Trust Board of Directors Meeting held in Public

Date: Wednesday 28 April 2021	Location: via MTeams
Start Time: 09:00	Finish Time: 11:40

Timings	Item No		Lead	Paper/Verbal
Opening Matters				
09:00		**The Board will receive training on the Bribery Act 2010 as part of their Board Development**	Hill Dickinson	
10:00	**P1-058-21**	Welcome & Apologies:	KD	
	P1-059-21	Declarations of Committee Members' and other attendees' interests concerning agenda items:	KD	
	P1-060-21	Minutes of last meeting:31 March 2021	KD	
	P1-061-21	Matters arising/Action Log	KD	
Risk and Assurance				
10:15	**P1-062-21**	Quality Committee Chair's Report	TJ	**Paper**
10:25	**P1-063-21**	Audit Committee Chair's Report	MT	**Paper**
10:35	**P1-064-21**	Staff Story	SB	**Verbal**
10:55	**P1-065-21**	Update on Walkabouts	SK/JSp/ LB	**Verbal**
11:05	**P1-066-21**	New Consultant Appointments	SK	**Paper**
11:10	**P1-067-21**	Mortality Dashboard: Quarter 3	SK	**Paper**
11:05	**P1-068-21**	Integrated Performance Exception Report: Month 12	JSp/JSh	**Paper**
11:10	**P1-069-21**	Integrated Performance Report Annual Review	JSp	**Paper**
11:15	**P1-070-21**	Cheshire & Merseyside Cancer Alliance Performance Report	LB	**Paper**
11:25	**P1-071-21**	Finance Report – Month 12	JT	**Paper**
Corporate Governance				

11:35	**P1-072-21**	Board Meeting Review	ALL	**Verbal**
		Any other business		

Next Meeting:

Date: Wednesday 26 May 2021	Location: TBC
Start Time: 09:00	Finish Time:

Agenda Item: P1-042-21

The Clatterbridge Cancer Centre NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART ONE – PUBLIC SESSION

Wednesday 31 March 2021 at 09:00am
Via MS Teams

Present:	Kathy Doran (KD)	Trust Chair
	Mark Tattersall (MT)	Non-Executive Director
	Geoff Broadhead (GB)	Non-Executive Director
	Elkan Abrahamson (EA)	Non-Executive Director
	Terry Jones (TJ)	Non-Executive Director
	Anna Rothery (AR)	Non-Executive Director
	Asutosh Yagnik (AY)	Non-Executive Director
	Liz Bishop (LB)	Chief Executive Officer
	James Thomson (JT)	Director of Finance
	Jayne Shaw (JSh)	Director of Workforce & OD
	Joan Spencer (JSp)	Chief Operating Officer & Interim Chief Nurse
	Sheena Khanduri (SK)	Medical Director
	Sarah Barr (SB)	Chief Information Officer
	Tom Pharaoh (TP)	Associate Director of Strategy
In Attendance:	Angela Wendzicha (AW)	Associate Director of Corporate Governance
	Emer Scott (ES)	Associate Director of Communications
	Jane Wilkinson (JW)	Lead Governor
	Mike Varey (MV)	Staff Side Chair

Item No.	Item	Action
	Opening Matters	
P1/40/21	**Chair Welcome and Note of Apologies** The Chair welcomed everyone to the Board meeting with no apologies noted. The Chair congratulated Emer Scott on her substantive appointment as Associate Director of Communications. The Chair further informed the Board that Sheila Lloyd, Director of Nursing and Quality had now left the organisation and will commence a new role at the Florence Nightingale Foundation from 1 April 2021. LB confirmed that Joan Spencer will carry out a dual role of Chief Operating Officer and Chief Nurse with additional internal support to manage the Clinical Governance function. In addition, we have recently appointed to the substantive Associate Director of Clinical Governance who will start in three months' time. LB further informed the Board that she has met with Head Hunters and JSh in order to source a high calibre Chief Nurse with the expectation that the advertisement goes out next week.	

	The Trust Board: • **Noted** the update provided.	
P1/41/21	**Declaration of Board Members' and other attendees interests concerning agenda items** Declarations of interests were received from the following: • Mark Tattersall – Nominated Non-Executive Director for PropCare • Terry Jones – Director of Liverpool Head and Neck Centre and Associate Medical Director for Research, Liverpool University Hospital NHS Foundation Trust. • Geoff Broadhead –Nominated Non-Executive Director of CPL • James Thomson – Executive Lead for PropCare and CPL • Angela Wendzicha – Company Secretary for PropCare and CPL	
P1/42/21	**Minutes of Previous Meetings:** The Board approved the minutes of the meeting held on Wednesday 31 March 2021 as an accurate record of the meeting.	
P1/43/21	**Action Log/ Matters Arising** The Board noted that actions were either complete, on the agenda or not due. **The Trust Board:** • **Noted** the position with the Action Log	
P1/44/21	**Chair's Report** KD informed the Board that discussions remain ongoing within the system around the Integrated Care System (ICS) with Cheshire and Merseyside being formally approved as an ICS from 1 April 2021; however discussions continue around what this will mean in practice. KD further informed the Board that she and LB attended the Partnership Assembly whereby an important discussion took place around inequalities of care and that there is a welcome commitment to do something around inequalities. **The Trust Board:** • **Noted** the update provided	

P1/45/21	**Quality Committee Chair Report** TJ informed the Board that the Quality was held in two parts with three papers being considered in Part 2 of Board. TJ introduced the Chair report alerting the Board to the following: a) Medicine Management Report: The Committee received this report for the first time and whilst it was a welcome addition to the agenda, the Committee requested additional analysis relating to patient safety incidents in addition to medication incidents. In addition further categorisation of the 'other' category on the Datix system is required. b) Controlled Drugs Incidents: The Committee was advised through the Integrated Governance Chair Report that a number of incidents relating to Controlled Drugs had been reported with the Committee requesting a review of those incidents to come back to the April Committee. KD highlighted that the three papers referred to are being dealt with in Part 2 of Board due to the potential personnel issues. JW sought clarity on whether the Governors need to be briefing on any matters with KD confirming that the Board needs to be clear around the personnel issues in the first instance. TJ added that the issues out with the personnel matter are largely straightforward and will come back through the main Quality Committee next month. **The Trust Board:** • **Discussed and noted** the content of the report.	
P1/46/21	**Performance Committee Chair Report** GB provided an overview of the report advising the Board that the Committee received and discussed the initial operational and financial plan for 2021/22 noting that NHSI/E have still to approve the final guidance. The Committee further received and discussed the Covid Recovery Road Map, encouraged by the key dates for the resumption of services within the Trust. GB highlighted that the Committee discussed the outcome of the Flowers case which has now been settled nationally and received assurance that any costs incurred will be covered centrally. GB informed the Board that the Committee, under delegated authority from the Board, approved the donation from PropCare to the Trust Charity. **The Trust Board:** • **Discussed and noted** the content of the report.	

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P1/47/21	**Charitable Funds Committee Chair Report** EA provided an overview of the report alerting the Board to the shortfall in fundraising income with work ongoing to develop alternative fundraising activities. EA further advised the Board that the Committee approved additional investment to continue with the lottery recruitment for a further 12 months. **The Trust Board:** • **Discussed and noted** the update provided.	
P1/48/21	**Patient Story** Unfortunately the patient due to attend Board was able to and would be heard at the next meeting.	
P1/49/21	**Update on Walkabouts** KD informed the Board that she had attended the first joint walkabout with SK utilising and testing the technology that would enable the governors to also attend. SK provided an overview of the visit to the Marina Dalglish unit informing the Board that staff had recently been involved in a Serious Incident and Inquest and the importance of speaking to the staff. SK reported on the feedback from staff and their experiences of working through the changes as a result of the Pandemic such as the increased use of Telemedicine. LB informed the Board that the second walkabout with EA and JW related to a visit to one of the ward areas in CCC-L whereby we were able to speak to patients and staff. EA added that one staff member was a newly qualified nurse who had been recruited during the Pandemic and therefore had no other framework of working to refer to. JW added that feedback had been provided to the Governors who are all encouraged to take part. KD added that the feedback from the Governors had been positive and that this method is a good substitute for Governors and Non-Executive Directors until we can come back into the Trust in person. **The Trust Board:** • **Discussed and noted** the update provided.	
P1/50/21	**Staff Survey Results** JSh provided an overview of the presentation reminding the Board that this survey is undertaken every year and provides a good source of information as to how staff are feeling noting that additional questions had been added this year in relation to Covid-19. JSh further added that 2020 had been the most challenging year across the NHS as a whole and we have had the additional challenges of opening a new hospital in Liverpool. The survey took place between	

September and November 2020 and whilst our response rate is down on the previous year, we are above the sector average. In addition, we are benchmarked against 14 Trusts across England.

The survey focused on four key priorities as follows:

a) Health and wellbeing: we have focused on this for a couple of years now and do as much as we can to support our staff.
b) Leadership and management: It was acknowledged that some of the actions in place had to be paused due to the pandemic but we were able to launch our leadership masterclass. In addition, investment in leadership has continued with some high profile speakers delivering talks to the leadership team.
c) Communication: Virtual communication has developed over the year which has become more important because we have not been able to see staff together in one room.
d) Staff recognition: It is important that our staff feel valued and we launched our 'thank you Thursday' in addition to re-launching our staff achievement award.

In terms of our results, the Board noted that in 9 out of 10 themes we scored higher than the previous year.

JSh went onto add that from an Equality, Diversity and Inclusion perspective, we are maintaining a high performance and that we are seeing improvements in our scores around health and wellbeing. The Board noted the improvement in the scores relating to immediate managers with improvement seen in the support they provide to their staff.

JW sought clarity on the surprising red RAG rating for Research and whether there was any underlying cause for that. JSh added that we are working with the teams understand the scores with LB adding that the staff within the Research team had been affected by the suspension of trails which resulted in a number of re-deployments and working from home and the focus will now be how we recover the teams.

GB requested that for next year if we could try and get more staff to complete the survey commenting that 58% response rate is good but up to 80% would enable us to have a fuller picture.

MT added that the results were excellent given the exceptional circumstances we have been in during the last year and commended the Executive team.

AR raised the issue around Equality Impact assessments highlighting that when the tool is used in an appropriate way it is good way of informing decisions. AW confirmed that Equality Impact assessments are completed and agreed to circulate an example to the Board.

AW

AY concurred with the view that the results were good but highlighted some contradictions in the responses with JSh confirming that work is ongoing to understand the scores.

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	KD concluded the overall results were good and the Board requested sight of an action plan in due course. **The Trust Board:** • **Discussed and welcomed** the findings from the staff survey and • **Requested** sight of the action plan in due course.	**JSh**
P1/51/21	**New Consultant Appointments** No new Consultant appointments to note this month.	
P1/52/21	**Integrated Performance Report: Month 11** JSp introduced the report highlighting that detailed discussions had taken place at both the Quality Committee and Performance Committee. It was noted that there was no change to the content but that a review of all the KPI's was in progress which would be presented at Board in April for approval. JSp further highlighted that whilst performance was good overall, we are currently working with other organisations across the system in order to prepare the Site Reference Groups around Covid recovery planning. In addition one case of Clostridium difficile was reported which is currently going through the harm free care review process. Under performance in complaints continues with an action plan being developed following the deep dive review. GB added that the Performance Committee reviewed the report in detail with challenge around the recovery post Covid. AY sought clarity on the increase in the use of telemedicine and whether we have any data around the quality of this service. JSp confirmed that a small survey had been conducted in the early stages of using telemedicine with LB adding that new guidance has stated that at least 25% of outpatient appointments are to continue using telemedicine. We are expecting telemedicine to continue but the clinical teams have the freedom to decide the most appropriate route for reviewing patients, especially our complex patient groups. TJ added that the concept of utilising telemedicine had to be clinically led and that we need to keep a watching brief on the effects on our patients through Quality Committee. **The Trust Board:** • **Discussed and noted** the content of the report.	**JSp**
P1/53/21	**Cheshire and Merseyside Cancer Alliance Performance Report** Lb provided an overview of the report highlighting the following: a) Urgent cancer care is at 115-120% which demonstrates that patients have the confidence to go back to their GP for referral and that patients are coming back into the system.	

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b) Cheshire and Merseyside is seeing the highest levels of recovery and as a consequence we are seeing an increase in diagnostics and we are seeing an increase in demand in chemotherapy.
c) The 62 day performance is being monitored very closely with the numbers waiting for diagnostics is the highest it has ever been.
d) Cancer surgery requires 250 surgical episodes to be carried out a month to stay on top of the activity.

Discussion ensued in relation to performance across the system with LB adding that the figures are reviewed on a weekly basis in relation to diagnostics and surgery. TJ supported LB around the complexities of this and from his own perspective as a clinician he is seeing patients that have more complex requirements than before.

EA sought clarity on the 37.5% performance for Faster Diagnostics at CCC with LB stating the only patients we see on the Faster Diagnostic pathway are Haemato-oncology patients. JSp added that a separate paper relating to the Faster Diagnostic Pathway is going to Quality Committee in May.

The Trust Board:
• Discussed and noted the content of the report.
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<tr><td>P1/54/21</td><td>
Covid-19 Recovery Roadmap
JSp provided an overview of the report noting that detailed discussions had taken place in the Performance Committee acknowledging that national guidance is still awaited on some aspects of the plan.

JSp further informed the Board that an action plan is monitored via Silver Command with AY seeking clarity on the risks to implementing the action plan. JSp confirmed the risk to delivery of the action plan will be patient and staff safety if we try and escalate too quickly and result in an outbreak of which we have not had throughout the pandemic.

The Trust Board:
• Discussed and noted the recovery roadmap with a degree of aspiration and expectation.
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<tr><td>P1/55/21</td><td>
Finance Report: Month 11
JT provided an overview of the report, informing the Board that the Trust is expected to meet the surplus plan, that we are still understanding the annual leave accrual position.

JT further added that as recruitment has increased we are beginning to see the payroll variants reduce.

AY sought clarity on the Linear accelerators being treated as revenue rather than capital with JT confirming this related to the movement of the Linacs from CCC-W to CCC-L.

JT further highlighted that debtors have reduced with our main big debtor being LUHFT>

The Trust Board:
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	• **Noted** the content of the report.	
P1/56/21	**Board meeting (including Quality)** KD summarised that some important discussions had taken place in relation to the staff survey. GB reflected that it was disappointing that we were not able to hear from the patient due at Board today and requested the good wishes of the Board be conveyed to him reminding the Board that it is important we get the perspective from our patients and we missed that today. LB added that we will check if he can come to April Board and if not we will have a staff group attend Board.	
P1/57/21	**Any Other Business**	
	End of the meeting held in public. The Board is asked to resolve that in accordance with Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudiced to the public interest.	
	Date of the next meeting: Wednesday 28 April 2021.	

Signed:

Kathy Doran
Chair

Dated:

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						P1-xxx-21
BOARD ACTION SHEET PART 1						
KEY: BLUE = COMPLETE / GREEN = ON TRACK / AMBER = AT RISK / RED = LATE						
Item No.	**Date of Meeting**	**Item**	**Action(s)**	**Action by**	**Date to complete by**	**Date Completed / update**
P1-155-20	28-Oct-20	Matters Arising - Unconscious bias training for Board	An independent EDI specialist to carry out unconscious bias training.	**JSh**	TBC	The Trust will be joining the Specialist Trusts for joint training: Date to be confirmed
P1-24-21	24-Feb-21	Action Log	Query in relation to new starters and the requirement to have the vaccination including in new contracts of employment to be raised with the National Cancer Board.	**LB**	May-21	
P1-32-21	24-Feb-21	Cheshire & Merseyside Cancer Alliance	Information relating to inequity of access to services to be presented at a future Board	**LB**	May-21	
P1-34-21	24-Feb-21	Gender Pay Gap Report	Paper setting out the options to reduce the gender pay gap to a future Board meeting.	**JSh**	Jun-21	
P1-50-21	31-Mar-21	Staff Survey Results	Examples of Equality Impact Assessments to be circualted to the Board	**AW**	Apr-21	Completed
P1-50-21	31-Mar-21	Staff Survey Results	Action Plan from the Staff Survey Results to Board in due course	**JSh**	Jul-21	
P1-52-21	31-Mar-21	Integrated Performance Report	Review of KPI's to the April Board	**JSp**	Apr-21	On the Agenda

Committee/Group 'Triple A' Chair's Report

Name of Committee/Group	Quality Committee	Reporting to:	Trust Board
Date of the meeting:	22 April 2021	Parent Committee:	
Chair:	Terry Jones	Quorate (Y/N)	Y

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Pharmacy Aseptic Unit: Update		The Committee received an update on the progress to date and the mitigations in place to re-establish the Aseptic Unit in CCC-L. Notification of a serious breach of GCP/Trial Protocol was submitted to the MHRA on 1st April relating to cold chain and transport of IMP. The Committee was assured that clinical prioritisation of each patient was being undertaken and that patient appointments were being scheduled to ensure ability to supply medicines. The long-term recovery plan for CCL APU remains in development The Committee further discussed the risk register relating to Pharmacy and the Aseptic Unit and requested a full review of those risks to be carried out. Specifically how the issues around the	The Committee to receive monthly updates until assurance received in addition to: a) Details on the Root Cause Analysis (RCA) when complete and b) Details of the impact on clinical trials and ECMC submission c) Review of the risk register relating to Pharmacy	JSp	May 2021

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
		Aseptic Unit impacts on clinical trial recruitment and the future ECMC submission.			
Datix ICloud Review		The Committee received the deep dive report into the Datix iCloud upgrade project which covered; governance arrangements to date, reasons for delays in the project and recommendations on how a decision may be reached on how to move forward. The Committee discussed the paper in detail along with the associated recommendations. The Committee were unanimous in agreeing that the Trust should move forward with the implementation of the Datix iCloud system to avoid further delay acknowledging that final approval was the responsibility of the Executive team.	A progress report for the Committee in June 2021	JM/JSp	June 2021
Incident Management		The Committee received and discussed two reports relating to: a) Overview of all incidents reported from April 2020 – March 2021 b) Medicine Safety Incident Report for March 2021. The Committee expressed the need to better understand the processes relating to medicine management and requested the planned Board seminar on this topic be brought forward.	The Committee to receive monthly medicine management and incident reports. Seminar to be arranged.	JMcC TJ/AW	Ongoing Arrange by end April 2021

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Management of Complaints Review		The Committee received a presentation on the review concluding that the Trust was partially compliant with regulations. The Committee were informed that there was some evidence of good practice. However, a number of themes were identified and gaps highlighted particularly those relating to in compliance with CQC KLOE. It was agreed that an action plan based on recommendations approved by the Committee and Trust Board would be translated into an action plan the effect of which would be monitored through the Quality Committee.	An action plan based on approved recommendations to be presented to the Committee	MW	May 2021
Review of Adverse Reactions to Medication		The Committee received a deep dive into Paclitaxel reactions over the past 2 years. The Committee were assured that data relating to the volume of use of Paclitaxel was robust and in line with expected outcomes. Receipt of further assurance on the systems and process relating to the use of the drug requested to be brought back in 6 months.	Updated report requested in 6 months' time.	JMcC	October 2021
Controlled Drugs Incidents Review		The Committee received the report outlining the findings of the deep dive into controlled drugs incidences identified within the acute care division at CCCL.	Progress report to the committee next quarter	JR/JSp	July 2021

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
		The Committee received assurances that no patient harm had been identified in addition to assurance that comprehensive actions have been taken to further mitigate drug incidences. Progress and delivery of the approved action plan would be monitored by the Medicines Safety Group (MSG)			
Any Other Business		The Committee was advised that the structure of the clinical governance sub-committees was under review. The purpose of the review was to ensure all statutory and regulatory requirements were being met and to improve the flow of clear and succinct assurance reporting up into Board committees.	A report to be presented to the committee outlining the revised clinical governance and reporting structure of quality focused sub- committees	JSp	June 2021

	ALERT the Committee on areas of non-compliance or matters that need addressing urgently
	ADVISE the Committee on any on-going monitoring where an update has been provided to the sub-committee and any new developments that will need to be communicated or included in operational delivery
	ASSURE the Committee on any areas of assurance that the Committee/Group has received

Committee/Group 'Triple A' Chair's Report

Name of Committee/Group	Audit Committee	Reporting to:	Trust Board
Date of the meeting:	22 April 2021	Parent Committee:	
Chair:	Mark Tattersall	Quorate (Y/N)	Y

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Management of Complaints Review		The Committee received the substantive Report following the deep dive review relating to the management of complaints noting that the report had been discussed in detail at Quality Committee and Integrated Governance Committee and requested sight of progress against the action plan at the next Audit Committee.	Progress on delivery on the action plan to the July Audit Committee.	JSp/MW	July 2021
Audit Tracker		The Committee discussed and welcomed the progress against the Audit Tracker and noted that the revised proposal to monitor the action plans from reviews via the Performance Reviews. The Audit Committee supported the proposal that the Trust join a pilot project with MIAA in sharing access to the same tracker.	Audit Committee will continue to receive the Audit Tracker as a standing agenda item. AW to liaise with MIAA in relation to the proposed pilot.	AW	Ongoing
MIAA: Internal Audit Progress Report		The Audit Committee received and discussed the MIAA Internal Audit Progress Report noting that despite the limitations presented by the effects of the Covid-19 Pandemic, the following reviews had been completed:	Actions plans aligned to all recommendations will be added to the Audit Tracker and progress monitored via Divisional Performance Reviews.	AW/JSp	Ongoing

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
		• ESR/Payroll: High Assurance with two low risk recommendations • Financial Systems: Substantial Assurance with three medium and two low risk recommendations • Patient Experience Framework: Substantial assurance with one low risk recommendation. • Integrated Performance Report: Substantial Assurance with three medium risk recommendations • Cyber Review- Organisation Controls: Substantial Assurance with five medium risk recommendations. • Data Security & Protection Toolkit – Progress review: Concluded that the Trust had clear detailed management of Data Security Toolkit submission; monitoring was in place with good controls in place to monitor compliance.			
Internal Audit Annual Report and Head of Internal Audit Opinion 2020/21		The Committee discussed and welcomed the Head of Internal Audit Opinion which highlighted in the overall opinion that for the period 1 April 2020 to 31 March 2021 Substantial Assurance can be given that there is a good system of internal control designed to meet the organisation's objectives, and that the controls are generally being applied consistently.	None required	N/A	N/A
MIAA Internal Audit Plan 2021/22		The Committee discussed and approved the proposed MIAA Internal Audit Plan and fee for the financial year subject to some of the timescales for reviews being amended following discussion with the Executive Team and MIAA.	Executive Team to agree a revised timetable for the reviews.	JT	End April 2021

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
MIAA: Anti-Fraud Annual Plan 2021/22		The Committee discussed and agreed the annual plan and fee for the year 2021/22 noting the additional scope extending to the Trust subsidiary companies.	Subsidiary company Boards to be alerted to the inclusion in the scope of the Anti-Fraud review.	JT	CPL:May PropCare:May
External Audit Plan		The Committee approved the Audit Plan relating to External Audit.	None required	N/A	N/A
Data Security Toolkit Update		The Committee received and discussed an updated position in relation to Trust preparations and readiness for the final submission in June 2021.	Continue with progress to submission date.	AI	June 2021
Terms of Reference		The Committee reviewed and approved updated Terms of Reference to include: • Provision of virtual meetings • Additional requirements relating to cyber security • Additional assurance requirements around collaborative working.	For publication on the Trust website.	AW	April 2021

	ALERT the Committee on areas of non-compliance or matters that need addressing urgently
	ADVISE the Committee on any on-going monitoring where an update has been provided to the sub-committee and any new developments that will need to be communicated or included in operational delivery
	ASSURE the Committee on any areas of assurance that the Committee/Group has received

Report Cover Sheet

Report to:	Trust Board	
Date of the Meeting:	28 April 2021	
Agenda Item:	P1-066-21	
Title:	Medical Consultant Appointments	
Report prepared by:	Catherine Hignett-Jones	
Executive Lead:	Jayne Shaw	
Status of the Report:	Public	Private
	x	

Paper previously considered by:	
Date & Decision:	

Purpose of the Paper/Key Points for Discussion:	To provide an overview of new consultant appointments in April 2021

Action Required:	Discuss	
	Approve	
	For Information/Noting	Yes

Next steps required	

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

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

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

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

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

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

Introduction

This paper provides an update to the Trust Board on consultant appointments in post for April 2021

A short biography and account of achievements for the Consultant appointment is provided as follows:

Name	*Dr Muhammad Ameer Saif*
Job Title	*Consultant Haematologist and Programme Director for Stem Cell Transplantation and Cellular Therapies*
Qualifications	*MBBS, King Edward Medical College* *MRCP, Royal College of Physicians* *FRCPath, Royal College of Pathologists* *CCT North Western Deanery* *MD, The University of Manchester*
Speciality	*Clinical Haematology*
GMC number	6046941
Membership/Appointments	
Details	*Previously employed at the National Centre of Cancer Care and Research , Doha, Qatar as Senior Consultant in haematology/BMT. Prior to this, employed at Manchester University Hospital as Consultant Haematologist (Stem Cell Transplant and Cellular Therapy)*

Name	*Dr Yngvar Floisand*
Job Title	*Consultant in Haematologist, Clinical Research Lead for Haemato-oncology and Associate Programme Director for Stem Cell Transplant Cellular Therapies*
Qualifications	*PhD, Oslo Norway* *Licensed Specialist in Haematology, Oslo, Norway* *Internal Medicine, Oslo, Norway* *Medical Degree, Düsseldorf , Germany*
Speciality	*Clinical Haematology*
GMC number	
Membership/Appointments	
Details	*Previously employed as Consultant Haematologist at Oslo University Hospital as Head of the acute Leukaemia Program and Senior member of allogeneic stem cell transplantation team. Including undertaking clinical trials in AML land allogeneic stem call transplant*

Report Cover Sheet

Report to:	The Trust Board	
Date of the Meeting:	28 April 2021	
Agenda Item:	P1-067-21	
Title:	Mortality dashboard & Lesson Learnt	
Report prepared by:	Helen Wong, Quality Manager (Audit & Statistics)	
Executive Lead:	Dr. Sheena Khanduri, Medical Director	
Status of the Report:	Public	Private
	X	

Paper previously considered by:	Quality Committee
Date & Decision:	

Purpose of the Paper/Key Points for Discussion:	The mortality dashboard and mortality lesson learnt were approved by the Mortality Surveillance Group and Quality Committee. The Board is asked to approve the mortality dashboard, mortality lesson learnt and summary report.

Action Required:	Discuss	
	Approve	X
	For Information/Noting	

Next steps required	Submit to the Trust Board

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

Deliver **outstanding care locally**	X	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**	X

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

BAF Risk	Please Tick
1. If we do not optimise quality outcomes we will not be able to provide outstanding care	X
2. If we do not prioritise the costs of the delivering the Transforming Cancer Care Programme we will not be able to maintain our long-term financial strength and make appropriate strategic investments.	
3. If we do not have the right infrastructure (estate, communication & engagement, information and technology) we will be unable to deliver care close to home.	
4. If we do not have the right innovative workforce solutions including education and development, we will not have the right skills, in the right place, at the right time to deliver the outstanding care.	
5. If we do not have an organisational culture that promotes positive staff engagement and excellent health and well-being we will not be able to retain and attract the right workforce.	X
6. If we fail to implement and optimise digital technology we will not deliver optimal patient outcomes and operational effectiveness.	
7. If we fail to position the organisation as a credible research partner we will limit patient access to clinical trials and affect our reputation as a specialist centre delivering excellent patient care in the future.	
8. If we do not retain system-side leadership, for example, SRO for Cancer Alliance and influence the National Cancer Policy, we will not have the right influence on the strategic direction to deliver outstanding cancer services for the population of Cheshire & Merseyside.	
9. If we do not support and invest in entrepreneurial ideas and adapt to changes in national priorities and market conditions we will stifle innovative cancer services for the future.	
10. If we do not continually support, lead and prioritise improved quality, operational and financial performance, we will not provide safe, efficient and effective cancer services.	X

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

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

Q3 2020/2021 Mortality Dashboard Executive Summary

Background

The National Guidance on Learning from Deaths published in March 2017 requires Trusts to collect and publish specified information on inpatient deaths on a quarterly basis. This should be tabled via a paper to a public Board meeting including learning points of data.

The data should include the total number of the Trust's inpatient deaths i.e. those deaths that the Trust has subjected to case record review. Of these, Trusts will need to provide how many deaths were judged more likely than not to have been due to problems in care.

Mortality Review Inclusion Criteria

Trust mortality review process started in June 2012. Patients who fit the following criteria are included:

- All inpatient deaths
- 30 day post chemotherapy or radiotherapy mortality (excluding spinal, bone metastases cases and those treated with one fraction of eight gray)
- 90 day post radical radiotherapy mortality
- 100 day or 1 year post bone marrow transplant mortality

All inpatient deaths are assessed using a Structured judgement review (SJR) proforma, which is an evidence-based methodology provided by the Royal College of Physicians.

Case Review and Selection Process

Phase I - Responsible consultants independently review the care patients to highlight areas of concern
Phase II – An in-depth SJR is conducted for all inpatient deaths. A multidisciplinary review of cases that may have concerns or good practice to highlight are brought for discussion at the Trust mortality review meeting to enable lessons to be learned
Phase III – A multidisciplinary mortality review meeting is held to discuss those cases selected in Phase II, and re-score the SJR score if necessary.

SJR score
Score 1: definitely avoidable
Score 2: strong evidence of avoidability
Score 3: Probably avoidable (more than 50:50)
Score 4: Possibly avoidable but not very likely (less than 50:50)
Score 5: Slight evidence of avoidability
Score 6: definitely not avoidable

Dashboard Interpretation

Data coverage: April 2020 – March 2021 for comparison to previous quarter

	Apr – Jun 20	July – Sept 20	Oct – Dec 20	Jan – Mar 21
No. of inpatient death	13**	23	32	29
No. of outpatient death post treatment	119	119	143	
No. of cases requiring review	107	119	159	
No. of cases reviewed (Phase I)	93(87%)	82(69%)	110 (69%)	
No. of cases for discussion (Phase III)	26	4	11	

**Process takes a minimum of 3 months to complete*
*** No. of inpatient death for April – June 2020 was low comparing to the same period of 2019 (23 patients) due to low bed occupancy during COVID period.*

- The face to face peer review process (phase II) has been interrupted by COVID-19 pandemic, a new process has been agreed, of which mortality cases are now randomly allocated to consultants for peer review. This had helped to share out workloads and speed up the process. The efficiency is continuously monitored and shared with the Site Reference Group Chairs.
- During Q3 20/21, a total of 159 cases were in scope, 110 cases required a review (phase I), of which 70 (64%) cases has completed phase II process, leaving 40 cases were in process (36%).
- 41 (11%) cases were selected for discussion in total
- 0 case was scored less than 6 of avoidability
- 0 cases required a LeDar (Learning Disability) submission
- 1 mortality case was subject to a Child Death Overview Panel (CDOP) form (required for in scope patients <=18).

SJR Score (avoidability score <6) case description

No case to report

The Clatterbridge Cancer Centre NHS Foundation Trust: Learning from Deaths Dashboard (Public)

Summary of total number of inpatient, 30 day SACT, 30 day RT, 90 day radical RT & BMT deaths	Date Range for data	April 20	-	March 21

Trust Mortality Programme QTR 1 - QTR 3

Total Number of Deaths in Scope	No.
QTR 1	134
QTR 2	142
QTR 3	192
QTR 4	0
YTD	468

Total Deaths Requiring Phase 1 Review (excluding not applicable eg bone mets, MSCC)	No.
QTR 1	108
QTR 2	119
QTR 3	173
QTR 4	0
YTD	400

Total Deaths Reviewed (Phase 1)	No.	%
QTR 1	94	*87%*
QTR 2	83	*70%*
QTR 3	116	*67%*
QTR 4	0	-
YTD	293	*73%*

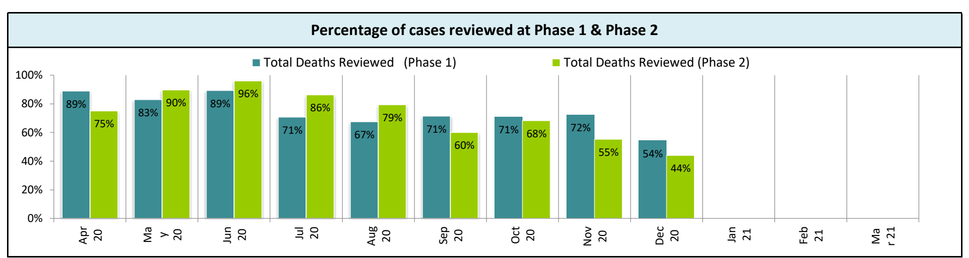
Total Structured Judgement Reviews completed and avoidability scored against RCP Methodology (Conducted for inpatient deaths only)

	Score 1 - Definitely avoidable	Score 2 - Strong evidence of avoidability	Score 3 - Probably avoidable (more than 50:50)	Score 4 - Probably avoidable but not very likely	Score 5 - Slight evidence of avoidability	Score 6 - Definitely not avoidable
QTR 1	0	0	0	0	0	12
QTR 2	0	0	0	0	0	4
QTR 3	0	0	0	0	0	2
QTR 4	0	0	0	0	0	0
YTD	0	0	0	0	0	18

Total Deaths Reviewed (Phase II)	No.	%
QTR 1	80	85%
QTR 2	63	76%
QTR 3	67	58%
QTR 4	0	-
YTD	210	*72%*

Total Deaths Reviewed (Phase III)	No.	%
QTR 1	33	35%
QTR 2	26	31%
QTR 3	2	2%
QTR 4	0	-
YTD	61	21%

Percentage of cases reviewed at Phase 1 & Phase 2



Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable: Learning Disabilities

Total Number of Deaths in Scope	No.
QTR 1	0
QTR 2	0
QTR 3	0*
QTR 4	0
YTD	0

LeDaR Submission Completed	No.	%
QTR 1	0	-
QTR 2	0	-
QTR 3	0	-
QTR 4	0	-
YTD	0	-

considered to have been potentially avoidable <=3	No.
QTR 1	0
QTR 2	0
QTR 3	0
QTR 4	0
YTD	0

* x1 CCC Patient with learning disabilities passed away in a network hospital, CCC ensured LeDaR notificaiton took place by this network hospital.

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable: Children

Total Number of Deaths in Scope	No.
QTR 1	0
QTR 2	0
QTR 3	1
QTR 4	0
YTD	0

CDOP Forms Completed	No.	%
QTR 1	0	-
QTR 2	0	-
QTR 3	1	*100%*
QTR 4	0	-
YTD	0	-

considered to have been potentially avoidable <=3	No.
QTR 1	0
QTR 2	0
QTR 3	0
QTR 4	0
YTD	0

Trust wide summary of total number of inpatient, 30 day SACT, 30 day RT, 90 day radical RT & BMT deaths

Date Range | **October 20 - December 20**

Lessons Learnt from Mortality Review Page 1

QTR	No.	Background	Actions Taken	CCC Lessons Learned	Action closed
QTR3	MRM29	An inpatient deteriorated rapidly but there was a lack of communication with the family about how unwell the patient had become. The patient's family were therefore not present when patient died and were informed of death over the telephone. Amber care bundle tool to be implemented	Trust appointed a new Amber Care & Advance Care Planning Project Lead to implement Amber Care Bundle and Advance Care Planning across the Trust	Early recognition of deteriorating patients with uncertain recovery is essential for timely and accurate communication with patients and families, including arranging for family to be present if they wish. This will be supported by the Launch of the AMBER care bundle	04/12/2020
QTR3	MRM27	A patient was transferred between wards at CCC whilst in pain. It was not essential that the patient be transferred given the discomfort it caused them.	MRM asked that the patient flow team review the transfer policy. The discharge and transfer policy was re-written after formal review of this case by Matron and Ward Manager.	Transferring of clinically unwell patients between wards is not good practice and the transfer policy has been updated to reflect this	04/12/2020
QTR3	MRM28	25% of HER2 positive breast patients may develop brain metastases. Clinician suggested scanning HER2 positive patients at diagnosis, giving a possibility for resection when metastases are small, enhancing patient's QOL.	MRM asked that the Breast SRG discuss the potential benefits of scanning this cohort of patients.	Patients receive brain scans when they are symptomatic. Scanning all patients does not add value in this setting because some patients can live for 10years+ before developing brain metastases, therefore subjecting them to numerous unnecessary scans.	04/12/2020
QTR3	MRM30	End of life care documentation was not fully completed for a patient.	The ward Manager confirmed this issue is now routinely discussed in morning safety huddles on the ward. Palliative Care consultant conducted a teaching session for the registrars on 9/5 covering documentation at end of life.	It is important to complete End of life documentation completely. Further training and awareness of paperwork was delivered.	04/12/2020
QTR3	MRM31	There were no next of kin (NOK) telephone details recorded in the electronic patient record for a patient.	The electronic patient record training was adjusted to reinforce how to document NOK details.	Next of kin details must be completed for new patients presenting to CCC. It is important for the hospital to be able to contact the patients NOK for urgent matters and for this to be obtainable out of hours and this now forms part of EPR training.	04/12/2020
QTR3	MRM44	Patient had one lung removed and the mortality group queried whether constraints for radiotherapy should be amended in these scenarios.	Lung SRG Consultant undertook a comprehensive literature review to determine best practice.	CCC currently follows best practice as supported by the literature evidence on this topic	04/12/2020
QTR3	MRM78	A recent audit by the Lower GI SRG into Capecitabine related deaths recommending greater awareness of side effects by patients due to toxicities noted in mortality reviews.	Lower GI SRG conducted a review of the consent form and importance of documentation of toxicity including life threatening side effects. The Lower GI SRG discussed the Capecitabine consent documentation and agreed to absorb the recommendations into practice.	Consent forms in lower GI regimes have been updated to reflect additional toxicities discussed in the consent process	17/12/2020
QTR3	MRM79, MRM80 & MRM87	Patient was admitted to CCC and remained on MSCC pathway for 6 weeks awaiting treatment.	MRM asked the CCC MSCC Coordinator to investigate delays in this case and general delays in the service in the form of an audit. The CCC MSCC coordinator conducted an audit and submitted findings to MRM: The delays involved in this patient's care were at DGH, at all points CCC had acted within process and network agreed timeframes. Despite this, CCC host the pathway and have taken a proactive approach to improve the service across the network. The MSCC coordinator raised Datix alerts with DGHs involved and asked them to conduct internal investigations. The MSCC team at CCC have also increased their resource to facilitate better "chasing" after initial referral as a safety net. In addition the process of reviewing MSCC deaths has been reviewed and going forwards all patients in this category will receive a review from the MSCC coordinator and linked into MRM process for further discussion where further lessons are identified.	As the host of the MSCC pathway, the MSCC team have oversight of the wider pathway to further direct local learning in other hospitals when needed.	04/12/2020
QTR3	MRM93 & MRM94	SACT assessment was not completed for a patient receiving Carboplatin on Delamere day ward	MRM asked that a Datix be raised regarding the assessment not being completed. A Datix was raised and an investigation conducted	The importance of documentation of assessments in real time is now reinforced during safety huddles.	04/12/2020
QTR3	MRM96a	A patient's consent form did not appear to be scanned into the correct place, as there are two places it could be found.	MRM asked that the administration team clarify the area that Consent form should be uploaded to in Meditech – is this Evolve or Reports?	Within meditech the consent form is visible in both the reports section on meditech and within the consent form section on Evolve, all paper documents are scanned into Evolve.	04/12/2020
QTR3	MRM96b	A patient's blood results undertaken at a DGH did not appear to be captured within Meditech.	CCC IM&T team were asked to clarify the mechanism for processing outside results into Meditech.	Currently Meditech is linked to the labs at LCL and Wirral. All other results require input manually – either by treatment staff (in Chemo clinic) or medical staff (no change in process). Work is ongoing to digitally link meditech with other labs. In the meantime printed results can be scanned into evolve.	04/12/2020

Report Cover Sheet

Report to:	Board of Directors	
Date of the Meeting:	28th April 2021	
Agenda Item:	P1-068-21	
Title:	IPR M12 2020/2021	
Report prepared by:	Hannah Gray, Head of Performance and Planning	
Executive Lead:	Joan Spencer, Chief Operating Officer / Interim Chief Nurse	
Status of the Report:	Public	Private
	X	

Paper previously considered by:	Quality Committee
Date & Decision:	22nd April 2021

Purpose of the Paper/Key Points for Discussion:	This report provides the Performance Committee with an update on performance for month twelve (March 2021). The access, efficiency (including the Covid-19 recovery activity scorecard), quality, research and innovation, workforce and finance 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. Points for discussion include under performance, developments and key actions for improvement.

Action Required:	Discuss	X
	Approve	
	For Information/Noting	

Next steps required	

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 12 2020/21)

Introduction

This report provides an update on performance for month twelve; March 2021. The access, efficiency (including Covid-19 recovery activity), quality, workforce, research and innovation, and finance 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. All Covid-19 recovery activity related exceptions are included in section 3.2.4 rather than in section 2, as a recovery summary is provided, rather than exceptions only.

A detailed quality section is included in this quarterly report, in section 3.3. This section will be included in each monthly version of the IPR in 2021/22.

The annual review of the IPR has been undertaken and a separate report will be presented to the Quality Committee and Trust Board in April 2021 to agree the content of the IPR in 2021/22.

A recent MIAA review into the IPR awarded a status of Substantial Assurance, which provides assurance to the Trust that there is a robust process for producing this document.

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.

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	Mar-21	YTD 2020/21	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
L	**7 days** from referral to first appointment		90%	85.3%	90.2%	A M J J A S O N D J F M
C/S	**2 week wait** from GP referral to 1st appointment		93%	100.0%	94.8%	A M J J A S O N D J F M
L	**24 days** from referral to first treatment		85%	92.0%	88.3%	A M J J A S O N D J F M
C/S	**28 day** faster diagnosis - (Referral to diagnosis)		75% (shadow monitoring)	100.0%	73.3%	A M J J A S O N D J F M
S	**31 day** wait from diagnosis to first treatment		96%	99.6%	99.2%	A M J J A S O N D J F M
C/S	**31 day** wait for subsequent treatment (Drugs)		98%	100.0%	99.5%	A M J J A S O N D J F M
C/S	**31 day** wait for subsequent treatment (Radiotherapy)		94%	99.7%	98.4%	A M J J A S O N D J F M
S	Number of **31 day** patients treated ≥ **day 73**		0	0	5	A M J J A S O N D J F M
C/S	**62 Day** wait from GP referral to treatment		85%	93.7%	90.8%	A M J J A S O N D J F M
C/S	**62 Day** wait from screening to treatment		90%	100.0%	96.9%	A M J J A S O N D J F M
L	Number of patients treated between **63 and 103 days** (inclusive)		No Target	38	346	A M J J A S O N D J F M
S	Number of patients treated => **104 days**		No Target	15	119	A M J J A S O N D J F M
L	Number of patients treated => **104 days AND at CCC for over 24 days**		0	3	30	A M J J A S O N D J F M
C/S	Diagnostics: **6 Week Wait**		99%	100%	100%	A M J J A S O N D J F M
C/S	**18 weeks** from referral to treatment (RTT) Incomplete Pathways		92%	99.0%	97.8%	A M J J A S O N D J F M

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	Feb-21	YTD 2020/21	Last 12 Months
Executive Director Lead: Liz Bishop, CMCA SRO						
C/S	**2 week wait** from GP referral to 1st appointment		93%	93.5%	88.8%	M A M J J A S O N D J F
C/S	**28 day** faster diagnosis - (Referral to diagnosis)		75% (shadow monitoring)	75.7%	74.5%	M A M J J A S O N D J F
C/S	**62 Day** wait from GP referral to treatment		85%	71.6%	76.1%	M A M J J A S O N D J F

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	Mar-21	YTD 2020/21	Last 12 Months
S	Length of Stay: Elective (days): Solid Tumour		≤6.5	6.4	6.1	A M J J A S O N D J F M
S	Length of Stay: Emergency (days): Solid Tumour		≤8	7.9	7.8	A M J J A S O N D J F M
S	Length of Stay: Elective (days): HO Ward 4		≤21	12.9	13.2	A M J J A S O N D J F M
S	Length of Stay: Emergency (days): HO Ward 4		≤22 (from Jan 21)	15.3	14.5	A M J J A S O N D J F M
S	Length of Stay: Elective (days): HO Ward 5		≤32	32.5	23.9	A M J J A S O N D J F M
S	Length of Stay: Emergency (days): HO Ward 5		≤46	0	28	A M J J A S O N D J F M
S	Delayed Transfers of Care as % of occupied bed days (Solid Tumour)		≤3.5%	2.1%	3.8%	A M J J A S O N D J F M
S	Bed Occupancy: Midnight (Ward 4: HO)		G: =>92% A: 88-91.9% R: <88%	93.7%	81.5%	A M J J A S O N D J F M
S	Bed Occupancy: Midnight (Ward 5: HO)		G: =>80% A: 76%-79.9% R: <76%	78.5%	69.1%	A M J J A S O N D J F M
S	Bed Occupancy: Midday (Solid Tumour)		G: =>92% A: 88-91.9% R: <88%	81.8%	71.5%	A M J J A S O N D J F M
S	Bed Occupancy: Midnight (Solid Tumour)		G: =>92% A: 88-91.9% R: <88%	82.5%	72.6%	A M J J A S O N D J F M
C/S	% of elective procedures cancelled on or after the day of admission		0%	0%	0%	
C/S	% of cancelled elective procedures (on or after the day of admission) rebooked within 28 days of cancellation		100%	0%	0%	
C/S	% of urgent operations cancelled for a second time		0%	0%	0%	
L	Imaging Reporting: Inpatients (within 24hrs)		G: =>90% A: 80-89.9% R: <80%	98.0%	96.4%	A M J J A S O N D J F M
L	Imaging Reporting: Outpatients (within 7 days)		G: =>90% A: 80-89.9% R: <80%	86.6%	93.4%	A M J J A S O N D J F M
L	Travel time to clinic appointment within 45 minutes		G: =>90%, R:<90%	97.8%	97.3%	A M J J A S O N D J F M
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%	94.9%	A M J J A S O N D J F M
C	Data Quality - % of outpatients with an outcome		G:=>95%, A:90% - 94.9%, R: <90%	97.6%	98.3%	A M J J A S O N D J F M
C	Data Quality - % of outpatients with an attend status		G:=>95%, A:90% - 94.9%, R: <90%	99.9%	98.5%	A M J J A S O N D J F M
Executive Director Lead: James Thomson, Director of Finance						
S	Percentage of Subject Access Requests responded to within 1 month		100%	100%	100%	A M J J A S O N D J F M
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	M	YTD 2020/21
Local	Covid-19 positive inpatients (Definite Healthcare Associated)*	0	0	0	0	0	0	1	0	0	0	1	0	0	2
Local	Covid-19 positive inpatients (Non 'Definite Healthcare Associated')*	No Target	13	3	3	0	0	8	12	11	3	2	5	3	63
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%	133%	93%
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%	223%	168%
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%	51%	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%	122%	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%	124%	104%
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%	123%	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%	65%	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%	66%	68%
Local	Referrals: Total (as % of 2019/20)**	2019/20 figures	87%	62%	83%	73%	85%	95%	83%	95%	83%	86%	82%	94%	85%
Local	SACT administration: Solid Tumour (as % of 2019/20)	2019/20 figures	89%	66%	97%	94%	90%	111%	96%	103%	121%	98%	128%	118%	99%
Local	Radiotherapy Treatments (as % of 2019/20)	2019/20 figures	93%	77%	70%	72%	63%	69%	72%	75%	84%	66%	79%	74%	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%	229%	162%
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%	152%	119%
Local	Stem Cell Transplants	8.3 per month (as per CCC plan)	1	1	5	8	6	6	4	5	7	6	4	11	64
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%	52%	65%
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%	48%	35%
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	7	863
Local	Staff sickness absence: Covid-19 related (total occurences)	No Target	49	36	18	21	4	18	26	24	21	68	21	9	315
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%	0.6%	1.4%

*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	Mar-21	YTD 2020/21	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
C/S	Never Events	↔	0	0	0	
C/S	Serious Untoward Incidents (month reported to STEIS)	↔	0	1	8	
C/S	Serious Untoward Incidents: % submitted within 60 working days / agreed timescales	↔	100%	100.0%	100%	
S	RIDDOR - number of reportable incidents	↔	0	0	2	
S	IRMER - number of reportable incidents	↔	0	1	11	
S	Incidents /1,000 Bed Days	↑	No target	197.3	210.96	
L	All incidents resulting in harm /1,000 bed days	↓	No target	17	18	
C/S	Inpatient Falls resulting in harm due to lapse in care	↔	0	0	1	
S	Inpatient falls resulting in harm due to lapse in care /1,000 bed days	↔	0	0	0.05	
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%	98.8%	
C/S	% of Sepsis patients being given IV antibiotics within an hour*	↓	90%	87.0%	94.0%	
C/S	VTE Risk Assessment	↔	95%	95.0%	96.0%	
S	Dementia: Percentage to whom case finding is applied	↔	90%	100.0%	99.0%	
S	Dementia: Percentage with a diagnostic assessment	-	90%	No patients	100%	
S	Dementia: Percentage of cases referred	-	90%	No patients	N/A	
C/S	Clostridiodes difficile infections (attributable)	↔	<=4 per yr	1	5	
C/S	E Coli (attributable)	↓	<=10 per yr	0	6	
C/S	MRSA infections (attributable)	↔	0	0	0	
C/S	MSSA bacteraemia (attributable)	↔	<=5 per yr	0	4	
C	Klebsiella (attributable)	↔	<=10 per yr	0	2	
C	Pseudomonas (attributable)	↔	<=5 per yr	0	1	
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	Mar-21	YTD 2020/21	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
C	Number of formal complaints received		No target	4	33	A M J J A S O N D J F M
S	Number of formal complaints / count of WTE staff (ratio)		No target	0.003	0.002	A M J J A S O N D J F M
C	% of formal complaints acknowledged within 3 working days		100%	100%	100%	A M J J A S O N D J F M
L	% of routine formal complaints resolved in month, which were resolved within 25 working days**		100%	100%	33%	A M J J A S O N D J F M
L	% of complex formal complaints resolved in month, which were resolved within 60 working days**	N/A	100%	0%	0%	
C/S	% of FOIs responded to within 20 days		100%	100.0%	99.7%	A M J J A S O N D J F M
C/S	Number of IG incidents escalated to ICO		0	0	0	
C	NICE Guidance: % of guidance compliant		90%	93%	93%	A M J J A S O N D J F M
L	Number of policies due to go out of date in 3 months		No target	36	N/A	A M J J A S O N D J F M
L	% of policies in date		100%	95%	96%	A M J J A S O N D J F M
C/S	NHS E/I Patient Safety Alerts: number not implemented within set timescale.		0	0	1	A M J J A S O N D J F M

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.
*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	Mar-21	YTD	12 Month Trend
Local	Study Recruitment (Activity less SE & PIC)		800 annual 66.7 per month	Number	3	5	21	24	123	175	98	95	92	119	105	69	929	
			100%	Percent	4%	7%	31%	36%	184%	262%	147%	142%	138%	178%	157%	103%	116%	
Local	Studies Opened		47 annual 3.9 per month	Number	3	0	4	6	3	4	6	5	2	4	7	2	46	
			100%	Percent	77%	0%	103%	154%	77%	103%	154%	128%	51%	103%	179%	51%	98%	
Local/ NIHR	Studies Unpaused		80% 6.7% per month	Number	0	4	26	24	5	7	10	7	1	0	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%	0.0%	106.3%	
					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	Mar-21	YTD 2020/21	Last 12 Months
Executive Director Lead: Jayne Shaw, Director of Workforce and Organisational Development						
S	Staff Sickness		G: ≤4% A: 4.1-4.9% R: ≥5%	3.3%	4.4%	A M J J A S O N D J F M
S	Staff Turnover		G: =<1.2%, A: 1.21– 1.24%, R: =>1.25%	1.25%	1.18%	A M J J A S O N D J F M
S	Statutory and Mandatory Training		G: ≥90% A: 75 - 89% R: ≤75%	95.19%	N/A	A M J J A S O N D J F M
L	PADR rate		G: ≥95% A: 75-94.9% R: ≤74%	90.25%	N/A	A M J J A S O N D J F M
S	FFT staff: Recommend as a place to work (Quarterly survey)		G: =>95%, A: 90 - 94.9%, R: =<90%	61%	66%	A M J J A S O N D J F M
S	FFT staff: Recommend care and treatment (Quarterly survey)		G: =>95%, A: 90 - 94.9%, R: =<90%	89%	93%	A M J J A S O N D J F M
L	% of Staff who have had the first dose Covid-19 vaccination (at month end)		No national target	90.9%	N/A	A M J J A S O N D J F M
L	% of BAME Staff who have had the first dose Covid-19 vaccination (at month end)		No national target	85.5%	N/A	A M J J A S O N D J F M
L	% of Staff who have had the first dose Covid-19 vaccination or have refused the vaccination (at month end)		No national target	94.9%	N/A	A M J J A S O N D J F M
L	% of BAME Staff who have had the first dose Covid-19 vaccination or have refused the vaccination (at month end)		No national target	88.7%	N/A	A M J J A S O N D J F M

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

1.6 Finance

For March 2021, the key financial headlines are:

Metric	In Mth 12 Actual	In Mth 12 Plan*	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit) (£000)	(183)	(557)	374		173	(854)	1,027	
CPL/Propcare Surplus/ (Deficit) (£000)	275	0	275		730	0	730	
Control Total Surplus/ (Deficit) (£000)	92	(557)	649		903	(854)	1,757	
Cash holding (£000)	63,533	43,285	20,248		63,533	43,285	20,248	
Capital Expenditure (£000)	4,428	2,193	(2,235)		14,221	13,759	(462)	

The Trust is showing a consolidated surplus of £903k, which is in line with the Trust forecast. While the revised Trust plan at month 7 was an £854k deficit as reflected in the above table, a revised forecast of £912k surplus was submitted to NHSE/I in January 2021.

Cash has consistently been running above plan, the Trust is holding this for future investments.

The £462k overspend on capital expenditure against plan is due to the Trust being asked by the Cheshire & Mersey ICS to bring forward some schemes due to an underspend of capital across Cheshire & Mersey.

2. Exception Reports

2.1 Access

7 Days from Referral to First Appointment	Target	Mar 21	YTD	Last 12 Months
	90%	85.3%	90.2%	A M J J A S O N D J F M

Reason for non-compliance

21 patients breached the Trust's internal 7-day target in March. None of these patients breached any other target.

The primary reason for not achieving the 7-day target was Consultant annual leave. Further details of these breaches are provided in section 3.1.1.

Action taken to improve compliance

- The Head of Service Delivery (Networked Services) is working closely with SRG Leads to ensure plans are in place for cover to be provided for Consultant annual leave.
- A review of approval for Consultants' annual leave is underway.

Expected date of compliance	Q1 2021/22
Escalation route	CWT Target Operational Group, Divisional Performance Reviews, Performance Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer/ Interim Chief Nurse

Long Waiting Cancer Patients: Number of patients treated => 104 days AND at CCC for over 24 days	Target	Mar 21	YTD	Last 12 Months
	0	3	30	A M J J A S O N D J F M

Reason for non-compliance

15 patients breached the 104+ day target in March; referred in between day 74 and 260 to CCC.

3 of the patients were at CCC for more than 24 days between referral and treatment. The 3 breaches were unavoidable; all due to patient choice:

- Patient 1 – Patient choice as patient requested thinking time regarding treatment (39 days at CCC)
- Patient 4 - Patient requested thinking time, and treatment was deferred for one week due to deranged bloods (34 days at CCC)
- Patient 6 - Patient requested thinking time and a second opinion at Christies before starting treatment (57 days at CCC).

The patient numbers relate to the breach table in section 3.1.1.

Action taken to improve compliance • N/A – all breaches due to patient choice	
Expected date of compliance	Q1 2021/22
Escalation route	CWT Target Operational Group, Divisional Performance Reviews, Performance Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

62 Cancer Standard (Alliance-level)	**Target**	**Feb 21**	**YTD**	**Last 12 Months** (to Feb)
	85%	71.57%	76.14%	M A M J J A S O N D J F

Reason for non-compliance

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

- Urology 62.83% (down from 72.53% last month)
- Lower Gastrointestinal 44.5% (up from 39.02%)
- Gynaecology 29.58% (down from 39.44%)

February'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).

Gynae performance was largely driven by a number of breaches at Liverpool Womens Hospital, Wirral Hospitals and East Cheshire Hospitals.

February's 62 day performance was also impacted by a large number of referrals received in December and January. First appointments were 25% higher than normal in December (higher than any other Alliance) and are currently approx. 20% higher.

Delays to diagnostic pathways are being monitored through the Cheshire and Mersey 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.

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

2.2 Efficiency

Length of Stay: Elective	**Target**	**Mar 21**	**YTD**	**Last 12 Months**
Ward 5 (HO)	≤32 days	32.5	23.9	A M J J A S O N D J F M

Reason for non-compliance

The LoS for Ward 5 elective admissions was 0.5 days above target at 32.5 days.

This high average LoS is due to the acuity of 2 patients.

- One patient was unwell with a long recovery time from Cycle 1.
- One patient remained as an inpatient for 4 Cycles. This patient was an inpatient from November 2020 and sadly died in March 2021.

No DTOC (delayed transfers of care) were recorded on HO wards, indicating appropriate bed utilisation.

Action Taken to improve compliance

- Preparation for the roll-out of the CUR tool to HO Wards is underway, with confirmation of the software licence awaited and training being planned to facilitate an effective roll-out.
- The 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.

Expected date of compliance	April 2021

Escalation route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Integrated Governance Committee, Quality Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

Bed Occupancy	**Wards**	**Target**	**Mar 21**	**YTD**	**Last 12 Months**
	Solid Tumour	G: =>92% A: 88-91.9% R: <88%	Midday **81.8%**	**71.5%**	A M J J A S O N D J F M
			Midnight **82.5%**	**72.6%**	A M J J A S O N D J F M
	Ward 5	G: =>80% A: 76%-79.9% R: <76%	78.5%	**69.1%**	A M J J A S O N D J F M

Reason for non-compliance

Bed occupancy for solid tumour Wards in March 2021 continues to be below the Trust's target of 92% however this has increased slightly since February 2021.

The position for March 2021 is;

- Average bed occupancy at midday was 81.8%
- Average bed occupancy at midnight was 82.5%

Ward 5 also continues to be below the Trust target of 80% at 78.5% for March 2021, although this has increased by 5% from February 2021 (73.6%), reflecting the rise in the number of transplant patients. 11 transplant patients were discharged in March 2021, achieving the monthly target of 9 patients for the first time in 2020/21. Bed occupancy on Ward 5 is expected to continue to increase further, as transplant patient numbers continue to rise, from the reduced levels during the pandemic.

These bed occupancy figures are calculated on a total bed base of 86 beds. There are a further 4 beds on ward 3 which have been agreed to be used as 'escalation beds' to support the Trust with winter/covid-19 pressures. These beds have not been used during March 2021.

The Trust has been predominantly on OPEL 1 (Green) during March 2021, however OPEL 3 has been recorded for the solid tumour wards on 7 occasions and for the Haemato-oncology wards on 13 occasions.

No Mutual Aid patients were transferred across to CCC Liverpool in March 2021. Communication continues between Acute Oncology and the Patient Flow Team. The bed pressures from the Covid-19 pandemic continue to ease, with the number of Covid-19 positive patients at CCCL also falling.

Action Taken to improve compliance

- The 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 Patient Flow Team continue to liaise with Acute Oncology, offering oncology beds to our patients when they are required.

Expected date of compliance	May 2021
Escalation route	Divisional Quality, Safety and Performance Meetings, Divisional Performance Review, Performance Committee, Trust Board.
Executive Lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

Radiology Reporting: Outpatients (within 7 days)	Target	Mar 21	YTD	Last 12 Months
	G: =>90% A: 80-89.9% R: <80%	86.6%	93.4%	A M J J A S O N D J F M

Reason for non-compliance

With the exception of September 2020 (outpatients 87.7%) and now March 2021 (outpatients 86.6%), the inpatient and outpatient targets (90%) for reporting turnaround times have been met each month in 2020/21.

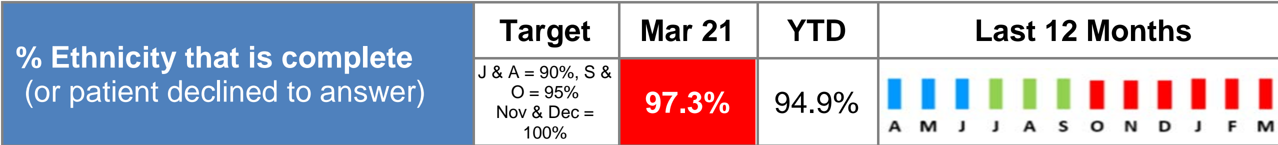
Reasons for the fall in compliance:

- An additional radiologist was recruited in December 2019, however they will not commence in post until later this year. The delay was due to Covid-19 and the inability for the candidate to travel to complete an essential examination. The candidate travelled to the UK for the January 2021 exam which was unfortunately cancelled due to lockdown measures. The candidate is due to take the exam in June 2021.
- Increase in Radiologist annual leave
- Increase in Radiology activity
- IR service activity growth
- Radiologist support for the Ultrasound service

Action taken to improve compliance

- Thorough review of reporting SITREP to identify any trends
- Ultrasonographer appointed to full-time post – awaiting completion of employment checks
- Radiologist Interviews planned for the 6th May to fill vacant post
- New post of Clinical Fellow in Oncology Imaging is going to advert in May 2021.

Expected date of compliance	May 2021
Escalation route	Divisional Performance Review, Performance Committee, Trust Board.
Executive lead	Joan Spencer, Chief Operating Officer/ Interim Chief Nurse



% Ethnicity that is complete (or patient declined to answer)	Target	Mar 21	YTD	Last 12 Months
	J & A = 90%, S & O = 95% Nov & Dec = 100%	97.3%	94.9%	A M J J A S O N D J F M

Reason for non-compliance

Whilst compliance remains high, at 97.3%, the 100% target has not been achieved.

Detailed analysis of the data reveals that compliance is lowest in HO clinics, in which there has been reduced clerical support due to vacancies.

Action taken to improve compliance

- Further detail has been provided of the individual areas so that focused attention can be given; compliance in HO clinics requires improvement
- HO clinics have had reduced clerical support due to vacancies; this is being addressed and compliance should improve in this area over the coming months
- Data is presented and reviewed at Divisional Performance Reviews
- Previous actions regarding contacting patients and directing patients to receptions to record this data are continuing.

Expected date of compliance	Q1 2021/22
Escalation route	Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

2.3 Quality

Serious Untoward Incidents (month reported to STEIS)	Target	Mar 21	YTD	Last 12 Months
	0	1	8	A M J J A S O N D J F M

Reason for non-compliance

One SUI was reported to STEIS in March 2021. This takes the total to 8 for 2020/21.

The details are as follows:

- Following an MDT meeting in June 2020 a patient was diagnosed with small cell lung cancer and was commenced on chemotherapy and radiotherapy

- A review in October 2020 identified the disease was not responding to the treatment as expected and a further test was requested (Ki-67 immunocytochemistry stain)
- The results of this test altered the diagnosis to a low grade neuroendocrine carcinoma which can be treated with surgery
- The patient's diagnosis changed part way through treatment. This is being investigated as part of the SUI investigation.

Action taken to improve compliance

- LHCH were contacted to request a review of the MDT. The Consultant and Associate Medical Director for Medicine have reviewed and discussed this case. They agree that this should not be classed as a misdiagnosis as the MDT arrived at their decision based on the results of the investigations that had been undertaken at that time
- SUI medical lead to raise the issue with the Cancer Alliance Lung Site Specific Group to ensure that all MDTs are implementing the IASLC guidance on Ki-67 in when an SCLC diagnosis is ambiguous
- A full SUI investigation is underway.

Expected date of compliance	April 2021
Escalation route	Divisional Quality, Safety and Performance meetings, LIRG Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

IRMER - number of reportable incidents	**Target**	**Mar 21**	**YTD**	**Last 12 Months**
	0	1	11	A M J J A S O N D J F M

Reason for non-compliance

During March 2021, 1 incident occurred that was notifiable to the IRMER Inspector under the SAUE notification criteria 7.1 – Therapy overexposure - 1.2 or more times the intended dose at any one fraction. There was no harm to the patient from the incident.

Whilst the patient was undergoing whole CNS radiotherapy, the brain and upper spine fields were delivered correctly but a move of 20cm instead of 22cm was made to set up the lower spine field. This resulted in an inadvertent overlap for 2cm of spine at the top of the lower field and an omission of 2cm of spine at the bottom of the lower field.

Immediate actions taken

- Consultant, MPE and TEP were informed as soon as the error was discovered and details of the error were recorded in the patient's Aria record
- Bed parameters for all treated fractions checked to confirm that no other errors had been made

- Plans produced to show the dose received by the patient on the day of the error and the overall treatment delivered incorporating the incorrectly delivered fraction
- Decision made for a third person is to be present at set up (MPE or TEP) for all remaining fractions with the sole purpose of checking calculation and resulting bed position. This will be incorporated into procedure for all whole CNS patients
- Patient/family informed of error and apology provided
- Incident reported to IRMER Inspector

Planned actions

- Investigate alternative approaches to planning or treatment for this indication which align more closely with standard processes and reduce manual intervention
- Review level of verification imaging required for whole CNS patients
- Ensure there is a clear requirement to carry out a weekly check and a checklist which indicates the individual items to be checked, including a check of daily bed positions
- Review tolerance table with a view to reducing longitudinal tolerance
- London Protocol Investigation to be undertaken

Expected date of compliance	London Protocol Report for submission to IRMER/MPE Management meeting May 21
Escalation route	Escalation and reporting as per Incident Reporting Policy Divisional Quality and Safety Meeting, LIRG, Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

% of Sepsis patients being given IV antibiotics within an hour	**Target**	**Mar 21**	**YTD**	**Last 12 Months**
	90%	87%	94%	A M J J A S O N D J F M

Reason for non-compliance

The target of 90% has not been achieved for the first time in 2020/21, at 87% (48 out of 55 patients, 1 on HO wards and 6 on ST wards).

Full reviews of all 7 target breaches are underway to identify any trends, lessons learned and any education requirements. No harm has been identified for the patients who did not receive their antibiotics in the prescribed time.

All instances of non-compliance are recorded as an incident on datix and are discussed at the Deteriorating Patient Safety Group (DPSG).

Action taken to improve compliance

- Education and awareness training is provided to all new starters and provided routinely on wards
- Visual prompts have been displayed in appropriate areas.
- Sepsis champions have been identified in all areas

- HO to be given training on utilisation of digital documentation
- Process of reviewing incidents via DPSG introduced, discussing lessons learned, undertaking 72 hour reviews and presentation to LIRG if required
- Working group established to review sepsis pathway, data capture and areas of non-compliance
- ACT working hours altered to reflect needs of service, allowing for more ward presence
- Reminders regarding timely review have been issued to Nursing and Medical staff
- Identification of individual staff remaining non-compliant with sepsis documentation and further training and support offered
- New discharge letter documentation to highlight sepsis during admission – to aid coding
- The introduction of a new Trust Patient Safety Forum is being explored.
- Networking with other Trusts and SEPSIS TRUST UK.

Expected date of compliance	April 2021
Escalation route	Deteriorating Patient Safety Group, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

Clostridiodes difficile infections (attributable)	**Target**	**Mar 21**	**YTD**	**Last 12 Months**
	<=4 per year	1	5	A M J J A S O N D J F M

Reason for non-compliance

There was 1 case of Clostridiodes difficile in March 2021 (Ward 2), bringing the total to 5 in 2020/21; 1 above the annual target of 4.

The patient was admitted to Ward 2 on 28.2.21 as a direct transfer from LUHFT. A stool sample collected on 02.03.21 identified Clostridiodes difficile infection (CDI). The patient had a history of diarrhoea prior to admission, and a stool sample collected on 01.03.21 was negative for CDI. The patient was commenced on IV Tazocin whilst at LUHFT for neutropenic sepsis and this was continued upon transfer to CCC. Discussion with the Infection Control Doctor has identified this as the most likely source of CDI. Tazocin was however prescribed within Trust Formulary and no learning points were identified, with the infection deemed to have been unavoidable.

Action taken to improve compliance

No learning points were identified.

The IPC Annual Report will be presented to the June 2021 Integrated Governance Committee.

Expected date of compliance	April 2021
Escalation route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

Complex complaints (resolved within 60 working days)	**Target**	**Mar 21**	**YTD**	**Last 12 Months**
	100%	**0%**	**0%**	1 formal complex complaint in 2020/21

Reason for non-compliance

The Trust received 1 formal complex complaint in 2020/21, this was resolved on day 90. Complex complaints are those involving other organisations. The details are as follows:

- A formal complex complaint was received on 26th October 2020 regarding a perceived lack of follow up care over 2 years which the complainant felt led to a terminal diagnosis
- On 19th November 2020, requests for information were sent to 2 other Trusts with a timeline for response of 18th December 2020
- No response was received by either Trust by the requested date or by the 60-day deadline
- The patient passed away on 15th January 2021
- As the patient had not given consent for the complaint response to be shared with anyone else, the complaint response letter was drafted and approved and will remain on file
- The response was approved and signed on 3rd March 2021.

Delay details:

- There was a delay at CCC of almost 4 weeks before a request was made to other Trusts
- There was a significant delay in the response from other Trusts
- There is no evidence that CCC kept the patient informed of the reason for the delay.

Action taken to improve compliance

- Processes have been reviewed and the Divisional Nurse Director (DND) now has responsibility to ensure the timely progress of all complaints responses
- Weekly meetings are held between the DND and Divisional Clinical Governance Lead to discuss and escalate any actual and/or potential delays
- A weekly complaints tracker continues to be sent out to all divisions with an update of each complaint response
- A deep dive review into the complaints process has made recommendations for improvements; this was presented to IGC in April 2021. The implementation of these recommendations is now in progress.

Expected date of compliance	May 2021
Escalation route	Divisional Quality, Safety and Performance meetings, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

% of Policies in Date	**Target**	**Mar 21**	**YTD**	**Last 12 Months**
	100 %	95%	96%	A M J J A S O N D J F M

Reason for non-compliance

Out of a total of 264 policies, thirteen were out of date at the end of March 2021, resulting in a compliance figure of 95%

Of the thirteen policies:

- One policy, Processing Charitable Donations Policy, is five months out of date, however this policy was approved at the Charitable Funds Committee in March and Document Control is awaiting the final policy and approval minutes before publication can take place
- Twelve policies are between one and three months out of date, however eight have been approved and Document Control is awaiting the final policy and approval minutes/approval email before publication can take place. Of the remaining four policies, two are awaiting virtual approval and two are currently being updated.

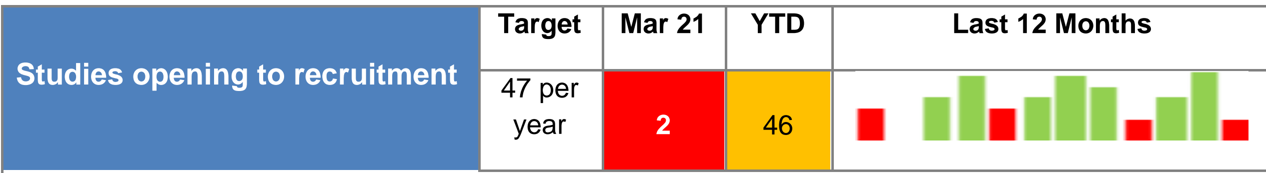
Action taken to improve compliance

Actions to improve compliance include:

- 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 polices 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 – Training scheduled for 19/20th April 2021

Expected date of compliance	May 2021
Escalation route	Associate Director of Corporate Governance, Information Governance Board, Integrated Governance Committee, Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Liz Bishop, Chief Executive

2.4 Research and Innovation



	Target	Mar 21	YTD	Last 12 Months
Studies opening to recruitment	47 per year	2	46	

Reason for non-compliance

Forty-six studies have been opened to recruitment against an internal target of forty-seven. There are eight studies which have been locally approved and can be opened to recruitment following sponsor approval. No cancer studies could open during April 2020 and the majority of May 2020 due to the pandemic which has meant we are slightly under target at the end of this year. We have also been unable to open new studies that use the aseptic facility since 5th March 2021 due to the current pause while we address some issues with the Aseptic Service.

Action Taken to improve compliance	
• The SRG Research Leads are actioned to review the NIHR portfolio to see if any further trials should be opened at CCC. • Work with the Network to optimise opportunities. • Work with Sponsors to greenlight studies where local approval has been given.	
Expected date of compliance	Q1 2021/22
Escalation route	SRG Research Leads / Committee for Research Strategy
Executive Lead	Sheena Khanduri, Medical Director

2.5 Workforce

Turnover	Target (in month)	Mar 2021	Target (12 month rolling)	12 month rolling	Last 12 Months (monthly figures)
	G: =<1.2%, A: 1.21– 1.24%, R: =>1.25%	1.25%	G: =<14%, A: 14.1 - 14.9%, R: =>15%	14.37%	A M J J A S O N D J F M

Reason for non-compliance

Both the rolling 12 month turnover figure and in-month figure increased in March 2021. The in-month figure is above Trust target at 1.25% (1.10% in February) the rolling 12 month figure increased to 14.37% (14.30% in February) taking it in to within the amber tolerance level.

To enable the Trust to track progress against the KPI and identify trends, turnover figures are calculated on a rolling 12-month basis. Year to date figures only provide a snapshot of activity within a specific time period (e.g. the turnover % in August will only take into account data from April – August) whilst 12 month rolling data provides a more holistic overview of the data, providing more valuable insight into turnover patterns and supports Trust management decisions in relation to workforce planning.

In total there were 20 leavers in March 2021, leaving for the following reasons:

Reason for Leaving	Number of Leavers
Voluntary Resignation – Promotion	8
Voluntary Resignation – Better Reward Package	1
Voluntary Resignation – Work Life Balance	3
Voluntary Resignation – Health	1
Voluntary Resignation – Other	3
Voluntary Resignation – Undertake further education / training	1
Retirement Age	1
End of Fixed Term Contract	2

The total number of leavers has increased in March 2021, from 16 leavers in February 2021.

5 employees left both the Chemotherapy and Radiation Services Directorates, there were 4 from Integrated Care, 3 from Corporate, 2 from Research and 1 from Haemato-Oncology.

The highest reason for absence in March was due to Promotion with 8 in total followed by 3 due to Work Life Balance and 3 due to 'Other/Unknown'. Leavers due to work life balance have decreased this month from 5 in February.

The area with the highest number of leavers due to Promotion was Radiation Services and Integrated Care with 3 leavers followed by Pharmacy with 2 leavers. Their destinations on leaving were NHS Employment (5), Private Sector (1), Self Employed (1) and Education Sector (1).

The areas with leavers due to Work Life Balance were Haemato-Oncology (1), Radiation Services (1) and Integrated Care (1). Their destinations on leaving were NHS Employment (2) and No Employment (1).

There were 9 Exit Interviews completed from the leavers in March 2021, from the following areas:

Directorate	Number of Exit Interviews
Radiation Services	3
Chemotherapy	2
Integrated Care	2
Haemato-Oncology	1
IM&T	1

The reasons for leaving cited on the exit interviews received range from new post within the NHS (5), Work Life Balance (1), new post in the Private Sector (1), Promotion (1) and End of Fixed Term Contract (1). Reasons that influenced their decision to leave include Lack of Career Opportunities (7), Relocation (2) and Travelling by Public Transport to CCCL (1).

Action Taken to improve compliance

- Amendments have been made to the Exit Interview questions to ensure that they are fit for purpose and gather meaningful data.
- Exit interview outcomes are reviewed monthly by the HR Business Partnering team to ensure that concerns are addressed and if appropriate, improvements are discussed.
- The Trust's Long Service Award Policy has now been launched and the rewards amended to 10, 20, 30 and 40 years.
- A nursing retention plan continues to be monitored via the Workforce Transformation Committee
- The admin and clerical retention plan continues to be monitored via the Workforce Transformation Committee
- In line with the NHS People Plan, the HR Business Partnering team plan to develop a 'Flexible Working Promise' to ensure managers understand the benefits and flexible working policies and the importance of its implementation in order to recruit and retain staff.

Expected date of compliance	May 2021
Escalation route	Divisional Performance Reviews, Workforce Transformation Committee, Quality Committee, Trust Board
Executive Lead	Jayne Shaw, Director of Workforce and OD

PADR	Target	Mar 2021	Last 12 Months
	G: =>95%, A: 75 - 94.9%, R: =<75%	90.25%	A M J J A S O N D J F M

Reason for non-compliance

Overall trust compliance for PADRs has not been achieved since September 2020. Directorates have reported that the impact of Covid-19 and subsequent staffing issues have affected their ability to undertake PADRs, alongside the structural reporting changes that have taken place as part of the new clinical model which are not currently aligned in ESR.

Approval was received at Quality Committee in January 2021 to move away from the Trust's current set window approach for PADRs and from 1st April 2021 to align PADR dates with pay progression dates. This approach supports the new NHS Terms and Conditions for pay progression, which states that staff must have an in-date appraisal, which is ideally linked to their pay gateway date, to successfully progress through the pay gateway.

Not only will this approach support the pay progression requirements, but it should also provide greater assurance around the quality of PADR conversations as a result of PADRs being spread across a 12-month period.

Following the structure changes in ESR, all Divisions will be issued with a yearly roadmap, detailing the PADRs that need to be completed in each month to ensure compliance.

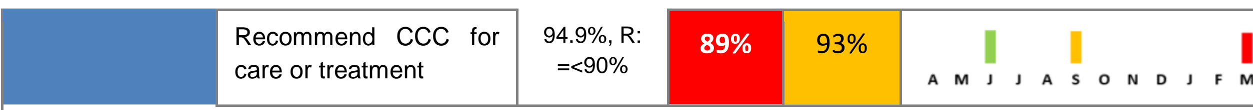
Action Taken to improve compliance

- Implement the changes to the PADR process as approved by Quality Committee
- Continue to support education and training around the PADRs
- Continue to provide monthly PADR data to managers
- Issue Divisions with a yearly roadmap for PADR completions in May 2021 (following the data alignment to new structures in ESR).

Expected date of compliance	31st May 2021
Escalation route	Divisional Performance Review, Quality Committee, Trust Board
Executive Lead	Jayne Shaw, Director of Workforce and OD

Staff 'Friends and Family' Test	KPI	Target	Q4	YTD	Last 12 Months (Quarterly survey)
	Recommend CCC as a place to work	G: =>95%, A: 90 -	61%	66%	A M J J A S O N D J F M

IPR Month 12 2020/2021 23



	Recommend CCC for care or treatment	94.9%, R: =<90%	89%	93%	A M J J A S O N D J F M

Reason for non-compliance

The Staff Friends and Family Test (FFT) for Q4 took place between 15th February and 12th March 2021.

The survey was completed by 519 staff (33%) which is a slight increase of 3% from Q2. Please note, the Staff FFT is not carried out in Q3, due to the national Staff Survey.

The Staff FFT includes the two nationally required questions on recommending the Trust as a place to work and recommending the trust as a place to receive care, plus four additional questions selected by the Trust to support the monitoring of the Trust's culture and engagement journey.

The results from Q4 show a decline across all 6 questions. The results will be triangulated with the results of the national Staff Survey and other workforce indicators and will be discussed at the culture and engagement groups to identify trends and areas for improvement. Results at divisional level have also been circulated and included in performance reviews for further analysis and action.

Action Taken to improve compliance

- New divisional culture and engagement groups will be implemented from April 2021 to help focus, at a local level, on staff engagement and making CCC the best place to work and receive care
- Following the results of the national Staff Survey (received in March 2021) divisional Improvement plans will be submitted by 30th April and monitored via the divisional culture and engagement groups and performance reviews
- Q4 Staff Friends and Family Test results will be included in divisional Staff Survey feedback sessions and triangulated with other workforce data to identify any trends and key areas for action
- Staff wellbeing, engagement and making CCC the best place to work and receive care remain key areas of priority as part of the Trust's Workforce and OD strategy
- Staff listening events will continue throughout 2021 to enable staff to share best practice, innovations and any areas of concern
- L&OD Team will focus on encouraging and supporting staff to complete the Staff FFT in Q1

Expected date of compliance	April 2022
Escalation route	Divisional Performance Reviews, WOD Committee, Quality Committee, Trust Board
Executive Lead	Jayne Shaw, Director of Workforce & OD

3. Detailed Reports

3.1 Access

3.1.1 Cancer Waiting Times Standards: CCC Performance

Whilst the overall performance for March has been good, reduced consultant availability due to leave has presented challenges to achieving the targets. The administration team continue to closely monitor the target patients and escalate when appropriate to ensure patients are seen and treated in a timely manner.

During this period of recovery from the Covid-19 pandemic, increases in referrals to CCC (following the recovery of screening, diagnostic and surgery activity) will have an impact on capacity and consequently the Trust's ability to achieve the cancer waiting times targets. To prepare for this, the Trust is developing activity forecasts for the next 6 months. CCC and system activity data is reviewed weekly at the CWT Targets Operational Group and weekly at the Silver Command meeting. The Business Intelligence Department are in the final stages of developing a Covid-19 recovery activity online dashboard which will be accessible to Divisions and SRGs to support planning.

2 Week Wait
The 93% target has been achieved, with performance for March at 100%

28-day Faster Diagnosis Standard (FDS)
The NHS Operational Planning and Contracting Guidance 2021/2022 states that the 28-day Faster Diagnosis Standard will be subject to formal performance management from Q3 2021/22, with a target of 75%. Data continues to be reported internally.

The 28 day FDS target was achieved in March at 100%.

62 Day wait from GP Referral to treatment
The 85% target is currently being achieved at 93.7% for March (final validation via national system 6th May 2021).

62 Day breaches by tumour group are not reported this month as we are in a period of transition to a new on-line Cancer Wait dashboard.

62 Day Screening
There were no 62 Day Screening breaches for March 2021.

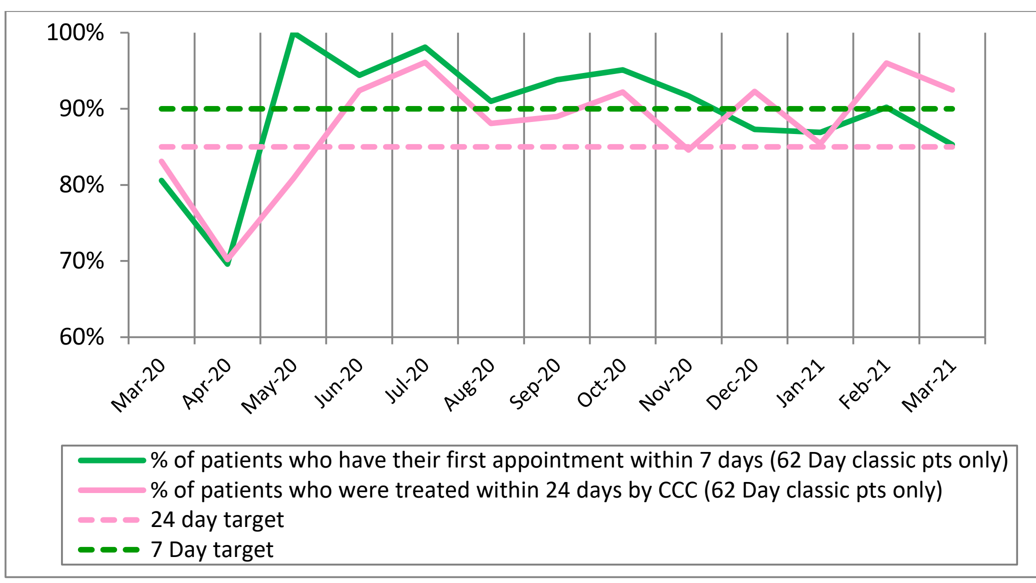
7 Day Performance (Internal Target)
Performance for March 2021 is 85.3% against a stretch target of 90%.

21 patients breached the internal 7 day target. None of these patients breached any other target. The following table provides a summary of these breaches:

Tumour Group	No. missing 7 Day	Consultant leave or COW	Clinic Full	Next Clinic	Awaiting Results
Breast	2		1	1	
Colorectal	1			1	
Gynae	2		1	1	
Head & Neck	2	1			1
Hepatobiliary	2	1	1		
Lung	1			1	
Skin	3	2		1	
Upper GI	2		1	1	
Urology	6	1	3	1	1
Grand Total	**21**	**5**	**7**	**7**	**2**

24 Day (Internal Target)
This was achieved for March 2021, with 92.5% against a stretch target of 85%.

The following chart shows 24 day and 7 day performance by month against the targets:



CCC continues to monitor 24 day performance for patients on the 62-day pathway. This is an internal target that aids breach avoidance for the system. 24 day awareness sessions continue to be available to all staff.

31 day long waiters 73 days +
There were no 31 Day long waiting breaches in March 2021.

62 Day long waiters 104 days +
15 patients breached the 104+ day target in March; referred in between day 74 and 260 to CCC. 3 of the 15 patients were at CCC for more than 24 days between referral and treatment and were accountable breaches to CCC.

The Clinical Harm Review for the February 2021 104+ day Long Waiting Patient was presented at the LIRG meeting on 16th March 2021. The LIRG accepted the findings of 'low harm' caused and no further action was identified.

Breach Details

									Internal Targets		National Standards					Long Waiters	
Patient	**Day into CCC**	**Days at CCC / to Diagnosis (28DFDS)**	**Treated on Day**	**Tumour**	**Referring Trust**	**Treatment**	**Reason**	**Avoidable Breach**	**7 Day**	**24 Days (treated within 62 days)**	**2 Week Wait**	**28 Day FDS2**	**62 Day GP: Full breaches***	**62 Day GP: Half breaches****	**62 Day Screening**	**31 Day ≥73 Days**	**≥104 days AND >24 at CCC**
1	99	39	138	H&N	LUHFT	Radical RT	Patient requested thinking time regarding treatment.	No						Y			Y
2	39	41	80	Lung	SORM	Pall TKI	Patient required a second biopsy for EGFR after referral to CCC as 1st sample inadequate, there was also a Medical delay as patient was admitted to CCCL with tumour related condition that required medication.	No						Y			
3	50	32	82	LGI	COC	Pall Chemo	Patient required further staging test after referral to CCC to rule out metastatic disease and further discussion in MDT was needed before treatment could commence.	No						Y			
4	106	34	140	UGI	WHH / LUHFT	Radical RT/ Chemo	Patient requested thinking time, and treatment was deferred for one week due to deranged bloods.	No						Y			Y
5	41	30	71	Sarcoma	LUHFT	Curative RT	Complex Sarcoma patient needed peer review due to this being a new complicated technique for sarcoma patients. This technique requires 3 computer plans.	No						Y			

									Internal Targets		National Standards					Long Waiters	
Patient	**Day into CCC**	**Days at CCC / to Diagnosis (28DFDS)**	**Treated on Day**	**Tumour**	**Referring Trust**	**Treatment**	**Reason**	**Avoidable Breach**	**7 Day**	**24 Days (treated within 62 days)**	**2 Week Wait**	**28 Day FDS2**	**62 Day GP: Full breaches***	**62 Day GP: Half breaches****	**62 Day Screening**	**31 Day ≥73 Days**	**≥104 days AND >24 at CCC**
6	74	57	131	Skin	LUHFT	Pal Immuno	Patient requested thinking time and a second opinion at Christies before starting treatment.	No						Y			Y

*Full breach to CCC: Patient received by CCC before day 38, but not treated within 24 days
**Half breach to CCC: Patient received by CCC after day 38 and not treated within 24 days

3.1.2 Cancer Waiting Times Standards: Cheshire and Merseyside Performance

Cheshire and Merseyside Performance

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Feb-21	YTD 2020/21	Last 12 Months
Executive Director Lead: Liz Bishop, CMCA SRO						
C/S	**2 week wait** from GP referral to 1st appointment		93%	93.5%	88.8%	M A M J J A S O N D J F
C/S	**28 day** faster diagnosis - (Referral to diagnosis)		75% (shadow monitoring)	75.7%	74.5%	M A M J J A S O N D J F
C/S	**62 Day** wait from GP referral to treatment		85%	71.6%	76.1%	M A M J J A S O N D J F

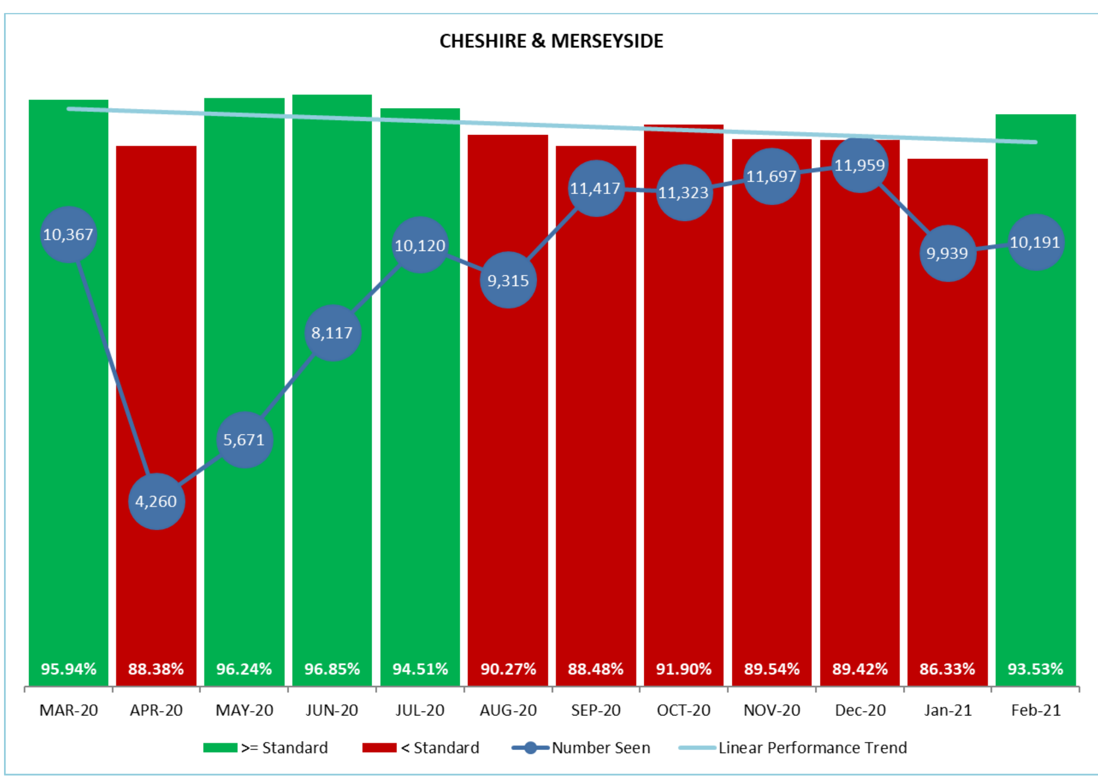
Notes:
Blue arrows are included for KPIs with no formal target and show the movement from last month's figure.

This section focusses on the last 12 month's performance for Cheshire and Merseyside as a whole, against the standards of 2 Week Wait, 28 day Faster Diagnosis Standard (FDS) and 62 Day wait from GP Referral to Treatment. The latest available data for this wider regional performance is February 2021.

The difference between the figures in this C&M section and the following national section is due to the timing of the reports being run.

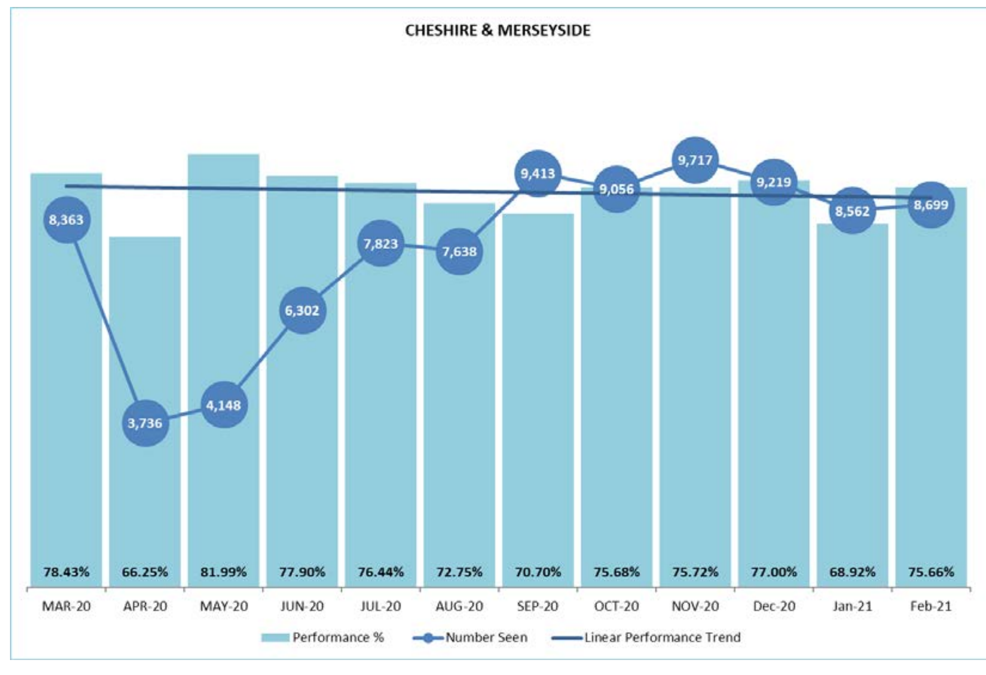
2 Week Wait

This chart shows the performance by month for Cheshire and Mersey and states the numbers of patients seen each month in the blue circles. The 93% target has been achieved in February 2021, at 93.5%.



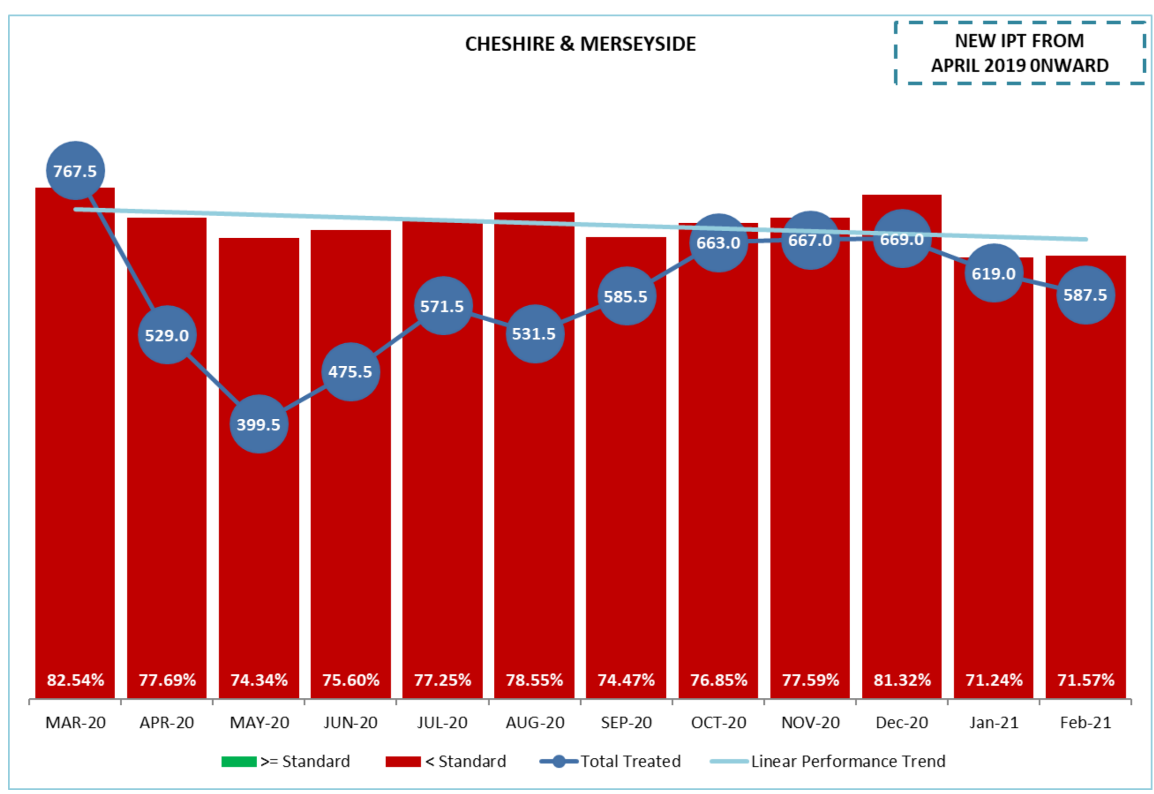
28 day Faster Diagnosis Standard (FDS)

This chart shows the performance by month in Cheshire and Mersey, with a trend line and states the numbers of patients seen each month in the blue circles. There is no RAG rating, as this standard is not subject to formal monitoring until Q3 2021/22, with the target confirmed as 75%. This has been achieved in February 2021, at 75.7%.



62 Day wait from GP Referral to treatment

This chart shows the performance by month in Cheshire and Mersey, with a trend line and states the numbers of patients seen each month in the blue circles. The 85% target has not been achieved in the last 12 months. Performance in February 2021 is 71.6%.

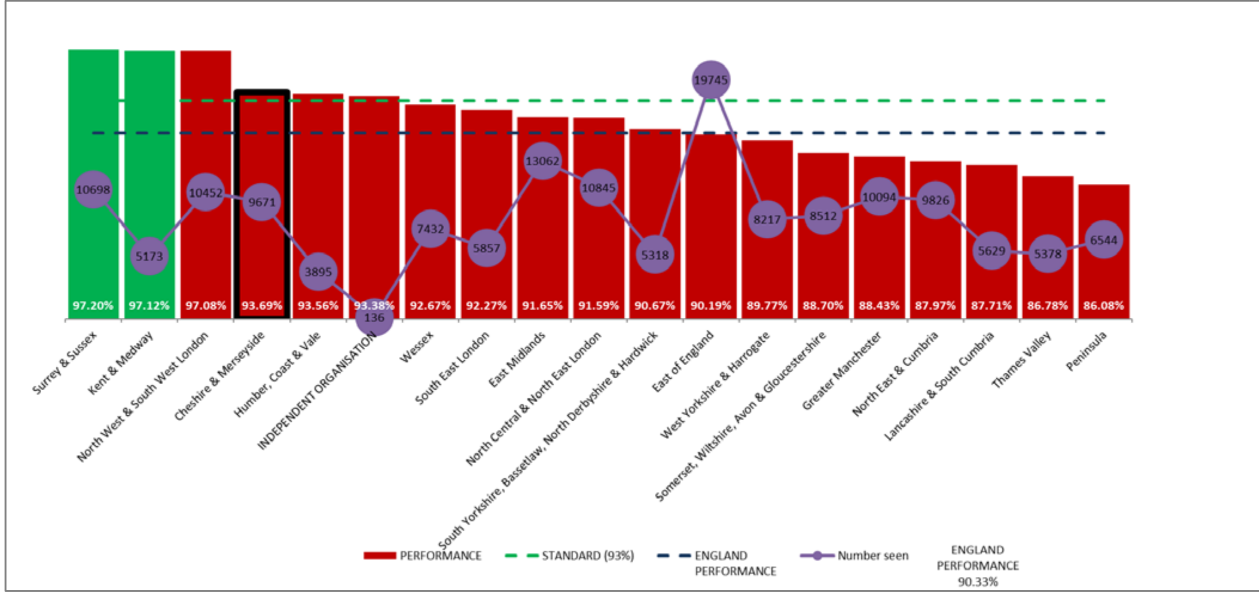


3.1.3 Cancer Waiting Times Standards: National Performance

This section focusses on National performance by Cancer Alliance, against the standards of 2 week wait and 62 Day wait from GP Referral to treatment. The latest available data for this national performance is February 2021. National data is not yet available for the 28 Day FDS as this is not yet subject to formal monitoring.

Two week wait

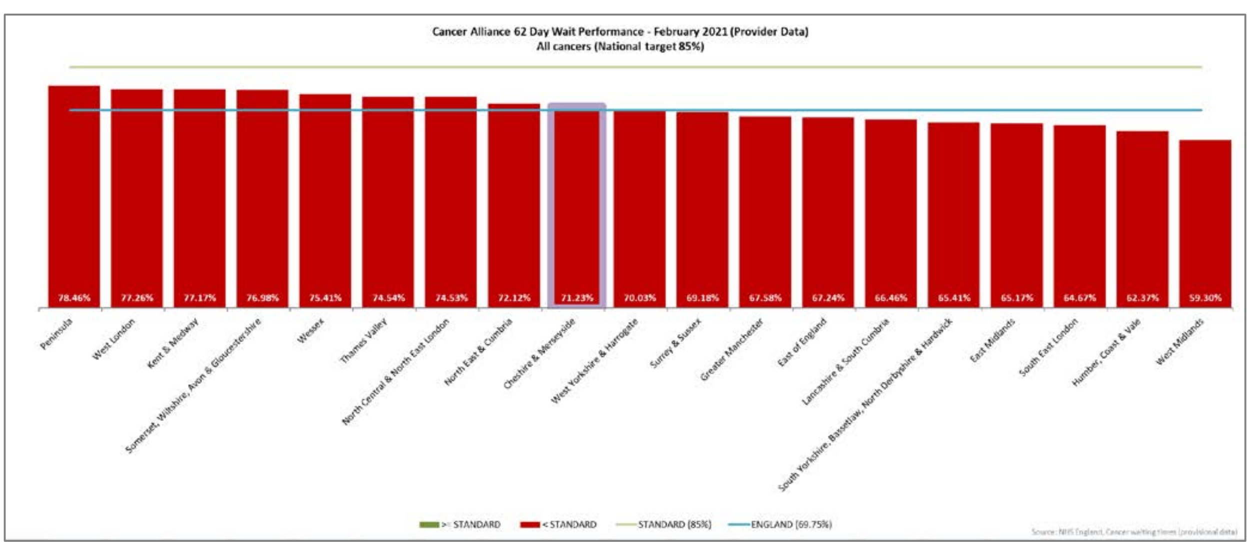
This chart shows the performance by Cancer Alliance for February 2021. Cheshire and Merseyside were the 4th best performing Alliance in February 2021 with 93.7% (up from 86.9%, and with an improved position, from 7th in January). The figure for England for February 2021, of 90.33%, is shown by the dashed blue line.



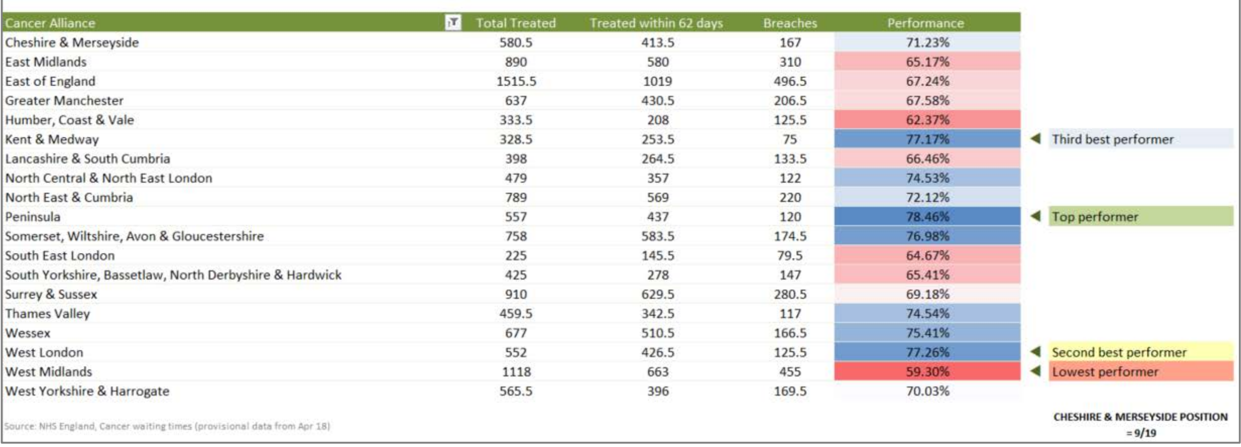
Source: NHS England, Cancer waiting times (provisional data)

62 Day wait from GP Referral to treatment

This chart shows the performance by Cancer Alliance for February 2021. Cheshire and Merseyside rose from 10th in January 2021, to 9th best performing Alliance in February 2021 with 71.23% (despite a marginal decrease from 71.36% in January 2021). The figure for England for February 2021, of 69.75%, is shown by the dashed blue line.



This table shows the same data as in the chart above, by Alliance (A-Z), including numbers of patients treated within and outside of the 62 days and the numbers of breaches.



Cancer Alliance	Total Treated	Treated within 62 days	Breaches	Performance	
Cheshire & Merseyside	580.5	413.5	167	71.23%	
East Midlands	890	580	310	65.17%	
East of England	1515.5	1019	496.5	67.24%	
Greater Manchester	637	430.5	206.5	67.58%	
Humber, Coast & Vale	333.5	208	125.5	62.37%	
Kent & Medway	328.5	253.5	75	77.17%	◄ Third best performer
Lancashire & South Cumbria	398	264.5	133.5	66.46%	
North Central & North East London	479	357	122	74.53%	
North East & Cumbria	789	569	220	72.12%	
Peninsula	557	437	120	78.46%	◄ Top performer
Somerset, Wiltshire, Avon & Gloucestershire	758	583.5	174.5	76.98%	
South East London	225	145.5	79.5	64.67%	
South Yorkshire, Bassetlaw, North Derbyshire & Hardwick	425	278	147	65.41%	
Surrey & Sussex	910	629.5	280.5	69.18%	
Thames Valley	459.5	342.5	117	74.54%	
Wessex	677	510.5	166.5	75.41%	
West London	552	426.5	125.5	77.26%	◄ Second best performer
West Midlands	1118	663	455	59.30%	◄ Lowest performer
West Yorkshire & Harrogate	565.5	396	169.5	70.03%	

Source: NHS England, Cancer waiting times (provisional data from Apr 18)

CHESHIRE & MERSEYSIDE POSITION = 9/19

3.2 Efficiency

3.2.1 Inpatient Flow

Bed Occupancy:

Bed occupancy for March continues to be below the Trust's target of 92% for both solid tumour Wards, with similar occupancy to February 2021.

Ward 5 also continues to be below Trust target of 80% at 78.5% for March, although has increased from last month (73.6%), reflecting the rise in the number of transplant patients.

Ward 4 bed occupancy is above target for the second consecutive month at 93.7%.

During March, there was 1 occasion in which the Trust was at OPEL 3 (Red) bed status. There were 7 occasions when Solid tumour wards were at OPEL 3 (Red) and 13 occasions when Haemato-oncology wards were at OPEL 3 (Red).

The daily bed status was mainly recorded as OPEL 1 (Green). The escalation beds on Ward 3 were not required to be used this month.

The CUR tool used to measure appropriate utilisation of beds; non-qualifying rate for March was 2% indicating an appropriate use of beds. This currently measures the utilisation for solid tumour wards only, however this is to be adopted across all inpatients wards in 2021/22.

The inpatient wards continue to allow capacity for 86 beds. Day case ascitic drains continue to take place on Wards 2 and 3. A task and finish group has been set up to review this care pathway and determine in which bed base these patients are best placed. The Teenage and Young Adult unit opened on the 12th April 2021.

There are currently 6 closed beds on Ward 3, 4 of which have been designated as 'escalation beds' to accommodate winter pressures and mutual aid during the Covid-19 pandemic. During the month of March, these beds were not required to be used. Bed pressures across our local DGHs are easing with the Covid-19 pandemic levelling and no requests have been made for solid tumour wards to accept mutual aid patients.

Length of Stay (LoS)

Solid Tumour Wards:

This chart shows the elective and non-elective LoS for Solid Tumour Wards against the targets.

The trust target for ST Wards' non-elective LoS is 8 days. Non-elective LoS for March 2021 is below the target at 7.9 days.

The trust target for ST Wards' elective LoS is 6.5 days. Elective LoS for March 2021 is below target at 6.4 days.

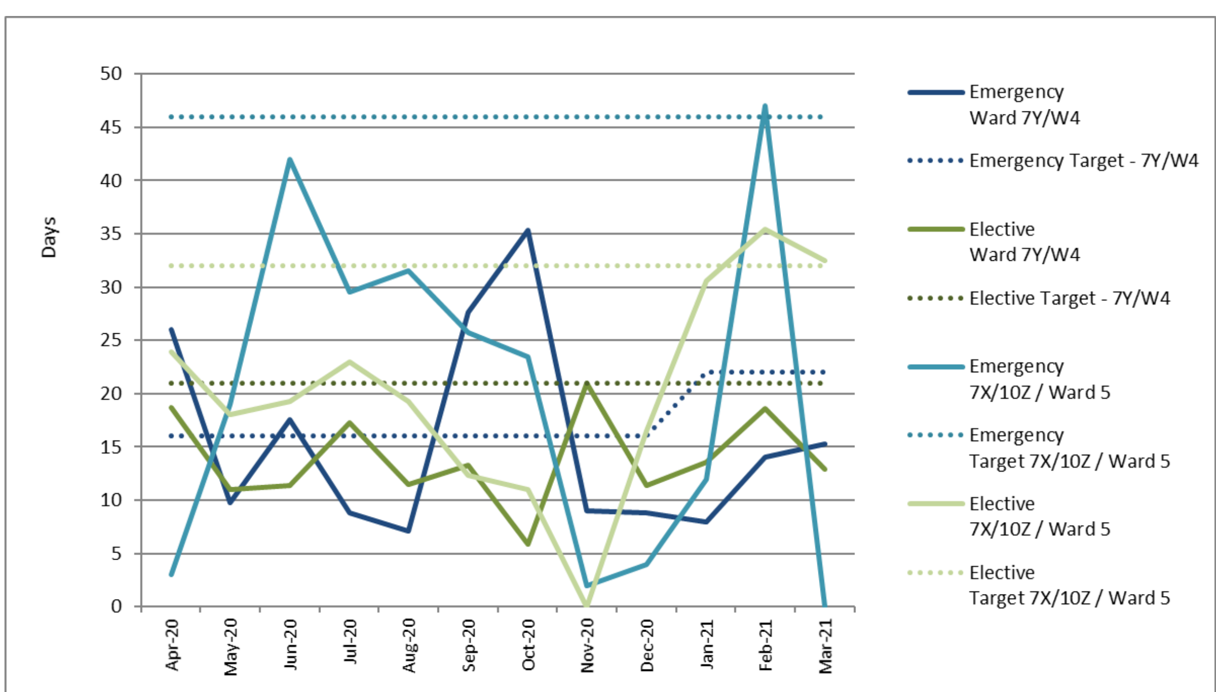
There were 7 DTOC (delayed transfers of care) this month, a reduction on last month. All delays involved Solid Tumour patients. The number of DTOC days is also fewer at 18 days in March compared with 38 days in February. The average length of DTOC for solid tumour patients was 3 days, with one patient waiting 4 days whilst the family prepared for downstairs living at home.

The delays were due to:

- Patients awaiting hospice placement
- 1 Patient awaiting preparation for downstairs living at home
- 1 Patient awaiting on Intermediate Care Bed
- Patients awaiting Continual Healthcare funded Package of Care at home

HO Wards:

This chart shows the elective and non-elective LoS for HO Wards against the targets.



All LoS targets were achieved in March 2021 except on Ward 5 which was marginally over target at 32.5 days.

This high average LoS is due to the acuity of 2 patients.

- One patient was unwell with a long recovery time from Cycle 1
- One patient remained as an inpatient for 4 Cycles. This patient was an inpatient from November 2020 and sadly died in March 2021.

No DTOCs were recorded on HO Wards in March 2021, indicating appropriate bed utilisation.

In a drive to reduce LoS, the Acute Care Division continue to progress with the AML and autologous ambulatory project.

Preparation for the roll-out of CUR to HO Wards is underway, with confirmation of the software licence awaited and training being planned to facilitate an effective roll-out.

Work is under way to introduce MDT meetings on the HO wards to ensure all CCC patients are receiving the same level of support with Discharge Planning.

3.2.2 Radiology Reporting

This table displays the reporting turnaround times for inpatients and outpatients by month.

		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend
Imaging reporting turnaround: inpatients within 24 hours	G: =>90%, A: 80-89%, R: <80%	89.7%	99.5%	96.7%	91.4%	95.0%	92.9%	97.9%	96.1%	95.2%	100.0%	97.7%	98.0%	
Imaging reporting turnaround: out patients within 7 days		95%	98%	98.1%	98.0%	91.5%	87.7%	93.2%	96.9%	91.7%	96.5%	93.0%	86.6%	

With the exception of September 2020 (out-patients 87.7%) and now March 2021 (out-patients 86.6%), the inpatient and outpatient targets for reporting turnaround have been met each month in 2020/21.

Despite a new radiologist starting with us in February 2021; we have failed to meet our out-patient reporting turnaround times this month. Annual leave, increased activity, a developing IR service and ultrasound service support may have contributed to this.

An additional radiologist was recruited in December 2019, though they will not commence in post until later this year. The delay is due to Covid-19 and the inability for the candidate to travel to complete an essential examination. The candidate travelled to the UK for the January exam which was unfortunately cancelled due to lockdown measures. The candidate is due to take the exam in June 2021.

Radiologist Interviews are planned for the 6th May. We have shortlisted 2 high calibre and suitably qualified candidates for the vacant post.

We are supporting a new post for a Clinical Fellow in Oncology Imaging. This post will be going out to advert in May.

This increase in Radiologist support will ensure our reporting turnaround times are more robust.

3.2.3 Patients receiving treatment closer to home

CCC delivers Systemic Anti-Cancer Treatment (SACT) therapies across the sector hub model to provide access to treatment closer to home. The Networked Services Division consistently achieves the target. Data for the last 12 months is displayed in the table below:

	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Patients travelling 45 minutes or fewer to their clinic appointment.	90%	96%	96%	96%	97%	97%	97%	97%	97%	98%	98%	98%	98%

3.2.4 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. An online Covid-19 recovery activity dashboard is in development (replacing these reports), to enable real time access to activity including referrals and will be available in April 2021.

Elective Admissions

The percentage comparison with the previous year's activity has risen significantly from February 2021 (121%) to March 2021 (133%) and remains above the Covid-19 'Phase Three Guidance' target of 90%. The actual number of elective admissions has increased from 91 in February 2021 to 113 in March 2021.

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

There has been an increase in Solid Tumour (ST) elective admissions from 64 patients in February, to 74 in March and an increase in HO elective admissions from 27 in February to 39 in March. In ST, the increase is in line with normal recovery. In HO, the increase is due to elective admissions being reinstated following the controlled measures implemented following a Covid-19 infection and the transfer of Teenage and Young Adult activity from ST to HO. Work continues to schedule patients to the most appropriate department to support flow across the trust.

Day Case

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

- Day Cases as % of Previous Year (CCC): 50.6% (improved on Feb 21 at 45%)
- Day Cases as % of Previous Year (HO): 68.3% (improved on Feb 21 at 53%)
- Day Cases as % of Previous Year (ST): 29.1% (improved on Feb 21 at 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 178 in February 2021 to 151 in March 2021 and ST day case activity has fluctuated over recent months and is at 53 for March 21. 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 (although this is starting to increase) 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 now reviewed 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 has been developed, with progress is being monitored via 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, ranging from 110% to 124%. New appointments in March 2021 continued to show an increase in recovery with 124% of March 2020 activity levels recorded. 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 phase of recovery will focus on maintenance of balance between F2F and remote consultation within OPD. Remote appointments for March reported as 66%, remaining static from the previous month.

SRG recovery principles have been developed and continue to guide recovery planning back out to local service provision where possible. SRGs are being supported operationally by designated Divisional Business Managers, who work with 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):

- 855 Liverpool patients
    - 653 discharged in full and 202 discharged to PDOA
- 136 Isle of Man patients (up to 31/03/21)
- 489 Wirral patients, of which number of patients discharged to PDOA =
    - 5 year follow up = 68
    - 7 year follow up = 21
    - 10 year follow up = 8

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

- 364 Wirral patients
- 198 Liverpool patients
- 40 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

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

Referrals

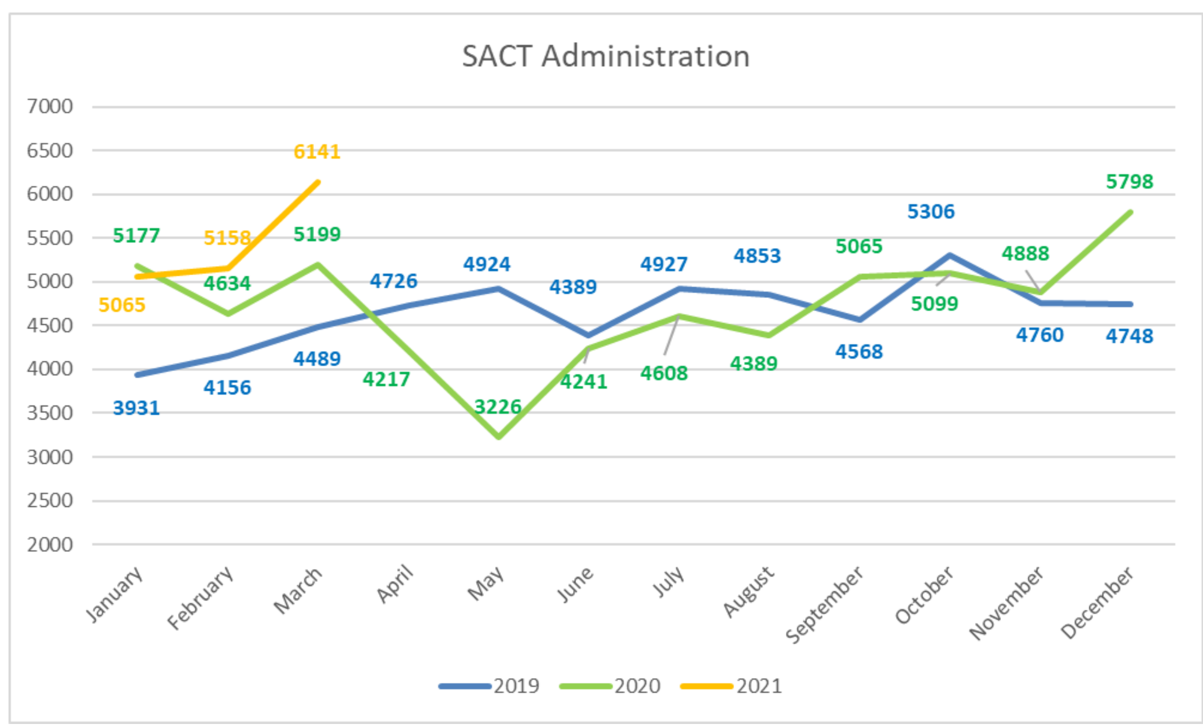
Referrals for March 2021 are at 94% (1029 referrals) of the March 2020 total (1092 referrals).

Endoscopy activity continues to rise and the Trust is starting to see more patients presenting with late stage disease. Based on diagnostic and surgical activity in the wider system, there is likely to be a 15-20% increase in referrals to CCC in late May and early June. SRGs are developing 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 5158 in February 2021 to 6141 in March 2021. This is 118% of March 2020 activity and the highest activity of any month since April 2019.



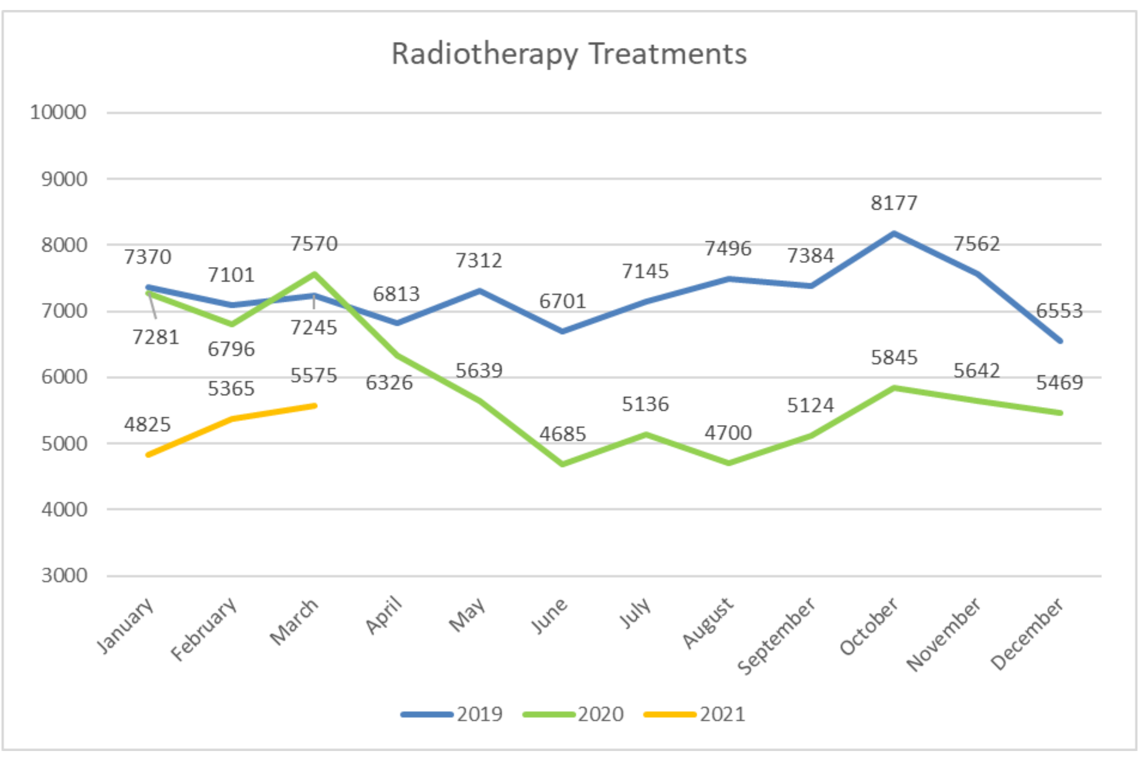
The activity has grown as NHSE NICE Covid-19 guidance has driven the replacement of shorter term classical chemotherapy with longer term treatments such as immuno-oncology. In addition, future activity trends may continue to identify spikes in oral SACT delivery due to multiple cycles of treatments being dispensed within a month, with fewer attendances but the same number of patients in these treatment groups.

The Networked Services Division will continue to focus on recovery planning to support the cancer backlog. The CMCA data on wider system activity will inform the plans.

The pharmacy production unit reduced production capacity from the 11th 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

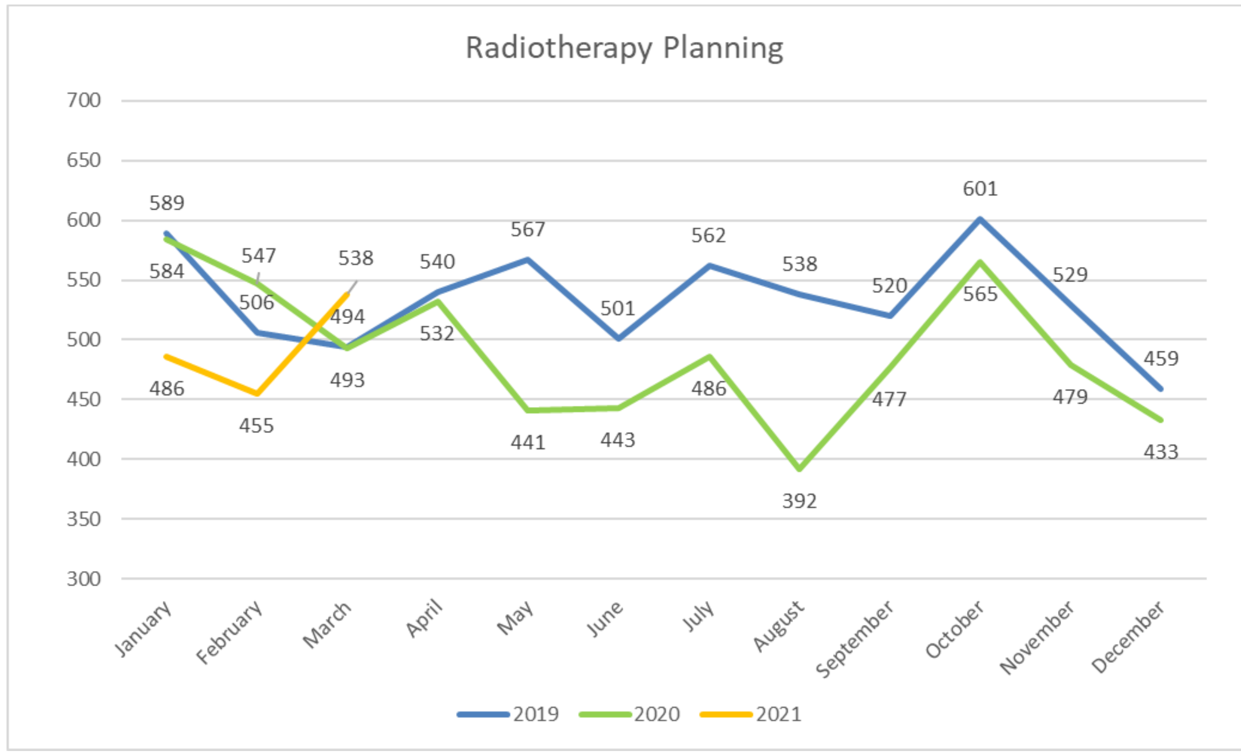
This chart compares the number of patients receiving radiotherapy treatment in 2019, 2020 and 2021.



Activity remains lower each month than in 2019. Total treatments have risen from 5365 in February 2021, to 5575 in March 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. March 2021 activity is 18% higher than February 2021 at 538. This is the second highest monthly activity in 2020/21, only lower than October 2020 at 565.



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 2020/21 so far:

- December 220 average number of fractions / day
- January 208 average number of fractions / day
- February 260 average number of fraction / day
- March 230 average number of fraction / day

This table shows the utilisation across the 3 sites in Q4 2020/21.

CCC Site	**Utilisation**		
	Jan 21	**Feb 21**	**March 21**
CCC Liverpool	69.2%.	79.4%	74.2%
CCC Wirral *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*	80.85%	74.2%	65.5%
CCC Aintree	56%	75.8	60.3%

Further discussions will be held with SRGs 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 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 the previous years' CT activity has been achieved, with 229% in March 2021, the highest during 2020/21.

The Phase Three Covid-19 Guidance target of 100% of the previous years' MRI activity has been achieved, with 152% in March 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 last year, with 231% of March 2020 activity in March 2021.

This is due to:

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

Stem Cell Transplants

In March 2021, 11 patients were discharged following a stem cell transplant against a target of 9 patients per month. This is the first month in which the target has been met in 2020/21. In 2020/2, 64 patients were discharged against a target of 92.

The recovery of activity to plan was expected by November 2020, however due to the second wave of Covid-19 and the impact of SARS-CoV-2 on donors and patients, a number of planned admissions have had to be delayed and or cancelled. Some transplants have been deferred through patient choice due to their fear of having a transplant in the midst of a second wave.

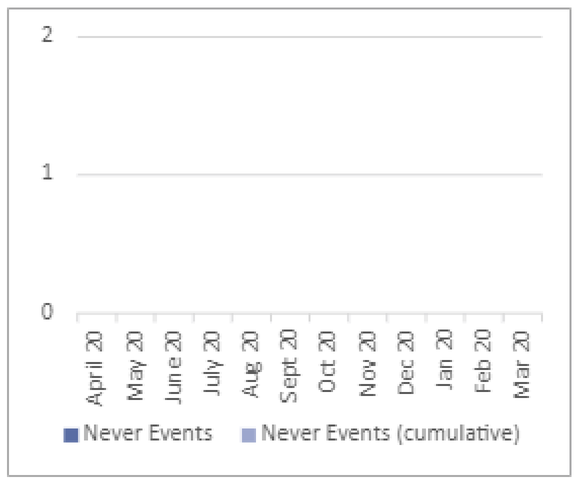
Patients are continually reviewed at weekly transplant MDT meetings, patients who have deferred through choice have been counselled regarding the risks and benefits and the team have risk assessed them as having disease stable enough to allow this, or the availability of an alternative treatment path.

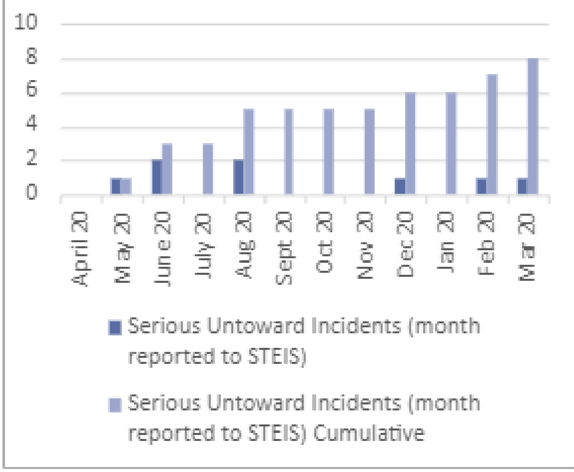
3.3 Quality

This section provides an overview of performance and associated actions in the following areas:

- Incidents
- Health Care Acquired Infections
- Inpatient Assessments
- Harm Free Care
- Complaints
- Patient Experience

Incidents





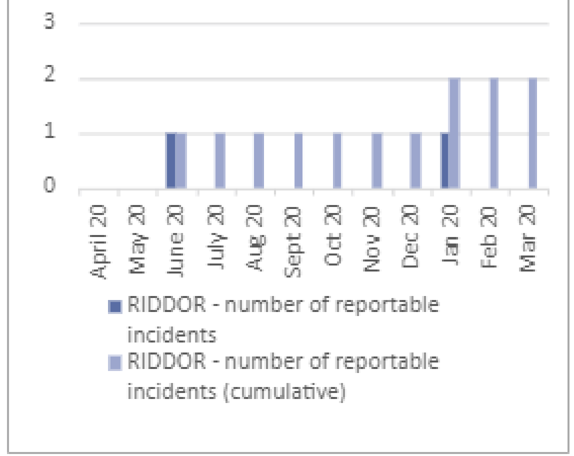
Q4 2020/21:

Never Events, SUI, RIDDOR and IRMER targets are 0.

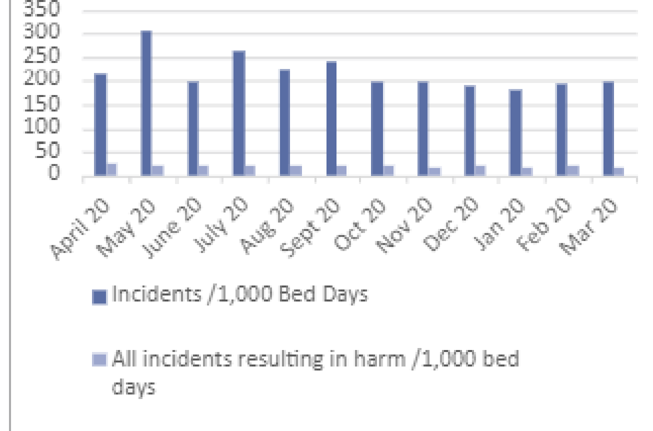
IRMER reportable incidents = 3 in Q4. 2 under criteria of 3 or more images taken in 1 session and 1 under criteria of 1.2 or more times the intended dose in 1 session - No harm to any patient. London Protocol investigations undertaken for 2/3 that demonstrated procedural errors. Actions include investigation of more proactive QA, clarification of responsibilities in fault situations and review of processes and checks for whole CNS treatments

There was 1 RIDDOR reportable incident in Q4

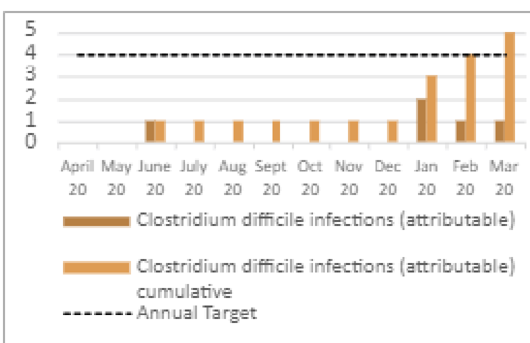
There were 2 SUIs in Q4. These are under review.

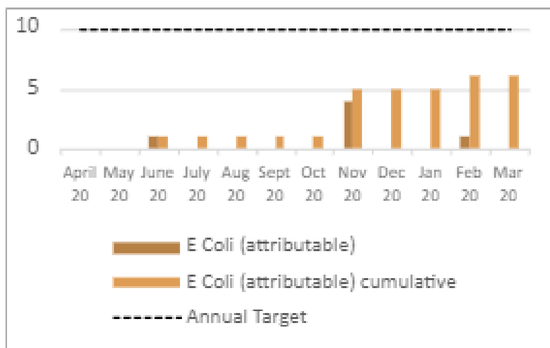


12
10
8
6
4
2
0
April 20
May 20
June 20
July 20
Aug 20
Sept 20
Oct 20
Nov 20
Dec 20
Jan 20
Feb 20
Mar 20
IRMER - number of reportable incidents
IRMER - number of reportable incidents (cumulative)



Health Care Acquired Infections





Q4 2020/21:

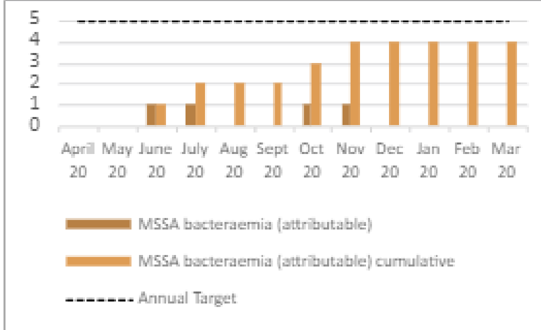
MRSA and Covid 19 targets are 0.

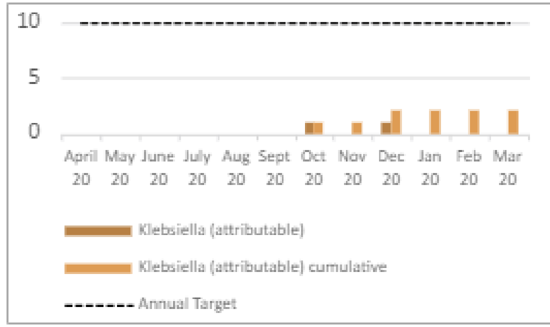
The annual targets have been met for E-coli, MRSA, Klebsiella, Pseudomonas. There were no MRSA, Klebsiella or Pseudomonas infections in Q4.

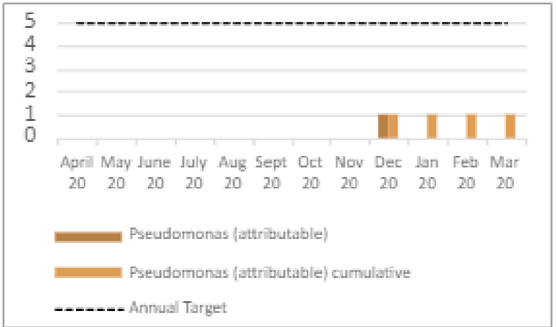
There were 2 healthcare associated Covid-19 infections in 2020/21. One patient was known to leave the ward to see family members, the other was a likely acquisition from an appointment at LUHFT.

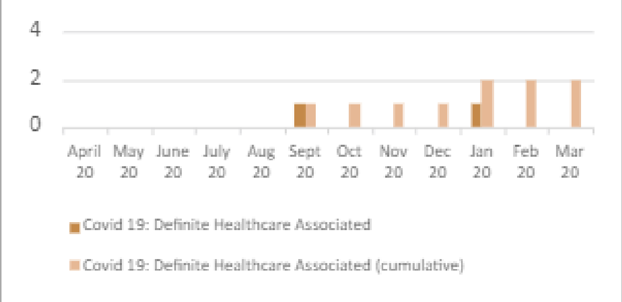
There were 5 C diff infections in 2020/21, 1 more than the annual target of 4. 4 of the 5 were in Q4.
Post infection reviews (PIR) identified 2 key themes:
- Lack of documentation detailing patients' baseline bowel patterns.
- Prescribing of anti-microbial therapy outside of Trust formulary.

The IPC Team have implemented the use of Bristol Stool Chart for all in-patients to ensure prompt identification of loose stools. Compliance with this will be audited by the IPC Team.
Whilst anti-microbial prescribing was outside of Trust Formulary and may have contributed to the development of C.diff infection, as each prescription was reviewed and approved by Medical Microbiology it is unlikely that the infection could have been avoided.

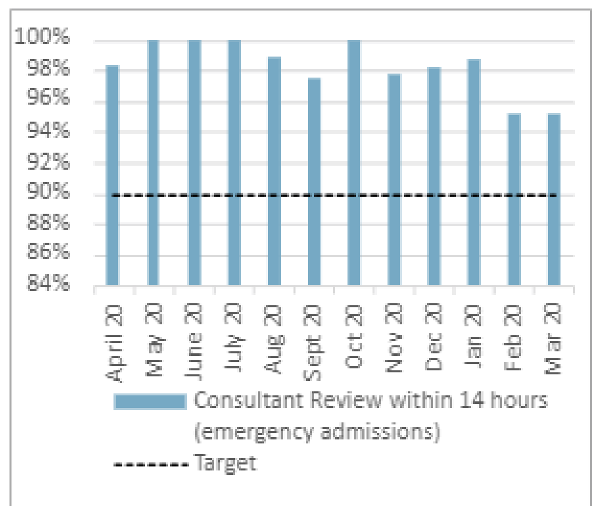


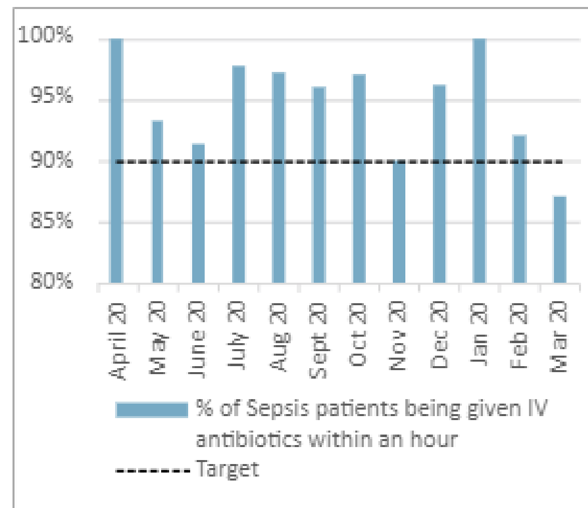


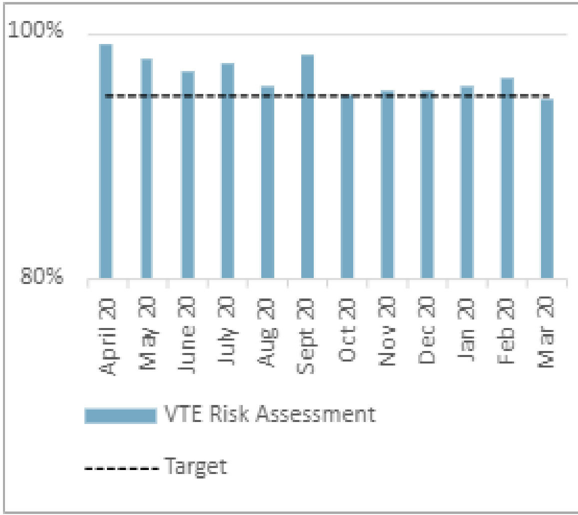


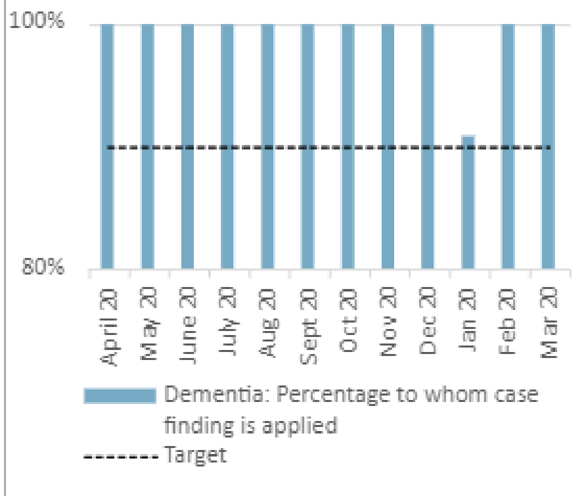


Inpatient Assessments









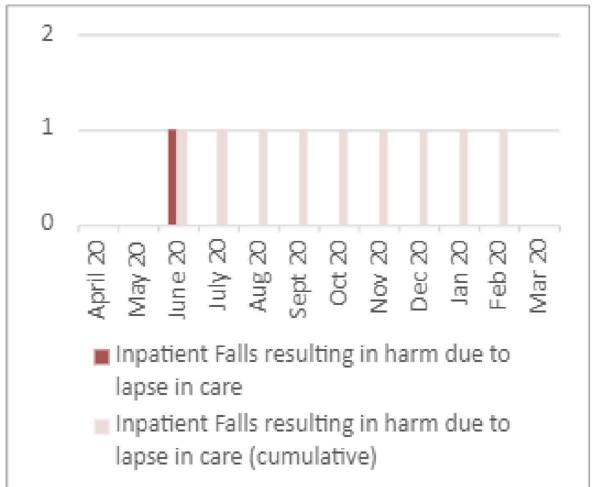
Q4 2020/21:

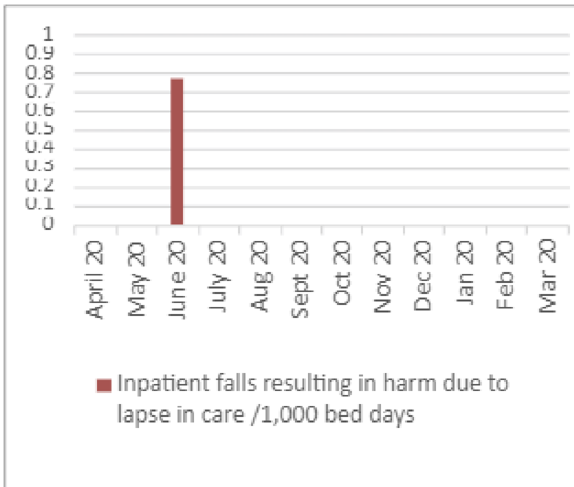
All targets for inpatient assessments have been achieved in 2020/21 except for % of sepsis patients being given IV antibiotics within an hour, in March 2021, at 87%.

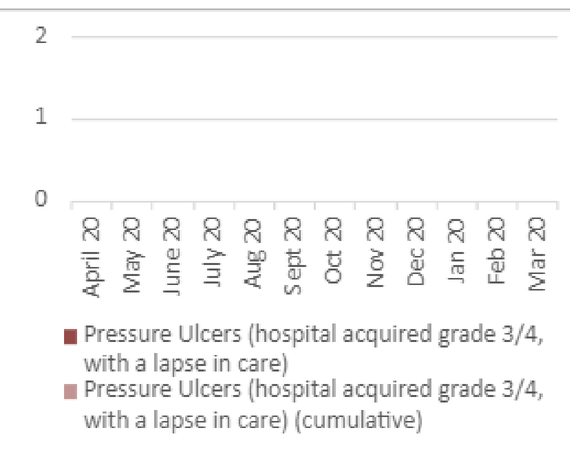
Regarding sepsis, the following actions are in place to maintain and further improve compliance:

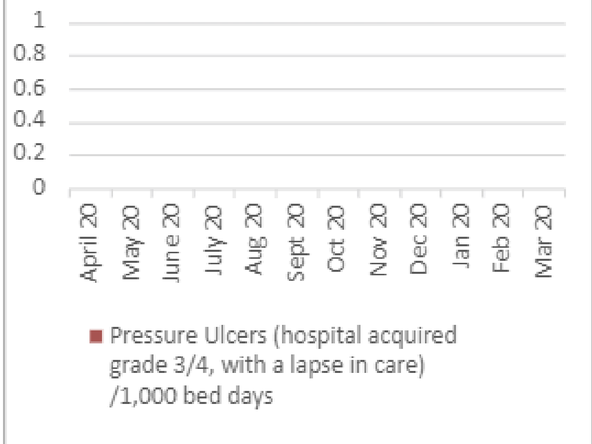
- Education and awareness training for all new started and new doctors
- CDU antibiotic doses to all be on meditech rather than paper script
- MIAA audit of the sepsis audit process Jan 2021
- Process of reviewing incidents via DPSG introduced, discussing lessons learned, 72 hour reviews and LIRG if required.
- Working group established to review sepsis pathway and areas of non-compliance. Reminders regarding timely review have been sent out to Nursing and Medical staff.
- Identification of individual staff that remains non-compliant with sepsis documentation- - further training and support offered. Compliance surveillance carried out via Meditech.
- ACT communications and sepsis awareness – especially importance of screening tool.
- New discharge letter documentation to highlight sepsis during admission – to aid coding.

Harm Free Care









Q4 2020/21:

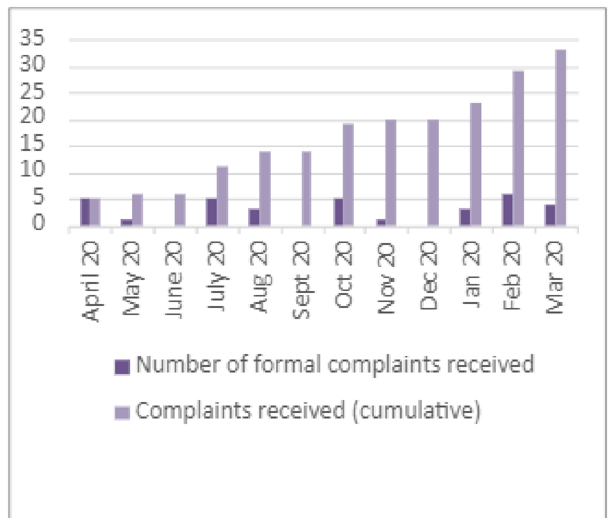
All Targets are 0

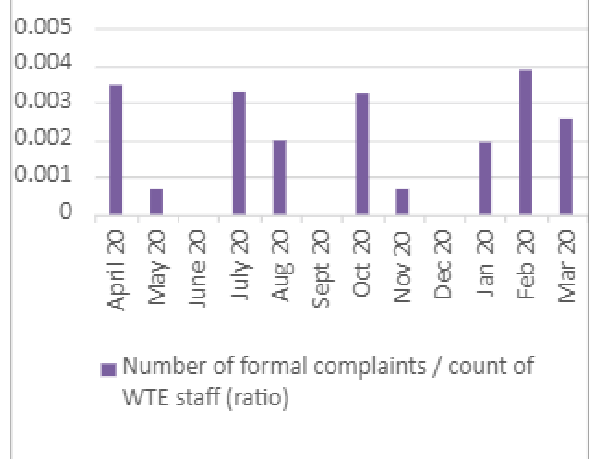
Pressure Ulcers: There have been no hospital aquired category 3 or 4 pressure ulcers with a lapse in care reported in 2020/21.

Falls: There have been no in patient falls that have resulted in harm due to a laspe in care reported for Q4. Ongoing programme of quality improvement and support for falls and pressure ulcers across all in patient services

Year to date, there has been 1 fall resulting in harm due to a lapse in care. Lessons learnt have been disseminated and additional ramblegard sensors purchased and implemented across all inpatient wards. To strengthen patient safety processes, lower level beds with under bed night lights, have been transfered from CCCW to CCCL which offer additional support to patients identified as a falls risk.

Complaints





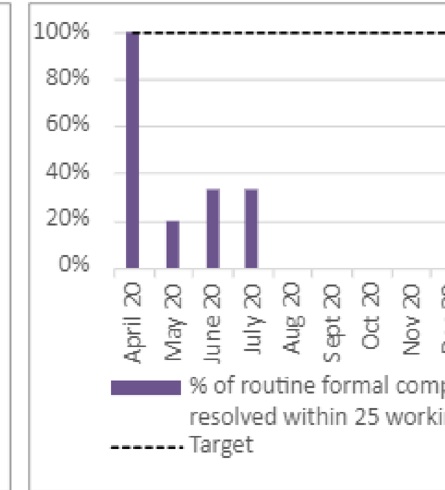
Q4 2020/21:

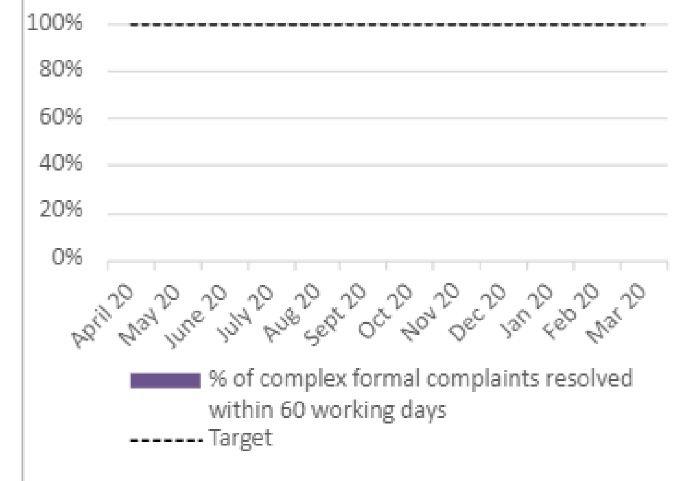
13 formal complaints were recieved in Q4, with 3 complaints closed in the quarter. No complaints were received in June, September and December.

The target for responding within 25 working days was met in 1 month of Q4. There was 1 formal complex complaint in 2020/21, this was resolved in March 2021; this was not within the 60 day target.

The complaints process task and finish group has reviewed the process, formal complaints training was provided by the Trust and the approval and sign off process was amended in order to streamine the process. These interventions have begun to deliver an improvement in the speed of resolving complaints, which will deliver improved compliance against the KPIs in 2021/22.

100%
80%
60%
40%
20%
0%
April 20
May 20
June 20
July 20
Aug 20
Sept 20
Oct 20
Nov 20
Dec 20
Jan 20
Feb 20
Mar 20
% of formal complaints acknowledged within 3 working days
Target





Patient Experience: Q4 2020/21 Update

Friends & Family Test (FFT)

The new FFT SMS Text reminder is now fully embedded, this has enabled a centrally managed data collation system and process that is completely paper free and digitally accessible from a number of sources, including patients own devices, CCC tablets on carts, inpatient TV system and will be available very soon to be available on the Trust website. Trusts have not been required to report this during Covid-19 however the results will be included in the 2021/22 IPR 'Quality' scorecard.

Key FFT headlines include;

- Despite continuing COVID-19 measures and operational pressures, the FFT survey uptake and sample size is now significant (with 4448 surveys completed in 2 months).
- During this 2 month period, the majority of participants, 95.5% rated their experience of care at CCC as Very Good or Good.
- Thematic analysis has shown that Environment, Staff Attitude and Implementation of Care should be commended and celebrated.
- The outpatient clinics based at the Countess of Chester NHSFT, Level 1 Day case and Wards 4 and 5 Teams based at CCC Liverpool received 100% positive sentiment responses and the patient free text comments also reflected the hard work and outstanding care provided
- The 2.24% of patients who rated their experience as poor or very poor along with the themes identified (Staffing levels and Outpatient waiting times) and locations will be addressed and monitored by the Divisional Quality and Safety action plans led by the Matrons and Clinical Governance leads, providing regular updates to PEIG.

National Cancer Patient Experience Survey (NCPES)

NHS England and Improvement has made the decision not to run the National Cancer Patient Experience Survey in 2020, however NHS Trusts were invited to opt in to participate on a voluntary basis with the Clatterbridge Cancer Centre opting to participate voluntarily in the survey for 2020/21. We have worked closely with the NHS England and Improvement Insights and Picker teams and the survey is now underway, closing on 18th June 2021.

Adult Inpatient Survey

This survey is now in progress and due to close in May 2021.

Key Patient Experience activity in Q4

January 2021:

- The Patient Experience Improvement Framework was launched at PEIG with Patient Participation Group sessions scheduled throughout February and March 2021 and facilitated by the NHS England and Improvement, Experience of Care Lead (Provider).
- The PLACE lite report and action plan was submitted to IGC.
- Cheshire and Merseyside Cancer Alliance Acute Oncology Patient & Professional Experience work stream started work on a regional patient survey.
- Divisional Governance leads received further training on the Envoy system (FFT Text) to support the new Divisional structure to provide divisional FFT reports and associated action plans which will be presented by Matrons at future PEIG meetings.

February 2021:

- First meeting of Cancer Specialist Heads of Patient Experience (HoPE) Network took place with colleagues from the Royal Marsden to share best practice and lessons learned. Established as monthly meetings and the Christie will join at March's meeting
- Patient Experience narrative to Trust Board – Research patient
- Volunteer Coordinator recruited
- Volunteer roles expansion to include supporting Pharmacy with Chemotherapy logistics and transport to hub sites
- CDU pilot led by Dr Anna Olsson-Brown and Junior Doctors to use Visionable App on mobile tablets when having care planning conversations with patients to include family/carer virtually at the patient bedside
- Always Events Launched
- Initial meeting with North West Veterans Covenant Healthcare Alliance (VCHA) lead

March 2021:

- Perfect Ward patient experience 'audit' created to commence on Patient Experience ward rounds
- Art Funding agreed for 2021/22 Arts Work Plan
- NICE Guidance 150: Supporting Adult Carers and assessment Task and Finish Group established to complete assessment by the 21st April
- Cheshire and Merseyside Cancer Alliance Patient Survey first draft available for patient partners to review
- Volunteers now support Level M1 OPD at CCC-Liverpool on busy clinic days to ensure regular communication with patients waiting for their appointments and cleaning of seats between waiting patients
- Helping Hand pilot commence on Ward 2 with housekeeper and Ward Volunteers

3.4 Research and Innovation

3.4.1 Achievements

- Top recruiter for the AREG study (Association between tumour amphiregulin, epiregulin and epidermal growth factor receptor (EGFR) expression and response to anti-EGFR agents in colorectal cancer. (Principal Investigator: Dr A Montazeri, Colorectal).

- Dr David Cobben, Clinical Oncologist, has been appointed as the new Cancer Sub-specialty Lead in Radiotherapy for the NIHR CRN North West Coast.

- The first research patient was treated within the Trust's Interventional Radiology Service for a deep lesion injection. This was part of the Replimune 2 ECMC study. (Principal Investigator: Dr Sacco, Liver)

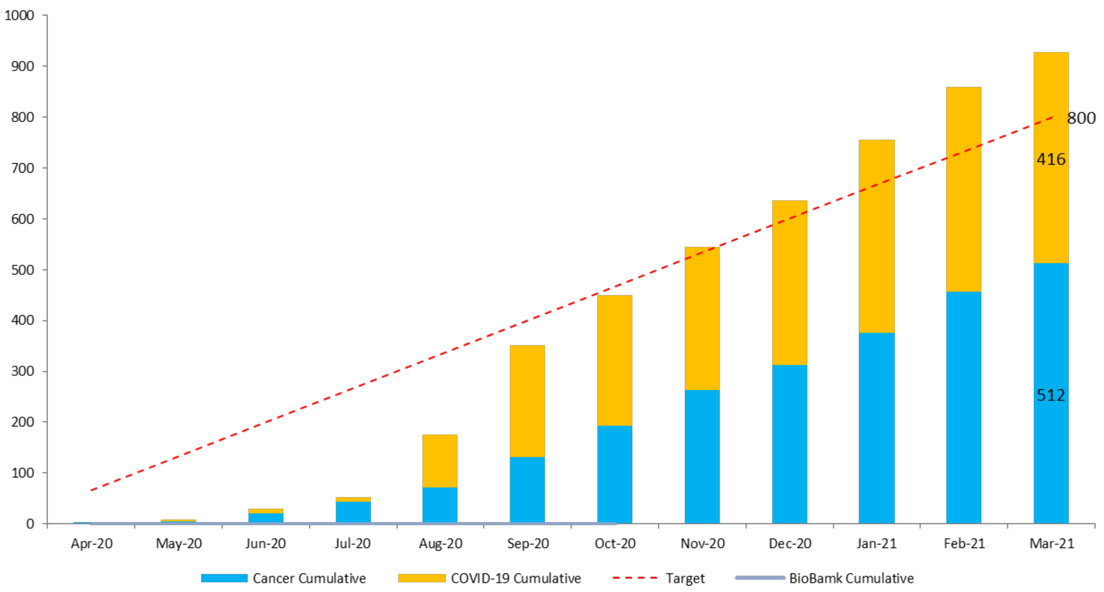
3.4.2 Monthly Recruitment

We have met the internal target (n=800) for recruitment onto cancer and COVID-19 studies. Currently we have recruited 929 patients which is 16.1% above target at Month 12. We have also supported a further 105 COVID-19 patient's data through audit and service evaluation giving a total of 1033 patients supported this year.

The internal target was set at 80% of the 2019/20 target. This is due to multiple reasons:

- Unable to recruit to cancer studies during April and the majority of May 2020.
- Biobank recruitment halted at the start of the pandemic in March 2020. Currently awaiting ethics review, as soon as this is received we will start recruitment again.
- Trials are being unpaused but this has taken time while trying to balance capacity, patient need and sponsor requirements. Currently we are 85.9% unpaused meaning not all studies are open to recruitment yet and there is also a period of screening which needs to be accounted for while trials resume.

We are currently addressing some issues with the Aseptic Pharmacy service that are having an impact on the delivery of clinical trials. Whilst the issues are being dealt with, a pause to recruitment to Clinical Trials that require an aseptic service became effective from 5th March 2021. The pause to recruiting to trials that use aseptics will have had an impact on the overall recruitment figure.



Graph 1. - Recruitment Against Time (no 'other activity'): Cumulative recruitment against internal target (n=800). Month on month split between Cancer (total Int&Obs), BioBank, COVID-19 (total UPH&Non-UPH) Cumulative stacked.

The data relating to recruitment can be found in the table below:

	Cancer		CCC BioBank	COVID-19		Other Activity (SE/PICC)
	Interventional	Observational		UPH	Non-UPH	
April	3	0		0	0	54
May	1	1		3	0	28
June	10	5		4	2	
July	18	6		0	0	
August	17	11		94	1	
September	24	35		115	1	
October	20	41		37	0	23
November	35	37		21	2	
December	17	31		5	39	
January	16	48		7	48	
February	20	61		4	20	
March	21	34		0	13	
Total(s)	202	310	N/A	290	126	105
	512			416		
	928					
	1033					

Table 1. – Recruitment breakdown: Cancer (Interventional, Observational), Biobank, COVID-19 (UPH, Non-UPH) and Other Research Activities (Service Evaluation, PICC) from 01/04/2020 to Data cut-off 30/03/2021.

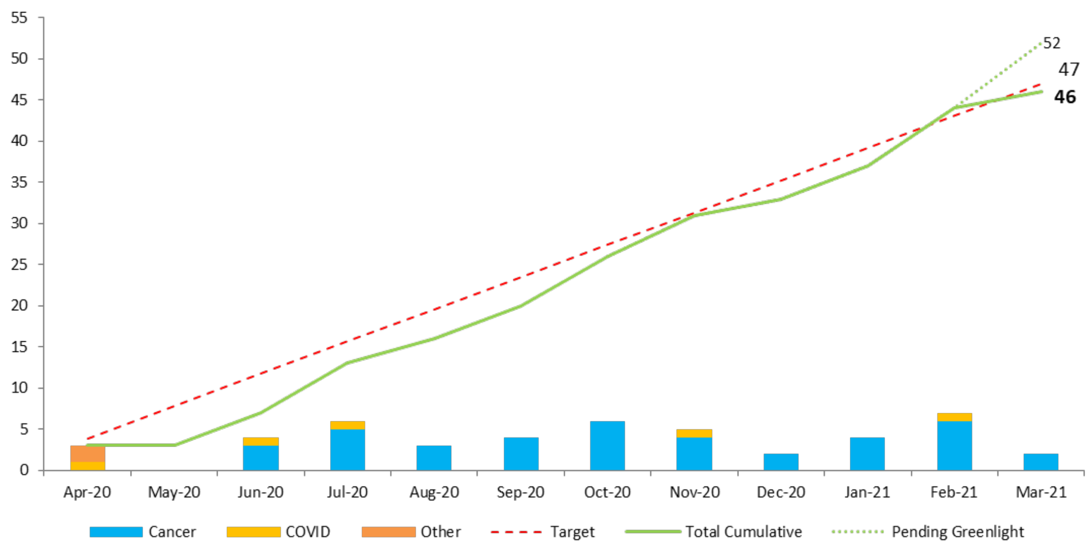
Of the 928 patients recruited onto Cancer and COVID studies, 796 relate to recruitment to portfolio studies and 696 relate to non-commercial portfolio recruitment. This means we will

receive research capability funding (£20k) from the Department of Health this year as we have recruited over 500 patients/ year to non-commercial portfolio studies.

3.4.3 Number of new studies open to recruitment

We have not met the internal target for studies opening to recruitment. Our internal target is forty-seven studies in-line with the number of studies opened in 2019/20. At Month 12 we had opened forty-six studies year to date. We also have eight additional studies which have been given local approval where we are waiting on the Sponsor to give their approval before we can open. It should be noted that no new Cancer studies opened during April and the majority of May 2020.

We are currently addressing issues with the Aseptic Pharmacy service that are having an impact on the delivery of clinical trials. Whilst the issues are being dealt with, a pause to the set-up of Clinical Trials requiring an aseptic service became effective from 5th March 2021. The pause to opening trials using aseptics will have had an impact on the overall figure.



Graph 2. – NEW Studies Opened: Number of studies opened month by month against internal target (n=47) with cumulative total. Split between Cancer (Int&Obs), COVID-19 (UPH&Non-UPH) and Other Activity (SE&PICC).

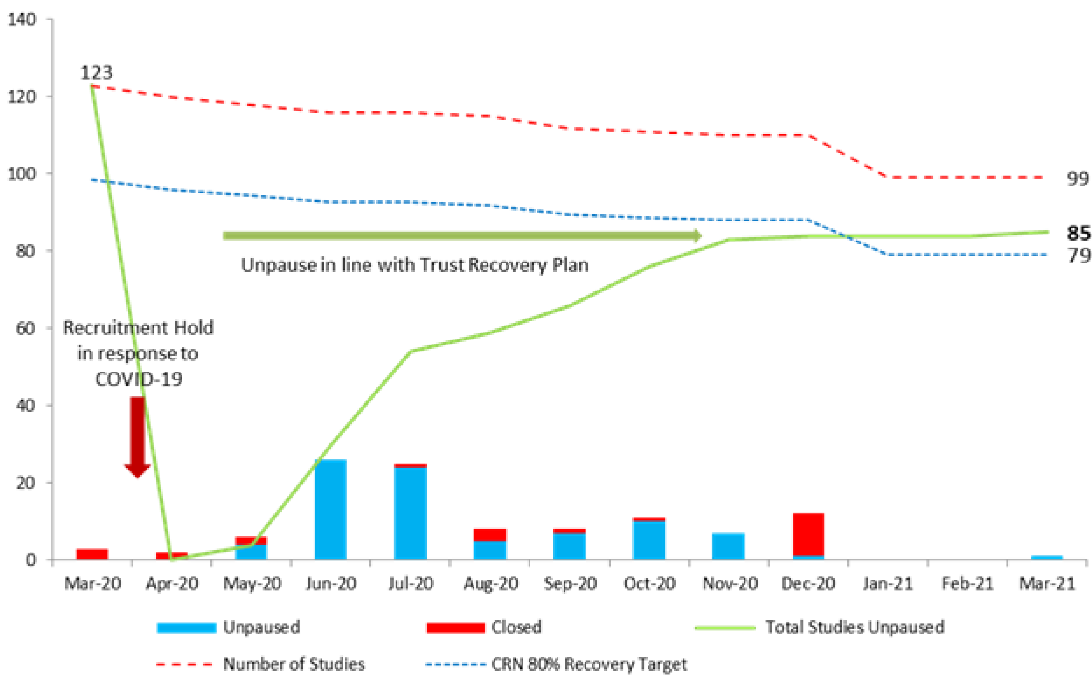
The new studies opened are split as follows:

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Cancer	0	0	**3**	**4**	**3**	**4**	**6**	**4**	**2**	**4**	**6**	**2**
COVID	**1**	0	**1**	**2**	0	0	0	**1**	0	0	**1**	0
Other	**2**	0	0	0	0	0	0	0	0	0	0	0

3.4.4 Recovery

123 actively recruiting studies were paused to recruitment on 17th March 2020. On 22nd May 2020 we unpaused recruitment to all studies and encouraged investigators to open pre-existing and paused studies.

At the end of January 2021, 24 of the original studies have been closed and 84 studies have been unpaused. An external target of 80% of available studies unpaused by End March 2021 has been set by the Clinical Research Network. At month 10 we had surpassed this target. We now have opened 85 studies out of a possible 99 = 85.9%.



Graph 3. – Unpaused Studies: Number of studies reopened/unpaused to recruitment month by month and studies closed by Sponsor each month. Target line reduction as available studies reduce due to closure. 80% CRN recovery target of available studies to reopen.

	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Unpaused	0	0	4	26	24	5	7	10	7	1	0	0	1
Closed	3	2	2	0	1	2	1	1	0	11	0	0	0

3.4.5 Study set-up times

No new set-up time data have been received since the last report to the Quality Committee.

No data for Q4 19/20, Q1 20/21 and Q2 20/21 will be reported as the Department of Health did not publish Trust level data.

Q3 20/21 and Q4 20/21 data are due for submission by 14th May 2021and data are expected later in the year.

3.5 Workforce

3.5.1 Workforce Overview

NB Workforce data will be realigned to enable reporting by Divisions (rather than Directorate) from April 2021 (i.e. May 2021 reports containing April 2021 Data)

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

	2020 / 04	2020 / 05	2020 / 06	2020 / 07	2020 / 08	2020 / 09	2020 / 10	2020 / 11	2020 / 12	2021 / 01	2021 / 02	2021 / 03
Leavers Headcount	21	14	15	14	25	18	15	17	22	23	20	20
Leavers FTE	18.16	13.56	13.04	11.57	20.80	16.06	13.51	14.91	20.26	18.88	18.41	17.73
Starters Headcount	26	41	45	28	20	32	25	29	17	38	24	20
Starters FTE	24.34	36.59	41.39	27.04	19.40	31.23	23.50	26.78	15.16	33.35	21.08	19.76
Maternity	37	38	41	44	49	50	55	54	54	53	52	50
Turnover Rate (Headcount)	1.40%	0.94%	1.00%	0.94%	1.67%	1.20%	1.00%	1.14%	1.47%	1.54%	1.34%	1.34%
Turnover Rate (FTE)	1.33%	0.99%	0.96%	0.85%	1.52%	1.18%	0.99%	1.09%	1.48%	1.38%	1.35%	1.30%
Avg Headcount	1,496.50	1,496.50	1,496.50	1,496.50	1,496.50	1,496.50	1,496.50	1,496.50	1,496.50	1,496.50	1,496.50	1,496.50
Average FTE	1,364.96	1,364.96	1,364.96	1,364.96	1,364.96	1,364.96	1,364.96	1,364.96	1,364.96	1,364.96	1,364.96	1,364.96
Leavers (12m)	222	212	214	210	210	213	217	218	226	227	227	224
Leavers FTE (12m)	197.01	190.36	191.56	188.03	186.87	189.19	192.38	193.53	200.67	198.43	198.91	196.89
Turnover Rate (12m)	15.98%	15.11%	15.08%	14.74%	14.65%	14.62%	14.77%	14.75%	15.22%	15.25%	15.14%	14.92%
Turnover Rate FTE (12m)	15.56%	14.90%	14.83%	14.45%	14.27%	14.22%	14.34%	14.34%	14.81%	14.62%	14.55%	14.37%
Avg Headcount (12m)	1,389.50	1,403.50	1,419.50	1,425.00	1,433.00	1,456.50	1,469.50	1,477.50	1,485.00	1,489.00	1,499.50	1,501.50
Average FTE (12m)	1,265.96	1,277.93	1,291.31	1,301.12	1,309.79	1,330.65	1,341.10	1,349.54	1,354.67	1,357.39	1,366.98	1,369.98

On 31st March 2021 the Trust employed 1575 (1419.52 FTE) staff, the headcount and FTE increased following the addition of 20 (19.76 FTE) new starters and 20 (17.73 FTE) leavers.

Recruitment Data

Recruitment data for March 2021 is detailed below;

Staff Group by Headcount	Bank/Locum	Fixed Term	Permanent	Total
Additional Clinical Services		2	7	9
Add Prof Scientific and Technic		1		1
Aministration and Clerical		4	3	7
Allied Health Professionals				0
Medical and Dental		1		1
Students				0
Nursing			2	2
Total	0	8	12	20

Reasons for Recruitment	Chemotherapy WTE	Corporate Directorate WTE	Haemato-oncology WTE	Integrated Care WTE	Nursing & Quality WTE	Radiation Services WTE	Research Directorate WTE	Cancer Alliance WTE	Grand Total WTE
Maternity Cover			3.00						3.00
Newly Created Post		1.00	1.00	1.00		1.00			4.00
Replacement Post	1.76	2.00	2.00	2.00		1.00	1.00		9.76
Retire & Return									0.00
Secondment Cover		1.00							1.00
Staff Reducing Hours									0.00
Long Term Sickness Cover		2.00							2.00
Student Redeployment									0.00
TOTAL	1.76	6.00	6.00	3.00	0.00	2.00	1.00	0.00	19.76

13 of the 20 new starters are within clinical roles;

- 2 Registered Nurses
- 8 Healthcare Assistants
- 1 Pharmacy Assistant
- 1 Physics Technician
- 1 Speciality Doctor

Other staff groups:

- 7 administration roles (2 x Band 2, 1 x Band 3, 1 x Band 4, 2 x Band 5 and 1 x Band 7)

Workforce Profile

The current workforce profile held in ESR is as follows:

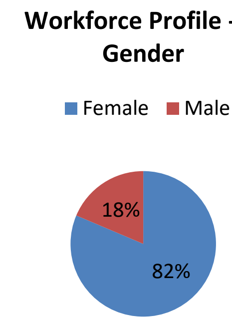
Directorate	FTE
158 Chemotherapy Services Directorate	251.52
158 Corporate Directorate	363.66
158 Haemato-oncology Directorate	131.25
158 Hosted Service Directorate	39.27
158 Integrated Care Directorate	245.71
158 Quality Directorate	16.20
158 Radiation Services Directorate	311.22
158 Research Directorate	58.69
158 Service Improvement Directorate	1.00
158 Support Services Directorate	1.00
Total	**1419.52**

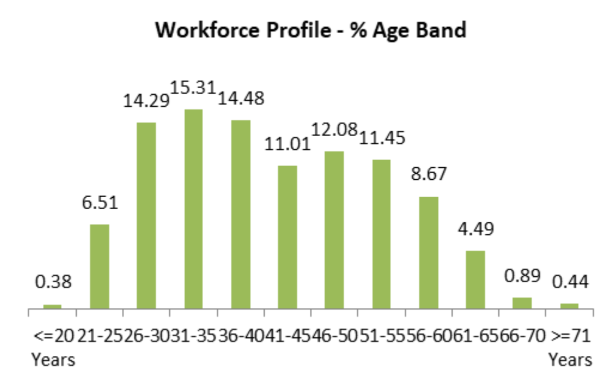
Assignment Category	FTE
Fixed Term Temp	70.17
Non-Exec Director/Chair	7.00
Permanent	1342.35
Total	**1419.52**

Staff Group	FTE
Add Prof Scientific and Technic	85.49
Additional Clinical Services	182.57
Administrative and Clerical	472.90
Allied Health Professionals	206.63
Healthcare Scientists	37.75
Medical and Dental	75.93
Nursing and Midwifery Registered	353.45
Students	4.80
Total	**1419.52**

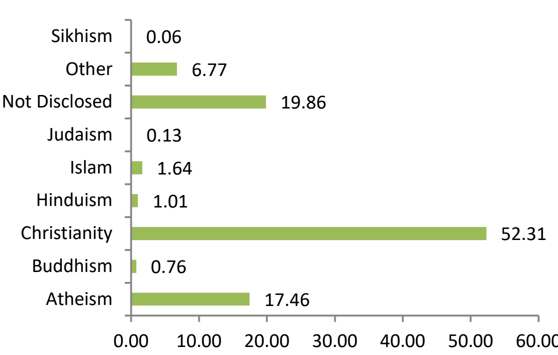
Assignment Status	FTE
Acting Up	9.45
Active Assignment	1330.66
Career Break	4.68
Internal Secondment	22.80
Maternity & Adoption	45.93
Out on External Secondment - Paid	3.00
Out on External Secondment - Unpaid	1.00
Suspend No Pay	2.00
Total	**1419.52**

3.5.2 Workforce EDI Profile

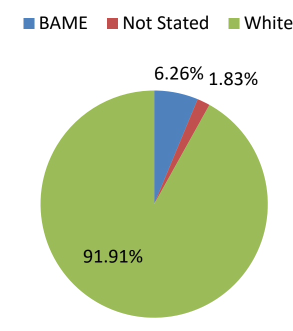


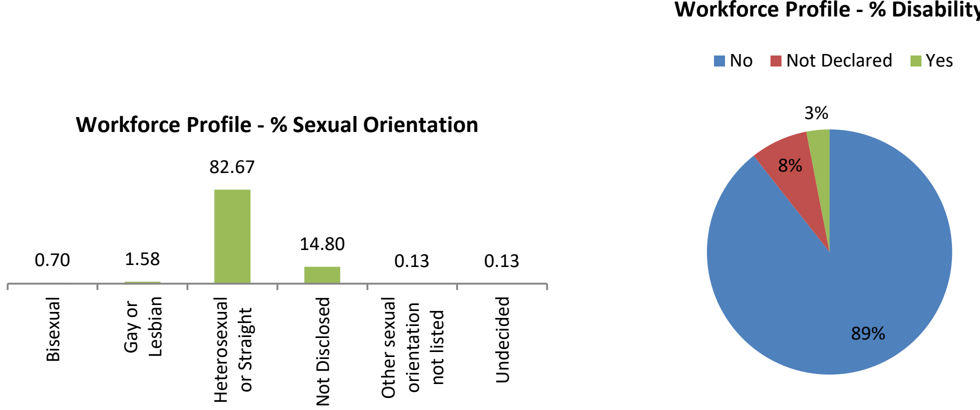


Workforce Profile - % Religious Belief



Workforce Profile - % Ethnic Group

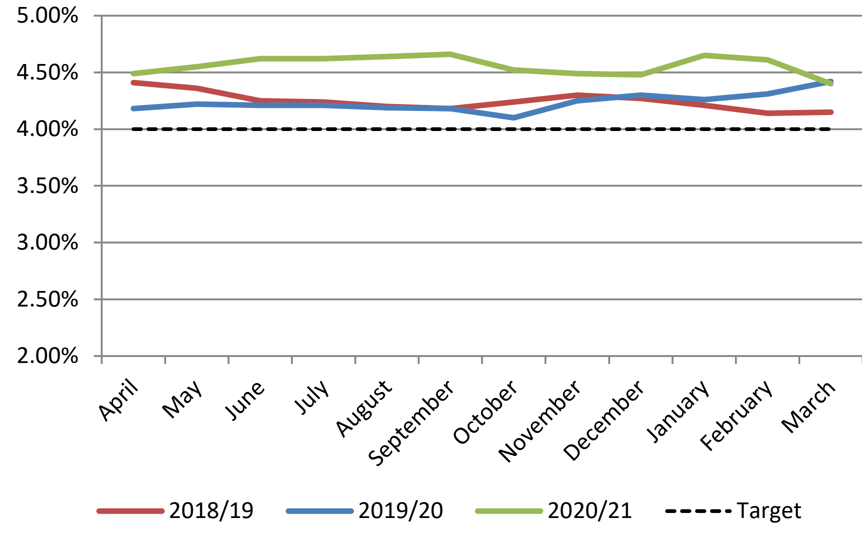




3.5.3 Sickness Absence

The Trust's absence target is 4%. The 12 month rolling sickness absence % for March 2021 has decreased slightly to 4.40% this is now lower than 2019/20 but higher than the figure for 2018/19. The sickness in month sickness absence % for March 2021 was 3.25% which is within the Trust target and the lowest in month absence % since June 2018 (3.16%).

To enable the Trust to track progress against the KPI and identify trends, sickness absence figures are calculated on a rolling 12-month basis. Year to date figures only provide a snapshot of activity within a specific time period (e.g. the absence % in August will only take into account data from April – August) whilst 12 month rolling data provides a more holistic overview of the data providing more valuable insight into absence patterns and supports Trust management decisions in relation to workforce planning.



Directorate / Corporate Service Level Sickness Absence:

Sickness absence per month and Directorate:

Directorate	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend
158 Chemotherapy Services Directorate	7.74%	6.63%	6.02%	6.57%	5.87%	5.22%	4.09%	5.07%	5.63%	10.10%	6.41%	4.51%	
158 Corporate Directorate	4.25%	4.27%	4.16%	3.09%	3.65%	4.03%	3.41%	3.73%	3.60%	4.33%	3.01%	2.88%	
158 Haemato-oncology Directorate	6.61%	5.14%	4.39%	3.78%	3.28%	5.22%	5.03%	3.38%	4.22%	8.45%	4.52%	3.47%	
158 Hosted Service Directorate	0.98%	5.65%	7.78%	3.06%	0.00%	0.00%	0.34%	6.89%	6.81%	6.16%	2.41%	2.78%	
158 Integrated Care Directorate	2.90%	2.66%	3.61%	4.44%	5.32%	6.40%	6.04%	7.48%	4.54%	7.37%	5.08%	3.99%	
158 Quality Directorate	3.30%	3.80%	11.10%	8.20%	5.15%	5.39%	8.67%	5.17%	5.57%	10.21%	3.95%	13.46%	
158 Radiation Services Directorate	4.83%	3.04%	2.76%	3.51%	2.86%	2.74%	3.08%	2.71%	2.99%	4.39%	2.79%	1.94%	
158 Research Directorate	8.45%	1.96%	2.18%	1.90%	2.76%	7.38%	2.07%	2.98%	1.85%	6.25%	5.14%	1.16%	

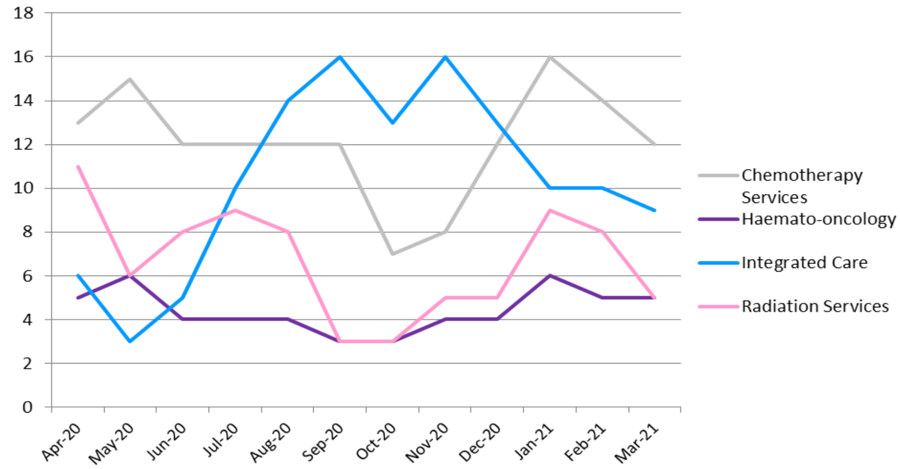
Long / short term sickness absence:

This table displays total Trust short and long term sickness absence, per month.

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend
Short term	148	104	106	123	102	153	138	163	150	279	117	99	
Long term	60	58	64	54	57	55	65	71	76	74	68	48	

Both long and short term absences decreased significantly in March and are both at their lowest levels for the 12 month period.

The following chart shows long term sickness by Directorate, over a rolling 12 months:



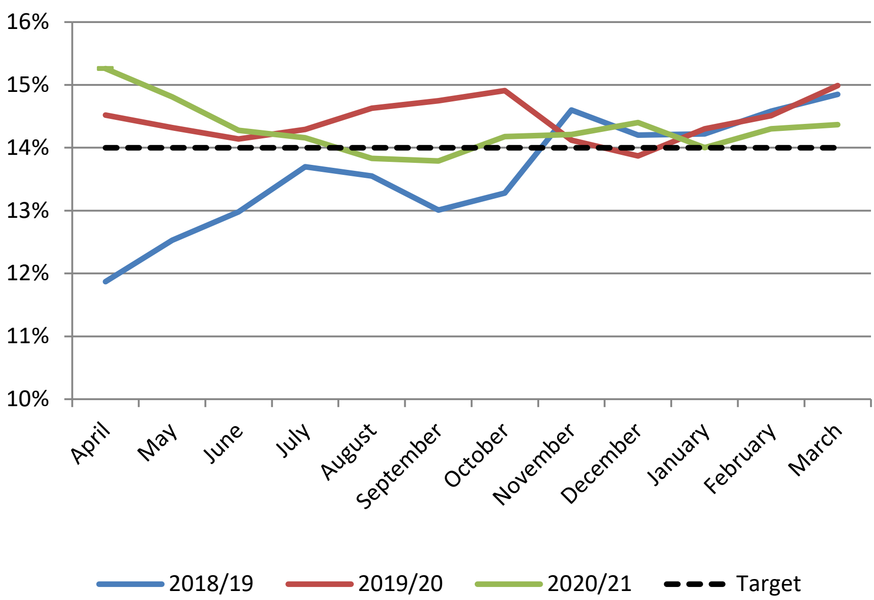
The top three reasons for sickness absence, with the number of episodes for each are shown below:

	Absence Reason	Number of Episodes
1	Anxiety/Stress/Depression	32
2	Gastrointestinal Problems	26
3	Headache / Migraine	13

3.5.4 Turnover

To enable the Trust to track progress against the KPI and identify trends, turnover figures are calculated on a rolling 12-month basis. Year to date figures only provide a snapshot of activity within a specific time period (e.g. the turnover % in August will only take into account data from April – August) whilst 12 month rolling data provides a more holistic overview of the data providing more valuable insight into turnover patterns and supports Trust management decisions in relation to workforce planning.

The graph below shows the rolling 12 month turnover figures against the Trust target of 14%. This increased in March 2021 to 14.37% from 14.30% the previous month which is above the Trust target however remains lower than previous years.

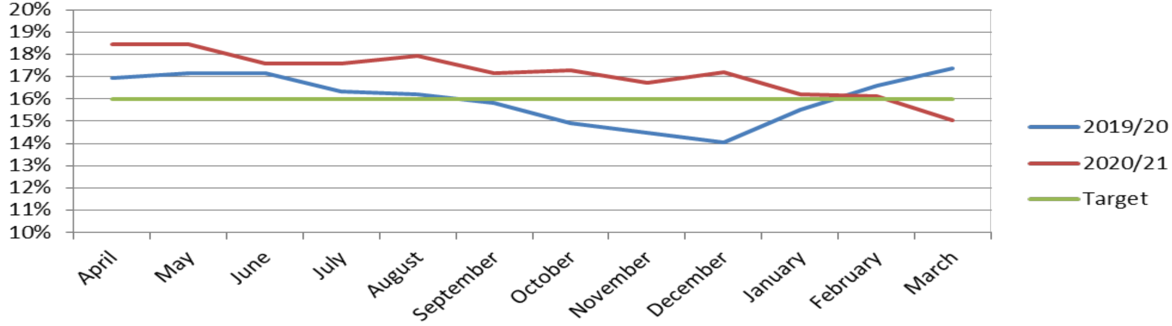


Turnover by Staff Group

The following charts show the stretch targets by staff groups. Recruitment and retention action plans sit underneath these targets.

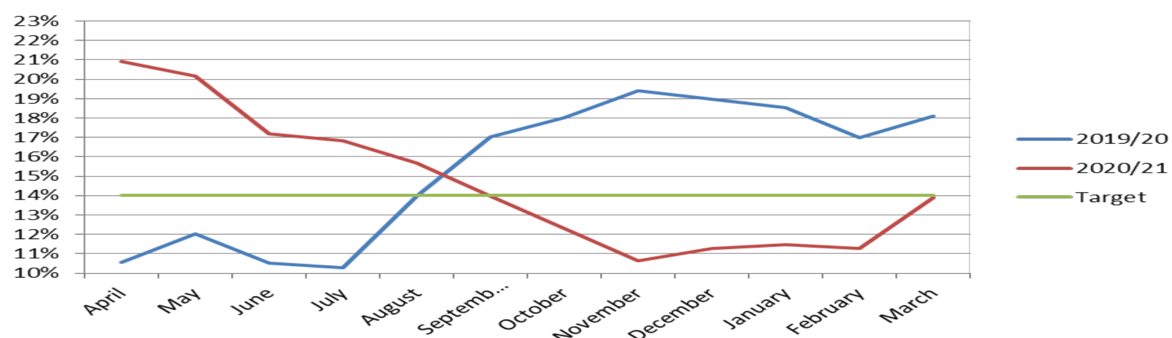
Administrative and Clerical Turnover – Annual Target 16%

The rolling 12 month turnover figure has decreased from 16.12% in February 2021 to 15.04% in March 2021 and is now lower than the same period in 2020. The figures for March equate to 5 leavers (4.20 FTE), the reasons for leaving were 1 Promotion, 1 End of Fixed Term Contract, 1 for Further Education, 1 Voluntary Resignation other, and 1 Better Reward Package



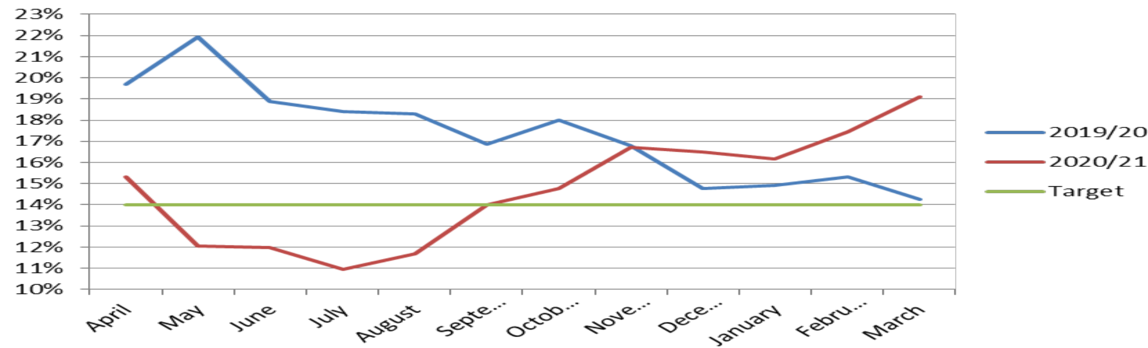
Additional Professional Scientific & Technical Turnover – Annual Target 14%

The rolling 12 month turnover figure has increased from the reported figure of 11.28% in February to 13.90% in March; this is lower than the same period in 2020 and below Trust target. There were 3 Leavers (3.00 FTE) Reasons for leaving were 2 Voluntary Resignation Promotion and 1 End of Fixed Term Contract.



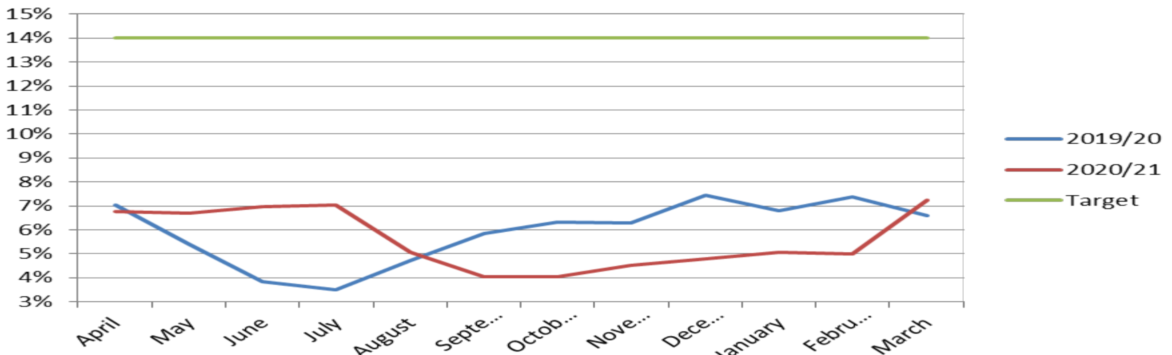
Additional Clinical Services' Turnover – Annual Target 14%

The rolling 12 month turnover figure has increased from 17.45% in February 2021 to 19.10% in March 2021, and is higher than 2020. The figures for March equate to 5 leavers (4.32 FTE), the reasons for leaving were 1 Work Life Balance, I Promotion, 1 Voluntary Resignation for Health Reasons, And 2 Voluntary Resignations Other

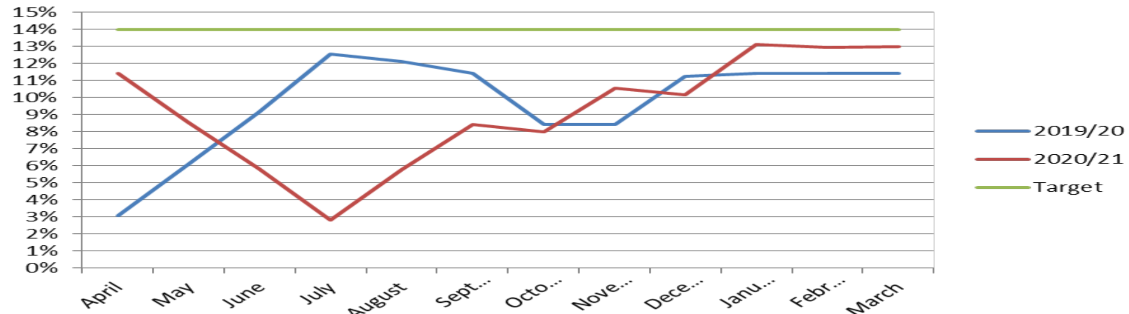


Allied Health Professionals' Turnover – Annual Target 14%

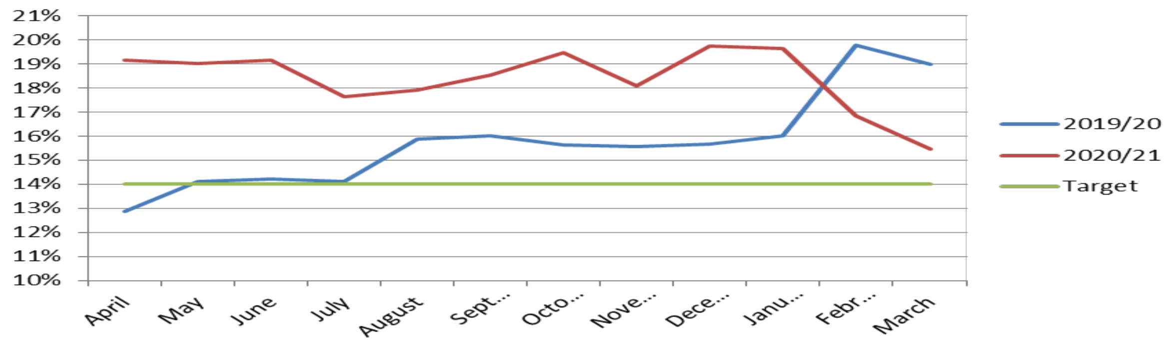
The rolling 12 month turnover figure has increased from 4.98% in February 2021 to 7.25% in March 2021; this is now higher than the same period in 2020. There were 5 (4.60 FTE) leavers in March and the reasons were 4 Promotion and 1 Work Life Balance.



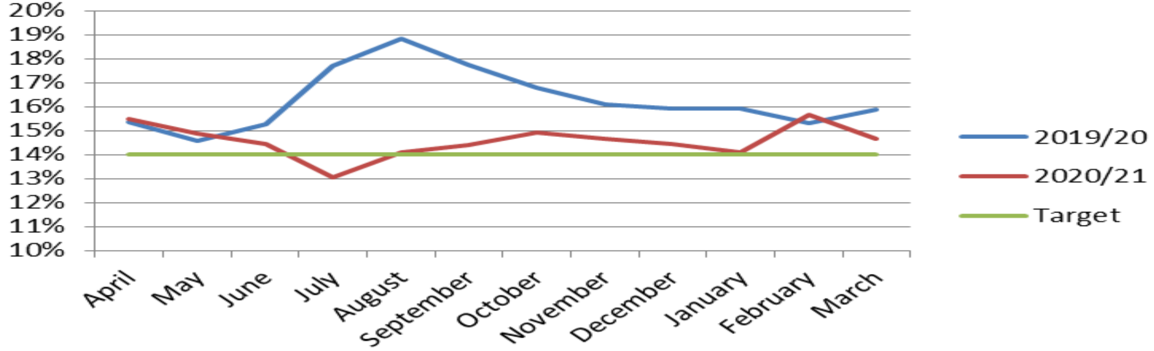
Healthcare Scientists' Turnover – Annual Target 14%
The rolling 12 month turnover figure has increased from 12.95% in February 2021 to 12.98% in March 2021. This is higher than the same period in 2020. There were no leavers for this staff group in March, the variation in % relates to a change in FTE for the 12 month period in which the turnover is measured.



Medical Turnover – Annual Target 14%
The rolling 12 month turnover figure has decreased from 16.83% in February 2021 to 15.45% in March 2021 and is now lower than the same period in 2020. There was no leavers in March.

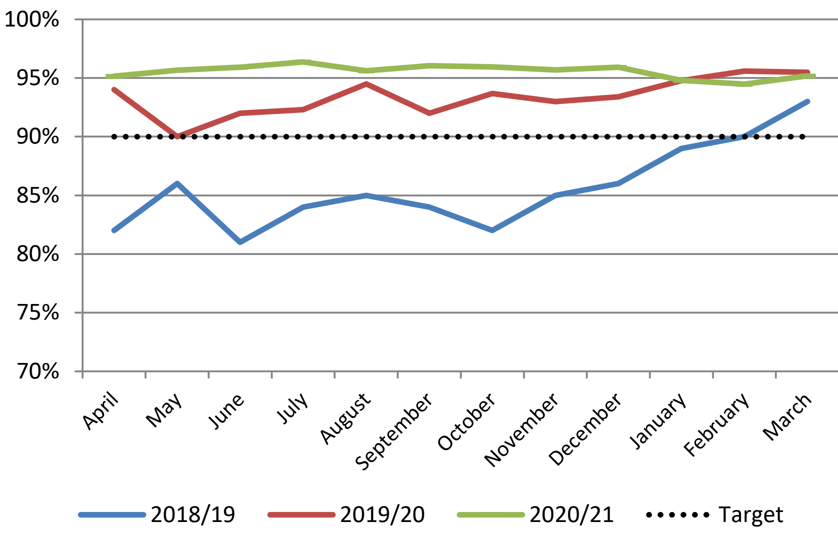


Registered Nursing Turnover – Annual Target 14%
The rolling 12 month turnover figure has decreased from 15.68% in February 2021 to 14.66% in March 2021 and is now lower than the same period in 2020. There were 2 leavers in March (1.61 FTE), the reasons for leaving were 1 Worklife Balance and 1 Work Life Balance.



3.5.5 Statutory and Mandatory Training

Overall Trust compliance at 31st March 2021 is 95.19% which is above the target of 90% and an increase from the previous month (94.48%).



The national compliance target for Information Governance is set at 95% whilst the Trust target for all other subjects is 90%.

Competence Name	Compliance %
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	96.93%
NHS|CSTF|Fire Safety - 2 Years|	95.22%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	94.08%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	95.08%
NHS|CSTF|Infection Prevention and Control - Level 2 - 2 Years|	93.39%
NHS|CSTF|Information Governance and Data Security - 1 Year|	93.15%
NHS|CSTF|Moving and Handling - Level 1 - 3 Years|	97.29%
NHS|CSTF|Moving and Handling - Level 2 - 2 Years|	93.80%
NHS|CSTF|NHS Conflict Resolution (England) - 3 Years|	95.88%
NHS|CSTF|Preventing Radicalisation - Basic Prevent Awareness - 3 Years|	96.01%

NHS|CSTF|Preventing Radicalisation - Prevent Awareness - 3 Years|	95.45%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	91.29%
NHS|CSTF|Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year|	85.26%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	95.36%
NHS|CSTF|Safeguarding Adults - Level 2 - 3 Years|	97.29%
NHS|CSTF|Safeguarding Children (Version 2) - Level 2 - 3 Years|	96.66%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	95.08%
NHS|CSTF|Safeguarding Children - Level 3 - 3 Years|	96.27%
NHS|MAND|COVID 19 Awareness - Clinical - Once only|	96.69%
NHS|MAND|COVID 19 Essential Guidance - Non-Clinical - Once Only|	94.48%
NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	96.69%

Information Governance training has seen a significant increase of 5.15% following targeted intervention with areas of underperformance, but is still not achieving national requirement of 95%.

Compliance with BLS and ILS continues to remain a concern for the Trust and both remain the two lowest performing subjects.

A deep dive into these areas highlights a consistent issue with staff not attending training they are booked onto and staff not proactively managing their renewal of training, despite being issued with notifications 3, 2 and 1 month prior to their competency requiring updating.

Not only does this impact on compliance, but it also leads to an increased number of training sessions having to be facilitated, as capacity planning at the start of the year is based on staff completing their training before their compliance expires.

The table below highlights the number of DNA's and unused capacity over the last three months:

	January 2021		**February 2021**		**March 2021**	
	DNA	Unused Places	DNA	Unused Places	DNA	Unused Places
ILS update	3	9	3	5	5	5
ILS Full	4	7	1	1	2	2
BLS Refresher	22	61	15	26	14	24

During March the L&OD Team and Resus Lead have worked closely with Divisions to support them to increase compliance for BLS. This has led to a significant in month increase of 4.46% and BLS is now achieving the target.

However, concern still remains around the sustainability of compliance for this subject area which has failed to retain compliance for more than a two month period over the last 12 months. The subject compliance will continue to be monitored closely by the Resus Lead to identify any further trends and escalation of DNAs.

The below table highlights areas of noncompliance for BLS which will be a focus in April 2021;

Radiation Services	
Clinical Oncologists	74.29%
Radiologists	66.67%
Chemotherapy	
Halton Hub	66.67%
Admin Services	
Patient Facing Wirral	73.33%
Haemato-Oncology	
7Y Day Ward	84.62%
Medical	85.71%
Integrated Care	
APH Team	80.77%
Common Cancers	87.50%
Matron Services	75%
Patient Support	50%
Ward 2	83.33%

Compliance for ILS has seen an in month decline of 1.71% and is currently underperforming against the KPI at 85.26% (39 staff non-compliant, with 10 of these staff booked onto a future session within the next 3 months and 29 outstanding). National Resus Guidance restricts capacity on this course to a maximum 6 people per trainer and a minimum of 4 people to enable the practical elements of the training to be successfully achieved. Due to these strict requirements any DNAs has a significant impact on compliance and can cause the class to be cancelled.

The below table highlights areas of noncompliance for ILS:

Chemotherapy	
Halton Hubs	83.33%
Home Treatment Team	85.71%
OP Wirral	60%
Haemato-Oncology	
7Y Day	50%
Clinicians/SPN's	75%
Ward 5	85.71%
Integrated Care	
AHP	0%
ICD Managers	0%
Matron Services	0%
Interventional Team	83.33%
Radiation Services	
Diagnostic Imaging	60%
Theatres	66.67%

Additional training dates for ILS have been made available in May, June and July to support the above areas to achieve compliance.

The Resus Lead, in partnership with L&OD and Lead Nurses will carry out a review of requirements for ILS in April 2021 to ensure the requirements are correctly assigned based on the new clinical model and structure.

Weekly trending data for both BLS and ILS continues to be issued to managers, alongside monthly targeted emails from the L&OD Team to staff who are non-compliant and ESR notifications issued to staff 3, 2 and 1 month prior to their compliance expiring.

A new reporting tool for all mandatory training has been developed by the L&OD Team and will be issued to managers monthly from May 2021. It is hoped that this new report will further help managers to proactively manage compliance.

<u>Compliance by Directorate</u>

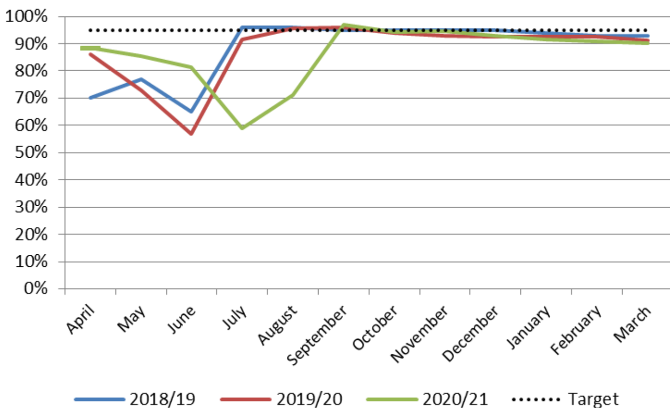
A breakdown of Directorate compliance, as at 31st March 2021 is detailed below.

Directorate	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend
158 Chemotherapy Services Directorate	90%	97.39%	97.10%	97.26%	97.46%	96.31%	96.77%	96.92%	96.31%	96.80%	96.66%	96.55%	96.54%	
158 Corporate Directorate	90%	94.33%	94.61%	94.92%	95.35%	94.61%	95.58%	94.30%	95.16%	95.37%	93.74%	92.90%	94.04%	
158 Haemato-oncology Directorate	90%	94.54%	94.48%	95.26%	95.34%	93.91%	95.26%	96.15%	94.96%	93.46%	91.41%	93.17%	93.43%	
158 Hosted Service Directorate	90%	97.28%	94.35%	93.54%	95.79%	96.01%	94.48%	94.58%	90.33%	89.16%	89.21%	87.25%	89.75%	
158 Integrated Care Directorate	90%	95.22%	96.86%	97.13%	97.04%	97.76%	95.11%	95.30%	94.65%	95.53%	94.01%	94.27%	94.65%	
158 Quality Directorate	90%	98.09%	97.13%	97.89%	96.82%	95.49%	95.83%	96.09%	97.16%	92.57%	94.92%	92.82%	92.19%	
158 Radiation Services Directorate	90%	93.57%	94.40%	94.85%	95.85%	97.17%	96.48%	96.53%	96.81%	97.53%	96.52%	95.42%	96.68%	
158 Research Directorate	90%	98.22%	98.42%	97.51%	98.76%	100.00%	98.40%	98.30%	96.13%	96.32%	97.45%	96.81%	97.50%	

All directorates are currently performing above the 90% target with the exception of Hosted Services who remain non-complaint for the 4th month in a row.

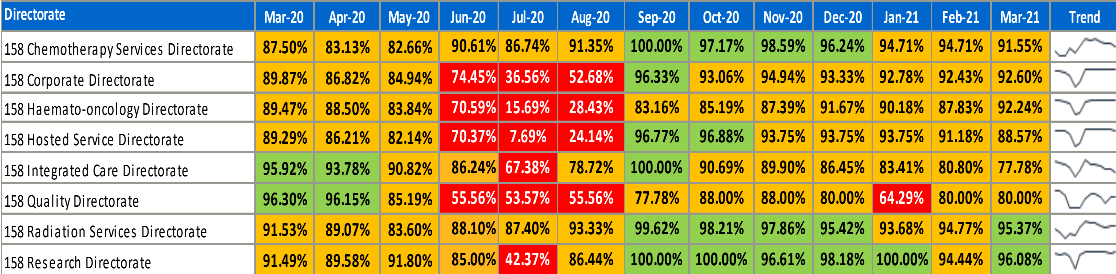
3.5.6 PADR Compliance

The Trust's overall compliance for PADRs as at 31st March 2021 is 90.25%, which is a decrease of 0.51% from the previous month and is below the target of 95%.



Overall trust compliance for PADRs has not been achieved since September 2020 and is now lower than the same period in 2020.

PADR Compliance by Directorate



Directorate	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Trend
158 Chemotherapy Services Directorate	87.50%	83.13%	82.66%	90.61%	86.74%	91.35%	100.00%	97.17%	98.59%	96.24%	94.71%	94.71%	91.55%	
158 Corporate Directorate	89.87%	86.82%	84.94%	74.45%	36.56%	52.68%	96.33%	93.06%	94.94%	93.33%	92.78%	92.43%	92.60%	
158 Haemato-oncology Directorate	89.47%	88.50%	83.84%	70.59%	15.69%	28.43%	83.16%	85.19%	87.39%	91.67%	90.18%	87.83%	92.24%	
158 Hosted Service Directorate	89.29%	86.21%	82.14%	70.37%	7.69%	24.14%	96.77%	96.88%	93.75%	93.75%	93.75%	91.18%	88.57%	
158 Integrated Care Directorate	95.92%	93.78%	90.82%	86.24%	67.38%	78.72%	100.00%	90.69%	89.90%	86.45%	83.41%	80.80%	77.78%	
158 Quality Directorate	96.30%	96.15%	85.19%	55.56%	53.57%	55.56%	77.78%	88.00%	88.00%	80.00%	64.29%	80.00%	80.00%	
158 Radiation Services Directorate	91.53%	89.07%	83.60%	88.10%	87.40%	93.33%	99.62%	98.21%	97.86%	95.42%	93.68%	94.77%	95.37%	
158 Research Directorate	91.49%	89.58%	91.80%	85.00%	42.37%	86.44%	100.00%	100.00%	96.61%	98.18%	100.00%	94.44%	96.08%	

The L&OD Team continue to work with managers to support the achievement of the PADR compliance. The revised model for PADRs, as approved by Quality Committee, will be implemented from 01st April 2021 and it is hoped that this will support more effective management of PADRs.

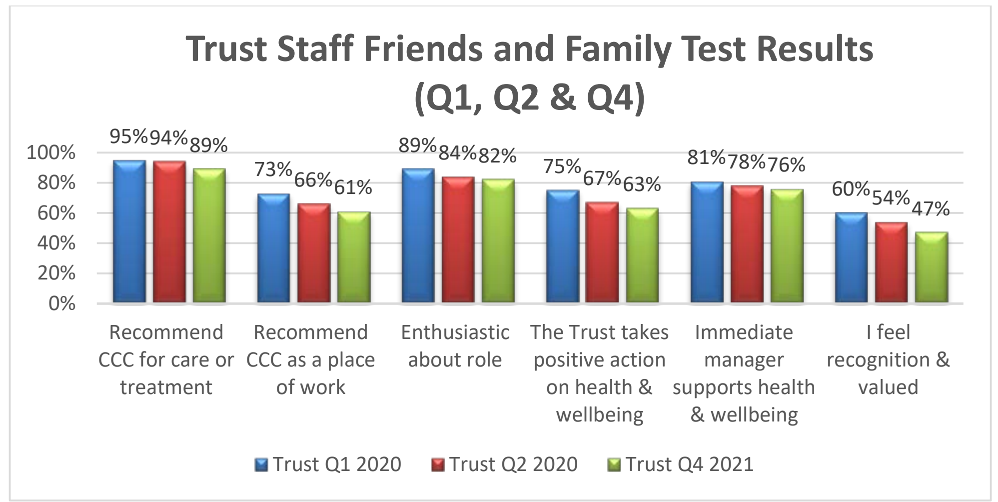
3.5.7 Staff Experience

Staff Friends and Family Test

The Staff Friends and Family Test (FFT) for Q4 took place during the period of 15th February and 12th March 2021.

The survey was completed by 519 staff (33%) which was a slight increase of 3% from Q2. Please note, the Staff FFT is not carried out in Q3, due to the national staff survey.

The Staff FFT includes the two nationally required questions on recommending the Trust has a place to work and recommending the trust has a place to received care, plus four additional questions selected by to trust to support the monitoring of the Trust's culture and engagement journey.



The results from Q4 show a decline across all 6 questions. These results will be triangulated with the results of national staff survey and will be discussed at the culture and engagement groups to identify trends and areas for improvement.

Results at a directorate level have been included in the directorate dashboards.

3.5.8 Covid-19 Vaccination

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	J	F	M	YTD	12 Month Trend
L	% of Staff who have had the first dose Covid-19 vaccination (at month end)	⬆	No national target	75%	88.4%	90.9%	N/A	A M J J A S O N D J F M
L	% of BAME Staff who have had the first dose Covid-19 vaccination (at month end)	⬆	No national target	58%	83.2%	85.5%	N/A	A M J J A S O N D J F M
L	% of Staff who have had the first dose Covid-19 vaccination or have refused the vaccination (at month end)	⬆	No national target	81%	92.8%	94.9%	N/A	A M J J A S O N D J F M
L	% of BAME Staff who have had the first dose Covid-19 vaccination or have refused the vaccination (at month end)	⬆	No national target	61%	86.9%	88.7%	N/A	A M J J A S O N D J F M

The above table indicates the Trust Covid-19 vaccination position at the end of March 2021.

The Trust has concluded and delivered the vaccination programme for the first dose, however will make arrangements for individuals not yet vaccinated, to have the vaccination elsewhere as required.

The Trust has continued to issue targeted communication and information for groups with particular concerns with regards to the Covid-19 vaccination. This includes staff with fertility concerns and the BAME community.

NHS England/Improvement have requested one-to-one conversations take place with frontline staff who have not so far taken up the offer of the Covid-19 vaccination to understand concerns and then signpost them to relevant information. Guidance has been distributed to line managers of the small number of staff who have not yet had the vaccination.

Of the 112 staff who had not initially taken the Covid-19 vaccine, just 30 members of staff remain who have not yet had a conversation with their line manager about the reasons why and whether they are continuing to choose not to have the vaccine or have now made the decision to have it.

Individual communication and reminders have been issued to all line managers for these remaining staff members to ensure that a discussion takes place as soon as possible.

3.6 Finance

For March 2021, the key financial headlines are:

Metric	In Mth 12 Actual	In Mth 12 Plan*	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit) (£000)	(183)	(557)	374		173	(854)	1,027	
CPL/Propcare Surplus/ (Deficit) (£000)	275	0	275		730	0	730	
Control Total Surplus/ (Deficit) (£000)	92	(557)	649		903	(854)	1,757	
Cash holding (£000)	63,533	43,285	20,248		63,533	43,285	20,248	
Capital Expenditure (£000)	4,428	2,193	(2,235)		14,221	13,759	(462)	

The Trust is showing a consolidated surplus of £903k, which is in line with the Trust forecast. While the revised Trust plan at month 7 was an £854k deficit as reflected in the above table, a revised forecast of £912k surplus was submitted to NHSE/I in January 2021.

Cash has consistently been running above plan, the Trust is holding this for future investments.

The £462k overspend on capital expenditure against plan is due to the Trust being asked by the Cheshire & Mersey ICS to bring forward some schemes due to an underspend of capital across Cheshire & Mersey.

Report Cover Sheet

Report to:	Trust Board	
Date of the Meeting:	28th April 2021	
Agenda Item:	P1-069-21	
Title:	Integrated Performance Report Annual Review	
Report prepared by:	Hannah Gray, Head of Performance and Planning	
Executive Lead:	Joan Spencer, Chief Operating Officer / Interim Chief Nurse	
Status of the Report:	Public	Private
		X

Paper previously considered by:	Quality Committee
Date & Decision:	22nd April 2021

Purpose of the Paper/Key Points for Discussion:	An Annual Review of the IPR is conducted each year in Q4, with the proposed approach for the following year presented to Performance and Quality Committees and Trust Board for approval, ready to start reporting in M1. The scope of the review includes the format and content of the IPR document including all KPIs. This paper describes the drivers and subsequent proposed changes to the format, content and bank of KPIs for 2021/22. Trust Board members are asked to consider the proposal with a view to approving this approach ready to implement in 2021/22.

Action Required:	Discuss	X
	Approve	
	For Information/Noting	

Next steps required	

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.

IPR Annual Review: 2021/22

An Annual Review of the IPR is conducted each year in Q4, with the proposed approach for the following year presented to Performance and Quality Committees and Trust Board for approval, ready to start reporting in M1. The scope of the review includes the format and content of the IPR document including all KPIs.

This paper describes the drivers and subsequent proposed changes to the format, content and bank of KPIs for 2021/22.

Drivers

Directives within the following publications are considered, with some caveats for 2021/22 due to Covid-19 related delays in the national planning and contracting process:

- NHS National Planning Guidance documents 2021/22
- NHS Standard Contract 2021/22 (in lieu of CCC signed contract)
- NHS System Oversight Framework 2021/22 (out for consultation, however the proposed metrics have not yet been shared)
- CCC Five Year Strategic Plan 2021 – 2025

As these documents are in varying stages of publication, final versions will be considered when available and any resulting changes to the IPR will be proposed to Performance and Quality Committees and Trust Board.

Format and Content

The presentation of the IPR has been continually refined during 2020/21 and significant changes were made in year as a result of the Covid-19 pandemic.

Consequently, the only two proposed changes to the format and content (aside from the KPIs) for 2021/22 is:

- To include a ‘Quality’ section in the main body of the report monthly from M1 2021/22

KPIs

The following table presents the proposed KPIs for 2021/22, with reasons for changes stated. The changes include:

- Introducing new KPIs
- Removing KPIs
- Amending targets, including introducing an ‘amber’ range
- Describing changes anticipated in year

The changing nature of the Covid-19 pandemic may require further changes in year to the format, content and/or KPIs within the IPR. The Performance and Quality Committees and Trust Board will be consulted regarding any changes.

Proposed KPIs for the 2021/22 IPR

ACCESS

CCC Performance

Directive	Target figure nationally / Commissioner defined	Key Performance Indicator	CHANGE	Reason for change	2020/2021 Red	2020/2021 Amber	2020/2021 Green	Proposed 2021/2022 Red	Proposed 2021/2022 Amber	Proposed 2021/2022 Green
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse										
L	N	**7 days** from referral to first appointment	Y	Trend change is more apparent	<90%		90%	<85%	85-89.9%	=>90%
C/S	Y	**2 week wait** from GP referral to 1st appointment	N		<93%		93%	<93%		93%
L	N	**24 days** from referral to first treatment	Y	Trend change is more apparent	<85%		85%	<80%	80-84.9%	=>85%
C/S	From Q3 2021/22	**28 day** faster diagnosis - (Referral to diagnosis)	Y		<75%		75% (shadow monitoring)	<75%		75% (shadow monitoring until Q3)
S	Y	**31 day** wait from diagnosis to first treatment	N		<96%		96%	<96%		96%
C/S	Y	**31 day** wait for subsequent treatment (Drugs)	N		<98%		98%	<98%		98%
C/S	Y	**31 day** wait for subsequent treatment (Radiotherapy)	N		<94%		94%	<94%		94%
S	N	Number of **31 day** patients treated => **day 73**	N		<0		0	<0		0
C/S	Y	**62 Day** wait from GP referral to treatment	N		<85%		85%	<85%		85%
C/S	Y	**62 Day** wait from screening to treatment	N		<90%		90%	<90%		90%
L	N	Number of patients treated between **63 and 103 days** (inclusive)	N		No Target	No Target	No Target	No Target	No Target	No Target
S	N	Number of patients treated => **104 days**	N		No Target	No Target	No Target	No Target	No Target	No Target
L	N	Number of avoidable breaches, treated => **104 days AND at CCC for over 24 days**	Y	Trend change is more apparent. Changed from 'all' to 'Avoidable'	<0		0	>1	1	0
C/S	Y	Diagnostics: **6 Week Wait**	N		<99%		99%	<99%		99%
C/S	Y	**18 weeks** from referral to treatment (RTT) Incomplete Pathways	N		<92%		92%	<92%		92%

Cheshire and Merseyside Performance

Directive	Target figure nationally / Commissioner defined	Key Performance Indicator	CHANGE	Reason for change	2020/2021 Target	2020/2021 Target	2020/2021 Target	Proposed 2021/2022 Target	Proposed 2021/2022 Target	Proposed 2021/2022 Target
Executive Director Lead: Liz Bishop, CMCA SRO										
C/S	Y	**2 week wait** from GP referral to 1st appointment	N		<93%		93%	<93%		93%
C/S	From Q3 2021/22	**28 day** faster diagnosis - (Referral to diagnosis)	Y	NHS Planning Guidance 2021/22 states formal reporting from Q3 2021/22 and confirms target as 75%	<75% (shadow monitoring)		75% (shadow monitoring)	<75% (shadow monitoring until Q3)		75% (shadow monitoring until Q3)
C/S	Y	**62 Day** wait from GP referral to treatment	N		<85%		85%	<85%		85%

EFFICIENCY (1 OF 2)

Directive	Target figure nationally / Commissioner defined	Key Performance Indicator	CHANGE	Reason for change	2020/2021 Red	2020/2021 Amber	2020/2021 Green	Proposed 2021/2022 Red	Proposed 2021/2022 Amber	Proposed 2021/2022 Green
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse										
S	N	Length of Stay: Elective (days): Solid Tumour	Y	Trend change is more apparent	>6.5		≤6.5	>6.8%	6.5% - 6.8%	≤6.5
S	N	Length of Stay: Emergency (days): Solid Tumour	Y	Trend change is more apparent	>8		≤8	>8.4%	8.1% - 8.4%	≤8
S	N	Length of Stay: Elective (days): HO Ward 4	Y	Trend change is more apparent	>21		≤21	>22.1%	21.1% - 22.1%	≤21
S	N	Length of Stay: Emergency (days): HO Ward 4	Y	Trend change is more apparent	>22 (from Jan 21)		≤22 (from Jan 21)	>23.1%	22.1% - 23.1%	≤22
S	N	Length of Stay: Elective (days): HO Ward 5	Y	Trend change is more apparent	>32		≤32	>33.6%	32.1% - 33.6%	≤32
S	N	Length of Stay: Emergency (days): HO Ward 5	Y	Trend change is more apparent	>46		≤46	>48.3%	46% - 48.3%	≤46
S	Y	Delayed Transfers of Care as % of occupied bed days (expanded from ST to CCC)	N		>3.5%		≤3.5%	>3.5%		≤3.5%
C	N	% of expected discharge dates completed	New from M4	Data available following HO transfer to CCC Meditech. Data flows being validated.				<90%	90% - 94.9%	=>95%
S	Y	Bed Occupancy: Midnight (Ward 4: HO)	Y (timing TBC)	Return to previous 85% target, post Covid-19	<88%	88-91.9%	=>92%	<88%	88-91.9%	=>92%
S	N	Bed Occupancy: Midnight (Ward 5: HO)	N		<76%	76%-79.9%	=>80%	<76%	76%-79.9%	=>80%
S	Y	Bed Occupancy: Midday (Solid Tumour)	Y (timing TBC)	Return to previous 85% target, post Covid-19	<88%	88-91.9%	=>92%	<88%	88-91.9%	=>92%
S	Y	Bed Occupancy: Midnight (Solid Tumour)	Y (timing TBC)	Return to previous 85% target, post Covid-19	<88%	88-91.9%	=>92%	<88%	88-91.9%	=>92%
C/S	N	% of elective procedures cancelled on or after the day of admission	N		>0%		0%	>0%		0%
C/S	Y	% of cancelled elective procedures (on or after the day of admission) rebooked within 28 days of cancellation	N		<100%		100%	<100%		100%
C/S	Y	% of urgent operations cancelled for a second time	N		>0%		0%	>0%		0%
L	N	Radiology Reporting: Inpatients (within 24hrs)	N		<80%	80-89.9%	=>90%	<80%	80-89.9%	=>90%
L	N	Radiology Reporting: Outpatients (within 7 days)	N		<80%	80-89.9%	=>90%	<80%	80-89.9%	=>90%
L	N	Travel time to clinic appointment within 45 minutes.	Remove	Improvement embedded following implementation of HUBs	<90%		=>90%			

EFFICIENCY (2 OF 2)

Directive	Target figure nationally / Commissioner defined	Key Performance Indicator	CHANGE	Reason for change	2020/2021 Red	2020/2021 Amber	2020/2021 Green	Proposed 2021/2022 Red	Proposed 2021/2022 Amber	Proposed 2021/2022 Green
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse										
C/Phase 3 Covid-19 Guidance	Y	Data Quality - % Ethnicity that is complete (or patient declined to answer)	N		J & A = <90% S & O = <95% Nov & Dec = <100%		J & A =>90% S & O =>95% Nov & Dec =100%	<100%		100%
C	N	Data Quality - % of outpatients with an outcome	N		<90%	90% - 94.9%	=>95%	<90%	90% - 94.9%	=>95%
C	N	Data Quality - % of outpatients with an attend status	N		<90%	90% - 94.9%	=>95%	<90%	90% - 94.9%	=>95%
Executive Director Lead: James Thomson, Director of Finance										
S	Y	Percentage of Subject Access Requests responded to within 1 month	N		<100%		100%	<100%		100%
S	Y	% of overdue ISN (Information Standard Notices)	N		>0%		0%	>0%		0%

QUALITY (1 OF 3)

Directive	Target figure nationally / Commissioner defined	Key Performance Indicator	CHANGE	Reason for change	2020/2021			Proposed 2021/2022		
					Red	Amber	Green	Red	Amber	Green
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse										
C/S	N	Never Events	N		>0		0	>0		0
C/S	N	Serious Untoward Incidents (month reported to STEIS)	N		>0		0	>0		0
C/S	Y	Serious Untoward Incidents: % submitted within 60 working days / agreed timescales	N		<100%		100%	<100%		100%
S	N	RIDDOR - number of reportable incidents	N		>0		0	>0		0
S	N	IRMER - number of reportable incidents.	Remove	Replaced by 2 x KPIs below			0			
L	N	Significant accidental or unintended exposure (SAUE); Radiotherapy delivered dose or Radiotherapy geographical miss - Treatment Errors	New	Benchmarking has enabled more valuable KPI development				>5	4 – 5	≤3
L	N	Significant accidental or unintended exposure (SAUE); Radiotherapy delivered dose or Radiotherapy geographical miss - Imaging Errors	New	Benchmarking has enabled more valuable KPI development				>12	9 – 12	≤8
S	N	Incidents /1,000 Bed Days	N		No target	No target	No target	No target	No target	No target
L	N	All incidents resulting in harm /1,000 bed days	N		No target	No target	No target	No target	No target	No target
C/S	N	Inpatient Falls resulting in harm due to lapse in care	N		>0		0	>0		0
S	N	Inpatient falls resulting in harm due to lapse in care /1,000 bed days	N		>0		0	>0		0
C/S	N	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care)	N		>0		0	>0		0
C/S	N	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care) /1,000 bed days	N		>0		0	>0		0
Strategy	N	Five Year Survival rate (not M1 2021/22)	TBC	Detail and reporting go live month TBC				TBC	TBC	TBC
NCEPOD / RCP	N	Consultant Review within 14 hours (emergency admissions)	N		<90%		90%	<90%		90%
C/S	Y	% of Sepsis patients being given IV antibiotics within an hour	N		<90%		90%	<90%		90%
C	Y	% of patients requiring screening for sepsis, who have been screened	New from Q2 2021/22	Data available following HO transfer to CCC Meditech. Data flows being validated.	<90%		90%	<90%		90%
C/S	Y	VTE Risk Assessment	N		<95%		95%	<95%		95%

QUALITY (2 OF 3)

Directive	Target figure nationally / Commissioner defined	Key Performance Indicator	CHANGE	Reason for change	2020/2021 Red	2020/2021 Amber	2020/2021 Green	Proposed 2021/2022 Red	Proposed 2021/2022 Amber	Proposed 2021/2022 Green
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse										
S	Y	Dementia: Percentage to whom case finding is applied	N		<90%		90%	<90%		90%
S	Y	Dementia: Percentage with a diagnostic assessment	N		<90%		90%	<90%		90%
S	Y	Dementia: Percentage of cases referred	N		<90%		90%	<90%		90%
C/S	Y (TBC nationally / commissioners)	Clostridioides difficile infections (attributable)	N		>4 per yr		<=4 per yr	>4 per yr		<=4 per yr
C/S	N	E Coli (attributable)	Y	Target lowered to drive further improvement	>10 per yr		<=10 per yr	>10 per yr	10 per yr	<=9 per yr
C/S	Y (TBC nationally / commissioners)	MRSA infections (attributable)	N		>0		0	>0		0
C/S	N	MSSA bacteraemia (attributable)	Y	Target lowered to drive further improvement	>5 per yr		<=5 per yr	>5 per yr	5 per yr	<=4 per yr
C	N	Klebsiella (attributable)	Y	Target lowered to drive further improvement	>10 per yr		<=10 per yr	>10 per yr	10 per yr	<=9 per yr
C	N	Pseudomonas (attributable)	Y	Target lowered to drive further improvement	>5 per yr		<=5 per yr	>5 per yr	5 per yr	<=4 per yr
C	N	FFT patient results (% positive ratings) - *Data split by OP and IP not available in M1. Go live month for this detail TBC*	Y	Trend change is more apparent	95%		95%	<90%	90% - 94.9%	=>95%
C	N/A	Number of formal complaints received	N		No target	No target	No target	No target	No target	No target
S	N/A	Number of formal complaints / count of WTE staff (ratio)	N		No target	No target	No target	No target	No target	No target
C	Y	% of formal complaints acknowledged within 3 working days	N		<100%		100%	<100%		100%
L	N	% of routine formal complaints resolved in month, which were resolved within 25 working days	N		<100%		100%	<65%	65% - 74.9%	75%
L	N	% of complex formal complaints resolved in month, which were resolved within 60 working days	N		<100%		100%	<65%	65% - 74.9%	75%

QUALITY (3 OF 3)

Directive	Target figure nationally / Commissioner defined	Key Performance Indicator	CHANGE	Reason for change	2020/2021 Red	2020/2021 Amber	2020/2021 Green	Proposed 2021/2022 Red	Proposed 2021/2022 Amber	Proposed 2021/2022 Green
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse										
C/S	Y	% of FOIs responded to within 20 days	N		<100%		100%	<100%		100%
C/S	N	Number of IG incidents escalated to ICO	N		>0		0	>0		0
C	N	NICE Guidance: % of guidance compliant	Y	Trend change is more apparent	<90%		90%	<85%	85 - 89.9%	90%
L	N/A	Number of policies due to go out of date in 3 months	N		No target	No target	No target	No target	No target	No target
L	N	% of policies in date	Y	Target changed to a more realistic level. Trend change is more apparent	<100%		100%	<93%	93 - 94.9%	95%
C/S	Y	NHS E/I Patient Safety Alerts: number not implemented within set timescale.	N		>0		0	>0		0

RESEARCH AND INNOVATION

Directive	Target figure nationally / Commissioner defined	Key Performance Indicator	CHANGE	Reason for change	2020/2021 Red	2020/2021 Amber	2020/2021 Green	Proposed 2021/2022 Red	Proposed 2021/2022 Amber	Proposed 2021/2022 Green
Executive Director Lead: Sheena Khanduri, Medical Director										
L	N	Study recruitment	Y	Revised targets for 2021/22			800 per yr	<1100	1100-1299	1300 per yr
National	Y	Study set up times (days)	N				=<40 days			=<40 days
L	N	Recruitment to time and target	New	Research Strategy objective				<45%	45 - 54.9%	=>55%
L	N	Studies Opened	Y	Revised targets for 2021/22			=>47 per yr	<45	45 - 51	=>52 per yr
L	N	Publications	New	Research Strategy objective				<110	110-129	130 per year

WORKFORCE

Directive	Target figure nationally / Commissioner defined	Key Performance Indicator	CHANGE	Reason for change	2020/2021 Red	2020/2021 Amber	2020/2021 Green	Proposed 2021/2022 Red	Proposed 2021/2022 Amber	Proposed 2021/2022 Green
Executive Director Lead: Jayne Shaw, Director of Workforce and Organisational Development										
S	N	Staff Sickness	N		=>5%	4.1 - 4.9%	=<4%	=>5%	4.1 - 4.9%	=<4%
S	N	Staff Turnover	N		=>1.25%	1.21– 1.24%	=<1.2%	=>1.25%	1.21– 1.24%	=<1.2%
S	N	Statutory and Mandatory Training	N		=<75%	75 - 89%	=>90%	=<75%	75 - 89%	=>90%
L	N	PADR rate	N		=<74%	75 - 94.9%	=>95%	=<74%	75 - 94.9%	=>95%
S	N	FFT staff: Recommend as a place to work (Quarterly survey)	N		=<90%	90 - 94.9%	=>95%	=<90%	90 - 94.9%	=>95%
S	N	FFT staff: Recommend care and treatment (Quarterly survey)	N		=<90%	91 - 94.9%	=>95%	=<90%	91 - 94.9%	=>95%
S	Y	% of Staff offered Flu Vaccination (vaccinated + refused): cumulative (National target) TO BE REPORTED DURING VACCINATION CAMPAIGN ONLY	N				100% (by end campaign)	TBC for 2021/22	TBC for 2021/22	TBC for 2021/22
L	Y	% of 'Frontline' Staff Flu Vaccinated: cumulative (CQUIN target) TO BE REPORTED DURING VACCINATION CAMPAIGN ONLY	N				90% by 28/02/21	TBC for 2021/22	TBC for 2021/22	TBC for 2021/22
C	N	% of Staff Flu Vaccinated: cumulative (CCC internal target) TO BE REPORTED DURING VACCINATION CAMPAIGN ONLY	N				95% by end Dec 20	TBC for 2021/22	TBC for 2021/22	TBC for 2021/22
L	N	% of Staff who have had the first dose Covid-19 vaccination (at month end) TO BE REPORTED DURING VACCINATION CAMPAIGN/S ONLY	N		No national target	No national target	No national target	TBC for 2021/22	TBC for 2021/22	TBC for 2021/22
L	N	% of BAME Staff who have had the first dose Covid-19 vaccination (at month end) TO BE REPORTED DURING VACCINATION CAMPAIGN/S ONLY	N		No national target	No national target	No national target	TBC for 2021/22	TBC for 2021/22	TBC for 2021/22
L	N	% of Staff who have had the first dose Covid-19 vaccination or have refused the vaccination (at month end) TO BE REPORTED DURING VACCINATION CAMPAIGN/S ONLY	N		No national target	No national target	No national target	TBC for 2021/22	TBC for 2021/22	TBC for 2021/22
L	N	% of BAME Staff who have had the first dose Covid-19 vaccination or have refused the vaccination (at month end) TO BE REPORTED DURING VACCINATION CAMPAIGN/S ONLY	N		No national target	No national target	No national target	TBC for 2021/22	TBC for 2021/22	TBC for 2021/22

Covid-19 Recovery Activity

This data will continue to be reported in 2021/22, with a review at M6. The 2021/22 NHS Planning Guidance stipulates the following targets, which will be applied from M1 2021/22:

- Elective activity: M1 = 70%, M2 = 75%, M3 = 80%, M4 - M6 = 85% (of 2019/20 activity)
- Non-elective activity: 'Overall non-elective demand from COVID and non- COVID returns to pre-pandemic (2019/20) levels from the beginning of the 2021/22, subject to the impact of any planned service developments'.

Cheshire & Merseyside
Cancer Alliance

Performance Report

April 2021

Contents

I. Summary
II. Restoration of cancer services – core metrics
III. 14 day standard and 28 Faster diagnosis standard
IV. 62 day standard

Version 1

Section I: Summary

Restoration of cancer services

The Cheshire and Merseyside Cancer Alliance is providing system leadership and operational oversight for the restoration of cancer services. The restoration is focusing on three objectives, namely:

- To create sufficient **capacity** to ensure that patients who have had their care pathways disrupted are delayed no further, and ensure that all newly referred patients are diagnosed and treated promptly;
- To ensure **equity of access** across the system so that patients are not disadvantaged because of local capacity constraints;
- To build **patient confidence** – patients need to be reassured that their diagnosis and treatment will take place in an environment and manner that is safe.

Measure	% of pre-Covid level
2WW referrals	117%
Cancer surgery activity	120%
SACT (inc chemo) delivery	137%

Measure	% of pre-Covid level
Radiotherapy planning	109%
Radiotherapy treatment	77%
Endoscopy capacity	107%

- There is sufficient capacity within SACT and radiotherapy to manage current demand. Lower levels of radiotherapy treatment reflect the adoption of new treatment regimes such as hypofractionation.
- Endoscopy capacity has more than doubled since August 2020, but further capacity is required in order to clear the backlog of patients on the endoscopy waiting list, hence the Amber rating. The Alliance has established an endoscopy operational recovery team (EORT) to oversee and co-ordinate restoration activities.

Summary

Cancer waiting times performance

The latest published 14 day and 62 day cancer waiting times performance data relate to **February 2021**.

- The Alliance achieved the **14 day standard** for urgent suspected cancer referrals in February, with just two trusts and two CCGs falling below the 93% threshold. The overall performance of the Alliance was 93.53%, up from 86.33% last month. The England average was 90.33%. CMCA was the 4th best performing Alliance in England out of 19 against this standard.

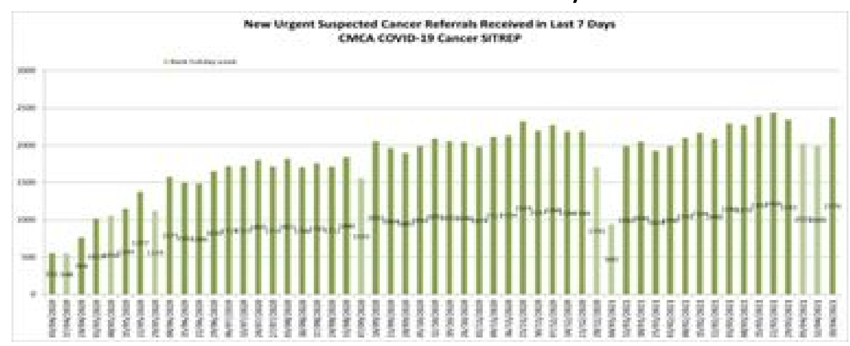
- The Alliance failed the **62 day standard**, achieving 71.23% (similar to 71.36% last month) against a standard of 85% (England average was 69.75%). Nine trusts and eight CCGs failed to meet the 62 day standard. Cheshire and Merseyside is the 9th best performing Alliance in England out of 19 against this standard.

- The number of patients waiting **over 62 days** is significantly higher than pre-Covid levels. On 11th April 2021 there were 1,042 patients waiting more than 62 days for a diagnosis or treatment. This has decreased from 1,113 reported last month.

- Of these, 337 have waited **over 104 days**. This has decreased from 373 reported last month.

Section II: Restoration of Cancer Services – Core Metrics

1. TWW referrals received in last 7 days



Referrals rose following the Easter bank holidays to similar levels to March (17% above pre-pandemic average levels).

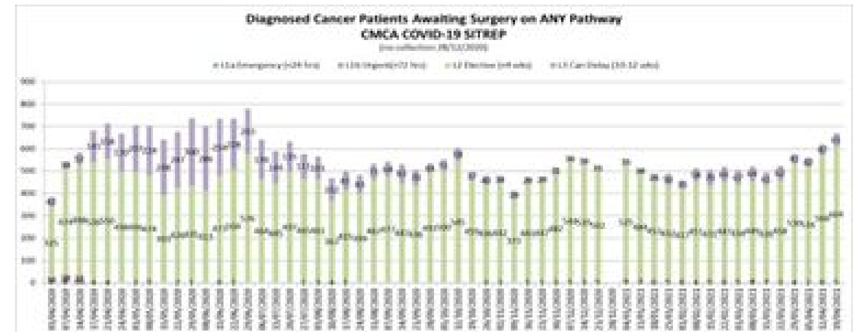
Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP.

2. Diagnostic backlog (referrals without a DTT)

Currently 9,578 active patients, of which 17 are suspended.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. No collection 28/12/2020.

3. Cancer patients awaiting surgery



670 patients with a surgical DTT. 609 at L1&L2 and 61 at L3.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. No collection 28/12/2020.

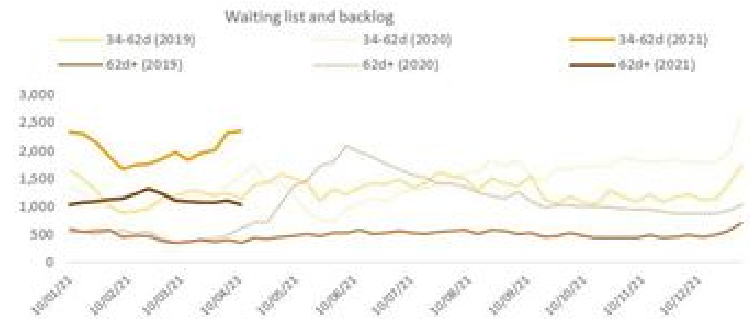
4. Cancer surgery performed in last 7 days

309 cancer operations, of which 3 were through the surgical hub.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. No collection 28/12/2020.

Restoration of Cancer Services – Core Metrics

5. Patients waiting over 62 days

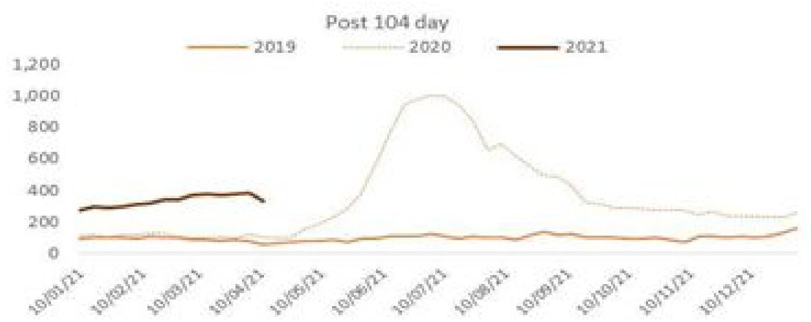


1,042 patients have waited over 62 days

- Down from 1,113 in previous week

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. For w/e 04/04/2021, Wirral data not submitted nationally but added locally

6. Patients waiting over 104 days



337 patients have waited over 104 days

- down from 383 in previous week

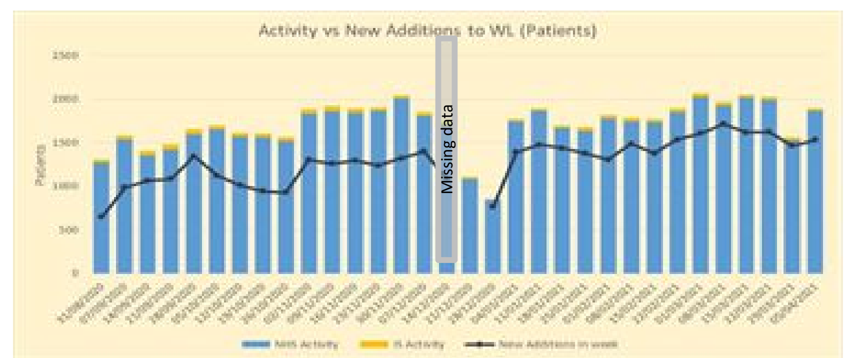
Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. For w/e 04/04/2021, Wirral data not submitted nationally but added locally

7. Endoscopy waiting list

Endoscopy waiting fell rose slightly to 10,575, 5% lower than Christmas

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. No data from East Cheshire or Mid Cheshire 14/12/20; No collection 21/12/2020

8. Endoscopy activity



Activity rose towards pre-Easter levels, with 1,890 patients seen

Data Quality Issues: No data from East Cheshire 14/12/20; no new additions collection 21/12/20

Cheshire & Merseyside
Cancer Alliance

9. Patients waiting between 63 and 103 days by provider

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total
Bridgewater											37				37
Clatterbridge						6									24
Countess Of Chester		16	17			30					5		17		91
East Cheshire						10									
Liverpool Foundation Trust		11			11	132					13	55	26		255
Liverpool Heart & Chest															
Liverpool Women's			27												27
Mid Cheshire						10									21
Southport & Ormskirk			20			8						5	10		50
St Helens & Knowsley			9		11	33					7	5	11		76
Walton Centre															
Warrington & Halton			6			39						7	16		71
Wirral						18							13		34
Grand Total		**31**	**87**	**11**	**29**	**286**					**68**	**85**	**99**		**705**

Tables from national Cancer PTL
Up to 11 April 2021

10. Patients waiting over 104 days by provider

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total
Bridgewater											39				39
Clatterbridge															12
Countess Of Chester						15					6				30
East Cheshire						9									15
Liverpool Foundation Trust		6			10	78						17	13		135
Liverpool Heart & Chest															
Liverpool Women's			15												15
Mid Cheshire															6
Southport & Ormskirk			5			5									16
St Helens & Knowsley					5	13					5				28
Walton Centre															
Warrington & Halton						9							6		22
Wirral													10		19
Grand Total		**10**	**28**	**6**	**18**	**141**					**55**	**31**	**39**		**337**

From 29 November 2020, data source changed from CMCA SITREP to national weekly PTL
- Data no longer split out for acute leukaemia or testicular
- New data for non site specific symptoms referrals

= fewer than 5 patients or hidden to prevent disclosure

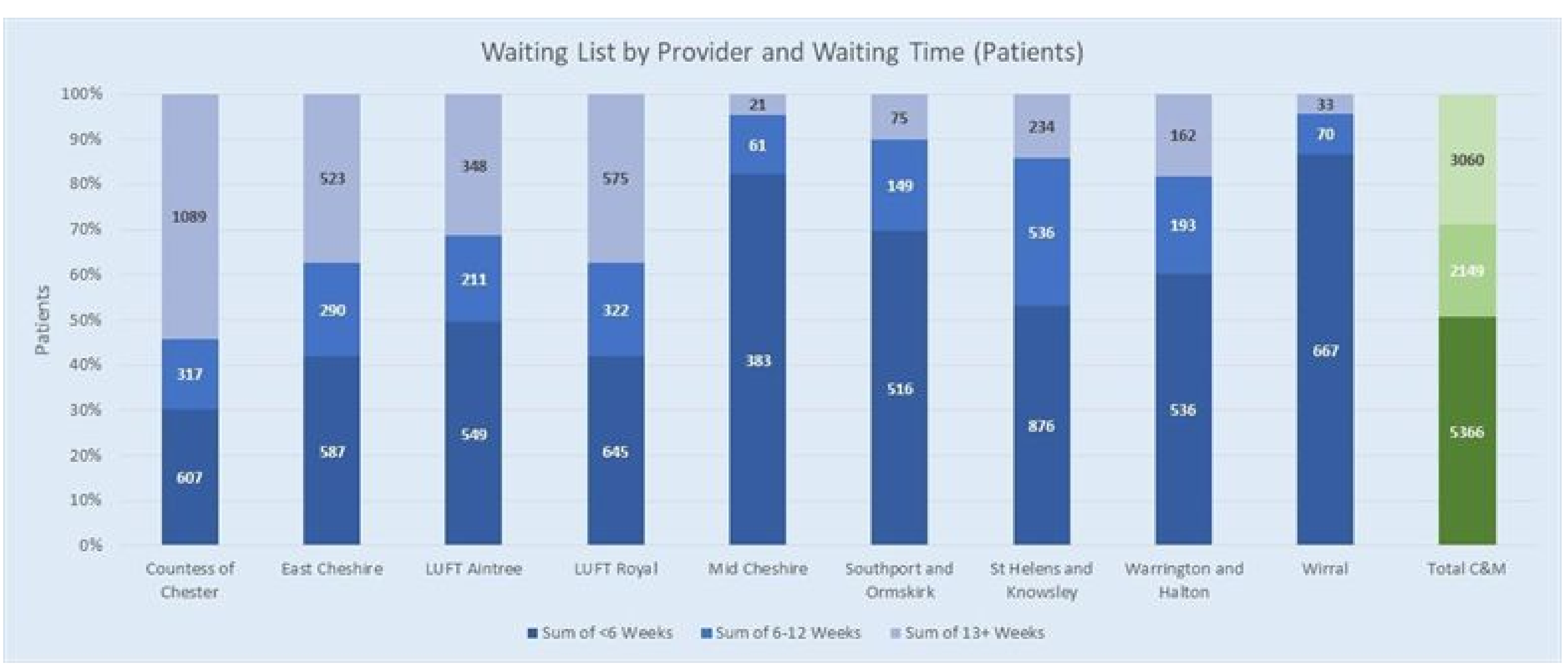
= no trust submission to national weekly PTL

Restoration of Cancer Services – Core Metrics

Endoscopy (cancer and non-cancer pathways)

There are currently 10,575 patients waiting for an endoscopy. 5,209 have waited more than six weeks, and of these 3,060 have waited 13 or more weeks (29% of the total).

There is significant variation across units, with CoCH, LUFT and East Cheshire having the greatest proportion of their waiting list made up of patients waiting 13 weeks or more (54%, 35% and 37% respectively).



Section II: 14 day and 28 day standards

14 Day Referral to First Seen Standard (February 2021)

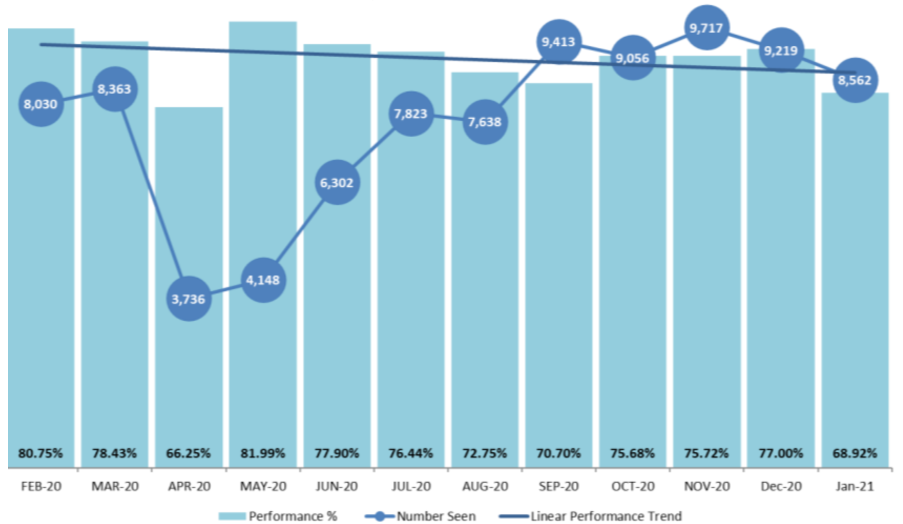
The following trusts did not meet the standard (93%):

- Countess of Chester (77.01%)
- Southport and Ormskirk (88.86%)

The following CCGs did not meet the standard:

- NHS Cheshire CCG (90.52%)
- NHS Southport and Formby CCG (88.03%)

28 Day Faster Diagnosis Standard (February 2021)



The 28 day FDS standard is still being shadow monitored. The standard is expected to be 75%. The following providers did not achieve 75%:

- Bridgewater (71.23%)
- Countess of Chester (65.41%)
- Warrington & Halton (74.48%)
- Liverpool University (74%)
- Liverpool Women's (67.95%)
- Southport and Ormskirk (69.09%)

The following CCGs did not achieve 75%:

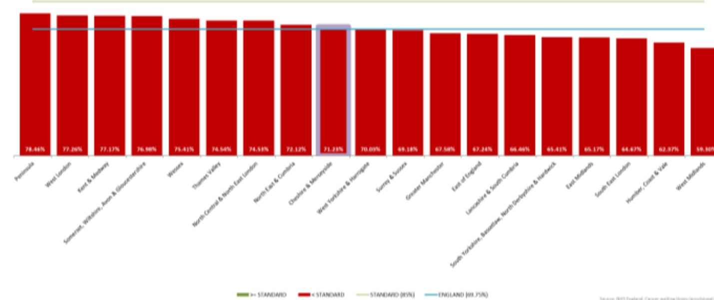
NHS Cheshire CCG (74.83%)

NHS South Sefton CCG (64.01%)

- NHS Warrington CCG (72.98%)
- NHS Southport & Formby CCG (71.63%)

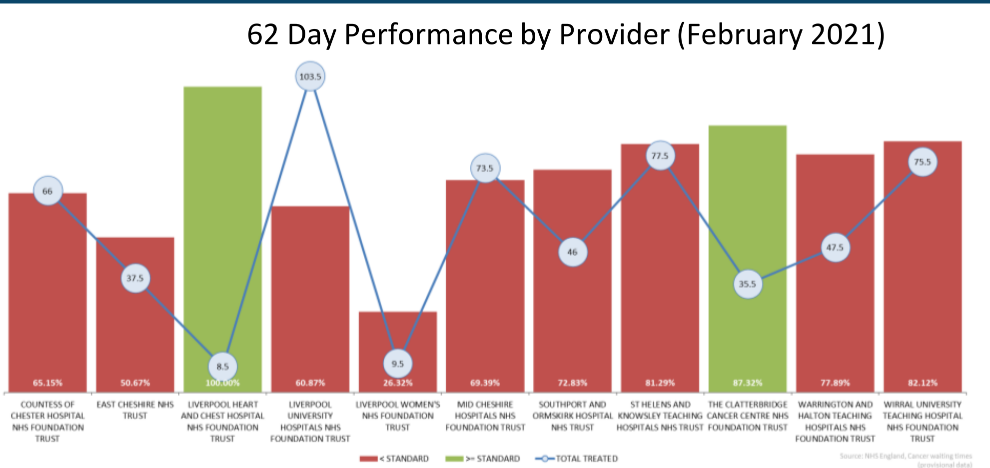
Section III: 62 Day Standard

62 Day Performance by Cancer Alliance (February 2021)

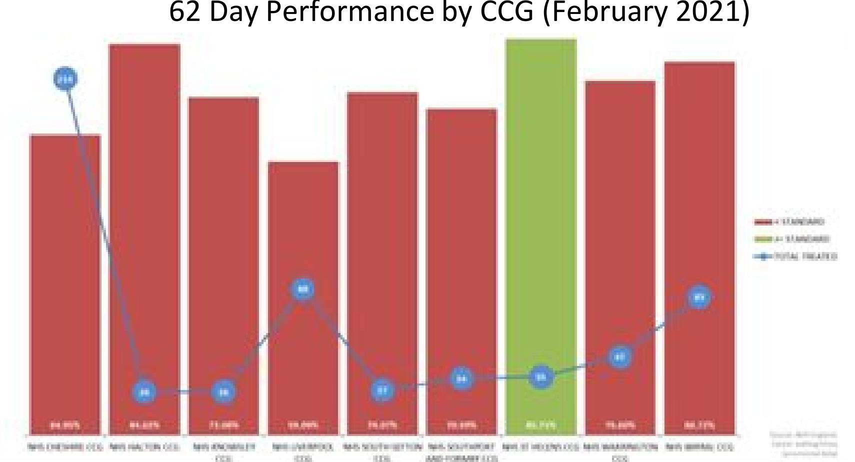


CMCA achieved 71.23% against a standard of 85%.
CMCA was the ninth best performer. The England average was 69.75%

62 Day Performance by Provider (February 2021)



62 Day Performance by CCG (February 2021)



Most Challenged Pathways (February 2021)

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

- Urology 62.83% (down from 72.53% last month)
- Lower Gastrointestinal 44.5% (up from 39.02%)
- Gynaecology 29.58% (down from 39.44%)

Cheshire & Merseyside
Cancer Alliance

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Cheshire and Merseyside Cancer Alliance is an NHS organisation that brings together NHS providers, commissioners, patients, cancer research institutions and voluntary & charitable sector partners to improve cancer outcomes for our local population.

Report Cover Sheet

Report to:	Trust Board	
Date of the Meeting:	28 April 2021	
Agenda Item:	P1-071-21	
Title:	Finance Report Month 12	
Report prepared by:	Jo Bowden, Deputy Director of Finance	
Executive Lead:	James Thomson, Director of Finance	
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:	To present the Trust's financial performance for the financial year 2020-21 : - The final outturn revenue position - Capital and cash position

Action Required:	Discuss	X
	Approve	
	For Information/Noting	X

Next steps required	The Trust Board will be informed of progress against the plan on a regular basis in accordance with the Board Reporting Cycle.

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

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

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

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

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

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

Trust Board
28th April 2021

Financial Performance Report

1. Introduction

1.1 This paper provides a summary of the Trust's financial performance for March 2021, the final month of the 2020-21 financial year.

Colleagues are asked to note the content of the report, and the associated risks.

2. Summary Financial Performance

2.1 For March the key financial headlines are:

Metric	In Mth 12 Actual	In Mth 12 Plan*	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit) (£000)	104	(557)	661		460	(854)	1,314	
CPL/Propcare Surplus/ (Deficit) (£000)	275	0	275		730	0	730	
Control Total Surplus/ (Deficit) (£000)	379	(557)	936		1,190	(854)	2,044	
Cash holding (£000)	63,522	43,285	20,237		63,522	43,285	20,237	
Capital Expenditure (£000)	4,428	2,193	2,235		14,221	13,759	(462)	

*The plan for month 12 reflects the plan submission for M7-12 (22nd October 2020)

3. Operational Financial Profile – Income and Expenditure

3.1 Overall Income and Expenditure Position

The year to date £854k deficit plan included in the table above reflects the initial trajectory for the second half of 2020-21, submitted to NHSI in October 2020. The Trust operated at a surplus for the first half of the year.

The Trust later revised its forecast outturn position and submitted an updated expected surplus position of £0.6m to NHSI in February 2021. The year to date consolidated financial position to the end of March is a surplus of £1.2m, this is above the planned surplus of £0.6m for two main reasons:

- The Trust was notified in March 2021 that it would receive funding from NHSE/I to cover the increase in the annual leave accrual in the year of £324k. This was not in the original forecast but was managed as an allowable reason for not achieving financial target.

- The Trust was also notified on the 19th of April as part of the close down process that it would receive funding of £287k for the under-recovery of non-NHS income during the year. This is an exceptional circumstance due to the pandemic so the Trust had forecast on the basis this income would be lost. Receipt of this income

improves the Trust's final surplus position. This funding is given by NHSE/I with the expectation that it improves Trust performance.

3.1.1 The table below summarises the Trust and consolidation position. Please see Appendix 1 for the more detailed Income & Expenditure position.

Metric (£000)	YTD Actual M12	Trust Plan YTD	Variance	Trust Annual Plan
Clinical Income	187,597	177,467	10,130	177,467
Other Income	20,426	17,421	3,005	17,421
Total Operating Income	**208,023**	**194,888**	**13,135**	**194,888**
Total Operating Expenditure	(202,714)	(191,018)	(11,696)	(191,018)
Operating Surplus	**5,309**	**3,870**	**1,439**	**3,870**
JV Profit	262	664	(402)	664
Finance Costs	(5,111)	(5,388)	277	(5,388)
Trust Surplus/Deficit	**460**	**(854)**	**1,314**	**(854)**
CPL/Propcare	730		730	
Consolidated Surplus/Deficit	**1,190**	**(854)**	**2,044**	**(854)**

As stated above, at the end of 2020/21 the Trust is reporting a £1.2m surplus. This is in line with the revised Trust forecast submitted on the 16th March of £0.6m with the additional funding of £0.3m for the increase in the annual leave accrual and an additional £0.3m to cover lost non-NHS funding due to Covid.

3.1.2 The table below summaries the consolidated financial position

March 2021 (12)	In Month Actual £'000s	YTD Actual £'000s
Trust Surplus/(Deficit)	**(5)**	**(397)**
Donated Depreciation	109	857
Trust Retained Surplus/(Deficit)	**104**	**460**
CPL	450	653
Propcare	(175)	77
Consolidated Financial Position	**379**	**1,190**

The final consolidated position of £1.2m surplus is a £2.0m positive variance against the plan submitted in NHSI for the 2nd half of the year. The key reasons for the positive variance are:

- Pay underspend due to delays in recruitments to additional posts for the new hospital.
- Depreciation on new hospital equipment assets lower than planned.
- Some contingencies relating to the new hospital move not materialising such as car parking costs.

3.1.3 Highlights in relation to the in-month position for March are as follows:

- Drug expenditure increased by £2.8m against plan, this was due to the large increase in activity during the month. The increased expenditure is matched with an increase in income received from NHSE as our high cost drugs are funded via a cost pass through arrangement.
- Depreciation is £84k higher than plan in month, this is due to the review of asset lives undertaken in February.
- Pay costs are £202k under plan. Pay spend in terms of run rate is increasing due to substantive vacancies continuing to being filled. There was an increase of 15 wte compared to the previous month. There has been an increase in bank costs in month 12 but a slight reduction in agency spend.
- Additional COVID-19 costs in March were £35k.
- Clatterbridge Pharmacy Ltd did not declare a dividend to the Trust during 2020-21, an original dividend of £458k was planned. This has the effect of showing an increased suplus for CPL and a reduced surplus for the Trust, but does not affect the consolidated position.

3.1.4 In terms of directorate budgetary performance, the March position is shown in the table below.

The in-month directorate pay position for March shows that operational departments are operating in line with plan, pay has further increased in terms of run rate. Drugs spend is showing on one line and is showing an overall overspend of £2.7m, offset by PBR income. In general, excluding drugs, the Directorates are near break-even against non-pay budgets, excluding our corporate budgets which is where both the additional depreciation charged in month and the CCCL Rates additional costs are charged.

£000	Pay			Non-Pay			Total Expenditure
	Budget	Actual	Variance	Budget	Actual	Variance	Variance
Radiation Services	(1,661)	(1,683)	**(23)**	(331)	(467)	**(136)**	**(159)**
Chemotherapy	(1,051)	(1,012)	**39**	(845)	(997)	**(152)**	**(113)**
Integrated Care	(979)	(1,055)	**(76)**	(98)	(136)	**(38)**	**(114)**
Haemato-Oncology	(573)	(654)	**(82)**	(342)	(415)	**(73)**	**(154)**
Drugs - All	0	0	**0**	(6,012)	(8,758)	**(2,746)**	**(2,746)**
Research	(316)	(279)	**37**	(30)	(32)	**(2)**	**35**
Other / Corporate	(1,901)	(1,872)	**29**	(2,193)	(3,563)	**(1,370)**	**(1,342)**
Sub-Total Operating	**(6,480)**	**(6,556)**	**(76)**	**(9,851)**	**(14,368)**	**(4,518)**	**(4,594)**
Cancer Alliance	(134)	(62)	**72**	(429)	(1,286)	**(857)**	**(786)**
Non Operating Costs	0	0	**0**	(405)	(29)	**376**	**376**
TOTAL	**(6,614)**	**(6,618)**	**(4)**	**(10,685)**	**(15,684)**	**(4,999)**	**(5,003)**

Overall wte have increased from M11 by 15wte, of which 6wte are substantive and 10wte are bank.

20-21 Budget M12	WTE			
	Budget	Actual	Variance	M11 Actual
Radiation Services	323.57	316.17	**7.40**	318.21
Chemotherapy	265.44	249.01	**16.43**	246.18
Integrated Care	344.60	363.73	**(19.13)**	343.31
Haemato-Oncology	57.06	56.01	**1.05**	54.58
Research	73.95	59.90	**14.05**	58.58
Other / Corporate	403.90	400.59	**3.31**	408.58
TOTAL	**1,468.52**	**1,445.41**	**23.11**	**1,429.44**
Cancer Alliance	27.40	25.28	**2.12**	25.26
TOTAL	**1,495.92**	**1,470.69**	**25.23**	**1,454.70**
Of which Bank		57.09	**(57.09)**	**47.02**
Of which Substantive	**1,495.92**	**1,413.60**	**82.32**	**1,407.68**

3.2 **Bank and Agency Reporting**

Bank spend is £175k in month. This has increased significantly since month 11. Agency spend in month is £55k which is an overall reduction compared to previous months spend. See Appendix E for a breakdown of bank and agency spend.

3.3 **Cost Improvement Programme (CIP)**

3.4 As previously reported CIP was suspended for the first 6 months of the year. In line with the STP minimum requirement of 1.1% for the second half of the year a CIP requirement of £600k has been planned for the final 6 months of the year.

3.5 A detailed piece of work was undertaken earlier in the year to check confidence in delivery. This has been split into a scheme profile for October to March:

- CIP achieved £248k
- CIP budget underspends £356k

Overall, this gives a total delivery value of £604k, in line with the plan. The achieved schemes have been approved and transacted.

4. Cash and Capital

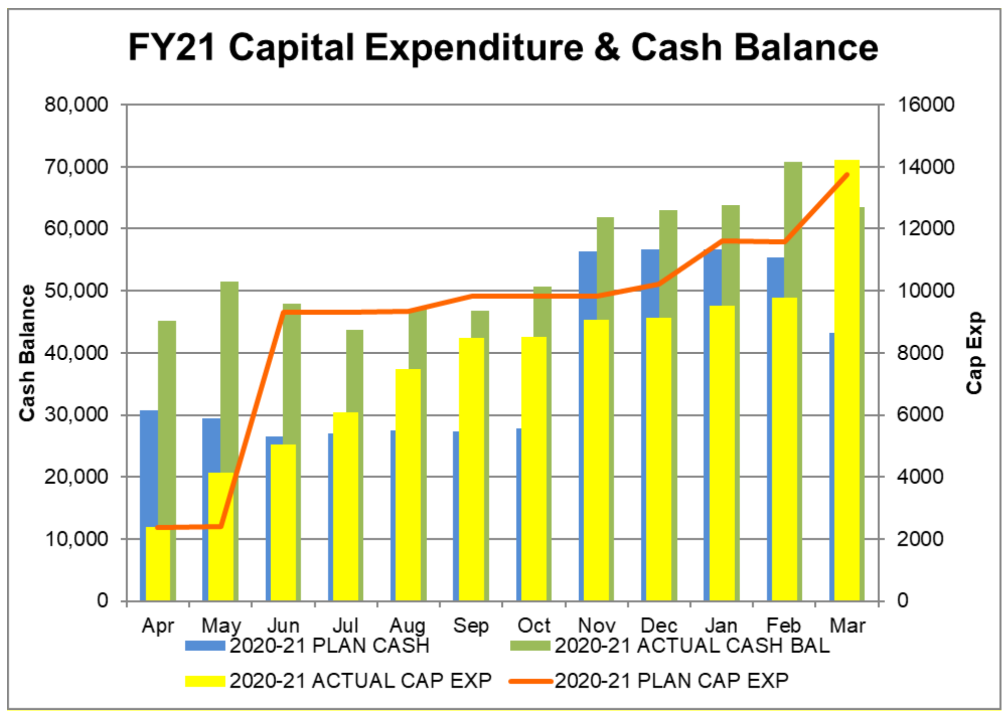
4.1 The original capital plan previously approved by the Board is £12.8m. It has since been revised to reflect additional national PDC funding received in year for agreed additional schemes. The final plan submitted to NHSI is £13.7m.

4.2 Capital expenditure of £14.2m has been incurred to the end of March against the year to date plan of £13.7m. The £462k overspend is due to the Trust being asked by the Cheshire & Mersey ICS to bring forward some schemes from 2021-22 due to an under-spend of capital resource across Cheshire & Mersey. If the money is not spent by the system in the year it is not carried forward to 2021-22.

4.3 The capital programme is supported by the organisation's cash position. The Group has a closing cash position of £63.5m, which is a positive variance of £20.2m to the planned closing cash position. While cash has reduced since the previous month due to the Trust no longer receiving cash in advance from commissioners for April it is still much higher

than plan, the reasons include receipt of significant debt balances due in February and also a large proportion of our capital programme spend being in March, therefore actual payments have not been made.

4.4 The Balance Sheet (Statement of Financial Position) is included in Appendix B and Cashflow in Appendix C.



This chart shows monthly planned and actual Cash Balances and Planned Capital Expenditure for 2020-21. It shows that for February the Trust has more cash than planned.

5. Recommendations

5.1 The Trust Board is asked to note the contents of the report, with reference to:

- The consolidated 2020-21 surplus of £1.2m (subject to audit)
- The capital spend in year is £14.2m, £0.5m higher than plan at the request of the C&M ICS
- The continuing strong liquidity position of the Trust

Appendix A – Income & Expenditure (Statement of Comprehensive Income)

	Month 12			Cumulative YTD				Annual Plan
	Plan (£000)	Actual (£000)	Variance (£000)	Plan (£000)	Actual (£000)	Variance (£000)	%	(£000)
Clinical Income	**15,199**	**19,249**	**4,051**	**177,467**	**187,595**	**10,128**	**6%**	**177,467**
Other Income	677	4,267	3,590	7,023	12,556	5,533		7,023
Hosted Services	867	1,904	1,038	10,398	7,873	(2,525)		10,398
Total Operating Income	**16,742**	**25,420**	**8,678**	**194,888**	**208,023**	**13,135**	**7%**	**194,888**
Pay: Trust (excluding Hosted)	(6,156)	(9,289)	(3,133)	(66,884)	(67,726)	(842)		(66,884)
Pay: Hosted	(450)	(342)	108	(5,367)	(4,297)	1,070		(5,367)
Drugs expenditure	(6,012)	(8,758)	(2,746)	(70,474)	(75,394)	(4,920)		(70,474)
Other non-pay: Trust (excluding Hosted)	(3,816)	(5,581)	(1,765)	(42,785)	(51,028)	(8,243)		(42,785)
Non-pay: Hosted	(459)	(1,318)	(859)	(5,508)	(4,269)	1,239		(5,508)
Total Operating Expenditure	**(16,892)**	**(25,287)**	**(8,395)**	**(191,019)**	**(202,714)**	**(11,696)**	**6%**	**(191,019)**
Operating Surplus	**(151)**	**133**	**284**	**3,869**	**5,309**	**1,440**	**37%**	**3,869**
Profit /(Loss) from Joint Venture	44	44	0	664	262	(402)		664
Interest receivable (+)	8	445	437	98	4,931	4,833		98
Interest payable (-)	(57)	(416)	(359)	(679)	(5,538)	(4,859)		(679)
Finance Lease interest	(1)	0	1	(7)	(2)	4		(7)
PDC Dividends payable (-)	(400)	(102)	298	(4,800)	(4,502)	298		(4,800)
Trust Retained surplus/(deficit)	**(556)**	**104**	**660**	**(854)**	**460**	**1,314**	**-154%**	**(854)**
CPL/Propcare	0	275	275	0	730	730		0
Consolidated Surplus/(deficit)]	**(556)**	**379**	**935**	**(854)**	**1,190**	**2,044**	**-154%**	**(854)**

6

Appendix B – Balance Sheet (Statement of Financial Position)

	Audited 2020 (£000)	NHSI Plan 2021 (£000)	Mar-21 YTD Plan (£000)	Mar-21 Actual YTD (£000)	Mar-21 Variance (£000)
Non-current assets					
Intangible assets	2,143	1,857	1,906	2,184	278
Property, plant & equipment	205,907	177,462	178,823	177,480	(1,342)
Investments in associates	519	710	93	181	87
Other financial assets	124,317	-	-	-	-
Trade & other receivables	21	-	-	161	161
Other assets	-		147		(147)
Total non-current assets	**332,908**	**180,029**	**180,969**	**180,006**	**(963)**
Current assets					
Inventories	1,649	4,000	4,372	4,201	(171)
Trade & other receivables					
NHS receivables	19,301	20,000	9,036	3,916	(5,119)
Non-NHS receivables	25,800	8,000	9,896	7,772	(2,124)
Cash and cash equivalents	29,299	43,285	63,734	60,248	(3,486)
Total current assets	**76,049**	**75,285**	**87,038**	**76,138**	**(10,900)**
Current liabilities					
Trade & other payables					
Non-capital creditors	35,747	37,000	46,540	28,974	(17,566)
Capital creditors	7,157	1,000	163	2,031	1,867
Borrowings					
Loans	1,925	1,830	1,871	1,916	45
Obligations under finance leases	56	-	-	-	-
Provisions	233	500	476	3,479	3,003
Other liabilities:-					
Deferred income	2,900	2,000	6,863	5,974	(888)
Other	-				-
Total current liabilities	**48,018**	**42,330**	**55,913**	**42,374**	**(13,539)**
Total assets less current liabilities	**360,939**	**212,984**	**212,094**	**213,769**	**1,676**
Non-current liabilities					
Trade & other payables					
Capital creditors		500	970	970	-
Borrowings					
Loans	35,550	33,820	33,945	33,820	(125)
Obligations under finance leases	-				-
Other liabilities:-					
Deferred income	1,156	-			-
Provisions	121				
PropCare liability	124,926		(1)		1
Total non current liabilities	**161,754**	**34,320**	**34,914**	**34,789**	**(125)**
Total net assets employed	**199,185**	**178,664**	**177,180**	**178,981**	**1,801**
Financed by (taxpayers' equity)					
Public Dividend Capital	60,819	65,457	65,457	67,374	1,917
Revaluation reserve	4,562	4,562	4,562	2,699	(1,863)
Income and expenditure reserve	133,804	108,645	107,162	108,908	1,746
Total taxpayers equity	**199,185**	**178,664**	**177,180**	**178,981**	**1,801**

Appendix C – Cash Flow Statement

Movement from 1st April 2020	Plan (£000)	Actual (£000)	Variance (£000)
Cash flows from operating activities:			
Operating surplus	(24,296)	(23,633)	663
Depreciation	5,832	7,913	2,081
Amortisation	214	329	115
Impairments	30,739	31,945	1,206
Movement in Trade Receivables	10,870	27,020	16,150
Movement in Other Assets	0	0	0
Movement in Inventories	(455)	(655)	(200)
Movement in Trade Payables	15,647	(2,493)	(18,140)
Movement in Other Liabilities	(900)	3,145	4,045
Movement in Provisions	165	3,144	2,979
CT paid	(174)	(345)	(171)
Net cash used in operating activities	**37,642**	**46,370**	**8,728**
Cash flows from investing activities			
Purchase of PPE	(23,062)	(21,459)	1,603
Purchase of Intangibles	0	(370)	(370)
Proceeds from sale of PPE	65	65	0
Interest received	58	35	(23)
Investment in associates	0	529	529
Net cash used in investing activities	**(22,939)**	**(21,200)**	**1,739**
Cash flows from financing activities			
Public dividend capital received	4,638	6,555	1,917
Public dividend capital repaid	(1,607)	0	1,607
Loans received	0	0	0
Movement in loans	0	(1,730)	(1,730)
Capital element of finance lease	(56)	(56)	0
Interest paid	(485)	(626)	(141)
Interest element of finance lease	(2)	2	4
PDC dividend paid	(1,200)	(4,502)	(3,302)
Finance lease - capital element repaid	0	0	0
Net cash used in financing activities	**1,288**	**(356)**	**(1,644)**
Net change in cash	**15,991**	**24,814**	**8,823**
Cash b/f	**35,435**	**35,435**	**0**
M7 adj for revised plan	**5,300**		**(5,300)**
Cash c/f	**56,726**	**60,248**	**3,522**

Appendix D – Capital

		NHSI plan		Month 12		Forecast	
	Profile	Full year £000	Month 12 £000	Actual £000	Variance £000	Profile	Full year £000
Estates							
DR X-ray room	Q1	40	40	61	21		49
Cyclotron office area refurb		0	0	25	25		28
CCC-A Linacc Oak Refurb		0	0	31	31		47
CCC-W Crest refurb		0	0	124	124		124
Spine		0	0	346	346		296
Contingency	Q4	500	500	0	-500		0
		540	**540**	**587**	**47**		**544**
Medical Equipment							
MRI (Liverpool)	Q1	632	632	564	-68		564
LinAcc transfer costs x4 (2020/21)	Q1	1,195	1,195	0	-1,195		0
X-ray (Liverpool)	Q1	153	153	153	0		153
HDR & Papillon transfer costs (Liverpool)	Q1	14	14	0	-14		0
DR X-ray room	Q1	180	180	183	3		194
Minor medical equipment	Q2	100	100	0	-100		100
CCC-W HVX Replacement		0	0	240	240		240
Brachytherapy applicators		0	0	265	265		279
Contingency:							
- Endoscopic Camera System	Q3/4	0	0	11	11		11
- Brachy Line Applicator	Q3/4	0	0	30	30		30
- Omniboard Accessories	Q3/4	0	0	11	11		11
- Draeger IACS Monitoring with C700	Q3/4	0	0	49	49		53
- Replacement of Mobius 3D (SunCHECK)		0	0	28	28		22
- Ultrasound		0	0	83	83		82
- Unallocated	Q4	500	500	0	-500		0
Prior year schemes		0	0	-119	-119		-119
Mobile X-Ray - DHSC Donation		96	96	96	0		
OPBT Equipment (Cyclotron)		1,149	1,149	1,054	-95		1,149
		4,019	**4,019**	**2,647**	**-1,372**		**2,769**
IM&T							
Infrastructure		161	161	122	-39		125
GDE		651	651	44	-607		123
Digital Aspirant Programme		1,310	1,310	768	-542		589
Covid		0	0	0	0		0
Other minor programmes	Q1-4	104	104	48	-56		0
7 Home Reporting Workstations		52	52	52	-0		52
Cyber Security Resilience		96	96	99	3		96
Ipads - Anytime Anywhere - Videoconf		20	20	24	4		20
		2,394	**2,394**	**1,156**	**-1,238**		**1,005**
Building for the Future							
Building works							
- Liverpool		3,234	3,234	5,071	1,837		5,071
- Wirral		1,200	1,200	0	-1,200		0
Group 3 equipment		2,310	2,310	2,357	47		2,357
IM&T		62	62	786	724		786
Link bridge installation		0	0	1,617	1,617		1,600
	Q1	**6,806**	**6,806**	**9,831**	**3,025**		**9,815**
TOTAL		**13,759**	**13,759**	**14,221**	**462**		**14,132**

Appendix E – Bank and Agency Spend