

BOARD OF DIRECTORS MEETING

Agenda Item	P1-034-19	Date: 1st March 2019
Subject /title	Integrated Performance Report – Month 10 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		
<p>This report presents Trust performance against agreed national and local performance metrics as at the end of Month 10 (January 2019).</p> <p>Overall, the Trust is performing well in most areas. There are a number of key metrics which have not been achieved; action plans have been developed and remedial action is underway.</p> <ul style="list-style-type: none"> - CQUIN requirements (although improved in Q3) - Venous Thrombo-Embolicism (VTE) risk assessment - Consultant Review within 14 hours. The stretch target of 90% (in line with national requirements) has been applied from month 10. - Sepsis: IV antibiotics received within an hour - 62 Day Cancer Waits target - Sickness absence - Statutory and Role Essential Training (although improved Trust wide and for specific training) 		
Strategic context and background papers (if relevant)		
<p>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</p>		
Recommended Resolution		
<p>The Trust Board members are asked to:</p> <ul style="list-style-type: none"> • Note Trust performance and associated actions for improvement, as at the end of January 2019. 		
Risk and assurance		
<p>This report highlights all risks rated 15 or over and provides both assurance of performance and detail of remedial actions in place as appropriate.</p>		
Link to CQC Regulations		
<p>Regulation 12: safe care and treatment Regulation 15: premises and equipment Regulation 17: good governance Regulation 18: staffing</p>		

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																															
<p>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.</p> <p>Application Exemptions:</p> <ul style="list-style-type: none"> • Prejudice to effective conduct of public affairs • Personal Information • Info provided in confidence • Commercial interests • Info intended for future publication 	<p>Please tick the appropriate box below:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50px; text-align: center; border: 1px solid black;"><input checked="" type="checkbox"/></td> <td>A. This document is for full publication</td> </tr> <tr> <td style="text-align: center; border: 1px solid black;"><input type="checkbox"/></td> <td>B. This document includes FOI exempt information</td> </tr> <tr> <td style="text-align: center; border: 1px solid black;"><input type="checkbox"/></td> <td>C. This whole document is exempt under FOI</td> </tr> </table> <p>IMPORTANT:</p> <p>If you have chosen B above, highlight the information that is to be redacted within the document, for subsequent removal.</p> <p>Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.</p>	<input checked="" type="checkbox"/>	A. This document is for full publication	<input type="checkbox"/>	B. This document includes FOI exempt information	<input type="checkbox"/>	C. This whole document is exempt under FOI																								
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Equality & Diversity impact assessment																															
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Are there concerns that the policy/service could have an adverse impact because of:</th> <th style="width: 15%;">Yes</th> <th style="width: 15%;">No</th> </tr> </thead> <tbody> <tr><td>Age</td><td></td><td style="text-align: center;">X</td></tr> <tr><td>Disability</td><td></td><td style="text-align: center;">X</td></tr> <tr><td>Sex (gender)</td><td></td><td style="text-align: center;">X</td></tr> <tr><td>Race</td><td></td><td style="text-align: center;">X</td></tr> <tr><td>Sexual Orientation</td><td></td><td style="text-align: center;">X</td></tr> <tr><td>Gender reassignment</td><td></td><td style="text-align: center;">X</td></tr> <tr><td>Religion / Belief</td><td></td><td style="text-align: center;">X</td></tr> <tr><td>Pregnancy and maternity</td><td></td><td style="text-align: center;">X</td></tr> <tr><td>Civil Partnership and Marriage</td><td></td><td style="text-align: center;">X</td></tr> </tbody> </table> <p>If YES to one or more of the above please add further detail and identify if full impact assessment is required.</p>		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
Are there concerns that the policy/service could have an adverse impact because of:	Yes	No																													
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Religion / Belief		X																													
Pregnancy and maternity		X																													
Civil Partnership and Marriage		X																													
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	<i>Working environment</i> Flexible opportunities, healthy and safe working conditions, staff support	X
Quality of care and environment	X	<i>Being heard:</i> <ul style="list-style-type: none"> • 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 10 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. There are a number of key metrics which have not been achieved; action plans have been developed and remedial action is underway.

- CQUIN requirements (although improved in Q3)
- Venous Thrombo-Embolicism (VTE) risk assessment
- Consultant Review within 14 hours. This target was originally set at 75% for CCC. As this has been consistently been achieved, we have now applied a stretch target of 90% (in line with national requirements), from month 10.
- Sepsis: IV antibiotics received within an hour
- 62 Day Cancer Waits target
- Sickness absence
- Statutory and Role Essential Training (although improved Trust wide and for specific training)

Risks

There are 32 corporate risks rated 15 or over as at 13th February 2019. 22 have been assigned to Quality Committee and 10 to the Finance & Business Committee. 3 are rated at 20; 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 Dementia target was achieved in January 2019. VTE risk assessment compliance was below target for the fourth consecutive month (at 92% for January) due a number of patients admitted to Sulby ward who are transferred to theatre before the medical staff reach the ward. The medical lead for VTE has re-enforced the process to medical staff during hand over to ensure that a medic is allocated to Sulby ward to complete outstanding assessments. The newly implemented stretch target of 90% for Consultant review within 14 hours was narrowly missed at 89%. There were no E coli or c diff infections in January 2019.

Caring

The % of inpatients recommending the Trust fell below the 95% target to 94.9% in November, 90.9% in December and 87% in January. This is largely due to an increase in the number of inpatients who answered 'don't know' in these months, however the comments tend to be positive despite selecting 'don't know' therefore the digital data capture system is being reviewed to understand this further. Following a fall in both the number of outpatients surveyed (to 321) and the % of inpatients (to 12%) in December, outpatients have risen significantly to 461 and there has been a marginal increase to 14% for inpatients. Matrons' action plans are monitored at the directorate Quality and Safety meetings, discussed at the monthly Directorate performance meetings and improvement trajectories will be set for each Directorate for 2019/20.

There was one complaint in January.

Effective

There has been no significant change in the number of inpatient deaths over the three years although CCCW monthly figures for the last 4 months have been 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); no change from December.

Responsive

In January 2019, the Trust met all cancer waits targets except 62 day pre (55%) and post allocation (81%). The as yet unvalidated post allocation position shows 9.5 breaches, equating to 14 patients (5 full breaches and 9 shared with another provider). The breach reasons are varied and include patient choice (3 patients had an element of this), medical reasons, capacity within CCC (including first appointment (related to consultant sick and annual leave) and dental (due to reduced service at Christmas)) and externally regarding PEG delays and IT issues at Whiston Hospital.

Clinic waiting times remain static, with both Wirral site and peripheral sites meeting the target of 80% of patients waiting fewer than 30 minutes with Delamere remaining at 77%.

The bed occupancy target has been adjusted to 85% in line with the targets set for CCC's new hospital, based on advice within NICE guidance. In January, average bed occupancy was as follows for 11am / 2am: Conway 80%/80%, Mersey 85%/84%, Sulby 60%/17%.

A decision was taken to close Sulby ward overnight for a temporary two month period from 11th February and changes to occupancy levels on Mersey and Conway wards will be closely monitored to ensure that all inpatient demand can be safely accommodated.

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 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.

The Trust has narrowly missed its PADR target, at 94% in January 2019.

The Trust 12 month rolling sickness absence is 4.21% and in month sickness absence has increased to 4.74% for January 2019, from 4.12% in December 2018. Cold, cough and flu, gastrointestinal problems and anxiety, stress and depression remain the three highest reasons for sickness absence across the Trust.

Turnover for January 2019 has remained static compared to December 2018 at 14.2%. There were 14 leavers in total in January. The majority of leavers in January were from the Nursing & Midwifery staff group.

Statutory and Role Essential training:

Statutory Training compliance remains slightly below the Trust's target of 90%, at 89% for January. In addition to managing the improvement of compliance against the prioritised areas highlighted above, there is an on-going project that is currently establishing more robust processes to ensure the effective delivery of accurate performance data for statutory and role essential training across the Trust. In addition, directorate performance is being monitored weekly. The project team are working with the directorates and have delivered:

- A new, documented process for requesting new Role Essential training with associated Governance for sign-off (through monthly Clinical Education Governance Committee)
- Directorate-level role essential training matrices to baseline all training requirements per job role for each directorate
- A formal change request process to maintain control over directorate training matrices
- Documented SOPs to manage the administration of statutory/ role essential training
- Implemented a new weekly report highlighting compliance of prioritised statutory training per directorate and lists of non-compliant staff per directorate
- Established links into the new Clinical Education Governance Committee

Progress since December - Trust wide (data correct as at 13/02/2019)

Data shows an improvement in most areas since December.

	Chemotherapy			Haem-Onc			Integrated Care			Radiation Services		
	Dec	Jan	Feb	Dec	Jan	Feb	Dec	Jan	Feb	Dec	Jan	Feb
BLS	55%	78%	83%	53%	90%	89%	71%	83%	84%	50%	79%	80%
ILS	42%	63%	72%	n/a	n/a	n/a	41%	70%	72%	67%	57%	68%
Safeguarding Children level 3	86%	86%	56%	11%	43%	70%	33%	65%	64%	-	33%	53%
Safeguarding Adults level 3	100%	100%	53%	11%	65%	70%	33%	53%	53%	-	21%	50%
Patient handling - level 2	67%	86%	88%	43%	82%	85%	78%	80%	81%	70%	77%	78%
Infection Control- level 2	75%	81%	84%	74%	100%	73%	49%	78%	81%	35%	55%	66%

There have been improvements to compliance figures across all areas except for:

- Chemotherapy for safeguarding level 3: this is due to the on-going review of the requirements for safeguarding level 3 which has resulted in additional staff being identified in the directorate which has a negative impact on the current compliance. The directorate are making arrangements for these staff to attend training.
- There has also been a small reduction in BLS and Infection Control compliance for Haemato-oncology.

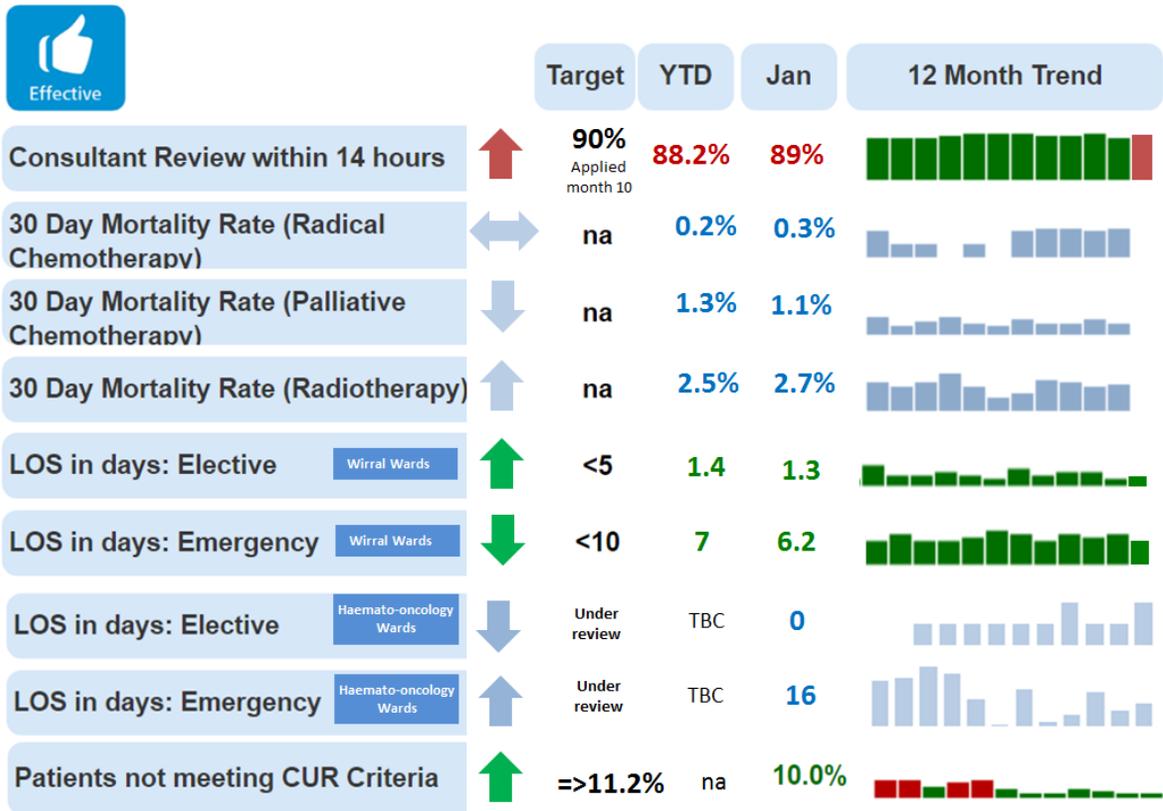
- Integrated Care – there are on-going challenges which are being assessed in relation to releasing staff from clinical care.
- Haemato-oncology – additional staff identified as requiring level 2 training in February.

Progress since December – Haemato-oncology (data correct as at 13/2/2019)

There has also been a focus on achieving compliance levels for role essential training within Haemato-oncology – the figures below show compliance for ward-based staff.

	December	January	February
AKI	81%	92%	95%
ANTT - online	100%	100%	100%
Sepsis	73%	92%	93%
Blood transfusion - online	74%	100%	100%
Blood transfusion - ward based	66%	100%	100%
Point of care	57%	98%	98%
Medical Devices	39%	52%	64%
COVAD	85%	95%	99%

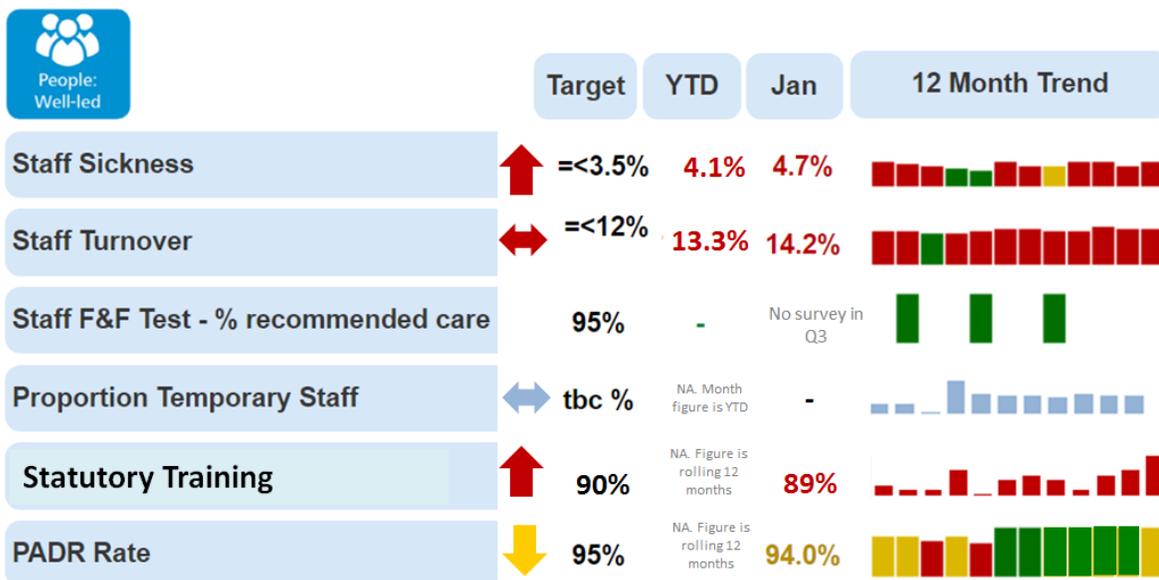
High Level Performance Dashboard: Month 10, YTD and 12 month trends



Haemato-oncology data is included in all the above KPIs where relevant except Consultant review within 14 hours which excludes HO before Oct 2018.



Haemato-oncology data is included in all the above KPIs.



Haemato-oncology data is included in all the above KPIs.



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

	KEY: Better than target	Green
	Below target	Red
	Below target but within acceptable limits	Amber
Key Indicator		
Group Surplus (incl Charity) of £4,305k against a planned surplus of £4,012k		Amber
Trust net surplus of £2,598k vs a planned surplus of £1,798k		Green
Net Trust I&E margin of 2.0% vs a planned margin of 1.5% (excludes impairments)		Green
NHSI Control total of £1,578k against actual year to date comparator of £3,619k		Green
Actual CIP achieved £1,693k against a plan of £1,340k		Green
Capital expenditure at £50,718k against a plan of £65,495k		Amber
Cash balances at £56,867k are £6,816k below planned balances of £63,683k		Amber
CQUIN funding of £1,437k against a plan of £1,762k		Red

Use of Resources: Risk Rating	
Capital Service Cover rating of 2 (against a plan of 2)	
Liquidity Rating of 1 (against a plan of 1)	
I&E Margin of 1 (against a plan of 1)	
Variance from Control Total rating of 1 (against a plan of 1)	
Agency spend of £896k, which is £63k below NHSI agency ceiling year to date – 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 – January 2019	
Agency medical locums £589k against a target of £417k	
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) The target of =<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 January 2019 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 December 2018 report. There are no new KPIs in any section in the January 2019 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 Sick days for medical and dental staff Ratio of occupied beds to other clinical 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. Ratio of delayed transfers and number of occupied beds
KPIs removed from these sections since the November insight report:			
None	None	None	None

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

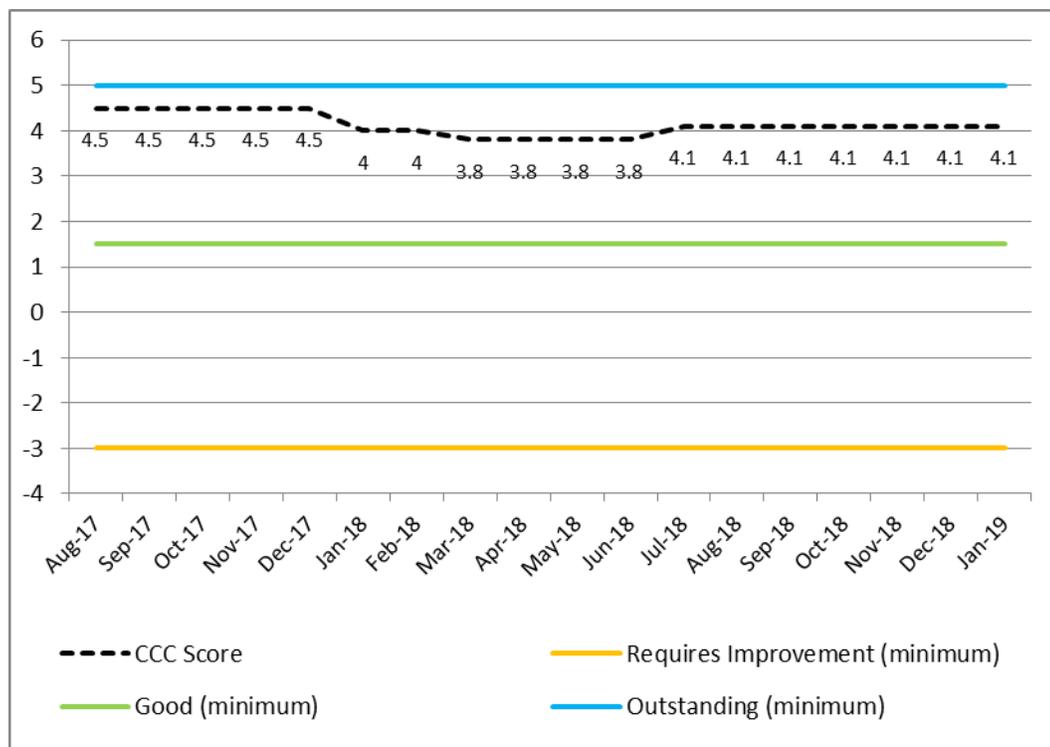
KPI	Definition	Latest performance	Previous performance	National Average	Comments / Actions
Much worse compared nationally					
Stability of Nursing and Midwifery staff	Retainment of the experienced workforce (employees with greater than 1 years' service). Lower = worse.	0.59 (July 2017 – June 2018)	None 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 produce an	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 results will be reviewed</p>

KPI	Definition	Latest performance	Previous performance	National Average	Comments / Actions
	engagement score on a scale of 1-5. Lower = worse.				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 page 27 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)	2.56 (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.
Ratio of delayed transfers and	Numerator: The total number of days delayed over the	0.01 (July 2018 –	0 (June 2017 –	0.02	This has increased from 2017 to 2018, however it is still 50% below,

KPI	Definition	Latest performance	Previous performance	National Average	Comments / Actions
number of occupied beds	quarter where the delay is attributable to the NHS. 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	Sept 2018)	Sept 2017)		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 submission for all except 1 CQUIN. Final assessment on the Q3 submission is likely to be made in early March 2019. 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 likely specialised commissioning CQUIN schemes have 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 wellbeing; MSK and stress.	£26,217	N/A								
Healthy food for NHS staff, visitors and patients		N/A								

CQUIN	Value	£ withheld in 18/19	2017/18				2018/19			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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 (Q3 not confirmed)								
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	£0								
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 (Q3 not yet confirmed)								
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								
Dose Banding: Standardise the doses of SACT in all units across England in order to increase	£210,915	£0								

CQUIN	Value	£ withheld in 18/19	2017/18				2018/19			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
safety, to increase efficiency and to support the parity of care across all NHS providers of SACT										

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.

Optimising Palliative Chemotherapy	
Reason for non-compliance	
<p>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. The commissioners' initial assessment of Q3 2018/19 is that CCC has again failed to achieve this CQUIN. Additional information will be provided by the project team prior to the commissioners' deadline for Trusts to provide further evidence.</p>	
Action Taken to improve compliance	
<ul style="list-style-type: none"> • The Meditech system has been amended to enable easier capture of these conversations and we expect compliance to improve in Q3 as a result. • The Pharmacy Team is working with the lead clinician to develop a system that will enable the peer discussion. • 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, Partial 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

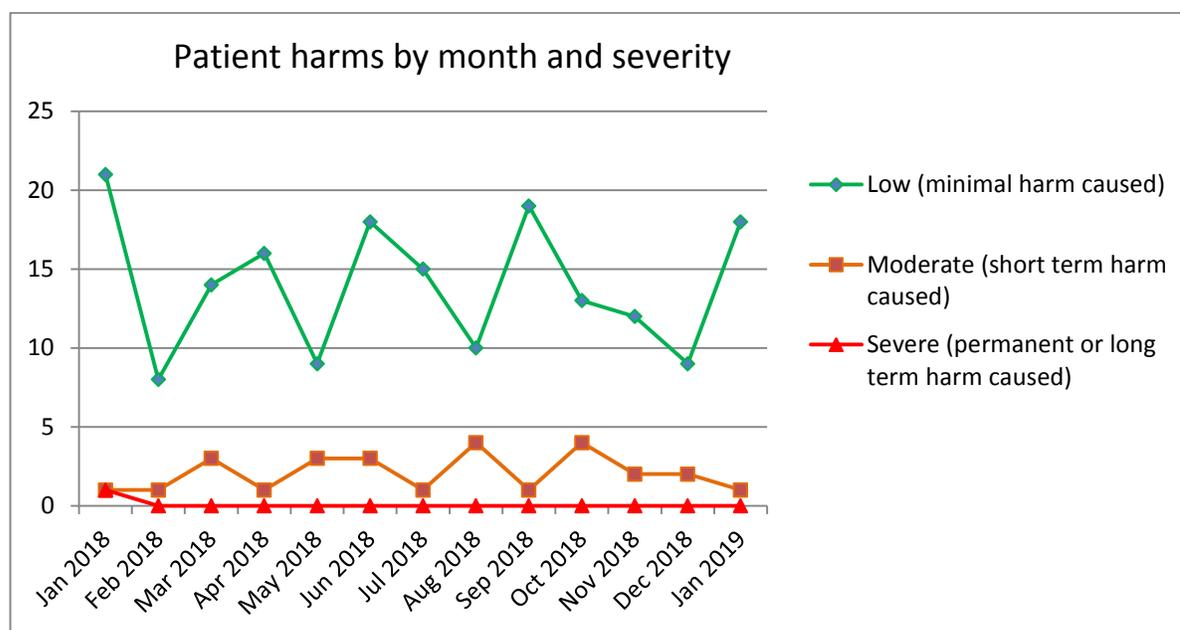
1. Safe

1.1 Never Events

There have been 0 never events from 1/4/18 – 31/01/19.

1.2 Incidents

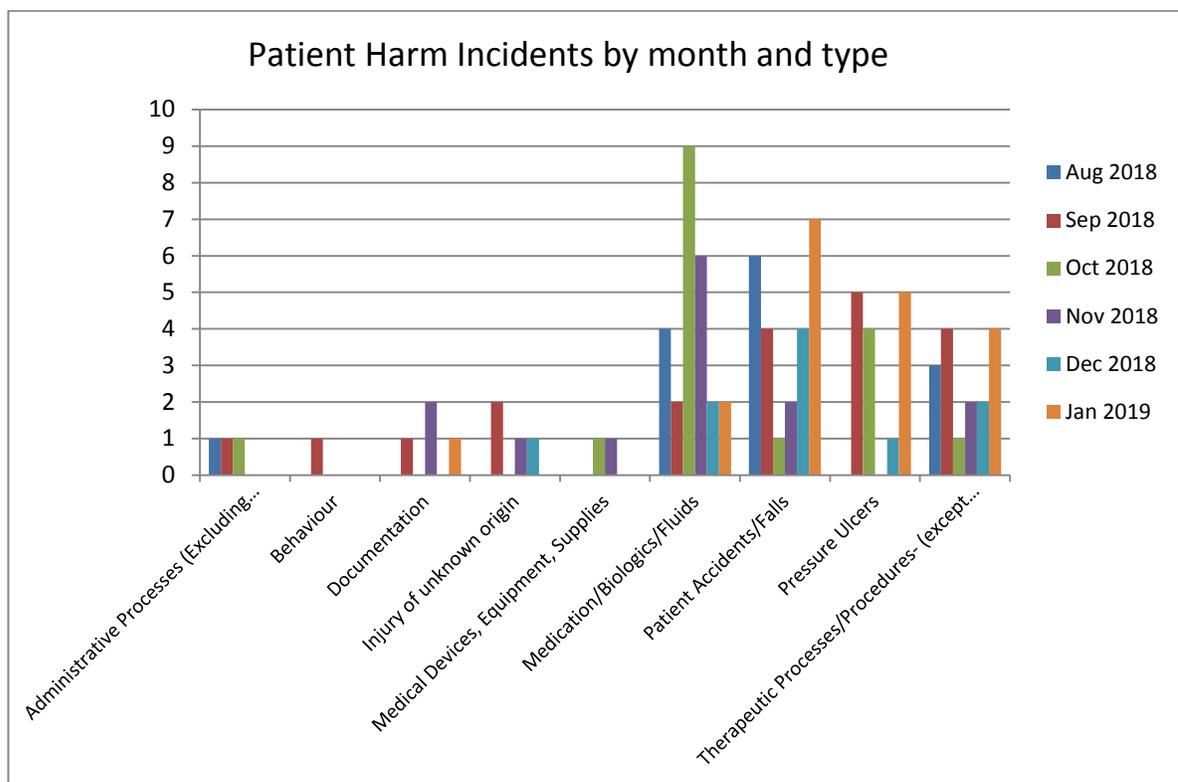
The chart below shows incidents resulting in harm, by level of harm and month from 1/1/18-31/01/19



The one moderate harm In January 2019 was a patient fall at HO:

The patient was sitting on the edge of the bed with a student present and said he felt sick, the student went to make nurse aware and returned to find the patient on the floor. The patient was assisted back to bed and with a doctor present, obs were taken, ECG carried out and the doctor reviewed the patient. The patient said he didn't know whether he felt dizzy and fell or blacked out. The patient had a bump to the head said he had hit it on the drip stand. The patient had a vasovagal attack. He was seen by the doctor and had some bleeding and bruising on the face. A CT scan was ordered and it was NAD. A review by the Matron and Quality Improvement Manager is underway.

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

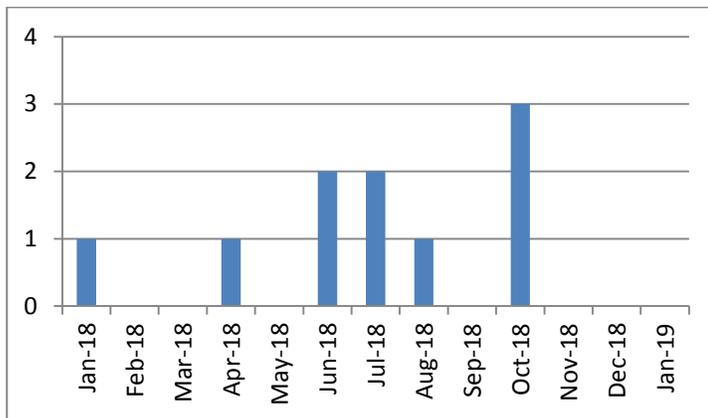


Falls, VTEs and pressure ulcers are reviewed at the harm collaboration meeting. The pressure ulcers reported here include those not attributable to CCC i.e. the patient was admitted with a pressure ulcer or it developed within 72 hours.

Serious untoward incidents:

There were no serious incidents in January 2019

Serious Incidents by month



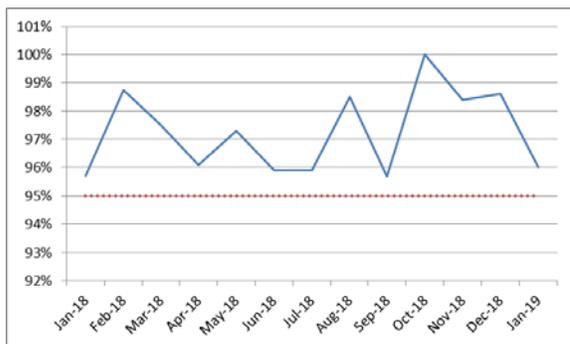
Inquests/Coroner's investigations

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

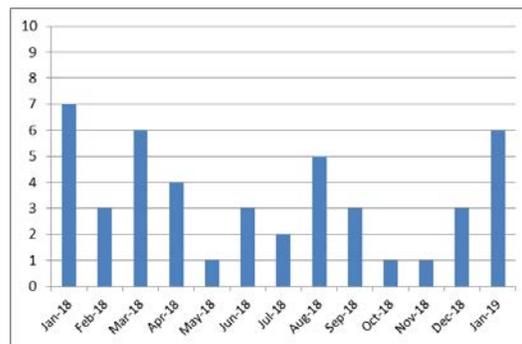
1.3 Harm Free Care

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

Safety Thermometer (CCC harm free) | Falls resulting in harm

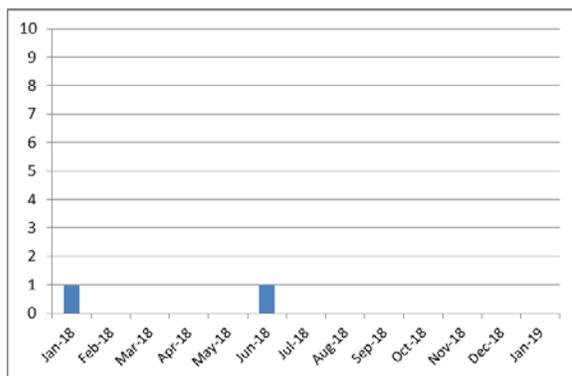


The target of 95% is consistently achieved.



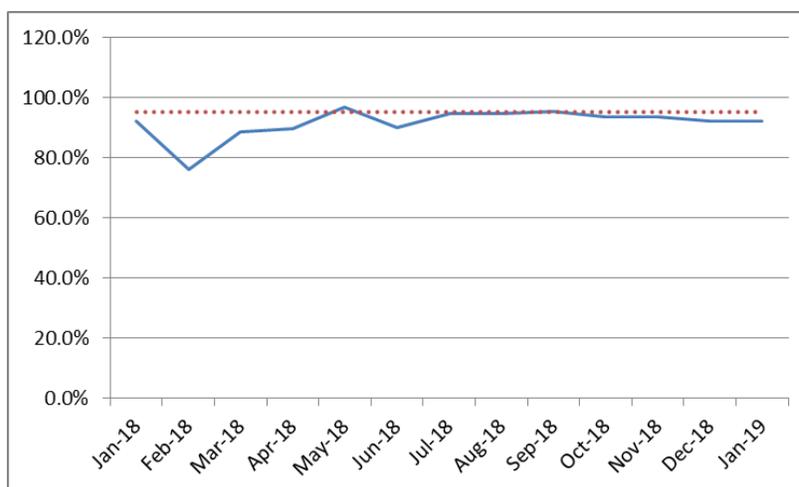
All falls are monitored and reviewed by the Falls and Manual Handling group. There is a falling trend over the last 13 months.

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



VTE risk assessment compliance by area for January 2019:

Ward / Directorate	Total Patients	Total Assessed	% compliance
Conway	15	15	100%
Mersey	24	23	95.83%
Sulby	51	39	76.47%
CDU	95	95	100%
Haemato-oncology	7	5	71.4%
CCC Total	192	177	92.2%

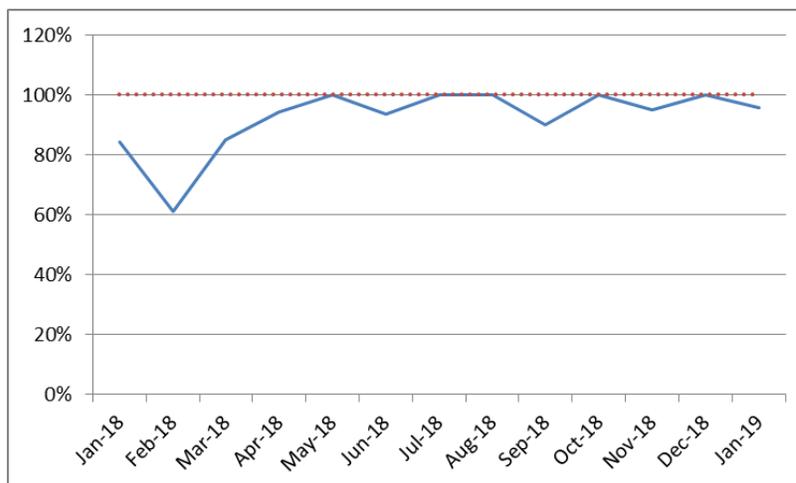
Compliance has improved in 2018/19; however the Trust is not consistently achieving the target.

Further review highlighted that a number of patients who have been admitted to Sulby ward are transferred to theatre before the medical staff reach the ward. It has also highlighted that this ward does not always have a designated medic if the other wards and CDU are busy.

Actions in place:

- Medical lead for VTE has re-enforced process to medical staff during hand over meeting to ensure that a medic is allocated to Sulby ward to complete outstanding jobs.
- 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.
- Quality Improvement Manager will also highlight to ward doctors on a daily basis the missed VTE assessments and request their completion. The ANP team will also pick these patients up to avoid them being missed. Admission list to be given to ANP on duty each morning.
- Compliance will be a standing agenda item on IC directorate Quality and Safety meeting monthly.
- Ward screens have been placed on all wards and are now in use.
- Flowchart developed for doctors' offices to provide further guidance to which patients require a VTE risk assessment.
- From March 2019 4 physician associates will be in post and will take responsibility for ensuring completion of VTE assessments.
- E prescribing due to be rolled out April 2019. Although details not yet finalised, a prompt or alert to be added to remind medics to complete VTE assessment.
- Weekly performance report until target is met.

Sepsis (IV Antibiotics within 1 hour)



Compliance has improved in 2018/19; however the Trust is not consistently achieving the target.

In January 2019, 1 patient did not receive IV antibiotics within an hour due to difficulties in obtaining access. This was achieved after a further 40 minutes. The patient was treated for confirmed neutropenic Sepsis and went home after 8 days.

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 sepsis screening and review tool went live in Meditech in December. This supports the appropriate management of the patient, ensuring national guidance is followed and ensures accurate documentation.

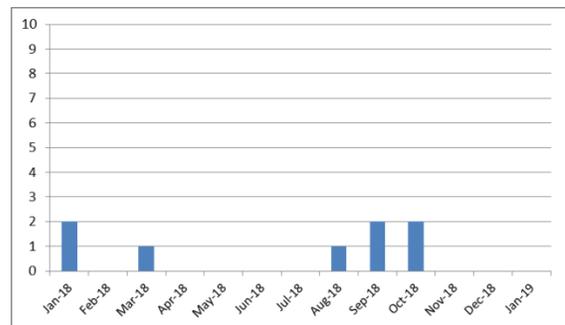
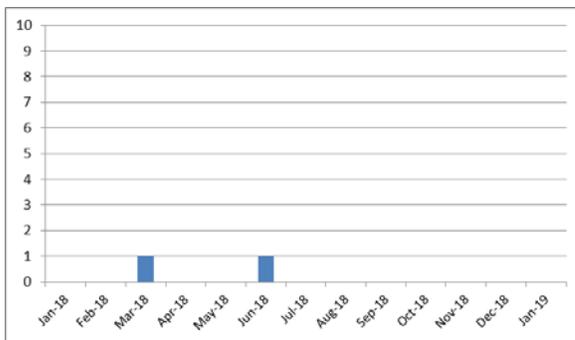
Dementia Screening, Assessment and Referral:

Compliance remains at 100% for January.

Health Care Acquired Infections

This section relates to 'reportable' bacteraemia.

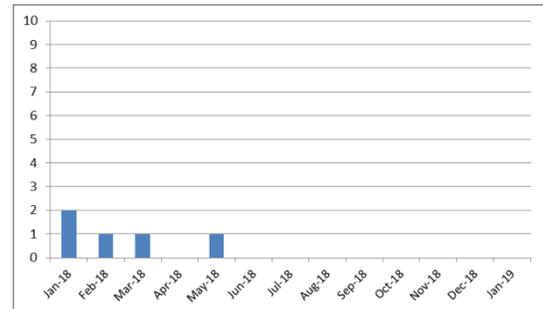
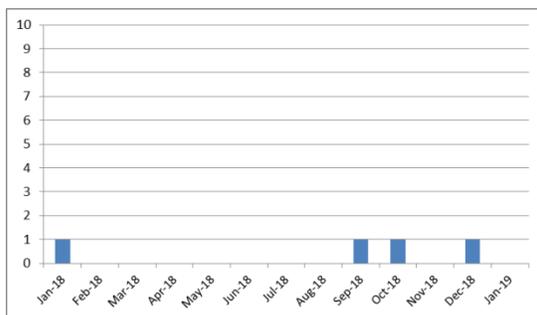
C difficile (attributable) | Threshold for 2018/19 =<4 **E Coli (attributable)**



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 January. All Bacteraemia cases are summarised and presented for review to the Harm Free Care Collaborative with actions agreed and followed up by the group.

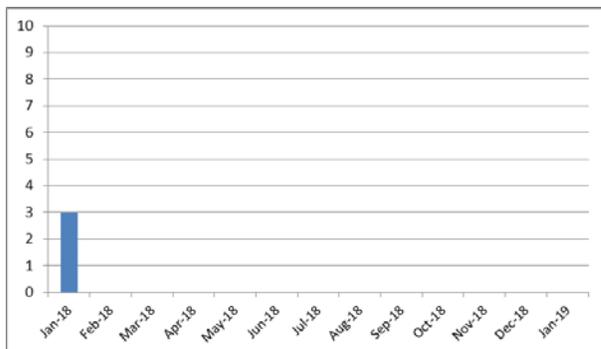
MSSA (attributable) **Klebsiella (attributable)**



There were no attributable cases in January.

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

Pseudomonas (attributable)	MRSA
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There were 0 cases of MRSA in 2017/18 and 0 from 1/4/18 – 31/01/19.

There have been no attributable cases in 2018/19.

'Non reportable' bacteraemia

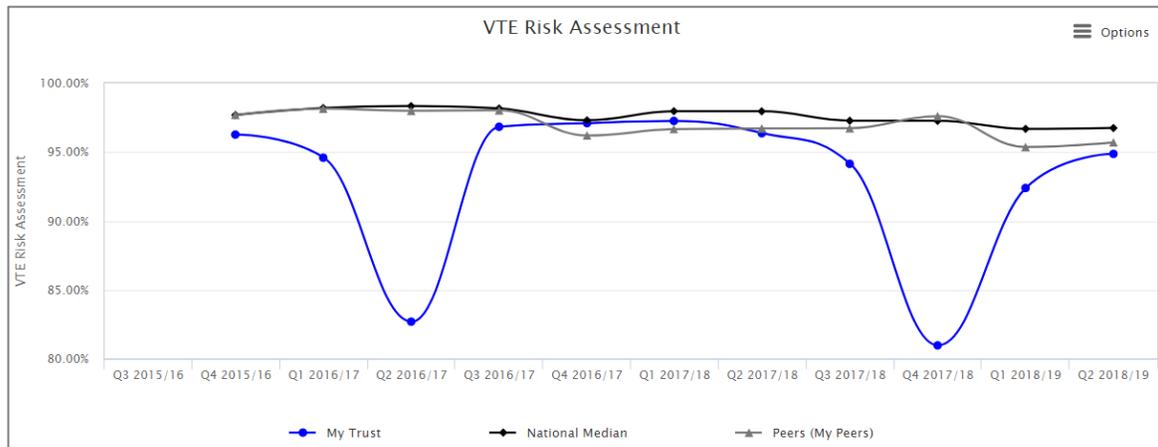
There is nothing to report for January 2019.

Benchmarked patient harm data:

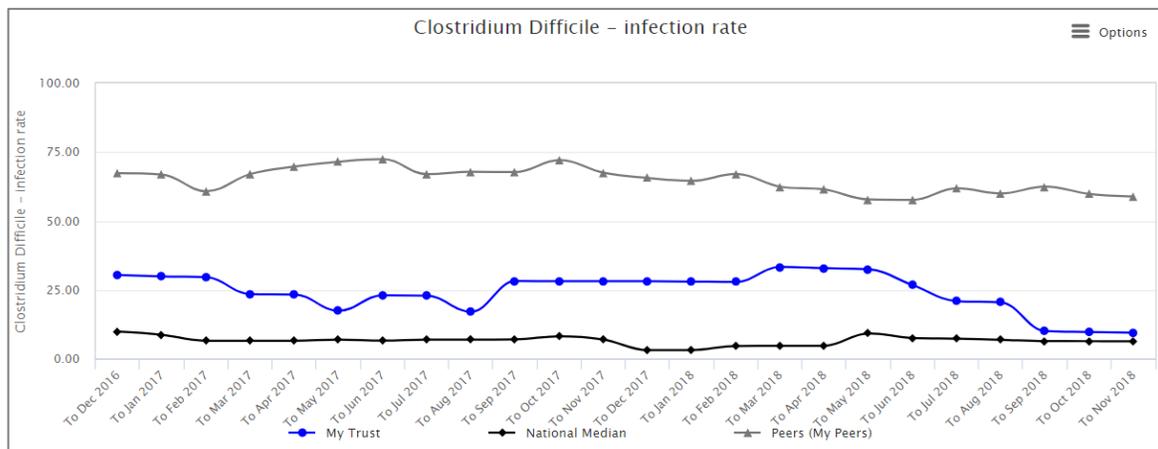
Safe	Data period	Trust value	Peer median	National median	Chart
VTE Risk Assessment	Q2 2018/19	■ 94.86%	95.70%	96.75%	
Clostridium Difficile - infection rate	To Nov 2018	■ 7.35	48.59	5.16	
MRSA bacteraemias	To Mar 2018	■ 0.00	2.61	0.00	
Potential under-reporting of patient safety incidents	30/11/2016	■ 0.12	0.07	N/A	No chart available
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Nov 2018	■ 66	120	16	
Meticillin-sensitive staphylococcus aureus (MSSA) rates to quality indicators	Nov 2018	■ 7	12	9	

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

VTE Risk Assessment (no update since last IPR)

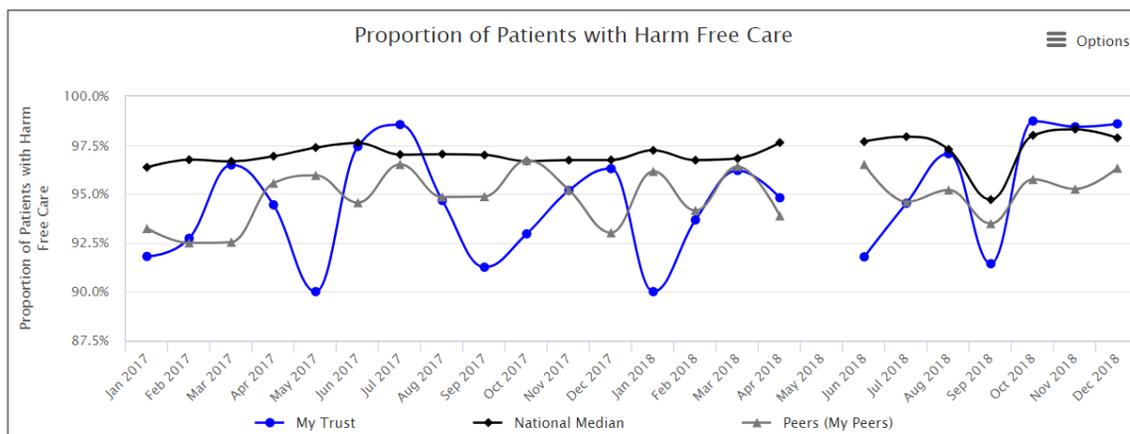


Clostridium difficile: infection rate (no update since last IPR)



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



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

January 2019 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										
Conway	1992	1836	744	708	1116	1116	744	732	92.2%	95.2%	100.0%	98.4%
Sulby	918	840	216	120	156	156	36	36	91.5%	55.6%	100.0%	100.0%
Mersey	2340	2064	744	492	1116	1116	744	504	88.2%	66.1%	100.0%	67.7%
7Y	1860	1478.3	930	702.5	713	747.5	713	678.5	79.5%	75.5%	104.8%	95.2%
10Z and 7X	1982.5	1945	632	599	976.5	1039.5	546	546	98.1%	94.8%	106.5%	100.0%

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

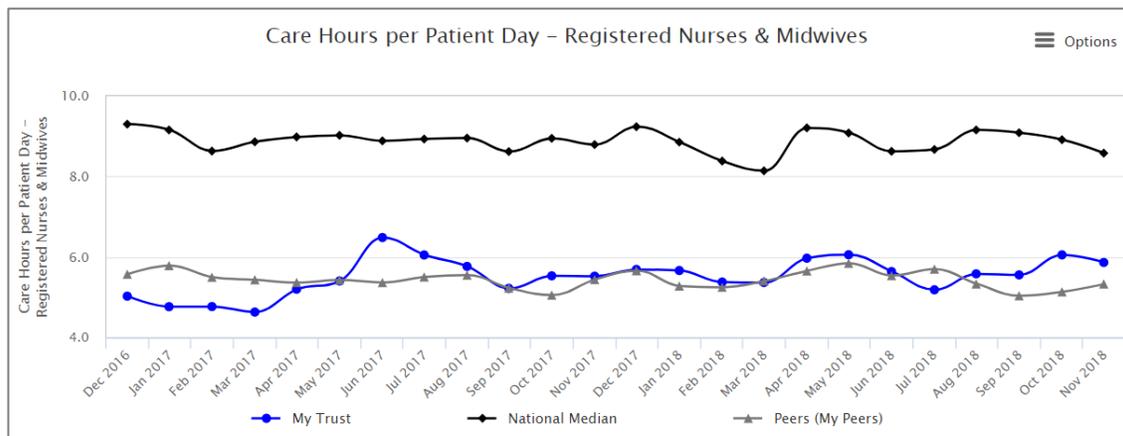
Care hours per patient day are calculated by dividing the total numbers of nursing hours on a ward or unit by the number of patients in beds. This calculation provides the average number of care hours available for each patient on the ward or unit.

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Trend
Care hours per patient day: Conway Ward	6.2	5.7	6	6.5	7.5	7.4	8.4	7.6	6.8	6.8	7.4	7.9	6.8	
Care hours per patient day: Sulby Ward	14.8	15.4	10.4	12	14	13.4	8.7	16.1	15.8	17.3	20.2	6.6	22.6	
Care hours per patient day: Mersey Ward	7.3	6.9	7.3	9.2	9.4	7.6	7.2	8.0	7.2	8.3	7.9	8.3	6.4	
Care hours per patient day: 7Y	5.7	5.7	5.5	5.7	5.6	5.8	5.5	5.7	5.7	5.9	6.2	6.0	5.8	
Care hours per patient day: 10Z and 7X	12.9	12.4	13.6	14.4	10.4	18.8	14.7	13.1	13.9	16.9	12.7	15.0	14.6	

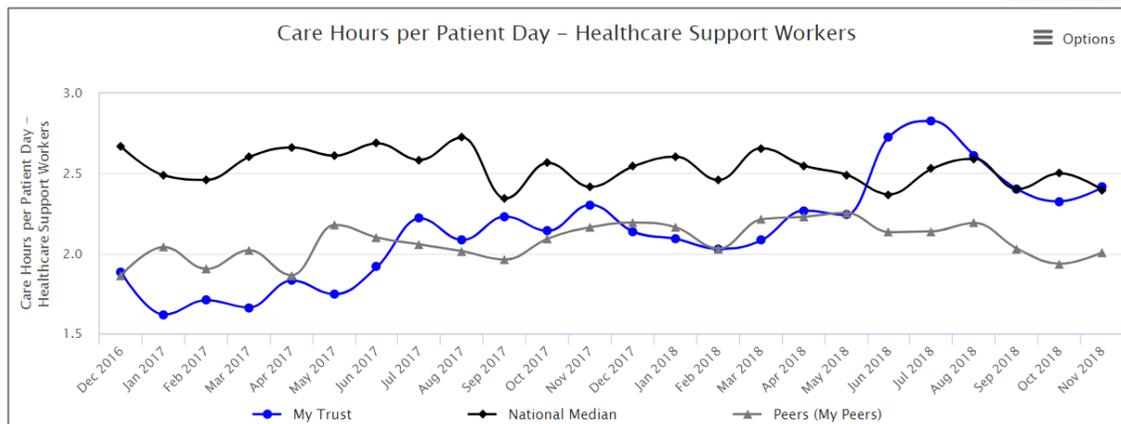
CHPPD benchmarked:

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 (although a higher number of registered nurses since August 2018) 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 still 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

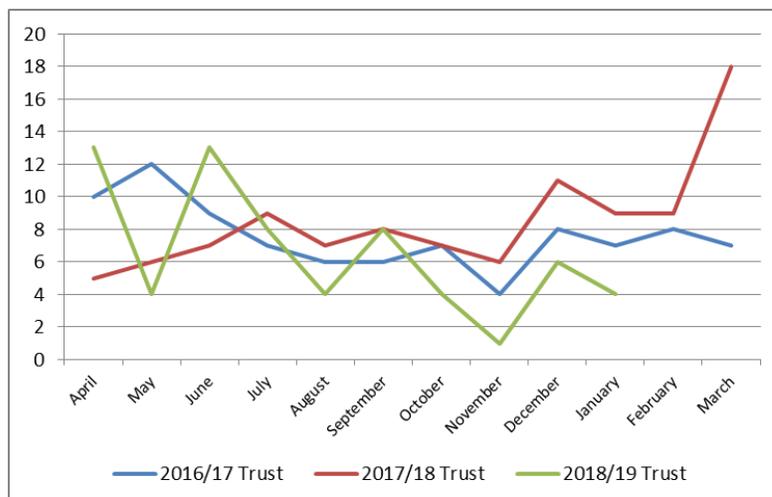
2.1 Clinical Outcomes

Mortality

Inpatient deaths:

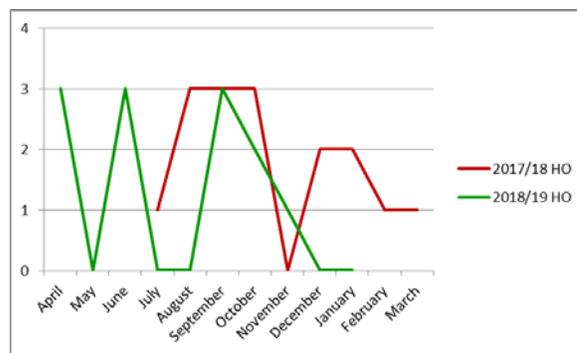
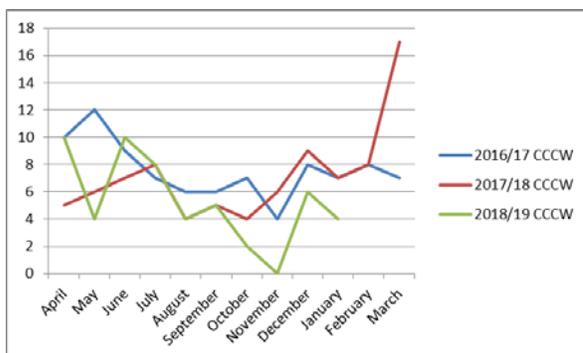
These charts show firstly all CCC inpatient deaths, followed by CCC Wirral only and Haemato-oncology only.

All CCC inpatient deaths



CCC Wirral wards

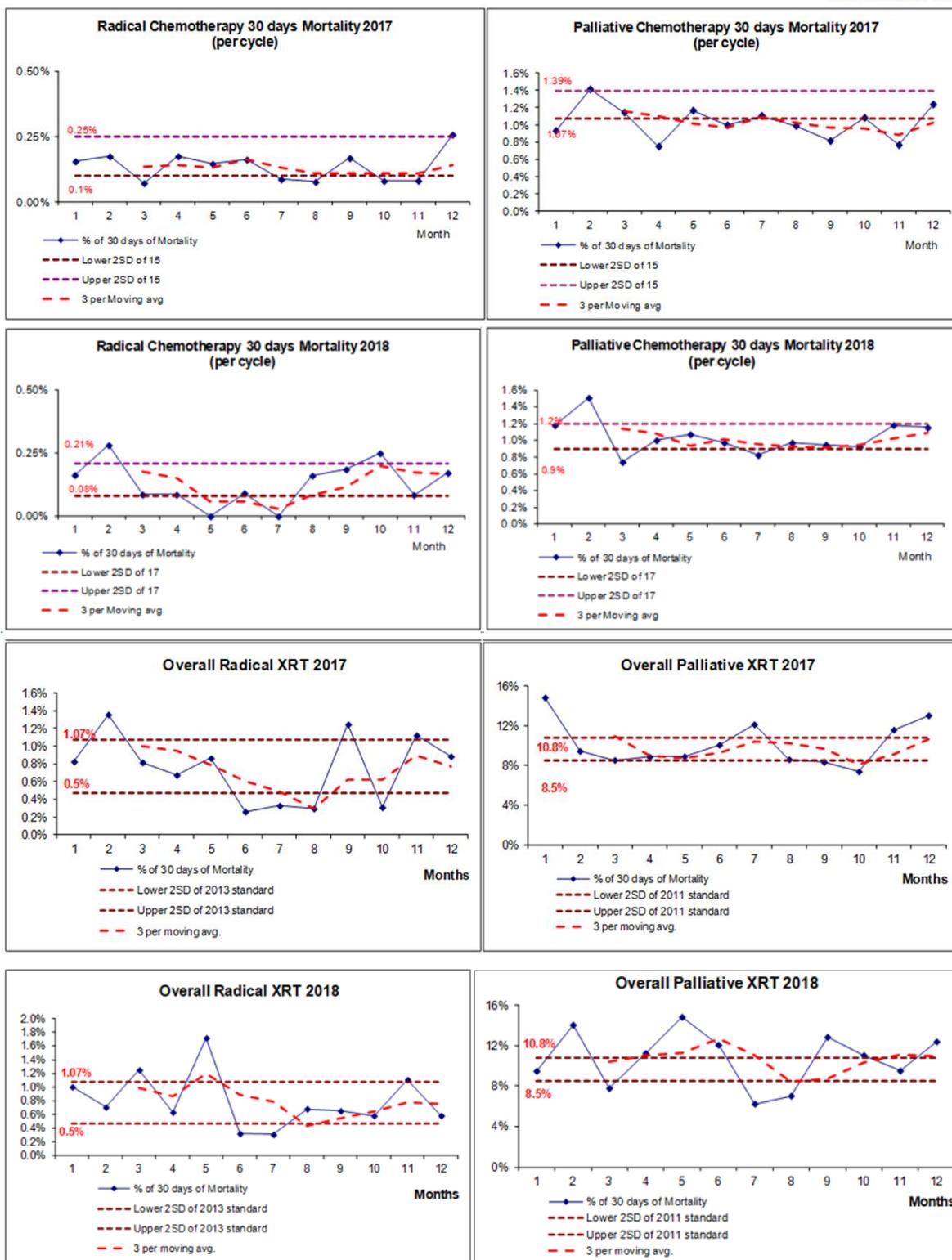
CCC HO wards



The charts reveal no significant change over the three years to date although CCCW monthly figures for the last 4 months have been 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 and 2018). This information is utilised alongside the outcomes of mortality reviews by the Mortality Surveillance Group, to provide assurance regarding the efficacy of treatment provided and the avoidance of harm.

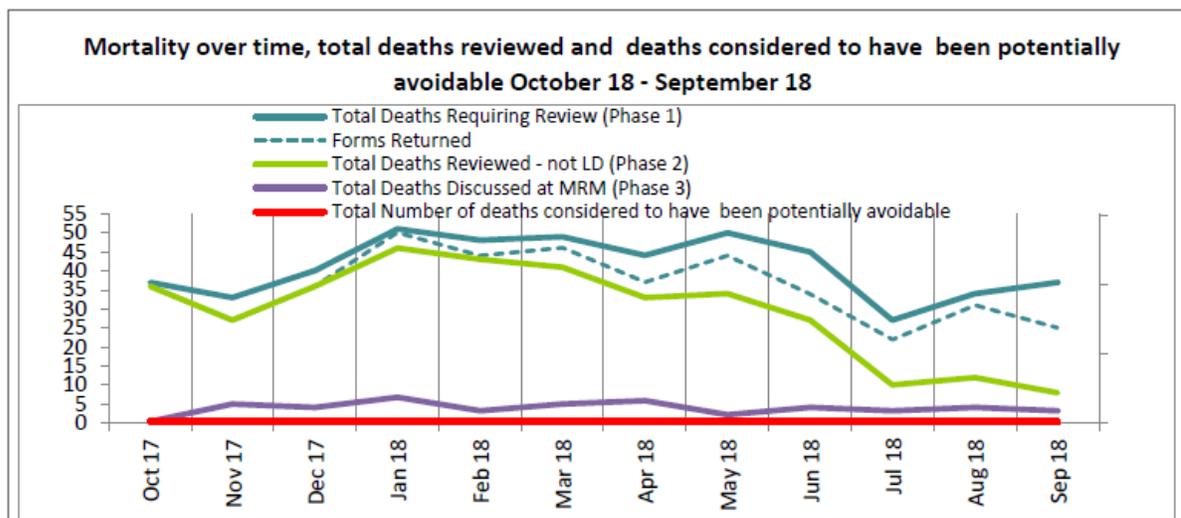


Mortality Review:

The Trust mortality review process adheres to the 2017 NHSI ‘learning from deaths’ Guidance. HO deaths are currently not included in the data below due to delays in receiving the data, which is captured on a different EPR.

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.



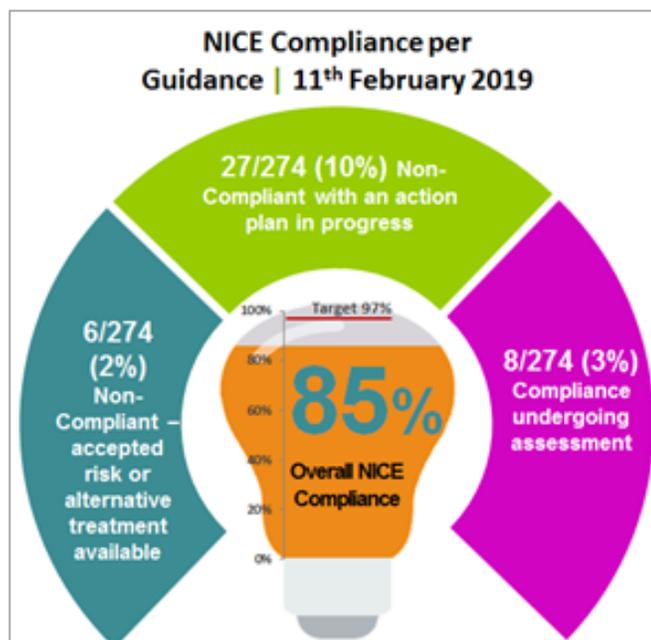
NB: A judgement on avoidability of death is only made on inpatient deaths.

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

This diagram shows the latest compliance with NICE guidance. There has been no change since last month.



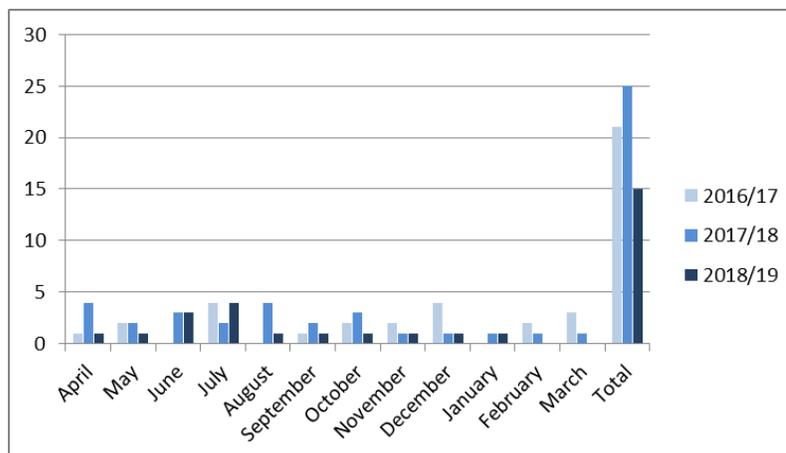
The Trust's NICE Committee is responsible for expedited implementation, including prioritising guidance for which non-compliance presents the greatest potential risk to patients. NICE compliance information is included in each Directorate data pack, which is reviewed monthly at each Directorate quality and safety meeting

3. CARING

3.1 Complaints and PALS

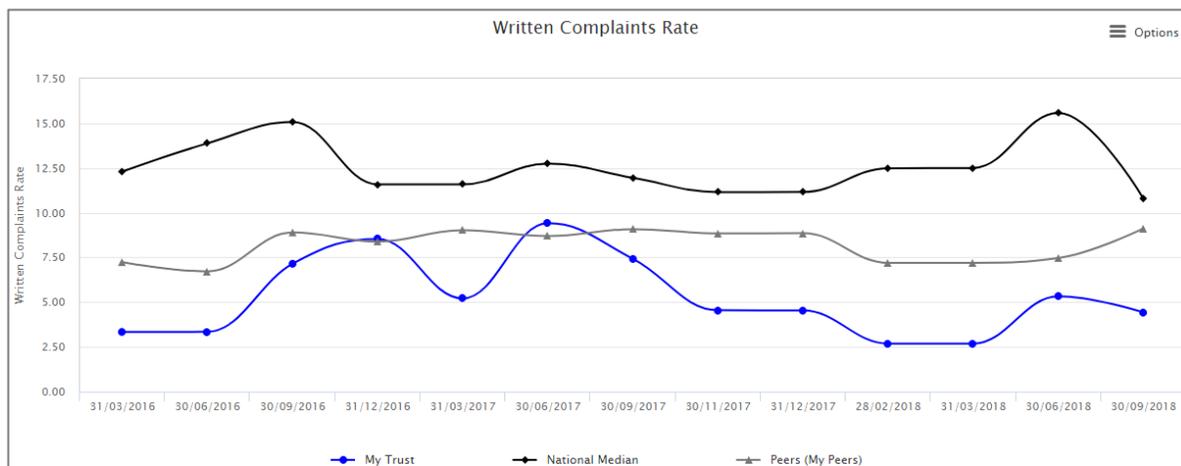
Complaints:

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 totals 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. This chart has not been updated on the Model Hospital portal since the last IPR.



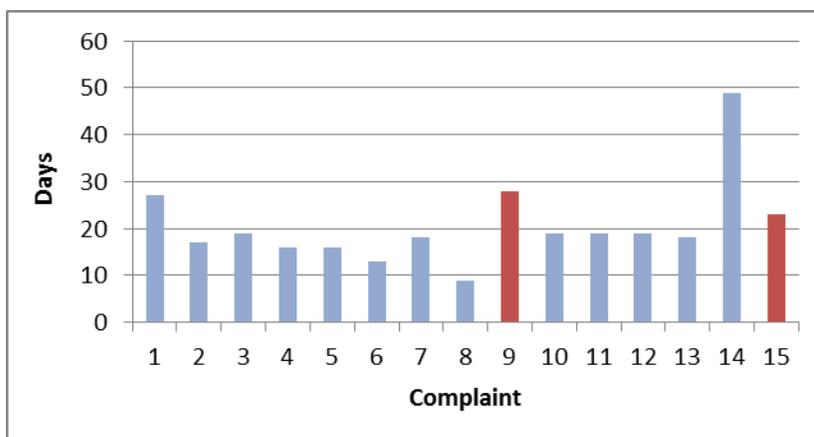
The table below provides a summary of the complaints received in 2018/19 (as at 13/02/19)

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	The Action plan has been sent to the	Moderate	Partially Upheld

Received	Complaint Type	Description	Lessons learned	Grade	Complaint Outcome
		news.	complainant.		
24/05/2018	Treatment and Care	Pt unhappy that side effects of chemo were not fully explained.	To ensure Pts have full understanding.	Low	Partially Upheld
03/06/2018	Treatment and Care	Patient's wife and daughter unhappy with communication and have questions about the sudden death of the patient.	Meeting to be arranged once complainant responds.	Very low	Not Upheld
05/06/2018	Communication	Pt complained that the booked interpreter did not attend his appointment. He also requested his own interpreter for next appointment in November.	The translation process is being reviewed.	Very low	Not Upheld
06/06/2018	Communication	The patient's daughter emailed with 3 separate issues concerning her mother's treatment at LMC- re transport, future appointments and scan times.	Acknowledge patient should have received future dates, staff has been reminded to give appointments before Pt leaves department.	Very low	Partially Upheld
09/07/2018	Other	Family have raised concerns relating to content of discharge letter- lack of communication around TTO's, DNAR process and communication relating to chemotherapy.	Action plan created and to be monitored at IC monthly meetings. 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 NWAS 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

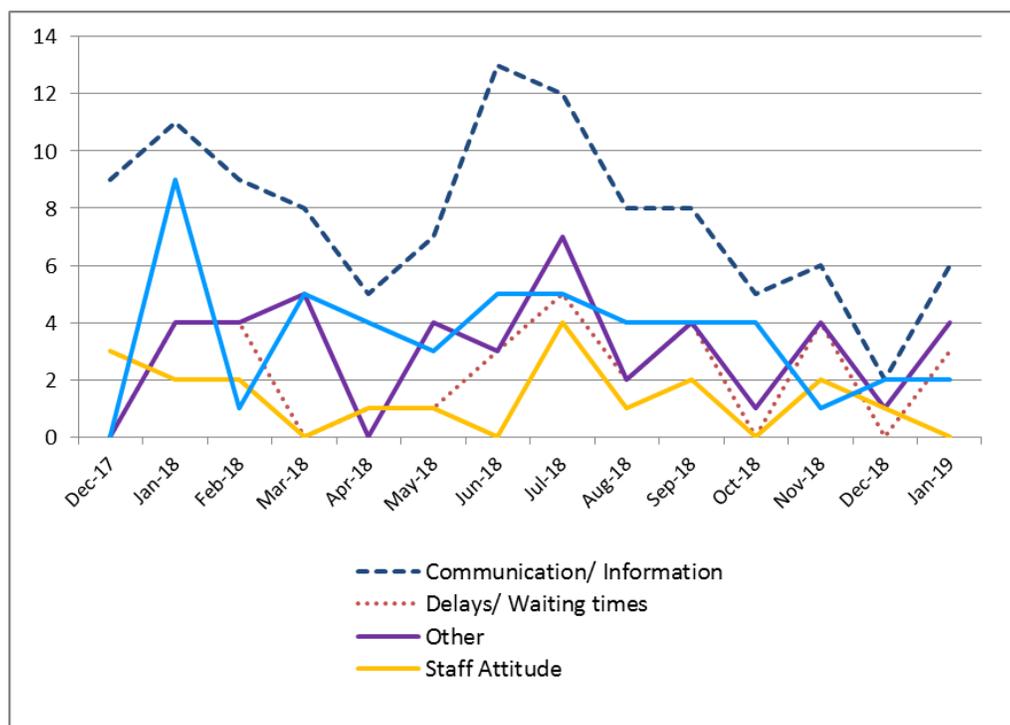
Received	Complaint Type	Description	Lessons learned	Grade	Complaint Outcome
18/09/2018	Treatment and Care	Unhappy with care. Noise at night. Patient fall.	Apologised and offered explanation. Senior staff did not review patient after fall in a timely manner. Staff reminded of escalation process and also 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.
15/11/2018	Treatment & care	Pt unhappy that they were not contacted when we became aware of late effects of Treatment	Not yet known	Low	Under investigation
28/12/2018	Staff attitude	Pt unhappy with attitude of staff member on ward	Staff reflected on their behaviour and shared with their Manager	Low	Upheld
02/01/2019	Discharge	Relative unhappy that patient was sent home without appropriate care at home and TTH's not explained.	Discharge Policy currently under review	Low	Partially upheld

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 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 and minor concerns.

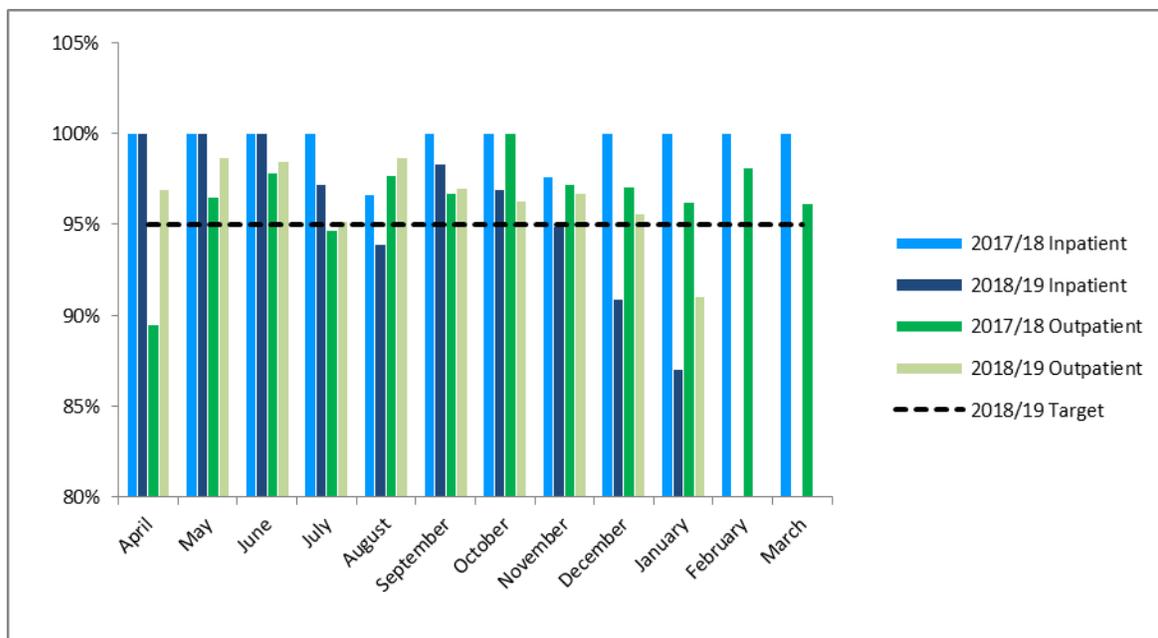
Whilst not featuring in the top 5, the following 'care' related contacts were also made in this period:

Category	Total contacts
Admissions, Discharge and Transfer	12
Consent	1
End of Life	2
Privacy, Dignity and Wellbeing	6

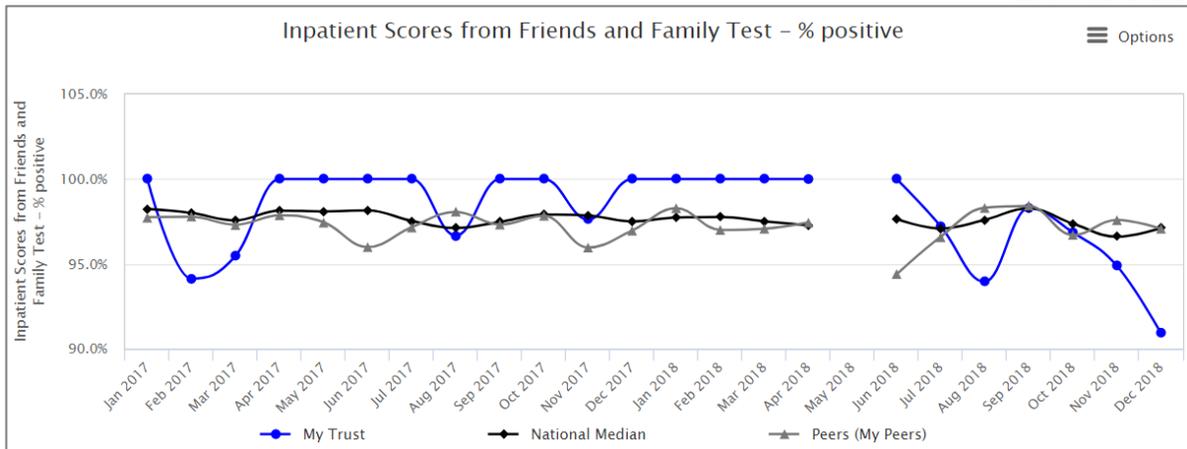
3.2 Surveys

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 three times to date in 2018/19. There was an increase in the number of patients who answered 'don't know' in December and January, resulting in a fall in the % of patients 'likely' or 'extremely likely' to recommend the Trust to friends and family. The comments tend to positive despite selecting 'don't know' therefore the digital data capture system is being reviewed to understand this further.



Benchmarked data: inpatient scores

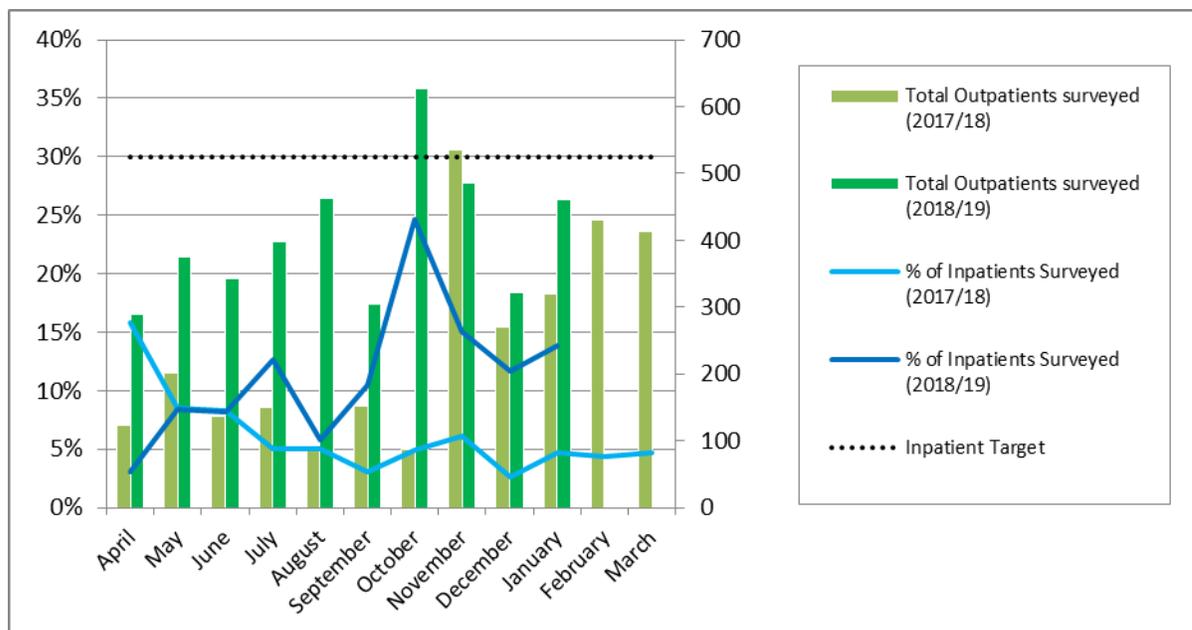


There is no data available for other trusts for outpatient scores on the Model Hospital

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 fall in both the number of outpatients surveyed (to 321) and the % of inpatients (to 12%) in December, outpatients have risen significantly to 461 and there has been a marginal increase to 14% for inpatients.

Matrons' action plans are monitored at the directorate Quality and Safety meetings and also discussed at the monthly Directorate performance meetings and Operational Delivery and Service Improvement Sub Committee.



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	Jan-19	Trend
% of admissions that had a partners in care assessment	13%	66%	90%	88%	84%	90%	88%	88%	90%	91%	

3.4 Claims

Open claims: there are 12 open claims in total as detailed in the table below. In addition there are a further 20 potential claims, i.e. the Trust has received notification that solicitors are investigating a potential claim. One new claim was received in January 19.

Claim Ref	ID	Date of claim	Nature of Claim (Alleged failure)	Progress/Action	Status
Clinical Negligence					
2018/40	40	25/1/19	Alleged failure to measure the tumour before starting chemotherapy, failure to change chemotherapy in light of disease progression, failure to initiate radiotherapy, delay in restarting treatment after surgery and incorrect treatment post op.	Reported to NHSR. Hill Dickinson instructed. Reports to be completed.	Letter of Claim
2017/21	21	5/11/18	Mismanagement of cancer treatment, including failure to identify/diagnose/treat inflammatory myofibroblastic tumour.	Reported to NHSR. 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 NHSR. Consultant comments uploaded. Experts instructed.	Letter of Claim
2018/02	27	10/10/18	Failure to check blood results prior to treatment.- Serious Incident Nivolumab ID 2224	Reported to NHSR. Panel solicitors instructed.	Letter of Claim
2018/33	33	28/08/18	Named as 5th Defendant -	Reported to NHSR. Panel	Particulars of

			allegations relate to the failure to request urgent for MRI, failure to consider presenting symptoms, delay in referring for treatment for metastatic treatment.	solicitors instructed. Defence due May 19.	Claim
2018/29	29	29/8/18	Extravasation	Reported to NHR. Panel solicitors instructed. Experts instructed, reports reviewed. Letter of Response served.	Letter of Response
2015/07	10	1/6/17	Misdiagnosis of brain metastases resulting in unnecessary radiotherapy	Reported to NHR. Panel solicitors instructed. Letter of Response sent. Case management conference set March 19.	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. NHR 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 NHR. 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 NHR to assess quantum and negotiate settlement. Still awaiting medical evidence.	Letter of Response
Public Liability					
2017/12	12	31/5/17	Needlestick	Reported to NHR – Admission. Awaiting medical evidence.	Letter of Response

4. RESPONSIVE

4.1 Cancer Waiting Times Standards

National Standards

*January figures are accurate as at 11th February, but are not finally validated until 5th March.

Standard	Target	Q1 2018/19	Q2 2018/19	Q3 2018/19	January 2019*
62 Day (pre allocation)	85%	59.4%	60.4%	55.5%	55%
62 Day (post allocation)	85%	87.4%	86.5%	87.5%	81.1%
31 Day (firsts)	96%	98.2%	96.6%	98.4%	99.2%
18 Weeks – incomplete pathways	92%	97%	98%	96%	93.6%
Diagnostics: <6 week wait	99%	100%	100%	100%	100%
2 Week Wait	93%	100%	97%	83%	100%

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 January reveals a lack of compliance with the 62 Day post allocation figure, at 81%. The breach details are as follows:

Pt	Day into CCC	Days at CCC	Treated on Day	Tumour	Referring Trust/s	Treatment	Reason	Avoidable Breach
Full breach to CCC: Patient received by CCC before day 38								
1	37	34	71	H&N	WHH/Whiston/Aintree	Curative RT/Chemo	Capacity Dental (14 days) & PEG due to Christmas dates	Yes
2	36	37	73	Skin	Wirral	Radical RT	Patient choice & Out-patient capacity to 1st app 22 days. Pt choice of start date due to holidays, could have been treated within 62 day target	Yes
3	0	89	89	HO	CCC		Admin delay to MDT and biopsy booked as routine in error.	Yes

Pt	Day into CCC	Days at CCC	Treated on Day	Tumour	Referring Trust/s	Treatment	Reason	Avoidable Breach
4	35	36	71	LGI	Aintree	Palliative Chemo	Out-patient capacity to 1st app 22 days. Chemotherapy provisionally booked to start within target but scheduler not aware of regime & pt needed PICC therefore chemotherapy cancelled and appointments rearranged	Yes
5	36	28	64	Lung	Whiston	Palliative Chemo	Admin delay to treatment being prescribed due to unexpected consultant leave - Chemotherapy not prescribed in his absence & major IT incident 28/1 therefore chemotherapy deferred	Yes
Half breach to CCC: Patient received by CCC before day 38 but not treated within 24 days								
6	78	28	106	Haem	COC	Radical RT	Admin Delay to treatment outlining due to consultant availability, annual leave & cross cover & pt DNA	Yes
7	46	29	75	HPB	SORM	Palliative Chemo	Patient choice thinking time and start date	No
8	43	28	71	H&N	Wirral/ Aintree/ ?COC	Curative RT/Chemo	Slight delay to tx plan - Delay due to treatment breaks over Christmas	Yes
9	55	25	80	LGI	SORM	Radical RT/Chemo	Patient choice of tx planning app 2/1 (pt offered 31/12 but declined) & cat 1 (Slight delay out-pt app (8 days 1st appt 28/12)) breached by 1 day	No
10	49	28	77	H&N	WHH/ Whiston/ Aintree	Radical RT	Dental capacity & delay to RT due to dr's outlining	Yes
11	42	40	82	H&N	Whiston/ Aintree	Curative RT/Chemo	Capacity dental & PEG - 7 days to 1st appt 9 days to M/R 5 days to dentist (next slot) 6 days to PEG (?cancelled due to major accident) 2 days to new PEG date 11 days to CRT	Yes
12	51	25	76	LGI	Whiston	Neo-adj RT/chemo	Out-patient capacity, slight delay to 1st app & RT booked within target but not outlined in time therefore moved by 1 day	Yes
13	219	32	251	HPB	RLH/Aintree	Palliative Chemo	Medical f/u rearranged as pt having cardiac investigations and slight delay to 1st app 11 days due to out-patient capacity.	No
14	124	38	172	Gynae	LWH	Palliative RT	Out-patient capacity to 1st app 16 day & pt thinking time	Yes

The Trust's Cancer Waiting Times Improvement Plan has recently been reviewed and shared with NHSI. Key actions and assurances in the plan are as follows:

System wide:

- System wide tumour specific pathway work led by Cancer Alliance (part funded by CCC) with Aintree University Hospital Trust leading on H&N and UGI.
- CCC to explore reinvestment of pathways funding to host a Merseyside and Cheshire performance group in partnership with the Alliance.

- CCC to submit a bid for additional funding to create extra MRI capacity for the M&C region.
- CCC supporting the STP Radiology Working group to identify a solution to the radiologists' workforce crisis.
- CCC appointed one new radiologist, 1 post vacant.
- CCC secured external support for additional radiologist reporting sessions to maintain a safe service.
- CCC leading & supporting the vague symptoms programme to ensure patients are referred to secondary care on the correct 2 wr pathway.
- CCC supporting some secondary care and primary care providers by offering advice and guidance prior to the GPs making a referral, (main areas of focus are RLBHHT and St Helens & Knowsley NHS Trust).
- CCC to enhance communication and feedback with referring trusts regarding breaches.
- CCC HO team supported LCL with recruitment of additional staffing for the Haematology Oncology Diagnostic Service. CCC agreed prioritisation and turn around times with LCL for PDL1 testing.
- Alliance Medical's failure to supply FDG: Daily monitoring and escalation in situ at CCC and weekly reporting to CCC Exec Team and NHSE. Daily prioritisation of patients waiting for urgent diagnostics or treatment planning to minimise delays.
- Intermittent delays at AUHT due to capacity issues within Gastroenterology dept: Inform senior management team at AUHT of any potential delays / new escalation process agreed with AUHT Senior managers.

2 Week Wait:

- CCC to register concern with Commissioners regarding patients being referred whilst unavailable (i.e. due to go on holiday).
- Ensure Admin staff are trained to reinforce the importance of timely attendance to a 2wr appointment with patients.
- Ensure flexibility within clinic capacity to accommodate patient availability.
- Clear SOP in place to ensure timely escalation of potential breaches. SOP to be shared with the RLBHHT booking team and managed daily.

Internal processes:

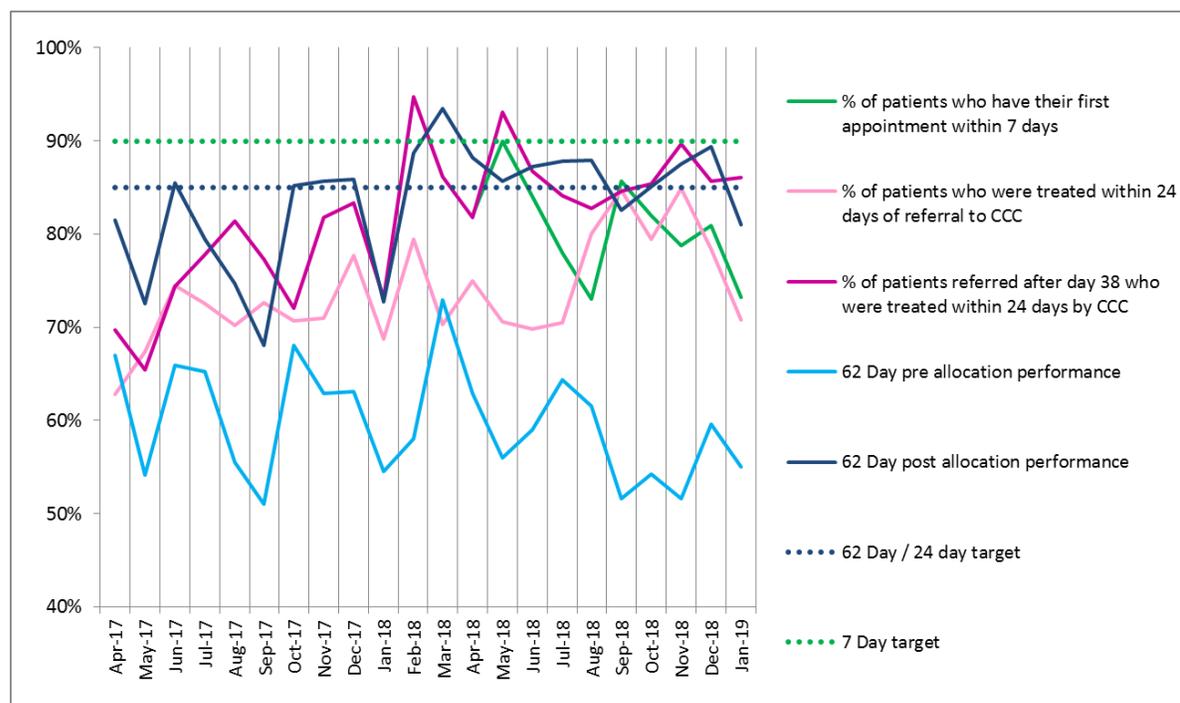
- Introduce a single digital referral system within CCC.
- Further role out of team based working in each tumour group.
- There is a robust escalation process in situ and the 7 day to first appointment internally set target continues to be closely monitored.

Consultant capacity:

- Locum cover in situ across Breast, HPB, UGI and H&N.
- Senior Trainees acting into Consultant posts within Breast and Urology.
- Medical oncologist post out to advert / 2 Clinical Oncologist posts out to advert.

- CCC funded two additional HO posts, 1 filled and one other out to advert.
- Non-medical Consultants appointed to Breast, Prostate, lower GI specialities.
- Tumour Specific ANPs and CNSs have own clinic templates and caseload.
- Request for additional non-medical consultants within CCC workforce plan 19-20.
- Review the process for allocating Consultant leave and cover arrangements within medical staffing.
- Reviewed Medical staffing roles, responsibilities and capacity to enhance engagement with operational teams.
- Non-medical consultants trained in planning and outlining from Feb 2019.
- Telehealth project underway within Lung, prostate and multiple other tumour groups delivering Immunotherapy treatments.
- CCC requested support from Commissioners to review new to follow up ratios and implementation of stratified follow up across all tumour groups.
- CCC engaged with North Mersey Out Patient Group to explore GP access to advice and support pre referral for diagnostics.

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 CWT Improvement Plan has recently been revised, including the incorporation of actions which will support system wide improvement. This continues to be monitored at the CWT Target Operational Group.



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 has been reviewed by CCC and other Trusts, all of whom have found it not to be accurate. NHS Digital is continuing to work on these reports and Trusts are due to have access to patient level data which will be reviewed for accuracy.

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%	
Urological (Excluding Testicular)	28	2	10	8	38	10	26.32%	80.00%	
Upper Gastrointestinal	22	3	15	9.5	37	12.5	40.54%	76.00%	
Breast	2	0	30	16	32	16	93.75%	100.00%	
Lower Gastrointestinal	12	0	20	14	32	14	62.50%	100.00%	
Head and Neck	18	5	8	6	26	11	30.77%	54.55%	
Gynaecological	5	0	7	5	12	5	58.33%	100.00%	
Haematological (Excluding Acute Leuka...)	5	2.5	4	2	9	4.5	44.44%	44.44%	
Sarcoma	5	0	2	1.5	7	1.5	28.57%	100.00%	
Other	1	0	4	3	5	3	80.00%	100.00%	
Skin	1	0	1	1	2	1	50.00%	100.00%	
Nasal cavity	1	0.5	0	0	1	0.5	0.00%	0.00%	

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 Leuka...)	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

Tumour Group	Breaches	Accountable Breaches	Hits	Accountable Hits	TOTAL	/ Accountable TOTAL	PreAllocated %	Allocated %	Allocated Performance
Lung	13	3.5	47	27	60	30.5	78.33%	88.52%	
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	9	6.5	40	7.5	22.50%	86.67%	
Head and Neck	18	3.5	15	9.5	33	13	45.45%	73.08%	
Gynaecological	18	1	7	4.5	25	5.5	28.00%	81.82%	
Urological (Excluding Testicular)	13	0.5	11	9	24	9.5	45.83%	94.74%	
Haematological (Excluding Acute Leuka...)	9	4.5	12	6.5	21	11	57.14%	59.09%	
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 January 2019, 12 patients were treated after day 104; referred between day 78 - 219 to CCC. 3 patients were not treated within 24 days by CCC for a variety of reasons including delay to treatment outlining due to consultant availability, annual leave and cross cover, patient DNA, out-patient capacity to 1st appointment and medical reasons.

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	Jan-19	Trend
CCC Outpatients Wirral: Seen within 30 minutes	80%	72%	77%	78%	78%	78%	78%	75%	79%	75%	76%	81%	85%	85%	
CCC Outpatients Wirral: Seen between 31 and 60 minutes		13%	12%	11%	12%	13%	14%	14%	12%	14%	15%	13%	10%	11%	
CCC Outpatients Wirral: Seen after 60 minutes		15%	11%	11%	10%	9%	9%	11%	9%	11%	9%	7%	5%	5%	
Delamere: Seen within 30 minutes	80%	81%	78%	82%	81%	80%	79%	78%	82%	78%	77%	79%	77%	77%	
Delamere: Seen between 31 and 60 minutes		10%	11%	9%	10%	11%	11%	11%	10%	12%	13%	10.0%	11.0%	12%	
Delamere: Seen after 60 minutes		9%	11%	9%	9%	10%	10%	11%	8%	10%	10%	10.6%	11.0%	11%	
Outpatient peripheral clinics: Seen within 30 minutes	80%	87%	89%	87%	89%	91%	91%	91%	91%	90%	89%	90%	91%	91%	
Outpatient peripheral clinics: Seen between 31 and 60 minutes		8%	8%	8%	7%	6%	6%	6%	6%	7%	8%	6.7%	2.2%	6%	
Outpatient peripheral clinics: Seen after 60 minutes		5%	3%	5%	4%	3%	3%	3%	4%	3%	3%	3.5%	1.6%	3%	

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

We have now concluded both HPb and Breast OPD Service Improvement projects and have seen a reduction in our OPD patient waiting figures which meet our targets.

The aim for the next period is to consolidate and reflect on what went well during both projects and implement the same approach in our Renal clinic which also experiences long waiting times. The Renal Clinic action plan has been approved and is due to be implemented by May 2019.

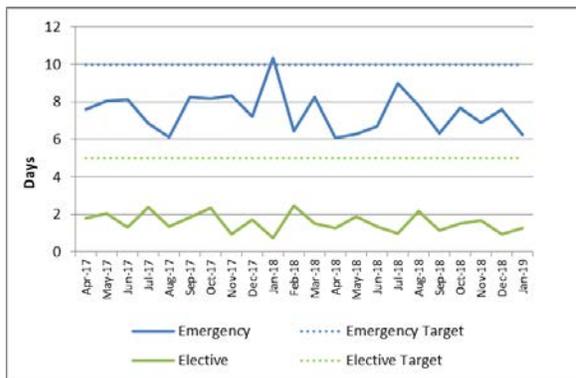
Waiting times on Delamere remain a significant challenge due to delays in the repatriation of patients to a treatment facility closer to home. Waiting times in all clinics are being reviewed to identify hotspots on which to target further service improvement efforts.

4.3 Length of Stay (LOS)

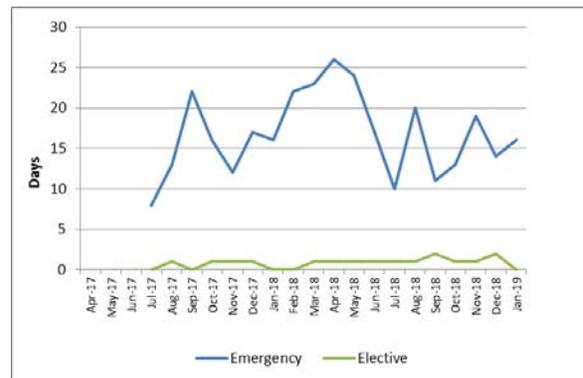
These charts show the elective and emergency average LOS in days per month for CCCW wards and HO wards. Wirral wards have been within target in all but 1 month in 2018/19 to date.

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

Wirral Wards x 3



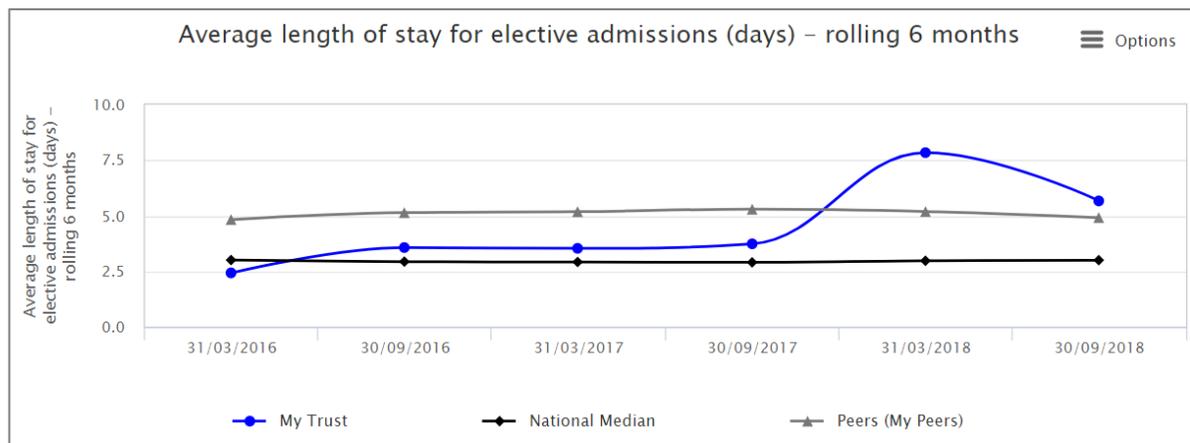
HO Wards x 2



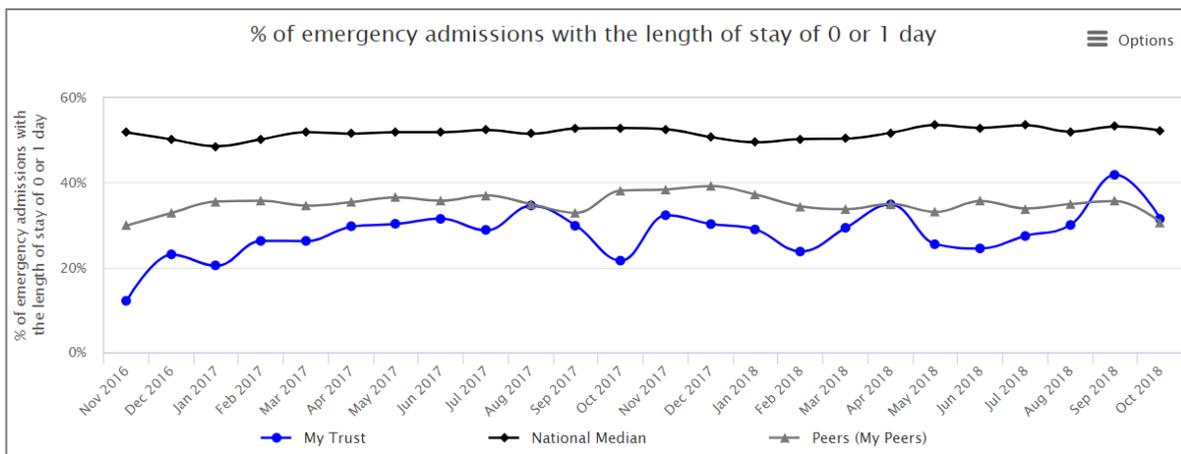
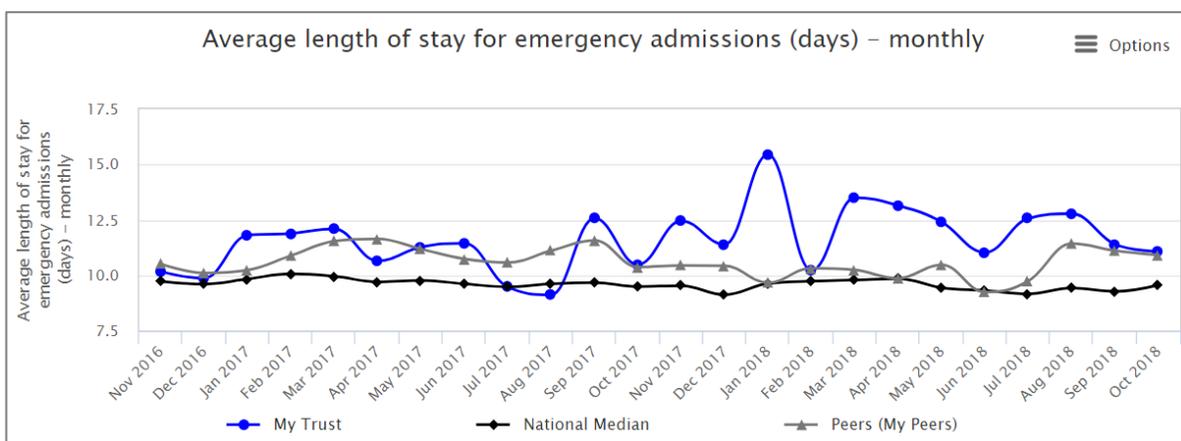
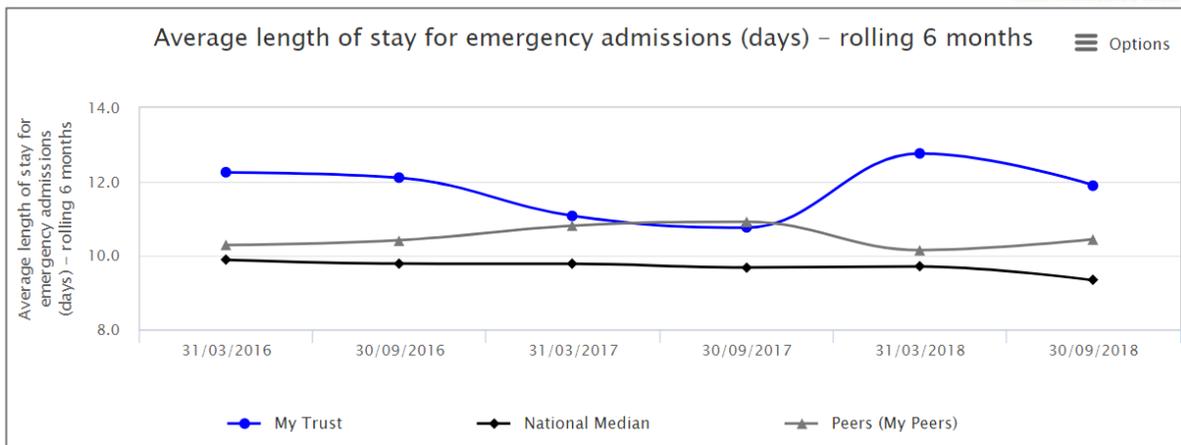
Benchmarked data:

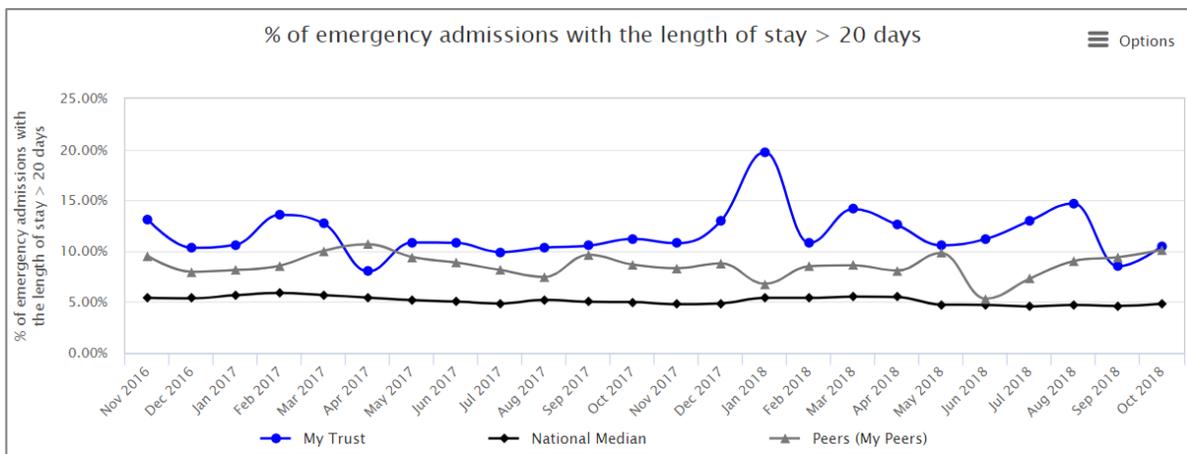
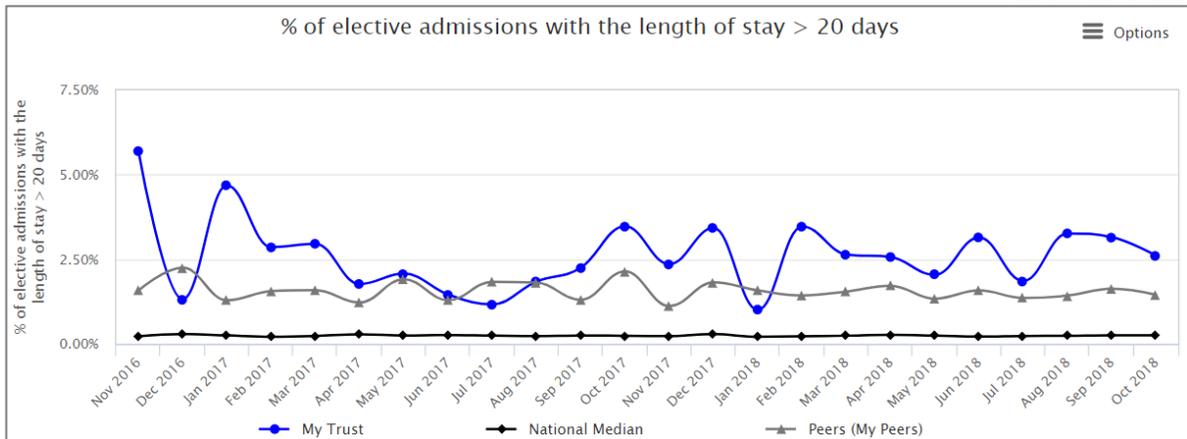
The charts have not been updated on the model hospital portal since the month 7 IPR.

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 53 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	Jan-19	Trend
Average Occupancy at 11 am (Conway)	85%*	85.7%	90.0%	88.7%	82.8%	69.0%	85.4%	84.0%	78.2%	77.2%	77.2%	75.0%	68.0%	80.0%	
Average Occupancy at 11 am (Mersey)	85%*	76.9%	81.0%	79.4%	66.2%	64.9%	77.6%	74.5%	68.0%	66.3%	66.3%	69.0%	72.0%	85.0%	
Average Occupancy at 11 am (Sulby)	85%**	42%	27%	49%	27%	27%	45%	81%	73.6%	70.2%	70.2%	49.0%	48.0%	60.0%	
Average Occupancy at 2 am (Conway)	85%*	75.4%	90.0%	88.8%	83.7%	69.2%	85.0%	84.1%	77.9%	78%	78%	75.4%	69.0%	80.0%	
Average Occupancy at 2 am (Mersey)	85%*	75.0%	79.8%	77.0%	64.8%	63.0%	76.0%	73.8%	67.0%	66.5%	66.5%	69.7%	70.0%	84.0%	
Average Occupancy at 2 am (Sulby)		25.1%	15.5%	28.9%	17.1%	14.8%	26%	33%	34.1%	32%	32%	19%	14%	17%	

*All targets have been increased from 75% to 85% from month 10 2018/19, in line with the CCC's new hospital targets.

** target applied to Sulby from month 10 2018/20

Data flows for HO wards' bed occupancy are being established

Following the opening of the CDU in November 2018, Sulby Ward's bed base was reconfigured to establish a short stay unit (Monday-Friday) and the CDU treatment area. A decision was taken to close Sulby ward overnight for a temporary two month period from 11th February and changes to occupancy levels on Mersey and Conway wards will be closely monitored to ensure that all inpatient demand can be safely accommodated.

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 January 2019 is 10%.
- 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

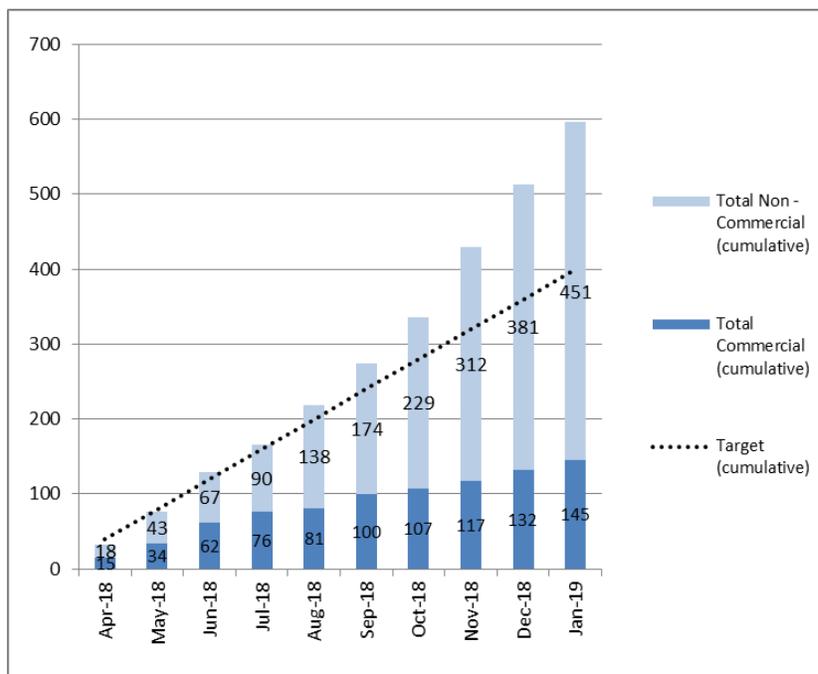
This table presents the reporting turnaround times for inpatients and outpatients and reveals that the Trust is failing to achieve the targets of 24 hours and 7 days respectively.

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	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%	73.9%	
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%	72.5%	

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 £2,342k above plan.

Performance and RAG ratings against these growth rates for April 2018 to January 2019 are as follows:

	Activity Variance	% year to date	Finance Value	% year to date
Admitted Patient Care – Spells	118	3.6%	£363k	7.2%

Admitted Patient Care Excess Bed Days	-848	-57.2%	-£209k	-57.4%
Outpatient Consultations	1,181	1.1%	£13k	0.1%
Outpatient Procedures	118	0.8%	£1,535k	70.8%
Radiotherapy and Proton	-3,284	-4.1%	-£120k	-0.7%
Chemotherapy	5,949	6.3%	£1,099k	6.9%
Diagnostic Imaging	1,620	8.9%	£260k	14.0%
Block			-£598k	-24.3%
Total Excluding Drugs			£2,341k	4.2%
Named Drugs			£7,056k	28.1%
CDF Drugs			-£360k	-5.5%
Total			£9,632k	10.8%

Radiotherapy – Red Rating

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

Chemotherapy – Green Rating

Chemotherapy is already over plan on predicted 5% growth, with an additional 1.9% cumulative position.

A contributing factor to the over performance is an increase in Chemotherapy Associated treatments, which is over performing by 26.9% 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 recorded. 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 £141k has been put in for non-achievement of CQUINs in the first ten 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 £1,535k; however activity is only 0.8% 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 months 9 to 10.

Overall clinical activity for HO, (excluding drugs), is £441k behind plan and drug income is over plan by £2.29m; 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

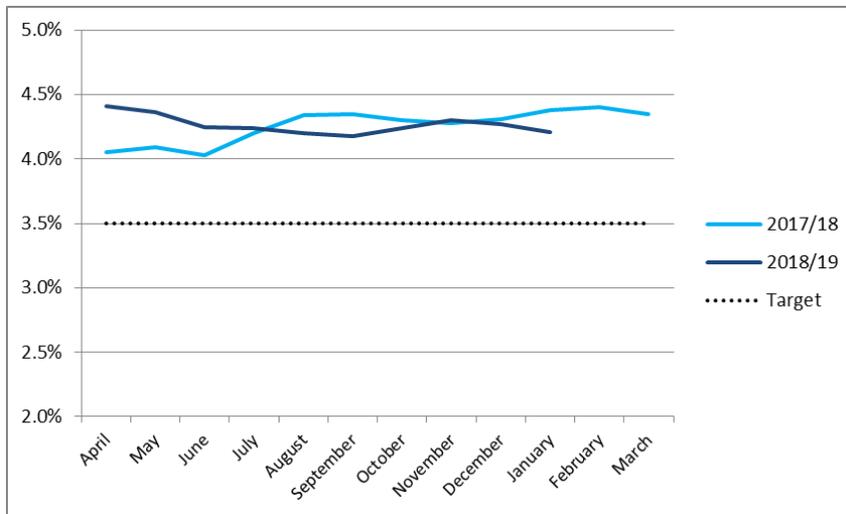
Workforce overview

	2018 / 02	2018 / 03	2018 / 04	2018 / 05	2018 / 06	2018 / 07	2018 / 08	2018 / 09	2018 / 10	2018 / 11	2018 / 12	2019 / 01	Trend
Headcount	1,259	1,258	1,270	1,265	1,261	1,260	1,274	1,274	1,292	1,295	1,295	1,299	
FTE	1,139.23	1,139.10	1,151.28	1,145.59	1,142.78	1,143.44	1,156.45	1,157.26	1,173.98	1,174.43	1,174.58	1,178.69	
Leavers Headcount	8	13	17	22	17	12	16	16	14	19	17	17	
Leavers FTE	6.68	11.25	13.22	18.80	15.91	11.49	13.52	13.64	12.75	17.56	14.87	14.72	
Starters Headcount	25	15	26	13	16	10	26	19	30	22	19	19	
Starters FTE	23.10	13.15	24.50	11.25	15.32	9.04	23.13	15.96	27.67	17.67	16.70	17.13	
Maternity	30	28	29	32	35	33	34	35	36	41	40	38	
Turnover Rate (Headcount)	0.64%	1.03%	1.34%	1.74%	1.35%	0.95%	1.26%	1.26%	1.08%	1.47%	1.31%	1.31%	
Turnover Rate (FTE)	0.59%	0.99%	1.15%	1.64%	1.39%	1.01%	1.17%	1.18%	1.09%	1.50%	1.27%	1.25%	
Leavers (12m)	152	154	146	158	164	165	172	169	174	190	187	188	
Turnover Rate (12m)	12.95%	12.94%	12.10%	12.92%	13.23%	13.26%	13.76%	13.46%	13.79%	15.01%	14.72%	14.74%	
Leavers FTE (12m)	135.46	137.37	127.92	138.37	144.62	147.40	152.36	147.87	152.66	167.42	164.11	164.41	
Turnover Rate FTE (12m)	12.77%	12.78%	11.73%	12.51%	12.90%	13.08%	13.46%	13.00%	13.36%	14.59%	14.25%	14.22%	

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

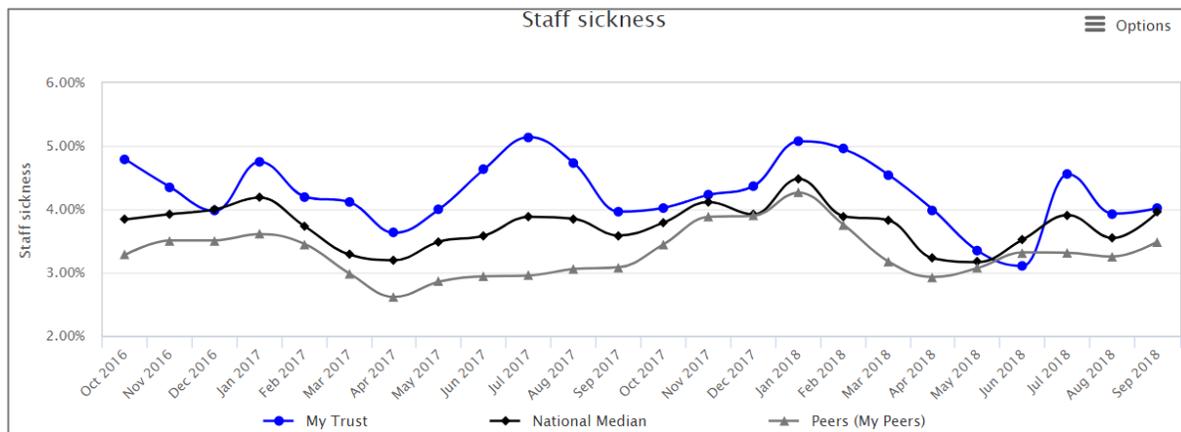
Sickness Absence

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:

All Admin Services staff now feature within the Corporate Directorate. The academic team was moved on ESR into the Research Team in January and the data backdated to April 2018. This explains the change in the data and the positive impact on the absence %, due to the increased size of the team.

	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Trend
Haemato-oncology Directorate	6.4%	3.8%	5.3%	4.0%	4.2%	4.5%	2.3%	3.6%	4.0%	3.6%	4.0%	4.4%	
Chemotherapy Services Directorate	6.0%	7.1%	5.3%	4.9%	3.4%	3.9%	3.0%	3.4%	4.0%	5.0%	5.6%	7.3%	
Intergrated Care Directorate	5.9%	6.2%	4.2%	3.3%	2.4%	4.4%	2.8%	4.2%	5.7%	4.4%	3.0%	4.6%	
Radiation Services Directorate	3.6%	2.1%	3.1%	2.4%	2.1%	3.2%	3.2%	2.3%	4.2%	5.0%	4.1%	3.4%	
Admin Services	7.4%	5.0%	4.6%	4.7%	5.0%	7.8%	8.0%	4.4%	1.9%	0.0%			
Corporate Services										4.07%	3.03%	2.93%	
Research	5.20%	4.83%	2.79%	3.71%	2.38%	4.58%	5.24%	4.18%	4.99%	4.24%	3.10%	3.93%	
Quality	6.2%	3.2%	1.4%	1.0%	2.2%	1.7%	0.7%	1.6%	3.4%	6.83%	10.21%		
Support Services	4.1%	4.2%	3.1%	2.9%	5.2%	7.9%	8.2%	8.1%	8.8%	6.0%	4.9%	7.1%	

The Trust 12 month rolling sickness absence is 4.21% and in month sickness absence has increased to 4.74% for January 2019, from 4.12% in December 2018. Cold, cough and flu, gastrointestinal problems and anxiety, stress and depression remain the three highest reasons for sickness absence across the Trust.

In January there were 65 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 January was gastrointestinal problems with 37 episodes. We have recently undertaken further analysis of sickness due to gastrointestinal problems and found Monday is recorded as having the highest number of staff reporting sick due to gastrointestinal and Wednesday has the least number of staff reporting sick due to gastrointestinal problems. The number of days taken by staff for gastrointestinal problems has been recorded as follows: 1 Day = 20 episodes, 2 Days = 7 episodes, 3 and 4 Days = 5 episodes. Reporting in ESR is not being utilised fully and we are working with managers to obtain more information with regards to these sickness episodes.

Our analysis with regards to sickness due to gastrointestinal problems has resulted in a number of recommendations. These include reviewing support and initiatives with infection control and Occupational Health in partnership with our trade union colleagues, further training for managers in fully utilising reporting in ESR, providing clarity in the Attendance Management Policy and supporting Tool Kit for managers on recording patient facing and non-patient facing staff on ESR and exclusion periods.

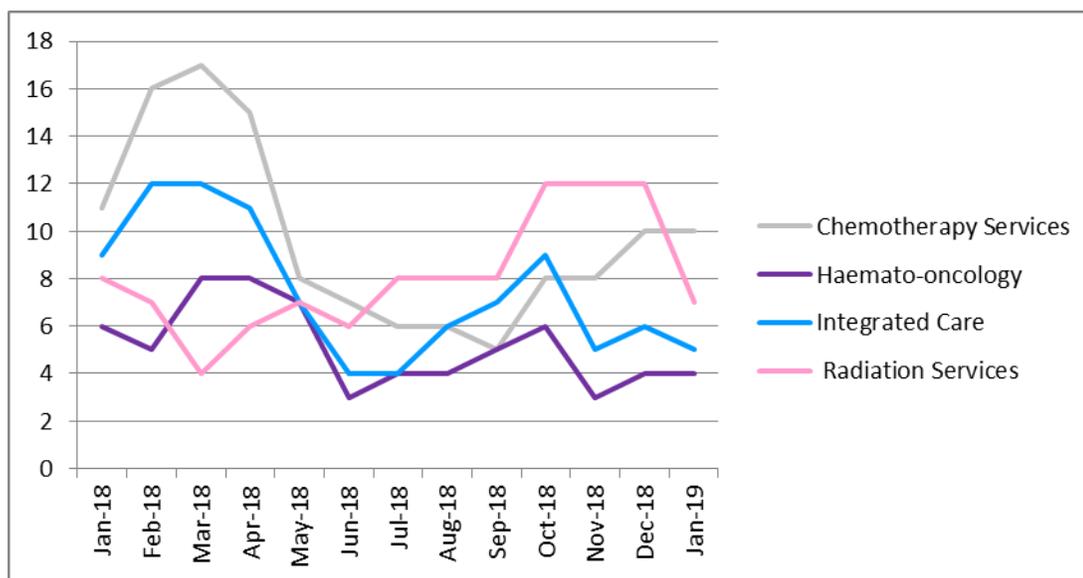
Monthly HR surgeries continue to take place within each department to ensure all sickness is being managed in line with Trust policy and procedure. Failure to close down sickness, and record the return to work discussion date on ESR is still a concern and is being escalated appropriately. We continue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

	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Trend
Short term	156	116	105	119	103	133	118	103	164	159	145	199	
Long term	60	62	56	44	33	45	48	45	56	45	46	39	

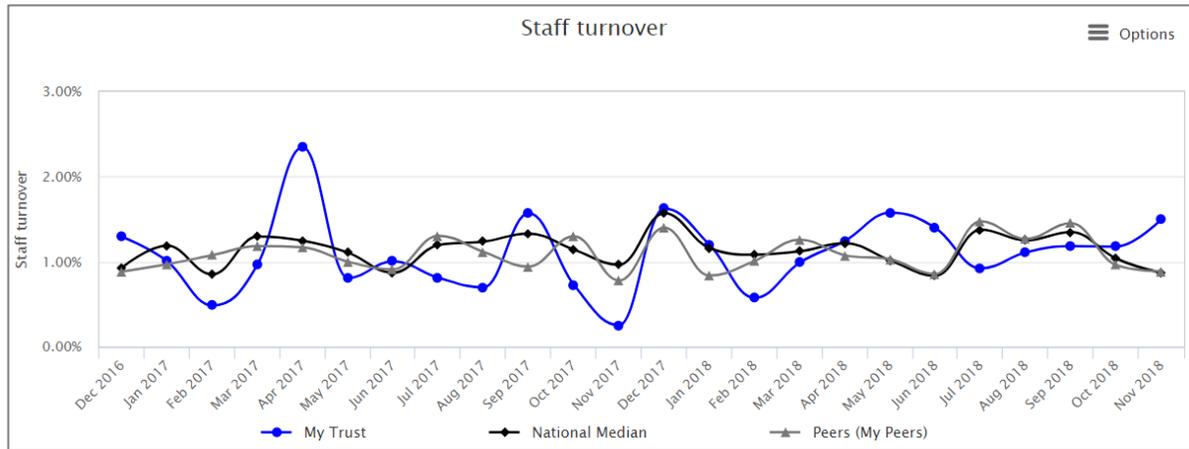
This chart presents this data for the Directorates. Detailed workforce information is considered at each Directorate meeting.



Staff Turnover

Turnover for January 2019 has remained static compared to December 2018 at 14.2%. There were 14 leavers in total in January. The majority of leavers in January were from the Nursing & Midwifery staff group. Reasons for leaving captured in ESR by managers continue to lack consistency, however work is ongoing to address this. For January 2019 the following analysis of reasons for leaving has been possible: 2 left due to end of fixed term contracts, 2 retired, 3 left for career development, 2 for work life balance reasons, 1 to go into further education, 2 due to poor working relationships, 1 relocated and 1 left due to the move to Liverpool, 3 unknown reasons. Work to address retention issues is under way and will involve ensuring that the Trust has reviewed all its key processes such as recruitment, induction, career development frameworks and exit discussions to ensure CCC can attract and retain the best staff.

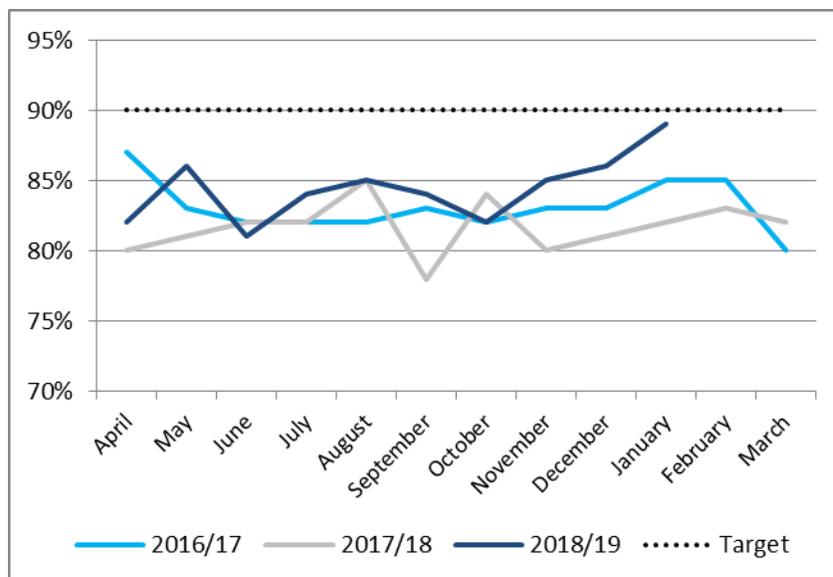
The chart below uses a different measure than ESR to calculate turnover; using this definition, CCC have similar, and often lower, levels of turnover to both peers and the national average.



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. Although the Trust is failing to achieve the 90% target, this has risen to 89% in January.



Directorate	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Trend
Haemato-oncology Directorate	58%	76%	74%	63%	66%	66%	54%	59%	58%	71%	
Chemotherapy Services Directorate	87%	89%	89%	86%	88%	88%	89%	89%	93%	94%	
Intergrated Care Directorate	87%	87%	87%	88%	89%	89%	87%	88%	87%	90%	
Radiation Services Directorate	86%	88%	87%	88%	89%	85%	86%	84%	87%	91%	
Admin Services	96%	96%	91%	95%	95%	93%	98%	89%			
Corporate Services								88%	84%	90%	
Quality	92%	91%	90%	94%	96%	97%	95%	94%	98%	99%	
Support Services	91%	92%	92%	92%	92%	93%	91%	91%	94%	97%	

Trust wide compliance by training and Directorate (data correct as at 13/02/2019):

	Chemotherapy			Haem-Onc			Integrated Care			Radiation Services		
	Dec	Jan	Feb	Dec	Jan	Feb	Dec	Jan	Feb	Dec	Jan	Feb
BLS	55%	78%	83%	53%	90%	89%	71%	83%	84%	50%	79%	80%
ILS	42%	63%	72%	n/a	n/a	n/a	41%	70%	72%	67%	57%	68%
Safeguarding Children level 3	86%	86%	56%	11%	43%	70%	33%	65%	64%	-	33%	53%
Safeguarding Adults level 3	100%	100%	53%	11%	65%	70%	33%	53%	53%	-	21%	50%
Patient handling - level 2	67%	86%	88%	43%	82%	85%	78%	80%	81%	70%	77%	78%
Infection Control-level 2	75%	81%	84%	74%	100%	73%	49%	78%	81%	35%	55%	66%

There are improvements to compliance figures across all areas except for:

- Chemotherapy for safeguarding level 3: this is due to the on-going review of the requirements for safeguarding level 3 which has resulted in additional staff being identified in the directorate which has a negative impact on the current compliance. The directorate are making arrangements for these staff to attend training
- There has also been a small reduction in BLS and Infection Control compliance for Haemato-oncology
- Integrated Care – there are on-going challenges which are being assessed in relation to releasing staff from clinical care
- Haemato-oncology – additional staff identified as requiring level 2 training in February

Haemato-oncology compliance by course (data correct as at 13/2/2019)

There has also been a focus on achieving compliance levels for role essential training within Haemato-oncology – the figures below show compliance for ward-based staff.

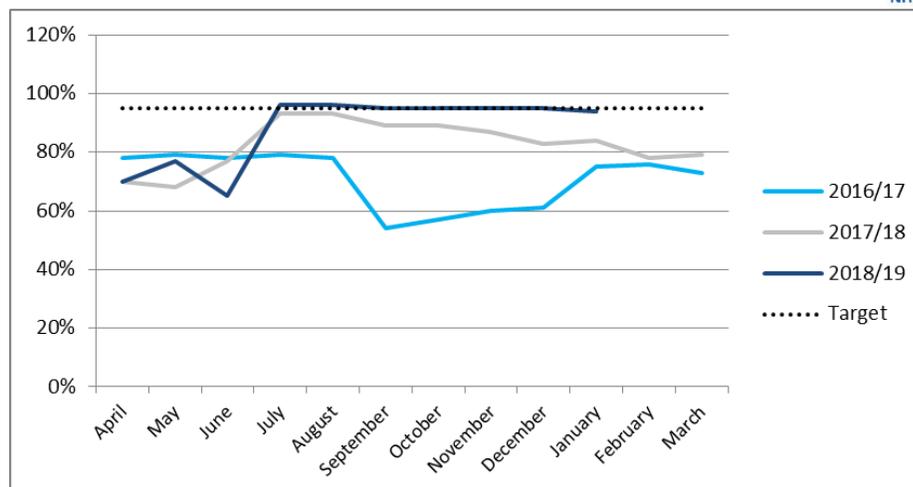
	December	January	February
AKI	81%	92%	95%
ANTT - online	100%	100%	100%
Sepsis	73%	92%	93%
Blood transfusion - online	74%	100%	100%
Blood transfusion - ward based	66%	100%	100%
Point of care	57%	98%	98%
Medical Devices	39%	52%	64%
COVAD	85%	95%	99%

In addition to managing the improvement of compliance against these prioritised areas, there is an on-going project that is currently establishing more robust processes to ensure the effective management of statutory and role essential training across the Trust. So far, the project team have;

- Created a new, documented process for requesting new Role Essential training with associated Governance for sign-off (through monthly Clinical Education Governance Committee)
- Created directorate-level role essential training matrices to baseline all training requirements per job role for each directorate
- Drafted a formal change request process to maintain control over directorate training matrices
- Documented SOPs to manage the administration of statutory/ role essential training
- Implemented a new weekly report highlighting compliance of prioritised statutory training per directorate and lists of non-compliant staff per directorate
- Established links into the new Clinical Education Governance Committee

PADR Compliance

Trust compliance has fallen slightly to 94%. 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.

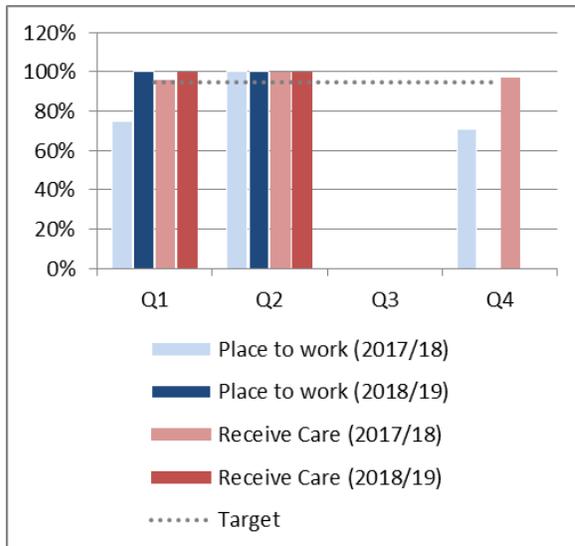


Directorate	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Trend
Haemato-oncology Directorate	81%	83%	40%	98%	99%	99%	97%	97%	96%	93%	↘
Chemotherapy Services Directorate	78%	81%	87%	99%	99%	98%	99%	98%	97%	93%	↘
Intergrated Care Directorate	65%	66%	62%	96%	97%	97%	96%	96%	93%	92%	↘
Radiation Services Directorate	79%	84%	67%	99%	99%	98%	95%	95%	95%	94%	↘
Admin Services	79%	91%	85%	98%	97%	97%	100%	100%			↘
Corporate Services								98%	96%	93%	↘
Quality	76%	77%	65%	98%	98%	100%	100%	100%	100%	100%	↘
Support Services	64%	65%	59%	86%	86%	85%	86%	90%	91%	95%	↘

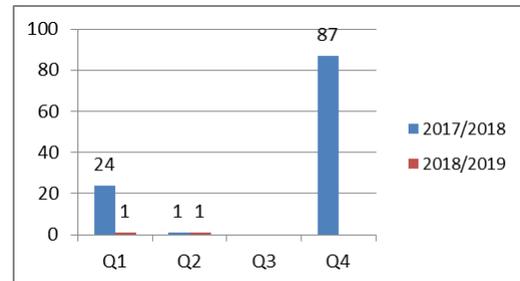
Staff Friends and Family Test

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

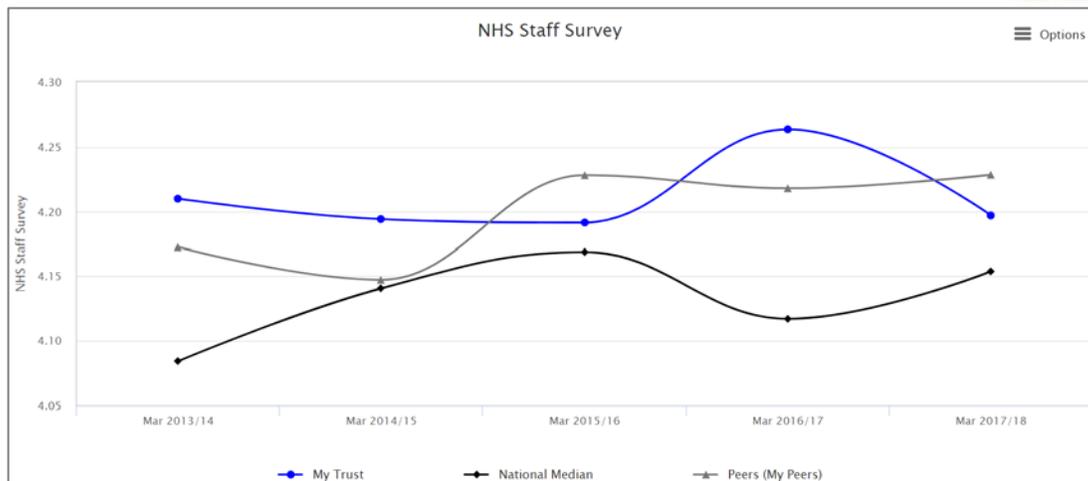


A communication campaign promoting the benefits of completing the survey is planned throughout Q4 to improve response rates. This includes:

- 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 ten months of 2018/19 as follows:

- A Group surplus (including Charity) of £4,305k against a planned surplus of £4,012k which is £293k 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 £2,598k against a planned surplus of £1,798k, a favourable variance of £800k. From month 9 this is a favourable movement against plan of £185k. The year to date variance is primarily due to below EBITDA items (depreciation and interest payable).
- The Trusts forecast outturn remains at £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 £1,578k, with an actual year to date comparator of £3,619k.
- 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 10 is based on actual activity for April to December and estimated for January for solid tumour. Haemato-Oncology is based on actual activity for April to November with estimates

for December and January except where actual data was available (for drugs and bone marrow transplants).

- Capital expenditure is £50,718k against a plan of £65,495k.
- The CIP programme has achieved savings of £1,693k, which is £353k above plan.
- The Trust has been issued with an Agency cap for 2018/19 of £1.1m by NHSI. At month 10, actual expend of £896k is £63k below the NHSI agency ceiling year to date.
- Cash held is £6.82m below plan, a slight deterioration from month 9. 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 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	1,798	2,598	800
The Clatterbridge Cancer Charity	1,647	1,037	(610)
The Clatterbridge Pharmacy Ltd	175	352	177
Clatterbridge Prop Care Services Ltd (excludes PURP)	392	552	160
*PURP		(234)	(234)
Total Group Surplus	4,012	4,305	293

* 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 apparent that there was a lack of embedded ownership within the relevant

	<p>Anticipated non delivery of 2018/19 CQUIN at month 10 is estimated at £325k. The Trust estimates that this will increase to £364k by year end. The Trust has utilised £119k from its CQUIN reserve towards this shortfall.</p>	<p>departments.</p> <p>Head of Performance & Planning and Associate Director of Operations are working with leads to make sure that milestones are met for the remainder of the year. The Director of Nursing & Quality is the Executive lead.</p>
<p>KPI “Red” or “Amber” from IPR report and metric above: Radiotherapy Activity (Red) below plan by 4.5% (A deterioration from month 9 which showed activity below plan by 3.9%).</p>	<p>For 2018/19 the plan was rebased on last year’s forecast outturn plus assumed growth of 1.9% so should reflect more accurately expected activity.</p>	<p>Any adverse in year impact on income is mitigated by the block contract.</p> <p>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</p> <p>Performance in other service lines.</p>

Medium Risks:

Issue	Reason	Risk / Mitigation
<p>KPI “Red” or “Amber” from metric table above: Group Surplus (Amber)</p>	<p>The Group has a combined surplus of £4,305k against a planned surplus of £4,012k. The Charity is £610k below plan at month 10. This is offset by an increased surplus within the Trust.</p>	<p>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.</p>
<p>KPI “Red” or “Amber” from IPR report and metric table above: Agency Spend (red) – Medical locum</p>	<p>The Trust has been issued with a ‘cap’ of £1.1m by NHS Improvement for the year. Spend to the end of January was £896k (of which £589k</p>	<p>Agency spend has been flagged with NHSI as a risk and they understand the Trust position and recognise that the provision of clinical</p>

	<p>relates to medical locums) against a NHSI ceiling to date of £959k,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 £589k against a plan of £417k, an overspend of £172k.</p>	<p>services is the priority.</p>
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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 £14.77m behind plan. This is mainly to Building for the Future being £14.02m 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 £6.82m below plan. This is because PDC of £28.2m has not yet been drawn down.	Risk of cashflow issues, however the Trust still has £56.87m 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 10.
- 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 £1,578k, with an actual year to date comparator of £3,619k.
- Note the forecast consolidated outturn of £3,147k.
- Note the KPI performance risks.

Statement of Comprehensive Income

	Trust Annual Plan £k	JAN 19			Cumulative YTD			
		Plan £k	Actual £k	Variance £k	Plan £k	Actual £k	Variance £k	%
Clinical Income:								
Elective	4,998	416	385	(32)	4,185	3,663	(522)	-12.5%
Non-Elective	4,533	378	433	55	3,796	4,586	791	20.8%
Out-patient Attends	18,416	1,535	1,667	132	15,419	17,261	1,841	11.9%
Radiotherapy Attends	19,727	1,644	1,467	(177)	16,517	16,320	(198)	-1.2%
Chemotherapy Attends	19,910	1,659	1,838	179	16,671	17,776	1,106	6.6%
Impact of Contract Tolerances / Agreed Outturn	136	21	(157)	(178)	136	(2,788)	(2,923)	-2157.4%
Drugs	51,154	4,263	5,324	1,061	42,831	52,412	9,581	22.4%
Diagnostic Imaging	2,215	185	180	(5)	1,855	2,131	276	14.9%
Bone marrow transplants	5,523	460	254	(207)	4,625	3,772	(852)	-18.4%
Other Currencies	3,080	257	163	(94)	2,578	2,054	(524)	-20.3%
Private Patients / External Drug Sales	791	66	90	24	659	621	(38)	-5.8%
Sub-Total: Total Clinical Income	130,483	10,883	11,643	760	109,271	117,809	8,537	7.8%
Other Income	8,070	400	666	266	6,788	8,611	1,823	26.9%
Hosted Services	7,093	445	555	110	6,065	6,291	226	3.7%
Total Operating Income	145,646	11,728	12,864	1,136	122,124	132,711	10,586	8.7%
Pay - Non Hosted	(51,003)	(4,270)	(4,270)	(0)	(42,508)	(42,145)	363	-0.9%
Pay reserves	(152)	(1)	(1)	0	(110)	(110)	0	0.0%
Pay - Hosted	(5,831)	(408)	(415)	(7)	(5,196)	(4,954)	241	-4.6%
Drugs expenditure	(35,452)	(2,954)	(3,695)	(741)	(29,684)	(37,424)	(7,739)	26.1%
Other non-pay - Non hosted	(40,111)	(3,364)	(3,470)	(106)	(33,630)	(36,844)	(3,214)	9.6%
Non-pay reserves	(1,224)	198	198	0	(980)	(696)	284	-29.0%
Non-pay hosted	(1,290)	(37)	(140)	(103)	(897)	(1,365)	(468)	52.1%
Total Operating Expenditure	(135,064)	(10,836)	(11,794)	(958)	(113,005)	(123,538)	(10,533)	9.3%
Earnings before Interest, Tax, Depreciation and Amortisation (EBITDA)	10,582.5	892	1,070	178	9,119	9,173	53	0.6%
Depreciation	(5,155)	(430)	(388)	41	(4,295)	(3,615)	681	-15.9%
Amortisation	0	0	(9)	(9)	0	(86)	(86)	0.0%
Fixed Asset Impairment	0	0	0	0	0	0	0	0.0%
Profit /(Loss) from Joint Venture	624	52	45	(7)	520	387	(133)	-25.6%
Interest receivable (+)	98	8	196	188	82	1,386	1,304	1596.8%
Interest payable (-)	(679)	(57)	(263)	(207)	(566)	(1,585)	(1,019)	180.1%
Profit on Disposal	0	0	0	0	0	0	0	0.0%
PDC Dividends payable (-)	(3,667)	(306)	(306)	(0)	(3,056)	(3,056)	(0)	0.0%
Finance lease interest	(7)	(1)	0	1	(5)	(7)	(2)	30.4%
Retained surplus/(deficit)	1,797	160	346	185	1,798	2,598	799	44.4%
NET I&E Margin (%)	1.2%	1.4%	2.7%	1.4%	1.5%	2.0%	0.5%	32.9%
EBITDA Margin (%)	7.3%	7.6%	8.3%	0.7%	7.5%	6.9%	-0.6%	-7.4%

Statement of Financial Position

	Post Audit 2018 £k	NHSI Plan 2019 £k	YTD Plan	Dec-18 YTD £k	Variance £k	YTD Plan	Jan-19 YTD £k	Variance £k
Non-current assets								
Intangible assets	717	608	639	640	1	628	631	3
Property, plant & equipment	89,306	168,785	145,140	130,423	(14,717)	151,834	136,409	(15,425)
Investments in associates	672	1,296	1,140	1,014	(126)	1,192	1,059	(133)
Other financial assets	18,715	4,560	5,845	57,515	51,670	5,417	63,095	57,678
Trade & other receivables	4,563	277	277	4,459	4,182	277	4,444	4,167
Other assets	-	92,515	70,974	-	(70,974)	78,108	-	(78,108)
Total non-current assets	113,972	268,041	224,015	194,051	(29,964)	237,456	205,638	(31,818)
Current assets								
Inventories	1,161	1,000	1,000	1,240	240	1,000	1,423	423
Trade & other receivables								
NHS receivables	18,419	5,000	5,000	5,442	442	5,000	5,752	752
Non-NHS receivables	12,267	15,000	15,000	19,603	4,603	15,000	20,025	5,025
Cash and cash equivalents	55,368	47,255	69,577	65,022	(4,555)	63,683	56,867	(6,816)
Total current assets	87,215	68,255	90,577	91,306	729	84,683	84,067	(616)
Current liabilities								
Trade & other payables								
Non-capital creditors	26,348	15,000	15,000	29,063	14,063	15,000	27,826	12,826
Capital creditors	107	1,000	1,000	97	(903)	1,000	97	(903)
Borrowings								
Loans	250	1,730	1,730	1,730	-	1,730	1,730	-
Obligations under finance leases	51	53	53	53	0	53	53	0
Provisions	461	489	489	392	(97)	489	392	(97)
Other liabilities:-								
Deferred income	2,307	4,000	4,000	3,068	(932)	4,000	3,235	(765)
Other	-	700	700	-	(700)	700	-	(700)
Total current liabilities	29,524	22,972	22,972	34,402	11,430	22,972	33,332	10,360
Total assets less current liabilities	171,663	313,324	291,620	250,956	(40,664)	299,167	256,373	(42,794)
Non-current liabilities								
Trade & other payables								
Capital creditors	-	301	301	-	(301)	301	-	(301)
Borrowings								
Loans	2,750	37,280	37,405	37,405	-	37,405	37,405	-
Obligations under finance leases	109	56	56	56	(0)	56	56	(0)
Other liabilities:-								
Deferred income	1,156	1,156	1,156	1,156	0	1,156	1,156	0
PropCare liability	18,996	92,515	70,974	59,838	(11,136)	78,108	65,964	(12,144)
Total non current liabilities	23,011	131,308	109,892	98,455	(11,436)	117,026	104,581	(12,445)
Total net assets employed	148,652	182,016	181,728	152,500	(29,228)	182,142	151,792	(30,350)
Financed by (taxpayers' equity)								
Public Dividend Capital	23,267	53,063	53,063	24,863	(28,200)	53,063	24,863	(28,200)
Revaluation reserve	7,839	7,839	7,839	7,839	(0)	7,839	7,839	(0)
Income and expenditure reserve	117,547	121,114	120,826	119,799	(1,027)	121,240	119,091	(2,149)
Total taxpayers equity	148,652	182,016	181,728	152,500	(29,228)	182,142	151,792	(30,350)

5.3 Risk

This section provides details of the 32 corporate risks rated 15 or over as at 13th February 2019. 22 have been assigned to Quality Committee and 10 to the Finance & Business Committee. 3 are rated at 20.

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
832	Inpatient Wards	Finance and Business Development	The allocation and retention of Junior Drs to CCC does not provide a safe junior Dr rota to deliver safe care on CCC in patient	<ol style="list-style-type: none"> 1. Cause - The current allocation of Junior Drs is 8.8WTE. 2. Effect - Minimum standard required to deliver a safe junior Dr rota is 9 WTEs 3. Impact - Medical cover for the Wirral inpatient wards is inadequate. 	<p>Reduced attendance for CMTs at OPD clinics Option of employing locum CMTs x 2 or 2 Clinical fellows. 2 clinical fellows appointed, awaiting start date. Secure long term funding for the three clinical fellow posts. Utilise Nurse practitioners to cover basic clinical tasks traditional done by CMTs. Junior Dr contract (notification of placement 6 weeks in advance)</p>	20	4	31/07/2019	28/02/2019	<p>Present options appraisal regarding ways to deliver a safe junior Dr rota</p> <p>Hospital at Night working group</p>
973	Haemato-Oncology	Finance and Business Development	HODS turnaround times	Cause - Inadequate laboratory and consultant staffing in HODS (haematopathology, cytogenetics, molecular genetics).	We have had repeated meetings with the HODS and Liverpool Clinical Laboratories management team. The lymphoma team	20	9	01/02/2019	28/02/2019	Escalation to LCL re HODS turnaround times On-going

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
				<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>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>					<p>monitoring of HODS turnaround times Monitoring of HODS turnaround times</p>
1073	Haemato-Oncology	Quality Committee	Meditech MAR issue for IP SACT	<p>Cause: Meditech functionality doesn't distinguish between 'stopped' and inactive medications after midnight in SACT. Effect: The HO EP implementation cannot progress for IP until this is resolved Impact: we may be issued with an improvement notice for non-delivery of EP for HO from our commissioners</p>	<p>We will not progress with the EP implementation until the MAR issue has been resolved, therefore this is a project risk rather than a clinical risk.</p> <p>Risk assessment completed</p>	20	4	15/07/2019	11/03/2019	

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
1010	Pharmacy	Quality Committee	Brexit & Implications for medicines supply	<p>Cause: Brexit deal has yet to be secured</p> <p>Effect: A no deal could adversely impact medicines availability in the UK.</p> <p>Impact: A shortage of medicines could have an adverse effect on patient safety and outcomes at CCC.</p>	The health secretary has asked trusts not to stockpile medicines as the DH is liaising directly with Pharma companies. This will ensure that adequate supplies are available should the UK reach a no-deal agreement.	16	8	01/04/2019	28/02/2019	<p>Assess buffer stock for Brexit</p> <p>Assess buffer stock</p> <p>Update BCP</p>
1036	Radiotherapy	Finance and Business Development	Supply of HDR Brachytherapy sources	<p>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</p> <p>Effect: Any delays with customs arrangements at new borders may impact the time a delivery can be made and the activity delivered.</p> <p>Impact: Sources not available and patient treatments cancelled</p>	None known	16	4	29/03/2018	04/03/2019	<p>Close communication with the company (ELEKTA) in relation to their strategy</p>
1017	Radiotherapy	Quality	Cessation of	Cause	Internal CCC MDT discussion	16	4	31/01/2019	04/03/2019	To agree a set of

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
	apy	Committee	contact x-ray (Papillon) MDT	<p>Contact SMDT at RLUH has been suspended indefinitely due to issues concerning governance and resources</p> <p>Effect</p> <p>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</p> <p>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.</p> <p>Reputational risk to the Trust</p> <p>Clinical risk to patients</p>	<p>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.</p> <p>Requested attendance to MDT from surgical colleague.</p>					<p>criteria the patients should fulfil before treatment</p> <p>To ensure colorectal surgeon attends local CCC meetings to give a surgical view</p>

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
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	04/03/2019	contingency plan

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
835	Haemato-Oncology	Quality Committee	Mandatory training	<p>Cause: Lack of mandatory training data from RLBUHT Lack of aligned HO staff training matrix</p> <p>Effect: Staff not aware what mandatory training required Completeness of HO staff training records</p> <p>Impact: Non-compliance to mandatory training. Staff not receiving training in line with competencies required.</p>	<p>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</p>	16	9	31/12/2018	28/02/2019	Statutory and role essential Training action plan in place

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
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 workforce)	There has been a significant reduction in the Consultant Oncologist workforce due to 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	Current medical staff taking on extra work to cover clinics Reconfiguration of some Consultant job plans to cover specialities most affected. Senior Registrar due to complete training within the next 6 months acting into consultant posts supervised and supported by a senior consultant. None medical consultant posts approved and appointed to. This includes consultant radiographers, pharmacists and nurses. Consultant oncologist posts	16	8	31/05/2019	31/01/2019	Appoint locum to manage Medical Oncology practice at LMC Secure locum cover for HPB Present paper regarding Consultant workforce risks to Exec Appointed to one medical consultant vacancy

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
					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.					
250	Delamere and Network clinics	Quality Committee	Noncompliance 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

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
365	Medical	Quality Committee	Revalidation	Revalidation/medical appraisals Overdue medical appraisals and outlier for deferral of revalidation Loss of medical manager; Lack of QA process for appraisers ; lack of time in job plan for appraisers Non-compliance of medical workforce with annual appraisal and risk of loss of licence to practice of non-compliant with revalidation	*New policy in place *MD reports sent to Board New appraisal lead appointed 2017; Medical manager post advertised-interim in place weekly escalation meetings with MD Business case for additional PA's in job plans completed	15	4	02/09/2019	11/03/2019	To ensure implementation of Action plan as per AOA 2018
78	Medical	Quality Committee	Poor compliance with mandatory training - Medical	Poor compliance with mandatory training	*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 in place	15	6	16/12/2019	18/03/2019	Agreement of key dates for 2019 for Consultants to focus on statutory training Final sign off of the training matrix for medical workforce
201	Workforce and Organisational Developm	Quality Committee	Failure to provide adequate support for employee stress, leading to increased absence	Failure to provide adequate support for employee stress, leading to increased absence from work	* Confidential counselling * Informal counselling * Staff support information * Outdated working practice to be revised in line with CIS	15	6	28/06/2019	31/03/2019	EAP Mental Wellbeing Steering Group

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
	ent		from work		<ul style="list-style-type: none"> * 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) 					
833	Delamere and Network clinics	Quality Committee	Consultants not documenting in meditech	<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>	<p>Nurses contacting consultants on a daily basis, resulting in delays in treatments</p> <p>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.</p>	15	3	08/07/2019	04/03/2019	Paperless strategy

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
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. 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 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. 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. Recent SUI demonstrated the error in transcribing after treatment on the wrong date results.</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	04/03/2019	Interfacing with host hospitals

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
854	Imaging	Finance and Business Development	Radiologist business continuity	<p>Cause: Insufficient numbers of radiologists 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 Impact: *Treatment decisions may be delayed *Patient arriving in clinic and reports not available</p>	<p>Asking visiting radiologists from RLBHCT 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	18/02/2019	<p>Hold put on half body scanning Explore further outsourcing reporting To work with HR on radiologist recruitment strategy</p>
862	Information Management & Technology	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</p>	<p>Planned controls include the following areas: • Full review of issues within the Information team- to include team focused session, stress questionnaire with staff, 360 degree feedback. Review of previous exit interviews. Work underway with HR and OD. Team session established for 22/2/18. Various follow up sessions have concluded and are</p>	15	9	30/04/2019	05/03/2019	<p>Project manage the activities of the new build data warehouse</p>

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
				to individual patient level. In addition, the way we are organised to deliver means that staff that could support a 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.	<p>on-going</p> <ul style="list-style-type: none"> Review of data warehouse technical infrastructure and 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 Quintiles report commissioned early 2017 for Pharmacy. Review of current staffing roles across the Trust delivering information management <p>Restructure is planned</p> <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 <p>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</p>					
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</p>	<p>We are met with L&D very regularly over the previous 18 months to rectify the problem with no success. We have developed a mandatory training matrix which has been sent to the CNS/ANP on CREST to manage their compliance</p>	15	4	01/12/2018	29/03/2019	Gaps identified, priority areas identified, staff approached to undertake their training

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
				required to maintain own paper records. Impact: Non-compliance with mandatory training	and sent to L&D in order to amend ESR, however this has not occurred. New training is added to ESR without staff knowing and staff are regularly unable to access ESR due to technical difficulties.					
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 cannulas 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 are having to continually look for a 'space' to enable removal of patients cannulas.</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	12/03/2019	identify new clinical space

ID	Dept.	Assuring Board Committee	Title	Description	Controls in place	Rating (current)	Rating (Target)	Target Grade Date	Next Review Date Due	Action Description
887	Delamere and Network clinics	Quality Committee	Immuno-oncology service	<p>Risk - There is a significant risk to the safe delivery and toxicity management of immuno-oncology patients.</p> <p>Cause - There is lack of trained staff to provide holistic patient care for the rapidly increasing population of patients receiving immuno-oncology therapy and their complications.</p> <p>Effect - It is internationally 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</p>	<p>IO Lead Nurse role</p> <p>On treatment review team</p> <p>Toxicity management protocols</p> <p>IO committee</p> <p>Alerts cards</p> <p>Pharmacy counselling for patients prior to discharge</p> <p>Medical speciality advisors</p> <p>Training to Hotline staff</p> <p>GP awareness letter</p> <p>Standardised blood panel to ensure consistency</p> <p>Meditech templates</p>	15	6	04/02/2019	25/03/2019	<p>Implementation of an IO bulletin</p> <p>Education to specific teams e.g. triage</p> <p>Collaboration between the Lead IO nurse and the Lead Education Nurse</p> <p>Mandatory training module</p> <p>Development of a steroids information card with sick day rules</p> <p>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
				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.						
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</p>	<ol style="list-style-type: none"> 1. Consultant cover for IOM OPD service 2. Service Provision Agreement between IOM/CCC 3. Protocols, Processes, Policies in place 	15	6	01/02/2019	28/02/2019	Activity Monitoring IOM patients Training Needs Analysis IOM SLA review IOM IOM Service Transformation Review Proposal for Developing Service Model

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				<p>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>						
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>n.b. contributing to this risk is the move from face to face to on-line teaching.</p>	<p>Medicines policies & procedures.</p> <p>Training matrix in place</p> <p>training available via ESR</p>	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> <p>MSAG agenda inc. mandatory training</p> <p>Medicines</p>

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										management metrics presentation

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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>	<p>Manipulation of injected activity and scan times to minimise cancellations. Being flexible and agreeing to fit extra patients in on other days.</p>	15	6	29/03/2019	12/03/2019	monitoring and informing FDG availability

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1022	Delamere and Network clinics	Quality Committee	Risk to Future clinical model not being fulfilled.	<p>Cause:</p> <p>We are struggling to transition patients/treatments from Wirral to sector/local hubs due in part to a lack of strategy to engage our clinicians/health professionals/patients</p> <p>Effect:</p> <p>1. We are unable to accommodate new and novel drugs at Wirral site due to capacity (i.e. recently compassionate use of durvolumab</p> <p>2. Risk to patient safety with currently 4 chairs per day over extended at Wirral site (evidenced capacity & demand modelling)</p> <p>3. We are having 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> <p>Impact:</p> <p>1. Safety implications with increase in flow through of patients at CCC Wirral site</p> <p>2. Quality of care implications relating to demand at CCC Wirral site</p> <p>3. Reputational damage to the Trust with inability to offer new & novel treatments</p> <p>4. Lack of patient choice/availability of drugs/patient</p>	<p>Staff are being bought back from hubs to cover clinics for safer staffing levels</p> <p>Weekly manager meeting to manage activity</p> <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>	15	1	08/04/2019	11/03/2019	<p>Review oral SACT Renal</p> <p>UKONS training 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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				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						
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	27/02/2019	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 coroners' 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	11/03/2019	complete risk assessment for DPD testing set up task & finish group

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1035	Workforce and Organisational Development	Quality Committee	Effective use of ESR	<p>Inaccuracy of the Trust hierarchy including position competencies within ESR impacts negatively upon workforce monitoring and reporting both internally and externally.</p> <p>Inaccuracy of establishment within ESR impacts upon the Trusts ability to accurately monitor and report workforce data and compliance.</p>	Manual work around processes in place to align the ledger with ESR.	15	4	31/12/2019	01/04/2019	ESR Project Plan
1039	Pharmacy	Quality Committee	Incorrect rate of infusion via pump	<p>Cause: Multiple incidents regarding incorrect infusion rate including a SUI across the Trust. 28 incidents reported since 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>Self-assessment by nurses available</p> <p>Train the trainer training available</p>	15	3	27/04/2018	28/02/2019	<p>Report on behalf of HO the pump training records for nursing staff</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> <p>Task & finish</p>

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										group for infusion incidents
1056	Workforce and Organisational Development	Quality Committee	Workforce Plan	Failure to develop and approve the workforce plan will impact upon the Trusts ability to respond and deliver the required workforce for the future.	Draft WFP presented to Board Dedicated resource assigned to develop and finalise the WFP. Workforce strategy OD Strategy	15	6	30/04/2019	28/02/2019	Workforce modelling
1011	Physics	Finance and Business Development	Overspend on parts required for repair of Linacs	Cause: Spend on parts from Varian to repair linacs has exceeded the expected yearly allocated budget of £280k. Effect: Additional spend is required to fund any further parts from Varian to repair linacs for the remainder of the financial year. 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.	None.	15	8	31/03/2019	04/03/2019	
990	Out Patients	Quality Committee	Future clinical model for oral SACT delivery	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	Until this is fully implemented several controls have been put in place to ensure patient safety. 1. Communication was given to all nursing staff that the practice of giving out oral	15	2	25/10/2019	29/03/2019	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. This plan is dependent on the successful implementation of</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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				the future clinical model whereby patients will be treated nearer to their home. Therefore freeing capacity for the transition of SACT out of OPD.						