



Report Cover Sheet

Report to:	Board of Directors	
Date of the Meeting:	25 th November 2020	
Agenda Item:	P1-184-20	
Title:	Integrated Performance Exception Report – Month 7 2020/2021	
Report prepared by:	Hannah Gray, Head of Performance and Planning	
Executive Lead:	Joan Spencer, Chief Operating Officer	
Status of the Report:	Public	Private
	X	

Paper previously considered by:	
Date & Decision:	

Purpose of the Paper/Key Points for Discussion:	<p>This report provides an update on performance for month seven (October 2020). The access, efficiency (including the Covid-19 recovery activity), quality, workforce and finance scorecards are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant. A Covid-19 recovery summary is provided, rather than exceptions only.</p> <p>Points for discussion include under performance, developments and key actions for improvement.</p>
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Action Required:	Discuss	X
	Approve	
	For Information/Noting	

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

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

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

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

Equality & Diversity Impact Assessment

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

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

Integrated Performance Report (Month 7 2020/21)

Introduction

This report provides an update on performance for month seven (October 2020). The access, efficiency (including the Covid-19 recovery activity), quality, workforce and finance scorecards are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant. A Covid-19 recovery summary is provided, rather than exceptions only, in section 3.

The Research and Innovation scorecard and exception reports have been reintroduced in this Month 7 IPR. Targets have been reviewed in light of the impact of Covid-19 and applied retrospectively from April and for the final 6 months of the year.

One additional Access KPI is newly reported in this Month 7 2020/21 IPR. This is 'The number of patients treated between 63 and 104 days', now providing oversight to Committees and Trust Board of patients treated within 62 days, between 63 – 104 and over 104 days from GP referral.

Complaints data and any exception reports will now be reported monthly, rather than quarterly in the IPR. The 25 day KPI for routine complaints and the 60 day KPI for complex complaints have been amended reporting solely on performance against these timescale excluding any extensions to the response times that have been agreed with complainants. Although reporting to date has been in line with the Trust's complaints policy, this revised approach ensures full transparency regarding actual response times and complainant experience.

Three additional Workforce KPIs are included in this Month 7 2020/21 IPR; these are the Staff flu vaccination KPIs; presenting performance against the national target, the CQUIN target and CCC's internal stretch target.

Although much of the national data collection initially suspended in line with Covid-19 guidance, remains as such (with details of metrics outlined in Month 1 and 2 IPRs), the Trust has maintained internal monitoring and reporting to ensure oversight and good performance.

The 'Third Phase of NHS Response to Covid-19' KPIs continue to be reported in this report in the Covid-19 Recovery Activity scorecard, with accompanying narrative in section 3.

1. Performance Scorecards

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

1.1 Access

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Oct-20	YTD	12 Month Trend
Executive Director Lead: Joan Spencer, Chief Operating Officer						
L	7 days from referral to first appointment	↔	90%	95.1%	92.3%	
C/S	2 week wait from GP referral to 1st appointment	↓	93%	88.9%	91.4%	
L	24 days from referral to first treatment	↔	85%	92.2%	86.7%	
C/S	28 day faster diagnosis - (Referral to diagnosis)	↓	75% (shadow monitoring)	62.5%	67.3%	
S	31 day wait from diagnosis to first treatment	↔	96%	98.1%	98.6%	
C/S	31 day wait for subsequent treatment (Drugs)	↔	98%	100.0%	99.5%	
C/S	31 day wait for subsequent treatment (Radiotherapy)	↔	94%	94.9%	97.8%	
S	Numbers of 31 day patients treated on day 73 or over	↑	0	0	28	
C/S	62 Day wait from GP referral to treatment	↔	85%	88.4%	90.9%	
C/S	62 Day wait from screening to treatment	↓	90%	67.0%	91.7%	
L	Number of patients treated between 63 and 104 days (inclusive)	↑	No Target	41	176	
S	Number of patients treated after 104 days	↑	No Target	15	37	
L	Number of patients treated after 104 days AND at CCC for over 24 days	↑	0	3	18	
C/S	Diagnostics: 6 Week Wait	↔	99%	100%	100.0%	
C/S	18 weeks from referral to treatment (RTT) Incomplete Pathways	↔	92%	98.5%	97.0%	

Notes:

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

28 Day Faster Diagnosis is only reported from January 2020

 This border indicates that the figure has not yet been validated and is therefore subject to change. This is because national CWT reporting deadlines are later than the CCC reporting timescales.

Cheshire and Merseyside Performance (until September 2020)

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Sep-20	YTD	12 Month Trend
Executive Director Lead: Joan Spencer, Chief Operating Officer						
C/S	2 week wait from referral to date first seen	↔	93%	88.48%	92.38%	
C/S	28 day faster diagnosis - (Referral to diagnosis)	↓	75% (shadow monitoring)	70.7%	74.19%	
C/S	62 Day wait from GP referral to treatment	↔	85%	74.47%	76.39%	

Notes:

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

1.2 Efficiency

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Oct-20	YTD	12 Month Trend
Executive Director Lead: Joan Spencer, Chief Operating Officer						
S	Length of Stay: Elective (days): Solid Tumour	↔	≤6.5	6.5	5.2	
S	Length of Stay: Emergency (days): Solid Tumour	↓	≤8	7.3	7.3	
S	Length of Stay: Elective (days): HO Ward 4	↔	≤21	5.90	12.1	
S	Length of Stay: Emergency (days): HO Ward 4	↔	≤16	35.30	15.4	
S	Delayed Transfers of Care as % of occupied bed days (Solid Tumour)	↔	≤3.5%	4.5%	4.8%	
S	Bed Occupancy: Midday (Solid Tumour)	↔	G: ≥92% A: 88-91.9% R: <88%	84.1%	64.3%	
S	Bed Occupancy: Midnight (Solid Tumour)	↔		77.8%	64.7%	
C/S	% of elective procedures cancelled on or after the day of admission	↔	0%	None cancelled	None cancelled	
C/S	% of cancelled elective procedures (on or after the day of admission) rebooked within 28 days of cancellation	↔	100%	None cancelled	None cancelled	
C/S	% of urgent operations cancelled for a second time	↔	0%	None cancelled	None cancelled	
L	Radiology Reporting: Inpatients (within 24hrs)	↔	G: ≥90% A: 80-89.9% R: <80%	97.9%	95.2%	
L	Radiology Reporting: Outpatients (within 7 days)	↑		93.2%	94.0%	
L	Travel time to clinic appointment within 45 minutes	↔	G: ≥90%, R: <90%	97.0%	97.0%	
C/Phase 3 Covid-19 Guidance	Data Quality - % Ethnicity that is complete (or patient declined to answer)	↓	July & Aug = 90% Sept & Oct = 95% Nov & Dec = 100%	93.6%	95.8%	
C	Data Quality - % of outpatients with an outcome	↔	G=95%, A=90% - 95%, R= <90%	97.7%	98.3%	
C	Data Quality - % of outpatients with an attend status	↔	G=95%, A=90% - 95%, R= <90%	97.1%	98.1%	
Executive Director Lead: James Thomson, Director of Finance						
S	Percentage of Subject Access Requests responded to within 1 month	↔	100%	100%	100%	
C	% of overdue ISN (Information Standard Notices)	↔	0%	0%	0%	

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 1st December 2020

1.2.1 Covid-19 Recovery Activity

A = August | S = September | O = October | P3G = Phase Three Covid-19 Guidance.
 Figures are coloured green / red where the target is not yet in force e.g. begins in August.

Directive	Data	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	YTD	Monthly Trend 2020/21
Local	Covid-19 positive inpatients (Definite Healthcare Associated)*	0	0	0	0	0	0	1	0	1	
Local	Covid-19 positive inpatients (Non Definite Healthcare Associated)*	No Target	13	3	3	0	0	8	15	42	
P3G	Overnight electives (as % of 2019/20)	A = 70%, S=80%, O = 90% (of last year's activity)	38%	60%	88%	80%	67%	89%	135%	78%	
P3G	Outpatient Procedures (as % of 2019/20)	A = 70%, S=80%, O = 90% (of last year's activity)	83%	85%	117%	158%	167%	185%	159%	137%	
P3G	Day Cases (as % of 2019/20)	A = 70%, S=80%, O = 90% (of last year's activity)	39%	43%	55%	57%	36%	50%	42%	46%	
P3G	Outpatient Appointments (as % of 2019/20)	A = 90%, S=100% (of last year's activity)	121%	114%	138%	132%	120%	132%	119%	124%	
P3G	Outpatient Appointments: New (as % of 2019/20)	A = 90%, S=100% (of last year's activity)	104%	71%	84%	79%	89%	116%	113%	94%	
P3G	Outpatient Appointments: Follow Up (as % of 2019/20)	A = 90%, S=100% (of last year's activity)	122%	118%	143%	137%	123%	133%	120%	128%	
P3G	% of all OP appointments which are by telephone or video	25% of all OP appts	71%	69%	69%	68%	69%	72%	70%	70%	
P3G	% of Follow Up OP appointments which are by telephone or video	60% of all FU OP appts	70%	68%	68%	67%	70%	72%	70%	69%	
Local	Referrals: Total (as % of 2019/20)**	2019/20 figures	87%	62%	83%	73%	85%	94%	83%	81%	
Local	SACT administration: Solid Tumour (as % of 2019/20)	2019/20 figures	89%	66%	97%	94%	90%	111%	96%	92%	
Local	Radiotherapy Treatments (as % of 2019/20)	2019/20 figures	94%	78%	71%	73%	64%	74%	94%	75%	
P3G	Investigations: CT (as % of 2019/20)	S=90%, O = 100% (of last year's activity)	71%	96%	132%	150%	179%	170%	206%	145%	
P3G	Investigations: MRI (as % of 2019/20)	S=90%, O = 100% (of last year's activity)	54%	67%	63%	88%	112%	128%	137%	94%	
Local	Stem Cell Transplants	8.3 per month (as per CCC plan)	1	1	5	8	6	6	4	31	
Local	Hotline Calls- Pts advised to attend A&E or CCC CDU: % advised to attend A&E	No Target	71%	63%	63%	73%	71%	68%	66%	68%	
Local	Hotline Calls- Pts advised to attend A&E or CCC CDU: % advised to attend CDU	No Target	29%	37%	37%	27%	29%	32%	34%	32%	
Local	Staff and household members tested (inc. external tests)	No Target	99	62	193	117	37	144	84	736	
Local	Staff sickness absence: Covid-19 related (total occurrences)	No Target	49	36	18	21	4	18	26	172	
Local	Staff sickness absence: Covid-19 related (%)	No Target	2.5%	2.1%	1.0%	1.2%	0.2%	0.9%	1.4%	1.4%	

Further detail on this data is provided in section 3.2.4 and in the Workforce section
 *The categories for Covid-19 positive infections are: Definite Healthcare Associated (First Positive specimen 15 days or more after admission), Probable Hospital Associated (8 - 14 days), Indeterminate Healthcare associated (3 - 7 days) and Community Acquired (0 - 2 days).
 NB: there were 2 Covid-19 positive (Definite Healthcare Associated) inpatients in March 2020.
 ** There are fewer referrals than New OP Appts as A. there can be 2 New appts if a patient is referred internally (i.e. Clin. Onc. to Med. Onc.) and B. there can be a New appt without a preceding referral if the patient's care transfers to another consultant.

1.3 Quality

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Oct-20	YTD	12 Month Trend
Executive Director Lead: Sheila Lloyd, Director of Nursing and Quality						
C/S	Never Events	↔	0	0	0	
C/S	Serious Untoward Incidents (month reported to STEIS)	↔	0	0	3	
C/S	Serious Untoward Incidents: % submitted within 60 working days / agreed timescales	↔	100%	100%	100%	
S	RIDDOR - number of reportable incidents	↔	0	0	1	
S	IRMER - number of reportable incidents	↑	0	1	5	
S	Incidents /1,000 Bed Days	↓	No target	206	233.7	
L	All incidents resulting in harm /1,000 bed days	↓	No target	19	22	
C/S	Inpatient Falls resulting in harm due to lapse in care	↔	0	0	1	
S	Inpatient falls resulting in harm due to lapse in care /1,000 bed days	↔	0	0	0.12	
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care)	↔	0	0	0	
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care) /1,000 bed days	↔	0	0	0	
S	Consultant Review within 14 hours (emergency admissions)	↔	90%	100%	99%	
C/S	% of Sepsis patients being given IV antibiotics within an hour	↔	90%	96%	96%	
C/S	VTE Risk Assessment	↔	95%	98%	98%	
S	Dementia: Percentage to whom case finding is applied	↔	90%	100%	100%	
S	Dementia: Percentage with a diagnostic assessment	↔	90%	100%	100%	
S	Dementia: Percentage of cases referred	↔	90%	100%	100%	
C/S	Clostridium difficile infections (attributable)	↔	<=4 per yr	0	1	
C/S	E Coli (attributable)	↔	<=10 per yr	0	1	
C/S	MRSA infections (attributable)	↔	0	0	0	
C/S	MSSA bacteraemia (attributable)	↑	<=5 per yr	1	3	
C	Klebsiella (attributable)	↑	<=10 per yr	1	1	
C	Pseudomonas (attributable)	↔	<=5 per yr	0	0	
C/S	FFT inpatient score (% positive)	-	95%	N/A	N/A	
C	FFT outpatient score (% positive)	-	95%	N/A	N/A	
C	Number of formal complaints received	↑	No target	5	14	
S	Number of formal complaints / count of WTE staff (ratio)	↑	No target	0.003	0.002	
C	% of formal complaints acknowledged within 3 working days	↔	100%	100%	100%	
L	% of routine formal complaints resolved within 25 working days*	↔	100%	None resolved	31%	
L	% of complex formal complaints resolved within 60 working days*	↔	100%	Non to resolve	Non to resolve	
C/S	% of FOIs responded to within 20 days	↔	100%	100.0%	99.3%	
C/S	Number of IG incidents escalated to ICO	↔	0	0	0	
C	NICE Guidance: % of guidance compliant	↔	90%	94%	92%	
L	Number of policies due to go out of date in 3 months	↑	N/A	33	N/A	
L	% of policies in date	↔	100%	94%	97%	
C/S	NHS E/I Patient Safety Alerts: number not implemented within set timescale.	↔	0	0	1	

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

HCAI targets are subject to change. Commissioners have advised CCC to use 2019/20 targets until otherwise advised.

* The NHS complaints process timelines have been relaxed to allow Trusts to prioritise the necessary clinical changes required to respond to the Covid-19 pandemic. The Trust Policy currently allows more than 25 days with patients' consent

1.4 Research & Innovation

The Research and Innovation scorecard and exception reports have been reintroduced in this Month 7 IPR. Targets have been reviewed in light of the impact of Covid-19 and applied retrospectively from April and for the final 6 months of the year.

Directive	Key Performance Indicator	Change in RAG Rating from previous Month	Target	Measure	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	YTD	12 Month Trend
Local	Study Recruitment	↓	800 annual 66.7 per month	Number	57	33	21	23	121	171	112	538	
			100%	Percent	85%	49%	31%	34%	181%	256%	168%	115%	
Local	SIREN Recruitment	↓	250 participants 50 per month	Number					94	112	32	238	
			100%	Percent					188%	224%	64%	159%	
Local	Studies Opened	↑	47 annual 3.9 per month	Number	3	0	4	6	3	4	6	26	
			100%	Percent	77%	0%	103%	154%	77%	103%	154%	95%	
Local / NIHR	Studies Unpaused	↑	80% 6.7% per month	Number	0	4	26	24	5	6	9	74	
			6.7%	Percent		4.5%	29.2%	27.0%	5.6%	6.7%	10.1%	142.6%	
DoH	Study Setup Times - Quarterly Data reporting		40 days	Number									

1.5 Workforce

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

Directive	Key Performance Indicator	Change in RAG rating from previous period	Target	Oct-20	YTD	12 Month Trend
Executive Director Lead: Jayne Shaw, Director of Workforce and Organisational Development						
S	Staff Sickness (monthly)	↔	G: <4%, A: 4.1 - 4.9%, R: >5%	4.2%	4.4%	
S	Staff Turnover (12 month rolling)	↑	G: <14%, A: 14.1 - 14.9%, R: >15%	14.2%	N/A	
S	Statutory and Mandatory Training	↔	G: >90%, A: 75 - 89%, R: <75%	95.9%	N/A	
L	PADR rate	↓	G: >95%, A: 75 - 94.9%, R: <74%	94.2%	N/A	
S	FFT staff: Recommend as a place to work	-	G: >95%, A: 90 - 94.9%, R: <90%	N/A	N/A	
S	FFT staff: Recommend care and treatment	-	G: >95%, A: 90 - 94.9%, R: <90%	N/A	N/A	
S	% of Staff offered Flu Vaccination (vaccinated + refused): cumulative (National target)	-	100% (by end campaign)	73.0%	N/A	N/A (campaign began in Oct 2020)
L	% of 'Frontline' Staff Flu Vaccinated: cumulative (CQUIN target)	-	90% by 28/02/21	74.1%	N/A	N/A (campaign began in Oct 2020)
C	% of Staff Flu Vaccinated: cumulative (CCC internal target)	-	95% by end Dec 20	71.4%	N/A	N/A (campaign began in Oct 2020)

1.6 Finance

For October the key financial headlines are:

Metric	In Mth 7 Actual	In Mth 7 Plan*	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Deficit (£000)	(664)	(733)	69	Green	(1,038)	(719)	(319)	Green
CPL/Propcare Surplus/ (Deficit) (£000)	66	0	66	Green	440	0	440	Green
Control Total Surplus/ (Deficit) (£000)	(598)	(733)	135	Green	(598)	(719)	121	Green
Cash holding (£000)	50,666	27,832	22,834	Green	50,666	27,832	19,649	Green
Capital Expenditure (£000)	11	9	2	Yellow	8,502	9,819	(1,865)	Yellow

*The plan for month 7 has now been updated to reflect the plan submission for M7-12 (22nd October 2020)

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

2. Exception Reports

2.1 Access

2 week wait from GP referral to 1 st appointment	Target	Oct 20	YTD	12 month trend
	93%	88.8%	91.4%	
Reason for non-compliance In October 2020, eight patients achieved the 14 day target. One patient breached the target as they were admitted to another Trust. The first appointment was rearranged once the patient was discharged and ready to attend.				
Action Taken to improve compliance This was an unavoidable breach, therefore no action required.				
Expected date of compliance	31/11/20			
Escalation route	CWT Target Operational Group, Directorate Performance Reviews, Performance Committee, Trust Board			
Executive Lead	Joan Spencer, Chief Operating Officer			

28 day faster diagnosis - (Referral to diagnosis)	Target	Oct 20	YTD	April 2020 – October 2020
	75% (shadow monitoring)	62.5%	67.3%	
Reason for non-compliance In October 2020, five patients achieved the 28 day FDS target and three patients breached the target. The breaches were due to the following reasons; patient DNA'd a diagnostic test appointment, there were delays to diagnostic tests and a lack of capacity for a HO diagnostic test.				
Action Taken to improve compliance <ul style="list-style-type: none"> The Trust now has greater control of capacity, as diagnostic tests are now available at CCCL. We will therefore also be able to manage and escalate any potential 28 FD breaches more effectively. Delivering the Rapid Diagnostic Centre (RDC) Project Proposal will ensure capacity for HO Diagnostic tests. 				
Expected date of compliance	31/11/20			
Escalation route	CWT Target Operational Group, Directorate Performance Reviews, Performance Committee, Trust Board			

Executive Lead

Joan Spencer, Chief Operating Officer

62 Day Wait from screening to treatment	Target	Oct 20	YTD	12 month trend
	90%	67%	91.7%	
Reason for non-compliance				
<p>There was one accountable 62 Day Screening breach in October 2020. This was a complex treatment plan patient, referred into CCC on day 67, who required the co-ordination of planning scans that needed to be done on the same day and, due to clinical reason (category 1 patient – treatment must be given in a single block of five sequential days), needed to commence treatment on a Monday. The patient waited 27 days from referral to CCC to treatment.</p>				
Action Taken to improve compliance				
<p>CWT Targets Operational Group (TOG) to work with Heads of Departments to review how scans that need to be completed on the same day can be expedited.</p>				
Expected date of compliance	31/11/20			
Escalation route	CWT Target Operational Group, Directorate Performance Reviews, Performance Committee, Trust Board			
Executive Lead	Joan Spencer, Chief Operating Officer			

Long Waiting Cancer Patients:	Target	Oct 20	YTD	12 month trend
62 Day patients (104+ days, with >24 days at CCC)	0	3	18	
Reason for non-compliance				
<p>Fifteen patients breached the 104+ day target in October; there were 3 breaches for which the patient was at CCC more than 24 days between referral first treatment. The breach reasons include;</p> <ul style="list-style-type: none">• Medical reason, patient required admission to CCCL for a tumour related condition (62 days at referring Trust and 46 days at CCC),• Delay due to requests for diagnostic tests being made on the incorrect form attributable to the CCCL move and the associated change to the request process (71 days at referring Trust and 39 days at CCC),• Complex patient, with additional delays due to requests for diagnostic tests being made on the incorrect form attributable to the CCCL move and the associated change to the request process (41 days at referring Trust and 73 days at CCC).				

As per the Cheshire and Merseyside agreement, CCC are coordinating the harm review for one patient, as they were at CCC for the majority of the time, and are contributing to the harm review (coordinated by referring Trusts) for the other 2 patients.

Action Taken to improve compliance

- HO move to Meditech is now complete and processes are being followed
- The Trust now has greater control of capacity, as diagnostic tests are now available at CCCL. We will therefore also be able to manage and escalate any potential 28 FD breaches more effectively.
- Delivering the Rapid Diagnostic Centre (RDC) Project Proposal will ensure capacity for HO Diagnostic tests.

Expected date of compliance	31/11/20
Escalation route	CWT Target Operational Group, Directorate Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

2 Week Wait Cancer Standard (Alliance-level)	Target	Sept 20	YTD	12 month trend (to Sept)
	93%	88.48%	92.38%	

Reason for non-compliance

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

- Breast 79.48% (down from 83.91% last month)
- Lower Gastrointestinal 85.67% (similar to last month at 85.35%)
- Upper GI 85.54% (up from 83.47% last month)

Poor performance in breast cancer at Countess of Chester Hospital NHS FT and Warrington and Halton Hospitals NHS FT had the most significant impact. Outpatient capacity issues were recorded as the breach reason in 78% of cases, and WHH recorded ‘other’ as the breach reason in 66% of cases (‘Other’ may include Covid-related issues).

Patient choice was also a key factor affecting all trusts across all tumour groups, with 37.5% of breaches resulting from patients wanting to delay their first appointment.

Action Taken to improve compliance

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

- 2ww referrals are now back to pre-pandemic levels

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

62 Day Cancer Standard (Alliance-level)	Target	Sept 20	YTD	12 month trend (to Sept)
	85%	74.29%	76.28%	

Reason for non-compliance

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

- Urology 64.8% (down from 70.51% last month)
- Lower Gastrointestinal 60% (up from 50.35% last month)
- Head and Neck 41.03% (down from 65.22%)
- Breast 81.89% (down from 93.54%)

September's performance has been affected by the Covid-19 pandemic. Whilst most services had been restored to near-normal capacity, there remained a significant backlog of patients waiting for diagnostics.

Lower GI pathways were particularly affected with performance falling from 73.27% in February (pre-pandemic) to 40.96% in July, but have improved to 60% in September. In May, the British Society of Gastroenterology advised a six-week pause in endoscopy services due to the risk of Covid-19 transmission, affecting lower GI, upper GI and urology pathways. There is a large backlog of patients waiting for endoscopy with patients being prioritised based on clinical need. There is a significant focus on restoring endoscopy activity and efficiency to pre-Covid-19 levels.

Delays to diagnostic pathways are being monitored through the Cheshire and Mersey Cancer Alliance, with endoscopy recovery led by a C&M recovery team.

Action Taken to improve compliance

- Continuation of surgical and diagnostics hubs as part of CMCA's response to Covid-19.
- The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group.
- The endoscopy operational recovery team, in collaboration with the C&M Hospital has produced a clear, prioritised plan to increase capacity.
- The Alliance has secured £5.4m capital investment to increase endoscopy capacity and improve productivity.
- £600,000 investment to support full implementation of symptomatic faecal immunochemical testing (sFIT) in primary care. This builds on the existing secondary care sFIT model. Implementation will reduce demand for endoscopy services.
- Patient and public communications to improve patient confidence to attend for appointments.

- 2ww referrals are now back to pre-pandemic levels

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

2.2 Efficiency

	Target	Oct 20	YTD	12 month trend
Length of Stay - Emergency: HO	21 days	35 days	15 days	

Executive Lead

Joan Spencer: Chief Operating Officer

Delayed Transfers Of Care (DTOCs): Solid Tumour Wards	Target	Oct 20	YTD	12 month trend
	<=3.5%	4.5%	4.8%	

Reason for non-compliance

Delayed Transfers of Care (DTOCs) as a % of occupied bed days for the month of October was above the Trust target of <= 3.5%, at 4.5%.

In October, DTOCs were mainly due to patients awaiting fast track funded packages of care (POC) at home and awaiting equipment or adaptations for home. Covid-19 has increased pressure on hospices, with reduced bed capacity resulting in delayed transfers of care, with some hospices currently closed to new admissions.

Action Taken to improve compliance

- Weekly 'Lengthened Length of Stay' meetings have continued with attendance of Matron and the Business Services Manager to ensure the flow of patients continues and any concerns can be escalated. The outcome of these meetings are forwarded to General Managers for review.
- The Patient Flow Team (PFT) continue to work with the wider MDT to aid discharge planning during the Covid-19 pandemic, ensuring patients are discharged safely home or to a suitable care setting. Weekly complex discharge meetings occur with the MDT.
- Daily COW MDT meetings continue to allow discussion of all inpatients so there is a clear plan for each patient.
- The PFT leader and Social Worker have met with local area Social Work team to identify their new way of working in response to the Government's hospital service discharge requirements, and monthly meetings are in place.

Expected date of compliance	30/11/2020
Escalation route	Monthly ICD meeting, Directorate Q and S Group, Integrated Governance Committee, Quality Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

Bed Occupancy:	Target	Sept 20	YTD	12 month trend
Solid Tumour Wards	G: ≥92% A: 88-91.9% R: 88%	Midday 84.1%	64.3%	
		Midnight 77.8%	64.7%	

Reason for non-compliance

Solid tumour (ST) inpatient ward bed occupancy has been low since the first wave of the Covid-19 pandemic in March 2020, however since then, this has increased every month. The position for October 2020 is;

- Average bed occupancy at midday was 81.4%
- Average bed occupancy at midnight was 77.8%

These figures are calculated on a total bed base of 51 beds. There are a further 4 beds on Ward 2 which have been used for day case activity for most of October. During the last week of October this activity has started to move as planned to Ward 1 day case, with TYA day activity remaining in the ST bed base until the transfer of HO inpatients onto the CCC EPR system (Meditech). This is scheduled for 1st December 2020.

There are no beds currently closed due to social distancing at CCC Liverpool, as all beds are in side rooms. On Ward 3 there is a RED zone for inpatients with a high clinical suspicion or confirmation of Covid-19 infection; this is a flexible space based on patient need.

The Patient Flow Team and the wider MDT continue to proactively discharge plan to ensure that patients are in the safest place for them during the Covid-19 pandemic.

LoS is on target for October 2020 for both elective and non-elective admissions, and there is a low CUR Non Qualifying rate of 5%.

Action Taken to improve compliance

- The Patient Flow Team continue to work with the wider MDT to aid discharge planning during the Covid-19 pandemic
- Mutual Aid has been offered to support LUHFT with acute oncology patients and palliative patients to relieve some of their bed pressures during the Covid-19 pandemic

Expected date of compliance	30/11/2020
Escalation route	Directorate Performance Review, Performance Committee, Trust Board.
Executive Lead	Joan Spencer, Chief Operating Officer

% Ethnicity that is complete (or patient declined to answer)	Target	Oct 20	YTD	12 month trend
	July & Aug = 90% Sept & Oct = 95% Nov & Dec = 100%		93.6%	95.8%
Reason for non-compliance				
<p>The target of 95% in October was not achieved, at 93.6%.</p> <p>The collection of this data is proving more challenging as there are fewer opportunities to ask for this information, with around 80% of patients now being seen remotely.</p>				
Action Taken to improve compliance				
<ul style="list-style-type: none"> • There has now been a change in process for all new patients to be asked their ethnicity as part of the enhanced call. • All patients having face to face appointments are also asked on arrival at their appointment. • Both the back office and patient facing clerical team will review the clinic lists and will provide the information as part of the clinic prep tasks, where they can contact the new and follow up patients. • Further communications will be sent to all nurse delivered clinics to reiterate the importance of asking this question and documenting the patient response. • Due to increasing remote working, all staff will be asked to check ethnicity to ensure this data is captured. 				
Expected date of compliance	30/11/2020			
Escalation route	Integrated Governance Committee, Performance Reviews, Quality Committee, Trust Board			
Executive Lead	Joan Spencer, Chief Operating Officer			

2.3 Quality

IRMER reportable incidents	Target	Oct 20	YTD	12 month trend
	0	1	5	
Reason for non-compliance				
<p>During October 2020, 1 incident occurred that was notifiable to the IRMER Inspector under the notification criteria – 4.2 equipment malfunction or procedural error leading to 3 or more imaging exposures in a single fraction. There was no harm to the patient from the incident.</p> <p>Description of incident 11097:</p> <ul style="list-style-type: none"> • A patient received 3 CBCT exposures at one fraction due to the machine faulting on 2 occasions. The first 2 exposures were partial exposures as the machine faulted during delivery of the CBCT. The third exposure was a full CBCT taken on a matched machine prior to successful delivery of treatment. An explanation and apology was provided to the 				

patient.

Findings:

A change of practice had been implemented after an IRMER notifiable incident in August 2020. To reduce the risk of 3 imaging exposures being taken at one fraction, it was decided that if a fault occurs when the patient has already undergone an exposure and treatment staff are unable to act on this without repeating the exposure, the patient will be moved to another treatment unit. However, this didn't happen on this occasion. Further investigation showed that this was because staff did not realise that the first failed CBCT was due to a fault condition but instead believed that the operator had inadvertently released the ASU button. Only after the CBCT had failed for a second time did staff realise that the first failure was caused by a machine fault meaning that a second CBCT should not have been attempted.

Actions Taken

- Calculation of additional dose undertaken by a Medical Physics Expert (MPE)
- 72 hour review held
- Incident reported to the IRMER Inspector within required timeframe.

A reminder will be issued to staff that if an exposure fails to complete and the cause is unclear they must not attempt to repeat that exposure without seeking further advice from a Treatment Expert Practitioner (TEP) or an MPE

Expected date of compliance	9 th November 2020
Escalation route	Escalation and reporting as per Incident Reporting Policy Directorate Q&S, LIRG, Performance Reviews, Quality Committee, Trust Board
Executive Lead	Sheila Lloyd, Director of Nursing and Quality

MSSA (attributable)	Target	Oct 20	YTD	12 month trend
	<=5 per year	1	3	

Reason for non-compliance

A hospital acquired Meticillin Staphylococcus Aureus (MSSA) positive result was identified from blood cultures collected from an inpatient on Ward 2. The patient had a line in the right arm and the site was reported as being red and swollen at the time of blood culture collection. This is the likely source of infection.

This is the third hospital acquired MSSA case in 2020/21, taking the year to date total to 3 against a threshold of 5 for 2020/21.

Action taken to improve compliance

A Post Infection Review to be undertaken with Ward Matron, Sister, Clinical Lead, Infection Control Doctor, Anti-microbial Pharmacist and Infection Prevention and Control Team.

Any learning points identified from this review will be disseminated to clinical staff involved in patient care via daily safety huddle, ward meetings and directorate Quality and Safety

meetings.	
Expected date of compliance	1 st December 2020
Escalation route	Harm Free Care Meeting / Infection Prevention and Control Committee / Integrated Governance Committee / Quality Committee / Trust Board
Executive Lead	Sheila Lloyd, Director of Nursing and Quality

Klebsiella Pneumoniae Bacteraemia (attributable)	Target	Oct 20	YTD	12 month trend
	<=10 per year	1	1	

Reason for non-compliance

A hospital acquired Klebsiella pneumoniae was identified from blood cultures collected from an inpatient on Ward 2. The patient has a history of Adenocarcinoma of prostatic urethra. The source is likely to be urinary, but the medical team were also exploring likelihood of prostatic abscess.

Action taken to improve compliance

A Post Infection Review was undertaken by the Infection Control Doctor and Infection Prevention and Control Team.

This infection was considered to be unavoidable due to the patient's underlying condition and inability to void their bladder completely. No learning points were identified.

Expected date of compliance	1 st November 2020
Escalation route	Harm Free Care Meeting / Infection Prevention and Control Committee / Integrated Governance Committee / Quality Committee / Trust Board
Executive Lead	Sheila Lloyd, Director of Nursing and Quality

Complaints: routine complaints responded to within 25 working days	Target	Oct 20	YTD	12 month trend
	100%	None Resolved	31%	

Reason for non-compliance

Year to date compliance with the KPI for responding to a complaint within 25 working days is 31%.

However, the current complaint policy is for a response to be provided to a complaint within 25 working days unless the complainant is informed and kept updated of any delay. Year to date compliance with the current complaints policy is 92%.

The financial year to date has seen the Trust dealing with the global pandemic of Covid-19. As a result of the pandemic the Trust acknowledgement template letter was amended to inform complainants that our response timescale may take longer than anticipated.

Complainants are referred to the Parliamentary and health Services Ombudsman if they are unsatisfied with a complaint response. Due to Covid 19, the PHSO closed its office in March 2020 through to July 2020. This information was also shared in final response letters to complainants.

Complaints received since April 2020 have been more complex in nature than in previous years, and have required more complex responses. There has also been an increase of complaints from members of parliament supporting their constituents and system wide complaints have also increased, all of which has contributed to the low compliance rate with the KPI.

Action Taken to improve compliance

In July 2020 the Complaints and PALS policy was refreshed and approved. The policy now includes a clear flowchart of the complaints process, template letters were developed to support complaint leads and a standard operational procedure was introduced to ensure roles and responsibilities throughout the complaints process are clear.

All General Managers, Clinical Directors, Matrons, Clinical Governance Leads, Director of Nursing and Quality and Director of Operations receive a complaints update tracker of progress on a weekly basis.

Following review of the complaints process it was agreed by the DON, MD and COO to have a task and finish group approach to the complaints process. A report on progress as agreed is being presented to the Quality Committee on 19th November 2020.

An action plan is in place which will be monitored until complete through Integrated Governance Committee. The Head of Risk and Compliance will continue to provide quarterly reports to ICG and QC on complaint activity across the Trust.

Expected date of compliance	End of Quarter 3
Escalation route	Directorate Q&S and Performance meetings, LIRG, Integrated Governance Committee, Quality Committee

% of Policies In Date	Target	Oct 2020	12 month trend
	100%	94%	
<p>Reason for non-compliance</p> <p>Out of a total of 267 policies, sixteen were out of date at the end of October 2020, resulting in a compliance figure of 94%.</p> <p>Of the sixteen policies, three are between three and five months out of date and the other thirteen between one and three months out of date.</p>			
<p>Action taken to improve compliance</p> <p>Actions to improve compliance include:</p> <ul style="list-style-type: none"> • Policy review reminders and instructions are sent to individual authors in advance of the review due dates • Escalation process for any major issues to Associate Director of Corporate Governance • Out of date policy information is provided for review at monthly Directorate meetings • Bi-monthly Document Control update reports are tabled at the Information Governance Board • Promotion of policy self-management with Document Owners - ongoing • Targeted meetings being held between Information Governance staff and Document Owners - ongoing • Undertake comprehensive training/overview of QPulse functionality with Ideagen to investigate greater use of automation e.g. policy review reminders to Document Owners – Initial training cancelled April 2020 due to COVID-19 to reschedule for remote delivery by end of Quarter 3 2020 • Undertake comprehensive review and update of Document Control Policy – by end of Quarter 3 2020 			
Expected date of compliance	December 2020		
Escalation route	Associate Director of Corporate Governance, Information Governance Board, Integrated Governance Committee, Quality Committee, Trust Board		
Executive Lead	Liz Bishop, Chief Executive		

2.4 Research and Innovation

	Target	Oct 20	YTD	2020/21 Trend
Studies opening to recruitment	47 (Year)	27	26	
<p>Reason for non-compliance</p> <p>Twenty-six studies have been opened to recruitment against an internal target of twenty-seven year to date. There are nine studies which have been locally approved and can be opened to recruitment following sponsor approval. No cancer studies could open during April and the majority of May 2020 due to the Covid-19 pandemic, which has meant that we are slightly under target.</p>				
<p>Action Taken to improve compliance</p> <ul style="list-style-type: none"> • The SRG Research Leads are actioned to review the NIHR portfolio to see if any further trials should be opened at CCC. • Work with the Network to optimise opportunities. • Work with Sponsors to greenlight studies where local approval has been given. 				
Expected date of compliance	Q4 2020/2021			
Escalation route	SRG Research Leads / Committee for Research Strategy			
Executive Lead	Sheena Khanduri, Medical Director			

2.5 Workforce

Sickness Absence	Target	Oct 2020	12 month rolling	12 Month Trend (in month figures)
	G: ≤4%, A:4.1-4.99%, R: ≥5.00%	4.23%	4.52%	

Reason for non-compliance

The Trust 12 month rolling sickness absence is 4.52%, with the in-month sickness figure for October 2020 at 4.23%; both have decreased from September (4.62% in month and 4.66% rolling).

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

	Absence Reason	Number of Episodes
1	Chest & Respiratory Problems	42
2	Anxiety / Stress / Depression	31
3	Headache / Migraine	19

Chest and Respiratory problems are the Trust's highest reason for absence in October 2020. The last time it was the Trust's most common reason was June 2020 during which there were 40 occurrences.

Chest and Respiratory has increased from 21 episodes in September 2020. Of the 42 episodes in October 2020, 29 were recorded as Covid-19. All but one of the absences were short term.

A breakdown of occurrences due to this reason by directorate is displayed below:

Directorate	Number of Episodes
Chemotherapy	12
Corporate	5
Haemato-Oncology	5
Hosted Services	1
ICD	6
Radiation Services	12
Research	1

Absences due to Anxiety/stress/depression have decreased significantly in October 2020 after being the Trust's highest reason for absence for 4 months. Absences have decreased from 43 to 31 episodes.

In total there were 9 new absences due to Anxiety/stress/depression, 3 that ended and 19 that continued into November 2020. Of the 31 absences, 22 are long term and 9 are short term.

A breakdown of occurrences due to this reason by directorate is displayed below:

Directorate	Number of Episodes
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ICD	5 (decrease of 6 in month)
Corporate	13 (remains static in month)
Chemotherapy	6 (decrease of 3 in month)
Radiation Services	3 (decreased of 1 in month)
Quality	2 (remains static in month)
Education	1 (remains static in month)
Haemato-Oncology	1 (decrease of 2 in month)

All directorates have seen a decrease or remained static in absences of this nature.

Corporate is still the directorate with the highest number of absences due to Anxiety/Stress/depression. The table below shows which areas/teams had the highest number of absences and whether these absences are work or personal related.

Team	Number of Episodes	Work/Personal/Unknown
IM&T	2	Work x1 Personal x1
SRG Tumour Groups	7	Personal x7
Waiting Times	1	Work x1
Access & Directorate Support	2	Work x1 Personal x1
Communications	1	Personal x1

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

Level 2 Reason	Number of Episodes
Anxiety	6
Stress	8
Depression	3
Other Psychiatric Reasons	1
Blank (no level 2 reason recorded)	11
Panic Attacks	1
Not specified	1

Anxiety and stress continue to be the highest secondary reason recorded under this category.

Action Taken to Improve Compliance:

- The introduction of a half a day Mental Health Awareness Course running virtually for staff throughout October and November 2020
- The Trust has pledged its support to the [Nursing Times 'COVID-19: Are you OK?' campaign](#). The campaign recognises the impact that the pandemic has had on so many healthcare staff and the need for appropriate support to be in place for staff mental health and wellbeing
- The Trust currently has 20 trained Mental Health First Aiders available for staff to contact for one to one support
- Health and wellbeing hub – available on the Trust Extranet which features supporting guides and resources
- Team Time - a virtual forum of staff support is available for any team within the Trust to have a dedicated session (45 minutes) exploring the impact of Covid-19 on them, both professionally and personally. Team Time sessions are prepared, facilitated and supported by trained members of the Schwartz Round Steering Group

Expected date of	June 2021
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compliance	
Escalation route	Directorates, WOD Committee, Performance Reviews, Quality Committee, Trust Board
Executive Lead	Jayne Shaw, Director of Workforce & OD

PADR	Target	October 2020	12 Month Trend
	G: =>95%, A: 75 - 94.9%, R: =<75%	94.18%	
Reason for non-compliance			
<p>The Trust PADR window closed on 31st September 2020. Whilst the KPI of 95% was achieved by this date, it has not been maintained this month mainly due to PADRs for new starters not being completed within the first 3 months of their employment. The Trust is currently underperforming against the target by 0.82%</p> <p>The HO Directorate continues to have a number of staff outstanding from the original PADR deadline of 31st September 2020.</p>			
Action Taken to improve compliance			
<ul style="list-style-type: none"> All directorates have been issued with a list of staff who are outstanding for PADRs, as well as a breakdown of staff who will be due a PADR within the next 3 months, to support them in actively managing compliance. 			
Expected date of compliance	November 2020		
Escalation route	Directorates, WOD Committee, Performance Reviews, Quality Committee, Trust Board		
Executive Lead	Jayne Shaw, Director of Workforce & OD		

Turnover	Target (in month)	Oct 2020	Target (12 month rolling)	12 month rolling	12 month trend (12 month rolling)
	G: =<1.2%, A: 1.21- 1.24%, R: =>1.25%	0.94%	G: =<14%, A: 14.1 - 14.9%, R: =>15%	14.18%	

Reason for non-compliance

The rolling 12 month turnover figure has increased from 13.79% in September to 14.18% (above the Trust target) in October. The in-month turnover figure has decreased from 1.00% in September to 0.94% in October, remaining compliant with the Trust Target.

In total there were 14 leavers in October 2020 for the following reasons:

Reason for Leaving	Number of Leavers
Voluntary Resignation - Promotion	3
Voluntary Resignation - Relocation	1
Retirement Age	2
Voluntary Resignation - Work Life Balance	7
Voluntary Resignation - Adult Dependants	1

The area with the highest number of leavers was the Corporate Directorate with 5 leavers, ICD had the second highest number of leavers with 3 followed by the Chemotherapy Directorate with 2. Research, Education, Haemato-Oncology and Radiation Services all had one leaver in October 2020.

Of the 5 leavers in the Corporate directorate, these were all from the Admin Services teams as follows:

Team	Number of leavers
SRG Tumour Team	3
Patient Facing Liverpool Team	1
Waiting Times Team	1

The reasons for leaving within these teams were due to Work Life Balance (3), Promotion (1) and Retirement Age (1).

Work life balance was the highest reason for leaving in October 2020. Leavers due to this reason were from a variety of departments including the Admin Services team (3), Ward 2 (2), Matron Services (1) and Delamere Wirral (1).

The staff group with the highest number of leavers in October 2020 was Admin & Clerical, with 6 leavers, followed by Nursing with 3 leavers and Additional Clinical with 2 leavers.

The destination of leavers in October 2020 is displayed below:

Destination on Leaving	Number of Leavers
No Employment	3
NHS Organisation	6
Private Health/Social Care	1
Unknown	3
Education Sector	1

The length of service for leavers in October 2020 is displayed below:

Length of Service (years)	Number of Leavers
Fewer than 12 months	4
1 years' service	3
2 years' service	2

3 years' service	1
4 years' service	1
10-20 years' service	2
20-30 years' service	1

There were 4 leavers who were within their first year of employment with CCC. There reasons for leaving were Promotion (3) and Work life Balance (1).

Of the 14 leavers in October 2020, 6 completed exit interviews. They cited reasons for leaving such as promotion, retirement, relocation, work life balance (left for part time work as it could not be supported in current post), promotion to a permanent role and due to TUPE to CCC. Three of these exit interviews were completed by employees in their first year of employment.

Action Taken to improve compliance

- The HR Business Partnering Team will review the accessibility of exit questionnaires and interviews to improve take up in order to gather intelligence regarding motives for leaving.
- The HR Business Partnering Team will ensure that any concerns raised within Exit interviews are explored with managers to identify improvements to retain staff
- WOD have now reviewed the long service awards and awards for 10, 20,30 and 40 year points have been agreed with trade unions
- The first draft of the Admin and Clerical retention action plan was approved at the Workforce, OD and Education Committee
- A nursing retention plan continues to be monitored via the Workforce, OD and Education Committee
- In line with the NHS People Plan, the HR Business Partnering Team are working on a 'Flexible Working Promise' to ensure managers understand the benefits of flexible working and the importance of its implementation in order to recruit and retain staff

Expected date of compliance	March 2021
Escalation route	Directorates, Performance Reviews, WOD Committee, Quality Committee, Trust Board
Executive Lead	Jayne Shaw, Director of Workforce & OD

3. Covid-19 Recovery: Activity Summary

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

The weekly Covid-19 Weekly Situation Report continues to be reported to Silver and Gold Command meetings every Thursday, with an additional Monthly report now being presented on the first Thursday of the month. A report outlining the Trust's latest assumptions regarding activity and finance will be submitted to the November 2020 Performance Committee.

Electives

October 2020 activity is significantly above the Covid-19 'Phase Three Guidance' target of 90% of 2019 activity, at 135%.

Patients are screened pre-admission in line with Covid-19 guidance, ensuring effective patient flow and utilisation of beds.

There has been an increase in Solid Tumour elective admissions from 61 patients in September to 85 patients in October; averaging 4 elective admissions a day. These are mainly TYA patients, chemotherapy inpatient regimes for sarcoma and testicular cancers and we have seen an increase in Isle of Man patients for inpatient radiotherapy. This is in line with Covid-19 recovery plans and continuation of treatment for Solid Tumour patients.

HO has seen an increase in elective admissions from 28 to 36 in September. This is due to an increase in bed capacity now that the service has moved to CCCL and due to HO outlier repatriation from LUHFT.

Day Case

October 2020 activity is below the Covid-19 'Phase Three Guidance' target of 90% of 2019 activity, at 42%. There has however been an increase in activity since September 2020; October 2019 activity was particularly high, with a 25% increase on the September 2019 total.

Solid Tumour (ST) has seen a slight increase in day case activity; from 78 patients in September to 83 patients in October, we would expect this to decrease from next month as planned day case activity is transferred to Level 1 and Level 6 day care units. TYA day case activity will remain within the ST bed base until HO go live with the Meditech EPR on 1st December 2020 and the service is transferred.

As reported in the M5 and M6 IPR, the three reasons for the reported underperformance in day case activity are:

- A change in the coding of some systemic anti-cancer treatments (SACT), which means that day case activity is not expected to return to 2019 levels.
- A reduction in the number of patients having an allogeneic transplant, following the implementation of national guidance during the Covid-19 pandemic and due to the move into the new CCCL, to ensure patient safety, as stem cell patients are at a higher risk of infection and can become acutely unwell.
- An initial drop in two week rule referrals. Although these rose to 14 in September 2020, this has fallen to 9 in October 2020, similar to July and August totals.

Outpatient Appointments

The following Phase Three Covid-19 Guidance targets have been achieved since April 2020:

- Total OP appointments: above 100% of 2019 levels since April 2020.
- Follow up OP appointments: above 100% of 2019 levels since April 2020.
- % of all OP appointments which are by telephone or video: at least 68% per month against the 25% target.
- % of follow up OP appointments which are by telephone or video: at least 67% per month against the 60% target.

The target of 100% of October 2019 activity for new appointments has been exceeded in both September, at 116% and in October, at 113%.

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

CCC continues to collaborate with the Cancer Alliance to support the strategy of supporting Patient Directed Open Access (PDOA) to stratify patient follow up, reduce the OPD attendance where possible and support system capacity for any backlog of new cancer referrals. Progress to 11th November 2020 against stratifying Breast Wirral patients back to local follow up is as follows:

- 785 Liverpool patients
- 110 Isle of Man patients
- 42 Wirral patients
- A further 424 patients have been identified as potentially suitable for stratifying.

A Nurse Associate role will soon be trialled within the outpatient department. This is in response to Covid-19 related NHSE guidance to reduce footfall at CCC. As virtual consultations have increased, there has also been an increase in administration

responsibilities for Consultants. To mitigate this increase, the Nurse Associate post is being piloted to support both face to face appointments and virtual clinics.

Referrals

The Trust has assumed that referrals will increase above usual levels during Q3 as the wider system manages the backlog in diagnostic testing and elective activity. This would recover the reduced patient volumes experienced in Q1-Q2. However, any reduction to the planned restoration programs in the system will adversely impact CCC's referrals. Following a rise in referrals in September 2020 to 94% of the September 2019 total, referrals in October 2020 have fallen to 83% of last year's activity.

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

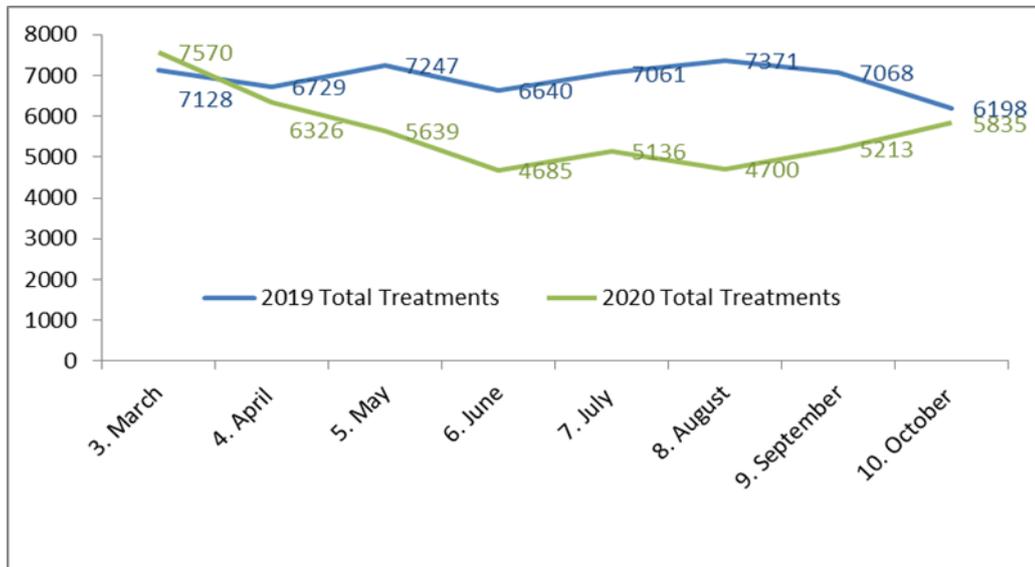
SACT Administration

Although October 2020 activity has fallen to 96% of October 2019 (from 111% in September 2020), SACT administration has increased in real terms from 5063 in September 2020 to 5099 in October 2020. The percentage reduction on October 2019 figures is due to a spike in activity last October, with increased Immunotherapy treatments being introduced.

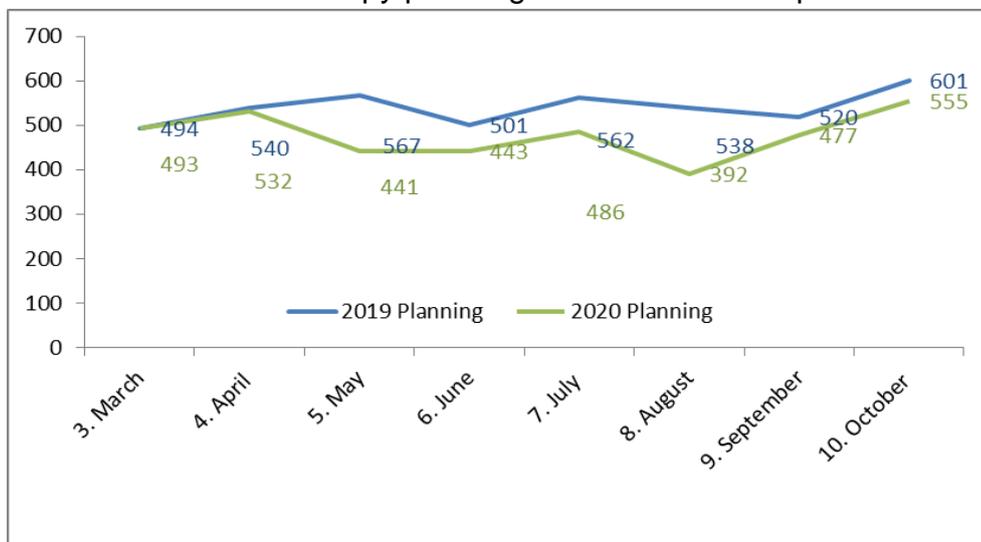
The Chemotherapy Directorate has worked to reinstate SRG recovery plans in line with the Phase 3 NHSE guidance. The activity includes a change in treatment regimens for Lung TKIs and prostate (extended treatments) and also the move to 6 weekly Pembrolizumab (from 3 weekly). In addition, future activity trends may continue to identify spikes in oral SACT delivery due to multiple cycles of treatments being dispensed within a month, with fewer attendances but the same number of patients for these treatment groups.

Radiotherapy Treatments

The chart below compares the number of patients receiving radiotherapy treatment since March, in 2019 and 2020. Activity has been steadily increasing since August 2020, however it remains slightly lower than in 2019; at 94% in October 2020.



The chart below shows the radiotherapy planning totals in 2020 compared to 2019.



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

The average utilisation on the Linacs from January 2020 to March 2020 was 93.5% with an average number of 320 fractions delivered per day. The average number of fractions delivered per day in October was 245.

Diagnostic Imaging

The Phase Three Covid-19 Guidance target of 100% of 2019 CT activity by October has been achieved, with 206% in October 2020.

The Phase Three Covid-19 Guidance target of 100% of 2019 MRI activity by October has been achieved, with 137% in October 2020.

CT and MRI activity continues to increase due to:

- Increased activity from HO for inpatients (opened mid-September) including the newly provided CT on-call service.
- Repatriation of radiotherapy planning for stereotactic radiosurgery MRI patients from The Walton Centre for Neurology and Neurosurgery.
- Increased in patient / CDU activity for all modalities
- Increase in MRI radiotherapy planning scan referrals including SABR
- Increase in MRI referrals from LWH

Ultrasound activity has also increased significantly with 249% of 2019 levels in October 2020.

This is due to:

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

The Trust is continuing to participate in the mutual aid scheme, with a similar number of repatriated patients this month, as well as patients from COCH, WUTH and LUHFT.

Stem Cell Transplants

In October 2020, 4 patients were discharged following stem cell transplant against a target of 9 patients per month. There have now been 31 patients YTD against a target of 58.

Stem Cell Transplant admissions were reduced during the month of September due to the in-patient move into CCCL. This step was taken to ensure patient safety, as stem cell patients are at a higher risk of infection and can become acutely unwell.

A full restoration plan was put in place and TCI dates set post move to CCCL. However due to the second wave of Covid-19 and the impact of SARS-CoV-2 on donors and patients, a number of planned admissions have had to be delayed and or cancelled. Some transplants have been deferred through patient choice due to their fear of having a transplant in the midst of a second wave. Patients are continually reviewed at weekly transplant MDT meetings, patients that have deferred through choice have been counselled regarding the risks and benefits and the team have risk assessed them as having disease stable enough to allow this.

The recovery of activity to plan was expected by November 2020 however this is now uncertain in the current climate of Covid-19, particularly in the North West of England. This is not isolated to the Clatterbridge Cancer Centre; transplant centres across the North West are experiencing the same uncertainty. Indeed nationally, from January 2020 to June 2020, there has been a 60% reduction in allogeneic transplants and a 50% reduction in autologous transplants. Capacity and impact of Covid-19 on restoration plans are a standing agenda item on the fortnightly North West BMT Cluster meetings.