secure capital and revenue investment to expand the current Rubrik Infrastructure and consider enhanced options found in Rubrik's enterprise suite offering. This business case is in production and will be submitted to Feb's Capital Board for approval. LHCH has been awarded capital





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