

Liverpool Heart and Chest Hospital 
NHS Foundation Trust

Strategic Oversight Framework

August 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 Month 5, three performance standards remain below target or show statistical variance. Each of these areas has been reviewed, and mitigation plans have been implemented where feasible. All indicators are being closely monitored and assessed against potential clinical risks.

Elective activity exceeded plan for the month, reaching 101%. Case mix and non-elective demand are reflected in our financial reporting.

Cancer performance is reported one month in arrears. In July, the 62-Day Pathway target was met; however, increased breaches in the Faster Diagnosis Standard resulted in a non-compliant position.

We have transitioned to tracking 52-week waiters for long-wait patients. Although there have been minor fluctuations this month, the position is being actively micromanaged.

Diagnostics (DM01) has seen significant improvement over recent months and has now returned to compliance.

Areas of Concern:

Elective and non-elective surgical activity continues to be closely monitored due to ongoing staffing constraints and critical care capacity risks. However, performance is continuing to improve.

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.














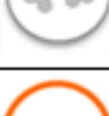















The FDS diagnostic wait times continue to remain a challenge as although we have a small number of breaches the denominator does not allow for significant slippage against the percentage performance. No Clinical Harm has been identified when the pathways have been reviewed and performance is monitored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

Cardiac surgical waiting lists remain under pressure, particularly due to ongoing non-elective demand and service-specific challenges, notably within Mitral and ACHD pathways. These pressures are exacerbated by workforce shortages and capacity deficits.

Forward Look (with actions):

- *Activity positions have now been aligned to the financial contract value with a reprofiling of activity currently being undertaken in Surgery.
- * Weekly monitoring of activity will continue, with enhanced data analysis to better understand case mix and non-elective demand in light of recent contracting changes. Additional sessions and capacity will be considered as needed, in line with financial governance.
- * FDS was achieved in 24/25 and continues to be an area of focus in 25/26. The 62-day 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 has been targetted and continues through Q2. The Divisions will be looking at waiting list processes through the Safe Waiting List Management Group and monitoring against RTT standards.

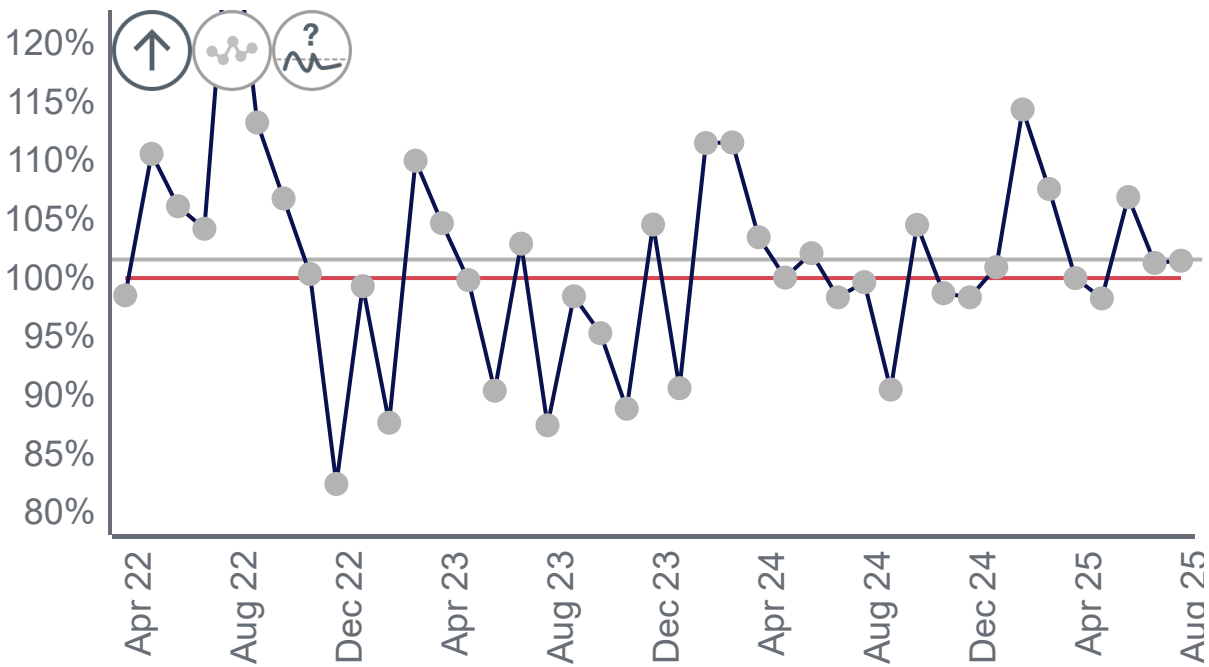
Operational Performance - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
Bed Occupancy	Aug-25	75.1	>=80%	79		
Cancelled Operations for non-clinical reasons	Aug-25	1.2	<=2%	2		
DNA Rate for most deprived areas	Aug-25	17.5	<=5%	16		
Elective Activity Levels	Aug-25	101.5	100%	102		
Letters waiting to be typed over 7 days	Aug-25	49	0	73		
Maximum 6-week wait for diagnostic procedures	Aug-25	99.5	>=95%	98		
Percentage of patients discharged on Ready for Discharge	Aug-25	98.1		98		
Overall Size of Waiting List	Aug-25	5667		5930		
Patients not booked in within 28 days (non clinical cancellations)	Aug-25	0.0	0	2		
RTT 18 weeks in aggregate - Incomplete Pathways	Aug-25	75.2	92%	72		
Referral to treatment - Incomplete Pathways 52+ weeks	Aug-25	42		49		
RTT 18 Week Backlog	Aug-25	1233		1463		
RTT Open Pathways - Percentage without an Ethnicity Status	Aug-25	49.3	<=35%	50		
RTT Pathway Waiters (52+ weeks) for the most deprived areas	Aug-25	1	0%	1		
Time to First Appointment	Aug-25	87.2	5%	83.6		
Cancer Patients meeting the Faster Diagnosis Target (FDT)	Jul-25	56.3	>=75%	65.3		
Cancer: 62-day referral to treatment standard	Jul-25	88.3	>=85%	91.0		



Operational Performance - Drive Metrics

Elective Activity Levels



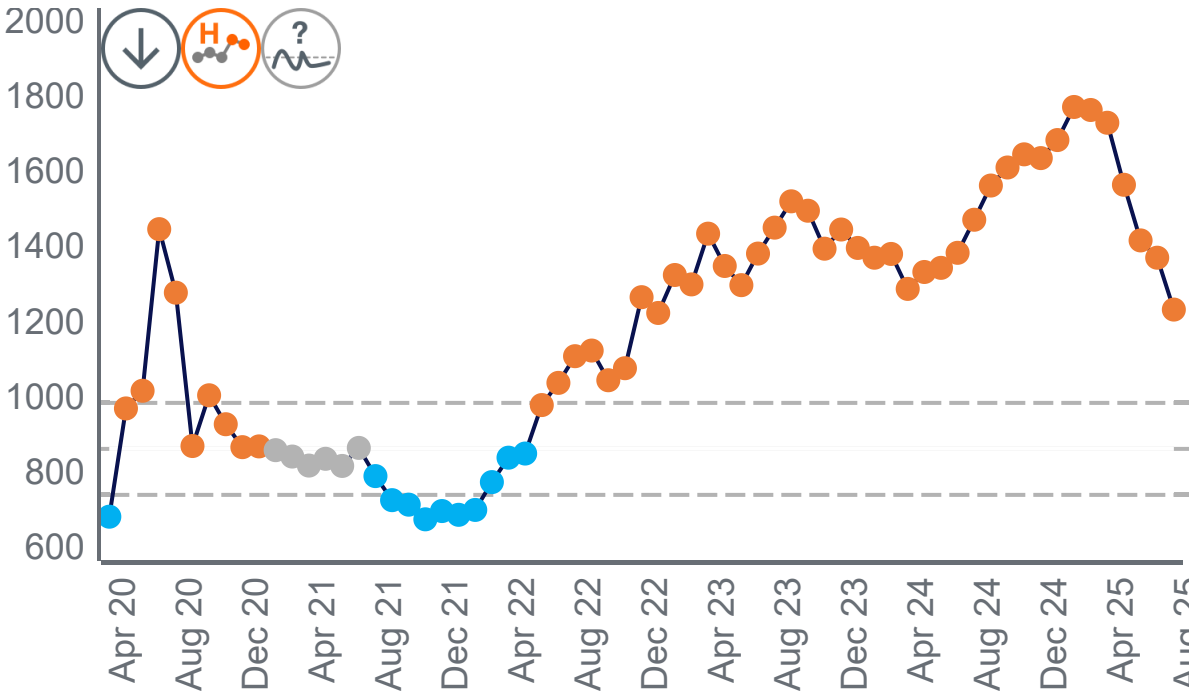
Technical Analysis:

Performance of 101% was achieved within Aug-25 against the target of 100%. Further work required across divisions to consistently achieve the target.

Actions:

- *Ongoing review of Surgery Elective Activity profile against capacity.
- *Weekly and Monthly monitoring continues through both Division and Trust Performance meetings.

RTT 18 Week Backlog



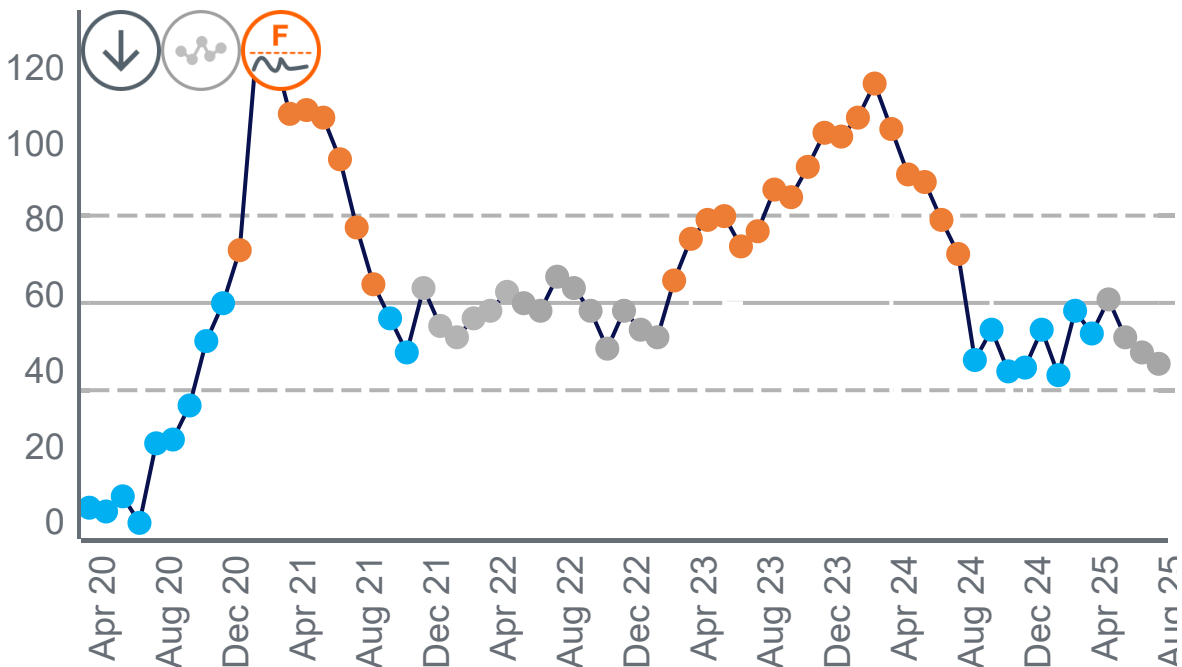
Technical Analysis:

RTT backlog continues to display special cause of a concerning nature. August's performance has shown continuous reduction but further work required to close gap on target.

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 Clinical Services DD.

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.

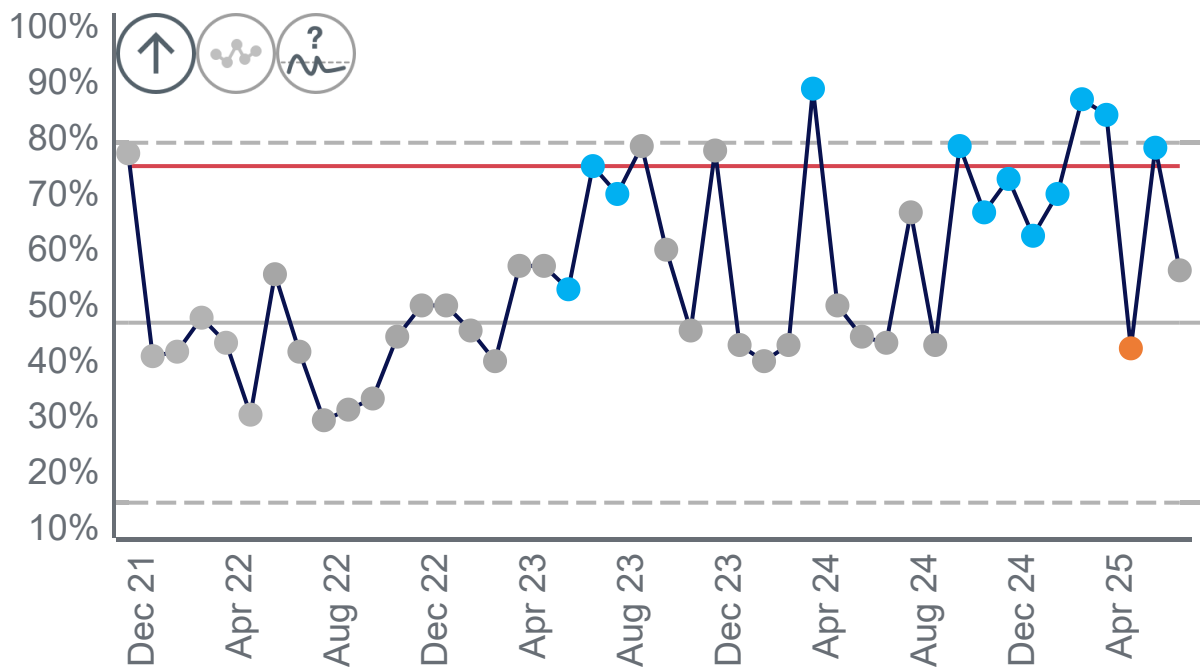
Actions:

- *Pathway RCAs undertaken for all patients who tip 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.
- *Risks around the ACHD long waits due to changes in medical workforce.



Operational Performance - Drive Metrics

Cancer Patients meeting the Faster Diagnosis Target (FDT)



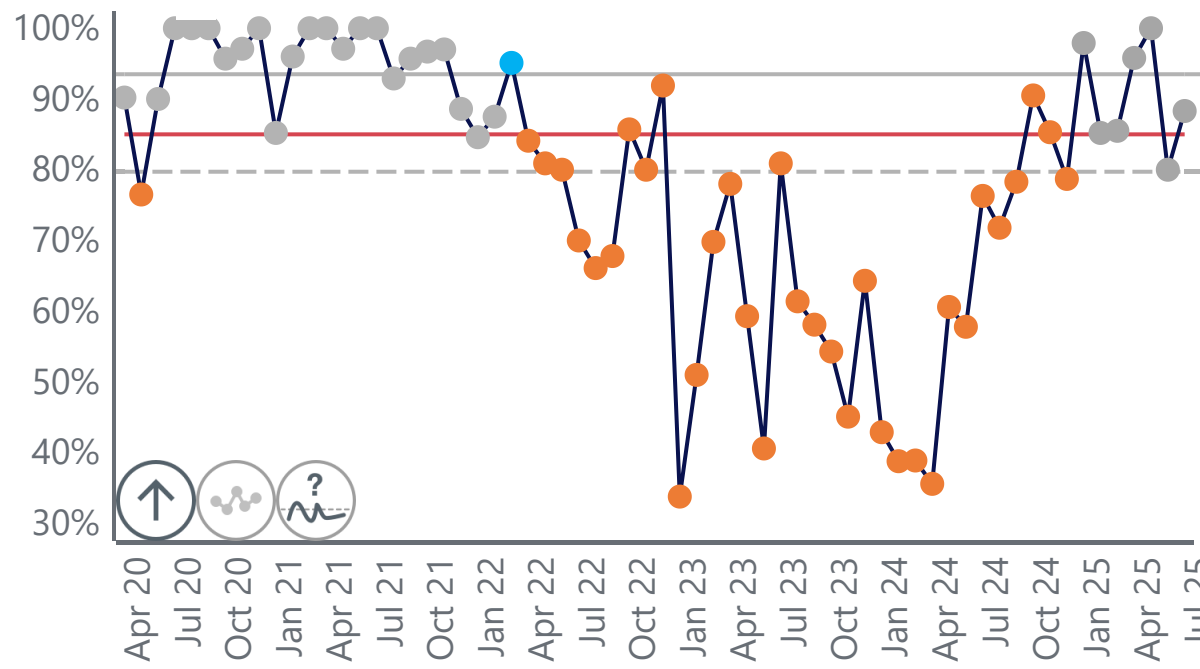
Technical Analysis:

Cancer performance is reported 2 months in arrears. The trust failed to achieve the target in Jul-25. 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



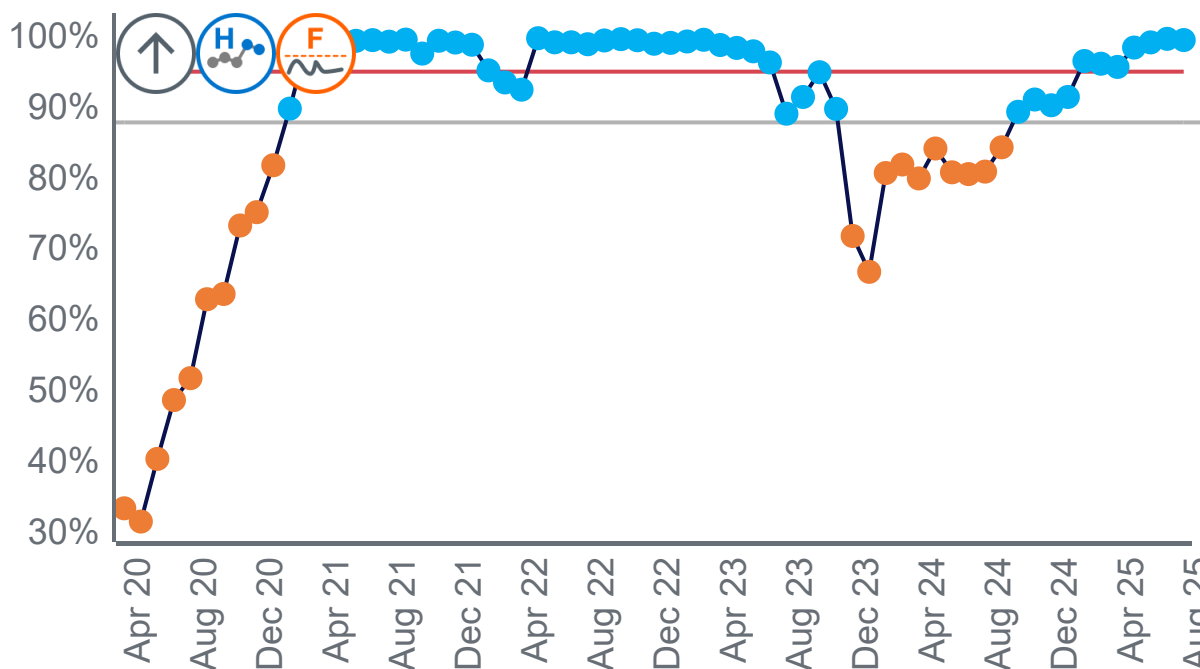
Technical Analysis:

Cancer performance is reported 2 months in arrears. The trust achieved the target within July. Further work required to move 62 day Cancer standard away from common cause variation to a position of special cause improvement.

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 in August continues to achieve the 6 week target. Performance is displaying special cause improvement having achieved the target over months.

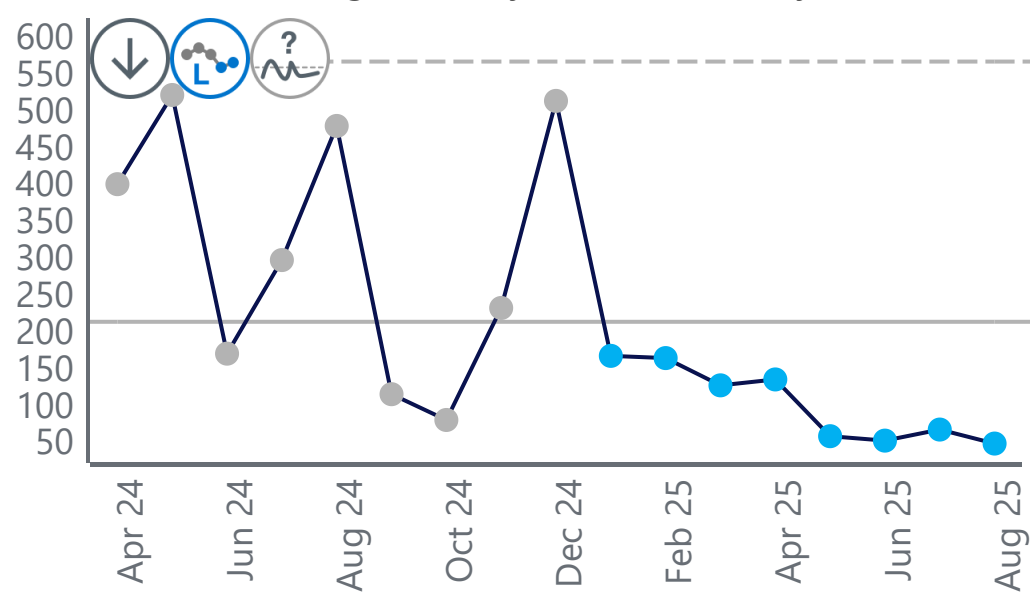
Actions:

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

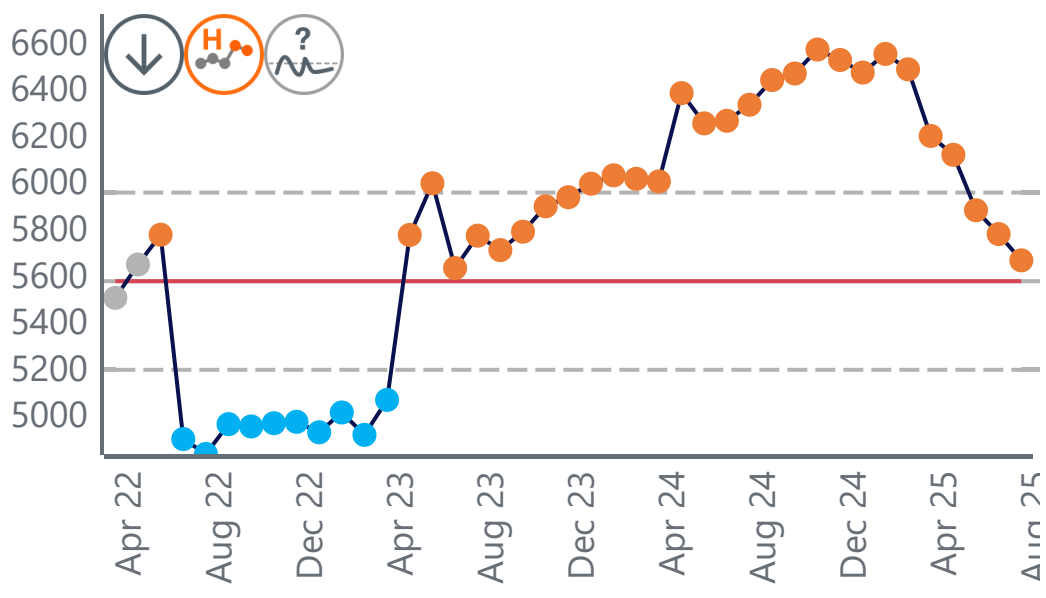


Operational Performance - Watch Metrics

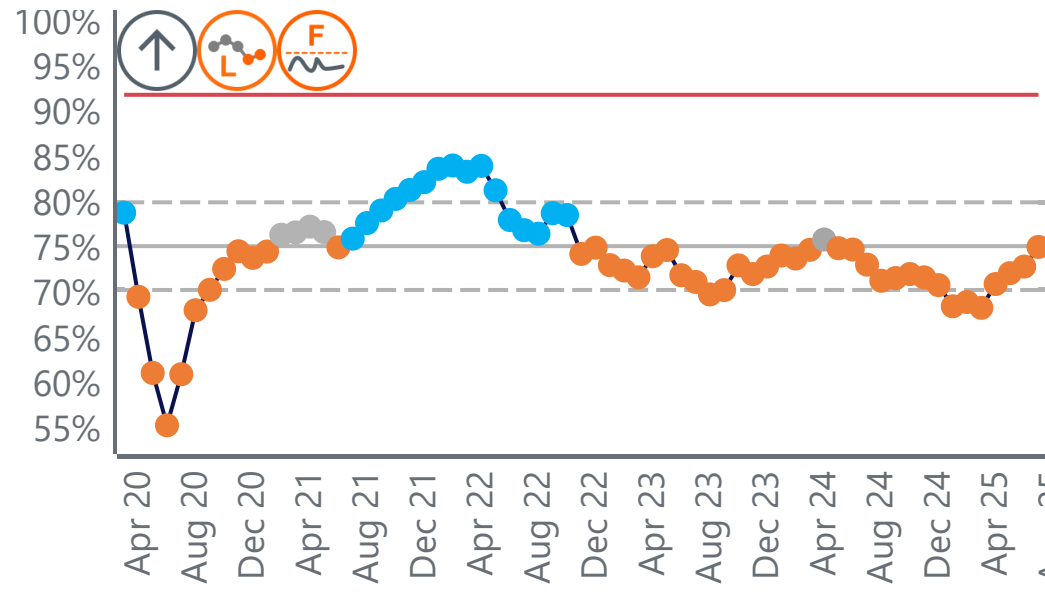
Letters waiting to be typed over 7 days



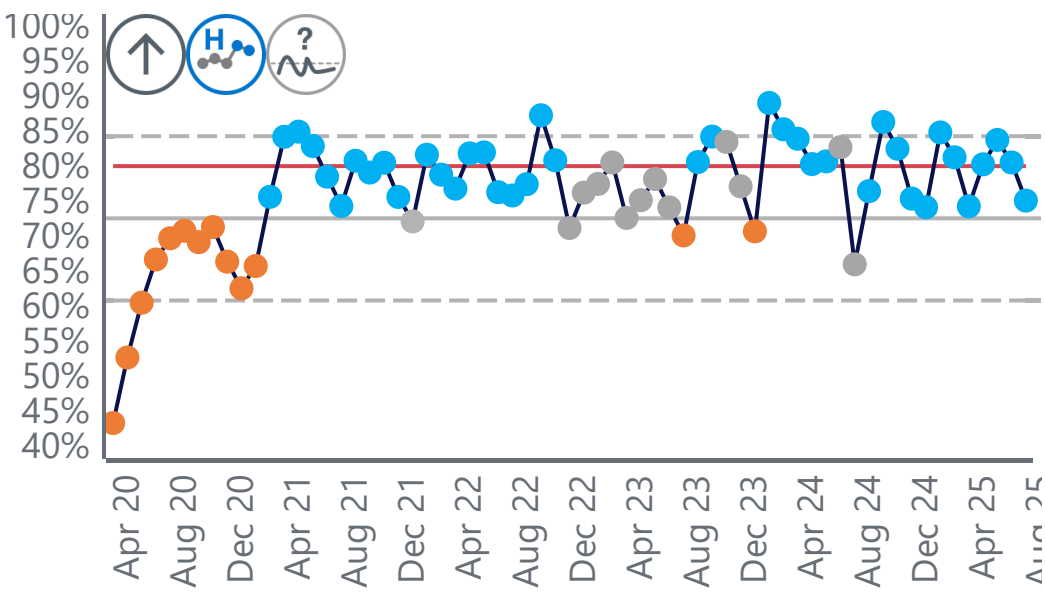
Overall Size of Waiting List



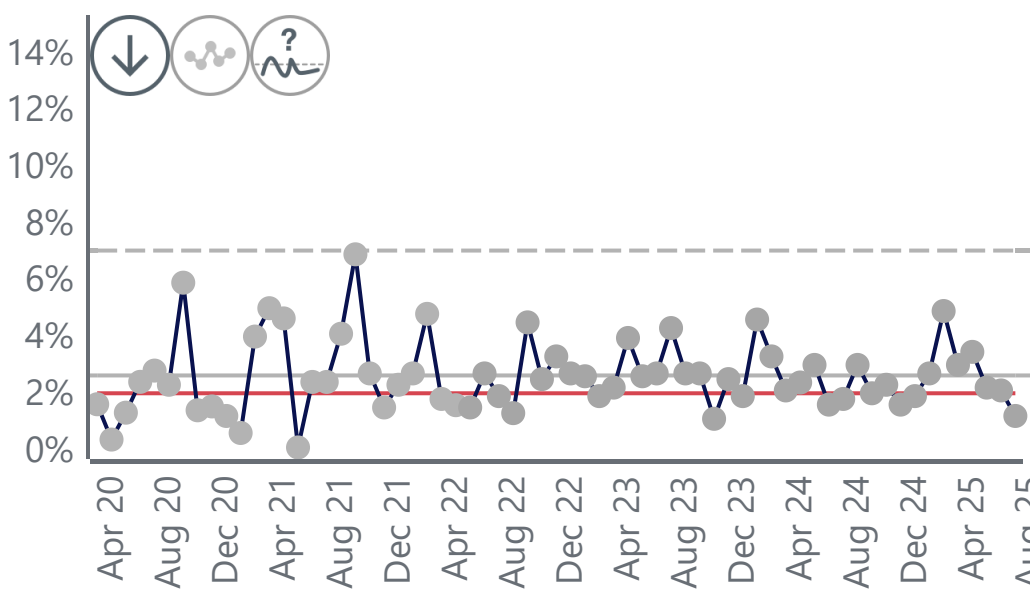
RTT 18 weeks in aggregate - Incomplete Pathways



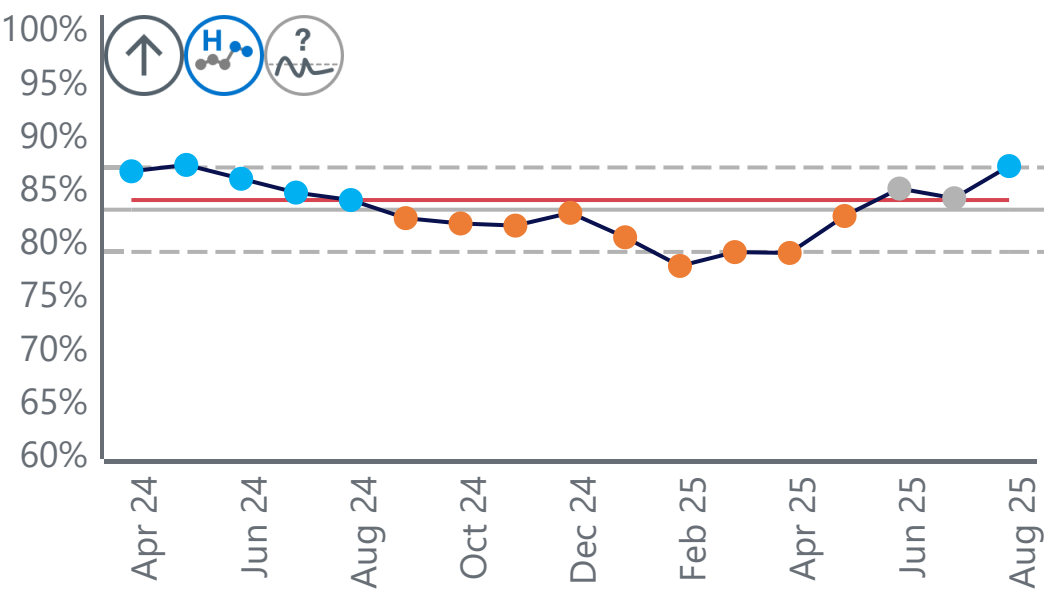
Bed Occupancy



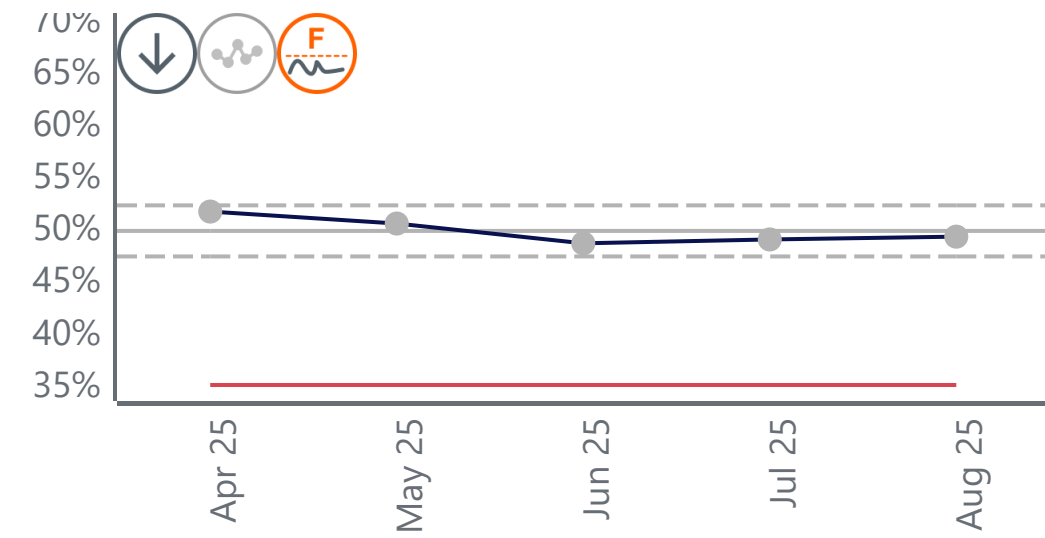
Cancelled Operations for non-clinical reasons



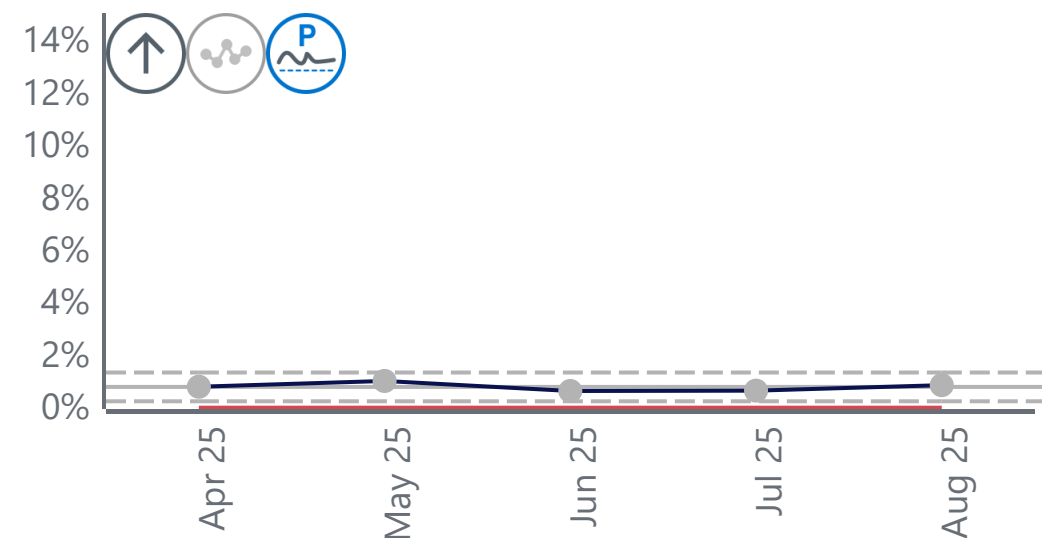
Time to First Appointment



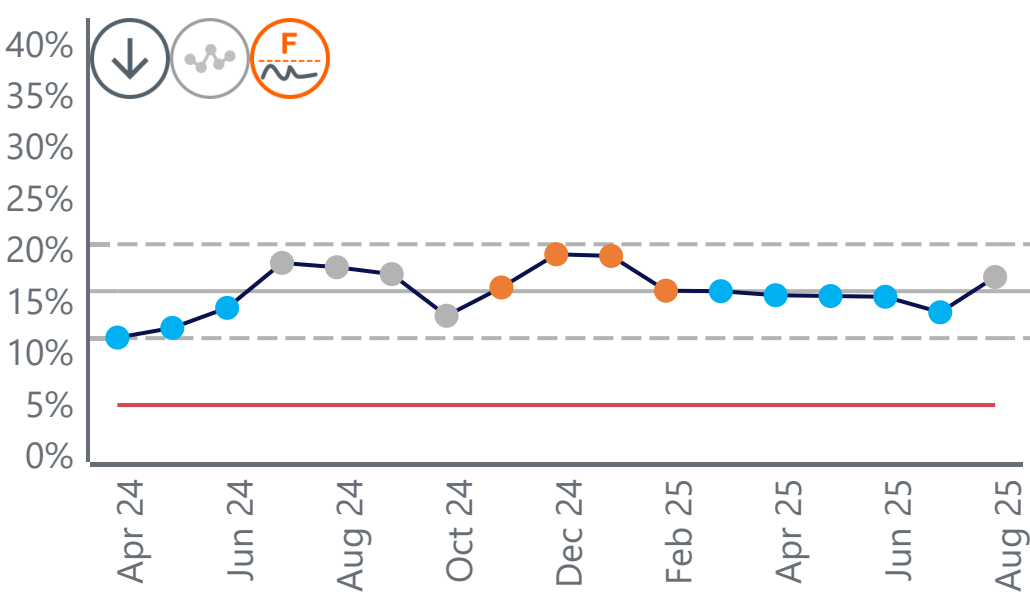
RTT Open Pathways - Percentage without an Ethnicity Status



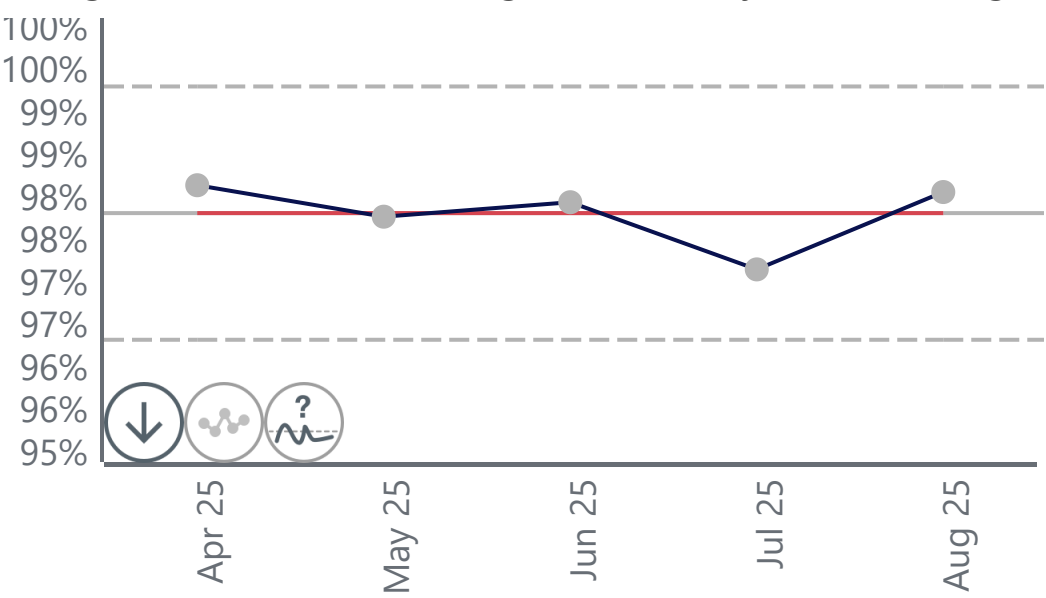
RTT Pathway Waiters (52+ weeks) for the most deprived areas



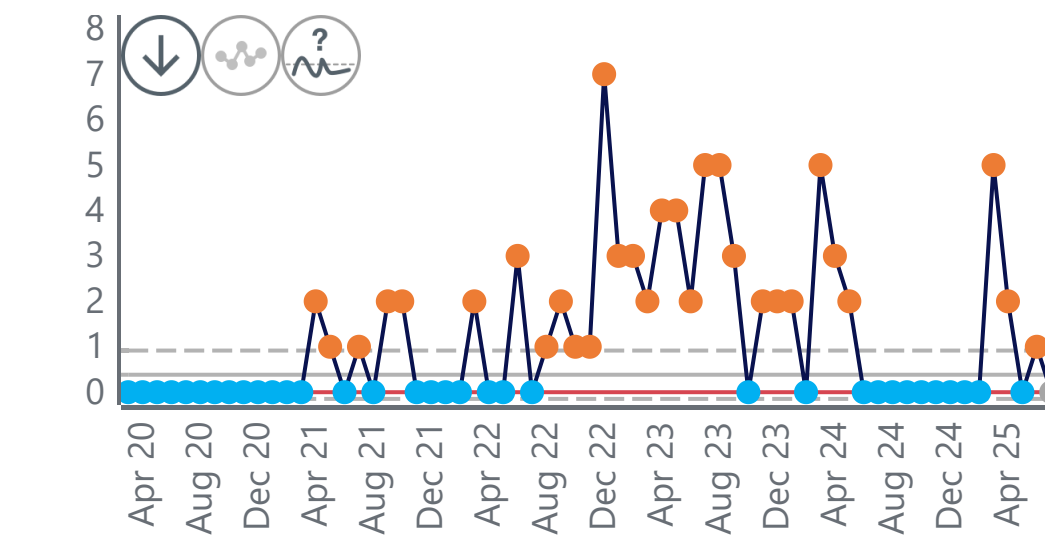
DNA Rate for most deprived areas



Percentage of patients discharged on Ready for Discharge



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



Productivity

SRO: Ben Davies, Associate Director of Transformation

Highlights:

- * PIFU performance has improved this month, and we have achieved our target. The standard operating procedure has been signed off on by the divisional boards. Ongoing work continues to explore how we can expand the implementation of PIFU as a trust.
- *The overall diagnostic DNA rate has once again improved this month, going from 6% to below 5%. CT and MRI DNAs remain below the 5% target, with Echo's rate reducing from 10% to 8%. The Sleep DNA rate, which had been improving over the last couple of months, increased slightly in August.
- * Risk-stratified overdue follow-ups performance has decreased this month, remaining slightly above the set target of 15%. The FOWL policy is currently being ratified through the Safer Waiting List group to help reduce these figures. The overdue follow-up watch metric has increased for August, which is due to capacity vs. demand issues. With PIFU live for ICC, this will aid in releasing capacity.
- * Slot utilisation performance has seen a massive improvement over the last 2 months, going from 42% to over 60%. This is due to the work the division has done reviewing our clinic templates to ensure we have the right capacity allocated accordingly.

Areas of Concern:








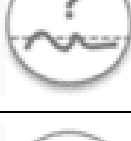




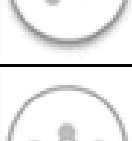

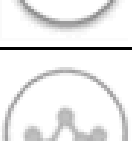
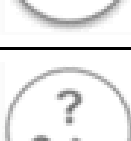










- * Core theatre session delivery performance has reduced again this month, which has been associated with lower bank uptake.
- * As mentioned above, risk-stratified overdue follow-up performance has decreased. Whilst it is felt that there is no clinical risk, we will explore how best to manage this and improve overall performance.

Forward Look (with actions):

- * The divisional leadership team continue to work on ensuring all theatre lists are fully utilised to improve theatre session utilisation. The team now have the theatre dashboard in place to aid with performance monitoring and management.
- * Ratification and implementation of the FOWL policy, which will support staff to more effectively manage overdue follow-up appointments.
- * The Medicine division is exploring the option of conducting ICC work in the community in the future.
- * Continue to review clinic templates, removal of legacy clinics and address any that are not set up in a standard format, that are currently impacting our performance data.



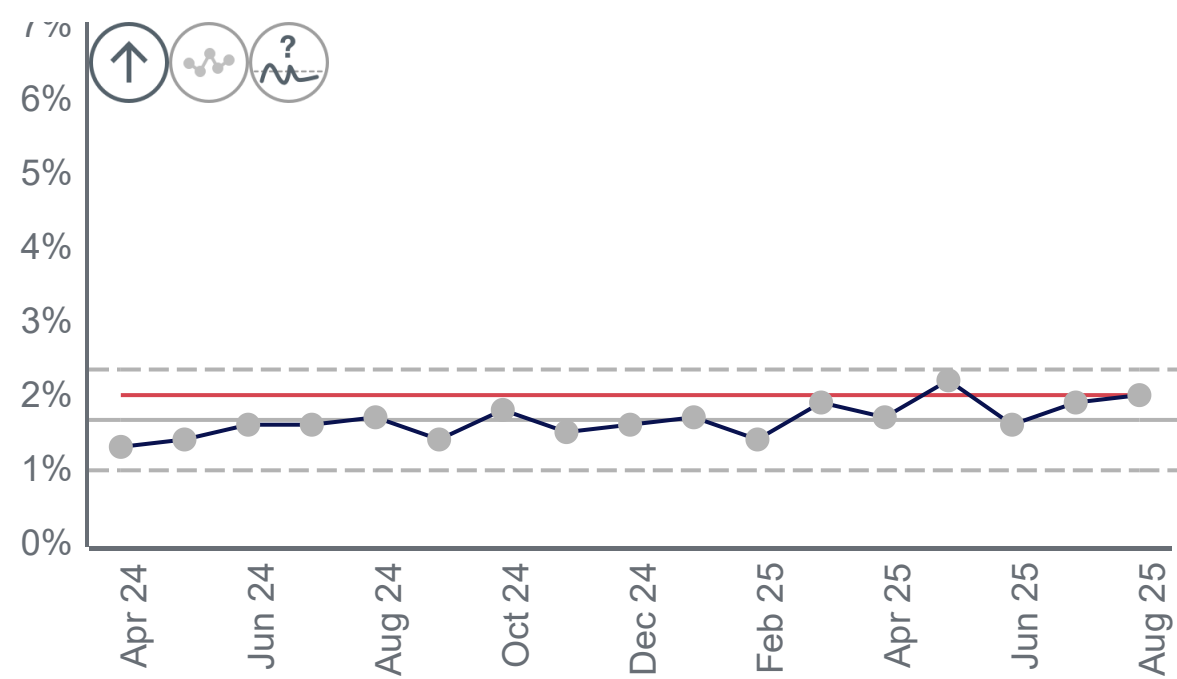
Productivity - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
% Avoidable Cancellations (Theatres)	Aug-25	1.2	1%	0.9		
% Core Session Delivery (Theatres)	Aug-25	92.5	95%	95.7		
% Session Utilisation (Theatres)	Aug-25	87.1	85%	84.1		
Diagnostic DNA Rate	Aug-25	5.0	3%	6.2		
CT DNA Rate	Aug-25	4.0	3%	3.8		
MRI DNA Rate	Aug-25	3	3%	3.8		
Echo DNA Rate	Aug-25	8	3%	9.6		
Sleep DNA Rate	Aug-25	13	3%	12.8		
% Patients on PIFU	Aug-25	2	2%	1.9		
Risk stratified Overdue Follow Ups (>25% overdue)	Aug-25	19.31		17.3		
Overdue Follow Ups	Aug-25	28.78	25%	25.7		
Slot Utilisation	Aug-25	63.4	85%	47.7		
Theatre and Cath Lab Utilisation Combined	Aug-25	89.44	85%	85.6		



Productivity - Drive Metrics

% Patients on PIFU



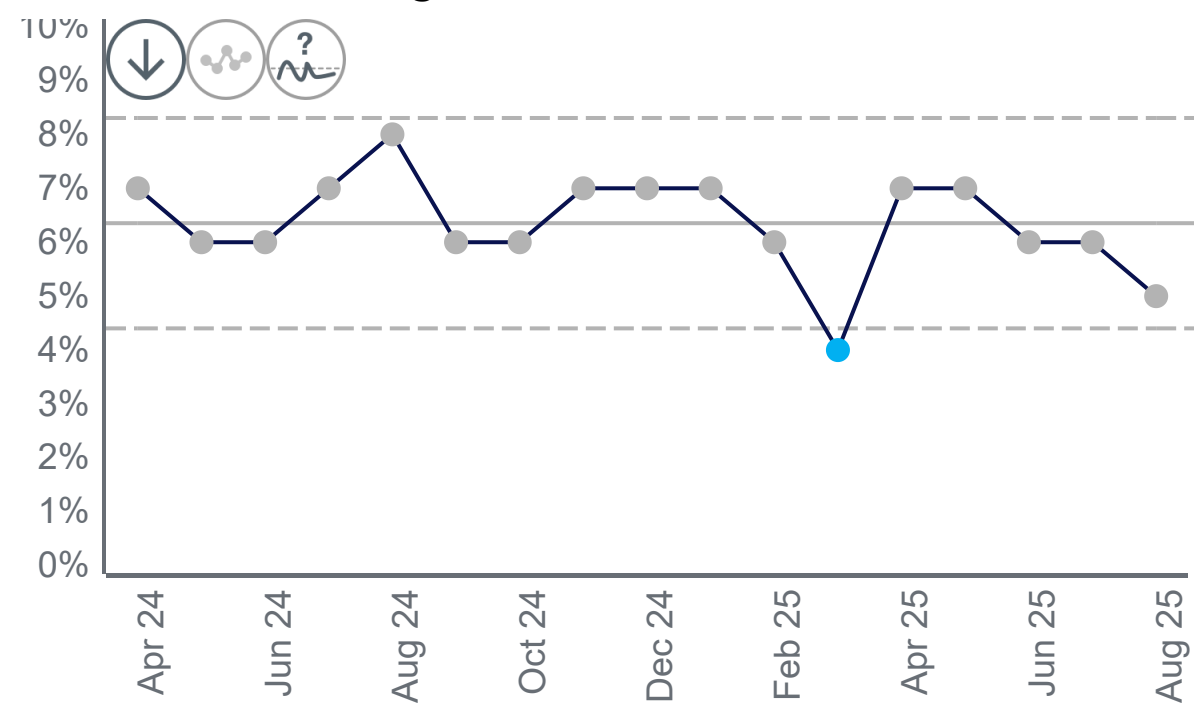
Technical Analysis:

The trust achieved the target of 2% target in Aug-25. Performance has routinely shown common cause variation with improvement required to achieve the target consistently.

Actions:

*With the SOP now signed off, we will continue to explore how we can implement PIFU more widely across the trust, where applicable.

Diagnostic DNA Rate



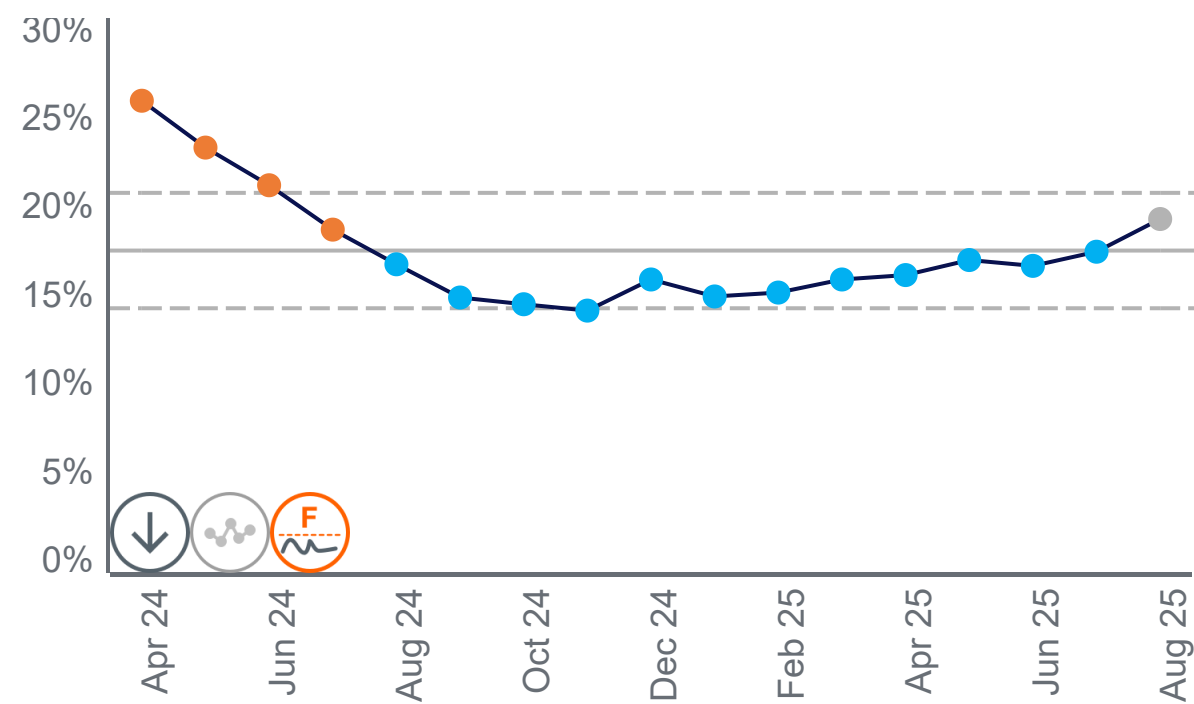
Technical Analysis:

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

Actions.

*Continue work to sustain our improvement by monitoring and tracking performance, noting that previous system issues have been addressed accordingly.

Risk stratified Overdue Follow Ups (>25% overdue)



Technical Analysis:

Performance continues to display inconsistency, following a period of improvement performance is beginning to display an upward trend. Further work required as the Trust continues to fall short the target.

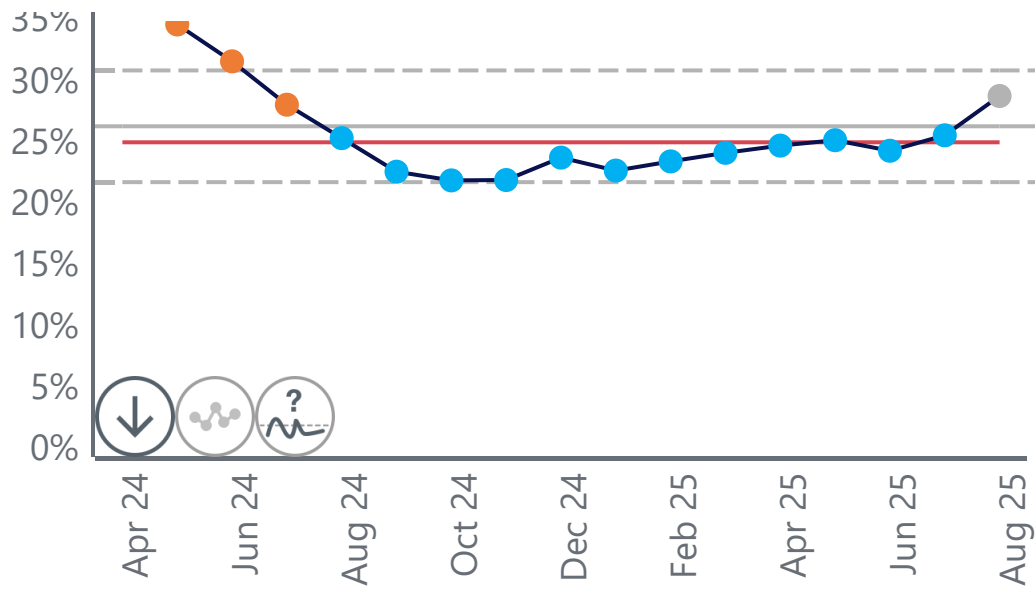
Actions:

* A focus on overdue follow-ups via the performance group.
* Once SOP for the management of patients on the FOWL has been ratified, this will be rolled out to staff to better manage performance.

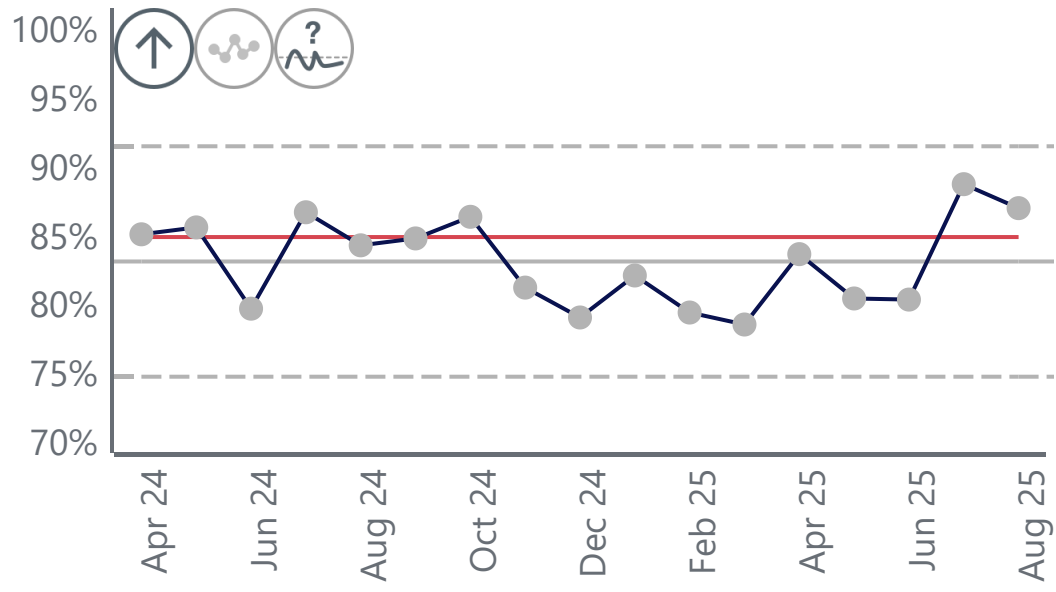


Productivity - Watch Metrics

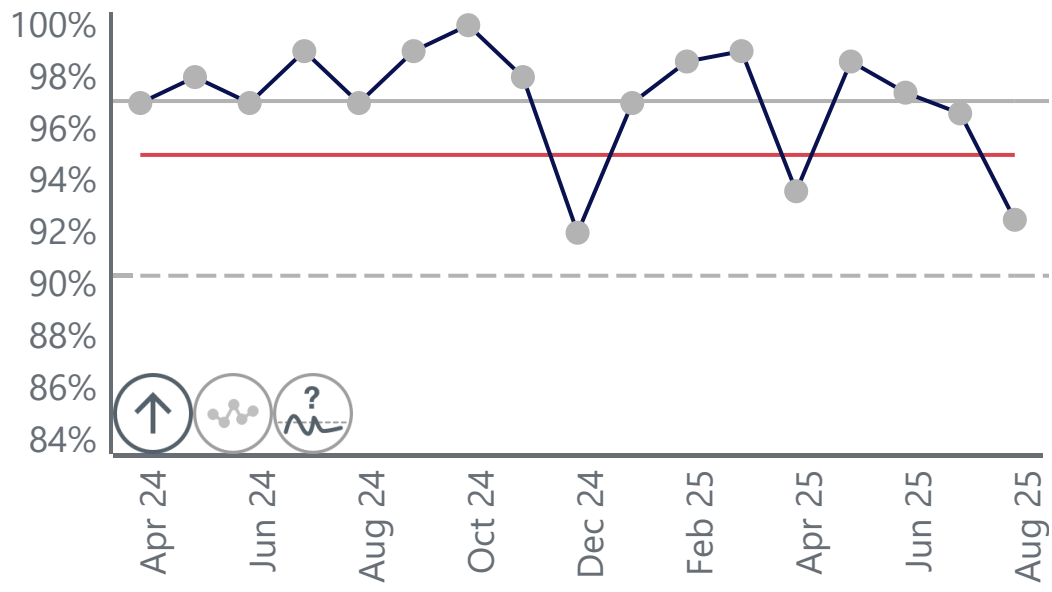
Overdue Follow Ups



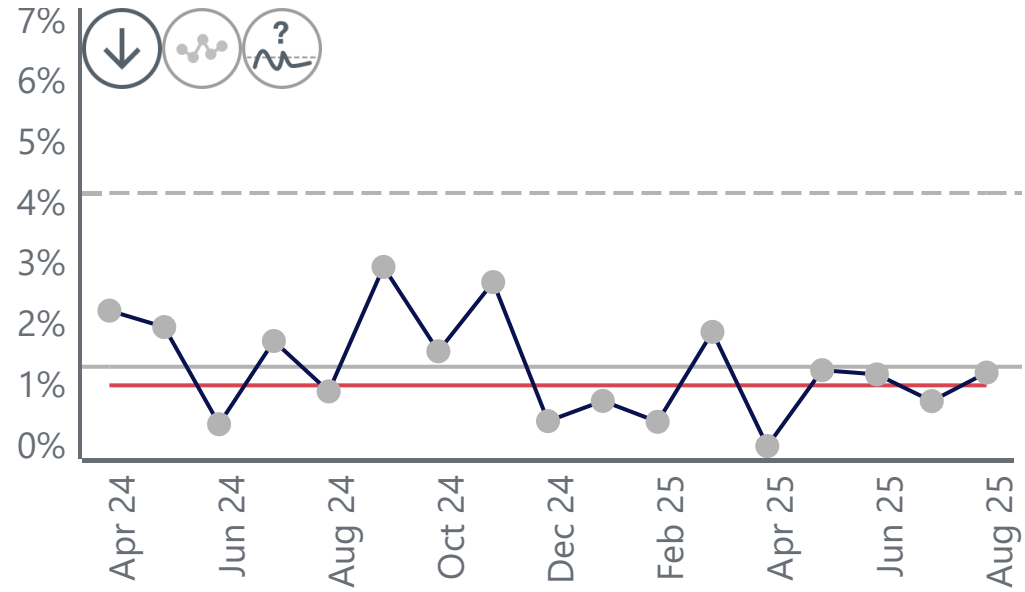
% Session Utilisation (Theatres)



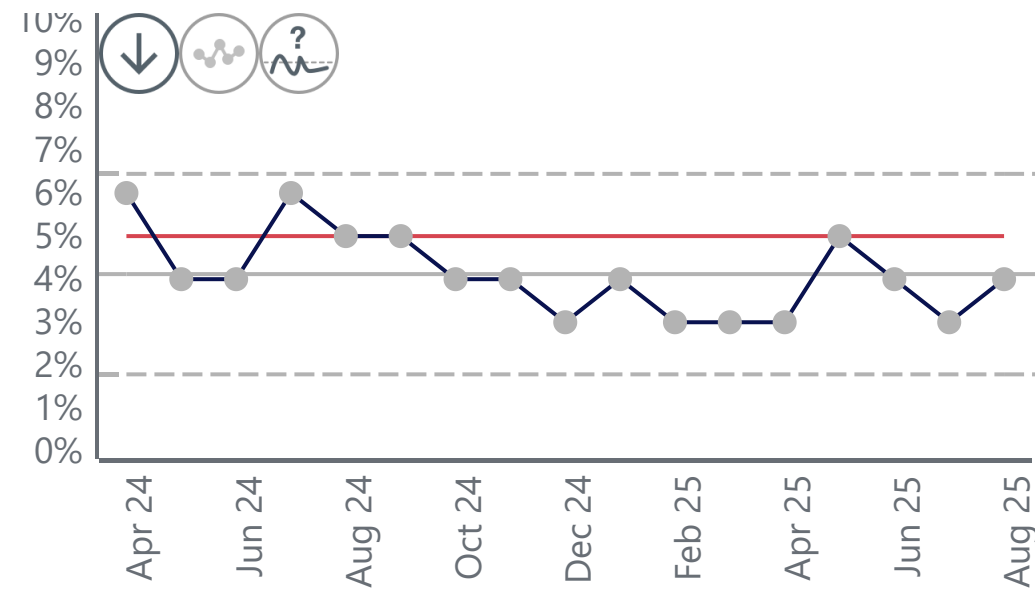
% Core Session Delivery (Theatres)



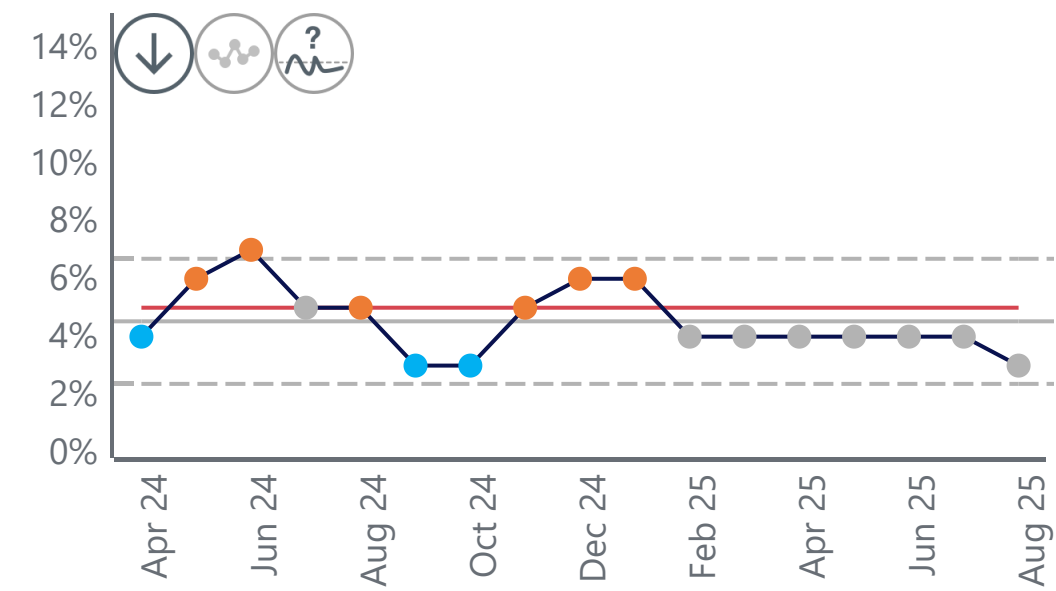
% Avoidable Cancellations (Theatres)



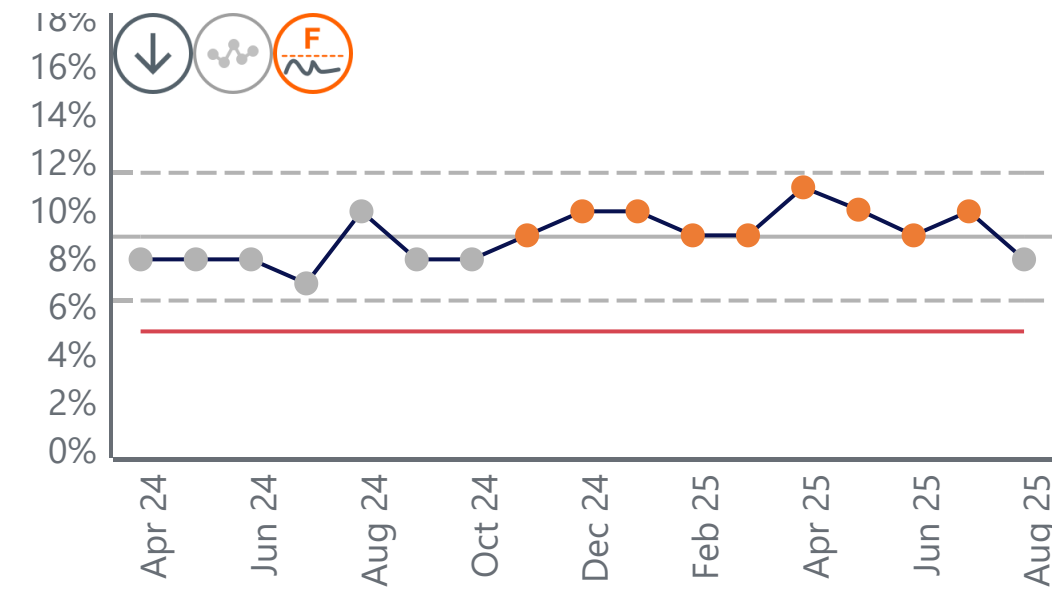
CT DNA Rate



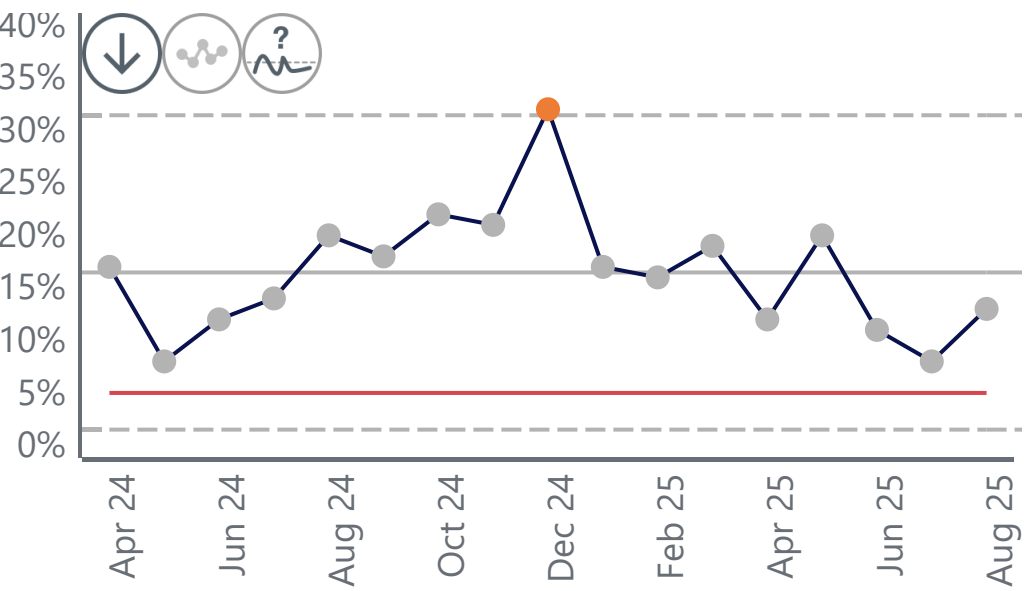
MRI DNA Rate



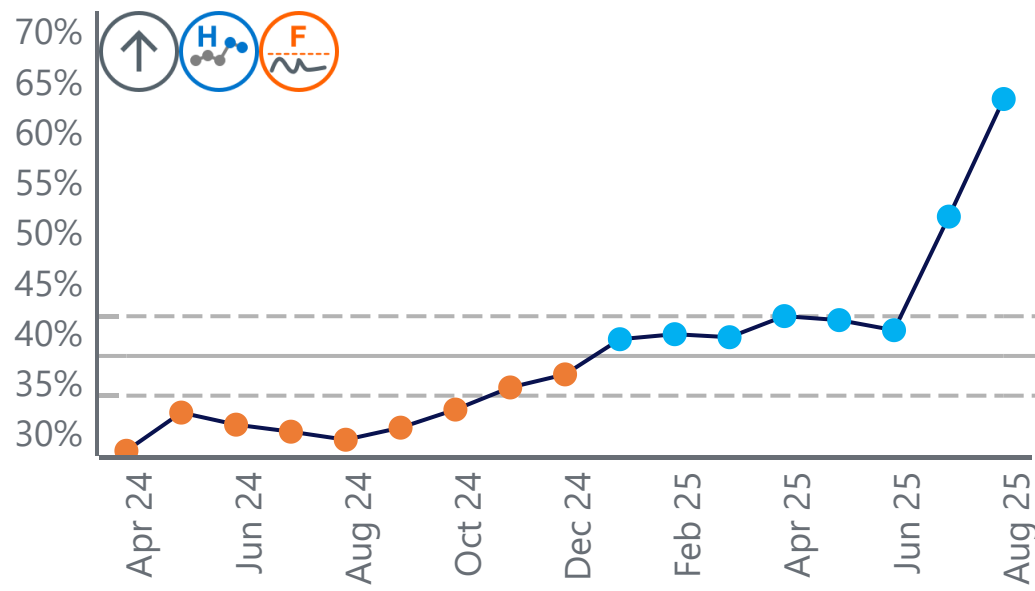
Echo DNA Rate



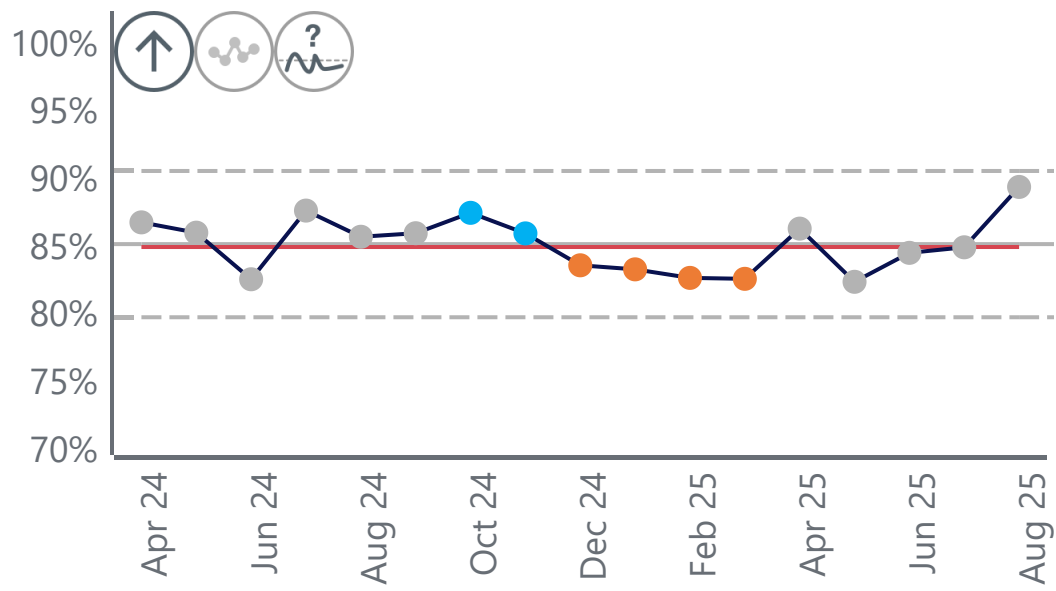
Sleep DNA Rate



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.
- *Following investigation it was deemed the incident involving a retained wire did not meet the full definition of a never event but did meet the exception criteria. 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.
- * New audit tool live now for SHMs without RARs, improving accuracy of data. Improved compliance see in June 2025.

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.
- *Mersey Care have ended the Mental Health SLA with LHCH which takes effect from 1st July 2025. As a result, the trust no longer has specialist access to Mental Health input. There is also now no Trust Delirium Lead although a consultant intensivist has been appointed to lead Delirium management in critical care.

Forward Look (with actions):

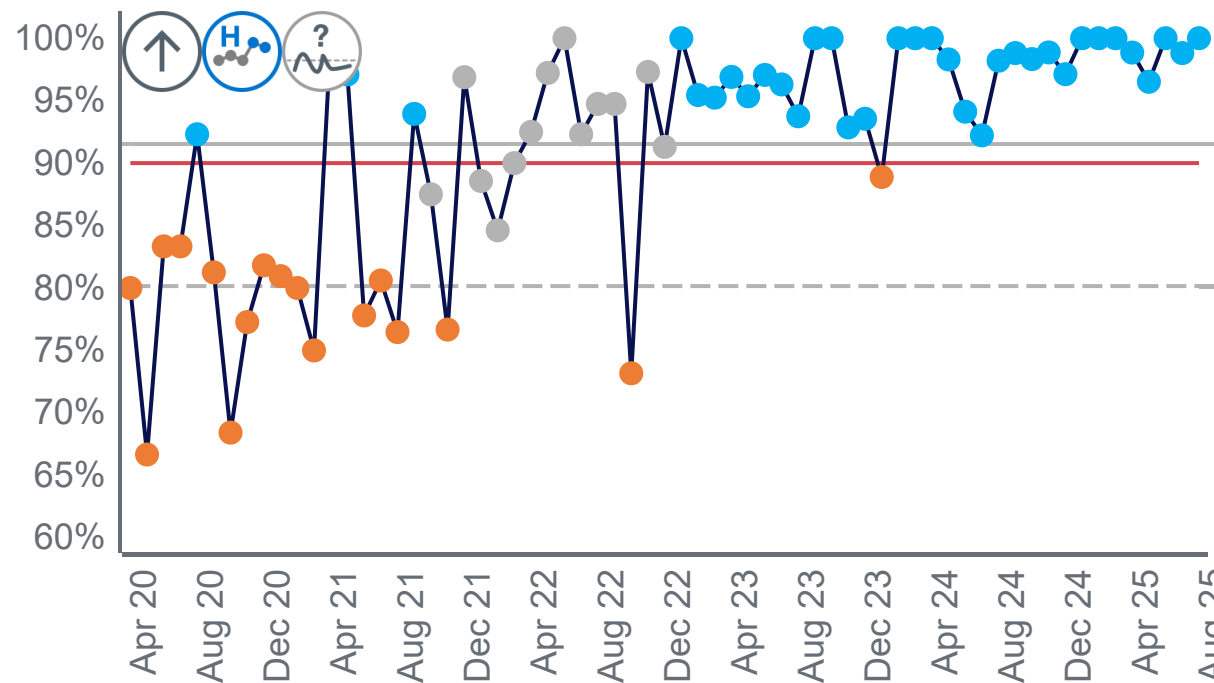
- *Radiology Alert Response (RAR) dashboard - Work has been completed on improving the quality of the audit tool as planned and the new dashboard and audit tool are live. Divisions continue to use this dashboard to improve compliance.is regularly used by Divisions to improve compliance. Ongoing work to improve data quality of the audit tool, which is more likely the issue.
- *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	Jul-25	94.9	>=95%	88.5		
95% of all patients to receive a copy of their Discharge Summary on day of discharge	Aug-25	96.2	>=95%	95.9		
Clostridium Difficile	Aug-25	0.0	0	0.0		
Delirium Risk Assessment to be completed on Admission and once a day	Aug-25	99.2	>=90%	99.4		
Delivery of at least one sepsis antibiotic within one hour of prescription (LHCH target)	Aug-25	100.0	>=90%	98.8		
Dementia - Find	Aug-25	100	>=90%	100.0		
Gram Negative Bacteraemias	Aug-25	2	0	1.2		
Incidents - Serious incidents, Never Events, Adverse Events (Red)	Aug-25	0	0	0.0		
MRSA Bacteraemias	Aug-25	0	0	0.0		
MSSA Bacteraemias	Aug-25	0	0	0.8		
Number of Falls	Aug-25	8		8.0		
Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care)	Aug-25	0	<=0.5	0.0		
Number of LHCH acquired grade 3+ pressure ulcers (due to lapses in care)	Aug-25	0.0	<=0	0.0		
Nutrition - Patients scoring high risk (2 or more) are referred to dietician	Aug-25	75	>=90%	89.0		
Occurrence of any Never Events	Aug-25	0.0	0	0.0		
Primary PCI - 60 minute 'Door-to-balloon' (national target)	Aug-25	76.8	>=75%	77.9		
Primary PCI - 150 minute 'Call-to-balloon' (national target)	Aug-25	63.3	>=95%	68.3		
Quantity of complaints	Aug-25	0	<=6	1.6		
Venous thromboembolism (VTE) risk assessment	Aug-25	95.2	95%	95.2		
Number of Incidents No Harm and Near Miss	Aug-25	87	143	110.0		
Number of Incidents rated Minor Harm or Above	Aug-25	38	25	28.8		
FFT: REPUTATION	Aug-25	99.7	>=95%	99.0		
FFT: AFTER STAY	Aug-25	97.8	>=95%	98.0		
FFT: ARRIVAL	Aug-25	99.3	>=90%	99.3		
FFT: PATIENT CONTRACT	Aug-25	99.3	>=95%	99.3		
FFT: STAY	Aug-25	99.7	>=95%	99.6		
FFT: TREATMENT	Aug-25	99.8	>=90%	99.3		
Incident Closures within 28 days	Jun-25	65.4	0	57.8		
Surgical Site Infections	Jun-25	7.7	0%	7.7		

Quality of Care - Drive Metrics

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



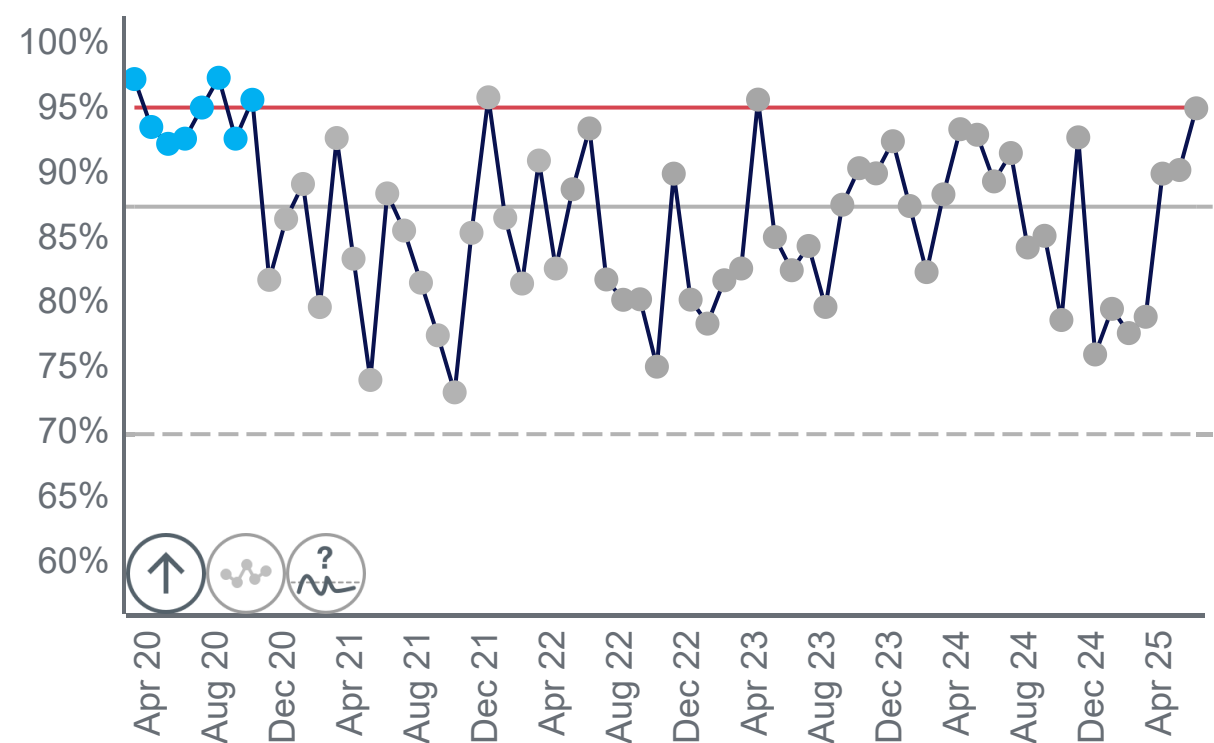
Technical Analysis:

Performance of the one hour Target remains above target. This displays positive consistency for Sepsis identification and treatment. The trust has not failed to achieve the target since Jan-24.

Actions:

Maintain weekly feedback to clinicians if this metric is missed

% of radiological alerts with a response document



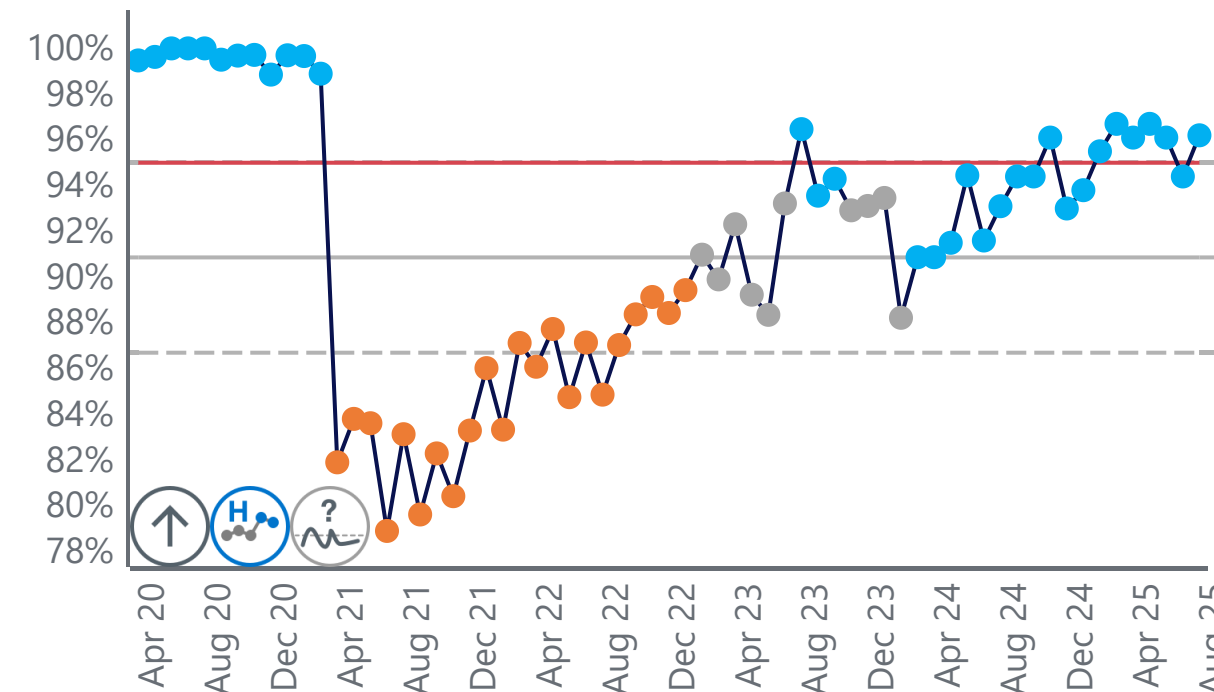
Technical Analysis:

July performance remains consistent with previous months displaying common cause variation. Improvement is required to achieve target on a consistent basis. The target was achieved for the first time since May-23. Metric reporting has been adjusted to report 2 months in arrears.

Actions:

Work has been completed on improving the quality of the audit tool as planned and the new dashboard and audit tool are live. Divisions continue to use this dashboard to improve compliance.

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



Technical Analysis:

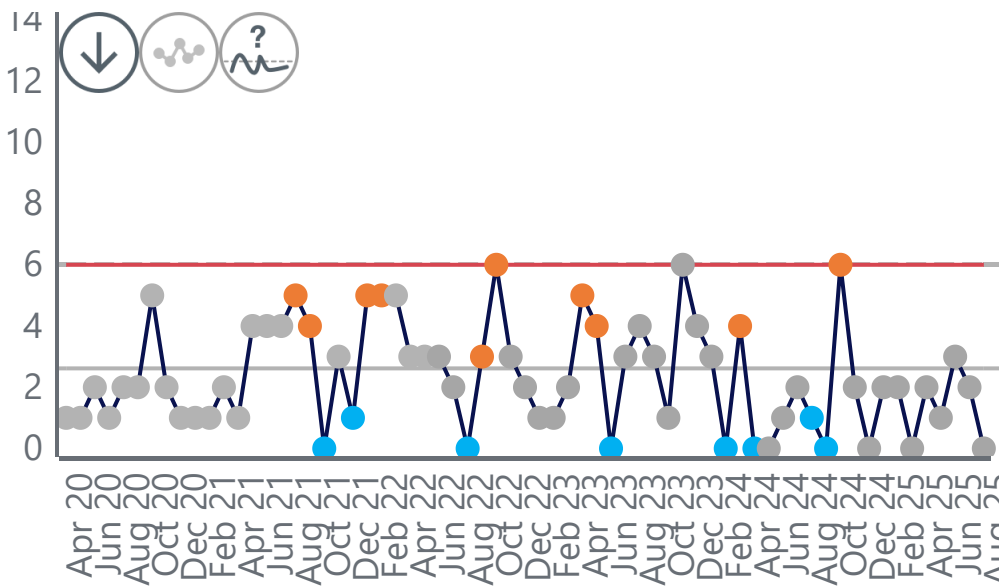
Performance in August is above the target of 95% displaying special cause improvement. Continual work required to consistently achieve target with the metric displaying inconsistency of passing and falling short of the target.

Actions:

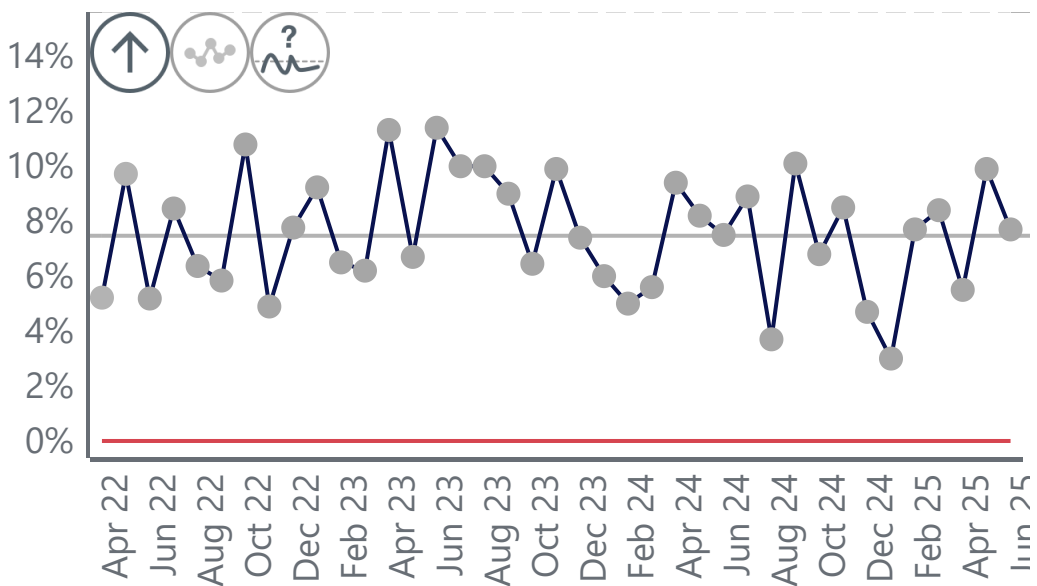
Continued focus on keeping up recent improvement.

Quality of Care - Watch Metrics

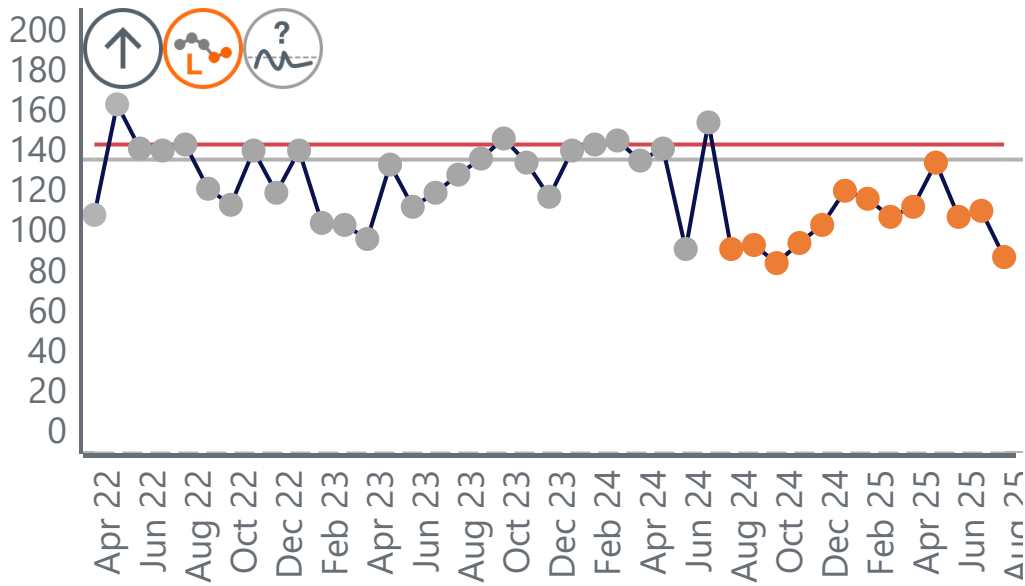
Quantity of complaints



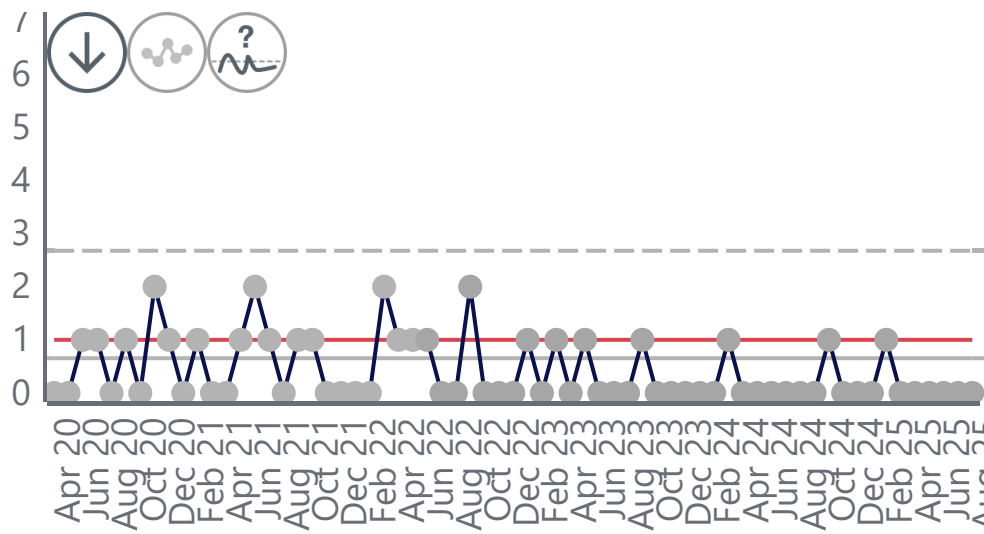
Surgical Site Infections



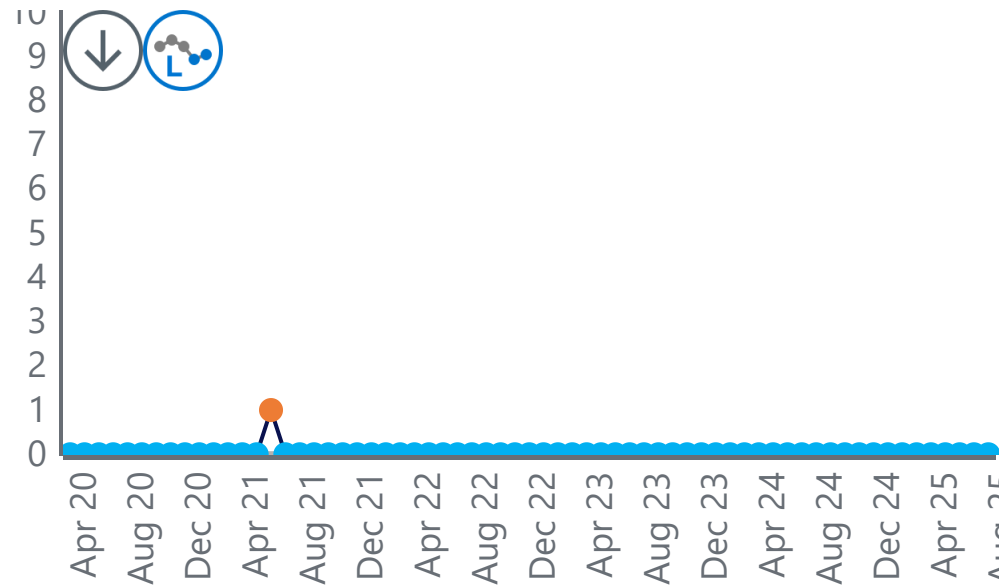
Number of Incidents No Harm and Near Miss



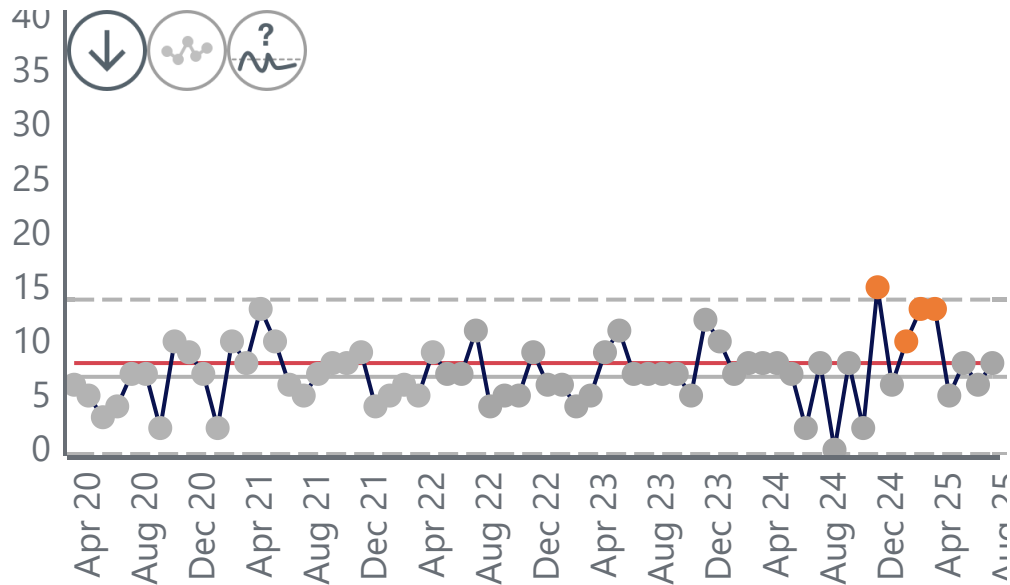
Incidents - Serious incidents, Never Events, Adverse Events (Red)



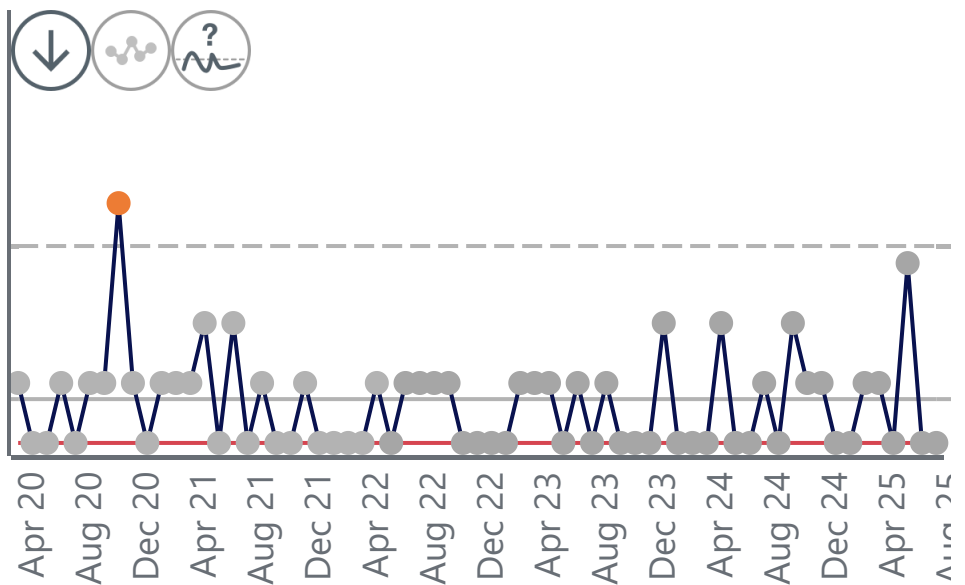
Occurrence of any Never Events



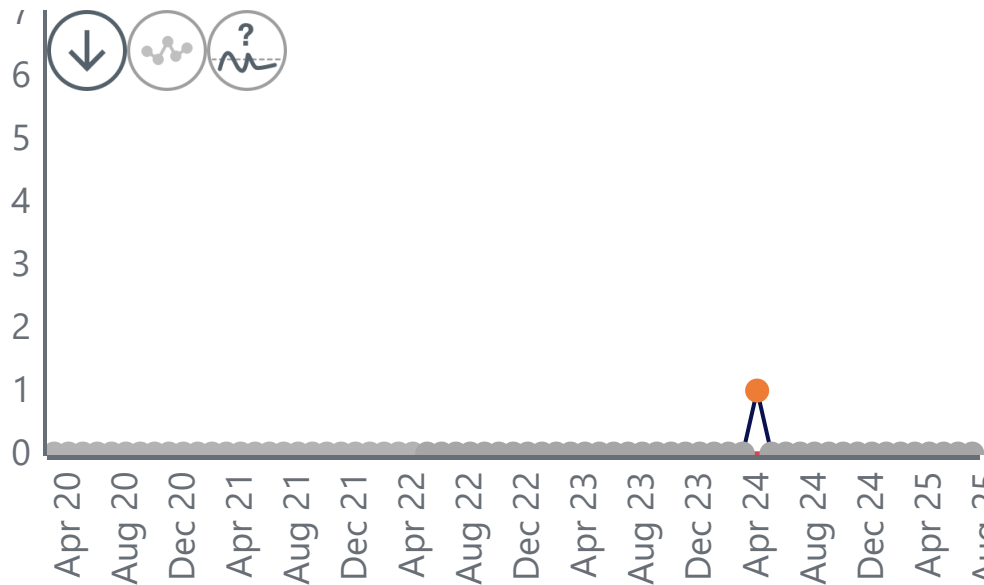
Number of Falls



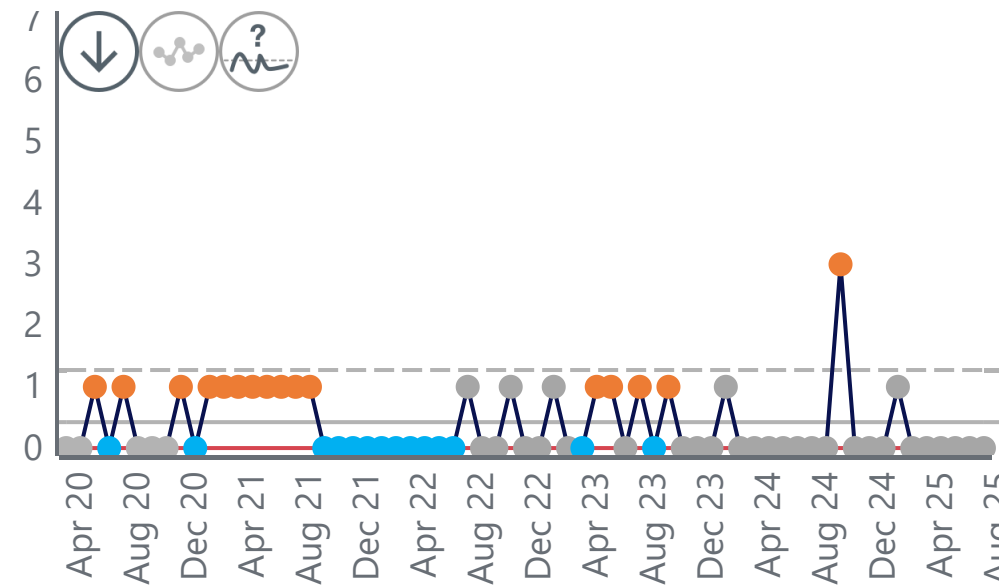
MSSA Bacteraemias



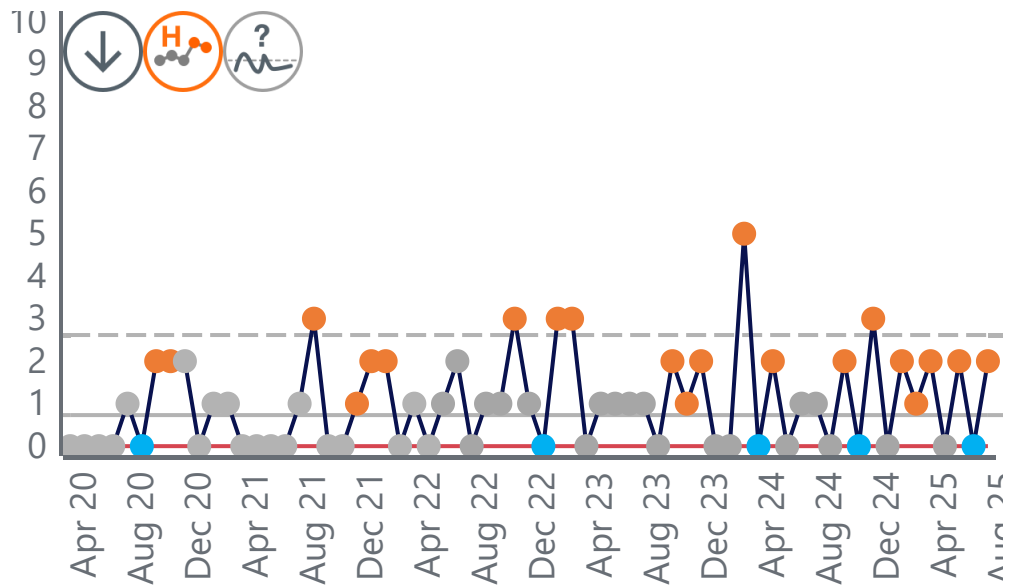
MRSA Bacteraemias



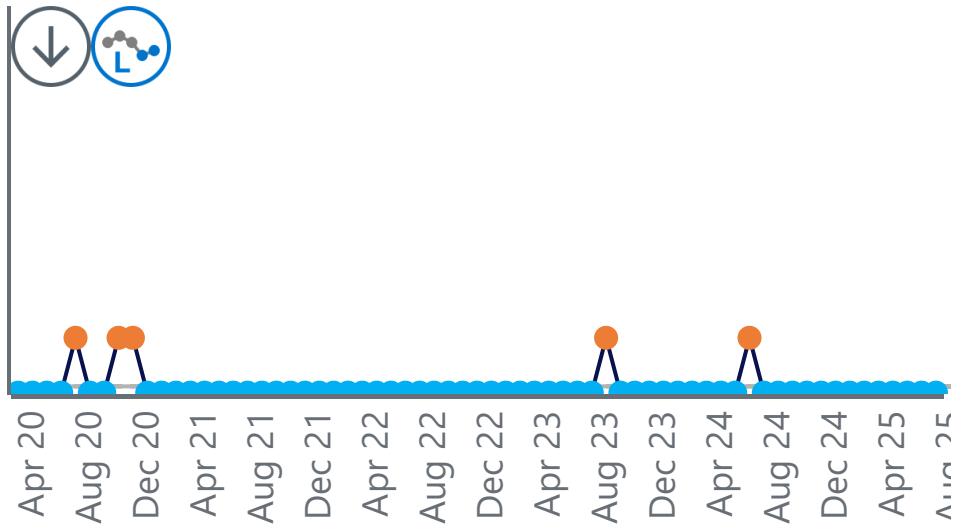
Clostridium Difficile



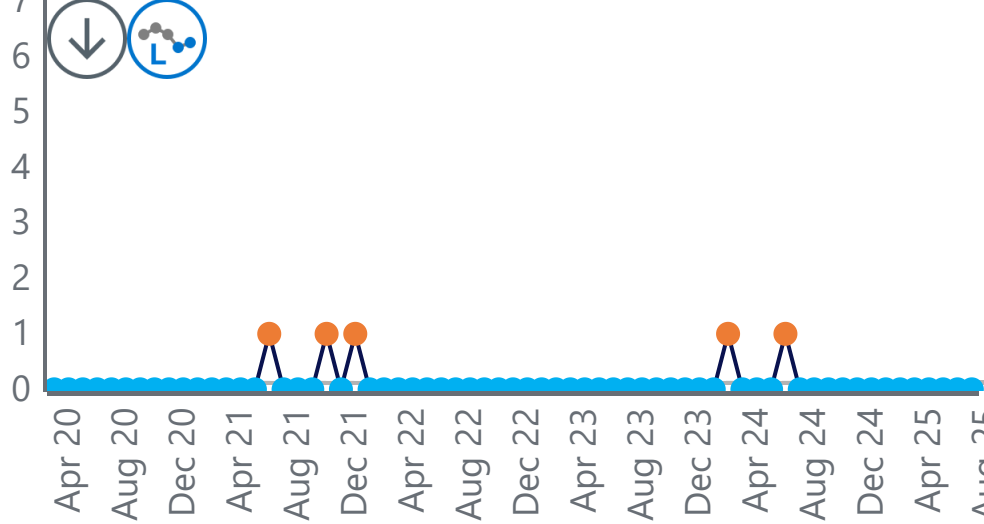
Gram Negative Bacteraemias



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

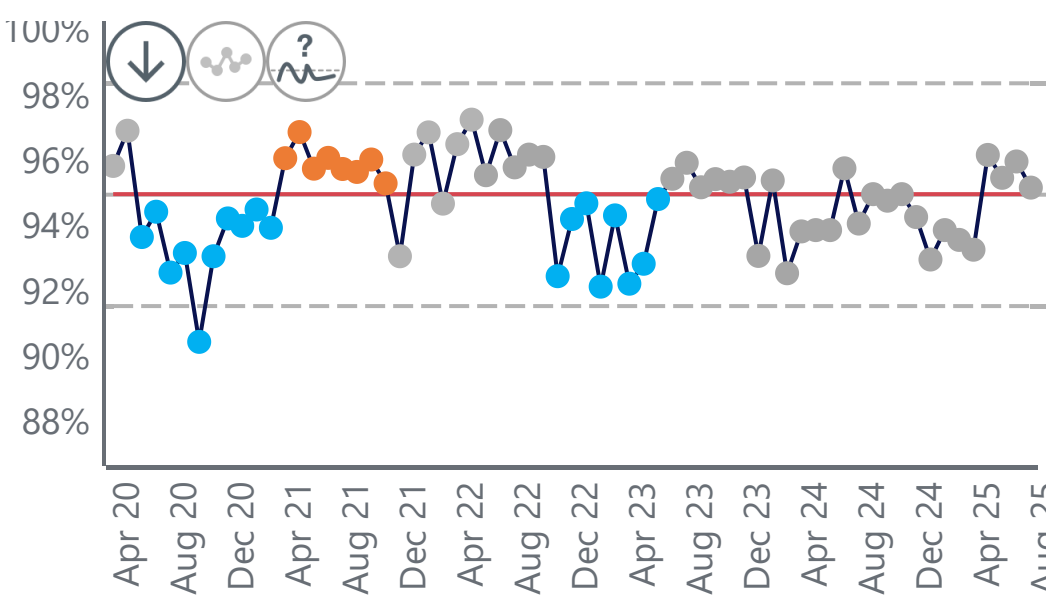


Number of LHCH acquired grade 3+ pressure ulcers (due to lapses in care)

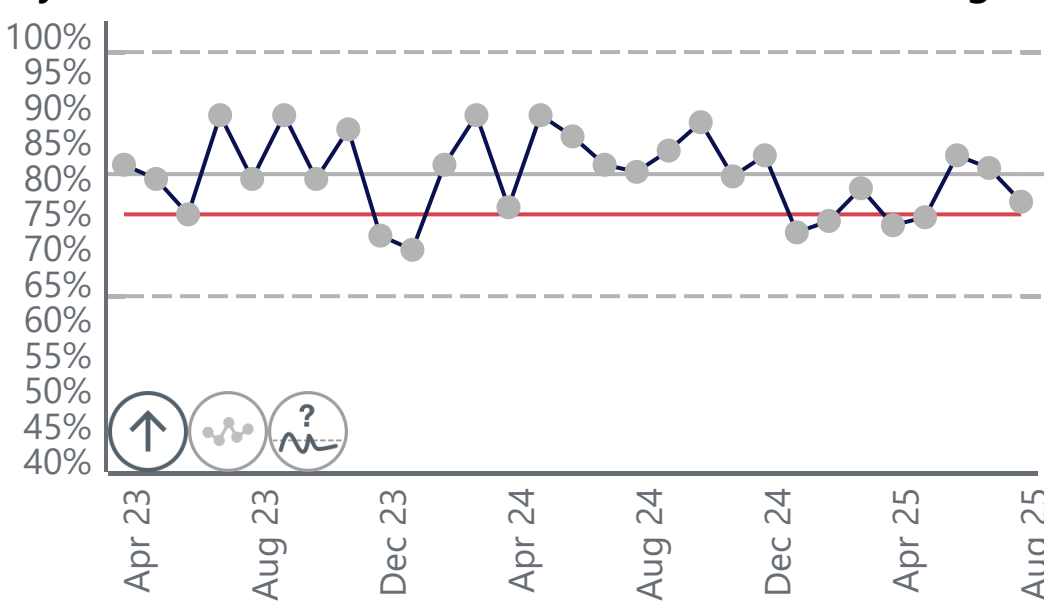


Quality of Care - Watch Metrics

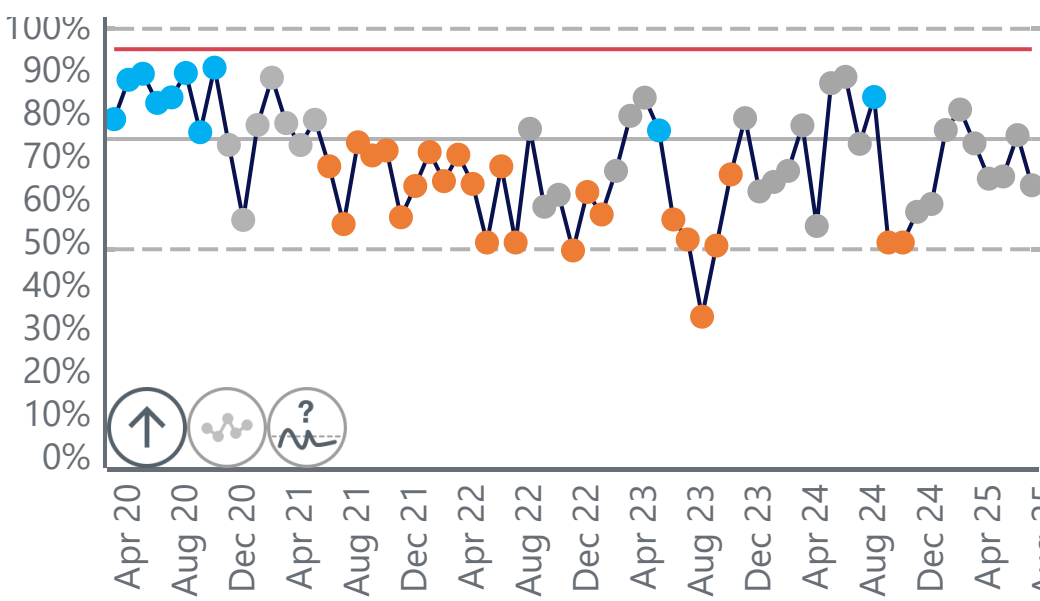
Venous thromboembolism (VTE) risk assessment



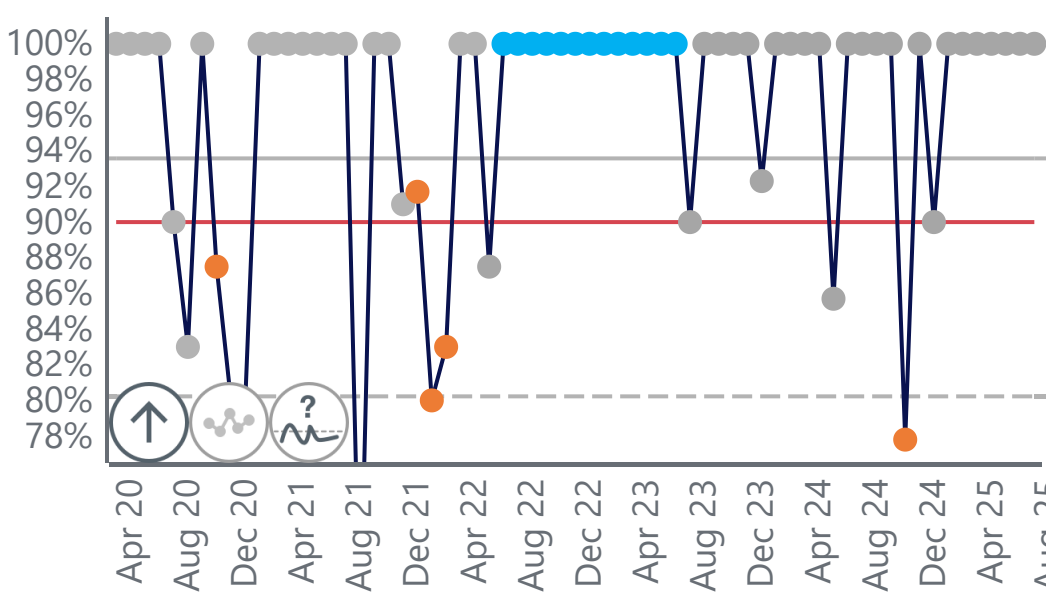
Primary PCI - 60 minute 'Door-to-balloon' (national target)



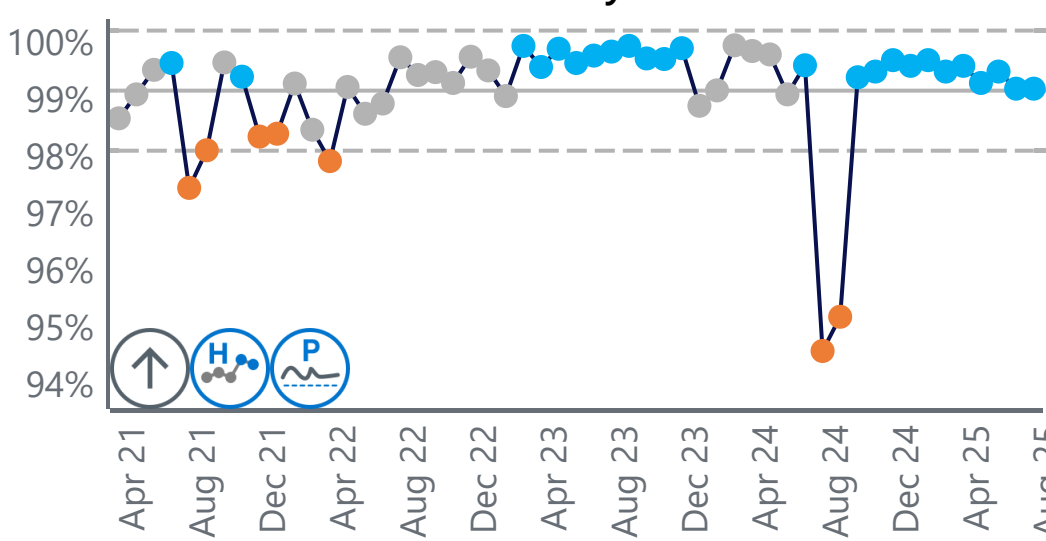
Primary PCI - 150 minute 'Call-to-balloon' (national target)



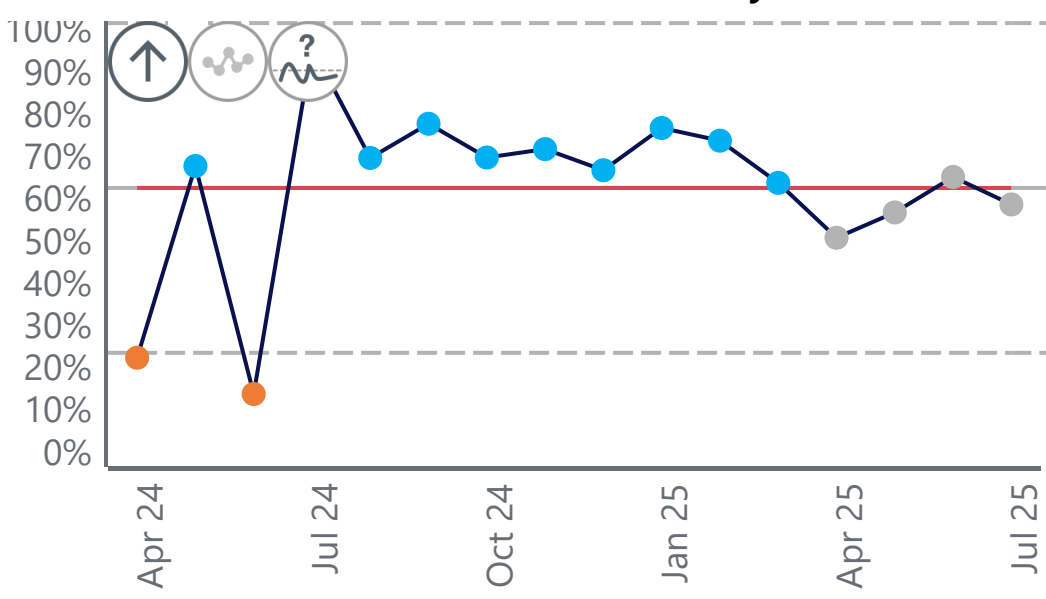
Dementia - Find



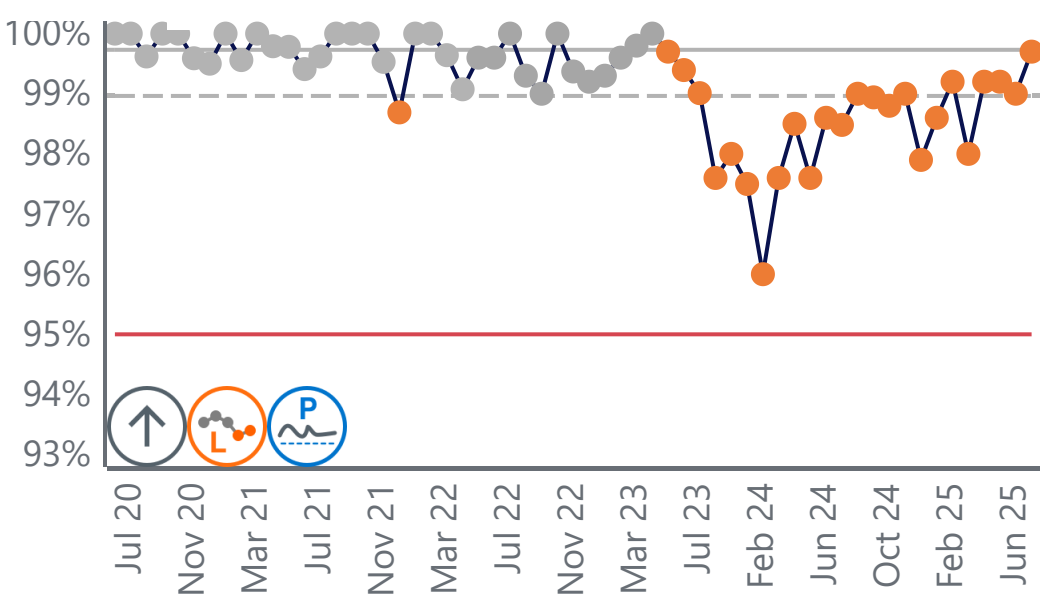
Delirium Risk Assessment to be completed on Admission and once a day



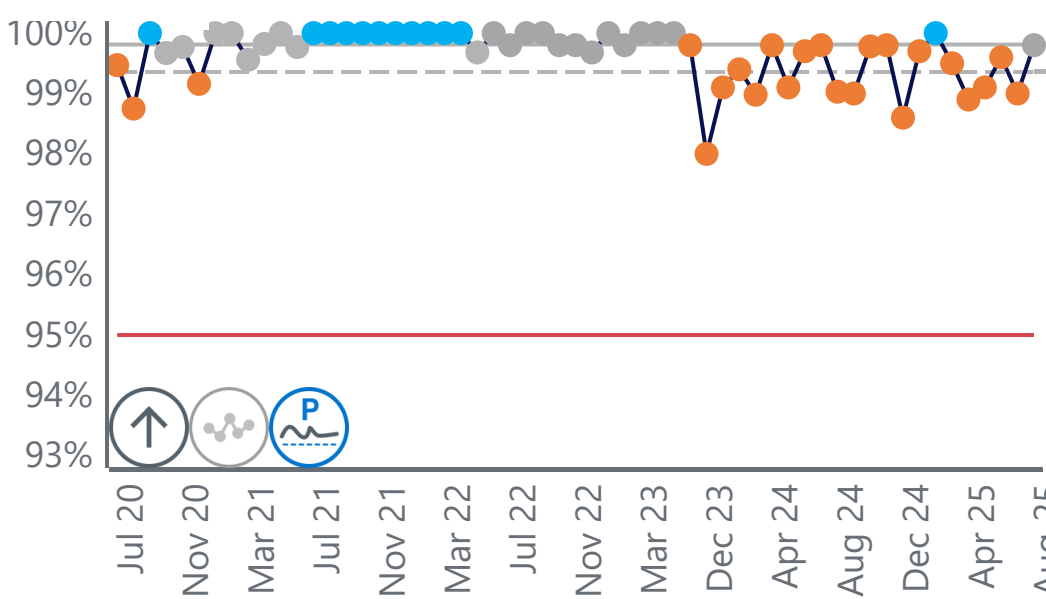
Incident Closures within 28 days



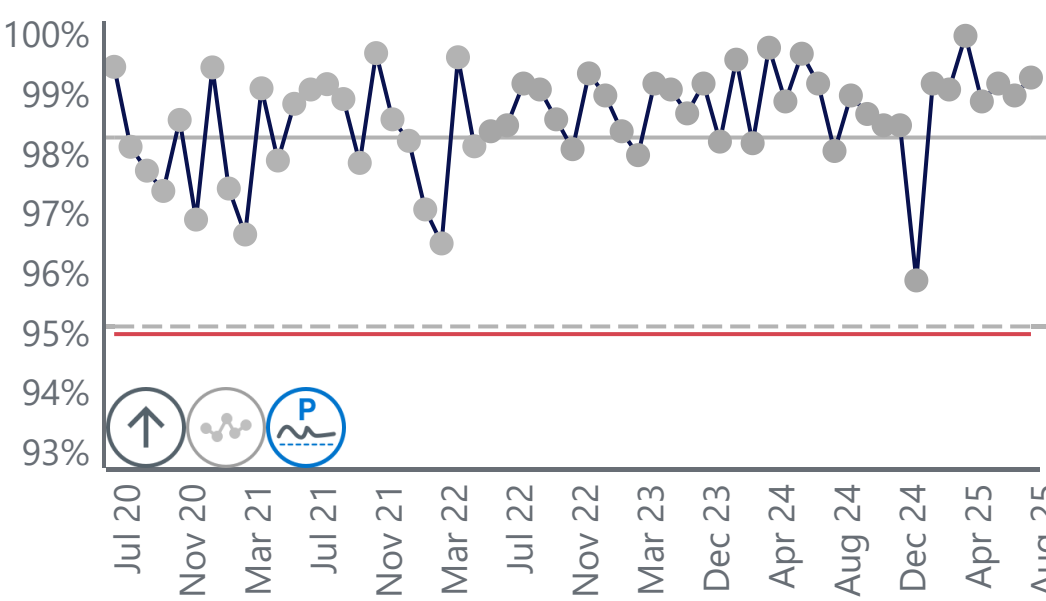
FFT: REPUTATION



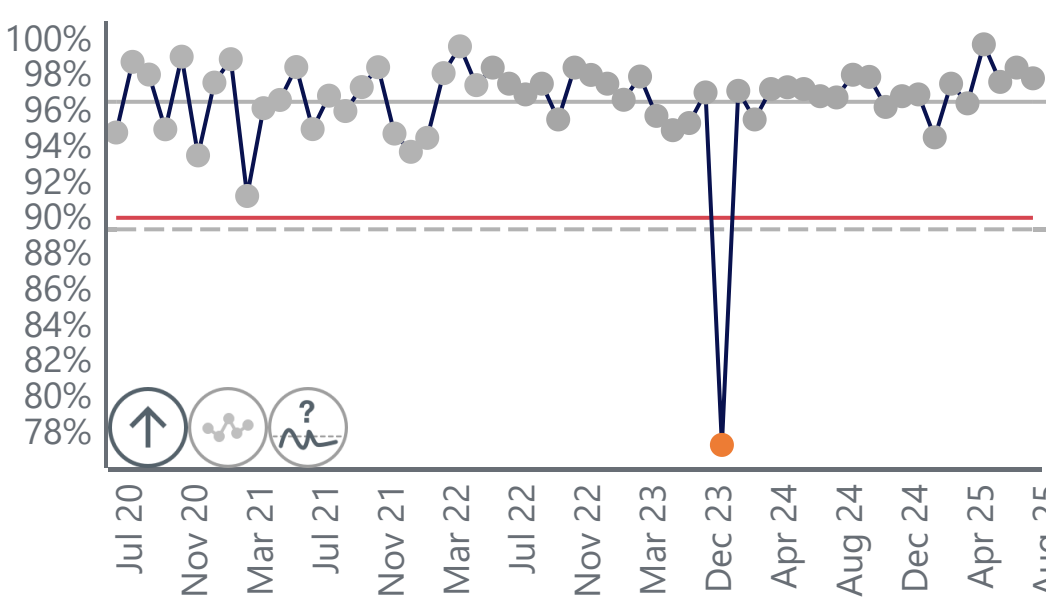
FFT: TREATMENT



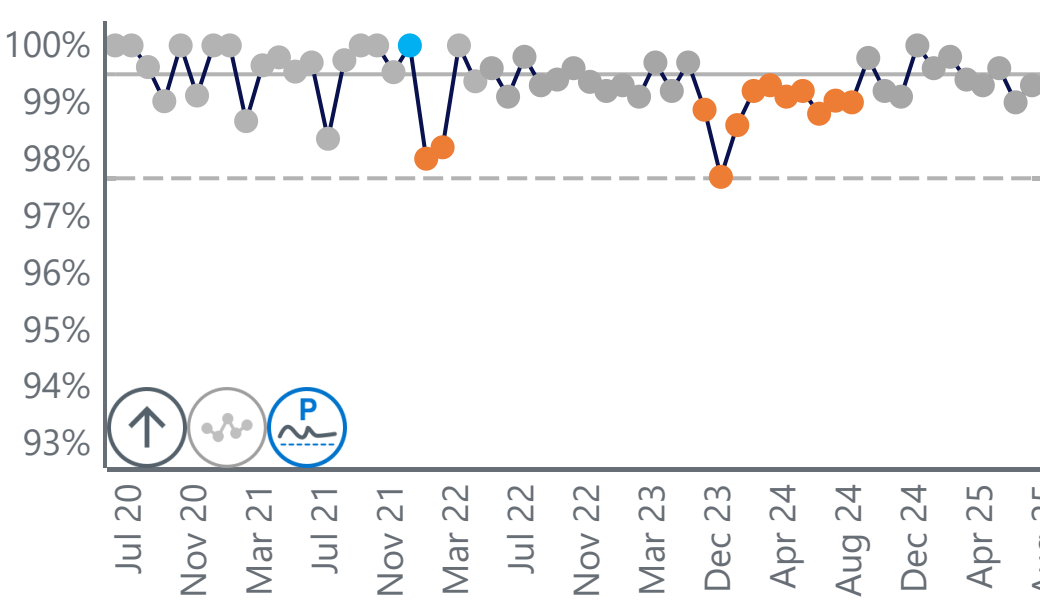
FFT: ARRIVAL



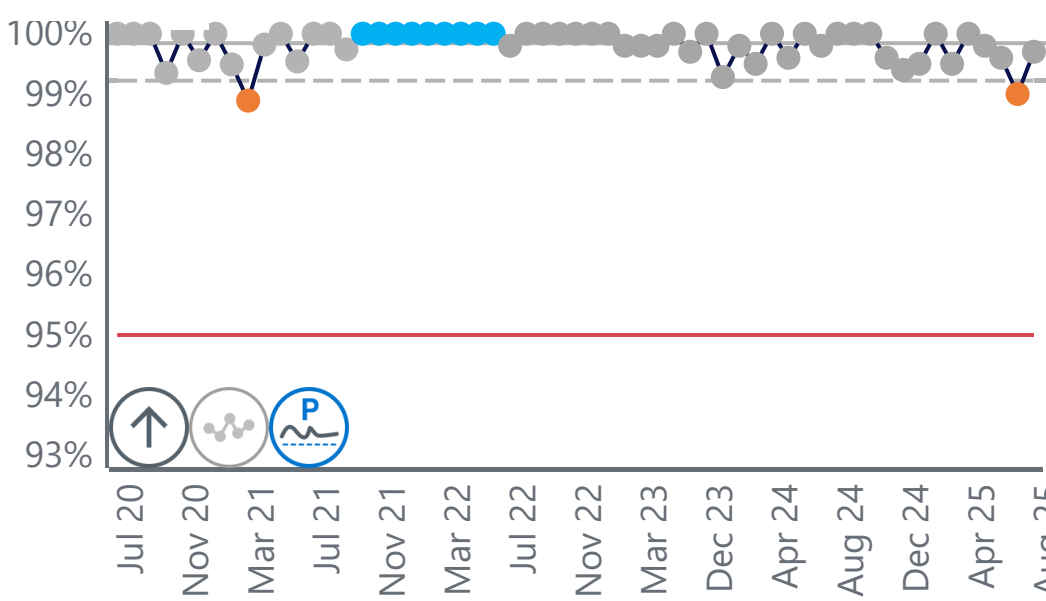
FFT: AFTER STAY



FFT: PATIENT CONTRACT



FFT: STAY



Finance

SRO: James Thomson, Chief Finance Officer

Highlights:

The month 5 year to date financial performance is a £3,439k surplus which represents a £5k favourable variance to plan. Month 5 saw positive performance against CIP delivery, income from Lung Cancer Screening and pay spend. This recovered the adverse variance from earlier in the year.

A number of shortfalls in income remain, most notably Wales and Private Patients. Income for the core contracts with Specialised commissioning and the ICB are in line with the plan.

Despite the positive CIP performance in month 5, there remains a shortfall in CIP delivery, and this continues to be the largest budgetary pressure. Confirm and Challenge sessions continue with each division, and high-risk corporate departments.

Pay costs are lower than plan with reductions in overtime and bank. The variable payments (bank, overtime, consultant additionality payments and agency) are all lower than the same period last year.

Non-pay spend is largely consistent with the budget, with the exception of the undelivered CIP which sits within non-pay budget codes.

The shortfall in income and CIP delivery in the first quarter of the year has been offset by non-recurrent actions to ensure the Trust's financial performance is consistent with the plan.

Areas of Concern:

Slippage against the CIP plan created a financial pressure in the first five months of the year. The annual CIP 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. Divisional CIP performance has shown a marked improvement over the last three months, but continued momentum is needed to turn CIP opportunities into fully delivered schemes. Surgery and Corporate departments are particular areas of concern.

The income position remains behind planned levels, with under-performance against a number of income targets. Most notable is the Wales under-performance. This demonstrated significant growth in recent years, but activity continues to be far lower than last year.












The investment in cath lab 7 is predicated on additional income from commissioners. Both the ICB and Specialised Commissioning have added this elective activity to the contracts, and activity is in line with the projections.

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 meeting the income and activity plan. 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.

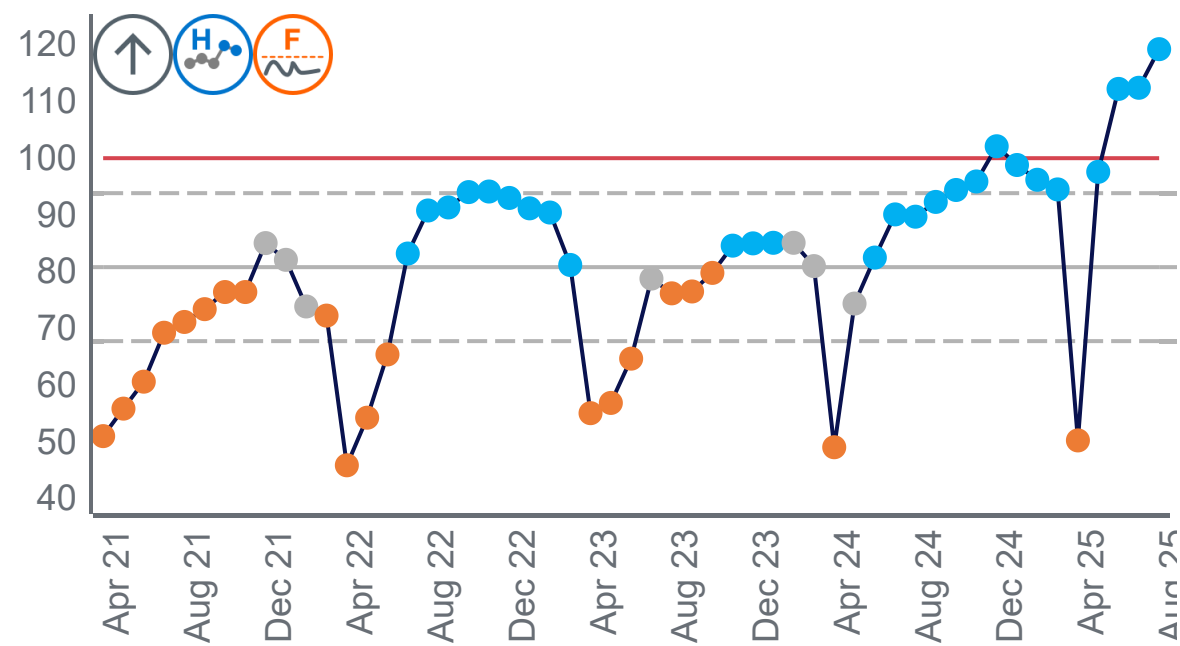
Finance - Metric Summary

Metric Name	Month	Performance	Target	Average / Cumulative	Variation	Assurance
I & E distance from target (cumulative) - £,000	Aug-25	500	0	3420		
Liquidity (days)	Aug-25	4200		4060		
Recurrent CIP identified	Aug-25	119	100	98		
Capital Expenditure (Trust Level)	Aug-25	221500000.0	4115000	95080000.0		
Cash in Bank (Trust Level)	Aug-25	5031900000		4855420000		
Pay Spend v Budget	Aug-25	1016500	10371	1038140		
WTE vs Workforce Plan	Aug-25	196400	1898	197100		



Finance - Drive Metrics

Recurrent CIP identified



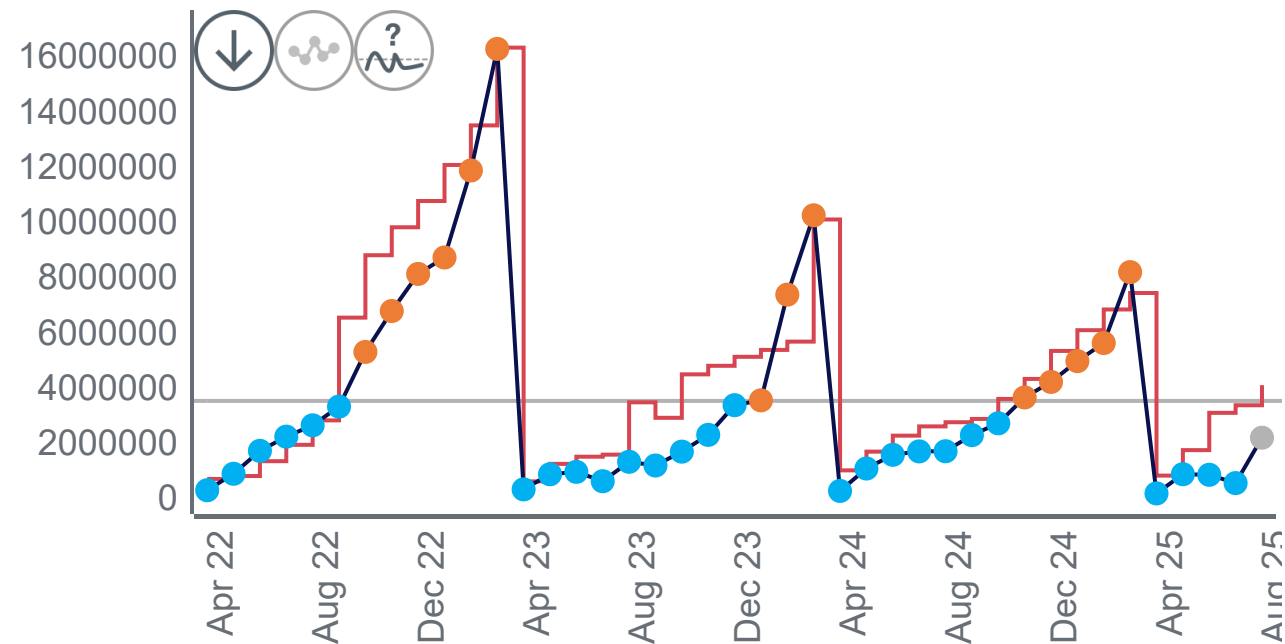
Technical Analysis:

CIP is displayed special cause improvement. Continued work required to maintain performance against target.

Actions:

Monthly monitoring of progress through gateways. Trust wide CIP workshop held in Feb. Revised transformation projects and governance arrangements to support delivery. Confirm and challenge sessions held and are scheduled. Focus is on turning CIP ideas into developed schemes.

Capital Expenditure (Trust Level)



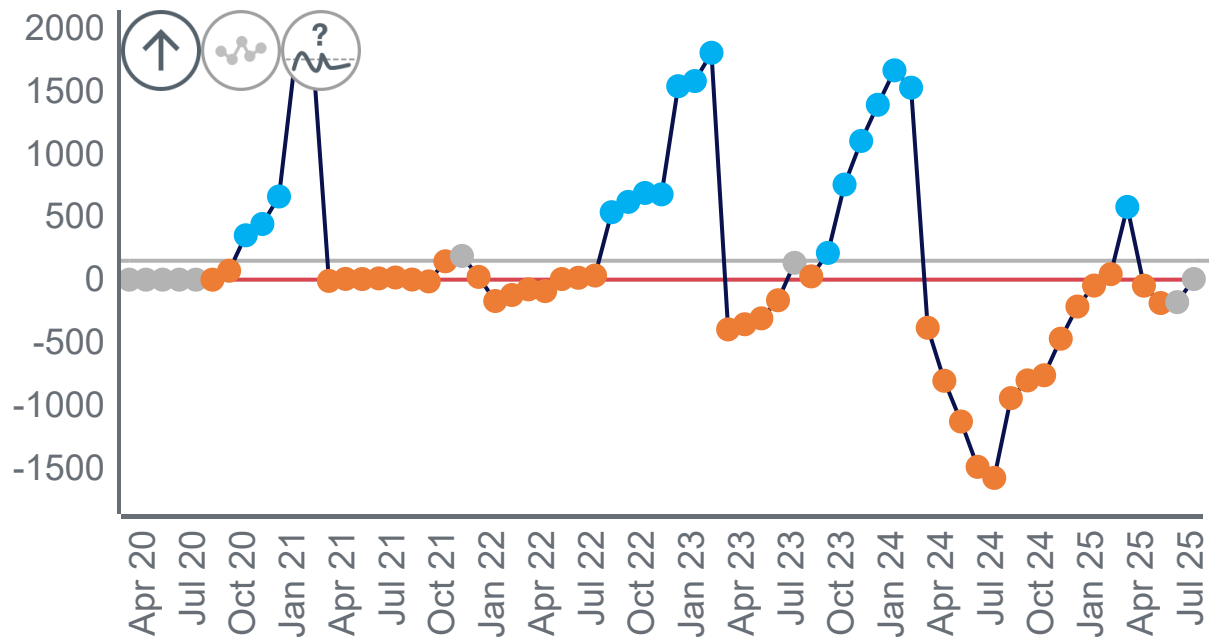
Technical Analysis:

Capital Expenditure is falling short of the target with further improvements required to close the gap.

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.

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



Technical Analysis:

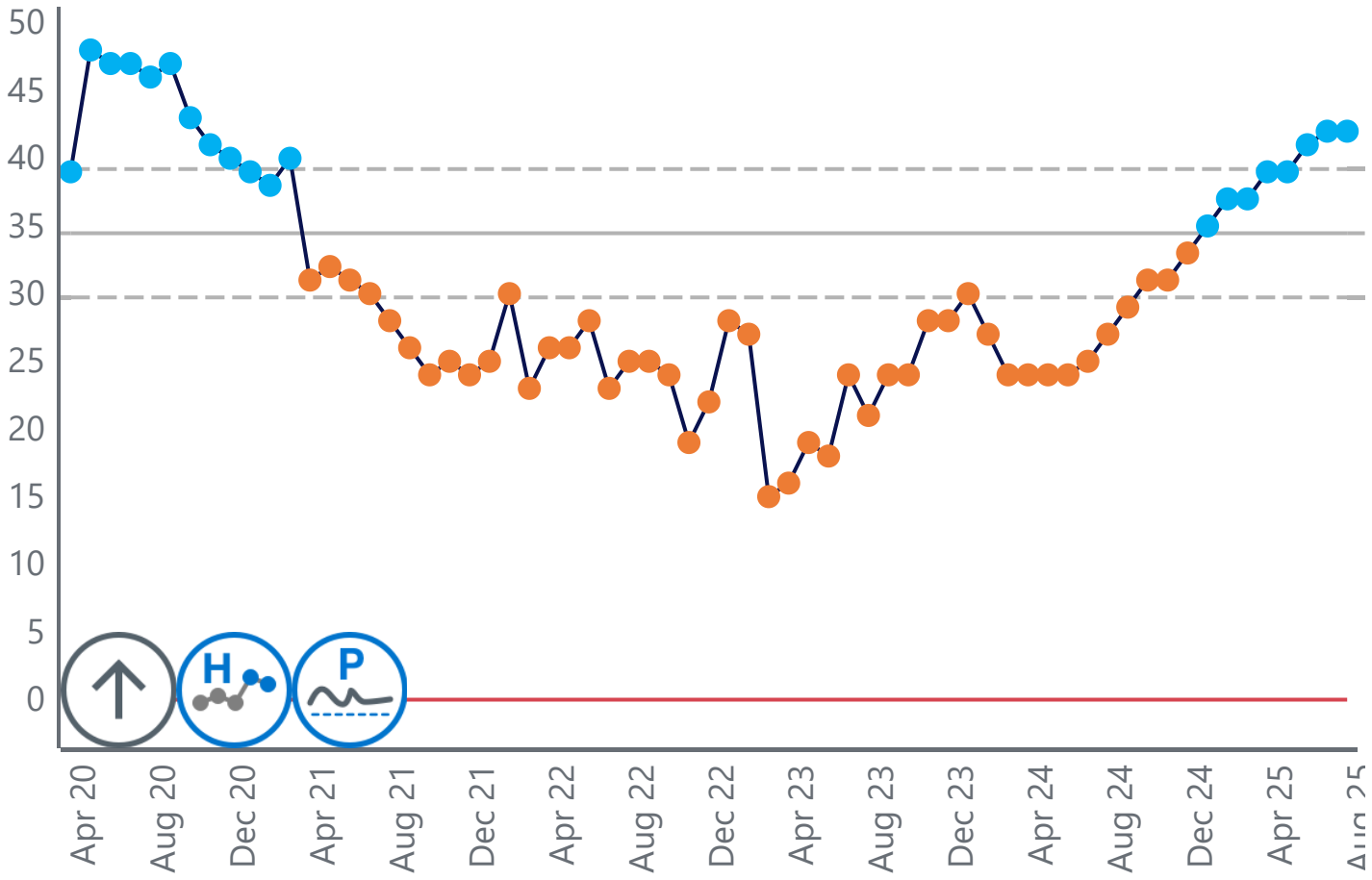
Performance is displaying common cause variation having met the target on three occasions in the last 8 months. Further work required to consistently achieve the target.

Actions:

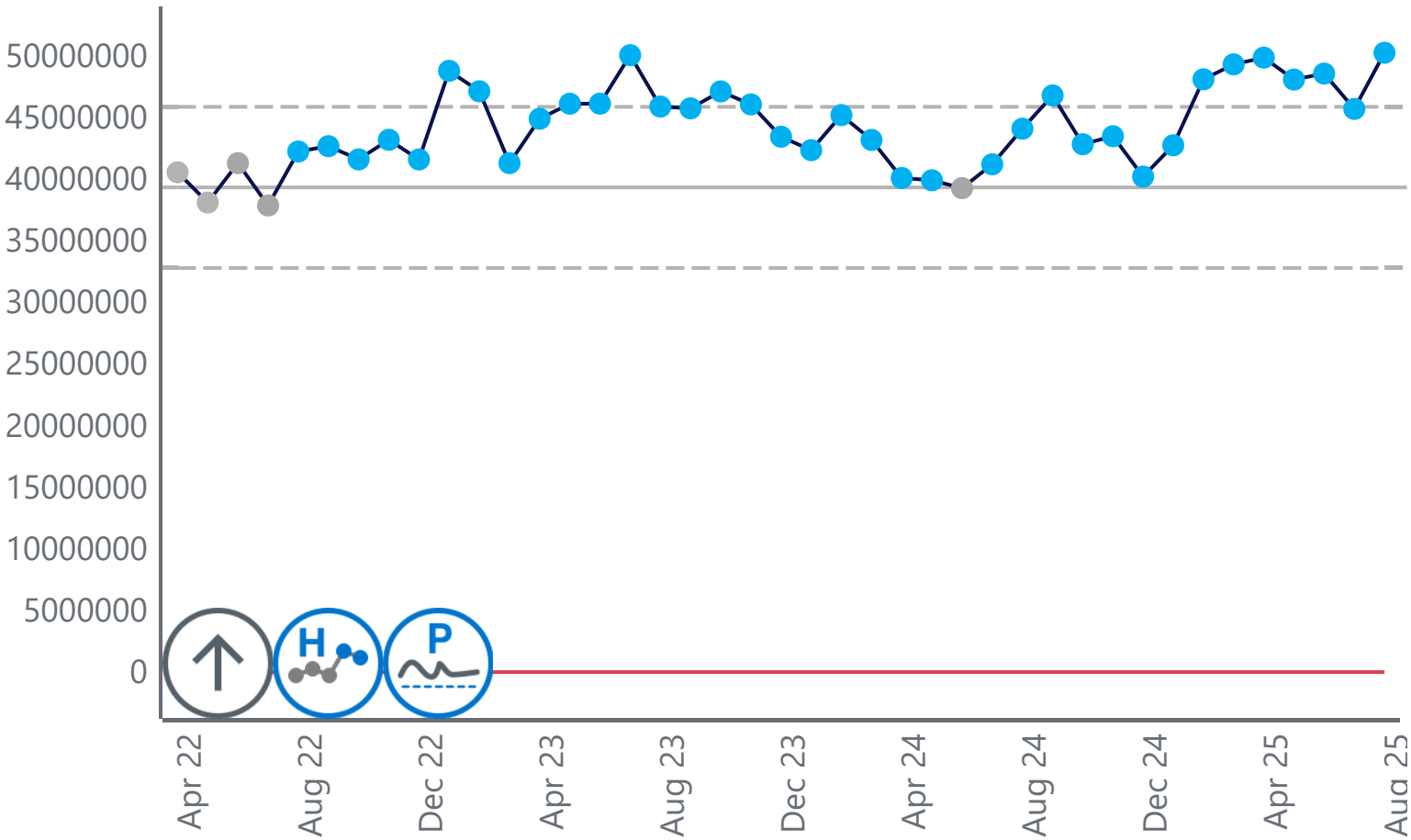
The Trust needs to expedite CIP delivery to ensure it remains on track to deliver the planned surplus. Management of other risks, most notably delivering, and being paid for, elective activity.

Finance - Watch Metrics

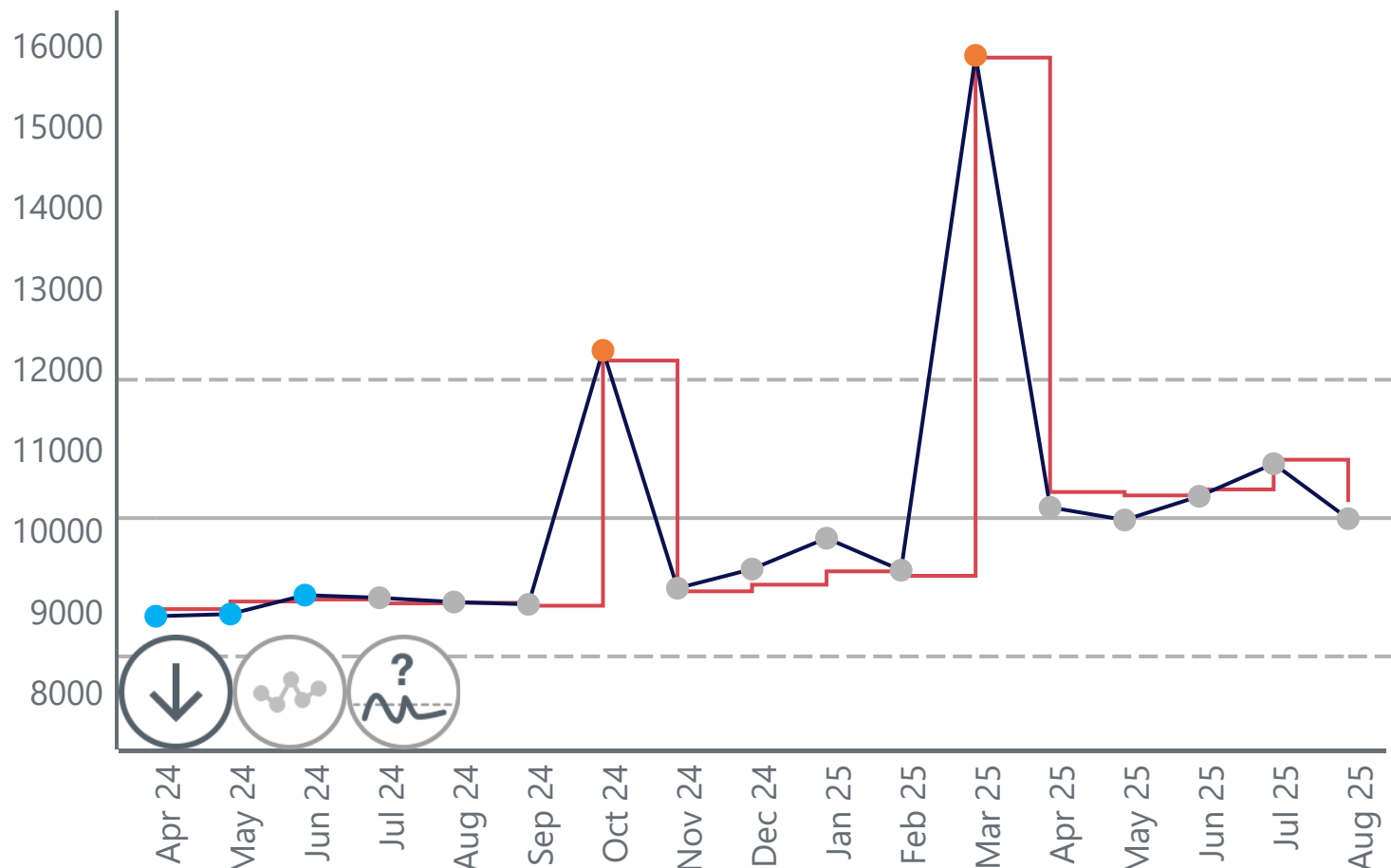
Liquidity (days)



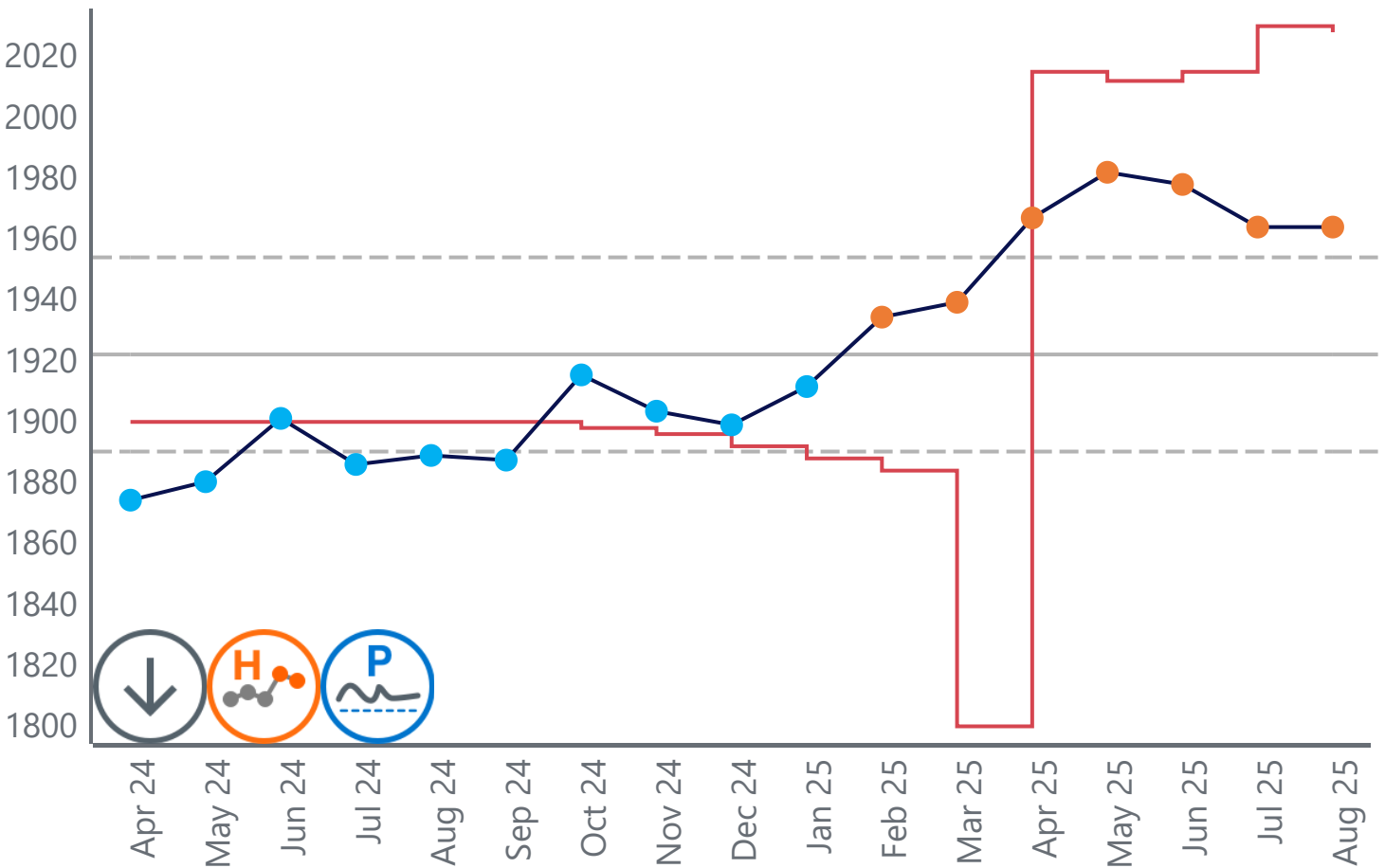
Cash in Bank (Trust Level)



Pay Spend v Budget



WTE vs Workforce Plan



People

SRO: Jane Royds, Chief People Officer

Highlights:

Turnover remains under the trust target of 10%, supported by the continued delivery of the retention plan. We are also seeing the influence of system-wide controls on staff movement, which is contributing to this reduction.

Bank and Agency usage reported a positive variance during the month, reflecting ongoing efforts to manage temporary staffing more effectively.

Mandatory Training compliance has further improved, exceeding the 95% target. A positive upward trend is evident across all divisions.

Areas of Concern:

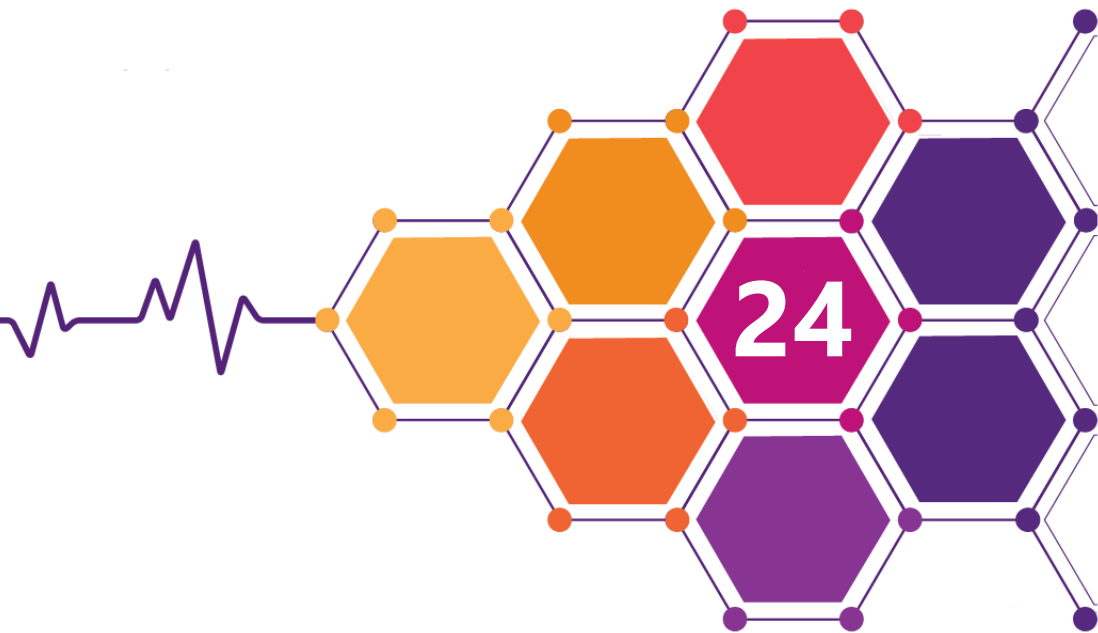
Sickness absence has shown marginal improvement but continues to be an area of focus. The sickness absence deep dive remains a valuable process, enabling the Business HR team to monitor trends, review individual cases, and ensure consistency in policy application. Long-term absence has reduced, reflecting sustained attention on LT cases and appropriate escalation to Stage 4. The most common reason for absence continues to be Anxiety, Stress, and other Psychiatric Illnesses, which typically result in longer periods away from work.

A slight increase in short-term sickness has been noted in Musculoskeletal and Gastrointestinal cases. These areas will be closely monitored over the coming months to identify any emerging trends and ensure early intervention where required.

Targeted actions agreed during the July Deep Dive session are being implemented to strengthen the approach to absence management. To further support managers, bitesize training on the new policy has been launched, alongside a landing page on the HR Front Door where resources have refreshed and been brought together. In parallel, close monitoring of short-term sickness continues, alongside ongoing promotion of Occupational Health support and resources to enable early resolution and improved wellbeing outcomes.

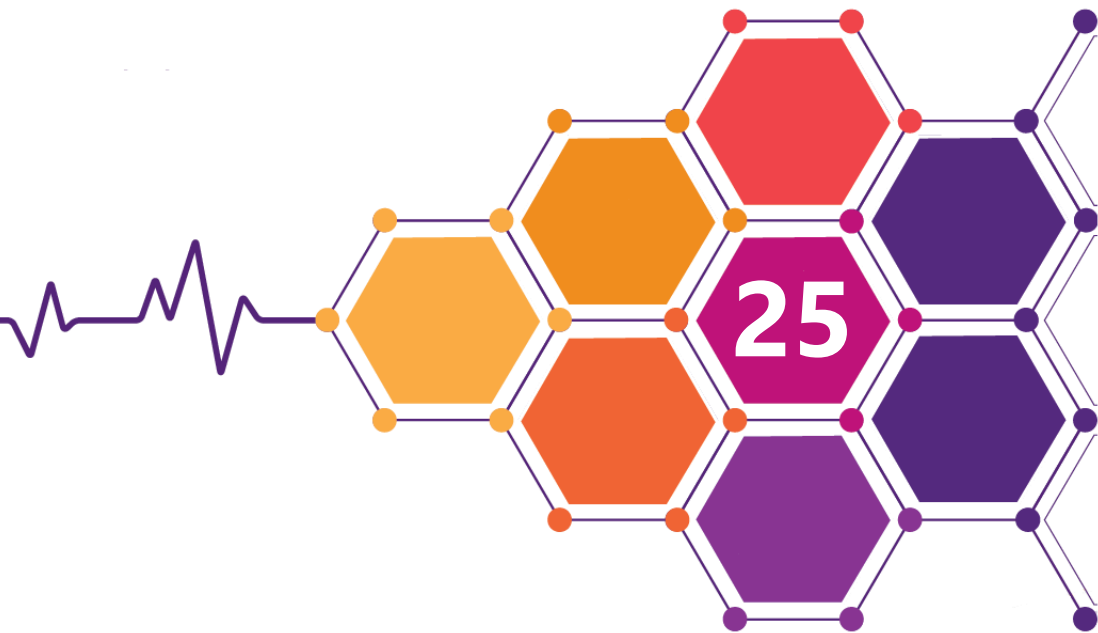
Forward Look (with actions):

The upcoming focus will be on appraisal compliance and ensuring completion within the designated appraisal window. Whilst compliance is showing an upward trend, to achieve consistent completion across the organisation, focused support and monitoring may be required, particularly within the Corporate and Medicine divisions. Ensuring timely completion will remain a key priority in the coming period.



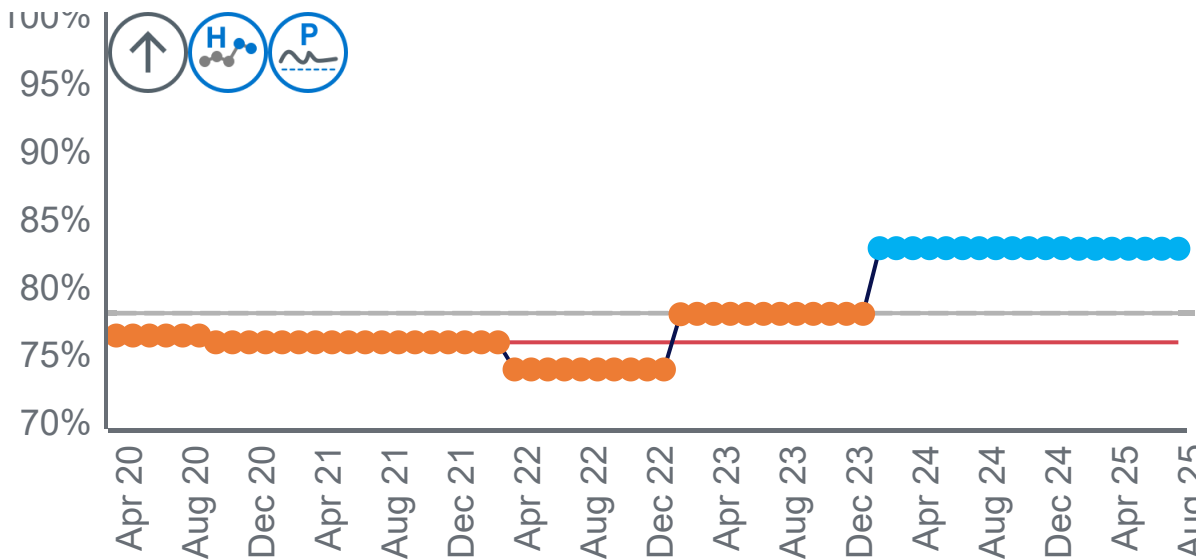
People - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
Appraisals Compliance	Aug-25	62.9	>=90%	64.4		
Mandatory Training Compliance	Aug-25	95.9	>=95%	94.8		
NHS Staff Survey - Staff recommendation of the organisation as a place to work	Aug-25	82.9	>=76%	82.9		
Staff Turnover	Aug-25	7.0	<=10%	7.3		
Staff Sickness (All Staff)	Aug-25	4.58	<=4.5%	4.8		
Long Term Sickness	Aug-25	2.66	<=4.5%	2.9		
Short Term Sickness	Aug-25	1.92	<=4.5%	1.8		
EDI: Bullying and Harassment of Staff by Patient and Relatives	Aug-25	11.5		12.2		
EDI: My Organisation Treats me fairly	Aug-25	68.8		68.8		



People - Drive Metrics

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



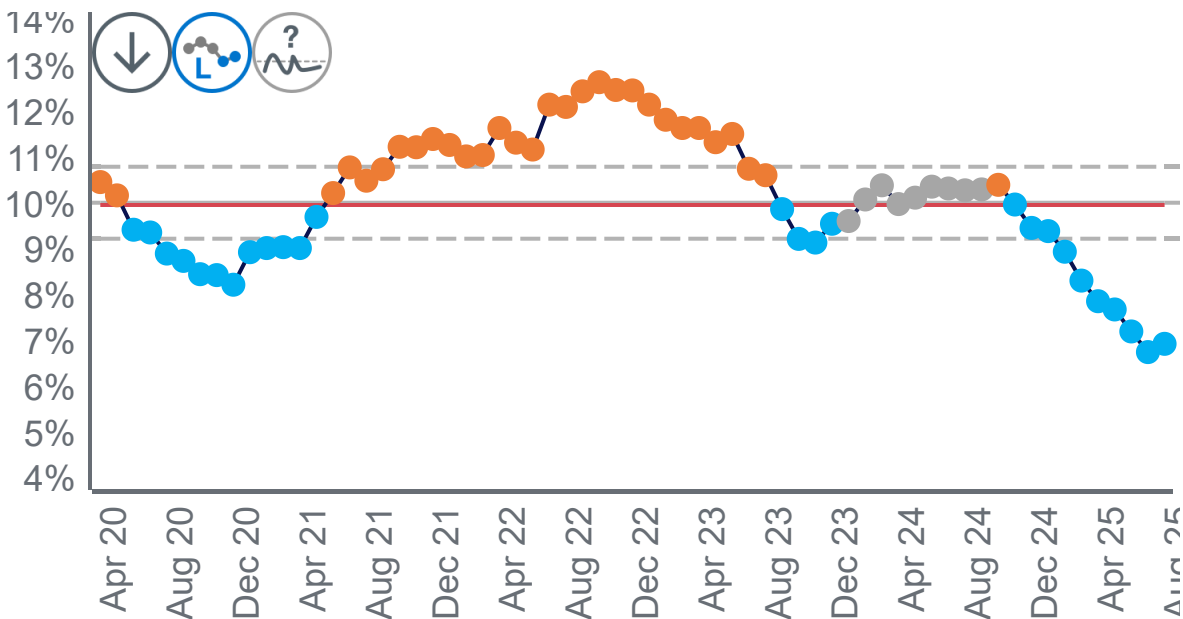
Technical Analysis:

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

Actions:

Annual Indicator - LHCH ranked top in the country for a Place to Work.

Staff Turnover



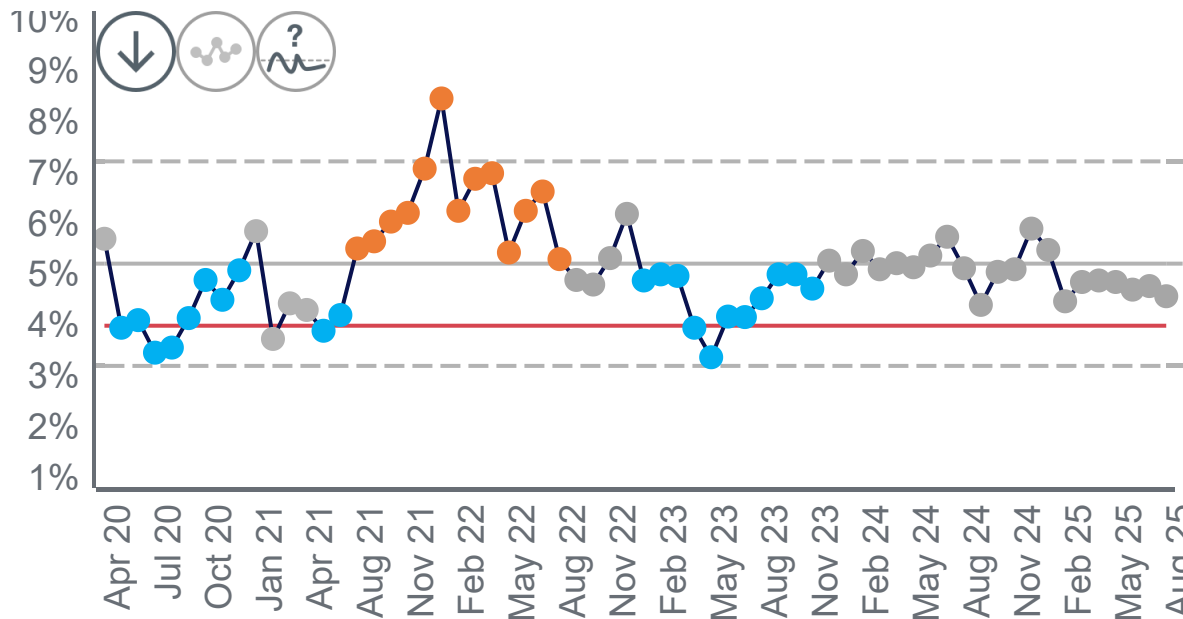
Technical Analysis:

Staff Turnover is displaying special cause improvement with a continual reduction over the most recent 7 month period. The Trust has achieved the target since the end of 2024.

Actions:

Continued Monitoring.

Staff Sickness (All Staff)



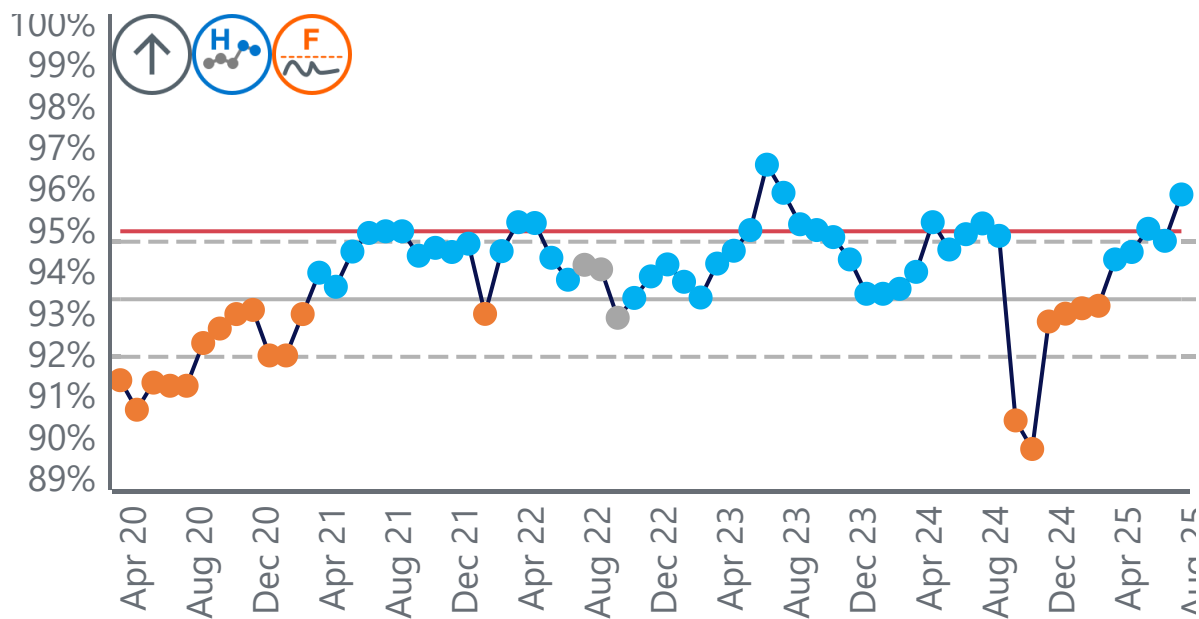
Technical Analysis:

Total absence in August 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:

Actions from Deep Dive being progressed.

Mandatory Training Compliance



Technical Analysis:

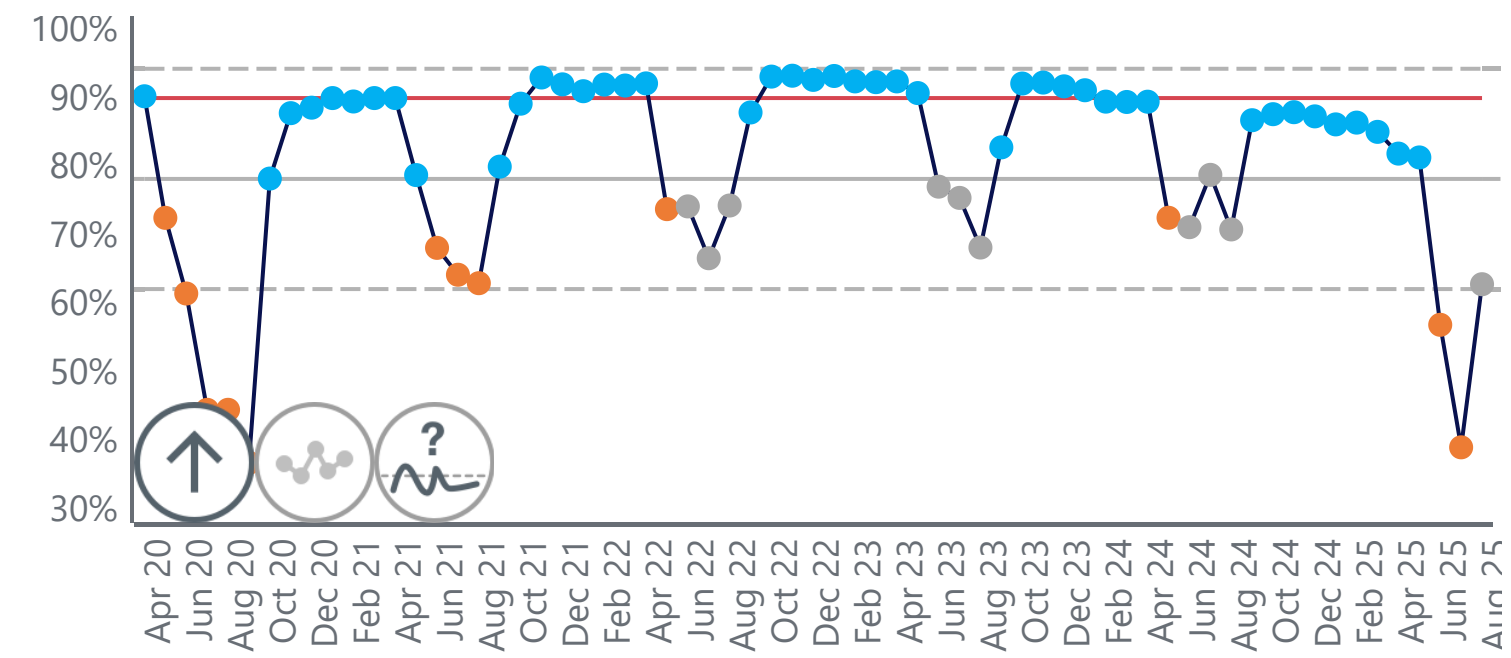
Performance has shown special cause improvement from the beginning of 2025. Continued work will see the gap close on achieving the target.

Actions:

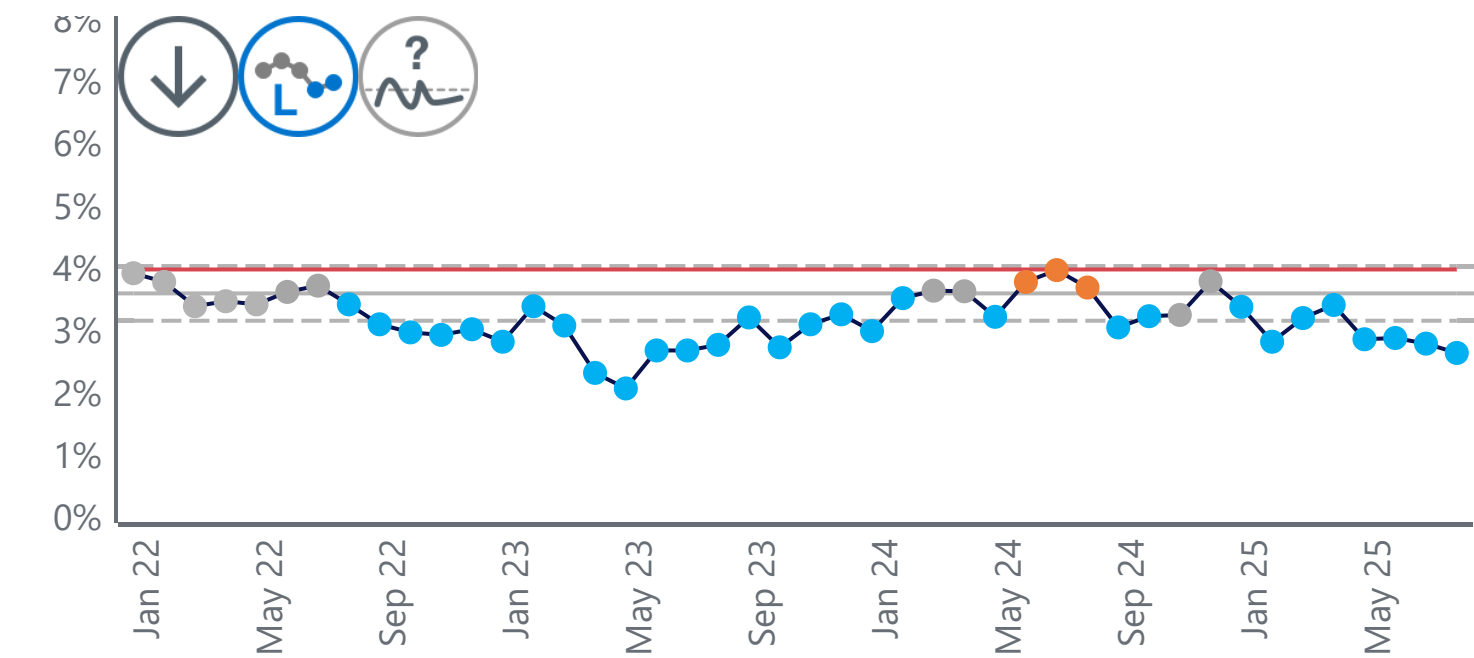
Improved MT position - continued focus required.

People - Watch Metrics

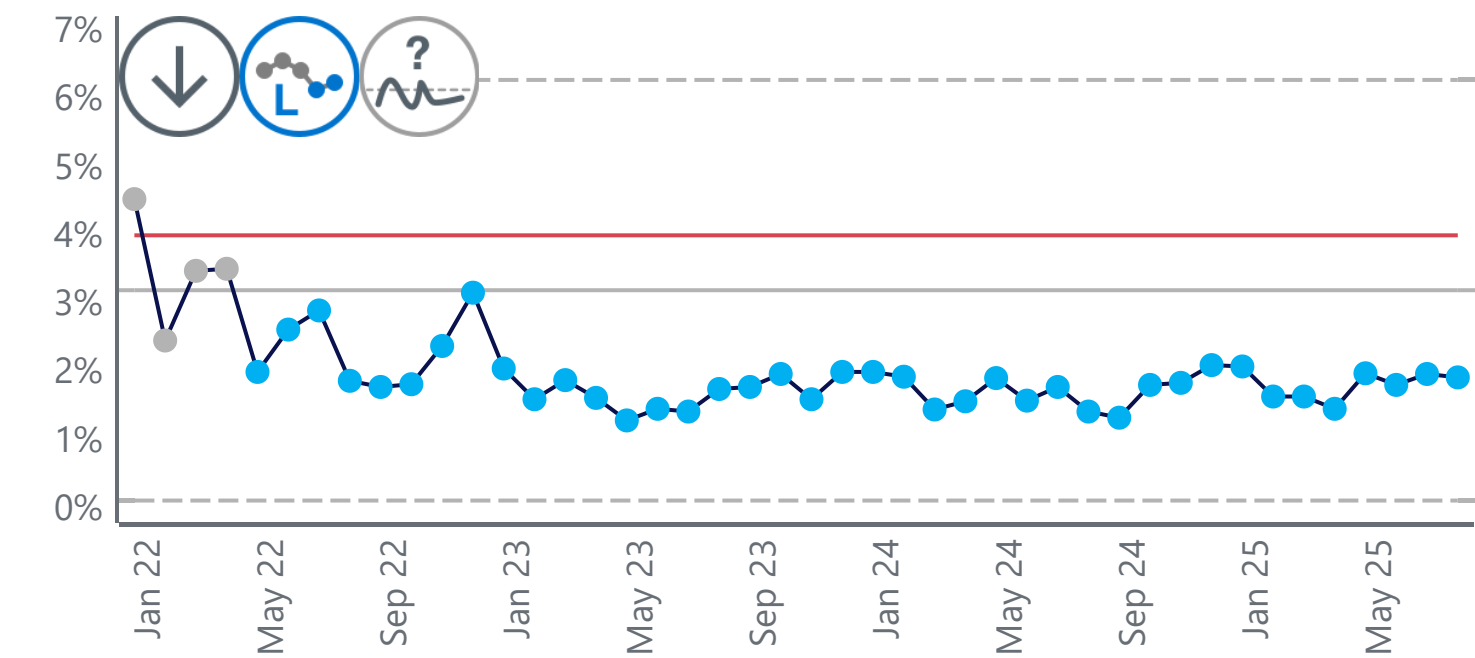
Appraisals Compliance



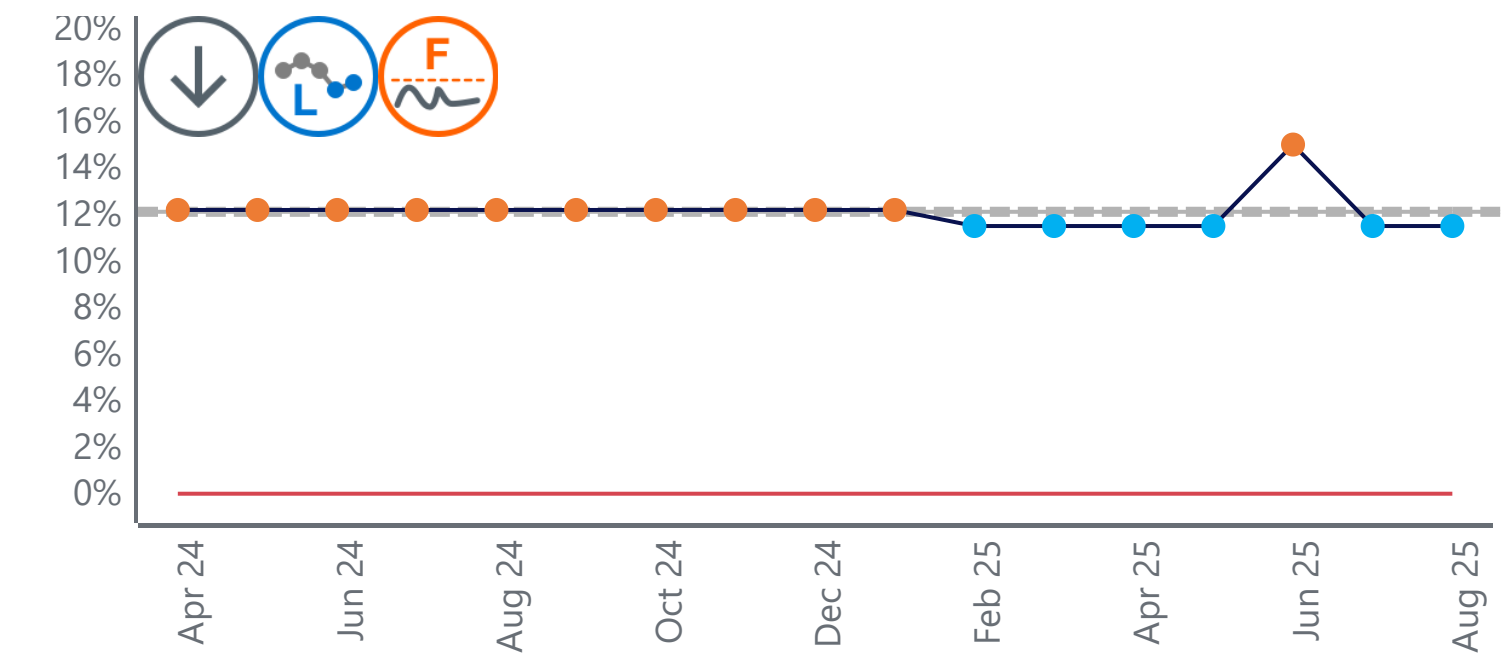
Long Term Sickness



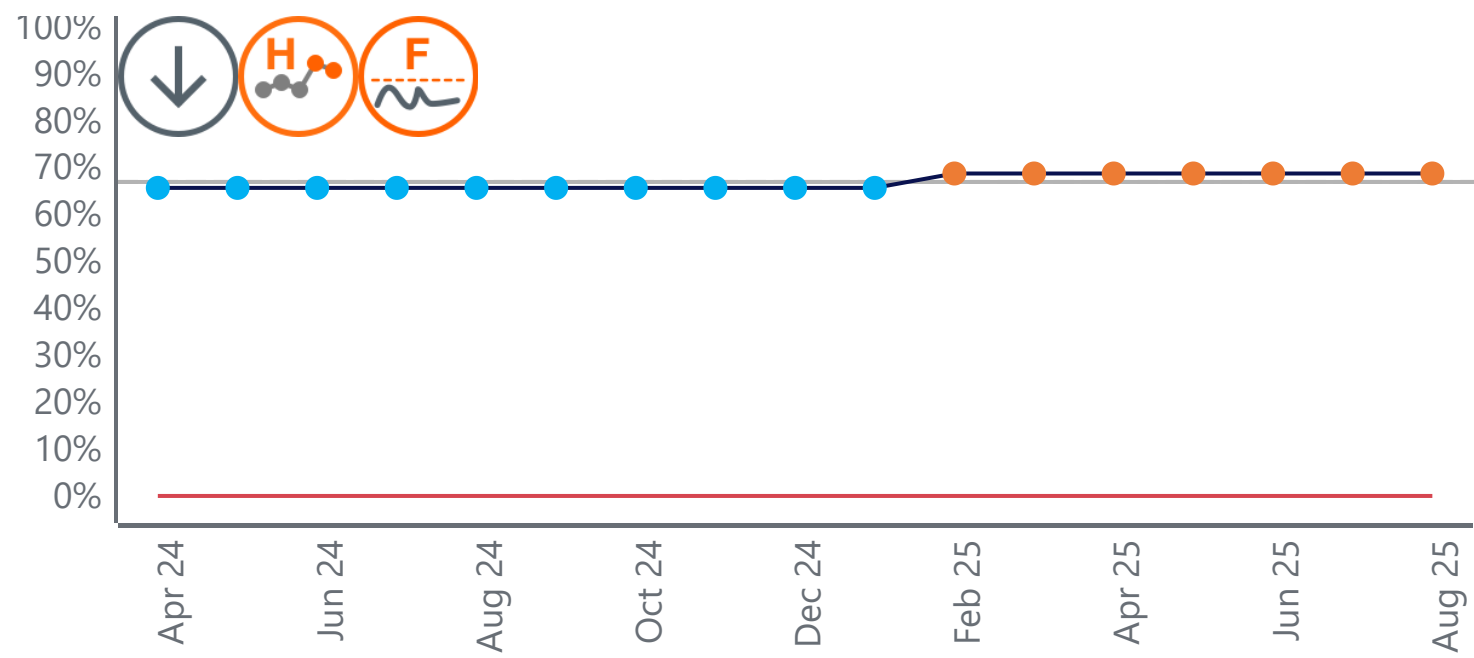
Short Term Sickness



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:

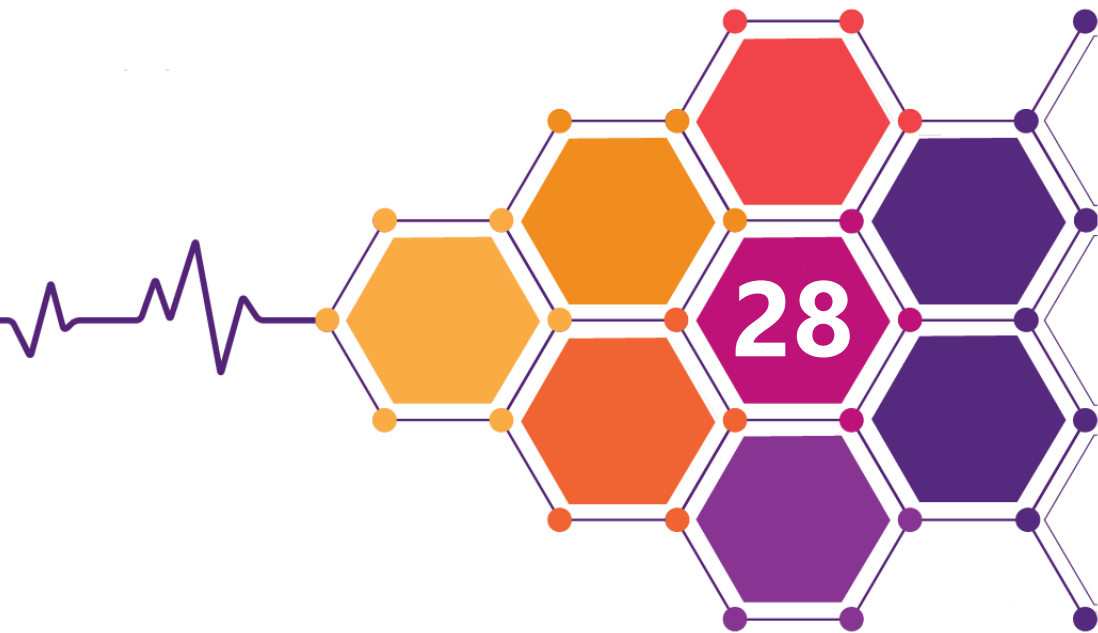
In August 2025, recruitment to time and target remained strong at 82%, exceeding the 80% goal, while the number of studies open was also well above target at 58 against 40. These reflect positive momentum in delivering research activity across the Trust. Set up times remain behind the 100 day target but have reduced from 185 days to 108 days.

Areas of Concern:















Key areas of concern in August 2025 include overall recruitment to studies, which remains below target at 52 against 70, despite recruitment to time and target being achieved. The average set-up time id currently 108 days, above the 100-day target, which may impact future delivery. Progress on successful NIHR grant applications is also behind trajectory, with only one secured against the annual target of three. In addition, the number of active PIs (33 against 39) and the number of AHP/CNS/Clinical Scientist PIs (2 against 5) remain below target. Support and strategies are being implemented to improve these metrics.

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.



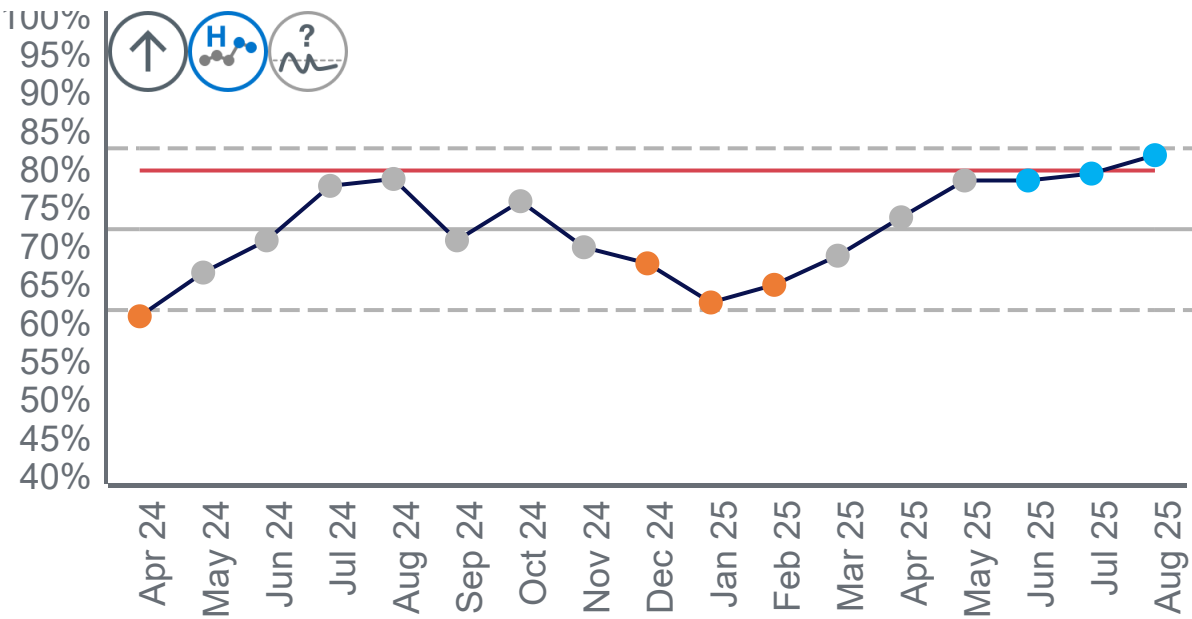
Research - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
Recruitment to all studies	Aug-25	25.0	70	80.6		
Number of studies open	Aug-25	58.0	40	56.2		
Recruitment to time and target for all research	Aug-25	82.0	80%	78.6		
Average set up time for Research	Aug-25	108	100 day avg	69.4		
Number of successful NIHR Grants	Aug-25	1.0	3 per annum	0.4		
Number of active PI's	Aug-25	33	39	32.4		
Number of AHP/CNS/ Clinical Scientist PI's	Aug-25	2	5	2.2		



Research - Drive Metrics

Recruitment to time and target for all research



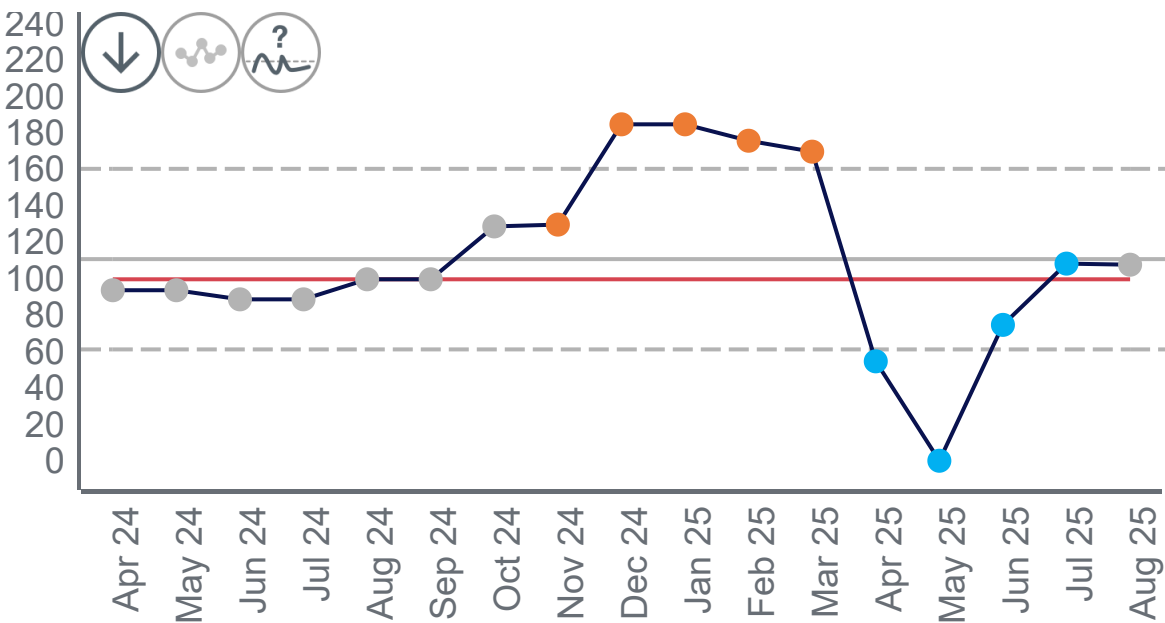
Technical Analysis:

Performance 2025/26 has shown an improvement as the metric moves to special cause improvement. Further improvement required to consistently achieve the target.

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 information. Discussion between R&I and PIs to set target during setup to ensure target can be met.

Average set up time for Research



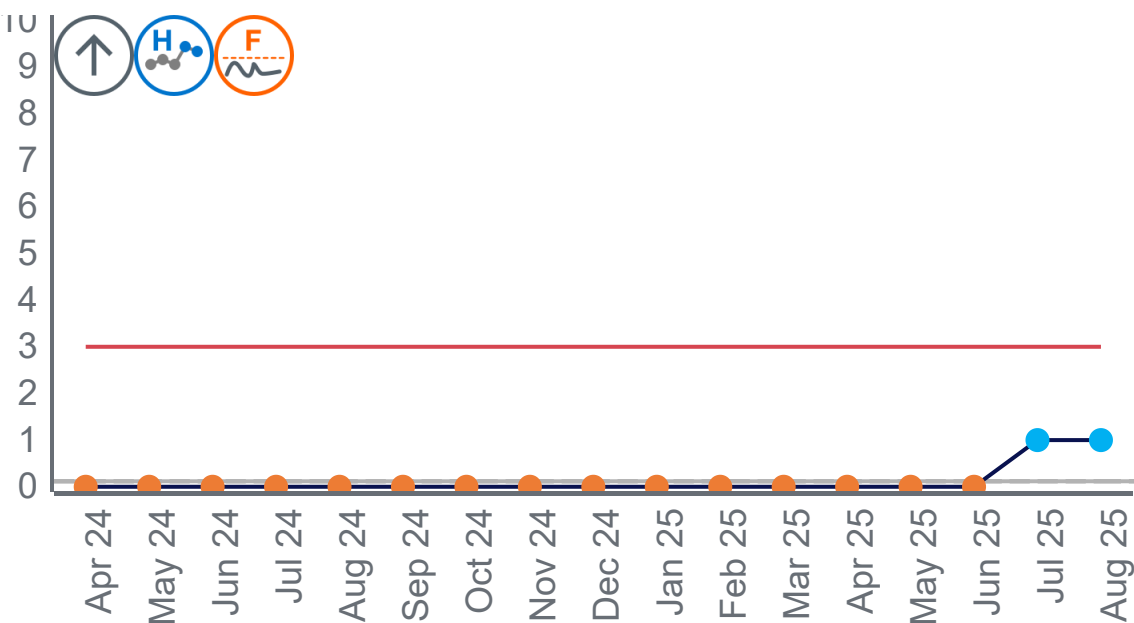
Technical Analysis:

Aug-25 is displaying similar performance to early 2024/25 following periods of significant increase and decrease. Consistency required to improve performance routinely.

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



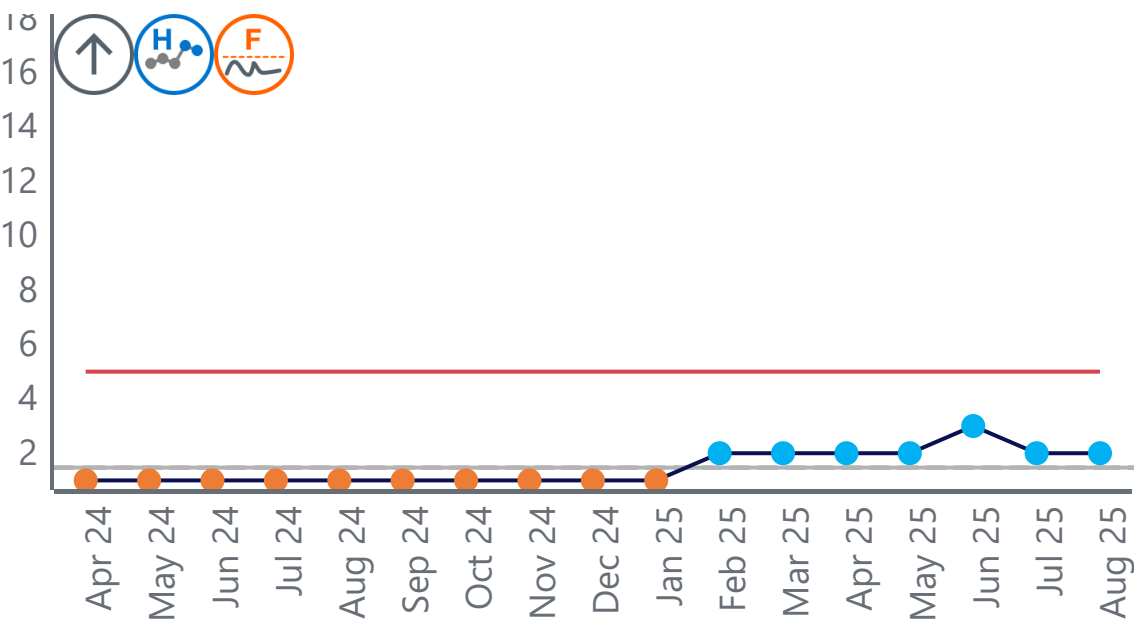
Technical Analysis:

The trust failed to meet the target of 3 grants per annum for 2024/25. Early 2025/26 is displaying special cause improvement, further work required over the course of the year.

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:

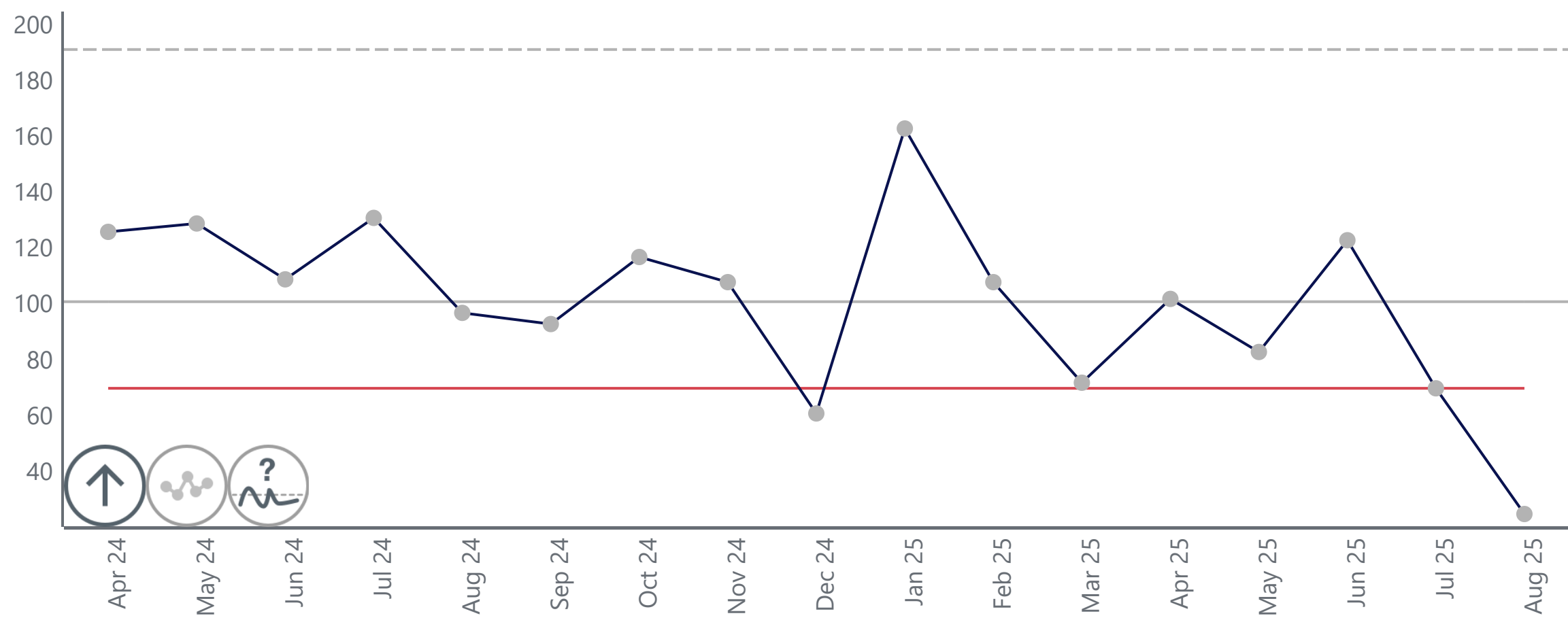
The trust continues to fail the target of 5 PI's. Improvement required to consistently achieve the target. Recent months are displaying special cause improvement.

Actions:

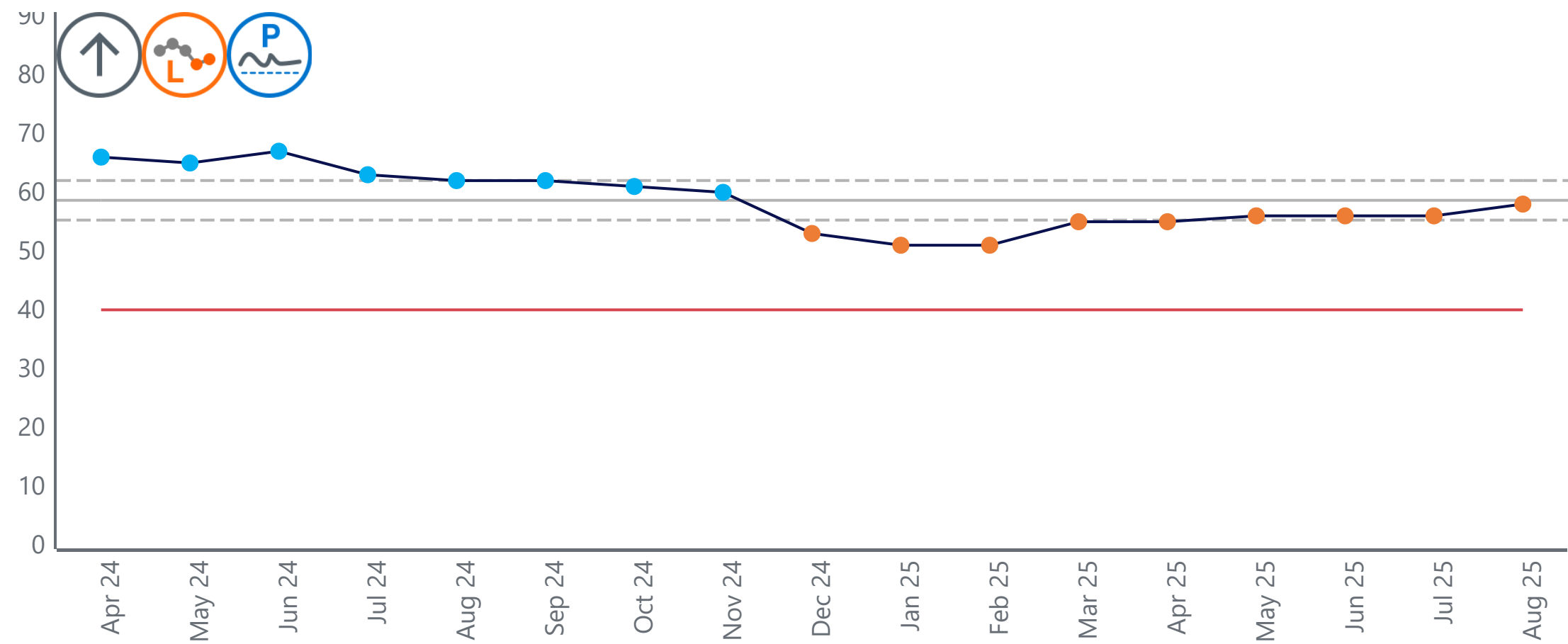
* Senior research team working on plans for research support mechanism for AHP/CNS and Clinical Scientist. *Research ambassadors within in clinical areas to be identified.

Research - Watch Metrics

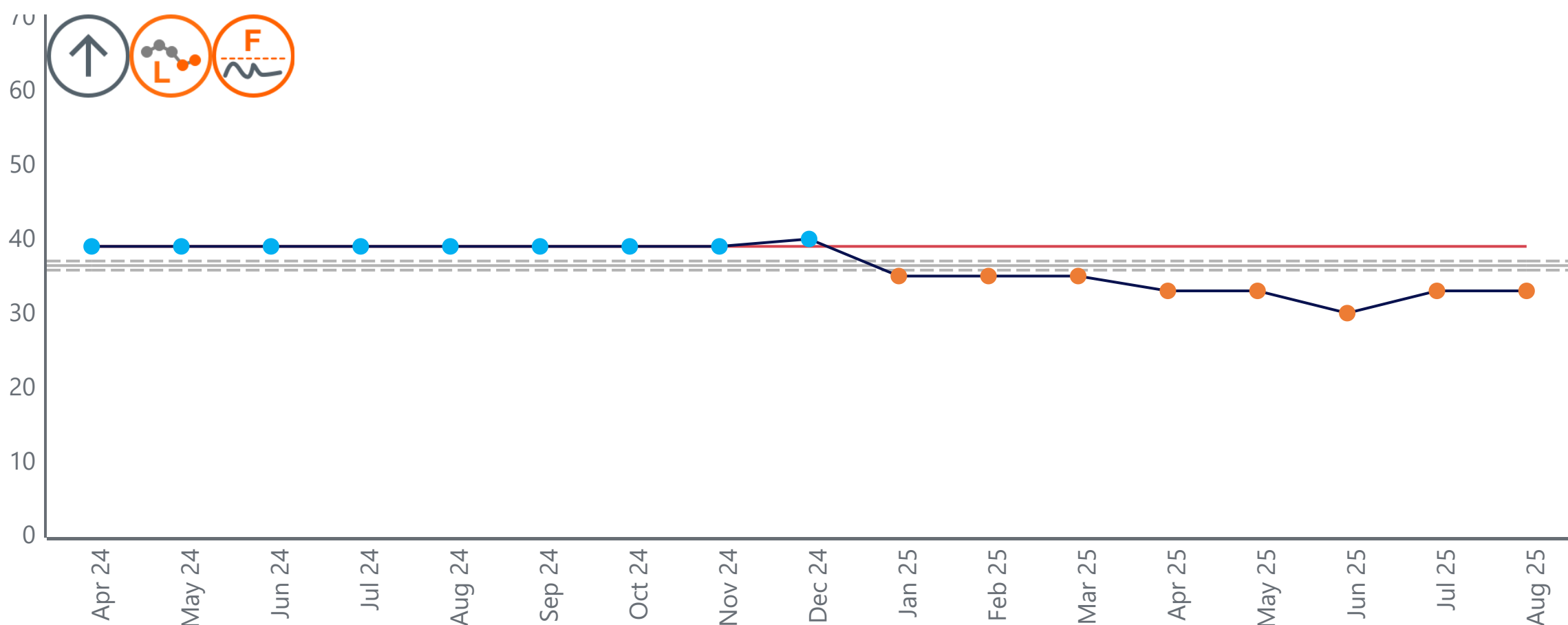
Recruitment to all studies



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.

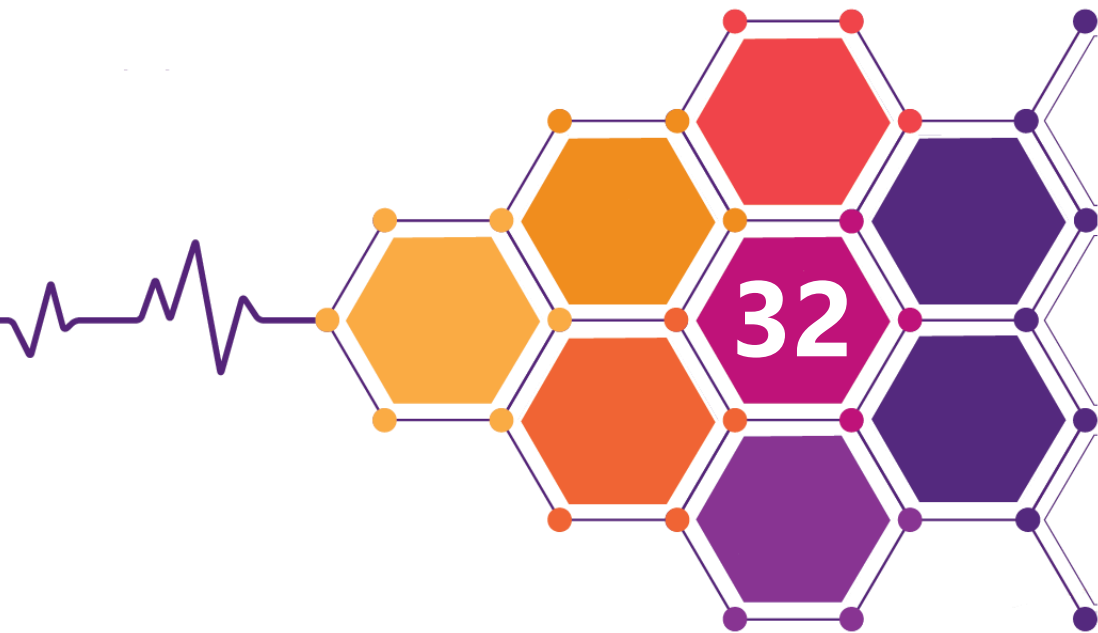
The Risk Management Committee continues to receive highlight reports including health and safety and fire safety, which provide assurance on the wider controls in place, and any significant gaps would be escalated to the Operational Board as required.

The information provided in this report is accurate as of 10th September 2025. Any further changes to the risk registers will be included in subsequent reports.

Key Risks

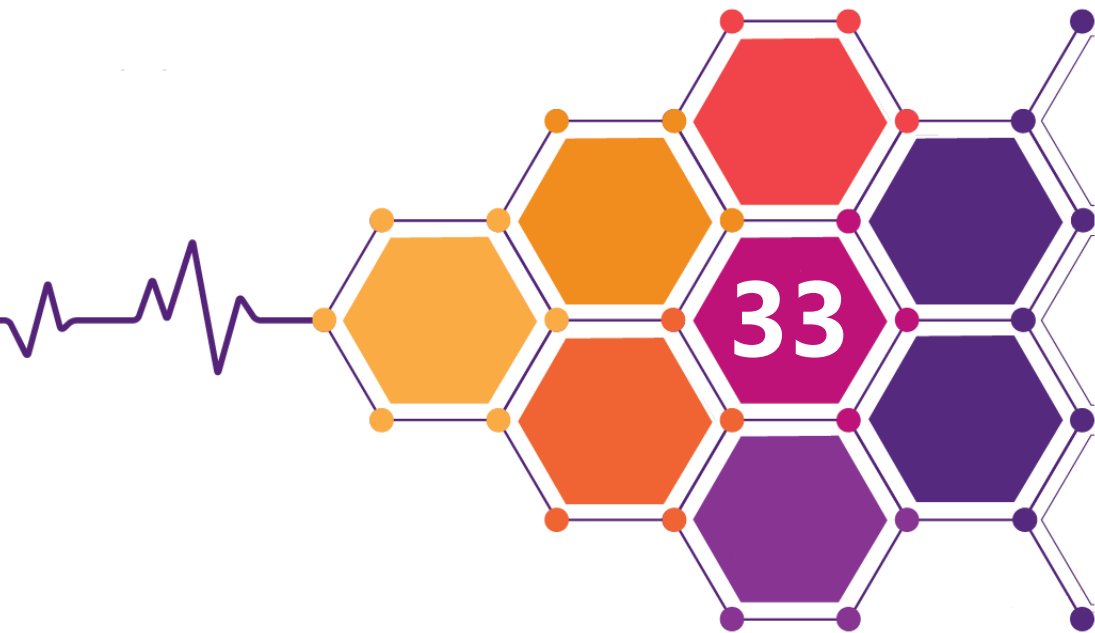
Currently there are 341 risks managed and mitigated below a residual score of 12. This leaves a total of 44 risks scoring 12 or over. Of these 43 have been reviewed within the last quarter (3 months).

division	1	2	3	4	5	6	8	9	10	12	15	16	Total
Medicine		1	8	21		28	7	15	3	10	1	1	95
Clinical Services	2	6	2	7		13	2	10	1	6			49
Corporate Services	17	24	7	22	3	30	26	22	5	16		2	174
Surgery	1	1	7	13		20	5	12		6	1	1	67
Total	20	32	24	63	3	91	40	59	9	38	2	4	385



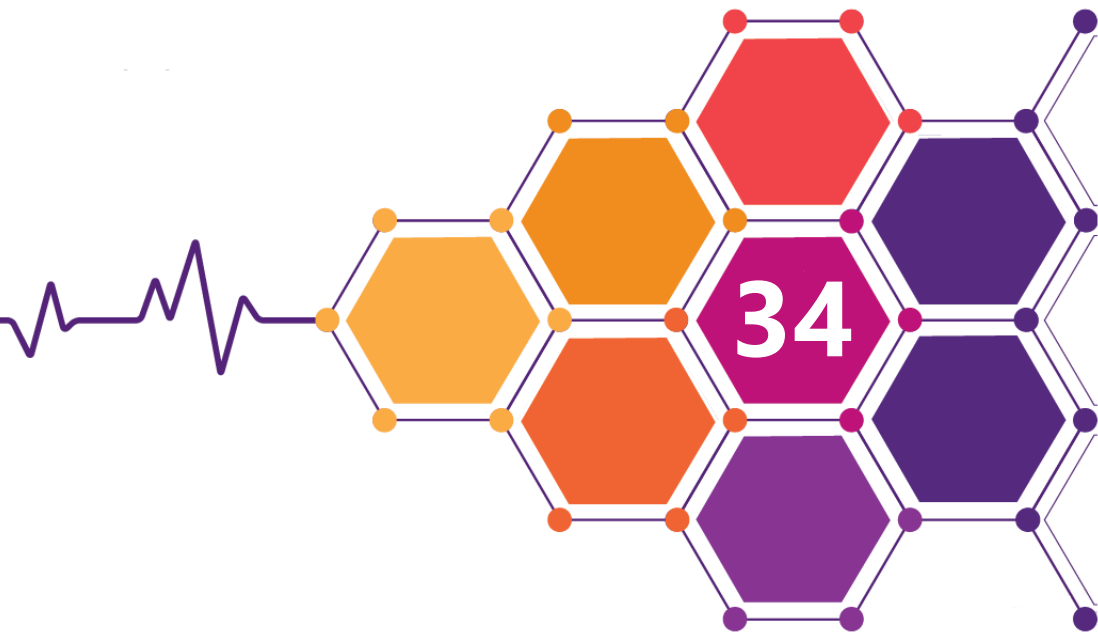
Risk - Divisional

Risk ID	Risk Description	Risk Location	Current Score	Current Controls	Further Mitigating Actions
2327	ACHD capacity risk	ACHD	15	Additional Clinical Fellow has been appointed to support the service.	Review the waiting list to assess any patients who could be support by the wider clinical workforce
1810	Risk to delivery of financial balance	Surgery	16	Income recovery plan in place through theatre staffing recruitment to deliver core and additional capacity A range of divisional controls have been established, including Matron check and challenge meetings, deep dive review of Theatre non-pay, introduction of departmental accountability meetings, introduction of theatre cancellation meetings WLLs being undertaken as much as possible Focussed management of theatre staffing to optimise capacity in theatres CIP planning & oversight meetings in place for 2025/26 with divisional schemes identified and each department being set a savings target Divisional Review Meetings established Business cases for pay & non-pay to deliver WLLs and additional activity in Thoracic and Cardiac Surgery WLLs have been stopped with a view to deliver this activity in the core sessions A locum Cardiac Surgeon post has been appointed to Add additional theatre list has been established on a Fridav	Exploration of income allocation for Urgent Surgery activity by the Senior Finance Team Divisional Review Meetings established Business cases for pay & non-pay to deliver WLLs and additional activity in Thoracic and Cardiac Surgery M6 forecast being undertaken Full review of activity plans for both NEL and Elective PODs CIP Planning has commenced for 2025/26 with divisional schemes identified and each department being set a savings target WLLs will be stopped with a view to deliver this activity in the core sessions A locum Cardiac Surgeon post will be put forward to PAG Friday Theatre List business case being written Exploration of expanding private patient capacity through use of Theatre K Elective Pathway Group has been established to implement improvements such as DOSA, improved pre-op, Cardiac Elective Co-ordinator etc
2317	ACHD intervention al waits	ACHD	16	Extra lists for intervention; regular listing meetings; tightening of governance	formation of a new cath lab nursing role; senior intervention fellow starting in 2 weeks



Risk - High Risks

Risk ID	Risk Description	Risk Location	Current Score	Current Controls	Further Mitigating Actions
1944	Clinical Letters Process	Corporate	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, Operational & Supplier 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 findings Further review being undertaken by CDIO
2297	Digital Infrastructure– VxRail Environment Capacity and Network Dependency	Digital Healthcare	16	Technical mapping of the dependency Process and change agreement with Alder Hey iDigital Escalation to Alder Hey senior stakeholders Regular meetings/discussions with 3rd party support providers (who are supporting this infrastructure). These are Intercity (Network) and Dell Technologies (Servers)	New infrastructure being designed and procured
0155	additional theatres, lack of perfusion staff	Theatres	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 new trainee to start Sept 2025.	Trainee appointed September 2023 who will qualify September 2025. With further trainee appointed September 2024 , qualifying September 2026. Use of locum perfusionists.





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