



Report Cover Sheet

Report to:	Board of Directors' Meeting	
Date of the Meeting:	29 th May 2019	
Agenda Item:	P1-099-19	
Title:	Integrated Performance Report – Month 1 2019/20	
Report prepared by:	Hannah Gray, Head of Performance and Planning	
Executive Lead:	Joan Spencer, Interim Director of Operations	
Status of the Report:	Public	Private
	Y	

Paper previously considered by:	Quality Committee
Date & Decision:	14 th May 2019

Purpose of the Paper/Key Points for Discussion:	<p>This report presents Trust performance against agreed national and local performance metrics as at the end of Month 1 (April 2019).</p> <p>The purpose of this report is to provide assurance that the strategic objective “Maintain excellent quality, operational and financial performance” is met, whilst highlighting any non-compliance and presenting the actions identified to mitigate this.</p> <p>In summary, the metrics that have not been achieved are as follows. Further detail, including actions in place, are provided in the report.</p> <p>CQUIN Requirements:</p> <ul style="list-style-type: none"> Q4 2018/19 - Partial compliance in 2 schemes and non-compliance in 2 schemes 2018/19 - Total funding withheld £409,724 2019/20 – Total value £988,158 <p>Sepsis</p> <ul style="list-style-type: none"> 91% against a target of 100% Two patients missed the target, however, both patients received antibiotics within 80 minutes <p>E coli:</p> <ul style="list-style-type: none"> 1 CCC attributable E coli blood stream infection on Mersey Ward – early indication indicates this was unavoidable. <p>Friends and Family test:</p> <ul style="list-style-type: none"> Inpatient response rate 28.4% against target of 30%
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	<ul style="list-style-type: none"> Outpatient responses fallen from 545 to 439 <p>Radiology reporting:</p> <ul style="list-style-type: none"> 90% target not achieved for inpatients (within 24 hours) or for out-patients (within 7 days) at 68% and 56% respectively <p>Sickness absence:</p> <ul style="list-style-type: none"> Trust 12 month rolling sickness absence is 4.15% and the downward trend for in month sickness absence continues, decreasing to 4.26% in April from 4.43% in March 2019 <p>Staff Turnover:</p> <ul style="list-style-type: none"> Turnover for April 2019 has decreased slightly from 14.9% to 14.5% 11 leavers in total, 5 of which from nursing <p>PADR:</p> <ul style="list-style-type: none"> Trust compliance is below the target of 95%, at 86% Annual PADR cycle has begun and a new online PADR tool rolled out Compliance expected by end of July 2019 <p>Areas of improved performance:</p> <p>Trust wide Statutory and Mandatory Training:</p> <ul style="list-style-type: none"> Performance for April is at 94%, showing continued improvement and meeting our overall target. Some Directorate level non-compliance remains. <p>Cancer Waiting Times:</p> <ul style="list-style-type: none"> 62 Day Cancer Waits Target: 91.7% (un-validated) against the 85% target.

Action Required:	Discuss	Y
	Approve	Y
	For Information/Noting	

Next steps required	The Trust Board members are asked to note Trust performance and associated actions for improvement, as at the end of April 2019.
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The paper links to the following strategic priorities (please tick)

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

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	Y
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.	Y
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.	Y
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.	Y
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.	Y

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

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 1 2019/20)

Introduction

This report provides the Trust Board with an update on the Trust's performance for month one (April 2019). The report includes the Integrated Governance Report for the Trust and an exception report of key performance indicators against which the Trust is not compliant.

The report sections have been changed to Quality, Workforce, Operations and Finance to align more closely with the Trust governance structures, providing additional clarity of assurance and escalation routes.

The Trust Board is asked to consider the following proposal; A full integrated performance report will be presented at all Quality Committee meetings and at Trust Board meetings quarterly, with a shorter overview (to include an exception report, the high level scorecards and a Cancer Waiting Times performance update), to be presented at Trust Board meetings every month.

A 'cancer scorecard' focussing on tumour groups is being developed for inclusion in this report from month four. This will link operational performance to clinical outcomes and patient experience by utilising data from multiple internal and external sources.

Data flows for several of CCC's strategic key performance indicators (KPIs) are in development and will be reported in this report from month two. These include research and innovation related KPIs as well as the percentage of patients receiving Chemotherapy closer to home, the 'percentage of first new outpatient appointments delivered in the sector hubs' and Immunotherapy activity.

Haemato-oncology data for VTE risk assessment, sepsis and length of stay has been excluded from the report as the quality of the data requires further scrutiny. IM and T are working with RLBUHT on a solution to ensure the data feed is both accurate and timely.

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

CQUIN requirements: This report includes performance for 2018/19 (with partial compliance in two schemes and non-compliance in two schemes for quarter four) and forecasts for 2019/20 performance. In 2018/19, the total CQUIN fund was £2,009,811 (eleven schemes), with the total withheld being £409,724. The total CQUIN funding for 2019/20 is £988,150 (eight schemes; three new and six ended in 2018/19). The CQUIN group is managing performance and delivery of each scheme.

Sepsis - Intravenous Antibiotics received within an hour: The April figure was 91% against a target of 100%. Two patients missed the target; both patients concerned received the

antibiotics within eighty minutes. A number of actions are in place or in progress to ensure key improvements.

E coli: There was one CCC attributable E coli blood stream infection on Mersey Ward in April. Early findings indicate an unavoidable case with the likely source of infection considered to be hepatobiliary. This case will be discussed at the May IPC sub-committee meeting.

Friends and Family test response rates: Although not meeting the 30% target, the inpatient response rate was 28.4% for April, 2.8% higher than March and the highest since May 2016. The HO service continues to work with IM&T to understand reported connectivity issues which will allow increased use of the handheld tablets on this site. Since February, outpatient responses have fallen month on month, from 575 to 545 to 439 in April. Matrons' action plans are monitored at the relevant directorate Quality and Safety meetings and improvement trajectories have been set for 2019/20.

Radiology reporting: The target of 90% was not achieved for inpatients (within twenty four hours) or for out-patients (within seven days) at 68% and 56% respectively. This performance reflects the capacity issues caused by annual leave, non-availability of locums, the unavailability of some ad-hoc reporters and slow turnaround from the outsourcing company. The situation improved at the end of April and has been sustained so far in May. Daily sit reps are completed by the department to ensure urgent imaging reports and reports needed to facilitate Out Patient Department appointments are delivered on time. There have been meetings with the outsourcing company to improve the process.

Sickness absence: The Trust twelve month rolling sickness absence is 4.15% and the downward trend for in month sickness absence continues, decreasing to 4.26% in April from 4.43% in March 2019. Gastrointestinal problems, anxiety/stress/depression/ and cold, cough and flu, remain the three highest reasons for sickness absence. There is on-going work within the workforce team to target stress/anxiety with a new focus on Health and Wellbeing of staff.

Staff Turnover: Turnover for April 2019 has decreased slightly from 14.9% to 14.5%. There were eleven leavers in total in April, with five from nursing. The WOD Team is contacting leavers to encourage the completion of exit questionnaires / interviews and the Work Stream for the Future Board has initiated a new Retention Work Stream.

PADR: Trust compliance for April is below the target of 95%, at 86%. The Annual PADR cycle has begun and a new online PADR tool is being rolled out across departments to ensure compliance by the end of July.

Areas of improved performance:

Trust wide Statutory and Mandatory Training: Performance for April is at 94%, showing continued improvement and meeting our overall target. All Clinical Directorates continue to be compliant with BLS. Three Directorates are non-complaint with ILS, at 83%, 88% and 89%. This will be rectified by the end of May 2019. Performance is being monitored weekly.

Cancer Waiting Times Update:

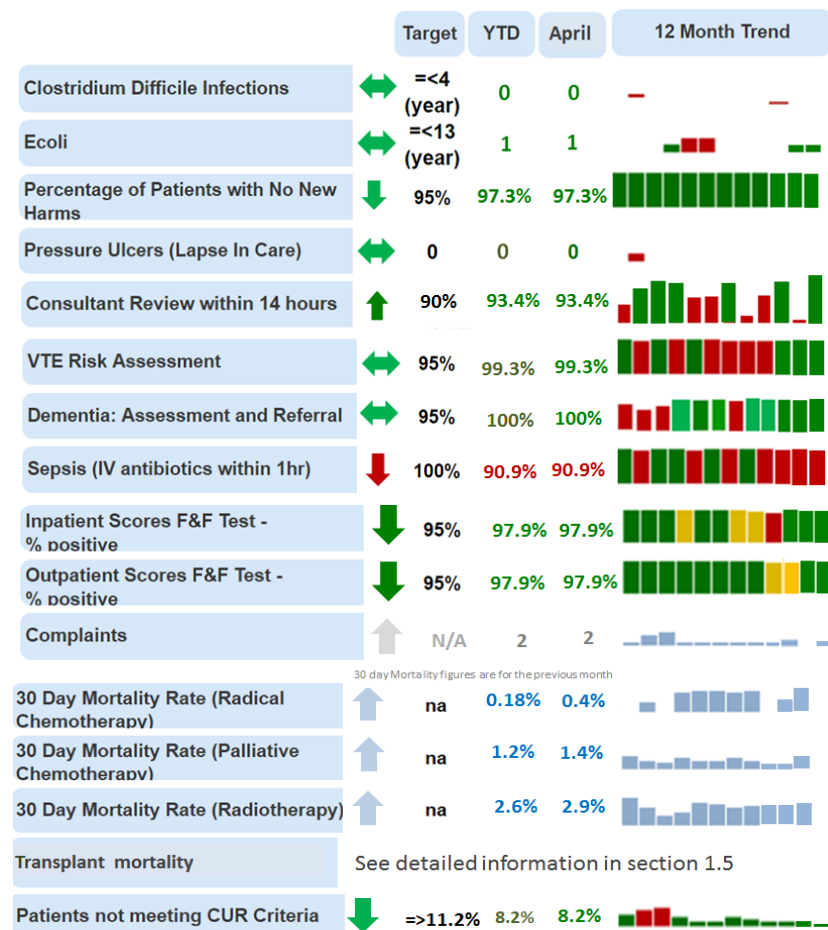
62 Day Cancer Waits Target: Performance for April is 91.7% (un-validated) against the 85% target. The seven day KPI for April was 79% and the twenty-four day performance was 89%.

The Cancer Waits Target Operational Group continues to monitor performance weekly and progress the Cancer Waiting Times Improvement Plan. The Interim Director of Operations and The Cancer Alliance Programme Director are working together to introduce a Provider Forum that will provide support to our partner organisations who are struggling with performance against the 62 day pathway.

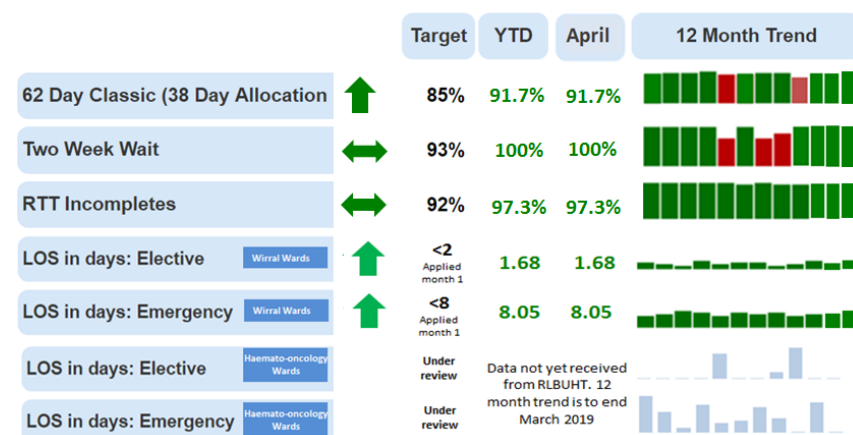
The new Cancer Waiting Time (CWT) Guidance (*Version 10*) and the *Interim Report of the Clinically Led Review of NHS Access Standards* have been published. All recommendations and changes to CWT Standards made within these documents have been considered by the Operational Team and presented to the Quality Committee. The impact of the V10 guidance on our performance is minimal, with the changes to the standards unlikely to cause CCC to either fail the standard or achieve it. It is not yet possible to assess the impact of the proposals made in the review report, as the detail has not yet been agreed. This will be developed during a period of consultation.

Performance Scorecard

Quality



Operational



Workforce



Financial

For April the key financial headlines are:

Metric	April Actual	April Plan	Variance	Risk Rag
NHSI SoF	1	1	0	
NHSI Control Total	£160k	£75k	£85k	
Cost Improvement Programme	£145	£145	£0	
Cash holding	£53,628	£58,563	-£4,935	
Capital Expenditure	£8,484	£4,204	£4,280	

The key drivers of the positions:

- **Income has overachieved plan by £1.062m.** This is primarily due to clinical income being £0.886m over plan, of which £0.819m relates to drug income, which is matched by expend.
- **Expenditure is over plan by £0.894m.** Consistent with the income position, mostly due to drug expend being £0.802m above plan.
- **Cash held is below plan by £4.93m.** Key driver is that capital expenditure is £4.28m above plan.
- **Capital expend is £4.28m above plan.** This all relates to TCC and a catch up in expend slipped from 2018/19.

CQUINs

In 2018/19, the total CQUIN fund was £2,009,811. The total withheld for 2018/19 was £409,724. The total CQUIN funding for 2019/20 is £988,150. There are eight schemes; three new for 2018/19 and six ended in 2018/19.

The CQUIN detail, including actual performance for 2018/19 and expected for 2019/20 is shown in the table below.

Where relevant to specific Directorates, CQUIN details are included in the Directorate 'data packs' and are discussed 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 CQUINs remains on the risk register. To ensure performance against the CQUIN targets for 19-20 improves, a dedicated CQUIN group, chaired by the Head of Performance and Planning, has been established. There is an identified lead for each CQUIN who will provide a monthly progress report at this meeting. CQUIN performance reports will be presented monthly at the Integrated Governance Committee from June 2019. Under performance will be escalated to the Interim Director of Operations for remedial action.

Actual and Forecast Performance:

Key to the table below:

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

CQUIN	2019/20 Value	£ withheld in 2018/19	2018/19				2019/20			
			Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Staff Survey	Not a CQUIN in 2019/20	£8,739								Not a CQUIN in 2019/20
Healthy food	Not a CQUIN in 2019/20	£0								Not a CQUIN in 2019/20
Flu vaccinations (the target has increased to 80%, of front line healthcare workers who have received their flu vaccination between 1st September 2019 and 28th February 2020)	£39,717	£0								
Alcohol and tobacco Training has been delayed due to a focus on statutory and mandatory training, although this is now being rolled out and will support achievement of the CQUIN in 2019/20.	£39,717	£20,232								

CQUIN	2019/20 Value	£ withheld in 2018/19	2018/19				2019/20			
			Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Three High Impact Actions to Prevent Hospital Falls	£39,717	N/A (new for 2019/20)	Not a CQUIN in 2018/19							
Self-care supported by digital technology	£9,929 (CCG) £40,071 (NHSE)	N/A (new for 2019/20)	Not a CQUIN in 2018/19							
Stratified follow up supporting better utilisation of outpatient capacity	£ 29,787 (CCG) £120,213 (NHSE)	N/A (new for 2019/20)	Not a CQUIN in 2018/19							
Holistic Needs Assessment	Not a CQUIN in 2019/20	£125,648					Not a CQUIN in 2019/20			
End of Treatment Summaries	Not a CQUIN in 2019/20	£37,692					Not a CQUIN in 2019/20			
Clinical Utilisation Review	£234,000	£0								
Enhanced Supportive Care Replaced in 2019/20 by 'phase two' 'Rethinking Conversations towards Open Compassionate Enabling Care of Patients with Long Term Conditions'	£200,000	£0								
Optimising Palliative Chemotherapy	Not a CQUIN in 2019/20	£217,413					Not a CQUIN in 2019/20			
Medicines Optimisation	£235,000	£0								
Dose Banding	Not a CQUIN in 2019/20	£0					Not a CQUIN in 2019/20			

1. Quality

		Target	YTD	April	12 Month Trend
Clostridium Difficile Infections	↔	=<4 (year)	0	0	—
Ecoli	↔	=<13 (year)	1	1	—
Percentage of Patients with No New Harms	↓	95%	97.3%	97.3%	—
Pressure Ulcers (Lapse In Care)	↔	0	0	0	—
Consultant Review within 14 hours	↑	90%	93.4%	93.4%	—
VTE Risk Assessment	↔	95%	99.3%	99.3%	—
Dementia: Assessment and Referral	↔	95%	100%	100%	—
Sepsis (IV antibiotics within 1hr)	↓	100%	90.9%	90.9%	—
Inpatient Scores F&F Test - % positive	↓	95%	97.9%	97.9%	—
Outpatient Scores F&F Test - % positive	↓	95%	97.9%	97.9%	—
Complaints	↑	N/A	2	2	—
30 day Mortality figures are for the previous month					
30 Day Mortality Rate (Radical Chemotherapy)	↑	na	0.18%	0.4%	—
30 Day Mortality Rate (Palliative Chemotherapy)	↑	na	1.2%	1.4%	—
30 Day Mortality Rate (Radiotherapy)	↑	na	2.6%	2.9%	—
Transplant mortality	See detailed information in section 1.5				
Patients not meeting CUR Criteria	↓	=>11.2%	8.2%	8.2%	—

Note: Haemato-oncology (HO) data is included in all the above KPIs except CUR, as HO is not due to be part of this initiative until Meditech is in use for HO inpatients.

HO VTE risk assessment and sepsis data has been excluded from the report as the quality of the data requires further scrutiny.

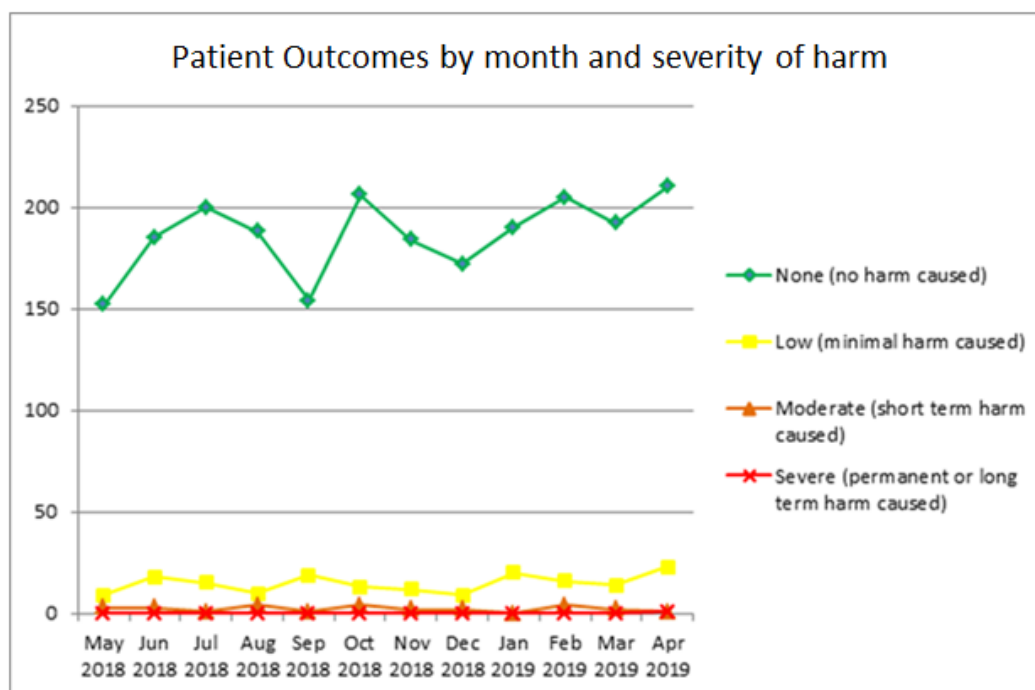
Infections are CCC attributable only, with both attributable and non-attributable reported in section 1.3.

1.1 Never Events

There have been 0 never events from 1st April 2018 to 30th April 2019

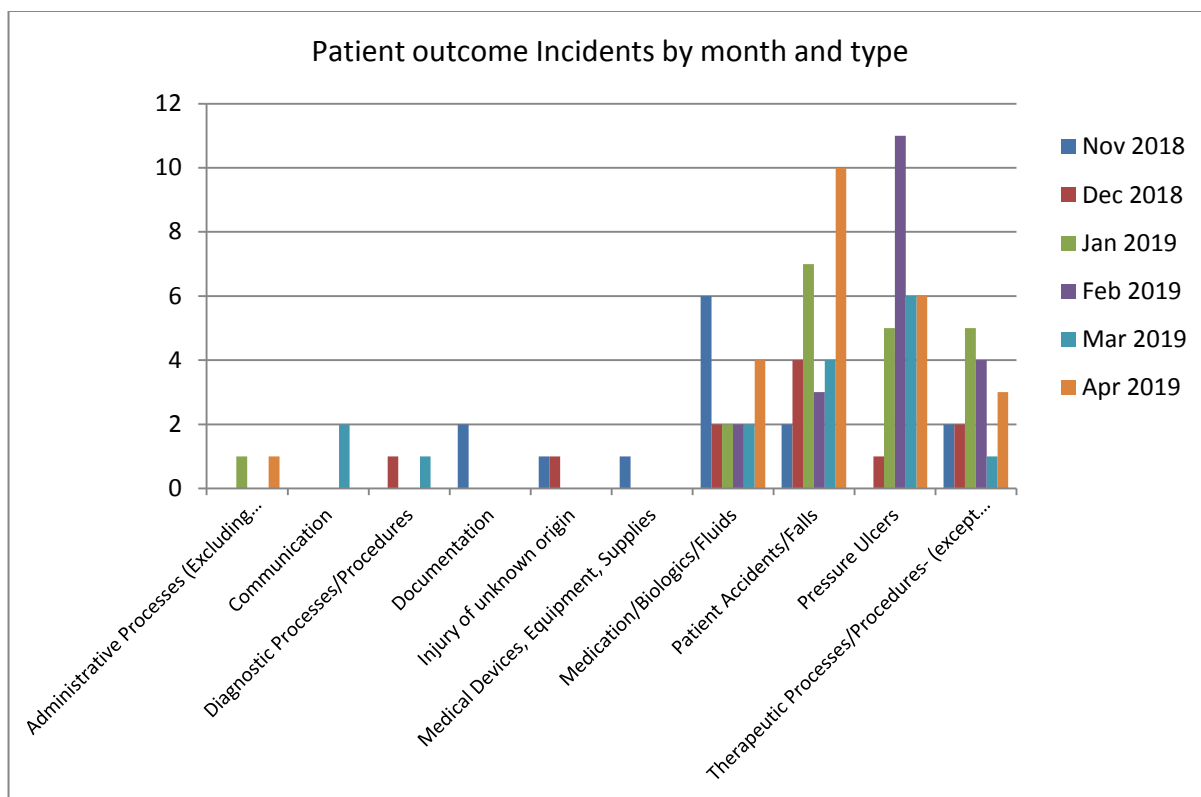
1.2 Incidents

The chart below shows incidents resulting in harm, by level of harm and month from 1st May 2018 to 30th April 2019.

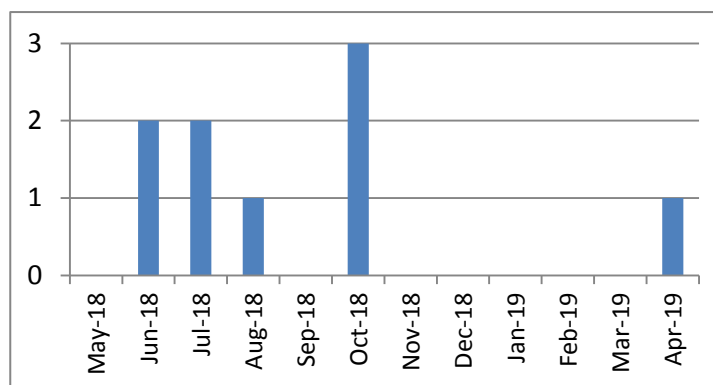


Two incidents have been graded as moderate harm by the reporter in April 19; the investigations are in progress via the relevant managers. One was an extravasation and the other was the serious medication incident. Details of the medication incident are contained in the serious incident section of this report. The extravasation policy has been followed for the patient who experienced an extravasation causing moderate harm and the extravasation site is currently being monitored by the burns unit and is healing well. Full explanation and apology has been provided to the patient in accordance with Duty of Candour requirements.

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



This chart shows the number of serious incidents by month; there was one serious incident in April 2019. The details are provided below.



April 2019 serious incident details:

The patient was admitted to an external hospital on 29th March 2019 and commenced on IV hydrocortisone following a possible reaction to chemotherapy or query Sepsis. The patient was transferred to CCC on 2nd April 2019 to continue with radiotherapy treatment. The patient had been an inpatient since 2nd April 2019 and had remained on IV hydrocortisone (four times a day) for a further nine days. The patient had a medical review each day but no review of hydrocortisone had been undertaken. This patient had daily bloods as urea and electrolytes had been

deranged and the patient had been very hypertensive, requiring anti-hypertensives, multiple IV electrolyte replacements, oedematous and fatigued and also needed cardiac monitoring. After the incident was discovered the steroid dose was tapered safely. Medical opinion is that the prolonged use of IV hydrocortisone had caused moderate harm to the patient. An apology and explanation has been provided to the patient in accordance with Duty of Candour.

A twenty-four hour review was held on 12th April 2019 and the incident reported to StEIS and a seventy-two hour review was completed on 15th April 2019. A serious incident learning meeting is scheduled for 21st May 2019.

Immediate key learning: Improvement in medication review, documentation, continuity of medical staff over seeing patient. Key learning has been communicated to all medical staff, pharmacy staff and to nursing staff on the ward. Additional training in steroid use will be delivered to medical and nursing staff. The full action plan and lessons learned will be shared more widely once the serious incident learning meeting has been held.

Inquests/Coroner's investigations

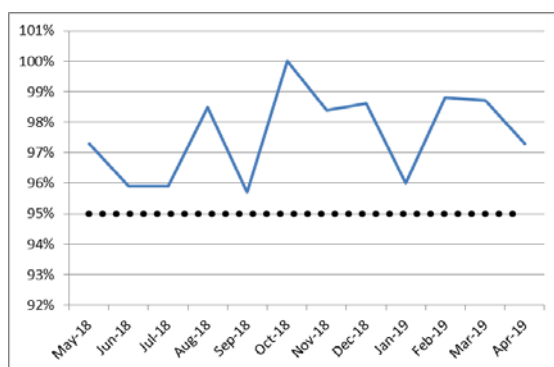
There were four new Coroner's investigation opened in April 2019, two for the Cheshire Coroner and two for Liverpool/Wirral.

Initial investigations have not highlighted any issues by the Clinicians involved and no incidents had previously been reported. Updates will be provided following the outcome of the Inquests/coroner investigations which are all expect to be completed by September 2019.

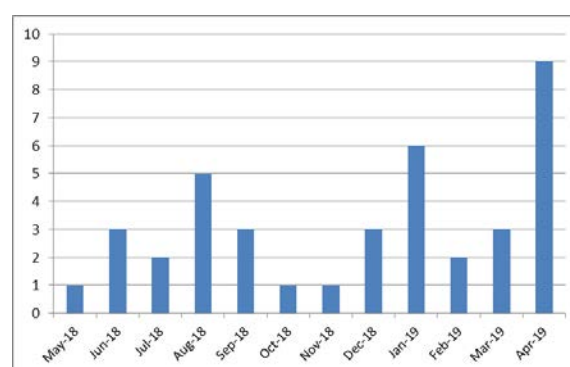
1.3 Harm Free Care

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

Safety Thermometer (CCC harm free)



Falls resulting in harm



The target of 95% is consistently achieved.

Of the sixteen falls in April, nine resulted in low harm and included two patients who fell twice. The rise in falls coincides with a period of high level occupancy on the wards.

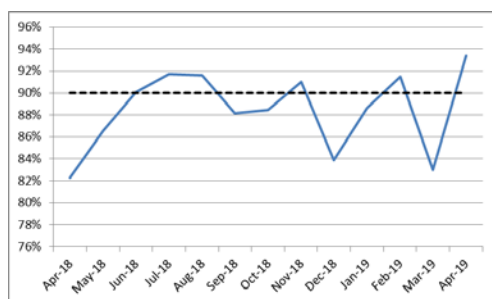
The Harm Free Care Collaborative Group review all falls resulting in harm. No lapses in care were identified for any reviewed in 2018/19. However, actions plans are developed to address specific issues or trends and monitored monthly. Detailed review has shown that patients are most likely to fall from chairs or when mobilising to or in the bathroom. Non slip mats have been ordered and the use of glow in the dark “footsteps” is being further explored.

The Trust is implementing the CQUIN ‘Three high impact actions to prevent hospital falls’ in 2019/20.

Pressure Ulcers

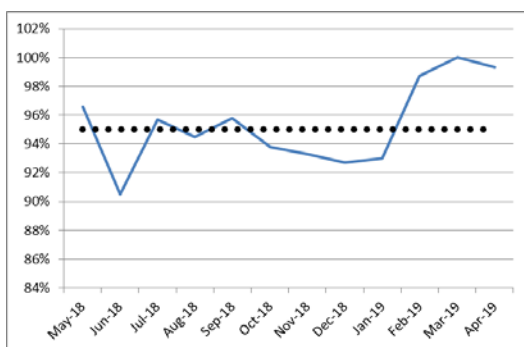
There was one CCC attributable grade two pressure ulcer in April. This was caused by O2 mask tubing and there was potentially a lapse in care. This will be reviewed in detail at the harms collaborative meeting on 21st May, with particular focus on whether appropriate dressings were in use. All pressure ulcers are reviewed at the Harms Collaborative Meeting, any lapses in care are identified and lessons learned shared. Full root cause analyses are conducted for all CCC attributable pressure ulcers.

Emergency admissions - 14 hour Consultant Review



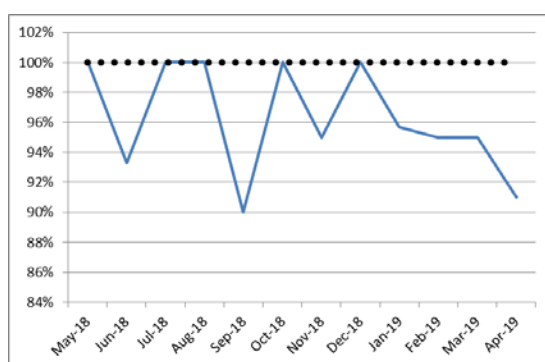
The target was achieved in April, with one out of two patients seen within the time frame on HO wards and 84 / 89 at CCCW. This metric forms part of the national Seven Day Services Assessment. Patients admitted for blood transfusion, uncomplicated electrolyte disturbances and spinal cord compression are treated on an ANP led pathway and are exempt from consultant review as long as treatment is as protocol.

VTE Risk Assessment



Following actions being put in place, including re-enforcement of process across the Trust, four additional physician associates appointed and weekly monitoring, the 95% target has been achieved at CCCW since February 2019. The HO VTE data is still being validated as at 20th May 2019.

Sepsis



The Trust is not consistently achieving the 100% target for antibiotics provided within sixty minutes, with 91% for CCCW (two out of twenty-two patients non-compliant, however both treated within eighty minutes) for April 2019. A number of key actions have been put in place and performance is monitored through the Deteriorating Patient Working Group.

Key actions include training for all relevant staff such as Advanced Nurse Practitioners, Allied Health Professionals and Senior Clinical Nurses, Clinical Directors working together to deliver improvements and competencies added as 'Role Essential' within the training matrix.

Work is ongoing to validate the processes for reporting HO sepsis data.

Dementia

Compliance for dementia screening, assessment and referral remains at 100% (thirteen out of thirteen) for April 2019.

The Dementia Strategy has had a full review with major changes to reflect the need to move from a clinical model to one that is strategically led with the inclusion of a reporting and governance structure. It has been signed off by both the Safeguarding and Integrated Governance Committees and was uploaded onto the intranet on 1st May 2019. The Risk Assessment and Reasonable Adjustment Care Plan (RA) has now been built into Meditech. The Strategy will be launched during Dementia Awareness Week (20th – 26th May) when there will be a roadshow which

will visit all the Hubs. During this time the Strategy will be showcased to staff and patients and there will be education around the use of the RA and pain assessment tools.

Health Care Acquired Infections

This table provides details of April's and year to date (YTD) CCC and community attributable infections.

	Annual Target	CCC attributable	YTD	Community attributable	YTD	Comments
Reportable						
C difficile	=<4	0	0	0	0	
E Coli		1	1	1	1	The post infection review is still underway however early findings indicate an unavoidable case with the likely source of infection considered to be hepatobiliary. This case will be discussed at the IPC sub-committee meeting.
MRSA	0	0	0	0	0	
MSSA	-	0	0	0	0	
Klebsiella	-	0	0	0	0	
Pseudomonas	-	0	0	0	0	
Non reportable						
VRE	-	0	0	0	0	
CPE	-	0	0	0	0	

1.4 Safe Staffing

This section provides an overview of planned versus actual hours for nursing and care staff by day and night in April 2019.

Planned staff means the number of staff (both registered nurses and care staff), required for each shift identified within the current funded establishment. Actual staff means the number of staff (both registered nurses and care staff), in attendance for each shift.

The national benchmark target for overall fill rates is 90%.

Registered Nurses

	DAY Hours	NIGHT Hours
Total monthly planned	7916	4018
Total monthly actual	7177	4110
Average Fill Rates %	91%	98%

Care Staff

	DAY Hours	NIGHT Hours
Total monthly planned	3130	2272
Total monthly actual	2933	2561

Average Fill Rates %	94%	89%
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This data provides assurance that the Trust is on average achieving the national target of 90% of all registered nurse hours being covered day and night. This is also achieved for care staff during the day and is 1% below, at 89%, for care staff at night. This is due to Mersey Ward fill rates for care staff in the day being at 76% and 65% at night. The only other area falling below 90% at either day or night was 7Y registered nurses during the day at 78%.

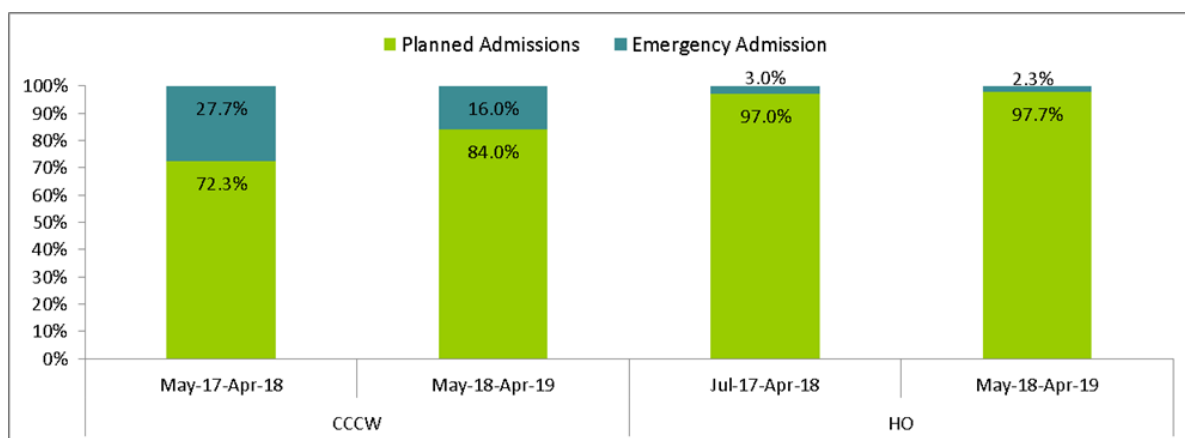
Rates are expected to improve over the coming months with further HCA appointments commencing in post. The introduction of NHSP to the trust and the launch of a “nurse pool” will provide added resilience within both the registered nurse and health care assistant workforce, especially to mitigate short term/ad hoc gaps.

1.5 Clinical Outcomes

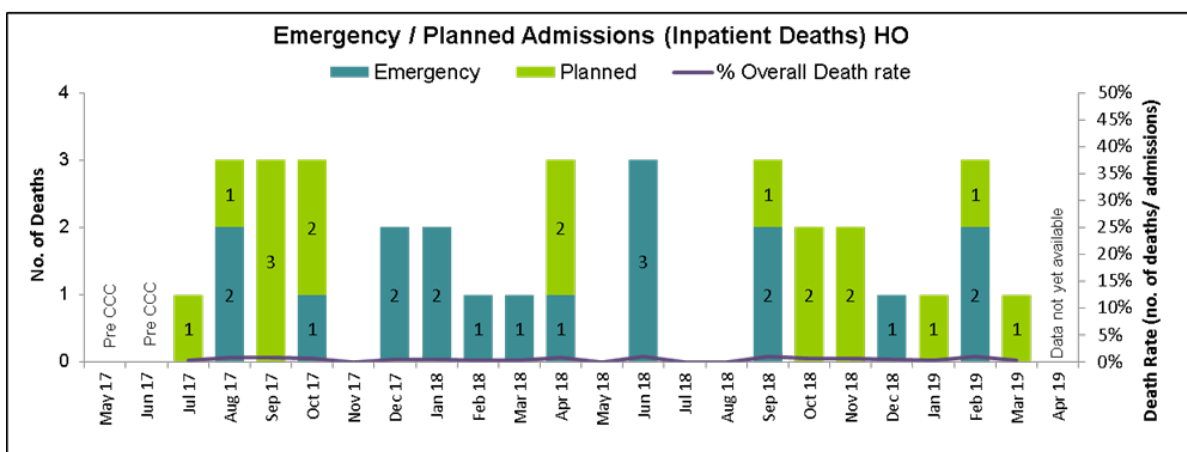
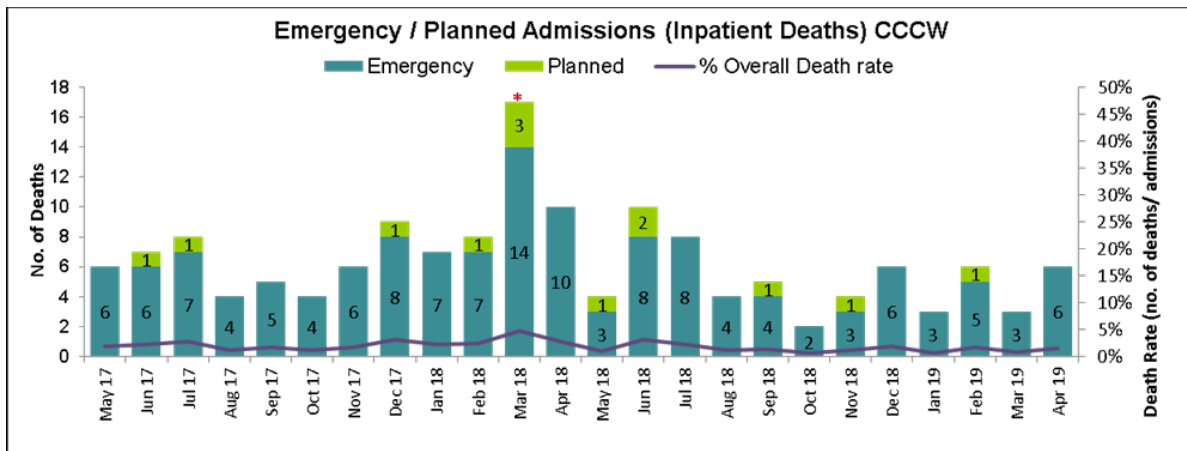
Mortality

Inpatient Deaths:

This chart shows the split of planned and emergency admission admissions at the CCCW and HO sites. It reveals that HO has a lower proportion of emergency admissions than CCCW, with 97% planned admissions.



These charts illustrate monthly inpatient death figures based on method of admissions (planned and emergency) as well as the overall death rate. No particular pattern was observed except an outlier in March 2018; this has been audited and the results demonstrated no patterns or concerns. These findings were subsequently reported to the Mortality Surveillance Group.



Solid Tumour Mortality within thirty days: The next quarterly update will be presented in the month two report.

Stem Cell Transplant Mortality: NHS England's Specialised Services Quality Dashboard Collections quarter four data is likely to publish in June 2019 and will therefore be presented in the month two report.

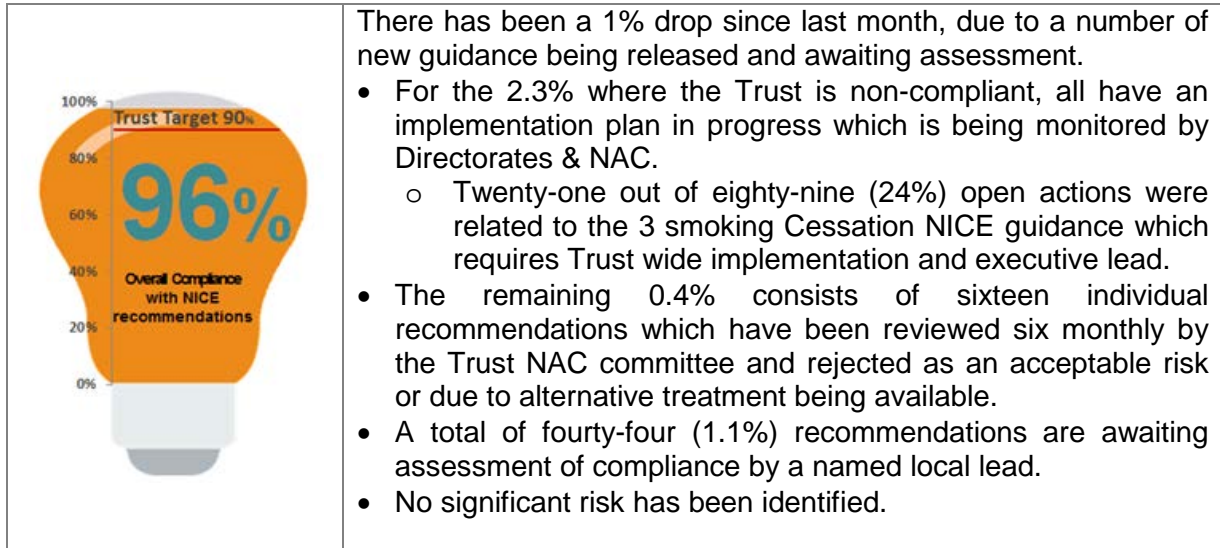
Mortality Review: The Mortality Surveillance Group meets monthly, therefore the next update will be provided in the month two report.

Other clinical outcomes

The first draft Outcome Dashboards have been completed for head and neck, Upper GI, Lung, Breast, Skin and Palliative care, Gynaecological and Colorectal. Dashboards for Urology, CNS, and AO/unknown primary are well underway and development of the Specialist SRG not yet started.

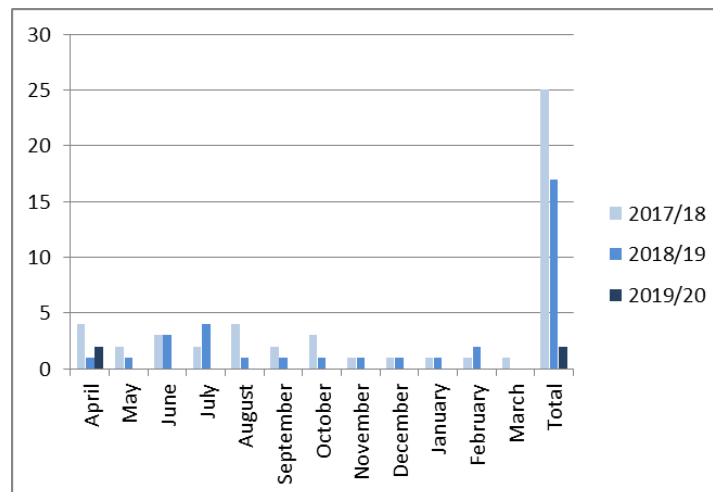
1.6 NICE Guidance

This diagram shows the latest compliance with NICE guidance at 96% as of 1st April 2019, which has exceeded the Trust's target of 90%.



1.7 Patient Experience

Complaints



The chart above shows total complaints per month for 2017/18, 2018/19 and 2019/20 to date.

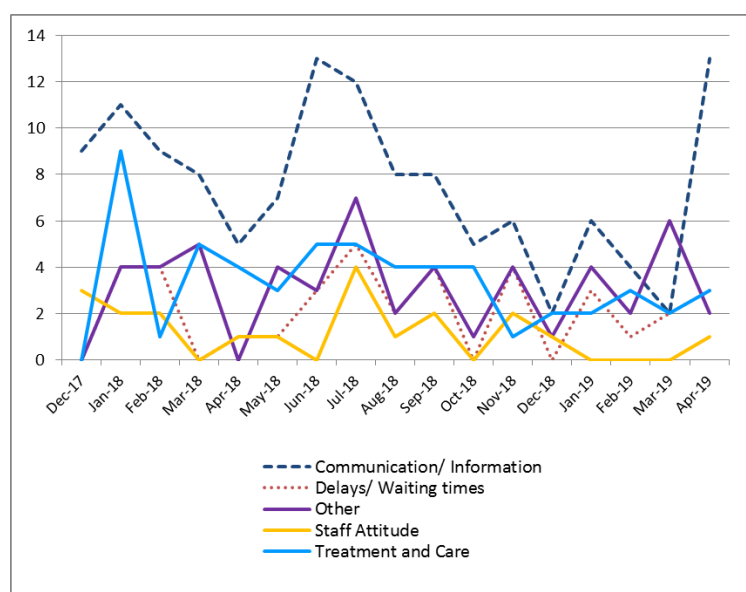
There were two complaints in April 2019. Both complaints were responded to within agreed timescales.

Immediate lessons learned

- Revised and improved processes and systems for medicines management put in place to ensure efficient stock use.
- Enhanced review of electronic patient record by staff to reduce unnecessary dispensing and supply of medication

Patient Advice and Liaison Service (PALS):

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



Following a falling trend since June 2018, there has been a significant rise, to thirteen in April, in the number of PALS contacts relating to communication / information. This does not correlate with any increase in patient numbers and will continue to be monitored. One PALS concern relating to medicines not being available for collection was escalated to a formal complaint and is being processed accordingly

Other communication/information concerns relate to confusion over Power of Attorney processes, two cancelled procedures - one at an external hospital and one at Haemato-Oncology, letters either being received when not required or not being received when requested, patients not satisfied with communication including confusing use of acronyms on letters and the use of fax causing delays in communication with other Trusts.

Immediate lessons learned

- Effective communication to patients, in line with Trust Standard Operating Procedure, must be ensured regarding cancelled appointments
- Improved written communication to patients to ensure easily understandable and without abbreviation
- Planned discontinuation of fax machines is in place

The following 'care' related contacts were also made in April:

Category	Total contacts
Admissions, Discharge and Transfer	1
Consent	0
End of Life	1
Privacy, Dignity and Wellbeing*	2
Total	4

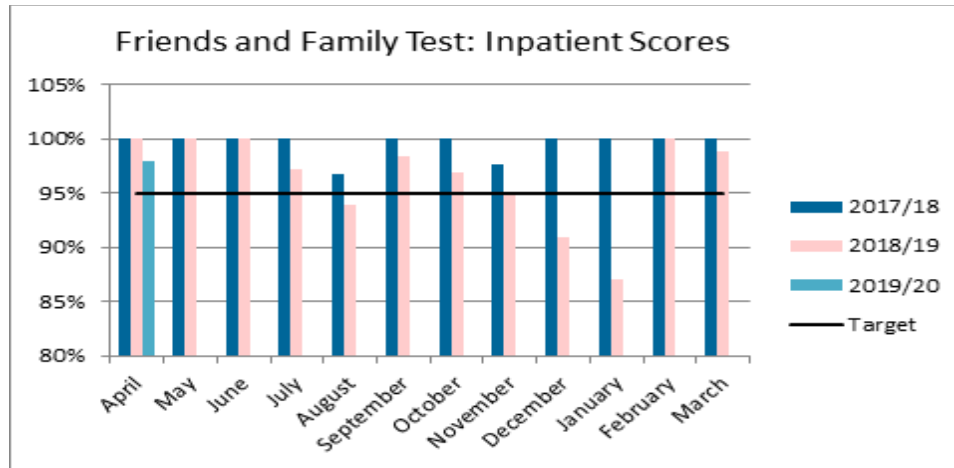
* The contacts made in the "privacy, dignity and wellbeing" category concerned intermittent compliance with a request to be treated by female staff only and concerns about confidentiality of patient identifiable information.

Details of and learning from all PALS contacts is included in the Directorate Quality and Safety data packs for discussion at monthly Quality and Safety meetings. Actions from specific issues raised or trends identified are also monitored through this route.

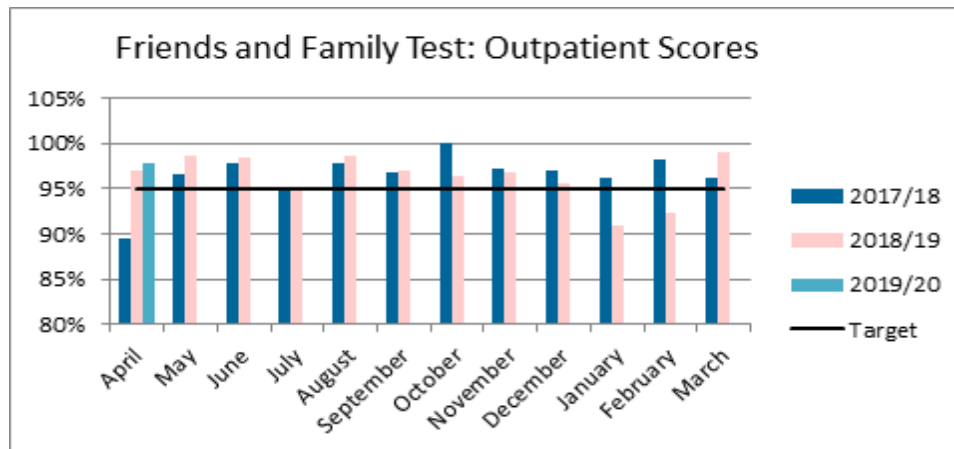
Patient Surveys

Friends & Family Test (FFT) Scores:

The chart below shows the percentage of inpatients that were 'likely' or 'extremely likely' to recommend the Trust to friends and family per month in 2018/19 and 2019/20 to date.



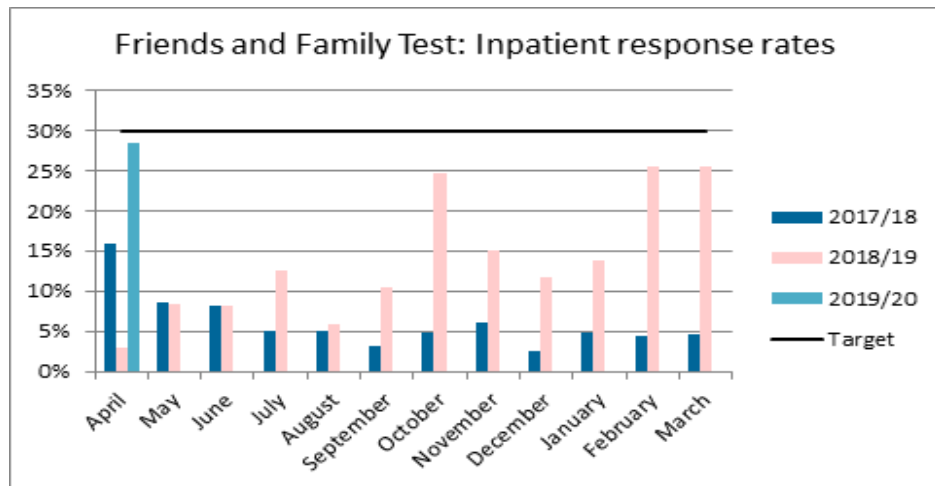
The chart below shows the percentage of outpatients who were 'likely' or 'extremely likely' to recommend the Trust to friends and family per month in 2018/19 and 2019/20 to date.



The targets for inpatients and outpatients recommending the Trust were achieved in April 2019.

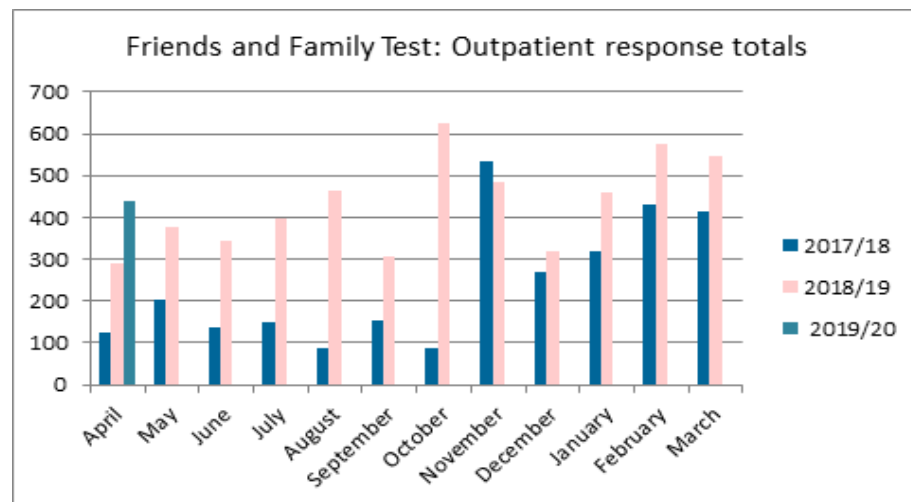
Friends & Family Test: Response rates:

The chart below shows the percentage of inpatients surveyed by month in 2018/19 and 2019/20 to date.



The inpatient response rate was 28.4% for April, 2.8% higher than March and the highest since May 2016. The HO service continues to work with IM&T to understand reported connectivity issues which will allow increased use of the handheld tablets on this site


The chart below shows the number of outpatients surveyed by month in 2018/19 and 2019/20 to date.



Since February, outpatient responses have fallen month on month, from 575 to 545 to 439 in April. Matrons' action plans are monitored at the relevant directorate Quality and Safety meetings and improvement trajectories have been set for 2019/20. Actions identified include utilising volunteers, housekeepers and radiotherapy support workers to promote completion of cards and raising awareness of the electronic option. Relevant staff need to be familiar with the electronic system so that they can assist patients to use it confidently.

Partners in Care

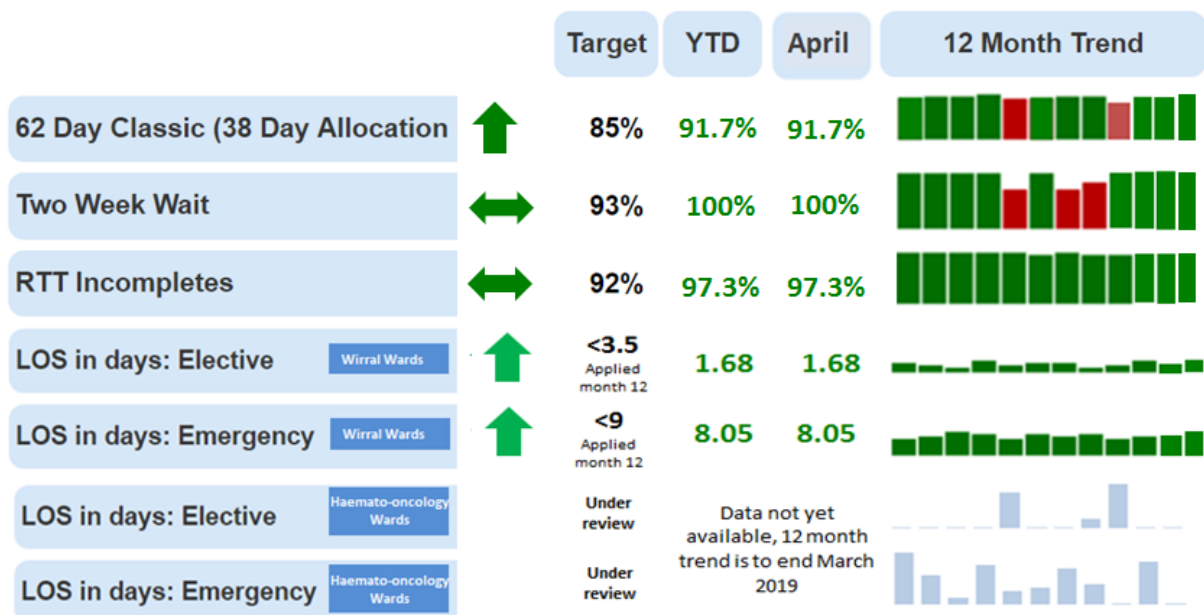
The Trust has successfully introduced the 'Partners in Care' service, which enables patients to choose a family member or close friend to become a member of their care team; assisting the nursing team on the ward to help deliver care and/or provide support. It has been developed by CCC to provide better patient centred care, to improve the patient experience and to align with John's campaign. The figures below show continued high completion of assessments.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend
% of admissions that had a partners in care assessment	13%	66%	90%	88%	84%	90%	88%	88%	90%	91%	91%	99%	93%	

Claims

There are currently thirteen open and ongoing claims against the Trust comprising of eight claims alleging clinical negligence and five liabilities to third party claims (employers/public liability).

2. Operational



2.1 Cancer Waiting Times Standards

National Standards:

Standard	Target	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	April 2019*
62 Day (post allocation)	85%	87.4%	86.5%	87.5%	84.5%	91.7%
31 Day (firsts)	96%	98.2%	96.6%	98.4%	99.2%	98.6%
18 Weeks – incomplete pathways	92%	99%	98%	98%	98%	97.3%
Diagnostics: <6 week wait	99%	100%	100%	100%	100%	100%
2 Week Wait	93%	100%	97%	83%	100%	100%

*April figures are accurate as at 05 May 2019, but are not finally validated until 5 June 2019.

The 28 day (faster diagnosis) standard data is being reviewed by the information team following concerns regarding accuracy related to data held on a RLBUH system and will therefore be reported from Month two. This will be shadow monitored in 2019/20 and go live in April 2020.

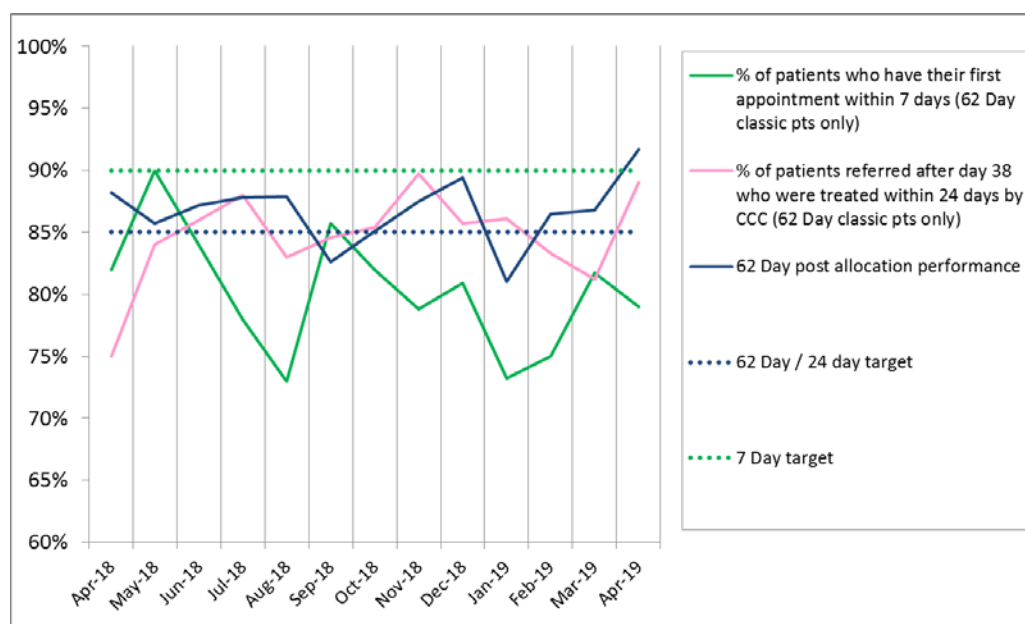
The HO team are developing a timed diagnostics pathway to identify areas of challenge that can be addressed before the go live date for the 28 day standard.

The 62 day breach details are as follows:

Day into CCO	Days @ CCC	Treated on Day	Tumour	Referring Trust	Treatment	Reason	Avoidable Breach
Full breach to CCC: Patient received by CCC before day 38 but not treated within 24 days							
None in this category							
Half breach to CCC: Patient received by CCC after day 38 and not treated within 24 days							
43	26	69	H&N	Whiston/ Aintree	Radical RT	Delay to radiotherapy (RT) - RT rearranged as the patient needed ultrasound which may change the treatment plan.	Yes
83	28	111	Lung	Wirral/ LHCH	Curative RT/Chemo	Slight delay to first appointment (three days) as the patient required a repeat scan after a haircut. The patient rearranged their planning appointment.	No
69	49	118	H&N/ Haem	RLH/LWH	Chemo	Delay to treatment due to patient having egg harvesting prior to chemotherapy.	No
80	28	108	LGI	Aintree	Neo-adj RT/Chemo	Delay to RT due to broken scanner and delay to P/A & PICC.	Yes

72	38	110	Lung	Whiston	Curative RT	Delay to first appointment (thirteen days), patient had flu and rearranged planning appointment (seven days), twelve days to SABR.	Yes
45	40	85	UGI	Wirral	Curative RT	Delay to first appointment (fourteen days) and patient choice, thinking time, was for SCOPE trial but declined chemotherapy at P/A and requested F/U to discuss RT.	No

This chart shows CCC's monthly performance for the 62 day classic standard, first appointment within seven days and treatment by CCC within twenty-four days.



Although the 90% target for seven days was not achieved in April, performance against the 62 day classic standard was good at 91.7%. Many of the patients not seen within seven days were therefore still treated within twenty-four days by CCC, preventing a CCC attributable breach.

62 Day performance by tumour group:

The tables below show the compliance by tumour group for quarter 4 2018/19. 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.

62 Day - CLASSIC									
Tumour Group	Breaches	Accountable Breaches	Hits	Accountable Hits	TOTAL	Accountable TOTAL	PreAllocated %	Allocated %	Allocated Performance
Lung	8	2.5	53	31.5	61	34	86.89%	92.65%	
Breast	6	1.5	50	27.5	56	29	89.29%	94.83%	
Upper Gastrointestinal	25	4	21	15	46	19	45.65%	78.95%	
Lower Gastrointestinal	26	3	13	10	39	13	33.33%	76.92%	
Head and Neck	20	5.5	13	7.5	33	13	39.39%	57.69%	
Urological (Excluding Testicular)	22	0.5	10	9	32	9.5	31.25%	94.74%	
Haematological (Excluding Acute Leukaemia)	10	2	10	5	20	7	50.00%	71.43%	
Gynaecological	8	0.5	4	2.5	12	3	33.33%	83.33%	
Other	0	0	6	3.5	6	3.5	100.00%	100.00%	
Skin	1	1	1	1	2	2	50.00%	50.00%	
Sarcoma	2	0	0	0	2	0	0.00%	-	
Brain/Central Nervous System	0	0	1	0.5	1	0.5	100.00%	100.00%	

Patients treated on or after 104 Days:

In April 2019, nine patients were treated after day 104. All were late referrals between days 69 - 160. Four patients were not treated within twenty-four days by CCC, due to delays to first appointment, delay to RT and patient related (including medical) reasons.

Cancer Waiting Times Improvement Plan:

A number of key actions are underway as part of the Improvement Plan. Progress since last month includes mitigating the impact on patients' pathways of planned and unplanned Consultant leave by making cover arrangements for gynaecological and anal clinics including holding additional clinics on four Saturdays for new and follow up appointments. An analysis of the quality of referrals has also been undertaken; the results for April by week are shown in the table below and reveal that most referrals do not meet the minimum defined criteria. Referring Trusts have been contacted requesting an improvement, to prevent the delays caused by incomplete referrals.

	Met		Not Met	
	Total	%	Total	%
Week 1	41	20	162	80
Week 2	64	35	121	65
Week 3	32	21	124	79
Week 4	21	10	187	90
Total	158	21	594	79

2.2 Clinic Waiting Times

The table below shows the % of patients waiting for fewer than thirty minutes, thirty – sixty minutes and more than sixty minutes for their outpatient appointment at the Wirral site, for Delamere and for the Trust's peripheral clinics. The targets have been met in each area for the last three months.

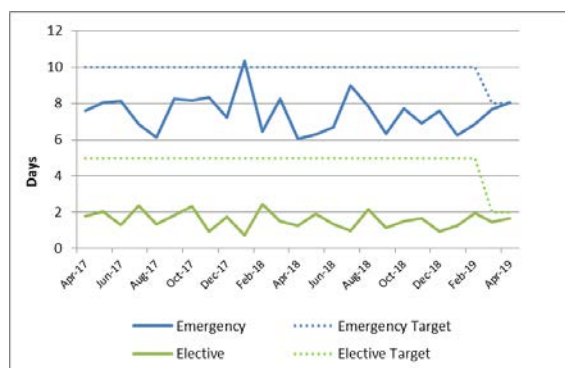
	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend
CCC Outpatients Wirral: Seen within 30 minutes	80%	78%	78%	78%	75%	79%	75%	76%	81%	85%	85%	85%	84%	86%	
CCC Outpatients Wirral: Seen between 31 and 60 minutes		12%	13%	14%	14%	12%	14%	15%	13%	10%	11%	10%	10%	8%	
CCC Outpatients Wirral: Seen after 60 minutes		10%	9%	9%	11%	9%	11%	9%	7%	5%	5%	6%	6%	5%	
Delamere: Seen within 30 minutes	80%	81%	80%	79%	78%	82%	78%	77%	79%	77%	77%	82%	81%	81%	
Delamere: Seen between 31 and 60 minutes		10%	11%	11%	11%	10%	12%	13%	10%	11%	12%	9%	10%	10%	
Delamere: Seen after 60 minutes		9%	10%	10%	11%	8%	10%	10%	11%	11%	11%	9%	9%	8%	
Outpatient peripheral clinics: Seen within 30 minutes	80%	89%	91%	91%	91%	91%	90%	89%	90%	91%	91%	90%	91%	89%	
Outpatient peripheral clinics: Seen between 31 and 60 minutes		7%	6%	6%	6%	6%	7%	8%	7%	2%	6%	7%	7%	8%	
Outpatient peripheral clinics: Seen after 60 minutes		4%	3%	3%	3%	4%	3%	3%	4%	2%	3%	3%	2%	3%	

Clinic waiting time compliance has been achieved with project management support from the PMO. As compliance has been sustained the project support has now been withdrawn. A wider piece of work is however required to ensure that the data has been correctly collected at source. This will be addressed as part of the data quality kite marking project.

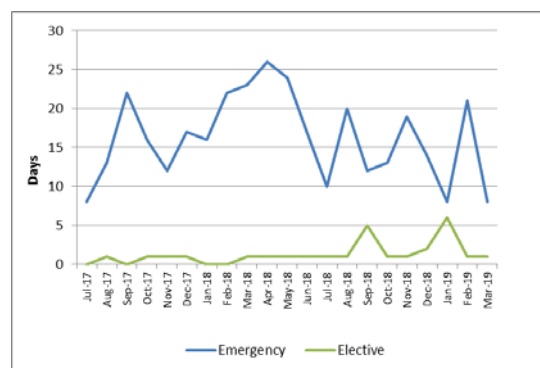
2.3 Length of Stay (LOS)

The following charts show the LOS for elective and emergency admissions in days per month for CCCW and HO wards. HO data for month one has not yet been received from RLBUHT.

Wirral Wards x 3



HO Wards x 2



Wirral wards have been within target throughout 2018/19 and the targets have therefore been reduced to eight (emergency admissions) and two (elective admissions) to drive further improvement. A target will be developed for HO wards by month two, 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.

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 from month two onwards.

2.4 Bed Occupancy

The table below shows the CCCW average bed occupancy by month and ward at two 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.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend
11 am (Conway)	83%	69%	85%	84%	78%	77%	77%	75%	68%	80%	84%	81%	88%	
11 am (Mersey)	66%	65%	78%	75%	68%	66%	66%	69%	72%	85%	88%	87%	86%	
11 am (Sulby)	27%	27%	45%	81%	74%	70%	70%	49%	48%	60%	53%	58%	58%	
2 am (Conway)	84%	69%	85%	84%	78%	78%	78%	75%	69%	80%	84%	81%	87%	
2 am (Mersey)	65%	63%	76%	74%	67%	67%	67%	70%	70%	84%	88%	86%	85%	
2 am (Sulby)	17%	15%	26%	33%	34%	32%	32%	19%	14%	17%	10%	4%	5%	

Target = 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

A bed occupancy report for HO and solid tumour inpatient wards is received daily by all senior managers to enable the HO and ICD Directorates to reconfigure staffing to areas in need. During times of high occupancy, additional bed meetings and occupancy reports are activated.

2.5 Radiology Reporting

This table displays the reporting turnaround times for inpatients and outpatients and reveals that the Trust is failing to achieve the respective targets of twenty-four hours and seven days.

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend
Imaging reporting turnaround: inpatients within 24 hours	G: >=90%, A: 80-89%, R: <80%	83.8%	81.9%	69.6%	70.0%	78.4%	82.3%	80.7%	78.6%	69.3%	73.9%	82.6%	62.5%	68.1%	
Imaging reporting turnaround: out patients within 7 days		94.9%	87.8%	68.8%	50.7%	50.3%	76.1%	73.1%	70.0%	67.8%	72.5%	89.6%	62.8%	55.8%	

This performance reflects the capacity issues faced by CCC. Whilst there was an improvement in February, a combination of annual leave, non-availability of locums and the inability of some ad-hoc reporters to attend at CCC has impacted on March performance and the backlog has continued into April. The situation was compounded by very poor performance in respect of the turnaround times from the outsourcing company.

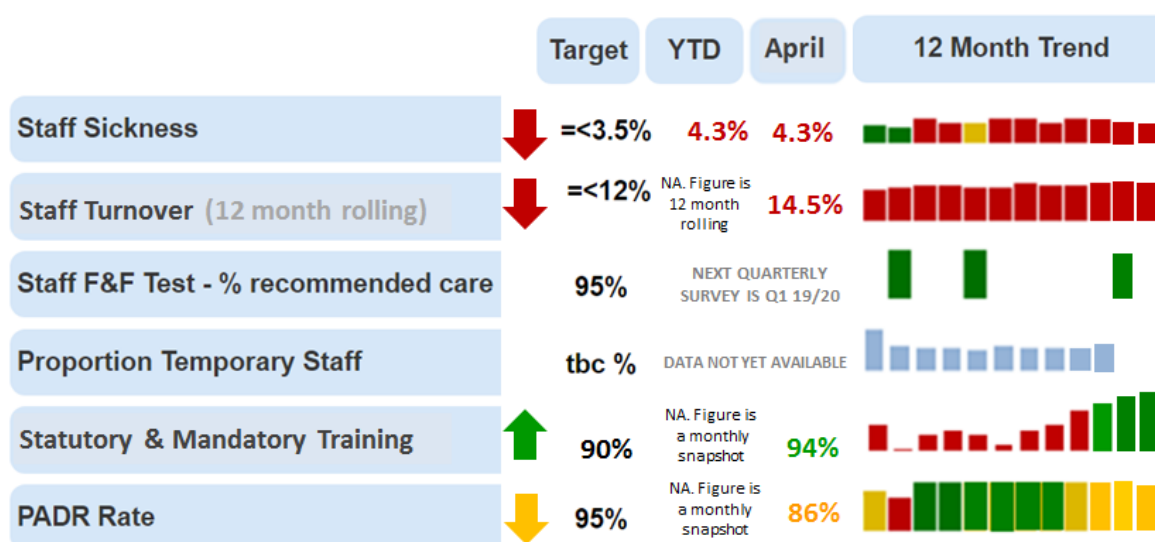
The situation began to improve at the end of April and the improvement has been sustained so far in May with the expectation of improved performance in May. There have been meetings with the outsourcing company to improve the process of reporting turnaround times.

To mitigate this underperformance, daily sit reps are completed by the department to ensure urgent imaging reports and reports needed to facilitate Out Patient Department appointments are delivered on time.

2.6 Patients recruited to trials

This section of the report is under review and will be reported in a new format from Month two, 2019/20.

3. Workforce



Workforce Overview

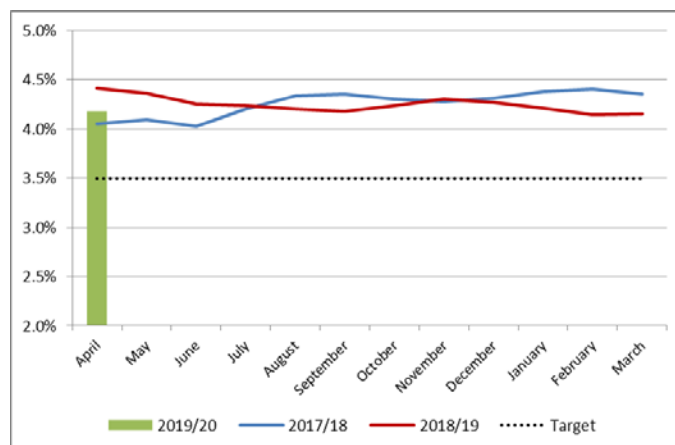
This table presents an overview of staff numbers and movement by month.

	2018 / 05	2018 / 06	2018 / 07	2018 / 08	2018 / 09	2018 / 10	2018 / 11	2018 / 12	2019 / 01	2019 / 02	2019 / 03	2019 / 04	Trend
Headcount	1,265	1,261	1,260	1,274	1,274	1,292	1,295	1,295	1,299	1,304	1,316	1,334	
FTE	1,145.82	1,143.00	1,143.67	1,156.67	1,157.35	1,174.17	1,174.63	1,174.77	1,178.28	1,183.51	1,195.06	1,209.74	
Leavers Headcount	22	17	12	16	16	14	19	17	17	14	20	11	
Leavers FTE	18.80	15.91	11.49	13.52	13.64	12.75	17.56	14.87	14.72	11.39	15.06	10.15	
Starters Headcount	13	16	10	26	19	30	22	19	19	21	24	36	
Starters FTE	11.25	15.32	9.04	23.13	15.96	27.67	17.67	16.70	17.13	18.66	20.88	33.07	
Maternity	32	35	33	34	35	36	41	40	39	40	42	46	
Turnover Rate (Headcount)	1.74%	1.35%	0.95%	1.26%	1.26%	1.08%	1.47%	1.31%	1.31%	1.07%	1.52%	0.82%	
Turnover Rate (FTE)	1.64%	1.39%	1.00%	1.17%	1.18%	1.09%	1.49%	1.27%	1.25%	0.96%	1.26%	0.84%	
Leavers (12m)	158	164	165	172	169	174	190	187	188	194	201	195	
Turnover Rate (12m)	12.92%	13.23%	13.26%	13.76%	13.46%	13.79%	15.01%	14.72%	14.74%	15.17%	15.66%	15.13%	
Leavers FTE (12m)	138.37	144.62	147.40	152.36	147.87	152.66	167.42	164.11	164.41	169.12	172.93	169.87	
Turnover Rate FTE (12m)	12.51%	12.90%	13.08%	13.46%	13.00%	13.36%	14.59%	14.25%	14.22%	14.58%	14.85%	14.52%	

The following data is presented by Trust and then Directorates/Services.

Sickness Absence

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



The Trust twelve month rolling sickness absence is 4.15% and the in month sickness absence position continues a downward trend decreasing to 4.26% in April from 4.43% in March 2019. Gastrointestinal problems, anxiety/stress/depression/ and cold, cough and flu, remain the three highest reasons for sickness absence across the Trust.








In April there were twenty-five episodes due to gastrointestinal problems, which was the highest reason for sickness. Integrated Care had the highest number of episodes of eight. The second highest reason for sickness in April 2019 was Anxiety/stress/depression with nineteen episodes. Chemotherapy had the highest

number of episodes with seven. The third is Cold/cough/influenza with sixteen cases. Radiation Services had the highest number of episodes with six.

Latest figures released by NHS Digital show that for December 2018 the monthly national NHS staff sickness absence was 4.5%, which is 0.10% less than it was in December 2017. Health Education North West region had the highest sickness absence percentage rate of 5.29% followed by West Midlands with 5.03%. The equivalent sickness rate for CCC's sickness in December 2018 was 4.12%.



Directorates & Corporate Services:

Sickness absence per month per Directorate:

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend
Haemato-oncology Directorate	5.3%	4.0%	4.2%	4.5%	2.3%	3.82%	3.85%	4.00%	4.41%	4.86%	4.85%	4.67%	3.85%	
Chemotherapy Services Directorate	5.3%	4.9%	3.4%	3.9%	3.0%	3.43%	3.89%	5.00%	5.72%	7.34%	6.92%	7.04%	5.82%	
Integrated Care Directorate	4.2%	3.3%	2.4%	4.4%	2.8%	4.62%	5.94%	4.36%	2.94%	4.11%	3.47%	4.99%	4.70%	
Radiation Services Directorate	3.1%	2.4%	2.1%	3.2%	3.2%	2.55%	3.96%	4.79%	4.11%	3.25%	3.57%	2.54%	2.96%	
Corporate Services	4.56%	3.95%	4.64%	6.88%	7.38%	5.99%	5.44%	4.95%	3.71%	4.83%	5.30%	4.44%	5.03%	
Research	2.79%	3.71%	2.38%	4.58%	5.24%	4.18%	4.99%	4.24%	3.10%	4.05%	2.90%	5.52%	2.73%	
Quality	1.4%	1.0%	2.2%	1.7%	1.7%	0.8%	4.3%	3.9%	5.15%	6.88%	3.88%	3.73%	6.69%	

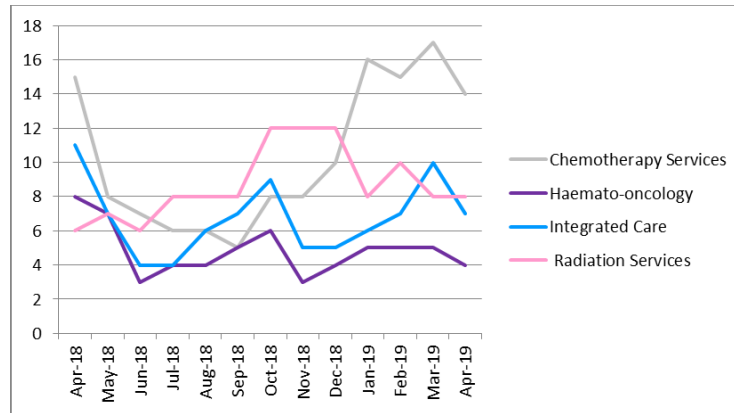
Long / short term sickness absence:

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

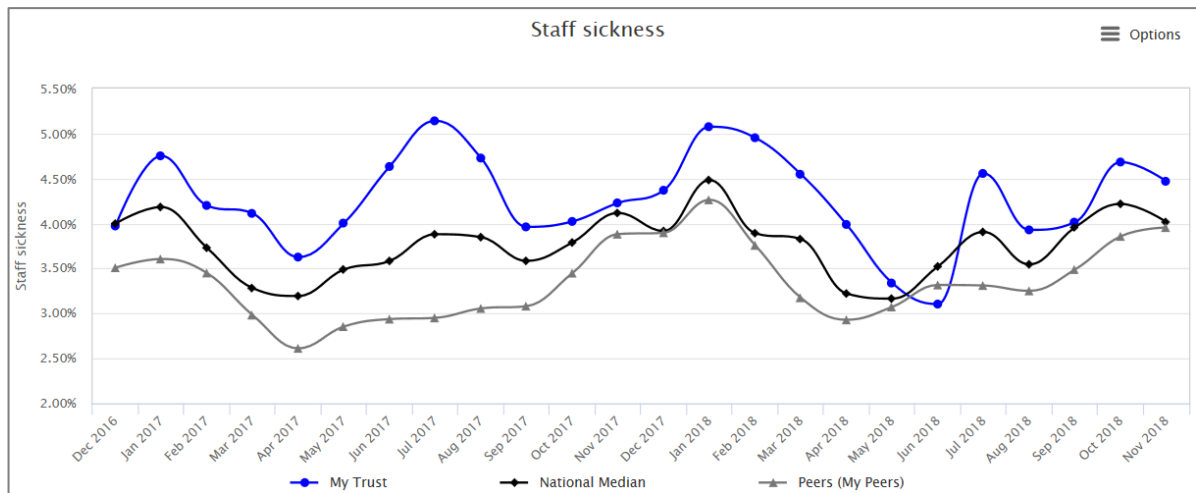
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend
Short term	105	119	103	133	118	103	164	159	148	195	151	139	106	
Long term	56	44	33	45	48	45	56	45	44	49	50	53	46	

Despite a rise in long term sickness absence since Dec 2018, this has reduced in April 2019. The previously rising trend of short term sickness has ended, with a reduction in each of the last three months.

The chart below presents this data by Directorate.

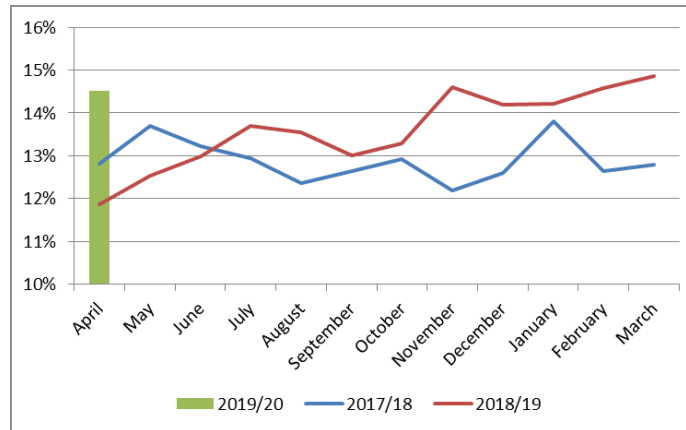


This chart of in month sickness absence shows generally higher figures for CCC than the national average and peers, however in May, June and September this was similar or indeed lower.



Turnover

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

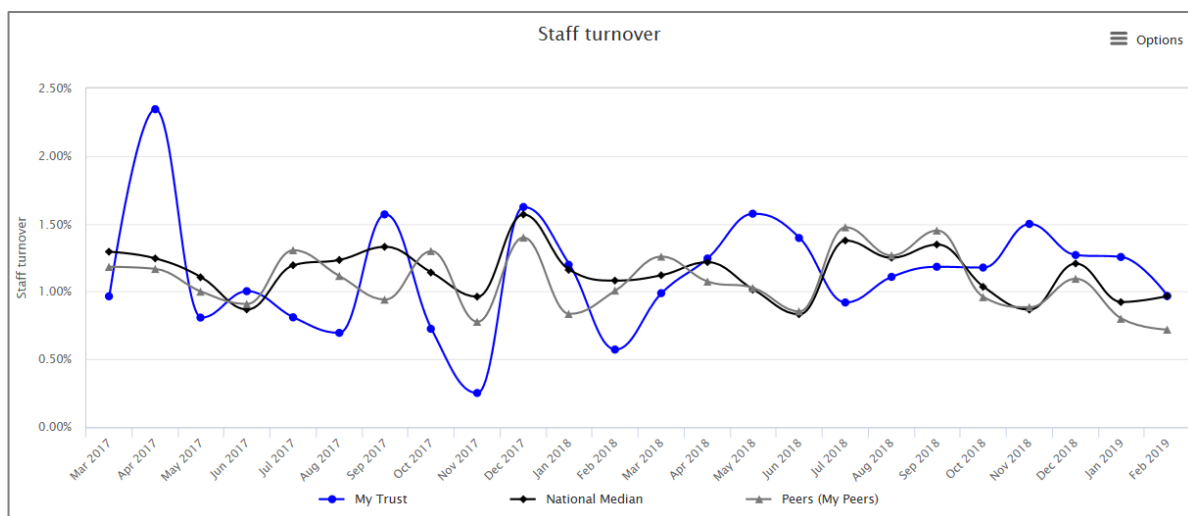


Turnover for April 2019 has decreased slightly from 14.9% to 14.5%. There were eleven leavers in total in April. The majority of leavers in April were from Nursing with five leavers with reasons being: move to Liverpool (one), Relocation (one), Promotion (two) and Retirement (one). In other areas the reasons for leaving were, retirement (one), Dismissal (capability) (one), Health (two) and Relocation (one) and Work life balance (one).

The WOD Team is contacting leavers to encourage the completion of exit questionnaires or to engage in exit interviews in order to gather meaningful information regarding reasons for leaving. In April, nine exit questionnaires were completed and three were started but not completed.

A new Retention Work stream reporting into the Work stream for the Future Board from June will ensure that retention continues to be priority for the Trust as it prepares for the move to Liverpool.

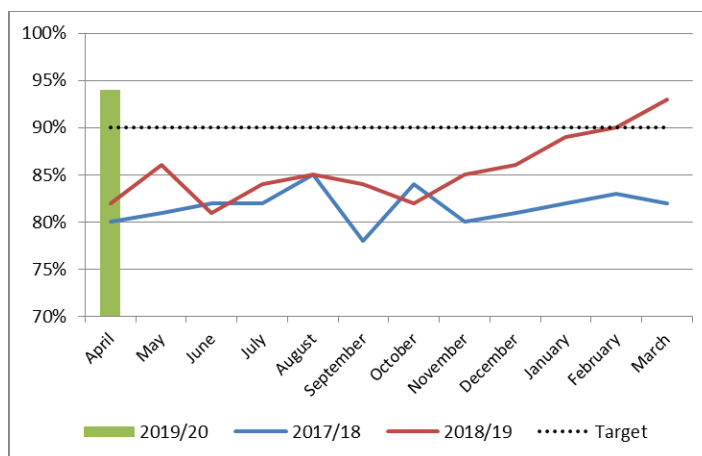
The 'Model Hospital' benchmarking chart below uses a different measure than ESR to calculate turnover; using this definition, CCC have similar, and often lower levels of turnover to both peers and the national average.



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 twelve month period

Statutory and Mandatory Training

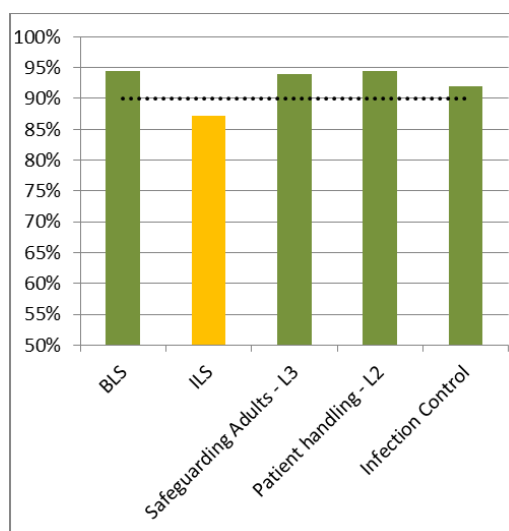
This section presents the Trust figures per month and year, the Directorate / Service compliance and then detailed actions and specific course compliance. The Trust has achieved the overall target in April 2019 at 94%.



Directorate	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend
Haemato-oncology Directorate	58%	76%	74%	63%	66%	66%	54%	59%	58%	72%	74%	85%	94%	
Chemotherapy Services Directorate	87%	89%	89%	86%	88%	88%	89%	89%	93%	95%	96%	97%	97%	
Intergrated Care Directorate	87%	87%	87%	88%	89%	89%	87%	88%	87%	90%	90%	93%	94%	
Radiation Services Directorate	86%	88%	87%	88%	89%	85%	86%	84%	87%	91%	92%	95%	94%	
Research and Innovation					79%	81%	81%	84%	83%	86%	87%	89%	90%	
Corporate Services								88%	84%	90%	90%	93%	94%	
Quality	92%	91%	90%	94%	96%	97%	95%	94%	98%	99%	97%	99%	94%	

Course Specific:

The chart below shows Trust compliance by course and the table below shows progress since December, by Clinical Directorate and course (the data is correct as at 7th May 2019). An amber threshold (80-89%) has been applied 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	21/03/2019	28/03/2019	10/04/2019	15/04/2019	07/05/2019
Chemotherapy	BLS	55%	72%	71%	76%	78%	79%	83%	85%	82%	84%	85%	86%	88%	95%	95%	97%
	ILS	42%	60%	61%	60%	63%	70%	72%	73%	80%	83%	84%	85%	87%	91%	92%	83%
	Safeguarding Adults - L3	86%	100%	86%	86%	86%	86%	53%	55%	55%	53%	70%	68%	68%	86%	100%	100%
	Patient handling - L2	67%	73%	71%	85%	86%	85%	88%	89%	92%	94%	96%	91%	91%	96%	98%	98%
	Infection Control	75%	79%	80%	81%	81%	84%	84%	84%	87%	87%	86%	87%	88%	92%	93%	95%
Haem Onc	BLS	53%	83%	90%	88%	88%	93%	89%	95%	96%	92%	97%	88%	88%	92%	95%	94%
	Safeguarding Adults - L3	11%	34%	43%	43%	65%	63%	70%	68%	78%	73%	68%	55%	55%	89%	95%	95%
	Patient handling - L2	43%	72%	82%	78%	78%	83%	85%	89%	95%	88%	81%	78%	80%	85%	95%	97%
	Infection Control	74%	76%	75%	75%	77%	71%	73%	67%	95%	75%	75%	50%	50%	77%	100%	100%
Integrated Care	BLS	71%	79%	79%	80%	83%	83%	84%	79%	78%	78%	83%	85%	87%	93%	94%	95%
	ILS	41%	68%	68%	69%	70%	71%	72%	71%	70%	70%	70%	70%	76%	93%	93%	88%
	Safeguarding Adults - L3	33%	75%	50%	47%	53%	53%	53%	53%	56%	50%	57%	60%	60%	75%	78%	100%
	Patient handling - L2	78%	78%	79%	78%	80%	81%	81%	80%	81%	82%	83%	84%	85%	89%	88%	95%
	Infection Control	49%	49%	76%	76%	78%	81%	81%	78%	79%	81%	80%	82%	84%	90%	91%	90%
Radiation Services	BLS	50%	75%	74%	71%	79%	81%	80%	82%	81%	82%	82%	84%	86%	95%	95%	92%
	ILS	67%	55%	47%	52%	57%	62%	68%	68%	69%	71%	76%	74%	76%	86%	86%	88%
	Safeguarding Adults - L3		23%	21%	21%	21%	21%	50%	50%	50%	50%	75%	75%	75%	100%	100%	100%
	Patient handling - L2	70%	72%	71%	73%	77%	81%	78%	81%	82%	83%	85%	87%	90%	96%	95%	95%
	Infection Control	35%	41%	52%	54%	55%	66%	66%	67%	71%	75%	78%	83%	84%	89%	88%	90%

- All directorates are at 90% or above for BLS, Safeguarding Children, Infection Control and Patient Handling.

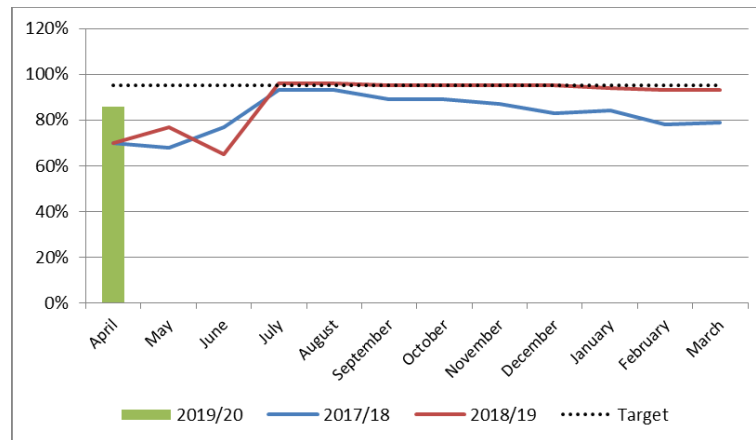
- Overall compliance of 90% was maintained for ILS during April; however compliance has dropped in early May for three directorates. Work continues to be undertaken to review who requires ILS and to forecast with the trainer on the number of sessions required to maintain 90% and above.
- Compliance has increased for Safeguarding level three through the targeting of non-compliant staff by the subject matter expert.
- Infection Control level two: all directorates are at Trust target or above.
- Patient Handling: All directorates are at Trust target or above. Work is being undertaken with the Patient Handling trainer to forecast numbers of sessions required each month in order to maintain compliance.

This table shows that HO ward based staff continue to be compliant with their role essential training.

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	10/04/2019	07/05/2019	Trend
AKI	81%	92%	92%	93%	94%	95%	96%	97%	99%	98%	99%	
ANTT - online	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Sepsis	73%	88%	92%	92%	92%	93%	94%	94%	97%	100%	100%	
Blood transfusion - online	74%	100%	100%	100%	100%	100%	100%	100%	100%	97%	99%	
Blood transfusion - ward based	66%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Point of care	57%	94%	98%	98%	98%	98%	98%	98%	97%	100%	100%	
Medical Devices	39%	49%	52%	65%	64%	64%	66%	55%	77%	97%	97%	
COVAD	85%	92%	95%	97%	98%	99%	98%	98%	100%	100%	100%	

PADR Compliance

Trust compliance for April is below the target of 95%, at 86%.



Compliance by Directorate:

Directorate	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend
Haemato-oncology Directorate	81%	83%	40%	98%	99%	99%	97%	97%	96%	94%	93%	89%	87%	√
Chemotherapy Services Directorate	78%	81%	87%	99%	99%	98%	99%	98%	97%	93%	94%	91%	77%	√
Intergrated Care Directorate	65%	66%	62%	96%	97%	97%	96%	96%	93%	92%	92%	91%	84%	√
Radiation Services Directorate	79%	84%	67%	99%	99%	98%	95%	95%	95%	95%	92%	92%	89%	√
Research and Innovation					87%	91%	91%	90%	90%	88%	87%	92%	87%	√
Corporate Services								98%	96%	93%	95%	95%	90%	√
Quality	76%	77%	65%	98%	98%	100%	100%	100%	100%	100%	100%	100%	88%	√

The Annual PADR cycle has begun and a new online PADR tool is being rolled out across departments. All managers will be contacted during May to confirm that they have a plan in place to ensure all PADRs are completed by the end of July. The Workforce and OD team are considering the introduction of revised (lower but increasing) targets during the PADR cycle months to closely monitor performance at this time and ensure compliance by the end of July each year.

Staff Experience

Staff Friends and Family Test

This survey is conducted quarterly, with the next survey due to take place during quarter one; this is likely to be reported in month five.

NHS National Staff Survey 2018

Further details of the results, including breakdowns per Directorate, will be provided to the Trust Board in May 2019.