



### Report Cover Sheet

Report to:	Trust Board	
Date of the Meeting:	31 <sup>st</sup> March 2021	
Agenda Item:	P1-052-21	
Title:	Integrated Performance Report - Month 11	
Report prepared by:	Hannah Gray, Head of Performance and Planning	
Executive Lead:	Joan Spencer, Chief Operating Officer	
Status of the Report:	Public	Private
	X	

Paper previously considered by:	Performance Committee and Quality Committee
Date & Decision:	24 <sup>th</sup> March 2021 and 25 <sup>th</sup> March 2021

Purpose of the Paper/Key Points for Discussion:	<p>This report provides an update on performance for month eleven (February 2021). The access, efficiency (including the Covid-19 recovery activity), quality, research and innovation, workforce and finance scorecards are presented, followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant. A Covid-19 recovery summary is provided, rather than exceptions only.</p> <p>Points for discussion include under performance, developments and key actions for improvement.</p>
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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 <b>outstanding care locally</b>	✓	Collaborative system <b>leadership</b> to deliver better patient <b>care</b>	✓
<b>Retain</b> and <b>develop outstanding staff</b>	✓	Be <b>enterprising</b>	
<b>Invest</b> in <b>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>	✓

*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 11 2020/21)**

## **Introduction**

This report provides an update on performance for month eleven (February 2021). The access, efficiency (including Covid-19 recovery activity), quality, workforce, research and innovation, and finance scorecards are presented, followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant. A Covid-19 recovery summary is provided, rather than exceptions only, in section 3.

Covid-19 vaccination KPIs are included again this month and will be reported until the end of the vaccination campaign. The only national target regarding Covid-19 vaccination delivery is that (100%) all staff have been offered the vaccine, against which we are compliant.

Although national Covid-19 guidance recommended the suspension of data collection for several KPIs / metrics, the Trust has maintained internal monitoring and reporting to ensure oversight and good performance.

As the 2021/22 National Planning Guidance has not yet been published, no new Nationally directed targets will be introduced into the Month 1 2021/22 IPR. This will be reviewed when the guidance is published. A proposed list of KPIs for the 2021/22 IPR (including any amendments to the target thresholds for existing local KPIs) will be included in the Month 12 IPR for agreement by Committees and Trust Board.

# 1. Performance Scorecards

Scorecards Directive Key: S = Statutory | C = Contractual | L = Local

## 1.1 Access

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Feb-21	YTD	12 Month Trend
Executive Director Lead: Joan Spencer, Chief Operating Officer						
L	7 days from referral to first appointment	↑	90%	90.2%	90.7%	M A M J J A S O N D J F
C/S	2 week wait from GP referral to 1st appointment	↔	93%	100.0%	94.2%	M A M J J A S O N D J F
L	24 days from referral to first treatment	↔	85%	96.0%	87.9%	M A M J J A S O N D J F
C/S	28 day faster diagnosis - (Referral to diagnosis)	↑	75% (shadow monitoring)	81.8%	72.2%	M A M J J A S O N D J F
S	31 day wait from diagnosis to first treatment	↔	96%	99.1%	99.1%	M A M J J A S O N D J F
C/S	31 day wait for subsequent treatment (Drugs)	↔	98%	100.0%	99.4%	M A M J J A S O N D J F
C/S	31 day wait for subsequent treatment (Radiotherapy)	↔	94%	99.7%	98.3%	M A M J J A S O N D J F
S	Number of 31 day patients treated => day 73	↔	0	0	5	M A M J J A S O N D J F
C/S	62 Day wait from GP referral to treatment	↑	85%	87.5%	90.7%	M A M J J A S O N D J F
C/S	62 Day wait from screening to treatment	↔	90%	100.0%	95.2%	M A M J J A S O N D J F
L	Number of patients treated between 63 and 103 days (inclusive)	↑	No Target	44	308	M A M J J A S O N D J F
S	Number of patients treated => 104 days	↓	No Target	12	104	M A M J J A S O N D J F
L	Number of patients treated => 104 days AND at CCC for over 24 days	↔	0	1	27	M A M J J A S O N D J F
C/S	Diagnostics: 6 Week Wait	↔	99%	100%	100.0%	M A M J J A S O N D J F
C/S	18 weeks from referral to treatment (RTT) Incomplete Pathways	↔	92%	98.4%	97.7%	M A M J J A S O N D J F

### Notes:

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

This border indicates that the figure has not yet been validated and is therefore subject to change.  
This is because national CWT reporting deadlines are later than the CCC reporting timescales.

### Cheshire and Merseyside Performance

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Jan-21	YTD	12 Month Trend
Executive Director Lead: Liz Bishop, CMCA SRO						
C/S	2 week wait from GP referral to 1st appointment	↔	93%	86.3%	90.9%	F M A M J J A S O N D J
C/S	28 day faster diagnosis - (Referral to diagnosis)	↓	75% (shadow monitoring)	68.9%	74.3%	F M A M J J A S O N D J
C/S	62 Day wait from GP referral to treatment	↔	85%	71.2%	76.6%	F M A M J J A S O N D J

### Notes:

Blue arrows are included for KPIs with no formal target and show the movement from last month's figure.

## 1.2 Efficiency

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Feb-21	YTD	12 Month Trend
Executive Director Lead: Joan Spencer, Chief Operating Officer						
S	Length of Stay: Elective (days): Solid Tumour	↓	≤6.5	5.5	6	
S	Length of Stay: Emergency (days): Solid Tumour	↔	≤8	8.7	7.8	
S	Length of Stay: Elective (days): HO Ward 4	↔	≤21	18.6	13.2	
S	Length of Stay: Emergency (days): HO Ward 4	↔	≤22 (from Jan 21)	14	14.4	
S	Length of Stay: Elective (days): HO Ward 5	↑	≤32	35.4	22.2	
S	Length of Stay: Emergency (days): HO Ward 5	↑	≤46	47	27	
S	Delayed Transfers of Care as % of occupied bed days (Solid Tumour)	↓	≤3.5%	2.3%	4.0%	
S	Bed Occupancy: Midnight (Ward 4: HO)	↑	G: ≥92% A: 88-91.9% R: <88%	93.9%	80.0%	
S	Bed Occupancy: Midnight (Ward 5: HO)	↔	G: ≥80% A: 76%-79.9% R: <76%	73.6%	68.0%	
S	Bed Occupancy: Midday (Solid Tumour)	↔	G: ≥92% A: 88-91.9% R: <88%	77.2%	70.5%	
S	Bed Occupancy: Midnight (Solid Tumour)	↔	G: ≥92% A: 88-91.9% R: <88%	81%	71.6%	
C/S	% of elective procedures cancelled on or after the day of admission	↔	0%	None cancelled	None cancelled	
C/S	% of cancelled elective procedures (on or after the day of admission) rebooked within 28 days of cancellation	↔	100%	None cancelled	None cancelled	
C/S	% of urgent operations cancelled for a second time	↔	0%	None cancelled	None cancelled	
L	Radiology Reporting: Inpatients (within 24hrs)	↔	G: ≥90% A: 80-89.9% R: <80%	97.7%	96.2%	
L	Radiology Reporting: Outpatients (within 7 days)	↔	G: ≥90% A: 80-89.9% R: <80%	93.0%	94.3%	
L	Travel time to clinic appointment within 45 minutes	↔	G: ≥90%, R: <90%	97.7%	97.3%	
C/Phase 3 Covid-19 Guidance	Data Quality - % Ethnicity that is complete (or patient declined to answer)	↔	J & A = 90% S & O = 95% Nov & Dec = 100%	97.3%	94.6%	
C	Data Quality - % of outpatients with an outcome	↔	G: ≥95%, A: 90% - 94.9%, R: <90%	100.0%	98.4%	
C	Data Quality - % of outpatients with an attend status	↔	G: ≥95%, A: 90% - 94.9%, R: <90%	99.0%	98.4%	
Executive Director Lead: James Thomson, Director of Finance						
S	Percentage of Subject Access Requests responded to within 1 month	↔	100%	100%	100%	
C	% of overdue ISN (Information Standard Notices)	↔	0%	0%	0%	

## 1.2.1 Covid-19 Recovery Activity

Target text key: A = August | S = September | O = October | P3G = Phase Three Covid-19 Guidance.

Figures are coloured green / red where the target is not yet in force e.g. begins in August. RAG rating is not applied to YTD figures when the target applies post April 2020.

Directive	Data	Target	A	M	J	J	A	S	O	N	D	J	F	YTD	Monthly Trend 2020/21
Local	Covid-19 positive inpatients (Definite Healthcare Associated)*	0	0	0	0	0	0	1	0	0	0	1	0	2	
Local	Covid-19 positive inpatients (Non 'Definite Healthcare Associated')*	No Target	13	3	3	0	0	8	12	11	3	2	5	60	
P3G	Overnight electives (as % of 2019/20)	A = 70%, S=80%, O = 90% (of last year's activity)	38%	60%	88%	80%	67%	89%	135%	129%	108%	95%	121%	89%	
P3G	Outpatient Procedures (as % of 2019/20)	A = 70%, S=80%, O = 90% (of last year's activity)	83%	85%	117%	158%	167%	185%	159%	180%	184%	198%	210%	162%	
P3G	Day Cases (as % of 2019/20)	A = 70%, S=80%, O = 90% (of last year's activity)	39%	43%	55%	57%	36%	50%	42%	37%	32%	49%	45%	44%	
P3G	Outpatient Appointments (as % of 2019/20)	A = 90%, S=100% (of last year's activity)	121%	114%	138%	132%	120%	132%	119%	123%	124%	108%	114%	121%	
P3G	Outpatient Appointments: New (as % of 2019/20)	A = 90%, S=100% (of last year's activity)	104%	71%	84%	79%	89%	116%	113%	110%	124%	116%	118%	102%	
P3G	Outpatient Appointments: Follow Up (as % of 2019/20)	A = 90%, S=100% (of last year's activity)	122%	118%	143%	137%	123%	133%	120%	125%	125%	109%	115%	124%	
P3G	% of all OP appointments which are by telephone or video	25% of all OP appts	71%	69%	69%	68%	69%	72%	70%	69%	66%	70%	66%	69%	
P3G	% of Follow Up OP appointments which are by telephone or video	60% of all FU OP appts	70%	68%	68%	67%	70%	72%	70%	69%	66%	69%	66%	69%	
Local	Referrals: Total (as % of 2019/20)**	2019/20 figures	87%	62%	83%	73%	85%	95%	83%	95%	83%	86%	82%	83%	
Local	SACT administration: Solid Tumour (as % of 2019/20)	2019/20 figures	89%	66%	97%	94%	90%	111%	96%	103%	121%	98%	128%	99%	
Local	Radiotherapy Treatments (as % of 2019/20)	2019/20 figures	93%	77%	70%	72%	63%	69%	72%	75%	84%	66%	79%	74%	
P3G	Investigations: CT (as % of 2019/20)	S=90%, O = 100% (of last year's activity)	72%	95%	132%	151%	155%	160%	184%	195%	204%	161%	204%	156%	
P3G	Investigations: MRI (as % of 2019/20)	S=90%, O = 100% (of last year's activity)	66%	85%	108%	112%	117%	131%	128%	135%	155%	111%	125%	116%	
Local	Stem Cell Transplants	8.3 per month (as per CCC plan)	1	1	5	8	6	6	4	5	7	6	4	53	
Local	Hotline Calls- Pts advised to attend A&E or CCC CDU: % advised to attend A&E	No Target	71%	63%	63%	73%	71%	68%	66%	59%	65%	67%	56%	66%	
Local	Hotline Calls- Pts advised to attend A&E or CCC CDU: % advised to attend CDU	No Target	29%	37%	37%	27%	29%	32%	34%	41%	35%	33%	44%	34%	
Local	Staff and household members tested (inc. external tests, where CCC is informed)	No Target	99	62	193	117	37	144	84	36	25	46	13	856	
Local	Staff sickness absence: Covid-19 related (total occurrences)	No Target	49	36	18	21	4	18	26	24	21	68	21	306	
Local	Staff sickness absence: Covid-19 related (%)	No Target	2.5%	2.1%	1.0%	1.2%	0.2%	0.9%	1.4%	1.3%	1.2%	2.4%	1.3%	1.5%	

\*The categories for Covid positive infections are: Definite Healthcare Associated (First Positive specimen 15 days or more after admission), Probable Hospital Associated (8 - 14 days), Indeterminate Healthcare associated (3 - 7 days) and Community Acquired (0 - 2 days).

## 1.3 Quality

Scorecard Directive Key: S = Statutory | C = Contractual | L = Local

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Feb-21	YTD	12 Month Trend
Executive Director Lead: Sheila Lloyd, Director of Nursing and Quality						
C/S	Never Events	↔	0	0	0	
C/S	Serious Untoward Incidents (month reported to STEIS)	↑	0	1	7	M A M J J A S O N D J F
C/S	Serious Untoward Incidents: % submitted within 60 working days / agreed timescales	↔	100%	0 requiring submission	100%	M A M J J A S O N D J F
S	RIDDOR - number of reportable incidents	↓	0	0	2	M A M J J A S O N D J F
S	IRMER - number of reportable incidents	↔	0	1	10	M A M J J A S O N D J F
S	Incidents /1,000 Bed Days	↑	No target	194.1	212.63	M A M J J A S O N D J F
L	All incidents resulting in harm /1,000 bed days	↑	No target	19	19	M A M J J A S O N D J F
C/S	Inpatient Falls resulting in harm due to lapse in care	↔	0	0	1	M A M J J A S O N D J F
S	Inpatient falls resulting in harm due to lapse in care /1,000 bed days	↔	0	0	0.06	M A M J J A S O N D J F
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care)	↔	0	0	0	
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care) /1,000 bed days	↔	0	0	0	
S	Consultant Review within 14 hours (emergency admissions)	↔	90%	100.0%	99.1%	M A M J J A S O N D J F
C/S	% of Sepsis patients being given IV antibiotics within an hour (ST)*	↔	90%	92%	96.0%	M A M J J A S O N D J F
C/S	VTE Risk Assessment	↔	95%	96.0%	96.0%	M A M J J A S O N D J F
S	Dementia: Percentage to whom case finding is applied	↔	90%	100.0%	99.0%	M A M J J A S O N D J F
S	Dementia: Percentage with a diagnostic assessment	-	90%	No patients	100%	M A M J J A S O N D J F
S	Dementia: Percentage of cases referred	-	90%	No patients	No patients	
C/S	Clostridium difficile infections (attributable)	↔	<=4 per yr	1	4	M A M J J A S O N D J F
C/S	E Coli (attributable)	↑	<=10 per yr	1	6	M A M J J A S O N D J F
C/S	MRSA infections (attributable)	↔	0	0	0	M A M J J A S O N D J F
C/S	MSSA bacteraemia (attributable)	↔	<=5 per yr	0	4	M A M J J A S O N D J F
C	Klebsiella (attributable)	↔	<=10 per yr	0	2	M A M J J A S O N D J F
C	Pseudomonas (attributable)	↔	<=5 per yr	0	1	M A M J J A S O N D J F
C/S	FFT inpatient score (% positive)	-	95%	N/A	N/A	
C	FFT outpatient score (% positive)	-	95%	N/A	N/A	

The Quality KPI scorecard continues on page 6

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Feb-21	YTD	12 Month Trend
Executive Director Lead: Sheila Lloyd, Director of Nursing and Quality						
C	Number of formal complaints received	↑	No target	6	29	
S	Number of formal complaints / count of WTE staff (ratio)	↑	No target	0.004	0.002	
C	% of formal complaints acknowledged within 3 working days	↔	100%	100%	100%	
L	% of routine formal complaints resolved in month, which were resolved within 25 working days**	↔	100%	0%	25%	
L	% of complex formal complaints resolved in month, which were resolved within 60 working days**	↑	100%	None to resolve	N/A	
C/S	% of FOIs responded to within 20 days	↔	100%	100.0%	99.6%	
C/S	Number of IG incidents escalated to ICO	↔	0	0	0	
C	NICE Guidance: % of guidance compliant	↔	90%	91%	93%	
L	Number of policies due to go out of date in 3 months	↑	No target	23	N/A	
L	% of policies in date	↔	100%	93%	96%	
C/S	NHS E/I Patient Safety Alerts: number not implemented within set timescale.	↔	0	0	1	

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

HCAI targets are subject to change. Commissioners have advised CCC to use 2019/20 targets until otherwise advised.

There have been no patients requiring Dementia referral in the last 12 months.

\*Sepsis data is subject to change following final validation.

\*\* The NHS complaints process timelines have been relaxed to allow Trusts to prioritise the necessary clinical changes required to respond to the Covid-19 pandemic.

The Trust Policy currently allows more than 25 days with patients' consent

## 1.4 Research and Innovation

Directive	Key Performance Indicator	Change in RAG Rating from previous Month	Target	Measure	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	YTD	12 Month Trend
Local	Study Recruitment (Activityless SE & PIC)	⬇️	800 annual 66.7 per month	Number	3	5	21	24	122	175	98	95	90	119	101	853	
			100%	Percent	4%	7%	31%	36%	183%	262%	147%	142%	135%	178%	151%	116%	
Local	Studies Opened	⬆️	47 annual 3.9 per month	Number	3	0	4	6	3	4	6	5	2	4	7	44	
			100%	Percent	77%	0%	103%	154%	77%	103%	154%	128%	51%	103%	179%	102%	
Local/ NIHR	Studies Unpaused	●	80% 6.7% per month	Number	0	4	26	24	5	7	10	7	1	0	0	84	
			6.7%	Percent		4.5%	29.2%	27.0%	5.6%	7.9%	11.4%	8.0%	1.1%	0.0%	0.0%	116.7%	
Apr-19 - Mar-20																	
DoH	Study Setup Times – Quarterly Data reporting		40 days	Number	Reporting Period: Jan-19 - Dec-19 Set-up median (days): 33												



## 1.5 Workforce

Scorecard Directive Key: S = Statutory | C = Contractual | L = Local

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Feb-21	YTD	12 Month Trend
Executive Director Lead: Jayne Shaw, Director of Workforce and Organisational Development						
S	Staff Sickness	↓	G: <4%, A: 4.1 - 4.9%, R: >5%	4.2%	4.5%	
S	Staff Turnover	↔	G: <1.2%, A: 1.21 - 1.24%, R: >1.25%	1.06%	0.94%	
S	Statutory and Mandatory Training	↔	G: >90%, A: 75 - 89%, R: <75%	94.48%	N/A	
L	PADR rate	↔	G: >95%, A: 75 - 94.9%, R: <74%	90.76%	N/A	
S	FFT staff: Recommend as a place to work (Quarterly survey)	-	G: >95%, A: 90 - 94.9%, R: <90%	N/A	N/A	
S	FFT staff: Recommend care and treatment (Quarterly survey)	-	G: >95%, A: 90 - 94.9%, R: <90%	N/A	N/A	
L	% of Staff who have had the first dose Covid-19 vaccination (at month end)	↑	No national target	88.4%	N/A	
L	% of BAME Staff who have had the first dose Covid-19 vaccination (at month end)	↑	No national target	83.2%	N/A	
L	% of Staff who have had the first dose Covid-19 vaccination or have refused the vaccination (at month end)	↑	No national target	92.8%	N/A	
L	% of BAME Staff who have had the first dose Covid-19 vaccination or have refused the vaccination (at month end)	↑	No national target	86.9%	N/A	

There is no CCC FFT staff survey in Q3 due to the National Staff Survey running at this time.

## 1.6 Finance

For February 2021 the key financial headlines are:

Metric	In Mth 11 Actual	In Mth 11 Plan*	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit) (£000)	161	79	82	Green	357	(297)	654	Green
CPL/Propcare Surplus/ (Deficit) (£000)	(17)	0	(17)	Green	455	0	455	Green
Control Total Surplus/ (Deficit) (£000)	144	79	65	Green	812	(297)	1,109	Green
Cash holding (£000)	70,830	55,400	15,430	Green	70,830	55,400	15,430	Green
Capital Expenditure (£000)	288	(50)	338	Yellow	9,793	11,566	1,773	Yellow

The Trust's funding for the remainder of the year as previously advised is a fixed allocation and includes amounts for both growth and Covid-19 costs. The funding continues to be routed through the Cheshire and Mersey HCP, with the HCP being required to achieve aggregate financial balance.

## 2. Exception Reports

### 2.1 Access

Long Waiting Cancer Patients:	Target	Feb 21	YTD	12 month trend
Number of patients treated => 104 days AND at CCC for over 24 days	0	1	27	
<b>Reason for non-compliance</b> <p>12 patients breached the 104+ day target in February; 11 of these patients were referred to CCC after day 38 (between day 82 and 172).</p> <p>1 of the 12 patients also breached the internal CCC 24 day target. This patient was referred to CCC by the GP and was delayed due to the complexity of the pathway. The details are as follows:</p> <ul style="list-style-type: none"> <li>Patient 2 - Complex pathway with delay to diagnostic test (biopsy of groin node) at another provider and slight delay to MDT. The patient also did not attend a follow up appointment as they were anxious to attend hospital for a diagnosis due to the pandemic (112 days at CCC).</li> </ul>				
<b>Action taken to improve compliance</b> <ul style="list-style-type: none"> <li>Biopsy services will be available at CCCL via Radiology from 30<sup>th</sup> September 2021, which will reduce delays. When there are capacity delays at another trust, patients' appointments are escalated and managed to ensure there are no delays in the pathway.</li> </ul>				
<b>Expected date of compliance</b>	May 2021			
<b>Escalation route</b>	CWT Target Operational Group, Divisional Performance Reviews, Performance Committee, Trust Board			
<b>Executive lead</b>	Joan Spencer, Chief Operating Officer			


2 week wait from GP referral to 1 <sup>st</sup> appointment (Alliance-level)	Target	Jan 21	YTD	12 month trend
	93%	86.3%	90.9%	
<b>Reason for non-compliance</b> <p>Non-compliance with the 14 day standard in January 2021 was largely driven by underperformance in the following tumour groups:</p> <ul style="list-style-type: none"> <li>Breast 80.46% (similar to 80.24% last month)</li> <li>Lower Gastrointestinal 80.76% (down from 85.10%)</li> <li>Upper GI 87.27% (similar to 87.06% last month)</li> </ul> <p>Poor performance in breast cancer at Liverpool University Hospitals NHS FT (LUHFT) had the biggest negative impact on performance, followed by poor performance in breast at Countess of Chester Hospital NHS FT. Outpatient capacity issues were recorded as the most frequent breach</p>				

reason (in 82% of cases for breast, and 68% of breaches in other tumour groups), followed by patient choice (15% in breast, and 22% in other tumour groups).

#### Action Taken to improve compliance

- Additional consultant recruitment at CoCH (breast).
- The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group to identify areas of service pressure.
- £600,000 investment to support full implementation of symptomatic faecal immunochemical testing (sFIT) in primary care. This builds on the existing secondary care sFIT model. Implementation will reduce demand for endoscopy services.
- Patient and public communications to improve patient confidence to attend for appointments.
- 2WW referrals are now back to pre-pandemic levels.

<b>Expected date of compliance</b>	Compliance with the 14 day standard is expected in to return in Q4.
<b>Escalation route</b>	NHS England, North West CCC Performance Committee, Trust Board
<b>Executive Lead</b>	Liz Bishop, CMCA SRO

62 Day wait from GP referral to treatment (Alliance-level)	Target	Jan 21	YTD	12 month trend
	85%	71.2%	76.6%	

#### Reason for non-compliance

Non-compliance with the 62 day standard in January 2021 was largely driven by underperformance in the following tumour groups:

- Urology 72.53% (up from 71.15% last month)
- Lower Gastrointestinal 39.02% (down from 60.98%)
- Gynaecology 39.44% (down from 53.23%)

January's performance has been affected by the Covid-19 pandemic. Whilst most services had been restored to near-normal capacity, there remained a significant backlog of patients waiting for diagnostics.

Lower GI pathways were particularly affected with performance falling from 73.27% in February 2020 (pre-pandemic) to a low of 25% in May. In May the British Society of Gastroenterology advised a six-week pause in endoscopy services due to the risk of Covid-19 transmission, affecting lower GI, upper GI and urology pathways. There is a large backlog of patients waiting for endoscopy with patients being prioritised based on clinical need. Endoscopy activity has now returned to pre-Covid levels (and beyond).

January's 62 day performance was also affected by a large number of referrals received in December. First appointments were 25% higher than normal in December (higher than any other Alliance).

Delays to diagnostic pathways are being monitored through the Cheshire and Merseyside (C&M) Cancer Alliance, with endoscopy recovery led by a C&M recovery team.


#### Action Taken to improve compliance

- Continuation of surgical and diagnostics hubs as part of CMCA's response to Covid-19.

- The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group.
- The endoscopy operational recovery team, in collaboration with the C&M Hospital has produced a clear, prioritised plan to increase capacity.
- The Alliance has secured £5.4m capital investment to increase endoscopy capacity and improve productivity.
- £600,000 investment to support full implementation of symptomatic faecal immunochemical testing (sFIT) in primary care. This builds on the existing secondary care sFIT model. Implementation will reduce demand for endoscopy services.
- Further £400k invested in using FIT to validate and risk stratify LGI endoscopy waiting lists and surveillance lists.
- Patient and public communications to improve patient confidence to attend for appointments.
- 2ww referrals are now higher than pre-pandemic levels.

<b>Expected date of compliance</b>	Compliance with the 62 day standard is expected in Q3 2021/2022.
<b>Escalation route</b>	NHS England, North West / CCC Performance Committee, Trust Board
<b>Executive Lead</b>	Liz Bishop, CMCA SRO

## 2.2 Efficiency

Length of Stay: Emergency Solid Tumour Wards	Target	Feb 21	YTD	12 month trend
	8 days	8.7	7.8	

### Reason for non-compliance

The length of stay (LoS) for emergency admissions on solid tumour wards was above target in February at 8.7 days.

The increased LoS for non-elective patients is explained by the high acuity of the patients and delays to discharge. The low CUR non qualifying rate of 4.3% indicates that the majority of patients had a valid clinical need to be an inpatient at CCC.

There were 9 DTOC (delayed transfers of care) this month on the solid tumour wards, equating to 27 days of lengthened hospital stay. 8 of the 9 DTOC patients were unplanned admissions.

Of these 8 DTOC, the average delay was 2 days on their hospital stay.

The delays were due to:

- 4 patients awaiting hospice placement
- 1 patient awaiting CHC funded nursing home placement
- 1 patient awaiting a social Package of Care at home
- patients awaiting CHC funded Package of Care at home

### Action Taken to improve compliance

- Patients with a lengthened LoS or complex discharge needs continue to be discussed at Weekly LoS meetings
- To ensure all patients have a clear plan and delays are prevented, daily COW MDT Board Rounds continue on the inpatient wards led by the COW and ward Registrar with MDT present to highlight any concerns with regards to patient's plan of care.
- Patient Flow Team leader to encourage ward DRs to have an Estimated Date of Discharge (EDD) for all patients, and for this to be displayed on patient boards and on Meditech, and to be discussed at Daily MDT Board Round.

<b>Expected date of compliance</b>	March 2021
<b>Escalation route</b>	Acute Care Divisional Quality, Safety and Performance Meeting, Performance Reviews, Quality Committee, Trust Board
<b>Executive Lead</b>	Joan Spencer, Chief Operating Officer

Length of Stay: Elective	Admission method	Target	Feb 21	YTD	12 month trend
Ward 5 (HO)	Elective	≤32 days	35	22	
	Non-elective	≤46 days	47	27	

### Reason for non-compliance

In February 2021 there were 2 Allogeneic Stem Cell Transplant patients on Ward 5 with long lengths of stay.

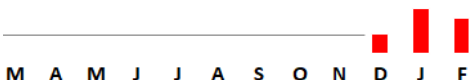
One patient was an elective admission and was an inpatient for 47 days. This patient's discharge was delayed due to immunocompromised sepsis.



One patient was a non-elective admission who was re-admitted within 24 hours of discharge with viral complications of transplant requiring intra-vesical treatment, urology input and bladder irrigation. This patient was also an inpatient for 47 days.

### Action Taken to improve compliance

- Ongoing Consultant Review
- Weekly MDT Review

<b>Expected date of compliance</b>	March 2021
<b>Escalation route</b>	Acute Care Divisional Quality, Safety and Performance Meeting, Performance Reviews, Quality Committee, Trust Board
<b>Executive Lead</b>	Joan Spencer, Chief Operating Officer

Bed Occupancy: Ward 5 (HO)	Target	Feb 21	YTD	12 month trend
	G: $\geq 80\%$ A: 76%-79.9% R: $< 76\%$	73.6%	68%	
<b>Reason for non-compliance</b> <p>Bed occupancy on Ward 5 in February 2021 was below the Trust's target of 80%.</p> <p>Reduced bed occupancy on Ward 5 is a reflection of the reduced number of transplants carried out both in the CCC Transplant Programme and nationally as a result of the Covid-19 pandemic. Details of the reduced number of transplants against the Trust target is in the Covid-19 recovery section of this report.</p> <p>Ward 5 continues to support Ward 4 and mutual aid by accepting patients from Ward 4 who are on the green pathway.</p>				
<b>Action Taken to improve compliance</b> <ul style="list-style-type: none"> <li>Continue to attend national and regional BMT meetings</li> <li>Continue to offer support to Ward 4 to relieve any of their bed pressures</li> <li>Daily outlier review of HO outliers in LUHFT continues</li> </ul>				
<b>Expected date of compliance</b>	May 2021			
<b>Escalation route</b>	Acute Care Divisional Quality, Safety and Performance Meeting, Performance Reviews, Quality Committee, Trust Board			
<b>Executive Lead</b>	Joan Spencer, Chief Operating Officer			

Bed Occupancy: Solid Tumour Wards	Target	Feb 21	YTD	12 month trend
	G: $\geq 92\%$ A: 88-91.9% R: $< 88\%$	Midday 77.2%	70.5%	
		Midnight 81%	71.6%	
<b>Reason for non-compliance</b> <p>Solid tumour inpatient ward occupancy continues to be below the Trust's target of 92% and has fallen since January 2021.</p> <p>The position for February 2021 is:</p> <ul style="list-style-type: none"> <li>Average bed occupancy at midday was 77.2%</li> <li>Average bed occupancy at midnight was 81%</li> </ul>				

These figures are calculated on a total bed base of 51 beds. There are a further 4 beds on ward 3 that have been identified as 'escalation beds' to help the Trust with winter/covid-19 pressures. These beds have not been used at all during February 2021.

The Trust has been predominantly on OPEL 1 (green) during February 2021, however OPEL 3 has been recorded for the solid tumour wards on 2 occasions. There was one occasion when Ward 2 was 100% occupied.

There has only been one Mutual Aid patient transferred across to CCC Liverpool in February. Communication continues between Acute Oncology and Patient Flow Team (PFT). The bed pressures from the Covid-19 pandemic have eased in February 2021, with the number of Covid positive patients also being reduced at CCC-Liverpool.

Patient Flow Team and the wider MDT continue to proactively discharge plan to ensure that patients are in the safest place for them during the COVID-19 pandemic.


The CUR non-qualifying rate for February is 4.3%, indicating good utilisation of the beds, and few delays.

The LoS for elective admissions was on target for February 2021, and the average LoS for non-elective admissions although above target was reduced from last month.

#### Action Taken to improve compliance

- PFT continue to work with the wider MDT to aid discharge planning during the Covid-19 pandemic, and also liaise with Acute Oncology so that we are offering oncology beds to our patients when they are required.

<b>Expected date of compliance</b>	March 2021
<b>Escalation route</b>	Acute Care Divisional Quality, Safety and Performance Meeting, Performance Reviews, Quality Committee, Trust Board
<b>Executive Lead</b>	Joan Spencer, Chief Operating Officer

Ethnicity that is complete (or patient declined to answer)	Target	Feb 21	YTD	12 month trend
	July & Aug = 90% Sept & Oct = 95% Nov & Dec = 100%	<b>97.3%</b>	94.6% (no RAG as target applied from M4)	 M A M J J A S O N D J F

#### Reason for non-compliance

The target of 100% for February was not achieved, however compliance is continuing to increase; up 1% from January 2021.

With around 80% of patients now being seen remotely, the opportunities previously available to ask patients for this information, e.g. at reception desks, are now significantly reduced. New processes have been implemented from the end of December 2020, including administration



clerks telephoning relevant patients prior to appointments to request this data. The impact of this process change is evident in the improved performance in January and February 2021. An additional data report is now received and is supporting a more streamlined process.


The compliance will continue to be monitored and improved and a targeted focus will be applied to any areas where there are gaps, such as lack of information from referring trusts which has been listed as a requirement in the planned new digital referral system process.

#### Action Taken to improve compliance

- New processes put in place to contact patients in advance of their remote clinic appointment are now working well.
- A weekly report is now received to support the collection of missing ethnicity data for patients in the following week.
- All face to face patients are asked to provide ethnicity information upon arrival. When self-check in machines are used, the volunteers supporting the patients have been reminded to direct the patient to the receptionist to capture this information.

<b>Expected date of compliance</b>	March 2021
<b>Escalation route</b>	Divisional Quality, Safety and Performance Meetings, Integrated Governance Committee, Performance Reviews, Quality Committee, Trust Board
<b>Executive Lead</b>	Joan Spencer, Chief Operating Officer

## 2.3 Quality

Serious Untoward Incidents (month reported on STEIS)	Target	Feb 21	YTD	12 month trend
	0	1	7	

#### Reason for non-compliance

There was 1 SUI reported on STEIS in February 2021.

This relates to the Pharmacy Aseptic Unit issues regarding SACT license durations and microbiological contamination. A full review was instigated and it has been confirmed that no patients received out of date SACT. Additional reports presented at March 2021 CCC Committees provide the full and latest details of this issue.

#### Action taken to improve compliance


- Additional reports presented at March 2021 CCC Committees provide the full and latest details of actions taken and in progress.
- The Commissioners are being updated on a monthly basis and updates are now a standing agenda item on the quality contract meeting
- CQC have been notified and are receiving weekly updates



<ul style="list-style-type: none"> <li>The MHRA have been notified and being kept updated regularly</li> <li>A specialist and experienced QC Pharmacist has been appointed as the investigation lead in order to provide an independent review of the service.</li> </ul>	
<b>Expected date of compliance</b>	March 2021
<b>Escalation route</b>	Acute Care Divisional Quality, Safety and Performance Meeting, Performance Reviews, LIRG, Integrated Governance Committee, Quality Committee, Trust Board
<b>Executive lead</b>	Sheila Lloyd, Director of Nursing and Quality

IRMER - number of reportable incidents	Target	Feb 21	YTD	12 month trend
	0	1	10	
<b>Reason for non-compliance</b> <p>During February 2021, 1 incident occurred that was notifiable to the IRMER Inspector under the SAUE notification criteria 4.2 – equipment malfunction leading to 3 or more imaging exposures in a single session. There was no harm to the patient from the incident.</p> <p>Description of incident:</p> <p>The patient received 3 sets of kV images at one fraction due to an equipment fault which occurred twice. 2 deviations from local procedure have been noted. The radiographers should have transferred the patient to a matched machine after the first fault rather than reattempting the imaging exposure. The technician did not complete all checks required by local procedure before handing the machine back for clinical use.</p>				
<b>Immediate actions taken</b> <ul style="list-style-type: none"> <li>When an MLC fault occurred after a set of kV images had been taken, a technician attended and MLCs were re-initialised. The plan was checked, the patient repositioned and a repeat pair of kV images taken but the MLC fault recurred. The patient was removed from the bed after the second fault and transferred to a matched machine where imaging and treatment exposures were successfully delivered</li> <li>Explanation and apology was provided to the patient</li> <li>Practitioner was informed and the incident was recorded in the patient record (Aria)</li> <li>72 hour review held, dose calculation performed and the incident was reported to the IRMER Inspector within the required timeframe</li> <li>An email has been sent to all radiographers reiterating the correct procedure to follow when a fault occurs after an imaging exposure has been given</li> <li>An email has been sent to all technicians requesting that they re-read the procedure and work instructions relating to maintenance and checks of radiotherapy equipment</li> </ul>				

<b>Planned actions</b> <ul style="list-style-type: none"> <li>• A London Protocol Investigation will be carried out</li> <li>• The instruction to remove the patient from the bed after a fault occurs which requires an imaging exposure to be repeated is currently only found in a maintenance procedure. This instruction will also be added to a procedure directly related to patient care.</li> </ul>	
<b>Expected date of compliance</b>	London Protocol Report will be completed for submission to IRMER/MPE Management meeting April 2021
<b>Escalation route</b>	Escalation and reporting as per Incident Reporting Policy Divisional Quality and Safety Meeting, LIRG, Performance Reviews, Quality Committee, Trust Board
<b>Executive lead</b>	Sheila Lloyd, Director of Nursing and Quality

Clostridium difficile infections (attributable)	Target	Feb 21	YTD	12 month trend
	<=4 per year	1	4	

### Reason for non-compliance

A patient admitted to Ward 2 on 22<sup>nd</sup> February 2021 had a stool sample collected on 26<sup>th</sup> February 2021, which identified Clostridium difficile infection (CDI). The patient has a history of diarrhoea and CDI may have been present on admission, however this cannot be confirmed due to a lack of completion of a stool chart.

The lack of a stool chart has been identified as a lapse in care during the Post Infection Review.

There were 2 Clostridium difficile infections in January 2021 however only 1 was reported in the M10 2020/21 IPR in error. The YTD figure is therefore now 4, which is at the target for 2020/21. The details of this infection are as follows:

A post allogeneic stem cell transplant patient was admitted on 19<sup>th</sup> December 2020, due to dropping eGFR, hypokalaemia and rising CRP. A stool sample was collected on 14<sup>th</sup> January 2021, which identified Clostridium difficile. Treatment for sepsis commenced on 13<sup>th</sup> January 2021, although following review by IPC Doctor, this is unlikely to be a contributing factor.

**Action taken to improve compliance**

February 2021 infection related actions: All in-patients should have a Bristol Stool Chart present and completed in the notes to support prompt identification of any infective diarrhoea. Stool charts have been given to ward leaders with instructions reminding staff how to use them and associated communications have also been provided. The IPC Team will undertake an audit in April 2021 to monitor compliance.

Additional January 2021 reported infection related actions:

No learning points were identified from this episode of infection

<b>Expected date of compliance</b>	April 2021
<b>Escalation route</b>	Harm Free Care Meeting, Acute Care Divisional Quality, Safety and Performance Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Performance Review Meeting, Quality Committee, Trust Board
<b>Executive Lead</b>	Sheila Lloyd, Director of Nursing and Quality

	Target	Feb 21	YTD	12 month trend
<b>E Coli (attributable)</b>	≤10 per yr	1	6	

#### Reason for non-compliance

There was a hospital acquired E Coli infection on Ward 4 in February 2021.

The patient was transferred from Aintree University Hospital to Ward 4 on 18<sup>th</sup> January 2021 for chemotherapy and had multiple co-morbidities including acute pancreatitis. The patient received a third cycle of chemotherapy on 5<sup>th</sup> February and became neutropenic on 13<sup>th</sup> February. Blood cultures were collected on 15<sup>th</sup> February and E Coli was confirmed on the 16<sup>th</sup> February.

The patient's fluid intake became increasingly poor prior to identification of the infection and the urine was dark and concentrated in appearance. The source of the infection was therefore determined to be urinary.

#### Action taken to improve compliance

Patient has commenced IV fluids. This infection was likely to be unavoidable and no further actions are required.

<b>Expected date of compliance</b>	March 2021
<b>Escalation route</b>	Harm Free Care Meeting, Acute Care Divisional Quality, Safety and Performance Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Performance Review Meeting, Quality Committee, Trust Board
<b>Executive lead</b>	Sheila Lloyd, Director of Nursing and Quality

	Target	Feb 21	YTD	12 month trend
<b>Routine Formal Complaints</b> (completed within 25 working days)	100%	0%	25%	

### Reason for non-compliance

Three routine formal complaints were closed in February 2021; all exceeded the 25 working day target.

Complaint 1 – received 29/07/2020, closed 15/02/2020

- The complaint required input from LUHFT, which added to the delay
- Delays occurred within the division in gathering information and completing the final response
- The complainant was informed of the delays throughout the process

Complaint 2 – received 20/08/2020, closed 03/02/2021

- The initial complaint was responded to within 25 working days.
- The complainant then made a number of further requests for information pertaining to the initial complaint
- The CEO, Medical Director and Head of Risk and Compliance then met with the complainant, after which further information was requested.
- The final response was sent out on 03/02/2021 and the complaint was closed

Complaint 3 – received 08/10/2020, closed 23/02/2021

- Delays occurred within the division in gathering information and completing the final response
- The complainant was informed of the delays throughout the process

### Action taken to improve compliance

- The Divisional Directors are prioritising complaints management
- Each Division has a named senior manager responsible for overseeing the complaints process within the division.
- Each Division has a weekly complaints meeting to ensure actions are monitored and delivered on time.
- A deep dive review of the overall complaints management process is underway

#### Expected date of compliance


May 2021

#### Escalation route

Divisional Quality, Safety and Performance meetings, LIRG, Integrated Governance Committee, Performance review Meetings, Quality Committee, Trust Board.

#### Executive lead

Sheila Lloyd, Director of Nursing and Quality

% of Policies in Date	Target	Feb 21	YTD	12 month trend
	100 %	93%	96%	 M A M J J A S O N D J F

### Reason for non-compliance

Out of a total of 267 policies, nineteen were out of date at the end of February 2021, resulting in a compliance figure of 93%.

Of the nineteen policies:

- One policy, Processing Charitable Donations Policy, is four months out of date, however this policy is due for approval at the Charitable Funds Committee in March.
- Eighteen of the policies are between one and three months out of date, however fourteen of these policies are due to be approved at Committees/Groups or by Senior Managers during March. The remaining four policies are currently being updated.

### Action taken to improve compliance


- Policy review reminders and instructions are sent to individual authors in advance of the review due dates.
- Escalation process to Associate Director of Corporate Governance for any policies three months out of date, or with any major issues.
- Out of date policy information is provided for review at monthly Divisional meetings and Performance Reviews.
- Bi-monthly Document Control update reports are presented at the Information Governance Board.
- Promotion of policy self-management with Document Owners – ongoing.
- Targeted meetings being held between Information Governance staff and Document Owners – ongoing.
- Undertake comprehensive training/overview of QPulse functionality with Ideagen to investigate greater use of automation e.g. policy review reminders to Document Owners – Initial training cancelled April 2020 due to COVID-19 to reschedule for remote delivery by the end of Quarter 4 2021.

<b>Expected date of compliance</b>	April 2021
<b>Escalation route</b>	Associate Director of Corporate Governance, Information Governance Board, Integrated Governance Committee, Performance Review Meetings, Quality Committee, Trust Board
<b>Executive lead</b>	Liz Bishop, Chief Executive

## 2.4 Research and Innovation

There are no Research and Innovation exception reports this month.

## 2.5 Workforce

Sickness Absence	Target	Feb 21	12 month rolling	12 Month Trend (in month figures)
	G: ≤4%, A: 4.1-4.99%, R: ≥5.00%	4.2%	4.61%	

**NB:** Workforce data is being realigned to enable reporting by Division (rather than Directorate) from 1<sup>st</sup> April 2021.

### Reason for non-compliance

The Trust 12 month rolling sickness absence is 4.61%, with the in-month sickness figure for February 2021 at 4.15%, the in-month figure has decreased from January's figure of 6.46% and the 12 month rolling figure has also decreased slightly from 4.65%.

The top three reasons for sickness absence, with the number of episodes for each are shown below:

	Absence Reason	Number of Episodes
1	Anxiety/Stress/Depression	31
2	Chest and Respiratory Problems	19
3	Gastrointestinal Problems	18

Absences relating to anxiety/stress/depression have decreased since January 2021 by 3 episodes. Of the total episodes, 11 ended in February and 20 continue into March 2021.

There were 3 absences due to anxiety/stress/depression that were due to work related reasons, compared with 4 in January 2021. 21 of the absences were due to personal circumstances. It is unknown whether the remaining 7 are due to work or personal reasons as confirmation has not been received from the manager.

A breakdown of absences due to anxiety/stress/depression are displayed below:

Directorate	Number of Episodes
Chemotherapy	9 (decrease of 3)
Integrated Care	8 (increase of 1)
Corporate	4 (decrease of 1)
Radiation Services	4 (increase of 1)
Haemato-Oncology	3 (remained static)
Hosted Services	1 (remained static)
Quality	1 (remained static)
Research	1 (remained static)

The secondary reason recorded in ESR relating to Anxiety/stress/depression is as follows:

Level 2 Reason	Number of Episodes
Stress	10

Anxiety	7
Blank (no level 2 reason recorded)	8
Panic Attacks	2
Not specified	2
Other Psychiatric illness	1
Depression	1

Stress remains the highest secondary reason recorded for those absent due to anxiety/stress/depression.

Chest and Respiratory absences have decreased significantly since January 2021 from 72 episodes to just 19.

The area with the highest number of absences due to this reason was the Integrated Care Directorate with 5 absences followed by Chemotherapy and Radiation Services with 4 episodes. A breakdown of the areas who experienced absences due to this reason is displayed below:

Directorate	Number of Episodes
Integrated Care	5
Chemotherapy	4
Radiation Services	4
Corporate	3
Haemato - Oncology	1
Research	2

Although absences relating to gastrointestinal problems are within the Trust's top 3 reasons for absence in February 2021 they have decreased since January 2021 by 10 episodes. The area with the highest number of absences due to this reason were Haemato-Oncology and Radiation Services both with 4 episodes followed by Chemotherapy, Corporate and Integrated Care with 3 episodes. The Research and Innovation directorate experienced just one episode in February.


#### **Action Taken to improve compliance**

- The introduction of Wellbeing Wednesdays – A new virtual drop-in surgery held by the L&OD team to signpost staff to the wellbeing support available across the Trust
- The Trust currently has 20 trained Mental Health First Aiders available for staff to contact for one to one support.
- Health and wellbeing hub – available on the Trust Extranet which features supporting guides and resources.

- The Trust has pledged its support to the [Nursing Times 'COVID-19: Are you OK?' campaign](#). The campaign recognises the impact that the pandemic has had on so many healthcare staff and the need for appropriate support to be in place for staff mental health and wellbeing.
- Team Time - a virtual forum of staff support. It is available for any team within the Trust to have a dedicated session (45 minutes) exploring the impact of COVID-19 on them, both professionally and personally. Team Time sessions are prepared, facilitated and supported by trained members of the Schwartz Round Steering Group.

<b>Expected date of compliance</b>	October 2021
<b>Escalation route</b>	Divisional Meetings, WOD Committee, Performance Review Meetings, Quality Committee, Trust Board
<b>Executive Lead</b>	Jayne Shaw, Director of Workforce and OD



PADR	Target	Feb 21	12 Month Trend
	G: =>95%, A: 75 - 94.9%, R: =<75%	90.76%	 M A M J J A S O N D J F
<p><b>NB:</b> Workforce data is being realigned to enable reporting by Division (rather than Directorate) from 1st April 2021.</p> <p><b>Reason for non-compliance</b></p> <p>Assurance was given by all underperforming Divisions that compliance would be achieved in both January and February, however due to the impacts of covid-19 and subsequent staffing issues, compliance has not been achieved by any Directorate, with four Directorates seeing a further in month decrease in compliance. Managers continue to receive monthly compliance data.</p> <p>Following approval at January's Quality Committee to replace the PADR window with a rolling 12-month PADR compliance from 1<sup>st</sup> April 2021, the L&amp;OD Team have been working with Managers to communicate this change and to undertake the necessary system enhancements.</p> <p>This approach supports the national changes to pay gateways and should provide greater assurance around the quality of PADR conversations as a result of PADRs being spread across a 12-month period.</p>			
<p><b>Action Taken to improve compliance</b></p> <ul style="list-style-type: none"> <li>• Continue to provide monthly PADR data to managers.</li> <li>• Continue to support education and training around the PADR system.</li> <li>• Implement the changes to the PADR process as approved by Quality Committee.</li> </ul>			
<b>Expected date of compliance</b>	May 2021		
<b>Escalation route</b>	Divisional Meetings, WOD Committee, Performance Review Meetings, Quality Committee, Trust Board		
<b>Executive Lead</b>	Jayne Shaw, Director of Workforce and OD		

## 3. Covid-19 Recovery Activity

This section provides explanatory narrative for the Covid-19 'Phase Three Guidance' KPIs reported in the Covid-19 Recovery Activity scorecard (section 1.2.1).

The weekly Covid-19 Weekly and Monthly Situation Reports continue to be reported to Silver and Gold Command meetings.

### Elective Admissions

The percentage comparison with the previous year's activity has risen significantly from January 2021 (95%) to February 2021 (121%) and remains above the Covid-19 'Phase Three Guidance' target of 90%. The actual number of elective admissions has decreased marginally from 103 in January 2021 to 91 in February 2021.

Patients are screened pre-admission in line with Covid-19 guidance, ensuring effective patient flow and utilisation of beds.

There has been a reduction in Solid Tumour (ST) elective admissions from 78 patients in January, to 64 in February and a slight increase in HO elective admissions from 25 in January to 27 in February. The decrease in ST elective admissions is due to Teenage and Young Adult activity transferring to HO (last week of February) and also a decrease in patients from the Isle of Man. The increase in HO is due to mutual aid admissions, the increase in the Stem Cell Transplant Programme activity and transfer of Teenage and Young Adult activity from ST to HO.

### Day Case

The day case activity figures continue to be significantly lower than in the previous year. February 2021 figures are as follows:

- Day Cases as % of Previous Year (CCC): 45%
- Day Cases as % of Previous Year (HO): 53%
- Day Cases as % of Previous Year (ST): 27%

This is due to the transfer of planned day case activity to Level 1 and Level 6 day care units. The change will be reflected in increased activity for outpatient attendances. TYA day case activity has moved from the ST bed base to Level 5.

HO day case activity has decreased from 186 in January 2021 to 178 in February 2021 and ST day case activity has also fallen, from 52 in January 2021 to 44 in February 2021. This is partly because a proportion of the peripheral blood tests, previously carried out in the Level 1 Day Care Unit have now moved to the blood room. The change is evidenced with increased phlebotomy activity within OPD.

As reported in previous IPRs, the main reasons for the reported underperformance in day case activity are:

- A change in the coding of some systemic anti-cancer treatments (SACT), which means that day case activity is not expected to return to 2019 levels.
- A reduction in the number of patients having an allogeneic transplant, following the implementation of national guidance during the Covid-19 pandemic and due to the move into the new CCCL, to ensure patient safety, as stem cell patients are at a higher risk of infection and can become acutely unwell.

Day case activity is currently 'in block', with the financial risk mitigated until at least the next financial year. However, a Task and finish group has been developed to review all HO and ST interventions for correct coding to ensure any financial risk is mitigated moving forward and to support effective internal planning. This has been added to the risk register and an action plan is in draft. Progress is reported to the Data Management Group and then to Digital Board.

## **Outpatient Appointments**

The following Phase Three Covid-19 Guidance targets have been achieved since April 2020:

- All OP attendances as a % of 2019 2020: above 100% of 2019 levels since April 2020.
- New OP attendances as a % of 2019 2020: above 100% of 2019 levels in April 2020 and then since September 2020.
- Follow up OP appointments: above 100% of 2019 levels since April 2020.
- % of all OP appointments which are by telephone or video: at least 66% per month against the 25% target.
- % of follow up OP appointments which are by telephone or video: at least 66% per month against the 60% target.

Despite a fall in new appointments in May 2020 – August 2020 (to between 71% and 89% of 2019 activity levels), higher levels of recovery have been reported in all other months since April 2020. This is in part due to CCC successfully adopting digital solutions for remote new and follow up appointments for a sustainable service delivery.

As virtual consultations have increased, there has also been an increase in administration responsibilities for Consultants. In order to embed the sustainability of digital solutions, OPD transformation and SRG Team support includes:

- New telehealth booths to support increase in remote OPD consultations for the CCCL site (delivered and in place February 2021).
- Remote Telehealth HCA support worker pilot to support additional telehealth admin generated from consultant workload (completed and in post February 2021).
- Nurse Associate role for CCCL OPD, in response to Covid-19 related NHSE guidance and to support the increase in administration responsibilities for consultants for face to face and virtual clinics (completed and in post February 2021).
- Enhanced training and education for CNS/ANPs to support ordering of investigations, including scans, in response to the consultant body conducting remote consultations

(priority training commenced from January 2021 – continued and expanded to AHPs and CDU staff).

- The implementation of a new process for managing the remote clinics.

The next step will be to ensure that CCC continue to maintain the balance between F2F and remote consultations within OPD and that the SRG's lead on recovery planning back out to local service provision where possible. For this reason, SRG principles have been developed and will be supported operationally within the Cancer Networked Division by the nominated Divisional Business Managers who will work with the SRG Leads to ensure our patients can receive high quality OP provision across the region.

CCC continues to collaborate with the Cancer Alliance to support the strategy of supporting Patient Directed Open Access (PDOA) to stratify patient follow up, reduce OPD attendances where possible and support system capacity for any backlog of new cancer referrals. Progress to date includes:

Breast stratification (back to local follow up):

- 850 Liverpool patients
- 110 Isle of Man patients
- 100 Wirral patients
- A further 400 patients identified (60+ awaiting stratification week commencing 15<sup>th</sup> March 2021)

Prostate stratification (maintained by CCC Cancer Support Worker on My Medical Record System):

- 360 Wirral patients
- 196 Liverpool patients
- 33 Warrington and Halton patients (commenced Feb 2021)

Haemato-oncology stratification (Monoclonal Gamopathy of Uncertain Significance or MGUS; Chronic Lymphocytic Leukaemia or CLL; Monoclonal B Lymphocytosis or MBL).

- to commence stratification on build of module expected April 21

The new approach also supports a reduction in patient travel and an optimum patient pathway experience.

## **Referrals**

Planned restoration programs in the system were affected by the second and third wave of Covid-19 and this continues to adversely impact CCC's referrals. Referrals for February 2021 are at 82% (892 referrals) of the February 2020 total (1082 referrals).

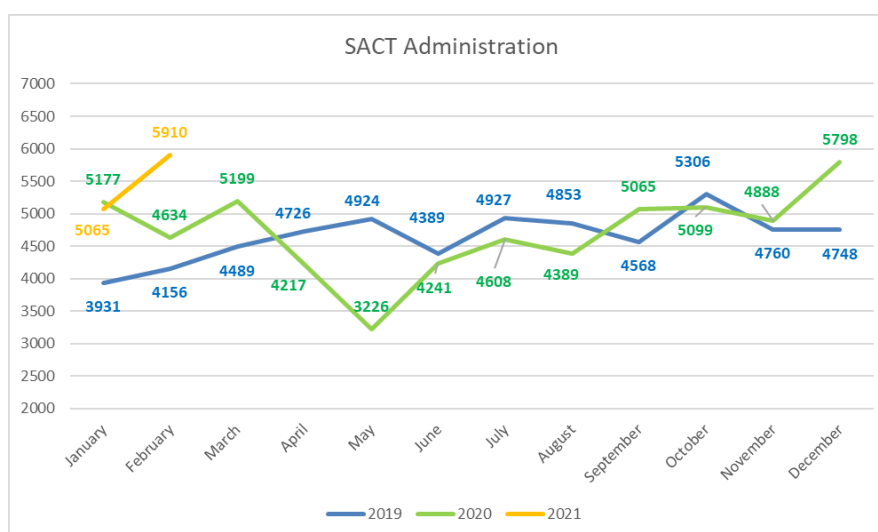
The expectation was that CCC was on the road to full recovery, with a steady increase up to November 2020 at 95% (1019 referrals) against last year's activity. This is significantly higher than the lowest recorded referral rate during the pandemic, with 607 referrals in May 2020. However, the third wave of Covid-19 (beginning in January 2021) and the subsequent effect on elective/urgent surgery, has adversely affected cancer referrals.

Endoscopy activity is however rising steeply, resulting in an estimated 10% increase in patients coming through the system for non-surgical oncology in coming weeks. It is also likely that more patients will come through with late stage disease, particularly colorectal and UGI cancers. This is likely to result in a 15-20% increase in referrals to CCC in late May and early June. SRGs have been tasked to develop plans to manage this extra activity.

The Trust monitors levels of pathway activity across the area, and is included in the Cancer Alliance work to increase patient flow. Referral patterns are also monitored weekly at the CCC Silver and Gold Command meetings and at the Cancer Waiting Times Target Operational Group (TOG). An online Covid-19 recovery activity dashboard is in development, to enable real time access to activity including referrals and will be available in April 2021.

## SACT Administration

There has been a significant increase from 5065 in January 2021 (98% of January 2020) to 5910 in February 2021. This is 128% of February 2020 and the highest activity in 2019, 2020 or 2021 to date.

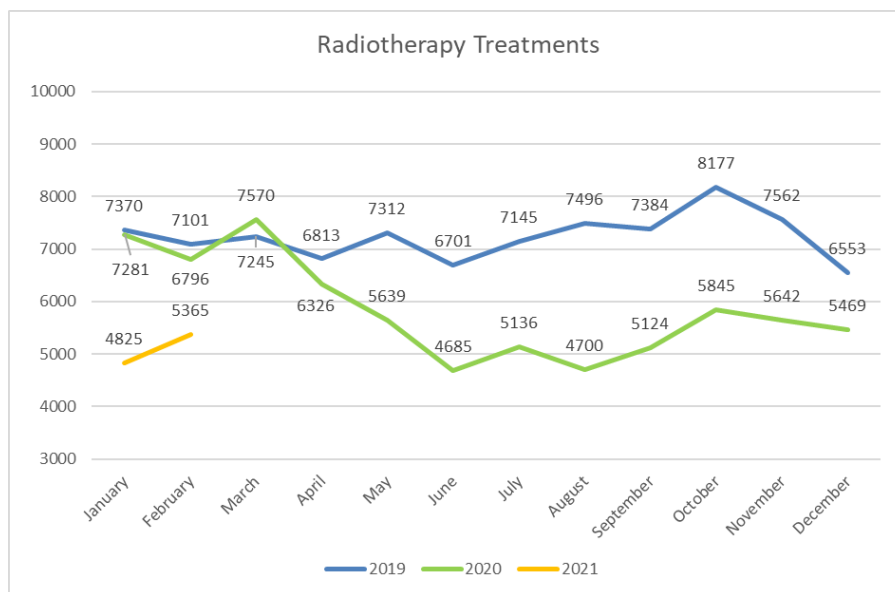


SRG recovery plans have now been reinstated in line with the Phase 3 Covid-19 NHSE guidance. The activity has grown as NHSE NICE COVID guidance has replaced shorter term classical chemotherapy with longer term treatments such as immuno-oncology which has increased activity. If cancer referrals decrease. In addition, future activity trends may continue to identify spikes in oral SACT delivery due to multiple cycles of treatments being dispensed within a month, with fewer attendances but the same number of patients in these treatment groups. Similarly, if cancer referrals decrease, SACT activity may also decrease.

The pharmacy production unit reduced production capacity from the 11<sup>th</sup> February 2021 due to changes in background microbiological surveillance however this has not reduced the SACT activity throughput as external company outsourcing has mitigated this.

## Radiotherapy Treatments

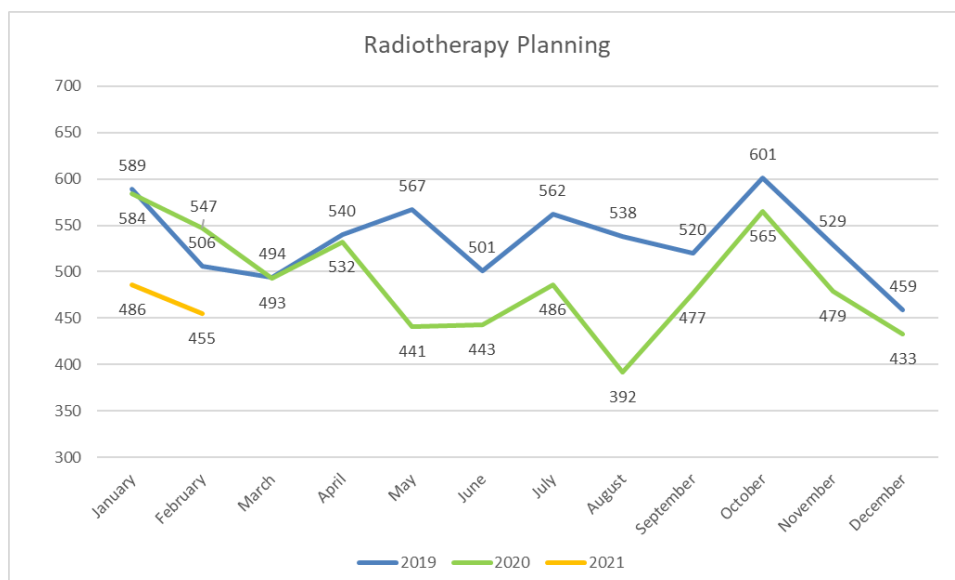
This chart compares the number of patients receiving radiotherapy treatment in 2019, 2020 and 2021.



Activity remains lower each month than in 2019. Total treatments have risen from 4825 in January 2021, to 5365 in February 2021, however this remains significantly lower than in previous years.

The amount of radiotherapy fractions delivered per day still remain lower in 2021, mainly due to the reduced fractionation regimes in Breast (from 15 to fractions to 5), adopted pre Covid-19 and due to continue, as this change is not related to Covid-19.

This chart shows the radiotherapy planning totals in 2019, 2020 and 2021.



For comparison to pre Covid-19 levels, the average utilisation on the Linacs from January 2020 to March 2020 was 93.5% with an average number of 320 fractions delivered per day.

The average number of fractions delivered per day per day in 2021 so far :

- December 220 average number of fractions / day
- January 208 average number of fractions / day
- February 260 average number of fraction / day

The variation in utilisation across the 3 sites has reduced for February.

CCC Site	Utilisation	
	Jan 21	Feb 21
CCC Liverpool	69.2%.	79.4%
CCC Wirral <i>If all the NHS patients were to be treated on the NHS Linacs at CCCW and non treated on the private linac the average utilisation at CCCW</i>	80.85%	74.2%
CCC Aintree	56%	75.8

Further discussions will be held with SRG's to determine whether reduced fraction regimes adopted during Covid-19 to reduce footfall of patients will remain after Covid-19 or whether the original fractionation regimes be reintroduced.

A review of the radiotherapy treatment data is underway, with the primary aim of forecasting activity for 2021/22.

## Radiology

The Phase Three Covid-19 Guidance target of 100% of 2019 CT activity has been achieved, with 204% in February 2021.

The Phase Three Covid-19 Guidance target of 100% of 2019 MRI activity has been achieved, with 125% in February 2021.

CT and MRI activity continues to remain high and increase due to:

- Increased activity from HO for inpatients (opened mid-September 2020)
- Increase in referrals for on-call CT scans and x-rays.
- Ongoing repatriation of oncology patients previously scanned at other Liverpool hospitals (all modalities)
- Increased inpatient / CDU activity for all modalities
- Increase in MRI radiotherapy planning scan referrals including SABR
- Increase in MRI referrals from LWH
- On-going participation in Mutual Aid provision continues for non-oncology CT scans for COCH, WUTH and LUHFT

Ultrasound activity continues to be higher than in previous years, with 127% of February 2020 activity in February 2021.

This is due to:

- HO demand (inpatient and outpatient).
- Increased inpatient/CDU activity.

## **Stem Cell Transplants**

In February 2021, 4 patients were discharged following stem cell transplant against a target of 9 patients per month. There have now been 53 patients YTD against a target of 92.

The second and third waves of Covid-19 have had an impact on donors and patients. Two planned admissions were delayed in January 2021 due to one patient testing positive for COVID-19. This was done to ensure the safety of all patients; these would have likely been discharged in February 2021.

It has been noted nationally in the monthly national Coronavirus meetings that the length of stay of allograft patients has increased slightly due to the cryo-preservation of donor stem cells. This has also been the experience of the CCC Stem Cell Transplant Programme.

One Allograft patient who would have normally been discharged in February required transfer to intensive care in LUHFT and remains there.

Patients are continually reviewed at weekly transplant MDT meetings, patients who have deferred through choice have been counselled regarding the risks and benefits and the team have risk assessed them as having disease stable enough to allow this, or the availability of an alternative treatment path.

Nationally in the first six months of 2020 there was a 60% reduction in allogeneic transplants and a 50% reduction in autologous transplants. Capacity and impact of Covid-19 on restoration plans are a standing agenda item on the fortnightly North West BMT Cluster meetings and Coronavirus National Meetings.