

Strategic Oversight Framework

September 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

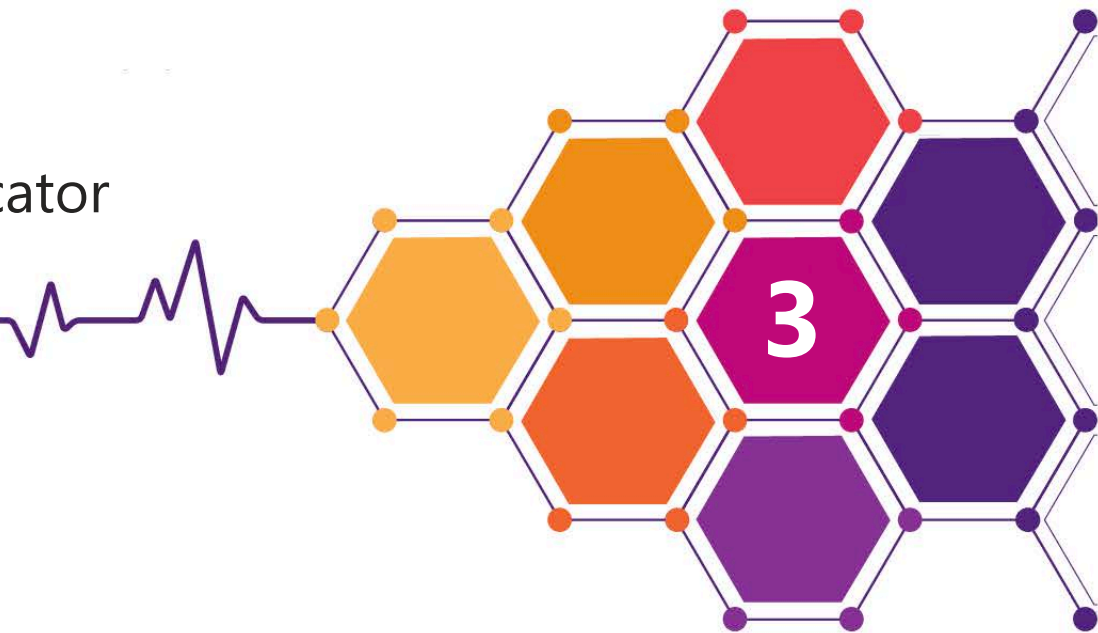
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

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.



Drive Metric Assurance

		Assurance		
		Consistently Passing	Inconsistent Performance	Consistently Failing
				
Variance	Special Cause - Improvement	• NHS Staff Survey - Staff recommendation of the organisation as a place to work	• Referral to Treatment - Incomplete Pathways 52+ Weeks • % of Radiological Alerts with a Response Document • Number of Incidents No Harm or Low Harm • Staff Sickness (All Staff) • Staff Turnover • 95% of all patients to receive a copy of their Discharge Summary on day of Discharge • Delivery of at least one sepsis antibiotic within one hour of prescription (LHCH target)	• Mandatory Training Compliance • Maximum 6-week wait for Diagnostic Procedures • Number of Successful NIHR Grants • Number of AHP/CNS/Clinical Scientist PI's
	Common Cause		• Elective Activity Levels • % Patients on PIFU • Cancer Patients meeting the Faster Diagnosis Target (FDT) • Cancer: 62-day referral to treatment standard • Diagnostic DNA Rate • Delivered CIP • Capital Expenditure (Trust Level) • Nutrition - Patients scoring high risk (2 or more) are referred to Dietician • I&E Distance from Target (Cumulative) - £,000 • Recruitment to Time and Target for all Research • Average Setup Time for Research	
	Special Cause - Concern		• RTT 18 week Backlog	• Risk Stratified Overdue Follow Ups (>25% Overdue)

Operational Performance

SRO: Jonathan Mathews, Executive Managing Director

Highlights:

- At the end of Month 6, 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 102%. Case mix and non-elective demand are reflected in our financial reporting.
- Cancer performance is reported one month in arrears. In Aug, 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:

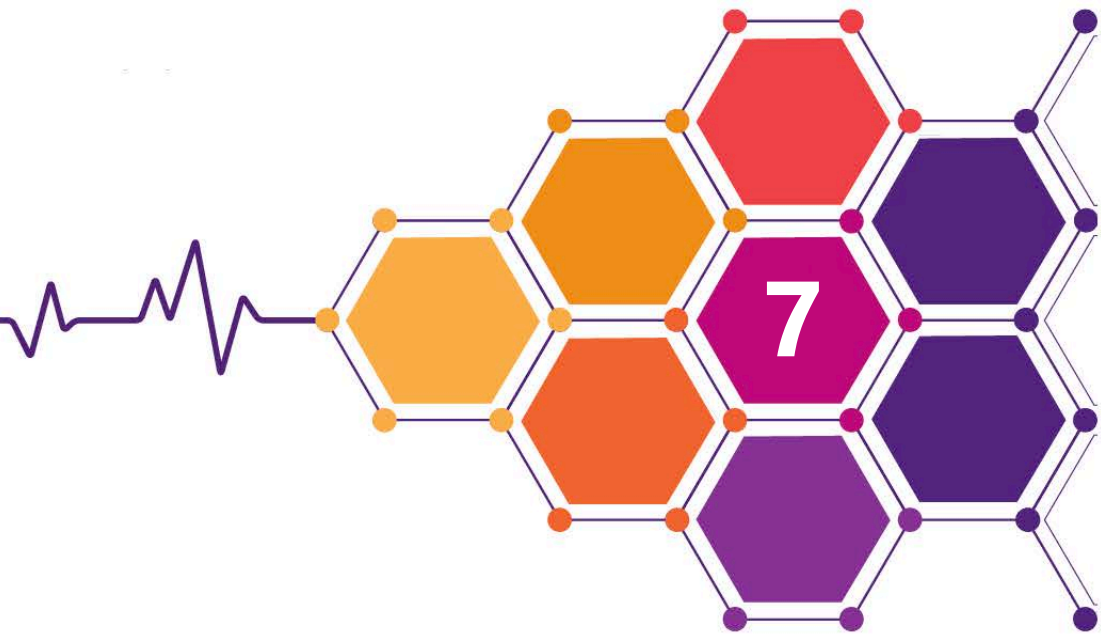
- Elective and non-elective surgical activity continues to be closely monitored due to ongoing staffing constraints and critical care capacity risks. However, performance is continuing to improve.
- Additional sessions and mutual aid from University Hospital Liverpool Group continue to support capacity 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. The Divisions will be looking at waiting list processes through the Safe Waiting List Management Group and monitoring against RTT standards.

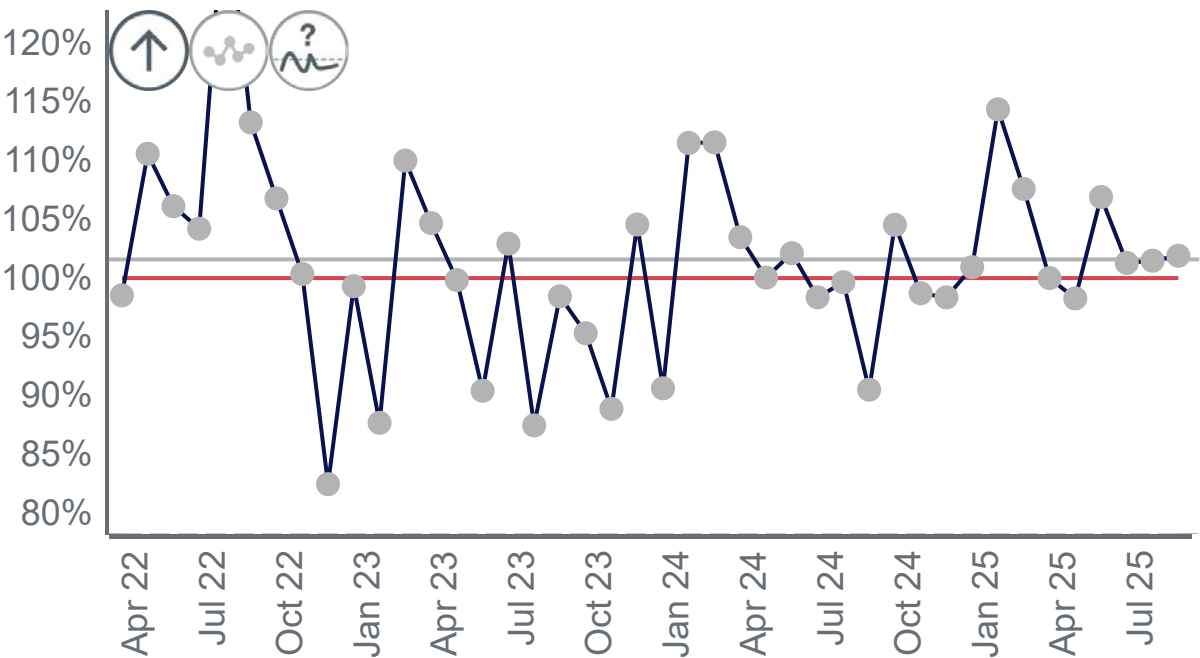
Operational Performance - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
Bed Occupancy	Sep-25	79.2	>=80%	79		
Cancelled Operations for non-clinical reasons	Sep-25	2.2	<=2%	2		
DNA Rate for most deprived areas	Sep-25	25.6	<=5%	17		
Elective Activity Levels	Sep-25	101.9	100%	102		
Letters waiting to be typed over 7 days	Sep-25	51	0	69		
Maximum 6-week wait for diagnostic procedures	Sep-25	99.8	>=95%	99		
Percentage of patients discharged on Ready for Discharge	Sep-25	98.2		98		
Overall Size of Waiting List	Sep-25	5543		5866		
Patients not booked in within 28 days (non clinical cancellations)	Sep-25	1.0	0	2		
RTT 18 weeks in aggregate - Incomplete Pathways	Sep-25	77.1	92%	73		
Referral to treatment - Incomplete Pathways 52+ weeks	Sep-25	41		48		
RTT 18 Week Backlog	Sep-25	1117		1406		
RTT Open Pathways - Percentage without an Ethnicity Status	Sep-25	47.8	<=35%	49		
RTT Pathway Waiters (52+ weeks) for the most deprived areas	Sep-25	1	0%	1		
Time to First Appointment	Sep-25	87.9	5%	84.3		
Cancer Patients meeting the Faster Diagnosis Target (FDT)	Aug-25	58.3	>=75%	63.9		
Cancer: 62-day referral to treatment standard	Aug-25	93.0	>=85%	91.4		



Operational Performance - Drive Metrics

Elective Activity Levels



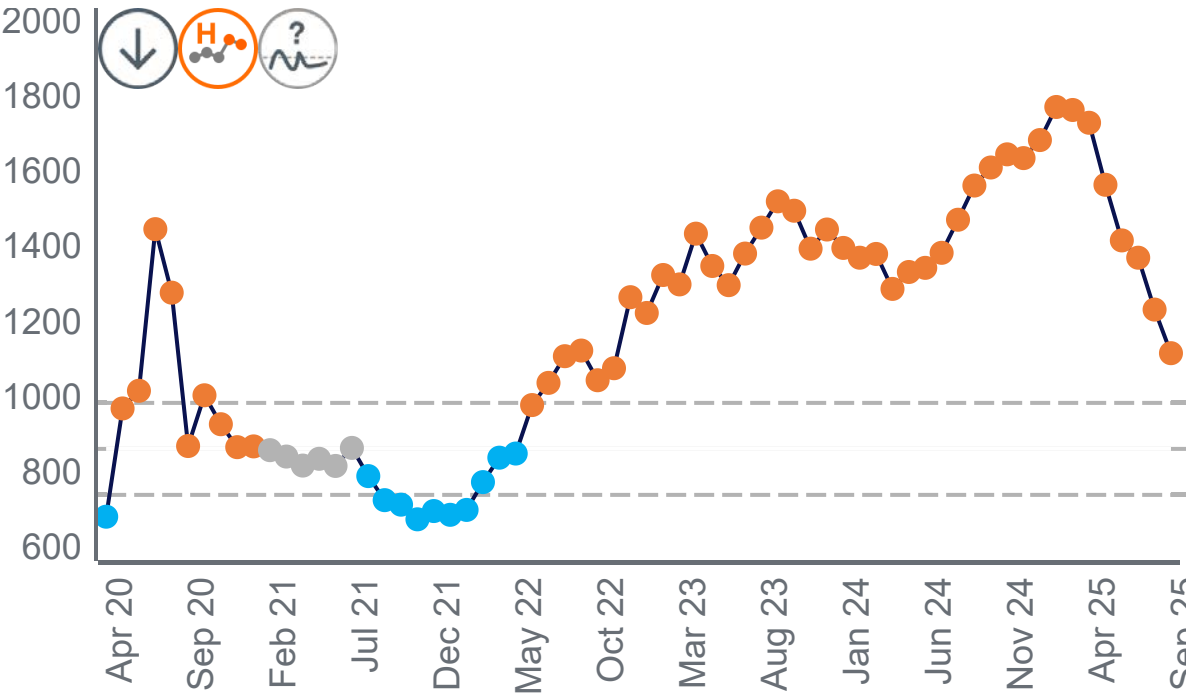
Technical Analysis:

Performance of 102% was achieved within Sep-25 against the target of 100%. Further work required across divisions to consistently achieve the target and move to performance of an improving nature.

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



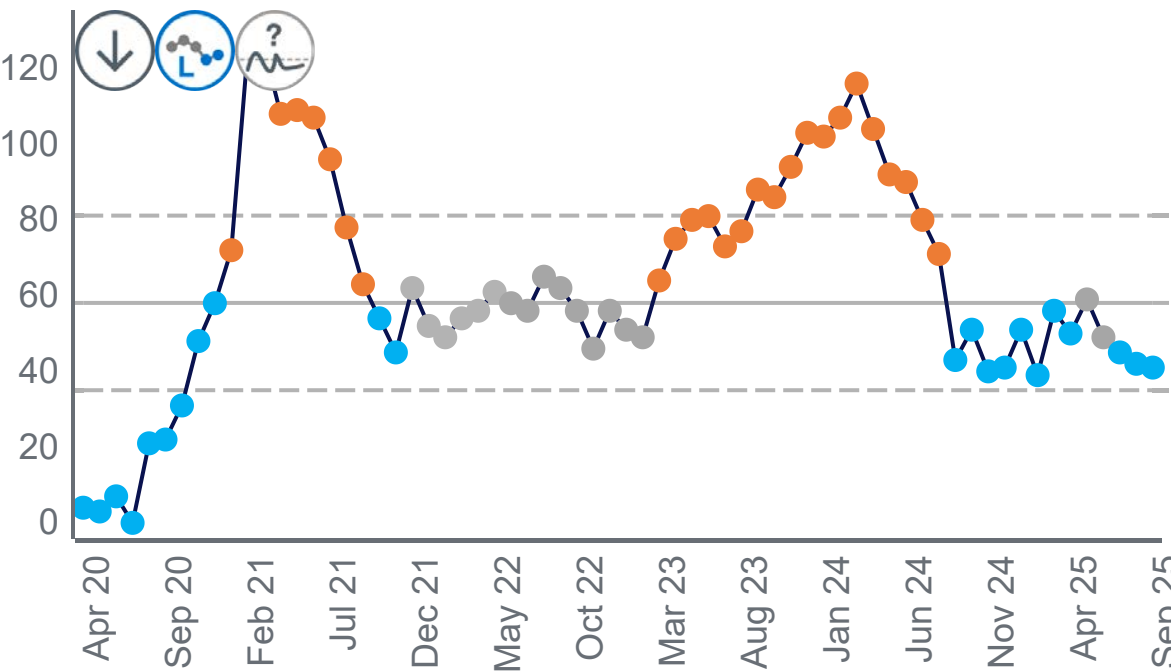
Technical Analysis:

RTT backlog continues to display special cause of a concerning nature. September'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

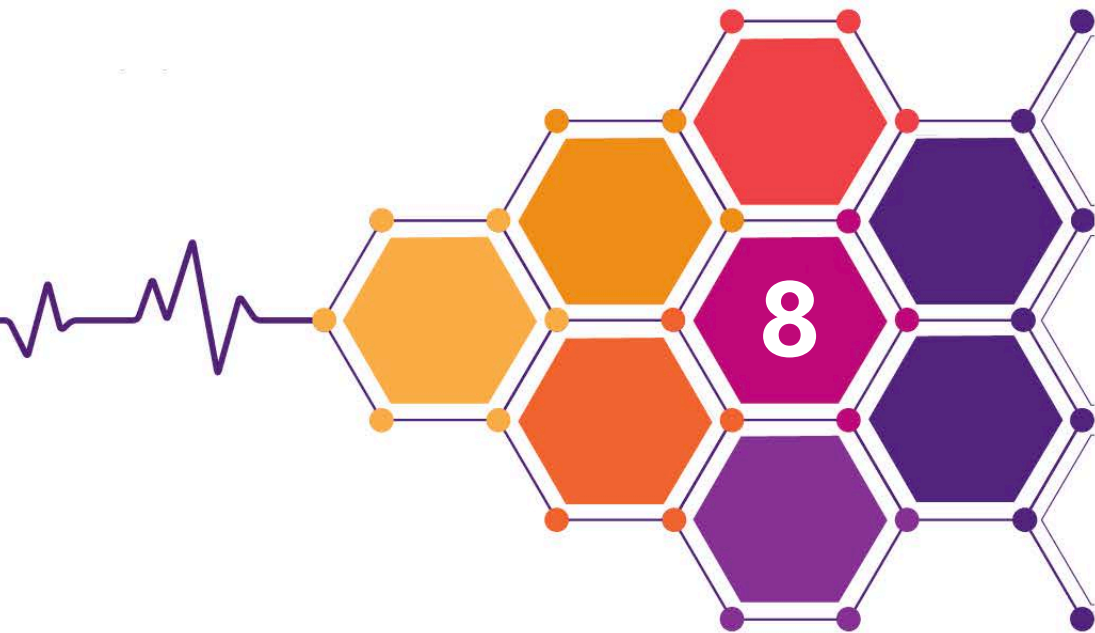


Technical Analysis:

Current performance is displaying special cause improvement. Surgery patients remain the most significant contributors to volumes. Further work required to achieve target.

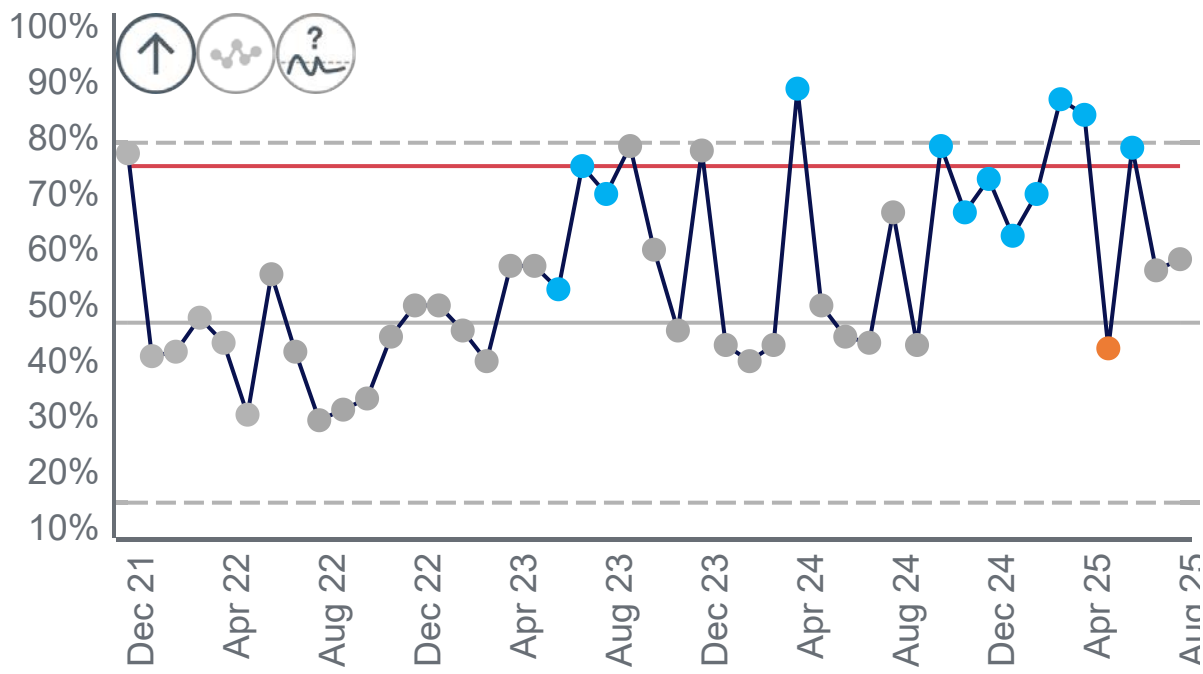
Actions:

- *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. *Risks around the ACHD long waits due to changes in medical workforce.



Operational Performance - Drive Metrics

Cancer Patients meeting the Faster Diagnosis Target (FDT)



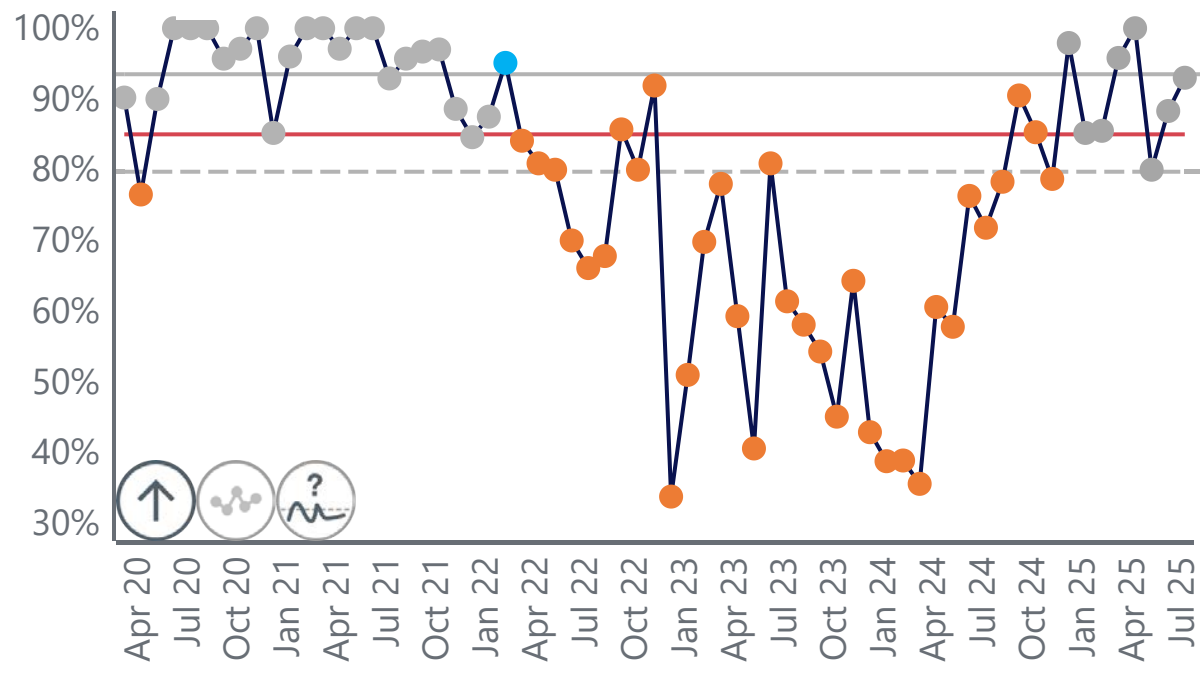
Technical Analysis:

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



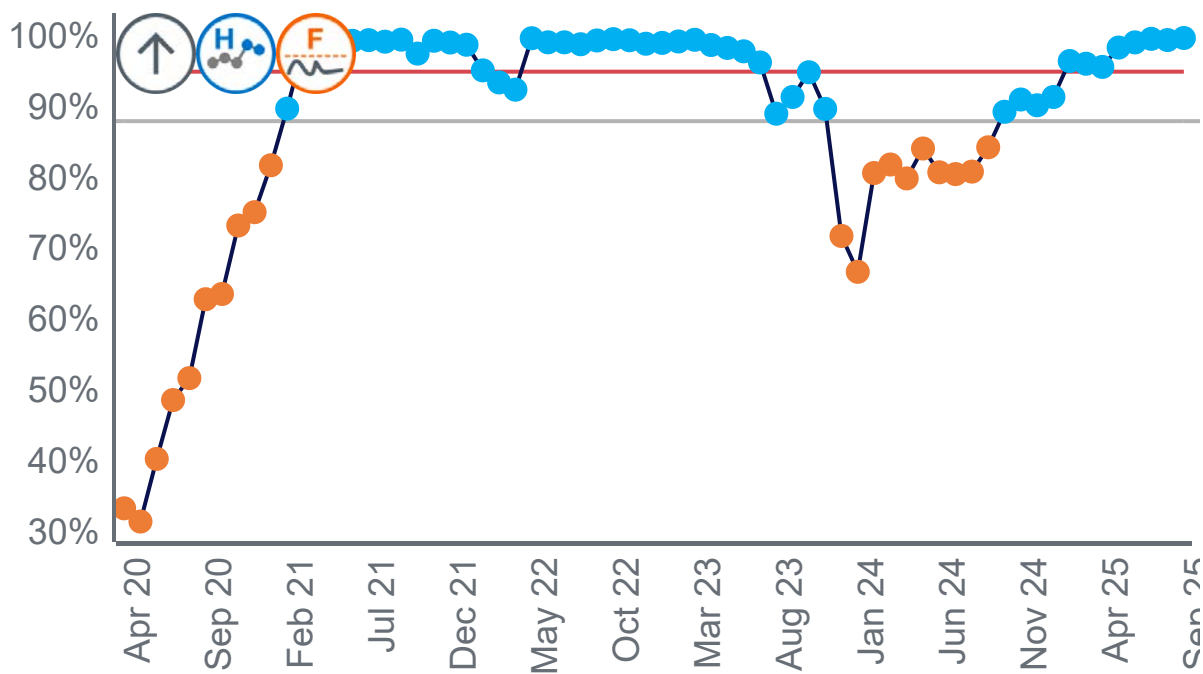
Technical Analysis:

Cancer performance is reported 2 months in arrears. The trust achieved the target within Aug-25. 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

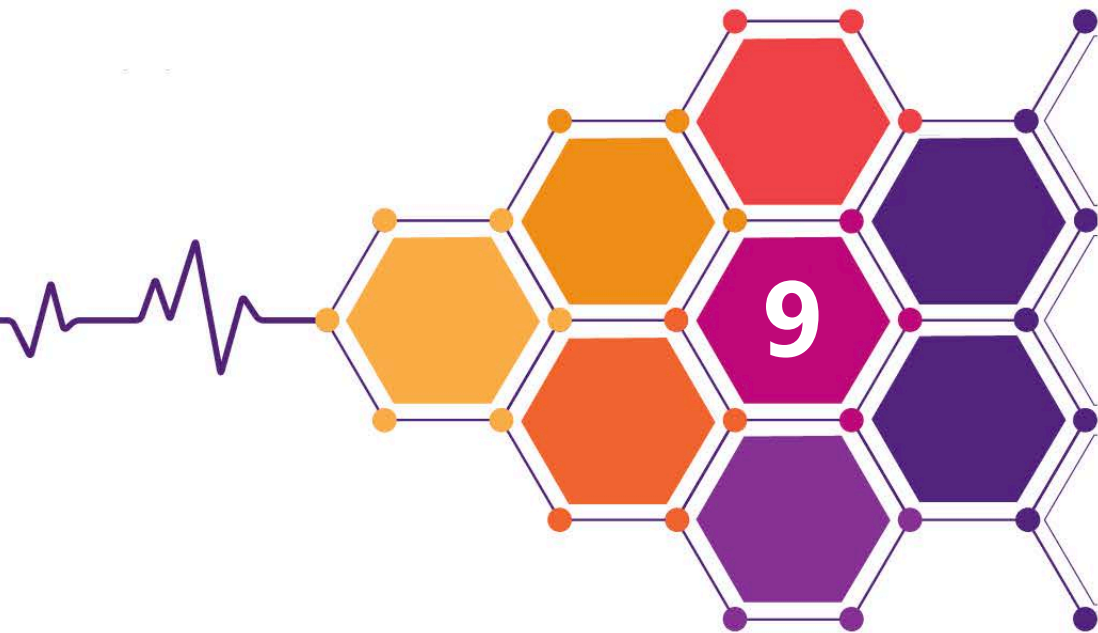


Technical Analysis:

Performance in September continues to achieve the 6 week target. Performance is displaying special cause improvement having achieved the target since the beginning of 2025.

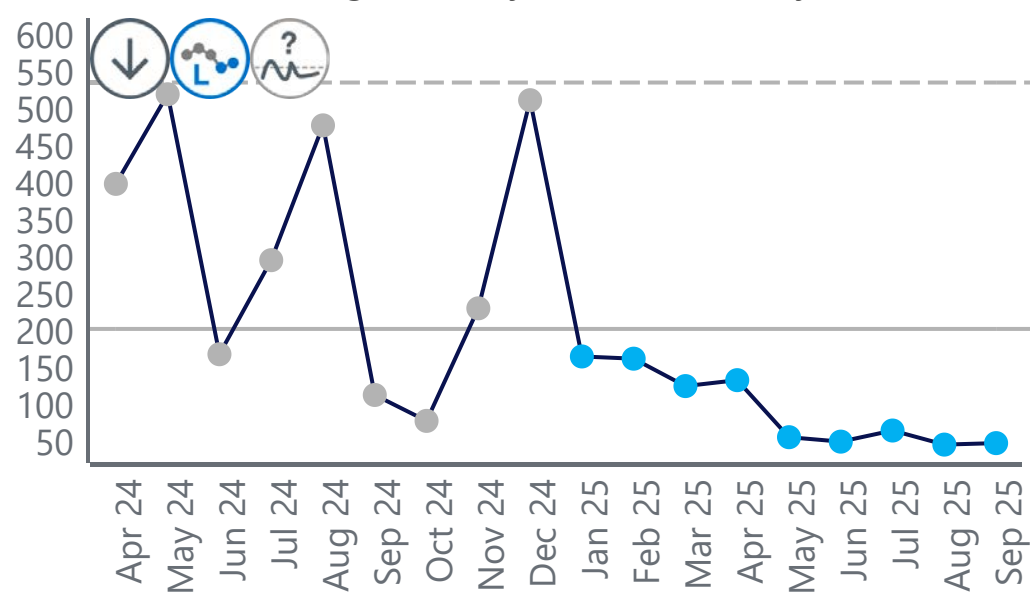
Actions:

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

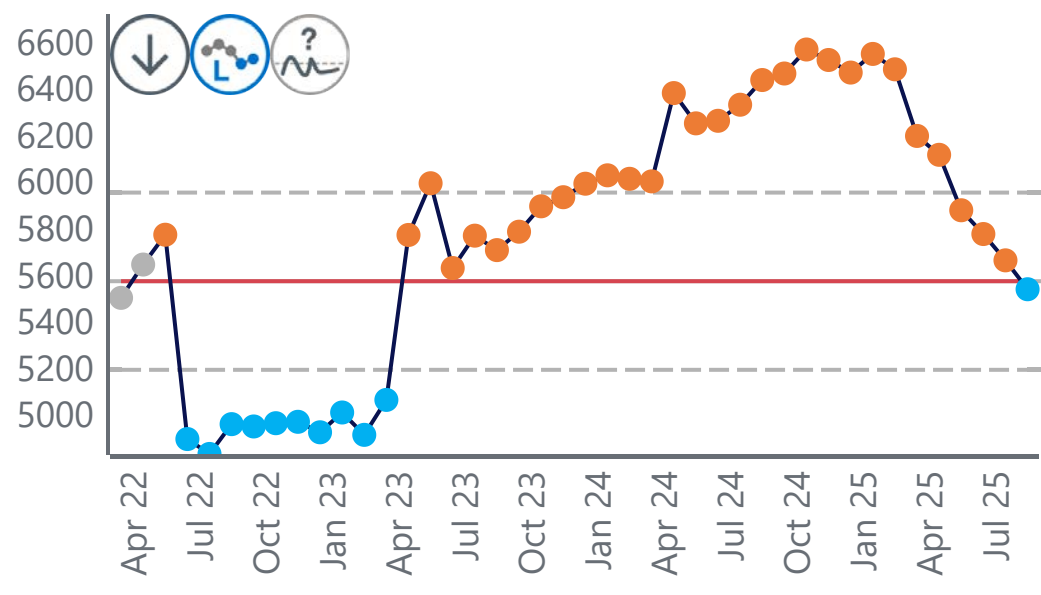


Operational Performance - Watch Metrics

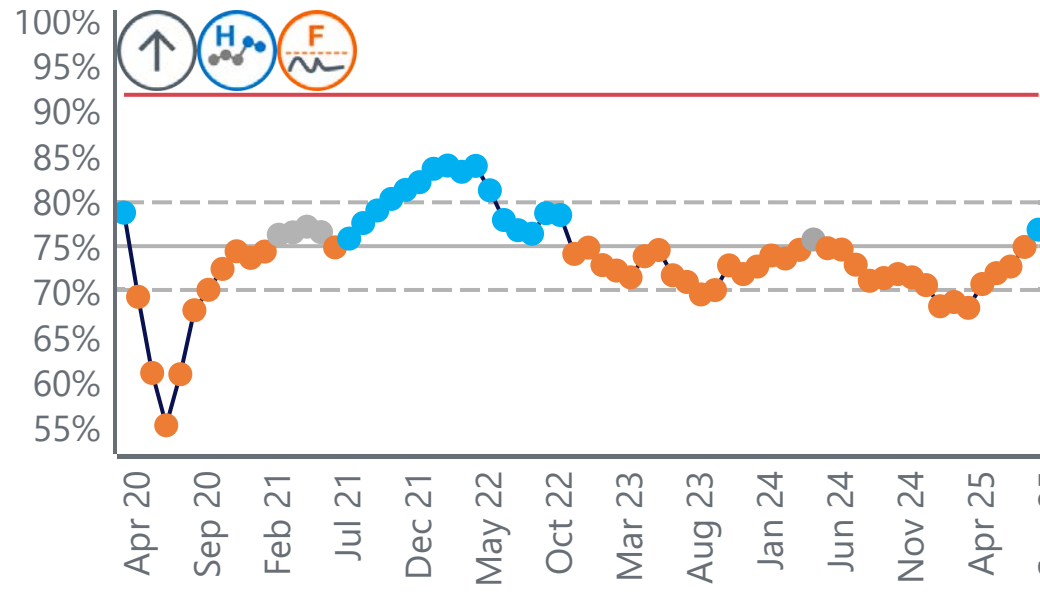
Letters waiting to be typed over 7 days



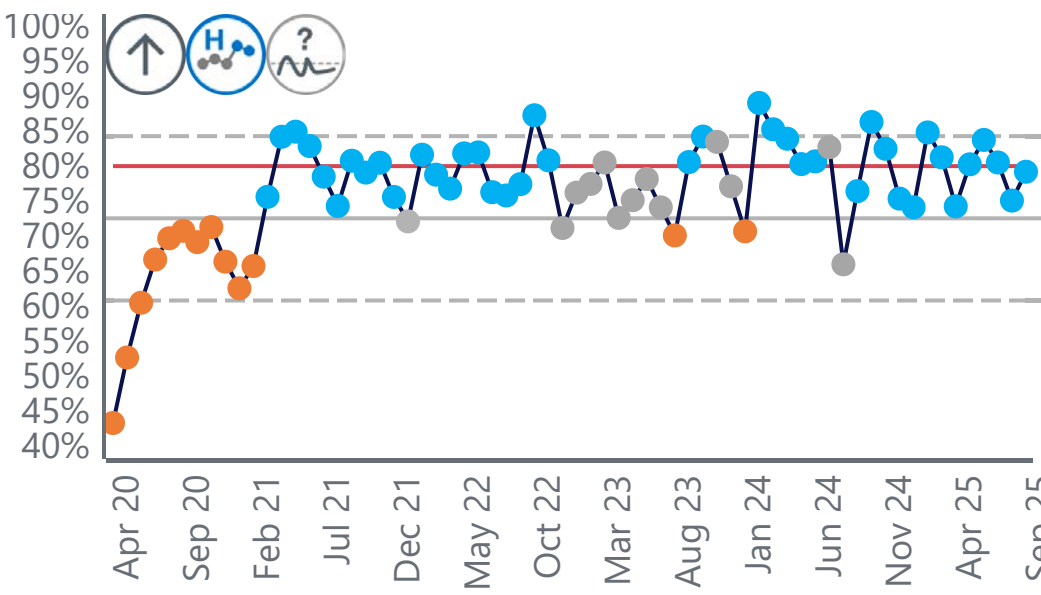
Overall Size of Waiting List



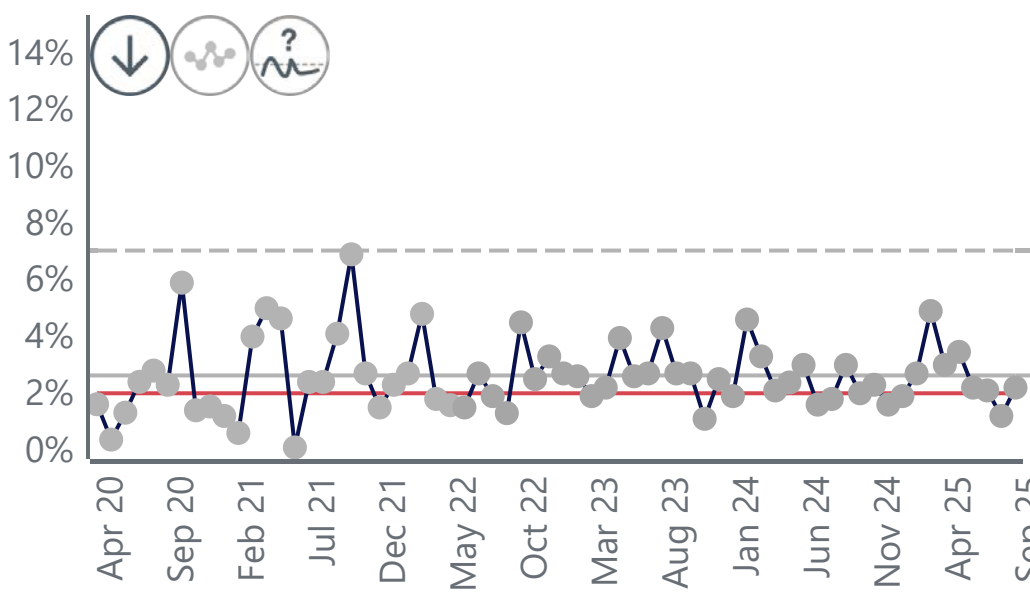
RTT 18 weeks in aggregate - Incomplete Pathways



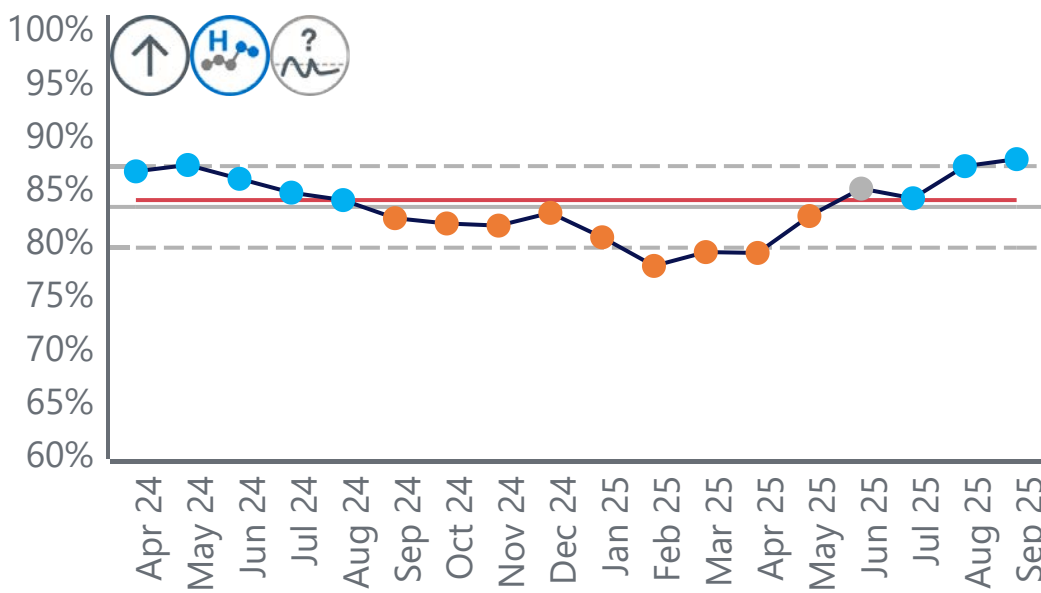
Bed Occupancy



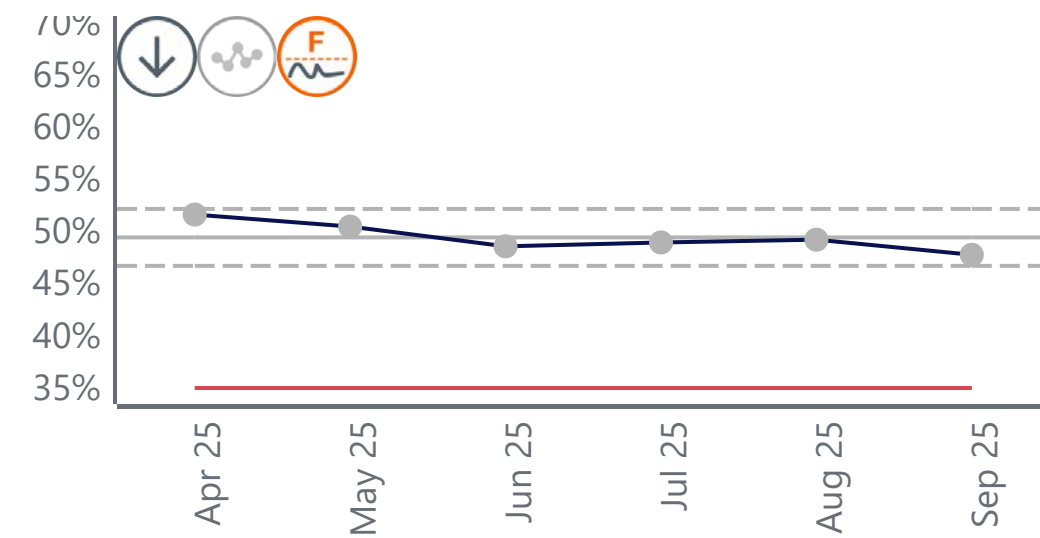
Cancelled Operations for non-clinical reasons



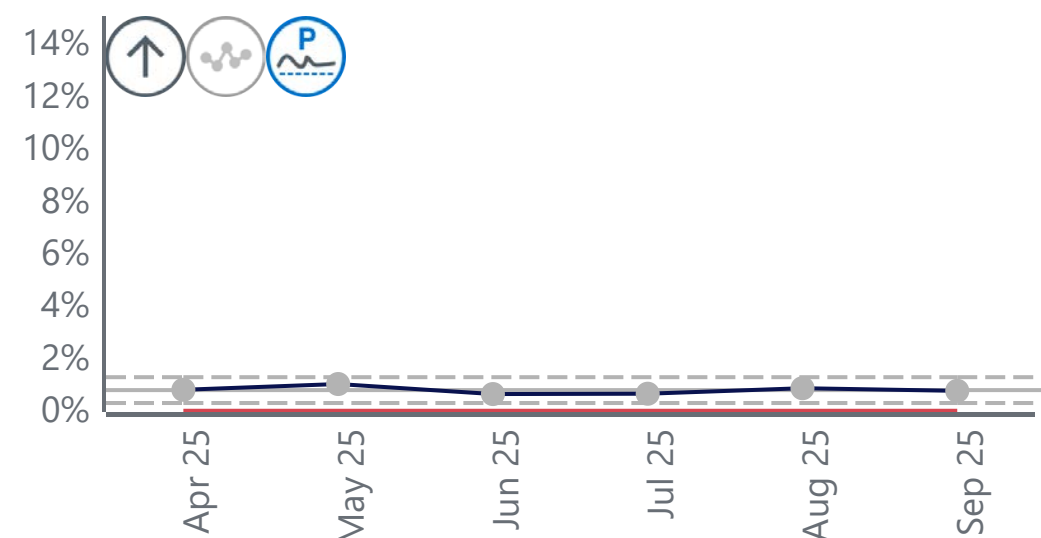
Time to First Appointment



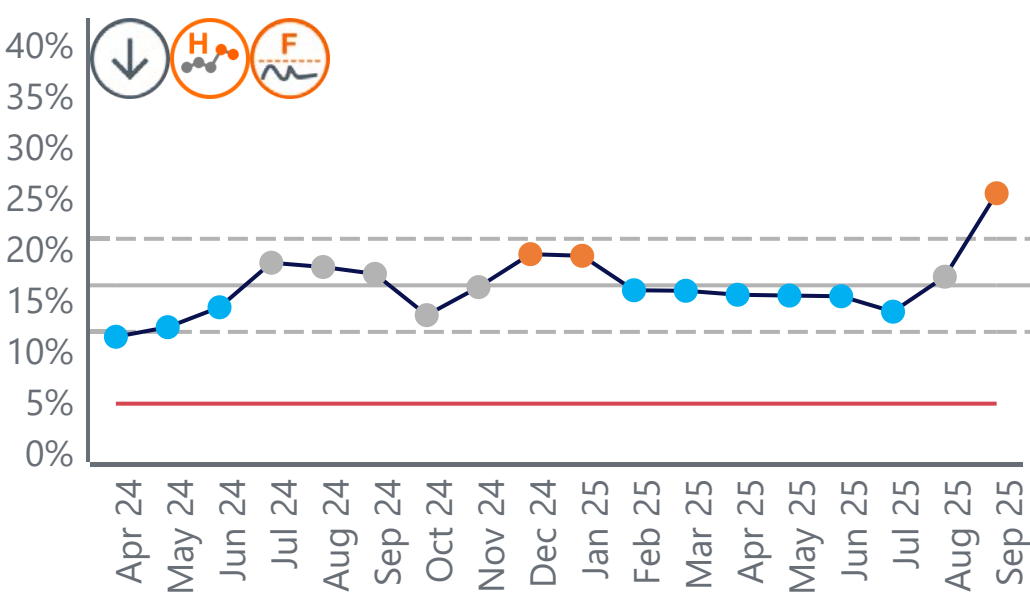
RTT Open Pathways - Percentage without an Ethnicity Status



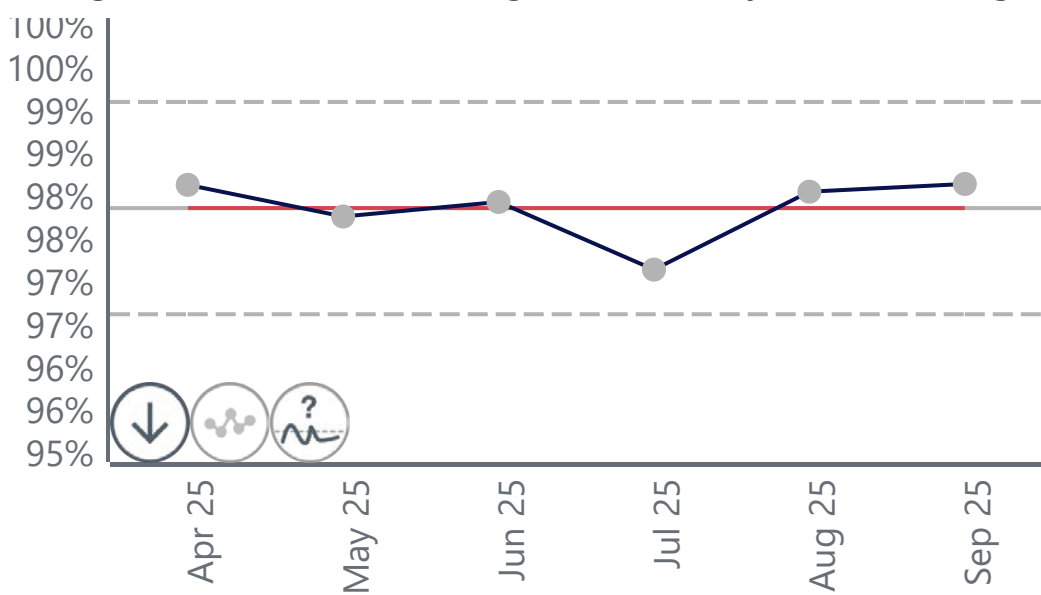
RTT Pathway Waiters (52+ weeks) for the most deprived areas



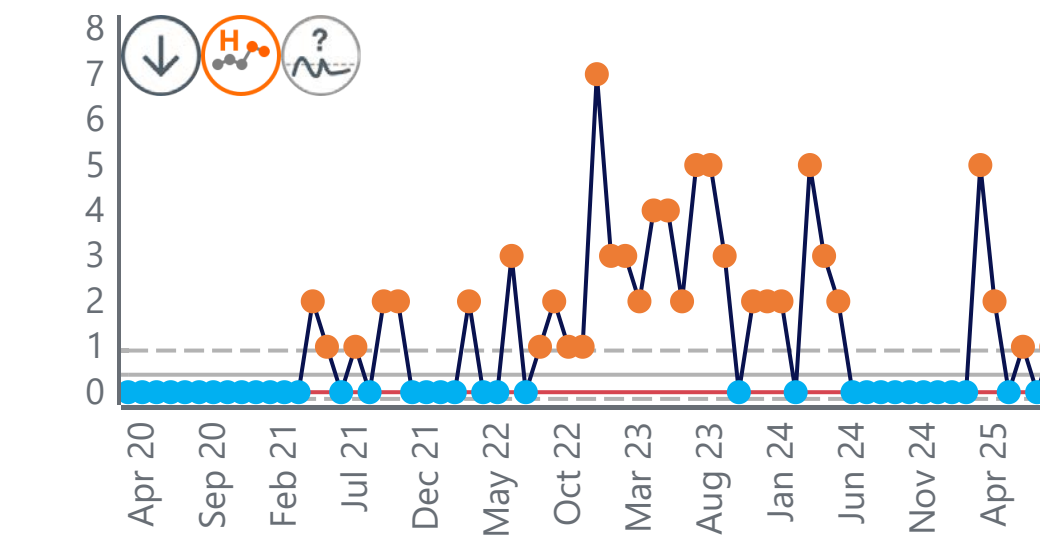
DNA Rate for most deprived areas



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 declined this month, falling below the established target for this metric. The standard operating procedure has been formally approved by the divisional boards. Work is ongoing to explore opportunities for broader implementation of PIFU across the Trust
- *The overall diagnostic DNA rate increased this month, rising from 5% to 7%. CT and MRI DNA rates remain within acceptable thresholds, staying below the target of 5%. However, the Echo DNA rate rose from 8% to 10%, and the Sleep service DNA rate increased from 13% to 15%, indicating areas requiring further review and intervention. Issues relating to the non-delivery of text message reminders have reoccurred; however, these have now been resolved
- * Performance against the risk-stratified overdue follow-ups metric has declined again this month, rising to 21% compared to the target threshold of 15%. The FOWL policy has now been formally ratified and is currently being implemented. Each division is leading the development of tailored competency frameworks to support the effective delivery of training across their respective teams.. Additionally, the 'Overdue Follow-Up Watch' metric has seen an increase this month, primarily driven by ongoing capacity and demand imbalances.
- * Slot utilisation performance has continued to improve for the third consecutive month, reaching 65%. This progress reflects the sustained efforts of the division to ensure clinic templates are appropriately configured and that sufficient capacity is allocated to support operational efficiency.

Areas of Concern:

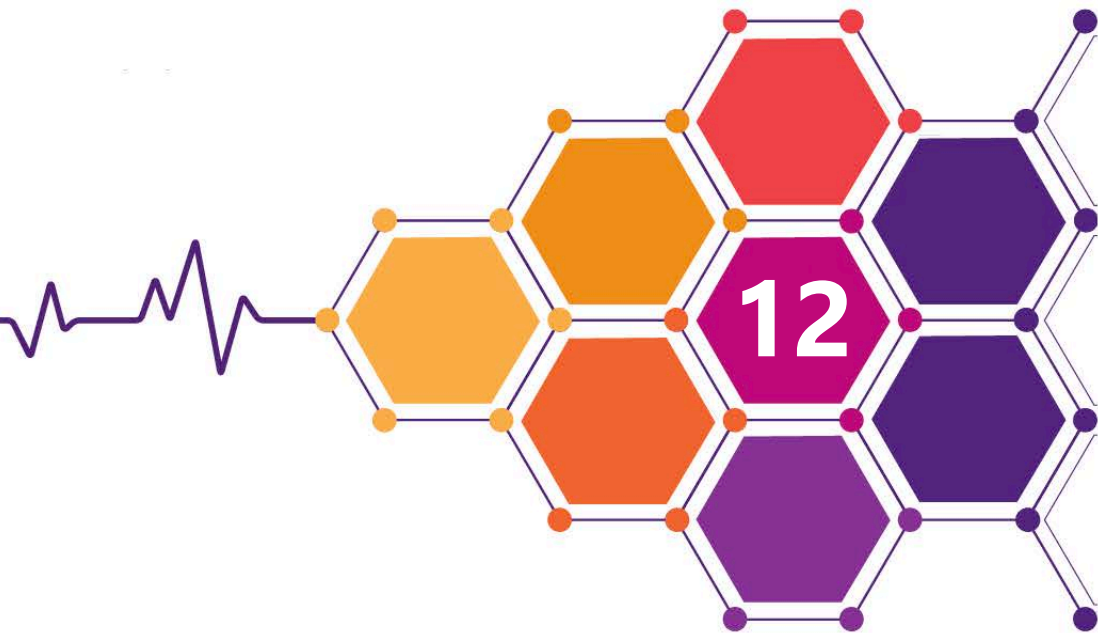
- * Echo and Sleep DNA rates remain above target despite recent interventions to resolve issues associated with the ENVOY system. While Sleep service performance initially showed improvement, it has deteriorated over the past two months. Echo performance continues to fluctuate on a month-to-month basis. A known issue within the Cardio-oncology pathway is currently being addressed through the weekly performance review meetings.
- * Core theatre session delivery performance has declined again this month, primarily due to staffing shortfalls within the Perfusion workforce and limited uptake of theatre bank shifts.
- * Performance in risk-stratified overdue follow-ups has declined again this month. While there is currently no indication of clinical risk, further analysis will be undertaken to determine the most effective approach to managing this issue and enhancing overall performance.

Forward Look (with actions):

- * Ongoing efforts by the divisional team are focused on optimising theatre list utilisation through the engagement of Locum staff to address perfusion capacity gaps and the sourcing of agency personnel to mitigate scrub staffing shortages. Regular cancellation review meetings have been established to minimise avoidable theatre list losses.
- * Continue the systematic review of clinic templates, ensuring the removal of legacy clinics and the alignment of all configurations to the standardised format, to mitigate the impact on performance reporting.
- * In response to the increased DNA rates within Echo, it has been agreed in consultation with the clinical team that adherence to the established policy is required, as current rebooking practices are occurring outside the parameters previously approved.

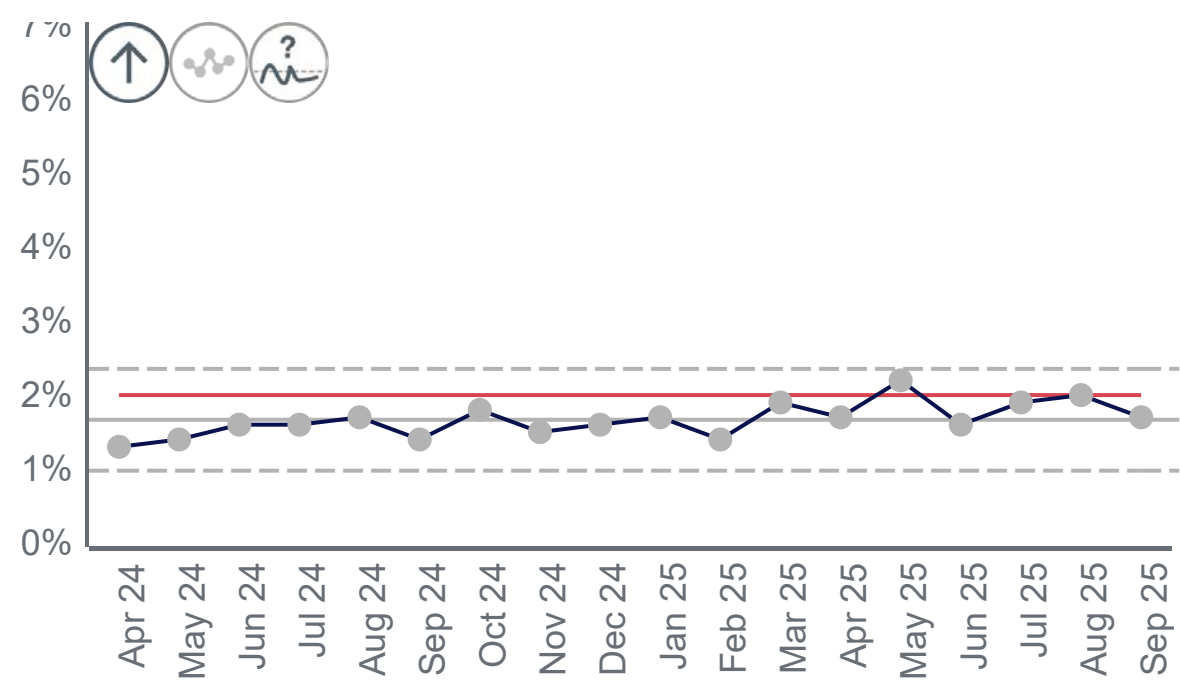
Productivity - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
% Avoidable Cancellations (Theatres)	Sep-25	4.8	1%	1.5		
% Core Session Delivery (Theatres)	Sep-25	98.7	95%	96.2		
% Session Utilisation (Theatres)	Sep-25	83.9	85%	84.1		
Diagnostic DNA Rate	Sep-25	7.0	3%	6.3		
CT DNA Rate	Sep-25	4.0	3%	3.8		
MRI DNA Rate	Sep-25	5	3%	4.0		
Echo DNA Rate	Sep-25	10	3%	9.7		
Sleep DNA Rate	Sep-25	16	3%	13.3		
% Patients on PIFU	Sep-25	1.7	2%	1.9		
Risk stratified Overdue Follow Ups (>25% overdue)	Sep-25	21.53		18.0		
Overdue Follow Ups	Sep-25	31.12	25%	26.6		
Slot Utilisation	Sep-25	64	85%	50.5		
Theatre and Cath Lab Utilisation Combined	Sep-25	85.57	85%	85.6		



Productivity - Drive Metrics

% Patients on PIFU



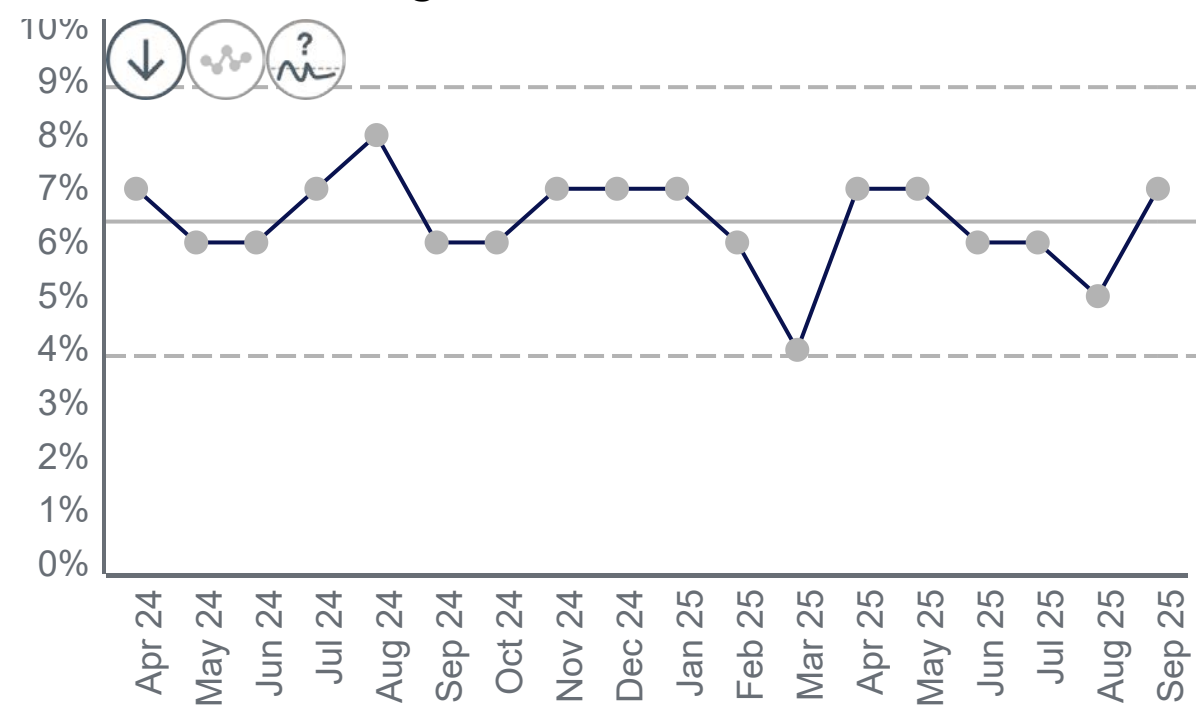
Technical Analysis:

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

Actions:

* Continue to assess opportunities for the broader implementation of PIFU across the Trust, where clinically appropriate and operationally feasible.

Diagnostic DNA Rate



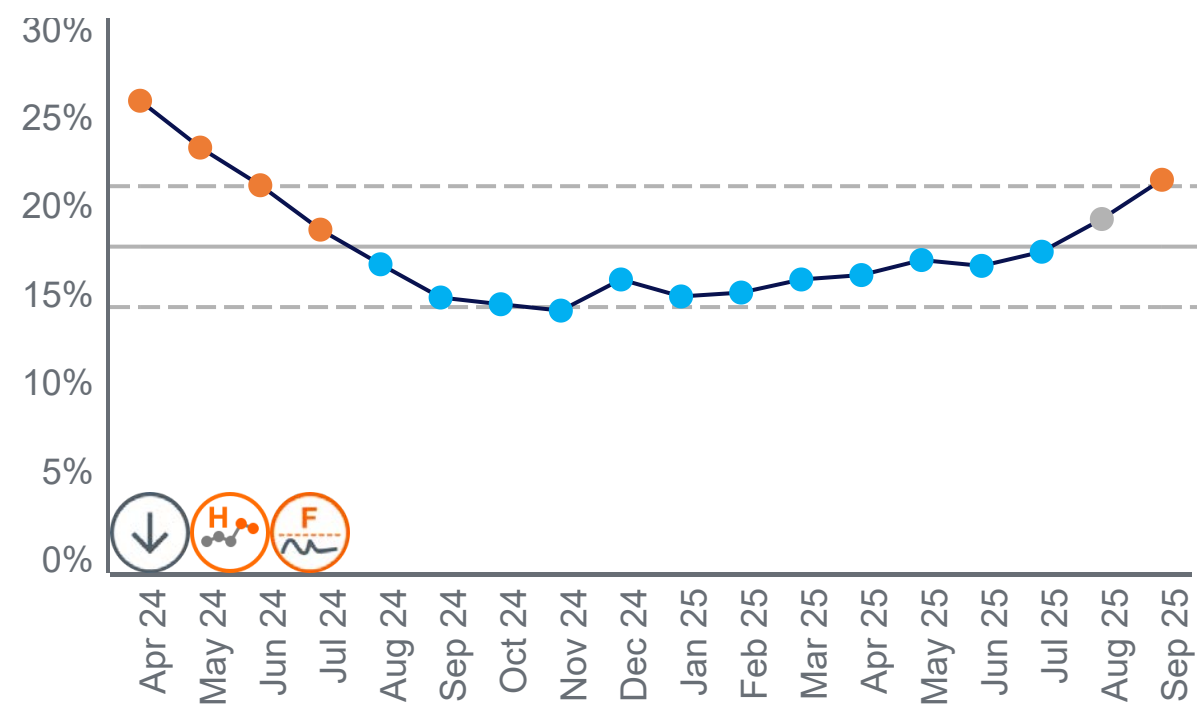
Technical Analysis:

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

Actions.

* A discussion was held with clinical staff to reinforce adherence to the access policy.
* The issue with test messages has been resolved. Ongoing monitoring will be conducted to ensure it does not recur.

Risk stratified Overdue Follow Ups (>25% overdue)



Technical Analysis:

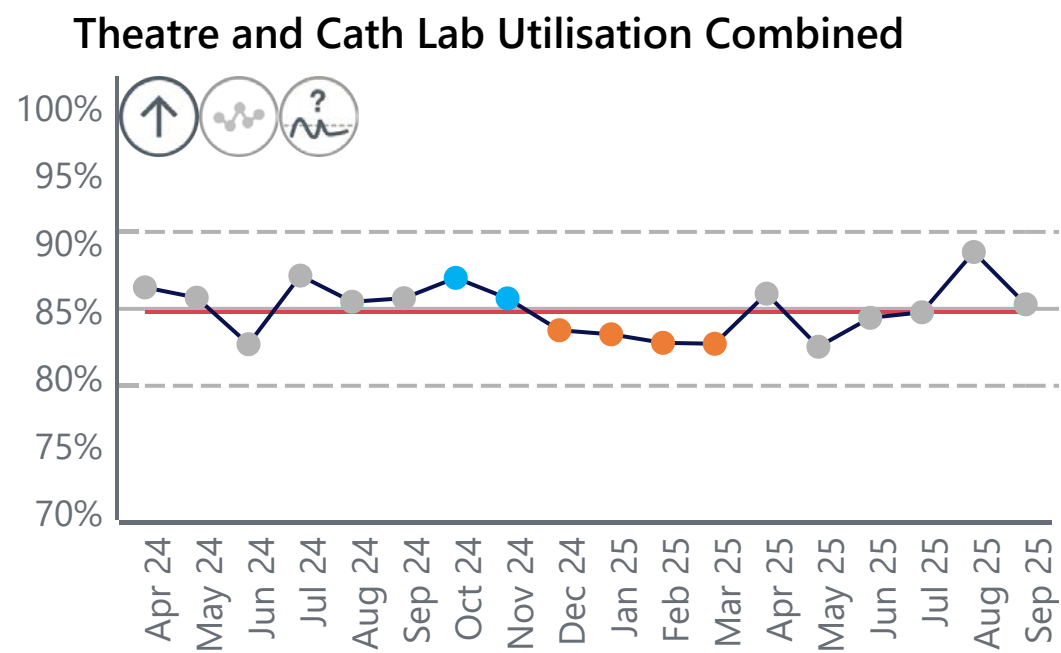
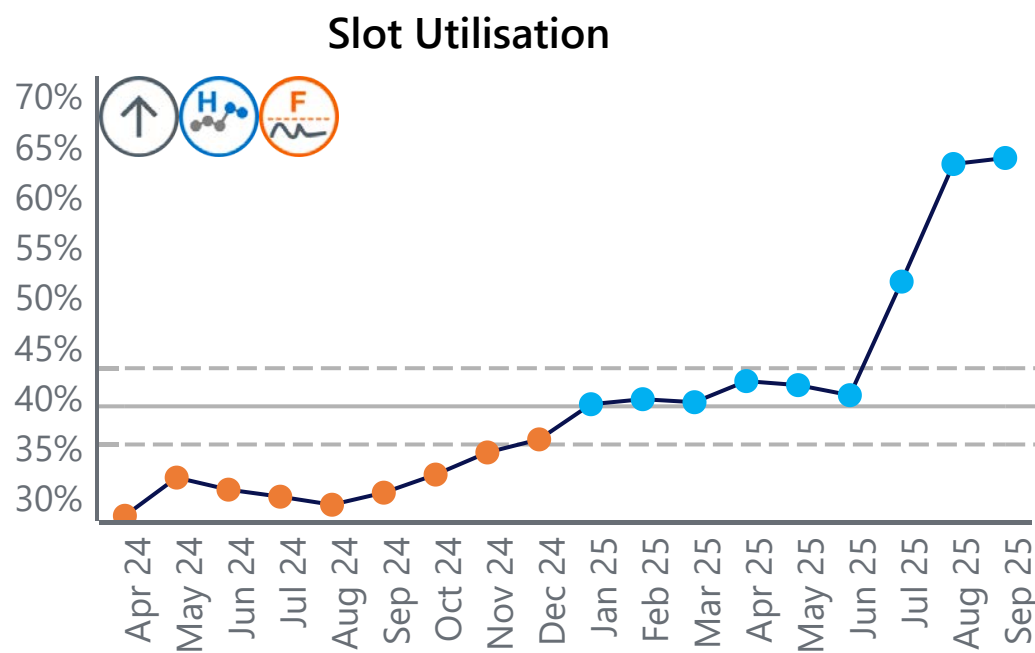
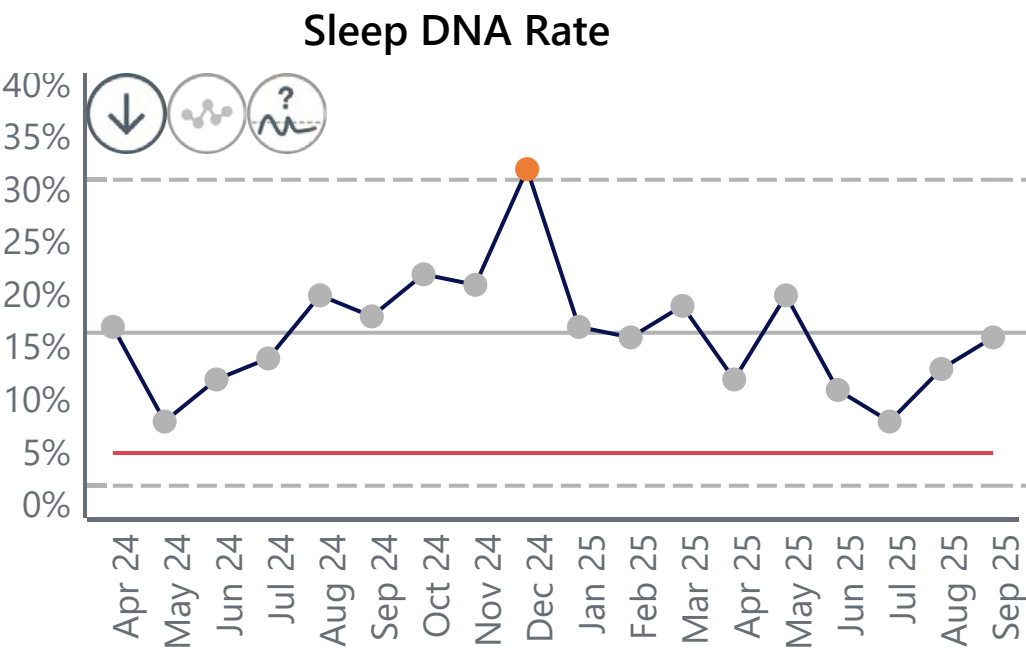
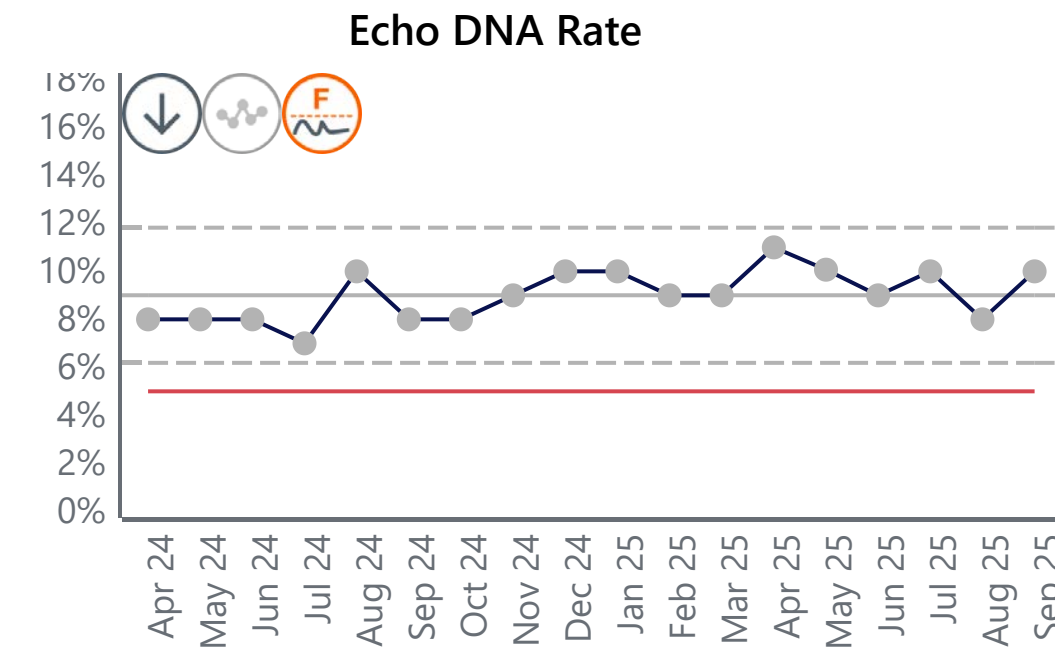
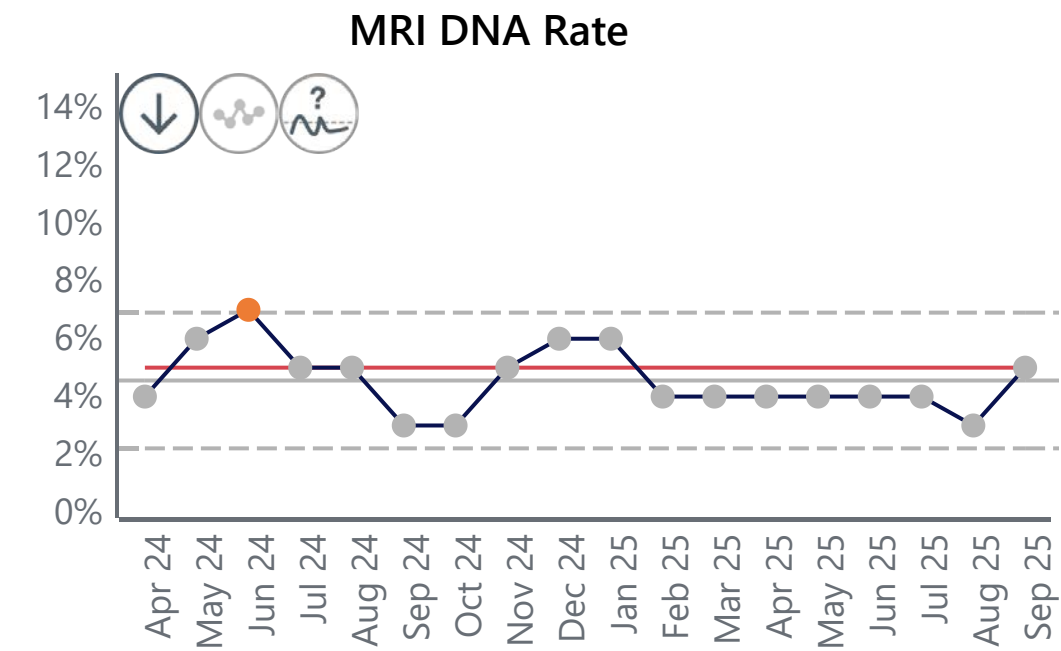
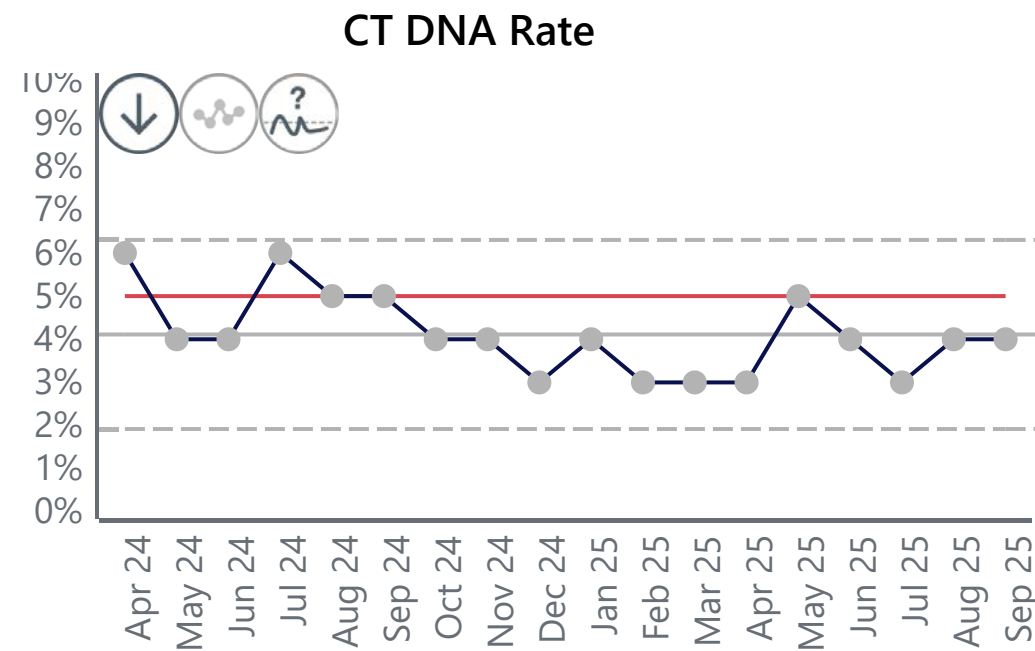
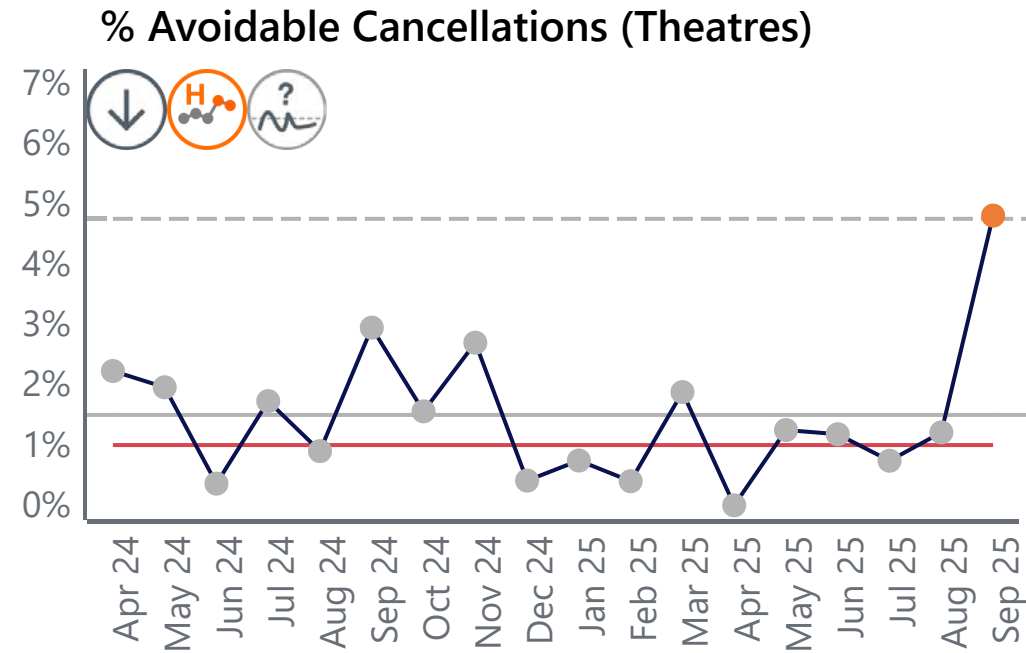
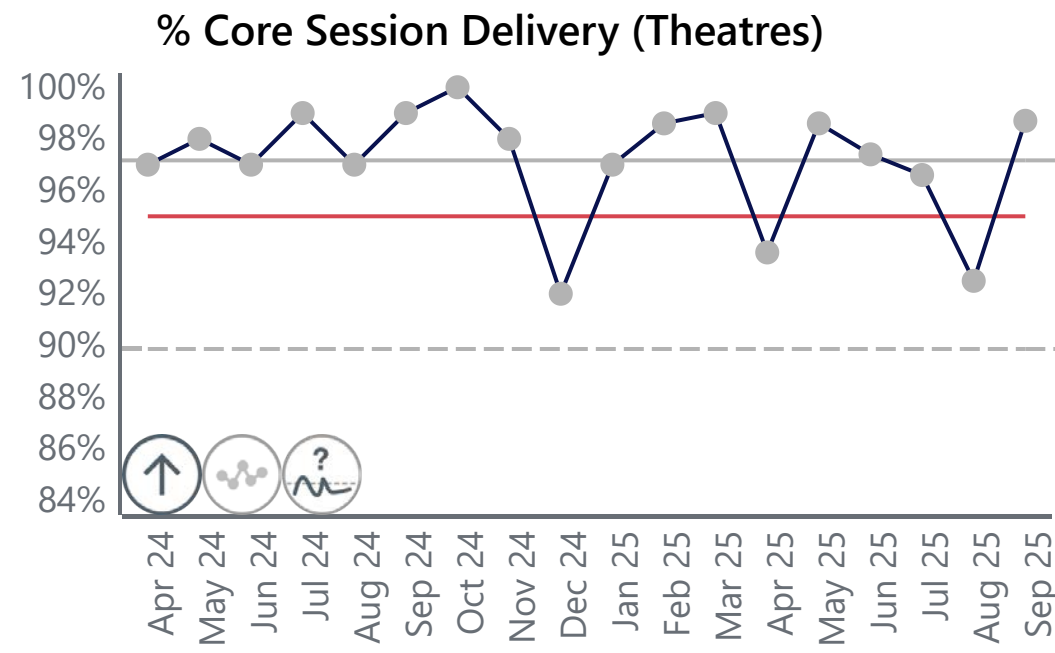
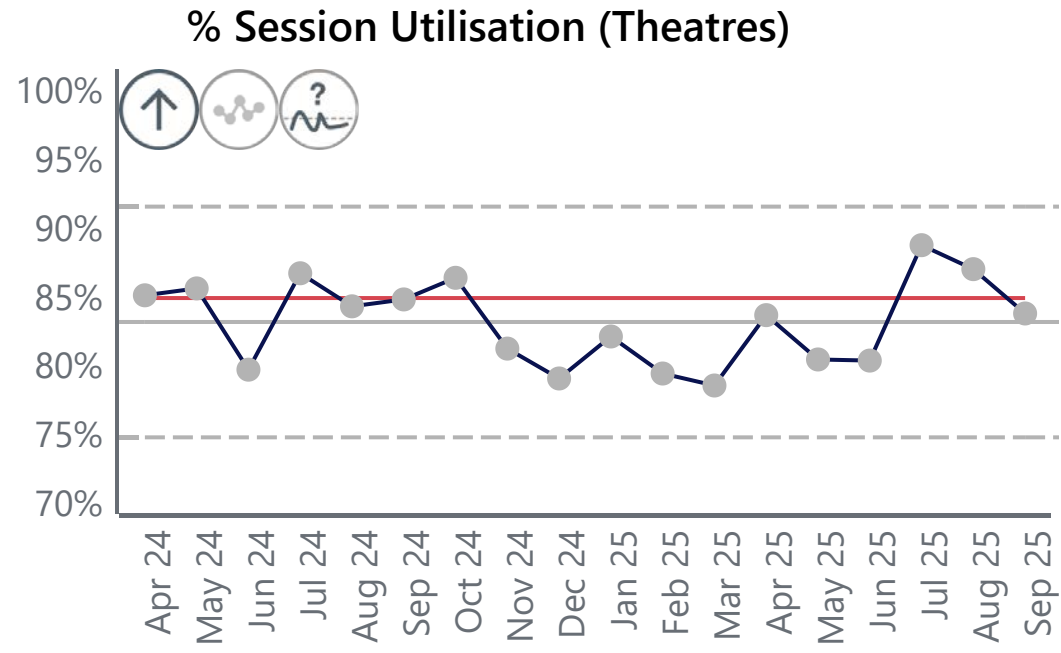
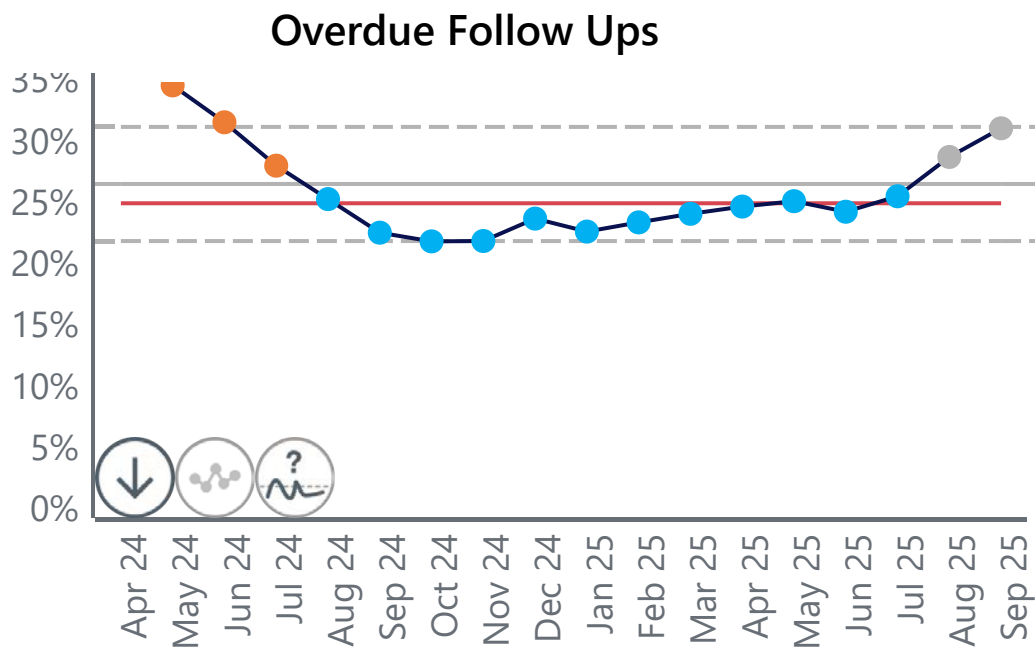
Performance continues to display inconsistency, following a period of improvement performance is has moved to cause for concern. Further work required as the Trust continues to fall short the target.

Actions:

* Explore possibility of performance being monitored via performance group.
* Implementation of the FOWL Standard Operating Procedure within the divisions to enhance the management and oversight of performance metrics.



Productivity - Watch Metrics



Quality of Care

SRO: Jennifer Taylor, 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.
- *Following investigation it was deemed an 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.
- *Surgical Site Infection shows sustained improving trends in recent months.
- * 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. PSIRF Post falls assessment document launched 22nd September - Full review of care and post falls management including hot debrief - 46 falls year to date of which 2 avoidable and 1 moderate harm which was deemed unavoidable.
- *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, discussions are planned with Merseycare regarding their commissioning agreement. 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):

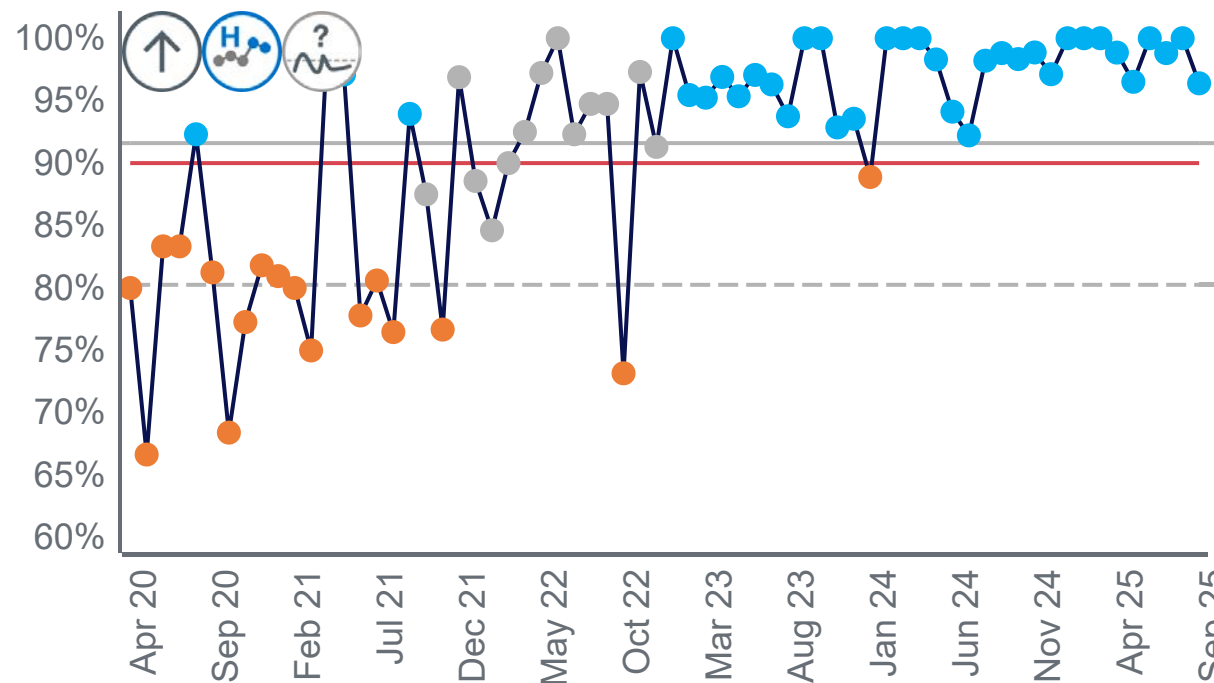
- *Radiology Alert Response (RAR) dashboard - Work has been completed on improving the quality of the audit tool as planned and the new dashboard and audit tool are live. Divisions continue to use this dashboard to improve compliance.
- *Patients receiving their discharge summary on day of discharge - 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	Aug-25	97.0	>=95%	90.2		
95% of all patients to receive a copy of their Discharge Summary on day of discharge	Sep-25	96.6	>=95%	96.0		
Clostridium Difficile	Sep-25	0.0	0	0.0		
Delirium Risk Assessment to be completed on Admission and once a day	Sep-25	99.3	>=90%	99.4		
Delivery of at least one sepsis antibiotic within one hour of prescription (LHCH target)	Sep-25	96.4	>=90%	98.4		
Dementia - Find	Sep-25	100	>=90%	100.0		
Gram Negative Bacteraemias	Sep-25	2	0	1.3		
MRSA Bacteraemias	Sep-25	0	0	0.0		
MSSA Bacteraemias	Sep-25	0	0	0.7		
Number of Falls	Sep-25	6		7.7		
Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care)	Sep-25	0	<=0.5	0.0		
Number of LHCH acquired grade 3+ pressure ulcers (due to lapses in care)	Sep-25	0.0	<=0	0.0		
Nutrition - Patients scoring high risk (2 or more) are referred to dietician	Sep-25	88.64	>=90%	89.0		
Incident Closures within 28 days	Sep-25	73.0	0	66.8		
Number of Incidents No Harm or Low Harm	Sep-25	75		141.3		
Number of Incidents Severe Harm	Sep-25	0		0.3		
Number of Incidents Moderate Harm	Sep-25	0		3.5		
Incident referred to RIDDOR	Sep-25	0		0.5		
Occurrence of any Never Events	Sep-25	0.0	0	0.0		
Primary PCI - 60 minute 'Door-to-balloon' (national target)	Sep-25	88.9	>=75%	79.8		
Primary PCI - 150 minute 'Call-to-balloon' (national target)	Sep-25	88.2	>=95%	71.6		
Quantity of complaints	Sep-25	0	<=6	1.3		
Venous thromboembolism (VTE) risk assessment	Sep-25	95.3	95%	95.3		
FFT: REPUTATION	Sep-25	99.5	>=95%	99.1		
FFT: AFTER STAY	Sep-25	98.6	>=95%	98.1		
FFT: ARRIVAL	Sep-25	99.2	>=90%	99.3		
FFT: PATIENT CONTRACT	Sep-25	99.3	>=95%	99.3		
FFT: STAY	Sep-25	99.8	>=95%	99.7		
FFT: TREATMENT	Sep-25	99.8	>=90%	99.4		
Surgical Site Infections	Jul-25	7.7	0%	7.7		
Hospital Standardised Mortality Ratio (HSMR) - all diagnoses	Apr-25	87.6	<=100	1.5		

Quality of Care - Drive Metrics

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



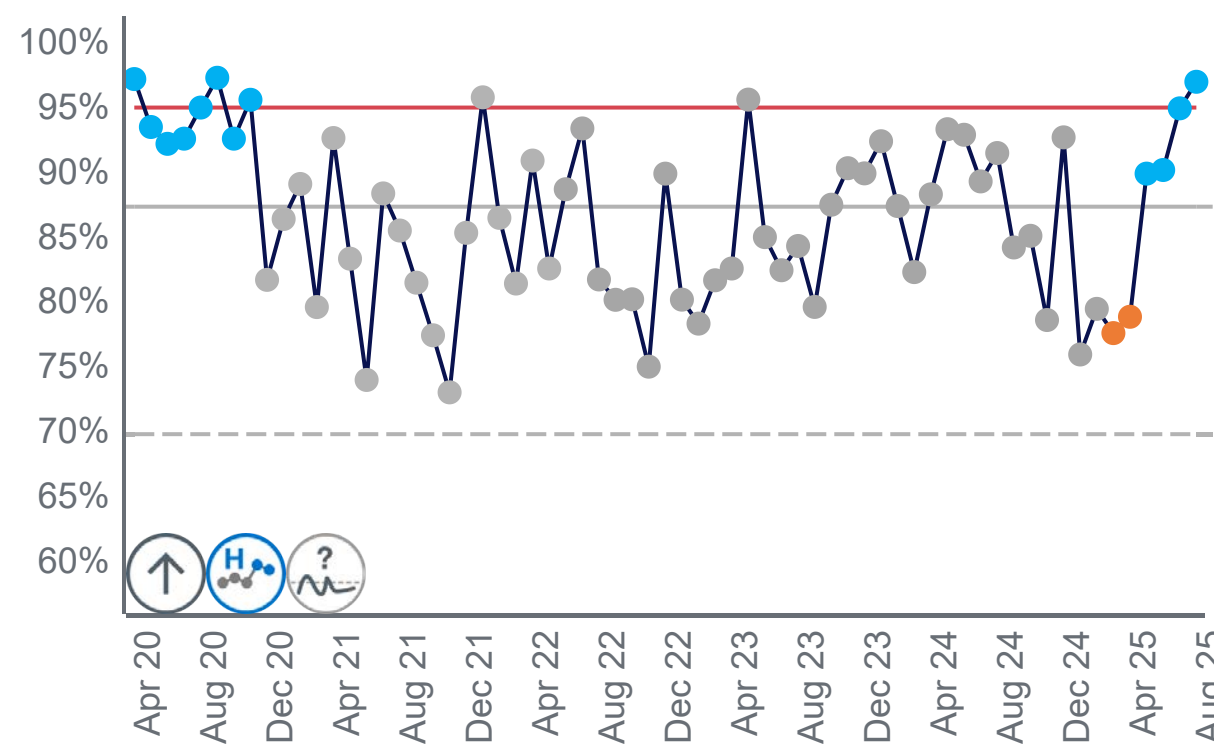
Technical Analysis:

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



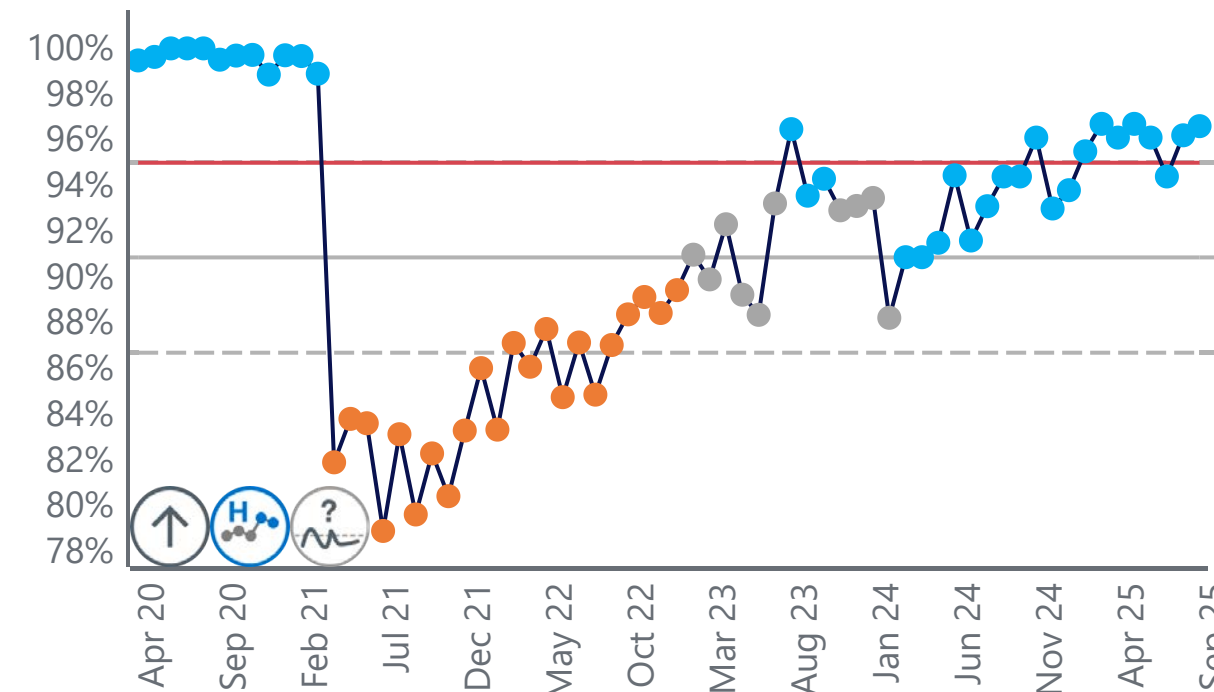
Technical Analysis:

August has moved performance into special cause improvement following continual improvement over recent months. The target was achieved for the second time since May-23. Metric reporting is 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:

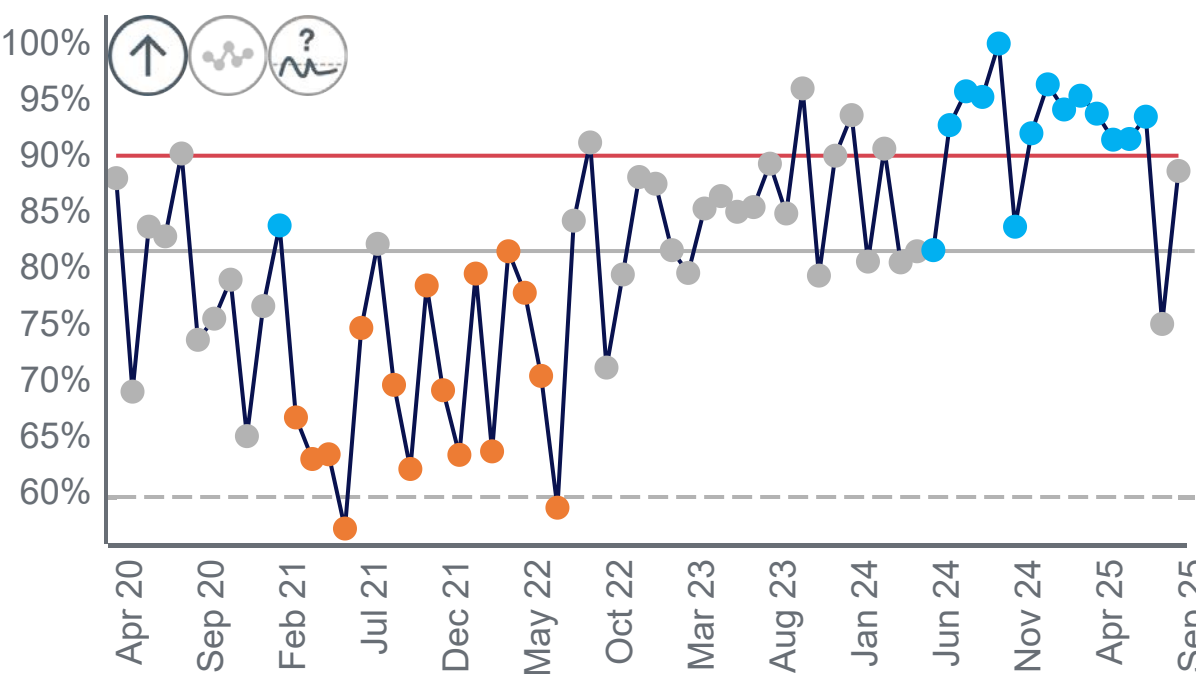
Performance in September is above the target of 95% displaying special cause improvement. Continual work required to consistently achieve target with the metric displaying inconsistency of passing and falling short of the target.

Actions:

Continued focus on keeping up recent improvement.

Quality of Care - Drive Metrics

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



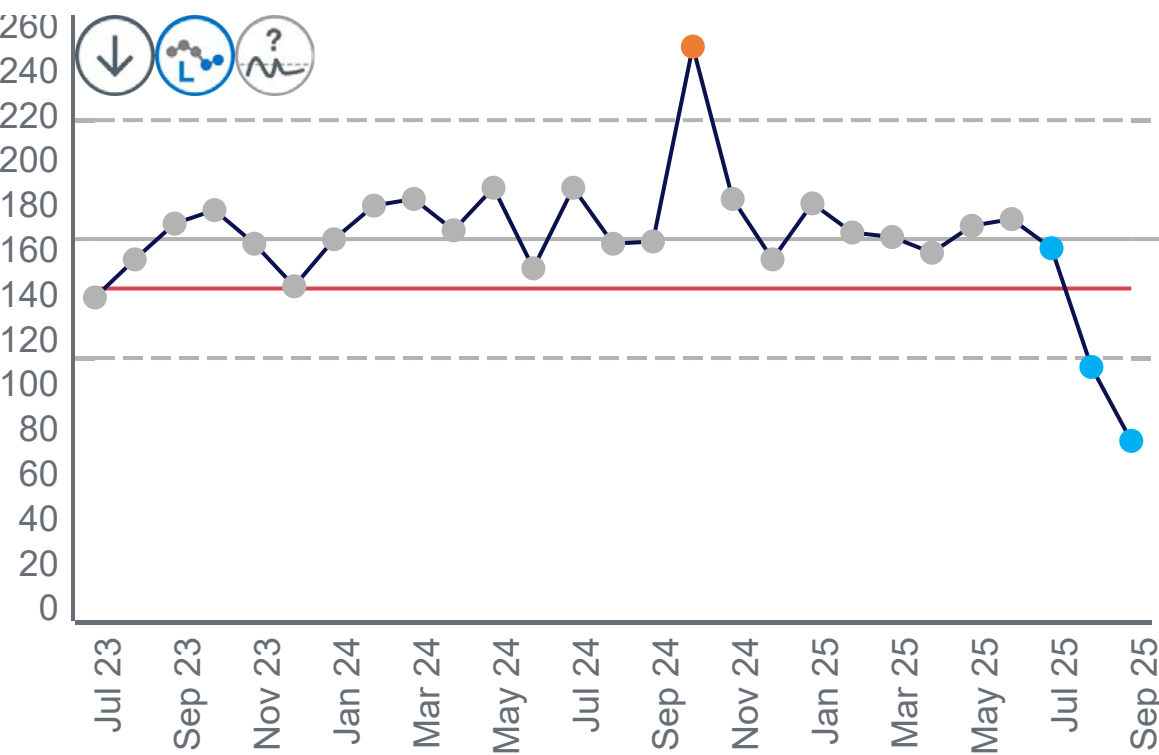
Technical Analysis:

September performance of 89% is marginally below the target of 90%. Improvement required to provide consistency which will see the metric move away from common cause variation of passing and failing the target.

Actions:

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

Number of Incidents No Harm or Low Harm



Technical Analysis:

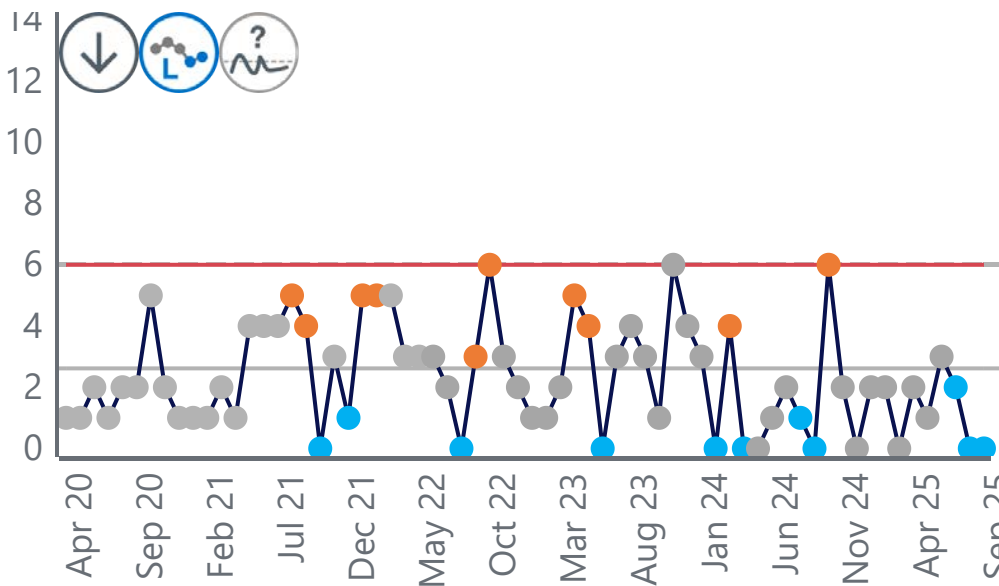
Metric has been updated to No Harm and Low Harm following. Incidents displayed are those approved, with fluctuations expected current reporting month. Performance is displaying performance of an improving nature over recent months.

Actions:

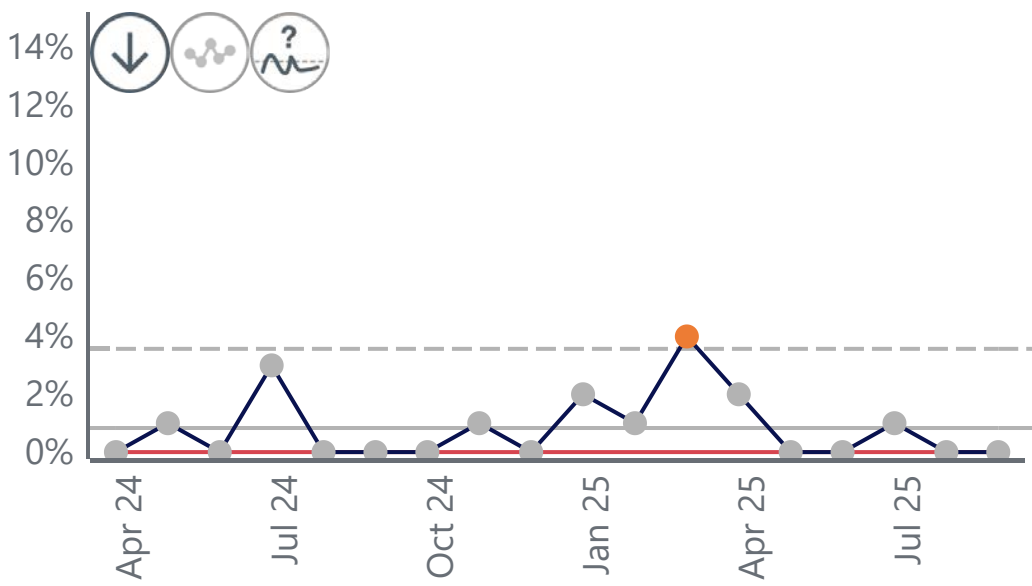
Strong reporting culture and learning from incidents. Reviews continue via safety surveillance and hasn't identified recurrent themes. A weekly patient safety meeting is now in place to review all moderate and above incidents, including action and learning. Further refinement of the KPI is needed and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

Quality of Care - Watch Metrics

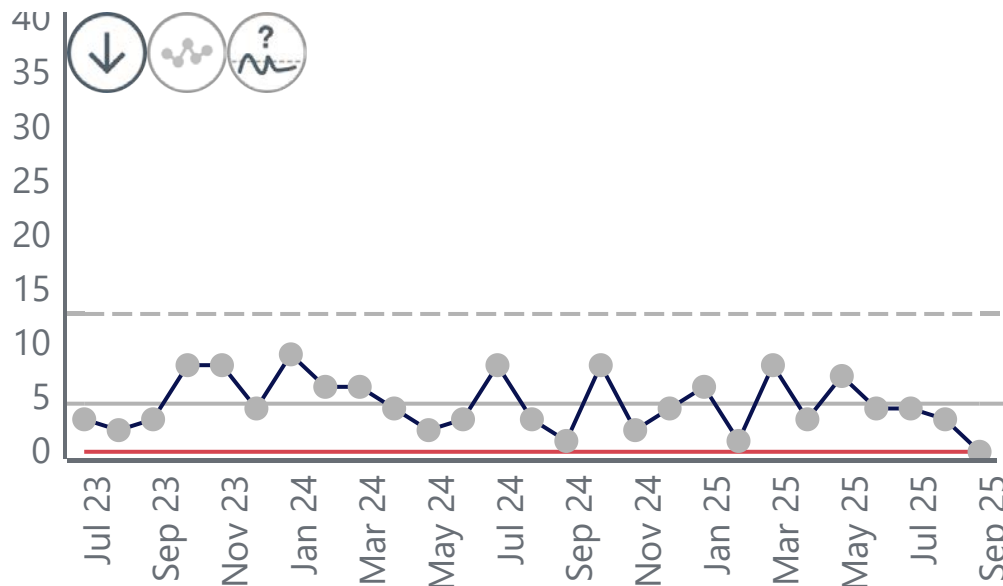
Quantity of complaints



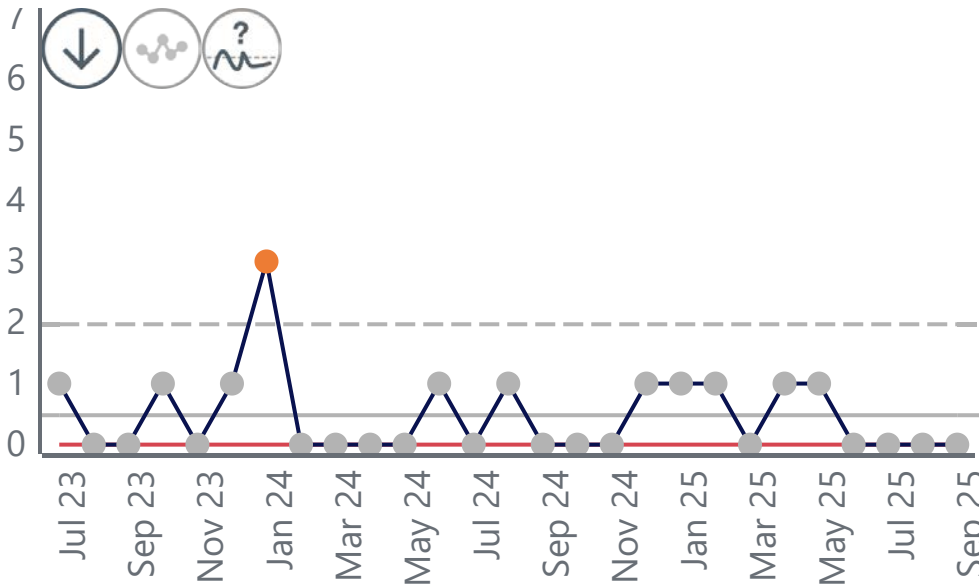
Incident referred to RIDDOR



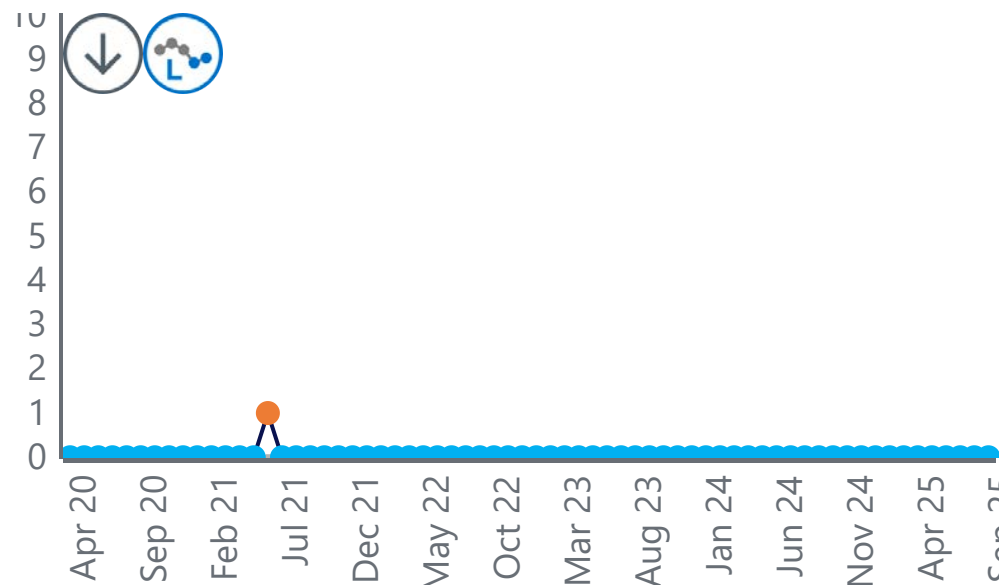
Number of Incidents Moderate Harm



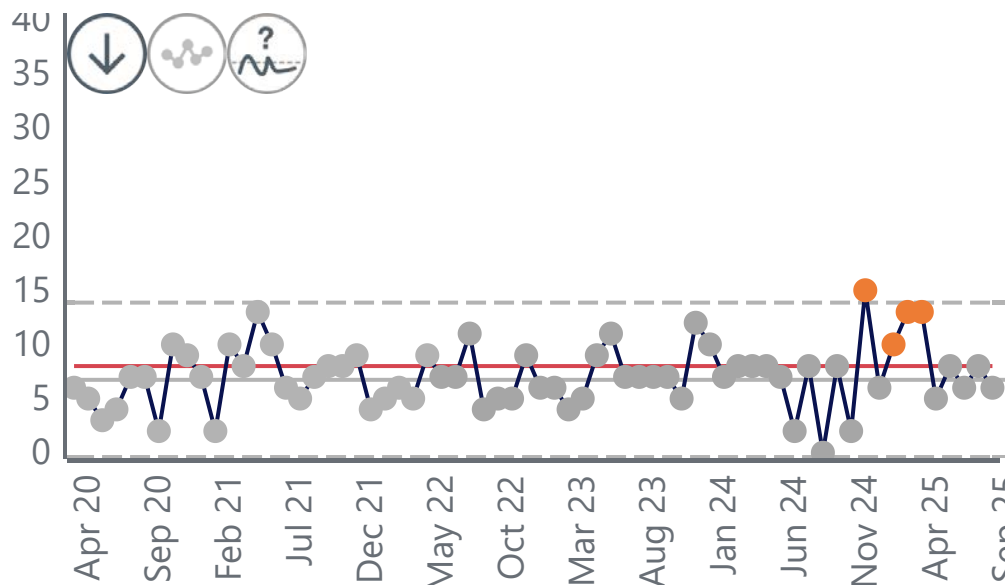
Number of Incidents Severe Harm



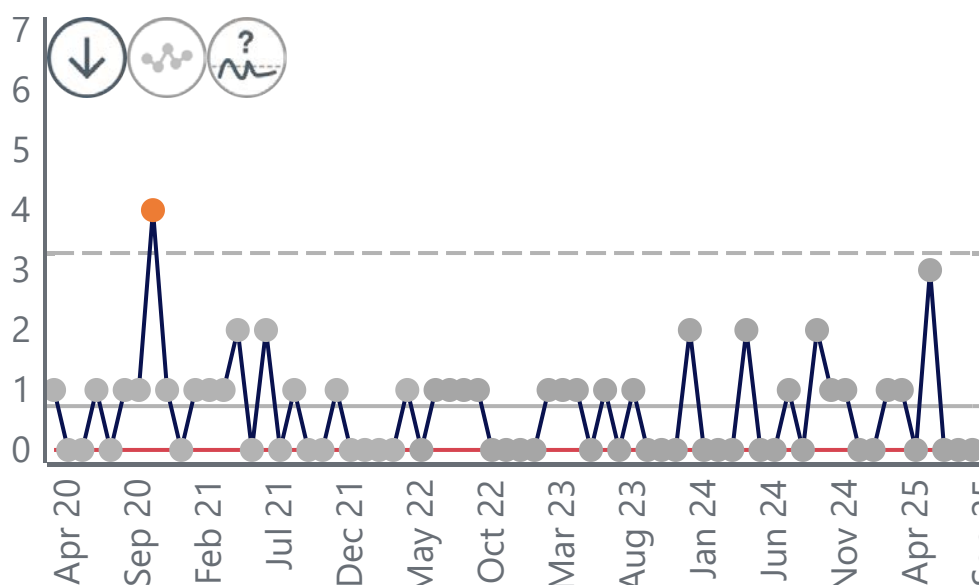
Occurrence of any Never Events



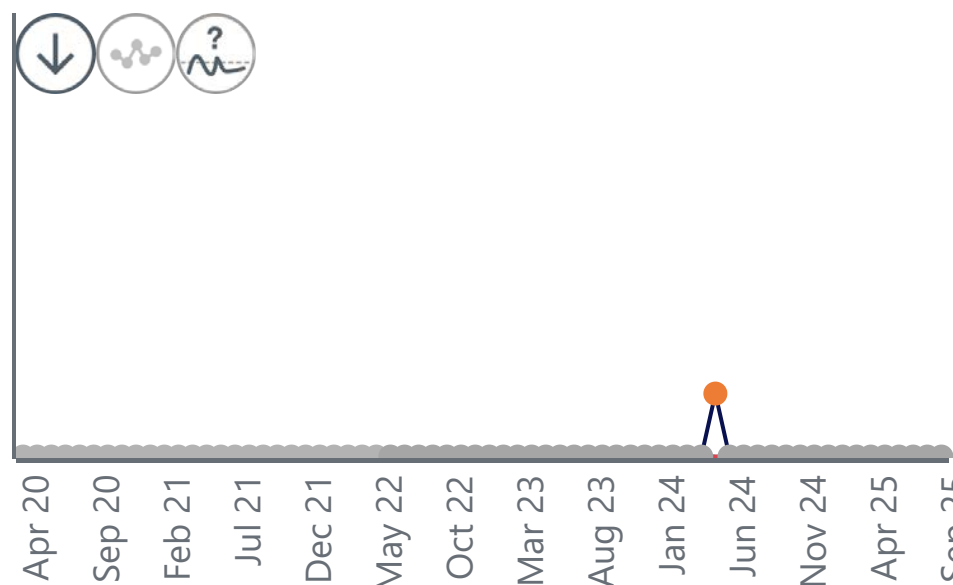
Number of Falls



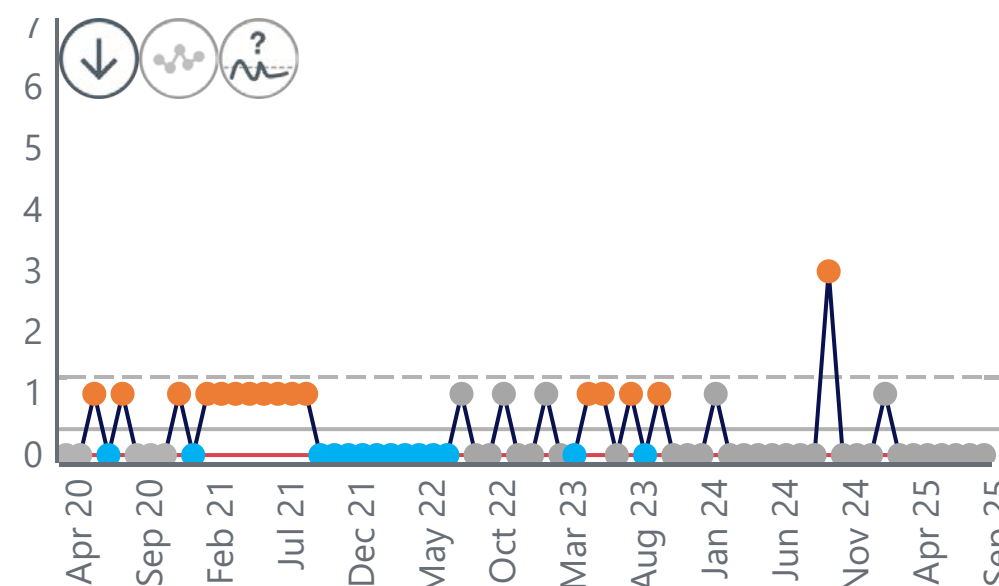
MSSA Bacteraemias



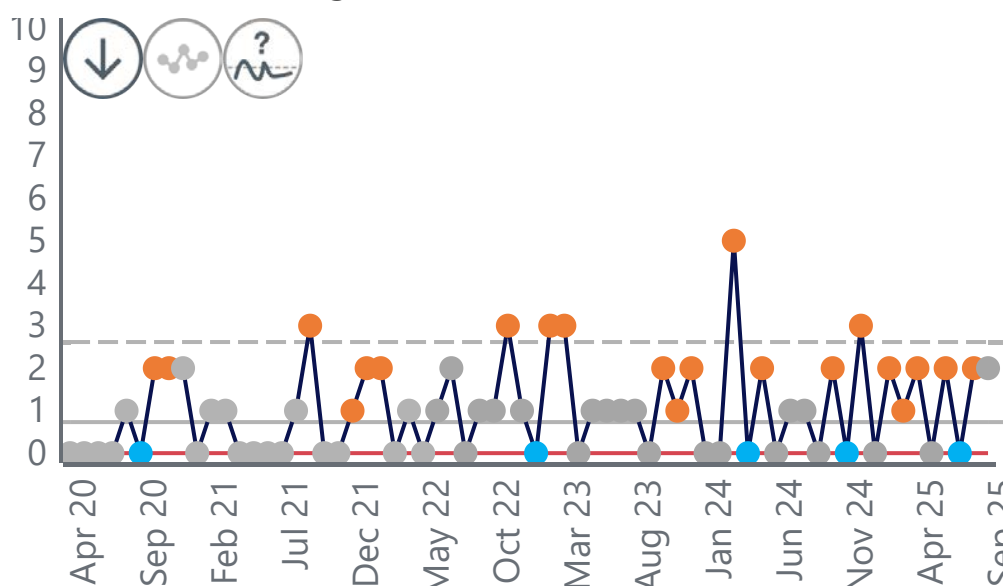
MRSA Bacteraemias



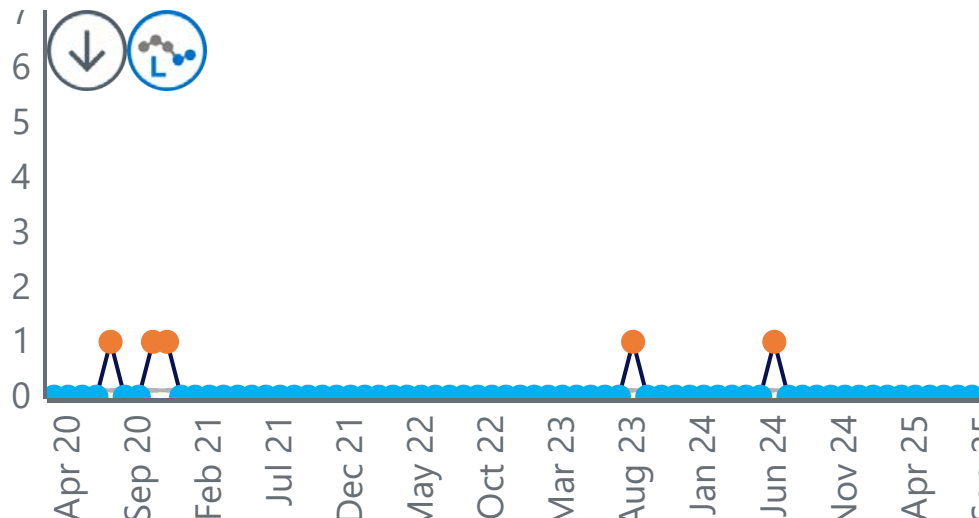
Clostridium Difficile



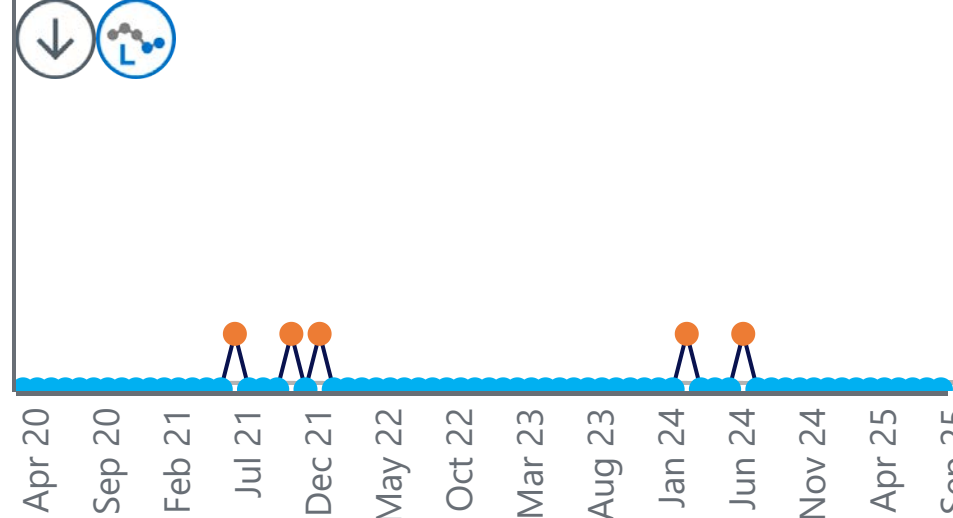
Gram Negative Bacteraemias



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

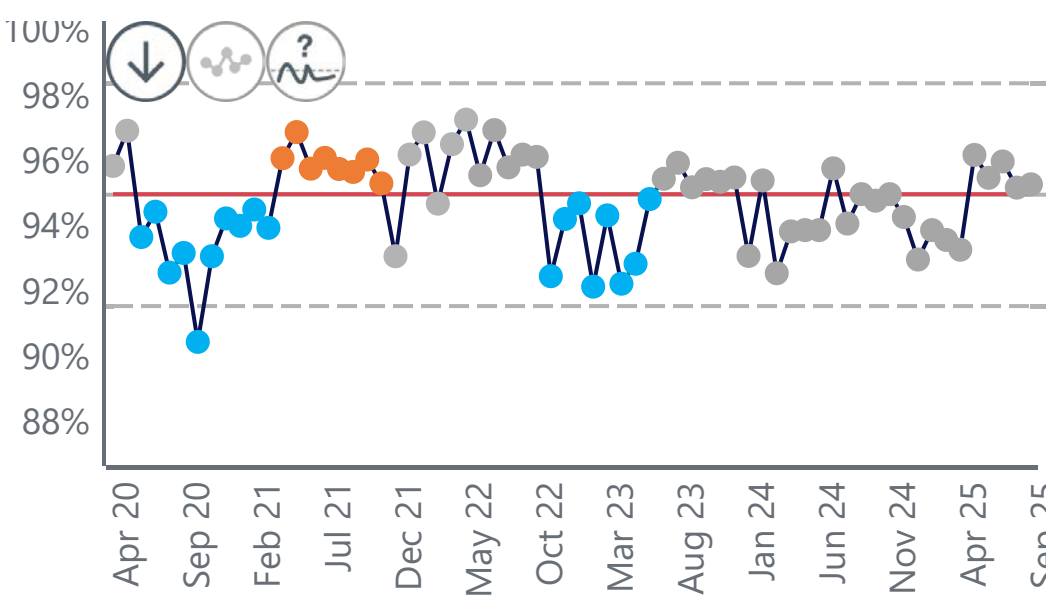


Number of LHCH acquired grade 3+ pressure ulcers (due to lapses in care)

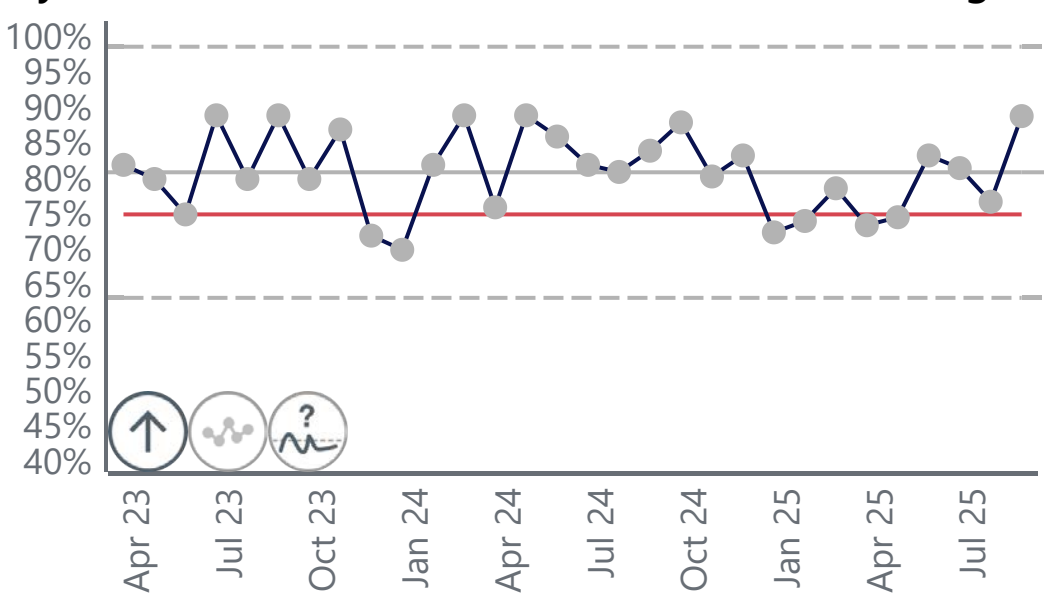


Quality of Care - Watch Metrics

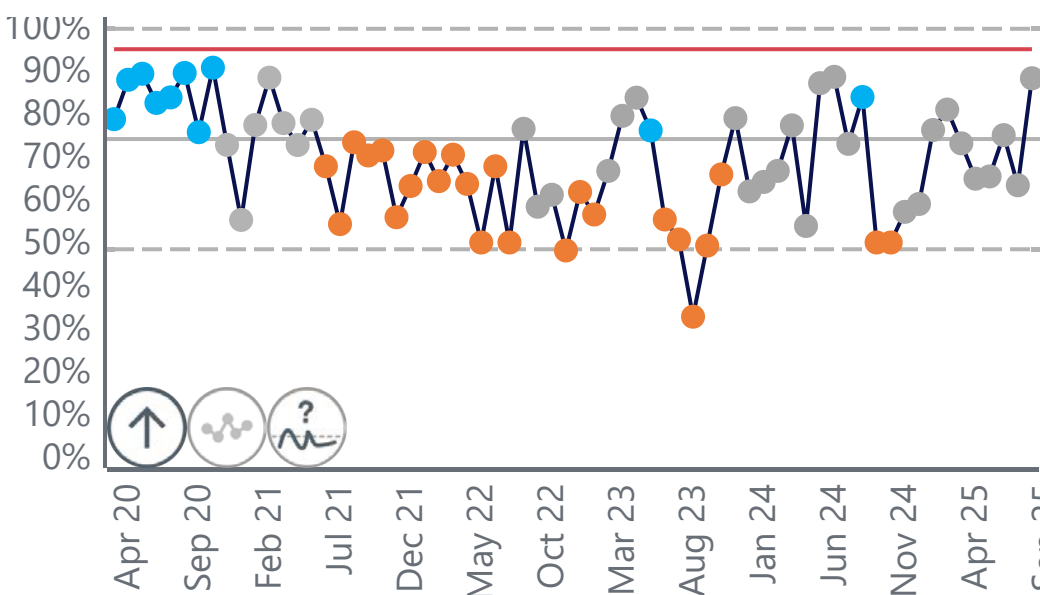
Venous thromboembolism (VTE) risk assessment



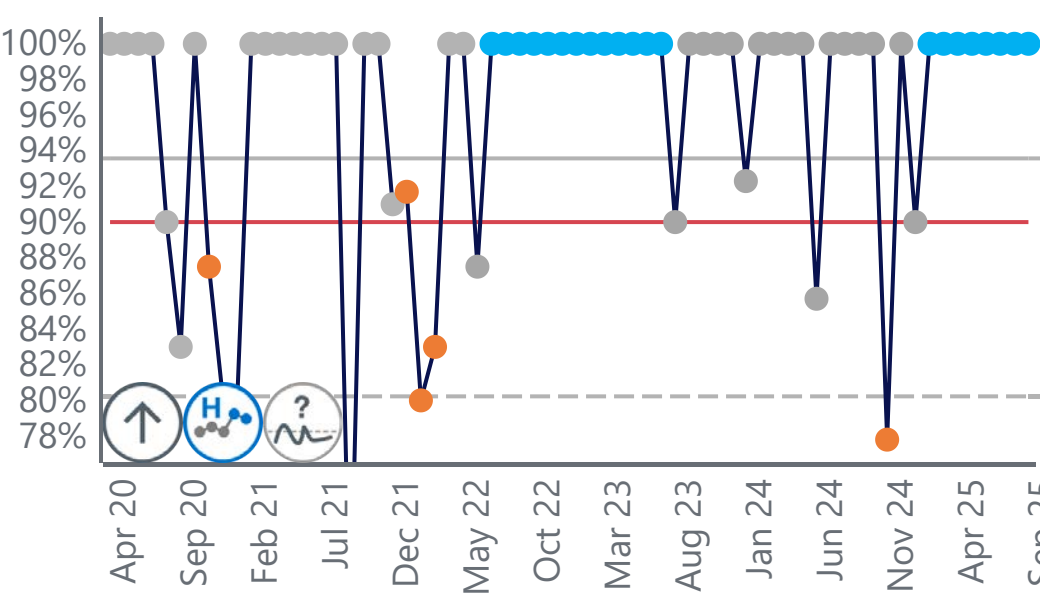
Primary PCI - 60 minute 'Door-to-balloon' (national target)



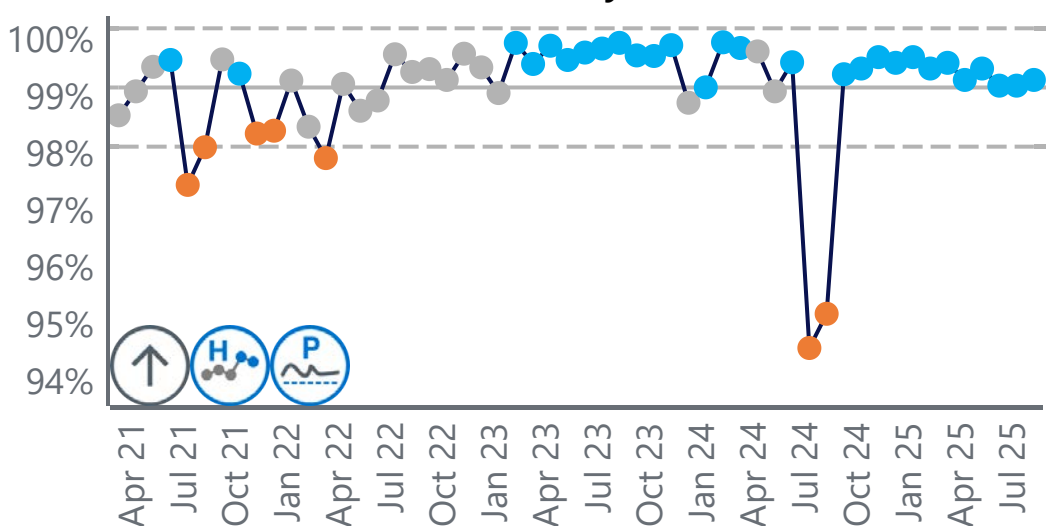
Primary PCI - 150 minute 'Call-to-balloon' (national target)



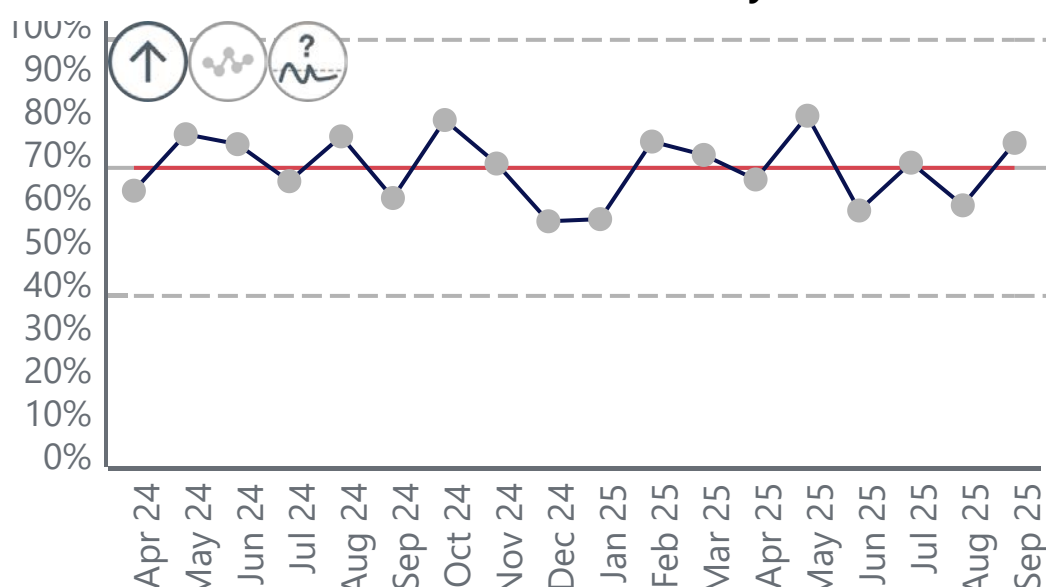
Dementia - Find



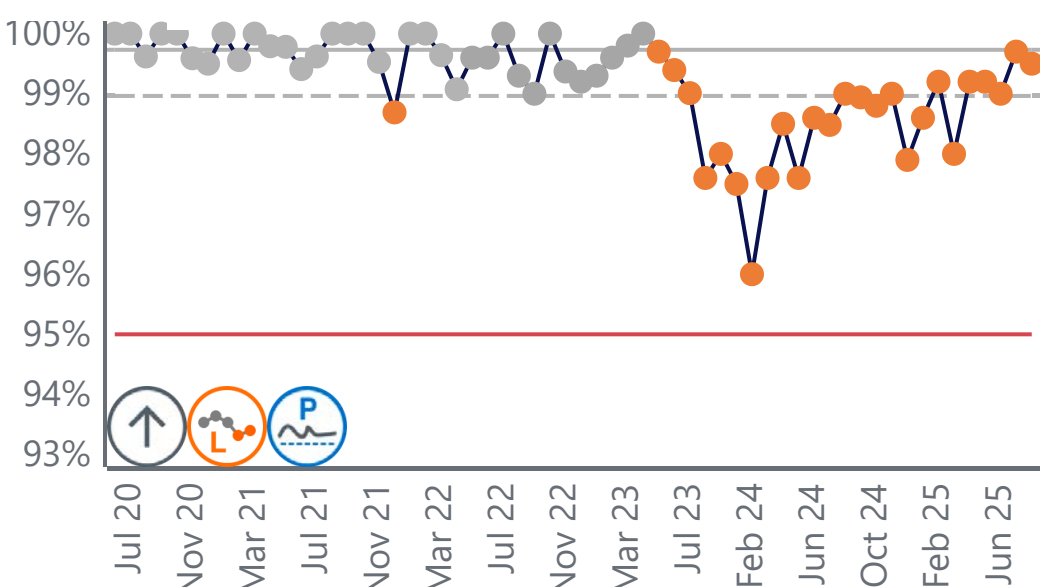
Delirium Risk Assessment to be completed on Admission and once a day



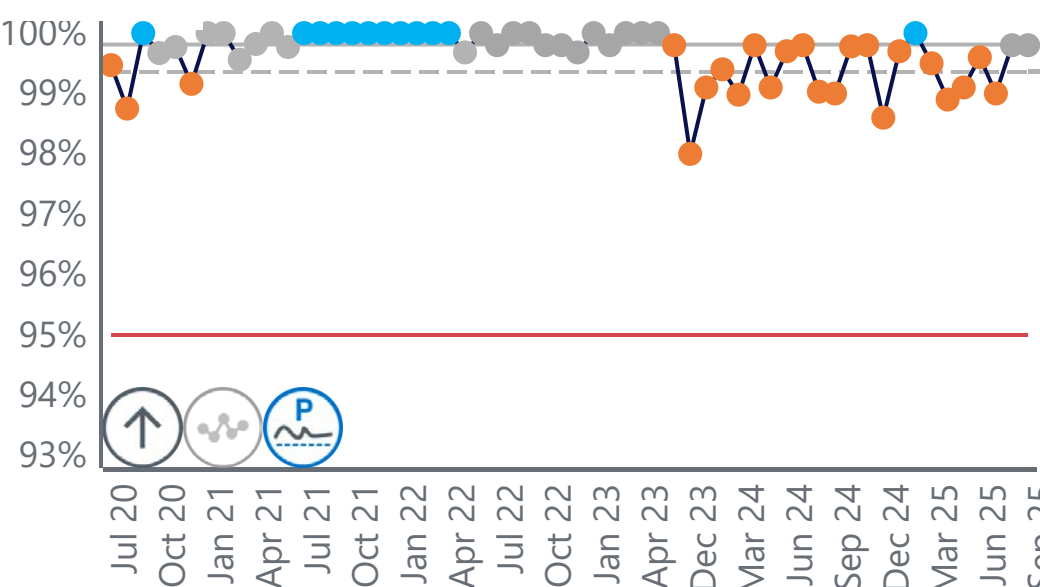
Incident Closures within 28 days



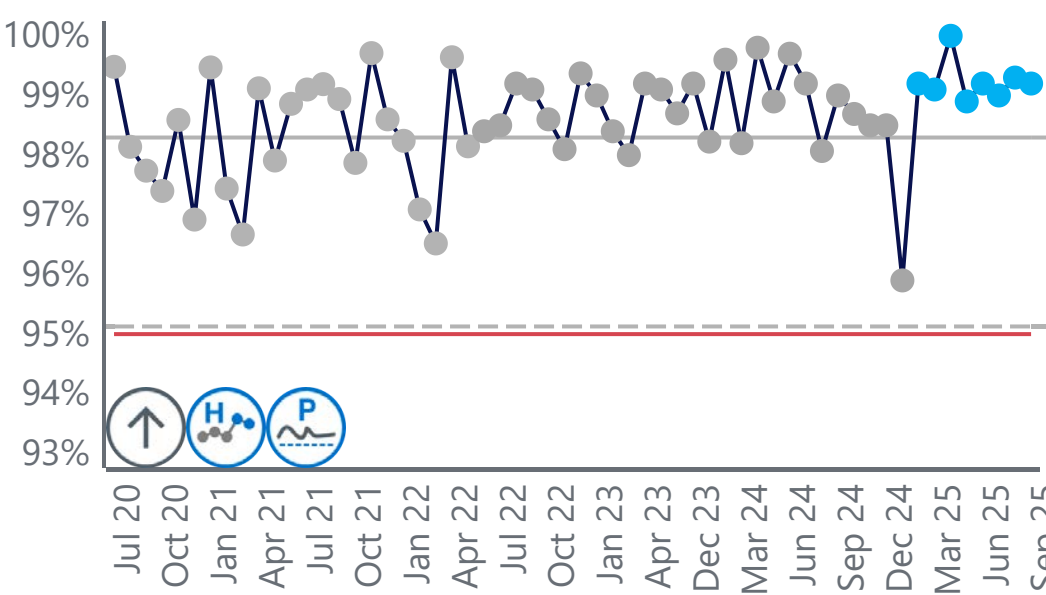
FFT: REPUTATION



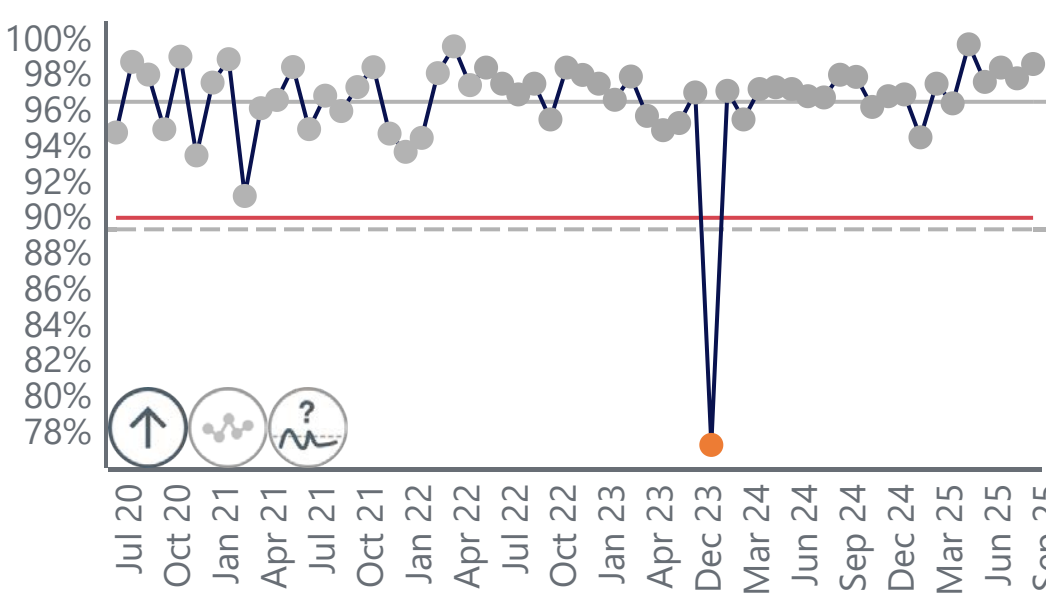
FFT: TREATMENT



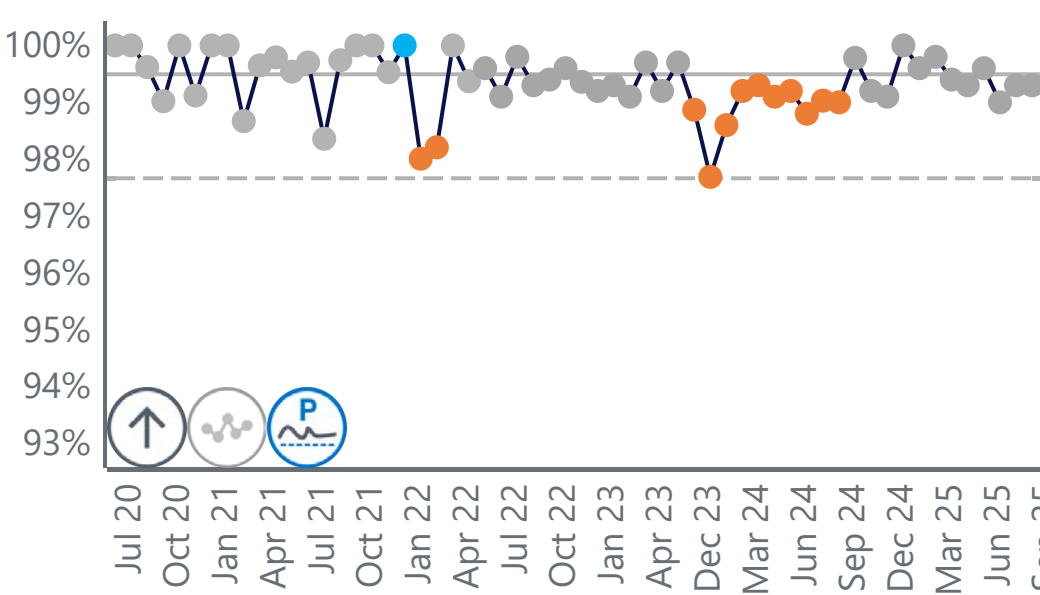
FFT: ARRIVAL



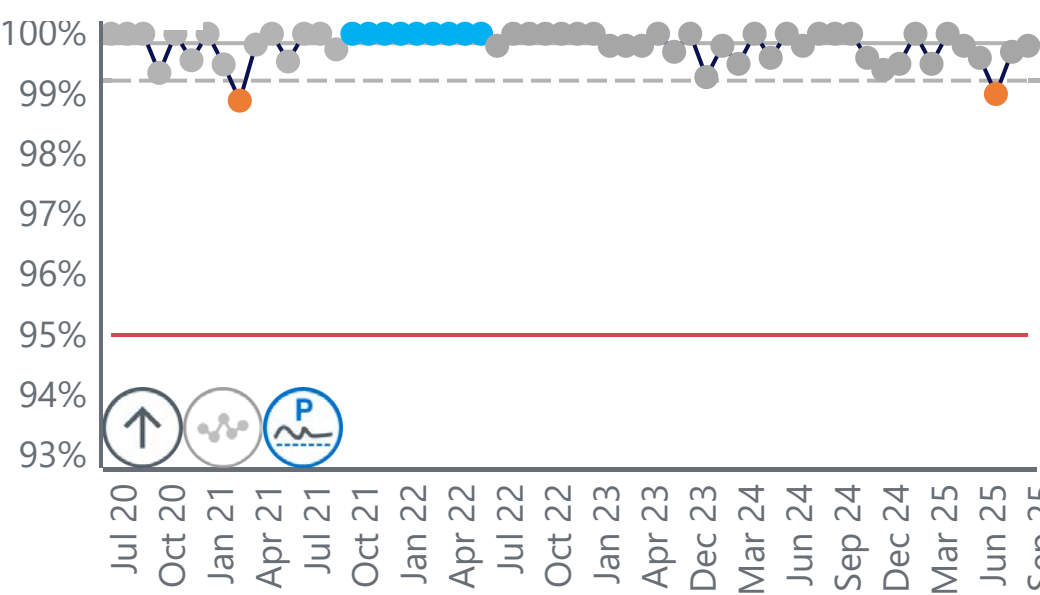
FFT: AFTER STAY



FFT: PATIENT CONTRACT

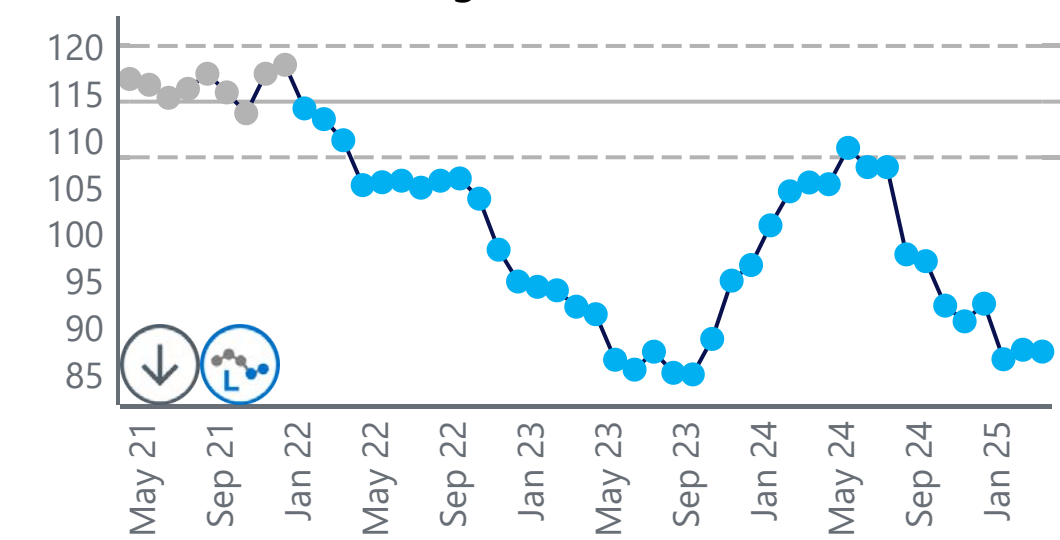


FFT: STAY

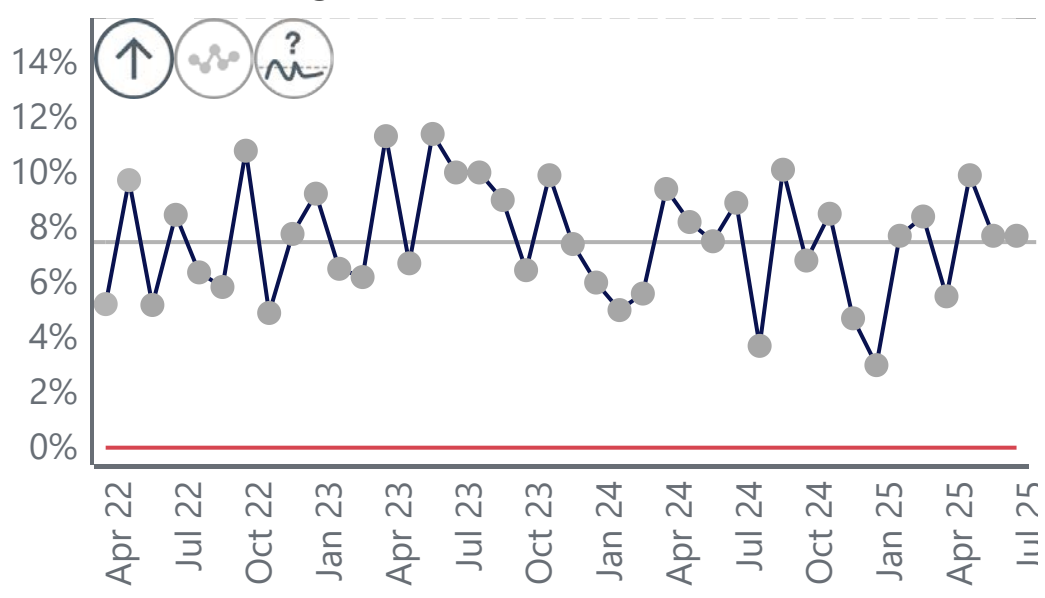


Quality of Care - Watch Metrics

Hospital Standardised Mortality Ratio (HSMR) - all diagnoses



Surgical Site Infections



Finance

SRO: James Bradley, Chief Finance Officer

Highlights:

The month 6 year to date financial performance is a £4,204k surplus which is consistent with the plan.

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

Despite the positive CIP performance in recent months, 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 half 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 half 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 four 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.

Forward Look (with actions):

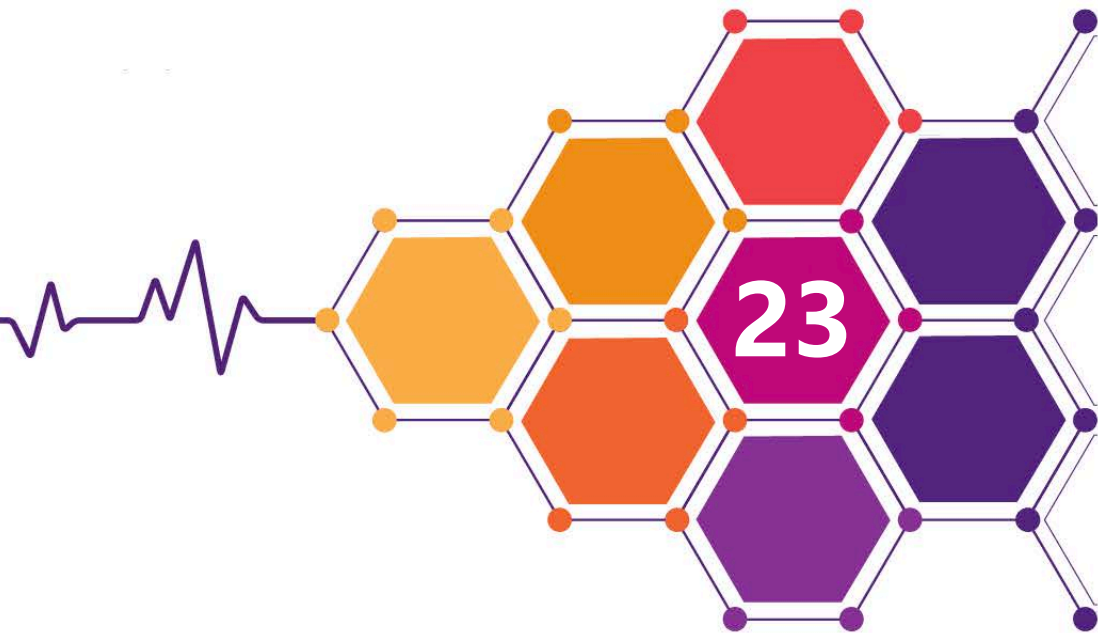
The Trust has a challenging financial target, with a planned surplus of £9.6m.

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.

The Trust has been tasked with going further than its planned surplus, and is working with PWC to review opportunities to expedite Broadgreen efficiency opportunities and review non-recurrent balance sheet flexibilities.

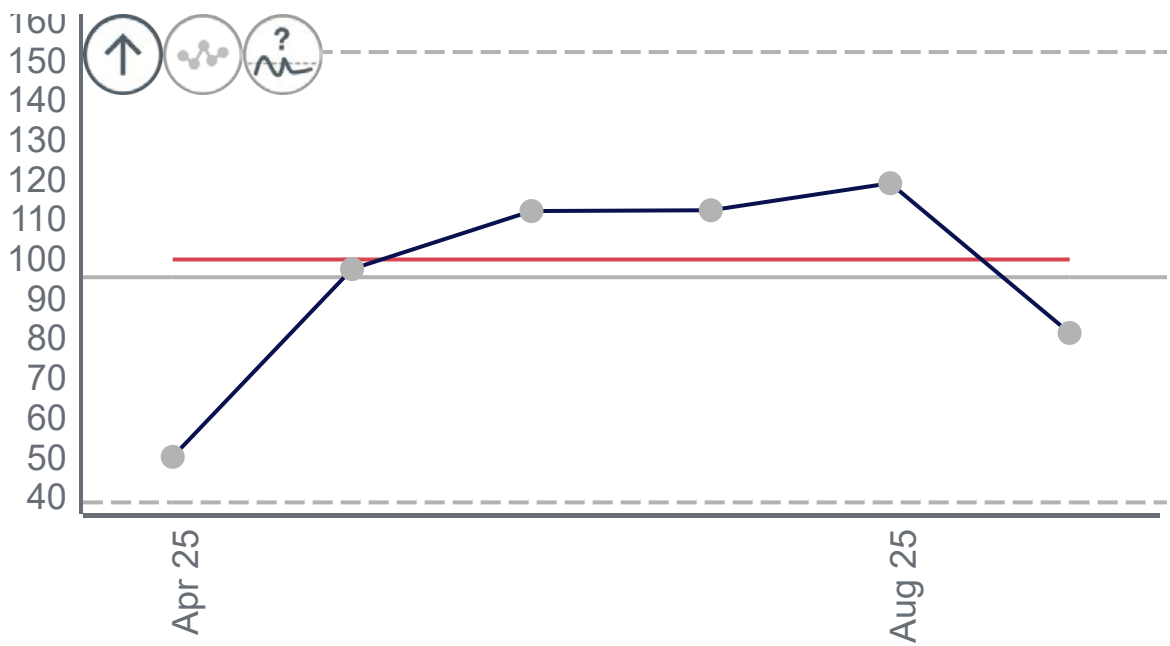
Finance - Metric Summary

Metric Name	Month	Performance	Target	Average / Cumulative	Variation	Assurance
I & E distance from target (cumulative) - £,000	Sep-25	-1	0	-1		
Liquidity (days)	Sep-25	44		41		
Delivered CIP	Sep-25	82	100	96		
Capital Expenditure (Trust Level)	Sep-25	2320000.0	4488000	2320000.0		
Cash in Bank (Trust Level)	Sep-25	43362000		47688833		
Pay Spend v Budget	Sep-25	10509	10460	10403		
WTE vs Workforce Plan	Sep-25	1977	1898	1972		



Finance - Drive Metrics

Delivered CIP



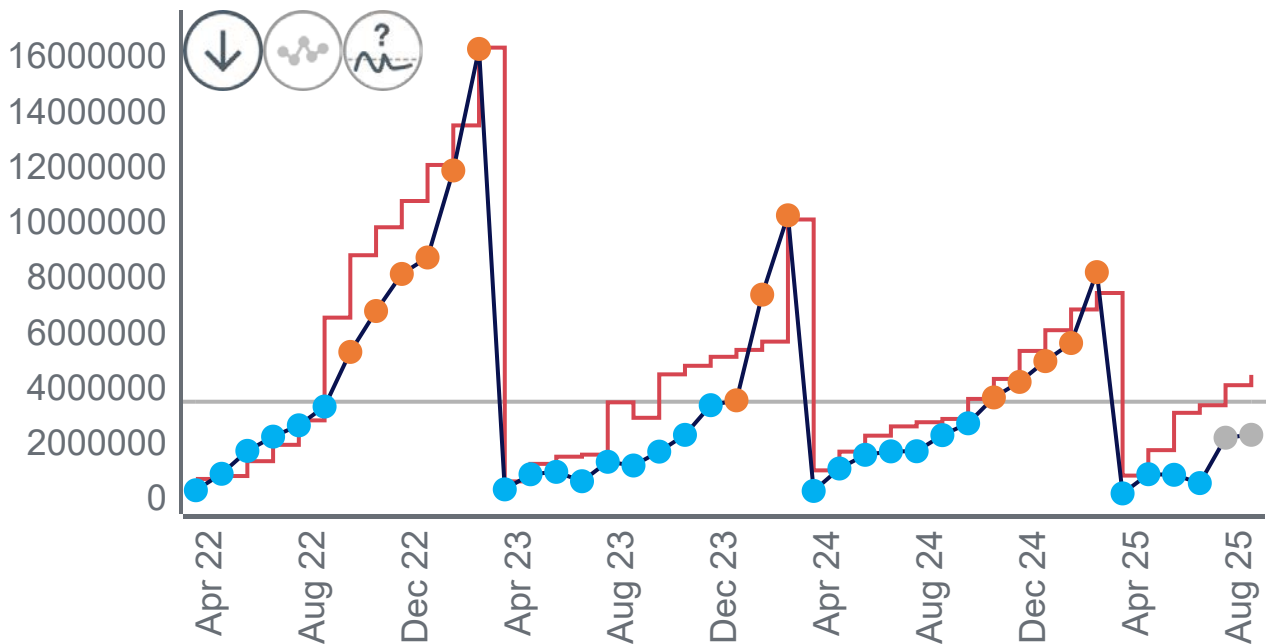
Technical Analysis:

CIP is displaying common cause variation. Continued work required to provide more consistency in achieving CIP.

Actions:

Monthly monitoring of progress through gateways. Trust wide CIP workshop held in February. Revised transformation projects and governance arrangements to support delivery. Regular confirm and challenge sessions. Review of Broadgreen efficiency opportunities.

Capital Expenditure (Trust Level)



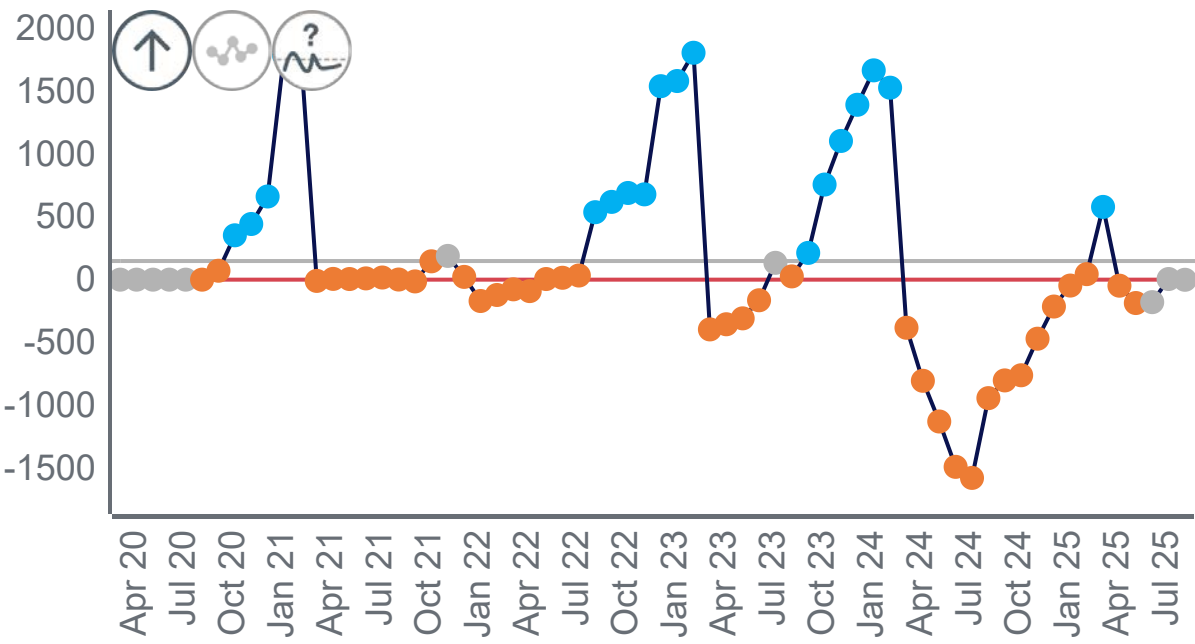
Technical Analysis:

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. Although capital spend has been lower than planned, the forecast remains to spend all of the capital allocation by the year end.

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



Technical Analysis:

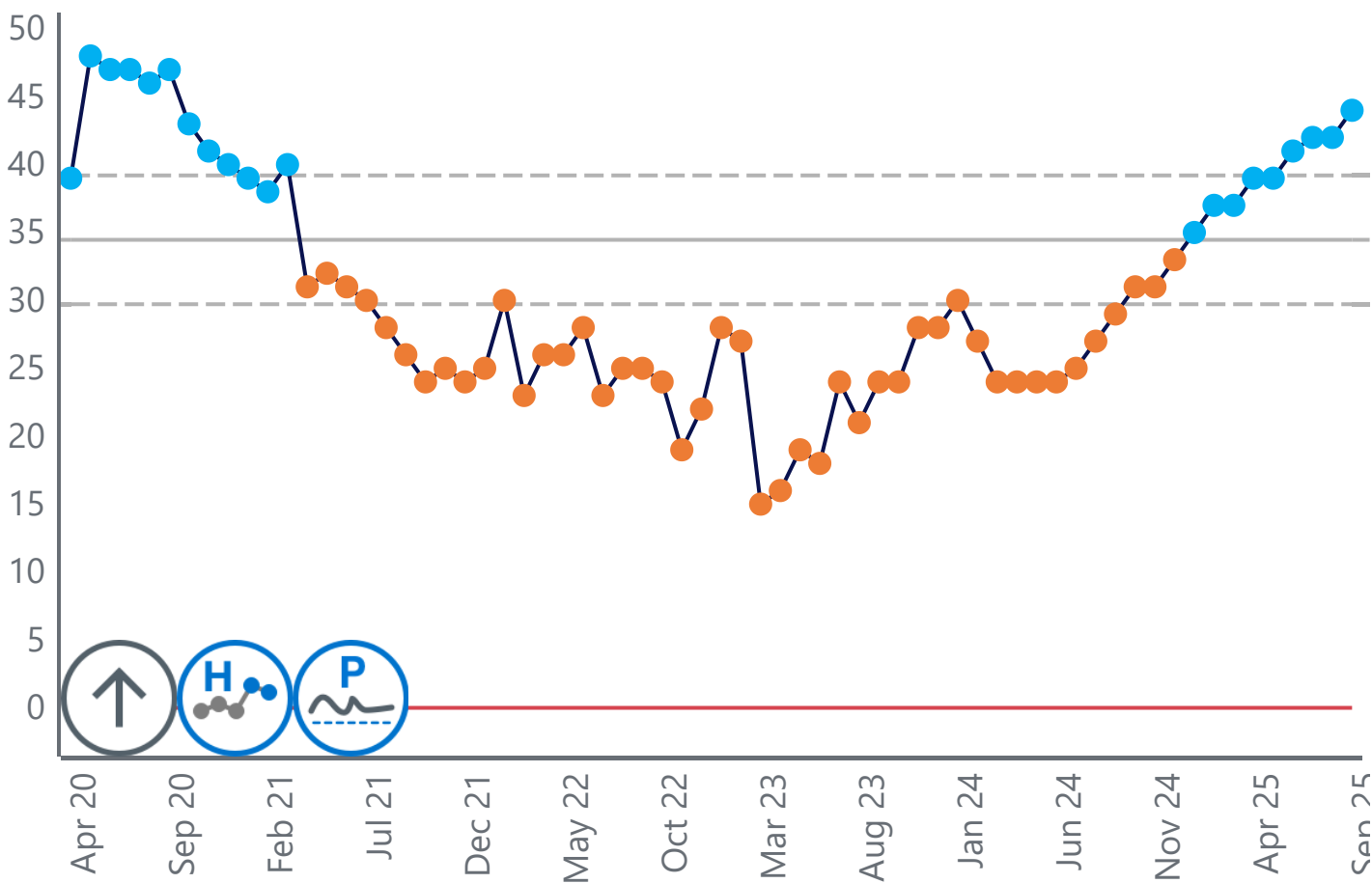
Performance is displaying common cause variation having met the target on three occasions in the last 9 months. Further work required to consistently achieve the target.

Actions:

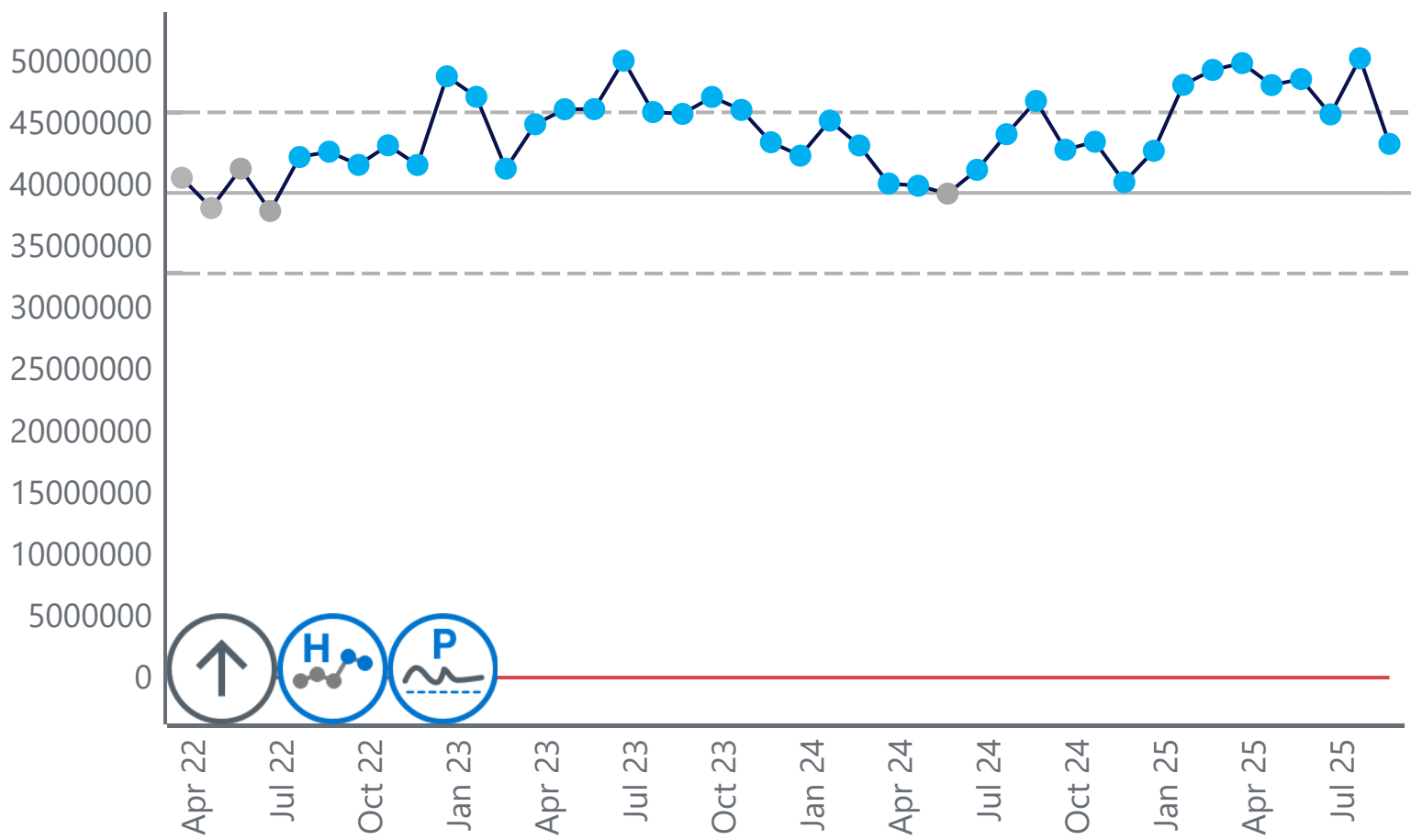
The Trust needs to expedite CIP delivery to ensure it remains on track to deliver the planned surplus. Management of other risks, most notably delivering, and being paid for, elective activity.

Finance - Watch Metrics

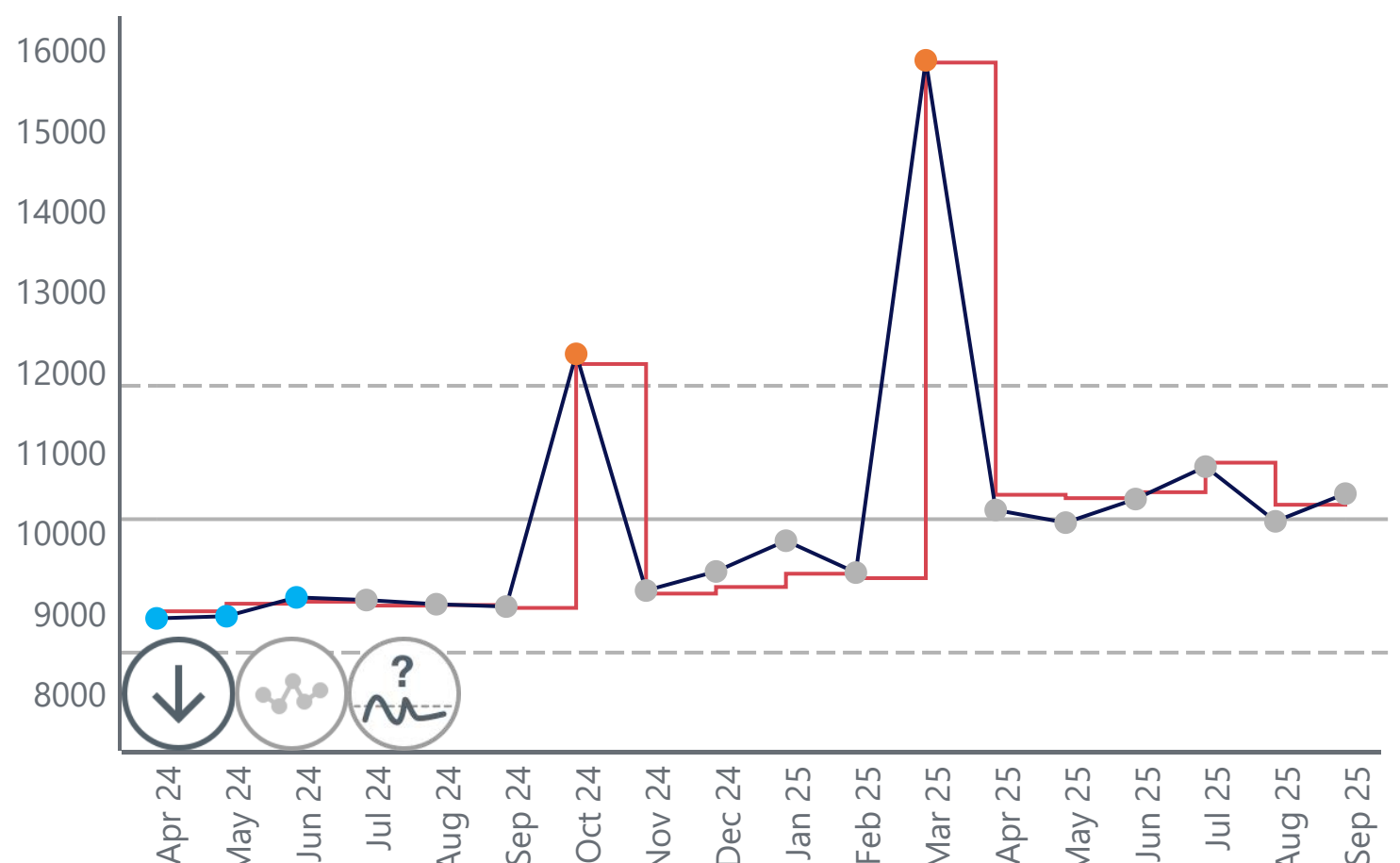
Liquidity (days)



Cash in Bank (Trust Level)



Pay Spend v Budget



People

SRO: Rachael McDonald, Chief People Officer

Highlights:

Workforce performance in Month 6 was positive, with improvements observed across key performance indicators. Voluntary turnover remains stable and sustained at a low level, supported by the continued impact of system-wide controls on staff movement, which are contributing to this ongoing reduction.

Sickness absence showed a positive variance in-month, reporting below target levels, indicating effective management.

At the close of the appraisal window, the Trust achieved an overall completion rate of 87.3%, demonstrating strong colleague engagement. Further work is underway to build on this progress and achieve the 90% target..

Areas of Concern:

Whilst sickness reported below target levels, it remain an area of focus, especially as we move into winter months.

Sickness absence cases are becoming increasingly complex and multifaceted, often involving a range of underlying factors. There is strong assurance that cases are being managed appropriately. Staff and managers are being well supported throughout the process, ensuring a consistent and compassionate approach to case management in line with the new Trust Managing Attendance Policy.

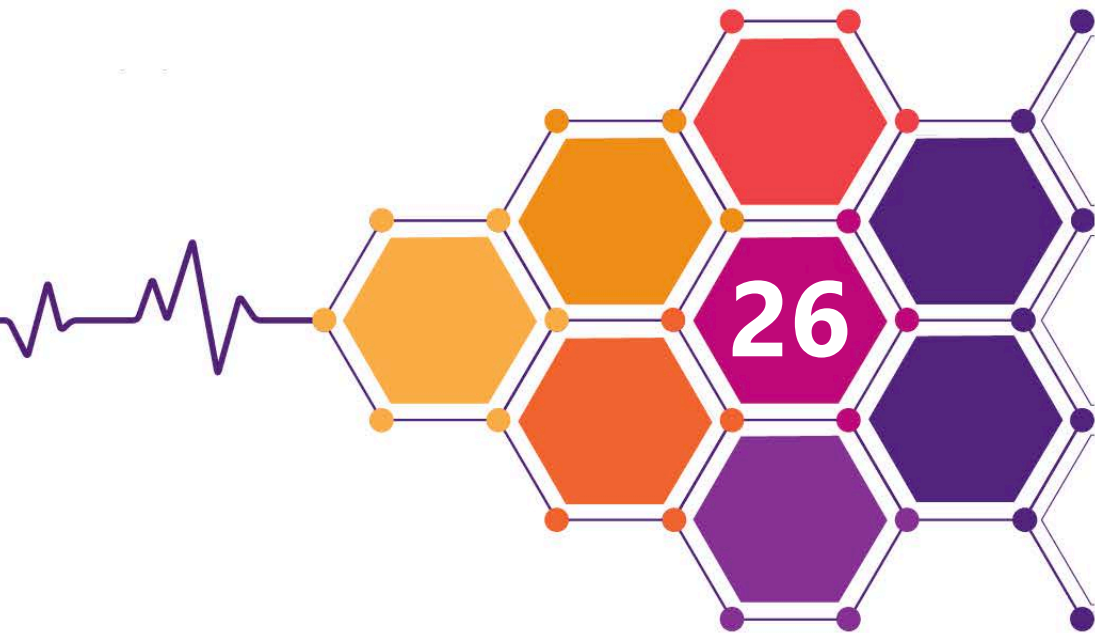
MSK absences remain largely non-work-related, though work-related MSK remains higher in clinical areas such as theatres and wards. Staff now have access to self-referral physiotherapy via the new Occupational Health provider, promoting early intervention.

Agency use continues in Theatres, Perfusion, and Clinical Coding and workforce plans are in place to address ongoing reliance. To strengthen controls, the roster team has expanded roster approval meetings, enhancing oversight and consistency in roster management

Forward Look (with actions):

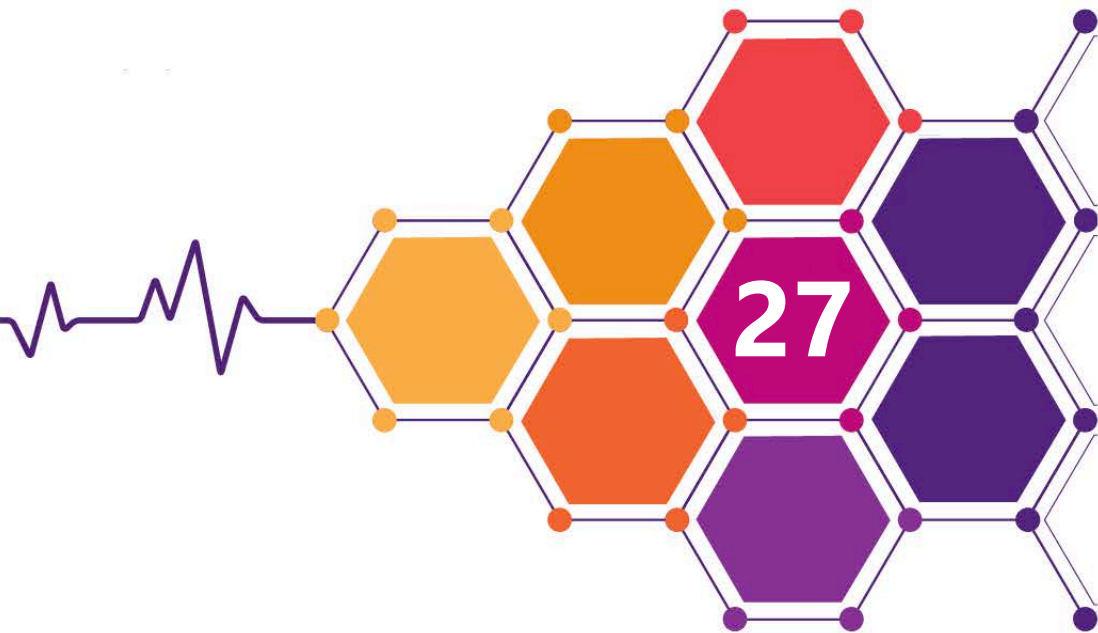
The NHS Staff Survey was launched on 28 September and will remain open until the end of November. Completion rates will be monitored and published throughout the survey period, supported by an active engagement plan designed to encourage participation and emphasise the importance of the staff voice as the organisation works through a period of change.

In addition, plans are being finalised to relaunch the ‘Be Civil, Be Kind’ campaign in October, reinforcing our ongoing commitment to fostering a respectful, inclusive, and supportive workplace culture.



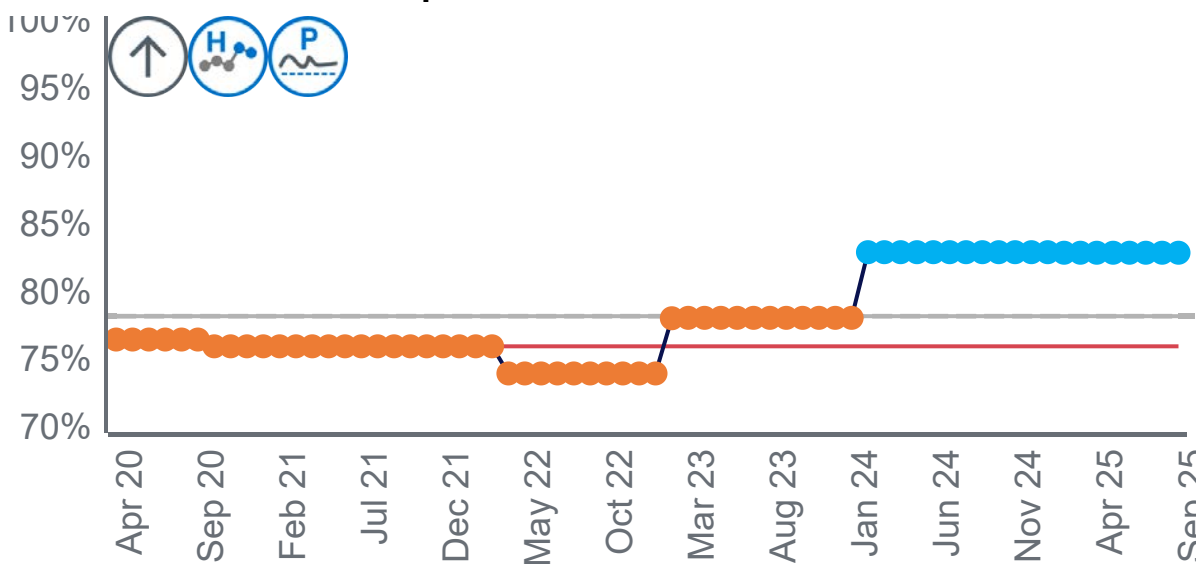
People - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
Appraisals Compliance	Sep-25	70.9	>=90%	65.5		
Mandatory Training Compliance	Sep-25	95.7	>=95%	95.0		
NHS Staff Survey - Staff recommendation of the organisation as a place to work	Sep-25	82.9	>=76%	82.9		
Staff Turnover	Sep-25	6.8	<=10%	7.2		
Staff Sickness (All Staff)	Sep-25	4.38	<=4.5%	4.7		
Long Term Sickness	Sep-25	2.62	<=4.5%	2.9		
Short Term Sickness	Sep-25	1.76	<=4.5%	1.8		
EDI: Bullying and Harassment of Staff by Patient and Relatives	Sep-25	11.5		12.1		
EDI: My Organisation Treats me fairly	Sep-25	68.8		68.8		



People - Drive Metrics

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



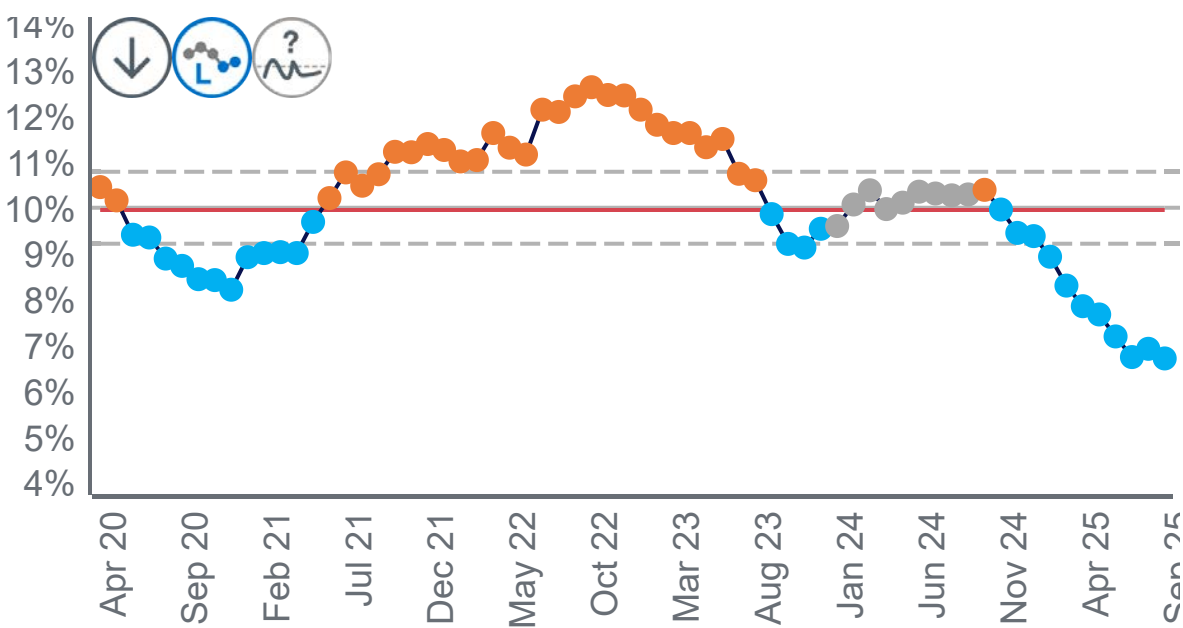
Technical Analysis:

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



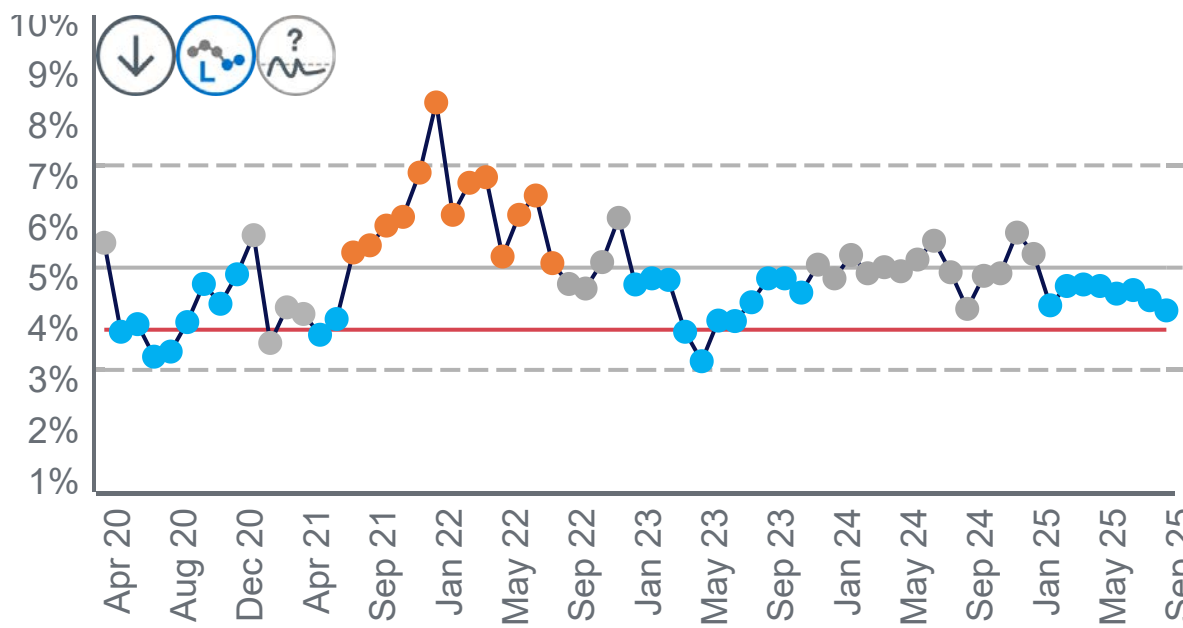
Technical Analysis:

Staff Turnover is displaying special cause improvement with a continual reduction since Nov-24. The Trust has consistently achieved the target since the end of 2024.

Actions:

Continued monitoring.

Staff Sickness (All Staff)



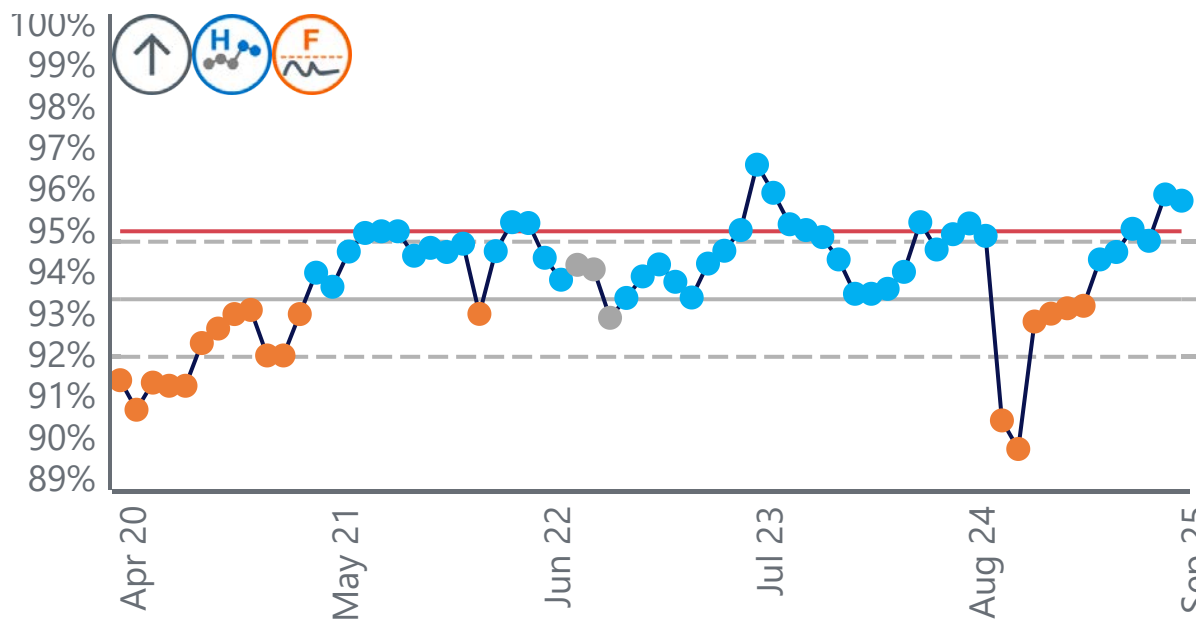
Technical Analysis:

Total absence in September was 4.4%, this is marginally below the target of 4.5%. The metric has moved to special cause improvement following steady progress over recent months. Continued work required to consistently achieve the target.

Actions:

In Sep-25, long-term sickness accounted for 2.62%, and short-term sickness for 1.76% both LT and ST have decreased in Sep. This improvement reflects the focused efforts on managing LT absences, which have led to progress in several complex cases, including Stage 4 dismissals and voluntary resignations

Mandatory Training Compliance



Technical Analysis:

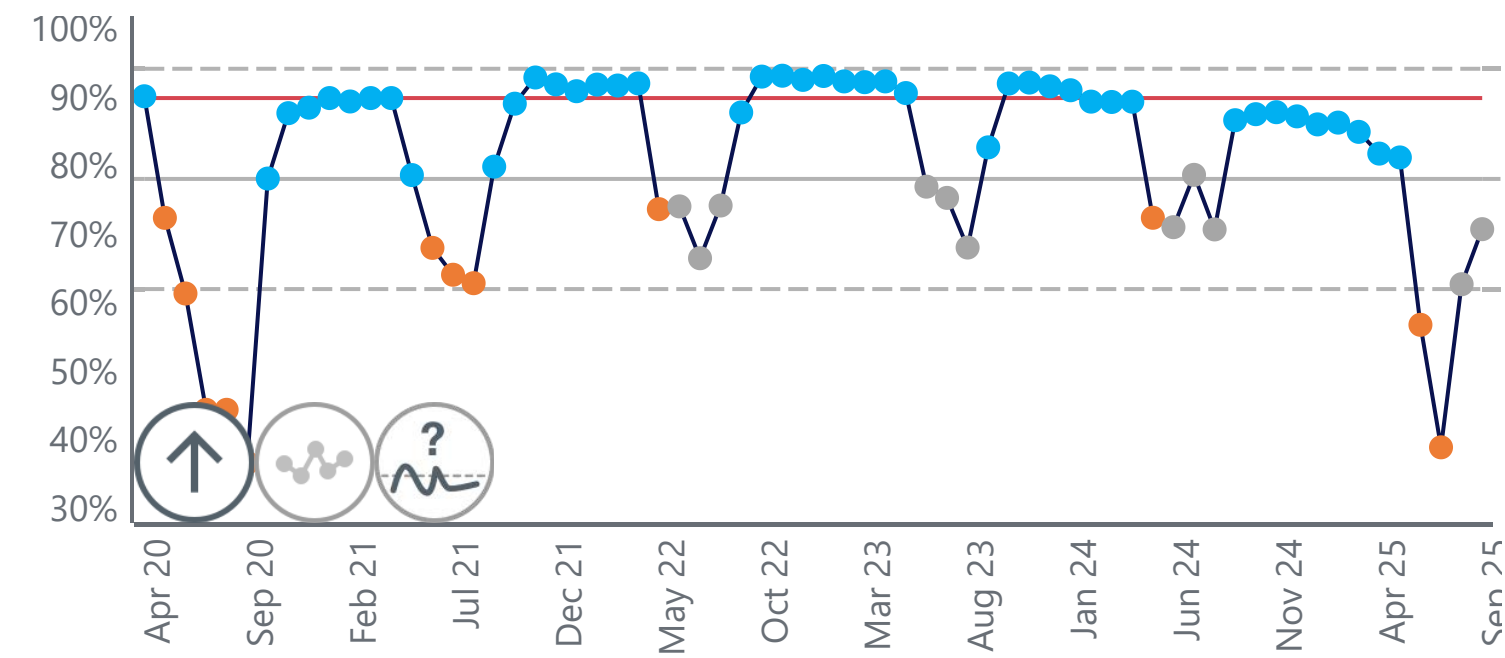
Performance has shown special cause improvement from the beginning of 2025. Continued work to consistently achieve the target.

Actions:

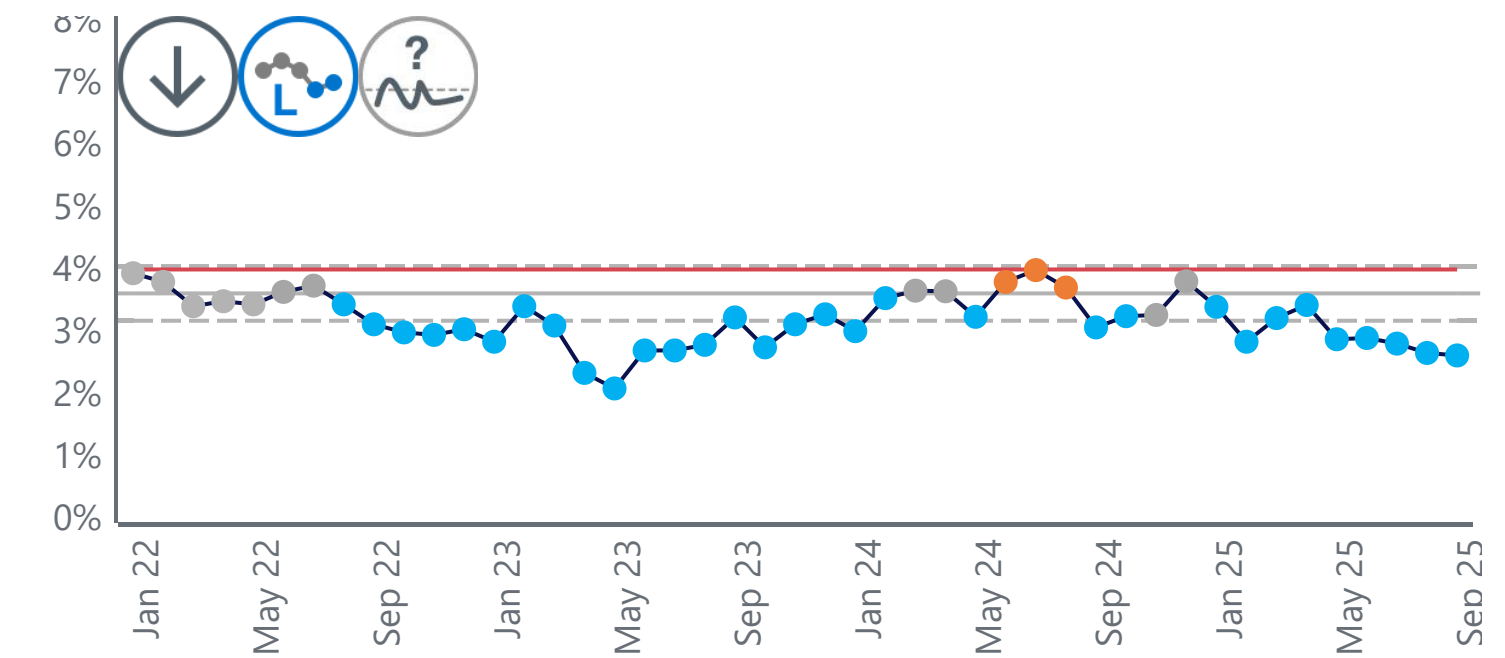
Improved MT position - continued focus required.

People - Watch Metrics

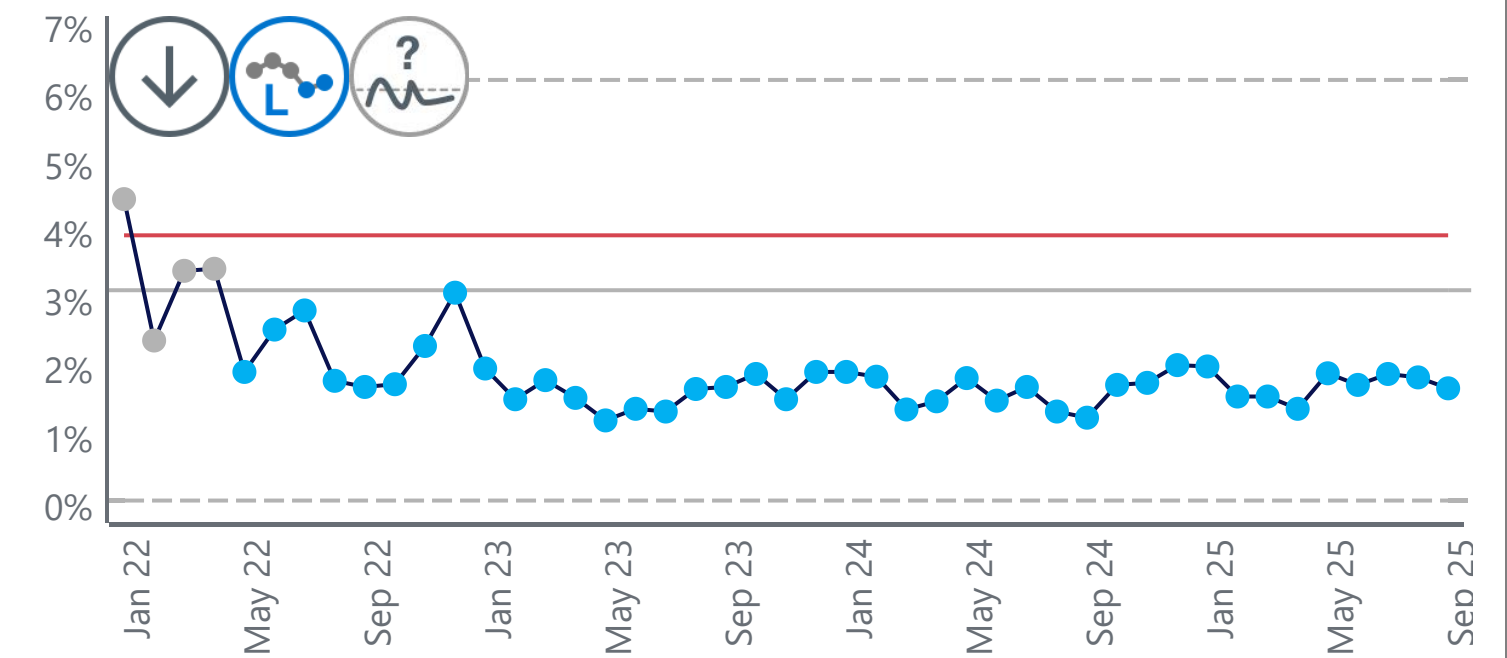
Appraisals Compliance



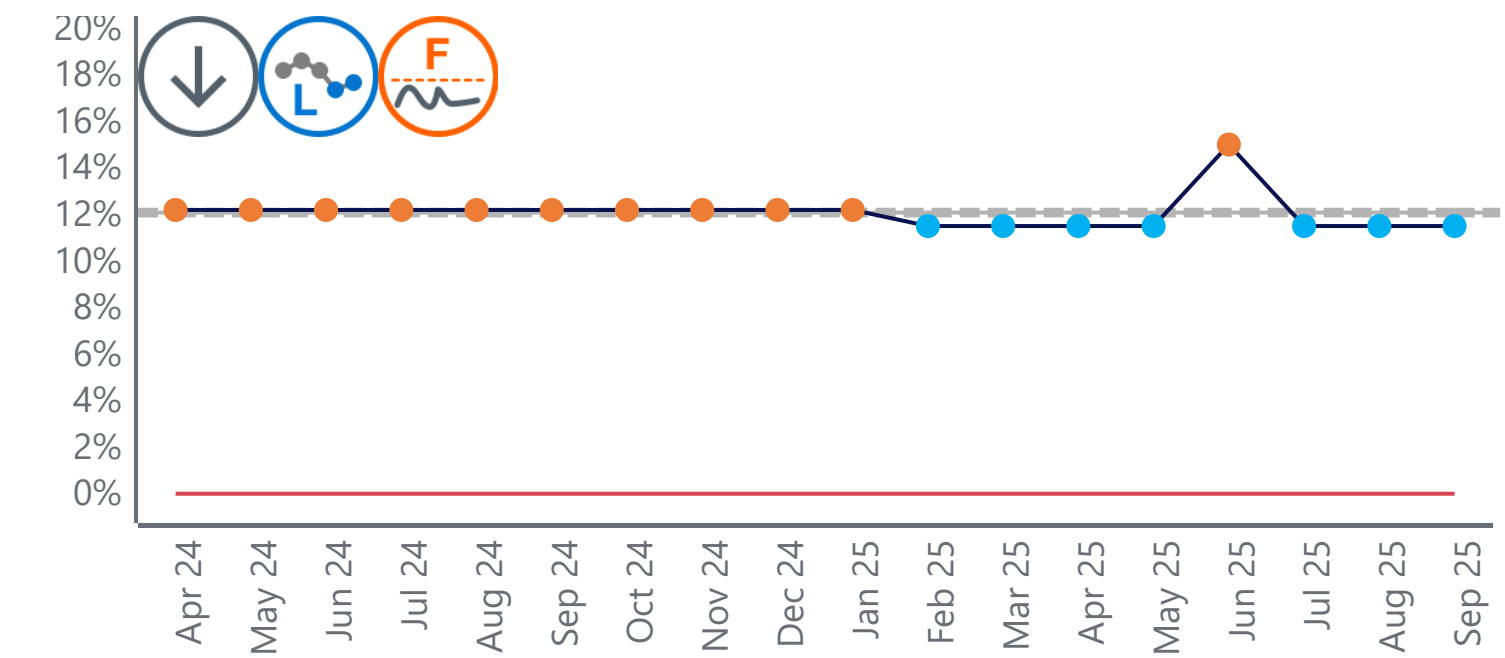
Long Term Sickness



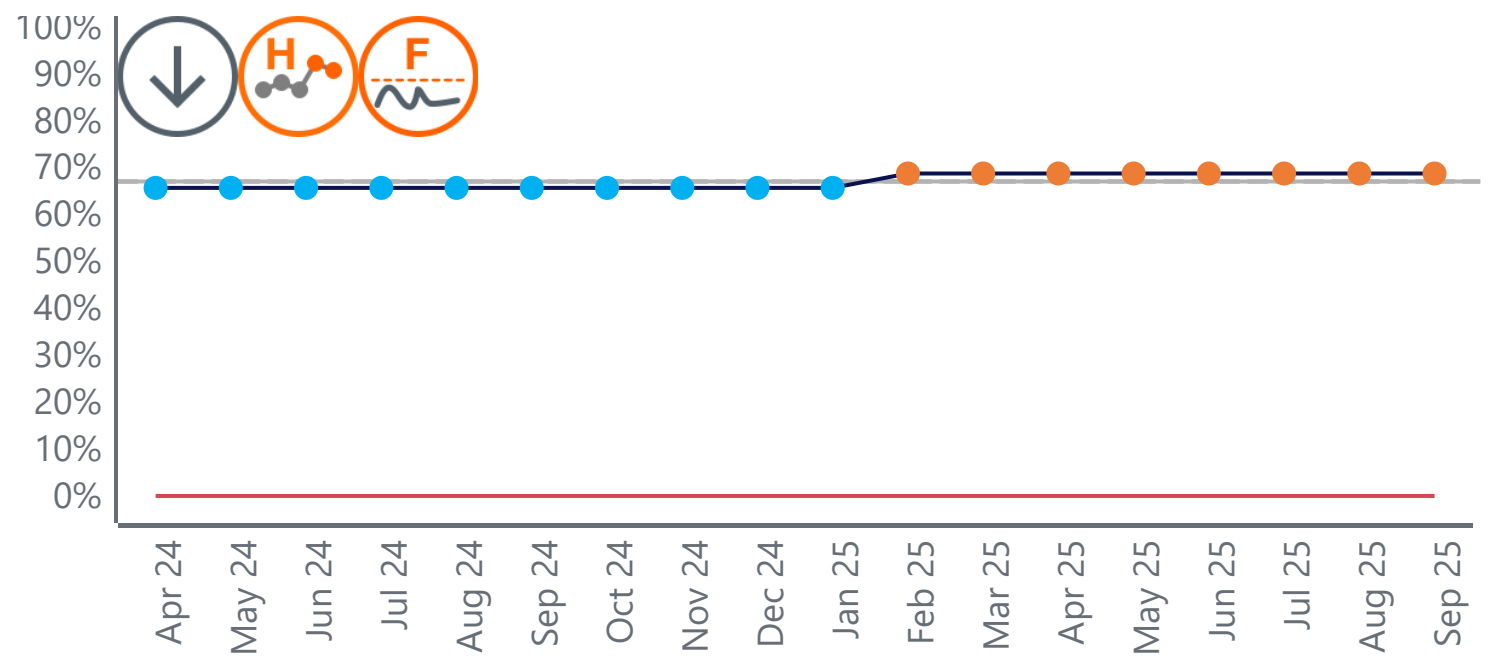
Short Term Sickness



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 September 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 57 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 107 days.

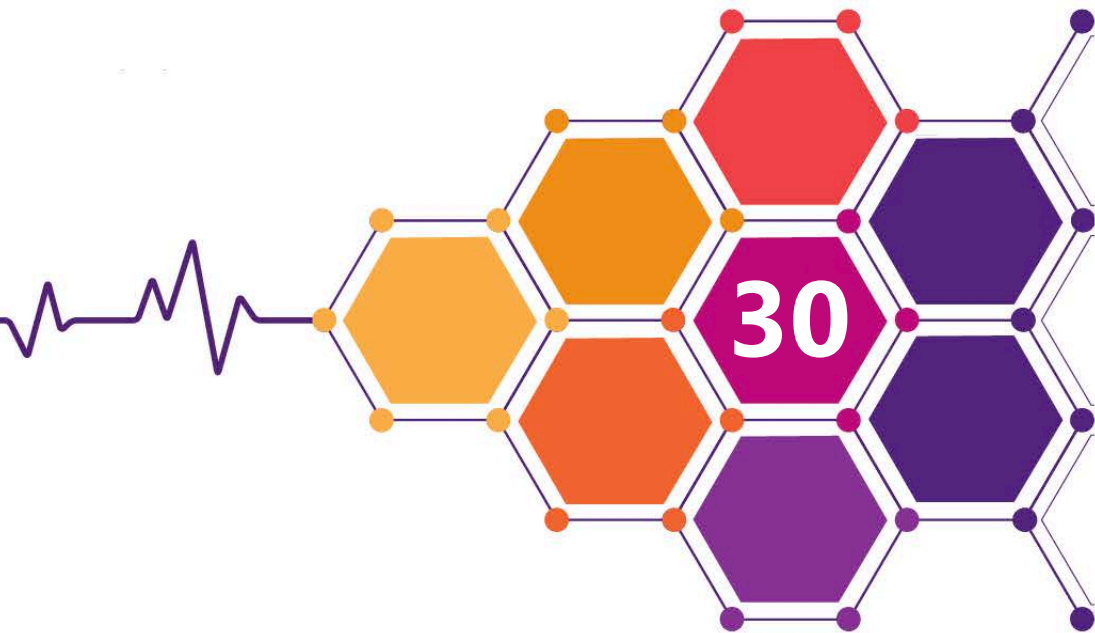
Areas of Concern:

Key areas of concern in September 2025 include overall recruitment to studies, which remains below target at 41 against 70, despite recruitment to time and target being achieved. The average set-up time is currently 107 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 (3 against 5) remain below target. Support and strategies are being implemented to improve these metrics.

Forward Look (with actions):

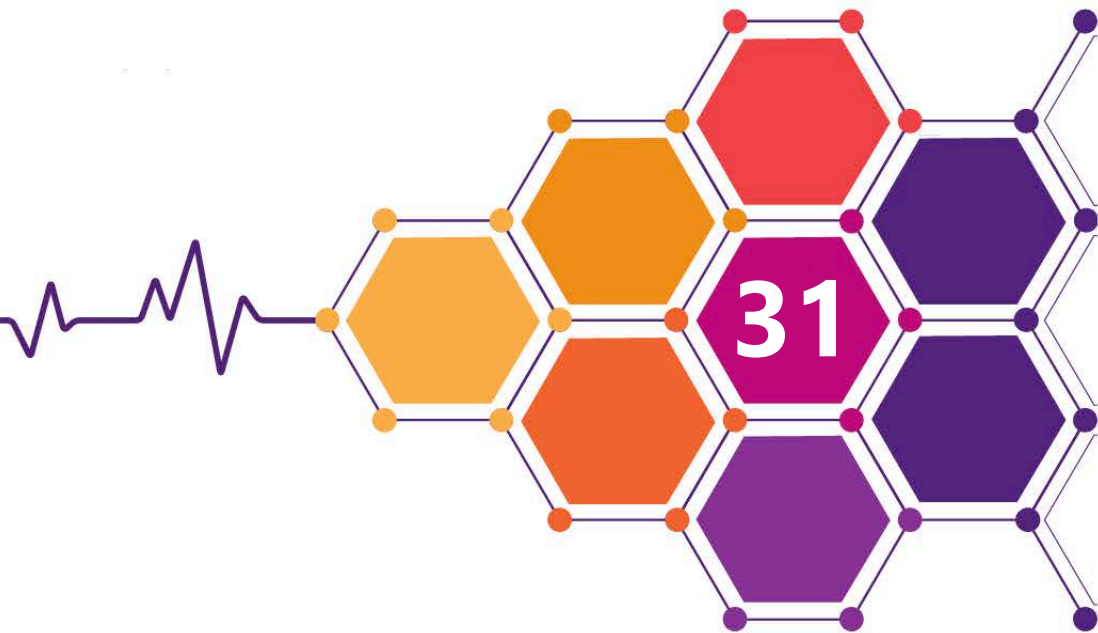
*Improve research set up times - named nurse to be identified for studies in the approvals stage. Head of governance working with team to identify any efficiencies for the process. * Improve time to target for open and recruiting studies - Weekly review of RAG status for all studies - highlighting concerns 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.

Please note target metrics will change in line with new RRDN target requirements - new targets will be implemented April 2026.



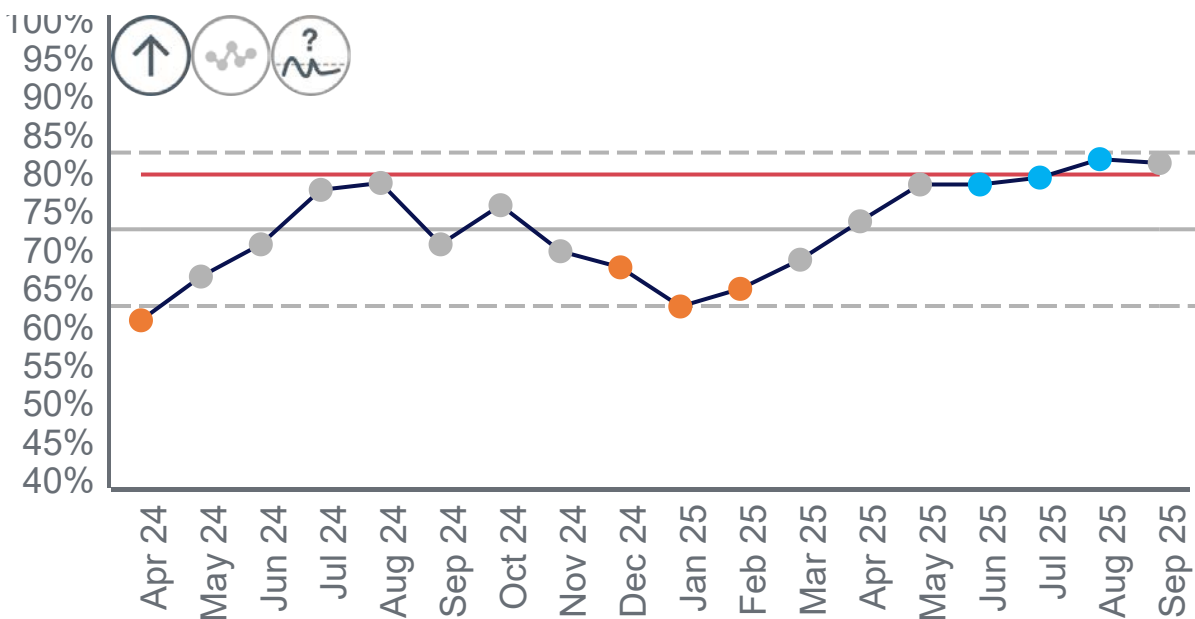
Research - Metric Summary

Metric Name	Month	Performance	Target	Average	Variation	Assurance
Recruitment to all studies	Sep-25	41.0	70	74.0		
Number of studies open	Sep-25	57.0	40	56.3		
Recruitment to time and target for all research	Sep-25	81.5	80%	79.1		
Average set up time for Research	Sep-25	107	100 day avg	75.7		
Number of successful NIHR Grants	Sep-25	1.0	3 per annum	0.5		
Number of active PI's	Sep-25	33	39	32.5		
Number of AHP/CNS/ Clinical Scientist PI's	Sep-25	3	5	2.3		
Recruitment to time and target for open commercial research	Sep-25	81.8		81.4		
Recruitment to time and target for open non-commercial research	Sep-25	81.4		78.4		



Research - Drive Metrics

Recruitment to time and target for all research



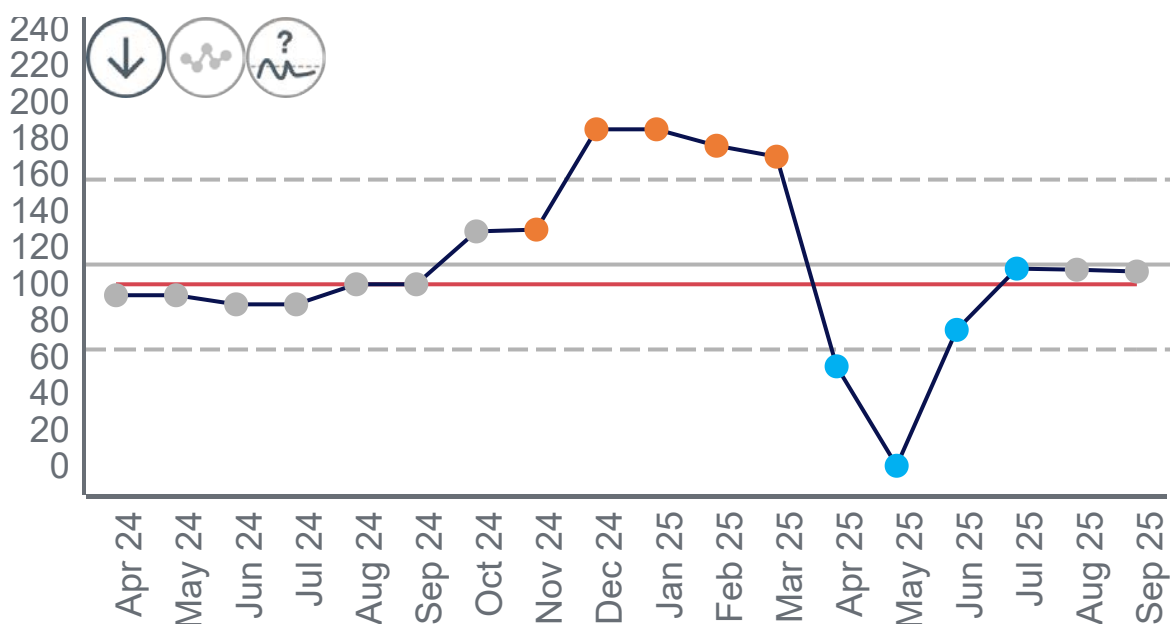
Technical Analysis:

Performance 2025/26 has shown an improvement but consistency is required as the metric moves to common cause variation. 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 set up to ensure target can be met..

Average set up time for Research



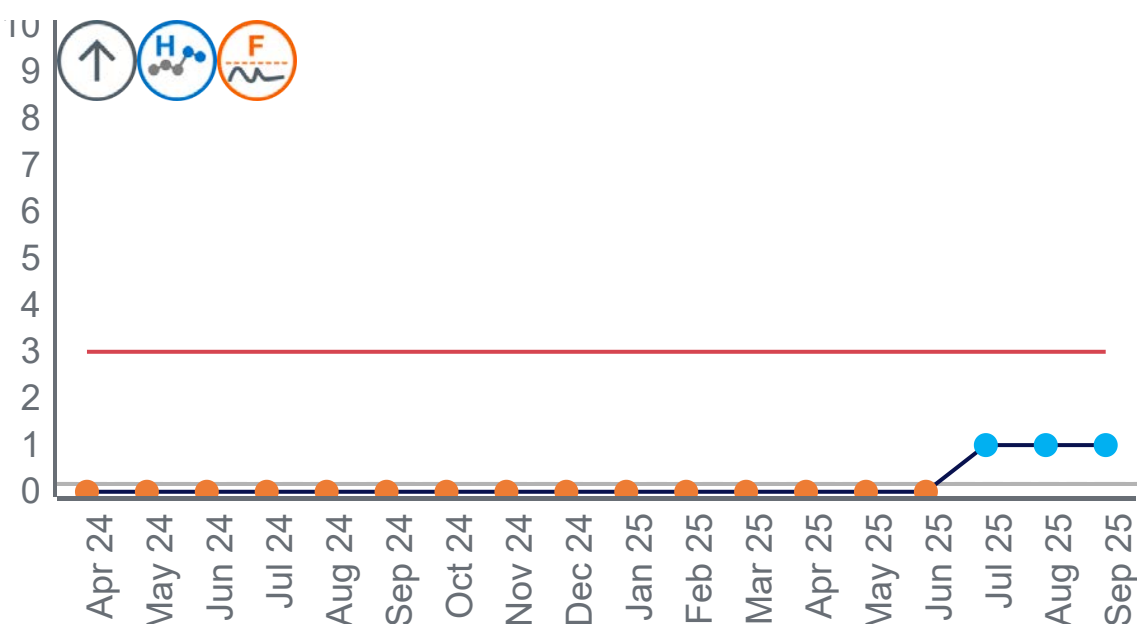
Technical Analysis:

Sep-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



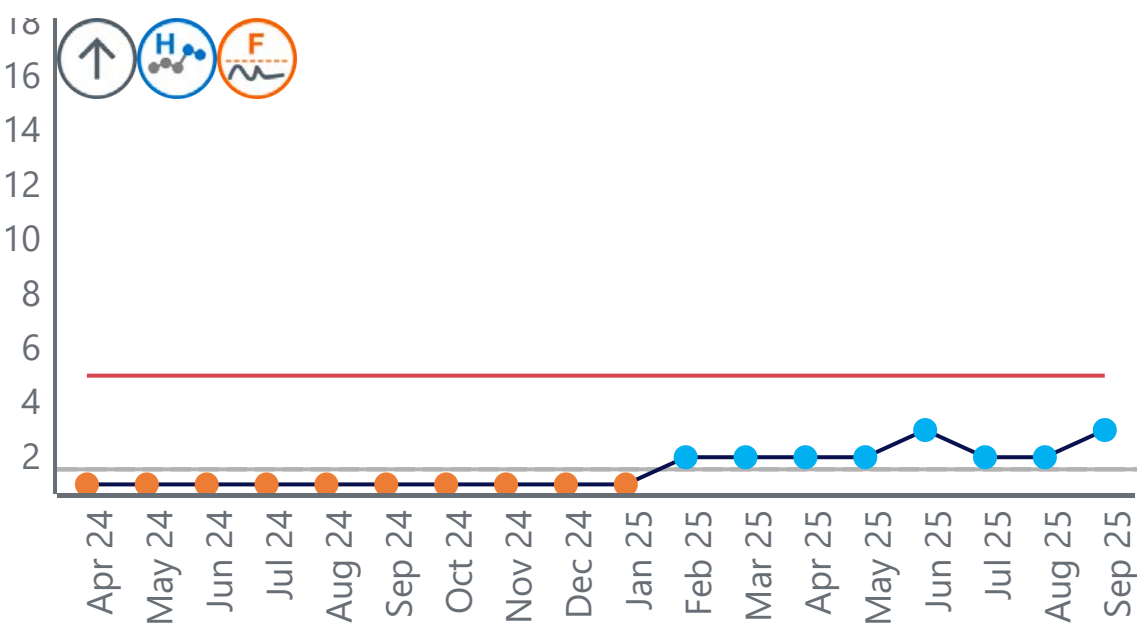
Technical Analysis:

The trust continues to fall short of 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:

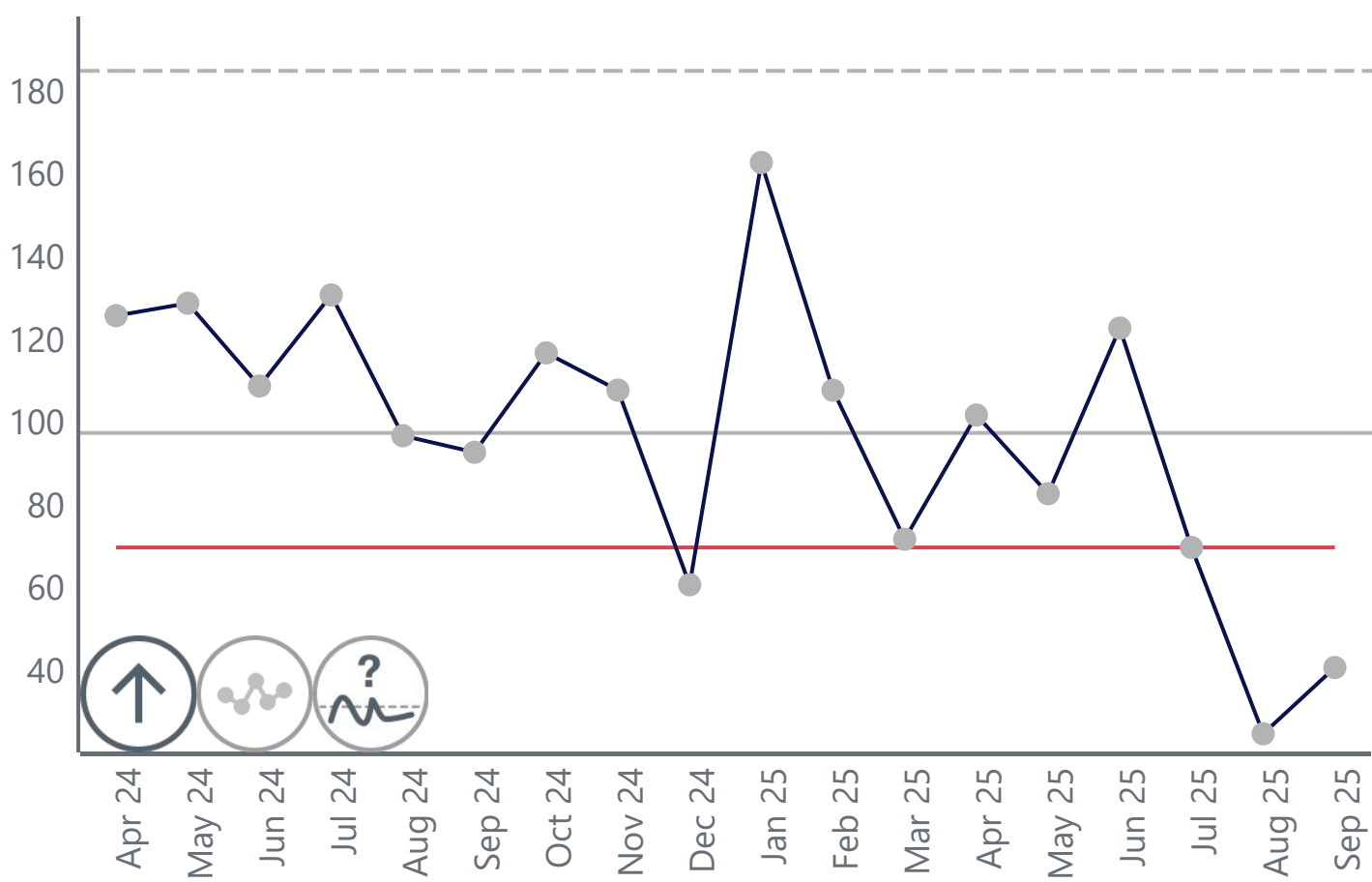
The trust continues to fail the target of 5 PI's. Improvement required to consistently achieve the target. Recent months are displaying special cause improvement.

Actions:

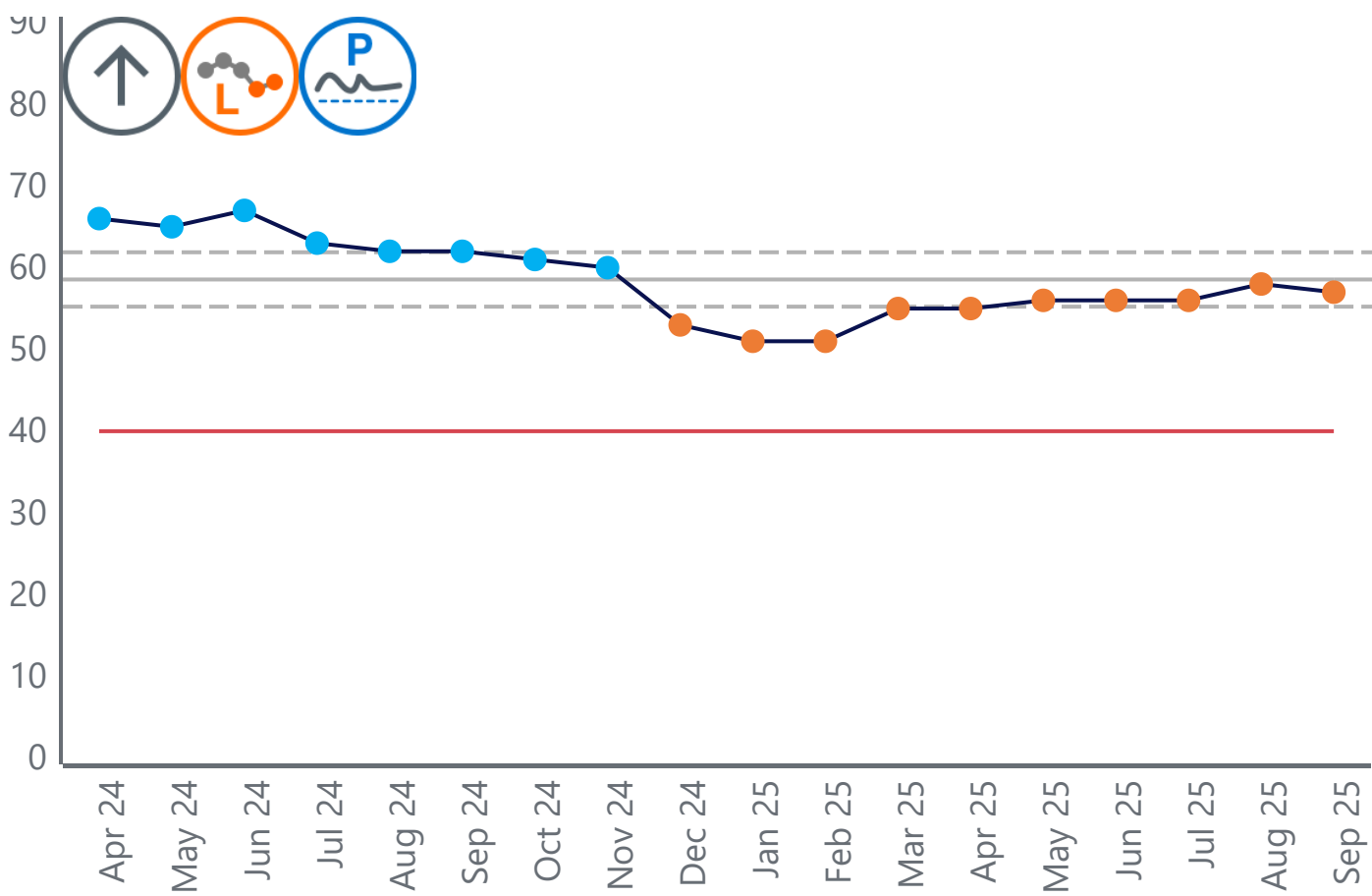
* Senior research team working on plans for research support mechanism for AHP/CNS and Clinical Scientist. *Research ambassadors within in clinical areas to be identified.

Research - Watch Metrics

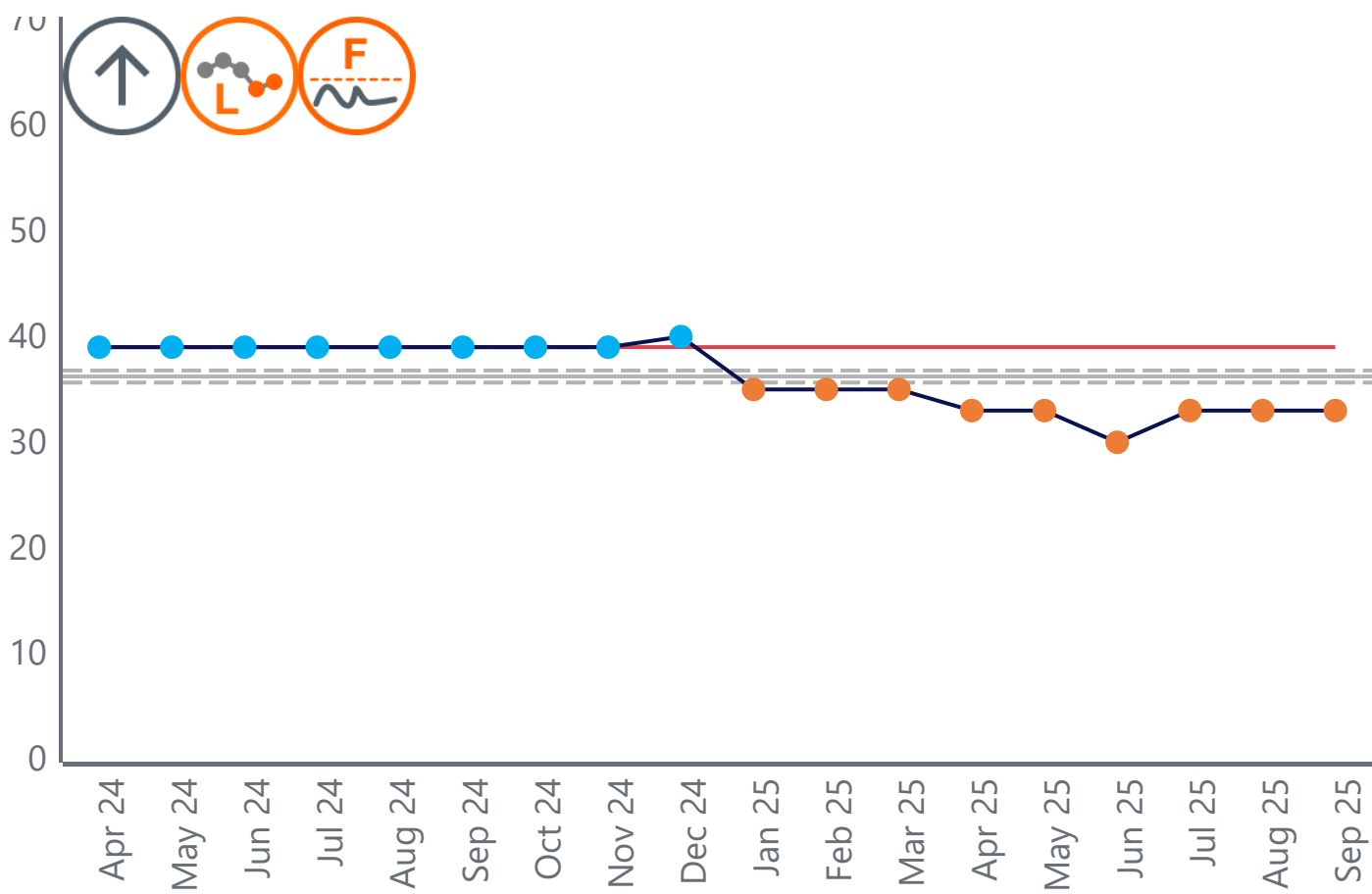
Recruitment to all studies



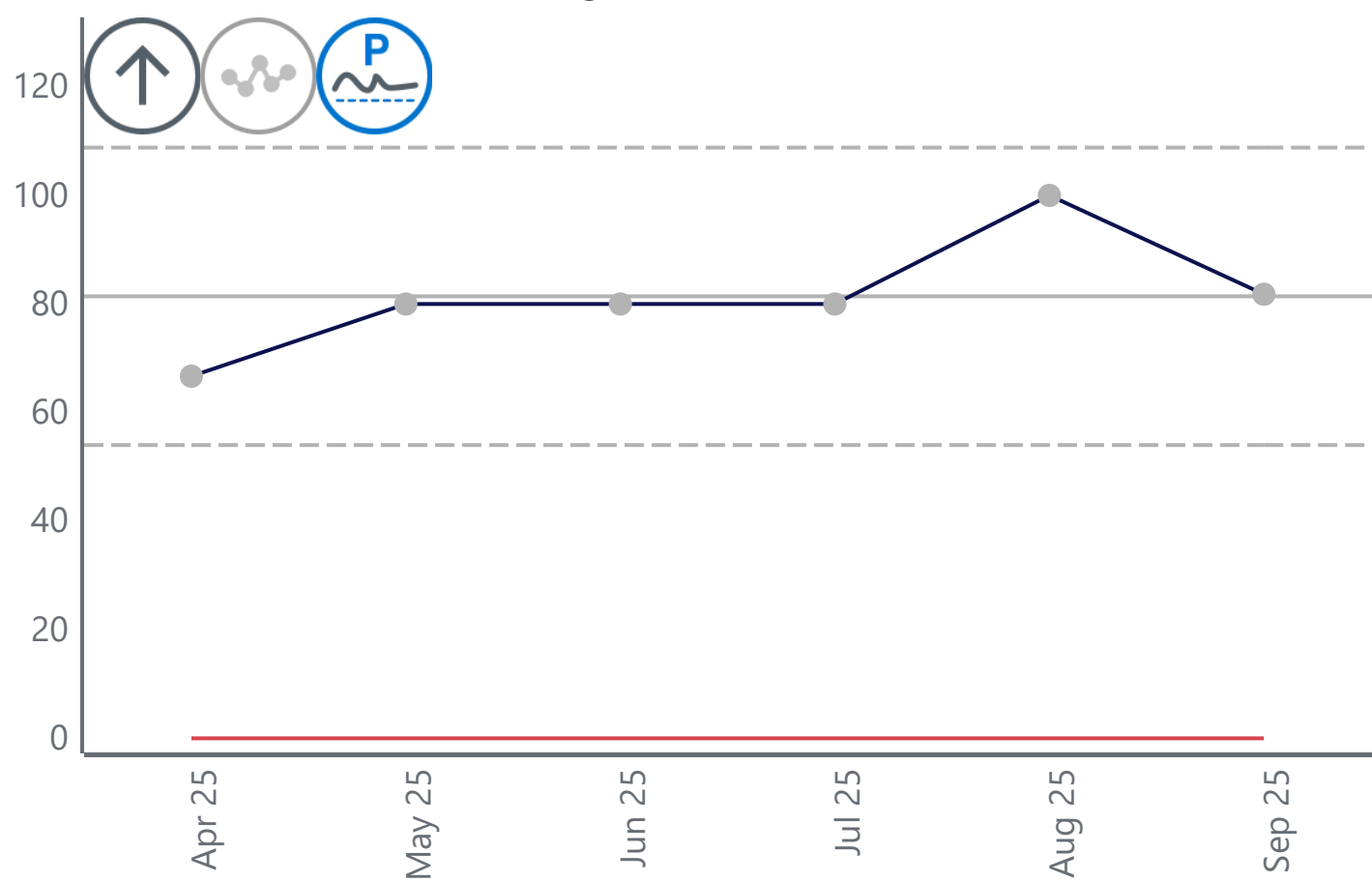
Number of studies open



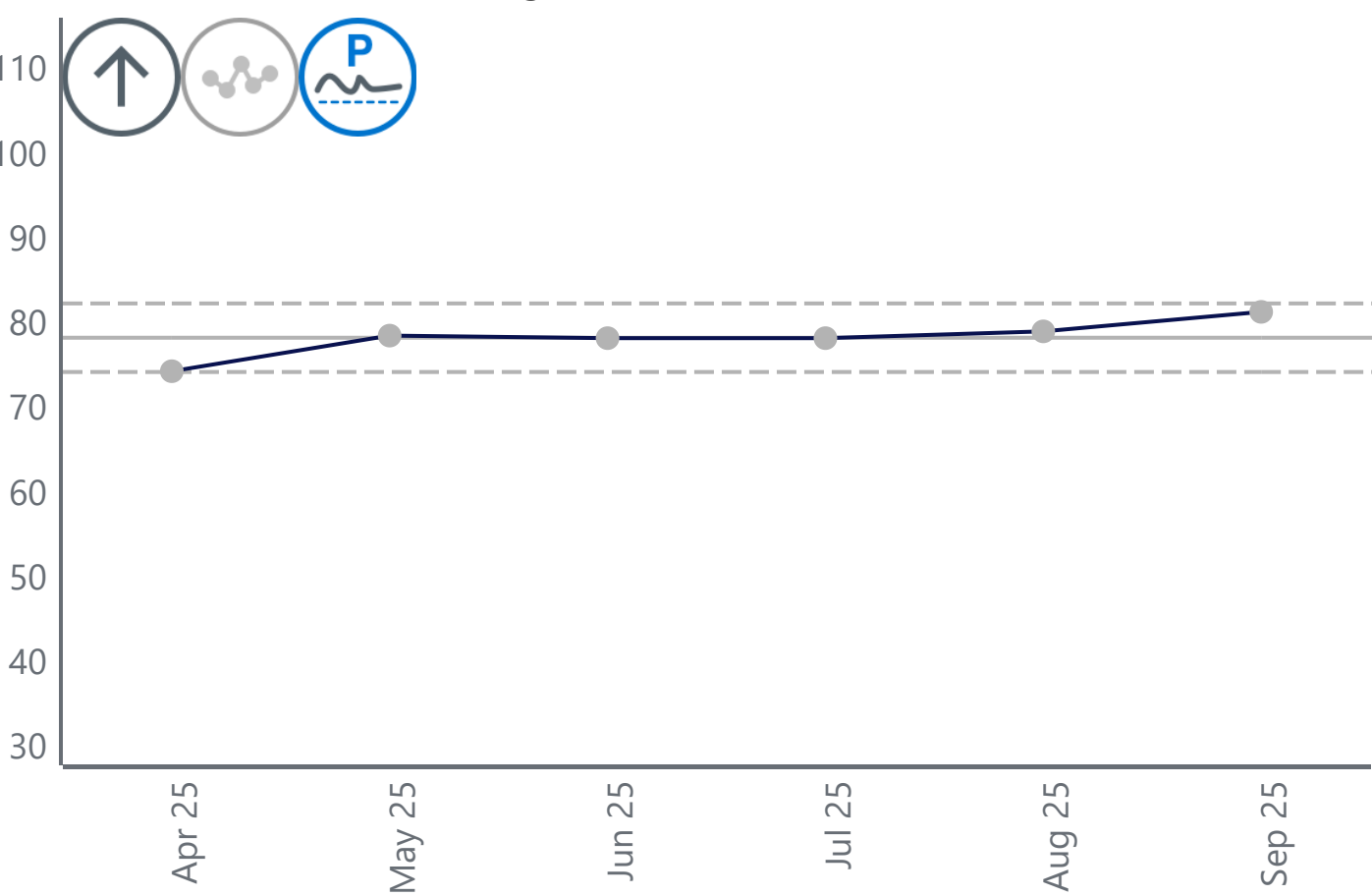
Number of active PI's



Recruitment to time and target for open commercial research



Recruitment to time and target for open non-commercial research



Risk Summary

Executive Summary

The InPhase Risk Register records risks identified within the organisation, along with actions and assurances.

Risk registers are reviewed monthly at Divisional Governance meeting and risk reports reviewed in a number of Groups, Committees and Boards. The Risk Management Group has a coordinating responsibility for maximising compliance with the risk management policy and cross organisational alignment to support HMB reporting. This report provides an overview of the risks within the risk register, along with KPI compliance. Detailed Divisional reports are provided separately

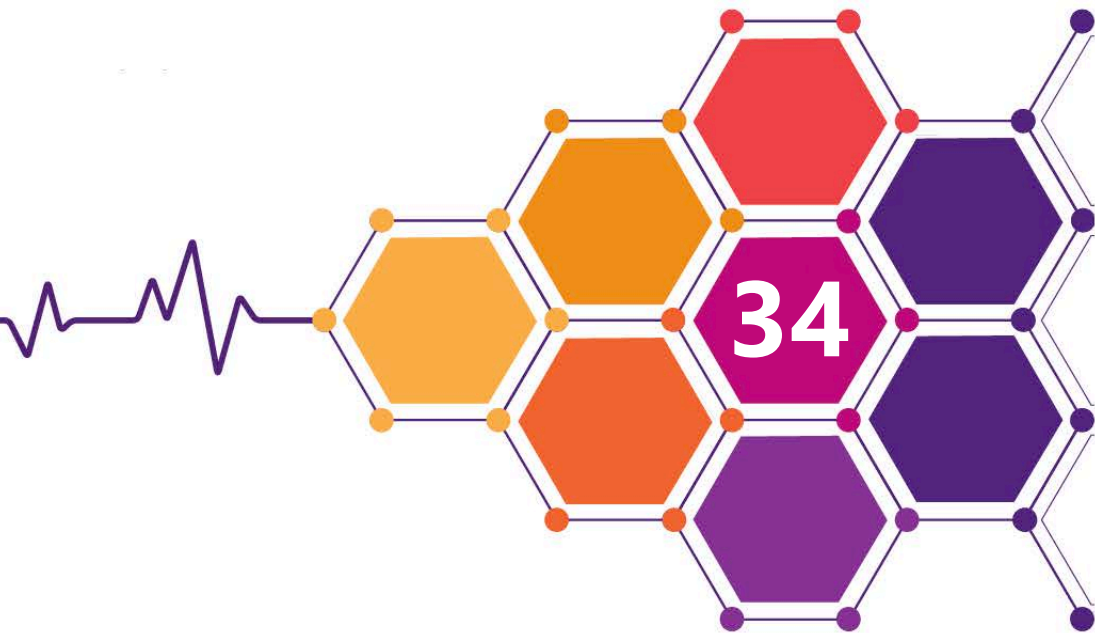
To note – for LHCH, target risk scores, relate to the 2025/6 agreed LHCH Board position. Target risk scores for UHLG are in the process of being applied to the in-phase system following recent notification.

The Trust has 388 active risks and regular review of risks is in line with policy expectations.

70% of incidents have been closed within 28 days. The number closed over 28 days is 32.

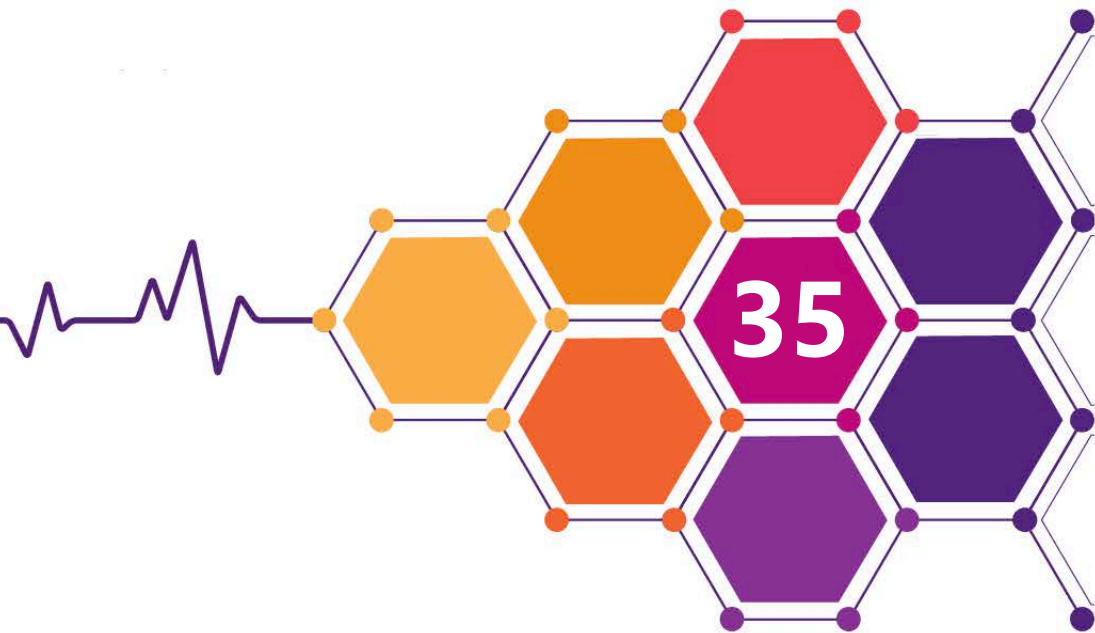
Live reports are available on InPhase showing the breakdown over division and area for risks open over 21 and 28 days.

Division	3-5 Low Risk	6-9 Moderate Risk	10-11 Serious Risk	12-15 Serious Risk	Total
Clinical Services	10	37	8	0	55
Corporate Services	42	118	21	0	181
Medicine	10	69	15	1	95
Surgery	15	45	4	3	67
Total	77	269	48	4	398



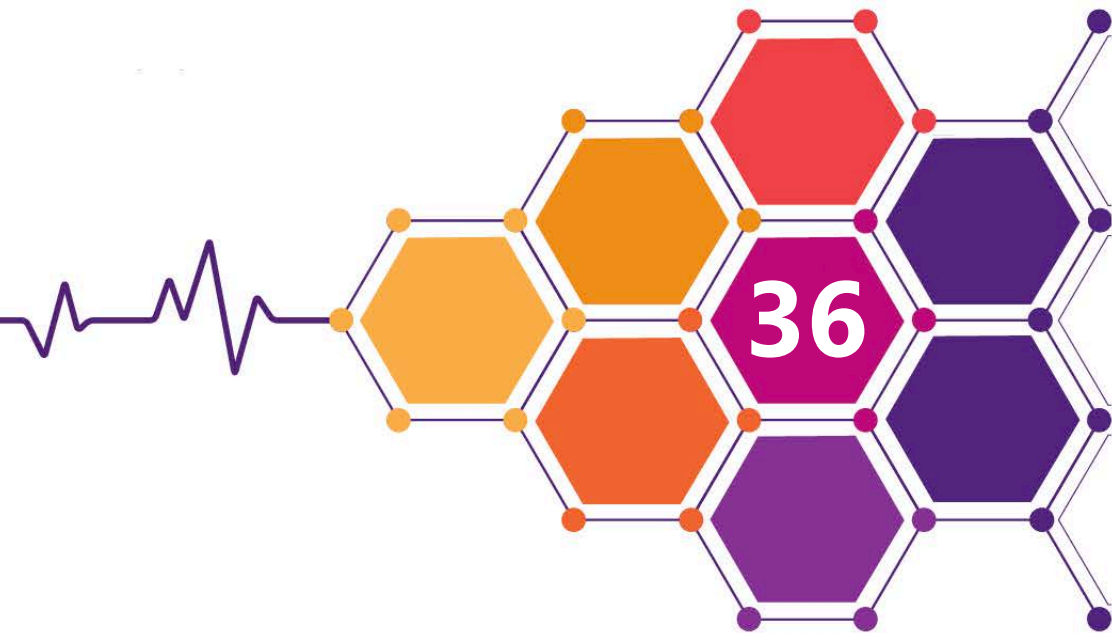
Risk - Divisional

Risk ID	Risk Description	Risk Location	Total Risk Profile Score	Current Controls	Further Mitigating Actions
1810	Risk to delivery of financial balance	Surgery	12	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 WLIs 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 WLIs and additional activity in Thoracic and Cardiac Surgery WLIs 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 Friday	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 WLIs 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 WLIs 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
2285	Inability to record emergency and urgent advice	Cardiac & Aortic Surgery	12	Images and imaging reports associated with all referrals to aortic service should be reviewed in person by the on-call team Aortic consultants to review all referrals received at least daily	LHCH to rapidly develop and introduce a system for recording, tracking and handing over all urgent external surgical referrals, including the advice given back to referrers The Patient Pass system has been agreed as the solution to record emergency and urgent advice
2327	ACHD capacity risk	ACHD	12	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



Risk - High Risks

Risk ID	Risk Description	Risk Location	Total Risk Profile Score	Current Controls	Further Mitigating Actions
2292	Ageing Theatre Estate	Theatres	12	Theatre staff to report issues immediately to estates. Estates to conduct a full review of key aspects of theatre & create a RAG rating improvements required. Weekly Checks • Water Temperature Monitoring o Sentinel outlets (e.g., WHBs and showers): Checked manually and via BMS to ensure compliance with HTM 04-01 guidelines for Legionella control. • Fire Alarm Function Test o Carried out to ensure fire alarm system operation in line with HTM 05-03 (Part B – Fire Detection and Alarm Systems). • Lift Auto-Dialler Tests o Ensures emergency communication systems are operational in compliance with HTM 08-02. • Medical Gas Air and Vacuum Plant Checks o Weekly to monthly depending on system criticality, per HTM 02-01. • Generator Off-Load Testing o Weekly run to verify engine operation and control/alarm functionality HTM 06-01 Monthly Checks • Water Sampling for Legionella & Pseudomonas o Undertaken in high-risk areas in accordance with HTM 04-01 Part B and Water Safety Plan • Theatre C Ventilation Verification o Conducted monthly in accordance with derogation mitigation measures and HTM 03-01 Part A. • Emergency Lighting Function Test o Monthly functional test in line with HTM 06-01 and BS 5266-1. • Visual Inspection of Fire Doors o To ensure integrity, closure, and signage per HTM 05-02. • Transfer Switch (ATS/MTS) Testing o Monthly operation test to confirm automatic or manual changeover capability (HTM 06-01). • Generator On-Load Testing o Load testing to confirm generator resilience. Quarterly Checks • Quarterly Inspection and Clean of Theatre AHUs o Visual inspection, filter condition, and cleanliness in line with HTM 03-01. • Clean of Theatre Ventilation Grilles and Diffusers o Routine dust removal and surface disinfection as per HTM 03-01 Appendix recommendations. • Medical Gas System o Maintenance and performance check on plant and manifolds, by External contractor as per HTM 02-01. • QC Northwest – Pharmacy Air Compressor Testing o Specialist audit of air quality, pressure, dew point, and microbial compliance for Medical Air 6-Monthly	A full review of management and engineering aspects of theatres will be undertaken by the Head of Estates and Facilities

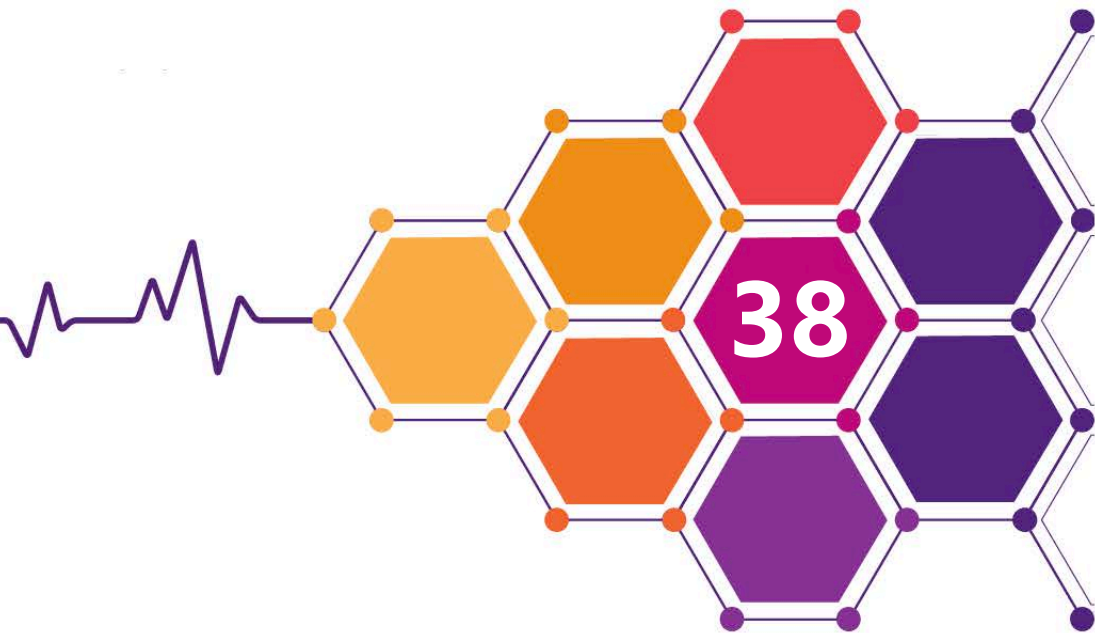


Risk - Corporate

Risk ID		Risk Owner	Risk Description	Total Risk Profile Score ▼	Target Score
1067	Estates Manager		Surgical corridor - defective concrete slab and steel	11	6
1640	Head of Estates		Failed electrical components to DTC (Block A, B, C, D)	11	9
1723	Head of Estates		insufficient training, site knowledge	11	9
1788	Head of IT		backups would be compromised	11	12
1944	Chief Operating Officer		Clinical Letters Process	11	12
2038	Head of IT		Isilon Capacity, Replication and Resilience	11	12
2297	Chief Information Officer		Digital Infrastructure– VxRail Environment Capacity and Network Dependency	11	12
2302	Head of IT		Failure of VPN between TIE and Telefonica [CRIS]	11	12
2329	Medical Director		Mental health provision	11	6
2349	Head of IT		Inadequate clinical data quality	11	6
0638	Head of IT		Switchboard, technical issues	10	16
1271	Estates Manager		Defective fire doors	10	6
1657	Estates Manager		Failure of Building Management System (BMS)	10	9
1802	All appropriate managers		Inability to deliver Elective Activity	10	6
1890	Chief Operating Officer		Outpatient Waiting Times	10	6
1899	Head of Estates		Fire Alarm System	10	9
2063	Head of IT		Inadequate Backup Capacity - Risk of losing patient and clinical data	10	12
2073	Head of IT		Unsecured Internal System - AD WEB Management	10	12
2143	Head of IT		Digital Team resource gaps impacting core deliverables and acceptable service performance	10	12
2299	Estates Manager		Generator failure	10	9
2341	Medical Director		Financial and Safety / Sustainability risk of implementing ICB mandated Resident Doctor Rate Card from 1st October 2025	10	12

Risk - Clinical Services

Risk ID	Risk Owner	Risk Description	Total Risk Profile Score	Target Score
2144	Therapy Manager	Office space and storage	11	9
2301	Head of IT	Unavailability of Medcon	11	6
2308	Head of IT	Intermittent Failure to Send Echo Studies from scanners to ISCV	11	6
2351	Head of IT	Inadequate access to incorrect image records	11	6
2352	Head of IT	Persistent crashes of PACS when remote users running MDT's	11	6
0006	All appropriate managers	Referral Management Processes and Systems	10	9
2050	Head of IT	Event Logs	10	9
2051	Chief Information Officer	Medical Devices & Network Segmentation	10	9

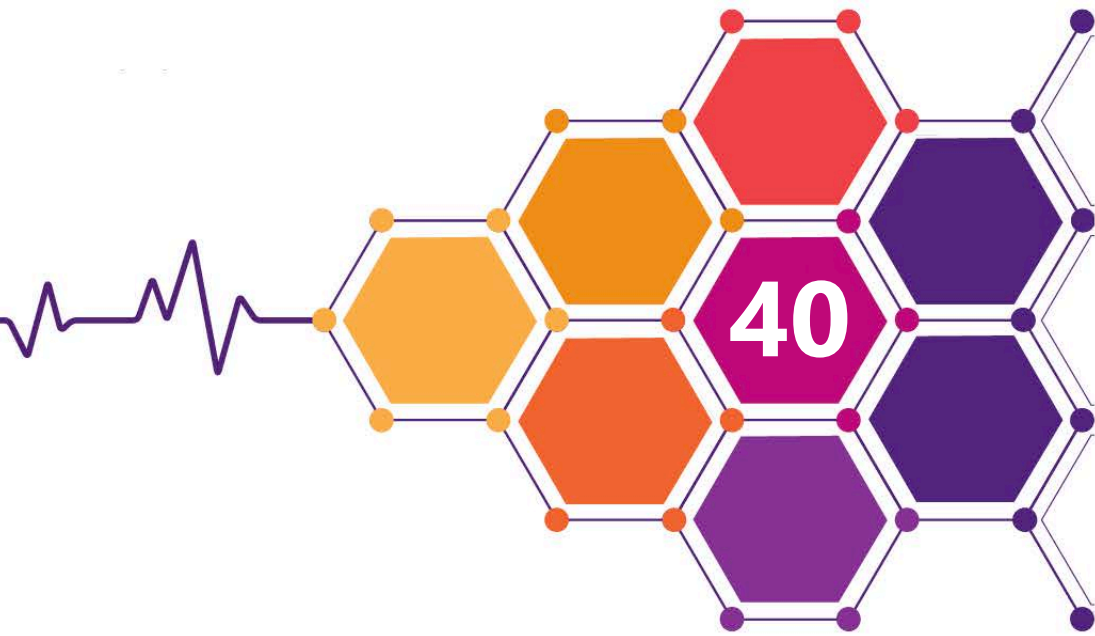


Risk - Medicine

Risk ID	Risk Owner	Risk Description	Total Risk Profile Score	Target Score
2327	Divisional Head of Operations, Medicine	ACHD capacity risk	12	12
0193	Head of IT	Unstable IT infrastructure in community KCVD	11	12
1102	Divisional Head of Operations, Medicine	Lack of space	11	6
2312	Divisional Head of Operations, Medicine	Financial Impact of Uptake Rates	11	12
2317	Clinical Lead for ACHD	ACHD interventional waits	11	9
2340	Clinical Lead for Knowsley Community COPD Service	Winter Pressures	11	6
0326	Lead Nurse for Community Services	Safe delivery of community services	10	12
0979	Divisional Head of Operations, Medicine	Identification of CIP schemes	10	12
1201	Head of IT	limitations / restrictions of the current telephony system	10	6
1728	Divisional Head of Operations, Medicine	Commercial Partnership Contractual Requirements	10	12
1781	Head of IT	Failure of all community spirometry services	10	6
1834	Divisional Head of Operations, Medicine	FOWL Waiting List	10	9
2113	Divisional Head of Nursing - Medicine	Admission of expecting mothers and care of their new born baby post delivery on Cherry Ward	10	6
2332	Capital Projects Manager	ACHD Echo machines (x2) end of life	10	9
2334	Business Manager - Medicine	IT connectivity in community LCS CT scanner units	10	12
2339	Clinical Lead for Knowsley Community Services	Pulmonary Rehabilitation Physiotherapy staffing	10	6

Risk - Surgery

Risk ID	Risk Owner	Risk Description	Total Risk Profile Score	Target Score
1810	Divisional Director of Operations, Surgery	Risk to delivery of financial balance	12	12
2285	Associate Medical Director - Surgery	Inability to record emergency and urgent advice	12	6
2292	Directorate Manager, Theatres	Ageing Theatre Estate	12	9
0155	Perfusion Manager	additional theatres, lack of perfusion staff	11	9
1135	Divisional Director of Operations, Surgery	Capacity of sub-specialised service lines	10	9
1917	Divisional Director of Operations, Surgery	Cardiac Surgery Urgent and Elective Waiting List	10	6
2337	Directorate Manager, Surgical Specialties	Surgeon availability	10	9





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