



### Report Cover Sheet

Report to:	Board of Directors' Meeting	
Date of the Meeting:	26 <sup>th</sup> June 2019	
Agenda Item:	P1-0127-19	
Title:	Integrated Performance Exception Report: Month 2 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 and Performance Committee
Date & Decision:	12 <sup>th</sup> June and 17 <sup>th</sup> June 2019

Purpose of the Paper/Key Points for Discussion:	<p>This report provides the Trust Board with an update on performance for month two (May 2019). The quality, operational, workforce and financial KPI scorecards are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant.</p> <p>As agreed at the May 2019 Board of Directors' meeting, this summary report will now be presented to the Board of Directors' meeting in the months between the quarterly presentation of the full Integrated Performance Report.</p> <p>Points for discussion include under performance, developments and key actions for improvement.</p>
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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 May 2019.
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*The paper links to the following strategic priorities (please tick)*

Deliver <b>outstanding care locally</b>	Y	Collaborative system <b>leadership</b> to <b>deliver better patient care</b>	
<b>Retain and develop</b>	Y	Be <b>enterprising</b>	

<b>outstanding staff</b>			
<b>Invest in research &amp; innovation</b> to deliver <b>excellent</b> patient <b>care</b> in the future		Maintain <b>excellent</b> quality, operational and financial <b>performance</b>	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: Summary (Month 2 2019/20)**

## **Introduction**

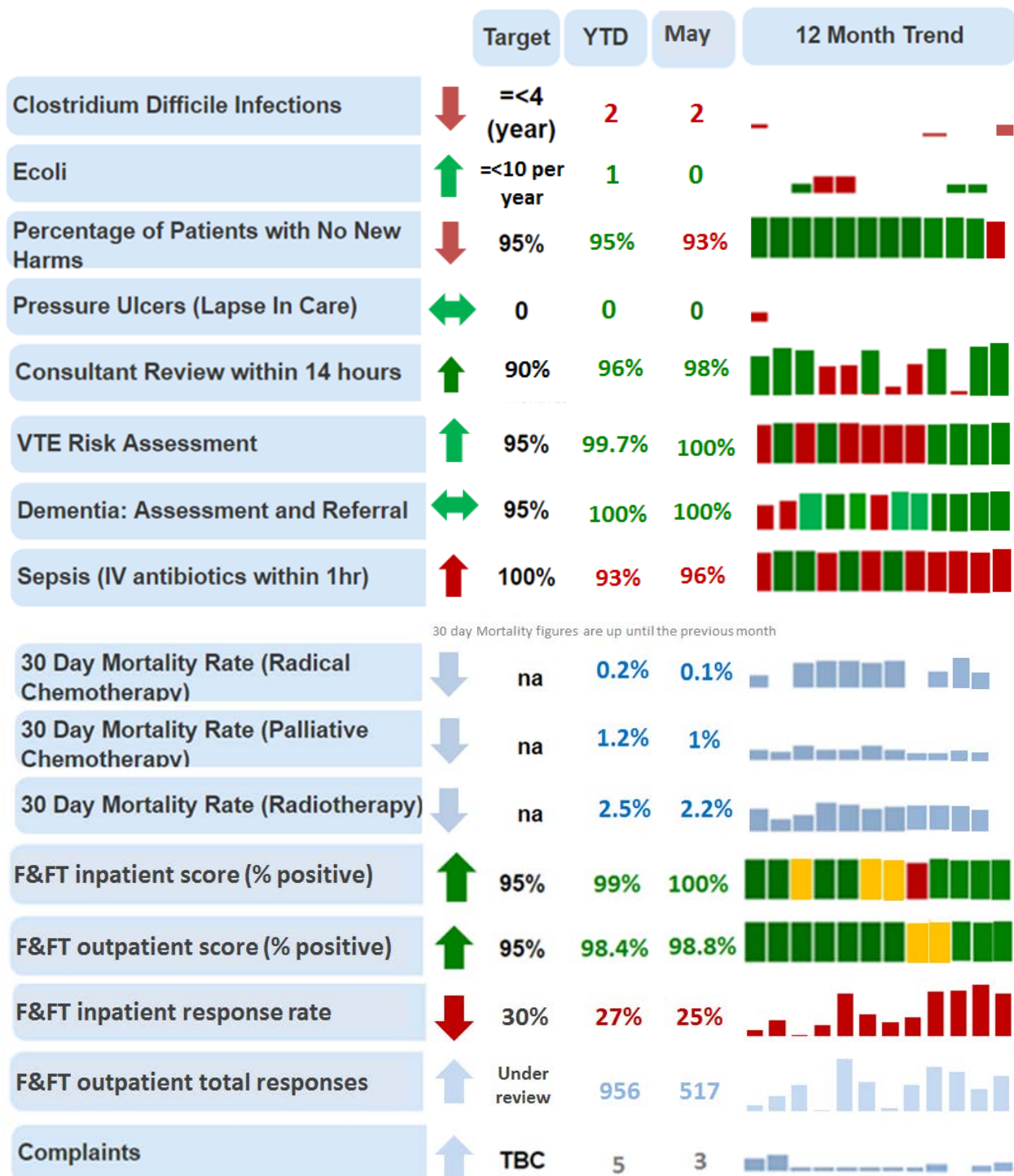
This report provides the Trust Board with an update on performance for month two (May 2019). The quality, operational, workforce and financial KPI scorecards are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant. Further detail, including full actions in place, has been reported to the Quality Committee and Performance Committee.

As agreed at the May 2019 Board of Directors' meeting, this summary report will now be presented to the Board of Directors' meeting in the months between the quarterly presentation of the full Integrated Performance Report.

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. This is being managed by the Data Management Group and is reported to Digital Board. Information Management and Technology (IM&T) are working on a solution with the Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT) to ensure the data feed is both accurate and timely. This is however a complex issue which will take time to resolve, therefore manual processes are now being implemented to ensure robust oversight of this data until IT system based solutions are found.

## Performance Scorecards and Exception Reports

### Quality



Clostridium Difficile Infections: There were two CCC attributable C difficile infections in May, both at CCCW. The target is four or fewer per year. CCC internal review has found no clear links between the infections and no lapses in care, however, these findings will need to be confirmed with commissioners (as per normal process at CCC). All patients were managed appropriately and discharged home.

Patients with No New Harms (Safety Thermometer): The target of 95% was not achieved in May (93%) with five patients affected, each with one 'new harm'. Four relate to new VTEs which will be reviewed in the harms meeting. Three of these relate to PICC/wand VTE, a known complication of a PICC device. The fifth harm was a grade two pressure ulcer, related to O2 mask tubing, and following review at the harms meeting, it was determined that there was no lapse in care. Actions identified include the utilisation of the Cheshire and Merseyside Tissue Viability Network to identify and share learning regarding oxygen therapy equipment related pressure ulcers, and the recruitment of a Trust lead for tissue viability.

Sepsis - Intravenous Antibiotics received within an hour: The May figure was 96% against a target of 100%. One of twenty-two patients was non-compliant, as although the patient received antibiotics, the administration time was not recorded. The Deteriorating Patient Working Group continues to progress with a number of key actions, including incorporating sepsis education into daily ward safety huddles and utilising digital solutions to alert staff to consider the possibility of sepsis. A vacancy within the DART team has been filled and this post holder has been tasked with the implementation of NEWS2 training and the monitoring and delivery of the sepsis target. The implementation of the in-patient electronic prescribing system at CCC Wirral will be completed by the end of June 2019; this will ensure accuracy regarding the time of drug administration.

Friends and Family test (FFT) response rates: The inpatient response rate fell from 28.4% in April to 25% in May against an internal stretch target of 30%. Following a fall in outpatient responses since February, there has been a rise from 439 in April to 517 in May. Actions identified include targeting regular attenders on Sulby ward; the FFT questions will be extracted from the larger patient experience survey, into an FFT only survey to support increased response rates. The scores for both inpatients and outpatients remain high and above target.

## Operations



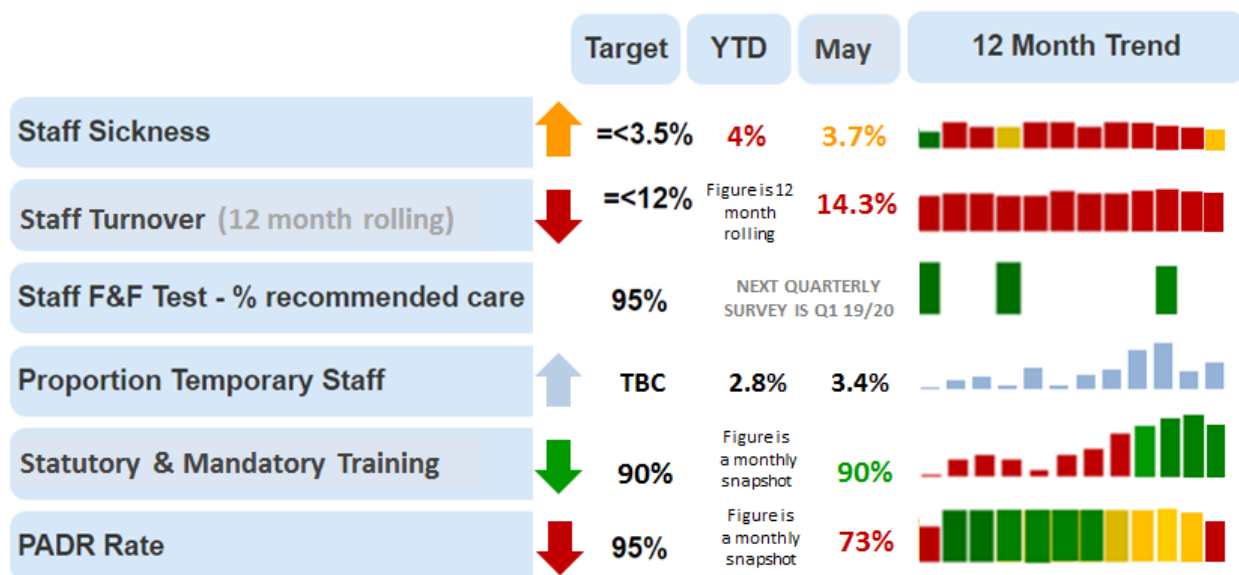
Two Week Wait Standard: The May (un-validated) performance is 90% against the 93% target. The underperformance relates to one unavoidable breach as the patient was unavailable to attend an appointment until May despite being referred to CCC in February 2019.

Length of Stay (LOS), emergency admissions: Stretch targets were set in April 2019 to drive further reductions in length of stay at CCCW. The May LOS for emergency admissions is 8.15 days, which is slightly above the new target of 8 days. The Patient Flow Team is working with ward staff to ensure discharge planning begins on admission; these actions will also support the delivery of the CUR CQUIN.

Patients not meeting CUR (Clinical Utilisation Review) criteria: This KPI forms part of Clinical Utilisation Review CQUIN. The reduced target of 10%, agreed with Commissioners for 2019/20, is due to be met by March 2020. The CUR project team and Patient Flow Team are implementing an action plan to continue to reduce the numbers of inpatients who do not meet the criteria; progress against this is reported to the Quality Committee.

Radiology reporting: The target of 90% (within twenty four hours) was not achieved for inpatients or for out-patients (within seven days) at 74% and 79% respectively. Whilst improved for May, this performance continues to reflect the capacity issues caused by unfilled vacancies, non-availability of locums, the unavailability of some ad-hoc reporters and slow turnaround from the outsourcing company. There is a clinical prioritisation process in place to ensure urgent scan reports are delivered on time. In addition there is an on-going recruitment plan in place, including the appointment of a joint post with the RLBUHT and the offer of an Associate Specialist role for an aspiring consultant who will follow the CESR pathway. An interview for an overseas candidate is also planned that will help reduce agency spend.

## Workforce



Sickness absence: The Trust twelve month rolling sickness absence is 4.22% and the in-month sickness absence position continues a downward trend decreasing to 3.72% in May from 4.26% in April in 2019. Gastrointestinal problems, anxiety/stress/depression and cold, cough and flu, remain the three highest reasons for sickness absence across the Trust. The Workforce and OD team are reviewing the last six months of sickness absence data relating to gastrointestinal problems. The conclusions and recommendations presented to the Workforce, Education and OD Committee in September 2019.

Staff Turnover: Turnover for May 2019 has decreased again slightly to 14.3% from 14.5%. There were twenty leavers in total in May 2019. The highest staff group for leavers was Admin and Clerical with twelve leavers followed by Nursing with four leavers. A new Recruitment and Retention programme is now in situ that includes the








offer of the payment of tunnel fees for potential new staff living in Liverpool. This will help the Trust attract the workforce needed to open the new hospital Liverpool.

PADR: Trust compliance for May is below the target of 95%, at 73%. 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. 1027 staff require a PADR by the end of July; this has been escalated to senior managers and recorded as a risk on the Datix system. All directorates have confirmed that all staff have a PADR booked before the end of July. The Trust is confident that it will deliver 95% again this year.

Trust wide Statutory and Mandatory Training: Performance for May meets the target, at 90%. All Clinical Directorates are now compliant with BLS, ILS and Patient Handling. The roll out of the new Training monitoring tool to the departmental training champions has commenced. The Mandatory Training policy and the role essential training matrix have been approved by the Education Group. An action plan is in development to ensure competencies on ESR are aligned to both training matrix documents.

## Finance

For May 2019 the key financial headlines are:

Metric	YTD Actual	YTD Plan	Variance	May Actual	May Plan	Variance	Risk RAG
NHSI SoF	2	1	1	2	1	1	
NHSI Control Total	727	534	193	567	459	108	
Cost Improvement Programme	293	300	-7	148	155	-7	
Cash holding	59,654	54,644	5,010	59,654	54,644	5,010	
Capital Expenditure	12,870	8,408	4,462	4,386	4,204	182	

The key drivers of the positions:

- **Income has overachieved plan by £2.339m (£1.277m in month).** This is primarily due to clinical income being £2.129m over plan, of which £1.961m relates to drug income, which is matched by expend.
- **Expenditure is over plan by £2.364m (£1.470m in month).** Consistent with the income position, mostly due to drug expend being £1.768m (£0.967m in month) above plan.
- **Cash held is now ahead of plan by £5.01m.** The increase in cash in month (was £4.93m below plan at month 1) has been due to a reduction in debtors in month of £9.46m.
- **Capital expend remains £4.46m above plan.** As noted in month 1, this all relates to TCC and a catch up in expend slipped from 2018/19.



- **Agency spend is in excess of the NHSI target** by £0.1m. For month 2, agency expenditure was £0.1m above the ceiling. Although the costs are covered by vacancies, there is a negative impact on the NHSI strategic outcomes framework, reducing the score from 1. NHSI have clarified that this would not impact on the overall risk assessment of the Trust at this stage. The agency position is being closely monitored by the Trust.