QUALITY ACCOUNT
2020/21

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Contents

Part 1: Statement on quality from the Chief Executive

Development of the Quality Account

Our 2020/21 Quality Account has been developed with our staff, stakeholders and partner organisations, including clinicians, senior managers and our commissioners. It has been approved by the Trust Board.

Chief Executive's Statement on Quality

On behalf of the Trust Board and staff working at The Clatterbridge Cancer Centre NHS Foundation Trust (CCC), I am delighted to provide an update report on our Quality Account for the year 2020/21.

The world changed fundamentally while we were getting ready to open the new cancer hospital in Liverpool (CCC-L) in June 2020. The response of our teams to the challenges posed by the COVID-19 pandemic has been unprecedented. I am very proud that the commitment and dedication of our staff ensured the provision of non-surgical oncology services for our vulnerable cancer patients was maintained. We quickly adopted new innovative ways of working and collaborated across the Cheshire and Merseyside system, to make the changes necessary to keep our patients, staff and visitors safe.

HRH The Prince of Wales kindly opened our new flagship hospital in Liverpool utilising the digital technology available. This was a special moment for all our staff, celebrating the hard work achieved under unparalleled circumstances.

We have continued to develop oncology services and clinical pathways throughout 2020/21. Integration of solid tumour and haemato-oncology service provision was achieved in collaboration with Liverpool University Hospitals NHS Foundation Trust (LUHFT). It was also possible to expand our Clatterbridge in the Community service, allowing patients to receive treatment in the comfort and safety of their own homes.

We have also been shortlisted for a number of HSJ awards including Enhanced Supportive Care (ESC) and CIED Monitoring in Radiotherapy. In addition, we were highly commended in the 'Changing Culture' category of the HSJ Patient Safety Awards 2020 in recognition of our work to learn from deaths to keep improving the quality and safety of the care we provide. Doctors and other healthcare professionals meet to reflect on every inpatient death and consider whether anything could have been done differently. The day after a patient has died, their family or carers have a sit-down conversation with a senior nurse where they receive practical and emotional support and can provide any feedback – positive or negative – about the care their loved one received.

Our Immunotherapy service and Research & Innovation team continue to lead the way nationally with delivering new pipeline drugs to improve patient outcomes and life expectancy.

I would like to thank our staff and volunteers for the professionalism, expertise and commitment that has resulted in the many achievements evidenced in this report.

To the best of my knowledge, the information in the document is accurate.

Liz Bishop
Chief Executive

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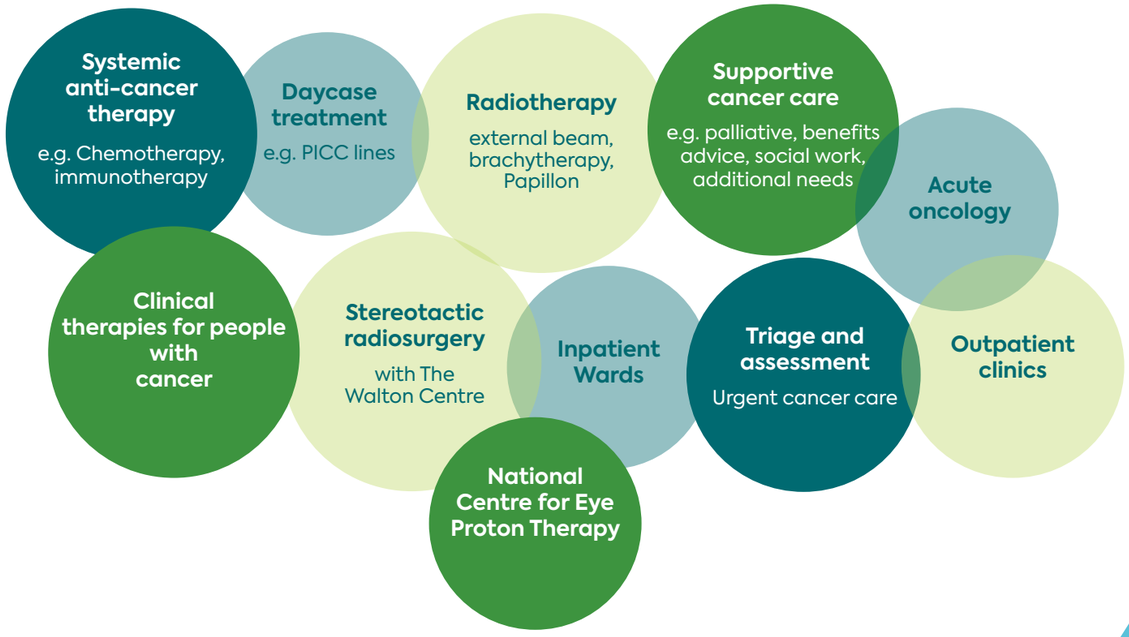
The Clatterbridge Cancer Centre (CCC) at a glance

We are a tertiary cancer centre, providing non-surgical cancer care. Our reputation and specialist services attract national and international cancer patients. Our three specialist cancer centres are in Aintree, Liverpool and Wirral. We also operate specialist chemotherapy clinics in four of Merseyside's district hospitals, making us one of the largest NHS providers of non-surgical cancer treatment for solid tumours and blood cancers. Our clinical model also includes the provision of chemotherapy in the home and workplace.

Together, this enables us to provide a comprehensive range of inpatient care, acute oncology, radiology, advanced radiotherapy, chemotherapy and other systemic anti-cancer therapies including gene therapies and immunotherapies. We are also the only facility in the UK providing low-energy proton beam therapy to treat rare eye cancers and we host the region's Teenage and Young Adult Unit. The diagram below describes the wide range of specialist services we provide across Cheshire and Merseyside.

What we do....

Tertiary non-surgical cancer care for the 2.4m people of Cheshire and Merseyside, including:



The opening of our new flagship specialist cancer centre in Liverpool

On 27th June 2020, the new Clatterbridge Cancer Centre in Liverpool (CCC-L) opened with the transfer of existing inpatients from the CCC-Wirral site. This was following an expedited 12-week commissioning process to ensure the building was ready to open and care for cancer patients during the height of the COVID-19 pandemic.

Following on from this significant milestone, the transfer of the Haemato-oncology service from Liverpool University Hospitals (based on the Royal Liverpool site) was successfully completed on 15th September 2020, thus realising the ambition to combine world-class cancer care for both solid tumours and blood cancers in one specialist treatment centre for the region. This was an amazing achievement and a truly collaborative effort from across the system with specific support from Liverpool University Hospitals, CCGs, North West Ambulance Service, Liverpool Clinical Laboratories and other partners during one of the most difficult and challenging times for the NHS as a whole.

The opening of the new hospital not only provides an outstanding environment for patients and staff in the heart of Liverpool but also provides state-of-the-art treatment facilities and greater research opportunities for patients with cancer.

Working collaboratively with Liverpool University Hospitals (LUHFT) has ensured mutual benefits for patients across both organisations. CCC patients have access to a range of clinical support and services from LUHFT, including the following:

- Critical Care access and support for acutely unwell patients
- Access to a wide range of specialist advice with the ability to refer patients for review
- Anaesthetic support for medical emergencies and theatre services
- Access to the Dental Hospital for patients specifically on Head and Neck treatment pathways and for some Haemato-oncology (H-O) patients.
- Provision of a comprehensive laboratory service, including analytical services, transfusion services, mortuary services, point-of-care testing and clinical support for microbiology / infection control.

A reciprocal arrangement of support is provided by CCC to LUHFT for services such as dosimetry, clinical support for the HODS service, and the provision of specialist clinical advice for oncology / haemato-oncology (H-O) patients who may attend or be an inpatient within LUHFT.

All of the above combine to provide a comprehensive, high-quality, safe and effective service for cancer patients in our region. Working with our partners across Cheshire and Merseyside in the opening of the new hospital and the continual development of services going forward has ensured that we can deliver the highest quality of care.

Care Quality Commission – inspection and ratings

The Clatterbridge Cancer Centre NHS Foundation Trust underwent an inspection of a number of core services and a Well Led inspection in Dec 2018/Jan 2019. The overall rating for the Trust was 'Good'. A comprehensive improvement plan, with weekly performance management meetings, was put in place to address the 'must do' and 'should do' recommendations raised within the inspection report published on 16th April 2019 with all actions now complete. The ratings grid is presented below:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Mar 2019	Good →← Mar 2019	Outstanding →← Mar 2019	Good Mar 2019	Requires improvement ↓ Mar 2019	Good →← Mar 2019
End of life care	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Outpatients	Good Mar 2019	Not Rated	Outstanding Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Diagnostic imaging	Requires improvement Mar 2019	Not Rated	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Chemotherapy	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Radiotherapy	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ Mar 2019	Good →← Mar 2019	Outstanding →← Mar 2019	Good Mar 2019	Requires improvement ↓ Mar 2019	Good →← Mar 2019

As part of the registration process for CCC-L, a number of virtual meetings were held with the CQC to enable the Trust to provide assurance that the building was fit for purpose and all appropriate risk assessments, processes and procedures were in place. Registration was granted in June 2020, prior to the building opening.

Although all CQC site visits were paused during 2020/21, the Trust continued to be in regular contact with the CQC engagement officer via videoconferencing and email. CCC has not participated in any special reviews or investigations by the CQC during the reporting period and no concerns were raised by CQC throughout the year.

Part 2:
Priorities for improving our quality of service

2.1 Priorities for improvement

Over the coming years, the Trust will retain a strong focus on improving the quality of the services it provides. This will be achieved via the delivery of the Clinical Quality Strategy 2019 – 2021. This three-year strategy had a clear focus on defining the quality objectives that delivered our Transforming Cancer Care programme. The 2019-2021 Clinical Quality Strategy is based on the CQC five domains:

- Are we safe?
- Are we effective?
- Are we caring?
- Are we responsive?
- Are we well led?

Our Quality goals continue to:

- Reduce avoidable harm
- Achieve the best clinical outcomes
- Provide the best patient experience

The strategy was developed and delivered through an ongoing programme of engagement with the Trust Board, Council of Governors, commissioners and local Healthwatch as well as with our staff via ongoing engagement processes throughout the year.

The purpose of the strategy is to articulate our ambitions for quality in a way that is meaningful and serves as a statement of intent that patients, carers, staff, commissioners and other stakeholders can use to hold the Trust Board to account for the delivery of high-quality services. By implementing this strategy, we want to enhance our reputation for providing the best possible treatment and treatment outcomes, delivered with excellence in care and compassion.

Quality Account priorities 2020/21

In the 2019/20 Quality Account, three specific priorities were stated for 2020/21. These were integral to a range of key quality priorities from our Clinical Quality Strategy 2019 – 2021 under the 5 CQC domains.

However, in this Quality Account, we have provided progress reports for all key quality priorities in our Clinical Quality Strategy 2019 – 2021, rather than only the three priorities listed.

The primary rationale for this is to provide greater assurance of quality improvement across the organisation, during a challenging year in which we opened CCC-L, transferred H-O services to CCC-L and faced the COVID-19 pandemic.

Section 3 includes details of progress against our key quality priorities in 2020/21 and our plans for 2021/22.

2.2 Statements of assurance from the Board

The required statements of assurance are included in the relevant sections of this report.

2.3 **Performance against core indicators**

The following tables present the Trust's performance against a core set of indicators. For each indicator (where the required data is made available by NHS Digital), the figures are compared with both:

- the national average
- NHS trusts and NHS foundation trusts with the highest and lowest figures.

To ensure standardisation of trusts' data, the source of this data is NHS Digital.

Table 1. Staff FFT:
% of staff who would recommend the Trust as a provider of care to their family or friends

Period	Trust Performance	National Average	National Range (lowest)	National Range (highest)
2020/21	89%	Data not published	Data not published	Data not published
2019/20	88%	70%	35%	95%
2018/19	90%	89%	77%	94%

Data source: NHS Digital Comparator group: Acute Specialist organisations
National figures for 2020/21 have not yet been published

The Clatterbridge Cancer Centre NHS Foundation Trust continues to review the quality of its services and develop improvements by:

- Continual development and monitoring of our internal quality indicators across a range of services.
- Ensuring staff views are heard directly by the Board through Patient Safety and Quality Leadership Walk Rounds.
- Sharing Trustwide staff survey results with all staff across the Trust.
- Sharing local staff survey results within individual teams and developing action plans in conjunction with the staff to improve services and experiences within their own areas.

Table 2. VTE:
The percentage of patients who were admitted to hospital and risk assessed for venous thromboembolism.

Period	Trust Performance	National Average	National Range (lowest)	National Range (highest)
Q4 20/21	95.5%	Not yet available	Not yet available	Not yet available
Q3 20/21	95.2%	Not yet available	Not yet available	Not yet available
Q2 20/21	97.26%	Not yet available	Not yet available	Not yet available
Q1 20/21	97.78%	Not yet available	Not yet available	Not yet available
Q4 19/20	93.76%	Not yet available	Not yet available	Not yet available
Q3 19/20	94.77%	95.25%	71.58%	100%
Q2 19/20	99.00%	95.40%	71.72%	100%
Q1 19/20	96.83%	95.56%	69.76%	100%

Data source: NHS Digital Comparator group: Acute Specialist organisations
(National figures for 2020/21 have not yet been published – VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic)

Overall, during 2020/21 the Trust was 96% compliant with timely completion of VTE risk assessments.

During 2020/21, 14 VTEs were identified of which 10 were classed as CCC-attributable, either occurring during an inpatient stay or the patient had had a previous inpatient stay within 90 days, as per NICE guideline definition. This compares to 53 VTEs identified during 2019/20, of which 26 were classed as CCC-attributable. All VTEs are discussed at the Harm Free Care Collaborative meeting to determine the level of harm, any lapses in care or lessons learnt. There were no incidents involving VTE reported as causing moderate harm, severe harm or death during 2020/21.

Table 3:
Patient safety incidents resulting in severe harm or death

Period	Trust Performance	National Average	National Range (lowest)	National Range (highest)
October 20 – March 21	1	Data not available	Data not available	Data not available
April 20 – September 20	0	Data not available	Data not available	Data not available
October 19 – March 20	0	1.64	0	8
April 19 – September 19	0	1	0	10
October 18 – March 19	0	1	0	4
April 18 – September 18	0	1	0	6

Data source: NHS Digital Comparator group: Acute Specialist (including acute specialist (children)) organisations

In December 2020, a patient suffered a reaction to chemotherapy treatment that resulted in their death. This was reported to the coroner and an inquest was opened along with a full internal investigation. Although the coroner gave a verdict of misadventure and no lapses in care were identified, a number of learning points were agreed and an action plan was developed; of the 7 actions arising from this investigation, 3 have been closed whilst 4 remain open and are due to be completed in June and December 2021.

During 2021/22 the Trust will continue to:

- Monitor incident reporting levels via the NRLS (National Reporting and Learning System)
- Improve feedback to staff who report incidents
- Continue to hold the daily incident call
- Launch the new Patient Safety Group to improve shared learning from a wide range of sources
- Develop a new SIRI Policy with a refreshed process in place
- Review and implement the NHSE/I Patient Safety Strategy Syllabus
- Improve organisational shared learning

According to the NRLS / National Patient Safety Agency, organisations that report more incidents usually have a better and a more effective safety culture. We will therefore continue to encourage staff to report all incidents and near misses as we see this as indicative of a proactive risk management and patient safety culture.

Table 4:
Patient safety incidents: Rate per 1,000 bed days

Period	Trust Performance	National Average	National Range (lowest)	National Range (highest)
October 20 – March 21	119.7	Data not available	Data not available	Data not available
April 20 – September 20	93.3	Data not available	Data not available	Data not available
October 19 – March 20	71.9	57.5	37.5	177
April 19 – September 19	92.0	64.0	23.0	184.1
October 18 – March 19	83.9	54.3	26.2	140.6
April 18 – September 18	72.9	52.3	19	142.8

Data source: NHS Digital Comparator group: Acute Specialist (including acute specialist (children)) organisations. There has been no national data published since Oct 19 – March 20

This figure is reported monthly through the Trust's Integrated Performance Report (IPR) to Trust Board.

There has been a significant increase in the reporting of patient safety incidents across the organisation during 2020/21; to support staff with the major service change, staff were encouraged to utilise the Trust Datix system to report any issues they felt may affect service delivery and patient care to enable rapid remedial action. This along with the COVID-19 pandemic has contributed to this change. Despite this high level of incident reporting, the level of patient harm has decreased in comparison to the previous year.

This indicates an excellent reporting culture and facilitates early identification of patient safety risks.

Part 3:
Progress on our Quality Priorities

This section provides detail on our progress and outlines plans for 2021/22 against a number of key quality priorities in the following 5 domains:

- **Patient safety**
- **Responsive**
- **Caring**
- **Clinically effective**
- **Well led**

Patient safety

		2019-21 Achieved
Safe: People are protected from abuse and avoidable harm		
S1	Develop and implement Infection Prevention and Control E.coli bundle to reduce the number of CCC associated infections	✓
S2	Deliver sustained and effective training in escalation and management of incidents and risk	✓
S3	Support a culture of safeguarding awareness, reporting & practice measured against internal and multi-agency action plans	✓
S4	Reduce avoidable harm so 95% of all inpatients receive VTE risk assessment and 100% receive prescribed prophylaxis	✓
S5	Ensure timely and efficient Sepsis/News2 patient management	✓
S6	Strengthen safer staffing through digital monitoring systems	✓
S7	Strengthen safety culture through standardisation of safety huddle agenda	✓
S8	Invest in research and innovation to deliver excellent patient care in the future	✓

S1. IPC: Develop and implement Infection Prevention & Control E.coli bundle to reduce the number of CCC-associated infections

Background

We are part of the cancer care E.coli collaborative, alongside The Royal Marsden, The Christie, Barts and Imperial College. Established in 2018, the aim of the collaborative is to gain a greater understanding of the aetiology of E.coli infections in cancer patients, benchmark, share best practice, and identify any themes particular to our patient group.

Key achievements to date

The ongoing SARS-CoV-2 pandemic proved challenging for the collaborative, with meeting frequencies reduced. However, at CCC work continued including:

- IPC attendance at Nutrition and Hydration Steering Group.
- Restructuring of the IPC team, with the recruitment of a new IPC matron and IPC doctor.
- Updated Trust antimicrobial prescribing formulary, coupled with 24-hour telephone advice available from a consultant microbiologist.
- Establishment of a robust post-infection review process to gain a better understanding of E.coli aetiology at CCC.
- A 44% reduction in healthcare-associated E.coli bloodstream infections since 2018/19, with all cases identified as unavoidable following post-infection review.

Aims and next steps

- Development of a three-year IPC strategy to include a sustained reduction in gram-negative bloodstream infections.
- Improved antimicrobial stewardship, including collaboration with LUHFT antimicrobial stewardship group.
- Establishment of a triumvirate ward round with IPC Nurse, Consultant Microbiologist and Antimicrobial Pharmacist to support in achieving this.
- Robust education in ANTT to support the risk associated with indwelling device management.
- Continued collaboration with other cancer care specialists.

S2. Training: Deliver sustained & effective training in escalation & management of incidents and risk

Background

In October 2020, the Trust had to cancel the planned Root Cause Analysis training due to COVID-19 pressures. This was reviewed in early 2021 but again had to be postponed. The National Patient Safety Syllabus was released in May 2021 and this will provide the training framework required by all healthcare organisations.

Key achievements

The Trust has recently recruited to the post of Associate Director of Governance and Patient Safety with the postholder joining the organisation in July 2021. The training framework will then be scrutinised and put into operation as we move through 2021 and into 2022.

Aims and next steps

A new Serious Incident Requiring Investigation Policy will be launched in the Trust. This policy will clearly identify the processes involved in identifying a potential serious incident, how to escalate the incident, roles and responsibilities, and set out how to manage any investigation that may follow. All serious incident investigations being undertaken in the Trust currently are closely monitored by the Head of Risk and Compliance with support and education of the process being given to the investigation leads prior to the start of the investigation and throughout the process.

In 2021/22 the Trust's risk register will be fully reviewed and split into 'risks' and 'issues' with a new Risk Management Policy in place to underpin the process. This will allow the Trust to have clear sight of the true risks that may occur and visualise the issues that have happened or are ongoing. This work is due to be completed by summer 2021.

In order to support the revised process, Risk Management Training will be provided by the Head of Risk and Compliance via the Managers Passport Training programme and ad hoc training is also available for any staff who require a refresher session or for new staff who are not familiar with the Datix system or with risk management.

S3. Safeguarding: Support a culture of safeguarding awareness, reporting & practice measured against internal & multi-agency action plans

Background

The Trust's Safeguarding Team and strategic safeguarding lead have continued to enable The Clatterbridge Cancer Centre to have robust systems and processes that meet the requirements of Working Together to Safeguard Children 2018 and the Care Act 2014.

Strategic leadership continues to enable robust relationships both internally across all Clatterbridge Cancer Centre sites and externally with safeguarding partners and commissioners.

Key achievements

- Appointment of a new Non-Executive Director (NED) Safeguarding Champion following retirement of previous NED.
- Achievement of all 'must do' and 'should do' requirements following the CQC inspection in 2019.
- Maintained the mandatory and contractual compliance rate of 90% for levels 1 and 2 for children and adults safeguarding training.
- Maintained mandatory and contractual compliance rate of 90% for basic prevention awareness (level 1&2) training and 85% for WRAP (level 3&4) training.
- Achievement of mandatory compliance rate of 90% for learning disability awareness and dementia awareness training.
- Development and launch of the Learning Disability and Autism Strategy: coproduced with service users, families and self-advocates.
- Development of a standard operating procedure for suicidal ideation together with the training and accreditation of 20 Trustwide mental health first aiders.
- Delivery of safeguarding supervision for key members of staff/teams.
- Participation in a multiagency domestic homicide review of a patient known to have received care at The Clatterbridge Cancer Centre.
- Detailed information/guidance on safeguarding during the COVID-19 pandemic and the potential for domestic abuse to occur during lockdown was developed and shared in the daily Trustwide COVID-19 communication bulletins.
- Timely responses to the national COVID-19 safeguarding directives and guidance were provided via the Trust's daily internal COVID-19 emergency incident reporting meetings, together with regular internal briefings for staff regarding access to domestic abuse and mental health support systems.
- Continued with safeguarding as business as usual during COVID-19 pandemic.
- The submission of the quarterly evidence against key performance indicators outlined in the NHS England/Improvement Specialised Commissioners and Wirral CCG Safeguarding Commissioning Standards has been maintained in 2020/21.

Aims and next steps

To ensure the Trust is compliant with statutory, regulatory and contractual safeguarding requirements the Trust's Safeguarding team will:

- Continue to achieve all the safeguarding contracting standards and Key Performance Indicators (KPI) and maintain the improvement.
- To provide stability of safeguarding vision, leadership and direction at all levels across all CCC sites.
- Be responsive and fully embed any new legislation and guidance.
- Maintain 90% compliance with safeguarding training.
- Continue to utilise themes and trends from safeguarding incidences to inform and improve practice and pathway development.
- Provide an updated direction and strategy for the organisation's response to the domestic abuse and violence agenda following introduction of the Domestic Abuse Act.
- Continue to plan for national changes from MCA/DoLs process to Liberty Protection Safeguards (LPS) process, ensuring the CCC pathway is in line with national guidance and legislative changes.
- Continue to improve the quality of reporting of safeguarding concerns and incidences.
- Continue to work in coproduction with patients, families and self-advocates to develop work plan and evaluation process for delivery of national learning disability standards.
- As we settle into the Clatterbridge Cancer Centre - Liverpool, safeguarding assurance will transfer from Wirral to Liverpool CCG via their designated safeguarding leads. Reporting arrangements and meetings with Liverpool CCG safeguarding team have already been established in June 2020.
- Continue to work with our dementia champions and patients to deliver and evaluate delivery of the dementia work plan via the dementia collaborative.

S4. VTE: Reduce avoidable harm so 95% of all inpatients receive VTE risk assessment and 100% receive prescribed prophylaxis

Background

Patients admitted to hospital are often at risk of developing venous thrombosis (VTE). A number of improvement measures have been implemented by the clinical teams to prevent and reduce this risk; screening has been one of the key elements of these improvement measures.

Key achievements

Overall for the year 2020/21, the Trust was 96% compliant for VTE assessments completed against the target of 95%.

The Clatterbridge Cancer Centre NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services by:

- Ongoing clinical audit including management of the whole VTE pathway.
- Daily review of compliance with all clinical risk assessments.
- VTE is now a standard agenda item in the monthly Harms Panel meeting the outcome of which is monitored through the Integrated Governance Committee.
- Ongoing education of junior doctors.

Aims and next steps

CCC will sustain our 95% achievement of admitted patients having a documented risk assessment and will continue to identify lessons learnt from any Hospital Associated Thrombosis (HATs) to improve patient care and treatment.

S5. Sepsis: Ensure timely and efficient Sepsis/News2 patient management

Background

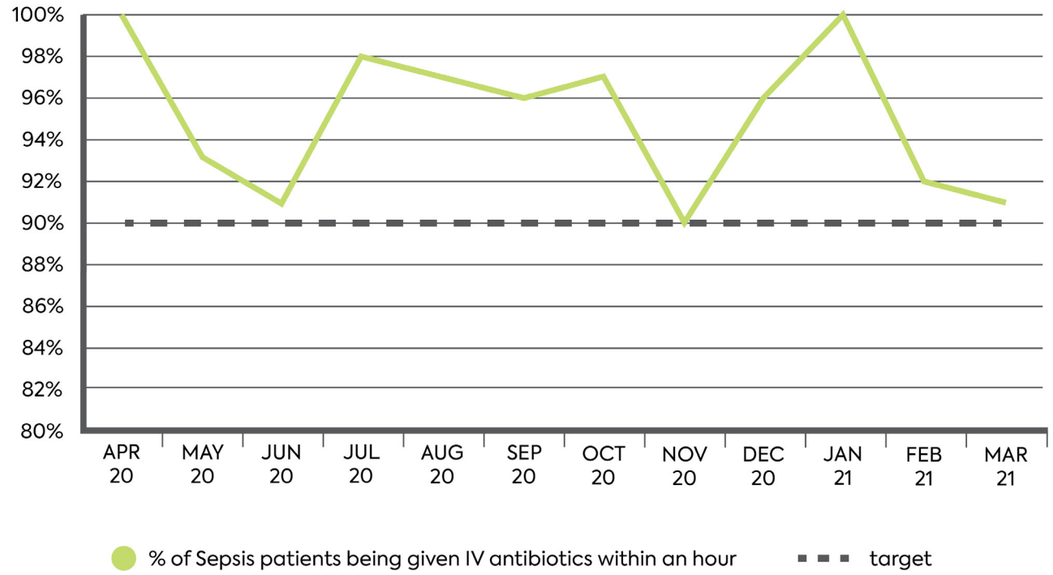
Sepsis is a major cause of death from infection. Evidence suggests that the percentage of 36%-40% of people diagnosed with sepsis can be halved by implementing evidence-based practice. At CCC we are committed to ensuring early identification and treatment of patients with sepsis as a priority objective.

Key achievements

The Clatterbridge Cancer Centre NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services by:

- Development of sepsis task and finish group to review the e-screening tool.
- Ward based training supported by the Acute Care Team (ACT).

Chart 1 shows our consistent compliance with the target in 2020/21.



Aims and next steps

Our aim is to launch our newly-developed electronic sepsis screening tool and roll out an online sepsis dashboard. Training and education will continue to be provided and supported by our dedicated ACT to improve patient outcomes.

S6. Safer staffing: Strengthen safer staffing through digital monitoring systems

Background

SafeCare is a digital application that matches nursing staffing levels to patient acuity in real time, allowing informed decision-making in staffing levels across the inpatient wards at CCC.

The guidance for safer staffing is determined by the National Quality Board (NQB). The NQB standards require trusts to provide assurance that organisational practices, skills development and evidence-based tools are in place.

The SafeCare Module was purchased as part of the Allocate Optima Package in 2019 with the aim of using patient numbers and acuity status, allowing ward managers and senior managers to make evidence-based decisions on staffing using real-time information.

Currently staffing ratios and patient acuity is recorded on a daily spreadsheet and disseminated twice daily across the Trust to key stakeholders by the Patient Flow team.

Key achievements

- Emergency safe staffing ratios during COVID-19, agreed and approved at Ethics Committee.
- 3 times daily safe staffing huddle in place with ward managers and matrons to ensure daily safe staffing ratios are available on the inpatient wards.
- Deficiencies in staffing ratios mitigated by redeployment of staff to wards/areas of greatest need.
- Implementation of E-roster completed.

Aims and next steps

- Implementation of one digital solution for recording of staffing and patient acuity.
- Training and standardisation of patient acuity for relevant ward staff on utilisation of Shelford Safer Nursing Care Tool (SNCT) by NHSE/I (previously cancelled due to the COVID-19 pandemic).
- Development of Task and Finish group to progress integration of safer staffing through digital monitoring systems.
- Complete interface of Health Roster with NHSP shifts.
- Development of digital safe staffing dashboards.

S7. Safety culture: Strengthen safety culture through standardisation of safety huddle agenda

Background

A safety huddle is a short meeting, 15 minutes or less, that is typically used once at the start of each workday. In inpatient areas, the huddle takes place at the start of each major shift. In outpatient / daycase areas, safety huddles occur once per day to discuss scheduled patients as a team.

The daily huddle gives teams a way to actively manage quality and safety, including a review of important standard work such as checklists.

Daily safety huddles are embedded as part of 'business as usual' across all divisions/ hubs across CCC, as a mechanism of empowering and engaging frontline staff in problem identification, building a culture of collaboration and quality.

Key achievements

The Clatterbridge Cancer Centre NHS Foundation Trust has taken the following actions to strengthen a safety culture through:

- Delivery of a daily safety huddle meeting across all clinical divisions.
- Standardisation of daily safety huddle template.
- Utilisation of the daily safety huddles to share lessons learnt from the Harm Free collaborative, reported incidences and safety bulletins.

Aims and next steps

Our aim is to continue to develop the daily safety huddle process as a way of empowering staff to increase awareness around important safety challenges and foster a culture of learning.

S8. Investing in Research & Innovation: Invest in research and innovation to deliver excellent patient care in the future

Please refer to Section 5 for updates and Appendix 6 for the **CCC Research Strategic Business Plan 2021-26.**

Responsive

		2019-21 Achieved
Responsive: Services are organised so that they meet people's needs		
R1	Deliver patient care closer to home through new clinical model so that 90% of patients travel less than 45 minutes to access treatment	✓
R2	Implement new Directorate complaints handling model monitored via biannual audits	✓
R3	Triangulate incidents, complaints and PALS to promote learning and improvements (working closely with the PEIG)	✓
R4	Strengthen care and experience of patients with additional needs	✓
R5	Deliver national learning disability standards	✓
R6	Share learning from PALS, complaints, deaths and serious incidents across the patient pathway, working in partnership with the Cancer Alliance	✓
R7	Expand the volunteer service to support the opening of the new hospital in Liverpool	✓
R8	Safe return of CCC-W volunteers post-COVID	✓

R1. Care closer to home: Deliver patient care closer to home through new clinical model so that 90% of patients travel less than 45 minutes to access

Background

CCC has developed a home-treatment service, referred to as 'Clatterbridge in the Community' (CiC), as an extension to the existing delivery model of treatment. CiC has grown since 2013 to include a range of treatments, ranging from simple subcutaneous treatments for breast cancer to more complex intravenous infusion immunotherapy treatments for conditions such as melanoma. The growth of the service has been based on a strategy for maximising patient benefit and service efficiency by releasing financial, workforce and infrastructure resources from established traditional hospital-treatment service model and focusing on treatment at home.

CiC strives to improve cancer patients' experience of care by offering independence and choice over treatment settings, reducing time spent travelling and waiting in clinics and releasing capacity in daycase clinics. In addition, CiC offers a compassionate use service for patients who may not have been eligible for home treatment as well as a first in kind, 'Treatment at Work' service.

The service has significant experience with treatment at home in breast, melanoma, prostate, NET and lung cancer patients, and wants to extend this to all tumour groups where suitable.

The service delivers treatment to patients in their homes or workplaces across a large geographical area of Cheshire, Merseyside, Lancashire and North Wales and has treated over 1,150 patients since 2015.

Key achievements to date

- >95% of patients travel fewer than 45 minutes from home to receive treatment.
- 2016 – First patients treated with immunotherapy in their homes.
- 2016 – Winner of the Service Delivery Award at the Health Collaboration Awards (EFPIA, Brussels).
- 2018 – Establishment of a new clinical model that enables SACT delivery in the workplace, which is the first of its kind in the UK.
- 2019 – Finalists in the RCNi Cancer Nursing Award.
- 2019 – Winners of the Nursing Times Awards.
- 2020 – Expansion of compassionate use programme to support patients during the COVID-19 crisis, which currently makes up around 25% of our patient cohort.
- Exemplary patient feedback and safety record including 100% patient satisfaction in the most recent patient survey.

Key benefits:

- Increasing capacity within the hospital settings
- Cost savings to NHS
- Improved patient experience

Currently CiC have 7 approved drugs covering 6 Site Reference Groups and any patients within these approved regimes can be referred to CiC. From these 7 approved drugs, 3 are in the top 10 of chemotherapy regimens delivered in CCC; therefore we have a vast group of patients who could be potentially referred into the CiC service.

We have identified 4 IO drugs for use in the CiC service and have a close working relationship with the Immunotherapy team and aim to identify more IO drugs for future use from various SRG groups.

We have identified 2 drug regimens from our Haemato-oncology (H-O) partners and are currently setting up dual training for our CiC nurses on the H-O daycase ward.

Aims and next steps

- Immunotherapy (IO)
- Haemato-oncology (H-O)
- Continued treatment and expansion of HER2-directed therapies (specifically pertuzumab/trastuzumab)
- Compassionate use programme

PHESGO is the new subcut version of IV pertuzumab and IV trastuzumab and has already been approved for CiC use. Currently, CiC have over 60 patients recruited for this new regime. This has had a positive impact on all clinical hubs as this has released chair capacity. Our compassionate service has seen an increase during COVID-19 and we have visited more vulnerable patients in their own homes during this difficult period. We now see up to 25% of our referrals into the CiC service as compassionate use patients.

One of the main objectives of CiC moving forward is to create a new hub in Aintree by the end of the financial year, making the service more cost-effective with travel and time. Creating a dual hub service will allow more patients to be seen and treated by the CiC service.

R2. Improving complaint management: Implement new Directorate complaints handling model monitored via biannual audits

Background

Following a deep dive review into the complaints management process that was completed at the end of 2020/21, a number of recommendations were made in order to support the divisional teams to achieve the local targets of 25 working days to respond to a routine complaint, and 60 working days to respond to a complex complaint.

Key achievements

A revised complaints management process and policy will be developed along with standard operating procedures to set out a robust process with clear roles, responsibilities and timescales. The new process and revised policy are due to be in place by June 2021.

Aims and next steps

Following the implementation of the new process, biannual audits will be completed by the Risk Management Facilitator in order to provide assurance to the Board of improved compliance with complaint response times. The first audit will be completed in December 2021.

Please refer to Appendix 1 for Complaints supplementary information

R3. Learning from complaints: Triangulate incidents, complaints and PALS to promote learning and improvements (working closely with the PEIG)

Background

A full review of the CCC complaints process was completed and recommendations and actions embedded within the new divisional structure to triangulate incidents, complaints and PALS for shared learning and patient experience improvement.

Key achievements

A full review of the complaints process was completed.

Aims and next steps

- The information being reviewed at local Quality and Safety meetings will be reviewed and revised to ensure learning is being shared and improvements are monitored.
- A new monthly, high-level 'Incidents, Complaints and PALS Report' will be developed and shared at the Integrated Governance Committee and the Quality Committee.
- A quarterly 'Incidents, Complaints and PALS Report' will provide more detail of trends and themes emerging from the data. The quarterly report will also be shared at the Integrated Governance Committee and the Quality Committee.
- The monthly report will also be presented at and shared with the Patient Experience and Inclusion Group as a standing agenda item.

In addition the Trust will launch a new Patient Safety Group (PSG).

The Patient Safety Group will provide oversight and scrutiny of the following:

- Lessons learnt arising from Serious Incident reports (SIRI) and review of action plans following sign-off at Divisional level.
- StEIS reports & recommendations.
- Transfusion Oversight Group – learning from SHOT incidents & reports.
- Oversight of patient safety alerts – NPSA, CAS alerts (including MHRA) & relevant actions.
- Learning from phase 3 mortality reviews.
- Lessons learnt arising from complaints following completion of complaint report and development of action plan.
- Trends analysis from divisional and organisational incidents and actions planned.
- Implementation of 'lessons learnt' monitoring.
- Review of external safety reports and associated actions.
- Oversight of Patient Safety Training compliance.
- Assurance as to the appropriate management of all incidents, actions and their closure.
- The PSG will escalate any significant patient safety issues via the Integrated Governance Committee through to Quality Committee and Trust Board.

R4. Improving patient experience: Strengthen care and experience of patients with additional needs

Background

To ensure compliance with statutory regulations, CCC has oversight of patients with additional needs, ensuring their individual needs are met.

A 'special indicator' tab has been developed and is available in Meditech (patient electronic record) to ensure all staff record and are aware of each patient's additional need.

Key achievements

- Introduction of special indicator for autism within Meditech to strengthen identification of this patient group.
- Recruitment of approximately 46 Dementia / LD Champions meeting on a bimonthly basis to drive forward the work of the Trust's learning disability/autism and dementia strategies.
- Mandating and achievement of over 90% compliance for dementia and learning disability awareness training for all patient-facing staff.
- Completion of Dementia Action Alliance benchmarking across the Trust, including all hubs.
- Additional training in Autism and Learning Disabilities via the Oliver McGowan Foundation for all CCC Dementia/Learning Disability and Autism champions.

Aims and next steps

- Continue to work in coproduction with patients, families and self-advocates via Confirm & Challenge Group and Service Users Reference Forum (SURF) to develop the work plan and evaluation process for delivery of National Learning Disability Standards.
- Continue to submit relevant KPIs.

R5. Supporting the delivery of national standards: Deliver national learning disability standards

Background

NHS Improvement Learning Disability Standards

In June 2018, NHS Improvement (NHSI) developed the new Learning Disability Improvement Standards for NHS trusts. They are intended to help the NHS measure the quality of service provided to people with learning disabilities, autism or both.

The Clatterbridge Cancer Centre gathered baseline information on our compliance with the standards, including the views of staff and submitted this information to NHSI in November 2019. A work plan was developed in response to the outcome of this information gathering.

Key achievements

- Collaboration with Cheshire and Merseyside Service users/carers and advocates with learning disability and/or autism in the coproduction of the Trust's first Learning Disability and Autism Strategy.
- Electronic version of Risk Assessment and Reasonable Adjustment Care Plan developed and uploaded into Meditech.
- Learning disability awareness e-learning training launched and application made to Learning and Development for training to be mandated, in a face-to-face and e-learning format.
- On-going collaboration with 'People First' in Liverpool and 'Pathways Associates' to ensure service user input with development of service and participation in a Learning Disability collaboration.
- Recruitment of approximately 46 Dementia/ LD Champions.
- Coproduction of local film highlighting the process of attending an appointment at CCC for radiotherapy with LD/autism. A big thank you to Lisa and Ruth from Knowsley Big group for helping as actors to produce this short film. https://youtu.be/5E6AMeLoDgs
- Invited to showcase our work with individuals with learning disabilities at national learning disability conference in Norway (subsequently postponed due to the COVID-19 pandemic).

Aims and next steps

During 2020/21, CCC continued to collaborate with Cheshire and Merseyside service users/ carers and advocates with learning disability and/or autism in the coproduction of the Trust's first Learning Disability and Autism Strategy.

It is envisaged that the above group will continue during 2021/22 to support the Trust and work in partnership to:

- Develop a feedback process for patients and carer/family with learning disability and/or autism.
- Collaborate in the implementation of the Learning Disability Standards Framework.
- Support and assist with the embedding of Trustwide recognition of the support required by patients with a learning disability.
- Hold the Trust to account for delivery of the Learning Disability standards via regular confirm and challenge sessions.
- Plan development of a further coproduction film following a patient journey through chemotherapy.

R6. Shared learning: Share learning from PALS, complaints, deaths and serious incidents across the patient pathway, working in partnership with the Cancer Alliance

Background

Whilst the learning achieved as a result of investigations from PALS, complaints, deaths and serious incidents is shared within the teams at CCC, there is currently no process in place to widen the learning across the region so trusts can share lessons learnt and improvement plans with each other.

Throughout 2021/22 CCC plans to work in partnership with the Cheshire and Merseyside Cancer Alliance to improve collaboration between organisations and develop a robust process to ensure each organisation can learn from the experiences of other trusts.

Key achievements

Key achievements will be:

- Process developed and agreed for how learning will be shared across the Cancer Alliance.
- Evidence of shared learning from other organisations included in CCC quality reporting to the sub-committees and committees of the Board.

Aims and next steps

The Trust aims to have a process developed and agreed by Q4 of 2021/22, with evidence of inter-organisation learning being reported through CCC by the end of Q1 of 2022/23.

R7. Developing CCC's volunteer programme: Expand the volunteer service to support the opening of the new hospital in Liverpool

Background

Volunteers play an important role in delivering services to the NHS and this is particularly so at The Clatterbridge Cancer Centre NHS Foundation Trust, where volunteers have over many years added significant value to the activities of healthcare staff, patients and the public.

The Trust recognises the huge role that volunteers have in supporting patients, enriching patient experience and bringing communities together. The Clatterbridge Cancer Centre acknowledges that volunteer roles are essential to strengthen patient experience processes, reduce the pressure on services and support staff in areas of greatest pressure within the organisation.

As we prepared to open the new hospital in Liverpool and in response to COVID-19, we undertook an active volunteer recruitment campaign. This resulted in:

- Request to local universities for volunteer support during COVID-19 pandemic.
- Collaborative working with both Liverpool and Everton Football Club volunteer managers to support the recruitment campaign.
- Support from Healthwatch Liverpool in communicating volunteer recruitment to the third-sector community. Liverpool Community Voluntary Service (LCVS) picked up the advert via Healthwatch Liverpool and advertised for volunteers in the LCVS Bulletin.
- Volunteer recruitment advert on social media and in Liverpool Echo in April 2020.
- Recruitment of over 104 volunteers during the COVID-19 pandemic.
- Recruitment of a full-time volunteer coordinator.
- Development and delivery of a programme of recruitment and induction for volunteers workforce at Liverpool.
- Access to and completion of the eLFH Volunteer core skills training framework via ESR to ensure all volunteers have access to a volunteer passport.

Aims and next steps

- Continue to build the CCC-L volunteer workforce to replace the students returning to their full-time educational programme.
- Continue to process recruitment applications in readiness for a full volunteering service to commence across all sites.
- To ensure that all mandatory training is completed as a matter of urgency to increase compliance figures to Green status.
- Develop Family Volunteer Service.

R8. Developing CCC's volunteer programme: Safe return of CCC-W volunteers post-COVID

Background

CCC has an excellent reputation of recruiting and supporting a large volunteer workforce at Clatterbridge Cancer Centre – Wirral (CCC-W). However, due to the COVID-19 pandemic, many of our CCC-W volunteers were shielding; this resulted in a limited number of volunteers on site at CCC-W.

Key achievements

- In planning the safe return of CCC-W volunteers post-COVID, all CCC-W volunteers have been contacted. A letter and volunteering questionnaire has been sent to all volunteers listed at CCC-W to ascertain if they are able and willing to return to CCC-W volunteer workforce once the COVID-19 restrictions are lifted.
- A comprehensive list of available volunteers wishing to return to the CCC-W site to support patients has been compiled.

Aims and next steps

- The CCC-W volunteering service will be resuming from 17th May 2021 with two volunteers covering the main reception as meet-and-greet volunteers, supporting patients to use the self-check-in kiosks, as well as providing beverages on Delamere (Chemotherapy Unit) to patients.
- Continue to work with the volunteers to the CCC-W site to secure their safe return to duties including completion of their training modules within the volunteers passport.

Caring environment

		2019-21 Achieved
Caring: Staff involve and treat people with compassion, kindness, dignity and respect		
C1	Continue to achieve top quartile results for patient experience	✓
C2	Deliver outcomes identified in dementia strategy to improve dementia care and patient experience	✓
C3	Deliver Patient and Public Involvement Strategy 2019-21 to improve our methods of engagement	✓
C4	Establish a Patient Experience and Involvement Group ensuring we listen and respond to what our service users are telling us that matters to them	✓
C5	Implement the End of Life Strategy to deliver greater choice and support for individuals nearing the end of life	✓
C6	Implement GDE quality digital work streams to include electronic patient information	✓
C7	Implement person-centred care audits and 'always events' in 2021/22	–

C1. Continue to achieve top quartile results for patient experience

Background

The National Cancer Patient Experience Survey (NCPES) 2019, published June 2020, is the ninth iteration of the survey. It has been designed to: monitor national progress on cancer care; to provide information to drive local quality improvements; to assist commissioners and providers of cancer care; and to inform the work of the various charities and stakeholder groups supporting cancer patients.

The Clatterbridge Cancer Centre was voted one of England's top hospitals for inpatients in the adult inpatient experience survey. The Trust is the highest scoring cancer hospital in the North West and one of only seven trusts in England to be rated 'consistently' well above average. The Care Quality Commission (CQC) uses the results from the survey in the regulation, monitoring and inspection of NHS acute trusts in England.

Key achievements to date

The Clatterbridge Cancer Centre continues to support and take part in both national patient experience surveys, including on a voluntary basis for 2020 despite the COVID-19 pandemic. The Trust's overall score for the NCPES 2019 was 9.1/10, maintaining the same score from 2018. CCC has also scored above the national average score for all seven questions included in phase 1 of the cancer dashboard developed by Public Health England and NHS England.

There are also 15 areas in which CCC's score is significantly higher than both the national upper expected range and national score, which is testament to how hard all our staff work to ensure an outstanding patient experience is achieved.

In response to both the 2019 adult inpatient experience and National Cancer Patient Experience Survey (NCPES), CCC always looks for opportunities to improve patient experience with robust action plans being developed with the operational Divisions to improve the Trust's current position. The 2019 Adult Inpatient experience survey action plan progress was monitored by the Patient Experience & Inclusion Group (PEIG) and has since been delivered.

Aims and next steps

The NCPES 2019 action plan will be delivered by August 2021, in preparation for the 2020 survey report publication by autumn 2021.

C2. Deliver outcomes identified in dementia strategy to improve dementia care and patient experience

Background

The Trust Dementia Strategy was ratified in April 2019 and it set out a three-year strategic plan (2019-2022) for The Clatterbridge Cancer Centre NHS Foundation Trust (CCC). The strategy included an action plan of the key developments which are required to be able to achieve the vision outlined in the strategy and they are underpinned by the national framework.

Key achievements to date

- The Dementia/Learning Disability and Autism Collaborative Group continue to focus and achieve on the actions within the strategy utilising the Dementia Champions across all three sites.
- Members of the Dementia/Learning Disability and Autism Collaborative Group have accessed training from the Oliver McGowan training in Learning Disability and Autism for NHS staff.
- Dementia Awareness training compliance achieved the target of 90% for all patient-facing staff and continues to be maintained at 96.4% in Q4.
- Dementia Action Alliance benchmarking work was completed across the Trust, including all hubs.
- Members of Service Users Reference Forum (SURF) were to be invited to visit CCC-L and complete the Kings Fund Dementia Environment Tool; however, this remains on hold due to the current COVID-19 restrictions. The Trust has therefore looked at alternative ways of completing the Environmental Tool virtually through digital means and produced a photobook which has ensured completion of the Environmental Tool.
- The Safeguarding Practitioner continues to meet virtually with the Liverpool Dementia Action Alliance (DAA) to be updated about dementia-friendly projects and local facilities available in Merseyside and to meet virtually at the monthly SURF meetings to liaise with patients, carers and families about the work being completed in CCC.
- The Liverpool DAA has asked the safeguarding practitioner to support the Dementia Awareness Week activities during the week commencing 17th May 2021. This forum was a platform to launch the photobook as part of the Dementia-Friendly status of the Hospital. An easy-read leaflet about patients attending as an outpatient and an easy-read complaints leaflet has been introduced within the Trust.

Aims and next steps

The key areas of work to be undertaken in the final year of the strategy will be;

- The Dementia Collaborative Group will continue to drive and progress the objectives within the Trust Dementia Strategy (2019-2022).
- We will continue to engage with the Dementia Action Alliance (DAA) and adoption of the Dementia Friendly Hospital Charter.
- The Safeguarding Practitioner will review and revise the current Dementia Strategy in 2022.
- The Trust is in the process of developing a Carers Policy to meet the criteria of the NICE guidance on carers in line with 'John's Campaign'.

C3. Deliver Patient and Public Involvement Strategy 2019-21 to improve our methods of engagement

Background

Excellent patient experience is indicative of excellent care. Central to the Trust's Patient and Public Involvement and Engagement Strategy (PPI&ES) 2019 – 2021 is the commitment to create a culture where patients really are at the heart of everything we do and that a patient centred way of working is embedded across the organisation.

The PPI&ES 2019-2021 was ratified by the Trust Board in January 2019. The strategy contains eight pledges to improve the experience of our patients, their carers and families. The Patient Experience & Inclusion Group (PEIG) receive monthly updates from the pledge leads on progress against each of the eight pledges.

Key achievements to date

We continue to listen and respond to service users via a variety of methods including:

- Friends and Family Test Text reminder, which was launched in October 2020 with national reporting resuming in January 2021.
- Patient experience rounds asking what matters to our patients the most.
- Capturing experience in real time using the recently launched Perfect Ward Person Centred audit tool.
- Feedback to matrons, ward managers and key clinical staff to address patient concerns promptly.

Aims and next steps

We will:

- Use the NHS England and Improvement patient experience improvement framework to develop a gap analysis and action plan to present to Trust Board. The framework is a patient experience assessment tool aligned to the CQC domains and six framework themes.
- Produce the new 2022-2026 Patient Experience, Engagement, Inclusion and Involvement (PEEII) 'commitment' with patient and carer voice representatives and staff by Quarter 4 2021/22.

C4. Establish a Patient Experience and Involvement Group ensuring we listen and respond to what our service users are telling us that matters to them

Background

The Patient Experience and Public Involvement and Engagement Strategy (PPI&ES) 2019-2021 was ratified by the Trust Board in January 2019. The strategy contains eight pledges to improve the experience of our patients, their carers and families. Pledge one was the improvement of the utilisation of our representatives/members and widening their responsibilities.

Key achievements to date

We have done this by establishing regular meetings and an agenda that listens and responds to what matters to our patients, families and carers, steered by the Patient Experience & Inclusion Group (PEIG) and sub-working group, the Patient Participation Group (PPG). We have widened the range of responsibilities for patients, families and carers to enable more involvement in Trust initiatives.

PEIG and PPG members who choose to engage, receive appropriate support, reimbursement and recognition for their time as Patient Partner Voice (PPV) representatives in line with NHS England guidance. PEIG now has seven patient and carer voice representatives, governors and a range of staff from across the Trust who regularly attend PEIG meetings. PEIG routinely reviews patient experience improvement pledges, actions and progress, to ensure any areas of poor patient experience are addressed.

Aims and next steps

The plan is to review the PEIG Terms of Reference in 2021 and refresh the group membership, moving those meetings to a quarterly basis and create an operational sub-group, the Patient Experience & Inclusion Operational Group (PEIOG). Our aim is to strengthen the patient and carer voice and experience further with the support of key operational staff.

C5. Implement the End of Life Strategy to deliver greater choice and support for individuals nearing the end of life

Please refer to Appendix 2 for the Specialist Palliative Care Team Annual Report.

C6. Implement GDE quality digital work streams to include electronic patient information

Background

'Be Digital' is a key strategic priority within the Trust's Five-Year Strategic Plan 2021-2025, strengthening the ambition to deliver digitally-transformed services and empower patients and staff.

During 2020/21, the Digital services team led the technology approach to support the organisation through the COVID-19 pandemic. A rapid deployment of laptops enabled staff to work effectively from home. An NHS-approved video platform, Attend Anywhere, was implemented to support patients with virtual appointments. An accelerated approach to the implementation of Microsoft Teams has enabled staff to use the collaboration tools for large-scale live events, video meetings and collaborative virtual work areas.

Digital COVID Response

The Digital Team were in a state of preparedness to support staff and patients during the pandemic

Digital Drop-In Sessions	Microsoft Teams	Attend Anywhere	Patient Communication	SharePoint Intranet
Digital drop-in clinics were held in early March to enable staff to work from home.	Clatterbridge has embraced new technologies to support agile working in response to COVID-19. In May 2020, CCC ranked 2nd in England for MS Teams activity.	Attend Anywhere, a secure NHS video call service for patients with pre-arranged appointments, was rapidly deployed and all clinicians trained.	A number of new initiatives have been developed to support patient communication. These have been consolidated onto single cart devices.	A new SharePoint staff intranet has been deployed making it much easier for staff to access and share key information.

*NHS England - Top 50 Organisations M5 Team Usage - 16/5/20 - Teams activity per active Team

In June 2020, The Clatterbridge Cancer Centre opened its new hospital in Liverpool city centre, at the height of the COVID-19 pandemic. The Digital team technically commissioned the new hospital within a shortened period to support patient care across the Cheshire and Merseyside healthcare system.

Digitally commissioning CCC-Liverpool

The team delivered the technical commissioning of the new hospital site in Liverpool in June 2020 during the height of COVID.

Clinician Virtual Desktop

An enterprise virtual desktop infastructure "Tap and Go" was configured and developed before the move to Clatterbridge Liverpool. During 2020/21, the Digital Team have scaled this solution across multiple areas to improve staff efficiency. The solution enables staff to quickly log in to workstations using proximity card and pin code, giving quick, seamless access to clinical information, from any location.

Self-Check-In Kiosks

Efficient patient flow supported by the introduction of kiosks have been deployed across all CCC sites to capture patient demographic changed and improve patient check-in experience.

Network & Telephony

We have implemented an ultra-high speed, highly resilient network throughout all of the Trust's sites across Merseyside. This is built on Open Services Architecture (OSA) technology, future proofing any forthcoming bandwith requirements.

Patient Communication Carts

Patient Communication Carts including tools such as:

- "Vision able" - a secure video calling platform that patients, their families and friends can use to communicate whilst face-to-face visiting is restricted.
- "Virtual Ward Rounds" - utilising MS Teams to support clinicians undertake virtual ward rounds.
- "My Perfect Ward" - to enable staff to undertake quality ward based audits.

Server Infrastructure

Over the course of the past twelve months, the Digital Team have designed and implemented a state-of-the-art server infastructure to host our digital systems. This new infastructure is now serving as the bedrock of our digital estate, offering high performance and resilience of systems. Part of this soution is now running in partnership with two additional NHS Trusts, which enabled all parties to realise efficiencies with collaborating, in advance and in line with the latest White Paper, "Integration and Innovation, working together to improve Health and Social Care for all".

Key achievements 2020/21

- The Clatterbridge Cancer Centre has completed all of its commitments as part of the Global Digital Exemplar (GDE) Programme and has now been accredited as a 2021 Digital Leader for successfully fulfilling its commitments.
- Clinical data is now available to staff through live and interactive dashboards, available in real time for cancer waiting times, activity reporting and to support key projects such as consultant results acknowledgement and pharmacy prescribing and production. There is a Business Intelligence plan detailing dashboard rollout, monitored through the Trust's Digital Board.
- The Trust undertook a digital maturity accreditation process based on Healthcare Information and Management Systems Society (HIMSS). The Trust was awarded level 5 in 2019 and is now working towards Level 7.
- The Trust is Cyber Essentials (CE) accredited and working towards CE plus and IS27001.
- The Trust has implemented a state-of-the-art server infrastructure to host all digital systems, offering high performance and resilience of systems. Part of this solution is now running in partnership with two additional NHS trusts, enabling all parties to realise efficiencies in collaborating, in advance of the White Paper, 'Integration and Innovation, working together to improve Health and Social Care for all'.
- The Trust recognises the importance of digital leadership. The Chief Information Officer (CIO) is a member of Trust Board. A new Chief Nursing Information Officer (CNIO) post has been recruited to and will strengthen digital clinical leadership further. The CNIO will work closely with the Chief Medicines Information Officer (CMIO) and the Chief Clinical Information Officer (CCIO) supporting digital transformational change.

C7. Implement person-centred care audits and 'Always Events' in 2021/22

Background

Whilst the Trust has made significant steps to embed these vital initiatives, progress has been hampered by COVID-19. This is a key priority for CCC in Q1 of 2021/22.

Key achievements to date

- A number of person-centred audits including Perfect Ward, Patient Experience Ward Rounds and Partners in Care have been undertaken at CCC; however, due to COVID-19 pandemic restrictions, the majority of the planned audits were postponed during 2020/21.
- The Clatterbridge Cancer Centre engaged with the national Always Event quality improvement initiative in 2020; however, due to COVID-19 pandemic restrictions, Always Events have been paused.

Aims and next steps

- A robust person-centred audit schedule has been planned for 2021/22.
- A robust Always Event plan for 2021/22 has been agreed with the first initiative, 'Chatter Buddies', to go live in April 2021.

Clinical effectiveness

		2019-21 Achieved
Effective: People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence		
CE1	Consistently meet national cancer waiting times standards	✓
CE2	Reduce unplanned admissions and readmissions	✓
CE3	Maintain regulatory compliance	✓
CE4	Improve clinical outcomes through the establishment of SRG KPIs, monitored via new digitised SRG dashboards	Partial
CE5	Achieve 90% compliance with NICE guidelines	✓

CE6	Aim to reduce avoidable deaths to zero by disseminating lessons learnt through quarterly newsletter	✓
CE7	Improve clinical audit monitoring via clinical audit subcommittee	✓
CE8	Achieve 90% or better statutory and role-essential training and role-based competency compliance across the Trust	Partial
CE9	Strengthen management of MCA and DoLS through increase in staff training LPS	✓
CE10	Implement stratified follow-up of patients to optimise clinical input and appropriate follow up to meet CQUIN requirements	✓

CE1. Consistently meet national cancer waiting times standards

Background

The NHS Constitution outlines what patients can expect and their rights when they are referred on a cancer diagnosis and treatment pathway. Cancer waiting times (CWT) measure the NHS' performance against these national NHS Constitution standards, as well as a number of other metrics. These measures are used by local and national organisations to monitor the timely delivery of services to patients.

Key achievements to date

Performance for waiting times remains consistent in 2020/21 with rare incidents of non-compliance due to patient choice to delay treatment during holiday seasons.

An online CWT dashboard has been implemented and is supporting the effective management and reporting of performance against cancer waiting times standards.

Aims and next steps

The NHS Operational Planning and Contracting Guidance 2021/22 states that the 28-day Faster Diagnosis Standard will be subject to formal performance management from Q3 2021/22, with a target of 75%. Trusts' data will be published from April 2021; however, CCC has been monitoring performance internally since January 2020. The Trust is implementing various initiatives to support the consistent achievement of this new target.

CE2. Reduce unplanned admissions and readmissions

Background

Clinical Utilisation Review (CUR) was introduced in 2016/17 in order to identify patients who should never have been admitted and systemic improvement opportunities for admission avoidance. CUR is a clinical decision support software tool that enables clinicians to make objective, evidence-based assessments of whether patients are receiving the right level of care in the right setting at the right time, based on their individual clinical need.

CUR supports providers and commissioners to deliver elements of the NHS Long Term Plan by cutting delays in patient discharge, supporting the delivery of cash-releasing productivity growth, reducing pressure on emergency and continuing care services, and providing evidence to support out of hospital care with patients managed in the most appropriate care setting, thus avoiding readmissions.

Key achievements to date

In 2018, The Clatterbridge Cancer Centre (CCC) introduced CUR for solid tumour wards. Key achievements to date have been a reduction in the length of stay, an increase in daily discharges, and reductions in internal waits such as diagnostics, physiotherapy and occupational therapy services. In addition, CUR has identified patients who should not have been admitted and reduced length of stay in patients over 3 weeks. CUR supports discharge planning and the prioritisation of patients who are delayed due to internal and external reasons, supports demand and capacity management across the Trust by evidencing gaps in service provision and delays across the service and, finally, but most importantly, CUR provides better care and service experience for patients and their families.

Aims and next steps

CCC will be rolling out CUR to the Haemato-Oncology (H-O) bed base. In addition, we will be undertaking a review of the function and operation of the Clinical Decisions Unit and the Patient Hotline. This review will include working in collaboration with NHS 111 and GPs across Cheshire and Merseyside.

CE3. Maintain regulatory compliance

Background

As a specialist healthcare organisation, CCC must be compliant with a number of regulatory standards to provide assurance of high standards of care as well as patient and staff safety.

Whilst the compliance with the regulatory standards has been recorded, reported and stored within separate divisions and departments, the Trust required a robust process to ensure all regulatory inspections and visits were documented in a central repository with a robust, corporately-owned process to ensure accurate information and reporting to the Trust Board.

Key achievements

We aim to achieve the following by July 2021:

- Development and agreement of a Trustwide Register of External Visits.
- Review and refresh the External Visits Policy.
- The Register of External Visits will be included as a standing agenda item on all sub-committees and committees of the Board.

CE4. Improve clinical outcomes through the establishment of SRG KPIs, monitored via new digitised SRG dashboards

Clinical data is now available to staff through live and interactive dashboards, available in real time for cancer waiting times, activity reporting and to support key projects such as consultant results acknowledgement and pharmacy prescribing and production. SRG dashboards have been created in recent years for a number of tumour groups; however, the dashboard rollout plan includes the development of new digitised SRG dashboards which will offer increased and real time access and greater functionality.

Following the recent restructure of Trust services into Divisions and Clinical Business Units, KPIs will now be mapped to this structure and down to SRG-level and reported via appropriate forums. This will provide additional clarity around clinical outcomes, enabling SRGs to more effectively drive targeted improvements.

CE5. Achieve 90% compliance with NICE guidelines

Background

The Trust is committed to implementing clinical guidance and advice and acting upon applicable recommendations from the National Institute for Health and Clinical Excellence (NICE) to provide the best possible care to our patients. The Trust internal target has been set at 90% compliance with applicable standards.

Achievements

NICE compliance has been above the Trust target of 90% since October 2018. NICE compliance currently sits at 95% as of 14th June 2021.

Aims and next steps

To maintain performance above 90%.

CE6. Aim to reduce avoidable deaths to zero by disseminating lessons learnt through quarterly newsletter

Background

The Trust Mortality Process aims to promote improvements in care and celebrate best practice in order to underpin the Trust's strategic goal to prioritise patient safety, improve patient care and prevent avoidable deaths. Lessons learnt from Trust Mortality Cases are distributed via the shared learning newsletter and the Trust Mortality Surveillance Group Dashboard on a quarterly basis. All lessons learnt are collated into an end-of-year annual mortality report. The Trust scores all inpatient deaths utilising the RCP avoidability scoring mechanism which outlines avoidability as follows, whereby score 1-3 is deemed avoidable:

1: Definitely avoidable
2: Strong evidence of avoidability
3: Probably avoidable
4: Deemed to have had a possibly avoidable but not very likely
5: Deemed to have had a slight evidence of avoidability
6: Definitely not avoidable

Achievements

To date CCC has reported zero deaths with a score between 1 and 3.

Aims and next steps

Mortality Surveillance Group to devise a mortality reduction strategy with a view to maintaining zero avoidable deaths. Please refer to Appendix 4 for Learning from Death supplementary information.

CE7. Improve clinical audit monitoring via the clinical audit subcommittee

Background

The Trust has a centralised Clinical Audit Sub-Committee which meets monthly to:

- Oversee the progress of all approved projects against the Trust audit schedule.
- Oversee the progress of action plans to drive improvement in patient care until completion.
- Ensure the areas of concern are escalated to relevant committees, groups and individuals.
- Ensure the design and methodology of projects are at a high standard and have relevant stakeholder engagement.

Achievements

During the COVID-19 pandemic, the clinical audit sub-committee continued to meet monthly via Microsoft Teams meetings. There were 34 projects completed during the last year, of which 9 provided assurance, 15 improved knowledge and provided assurance, and 10 projects resulted in an action plan to improve patient care (of which 100% were included in quarterly shared learning newsletters across the Trust). All 34 completed projects were reported to local committees/ groups across the Trust and monthly quality and safety governance data packs.

Aims and next steps:

To increase the ratio of quality improvement projects against assurance projects in order to drive continuous improvement. We aim to do this by increasing promotion of quality improvement cycles through shared learning newsletters and continuous education through audit events.

Please refer to Appendix 3 for Audit information.

CE8. Achieve 90% or better statutory and role-essential training and role-based competency compliance across the Trust

Background

The Trust is committed to the provision of the highest standards of safe and effective patient care, which requires us to ensure that our staff are competent, capable and safe through the provision of mandatory training.

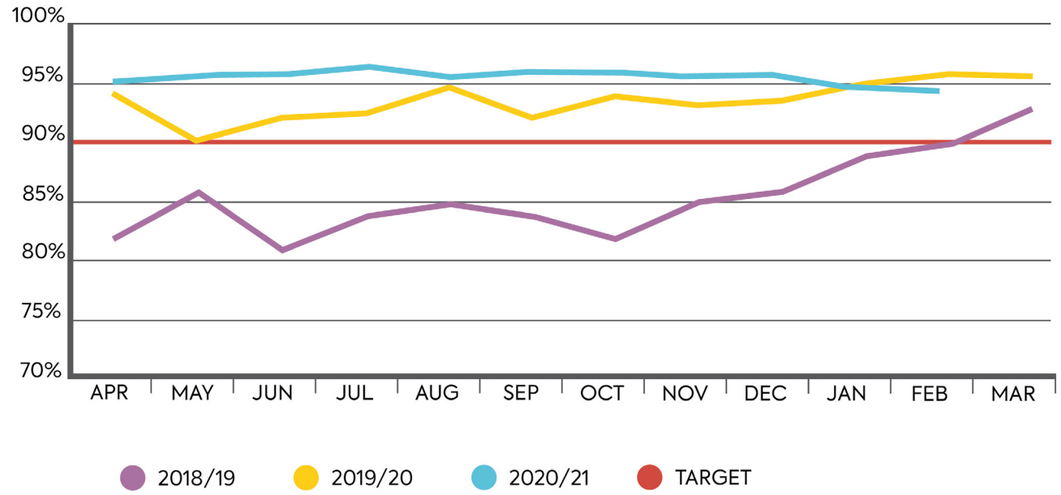
Mandatory training is compulsory training that enables employees to carry out their duties safely and effectively, as well as to develop and maintain their skills and knowledge to the required standards.

The Trust has a KPI of 90% for mandatory and role-essential training and compliance against this target is monitored via the Trust's committee structure.

Achievements to date

The Trust has made significant improvements to the provision of mandatory training over the last 18 months and has achieved the Trust target of 90% for the duration of 2020/21.

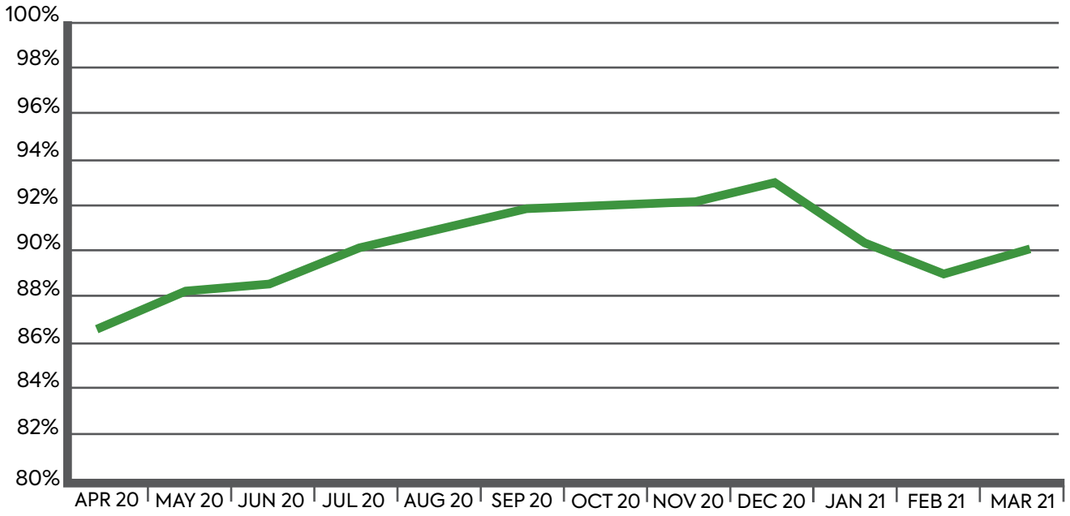
Trust Compliance for Mandatory Training 2018 – 2021



In 2020, the Trust introduced role-essential training and aligned competency requirements by staff group into ESR to enable monitoring and reporting.

The graph below shows the compliance in 2020/21 against the target of 90%.

Trust Role-Essential Compliance April 2020 - March 2021



The Trust has introduced a number of enhancements to mandatory training and role-essential training, including:

- Review of competency profiles within ESR.
- Developed and introduced mandatory training and role-essential training matrix.
- Introduced new reporting to support the effective management and planning of mandatory training.
- Developed and implemented robust exception reporting, compliance monitor and governance processes via Education Governance Committee.
- Implemented compliance reporting for role-essential training compliance at Trust and divisional level.
- Enhanced the use of e-learning and virtual training capabilities.

Aims and next steps

The Trust will continue to ensure it meets its requirements for mandatory and role-essential training compliance and will continue to monitor compliance through the Trust's committee structures.

Key priorities for 2021/22 include:

- Further develop reporting processes for role-essential training, including detailed divisional reporting by subject.
- Enhance clinical skills provision to support ward-based competencies.
- Continue to advance e-learning and simulation capabilities to improve provision of mandatory training.
- Further develop effective processes for the management of ward-based clinical competencies.

CE9. Strengthen management of MCA and DoLS through increase in staff training

Background

The Mental Capacity (Amendment) Act 2019 received the Royal Assent on 16th May 2019. The purpose of the Act is to abolish the Deprivation of Liberty Safeguards (DoLS) and to replace them with a completely new system, the Liberty Protection Safeguards (LPS).

LPS will authorise deprivation of liberty in order to provide care or treatment to an individual who lacks capacity to consent to their arrangements in England and Wales. It will replace a system that many agree is overly bureaucratic and complicated.

The main points of the new LPS are:

- One scheme will apply in all settings (e.g. care homes, nursing homes, hospitals, supported living, people's own homes, day services, sheltered housing, extra care, Shared Lives).
- The LPS will apply to anyone aged 16+.
- There will be no statutory definition of 'deprivation of liberty' under LPS; therefore the 'Acid Test' set by the Supreme Court in the 'Cheshire West' case remains.
- The role of 'Supervisory Body', which authorises deprivations of liberty, will be abolished. It will be replaced by the 'Responsible Body'. There will be different Responsible Bodies in different settings.
- For some cases the Responsible Body will be the NHS trust; in other cases, the role will be filled by the Clinical Commissioning Group (or Local Health Board in Wales); and in other cases still it will be the local authority.
- There will only be 3 assessments: the 'Capacity' assessment, the 'Medical' assessment and the 'Necessary and Proportionate' assessment.
- There will be a brand new role of Approved Mental Capacity Professional to deal with more complex cases.
- There will be an expansion of the role of the Independent Mental Capacity Advocate.

The implementation of the new LPS has been delayed from the original date of October 2020 to April 2022 due to the impact of the COVID-19 pandemic.

An update on the proposed changes and implementation required by The Clatterbridge Cancer Centre was provided to Trust Board via Quality and Integrated Governance Committees in 2020.

The current progress of the national implementation plan is:

- The national team is undertaking a public consultation on the draft regulations and Code of Practice for LPS.
- The next step after consultation is the updated Code and regulations will need to be laid in Parliament to allow for proper scrutiny.

Publication of the national regulations and Code of Practice for LPS is planned for the autumn of 2021. In the meantime, the Trust is expected to continue to use the current code of practice for DoLS within Trust practices.

Key achievements

During 2020/21 the Trust has seen a slight increase in the number of applications from previous years, as demonstrated in the table below:

Table 5. Numbers of DoLS applications per year

2018/19	2019/20	2020/21
7	6	7

During the reporting period (April 2020-March 2021), 7 patients were identified as requiring a Deprivation of Liberty Safeguards application which was submitted to their local authority.

Due to low numbers, bespoke DoLS application training is currently provided to ward staff on a one-to-one basis and covered as part of levels 2 and 3 adults safeguarding training.

During 2020/21 the following actions were undertaken to improve the Trust's MCA and DoLS practice:

- Continue to utilise Datix incident reporting in the event of submission of DoLS application and any delay in the assessment by the local authority.
- The Trust MCA/DoLS leads/safeguarding team have completed all DoLS applications for any patient who meets the DoLS criteria, submitting applications to the relevant local authority of the patient.
- Training support and advice for staff to recognise the need for a Mental Capacity assessment and completion of a DoLS application.
- Support and advice for staff to recognise the need for a best interest meeting.
- Maintenance of the Trust DoLS electronic database within the shared safeguarding folder.
- Trust Safeguarding team members attend relevant LPS training sessions to ensure teams are updated on LPS.

Aims and next steps

- Continue to use the current code of practice for DoLS.
- Review current Trust policies following receipt of new code and regulations for LPS to ensure CCC pathway is in line with national guidance and legislative changes.

CE10. Implement stratified follow-up of patients to optimise clinical input and appropriate follow up to meet CQUIN requirements – Patient Initiated Follow-Up (PIFU)

Background

By 2028, 55,000 more people will survive cancer for five years or more each year; and at this date, 75% of people will be diagnosed at an early stage (stage one or two). In just five years the number of people diagnosed with cancer has grown by an extra 400,000 with 2.5 million people living with cancer in the UK. The NHS will struggle to support the expected increase in people living with cancer in the UK without the development of a personalised supported self-management pathway.

My Medical Record (MMR) is a dual registration digital system with patient portal views. There are mutual benefits of sharing of ideas, best practice and two-way feedback. Patients are able to be stratified based on the agreed cancer tumour-specific follow-up requirements.

There are significant benefits to patients, including regular calls from the CCC Cancer Support Worker and efficient handling of errors and issues with a dedicated point of contact. The initiative allows for improved utilisation and release of outpatient capacity for new patient appointments and supports the achievement of cancer waiting times standards.

Key achievements to date

In 2019 the Trust, in collaboration with the Cheshire and Merseyside Cancer Alliance (CMCA), agreed to support a Commissioning for Quality and Innovation (CQUIN) to stratify patients within Breast, one of the common cancer tumour Site Reference Groups (SRG). The CQUIN has been extended to include Prostate cancer patients and up to 1,500 patients within Liverpool, Wirral and Warrington have now been stratified with associated patient and NHSE benefits. The CQUIN has now been completed but CCC have continued to embed PIFU as a standard within some SRGs.

Aims and next steps

The plan is to now stratify up to 240 haemato-oncology patients identified as eligible for PIFU by Q4 2021/22. CCC will also strive to include other relevant SRGs within the CMCA guidelines to release staff and outpatient clinic space for the expected cancer backlog due to the COVID-19 pandemic.

Well Led

		2019-2021 Achieved
Well Led: Leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture		
WL1	Deliver on Trust's quality focused strategic priorities	✓
WL2	Embed new corporate governance and risk committee structure	✓
WL3	Increase national profile and collaborative working as a system leader against regional & national quality priorities/indicators structure	✓
WL4	Carry out monthly human factors focused quality and safety leadership walk rounds 2021-22	Partially met
WL5	Strengthen Nurse and AHP leadership	✓
WL6	Patient and Staff experience narrative delivered at Trust Board	✓

WL1. Deliver on Trust's quality-focused strategic priorities

Background

The Trust had two quality-focused strategic priorities in place for 2020/21: 'Transforming cancer care through our new clinical model' and 'Maintaining excellent quality, operational and financial performance'.

Key achievements to date

The development of our new specialist hospital, Clatterbridge Cancer Centre – Liverpool (CCC-L), was the key part of our Transforming Cancer Care programme. In June 2020 we opened CCC-L, delivering Liverpool's first specialist cancer hospital in the midst of a global pandemic on time and on budget. In so doing, we have improved access to cancer care, ensuring that 90% of our patients are within 45 minutes of one of our sites. By opening our new centre we have also ensured that our patients have seamless access to supporting acute services and we have completed the integration of haemato-oncology services into CCC-L.

Aims and next steps

Having delivered our last five-year strategic plan, opening CCC-L and embedding our unique networked model of care, our attention for the next five years needs to be on maximising the benefits of these developments for patient outcomes and experience. To this end we have developed a new statement of our mission for the next five years as part of our new five-year strategic plan for 2021-2025. We will drive improved outcomes and experience through our unique network of specialist cancer care across Cheshire and Merseyside.

Our new six strategic priorities include 'Be outstanding: Deliver safe, high-quality care and outstanding operational and financial performance'. We are already making good progress against the commitments that we have made against this strategic priority and we will continue to drive our delivery against the new strategic plan.

WL2. Embed new corporate governance and risk committee structure

Background

A systematic review of the governance and risk committee structure is required following the restructure of 4 directorates into 3 divisions: Acute Care, Networked Services and Radiation Services.

Achievements to date

The 3 Divisions have developed governance structures supported by dedicated Governance Managers.

Monthly divisional Quality and Safety meetings report any escalation to the Trust Performance Review meetings. At these reviews, the Divisional Directors provide assurance relating to key performance indicators relating to quality, safety and the operational management of their divisions.

Aims and next steps

Going into 2021/22, the Trust's internal assurance and governance processes will continue to be reviewed to ensure that there is full visibility of the Trust's compliance with the requirements and recommendations of all regulatory, advisory and other external bodies and that there is clear accountability for any actions necessary to achieve compliance.

In order to achieve this, a full register of external regulatory visits/inspections is being developed and the register will be reviewed and shared at all sub-committees and committees of the Board to provide assurance of our compliance with any actions or recommendations made.

The Chairperson of each group and committee within the Trust will be required to review their terms of reference, their membership and their standing agenda items to ensure that only the appropriate information is provided to the committee and that all regulatory activities are being reported on and actioned wherever necessary.

There will be a review of the committee structures across the Trust to ensure that information is being escalated and reviewed appropriately by the correct team. It is envisioned that this work will be completed by August 2021.

WL3. Increase national profile and collaborative working as a system leader against regional & national quality priorities/indicators

Key achievements to date

CCC collaborates with multiple partners locally, regionally and nationally to improve cancer pathways and outcomes for patients.

As host of the Cheshire and Merseyside Cancer Alliance (CMCA), CCC has been successful in positioning itself as a system leader in the delivery of the cancer surgery recovery plans across Cheshire and Merseyside following the COVID-19 pandemic and has a position on the National Cancer Board.

CCC also works collaboratively with other specialist cancer service providers across the North West via the Operational Delivery Networks (ODNs). The purpose of these networks is to improve patient access to non-surgical cancer care, develop higher-quality services and help advance in techniques and innovate new procedures.

Our Deputy Medical Director is the national lead for the delivery of Acute Oncology Services.

The Chief Operating Officer is Chair of the Regional Urgent Cancer Care Programme Board, whose main objective is to improve urgent cancer care pathways and develop same-day urgent cancer care pathways across Cheshire and Merseyside. The Board has a wide range of members including GPs and colleagues from NHSE/I.

Next steps

- Development of a Teenage & Young Adult (TYA) ODN.
- Pilot of same-day emergency care pathways (SDEC) across three provider sites.

WL4. Carry out monthly human factors-focused quality and safety leadership walk rounds

In May 2021, the Academy of Medical Royal Colleges published the 'Implementation of National Patient Safety Syllabus' paper. The syllabus takes a proactive approach to identifying risks to safe care and includes a focus on systems thinking and human factors. The Trust will be implementing the syllabus in 2021/22 with the aim of preventing harm before it occurs and identifying and mitigating risks to patient safety.

WL5. Strengthen Nurse and AHP leadership

Background

The national critical shortage of registered nurses and AHPs is a worrying theme in healthcare. In response to this situation, more organisations are turning to a shared governance model. This model enables shared decision-making based on the principles of partnership, equity and ownership that empowers all members of the healthcare workforce to have a voice in decision-making that directly influences safe patient care and experience.

Achievements to date

- Restructure of the clinical directorates in January 2021 to three clinical divisions led by a triumvirate of manager, medic and nurse/AHP providing the strong leadership needed to deliver high-quality patient care.
- Appointment of a Chief AHP to facilitate a strong leadership and governance model within the Trust who will be represented at Board level by Director of Nursing and Quality (DoN&Q).
- Matrons, quality leads and ward leaders are working closely with the DoN&Q and the Deputy Director of Nursing (DDoN) to ensure the successful delivery of the Quality Agenda.
- A professional nurse forum and AHP forum is attended by an increasing number of registered nurses/AHPs across the organisation. Although these meeting were suspended during the COVID-19 pandemic, a clear emergency planning escalation process and communication strategy ensured that all staff were updated on any national, regional or local developments during this time.
- Development of a Matrons Charter.
- Implementation of daily nursing and AHP safety huddles.

Aims and next steps

- Development of a Cancer Professionals Forum, with the first meeting to be held in July 2021.
- A new Chief Nurse has been appointed and will be joining the organisation in October 2021.
- Embedding in the Matrons Charter.
- Development of an AHP strategy.

WL6. Patient and Staff experience narrative delivered at Trust Board

Background

The Patient Experience and Public Involvement and Engagement Strategy (PPI&ES) 2019-2021 was ratified by the Trust Board in January 2019. The strategy contains eight pledges to improve the experience of our patients, their carers and families. Pledge two was the introduction of 'In your shoes' initiative, identifying areas where shadowing can be undertaken across the Trust, helping to create a 'map' of a patient and family's journey through their own lived experience at The Clatterbridge Cancer Centre. It helps to highlight any concerns real time, encourages valuable feedback and overall improves patient experience.

Key achievements to date

In 2020 the 'In your shoes' initiative was expanded to include patient and professional narratives presented at Trust Board level, with a robust monthly schedule hearing the voice first hand of the patients, families and carers, their experiences of care and of the staff caring for them.

Aims and next steps

The plan is to continue to deliver these patient and professional narratives consistently to encompass all Divisions and services in 2021/22 and beyond. We aim to learn lessons from the impact of the COVID-19 pandemic and utilise digital storytelling in the future to share these experiences. Also in 2021/22, the monthly patient experience 'rounds' with the Head of Patient Experience and Inclusion, Governors and Executives will re-commence across all CCC sites.

Part 4:
Trust Assurance

4.1 Review of services

During 2020/21, to support neighbouring acute trusts during the COVID-19 pandemic, The Clatterbridge Cancer Centre (CCC) provided mutual aid in the form of inpatient admissions and diagnostic imaging services.

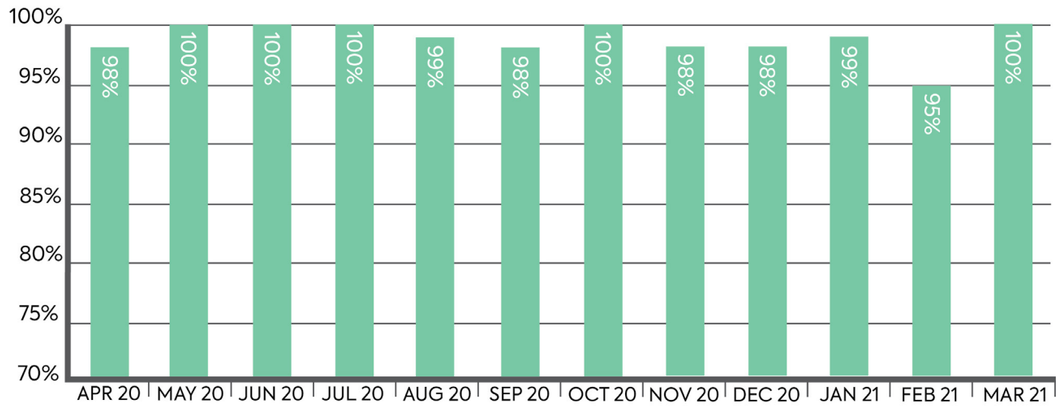
The income generated from the provision of relevant health services represents 100% of the total income generated from the provision of relevant health services by CCC.

4.2 Priority clinical standards for seven-day hospital services

During 2020/21, to support neighbouring acute trusts during the COVID-19 pandemic, The Clatterbridge Cancer Centre (CCC) provided mutual aid in the form of inpatient admissions and diagnostic imaging services.

The income generated from the provision of relevant health services represents 100% of the total income generated from the provision of relevant health services by CCC.

Compliance with the 14-hour target



The Trust is also consistently compliant in the delivery of the following Priority Clinical Standards for seven-day hospital services:

Standard 1 – Information gathered via our FFT, inpatient surveys and the patient experience group indicate we are compliant with this measure.

Standard 3 – All emergency admissions are assessed for complex and/or ongoing needs via the MDT ward round, as per the Transfer and Discharge policy. All ward rounds are led by a consultant. The input of the flow team into the Board rounds has made it more robust and complex discharges can be picked up early within 24 hours of admission.

Standard 4 – Handovers occur at 9am and 4pm daily in a designated location, handover is led by a consultant and attended by all the junior doctors, consultants on call x2, registrar on call, spinal cord compression coordinator, ward managers, palliative care nurse, critical care outreach nurse, physician associates, a representative from medical staffing and the AHP Patient Safety Leads. All clinical data is recorded on an Electronic Patient Record system.

There is also a twice-daily handover between CCC staff and critical care staff from LUHFT.

Standard 7 – Urgent psychiatric and psychological support is available from the Psychological Medicine team within CCC for solid tumour and H-O inpatients in both CCC-W and CCC-L. There is a SLA with Mersey Care, which supports emergencies out-of-hours.

Standard 9 – During 2019/20 the Trust introduced a designated Discharge Coordinator and Patient Flow Team. This Team proactively identify patients that may require additional support within the community following discharge and coordinate individual care packages for this patient group. Since this team has been in post, the Trust has been fully compliant with standard 9.

Standard 10 – The Trust Integrated Performance report is presented to the Trust Board monthly; this includes performance data relating to quality improvement and patient outcomes. The management and supervision of junior trainees is delivered by an identified education lead for each professional group; this includes Practice Education Facilitators, Medical Education Team, Radiographer Lead and the Head of Physics.

4.3 Performance against additional quality indicators relevant to CCC

All data and metrics are monitored through the Trust Board Integrated Performance Report (IPR) and through performance and quality review processes. Appendix 5 provides a breakdown of all metrics and performance monitored within our 2020/21 Trust IPR. The Board, in consultation with stakeholders, has determined a number of metrics against which it can measure performance in relation to the quality of care it provides as demonstrated within the Trust IPR.

The Trust has chosen metrics which are relevant to its speciality (i.e. non-surgical oncology) and which are identified as important to the public. However, this does mean that data is predominantly internally generated and may not be subject to benchmarking at this stage.

The following table presents compliance against a number of key quality indicators, which are routinely monitored by the Trust.

Table 6. Performance against additional quality indicators relevant to CCC

Indicator	2020/21	2019/20	2018/19
18 weeks from point of referral to treatment (patients on an incomplete pathway)	98% (92%)	99% (92%)	98% (92%)
62 day wait for first treatment from urgent GP referral for suspected cancer	91% (85%)	88.1% (85%) KPI definition changed in 2019/20	84.6% (85%)
62 day wait for first treatment from NHS Cancer Screening Service referral	97% (90%)	87.2% (90%) KPI definition changed in 2019/20 Target achieved in Q3 and Q4.	64.5% (90%)
Maximum 6 week wait for diagnostic procedures	100%	100%	100%
'Never Events'	0	0	0
Clostridium difficile (attributable)	5 (annual 4)	11 (annual 4) Only 1 case identified a lapse in care	2 (annual 4)
C Diff cases per 1,000 bed days	0.24	0.47	0.09
MRSA bacteraemia cases per 10,000 days	0	0.43	0
Attributable category 2 or above pressure ulcers per 1,000 bed days	1.99	2.90	2.08
Patient Friends and Family Test: recommend the Trust for Care and Treatment	Data not published (April 2021: total positive ratings = 96%)	88%	90%

All indicators: Data source: CCC

Cancer Waiting Times performance is generally very good, with rare instances of monthly non-compliance relating to patients choosing to delay treatment at seasonal holiday times.

The Trust reported a total of 5 cases of Clostridium Difficile throughout 2020/21. This is 1 over the ambitious target of no more than 4.

The Trust had no patients with attributed MRSA bloodstream infections in 2020/21.

The Trust has not reported any hospital-acquired category 3 or category 4 pressure ulcers during 2020/21. All category 2 pressure ulcers were reported through the Datix system and a full review undertaken for discussion at the monthly Harm Free Care collaborative meeting.

Over the past year, staff have had virtual training for skin barrier products to protect patients' skin. A robust Tissue Viability service (TVS) has been implemented at CCC; a TV Nurse Lead was appointed in Q4 and has made a significant impact regarding visible support and advice for nursing and medical staff. ELearning was made an essential skill with a new package made available to staff via ESR.

The Patient Friends and Family Test (FFT) scores reflect the consistently high satisfaction reported by users of CCC services.

4.4. Mortality data and learning from deaths

During 2020/21, 102 patients died as an inpatient at The Clatterbridge Cancer Centre. This comprised the following number of deaths which occurred in each quarter of that reporting period: 12 in the first quarter; 24 in the second quarter; 35 in the third quarter; 31 in the fourth quarter.

As of 9th June 2021, 64 (63%) case reviews have completed phase I, out of which 56 (88%) were further investigated at phase II and 14 were selected for discussion in the Trust's Mortality Review Meeting.

Out of the 14 cases discussed at the mortality review meeting, the number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 1 in the first quarter 2020-2021
- 3 in the second quarter 2020-2021
- 0 in the third quarter 2020-2021
- 7 in the fourth quarter 2020-2021

The Trust Mortality Review Meetings have resulted in a number of changes to clinical care, driven by lessons learnt, such as changes to clinical practice, documentation and education and training.

Mortality performance and progress is monitored at the Mortality Surveillance Group and reported to the Board via the Quality Committee.

Further supplementary information in relation to Learning from Deaths can be found in Appendix 4.

	QTR 1	QTR 2	QTR 3	QTR 4	Total
Definitely avoidable (1)	0	0	0	0	0
Strong evidence of avoidability (2)	0	0	0	0	0
Probably avoidable (more than 30:30) (3)	0	0	0	0	0
Possibly avoidable but not very likely (less than 50:50) (4)	0	0	0	1	1
Slight evidence of avoidability (5)	0	0	1	0	0
Definitely not avoidable (6)	11	11	20	12	54
Total No. of structured judgement reviews	11	11	21	13	54
% patient deaths are judged more likely to have been due to problem in care provided	0%	0%	0%	0%	0%

As a specialist trust, The Clatterbridge Cancer Centre is not eligible to utilise SHMI or HSMR as a mortality review tool.

The Trust continues to regularly evaluate, modify and improve the quality of its comprehensive mortality review processes. The Mortality Surveillance Group (MSG) maintains an effective strategic lead in the monitoring and promotion of mortality reduction, having oversight of all Trust-related deaths via the Trust-developed mortality dashboard. The MSG takes the lead in reviewing all high-risk mortality areas, and reviews hard and soft intelligence in this regard, as well as internal and external clinical audit feedback. In-depth statistical analysis of chemotherapy and radiotherapy-related deaths continues, providing a platform for the interrogation of individual consultant performance, and continuous monitoring of chemotherapy regimens and variations in clinical practice.

Trustwide feedback and dissemination of learning from deaths from Mortality Review Meetings is in place via the Trust Shared learning Newsletter. Structured Judgment Review methodology has been successfully introduced, with all consultants expected to engage in such reviews, to highlight areas of good practice as well as identify any suboptimal care provision and avoidable deaths. All Trust deaths in care are subject to one or more of five levels of scrutiny, to include a documented specialist Site Reference Group Review or Specialist Committee Review response to a mortality alert investigation process. The Trust continues to share this learning widely with external healthcare providers, including other hospital trusts, GPs and coroners.

The adoption of national mortality guidance and policy has seen the Trust's closer liaison with national and regional partners and external agencies, to include CDOP (Child Death Overview Panel) and LeDER (NHSE Learning Disabilities Mortality Review Programme). There has also been a focused emphasis on the early involvement of families, and continued open and honest communication with families and carers, in the event of Serious Untoward Incident investigations. In line with statutory guidance in relation to the management of child (0-18yrs) deaths, the Trust now has an identified Key Worker for any families affected by the death of a child. The Trust is committed to improving mortality review and review of serious incidents as a driver for improved quality and patient safety.

The Trust Mortality Review Meetings have resulted in a number of changes to clinical care, driven by lessons learnt, such as changes to clinical practice, documentation and education and training.

Mortality performance and progress is monitored at the Mortality Surveillance Group and reported to the Board via the Quality Committee.

Further supplementary information in relation to Learning from Deaths can be found in Appendix 4.

4.5 Participation in clinical audits and national confidential enquiries

During 2020/21, 10 national clinical audits and 0 national confidential enquiry were relevant to the health services provided by CCC.

The national clinical audits and national confidential enquiries in which CCC participated, and for which data collection was completed during 2020/21, are listed on the right.

- Cancer Outcomes and Services Dataset (COSD)
- National Bowel Cancer Audit (NBOCA)
- National Lung Cancer Audit (NCLA)
- National Oesophago-Gastric Cancer Audit (NOGCA)
- National Systemic Cancer Therapy Dataset (SACT)
- National Audit of Breast Cancer in Older Patients (NABCOP)
- Quality of Life Questionnaire for SRS
- BSBMT long-term outcomes audit with UK benchmarking
- Use of Pembrolizumab in head and neck cancer during COVID-19
- A prospective multi-centre observational cohort study to assess the presentation, management and outcomes of patients with CNS disease secondary to breast cancer (PRIMROSE)

The national clinical audits and national confidential enquiries that CCC participated in, and for which data collection was completed during 2020/21, are listed on the next page alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit and NCEPOD eligible studies	Cases submitted
Cancer Outcomes and Services Dataset (COSD)	12/12 (100%) files uploaded successfully
National Systemic Cancer Therapy Dataset (SACT)	12/12 (100%) files uploaded successfully
National Lung Cancer Audit	12/12 (100%) files uploaded successfully
National Bowel Cancer Audit	658/795 (83%) oncology treatment records uploaded. The remaining 17% not being uploaded due to not being registered by the acute Trust.
National Oesophago-Gastric Cancer Audit	218/281 (78%) oncology treatment records treatment uploaded. The remaining 22% not being uploaded due to not being registered by the acute Trust.
National Audit of Breast Cancer in Older Patients	12/12 (100%) files uploaded successfully
Quality of Life Questionnaire for SRS	88 patient questionnaires collected
100 day mortality post allogeneic stem cell transplantation	Data has been uploaded to Quality Surveillance Information System (SSQD). Performance has been monitored by the Mortality Surveillance Group Quarterly
BSBMT long-term outcomes audit with UK benchmarking	Data has been uploaded to Quality Surveillance Information System (SSQD). Performance has been monitored by the Mortality Surveillance Group Quarterly
NHSE dashboard: outcomes audit with UK benchmarking	Data has been uploaded to Quality Surveillance Information System (SSQD). Performance has been monitored by the Mortality Surveillance Group Quarterly
Use of Pembrolizumab in head and neck cancer during COVID	14 records identified for submission.
PRIMROSE	Data has been submitted

The reports of seven national clinical audits were reviewed by the provider in 2020/21 and The Clatterbridge Cancer Centre NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National Clinical Audit and NCEPOD eligible studies	Cases submitted
NBOCAP (Bowel Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2021-22 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
NOGCA (Oesophago - Gastric Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2021-22 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
NCLA (Lung Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2021-22 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
NPCA (Prostate Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2021-22 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
NCEPOD – Pulmonary Embolism study (Know the Score)	A VTE working group has been established looking at the VTE pathway. When developing the pathway the NCEPOD recommendations and report and will be taken into account.

National Audit of Care at the End of Life (NACEL) - Round 2	Round 2 report and recommendations were submitted to the Mortality Surveillance Group. A comprehensive action plan was formulated and all actions have now been implemented prior to commencement of NACEL Round 3
The National Audit of Breast Cancer in Older Patients	The annual report and recommendations were reviewed by the SRG Data submissions continue to be extracted from COSD dataset. SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
Getting it Right First Time (GIRFT) Thrombosis Survey	The data pack was circulated to Medical Director, VTE clinical leads and discussed at the Deteriorating Patient Steering Group. A VTE working group has been established looking at the VTE pathway.

*SRG – Site Reference Group

The reports of 34 local clinical audits were reviewed by the provider in 2020/21. The actions CCC intends to take to improve the quality of healthcare provided are detailed in Appendix 3.

4.6 CQUINS

CCC's income in 2020/21 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because CQUINS were paused during the COVID-19 pandemic. Despite this, the Trust continued to make improvements in all areas as follows:

Flu vaccination programme 2020/21:

Vaccination Uptake	
Doctors	91.7%
Nurses	90.6%
AHP staff	94.7%
Patient-facing support	87.1%
Non-patient-facing	75.1%
Clinical uptake	**90.6%**
All staff uptake	**85.6%**

Alcohol and tobacco screening and brief advice

- Advice and guidance on where and how to access smoking cessation information for staff was made available on the Trust intranet.
- A Trustwide smoking cessation policy is being drafted with plans in place to support patients to stop smoking.

High impact interventions to prevent hospital falls

- A number of beds transferred from the Wirral site with the facility to go to a lower height and the addition of night lights.
- E-Learning developed and live on Electronic Staff Records (ESR).
- E-Learning now part of Essential training for some cohorts of staff.
- Non-slip (Grip) anti-embolic stockings launched.
- Falls care plan updated following recommendations from Learning from Incident Review Group.
- Dyspnea care plan updated following recommendations from Learning from Incident Review Group.
- Ramblegard sensors launched on Wards 4 and 5 and numbers of sensors increased on all other inpatient wards.
- Ward-based Ramblegard training provided for all inpatient wards.
- Ward maps purchased to allow inpatient falls to be plotted.
- 'Helping Hand' project currently being piloted on one ward.
- Lessons learnt are displayed in staff beverage bays.

Redesign of outpatient pathways

- The COVID-19 pandemic has rapidly changed our Outpatients Department (OPD) service provision to include digital solutions for working from home, new hybrid support roles for face-to-face (F2F) and telehealth and more telehealth booths to expand and sustain this flexible approach.
- Videoconferencing and telephone appointments are in place which are accessible to all appropriate patients. We will continue to expand the use of Attend Anywhere video consultations to support a flexible approach to OPD consultations.
- For those patients requiring F2F appointments, this remains available. Patients can now utilise electronic check-in for F2F appointments.
- E-prescribing (now includes the Isle of Man). E-consent and multiple cycle prescribing will help create capacity for the backlog of cancer referrals accumulated as a result of COVID-19.
- We will continue to expand e-consent to support digitalised solution for SACT delivery and streamlined pathways.
- Point of Care testing will support quick SACT delivery and reduce phlebotomy waits.
- We will work with Liverpool CCG to support our patients accessing phlebotomy services closer to their homes.

4.7 Patient-Led Assessments of the Care Environment (PLACE)

PLACE is a system for assessing the quality of the patient environment. It is an organisational voluntary self-assessment which takes place annually and applies to NHS trusts, voluntary, independent and private healthcare providers.

PLACE results show how hospitals are performing both nationally and in relation to other hospitals providing similar services. They provide motivation for improvement by offering a clear message, directly from stakeholders, about how the environment or services might be enhanced.

Due to the COVID-19 pandemic, the annual PLACE assessment was deferred nationally with an option for NHS providers to undertake a non-mandatory PLACE LITE assessment, which was undertaken at CCC-L on 7th December 2020.

PLACE LITE focused on the following domains:

- First impressions
- Cleanliness, condition and appearance
- Hand hygiene and equipment
- Access
- Dementia-friendly environment
- Privacy, dignity and wellbeing
- Staff assessment of food and facilities
- Lasting impressions

As we were unable to utilise the involvement of local people (known as Patient Assessors) as part of the assessment team, due to social distancing requirements, shielding and a reduction in unnecessary footfall as part of the pandemic response, CCC-L volunteers undertook the PLACE LITE assessment in the absence of patient assessors.

The 2020 PLACE LITE assessment was led by PropCare, supported by non-patient-facing CCC staff, a dietetics representative, ISS Operational Managers and CCC-L volunteers.

PLACE LITE assessments took place across all wards at CCC-L on 7th December 2020. CCC-L was one of only three hospitals across England to undertake PLACE LITE in 2020.

As this was a local voluntary undertaking, no data was required to be uploaded onto NHS Digital and therefore no local or national comparative PLACE LITE data will be available. Whilst the areas of concern have been noted, a number of those highlighted are being addressed currently as part of the transitional activities of settling into CCC-L e.g. art work by the new Arts Coordinator, further development work on the inpatient TV system based on inpatient & staff feedback, and bedroom & ward orientation carried out by housekeepers upon patient admission. These actions will be monitored by PEIG going forward.

A number of dementia and signage-related concerns have been highlighted but PropCare have gathered quotes to organise the fall-shorts related to dementia/disability in common areas at CCC-L, to ensure future compliance with DAA environmental audit requirements and Communications are in the process of developing signage details for the lift directories.

Protected meal times across the inpatient wards at CCC-L are in place, clearly advertised and monitored by matrons and ward managers.

The assessment team unanimously reported that they were very confident that a good level of patient care and experience is and will be delivered within the CCC-L environment.

4.8 Data quality

The Clatterbridge Cancer Centre NHS Foundation Trust submitted records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS number was: 100.0% for admitted patient care and 99.9% for outpatient care. The Trust does not provide accident and emergency care.
- Which included the patient's valid General Practitioner Registration Code was: 100.0% for admitted patient care and 99.8% for outpatient care. The Trust does not provide accident and emergency care.

The above figures are in line with the SUS data quality dashboard methodology:

- Where there is an NHS number this is classed as valid.
- The General Practitioner Registration Code figures include the default not known/not applicable codes as valid.
- The General Practitioner Registration Code figures class any GP practice that was closed prior to the beginning of the financial year as invalid.

The Information Governance Assessment against all 40 mandatory standards of the new NHS Digital Data Protection and Security Toolkit for 2019/20 was delayed until the end of September 2020 by NHS Digital/NHSX.

CCC was not subject to the Payment by Results clinical coding audit during 2020/21 by the Audit Commission.

Data quality improvement plans 2020/21:

Good quality information that is accurate, valid, reliable, timely, relevant and complete is vital to enable the Trust and our staff to evidence that high quality, safe and effective care is delivered.

Good quality information also supports the Trust to manage service planning, performance management and commissioning processes.

The Trust has a Data Quality Policy in place which outlines expected standards around data recording. The Trust has an active Data Management Group which is chaired by the Director of Finance and meets monthly with a clear focus on Data Quality and Business Intelligence. Over 2020/21 the Business Intelligence team has significantly improved access to information with the building of data quality dashboards to support timely and accurate entering of data.

The importance of data quality is highlighted in Electronic Patient Record (EPR) system training along with the importance of good record-keeping.

4.9 Workforce

Staff survey results 2020

The NHS National Staff Survey is the largest annual workforce survey in the world. The survey results are categorised under 10 themes which are scored on a scale of 0-10 where a higher score indicates a better result.

We are committed to listening to the views of our staff and recognising their achievements on a regular basis. We believe that motivated and engaged staff deliver better outcomes for our patients and our ongoing aspiration is to improve levels of staff engagement on a year-on-year basis, as measured by the NHS National Staff Survey.

The results from the survey and action plans are closely monitored and discussed at the Board meetings.

Since the 2019 survey, we have focused on making positive changes in the four areas highlighted in our 2020/21 improvement plans: Health and Wellbeing, Communication, Leadership and Staff Recognition.

It is therefore pleasing to see significant improvements in all four areas in the 2020 survey results.

The Trust response rate to the 2020 survey was 58% (862), which was less than in 2019 when the response rate was 66% (853).

In 2020 we have improved our score in 9 out of the 10 themes, with two themes (Health and Wellbeing and Staff Environment – Bullying and Harassment) seeing a significant improvement. The Trust was the top-performing specialist acute trust in 4 out of the 10 themes.

The results of the staff survey were communicated to the Trust as a whole and were reported through the committee structures. Individual teams scores were shared with the relevant manager with a request made for the manager and the teams to discuss the results and develop a local improvement plan for their area.

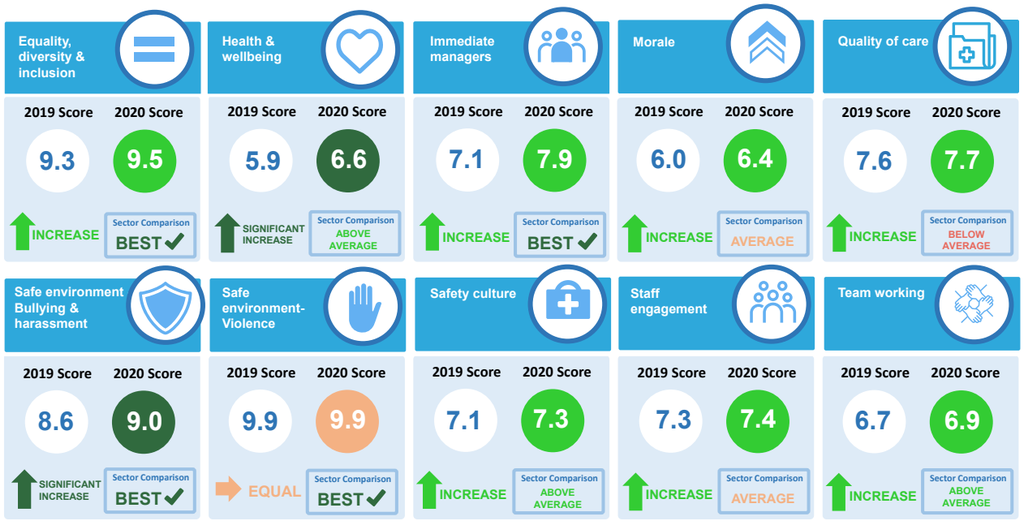


Table 9. Staff survey results, compared with sector averages, for the last three years.

	2020		2019		2018	
Themes	**Trust**	**Sector**	**Trust**	**Sector**	**Trust**	**Sector**
Equality, diversity & inclusion	9.5	9.5	9.3	9.5	9.4	9.5
Health & wellbeing	6.6	6.8	5.9	6.6	6.0	6.6
Immediate managers	6.6	7.3	7.1	7.3	7.1	7.3
Morale	6.4	6.7	6.0	6.6	6.2	6.7
Quality of care	7.7	8.1	7.6	8.1	7.8	8.1
Safe environment – Bullying & harassment	9.0	9.0	8.6	8.7	8.6	8.8
Safe environment – Violence	9.9	9.9	9.9	9.9	9.9	9.9
Safety culture	7.3	7.5	7.1	7.5	7.1	7.6
Staff engagement	7.4	7.6	7.3	7.7	7.3	7.7
Team working	6.9	7.0	6.7	7.1	6.9	7.3

Based on the pressures and climate in which the 2020 survey was undertaken, the results are pleasing and show positive progress in our continuous culture and engagement journey.

Key areas for focus in 2021/22 include:

- Continuing to engage with teams to focus on how we can make CCC an even better place to work and receive care.
- Continued focus on further improving staff wellbeing, staff engagement and morale and quality of care.
- Implementation of Divisional Culture and Engagement Groups.

Staff Diversity Profile (Snapshot in March 2021)

Clinical education

Delivery of clinical education during a pandemic has realised both challenges and opportunities. CCC education teams and wider staff have adapted and responded to ensure continued support for the ongoing learning of all students and staff, ensuring high-quality patient care and consistent, responsive teaching and assessing environments. Maintaining socially-distanced education, Clinical Education has embraced technology-enhanced learning during 2020/21, working at a sustained pace to ensure the quality of student support, both in practice placements and in their academic modules.

Coordinating and supporting redeployed nurses in practice under the NMC emergency standards, to finding new ways of enabling students to undertake exams during lockdown, has required new ways of thinking around how to achieve the same goal and quality learning experience. During 2020/21, all of our education provision was delivered online and consisted of a hybrid of live lectures, activities and recorded sessions. The quality of courses delivered was not compromised and we continued to engage with students personally through a variety of remote media such as face-to-face tutorials and interactive teaching on online platforms. We have been busy learning how to maximise available technology to achieve a consistent goal of providing a quality learning experience.

From April 2020 – March 2021, the CCC Clinical Education Department planned delivery of 16 academic modules, short courses and workshops. Six were cancelled due to COVID-19 impacting staff and student attendance, internal and external to CCC, and restrictions on study leave due to clinical pressures. In spite of this, 76 students were supported during the 2020/21 pandemic to achieve their goals and learning outcomes: 40 internal and 36 external multidisciplinary students. In addition, a new set of educational Key Performance Indicators were introduced in 2020/21 and successfully met, including all regulatory and contractual obligations. Delivery against the Clinical Education Strategy 2019-22 implementation plan has met all milestones during 2020/21, with oversight of all clinical education activity by the Trust's Education Governance Committee.

There has continued to be a focus on collaborative, partnership working across Cheshire & Merseyside, which included development of a new joint CCC/University of Liverpool MSc in Cancer Care launching in Sept 2021. A new CCC Nursing Career Pathway and Competency Framework was introduced in May 2020, supporting the introduction of multiple new clinical roles and providing direction for career support and progression. Additionally CCC was successful in securing expanded student nurse and AHP placement capacity via a pan-Merseyside collaborative in 2020/21. Clinical Education has remained a Trust priority throughout 2020/21.

Raising concerns

The Trust Board is committed to listening to our staff, learning lessons and improving patient care and supporting an open and honest culture where staff feel comfortable and safe to speak up.

There are a number of ways in which staff here at The Clatterbridge Cancer Centre can raise concerns they have around patient safety.

The Trust has a Freedom to Speak Up: Raising Concerns in the Workplace Policy which supports staff who wish to raise a concern around patient safety. This has been reviewed and refreshed during 2020/21.

We encourage staff to raise concerns through their line management structure but we recognise that staff will not always want to use this route. We have a Lead Freedom to Speak Up Guardian in the Trust who is supported by three Local Guardians whose contact details are widely publicised and an Executive Lead who supports the process.

In addition, we have, during the last year enlisted the support of a number of 'Speaking Up Champions' from a variety of disciplines to encourage staff to speak up if they have any concerns.

During 2020/21, a total of 8 contacts were made via the Freedom to Speak Up Guardians, all of which reached resolution for the individuals concerned.

Activity is reported on an anonymous basis to the Quality Committee and Trust Board.

Part 5:
Research and Innovation

Background

The COVID-19 pandemic presented the NHS with its greatest challenge across all healthcare sectors since its inception. The need for scientific and clinical research had never been stronger. The R&I Directorate confronted this test head-on, managing the research portfolio as understanding and knowledge increased on the virus and its action, providing system support through the city region, acting both as Sponsor and Participating site for COVID-19 specific research, continuing to open critically important cancer trials and then recovering as rapidly and safely as possible.

The clear focus was on both our patient and staff safety and wellbeing throughout all our activity. The middle of the year brought our welcome relocation to our new Centre of Excellence at CCC-L which will enable a step change in our capability to support cutting edge research and offer our patients the most novel agents and therapies.

Key achievements:

- Opened 46 research trials and studies (52 given permission to open at CCC).
- The number of patients receiving relevant health services provided or subcontracted by CCC in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee: 942.
- Significantly increased the number of clinician-led studies for which CCC acts as Sponsor with 8 trials and studies open and 12 in set-up.
- 85% of clinical trials unpaused as part of COVID-19 recovery, which has exceeded the national target.
- Pivotal in the set up CCC's first ever Interventional Radiology Service based at CCC-L to support clinical trials, working in collaboration with Radiation Services.
- Implemented a new PPI group to ensure patient voices and opinions are heard and heeded in research.
- Implemented the 'Research Rounds' fortnightly set of presentations by CCC researchers and university scientists to foster and reinvigorate a research community at CCC.
- Establishment of a R&I COVID-19 Research Group.
- Participation in COVID trials to support patient care and treatment (12 to date).
- Recognised by the NIHR NWC CRN for 'demonstrating outstanding commitment and dedication during the crisis'.
- R&I were finalists at the RCNi Nursing Awards 2020. Two teams were shortlisted for the 'Excellence in Cancer Research Nursing' category: Early Phase Trials Team and Research & Innovation Nursing Team.
- R&I continue to meet the Department of Health and Social Care targets for study set-up with metrics consistently achieving the target of median 40 days.

Research Strategy

The new Trust Research Strategy (2021 – 2026) was fully endorsed by the Trust Board in October 2020 and the associated Business Plan gained approval in January 2021. It is envisaged that implementation of the five-year plan will have a positive impact on:

- Patient outcomes, experience and journey.
- Research culture, ethos and outputs within the organisation, ensuring reputation in provision of world-class cancer care.
- Staff engagement and education both within the organisation and as system leaders for cancer services.

Aims and next steps

Please refer to Appendix 6 for the CCC Research Strategy.

Appendices

Appendix 1: Complaints supplementary information

Appendix 2: End of Life

Appendix 3: Audit Assurance

Appendix 4: Learning from Deaths Supplementary Information

Appendix 5: Trust IPR

Appendix 6: CCC Research Strategic Business Plan 2021-26

healthwatch Liverpool

Healthwatch Liverpool Comment on Clatterbridge Cancer Centre Quality Accounts 2020/21

Healthwatch Liverpool welcomes the opportunity to provide comments on this report which covers a time of considerable change and pressure on patients and staff. The opening of the new Liverpool hospital, and the transfer of the Haemato-oncology service from the Royal Liverpool Hospital site would have been significant at any time, but the Trust is to be congratulated for achieving these during the Covid-19 pandemic whilst maintaining quality indicator levels and KPIs.

We also welcome the Trust's commitment to partnership working and mutual aid, through which it has been able to move cancer patients out of other local hospitals and supported them through diagnostics, palliative care, and surgical cancer recovery care.

Congratulations to the palliative care team on their award for post death support for families. It is to be hoped that good practice and learning from the Trust's approach will be shared with other local NHS Trusts, and beyond.

Healthwatch Liverpool is particularly pleased to note the Trust's commitment to becoming more dementia, autism and learning disability aware (e.g. the recruitment of Dementia/LD Champions and the introduction of the 'special indicator' tab on Meditech) and would support any initiatives to improve equality, diversity and inclusion across the board for patients and staff and we look forward to learning more about the work of the Divisional Culture and Engagement Groups.

We also note the Trust's success in recruiting 100+ volunteers to support the move to Liverpool, and to provide valuable additional support to patients – including supporting them to make video calls to their families.

We are interested in CCC's approach to digital working and we would be interested to know more about work to ensure digital/telehealth inclusion.

We support the initiatives introduced to reduce falls, such as the Ramblegard sensors on Wards 4 and 5, and the increase of sensors on other inpatient wards. We also welcome CCC's changes to treatment pathways to allow more treatment at home (e.g. chemotherapy), and are encouraged to learn that patient feedback about this has been positive.

It is also encouraging to note that Cancer Waiting Times/Referral to Treatment times and Friends and Family Test feedback remain good even in such challenging circumstances and that NICE Compliance is at 95% at the time of writing.

Healthwatch Liverpool wishes to thank all CCC staff and volunteers for their hard work and commitment to patient care and safety during this extremely difficult time, and looks forward to developing our partnership work in support of high quality care and patient inclusion/engagement over the coming months and years, through participation in the Patient Experience and Inclusion Group (PEIG) and Patient Participation Group (PPG) and receipt of regular 'Incidents, Complaints and PALS Reports'. We also hope to become actively engaged in e.g. Listening Events and PLACE assessments as Covid-19 restrictions ease, and to develop links with the Teenage and Young Adult Unit. The impact of the past year will doubtless be felt for some time to come across the health sector and we hope to work together to ensure the best possible experiences and outcomes for all patients and family members.

Appendix 1:
Complaints supplementary information

Complaints – Supplementary Information

During 2020/21 a total of 33 formal complaints were received by the Trust; the number of formal complaints received/count of WTE staff (ratio) is 0.002.

By the end of 2020/21 24 routine complaints and 2 complex complaints had been resolved.

Despite having a refreshed process in place for complaints management, the Trust was not fully compliant with the internal target of responding to routine complaints within 25 working days and responding to complex complaints within 60 working days. However, all delays to complaint responses were discussed with the complainants and new response times agreed.

In February 2021 a full review of the complaints process was undertaken to understand the reasons for the delays in complaint responses being returned to the complainant. From this review an action plan was developed and agreed with all actions to be completed by June 2021.

Chart 1 Complaints by Division

	Acute Care	Integrated Care	Haemato-Oncology	Networked Services	Chemotherapy Services	Radiation Services	Corporate	**Total**
Apr-20	0	1	0	0	1	2	1	5
May-20	0	0	0	0	1	0	0	1
Jun-20	0	0	0	0	0	0	0	0
Jul-20	0	1	0	0	0	3	1	5
Aug-20	0	0	1	0	0	2	0	3
Sep-20	0	0	0	0	0	0	0	0
Oct-20	0	0	0	0	2	3	0	5
Nov-20	0	0	0	0	1	0	0	1
Dec-20	0	0	0	0	0	0	0	0
Jan-21	1	0	0	2	0	0	0	3
Feb-21	0	0	0	0	0	2	4	6
Mar-21	0	0	0	4	0	0	0	4
Total	1	2	1	6	5	12	6	33

Routine complaints resolved in 2020/2021	Chemotherapy Services	Acute Care	Corporate	Networked Services	Radiation Services	Haemato-Oncology	Integrated Care
Apr-20	0	0	1	0	0	0	0
May-20	2	0	0	0	2	0	1
Jun-20	1	0	0	0	2	0	0
Jul-20	1	0	1	0	1	0	0
Aug-20	0	0	0	0	0	0	0
Sep-20	0	0	0	0	1	0	0
Oct-20	0	0	1	0	0	0	0
Nov-20	0	0	0	0	0	1	0
Dec-20	0	0	0	0	2	0	0
Jan-21	0	0	0	0	0	0	0
Feb-21	0	1	0	0	2	0	1
Mar-21	1	0	1	0	1	0	0

Lessons Learned from Complaints

Learning and actions taken as a result of the upheld and partially upheld complaints received in 2020/21 include:

- Cancer pathway delays are now escalated to the divisional Clinical Director and Divisional Director for the service to ensure that any delays and issues with other organisations and services are addressed promptly
- There is now a daily report taken from the NHS Spine so patients' electronic health record can be updated contemporaneously
- A template to support the checking of all prescribed medicines has been developed to support ward rounds.
- The clinic preparation SOP has been updated
- The ‘lost to follow up report’ run by the admin team has been amended so all non-consultant appointments are no longer taken into account when scheduling appointments
- A review of the Acute Oncology service between CCC and Wirral University Teaching Hospital NHS Foundation Trust will take place.

Patient Advise and Liaison Service (PALS)

In 2020/2021 a total of 337 PALS contacts were recorded; an increase from 315 in 2019/2020.

All PALS contacts aim to be dealt with within 3 working days and if unable to be dealt with by the PALS officer, are immediately escalated to the relevant directorate for review and response.

The average number of days taken to respond to PALS contacts in 2020/21 was 4 working days. This figure was brought up by 14 PALS contacts taking over 10 days to respond to. All delays had been discussed with the patient/carer with the reason for the delay being explained.

The number of PALS concerns received by month throughout 2020/2021 shows that there were spikes in July 2020 and October 2020. The move to CCC Liverpool contributed to the higher numbers in July 2020 but there are no trends identified for the spike in October.

Appendix 2:
End of Life

Specialist Palliative Care Team

Annual Report 2020-2021

Prepared by: **D Monnery**
Consultant in Palliative Medicine

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Contents

Introductory statement

This year the focus for our teams has been preserving quality and responsiveness of patient care through COVID-19. We have made a number of changes to accessibility and delivery of our service to suit the needs of more patients and the healthcare landscape. We have continued to work towards our KPIs as a secondary goal and striven to produce high quality outputs educationally and academically along the way.

Despite a challenging year, the teams' activity demonstrates we are seeing more inpatients than ever before yet are still managing to see 98% of referrals within 24 hours. We are also getting increasing numbers of patients home at the end of their admission. Our KPIs also show progressive improvement on last year overall. Levels of training compliance in role-essential training in end of life care continue to rise. The use of the end of life care and communication record to support the care of dying patients has now reached 95%!

As predicted we are starting to see the use of GSF pick up in the palliative care setting since this tool was launched last year and will be making a concerted effort to embed this more broadly in oncology in the coming months alongside the newly launched AMBER Care Bundle and Advance Care Planning processes.

We are looking forward this year to newly appointed team members joining us, including the Trust's new Family Support Worker which will make such a difference to patients' and families' experience of care.

We hope you enjoy this report and the way in which it is presented. Further information can be obtained on request from Dr Dan Monnery, Consultant in Palliative Medicine **(daniel.monnery@nhs.net)**.

The team

- Consultant in Palliative Medicine
- Consultant and Clinical Research Lead in Palliative Medicine
- 0.6 WTE Specialty Doctor in Palliative Medicine
- 5.2 WTE Clinical Nurse Specialists in Palliative Medicine
- 1 WTE Clinical Nurse Specialist in Palliative Medicine and Lead for AMBER and Advance Care Planning
- 1.0 WTE Palliative Care Team Coordinator

Top achievements in the last year

Our goals from last year

We Said	We Did
Expansion of CNS clinics to support joint working with oncology in sites such as HPB and Lung Cancers.	Launched a joint clinic model within HPB cancers at CCC-W.
Develop the team's research portfolio and focus on publications/presentations.	Expressed interest in commercial studies, progressed existing work on biology of dying. Submitted a total of 10 abstracts for ASCO, MASCC and EAPC. All abstracts have been accepted for oral or poster presentations. Our service evaluation work has also been shortlisted twice for the HSJ Value in Healthcare Award 2021.
Embed Advance Care Planning and the AMBER Care Bundle within the Trust.	Launched AMBER Care and Advance Care Planning processes and supporting education in April 2021.

Our top three achievements

1

Our work delivering the day after death service to support the Trust mortality review process was shortlisted and received a high commendation at the HSJ Patient Safety Awards 2020. Furthermore a member of our team was shortlisted for the Audit Hero Award 2020.

2

Our team has developed and adapted to a changing environment (global pandemic) and the move to a new site, including setting up a new ambulatory ESC service in CDU which has been shortlisted for the HSJ Value in Healthcare Award 2021.

3

We have successfully launched the AMBER Care Bundle and Advance Care Planning within CCC to allow our care to be truly patient-centred.

Our activity and key performance indicators

Activity	2019/20	2020/21	Comments/explanation
New Outpatient Consultations	775	465	Due to COVID-19, the number of patients receiving palliative diagnoses reduced so new referrals to ESC dropped. Compared to last year, ESC saw a greater proportion of patients diagnosed with palliative illness however
Follow up Outpatient Consultations	1137	1458	
New Inpatient Consultations	375	503	
Follow up Inpatient Consultations	2961	2614	
Inpatients seen within 24 hours of referral	99.30%	98.30%	
Inpatients discharged home at the end of admission	52.60%	57.60%	More patients than ever before are getting home from hospital following review by the specialist palliative care team
New patients seen at weekends	48	54	
Follow up patients seen at weekends	640	485	
Average Length of stay (days)	11.07	9.7	

Key Performance Indicators	2019/20	2020/21	Comments/explanation
Proportion of patients who have an expected death at CCC and who have completed End of Life Care and Communication Record	87%	95%	
The proportion of patients who died in the year who had a GSF notification	1.30%	1.50%	10.6% if referred to Palliative Care
The proportion of patients dying in hospital who were not admitted for end of life care with a completed AMBER care bundle	0%	0%	AMBER Care Bundle was launched in April 2021 so the uptake will be seen in next year's report
Proportion of patients with incurable disease offered referral to Enhanced Supporting Care (ESC)	16.60%	17.70%	
The proportion of inpatients in the last 12 months of their life who were offered Advance Care Planning	7.50%	7.50%	Advance Care Planning tool and education launched April 2021 so expect to see increased uptake in next year's report
Proportion of patients dying at CCC who do so as their preferred place of care/ death	**YES** 56%	**YES** 48%	We have got better at asking where the patient's preferred place of care is. As many hospices have been struggling with capacity and even closed for periods during the year it has not been possible to achieve PPC as much as we would have liked
	NO 12%	**NO** 20%	
	UNKNOWN 33%	**UNKNOWN** 30%	

Key Performance Indicators	2019/20	2020/21	Comments/explanation
We have continued to ensure 100% of patients receiving palliative care input have completed IPOS scores	100%	100%	
The proportion of inpatient deaths reviewed as part of the mortality review process	90%	98%	
Proportion of patients receiving palliative treatment and/or their families offered referral to the Family Support Worker	0%	0%	Family Support Worker appointed in April 2021 so uptake will be recorded in next year's report
The proportion of bereaved family/carers who have a completed bereavement risk assessment	68%	42%	Due to COVID-19 families were less present with their loved ones during hospital admissions and did not return to the hospital to access the day after death service so the use of the bereavement risk indexes reduced. This process has now been digitalised within the end of life care and communication record to aid uptake
Undertake a CODE review every two years to obtain feedback from bereaved relatives/carers	100%	100%	
Proportion of staff compliant with role-essential training in End of Life Care	78.10%	91.74%	
The proportion of eligible staff who received communication skills training	8.50%	2.80%	One advanced communications course has been able to run in 2020/21 due to COVID-19

Aims for the year to come

Our top three goals for this year

1

Expand our ward-based education portfolio to facilitate regular training in symptom control and complex communication and support for patients.

2

Development of the Palliative Care page on the Trust intranet including the embedding of learning resources to facilitate the successful launch of our palliative care link nurse programme.

3

Embed a new family support service within CCC to provide greater specialist emotional support for patients and permit CCC to join a network of services providing responsive bereavement support.

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www.clatterbridgecc.nhs.uk

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Appendix 3:
Audit Assurance

Table 1a: Audits: cases submitted

National Clinical Audit and NCEPOD eligible studies	Cases submitted
Cancer Outcomes and Services Dataset (COSD)	12/12 (100%) files uploaded successfully
National Systemic Cancer Therapy Dataset (SACT)	12/12 (100%) files uploaded successfully
National Lung Cancer Audit	12/12 (100%) files uploaded successfully
National Bowel Cancer Audit	658/795 (83%) oncology treatment records uploaded. The remaining 17% not being uploaded due to not being registered by the acute Trust.
National Oesophago-Gastric Cancer Audit	218/281 (78%) oncology treatment records treatment uploaded. The remaining 22% not being uploaded due to not being registered by the acute Trust.
National Audit of Breast Cancer in Older Patients	12/12 (100%) files uploaded successfully
Quality of Life Questionnaire for SRS	88 patient questionnaires collected
100 day mortality post allogeneic stem cell transplantation	Data has been uploaded to Quality Surveillance Information System (SSQD). Performance has been monitored by the Mortality Surveillance Group Quarterly
BSBMT long-term outcomes audit with UK benchmarking	Data has been uploaded to Quality Surveillance Information System (SSQD). Performance has been monitored by the Mortality Surveillance Group Quarterly
NHSE dashboard: outcomes audit with UK benchmarking	Data has been uploaded to Quality Surveillance Information System (SSQD). Performance has been monitored by the Mortality Surveillance Group Quarterly
Use of Pembrolizumab in head and neck cancer during COVID	14 records identified for submission.
PRIMROSE	Data has been submitted

Table 1b: Audits: Action

The reports of seven national clinical audits were reviewed by the provider in 2020/21 and The Clatterbridge Cancer Centre NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National Clinical Audit and NCEPOD eligible studies	Actions to improve quality of care
NBOCAP (Bowel Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2021-22 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
NOGCA (Oesophago - Gastric Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2021-22 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
NCLA (Lung Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2021-22 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
NPCA (Prostate Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2021-22 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
NCEPOD – Pulmonary Embolism study (Know the Score)	A VTE working group has been established looking at the VTE pathway. When developing the pathway the NCEPOD recommendations and report and will be taken into account.
National Audit of Care at the End of Life (NACEL) - Round 2	Round 2 report and recommendations were submitted to the Mortality Surveillance Group. A comprehensive action plan was formulated and all actions have now been implemented prior to commencement of NACEL Round 3
The National Audit of Breast Cancer in Older Patients	The annual report and recommendations were reviewed by the SRG Data submissions continue to be extracted from COSD dataset SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
Getting it Right First Time (GIRFT) Thrombosis Survey	The data pack was circulated to Medical Director, VTE clinical leads and discussed at the Deteriorating Patient Steering Group. A VTE working group has been established looking at the VTE pathway.

**SRG – Site Reference Group*

Table 1c: Local Audits/Quality Improvement Projects

The reports of 34 local clinical audits were reviewed by the provider in 2020/2021 (compared to 44 in 2019-20), of which 9 provided assurance (compared to 28 in 2019-20) and 15 made improvements through action plans to improve the quality of healthcare provided (compared to 16 in 2019-20).

Improvement Made Projects

Improvements Made / Learning	Improvement Demonstrated (Theme): Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
1. Immunotherapy in bladder cancer patients In conjunction with a peer oncology Trust, we developed and validated a prognostic model for survival in metastatic bladder cancer patients treated with Immune Checkpoint Inhibitors (ICIs) based on real world data. The prognostic factors identified within this study have the potential to contribute meaningfully to future trials, generate hypotheses and emphasize the importance of using real-world data in reporting survival and safety data of new therapies.	✓	✓	✓		
2. DPYD genotyping for patients who develop severe toxicities on 5FU/Capectabine based regimens As a result of this project DPYD, genotyping can now be offered at CCC to patients who have already started on treatment and have developed severe toxicities (grade 3-4) but also some patients with grade 2 toxicities who in the opinion of the treating oncologist would benefit from the test. A rapid implementation of the test, through internal CCC funding, is likely to save lives and will help setting up the required pathways for testing, ready for immediate utilisation once NHSE provide direct funding to North West GLH during 2021.	✓	✓	✓	✓	

Improvements Made / Learning	Improvement Demonstrated (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
3. Blood Product Transfusion Time Following this study the CCC Digital team undertook a project to improve the blood pathway. CCC are now using an electronic system called Blood360 (previously Bloodhound) as part of our new blood transfusion process which was implemented when the Trust moved into the new Liverpool hospital site. There is also now an electronic checklist in the Trusts Electronic Patient Record (Meditech) which is mandatory for the nurses to complete at the bedside during a transfusion. A new 'Transfusion of blood/blood products' policy has been written along with a Standard Operating Procedure (SOP), both of which can be found on the CCC intranet. To increase awareness of this new procedure the CCC digital team attended as many medical handovers and morning meetings as possible to communicate this to the doctors. The Digital Project manager worked with Matron to ensure that as many nurses as possible were also informed of these changes, and they all had to be trained on Blood360 for certain parts of the process. The Digital Project manager also attended the junior doctors' induction to talk them through the process and blood transfusion has been included on the doctors' future training agendas. Project manager attends the Transfusion Oversight Group meetings to provide updates on the new process to Trust lead clinicians.			✓		✓

Improvements Made / Learning	Improvement Demonstrated (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
4. Number of cycles of first line platinum combination chemotherapy and patient survival in advanced small cell lung cancer (SCLC) 4v6 The project highlighted a lack of survival benefit from extending first-line platinum chemotherapy beyond 4 cycles in stage IV small cell lung cancer and recommended that CCC guidelines should limit the recommended cycle number to 4 until the superiority of cycles greater than 4 is identified in a randomised study. The project was discussed at the Lung Site Reference Group (SRG) who collectively agreed to amend the protocol.		✓	✓	✓	
5. Highlighting blood results on the ward Following this study the CCC Digital team undertook a project to improve the blood pathway. CCC are now using an electronic system called Blood360 (previously Bloodhound) as part of our new blood transfusion process which was implemented when we moved into the new Liverpool hospital site. There is also now an electronic checklist in Meditech which is mandatory for the nurses to complete at the bedside during a transfusion.			✓		✓

Improvements Made / Learning	Improvement Demonstrated (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
6. Baseline review of level 1 psychological interventions provided by staff to patients attending CCC The project identified a number of themes such as concerns around education and training, questions over whose responsibility it is to undertake level 1 psychological interventions and the designation of staff who should undertake these. Awareness raising and awareness of pathways and processes were also explored in this area. The audit lead had discussions with key staff leading in End of Life training, Radiotherapy/Imaging training plans, Clinical supervision frameworks (across the wards), Preceptorship development programme and Induction/PADRs An action plan was raised to improve and raise awareness of communication skills courses and we now include communication skills in the L&D mandatory training matrix. Advanced Communications skills training was also a part of the wider 'care of the dying evaluation' (CODE) action plan, this is now completed and Advanced Communications skills training is now included in competency framework.		✓		✓	✓

Improvements Made / Learning	Improvement Demonstrated (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
7. Physiotherapy in Enhanced Supportive Care (ESC) Due to the demands on the physiotherapy services and reduced staffing they have had to adapt their service to support the ESC project by way of introducing a triage service. From this audit the team developed an effective data collection form which has been edited to allow for therapy assistants to use for other outpatient referrals. The audit has also helped evolve the physiotherapy triage service, in which they now complete triaging for all falls/mobility/ESC and neurological patient referrals.				✓	✓
8. Weaning down the dexamethasone in MSSC patients A two cycle Quality Improvement Project (QIP) was undertaken. Initial findings were presented to the Multidisciplinary team and their attention was drawn to the guidance and a formal teaching session was also delivered. Awareness was raised by putting up numerous posters around the wards with reminders of the titrating dexamethasone regime for MSCC patients. Further to these interventions, the QIP second cycle demonstrated an improvement with 78% of MSCC patients receiving the appropriate dexamethasone regime as opposed to 52% in first cohort.		✓	✓	✓	

Improvements Made / Learning	Improvement Demonstrated (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
9. NEWS2 Trigger Score and appropriate oxygen prescribing The audit identified that although NEWS2 scores were initially being calculated correctly and appropriate action plans were followed, there was a poor response rate to NEWS 2 scores being repeated as per policy on all 3 inpatient wards. In conjunction with Digital, the audit team updated the NEWS2 Trigger score for oncology patients on Meditech which allowing doctors to complete an up-to-date score for patients to prevent unnecessary MET calls and optimise patient care. The newer form was found to be easier to complete and was implemented into clinical practice. Doctors were educated on online Oxygen prescribing through the morning handover and during ward rounds. A session was also delivered as part of junior doctors Tuesday teaching. The audit cycle was repeated 4 months after introduction of the updated NEWS2 Trigger score to allow time to identify any immediate issues and introduce appropriate actions with new doctors following changeover and allow them time to become familiar with Meditech.		✓	✓	✓	✓

Improvements Made / Learning	Improvement Demonstrated (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
10. Determination of appropriate Cone Beam CT (CBCT) imaging doses for bladder daily imaging protocol The new CBCT modes produced images of a similar quality to those produced by the standard mode and all produce images that are suitable for soft tissue matching. This will not only reduce the patient exposure but could also reduce the likelihood of future incidents being externally reportable. The CTDI measurements demonstrated that the small, medium and large CBCT modes reduced patient imaging dose, and so also the risk of secondary cancer induction (ignoring contribution from treatment fields), by 82%, 71% and 44% respectively. As a result of this project the new modes are now in use on all treatment sets and so far staff feedback has been good.	✓		✓		✓

Provided Assurance & Improved Knowledge Projects

Provided Assurance & Improved Knowledge	Assurance & Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
1. Re-Audit to Investigating rate of thromboembolic events in bladder cancer patients receiving neo-adjuvant chemotherapy 14% of all patients had DVT/PE during neo-adjuvant chemotherapy (of those with Khorana score >=2 13% developed DVT/PE). 9% of pts had DVT/PE during standard of care chemotherapy compared to a retrospective multicentre study (published in 2016) suggested 8% of pts had DVT/PE during standard of care chemotherapy indicating CCC is comparable with the Trials results.			✓	✓	
2. Preoperative chemo-radiotherapy oesophagus This retrospective review of patients showed a good 18 month survival with the current regimen of chemo-radiotherapy being reasonably well tolerated. Complete pathological response was noted in half the number who underwent surgery with post chemo-radiotherapy PET being a good predictor of response to treatment.		✓	✓	✓	
3. Review of current outcomes of second line systemic treatment for advanced urothelial cancer This audit shows that outcomes following second line palliative systemic therapy for advanced bladder cancer at CCC are in line with published data. This data set provides a comprehensive overview of outcomes of advanced bladder cancer patients at CCC over a 10 year period. It can be used as a comparative data set when auditing the outcomes of the use of immunotherapy for advanced bladder cancer in the first and second line settings.	✓		✓	✓	
4. Audit of use of PARP inhibitors in patients with ovarian, primary peritoneal and fallopian tube cancer The audit showed that fewer treatments were stopped due to toxicity than in phase 3 trial data (Niraparib 6%, Rucaparib 5%, Olaparib 0%). It also showed lower levels of grade 3 or higher anaemia than in phase 3 trials data (Rucaparib 5%, Olaparib 0%, Niraparib 11%) and lower levels of grade 3+ or higher thrombocytopenia (Niraparib 2%)	✓	✓	✓	✓	

Provided Assurance & Improved Knowledge	Assurance & Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
5. DNACPR documentation audit It is clear from this audit that all Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions audited in this time period were made on the basis of an individualised assessment and appropriate discussion with either the patient or (less commonly) with those important to them. The only instances where this was discussed with those important to the patient instead of the patient were instances where the patient was too unwell and lacked capacity to have the discussion.			✓	✓	✓
6. Benefit of Topotecan in non-pulmonary neuroendocrine carcinoma (NEC) Topotecan was effective as a second line treatment in some patients with pure grade III (G3) NEC. Olsen et al (Journal of Cancer. 2014; 5(8): 628-632) showed no benefit for Topotecan; however most patients in their study had it third/fourth line and only 36% had an oesophageal primary. Whereas in our study all patients had Topotecan second line and most had an oesophageal primary. Anatomical location of G3 NEC is known to affect prognosis and response to treatment. We conclude that Topotecan should be explored as a treatment option for patients with advanced gastroesophageal G3 NEC	✓	✓	✓	✓	

Provided Assurance & Improved Knowledge	Assurance & Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
7. Audit of Non-Medical Prescriber (NMP) pharmacist activity The interventions made by pharmacist prescribers impacted patients by improving continuity of care and patient counselling, whilst reducing patient waiting times. Pharmacist prescribers provided a different perspective of care compared to nurses and consultants. They helped educate multidisciplinary team members and reduced consultant's workloads.			✓	✓	✓
8. Frailty in Myeloma Performance Status (PS) 0-1 and PS 3-4 correlate well to frailty assessment i.e. they appear to pick out the extremes, however PS 2 is a mixture with some frail and some less frail patients within this group.			✓		
9. Ovarian Survival Analysis patients diagnosed between Sept 16 & Aug 17 Sustained significant improvement in overall survival was demonstrated for advanced ovarian cancer for this cohort compared to our baseline audit looking at 2006-2009 data.	✓		✓		

Knowledge Improvement Projects

Improved Knowledge	Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
1. Outcomes for Patients with Cancer of Unknown Primary (CUP) Patients Since 2014 CUP patients in the Mersey and Cheshire region have been discussed at a regional Multi-Disciplinary Team (MDT) meeting with recommendations for investigations and management made for these patients. This was one of the first examples of this model in the country A large number of patients are referred into the CUP MDT service. Many referrals have a non-malignant diagnosis, particularly amongst those who present with bone only disease. A minority of patients do go on to have a tumour directed diagnosis. A minority of patients receiving cytotoxic therapy. Survival for this group remains very poor.	✓	✓	✓	✓	
2. Management of Agitation in the Last Days and Hours of Life This audit revealed the challenges and wide variation in practice with regards to management of terminal agitation. These findings have informed an update of the regional palliative care guidelines.		✓		✓	

Improved Knowledge	Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
3. Re-Audit of palliative radiotherapy in Head and Neck (H&N) patients at CCC Previous audit in 2011 demonstrated 66% of patients had a complete or partial response following radiotherapy. This audit demonstrated that 71% of patients achieved a complete or partial response, which is an 8% increase from the previous audit.	✓				
4. The use of compassionate leadership to support the Advanced Nursing Workforce The main audit recommendation was for the audit lead to utilise compassionate leadership within all of their practice and encourage its use by others to support the implementation of compassionate care. The implementation and modification of the study design and utilising a wider cohort of staff would not change the results already achieved, but would allow for possible differences or issues to be noted, if the study was to be repeated.					✓

Improved Knowledge	Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
5. An audit to determine significance of using a compression belt for Gynaecological Pelvic MRI The aim of the project was to prove or disprove the idea that the use of a compression belt would improve image quality. The study concluded that there would need to be a repeat of the project with a considerably larger sample size and with the SFOV Sagittal sequence being repeated straight after the original sequence.	✓				
6. Barriers to DNACPR decisions, the impact on oncology ward nurses From conducting this study and a systematic review of the literature carried out it was established that there is an unease amongst medical professionals about the uncertainty as to the right time at which the judgement should be made regarding Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and reactions from patients and families to the idea. The difficulty is exacerbated by the lack of understanding amongst the general public of what CPR actually involves, and the fear that a DNAPCR actually goes beyond simple resuscitation and may lead to a reduction in overall level of care, this was part of the downfall of the Liverpool Care Pathway, now abandoned as its implementation was unsatisfactory to address end-of-life care, contrary to its original intention behind it. A richer understanding of patient and family experiences of DNACPR discussions will enhance our evidence base regarding CPR decision making and communication and inform education processes and policy to guide medical practitioners on how to approach these conversations.				✓	✓

Improved Knowledge	Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
7. Assessing weight change and BMI in patients receiving LHRH injections for prostate cancer at the Clatterbridge Cancer Centre There is evidence that Androgen deprivation therapy (ADT) is linked to weight gain and it is noted from this study and the available evidence base that this also carries an increased risk of developing metastasis, diabetes and Cardio Vascular Disease (CVD). As health professionals we are therefore required to ensure the education of our patients and staff when prescribing and administering ADT. There is also a responsibility for adequate information provision to the primary health care team to ensure appropriate monitoring and risk assessment.	✓	✓	✓	✓	✓

Improved Knowledge	Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
8. Review of Single nurse checking of controlled drugs Although there are very obvious benefits from single nurse checking of controlled drugs in areas where nurses are familiar with the drugs utilised in their specialist area, as with any high risk drug appropriate caution must be taken when considering such a change in practice. The development of robust procedures, protocols and training should play a key part in ensuring the safe implementation of this change in practice followed up by regular audit and monitoring to ensure the change remains of greater benefit than risk to the very group we seek to serve ‘our patients’.			✓		✓

Improved Knowledge	Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
9. Re-audit assessing the standards of radiographer led on-treatment review (OTR): A questionnaire based service evaluation Competencies of the On Treatment Review Radiographers (OTRRs) allowed for effective clinical management of treatment side effects. Both the literature and results from this audit indicate the importance of adequate training in clinical examination and diagnostics, enabling the appropriate investigation, treatment and referral to other health care professionals where required. Some staff groups tended to view the efficiency of the service more positively regarding the benefits this had on their own services. This allocation of time not only implies that the OTRR is a valuable resource to the NHS, but also the savings of the OTRR clinic compared to that of the consultant are clear. It is important that staff members have a common understanding of the OTR role to ensure that they utilise the service appropriately and to its full potential.		✓	✓	✓	✓

Improved Knowledge	Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
10. How do we manage the acute care needs of an acutely unwell patient along the radiotherapy pathway? A vast range of complications were referred into the Clinical Decision Unit (CDU). The majority of treatment complications can be managed within the radiotherapy department depending on grade and severity of the complication. It is this grade of severity which can lead to the requirement of further medical support and management, potentially leading to hospital admission. Once open, centre A will treat the majority of patients from all SRG's. Consideration regarding the possible treatment complications per SRG is required when agreeing on the treatment of patients from each SRG at both centres B and C. The level of medical support required at each centre should be shaped by this information and reviewed if patient group(s) treated at each centre changes. Once Centre A opens there should be a period of review to ensure that any measures put in place are safe, adequate and effective.			✓	✓	✓

Improved Knowledge	Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
11. Out of hours Medical Review of Haemato-oncology (HO) patients The scope of the project was to map out the requirement for HO patients to have out of hour medical reviews and reviews from medical specialities. The resulting report contained mapping exercises undertaken by the team indicating the percentage of patients requiring each review.			✓	✓	✓

Improved Knowledge	Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
12. Contour from home pilot for Clinical Oncologists There was strong interest and support amongst the clinical oncology consultant to adopt contouring from home. There was good support from the management team to incorporate this into routine work where feasible in individual job plans as well. Due to the COVID pandemic and the resulting change in work patterns, this was in essence enforced on most if not all consultants, who were advised to isolate due to the pandemic at one time or the other and at present a significant proportion potentially up to 50% of contouring work is being done remotely, making this a new way or working for several consultants already and rendering the proposed pilot project a moot point. It may require formal integration of periods of remote working in to consultant job plans in the future when the return from COVID related patterns to a more normal pattern of work is contemplated. Further work about measurement of productivity etc during this work would be interesting to undertake across a broader group.					✓

Improved Knowledge	Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
13. The impact of Capecitabine versus 5FU in the treatment of CRC. Analysing different practices and potential patient differences which may influence future practice. The project looked at the impact of Capecitabine versus 5FU in the treatment of Colorectal Cancer (CRC). The project found that overall there are pros and cons to each regimen for adjuvant patients and no definite winner. Clinical preference for adjuvant patients may depend on staging. For palliative patients clinician preference is to use a 5FU based regime i.e. 64% 5FU v 36% Cape. There is a 6% higher drop in performance status (PS) for the 5FU palliative cohort. There is also less grade 3-4 toxicities with 5FU i.e. 26% v 11% and less mortality with 5FU.		✓	✓	✓	

Improved Knowledge	Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
14. Waiting Time Audit The aim of the project was to ascertain whether the waiting time for a patient to be seen by a doctor is higher for the morning clinics for Haemato-oncology (HO) patients based at the Royal Liverpool University Hospital (RLUH). The conclusion drew a number of factors indicating that there was an increased wait in the morning, due to reasons such as doctors trying to locate paper documentation. The HO team have since moved to the CCC Liverpool site and documentation is now electronic.				✓	✓

Improved Knowledge	Knowledge gained (Theme):				
	Patient Outcomes	Quality of Life	Patient Safety	Patient Experience	Staff Experience
15. The Upper GI Enteral Feeding Audit The Project investigated the possibility of adopting an early (pre-treatment) individualised dietetic assessment and interventions to minimise total weight loss in Upper GI patients due to many patients at first consultation already having lost significant weight and experiencing varying degrees of dysphagia, hence often starting treatment at a disadvantage. The CCC team liaised with a peer oncology Trust where a discussion was had with UGI Dietitian regarding practice. The Trust do not routinely place prophylactic gastrostomy tubes / NGT's in upper GI cancer patients. They tend to adopt reactive approach with NGT's or gastrostomy tubes as that Trust have facilities to place these. Due to the lack of clear patterns identified in the cohort it was not possible to develop a local protocol and it was instead deemed that CCC should continue with the reactive NG tube placement/ feeding.				✓	

Appendix 4:
Learning from Deaths Supplementary Information

Learning from Deaths

In-patient Deaths

During 2020/21 102 patients died as an inpatient at The Clatterbridge Cancer Centre NHSFT. This comprised the following number of deaths which occurred in each quarter of that reporting period: 12 in the first quarter; 24 in the second quarter; 35 in the third quarter; 31 in the fourth quarter.

Table 1 – Deaths by quarter 2020/2021

2020-2021	No. of Inpatient Deaths
Q1	12
Q2	24
Q3	35
Q4	31
Total	102

As of 9th June 2021, 64 (63%) case reviews have completed phase I*, out of which 56 (88%) were further investigated at phase II** and 14 were further selected for discussion at phase III*** the Trusts formal Mortality Review Meeting.

38 cases require phase I review and will be completed during 2021-22.
46 cases require phase II review and will be completed during 2021-22.
2 cases require phase III review and will be completed during 2021-22.

Out of the 12 cases discussed at the formal phase III mortality review meeting, the number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 1 in the first quarter 2020-2021;
- 3 in the second quarter 2020-2021;
- 0 in the third quarter 2020-2021;
- 7 in the fourth quarter 2020-2021;
- 1 in the first quarter 2021-2022

Out of the 56 Structured Judgement Review (SJR) completed, 42 were scored 6 (definitely not avoidable) and were not selected for discussion. Of the remaining 14, 12 have been discussed at phase III and final avoidability scores were agreed as follows:

- 0 were score 1: Definitely avoidable
- 0 were score 2: Strong evidence of avoidability
- 0 were score 3: Probably avoidable
- 0 were score 4 - Deemed to have had a possibly avoidable but not very likely
- 1 was scored 5 - Deemed to have had a slight evidence of avoidability
- 11 were scored 6 - Definitely not avoidable.

2 require a phase III discussion for a final avoidability score to be agreed, the meeting will held Q2 2021-22.

** Consultant case record review of own case, ** Multi-disciplinary case selection panel, *** Trust – wide formal multi-disciplinary mortality & learning from deaths review meetings)*

Table 2 - Estimated Death more likely than not to have been due to problems in care provided

	QTR 1	QTR 2	QTR 3	QTR 4	Total
Definitely avoidable (1)	0	0	0	0	0
Strong evidence of avoidability (2)	0	0	0	0	0
Probably avoidable (more than 30:30) (3)	0	0	0	0	0
Possibly avoidable but not very likely (less than 50:50) (4)	0	0	0	1*	1
Slight evidence of avoidability (5)	0	0	1	0	0
Definitely not avoidable (6)	11	11	20	12**	55
Total No. of SJR	11	11	21	13	56
% patient deaths are judged more likely to have been due to problem in care provided	0%	0%	0%	0%	-

*x1 score 4 provisional score not yet agreed at phase III meeting
**x1 score 6 provisional score not yet agreed at phase III meeting

Outpatient Deaths

In addition to reviewing all inpatient deaths, The Clatterbridge Cancer Centre NHSFT is also committed to reviewing outpatient deaths for patients within our care who meet the mortality review criteria; deaths within 30 days of chemotherapy or radiotherapy treatment, and within 90 days of radical radiotherapy treatment. Radiotherapy for spinal cord compression and bone metastases cases do not require review, on the condition that the dose and fractionation given was as per Trust protocol, in addition patients receiving one fraction of eight gray. Therefore the corresponding figures for the outpatient deaths during the period are as follows;

During April 2020–March 2021, 536 of The Clatterbridge Cancer Centre NHSFT out patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period: 123 in the first quarter; 121 in the second quarter; 161 in the third quarter; 131 in the fourth quarter*.

Table 3 – Outpatient deaths by quarter 2020/2021

2020-2021	No. of Outpatient Deaths
Q1	123
Q2	121
Q3	161

Q4	131
Total	536

Of the 536 deaths, 446 cases required a review following the above aforementioned criteria. By 9th June 2021 331 case reviews have completed phase I, out of which 255 were further investigated at phase II and 45 were further selected for discussion at phase III the Trusts formal Mortality Review Meeting out of which 36* were discussed during the period.

Table 4 – Outpatients reviewed 2020/2021

2020-2021	No. of Outpatient Deaths Reviewed
Phase I	331*
Phase II	255**
Phase II	36***

**115 cases require phase I review and will be completed during 2021-22;*
***76 cases require phase II review and will be completed during 2021-22;*
****9 cases waiting for phase III review will be discussed during 2021-22.*

Out of the 36 cases discussed at the formal mortality review meeting, the number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 0 in the first quarter;
- 12 in the second quarter;
- 5 in the third quarter;
- 10 in the fourth quarter;
- 9 in the first quarter 2021-2022.

Appendix 5:
Trust IPR

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	A M J J A S O N D J F M
C/S	Serious Untoward Incidents: % submitted within 60 working days / agreed timescales	⇔	100%	100.0%	100%	A M J J A S O N D J F M
S	RIDDOR - number of reportable incidents	⇔	0	0	2	A M J J A S O N D J F M
S	IRMER - number of reportable incidents	⇔	0	1	11	A M J J A S O N D J F M
S	Incidents /1,000 Bed Days	↑	No target	197.3	210.96	A M J J A S O N D J F M
L	All incidents resulting in harm /1,000 bed days	↓	No target	17	18	A M J J A S O N D J F M
C/S	Inpatient Falls resulting in harm due to lapse in care	⇔	0	0	1	A M J J A S O N D J F M
S	Inpatient falls resulting in harm due to lapse in care /1,000 bed days	⇔	0	0	0.05	A M J J A S O N D J F M
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%	A M J J A S O N D J F M
C/S	% of Sepsis patients being given IV antibiotics within an hour*	↓	90%	87.0%	94.0%	A M J J A S O N D J F M
C/S	VTE Risk Assessment	⇔	95%	95.0%	96.0%	A M J J A S O N D J F M
S	Dementia: Percentage to whom case finding is applied	⇔	90%	100.0%	99.0%	A M J J A S O N D J F M
S	Dementia: Percentage with a diagnostic assessment	-	90%	No patients	100%	A M J J A S O N D J F M
S	Dementia: Percentage of cases referred	-	90%	No patients	N/A	
C/S	Clostridiodes difficile infections (attributable)	⇔	<=4 per yr	1	5	A M J J A S O N D J F M
C/S	E Coli (attributable)	↓	<=10 per yr	0	6	A M J J A S O N D J F M
C/S	MRSA infections (attributable)	⇔	0	0	0	
C/S	MSSA bacteraemia (attributable)	⇔	<=5 per yr	0	4	A M J J A S O N D J F M
C	Klebsiella (attributable)	⇔	<=10 per yr	0	2	A M J J A S O N D J F M
C	Pseudomonas (attributable)	⇔	<=5 per yr	0	1	A M J J A S O N D J F M
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%	

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	

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.

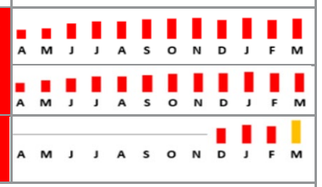
No DTOC (delayed transfers of care) were recorded on HO wards, indicating appropriate bed utilisation.

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%** Midnight **82.5%**	**71.5%** **72.6%**	
	Ward 5	G: =>80% A: 76%-79.9% R: <76%	78.5%	**69.1%**	

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%	

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	Target	Mar 21	YTD	Last 12 Months

(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

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%	

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).

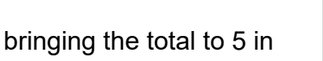
Full reviews of all 7 target breaches are underway to identify any trends, lessons learned and any education requirements. No harm has been identified for the patients who did not receive their antibiotics in the prescribed time.

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	

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

Studies opening to recruitment	Target	Mar 21	YTD	Last 12 Months
	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%	

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

	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.

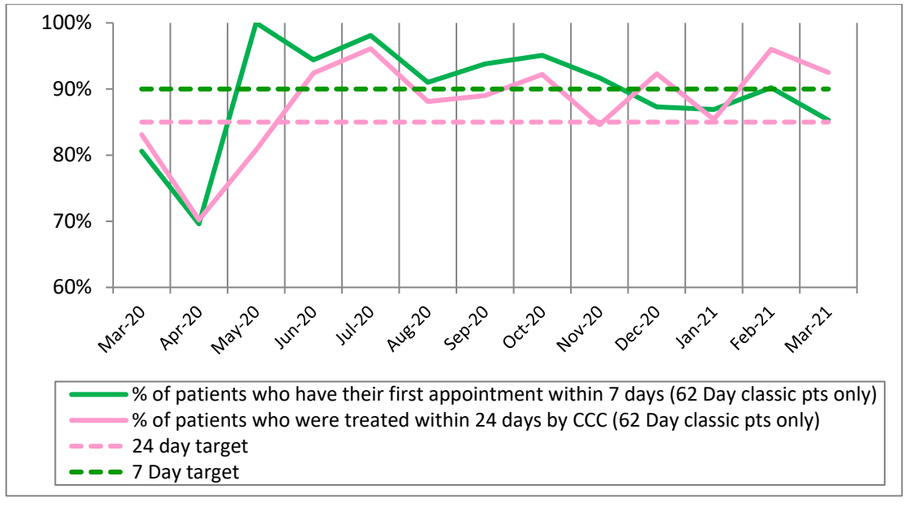
7 Day Performance (Internal Target)
Performance for March 2021 is 85.3% against a stretch target of 90%.

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

Patient	Day into CCC	Days at CCC / to Diagnosis (28DFDS)	Treated on Day	Tumour	Referring Trust	Treatment	Reason	Avoidable Breach	Internal Targets		National Standards					Long Waiters	
									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			

Patient	Day into CCC	Days at CCC / to Diagnosis (28DFDS)	Treated on Day	Tumour	Referring Trust	Treatment	Reason	Avoidable Breach	Internal Targets		National Standards					Long Waiters	
									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

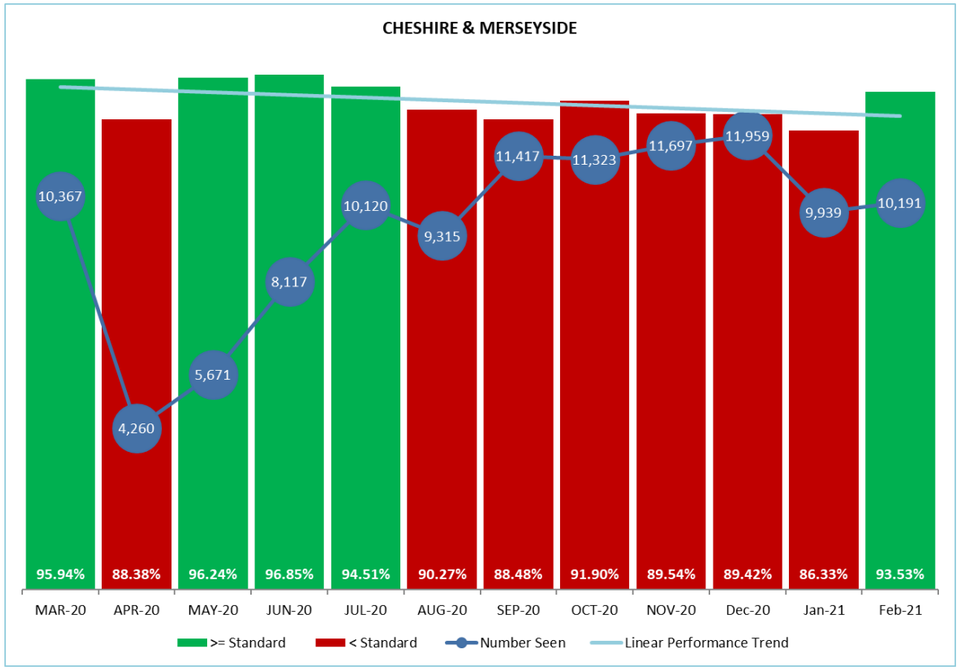
Notes:
Blue arrows are included for KPIs with no formal target and show the movement from last month's figure.

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.

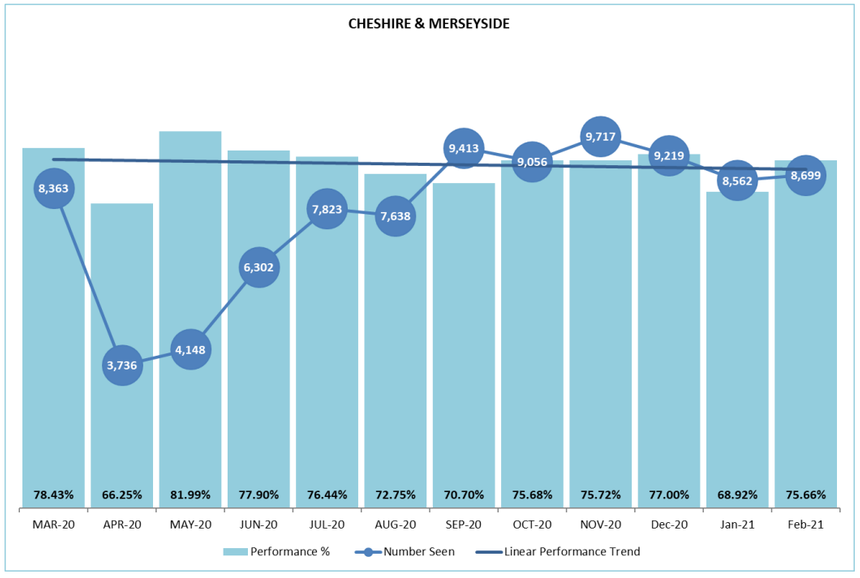
2 Week Wait

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%.



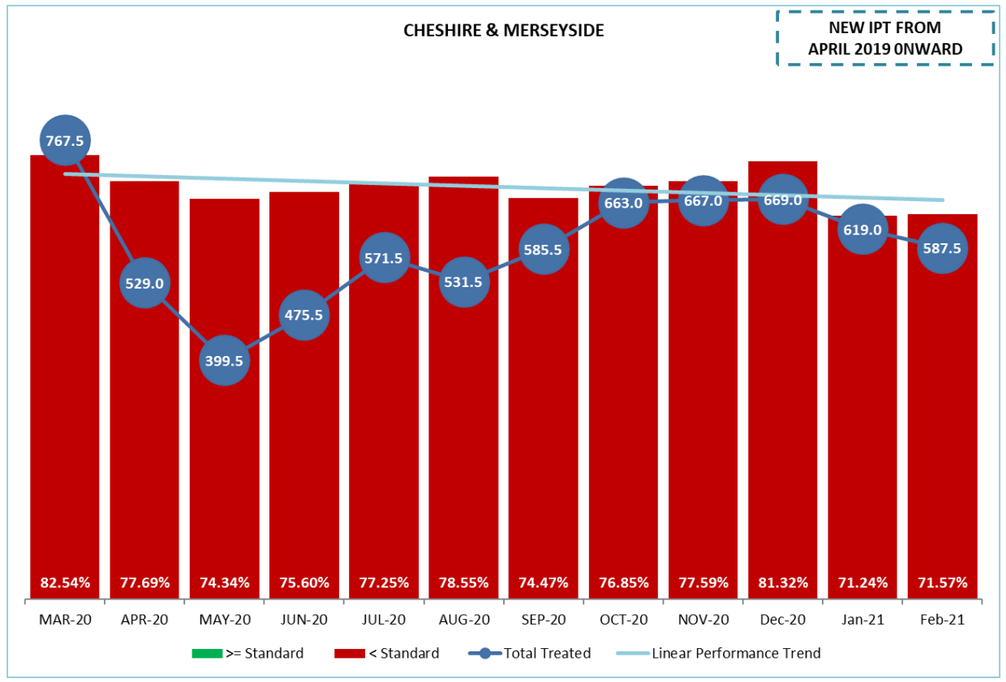
28 day Faster Diagnosis Standard (FDS)

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%.

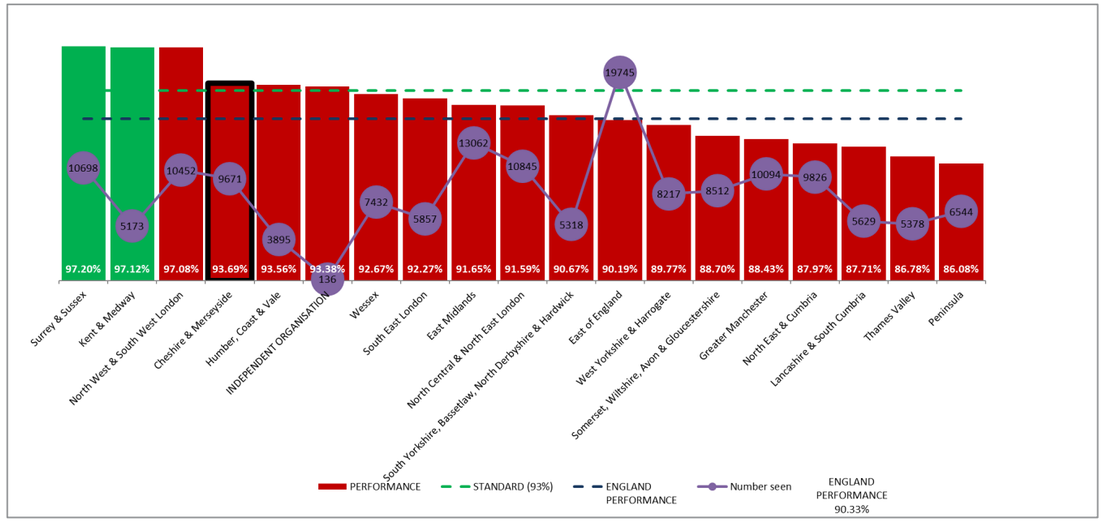


3.1.3 Cancer Waiting Times Standards: National Performance

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

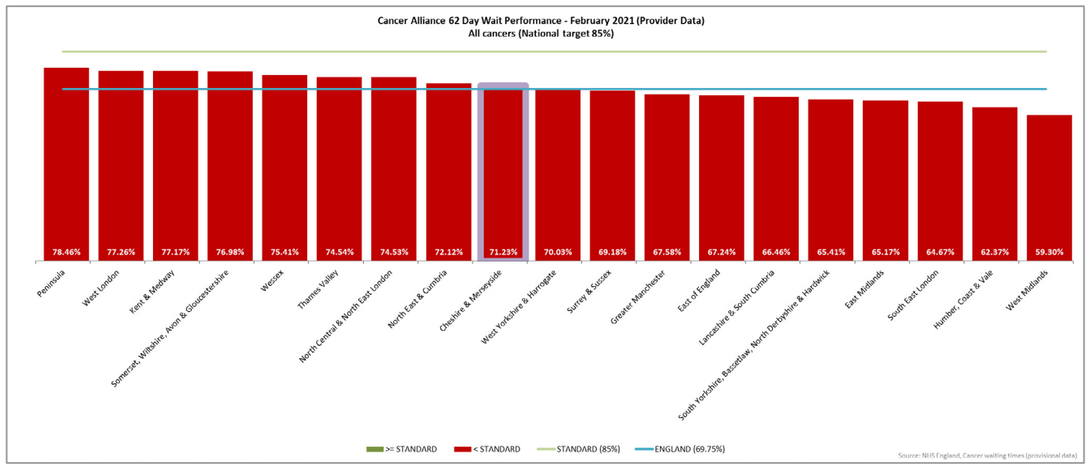
This chart shows the performance by Cancer Alliance for February 2021. Cheshire and Merseyside were the 4th best performing Alliance in February 2021 with 93.7% (up from 86.9%, and with an improved position, from 7th in January). The figure for England for February 2021, of 90.33%, is shown by the dashed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

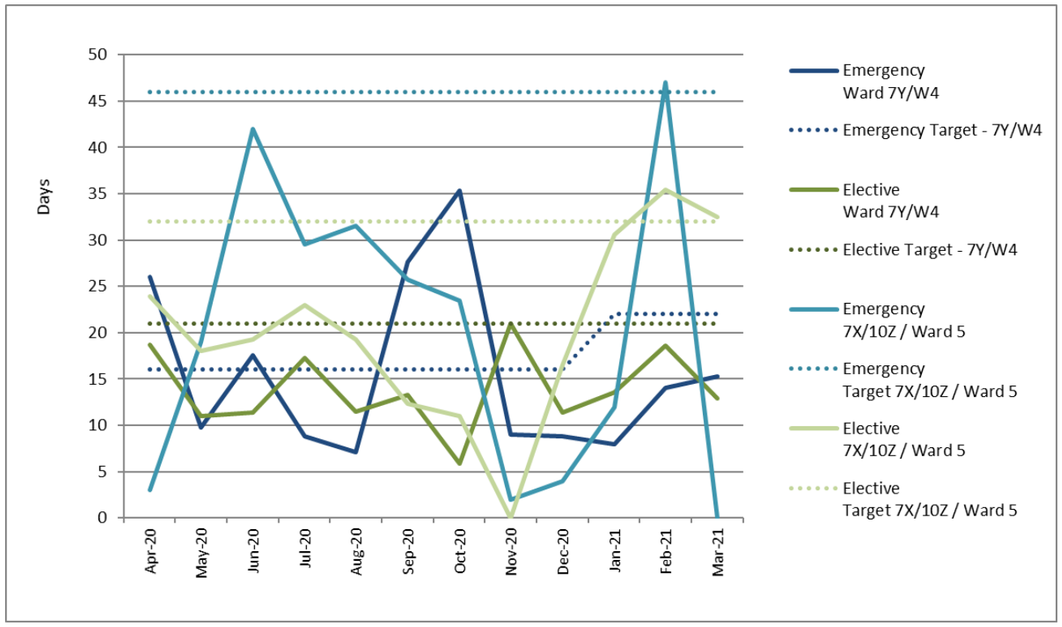
There were 7 DTOC (delayed transfers of care) this month, a reduction on last month. All delays involved Solid Tumour patients. The number of DTOC days is also fewer at 18 days in March compared with 38 days in February. The average length of DTOC for solid tumour patients was 3 days, with one patient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

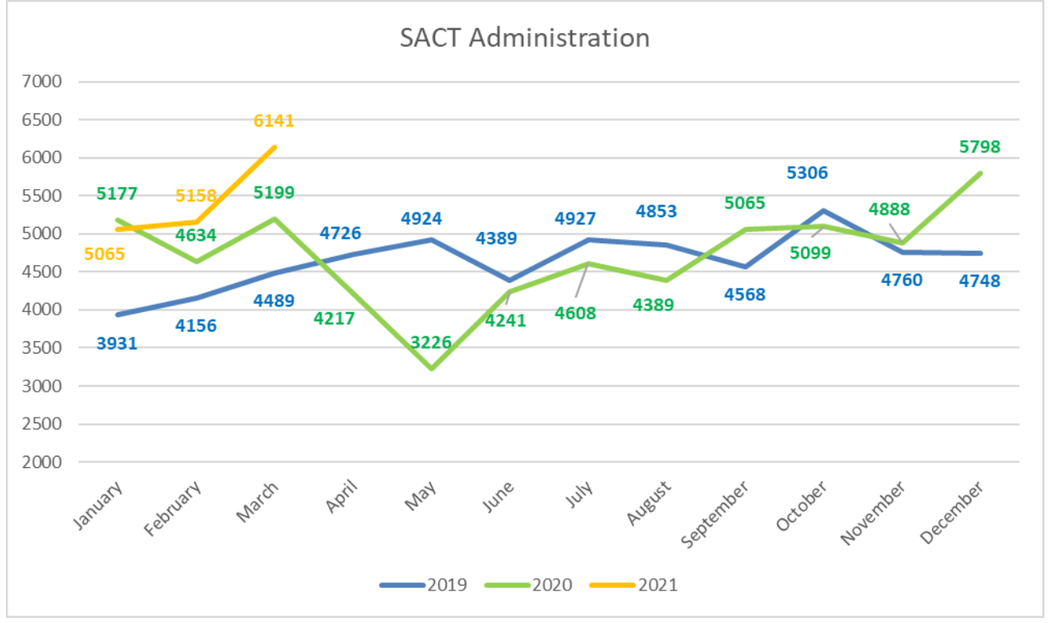
Referrals for March 2021 are at 94% (1029 referrals) of the March 2020 total (1092 referrals).

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

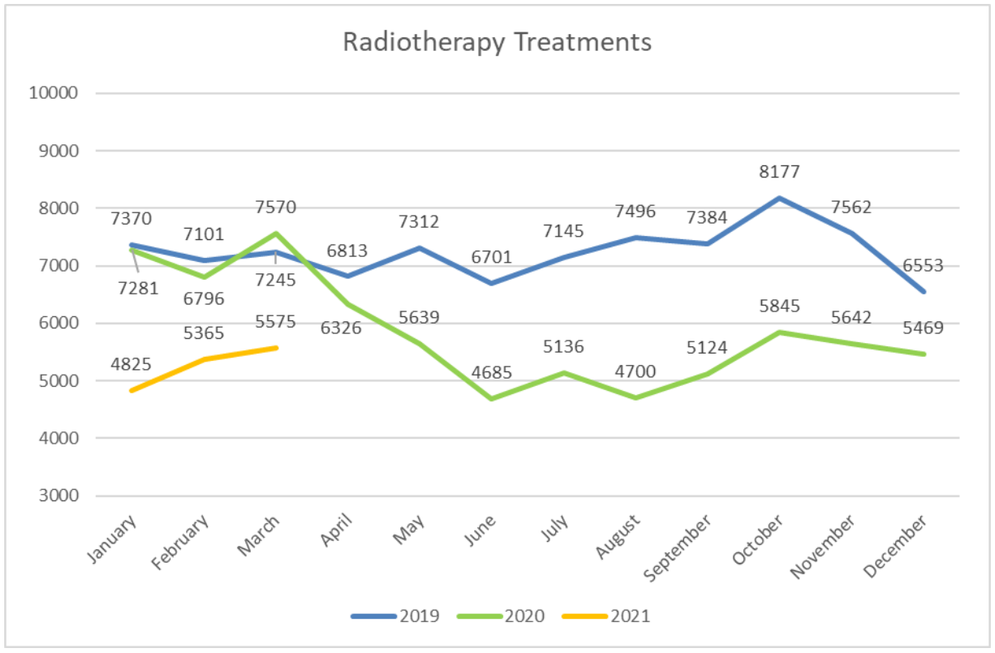
multiple cycles of treatments being dispensed within a month, with fewer attendances but the same number of patients in these treatment groups.

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

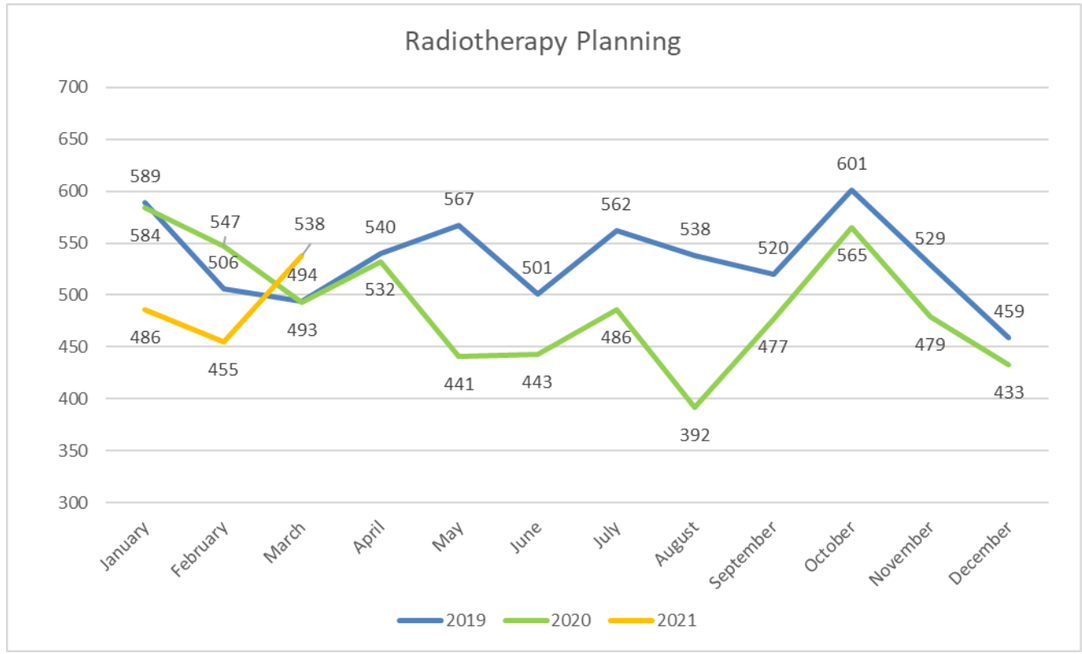
This chart compares the number of patients receiving radiotherapy treatment in 2019, 2020 and 2021.



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.

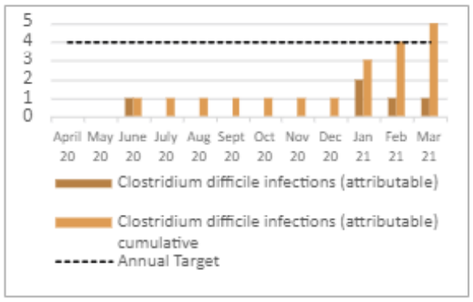
Patients are continually reviewed at weekly transplant MDT meetings, patients who have deferred through choice have been counselled regarding the risks and benefits and the team have risk assessed them as having disease stable enough to allow this, or the availability of an alternative treatment path.

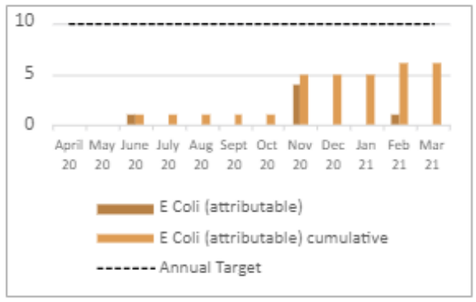
3.3 Quality

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

Health Care Acquired Infections





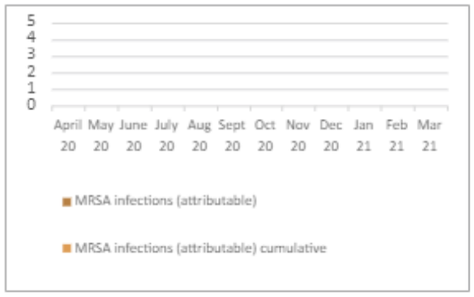
Q4 2020/21:

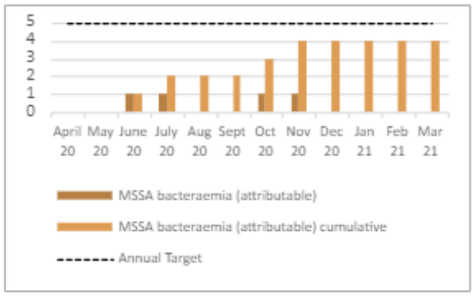
MRSA and Covid 19 targets are 0.

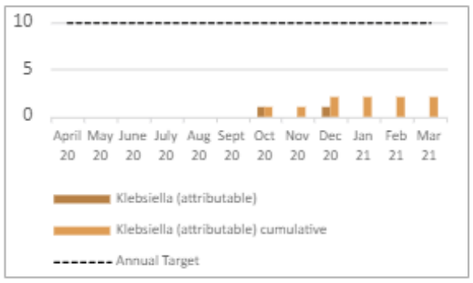
The annual targets have been met for E-coli, MRSA, Klebsiella, Pseudomonas. There were no MRSA, Klebsiella or Pseudomonas infections in Q4.

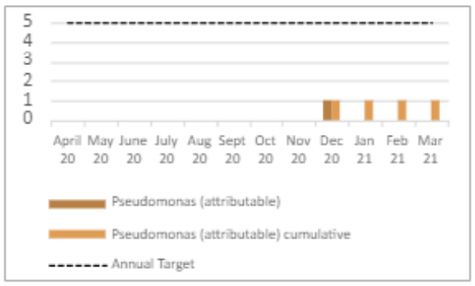
There were 2 healthcare associated Covid-19 infections in 2020/21. One patient was known to leave the ward to see family members, the other was a likely acquisition from an appointment at LUHFT.

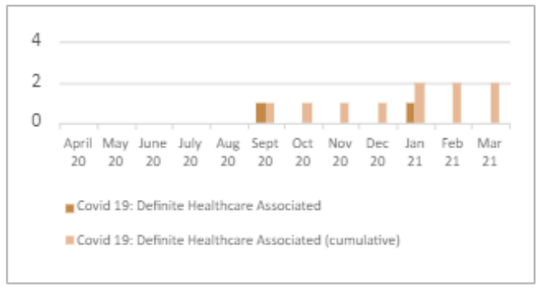
There were 5 C diff infections in 2020/21, 1 more than the annual target of 4. 4 of the 5 were in Q4.
Post infection reviews (PIR) identified 2 key themes:
• Lack of documentation detailing patients' baseline bowel patterns.
• Prescribing of anti-microbial therapy outside of Trust formulary.
The IPC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



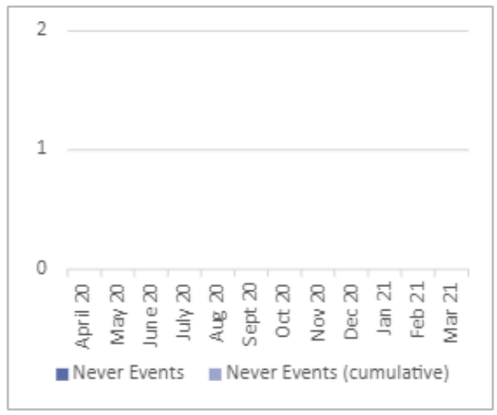


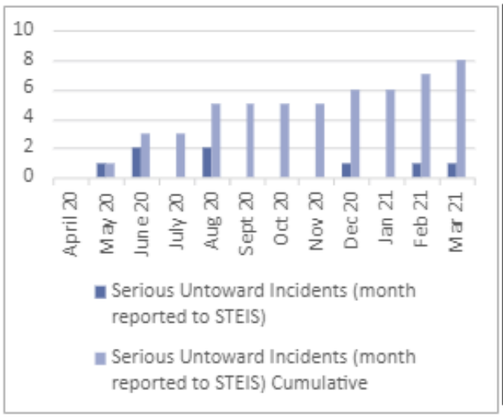






Incidents





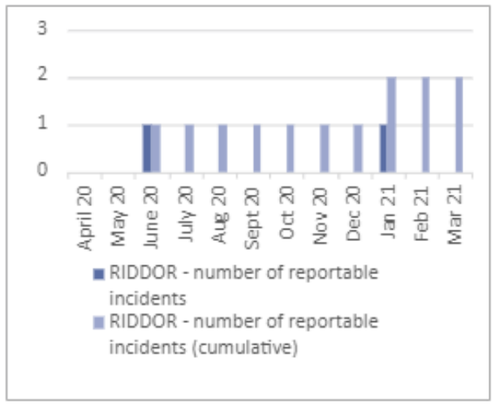
Q4 2020/21:

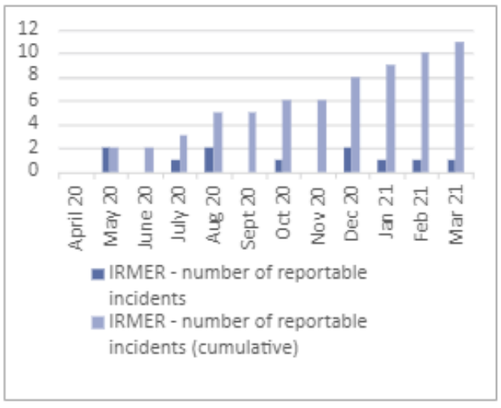
Never Events, SUI, RIDDOR and IRMER targets are 0.

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

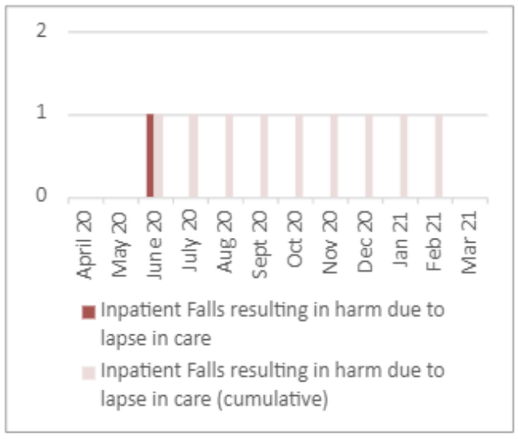
There was 1 RIDDOR reportable incident in Q4

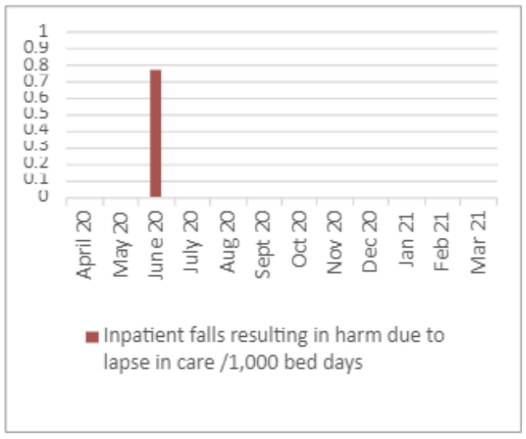
There were 2 SUIs in Q4. These are under review.





Harm Free Care





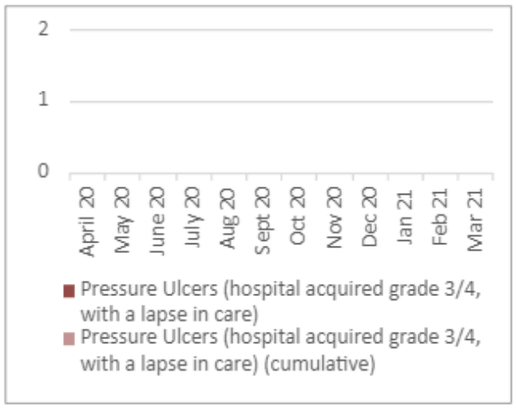
Q4 2020/21:

All Targets are 0

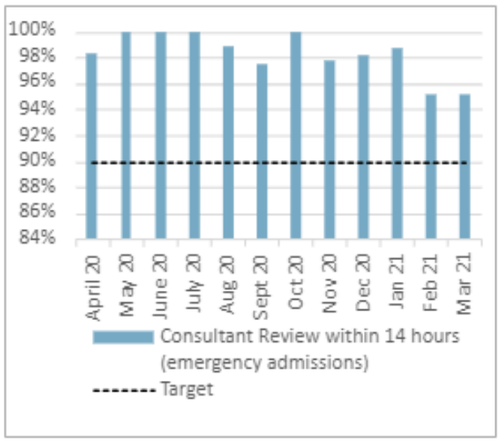
Pressure Ulcers: There have been no hospital aquired category 3 or 4 pressure ulcers with a lapse in care reported in 2020/21.

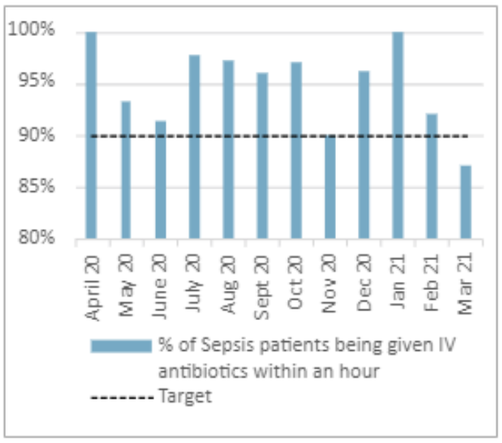
Falls: There have been no in patient falls that have resulted in harm due to a laspe in care reported for Q4. Ongoing programme of quality improvement and support for falls and pressure ulcers across all in patient services

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.



Inpatient Assessments



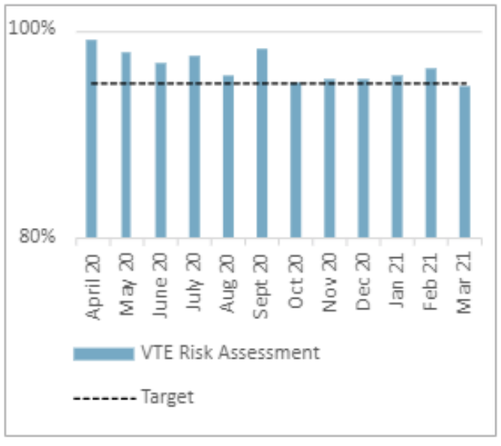


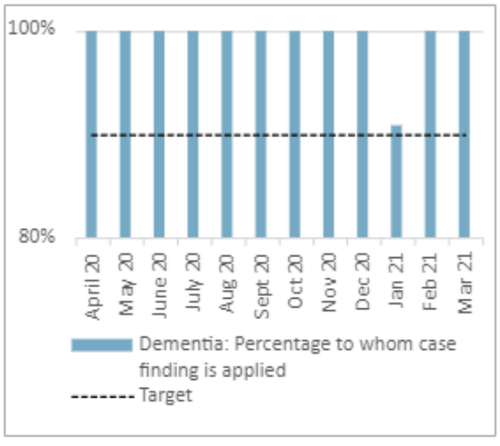
Q4 2020/21:

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%.

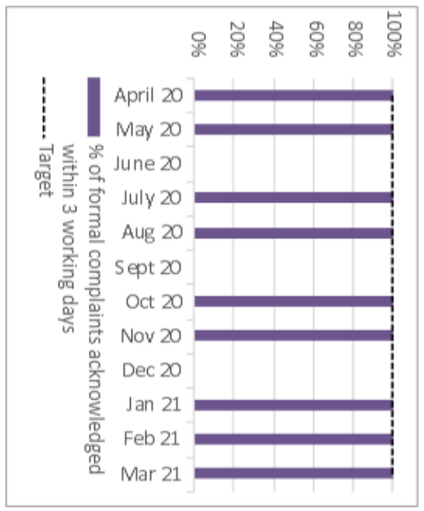
Regarding sepsis, the following actions are in place to maintain and further improve compliance:

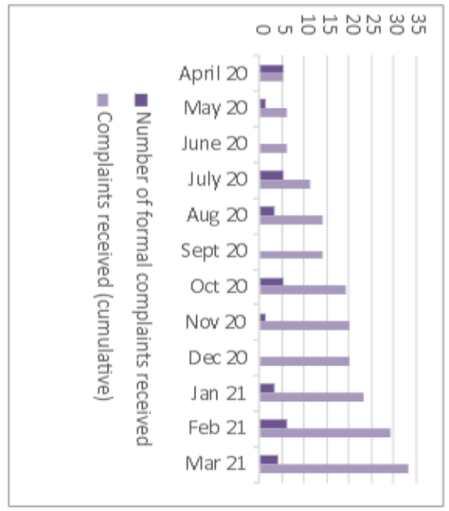
- Education and awareness training for all new started and new doctors
- CDU antibiotic doses to all be on meditech rather than paper script
- MIAA audit of the sepsis audit process Jan 2021
- Process of reviewing incidents via DPSG introduced, discussing lessons learned, 72 hour reviews and LIRG if 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.

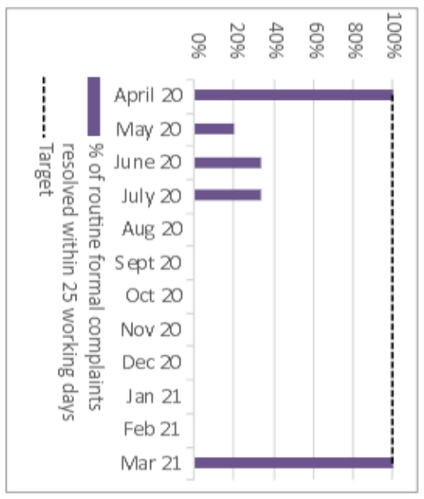


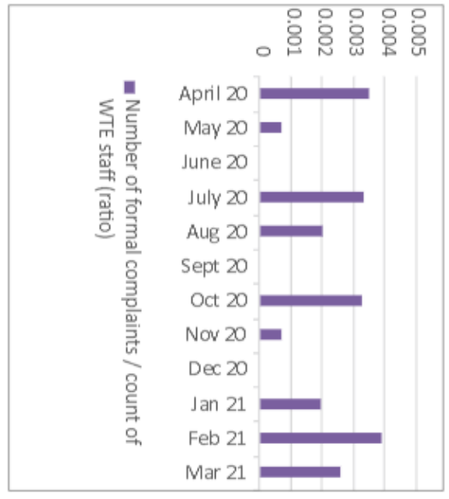


Complaints







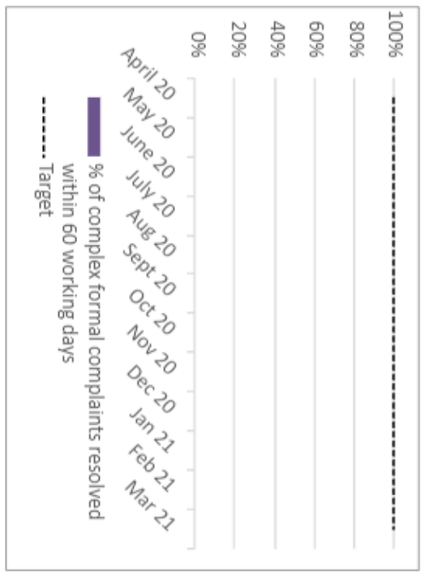


Q4 2020/21:

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.



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)

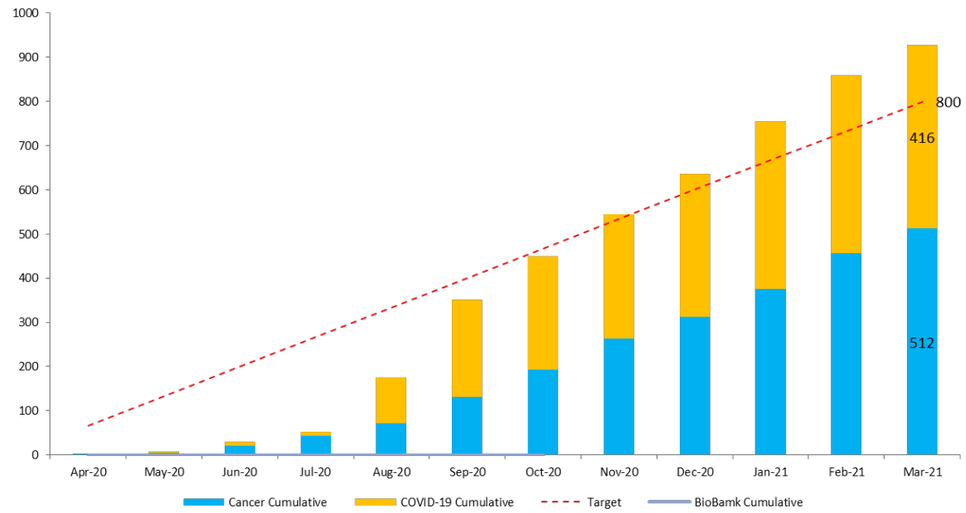
3.4.2 Monthly Recruitment

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.

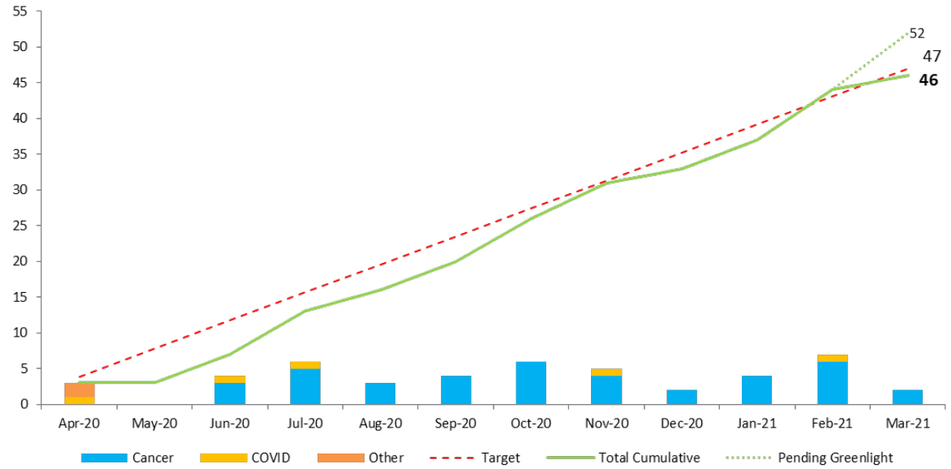
Of the 928 patients recruited onto Cancer and COVID studies, 796 relate to recruitment to portfolio studies and 696 relate to non-commercial portfolio recruitment. This means we will

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).

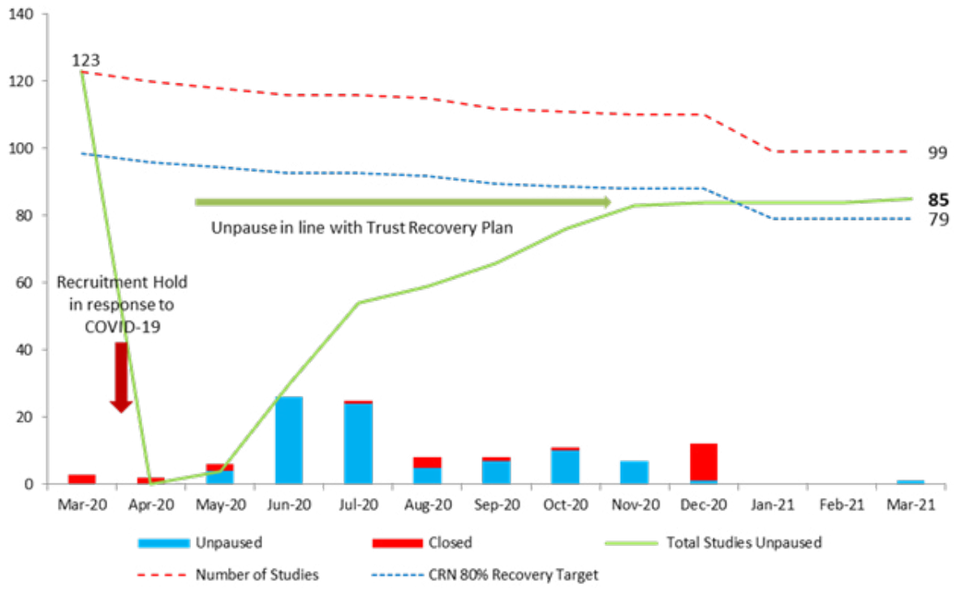
The new studies opened are split as follows:

	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:

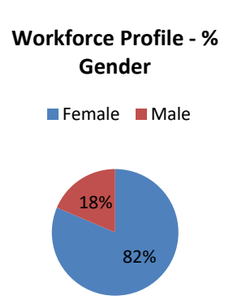
Directorate	FTE
158 Chemotherapy Services Directorate	251.52
158 Corporate Directorate	363.66
158 Haemato-oncology Directorate	131.25
158 Hosted Service Directorate	39.27
158 Integrated Care Directorate	245.71
158 Quality Directorate	16.20
158 Radiation Services Directorate	311.22
158 Research Directorate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

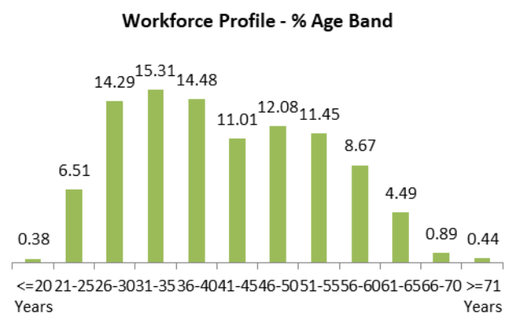
Assignment Category	FTE
Fixed Term Temp	70.17
Non-Exec Director/Chair	7.00
Permanent	1342.35
Total	**1419.52**

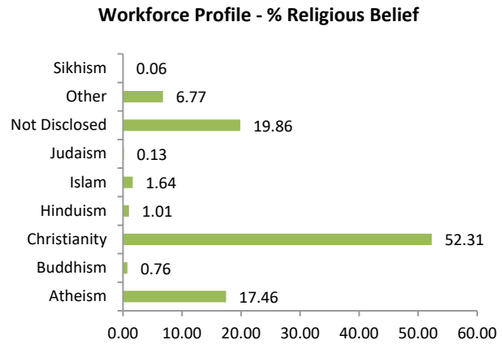
Staff Group	FTE
Add Prof Scientific and Technic	85.49
Additional Clinical Services	182.57
Administrative and Clerical	472.90
Allied Health Professionals	206.63
Healthcare Scientists	37.75
Medical and Dental	75.93
Nursing and Midwifery Registered	353.45
Students	4.80
Total	**1419.52**

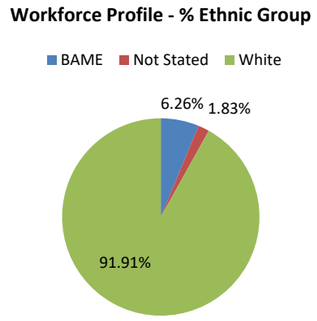
Assignment Status	FTE
Acting Up	9.45
Active Assignment	1330.66
Career Break	4.68
Internal Secondment	22.80
Maternity & Adoption	45.93
Out on External Secondment - Paid	3.00
Out on External Secondment - Unpaid	1.00
Suspend No Pay	2.00
Total	**1419.52**

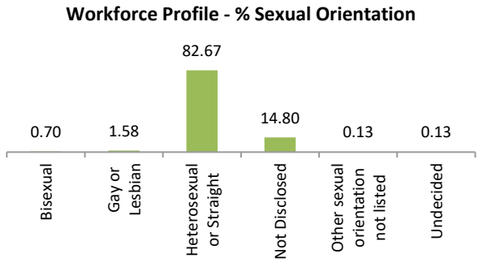
3.5.2 Workforce EDI Profile

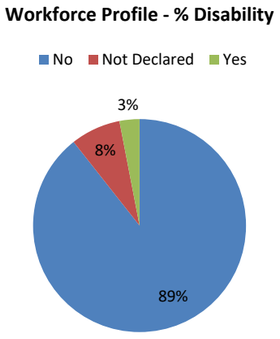








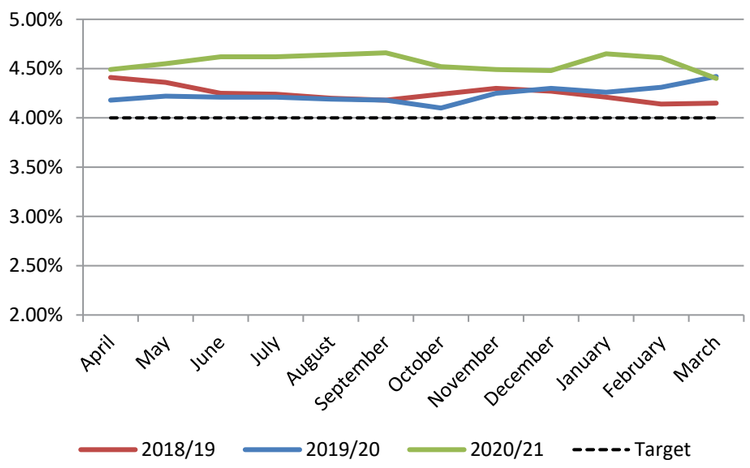




3.5.3 Sickness Absence

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%	

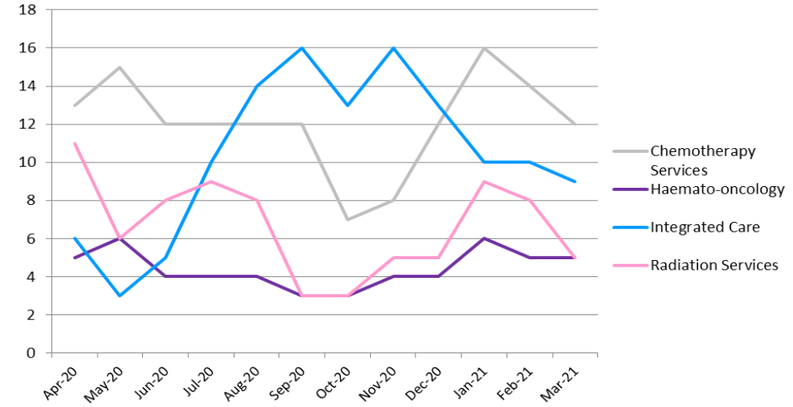
Long / short term sickness absence:

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:



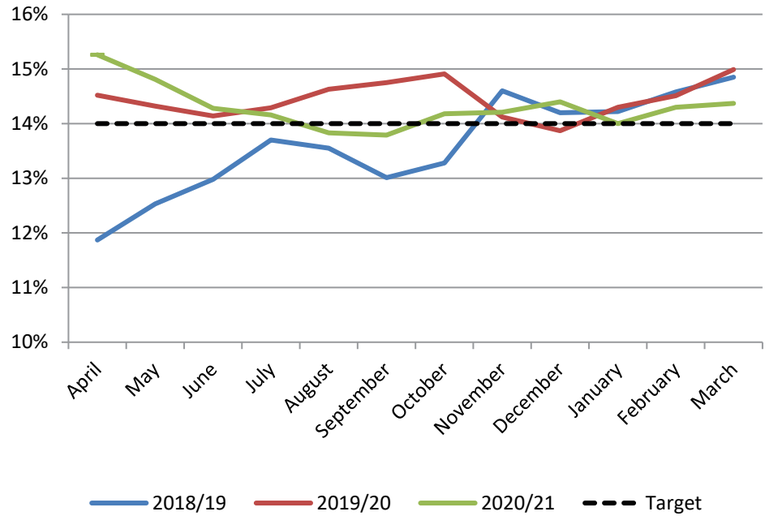
The top three reasons for sickness absence, with the number of episodes for each are shown below:

	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.

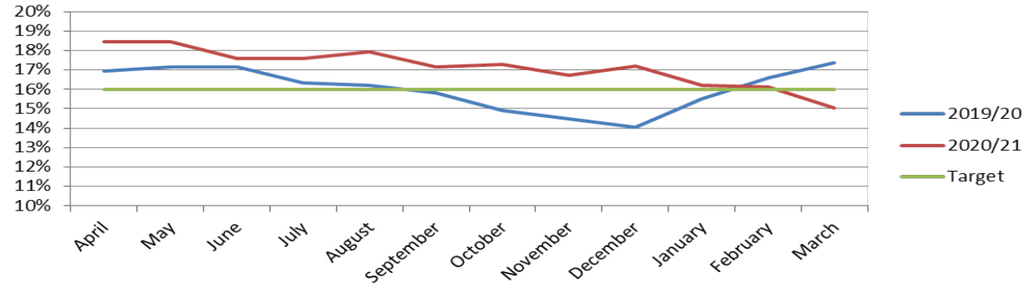


Turnover by Staff Group

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

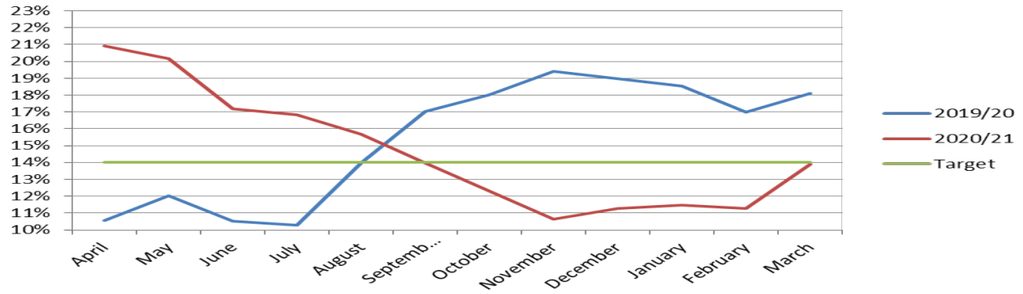
Administrative and Clerical Turnover – Annual Target 16%

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



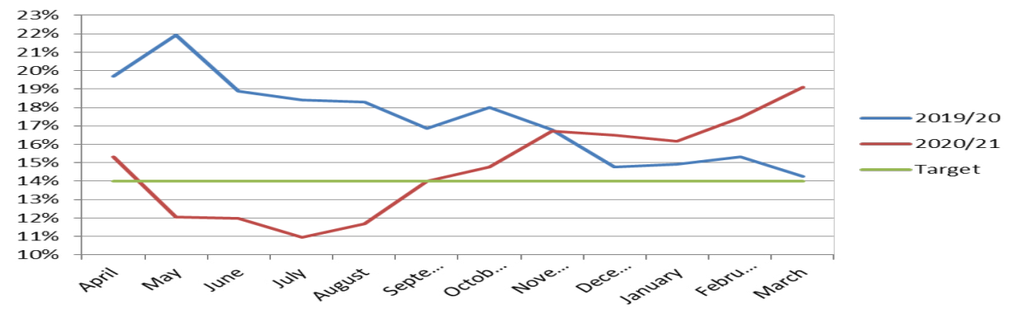
Additional Professional Scientific & Technical Turnover – Annual Target 14%

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.



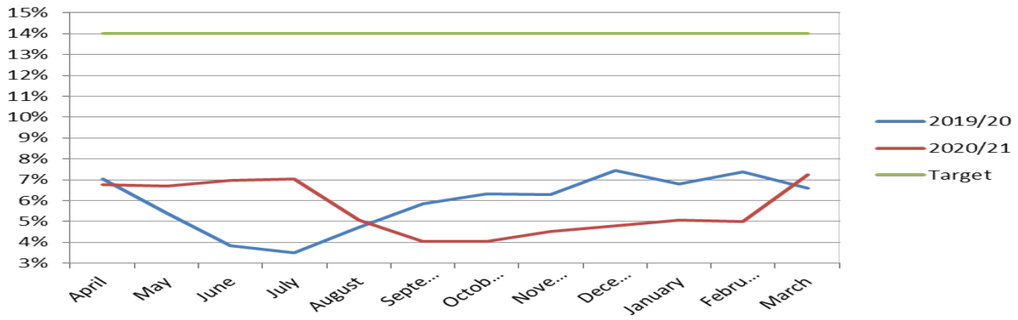
Additional Clinical Services' Turnover – Annual Target 14%

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



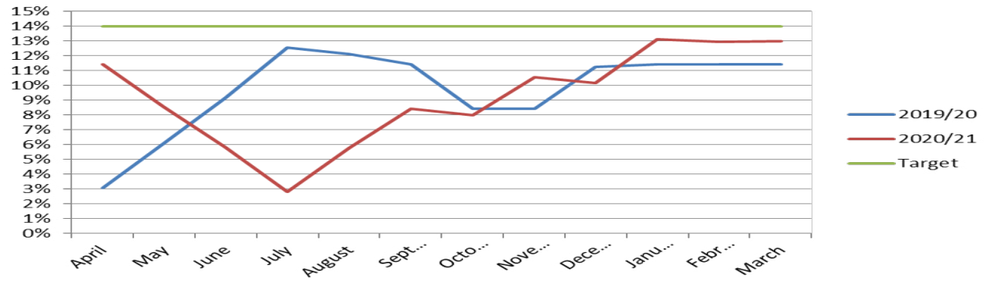
Allied Health Professionals' Turnover – Annual Target 14%

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.



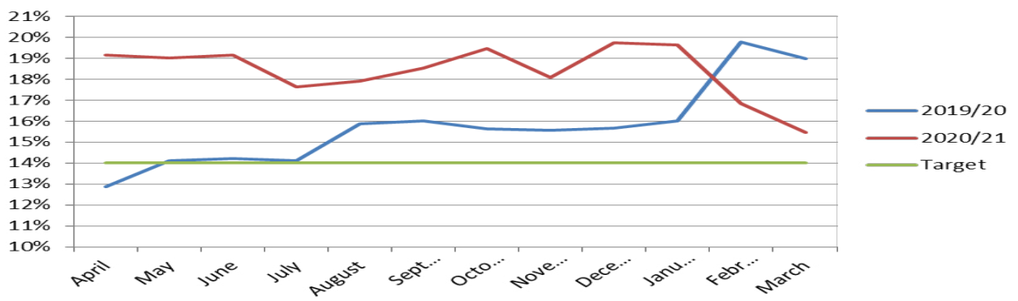
Healthcare Scientists' Turnover – Annual Target 14%

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.



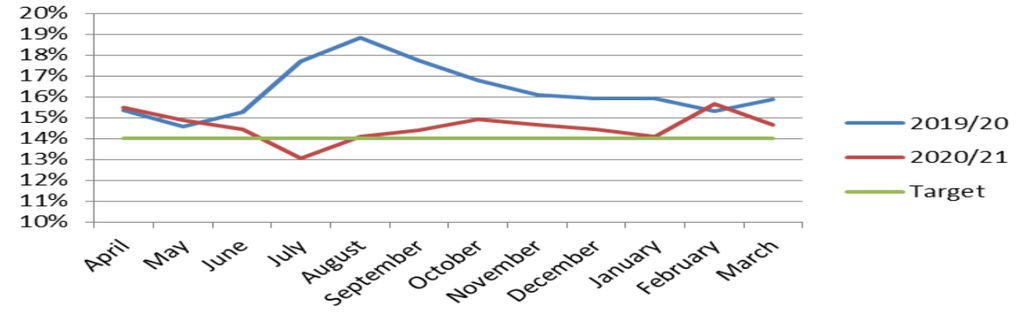
Medical Turnover – Annual Target 14%

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.



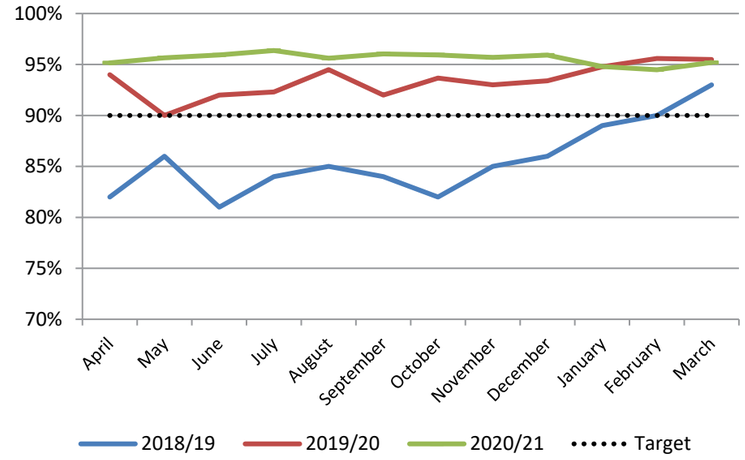
Registered Nursing Turnover – Annual Target 14%

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.

Compliance by Directorate

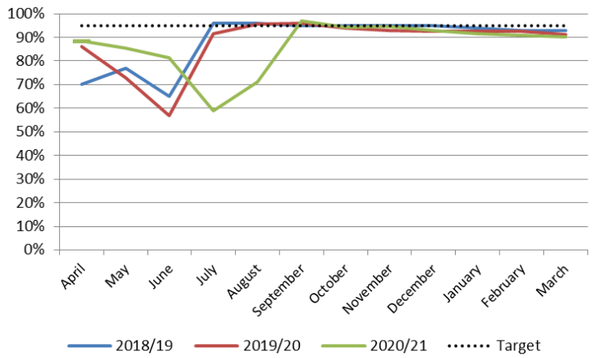
A breakdown of Directorate compliance, as at 31st March 2021 is detailed below.

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.

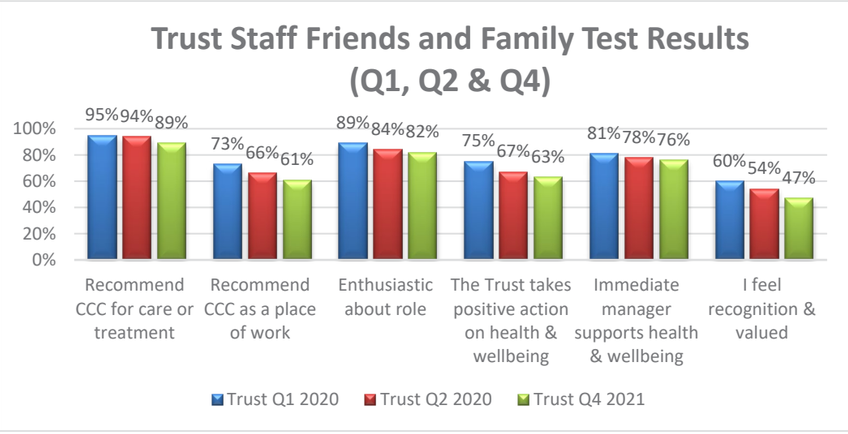
3.5.7 Staff Experience

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.

Appendix 6:

CCC Research Strategic Business Plan 2021-26

Research Strategic Business Plan 2021-2026
Outline of implementation plan

Objective	Impact and Value	Outputs
1. Support the establishment and implementation of The Liverpool Cancer Research Institute (LCRI) in collaboration with the UoL by End 2021.	• Will enhance engagement of CCC staff (clinical and non-clinical) in academic research activities and foster wider collaborations within the region. • Active participation of CCC in formulation and implementation of cancer allied biomedical research within the region • Greater collaboration and interactions of CCC and UoL to improve and enhance research outputs and external grant income for basic and correlative science. • Active planning and participation of CCC to prepare and submit applications to (re-)secure LECMC, CRUK centre and LCTU status • Identification and promotion of key and unique research strengths within CCC and Liverpool	• LCRI implemented • LCRI governance arrangements being formalised • Formal LCRI launch event • Support LCRI activities • CCC participation in submitted EoI from UoL for CR-UK centre status
2. Contribute to the delivery of the LHP Cancer programme	• LHP-SPARK Leadership • Early diagnosis, Streamlining regional patient pathways, Survivorship, and End of Life care work streams • Cross-working with other Trusts for Cancer-related service and research themes	• CCC Link to LHP Cancer Programme Activities and Outputs
3. Increase patient recruitment to Clinical Trials by 10% per year to (target of 1750 – 2000 by 2026).	• Increased patient participation, choice and improved outcomes • Reputational impact to ensure that CCC activity is in line with national targets and comparable to clinical trial activities of other Cancer-specific trusts • To ensure that CCC fulfils the objectives and obligations outlined in the NHS Long Term Plan	Recruitment targets: • By 04/2022 = 1300 • By 04/2023 = 1430 • By 04/2024 = 1573 • By 04/2025 = 1730 • By 04/2026 = 1903
4. Double the number of research-active NHS consultants in CCC over the next 5 years.	• Enhancing and promoting engagement of NHS clinicians in research activities from current levels (<10% of staff currently involved) is essential to address objectives 1 and 3. • Will help enhance external research income to the Trust • Will facilitate research performance and outputs of the Trust • Improved patient participation in clinical trials and access to novel and emerging therapies • Supports Objectives 1 and 3	• Protected research time in job plans (with linked PAs if needed) • Increase NHS Consultant Trial income by 10% (by 2026)
5. Strengthen key and essential aspects of the research and innovation staffing infrastructure	• Continue to make progress on reducing Trial set-up times • Improve Clinical Trial Oversight, Quality, Performance, and Governance • Facilitate pump priming of projects that benefit allied healthcare professionals and research nurse involvement.	• Meeting national trial set-up targets • Successful MHRA/HTA inspections • Increased research grants from CCC staff – links into objective 10

	• Ensuring capacity, support, and management of Real World data studies (especially NIHR portfolio adopted) • Development of a workplan to facilitate and support 'innovation' within the Trust • Support for medical writing/grantsmanship/statistics/peer review • Supports objectives 3 and 4.	
6. Continue to improve trial set-up times and time to first patient targets so that they are in-line with national averages and edicts	• Streamlined, responsive, and enhanced Research governance • Increased CCC sponsorship of trials to increase research income and outputs • National and International reputation • Supports Objectives 3, 4 and 5.	• See objective 10 for Grant income increase
7. Seek and appoint 5 new clinical academic posts over the next 5 years.	• Increased academic activities and Research (especially Trials) outputs • National and Global Reputation • Attractive to Industry (Pharmaceutical and Biomedical) and CROs • Increased number of research applications for external grants • Embedding and fostering research activities and collaborations within and across SRGs • Addresses and supports Objectives 1, 2, 3, 4, 8 and 10.	• 5 additional clinical academic positions by 2026 (requires collaboration and discussions with UoL). • Increase academic research income by 25% by 2026, with the aim for the Academic appointments to be self-funding by year 5 after commencement in post.
8. Recruit 5 additional clinical research fellows over the next 5 years.	• Train and retain promising local junior doctor/specialist trainee talent and provide them with the academic and clinical research environment to flourish • Attract excellent external national and international talent • Succession planning within SRGs • Supports Objectives 1, 3, 4, 7, 10, 12, 13, 14, 15 and 16.	• 5 additional clinical research fellows to be recruited to CCC by 2026
9. Offer support to allied healthcare staff for 2 higher education/postgraduate studentships per year.	• Improving research awareness and participation of nursing and allied healthcare staff (pharmacy, radiation etc.) • Will likely impact objectives 1, 3, 4, and 10.	• Support 10 staff by 2026 and monitor outputs
10. Facilitate and promote applications for external project and programmatic grant funding especially from CR-UK and NIHR funding streams.	• Increase Research activities • Increase in Research Income to Trust • Supports Objectives 1, 2, 12, 14, 15, and 16	Projected growth: • Year 1 = £50k • Year 2 = £150k • Year 3 = £250k • Year 4 = £350k • Year 5 = £450k
11. Increase investment in the Clatterbridge Research Funding Scheme to £250k per year over the next 5 years.	• Pump priming projects that hold promise for seeking external grant funding in due course • Research outputs – publications, presentations, collaborations • Increased collaboration of academic /non-academic staff • Enhanced Research culture and ethos within the Trust • Supports Objectives 1, 3, 4, 7, 8, 9, 10, 12, 13, 14, and 15	

12. Secure renewal of the CR-UK/NIHR ECMC in 2021	• Important for Objectives 1, 3, 10, 12, 13, 15 and 15.	
13. Help to secure Liverpool CR-UK Centre status.	• External and Infrastructure grant funding • Reputational and supports Objective 1, 14 and 15.	• Research income • Reputational
14. Help secure CR-UK CTU programme funding	• Support and Increase Cancer Trials activities • Support leadership for locally led regional and multisite studies • Helps Objectives 1 and 13	• Research income • Reputational
15. Contribute to cancer aligned workstreams in the Liverpool BRC centre bid.	• Supports Objectives 1 and 2	• Reputational for Liverpool and CCC • Research income
16. Increase publications originating from CCC over the next 5 years.	• Research outputs • Facilitates grant applications and income • Reputational impact	• Increase from a baseline of 100 to 150 per year by 2026
17. Establish and sustain a bi-monthly research seminar series	• Awareness of regional, national and international research trends • Stimulate interactions (local and external) • Showcase achievements and talent • Cross-cutting impact on all objectives	• Bi-monthly rolling seminar programme initiated. • Increased awareness and collaborations
18. Hold an annual 'Research@Clatterbridge Day'	• Research awareness – Patients and Healthcare staff • PPI • Trial participation • Bioresources	• Research@Clatterbridge Day established as an annual event with wide participation. • Impact on income to Clatterbridge Cancer Charity

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