

## BOARD OF DIRECTORS MEETING

Agenda Item	P1/159/17	Date: 5 <sup>th</sup> July 2017
Subject /title	Integrated Performance Report	
Author	Hannah Gray, Head of Performance and Planning Jason Pawluk, Senior Programme Manager	
Responsible Director	Helen Porter, Director of Nursing & Quality	
Executive summary and key issues for discussion		
<p>The Integrated Performance Report provides an overview of the main performance indicators across all areas of the agenda in a combined report.</p>		
<p style="text-align: center;"><b>KPI Detail</b></p>		
<p><b>VTE (Venous Thromboembolism): Percentage of patients being assessed and percentage of 'at risk' patients receiving prophylaxis</b></p>		
<p>Following the amendments to the VTE risk assessment data, we continue to be compliant with our 95% target, with performance at 97.7% for May 2017.</p>		
<p>Administration of prophylaxis has risen again, to 97% for May 2017. We continue to strive for 100% and improvements to address this are ongoing; the medical VTE is now mandatory on the unplanned admissions pathway, and work is underway to extend this to planned admissions. The nursing and medical assessments are being combined on Meditech, with the required system changes currently in the testing phase, likely to go live in Q2 2017/18. VTE occurrence is monitored closely at CCC with incident forms completed and Root Causes Analyses undertaken for those which developed at CCC.</p>		
<p><b>Sepsis</b></p>		
<p>Although not a CQUIN for 2017/18, we recognise that this is a vital standard for our patients and will therefore be continuing to record this and monitor our compliance against our internally developed stretch target of 100% of patients presenting with sepsis to receive IV antibiotics within an hour of presentation. Following a fall in compliance to 76% in April 2017, this has increased to 90% for May 2017.</p>		
<p><b>Dementia</b></p>		
<p>Following a dip below 85% in December and January, we then achieved 100% in February and March. April and May figures have again fallen; to 89% and 88% respectively. Due to the recent inconsistencies in achieving the target, we have recently included this assessment in a daily 'incomplete assessment' report provided to the wards, which they use as an additional reminder to complete any unfinished assessments. We will also be reviewing the dementia assessment training that staff receive, including within the dementia training module and that received by nursing staff at induction, to ensure this is comprehensive.</p>		

## **Cancer Waiting Times (CWT)**

From 1<sup>st</sup> April, the Trust is reporting performance against the revised 62 day target (based on 2016 guidance from NHS England & NHS Improvement). This was 81.5% for April (narrowly missing the target of 85%), falling to 68.8% for May, but increasing for June and on track to exceed the target at 89.2% (data for 1<sup>st</sup> – 27<sup>th</sup> June only and prior to validation).

In May, we saw an improvement in the ‘% of patients who have their first appointment within 7 days’ at 58%, however the ‘% of patients who are treated within 24 days of referral to CCC’ fell to 45%.

Please see the included ‘Performance Improvement Plan’ document, produced at NHS England’s request, for further details of the challenges faced by CCC, our improvement plan and proposed trajectory for compliance against the target.

## **Staff Indicators**

### **Attendance & Stress Related Absence:**

Absence across the Trust has increased slightly by 0.04%. The highest reason for absence in May 2017 was anxiety/stress/depression (24 cases), followed by gastrointestinal problems (20 cases) and genitourinary problems (13 cases). Stress related absence has also increased in May 17. The figure of 0.97% relates to 24 cases in total, (11 long and 13 short term). Absences relating to work related stress have increased to 7 cases.

### **Retention / Turnover:**

Staff turnover has decreased for May 2017 with 8 leavers compared with 25 in April 2017. The main reason for leaving in May 2017 was for promotion in other organisations.

### **Mandatory Training:**

The Learning and Development team are undertaking / facilitating the following actions to raise compliance:

- Organisation of an additional PREVENT session for the Imaging Team,
- Review of Nurses’ Mandatory training week following feedback from subject matter experts regarding requirements,
- Facilitation of a bespoke Mandatory training day for Delamere staff,
- Upgrade to the Internet Explorer and Java updates which will enable the Trust to start using ESR for completing E-Learning and to support staff & managers with monitoring their own and their team’s mandatory training.

### **PADRs:**

The Learning and Development team have been receiving a steady stream of PADR completion notifications. A number of PADR training sessions have been facilitated for

small groups and individuals, to support managers to meet the end July 2017 target of 95% compliance, however overall compliance is still low at 68% in May 2017.

## Finance and activity

At month 2, the Trust is reporting a deficit of £51k against a planned deficit of £1547k, a favourable variance of £103k.

Activity and drug data for Month 2 has been estimated as plan, due to timing issues, so there are no variances to report.

The Trust had planned for a deficit in months 1 and 2 ( as there were only 18 working days in month 1 due to two bank holidays over the Easter period), with the expectation that the Trust will move into surplus in month 3.

The Trust has been issued with an 'agency cap' for 2017-18 of £1.2m by NHS Improvement; this is the same as 2016-17. In month 2, agency spend was £0.060m, which is below the monthly run rate of £0.100m.

The CIP programme has achieved savings of £251k, which is £53k below plan.

The Trust holds cash at the end of month 2 of £59.1 million, which is £6.0m below plan. The main reason cash is below plan is following recent negotiations with the Royal Liverpool University Hospital, the Trust agreed to pay £10m upfront to secure future cash flows for the newly acquired Haemato-oncology service. This is offset by a underspend against the capital programme of circa £5m

## Strategic context and background papers (if relevant)

N/A

## Recommended Resolution

The Trust Board are asked to:

- Note the report and approve the actions being taken to address highlighted areas.

## Risk and assurance

The report is part of the overall Trust Performance Management System, ensuring delivery of external KPIs

## Link to CQC Regulations

Regulation 12: safe care and treatment

Regulation 17: good governance

Regulation 18: staffing

## Resource Implications

N/A

## Key communication points (internal and external)

Communicated with internal senior management team for information and action where appropriate.

## Freedom of Information Status

FOI exemptions must be applied to specific

Please tick the appropriate box below:

documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.

**Application Exemptions:**

- Prejudice to effective conduct of public affairs
- Personal Information
- Info provided in confidence
- Commercial interests
- Info intended for future publication

X

**A. This document is for full publication**

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**IMPORTANT:**

If you have chosen B above, highlight the information that is to be redacted within the document, for subsequent removal.

Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.

**Equality & Diversity impact assessment**

Are there concerns that the policy/service could have an adverse impact because of:	Yes	No
Age		X
Disability		X
Sex (gender)		X
Race		X
Sexual Orientation		X
Gender reassignment		X
Religion / Belief		X
Pregnancy and maternity		X
Civil Partnership and Marriage		X

If YES to one or more of the above please add further detail and identify if full impact assessment is required.

**Next steps**

**Appendices**

**Strategic Objectives supported by this report**

Improving Quality	X	Maintaining financial sustainability	X
Transforming how cancer care is provided across the Network		Continuous improvement and innovation	X
Research		Generating Intelligence	X

**Link to the NHS Constitution**

Patients		Staff	
Access to health care	X	Working environment Flexible opportunities, healthy and safe working conditions, staff support	
Quality of care and environment	X	Being heard:	

Nationally approved treatments, drugs and programmes		<ul style="list-style-type: none"> <li>Involved and represented</li> <li>Able to raise grievances</li> </ul>	
Respect, consent and confidentiality	X	<ul style="list-style-type: none"> <li>Able to make suggestions</li> <li>Able to raise concerns and complaints</li> </ul>	
Informed choice	X	Fair pay and contracts, clear roles and responsibilities	
Involvement in your healthcare and in the NHS		Personal and professional development	
Complaint and redress		Treated fairly and equally	X



## Integrated Performance Report: 2017/18 Month 2



Key Performance Indicator		Director	Target	Directive	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	YTD	12 month trend
<b>Safe</b>																		
<b>Harm Free Care</b>	Total incidents resulting in harm to patients	HP		Internal	23	18	28	13	16	10	11	11	5	2	16	NYP	16	
	Percentage of Patients with no 'new' harms (ST)	HP	95%	C, SU2S, OH	96.2%	98.3%	91.2%	96.6%	96.6%	94.8%	94.6%	95.1%	96%	98%	94%	95%		
	Number of patients recorded as having a category 2-4 hospital acquired pressure ulcer (CCC lapse in care)	HP	0	OH	0	0	1	0	0	0	1	1	1	0	2	0	2	
	Clostridium difficile infections (attributable)	HP	1	C, OH, SOF	1	1	1	0	0	0	0	0	0	0	0	0	0	
	MRSA infections (attributable)	HP	0	C, OH, SOF	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number of Never Events	HP	0	DoH, C, SOF	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number of falls per 1,000 admissions	HP	TBA	OH	58	31	11	27	31	28	20	15	19	12	19	19		
	Chemotherapy Medication Errors per 1000 doses	HP	TBA	C, QR				0.82	0.67	0.99	0.69	0.46	0.17	0.14	1.43	0.7		
	Number of Chemotherapy Medication Errors	HP	TBA	C, QR	3	4	3	5	4	6	4	3	1	1	9	5	14	
	Radiotherapy Treatment Errors per 1,000 fractions (Per 1000 figure unavailable for May. May=8 total)	HP	TBA	C, QR	1.58	1.4	1.6	1	1.1	1.16	1.2	1.6	1.1	0.76	0.62	0.94		
	Percentage of adult admissions with VTE Assessment	HP	95%	C, SOF	98.5%	96.4%	95.7%	98.2%	97.7%	97.9%	95.0%	99.0%	96.9%	95.5%	97.2%	97.7%		
<b>Medication</b>	Dose Banding Adult Intravenous SACT	HP	Q1 baseline, Q2 - Q4 TBA based on Q1 baseline	CQUIN			22%			76%			95%		QR	QR		
	Composite Indicator for Dementia Screening	HP	R: <95%, A: 95%-99%, G: 100%	Internal	93.7%	100%	100%	100%	93%	92%	82%	84%	100%	100%	89%	88%		
	Percentage completeness of the AKI data items (four per discharge)	HP	R: <95%, A: 95%-99%, G: 100%	Internal	0%	0%	67%	44%							92%	NYP		
<b>Sepsis</b>	Percentage of patients requiring screening for sepsis, who have been screened as part of the admission process.	HP	100%	Internal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	Percentage of patients presenting with severe sepsis, Red Flag Sepsis or Septic Shock, who have received IV antibiotics within an hour of presentation.	HP	2017/18: R: <95%, A: 95%-99%, G: 100%	Internal	83%	83%	82%	84%	83%	86%	100%	100%	90%	96%	76%	90%		
<b>Effective</b>																		
<b>Mortality</b>	Total number of in-hospital deaths	HP/PK		Internal	9	7	6	6	7	4	8	7	8	7	5	6	11	
	30 day mortality rate (radical chemotherapy)	HP		QR	0.4%	0.3%	0.3%	0.4%	0.3%	0%	0%	0.1%	0.2%	0.3%	0.3%	NYP		
	30 day mortality rate (palliative chemotherapy)	HP		QR	1.1%	1.5%	1.5%	1.7%	2.3%	1.7%	1.4%	1.2%	1.1%	1.6%	1.3%	NYP		
	30 day mortality rate (radical radiotherapy)	PK		QR	2.2%	3.5%	2.4%	2.1%	2.5%	3.4%	3.2%	3.6%	2.9%	1.9%	1.8%	NYP		
	30 day mortality rate (palliative radiotherapy)	PK		QR														
<b>Time to Consultant Assessment</b>	Percentage of patients admitted as an emergency by A&E or directly from the community, who have a documented assessment by a consultant, within 14 hrs of arrival at hospital.	HP	75%	Royal College of Physicians	77.0%	80%	78%	69%	68%	86%	80%	72%	71%	70%	93%	83%		





## Integrated Performance Report: 2017/18 Month 2



	Key Performance Indicator	Director	Target	Directive	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	YTD	12 month Trend	
Efficiency	Length of Stay Elective Care (Average number of days on discharge)	HP	5	Internal	1.81	2.40	2.1	2.79	2.6	4.61	2.25	4.40	3.82	2.59	1.78	2.05			
	Length of Stay Emergency Care (Average number of days on discharge)	HP	10	Internal	9.76	10.61	6.67	12.14	13.15	10.04	6.91	9.61	8.96	8.94	7.42	8.04			
	% of patients not meeting the 'Clinical Utilisation Review' criteria	HP	TBC with NHSE	CQUIN											40%	45%			
	Linac Downtime	PK	2%	Internal	6.4%	2.42%	3.45%	3.25%	3.90%	2.72%	1.53%	4.04%	2.74%	2.34%	2.36%	2.38%	2.37%		
	Linac Utilisation	PK	85%	Internal	82.8%	81.2%	77.9%	83.5%	86.5%	89.0%	80.9%	83.3%	96.4%	94.8%	86.7%	87.2%			
	Care hours per patient day: Conway Ward	HP	Awaiting inclusion of KPI in 'Model Hospital' Portal	NHSI	7.6	7.0	6.2	5.8	5.6	6	6.3	5.9	6	6	6.2	6.2			
	Care hours per patient day: Sulby Ward	HP		NHSI	9.9	6.7	8.2	6.6	9.4	8.5	10.8	7.3	7.4	7.3	9	10			
	Care hours per patient day: Mersey Ward	HP		NHSI	6.9	7.1	7.1	6.3	6.1	6.8	6.7	6.6	6.7	6.3	7.3	7.4			
	Time to recruit staff (days)	AC	60	Internal	31	31	43	59	61	59	63	41	67	66	26	39			
Clinical Trials	Number of patients enrolled into clinical trials	PK	400 per annum	Internal		Q2 = 83			Q3 = 87			Q4 = 71			QR	QR			
Caring																			
The NHS Friends and Family Test (FFT): Inpatients	Total responses as a percentage of those eligible to respond.	HP	30%	C	27%	12.9%	11.80%	19.10%	19.10%	23.10%	10.80%	10.95%	13.80%	15.00%	15.80%	8.50%			
	Percentage of respondents who were either likely or extremely likely to recommend to friends and family.	HP	R: <90, A: 90-94, G: >=95	C, O&H, SOF	95%	100%	95%	98.20%	94.10%	97.01%	96.88%	100.00%	94.11%	93.30%	100%	100%			
The NHS Friends and Family Test (FFT): Outpatients	Percentage of respondents who were either likely or extremely likely to recommend to friends and family.	HP	R: <90, A: 90-94, G: >=95	C	94.0%	97.7%	96.60%	94.80%	96.68%	96.36%	96.88%	96.44%	96.92%	95.07%	89.52%	96.53%			
Waiting Times	Percentage waiting 30 minutes or less in a CCC outpatient clinic	HP	65%	Internal		79.1%	79.96%	78.29%	79.23%	77.48%	73.24%	77.46%	72.74%	77.27%	74.07%	71.44%			
	Percentage waiting 30 minutes or less for Radiotherapy	PK	80%	Internal	DC	DC	DC	DC	DC	DC	DC	DC	DC	DC	DC	DC			
	Percentage waiting 30 minutes or less for Delamere	HP	80%	Internal		91.1%	92%	91%	90%	91%	87%	86%	87%	86%	86%	83%			
	Percentage waiting 30 minutes or less for outpatient peripheral clinics	HP	65%	Internal				96%	96%	93%	94%	93%	88%	86%	86%	84%			
Complaints	Number of Complaints	HP	0	C, SOF	0	4	0	1	2	2	4	0	2	3	4	2	6		
Responsive																			
All Cancers: 62 Day Wait for First Treatment	From urgent GP referral to treatment (classic) post allocation* - English Patients	HP/PK	85%	SOF, C	77.0%	82.2%	66.3%	80.4%	80.0%	78.5%	80.2%	74.4%	78.0%	81.4%	81.5%	68.8%	Latest figures are subject to change		
	From urgent GP referral to treatment (classic) pre allocation* - English Patients	HP/PK	85%	SOF, C	63.4%	63.0%	54.90%	60.60%	67.90%	68.90%	65.90%	64.00%	60.90%	65.80%	67.00%	52.10%	Latest figures are subject to change		
	From urgent GP referral to treatment (classic) post allocation* - All Patients	HP/PK	85%	SOF, C	77.0%	82.5%	65.30%	80.60%	79.10%	78.70%	78.30%	75.50%	77.20%	81.40%	81.50%	69.50%	Latest figures are subject to change		
	From urgent GP referral to treatment (classic) pre allocation* - All Patients	HP/PK	85%	SOF, C	63.8%	63.4%	53.60%	61.50%	68.60%	68.20%	64.30%	65.20%	61.30%	64.00%	67.00%	52.10%	Latest figures are subject to change		
	% of patients who have their first appointment within 7 days	HP/PK	90%	Linked to 62 Day waits										54.55%	47.50%	57.80%			
	% of patients who are treated within 24 days of referral to CCC	HP/PK	85%	Linked to 62 Day waits										62.10%	62.50%	45.10%			



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	Key Performance Indicator	Director	Target	Directive	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	YTD	12 month Trend
All Cancers: 62 Day Wait for First Treatment	All Tumours	HP/PK	85%	DoH	90%	88%	87.10%	88.50%	88.40%	89.60%	88.30%	89.10%	89.10%	89.2%	87.5%	76.7%		
	Brain/CNS	HP/PK	85%	DoH										100.0%				
	Breast	HP/PK	85%	DoH	100%	100%	91.80%	96.40%	93.10%	97.10%	94.94%	95.74%	96.00%	96.2%	87.5%	93.3%		
	Gynaecological	HP/PK	85%	DoH	100%	100%	100%	100%	100%	100%	100%	100%	100%	93.1%	100.0%	40.0%		
	Haematological	HP/PK	85%	DoH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			
	Head & Neck	HP/PK	85%	DoH	62.5%	67.7%	72.40%	72.40%	73.30%	73.30%	76.81%	78.38%	80.5%	80.2%	100.0%	80.0%		
	Lower GI	HP/PK	85%	DoH	100%	100%	100%	100%	100%	100%	91%	90%	90%	91.3%	86.7%	75.0%		
	Lung	HP/PK	85%	DoH	92%	89.6%	87.80%	88.80%	90.50%	90.80%	92.59%	93.89%	93.70%	92.7%	100.0%	84.1%		
	Other	HP/PK	85%	DoH	100%	83.3%	85.70%	86.70%	86.70%	88.20%	80.00%	76.00%	78.60%	79.3%	100.0%	100.0%		
	Sarcoma	HP/PK	85%	DoH						33.30%			100.00%	100.0%		50.0%		
	Skin	HP/PK	85%	DoH	100%	100%	100%	100%	100%	66.70%	50.00%	55.56%		55.6%		100.0%		
	Upper GI	HP/PK	85%	DoH	84.6%	83.8%	83.80%	84.20%	83.80%	84.20%	83.78%	85.88%	82.40%	83.5%	60.0%	47.8%		
	Urological	HP/PK	85%	DoH	75.0%	75.0%	75%	78%	75%	78%	81%	83%	83%	85.7%	42.9%	68.4%		
	Urological/Testicular	HP/PK	85%	DoH														
	Not Specified	HP/PK	85%	DoH														
All cancers: 31 day wait from	From consultant screening service referral post reallocation* - English Patients	HP/PK	90%	SOF, C	80%	67%	100%	100%	100%	80%	100%	0%	67%	100%	100%	67%		
	From consultant screening service referral post reallocation* - All Patients	HP/PK	90%	SOF, C	80%	67%	100%	100%	100%	80%	100%	0%	67%	100%	100%	67%		
	Decision to Treat to first treatment - English Patients	HP/PK	96%	DoH, C	98.70%	97.90%	97.60%	96.50%	97.70%	98.50%	98.20%	97.10%	100.00%	96.70%	98.80%	96.40%		
	Decision to Treat to first treatment - All Patients	HP/PK	96%	DoH, C	98.40%	98.00%	97.30%	96.70%	97.90%	98.50%	97.60%	96.30%	100.00%	96.40%	98.30%	96.50%		
	Decision to Treat to subsequent treatment	HP	98%	DoH, C	98.10%	98.60%	99.30%	98.20%	97.90%	99.40%	99.50%	96.70%	99.70%	98.70%	97.00%	98.40%		
	Anti cancer drug treatment - English Patients	HP	98%	DoH, C	98.20%	98.70%	99.30%	98.20%	98.00%	99.40%	99.00%	96.90%	99.70%	98.80%	97.10%	98.50%		
	Anti cancer drug treatment - All Patients	HP	98%	DoH, C	98.20%	98.70%	99.30%	98.20%	98.00%	99.40%	99.00%	96.90%	99.70%	98.80%	97.10%	98.50%		
Referral to treatment waiting times (18 weeks)	Decision to Treat to subsequent treatment	PK	94%	DoH, C	94.10%	96.70%	96.50%	95.70%	96.80%	98.50%	97.80%	97.40%	98.30%	98.90%	98.0%	97.8%		
	Radiotherapy - English Patients	PK	94%	DoH, C	93.10%	96.80%	96.30%	95.50%	96.90%	98.50%	97.90%	97.30%	98.20%	98.70%	97.8%	98.0%		
	Radiotherapy - All Patients	PK	94%	DoH, C	93.10%	96.80%	96.30%	95.50%	96.90%	98.50%	97.90%	97.30%	98.20%	98.70%	97.8%	98.0%		
	Radiotherapy - All Patients	PK	94%	DoH, C	93.10%	96.80%	96.30%	95.50%	96.90%	98.50%	97.90%	97.30%	98.20%	98.70%	97.8%	98.0%		
Referral to treatment waiting times (18 weeks)	Admitted patients	HP/PK	90%	SOF	97%	97%	100%	95%	100%	100.0%	100.0%	100.0%	95.2%	96.9%	100.0%	100.0%		
	Non-admitted patients	HP/PK	95%	SOF	98.0%	98.2%	97.70%	98.20%	99.2%	98.7%	98.3%	98.3%	96.2%	98.5%	98.3%	97.8%		
	Incomplete Pathways	HP/PK	92%	SOF, C	94.7%	95.5%	95.19%	96.29%	95.1%	96.7%	96.3%	96.1%	96.1%	96.7%	96.9%	96.7%		
Referral to treatment waiting times (18 weeks)	Zero tolerance RTT waits over 52 weeks for Incomplete pathways	HP/PK	0	SOF	0	0	0	0	0	0	0	0	0	0	0	0		
	Patients waiting less than six weeks at month end as a percentage of total waiting (Diagnostics)	PK	99%	C	100%	100%	100%	100%	100%	100%	98.9%	98.5%	100.0%	100.0%	100.0%	100.0%		
People Management and Culture: Well Led																		
Staff Attendance and Turnover	Attendance (Sickness Level)	AC	R: >=4%, A: 3.6% - 3.9%, G: <=3.5%	SOF	4.6%	4.07%	3.34%	3.85%	4.49%	4.28%	3.79%	4.84%	4.14%	4.14%	4.05%	4.09%		
	Retention (Turnover FTE rolling 12 months)	AC	<12%	SOF	14.89%	14.80%	14.65%	13.16%	13.43%	13.56%	13.24%	13.14%	12.92%	12.28%	12.81%	13.69%		
Staff Development (The figures recorded for each month are rolling 12 month figures, rather than for the month only)	Statutory Mandatory Training (Rolling 12 months)	AC		Internal	82.0%	82.0%	82%	83%	82%	83%	83%	85%	85%	80%	80%	81%		
	Mandatory Role Essential Training (Rolling 12 months)	AC	R: <75%, A: 75% 94%, G: >=95%	Internal	78.0%	79.0%	78%	78%	75%	70%	71%	68%	81%	73%	79%	80%		
	Performance Development Reviews (PADR) (Rolling 12 months)	AC		Internal	57%	46%	46%	54%	57%	60%	61%	75%	76%	73%	70%	68%		
The NHS Friends and Family Test (FFT): Staff	Percentage of respondents who were either likely or extremely likely to recommend to friends and family as a place to work.	AC	R: <90, A: 90-94, G: >=95	SOF, O&H	90.0%			91%			No report due to National Staff Survey			22%	QR	QR		
	Percentage of respondents who were either likely or extremely likely to recommend to friends and family as a place for treatment or care.	AC		SOF, O&H	100.0%			95%			No report due to National Staff Survey			83%	QR	QR		





## Integrated Performance Report: 2017/18 Month 2



Key Performance Indicator		Director	Target	Directive	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	YTD	12 month Trend
<b>Finance and Activity</b>																		
<b>Finance</b> <small>(The figures recorded for each month are YTD figures, rather than the month only)</small>	Operating Surplus (EBITDA margin) YTD	YB	6.4%	Internal	9.2%	9.0%	9.8%	11.1%	10.2%	10.6%	10.1%	10.1%	9.9%	10.8%	2.1%	6.6%		
	Net Surplus (Net Income & Expenditure Margin) YTD	YB	-0.9%	Internal	3.8%	3.6%	4.5%	6.0%	5.3%	5.7%	5.1%	5.1%	4.8%	5.9%	-5.6%	-0.3%		
	Net Surplus versus Trust Plan (£'000s) (YTD)	YB	-154	SOF		1,282	2,042	3,317	3,377	4,136	4,168	4,631	4,816	6,544	-461	-51		
	Net Surplus versus NHSI Control Target (£'000s) (YTD)	YB	-532	SOF		1,353	2,042	3,444	3,508	4,305	4,354	4,841	5,492	5,921	-398	113		
	C-I-P Savings (Percentage of identified savings) YTD	YB	12.6%	Internal	17%	24.5%	31.0%	48.4%	57.8%	65.7%	72.0%	81.5%	89.6%	103.9%	5.1%	10.4%		
	Capital Spend versus Plan (%) YTD	YB	15.3%	Internal	12%	11.0%	16.3%	19.8%	22.6%	27.4%	33.6%	59.0%	62.7%	99.5%	7.8%	3.1%		
	Cash Balances versus Plan (£'000s) (YTD)	YB	65,084	Internal		79,132	78,509	77,189	75,806	76,015	72,983	76,640	89,213	62,831	58,661	59,075		
	Liquidity Position (Liquid ratio in days) YTD	YB	214 days	SOF	266	265	262 days	265	266	265	259	255	252	210	213	212		
	Use of Resources	YB	1	SOF	4	4	4	4	3	3	3	3	3	3	1	1		
	Agency Staff Spend (£'000s) YTD	YB	85	SOF	612	962	1,139	1,325	1,500	1,620	1,700	1,820	1,885	1,940	96	60		
<b>Activity</b> <small>(The figures recorded for each month are YTD figures, rather than the month only)</small>	Agency and Bank Staff Spend (£'000s) YTD	AC	85	Internal				1,349	1,519	1,644	1,729	1,857	1,929	1,980	97	66		
	Agency medical locum spend (reduce by £75K by the end of 2017/18 compared to 2016/17 outturn spend)	YB	TBC	SOF														
	Contract versus Plan (£)	YB	6,625,426	Internal				31,338,820	36,441,467	41,590,185	46,615,956	52,230,726	57,405,886	63,358,686	5,678,936	6,625,426		
	Radiotherapy Activity (percentage growth YTD)	PK	1.9%	C				-10.1%	-9.9%	-9.3%	-9.3%	-8.2%	-9.1%	-8.6%	1.9%	1.9%		
	Chemotherapy Activity (percentage growth YTD)	HP	5.0%	C				-5.3%	-5.7%	-2.9%	-0.8%	4.3%	4.5%	4.7%	5.0%	5.0%		
	Inpatient Activity (percentage growth YTD)	HP	1%	C				7.7%	8.0%	8.8%	9.3%	-2.4%	-3.4%	-3.0%	1%	1%		
	Outpatient Activity (percentage growth YTD)	HP	1%	C				6.7%	7.5%	6.6%	6.4%	3.1%	4.7%	5.3%	1%	1%		



**Titles key:** Directive = Rationale for inclusion (see detailed key below), YTD = Year to date

**Directive key:** Department of Health (DoH), NHS Improvement (NHSI), Single Oversight Framework (SOF), CQUIN (CQUIN), Quality Report (QR), Sign up to Safety campaign (SU2S), Contract KPIs (C), Open and Honest (OH)

**General key:** DC = Data capture system under development, TBA = To be agreed, TBC = To be confirmed, QR = Quarterly Reporting, NYP = Data not yet published for this time period, NA = Not Applicable, ST = Safety Thermometer (this is a survey carried out on one day a month on all wards. The data relates only to the inpatients present on that day, rather than capturing all harm data for the month), Grey shaded cells = Not applicable, or data not available for this period.

## CCC 62 Day Recovery Plan

### Introduction:

This paper provides further information on the matters requested by the NHSE DCO team following a telephone conference on 21<sup>st</sup> June, further to the requirement to produce a system-wide recovery plan for the 62 day operational standard by September.

The information specifically requested was as follows:

1. Details of late referrals in to the Centre, with actions that can be taken at CCC to mitigate.
2. Performance improvement trajectory relating to delivering a first outpatient appointment slot at the Centre within 7 days of referral
3. Performance improvement trajectory relating to coordination and tracking issues in the radiotherapy service at CCC.

Improvements across these three areas will support the performance improvement planned in the trajectory as defined on the attachment.

### 1.0 Late Referrals in to CCC

“Late” referrals in to CCC are defined as any transfer of care beyond day 38 of the 62 day pathway. This is based on the principle of CCC having a 24 day period to complete the treatment planning and delivery component of the pathway within the overall 62 day window, when a minimum data set (as agreed by the national protocol and at Alliance level) is shared between the organisations.

The new approach, effective from April 2017, requires CCC to manage the care of pathways received within 24 days irrespective of the date of transfer, so as to avoid accountability for either a “full” or “half” breach.

In any event, data reviewed by NHSE, which was used to define the analysis of trusts requiring improvement is based on the “raw” or “pre-reallocation” position. As such, the data on late referrals is presented on the basis of seeking to improve the pathway for patients overall, as opposed to being strictly linked to the performance trajectory for CCC as a distinct institution. In terms of interpreting the data, the first / middle trust is not always the same as the host CCG, which is based on the patient’s GP, and in some instances the date of handover is validated between the organisations as part of the performance verification process for establishing the “post reallocation” position. This is shown in the relatively small number of “disputed” reallocations, which are marked as such during performance upload.

The trust has complete reallocation data for Q3 and Q4 2016/17.

### Q3 – 16/17

- 92 patients that breached the 62 day target (\*75 Reallocated to the referring trust and 17 reallocated to CCC, 4 disputed reallocations).

The table below shows the number of classic breaches per Trust, giving a breakdown on how many breaches were received before day 42, after day 42 and after day 62. There were 4 screening patients reallocated to the referring trust & 25 upgraded patients who breached the target. For context, for CCC to achieve 85% on the pre-reallocation measure, the number of late referrals would

need to be either one or two per provider per month depending on institution size and referral volumes.

Trust	Number of breaches per Trust	Before Day 42	After Day 42	After Day 62
AUHFT	10	2	5	3
COCH	7	3	2	2
LWH	2	0	0	2
RLUBHT	6	0	5	1
SORM	5	0	2	3
WHH	11	2	5	4
STHK	8	2	3	3
WUTH	21	4	10	7
3 Trust Pathways	22	4	8	10
Total	92	17	40	35

#### Q4 – 16/17

The Trust had 104 patients that breached the 62 day target (\*95 Reallocated to the referring trust and 9 reallocated to CCC). The table below shows the number of classic breaches per Trust, giving a breakdown on how many breaches were received before day 42, after day 42 and after day 62.

Trust	Number of breaches per Trust	Before Day 42	After Day 42	After Day 62
AUHFT	14	1	7	6
COCH	6	1	2	3
LHCH	2	0	1	1
LWH	2	0	2	0
RLBUHT	10	1	5	4
SORM	9	0	5	4
WHH	9	1	5	3
STHK	9	1	3	5
WUTH	18	1	5	12

3 Trust	25	3	13	9
Total	104	9	48	47

Although the trust does not yet have complete data for the period 17/18 Q1, the following analyses can be identified:

- No trust has substantially improved performance relating to late referrals in to the Centre.
- A substantial proportion of late referrals occur after day 62, meaning that CCC has no opportunity to prevent the breach.
- The providers who are over-represented by late referrals relative to referral volumes are similar to the previous analysis submitted in 2016. These are WUTH and WHH in particular, with some tumour site specific issues relating to COCH, SORM, AUHFT, and RLUBHT.
- Tumour site issues are broadly similar to the national analysis with the exception of lung cancer, where Alliance performance is stronger than the national comparison (so is not as strong an opportunity for performance uplift as indicated), and excluding head and neck, where there is probably more opportunity for performance uplift linked to the issues of late referral volumes.
- Appendix 1 gives further pathway specific detail relating to the above.

With respect to this issue, CCC is able to and taking the following actions to support other providers:

- Leadership via the CCC funded Pathways programme in terms of cross-sector clinical reference and pathway review groups in lung, colorectal, upper gastrointestinal, head and neck and prostate cancers. Significant success in lung cancer.
- Continued development of action learning sets for cancer managers focussing on coordination/administrative actions, which are developed in partnership with commissioners via the Cancer Managers Advisory Group.
- Leadership of “field visits” for cancer waiting times at trusts focussing on the high impact actions, working closely with the Cancer Alliance team, in CCC’s system leadership role..
- Details of late referral data have been shared with Wirral CCG (host) and the Cancer Alliance in the first instance, with a commitment to provide summary data monthly, and a full report quarterly, as required. This will help to ensure that performance issues specific to certain institutions and pathways can be managed at commissioner to provider level.

## **2.0 Performance improvement trajectory relating to delivering a first outpatient appointment slot at the Centre within 7 days of referral**

The trust has developed a performance trajectory to deliver 75% of first outpatient appointments within 7 days, allowing for patient choice and clinical complexity. This is a performance trajectory towards September, which is based on implementation of operational plans relating to clinical capacity and ensuring that appointments for common cancer are accessible in each “sector” or “hub” area of C&M. Implementation of this plan would significantly assist compliance of the 24 day standard and will complimented by transition to a single nominated point of Executive accountability for cancer waiting times, Barney Schofield, by 1<sup>st</sup> August. Full details of the improvement plan are on the excel attachment – this in turn triangulates specific improvement actions linked to the step change in performance.

### **3.0 Performance improvement trajectory relating to coordination and tracking issues in the radiotherapy service at CCC.**

This is understood to be a delay factor within the control of CCC which is susceptible to performance improvement initiated and led by the Cancer Centre. The attached shows a detailed operational plan for how this will be achieved and necessary resources have been channelled internally towards implementation of the plan.

This is complimented by a further sequence of other actions which are again tracked in detail on the attachment, based on a thematic summary which has been approved by the trust Executive Management Team. This includes a structured assessment and implementation of the ten high impact actions.

## CWT Executive Lead: Barney Schofield

Back Stop Review Lead: Dr Peter Kirkbride

Area for Improvement	Item No	Action	Lead/s	Timescale	RAG rating	Comments	Impact
Communication	1.6	Deliver awareness sessions / communication continue to directorates e.g. Chemotherapy, Radiation Services and Integrated Care.	HH / MW	31/07/2017	In progress	KW to provide dates	
CWT Administration Workload & Resources	3.3	Develop a business case to support increased resource in the monitoring / tracking of patients with a specific focus on start of pathway / Radiotherapy services.	SE / JS	31/07/2017	In progress	Band 4 post recruited to and in post. Band 3 on workforce plan holding list now approved and recruitment in progress.	
Clinical Workforce	4.1	Review of consultant job plans to ensure capacity and cover to achieve 7 day KPI; supporting improvement of both CCC and overall network performance.	PK	31/12/2017	In progress	Current consultant workforce not able to deliver 7 day KPI.	
	4.2	Improve capacity through recruitment of AHP roles to support medical workforce and aligning specialty clinics	GMs/CDs	31/12/2017	In progress		
	4.3	Reconfiguration of services to meet local demand and centralisation of teams in sectors to maintain a service during periods of annual leave.	GMs/CDs	31/12/2017	In progress		
	4.4	Identify clinic capacity and demand for Q2 (using intelligence including previous activity data, available appointments in Q2 and consultant leave), and consider creating additional capacity (e.g. WLI) if there is insufficient to support first appointments within 7 days.	JS/SE/HG/IC	30/06/2017	In progress	IO to obtain the past activity and future capacity data (liaising with EPR team). SE to identify planned consultant leave. HG to analyse breach data re 7 day breaches.	
Performance Reporting	5.1	Increase from monthly to fortnightly reporting on CWT to Management Group	HG	26/06/2017	In Progress		All
	5.2	Develop CWT dashboard to support tracking and to streamline access to realtime performance data.	HH / HG / CMcM	30/06/2017	In Progress	IO attended TOG 19/5/17 and presented draft which was well received. Continued development in progress with user input.	
	5.3	Develop a report on 2ww Haemato-oncology activity / performance to enable accurate and efficient reporting of this standard in preparation for the transfer of services.	CMcM / HH	30/03/2017	In Progress	LF has escalated the data requirements from RLBUH. Jan and Feb actual patient numbers and breaches have been provided by KM (RLBUH) to HH. CMcM confirmed at TOG 12/5/17 that RLBUH have agreed to start sending data.	
	5.4	Review integration of HO pathways relating to infrastructure, tracking and performance actions.	CMcM / HH	01/07/2017	In Progress		

Breach monitoring & reporting	7.2	Develop an electronic RCA form to incorporate into EPR / Meditech	HH	31/08/2017	Planned	Request with EPR team	All
	7.3	RCAs to be themed and presented at the Trust Operational Group and at Management Group	HH	31/08/2017	In progress		All
Radiation Services	9.1	Paperless project review - Carepath	KW / LB	30/06/2017	In progress	Implementation going well. Head and Neck started May 2017.	●
	9.2	Introduce and monitor timed pathways in Radiotherapy	LB	31/03/2017	In progress	Pathways introduced, however full adherence challenged by reduction in consultant resource. Continuing escalation.	●
	9.4	Introduction of Consultant Radiographer posts (prostate, breast and palliative care) to improve capacity	KW / LB	31/12/2017	In progress		● ●
	9.5	Improve patient tracking in Radiation Services	LB/HH	30/06/2017	In progress	0.4 WTE reallocated from Access team temporarily. Business Case now approved and recruitment in progress.	●
Administration Services	10.1	Develop and implement an improvement plan for administration services to support an increase in the numbers of patients who have a first appointment within 7 days of referral to CCC (Target = 75% by September 2017)	SE / LBo	30/09/2017	In Progress		● ●
	10.4	Introduce a central referrals system	SE	31/07/2017	In progress	Processes have been agreed. 4 desktop scanners ordered. New referrals are all now being scanned into Meditech. However, the worklist on all consultants' accounts hasn't yet been made available by IM&T. SE and BT to meet to progress this.	●
	10.5	Amend the escalation policy in line with imminent changes to executive team lines of accountability.	HH	31/07/2017	Planned		●

#### Key to impact areas:

Delay to first appt  
 Delay to Radiotherapy  
 Consultant Leave  
 Admin (inc: wrong ref date)  
 Clinical Trials



## CWT Executive Lead: Barney Schofield

Back Stop Review Lead: Dr Peter Kirkbride

Area for Improvement	Item No	Action	Lead	Timescale	RAG rating	Comments
Communication	1.1	Local breach reallocation policy agreed at Cancer Managers Advisory Group.	MW / JP	Q4 16/17	Complete	
	1.2	Presented at the Executive's meeting and Trust Management Group	HG / JS	Q4 16/17	Complete	
	1.3	Integrated Performance Board Report, Team Brief & Ebulletin	HG / HH / MW	Q4 16/17	Complete	
	1.4	Gain TOG approval to feed actions through group	HH / MW	Q4 16/17	Complete	
	1.5	Meet SRG chairs to discuss impact on performance	MW / HH	30/11/2016	Complete	
	1.7	Formal communication to be planned and agreed in readiness for the formal "go live" date	JS / MW	31/03/2017	Complete	
Performance Modelling	2.1	MW to complete June & August performance modelling and detailed report to TOG	MW	Q3 16/17	Complete	
	2.2	MW & HH to complete further pathway audit to establish true impact of additional breaches	MW / HH	Q3 16/17	Complete	
	2.3	To correlate Haemato-oncology 62 day performance from RLUH with CCC existing performance for Q2 & 3 2016 & going forward to identify the expected cumulative performance position for the transfer of Haemato-oncology service to CCC in 2017.	CM / MW	01/09/2017	Complete	Q3 performance received from RLBUEH. Further data requested but not yet received. LF has escalated this. Jan and Feb actual patient numbers and breaches have been provided by Karen Mason to HH. CMcM confirmed at TOG 12/5/17 that RLBUEH have agreed to start sending data.
	2.4	To develop and agree a 62 day performance trajectory for CCC to meet the 85% threshold following the implementation of the 38 day Breach Reallocation guidance.	JS / MW / HH	23/02/2017	Complete	Presented at TMG 27th Feb 2017. Submission to NHSI re 'STF Performance Trajectory Expectations' made 31/3/17.
CWT Administration Workload & Resources	3.1	HH to speak to Sue Eagle to highlight anticipated increase in team workload	HH	Q4 16/17	Complete	
	3.2	To undertake a review of the workload of the current CWT team to assess the impact of the increase in activity as a direct result of the policy.	HH / MW	30/11/2016	Complete	
	3.4	Review the structure of the CWT team, including roles & responsibilities of the Waiting Times Manager, Waiting Times Facilitator and Pathway co-ordinators. Agree reporting arrangements to allow adequate and consistent focus on tracking, breach analysis, liaison with referring Trusts and support of the CWT tracking team.	SE / MW / HH	31/01/2017	Complete	Draft structure agreed with JS & SE (depending upon outcome of BC). Roles & responsibilities in draft.
Performance Reporting	5.2	HG & MW to liaise with CMcM to ensure weekly performance includes shadow monitoring of new Breach reallocation rules (referred by day 38, treated within 24 days of referral)	HG / MW / CMcM	30/10/2016	Complete	Weekly CWT report now includes 38 day position based on new rules.



Shadow Monitoring	6.1	HH & LC to review CWT team processes of new policy standards to enable reporting from October	HH /LC	31/03/2017	Complete	
	6.2	HH to review process for reporting breaches to Network cancer managers and obtain formal agreement at CMAG.	HH	31/03/2017	Complete	Agreed 27/2/17
Breach monitoring & reporting	7.1	To introduce a concise RCA review for every 62 day classic breach using the revised RCA form to enable continuous monitoring of themes / trends.	HH / MW	30/10/2016	Complete	Revised RCA form now in use.
	7.4	RCAs to be sent to responsible clinicians and SRGs for clinical review	HH	30/10/2016	Complete	
	7.5	Summary of performance and breach details to Management Group (Monthly)	HH/HG	26/06/2017	Superseded	
Organisational Responsibility	8.2	Develop and agree the Trust Cancer Access Policy	MW / HH / HG	31/03/2017	Complete	Access policy ratified at TOG 07.04.17
	8.3	Revise and update the Trust Escalation policy to provide clarity on the roles & responsibilities of clinical and non-clinical staff .	SE / HH / MW	31/03/2017	Complete	
Administration Services	10.2	Data validation team	SE	27/01/2017	Complete	Manager started 15.04.17, with 2 other posts now filled.
	10.3	Consultant clinic activity review	SE	27/01/2017	Complete	
Chemotherapy Services	11.1	ASM induction	LC	24/02/2017	Complete	meeting 7/3/17
Trials	12.1	PACE	LB	27/01/2017	Complete	Process reviewed
Somerset (SCR)	15.1	Icare development board - item moved to TOG action sheet	SE	27/01/2017	Complete	

<b>Key to impact areas:</b>	
Delay to first appt	
Delay to Radiotherapy	
Consultant Leave	
Admin (inc: wrong ref date)	
Clinical Trials	

