

BOARD OF DIRECTORS MEETING

Agenda Item	P1-091-18	Date: 25 th July 2018
Subject /title	Integrated Performance Report – Month 3 2018/19	
Author	Hannah Gray, Head of Performance and Planning	
Responsible Director	Barney Schofield, Director of Operations and Transformation	
Executive summary and key issues for discussion		
Introduction The purpose of this integrated performance report is to provide assurance to the Finance & Business Development Committee and the Board that the strategic objective “Maintain excellent quality, operational and financial performance” is met, and highlight emerging risks and appropriate actions to mitigate the risks. The Board development plan recognised the need to produce an integrated quality, operational and financial report to best fit our aim to retain an outstanding rating by the CQC and NHSI and this report continues to develop to fulfil that purpose.		
Overall Core Performance Overall, the Trust is performing well in many areas, including 62-day cancer waits (post-allocation) however, there are a number of key metrics which have not been achieved. The Trust has not met all the CQUIN requirements for 2017/18. More robust systems have been implemented to monitor progress and drive improvement in 2018/19, with the Quality and Safety Sub Committee overseeing their delivery. There are risks to achieving the Enhanced Supportive Care and Holistic Needs Assessment / End of Treatment Summaries CQUINs for Q1.		
Safe Following improved compliance against VTE assessment and Sepsis in May, the targets have not been met for June. Dementia assessment compliance continues to be below the target. The exception tables within the report detail the actions identified to improve performance in each case.		
Caring Whilst the Friends and Family Test (FFT) results have been above the 95% target since August 2017, the inpatient response rates are well below the 30% target. Work is underway to digitise the FFT process using hand held devices, enabling easier capture, analysis and reporting of this feedback. This will be fully operational by August 2018. There were three complaints in June.		
Effective		

The Trust is developing further Clinical Outcome information via the SRGs, which will be included in this report when available.

The Trust is 82% compliant with NICE Guidance. A NICE Committee has recently been established to expedite implementation; prioritising guidance for which non-compliance presents the greatest risk to patients.

Responsive

The Trust has met the 62 Day standard (post allocation) in every month except January, since October 2017.

Bed occupancy and delayed transfers of care are currently being reviewed by the ICD Matron; a report will be presented at the Senior operational team meeting for discussion on the 23rd July 2018.

Well Led

The separate Finance Report provides a more detailed focus on the Trust's Finance KPIs.

The Trust's financial position is satisfactory and the Use of Resources score (Single Oversight Framework) remains at 1 for June. PADR rates and Mandatory Training compliance are continually below the Trust's targets, although PADR compliance is expected to increase in Q2 following the Trust's annual round of PADRs in Q1 and July. The 12 month rolling staff sickness has been falling since April and the monthly figure has fallen each month since January 2018; now at 3.15% for June.

Strategic context and background papers (if relevant)

This report is aligned to the strategic objective "Maintain excellent quality, operational and financial performance"

Recommended Resolution

The Trust Board members are asked to:

- Note Trust performance and associated actions for improvement, as at the end of June 2018.
- Determine that this format of report is required for Trust Board.

Risk and assurance

This report highlights any BAF related risks and provides both assurance of performance and detail of remedial actions in place as appropriate.

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 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.

Application Exemptions:

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

Please tick the appropriate box below:

X

A. This document is for full publication

B. This document includes FOI exempt information

C. This whole document is exempt under FOI

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	X

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	X
Complaint and redress	X	Treated fairly and equally	X

THE CLATTERBRIDGE CANCER CENTRE

TITLE: INTEGRATED PERFORMANCE REPORT –
MONTH 3 2018/19

AUTHOR: HANNAH GRAY, HEAD OF PERFORMANCE AND
PLANNING

**RESPONSIBLE
DIRECTOR:** BARNEY SCHOFIELD, DIRECTOR OF OPERATIONS
AND TRANSFORMATION

FOR: DISCUSSION / DECISION

This report presents:

- Trust high level and emerging risks relating to the strategic objective “Maintain excellent quality, operational and financial performance”,
- A high level integrated dashboard, with supporting information and exception reports,
- A summary of performance against the Trust’s CQUINs,
- Detailed performance categorised into the sections: Safe, Caring, Effective, Responsive and Well Led. Benchmarked data from the Model Hospital (NHS Improvement) is presented where available and this aspect of the report will continue to be developed utilising other sources of information.

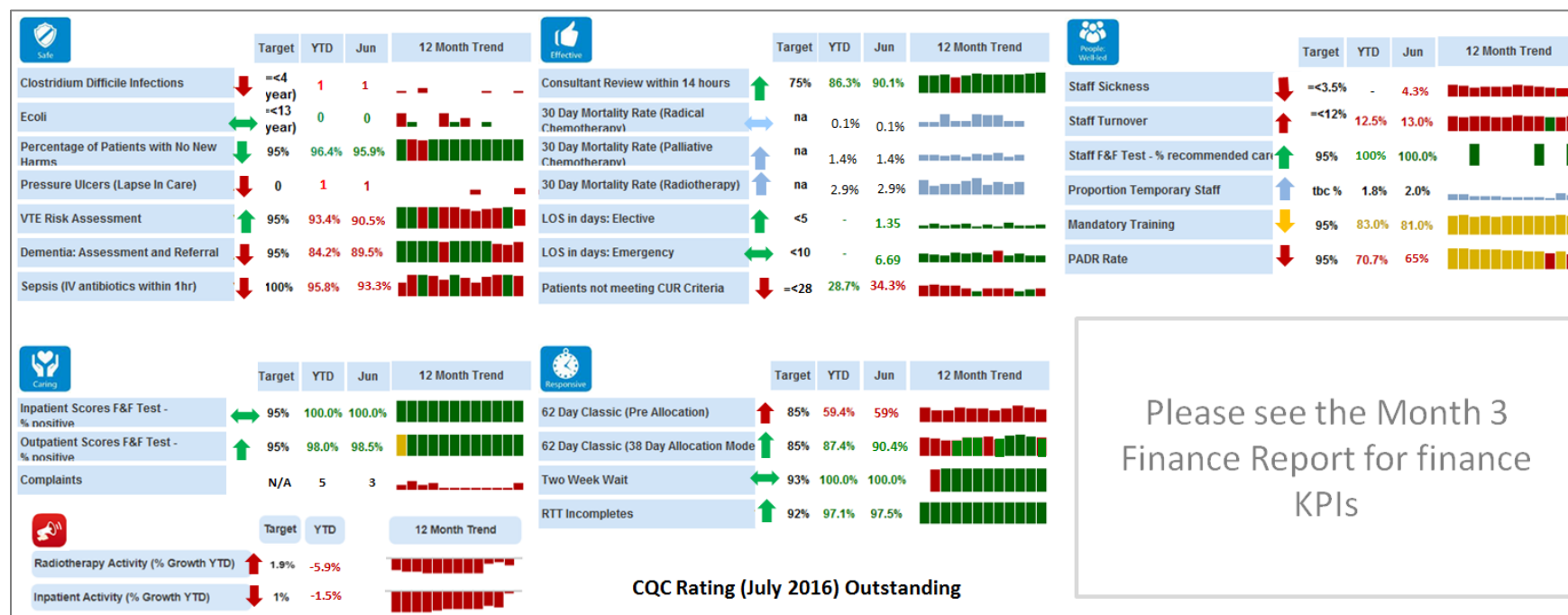
Risks

There are 21 operational risks graded 15 or above; the details are presented in section 5.3.

The 21 risks include the 3 ‘emerging risks’ that will reviewed by the Operational and Service Development Sub Committee in July:

- Risk 906: Isle of Man Service Provision Review
- Risk 893: High temperatures in HO medicines storage
- Risk 799: Reduction in medical staffing (Consultant workforce)

High Level Performance Dashboard: Month 3, YTD and 12 month trends



Key points to note:

- The complaints target of 0 has been removed with agreement from Commissioners. The Trust appreciates the value of complaints and will focus on lessons learnt, to drive improvement.
- The 30 day mortality data is for April 2018. These figures will be updated in the Month 4 report.
- The bar charts show the RAG rated performance per month for the last 12 months.
- Not all data is inclusive of Haemato-oncology (HO). However, relevant data continues to be monitored by HO and systems are being developed to integrate HO data.
- The target of 30% for Patients not meeting the CUR criteria is to be achieved by 31st March 2019, rather than in every month.

CQC Insight Composite Score

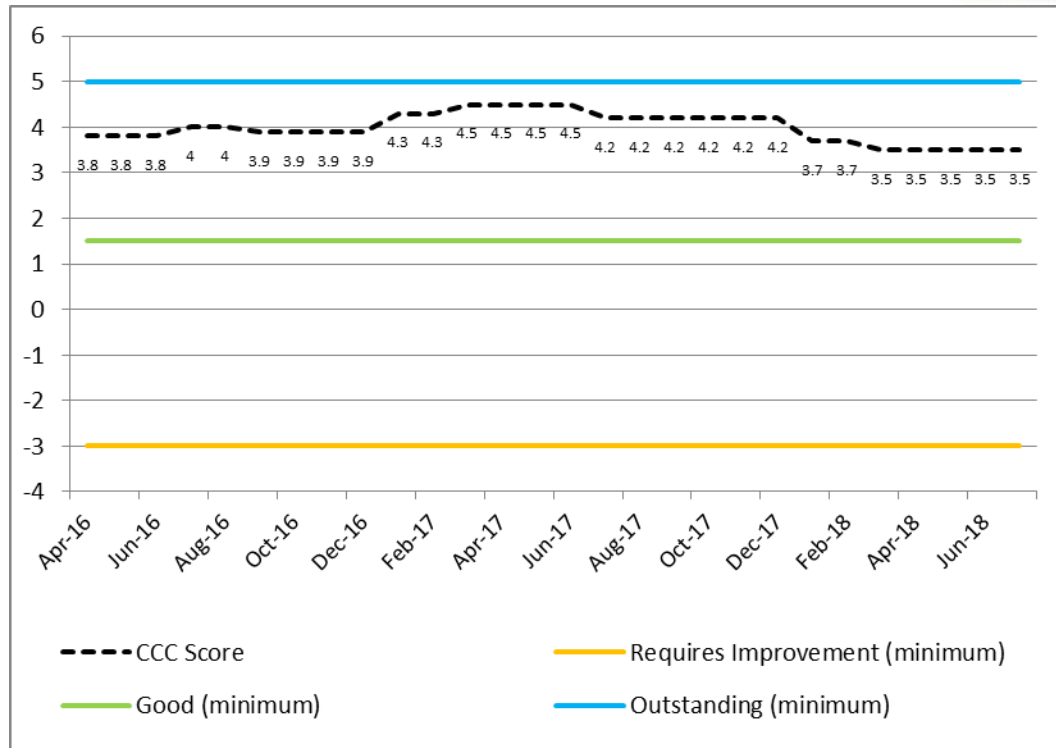
The CQC produce a monthly report 'CQC Insight' which is part of the CQC's approach to monitoring and regulating providers; it brings together all the information the CQC holds about our services. The CQC use this intelligence to help them decide what, where and when to inspect.

The report highlights how CCC compares to other Trusts and also to CCC's performance 12 months ago, against a range of indicators. KPIs in the 4 categories of particular interest are shown here (taken from the July 2018 report, however the data relates to a range of different time periods):

Much better compared nationally	Much worse compared nationally	Improved (compared to 12 months ago)	Declined (compared to 12 months ago)
<ul style="list-style-type: none"> • Ratio of consultant to non-consultant doctors • Ratio of occupied beds to nursing staff • Ratio of occupied beds to other clinical staff 	No indicators are in this category this month	<ul style="list-style-type: none"> • Patient-led assessment of food (%) • Ratio of consultant to non-consultant doctors • Staff appraised in last 12 months (%) 	<ul style="list-style-type: none"> • Inpatient response rate (%) • NRLS - Consistency of reporting • Overall engagement (1-5) • Patient-led assessment of facilities (%) • Patient-led assessment of privacy, dignity, and well-being (%) • Ratio of delayed transfers and number of occupied beds • Ratio of occupied beds to medical and dental staff • Ratio of senior staff nurses to staff nurses • Ratio of ward manager nurses to senior and staff nurses

The Trust has developed an action plan to improve performance in the areas in which we have 'declined' and this is being led by the Quality Committee. Due to the annual nature of reporting, the benefit of our improvement work is unlikely to be reflected in the CQC insight report until 2019.

This chart shows CCC's composite indicator score* per month and the minimum value of the range for each rating (e.g. 'Good' is between 1.5 and 5). This is not a final rating, rather it indicates how the composite score compares to trusts being awarded these final ratings. CCC have had a composite score similar to that of Trusts rated as 'Good', since April 2016. CCC's composite score was 3.8 when the Trust was last inspected in June 2016.



*The trust composite is a pilot indicator created from 12 specific indicators within Insight. The composite indicator score helps to assess a trust's overall performance but it is not a rating, nor a judgement. The composite should be used alongside other evidence in monitoring trusts' (extract from CQC Insight reports).

CQUINS

The Trust's performance against the CQUINs deteriorated significantly in 2017/18, with commissioners finding non-compliance or partial compliance for 3 (potentially 4, with 1 still to be confirmed) CQUINs. The detail, including expected performance for Q1 2018/19 is shown in the table below.

Commissioners will withhold a maximum (subject to confirmation of achievement on 1 CQUIN) of £402,102 out of a possible £1,384,011 available, which equates to 23% of the CQUIN monies.

More robust systems have now been implemented to monitor and improve performance in 2018/19. CQUIN details (including a performance projection for 2018/19) are included in the recently developed Directorate 'data packs' which will be presented at the monthly Directorate meetings. Risks to achievement will be escalated to the relevant Sub Committee and added to the risk register as appropriate.

The CQUINs for 2018/19 have been agreed with Commissioners as below. These are the same as in 2017/18, with an additional one of 'Preventing ill health by risky behaviours – alcohol and tobacco', which NHSE has extended to all providers for 2018/19.

CQUIN	Value	Withheld	2017/18				2018/19
			Q1	Q2	Q3	Q4	Q1
Staff Survey: Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing; MSK and stress.	£23,253	£23,253					
Healthy food for NHS staff, visitors and patients	£23,253	TBC					
Improving the uptake of flu vaccinations for frontline clinical staff (target 70% by 28 th February 2018)	£23,253	£0					
Preventing ill health by risky behaviours – alcohol and tobacco: inpatient screening, advice, referral and medication							
Holistic Needs Assessment and End of Treatment Summaries	£354,031 (NHSE) £69,758 (LCCG)	£255,066					
Clinical Utilisation Review: Installation and Implementation of software; reduction in inappropriate hospital utilisation and reporting of results	£469,294	£0					
Enhanced Supportive Care: Ensuring patients with advanced cancer are, where appropriate, referred to a Supportive Care Team, to secure better outcomes and avoidance of inappropriate treatments.	£321,095	£95,442					

Optimising Palliative Chemotherapy: To ensure systematic review of further chemotherapy decisions for patients with poor clinical response. To ensure effective Mortality Review processes are in place.	£189,364	£0					
Medicines Optimisation: Funded pharmacist change programme to optimise use of high cost drugs: adoption of bio-similars and generics; improved drug data quality; utilising most cost-efficient dispensing cost channels; compliance with policies/guidelines, so to tackle variation & waste	£123,498	TBC				T B C	
Dose Banding: Standardise the doses of SACT in all units across England in order to increase safety, to increase efficiency and to support the parity of care across all NHS providers of SACT	£189,364	£0					

Key:

Full shaded denotes confirmed level of achievement / payment: R=none, A=partial, G=full
Diagonal lines R,A,G denotes expected but yet to be confirmed level of achievement.

CQUIN Exception Reports

The Risky Behaviours CQUIN expected Q1 compliance has been set at amber as a precaution as this is the first time the Trust will report on progress to Commissioners.

The Trust is checking data provided for the Medicines Optimisation CQUIN and confirmation of compliance for Q4 will be provided in the Month 4 report.

As there are multiple targets, improvement requirements and trends for CQUINs, these are not shown in the exception reports below.

Enhanced Supportive Care

Reason for non-compliance

The ESC service has not been fully integrated into patient pathways. Referrals across tumour groups are inconsistent depending on perceived benefits and engagement with the purpose of the service. This has resulted in low rates of referral for some patient groups, below the expected CQUIN target.

Action Taken to improve compliance

Actions to improve compliance include:

- Raising awareness of the service with consultants, CNS workforce, and medical secretaries to improve referral rates

- Changes to referral process to make as simple as possible
- Locum Palliative Care Consultant due to start in post October 2018, which will increase capacity to see referred patients and improve engagement with the service
- Production of action plan to identify key actions to improve compliance
- A pool of 11 'Cancer Support Workers' are in the process of being recruited (utilising a variety of funding streams); these posts will primarily support the Holistic Needs Assessment CQUIN, but also facilitate aspects of the requirements of the Optimising Palliative Chemotherapy and Enhanced Supportive care CQUINs. These roles will work across all hubs, which will help increase access across geographic footprint
- A meeting is being arranged for the leads of the Holistic Needs Assessment, Optimising Palliative Chemotherapy and Enhanced Supportive care CQUINs to ensure a joined up approach to these initiatives and drive improvement in those with which we are not compliant.
- Discussions with commissioners are planned to ensure clarity on expectations for year 3 of the CQUIN; with particular focus on agreeing local target

Expected date of compliance	Q3 2018/19
Escalation route	Directorates / Quality and Safety Sub Committee / Quality Committee
Executive Lead	Sheena Khanduri, Medical Director

Holistic Needs Assessment and End of Treatment Summaries

Reason for non-compliance

The required number of Holistic Needs Assessments were not completed in Q2,3 and 4 initially due to systems not being implemented within the timescales and then due to staff absence.

Action Taken to improve compliance

- A pool of 11 'Cancer Support Workers' are in the process of being recruited (utilising a variety of funding streams); these posts will primarily support the Holistic Needs Assessment CQUIN, but also facilitate aspects of the requirements of the Optimising Palliative Chemotherapy and Enhanced Supportive care CQUINs. These roles will work across all hubs, which will help increase access across geographic footprint.
- A meeting is being arranged for the leads of the Holistic Needs Assessment, Optimising Palliative Chemotherapy and Enhanced Supportive care CQUINs to ensure a joined up approach to these initiatives and drive improvement in those with which we are not compliant.

Expected date of compliance	Q3 2018/19
Escalation route	Directorates / Quality and Safety Sub Committee / Quality Committee

Executive Lead	Sheila Lloyd, Director of Nursing and Quality
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Clinical Utilisation Review

Reason for non-compliance

The % of un-met criteria for June has risen to 34%. The reasons for non-compliance are:

- 1) Clinical assessment: increase in number of complex referrals and MSCC patients for physiotherapy has resulted in assessment delays
- 2) Consultant decision: awaiting consultant decision and decision taken to keep patient in the bed
- 3) Awaiting diagnostic test: patients waiting for diagnostic tests required. This includes delays in results from external providers
- 4) Patient / family decision: refusal to accept discharge
- 5) Package of care: awaiting social care package

Action Taken to improve compliance

CUR Project Nurse is meeting with AHP teams to put an action plan in place to address assessment delays.

Recognition of limitations of the previous CUR software has resulted in a transition to a new software supplier from 1st July. The change in CUR software will allow greater level of information, improved data manipulation and understanding of the reasons for un-met criteria. This will support proactive bed management and patient discharge planning.

Expected date of compliance	July 2018
Escalation route	Directorates / Quality and Safety Sub Committee / Quality Committee
Executive Lead	Sheena Khanduri, Medical Director

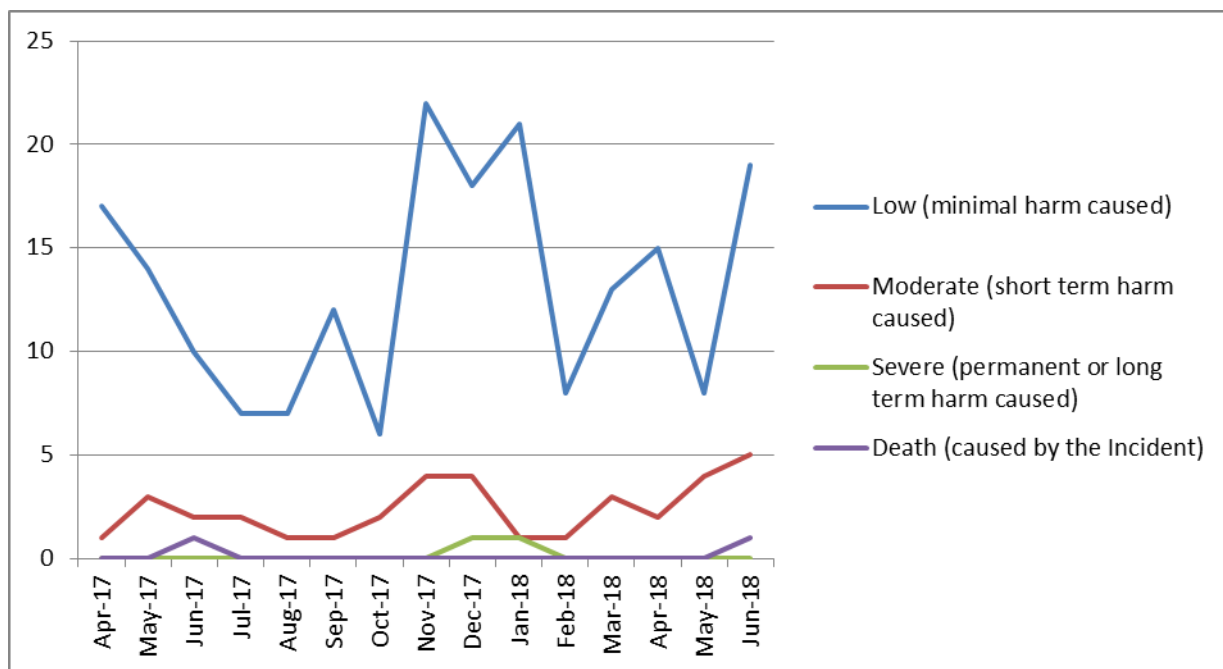
1. Safe

1.1 Never Events

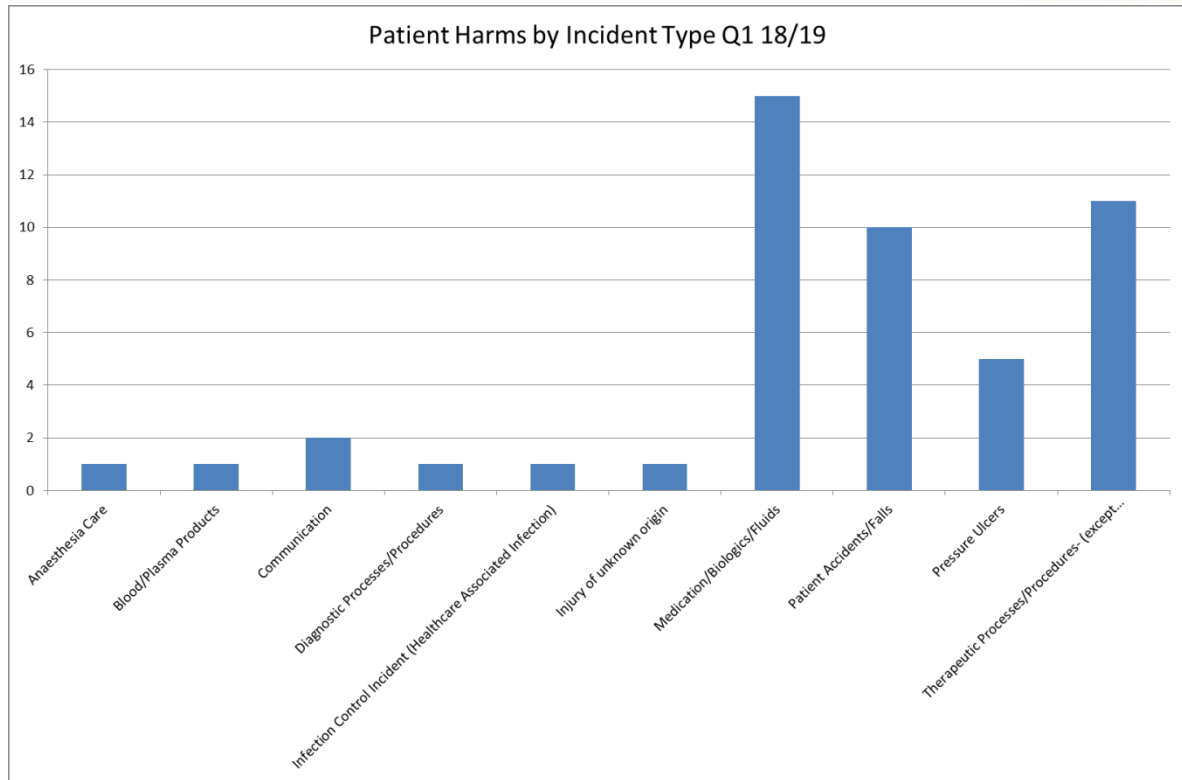
There were 0 never events in 2017/18 and 0 in April or May 2018.

1.2 Incidents

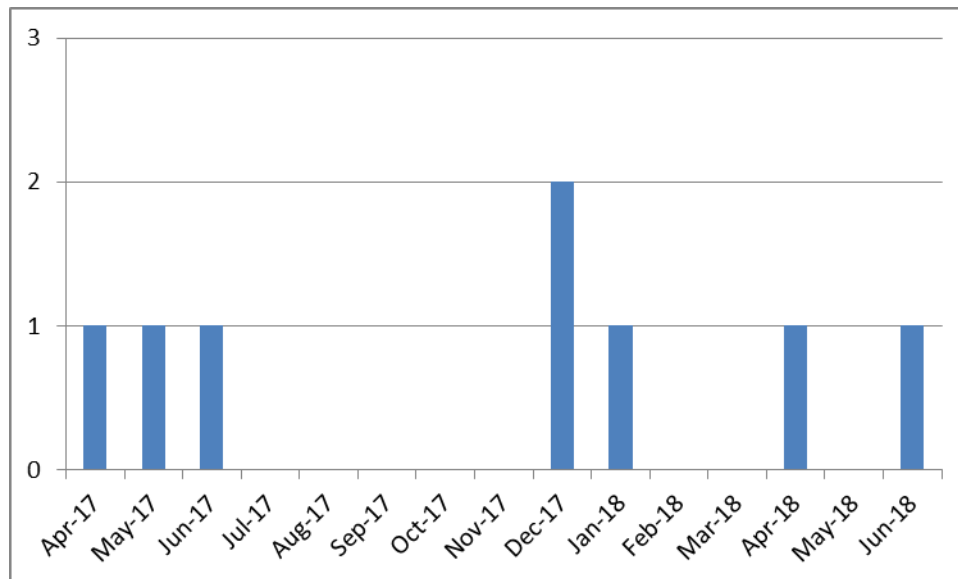
Incidents resulting in harm (by level of harm):



Incidents resulting in harm (by category for Q1):



Serious untoward incidents:



The 2 serious incidents in June 2018 have been reported to Steis:

ID 3338 Contrast medication incident – potential reaction to contrast administered as part of radiotherapy planning scan.

Patient attended for radiotherapy planning scan, she was cannulated and given 10ml saline x 2 prior to the scan and 55ml Optiray 300 at 1ml/sec during the scan. No problems with the contrast or scan reported by the patient. The CT scan was completed and another 10ml saline was given to flush the cannula, and the cannula was removed. The patient was taking deep breaths and on questioning, she reported having panic attacks. The patient was reassured that the scan was finished and she could relax and to keep taking deep breaths. She said she was panicking about getting up off the bed but with support she sat up no problem and sat on the end of the bed for a couple of minutes to get her bearings. She said she felt ok and walked over to the chairs. She was offered a cup of water but declined. She sat for a few seconds and then said that she was struggling to breathe. She was asked if she ever experienced that before to which she replied no.

Doctor came straight through and the patient was sat on the chairs breathing and talking but clearly distressed, she kept stating she couldn't breathe. One of the radiographers went for the Obs machine and a call for the met team was made. Patient was with Doctor and Radiographer when she stated she still couldn't breathe and slumped over as she was clutching onto them. Doctor asked for oxygen which was applied via mask. A crash call was made and the crash trolley was brought to the scanner. The patient then slumped forward and the doctor and radiographer helped to lower her to the floor. As this happened the MET team arrived. A pulse could not be detected and compressions were started. The patient was transferred to Arrowe Park Hospital where she later died.

Initial investigation findings:

Initial review has shown that all procedures regarding the scan and administration of contrast were followed correctly. Coroner's investigation underway and reports are being prepared by staff. Serious incident panel to be held.

ID 3555 Blinatumomab medication incident – Incorrect rate of administration

Date of incident: 27/06/2018

Brief Description of incident:

Patient receiving Blinatumomab at a rate of 3.3ml/ hour 72 hour infusion started 25/06/2018 15:25. At 14:25 on the 27/06/2018 the rate was changed in error to 50 ml/hour this was identified by the patient who alerted staff. Infusion immediately stopped, reassurance given to patient. Observations taken. On call registrar informed who after discussing with pharmacist advised to disconnect patient without flushing PICC line it was going through. repeat bloods taken at 22:00 hourly observation taken until 22:00 and 2-hourly observations throughout the night. No Harm to patient observed, it should be noted that this chemotherapy has a short half-life 6 -12 hours. Chemotherapy restarted 28/06/2018 16:30.

Initial investigation findings:

Review of the pump software log shows that the rate of administration was changed from 3.3ml/hour to 50ml/hour. From a safety perspective the matron has implemented additional pump checklists for staff which will be reviewed hourly. The pumps have also been separated and administration lines have been labelled to try to make things easier for staff and thus avoid further confusion or room for error. Serious incident panel to be held on 19/7/18.

Inquests/Coroner's investigations

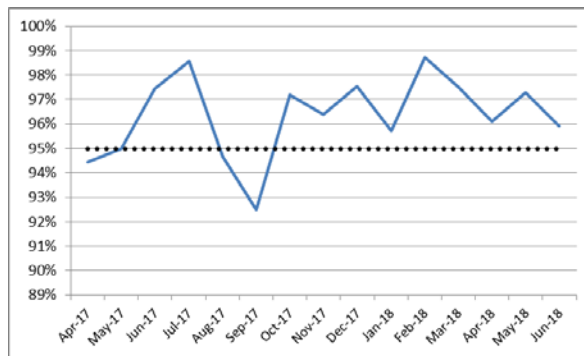
One inquest has been concluded and 2 new Coroner Investigations have been opened.

Inquest Number	Date of Request	Coroner	Date of Inquest	Staff requested to attend	Conclusion
2018/01	8/1/18	Warrington	22/6/18	No	Industrial Disease
2018/02	23/2/18	North Wales	17/7/18	No	
2018/04	28/6/18	Liverpool/Wirral			
2018/05	13/7/18	Liverpool/Wirral			

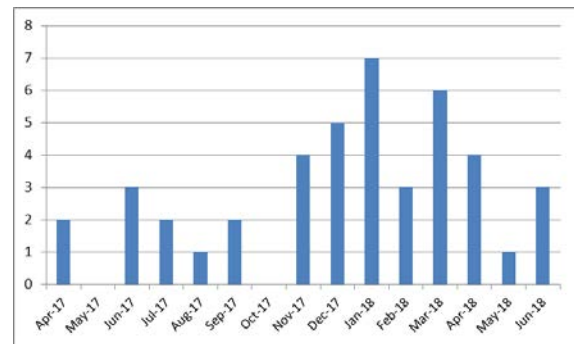
1.3 Harm Free Care

The dotted line represents the target (where one has been set).

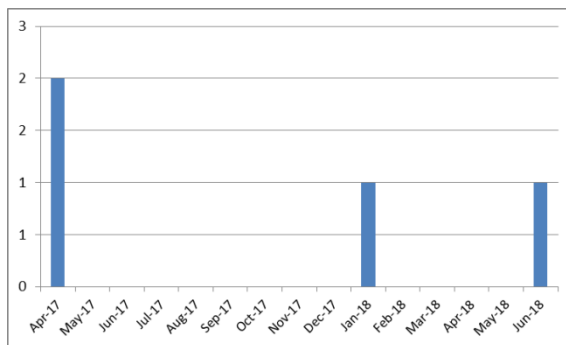
Safety Thermometer (CCC harm free)



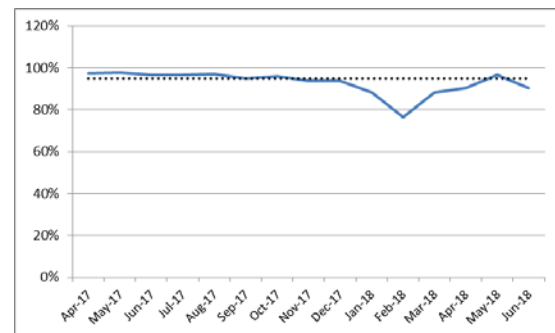
Falls resulting in harm



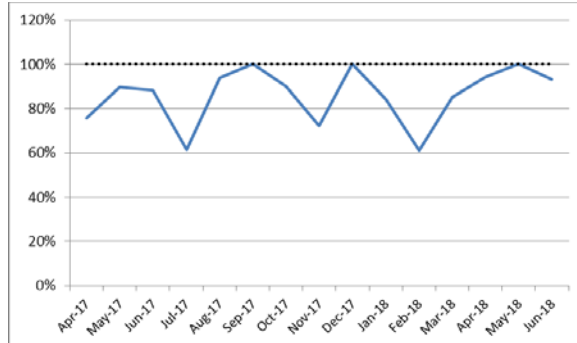
Pressure Ulcers (attributable) | Target = 0



VTE assessment



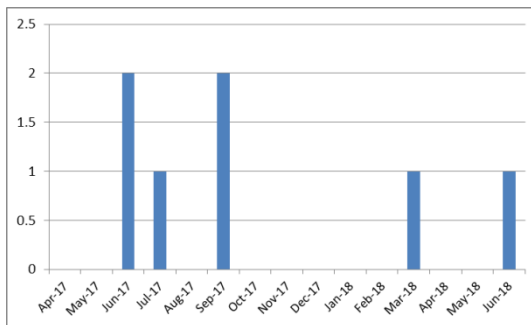
Sepsis (IV Antibiotics with 1 hr)



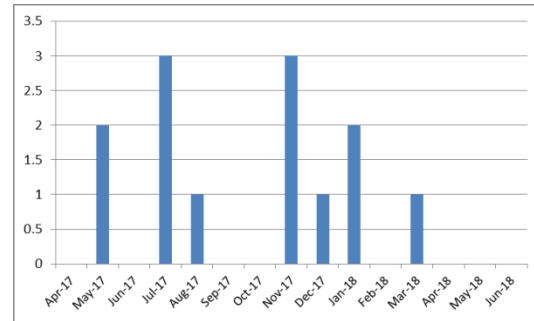
MRSA

There were 0 cases of MRSA in 2017/18 and 0 in Q1 2018/19.

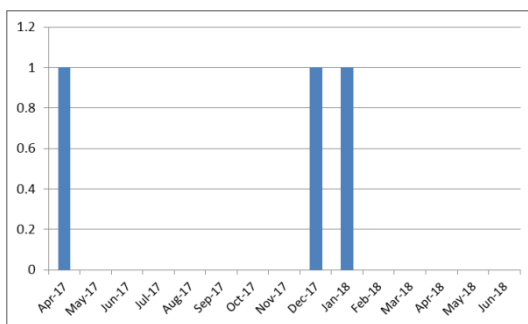
C difficile | Threshold for 2018/19 =<4



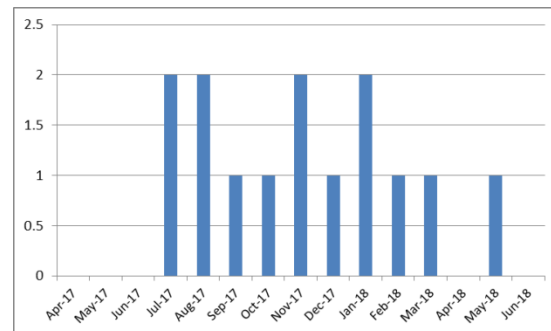
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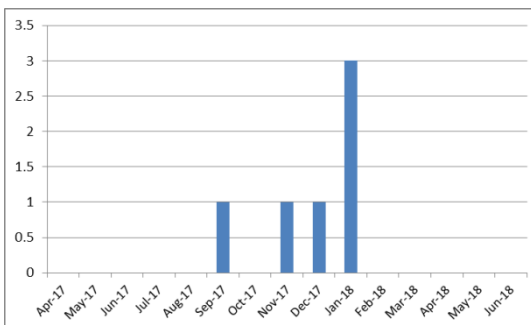
MSSA



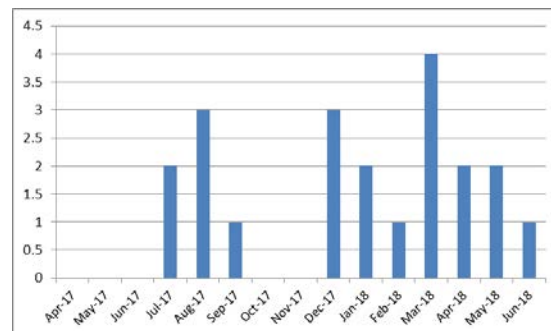
Klebsiella



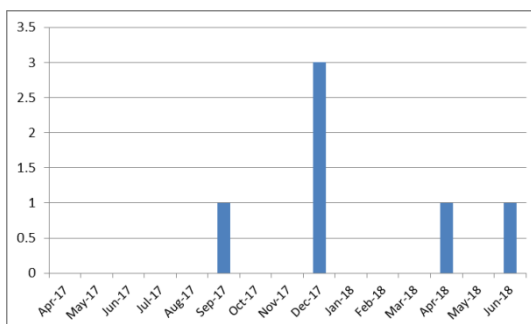
Pseudomonas



VRE

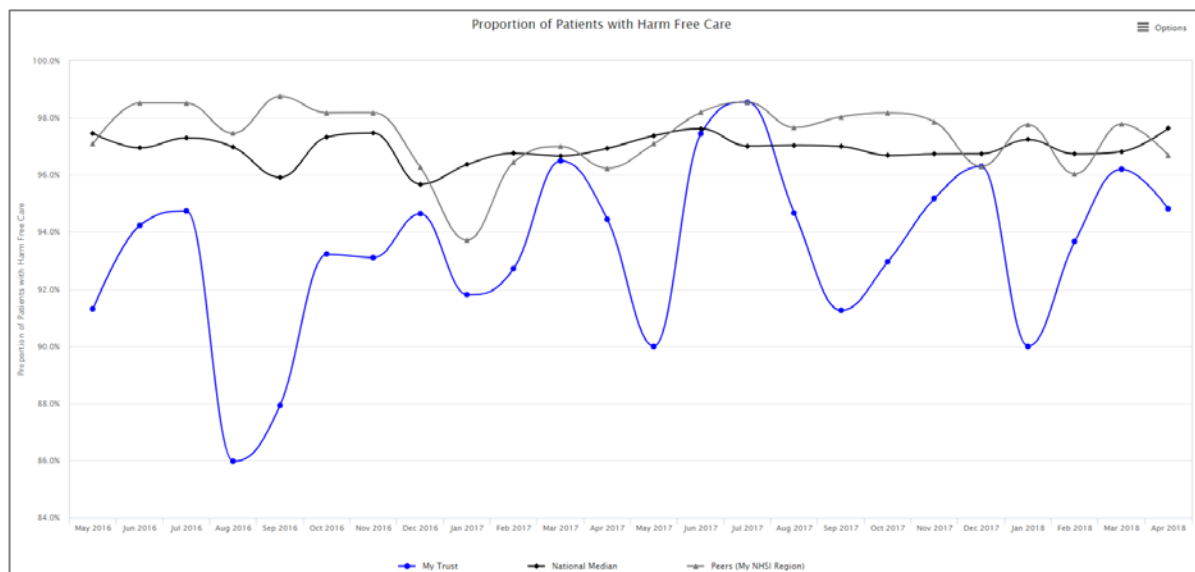


CPE



Benchmarked data

Safe	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
VTE Risk Assessment	Q4 2017/18	80.96%	97.61%	97.26%			
Clostridium Difficile - infection rate	To May 2018	38.21	58.41	9.29			
MRSA bacteraemias	To Mar 2018	0.00	2.64	0.00			



NB: The Safety thermometer data in this chart will differ from that in the CCC chart as the Trust reports 'new harm' free care i.e. that which happened at CCC. The harms included in the Model Hospital chart include those such as pressure ulcers with which the patient was admitted.

Charts key: blue line = CCC | grey line = peers | black line = national median

'Peers' = CCC's NHSI region.

Data courtesy of the Model Hospital (NHS Improvement)

1.5 Nurse Safe Staffing

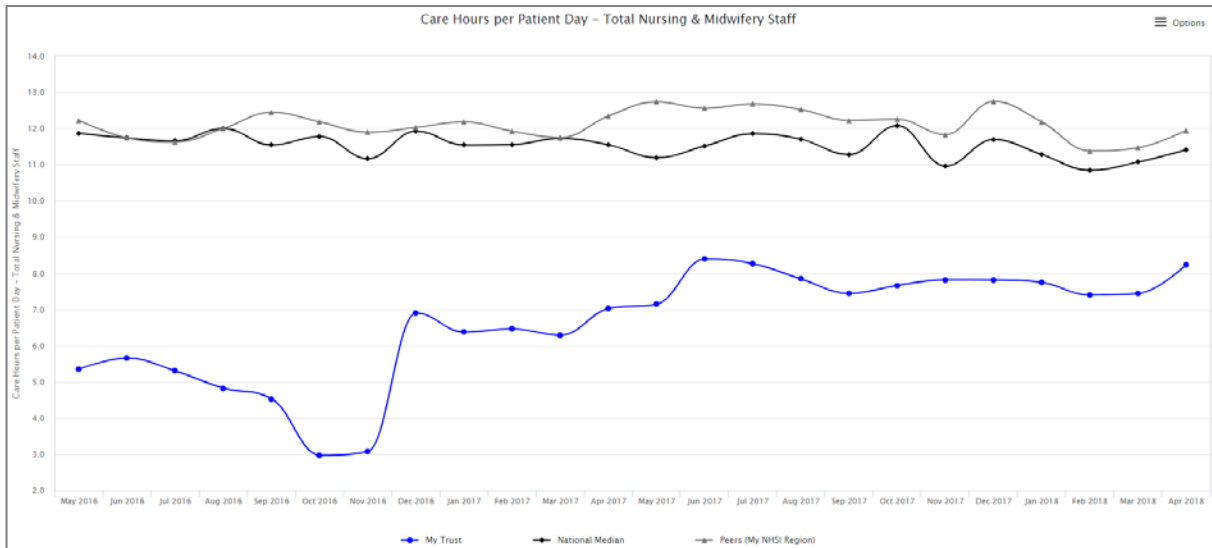
June 2018 staffing figures (hours):

Ward name	Day				Night				Day		Night		
	Registered Nurses		Care Staff		Registered Nurses		Care Staff		Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	
	Total monthly planned	Total monthly actual	Total monthly planned	Total monthly actual	Total monthly planned	Total monthly actual	Total monthly planned	Total monthly actual					
Conway	1908	1914	720	864	1080	1080	720	1020	100.3%	120.0%	100.0%	141.7%	
Sulby	1350	1098	198	198	384	372	0	12	81.3%	100.0%	96.9%	-	
Mersey	2238	2112	720	564	1080	1080	720	576	94.4%	78.3%	100.0%	80.0%	
7Y	1800	1266.5	900	835	690	690	690	667	70.4%	92.8%	100.0%	96.7%	
10Z and 7X	1555	1522.5	716.5	691.5	997.5	976.5	441	441	97.9%	96.5%	97.9%	100.0%	


Care Hours Per Patient Day (CHPPD) figures and trends:


Key Performance Indicator	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Trend
Care hours per patient day: Conway Ward	7.2	6.5	6	6.5	6.2	6.1	6.2	5.7	6	6.5	7.5	7.4	
Care hours per patient day: Sulby Ward	14.4	9.6	11	16.6	15.2	19	14.8	15.4	10.4	12	14	13.4	
Care hours per patient day: Mersey Ward	8.4	7.9	7.1	7.4	6.8	7.4	7.3	6.9	7.3	9.2	9.4	7.6	
Care hours per patient day: 7Y	6.1	6.3	6.2	6.7	6.3	5.6	5.7	5.7	5.5	5.7	5.6	5.8	
Care hours per patient day: 10Z and 7X	12.2	12.8	12	12.5	13.5	14.3	12.9	12.4	13.6	14.4	10.4	18.8	

CHPPD: 'Peers' = CCC's NHSI region:



CHPPD: 'Peers' = Christie and Royal Marsden:

VTE	Target	June	YTD	12 month trend
	95%	90.5%	93.4%	
Reason for non-compliance				
Target of 95% missed for past 6 months, reduction in compliance noted since change to VTE risk assessment in January. Performance has been increasing from 76.5% - 96.6% May. However improvements not upheld for June 2018 with compliance at 90.48%.				
Action Taken to improve compliance				
<ul style="list-style-type: none"> Medical lead for VTE has re-enforced process to medical staff. VTE education continues on medical induction. Fall in compliance has been escalated to the Integrated care Matron, Ward Managers and Clinical Director for Integrated Care receive daily list of missed assessments. Compliance also to be fed directly into IC directorate from May 18. Matron for IC directorate attending doctor's morning handover each morning to reinforce VTE compliance. Ward screens have been placed on all wards and are now in use with the exception of Conway ward with the aim that this will be completed 13th July. Physician associates to continue to support junior doctors with the VTE assessments for planned admissions. <p>Flowchart developed for doctors' offices to provide further guidance to which patients require a VTE risk assessment.</p>				
Expected date of compliance	July 2018			
Escalation route	Directorates / Quality and Safety Sub Committee / Quality Committee			
Executive Lead	Sheila Lloyd, Director of Nursing and Quality			

Sepsis	Target	June	YTD	12 month trend
	100%	93.3%	95.8%	
Reason for non-compliance				
The target of 100% has been missed in 9 of the last 12 months; with non-compliant figures ranging from 61% to 100%. No non-compliance within the 90minute target as 100% of in-patients with red flag indicators of sepsis were treated within the 90 minute target time of antibiotic administration.				
One patient was identified as missing this target. The clinical notes give no documented reason for non-compliance. There is a suggestion from the clinical notes that patient is needle phobic which may have contributed to delay. No harm appears to have occurred due to this delay. Patient recovered and length of stay does not appear extended. Subsequent SACT has been given on time with no dose adjustment.				
Action Taken to improve compliance				
This fall in compliance has been escalated to the Integrated care Matron, Ward Managers,				

acute oncology team and the Clinical Director for Integrated Care. The Sepsis working group is focusing on improving education and training; work with nursing teams and junior medics continues, to ensure a good understanding of the targets and the importance of clearly documenting the reasons when the target has been missed, including when this is clinically appropriate.

Expected date of compliance	Q2 2018/19
Escalation route	Directorates / Quality and Safety Sub Committee / Quality Committee
Executive Lead	Sheila Lloyd, Director of Nursing and Quality

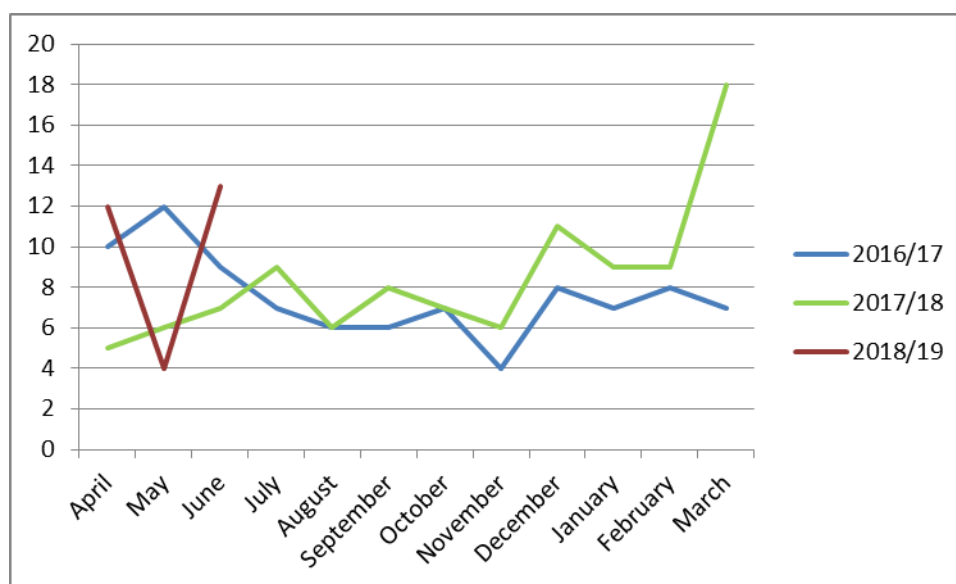
C Difficile	Target	June	YTD	12 month trend		
	=<4	1	1	-	-	-
Reason for non-compliance						
There was 1 case of c difficile in June 2018 which has been identified as attributable to CCC. The root causes and any lapse in care will be confirmed following a review by NHSE.						
Action Taken to improve compliance						
Actions will be identified following completion of NHSE review.						
Expected date of compliance						
Escalation route	Directorates / Quality and Safety Sub Committee / Quality Committee					
Executive Lead	Sheila Lloyd, Director of Nursing and Quality					

2. EFFECTIVE

2.1 Clinical Outcomes

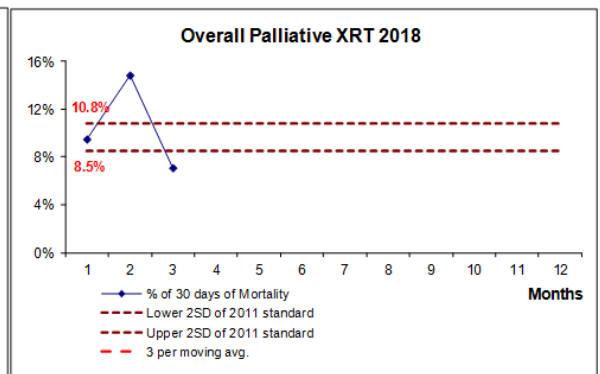
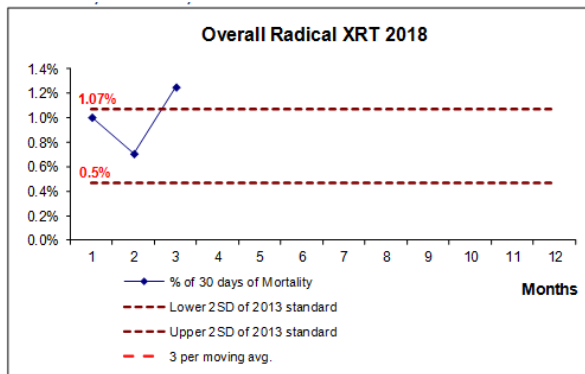
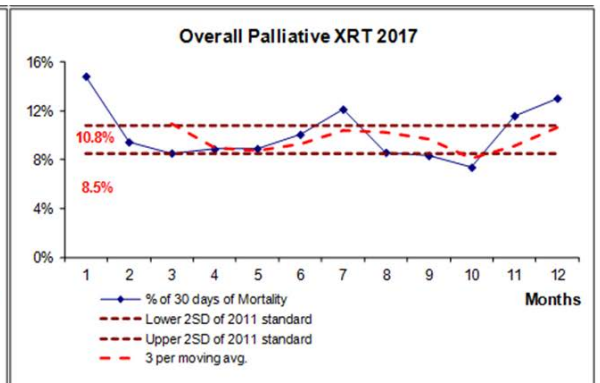
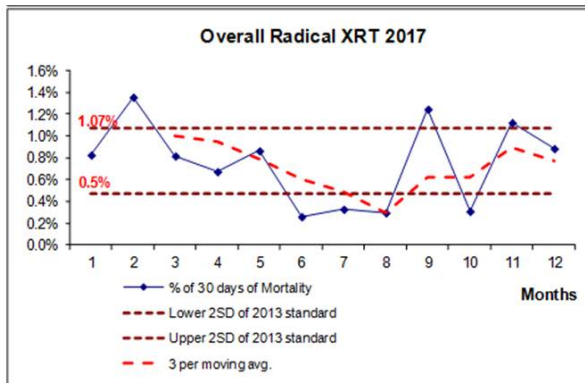
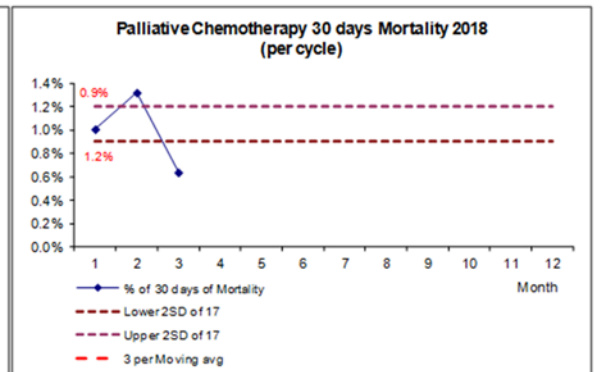
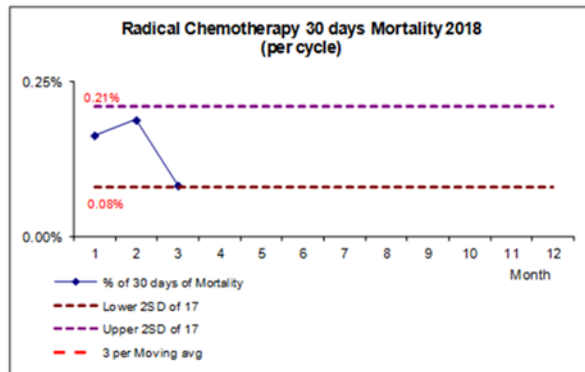
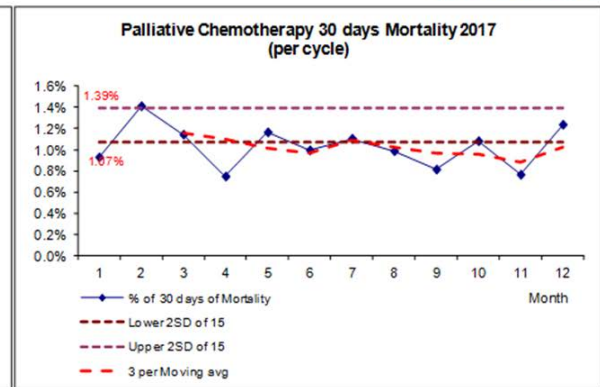
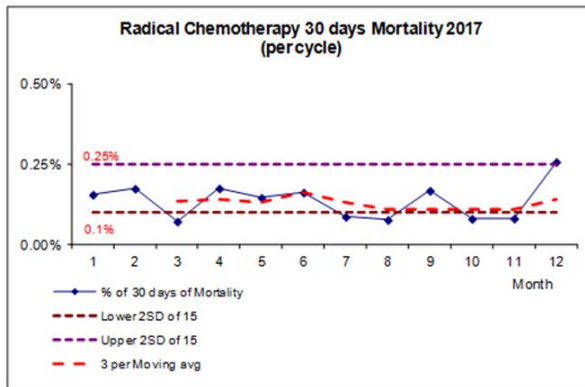
Mortality

Inpatient deaths:



Mortality within 30 days:

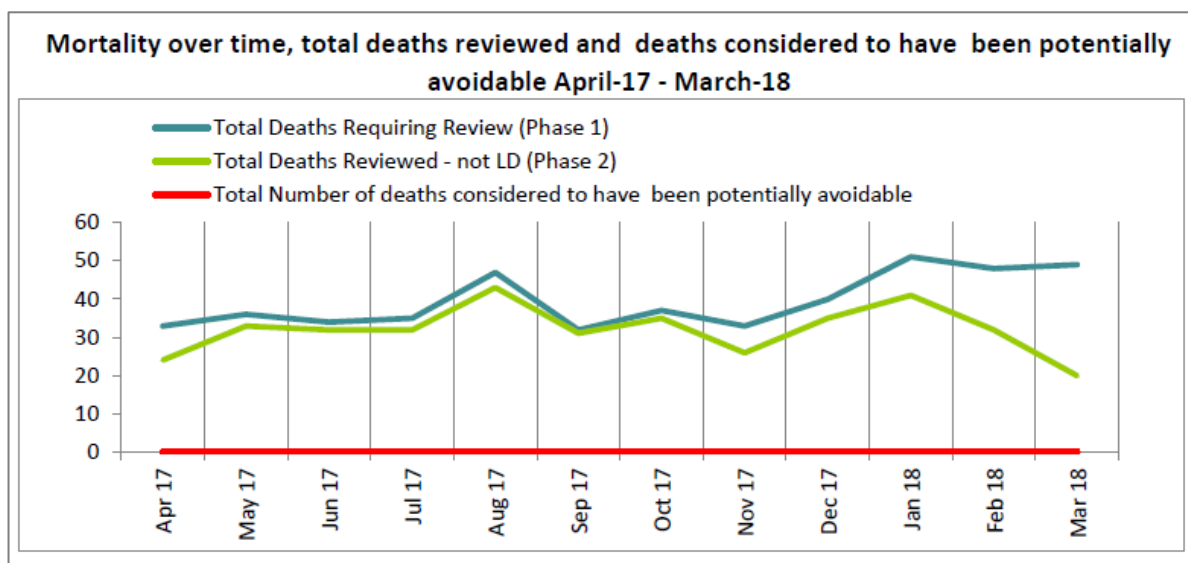
The HSMR and SHMI mortality indicators are not applied to specialist trusts such as CCC, therefore the Trust has developed its own approach to monitoring statistically significant changes in levels of mortality (see charts below for 2017 and January - March 2018. These are due to be updated in Q2). This information is utilised alongside the outcomes of mortality reviews by the Mortality Surveillance Group, to provide assurance regarding the efficacy of treatment provided and the avoidance of harm.



Mortality Review:

The Trust mortality review process adheres to the 2017 NHSI 'learning from deaths' Guidance. HO deaths are currently not included in the data below due to delays in receiving the data. All in patient deaths, out-patient 30 day chemotherapy/radiotherapy mortality and 90 day radical radiotherapy mortality are reviewed by the caring consultant (phase 1) and a further review (phase 2) is undertaken by a multiple multidisciplinary group where individual cases are selected for Mortality Review Meeting presentation. This process is managed by the Mortality Surveillance Group.

This chart has not been updated since the Month 1 report as the information is produced bi-monthly. A revised version will be presented in the Month 4 report.



NB: A judgement on avoidability of death is only made on inpatient deaths.

Other clinical outcomes:

This data is being developed in conjunction with SRG leads and will be presented in this report when available.

2.2 NICE Guidance

See exception report

2.3 Exception Reports

NICE Guidance

Details of non-compliance

- 258 (82%) guidance are compliant
- 12 (4%) guidance are undergoing assessment
- 41 (13%) guidance is working towards compliance with action plan in place.
- 4 (1%) guidance were rejected by the Trust due to alternative effective treatment being available

Action Taken to improve compliance

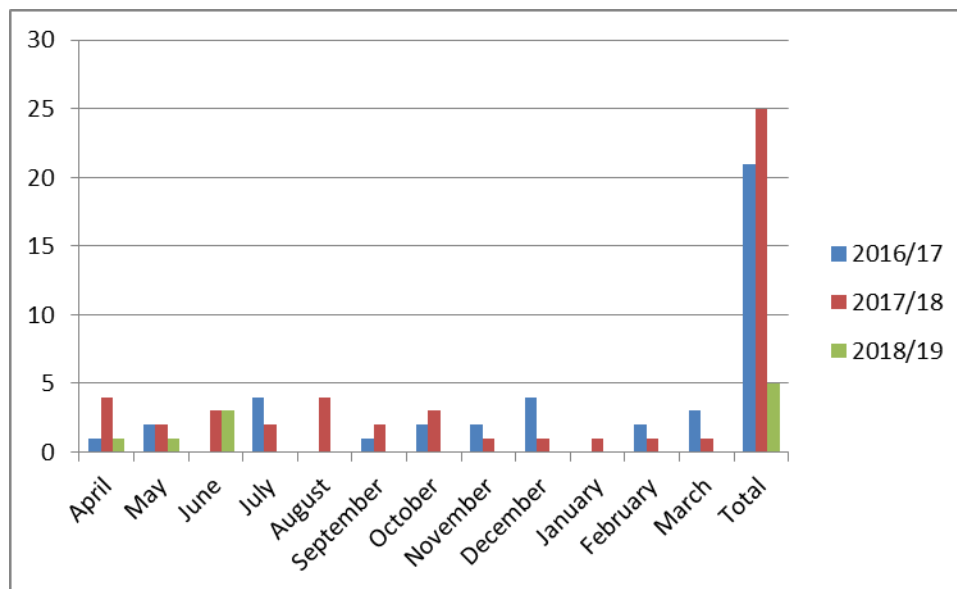
A NICE Committee has recently been established to expedite implementation; prioritising guidance for which non-compliance presents the greatest potential risk to patients.

Expected date of compliance	The newly formed Committee is tasked with improving compliance; risk assessing delays with implementation and identifying This will be reported monthly in this report to assess the pace of change and set trajectories.
Escalation route	Directorates and NICE Committee / Quality and Safety Sub Committee / Quality Committee
Executive Lead	Sheila Lloyd, Director of Nursing and Quality

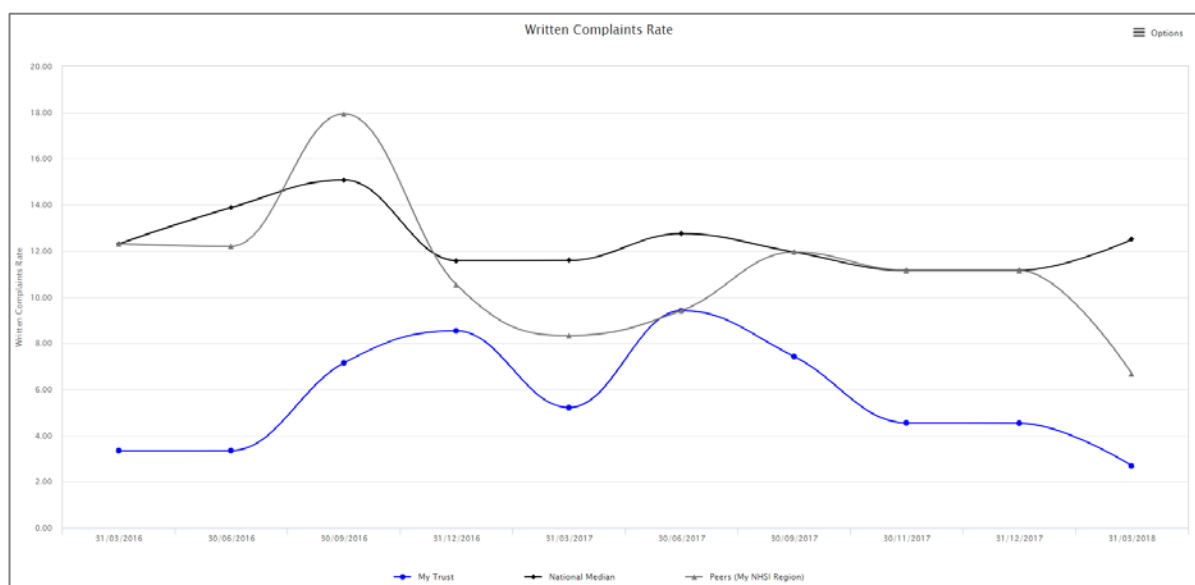
3. CARING

3.1 Complaints and PALS

Complaints:



Benchmarked Data

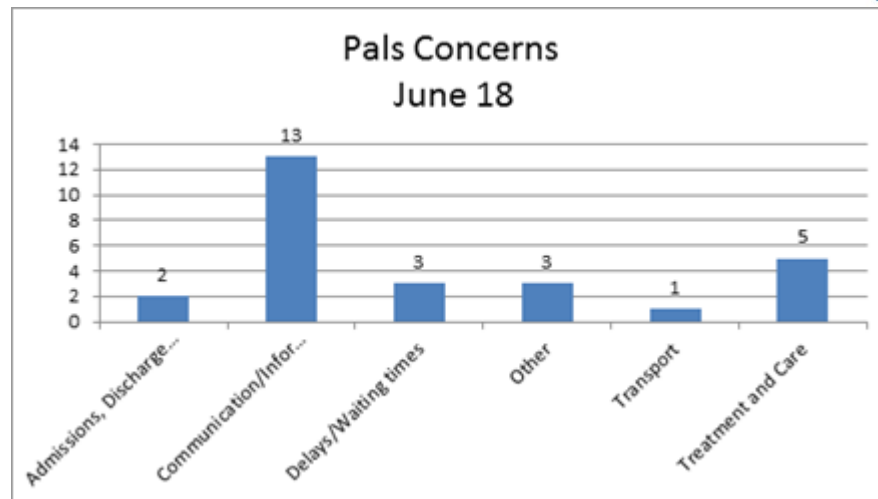


'Peers' are Trusts in CCC's NHSI region.
Data courtesy of the Model Hospital (NHS Improvement)

Details of complaints received in 2018/19 (as at 17/7/18)

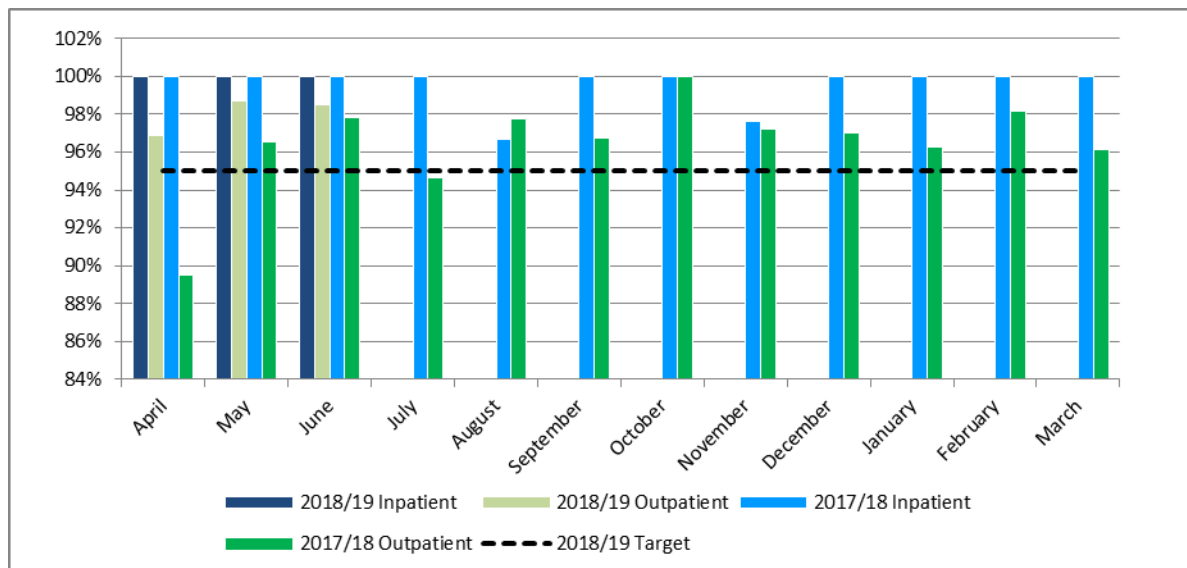
First received	Complaint Type	Department Raised Against	Description	Grade	Complaint Outcome
09/04/2018	Treatment and Care	Medical	Patient has questions for Consultant re side effect of treatment.	Low	Not Upheld/ further letter received 31/5- awaiting response
15/05/2018	Communication	Haemato-Oncology	Relative unhappy with attitude of doctors when giving bad news.	Moderate	Partially upheld, action plan to be finalised.
03/06/2018	Treatment and Care	Medical	Patient's wife and daughter emailed to raise a formal complaint concerning the lack of care the patient received.	Very low	Not upheld. A meeting has been offered but not yet taken up.
05/06/2018	Communication	Haemato-Oncology	Patient complained that the booked interpreter did not attend his appointment.	Very low	Not upheld. Translation process being reviewed
06/06/2018	Communication	Delamere and Network clinics	The patient's daughter emailed with 3 separate issues concerning her mother's treatment at LMC.	Very low	Partially upheld

Patient Advice and Liaison Service (PALS):

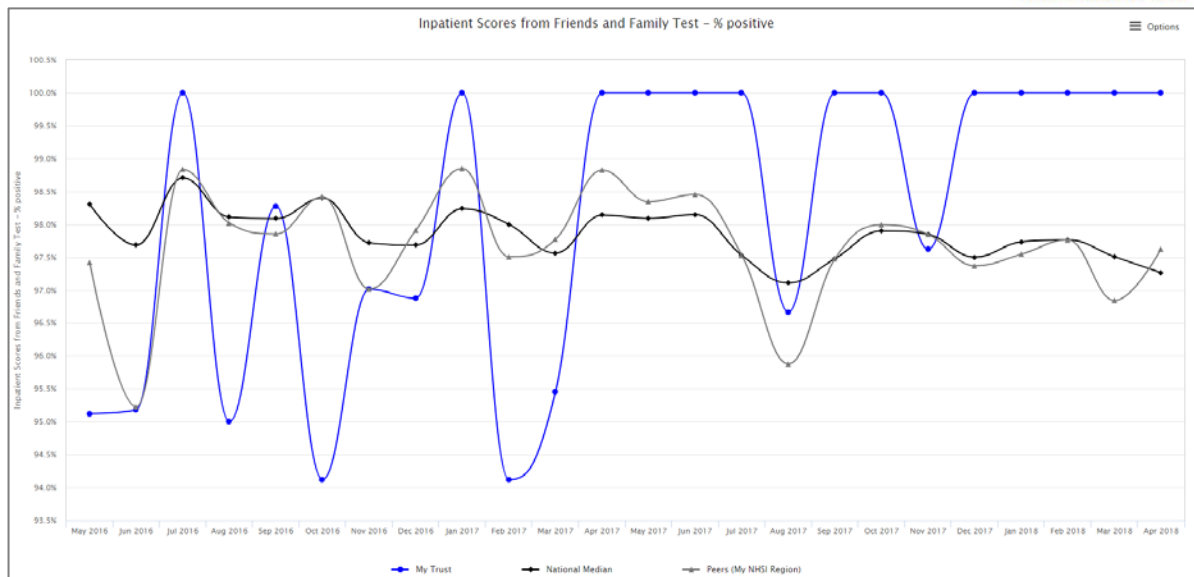


3.2 Surveys

Friends & Family Test: Scores

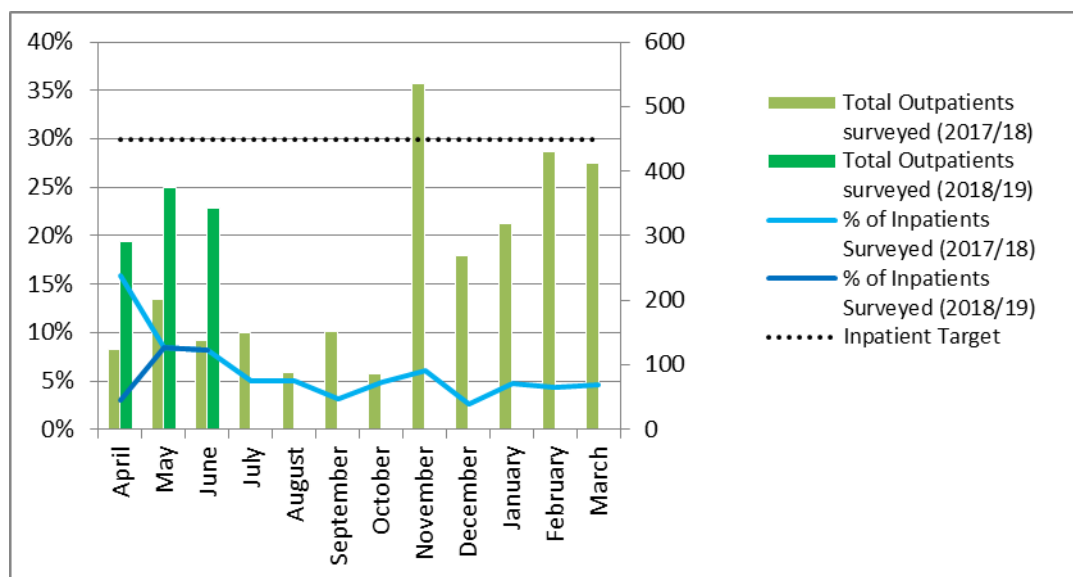


Benchmarked data



'Peers' are Trusts in CCC's NHSI region.
Data courtesy of the Model Hospital (NHS Improvement)

Friends & Family Test: Response rates




3.3 Claims

Open claims (excluding potential claims received):

Claim Number	Claim Date (Letter of Claim)	Nature of Claim (Alleged failure)	Claim status
Clinical Negligence			
2017/19	18/4/18	Alleged failure to provide treatment and follow up care	Open
2015/07	1/6/17	Misdiagnosis resulting in unnecessary treatment	Open
2016/03	21/6/16	Patient fall	Claim settled total=£89,288 (of which damages =£11,310)
Employer Liability			
2017/15	4/9/17	Staff fall	File re-opened, repudiation challenged.
2017/14	17/7/17	Staff fall	File closed. NHSR LTPS CLOSURE FORM received - claim repudiated
2016/10	13/2/17	Staff manual handling (non-patient)	Open
2016/01	19/4/16	Staff fall	Open
2015/14	23/12/15	Staff manual handling (non-patient)	Open
Public Liability			
2017/12	31/5/17	Needlestick	Open
2017/11	27/4/17	Contractor fall	File closed. NHSR LTPS CLOSURE FORM received - claim repudiated

3.4 Exception Reports

Friends and Family Test (response rates)		Target	June	YTD	12 month trend
		30%	8.2%	6.7%	
Reason for non-compliance					
Response rates to the Friends and Family test has been poor due to the methods of collecting data. This has resulted in significant delays in receiving data from clinical areas before deadlines.					
Action Taken to improve compliance					
The Trust has now uploaded the FFT to hand held electronic devices; this will ensure that data is immediately recorded and available to the Trust. This will enable a more detailed analysis of results in real time and will enable the patient experience team to identify areas where response rates are poor and take action. Connectivity in some areas across the Trust has caused problems with data collection however IT are identifying ways to resolve this issue.					
The devices will be distributed across all CCC clinical service from Aug 2018 with a target of a 30% response rate for all areas. Performance will be monitored and escalated through the Directorate meetings.					
Expected date of compliance	August 2018				
Escalation route	Directorates / Quality and Safety Sub Committee / Quality Committee				
Executive Lead	Sheila Lloyd, Director of Nursing and Quality				

4. RESPONSIVE

4.1 Cancer Waiting Times Standards

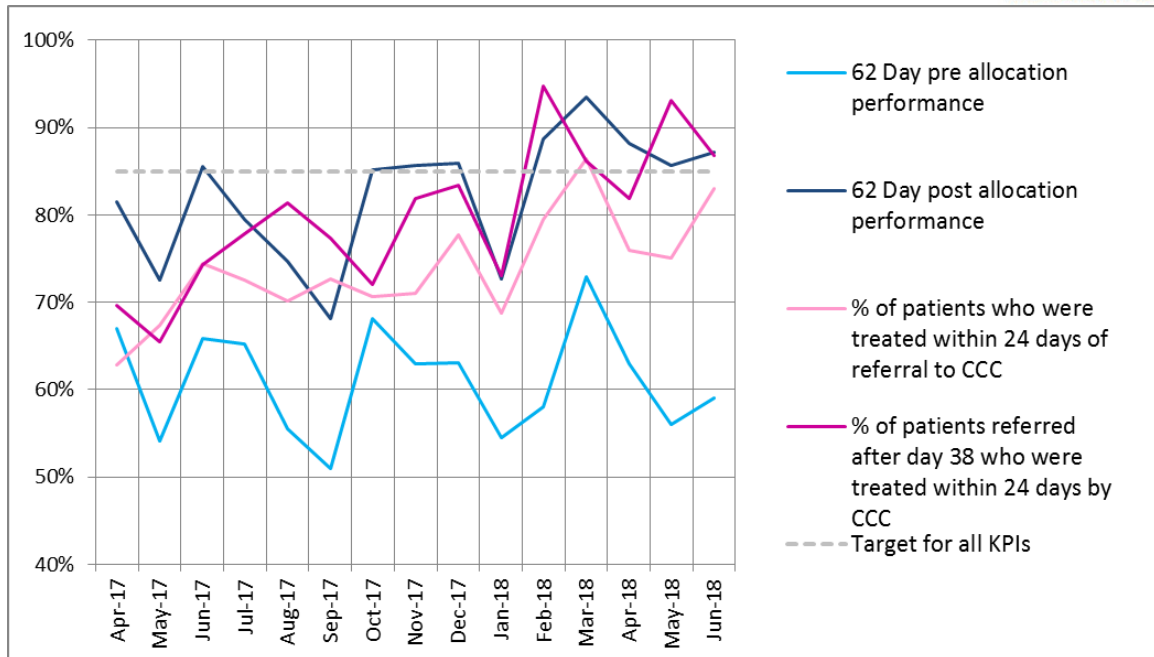
National Standards

Standard	Target	Q1 2017/18	June 2018
62 Day (pre allocation)	85%	59.4%	59%
62 Day (post allocation)	85%	87.4%	90.4%
31 Day (firsts)	96%	98.2%	98.5%
18 Weeks – incomplete pathways	92%	97%	96.4%
Diagnostics: <6 week wait	99%	100%	100%
2 Week Wait	93%	100%	100%

Please note: the post allocation performance figure is a true reflection of CCC performance against the CWT standards. The pre allocation performance figure is adversely affected by late referrals into CCC from referring trusts. The Cancer Delivery Group (NHSE/NHSI/The Cancer Alliance) is fully aware and acknowledges this issue.

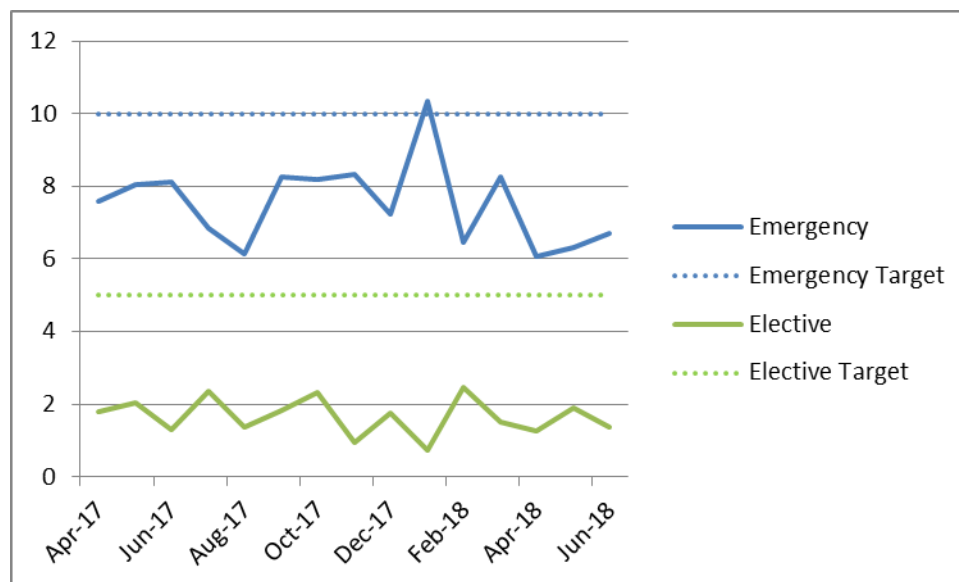
The new national CWT database (Cherwell) is in development and is expected to show the Trust's pre and post allocation position from July 2018. It is anticipated that from September 2018 only the post allocation performance data will be collected and published nationally.

This chart shows CCC's monthly performance for 62 day waits (pre and post allocation*) and treatment by CCC within 24 days (all patients, and those referred after day 38). The 7 day data is under review following a change in how this is produced.



Additional charts will be included in this report, showing performance against other standards by exception.

4.2 Length of Stay (days)



The length of stay data in the Model Hospital portal will be reviewed to determine the value to CCC.

4.3 Bed Occupancy

	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Average Occupancy at 11am (Conway)		76%	86%	87%	86%	91%	89%	83%	69%	85%
Average Occupancy at 11am (Mersey)		72%	78%	78%	77%	83%	79%	66%	65%	78%
Average Occupancy at 11 am (Sulby)	75% (ex Sulby)	48%	39%	39%	42%	27%	49%	27%	46%	45%
Average Occupancy at 2 am (Conway)		85%	88%	88%	75%	90%	89%	84%	69%	85%
Average Occupancy at 2 am (Mersey)		70%	76%	76%	75%	80%	77%	65%	63%	76%
Average Occupancy at 2 am (Sulby)		24%	20%	20%	25%	15%	29%	17%	25%	26%

Data flows for HO wards' bed occupancy have not yet been established

Work is underway to reconfigure Sulby Ward bed base. This will include a combination of short stay, day case and overnight stay beds. This work will be completed by 31/8/18.

The bed occupancy target will be applied to Sulby ward from 1/9/18

A daily bed occupancy report for HO and solid tumour in patient wards is received by all senior managers to enable the HO & ICD Directorates to reconfigure staffing to areas in need.

4.4 Patients recruited to trials

The table below shows trials figures for 2017/18. This data will be updated in the Month 4 report.

Phase of study	Number of patients recruited – 2017-18			
	Commercial non-portfolio	Commercial portfolio	Non-commercial portfolio	Non-commercial Non-portfolio
Phase I	12	3	3	
Phase I/II		15	10	
Phase II		13	52	1
Phase II/III			21	
Phase III		27	125	
Phase IV		7		
No Phase Studies		88	93	56
Grand Total	12	153	304	57

Number of patients recruited to studies shown by phase and study type. This is divided into commercially funded and non-commercially funded studies, then further by those that are



included on the National Institute for Health Research (NIHR Portfolio). The data Includes Haemato-oncology since 1/07/2018.

Studies that have no phase are either Biobank, or specialist studies involving translational sample collection or data collection and some radiotherapy studies.

4.5 Activity

The presentation of activity data is currently being reviewed to ensure that it is of maximum value in the analysis, planning and development of services. This will be included in Q2 2018/19.

4.6 Exception Reports

	Target	June	YTD	12 month trend
62 Day Cancer Waits (pre allocation)	85%	56%	59%	
62 Day Cancer Waits (post allocation)	85%	84%	87%	
Reason for non-compliance				
<p>The post allocation performance figure is a true reflection of CCC performance against the CWT standards. The pre allocation performance figure is adversely affected by late referrals into CCC from referring trusts. The Cancer Delivery Group (NHSE/NHSI/The Cancer Alliance) acknowledges this issue. CCC has achieved the post allocation target every month (except January) since October 2017.</p>				
Escalation route	Trust Operational Group / OD&SISC / F&BDC			
Executive Lead	Barney Schofield, Director of Operations and Transformation			

5. WELL LED

5.1 Workforce

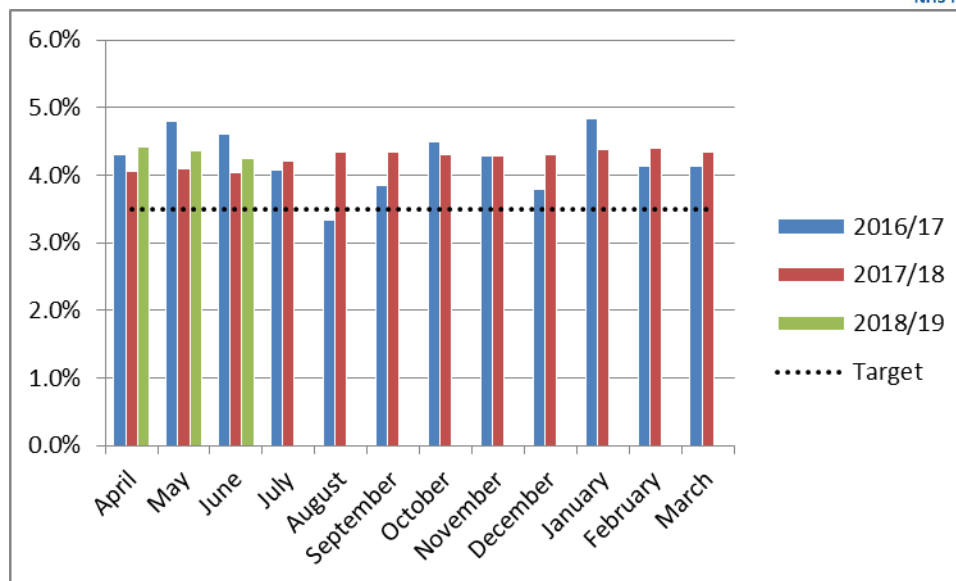
NB: Where information is reported by Directorate, the Information Team and PMO are captured within the 'Quality Directorate'. 'Support Services includes all Corporate services except those in the Quality Directorate and those listed separately above i.e. Admin Services and HR & OD.

Workforce overview

	2017 / 07	2017 / 08	2017 / 09	2017 / 10	2017 / 11	2017 / 12	2018 / 01	2018 / 02	2018 / 03	2018 / 04	2018 / 05	2018 / 06
Headcount	1,194	1,209	1,205	1,223	1,239	1,240	1,242	1,259	1,258	1,270	1,265	1,261
FTE	1,079.36	1,093.28	1,091.50	1,107.44	1,120.02	1,120.59	1,123.67	1,140.33	1,140.19	1,151.93	1,146.24	1,143.72
Leavers Headcount	11	9	19	9	3	20	16	8	13	18	22	17
Leavers FTE	8.72	8.56	18.13	7.96	2.80	18.18	14.42	6.68	11.25	14.22	18.80	15.91
Starters Headcount	138	24	14	28	19	16	19	26	15	26	13	16
Starters FTE	124.98	22.93	13.16	26.14	16.89	13.92	18.12	24.10	13.15	24.50	11.25	15.32
Maternity	35	34	33	34	35	31	29	30	28	29	32	32
Turnover Rate (Headcount)	0.92%	0.74%	1.58%	0.74%	0.24%	1.61%	1.29%	0.64%	1.03%	1.42%	1.74%	1.35%
Turnover Rate (FTE)	0.81%	0.78%	1.66%	0.72%	0.25%	1.62%	1.28%	0.59%	0.99%	1.23%	1.64%	1.39%
Leavers (12m)	143	138	142	146	140	146	150	152	154	147	159	165
Turnover Rate (12m)	13.50%	12.83%	13.00%	13.17%	12.45%	12.79%	12.97%	12.96%	12.95%	12.19%	13.01%	13.32%
Leavers FTE (12m)	125.39	121.29	125.73	129.33	124.05	130.08	133.96	135.46	137.37	128.92	139.37	145.62
Turnover Rate FTE (12m)	13.10%	12.47%	12.73%	12.90%	12.19%	12.60%	12.80%	12.77%	12.77%	11.82%	12.60%	12.98%

The following data is presented by Trust and then 'Directorates'.

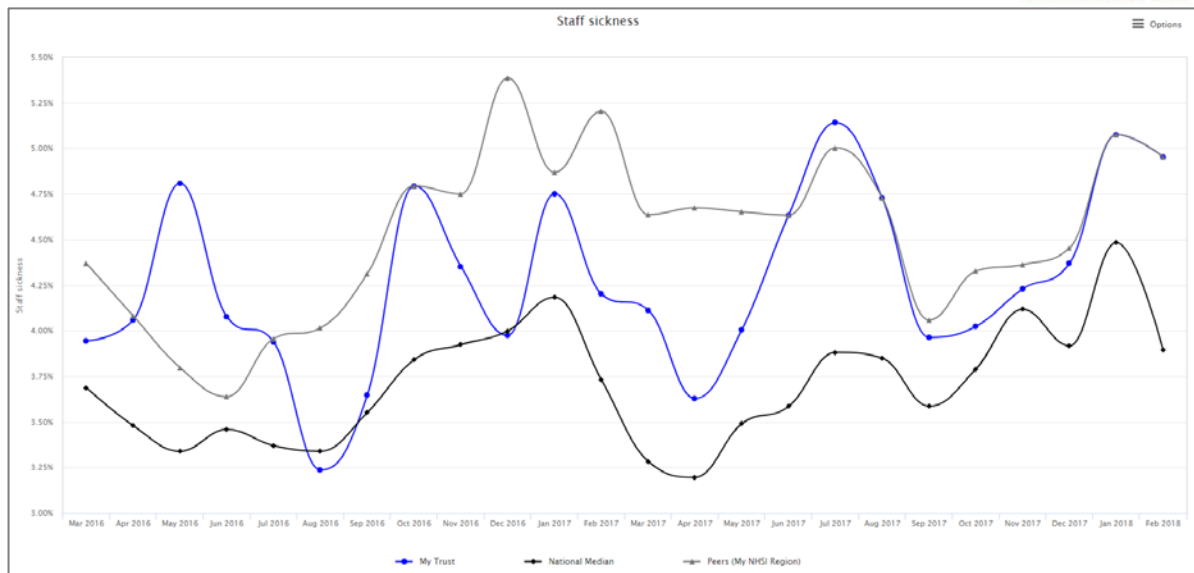
Sickness Absence



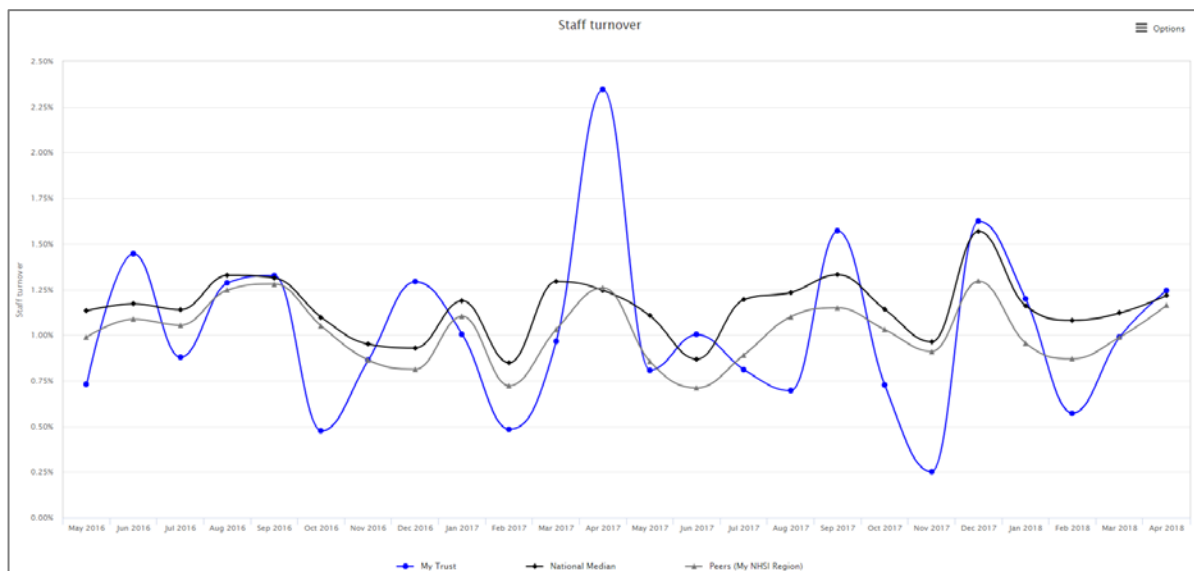
NB: the Trust data is rolling 12 months and 'Directorate' is monthly.

	2017 / 05	2017 / 06	2017 / 07	2017 / 08	2017 / 09	2017 / 10	2017 / 11	2017 / 12	2018 / 01	2018 / 02	2018 / 03	2018 / 04	2018 / 05	2018 / 06	Trend
158 Haemato-oncology Directorate			4.44%	1.96%	3.11%	4.08%	3.60%	4.29%	5.20%	6.45%	3.84%	4.78%	4.50%	2.93%	
158A Admin Services Directorate	6.50%	7.42%	7.02%	7.37%	5.10%	5.93%	5.90%	5.26%	6.78%	7.39%	4.99%	4.61%	4.66%	4.48%	
158A Chemotherapy Services Directorate	3.55%	3.22%	5.67%	6.46%	4.73%	4.39%	4.32%	5.97%	5.14%	6.03%	7.10%	5.32%	4.72%	3.22%	
158A HR & OD Directorate	4.41%	6.22%	7.07%	4.90%	2.98%	4.57%	6.40%	3.42%	7.22%	2.73%	3.47%	2.92%	0.64%	3.82%	
158A Intergrated Care Directorate	4.24%	6.28%	8.41%	7.13%	6.52%	5.64%	4.79%	5.18%	6.50%	5.86%	6.24%	4.04%	3.12%	2.20%	
158A Medical Directorate	3.62%	4.53%	6.23%	6.36%	4.85%	4.40%	3.19%	1.92%	1.93%	2.48%	2.74%	2.23%	2.23%	3.31%	
158A Quality Directorate	6.55%	5.65%	4.02%	2.99%	4.03%	5.66%	5.15%	5.00%	4.89%	6.21%	3.25%	1.39%	0.97%	2.21%	
158A Radiation Services Directorate	2.94%	2.82%	2.22%	2.24%	1.66%	1.79%	3.30%	2.85%	3.83%	3.59%	2.11%	3.02%	2.48%	2.87%	
158A Support Services Directorate	3.05%	4.70%	2.83%	2.03%	2.87%	2.24%	4.01%	4.94%	6.77%	4.12%	4.17%	3.08%	2.92%	5.23%	
158A Trust Board Directorate	0.00%	0.00%	0.56%	0.00%	0.00%	0.00%	0.18%	0.00%	0.00%	1.67%	8.40%	12.82%	8.35%	2.04%	

Benchmarked data – sickness and turnover

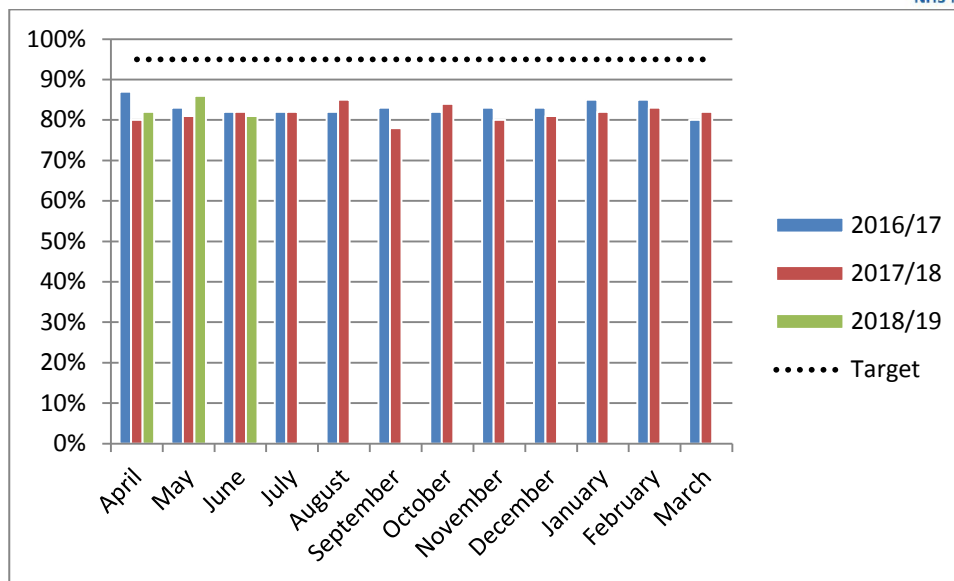


Of these national peers, for this period of time, the 3 organisations with higher sickness than CCC, are the Liverpool Women's NHS FT, Alder Hey Children's NHS FT and the Walton Centre NHS FT. Royal Marsden NHS FT is 3.46% and Christie's NHS FT is 4.05%



'Peers' are Trusts in CCC's NHSI region.
Data courtesy of the Model Hospital (NHS Improvement)

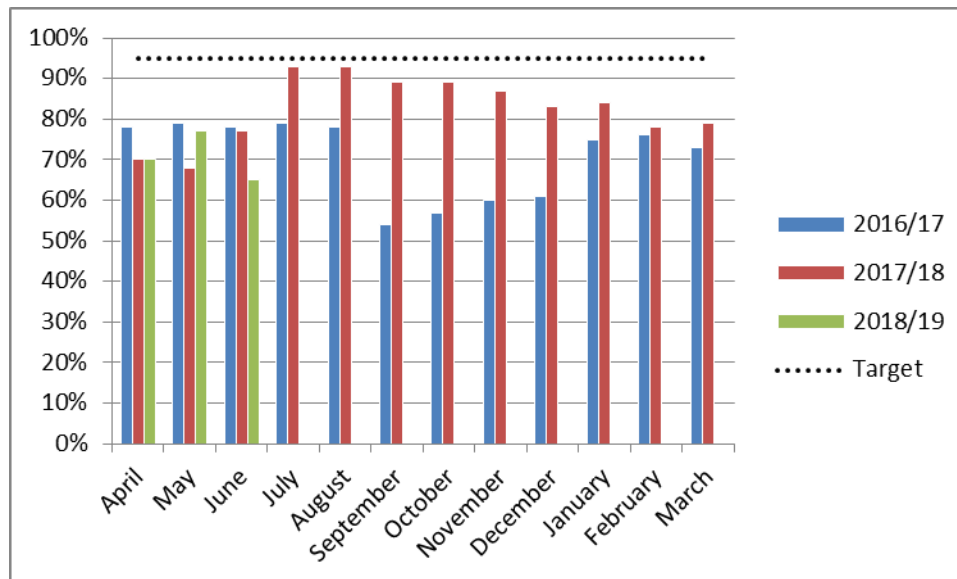
Mandatory Training



Directorate	Target	Apr-18	May-18	Jun-18
158 Haemato-oncology Directorate	95%	57.65%	76.01%	74%
158A Admin Services Directorate	95%	95.55%	95.92%	91%
158A Chemotherapy Services Directorate	95%	86.97%	88.52%	89%
158A HR & OD Directorate	95%	98.41%	96.25%	93%
158A Intergrated Care Directorate	95%	86.53%	86.57%	87%
158A Medical Directorate	95%	59.61%	63.90%	64%
158A Quality Directorate	95%	91.53%	91.30%	90%
158A Radiation Services Directorate	95%	86.48%	87.55%	87%
158A Support Services Directorate	95%	90.88%	91.97%	92%
158A Trust Board Directorate	95%	58.20%	58.06%	58%

The Operational Team is working with L&D to ensure all departments have action plans in place that will ensure mandatory Training compliance is above the 90% by Sept 2018 and at 95% by De 2018.

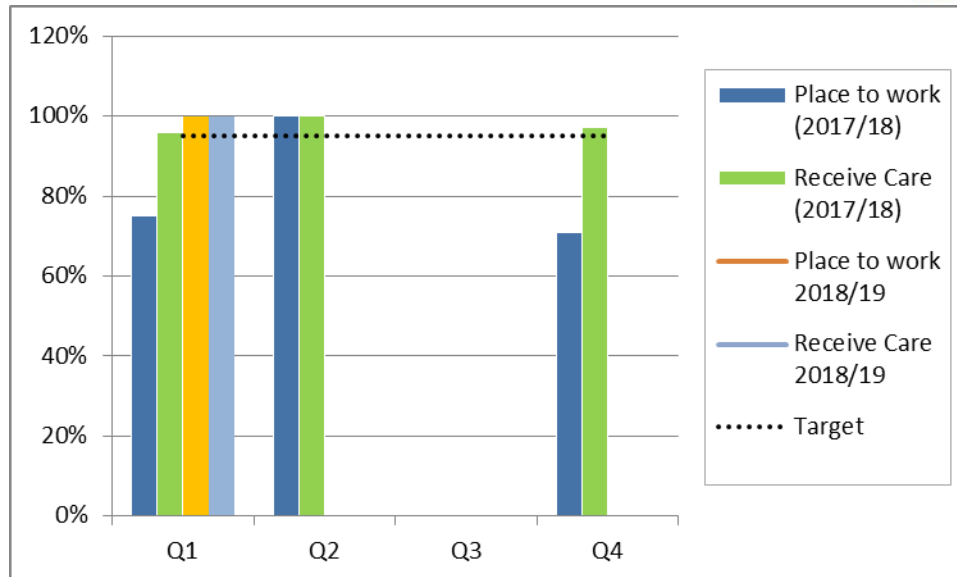
PADR Compliance



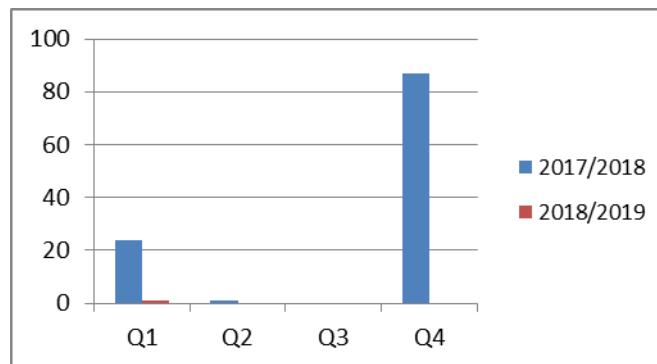
Directorate	Target	Apr-18	May-18	Jun-18
158 Haemato-oncology Directorate	95%	81%	83%	40%
158A Admin Services Directorate	95%	79%	91%	85%
158A Chemotherapy Services Directorate	95%	78%	81%	87%
158A HR & OD Directorate	95%	78%	76%	69%
158A Intergrated Care Directorate	95%	65%	66%	62%
158A Quality Directorate	95%	76%	77%	65%
158A Radiation Services Directorate	95%	79%	84%	67%
158A Support Services Directorate	95%	64%	65%	59%
158A Trust Board Directorate	95%	50%	50%	50%

The Operational Team is working with L&D to ensure all departments have action plans in place, to deliver the PADR target of 95% by 31st July t 2018.

Staff FFT: Scores

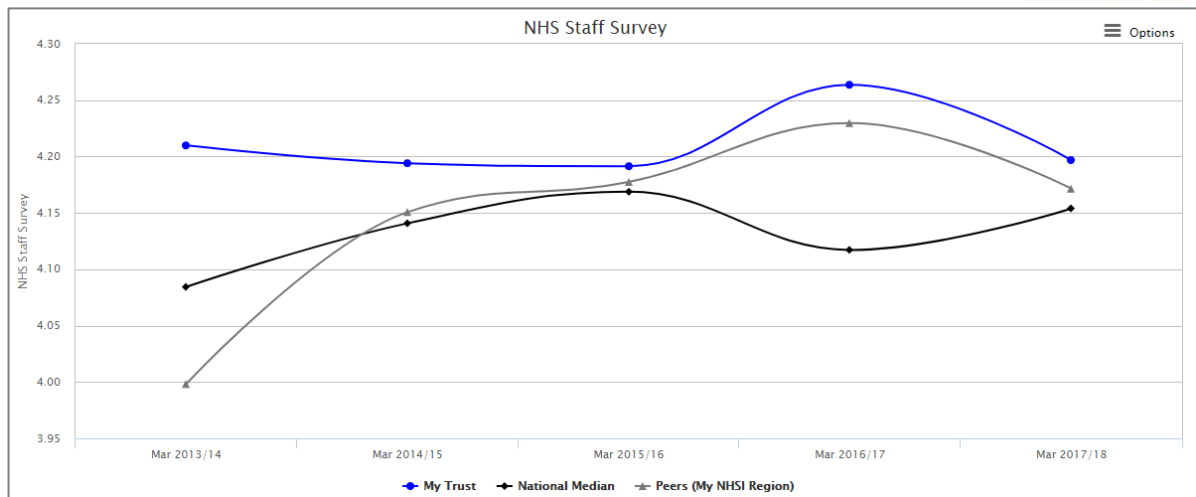


Staff FFT: Response rates



Benchmarked data

NHS Staff Survey	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
NHS Staff Survey	Mar 2017/18	4.20	4.17	4.15			



'Peers' are Trusts in CCC's NHSI region.
Data courtesy of the Model Hospital (NHS Improvement).

5.2 Finance

Please refer to the Finance Report for Month 3 2018/19.

5.3 Risk

This section will be updated following a refresh of the operational risks at the end of June 2018.

Risks rated 15 and above:

Risk	Department	Initial Rating	Current Rating	Key actions / mitigations
832: Significant reduction in the number of Junior Doctors covering wards at CCC	Inpatient Wards	20	20	<ul style="list-style-type: none"> Two Clinical Fellows appointed, awaiting start date. Physician Associates, intern year, have been pulled back to wards to support basic tasks. Ongoing discussion with Lead Consultants to support the trainees Options appraisal re future staffing model to cover Junior Dr duties with costings prepared for discussion at Operations Delivery & Business Development Committee 9th July 2018. Task & finish group meeting to be held 18th July. Secure long term funding for the three clinical fellow posts. Palliative care Team working with Liverpool university to try and increase the number of GP trainees
851: Failure to adhere to Trust Patient Identification Policy resulted in patients being exposed to unnecessary procedure	Imaging	20	16	<ul style="list-style-type: none"> Remind staff and reinforce the Patient Identification Policy Agreed to add a pop up box into Meditech for ordering Imaging to confirm that the correct patient has been selected. Confirmation of ID also to be added to EAS - exploring pop up box for future. Undertake an audit of application of compliance with policy
879: Consultant workforce within HO Directorate not adequate to deliver	Haemato-Oncology	20	20	<ul style="list-style-type: none"> CD delivering additional clinical sessions, however, this is not sustainable. CD role shared between two clinicians to alleviate pressure Two business cases presented at Operational and Business

service requirements				<p>development committee on the 11/06/2018 and agreed in principal but further review and agreement for next steps required.</p> <ul style="list-style-type: none"> • Business cases to be presented at Finance and Business development committee 17/7/18
883: Underestimation of SUV via PET CT that had potential to cause patient harm and reputational damage	Imaging	20	16	<ul style="list-style-type: none"> • Robust action plan in situ that is shared with NHSI/E via weekly teleconference. • Amended QA processes and process for entering source dates in place • All scans affected identified and reviewed by 31st May 2018 • Assessment of harm being made between reporting radiologist and referring clinician in all patients where there may have been a change to the report had the incident not occurred • Communications to patients / relative potentially affected prepared for release after all scans reviewed. Final case discussed at MDT awaiting review by Medical Director.
835: Mandatory training	Haemato-Oncology	16	16	<ul style="list-style-type: none"> • CCC Workforce and OD Dept.(WOD) working with RLBUHT to pull together information. • HO PDN assisting WOD in HO competency requirements • Escalation to RLBUHT via monthly contract meetings • Individual reports and e mail alerts are being received by staff. • HO maintaining own records until accurate data can be pulled from RLH system • Directorate to maintain paper record to identify staff who are non compliant
836: Stem Cell Unit Staffing	Haemato-Oncology	16	16	<ul style="list-style-type: none"> • Daily review of staffing by Matrons • Deployment of staff from other HO wards. • PDN to develop a face to face training program • Close working with WOD to develop a recruitment plan. • Reduction in management days for junior sisters • Matron to work within nursing numbers. • Staff awareness in raising red flag • 7x as a step down facility with a nursing ratio of 1:4 and increased productivity through 10 z by transplanting both auto / allo transplants • Loan of nurses from chemo directorate • 7x to close at the weekend for two weeks during August to ensure safe staffing and care.
755: Cyclotron	Cyclotron	16	16	<ul style="list-style-type: none"> • Extensive maintenance of the equipment, changing of parts that show signs of wear, upgrade where possible

Lifespan				<ul style="list-style-type: none"> SOC being developed for replacement
774: Non CE marked Patient Immobilisation devices in Radiation Services	Radiotherapy	16	16	<ul style="list-style-type: none"> Where possible CE marked equipment is being purchased to reduce the amount of non-CE marked equipment in use for patient treatment. All immobilisation equipment is being regularly inspected by Mechanical Workshop staff, and inspected for significant damage by radiographers prior to each use. All radiographers have been trained in the inspection, cleaning and use of immobilisation equipment in current use. New immobilisation equipment arrived in department in March 2018. Once the camera mounts and the MRI boards have been received and training is complete, this risk will be removed . This risk will be reduced to a minimum by start of August once existing patients have stopped using the older immobilisation equipment. On the 18th June the new immobilisation equipment was introduced for new patients being CT scanned.
776: PET CT reporting	Imaging	16	16	<ul style="list-style-type: none"> Current radiologist agreed to do additional work OOH, however there are still delays in getting these scans reported. Outsourcing company are unable to report PET/CT
NEW 906: Isle of Man Service Provision Review	Out Patients	15	15	<p>Controls:</p> <ul style="list-style-type: none"> Consultant cover for IOM OPD service Service Provision Agreement between IOM/CCC Protocols, Processes, Policies in place <p>Actions:</p> <ul style="list-style-type: none"> Activity Monitoring IOM patients Training Needs Analysis IOM SLA review IOM IOM Service Transformation Review
NEW 893: High temperatures in HO medicines storage	Haemato-Oncology	15	15	<p>Controls:</p> <ul style="list-style-type: none"> Temp monitoring. QCNW algorithm to reduce expiry of products if stored above a certain temp for a specific time period. <p>Actions:</p> <ul style="list-style-type: none"> Pharmacy assistant support in place

				<ul style="list-style-type: none"> Investigate options to cool unit down
NEW 799: Reduction in medical staffing (Consultant workforce)	Medical	25	15	<ul style="list-style-type: none"> Current medical staff taking on extra work to cover clinics Reconfiguration of some Consultant job plans to cover specialities most affected. Senior Registrar due to complete training within the next 6 months acting into consultant posts supervised and supported by a senior consultant. None medical consultant posts approved and appointed to. This includes consultant radiographers, pharmacists and nurses. Consultant oncologist posts advertised, one appointment made.
201: Failure to provide adequate support for employee stress, leading to increased absence from work	Workforce and Organisational Development	15	15	<ul style="list-style-type: none"> Stress Action Group established 2017 Review of Stress Management Policy currently underway 2 staff trained as train the trainers for mental health 1st aid training. Training to be rolled out from June 2018. ViVup staff benefits package being explored as part of wider review of reward strategy including EAP.
761: Clinicians may be working from out of date SACT protocols	Pharmacy	15	15	<ul style="list-style-type: none"> An urgent protocol meeting was held in May 2018, at which an action plan was developed to address gaps in the protocols i.e. not on the intranet. Pharmacy leading this work and targeting individual SRGs
765: Cyber Security Attack	Information Management & Technology	15	15	<ul style="list-style-type: none"> Anti Virus software is up to date across Server and PC estate and CCC is an early CareCert (NHS Digital) adopter for Cyber Security with NHS Digital. There is additional mitigation to be provided through Domain migration and a new enterprise back up solution which were actions from a recent MIAA Cyber Security Assessment. The Head of ICT is a key member of the Cyber Security STP team. Coming towards the end of data migration work, firewalls been upgraded the enterprise back up solution is now installed. Risk remains high due to constantly changing sources of attack Cyber security action plans monitored on a monthly basis.
854: Radiologist business continuity	Imaging	15	15	<ul style="list-style-type: none"> Asking visiting radiologists from RLBUHT to provide additional reporting cover for urgent cases. Asking Trust registrars to provide clinical cover following the rare occasion an emergency arises following contrast injection.

				<ul style="list-style-type: none"> • Currently advertising for additional radiologists and seeking locum cover. • Outsourcing work to ensure reports are available for patients as planned
848: Brachytherapy protocols and mismatch to EAS	Radiotherapy	15	15	<ul style="list-style-type: none"> • Concessions system to record any dose fractionations that are not protocol. • Radiation Therapeutic Committee established June 2018
862: Organisation of Information Management Resources Trust wide to achieve Trust objectives	Information Management & Technology	15	15	<ul style="list-style-type: none"> • Full review of issues within the Information team, to include team focused sessions (started 22/2/18), stress questionnaire with staff, 360 degree feedback. Review of previous exit interviews. Work underway with HR and OD. • Review of data warehouse technical infrastructure and a review of the Trust's aspiration for business intelligence team. Working with an external team to provide support for review (on-going). Met with Clickhealth and are to be commissioned to support a review and support data visualisation. Review of IMS Quintilles report commissioned early 2017 for Pharmacy. Review of current staffing roles across the Trust delivering information management. • Funding to pump prime any changes may be required. • Agreed strategy for business intelligence to sit within the refreshed DIGITAL strategy.
880: Hotline cisco overnight phones	Inpatient Wards	15	15	<ul style="list-style-type: none"> • Staff have received training on the phones but we continue to have issues with the system and this is a patient safety concern. • Staff have been asked to check phones hourly to ensure active but calls are still being missed due to the above issues. • Options discussed with IM&T however no IT solution is available.
881: No ARSAC Certificate for research since the new process Jan 2018	Research	15	15	<ul style="list-style-type: none"> • R&I have requested that the ARSAC Certificate is applied for, offered support and requested updates through the Research Radiographer as this sits with Radiation Services to apply for the certificate. Support has been offered.


887: Immuno-oncology service	Delamere and Network clinics	15	15	<ul style="list-style-type: none"> • IO Lead Nurse role established, new post holder commences 1/9/18 • On treatment review team established, lead by senior band 7 ANP • Toxicity management protocols developed and shared with staff • IO committee established, well supported via clinicians and service managers • Alerts cards provided to all patients on IO • Pharmacy counselling for all patients available prior to discharge • Medical speciality advisors • Training to hotline staff in progress • GP awareness letter • Standardised blood panel to ensure consistency • Meditech templates
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Risks downgraded or removed since the last report:

Study delivery for Haemato-Oncology	Haemato-Oncology	Downgraded to 12	<ul style="list-style-type: none"> • Bringing over a Network funded RP from the Aintree-based service to CCC Liverpool April 2019. • Requesting funding and pump-priming for new posts. • Review of portfolio. • There remain acute capacity issues within the H-O team and studies are therefore on hold. The issue is compounded by finance limitations and investment potential as we still are not in full receipt of monies from the RLBUHT. JA investigating this issue.
Lack of security cover at weekends	Inpatient Wards	Downgraded to 12	<ul style="list-style-type: none"> • Staff have walkie talkies in use to keep in contact with ward staff when walking off the ward with patient. • Extra staffing has been requested and put out to bank and agency companies to cover the one to one supervision that patient requires for the duration of the inpatient stay.

			<ul style="list-style-type: none"> • Health and safety officer informed of patient's admission and behaviour problems and extra security put in place for foreseeable night duty. • All ward staff informed of patient's unpredictable behaviour and for them to be vigilant regarding their own safety and the safety of other patients. • security cover over weekends has now been established
Inability to provide medical cover to ensure safe delivery of services	Medical	Risk combined with 799	<ul style="list-style-type: none"> • Advance Nurse practitioners to support clinics • Long term medical workforce strategy to be developed • Medical staffing manager and administrator in place to support escalations • Consultant responsible for managing own cover (secondary check by Medical Staffing Administrator) • Medical Workforce Strategy Group To be established post extra ordinary Ops COMMITTEE ON THE 9/7/18 • Job Planning underway with over 74% of job plans complete • Succession Planning COMMENCED IN Neuro/CNS/H&N SPECIALITIES. • New ways of working with increased use of AHPs, CNSs and non medical consultants . • New ways of working with future clinical model- team based SRG's


5.4 Exception Reports


Staff Sickness		Target	June	12 month trend
		=<3.5%	4.25%	
Reason for non-compliance				
Sickness for the month of June 2018 has decreased for the second month in a row to 3.15%, however the rolling absence % has remained higher due to sickness % being over Trust target since the start of the year.				
Action Taken to improve compliance				
<ul style="list-style-type: none"> The Trust's Attendance Management policy has been fully reviewed in partnership, to ensure that the Trust's current triggers and overall process is fit for purpose. The use of the ESR system is being expanded to ensure managers are effectively recording data and WOD are reporting sickness absence accurately, with the aim of improving the use of data in order to target support and management action. A Stress Task and finish group is established to focus on reducing stress related absence. Staff benefits package which would include access to an Employee Assistance Programme (EAP). The Trust Board approved the recruitment of 52 WTE posts in April 2018. We expect this investment to positively impact workload pressures for staff. 				
Expected date of compliance	Amber: 4% - 3.6% - September 2018 / Green: 3.5% - October 2018			
Escalation route	Directorates / Sub Committees / Quality Committee			
Executive Lead	Heather Bebbington, Director of Workforce and OD			

Staff Turnover		Target	June	12 month trend
		=<12%	12.98%	
Reason for non-compliance				
Turnover has increased slightly in June from 12.53% to 12.98%. This equates to 17 leavers; 5 for promotion, 4 relocating, 4 retirements, 2 did not provide a reason, 1 end of fixed term contract and 1 for reasons relating to work life balance.				
Action Taken to improve compliance				
<ul style="list-style-type: none"> A review of engagement with the exit interview process has been completed. The outcome and action planning from this has been cascaded into PADR objectives for the HR Business Advisor and forms part of the WOD action plan to support the delivery of Trust strategy. 				

- Trends for the reasons for leaving within departments are picked up by WOD Business Partners for discussion with senior manager
- The leaver form has been redesigned so that staff / managers can no longer select the reason 'other / not know' to improve data quality.

Expected date of compliance	The threshold of 12% is under review and likely to be adjusted in view of the upcoming period of significant organisational change.
Escalation route	Directorates / Sub Committees / Quality Committee
Executive Lead	Heather Bebbington, Director of Workforce and OD

PADR		Target	June	12 month trend
		95%	65%	
Reason for non-compliance				
The Trust requires all PADRs to be completed between 1st April and 31st July each year. The month 4 report should demonstrate a significant improvement in compliance.				
Action Taken to improve compliance				
PADR paperwork including guidance and templates was issued to all managers prior to 1 st April along with a reminder of the PADR completion target date. All senior managers were contacted at the start of June with details of PADR compliance for their areas with a further reminder regarding the Trust PADR completion target of 31 st July. A weekly email is issued to all senior managers to monitor compliance until end of July. The Executive Director of WOD has contacted all senior managers for assurance that PADRs will be completed by the 31 st July 2018.				
Expected date of compliance	95% by end of July 2018			
Escalation route	Directorates / Sub Committees / Quality Committee			
Executive Lead	Heather Bebbington, Director of Workforce and OD			

Mandatory Training		Target	June	12 month trend
		95%	81%	
Reason for non-compliance				
Compliance across topics requiring face to face training is lower than the topics that can be completed by e-learning although compliance across e-learning topics is still not achieving the Trust target. Compliance across the medical workforce is lower than clinical workforce. Information on ESR indicates that compliance will reduce over the next 3 months unless additional training is organised and staff complete their e-learning on time.				
Action Taken to improve compliance				

Senior Managers have been requested to submit a 3 month action plan in order to achieve the Trust target of 95%. L&D are liaising with managers and Trust trainers to identify what support is required by departments to achieve compliance.

Expected date of compliance	End September 90% End December 95%
Escalation	Directorates / Quality and Safety Sub Committee / Quality Committee
Executive	Heather Bebbington, Director of Workforce and OD

Capital Spend v Plan

Reason for non-compliance

Capital expenditure is £10.67m against a plan of £13.23m, a variance of £2.56m. This is because CT equipment on the CCC site was planned to be operational by month 2 (May) but is currently being commissioned with £0.49m to pay. The building for the future programme is £2.4m behind plan due to profiling of the budget.

Action Taken to improve compliance

The balance of expenditure on CT equipment is due to take place in July /August.

Escalation	Finance Sub-Committee
Executive	John Andrews, Acting Director of Finance

Please see the Month 3 Trust Board Finance Report for details of compliance with all other finance indicators.