



Report Cover Sheet

Report to:	Trust Board	
Date of the Meeting:	29 th January 2020	
Agenda Item:	P1-009-20	
Title:	IPR Report M9 19/20	
Report prepared by:	Pippa Mullan Interim Head of Performance & Planning	
Executive Lead:	Joan Spencer Interim Director of Operations	
Status of the Report:	Public	Private
	X	

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

Purpose of the Paper/Key Points for Discussion:	Review of the Trust Integrated Performance
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Action Required:	Discuss	X
	Approve	
	For Information/Noting	

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

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

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	✓
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.	✓
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.	✓

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 9 2019/20)

Introduction

This report provides the Trust Board with an update on performance for month nine (December 2019). The operational, quality, research and innovation, workforce and finance performance scorecards are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant. Further detail then follows in each section, including full actions in place.

No changes have been made to the content and presentation of the IPR.

On-going work is taking place to do a full review of the IPR content and recommendations are being presented to the January 2020 Performance Committee.

1. Performance Scorecards

Operational

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Dec-19	YTD	12 Month Trend
Operational						
	62 Day Cancer Waiting Times Standard	↔	85%	92.9%	89.1%	
	2 Week Cancer Waiting Times Standard	↔	93%	100.0%	96.9%	
	Referral to Treatment: 18 weeks (Incompletes)	↔	92%	98.7%	98.3%	
	Diagnostics: 6 Week Wait	↔	99%	100.0%	100.0%	
	Clinic Waits: Outpatients Wirral (<30 mins)	↔	80%	84.0%	83.3%	
	Clinic Waits: Delamere (<30 mins)	↔	80%	83.3%	81.9%	
	Clinic Waits: Outpatients Peripheral (<30 mins)	↔	80%	90.9%	87.5%	
	Length of Stay: Elective (days) CCCW	↔	2	4.7	6.5	
	Length of Stay: Emergency (days) CCCW	↔	8	8.2	8.3	
	Length of Stay: Elective (days) CCCHO 7Y	↔	21	11.0	16.2	
	Length of Stay: Emergency (days) CCCHO 7Y	↓	16	37.9	23.4	
	Bed Occupancy: Conway Ward 12 noon CCCW	↓	G: 80-85%	68.0%	75.9%	
	Bed Occupancy: Mersey Ward 12 noon CCCW	↓	A: 75-79% & 86-90%	69.0%	80.0%	
	Bed Occupancy: Conway Ward 12 midnight CCCW	↓	R: <75% & >90%	68.0%	75.9%	
	Bed Occupancy: Mersey Ward 12 midnight CCCW	↓		66.0%	78.0%	
	Clinical Utilisation Review: patients not meeting criteria CCCW	↔	Dec - 13%	6.9%	N/A	
	Radiology Reporting: Inpatients (within 24hrs) CCCW	↑	G: =>90% A: 80-90% R: <80%	89.0%	75.1%	
	Radiology Reporting: Outpatients (within 7days) CCCW	↑		95.1%	71.8%	
	Travel time to clinic appointment within 45 minutes CCCW	↔	G: =>90%, R: <90%	97.0%	97.3%	

Robust Bed Occupancy data for Haemo-Onc will not be available until the inpatient data is collected in Meditech - indicative date is May 2020

Quality

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Dec-19	YTD	12 Month Trend
Quality						
	Never Events	↔	0	0	0	
	Serious Untoward Incidents	↔	0	0	2	
	Safety Thermometer	↑	95%	97.5%	94.8%	
	Inpatient Falls resulting in harm (due to lapse in care)	↔	-	0	0	
	Pressure Ulcers (hospital acquired cat 3/4 with a lapse in care)	↔	0	0	0	
	Consultant Review within 14 hours (non-emergency admissions)	↔	90%	99.1%	98.1%	
	VTE Risk Assessment	↔	95%	96.2%	96.7%	
	Sepsis: IV antibiotics within 1 hour	↔	100%	96.4%	96.2%	
	Dementia: Screening, Assessment and Referral	↔	95%	100.0%	99.0%	
	Clostridium Difficile Infections	↔	≤4 per yr	0	9	
	E coli	↔	≤10 per yr	0	4	
	MRSA	↔	0	0	0	
	MSSA	↑	≤5 per yr	0	3	
	Klebsiella	↔	≤10 per yr	0	4	
	Pseudomonas	↑	≤5 per yr	0	8	
	Staffing fill rate: Trust	↑		90.7%	90.8%	
	Staffing fill rate: Nurses – days	↑	G: 90 - 100%, A: 85 - 89% and 101 - 105%, R: <85 & >105%	84.4%	85.3%	
	Staffing fill rate: Nurses – nights	↔		91.8%	96.3%	
	Staffing fill rate: Care staff – days	↔		91.4%	91.8%	
	Staffing fill rate: Care staff – nights	↔		89.9%	90.4%	
	30 Day Mortality Rate: Radical Chemotherapy	↓		0.5%	0.3%	
	30 Day Mortality Rate: Palliative Chemotherapy	↓		1.1%	1.1%	
	30 Day Mortality Rate: Chemotherapy	↓		0.9%	0.9%	
	30 Day Mortality Rate: Radiotherapy	↑	-	2.7%	2.5%	
	Partners in Care Assessments	↑	G: 90%, A: 85% - 89%, R: <85%	89.7%	86.6%	
	FFT inpatient score (% positive)	↓	95%	94.8%	98.8%	
	FFT outpatient score (% positive)	↔	95%	97.3%	98.1%	
	FFT inpatient response rate	↑	G: 30%, A: 25% - 29%, R: <25%	25.0%	25.1%	
	FFT outpatient total responses	↔	-	294	5135	
	Complaints	↔	-	1	19	

NB: blue arrows are included for KPIs with no target and show the movement from last month's figure.

To Note:

- 30-Day Mortality figures are always for the previous month. There is a single national target of 4.3% for 30-day mortality post chemotherapy. The Trust splits the target to enable greater oversight of the radical chemotherapy data set. Combined the performance figures fall within the accepted range.
- Infections other than c diff are CCC attributable only, with both attributable and non-attributable reported in section 1.3.

Research & Innovation

Directive	Key Performance Indicator	Change in RAG rating from previous	Target	Dec-19	YTD	12 Month Trend
Research and Innovation						
	Study recruitment: Portfolio	↔	-	29	374	
	Study recruitment: Non-Portfolio	↔	-	69	601	
	Study recruitment: Total	↑	83.3 per month	98	975	
	Studies Opened	↑	5.3 per month	8	54	
	Study set up times	↔	40 days	33		

NB: blue arrows are included for KPIs with no target and show the movement from last month's figure.

Workforce

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Dec-19	YTD	12 Month Trend
Workforce						
	Staff Sickness (monthly)	↔	G: <3.5%, A: 3.6-3.9%, R: >4%	4.3%	4.2%	
	Staff Turnover (12 month rolling)	↔	12%	13.9%	N/A	
	Statutory and Mandatory Training	↑	90%	93.4%	N/A	
	PADR rate	↔	95%	92.6%	N/A	
	FFT staff: Recommend care and treatment	↓	G: >95%, A: 90-94%, R: <90%	91.8%	Q2	
	FFT staff: Recommend as a place to work	↔		61.9%	Q2	
	FFT staff: Response rate	↓	TBC	23.4%	Q2	

NB: blue arrows are included for KPIs with no target and show the movement from last month's figure.

Finance

For December the key financial headlines are:

Metric (£000)	M9 Actual	M9 Plan	Variance	YTD Actual	YTD Plan	Variance	Risk RAG
NHSI SoF	3	1	2	3	1	2	
NHSI Control Total (£000)	-326	-383	57	3,585	3,124	461	
Cost Improvement Programme (£000)	145	153	-8	1,452	1,342	110	
Cash holding (£000)	36,763	28,969	7,794	36,763	28,969	7,794	
Capital Expenditure (£000)	3,407	5,315	-1,908	39,736	39,847	-111	

2. Exception Reports

Operational

62 Day Cancer Waiting Times Standard


The 85% target has been achieved for December and is currently at 92.9% (final validation via national system 4 February 2020). There were six shared breaches where two were avoidable.

There were no 2ww breaches in December.


There was one screening breach in December due to patient admin reason.

CCC continues to monitor 24-day performance for patients referred on or after day 38 of the 62-day pathway. This is an internal target that aids breach avoidance for the system.

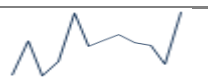
Current 24-day performance is 85% against a target of 85%. Performance against the 7 day to first appointment internal target for patients on a 62-day pathway is 78.9% against a stretch target of 90%.

	Target	Dec 19	YTD	12 month trend
62 Day Screening Breach	90%	85.7%	85.1%	
Reason for non-compliance Admin - Radiotherapy treatment was booked within target date but there were no chemo slots available and this issue was not escalated to prevent a target breach				
Action Taken to improve compliance <ul style="list-style-type: none">Review of the visibility of target dates in Meditech for Paperless Project, meeting 14/1/2020.Cancer waiting times target awareness/refresher sessions available for Booking Office staff.				
Expected date of compliance	31/01/20			
Escalation route	Target Operational Group			
Executive Lead	Joan Spencer, Interim Director of Operations			


Length of Stay – Wirral

Length of Stay Elective - Wirral		Target	Dec 19	YTD	12 month trend
		2	4.7	6.5	
Reason for non-compliance LoS for elective admissions at CCC Wirral is not meeting the current target. Targets are under review due to a change in process of recording.					
Action Taken to improve compliance Following a review of the LoS data and a benchmarking exercise it is anticipated that the target for LoS will increase from 2 days to 7 days. The detail of which will be discussed as part of the IPR position paper to be presented at Performance Committee 23 rd January 2020					
Expected date of compliance	31/01/20				
Escalation route	Monthly ICD meeting, Q+S group, integrated governance				
Executive Lead	Joan Spencer, Interim Director of Operations				





Length of Stay – non elective Haemato-Oncology

Length of Stay 7Y Emergency (HO)		Target	Dec 19	YTD	12 month trend
		16	37.9	23.4	
Reason for non-compliance Several patients were discharged during December who had an higher than average length of stay. The increase in length of stay was noted due to post transplantation and acute Leukaemia complications which is not unusual in this cohort.					
Action Taken to improve compliance To provide ongoing monitoring of performance against this target the directorate is implementing a bi weekly CD / GM and a weekly LOS oversight review as part of the consultant team meetings. This increased monitoring will commence in January 2020. The directorate has also implemented a stem cell transplant program length of stay review. This forms part of the stem cell mortality meeting. This will be reported to Dr Khanduri each month together with program mortality data. This is to ensure robust oversight and reporting of the stem cell program and outcomes.					
Expected date of compliance	31/03/20				
Escalation route	Monthly ICD meeting, Q+S group, integrated governance				
Executive Lead	Joan Spencer, Interim Director of Operations				

Bed Occupancy

Bed Occupancy - Wirral Site	Target	Dec 19	12 month trend
	80-85%	69%	
Reason for non-compliance Bed occupancy on both Mersey and Conway Ward was below target at 69% occupied for December 2019. There was a reduction in activity over the Christmas period, which is consistent with previous year's activity data.			
Action Taken to improve compliance <ul style="list-style-type: none"> Patient Flow Team will continue to monitor bed occupancy 			
Expected date of compliance	31/01/20		
Escalation route	Monthly ICD meeting, monthly performance review, Q+S group, Integrated Governance		
Executive Lead	Joan Spencer, Interim Director of Operations		

Radiology Reporting

Radiology Reporting	Target	Sept 19	Oct 19	Nov 19	Dec 19	12 month trend
Imaging reporting turnaround time within 24hrs : In-patients	90%	72.0%	73.5%	73.6%	89.0%	
Imaging reporting turnaround time within 48hrs : In-patients		77.5%	84.2%	78.24%	94.8%	
Imaging reporting turnaround time within 7 days : Out-patients	90%	63.9%	75.1%	80.8%	95.1%	
Imaging reporting turnaround time within 10 days : Out-patients		80.6%	86.2%	91.05%	98.36%	
Reason for non-compliance The inpatients target of 90% within twenty four hours was not achieved (89.01%), however there was a significant improvement and the target was achieved in 48 hours (94.76%). The out-patients target of 90% within seven days was achieved at 95.08% and reached 98.36% at 10 days. This is an improving trend that will continue to be monitored closely over the coming months.						
Action Taken to improve compliance <ul style="list-style-type: none"> Increased capacity with outsourcing company Increased number of visiting radiologists PAs from other Trusts 						

- Advert out for additional radiologists

Expected date of compliance	New radiologist appointed on 23/12/19, start date likely to be May/June 2020
Escalation route	Through quality and safety committee structure, monthly performance review & Performance Committee
Executive Lead	Joan Spencer

Quality

Sepsis 1hr to Antibiotics

	Target	DEC19	YTD	12 month trend
Title: Sepsis -1hr to Antibiotics	100%	96.4%	96.2%	

Reason for non-compliance: this relates to only 1 patient

CCC-W had 1 antibiotic miss in M9. Patient was reviewed due to pyrexia & had a sepsis screening tool performed at 13.12. There were 2 red flags, a lactate of 2 and acutely confused. The antibiotic had been prescribed electronically for the 2200hrs medication round rather than a STAT dose to be given within the hour, nursing staff documented medic stated that patient could start IV antibiotics with 22.00 dose. The antibiotics were then administered on the night-time drug round at 20.56, making them nearly eight hours late.

When doctors prescribe intravenous antibiotics, Meditech defaults to the next routine scheduled drug round for the start time, which can be up to 7 hours from time of prescription. The doctors have now been advised of the need to check prescription start time, alter and advise nursing staff of the immediate need to deliver the antibiotic.

Following completion of audit and consultant agreement for Dec 2019 = 1 miss.

The following actions are in place to maintain compliance:

- ICD Clinical Director reviewed with Junior Doctors
- Education to all clinical staff around correct documentation of patients treated for Sepsis
- Clinical staff (band 6 and above) completion of Sepsis passport
- Sepsis SOP in place to support compliance
- Sepsis trolleys functional and in operation in clinical areas
- Ongoing face to face training (Nurses week), Trust wide on Sepsis/NEWS 2
- World sepsis day raised awareness for staff, patients
- Sepsis training non-compliant staff identified, training and support offered
- E-learning package on ESR
- Acute Care Team nursing staff educating at all Medical Emergency calls


- Acute Care Team will continue to reiterate 1-hour target of Suspected/Confirmed Sepsis to needle time
- Sepsis champions identifies in all areas at CCC-W

Action taken to improve compliance

- The Meditech default start time for intravenous antibiotics to be removed; doctors will be required to add an appropriate start time
- Education on sepsis to be delivered to medics on Trust induction
- Ward Manager to review this month's 'miss' to determine if RCA is required
- Datix will be completed for any delay in treatment and non-compliance with documentation on Meditech, to support lessons learnt
- Nursing staff educated regarding alerting correct personnel regarding septic patients, and escalation of care, as per policy
- Continuing education to all clinical staff around compliance in documenting on the sepsis screening tool, and the sepsis care plan
- Sepsis Nurse providing individual portable information to all clinical staff
- Continued education around importance of Sepsis documentation to all clinical staff.
- Roles and responsibilities to be added into existing Acute Care Team presentations, highlighting NMC Code of Conduct
- All issues to be discussed at the Deteriorating Patient Steering Group (DPSG)

Expected date of compliance	January 2020
Escalation route	Deteriorating Patient Steering Group /Directorates/ Quality and Safety Sub Committee/ Quality committee
Executive Lead	Sheila Lloyd

Infection Control

Clostridioides difficile (C. difficile)	Target	Dec-19	YTD	Trend
	4	0	9	
Reason for non-compliance <p>Almost every patient coming into the care of CCC is at the highest risk of developing C. difficile infection and may have multiple risk factors including: impaired/altered immunity; multiple hospital admissions; poor nutritional state; frequent exposure to antibiotics; frail/elderly condition and or use of opiates/laxatives. Our role at CCC is to identify quickly any infection, ensure appropriate clinical management and isolate to prevent the spread of infection to other vulnerable patients. This includes ensuring the environment and any equipment is safe, clean and fit for purpose and that we learn from previous experiences.</p> <p>We reported another CCC attributed C. difficile infection (HOHA) in a patient with significant disease and gastrointestinal problems. The patient had several admissions to other hospitals</p>				

including two episodes at LUHFT for duodenal stent replacement. The patient's care was appropriate at CCC and internal Post Infection Review did not identify any lapse in care. An assurance meeting is scheduled for mid - January and the care will be reviewed independently by NHSE Quality Team.

The patient was discharged into the care of a hospice near his family to complete the course of treatment for C. difficile but has since died.

Action taken to improve compliance

All Trust-wide actions to date have been successful and this case appears to be unavoidable. In addition to policies, procedures and routine measures embedded within the Trust, we undertake ongoing ward reviews to try to ensure prompt specimen collection and isolation of all patients with diarrhoea.

Learning from previous case (lapse in care May)

Additional ATP swabbing of mattresses and commodes to provide assurance that equipment is clean and safe and environmental decontamination processes are effective - completed

Additional Triage prompt for staff to check medical alerts status in Meditech - completed

Development of Infection Alert Card - for final agreement at January Infection Prevention and Control Committee

Expected date of compliance	April 2020
Escalation route	Directorates / Quality and Safety Sub Committee / Quality Committee
Executive Lead	Sheila Lloyd, Director of Nursing and Quality

Research & Innovation

Studies opening to recruitment	Target	Dec 19	YTD	12 month trend
	63	47	37	
Reason for non-compliance <p>Thirty-seven studies have been opened against an internal target of forty-seven year to date. There are five studies which have been locally approved and can be opened following sponsor approval. Combined this gives a total of forty-two studies either opened or are ready to open. To bridge the gap the expectation is that the newly appointed SRG Research Leads will increase the study numbers within their SRG. This will be part of their role.</p>				
Action Taken to improve compliance <ul style="list-style-type: none"> The SRG Research Leads are actioned to review the NIHR portfolio to see if any further trials should be opened at CCC. Next meeting scheduled for 23rd January 2020. Work with the Network to optimise opportunities. 				
Expected date of compliance	Q4 19/20			
Escalation route	SRG Research Leads / Committee for Research Strategy			

Workforce

Sickness	Target	Dec 2019	YTD
	3.5%	4.2%	4.2%

Reason for non-compliance

The Trust 12 month rolling sickness absence is 4.27% with the in-month sickness absence position 4.15% for December 2019 down from November's figure of 4.77%.

In December 2019 the top three reasons for absence (along with the related number of episodes) were:

1	Cough/Cold/Flu	45 episodes
2	Gastrointestinal problems	37 episodes
3	Anxiety/Stress/Depression	31 episodes

The comparable numbers of episodes for December 2018 were 47 episodes due to Cough/Cold/Flu, 30 episodes for Gastrointestinal Problems and 20 episodes due to Anxiety/Stress/Depression.

Further details regarding the 45 episodes for Cough/Cold/Flu are as follows:

- All episodes are short term.
- 8 episodes start on a Friday, 13 starts on a Monday, 4 starts on a Thursday, 8 starts on a Tuesday, 11 starts on a Wednesday and 1 started on a Sunday.
- 4 episodes are in Chemotherapy, 15 Corporate Directorates, 5 HO, 3 Hosted Services, 7 IC, 9 Radiation Services and 2 Research.

The flu vaccination position as of December 2019 for front facing clinical staff is 80.43% vaccinated. This is broken down into the following staff groups:

Trust Uptake							
Doctors	70.4%	Prof/Tech	81.3%	Nurses	82.2%	Support	80.3%

Of the 37 Gastrointestinal Problems 3 cases are long term (1 Radiation Services, 1 Corporate and 1 Research) the remainder are short term (10 Corporate, 9 Chemotherapy, 6 each for IC and Radiation Services, 1 HO and 2 Research).

Of the 31 Anxiety/Stress/Depression 22 cases are long term (6 Chemotherapy, 10 Corporate, 3 IC, 2 Radiation Services and 1 Research).

The Trusts rolling twelve month sickness absence is currently 4.47% which is significantly lower when benchmarked against the Cheshire and Wirral rolling absence figure of 5.01%

Action Taken to improve compliance

- Ongoing seasonal flu campaign
- Continuation of review of sickness cases at HR surgeries with line managers
- Dedicated resilience sessions rolled out for all staff
- Employee Assistance Programme in place
- Support from HR team in conducting stress risk assessments

<ul style="list-style-type: none"> Trust wide stress audit completed in December 2019. 	
Expected date of compliance	September 2020
Escalation route	Directorates, WOD Committee, Quality Committee
Executive Lead	Jayne Shaw, Director of Workforce & OD

Turnover	Target	Dec 2019	YTD
	12%	0.94%	13.9%

Reason for non-compliance

The rolling 12 month turnover has decreased from 14.12% to 13.87% in December 2019 and is at its lowest for 2019. In month turnover was at 0.94% with a total of 13 leavers. This is in comparison to the November in month figure of 0.96%

The highest reason for leaving overall was Promotion (4) and out of these, 2 took up employment at General Practice Surgeries, 1 St Helen & Knowsley and 1 Education Sector.

The highest staff group for leavers was Admin & Clerical with 5 leavers. The reasons were as follows: 1 End of Fixed Term Contract, 1 Health, 1 Promotion, 1 Work Life Balance and 1 Other/Not Known. There were 3 leavers across Nursing & Midwifery and these left for the following reasons: 1 Early Retirement, 1 Promotion (to General Practice) and 1 Work Life Balance (NHS Wales).

Leavers with less than 12 months services:

Department	Reason	Number Months
Admin Services	Health	1
Sulby/Hotline/CDU	Promotion	10

The remaining 11 leavers had over 12 month's service; with 2 members of staff having more than 29 years service.

There were no leavers this month that stated that their reason for leaving was due to Liverpool.

At 31st December 2019 the Trust had appointed to all vacancies within the workforce plan for 2019-20.

Action Taken to improve compliance

- Work is underway to develop an Apprenticeship Development Pathway for admin and clerical staff at levels 2,3 and 4
- CCC Nursing Career Pathway & Competency Framework has been approved and launched. This is expected to improve attraction to the Trust and retain staff with a clear route for development and career progression.
- Work is underway for extending our offer for Nursing Preceptorship Programme from 1 to 2 years which will better support newly qualified nurses
- 2020 Leadership Toolkit developed and launched in Dec 2019
- Nurse retention plan in place and monitored via Workforce, Education & OD Committee

Expected date of compliance	September 2020
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Escalation route	Directorates, WOD Committee, Quality Committee		
Executive Lead	Jayne Shaw, Director of Workforce & OD		
PADR	Target	December 2019	
	95%	92.6%	
Reason for non-compliance			
<p>Overall Trust compliance for PADR as at December 2019 is 92.56%, which is below the KPI of 95% and a 0.44% decline from the previous month.</p> <p>The Following Directorates are underperforming against the KPI;</p> <ul style="list-style-type: none">• Haemato-Oncology Directorate – 89%• Integrated Care Directorate – 90%• Chemotherapy Service Directorate – 91%• Corporate Directorate – 93%• Radiation Services Directorate – 94% <p>A breakdown of staff that are non-compliant with PADRs has been distributed to Managers, with an aspirational target date of completion set as 30th January 2020.</p> <p>A deep drive into non-compliance has identified that the process for ensuring new starters receive a PADR within their first 3 months needs refining.</p> <p>A revised process is being introduced from January 2020 and will be monitored closely through the performance review meetings to ensure robustness.</p>			
Action Taken to improve compliance			
<ul style="list-style-type: none">• List of non-complaint staff sent to managers with an aspirational target date for completion set as 30/01/2020• Revised process for new starters to be introduced from January 2020• PADR requirements to be included on Induction to increase awareness to new starters from January 2020.			
Expected date of compliance	February 2020		
Escalation route	Directorates, WOD Committee, Quality Committee		
Executive Lead	Jayne Shaw, Director of Workforce & OD		