



Report Cover Sheet

Report to:	Trust Board	
Date of the Meeting:	27 March 2019	
Agenda Item:	P1/056/19	
Title:	Integrated Performance Report – Month 11 2018/19	
Report prepared by:	Hannah Gray, Head of Performance and Planning	
Executive Lead:	Barney Schofield, Director of Operations and Transformation	
Status of the Report:	Public	

Paper previously considered by:	N/A
Date & Decision:	N/A

Purpose of the Paper/Key Points for Discussion:	<p>This paper provides the Board with an update on the Trust's performance for Month 11 (February 2019).</p> <p>The report includes the Integrated Governance Report (IPR) for the Trust and a commentary on the red rated indicators:</p> <p><u>CQUIN requirements:</u> despite marked improvement in Q3, with 5 achieved out of 8 assessed, the confirmed value withheld for Q3 is £58,609. There is a dedicated CQUIN group focussing on the delivery of the current CQUIN targets and preparing for the new CQUINs in 2019-20.</p> <p><u>Sepsis:</u> IV antibiotics received within an hour – 95% for February (1 patient) against a target of 100%, this was due to a single patient with IV access problems. An education programme has been developed for NEWS 2 for the deteriorating patient</p> <p><u>Sickness absence:</u> 4.14% for February against the target of 3.5% or less. There has been improvement in month 11. Seasonal flu has been the main reason for sickness but there is on-going work in the workforce team to target stress/anxiety with new focus on Health & Well Being of staff</p> <p><u>PADR:</u> 93% for February against the target of 95%. This decline is related to Long Term Sickness and Maternity leave. A new process is being put in place for this group.</p> <p><u>Agency cap-</u> The Trust has breached the Agency Cap in month 11, and will breach the cap at the year end. This is due to shortage of Consultant radiologists and clinical oncologists. Some recruitment complete and more underway.</p> <p><u>62 Day Cancer Waits target:</u> 86.5% (unvalidated) for February 2019 after reallocation. Extra clinics have been</p>
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	<p>mobilised in lung/UGI to provide additional capacity. System wide actions include a review of key pathways that are problematic (colorectal; UGI and H&N), this is being led by the Cancer Managers Group (Cancer Alliance).</p> <p><u>VTE</u> is resolving with the ownership but remains under close monitoring to gain assurance that improvements have been embedded:</p> <p><u>Trust wide Statutory and Mandatory Training:</u> At 90% for February. There is significant improvement across all areas however; some areas have yet to meet the target. Anticipate BLS and ILS compliance to be achieved by 6 April. Weekly monitoring is in progress. In addition, directorate performance is being monitored at a weekly meeting and a new, well received e-tool has been developed to enable Directorates to monitor compliance more closely.</p>
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Action Required:	Discuss	X
	Approve	
	For Information/Noting	X

Next steps required	
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The paper links to the following strategic priorities (please tick)

Deliver outstanding care locally	X	Collaborative system leadership to deliver better patient care	X
Retain and develop outstanding staff		Be enterprising	X
Invest in research & innovation to deliver excellent patient care in the future		Maintain excellent quality, operational and financial performance	X

The paper relates to the following Board Assurance Framework (BAF) Risks

BAF Risk	Please Tick
1. If we do not optimise quality outcomes we will not be able to provide outstanding care	X
2. If we do not prioritise the costs of the delivering the Transforming Cancer Care Programme we will not be able to maintain our long-term financial strength and make appropriate strategic investments.	
3. If we do not have the right infrastructure (estate, communication & engagement, information and technology) we will be unable to deliver care close to home.	
4. If we do not have the right innovative workforce solutions including education and development, we will not have the right skills, in the right place, at the right time to deliver the outstanding care.	
5. If we do not have an organisational culture that promotes positive staff engagement and excellent health and well-being we will not be able to retain and attract the right workforce.	X
6. If we fail to implement and optimise digital technology we will not deliver optimal patient outcomes and operational effectiveness.	
7. If we fail to position the organisation as a credible research partner we will limit patient access to clinical trials and affect our reputation as a specialist centre delivering excellent patient care in the future.	

8. If we do not retain system-side leadership, for example, SRO for Cancer Alliance and influence the National Cancer Policy, we will not have the right influence on the strategic direction to deliver outstanding cancer services for the population of Cheshire & Merseyside.	
9. If we do not support and invest in entrepreneurial ideas and adapt to changes in national priorities and market conditions we will stifle innovative cancer services for the future.	
10. If we do not continually support, lead and prioritise improved quality, operational and financial performance, we will not provide safe, efficient and effective cancer services.	X

Equality & Diversity Impact Assessment

Are there concerns that the policy/service could have an adverse impact on:	YES	NO
Age		
Disability		
Gender		
Race		
Sexual Orientation		
Gender Reassignment		
Religion/Belief		
Pregnancy and Maternity		

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

Integrated Performance Report (Month 11)

Introduction

The report provides the Board with an update on the Trust's performance for month 11 (February 2019). The report includes the Integrated Governance Report for the Trust in addition to commentary on those indicators rated 'red'.

The following changes have been made to the report to include:

- All dashboards are presented at the beginning of the report in order to facilitate a collective visual of performance
- The Risk Register has been removed due to the fact this is now reviewed at the new Risk Management Committee, relevant sub-committees and escalated to the Board as appropriate.
- The CQC Insight section has been removed as this is analysed, reported and managed via the Integrated Governance Committee
- Stem Cell Transplant mortality data has been included in the report.

In summary, the metrics that have not been achieved are as follows:

CQUIN requirements: Despite marked improvements in Quarter 3 with 5 out of 8 being assessed, the confirmed value withheld for Quarter 3 is £58,609.00. A dedicated CQUIN group is focussing on the delivery of the current CQUIN targets in addition to preparing for the new CQINS in 2019-2020.

Sepsis- Intravenous Antibiotics received within an hour: For February, 95% (1 patient) against a target of 100% which was due to one patient with problems relating to intravenous access. An education programme has been developed for NEWS2 (early warning tool for recognising a deteriorating patient).

Sickness absence: Although there has been an improvement in Month 11, performance for February was 4.14% against a target of 3.5% or less. Seasonal flu has been the main reason for sickness however, there is on-going work within the workforce team to target stress/anxiety with a new focus on Health and Wellbeing of staff.

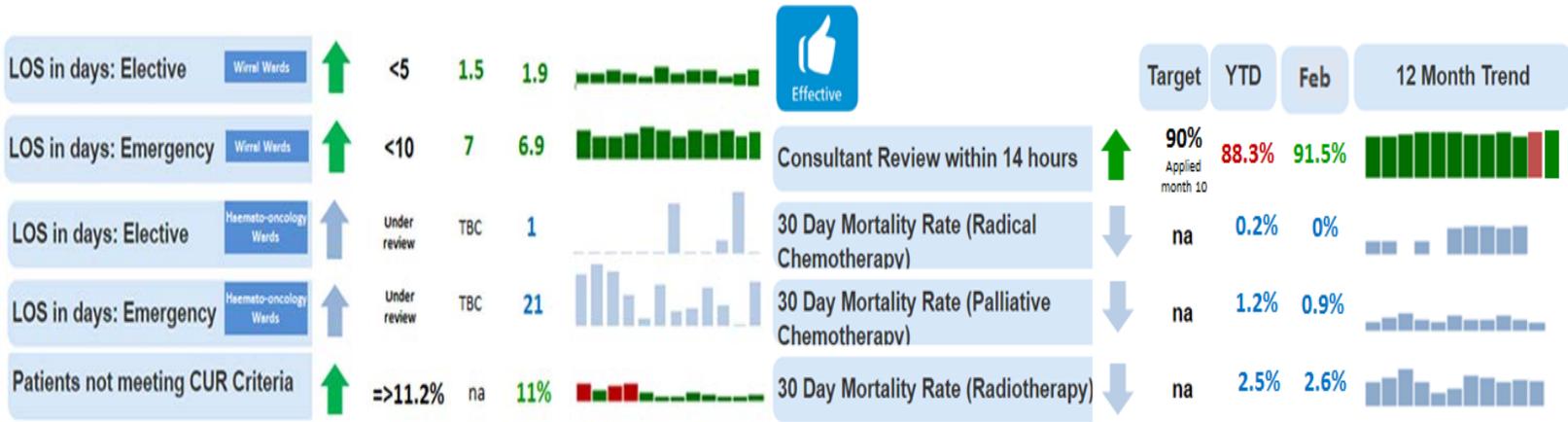
PADR: Performance for February was 93% against a target of 95%. This decline has been attributed to Long Term Sickness and Maternity Leave. A new process is being established for staff in those groups.

Agency Cap: The Trust breached the Agency Cap in Month 11 and will breach the Cap at the year end. This is due to a shortage of Consultant Radiologists and Clinical Oncologists. Some recruitment has been completed with more underway.

62 Day Cancer Waits Target; After reallocation, performance for February is 86.5% (un-validated). Additional clinics have been mobilised in lung/upper Gastroenterology to provide additional capacity. System wide actions include a review of key pathways such as colorectal, upper GI and head and neck which is being led by the Cancer Managers Group (Cancer Alliance).

VTE: Remains under close monitoring in order to gain assurance that improvements have been embedded.

Trust wide Statutory Training: Performance for February is at 90%. There is significant improvement across all areas however some areas have yet to meet the target. It is anticipated that BLS and ILS compliance will be achieved by 6 April. Weekly monitoring is currently in progress. In addition, Directorate performance is being monitored weekly, and a new, well received e-tool has been developed to enable Directorates to monitor compliance more closely.



Stem Cell Transplant Mortality See detailed information in section 2.1

CQUIN Update and Performance

In 2018/19, the total CQUIN fund across both Commissioners is £2,009,811. In Quarter 3 5 CQUINs were achieved, 1 not achieved, 1 partially achieved, 1 still to be confirmed by commissioners (although likely to be fully compliant) and 3 not assessed by commissioners until Quarter 4. The confirmed value to date withheld for Quarter 3 is £58,609. 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 Committee via the 'Triple A' Report and non-achievement of all CQUINs remains on the risk register. A dedicated CQUIN group meets to drive improvement.

The 2019/20 CQUIN value and number of schemes will be reduced. Specialised commissioning CQUIN schemes are likely to be:

- 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)

The CQUIN schemes proposed by Liverpool CCG are as follows:

- Staff Flu Vaccinations
- Alcohol and Tobacco – Screening and advice
- Three high impact actions to prevent hospital falls

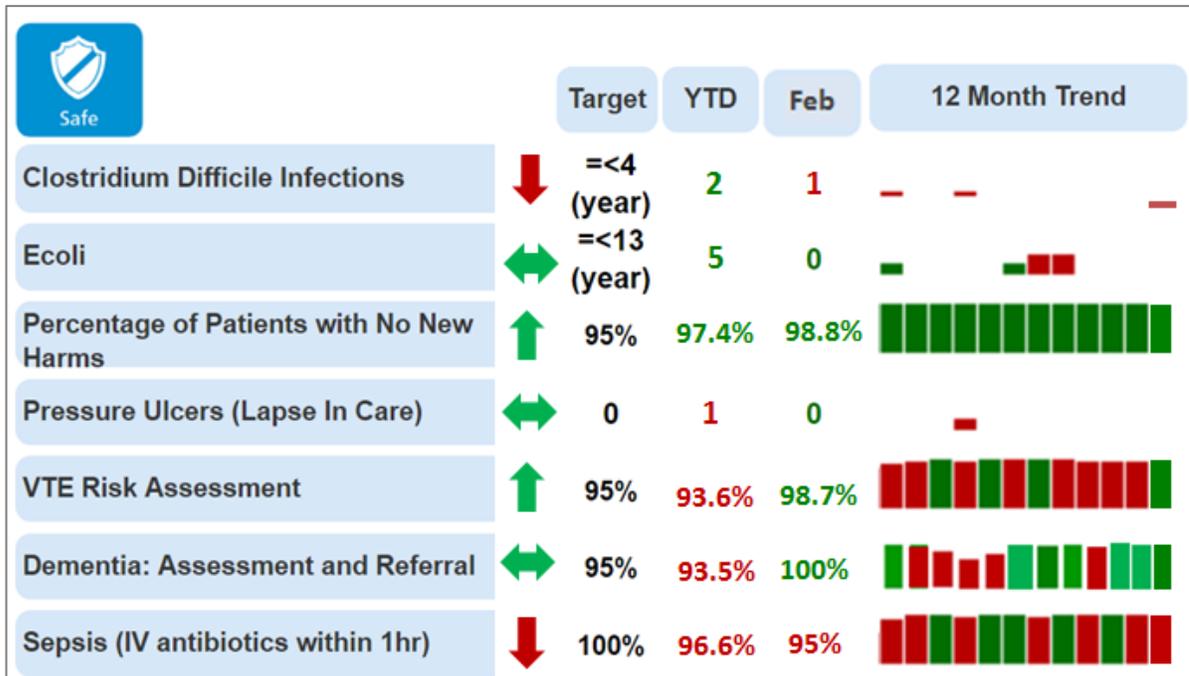
2018 / 19 performance:

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 and exception comments	Value	£ withheld in 18/19	2017/18				2018/19				
			Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Staff Survey Although the final CQUIN figures have not been published, the results received to date indicate that the improvement required has not been achieved. The full survey results are being analysed and the Trust's staff survey action plan will be revised accordingly.	£26,217	Not yet assessed									
Healthy food		Not yet									
Flu vaccinations		Not yet									
Alcohol and tobacco Training has been delayed to a focus on statutory and mandatory training, although this is now ready to be rolled out	£26,217	£16,858									
Holistic Needs Assessment	£198,926 (NHSE) £52,370 (LCCG)	£125,648									
End of Treatment Summaries	£198,926 (NHSE) £52,370	£0									
Clinical Utilisation Review	£528,273	£0* (*dependent on Q3&Q4 compliance)									
Enhanced Supportive Care	£357,944	£0									
Optimising Palliative Chemotherapy The required number of peer discussions were not completed / recorded for Q1 or Q2 2018/19. Action Taken to improve compliance •The Meditech system has been amended to enable easier capture of these conversations and we expect compliance to improve in Q4 as a result. •The Pharmacy Team is working with the lead clinician to develop a system that will enable the peer discussion.	£217,413	£163,060									
Medicines Optimisation	£140,241	£0									
Dose Banding	£210,915	£0									

1. Safe



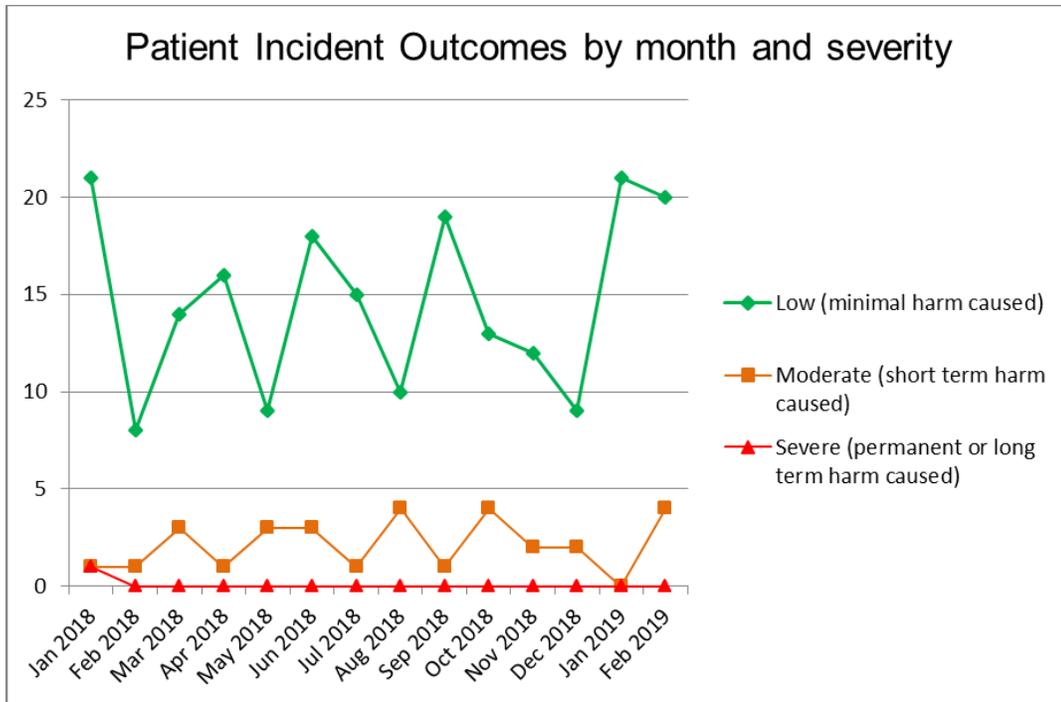
Haemato-oncology (HO) data is included in all the above KPIs except Sepsis which will be included from the Month 12 report. Infections are CCC attributable only.

1.1 Never Events

There have been 0 never events from 1/4/18 – 28/02/19.

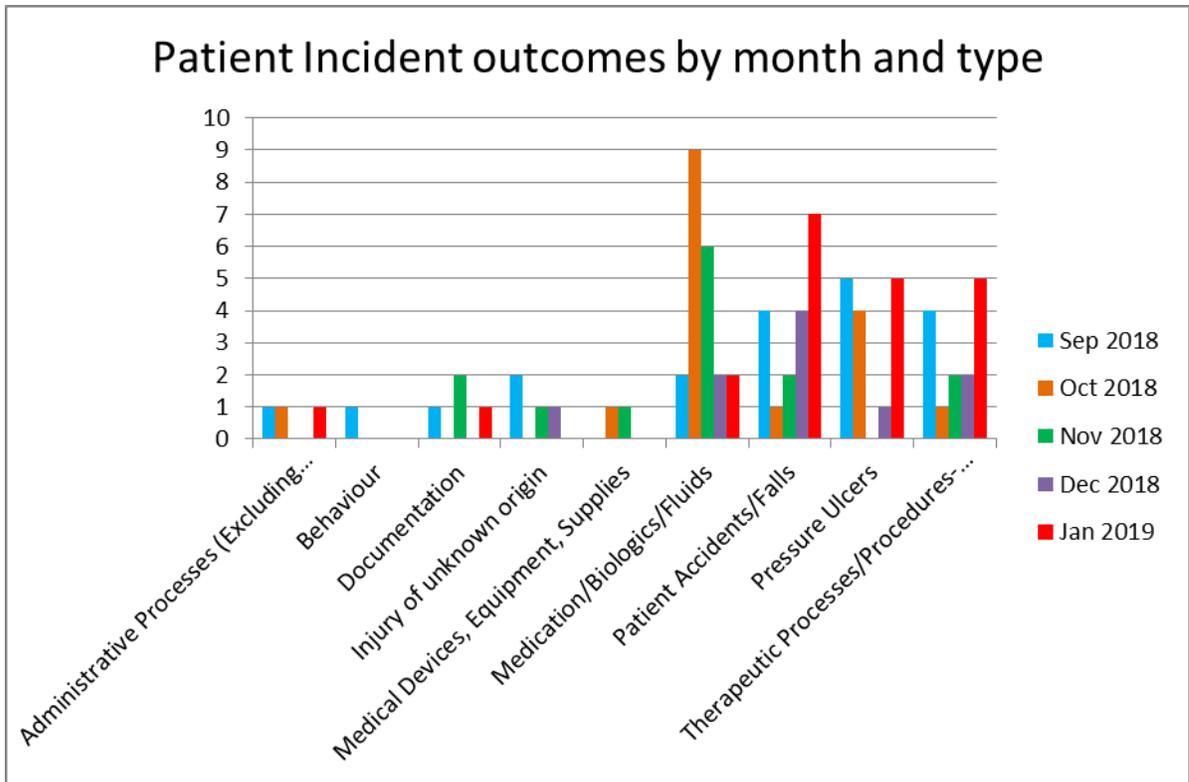
1.2 Incidents

The chart below shows incidents resulting in harm, by level of harm and month from 1/1/18-28/02/19



Four incidents have been graded as moderate harm by the reporter in February; the investigations are in progress via the relevant managers and on completion grading will be confirmed. Two incidents involved extravasations, one patient fall in Radiotherapy and one relating to a delay in Radiotherapy.

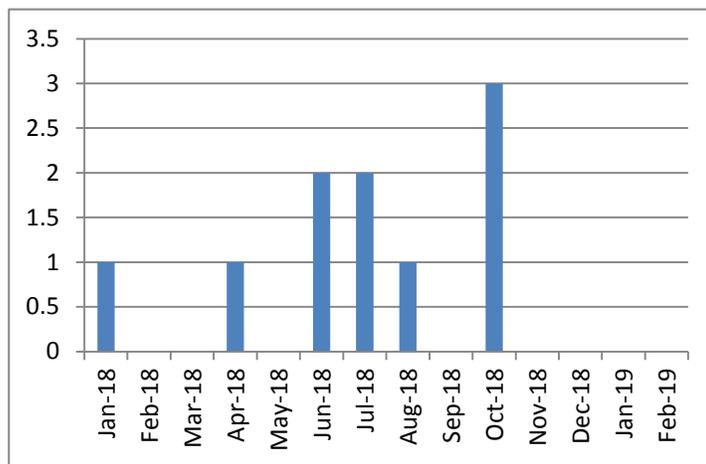
The chart below illustrates incidents resulting in harm, by incident type/category for the last 6 months. Falls, VTEs and pressure ulcers are reviewed at the monthly harm collaboration meeting.



Serious incidents:

There were no serious incidents in February 2019.

Serious Incidents by month



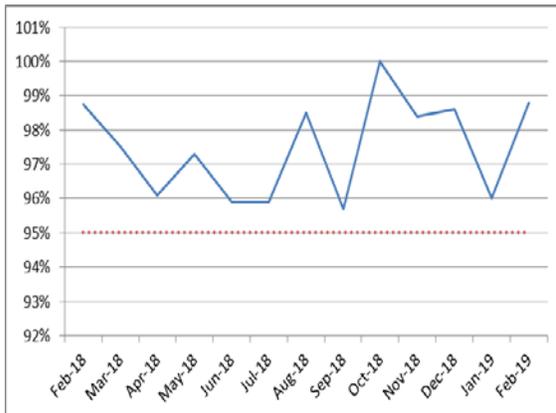
Inquests/Coroner's investigations

Two new Coroner's investigations were opened in February 2019. Reports have been provided to the respective Coroners (Cheshire Coroner and Merseyside Coroner) following which further Directions will be provided to the Trust.

1.3 Harm Free Care

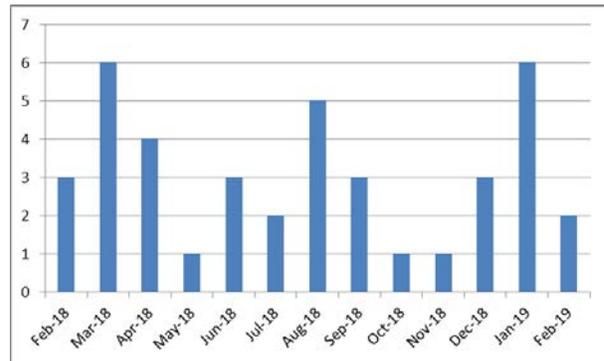
The dotted line represents the target (where one has been set).

Safety Thermometer (CCC harm free)



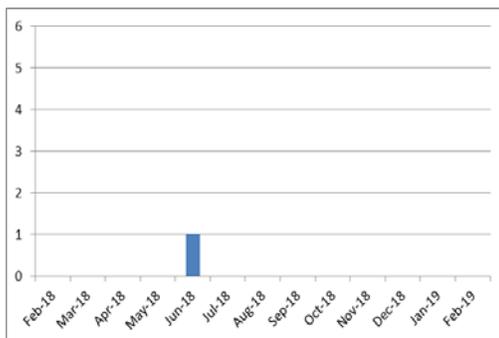
The target of 95% is consistently achieved.

Falls resulting in harm



Slight increase in inpatient falls noted Dec 18/Jan19- 19.99% of patient falls risk assessments completed on admission (within 24 hours). No identifiable trends.

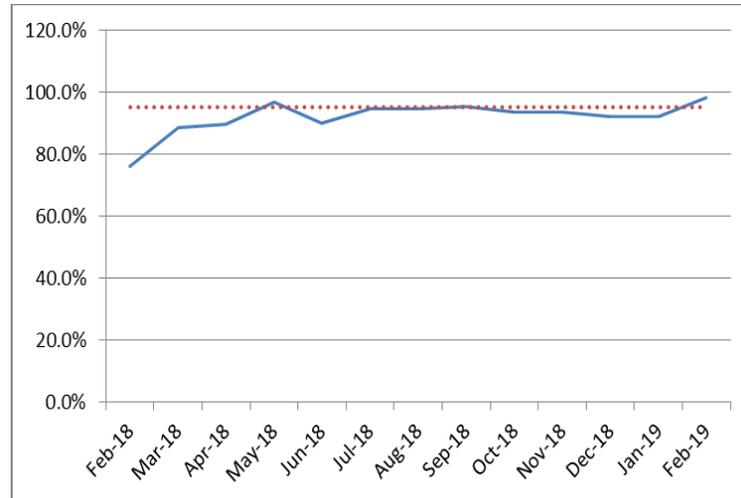
Pressure Ulcers (attributable) | Target = 0



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

VTE Risk Assessment

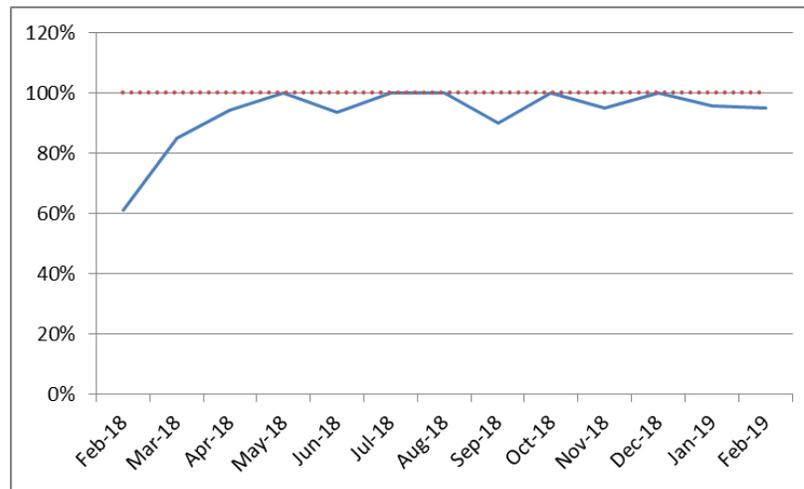
Compliance has improved in 2018/19 and the target has been achieved in February 2019.



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 highlighting missed VTE assessments to ward Doctors on a daily basis to ensure completion.
- 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.
- Discussion with Sulby ward manager, agreement made that 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.
- 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 finalised yet, a prompt or alert to be added to remind medics to complete VTE assessment.
- Weekly performance report until the target is met.

Sepsis (IV Antibiotics within 1 hour)



Compliance has improved in 2018/19; however the Trust is not consistently achieving the target, with 95% for February 2019.

In February 2019, 1 patient with red flag sepsis indicators did not receive antibiotics within 1 hour due to difficulties with Intravenous access. The patient died during this admission; a review of the notes indicates this patient died due to disease progression. This death will also be reviewed as part of the mortality review process. There is no documented evidence that the sepsis screening tool was completed for this patient.

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

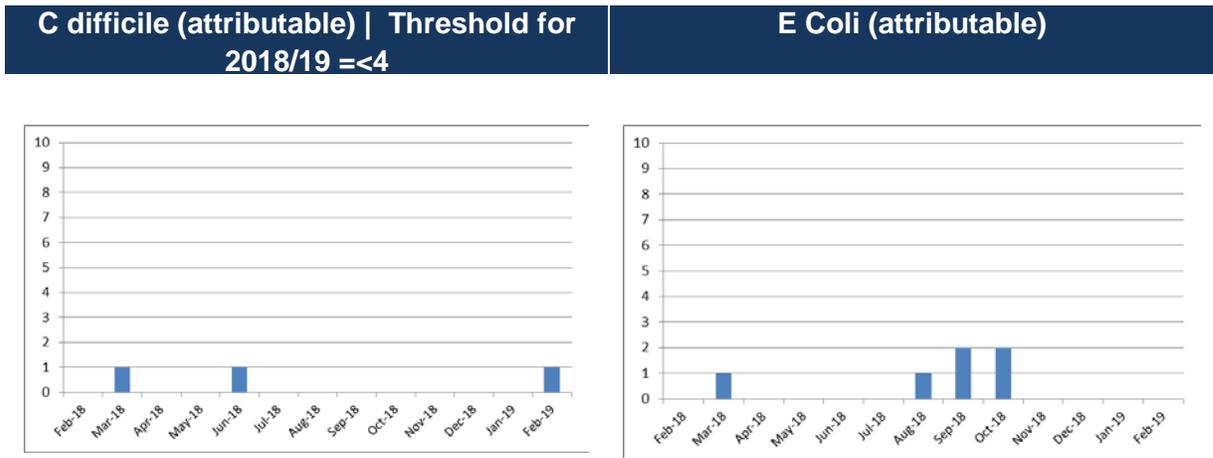
In addition, the sepsis screening and review tool went live in Meditech in December 2018. This supports the appropriate management of the patient, ensuring national guidance is followed and ensures accurate documentation.

Dementia Screening, Assessment and Referral

Compliance remains at 100% for February.

Health Care Acquired Infections

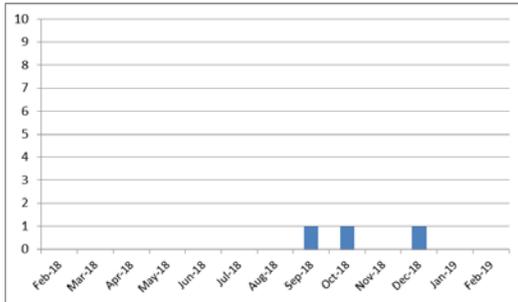
This section relates to 'reportable' bacteraemia.



There was 1 attributable case on Conway ward in February 2019. The Trust is performing well against the target of 4 attributable cases of c diff, with 2 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 to date. The analysis of the February case is currently in progress.

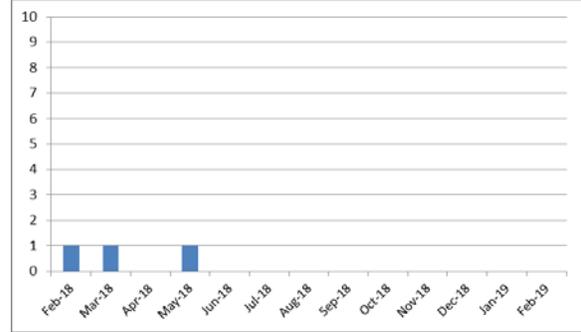
There were no attributable E coli blood stream infections in February. All Bacteraemia cases are summarised and presented for review to the Harm Free Care Collaborative with actions agreed and followed up by the group.

MSSA (attributable)



There were no attributable cases in February.

Klebsiella (attributable)



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

Pseudomonas (attributable)

There have been no attributable cases in 2018/19.

MRSA

There were 0 cases of MRSA in 2017/18 and 0 from 1/4/18 – 28/02/19.

'Non reportable' bacteraemia

Nil to report for February 2019.

1.4 Safe Staffing: Nursing and Health Care Support Workers

Safer Staffing is currently under review and will be reported in a new format from Month 1, April 2019.

2. EFFECTIVE



Haemato-oncology data is included in all the above KPIs where relevant except Consultant review within 14 hours which excludes HO before Oct 2018. The 30 day mortality data is for the previous month. 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.

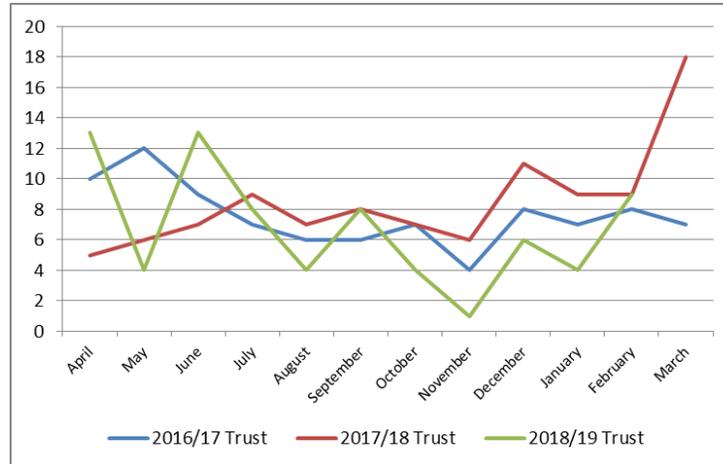
2.1 Clinical Outcomes

Mortality

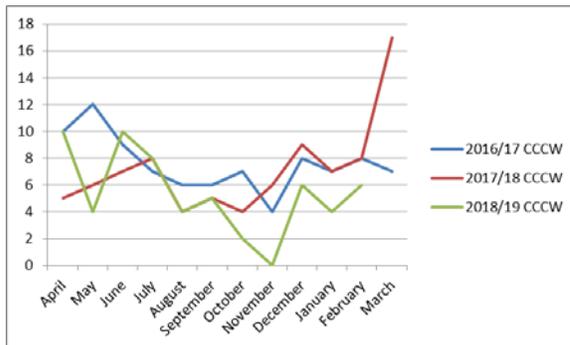
Inpatient deaths:

The first chart illustrates all CCC inpatient deaths, followed by a break down between CCC Wirral and Haemato-oncology.

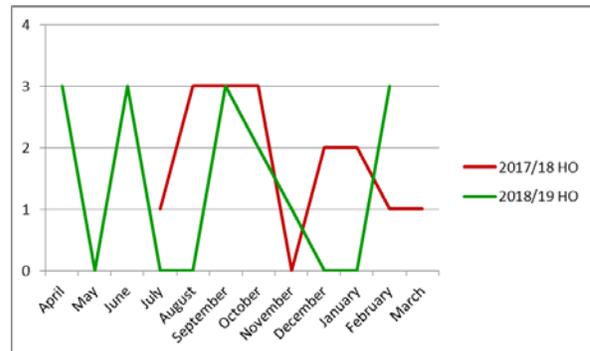
All CCC inpatient deaths



CCC Wirral wards



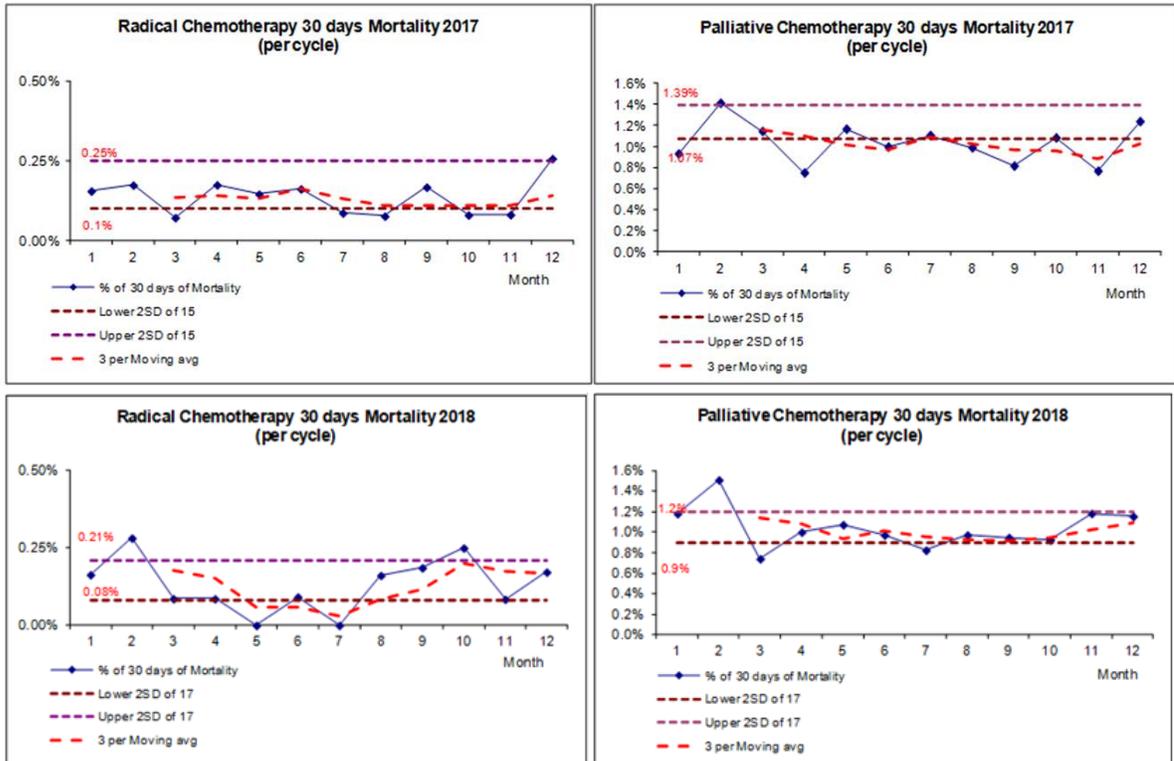
CCC HO wards

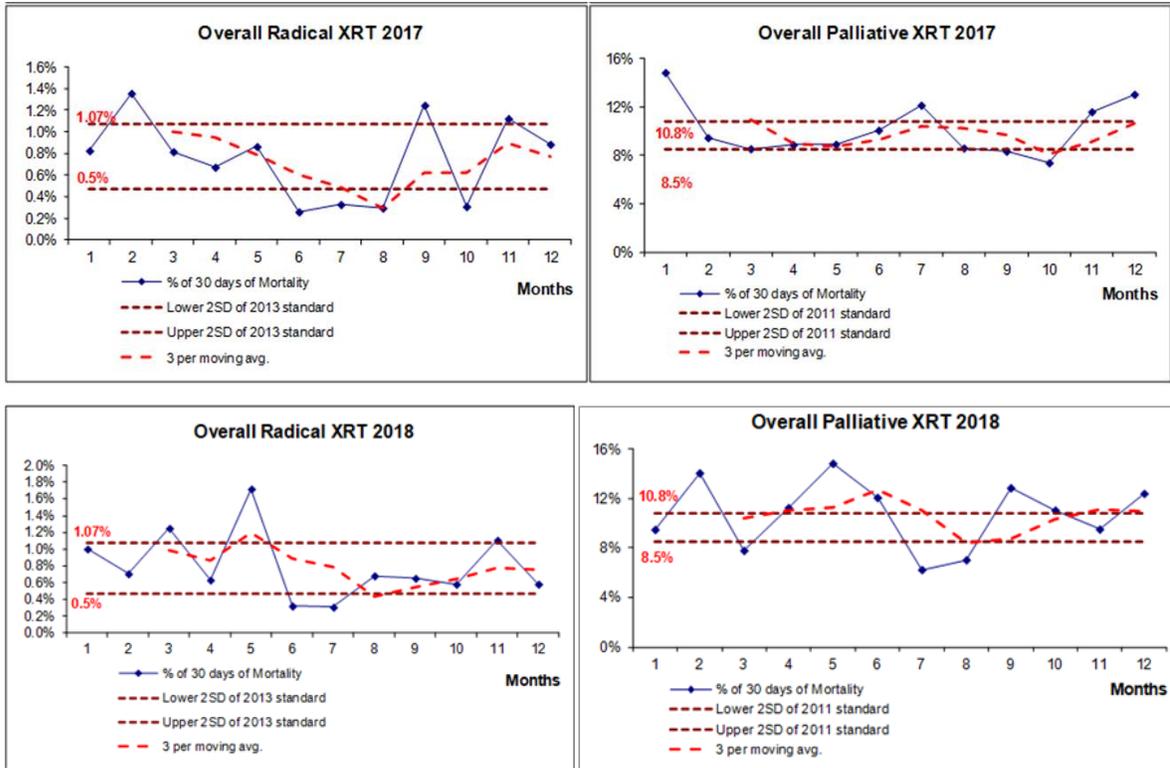


The charts reveal no significant change over the three years to date although CCC Wirral monthly figures for the last 5 months have been lower than those in the previous three years.

Solid Tumour 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 for patients receiving chemotherapy and radiotherapy (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.





Stem Cell Transplant mortality

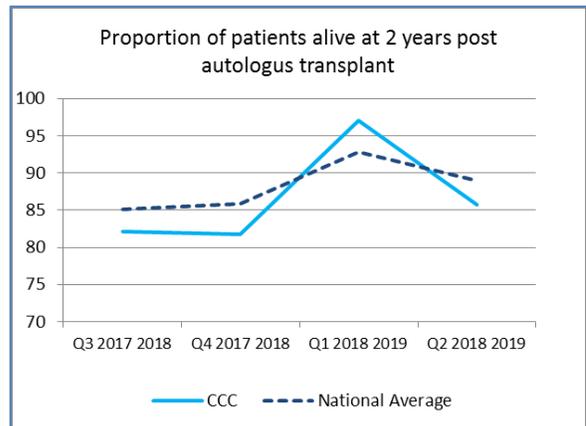
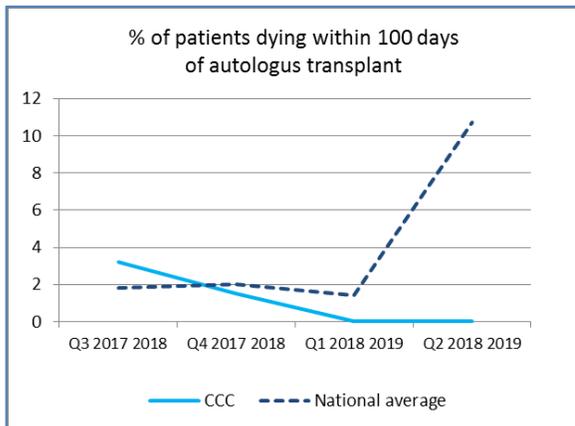
The following information is taken from NHS England's Specialised Services Quality Dashboard Collections, part of the Quality Surveillance Programme. The following data and charts relate to the latest available data, Q2 2018 2019 and show that CCC are performing better than the national average for all KPIs.

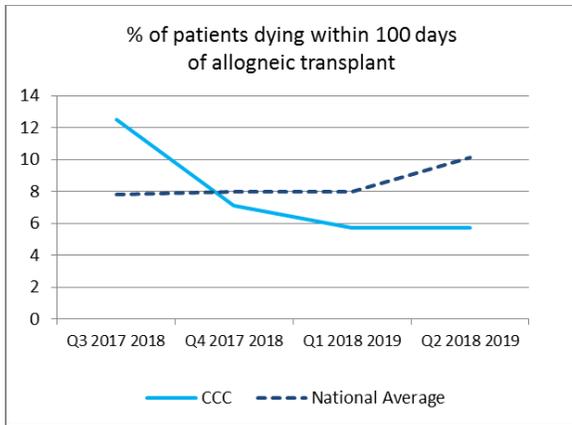
Key:



Ref	Description	Period	Num	Denom	Value	Nat Avg	Chart	Trend
BMT08a-A	Percentage of patients dying within 100 days of transplant	Oct 17 - Sep 18	0.0	66.0	0.0	10.7		
<p>Theme: Clinical Outcome Numerator Description: <div>Number of patients in denominator who died within 100 days of transplant</div> Denominator Description: <div>Total number of autologous transplants in the first 365 days of the previous 465 day reporting period</div> Interpretation Guidance: Lower is better</p>								
BMT09a-A	Percentage of patients alive at 1 year post transplant	Oct 17 - Sep 18	54.0	63.0	85.7	89.0		
<p>Theme: Clinical Outcome Numerator Description: <div>Number of patients in denominator alive 1 year after transplant</div> Denominator Description: <div>Total number of autologous transplants in the first 12 months of the previous 24 month reporting period</div> Interpretation Guidance: Higher is better</p>								
BMT13-A	Percentage of patients dying within 100 days of transplant	Oct 17 - Sep 18	*	*	5.7	10.1		
<p>Theme: Clinical outcome Numerator Description: <div>Number of patients in denominator who died within 100 days of allogenic transplant</div> Denominator Description: <div>Total number of allogenic transplants in the first 365 days of the previous 465 day reporting period</div> Interpretation Guidance: Lower is better</p>								

The following charts show changes in performance over time and reveal a positive trend for post-transplant 100 day mortality KPIs over the 12 month period

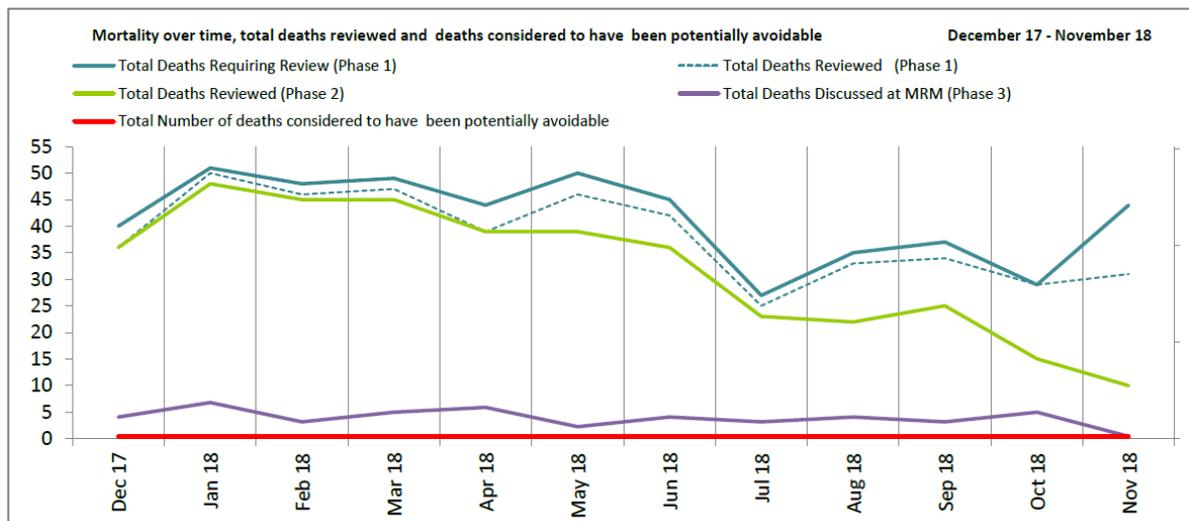




Mortality Review:

The Trust mortality review process adheres to the 2017 NHSI 'learning from deaths' Guidance. HO deaths are not included in the chart below due to delays in receiving the data, which is captured on a different EPR. The HO team continue to follow the RLBH approach; utilising MDTs to peer review all cases, with involvement of all HO consultants, nursing staff and other specialities as required. However since Dec 2018 a revised process has been agreed which now aligns mortality data collection and combines reporting. HO mortality is now included on the Trust's mortality dashboard.

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.



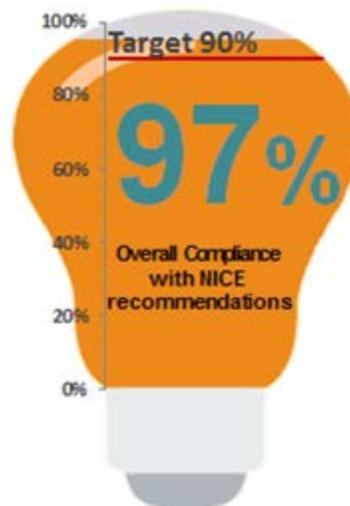
NB: A judgement on avoidability of death is only made on inpatient deaths.

Other clinical outcomes:

Head and Neck, Lung, Upper GI, Breast and Skin SRG dashboards have been developed in line with plans. The first draft of a Palliative Care Dashboard has also completed. Gynaecology and Colorectal are 90% completed. The next phase includes Urology, CNS, Specialist SRG and AO/Unknown Primary which are due to be complete by end of March. 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.

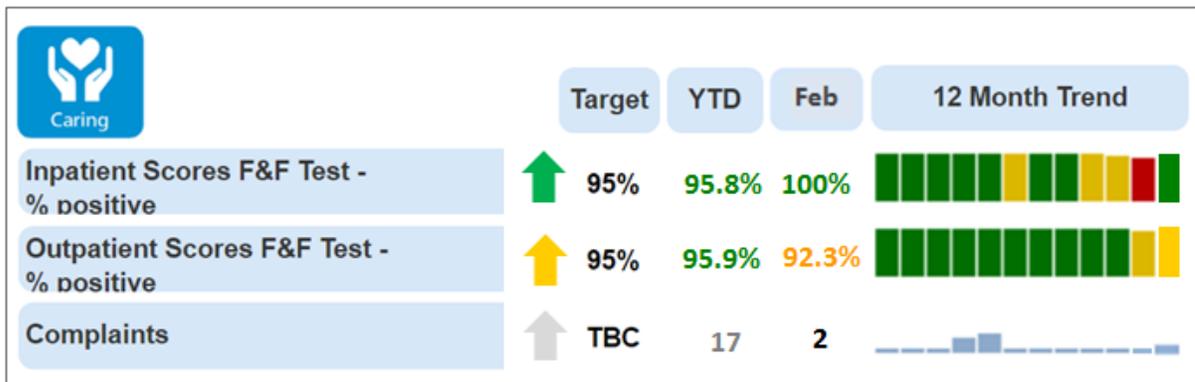


The Trust's NICE Assurance Committee provides assurance in relation to Trust compliance against the NICE Guidance.

For the 2.5% where the Trust is non-compliant, all have an implementation plan in progress which is being monitored as above. The remaining 0.5% consists of 13 individual recommendations which have been reviewed by the Trust and rejected as an acceptable risk or due to alternative treatment being available (example: a new chemotherapy drug has been made available, but an existing drug utilised by the Trust has comparable or better outcomes for patients). All rejected guidelines are monitored 6-monthly by NAC and included within monthly quality and safety meetings. A total of 22 recommendations are awaiting assessment of compliance by a named local lead, out of which 9 had not yet been assessed within the agreed timeframe.

NICE compliance information is included in each Directorate data pack, which is reviewed monthly at each Directorate quality and safety meeting

3. CARING

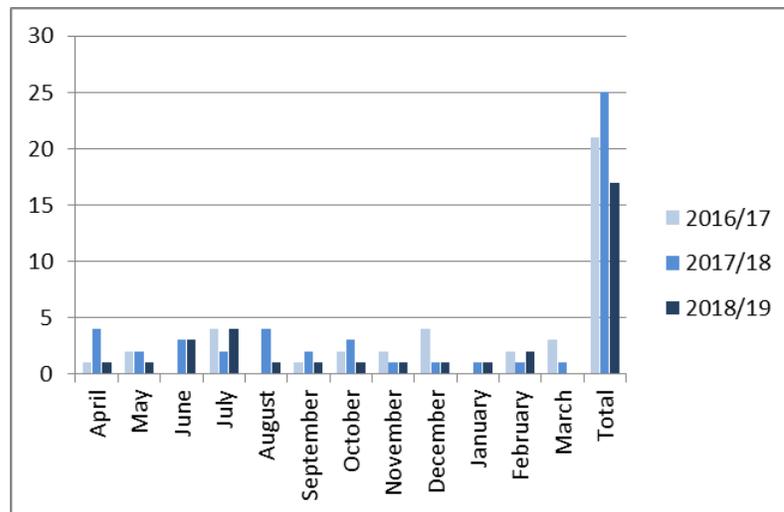


Haemato-oncology data is included in all the above KPIs.

3.1 Complaints and PALS

Complaints:

This chart below 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.



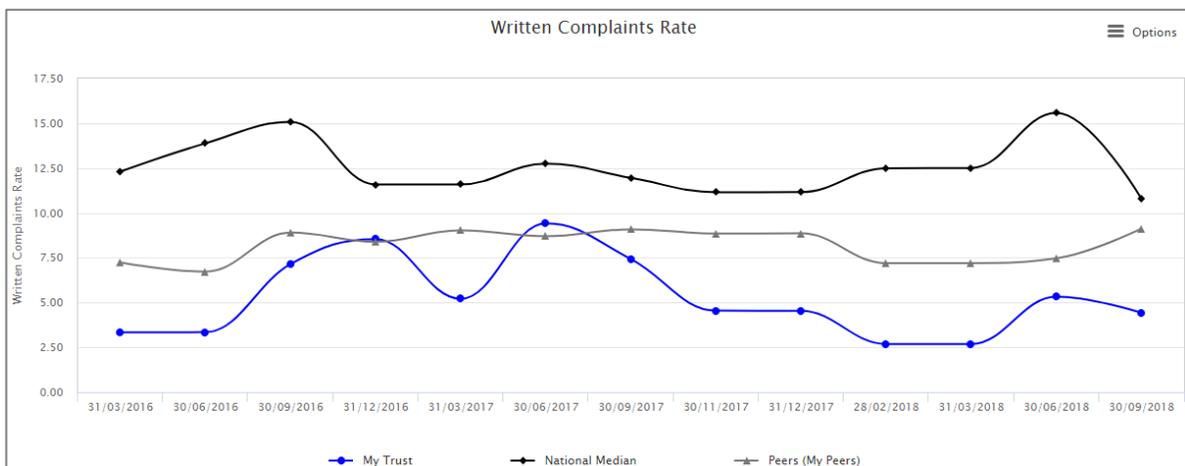
Number of Complaints (February 2019)	Received	Closed
	2	1

Lesson Learnt from Complaints

Date Closed	Responded to within 20 days	Learning
5 February 2019	No – responded within 24 days. Delay in internal approval process	<ul style="list-style-type: none"> • Staff to ensure patients have a full understanding of their medication • Document discussion in the electronic system • Patient flow team reviewing discharge procedures to ensure effective and seamless community discharge

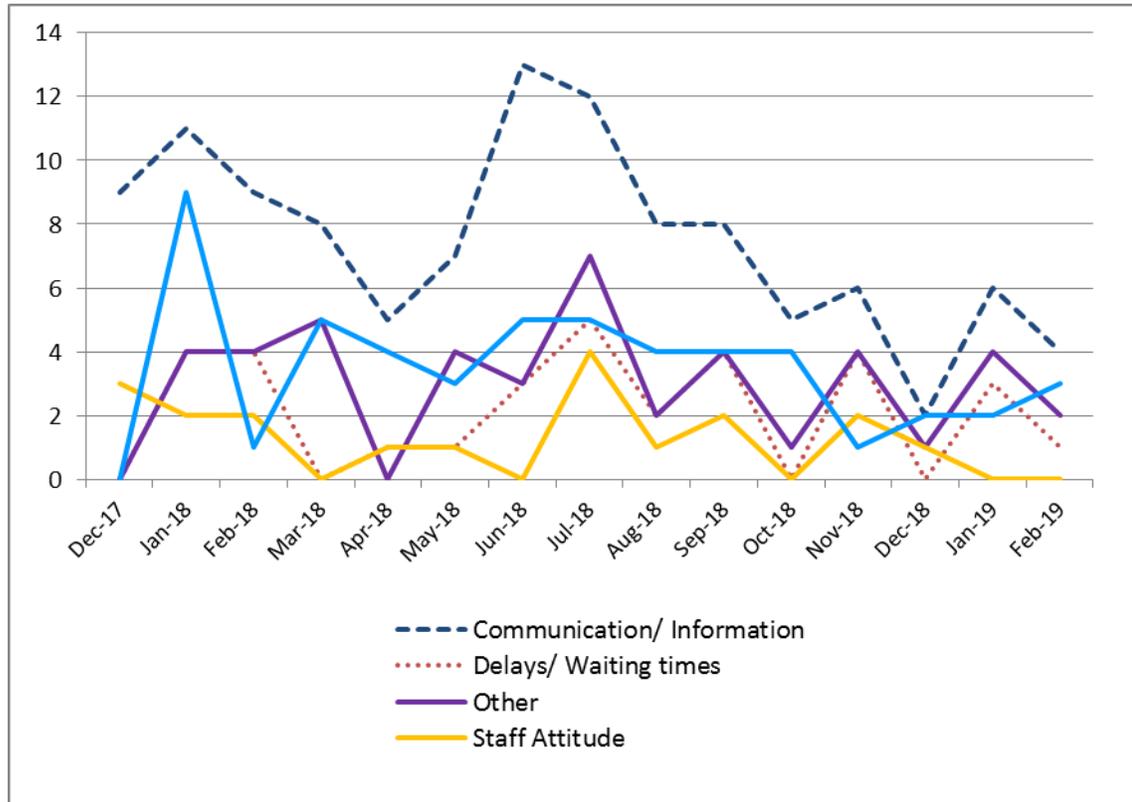
Benchmarked Data

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.



Patient Advice and Liaison Service (PALS):

This chart shows the trends for the 5 most common categories of PALS contact.



In Quarter 2 and Quarter 3 there has been a significant reduction in the number of PALS contacts relating to communication / information. This lower level is maintained in Quarter 4.

Since April 2018, 54% of contacts in the category of 'other' were compliments on care or treatment. The remaining contacts include enquiries and minor concerns.

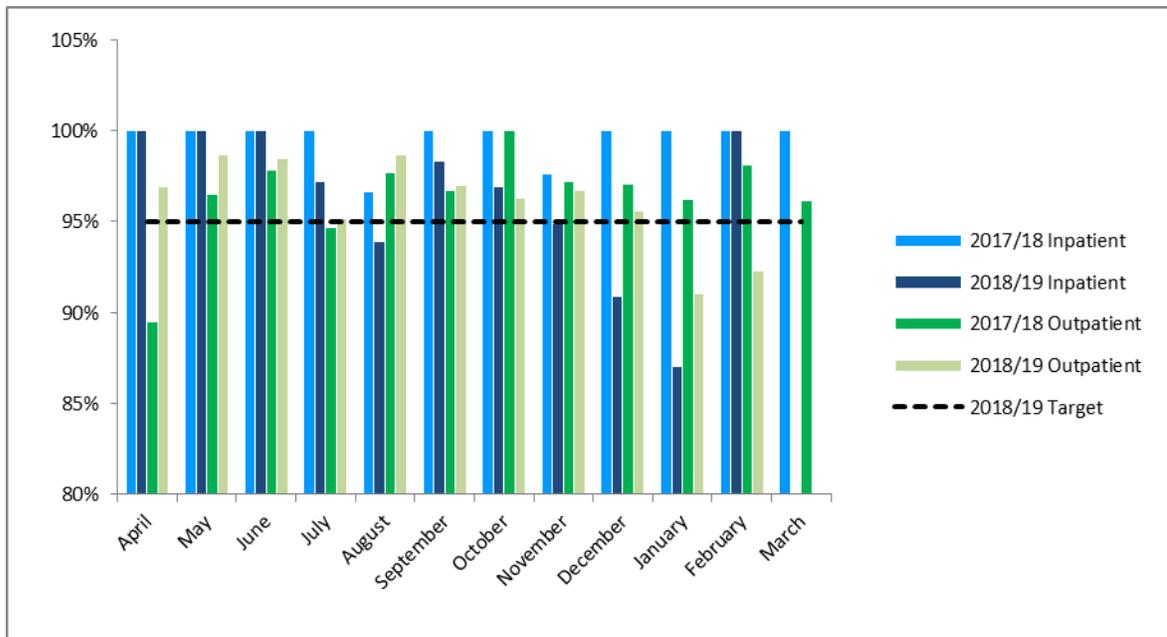
Whilst not featuring in the top 5, the following 'care' related contacts were also made in this 11 month period:

Category	Total contacts
Admissions, Discharge and Transfer	10
Consent	1
End of Life	1
Privacy, Dignity and Wellbeing	3
Total	15

3.2 Surveys

Friends & Family Test (FFT): 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.



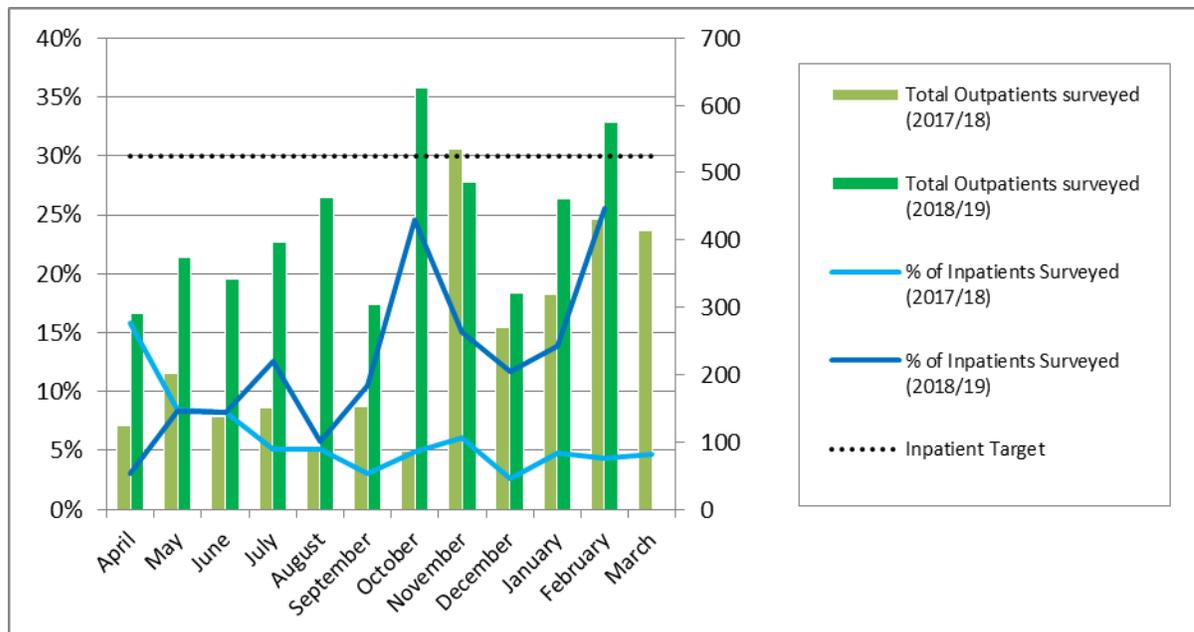
The target for inpatients recommending the Trust was achieved in February 2019 (100%) after falling below the 95% target for the previous 3 months. The outpatient scores are below the target for the second consecutive month, at 91% (January) and 92% (February).

The outpatient feedback is generally very positive, however there has been a recent increase in the number of patients answering 'don't know', resulting in a fall in the % of patients 'likely' or 'extremely likely' to recommend the Trust to friends and family, as indicated in the table below. FFT methodology is columns 1 and 2 divided by number of responses. This trend is being reviewed with the digital system supplier to understand if this relates to the usability of the hand held device version of the survey.

	Total Responses						Number of cards returned
	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know	
Apr-18	240	41	6	1	0	2	290
May-18	338	32	2	0	1	2	375
Jun-18	303	34	3	2	0	0	342
Jul-18	318	60	2	7	2	2	391
Aug-18	388	69	1	2	1	2	463
Sep-18	281	15	1	2	1	5	305
Oct-18	549	54	5	3	2	13	626
Nov-18	414	55	2	2	1	11	485
Dec-18	275	32	1	3	0	10	321
Jan-19	381	38	1	2	1	38	461
Feb-19	477	54	5	3	0	36	575

Friends & Family Test: Response rates

The chart below shows the total outpatients and % of inpatients surveyed by month in 2017/18 and 2018/19.



Inpatient response rate stands at 25.5%, this is a significant improvement due to an error being identified in the discharge figures for HO. Outpatient responses have also risen significantly to 461 received in January and then 575 received in February. 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.

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

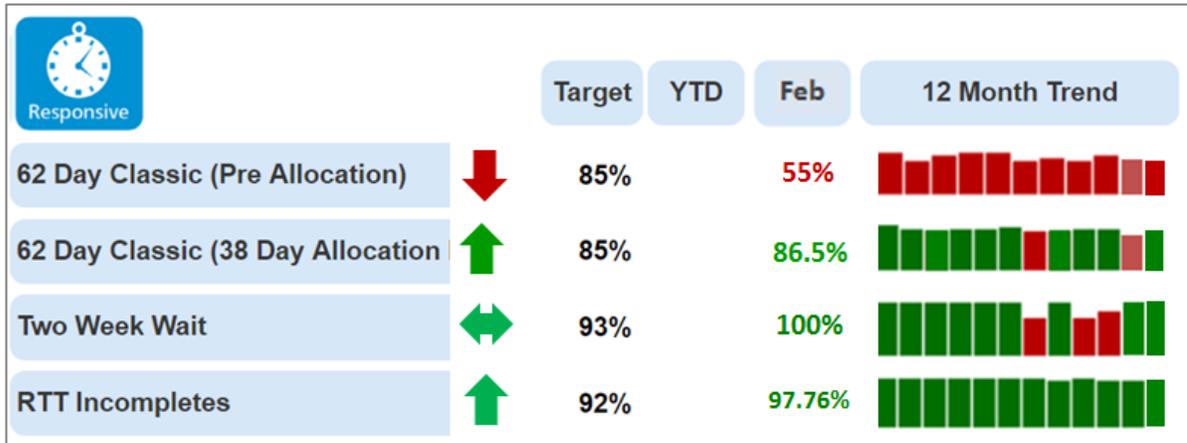
3.4 Claims

There are currently 12 open and ongoing claims against the Trust comprising 7 claims alleging clinical negligence, 4 employers liability and one public liability claim.

Lessons learned from claims:

- Accurate and complete documentation at the time of the incident, including risk assessments. Risk assessment and checking process reviewed.
- One claim was a serious incident and actions identified following the serious incident learning meeting included additional clinical checks for overseeing blood results in Trials from senior nursing staff.

4. RESPONSIVE



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

4.1 Cancer Waiting Times Standards

National Standards

*February figures are accurate as at 16th March, but are not finally validated until 5th April.

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

The 62 day screening target was not achieved, at 50% (number of patients below deminimus level). Two patients breached, both late referrals. One patient was treated within 24 days and one breached due to a slight delay to 1st appointment and availability of an interpreter for their planning appointment.

62 Day waiting times standard:

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 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.

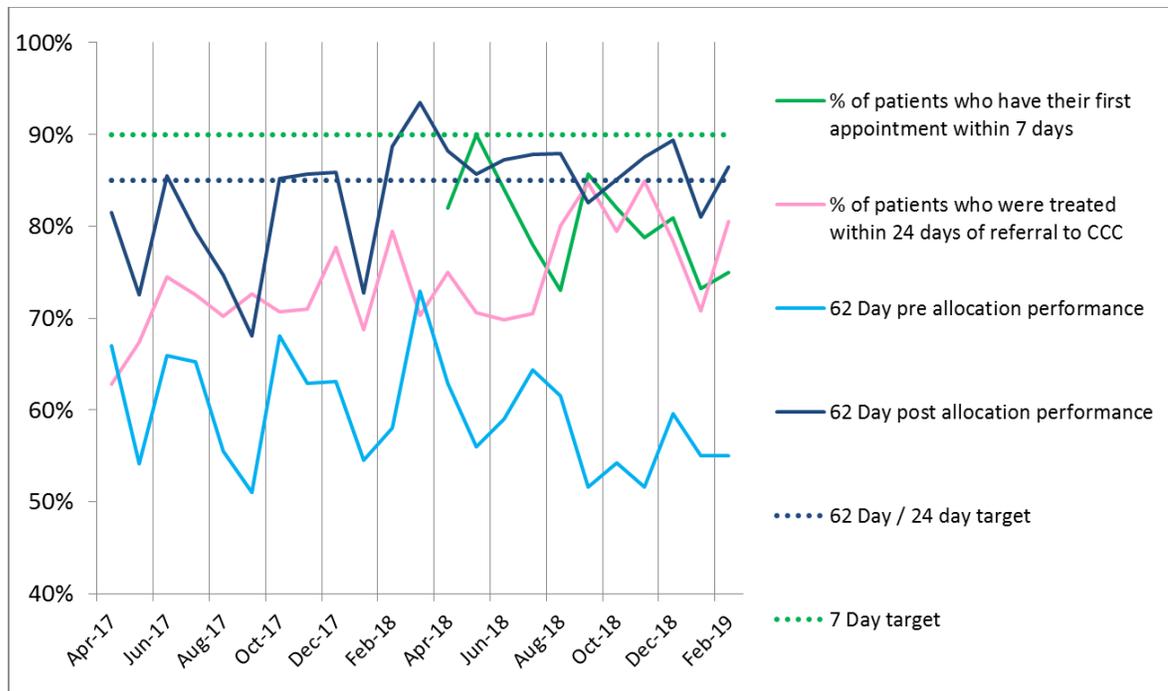
Trusts have been advised that the NHS Cancer Waiting Times Guidance Version 10.0 will be published in April 2019. The expected changes to the current rules are likely to have positive implications for CCC's 62 Day performance figures.

The as yet un-validated position for February is one of compliance with the 62 Day post allocation figure, at 86.5%. The breach details are as follows:

Pt	Day into CCO	Days at CCC	Treated on Day	Tumour	Trust	Treatment	Reason	Avoidable Breach
Half breach to CCC: Patient received by CCC after day 38 but not treated within 24 days								
1	56	65	121	Breast	RLH	Palliative Chemo	Medical - pt required treatment to mets prior to primary treatment & delay to chemo due to patient severe anxiety re treatment & choice of start date	No
2	50	27	77	Lung	LHCH	Radical RT	Patient delay to treatment/choice Tx planned to start within 62 day target but pt had work commitments. Booked within the 24 day target but patient not happy to go ahead with treatment on the basis of nerve damage & wanted to see consultant before starting tx	No
3	51	28	79	Breast	Aintree	Palliative Chemo	Patient choice to leave consultation to attend dental appointment & Admin @ referring trust - Pt unaware of 1st appt. JOH advised that Aintree were going to advise pt when she was told her diagnosis	No

Pt	Day into CCO	Days at CCC	Treated on Day	Tumour	Trust	Treatment	Reason	Avoidable Breach
4	57	28	85	H&N	WHH/STH/AIN	Radical RT/Chemo	Patient choice - changed mind about PEG. Declined PEG at 1st and changed his mind	No
5	104	29	133	H&N	Wirral/Aintree	Radical RT	Medical – Patient admitted to referring trust with respiratory tract infection & too ill to attend dental app	No
6	43	34	77	H&N	Whiston/Aintree	Radical RT	Patient dna'd 1st oncology appt due to family (father) bereavement & delay to tx CAT-1	Yes
7	82	27	109	UGI	COC/RLH	Neo-adj RT/Chemo	Slight delay to tx plan & outlining needed peer review. Slight delay to 1st app	Yes
8	147	39	186	UGI	RLH	Palliative RT	Medical & pt choice - Pt cancelled 1st appt as unwell with flu & thinking time	No
9	43	28	71	UGI	WHH	Palliative Chemo	Admin - Delay to 1st app due to Access team capacity to register referral 13 days & Medical as patient required antibiotics for Cellulitis prior to treatment - chemo deferred & escalated but unable bring forward	Yes

The chart below shows CCC's monthly performance for 62 day waits (pre and post allocation) and treatment by CCC within 24 days. 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.



62 Day performance by tumour group:

The tables below show the Q1, Q2, Q3 and Q4 (to date) 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%	

Q4 (to 11/3/19 – as yet unvalidated)

Tumour Group	Breaches	Accountable Breaches	Hits	Accountable Hits	TOTAL	Accountable TOTAL	PreAllocated %	Allocated %	Allocated Performance
Lung	5	1.5	40	23.5	45	25	88.89%	94.00%	
Breast	5	1	36	20	41	21	87.80%	95.24%	
Upper Gastrointestinal	21	3	18	12.5	39	15.5	46.15%	80.65%	
Lower Gastrointestinal	26	3.5	11	8.5	37	12	29.73%	70.83%	
Head and Neck	15	4	10	6	25	10	40.00%	60.00%	
Urological (Excluding Testicular)	17	0.5	5	4	22	4.5	22.73%	88.89%	
Haematological (Excluding Acute Leuka...)	10	2	4	2	14	4	28.57%	50.00%	
Gynaecological	6	0.5	2	1.5	8	2	25.00%	75.00%	
Other	1	0	2	1.5	3	1.5	66.67%	100.00%	
Skin	1	1	1	1	2	2	50.00%	50.00%	

Patients treated on or after 104 Days

In February 2019, 13 patients were treated after day 104; referred between day 56 - 231 to CCC. 4 patients were not treated within 24 days by CCC, 3 of which were due to medical reason (mets treated before primary, patient too unwell to attend due to flu and patient required admission to referring trust due to chest infection) and one patient had a delay to treatment due to peer review delay to outlining treatment plan.

Key actions and assurances in the Cancer Waiting Times Improvement 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 supporting the STP Radiology Working group to identify a solution to the workforce challenges around radiologist recruitment.
- 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 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 RLBH and St Helens & Knowsley NHS Trust).
- CCC working with the Cancer Alliance 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.
- Isotope disruption at Liverpool Radiopharmacy: causing patient cancellations e.g. 21 patients w/c 18/2/19. The Christie is being used as a provider in an emergency and will be considered in future.

2 Week Wait:

- 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 RLBHUT 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.
- 1 Medical oncologist post out to advert / 2 Clinical Oncologist posts filled with another post out to advert.
- CCC funded two additional Consultant 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 of the process for allocating Consultant leave and cover arrangements within medical staffing underway.
- 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.

Dental capacity at Christmas / New Year

- This has been addressed with the dentist in preparation for 2019/20 - Alternative sessions will be booked to mitigate the impact of bank holidays.

4.2 Clinic Waiting Times

The table below 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.

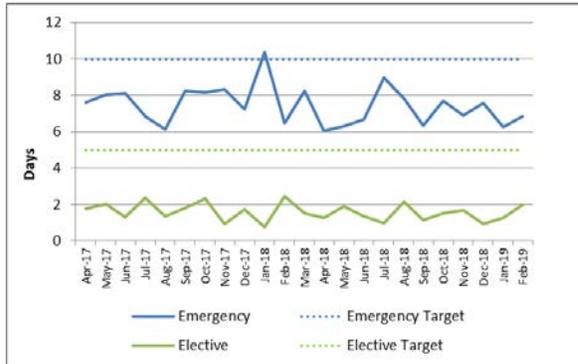
	Target	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend
CCC Outpatients Wirral: Seen within 30 minutes	80%	77%	78%	78%	78%	78%	75%	79%	75%	76%	81%	85%	85%	85%	
CCC Outpatients Wirral: Seen between 31 and 60 minutes		12%	11%	12%	13%	14%	14%	12%	14%	15%	13%	10%	11%	10%	
CCC Outpatients Wirral: Seen after 60 minutes		11%	11%	10%	9%	9%	11%	9%	11%	9%	7%	5%	5%	6%	
Delamere: Seen within 30 minutes	80%	78%	82%	81%	80%	79%	78%	82%	78%	77%	79%	77%	77%	82.3%	
Delamere: Seen between 31 and 60 minutes		11%	9%	10%	11%	11%	11%	10%	12%	13%	10.0%	11.0%	12%	9.1%	
Delamere: Seen after 60 minutes		11%	9%	9%	10%	10%	11%	8%	10%	10%	10.6%	11.0%	11%	8.6%	
Outpatient peripheral clinics: Seen within 30 minutes	80%	89%	87%	89%	91%	91%	91%	91%	90%	89%	90%	91%	91%	89.9%	
Outpatient peripheral clinics: Seen between 31 and 60 minutes		8%	8%	7%	6%	6%	6%	6%	7%	8%	6.7%	2.2%	6%	7.2%	
Outpatient peripheral clinics: Seen after 60 minutes		3%	5%	4%	3%	3%	3%	4%	3%	3%	3.5%	1.6%	3%	2.9%	

Now that the Service Improvement Team have concluded both HPB and Breast OPD Service Improvement projects, the focus now turns to the Renal OPD clinic which also struggles to achieve the targeted 30 minute patient waiting time for 80% of our Patients. Although the clinic action plan has been approved, we are also looking at the possibility of an external company to plan further renal clinic improvements across the patch rather than a localised approach.

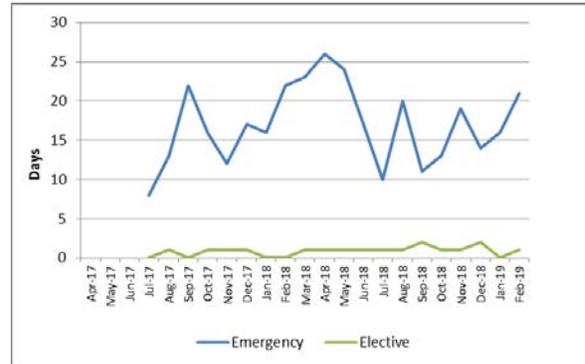
4.3 Length of Stay (LOS)

The following charts show the elective and emergency average LOS in days per month for CCCW wards (against the targets) and HO wards.

Wirral Wards x 3



HO Wards x 2

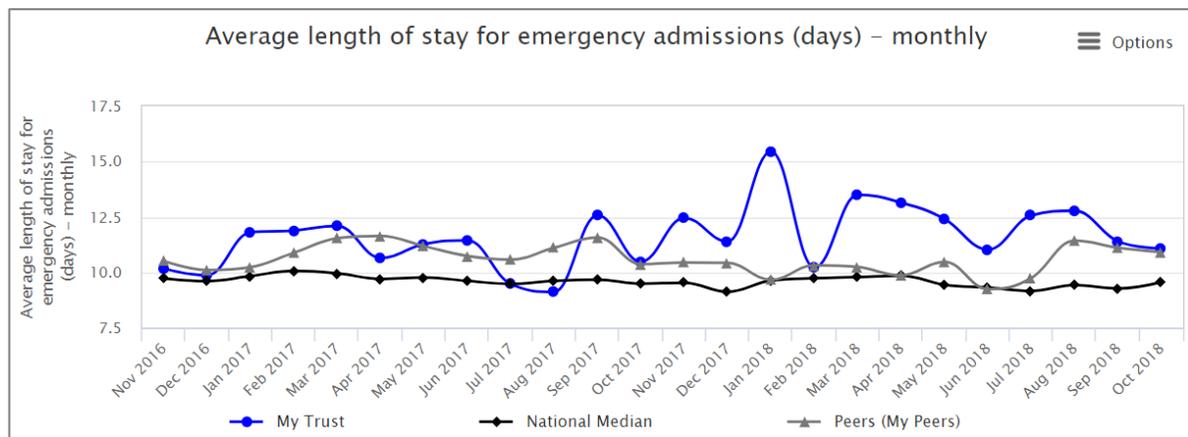


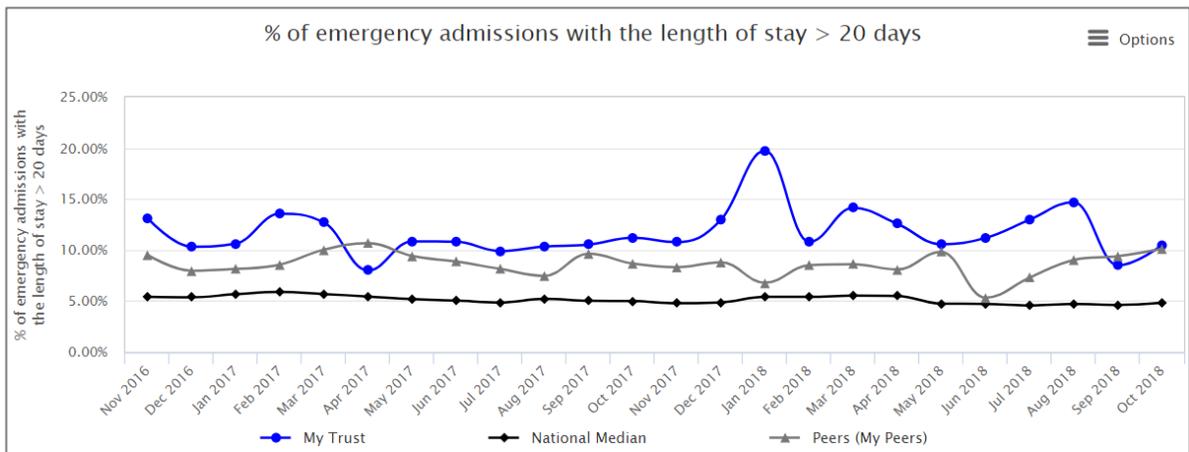
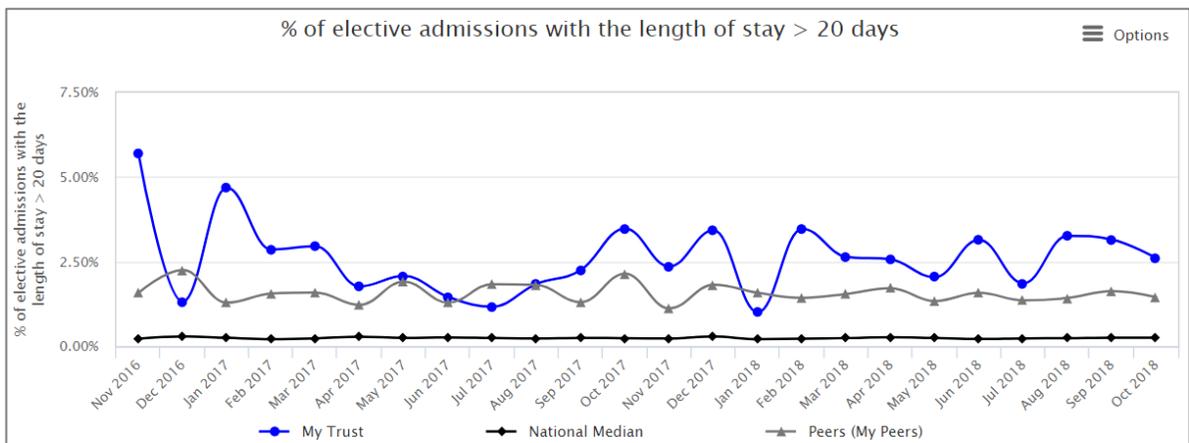
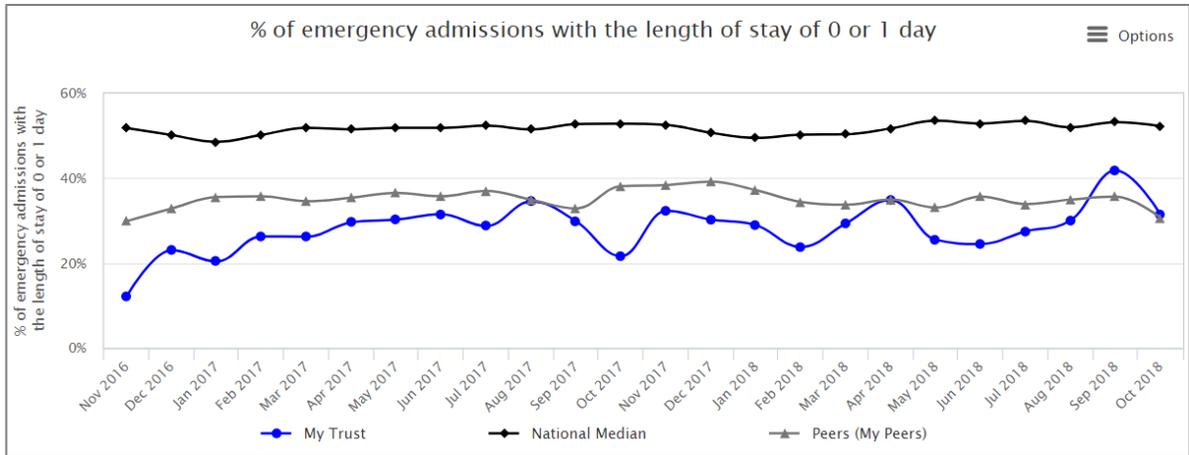
Wirral wards have been within target in all but 1 month in 2018/19 to date. A revised, more stretching target will be introduced for these wards, of 9 days (emergency) and 3.5 days (elective), to ensure a continued focus on reducing length of stay. A target will be developed for HO wards in 19/20, using data from peers nationally. Work will be carried out on pathways in both solid tumour and HO wards to bring both in line with our best performing peers.

Benchmarked data:

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

These charts show CCC LOS against the national median and set peers (Christie and Royal Marsden). CCC figures include both solid tumour and HO wards.





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 affect our LOS.

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

4.4 Bed Occupancy

The table below shows the average bed occupancy by month and ward at 2 different times of day. The targets are G: 80-85%, A: 75-79 and 86-90, R:<75 & >90 (except Sulby at 2am for which no target is applied). Data flows for HO wards' bed occupancy are being established.

Average Occupancy	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend
11 am (Conway)	90%	89%	83%	69%	85%	84%	78%	77%	77%	75%	68%	80%	84%	
11 am (Mersey)	81%	79%	66%	65%	78%	75%	68%	66%	66%	69%	72%	85%	88%	
11 am (Sulby)	27%	49%	27%	27%	45%	81%	74%	70%	70%	49%	48%	60%	53%	
2 am (Conway)	90%	89%	84%	69%	85%	84%	78%	78%	78%	75%	69%	80%	84%	
2 am (Mersey)	80%	77%	65%	63%	76%	74%	67%	67%	67%	70%	70%	84%	88%	
2 am (Sulby)	15%	29%	17%	15%	26%	33%	34%	32%	32%	19%	14%	17%	10%	

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.

4.6 Radiology Reporting

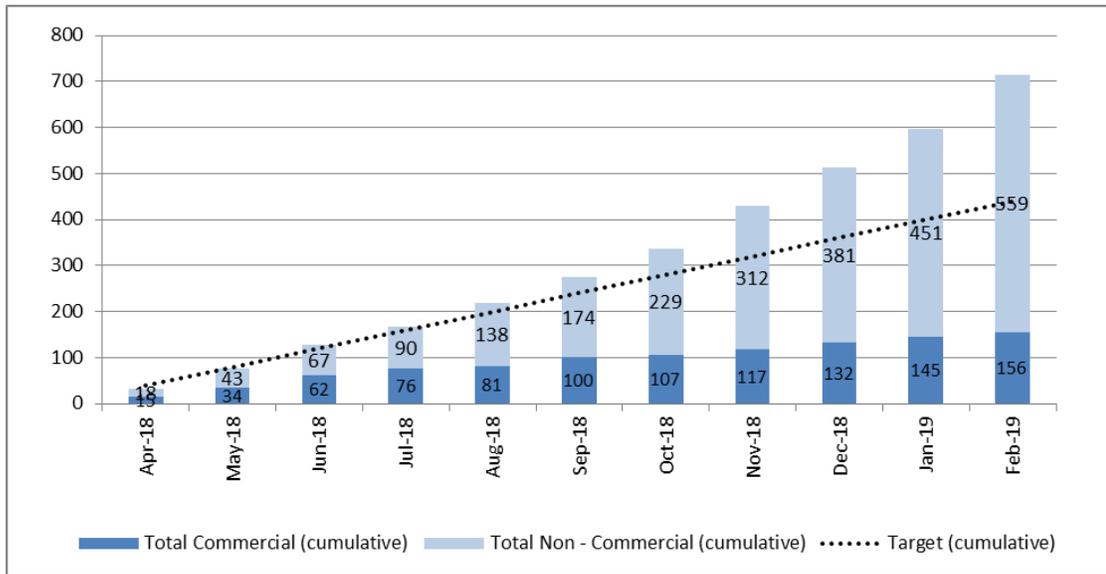
This table displays the reporting turnaround times for inpatients and outpatients and reveals that although there have been recent improvements, the Trust is failing to achieve the respective targets of 24 hours and 7 days.

		Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend
Imaging reporting turnaround: inpatients within 24 hours	G: =>90%, A: 80-89%, R: <80%	57.2%	83.8%	83.8%	81.9%	69.6%	70.0%	78.4%	82.3%	80.7%	78.6%	69.3%	73.9%	82.6%	
Imaging reporting turnaround: out patients within 7 days		88.5%	94.3%	94.9%	87.8%	68.8%	50.7%	50.3%	76.1%	73.1%	70.0%	67.8%	72.5%	89.6%	

This performance reflects the capacity issues faced by CCC. The recent appointment of 1 radiologist and the commitment of reporting capacity externally will significantly improve performance. 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.



5. WELL LED



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

5.1 Workforce

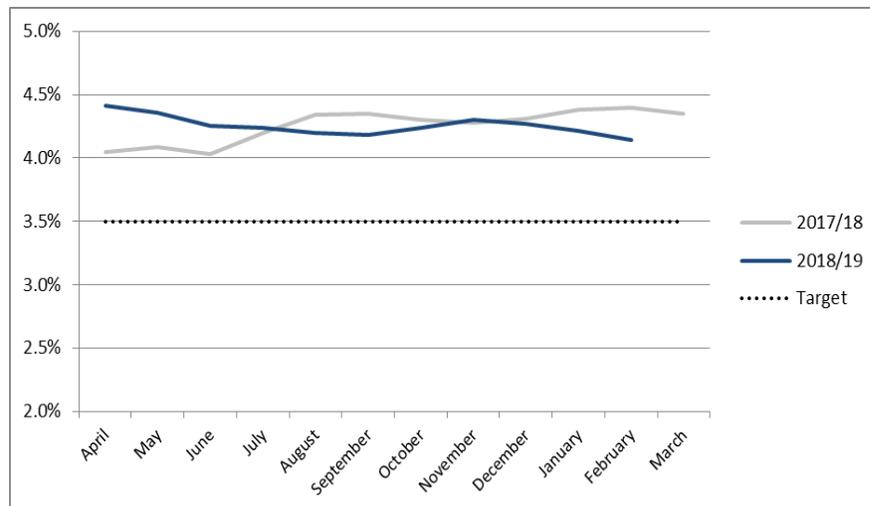
Workforce overview

	2018 / 03	2018 / 04	2018 / 05	2018 / 06	2018 / 07	2018 / 08	2018 / 09	2018 / 10	2018 / 11	2018 / 12	2019 / 01	2019 / 02	Trend
Headcount	1,258	1,270	1,265	1,261	1,260	1,274	1,274	1,292	1,295	1,295	1,299	1,304	
FTE	1,139.10	1,151.31	1,145.62	1,142.80	1,143.47	1,156.47	1,157.15	1,173.87	1,174.33	1,174.47	1,177.98	1,183.41	
Leavers Headcount	13	17	22	17	12	16	16	14	19	17	17	14	
Leavers FTE	11.25	13.22	18.80	15.91	11.49	13.52	13.64	12.75	17.56	14.87	14.72	11.39	
Starters Headcount	15	26	13	16	10	26	19	30	22	19	19	21	
Starters FTE	13.15	24.50	11.25	15.32	9.04	23.13	15.96	27.67	17.67	16.70	17.13	18.66	
Maternity	28	29	32	35	33	34	35	36	41	40	39	41	
Turnover Rate (Headcount)	1.03%	1.34%	1.74%	1.35%	0.95%	1.26%	1.26%	1.08%	1.47%	1.31%	1.31%	1.07%	
Turnover Rate (FTE)	0.99%	1.15%	1.64%	1.39%	1.01%	1.17%	1.18%	1.09%	1.50%	1.27%	1.25%	0.96%	
Leavers (12m)	154	146	158	164	165	172	169	174	190	187	188	194	
Turnover Rate (12m)	12.94%	12.10%	12.92%	13.23%	13.26%	13.76%	13.46%	13.79%	15.01%	14.72%	14.74%	15.17%	
Leavers FTE (12m)	137.37	127.92	138.37	144.62	147.40	152.36	147.87	152.66	167.42	164.11	164.41	169.12	
Turnover Rate FTE (12m)	12.78%	11.73%	12.51%	12.90%	13.08%	13.46%	13.00%	13.36%	14.59%	14.25%	14.22%	14.58%	

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

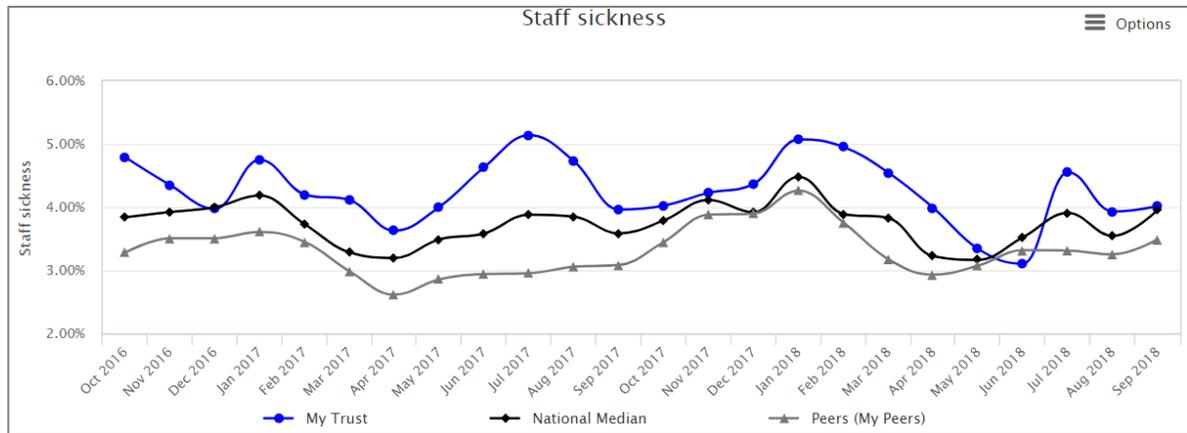
Sickness Absence

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 generally higher figures for CCC than the national average and peers, however in May, June and September this was similar or indeed lower. This has not been updated since the last report.



The Trust 12 month rolling sickness absence is 4.14% and in month sickness absence has decreased to 4.46% from 4.74% in January 2019. Cold, cough and flu, gastrointestinal problems and anxiety, stress and depression remain the three highest reasons for sickness absence across the Trust.

In February there were 50 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. Of the 50 cases, 5 are recorded as Influenza.

The second highest reason for sickness in February was gastrointestinal problems with 39 episodes. The third is Anxiety/stress/depression with 23 cases.

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	Feb-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%	4.1%	3.5%	
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%	6.9%	
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%	4.5%	4.0%	
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%	3.2%	3.6%	
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%	3.50%	4.30%	
Research	5.20%	4.83%	2.79%	3.71%	2.38%	4.58%	5.24%	4.18%	4.99%	4.24%	3.10%	4.00%	2.80%	
Quality	6.2%	3.2%	1.4%	1.0%	2.2%	1.7%	1.7%	0.7%	1.6%	3.4%	5.00%	6.70%	3.80%	
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%	5.9%	

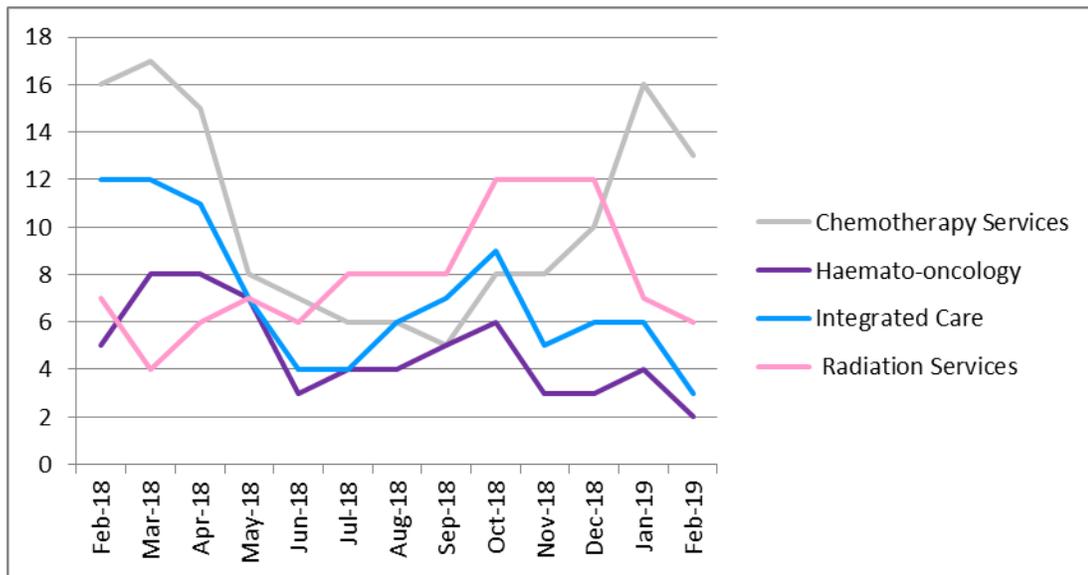
Long / short term sickness absence:

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

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend
Short term	116	105	119	103	133	118	103	164	159	145	197	153	
Long term	62	56	44	33	45	48	45	56	45	46	47	35	

There has been a downward trajectory for long term sickness absence since October 2018, following the review of the Attendance Management Policy and significant focus within the Workforce & OD team on supporting early intervention and implementation of support to enable staff to return to work as quickly as possible. At the same time however, there is a rising trend of short term sickness.

The chart below presents this data by Directorate:



Actions:

The Employee Assistance Provision was launched on 31 Jan 2019 which gives employees 24/7/365 access to telephone counselling services. Early indications from staff accessing the service are positive and the impact of the service on the Trust sickness due to anxiety stress and depression will be monitored.

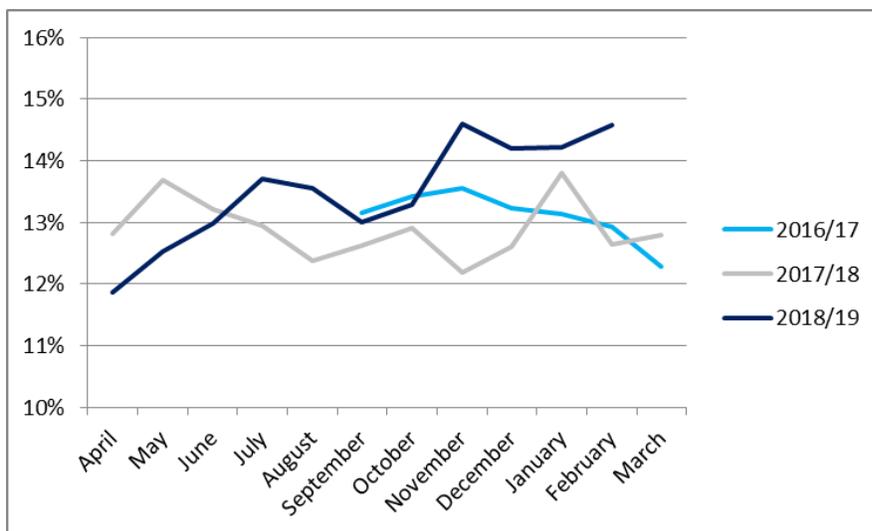
Reporting in ESR is not being utilised fully and we are working with managers to obtain more information with regards to these sickness episodes. The WOD team continues to work with line managers at monthly HR surgeries to ensure all sickness is being managed in line with Trust policy and procedure.

Failure to close down sickness, and record the return to work discussion date on ESR is still a concern and is being escalated appropriately within departments and directorates. The WOD team continues to work with managers to reinforce the importance of ensuring ESR is updated in a timely manner.

The top 3 areas with the highest sickness absence this month are: Admin Services with 12 cases, Radiotherapy with 8 cases and Haemato-oncology with 5 cases. Detailed workforce information is considered at each Directorate meeting.

Staff Turnover

This chart shows the rolling 12 month turnover figures by end month and year, revealing a rising trend in 2018/19.



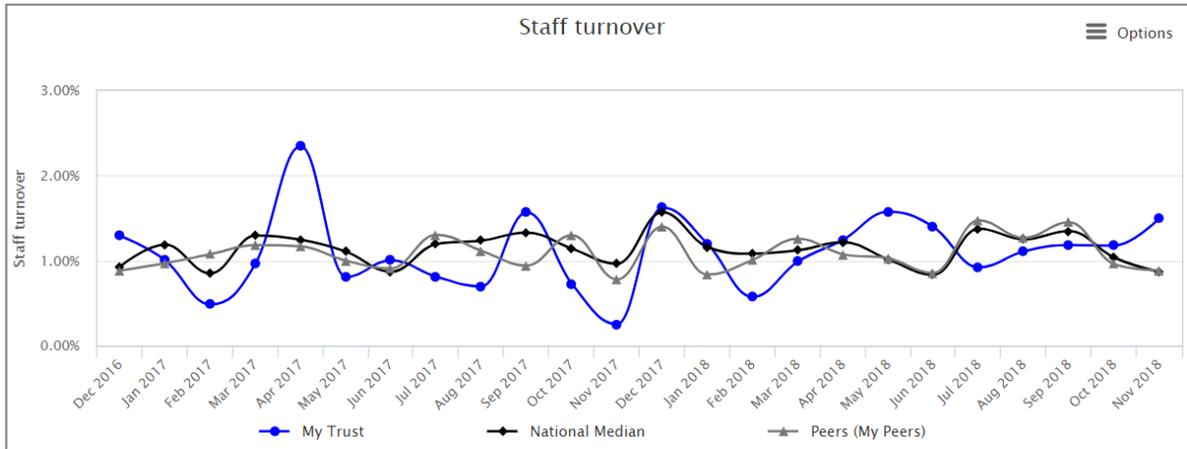
Turnover for February 2019 has increased slightly from 14.2% to 14.6%. There were 14 leavers in total in February. The majority of leavers in February were from the Admin and Clerical staff group followed by the Nursing & Midwifery staff group.

The reasons for leaving captured by managers were as follows: 3 staff left due to work life balance, 3 for promotion, 1 due to forthcoming end of a fixed term contract, 1 dismissal due to capability, 1 relocation, 1 to pursue further education, 4 due to unknown reasons.

The WOD team continues to follow up with line managers to obtain meaningful data regarding reasons for leaving. Due to the continuing low response rate of exit questionnaires (despite e-mail request from line managers and the WOD team), with effect from March onwards, a personal contact will be made with all leavers from the WOD team to offer staff an exit questionnaire or alternatively request that a questionnaire is completed. In addition the team will look to roll out the 'itchy feet' programme, which has received good outcomes in other Trusts nationally.

Utilising NHS Employers' best practice approaches, a Recruitment and Retention programme will commence in March 2019, focusing specifically on nursing in the first instance. This will be led by the Deputy Director of Nursing and Associate Director of Workforce & OD.

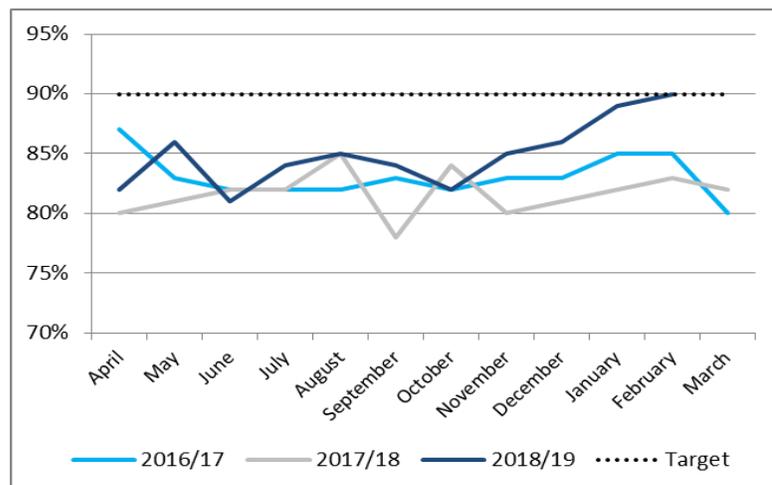
The 'Model Hospital' benchmarking chart below uses a different measure than ESR to calculate turnover; using this definition, CCC have similar, and often lower, levels of turnover to both peers and the national average. This has not been updated since the last report.



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 and Mandatory Training

This section presents the Trust figures per month and year, the Directorate / Service compliance and then detailed actions and specific course compliance. The Trust has achieved the 90% target in February 2019.



Directorate	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend
Haemato-oncology Directorate	58%	76%	74%	63%	66%	66%	54%	59%	58%	72%	74%	
Chemotherapy Services Directorate	87%	89%	89%	86%	88%	88%	89%	89%	93%	95%	96%	
Intergrated Care Directorate	87%	87%	87%	88%	89%	89%	87%	88%	87%	90%	90%	
Radiation Services Directorate	86%	88%	87%	88%	89%	85%	86%	84%	87%	91%	92%	
Admin Services	96%	96%	91%	95%	95%	93%	98%	89%				
Corporate Services								88%	84%	90%	90%	
Quality	92%	91%	90%	94%	96%	97%	95%	94%	98%	99%	97%	
Support Services	91%	92%	92%	92%	92%	93%	91%	91%	94%	98%	97%	

Course Specific

The table below shows weekly progress since December, by Clinical Directorate and course (data correct as at 14/03/2019). An amber threshold (80-85%) has been applied to this table to better show improvement and areas of highest concern.

Directorate	Course	Decemeber 2018	10/01/2019	17/01/2019	24/01/2019	31/01/2019	07/02/2019	14/02/2019	21/02/2019	28/02/2019	07/03/2019	14/03/2019	Trend
Chemotherapy	BLS	55%	72%	71%	76%	78%	79%	83%	85%	82%	84%	85%	
	ILS	42%	60%	61%	60%	63%	70%	72%	73%	80%	83%	84%	
	Safeguarding level 3	86%	100%	86%	86%	86%	86%	53%	55%	55%	53%	70%	
	Patient handling - level 2	67%	73%	71%	85%	86%	85%	88%	89%	92%	94%	96%	
	Infection Control	75%	79%	80%	81%	81%	84%	84%	84%	87%	87%	86%	
Haem Onc	BLS	53%	83%	90%	88%	88%	93%	89%	95%	96%	92%	97%	
	Safeguarding level 3	11%	34%	43%	43%	65%	63%	70%	68%	78%	73%	68%	
	Patient handling - level 2	43%	72%	82%	78%	78%	83%	85%	89%	95%	88%	81%	
	Infection Control	74%	76%	75%	75%	77%	71%	73%	67%	95%	75%	75%	
Integrated Care	BLS	71%	79%	79%	80%	83%	83%	84%	79%	78%	78%	83%	
	ILS	41%	68%	68%	69%	70%	71%	72%	71%	70%	70%	70%	
	Safeguarding level 3	33%	75%	50%	47%	53%	53%	53%	53%	56%	50%	57%	
	Patient handling - level 2	78%	78%	79%	78%	80%	81%	81%	80%	81%	82%	83%	
	Infection Control	49%	49%	76%	76%	78%	81%	81%	78%	79%	81%	80%	
Radiation Services	BLS	50%	75%	74%	71%	79%	81%	80%	82%	81%	82%	82%	
	ILS	67%	55%	47%	52%	57%	62%	68%	68%	69%	71%	76%	
	Safeguarding level 3		23%	21%	21%	21%	21%	50%	50%	50%	50%	75%	
	Patient handling - level 2	70%	72%	71%	73%	77%	81%	78%	81%	82%	83%	85%	
	Infection Control	35%	41%	52%	54%	55%	66%	66%	67%	71%	75%	78%	

Whilst there is generally increasing compliance across the priority areas, the Trust has not yet achieved 90% compliance with BLS and ILS. Chemotherapy have now met the Trust target for Patient Handling and Haemonc have now met the Trust target for BLS.

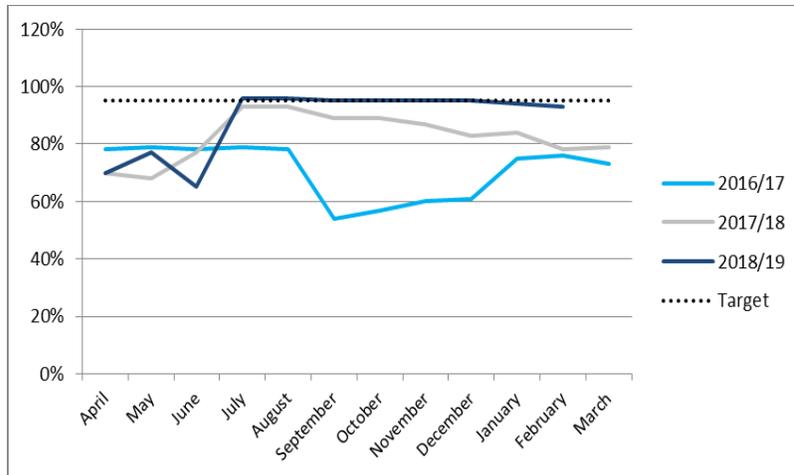
There is an on-going project which is managing the improvement of compliance against prioritised areas and also establishing more robust processes to ensure the effective delivery of accurate performance data for statutory and role essential training across the Trust. In addition, directorate performance is being monitored weekly and a new, well received e-tool has been developed to enable Directorates to monitor compliance more closely. The Integrated Care Directorate is currently developing a training plan that includes additional training capacity for ILS and BLS to ensure the Trust meets the 90% target for ILS and BLS early April 2019.

There has also been a focus on achieving compliance levels for role essential training within Haemato-oncology. This table shows compliance for ward-based staff since December (data correct as at 14/03/2019). Again, an amber threshold (80-85%) has been applied to this table to better show improvement and areas of highest concern:

Course	December	17/01/2019	24/01/2019	31/01/2019	07/02/2019	13/02/2019	20/02/2019	27/02/2019	14/03/2019	Trend
AKI	81%	92%	92%	93%	94%	95%	96%	97%	99%	
ANTT - online	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Sepsis	73%	88%	92%	92%	92%	93%	94%	94%	97%	
Blood transfusion - online	74%	100%	100%	100%	100%	100%	100%	100%	100%	
Blood transfusion - ward based	66%	100%	100%	100%	100%	100%	100%	100%	100%	
Point of care	57%	94%	98%	98%	98%	98%	98%	98%	97%	
Medical Devices	39%	49%	52%	65%	64%	64%	66%	55%	77%	
COVAD	85%	92%	95%	97%	98%	99%	98%	98%	100%	

PADR Compliance

Trust compliance has fallen slightly to 93% as shown in the chart below. Non-compliance with PADR completion is mainly due to staff who have returned from maternity leave and new starters. 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. This is also monitored as Directorate's monthly performance review meetings.

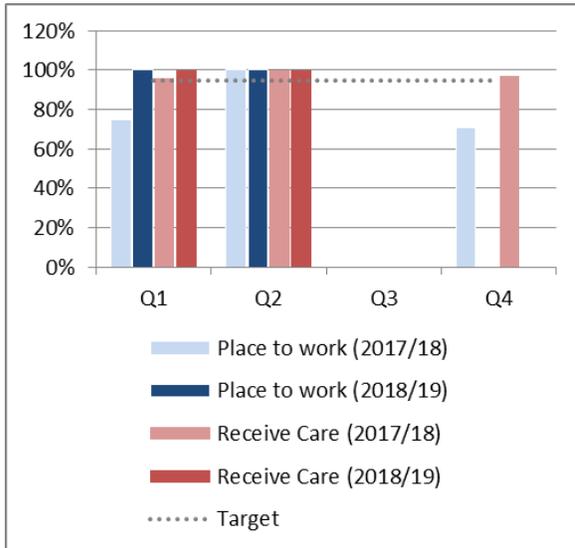


Directorate	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Trend
Haemato-oncology Directorate	81%	83%	40%	98%	99%	99%	97%	97%	96%	94%	93%	
Chemotherapy Services Directorate	78%	81%	87%	99%	99%	98%	99%	98%	97%	93%	94%	
Intergrated Care Directorate	65%	66%	62%	96%	97%	97%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

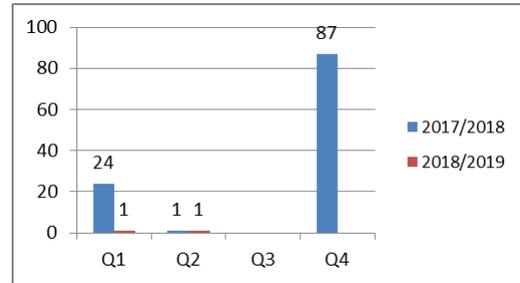
Staff Friends and Family Test

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



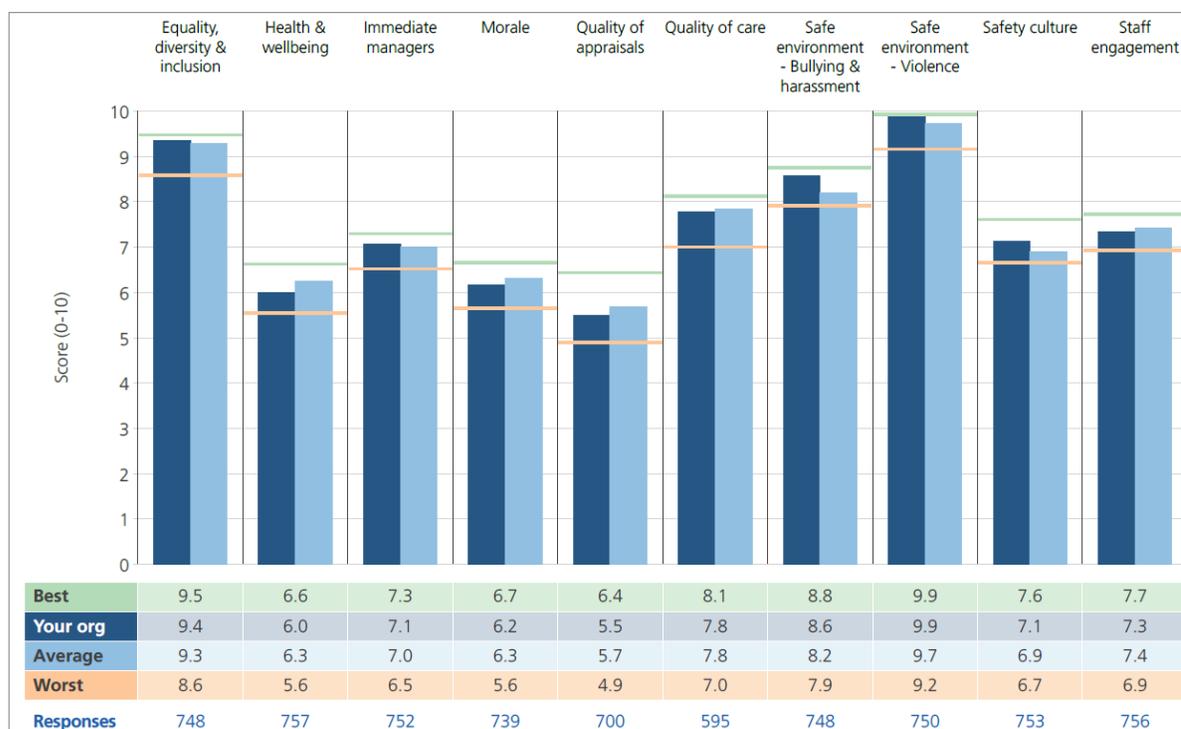
A communication campaign promoting the benefits of completing the survey is planned throughout Q4 to improve response rates. This includes:

- 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.

NHS Staff Survey 2018

Our Trust response rate in the 2018 NHS Staff Survey was 62%, the same as last year and higher than the national sector response rate of 53%. For the 2018 survey, key findings have been replaced with ten themes, scored on a 0 – 10 point scale. Overall our results are similar to our comparator group and there are no significant changes from last year at theme or question level.

The following table shows CCC’s performance across the 10 themes (Your org) compared to the best, average and worst organisations in the national sector.



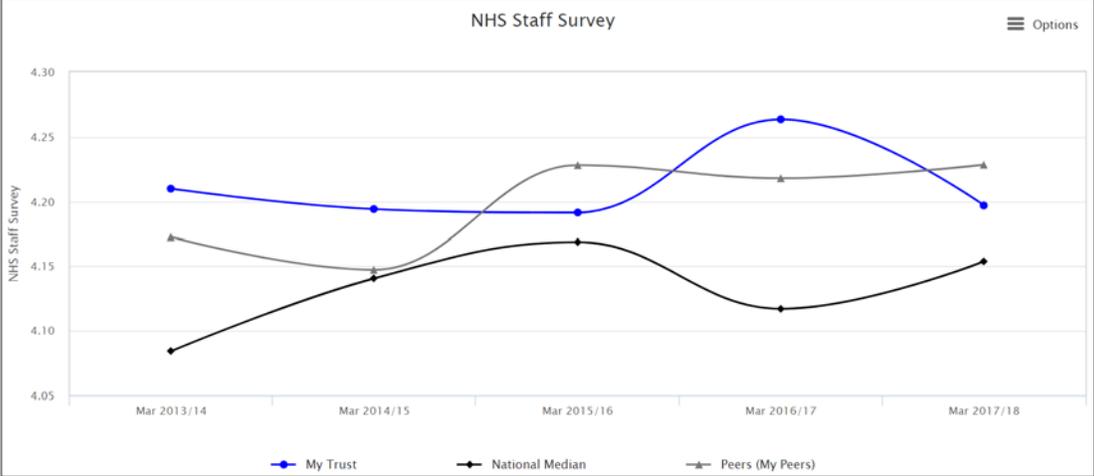
We in the process of communicating our results widely across the Trust, they have been shared with the Strategic Partnership Forum, Workforce and OD Committee and the Senior Leaders Forum and included in Team Brief. Departmental managers have been provided with a presentation provided by Quality Health, our survey provider along with a breakdown of their departmental results and are tasked with sharing the results and working with their team members to develop and implement local action plans to bring about improvements. These action plans will be reported up through the Trust’s governance process. At Trust level we will continue to work on the following top three themes from the 2017 survey and will review and refresh our action plan to drive improvements in 2019/20.

- support staff to improve their health and wellbeing (particularly mental health)
- improve staff engagement and involvement in change
- enhance the quality of appraisals

In addition we will talk to managers and staff about how we can continue to improve the support that is offered from immediate managers (this score has increased from last year however there is more work to do particularly as we prepare to mobilise our workforce and open our new hospital in Liverpool in 2020.

Benchmarked data:

The chart below 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.



6. Activity and Finance



	KEY: Better than target	Green
	Below target	Red
	Below target but within acceptable limits	Amber
Key Indicator		
Group Surplus (incl Charity) of £4,520k against a planned surplus of £4,060k		Amber
Trust Surplus of £2,596k vs a planned surplus of £1,666k		Green
Net Trust I&E margin of 1.8% vs a planned margin of 1.2% (excludes impairments)		Green
NHSI Control total of £1,833k against actual year to date comparator of £2,981k		Green
Actual CIP achieved £1,741k against a plan of £1,475k		Green
Capital expenditure at £58,632k against a plan of £72,929k		Amber
Cash balances at £52,286k are £4,573k below planned balances of £56,859k		Amber
CQUIN funding of £1,565k against a plan of £1,938k		Red
Use of Resources: Risk Rating		
Capital Service Cover rating of 2 (against a plan of 2)		Green
Liquidity Rating of 1 (against a plan of 1)		Green
I&E Margin of 1 (against a plan of 1)		Green
Variance from Control Total rating of 1 (against a plan of 1)		Green
Agency spend of £1,100k, which is £47k above the NHSI agency ceiling year to date – giving a rating of 2 (against a plan of 1)		Red
Use of resources – overall risk rating of 1 (against a plan of 1)		Green
Finance and Activity		
Agency medical locums £771k against a target of £458k		Red
Radiotherapy activity - 1.9% growth		Red
Chemotherapy activity - 5.0% growth		Green
Inpatient activity - 1% growth		Green
Outpatient activity -1% growth		Green

6.1 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 £2,803k above plan.

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

	Activity Variance	% year to date	Finance Value	% year to date
Admitted Patient Care – Spells	208	5.8%	£497k	9.0%
Admitted Patient Care Excess Bed Days	-956	-58.9%	-£236k	-59.2%
Outpatient Consultations	5,948	5.0%	£66k	0.5%
Outpatient Procedures	277	1.7%	£1,686k	71.0%
Radiotherapy and Proton	723	0.8%	-£182k	-1.0%
Chemotherapy	6,773	6.6%	£1,325k	7.6%
Diagnostic Imaging	2,293	11.5%	£294k	14.5%
Block			-£645k	-24.0%
Total Excluding Drugs			£2,803k	4.6%
Named Drugs			£8,616k	30.2%
CDF Drugs			-£546k	-7.6%
Total			£10,873k	11.1%

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 2.6% cumulative position.

A contributing factor to the over performance is an increase in Chemotherapy Associated treatments, which is over performing by 35.1% 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 11 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 £1,686k; however activity is only 1.7% 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 December (month 1 to 9). Actual activity has been used for month 1 - 9, with activity estimated for months 10 to 11.

Overall clinical activity for HO, (excluding drugs), is £363k behind plan and drug income is over plan by £2.55m; 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.

6.2 Finance

1. Key Points of Note

The financial performance for the eleven months of 2018/19 to date is as follows:

- A Group surplus (including Charity) of £4,520k against a planned surplus of £4,060k which is £460k 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 £2,596k against a planned surplus of £1,666k, a favourable variance of £930k. From month 10 this is a favourable movement against plan of £130k. The year to date variance continues to be primarily due to below EBITDA items (depreciation and interest payable). Of the £130k favourable in month variance, £87k relates to below EBITDA items.
- As reported previously to the Finance & Business Development Committee, the Trusts forecast outturn has increased by £750k to £2,547k, with a further £600k from subsidiary companies on consolidation. This means that the Trust will over achieve on its control total by £1,621k. The Trust is waiting on confirmation from NHSI that this overachievement will be matched £ for £ from the provider sustainability fund (PSF).
- The Trust has delivered against its notified control total of £1,833k, with an actual year to date comparator of £2,981k.
- The Trust has an overall use of resources risk rating of 1, which is in line with plan.
- As noted in previous months, due to the NHSI submission deadline, the financial position at month 11 is based on actual activity for April to January and estimated for February for solid tumour. Haemato-Oncology is based on actual activity for April to December with estimates for January and February except where actual data was available (for drugs and bone marrow transplants).
- Capital expenditure is £58,632k against the original plan of £72,929k. The Trust is forecasting outturn expend of £75,118k which is £8,215k less than the original plan, primarily due to Building for the Future. This has been moved into 2019/20 in the Trust plans.
- The CIP programme has achieved savings of £1,741k, which is £266k above plan.

- The Trust has been issued with an Agency cap for 2018/19 of £1.1m by NHSI. At month 11, actual expend of £1,100k is £47k **above** the NHSI agency ceiling year to date. The Trust has therefore breached the Agency cap.
- Cash held is £4.57m below plan, which is an improvement (of £2.24m) from month 10. The drawdown of Public Dividend Capital (PDC) of £28.2m was originally planned to be drawdown earlier in the year (Quarter 2), but has actually been received in March. so is the main reason why cash is still below plan.
- 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	1,666	2,596	930
The Clatterbridge Cancer Charity	1,841	1,192	(649)
The Clatterbridge Pharmacy Ltd	92	385	293
Clatterbridge Prop Care Services Ltd (excludes PURP)	461	615	154
*PURP		(268)	(268)
Total Group Surplus	4,060	4,520	460

* 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. Anticipated non delivery of 2018/19 CQUIN at month 11 is estimated at £373k, which is a slight improvement on the previous estimate of	Loss of income was higher than expected due to a number of CQUIN scheme milestones not being delivered. It has become apparent that there was a lack of embedded ownership within the relevant departments. Head of Performance & Planning and Associate Director of Operations are working with leads to make sure that milestones are met

	£415k. The Trust has utilised £119k from its CQUIN reserve towards this shortfall.	for the remainder of the year. The Director of Nursing & Quality is the Executive lead.
KPI “Red” or “Amber” from IPR report and metric above: Radiotherapy Activity (Red) below plan by 3.9% (An improvement from month 8 which showed activity below plan by 5.9%).	For 2018/19 the plan was rebased on last year’s forecast outturn plus assumed growth of 1.9% so should reflect more accurately expected activity.	Work has been undertaken by the Directorate to investigate the drivers behind this position, and has been reported through the Quality committee. Any adverse in year impact on income is mitigated by the block contract. There is a potential loss of income of circa £1m When the contract is rebased for 2019/20. However based on current activity levels this would be mitigated by over performance in other service lines.

Medium Risks:

Issue	Reason	Risk / Mitigation
KPI “Red” or “Amber” from metric table above: Group Surplus (Amber)	The Group has a combined surplus of £4,520k against a planned surplus of £4,060k. The Charity is £649k below plan at month 11. This is offset by an increased surplus within the Trust. Although the overall consolidated surplus is above plan, the rating is Amber as the Charity is below plan.	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 Charity has revised the total forecast down to £10.8m rather than £11.7m. Mitigations against this risk are considered further in the TCC – Financial Update paper.
KPI “Red” or “Amber” from IPR report and metric table above: Agency Spend (red) – Medical locum	The Trust has been issued with a ‘cap’ of £1.1m by NHS Improvement for the year. Spend to the end of December was £1,100k (of which £771k relates to	Agency spend has been flagged with NHSI as a risk and they understand the Trust position and recognise that the provision of clinical services is the priority.

	<p>medical locums) against a NHSI ceiling to date of £1,053k, so overall the Trust has breached the 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 £771k against a plan of £458k, an overspend of £313k.</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 £14.30m behind plan. This is mainly to Building for the Future being £14.61m behind plan.	Risk of slippage in the programme having an adverse impact on patient care. This is not anticipated to be the case, so no significant risk at this point.
KPI “Red” or “Amber” from metric table above: Cash Held (Amber)	Cash is £4.57m below plan. This is because PDC of £28.2m was not drawn down until March. This is offset in part by Capital expend being £14.30m behind plan.	Risk of cashflow issues, however the Trust still has £58.63m in the bank. The Trust has drawn down the £28.2m PDC in March.

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

3. Recommendations

- Note the satisfactory financial performance and surplus for month 11.
- 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 £1,833k, with an actual year to date comparator of £2,981k.
- ***Note that the Trust has breached the Agency Cap in month 11, and will breach the cap at the year end.***
- Note the forecast outturn surplus for the group of £3,147k.
- Note the KPI performance risks.
- Approve the declaration to NHSI for month 11, that the board anticipates the Trust will maintain a financial risk rating of at least 2 over the next 12 months.

Statement of Comprehensive Income

	Trust Annual Plan £k	FEB 19			Cumulative YTD			
		Plan	Actual	Variance	Plan	Actual	Variance	%
		£k	£k	£k	£k	£k	£k	
Clinical Income:								
Elective	4,998	397	418	22	4,581	4,081	(500)	-10.9%
Non-Elective	4,533	360	482	122	4,155	5,068	913	22.0%
Out-patient Attends	18,416	1,462	1,672	211	16,881	18,933	2,052	12.2%
Radiotherapy Attends	19,727	1,566	1,496	(70)	18,083	17,815	(268)	-1.5%
Chemotherapy Attends	19,910	1,580	2,056	476	18,251	19,833	1,582	8.7%
Impact of Contract Tolerances / Agreed Outturn	211	76	(423)	(499)	211	(3,211)	(3,422)	-1618.9%
Drugs	51,154	4,060	5,102	1,042	46,891	57,514	10,623	22.7%
Diagnostic Imaging	2,215	176	210	34	2,030	2,341	310	15.3%
Bone marrow transplants	5,523	438	181	(257)	5,063	3,954	(1,110)	-21.9%
Other Currencies	3,080	244	206	(38)	2,823	2,261	(562)	-19.9%
Private Patients / External Drug Sales	791	66	51	(14)	725	672	(53)	-7.3%
Sub-Total: Total Clinical Income	130,559	10,424	11,453	1,029	119,695	129,261	9,566	8.0%
Other Income	8,586	683	978	295	7,908	9,573	1,665	21.1%
Hosted Services	6,591	282	343	60	5,910	6,650	739	12.5%
Total Operating Income	145,736	11,389	12,773	1,384	133,514	145,484	11,971	9.0%
Pay - Non Hosted	(51,453)	(4,328)	(4,228)	100	(47,172)	(46,341)	832	-1.8%
Pay reserves	(145)	(14)	(14)	(0)	(125)	(125)	0	0.0%
Pay - Hosted	(5,448)	(250)	(251)	(1)	(5,110)	(5,237)	(127)	2.5%
Drugs expenditure	(46,371)	(3,680)	(4,914)	(1,234)	(42,507)	(53,592)	(11,085)	26.1%
Other non-pay - Non hosted	(29,385)	(2,366)	(2,513)	(147)	(26,992)	(28,176)	(1,184)	4.4%
Non-pay reserves	(1,224)	(122)	(122)	(0)	(1,102)	(818)	284	-25.7%
Non-pay hosted	(1,138)	(29)	(87)	(58)	(787)	(1,379)	(592)	75.2%
Total Operating Expenditure	(135,164)	(10,789)	(12,130)	(1,341)	(123,795)	(135,668)	(11,873)	9.6%
Earnings before Interest, Tax, Depreciation and Amortisation (EBITDA)	10,572	601	644	43	9,719	9,816	97	1.0%
Depreciation & Amortisation	(5,155)	(430)	(396)	33	(4,725)	(4,097)	628	-13.3%
Profit/(Loss) from Joint Venture	624	52	59	7	572	446	(126)	-22.0%
Interest receivable (+)	98	8	277	269	90	1,662	1,573	1750.7%
Interest payable (-)	(679)	(57)	(279)	(222)	(622)	(1,864)	(1,241)	199.4%
PDC Dividends payable (-)	(3,667)	(306)	(306)	0	(3,361)	(3,361)	(0)	0.0%
Finance lease interest	(7)	(1)	0	1	(6)	(7)	(1)	18.6%
Retained surplus/(deficit)	1,787	(131)	(2)	130	1,666	2,596	930	55.8%
NET I&E Margin (%)	1.2%	-1.2%	0.0%	1.1%	1.2%	1.8%	0.5%	43.0%
EBITDA Margin (%)	7.3%	5.3%	5.0%	-0.2%	7.3%	6.7%	-0.5%	-7.3%

Statement of Financial Position

	Post Audit 2018 £k	NHSI Plan 2019 £k	YTD Plan	Jan-19 YTD £k	Variance £k	YTD Plan	Feb-19 YTD £k	Variance £k
Non-current assets								
Intangible assets	717	608	628	631	3	618	622	4
Property, plant & equipment	89,306	168,785	151,834	136,409	(15,425)	158,825	143,935	(14,890)
Investments in associates	672	1,296	1,192	1,059	(133)	1,244	1,118	(126)
Other financial assets	18,715	4,560	5,417	63,095	57,678	4,988	71,556	66,568
Trade & other receivables	4,563	277	277	4,444	4,167	277	1,866	1,589
Other assets	-	92,515	78,108	-	(78,108)	85,538	-	(85,538)
Total non-current assets	113,972	268,041	237,456	205,638	(31,818)	251,490	219,097	(32,393)
Current assets								
Inventories	1,161	1,000	1,000	1,423	423	1,000	1,552	552
Trade & other receivables								
NHS receivables	18,419	5,000	5,000	5,752	752	5,000	4,295	(705)
Non-NHS receivables	12,267	15,000	15,000	21,079	6,079	15,000	24,283	9,283
Cash and cash equivalents	55,368	47,255	63,683	56,867	(6,816)	56,859	52,286	(4,573)
Total current assets	87,215	68,255	84,683	85,121	438	77,859	82,416	4,557
Current liabilities								
Trade & other payables								
Non-capital creditors	26,348	15,000	15,000	27,826	12,826	15,000	31,410	16,410
Capital creditors	107	1,000	1,000	97	(903)	1,000	26	(974)
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	3,235	(765)	4,000	3,637	(363)
Other	-	700	700	-	(700)	700	-	(700)
Total current liabilities	29,524	22,972	22,972	33,332	10,360	22,972	37,248	14,276
Total assets less current liabilities	171,663	313,324	299,167	257,427	(41,741)	306,377	264,266	(42,111)
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	78,108	65,964	(12,144)	85,538	72,805	(12,733)
Total non current liabilities	23,011	131,308	117,026	104,581	(12,445)	124,456	111,422	(13,033)
Total net assets employed	148,652	182,016	182,142	152,846	(29,296)	181,921	152,844	(29,078)
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	121,240	120,144	(1,096)	121,019	120,142	(877)
Total taxpayers equity	148,652	182,016	182,142	152,846	(29,296)	181,921	152,844	(29,077)