



Report Cover Sheet

Report to:	Board of Directors' Meeting	
Date of the Meeting:	25 th March 2020	
Agenda Item:	Integrated Performance Exception Report - Month 11	
Title:	IPR Exception Report M11 2019/2020	
Report prepared by:	Hannah Gray, Head of Performance and Planning	
Executive Lead:	Joan Spencer, Interim Director of Operations	
Status of the Report:	Public	Private
	X	

Paper previously considered by:	Quality Committee and Performance Committee (full version of the IPR)
Date & Decision:	19 th March 2020

Purpose of the Paper/Key Points for Discussion:	<p>This report provides the Trust Board with an update on performance for month eleven (February 2020). The operational, quality, research and innovation, workforce and finance performance scorecards are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant. Further detail, including full actions in place, has been reported to the Quality Committee and Performance Committee.</p> <p>Points for discussion include under performance, developments and key actions for improvement.</p>
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Action Required:	Discuss	X
	Approve	
	For Information/Noting	

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

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

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

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

Equality & Diversity Impact Assessment

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

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

Integrated Performance Report (Month 11 2019/20)

Introduction

This report provides the Trust Board with an update on performance for month eleven (February 2020). The operational, quality, research and innovation, workforce and finance performance scorecards are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant. Further detail, including full actions in place, has been reported to the Quality Committee and Performance Committee.

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

Please note that the Trust has instigated operational planning and emergency preparedness activity to monitor and manage the impact of COVID-19 on operational planning and performance.

1. Performance Scorecards

Operational

Key Performance Indicator	Change in RAG rating from previous month	Target	Feb-20	YTD	12 Month Trend
62 Day Cancer Waiting Times Standard	↑	85%	88.4%	88.0%	
2 Week Cancer Waiting Times Standard	↑	93%	100%	96.3%	
Referral to Treatment: 18 weeks (Incompletes)	↔	92%	99.0%	98.3%	
Diagnostics: 6 Week Wait	↔	99%	100%	100.0%	
Clinic Waits: Outpatients Wirral (<30 mins)	↔	80%	83.5%	83.3%	
Clinic Waits: Delamere (<30 mins)	↔	80%	82.4%	82.2%	
Clinic Waits: Outpatients Peripheral (<30 mins)	↔	80%	89.6%	87.9%	
Length of Stay: Elective (days) CCCW	↔	2	6.28	6.18	
Length of Stay: Emergency (days) CCCW	↔	8	7.2	7.9	
Length of Stay: Elective (days) CCCHO 7Y	↔	21	2.38	14.64	
Length of Stay: Emergency (days) CCCHO 7Y	↔	16	24.60	24.27	
Bed Occupancy: Conway Ward 12 noon CCCW	↔	G: 80-85%	72.0%	73.9%	
Bed Occupancy: Mersey Ward 12 noon CCCW	↑	A: 75-79% & 86-90%	79.0%	78.5%	
Bed Occupancy: Conway Ward 12 midnight CCCW	↔	R:<75% & >90%	71.0%	73.8%	
Bed Occupancy: Mersey Ward 12 midnight CCCW	↑		76.0%	76.5%	
Clinical Utilisation Review: patients not meeting criteria CCCW	↔	Feb = 11%	11.0%	N/A	
Radiology Reporting: Inpatients (within 24hrs) CCCW	↑	G: =>90%	84.2%	76.3%	
Radiology Reporting: Outpatients (within 7days) CCCW	↓	A: 80-90% R: <80%	85.8%	75.2%	
Travel time to clinic appointment within 45 minutes CCCW	↔	G: =>90%, R:<90%	97.0%	97.2%	

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

Quality

Key Performance Indicator	Change in RAG rating from previous month	Target	Feb-20	YTD	12 Month Trend
Never Events	↔	0	0	0	
Serious Untoward Incidents	↔	0	0	2	
Safety Thermometer	↑	95%	96.0%	94.4%	
Inpatient Falls resulting in harm (due to lapse in care)	↔	-	0	0	
Pressure Ulcers (hospital acquired cat 3/4 with a lapse in care)	↔	0	0	0	
Consultant Review within 14 hours (emergency admissions)	↔	90%	98.8%	98.3%	
VTE Risk Assessment	↑	95%	98.6%	96.6%	
Sepsis: IV antibiotics within 1 hour	↔	100%	100%	97.4%	
Dementia: Screening, Assessment and Referral	↔	95%	100%	99.2%	
Clostridium Difficile Infections	↑	<=4 per yr	1	10	
E coli	↔	<=10 per yr	1	7	
MRSA	↔	0	0	0	
MSSA	↔	<=5 per yr	0	3	
Klebsiella	↔	<=10 per yr	0	4	
Pseudomonas	↔	<=5 per yr	0	8	
Staffing fill rate: Trust	↔		90.6%	90.7%	
Staffing fill rate: Nurses - days	↓	G: 90 - 100%	79.9%	85.0%	
Staffing fill rate: Nurses - nights	↔	A: 85 - 89% and 101 - 105%	95.5%	96.5%	
Staffing fill rate: Care staff - days	↔	R: <85 & >105%	100.0%	93.0%	
Staffing fill rate: Care staff - nights	↔		95.7%	91.3%	
30 Day Mortality Rate: Radical Chemotherapy	↓	-	0.2%	0.3%	
30 Day Mortality Rate: Palliative Chemotherapy	↓	-	1.0%	1.1%	
30 Day Mortality Rate: Chemotherapy	↓	-	2.5%	2.9%	
30 Day Mortality Rate: Radiotherapy	↓	-	2.2%	2.5%	
Partners in Care Assessments	↔	G: 90%, A: 85% - 89%, R: <85%	96.9%	87.4%	
FFT inpatient score (% positive)	↔	95%	97.2%	99.2%	
FFT outpatient score (% positive)	↔	95%	99.3%	98.1%	
FFT inpatient response rate	↑	G: 30%, A: 25% - 29%, R: <25%	41.6%	23.5%	
FFT outpatient total responses	↑	-	559	6238	
Complaints	↑	-	3	23	

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

To Note:

- A Dec 2019 case of C diff was omitted in error from Month 9 and month 10 reports.
- 30-Day Mortality figures are always for the previous month. There is a single national target of 4.3% for 30-day mortality post chemotherapy. The Trust splits the target to enable greater oversight of the radical chemotherapy data set. Combined, the performance figures fall within the accepted range.
- C diff monthly figures include community acquired infections, from April 2019, as per national guidance (amended and back dated from Month 5 report). Infections other than c diff are CCC attributable only.
- The sepsis YTD figure does not include April and May HO figures, as robust data capture processes were implemented in June 2019

Research & Innovation

Key Performance Indicator	Change in RAG rating from previous month	Target	Feb-20	YTD	12 Month Trend
Study recruitment: Portfolio	↑	-	54	486	
Study recruitment: Non-Portfolio	↓	-	41	674	
Study recruitment: Total	↔	83.3 per month	95	1160	
Studies Opened	↓	5.3 per month	4	47	
Study set up times	N/A	40 days	N/A	Dec = 33 days	

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

Workforce

Key Performance Indicator	Change in RAG rating from previous month	Target	Feb-20	YTD	12 Month Trend
Staff Sickness (monthly)	↔	G: =<3.5%, A: 3.6-3.9%, R: =>4%	4.3%	4.2%	
Staff Turnover (12 month rolling)	↔	12%	14.6%	N/A	
Statutory and Mandatory Training	↔	90%	95.6%	N/A	
PADR rate	↔	G: =<95%, A: 90-94.9%, R: =>93.9%	92.5%	N/A	
FFT staff: Recommend care and treatment	↓	G: =<95%, A: 90-94.9%, R: =>93.9%	N/A	Dec = 87% (Q3 National survey)	
FFT staff: Recommend as a place to work	↔		N/A	Dec = 64% (Q3 National survey)	
FFT staff: Response rate	↑		N/A	Dec = 60% (Q3 National survey)	

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

Finance

For February the key financial headlines are:

Metric (£000)	M11 Actual	M11 Plan	Variance	YTD Actual	YTD Plan	Variance	Risk RAG
NHSI SoF	3	1	2	3	1	2	Orange
NHSI Control Total (£000)	-351	-384	33	3,657	3,114	543	Green
Cost Improvement Programme (£000)	135	153	-18	1,761	1,643	118	Green
Cash holding (£000)	34,195	20,821	13,374	34,195	20,821	13,374	Green
Capital Expenditure (£000)	1,947	4,204	-2,257	44,295	50,125	-5,830	Orange

The key drivers of the positions are:

- **Income has overachieved plan by £14.6m, £2.2m in month.** This is due to clinical income being £9.7m over plan, of which £9.9m relates to drug income.
- **Expenditure is overspent by £14.6m, £2.2m in month.** Consistent with the income position, mostly due to drug expenditure being £9.9m above plan.
- **Cash held is ahead of plan by £13.4m**
- **Capital expenditure is £5.8m behind plan.**

2. Exception Reports

Operational

Length of Stay (LoS): Elective admissions Wirral Wards	Target	Feb 20	YTD	12 month trend
	=<2 days	6.28 days	7.92 days	
Reasons for non-compliance <ul style="list-style-type: none"> Increased number of external delays, e.g. <ul style="list-style-type: none"> Delay in patient repatriation due to lack of bed availability in Whiston Hospital Increased number of complex cases, e.g. <ul style="list-style-type: none"> Patient declared homeless on admission – required housing before discharge Repatriation of patient refused by APH, despite this being planned on acceptance for radiotherapy. Patient lacked capacity, with no identified next of kin. An Independent Mental Capacity Advocate was required to support a best interest meeting before a discharge plan could be finalised. <p>The target has been reviewed and benchmarked nationally against similar trusts. Day case elective admissions are now recorded separately and a new target of 6.5 days will be in place from April 2020.</p>				
Action Taken to improve compliance <ul style="list-style-type: none"> The Patient Flow Team continues to utilise the Clinical Utilisation Review (CQUIN) approach, providing information to actively manage appropriate utilisation of beds. Weekly long length of stay meetings. Daily Consultant board rounds. 				
Expected date of compliance	30/06/20			
Escalation route	Directorate Performance Review and Performance Committee			
Executive Lead	Joan Spencer, Interim Director of Operations			

Length of Stay (LoS): Emergency Admissions Ward 7Y	Target	Feb 20	YTD	12 month trend
	=<16 days	24.6 days	24.7 days	
Reason for non-compliance <p>Of the ten non-elective patients discharged in February, seven had a high LOS. A review of all seven cases revealed that:</p> <ul style="list-style-type: none"> 6 patients were palliative. One patient had had an ITU admission and one patient was transferred to Marie Curie. 1 patient was acutely unwell with multiple medical issues. 				

Action taken to improve compliance

- Continued weekly inpatient review of patients' LOS on ward 7Y by Matron and Deputy GM.
- Similar benchmarking exercise as that in the integrated care directorate is being undertaken with Royal Marsden and The Christie for HO wards and stem cell transplant.
- Introduction of anti-viral medication (letamvir – prophylactic CMV) in stem cell transplant. The effect of this will be audited. Provisional review has indicated that non-elective admissions post stem cell transplant have reduced.
- The new HO CCC palliative care service will commence following the inpatient move in September. The HO Clinical Director has begun discussions with Dr Monnery.

Expected date of compliance	September 2020
Escalation route	Directorate Performance Review and Performance Committee
Executive Lead	Joan Spencer, Interim Director of Operations

Bed Occupancy : Wirral	Wards	Target	Feb -20	YTD	12 month trend
	Conway	80-85%	72%	74%	
Mersey	79%				

Reason for non-compliance

Both Wirral inpatient wards remain below the average bed occupancy target. For February 2020, Conway ward's average bed occupancy at midday is 72% and Mersey's is 79%.

Daily bed status was predominantly 'Green' throughout February. There were 5 occasions when the bed status was 'Red', i.e. no beds available but we have patients to be discharged. There were no days of 'Amber' bed status or 'Black' bed status. Bed status is recorded twice a day.

Action Taken to improve compliance

- The Patient Flow Team Leader is working with the Cancer Nurse Specialists to identify any reasons why bed occupancy may be lower than expected. This includes any changes in treatment plans or new ways of working.
- Matrons and Ward Managers continue to meet daily to review occupancy and deploy staff to areas of higher activity, such as Hotline and CDU services.
- The Patient Flow Team continue to audit appropriate bed utilisation via the Clinical Utilisation Review process and have started to explore changes or projects that may have occurred more recently, which has reduced the need for admission or reduced the length of stay required.
- A vacancy in the Patient Flow Team has been recruited to and a start date has been agreed for 6th April 2020.

Expected date of compliance	30/06/20
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Escalation route	Monthly ICD Meeting, Q & S Group, Integrated Governance Committee
Executive Lead	Joan Spencer, Interim Director of Operations

Clinical Utilisation Review (CUR)	Month Target	Feb 20	YTD	12 month trend
	=<11%	11%	9.4%	

Reason for non-compliance

Although the target was met for February 2020, this is the highest CUR non qualifying (NQ) rate since July 2019.

There have been an increased number of external delays this month, with additional complex cases, for example:

- Patient declared homeless on admission – required housing before discharge.
- Patient refusal to be repatriated, despite this being planned on acceptance for radiotherapy. Patient lacked capacity, with no identified next of kin. An Independent Mental Capacity Advocate was required to support a best interest meeting before a discharge plan could be finalised.
- Lower bed occupancy resulted in delays having a greater impact on the NQ rate.

A vacancy within the Patient Flow Team contributed to reduced capacity to manage effective discharge planning.

Action Taken to improve compliance

- Repatriation SOP has now been finalised and document controlled.
- Increased monitoring of performance throughout March.
- Vacancy in the Patient Flow Team has been recruited to and a start date has been agreed for 6th April 2020.

Expected date of compliance	31/03/20
Escalation route	Monthly ICD meeting, Quality and Safety group, Integrated Governance Committee, CUR steering group
Executive Lead	Joan Spencer, Interim Director of Operations

Radiology Reporting	Target	Feb 20	YTD	12 month trend
Imaging reporting turnaround: Inpatients (% within 24 hours)	G: =>90% A: 80-89% R: <89%	84.2%	76.3%	
Imaging reporting turnaround: Outpatients (% within 7 days)		85.8%	75.2%	

Reason for non-compliance

The inpatient target of 90% within twenty four hours was not achieved (84.2%), however there has been a slight improvement in turnaround times since last month. Work continues to ensure timely reporting of inpatient plain film x-rays.

The outpatient radiology reporting target has shown a slight dip in February (85.8%). This is due to continued reliance on an outsourcing company for outpatient reporting. In addition we have lost some locum radiologist capacity. We continue to monitor it daily and clinically prioritise patients accordingly.

Action taken to improve compliance

- Daily monitoring of activity and accurate recording of imaging codes.
- Additional reporting capacity has been secured via the outsourcing company and an additional radiologist was recruited in December and is likely to start in summer 2020. A review meeting is planned in April, which will include a review of their turnaround times.
- Further interviews will take place in April for another radiologist.

Expected date of compliance	<ul style="list-style-type: none"> • Improved coding compliance with immediate effect. • Radiologist recruited on 23/12/19, start date likely summer 2020. • Interviews for radiologist April 2020, start date likely to be October 2020.
Escalation route	Directorate Performance Review and Performance Committee
Executive Lead	Joan Spencer, Interim Head of Operations

Quality

Infection Control: C – Difficile	Annual Target	Feb 20	YTD	12 month trend
	=<4	1	10	

Reason for non-compliance

There was one reported case in February 2020, however a detailed review found that there was no lapse in care. As previously reported, the new criteria for allocating C. difficile infections to acute Trusts were retrospectively applied to our patients. There have been 13 cases YTD, 10 of these cases are attributable to CCC.

All patients receive an immediate Post Infection Review (PIR) of care at/ or involving CCC and these are discussed with NHS England. Currently we have one reported lapse in care (May 2019).

Table 1 : Current C. difficile reportable cases - cases highlighted in blue are attributed to CCC <i>Clostridioides difficile</i>	February 2020	Total
Actual COHA	0	2
Actual HOHA	1	8
Actual COIA	0	2

Actual COCA	0	1
Annual Total (All sites)		13

Action Taken to improve compliance

All appropriate treatment and processes were followed and will continue to be monitored.

Expected date of compliance	May 2020
Escalation route	IPC committee
Executive Lead	Sheila Lloyd, Director of Nursing and Quality.

Infection Control: E Coli Bacteraemia	Annual Target	Feb 20	YTD	12 month trend
	=<10	1	7	

Reason for non-compliance

There was one E.coli bacteraemia in February 2020. This was at CCCHO. A full review has been completed and no lapse in care identified.

The patient was an elective admission for bone marrow transplant and developed bacteraemia. Prompt and regular microbiology input helped tailor antibiotic needs and appropriate duration of treatment. The source of infection is unclear but likely due to translocation of bowel flora.

Action Taken to improve compliance

Practices improved some time ago and we continue to participate in the E.coli Cancer Collaborative initiatives.

Reminder issued to all clinical staff re: timely collection of microbiology samples.

We will continue to undertake post infection review in an attempt to identify any potential causes as well as any risks, lapses in care and lessons for future patients.

Current projects include: Infection Alert Cards being given out to all patients to improve communication and awareness and a plan to enhance patient hydration which is being clinically led via the Nutritional Steering Group.

Expected date of compliance	May 2020
Escalation route	IPC committee
Executive Lead	Sheila Lloyd, Director of Nursing and Quality.

Staffing Fill Rate	Annual Target	Feb 20	YTD	12 month trend
	90% - 100%	79.9%	85%	

Reason for non-compliance

Following Trust wide recruitment drive our current vacancy position is much improved.

The current fill rate is reflective of the 'Time for hire' process.

Action Taken to improve compliance

Matrons review staffing across all areas in the daily safety huddles and staff are reallocated as necessary to ensure all areas are safe. As recruited staff commence in post, the "fill rate" for registered nurses will increase. NHSP is also being utilised to fill staffing gaps and the resilience that this offers is also expected to improve over the coming months.

Robust continuous recruitment processes are now in place.

Expected date of compliance	May 2020
Escalation route	Integrated Governance Committee/Quality Committee
Executive Lead	Sheila Lloyd, Director of Nursing and Quality.

Research and Innovation

	Target	Feb 20	YTD	12 Month Trend
Studies opening to recruitment	Annual : =>63	4	47	
	Monthly : =>5.3			

Reason for non-compliance

Forty-seven studies have been opened against an internal target of fifty-eight year to date. There are five studies which have been locally approved and can be opened following sponsor approval. Combined this gives a total of fifty-two studies either opened or are ready to open. To bridge the gap the expectation is that the SRG Research Leads will increase the study numbers within their SRG. This will be part of their role.

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. Next meeting scheduled for 24th March 2020.
- Work with the Network to optimise opportunities.

Expected date of compliance	Q4 19/20
Escalation route	SRG Research Leads / Committee for Research Strategy
Executive Lead	Sheena Khanduri, Medical Director

Workforce

	Target	Feb 20	YTD	12 Month Trend
Sickness	=<3.5%	4.31%	4.28%	

Reason for non-compliance

The Trust 12 month rolling sickness absence is 4.28%, with the in-month sickness absence for February

2020 at 4.31%; this is a slight decrease from January's figure of 4.48%. In February 2019, the sickness figure was similar at 4.46% and if the same trends are followed, we may expect to see a steady decrease in sickness absence over the next few months as we move towards the spring and summer, however the COVID 19 outbreak might change this pattern. The below table details the sickness absence percentages for February – May over the last two years.

Year	February	March	April	May
2019	4.46%	4.43%	4.26%	3.72%
2018	5.05%	4.56%	3.99%	3.99%

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

1	Gastrointestinal Problems	35 episodes
2	Anxiety/ Stress/ Depression	30 episodes
3	Cold/ Cough/ Flu	26 episodes

The Administration and Clerical staff group have, for the second month, had the highest number of absence episodes due to gastrointestinal problems with 14, however this is the largest staff group within the Trust, accounting for 35.6% of the overall staffing and therefore this is not considered unusual. There are no other particular trends identified.

Of the absence episodes due to anxiety / stress / depression, the further breakdown is recorded as follows:

Level 2 Reason	Number of Episodes
Stress	15
Anxiety	8
Depression	4
Unknown	3

16 of the stress related absence episodes were long-term and 4 of these returned to work in February 2020, therefore 12 continue into March 2020. The other 14 episodes were short-term and 8 of these have returned to work, whilst 6 continue into March. The average length of absence due to anxiety/ stress/ depression is currently 59 days, which is the highest average over the last 6 months, with the lowest average being 40 days in November 2019.

6 of the absences related to stress were reported as work-related and in all of these cases, the relevant support has been provided by both the managers' and the Workforce and OD Business Partnering Team.

The number of absence episodes due to cold/ cough/ flu has significantly reduced from last month from 44 episodes to 26. This significant decrease was also seen across the same months last year, as in January 2019 there were 65 episodes due to cold/ cough/ flu and in February 2019 there were 23 episodes. The Nursing and Midwifery staff group had the highest number of absence episodes due to cold/ cough/ flu with 8, with the remaining staff groups as follows:

- Administration and Clerical with 5
- Allied Health Professionals with 5
- Additional Clinical Services with 4
- Healthcare Scientists with 3
- Additional, Professional and Technical with 1

Guidance has been circulated to managers in relation to COVID 19 and any cases will be closely managed and monitored.

Action Taken to improve compliance

- The annual stress audit report was taken to SPF on 10th February 2020 and will be presented at WOD committee on 10th March 2020. The Workforce and OD business partnering team will continue to ensure that managers' are completing their departmental action plans.
- Resilience sessions for all staff provided throughout quarter 3
- Health & Wellbeing plan and calendar of events developed

Expected date of compliance	September 2020
Escalation route	Directorates, WOD Committee, Quality Committee
Executive Lead	Jayne Shaw, Director of Workforce and OD

Turnover	Target	February 2020	YTD	12 Month Trend
	=<12%	1.16%	14.51%	

Reason for non-compliance

The rolling 12 month turnover figure has increased from 14.30% in January 2020 to 14.51% in February 2020; however the in-month turnover figure has slightly decreased from 1.63% in January 2020 to 1.16% in February 2020.

The reasons for leaving in February 2020 are as follows:

Reason for Leaving	Number of Leavers
Promotion	6
Better Reward Package	2
Retirement	2
Move to Liverpool	1
Work Life Balance	1
Flexi Retirement	1
Further Education/ Training	1
Child/ Dependants	1
Other/ Not Known	1

The highest reason for leaving overall was due to promotion with 6 leavers; 3 of these went to other NHS Trusts, 2 went to other public sector organisations and 1 left to undertake employment within the armed forces. Of the 6 leavers due to promotion, 3 of these were from the Admin Services department and they all had over 2 years' service with Trust.

Almost half of the leavers in February 2020 were from the Corporate Services Directorate with 9 leavers; 5 of these were from Administration Services, 2 from Workforce and OD, 1 from IM&T and 1 from the Executive Department. The remaining leavers were as follows:

- Chemotherapy Services with 2
- Radiation Services with 2
- Research with 1
- Integrated Care with 1
- Hosted Service with 1

The majority of leavers in February 2020 had over 2 years' service with the Trust; this relates to 11 leavers. 2 leavers had over one years' service and 3 had less than one years' service. One of the leavers with less than one years' service took up employment at one of the Trust's subsidiary companies.

There were 5 further leavers in February 2020 who are not included in the month's figures due to late paperwork from the departments. 2 of these leavers are Medical, 1 is from the Delamere Aintree Hub, 1 from the Haemato-oncology Admin Team and 1 from Clinical Education. The Workforce & OD Business

Partnering Team are working with the departmental managers to ensure future compliance with timescales.

Action Taken to improve compliance

- The Nurse Career Pathway which is due to be launched should raise awareness with nursing staff on options for progression and development within CCC.
- Flexible working toolkit developed for managers
- Agile working workshop planned for March 2020
- Health & Wellbeing plan and calendar of events developed

Expected date of compliance	September 2020
Escalation route	Directorates, WOD Committee, Quality Committee
Executive Lead	Jayne Shaw, Director of Workforce and OD

PADR	Target	February 2020	12 Month Trend
	=>95%	92.52%	

Reason for non-compliance

Overall Trust compliance for PADRs as at January 2020 is 92.52%, which is below the target of 95% and a 0.02% decline from the previous month.

The following directorates are underperforming against the KPI;

- Haemato-oncology Directorate – 90% (in month increase of 1%)
- Chemotherapy Service Directorate – 91% (in month increase of 2%)
- Corporate Directorate – 92% (in-month decline of 1%)
- Radiation Services Directorate – 93%
- Integrated Care Directorate – 94% (in month increase of 2%)

PADR window for 2020/21 opened on 1st March 2020 and will close on 30th September 2020.

Action Taken to improve compliance

- Reminder emails have been sent to managers whose staff are non-compliant
- Revised process for new starters introduced from January 2020
- PADR requirements to be included on Induction to increase awareness to new starters from January 2020
- Increased number of manager and staff PADR training sessions
- Pay Progression policy includes the requirement for compliance with PADR in order to receive their next pay step
- PADR window for 2020/21 opened on 1st March 2020 and will close on 30th September 2020.

Expected date of compliance	September 2020
Escalation route	Directorates, WOD Committee, Quality Committee
Executive Lead	Jayne Shaw, Director of Workforce & OD