



**Report Cover Sheet**

Report to:	Trust Board	
Date of the Meeting:	26 <sup>th</sup> February 2020	
Agenda Item:	P1-029-20	
Title:	IPR Report M10 19/20	
Report prepared by:	Pippa Mullan Interim Head of Performance & Planning	
Executive Lead:	Joan Spencer Interim Director of Operations	
Status of the Report:	Public	Private
	X	

Paper previously considered by:	N/A
Date & Decision:	N/A

Purpose of the Paper/Key Points for Discussion:	Review of the Trust Integrated Performance
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Action Required:	Discuss	X
	Approve	
	For Information/Noting	

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

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

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

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

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

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

# **Integrated Performance Report (Month 10 2019/20)**

## **Introduction**

This report provides the Trust Board with an update on performance for month ten (January 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 then follows in each section, including full actions in place.

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

# 1. Performance Scorecards

## Operational

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Jan-20	YTD	12 Month Trend
<b>Operational</b>						
	62 Day Cancer Waiting Times Standard	↓	85%	76.1%	89.1%	
	2 Week Cancer Waiting Times Standard	↓	93%	87.5%	96.0%	
	Referral to Treatment: 18 weeks (Incompletes)	↔	92%	97.9%	98.2%	
	Diagnostics: 6 Week Wait	↔	99%	100.0%	100.0%	
	Clinic Waits: Outpatients Wirral (<30 mins)	↔	80%	83.1%	83.3%	
	Clinic Waits: Delamere (<30 mins)	↔	80%	85.3%	82.2%	
	Clinic Waits: Outpatients Peripheral (<30 mins)	↔	80%	89.5%	87.7%	
	Length of Stay: Elective (days) CCCW	↔	2	3.7	6.2	
	Length of Stay: Emergency (days) CCCW	↑	8	5.3	8.0	
	Length of Stay: Elective (days) CCCHO 7Y	↔	21	5.7	15.4	
	Length of Stay: Emergency (days) CCCHO 7Y	↔	16	31.0	24.0	
	Bed Occupancy: Conway Ward 12 noon CCCW	↔	G: 80-85%	58.0%	74.1%	
	Bed Occupancy: Mersey Ward 12 noon CCCW	↔	A: 75-79% & 86-90%	64.0%	78.4%	
	Bed Occupancy: Conway Ward 12 midnight CCCW	↔	R: <75% & >90%	58.0%	74.1%	
	Bed Occupancy: Mersey Ward 12 midnight CCCW	↔	R: <75% & >90%	63.0%	76.5%	
	Clinical Utilisation Review: patients not meeting criteria CCCW	↔	Jan = 12%	5.5%		
	Radiology Reporting: Inpatients (within 24hrs) CCCW	↓	G: =>90% A: 80-90% R: <80%	79.4%	75.5%	
	Radiology Reporting: Outpatients (within 7days) CCCW	↔		95.5%	74.2%	
	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 May 2020

# Quality

Directive	Key Performance Indicator	Change in RAG rating from	Target	Jan-20	YTD	12 Month Trend
Quality	(Ctrl) ▾					
	Never Events	→	0	0	0	
	Serious Unlawful Incidents	→	0	0	2	
	Safety Thermometer	←	95%	92.6%	94.2%	
	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%	98.9%	98.2%	
	VTE Risk Assessment	↓	95%	93.3%	96.4%	
	Sepsis: IV antibiotics within 1 hour	↑	100%	100.0%	96.6%	
	Dementia: Screening, Assessment and Referral	→	95%	100%	99.1%	
	Clostridium Difficile Infections	→	<=4 per yr	0	8	
	E coli	↑	<=10 per yr	2	6	
	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	→		93.3%	91.0%	
	Staffing fill rate: Nurses - days	→	G: 90 - 100%	87.7%	85.6%	
	Staffing fill rate: Nurses - nights	→	A: 85 - 89% and 101 - 105%	100.7%	96.7%	
	Staffing fill rate: Care staff - days	→	R: <85 & >105%	97.4%	92.3%	
	Staffing fill rate: Care staff - nights	↑		94.0%	90.7%	
	30 Day Mortality Rate: Radical Chemotherapy	→		0.4%	0.3%	
	30 Day Mortality Rate: Palliative Chemotherapy	→		1.4%	1.2%	
	30 Day Mortality Rate: Chemotherapy	→		1.1%	0.9%	
	30 Day Mortality Rate: Radiotherapy	→		2.5%	2.5%	
	Partners in Care Assessments	↑	G: 90%, A: 85% - 89%, R: <85%	94.1%	87.4%	
	FFT inpatient score (% positive)	↑	95%	100.0%	98.9%	
	FFT outpatient score (% positive)	→	95%	98.2%	98.1%	
	FFT inpatient response rate	↓	G: 30%, A: 25% - 29%, R: <25%	16.8%	24.8%	
	FFT outpatient total responses	→	-	544	5679	
	Complaints	→	-	1	20	

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

## To Note:

- 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.
- Infections other than c diff are CCC attributable only, with both attributable and non-attributable reported in section 1.3.

# Research & Innovation

Directive	Key Performance Indicator	Change in RAG rating from previous	Target	Jan-20	YTD	12 Month Trend
<b>Research and Innovation</b>						
	Study recruitment: Portfolio	↔	-	58	374	
	Study recruitment: Non-Portfolio	↔	-	32	601	
	Study recruitment: Total	↗	83.3 per month	90	975	
	Studies Opened	↗	5.3 per month	6	43	
	Study set up times	↗	40 days	33	Q3	

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

# Workforce

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Jan-20	YTD	12 Month Trend
<b>Workforce</b>						
	Staff Sickness (monthly)	↔	G: <3.5%, A: 3.6 - 3.9%, R: >4%	4.5%	4.2%	
	Staff Turnover (12 month rolling)	↔	12%	14.3%	N/A	
	Statutory and Mandatory Training	↗	90%	94.8%	N/A	
	PADR rate	↗	95%	92.5%	N/A	
	FFT staff: Recommend care and treatment	↓	G: >95%, A: 90-94%, R: <90%	91.8%	Q2	
	FFT staff: Recommend as a place to work	↔	<90%	61.9%	Q2	
	FFT staff: Response rate	↓	TBC	23.4%	Q2	

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

# Finance

For January the key financial headlines are:

Metric (£000)	M10 Actual	M10 Plan	Variance	YTD Actual	YTD Plan	Variance	Risk RAG
NHSI SoF	3	1	2	3	1	2	<span style="background-color: orange;"> </span>
NHSI Control Total (£000)	423	374	49	4,008	3,498	510	<span style="background-color: green;"> </span>
Cost Improvement Programme (£000)	173	150	23	1,626	1,492	134	<span style="background-color: green;"> </span>
Cash holding (£000)	33,952	25,028	8,924	33,952	25,028	8,924	<span style="background-color: green;"> </span>
Capital Expenditure (£000)	2,612	6,074	-3,462	42,348	45,921	-3,573	<span style="background-color: orange;"> </span>

## 2. Exception Reports

### Operational

62 Day Cancer Waiting Times		Target	Jan 20	YTD	12 month trend
		85%	76.1%	89.1%	
<b>Reason for non-compliance</b>					
<p>There were 10 accountable breaches for January 20. 6.5 unavoidable breaches were due to complex, medical pathways and patient choice. The 3.5 avoidable breaches were due to admin reason and capacity to first appointment.</p>					
<b>Action Taken to improve compliance</b>					
<ul style="list-style-type: none"> <li>Continued review of HOD's delay and identification of target patient for prioritisation</li> <li>Continued review of Consultant leave cover</li> <li>Review of treatment start dates delay due to bank holidays in progress</li> <li>Cancer waiting times target awareness/refresher sessions available for all staff</li> </ul>					
<b>Expected date of compliance</b>	29/02/20				
<b>Escalation route</b>	Target Operational Group				
<b>Executive Lead</b>	Joan Spencer, Interim Director of Operations				

2 Week Wait		Target	Jan 20	YTD	12 month trend
		93%	87.5%	96.0%	
<b>Reason for non-compliance</b>					
<p>The breach occurred as admin booked the first appointment out of target and not escalated.</p>					
<b>Action Taken to improve compliance</b>					
<ul style="list-style-type: none"> <li>Target awareness sessions available to all staff.</li> </ul>					
<b>Expected date of compliance</b>	29/02/2020				
<b>Escalation route</b>	Target Operational Group				
<b>Executive Lead</b>	Joan Spencer, Interim Director of Operations				

Length of Stay – Elective Admissions	Target	Jan 20	YTD	12 month trend
		2	3.7	6.2
<b>Reason for non-compliance</b> LoS for elective admissions at CCC Wirral is above target. Current target under review to match national guidance and any evidence best practice e.g. benchmark with other Specialist hospitals' Length of Stay targets.				
<b>Action Taken to improve compliance</b> Continued discussions with Business Intelligence regarding appropriate length of stay target.				
<b>Expected date of compliance</b>	29/02/2020			
<b>Escalation route</b>	Monthly ICD meeting, Q+S group, Integrated Governance			
<b>Executive Lead</b>	Joan Spencer, Interim Director of Operations			

Ward 7Y Non-Elective Admissions	Target	Jan 20	YTD	12 month trend
		16	31.0	24.0
<b>Reason for non-compliances</b> There were four patients discharged in month with a high LoS. All patients have been validated.  Of these four patients: <ol style="list-style-type: none"> <li>Two were on phase 1 induction chemotherapy and patients are not discharged until blood counts are recovered. This can be up to 6 weeks.</li> <li>One patient was acutely unwell post-transplant with multiple viral and bacterial infections</li> <li>One patient (&gt;75) admitted for a cycle of intensive salvage chemotherapy and became frail post cycle (This regime has can cause more side effects for older people).</li> </ol>				
<b>Action Taken to improve compliance</b> <ul style="list-style-type: none"> <li>Continued weekly inpatient review of patients LoS on ward 7Y by Matron and Deputy GM.</li> </ul>				
<b>Expected date of compliance</b>	End of June 2020			
<b>Escalation route</b>	Performance review			
<b>Executive Lead</b>	Joan Spencer			

Bed Occupancy - Wirral		Target	Jan 20	YTD	12 month trend
		80-85%	64.0% /58.0%	74.1% /78.4%	
<b>Reason for non-compliance</b>					
<p>Bed occupancy on both inpatient wards was below target for the month of January 20220.</p> <ul style="list-style-type: none"> <li>Mersey 64%</li> <li>Conway 58%.</li> </ul> <p>The occupancy levels have remained low in Month 10. CUR data shows that bed usage was being appropriately managed and the number of patients reported to be delayed was only 4 which may have contributed to lower occupancy.</p> <p>CDU has supported in reducing admissions through effective assessments whereby instead of patients being admitted they are treated and sent home</p>					
<b>Action Taken to improve compliance</b>					
Request submitted to BI for further information regarding number of elective and non-elective admissions to identify any trends.					
<b>Expected date of compliance</b>	29/02/20				
<b>Escalation route</b>	Monthly ICD Meeting, Q+S group, integrated governance				
<b>Executive Lead</b>	Joan Spencer, Interim Director of Operations				

Radiology Reporting - Inpatients		Target	Jan 20	YTD	12 month trend
		>=90%	79.4%	75.5%	
<b>Reason for non-compliance</b>					
<p>The inpatients target of 90% within twenty four hours was not achieved (79.4%), however performance against the 48 hours target is reflecting a more improved position (84.7%).</p> <p>The reason for the breach of the target is due to a key member of staff having 4 weeks annual leave in the month of January.</p>					
<b>Action Taken to improve compliance</b>					
<p>Increased capacity with outsourcing company</p> <p>Increased number of visiting radiologists PAs from other Trusts</p> <p>An additional radiologist was recruited in December 2019 however will not start for several months. Further interviews will take place for another radiologist in March</p>					

<b>Expected date of compliance</b>	29/02/20
<b>Escalation route</b>	
<b>Executive Lead</b>	Joan Spencer, Interim Director of Operations

## Quality

Safety Thermometer Compliance	Target	Jan 20	YTD	12 month trend
Using safety thermometer tool	95%	92.6%	94.2%	
'True New Harm' attributable to CCC	95%	97.0%	95.1%	

### Reason for non-compliance

The 'new harm' cases identified by the safety thermometer survey in January relate to:

- 2 new Catheter Associated Urine Tract Infections (CAUTIs) on Conway ward – both CAUTIs were discussed at the February Harm Free Care Collaborative meeting, the group identified that there had been no lapses in care.
- 2 old pressure ulcers were also reported, both being identified on admission to CCC. One was a category 2 and the other category 4 pressure ulcer.
- 1 'new' PE was also reported on Mersey ward however, after investigation this was noted to be an incidental finding and not attributable to CCC.

Therefore using the safety thermometer tool, CCC resulted in 92.6% compliance. However, the percentage of true 'new harms' is 97%.

Safety thermometer is performed on every ward on one day during the month. It provides a snapshot of the patients on ward at the time of the audit (focusing on CAUTI, pressure ulcer, falls and VTE). However, CCC report and investigate all attributable harms which are then presented at the Harm Free Care Collaborative meeting to determine any lapses in care and to ensure lessons learnt are shared at directorate level.

### Action Taken to improve compliance

- Root Cause Analysis investigations have been initiated by the ward leaders.
- All harms presented at Harm free care collaborative meeting and lessons learnt shared at directorate level.

Benchmarking information (December data):

The Christie = 99.04%

The Marsden = 98.47%

National figure = 93.99%

<b>Expected date of compliance</b>	February 2020
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<b>Escalation route</b>	Harm Free Care Collaborative meeting, Q+S Directorate meetings, IG committee through Triple A.
<b>Executive Lead</b>	Sheila Lloyd

VTE Risk Assessment	Target	Jan 20	YTD	12 month trend
	95%	93.3%	96.4%	

**Reason for non-compliance**

Target of 95% was not reached for the month of January 2020.

**Haem-Onc:**

The common theme for missed VTE assessments were identified as being patients admitted over the weekend, potentially cause by a reduction in the number of junior doctors during this time.

**ICD :**

- Assessments being missed despite medical staff being prompted by nursing staff.
- Patients originally not being planned to stay in overnight.
- VTE assessments being completed but missing the 24 hour timeframe, one patient by 44 minutes.
- Planned/emergency proforma not being completed.

**Action Taken to improve compliance**

- Compliance level escalated to the Clinical Directors, General Managers, Matrons and Ward Managers in both directorates.
- Medical lead for VTE informed of compliance rate.
- VTE education continues on medical induction.
- All inpatient areas receive a daily list of missed assessments, quality Improvement manager, ward managers and matron continue to highlight to ward doctors missed VTE assessments on a daily basis and request their completion.
- Use of ward screens reiterated to allow medics to see daily compliance 'live'.
- Compliance will be a standing agenda item on the directorate Quality and Safety monthly meetings.
- Weekly performance report continues.

<b>Expected date of compliance</b>	February 2020
<b>Escalation route</b>	Directorates / Quality and Safety Sub Committee / Quality Committee
<b>Executive Lead</b>	Sheila Lloyd, Director of Nursing and Quality

Infection Control - E Coli Bacteraemia	Target	Jan 20	YTD	12 month trend
	10	2	6	

**Reason for non-compliance**

Two E.coli bacteraemia identified in month - one from CCC-Wirral and the other within haematology. Both infections appear to be unavoidable in patients with multiple risk factors. The source of infection is unknown in both cases but in one patient it may have been associated with an indwelling pleural drain.

**Action Taken to improve compliance**

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

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 and Hydration strategy lead by clinical teams.

<b>Expected date of compliance</b>	May 2020
<b>Escalation route</b>	IPC committee
<b>Executive Lead</b>	Sheila Lloyd

FFT – Inpatient Response Rate	Target	Jan 20	YTD	12 month trend
	25%	16.8%	24.8%	

#### Reason for non-compliance

The trust set a stretch target of 30% (national average 24%) for response rate to FFT  
There has been an ongoing monthly fluctuation as seen from the trend graph above.

Inpatient areas still continue to encourage patients to complete FFT, supported with completion of cards and **Isee** devices. This has been challenging throughout January.

From April 2020 the national guidance is changing and the submission of response rate is no longer required.

The emphasis is on trusts using the qualitative feedback from patients to monitor patient experience and drive quality improvement. This will be led by our Patient Experience Manager and Matrons.

#### Action Taken to improve compliance

- Implementation plan in place to comply with new guidance from April 2020
- Create link on trust website for patients to complete FFT
- FFT to be encouraged throughout the patients journey, not just upon discharge
- FFT to be available for relatives and carers
- Implementing Text messaging functionality
- Supporting FFT as a role for recruitment of new volunteers

<b>Expected date of compliance</b>	June 2020
<b>Escalation route</b>	Patient Experience Inclusion Group
<b>Executive Lead</b>	Sheila Lloyd, Director of Nursing and Quality

## Research and Innovation

Studies opening to recruitment	Target	Jan 20	YTD	12 month trend
	63	52	43	

### Reason for non-compliance

Forty-three studies have been opened against an internal target of fifty-two year to date. There are four studies which have been locally approved and can be opened following sponsor approval. Combined this gives a total of forty-seven studies either opened or are ready to open. To bridge the gap the expectation is that the newly appointed 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 24<sup>th</sup> March 2020.
- Work with the Network to optimise opportunities.

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

## Workforce

Sickness	Target	Jan 20	YTD	12 month trend
	3.5%	4.5%	4.2%	

### Reason for non-compliance

The Trust 12 month rolling sickness absence is 4.26%, with the in-month sickness absence for January 2020 at 4.48%; this is a slight increase from December's figure of 4.15%.

The top three reasons remain the same as last month, and have been for the past 4 months, with the number of episodes for each as follows:

1	Colds/ Coughs/ Flu	44 episodes
2	Gastrointestinal Problems	43 episodes
3	Anxiety/ Stress/ Depression	30 episodes

Of the 44 episodes of Colds/ Coughs/ Flu, the Radiotherapy Department had the highest number of episodes with 6, followed by Haemato-oncology BMT, Haemato-oncology 7Y Day Ward and Sulby Ward all with 3 episodes each.

The number of absence episodes due to gastrointestinal problems has risen from last month, 37, to 43 this month. This trend is comparable with the same months last year, as in December 2018 there were 30 absences due to gastrointestinal problems and in January 2019 there were 37 episodes. Almost half of the total numbers of absence episodes due to gastrointestinal problems were within the Administration and Clerical staff group with 20, which is significantly higher than all other staff groups:

- Additional Clinical Services with 8
- Nursing and Midwifery with 6
- Allied Health Professionals with 4
- Additional, Professional, Technical and Scientific with 4
- Healthcare Scientists with 1

Further analysis shows that the most common level 2 reasons for absence due to gastrointestinal problems were diarrhoea and vomiting with 21 episodes; however, there were also 2 absences due to Crohn's disease, gall bladder disease and gastroenteritis, 1 absence episode each due to abdominal pain and liver disease and a further 4 due to an upset stomach.

There were 17 absence episodes due to gastrointestinal problems that began on a Monday, 8 on a Thursday and 6 on a Friday, Tuesday and Wednesday.

Of the 30 absence episodes related to Anxiety / Stress / Depression, these have been recorded as below:

Level 2 reason	Number of Episodes
Stress	12
Anxiety	6
Depression	5

Level 2 reason	Number of Episodes
Insomnia	1
Panic Attacks	3
Unknown	3

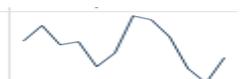
20 of the absence episodes were long-term and 7 of these returned in January 2020; 13 continue into February 2020.

6 of the absences due to stress were work-related and the managers' of these individuals have been supported by the Workforce and OD business partnering team in order to manage this; this includes support with the completion of the stress questionnaires and action plans.

#### Action Taken to improve compliance

- Continuing to offer resilience sessions in February and March 2020 for all staff. Following requests from staff at CCC-A and Haemato-oncology, two additional sessions are currently being arranged to take place in Liverpool in March.
- Stress audit has been completed and is due to go to SPF on 10<sup>th</sup> February for discussion with regards to findings and recommendations.
- Departmental managers to create action plans following the results of the stress questionnaires.
- The provision of a new Occupational Health service, with effect from 1 April 2020 will provide an opportunity to review the support available for staff presenting with stress.
- In conjunction with our Occupational Health Department and Communication Team establish a communication/ promotion campaign with regards to preventing and avoiding infection.
- Introduce additional questions as part of the management of the attendance management procedure whilst dealing with absence due to gastrointestinal problems. This would include understanding further whether food, family/ friends/ work have contributed to their absence.

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

Turnover	Target	Jan 20	YTD	12 month trend
	12%	1.63%	14.3%	

#### Reason for non-compliance

The rolling 12 month turnover has increased from 13.87% in December 2019 to 14.30% in January 2020. The in-month turnover figure has also increased from 0.94% in December 2019 to 1.63% in January 2020; this is due to a noticeable increase in leavers from 13 to 21.

Overall, the highest reason for leaving in January 2020 was 7 leavers due to promotion and 3 of these went to other NHS organisations, whilst the other 4 leavers went to other private sector organisations.

There were 8 leavers with less than 8 months' service with the Trust, these are as follows:

Department	Number of Leavers	Reason	Number of Months
Admin Services	3	Health	0
		Better Reward Package	4
		Work Life Balance	0
Delamere Royal Hub	1	Health	4
Research	1	Incompatible Working Relationships	7
Delamere Wirral Hometreat	1	Other/ Not Known	4
Delamere Wirral Hub	1	Other/ Not Known	3
Conway Ward	1	Relocation (out of area)	8

For the leavers above that have the reason down as other/ not known, one of these left to commence a Physician Associate course and had their start date brought forward; the other leaver decided that the department was not the right fit for them.

The Directorates with the highest number of leavers in January 2020 were Chemotherapy with 6 and Corporate with 6, with the remaining Directorates as follows;

- Haemato-oncology with 1
- Hosted Service with 2
- Integrated Care with 2
- Radiation Services with 2
- Research with 2

There were no leavers this month that stated that their reason for leaving was due to Liverpool.

#### Action Taken to improve compliance

- An analysis of turnover within the Chemotherapy Directorate has been undertaken, with WOD due to meet with managers to agree an action plan to address any potential areas of concern.
- Development of a flexible working toolkit for managers' which will help address issues with those leaving due to work-life balance/ due to the move to Liverpool and needing to work more flexibly.

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

PADR	Target	Jan20	12 month trend
	95%	92.5%	
<p><b>Reason for non-compliance</b></p> <p>Overall Trust compliance for PADR as at January 2020 is 92.54%, which is below the KPI of 95% and a 0.02% decline from the previous month.</p> <p>The following Directorates are underperforming against the KPI;</p> <ul style="list-style-type: none"> <li>• Haemato-oncology Directorate – 89%</li> <li>• Chemotherapy Service Directorate – 89% (In month decline of 2%)</li> <li>• Integrated Care Directorate – 92% (In month increase of 2%)</li> <li>• Corporate Directorate – 93%</li> <li>• Radiation Services Directorate – 93% (In-month decline of 1%)</li> </ul> <p>A breakdown of staff that were non-compliant with PADRs was distributed to managers in December 2019, with an aspirational target date of completion set as 30<sup>th</sup> January 2020.</p> <p>This target has not been achieved and a number of discussions with managers has highlighted that due to the close proximity to the 2020/21 PADR opening, they are prioritising completion in March 2020.</p>			
<p><b>Action Taken to improve compliance</b></p> <ul style="list-style-type: none"> <li>• Reminder emails have been sent to managers whose staff are non-compliant</li> <li>• Revised process for new starters to be introduced from January 2020</li> <li>• PADR requirements to be included on Induction to increase awareness to new starters from January 2020</li> <li>• Increased number of manager and staff PADR training sessions</li> <li>• Pay Progression policy includes the requirement for compliance with PADR in order to receive their next pay step</li> </ul>			
<b>Expected date of compliance</b>	September 2020		
<b>Escalation route</b>	Directorates, WOD Committee, Quality Committee		
<b>Executive Lead</b>	Jayne Shaw, Director of Workforce & OD		