



Report Cover Sheet

Report to:	Board of Directors	
Date of the Meeting:	24 th February 2021	
Agenda Item:	P1-031-21	
Title:	IPR M10 2020/2021	
Report prepared by:	Hannah Gray, Head of Performance and Planning	
Executive Lead:	Joan Spencer, Chief Operating Officer	
Status of the Report:	Public	Private
	X	

Paper previously considered by:	Quality Committee
Date & Decision:	18 th February 2021

Purpose of the Paper/Key Points for Discussion:	<p>This report provides an update on performance for month ten (January 2021). The access, efficiency (including the Covid-19 recovery activity), 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. A Covid-19 recovery summary is provided, rather than exceptions only.</p> <p>Points for discussion include under performance, developments and key actions for improvement.</p>
---	---

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 10 2020/21)

Introduction

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

The staff Flu vaccination KPIs have been removed this month as these have been achieved for the year.

Staff Covid-19 vaccination KPIs are included this month. 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. A letter from NHSE/I on 26th January 2021 'Reducing burden and releasing capacity to manage the COVID-19 pandemic' updates and reconfirms (their) position on regulatory and reporting requirements for NHS trusts and foundation trusts'.

The 'Third Phase of NHS Response to Covid-19' KPIs are included in this report. There is a Covid-19 Recovery Activity scorecard, with accompanying narrative in section 3.

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	Jan-21	YTD	12 Month Trend
Executive Director Lead: Joan Spencer, Chief Operating Officer						
L	7 days from referral to first appointment	↔	90%	86.9%	90.8%	
C/S	2 week wait from GP referral to 1st appointment	↔	93%	100.0%	93.8%	
L	24 days from referral to first treatment	↔	85%	85.4%	87.0%	
C/S	28 day faster diagnosis - (Referral to diagnosis)	↓	75% (shadow monitoring)	33.0%	70.9%	
S	31 day wait from diagnosis to first treatment	↔	96%	99.5%	98.9%	
C/S	31 day wait for subsequent treatment (Drugs)	↔	98%	99.6%	99.4%	
C/S	31 day wait for subsequent treatment (Radiotherapy)	↔	94%	99.4%	98.2%	
S	Number of 31 day patients treated => day 73	↔	0	0	5	
C/S	62 Day wait from GP referral to treatment	↓	85%	83.5%	90.7%	
C/S	62 Day wait from screening to treatment	↔	90%	100.0%	95.2%	
L	Number of patients treated between 63 and 103 days (inclusive)	↑	No Target	37	264	
S	Number of patients treated => 104 days	↑	No Target	13	92	
L	Number of patients treated => 104 days AND at CCC for over 24 days	↔	0	3	26	
C/S	Diagnostics: 6 Week Wait	↔	99%	100%	100.0%	
C/S	18 weeks from referral to treatment (RTT) Incomplete Pathways	↔	92%	98.3%	97.6%	

Cheshire and Merseyside Performance

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Dec-20	YTD	12 Month Trend
Executive Director Lead: Liz Bishop, CMCA SRO						
C/S	2 week wait from GP referral to 1st appointment	↔	93%	90.1%	91.4%	
C/S	28 day faster diagnosis - (Referral to diagnosis)	↑	75% (shadow monitoring)	77.0%	75.0%	
C/S	62 Day wait from GP referral to treatment	↔	85%	81.0%	77.2%	

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	Jan-21	YTD	12 Month Trend
Executive Director Lead: Joan Spencer, Chief Operating Officer						
S	Length of Stay: Elective (days): Solid Tumour	↑	≤6.5	8.8	6.1	
S	Length of Stay: Emergency (days): Solid Tumour	↔	≤8	9.7	7.7	
S	Length of Stay: Elective (days): HO Ward 4	↔	≤21	13.6	12.3	
S	Length of Stay: Emergency (days): HO Ward 4	↔	≤22 (from Jan 21)	8	14.4	
S	Length of Stay: Elective (days): HO Ward 5	↔	≤32	30.6	20.3	
S	Length of Stay: Emergency (days): HO Ward 5	↔	≤46	12	26	
S	Delayed Transfers of Care as % of occupied bed days (Solid Tumour)	↑	≤3.5%	4.6%	4.2%	
S	Bed Occupancy: Midnight (Ward 4: HO)	↓	G: ≥92% A: 88-91.9% R: <88%	85.9%	78.2%	
S	Bed Occupancy: Midnight (Ward 5: HO)	↔	G: ≥80% A: 76%-79.9% R: <76%	74.6%	67.4%	
S	Bed Occupancy: Midday (Solid Tumour)	↔	G: ≥92% A: 88-91.9% R: <88%	84.7%	69.9%	
S	Bed Occupancy: Midnight (Solid Tumour)	↔	G: ≥92% A: 88-91.9% R: <88%	87.3%	70.7%	
C/S	% of elective procedures cancelled on or after the day of admission	↔	0%	None cancelled	None cancelled	
C/S	% of cancelled elective procedures (on or after the day of admission) rebooked within 28 days of cancellation	↔	100%	None cancelled	None cancelled	
C/S	% of urgent operations cancelled for a second time	↔	0%	None cancelled	None cancelled	
L	Radiology Reporting: Inpatients (within 24hrs)	↔	G: ≥90% A: 80-89.9% R: <80%	100.0%	96.0%	
L	Radiology Reporting: Outpatients (within 7 days)	↔	G: ≥90% A: 80-89.9% R: <80%	96.5%	94.4%	
L	Travel time to clinic appointment within 45 minutes	↔	G: ≥90%, R: <90%	97.2%	97.2%	
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%	96.3%	94.2%	
C	Data Quality - % of outpatients with an outcome	↔	G: ≥95%, A: 90% - 94.9%, R: <90%	98.4%	98.4%	
C	Data Quality - % of outpatients with an attend status	↔	G: ≥95%, A: 90% - 94.9%, R: <90%	98.8%	98.3%	
Executive Director Lead: James Thomson, Director of Finance						
S	Percentage of Subject Access Requests responded to within 1 month	↔	100%	100%	100%	
C	% of overdue ISN (Information Standard Notices)	↔	0%	0%	0%	

1.2.1 Covid-19 Recovery Activity

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	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD	Monthly Trend 2020/21
Local	Covid-19 positive inpatients (Definite Healthcare Associated)*	0	0	0	0	0	0	1	0	0	0	1	2	
Local	Covid-19 positive inpatients (Non 'Definite Healthcare Associated')*	No Target	13	3	3	0	0	8	12	11	3	2	55	
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%	87%	
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%	157%	
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%	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%	122%	
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%	100%	
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%	125%	
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%	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%	69%	
Local	Referrals: Total (as % of 2019/20)**	2019/20 figures	87%	62%	83%	73%	85%	95%	83%	95%	83%	86%	83%	
Local	SACT administration: Solid Tumour (as % of 2019/20)	2019/20 figures	89%	66%	97%	94%	90%	111%	96%	103%	121%	109%	97%	
Local	Radiotherapy Treatments (as % of 2019/20)	2019/20 figures	93%	77%	70%	72%	63%	71%	71%	74%	83%	66%	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%	151%	
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%	115%	
Local	Stem Cell Transplants	8.3 per month (as per CCC plan)	1	1	5	8	6	6	4	5	7	6	49	
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%	67%	
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%	33%	
Local	Staff and household members tested (inc. external tests)	No Target	99	62	193	117	37	144	84	36	25	46	843	
Local	Staff sickness absence: Covid-19 related (total occurrences)	No Target	49	36	18	21	4	18	26	24	21	68	285	
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%	1.5%	

Further detail on this data is provided in section 3

*The categories for Covid-19 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).

NB: there were 2 Covid-19 positive (Definite Healthcare Associated) inpatients in March 2020.

1.3 Quality

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

Directive	Key Performance Indicator	Change in RAG rating from	Target	Jan-21	YTD	12 Month Trend
Executive Director Lead: Sheila Lloyd, Director of Nursing and Quality						
C/S	Never Events	↔	0	0	0	
C/S	Serious Untoward Incidents (month reported to STEIS)	↓	0	0	6	
C/S	Serious Untoward Incidents: % submitted within 60 working days / agreed timescales	↔	100%	0 requiring submission	100%	
S	RIDDOR - number of reportable incidents	↑	0	1	2	
S	IRMER - number of reportable incidents	↔	0	1	9	
S	Incidents /1,000 Bed Days	↓	No target	181	214.88	
L	All incidents resulting in harm /1,000 bed days	↓	No target	16	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	0.06	
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%	98.7%	99.0%	
C/S	% of Sepsis patients being given IV antibiotics within an hour (ST)	↔	90%	97.2%	96.0%	
C/S	VTE Risk Assessment	↔	95%	96.0%	96.0%	
S	Dementia: Percentage to whom case finding is applied	↔	90%	91.0%	99.0%	
S	Dementia: Percentage with a diagnostic assessment	-	90%	No patients	100%	
S	Dementia: Percentage of cases referred	-	90%	No patients	No patients	No cases referred
C/S	Clostridium difficile infections (attributable)	↑	<=4 per yr	1	2	
C/S	E Coli (attributable)	↔	<=10 per yr	0	5	
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	

Quality scorecard continued on page 6

Directive	Key Performance Indicator	Change in RAG rating from	Target	Jan-21	YTD	12 Month Trend
Executive Director Lead: Sheila Lloyd, Director of Nursing and Quality						
C/S	FFT inpatient score (% positive)	-	95%	N/A	N/A	
C	FFT outpatient score (% positive)	-	95%	N/A	N/A	
C	Number of formal complaints received	↑	No target	3	23	
S	Number of formal complaints / count of WTE staff (ratio)	↑	No target	0.002	0.002	
C	% of formal complaints acknowledged within 3 working days	↔	100%	100%	100%	
L	% of routine formal complaints resolved in month, which were resolved within 25 working days*	-	100%	None resolved	27%	
L	% of complex formal complaints resolved in month, which were resolved within 60 working days*	-	100%	None resolved	N/A	
C/S	% of FOIs responded to within 20 days	↔	100%	100.0%	99.5%	
C/S	Number of IG incidents escalated to ICO	↔	0	0	0	
C	NICE Guidance: % of guidance compliant	↔	90%	94%	93%	
L	Number of policies due to go out of date in 3 months	↓	No target	15	N/A	
L	% of policies in date	↔	100%	94%	96%	
C/S	NHS E/I Patient Safety Alerts: number not implemented within set timescale.	↔	0	0	1	

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

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.

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	YTD	12 Month Trend
Local	Study Recruitment (All Activity incl SE & PIC)	↑	800 annual 66.7 per month	Number	57	33	21	24	122	175	121	92	90	116	851	
			100%	Percent	85%	49%	31%	36%	183%	262%	181%	138%	135%	174%	128%	
Local	Study Recruitment (Activity less SE & PIC)	↑	800 annual 66.7 per month	Number	3	5	21	24	122	175	98	92	90	116	746	
			100%	Percent	4%	7%	31%	36%	183%	262%	147%	138%	135%	174%	112%	
Local	SIREN Recruitment	● Target Achieved	250 participants 50 per month	Number					94	112	32	9	3		250	
			100%	Percent					188%	224%	64%	18%	6%		100%	
Local	Studies Opened	↑	47 annual 3.9 per month	Number	3	0	4	6	3	4	6	5	2	4	37	
			100%	Percent	77%	0%	103%	154%	77%	103%	154%	128%	51%	103%	95%	
Local/ NIHR	Studies Unpaused	↓	80% 6.7% per month	Number	0	4	26	24	5	7	10	7	1	0	84	
			6.7%	Percent		4.5%	29.2%	27.0%	5.6%	7.9%	11.4%	8.0%	1.1%	0.0%	129.2%	
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	Jan-21	YTD	12 Month Trend
Executive Director Lead: Jayne Shaw, Director of Workforce and Organisational Development						
S	Staff Sickness (monthly)	↑	G: <=4%, A: 4.1 - 4.9%, R: >=5%	6.5%	4.6%	
S	Staff Turnover	↔	G: <=1.2%, A: 1.21- 1.24%, R: >=1.25%	0.8%	0.93%	
S	Statutory and Mandatory Training	↔	G: >=90%, A: 75 - 89%, R: <=75%	94.80%	N/A	
L	PADR rate	↔	G: >=95%, A: 75 - 94.9%, R: <=74%	91.4%	N/A	
S	FFT staff: Recommend as a place to work (Quarterly survey)	-	G: >=95%, A: 90 - 94.9%, R: <=90%	N/A	N/A	
S	FFT staff: Recommend care and treatment (Quarterly survey)	-	G: >=95%, A: 90 - 94.9%, R: <=90%	N/A	N/A	
L	% of Staff who have had the first Covid-19 vaccination (at month end)	-	No national target	75%	N/A	
L	% of BAME Staff who have had the first Covid-19 vaccination (at month end)	-	No national target	58%	N/A	
L	% of Staff who have had the first Covid-19 vaccination or have refused the vaccination (at month end)	-	No national target	81%	N/A	
L	% of BAME Staff who have had the first Covid-19 vaccination or have refused the vaccination (at month end)	-	No national target	61%	N/A	

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

1.6 Finance

For January 2021 the key financial headlines are:

Metric	In Mth 10 Actual	In Mth 10 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit) (£000)	491	(112)	603	Green	195	377	(182)	Green
CPL/Propcare Surplus/ (Deficit) (£000)	(1)	0	(1)	Green	472	0	472	Green
Control Total Surplus/ (Deficit) (£000)	490	(112)	602	Green	667	377	290	Green
Cash holding (£000)	63,734	56,139	7,595	Green	63,734	56,139	7,595	Green
Capital Expenditure (£000)	387	1,408	(1,021)	Yellow	9,505	11,616	2,111	Yellow

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

2. Exception Reports

2.1 Access

7 Days from referral to 1 st appointment:	Target	Jan 21	YTD	12 month trend
Number of patients seen => 7 days	90%	86.9%	90.8%	
Reason for non-compliance 17 patients breached the 7 day target in January. None of these patients breached any other target. The main tumour group for the breaches was urology. This was due to sickness within the Consultant Team, who has now returned to work.				
Action Taken to improve compliance <ul style="list-style-type: none"> Potential 7 day breaches are managed on an individual basis to ensure they are seen in a timely manner. The SRG lead for urology is reviewing new referrals to ensure there is equity for both the North and South sectors. 				
Expected date of compliance	31/3/21			
Escalation route	CWT Target Operational Group, Divisional Performance Reviews, Performance Committee, Trust Board			
Executive Lead	Joan Spencer, Chief Operating Officer			

28 day Faster Diagnosis (referral to diagnosis or ruling out of cancer)	Target	Jan 21	YTD	12 month trend
	75% (not yet formally agreed)	33.3%	70.9%	
Reason for non-compliance 4 patients breached the 28 FDS day target in January. 3 of the breaches were avoidable and 1 was unavoidable. The avoidable breaches were due to delay to diagnostics (CT and bone marrow aspirate) due to capacity and an IT system related issue at RLH which affected ENT referrals. The patient requiring a CT was given an initial appointment beyond the target deadline, The cancer waits trackers attempted to escalate, however there was then no capacity to bring this forward. Delays to Bone Marrow aspirate were due to changes within the service and capacity. The unavoidable breach was due to a complex patient pathway.				
Action Taken to improve compliance				

<ul style="list-style-type: none"> Diagnostic Imaging capacity issues are escalated to the Business Managers for expedition and potential breaches are managed on an individual basis to ensure they are seen in a timely manner. HO Business Manager to review emergency Bone Marrow Aspirate appointment capacity and to review staff training to undertake this work. The IT system issues regarding requesting referrals to ENT via ICE on migration from IPM to Meditech have now been resolved. 	
Expected date of compliance	31/3/21
Escalation route	CWT Target Operational Group, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

62 Day wait from GP referral to treatment	Target	Jan 21	YTD	12 month trend
	85%	83.5%	90.7%	
<p>Reason for non-compliance</p> <p>Non-compliance with the 62 day standard in January 2021 was due to 9 patients breaching the 24 and 62 day target.</p> <p>7 of the breaches were unavoidable. 3 of these 7 patients required further molecular/genetic tests. These test results can often take a long time to report, however they offer patients the opportunity to receive individual care that can improve patient outcomes. The reasons for the remaining unavoidable breaches include patient choice and medical reasons.</p> <p>There were 2 avoidable breaches, which were due to the operational pressures within the Pharmacy department and delays with ordering DYPD testing (The DPD enzyme helps our body to break down Fluorouracil and Capecitabine used as a treatments for a number of different cancers).</p>				
<p>Action Taken to improve compliance</p> <ul style="list-style-type: none"> Pharmacy experienced operational issues during January which resulted in a number of treatments being delayed, these issues are now resolved and Pharmacy are back to business as normal. DPYD process has been reviewed and patients no longer need to travel to CCCL from other sites. Introduced a DPYD blood appointment on Meditech to ensure Phlebotomy staff can identify patient needing DPYD test. The DPYD SOP has been updated to reflect the changes and communicated to all staff. 				
Expected date of compliance	28/2/21			

Escalation route	CWT Target Operational Group, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

Long Waiting Cancer Patients:	Target	Jan 21	YTD	12 month trend
Number of patients treated => 104 days AND at CCC for over 24 days	0	3	26	

Reason for non-compliance

13 patients breached the 104+ day target in January; All patients were referred to CCC after day 38 (between day 70 and 300).

3 of the 13 patients also breached the CCC 24 day target. Two of the breaches (patients 8 and 9) were unavoidable. The breach details are as follows:

- Chemotherapy was booked to start within the target date but was deferred due to the delay to DPYD results (110 days at referring trust and 29 days at CCC).
- Patient required discussion in HO MDT meeting and review of unrelated medical condition prior to commencing treatment (84 days at referring trust and 33 days at CCC).
- Complex pathway – Patient has 2 lung primaries and requested a second surgical opinion. There was a change in the treatment plan due to disease progression (70 days at referring Trust and 38 days at CCC).

Action Taken to improve compliance

The DPYD process has been reviewed and patients no longer need to travel to CCCL from other sites. A DPYD blood appointment has been created in Meditech to ensure Phlebotomy staff can identify patients needing a DPYD test. The DPYD SOP has been updated to reflect the changes and communicated to all staff.

Expected date of compliance	28/2/21
Escalation route	CWT Target Operational Group, Divisional Performance Reviews, Performance Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer

2 week wait from GP referral to 1st appointment (Alliance-level)	Target	Dec 20	YTD	12 month trend (to Dec)
	93%	90.1%	91.4%	

Reason for non-compliance

Non-compliance with the 14 day standard in December 2020 was largely driven by underperformance in the following tumour groups:

- Breast 80.24% (similar to 80.93% last month)
- Lower Gastrointestinal 85.10% (down from 88.44% last month)

- Upper GI 87.06% (down from 88.83%)

Poor performance in breast cancer at Liverpool University Hospitals NHS FT had the biggest negative impact on performance, followed by poor performance in breast at Countess of Chester Hospital NHS FT. Outpatient capacity issues were recorded as the most frequent breach reason (in 88% of cases for breast, and 73% of breaches in other tumour groups), followed by patient choice (9% in breast, and 18% in other tumour groups).

Action Taken to improve compliance

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

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

62 Day wait from GP referral to treatment (Alliance-level)	Target	Dec 20	YTD	12 month trend (to Dec)
	85%	81.0%	77.2%	

Reason for non-compliance

Non-compliance with the 62 day standard in December 2020 was largely driven by underperformance in the following tumour groups:

- Urology 71.15% (down from 75.28% last month)
- Lower Gastrointestinal 60.98% (up from 58% last month)
- Gynaecology 53.23% (down from 63.41%)

December'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. There is a significant focus on restoring endoscopy activity and efficiency to pre-Covid-19 levels.

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 back to pre-pandemic levels

Expected date of compliance	Compliance with the 62 day standard is expected in Q4 2020/2021. However, recovery is at risk due to the second wave and potential third wave of Covid-19.
Escalation route	NHS England, North West CCC Performance Committee, Trust Board
Executive Lead	Liz Bishop, CMCA SRO

2.2 Efficiency

Length of Stay: Elective Solid Tumour Wards	Target	Jan 21	YTD	12 month trend
	<=6.5 days	8.8 days	6.1 days	
Reason for non-compliance				
<p>LoS for elective admissions is above target at 8.8 days.</p> <p>The increased LoS for elective patients in January 2021 was due to the complexity of the patients; in some cases requiring full MDT involvement to achieve their discharge from hospital.</p> <p>3 patients on an elective pathway experienced a delayed transfer of care.</p>				

The Patient Flow Team continue to work alongside the MDT to agree expected date of discharge and commence discharge planning earlier to prevent any delays. The teams are working hard to follow the 'Discharge to Assess' approach that the Government has provided in a response to the Covid-19 pandemic to ensure that patients are in the safest place during this very challenging time.

The CUR non-qualifying rate was 4.7% for January, indicating that the majority of patients had a valid clinical need to be an inpatient at CCC.

Action Taken to improve compliance

- Weekly LoS meetings continue to discuss any patients with a lengthened LoS or complex discharge needs
- Working with patient's Oncologist for a clear plan of care for the patient from early on in their admission
- Daily communications with MDT to ensure all are working towards discharge plan from admission when any complex discharge needs are raised

Expected date of compliance	30/02/21
Escalation route	Divisional Monthly Meeting / Quality and Safety Meeting, Divisional Performance Review, Integrated Governance Committee, Quality Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

Length of Stay: Emergency	Target	Jan 21	YTD	12 month trend
Solid Tumour Wards	8 days	9.7 days	7.7 days	

Reason for non-compliance

LoS for non-elective patients is 1.7 days above target at 9.7 days.

The lengthened LoS for non-elective patients is due to a combination of CCC offering mutual aid to LUHFT (increasing the acuity and therefore LoS of patients at CCC) and there being a number of complex discharges in January 2021.

There were 10 delayed transfers of care (DTOC) on ST wards this month and 1 on HO Wards equating to 59 days of lengthened hospital stay. 8 of the 11 DTOC patients were non-elective admissions.

Patients experienced delays for the following reasons:

- Very unwell patients requiring full MDT involvement to achieve their discharge
- Hospice transfers (especially as some have closed to admissions due to Covid-19)
- Nursing home placements
- Social packages of care to enable return home

Action Taken to improve compliance

- Weekly LoS meetings continue to discuss any patients with a lengthened LoS or complex discharge needs
- Daily COW MDT Board Rounds now take place on the inpatient wards led by the COW and ward Registrar with MDT present to highlight any concerns with regards to patient's plan of care, with the aim to ensure all patients have a clear plan and delays are prevented

Expected date of	30/02/21
Escalation route	Divisional Monthly Meeting / Quality and Safety Meeting, Divisional Performance Review, Integrated Governance Committee, Quality Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

Delayed Transfers Of Care (DTCOs): Solid Tumour Wards	Target	Jan 21	YTD	12 month trend
	≤3.5%	4.6%	4.2%	

Reason for non-compliance

There has been an increase in DTCOs on solid tumour wards from 2.6% in December 2020, to 4.6% in January 2021. There were a total of 59 days in delays, with 10 patients experiencing a DTOC (9 on ST wards and 1 on HO wards), ranging from 3 days to 14 days.

There were a number of complex patients, requiring the involvement of the full MDT to achieve their discharge. One patient was delayed for 14 days as they were referred to a hospice which then closed to admissions due to Covid-19 and the discharge plan had to be changed to a fast track Continuing Health Care (CHC) funded nursing home placement. 9 out of 11 patients required a CHC fast track application for package of care at home or a nursing home placement due to complex nursing needs and rapidly deteriorating condition/poor prognosis.

Action Taken to improve compliance

- Weekly 'Lengthened Length of Stay' meetings, including the AHP Team Leader, continue to ensure the flow of patients continues and any concerns can be escalated
- The Patient Flow Team continue to work with wider MDT to aid discharge planning during the COVID-19 pandemic, ensuring patients are discharged safely home or to a suitable care setting
- Daily COW MDT meetings continue to allow discussion of all inpatients so there is a clear plan for each patient

Expected date of compliance	30/02/21
Escalation route	Divisional Performance Reviews, Performance Committee, Trust Board

Bed Occupancy: Solid Tumour Wards	Target	Jan 21	YTD	12 month trend
	G: ≥92% A: 88-91.9% R: <88%	Midday 84.7%	69.9%	
	Midnight 87.3%	70.7%		
Reason for non-compliance				
<p>Solid tumour inpatient ward occupancy continues to be below the Trust's target of 92%, however this has increased month on month since April 2020 (except in December).</p> <p>During the month of January, there were 18 occasions on which the solid tumour wards were recorded at OPEL 3 level (red). The escalation beds on ward 3 were not used this month. There were however, 3 occasions on which patients were moved to HO Ward 4 to ensure bed availability for admissions via CDU and the planned pathway.</p> <p>The CUR non-qualifying rate for January is 4.7%, indicating appropriate utilisation of the beds.</p>				
Action Taken to improve compliance				
<ul style="list-style-type: none"> • Patient Flow Team continue to work with wider MDT to aid discharge planning during the COVID-19 pandemic • Continue to offer Mutual Aid to support LUHFT Trust with acute oncology patients and palliative patients to relieve bed pressures during the Covid-19 pandemic. 				
Expected date of compliance	30/02/21			
Escalation route	Divisional Performance Review, Performance Committee, Trust Board.			
Executive Lead	Joan Spencer, Chief Operating Officer			

Bed Occupancy: HO Wards	Ward	Target	Jan 21	YTD	12 month trend
	4	G: ≥92%, A: 88-91.9%, R: <88%	85.9%	78.2%	
5	G: =>80%, A: 76-79.9%, R: <76%	74.6%	67.4%		
Reason for non-compliance					
<p>In January 2021, bed occupancy on ward 4 continued to be under the Trust's target of 92% and was slightly decreased from December.</p> <p>In January 2021, bed occupancy on ward 5 (BMT Unit) was below the Trust's target of 80% (80% target benchmarked against other BMT units).</p>					

Reduced bed occupancy on ward 5 is a reflection of the reduced number of transplants carried out both in the CCC Transplant Programme and nationally as a result of the Covid-19 pandemic. In addition there was pause to the Stem Cell Transplant Programme in January for two weeks and elective admissions postponed to ensure patient safety, following a probable healthcare associated COVID-19 infection in a patient.

During January, Ward 4 have continued to offer support to the region to relieve bed pressures due to COVID-19. In addition there were 3 occasions where patients were moved to Ward 4 to relieve bed pressures on the solid tumour wards to ensure bed availability for admissions via CDU and the planned pathway.

Action Taken to improve compliance

- Continue to attend national and regional BMT meetings to maintain awareness of the latest position and guidance, to enable effective planning and preparation of patients eligible for BMT. Continue to work more closely with the Patient Flow Team and wider MDT to aid any discharge planning during the Covid-19 pandemic.
- Continue to offer Mutual Aid to support AUH and other Trust in the Cheshire & Merseyside Network with HO patients to relieve some of their bed pressures in response to the Covid-19 pandemic.
- Daily outlier review of HO outliers in LUHFT continues to ensure prompt transfer to CCC when clinically appropriate
- Continue to support the Trust with patient flow bed pressures to ensure bed availability for admissions

Expected date of compliance	28/02/21
Escalation route	Divisional Performance Review, Performance Committee, Trust Board.
Executive Lead	Joan Spencer, Chief Operating Officer

Ethnicity that is complete (or patient declined to answer)	Target	Jan 21	YTD	12 month trend
	July & Aug: 90% Sept & Oct: 95% Nov & Dec: 100%	96.3%	94.2% <small>(no RAG as target applied from M4)</small>	

Reason for non-compliance

The target of 100% for January was not achieved, however compliance has significantly improved from 89.5% in December to 96.3% in January.

With around 80% of patients now being seen remotely, the opportunities previously available to ask patients for this information, e.g. at reception desks, are now significantly reduced. New processes have been implemented from end of December 2020, including administration clerks telephoning relevant patients prior to appointments to request this data. The impact of this process change is evident in the improved performance in January 2021. An additional data report is now received and is supporting a more streamlined process. The compliance

will continue to be monitored and improved and a targeted focus will be applied to any areas where there are gaps, such as lack of information from referring trusts.

Action Taken to improve compliance

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

Expected date of compliance	31/3/21
Escalation route	Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

2.3 Quality

RIDDOR reportable incident	Target	Jan 21	YTD	12 month trend
	0	1	2	

Reason for non-compliance

On 20th January 2021 a staff member was working in the Aseptic Unit TIMP isolator room mixing chemotherapy. The hatch door was open and had been secured by the plastic catch. Whilst the staff member was working the plastic catch suddenly failed and the hatch door came down hitting the staff member on the head.

The staff member complained of feeling unwell following this incident and was taken to the Emergency Department for assessment by a colleague. As a result the staff member was absent from work over 7 days.

The incident was reported to the HSE as a RIDDOR on 2nd February 2021.

Action Taken to improve compliance

- Vinci was contacted and the latch to hold the door hatch was tightened straight away.
- The Envair engineer was contacted to come to site and assess all catches on the isolator.
- Isolator catches are under review with different options being considered to ensure the most appropriate latches are in use.
- Operators have been informed that they must check the latches prior to each session to ensure they are not loose.

Expected Date of Compliance	February 2021
------------------------------------	---------------

Escalation Route	Divisional Quality and Safety Meeting, Divisional Performance Review, LIRG, Integrated Governance Committee, Quality Committee, Trust Board
Executive Lead	Sheila Lloyd, Director of Nursing and Quality

IRMER reportable incidents	Target	Jan 21	YTD	12 month trend						
	0	1	9							

Reason for non-compliance

During January 2021, 1 incident occurred that was notifiable to the IRMER Inspector under the notification criteria – equipment malfunction leading to 3 or more imaging exposures in a single fraction. There was no harm to the patient from the incident.

Description of incident

Patient received 4 sets of kV images at one fraction after 3 faults occurred post verification imaging on two different machines.

Immediate actions taken

- The patient was transferred to a matched machine when the first fault occurred. A second unrelated fault then occurred after imaging on the matched machine. The patient was removed from the bed whilst necessary tests were carried out on the machine and on the patient’s plan but unfortunately the fault recurred again after a third set of images were taken. The patient was successfully imaged and treated on the initial machine after parts had been replaced and the machine handed back for clinical use. Local procedures were followed in full in response to each fault.
- An explanation and apology was provided to the patient.
- The practitioner was informed and the incident was recorded in the patient record (Aria).
- A 72 hour review was held, dose calculation performed and the incident was reported to the IRMER Inspector within the required timeframe.

Planned actions

- Investigate the use of Machine Performance Check (MPC) software daily to predict Collimator faults that may occur. The standard MPC software does not give the detail of individual leaves within the collimator and therefore the aim of the investigation is to determine whether additional software development would be possible and prove useful.

Expected date of compliance	To be confirmed dependent on whether action requiring software development is taken forward
Escalation route	Escalation and reporting as per Incident Reporting Policy Divisional Quality and Safety Meeting, Divisional Performance Review, LIRG, Quality Committee, Trust Board

Executive Lead	Sheila Lloyd, Director of Nursing and Quality
-----------------------	---

Clostridium Difficile (attributable)	Target	Jan 21	YTD	12 month trend
	<=4 per yr	1	2	■ ■ ■ ■ ■
<p>Reason for non-compliance</p> <p>A patient on Ward 2 received multiple antibiotic treatments for ongoing line sepsis and developed loose stools 15 days post admission following clinical deterioration in their condition. The patient was transferred to critical care at LUHFT where they died, due to an underlying clinical condition.</p> <p>Early indication is that one of the antibiotics used (Ciprofloxacin) is not recommended for line infection treatment and can increase the risk of C.diff development.</p>				
<p>Action taken to improve compliance</p> <p>Improved antimicrobial prescribing will be monitored by the antimicrobial pharmacist as per the ongoing audit program. The clinical team involved in this incident have been notified and discussions are taking place regarding appropriate antimicrobial prescribing.</p> <p>A Post Infection Review (PIR) is in progress and any lessons learned identified will be shared with clinical teams via the Divisional structure.</p>				
Expected date of	01/03/21			
Escalation route	Harm Free Care Meeting, Infection Prevention and Control Committee, Divisional Quality and Safety Meeting, Divisional Performance Reviews, Integrated Governance Committee, Quality Committee, Trust Board			
Executive Lead	Sheila Lloyd, Director of Nursing and Quality			

Complaints: routine and complex	Jan 21
	None Resolved
<p>Reason for non-compliance</p> <p>Two complaints were due to be closed in January 2021; 1 routine and 1 complex.</p> <p><u>Routine Complaint</u></p> <p>The initial complaint had been responded to in August 2020 but on 10th December 2020 the complainant contacted Warrington Hospital (leading the complaint) raising further questions for both them and CCC. CCC were notified the same day and the complaint was re-opened. The due date for the complaint response was 29th January 2021.</p>	

The complainant was made aware that the response time may exceed the 29th January due to the complexity of the questions raised. The complaint response remains outstanding.

Whilst the complaint has not met the 25 working day KPI target, it is compliant with the policy in place at that time with regard to liaising with the complainant and explaining the delay and need for a revised response date.

Complex Complaint

The complaint was received into the Trust on 26th October 2020 and required input from 2 other organisations in order to answer the queries raised, therefore the complaint was opened as complex and the due date was 20th January 2021.

On 14th January 2021 an attempt was made to contact the complainant to explain we were still waiting for a response from another organisation and our full response would be delayed, however we were unable to contact the complainant.

On 20th January 2021 it was noted that the patient had passed away. As there was no consent from the complainant to share the response with anyone else, a decision was made to complete the complaint response and save the response on file, ensuring any lessons learned were shared as per usual process. Once the complaint response is approved the complaint will be closed.

Action Taken to improve compliance

A weekly tracker of complaints is sent to the divisions on a weekly basis with a request to ensure all outstanding responses are completed.

Complaints are included in the Divisional Quality and Safety and Performance meetings

Complaints are now reported to IGC on a monthly basis.

A deep dive is being undertaken to review the process of complaints management and recommend changes to streamline the process and improve compliance.

Expected date of compliance	March 2021
Escalation route	Divisional Quality and Safety and Performance meetings, LIRG, Integrated Governance Committee, Quality Committee, Trust Board
Executive Lead	Sheila Lloyd, Director of Nursing and Quality

% of Policies In Date	Target	Jan 21	YTD	12 month trend
	100%	94%	96%	

Reason for non-compliance

Out of a total of 267 policies, sixteen were out of date at the end of January 2021, resulting in a compliance figure of 94%.

Of the sixteen policies:

- One policy, Long Service Awards Policy, is four months out of date, however this policy was approved at the December 20 Workforce, Education & OD Committee and the Document Control Manager is awaiting the final draft of the policy and Committee meeting minutes to enable publication.
- Fifteen policies are between one and three months out of date, however ten of these policies are due to be approved at Committees/Groups or by Senior Managers during February and March. The remaining five policies 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 policies three months out of date, or with any major issues.
- Out of date policy information is provided for review at monthly Divisional meetings and Performance Reviews.
- Bi-monthly Document Control update reports are presented at the Information Governance Board.
- Promotion of policy self-management with Document Owners – ongoing.
- Targeted meetings being held between Information Governance staff and Document Owners – ongoing.
- Undertake comprehensive training/overview of QPulse functionality with Ideagen to investigate greater use of automation e.g. policy review reminders to Document Owners – Initial training cancelled April 2020 due to COVID-19 to reschedule for remote delivery by during Quarter 4 21.

Expected date of	31/03/21
Escalation route	Associate Director of Corporate Governance, Information Governance Board, Divisional Performance Reviews, Integrated Governance Committee, Quality Committee, Trust Board
Executive Lead	Liz Bishop, Chief Executive

2.4 Research and Innovation

	Target	Jan 21	YTD	12 month trend
--	--------	--------	-----	----------------

Studies opening to recruitment	47 per year, 3.9 per month	4	37	
Reason for non-compliance				
Thirty-seven studies have been opened to recruitment against an internal target of thirty-nine year to date. There are nine studies which have been locally approved and can be opened to recruitment following sponsor approval. No cancer studies could open during April and the majority of May 2020 due to the pandemic which has meant we are slightly under target.				
Action Taken to improve compliance				
<ul style="list-style-type: none"> The SRG Research Leads are actioned to review the NIHR portfolio to see if any further trials should be opened at CCC. Work with the Network to optimise opportunities. Work with Sponsors to greenlight studies where local approval has been given. 				
Expected date of compliance	Q4 2020/21			
Escalation route	SRG Research Leads, Committee for Research Strategy			
Executive Lead	Sheena Khanduri, Medical Director			

2.5 Workforce

Sickness Absence	Target	Jan 21	12 month rolling	12 Month Trend (in month figures)
	G: ≤4%, A:4.1-4.99%, R: ≥5.00%	6.46%	4.65%	
Reason for non-compliance				
The Trust 12 month rolling sickness absence is 4.65%, with the in-month sickness figure for January 2021 at 6.46%, the in-month figure has increased from December's figure of 4.12% and the 12 month rolling has also increased from 4.48%.				
The top three reasons for sickness absence, with the number of episodes for each are shown below:				
	Absence Reason	Number of Episodes		
1	Chest and Respiratory Problems	72		
2	Cold / Cough / Flu-Influenza	68		
3	Anxiety/Stress/Depression	34		
Chest and Respiratory was the Trust's highest reason for absence in January 2021. It was last the Trust's highest reason in October 20 with a total of 42 episodes. There has therefore been a significant increase in this figure for January 2021 and this may be attributed to the Covid-19 vaccine programme.				

The area with the highest number of absences due to this reason was the Chemotherapy Directorate with 21 absences followed by Integrated Care with 16 and Corporate with 14. A breakdown of the areas who experienced absences due to this reason is displayed below:

Directorate	Number of Episodes	Directorate	Number of Episodes
Chemotherapy	21	Research	3
Integrated Care	16	Haemato - Oncology	3
Corporate	14	Hosted Services	2
Radiation Services	13		

Within Chemotherapy, Outpatients CCCL experienced the highest number of Chest and Respiratory related absences with 8 in total, followed by Delamere Wirral with 6, Delamere Aintree with 5 and Outpatients Wirral and Pharmacy both experiencing just 1 absence each.

Within Integrated Care the AHP team experienced the highest number of Chest and Respiratory related absences with 9 in total followed by Ward 2 with 3 absences, Advanced Nursing and Common Cancers with 2 and the Interventional Team and Rare Cares both with just 1 absence.

Within Corporate, the SRG Tumour Group Team experienced the most Chest & Respiratory absences with 6 followed by Workforce & OD with 3 absences.

Absences due to cold/cough/influenza have increased significantly from 23 episodes in December 20 to 68 in January 2021.

A breakdown of areas with absences due to cold/cough/influenza are as follows:

Directorate	Number of Episodes	Directorate	Number of Episodes
Corporate	18	Chemotherapy	8
Integrated Care	14	Research	5
Haemato - Oncology	11	Hosted Services	2
Radiation Services	10		

Within Corporate, IM&T had the highest number of absences due to this reason with 6 in total followed by Workforce & OD and the Access & Directorate support team with 3, CET with 2 and Clinical Education, Executive Office, Finance and SRG Tumour Group Team all with 1 episode each.

Integrated Care had the second higher number of absences due to cold/cough/influenza with the majority of these occurring on ward 3 with 8 episodes, followed by ward 2 with 3 episodes. Common Cancers had 2 episodes and CDU/Hotline had one.

Absences relating to anxiety/stress/depression have remained the same since December 2020 with 34 episodes.

Of the total episodes 19 of them continued from December 2020 and 15 were new absences in January 2021. 14 of the total absences ended in January and 2020 continue into February 2021.

There were 4 absences due to anxiety/stress/depression that were due to work related reasons compared with 24 that were due to personal circumstances. It is unknown of the remaining 6 whether they are due to work or personal reasons due to being unable to receive confirmation from the manager.

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

Directorate	Number of Episodes
Chemotherapy	12 (increase of 4)
Corporate	7 (decrease of 3)
Integrated Care	5 (decrease of 1)
Haemato-Oncology	3 (decrease of 1)
Radiation Services	3 (decrease of 1)
Quality	2 (increase of 1)
Hosted Services	1 (decrease of 2)
Research	1 (increase of 1)

In January Chemotherapy had the highest number of absences due to anxiety/stress/depression. Pharmacy experienced 4 episodes followed by Outpatients, Delamere Wirral and Delamere Royal all with 2 episodes and Delamere home treat and Immunotherapy experienced one episode each.

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

Level 2 Reason	Number of Episodes
Stress	12
Anxiety	10
Blank (no level 2 reason recorded)	9
Panic Attacks	1
Not specified	1
Depression	1

Action Taken to improve compliance

- The introduction of Wellbeing Wednesdays – A new virtual drop-in surgery held by the L&OD team to signpost staff to the wellbeing support available across the Trust
- The Trust currently has 20 trained Mental Health First Aiders available for staff to contact for one to one support
- Health and wellbeing hub – available on the Trust Extranet which features supporting guides and resources
- The Trust has pledged its support to the Nursing Times 'COVID-19: Are you OK?' campaign. The campaign recognises the impact that the pandemic has had on so many healthcare staff and the need for appropriate support to be in place for staff mental health and wellbeing
- Team Time - a virtual forum of staff support. It is available for any team within the Trust to have a dedicated session (45 minutes) exploring the impact of COVID-19 on them, both professionally and personally. Team Time sessions are prepared, facilitated and supported by trained members of the Schwartz Round Steering Group.

Expected date of compliance	31/10/21
Escalation route	Divisional Meetings and Performance Reviews, WOD Committee, Quality Committee, Trust Board
Executive Lead	Jayne Shaw, Director of Workforce & OD

PADR	Target	Jan 21	12 Month Trend
	G: =>95%, A: 75 - 94.9%, R: =<75%	91.40%	
<p>Reason for non-compliance</p> <p>The Trust PADR window closed on 31st September 2020. Whilst the target of 95% was achieved by this date, it was only maintained for 1 month.</p> <p>Assurance was given by all underperforming directorates that compliance would be achieved by in January but due to the impacts of Covid-19 and subsequent staffing issues, only one directorate has achieved compliance.</p> <p>A report was presented and approved at the January 2021 Quality Committee to remove the PADR window and instead move towards a rolling 12-month PADR compliance. This approach supports the national changes to pay gateways and should provide greater assurance around the quality of PADR conversations as a result of PADRs being spread across a 12-month period.</p> <p>The committee also approved some changes to the PADR paperwork, linking it more subsequently to the new trust strategy and the NHS People Plan.</p>			
<p>Action taken to improve compliance.</p> <ul style="list-style-type: none"> • Continue to support directorates to effectively manage PADR completions. • Continue to provide monthly data on PADR due and outstanding PADR by directorate. • Continue to offer education and training around the Trust's PADR process and its importance. • Implement the changes to the PADR process as approved by Quality Committee. 			
Expected Date of Compliance	31/05/21		
Escalation Route	Divisional Meetings and Performance Reviews, Workforce Transformation Committee, Quality Committee, Trust Board		
Executive Lead	Jayne Shaw, Director of Workforce & OD		

3. Covid-19 Recovery Activity

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

The weekly Covid-19 Weekly Situation Report continues to be reported to Silver and Gold Command meetings every Thursday, and a Monthly report presented by the second Thursday of the month.

Elective Admissions

Although the percentage comparison with the previous year's activity has fallen from December 2020 (108%) to January 2021 (95%), this remains above the Covid-19 'Phase Three Guidance' target of 90%. The actual number of elective admissions has risen marginally from 92 admissions in December 2020 to 103 in January 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 59 patients in December to 78 patients in January and a reduction in HO elective admissions from 33 in December to 25 in January. In ST, the increase is in line with normal recovery following the Christmas and New Year period. In HO, the reduction is due to elective admissions being postponed to ensure patient safety, following a probable healthcare associated COVID-19 infection in a patient. Work continues to schedule patients to the most appropriate department to support flow across the trust.

Day Case

January 2021 data indicates a similar drop in activity for day cases as seen in previous months.

- Day Cases as % of Previous Year (HO): 67.4%
- Day Cases as % of Previous Year (ST): 25.2%

This is due to the transfer of planned day case activity to Level 1 and Level 6 day care units. TYA day case activity will remain within the ST bed base with a phased approach planned to move activity to Level 5.

HO day case activity has increased from 124 in December to 186 in January, with ST day case activity remaining static at around 50. 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.

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

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

A Task and finish group has been developed to review all HO and ST interventions for correct coding, to support effective internal planning and to ensure any financial risk is mitigated moving forward. This has been added to the risk register and an action plan is being developed.

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.

Full SRG recovery plans and reinstatement of local service provision have been implemented as per NHSE Covid-19 Phase 3 guidance. Despite a fall in new appointments in May – July (to between 71% and 84% of 2019 activity levels), higher levels of recovery have been reported in all other months since April 2020, as CCC successfully adopted digital solutions for remote new and follow up appointments and were able to sustain service provision.

As virtual consultations have increased, there has also been an increase in administration responsibilities for Consultants. In order to embed 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).
- The implementation of a new process for managing the remote clinics.

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 the OPD attendance where possible and support system capacity for any backlog of new cancer referrals. Progress to date includes:

Breast stratification (back to local follow up):

- 850 Liverpool patients
- 110 Isle of Man patients
- 42 Wirral patients
- A further 450 patients identified (awaiting stratification)

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

- 339 Wirral patients
- 163 Liverpool patients
- Warrington and Halton patients to be included in next phase of the plan (to commence February 2021)

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

Referrals

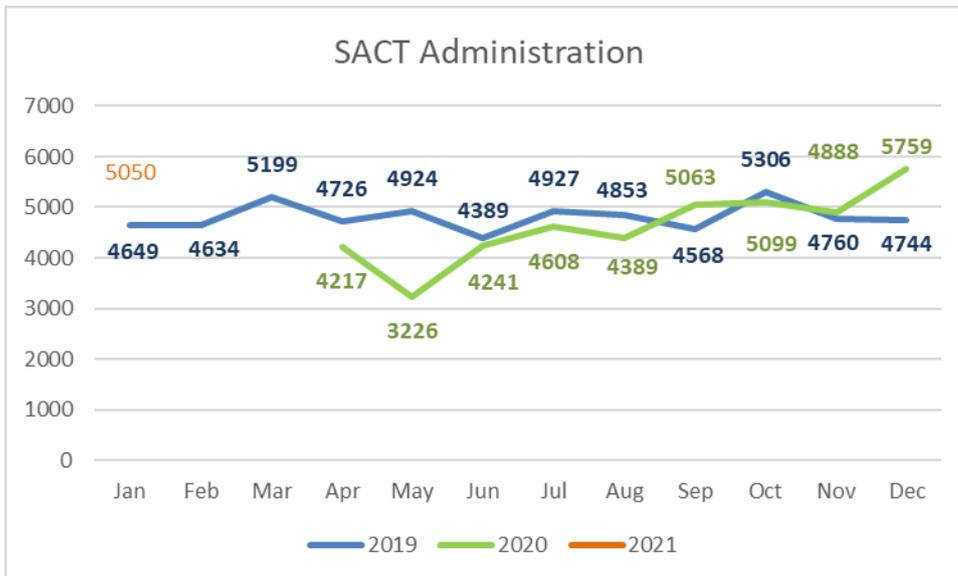
The Trust's assumption that referrals would increase above usual levels during Q3 (as the wider system manages the backlog in diagnostic testing and elective activity) were not realised. Planned restoration programs in the system were affected by the second and third wave of Covid-19 and this continues to adversely impact CCC's referrals. Referrals for January 2021 are at 86% (920 referrals) against the January 2020 total (1070 referrals).

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

The Trust monitors levels of pathway activity across the area, and is included in the Cancer Alliance work to increase patient flow.

SACT Administration

Although the Chemotherapy Department are currently working over plan, January 2021 data indicates a decrease to 5050 (108.6% of January 2020) on December 2020 activity of 5759 (121% of December 2019). This chart shows activity in 2019, 2020 and 2021.

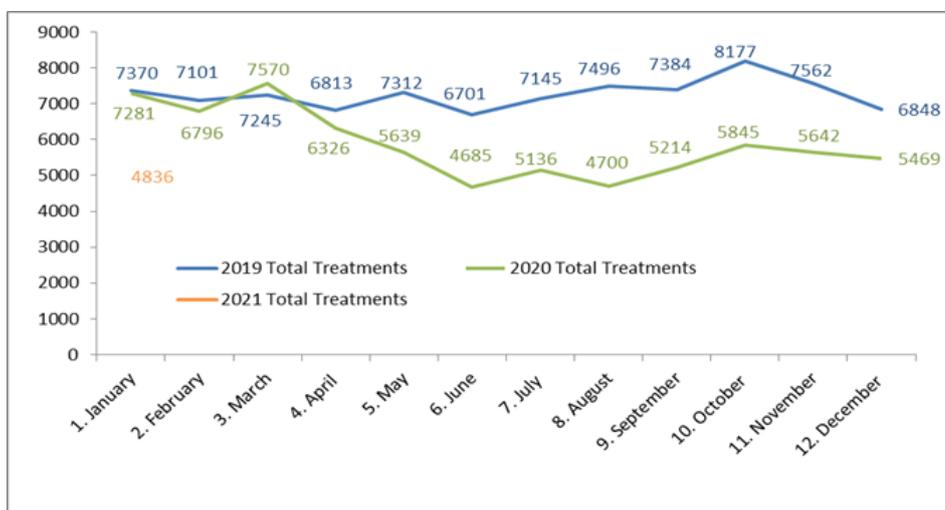


SRG recovery plans have now been reinstated in line with the Phase 3 Covid-19 NHSE guidance. The activity includes a change in treatment regimens for Lung TKIs and prostate (extended treatments) and also the move to 6 weekly Pembrolizumab (from 3 weekly). In addition, future activity trends may continue to identify spikes in oral SACT delivery due to multiple cycles of treatments being dispensed within a month, with fewer attendances but the same number of patients in these treatment groups. Similarly if cancer referrals decrease, SACT activity may also decrease, although the use of Immunotherapy continues to grow and may compensate for any reduction in new referrals.

The new pharmacy aseptic unit was operational at CCC-Liverpool on the 11th January 2021 to support the increase in activity. However, due to mould findings within the new production unit, the aseptic unit moved back to CCC-Wirral site on the 23rd January 2021.

Radiotherapy Treatments

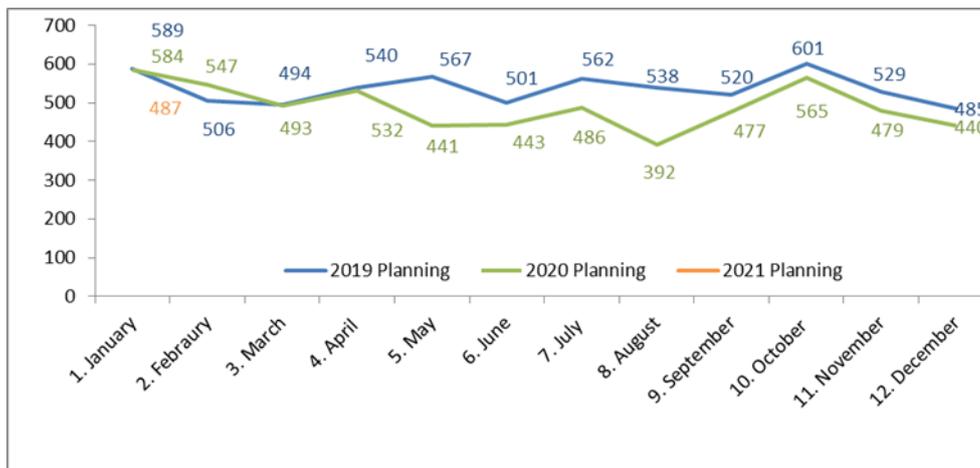
This chart compares the number of patients receiving radiotherapy treatment in 2019, 2020 and 2021.



Activity remains lower each month than in 2019 and this has fallen to 4836 in January 2021, which is significantly lower than in previous years.

The amount of radiotherapy fractions delivered per day still remain lower in 2020, mainly due to the reduced fractionation regimes in Breast (from 15 to fractions to 5), adopted pre Covid-19 and due to continue, as this change is not related to Covid-19.

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



For comparison to pre Covid-19 levels, the average utilisation on the Linacs from January 2020 to March 2020 was 93.5% with an average number of 320 fractions delivered per day. The average number of fractions delivered per day has reduced in January to 208 from 220 in December.

Utilisation over the last 2 weeks varies across the 3 sites;

CCC Site	Utilisation
CCC Liverpool	69.2%.
CCC Wirral	80.85% (number of pts treated at CCCW is 240 on NHS linacs & 71 NHS pts treated on PP linac)
CCC Aintree	56%

Discussions are ongoing with the clinical teams and the RT booking desk to allow other tumour sites to be safely treated at CCCW and CCCA with the necessary clinical support in place. The Radiotherapy department are producing an SBAR to recommend ways to allow more tumour sites to be treated across the 3 sites to more evenly spread the utilisation of the linacs.

Due to the third wave of Covid-19, it is likely that some elective surgery will be cancelled and referrals for radiotherapy will decrease.

Radiology

The Phase Three Covid-19 Guidance target of 100% of 2019 CT activity has been achieved, with 161% in January 2021.

The Phase Three Covid-19 Guidance target of 100% of 2019 MRI activity has been achieved, with 111% in January 2021.

CT and MRI activity continues to increase due to:

- Increased activity from HO for inpatients (opened mid-September)
- 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 also remains higher than in 2019, with 103% of 2019 activity in January 2021.

This is due to:

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

Stem Cell Transplants

In January 2021, 6 patients were discharged following stem cell transplant against a target of 9 patients per month. There have now been 49 patients YTD against a target of 83.

One patient on Ward 5 tested positive for Covid-19. To ensure the safety of all patients, 2 patients were delayed and the planned number was therefore not achieved. Effective infection control ensured that no further patients were infected.

The recovery of activity to plan was expected by November 2020, however due to the second and third waves 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 the pandemic.

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

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