

BOARD OF DIRECTORS MEETING

Agenda Item	P1/009/18	Date: 7 th February 2018
Subject /title	Integrated Performance Report – Month 9 2017/18	
Author	Hannah Gray, Head of Performance and Planning Yvonne Bottomley, Deputy Chief Executive / Finance Director	
Responsible Director	Yvonne Bottomley, Deputy Chief Executive / Finance Director	
Executive summary and key issues for discussion		

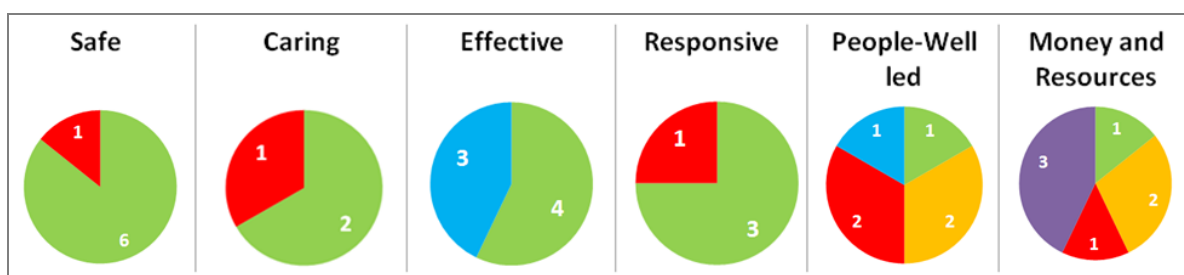
There are two parts to this report;

- The latest performance, as at end December 2017, year to date position and monthly trends.
- Further details of non-compliant KPIs

This report presents performance in 6 categories, providing an overview that enables the Board to more easily receive assurance of organisational performance. There are 3-8 metrics in each of the 6 categories, which give assurance that the organisation is delivering on each category. The choice of categories reflects the approach outlined in the Carter Report: Safe, Effective, Caring, Responsive, People: Well-Led and Money and Resources.

In summary, based on the revised pan-organisational metrics, the performance across the six categories is as follows:

December 2017



In December 2017, 17 (15 in Nov) of the 34 KPIs are green, 4 (4 in Nov) are amber, 6 (9 in Nov) are red, 4 (4 in Nov) have no target set (blue shading) and for 3, it is only appropriate to report these on a year to date basis, therefore there is no monthly figure and no associated RAG rating has been assigned (purple shading).

Year to Date 2017 2018:

<div>Safe</div> <div><div><div></div><div></div><div></div></div><div>34</div></div>	<div>Caring</div> <div><div><div></div><div></div><div></div></div><div>12</div></div>	<div>Effective</div> <div><div><div></div><div></div><div></div></div><div>331</div></div>	<div>Responsive</div> <div><div><div></div><div></div><div></div></div><div>112</div></div>	<div>People-Well led</div> <div><div><div></div><div></div><div></div><div></div></div><div>1122</div></div>	<div>Money and Resources</div> <div><div><div></div><div></div><div></div></div><div>115</div></div>
<p>Year to date (YTD), 16 of the 34 KPIs are green, 3 are amber, 10 are red, 4 have no target set (blue shading) and for 1, it is only appropriate to report this on a monthly basis, therefore there is no YTD figure and no associated RAG rating has been assigned (purple shading).</p>					
<div>Strategic context and background papers (if relevant)</div> <p>This new approach is aligned to the new Trust governance structure.</p>					
<div>Recommended Resolution</div> <p>The Trust Board are asked to:</p> <div>a. Note Trust performance and associated actions for improvement, as at the end of December 2017</div>					
<div>Risk and assurance</div> <p>The report is part of the overall Trust Performance Management System, providing assurance to the Trust Board. The section on exceptions outlines any risks to achievement of targets.</p>					
<div>Link to CQC Regulations</div> <p>Regulation 12: safe care and treatment Regulation 17: good governance Regulation 18: staffing</p>					
<div>Resource Implications</div> <p>N/A</p>					
<div>Key communication points (internal and external)</div> <p>Communicated with internal senior management team for information and action where appropriate.</p>					
<div>Freedom of Information Status</div> <div><div><div>FOI exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.</div><div><div>Application Exemptions:</div><div><div>Prejudice to effective conduct of public affairs</div><div>Personal Information</div><div>Info provided in confidence</div><div>Commercial interests</div><div>Info intended for future publication</div></div></div></div><div><div>Please tick the appropriate box below:</div><div><div><div>X</div><div></div><div></div></div><div><div>A. This document is for full publication</div><div>B. This document includes FOI exempt information</div><div>C. This whole document is exempt under FOI</div></div></div><div><div>IMPORTANT:</div><div>If you have chosen B above, highlight the information that is to be redacted within the document, for subsequent removal.</div><div>Confirm to the Trust Secretary, which applicable exemption(s)</div></div></div></div>					

	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	<i>Working environment</i> Flexible opportunities, healthy and safe working conditions, staff support	
Quality of care and environment	X	<i>Being heard:</i> <ul style="list-style-type: none"> Involved and represented Able to raise grievances Able to make suggestions Able to raise concerns and complaints 	
Nationally approved treatments, drugs and programmes			
Respect, consent and confidentiality	X		
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

THE CLATTERBRIDGE CANCER CENTRE

TITLE: INTEGRATED PERFORMANCE REPORT – MONTH 9
2017/18

AUTHOR: HANNAH GRAY, HEAD OF PERFORMANCE AND
PLANNING
YVONNE BOTTOMLEY, DEPUTY CHIEF EXECUTIVE/
FINANCE DIRECTOR

**RESPONSIBLE
DIRECTOR:** YVONNE BOTTOMLEY, DEPUTY CHIEF EXECUTIVE/
FINANCE DIRECTOR

FOR: DISCUSSION / DECISION

1. INTRODUCTION

There are three parts to this report;

- The latest performance, as at end December 2017, year to date position and monthly trends.
- Further details of non-compliant KPIs

This report presents performance in 6 categories, providing an overview that enables the Board to easily receive assurance of organisational performance. There are 3-8 metrics in each of the 6 categories, which give assurance that the organisation is delivering on each category. The choice of categories reflects the approach outlined in the Carter Report: Safe, Effective, Caring, Responsive, People: Well-Led and Money and Resources.

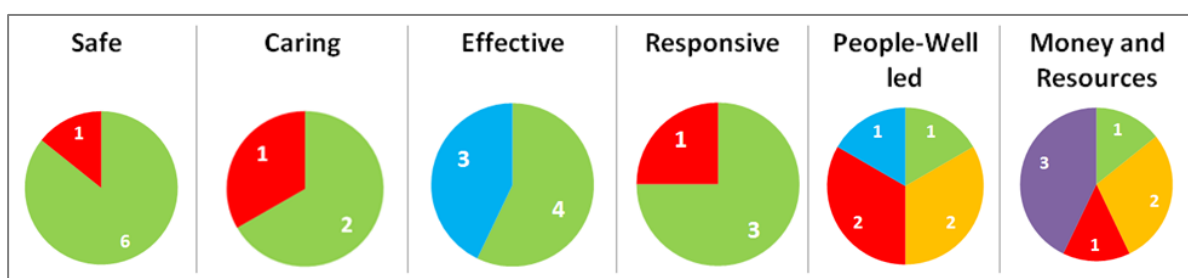
Performance is displayed for 34 appropriately categorised key performance indicators (KPIs). As well as the core list of 34, there are a further 35 KPIs (including 15 tumour group specific 62 Day Cancer Waiting Times KPIs) which we have identified as 'alert' KPIs. These KPIs will not be routinely reported in the core IPR each month but will be shown as alerts when they meet set criteria.

2. LATEST PERFORMANCE

Attached at Appendix 1 is a copy of the Trust Board Performance Dashboard for December.

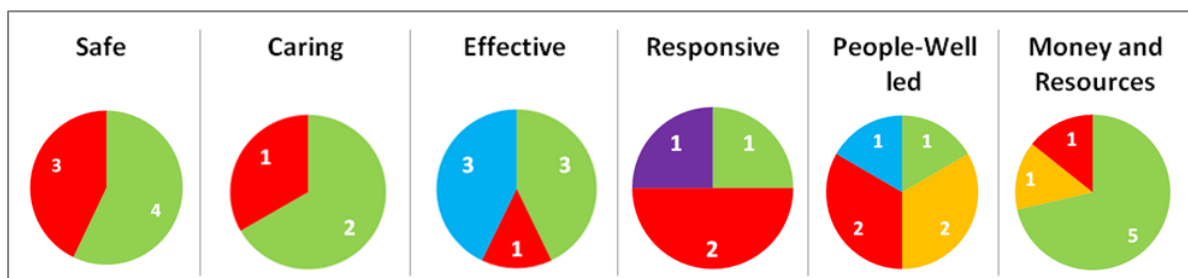
In summary, the performance across the six categories contained in the Dashboard is as follows for the month of December 2017 and 2017/18 year to date. The performance trend chart shows how many KPIs have been 'green' each month in total and per category.

December 2017



In December 2017, 17 (15 in Nov) of the 34 KPIs are green, 4 (4 in Nov) are amber, 6 (9 in Nov) are red, 4 (4 in Nov) have no target set (blue shading) and for 3, it is only appropriate to report these on a year to date basis, therefore there is no monthly figure and no associated RAG rating has been assigned (purple shading).

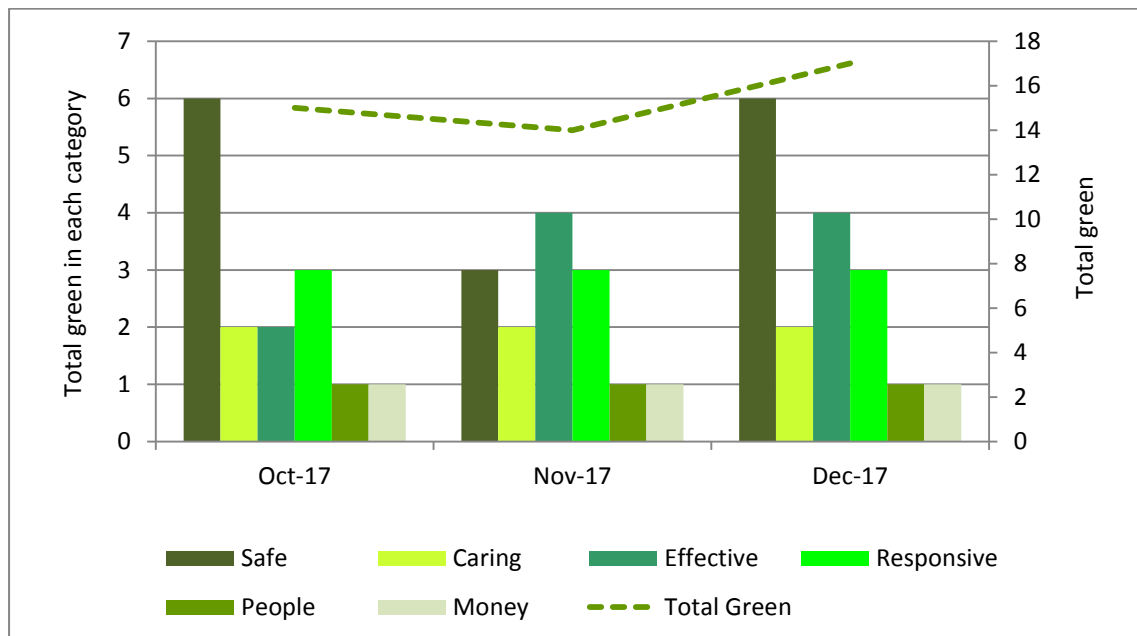
Year to Date 2017 2018:



Year to date (YTD), 16 of the 34 KPIs are green, 3 are amber, 10 are red, 4 have no target set (blue shading) and for 1, it is only appropriate to report this on a monthly basis, therefore there is no YTD figure and no associated RAG rating has been assigned (purple shading).

Performance Trend

The performance by month; total green KPIs in each category and total across all, since October 2017 is as follows:



NB: There have been changes to the numbers of KPIs reported monthly since October. This chart excludes KPIs which are no longer reported monthly.

3. DETAIL OF NON-COMPLIANT KPI'S

For each non-compliant KPI, and for those KPIs which are showing a deteriorating trend towards non-compliance, this section outlines, the reason for non-compliance, details of actions taken, a trajectory for improvement, details of the relevant forums providing assurance and the accountable Executive lead.



Of the 7 KPIs in the **Safe** category, 1 is red as follows:

VTE: Risk assessment compliance

Compliance	The target of 95% has been narrowly missed in 3 of the last 12 months;
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trend	94.9% in September 2017, 94% in November 2017 and 94% in December 2017.
Reason for non-compliance	<p>The patients not assessed in December were as follows:</p> <ul style="list-style-type: none"> Although fewer than last month, some 'treat and transfer' patients were not assessed. A number of patients were admitted as emergencies but then discharged within a few hours. One patient was admitted onto Meditech in error and then removed.
Action Taken	The Ward Manager will reinforce to staff that this group of patients are to be included in the VTE risk assessments pending discussion at the March VTE group regarding extending the excluded cohort of patients to include treat and transfer patients. Commissioners will be consulted prior to any change.
Timescale for Improvement	March 2018
Assurance provided by	Quality and Safety Sub Committee / Quality Committee
Executive Lead	Helen Porter, Director of Nursing and Quality



Of the 3 KPIs in the **Caring** category, 1 is red as follows:

Complaints	
Compliance trend	The target of 0 has been missed in 11 of the last 12 months; with non-compliant figures ranging from 1 to 4 complaints per month.
Reason for non-compliance	22 formal complaints have been made since 1 st April 2017 against a target of 0. No trends have been identified.
Action Taken	Action is taken specific to each complaint where appropriate, however due to a lack of themes, no overarching actions have been identified and pursued.
Timescale for improvement	
Assurance provided by	Quality and Safety Sub Committee / Quality Committee
Executive Lead	Helen Porter, Director of Nursing and Quality



Of the 7 KPIs in the **Effective** category, 0 are red



Of the 4 KPIs in the **Responsive** category, 1 is red as follows:

62 Day Waiting times - classics (pre allocation)	
Compliance trend	The pre allocation target is consistently not achieved. In 2016, NHSI and NHSE published guidance which stated that Trusts should adopt a new '38 day' post allocation approach from April 2017. This was implemented at CCC and at many other Trusts however Trusts continue to be monitored against both pre and post allocation performance.
Reason for non-compliance	We are not meeting the 'pre allocation' target, largely due to the significant numbers of patients referred late to CCC by other Trusts. However, we have seen a significant improvement in our post reallocation performance and have exceeded the 62 day target every month since October 2017.
Action Taken	<p>Two key actions have contributed to the improved post reallocation position, they are;</p> <ul style="list-style-type: none"> Over 90% of patients on a 62 day pathway are now seen within 7 days of CCC receiving the referral. Radiation services have made several changes to the planning pathway that has resulted in shorter waiting times to treatment start dates. <p>We continue to work closely with NHSE and the Cancer Alliance to support the reduction of late referrals from referring Trusts that in turn will help improve our performance.</p>
Timescale for improvement	We do not expect to achieve 85% for January 2018 due to the number of patients that choose to delay treatment until after the festive period. Our ability to achieve 85% pre allocation is significantly dependent on the performance of referring Trusts, therefore until system changes are made there, we will not achieve the target.
Assurance provided by	Trust Operational Group / Operational Delivery & Service Improvement Sub-Committee / Finance and Performance Committee
Executive Lead	Barney Schofield, Director of Operations and Transformation



Of the 6 KPIs in the **People – Well led** category, 2 are red as follows:

Staff Sickness	
Reason for non-compliance	The Trust's absence figure is 4.47% for the month of December 2017. In December 2017, cold, cough, flu was the highest reason for absence followed by gastrointestinal. Stress related absence continues to be one of the top three reasons for absence.
Action Taken	<ul style="list-style-type: none"> The Trust's Attendance Management policy is currently being reviewed to ensure that the Trust's current triggers and overall process is fit for purpose. The use of the ESR system is also being reviewed to ensure the Workforce and Organisational Development (WOD) department are effectively recording and reporting sickness absence, with the aim of improving the use of accurate data in order to target support and management action. In 2018 there will be added focus on health and wellbeing initiatives and the possibilities of additional staff benefits to support staff to remain in work. The WOD team will also be visiting the Christies team to learn how they manage and maintain attendance.
Trajectory for improvement	Amber: 3.6% - 3.9% - April 2018 Green: <3.5% - September 2018
Assurance provided by	Workforce Sub Committee / Quality Committee
Executive Lead	Andrew Cannell, Chief Executive

Staff Turnover	
Reason for non-compliance	Turnover has increased slightly for December 2017 from 12.1% to 12.6%; this remains above the Trust target of 12%. This has been impacted by the decommission of the NATCANSAT Team. Removal of this from the overall turnover figure reduces it to 12.1%
Action Taken	<p>The HR team continue to encourage managers to ask staff to complete exit interviews when leaving the Trust. HR Advisors along with the Workforce team are also ensuring that staff is invited to take part in the exit interview process by sending a separate email.</p> <p>This process will be reviewed in 3 months to see if there has been an increase in the number of responses.</p>
Trajectory for	The threshold of 12% is under review and likely to be adjusted in light of

improvement	the upcoming period of significant organisational change.
Assurance provided by	Workforce Sub Committee / Quality Committee
Executive Lead	Andrew Cannell, Chief Executive Officer



Of the 7 KPIs in the **Money and Resources** category, 1 is red as follows:

Capital Spend v Plan	
Reason for non-compliance	Capital expenditure is £13,290k against a plan of £31,497k, a variance of £18,207k. The underspend is due mainly to slippage on the Building for the Future project as a result of the stage 4 contract sign off.
Action Taken	NHSI have been informed and a revised forecast outturn has been submitted as part of the Trust's monthly returns to NHSI.
Timescale for improvement	The revised capital expenditure forecast for the full year is £21,424k and the Trust is on target to deliver this revised forecast.
Assurance provided by	Finance Sub-Committee / Finance and Performance Committee
Executive Lead	Yvonne Bottomley, Director of Finance and Deputy Chief Executive

4. DETAIL OF ALERT KPIs

These KPIs are not routinely reported in the core dashboard each month but will be shown as alerts when they meet set criteria. All of the alert KPIs are reported routinely to the relevant committee below Trust Board at various levels of granularity.

For December the following Alert KPIs are red and drawn to the Board's attention.



'Alert' KPIs:

- **Radiotherapy Activity (% growth YTD) and Inpatient Activity (% growth YTD)**
- **Agency Medical Locum Spend**

Radiotherapy and Inpatient Activity

Compliance trend	Activity has been below plan since June 2017, when there was a significant drop in activity in these areas.
Reason for non-compliance	Key issues include: <ul style="list-style-type: none"> • In-patients – reduced excess bed days and LoS reduction • RT – impact of hypofractionation
Action Taken	<ul style="list-style-type: none"> • Data extraction scripts from Aria have been amended and underperformance expected to reduce by 3.7% per month.
Timescale for improvement	TCC activity model being refreshed, future bed and RT capacity requirements to be reviewed in the light of this.
Assurance provided by	Operational Delivery & Service Improvement Sub-Committee / Finance and Performance Committee
Executive Lead	Barney Schofield, Director of Operations and Transformation

Agency Medical Locum Spend

Compliance trend	The Trust is required to reduce its outturn locum doctor spend from £587k in 2016/17 to £511k in 2017/18. At month 9, Medical staffing spend to date is £492k and is over plan by £195k.
Reason for non-compliance	This is mainly due to spend on radiologists and based on current projections is likely to exceed the NHSI target spend by circa £200k.
Action Taken	A further 2 radiologist posts have been approved. This is unlikely to improve until the new financial year when the radiologist posts are filled.
Timescale for improvement	Finance Sub-Committee / Finance and Performance Committee.
Assurance provided by	Finance Sub-Committee / Finance and Performance Committee.

Executive Lead	Yvonne Bottomley, Director of Finance and Deputy Chief Executive.
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5. CARE HOURS PER PATIENT PER DAY (CHPPD)

It is a mandatory requirement that this information is presented to Trust Board. Whilst the Trust captures this information, monitors trends and compares across wards internally, external benchmarking will not be possible until access to other Trusts' data becomes available. This is likely to be accessible in the future via NHS Improvement's Model Hospital resource.

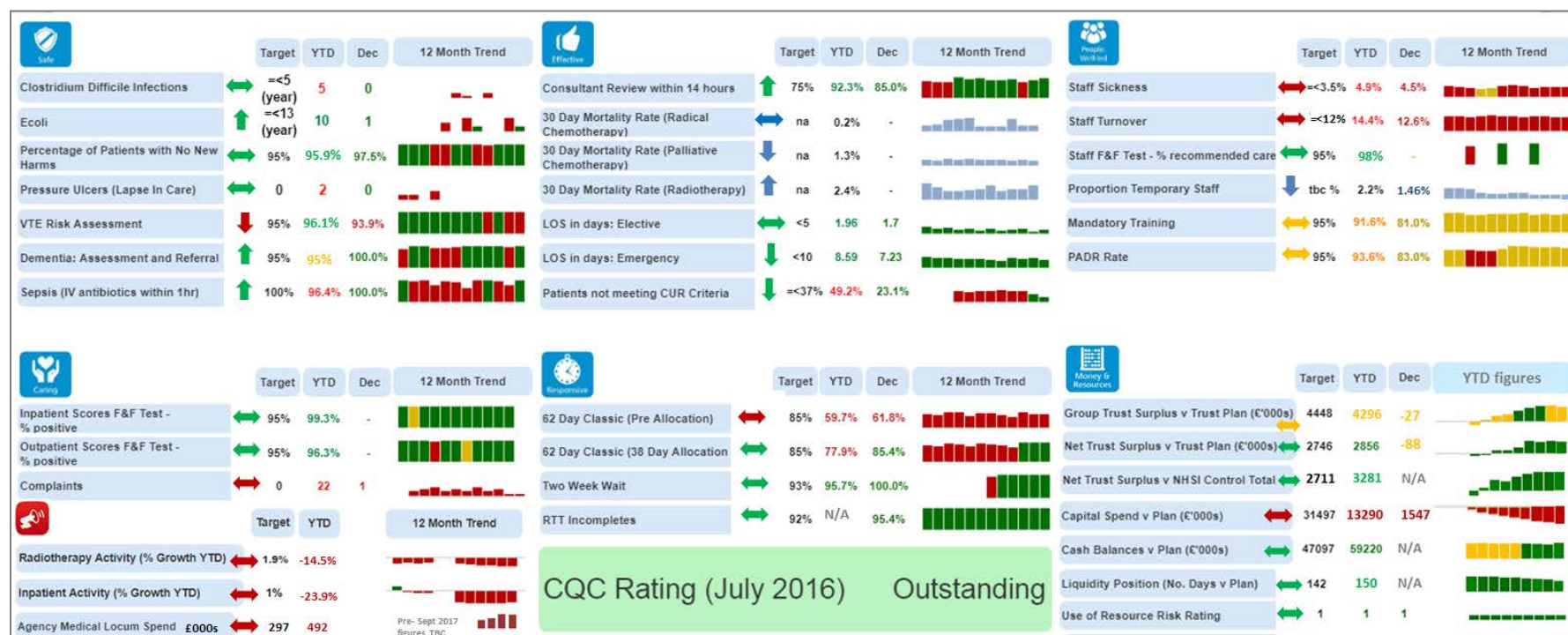
Key Performance Indicator	Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Care hours per patient day: Conway Ward	Awaiting	5.9	6.0	6.0	6.2	6.2	7.5	7.2	6.5	6	6.5	6.2	6.1
Care hours per patient day: Sulby Ward	inclusion	7.3	7.4	7.3	9	10	11.7	14.4	9.6	11	16.6	15.2	19
Care hours per patient day: Mersey Ward	of KPI in	6.6	6.7	6.3	7.3	7.4	8.4	8.4	7.9	7.1	7.4	6.8	7.4
Care hours per patient day: 7Y	'Model							6.1	6.3	6.2	6.7	6.3	5.6
Care hours per patient day: 10Z and 7X	Hospital'							12.2	12.8	12	12.5	13.5	14.3
	Portal												

6. RECOMMENDATIONS

The Trust Board members are asked to:

- Note Trust performance and associated actions for improvement, as at the end of December.

APPENDIX 1: TRUST BOARD PERFORMANCE DASHBOARD FOR DECEMBER 2017



Key points to note:

- The dashboard shows the performance over the six categories for the latest month and year to date (YTD) where appropriate, against the target.
- The bar charts show the RAG rated performance per month for the last 12 months including October (the exception being 'Money and Resources' charts which show YTD).
- The alert KPIs are shown in the bottom left corner; all those which are 'red' for December 2017 have been included in the exception report.
- Not all data is inclusive of Haemato-oncology (HO), data which continues to be monitored by HO; systems are being developed to include this for all KPIs.
- External benchmarking information will be introduced as and when meaningful comparisons can be made.
- The target of 37% for Patients not meeting the CUR criteria is to be achieved by 31st March 2018, rather than in every month.
- Although an exception table for Agency Medical Locum spend was presented in the month 8 report, the data was omitted from the dashboard in error.