

BOARD OF DIRECTORS MEETING

Agenda Item	P1-012-19	Date: 30 th January 2019
Subject /title	Integrated Performance Report – Month 9 2018/19	
Author	Hannah Gray, Head of Performance and Planning	
Responsible Director	Barney Schofield, Director of Operations and Transformation	
Executive summary and key issues for discussion		
This report presents Trust performance against agreed national and local performance metrics as at the end of Month 9 (December 2018).		
Overall, the Trust is performing well in most areas; however, there are a number of key metrics which have not been achieved, the key areas where specific attention is required being:		
<ul style="list-style-type: none">- CQUIN requirements- Venous Thrombo-Embolism (VTE) risk assessment- 2 week wait Cancer access target- Sickness absence- Statutory and Role Essential Training		
Strategic context and background papers (if relevant)		
This report is aligned to the strategic objective “Maintain excellent quality, operational and financial performance” and provides assurance to support the Trust’s Board Assurance Framework		
Recommended Resolution		
The Trust Board members are asked to: <ul style="list-style-type: none">• Note Trust performance and associated actions for improvement, as at the end of December 2018.		
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:

X

A. This document is for full publication

B. This document includes FOI exempt information

C. This whole document is exempt under FOI

IMPORTANT:

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

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

Equality & Diversity impact assessment

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

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

Next steps

Appendices

Strategic Objectives supported by this report

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

Link to the NHS Constitution

Patients		Staff	
Access to health care	X	Working environment Flexible opportunities, healthy and safe working conditions, staff support	X

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

THE CLATTERBRIDGE CANCER CENTRE

TITLE: INTEGRATED PERFORMANCE REPORT –
MONTH 9 2018/19

AUTHOR: HANNAH GRAY, HEAD OF PERFORMANCE AND
PLANNING

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

FOR: DISCUSSION / DECISION

Introduction

The purpose of this integrated performance report is to provide assurance to the Finance & Business Development Committee and the Board that the strategic objective “Maintain excellent quality, operational and financial performance” is met, highlight any non-compliance and high level risks and present the actions identified to mitigate these.

This report presents:

- A high level integrated dashboard
- 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.
- Trust high level risks relating to the strategic objective “Maintain excellent quality, operational and financial performance”

Executive Summary

Overall Core Performance

Overall, the Trust is performing well in most areas; however, there are a number of key metrics which have not been achieved, the key exceptions being:

- CQUIN requirements
- Venous Thrombo-Embolicism (VTE) risk assessment
- 2 week wait Cancer access target
- Sickness absence
- Statutory and Role Essential Training

Risks

There are 43 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 subcommittee.

Safe

The Sepsis and Dementia targets were achieved in December 2018. VTE risk assessment compliance was below target for the third consecutive month, however a number of patients had been admitted for a matter of hours before being discharged; patients who will be excluded from the data if agreement is reached with commissioners regarding the extension to the current exclusion cohort group. There were no E coli or c diff infections in December.

Caring

The % of inpatients recommending the Trust fell below the 95% target to 94.9% in November and 90.9% in December (largely due to an increase in the number of inpatients who answered 'don't know' in December). Following a rise in the Friends and Family Test (FFT) response rates in October, this then fell in November and December. Matrons across both sites will be presenting action plans to the relevant Directorate Quality and Safety meetings. These will be monitored at these forums and also discussed at the monthly Directorate monthly performance meetings.

There was one complaint in December.

Effective

There has been no significant change in the number of inpatient deaths over the three years (2018/19 to end Dec only) although CCCW monthly figures for the last 6 months have been similar to or lower than those in the previous three years.

Head and Neck, Lung, Upper GI, Breast and Skin SRG dashboards have been developed in line with plans. The next phase includes Gynaecological, Urology CNS and Colorectal which are due to be complete by end of February. Options for benchmarking are being considered to identify and strive for 'best in class'.

The Trust is 85% compliant with NICE Guidance (including Quality Standards); a 1% increase from November.

Responsive

In December 2018, the Trust met all cancer waits targets except 62 day pre allocation and 2 Week Waits. The Trust has failed to meet the 2WW target three times since April 2018. The 2ww target only applies to haemato-oncology and small numbers of breaches cause the trust to fail this target. The primary reason is related to consultant sickness absence. Additional clinical capacity and tightened escalation processes have been put in place. The 2 patients who breached in December were seen in 15 and 18 days.

Both Wirral site and peripheral site clinic waiting times have improved in both November and December, to meet the target of 80% of patients waiting fewer than 30 minutes. Bed occupancy and radiology reporting targets are not consistently being achieved. Further detail, including challenges and actions taken are presented in the report.

Well Led

The Trust has achieved its PADR target since July 2018.

The Trust 12 month rolling sickness absence is 4.27% and in month sickness absence has reduced to 4.12% for December, from 4.86% in November. Cold, cough and flu, gastrointestinal problems and anxiety, stress and depression remain the three highest reasons for sickness absence across the Trust.

Turnover for December 2018 has fallen slightly to 14.2% from 14.6% in November 2018. The majority of leavers were from Additional Clinical Services (this staff group includes Health Care Assistants, Support workers and pharmacy technicians) followed by the Admin and Clerical staff group.

The Trust has an overall use of resources risk rating of 1, (a rating of 1 being the best and a rating of 4 being the worst). The Trust is delivering against its key financial objectives.

Statutory and Role Essential training

Statutory Training compliance remains below the Trust's target of 90%, at 86% for December. Following the CQC unannounced visit in December, concerns were raised regarding statutory training compliance trust wide, as well as specific concerns regarding evidenced levels of competence. A dedicated project manager has been secured with effect from 3rd January 2019 to ensure statutory training compliance in line with trust and national targets utilising a sustainable project governance approach as follows:

- Initial focus has been on achieving compliance against five prioritised training types and ensuring reporting supports Directorates to identify any compliance issues
- All Directorates have reviewed statutory training data to ensure staff has the correct statutory training assigned against their role. This has resulted in a negative impact on compliance levels for some training types across some roles
- Over the next three weeks, all Directorates will review their role essential training requirements. This has already been completed for Haem-Onc in line with feedback from the CQC and this Directorate are focusing on improving role essential compliance levels
- Work is being undertaken to strengthen Learning & Development (L&D) processes to improve quality of data and enable more robust monitoring of compliance levels to take place
- Directorates are now receiving weekly compliance reports to manage progress in line with Trust and national targets, with the initial aim of achieving compliance in these key areas by end of March (subject to capacity constraints).
- A project team with a representatives from Operations, L&D, HR and Administration Services has been created to ensure delivery against the project plan
- Weekly executive team oversight of project deliverables

Progress since December: Trust wide Statutory Training (data correct as at 17/01/2019)

	Chemotherapy		Haem-Onc		Integrated Care		Radiation Services	
	Dec	Jan	Dec	Jan	Dec	Jan	Dec	Jan
BLS	55%	74%	53%	90%	71%	80%	50%	74%
ILS	42%	63%	n/a	n/a	41%	68%	67%	50%
Safeguarding level 3	86%	86%	11%	43%	33%	50%		21%
Patient handling - level 2	67%	86%	43%	82%	78%	80%	70%	72%
Infection Control- level 2	75%	80%	74%	100%	49%	76%	35%	52%

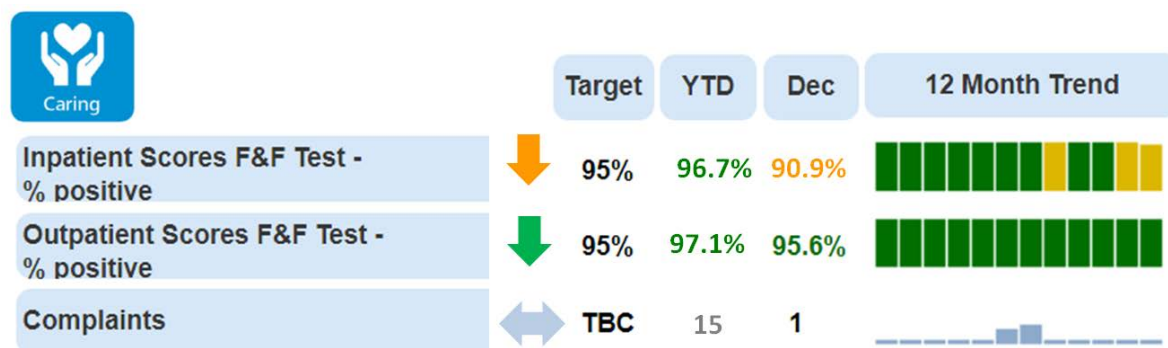
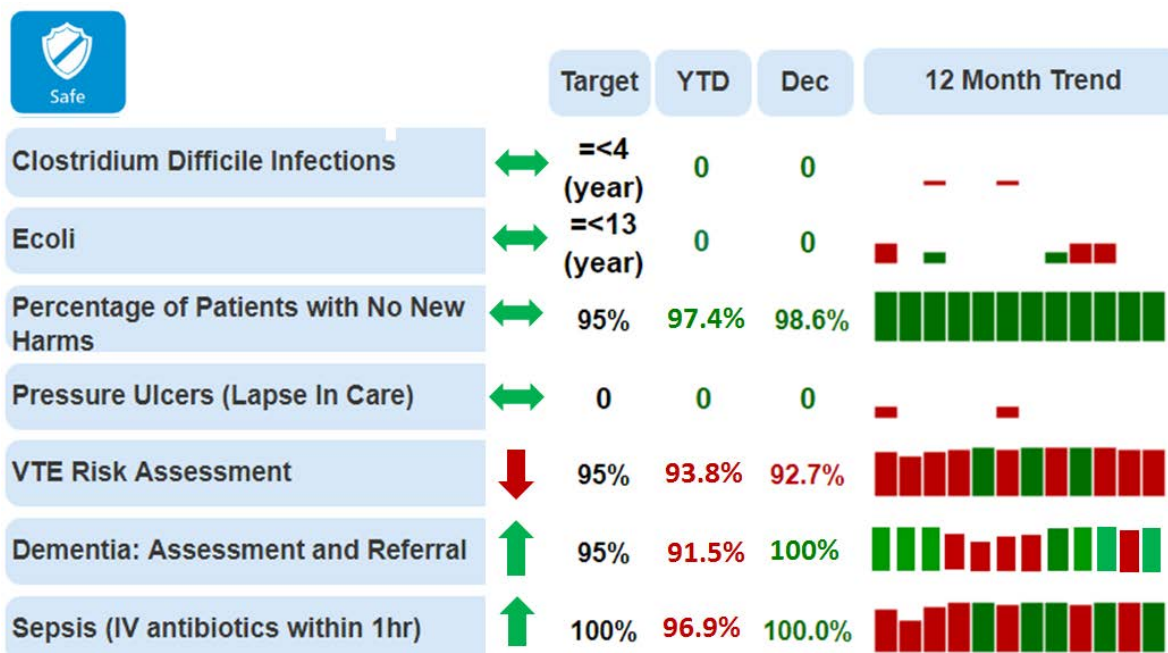
There have been improvements to compliance figures in all areas except:

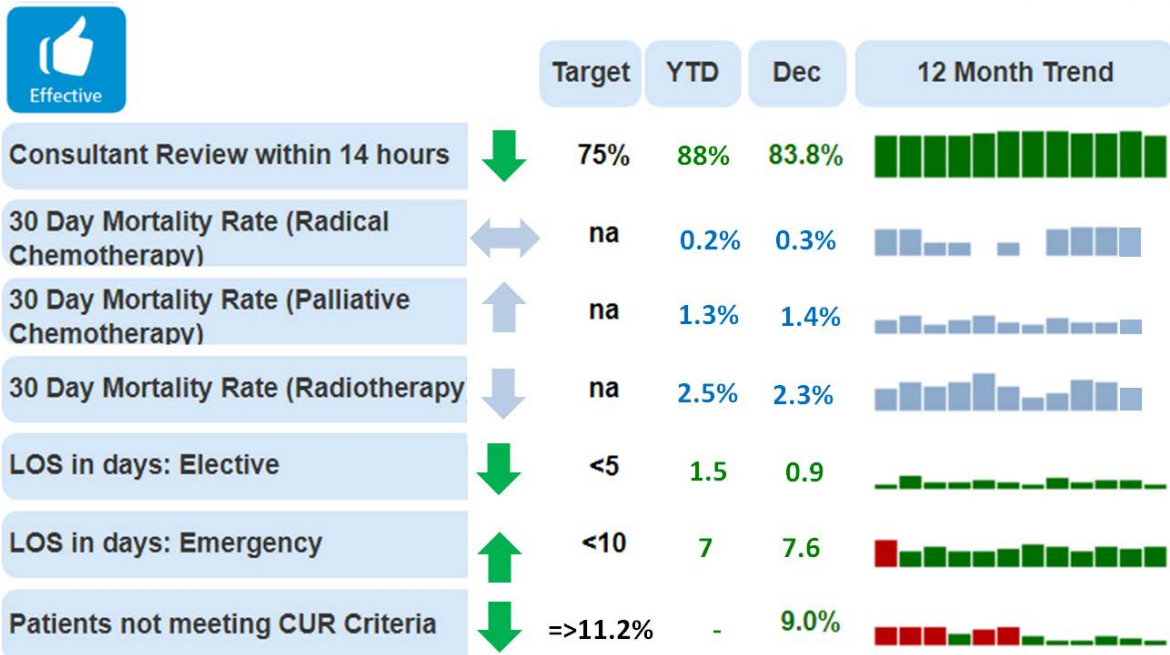
- Radiation Services – a number of new staff were identified as requiring ILS and therefore compliance has reduced
- Haem-Onc, in which staff do not require ILS due to location within the Royal Liverpool
- There are some issues relating to who should have Safeguarding level 3 across the trust which are being addressed and are captured within the project plan – across Haem-Onc and Radiation Services new staff were identified as requiring level 3 training

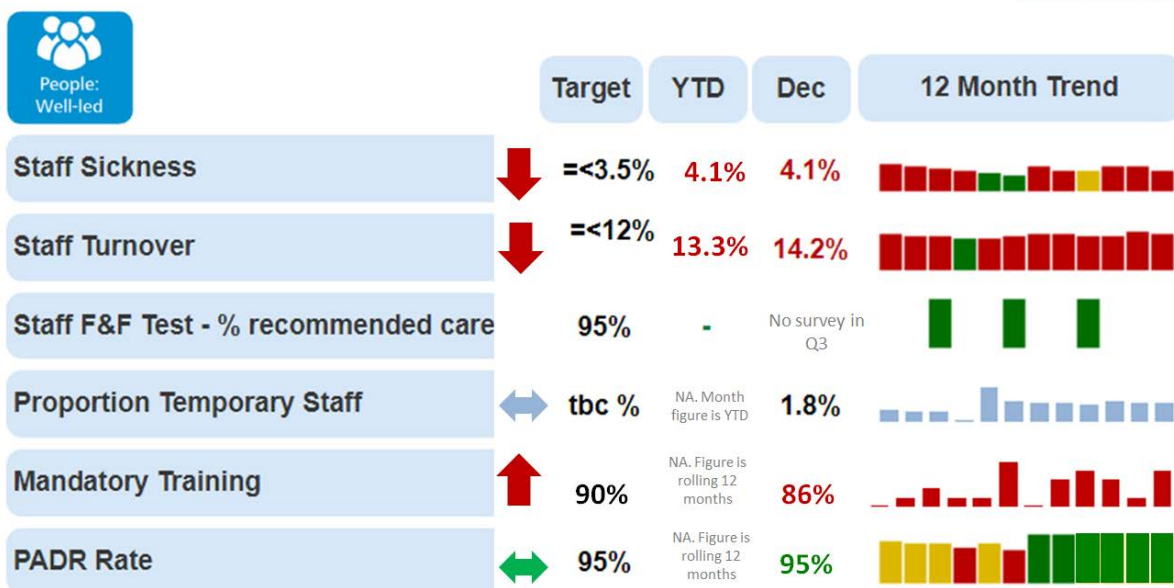
Progress since December: Haem-Onc Role Essential Training (data correct as at 17/01/2019)

The figures below show compliance for ward-based staff. There has been an improvement in all training.

Haem-Onc	December	January
AKI	81%	92%
ANTT - online	100%	100%
Sepsis	73%	92%
Blood transfusion - online	74%	100%
Blood transfusion - ward based	66%	100%
Point of care	57%	98%
Medical Devices	39%	52%
COVAD	85%	95%







KEY: Better than target		Green
Below target		Red
Below target but within acceptable limits		Amber
Key Indicator		
Group Surplus (incl Charity) of £3,824k against a planned surplus of £3,686k		Amber
Trust net surplus of £2,252k vs a planned surplus of £1,638k		Green
Net Trust I&E margin of 1.9% vs a planned margin of 1.5% (excludes impairments)		Green
NHSI Control total of £1,566k against actual year to date comparator of £3,180k		Green
Actual CIP achieved £1,461k against a plan of £1,209k		Green
Capital expenditure at £44,344k against a plan of £58,357k		Amber
Cash balances at £65,022k are £4,555k below planned balances of £69,577k		Amber
CQUIN funding of £1,171k against a plan of £1,586k		Red
Use of Resources: Risk Rating		
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 –		Green

giving a rating of 1 (against a plan of 1)	
Use of resources – overall risk rating of 1 (against a plan of 1)	
Finance and Activity – December 2018	
Agency medical locums £508k against a target of £375k	
Radiotherapy activity - 1.9% growth	
Chemotherapy activity - 5.0% growth	
Inpatient activity - 1% growth	
Outpatient activity -1% growth	

High level dashboard, key points to note:

- (a) The arrows show movement from the previous month, with the colour indicating this month's performance.
- (b) The 62 Day cancer waiting times figure is validated at the end of the following month, therefore the figure presented is unvalidated.
- (c) Infections are CCC attributable only.
- (d) The 30 day mortality data is for the previous month.
- (e) 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).
- (f) 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.
- (g) The target of $\leq 11.2\%$ for Patients not meeting the CUR criteria is to be achieved by 31st March 2019, rather than in every month.

CQC Insight Composite Score

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

The report highlights how CCC compares to other Trusts and also to CCC's performance 12 months ago, against a range of indicators. KPIs in the 4 categories of particular interest are shown here (taken from the December 2018 report, however the data relates to a range of different time periods). The report describes CCC's position including KPIs which are **NEW** to each section since the November 2018 report. For example, CCC's performance has been identified in the December report as being much better than the national average for 'Sick days for medical and dental staff' but was not described as such in the November report.

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

This table provides further detail on the 'much worse' or 'declined' KPIs including CCC's improvement actions.

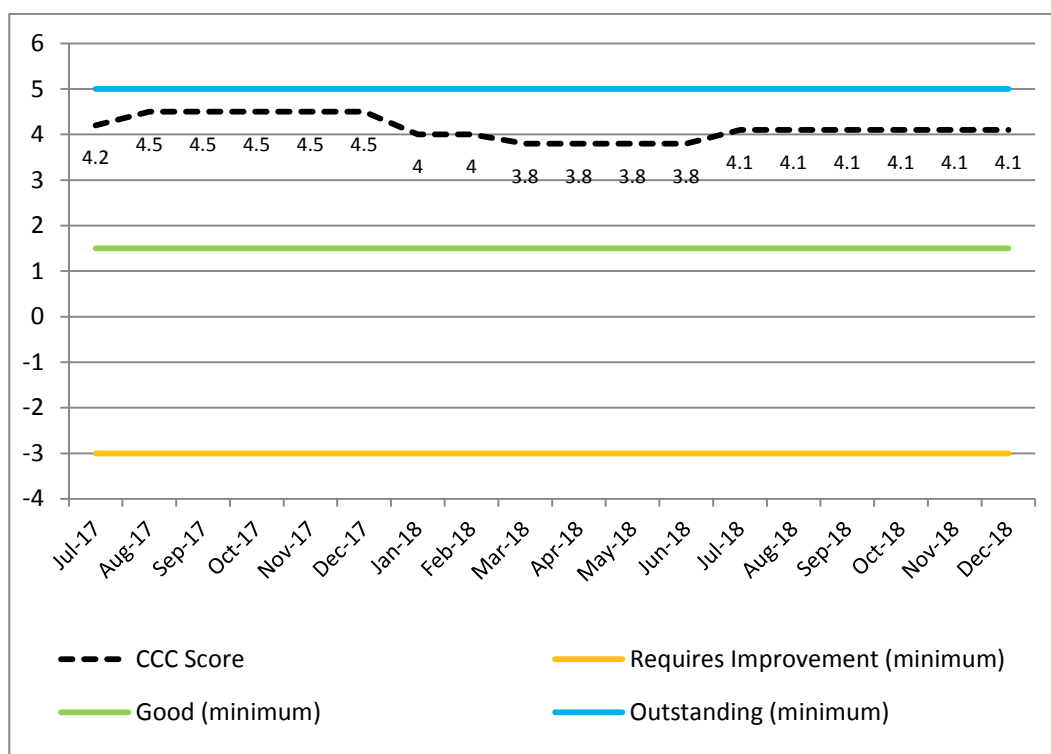
KPI	Definition	Latest performance	Previous performance	National Average	Comments / Actions
Much worse compared nationally					
Stability of Nursing and Midwifery staff	Retainment of the experienced workforce (employees with greater than 1 years' service). Lower = worse.	0.59 (July 2017 – June 2018)	None stated	0.88	<p>The figures show that CCC's retention of employees with greater than 1 years' service is worse than the national average.</p> <p>Comparisons on turnover of all staff (provided by NHSI's Model Hospital resource), show CCC to be similar to both peers and the national average.</p> <p>See page 60 for further detail on turnover.</p>
Declined (compared to 12 months ago)					
Overall engagement (1-5)	NHS Staff Surveys: Scores from key findings 1 (staff recommendation), 4 (staff motivation) and 7 (ability to contribute at work) were averaged to	3.96 (Sep 17 - Dec 17)	4.03 (Sep 16 - Dec 16)	None stated	<p>This has worsened marginally from 2016 to 2017.</p> <p>CCC's staff survey action plan aims to address any areas of concern. The 2018 survey</p>

KPI	Definition	Latest performance	Previous performance	National Average	Comments / Actions
	produce an engagement score on a scale of 1-5. Lower = worse.				results will be reviewed when available and the existing action plan revised accordingly.
Ratio of occupied beds to nursing staff	Estimated patient contact hours in one week: Occupied overnight beds and occupied day beds / Estimated staff contract hours available in one week (z scored). Higher = worse.	1.41 (June 17 – June 18)	1.16 (Oct 16 – June 17)	2.12	There has been a deliberate change to the bed base during 2017/18 at CCCW to improve bed utilisation. This change increased bed occupancy and therefore affected the ratio of occupied beds to nursing staff. However our staff ratio to occupied beds remains better than the national average. See pages 29 for nurse staffing related information.
Ratio of occupied beds to medical and dental staff	Estimated patient contact hours in one week: Occupied overnight beds and occupied day beds / Estimated staff contract hours available in one week (z scored). Higher = worse.	3.65 (June 17 – June 18)	2.65 (Oct 16 – June 17)	4.27	This has increased from 2016/2017 to 2017/2018, however it is still better than the national average. Reason for change as above.

KPI	Definition	Latest performance	Previous performance	National Average	Comments / Actions
Ratio of delayed transfers and number of occupied beds	<p>Numerator: The total number of days delayed over the quarter where the delay is attributable to the NHS.</p> <p>Denominator: The total number of occupied beds in the quarter (The average number of occupied beds taken from the KH03 data multiplied by the number of days in the quarter and then adding the number of occupied non-consultant beds). Z scored. Higher = worse</p>	0.01 (July 2018 – Sept 2018)	0 (July 2017 – Sept 2017)	0.02	This has increased from 2017 to 2018, however it is still 50% below, i.e. better, than the national average.

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 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 Q2 2018/19 submission, however the value withheld for 2 of the CQUINs is not yet confirmed as this is dependent on performance in future quarters. The value reported as withheld in the finance section of the high level dashboard (p.4) is likely to be underreporting the final value. The CQUIN detail, including expected performance for 2018/19 is shown in the table below.

Where relevant to specific Directorates, CQUIN details are included in the Directorate 'data packs', presented at the monthly Directorate quality and safety meetings. Risks to achievement are escalated to the relevant Sub Committee via the 'Triple A' Report and risk ref. 1015 (see section 5.3) remains on the risk register. A dedicated CQUIN group meets to drive improvement.

The 2019/20 CQUIN value will be reduced by 50% and there will be an associated reduction in the numbers of CQUINs for CCC. Details of potential specialized commissioning CQUIN schemes have recently been shared with Trusts and CCC has provided feedback. Following this engagement process and the release of the final indicators, CCC will be advised of the proposed CQUIN indicators for the organisation.

These are likely to be 2 or 3 of the following:

- Medicines Optimisation (follows on from 2018/19)
- Clinical Utilisation Review (follows on from 2018/19)
- Rethinking Conversations (builds on the Enhanced Supportive Care CQUIN 2018/19)

There will also be a number of CQUIN schemes proposed by Liverpool CCG; details of these are not yet known.

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 in 18/19	2017/18				2018/19			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Staff Survey: Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and	£26,217	N/A								

CQUIN	Value	£ withheld in 18/19	2017/18				2018/19			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
wellbeing; MSK and stress.										
Healthy food for NHS staff, visitors and patients		N/A								
Improving the uptake of flu vaccinations for frontline clinical staff (target 70% by 28 th February 2018)		N/A								
Preventing ill health by risky behaviours – alcohol and tobacco: inpatient screening, advice, referral and medication	£26,217	£12,602								
Holistic Needs Assessment	£198,926 (NHSE) £52,370 (LCCG)	£125,648								
End of Treatment Summaries	£198,926 (NHSE) £52,370 (LCCG)	£0								
Clinical Utilisation Review: Installation and Implementation of software; reduction in inappropriate hospital utilisation and reporting of results	£528,273	£0 (although dependent on compliance in Q3&Q4)								
Enhanced Supportive Care: Ensuring patients with advanced cancer are, where appropriate, referred to a Supportive Care Team, to secure better outcomes and avoidance of inappropriate treatments.	£357,944	To be confirmed by NHSE								
Optimising Palliative Chemotherapy: To ensure systematic review of further chemotherapy decisions for patients with poor clinical response. To ensure effective Mortality Review processes are in place.	£217,413	£108,706								
Medicines Optimisation: Funded pharmacist change programme to optimise use of high cost drugs: adoption of bio-similars and generics; improved drug data quality; utilising most cost-efficient dispensing cost channels; compliance with policies/guidelines, so to tackle variation & waste	£140,241	£0								

CQUIN	Value	£ withheld in 18/19	2017/18				2018/19			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Dose Banding: Standardise the doses of SACT in all units across England in order to increase safety, to increase efficiency and to support the parity of care across all NHS providers of SACT	£210,915	£0								

The exception reports below relate to CQUINS for which

- Commissioners have confirmed or potential under performance for Q2 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.

Clinical Utilisation Review:

It is expected that performance against this CQUIN will remain compliant, or with minimal funding withheld.

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	
<ul style="list-style-type: none"> • A pool of 11 'Cancer Support Workers' have now been recruited (utilising a variety of funding streams), have undergone training and are operational. These roles will by quarter 4 work across all hubs, which will increase access across the Trust's geographic footprint. • A leaflet has been produced to raise awareness of the service. • Early indications are that the assessments are proving valuable and there is effective signposting to appropriate services within and external to CCC. • Dedicated CQUIN monthly meetings for the CQUIN leads are now being held, which supports a collaborative approach to improvement in all CQUINs. • There has been significant improvement in Q3. 	
Expected date of compliance	Partial: Q3 2018/19, Full: Q4 2018/19

Escalation route	Directorates / Quality and Safety Sub Committee / Quality Committee / Trust Board
Executive Lead	Sheila Lloyd, Director of Nursing and Quality

Enhanced Supportive Care	
Reason for non-compliance	
<p>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.</p> <p>During Q2, the Palliative Care Consultant was absent from work. As the sole consultant for ESC, this absence led to cancellation of ESC clinics. Referrals to the service were still encouraged and accepted, but there was an inevitable decrease in referrals, which has resulted in commissioner assessment of performance being non-compliant.</p>	
Action taken to improve compliance	
<p>Actions to improve compliance include:</p> <ul style="list-style-type: none"> • 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 <p>On-going actions include:</p> <ul style="list-style-type: none"> • 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 (22nd 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' have been recruited; these posts will primarily support the Holistic Needs Assessment CQUIN, but also facilitate aspects of the Enhanced Supportive care CQUIN. • The CQUIN lead attended MAC to increase Consultant engagement. • Patients are 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 • Dedicated CQUIN monthly meetings for the CQUIN leads are now being held, which supports a collaborative approach to improvement in all CQUINs. 	
Expected date of compliance	Q4 2018/19
Escalation route	Quality and Safety Sub Committee / Quality Committee / Trust Board

Executive Lead	Sheila Lloyd, Director of Nursing and Quality
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Optimising Palliative Chemotherapy	
Reason for non-compliance	
The required number of peer discussions were not completed / recorded for Q1 or Q2 2018/19. The second aspect of this CQUIN, mortality review, was achieved in 2017/18.	
Action Taken to improve compliance	
<ul style="list-style-type: none"> • 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 in time will 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. • The Meditech system has been amended to enable easier capture of these conversations and we expect compliance to improve in Q4 as a result. • Dedicated CQUIN monthly meetings for the CQUIN leads are now being held, which supports a collaborative approach to improvement in all CQUINs. 	
Expected date of compliance	Partial in Q3, Full in Q4 2018/19
Escalation route	Directorates / Quality and Safety Sub Committee / Quality Committee / Trust Board
Executive Lead	Sheila Lloyd, Director of Nursing and Quality

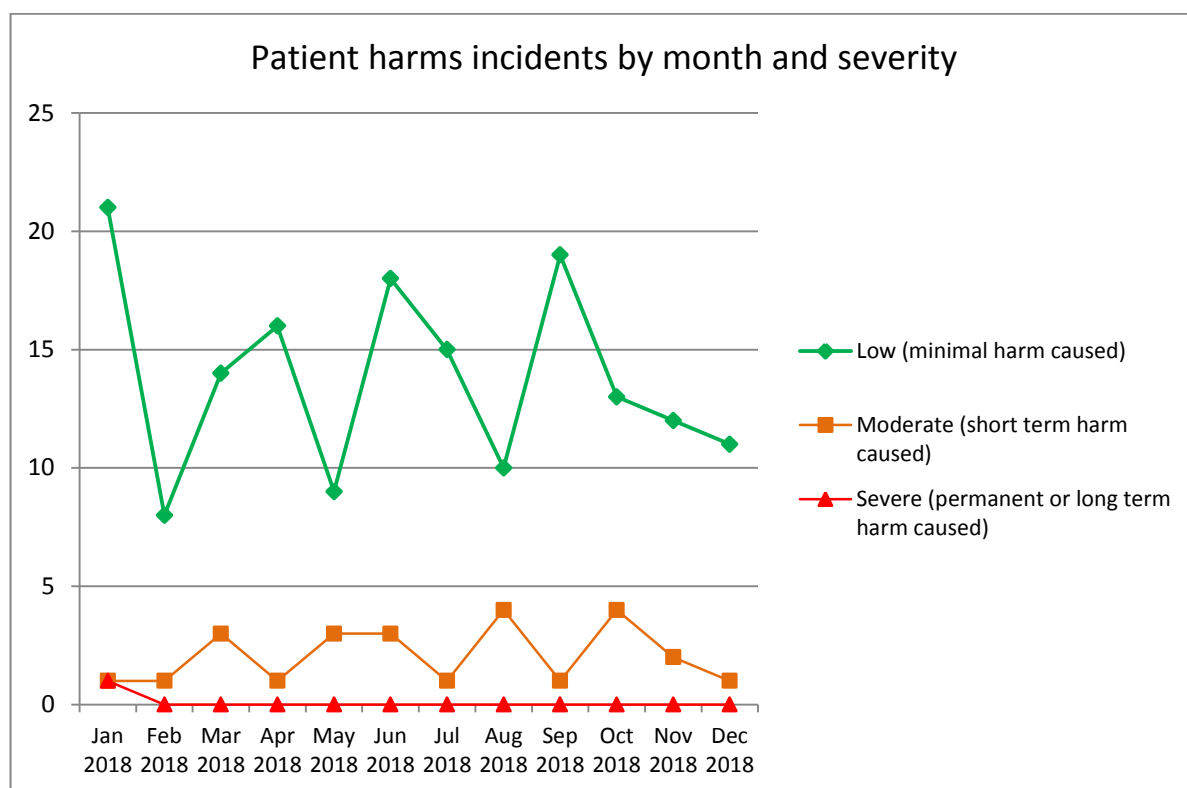
1. Safe

1.1 Never Events

There have been 0 never events from 1/4/18 – 31/12/18.

1.2 Incidents

The chart below shows incidents resulting in harm, by level of harm and month since April 2017.

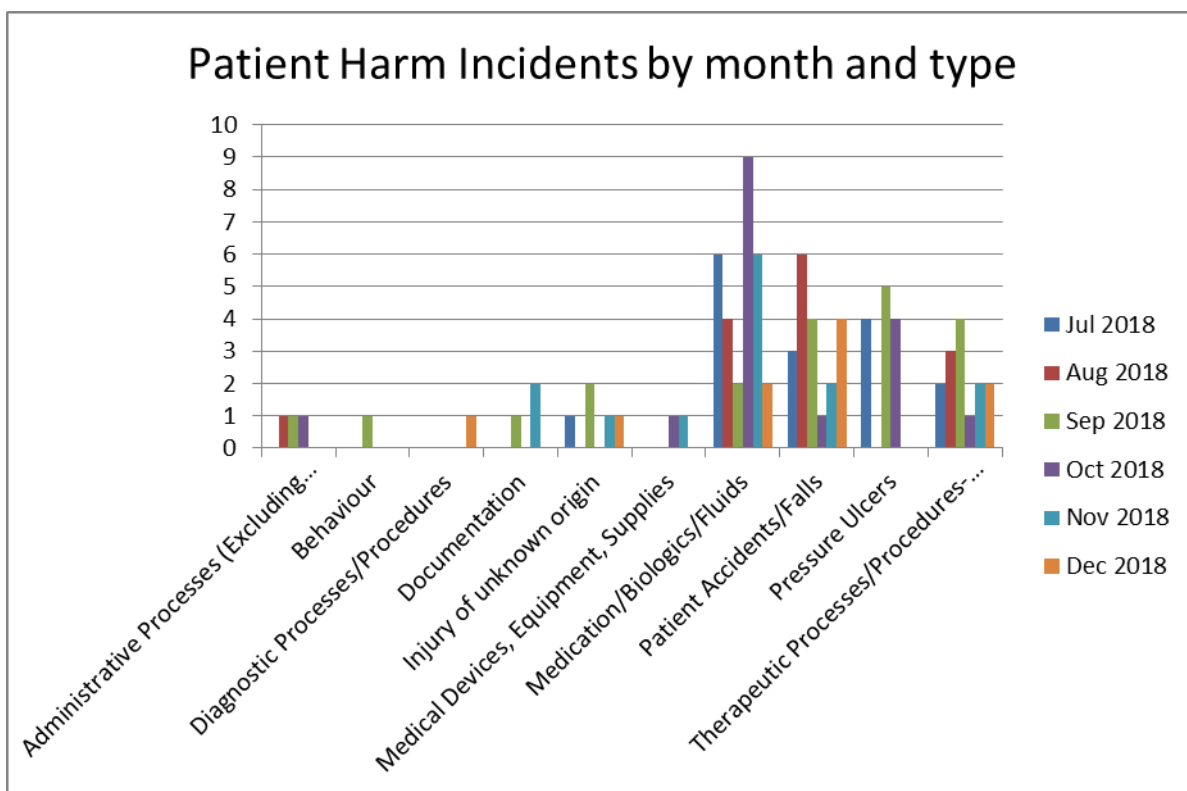


There are no significant trends and whilst there has been a gradual rise in incidents resulting in low harm since mid-2017, this coincides with the Haemato-oncology service joining CCC. An increase in low harm, with no increase in incidents resulting in a greater severity of harm suggests improved reporting rather than any fall in the quality of care. More recently, there has been a fall in incidents of both low and moderate severity in Q3.

The one moderate harm in December 2018 was a medication incident:

ID5084: Patient received on treatment review and go ahead given 20/12/18 on bloods taken 17/12/18. Go ahead given to treat on the 21/12/18. Staff asked to repeat Cortisol when patient attended for treatment, full Immunotherapy bloods taken however results not reviewed. Treatment given without bloods taken on the 21/12/18 being reviewed at which time patient had a Grade 2 Hepatitis. Patient has since attended CDU and found to have a Grade 4 Hepatitis. Incident learning meeting has taken place and action plan developed.

The chart below shows incidents resulting in harm, by category for the last 6 months. All incidents are reviewed individually.

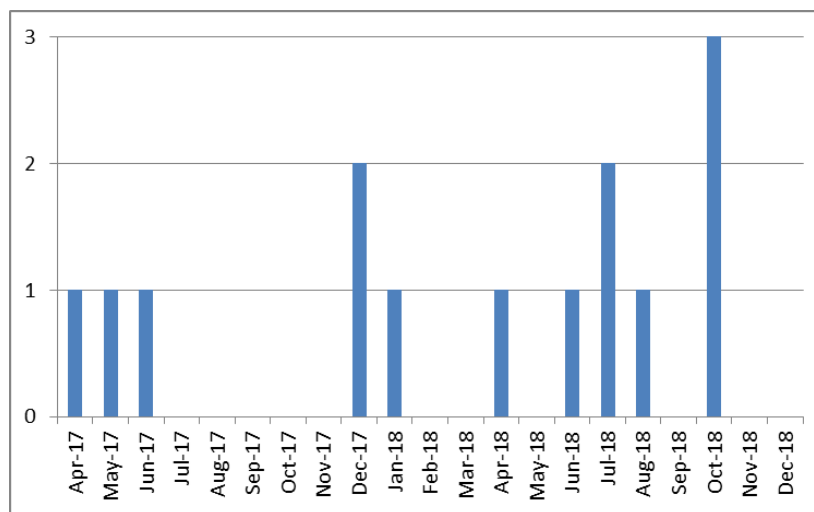


Falls and pressure ulcers are reviewed at the harm collaboration meeting. NB, the pressure ulcers reported here include those not attributable to CCC i.e. the patient was admitted with a pressure ulcer or it developed within 72 hours.

Serious untoward incidents:

The chart below shows the numbers of serious incidents per month for the last 12 months.

There were no serious incidents in December 2018.



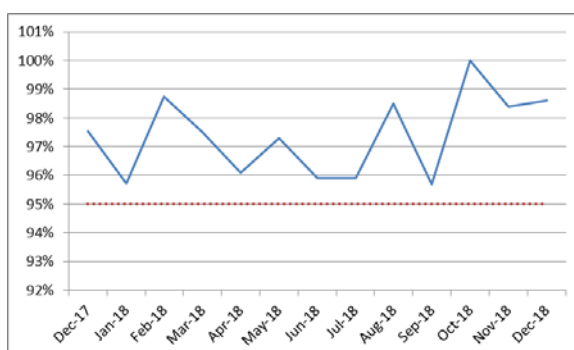
Inquests/Coroner's investigations

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

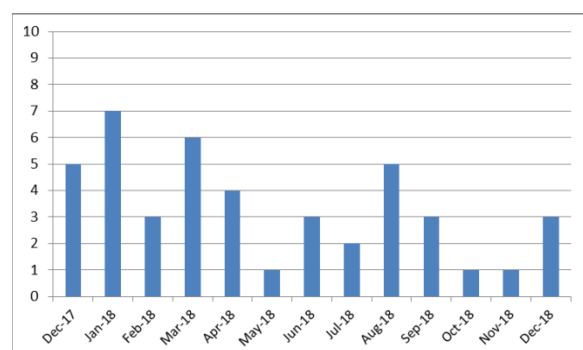
1.3 Harm Free Care

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

Safety Thermometer (CCC harm free)



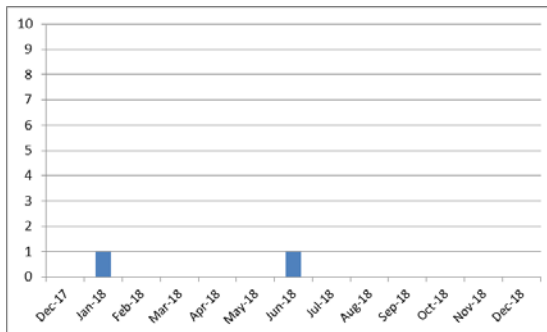
Falls resulting in harm



The target of 95% is consistently achieved.

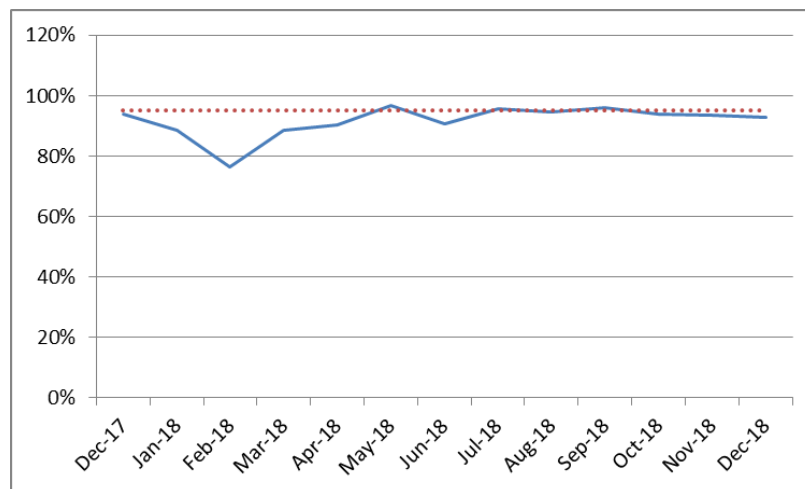
All falls are monitored and reviewed by the Falls and Manual Handling group. There is a falling trend over the last 13 months.

Pressure Ulcers (attributable) | Target = 0



The target of 0 attributable grade 2 – 4 pressure ulcers has not been achieved in 2018/19, with 1 in June. There were 3 attributable grade 2 – 4 pressure ulcers in 2017/18. All pressure ulcers are reviewed at the harms collaborative meeting, any lapses in care identified and lessons learned shared. Full root cause analyses are conducted for all CCC attributable pressure ulcers.

VTE Risk Assessment



Compliance has improved in recent months; however the Trust is not consistently achieving the target.

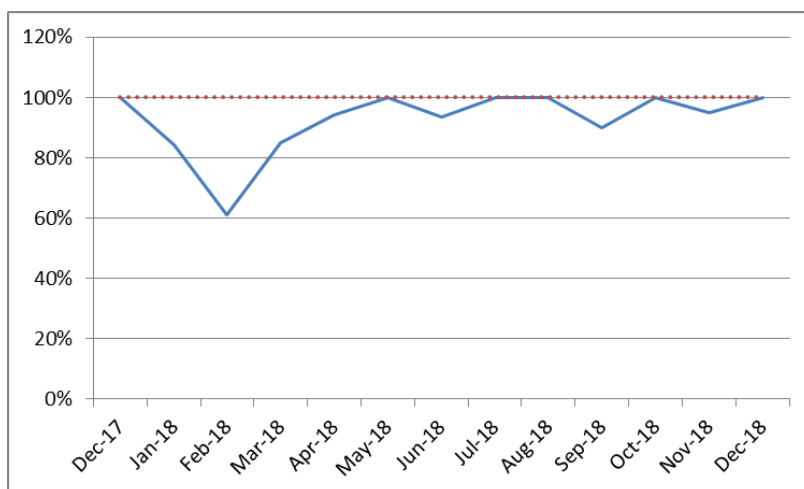
A further review identified a number of patients had been missed, although some patients are being admitted and discharged on the same day. Other patients had been admitted for a matter of hours before being discharged; patients who will be excluded from the data

once agreement is reached with commissioners regarding the extension to the current exclusion cohort group.

Actions in place:

- Medical lead for VTE has re-enforced process to medical staff. VTE education continues on medical induction.
- Fall in compliance has been escalated to the Integrated care Matron, Ward Managers and Clinical Director for Integrated Care receive daily list of missed assessments.
- Compliance also to be fed directly into IC directorate through Quality and Safety data pack.
- Matron for IC directorate attending doctor's morning handover each morning to reinforce VTE compliance.
- Ward screens have been placed on all wards and are now in use.
- Physician associates and ANP (CDU) to continue to support junior doctors with the VTE assessments for planned admissions.
- Flowchart developed for doctors' offices to provide further guidance to which patients require a VTE risk assessment.
- Exclusion criteria are currently under review following a meeting with the commissioners.
- Discussion with Sulby ward manager, agreement made that the ANP team will also pick these patients up to avoid them being missed

Sepsis (IV Antibiotics within 1 hour)



Compliance has improved in recent months; however the Trust is not consistently achieving the target.

The Sepsis Working Group will continue to facilitate the following actions:

- Conduct weekly audits
- Focus on education and training, ensuring all policies are up to date, discuss and report up to date best practice and establish a standard supply of resources.
- Raising awareness of Sepsis recognition and management to all clinical staff
- Reducing the numbers of inappropriate antibiotic usage
- Development of education strategy for Sepsis
- Compliance with NICE and UK Sepsis Trust guidelines
- Improving PGD training and compliance of antibiotic prescribing, supporting efficiency of antibiotic delivery.
- Establishing and achieving competences and skill for identified first responds to patients with suspected Sepsis
- Identify Sepsis Champions for each area
- Launch Sepsis pathways to support both inpatient and outpatient staff
- Commence AQuA Sepsis audit program

In addition, the Critical Care Outreach Team continues to work with IM&T to complete the development of the Sepsis Screening Tool in Meditech and launch it alongside both the 2018 National Guidelines and NEWS2 in December 2018.

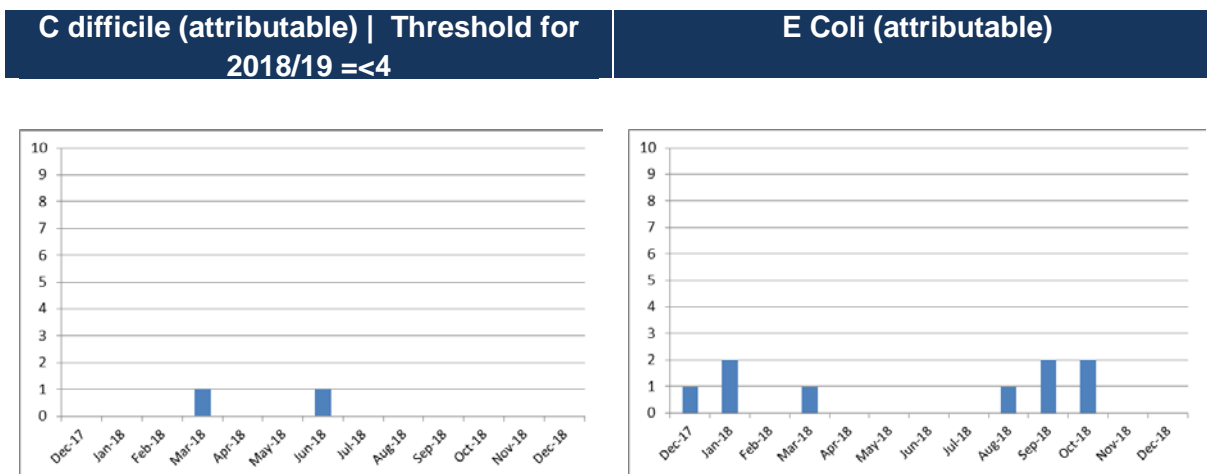
NB: The target for inpatients was changed from 90 to 60 minutes in October 2018.

Dementia Assessment:

Following a fall to 89% during November 2018, compliance is 100% for December.

Health Care Acquired Infections

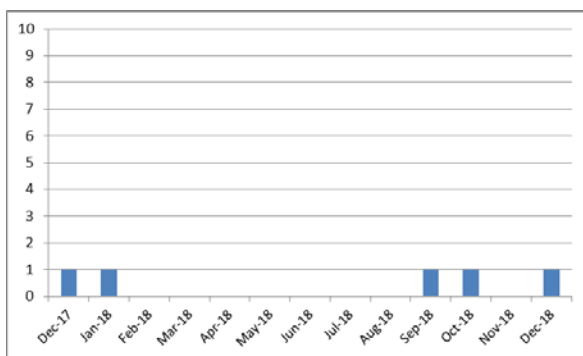
This section relates to 'reportable' bacteraemia.



The Trust is performing well against the target of 4 attributable cases of c diff, with 1 since April 2018. There were 5 at the same point in 2017/18, with a total for 2017/18 of 6. Full root cause analyses are conducted (with NHSE) for all CCC attributable cases; no lapses in care have been identified in 2018/19.

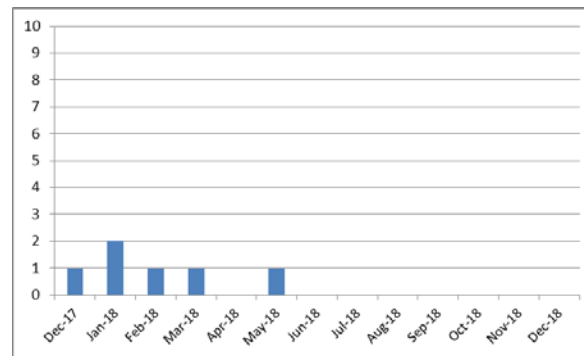
There were no attributable E coli blood stream infections in December. All Bacteraemia cases are summarised and presented for review to the Harm Free Care Collaborative with actions agreed and followed up by the group.

MSSA (attributable)



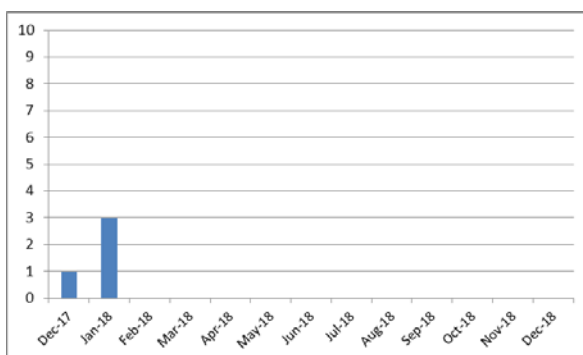
There was 1 attributable case in December, relating to an out-patient on 7Y Day Care.

Klebsiella (attributable)



The case in May 2018 was likely associated with hepatobiliary source. There have been no other attributable cases in 2018/19.

Pseudomonas (attributable)



There have been no attributable cases in 2018/19.

MRSA

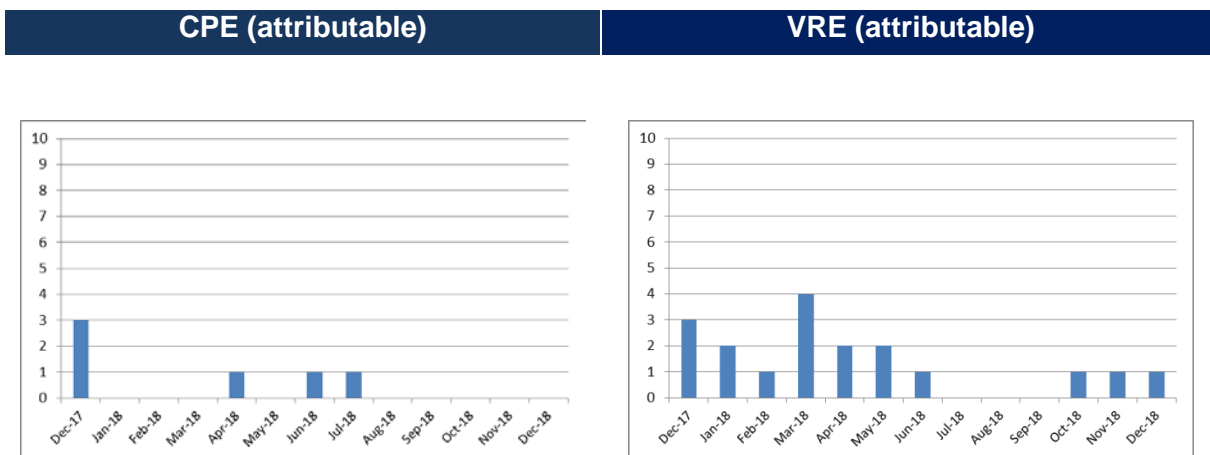
There were 0 cases of MRSA in 2017/18 and 0 from 1/4/18 – 31/12/18.

'Non reportable' bacteraemia

There have been 3 cases of GDH Tox B (equivocal) C.diff reported in December for HO. Two of these cases were identified on HO ward 10Z. Following liaison with the IPC team at the Royal Liverpool, it can be confirmed that these cases are not linked.

There were 2 Trust acquired CPE screens, on HO Ward 7Y.

There was 1 Trust acquired VRE screen, on Mersey ward. This patient was screened late (on day 3 of admission), but it is by surveillance definition it falls into Trust acquired.



There have been no attributable cases since July 2018.

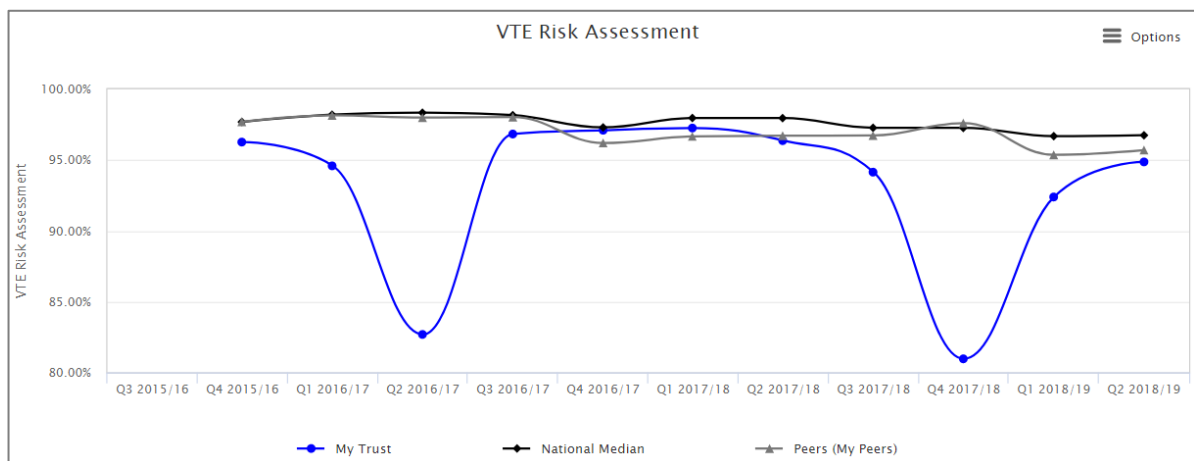
We continue to detect an increase in VRE bowel colonisation by routine pre admission screening. There were a further two cases in Q2 (one at each site), however these were identified on admission and therefore not attributable to CCC. The attributable case in December related to an out-patient on 7Y Day Care.

Benchmarked patient harm data:

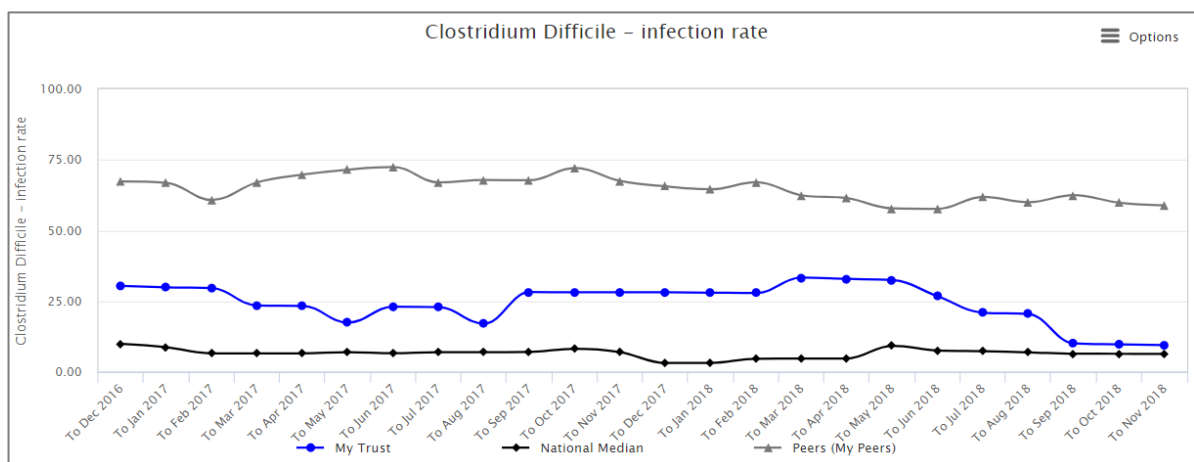
Safe	Data period	Trust value	Peer median	National median	Chart
VTE Risk Assessment	Q2 2018/19	94.86%	95.70%	96.75%	
Clostridium Difficile - infection rate	To Nov 2018	9.40	58.85	6.31	
MRSA bacteraemias	To Mar 2018	0.00	2.61	0.00	
Potential under-reporting of patient safety incidents	30/11/2016	0.12	0.07	N/A	No chart available
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Nov 2018	85	145	19	
Meticillin-sensitive staphylococcus aureus (MSSA) rates to quality indicators	Nov 2018	9	15	11	

The circle on each chart is CCC and diamond is 'my peer' median.

VTE Risk Assessment

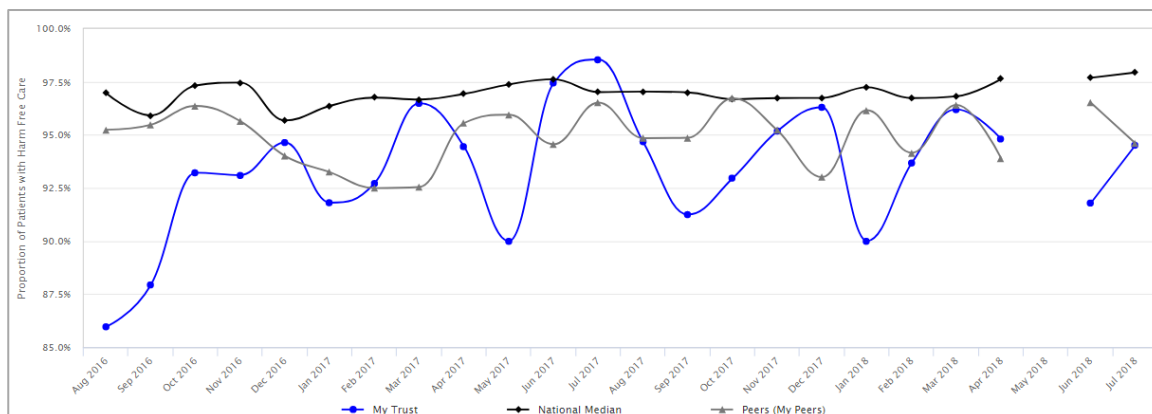


Clostridium difficile (infection rate)



Model Hospital KPI definition: Rolling 12 month count of trust-apportioned C. difficile infections in patients aged 2 years and over/Rolling 12 Month Average Occupied bed days per 100,000 beds.

Safety Thermometer (not updated on Model Hospital since Month 6 IPR)



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

December 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	1938	1920	744	720	1116	1032	744	732	99.1%	96.8%	92.5%	98.4%	
Sulby	744	672	186	90	120	96	0	12	90.3%	48.4%	80.0%	-	
Mersey	2328	2118	744	648	1116	1140	744	612	91.0%	87.1%	102.2%	82.3%	
7Y	1860	1548.5	930	729	713	782	713	644	83.3%	78.4%	109.7%	90.3%	
10Z and 7X	1845	1845	613.5	586	976.5	976.5	472.5	483	100.0%	95.5%	100.0%	102.2%	

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

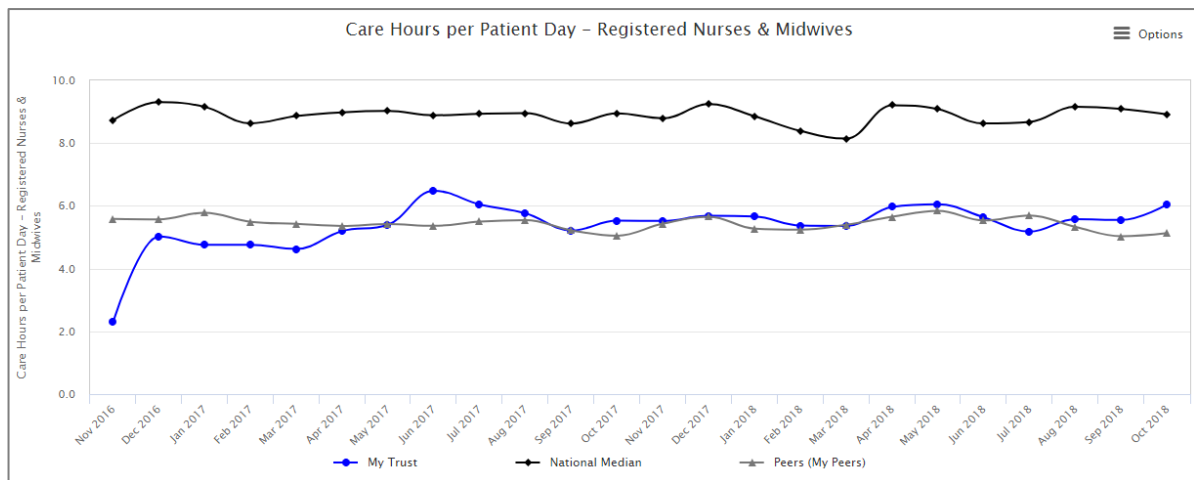
Care hours per patient day are calculated by dividing the total numbers of nursing hours on a ward or unit by the number of patients in beds. This calculation provides the average number of care hours available for each patient on the ward or unit.

	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
Care hours per patient day: Conway Ward	6.1	6.2	5.7	6	6.5	7.5	7.4	8.4	7.6	6.8	6.8	7.4	7.9	
Care hours per patient day: Sulby Ward	19	14.8	15.4	10.4	12	14	13.4	8.7	16.1	15.8	17.3	20.2	6.6	
Care hours per patient day: Mersey Ward	7.4	7.3	6.9	7.3	9.2	9.4	7.6	7.2	8.0	7.2	8.3	7.9	8.3	
Care hours per patient day: 7Y	5.6	5.7	5.7	5.5	5.7	5.6	5.8	5.5	5.7	5.7	5.9	6.2	6.0	
Care hours per patient day: 10Z and 7X	14.3	12.9	12.4	13.6	14.4	10.4	18.8	14.7	13.1	13.9	16.9	12.7	15.0	

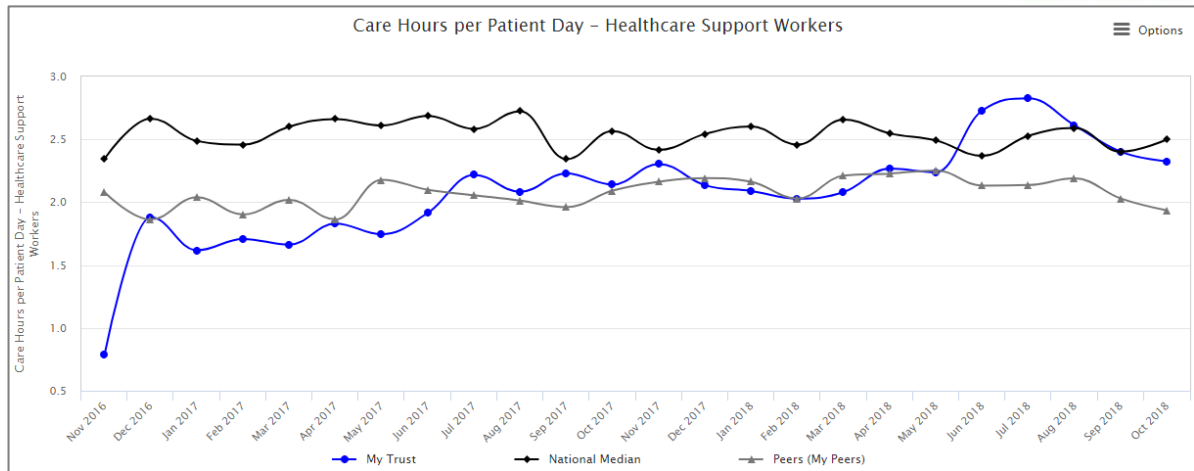
CHPPD benchmarked:

The model hospital CHPPD data has not been updated since the Month 7 IPR. These charts show only Christie as a peer, due to the Royal Marsden having an ITU and therefore a staffing ratio with which we would find limited value in benchmarking. The data shows a similar CHPPD to Christie for both nurses and support workers since December 2016.

Registered Nurses:



Healthcare support workers



A review of the use of CHPPD in the Trust, including a self-assessment against guidance from NHS Improvement on how to collect and use the data, is being conducted by the Matrons.

The CHPPD data is due to be published on My NHS from September 2018 for acute trusts and January 2019 for acute specialist, community health and mental health trusts. CCC's data is however not listed on My NHS, an issue they are looking into.

Safer staffing reports are presented to the Quality and Safety Sub Committee and data is made available on the Trust website.

2. EFFECTIVE

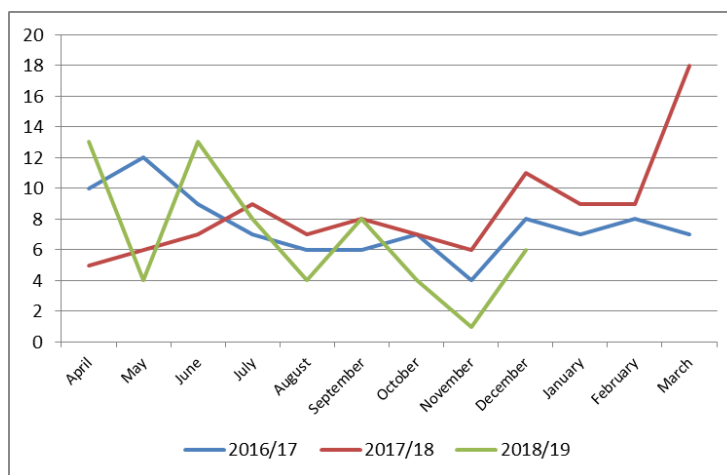
2.1 Clinical Outcomes

Mortality

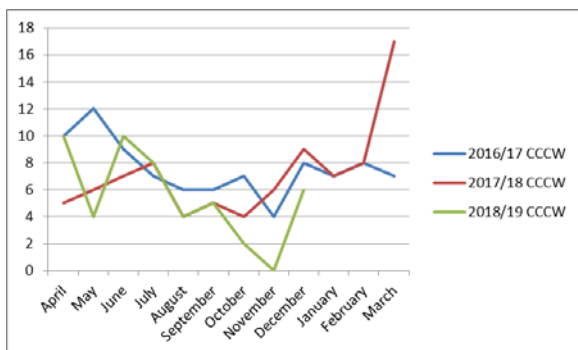
Inpatient deaths:

These charts show firstly all CCC inpatient deaths, followed by CCCW only and Haemato-oncology only.

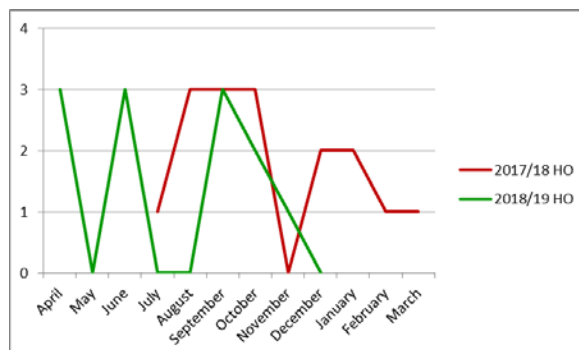
All CCC inpatient deaths



CCC Wirral wards



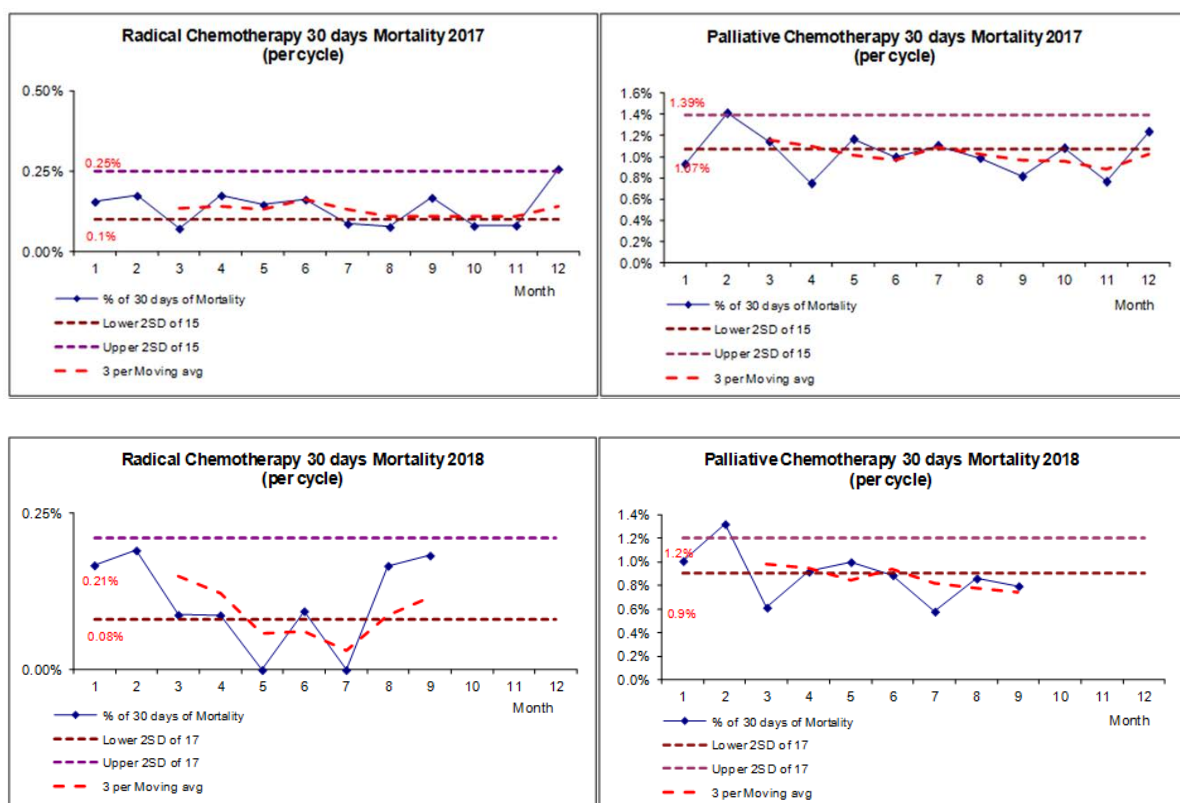
CCC HO wards

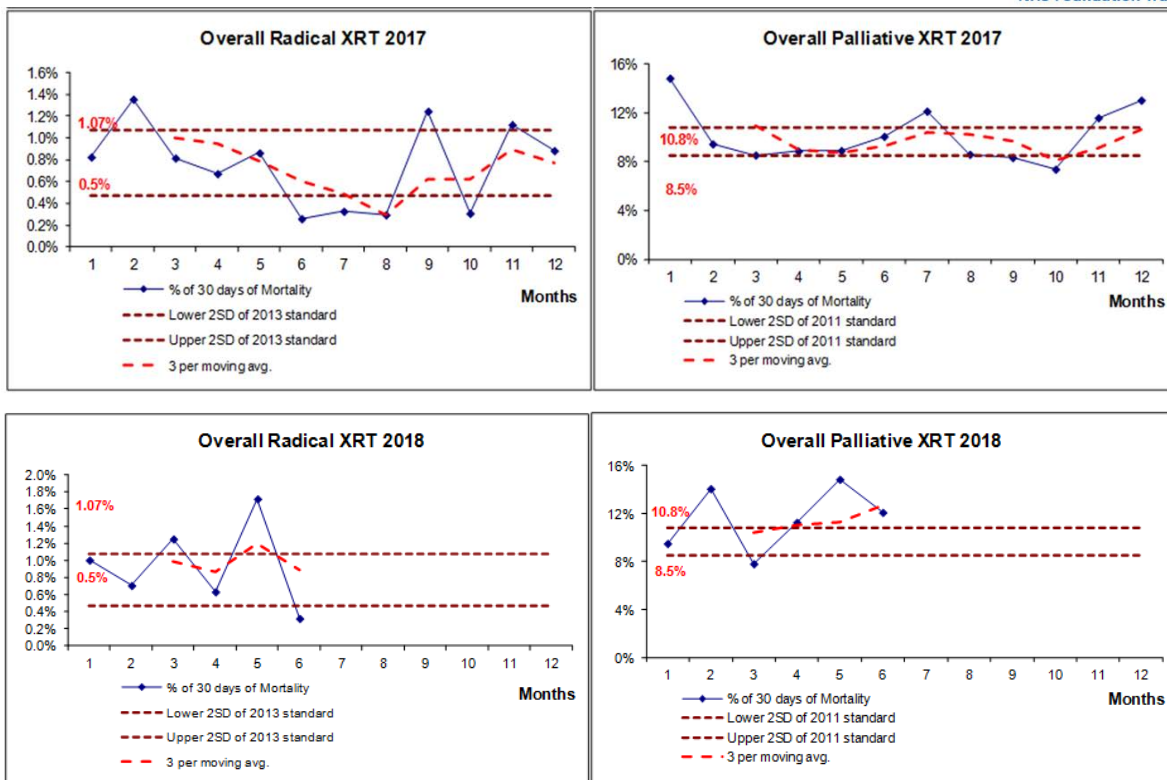


The charts reveal no significant change over the three years (2018/19 is to the end of Dec only) although CCCW monthly figures for the last 5 months have been similar to or lower than those in the previous three years.

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 latest charts below for 2017, Q2 for Radiotherapy is not yet available). 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.



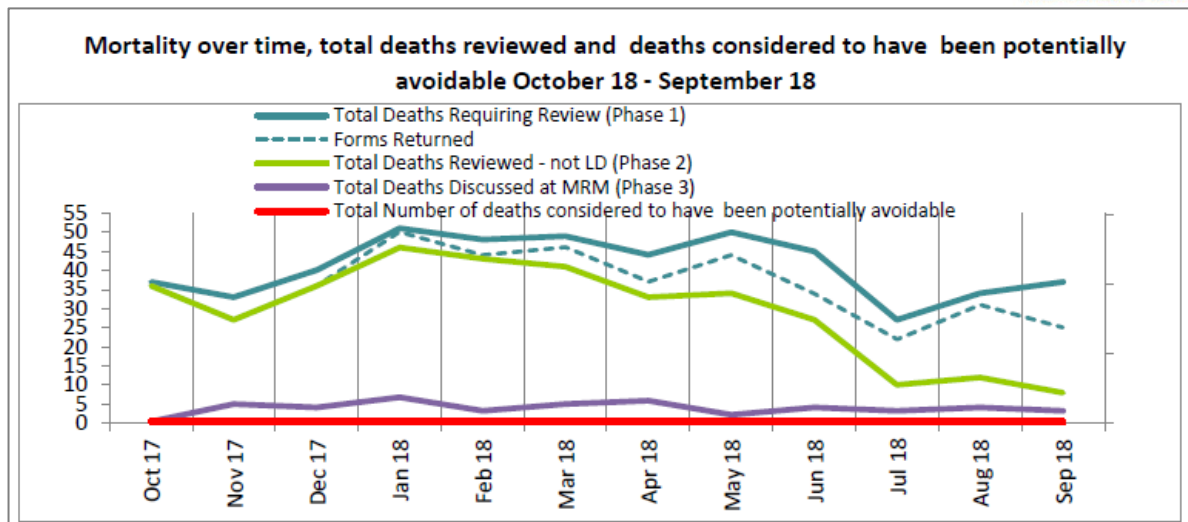


Mortality Review:

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.

The HO team continue to follow the RLBUH approach; utilising MDTs to peer review all cases, with involvement of all HO consultants, nursing staff and other specialities as required.

All CCCW inpatient 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.

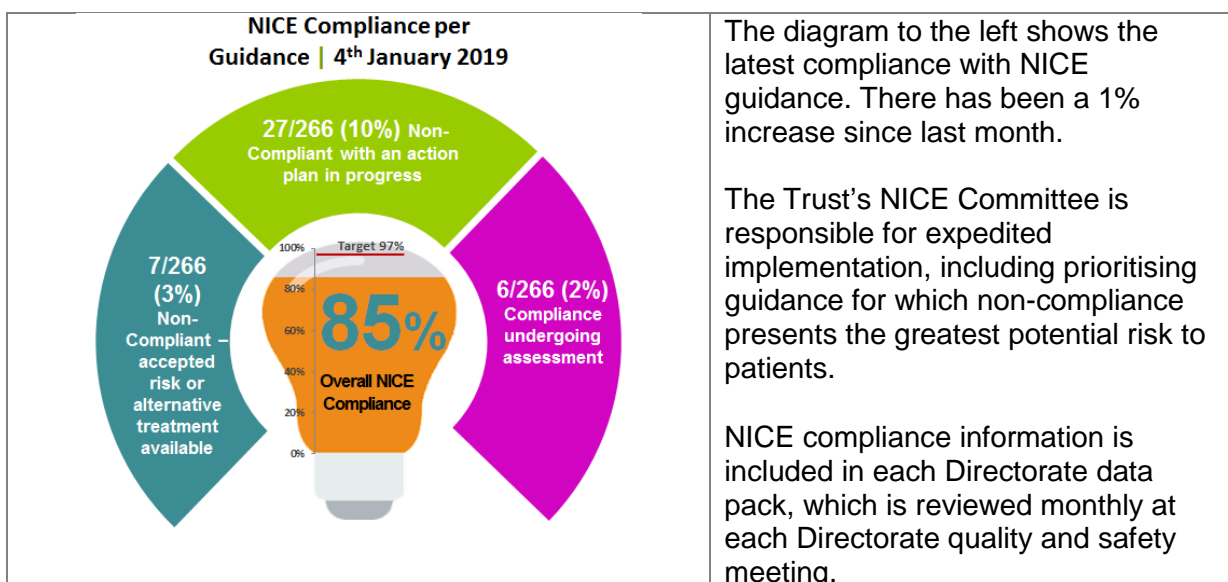


NB: A judgement on avoidability of death is only made on inpatient deaths.

Other clinical outcomes:

Head and Neck, Lung, Upper GI, Breast and Skin SRG dashboards have been developed in line with plans. The next phase includes Gynaecological, Urology CNS and Colorectal which are due to be complete by end of February. Options for benchmarking are being considered to identify and strive for 'best in class'.

2.2 NICE Guidance

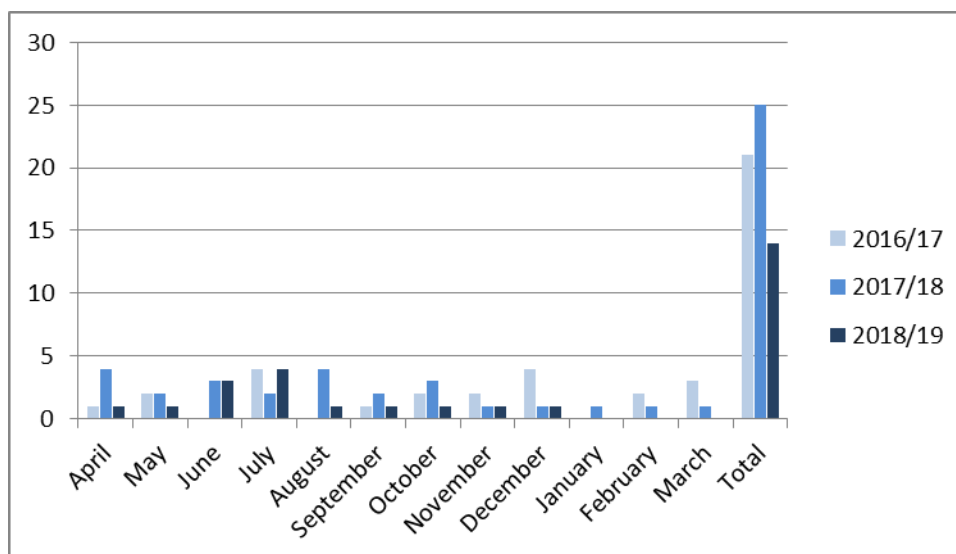


3. CARING

3.1 Complaints and PALS

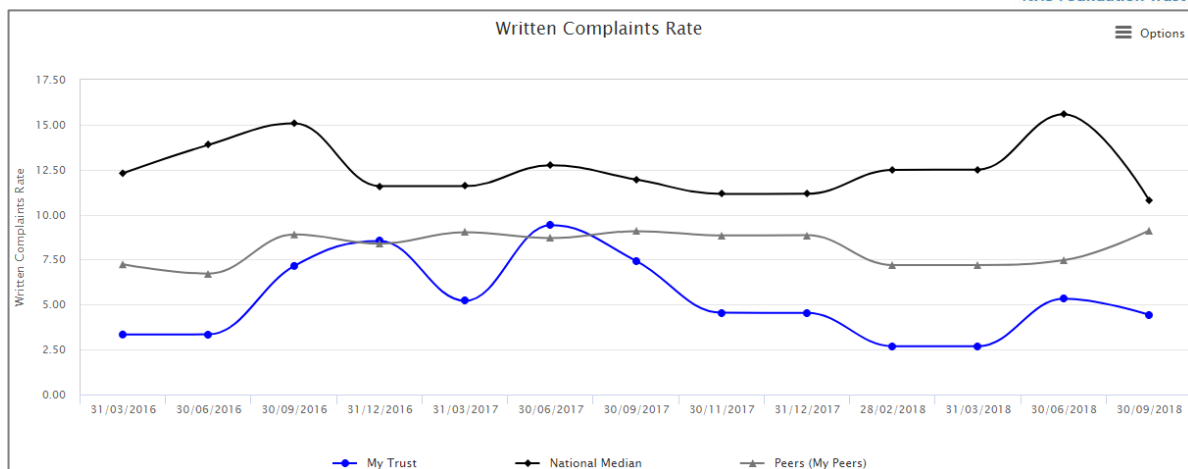
Complaints:

This chart shows total complaints per month for 2016/17, 2017/18 and 2018/19 to date and reveals that the numbers since April 2016 have remained relatively static, with a reduction or comparable total to previous years since August 2018.



Benchmarked Data

The chart reveals that CCC has a generally lower complaints rate than its peers and a significantly lower rate than the national average.



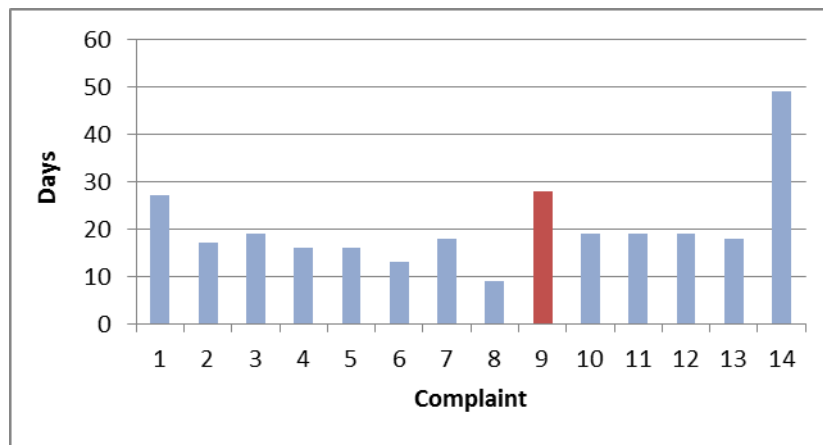
The table below provides a summary of the complaints received in 2018/19 (as at 31/12/18)

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 has been 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

Received	Complaint Type	Description	Lessons learned	Grade	Complaint Outcome
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. A new DNAR policy has been 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 NWS regarding transport concerns and explanation provided as to why the receptionist could not give detailed information.	Low	Not Upheld
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
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
09/10/2018	Treatment & care	Relative has questions about patient's care	Directorate to make AO's roles and responsibilities clear	Low	Responded have received further questions further letter sent..

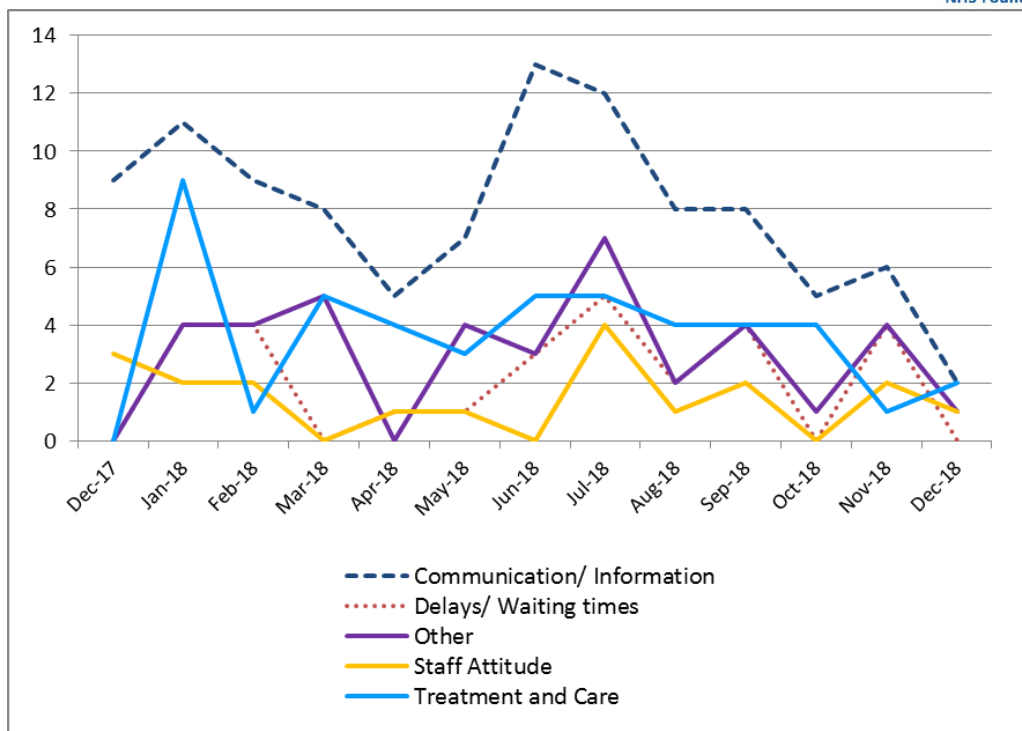
Received	Complaint Type	Description	Lessons learned	Grade	Complaint Outcome
15/11/2018	Treatment & care	Pt unhappy that they were not contacted when we became aware of late effects of Treatment	Not yet known		Under investigation
28/12/2018	Staff attitude	Pt unhappy with attitude of staff member on ward	Not yet known		Under investigation

The chart below shows the response times for these complaints. The red bar/s show the complaints not responded to within an agreed timeframe.



Patient Advice and Liaison Service (PALS):

This chart shows the trends for the 5 most common categories of PALS contact in the last 13 months.



In Q2 and Q3 there has been a significant reduction in the number of PALS contacts relating to communication / information.

Since April 2018, 50% of contacts in the category of 'other' were compliments on care or treatment. The remaining contacts include enquiries, minor concerns and 1 which may be escalated to a complaint.

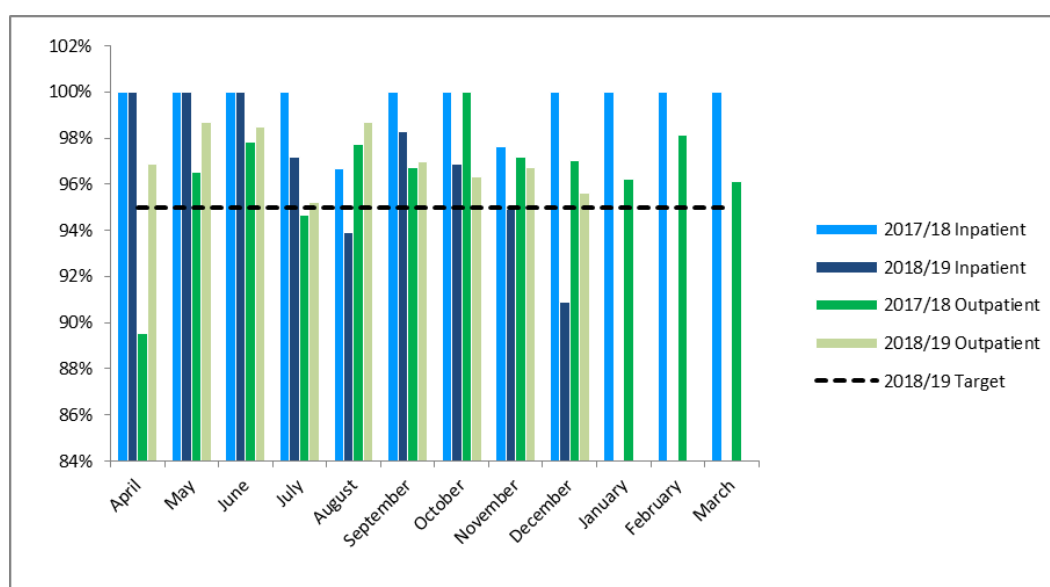
Whilst not featuring in the top 5, the following 'care' related contacts were also made in this 13 month period:

Category	Total contacts
Admissions, Discharge and Transfer	11
Consent	1
End of Life	2
Privacy, Dignity and Wellbeing	6

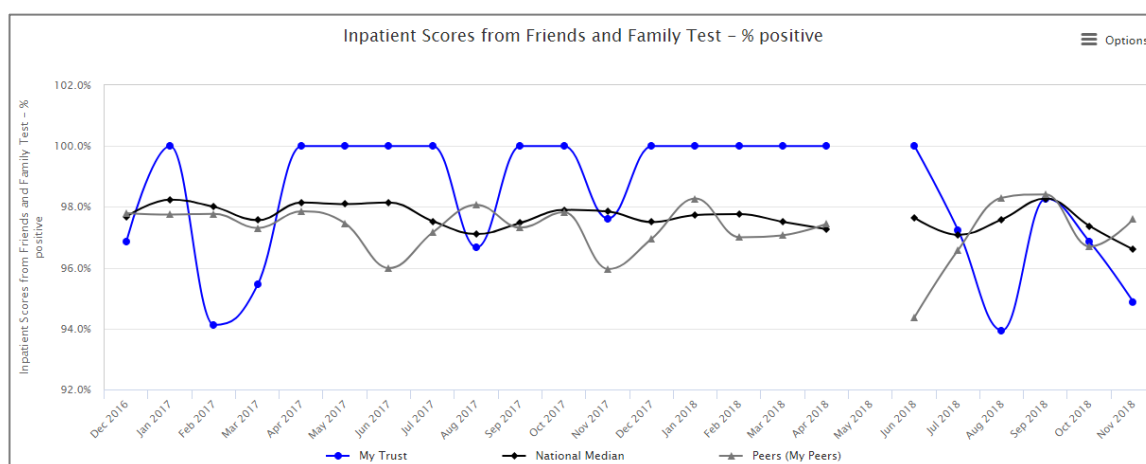
3.2 Surveys

Friends & Family Test: Scores

The chart below shows the % of inpatients and outpatients who were 'likely' or 'extremely likely' to recommend the Trust to friends and family per month in 2017/18 and 2018/19. The 95% target was missed twice in 2017/18 and twice to date in 2018/19. There was an increase in the number of patients who answered 'don't know' in December, resulting in a fall in the % of patients 'likely' or 'extremely likely' to recommend the Trust to friends and family. Haemato-oncology outpatient services are not included in the figures below.



Benchmarked data: inpatient scores

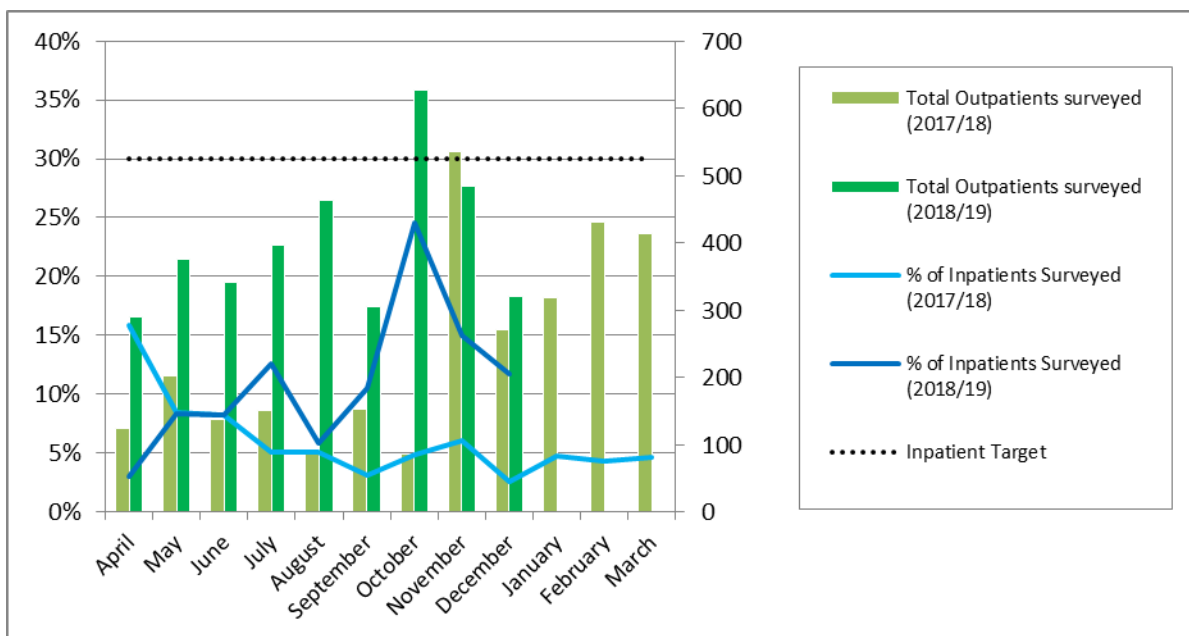


There is no data available for other trusts for outpatient scores on the Model Hospital

Friends & Family Test: Response rates

The chart below shows the total outpatients and % of inpatients surveyed by month in 2017/18 and 2018/19. Following a significant increase in both the number of outpatients surveyed (to over 600) and the % of inpatients, to 25%, this has fallen in both November and December.


Matrons across both sites will be presenting action plans to the relevant directorate Quality and Safety meetings. These will be monitored at these forums and also discussed at the monthly Directorate monthly performance meetings.



There is no data available for other trusts' response rates on the Model Hospital

3.3 Partners in Care

The Trust has successfully introduced the 'Partners in Care' service, which enables patients to choose a family member or close friend to become a member of their care team; assisting the nursing team on the ward to help deliver care and/or provide support. The figures below show the successful embedding of this service at significant pace.

Partners in Care	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
% of admissions that had a partners in care assessment	13%	66%	90%	88%	84%	90%	88%	88%	90%	

3.4 Claims

Open claims: there are 11 open claims in total as detailed in the table below. In addition there are a further 19 potential claims, i.e. the Trust has received notification that solicitors are investigating a potential claim.

No new claims have been received in December and the following claims have been closed:

ID9: Clinical negligence claim but the allegations did not relate to CCC so file closed – no costs/payments.

ID28: Alleged delay in assessment, failure to provide treatment and/or investigate possible treatment options, resulting in the claimant being unable to have curative surgery. Allegations denied and claim discontinued against CCC.

Claim Ref	ID	Date of claim	Nature of Claim (Alleged failure)	Progress/Action	Status
Clinical Negligence					
2017/21	21	5/11/18	Mismanagement of cancer treatment, including failure to identify/diagnose/treat inflammatory myofibroblastic tumour.	Reported to NHR. Hill Dickinson instructed. Consultant report completed.	Letter of Claim
2017/18	18	25/9/18	Performed Papillon treatment which caused nerve damage and damage to the bowel and sphincter	Reported to NHR. Consultant comments uploaded.	Letter of Claim
2018/02	27	10/10/18	Failure to check blood results prior to treatment.- Serious Incident Nivolumab ID 2224	Reported to NHR. Panel solicitors instructed.	Letter of Claim
2018/33	33	28/08/18	Named as 5th Defendant - allegations relate to the failure to request urgent for MRI, failure to consider presenting symptoms, delay in referring for treatment for metastatic treatment.	Reported to NHR. Panel solicitors instructed.	Letter of Claim
2018/29	29	29/8/18	Extravasation	Reported to NHR. Panel solicitors instructed. Experts instructed, reports reviewed. Response prepared.	Particulars of Claim

2015/07	10	1/6/17	Misdiagnosis of brain metastases resulting in unnecessary radiotherapy	Reported to NHSR. Panel solicitors instructed. Letter of Response sent.	Particulars of Claim
Employer Liability					
2017/15	15	4/9/17	Staff slip/trip/fall	File re-opened, repudiation challenged. No further correspondence from Claimant's solicitors	Letter of Response – repudiation challenged
2015/14	23	23/12/15	Staff manual handling	Portal claim. Particulars of Claim received, panel solicitors instructed. NHSR update report received. List of documents disclosure form sent. Witness statements compiled.	Particulars of Claim
2016/10	7	13/2/17	Staff manual Handling	Reported to NHSR. Panel solicitors instructed. Allegations denied. Further information requested and disclosed. Letter of Response challenged. Claimant solicitors visited for a site visit. No further correspondence received.	Letter of Response – challenged
2016/01	24	19/4/16	Staff slip/trip/fall	Portal Claim. Breach of Duty admitted. Claimant solicitors have obtained medical evidence, once received updated medical report NHSR to assess quantum and negotiate settlement. Still awaiting medical evidence.	Letter of Response
Public Liability					
2017/12	12	31/5/17	Needlestick	Reported to NHSR – Admission. Awaiting medical evidence.	Letter of Response

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 December figures are accurate as at 21st January, but are as yet unvalidated.

Standard	Target	Q1 2018/19	Q2 2018/19	Q3 2018/19
62 Day (pre allocation)	85%	59.4%	60.4%	55.5%
62 Day (post allocation)	85%	87.4%	86.5%	87.5%
31 Day (firsts)	96%	98.2%	96.6%	98.4%
18 Weeks – incomplete	92%	97%	98%	96%
Diagnostics: <6 week wait	99%	100%	100%	100%
2 Week Wait	93%	100%	97%	83%

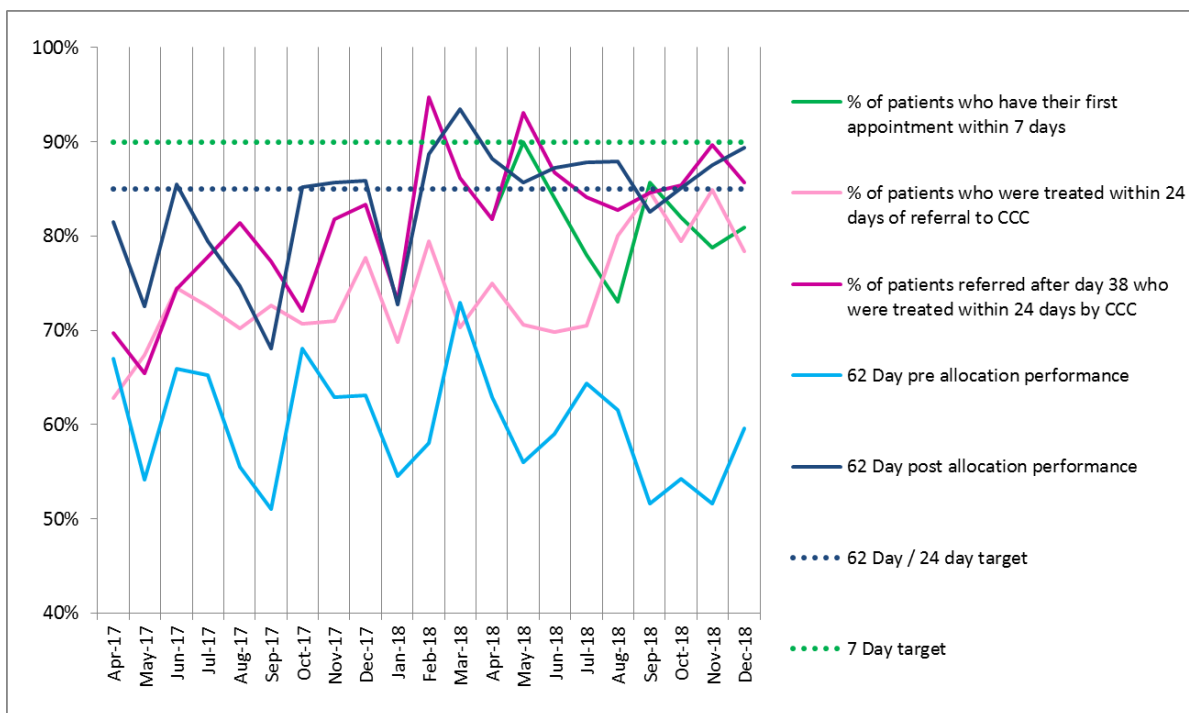
The post allocation performance figure is a true reflection of CCC performance against the CWT standards. The pre allocation performance figure is adversely affected by late referrals into CCC from referring trusts. The Cancer Delivery Group (NHSE/NHSI/The Cancer Alliance) is fully aware of and acknowledges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

The as yet unvalidated position for December is a lack of compliance with the:

- 2 Week Wait: 2 breaches, both related to consultant capacity. Temporary mitigating escalation processes are being tightened to prevent the risks of future breaches relating to this issue. The 2 patients who breached were seen in 15 and 18 days.

The new national CWT database (Cherwell) is experiencing continuing delays to development and is not expected to show the Trust's post allocation position until April 2019. The first 'shadow' report from NHS Digital was received on 21st January 2019. This data will be reviewed by CCC by the end of January.

This chart shows CCC's monthly performance for 62 day waits (pre and post allocation) and treatment by CCC within 24 days (all patients and those referred after day 38). The Cancer Waits Improvement Plan is monitored monthly at the Cancer Waits Target Operational Group (TOG).



62 Day performance by tumour group

The tables below show the Q1, Q2 and Q3 2018/19 compliance by tumour group for the pre and post allocation 62 day target. As the numbers are small, there can be considerable variation in compliance from month to month, however consistent challenges are Head and Neck (due to the frequent inclusion of dental treatment in the pathway) and haematological, as these are complex pathways requiring additional diagnostic tests.

Q1

Tumour Group	Breaches	Accountabl...	Hits	Accountabl...	TOTAL	/ Accountabl...	PreAllocated %	Allocated %	Allocated Perform...
Lung	16	4.5	76	43.5	92	48	82.61%	90.63%	<div><div></div></div>
Urological (Excluding Testicular)	28	2	10	8	38	10	26.32%	80.00%	<div><div></div></div>
Upper Gastrointestinal	22	3	15	9.5	37	12.5	40.54%	76.00%	<div><div></div></div>
Breast	2	0	30	16	32	16	93.75%	100.00%	<div><div></div></div>
Lower Gastrointestinal	12	0	20	14	32	14	62.50%	100.00%	<div><div></div></div>
Head and Neck	18	5	8	6	26	11	30.77%	54.55%	<div><div></div></div>
Gynaecological	5	0	7	5	12	5	58.33%	100.00%	<div><div></div></div>
Haematological (Excluding Acute Leukaemia)	5	2.5	4	2	9	4.5	44.44%	44.44%	<div><div></div></div>
Sarcoma	5	0	2	1.5	7	1.5	28.57%	100.00%	<div><div></div></div>
Other	1	0	4	3	5	3	80.00%	100.00%	<div><div></div></div>
Skin	1	0	1	1	2	1	50.00%	100.00%	<div><div></div></div>
Nasal cavity	1	0.5	0	0	1	0.5	0.00%	0.00%	<div><div></div></div>

Q2

Tumour Group	Breaches	Accountable Breaches	Hits	Accountable Hits	TOTAL	Accountable TOTAL	PreAllocated %	Allocated %	Allocated Performance
Lung	16	2	70	41	86	43	81.40%	95.35%	
Breast	4	1	33	19	37	20	89.19%	95.00%	
Lower Gastrointestinal	21	1	16	9	37	10	43.24%	90.00%	
Urological (Excluding Testicular)	20	2	16	12.5	36	14.5	44.44%	86.21%	
Head and Neck	22	5	13	8.5	35	13.5	37.14%	62.96%	
Upper Gastrointestinal	20	5	12	9	32	14	37.50%	64.29%	
Gynaecological	9	0	6	4	15	4	40.00%	100.00%	
Haematological (Excluding Acute Leukaemia)	4	1	9	5	13	6	69.23%	83.33%	
Other	3	0.5	2	1	5	1.5	40.00%	66.67%	
Sarcoma	2	0	1	0.5	3	0.5	33.33%	100.00%	
Skin	0	0	1	1	1	1	100.00%	100.00%	

Q3 (December 2018 data as yet unvalidated)

Tumour Group	Breaches	Accountable Breaches	Hits	Accountable Hits	TOTAL	Accountable TOTAL	PreAllocated %	Allocated %	Allocated Performance
Lung	13	3.5	49	28	62	31.5	79.03%	88.89%	
Breast	4	0	49	26.5	53	26.5	92.45%	100.00%	
Lower Gastrointestinal	28	3	17	13.5	45	16.5	37.78%	81.82%	
Upper Gastrointestinal	31	1	11	8	42	9	26.19%	88.89%	
Head and Neck	19	3.5	14	8.5	33	12	42.42%	70.83%	
Urological (Excluding Testicular)	14	0.5	11	9	25	9.5	44.00%	94.74%	
Gynaecological	18	1	7	4.5	25	5.5	28.00%	81.82%	
Haematological (Excluding Acute Leukaemia)	9	3.5	12	6.5	21	10	57.14%	65.00%	
Other	2	1	4	3	6	4	66.67%	75.00%	
Skin	2	0	1	1	3	1	33.33%	100.00%	
Sarcoma	0	0	2	1	2	1	100.00%	100.00%	

Patients treated on or after 104 Days

In December 2018, 8 patients were treated after day 104; referred between day 83 - 245 to CCC. 3 patients were not treated within 24 days by CCC, this was due to theatre capacity and patient related reasons of thinking time/holidays and compliance.

4.2 Clinic Waiting Times

This table shows the % of patients waiting for fewer than 30 minutes, 30 – 60 minutes and more than 60 minutes for their outpatient appointment at the Wirral site, for Delamere and for the Trust's peripheral clinics.

	Target	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
Safe														
CCC Outpatients Wirral: Seen within 30 minutes (as a percentage)	80%	72%	77%	78%	78%	78%	78%	75%	79%	75%	76%	79%	85%	
CCC Outpatients Wirral: Seen between 31 and 60 minutes (as a percentage)		13%	12%	11%	12%	13%	14%	14%	12%	14%	15%	13%	10%	
CCC Outpatients Wirral: Seen after at least 60 minutes (as a percentage)		15%	11%	11%	10%	9%	9%	11%	9%	11%	9%	7%	5%	
Delamere: Seen within 30 minutes %	80%	81%	78%	82%	81%	79.5%	79%	78%	82.1%	77.6%	77.4%	79.3%	77.0%	
Delamere: Seen between 31 and 60 minutes %		10%	11%	9%	10%	11%	11%	11%	9.9%	12.0%	12.5%	10.0%	11.0%	
Delamere: Not seen within 60 minutes %		9%	11%	9%	9%	10%	10%	11%	8.0%	10.4%	10.0%	10.6%	11.0%	
Outpatient peripheral clinics: Seen within 30 minutes %	80%	87%	89%	87%	89%	91%	91%	91%	90.5%	90.5%	88.7%	89.8%	96.2%	
Outpatient peripheral clinics: Seen between 31 and 60 minutes %		8%	8%	8%	7%	6%	6%	6%	5.9%	6.6%	8.3%	6.7%	2.2%	
Outpatient peripheral clinics : Not seen within 60 minutes %		5%	3%	5%	4%	3%	3%	3%	3.6%	2.9%	3.1%	3.5%	1.6%	

The Service Improvement Team has been working with the Chemotherapy Directorate to target two particular specialities, HPb and Breast, which have the longest OPD Clinic waiting times.

For the HPb Clinic, most of the recommendations outlined in the audit have been implemented and have seen an improvement in the delivery of the clinic. OPD HPb staff

has reported a reduction in pressure which is primarily due to better ways of working implemented during the project. This has had an impact on patients who have seen improvements in overall waiting times.

An analysis of waiting time data and appointment management in the Breast clinic at the Linda McCartney Centre led to the identification of a number of actions agreed by the Chemotherapy directorate and the Clinical team. The project team have held a number of planning meetings with the clinic team to agree actions and to deliver change.

Waiting times on Delamere remain a significant challenge due to delays in the repatriation of patients to a treatment facility closer to home.

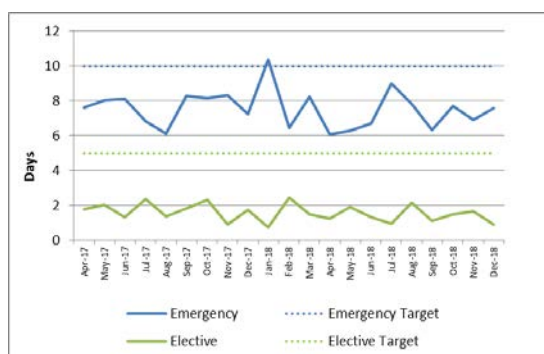
Waiting times in all clinics are being reviewed to identify hotspots on which to target further service improvement efforts.

4.3 Length of Stay (LOS)

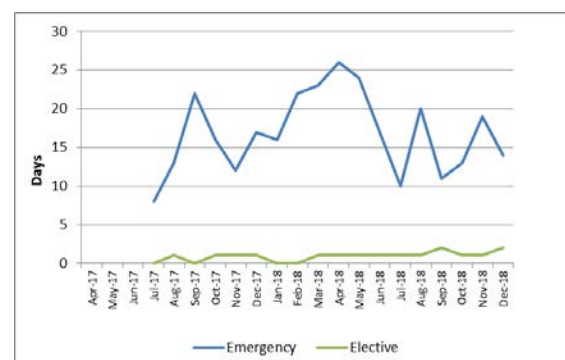
These charts show the elective and emergency average LOS in days per month for CCCW wards and HO wards. Wirral wards have been within target in all but 1 month in 2018/19 to date.

LOS within our HO service will be benchmarked against peers for February 2019 data onwards.

Wirral Wards x 3



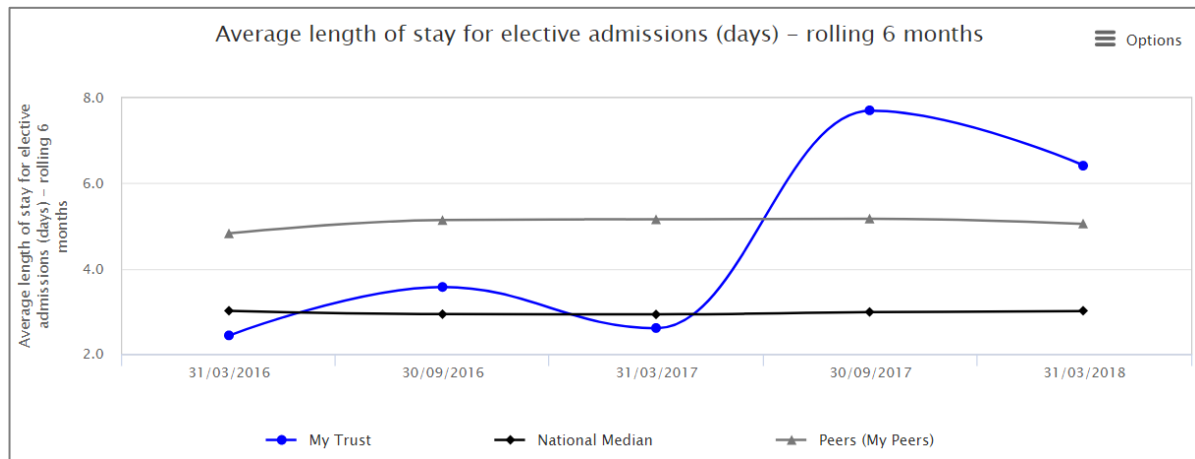
HO Wards x 2



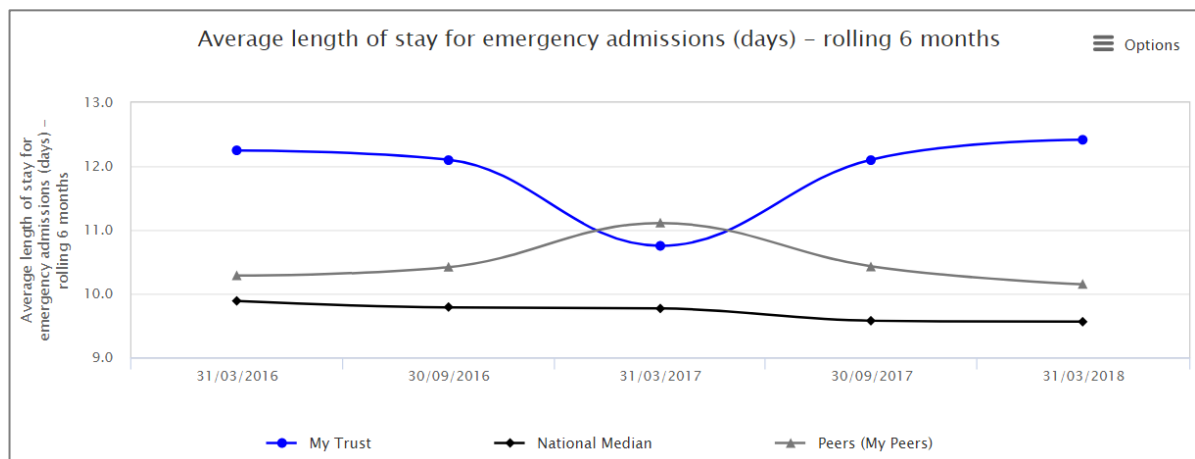
Benchmarked data:

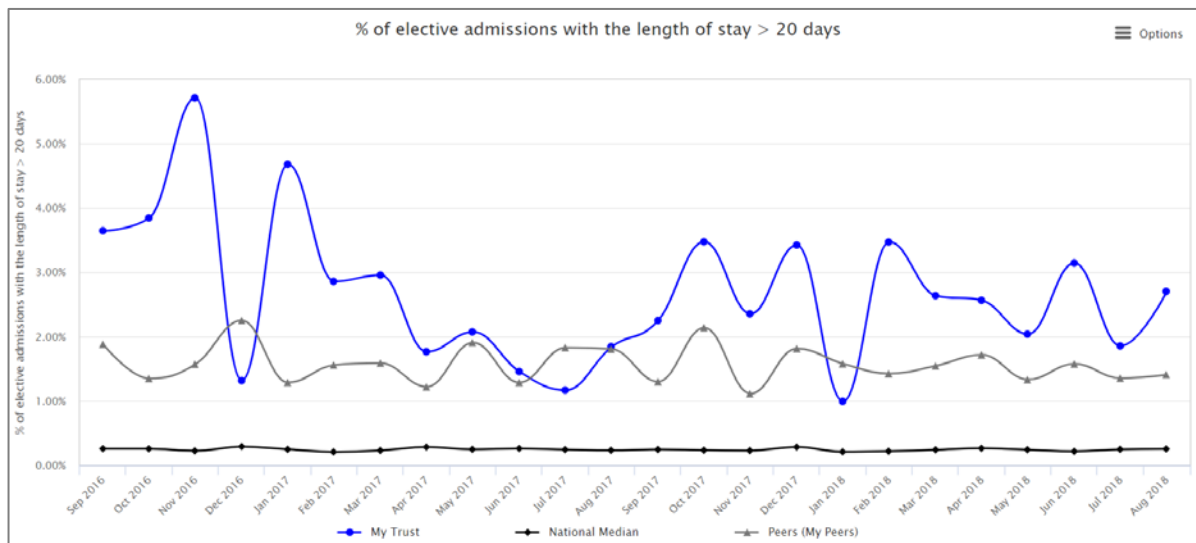
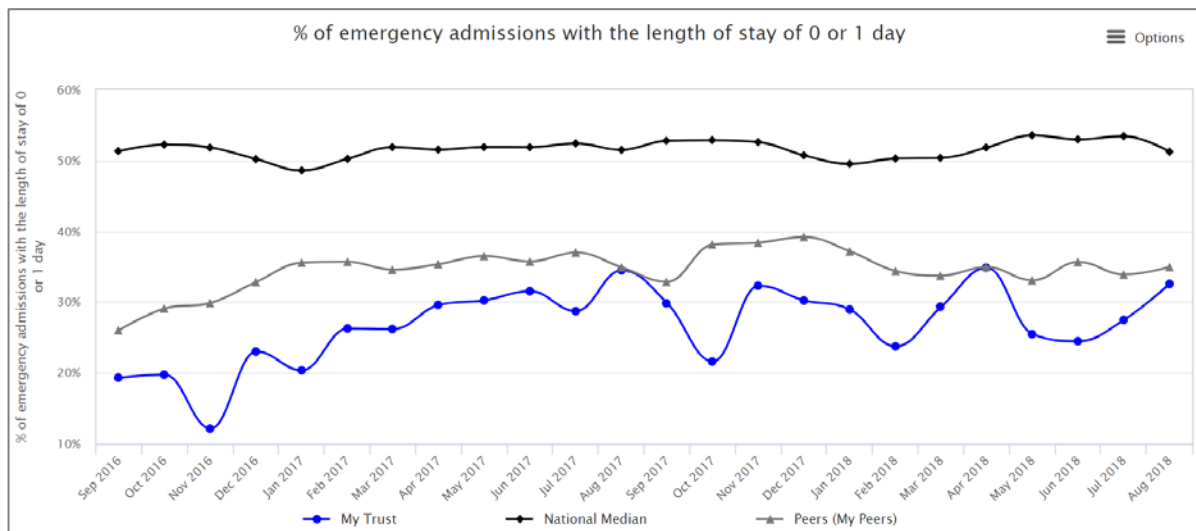
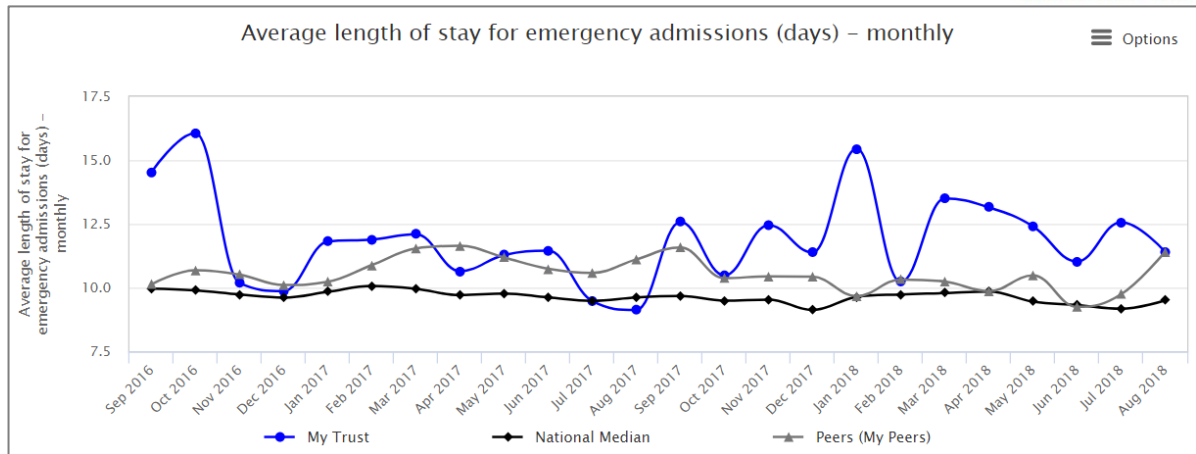
The charts have not been updated on the model hospital portal since the month 7 IPR.

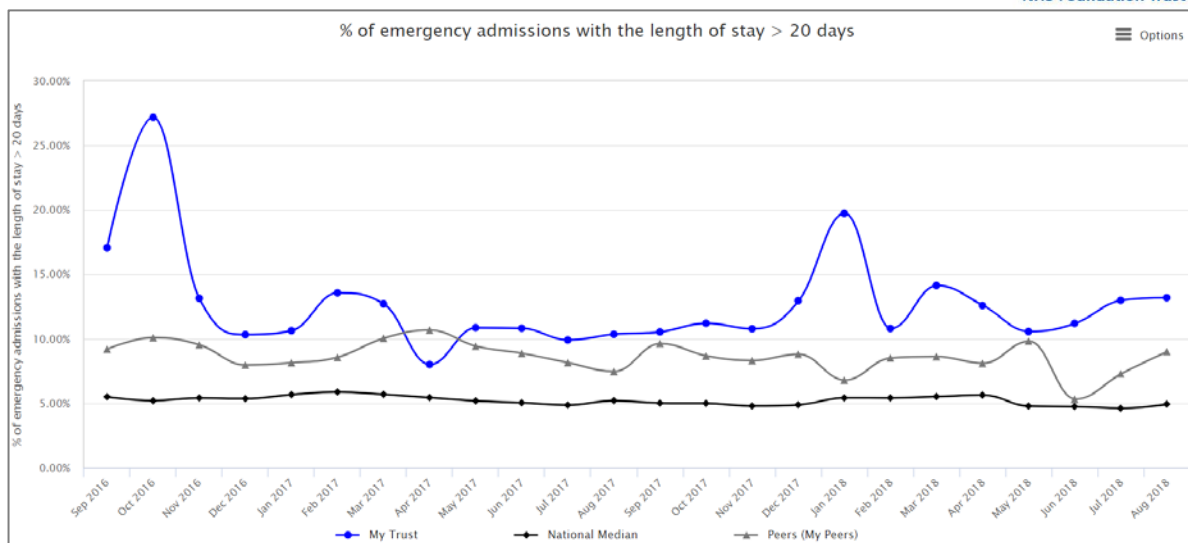
These charts show CCC LOS (average and over 20 days for elective and emergency admissions and 0-1 day emergency admissions), against the national median and set peers (Christie and Royal Marsden).



The significant and sustained rise in Q2 2018/19 can be explained by the HO service joining CCC.







Changes to the Trust admission and discharge policy, the introduction of the new patient flow team and the developments underpinned by the Clinical Utilisation Review CQUIN will have a positive impact on our LOS performance.

Delayed transfers of care will be reported for February data onwards.

Please see the activity report on page 55 for excess bed day figures.

4.4 Bed Occupancy

	Target	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
Average Occupancy at 11 am (Conway)	75%	85.7%	90.0%	88.7%	82.8%	69.0%	85.4%	84.0%	78.2%	77.2%	77.2%	75.0%	68.0%	
Average Occupancy at 11 am (Mersey)	75%	76.9%	81.0%	79.4%	66.2%	64.9%	77.6%	74.5%	68.0%	66.3%	66.3%	69.0%	72.0%	
Average Occupancy at 11 am (Sulby)		42%	27%	49%	27%	27%	45%	81%	73.6%	70.2%	70.2%	49.0%	48.0%	
Average Occupancy at 2 am (Conway)	75%	75.4%	90.0%	88.8%	83.7%	69.2%	85.0%	84.1%	77.9%	78%	78%	75.4%	69.0%	
Average Occupancy at 2 am (Mersey)	75%	75.0%	79.8%	77.0%	64.8%	63.0%	76.0%	73.8%	67.0%	66.5%	66.5%	69.7%	70.0%	
Average Occupancy at 2 am (Sulby)		25.1%	15.5%	28.9%	17.1%	14.8%	26%	33%	34.1%	32%	32%	19%	14%	

Data flows for HO wards' bed occupancy are being established

Following the opening of the CDU in November 2018, Sulby Ward's bed base has been reconfigured to establish a short stay unit (Monday-Friday) and the CDU treatment area.

The fall in occupancy in December is explained by efforts to discharge as many patients as possible over the Christmas period.

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.

Our HO service remains challenged with demand for bed capacity, there is a minimum of 8 HO outliers within the RLBUHT bed base at any one time.

4.5 Clinical Utilisation Review (CQUIN)

The Clinical Utilisation Review (CUR) initiative is concerned with reviewing all inpatients; assessing whether it is appropriate for them to be in a CCC bed. The initiative requires Trusts to implement and utilise a digital tool to capture various data which should then be used to drive a reduction in inappropriate hospital utilisation. HO inpatients are not yet included in this initiative as they are still managed on the RLBUH EPR. There are 2 main KPIs associated with the project and upon which the Trust is monitored:

- 1 % of occasions / bed days when patients do not meet the observed clinical criteria for admission / on-going care. The target for this KPI was amended in October 2018 due to the change in software made by CCC. The target is now 11.2% by end March 2018. The figure for December 2018 is 9%.
- 2 % compliance associated with undertaking CUR assessments (National target 85 - 95%). 100% is routinely achieved by CCC.

Data extracted from the CUR review have identified key areas of concern related to extended and inappropriate admissions. The results have identified a variety of factors that impact upon the time taken to discharge, the decision making process, and the readiness of the patient to leave the hospital. These data are being used to drive change in the way that discharge is managed, recognising the benefits of separating the discharge process from daily care management as well as having an independent team to manage the discharge process.

Compliance with targets and progress with service improvement initiatives is reported to the Operational Delivery and Service Improvement Sub Committee.

4.6 Radiology Reporting

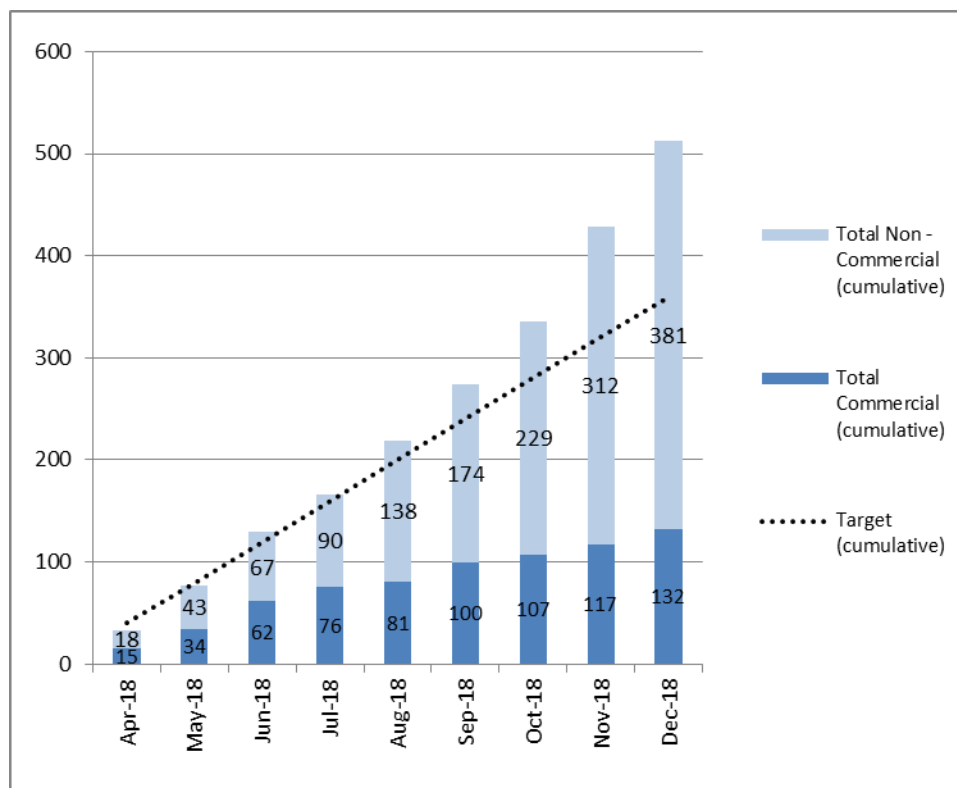
This table presents the reporting turnaround times for inpatients and outpatients and reveals that the Trust is failing to achieve the targets of 24 hours and 7 days respectively.

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
Imaging reporting turnaround: inpatients within 24 hours	G: ≥90%, A: 80-89%, R: <80%	87.7%	57.2%	83.8%	83.8%	81.9%	69.6%	70.0%	78.4%	82.3%	80.7%	78.6%	69.3%	
Imaging reporting turnaround: out patients within 7 days		77.6%	88.5%	94.3%	94.9%	87.8%	68.8%	50.7%	50.3%	76.1%	73.1%	70.0%	67.8%	

This performance reflects the capacity issues faced by CCC; those which the recent recruitment of 2 radiologists should help to relieve. A weekly situation report is produced and submitted to the Executive team and commissioners to outline the latest position regarding both radiologist capacity and progress against a number of actions identified to improve the situation.

4.7 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. The trials activity is above plan.



4.8 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 £2,262k above plan.

Performance and RAG ratings against these growth rates for April 2018 to December 2018 are as follows:

	Activity Variance	% year to date	Finance Value	% year to date
Admitted Patient Care – Spells	141	4.8%	£332k	7.3%
Admitted Patient Care Excess Bed Days	-698	-52.2%	-£172k	-52.5%
Outpatient Consultations	1,545	1.6%	£104k	1.0%
Outpatient Procedures	-216	-1.6%	£1,318k	67.5%
Radiotherapy and Proton	-2,532	-3.5%	£49k	0.3%
Chemotherapy	5,309	6.3%	£961k	6.7%
Diagnostic Imaging	1,548	9.4%	£267k	16.0%
Block			-£497k	-22.5%
Total Excluding Drugs			£2,362k	4.7%
Named Drugs			£6,575k	28.0%
CDF Drugs			-£152k	2.6%
Total			£8,784k	10.9%

Radiotherapy – Green 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 1.3% cumulative position.

A contributing factor to the over performance is an increase in Chemotherapy Associated treatments, which is over performing by 25.8% 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, (£457k in total, but a provision was put in during last financial year of £163k, therefore net for 2017/18 is £294k), 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 £1,318k; however activity is only 1.6% ahead of 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 November (month 1 to 8). Actual activity has been used for month 1 - 8, with activity estimated for month 9. The data for month 8 is being reviewed.

Overall clinical activity for HO, (excluding drugs), is £310k behind plan and drug income is over plan by £2.097k; 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.

5. WELL LED

5.1 Workforce

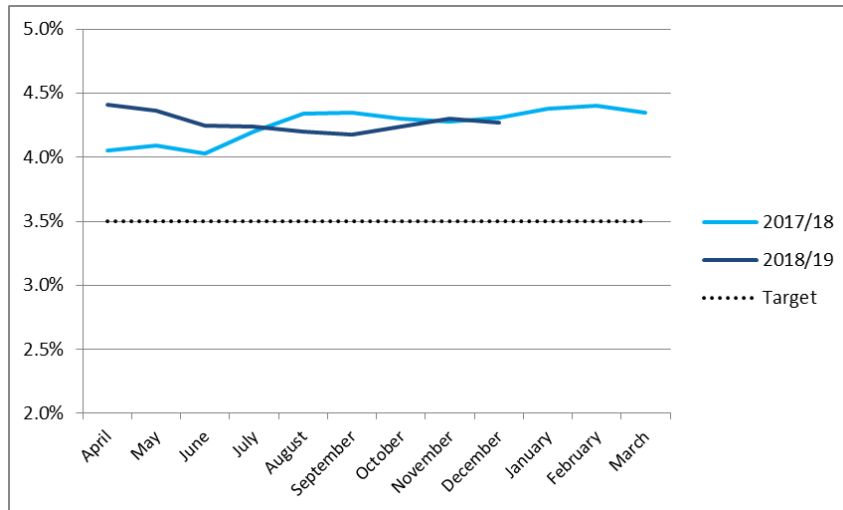
Workforce overview

	2018 / 01	2018 / 02	2018 / 03	2018 / 04	2018 / 05	2018 / 06	2018 / 07	2018 / 08	2018 / 09	2018 / 10	2018 / 11	2018 / 12	Trend
Headcount	1,242	1,258	1,257	1,269	1,264	1,260	1,259	1,273	1,273	1,291	1,293	1,294	
FTE	1,123.73	1,139.23	1,139.10	1,151.28	1,145.59	1,142.78	1,143.44	1,156.45	1,157.30	1,173.98	1,173.43	1,174.22	
Leavers Headcount	16	8	13	17	22	17	12	16	16	14	19	16	
Leavers FTE	14.42	6.68	11.25	13.22	18.80	15.91	11.49	13.52	13.64	12.75	17.56	14.27	
Starters Headcount	19	25	15	26	13	16	10	25	19	30	22	19	
Starters FTE	18.12	23.10	13.15	24.50	11.25	15.32	9.04	22.13	15.96	27.67	17.67	16.70	
Maternity	29	30	28	29	32	35	33	34	35	36	41	40	
Turnover Rate (Headcount)	1.29%	0.64%	1.03%	1.34%	1.74%	1.35%	0.95%	1.26%	1.26%	1.08%	1.47%	1.24%	
Turnover Rate (FTE)	1.28%	0.59%	0.99%	1.15%	1.64%	1.39%	1.01%	1.17%	1.18%	1.09%	1.50%	1.22%	
Leavers (12m)	150	152	154	146	158	164	165	172	169	174	190	186	
Turnover Rate (12m)	12.97%	12.96%	12.95%	12.11%	12.93%	13.24%	13.27%	13.77%	13.47%	13.80%	15.02%	14.65%	
Leavers FTE (12m)	133.96	135.46	137.37	127.92	138.37	144.62	147.40	152.36	147.87	152.66	167.42	163.51	
Turnover Rate FTE (12m)	12.80%	12.77%	12.78%	11.73%	12.51%	12.90%	13.08%	13.46%	13.00%	13.36%	14.59%	14.20%	

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

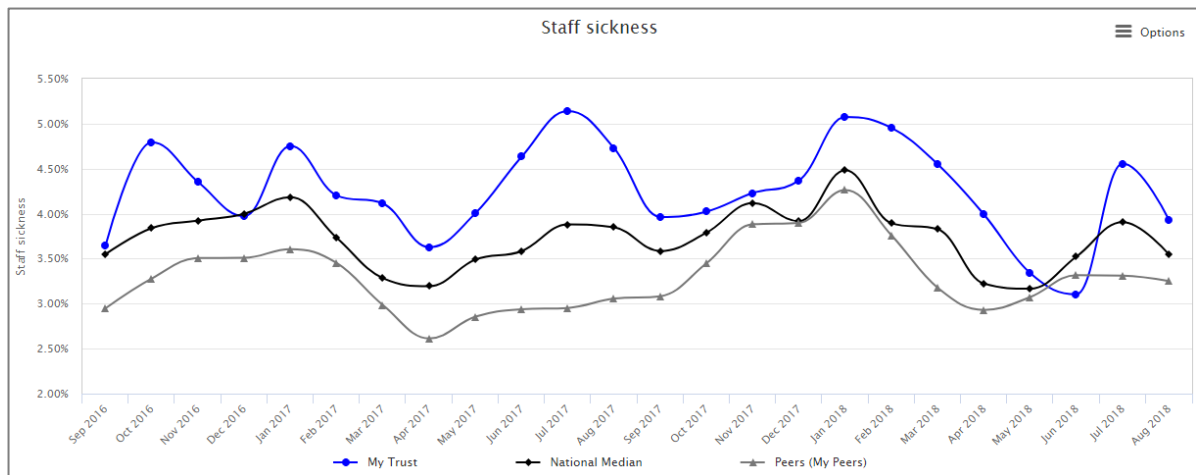
Sickness Absence

The chart below shows the Trust's rolling 12 months sickness absence per month and year since April 2017, with little movement between 4% and 4.5% during this time.















Benchmarked data

This chart of in month sickness absence shows higher figures for CCC than the national average and peers, however in May and June this was similar or indeed lower.



Directorates / Corporate Services:

CCC medics are slowly being moved into the other Directorates, and most are not now represented within the medic category below. Similarly, all Admin Services staff now feature within the Corporate Directorate.

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
Haemato-oncology Directorate	5.2%	6.4%	3.8%	5.3%	4.0%	4.2%	4.5%	2.3%	3.6%	4.0%	3.6%	4.0%	
Chemotherapy Services Directorate	5.1%	6.0%	7.1%	5.3%	4.9%	3.4%	3.9%	3.0%	3.4%	4.0%	5.0%	5.6%	
Integrated Care Directorate	6.5%	5.9%	6.2%	4.2%	3.3%	2.4%	4.4%	2.8%	4.2%	5.7%	4.4%	3.0%	
Radiation Services Directorate	3.8%	3.6%	2.1%	3.1%	2.4%	2.1%	3.2%	3.2%	2.3%	4.2%	5.0%	4.7%	
Admin Services	6.8%	7.4%	5.0%	4.6%	4.7%	5.0%	7.8%	8.0%	4.4%	1.9%	0.0%		
Corporate Services											3.9%	3.4%	
HR & OD	7.2%	2.7%	3.5%	2.9%	0.6%	3.8%	0.0%	0.1%	0.0%	2.4%	2.3%	1.3%	
Medical	1.9%	2.5%	2.7%	2.2%	2.2%	3.3%	4.7%	3.6%	4.7%	3.2%	0.0%	0.0%	
Research	3.7%	5.6%	5.2%	3.0%	3.7%	3.6%	7.0%	9.4%	9.0%	7.6%	6.4%	5.2%	
Quality	4.9%	6.2%	3.2%	1.4%	1.0%	2.2%	1.7%	1.7%	0.7%	1.6%	3.4%	6.1%	
Support Services	6.8%	4.1%	4.2%	3.1%	2.9%	5.2%	7.9%	8.2%	8.1%	8.8%	6.0%	3.7%	
Trust Board Directorate	0.0%	1.7%	8.4%	12.8%	8.3%	2.0%	5.3%	7.9%	9.5%	5.3%	4.1%	0.0%	

The Trust 12 month rolling sickness absence is 4.27% and in month sickness absence has reduced to 4.12% for December, from 4.86% in November. Cold, cough and flu, gastrointestinal problems and anxiety, stress and depression remain the three highest reasons for sickness absence across the Trust.



In December there were 47 episodes due to cold, cough, flu, which was the highest reason for sickness. We have seen an increase in sickness for cold, cough and flu in recent months which is expected at this time of year.

The second highest reason for sickness in December was gastrointestinal problems with 30 episodes this remains a cause for concern and the Workforce and OD Department are liaising with Occupational Health for advice and support with regards to how these episodes are managed. Further analysis is also underway to understand which departments have a high number of absences for this reason, the length of these absences and the first day of absence.

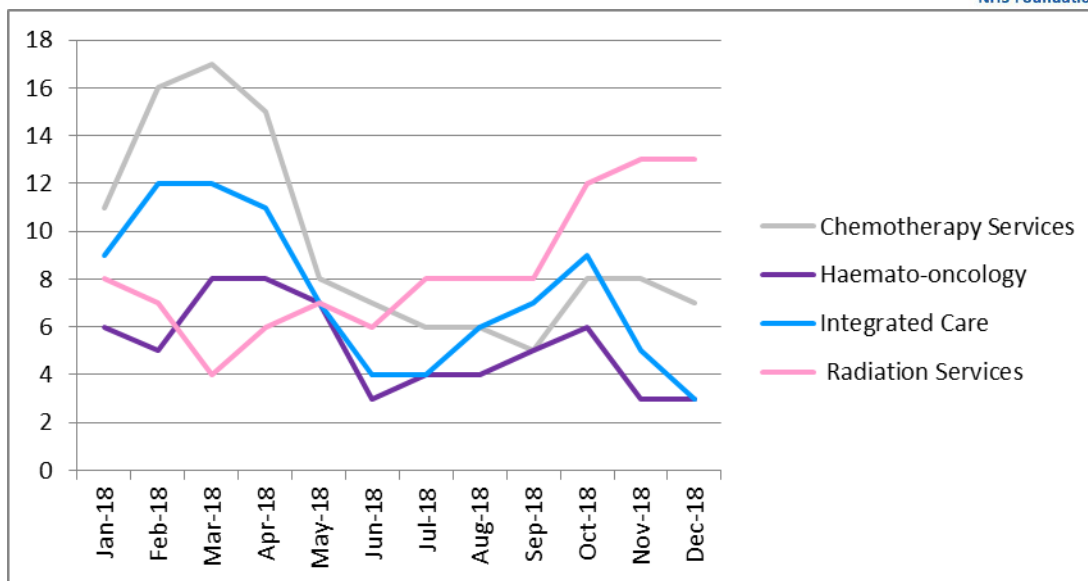
Monthly HR surgeries continue to take place within each department to ensure all sickness is being managed in line with Trust policy and procedure. Failure to close down sickness, and record the return to work discussion date on ESR is still a concern. We continue to work with managers to reinforce the importance of ensuring ESR is updated in a timely manner.

Further detail on sickness absence:

Occurrences of short and long term sickness absence, per month, trust wide.

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
Short term	192	156	116	105	119	103	133	118	103	164	159	151	
Long term	55	60	62	56	44	33	45	48	45	56	45	36	

This chart presents this data for the Directorates. Following increases to some degree for all Directorates between February and June, the general trend is then one of reduction and stability, however there has been a recent rise in Radiation Services. Detailed workforce information is considered at each Directorate meeting.

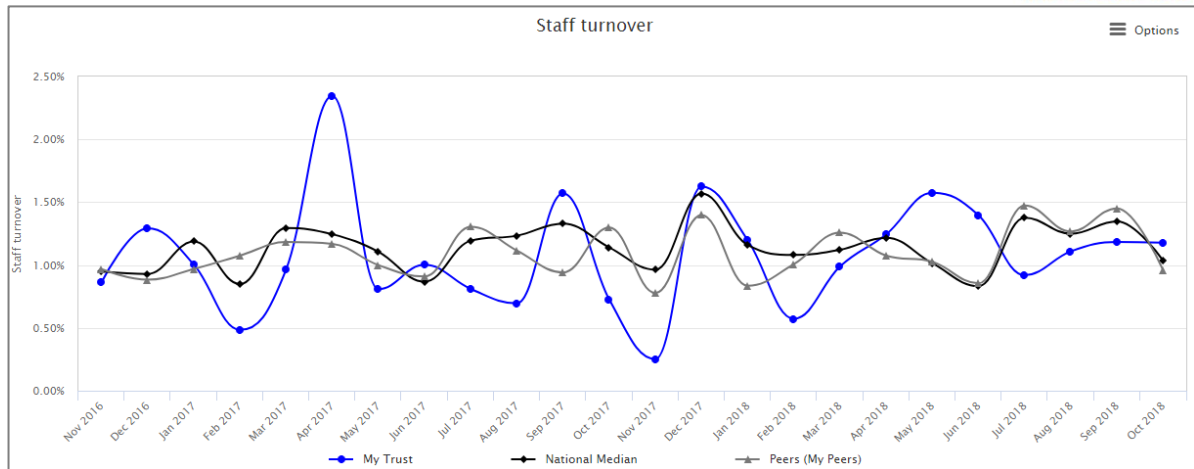


Staff Turnover

Turnover for December 2018 has fallen slightly to 14.2% from 14.6% in November 2018. The majority of leavers were from Additional Clinical Services (this staff group includes Health Care Assistants, Support workers and pharmacy technicians) followed by the Admin and Clerical staff group. There were 16 leavers in December, 4 left for work life balance reasons (mainly to work closer to home) 3 due to promotion and 3 due to the role not being suitable, the remainder left due to a variety of reasons.

In December 2018 NHS Employers published manager resource following some case studies entitled “Improving staff retention: Key conversations to have with your staff” which the HR team will review as part of its ongoing work to improve Trust retention rates.

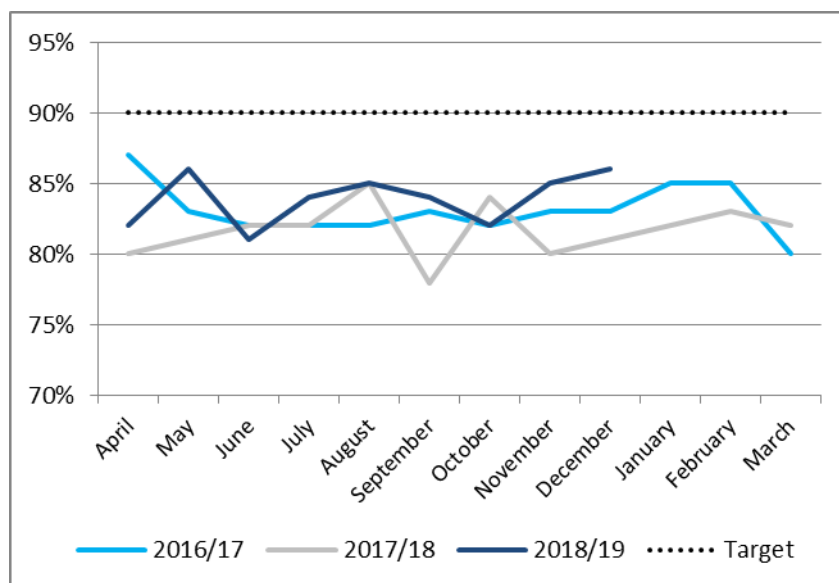
The chart below uses a different measure than ESR to calculate turnover; using this definition, CCC have similar, and often lower, levels of turnover to both peers and the national average.



KPI definition: Number of Staff leavers reported within the period /Average of number of Total Employees at end of the month and Total Employees at end of the month for previous 12 month period

Statutory Training

This section presents the Trust figures per month and year, the Directorate / Service compliance and then detailed actions and specific course compliance. The Trust is failing to achieve the 90% target, with 85% delivered sporadically.



Directorate	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
Haemato-oncology Directorate	58%	76%	74%	63%	66%	66%	54%	59%	58%	
Chemotherapy Services Directorate	87%	89%	89%	86%	88%	88%	89%	89%	93%	
Intergrated Care Directorate	87%	87%	87%	88%	89%	89%	87%	88%	87%	
Radiation Services Directorate	86%	88%	87%	88%	89%	85%	86%	84%	87%	
Admin Services	96%	96%	91%	95%	95%	93%	98%	89%		
Corporate Services								88%	84%	
HR & OD	98%	96%	93%	98%	95%	98%	96%	93%	93%	
Medical	60%	64%	64%	65%	55%	56%	69%	68%	85%	
Quality	92%	91%	90%	94%	96%	97%	95%	94%	98%	
Support Services	91%	92%	92%	92%	92%	93%	91%	91%	94%	
Trust Board	58%	58%	58%	59%	61%	60%	79%	79%	76%	

Following the CQC unannounced visit in December, concerns were raised regarding statutory training compliance trust wide, as well as specific concerns regarding evidenced levels of competence. A project manager has been employed to ensure statutory training compliance in line with trust and national targets utilising a sustainable project governance approach as follows:

- Initial focus has been on achieving compliance against five prioritised training types and ensuring reporting supports Directorates to identify any compliance issues
- All Directorates have reviewed statutory training data to ensure staff has the correct statutory training assigned against their role. This has resulted in a negative impact on compliance levels for some training types across some roles
- Over the next three weeks, all Directorates will review their role essential training requirements. This has already been completed for Haem-Onc in line with feedback from the CQC and this Directorate are focusing on improving role essential compliance levels
- Work is being undertaken to strengthen Learning & Development (L&D) processes to improve quality of data and enable more robust monitoring of compliance levels to take place
- Directorates are now receiving weekly compliance reports to manage progress in line with Trust and national targets, with the initial aim of achieving compliance in these key areas by end of March (subject to capacity constraints).
- A project team with a representatives from Operations, L&D, HR and Administration Services has been created to ensure delivery against the project plan
- The governance structure is due to be agreed by 25/01/2019 to ensure Executive oversight of project deliverables and training compliance

Progress since December: Trust wide Statutory Training (data correct as at 17/01/2019)

	Chemotherapy		Haem-Onc		Integrated Care		Radiation Services	
	Dec	Jan	Dec	Jan	Dec	Jan	Dec	Jan
BLS	55%	74%	53%	90%	71%	80%	50%	74%
ILS	42%	63%	n/a	n/a	41%	68%	67%	50%
Safeguarding level 3	86%	86%	11%	43%	33%	50%		21%
Patient handling - level 2	67%	86%	43%	82%	78%	80%	70%	72%
Infection Control- level 2	75%	80%	74%	100%	49%	76%	35%	52%

There have been improvements to compliance figures in all areas except:

- Radiation Services – a number of new staff were identified as requiring ILS and therefore compliance has reduced
- Haem-Onc, in which staff do not require ILS due to location within the Royal Liverpool
- There are some issues relating to who should have Safeguarding level 3 across the trust which are being addressed and are captured within the project plan – across Haem-Onc and Radiation Services new staff were identified as requiring level 3 training

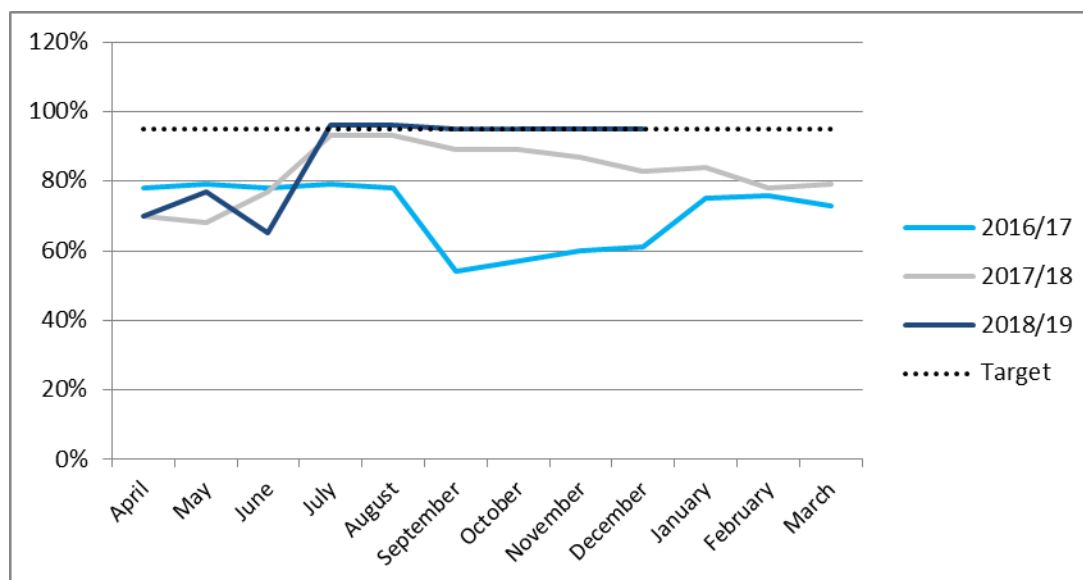
Progress since December: Haem-Onc Role Essential Training (data correct as at 17/01/2019)

The figures below show compliance for ward-based staff. There has been an improvement in all training.

Haem-Onc	December	January
AKI	81%	92%
ANTT - online	100%	100%
Sepsis	73%	92%
Blood transfusion - online	74%	100%
Blood transfusion - ward based	66%	100%
Point of care	57%	98%
Medical Devices	39%	52%
COVAD	85%	95%

PADR Compliance

Trust compliance remains compliant at 95%. Managers of teams where the Trust target is not being achieved will now be contacted to ensure that PADR information in ESR is accurate and to request an action plan.

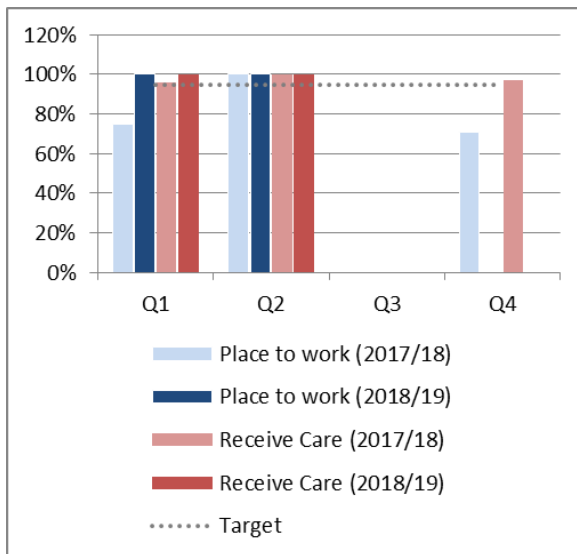


Directorate	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
Haemato-oncology Directorate	81%	83%	40%	98%	99%	99%	97%	97%	96%	
Chemotherapy Services Directorate	78%	81%	87%	99%	99%	98%	99%	98%	97%	
Intergrated Care Directorate	65%	66%	62%	96%	97%	97%	96%	96%	93%	
Radiation Services Directorate	79%	84%	67%	99%	99%	98%	95%	95%	95%	
Admin Services	79%	91%	85%	98%	97%	97%	100%	100%		
Corporate Services								98%	96%	
HR & OD	78%	76%	69%	100%	100%	100%	95%	90%	90%	
Quality	76%	77%	65%	98%	98%	100%	100%	100%	100%	
Support Services	64%	65%	59%	86%	86%	85%	86%	90%	91%	
Trust Board	50%	50%	50%	56%	50%	81%	82%	89%	100%	

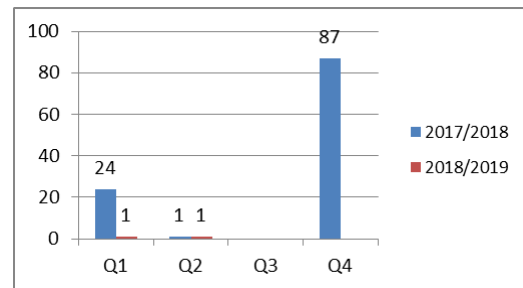
Staff Friends and Family Test

The charts below show the % of staff that is likely or extremely likely to recommend the Trust as a place to work and the numbers of surveys completed, since April 2017. The data has not been updated since the Month 6 report, as this is not collected in Q3 due to the national staff survey. Whilst the scores are high, the response rates are often very low, significantly reducing the value of the feedback.

Scores



Response totals

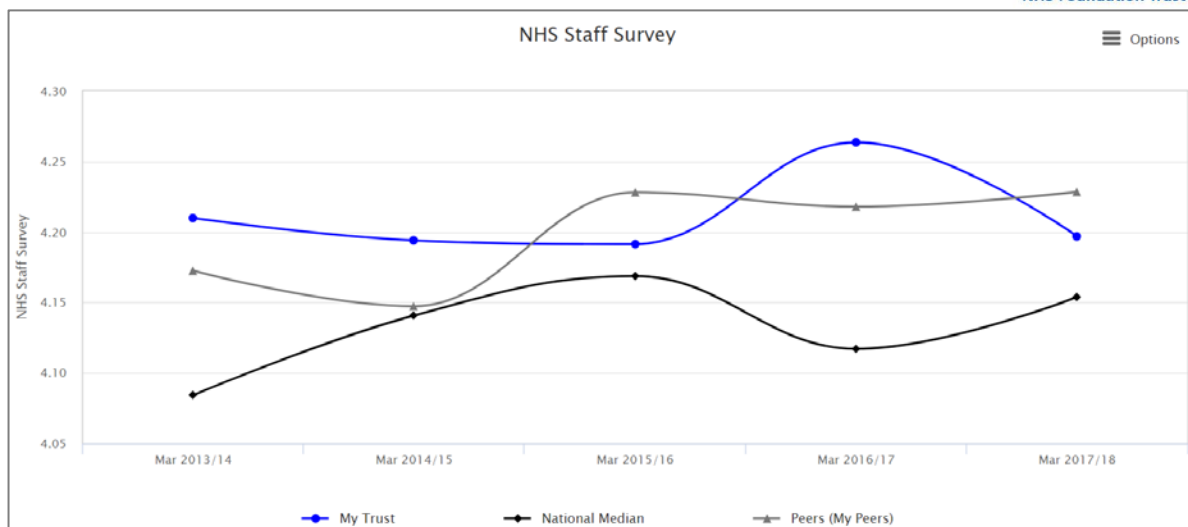


A communication campaign promoting the benefits of completing the survey is planned throughout Q4 to improve response rates. This includes:

- Regular updates in e-bulletin and Team Brief with links to the on-line survey,
- Payslips attachments for staff to complete paper versions of the survey,
- Regular walkabouts across the Trust with mobile devices to enable staff to complete the survey there and then.

Benchmarked data: NHS Staff Survey Scores

This chart reveals that we perform favourably against both the national average and our peers. This has not been updated on the Model Hospital site since the Month 7 IPR.



5.2 Finance

1. Key Points of Note

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

- A Group surplus (including Charity) of £3,824k against a planned surplus of £3,686k which is £138k above 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 £2,252k against a planned surplus of £1,638k, a favourable variance of £614k. From month 8 this is a favourable movement against plan of £80k. The year to date variance is primarily due to below EBITDA items (depreciation and interest payable).
- As reported at October's Finance & Business Development Committee, the Trusts forecast outturn has increased by £750k to £2,547k, with a further £600k from subsidiary companies on consolidation. This means that the Trust will over achieve on its control total by £1,621k. The Trust is waiting on confirmation from NHSI that this overachievement will be matched £ for £ from the provider sustainability fund (PSF).
- The Trust has delivered against its notified control total of £1,566k, with an actual year to date comparator of £3,180k.
- 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 9 is based on actual activity for April to November and estimated for December for solid tumour. Haemato-Oncology is based on actual activity for April to October with estimates for November and December except where actual data was available (for drugs and bone marrow transplants).
- Capital expenditure is £44,344k against a plan of £58,357k.
- The CIP programme has achieved savings of £1,461k, which is £252k above plan.
- The Trust has been issued with an Agency cap for 2018/19 of £1.1m by NHSI. At month 9, actual expend of £778k is £87k below the NHSI agency ceiling year to date.
- Cash held is £4.56m below plan, an improvement on month 8 .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:

The Clatterbridge Cancer Centre Group Accounts:	£000	£000	£000
	Plan	Actual	Variance
The Clatterbridge Cancer Centre NHS Foundation Trust	1,638	2,252	614
The Clatterbridge Cancer Charity	1,484	959	(525)
The Clatterbridge Pharmacy Ltd	157	311	154
Clatterbridge Prop Care Services Ltd (excludes PURP)	407	505	98
*PURP		(203)	(203)
Total Group Surplus	3,686	3,824	138

* 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)	Non delivery of 2017/18 CQUIN by £330k less year end provision made of £163k = £167k adverse impact in 2018/19.	Loss of income was higher than expected due to a number of CQUIN scheme milestones not being delivered. It has become

	Anticipated non-delivery of 2018/19 CQUIN at quarter 3 is estimated at £415k. The Trust expects to achieve its full CQUIN payment in quarter 4. The Trust has utilised £119k from its CQUIN reserve towards this shortfall.	<p>apparent that there was a lack of embedded ownership within the relevant departments.</p> <p>Head of Performance & Planning and Associate Director of Operations are working with leads to deliver improvements. The Director of Nursing & Quality is the Executive lead.</p>
KPI "Red" or "Amber" from IPR report and metric above: Radiotherapy Activity (Red) below plan by 3.9% (An improvement from month 8 which showed activity below plan by 5.9%).	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>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 metric table above: Group Surplus (Amber)	The Group has a combined surplus of £3,824k against a planned surplus of £3,686k. The Charity is £525k below plan at month 9. This is offset by an increased surplus within the Trust.	Risk that the Charity is not 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 December was £778k (of which £508k relates to medical locums) against a NHSI ceiling to date of £865k, 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 £508k against a plan of £375k, an overspend of £133k.</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.
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Low Risk:

Issue	Reason	Risk / Mitigation
KPI “Red” or “Amber” from metric table above: Capital expend (Amber)	Capital expend to date is £14.01m behind plan. This is mainly to Building for the Future being £13.02m 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 £4.55m below plan. This is because PDC of £28.2m has not yet been drawn down.	Risk of cashflow issues, however the Trust still has £69.58m in the bank. The Trust anticipates that it will drawdown £28.2m PDC by the end of Quarter 4.

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

4. Recommendations

- Note the satisfactory financial performance and surplus for month 9.

- Note the overall financial risk rating of a 1 under the risk assessment framework, which is in line with the plan.
- Note the Trust has delivered against its control total of £1,566k, with an actual year to date comparator of £3,180k.
- Note the forecast consolidated outturn of £3,147k.
- Note the KPI performance risks.
- Approve the declaration to NHSI for quarter 3, that the board anticipates the Trust will maintain a financial risk rating of at least 2 over the next 12 months.

Statement of Comprehensive Income 2018/19 (page 1 of 2):

	Trust Annual Plan £k	DEC 18			Cumulative YTD			
		Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	%
Clinical Income:								
Elective	4,998	377	430	53	3,768	3,278	(490)	-13.0%
Non-Elective	4,533	342	461	119	3,418	4,153	736	21.5%
Out-patient Attends	18,416	1,388	1,646	257	13,885	15,594	1,709	12.3%
Radiotherapy Attends	19,727	1,487	1,721	234	14,873	14,853	(21)	-0.1%
Chemotherapy Attends	19,910	1,501	1,650	148	15,012	15,938	927	6.2%
Impact of Contract Tolerances / Agreed Outturn	114	22	(1,200)	(1,222)	114	(2,631)	(2,745)	-2397.9%
Drugs	51,154	3,857	5,307	1,450	38,568	47,088	8,520	22.1%
Diagnostic Imaging	2,215	167	544	377	1,670	1,951	281	16.8%
Bone marrow transplants	5,523	416	458	42	4,164	3,519	(646)	-15.5%
Other Currencies	3,080	232	222	(10)	2,322	1,892	(430)	-18.5%
Private Patients / External Drug Sales	791	66	64	(2)	593	531	(63)	-10.5%
Sub-Total: Total Clinical Income	130,462	9,856	11,302	1,446	98,388	106,166	7,778	7.9%
Other Income	8,393	677	949	272	6,388	7,945	1,557	24.4%
Hosted Services	7,107	959	1,033	74	5,620	5,736	116	2.1%
Total Operating Income	145,962	11,492	13,284	1,792	110,396	119,847	9,451	8.6%
Pay - Non Hosted	(50,977)	(4,302)	(4,215)	88	(38,238)	(37,875)	364	-1.0%
Pay reserves	(171)	(3)	(3)	0	(109)	(109)	0	0.0%
Pay - Hosted	(5,846)	(780)	(758)	22	(4,788)	(4,539)	249	-5.2%
Drugs expenditure	(35,452)	(2,673)	(3,805)	(1,132)	(26,730)	(33,728)	(6,998)	26.2%
Other non-pay - Non hosted	(40,010)	(3,262)	(3,776)	(514)	(30,266)	(33,374)	(3,108)	10.3%
Non-pay reserves	(1,633)	(82)	(184)	(102)	(1,178)	(894)	284	-24.1%
Non-pay hosted	(1,289)	(179)	(275)	(96)	(860)	(1,225)	(365)	42.4%
Total Operating Expenditure	(135,379)	(11,282)	(13,016)	(1,734)	(102,169)	(111,744)	(9,575)	9.4%
Earnings before Interest, Tax, Depreciation and Amortisation (EBITDA)	10,582	211	268	57	8,227	8,102	(124)	-1.5%

Statement of Comprehensive Income 2018/19 (page 2 of 2):

	Trust Annual Plan £k	DEC 18			Cumulative YTD			
		Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	%
Depreciation	(5,155)	(430)	(367)	62	(3,866)	(3,226)	639	-16.5%
Amortisation	0	0	(9)	(9)	0	(77)	(77)	0.0%
Fixed Asset Impairment	0	0	0	0	0	0	0	0.0%
Profit /(Loss) from Joint Venture	624	52	29	(23)	468	342	(126)	-26.9%
Interest receivable (+)	98	8	180	172	73	1,190	1,116	1519.0%
Interest payable (-)	(679)	(57)	(237)	(181)	(509)	(1,322)	(812)	159.5%
Profit on Disposal	0	0	0	0	0	0	0	0.0%
PDC Dividends payable (-)	(3,667)	(306)	(306)	(0)	(2,750)	(2,750)	(0)	0.0%
Finance lease interest	(7)	(1)	0	1	(5)	(7)	(2)	44.9%
Retained surplus/(deficit)	1,797	(521)	(442)	80	1,638	2,252	614	37.5%
NET I&E Margin (%)	1.2%	-4.5%	-3.3%	1.2%	1.5%	1.9%	0.4%	26.6%
EBITDA Margin (%)	7.3%	1.8%	2.0%	0.2%	7.5%	6.8%	-0.7%	-9.3%

5.3 Risk

This section provides details of the 43 corporate risks (32 high, 11 moderate) rated 15 or over as at 21st January 2019. 30 have been assigned to Quality Committee and 13 to the Finance & Business Committee. 2 are rated 20.

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
973	Haemato-Oncology	Finance and Business Development	HODS turnaround times	<p>Cause - Inadequate laboratory and consultant staffing in HODS (haematopathology, cytogenetics, molecular genetics).</p> <p>Effect - poor turnaround times for biopsy samples for suspected lymphoma, molecular genetics for AML and other myeloid disorders, and cytogenetics for all haematological malignancies</p> <p>Impact: -anxiety and distress for patients and families -complaints -delays in clinical decision-making, potentially impacting on patient care</p>	<p>We have had repeated meetings with the 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.</p>	20	9	01/02/2019	31/01/2019	<p>Escalation to LCL re HODS turnaround times</p> <p>Ongoing monitoring of HODS turnaround times</p> <p>Monitoring of HODS turnaround times</p>
832	Inpatient Wards	Finance and Business Development	The allocation and retention of Junior Drs to CCC does not	<p>1. cause - The current allocation of Junior Drs is 8.8WTE.</p> <p>2. effect - Minimum standard required to deliver a safe junior Dr rota is 9 WTEs</p>	<p>Reduced attendance for CMTs at OPD clinics</p> <p>Option of employing locum CMTs x 2 or 2 Clinical fellows.</p>	20	4	31/07/2019	25/01/2019	PRESENT OPTIONS APPRAISAL REGARDING

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
			provide a safe junior Dr rota to deliver safe care on CCC in patient	3. Impact - Medical cover for the Wirral inpatient wards is inadequate.	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)					WAYS TO DELIVER A SAFE JUNIOR DR ROTA Hospital at Night working group
755	Cyclotron	Finance and Business Development	Cyclotron Lifespan	The Cyclotron is more than 30 years old and is the oldest medical Cyclotron in clinical use. The risk is that there will be a catastrophic equipment failure resulting in an inability to deliver the service for a considerable time Developing a strategy for protons to include equipment replacement or de-commissioning	Extensive maintenance of the equipment, changing of parts that show signs of wear, upgrade where possible Development of replacement / de-commissioning plan Workshop booked for 22nd March to develop plans ASTRO conference being attended to speak to manufacturers about potential replacement Briefing paper developed to aid conversations with commissioners	16	8	01/12/2020	05/03/2019	Develop SOC
799	Medical	Finance and Business Development	Reduction in medical staffing (Consultant	There has been a significant reduction in the Consultant Oncologist workforce due to	Current medical staff taking on extra work to cover clinics Reconfiguration of some	16	8	31/05/2019	31/01/2019	appoint locum to manage Medical Oncology practice

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
			workforce)	unfilled vacancies and long term sickness. The tumour groups affected are; Breast Services North Sector, South Sector, East sector, central Urology Services, North Sector, Central (Liverpool) Lower GI southern Sector, Eastern Sector HPB southern Sector and Central H&N north sector	Consultant job plans to cover specialities most affected. Senior Registrar due to complete training within the next 6 months acting into consultant posts supervised and supported by a senior consultant. None medical consultant posts approved and appointed to. This includes consultant radiographers, pharmacists and nurses. Consultant oncologist posts advertised, one appointment made. Consultant vacancies advertised again with new advert. Recruitment plan agreed with HR that includes use of recruitment agencies and possible international recruitment. Use of locums in HPB, UGI H&N and Breast services. Non medical consultants ready to take on own work load from Jan 2018 as all competencies signed off.					at LMC secure locum cover for HPB present paper regarding Consultant workforce risks to Exec appointed to one medical consultant vacancy
835	Haemato-Oncology	Quality Committee	Mandatory training	Cause: Lack of mandatory training data from RLBUHT Lack of aligned HO staff training matrix Effect: Staff not aware what mandatory training required Completeness of HO staff training records	1/ Michelle March leading to pull 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	16	9	31/12/2018	31/01/2019	Monitoring Booking staff on manual handling training with CCC trainer Booking staff onto manual handling training delivered by CCC trainer

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
				Impact: Non compliance to mandatory training. Staff not receiving training in line with competencies required.						Assistance from L&D to ensure on-going evaluation and input into CCC ESR system Monitoring of action plan from 21st Aug 2018 Monitoring of action plan
1017	Radiotherapy	Quality Committee	Cessation of contact x-ray (Papillon) MDT	<p>Cause Contact SMDT at RLUH has been suspended indefinitely due to issues concerning governance and resources</p> <p>Effect Patients where contact therapy is not standard of care are no longer able to be discussed within the MDT to receive radiological and surgical input. NICE guidance states that this should happen as patients may not have been counselled for surgery as the standard of care by the referring clinician before patient consents to treatment.</p> <p>Impact Lack of governance to ensure patients who are suitable for surgery are giving fully informed consent to contact therapy. Patients cannot be treated with contact therapy until this is completed. Reputational risk to the Trust Clinical risk to patients</p>	<p>Internal CCC MDT discussion process in place. Patients for whom contact therapy is recommended via NICE recommendation can be approved for contact treatment.</p> <p>Patients for whom contact therapy is not recommended cannot be progressed to treatment.</p> <p>Criteria developed for those patients to be approved. Requested attendance to MDT from surgical colleague.</p>	16	4	31/01/2019	04/03/2019	<p>To agree a set of criteria the patients should fulfil before treatment</p> <p>To ensure colorectal surgeon attends local CCC meetings to give a surgical view</p>

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993	Imaging	Finance and Business Development	Supply of Radiopharmaceuticals post leaving the EU	<p>There was a BNMS council meeting on 5th September in which the supply of radiopharmaceuticals post our leaving the European Union was discussed. Whatever happens concerning a transitional arrangement or a no-deal "Brexit" there may well be disruption to the supply of radiopharmaceuticals. Unlike other medicines we cannot stockpile radiopharmaceuticals so any delays at new border arrangements may impact the time a delivery can be made and the activity delivered</p> <p>Due to changes in the exchange rate of the pound and increased costs of importation and customs clearance it is also likely to be an increased cost for the radiopharmaceuticals and delivery costs</p> <p>The BNMS council believe it would be prudent to ensure that these possible delivery issues and costs changes are flagged and added to risk register. This could cause serious problems for patients having Nuclear Medicine scans with the effect of increasing the waiting list.</p>	No known controls can be put in place	16	4	29/03/2019	04/02/2019	contingency plan
1010	Pharmacy	Quality Committee	Brexit & Implications for medicines	<p>Cause: Brexit deal has yet to be secured</p> <p>Effect: A no deal could adversely</p>	The health secretary has asked trusts not to stockpile medicines as the DH is	16	8	01/04/2019	21/02/2019	Assess buffer stock for Brexit Assess buffer

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
			supply	impact medicines availability in the UK. Impact: A shortage of medicines could have an adverse effect on patient safety and outcomes at CCC.	liaising directly with Pharma companies. This will ensure that adequate supplies are available should the UK reach a no-deal agreement.					stock Update BCP
1036	Radiotherapy	Finance and Business Development	Supply of HDR Brachytherapy sources	1. Cause: Whatever happens concerning a transitional arrangement or a no-deal "Brexit" there may well be disruption to the supply of HDR brachytherapy sources. It is not possible to stockpile the sources as the radioactivity decays over time and after approximately 3 months the treatment times become excessive Effect: Any delays with customs arrangements at new borders may impact the time a delivery can be made and the activity delivered. Impact: Sources not available and patient treatments cancelled	None known	16	4	29/03/2018	04/03/2019	Close communication with the company (ELEKTA) in relation to their strategy
1039	Pharmacy	Quality Committee	Incorrect rate of infusion via pump	Cause: Multiple incidents regarding incorrect infusion rate including a SUI across the Trust. 28 incidents reported since	Self assessment by nurses available Train the trainer training available	15	3	27/04/2018	28/01/2019	Report on behalf of HO the pump training records for nursing staff

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				<p>datix reported.</p> <p>Effect: Patients receiving medications at the incorrect rate of infusion.</p> <p>Impact: Increased risk of side effects and infusion related events</p>						<p>Report on behalf of integrated care the pump training records for nursing staff</p> <p>Report on behalf of Chemotherapy the pump training records for nursing staff</p> <p>Task and finish group for smart pump libraries</p> <p>Pump checking policy</p>
1056	Workforce and OD	Quality Committee	Workforce Plan	<p>Failure to develop and approve the workforce plan will impact upon the Trusts ability to respond and deliver the required workforce for the future.</p>	<p>Draft WFP presented to Board</p> <p>Dedicated resource assigned to develop and finalise the WFP.</p> <p>Workforce strategy</p> <p>OD Strategy</p>	15	6	30/04/2019	28/02/2019	Workforce modelling

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765	IM&T	Quality Committee	Cyber Security Attack	There is a risk that there could be major clinical and corporate service disruption and/or data loss due to Cyber Attack	<p>Anti Virus software is up to date across Server and PC estate and CCC is an early CareCert (NHS Digital) adopter for Cyber Security with NHS Digital. There is additional mitigation to be provided through Domain migration and a new enterprise back up solution which were actions from a recent MIAA Cyber Security Assessment. The ICT Security Manager is a key member of the Cyber Security group within Cheshire and Merseyside.</p> <p>Windows Advanced Threat (ATP) protection is being rolled out across the trust in line with NHS Digital Windows 10 upgrade. Windows 10 roll out plan in place</p> <p>Working towards Cyber Essentials Certification</p> <p>Firewalls are upgraded the enterprise back up solution is now installed.</p> <p>Cyber security action plans monitored on a monthly basis.</p>	15	9	29/03/2019	17/02/2019	Review of Monthly Cyber action Plan

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1011	Physics	Finance and Business Development	Overspend on parts required for repair of Linacs	<p>Cause: Spend on parts from Varian to repair linacs has exceeded the expected yearly allocated budget of £280k.</p> <p>Effect: Additional spend is required to fund any further parts from Varian to repair linacs for the remainder of the financial year.</p> <p>Impact: If additional finance is not available to purchase parts then linacs will not be safe to operate if they require repair in this financial year.</p>	None.	15	8	31/03/2019	04/03/2019	
998	Crest	Quality Committee	Inaccurate information in ESR for CREST CNS/ANP mandatory training	<p>Cause: ESR position numbers are not aligned to the CNS/ANP job roles within CREST.</p> <p>Effect: The appropriate training matrix is not aligned with staff, leading to ESR showing as not compliant with mandatory training, and the required training is missing. Staff required to maintain own paper records.</p> <p>Impact: Non-compliance with mandatory training</p>	<p>We have developed a mandatory training matrix which has been sent to the CNS/ANP on CREST to manage their compliance and sent to L&D in order to amend ESR</p> <p>Communication processes regarding new training is not robust and staff are regularly unable to access ESR due to technical difficulties.</p>	15	4	01/12/2018	01/02/2019	<p>Escalated to GM.</p> <p>Staff now also hold their own records.</p>

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1001	Imaging	Quality Committee	Lack of room capacity for cannula removal	<p>Cause: Following an SUI and coroners court hearing and to follow RCR guidance, we immediately introduced the recommendations and are now leaving cannula's in CT patients for up to 30mins post scan to enable immediate access to a vessel in the case of a reaction.</p> <p>Effect: This is creating operational issues due to lack of clinical space to remove the cannulas. Staff is having to continually look for a 'space' to enable removal of patients cannula's.</p> <p>Impact: It is an infection control risk removing cannulas in non clinical areas, it also creates an unprofessional appearance to patients when they are taken into an inappropriate environment.</p>	When possible an empty x-ray room is being used as this is a clinical environment. Infection control have inspected the area and estates have been contacted to advise next steps	15	4	18/03/2019	12/02/2019	Identify new clinical space
1018	Pharmacy	Quality Committee	Staff are not-compliant with medicines management training	<p>Cause-Staff compliance in medicines related mandatory training (see also insulin risk) is below target compliance.</p> <p>Effect-Staff may be administering medicines without the required knowledge.</p> <p>Impact-May impact the rate of medication errors.</p> <p>Contributing to this risk is the move from face to face to on-line teaching.</p>	Medicines policies & procedures. Training matrix in place training available via ESR	15	6	14/01/2019	18/03/2019	<p>Provide lists of medicines management compliance</p> <p>Cross reference training from medicines management 2</p> <p>Issue an improvement request to general managers</p> <p>Issue ward /department improvement requests</p>

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										MSAG agenda inc. mandatory training Medicines management metrics presentation
1019	Imaging	Finance and Business Development	FDG Supply	<p>Cause: The supply of FDG from Alliance Medical Radiopharmacy is unreliable due to a rolling programme of updating the cyclotrons which produce the tracer. Currently all doses come from Preston Radiopharmacy.</p> <p>Effect: There have been occasions when we have had no FDG delivered for a whole day meaning that up to 11 patients need to be cancelled and rebooked for appointments later in the week. On other occasions the number of doses is reduced meaning that we have to scan patients using less dose and scan for longer. This is to avoid cancelling as few patients as possible.</p> <p>Impact: It is quite pressured for the staff having to tell patients that they can't be scanned on the day when the patients are already anxious. It also has an impact on the days when we are scanning as we have a busy list and staff feel stressed.</p>	Manipulation of injected activity and scan times to minimise cancellations. Being flexible and agreeing to fit extra patients in on other days.	15	6	12/03/2019	12/02/2019	Monitoring and informing FDG availability (including to Commissioners)
1022	Delamere and Network clinics	Quality Committee	Risk to Future clinical model not being fulfilled.	<p>Cause: We are struggling to transition patients/treatments from Wirral to sector/local hubs due in part to a lack of strategy to engage</p>	Staff are being bought back from hubs to cover clinics for safer staffing levels Weekly manager meeting to manage activity	15	1	08/04/2019	11/02/2019	Review oral SACT Renal UKONS training

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				<p>our clinicians/health professionals/patients</p> <p>Effect:</p> <ol style="list-style-type: none"> 1. We are unable to accommodate new and novel drugs at Wirral site due to capacity (i.e. recently compassionate use of durvolumab 2. Risk to patient safety with currently 4 chairs per day over extended at Wirral site (evidenced capacity & demand modelling) 3. We are having to renege on our staffing model following the consultation by having to bring back staff on a daily basis from the sector hubs to cover clinics <p>Impact:</p> <ol style="list-style-type: none"> 1. Safety implications with increase in flow through of patients at CCC Wirral site 2. Quality of care implications relating to demand at CCC Wirral site 3 Reputational damage to the Trust with inability to offer new & novel treatments 4. Lack of patient choice/availability of drugs/patient satisfaction/increase complaints relating to clinic wait times at Wirral etc. 5. Risk to staff morale/sickness/retention etc. 6. Risk to TCC transformation plans and Directorate business plans 	<p>External stakeholder meetings for additional capacity COCH</p> <p>Discussion PMO and at Exec level to support a strategy to standardise, communicate, engage and buy in at internal level</p> <p>Operational planning to mitigate any challenges</p>					<p>for SACT assessments</p> <p>Transition Mould Room activity to DDCU</p> <p>Review oral SACT Lung clinics</p> <p>Review one stop Brain clinics</p>

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1032	Pharmacy	Quality Committee	SACT PROTOCOLS-HO DIRECTORATE	Please also see SACT protocols-Chemotherapy Cause: SACT protocols require further nursing input & some leaflets are missing. Effect: Protocols not optimised for the user, some regimens requiring multiple leaflets. Impact: Increased nursing time required for queries & possible branding issue.	Pharmacist verification hub pharmacists advice line.	15	6	21/06/2019	28/01/2019	Gap analysis of leaflets matched to protocol Missing protocols for HO Link protocol and patient information leaflet to the P Create patient information leaflet where gaps exist
1033	Pharmacy	Quality Committee	DPD testing	Cause: Patients receiving 5-FU based/Capecitabine regimens may be DPD deficient. There has been recent media attention regarding a patient death (not CCC) whereby the coroner's report stated DPD deficiency. Effect: Patient anxiety, pressure on clinics Impact: No clear guidance nationally and no commissioner funding-no clear options for Consultants during consultation.	Reference to the CRUK document	15	6	28/02/2019	11/02/2019	Complete risk assessment for DPD testing set up task & finish group

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1035	Workforce and OD	Quality Committee	Effective use of ESR	Inaccuracy of the Trust hierarchy including position competencies within ESR impacts negatively upon workforce monitoring and reporting both internally and externally. Inaccuracy of establishment within ESR impacts upon the Trusts ability to accurately monitor and report workforce data and compliance.	Manual work around processes in place to align the ledger with ESR.	15	4	31/12/2019	01/04/2019	ESR Project Plan
250	Delamere and Network clinics	Quality Committee	Non-compliance with Mandatory Training - Delamere and OPD	Cause :Inability to either allocate time to mandatory training and/or be able to access training and/or have Directorate records reflect the correct training data Effect: Key Performance Indicators not achieved Impact: Risk to patient safety and credibility of staff and Trust	* Increased training days * Admin Manager appointed * L&D information on a monthly basis Display monthly for staff so they are aware of non-compliance in all clinical areas	15	4	29/03/2019	29/03/2019	Allocate a co-ordinator to monitor ward compliance

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731	Delamere and Network clinics	Quality Committee	Transcribing clinical information i.e. blood results	<p>Update* This risk has increased as we work towards our future clinical model and more of our patients are treated closer to home.</p> <p>1. Cause - Blood transcribing error</p> <p>Patients are requested to have their bloods taken before their treatment appointments to ensure that we have the required information to assess for treatment eligibility. Many patients are out area and therefore have the bloods done closer to their home.</p> <p>2. Effect</p> <p>The current process requires staff to telephone the host labs for blood results transcribe them onto blood result pad then further transcribe into outside blood results on Meditech</p> <p>This leaves two opportunities for transcription errors to occur.</p> <p>Staff transcribing blood results after patients received chemotherapy in Southport Clinic. This has occurred as using the summary sheet which shows all results throughout the patients stay. However not all the same date results are on the same line.</p> <p>Recent SUI demonstrated the error in transcribing after</p>	<p>Staff are now printing off same day blood results and printing off Summary sheets for previous results. Keep on system to review in 6 months</p> <p>IM&T are working closely with the host hospitals, WUTH Hospitals and the Royal labs have now successfully interfaced with our systems, however other hospitals are unable to do this currently, this is on the GDE agenda.</p>	15	6	05/11/2019	04/02/2019	Interfacing with host hospitals

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				treatment on the wrong date results.						
78	Medical	Quality Committee	Poor compliance with mandatory training - Medical	Poor compliance with mandatory training	<ul style="list-style-type: none"> *All new consultants undergo Trust Induction *Provision of e-learning *Learning & development policy *Medical Staffing Advisor logs all training *ESR (Consultants and staff grades) *New workbooks *Consultant training days introduced- Oct 2018 *Pay progression dependent on compliance *Rolling half day programme 	15	6	16/12/2019	15/02/2019	Agreement of key dates for 2019 for Consultants to focus on statutory training Final sign off of the training matrix for medical workforce

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					in place					
201	Workforce and Organisational Development	Quality Committee	Failure to provide adequate support for employee stress, leading to increased absence from work	Failure to provide adequate support for employee stress, leading to increased absence from work	<ul style="list-style-type: none"> * Confidential counselling * Informal counselling * Staff support information * Outdated working practice to be revised inline with CIS * Work life balance * Flexi time * Training * Stress Risk Assessment - HSE * Flexible Working in place * Time management encouraged and observed * Stress Action Group established (2017) * 2017 Stress audit (as part of regular audit cycle) 	15	6	28/06/2019	31/03/2019	EAP Mental Wellbeing Steering Group

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833	Delamere and Network clinics	Quality Committee	Consultants not documenting in meditech	<p>UPDATE * THIS RISK HAS BEEN INCREASED DUE TO INCREASE IN INCIDENTS</p> <p>Various consultants not documenting in real time on Meditech , safety issue with nurses unable to know the full treatment plan . Patients arriving for treatment having seen a consultant but nothing documented on the system re the plan .</p>	nurses contacting consultants on a daily basis, resulting in delays in treatments A 'Route to Paperless Strategy' has been submitted to the Clinical Reference Group and Digital Board to identify the current situation with regard to use of paper in clinical charting; the barriers to removal; and to formulate the necessary steps to improve clinical and administrative workflows at CCC. An action plan is in development and will be submitted to CRG/Digital Board for review and approval in Q4 18/19.	15	3	08/07/2019	04/02/2019	Paperless strategy
990	Out Patients	Quality Committee	Future clinical model for oral SACT delivery	<p>Please note this risk is an amalgamation of risks 827 and 817 which will now be closed. Cause: Pressures to enable timely access to oral Systemic Anti-Cancer Treatments [SACT] have seen the development of multiple CCC-Wirral areas and</p>	<p>Until this is fully implemented several controls have been put in place to ensure patient safety.</p> <p>1. Communication was given to all nursing staff that the practice of giving out oral</p>	15	2	25/10/2019	28/01/2019	Phasing of oral SACT delivery SACT training for OPD staff

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				<p>clinics being involved in the administration and delivery of oral SACTs without appropriate processes in place.</p> <p>Effect: A recent audit has identified numerous areas whereby drug treatment is delivered without the full compliance of both local and national measures including peer review and this level of risk to patient safety cannot continue.</p> <p>Impact: There is an urgent need to move these treatments, due to patient safety, into the realm of the chemotherapy nursing teams on Delamere Day Case Unit (DDCU) and at CCC peripheral hub sites. Doing so will release time to support a robust and efficient outpatient facility, with the aim of reducing clinic wait times, improving patient flows through clinics and releasing pressure on staff and consultants to focus on the clinic consultation; aligned to CQC recommendations.</p> <p>The plan is for all oral SACT to be given on DDCU and sector hubs in the appropriate controlled environment.</p> <p>This plan is dependant on the successful implementation of the future clinical model whereby patients will be treated nearer to their home. Therefore freeing capacity for the transition of SACT out of OPD.</p>	<p>SACT prior is not acceptable and should not happen.</p> <p>2. All patients now encouraged to have bloods taken 48-24 hours before their appointment. Patients will now receive their results at their appointment and will not have to wait for them on the day therefore reducing waiting times.</p> <p>3. PharmaC now check that all SACT assessments are complete and then dispense medication.</p> <p>4. Mould room transition is now complete with SACT and pre-assessment being delivered on DDCU.</p> <p>5. Capecitabine clinic transition also complete with SACT and pre-assessment being delivered on DDCU.</p>					

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854	Imaging	Finance and Business Development	Radiologist business continuity	<p>Cause: Insufficient numbers of radiologists</p> <p>Effect: *With low numbers of radiologist during unexpected sickness absence and during peak annual leave periods it can leave the diagnostic imaging without medical presence on certain days *Inability to report Planning PET CT scans *Lack of clinical cover for procedures involving contrast administration *Backlog of reporting and delays in turnaround times for scan results</p> <p>Impact: *Treatment decisions may be delayed *Patient arriving in clinic and reports not available</p>	<p>Asking visiting radiologists from RLBUHT to provide additional reporting cover for urgent cases. Asking Trust registrars to provide clinical cover following the rare occasion an emergency arises following contrast injection. Additional reporting capacity provided by outsourcing companies, exploring possibility of also providing PET CT reporting. ROI only scan currently being performed for planning PET CT. Locum radiologist employed</p> <p>Currently exploring re-advertising for additional radiologists and possible overseas recruitment</p>	15	6	28/01/2019	21/02/2019	<p>Hold put on half body scanning Explore further outsourcing reporting To work with HR on radiologist recruitment strategy</p>
862	IM&T	Quality Committee	Organisation of Information Management Resources Trust wide to achieve Trust objectives	<p>The Trust has a data warehouse in place which has been operational for 4 years. It is not currently the single repository for all information and data assets in the Trust and there is not a shared vision, strategy or roadmap to ensure we are exploiting all of the data from a single source and providing information to our clinical staff within front end dashboards which can filter through wards and down to individual patient level. In addition, the way we are organised to deliver means that staff that could support a</p>	<p>Planned controls include the following areas:</p> <ul style="list-style-type: none"> • Full review of issues within the Information team- to include team focused session, stress questionnaire with staff, 360 degree feedback. Review of previous exit interviews. Work underway with HR and OD. Team session established for 22/2/18. Various follow up sessions have concluded and are on going • Review of data warehouse technical infrastructure and 	15	9	30/04/2019	16/02/2019	<p>Project manage the activities of the new build data warehouse</p>

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				business intelligence function are pockets of small teams and differing processes spanning many teams within the Trust; most predominantly IM&T and Quality functions. There is a current risk that reporting is pulled from several different sources (data warehouse, staging tables) and that could have an impact on the accuracy of data and the current technical infrastructure and current processes may not be fit for purpose. Within the Information team, sitting in IM&T there is currently a high turnover of staff which is impacting organisational knowledge and consistency in delivery and root cause for turnover needs to be established.	a review of the Trust's aspiration for business intelligence team. Presentation to Executive Committee took place on 29/3/18. Working with an external team to provide support for review (on-going). Met with clickhealth and are to be commissioned to support a review and support data visualization. Review of IMS Quintilles report commissioned early 2017 for Pharmacy. Review of current staffing roles across the Trust delivering information management Restructure is planned <ul style="list-style-type: none"> • Funding to pump prime any changes have been approved. • Agreed strategy for business intelligence to sit within the refreshed DIGITAL strategy. Work commenced on new build of data warehouse Head of BI post approved Nov 18 as part of new IM&T senior leadership Team- out to recruitment. restructure of the team to follow					
968	Haemato-Oncology	Quality Committee	Fragmentation of Infection Prevention and Control support / services within	Cause: Fragmentation of Infection Prevention and Control support / services within HO Effect: Lack of clarity in relation to accountability and responsibility	Development of new IPC committee chaired by Matron Foulds CCC has clear IPC governance processes in place which include HO staff	15	6	03/12/2018	31/01/2019	Completion of action plan Meeting with Tim Neil Infection control to be added to clinical

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			HO	Impact: This has led to lack of data, inaccurate data submission backlog of RCAs', lack of governance and review of RCA's, different policies and procedures and staff not sure of what team to contact or who to escalate issues to.						interface project Joint oversight meeting Date set for RCA review Monitoring of infection control processes Develop IPC Pathways with HO
887	Delamere and Network clinics	Quality Committee	Immuno-oncology service	Risk - There is a significant risk to the safe delivery and toxicity management of immuno-oncology patients. Cause - There is lack of trained staff to provide holistic patient care for the rapidly increasing population of patients receiveing immuno-oncology therapy and their complications. Effect - It is internationally	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	15	6	04/02/2019	21/02/2019	Implementation of an IO bulletin Education to specific teams e.g. triage Collaboration between the Lead IO nurse and the Lead

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				<p>recognised that I-O treatment carries a different set of needs to other SACT. There is requirement for continuous monitoring of a patients physiological status throughout the time they are receiving treatment. There is a need for early recognition of toxicities and urgent intervention to prevent significant patient harm including death. IO therapies also differ in the fact that toxicity required long term co-ordination and follow-up in a way that is not needed in other. Additionally the management of specific toxicities is complex and again different from other SACT. The trust has been proactive in instituting management pathways and an steering committee however to meaningfully and effectively manage patients on IO the requirement is now for staff members to implement this work. There have been a number of near misses with patient care as a result of lack of follow up due to insufficient staffing levels within a specific IO team. Additionally CCC is considered to be a leader in the field of IO and its management. If this recognised risk is not supported by the trust with effective change and an incident occurs not only is there a risk to patients and staff but also to the standing of CCC in the eyes of other healthcare professionals and the public.</p>	<p>Standardised blood panel to ensure consistency Meditech templates</p>					<p>Education Nurse Mandatory training module Development of a steroids information card with sick day rules Appointment of a Band 6 nurse</p>

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
906	Out Patients	Finance and Business Development	Isle of Man Service Provision Review	<p>Cause: Consultants travel to Isle of Man to deliver OPD clinics across the tumour specific groups including HO. There is a reduction in availability of consultants nationally, in addition there has been 5% growth in chemotherapy activity year on year, with an expected rise in immunotherapy of 10% for 18/19. Job planning session feedback has suggested that the consultants are requesting a change in working practice to support a sustainable IOM service moving forward.</p> <p>Effect: The effect of this on the mainland is that CCC have developed a sector and hub clinical model to release consultant time, that has previously been spent travelling across the north west. However the consultants continue to travel to the IOM and are struggling to cope with the activity rise, the travel time and manage the skill set required for safe delivery of OPD appointments.</p> <p>Impact: Although the IOM patients are not counted as 'target' patients, delays of 6 weeks and above are being reported from Admin Services, which creates an inequity of service provision.</p>	<p>1. Consultant cover for IOM OPD service</p> <p>2. Service Provision Agreement between IOM/CCC</p> <p>3. Protocols, Processes, Policies in place</p>	15	6	01/02/2019	28/01/2019	<p>Activity Monitoring IOM patients</p> <p>Training Needs Analysis IOM</p> <p>SLA review IOM</p> <p>IOM Service Transformation Review</p> <p>Proposal for Developing Service Model</p>

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991	Radiotherapy	Finance and Business Development	No MET cover only CRASH cover between 9am to 5pm at Aintree	<p>There is currently no emergency team cover at CCCA. It was previously provided by AUH, but this service was withdrawn in December 2017. Walton provides CRASH only cover 9-5pm contingent on medical staff being present in CCCA. Current medical cover at CCCA means we are breaching the terms of this agreement. The CRASH cover is in place based on urgent re-negotiation of the terms of the agreement. The next meeting is scheduled for 20th August 2018, and representation from CCC, Walton and AUH are required. At present, there is no MET cover and only 9-5pm CRASH cover. This poses a significant risk to all patients attending for planning and treatment. Lack of medical cover has been a risk at CCCA for a significant period of time. This has been exacerbated due to long term sickness of medical staff based at CCCA. This combined with the information presented at the meeting on 23rd July 2018 means the staff and patients at CCCA are particularly vulnerable in the event of an acutely unwell patient. Risks are further increased by the recent introduction of scanning patients with IV contrast at CCCA and the extended working hours of the treatment sets.</p>	<p>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</p>	12	5	31/01/2019	31/01/2019	MET & CRASH cover at Aintree

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977	Workforce and Organisational Development	Quality Committee	Lack of project lead for medical model.	It has been identified that there has been no defined project plan and delivery of actions required to move consultants into teams, to drive SRGS to deliver clinical models of care to support TCC and to deliver this into a Workforce plan. This leaves the main TCC programme at risk as all subsequent planning assumptions have been based on the presumption that this work was progressing in a structured and robust way, ensuring the right people would be in the right place to deliver the right care in a timely manner.	Initial engagement work with SRG leads has taken place. External consultancy has reviewed the TCC program; strategic engagement with external stakeholders in progress	12	6	31/03/2018	21/02/2019	Identify PMO lead for project
226	Inpatient Wards	Quality Committee	Nurse safe staffing & Recruitment	<p>Cause: We do not have a strategic plan for the recruitment of nurses across directorates to ensure that all vacancies are filled in a timely and responsive fashion in order to maintain safe levels of care</p> <p>Effect: unfilled vacancies across multiple departments lead to independent recruitment drives that are time consuming, expensive, reactive and do not address the strategic issue</p> <p>impact: ability to fill vacant posts with overtime, bank staff, agency or other means impacts upon the moral, health and well being of current workforce, and our ability to consistently deliver safe care</p>	<p>*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</p> <p>*New NICE recommended acuity tool implemented</p> <p>*recruitment to vacant posts within the directorate</p>	12	6	30/04/2019	22/03/2019	<p>Repeat acuity tool</p> <p>Nurse Recruitment strategy</p> <p>Cost and scope</p> <p>Safe care module for E Roster</p> <p>Draft strategic plan for Trust wide nurse recruitment</p>

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761	Haemato-Oncology	Quality Committee	SACT PROTOCOLS-Chemo DIRECTORATE	<p>Cause: Protocols for SACT treatment & leaflets are not developed and approved by the SRG in a timely manner, not updated onto key document sources such as the intranet and Meditech. Predominantly for the HO protocols now the Senate does not exist.</p> <p>Effect: Protocols are not available for other institutions to reference to from an AO perspective. Patient information leaflets not always available from Macmillan. Most importantly nursing staff do not always have access to the most up to date protocols.</p> <p>Impact: Potential patient harm by incorrect protocol being used. Delays to patient treatment.</p>	<p>Pharmacist verification and pharmacists available 24/7 for pharmaceutical advice.</p> <p>Nursing staff utilise this service readily.</p> <p>SACT committee process mapping complete, group being set up & protocols uploaded to website</p> <p>Advice line available</p>	12	4	04/02/2019	25/03/2019	<p>SACT protocol project</p> <p>check MAR link to protocol</p> <p>SOP Protocol update & control</p> <p>Gap analysis of leaflets matched to protocols</p> <p>Create SACT PIL where gaps</p> <p>Provide leaflet template</p> <p>remove redundant protocols</p> <p>Link protocol & PIL to the P</p> <p>Communicate new protocol/PIL SOP</p> <p>Patient information</p> <p>Present list of missing protocols to DTC</p> <p>Protocol action plan</p> <p>Implement new flowchart for PI</p> <p>Cancer Alliance protocols</p>

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850	Physics	Quality Committee	Compliance with IRMER legislation	<p>Cause: Gaps in compliance with Ionising Radiation (Medical Exposures) Regulations 2018, also known as IRMER, have been identified.</p> <p>Effect: Not all work involving medical exposures using ionising radiation is performed in accordance with Statutory legislation.</p> <p>Impact: Trust is at risk of receiving an improvement notice or fines from future CQC or IRMER inspections. Compliance issues are likely to negatively impact CQC rating for 'Are we safe?'.</p>	<p>1. IRMER procedures reviewed and updated to comply with new regulations.</p> <p>2. Staff reading list produced to ensure staff are aware of, and follow, Employer's procedures.</p> <p>3. IRMER training included in role essential training for staff working with ionising radiation.</p> <p>4. Training Records produced for Practitioners in radiotherapy.</p>	12	8	31/01/2019	10/04/2019	
1015	Operational	Quality Committee	CQUINs: Quality,	Requirements for the Holistic Needs Assessment (HNA), Risky Behaviours and Optimising	There are a range of controls in place for all CQUINs (including the successful	12	6	31/01/2019	28/02/2019	Meet with CSW to ensure focus

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			financial and reputational risk of failing to meet requirements in 2018/19	Palliative Chemotherapy for Q1 and Q2 2018/19 have not been met. There is a risk to achieving the Enhanced Supportive Care and Clinical Utilisation Review CQUINs in Q2. There is an impact on patients (who do not benefit from these initiatives), Trust finances (with over £300K withheld in 2017/18 and a worsened trajectory for 2018/19) and the Trust's reputation with Commissioners and beyond.	recruitment of an additional palliative care consultant and 11 Cancer Support Workers) however these are not sufficient to guarantee achievement of all requirements. A monthly CQUIN meeting is in place for the leads. The Trust Board receive the Integrated Performance Report which includes a CQUIN section. The Quality and Safety Sub Committee receives a monthly CQUIN report and a more robust system for managing new CQUINs via this forum has been implemented, to start February 2019. This will ensure the right lead is assigned, the right support people are identified and implementation costs are agreed.					on improving performance against the CQUIN target Improve performance against ESC CQUIN
735	PMO	Finance and Business Development	The Trust's current/future clinical model is not supported by all key stakeholders	The Trust's future clinical model will require agreement with commissioners (Spec Comm and CCGs) and partner Trusts - bilaterally and in the context of Local Delivery System and STP plans. Without clarity on the model and agreement from local partners the operational and financial	Exec to Exec dialogue Bilateral discussion with individual organisations and Local Delivery Systems completed Clinical model now agreed with Clinical Directors and Site Reference Groups Public consultation in Eastern sector via established commissioner	9	9	29/03/2019	11/02/2019	

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				sustainability of distributed services may be undermined.	process					
419	Quality	Quality Committee	Non compliance with NICE guidance:	<p>Non compliance with current NICE guidance (18%) will result in failure to follow recommendations for best practice and may impact on patient safety and incur reputational damage</p> <p>1. Cause The outstanding recommendations are mostly related to Trust wide issues, i.e. smoking cessation, Holistic needs Assessment, Key workers</p> <p>2. Effect Requires senior leaders to drive the implementation and Trust investment</p> <p>3. Impact Delay in implementation and NICE complaint percentage</p>	<p>Policy SOP CET report compliance Audit Monitoring by Q&S Sub Committee SRGs within directorates NICE Database NICE Assurance Committee Monthly data packs</p> <p>Noncompliance is at 16% for guidance and quality standards (21/1/19)</p>	9	4	31/12/2019	31/03/2019	Continue to drive improvement via the NICE Committee
552	PMO	Finance and Business Development	Benefits of the cancer centre cannot be realised because decisions are not able to be made within the timescales	Commissioner and key partner confidence in the trust is substantially undermined because the trust fails to corporately resolve investment decisions relating to the future clinical model within the planning/lead in timeline required to execute delivery successfully.	*Effective Executive level ownership via the Medical Director (risk owner) with the support of the Director of Operations, Transformation and Innovation (risk manager). Project work is supported by the Programme Management	9	8	04/05/2020	04/02/2019	Establishment of a Programme Management Office to ensure co-ordination with the wider Transformation Programme

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			required. (PMO)	<p>"Strategy drift" means that the benefits outlined in the Full Business Case cannot be optimally realized because TCC does not have a clear defined delivery scope beyond the move to Liverpool. This would lead to partial failure to deliver TCC programme benefits and substantial trust reputational damage, which would materialize through excess workforce attrition and challenges to achieving long-term financial sustainability.</p>	<p>Office team and senior operational stakeholders.</p> <p>*Bilateral discussions at senior manager level with partner trusts, CCG commissioners, and Spec Comm to agree plans.</p> <p>*Programme governance is developed through reference of the discussions at the Operations and Business Development Committee to the formal board sub-committee (Finance and Business Development Committee).</p> <p>*Clear project plan and timetable to be agreed by the Trust, Commissioners, and partner Trusts - this has been shared with Board.</p> <p>*Agreed plan to mobilise workforce planning aspects in Autumn/Winter 2017/18 with workforce and activity projections. Alignment with operational work delivering sustainability of clinical services.</p> <p>*Developing plan for position of future clinical model in terms of long-term trust strategy.</p>					

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873	Workforce and Organisational Development	Quality Committee	Decline in Staff Survey Engagement Scores	Levels of staff engagement reduce resulting in low morale and increased absence.	The Executive Director of W&OD is responsible for the staff survey, reporting the results, analysis and action plans to the WOD Sub Committee and Quality Committee. Focus groups within Directorates are in place to understand the underlying messages from the survey Directorate ownership through local action planning Performance reviews include staff survey response rates and associated mitigation / action plans. Staff survey focus at the Board due in July 2018 to ensure corporate drive from the top down.	9	6	29/03/2019	31/01/2019	Provide progress report to the WOD Sub-Committee
912	Pharmacy	Quality Committee	PGD-non adherence to policy	Cause: PGD practitioner documentation is often incomplete or missing. Recent audit shown very poor compliance Effect: PGDs being used incorrectly e.g. medication outside of PGD indication Impact: Non-compliance with legislation-uncontrolled medicines administration	Policy & procedure. Training process & revalidation. Robust use of PGDs in imaging. Improvement action plan in place.	9	4	07/01/2019	21/02/2019	Extraordinary meeting to discuss issues Audit compliance with new procedure PGD Policy update Supply of medicines under PGD procedure Register check Proposal form update Documenting supply in Meditech

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										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