



### Report Cover Sheet

Report to:	QC / PC / Board of Directors' Meeting	
Date of the Meeting:	29 <sup>th</sup> April 2020	
Agenda Item:	P1-073-20	
Title:	IPR M12 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:	
Date & Decision:	

Purpose of the Paper/Key Points for Discussion:	<p>This report provides the Trust Board with an update on performance for month twelve (March 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.</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 <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 patient 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 12 2019/20)**

## **Introduction**

This report provides the Trust Board with an update on performance for month twelve (March 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.

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.

In addition NHSE/I communicated the 'Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic' letter to all Trusts on the 28<sup>th</sup> March 2020. This included the following guidance relevant to The CCC regarding the reporting of data:

- Friends and Family test: Stop reporting requirement to NHS England and NHS Improvement
- RTT: Recording of clock starts and stops should continue in line with current practice for people who are self-isolating, people in vulnerable groups, patients who cancel or do not attend due to fears around entering a hospital setting, and patients who have their appointments cancelled by the hospital
- The 28-day Faster Diagnosis Standard (which was due to come into effect from Wednesday 1 April) will still have data collected, but will not be subject to formal performance management.
- Mandatory training: Reduce (non-ICU) mandatory training as appropriate
- The following returns are not required for submission between 1 April 2020 and 30 June 2020: Delayed Transfers of Care, VTE Risk Assessment, dementia assessment and referral.

Despite this guidance, the Trust will continue to monitor these targets internally.

# 1. Performance Scorecards

## Operational

Key Performance Indicator	Change in RAG rating from previous month	Target	Mar-20	YTD	12 Month Trend
62 Day Cancer Waiting Times Standard	↔	85%	86.0%	87.8%	
2 Week Cancer Waiting Times Standard	↔	93%	100%	96.6%	
Referral to Treatment: 18 weeks (Incompletes)	↔	92%	99.0%	98.4%	
Diagnostics: 6 Week Wait	↔	99%	100%	100.0%	
Clinic Waits: Outpatients Wirral (<30 mins)	↔	80%	84.7%	83.5%	
Clinic Waits: Delamere (<30 mins)	↔	80%	82.5%	82.3%	
Clinic Waits: Outpatients Peripheral (<30 mins)	↔	80%	91.4%	88.1%	
Length of Stay: Elective (days) CCCW	↔	2	8.12	6.30	
Length of Stay: Emergency (days) CCCW	↔	8	5.8	7.7	
Length of Stay: Elective (days) CCCHO 7Y	↓	21	17.42	15.75	
Length of Stay: Emergency (days) CCCHO 7Y	↓	16	13.92	23.51	
Bed Occupancy: Conway Ward 12 noon CCCW	↔	G: 80-85%	65.0%	73.2%	
Bed Occupancy: Mersey Ward 12 noon CCCW	↓	A: 75-79% & 86-90%	65.0%	77.3%	
Bed Occupancy: Conway Ward 12 midnight CCCW	↔	R: <75% & >90%	65.0%	73.1%	
Bed Occupancy: Mersey Ward 12 midnight CCCW	↓		61.0%	75.2%	
Clinical Utilisation Review: patients not meeting criteria CCCW	↔	Feb = 11%	8.1%	N/A	
Radiology Reporting: Inpatients (within 24hrs) CCCW	↑	G: =>90%	91.9%	77.6%	
Radiology Reporting: Outpatients (within 7 days) CCCW	↔	A: 80-90% R: <80%	86.7%	76.2%	
Travel time to clinic appointment within 45 minutes CCCW	↔	G: =>90%, R: <90%	96.0%	97.1%	

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

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

HO LoS data was incorrectly reported in the Month 11 IPR as 2 days (green) rather than the actual 22 days (red).

# Quality

Key Performance Indicator	Change in RAG rating from previous month	Target	Mar-20	YTD	12 Month Trend
Never Events	↔	0	0	0	
Serious Untoward Incidents	↑	0	0	3	
Safety Thermometer	↔	95%	95.6%	94.5%	
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%	97.9%	98.2%	
VTE Risk Assessment	↔	95%	96.3%	96.6%	
Sepsis: IV antibiotics within 1 hour	↓	100%	97.5%	97.0%	
Dementia: Screening, Assessment and Referral	↔	95%	100%	99.3%	
Clostridium Difficile Infections	↔	<=4 per yr	1	11	
E coli	↔	<=10 per yr	1	8	
MRSA	↑	0	1	1	
MSSA	↔	<=5 per yr	0	3	
Klebsiella	↔	<=10 per yr	0	4	
Pseudomonas	↔	<=5 per yr	0	8	
Staffing fill rate: Trust	↔	G: 90% - 100% A: 85% - 89% and 101% - 105% R: <85% & >105%	90.0%	90.9%	
30 Day Mortality Rate: Radical Chemotherapy	↓	-	0.1%	0.3%	
30 Day Mortality Rate: Palliative Chemotherapy	↑	-	1.2%	1.1%	
30 Day Mortality Rate: Chemotherapy	↑	-	0.9%	0.9%	
30 Day Mortality Rate: Radiotherapy	↓	-	2.1%	2.4%	
Partners in Care Assessments	↔	G: 90%, A: 85% - 89%, R: <85%	97.8%	88.9%	
FFT inpatient score (% positive)	-	95%	no responses	98.7%	
FFT outpatient score (% positive)	↔	95%	99.3%	98.2%	
FFT inpatient response rate	↓	G: 30%, A: 25% - 29%, R: <25%	0%	24%	
FFT outpatient total responses	↓	-	145	6383	
Complaints	↑	-	4	27	

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

Sepsis YTD does not include April and May HO figures, as robust data capture processes were implemented in June 2019.

30 Day Mortality figures are always for the previous month.

C diff monthly figures include community acquired infections, from April 2019, as per national guidance (amended and back dated from Month 5 report)

## Research & Innovation

Key Performance Indicator	Change in RAG rating from previous month	Target	Mar-20	YTD	12 Month Trend
Study recruitment: Portfolio	↓	-	32	518	
Study recruitment: Non-Portfolio	↓	-	13	687	
Study recruitment: Total	↓	83.3 per month	45	1205	
Studies Opened	↔	5.3 per month	0	47	
Study set up times (days)	↔	40 days	27	N/A	

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	Mar-20	YTD	12 Month Trend
Staff Sickness (monthly)	↔	G: <=3.5%, A: 3.6 - 3.9%, R: >=4%	5.8%	4.4%	
Staff Turnover (12 month rolling)	↔	12%	14.8%	N/A	
Statutory and Mandatory Training	↔	90%	95.5%	N/A	
PADR rate	↔	G: <=95%, A: 90- 94.9%, R: >=93.9%	91.1%	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	-	G: <=95%, A: 90- 94.9%, R: >=93.9%	N/A	Dec = 64% (Q3 National survey)	
FFT staff: Response rate	-	TBC	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 March the key financial headlines are:


Metric (£000)	M12 Actual	M12 Plan	Variance	YTD Actual	YTD Plan	Variance	Risk RAG
NHSI SoF	3	1	2	3	1	2	
NHSI Control Total (£000)	6926	378	6,548	10,583	3,492	7,091	
Cost Improvement Programme (£000)	538	156	382	2,299	1,800	499	
Cash holding (£000)	29,299	19,035	10,264	29,299	19,035	10,264	
Capital Expenditure (£000)	12,184	4,538	7,646	56,479	54,663	1,816	

The key drivers of the positions are:

- **Income has overachieved plan by £23.9m, £9.3m in month.** This is due to clinical income being £11.9m over plan, of which £11.1m relates to drug income. The Trust also received a donation from the Charity which contributes to the overachievement of the income plan.
- **Expenditure is overspent by £17.3m, £2.7m in month.** Consistent with the income position, mostly due to drug expenditure being £11.2m above plan.
- **Cash held is ahead of plan by £10.3m**
- **Capital expenditure is £1.8m ahead of plan.**

## 2. Exception Reports

### Operational

Length of Stay (LoS): Elective Admissions Wirral Wards	Target	Mar 20	YTD	12 month trend
	2 days	8.2 days	6.3 days	
<b>Reason for Non-Compliance</b> <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> <p>However, The Trust is experiencing an increased number of external delays, for example:</p> <ul style="list-style-type: none"> <li>○ Currently the CCG are not fast tracking any Continuous Health Care packages due to COVID-19. This causes potential delays to patient transfers e.g. into nursing homes</li> <li>○ Low bed capacity in hospices to accommodate our patients</li> <li>• There are an increased number of complex cases, for example: <ul style="list-style-type: none"> <li>○ Patients needing nutritional needs assessments and nursing homes not having staff trained to deal with feeding pumps (due to COVID-19, face to face training has been cancelled)</li> <li>○ Some patients not having families prepared to deal with continuous support health issues with limited support from community services.</li> </ul> </li> </ul>				
<b>Action Taken to Improve Compliance</b> <ul style="list-style-type: none"> <li>• To explore different elective pathways and process for reporting.</li> <li>• Continue with MDT Discharge planning meetings in line with NHSE/I guidance.</li> <li>• Escalate any challenges from the twice daily handovers using the patient flow processes.</li> </ul>				
<b>Expected date of compliance</b>	30/06/2020			
<b>Escalation route/s</b>	Directorate Performance Review, Performance Committee, Trust Board.			
<b>Executive lead</b>	Joan Spencer, Interim Director of Operations			

Bed Occupancy: Wirral	Wards	Target	Mar 20	YTD	12 month trend
	Bed Occupancy: Conway Ward 12 noon CCCW	G: 80-85%	65.0%	73.2%	
	Bed Occupancy: Mersey Ward 12 noon CCCW	A: 75-79% & 86-90%	65.0%	77.3%	
	Bed Occupancy: Conway Ward 12 midnight CCCW	R: <75% & >90%	65.0%	73.1%	
	Bed Occupancy: Mersey Ward 12 midnight CCCW		61.0%	75.2%	
<b>Reason for non-compliance</b> <p>Both in patient wards are below the target bed occupancy for March 2020.</p> <p>Part month, the directorate experienced a significant decrease in both elective and non-elective activity. This can be explained through reduced planned activity and proactive daily discharge planning at CCC Wirral in response to the COVID-19 pandemic.</p>					
<b>Action Taken to improve compliance</b> <ul style="list-style-type: none"> <li>Weekly LLOS directorate meetings have been replaced by daily monitoring.</li> <li>The Patient Flow Team continues to work with the wider MDT to aid discharge planning during the COVID-19 pandemic.</li> </ul>					
<b>Expected date of compliance</b>		30/06/2020			
<b>Escalation route</b>		Directorate Performance Review, Performance Committee, Trust Board.			
<b>Executive Lead</b>		Joan Spencer, Interim Director of Operations			

Radiology Reporting	Target	March 2020	YTD	12 Month trend
Imaging reporting turnaround: Inpatients (% within 24 hours)	G: =>90%	91.9%	77.6%	
Imaging reporting turnaround: Outpatients (% within 7 days)	A: 80-90% R: <80%	86.7%	76.2%	

### Reason for non-compliance

The inpatient target of 90% within twenty four hours was achieved this month (91.6%). This improvement is a result of the additional training provided to Imaging staff in regard to correct clinical coding. The outpatient target has shown a slight increase since February from 85.8% to 86.7% in March.

There is a high reliance on the outsourcing company for outpatient reports and this will continue to grow as the locum radiologist has now left. This company’s turnaround times are often longer than the required target times, a concern which was raised with them at this month’s review meeting.




**Action taken to improve compliance**

Additional reporting capacity is now in place from the outsourcing company and a review meeting is planned in April which will include a review of their turnaround times.

An additional radiologist was recruited in December however will not start for several months. Further interviews will take place for another radiologist, however this is now postponed due to the COVID-19 pandemic.

<b>Expected date of compliance</b>	<ul style="list-style-type: none"> <li>Improved coding compliance with immediate effect.</li> <li>September 2020</li> </ul>
<b>Escalation route</b>	Directorate Performance Review, Performance Committee, Trust Board.
<b>Executive Lead</b>	Joan Spencer, Interim Director of Operations

## Quality

Serious Untoward Incident (SUI)	Target	Feb 20	YTD	12 month trend
	0	1	3	

**Reason for non-compliance**

There were a total of three SUIs in 2019/20. The Trust declared 1 Serious Untoward Incident during March (the incident itself occurred in February). A patient was discharged without filgrastam (drug that boosts white cell count to fight infection) injections and was subsequently admitted to an acute hospital with neutropenic sepsis.


The incident was reported on 19th February and a 72 hour review was requested the following morning at the daily incident review call. Unfortunately due to unforeseen circumstances regarding staff availability, there was a delay in the report being produced. The directorate staff did, however, contact the family by telephone and explain the situation. The incident was STEIS reported within the required timescales.


This incident has also been logged in Datix as a formal complaint and as a claim.

**Action taken to improve compliance**

A full root cause analysis investigation is underway.

<b>Expected date of compliance</b>	The target has not been achieved in 2019/20.
<b>Escalation route</b>	<p>Immediate escalation once aware of the incident, as per Incident management Policy</p> <p>Monthly Directorate Quality and Safety Group, Integrated Governance Committee, Quality Committee, Trust Board.</p>
<b>Executive Lead</b>	Sheila Lloyd, Director of Nursing and Quality

Sepsis - 1hr to Antibiotics	Target	Mar 20	YTD	12 month trend
	100%	97.9%	97.5%	
<b>Reason for non-compliance</b> 97.9% was achieved for March 2020 (39/40 for Wirral wards and 8/8 for HO wards).  The one hour target was missed for one patient. In this case the Sepsis screening tool was completed by the medic, however the antibiotics were not delivered to the patient by the nursing team on time.				
<b>Actions taken to improve compliance</b> <ul style="list-style-type: none"> <li>Ward leaders to hold face to face briefing with staff involved in any breaches. Investigation to be conducted and fed back to Deteriorating Patient Steering Group (DPSG).</li> <li>Improvements in communications via handover/ regular huddles – electronic ACT/ANP/ACT - 24/7.</li> <li>Board round attended daily by Acute Care Team to identify and follow up sepsis patients.</li> <li>Education:               <ul style="list-style-type: none"> <li>Face to face sessions (including medic induction) and e-learning, plus at MET calls and ward based education.</li> <li>Clinical Band 6s and above completion of Sepsis competency passport.</li> <li>Sepsis champions identified in all areas.</li> <li>CCC screensaver of the new Sepsis 6 due to be launched.</li> <li>Visual prompts created and displayed in appropriate areas.</li> </ul> </li> <li>Networking with other Trusts, RCUH, STHK, SEPSIS TRUST UK.</li> <li>Default start time for intravenous antibiotics removed from Meditech, to eradicate risk of missed dose.</li> <li>Sepsis medication order sets in process of being built to expedite treatment times, in line with WUTH formulary until May 2020 then new build for post May with RLUH formulary.</li> <li>Datix completed for any delay in treatment and non-compliances of documentation on Meditech.</li> </ul>				
<b>Expected date of compliance</b>	May 2020			
<b>Escalation route</b>	DPSG /Directorates/ Integrated Governance Committee/ Quality Committee/Trust Board			
<b>Executive Lead</b>	Sheila Lloyd, Director of Nursing and Quality			

Infection Control: CDifficile - Attributable	Annual Target	Mar 20	YTD	12 month trend
	=<4	1	11	
<b>Reason for non-compliance</b> There was one reported case in March 2020 (at CCCW) for which a detailed review is to be undertaken. As previously reported, the new criteria for allocating C. difficile infections to acute Trusts were retrospectively applied to our patients. There have been 14 cases YTD, 11 of these cases are attributable to CCC. The annual threshold of 4 for 2019/20 has therefore not been achieved.				

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>	March 2020	Total
Actual COHA	0	2
Actual HOHA	1	9
Actual COIA	0	2
Actual COCA	0	1
<b>Annual Total (All sites)</b>		<b>14</b>

#### Action taken to improve compliance

Preliminary findings indicate that appropriate treatment and processes were followed. This will be further explored and confirmed following the detailed review.

<b>Expected date of compliance</b>	May 2020
<b>Escalation route</b>	IPC Committee
<b>Executive Lead</b>	Sheila Lloyd, Director of Nursing and Quality.

Infection Control: E Coli Bacteraemia - Attributable	Annual Target	Mar 20	YTD	12 month trend
	=<10	1	8	

#### Reason for non-compliance

There was one E.coli bacteraemia in March 2020 (at CCCHO) for which a detailed review will be completed.

The Trust has however not breached the annual threshold of 10 for 2019/20.


#### Action Taken to improve compliance

We continue to participate in the E.coli Cancer Collaborative initiatives which support and strengthen changes in practice.

Regular reminder prompts issued to all clinical staff re: timely collection of microbiology samples.

Post infection reviews are undertaken to identify any potential causes as well as any risks, lapses in care and lessons for future patients.


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

Infection Control: MRSA Bacteraemia	Annual Target	Mar 20	YTD	12 month trend
	0	1	1	
<b>Reason for non-compliance</b> <p>There was one MRSA bacteraemia in March 2020 (at CCCW) for which a detailed review will be completed.</p> <p>The annual target of 0 for 2019/20 has therefore not been achieved.</p>				
<b>Action Taken to improve compliance</b> <p>Preliminary findings indicate that appropriate treatment and processes were followed. This will be further explored and confirmed following the detailed review.</p> <p>Post infection reviews are undertaken to identify any potential causes as well as any risks, lapses in care and lessons learned for future patients.</p>				
<b>Expected date of compliance</b>	May 2020			
<b>Escalation route</b>	IPC committee			
<b>Executive Lead</b>	Sheila Lloyd, Director of Nursing and Quality.			

## Research and Innovation

Studies opening to recruitment	Target	Mar 20	YTD	12 month trend
	63	0	47	
<b>Reason for non-compliance</b> <p>In light of the COVID-19 pandemic a temporary halt was put on opening new research studies to recruitment on 16<sup>th</sup> March 2020.</p> <p>At this point forty-seven studies had been opened against an internal target of sixty-three. There were six studies which had been locally approved and could be opened following sponsor approval and once the temporary halt has been lifted. Combined, this gives a total of fifty-three studies either opened or ready to open. The target set at the beginning of the year has not been met. However, the internal and external recruitment targets have been met, which is more indicative of activity.</p>				
<b>Action Taken to improve compliance</b> <ul style="list-style-type: none"> <li>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 7<sup>th</sup> April 2020.</li> <li>Work with the Network to optimise opportunities.</li> </ul>				
<b>Expected date of compliance</b>	Target to be reviewed for 2020/21			
<b>Escalation route</b>	SRG Research Leads / Committee for Research Strategy			
<b>Executive Lead</b>	Sheena Khanduri, Medical Director			

## Workforce

Sickness	Target	Mar 2020	YTD	12 month trend
	3.5%	5.8%	4.18%	

### Reason for non-compliance

The Trust 12 month rolling sickness absence is 4.18%, with the in-month sickness absence for March 2020 at 5.76%. This is an increase from February's figure of 4.31%; this increase was to be expected with the COVID-19 outbreak.

The top three reasons for sickness absence for March 2020 (with the number of episodes for each), are shown below:

	Absence Reason	Number of Episodes
1	Chest & respiratory problems	81
2	Cold, Cough, Flu – Influenza	38
3	Anxiety/stress/depression	37

We would have expected Chest and Respiratory problems to be the highest reason for absence in March 2020 as this is how Covid-19 related absences have been recorded; as well as using the Level 2 reason as 'Other Chest and Respiratory problems' and the breakdown of these are included below:

Level 2 Reason	Number of Episodes
Other chest and respiratory problems	66
Breathing problems	1
Lower respiratory tract infection	1
Pleurisy	2
Upper respiratory tract infection	2
Not entered	9

The data above shows that there were 66 absences of staff members who reported Covid-19 related symptoms and were too unwell to attend work or work from home. Of these absences, 32 have returned to work and 34 of these are still ongoing.

The Workforce and Organisational Development Team are also recording other absences related to Covid-19 under different fields within ESR. Therefore this absence data alone does not provide the overall number of absences relating to Covid-19; however, the full data is reported daily.

The directorate with the highest number of absences under 'Other chest and respiratory problems' is Radiation Services with 19 episodes, followed by Chemotherapy with 17 episodes and Integrated Care with 15 episodes.

The second highest reason for absence was Cold, Cough and Flu with 38 episodes. The breakdown of these episodes by directorate is as follows:


Directorate	Number of Episodes
Chemotherapy	4
Corporate	9
Haemato-Oncology	4
Hosted Service	1
Integrated Care	3
Quality	1
Radiation Services	13
Research	3

The third highest reason for absence in March 2020 was anxiety/ stress/ depression with 37 episodes. Of these episodes, 23 are long-term and 14 are short-term; 17 of these absences have ended and 20 of these are ongoing. Of the overall total of absences relating to anxiety/ stress/ depression, 18 episodes identified 'Stress' as the Level 2 reason and of these stress-related absences 5 are work-related. The Workforce and OD business support team are continuing to work with the managers in order to manage these absences.

#### Action taken to improve compliance

- The Trust recognises that this difficult time will have an impact on the health and wellbeing of staff and therefore there is support being provided through Vivup's EAP service, as well as the launch of the Health and Wellbeing Hub on the Extranet.
- The Workforce and OD team have produced numerous guidance documents relating to Covid-19 in order to support staff and managers; these include working from home principles, childcare principles, recording of absence in ESR etc.
- The Workforce and OD team are supporting clinical staff with the Coronavirus testing by scheduling appointments and communicating results to staff. This support should help staff members return to work sooner should their results come back negative.
- The Workforce and OD team will be supporting managers with inputting absences into ESR so that this enables clinical staff to focus on other duties.
- An overall cleanse of the absence data relating to Covid-19 will be undertaken by the Workforce & OD team to ensure that all absences are being recorded correctly. This will include sickness data, as well as 'Medical Suspension' and 'Special Leave' recorded absences.

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

Turnover	Target	March 2020	12 month trend
	12%	14.8%	

#### Reason for non-compliance

The rolling 12 month turnover figure has increased from 14.51% in February 2020 to 14.79% in March 2020; the in-month turnover figure has also increased for from 1.16% in February 2020 to 1.31% in March 2020.

There were 19 leavers in March 2020 and the reasons for leaving are as follows:

Reason for Leaving	Number of Leavers
Promotion	4
Better Reward Package	1
Retirement	4
Work Life Balance	4
End of Fixed-Term Contract	2
Early Retirement	1
Health	1
Dismissal	2

As is evident from the table above, there were 3 joint top reasons for leaving in March 2020; promotion, work-life balance and retirement all with 4 leavers each. Of those that left due to promotion, 3 of these took up employment at other local NHS Trusts, whilst one went on to private sector. Of those that left due to work-life balance, 2 of these went to local NHS Trusts, 1 went to a GP Practice and 1 to no employment.

The majority of leavers in March 2020 were from either the Integrated Care Directorate, with 7 leavers, or the Corporate Directorate with 6 leavers. Of the leavers from Integrated Care, 5 of these were from the Nursing and Midwifery staff group and the other two were Administrative and Clerical staff.


In March 2020, 6 of the 19 leavers had less than 1 years' service with the Trust and the breakdown of these reasons for leaving are as follows:

- Promotion, with 2
- End of Fixed-Term Contract, with 2
- Work-Life Balance, with 1
- Dismissal, with 1

#### 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

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

PADR	Target	Mar 2020	12 month trend
	95%	91.1%	

#### Reason for non-compliance

Overall Trust compliance for PADRs as at March 2020 is 91.09%, which is below the KPI of 95% and a decline of 1.43% from the previous month.

All directorates with the exception of Integrated Care and Quality are underperforming against the KPI.

The PADR window for 2020/21 opened on 1<sup>st</sup> March 2020, however due to Covid-19 and the need to free up clinical capacity and in line with national guidance issued by NHSI, the Trust has paused PADR completion until further notice.

We are however encouraging staff who do have some capacity over the coming weeks to take the opportunity to complete some or all of the various aspects of the ePADR process.

#### 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 202.
- 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.

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

## 3. Detailed Reports

### 3.1 Operational

#### 3.1.1 Cancer Waiting Times Standards

National Standards:

Standard	Target	Q1 2019/2	Q2 2019/20	Q3 2019/20	Jan 2020	Feb 2020	March 2020*	Q4 2019/20*
62 Day (classic)	85%	88.6%	87.6%	91.2%	77.5%	90.6%	86%	85.1%
31 Day (firsts)	96%	98.9%	98.7%	99.1%	96.3%	99.1%	97.6%	98.5%
18 Weeks – incomplete pathways	92%	97.8%	98.6%	98.4%	97.9%	98.95%	97.1%	98%
Diagnostics: <6 week wait	99%	100.0%	100.0%	100.0%	100.0%	100%	100%	100%
2 Week Wait	93%	97.6%	95%	100%	87.5%	100%	100%	95.8%
28 Day Faster Diagnosis	TBC					42.8%	72.7%*	55.5%*

\*subject to final validation on 6<sup>th</sup> May 2020.

#### 62 Day Cancer Waiting Times Standard

The 85% target has been achieved for quarter four 2019/20 and for March, at 86% (final validation via national system 6 May 2020). There were six accountable breaches, made up of twelve half breaches.

The breach details are as follows:

Day into CCO	Days @ CCC	Treated on Day	Tumour	Referring Trust	Treatment	Reason	Avoidable Breach
<b>2WW breach to CCC: 14 days to 1<sup>st</sup> app</b>							
No 2ww Breaches							
<b>Full breach to CCC: Patient received by CCC before day 38 but not treated within 24 days</b>							
No Full breaches							
<b>Half breach to CCC: Patient received by CCC after day 38 and not treated within 24 days</b>							
44	27	71	H&N	LUH (Aintree)	Radical RT	Delay due to dental capacity	Yes



Day into CCO	Days @ CCC	Treated on Day	Tumour	Referring Trust	Treatment	Reason	Avoidable Breach
80	35	105	LGI	COC	Radical RT	Delayed for medical reason as patient required admission to referring trust for unrelated medical condition	No
76	44	120	H&N	COC/ LUH (Aintree)	Radical RT	Patient choice – thinking time as patient requested follow up appointment as unsure about treatment. Patient Dna'd planning appointment and choice of planning and treatment dates	No
43	33	76	H&N	LUH (RLH & Aintree)	Radical RT/ Chemo	Dental capacity and medical recovery for teeth extractions	Yes
58	33	81	H&N	WHH/ LUH (Aintree)	Radical RT	Patient choice as patient requested teeth extraction at own dentist	No
73	25	98	LGI	LUH (RLH)	Neo-Adj RT	Delay to 1 <sup>st</sup> appointment and radiotherapy was required to start one week prior to surgery for optimal treatment outcome	Yes
46	27	73	H&N	Wirral	Radical RT	Delay at referring trust for insertion of feeding tube for nutritional support during treatment and slight delay to dentist appointment due to capacity	Yes
99	28	127	H&N	SORM/ LUH (Aintree)	Radical RT	Patient choice due to thinking time and a change in treatment plan dose due to COVID-19	No
49	71	120	Lung	Whiston	Curative RT	Medical reason as patient required cardio assessment and re-positioning of pacemaker prior to starting radiotherapy treatment	No
54	27	73	H&N	WHH/ LUH (Aintree)	Radical RT/ Chemo	Medical recovery teeth extraction	No
41	26	67	LGI	COC	Neo-adj RT/ Chemo	Delay to radiotherapy as patient Category 1 and required treatment to commence on a Monday	Yes
51	26	77	Lung	Whiston	Palliative RT	Delay to radiotherapy due to treatment machine breakdown	Yes
<b>28 FDS Breaches (February data)</b>							
48		68	Haem	LUH	Chemo	Late referral to CCC (day 48), re listed for MDT as sample not received by HODs	Yes
0		59	Haem	GP	Ruling out of cancer	Delay to diagnostics MRI	Yes

Day into CCC	Days @ CCC	Treated on Day	Tumour	Referring Trust	Treatment	Reason	Avoidable Breach
57		100	Haem	LUH	Pall care	Late referral to CCC (day 57) and admin as delay in sample being passed to HODs	Yes
0		52	Haem	GP	Ruling out of cancer	Admin delay; appointment booked for after target date.	Yes

#### Quarter 4 (2019/20) 62 Day breaches by tumour group (subject to final validation)

62 Day - CLASSIC									
Tumour Group	Breaches	Accountable Breaches	Hits	Accountable Hits	TOTAL	Accountable TOTAL	PreAllocated %	Allocated %	Allocated Performance
Lung	14	3.5	57	31	71	34.5	80.28%	89.86%	
Breast	1	0	48	25	49	25	97.96%	100.00%	
Urological (Excluding Testicular)	38	0.5	8	7	46	7.5	17.39%	93.33%	
Head and Neck	24	6.5	20	13	44	19.5	45.45%	66.67%	
Lower Gastrointestinal	24	3	16	10	40	13	40.00%	76.92%	
Upper Gastrointestinal	24	1.5	14	7.5	38	9	36.84%	83.33%	
Gynaecological	14	0.5	3	2.5	17	3	17.65%	83.33%	
Haematological (Excluding Acute Leuka...)	7	3	5	2.5	12	5.5	41.67%	45.45%	
Sarcoma	1	0	6	4.5	7	4.5	85.71%	100.00%	
Other	3	0.5	3	2.5	6	3	50.00%	83.33%	
Testicular	0	0	1	0.5	1	0.5	100.00%	100.00%	

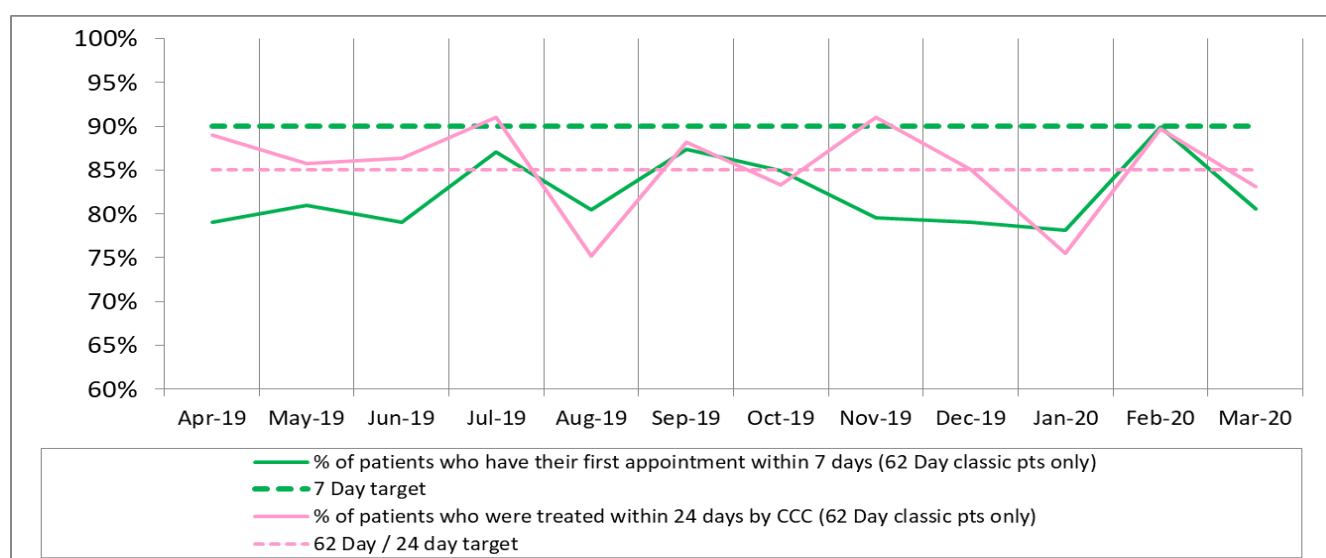
#### 24 Day and 7 Day Performance (Internal Targets)

CCC continues to monitor 7 day (to first appointment) and 24 day (to treatment) performance for patients on a 62-day pathway. These are internal targets that aid breach avoidance for the whole system.

The 7 day KPI for March 2020 is at 80.6% against a stretch target of 90%

The 24 day KPI for March 2020 is at 83.1% against a stretch target of 85%.

The 24 day and 7 day performance can be seen in the following graph:



Performance for April 2020 2WW and 24 day targets will be impacted by COVID-19. We have 2WW breaches due to patient choice of appointment dates and 24 day breaches due to capacity

to first/planning (CCCA) appointments. Chemotherapy treatment is on hold for some patients due to COVID (decision based on risk benefit) so there will be future breaches in pathways.

## 28-day Faster Diagnosis Standard (FDS)

The performance threshold for the cancer 28-day faster diagnosis standard will initially be set in the range between 70% and 85%, with a phased increase in future years if appropriate, subject to the recommendations of the Clinical Review of Standards

NHSE have advised that although data will still be recorded by NHS Digital, formal performance monitoring of the 28-day Faster Diagnosis Standard (which was due to come into effect from Wednesday 1<sup>st</sup> April 2020) will be delayed due to the COVID-19 pandemic.

In February 2020 3 patients achieved the 28 day FDS target and 4 breached the target due to administrative factors (samples not received by HODs, delay to first appointment and delay to diagnostics MRI) and late referral to CCC. The breach reasons for March 2020 breaches will be presented in the Month 1 2020/21 report.

## Patients treated on or after 104 Days

In March 2020, 12 patients were treated after day 104; referred between day 76 and 216 to CCC. Four patients were not treated within twenty-four days by CCC due to patient choice and medical reasons (admission to referring trust with unrelated medical condition and cardio/Pacemaker assessment).

## Cancer Waiting Times Improvement Plan:

Key actions are underway as part of the Improvement Plan including:

- Continued review of dental capacity and radiotherapy pathway.
- Cancer waiting times target awareness/refresher sessions available for all staff.
- A number of 24 day awareness sessions have been held and continue to be available to all staff.

### 3.1.2 Clinic Waiting Times

The table below shows the percentage of patients waiting for fewer than 30 minutes, 30-60 minutes and more than 60 minutes for their outpatient appointment at the Wirral site, for Delamere Daycase Unit and for the Trust's peripheral clinics. Scoping of clinic wait times and implementation of service improvement has achieved the internal Trust target of 80% of patients seen within 30 minutes with targets met in each area for March 2020.

	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend
CCC Outpatients Wirral: % Seen within 30 minutes	80%	86.0%	82.0%	80.4%	86.5%	82.6%	80.3%	85.1%	82.7%	84.2%	83.1%	83.5%	84.7%	
CCC Outpatients Wirral: % Seen between 31 and 60 minutes		8.0%	10.8%	10.6%	7.2%	9.7%	10.6%	8.9%	10.0%	8.6%	8.4%	10.4%	8.3%	
CCC Outpatients Wirral: % Seen after at least 60 minutes		5.0%	7.0%	9.0%	6.3%	7.6%	9.1%	6.1%	7.4%	7.2%	8.4%	6.2%	7.0%	
Delamere: % Seen within 30 minutes %	80%	81.3%	83.0%	81.4%	82.3%	82.6%	81.3%	80.4%	80.9%	83.3%	85.3%	85.4%	84.7%	
Delamere: % Seen between 31 and 60 minutes %		10.3%	9.6%	9.4%	9.3%	9.8%	10.2%	10.6%	11.1%	9.2%	7.6%	8.7%	8.6%	
Delamere: % Not seen within 60 minutes		8.4%	7.7%	9.2%	8.5%	7.6%	8.5%	9.0%	8.0%	7.5%	7.2%	5.9%	8.5%	
Outpatient peripheral clinics: % Seen within 30 minutes	80%	88.7%	85.0%	85.3%	88.7%	89.4%	88.9%	88.3%	89.9%	86.1%	89.5%	89.6%	91.4%	
Outpatient peripheral clinics: % Seen between 31 and 60 minutes		8.0%	8.5%	6.9%	7.5%	7.8%	7.5%	7.9%	6.6%	7.4%	6.5%	7.2%	6.0%	
Outpatient peripheral clinics : % Not seen within 60 minutes		3.3%	4.3%	7.8%	3.8%	2.8%	3.5%	3.8%	3.5%	6.4%	4.0%	3.2%	2.7%	

### 3.1.3 Inpatient Flow

## Length of Stay: Wirral Wards

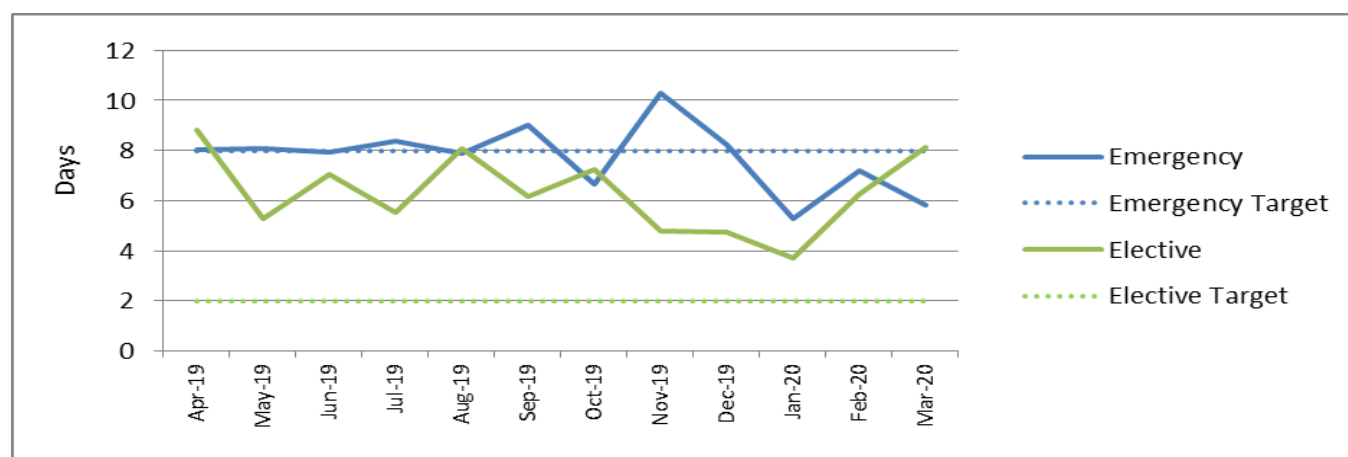
The trust target for non-elective LoS is 8 days. The non-elective LoS for March 2020 is on target at 5.82 days.

The trust target for elective LoS is 2 days (6.5 days from April 2020). The elective LoS for March 2020 is above target at 8.2 days.

Patient Flow Team continue to work hard to reduce length of stay and be in control of the flow of patients, ensuring quality of care and reducing delays in care delivered. The daily COW MDT board round is proving successful with all patients being discussed each morning.

In response to the COVID-19 pandemic there is now an additional MDT discussion meeting held each day at 8:30am. The directorate has also replaced the weekly LLOS meeting with a daily Discharge Planning progress meeting, with senior management involvement three times a week. This provides an opportunity to escalate and highlight any concerns or delays.

Elective admissions with a length of stay <1 day are no longer recorded in monthly reporting.



## Length of Stay : Haemato-Oncology – Ward 7Y

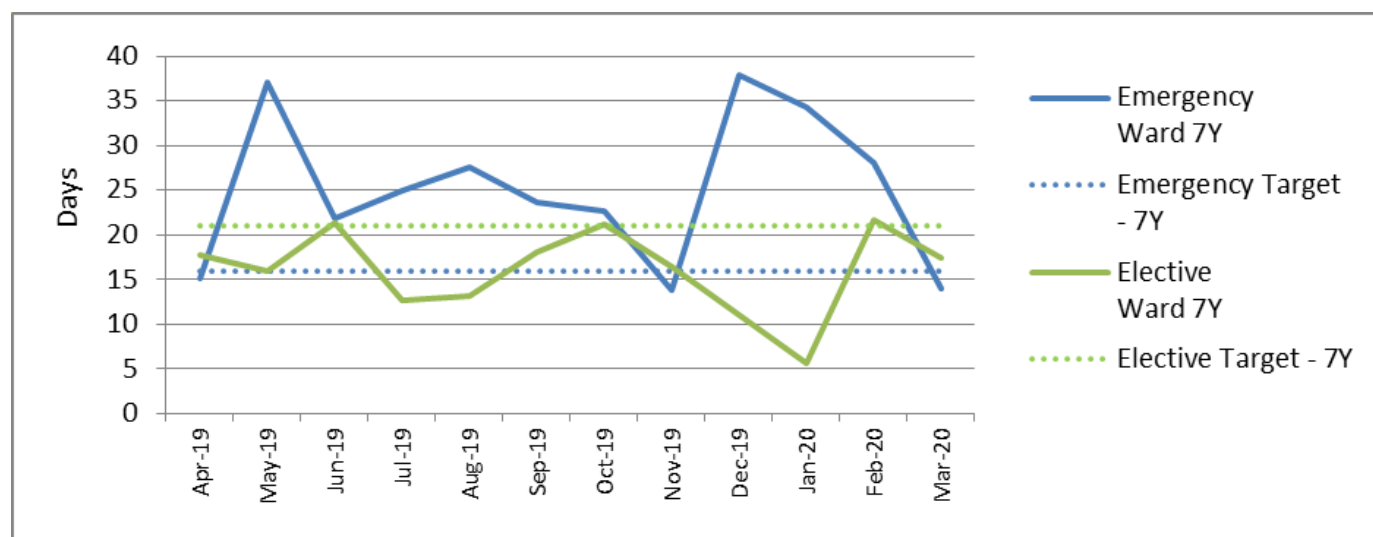
The average LoS for March 2020 for both elective and emergency admissions to Ward 7Y are within the target number of days.

The directorate continues to develop improvement initiatives to continuously improve pathways and length of stay, this includes ambulatory care models within higher intensity pathways.

A paper presented at the March 'Quality Committee' outlined one such model; the proposal to reduce length of stay through developing an ambulatory care within the autologous stem cell pathway.

Due to current consultant capacity the intention is that the new SCT Programme Director will take forward this improvement together with the clinical team following the service move to the new CCCL. This will be managed together with the development of the stem cell late effects service as a service improvement project. These projects will report through the appropriate governance framework.

This chart shows the LoS and targets for HO Ward 7Y for the last 12 months.



### Bed Occupancy: Wirral Wards

During the month of March there were no days of Black or Red bed status. The majority of the days were on Green bed status, with 4 occasions recorded on Amber. Bed status is currently recorded twice a day, excluding weekends.

Bed Occupancy has been low on both wards during March with an average occupancy of 65%, below the Trust target of 80-85%.

This can be explained by the actions taken in response to COVID-19 pandemic, including:

- Reduced planned activity.
- Daily discharge progress meetings, with support from the wider MDT, to ensure patients are discharged to a suitable, safe care setting as soon as possible.

CUR Non-Qualifying rate for March was 8%. There were 10 delayed transfers of care for March, both within target and expected within the directorate.



### Clinical Utilisation Review (CQUIN)

The non-qualified review target was achieved in March, with only 8.1% of inpatients assessed as not meeting the CQUIN inpatient criteria. Compliance with the CQUIN KPI requires achievement of fewer than 10% of reviews not meeting the criteria by March 2020; the 8.1% monthly performance therefore results in the achievement of this KPI for 2019/20. All delayed discharges are reviewed at the weekly LoS meeting, with allocated actions feeding into the CUR service improvement plan. Performance against CQUIN targets is also monitored at quarterly steering groups and monthly CQUIN lead meetings.

Due to system issues, until HO inpatients are managed on Meditech, this initiative reviews patients on Wirral wards only.

### 3.1.4 Radiology Reporting

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

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend
Imaging reporting turnaround: inpatients within 24 hours	G: =>90%, A: 80-89%, R: <80%	68.1%	73.7%	82.3%	75.8%	68.1%	72.0%	73.5%	73.6%	89.0%	79.4%	84.2%	91.9%	
Imaging reporting turnaround: out patients within 7 days		55.8%	79.0%	71.9%	65.9%	59.0%	63.9%	75.1%	80.8%	95.1%	95.5%	85.8%	86.7%	

Additional reporting capacity is now in place from the outsourcing company and increased number of visiting radiologist PAs from other Trusts.

An additional radiologist was recruited in December, however they will not commence in post for several months. Further interviews will take place for another radiologist, however this is now postponed due to the COVID 19 pandemic.

The inpatients' target of 90% within twenty four hours was achieved (91.9%). Work is continuing to ensure the correct urgency codes are used at all times for inpatient plain x-ray.

The outpatient target has shown a slight increase since February from 85.8% to 86.7%. There is a high reliance on the outsourcing company for outpatient reports; this will remain as we have a reduced locum capacity. Turnaround times are closely monitored and at the review meeting held this month we raised our concerns regarding slower turnaround times with the company.

### 3.1.5 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 Chemotherapy Directorate consistently achieve the target.

Data for 2019/20 to date is displayed in the table below:

	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Patients travelling 45 minutes or fewer to their clinic appointment.	90%	98%	96.4%	96.7%	97.9%	97.2%	97.0%	98.0%	97.5%	97.0%	97.0%	97.2%	96.0%

## 3.2 Quality

### 3.2.1 CQUINS

CQUINS for Q4 and 2020/21 have been stood down due to Covid -19. The CCG have agreed to support payment for Q4.

### 3.2.2 Never Events

There have been nil never events from 1<sup>st</sup> April 2019 to 31<sup>st</sup> March 2020.

### 3.2.3 Incidents

During March 2020 there were a total of 236 incidents reported across the Trust. None were reported as causing moderate or severe harm.

Level of Harm	
The level of harm was recorded as:	No. Incidents
None	210
Low	26
Moderate	0
Severe	0

The Trust declared a Serious Untoward Incident during March (the incident itself occurred in February) – a patient was discharged without filgrastam injections and was subsequently admitted to an acute hospital with neutropenic sepsis. A full root cause analysis investigation is currently ongoing.

### 3.2.4 Health Care Acquired Infections

#### Gram Negative Bacteraemia

There was one E.coli bacteraemia in March 2020 (at CCCHO) for which a detailed review will be completed. The annual threshold of 10 for 2019/20 has however been achieved, with 8 in total.

We continue to participate in the E.coli Cancer Collaborative initiatives which support and strengthen changes in practice. Regular reminder prompts are issued to all clinical staff regarding the timely collection of microbiology samples. Post infection reviews are undertaken to identify any potential causes as well as any risks, lapses in care and lessons for future patients.

#### Clostridioides difficile Infections (C. difficile)

There was one reported case in March 2020 (at CCCW) for which a detailed review is to be undertaken. Preliminary findings indicate that appropriate treatment and processes were followed. This will be further explored and confirmed following the review.

As previously reported, the new criteria for allocating C. difficile infections to acute Trusts were retrospectively applied to our patients. There have been 14 cases YTD, 11 of these cases are attributable to CCC. The annual threshold of 4 for 2019/20 has therefore not been achieved.

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).

Current C. difficile reportable cases - cases highlighted in blue are attributed to CCC <i>Clostridioides difficile</i>	March 2020	Total
Actual COHA	0	2
Actual HOHA	1	9
Actual COIA	0	2
Actual COCA	0	1
<b>Annual Total (All sites)</b>		<b>14</b>



## MRSA

There was one MRSA bacteraemia in March 2020 (at CCCW) for which a detailed review will be completed. The annual target of 0 for 2019/20 has therefore not been achieved.

Preliminary findings indicate that appropriate treatment and processes were followed. This will be further explored and confirmed following the detailed review. Post infection reviews are undertaken to identify any potential causes as well as any risks, lapses in care and lessons learned for future patients.

There were no cases of MSSA, Pseudomonas or Klebsiella in March 2020. The 2019/20 targets have been achieved for all except Pseudomonas; for which there have been 8 cases against a threshold of 5.

### 3.2.5 Sepsis

The antibiotics within 1 hour target was not met for March, at 97.9% (39/40 patients for Wirral wards and 8/8 patients for HO wards).

The one hour target was missed for one patient. In this case, the sepsis diagnosis was made at 20.36 hrs and the IV Antibiotics were given at 05.44 hrs the following morning. No reference was made in the nurse's documentation regarding sepsis and no care plan was completed by nursing staff. The Sepsis screening tool was completed by the medic.

Compliance with use of the sepsis screening tool was 77% (34/44) for March. All except one patient that required screening was clinically assessed, diagnosed and treated appropriately in a timely manner.

Compliance with the 72 hour Antibiotic review was 100% (38/38) for March.

Actions taken to improve compliance include:

- Ward leaders to hold face to face briefing with staff involved in any misses. Investigation to be conducted and fed back to Deteriorating Patient Steering Group (DPSG).
- Improvements in communications via handover/ regular huddles – electronic ACT/ANP/ACT - 24/7.
- Board round attended daily by Acute Care Team to identify and follow up sepsis patients.
- Education:
  - Face to face sessions (including medic induction) and e-learning, plus at MET calls and ward based education.
  - Clinical Band 6s and above completion of Sepsis competency passport.
  - Sepsis champions identified in all areas.
  - CCC screensaver of the new Sepsis 6 due to be launched.
  - Visual prompts created and displayed in appropriate areas.
- Networking with other Trusts, RCUH, STHK, SEPSIS TRUST UK.
- Default start time for intravenous antibiotics removed from Meditech, to eradicate risk of missed dose.
- Sepsis medication order sets in process of being built to expedite treatment times, in line with WUTH formulary until May 2020 then new build for post May with RLUH formulary.
- Datix completed for any delay in treatment and non-compliances of documentation on Meditech.



### 3.2.6 Consultant Review within 14 hours (emergency admissions)

The target has been met for CCC, with 100% on CCCHO wards and 98% on CCCW wards, against the trust target of 90%.

At CCCW, two patients were missed:

- Patient 1 was discussed with Registrar and the appropriate management plan was in place. The patient was reviewed on the Consultant ward round the following morning. The reason for this delay is unclear, however there is no evidence to suggest this delay resulted in harm to the patient.
- Patient 2's care was discussed with the patient's own Oncologist via email and a management plan was in place. The patient was reviewed on the Consultant ward round the morning after the day of admission. The reason for this delay to consultant review is unclear, however there is no evidence to suggest this delay resulted in harm to the patient.

All emergency admissions are discussed at medical handover and are prioritised for Consultant review.

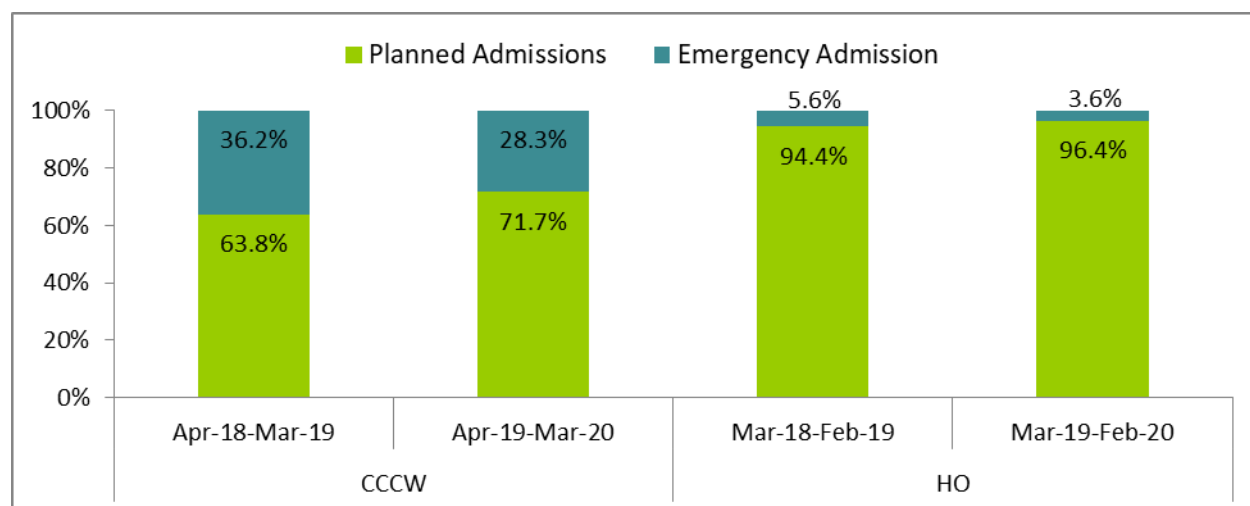
### 3.2.7 Safer Staffing

The Trust's mandated monthly submission of staffing (headcount) levels to NHS Choices/Unify website presented an overall % fill rate of 90% (of planned inpatient staffing levels against actual staffing levels for the month of March 2020), against an accepted national level of 90%.

### 3.2.8 Clinical Outcomes

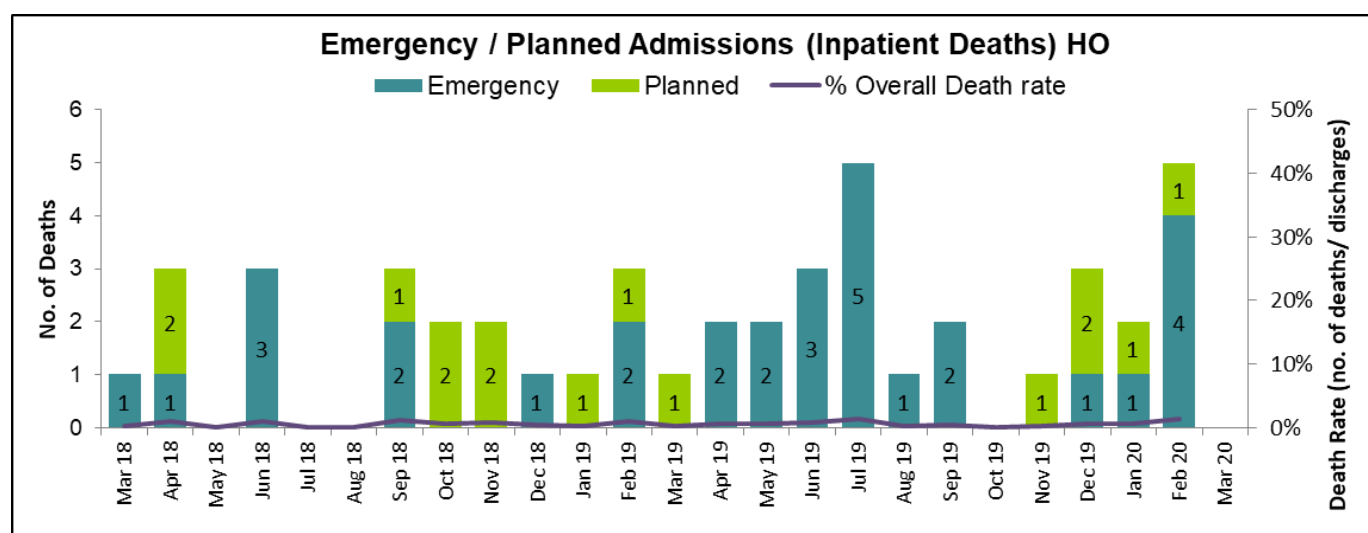
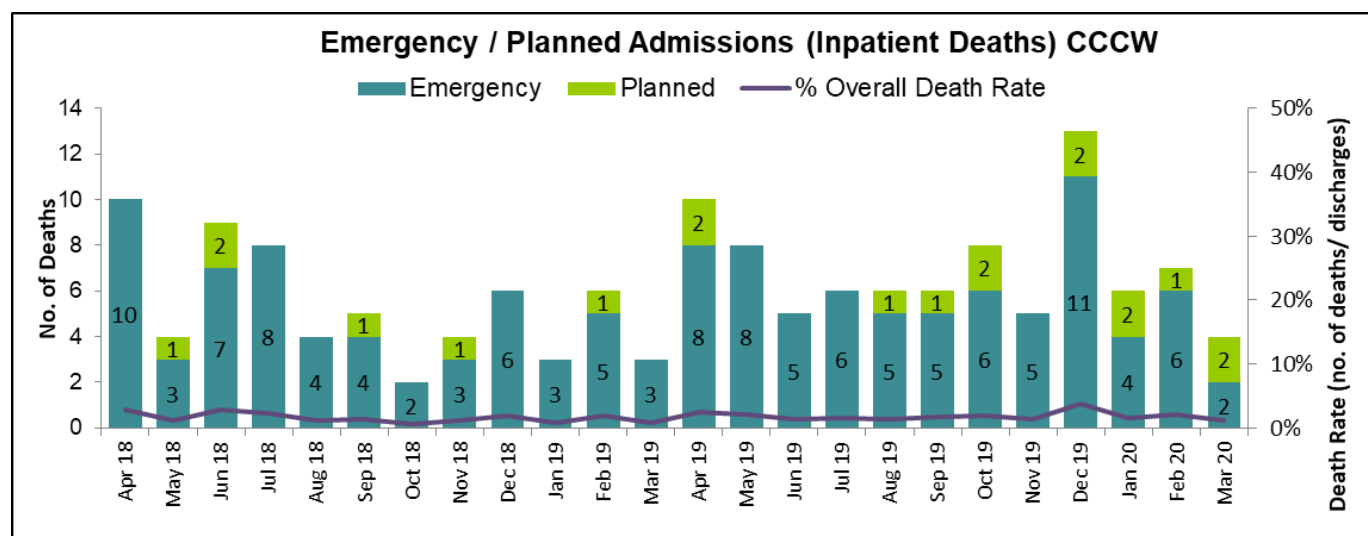
#### Mortality Review:

The chart below illustrates the planned and emergency admission proportion for CCCW and CCCHO. It shows that HO has lower emergency admission proportion than CCCW; 96.4% were planned admissions.



\*HO IP CDS 1 moth behind CCC

This chart shows the monthly inpatient death figures based on method of admissions (planned and emergency) and an overall percentage death rate. December 2019 may appear to demonstrate a spike in deaths; however, it has not been highlighted as an outlier using statistical control software.

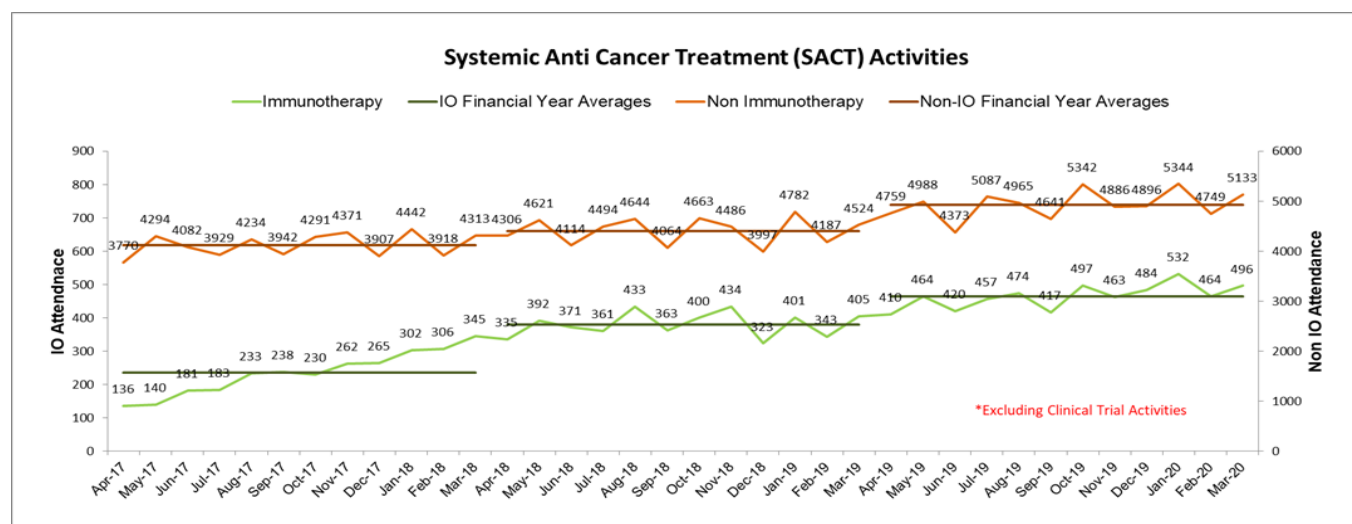


\*HO IP CDS 1 month behind CCC

### 30 day Mortality Analysis:

The next analysis will be presented in the month 2 report.

## Immunotherapy Activities



### IO activity splits by tumour group and home treat

The data will be presented in this way in the online dashboards, which are in development.

### Outcome Dashboard

First draft dashboard completed: head and neck, upper GI, Lung, Breast, Skin and Palliative care, Gynaecological, Colorectal, CNS.

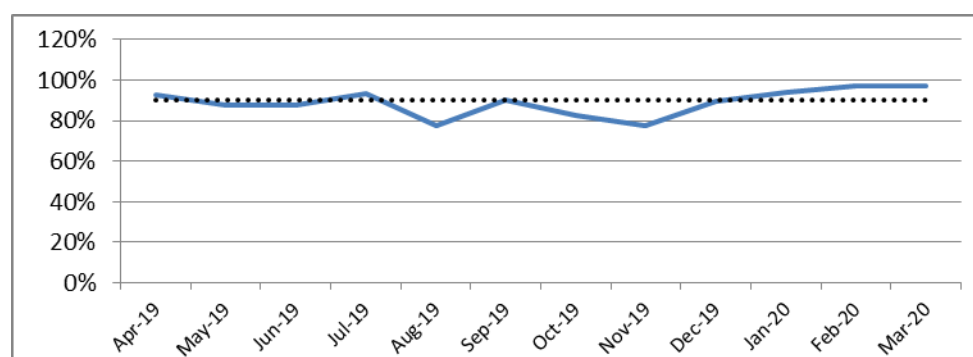
Urology: 80% complete

AO/unknown primary: Development on hold as the Chair of the SRG has stepped down and a new one is awaited.

Specialist SRG: 0% complete. There has been a delay in the development of the outcome dashboards due to the complexity and volume of data.

## 3.2.9 Patient Experience

### Partners in Care Assessments



The 'Partners in Care' initiative enables patients to choose a family member or close friend to become a member of their care team; assisting their relative/friend with the extra help and support they need. The figures for March 2020 show the target of 90% was achieved.

## Friends & Family Test

Zero postcards were received in March 2020. The digital system was not accessible in early April to enable the download of inpatient or outpatient figures for March.

The overall score for outpatients was 99% from 145 responses, down from 559 in February. The significant reduction in responses and inability to access the e-responses held by an external company can be attributed to the impact of the COVID-19 pandemic.

## Complaints

Since April 2019, 32 formal complaints have been received into the trust, with 24 completed and closed.

During March 2020 there were 4 new formal complaints received into the Trust:

ID	Description	Date Received	Date due	Date completed
96	Letter received from pts MP regarding a failure to provide a palliative package of care on discharge.	21/02/2020	20/03/2020	Delayed within directorate
98	Pt waited 2 weeks for an urgent referral and received poor prognosis over the telephone.	27/03/2020	23/04/2020	
100	Lack of SALT referral during treatment.	30/03/2020	24/04/2020	
101	MP requested information regarding pathway breaches for west Lancashire patients.	19/03/2020	20/04/2020	01/04/2020

During March 2020 there were 2 formal complaints closed:

ID	Description	Lessons Learned	Completed within timescale
83	Referral to The Christie Hospital had not been completed and cannula was not removed on leaving the imaging department.	Imaging department have changed their practice for removing cannulae following imaging procedures.	No – delay was in gaining information from The Christie Hospital, patient was kept informed.
92	Complaint regarding refusal to have access to late fathers medical records and allegation of abuse of late father by family members whilst in the care of the Trust.	None – complaint not upheld.	No – delay in gaining witness statements from staff as incident happened 10 years ago.

One case was reviewed by PHSO but was not upheld.

### 3.2.10 Inquests & Litigations

#### Inquests

The Trust was notified of one new Inquest during March 2020 resulting in a total of 6 open Inquests. The Trust provided evidence at one Inquest in March 2020 which has been adjourned until a date to be determined in September 2020.

#### Litigation

The Trust has a total of 11 ongoing claims in clinical negligence in addition to 8 Employer's liability claims and 1 public liability claim.

## 3.3 Research and Innovation

### 3.3.1 Achievement Highlights for February 2020

#### Recruitment

- CCC is the first Centre globally to recruit a CNS patient to the RAGNAR study. This case is of significant interest to study team and beyond. The patient was recruited within the 30 day target (13 days). (Principal Investigator: Professor Dan Palmer, CNS).
- CCC was the highest recruiter for OPTIMA in February 2020. This was detailed in their March 2020 Newsletter. (Principal Investigator: Professor Palmieri, Breast).

#### Feedback

- The Urology team received feedback from a patient who took part in the Source Trial (Principal Investigator: Dr Richard Griffiths, Renal). The patient said:

*"Myself and my wife would like to thank Dr Griffiths and the trial team for looking after me when I joined the trial. As you can imagine, we were somewhat shell shocked and panicky after I had my kidney removed, and we didn't know how to move forward. The literature that we received about the trial was very informative and we had everything explained to us if we had any questions or concerns. At the time the actual length of the trial seemed a bit daunting, but the time flew by and I felt quite well. All in all, I had a positive experience throughout."*

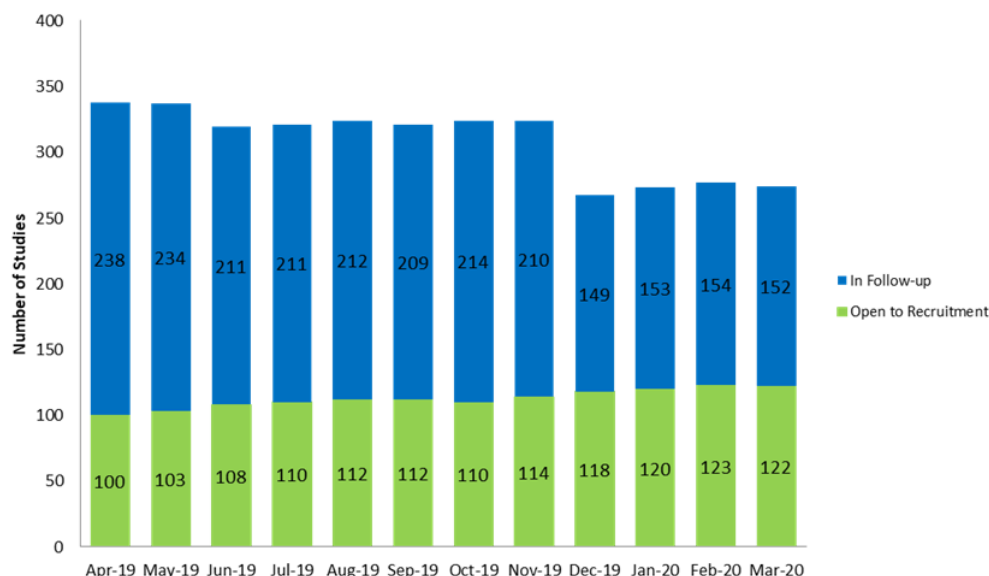
- Josh received some feedback from the Operations and Transformation Manager for Chemotherapy at CCC. They said:

*"Please can I highlight a member of your staff 'Josh' he is always so helpful a true team player. This morning we needed an extra hand in phlebotomy because we are trying to move patients through quickly with the Covid-19 situation. Josh helped out with no questions asked. He is a breath of fresh air."*

### 3.3.2 Activity by Month – Studies Open to Recruitment and in Follow-up

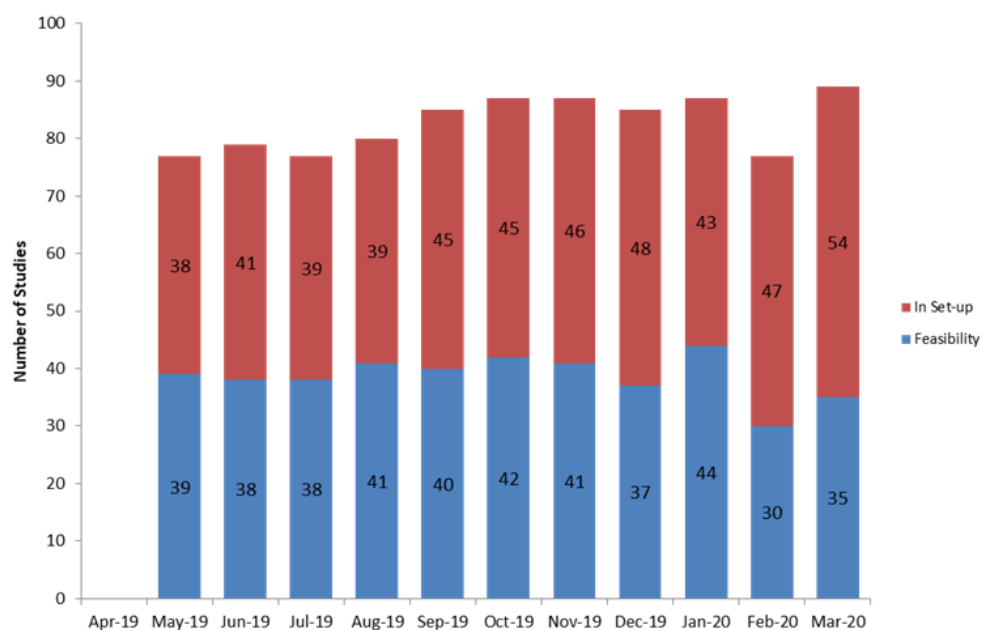
The trend shows the number of actively recruiting studies has decreased by one this month. Overall there has been a 22% increase in trials actively recruiting since start April 2019 with no increase in staffing levels. Studies in follow up have decreased by two. The decrease of studies in follow up from December 2019 is due to the following reasons:

- Planned data cleanse of EDGE to ensure studies are still in follow-up and not actually closed.
- Number of historical studies which had not been closed off.
- Further cleansing is still to take place so number may reduce further.



### 3.3.3 Studies in Pipeline

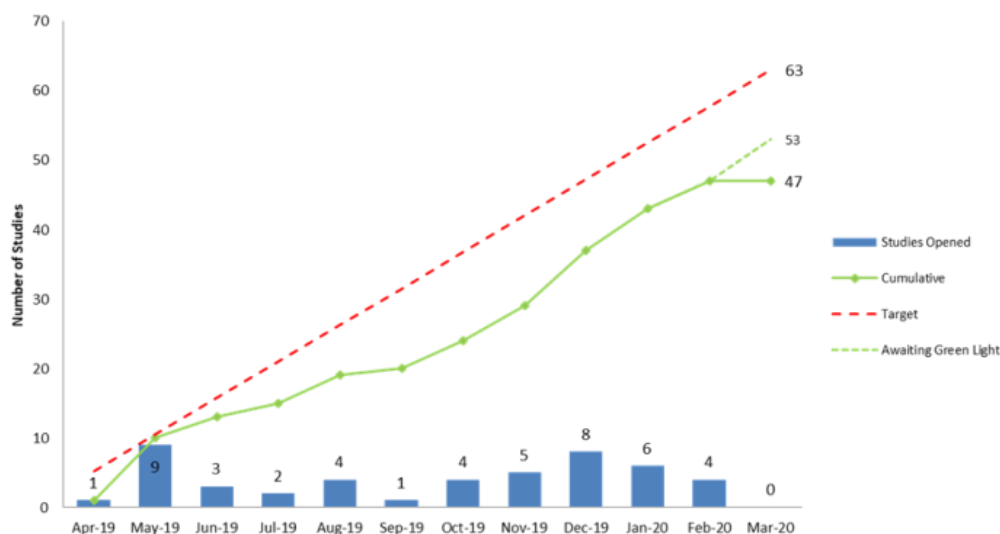
The number of studies in set-up has increased by seven while studies in feasibility has increased by five.



### 3.3.4 Number of New Studies Open to Recruitment

In light of the Covid-19 pandemic a temporary halt was put on opening new research studies to recruitment on 16<sup>th</sup> March 2020.

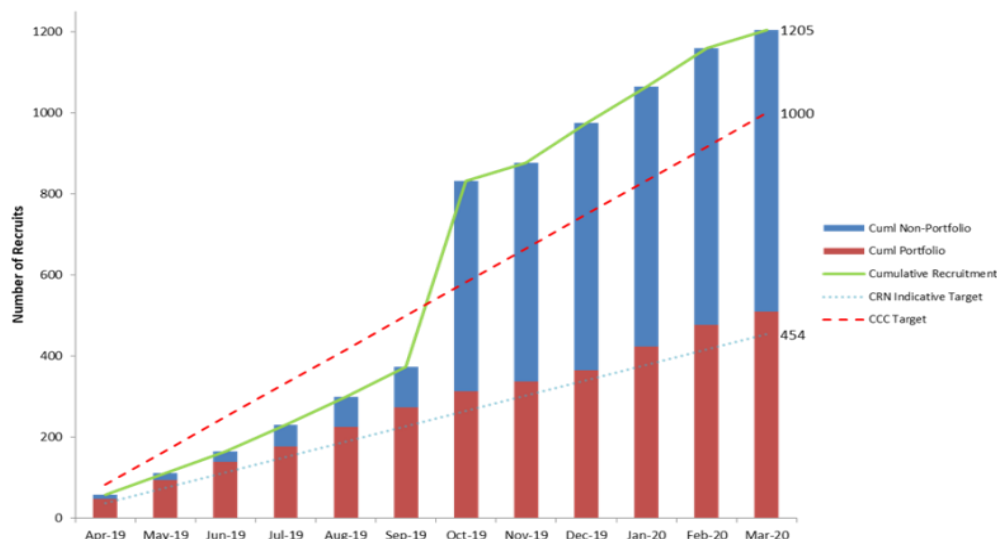
Forty-seven studies have been opened against an internal target of sixty-three at this point. There were six studies which had been locally approved and could be opened following sponsor approval and once the temporary has been lifted. Combined this gives a total of fifty-three studies either opened or are ready to open. The target set at the beginning of the year has not been met. However, the internal and external recruitment targets have been met which is more indicative of activity.



### 3.3.5 Monthly Recruitment

To note: In light of the Covid-19 pandemic recruitment of new patients to research trials was temporarily halted on 16<sup>th</sup> March 2020.

In spite of this we met the external target (n=454) for recruitment onto portfolio studies. We have recruited 504 patients at Month 12 which is 11.1% above target. We also met the internal target of 1000 participants recruited onto all studies. We have recruited 1205 participants on to research studies at the end of Month 12, which is 12.1 % above target.



	01 Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	16 Mar-20
Portfolio	48	46	46	38	47	48	40	24	29	58	54	32
Non-Portfolio	10	7	9	26	23	26	418	21	69	32	41	13
Total	58	53	55	64	70	74	458	45	98	90	95	45

Reviewing the split between interventional, observational and biobank studies, observational and biobank studies have exceeded their target at 152.0% and 102.4% respectively. Interventional studies achieved 98.0% compliance by 16<sup>th</sup> March 2020 when recruitment halted.

	Actual at End 03/20	Target at End 03/20	% Target End 07/19	% Target End 08/19	% Target End 09/19	% Target End 10/19	% Target End 11/19	% Target End 12/19	% Target End 01/20	% Target End 02/20	% Target End 16/03/20
Interventional	383	391	95.4	98.2 ▲	101.8▲	101.8 ▲	94.2 ▼	94.2 ►	96.6 ▲	101.1 ▲	98.0 ▲
Observational	608	400	46.6	51.5 ▲	48.5 ▼	212.0 ▲	190.2 ▼	183.0 ▼	173.0 ▼	162.6 ▼	152.0 ▼
Biobank	214	209	62.9	62.1 ▼	74.6 ▲	86.9 ▲	90.6 ▲	96.2 ▲	100.0 ▲	104.7 ▲	102.4 ▲
Total	1205	1000	69.0	72.0 ▲	74.8 ▲	142.7 ▲	131.5 ▼	130.0 ▼	127.9 ▼	126.5 ▼	120.5 ▼

- Interventional studies – 98.0% of target at 16<sup>th</sup> March 2020
- Observational studies – 152.0% of target at 16<sup>th</sup> March 2020
- Biobank studies – 102.4% of target at 16<sup>th</sup> March 2020

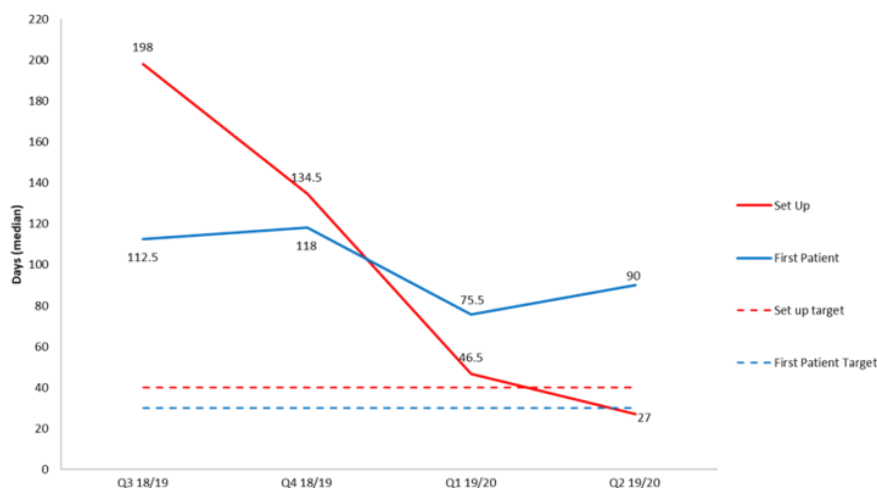
### 3.3.6 Study Set Up Times

A reduction in set-up times from 46.5 days (median) to 27.0 days (median) has been achieved for the most recent submission to the Department of Health. Target met. Recruitment of our first patient has increased from 75.5 days (median) to 90 days (median) but is still below Q3 and Q4 18/19 data.

Q3 19/20 data were submitted at End January 2020, it was anticipated that data would be returned in March 2020. We have not yet received the data, this delay maybe due to the pandemic.

We have received notification from the Department of Health that in light of the Covid-19 pandemic they are postponing the submission and publication deadline for the Performance in Initiating and Delivering (PID) Q4 reporting exercise. They will keep future reporting deadlines under review and when appropriate they will set a new deadline for reporting of all outstanding data in consultation with NHS R&D and NHS England and NHS Improvement.





Set-up data will continue to be monitored internally as shown in the table below:

### CCC Monitored data:

Time period	Median Set-up (days)	Study Count
Apr - Jun 2019	30	10
July – Sept 2019	10	11
Oct – Dec 2019	30	18
Jan - Mar 2020	34	9

## 3.4 Workforce

### 3.4.1 Workforce Overview

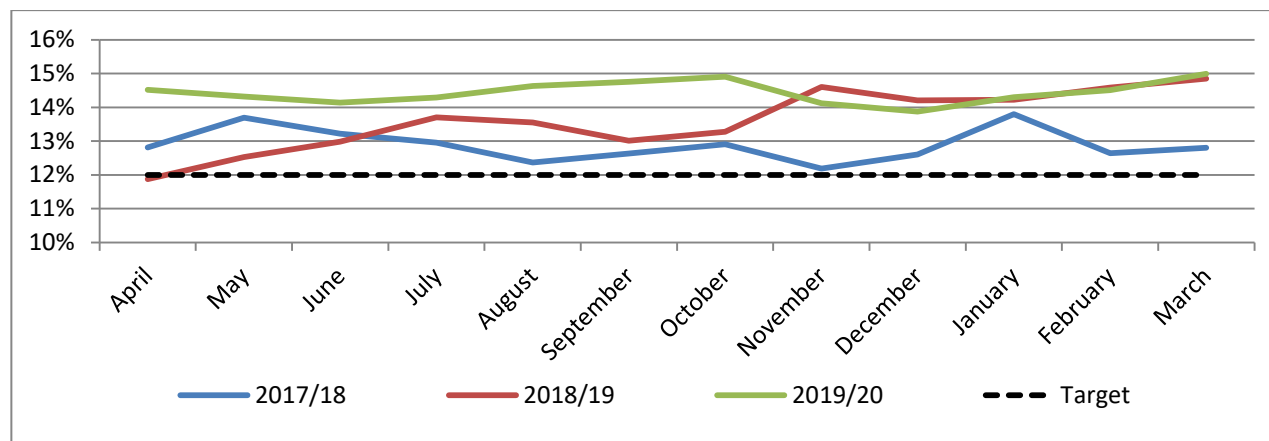
This table presents an overview of staff numbers and movement by month.

	2019 / 04	2019 / 05	2019 / 06	2019 / 07	2019 / 08	2019 / 09	2019 / 10	2019 / 11	2019 / 12	2020 / 01	2020 / 02	2020 / 03	Trend
Headcount	1,335	1,337	1,342	1,338	1,337	1,357	1,390	1,406	1,409	1,423	1,420	1,440	
FTE	1,214.88	1,217.14	1,220.44	1,214.75	1,219.28	1,238.47	1,269.86	1,283.40	1,287.95	1,297.91	1,293.37	1,312.44	
Leavers Headcount	11	24	13	18	25	15	11	16	14	22	20	19	
Leavers FTE	10.15	20.21	11.84	15.10	21.96	13.74	10.32	13.76	13.12	21.12	17.93	16.49	
Starters Headcount	37	23	18	17	24	37	40	34	15	30	22	38	
Starters FTE	36.07	21.02	16.28	15.53	23.72	34.56	37.48	30.18	14.36	27.52	20.22	33.81	
Maternity	47	49	47	46	41	42	43	39	36	34	34	36	
Turnover Rate (Headcount)	0.80%	1.74%	0.94%	1.30%	1.81%	1.09%	0.80%	1.16%	1.01%	1.59%	1.45%	1.38%	
Turnover Rate (FTE)	0.81%	1.61%	0.94%	1.20%	1.75%	1.09%	0.82%	1.10%	1.04%	1.68%	1.43%	1.31%	
Avg Headcount	1,380.00	1,380.00	1,380.00	1,380.00	1,380.00	1,380.00	1,380.00	1,380.00	1,380.00	1,380.00	1,380.00	1,380.00	
Average FTE	1,256.03	1,256.03	1,256.03	1,256.03	1,256.03	1,256.03	1,256.03	1,256.03	1,256.03	1,256.03	1,256.03	1,256.03	
Leavers (12m)	195	197	193	199	208	207	204	201	198	203	209	208	
Leavers FTE (12m)	169.87	171.28	167.21	170.82	179.26	179.36	176.93	173.13	171.38	177.78	184.32	185.75	
Turnover Rate (12m)	15.00%	15.17%	14.83%	15.24%	15.93%	15.63%	15.20%	14.88%	14.62%	14.89%	15.28%	14.99%	
Turnover Rate FTE (12m)	14.39%	14.51%	14.15%	14.41%	15.09%	14.87%	14.48%	14.09%	13.90%	14.34%	14.82%	14.70%	
Avg Headcount (12m)	1,300.00	1,299.00	1,301.00	1,306.00	1,305.50	1,324.50	1,342.50	1,350.50	1,354.00	1,363.50	1,368.00	1,387.50	
Average FTE (12m)	1,180.61	1,180.33	1,181.66	1,185.36	1,187.89	1,205.89	1,221.78	1,228.63	1,232.60	1,240.09	1,243.89	1,263.66	

### 3.4.2 Sickness Absence

#### Trust Level

The graph below shows the 12 month rolling sickness absence percentages against a target of 3.5%; it also shows a comparison against the previous 2 years.



#### Directorate / Corporate Service Level

Sickness absence per month and Directorate:

Org L4	2019 / 04	2019 / 05	2019 / 06	2019 / 07	2019 / 08	2019 / 09	2019 / 10	2019 / 11	2019 / 12	2020 / 01	2020 / 02	2020 / 03	Trend
158 Chemotherapy Services Directorate	4.88%	4.08%	3.11%	4.07%	3.73%	4.55%	7.37%	6.56%	5.22%	7.04%	5.38%	7.33%	
158 Corporate Directorate	5.23%	3.70%	3.10%	4.09%	3.95%	3.18%	4.35%	5.41%	4.14%	4.62%	4.49%	4.50%	
158 Education Directorate	0.00%	0.00%	12.49%	0.00%	0.00%	0.00%	9.40%	1.48%	0.00%	3.27%	2.47%	14.26%	
158 Haemato-oncology Directorate	4.33%	3.57%	4.69%	5.13%	4.53%	5.95%	5.34%	2.42%	3.44%	5.03%	3.92%	4.04%	
158 Hosted Service Directorate	0.00%	0.11%	1.55%	1.19%	2.89%	3.80%	3.72%	5.07%	6.76%	6.36%	3.95%	2.46%	
158 Integrated Care Directorate	5.18%	4.38%	4.99%	6.43%	4.61%	5.98%	7.73%	5.57%	6.26%	4.80%	5.07%	5.40%	
158 Quality Directorate	3.39%	1.49%	3.29%	3.80%	5.39%	0.00%	0.38%	1.37%	0.34%	2.90%	4.36%	4.32%	
158 Radiation Services Directorate	3.08%	3.24%	2.94%	3.62%	2.92%	3.06%	2.21%	3.63%	3.02%	3.65%	3.95%	6.70%	
158 Research Directorate	1.12%	2.15%	3.40%	3.98%	1.90%	3.77%	1.33%	4.29%	3.81%	2.40%	5.97%	9.77%	

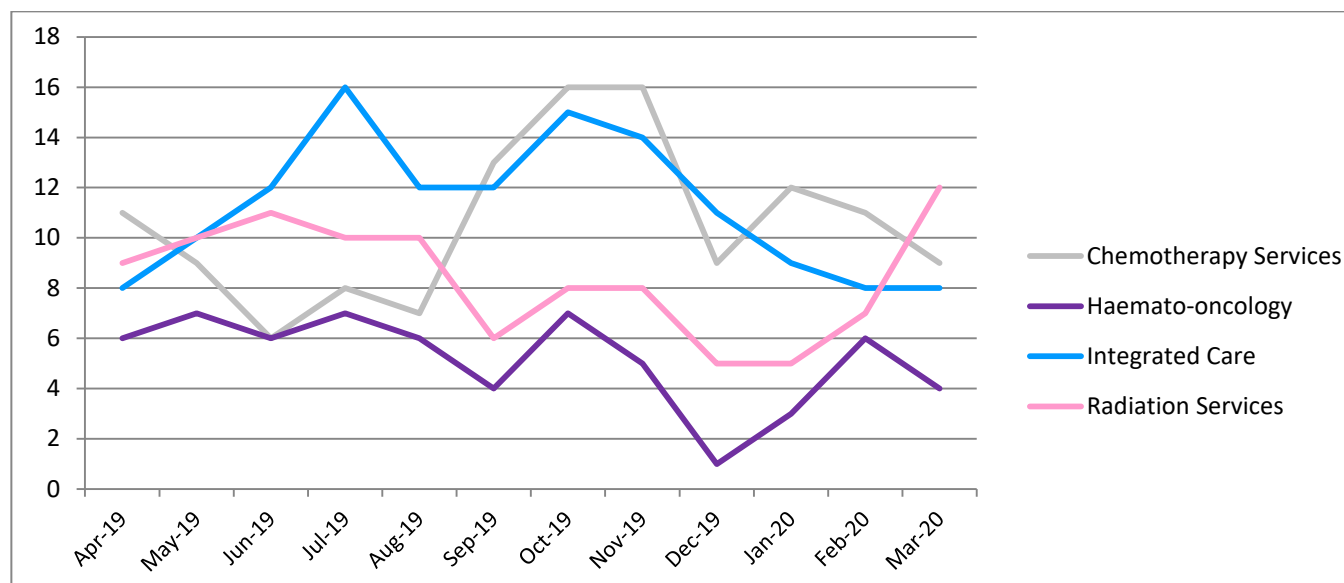
#### Long / short term sickness absence:

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

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend
Short term	120	129	115	118	102	134	187	160	166	180	133	180	
Long term	52	52	46	56	52	49	61	62	49	42	47	54	

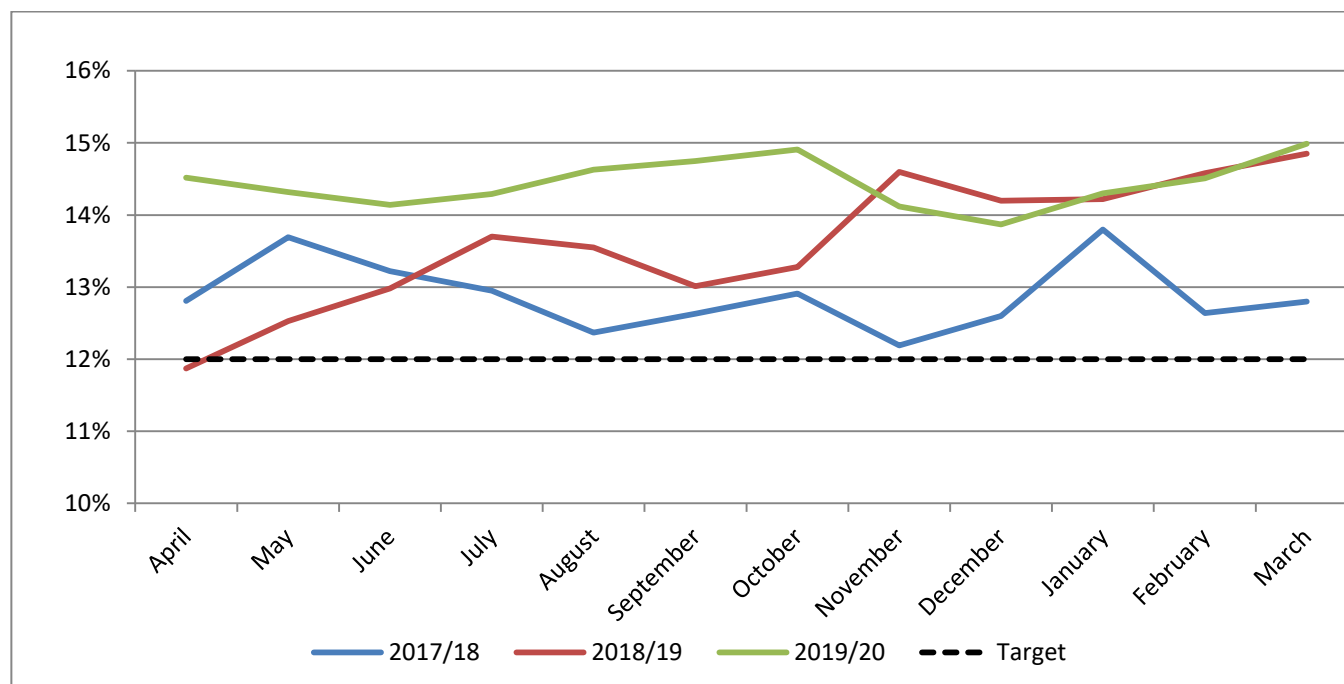
It is clear from the data above that there has been a significant increase in the number of short-term absence episodes as would be expected due to the current Covid-19 pandemic.

This chart shows long term sickness by Directorate, per month:



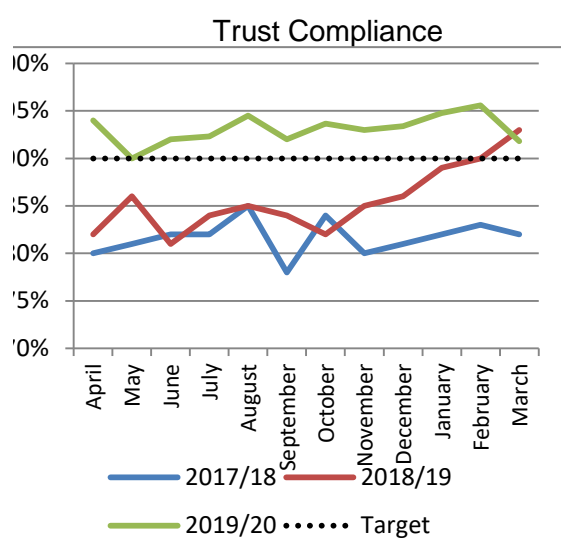
### 3.4.3 Turnover

The graph below shows the rolling 12 month turnover figures, against a target of 12%.



### 3.4.4 Statutory and Mandatory Training

Overall Trust compliance at 31<sup>st</sup> March is 91.81% which is above the KPI of 90% and a decrease in compliance of 3.78% from the previous month.



**Compliance by Subject**

Competence Name	Compliance %
NHS CSTF Equality, Diversity and Human Rights - 3 Years	97.80%
NHS CSTF Fire Safety - 2 Years	94.19%
NHS CSTF Health, Safety and Welfare - 3 Years	95.76%
NHS CSTF Infection Prevention and Control - Level 1 - 3 Years	98.35%
NHS CSTF Infection Prevention and Control - Level 2 - 2 Years	97.10%
NHS CSTF Information Governance and Data Security - 1 Year	95.45%
NHS CSTF Moving and Handling - Level 1 - 3 Years	97.80%
NHS CSTF Moving and Handling - Level 2 - 2 Years	91.74%
NHS CSTF NHS Conflict Resolution (England) - 3 Years	97.35%
NHS CSTF Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	84.60%
NHS CSTF Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	82.30%
NHS CSTF Safeguarding Adults - Level 1 - 3 Years	96.55%
NHS CSTF Safeguarding Adults - Level 2 - 3 Years	95.36%
NHS CSTF Safeguarding Children (Version 2) - Level 2 - 3 Years	95.75%
NHS CSTF Safeguarding Children - Level 1 - 3 Years	96.70%
NHS CSTF Safeguarding Children - Level 3 - 3 Years	86.79%
NHS MAND Safeguarding Adults Level 3 - 3 Years	88.21%

Due to Covid-19 a number of face to face mandatory training programmes have been cancelled and the Learning and Organisational Development have, where possible, replaced this with e-learning, videos of training and/or workbooks to help staff maintain their compliance.

The L&OD Team will continue to send monthly reminder emails to staff that are non-compliant, alongside ESR reminders and will work closely with the lead trainers to ensure compliance remains above 90%. It is recognised that the current COVID-19 pandemic has created some increased clinical pressures and staffing shortages. In addition teams are preparing for the move to CCC-L; this may cause a decline in mandatory training compliance.

Concern has been escalated over BLS and ILS compliance which remains significantly under the Trust target of 95%.

Following consultation with managers and approval at Education Governance Committee, the manager approval functionality in ESR for mandatory training bookings has been removed. It is hope that this will support a more seamless booking process for staff.

Prevent training has been changed from a once only requirement to a 3 yearly requirement, in line with national guidance. Therefore, Prevent has been removed from the overall Trust compliance figure for a 3 month period (January – March 2020) to enable staff to meet the new requirement.

### Compliance by Directorate

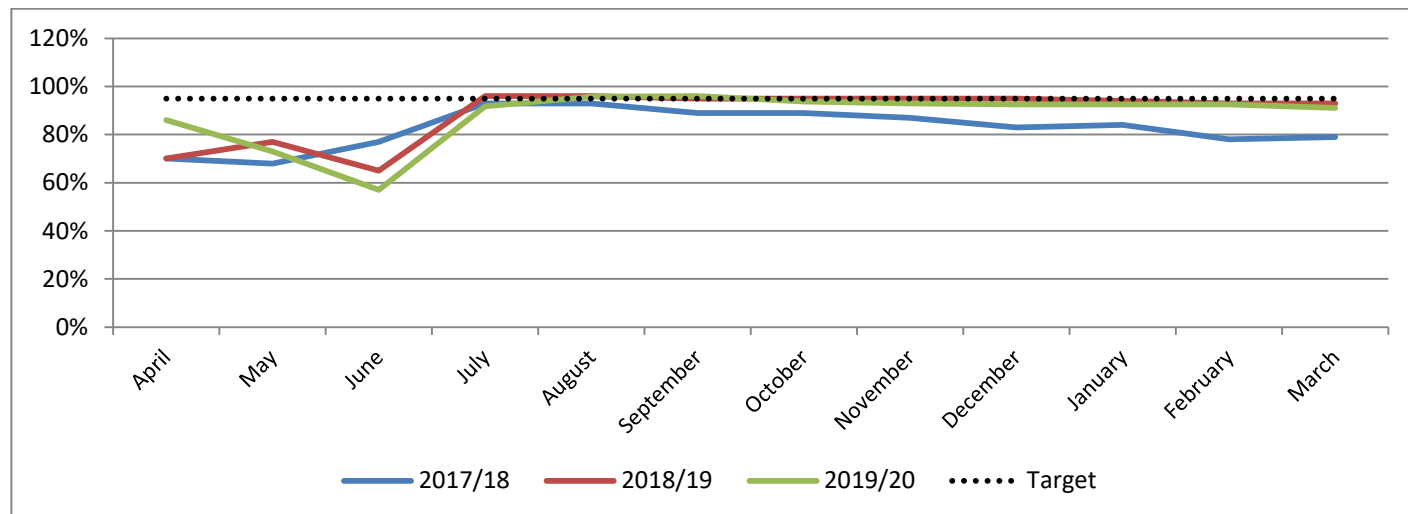
A breakdown of Directorate compliance, as at 31<sup>st</sup> March 2020 is detailed below.

Directorate	Target	Mar-19	Apr-19	May-19	Jun-19	Update 12/07/19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend
158 Chemotherapy Services Directorate	90%	97%	97%	96%	95%	97%	96%	96%	94%	85%	87%	97%	98%	98%	93.78%	
158 Corporate Directorate	90%	93%	94%	93%	92%	92%	94%	97%	93%	92%	89%	92%	93%	95%	90.28%	
158 Education Directorate	90%	96%	100%	100%	99%	98%	100%	100%	100%	98%	98%	89%	89%	94%	96.05%	
158 Haemato-oncology Directorate	90%	85%	94%	89%	86%	94%	88%	87%	87%	89%	86%	93%	95%	95%	90.96%	
158 Hosted Service Directorate	90%	82%	92%	92%	94%	90%	95%	99%	94%	93%	91%	91%	91%	95%	90.11%	
158 Integrated Care Directorate	90%	93%	94%	91%	93%	95%	90%	95%	91%	80%	81%	94%	95%	94%	91.61%	
158 Quality Directorate	90%	98%	94%	94%	95%	94%	96%	96%	97%	96%	92%	95%	95%	98%	92.59%	
158 Radiation Services Directorate	90%	95%	94%	92%	93%	95%	93%	94%	92%	91%	84%	91%	94%	96%	91.78%	
158 Research Directorate	90%	89%	90%	89%	89%	95%	90%	97%	92%	85%	88%	98%	98%	98%	94.57%	

All Directorates are achieving the KPI of 90%.

### 3.4.5 PADR Compliance

Trust compliance as at 31<sup>st</sup> March 2020 is at 91.09%, which is below the KPI of 95% and an in month decline of 1.43%.



### Compliance by Directorate

A breakdown of Directorate compliance, as at 31<sup>st</sup> March is detailed below.

Directorate	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trend
158 Chemotherapy Services Directorate	91%	77%	65%	48%	96%	96%	94%	94%	93%	91%	89%	91%	88%	
158 Corporate Directorate	95%	90%	86%	51%	94%	95%	95%	94%	94%	93%	93%	92%	90%	
158 Education Directorate	100%	100%	100%	58%	100%	100%	100%	100%	100%	100%	100%	100%	86%	
158 Haemato-oncology Directorate	83%	87%	84%	56%	70%	93%	91%	89%	89%	89%	89%	90%	89%	
158 Hosted Service Directorate	100%	93%	87%	34%	90%	100%	100%	100%	100%	100%	100%	100%	89%	
158 Integrated Care Directorate	91%	84%	65%	53%	94%	96%	93%	91%	89%	90%	92%	94%	96%	
158 Quality Directorate	100%	88%	80%	52%	93%	100%	100%	100%	96%	100%	96%	96%	96%	
158 Radiation Services Directorate	92%	89%	85%	74%	94%	96%	98%	96%	95%	94%	93%	93%	92%	
158 Research Directorate	92%	87%	77%	78%	100%	98%	98%	98%	98%	98%	98%	96%	91%	

All directorates with the exception of Integrated Care and Quality are underperforming against the KPI.

The PADR window for 2020/21 opened on 1<sup>st</sup> March 2020, however due to Covid-19 and the need to free up clinical capacity and in line with national guidance issued by NHSI, the Trust has paused PADR completion until further notice.

We are however encouraging staff how do have some capacity over the coming weeks to take the opportunity to complete some or all of the various aspects of the ePADR process.

### 3.4.6 Staff Experience

#### Staff Friends and Family Test – Q4 Survey

Quarter 4 Staff Friends and Family data is not due until 24<sup>th</sup> April 2020.

## Finance

For March the key financial headlines are:

Metric (£000)	M12 Actual	M12 Plan	Variance	YTD Actual	YTD Plan	Variance	Risk RAG
NHSI SoF	3	1	2	3	1	2	
NHSI Control Total (£000)	6926	378	6,548	10,583	3,492	7,091	
Cost Improvement Programme (£000)	538	156	382	2,299	1,800	499	
Cash holding (£000)	29,299	19,035	10,264	29,299	19,035	10,264	
Capital Expenditure (£000)	12,184	4,538	7,646	56,479	54,663	1,816	

The key drivers of the positions are:

- **Income has overachieved plan by £23.9m, £9.3m in month.** This is due to clinical income being £11.9m over plan, of which £11.1m relates to drug income. The Trust also received a donation from the Charity which contributes to the overachievement of the income plan.
- **Expenditure is overspent by £17.3m, £2.7m in month.** Consistent with the income position, mostly due to drug expenditure being £11.2m above plan.
- **Cash held is ahead of plan by £10.3m**
- **Capital expenditure is £1.8m ahead of plan.**