

## BOARD OF DIRECTORS MEETING

Agenda Item	P1-110-18	Date: 31 <sup>st</sup> October 2018
Subject /title	Integrated Performance Report – Month 6 2018/19	
Author	Hannah Gray, Head of Performance and Planning Paul Corbett, Assistant Director of Finance	
Responsible Director	Barney Schofield, Director of Operations and Transformation John Andrews, Acting Director of Finance	
Executive summary and key issues for discussion		

### Introduction

The purpose of this integrated performance report is to provide assurance to 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, with financial information incorporated for the first time in this Month 6 report.

### Overall Core Performance

Overall, the Trust is performing well in many areas, however, there are a number of key metrics which have not been achieved.

The Trust has not met all the CQUIN requirements for Q1 2018/19. Compared with Q4 2017/18, performance for Q1 has improved for 2 CQUINs and deteriorated for 1 (potentially 2, still to be agreed with commissioners).

### Safe

The VTE assessment and Dementia targets have been met, however Sepsis is at 90% for September. There were 2 E coli infections in September, bringing the total to 3 year to date against a threshold of no more than 12 for 2018/19.

The exception tables within the report detail the actions identified to improve performance.

### Caring

Following a fall to 93.9% in August, the % of inpatients likely or extremely likely to recommend CCC is 98% for September. Whilst the Friends and Family Test (FFT) results are generally excellent, the inpatient response rates remain well below the 30% target, at 10% for September. A number of actions have been identified including resolving connectivity issues of the hand held devices now in operation and tightening processes of escalating and reporting low response rates.

There was one complaint in September.

## Effective

The draft Head and Neck clinical outcomes dashboard has been completed and was well received at the SRG chairs' meeting on 24th September. An Upper GI dashboard has also been completed and circulated to relevant consultants for comment. Options for benchmarking are being considered to identify and strive for 'best in class'.

The Trust remains at 82% compliant with NICE Guidance (including Quality Standards).

## Responsive

The Trust has met the 62 Day standard (post allocation) since October 2017, except in January 2018 and September 2018. The 31 Day (firsts) target of 96% was narrowly missed at 95.1% and the 2 Week Wait target of 93% was also just missed at 91%. The primary reasons for this situation are a relatively low number of total patients and unavoidable breach reasons such as patient choice and medical reasons. Challenges regarding the provision of annual leave cover for our medical colleagues whilst the Trust is carrying vacancies are also apparent.

## Well Led

The Trust has achieved its PADR target since July 2018. Mandatory Training compliance remains below the Trust's target of 90% at 85% for September. The position for October is expected to improve following the provision of a doctors' mandatory training day in October. The '12 month rolling' and 'in month' staff sickness both reduced again slightly in September.

## Finance

Overall financial performance is positive. The Trust surplus is ahead of plan (by £598k). EBITDA is in line with plan, with the additional surplus being delivered due to interest payable and depreciation (below EBITDA items) being below plan. As a result, and with consolidation of the subsidiary company performance, the Trust is over delivering against the NHSI Control Total (by £1,145k) for the 6 months to date. It has a financial risk rating of 1.

CIP delivery is now ahead of plan both recurrently and non-recurrently. Capital Expenditure is behind plan but is expected to catch up to be on plan by the year end.

The main in year risks identified relate to:

- Non-delivery of CQUIN, although performance is expected to improve in Q3 and Q4.
- Radiotherapy Activity, although the financial impact is fully mitigated by over-performance on other service lines (e.g. Chemotherapy and Out-patient procedures)

## 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 September 2018.
- Note the satisfactory financial performance and surplus for month 6, including the overall financial risk rating of 1.
- Approve the declaration to NHSI for quarter 2, that the Board anticipates the Trust will remain a financial risk rating of at least a 2 over the next 12 months.

## Risk and assurance

This report highlights all risks rated 15 or over 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 15: premises and equipment  
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:

☒

**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.			
<b>Next steps</b>			
<b>Appendices</b>			
Financial Statements Year to Date			

### 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	X	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	X
Quality of care and environment	X	<i>Being heard:</i> <ul style="list-style-type: none"> <li>Involved and represented</li> <li>Able to raise grievances</li> <li>Able to make suggestions</li> <li>Able to raise concerns and complaints</li> </ul>	
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 6 2018/19

**AUTHOR:** HANNAH GRAY, HEAD OF PERFORMANCE AND  
PLANNING  
PAUL CORBETT, ASSISTANT DIRECTOR OF FINANCE

**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\* taken 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.

\* Model Hospital charts detail:

Chart detail: blue line = CCC | grey line = peers | black line = national median  
‘Peers (my peers)’ = Christie and Royal Marsden | ‘Peers (my NHSI Region)’ = All Trusts in CCC’s NHSI region.

### Risks

There are 29 corporate risks graded 15 or above; the details are presented in section 5.3. The risks are reviewed by the leads, at Directorate monthly meetings and escalated to the relevant sub committee.

## High Level Performance Dashboard: Month 6, YTD and 12 month trends



### Key points to note:

- The 62 Day cancer waiting times figure is validated at the end of the following month, therefore the figure presented is unvalidated.
- The 30 day mortality data is for the previous month.
- The bar charts show the RAG rated performance per month for the last 12 months (this includes staff sickness; monthly rather than rolling 12 months).
- The Mandatory Training RAG rating has been confirmed as R: <90% and G: =>90%
- 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 =<28% for Patients not meeting the CUR criteria is to be achieved by 31<sup>st</sup> March 2019, rather than in every month.

## Key Financial Performance Indicators

The key financial performance indicators, with RAG ratings, for the Trust are shown in the table below.

KEY: Better than target		Green
Below target		Red
Below target but within acceptable limits		Amber
<b>Key Indicator</b>		
Group Surplus (incl Charity) of £2,194k against a planned surplus of £2,252k		Amber
Trust net surplus of £1,532k vs a planned surplus of £934k		Green
Net Trust I&E margin of 1.9% vs a planned margin of 1.3% (excludes impairments)		Green
NHSI Control total of £1,002k against actual year to date comparator of £2,147k		Green
Actual CIP achieved £1,059k against a plan of £791k		Green
Capital expenditure at £27,210k against a plan of £36,372k		Amber
Cash balances at £79,266k are £9,967k below planned balances of £89,233k		Amber
CQUIN funding of £869k against a plan of £1,057k		Red
<b>Use of Resources: Risk Rating</b>		
Capital Service Cover rating of 1 (against a plan of 2)		Green
Liquidity Rating of 1 (against a plan of 1)		Green
I&E Margin of 1 (against a plan of 1)		Green
Variance from Control Total rating of 1 (against a plan of 1)		Green
Agency spend of £501k, which is £82k below NHSI agency ceiling year to date – giving a rating of 1 (against a plan of 1)		Green
Use of resources – overall risk rating of 1 (against a plan of 1)		Green
<b>Finance and Activity – September 2018</b>		
Agency medical locums £309k against a target of £250k		Red
Radiotherapy activity - 1.9% growth		Red
Chemotherapy activity - 5.0% growth		Green
Inpatient activity - 1% growth		Green
Outpatient activity -1% growth		Green

## 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 October 2018 report, however the data relates to a range of different time periods). No Insight Reports were published in August and September. The October report has been published and describes CCC's position including KPIs which are NEW to each section since the July 2018 report, as follows:

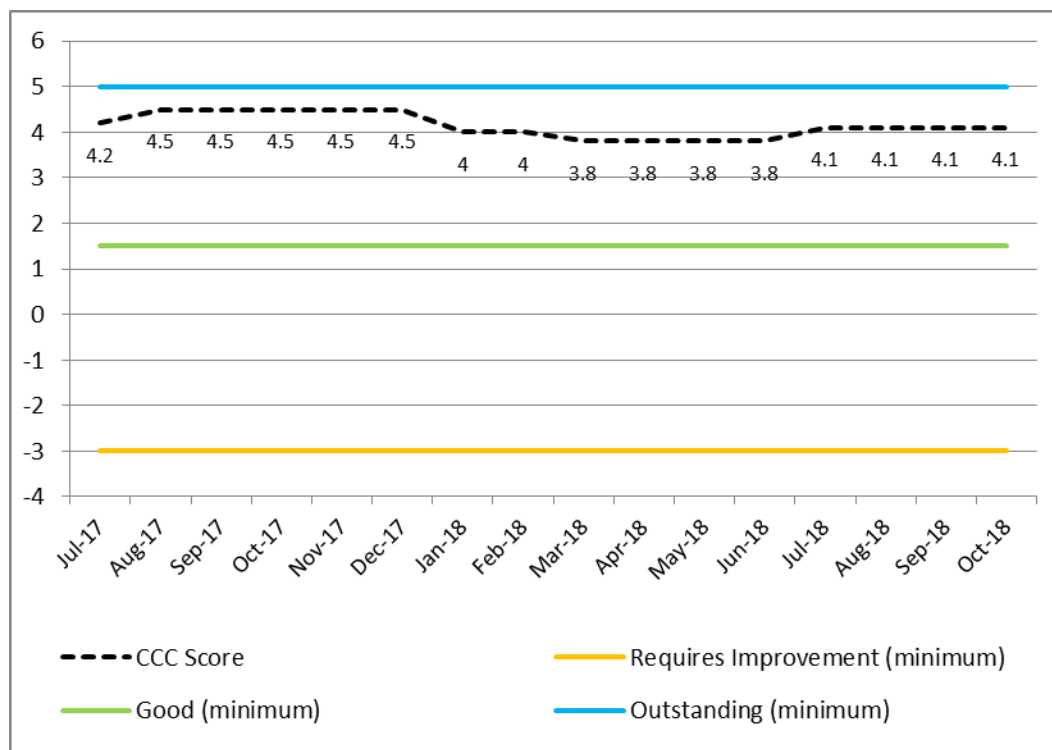
Much better compared nationally	Much worse compared nationally	Improved (compared to 12 months ago)	Declined (compared to 12 months ago)
<ul style="list-style-type: none"> <li>Ratio of consultant to non-consultant doctors</li> <li>Ratio of occupied beds to other clinical staff</li> </ul>	<ul style="list-style-type: none"> <li><b>NEW</b> Stability of Nursing and Midwifery staff</li> </ul>	<ul style="list-style-type: none"> <li>Staff appraised in last 12 months (%)</li> <li><b>NEW</b> Patient – led assessment of environment for dementia care (%)</li> <li><b>NEW</b> NRLS- Consistency of reporting</li> <li><b>NEW</b> Patient-led assessment of privacy, dignity, and well being (%)</li> <li><b>NEW</b> Ratio of delayed transfers and number of occupied beds</li> </ul>	<ul style="list-style-type: none"> <li>Overall engagement (1-5)</li> <li><b>NEW</b> Ratio of occupied beds to nursing staff</li> <li><b>NEW</b> Inpatient response rate (%)</li> </ul>
KPIs removed from these sections since the July insight report:			
<ul style="list-style-type: none"> <li>Ratio of occupied beds to nursing staff</li> </ul>		<ul style="list-style-type: none"> <li>Patient-led assessment of food (%)</li> <li>Ratio of consultant to non-consultant doctors</li> </ul>	<ul style="list-style-type: none"> <li>NRLS - Consistency of reporting</li> <li>Patient-led assessment of facilities (%)</li> <li>Patient-led assessment of privacy, dignity, and well-being (%)</li> <li>Ratio of delayed transfers and number of occupied beds</li> <li>Ratio of occupied beds to medical and dental staff</li> <li>Ratio of senior staff nurses to staff nurses</li> <li>Ratio of ward manager nurses to senior and staff nurses</li> </ul>



This shows a positive improvement, with an increasing number of 'improved' KPIs and a reducing number of 'declined' KPIs. This is reflected in the increasing composite score below.

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

In 2018/19, the total CQUIN fund across both Commissioners is £2,009,811.

Commissioners have provided final feedback on the Q1 2018/19 submission, taking into account additional information provided by the Trust. The CQUIN detail, including expected performance for 2018/19 is shown in the table below.

The maximum and minimum funding (subject to negotiation outcomes for the Optimising Palliative Chemotherapy CQUIN) being withheld for Q1 2018/19 is £125,534 and £71,181 respectively. The Q2 submission will be made on 26<sup>th</sup> October.

More robust systems have now been implemented to monitor and improve performance in 2018/19. CQUIN details (including the performance projection for 2018/19 included in the table below) are included in the recently developed Directorate 'data packs' which are presented at the monthly Directorate meetings. Risks to achievement are escalated to the relevant Sub Committee via the 'Triple A' Report and added to the risk register as appropriate. A new weekly, moving to monthly CQUIN group will start to meet in November 2018.

### Key to the table below:

- Full shaded RAG ratings denotes a confirmed level of achievement: R=none, A=partial, G=full.
- Lighter shaded R,A,G with bold border denotes expected, but yet to be confirmed level of achievement.

CQUIN	Value	£ withheld for Q1 18/19	2017/18				2018/19			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<b>Staff Survey:</b> Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing; MSK and stress.	£26,217	N/A								
<b>Healthy food for NHS staff, visitors and patients</b>		N/A								
<b>Improving the uptake of flu vaccinations for frontline clinical staff</b> (target 70% by 28 <sup>th</sup> February 2018)		N/A								
<b>Preventing ill health by risky behaviours – alcohol and tobacco:</b> inpatient screening, advice, referral and medication	£26,217	£8,357								

CQUIN	Value	£ withheld for Q1 18/19	2017/18				2018/19			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<b>Holistic Needs Assessment</b>	£198,926 (NHSE) £52,370 (LCCG)	£62,824								
<b>End of Treatment Summaries</b>	£198,926 (NHSE) £52,370 (LCCG)	£0								
<b>Clinical Utilisation Review:</b> Installation and Implementation of software; reduction in inappropriate hospital utilisation and reporting of results	£528,273	£0								
<b>Enhanced Supportive Care:</b> Ensuring patients with advanced cancer are, where appropriate, referred to a Supportive Care Team, to secure better outcomes and avoidance of inappropriate treatments.	£357,944	£0								
<b>Optimising Palliative Chemotherapy:</b> To ensure systematic review of further chemotherapy decisions for patients with poor clinical response. To ensure effective Mortality Review processes are in place.	£217,413	Maximum possible to be withheld: £54,353 (to be confirmed in Nov 2018)								
<b>Medicines Optimisation:</b> 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	£140,241	£0								
<b>Dose Banding:</b> 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	£210,915	£0								

## CQUIN Exception Reports

The exception reports below relate to CQUINS for which

- Commissioners have confirmed or potential under performance for Q1 2018/19.
- A risk to achievement has been identified in any quarter in 2018/19.

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

### Holistic Needs Assessment

#### Reason for non-compliance

The required number of Holistic Needs Assessments were not completed for Q1 or Q2 2018/19 due to a combination of systems not being implemented within the timescales and 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), with 9 now in post and undergoing training; 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 dedicated CQUIN monthly meeting will start in November 2018 for the CQUIN leads and supporting staff to ensure a joined up approach to these initiatives and drive improvement in those with which we are not compliant.

<b>Expected date of compliance</b>	Partial: Q3 2018/19, Full: Q4 2018/19
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<b>Escalation route</b>	Directorates / Quality and Safety Sub Committee / Quality Committee / Trust Board
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<b>Executive Lead</b>	Sheila Lloyd, Director of Nursing and Quality
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### Enhanced Supportive Care

#### Reason for non-compliance

The ESC service is yet to be 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.

During Q2, the Palliative Care Consultant has been absent from work. As the sole consultant for ESC, this absence has led to cancellation of ESC clinics. Referrals to the service were still encouraged and accepted, but there has been an inevitable decrease in referrals, which is likely to have an impact on compliance with CQUIN expectations for Q2.

### **Action Taken to improve compliance**

Actions to improve compliance include:

- During the period of Palliative Care Consultant absence, communications were sent to all referrers to encourage continuation of referrals into the service
- The Palliative Care Team adopted a triage approach to review and actively manage referrals received

On-going actions 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 has started in post (22<sup>nd</sup> 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), with 9 now in post and undergoing training; 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.

Newly agreed actions:

- The CQUIN lead will attend MAC to increase Consultant engagement.
- Patients will targeted as appropriate via the pre assessment clinics.
- Breast and Unknown Primary cohorts to be added to the service for Q4
- Referrals to be introduced as part of pre-assessments at Outpatients and Radiotherapy
- A dedicated CQUIN monthly meeting will start in November 2018 for the CQUIN leads and supporting staff to ensure a joined up approach to these initiatives and drive improvement in those with which we are not compliant.

<b>Expected date of compliance</b>	Q4 2018/19
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<b>Escalation route</b>	Directorates / Quality and Safety Sub Committee / Quality Committee / Trust Board
<b>Executive Lead</b>	Sheena Khanduri, Medical Director

## Optimising Palliative Chemotherapy

### Reason for non-compliance

The required number of peer discussions were not completed / recorded for Q1 2018/19 and early indications are that this is the same for Q2. Commissioners have withheld a decision on compliance for Q1 pending receipt of the Q2 figures. There is a risk therefore of failing to achieve the requirements for both Q1 and Q2.

### 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), with 9 now in post and undergoing training; 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 dedicated CQUIN monthly meeting will start in November 2018 for the CQUIN leads and supporting staff to ensure a joined up approach to these initiatives and drive improvement in those with which we are not compliant.

<b>Expected date of compliance</b>	Q3 2018/19
<b>Escalation route</b>	Directorates / Quality and Safety Sub Committee / Quality Committee / Trust Board
<b>Executive Lead</b>	Sheila Lloyd, Director of Nursing and Quality

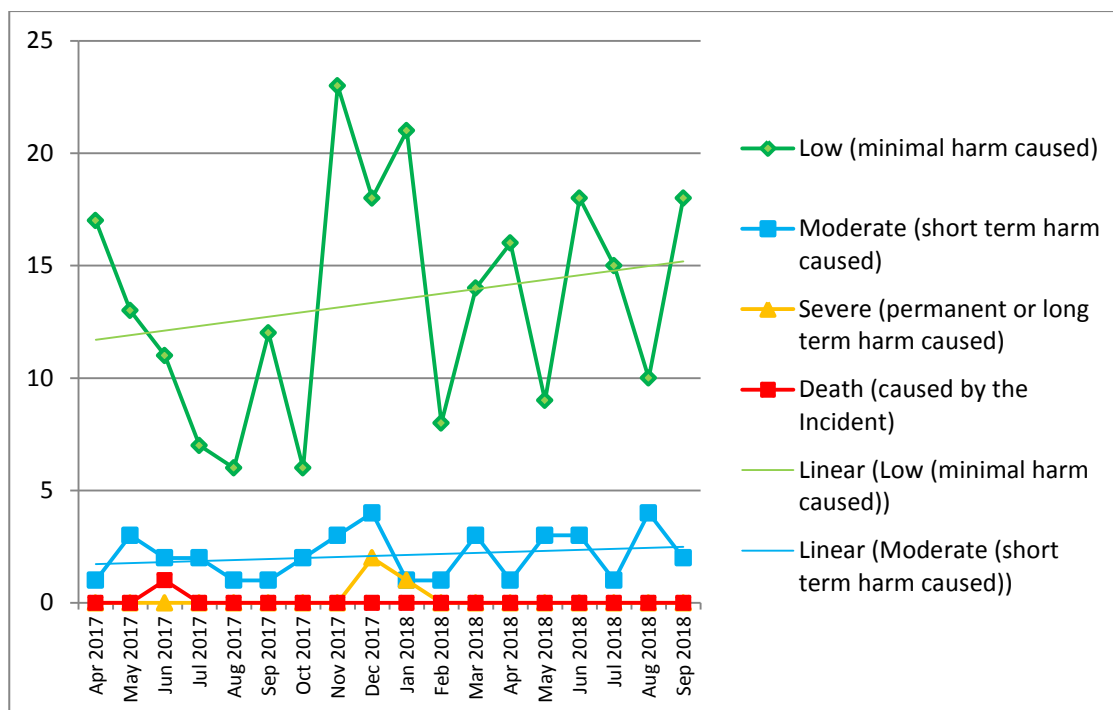
# 1. Safe

## 1.1 Never Events

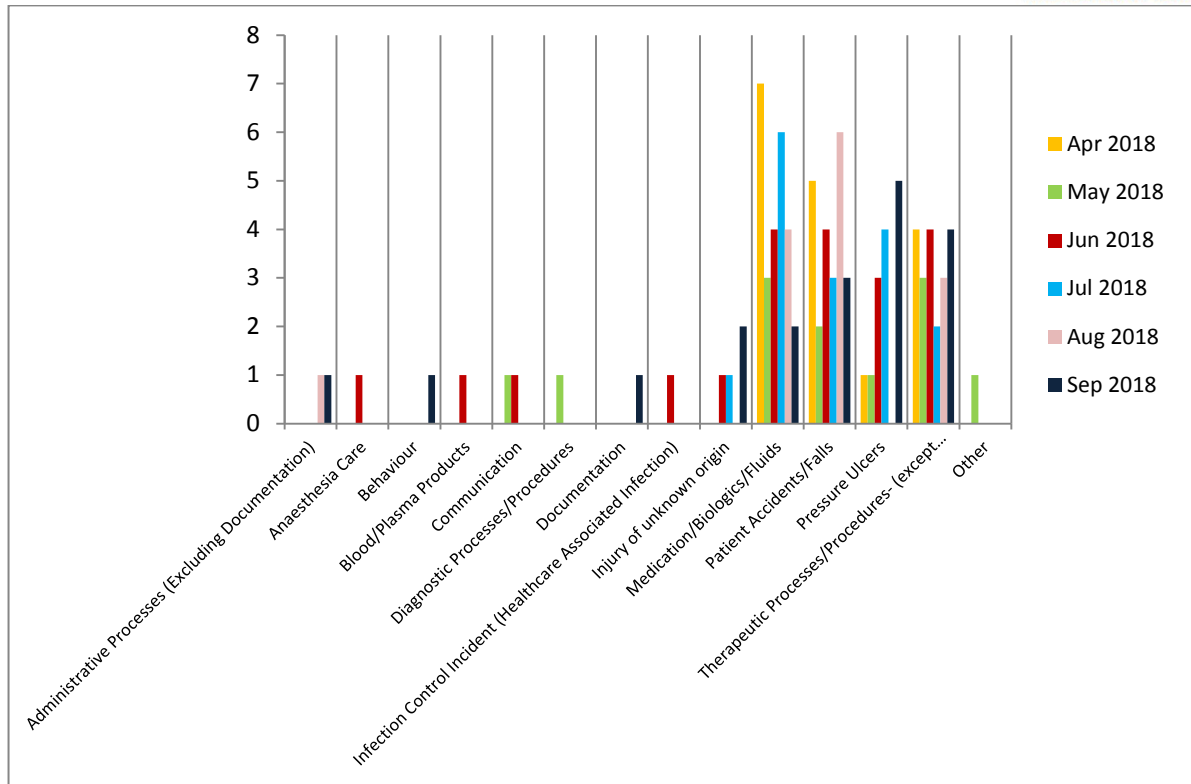
There have been 0 never events from 1/4/18 – 30/9/18.

## 1.2 Incidents

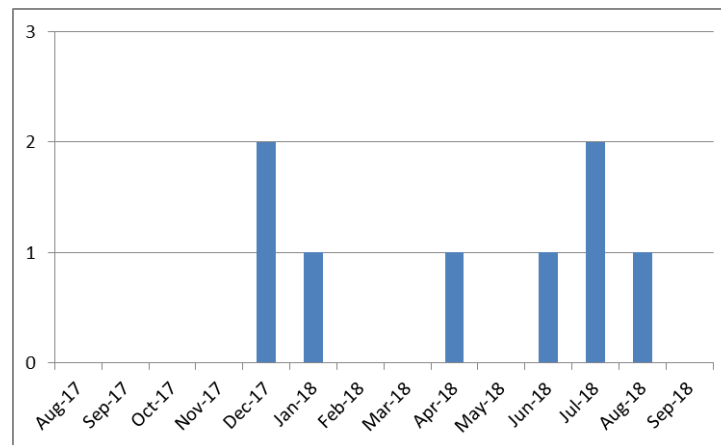
Incidents resulting in harm (by level of harm):



Incidents resulting in harm, by category for the last 6 months:



### Serious untoward incidents:



There were no serious incidents in September 2018. There have been 3 serious incidents in October to date:

#### 1. Datix. ID 4415 – Triage: Cardiac Arrest

Date of incident: 7/10/2018



Date Incident identified: 7/10/2018

Incident Panel date: 26/10/2018

**Brief Description of incident:**

Patient rang triage feeling unwell. After being assessed following UKONS, patient asked to attend CCC-W for further assessment. On arrival Met call raised as patient collapsed in car. Son reports his father had collapsed in the car approx. 10minutes previous. Patient died on transfer to Arrowe park Hospital.

**2. Datix ID 4461 – Haemato-oncology referrals**

Date of incident: 16/04/2018

Date Incident identified: 01/10/2018

Incident Panel date: TBC

**Brief Description of incident:**

Two legacy patients first treated April/June 2018. Both patients were incorrectly referred by their GP's into the BMT service. Both patients have MS and underwent conditioning regimes and Stem Cell collection. Both diagnoses is that of primary MS with no active MRI activity. It has been identified that both patients do not meet the BSBMT and NHSE criteria. Therefore pathway suspended pending investigation.

**3. Datix Ref. ID 4384 – Clinical Letters**

Date of incident: 03/10/18 & 05/10/18

Date Incident identified: 03/10/18 & 05/10/18

Incident Panel date: TBC

A total of 547 new and follow up clinic letters have not been sent for two new consultants (72 New letters and 478 follow up letters). This has affected a total of 377 patients. The error relates to one consultant who started using their own templates from 12/6/18 and one consultant that started using their own templates from 20/8/18. To put this in context, over 16,500 individual new and follow up clinic letters have been generated on MEDITECH, with average of 2-3 copies of each individual being electronically processed printed and sent to the intended recipients correctly since 12/6/18.

The situation was highlighted for one of the consultants by Admin services on 3<sup>rd</sup> October 2018, immediate investigation identified that a step in the set up process had not been undertaken resulting in the this new consultant not being correctly mapped in the Trust Integration Engine (TIE) which resulted in their letters not being electronically processed by the TIE.

Thorough investigation, by comparison of consultant mappings within the process, the following day, 4<sup>th</sup> October 2018, identified a second consultant who had not been set up correctly, and confirmed that no other consultants were affected.

The failure was due to a human error, i.e. missing a step in the process

A further incident was highlighted when a total of 156 internal follow up clinic letters have been identified as not being sent via internal post between 27<sup>th</sup> March 2018 and 10<sup>th</sup> October 2018. This has affected a total of 106 patients. It is important to note that the clinical follow up letters have been electronically recorded on Meditech and have been sent via the Synertec process to the intended external recipients at the time of creation (e.g. GPs, external consultants not on the Wirral internal post site). Immediate investigation identified a human error which meant correspondence hasn't been picked up to go through the Synertec process and a comprehensive review of all follow up correspondence was initiated (1 consultant - 131 letters for 82 patients identified).

The investigation has highlighted an additional 6 consultants affected by this issue, however the volume of letters affected is much smaller (6 consultants - 25 letters for 24 patients). The failure was due to a human error, i.e. missing a step in the process.

We are undertaking a full clinical letter review process to identify those containing no direct action and those that require clinical review. This will be systematic and will be reported on daily with a weekly risk stratification meeting to determine any impact on patient care.

### **Inquests/Coroner's investigations**

No new Coroner's investigations or Inquests have been held.

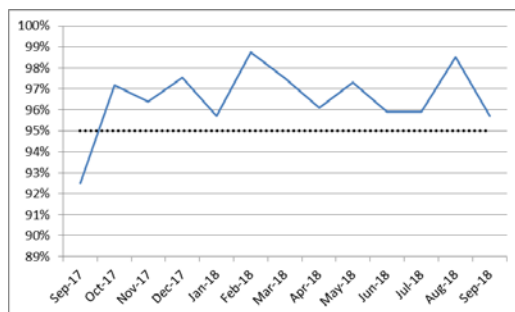
<b>Inquest Number</b>	<b>Date of Request</b>	<b>Coroner</b>	<b>Date of Inquest</b>	<b>Staff requested to attend</b>	<b>Conclusion</b>
2018/01	8/1/18	Warrington	22/6/18	No	Industrial disease
2018/02	23/2/18	North Wales	17/7/18	No	Cause of Death was  1a) Mesothelioma.  The Coroner recorded an open verdict.
2018/04	28/6/18	Liverpool/Wirral	N/A	No	The Coroner has discontinued the case. Cause of death =

					natural.  1.a Cardiac arrhythmia 1.b Hypercalcaemia 1.c Non-Hodgkins lymphoma
2018/05	13/7/18	Liverpool/Wirral	28/8/18	Yes	1a Anaphylactic Shock,  1b Hypersensitivity to intravenous contrast medium,  II Ischaemic heart disease, coronary artery atherosclerosis  The Coroner concluded Misadventure

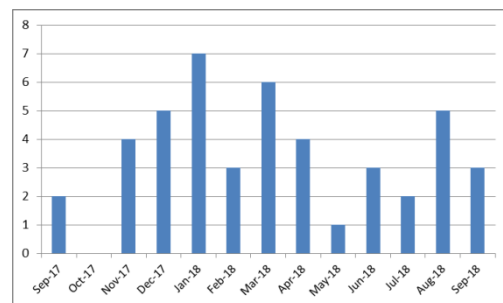
### 1.3 Harm Free Care

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

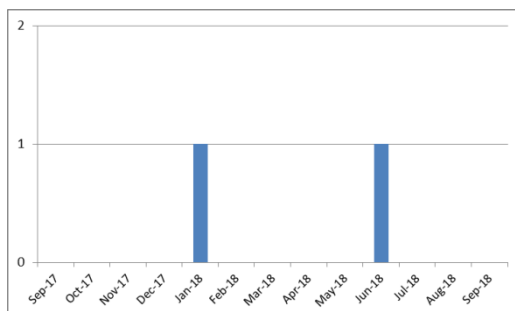
Safety Thermometer (CCC harm free)



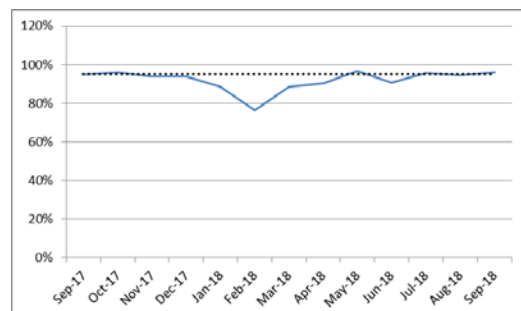
Falls resulting in harm



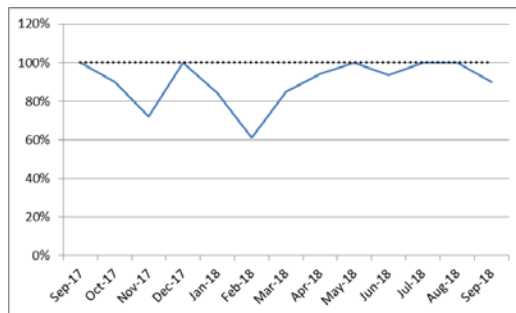
Pressure Ulcers (attributable) | Target = 0



VTE assessment



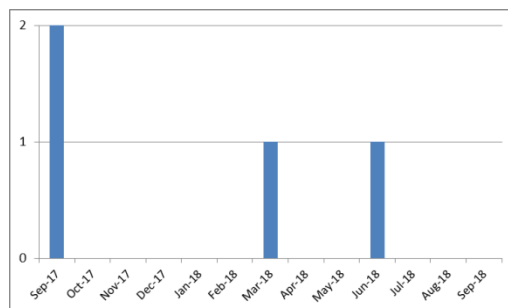
## Sepsis (IV Antibiotics with 1 hr)



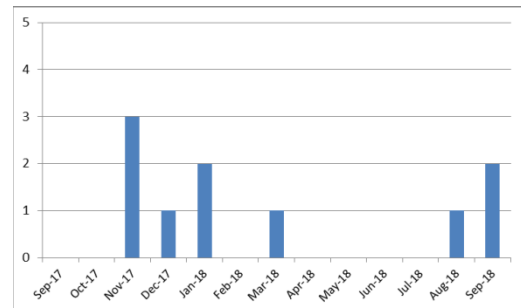
## MRSA

There were 0 cases of MRSA in 2017/18 and 0 from 1/4/18 – 30/9/18.

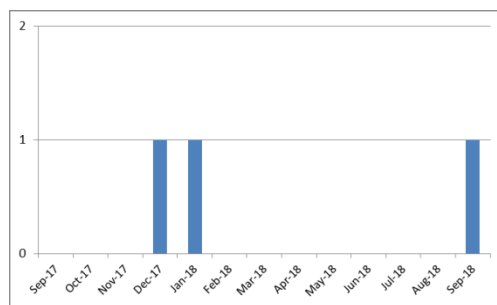
## C difficile | Threshold for 2018/19 =<4



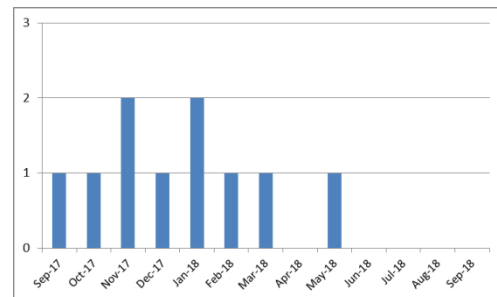
## E Coli



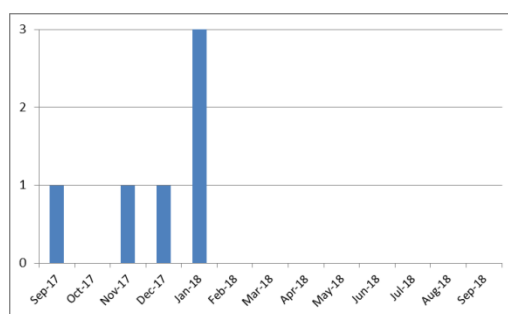
## MSSA



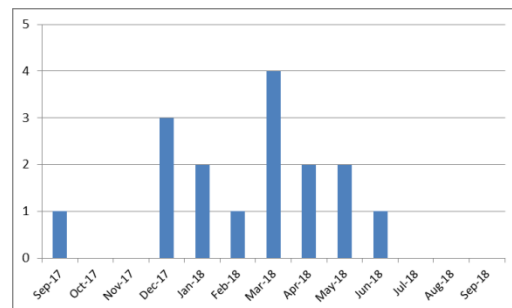
## Klebsiella



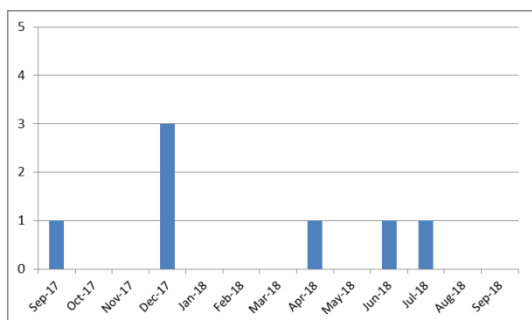
## Pseudomonas



## VRE



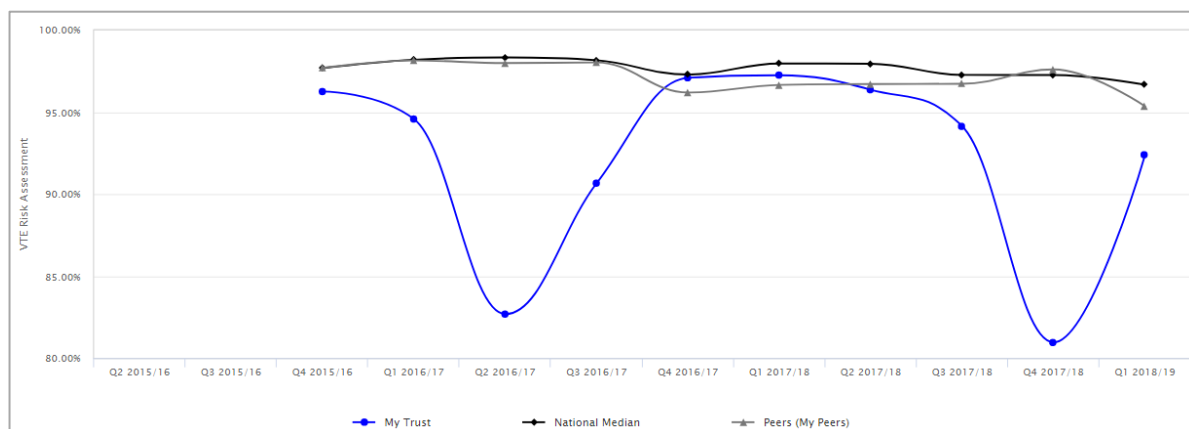
## CPE



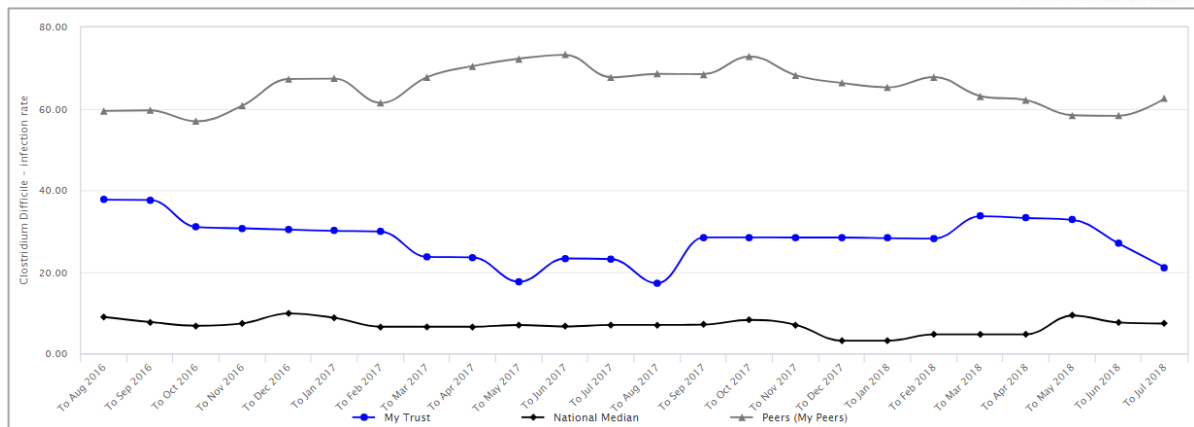
## Benchmarked data

Safe	Data period	Trust value	Peer median	National median	Chart
VTE Risk Assessment	Q1 2018/19	92.39%	95.36%	96.68%	
Clostridium Difficile - infection rate	To Jul 2018	21.09	62.53	7.33	
MRSA bacteraemias	To Mar 2018	0.00	2.64	0.00	
Potential under-reporting of patient safety incidents	30/11/2016	0.12	0.07	N/A	No chart available
Escherichia coli (E. coli) bacteraemia bloodstream i...	Jul 2018	63	140	19	
Meticillin-sensitive staphylococcus aureus (MSSA) r...	Jul 2018	5	14	13	

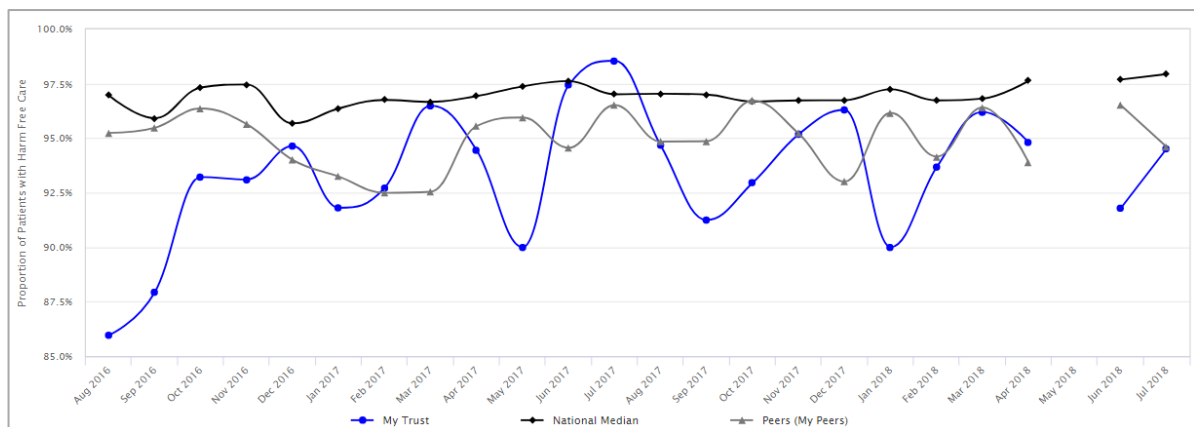
## VTE Risk Assessment



## Clostridium difficile (infection rate)



## Safety Thermometer



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. only including 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.






## 1.5 Nurse Safe Staffing

September 2018 staffing figures (hours):

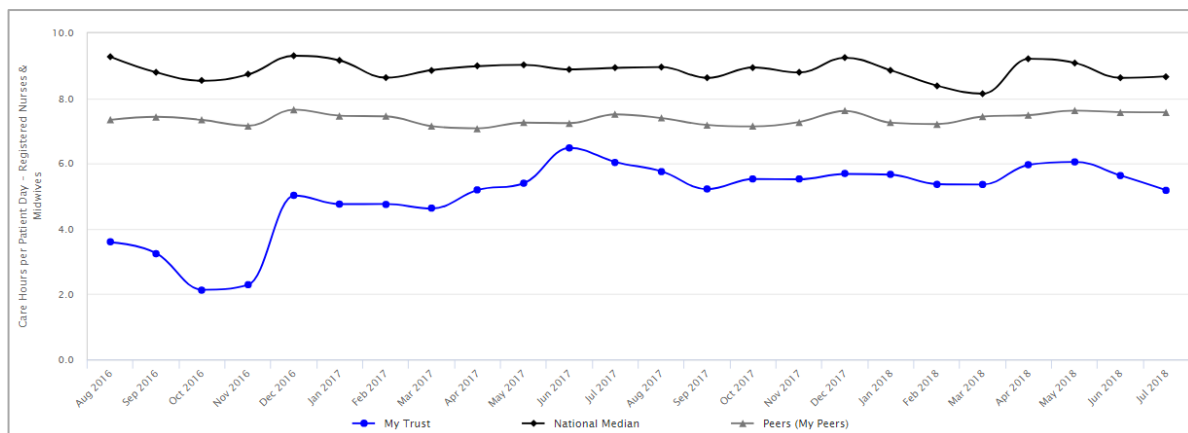
Ward name	Day				Night				Day		Night	
	Registered Nurses		Care Staff		Registered Nurses		Care Staff		Average fill rate - registered nurses (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses (%)	Average fill rate - care staff (%)
	Total monthly planned	Total monthly actual	Total monthly planned	Total monthly actual	Total monthly planned	Total monthly actual	Total monthly planned	Total monthly actual				
Conway	1878	1710	720	510	1080	996	720	600	91.1%	70.8%	92.2%	83.3%
Sulby	1230	1062	204	192	432	480	0	0	86.3%	94.1%	111.1%	-
Mersey	2244	1860	720	480	1080	1068	720	612	82.9%	66.7%	98.9%	85.0%
7Y	1800	1221	900	816	690	690	690	690	67.8%	90.7%	100.0%	100.0%
10Z and 7X	1628	1578	641	621.5	945	903	483	483	96.9%	97.0%	95.6%	100.0%

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

Care hours per patient day are calculated by dividing the total numbers of nursing hours on a ward or unit by the number of patients in beds. This calculation provides the average number of care hours available for each patient on the ward or unit.

Key Performance Indicator	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Trend
Care hours per patient day: Conway Ward	6	6.5	6.2	6.1	6.2	5.7	6	6.5	7.5	7.4	8.4	7.6	6.8	
Care hours per patient day: Sulby Ward	11	16.6	15.2	19	14.8	15.4	10.4	12	14	13.4	8.7	16.1	15.8	
Care hours per patient day: Mersey Ward	7.1	7.4	6.8	7.4	7.3	6.9	7.3	9.2	9.4	7.6	7.2	8.0	7.2	
Care hours per patient day: 7Y	6.2	6.7	6.3	5.6	5.7	5.7	5.5	5.7	5.6	5.8	5.5	5.7	5.7	
Care hours per patient day: 10Z and 7X	12	12.5	13.5	14.3	12.9	12.4	13.6	14.4	10.4	18.8	14.7	13.1	13.9	


### CHPPD benchmarked (nursing and midwifery staff):



A review of the use of CHPPD in the Trust, including a self-assessment against newly published guidance from NHS Improvement on how to collect and use the data, is underway.

The CHPPD data is due to be published on My NHS and NHS Choices from September 2018 for acute trusts and January 2019 for acute specialist, community health and mental health trusts. CCC is however not listed on this site and discussions are on-going to resolve this.

## 1.6 Exception Reports

Sepsis	Target	Sept	YTD	12 month trend
	100%	90%	96.2%	
<b>Reason for non-compliance</b>				
Target of 100% missed with 90% achieved in September. Two patients who presented with red flag indicators of sepsis in October did not meet the antibiotics within the one hour target time. No harm was caused by missing the one hour target time; both patients recovered and have been discharged home. All inpatients who developed red flag indicators of sepsis during their inpatient stay received antibiotics within the 90 minute target time.				
<b>Action Taken to improve compliance</b>				
<ul style="list-style-type: none"> <li>Failure to meet the target time has been escalated to the respective ward manager for further investigation and understanding of cause. The Matron for Integrated care has also been advised and has requested actions from both ward managers.</li> <li>Sepsis working group continues to facilitate and add to the actions identified in the annual Sepsis audit.</li> <li>Weekly audit conducted.</li> <li>Clinical staff awareness that antibiotics must be given in one hour of suspected Sepsis.</li> <li>The Critical Care Outreach Team and GDE team will complete the Sepsis Screening Tool on Meditech and launch it (including the 2018 National Guidelines) along with NEWS2 in December 2018. This will be achieved by a travelling Road show event over a three week period.</li> </ul>				
<b>Expected date of compliance</b>	October 2018			
<b>Escalation route</b>	Directorates / Quality and Safety Sub Committee / Quality Committee			
<b>Executive Lead</b>	Sheila Lloyd, Director of Nursing and Quality			

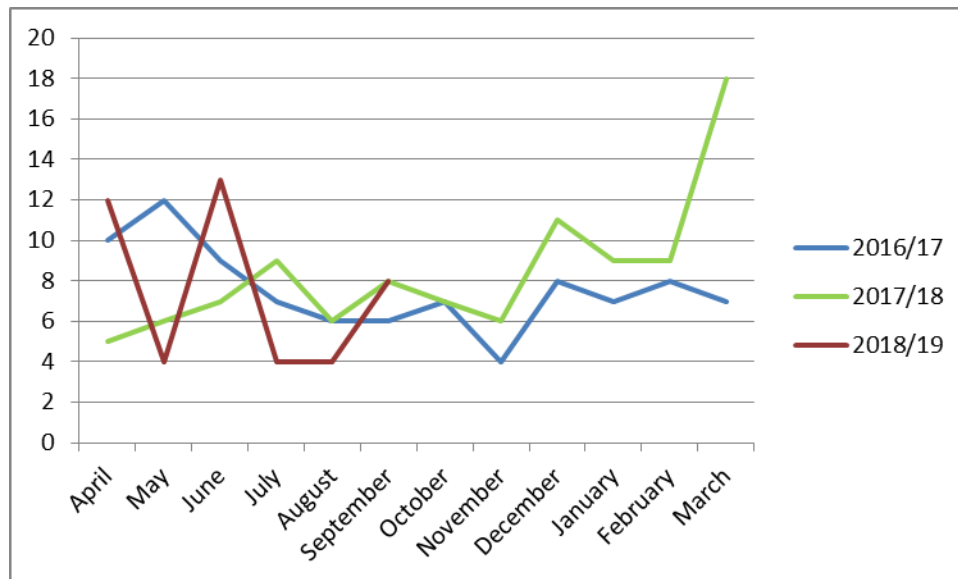


## 2. EFFECTIVE

### 2.1 Clinical Outcomes

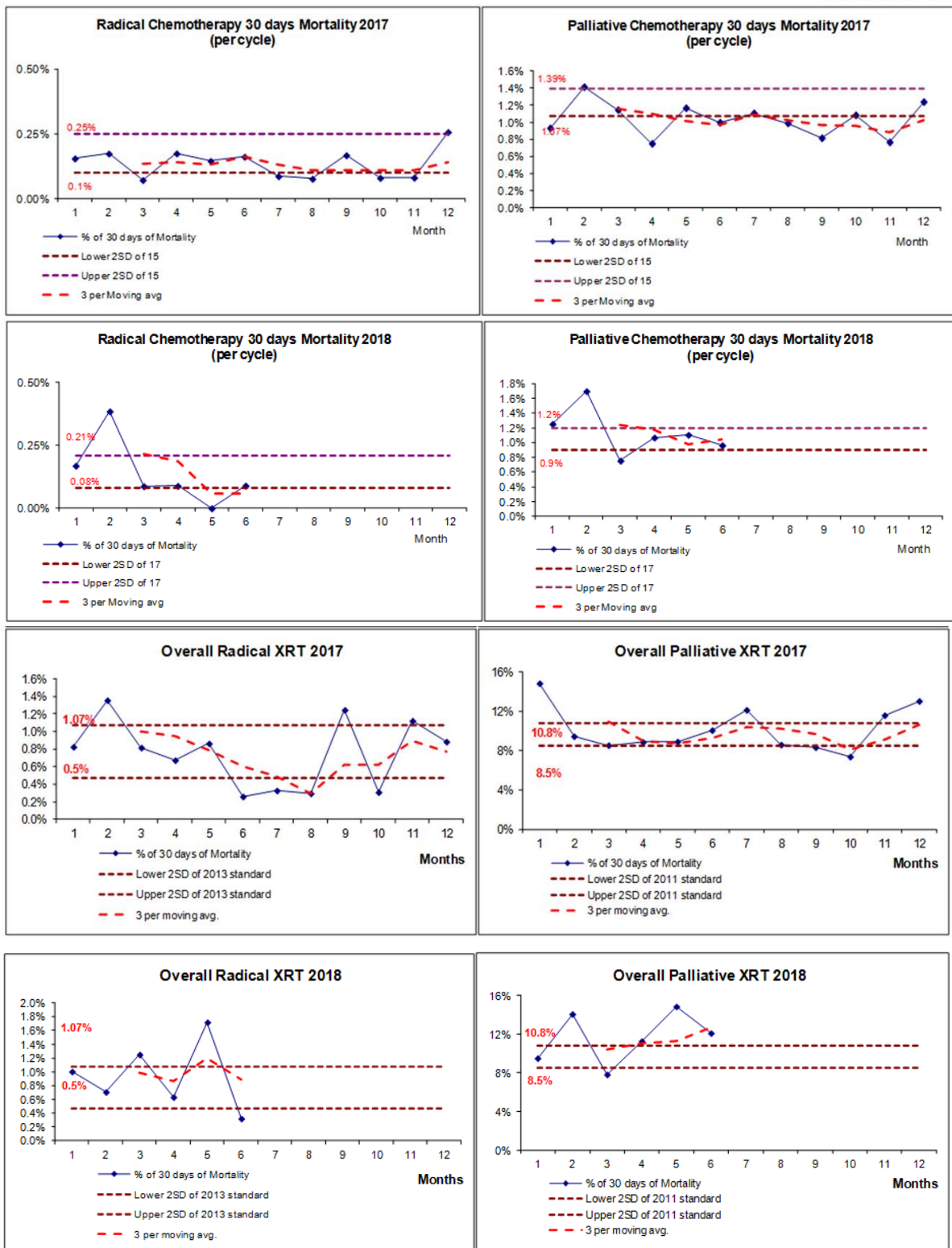
#### Mortality

##### Inpatient deaths:



##### Mortality within 30 days:

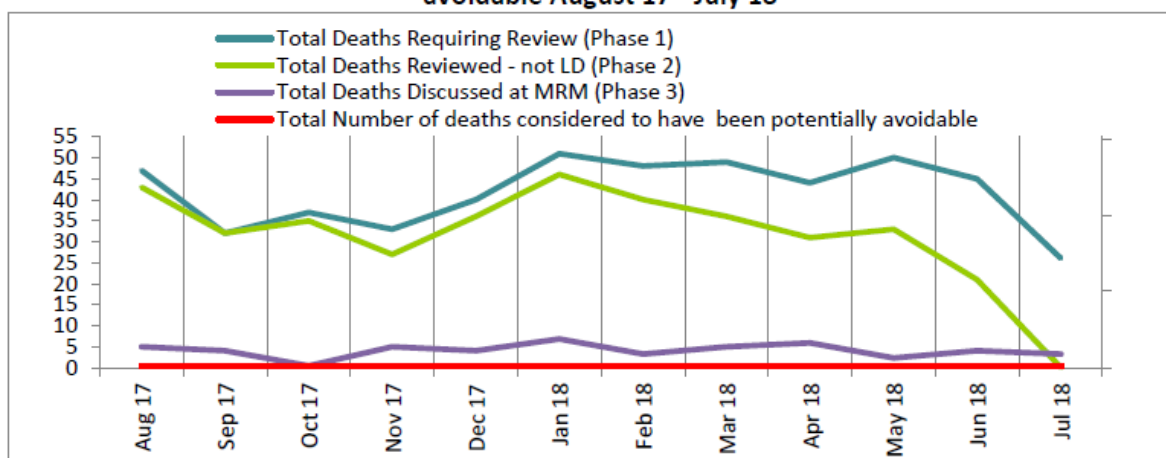
The HSMR and SHMI mortality indicators are not applied to specialist trusts such as CCC, therefore the Trust has developed its own approach to monitoring statistically significant changes in levels of mortality (see charts below for 2017 and January - June 2018). This information is utilised alongside 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, which is captured on a different EPR. 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.

**Mortality over time, total deaths reviewed and deaths considered to have been potentially avoidable August 17 - July 18**



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

## Other clinical outcomes:

The draft Head and Neck dashboard has been completed and was well received at the SRG chairs' meeting on 24th September. Some suggestions were made, which will be incorporated after all SRGs have received their first draft dashboard. An Upper GI dashboard has also been completed and circulated to relevant consultants for comment. Options for benchmarking are being considered to identify and strive for 'best in class'.

## 2.2 NICE Guidance

See exception report

## 2.3 Exception Reports

### NICE Guidance

#### Details of non-compliance

- 216 (82%) guidance are compliant
- 6 (2%) guidance are undergoing assessment
- 3 (50%) assessments were not completed in 4 weeks of distribution to local lead.
- 33 (13%) guidance is working towards compliance with action plan in place.
- 25 (76%) guidance were not compliant 12 months post publication.
- 4 (2%) guidance were not implemented by CCC due to alternative effective treatment being available.
- 3 (1%) of guidance are non-compliant with accepted risk.

NB: These figures include NICE 'Quality Standards' as well as full NICE Guidance.

#### Action Taken to improve compliance

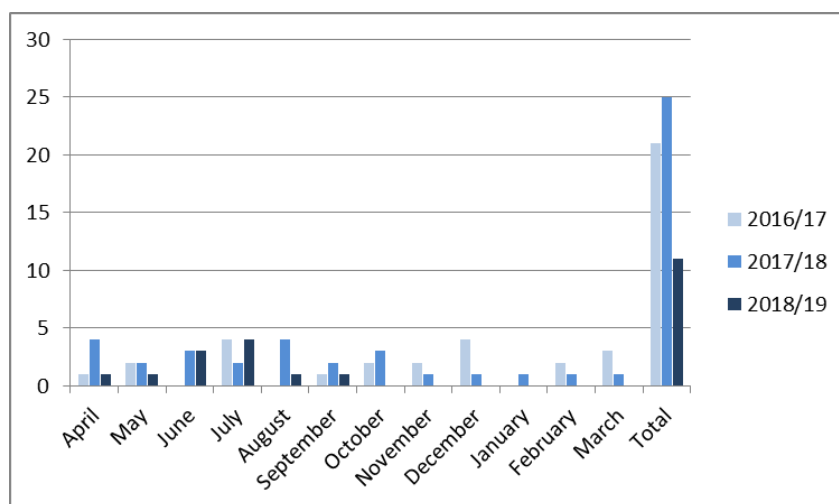
The Trust's NICE Committee has a responsibility to expedite implementation, including prioritising guidance for which non-compliance presents the greatest potential risk to patients.

<b>Expected date of compliance</b>	The NICE Committee is tasked with improving compliance, including risk assessing delays with implementation. The figures will be reported monthly in this report to assess the pace of change and set trajectories. The Quality and Safety Sub Committee receives reports from the NICE Committee and will challenge progress.
<b>Escalation route</b>	Directorates and NICE Committee / Quality and Safety Sub Committee / Quality Committee.
<b>Executive Lead</b>	Sheila Lloyd, Director of Nursing and Quality

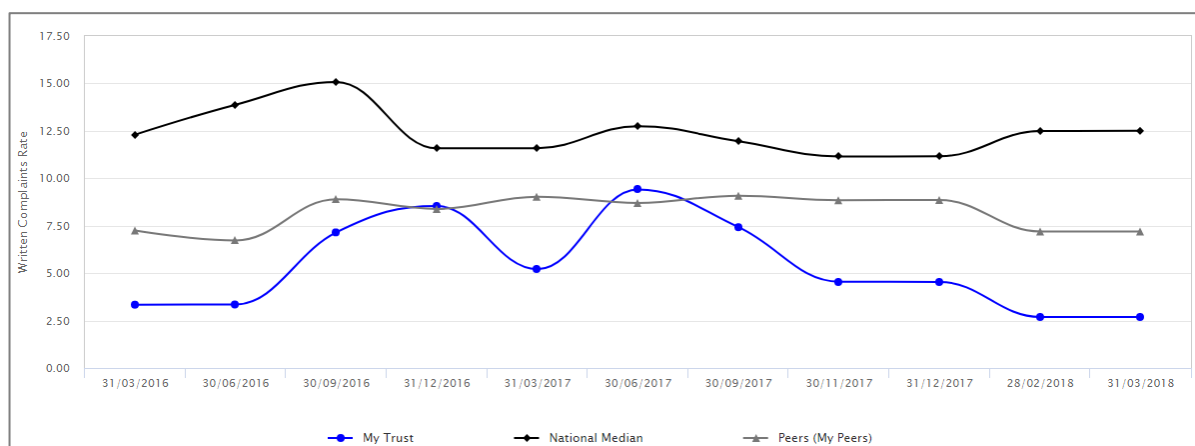
## 3. CARING

### 3.1 Complaints and PALS

Complaints:



Benchmarked Data (this has not been updated on the Model Hospital site)



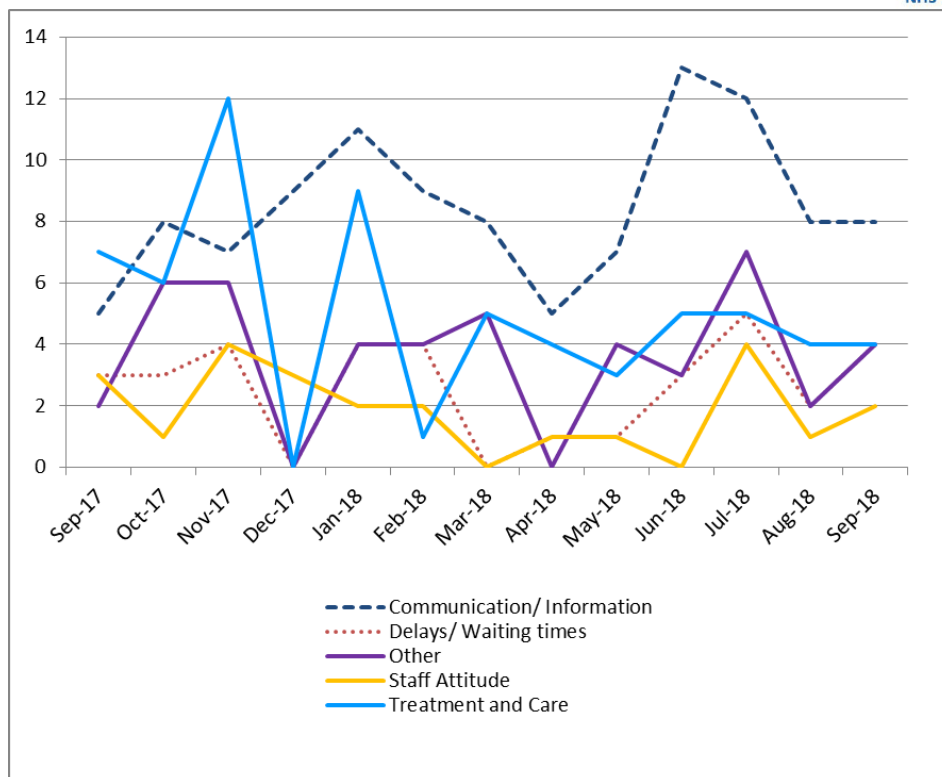
The table below provides a summary of the complaints received in 2018/19 (as at 18/10/18)

Received	Complaint Type	Description	Lessons learned	Grade	Complaint Outcome
09/04/2018	Treatment and Care	Pt has questions for Consultant regarding side effect of treatment.	Identified communication issues at another Trust. CCC Admin services to contact the Trust.	Low	Not Upheld
15/05/2018	Communication	Relative unhappy with attitude of doctors when giving bad news.	The Action plan is due to be sent to the complainant.	Moderate	Partially Upheld
24/05/2018	Treatment and Care	Pt unhappy that side effects of chemo were not fully explained.	To ensure Pts have full understanding.	Low	Partially Upheld
03/06/2018	Treatment and Care	Patient's wife and daughter unhappy with communication and have questions about the sudden death of the patient.	Meeting to be arranged once complainant responds.	Very low	Not Upheld
05/06/2018	Communication	Pt complained that the booked interpreter did not attend his appointment. He also requested his own interpreter for next appointment in November.	The translation process is being reviewed.	Very low	Not Upheld
06/06/2018	Communication	The patient's daughter emailed with 3 separate issues concerning her mother's treatment at LMC- re transport, future appointments and scan times.	Acknowledge patient should have received future dates, staff has been reminded to give appointments before Pt leaves department.	Very low	Partially Upheld
09/07/2018	Other	Family have raised concerns relating to content of discharge letter- lack of communication around TTO's , DNAR process and communication relating to chemotherapy.	Action plan created and to be monitored at IC monthly meetings. New DNAR policy to be produced.	Low	Upheld
11/07/2018	Access to Treatment	Patient unhappy that her treatment is currently on hold as not ca patient	Under investigation	Low	
12/07/2018	Administration	Patient unhappy with waiting times for transport and lack of information from reception staff.	None: Pt. signposted to NWAS regarding transport concerns and explanation provided as to why the receptionist could not give detailed information.	Low	Not Upheld

Received	Complaint Type	Description	Lessons learned	Grade	Complaint Outcome
27/07/2018	Access to Treatment	Family unhappy that patient has had immunotherapy stopped and has turned up twice for treatment without it being available.	Immunotherapy stopped due to patient's poor PS, which was explained. Communication regarding the appointment should have been better.	Low	Upheld
1/08/2018	Communication	Incorrect number used to contact DNs raised by investigation from Merseycare.	Under investigation	Low	
13/08/2018	Treatment and Care	Unhappy with administration errors (Consultant booked a scan in error – this had already taken place).	Explanations offered and change of consultant facilitated.	Low	Upheld
18/09/2018	Treatment and Care	Unhappy with care. Noise at night. Patient fall.	Apologised and offered explanation. Senior staff did not review patient after fall in a timely manner. Staff reminded of escalation process and also reminded of bed rail assessment.	Low	Partially upheld

### **Patient Advice and Liaison Service (PALS):**

This chart shows the trends for the 5 most common categories of PALS contact in the last 12 months.



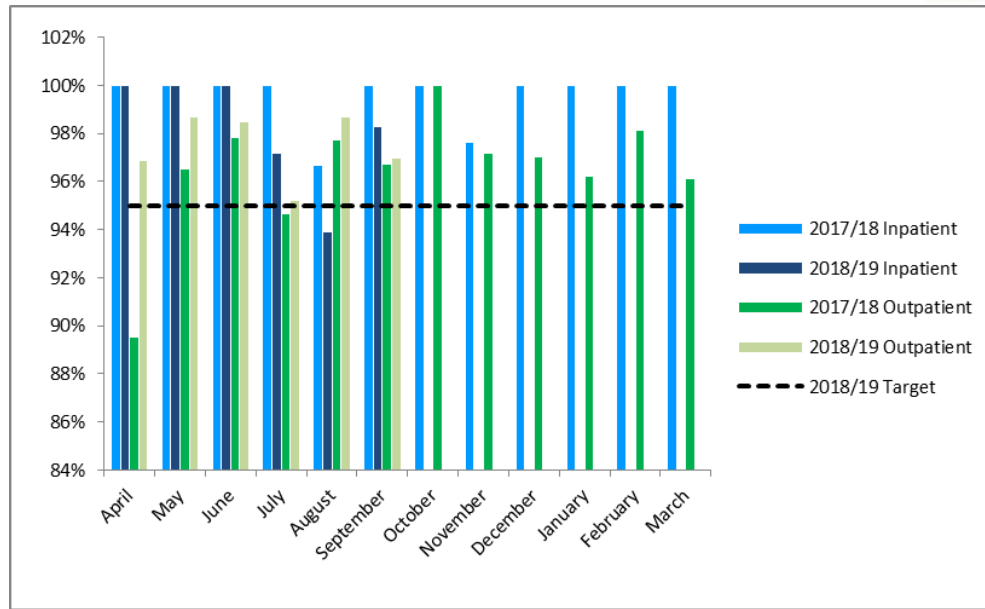
Whilst not featuring in the top 5, the following 'care' related contacts were also made in this 13 month period:

Category	Total contacts
Admissions, Discharge and Transfer	8
Consent	1
End of Life	2
Privacy, Dignity and Wellbeing	7

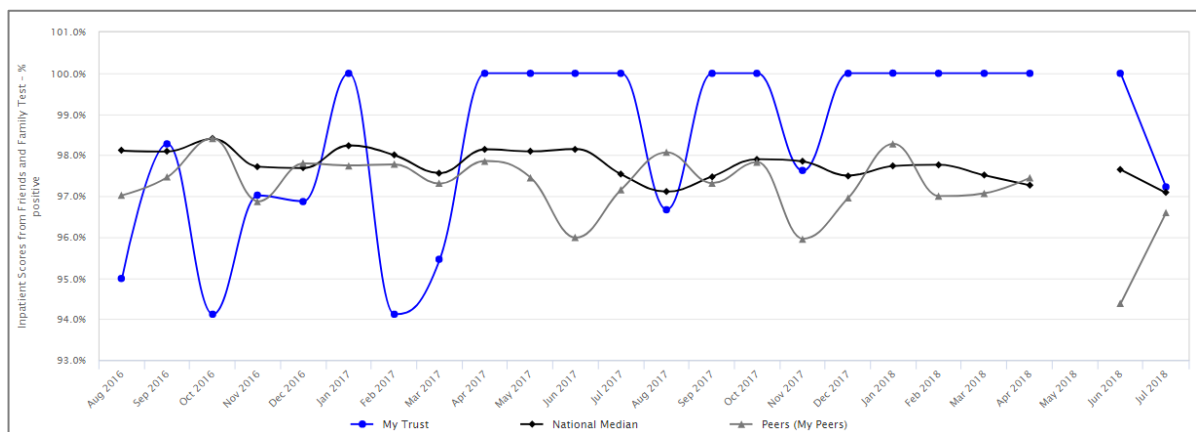
### 3.2 Surveys

#### Friends & Family Test: Scores

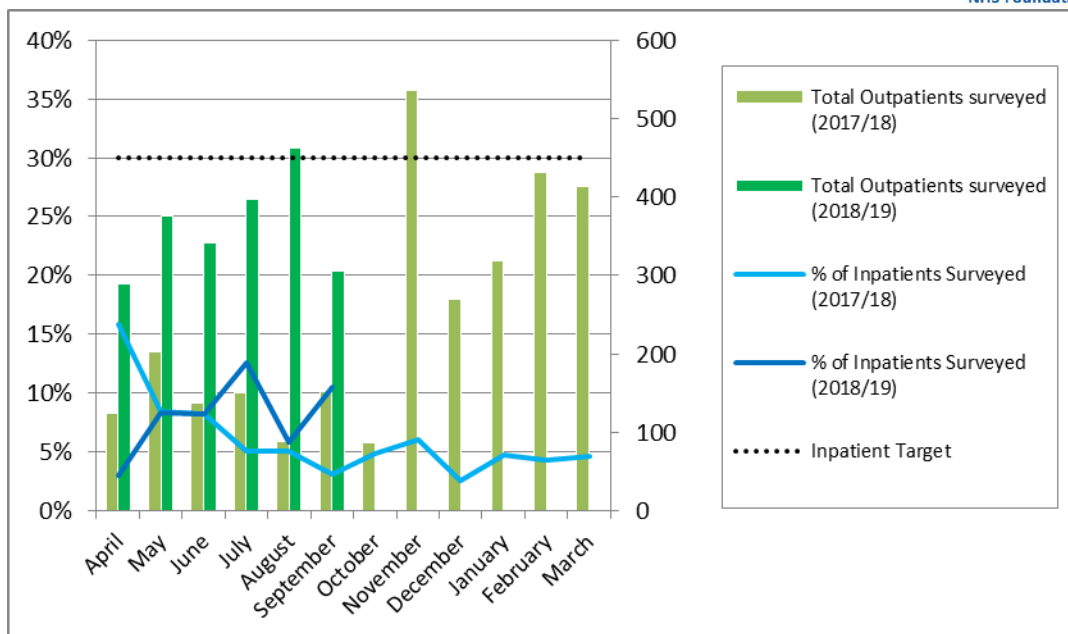




## Benchmarked data



## Friends & Family Test: Response rates



### 3.3 Claims

Open claims: There are 12 claims in total as detailed in the table below. In addition there are a further 18 potential claims, i.e. the Trust has received notification that solicitors are investigating a potential claim.

Open claims:

Claim Number	Nature of Claim (Alleged failure)	Progress/Action
<b>Clinical Negligence</b>		
2018/18	Performed Papillon treatment which caused nerve damage and damage to the bowel and sphincter	Reported to NHR.
2018/02/27	Failure to check blood results prior to treatment.	Reported to NHR. Panel solicitors instructed
2018/33	Named as 5th Defendant - allegations relate to the failure to request urgent for MRI in Oct 15, failure to consider presenting symptoms, delay in referring for treatment for metastatic treatment	Reported to NHR. Panel solicitors instructed.
2018/29	Extravasation	Reported to NHR. Panel solicitors instructed.
2018/28	Delay in assessment, failure to provide treatment and/or investigate possible treatment options, resulting in the claimant being unable to have curative surgery	Reported to NHR. Panel solicitors instructed.

2017/19	Failure to provide treatment and follow up care	Reported to NHSR. Panel solicitors instructed.
2015/07	Misdiagnosis of brain metastases resulting in unnecessary radiotherapy	Reported to NHSR. Panel solicitors instructed.
<b>Employer Liability</b>		
2017/15	Staff fall	File re-opened, repudiation challenged.
2015/14	Staff manual handling	Portal claim. Particulars of Claim received, panel solicitors instructed.
2016/10	Staff manual Handling	Reported to NHSR. Panel solicitors instructed
2016/01	Staff slip/trip/fall	Portal Claim
<b>Public Liability</b>		
2017/12	Needlestick	Reported to NHSR.

### 3.4 Exception Reports

Friends and Family Test (inpatient response rates)		Target	Sept	YTD	12 month trend
		30%	10.5%	8.1%	
<b>Reason for non-compliance</b>					
This has increased to 10.5% in September however this is still significantly below the 30% target. This remains low due partly to connectivity issues relating to the use of the recently rolled out handheld devices.					
<b>Action Taken to improve compliance</b>					
<p>Actions to improve compliance include:</p> <ul style="list-style-type: none"> <li>• IM&amp;T continue to work with the 'I See' company to resolve the connectivity issues.</li> <li>• Postcards are still available for use by patients who do not wish to use the hand held device and also when there is a connectivity problem with the device.</li> <li>• A users' guide to the hand held device has been circulated to all depts/ managers.</li> <li>• The new patient flow team will support FFT compliance.</li> <li>• Wards are to complete a monthly exception report if they do not meet the target.</li> <li>• Performance is monitored and escalated through the Directorate meetings.</li> <li>• Volunteers have been recruited to promote FFT with patients.</li> </ul>					
<b>Expected date of compliance</b>	November 2018				
<b>Escalation route</b>	Directorates / Quality and Safety Sub Committee / Quality Committee / Trust Board				
<b>Executive Lead</b>	Sheila Lloyd, Director of Nursing and Quality				

## 4. RESPONSIVE

### 4.1 Cancer Waiting Times Standards

#### National Standards

All cancer waiting times figures are validated at the end of the following month, therefore the figures presented are accurate as at 21<sup>st</sup> October, but are as yet unvalidated.

Standard	Target	Q1 2017/18	September 2018
62 Day (pre allocation)	85%	59.4%	52.2%
62 Day (post allocation)	85%	87.4%	82.9%
31 Day (firsts)	96%	98.2%	95.1%
18 Weeks – incomplete pathways	92%	97%	96.5%
Diagnostics: <6 week wait	99%	100%	100%
2 Week Wait	93%	100%	91%*

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 of and acknowledges this issue.

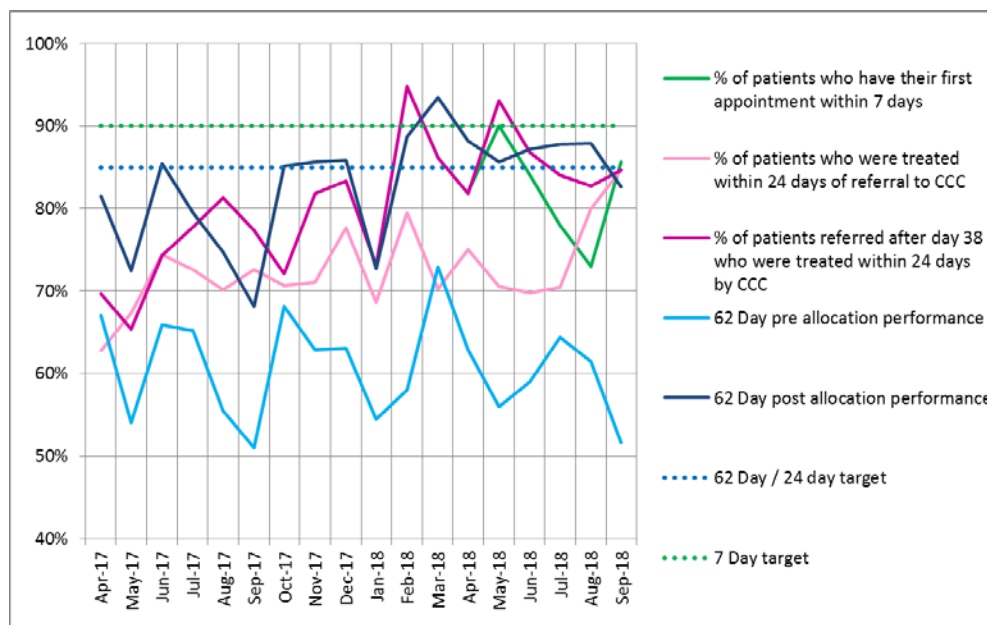
62 Day post allocation: there were 6 breaches in September; 85% would normally be achieved with this number of breaches, however the total number of patients treated was lower than usual in Sept. The breach reasons included patient choice, medical reasons and 1 related to capacity at CCC.

31 Day: This relates to 7 breaches / patients. There is overlap between these patients and those who breached the 62 day target. The reasons for breaching include patient choice, medical, trials, delay at CCC to CT, and 1 patient started treatment and then had to be transferred for a clip insertion.

\*2 Week wait: There is 1 definite breach, caused an admin error at the RLUBH where the patient was booked into the wrong clinic. There is one further possible breach which is being investigated and if confirmed, would equate to performance of 82%.

The new national CWT database (Cherwell) has experienced some delays to development and is now expected to show the Trust's pre and post allocation position from October 2018.

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).



### Patients treated on or after 104 Days

In September 2018, 13 patients were treated after day 104; referred to CCC between day 69 - 138. 5 patients were not treated within 24 days by CCC, this was due to a patient choice (holiday and patient rearranged treatment start date due to a bereavement) and medical reasons.

## 4.2 Clinic Waiting Times

This table shows the % of patients waiting for less than 30 minutes, 30 – 60 minutes and over 60 minutes for outpatients at the Wirral site, for Delamere and for the Trust's peripheral clinics.

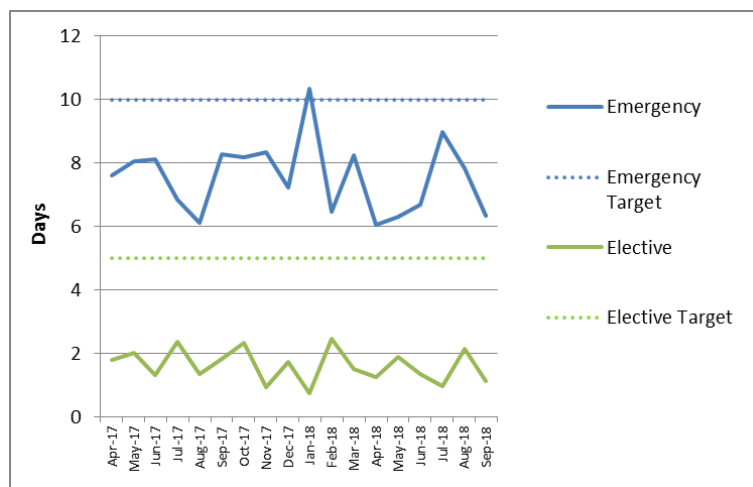
The Service Improvement Team are working with the Chemotherapy Directorate to target two particular specialities that have long clinic waiting times.

	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
CCC Outpatients Wirral: Seen within 30 minutes (as a percentage)	80%	77%	77%	75%	72%	77%	78%	78%	78%	78%	75%	79%	75%
CCC Outpatients Wirral: Seen between 31 and 60 minutes (as a percentage)		12%	13%	12%	13%	12%	11%	12%	13%	14%	14%	12%	14%
CCC Outpatients Wirral: Seen after at least 60 minutes (as a percentage)		11%	10%	13%	15%	11%	11%	10%	9%	9%	11%	9%	11%
Delamere: Seen within 30 minutes %	80%	80%	82%	81%	81%	78%	82%	81%	80%	79%	78%	82.1%	77.6%
Delamere: Seen between 31 and 60 minutes %		11%	10%	11%	10%	11%	9%	10%	11%	11%	11%	9.9%	12.0%
Delamere: Not seen within 60 minutes %		10%	8%	8%	9%	11%	9%	9%	10%	10%	11%	8.0%	10.4%
Outpatient peripheral clinics: Seen within 30 minutes %	80%	88%	86%	87%	87%	89%	87%	89%	91%	91%	91%	90.5%	90.5%
Outpatient peripheral clinics: Seen between 31 and 60 minutes %		8%	8%	7%	8%	8%	8%	7%	6%	6%	6%	5.9%	6.6%
Outpatient peripheral clinics : Not seen within 60 minutes %		5%	5%	6%	5%	3%	5%	4%	3%	3%	3%	3.6%	2.9%

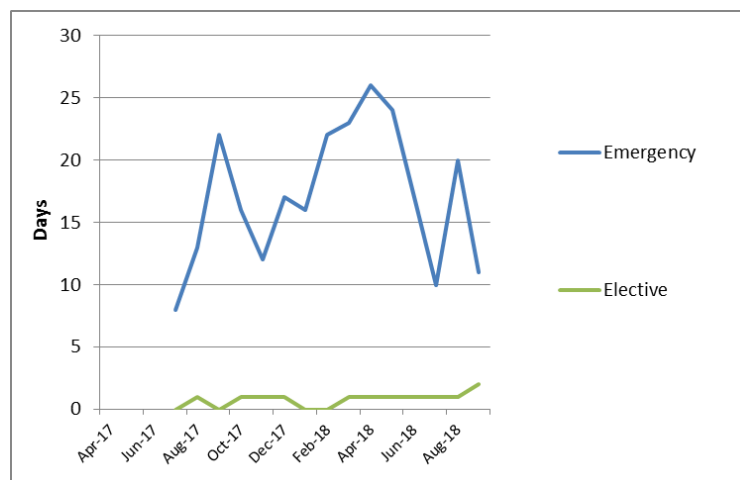
## 4.3 Length of Stay (days)

Trust elective and emergency average length of stay per month against the targets:

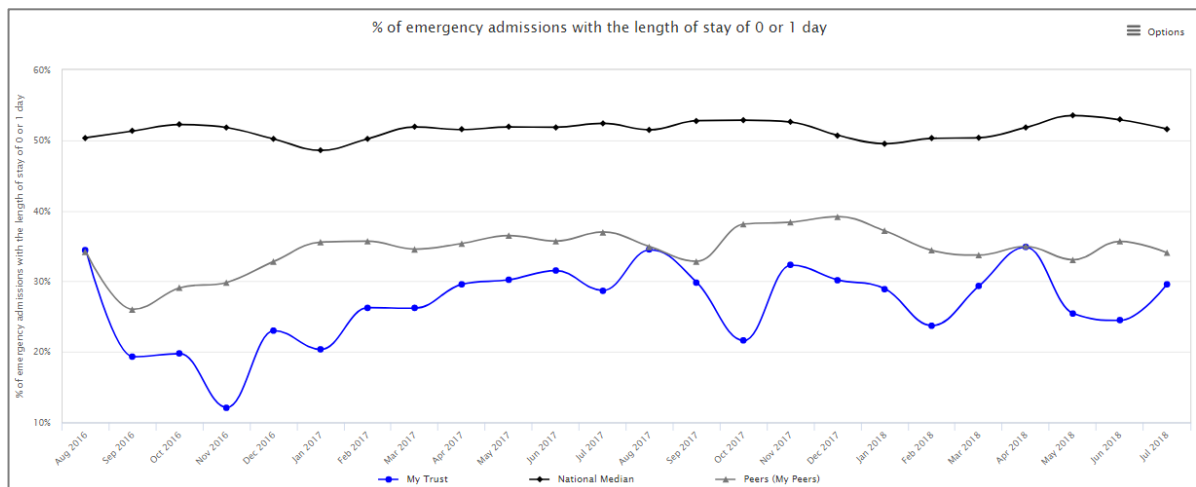
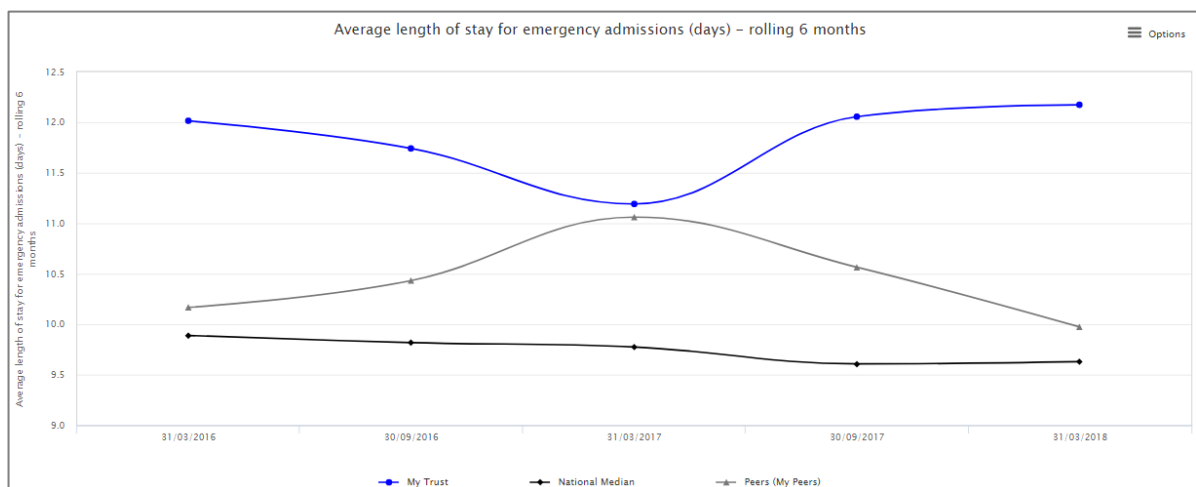
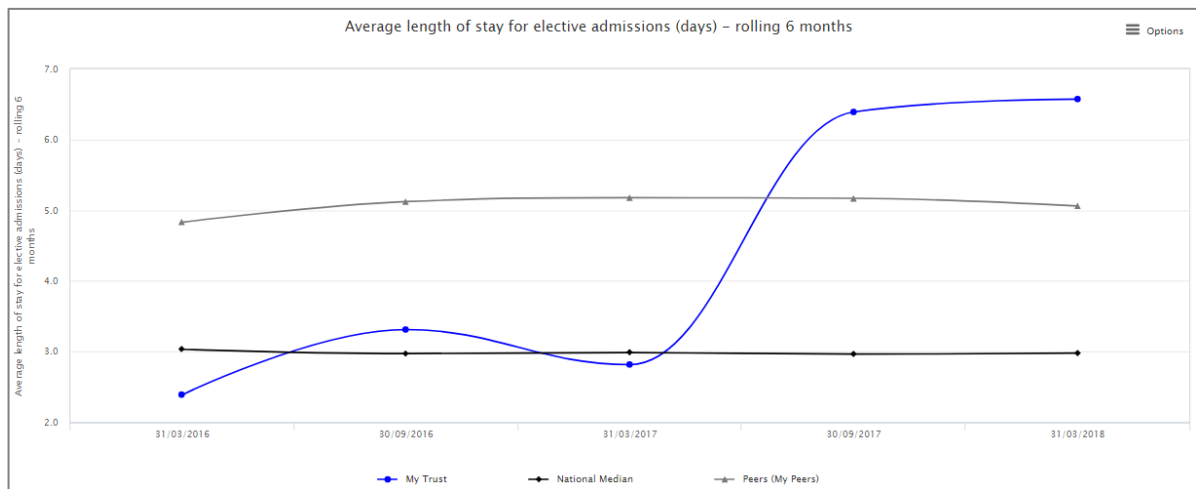
### CCC Wirral Wards

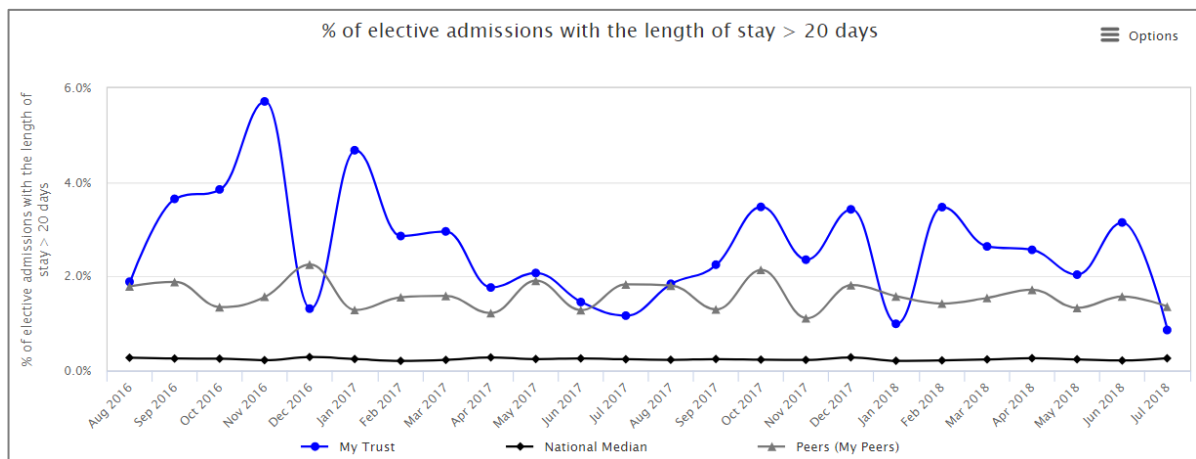
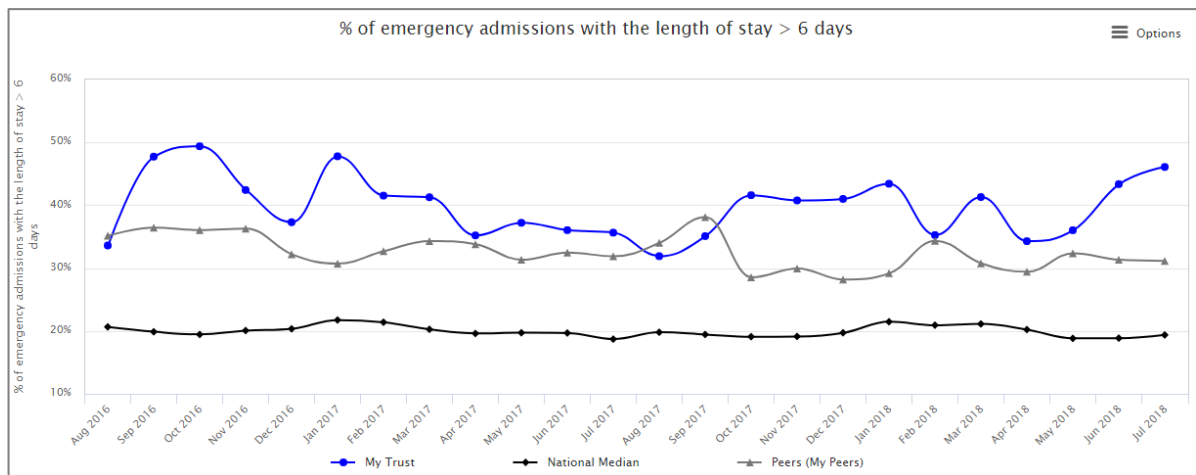
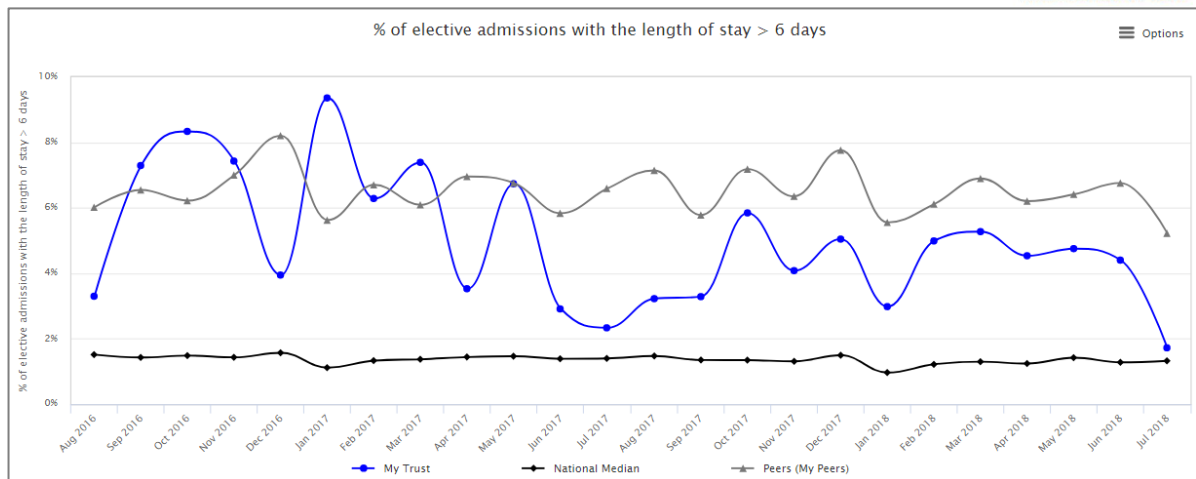


### CCC HO Wards

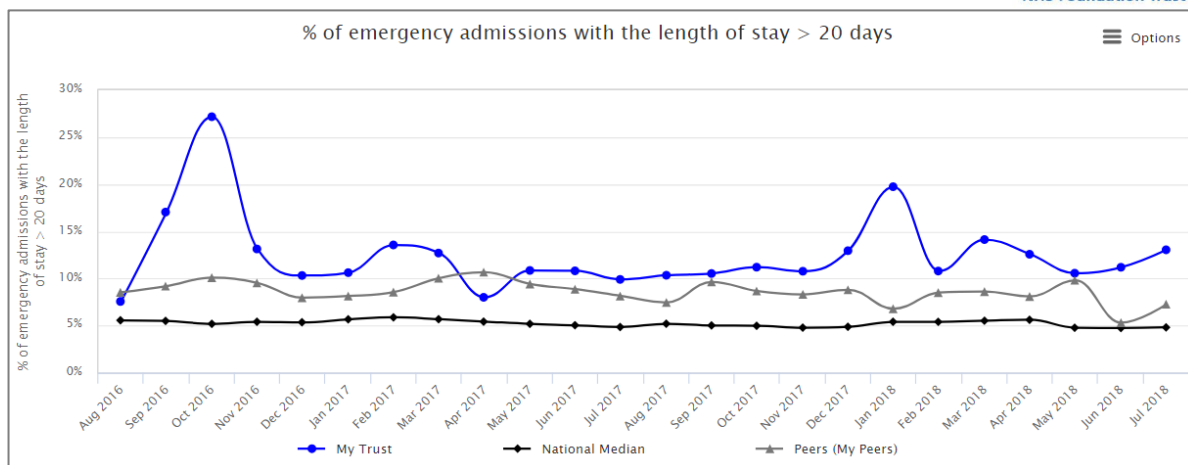


Benchmarked data (not updated on Model Hospital portal):









Changes to the Trust admission and discharge policy and the introduction of the new patient flow team in October 2018 will have a positive impact on our LOS performance.

Please see the activity report on page 37 for excess bed days figures.

## 4.4 Bed Occupancy

	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Average Occupancy at 11 am (Conway) as a percentage	75%	76.0%	86.0%	87.5%	85.7%	90.0%	88.7%	82.8%	69.0%	85.4%	84.0%	78.2%	71.3%
Average Occupancy at 11 am (Mersey) as a percentage	75%	72.0%	78.0%	77.7%	76.9%	81.0%	79.4%	66.2%	64.9%	77.6%	74.5%	68.0%	75.3%
Average Occupancy at 11 am (Sulby) as a percentage	TBC	48.0%	39.0%	38.9%	41.6%	27.0%	49.4%	27.2%	36.0%	44.5%	80.8%	73.6%	82.0%
Average Occupancy at 2 am (Conway) as a percentage	75%	85%	88%	88.0%	75.4%	90.0%	88.8%	83.7%	69.2%	85.0%	84.1%	77.9%	71.5%
Average Occupancy at 2 am (Mersey) as a percentage	75%	70%	76%	76.0%	75.0%	79.8%	77.0%	64.8%	63.0%	76.0%	73.8%	67.0%	74.5%
Average Occupancy at 2 am (Sulby) as a percentage	TBC	24%	20%	20.0%	25.1%	15.5%	28.9%	17.1%	14.8%	26%	33%	34.1%	42%

Data flows for HO wards' bed occupancy are being established

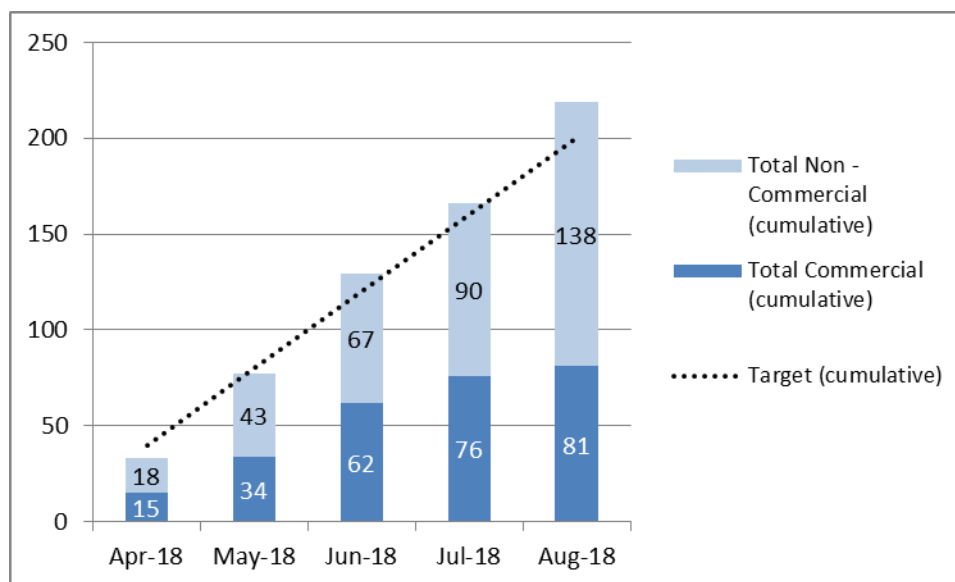
Following the opening of the CDU, Sulby Ward's bed base has been reconfigured, to include a combination of short stay, day case and overnight stay beds.

The bed occupancy target will now be applied to Sulby ward from 1/1/19. This will give time, following the opening of the CDU, to understand the impact of this on Sulby's occupancy and therefore enable an appropriate target to be set.

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

#### 4.5 Patients recruited to trials

This chart shows the cumulative number of patients recruited to non-commercial and commercial studies against the trajectory for 2018/19.



#### 4.6 Activity

##### Performance against Contracted Growth Rates

The contract plan is based on actual activity from 2017/18 to month 8, (November 2017) forecast to year end, plus growth. The growth rates used are the same growth rates that underpin the recurrent income assumptions in the Trust's Long Term Financial Planning Model for Building for the Future. The rates applied are:

- Chemotherapy 5.0% per year
- Radiotherapy 1.9% per year
- Proton Therapy No growth planned as per the contract
- All other activity 1% per year

Overall clinical activity (excluding drugs and HO), is £1,091k above plan.

Performance and RAG ratings against these growth rates for April 2018 to September 2018 are as follows, (please note this is using the actual data for Month 1 – Month 5 and estimated for Month 6):

	Activity Variance	% year to date	Finance Value	% year to date
Admitted Patient Care - Spells	121	6.2%	£259k	8.6%
Admitted Patient Care Excess Bed Days	-387	-43.6%	-£94k	-43.2%
Outpatient Consultations	780	1.2%	£30k	0.4%
Outpatient Procedures	-12	-0.1%	£923k	71.3%
Radiotherapy and Proton	-3,442	-7.2%	-£211k	-2.2%
Chemotherapy	3,259	5.8%	£564k	5.9%
Diagnostic Imaging	986	9.0%	£39k	3.6%
Block			-£419k	-28.5%
<b>Total Excluding Drugs</b>			<b>£1,091k</b>	<b>3.3%</b>
Named Drugs			£3,421k	22.0%
CDF Drugs			£598k	15.4%
<b>Total</b>			<b>£5,110k</b>	<b>9.6%</b>

### Radiotherapy – Red Rating

Re-basing of the contract to reflect prostate hypo fractionation has resulted in a more realistic plan. However, the Division had for some time felt the expected growth of 1.9% is unrealistic, and work is being undertaken by the Division to investigate the actual position, and is due to be reported to the Board through the appropriate committees.

### Chemotherapy – Green Rating

Chemotherapy is already over plan on predicted 5% growth, with an additional 5.8% cumulative position.

A contributing factor to the over performance is an increase in Chemotherapy Associated treatments, which is over performing by 22.7% on the plan, which has the 5% historical growth built in. After further investigation, this is due to an increase in clinical trials patients, bisphosphonates and deferred patients, however in the main this is due to an increase in blood pressure tests which are being incorrectly. This result is due to a change in advice from drug companies, and additional monitoring for immunotherapy patients.

### Block – Red Rating

This is due to a non-achievement of CQUINs in 2017/18, (£379k in total, but a provision was put in during last financial year of £163k, therefore net for 2017/18 is £216k), work is underway in 2018/19 to make sure that milestones are met and financial funding is not taken away. A provision of £188k has been put in for non-achievement of CQUINs in the first six months of 2018/19, but the value is likely to rise as some of the triggers we are unlikely to meet for the whole of quarter 2 and possibly into quarters 3 and 4.

### Outpatient Procedures – Green Rating

This is currently over plan on finance by £923k; however activity is on plan. This looks to be a change in coding since February 2018, which has meant the tariff for these procedures from £118 to £238.

### HO Activity Performance

Activity is reported to different timescales at the Royal Liverpool and involves an external provider for drug information. This means activity information will always be one month in



arrears with current month having to be estimated until HO patients are recorded directly onto CCC's clinical system.

The Trust has received activity data from the Royal Liverpool for April to August (month 1 to 5). Actual activity has been used for month 1 - 4, with activity estimated for months 5 and 6. The data for month 5 is being reviewed.

Overall clinical activity for HO, (excluding drugs), is £55k ahead of plan and drug income is over plan by £1,247k; this is due to increased admitted patient care levels compared to plan and outpatient consultations, possibly due to the additional Acute Leukaemia patients that have transferred from Aintree.

The Division are forecasting a decrease in the Bone Marrow Transplants this year, even though national growth is at 5% in this area, due to changes in criteria for acceptable cohort of patients. Bone Marrow Transplants has always exceeded forecast plans in previous years and the prediction is that they will increase in following years.

#### 4.7 Exception Reports














	Target	Sept	YTD	12 month trend
<b>62 Day Cancer Waits (pre allocation)</b>	85%	52.2%	60.5%	
<b>62 Day Cancer Waits (post allocation)</b>	85%	82.9%	86.5%	
<b>Reason for non-compliance</b>				
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 and September) since October 2017. The post allocation target was not achieved for September as there were 6 breaches and a relatively low total number of patients. Breach details are provided in section 4.1.				
<b>Escalation route</b>	Trust Operational Group / OD&SISC / F&BDC / Trust Board			
<b>Executive Lead</b>	Barney Schofield, Director of Operations and Transformation			

## 5. WELL LED

### 5.1 Workforce

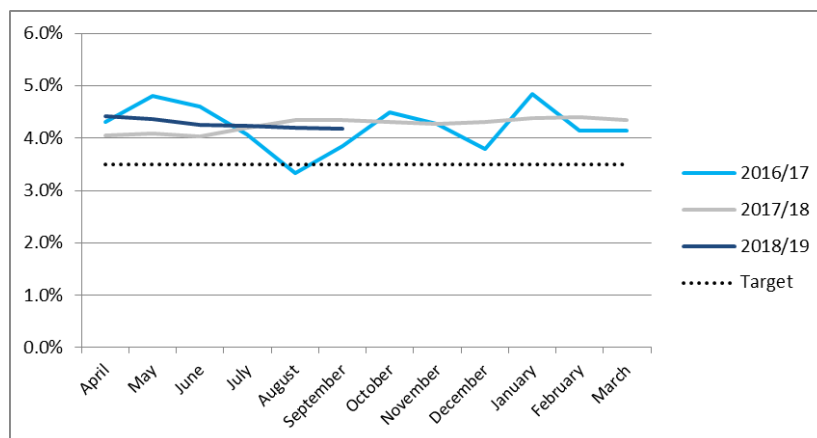
NB: Where information is reported by Directorate, the Information Team and PMO are captured within the 'Quality Directorate'. 'Support Services includes all Corporate services except those in the Quality Directorate and those listed separately above i.e. Admin Services and HR & OD.

#### Workforce overview

	2017 / 10	2017 / 11	2017 / 12	2018 / 01	2018 / 02	2018 / 03	2018 / 04	2018 / 05	2018 / 06	2018 / 07	2018 / 08	2018 / 09	Trend
Headcount	1,222	1,238	1,239	1,241	1,257	1,256	1,269	1,264	1,260	1,259	1,273	1,273	
FTE	1,106.50	1,119.09	1,119.65	1,122.73	1,138.23	1,138.10	1,150.88	1,145.19	1,142.38	1,142.04	1,155.05	1,155.55	
Leavers Headcount	9	3	20	16	8	13	17	22	17	12	16	16	
Leavers FTE	7.96	2.80	18.18	14.42	6.68	11.25	13.22	18.80	15.91	11.49	13.52	13.64	
Starters Headcount	28	19	16	19	25	15	26	13	16	10	25	19	
Starters FTE	26.14	16.89	13.92	18.12	23.10	13.15	24.50	11.25	15.32	9.04	22.13	15.96	
Maternity	34	35	31	29	30	28	29	32	35	33	34	34	
Turnover Rate (Headcount)	0.74%	0.24%	1.61%	1.29%	0.64%	1.04%	1.34%	1.74%	1.35%	0.95%	1.26%	1.26%	
Turnover Rate (FTE)	0.72%	0.25%	1.62%	1.28%	0.59%	0.99%	1.15%	1.64%	1.39%	1.01%	1.17%	1.18%	
Leavers (12m)	146	140	146	150	152	154	146	158	164	165	172	169	
Turnover Rate (12m)	13.18%	12.45%	12.80%	12.97%	12.97%	12.96%	12.12%	12.93%	13.25%	13.27%	13.78%	13.47%	
Leavers FTE (12m)	129.33	124.05	130.08	133.96	135.46	137.37	127.92	138.37	144.62	147.40	152.36	147.87	
Turnover Rate FTE (12m)	12.91%	12.19%	12.60%	12.81%	12.78%	12.78%	11.73%	12.52%	12.91%	13.09%	13.47%	13.01%	

The following data is presented by Trust and then 'Directorates'. The Trust data is rolling 12 months and 'Directorate' is monthly.

#### Sickness Absence

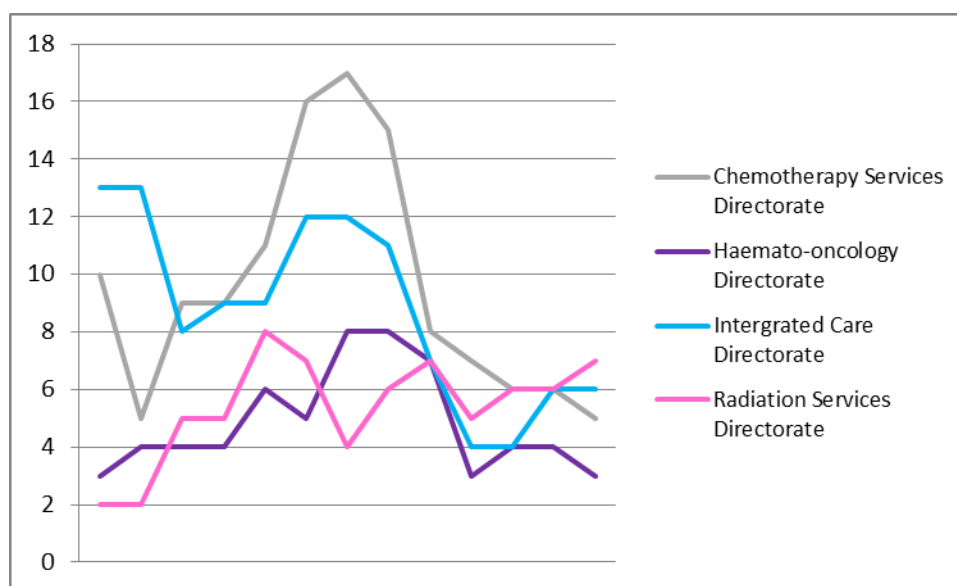


	2017 / 10	2017 / 11	2017 / 12	2018 / 01	2018 / 02	2018 / 03	2018 / 04	2018 / 05	2018/6	2018/7	2018/8	2018/9	Trend
Haemato-oncology Directorate	4.1%	3.6%	4.3%	5.2%	6.4%	3.8%	5.3%	4.0%	4.2%	4.5%	2.3%	3.6%	
Chemotherapy Services Directorate	4.4%	4.3%	6.0%	5.1%	6.0%	7.1%	5.3%	4.9%	3.4%	3.9%	3.0%	3.4%	
Intergrated Care Directorate	5.6%	4.8%	5.2%	6.5%	5.9%	6.2%	4.2%	3.3%	2.4%	4.4%	2.8%	4.2%	
Radiation Services Directorate	1.8%	3.3%	2.8%	3.8%	3.6%	2.1%	3.1%	2.4%	2.1%	3.2%	3.2%	2.3%	
Admin Services	5.9%	5.9%	5.3%	6.8%	7.4%	5.0%	4.6%	4.7%	5.0%	7.8%	8.0%	4.4%	
HR & OD	4.6%	6.4%	3.4%	7.2%	2.7%	3.5%	2.9%	0.6%	3.8%	0.0%	0.1%	0.0%	
Medical	4.4%	3.2%	1.9%	1.9%	2.5%	2.7%	2.2%	2.2%	3.3%	4.7%	3.6%	4.7%	
Research	8.4%	6.4%	4.3%	3.7%	5.6%	5.2%	3.0%	3.7%	3.6%	7.0%	9.4%	9.0%	
Quality	5.7%	5.1%	5.0%	4.9%	6.2%	3.2%	1.4%	1.0%	2.2%	1.7%	1.7%	0.7%	
Support Services	2.2%	4.0%	4.9%	6.8%	4.1%	4.2%	3.1%	2.9%	5.2%	7.9%	8.2%	8.1%	
Trust Board Directorate	0.0%	0.2%	0.0%	0.0%	1.7%	8.4%	12.8%	8.3%	2.0%	5.3%	7.9%	9.5%	

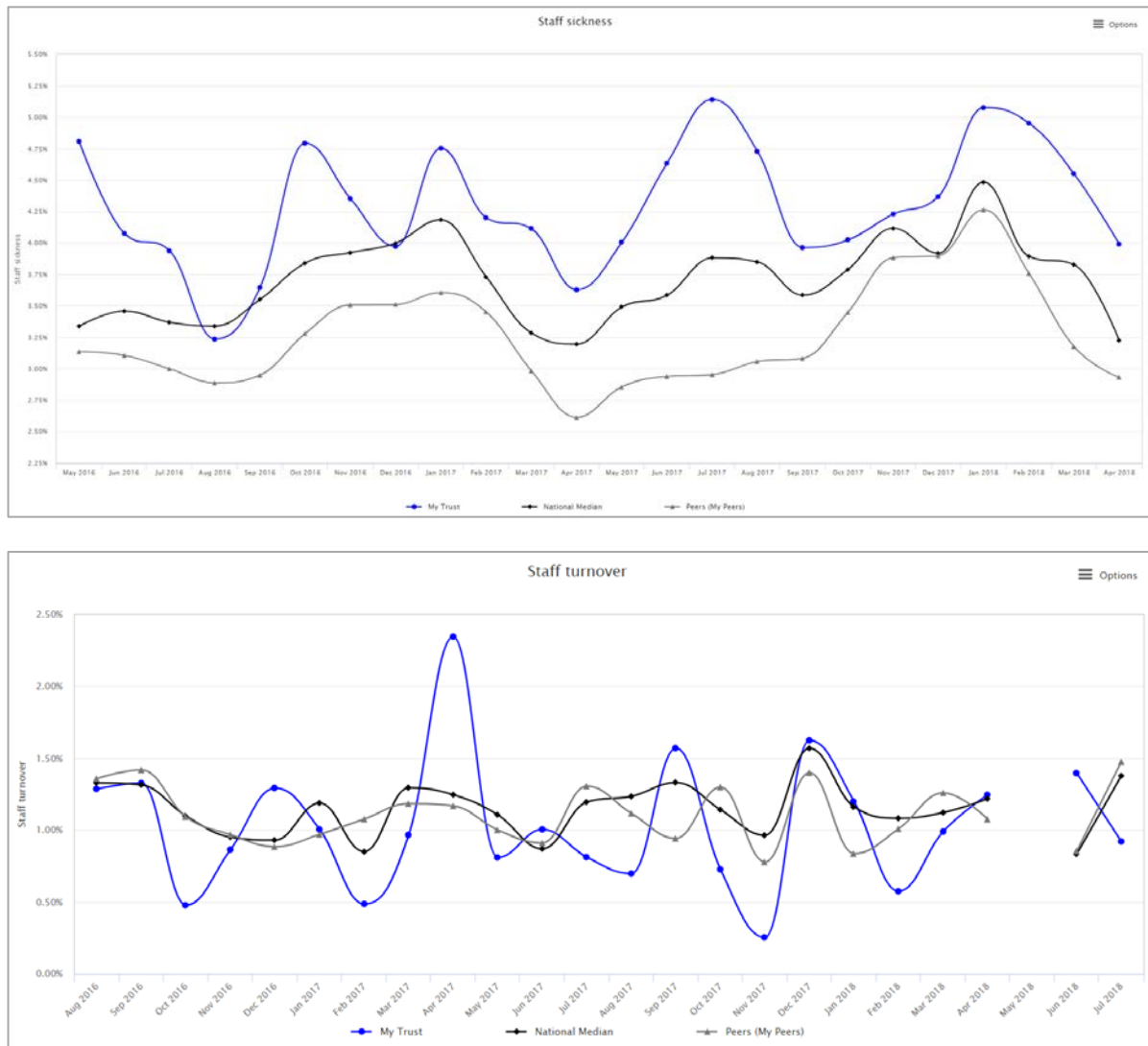
Absence by FTE and numbers of staff on long term sick, per month.

	2017 / 09		2017 / 10		2017 / 11		2017 / 12		2018 / 01		2018 / 02		2018 / 03		2018 / 04		2018 / 05		2018 / 06		2018 / 07		2018 / 08		2018 / 09	
	Abs	Long	Abs	Long	Abs	Long	Abs	Long	Abs	Long	Abs	Long	Abs	Long	Abs	Long	Abs	Long	Abs	Long	Abs	Long	Abs	Long	Abs	Long
	(FTE)	Term	(FTE)	Term	(FTE)	Term	(FTE)	Term	(FTE)	Term	(FTE)	Term	(FTE)	Term	(FTE)	Term	(FTE)	Term	(FTE)	Term	(FTE)	Term	(FTE)	Term	(FTE)	Term
Chemotherapy Services Directorate	223	10	215	5	209	9	311	9	268	11	294	16	391	17	310	15	292	8	198	7	241	6	187	6	207	5
Haemato-oncology Directorate	105	3	139	4	118	4	141	4	172	6	197	5	131	8	176	8	137	7	140	3	152	4	80	4	132	3
Intergrated Care Directorate	394	13	364	13	277	8	342	9	430	9	351	12	419	12	260	11	206	7	144	4	283	4	180	6	275	6
Radiation Services Directorate	120	2	134	2	243	5	218	5	293	8	246	7	161	4	227	6	183	7	158	5	242	6	222	6	181	7
Admin Services Directorate	154	7	187	6	180	7	167	6	217	7	215	7	159	6	141	4	149	4	152	4	238	10	237	9	129	6
HR & OD Directorate	17	1	28	1	40	1	22	1	44	1	16	1	22	1	18	1	4	0	22	0	2	0	1	0	0	0
Medical Directorate	46	2	24	1	12	0	1	0	12	0	3	0	19	1	3	0	6	1	31	2	41	2	49	3	62	3
Research Directorate	111	5	126	4	96	5	67	3	54	3	74	2	75	3	40	3	52	2	29	1	70	2	108	4	120	4
Quality Directorate	64	3	73	3	67	3	70	3	76	4	88	4	51	3	21	2	28	1	32	1	19	1	17	1	6	1
Support Services Directorate	79	1	71	2	125	5	161	4	216	6	120	6	131	5	95	4	95	5	164	6	256	8	272	9	268	8
Trust Board Directorate	0	0	0	0	1	0	0	0	0	0	9	0	54	2	81	2	53	2	11	1	34	1	47	1	54	1
Grand Total	1,315	47	1,365	41	1,369	47	1,499	44	1,782	55	1,612	60	1,613	62	1,372	56	1,204	44	1,081	34	1,578	44	1,400	49	1,434	44

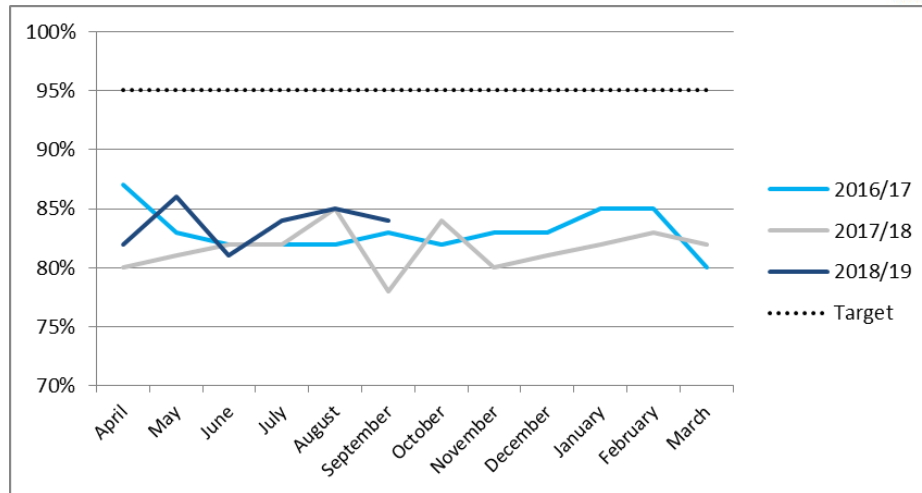
This chart presents the long term sickness data for the Directorates in the table above, i.e. numbers of staff on long term sick per month:



## Benchmarked data – sickness and turnover



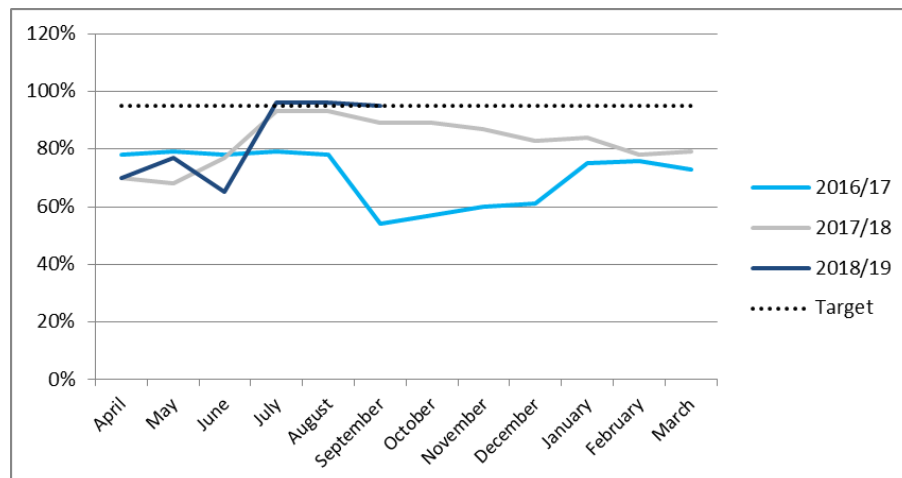
## Mandatory Training



Directorate	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Trend
Haemato-oncology Directorate	95%	58%	76%	74%	63%	66%	66%	
Chemotherapy Services Directorate	95%	87%	89%	89%	86%	88%	88%	
Intergrated Care Directorate	95%	87%	87%	87%	88%	89%	89%	
Radiation Services Directorate	95%	86%	88%	87%	88%	89%	85%	
Admin Services	95%	96%	96%	91%	95%	95%	93%	
HR & OD	95%	98%	96%	93%	98%	95%	98%	
Medical	95%	60%	64%	64%	65%	55%	56%	
Quality	95%	92%	91%	90%	94%	96%	97%	
Support Services	95%	91%	92%	92%	92%	92%	93%	
Trust Board	95%	58%	58%	58%	59%	61%	60%	

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

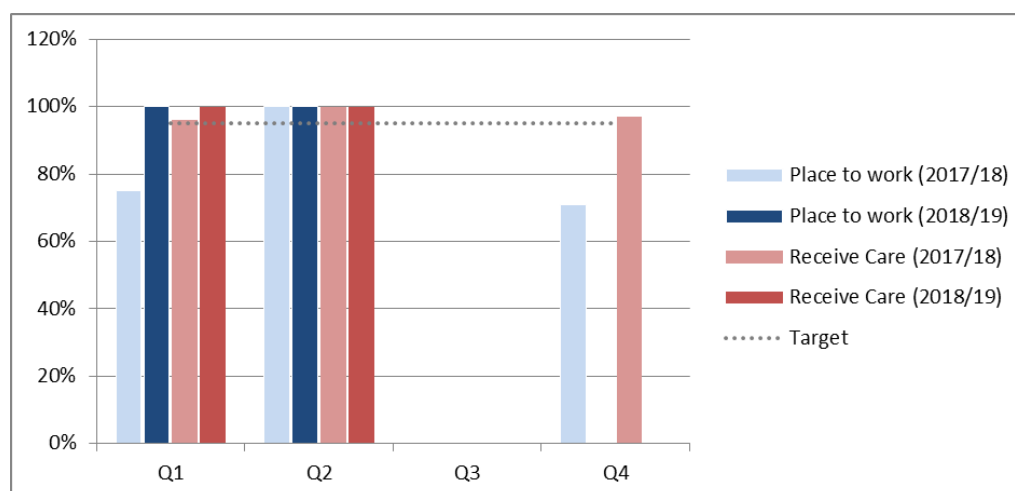
## PADR Compliance



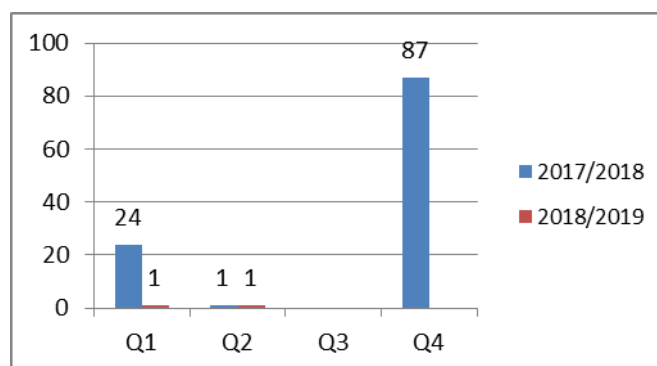


Directorate	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Trend
Haemato-oncology Directorate	95%	81%	83%	40%	98%	99%	99%	
Chemotherapy Services Directorate	95%	78%	81%	87%	99%	99%	98%	
Intergrated Care Directorate	95%	65%	66%	62%	96%	97%	97%	
Radiation Services Directorate	95%	79%	84%	67%	99%	99%	98%	
Admin Services	95%	79%	91%	85%	98%	97%	97%	
HR & OD	95%	78%	76%	69%	100%	100%	100%	
Quality	95%	76%	77%	65%	98%	98%	100%	
Support Services	95%	64%	65%	59%	86%	86%	85%	
Trust Board	95%	50%	50%	50%	56%	50%	81%	

### Staff Friends and Family Test: Scores

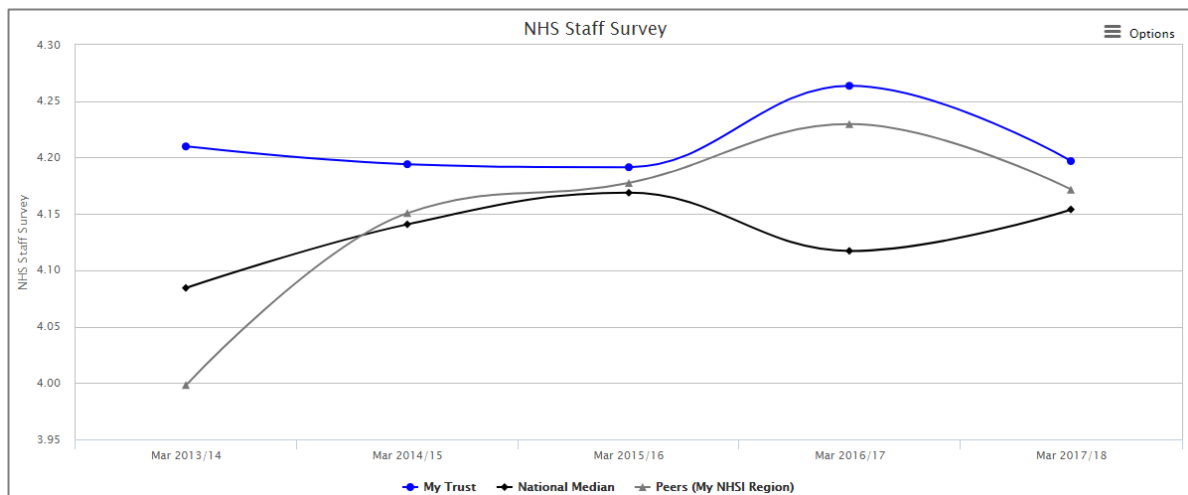


### Staff Friends and Family Test: Response totals



Benchmarked data (not updated on the Model Hospital portal)

NHS Staff Survey	Data period	Trust value	Peer median	National median	Chart
NHS Staff Survey	Mar 2017/18	4.20	4.23	4.15	



## 5.2 Finance

The financial performance of the Trust for the first six months of 2018/19 as follows:

- A Group surplus (including Charity) of £2,194k against a planned surplus of £2,252k which is £58k below plan. The Charity position is below plan for the year to date offset by the Trust position being ahead of plan.
- A Trust surplus of £1,532k against a planned surplus of £934k, a favourable variance of £598k. From month 5 this is a favourable movement against plan of £68k. This is primarily due to items below operating expenditure (EBITDA).

The Trust is benefiting from :-

- reduced depreciation of £401k, as a result of slippage and rephrasing of the capital programme and
- Lower interest charges of £265k, partly due to the Trust not drawing down the ITFF loan until quarter 2.
- The Trust has delivered against its notified control total of £1,002k, with an actual year to date comparator of £2,147k.

- The Trust has an overall use of resources risk rating of 1, which is in line with plan.
- Due to the NHSI submission deadline, the financial position at month 6 is based on actual activity for April to August and estimated for September for solid tumour. Haemato-Oncology is based on actual activity for April to July with estimates for August and September except where actual data was available (for drugs and bone marrow transplants).
- Capital expenditure is £27,210k against a plan of £36,372k.
- The CIP programme has achieved savings of £1,059k, which is £268k above plan.
- The Trust has been issued with an Agency cap for 2018/19 of £1.1m by NHSI. At month 6, actual expend of £501k is £82k below the NHSI agency ceiling year to date.
- An assessment of achievability of CQUIN funding has been made and a provision of £188k has been made for non achievement of CQUINs in the first six months of 2018/19.
- Cash held is £9.97m below plan, an improvement on month 5 (£42.2m below plan), due to the Trust drawing down the approved Independent Trust Financing facility (ITFF) loan of £37m. The drawdown of Public Dividend Capital (PDC) of £28.2m is in the plan for quarter 2, but has not taken place and is the main reason of why cash is still below plan. The drawdown of PDC is expected to happen in quarter 4.
- The Trust is delivering against its Key Financial Objectives.
- The group surplus is made up of the following components:-

<b>The Clatterbridge Cancer Centre Group Accounts:</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
	Plan	Actual	Variance
The Clatterbridge Cancer Centre NHS Foundation Trust	934	1,532	598
The Clatterbridge Cancer Charity	976	256	(720)
The Clatterbridge Pharmacy Ltd	105	210	105
Clatterbridge Prop Care Services Ltd (excludes PURP)	237	316	79
*PURP		(120)	(120)
<b>Total Group Surplus</b>	<b>2,252</b>	<b>2,194</b>	<b>(58)</b>

\* PURP is the Provision for Unrealised Profit which results from accounting for the Prop Care agreement for the new build in Liverpool. It has to be excluded on consolidation.

## 2. KPI Performance Risks:

### High Risks:

Issue	Reason	Risk / Mitigation
KPI “Red” or “Amber” from metric table above: CQUIN Funding (Red)	<p>Non delivery of 2017/18 CQUIN by £390K less year end provision made of £163k = £228k adverse impact in 2018/19.</p> <p>Anticipated non delivery of 2018/19 CQUIN at quarter 2 is estimated at £188k. This is likely to increase by a further £48k in quarter 3 to £236k. The Trust expects to achieve its full CQUIN payment in quarter 4. The Trust has utilised £114k from its CQUIN reserve for this shortfall.</p>	<p>Loss of income was higher than expected due to a number of CQUIN scheme milestones not being delivered. It has become apparent that there was a lack of embedded ownership within the relevant departments.</p> <p>Head of Performance &amp; Planning and Associate Director of Operations are working with leads to make sure that milestones are met for the remainder of the year. The Director of Nursing &amp; Quality is the Executive lead.</p>
KPI “Red” or “Amber” from IPR report and metric above: Radiotherapy Activity (Red) below plan by 7.7%.	<p>For 2018/19 the plan was rebased on last year's forecast outturn plus assumed growth of 1.9% so should reflect more accurately expected activity.</p> <p>The Directorate are currently undertaking a validation exercise to ensure all activity is being captured and is due to report back to the Quality committee with its findings.</p>	<p>Work is being undertaken by the Directorate to investigate the actual position, and is due to be reported to the Board through the appropriate committees.</p> <p>Any adverse in year impact on income is mitigated by the block contract. There is a potential loss of income of circa £1m When the contract is rebased for 2019/20. However based on current activity levels this would be mitigated by over performance in other service lines.</p>

### Medium Risks:

Issue	Reason	Risk / Mitigation
KPI “Red” or “Amber” from	The Group has a combined	Risk that the Charity is not

metric table above: Group Surplus (Amber)	surplus of £2,194k against a planned surplus of £2,252k. The Charity is £720k below plan at month 6. This is offset by an increased surplus within the Trust.	able to generate sufficient resources to support Building for the Future. However there are some significant legacies (totally £1m) expected to be received in year. The Charitable Funds Committee will monitor performance in year.
KPI "Red" or "Amber" from IPR report and metric table above: Agency Spend (red) – Medical locum	<p>The Trust has been issued with a 'cap' of £1.1m by NHS Improvement for the year. Spend to the end of September was £501k (of which £309k relates to medical locums) against a NHSI ceiling to date of £583k, so overall the Trust is within its cap.</p> <p>Within the cap of £1.1m medical locums have a target spend of £0.5m. As noted above, performance to date is £309k against a plan of £250k, an overspend of £59k.</p>	Agency spend has been flagged with NHSI as a risk and they understand the Trust position and recognise that the provision of clinical services is the priority.

**Low Risk:**

Issue	Reason	Risk / Mitigation
KPI "Red" or "Amber" from metric table above: Capital expend (Amber)	Capital expend to date is £9.16m behind plan. This is mainly to Building for the Future being £7.68m behind plan.	Risk of slippage in the programme having an adverse impact on patient care. This is not anticipated to be the case, so no significant risk at this point.
KPI "Red" or "Amber" from metric table above: Cash Held (Amber)	Cash is £9.97m below plan. This is because PDC of £28.2m has not yet been drawn down.	Risk of cashflow issues, however the Trust still has £79.3m in the bank. The Trust anticipates that it will drawdown £28.2m PDC by the end of Quarter 4.

**All Other Financial issues are on plan, and there are no other major/critical issues to report this month.**

**STATEMENT OF COMPREHENSIVE INCOME**  
**2018-19**

	Trust Annual Plan £k	Sept 18			Cumulative YTD			
		Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	%
<b>Clinical Income:</b>								
Elective	4,998	397	346	(50)	2,499	2,078	(421)	-16.9%
Non-Elective	4,533	360	437	77	2,267	2,910	643	28.4%
Out-patient Attends	18,416	1,462	1,496	35	9,208	10,373	1,165	12.7%
Radiotherapy Attends	19,727	1,566	1,475	(91)	9,863	9,606	(257)	-2.6%
Chemotherapy Attends	19,910	1,580	1,727	147	9,955	10,496	541	5.4%
Impact of Contract Tolerances / Agreed Outturn	112	75	(2,227)	(2,302)	112	(959)	(1,071)	-956.6%
Drugs	51,154	4,060	4,723	664	25,577	30,843	5,266	20.6%
Diagnostic Imaging	2,215	176	203	27	1,108	1,153	45	4.1%
Bone marrow transplants	5,523	438	410	(29)	2,762	2,572	(190)	-6.9%
Other Currencies	3,080	244	220	(24)	1,540	1,167	(373)	-24.2%
Private Patients / External Drug Sales	791	66	46	(20)	395	339	(56)	-14.2%
<b>Sub-Total: Total Clinical Income</b>	<b>130,459</b>	<b>10,423</b>	<b>8,855</b>	<b>(1,568)</b>	<b>65,285</b>	<b>70,576</b>	<b>5,291</b>	<b>8.1%</b>
Other Income	8,704	761	1,041	280	4,414	5,015	601	13.6%
Hosted Services	7,083	292	280	(12)	3,807	3,713	(94)	-2.5%
<b>Total Operating Income</b>	<b>146,247</b>	<b>11,477</b>	<b>10,176</b>	<b>(1,301)</b>	<b>73,506</b>	<b>79,305</b>	<b>5,799</b>	<b>7.9%</b>
<b>Pay - Non Hosted</b>	<b>(51,200)</b>	<b>(4,590)</b>	<b>(4,127)</b>	<b>463</b>	<b>(25,631)</b>	<b>(25,081)</b>	<b>549</b>	<b>-2.1%</b>
Pay reserves	(212)	133	133	0	(82)	(82)	0	0.0%
Pay - Hosted	(5,813)	(266)	(228)	38	(3,275)	(3,056)	219	-6.7%
Drugs expenditure	(35,452)	(2,814)	(3,251)	(438)	(17,726)	(22,160)	(4,434)	25.0%
Other non-pay - Non hosted	(39,175)	(3,294)	(2,022)	1,272	(19,780)	(21,880)	(2,100)	10.6%
Non-pay reserves	(2,514)	(81)	(81)	0	(1,148)	(1,034)	114	-10.0%
Non-pay hosted	(1,299)	(29)	(55)	(26)	(537)	(663)	(126)	23.4%
<b>Total Operating Expenditure</b>	<b>(135,664)</b>	<b>(10,941)</b>	<b>(9,630)</b>	<b>1,311</b>	<b>(68,180)</b>	<b>(73,956)</b>	<b>(5,776)</b>	<b>8.5%</b>
<b>Earnings before Interest, Tax, Depreciation and Amortisation (EBITDA)</b>	<b>10,582</b>	<b>536</b>	<b>546</b>	<b>10</b>	<b>5,327</b>	<b>5,349</b>	<b>22</b>	<b>0.4%</b>
Depreciation	(5,155)	(430)	(359)	70	(2,577)	(2,125)	452	-17.6%
Amortisation	0	0	(9)	(9)	0	(51)	(51)	0.0%
Fixed Asset Impairment	0	0	0	0	0	0	0	0.0%
Profit /(Loss) from Joint Venture	624	52	52	0	312	221	(91)	-29.2%
Interest receivable (+)	98	8	126	117	49	631	582	1187.2%
Interest payable (-)	(679)	(57)	(178)	(122)	(339)	(653)	(313)	92.2%
Profit on Disposal	0	0	0	0	0	0	0	0.0%
PDC Dividends payable (-)	(3,667)	(306)	(306)	(0)	(1,833)	(1,834)	(0)	0.0%
Finance lease interest	(7)	(1)	0	1	(3)	(7)	(4)	117.3%
<b>Retained surplus/(deficit)</b>	<b>1,797</b>	<b>(196)</b>	<b>(128)</b>	<b>68</b>	<b>934</b>	<b>1,532</b>	<b>598</b>	<b>64.0%</b>
<b>NET I&amp;E Margin (%)</b>	<b>1.2%</b>	<b>-1.7%</b>	<b>-1.3%</b>	<b>0.5%</b>	<b>1.3%</b>	<b>1.9%</b>	<b>0.7%</b>	<b>52.0%</b>
<b>EBITDA Margin (%)</b>	<b>7.2%</b>	<b>4.7%</b>	<b>5.4%</b>	<b>0.7%</b>	<b>7.2%</b>	<b>6.7%</b>	<b>-0.5%</b>	<b>-6.9%</b>

**STATEMENT OF FINANCIAL POSITION**

	Post Audit 2018	NHSI Plan 2019	Aug-18			Sep-18		
	£k	£k	YTD Plan	YTD	Variance	YTD Plan	YTD	Variance
			£k	£k	£k	£k	£k	£k
<b>Non-current assets</b>								
Intangible assets	717	608	680	674	(6)	669	665	(4)
Property, plant & equipment	89,306	168,785	115,082	108,681	(6,401)	124,491	114,391	(10,100)
Investments in associates	672	1,296	932	841	(91)	984	893	(91)
Other financial assets	18,715	4,560	7,558	34,277	26,719	7,130	40,386	33,256
Trade & other receivables	4,563	277	277	4,771	4,494	277	4,490	4,213
Other assets	-	92,515	40,797	-	(40,797)	49,002	-	(49,002)
<b>Total non-current assets</b>	<b>113,972</b>	<b>268,041</b>	<b>165,326</b>	<b>149,243</b>	<b>(16,083)</b>	<b>182,553</b>	<b>160,825</b>	<b>(21,728)</b>
<b>Current assets</b>								
Inventories	1,161	1,000	1,000	1,182	182	1,000	1,006	6
Trade & other receivables								
NHS receivables	18,419	5,000	5,000	7,454	2,454	5,000	8,228	3,228
Non-NHS receivables	12,267	15,000	15,000	16,490	1,490	15,000	14,195	(805)
Cash and cash equivalents	55,368	47,255	96,984	54,777	(42,207)	89,233	79,266	(9,966)
<b>Total current assets</b>	<b>87,215</b>	<b>68,255</b>	<b>117,984</b>	<b>79,903</b>	<b>(38,081)</b>	<b>110,233</b>	<b>102,695</b>	<b>(7,537)</b>
<b>Current liabilities</b>								
Trade & other payables								
Non-capital creditors	26,348	15,000	15,000	33,336	18,336	15,000	24,776	9,776
Capital creditors	107	1,000	1,000	96	(904)	1,000	97	(903)
Borrowings								
Loans	250	1,730	1,730	250	(1,480)	1,730	1,730	-
Obligations under finance leases	51	53	53	53	0	53	53	0
Provisions	461	489	489	461	(28)	489	448	(41)
Other liabilities:-								
Deferred income	2,307	4,000	4,000	3,425	(575)	4,000	3,665	(335)
Other	-	700	700	-	(700)	700	-	(700)
<b>Total current liabilities</b>	<b>29,524</b>	<b>22,972</b>	<b>22,972</b>	<b>37,621</b>	<b>14,649</b>	<b>22,972</b>	<b>30,769</b>	<b>7,797</b>
<b>Total assets less current liabilities</b>	<b>171,663</b>	<b>313,324</b>	<b>260,338</b>	<b>191,524</b>	<b>(68,814)</b>	<b>269,814</b>	<b>232,751</b>	<b>(37,062)</b>
<b>Non-current liabilities</b>								
Trade & other payables								
Capital creditors	-	301	301	-	(301)	301	-	(301)
Borrowings								
Loans	2,750	37,280	38,270	2,750	(35,520)	38,145	38,145	-
Obligations under finance leases	109	56	56	56	(0)	56	56	(0)
Other liabilities:-								
Deferred income	1,156	1,156	1,156	1,156	1	1,156	1,156	1
PropCare liability	18,996	92,515	40,797	37,251	(3,546)	49,002	43,210	(5,791)
<b>Total non current liabilities</b>	<b>23,011</b>	<b>131,308</b>	<b>80,580</b>	<b>41,213</b>	<b>(39,367)</b>	<b>88,659</b>	<b>82,567</b>	<b>(6,092)</b>
<b>Total net assets employed</b>	<b>148,652</b>	<b>182,016</b>	<b>179,759</b>	<b>150,312</b>	<b>(29,447)</b>	<b>181,154</b>	<b>150,184</b>	<b>(30,971)</b>
<b>Financed by (taxpayers' equity)</b>								
Public Dividend Capital	23,267	53,063	51,467	23,267	(28,200)	53,063	23,267	(29,796)
Revaluation reserve	7,839	7,839	7,839	7,839	(0)	7,839	7,839	(0)
Income and expenditure reserve	117,547	121,114	120,453	119,206	(1,247)	120,252	119,078	(1,174)
<b>Total taxpayers equity</b>	<b>148,652</b>	<b>182,016</b>	<b>179,759</b>	<b>150,312</b>	<b>(29,447)</b>	<b>181,154</b>	<b>150,184</b>	<b>(30,970)</b>



### 5.3 Risk

This section provides details of the 29 risks rated 15 or over as at 19<sup>th</sup> October 2018. The Strategic risks are not shown here, as these are included in the Board Assurance Framework. Any CCC subsidiary company risks are managed by their respective Board of Directors and are therefore not included in this section. New risks are highlighted as **NEW** in the title column.

Title	Department	Assurance Forum	Controls in place	Actions	Rating (current)	Next Review Date Due
832: The allocation and retention of Junior Drs to CCC does not provide a safe junior Dr rota to deliver safe care on CCC in patient wards.	Inpatient Wards	Finance and Business Development	Reduced attendance for CMTs at OPD clinics. Option of employing locum CMTs x 2 or 2 Clinical fellows. 2 clinical fellows appointed, awaiting start date. Secure long term funding for the three clinical fellow posts. Utilise Nurse practitioners to cover basic clinical tasks traditional done by CMTs. Junior Dr contract (notification of placement 6 weeks in advance).	Present options appraisal regarding ways to deliver a safe junior dr rota.  Hospital at night working group due to start 28/10/18.  Workforce model for H@N and ANP team under review in line with TCC agenda. Current doctor rotation to continue on this site supported by Clinical Fellows and PA role.	20	05/11/2018

Title	Department	Assurance Forum	Controls in place	Actions	Rating (current)	Next Review Date Due
				Trust in discussion with HEE regarding future allocation of junior Drs.		
854:Radiologist business continuity	Imaging	Finance and Business Development	<p>Asking visiting radiologists from RLBUHT to provide additional reporting cover for urgent cases.</p> <p>Asking Trust registrars to provide clinical cover following the rare occasion an emergency arises following contrast injection.</p> <p>Additional reporting capacity provided by outsourcing companies, exploring possibility of also providing PET CT reporting.</p> <p>ROI only scan currently being performed for planning PET CT.</p> <p>Locum radiologist employed.</p>	<p>Hold put on half body scanning.</p> <p>Explore further outsourcing reporting.</p> <p>To work with HR on radiologist recruitment strategy.</p> <p>Currently exploring re-advertising for additional radiologists and possible overseas recruitment.</p> <p>PET/CT reporting is being investigated with Medica.</p>	20	15/11/2018

Title	Department	Assurance Forum	Controls in place	Actions	Rating (current)	Next Review Date Due
879: Consultant workforce within HO Directorate is under resourced by 2 WTE consultants (Lymphoma & Acute Leukaemia)	Haemato-Oncology	Finance and Business Development	CD delivering additional clinical sessions, however, this is not sustainable. Second Consultant given one additional PA to support the service and the CD role. Additional Lymphoma Consultant post approved in WFP and awaiting financial approval. BC for AL consultant approved at Finance and business Committee.	Meeting with CCG. Advertisement of Lymphoma post. Meeting with RLBUHT, CCC and CCG to discuss income for additional capacity business case.	20	16/11/2018
973: HODS turnaround times	Haemato-Oncology	Finance and Business Development	Repeat meetings held between HODS and Liverpool Clinical Laboratories management team.  The lymphoma team has formally written to LCL, expressing concern about turnaround times.  The HODS team has submitted a business case for an additional consultant haematopathologist and laboratory integration.  A consultant haematologist whose role is predominantly in HODS has been appointed and commenced in March 2018.		20	23/11/2018

Title	Department	Assurance Forum	Controls in place	Actions	Rating (current)	Next Review Date Due
991: No MET cover, only CRASH cover between 9am to 5pm at Aintree	Radiotherapy	Finance and Business Development	CRASH 9-5pm. Intermittent medical cover. Some scanning staff trained to recognise and give initial treatment for anaphylaxis. Permanent scanning staff trained in ILS Scanning will only be undertaken 9am-5pm limiting risk to patients attending for planning. OPD clinics to run no later than 5pm.	DoO&T has approached Aintree University Hospital Trust for support. DoO at AUHT exploring possible solutions	20	30/10/2018
<b>NEW</b> 1010: Brexit & Implications for medicines supply	Pharmacy	Quality Committee	The health secretary has asked trusts not to stockpile medicines as the DH is liaising directly with Pharma companies. This will ensure that adequate supplies are available should the UK reach a no-deal agreement.	Assess buffer stock for Brexit  Update BCP	16	5/11/18
<b>NEW</b> 993: Supply of Radiopharmaceuticals post leaving the EU	Imaging	Finance and Business Development	No known controls can be put in place	This risk needs to be closely monitored prior to and following March 2019. A contingency plan for possible alternative imaging examinations will be looked into.	16	7/12/18

Title	Department	Assurance Forum	Controls in place	Actions	Rating (current)	Next Review Date Due
835: Mandatory training	Haemato-Oncology	Quality Committee	1. CCC WOD pulling together information together with RLBUHT. 2. HO PDN assisting Michelle in HO competency requirements 3. Escalation to RLBUHT via monthly contract meetings 4. Directorate to maintain paper record to identify staff who are non-compliant	Monitoring of action plan	16	24/10/2018
836: Stem Cell Unit Staffing	Haemato-Oncology	Finance and Business Development	1. Daily review of staffing by Matron Foulds/ Hetherington. 2. Deployment of staff from other HO wards. 3. PDN to develop a face to face training program 4. Close working with HR. 5. Reduction in management days for junior sisters 6. Matron to work within nursing numbers. 7. Staff awareness in raising red flag 8. 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 9. Loan of nurses from chemo directorate	1. Monitoring of staffing and acuity and waiting list 2. Maintain patient safety 3. Monitoring 4. Address issues with delays in recruitment 5. Review of staffing to review 7X auto planning 6. Recruitment of staff	16	31/10/2018

Title	Department	Assurance Forum	Controls in place	Actions	Rating (current)	Next Review Date Due
755: Cyclotron Lifespan	Cyclotron	Finance and Business Development	1. Extensive maintenance of the equipment, changing of parts that show signs of wear, upgrade where possible 2. Development of replacement / de-commissioning plan 3. Workshop booked for 22nd March to develop plans 4. ASTRO conference being attended to speak to manufacturers about potential replacement	Develop SOC	16	04/12/2018
<b>NEW</b> 1011: Overspend on parts required for repair of Linacs	Physics	Finance and Business Development	None, preventative maintenance is performed on all linacs, but breakdown is outside the control of CCC.		15	8/11/18
<b>NEW</b> 1001: lack of room capacity for cannula removal	Imaging	Quality Committee	When possible an empty x-ray room is being used as this is a clinical environment. Infection control have inspected the area.	Estates have been contacted to advise next steps.	15	30/10/18
<b>NEW</b> 1005: PETCT doors to controlled area	Imaging	Quality Committee	The doors lock on occasion and staff are around to monitor access but not all of the time	Continue to attempt to fix	15	6/11/18
<b>NEW</b> 833: Consultants not always documenting in real time in meditech	Delamere and Network clinics	Quality Committee	Nurses contacting consultants on a daily basis to check treatment plan		15	5/12/18
<b>NEW</b> 731:	Delamere and	Quality	Staff are printing off same day	IM&T are working	15	5/12/18

Title	Department	Assurance Forum	Controls in place	Actions	Rating (current)	Next Review Date Due
Transcribing blood results	Network clinics	Committee	blood results and printing off summary sheets for previous results.	closely with the host hospitals. The Royal labs have now interfaced with our systems however other hospitals are unable to do this currently. This is on CCC's GDE agenda but as yet there are no concrete plans.		
906: Isle of Man Service Provision Review	Out Patients	Finance and Business Development	1. Consultant cover for IOM OPD service 2. Service Provision Agreement between IOM/CCC 3. Protocols, Processes, Policies in place	1. Activity Monitoring IOM patients 2. Training Needs Analysis IOM 3. SLA review IOM 4. IOM Service Transformation Review	15	09/11/2018
912: PGD-non adherence to policy	Pharmacy	Quality Committee	1. Policy & procedure. 2. Training process & revalidation. 3. Robust use of PGDs in imaging. 4. Improvement action plan in place	Audit compliance with new procedure. PGD Policy update. Supply of medicines under PGD procedure. Register check. Proposal form update. Documenting supply	15	12/11/2018

Title	Department	Assurance Forum	Controls in place	Actions	Rating (current)	Next Review Date Due
				<p>in Meditech. Powerpoint Training revamp. Competency frameworks update to inc. NICE guidance. Update Flu PGD for 2018/19 vaccine when SPC available. FLU PGD training dates. Oxygen PGD training document. Out of review date PGDs. PGD Purple folder audit.</p>		
968: Fragmentation of Infection Prevention and Control support / services within HO	Haemato-Oncology	Quality Committee	Development of new IPC committee	<p>1. Completion of action plan 2. Meeting with Tim Neil 3. Infection control to be added to clinical interface project 4. Joint oversight meeting 5. Date set for RCA review by Dr Haliwell 6. Monitoring of</p>	15	16/11/18



Title	Department	Assurance Forum	Controls in place	Actions	Rating (current)	Next Review Date Due
				infection control processes		
761: SACT PROTOCOLS	Pharmacy	Quality Committee	Pharmacist verification and pharmacists available 24/7 for pharmaceutical advice. Nursing staff utilise this service readily. SACT committee process mapping complete, group being set up & protocols uploaded to website	SACT protocol project. Check MAR link to protocol. SOP Protocol update & control. Gap analysis of leaflets matched to protocols. Create SACT PIL where gaps. Provide leaflet template. Remove redundant protocols. Communicate new protocol/PIL SOP. Patient information. Protocol action plan. Implement new flowchart for PI.	15	12/11/2018
765: Cyber Security Attack	Information Management & Technology	Quality Committee	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	Review of Monthly Cyber action Plan	15	05/11/2018

Title	Department	Assurance Forum	Controls in place	Actions	Rating (current)	Next Review Date Due
			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 group within Cheshire and Merseyside. Firewalls are upgraded the enterprise back up solution is now installed. Cyber security action plans monitored on a monthly basis.			
799: Reduction in medical staffing (Consultant workforce)	Medical	Finance and Business Development	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	Present paper: Consultant re Provision for Sector Hub Model	15	31/10/2018

Title	Department	Assurance Forum	Controls in place	Actions	Rating (current)	Next Review Date Due
			advertised, one appointment made. Consultant vacancies advertised again with new advert. Recruitment plan agreed with HR that includes use of recruitment agencies and possible international recruitment.			
848: Brachytherapy protocols and mismatch to EAS	Radiotherapy	Quality Committee	Concessions system to record any dose fractionations that are not protocol.	Re-write and re-issue mismatched protocols	15	18/11/2018
880: Hotline cisco overnight phones	Inpatient Wards	Finance and Business Development	Discussed with IM&T who identified some user error.  Staff have received training on the phones but system issues continue.  WI FI connectivity remains an issue.  Staff have been asked to check phones hourly to ensure active but calls are still being missed due to the above issues.		15	19/11/2018

Title	Department	Assurance Forum	Controls in place	Actions	Rating (current)	Next Review Date Due
887: Immuno-oncology service	Delamere and Network clinics	Quality Committee	IO Lead Nurse role. On treatment review team. Toxicity management protocols. IO committee. Alerts cards. Pharmacy counselling for patients prior to discharge. Medical speciality advisors. Training to Hotline staff. GP awareness letter. Standardised blood panel to ensure consistency. Meditech templates.	Implementation of an IO bulletin. Education to specific teams e.g. triage. Collaboration between the Lead IO nurse and the Lead Education Nurse. Mandatory training module. Development of a steroids information card with sick day rules. Appointment of a Band 6 nurse.	15	05/11/2018
893: High temperatures in HO medicines storage	Haemato-Oncology	Quality Committee	Temp monitoring. QCNW algorithm to reduce expiry of products if stored above a certain temp for a specific time period.	Pharmacy assistant support Investigate options to cool unit down. Medicines storage check. Review medicines stock in high temp areas.	15	05/11/2018
862: Organisation of Information Management Resources Trust wide	Information Management & Technology	Quality Committee	Planned controls and actions include the following areas: • Full review of issues within the Information team- to include team focused session, stress questionnaire with staff, 360 degree feedback. Review of previous exit		15	19/11/2018


Title	Department	Assurance Forum	Controls in place	Actions	Rating (current)	Next Review Date Due
to achieve Trust objectives			<p>interviews. Work underway with HR and OD. Team session established for 22/2/18. Various follow up sessions have concluded and are on going</p> <ul style="list-style-type: none"> <li>• Review of data warehouse technical infrastructure and a review of the Trust's aspiration for business intelligence team.</li> <li>• Clickhealth have been commissioned to support a review and support data visualization. Initial DW build has commenced. Initial high level plan in place.</li> <li>• Review of IMS Quintiles report commissioned early 2017 for Pharmacy.</li> <li>• Review of current staffing roles across the Trust delivering information management.</li> <li>• Restructure is planned</li> <li>• Funding to pump prime any changes have been approved.</li> <li>• Agreed strategy for business intelligence to sit within the refreshed DIGITAL strategy.</li> </ul>			
864: Unable to save theatre Brachytherapy Ultrasound guidance images from to PACS	Radiotherapy	Quality Committee	The ultrasonographer can currently produce a small, hard copy thermal image if necessary. It is impractical and expensive to do this for every examination and appropriate storage and accessibility of the image is an issue.	Purchase new ultrasound machine. New US machine ordered 07/09/18. Manufacturer states 6-8 weeks for delivery. Acceptance testing to be performed before use.	15	22/11/2018

Title	Department	Assurance Forum	Controls in place	Actions	Rating (current)	Next Review Date Due
201: Failure to provide adequate support for employee stress, leading to increased absence from work	Workforce and Organisational Development	Quality Committee	<ul style="list-style-type: none"> <li>Confidential counselling</li> <li>Informal counselling</li> <li>Staff support information</li> <li>Outdated working practice to be revised in line with CIS</li> <li>Work life balance</li> <li>Flexi time</li> <li>Training</li> <li>Stress Risk Assessment - HSE</li> <li>Flexible Working in place</li> <li>Time management encouraged and observed</li> <li>Stress Action Group established (2017)</li> <li>Stress audit (as part of regular audit cycle)</li> </ul>		15	04/12/2018
226: Nurse staffing levels	Inpatient Wards	Quality Committee	<ul style="list-style-type: none"> <li>Staffing requirements reviewed daily and throughout day if required to assess bed occupancy, skill mix, patient acuity in each area, moving staff across wards to support vacant shifts, leave and sickness depending on occupancy and acuity</li> <li>New NICE recommended acuity tool implemented</li> <li>Recruitment to vacant posts within the directorate</li> </ul>	<p>Repeat acuity tool</p> <p>Draft strategic plan for Trust wide nurse recruitment</p> <p>Acuity report</p>	15	19/11/2018

**Risks downgraded or removed since the last report:**

Ref	Title	Current grading
850	Compliance with IRMER legislation	12

## 5.4 Exception Reports

Staff Sickness (rolling 12 months)		Target	Sept	12 month trend
		=<3.5%	4.2%	
<b>Reason for non-compliance</b>				
<p>Although the 12 month rolling absence is 4.2%, in month sickness absence has reduced to 3.97% for September, from 4.10% in August. Gastrointestinal problems remain the highest reason for sickness across the Trust for August and September, 40 episodes and 27 episodes respectively. Anxiety, stress, depression remains the second highest with 32 episodes in August and 24 in September.</p>				
<b>Action Taken to improve compliance</b>				
<ul style="list-style-type: none"> <li>The Trust's revised Attendance Management policy has been launched and training for line managers in the application of the policy has commenced. 53 managers having attended so far and another 26 managers are due to attend before the end of October.</li> <li>Updated template letters and forms have been redrafted in line with the new Attendance Management Policy and will be collated into a toolkit to be circulated to managers.</li> <li>Following an MIAA Sickness Absence review the following actions are underway: <ul style="list-style-type: none"> <li>HRBAs will produce a report for all departments that breach the Trust target for 3 months consecutively and incorporate an action plan for manager's use. HRBAs will support managers in the completion of the action plan.</li> <li>failure by managers to close sickness on ESR in a timely manner will be escalated to the HRBP.</li> <li>at HR Surgeries HRBAs are reinforcing the importance to managers of entering the Return to Work Discussion date into ESR.</li> </ul> </li> <li>Bullying and Harassment Training has been arranged throughout November to support managers in the management and prevention of bullying and harassment.</li> </ul>				
<b>Expected date of compliance</b>	October 2018: Amber, 3.6% - 4%   November 2018: Green: <=3.5%			
<b>Escalation route</b>	Directorates / Quality and Safety Sub Committee / Quality Committee / Trust Board			
<b>Executive Lead</b>	Heather Bebbington, Director of Workforce and OD			

Staff Turnover		Target	Sept	12 month trend
		=<12%	13%	
<b>Reason for non-compliance</b>				




Turnover for the month of September 2018 decreased slightly to 13.01% from 13.6% in August. The majority of leavers in September were from the Admin and Clerical staff group followed by Nursing and Midwifery. Reasons for leaving include promotion opportunities and work life balance.

#### Action Taken to improve compliance

- Work is progressing on an analysis and review of data captured in the exit questionnaires and 3 and 9 month temperature checks for the 6 month period between April 2018 and September 2018 and will be presented to OPF in November 2018.
- In the meantime, the WOD team continues to encourage the completion of exit interviews and an Exit Process Policy is currently being drafted.

<b>Expected date of compliance</b>	Work is ongoing to review the threshold of 12% and is likely to be adjusted to reflect specific staff groups in light of the upcoming period of significant organisational change.
<b>Escalation route</b>	Directorates / Quality and Safety Sub Committee / Quality Committee / Trust Board
<b>Executive Lead</b>	Heather Bebbington, Director of Workforce and OD

Mandatory Training	Target	Sept	12 month trend
	90%	84%	
<b>Reason for non-compliance</b>			
Compliance continues to be lowest across Haemonc services due to continuing issues regarding staff accessibility to training and reliability of training data being transferred from their training provider through the SLA. Compliance across the Medical workforce also continues to be lower than other staff groups due to doctors' capacity to complete/attend their training.			
<b>Action Taken to improve compliance</b>			
L&D have escalated the issues affecting the Haemonc training with the GM. L&D have met with the senior managers to agree a plan of supporting the managers with validation of training records through the use of manager self-service as well as the organization of additional training to support Haemonc staff to access training. A mandatory training day for all doctors to complete and attend has been organised for mid October with a proposal to support the training day. All doctors have been sent details of their e-learning and how to access this along with details regarding which topics to focus on as well as individual support for the doctors accessing ESR. Senior medical leadership team have been requested to ensure doctors are supported to attend the training day.			
<b>Expected date of compliance</b>	End September 90%   End December 95%		

<b>Escalation</b>	Directorates / Quality and Safety Sub Committee / Quality Committee
<b>Executive Lead</b>	Heather Bebbington, Director of Workforce and OD