AGENDA

Trust Board of Directors Meeting held in Public

Date: Wednesday 26 January 2022	Location: via MS Teams
Start Time: 09:00	Finish Time: 12:00

Timings	Item No		Lead	Paper/Verbal
		Opening Matters		
09:00	P1-01-22	Welcome & Apologies:	KD	Verbal
	P1-02-22	Declarations of Interest	KD	Verbal
	P1-03-22	Minutes of last meeting: 24 November 2021	KD	Paper
	P1-04-22	Matters Arising/Action Log	KD	Paper
	P1-05-22	Chair's Report to the Board	KD	Verbal
		Risk and Assurance		
9:15	P1-06-22	Quality Committee Chair's Report	TJ	Paper
9:25	P1-07-22	Performance Committee Chair's Report	GB	Paper
09:35	P1-08-22	Audit Committee Chair's Report	MT	Paper
9:45	P1-09-22	Transition of Aseptic Pharmacy Production to CCC-L: Summary Report	JSp	Paper
9:55	P1-10-22	Patient Story – Network Services	JG	Verbal
10:10	P1-11-22	Patient Experience Visits	JG	Paper
10:20	P1-12-22	New Consultant Appointments	SK	Paper
10:30	P1-13-22	Integrated Performance Exception Report: Month 09	JSp/JSh	Paper
10:40	P1-14-22	Finance Report: Month 09	JT	Paper
11:00	P1-15-22	Nursing Safer Staffing Report	JG	Paper

Agenda: April 2021: Version 2: Author: Corporate Governance

AGENDA

11:10	**P1-16-22**	Caldecott Guardian Annual Report	**SK**	**Paper**
11:20	**P1-17-22**	The CCC Green Plan: 2022-2027	**TP**	**Paper**
11:30	**P1-18-22**	Our People Commitment- Implementation Plan Update	**JSh**	**Paper**
11:40	**P1-19-22**	Health & Wellbeing at CCC	**JSh**	**Paper**
11:50	**P1-20-22**	Shadow Board Development Programme	**JSh/MT**	**Paper**
System Working				
12:00	**P1-21-22**	Cheshire & Merseyside Cancer Alliance Performance Report	**LB**	**Paper**
12:10	**P1-22-22**	Inequalities of Access to Services	**LB**	**Paper**
Corporate Governance				
12:20	**P1-23-22**	Board Assurance Framework - Quarter 3 Report	**MS**	**Paper**
12:25	**P1-24-22**	Constitution Amendments for Approval	**MS**	**Paper**
Closing Matters				
12:30	**P1-25-22**	Board Meeting Review	**ALL**	**Verbal**
	P1-26-22	Any Other Business	**ALL**	**Verbal**

Next Meeting:

Date: Wednesday 23 February 2022	Location: MS Teams
Start Time: 09:00	Finish Time: 12:30

Agenda: April 2021: Version 2: Author: Corporate Governance

Minutes of the Trust Board of Directors held in Public

Held on: Wednesday 24 November 2021	Location: **MS Teams**
Start time: 9:00am	Finish time:

Present

Kathy Doran (KD)	Chair
Mark Tattersall (MT)	Non-Executive Director
Terry Jones (TJ)	Non-Executive Director
Elkan Abrahamson (EA)	Non-Executive Director
Asutosh Yagnik (AY)	Non-Executive Director
Liz Bishop (LB)	Chief Executive
James Thomson (JT)	Director of Finance
Joan Spencer (JSp)	Chief Operating Officer & Interim Chief Nurse
Jayne Shaw (JSh)	Director of Workforce and OD
Sheena Khanduri (SK)	Medical Director
Sarah Barr (SB)	Chief Information Officer
Tom Pharaoh (TP)	Director of Strategy
Julie Gray (JG)	Chief Nurse

In attendance

Margaret Saunders (MS)	Associate Director of Corporate Governance
Emily Kelso (EK)	Corporate Governance Manager **(minutes)**
Jane Wilkinson (JW)	Lead Governor
Alun Evans (AE)	Staff Side Representative

Observer

Janice Smith (JS)	Good Governance Institute

Item no.	Agenda item	Action
P1-186-21	**Chair Welcome and Note of Apologies** The Chair welcomed all to the meeting, no apologies were noted.	
P1-187-21	**Declarations of Board Members and other attendees' interests concerning agenda items:** • Mark Tattersall – Nominated Non-Executive Director for PropCare • Terry Jones – Director of Liverpool Head and Neck Centre and Medical Director of Research, Liverpool University Hospital NHS Foundation Trust • Geoff Broadhead – Nominated Non-Executive Director for CPL • James Thomson – Executive Lead for PropCare and CPL	
P1-188-21	**Minutes of Previous Board Meeting: 27 October 2021**	

	The minutes of the Board meeting held on 27 October 2021 were approved subject to one minor amendment: • Item P1-184-21 be amended to read - JT provided a further update on BAF 3 confirming the risk scoring had increased from 12 to 16. **The Trust Board:** **Approved** the minutes of the previous meeting subject to the above amendment.	
P1-189-21	**Matters Arising/Action Log** The Board noted that actions were either complete, on the Agenda or not yet due. In addition the following amendment was requested: **P1-103-21 - 5-Year Strategy Implementation Plan** should have a completion date of January 2022 as opposed to January 2021. **The Trust Board:** **Noted** the position in relation to the Action Log.	MS
P1-190-21	**Chair's Report to the Board** KD informed the Board of the appointment of the ICS Chief Executive Graham Urwin who had previously held the position of Director of Performance for the North West with NHSE. It was expected that he would start the position in December, the Trust looked forward to establishing a good working relationship with Graham who had been invited to visit CCC in January. It was further confirmed that David Flory remained as the Interim Chair for the ICS until at least January 2022, whilst recruitment plans took place. KD gave an overview of her activities throughout the month; most In relation to ICS matters with specialist Trusts, the Provider Alliance and Chair colleagues across the region, discussions were focused on working together on priorities. It was confirmed that that during the Provider Alliance development session two clinical areas were identified as priorities for Cheshire and Merseyside; those were Orthopedics and Endoscopy, and in addition Cancer remained as the top priority. KD further informed the Board of her involvement in the recruitment process for the new Chair of Liverpool Heart & Chest (LH&C) NHF FT, which had been successful and a candidate was to be recommended to the LH&C Council of Governors for approval The Board were further advised of the meeting that had taken place on Monday 22nd November instigated by David Flory with national representatives on health inequalities from NHSE, to look at the Health Inequalities Framework to ensure that all Trusts respect the need to address national health inequalities, and the workstreams to be taken forward to address. **The Trust Board:** **Noted** the Report	
	Risk and Assurance	
P1-191-21	**Quality Committee Chair Report**	

	TJ introduced the report, alerting the Board to progress on the Aseptic Pharmacy Unit noting that positive progress had continued against the projected move date of the 6th December. Assurance was received on the action plan and mitigations of risks, which could contribute to any further delays. Assurance was received that despite staffing challenges, sufficient establishment was in place to support the move to CCC Liverpool. TJ further advised the Board of the transition to the new Datix Cloud IQ system and highlighted that the manual move of information from the previous system had posed some challenges but continued to progress well. Improvements to reporting content and format were to be reflected in future reports. TJ advised that the performance against Research and Innovation KPI, recovery trajectory would be monitored through more detailed exception reporting in to the committee. LB confirmed that a further Aseptic Pharmacy Programme Board meeting had taken place on Monday 22nd November where it was confirmed by the Interim Chief Pharmacist that the that the projected move date remained as 6th December, a final confirmation on quality assurance from North West Pharmaceutical Quality Assurance (NWPQA) was expected on the 29th November. KD asked that the Board be kept informed on the progress following receipt of the NWPQA report on the 29th November. **The Trust Board:** **Discussed and noted** the content of the report. **Agreed** progress updates on APU planned move date 6th December would be circulated to all Board members and Trust Staff.	**LB/JSp**
P1-192-21	**Performance Committee Chair's Report** GB introduced the report informing the Board of the detailed discussion that had taken place during the committee meeting in relation to operational and financial planning particularly in relation to the uncertainty around the ERF. It was noted that JT would go into further detail on the updated position and the Trusts submission to the ICS under Item P1-198-21. GB further advised the Board of the ongoing work with LUHFT and commissioners on the transfer of the Hematology-Oncology service to CCCL, specifically around agreed income. It was expected this would be resolved in the coming months and the Board would be kept informed on the progress. The committee had discussed the challenges around the CIP for H2, including the additional requirement following the H2 planning process and contribution to the system planning gap. The committee requested a further analysis of the CIP schemes be in included in monthly finance reporting in to the committee. GB informed the Board that the Medical Staffing Deep Dive had been deferred to January 2022, due to some further diagnostic work taking place, which was essential to the robustness of the report. **The Trust Board:** **Discussed and noted** the content of the report	

<table>
<tr><td>P1-193-21</td><td>Charitable Funds Chair's Report

EA introduced the report advising the Board of the shortfall in charitable funds, which had the potential to become a risk if income did not see an increase.

The Board were further assured of the assessment of charity artwork donations. An action was agreed that an asset register to be set up of the Trust's artwork, following this the Trust's insurance was to be reviewed to ascertain sufficiency.

KD sought assurance that the implications of the shortfall in charitable funds had been built in to the Trusts financial planning. JT confirmed that risks were being managed, based on the latest charity forecast.

The Trust Board:

Discussed and noted the content of the report</td><td></td></tr>
<tr><td>P1-194-21</td><td>Staff Story

KD informed the Board that the staff member who had been scheduled to present their staff story this month was unable to attend the meeting.

KD asked that the story be rescheduled for 2022.

The Trust Board:

Noted the deferral of the staff story</td><td>JSh</td></tr>
<tr><td>P1-195-21</td><td>Patient Experience Visits

JSp provided an overview of the report informing the Board that the Patient Experience 'rounds' were conducted on the 16th November 2021, visiting radiation and chemotherapy services at CCC Aintree and Marina Dalglish sites. Due to Covid-19 restrictions across all CCC sites took place virtually. JSp highlighted the following key points taken from they visit:
Patients enjoyed sitting in the communal seating areas prior to treatment where they were able to share their experiences with others
Some challenges with car parting accessibility were noted, the Board were assured that these were being addressed and that there were car park transfer options available to patients, however communications of the available options required some improvement.
Overall staff enjoyed working at the Aintree site and were happy to see medical staff returning to outpatient departments, following Covid-19 restrictions.
MT commented that the Shadow Board had discussed the car parking accessibility issues and made a number of possible suggestions to mitigate. JSp confirmed these suggestions would be considered along with others in order to improve the experience of patients and their family members.

MT sought clarification on the recording and communicating of themes/outputs from patient visits and how these were communicated to Trust staff, as discussions in Shadow Board suggested that feedback was not always received. JSp confirmed that the Teams received feedback following the visits, however this could be picked up with individuals and any barriers to the communication flow would be identified and resolved.</td><td>JSp</td></tr>
</table>

	The Trust Board: **Discussed and noted** the content of the report	
P1-196-21	**New Consultant Appointments** KD acknowledged that no new Consultants had commenced at the Trust in month.	
P1-197-21	**Integrated Performance Report: Month 07** JSp provided an overview of the report highlighting that both the Performance Committee and Quality Committee had reviewed the reports in detail. The following exceptions were highlighted: There were key challenges around infection rates which were being monitored by the Quality Committee and had been presented in the Infection Prevention & Control Deep Dive along with the associated action plans to support improved care delivery. JSp informed the Board that an Outpatient Reporting Recovery Plan paper had been presented to the Performance Committee who had approved the recommendations in order to improve the position. JW queried the indents per 1000 bed days resulting in harm. It was explained that rather than recording an absolute figure the report was per 1000 bed days in order to identify trends, which were managed by the Quality Committee. AY explained that the figure given was a Year to Date figure, which in month had shown a decrease compared to the previous month and had not been flagged as a concern by the Quality Committee. MT queried the increased demand for ambulance services (to transfer patients to other hospitals and hospices) resulting in delays in arrival, which was referenced under efficiency section 2.2 of the IPR and flagged by the Shadow Board who discussed the consideration of using private ambulance services. JSp confirmed that the Trust was engaging in conversations with LUHFT on capacity available within their private ambulance contract. **Workforce** JSh introduced the workforce section of the report highlighting the following: I. Sickness absence had increased from 4.73% to 5.05%, it was further noted that there were a number of divisions where performance was above target. II. PADRs continued to show a steady improvement and were currently sitting slightly above 94% against the 95% target. III. It was noted that information on Flu and Covid-19 vaccination rates had been included in the report; however, some adjustments were to be made to the Covid-19 vaccination information to break it down into 1st, 2nd and booster categories. IV. JSh further highlighted the response rate for the national staff survey, which was to close at the end of the week. The Trust target had been set at 60%, to date the Trust had seen 61% and it was hopeful 62% would be achieved. It was further noted that the Trust was sitting at the top of the national response rate chart. MT sought assurance on the Trusts plans following the announcement that Covid-19 vaccinations were to be mandatory for health and social care staff by the end of March and whether any further guidance had been received. JSh confirmed that no further	**JSp**

	guidance had been received to date, however data was being analysed so that the Trust was clear on the vaccination position and identifying any risk areas. **The Trust Board:** **Discussed and noted** the content of the report.	
P1-198-21	**Finance Report: Month 07** JT introduced report which provided a summary of the Trust financial performance for October 2021, the seventh month of the 2021/22 financial year. The following key points were highlighted from the report: I. The ICS were managing the required financial position of each Trust through a whole system approach. The requirement for the Trust for the first six months of the year (H1) was to achieve a break-even position. II. The had submitted a draft plan to the ICS for the second six months of the year (H2) on 11th November, which identified a planned deficit of £6.167m, which had been impacted by the loss of ERF income. III. It was highlighted that the underspends were reduced because of CIP commitment, resulting in a financial position of £468k deficit against an £806k deficit plan at the close of month 7. IV. Cheshire & Merseyside organisations had been asked to review their positions and identify slippage and unrequired contingency. The Trust had identified £150k and offered a further £350k to support system pressures. MT commented that there had been some discussion at Shadow Board around the increased CIP requirements for H2 as outlined in the paper and how this was going to be managed by the Trust. JT confirmed that the CIP increase had not been passed back to divisions but instead managed centrally, both non-recurrently and recurrently including the work being undertaken around payroll. It was explained that supporting managers to effectively manage CIP risks and work towards targets was a priority for the Trust. It was further noted that strategic planning in regards to the transformation of services in line with ICS plans were crucial to achieving system wide cost improvement. KD highlighted to the Board, the recent Award won by James Thomson - Finance Director. The award was for Finance Director of the Year, JT added that the award reflected the hard work and commitment of the Trusts Finance Team. **The Trust Board:** **Discussed and approved** the financial position of the Trust	
P1-199-21	**Learning from Deaths – Mortality Dashboards** SK introduced the report The National Guidance on Learning from Deaths published in March 2017 requires Trusts to collect and publish specified information on inpatient deaths on a quarterly basis, which is made available to the public through a report to the Trust Board and includes, lessons learned from the analysed data. SK explained that the lag in reporting was due to the time taken for the review process, and for this reason the Board was receiving the Quarter 1 report in Month 8. SK further explained the mortality review inclusion criteria and the case review selection process as detailed within the report.	

	From the report it was noted that from the 51 cases were selected for discussion, 38 cases were discussed, of which 33 cases were scored a RCP score of 6, 3 were scored 5 and 1 was scored 4. SK provided the Board with detail on each of the cases which had scored below 6 using the Structured Judgement Review (SJR) pro-forma, the evidence-based methodology provided by the Royal College of Physicians. MT queried whether any external support or peer assessment was sought through the review process. SK explained the mortality review meeting, involving a peer review from colleagues within the Trust who did not practice within the tumor site in question, providing internal challenge in addition to benchmarking against other cancer specialist Trusts. A medical examiner review which was also completed which was an independent review normally carried out by a LUHFT clinician. EA queried the process for patients who chose to opt for DNR, which was an issue currently receiving media attention and public concern. SK explained the Trusts robust process for consent to DNR as part of the discussions and paperwork when agreeing treatment options, signed by both the patient and clinician. The Board were assured that in a case where a patient condition deteriorates quickly family members (next of kin) were fully engaged in decision making around DNR. It was further noted that if a patient were to deteriorate quickly and refuses or declines treatment these discussion were captured in the clinical notes, and a letter would follow summarising the discussion and choices made. EA sought further assurance around the process specifically asking patients to sign and agree to DNR and standardisation with national protocol/processes. SK agreed this could be picked up with the clinical teams and assurance provided to the Board on the process in line with national guidance. AY sought more detail on each of the phases in the review process, which were summarised within the report. SK provided a clear explanation on each of the phases. It was noted that where trends were identified with an individual consultant or specific treatment regimes an audit process was undertaken and findings reported through the Trusts Mortality Surveillance Group. The Board were assured that in most cases a volume effect was the cause of the spike, i.e. a consultant treating more patients and when taken as a percentage and benchmarked the figures compared well. It was agreed that some further work could be carried out on presentation of Mortality processes to Board and Board Committees in order to provide assurance. **The Trust Board** **Noted** the Report	SK
System Working		
P1-200-21	**Cheshire & Merseyside Cancer Alliance Performance Report** LB provided an overview of the system wide performance report highlighting that restoration of cancer services continued with a focus on creating sufficient capacity, to ensure equity of access across the system and to build patient confidence. The key highlights from the report were: I. 2 week wait referrals continue to be high, 121% of pre-Covid level II. Cancer surgery activity was reporting high at 129% of pre-Covid levels , and the demand continues to be high III. There was a sustained increase in SACT which continued to present challenges to service delivery, however CCC was taking a number of steps to ensure that demand continued to be met.	

	IV. Some issues were noted in relation to endoscopy, due to one provider underreporting, it was expected this would be resolved by month end. Demand continued to be very high, doubling between July 2020 and March 2021. It was noted that The Alliance had established an endoscopy operational recovery team (EORT) to oversee and co-ordinate restoration activities. V. The Trust was benchmarking in a median position when compared national, and particular attention was being focused on the Faster Diagnosis Standard VI. There was some concern around 62 and 104 day waits which was being driven by the diagnostic backlogs, as detailed within the reported charts, with the 62-day wait showing an increment for several weeks, which was driving an increase in the 104 day wait. The target was to decrease these waiting times by March 2022, which would be a challenge. **The Trust Board:** **Noted** the content of the report.	
P1-201-21	**North West Region Health & Wellbeing Pledge** JSh introduced the report which contained information on the current regional position for sickness and outlined the proposal around the North West Wellbeing Pledge. The key pointes taken from the report were as follows: I. the North West Region has the highest rates of sickness absence in England II. The Trusts sickness absence had been on an upward trajectory since April 2021. However, in comparison to the rest of the North West region, the Trust's sickness absence rates are consistently below the regional average III. At the North West HR Directors Network Wellbeing workshop in September 2021 it was highlighted that the current focusing on sickness absence was missing the opportunity to improve health and wellbeing more generally. As an output from the workshop organisations were asked to sign up to Our Pledge for the Wellbeing of our NHS People, details of which were outlined in the report. The Board discussed the paper and the pledge agreeing that the pledge was somewhat vague and created uncertainty as to what the Board were being asked to support. KD led the Boards discussion around the Trusts commitment to supporting the Health and Wellbeing of all staff and that the pledge whilst not explicit shared the Trusts strategic objective to Be a Great Place to Work by focusing on supporting a culture of wellbeing. It was agreed that the Board would support the pledge in principle and further details on would be presented to the Board in January. This would form part of the pledge implementation plans for the region particularly given the position of the North West region as an outlier in regards rates of sickness. **The Trust Board:** **Noted** the content of the report. **Supported** in principle, the North West Health & Wellbeing Pledge **Agreed** that further detail would be presented to the Board in January	**JSh** **JSh**
	Closing Matters	
P1-202-21	**Board Meeting Review**	

Version: 1.0 Ref: FCGOMINS Review: May 2024

	KD reflected on the meeting together with Board members, it was agreed that the meeting had been effective with constructive challenge and conversation on key topics such as the Trusts CIP, quality, work around patient experience and mortality dashboards. It was agreed all discussions aligned well to the progression against the Trusts strategic objectives.	
P1-203-21	**Any Other Business** The Board discussed the opportunities available for NEDs to be involved in the Shadow Board programme in future years, it was agreed the programme had enriched the board debate as well as provided a developmental tool to senior managers. EA explained that some of the scheduled PEIG/PEIOG meetings clashed with Trust Committee meetings and asked if any other NEDs may be available to attend the meetings when he was unavailable. It was agreed this could be discussed as part of the Non-Executive Directors (NED) Board Committee Membership, Subsidiary Company Directorships and Champion Roles 2021/2022.	

Next meeting:

Date: Wednesday 26 January 2021	Location: **MS Teams**
Start time: 09:00 hours	Finish time: 11:30

Signature:	Date:
Chair	(Insert date when minutes are signed)

ACTION PLAN

Trust Board

Last updated: 15 December 2021

Updated by: Emily Kelso

Key
R = Compromised or significantly off-track. To be escalated / rescheduled
A = Experiencing problems - off track but recoverable
G = On track
B = Completed

Item Ref	Date of Meeting	Item	Actions	Owner	Completion Date	RAGB	Status Update
P1-103-21	30-Jun-21	5 Year Strategy: Implementation Plan	To revise formatting of the Report as discussed including a summary of key milestones. Future progress reports to be presented to the Board 6-monthly.	**TP**	Jan-22	A	On the Trust Board Agenda January 2021 - Deferred to March 2022 alongside Performance Committee Presentations
P1-127-21	28-Jul-21	Inequalities of Access to Services	Cancer Alliance to provide an update report on prioritisation of access	**JH/LB**	Jan-22	G	On January Board Agenda P1-22-22
P1-147-21	29-Sep-21	Gender Pay Gap	To provide assurance on the gender pay gap amongst sub-contacted staff. An analysis of pay arrangements across the Trust's subsidiaries, was planned.	**JSh/MS**	Jan-22	G	
P1-148-21	29-Sep-21	Workforce Race Equality Standard (WRES)	To extend Staff Surveys to contracted ISS staff Governance Review of the reporting processes and frequency of WRES & WRDS, it was agreed quarterly reporting thorough Quality Committee should be taken forward Staff member from the BAME network to be invited to present at Board Navajo project to be considered for involvement by the Trust once the new EDI lead was in post	**JSh** **JSh** **JSh** **AR/EDI Lead/JSh**	Jan-22	G	 Scheduled for November 21, due to staff member being unavailable deferred to March 2022

ACTION PLAN

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

P1-150-21	29-Sep-21	Staff Survey – Culture and Engagement Update	Results of the new Staff Survey to be presented to the Board	**JSh**	Feb-22		
Any Other Business	29-Sep-21	Any Other Business	Shadow Board participants to be invited to share their story with the Board on completion of the programme	**JSh**	Feb-22		
P1-168-21	27-Oct-21	Minutes of the Previous Meeting	Governor involvement in "Clatterbridge Radio" options to be explored	**SB/JW**	Jan-22		
P1-177-21	27-Oct-21	Integrated Performance Report: Month 06	Medical Workforce Deep Dive to be presented to the Performance Committee in November	**JSh**	Nov-21		Deferred to Jan 2022 Performance Committee Meeting PC-12-22
P1-178-21	27-Oct-21	Finance Report - Month 6	Financial Impact Analysis report on APU to be presented to Performance Committee Details of CIPs to be presented through the Performance Committee	**JT**	March-22		Performance Committee revived a JV Report presented by JT Item PC-108-21 Quality Committee revived the APU Diagnostic Report 18th November QC-243-21 presented by JSp & TP, and presented at Board Part 2 Report to be presented to Performance Committee Q4
P!-184-21	27-Oct-21	Board Assurance Framework	A further review of the Trust BAF to take place	**MS**	Feb-22		Further review of the Trust BAF, a report on progress to be presented
P1-179-21	27-Oct-21	Research & Innovation Annual Report	Bright Ideas Scheme progress Update and Outcomes to be presented to the Board	**GH**	Feb-22		
P1-180-21	27-Oct-21	Guardian of Safe Working	Future reports to include content around the nature of exceptions and how they were managed	**SK**	Q3 2021/22		
P1-195-21	24-Nov-21	Patient Experience Visits	Feedback following the visits, to be picked up with individuals and any barriers to the communication flow identified and resolved	**JSp**	Jan-22		
P1-199-21	24-Nov-21	Mortality Dashboards	Further work to be carried out on presentation of Mortality processes to Board and Board Committees in order to provide assurance.	**SK**	Q4-2021/22		
P1-201-21	24-Nov-21	North West Health & Wellbeing Pledge	It was agreed that the Board would support the pledge in principle and further details	**JSh**	Jan-22		Agenda Item for January Board P1-19-22

			on would be presented to the Board in January.				

Guidance Notes:

This word document contains a basic template for an action plan. It can be used for most purposes and can be adapted to meet your specific needs. For example, extra columns can be added to show which department(s) actions relate to, or to add the names of clinical and executive leads.

Your action plan will be more effective if you try to adhere to S.M.A.R.T principles:

S - Be **Specific** about what you want to achieve. Do not be ambiguous and communicate clearly.
M - Ensure your result is **Measurable**. Have a clearly defined outcome and ensure this is measurable (KPIs).
A - Make sure it is **Appropriate**. Is it an **Achievable** outcome? Does everyone **Agree**?
R - Check that it is **Realistic.** It must be possible taking account of time, ability and finances.
T - Make sure it is **Time** restricted. Set yourself an achievable timeframe. Set deadlines and milestones to check your progress.

Use the RAGB (red, amber, green and blue) traffic light system to make it easy to see progress at a glance.

Key:

R = Compromised or significantly off-track. To be escalated / rescheduled
A = Experiencing problems - off track but recoverable
G = On track
B = Completed

Committee/Group 'Triple A' Chair's Report

Name of Committee/Group	Quality Committee	Reporting to:	Trust Board
Date of the meeting:	20 January 2022	Parent Committee:	
Chair:	Terry Jones	Quorate (Y/N)	Y

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Risk & Issues Summary Report		The Committee discussed in detail the transition to the new Datix Cloud IQ system. It was noted that further work was to take place with the system developers following some delays experienced in data extraction. The committee received assurance of the progress being made in risk reporting across the Trust, and it was noted that the report would evolve over the coming months.	Committee to receive a revised report in February	SB/JSp/CL	February 2022
Nursing Safer Staffing Reports & Dashboard		The Nursing Safer Staffing Report was accepted and the committee noted that staffing establishments for in-patient wards were sufficient to provide safe and compassionate care. The committee requested a similar report for the wider clinical workforce.	Assurance report on Medical Staffing that was presented at Performance Committee to be circulated to the QC Assurance report on the wider clinical workforce and plans to be brought back to the Committee	JSh/SK	Immediate April 2022
Drugs & Therapeutics Committee Chairs Report		Compassionate Funding - The Committee discussed in detail the Trusts' provision of an additional funding route for cohorts of patients who fell outside of NHSE funding criteria and the associated financial and ethical risks to the Trust. It was agreed the risk required adding to the Trust Risk Register. The Committee received assurance that the matter would be reported through the Trusts committee structure and where required	Assurance to be reported back into the Committee, through the Trusts robust governance reporting and structure.	JSp	February 2022

Trust Board - 26 January 2022-26/01/22

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
	(Amber)	would be reported into Quality Committee and Trust Board.			

(Red)	**ALERT** the Committee on areas of non-compliance or matters that need addressing urgently
(Amber)	**ADVISE** the Committee on any on-going monitoring where an update has been provided to the sub-committee and any new developments that will need to be communicated or included in operational delivery
(Green)	**ASSURE** the Committee on any areas of assurance that the Committee/Group has received

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Committee/Group 'Triple A' Chair's Report

Name of Committee/Group	Performance Committee	Reporting to:	Trust Board
Date of the meeting:	19 January 2022	Parent Committee:	
Chair:	Geoff Broadhead	Quorate (Y/N)	Y

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Operational and Financial Planning		The Committee received a presentation on the Financial and Operational Planning for 2022/23 and discussed in detail the following: • NHSE had published guidance 24th December 21 • Final planning submissions from Trusts and Systems (ICS) had been delayed to the end of April • The 10 planning themes identified which were consistent with the NHS Long Term plan • The key targets for the system and the Trust, notably increasing elective and diagnostic activity and reducing outpatient follow ups • The duty for the Trust to achieve a breakeven position for 2022/23 and the risks in achieving this, including inflation uplift/costs, efficiency targets and receipt of activity based funding	Updates would continue to be shared with the committee bi-monthly	JT	Ongoing
Finance Report – Month 9		The Committee received and discussed the report, noting: • The current strong liquidity of the Trust • The Trusts reliance upon receiving Elective Recovery Funding (ERF) to achieve a breakeven position for H2 and the risks associated. **Cost Improvement Programme (CIP)** The committee again discussed the challenges around the CIP and welcomed the inclusion of details around CIP schemes.	Bi-monthly updates to continue into the Committee.	JT	Ongoing

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Medical Staffing Deep Dive		The Committee received a presentation summarising the Trust's current position in regards to medial staffing, providing an update in regards to the current issues and opportunities identified to mitigate potential risk. The committee discussed in detail the recommendations and were assured that the trust were taking the necessary actions to mitigate issues, recognising this was a national concern. It was acknowledged that there was some further work to be undertaken around Nursing and AHP establishment to identify gaps and to mitigate risks.	It was agreed an update report would be presented again in 6 months' time.	JSh	July-22
Covid-19 Response Tiers - Update		The committee received the update report on the tiered levels of Covid-19 response, determined by the local case rates. It was noted that the current version had been revised to include new measures implemented since moving in to the Red Tier in December 2021. It was noted that the tool would remain under review and would be adapted, based on national guidance received.	Bi-monthly reports to continue into the committee	JSp	March-22
Integrated Performance Report – Month 9		The committee received the IPR and discussed the exceptions as acknowledged within the report. The committee discussed in detail the underperformance against the sepsis KPI. It was noted this was under review. The committee were reminded that a deep dive into bed occupancy was taking place.	Review to be reported in the M10 IPR. To be reported back to the committee in Q4.	HG JSp/JG	March-22 March-22
Research & Innovation Business Plan		The committee received the report and noted the progress against the Workstreams. It was recognised that 20/21 had been a challenging year for the Trust in relation to R&I and that recovery against KPIs was starting to show some promising trajectories.	4 monthly performance reports to continue into the Committee	GH	May 2022
Update on Clinical Decision Unit (CDU) Service Development		The committee received the report presented by Dr Anna Olson-Brown - Project Lead, noting the positive progress made to date following on from the move to the new CCCL and the integration of HO services.	Further progress reports to be presented to the committee in 6 months' time	JSp	July 2022

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
		The Committee received assurance on the development of the improvement programme and the identification of the next steps required.			
Green Plan		The Committee received the Green Plan which had been reviewed by the Sustainability Group and Executive Team in December 2021. The plan was agreed to recommend to the Board for approval. It was noted that the ICS were to develop a consolidated system-wide Green Plan by 31st March 2022.	Agreed to recommend the Green Plan to Board for approval at its January meeting. Asked to receive a further progress report in 6 months' time	TP	26 Jan 2022 July 2022

	ALERT the Committee on areas of non-compliance or matters that need addressing urgently
	ADVISE the Committee on any on-going monitoring where an update has been provided to the sub-committee and any new developments that will need to be communicated or included in operational delivery
	ASSURE the Committee on any areas of assurance that the Committee/Group has received

CHAIR'S REPORT

Committee/Group 'Triple A'

ALERT the Committee on areas of non-compliance or matters that need addressing urgently
ADVISE the Committee on any on-going monitoring where an update has been provided to the sub-committee and any new developments that will need to be communicated or included in operational delivery
ASSURE the Committee on any areas of assurance that the Committee/Group has received

Name of Committee/Group: Audit Committee	Reporting to: Trust Board
Date of meeting: 20 January 2022	Parent Committee:
Chair: Mark Tattersall	Quorate: Yes

Agenda item	RAG	Key points	Actions required	Action lead	Expected date of completion
AUD-006-22 Internal Audit Progress Report	Green	Two reports finalized Health Roster, and Key Financial Systems both received substantial assurance. Medical Devices report currently draft. Two reviews currently in progress, Research and Incident Management. Reviews for Q4 in planning/implementation phase.	Continue to monitor progress of Reviews and recommended actions.	Internal Audit Manager Associate Director of Corporate Governance	1 April 2022
AUD- 008-22 Anti-Fraud Progress Report	Amber	The Government Functional Standard for Counter Fraud (GovS 013) Component 3 first stage of mapping fraud risks completed. Fraud risk assessment for Trust and two subsidiary companies completed. A green rating is anticipated by April 2022 The final rating for Component 12 Conflicts of Interest and Gifts and Hospitality arrangements/registers is dependent upon AUD-020—22, below.	Risks to be recorded in line with the Trust Risk Management Policy. Implementation of the recommendations resulting from the MIAA Management of Conflicts of Interest Review having received limited assurance.	Director of Finance (DoF)/ Associate Director of Corporate Governance	April 2022

CHAIR'S REPORT

AUD- 009-22 Anti-Fraud, Bribery and Corruption Policy Review		Review complete	Approved	MIAA Anti-Fraud Specialist	Approved 20 January 2022
AUD-011-22 External Audit Introduction – Ernst Young		Introductory meeting with update of current planning position.	Submission of Audit Plan 2021/2022.	Ernst Young	1 April 2022
AUD-012-22 Director of Finance Report		Planning for a balanced financial position by the end of the year. Detail provided to Performance Committee – Wednesday 19 January 2022.	Continue to monitor in preparation for final account 2021/2022.	Director of Finance (DoF)	May 22
AUD-013-22 Key Finance Assurance Indicators		This is the first month that performance in respect of paying creditors-BPPC-is greater than 95% in all areas. Significant improvements made in reduction of aged creditors and debtors with a significant decrease in 'write off'.	Maintain improvements delivered in all areas and under timescales put ongoing.	Deputy Director of Finance (DoF)	On-going
AUD-020—22 Managing Conflicts of Interest Update		Actions implemented to address recommendations in MIAA Managing Conflicts of Interest Report, Recommendation 1, Declarations of Interest. 8 recommendations remain with an anticipated date for completion no later than September 2022.	Continue to receive regular assurance regarding all recommendations with Report.	Associate Director of Corporate Governance	September 2022

REPORT COVER

Report to:	Trust Board
Date of meeting:	26th January 2022
Agenda item:	P1-09-22
Title:	Transition of aseptic pharmacy production to CCC-L: summary report
Report prepared by:	Jayne Shaw – Director of Workforce & OD Joan Spencer - Director of Operations Tom Pharaoh – Director of Strategy
Executive Lead:	As above
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Trust Executive Group
Date & decision:	7th December 2021

Purpose of the paper/key points for discussion:	The purpose of this paper is to summarise the position with regard to the transition of aseptic pharmacy production to CCC-Liverpool. The paper summarises the preparations and governance put in place to support the transition of aseptic pharmacy production to CCC-L in December 2021. The paper notes the decision of the Aseptic Pharmacy Move Programme Board to support the proposed transition of production to CCC-L on 6th December on behalf of the Trust.

Action required: (please tick)	Discuss	☐
	Approve	☐
	For information/noting	☒

Next steps required:	

Version 1.1 Ref: FCGOREPCOV Review: July 2024

REPORT COVER

The paper links to the following strategic priorities and Board Assurance Framework (BAF) Risks (please select)

☒ BE **OUTSTANDING**

BAF Risk	Please select
If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	☐
Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	☒
Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☐

☒ BE **COLLABORATIVE**

BAF Risk	Please select
If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	☐

☒ BE **RESEARCH LEADERS**

BAF Risk	Please select
If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	☒
Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	☒

☐ BE **A GREAT PLACE TO WORK**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☐
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	☒
If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	☐

☐ BE **DIGITAL**

BAF Risk	
If we do not invest a clear vision, sufficient capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve its digital ambition.	☐
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	☐

☐ BE **INNOVATIVE**

BAF Risk	
If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	☐

EQUALITY & DIVERSITY IMPACT ASSESSMENT								
Are there concerns that the policy/service could have an adverse impact on:								
Age	Yes ☐	No ☒	Disability	Yes ☐	No ☒	Gender	Yes ☐	No ☒
Race	Yes ☐	No ☒	Religious/belief	Yes ☐	No ☒	Sexual orientation	Yes ☐	No ☒
Gender Reassignment	Yes ☐	No ☒	Pregnancy/maternity	Yes ☐	No ☒			

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

Version 1.1 Ref: FCGOREPCOV Review: July 2024

Transition of aseptic pharmacy production to CCC-L

Summary report 10/01/22

Contents

1.0 Introduction 2
2.0 Aseptic Pharmacy Move Programme Board 2
3.0 Workforce and recruitment 3
4.0 CCC infection prevention and control 3
5.0 External quality assurance 4
6.0 Mobilisation planning 5
7.0 After the move 5
8.0 Conclusion 6

REPORT

1.0 Introduction

The purpose of this paper is to summarise the position with regard to the transition of the Aseptic Pharmacy Production Unit from CCC - Wirral to CCC-Liverpool that took place on the 6th December 2021.

2.0 Aseptic Pharmacy Move Programme Board

To ensure a successful move the planning and preparations for this work programme were subjected to a full assurance process that mirrored the governance process in place for the opening of CCC-L in June 2020.

The creation of a new time-limited Aseptic Pharmacy Move Programme Board was a key part of this assurance process. The programme board started meeting in May 2021 and its remit has been to:

- Scrutinise and challenge the preparations for the opening of the CCC-L unit
- Ensure that the full range of preparations are in place and that no one element of these preparations gets undue attention
- Advise the wider Trust on the readiness of the Pharmacy Team to open the CCC-L unit and make recommendations as appropriate
- To provide the governance and senior leader oversight of the plan to increase the scale of production in CCC-Liverpool.

The programme board is chaired by the Director of Workforce and Organisational Development, with membership made up of the Medical Director, Chief Operating Officer/Interim Chief Nurse, Director of Finance, Chief Information Officer and Director of Strategy, as well as the Divisional Director for Acute Care, senior members of the pharmacy team and other key senior managers.

The programme board meets monthly to receive regular situation reports on the progress, key issues and risks in the programme to prepare to open the CCC-L aseptic unit. Progress updates have covered all relevant topics, including workforce and recruitment, estates issues, quality assurance and the qualification process, and staff training and familiarisation.

The initial intention was for the programme board to gain assurance that the transition to the CCC-L unit should proceed and make this recommendation to the Trust Executive Group (TEG). As it became clear that the earliest possible move date would be 6th December 2021 it was noted that this was out of sync with the TEG schedule. As such it was proposed and agreed that:

REPORT

- In addition to the scheduled programme board meeting on 22nd November 2021, a further "go/no go" programme board meeting should be scheduled for 30th November 2021 in line with the dates of the expected external quality assurance process (see section 5)
- The membership of the programme board was expanded to include the full executive team for the meeting on 22nd November 2021 and the go/no go meeting (adding the Chief Executive Officer and the newly-appointed Chief Nurse)
- The programme board would then be in a position to make the go/no go decision on behalf of the Trust (as the CCC-L Programme Board had done for the opening of the new hospital in June 2020)

3.0 Workforce and recruitment

Staffing was identified as a key risk early in the preparations to open the CCC-L unit. A business case was developed, scrutinised and agreed through the Trust's governance processes to ensure that the pharmacy team was appropriately resourced to make the move to CCC-L.

The programme board continues to receive regular updates on the progress of recruitment to key posts and the ongoing pipeline of recruitment. At the programme boards on both 22nd and 30th November 2021 the pharmacy team reported sufficient staff in post to make the transition but that additional recruitment will be required to further increase production at CCC-Liverpool following the move and that this resource was included in the business case.

4.0 CCC infection prevention and control

On 26th November 2021 a review of the pharmacy environment at CCC-Liverpool was undertaken by the Trust's infection prevention and control (IPC) team. The aim of the review was to ensure that issues identified on previous IPC reviews had been rectified ahead of the relocation of services from Wirral to Liverpool. The review was limited to the outer areas of the department as the aseptic unit itself was due to be reviewed by external quality assurance on 29th November.

At the go/no go meeting on 30th November 2021 the programme board received the report of the IPC team. The report made a number of recommendations for minor improvements but concluded that:

REPORT

"Overall, it was evident that huge improvements have been made to both practice and environment. A bespoke pharmacy audit tool has been developed, this was used as a baseline for the review and an overall score of 97% was achieved. The review team are happy that from an IPC perspective, Wirral services can be relocated back to Liverpool. However, both the IPC team and Pharmacy team are mindful that this review provides a snapshot in time and there needs to be an emphasis on sustaining the improvements as the unit become fully operational."

5.0 External quality assurance

There are two key local agencies involved in pharmacy quality assurance: North West Pharmaceutical Quality Assurance (NWPQA) and Quality Control North West (QCNW). While their names are often used interchangeably, they are separate and distinct. QCNW undertakes laboratory based and scientific testing for hospital pharmacies in support of quality control within their production processes; NWPQA supports the quality assurance programmes of pharmacy production units though audits and advisory services. It is the audits and recommendations of NWPQA that are most relevant to the decision to move aseptic production to CCC-Liverpool.

The pharmacy team has reported close working with colleagues from NWPQA through the process to prepare for the opening of the CCC-Liverpool unit. Following on from this supportive work, NWPQA made a formal audit visit on 29th November 2021 to assess the readiness for opening the unit.

At the go/no go meeting on 30th November 2021 the programme board received a copy of email correspondence from NWPQA summarising its position following the formal audit.

"The visit took place to review the qualification of the new unit ahead of commencing preparation under section 10 on the site. The scope of the visit was restricted to review of facility qualification, and therefore no risk rating has been assigned. A full audit has been scheduled for January 20th 2022. Having reviewed evidence of the qualification testing to date, no concerns have been identified with respect to the facility which is planned to be brought into use on 6th December 2021.

NWPQA provided feedback to the Pharmacy Team immediately after their visit via email. The email from NWPQA gave advance notice of areas for further improvement that would be noted in the full written report. The pharmacy team presented an action plan

REPORT

that had been developed to address these further improvements at the go/no go meeting of the programme board on 30th November 2021.All actions have now been completed.

6.0 Mobilisation planning

A detailed mobilisation plan – similar to those produced by all services prior to the opening of CCC-Liverpool in June 2020 – has been developed by the pharmacy team. The mobilisation plan outlines all of the preparations necessary to support the opening of the unit on the planned date and includes plans in a wide range of areas, including staff training, rotas for the move period, the communications plan for the move, and arrangements for deliveries and consumables.

The final version of the mobilisation plan was presented to the programme board at the go/no go meeting on 30th November 2021. The programme board noted considerable progress with the ongoing elements of the plan since its meeting on 22nd November 2021. The programme board noted that the planned actions were largely complete but that some remained open and would need completion in the final week before the move. The pharmacy team stated that a daily operational team meeting had been scheduled in the run up to 6th December 2021 and then that a command and control would take place 3 times a day over the first week of operation to ensure that any operational issues can be quickly addressed.

7.0 After the move

The aseptic production unit at CCC-Wirral unit will remain operational following the opening of the CCC-Liverpool unit. There are two reasons for this:

1. To begin to develop batch production processes that will once developed take place in CCC-Liverpool
2. To be available in the (unlikely) event that the transition to CCC-Liverpool is again unsuccessful and production needs to return in full to CCC-Wirral

The CCC-Wirral unit will continue to be cleaned and maintained until all production is taking place at CCC-Liverpool and the CCC-L unit is fully established.

Following the move to CCC-Liverpool the pharmacy team will initially undertake small scale production in the new unit. The pharmacy team is already developing a plan to increase the scale of production in CCC-Liverpool over time, repatriating production currently being undertaken by LUHFT and reducing the volume of outsourced drugs that the Trust buys in.

It is proposed that the Aseptic Pharmacy Move Programme Board continues to meet beyond the 6th December 2021 transition date to oversee and monitor the plans to increase production at CCC-L, repatriate work from LUHFT and reduce outsourced production.

8.0 Conclusion

Following its assessment of the progress made towards commencing aseptic production at CCC-Liverpool – and taking into account the internal assurance from the IPC team and external assurance from NWPQA – the Aseptic Pharmacy Move Programme Board agreed that the move should proceed on 6th December 2021 as proposed.

This decision, and the key documentation that supported it, were shared with commissioning colleagues following the go/no go meeting of the programme board and their support was received to proceed with the transition.

Addendum 6th December 2021
The transition to CCCL on the 6th December 2021 was a success, production commenced and continues without issue. Staff are delighted to be working as a single team at one site. The Senior Operational Team were on site to welcome and support staff. The Charity Team provided funds for breakfast and lunch for the Pharmacy Team, who were delighted with this gesture.
The Aseptic Pharmacy Move Programme Board will continue to provide regular progress reports to the Trust Executive Group until full scale production is achieved.

REPORT COVER

Report to:	Trust Board	
Date of meeting:	26 January 2022	
Agenda item:	P1-10-22	
Title:	Patient Story – Network Services	
Report prepared by:	Julie Gray – Chief Nurse	
Executive Lead:	Julie Gray – Chief Nurse	
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	n/a
Date & decision:	n/a

Purpose of the paper/key points for discussion:	The Patient story provides the Board with insight into an individual patients experience. It is told from their own perspective, giving the Trust an opportunity to understand their experience of the care they have received, and what could be done to improve their experience, as detailed within the report under Actions Already Taken and Action Plan.

Action required: (please tick)	Discuss	☒
	Approve	☐
	For information/noting	☒

Next steps required:	As detailed within the Action Plan

REPORT COVER

The paper links to the following strategic priorities and Board Assurance Framework (BAF) Risks (please select)

☒ BE **OUTSTANDING**

BAF Risk	Please select
If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	☒
Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	☐
Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☐

☒ BE **COLLABORATIVE**

BAF Risk	Please select
If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	☐

☐ BE **RESEARCH LEADERS**

BAF Risk	Please select
If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	☐
Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	☐

☐ BE **A GREAT PLACE TO WORK**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☐
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	☐
If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	☐

☐ BE **DIGITAL**

BAF Risk	
If we do not invest a clear vision, sufficient capacity and investment6 in our digital programme and teams there is a risk that the Trust will not achieve its digital ambition.	☐
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	☐

☐ BE **INNOVATIVE**

BAF Risk	
If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	☐

EQUALITY & DIVERSITY IMPACT ASSESSMENT								
Are there concerns that the policy/service could have an adverse impact on:								
Age	Yes ☐	No ☐	Disability	Yes ☐	No ☐	Gender	Yes ☐	No ☐
Race	Yes ☐	No ☐	Religious/belief	Yes ☐	No ☐	Sexual orientation	Yes ☐	No ☐
Gender Reassignment	Yes ☐	No ☐	Pregnancy/maternity	Yes ☐	No ☐			

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

Version 1.0 Ref: FCGOREPCOV Review: May 2024

Patient/Staff Story – Action Report

Julie Gray – Chief Nurse

Version: 1.0 Ref: FCGOREPO Review: May 2024

Patient/Staff Story Action Report

Story ID	Sarah	Committee	Board of Directors		
Date Presented	26/01/22	Patient Story	☒	Staff Story	☐
		In person	☐	Digital	☒
Date Consent Obtained	10/01/22	Consented by	Head of Patient Experience & Inclusion	Consent for:	Internal ☒ External ☒ Online ☒
Division/s involved	Networked Services - Outpatients & Clinical Support		External Organisation involved		
Formal Complaint	☐	Complaint closed	☐	Complaint Upheld	☐

1. Action Already Taken

No	Issue	Action taken	Action Lead
1	Awareness of issues experienced by the patient	Patient story shared with divisional teams	Head of Patient Experience & Inclusion
2	Scan-xiety – impact on the patient	Discussed by clinical specialists in PET/CT	Radiology Quality & Operational lead
3	Text messaging process	Review of appropriateness of message content	Chief Nursing Information Officer
4	Named Consultant	Contact details provided to Sarah	Administrative Service Lead

2. Action Plan *(for outstanding actions not covered above)*

No	Issue	Action required	Action Lead	Deadline Date	Expected Evidence of Completion
1	Scan-xiety	1.Review current provision of advanced communication training 2.Develop Scanxiety animated infographic	Psycho-oncology team	June 2022	Training prospectus Communi-cation tool
2	Flight process from Isle of Man - The patient liaises directly with the IOM Patient Transfer team CCC team provide contact details	1.Review of current process to identify areas for improvement 2.Undertake annual audit of patient experience (if numbers >10)	Administrative Service Lead	March 2022 March 2022	Review paper Audit report
3	Text messaging process 7 days before the appointment - standard reminder text message Day before the appointment - standard reminder text message One way text - patients would need to call back on the number stated on appointment letter. Follow up appointments/text messages are managed by scheduling team	1.Review of current process to identify areas for improvement 2.Survey patient understanding and satisfaction with this service	Administrative Service Lead Chief Nursing Information Officer	March 2022 March 2022	Review paper Survey report

4	Named consultant All CCC patients have a named Consultant and associated phone numbers clearly stated on the appointment letter	1. Random sample audit of patients awareness of named consultant	Administrative Service Lead/Matron OPD	March 2022	Audit report
5.	Patient required scheduling and checking	1.Review current pathway and identify areas for improvement	Divisional Director	June 2022	Task & Finish group report

3. Process for monitoring completion of identified improvement/assurance actions

All actions identified during the collation of patient and staff experience stories will follow the process set out in the Patient and Staff Experience Story Process Standard Operating Procedure. Actions will be assigned to the appropriate subject matter committee for action and evidence of resolution. Where significant service transformation is required, that is beyond the remit of the Head of Patient Experience & Inclusion, the management of the change process will be handed over to the Transformation and Improvement Committee. An annual report summarising any themes, learning and changes in practice will be collated by the Head of Patient Experience & Inclusion.

REPORT COVER

Report to:	Trust Board
Date of meeting:	26 January 2022
Agenda item:	P1-11-22
Title:	Patient Experience Visits 09.12.2021
Report prepared by: In attendance at visit:	Kirsteen Scowcroft, Head of Patient Experience John Roberts, Governor
Executive Lead:	Julie Gray, Chief Nurse
Status of the report: (please tick)	Public ☒ Private ☒

Paper previously considered by:	n/a
Date & decision:	n/a

Purpose of the paper/key points for discussion:	The purpose of this report is to provide Trust Board with oversight and a summary of the NED & Governor Patient Experience visit conducted on the 9th December 2021 at CCC Wirral Outpatients, Radiotherapy and Delamere chemotherapy unit.

Action required: (please tick)	Discuss	☐
	Approve	☐
	For information/noting	☒

Next steps required:	Trust Board are requested to; • Note the visit undertaken and patient voice accounts of their experience of care at CCC • Request further updates as required

REPORT COVER

The paper links to the following strategic priorities and Board Assurance Framework (BAF) Risks (please select)

☐ BE **OUTSTANDING**

BAF Risk	Please select
If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	☒
Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	☒
Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☐

☐ BE **COLLABORATIVE**

BAF Risk	Please select
If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	☐

☒ BE **RESEARCH LEADERS**

BAF Risk	Please select
If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	☐
Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	☐

☐ BE **A GREAT PLACE TO WORK**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☐
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	☒

☐ BE **DIGITAL**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☐
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	☐

☐ BE **INNOVATIVE**

BAF Risk	
If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	☐

EQUALITY & DIVERSITY IMPACT ASSESSMENT								
Are there concerns that the policy/service could have an adverse impact on:								
Age	Yes ☐	No ☒	Disability	Yes ☐	No ☒	Gender	Yes ☐	No ☒
Race	Yes ☐	No ☒	Religious/belief	Yes ☐	No ☒	Sexual orientation	Yes ☐	No ☒
Gender Reassignment	Yes ☐	No ☒	Pregnancy/maternity	Yes ☐	No ☒			

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

Version 1.0 Ref: FCGOREPCOV Review: May 2024

Patient Experience Visits 09.12.2021

John Roberts, Governor
Kirsteen Scowcroft, Head of Patient Experience

Report: April 2021: Version 2: Author: Corporate Governance

1. Summary

Patient Experience 'rounds' were conducted on the 9th December 2021, visiting radiation, networked and chemotherapy services at CCC Wirral site. Due to Covid-19 restrictions across all CCC sites John Roberts, Governor was able to accompany Kirsteen Scowcroft, Head of Patient Experience virtually on this occasion as scheduled.

The below key findings and observations are intended to be taken as a first-hand account as told by the patients and staff.

2. Key Findings and Observations

- Patient experiences and comments - Four patients and a carer in the Delamere bays & waiting area receiving chemotherapy at CCC Wirral were asked to share their experiences of their treatment ranging from 30 minutes up to 7 hours depending on their treatment plans. Sharing that you can't improve on perfection, for two patients it was their first visit and everything & everyone caring for them was 'spot on'. It helped being close to home as relatives are able to drop off/collect them at the main entrance and park up and wait, but unfortunately not able to accompany them to their treatment. They turn to their own digital devices or a good book to keep them occupied with the TVs playing the radio for background noise and distraction. Although one patient commented how poor the mobile phone signal and WIFI network was in Bay 3 & 4 areas. One patient was on their first treatment using the cold cap, which is understandably cold, but had researched online as to what to bring with them and what to expect so brought a blanket and warm clothing, so didn't feel scared or anxious. Another patient commented whilst waiting for a blood test, that not having family with them was hard, but understandable, but it did force them to talk to other patients waiting in the waiting area for social contact and with those going through similar experience, which was a positive that they took from it. One carer waiting for their relative who had travelled from North Wales shared how hard it had been in the past year losing one relative and then receiving the news of a terminal diagnosis of another. They highlighted their frustrations as a carer and family member about the lack of Mental Health support outside of hospitals not just for the patient, but also the family.

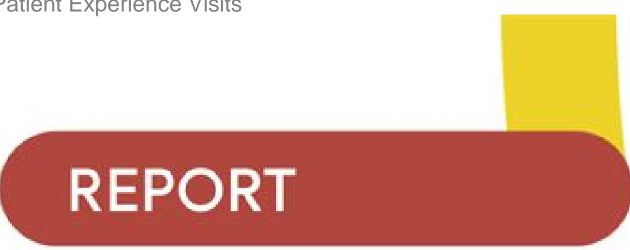
- Patient experiences and comments – One inspirational patient at the outpatient's department shared that they felt very well cared for by the staff, and having good family and friends to support them helped as they undergo four weeks of intensive radiotherapy and chemotherapy to 'blast' their cancer. It was

always appreciated that a good cup of tea and biscuits are provided by the housekeeping staff in outpatients, but if they could have one wish, often waiting up to an hour or longer in Radiotherapy waiting area, would be to have the same refreshments provided in Radiotherapy on the CCC Wirral site. In Radiotherapy a patient and carer who was accompanying them as they find it difficult to walk now and extremely fatigued, due to being on the 6th cycle out of 12 for radiotherapy. The patient is taking it all in their stride, having their carer with them helps greatly, but the emotional toll on their carer was visible and raw for them as they come to terms with the diagnosis and prognosis of their family member. They commented that the use of technology was great to see being used in this way to conduct walkabouts with a governor, but it was difficult to hear, so would have been better with clearer sound.

- Staff experiences and comments
  Staff shared their experiences of working at CCC Wirral and Delamere unit. One recently joined the Trust three weeks ago and was finding their way around the site with the help of colleagues. Another member of staff has worked on outpatients as a support worker for eight years and wanted to learn more about the role of the governor, which John was glad to share. Car parking is much easier and available on the CCC Wirral site compared to CCC Liverpool where some chemotherapy staff also work on a rotational basis. Also comments and discussion about how helpful it is to have a volunteer on Delamere to help with beverages, biscuits and handing out sandwiches to patients, how the Christmas tree on Delamere was spreading festive cheer and that Delamere remains a constant and busy unit, continuing to treat 60+ patients per day on the CCC Wirral site.

- What does CCC do well?
  Patients feel well supported and cared for and put at ease during a difficult time, especially where visitors restrictions continue.
  Staff working extremely hard, during extremely busy and challenging time in the lead up to Christmas and New Year.

- What can CCC do better?
  Review a beverage and biscuit provision at Radiotherapy department on the CCC Wirral site, particular as the CCC Liverpool Radiotherapy department have a beverage bay, where patients can stay hydrated whilst they are waiting for their treatment.



3. Next Steps and Recommendations

- Discuss report findings at Trust Board
- Note content of report
- Feedback shared with areas during the visit
- Acknowledge the need for further action required to share feedback received with relevant Divisional leaders and teams, by the Head of Patient Experience
- Request further updates as required

REPORT COVER

Report to:	Trust Board
Date of meeting:	26th January 2022
Agenda item:	P1-12-22
Title:	Consultant Appointment
Report prepared by:	Catherine Hignett-Jones
Executive Lead:	Jayne Shaw
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	
Date & decision:	

Purpose of the paper/key points for discussion:	Information on appointment of new consultants

Action required: (please tick)	Discuss	☐
	Approve	☐
	For information/noting	☒

Next steps required:	N/A

REPORT COVER

The paper links to the following strategic priorities and Board Assurance Framework (BAF) Risks (please select)

☐ BE **OUTSTANDING**

BAF Risk	Please select
If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	☐
Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	☐
Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☐

☐ BE **COLLABORATIVE**

BAF Risk	Please select
If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	☐

☐ BE **RESEARCH LEADERS**

BAF Risk	Please select
If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	☐
Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	☐

☐ BE **A GREAT PLACE TO WORK**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☐
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	☒
If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	☐

☐ BE **DIGITAL**

BAF Risk	
If we do not invest a clear vision, sufficient capacity and investment6 in our digital programme and teams there is a risk that the Trust will not achieve its digital ambition.	☐
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	☐

☐ BE **INNOVATIVE**

BAF Risk	
If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	☐

EQUALITY & DIVERSITY IMPACT ASSESSMENT								
Are there concerns that the policy/service could have an adverse impact on:								
Age	Yes ☐	No ☒	Disability	Yes ☐	No ☒	Gender	Yes ☐	No ☒
Race	Yes ☐	No ☒	Religious/belief	Yes ☐	No ☒	Sexual orientation	Yes ☐	No ☐
Gender Reassignment	Yes ☐	No ☒	Pregnancy/maternity	Yes ☐	No ☒			

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

Version 1.0 Ref: FCGOREPCOV Review: May 2024

Introduction

This paper provides an update to the Trust Board on consultant appointments in post December 2021

A short biography and account of achievements for the Consultant appointment is provided as follows:

Name	Dr Matthew Howell
Job Title	Consultant Medical Oncologist
Qualifications	MBChB MRCP Medical Oncology Specialty Examination
Speciality	Lung & AO
GMC number	GMC: 6156553
Membership/Appointments	
Details	Recently employed by Manchester University NHS Foundation Trust as Lung cancer Clinical Fellow with responsibility for outpatient clinics, inpatient care, conduct of clinical trials, MDTs, acute oncology (all cancer subtypes) and teaching Previously employed by The Christie as Medical Oncology registrar with responsibility for outpatient clinics, acute oncology inpatient care, conduct of clinical trials, MDTs, and teaching

REPORT COVER

Report to:	Board of Directors
Date of meeting:	Wednesday 26th January 2022
Agenda item:	P1-13-22
Title:	Integrated Performance Report M9 2021/2022
Report prepared by:	Hannah Gray: Head of Performance and Planning
Executive Lead:	Joan Spencer: Chief Operating Officer
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Performance Committee and Quality Committee
Date & decision:	Wednesday 19th and Thursday 20th January 2022

Purpose of the paper/key points for discussion:	This report provides the Board of Directors with an update on performance for month 9 2021/22 (December 2021). The access, efficiency, quality, research and innovation, workforce and finance scorecards are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant. Points for discussion include under performance, developments and key actions for improvement.

Action required: (please tick)	Discuss	☒
	Approve	☒
	For information/noting	☐

Next steps required:	

Version 1.1 Ref: FCGOREPCOV Review: July 2024

REPORT COVER

The paper links to the following strategic priorities and Board Assurance Framework (BAF) Risks (please select)

☒ BE **OUTSTANDING**

BAF Risk	Please select
If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	☒
Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	☒
Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☒

☒ BE **COLLABORATIVE**

BAF Risk	Please select
If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	☒

☒ BE **RESEARCH LEADERS**

BAF Risk	Please select
If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	☒
Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	☒

☒ BE **A GREAT PLACE TO WORK**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☒
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	☒
If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	☒

☒ BE **DIGITAL**

BAF Risk	
If we do not invest a clear vision, sufficient capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve its digital ambition.	☒
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	☐

☒ BE **INNOVATIVE**

BAF Risk	
If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	☐

EQUALITY & DIVERSITY IMPACT ASSESSMENT								
Are there concerns that the policy/service could have an adverse impact on:								
Age	Yes ☐	No ☒	Disability	Yes ☐	No ☒	Gender	Yes ☐	No ☒
Race	Yes ☐	No ☒	Religious/belief	Yes ☐	No ☒	Sexual orientation	Yes ☐	No ☒
Gender Reassignment	Yes ☐	No ☒	Pregnancy/maternity	Yes ☐	No ☒			

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

Version 1.1 Ref: FCGOREPCOV Review: July 2024

REPORT

Integrated Performance Report (Month 9 2021/22)

Hannah Gray: Head of Performance and Planning
Joan Spencer: Chief Operating Officer

Introduction

This report provides an update on performance for month nine; December 2021. The access, efficiency, quality, workforce, research and innovation, and finance scorecards are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant.

Staff flu vaccine and Covid booster vaccine data is again included in this M9 report. The following document was published on 6 December 2021; The Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers Phase 1: Planning and Preparation (V1). This is not yet mandated and therefore targets have not yet been applied, or figures reported for specific staff groups in the IPR.

NHS England and Improvement published 'The 2022/23 priorities and operational planning guidance' on 24th December 2021. The guidance includes targets for elective, diagnostic and outpatient follow up activity. The Trust is reviewing how these targets will inform both the Trust Operational Plan for 2022/23 and activity reporting in the IPR.

As part of the IPR annual review, the following developments are planned for 2022/23:

- Using Statistical Process Control charts to display the performance data,
- The development of an online IPR dashboard.

1. Performance Scorecards

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

1.1 Access

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Dec-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer						
L	**9 days** from referral to first appointment	↔	G: ≥90% A: 85-89.9% R: <85%	92.5%	93.7%	J F M A M J J A S O N D
C/S	**2 week wait** from GP referral to 1st appointment	↔	93%	93.3%	98.0%	J F M A M J J A S O N D
L	**24 days** from referral to first treatment	↔	G: ≥85% A: 80-84.9% R: <80%	92%	88.6%	J F M A M J J A S O N D
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	↔	75% (formally monitored since Oct 2021)	78.6%	83.0%	J F M A M J J A S O N D
C/S	**28 day** faster diagnosis - (Screening)	-	75% (formally monitored since Oct 2021)	No patients	0%	There has only been 1 28 Day FDS Screening patient during this time
S	**31 day** wait from diagnosis to first treatment	↔	96%	98.7%	99.3%	J F M A M J J A S O N D
C/S	**31 day** wait for subsequent treatment (Drugs)	↔	98%	99.2%	99.4%	J F M A M J J A S O N D
C/S	**31 day** wait for subsequent treatment (Radiotherapy)	↔	94%	100.0%	98.8%	J F M A M J J A S O N D
S	Number of **31 day** patients treated **≥ day 73**	↔	0	0	0	0 for all months
C/S	**62 Day** wait from GP referral to treatment	↔	85%	91.9%	89.3%	J F M A M J J A S O N D
C/S	**62 Day** wait from screening to treatment	↓	90%	75.0%	88.2%	J F M A M J J A S O N D
L	Number of patients treated between **63 and 103 days** (inclusive)	↑	No Target	47	385	J F M A M J J A S O N D
S	Number of patients treated => **104 days**	↓	No Target	12	131	J F M A M J J A S O N D
L	Number of patients treated => **104 days AND at CCC for over 24 days (Avoidable)**	↔	G: 0 A: 1 R: >1	0	4	J F M A M J J A S O N D
C/S	Diagnostics: **6 Week Wait**	↔	99%	100%	100%	J F M A M J J A S O N D
C/S	**18 weeks** from referral to treatment (RTT) Incomplete Pathways	↔	92%	97.7%	98.5%	J F M A M J J A S O N D

Notes:

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

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

Cheshire and Merseyside Cancer Waiting Times Performance:

This data has not yet been published nationally.

1.2 Efficiency

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Dec-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer						
S (SOF)	Diagnostic activity as % of the same month in 2019/2020		95% of 2019/20 levels	189%	184%	J F M A M J J A S O N D
S (SOF)	% of all (non-treatment) outpatient activity delivered remotely via telephone or video		25%	66%	69%	J F M A M J J A S O N D
L	Outpatient Appointments (including treatments) as % of the same month in 2019/2020		95% of 2019/20 levels	129%	129%	J F M A M J J A S O N D
S	Length of Stay: Elective (days): Solid Tumour		G: ≤6.5 A: 6.5-6.8 R: >6.8	8.9	6.8	J F M A M J J A S O N D
S	Length of Stay: Emergency (days): Solid Tumour		G: ≤8 A: 8.1-8.4 R: >8.4	9.1	8.1	J F M A M J J A S O N D
S	Length of Stay: Elective (days): HO Ward 4		G: ≤21 A: 21.1-22.1 R: >22.1	17.3	16.3	J F M A M J J A S O N D
S	Length of Stay: Emergency (days): HO Ward 4		G: ≤22 A: 22.1-23.1 R: >23.1	5.5	11.4	J F M A M J J A S O N D
S	Length of Stay: Elective (days): HO Ward 5		G: ≤32 A: 32.1-33.6 R: >33.6	17.6	19.2	J F M A M J J A S O N D
S	Length of Stay: Emergency (days): HO Ward 5		G: ≤46 A: 46.1-48.3 R: >48.3	10.8	12.5	J F M A M J J A S O N D
S	Delayed Transfers of Care as % of occupied bed days		≤3.5%	4.4%	3.1%	J F M A M J J A S O N D
S	Bed Occupancy: Midnight (Ward 4: HO)		G: ≥85% A: 81-84.9% R: <81%	84.4%	86.9%	J F M A M J J A S O N D
S	Bed Occupancy: Midnight (Ward 5: HO)		G: ≥80% A: 76-79.9% R: <76%	66.2%	73.7%	J F M A M J J A S O N D
S	Bed Occupancy: Midday (Solid Tumour)		G: ≥85% A: 81-84.9% R: <81%	71.7%	71.5%	J F M A M J J A S O N D
S	Bed Occupancy: Midnight (Solid Tumour)		G: ≥85% A: 81-84.9% R: <81%	70.7%	72.1%	J F M A M J J A S O N D
C	% of expected discharge dates completed		G: ≥95% A: 90-94.9% R: <90%	89.0%	86.0%	J F M A M J J A S O N D
C/S	% of elective procedures cancelled on or after the day of admission		0%	0%	0%	0% for all months
C/S	% of cancelled elective procedures (on or after the day of admission) rebooked within 28 days of cancellation	-	100%	None cancelled	N/A	No elective procedures have been cancelled on or after the day of admission
C/S	% of urgent operations cancelled for a second time		0%	0%	0%	0% for all months
L	Imaging Reporting: Inpatients (within 24hrs)		G: ≥90% A: 80-89.9% R: <80%	94.5%	96.5%	J F M A M J J A S O N D
L	Imaging Reporting: Outpatients (within 7 days)		G: ≥90% A: 80-89.9% R: <80%	85.3%	81.1%	J F M A M J J A S O N D
C/Phase 3 Covid-19 Guidance	Data Quality - % Ethnicity that is complete (or patient declined to answer)		G: ≥95% A: 90-94.9% R: <90%	97.7%	96.8%	J F M A M J J A S O N D
C	Data Quality - % of outpatients with an outcome		G: ≥95% A: 90-94.9% R: <90%	100.0%	99.7%	J F M A M J J A S O N D
C	Data Quality - % of outpatients with an attend status		G: ≥95% A: 90-94.9% R: <90%	100.0%	99.7%	J F M A M J J A S O N D
Executive Director Lead: James Thomson, Director of Finance						
S	Percentage of Subject Access Requests responded to within 1 month		100%	100%	99.5%	J F M A M J J A S O N
C	% of overdue ISN (Information Standard Notices)		0%	0%	0%	0% for all months

1.3 Quality

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Dec-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Julie Gray, Chief Nurse						
C/S	Never Events		0	0	0	0 for all months
C/S	Serious Untoward Incidents (month reported to STEIS)		0	0	4	J F M A M J J A S O N D
C/S	Serious Untoward Incidents: % submitted within 60 working days / agreed timescales		100%	0 requiring submission	80%	J F M A M J J A S O N D
S	RIDDOR - number of reportable incidents		0	0	2	J F M A M J J A S O N D
S	Significant accidental or unintended exposure (SAUE); Radiotherapy delivered dose or Radiotherapy geographical miss - Treatment Errors		G: ≤3 A: 4-5 R: >5	0	0	J F M A M J J A S O N D
S	Significant accidental or unintended exposure (SAUE); Radiotherapy delivered dose or Radiotherapy geographical miss - Imaging Errors		G: ≤8 A: 9-12 R: >12	0	1	J F M A M J J A S O N D
S	Incidents /1,000 Bed Days		No target	156.6	193.35	J F M A M J J A S O N D
L	Incidents resulting in harm /1,000 bed days		No target	11	19	J F M A M J J A S O N D
C/S	Inpatient Falls resulting in harm due to lapse in care		0	0	0	0 for all months
S	Inpatient falls resulting in harm due to lapse in care /1,000 bed days		0	0	0	0 for all months
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care)		0	0	0	0 for all months
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care) /1,000 bed days		0	0	0	0 for all months
S	Consultant Review within 14 hours (emergency admissions)*		90%	95.9%	97.8%	J F M A M J J A S O N D
C/S	% of Sepsis patients being given IV antibiotics within an hour*	-	90%	Data not yet validated	94.8%	J F M A M J J A S O N D
C/S	VTE Risk Assessment		95%	95.0%	95.6%	J F M A M J J A S O N D
S	Dementia: Percentage to whom case finding is applied		90%	100.0%	98.0%	J F M A M J J A S O N D
S	Dementia: Percentage with a diagnostic assessment	-	90%	No patients	N/A	No patients were referred
S	Dementia: Percentage of cases referred	-	90%	No patients	N/A	No patients were referred
C/S	Clostridiodes difficile infections (attributable)		≤11 (pr yr)	0	11	J F M A M J J A S O N D
C/S	E Coli (attributable)		≤6 (pr yr)	1	8	J F M A M J J A S O N D
C/S	MRSA infections (attributable)		0	1	1	J F M A M J J A S O N D
C/S	MSSA bacteraemia (attributable)		G: ≤4, A: 5 R: >5 (pr yr)	1	2	J F M A M J J A S O N D
C	Klebsiella (attributable)		≤6 (pr yr)	1	5	J F M A M J J A S O N D
C	Pseudomonas (attributable)		≤10 (pr yr)	0	0	0 for all months
C/S	FFT score: Patients (% positive)		G: ≥95% A: 90-94.9% R: <90%	97%	96%	J F M A M J J A S O N D

The Quality KPI scorecard continues on page 5

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Dec-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Julie Gray, Chief Nurse						
C	Number of formal complaints received		No target	7	32	J F M A M J J A S O N D
S	Number of formal complaints / count of WTE staff (ratio)		No target	0.004	0.002	J F M A M J J A S O N D
C	% of formal complaints acknowledged within 3 working days		100%	100%	97%	J F M A M J J A S O N D
L	% of routine formal complaints resolved in month, which were resolved within 25 working days**		G: ≥75% A: 65-74.9% R: <65%	0%	64%	J F M A M J J A S O N D
L	% of complex formal complaints resolved in month, which were resolved within 60 working days	-	G: ≥75% A: 65-74.9% R: <65%	None to resolve	N/A	100% or None to be resolved in all months, except 0% in March 2021 and Sept 2021
C/S	% of FOIs responded to within 20 days		100%	100%	100%	J F M A M J J A S O N D
C/S	Number of IG incidents escalated to ICO**	-	0	Data under review	0	1 incident under review as at 14/1/22
C	NICE Guidance: % of guidance compliant		G: ≥90% A: 85-89.9% R: <85%	94%	93%	J F M A M J J A S O N D
L	Number of policies due to go out of date in 3 months		No target	24	N/A	J F M A M J J A S O N D
L	% of policies in date		G: ≥95% A: 93.1-94.9% R: <93%	94%	96%	J F M A M J J A S O N D
C/S	NHS E/I Patient Safety Alerts: number not implemented within set timescale.		0	0	0	0 for all months

NB: blue arrows are included for KPIs with no target and show the movement from last month's figure.
HCAI targets have been amended in line with National Guidance. An amber, rather than red RAG rating is now applied to YTD figures that do not breach the annual target.
*This data is subject to change following final validation. The sepsis target was not achieved in November 2021 – no patients experienced harm as a result of this, however a full review is underway and will be reported in the M10 IPR.
** One Dec 2021 IG incident is under review, to determine whether this requires reporting to the ICO.
The NHS complaints process timelines have been relaxed to allow Trusts to prioritise the necessary clinical changes required to respond to the Covid-19 pandemic. The Trust Policy currently allows more than 25 days with patients' consent.

1.4 Research and Innovation

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Dec-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Sheena Khanduri, Medical Director						
L (Strategy)	Study recruitment		G: ≥108 A: 92-107 R: <92 (pr month)	133	610	J F M A M J J A S O N D
National	Study set up times (days)		≤40 days	N/A	N/A	Latest reporting period is 1/10/20 – 30/09/21: **30 days**
L (Strategy)	Recruitment to time and target		G: ≥55% A: 45-54.9% R: <45%	N/A	N/A	Latest reporting period is 1/10/20 – 30/09/21: **0 days**
L (Strategy)	Studies Opened		G: ≥5 A: 4-5 R: <4 (pr month)	1	31	J F M A M J J A S O N D
L (Strategy)	Publications		G: ≥11 A: 10-9 R: <9 (pr month)	17	157	J F M A M J J A S O N D

An amber, rather than red RAG rating is now applied to YTD figures that do not breach the annual target.

1.5 Workforce

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Dec-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Jayne Shaw, Director of Workforce and Organisational Development						
S	Staff Sickness Absence		G: ≤4% A: 4.1-4.9% R: ≥5%	6.2%	4.9%	J F M A M J J A S O N D
S	Staff Turnover*		G: ≤1.2% A: 1.21–1.24% R: ≥1.25%	1.11%	12.7%	J F M A M J J A S O N D
S	Statutory and Mandatory Training		G: ≥90% A: 75-89% R: ≤75%	95.39%	N/A	J F M A M J J A S O N D
L	PADR rate		G: ≥95% A: 75-94.9% R: ≤74%	94.35%	N/A	J F M A M J J A S O N D
C	Flu: % of 'Frontline' CCC Staff Vaccinated (at 31/12/21)		85% by campaign end	67%	N/A	-
L	Covid-19: % of CCC Staff who have had the **first** dose vaccination (at 31/12/21)		No national target	96%	N/A	-
L	Covid-19: % of CCC Staff who have had the **first and second** dose vaccination (at 31/12/21)		No national target	94%	N/A	-
L	Covid-19: % of CCC Staff who have had the **first, second and booster** vaccination (at 31/12/21)		No national target	79%	N/A	-

*The YTD figure is cumulative; this enables monitoring of the annual target of 14%. Data is extracted from ESR on the first working day of the new month, however staff leaving and joining the Trust in the previous month can be recorded on the system after this time. A decision was therefore taken to extract the YTD data from ESR each month, rather than use the data provided monthly to calculate this. This explains why the YTD figure may not appear representative of the monthly figures to date. This early extraction of data is necessary to meet the deadlines for Committees.

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

1.6 Finance

For December, the key financial headlines are:

Metric (£000)	In Mth 9 Actual	In Mth 9 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	(76)	34	(110)		(516)	102	(618)	
CPL/Propcare Surplus/ (Deficit)	51	0	51		514	0	514	
Control Total Surplus/ (Deficit)	(25)	34	(59)		(2)	102	(104)	
Group Cash holding	64,719	58,566	6,153		64,719	58,566	6,153	
Capital Expenditure	994	957	(37)		1,397	2,408	1,011	
Agency Cap	58	95	37		645	855	210	

2. Exception Reports

2.1 Access

62 Day wait from screening to treatment	Target	Dec-21	YTD	Last 12 Months
	G: ≥ 90% R: < 90%	75%	88.2%	J F M A M J J A S O N D

Reason for non-compliance

1 patient breached the Screening target in December. The patent was referred from another trust on day 40 of the Screening pathway and required further diagnostic tests after referral to CCC. The patient was also required to stop medication for an unrelated medical condition prior to commencing treatment. The breach was deemed to be unavoidable.

Action taken to improve compliance

- Unavoidable breach

Expected Date of Compliance	January 2022
Escalation Route	CWT Target Operational Group, Divisional Quality Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

2.2 Efficiency

Length of Stay: Elective (days) Solid Tumour	Target	Dec-21	YTD	Last 12 Months
	G: ≤6.5 A: 6.5-6.8 R: >6.8	8.9	6.8	J F M A M J J A S O N D

Reason for non-compliance

The LOS for elective admissions to ST wards was 2.4 days above the target at 8.9 days.

Two patients with a learning disability were admitted for their whole 6 weeks of planned treatment.

Two patients with a newly formed Tracheotomy were admitted on a planned pathway for Radiotherapy. Discharge was delayed as the patients had not yet been at home with the Tracheotomy. Due to community staffing issues and the number of referrals, it continues to take much longer to commission Packages of Care (POC), with delays of months now rather than weeks. The CUR non-qualifying rate for December was 3%, which provides assurance that there is low incidence of inappropriate utilisation of beds	
Action taken to improve compliance Patient flow team to continue to work with wider MDT to start discharge planning on admission to prevent delays when patients are medically fit for discharge.	
Expected date of compliance	February 2022
Escalation route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Integrated Governance Committee, Quality Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer

Length of Stay: Non-Elective (days) Solid Tumour	Target	Dec-21	YTD	Last 12 Months
	G: ≤8 A: 8.1-8.4 R: >8.4	9.1	8.1	J F M A M J J A S O N D

Reason for non-compliance

The LOS for non-elective admissions on ST wards was 1.1 days over target at 9.1 days.

In December, there was an increase in patients admitted on an unplanned pathway with Immunotherapy toxicities.

In December there were a number of IOM patients who had started treatment as out patients but became unwell and needed to completed Radiotherapy on an unplanned pathway.

Due to community staffing issues and the number of referrals, it continues to take much longer to commission Packages of Care (POC), with delays of months now rather than weeks.

The CUR non-qualifying rate for December is 3%, which provides assurance that there was a low incidence of inappropriate utilisation of beds.

Action taken to improve compliance

The Patient Flow Team continue to work alongside the MDT to start discharge planning earlier with patients to prevent the delays once patients are medically fit and ready for discharge.

Expected date of compliance	February 2022
Escalation route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Integrated Governance Committee, Quality Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer

Delayed Transfers of Care as % of occupied bed days	**Target**	**Dec-21**	**YTD**	**Last 12 Months**
	G: ≤3.5%	4.4%	3.1%	J F M A M J J A S O N D

Reason for non-compliance

Delayed transfers of care were at 4.4% in December 2021, against a target of 3.5%.

The number of patients affected by DTOC has increased since last month, with 14 patients affected in December. The number of DTOC days decreased from 99 days in November to 83 days in December. The average length of DTOC was 5.9 days; a reduction from 9.9 days in November. Delays involved both Solid Tumour and HO patients.

The delays were due to:

- 9 Patients awaited Fast Track Packages of Care at Home.
- 1 Patient awaited transport and for equipment to be moved to the discharge location.
- 4 Patients awaited hospice placement

There remains an increase in the length of time from CHC/Fast track funding agreement to commissioning packages of care, due to covid related reduced staffing.

Action taken to improve compliance

- Weekly ‘Lengthened Length of Stay’ meetings are held to ensure the flow of patients continues and any concerns can be escalated.
- 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 include a discussion of all inpatients, ensuring that there is a clear plan for each patient.

Expected date of compliance	February 2022
Escalation route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Integrated Governance Committee, Quality Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer

Bed Occupancy	Wards	Target	Dec-21	YTD	Last 12 Months
	Solid Tumour (Midday)	G: ≥85% A: 81-84.9% R: <81%	71.7%	71.5%	J F M A M J J A S O N D
	Solid Tumour (Midnight)	G: ≥85% A: 81-84.9% R: <81%	70.7%	72.1%	J F M A M J J A S O N D
	Ward 4 (HO) (Midnight)	G: ≥85% A: 81-84.9% R: <81%	84.4%	86.9%	J F M A M J J A S O N D
	Ward 5 (HO) (Midnight)	G: ≥80% A: 76-79.9% R: <76%	66.2%	73.7%	J F M A M J J A S O N D

Reason for non-compliance

Solid tumour ward bed occupancy continues to be below the Trust's target of 85%, with midday occupancy falling 3.9% from November to December. This is to be expected over the Christmas and the New Year period. Average bed occupancy during this period was 65%.

Ward 4 (HO) occupancy has fallen 9% to 84.4% in December, which is 0.6% below Trust target.

Ward 5 (HO) occupancy has fallen 9.6% to 66.2% in December, which is 13.8% below Trust target.

These figures are calculated on a total bed base of 86 beds. An additional 4 beds on Ward 3 have been designated as 'escalation beds' to help the Trust and the wider system with winter/Covid-19 pressures. These beds have not been used in December. 3 mutual aid patients have transferred across to CCC Liverpool from LUHFT in December 2021.

In December 2021, solid tumour wards have been at OPEL 3 level on 19 occasions and Haemato-oncology wards on 24 occasions.

The PFT 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.

Action taken to improve compliance

- PFT continue to work with wider MDT to aid discharge planning during the COVID-19 pandemic, and also liaise with Acute Oncology so that we are offering oncology beds to our patients when they are required
- Review of daily occupancy data to inform LoS and bed occupancy improvements.
- The ST inpatient / day case coding review continues.
- An Acute Service improvement facilitator role is being developed, with responsibility for reviewing emergency pathways of care; identifying patients on a daily basis who are appropriate for transfer from LUHFT to CCC. This role will formalise existing ad hoc provision of this in-reach activity and ensure that it is embedded and sustainable.
- The Ward 1 day case model is under review. This may result in an increase in demand for inpatient beds.

• Patients with sarcoma are now being transferred from Preston to CCC (2 patients to date). This is a small number of patients who often have a long length of stay. • A report on bed utilisation is due to be presented at the Performance Committee in Q4 2021/22.	
Expected date of compliance	Q4 2021/22
Escalation route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Integrated Governance Committee, Quality Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer

% of expected discharge dates completed	Target	Dec-21	YTD	Last 12 Months
	G: ≥95% A: 90-94.9% R: <90%	89%	86%	J F M A M J J A S O N D

Reason for non-compliance

Following a review of compliance, it has been identified that the Haemato-oncology (HO) admission documentation requires amendments to improve the capture of expected discharge dates (EDD) information.

Action taken to improve compliance

- The Digital team are working with HO staff to review admission documentation to ensure EDD data fields are recorded
- The Patient Flow Team will monitor data to ensure that all EDDs are completed within 24 hours of admission
- The Patient Flow Team are also working with the Digital team on the 'virtual ward round' system to ensure EDDs are regularly reviewed and that the rationale is captured for any variations noted, to inform service improvement requirements.

Expected date of compliance	March 2022
Escalation route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Integrated Governance Committee, Quality Committee, Trust Board
Executive lead	Joan Spencer: Chief Operating Officer

Imaging Reporting: Outpatients (within 7 days)	Target	Dec-21	YTD	Last 12 Months
	G: ≥90% A: 80-89.9% R: <80%	85.3%	81.1%	J F M A M J J A S O N D

Reason for non-compliance

The target has not been achieved, however performance improved from 77.8% in November, to 85.3% in December against a target of 90%.

Reasons for non-compliance include:

- Radiology activity has increased since CCCL opened, placing increasing demands on the Radiologist team.
- Loss of reporting capacity due to Radiologists supporting clinical services; Interventional Radiology and Ultrasound, whilst recruitment is underway and during planned and unplanned ultrasound staff absence.
- Implementation of the recruitment plan delayed due to availability of workforce and competing rates of pay locally and nationally.
- CCC Radiologists supporting additional MDT activity.
- Radiologist planned and unplanned absence.

The inpatient reporting target has been met over the last 12 months.

Action taken to improve compliance

- On-going outsourcing of reporting activity to Medica (100 scans (CT/ MRI) per week).
- Reduced outsourcing to Medica as TATs were not being met.
- Radiologist recruited in December 2019 was delayed by COVID in their country of residence. Recruitment is now progressing, with a likely start date of February 2022.
- Successful recruitment of an additional locum Radiologist – started in January 2022.
- Bi-weekly report received by senior radiology team enabling continuous monitoring and prioritisation of outstanding reports.
- Business case / 3 year plan developed to support an increase in CCC Radiologist workforce.

Expected date of compliance	September 2022
Escalation route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Performance Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer

2.3 Quality

E.coli infections (attributable)	Target	Dec-21	YTD	Last 12 Months
	≤6 (pr year)	1	8	J F M A M J J A S O N D

Reason for non-compliance

There was 1 CCC attributable case of *E.coli* in December, taking the total to 8 YTD against a target of ≤ 6 per year.

Initial investigation indicates that the infection may relate to an infected thrombus from an arterial line removed at LUHFT 2 days prior to transfer to CCC.

MSSA also identified in the same set of blood cultures. *E.coli* is a likely contaminant.

The MSSA exception report relates to the same patient.

Action taken to improve compliance

- Post Infection Review in process to determine if *E.coli* is a contaminant.

Expected date of compliance	January 2022
Escalation route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive lead	Julie Gray: Chief Nurse/DIPC

MRSA infections (attributable)	Target	Dec-21	YTD	Last 12 Months
	0 per yr	1	1	J F M A M J J A S O N D

Reason for non-compliance

There was 1 CCC attributable case of MRSA in December, taking the total to 1 YTD against a zero tolerance threshold.

This acute myeloid leukaemia patient (admitted for chemotherapy) has a history of MRSA throat colonisation. The patient was treated for a dental infection during a previous admission and the source of infection is believed to be dental.

Action taken to improve compliance

- No learning points have been identified that contributed to this episode of infection.

Expected date of compliance	January 2022
Escalation route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive lead	Julie Gray: Chief Nurse/DIPC

MSSA infections (attributable)	**Target**	**Dec-21**	**YTD**	**Last 12 Months**
	G: =<4, A: 5, R >5 (per yr)	1	2	J F M A M J J A S O N D

Reason for non-compliance

There was 1 CCC attributable case of MSSA in December, taking the total to 2 YTD against a target of ≤4 per year.

The initial investigation indicates that the infection may relate to an infected thrombus from an arterial line removed at LUHFT 2 days prior to transfer to CCC.

E.coli was also identified in the same set of blood cultures and is a likely contaminant.

The E.coli exception report relates to the same patient.

Action taken to improve compliance

- No learning points identified at this point from the MSSA infection. The Post Infection Review is in process to determine if E.coli is a contaminant.

Expected date of compliance	January 2022
Escalation route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive lead	Julie Gray: Chief Nurse/DIPC

Klebsiella infections (attributable)	**Target**	**Dec-21**	**YTD**	**Last 12 Months**
	≤6 (pr yr)	1	5	J F M A M J J A S O N D

Reason for non-compliance

There was 1 CCC attributable case of Klebsiella pneumoniae in December, taking the total to 5 YTD against a target of 6 or fewer for the year.

Klebsiella pneumoniae bacteraemia of unknown origin. Investigations to determine the source of infection have not yielded any conclusions.

Action taken to improve compliance

- No learning points identified

Expected date of compliance	January 2022
Escalation route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive lead	Julie Gray: Chief Nurse/DIPC

% of routine formal complaints resolved in month, which were resolved within 25 working days	**Target**	**Dec-21**	**YTD**	**Last 12 Months**
	R: <65% A: 65-74.9% G: 75%	**0%**	**64%**	J F M A M J J A S O N D

Reason for non-compliance

One complaint was resolved in December 2021; this was resolved on day 26.

This delay occurred as additional information was required to clarify a point raised during the investigation. This issue was not raised in the original complaint.

Action taken to improve compliance

Response timeframes to be monitored by Associate Director of Clinical Governance and Patient Safety on a weekly basis at a new Divisional Governance Manager Meeting commencing 28th January 2022.

Expected Date of Compliance	January 2022
Escalation Route	Divisional Quality, Safety and Performance meetings, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Director Lead	Julie Gray: Chief Nurse/DIPC

% of Policies in Date	Target	Dec-21	YTD	Last 12 Months
	R: <93% A: 93-94.9% G: =>95%	94%	96%	J F M A M J J A S O N D

Reason for non-compliance

Sixteen out of the total 268 policies were out of date at the end of December 2021, resulting in a compliance figure of 94%.

The sixteen policies are between one and eight months out of date. A summary of the status of the policy reviews is as follows:

- Seven polices became out of date on 31st December 2021.
- Five policies were submitted to forums for approval in December and now require submission to the document control team for processing.
- Four policies have not yet been submitted to the relevant forum for approval.

Action taken to improve compliance

- Policy review reminders and instructions are sent to individual authors three months in advance of the review due. Further follow ups are then made.
- Weekly out of date policies report provided to Associate Director of Corporate Governance, and any major issues are escalated.
- Out of date policy information is reviewed at monthly Divisional meetings and bi-monthly Performance Review Groups.
- Bi-monthly Document Control update reports are presented at the Information Governance Board.
- Promotion of policy self-management with Document Owners is ongoing.
- Targeted meetings between Information Governance staff and Document Owners are planned.

Expected Date of Compliance	January 2022
Escalation Route	Information Governance Board, Integrated Governance Committee, Divisional Performance Review, Quality Committee, Trust Board
Executive Director Lead	Liz Bishop, Chief Executive

2.4 Research and Innovation

<table>
<tr><th rowspan="2">Studies opening to recruitment</th><th>Target</th><th>Dec-21</th><th>YTD</th><th>Last 12 Months</th></tr>
<tr><td>52
(per yr)</td><td>1</td><td>31</td><td>J F M A M J J A S O N D</td></tr>
<tr><td colspan="5">Reason for non-compliance

Thirty-one studies have opened to recruitment against an internal target of thirty-nine at the end of Month 9 (79% of target).
• A key reason we have not met the target relates to two separate pauses to opening trials to recruitment. The first due to the pandemic and the second due to aseptic issues.
• CCC has issued local approval for seven additional studies, for which we are awaiting Sponsor Greenlight. If all studies had been greenlighted we would have opened 38 studies (97% of target at Month 9).</td></tr>
<tr><td colspan="5">Action Taken to improve compliance

• Work with Interim Chief Pharmacist to open new studies that use the aseptic service.
• Work with the SRG Research Leads and the Network to optimise opportunities with observational studies.
• Work with Sponsors to greenlight studies where local approval has been given, once capacity has been agreed with Pharmacy.</td></tr>
<tr><td>Expected date of compliance</td><td colspan="4">The 2021/22 target will not be achieved. The key reason is due to the pauses to opening clinical trials to recruitment.</td></tr>
<tr><td>Escalation route</td><td colspan="4">SRG Research Leads / Committee for Research Strategy</td></tr>
<tr><td>Executive Lead</td><td colspan="4">Sheena Khanduri, Medical Director</td></tr>
</table>

Recruitment to Time and Target	Target	Q2 2021/22	Last 12 months
	G: ≥50%, A: 30 – 40%, R: <30%	**0%**	For the previous reporting period of 1/7/20 – 30/6/21, compliance was 33%

Reason for non-compliance

The latest reporting period of ‘Q2 2020/21’ relates to the 12 month period of 1/10/20 – 30/09/21.

- CCC data are skewed due to the low number of studies submitted (n=1).
- The target is an internal metric, no national metric is available.
- Recruitment to Time & Target has shown a reduction at other NHS Trusts when compared to pre-pandemic data.

Action Taken to improve compliance

- Currently 100% studies have now been unpaused to recruitment pre-COVID.
- Full review of current trial information to predict and manage Time and Target data in progress.

Expected date of compliance	Q4 2021/22
Escalation route	SRG Research Leads, Committee for Research Strategy
Executive Lead	Sheena Khanduri, Medical Director

2.5 Workforce

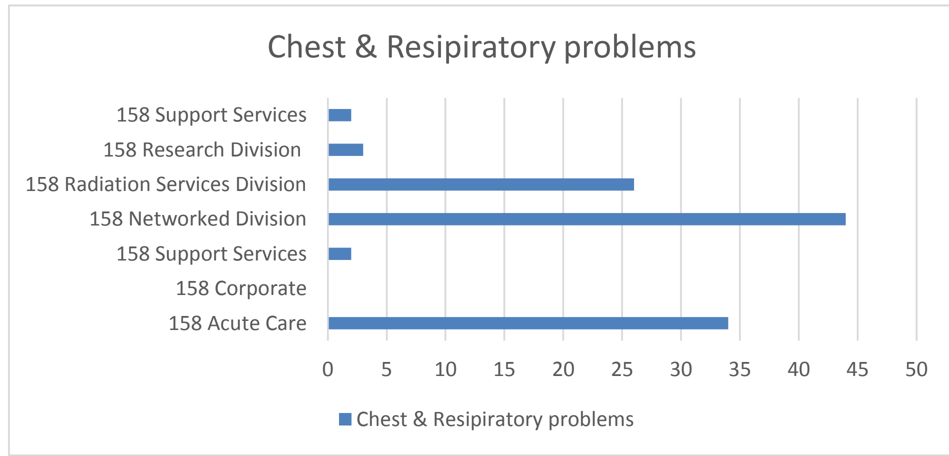
Staff Sickness Absence	Target	Dec-21	YTD	Last 12 Months
	G: ≤4% A: 4.01–4.99% R: ≥ 5%	6.19%	4.94%	J F M A M J J A S O N D

Reason for non-compliance

The in-month figure for absence has increased from 5.54% to 6.19% in December 2021. The 12-month figure has also increased from 4.77% to 4.94%. The highest reasons for absence are summarised in the table below:

Absence Reason	Number of Episodes
S15 Chest and Respiratory problems	111
S13 Cold, Cough, Flu - Influenza	55
S10 Anxiety/stress/depression/other psychiatric illnesses	52

Chest and Respiratory problems has significantly increased from November in which it was at 44 and is now at 111 absences for December ("Chest and Respiratory" includes Covid-19 as a reason for absence).



The Networked Services division had the highest number of absence episodes due to Chest & Respiratory problems with 44 episodes. CBU1 and CBU3 made up most of these absences across the division with 17 and 24 episodes respectively. Out of the 44 absence episodes, 42 were Covid-19 related and this is likely to be as a result of the rise in the Omicron variant. Acute Care closely followed with 34 episodes. Prior to November, Chest and Respiratory problems had not appeared in the top 3 reasons for absence since August 2021 but is currently the top reason for December 2021.

Cold, cough and flu has moved to the second top absence reason but still had a small increase since November from 52 to 55. The Networked Services division still has the highest number of absence episodes due to cold, cough and flu with 26 episodes.

Anxiety, stress and depression remains the third highest reason for absence, however, there has been a slight increase in the number of episodes from 43 in November to 52 in December. Of the 52 episodes, 7 were work related and 45 were personal related; this is a decrease of 3 work-related stress absences from the previous month. Of the total stress related absences, 32 are long-term which is an increase of 4 episodes from last month and only 9 of these ended in December whilst 23 continue into January. Of the 20 short-term absences, 4 continue into January. The business units with the highest number of absences due to anxiety/ stress/ depression were CBU5 with 11 episodes, CBU1 with 10 episodes and CBU4 with 8 episodes.

Action taken to improve compliance

- In light of the government guidance mandating the Covid-19 vaccine as a condition of deployment for healthcare workers, the HRBP team are continuing to support line managers on holding supportive conversations with staff who are not fully vaccinated. More details will follow shortly once it has been through parliamentary approval.

- A review of the absences recorded with a related reason of Covid-19, has highlighted that some were recorded incorrectly i.e. with a level 1 reason of ‘Other’ rather than ‘Chest and Respiratory Problems’; for this reason, the HRBP team will highlight this in the monthly HR surgeries to ensure that all Covid-19 absences are recorded correctly so that we are reporting the sickness accurately, especially with the number of cases rising.

- The HRBP Team are supporting with the Test to Return and Asymptomatic Testing for staff to ensure we help reduce staff pressures and also absence rates where possible. The team will be working closely with Infection Control to support the roll out of this.

Expected date of compliance	February 2022
Escalation route	Divisional Meetings, Workforce Transformation Committee, Performance Review Meetings, Quality Committee, Trust
Executive lead	Jayne Shaw, Director of Workforce and OD

	Target	Dec-21	Last 12 Months
PADR	G: ≥95% A: 75% - 94.9% R: ≤74%	94.35%	J F M A M J J A S O N D

Reason for non-compliance

Overall trust compliance has dropped from 95.72% to 94.35%, which is marginally below the target of 95%.

Areas performing below the target are detailed below.

Org L4	Assignment Count	Reviews Completed	Reviews Completed %
158 CBU1 - Day Care & Network	136	124	91.18
158 CBU5 - Inpatient Care	191	168	87.96
158 CBU7 - Radiology Services	53	50	94.34
158 Cancer Alliance	24	22	91.67
158 Networked Leadership	9	8	88.89

Whilst the L&OD team continue to provide data to support managers in proactively managing compliance, it is forecast that a further decline in compliance will been seen over the forthcoming weeks due to operational and staffing pressures.

Action taken to improve compliance

- All divisions have been issued with detailed reports to support the proactive management of PADR compliance.
- The L&OD Team will continue to work with divisions to support them in achieving compliance, but more importantly to ensure that all staff have a meaningful and purposeful annual appraisal conversation.

Expected date of compliance	March 2022
Escalation route	Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

REPORT COVER

Report to:	Trust Board	
Date of meeting:	26th January 2022	
Agenda item:	P1-14-22	
Title:	Finance Report - Month 9	
Report prepared by:	Jo Bowden, Deputy Director of Finance	
Executive Lead:	James Thomson, Director of Finance	
Status of the report: (please tick)	Public ☐	Private ☒

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

Purpose of the paper/key points for discussion:	To present the financial position of the Trust to December (Month 9) 2021-22.

Action required: (please tick)	Discuss	☐
	Approve	☐
	For information/noting	☒

Next steps required:	N/A

Version 1.0 Ref: FCGOREPCOV Review: May 2024

REPORT COVER

The paper links to the following strategic priorities and Board Assurance Framework (BAF) Risks (please select)

☐ BE **OUTSTANDING**

BAF Risk	Please select
If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	☐
Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	☒
Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☒

☐ BE **COLLABORATIVE**

BAF Risk	Please select
If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	☐

☐ BE **RESEARCH LEADERS**

BAF Risk	Please select
If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	☐
Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	☐

☐ BE **A GREAT PLACE TO WORK**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☐
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	☒

☐ BE **DIGITAL**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☒
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	☐

☐ BE **INNOVATIVE**

BAF Risk	
If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	☒

EQUALITY & DIVERSITY IMPACT ASSESSMENT								
Are there concerns that the policy/service could have an adverse impact on:								
Age	Yes ☐	No ☐	Disability	Yes ☐	No ☐	Gender	Yes ☐	No ☐
Race	Yes ☐	No ☐	Religious/belief	Yes ☐	No ☐	Sexual orientation	Yes ☐	No ☐
Gender Reassignment	Yes ☐	No ☐	Pregnancy/maternity	Yes ☐	No ☐			

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

Finance Report

Jo Bowden - Deputy Director of Finance

Version: 1.0 Ref: FCGOREPO Review: May 2024

Contents

1.0 Introduction

2.0 Summary Financial Performance

3.0 Operational Financial Profile – Income and Expenditure

4.0 Cash and Capital

5.0 Balance Sheet Commentary

6.0 Recommendations

1. Introduction

1.1 This paper provides a summary of the Trust's financial performance for December 2021, the ninth month of the 2021/22 financial year.

Colleagues are asked to note the content of the report, and the associated risks.

2. Summary Financial Performance

2.1 For December the key financial headlines are:

Metric (£000)	In Mth 9 Actual	In Mth 9 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	(76)	34	(110)		(516)	102	(618)	
CPL/Propcare Surplus/ (Deficit)	51	0	51		514	0	514	
Control Total Surplus/ (Deficit)	(25)	34	(59)		(2)	102	(104)	
Group Cash holding	64,719	58,566	6,153		64,719	58,566	6,153	
Capital Expenditure	994	957	(37)		1,397	2,408	1,011	
Agency Cap	58	95	37		645	855	210	

2.2 For 2021/22 the Cheshire & Merseyside ICS are managing the required financial position of each Trust through a whole system approach. The requirement for the Trust for the second six months of the year (H2) was to achieve a break-even position. The Trust position for H2 is reliant upon receiving Elective Recovery Funding (ERF) of £6.4m. The Trust included recovery costs of £4.8m against this. This leaves a residual risk of £1.6m if no ERF was to be received.

3. Operational Financial Profile – Income and Expenditure

3.1 Overall Income and Expenditure Position

The Trust's financial position to the end of December is a £516k deficit, the group consolidated position is a £2k deficit. The group cash position is a closing balance of £64.7m, which is £6.2m above plan. Capital spend has increased by £994k in month, however, this is still under plan by £1m year to date, the majority of spend being profiled in the last quarter. The Trust is under the agency cap by £37k in month and £210k in the year to date.

3.2 The table below summarises the position. Please see Appendix A for the more detailed Income & Expenditure analysis.

Metric (£000)	Actual M9	Trust Plan M9	Variance	Actual YTD	Trust Plan YTD	NHSI Variance	Draft Trust Annual Plan
Clinical Income	17,888	17,379	510	155,225	153,893	**1,332**	206,029
Other Income	2,081	1,804	277	17,160	16,496	**664**	22,063
Total Operating Income	**19,970**	**19,183**	**787**	**172,385**	**170,389**	**1,997**	**228,092**
Total Operating Expenditure	(19,773)	(18,827)	(946)	(169,793)	(167,393)	**(2,401)**	(224,232)
Operating Surplus	**197**	**356**	**(159)**	**2,592**	**2,996**	**(404)**	**3,859**
PPJV	126	67	59	662	603	**59**	804
Finance Costs	(398)	(389)	(10)	(3,770)	(3,497)	**(273)**	(4,663)
Trust Surplus/Deficit	**(76)**	**34**	**(110)**	**(516)**	**102**	**(618)**	**(0)**
Subsidiaries	51	0	51	514	0	**514**	**0**
Consolidated Surplus/Deficit	**(25)**	**34**	**(59)**	**(2)**	**102**	**(104)**	**(0)**

The table below summaries the consolidated financial position:

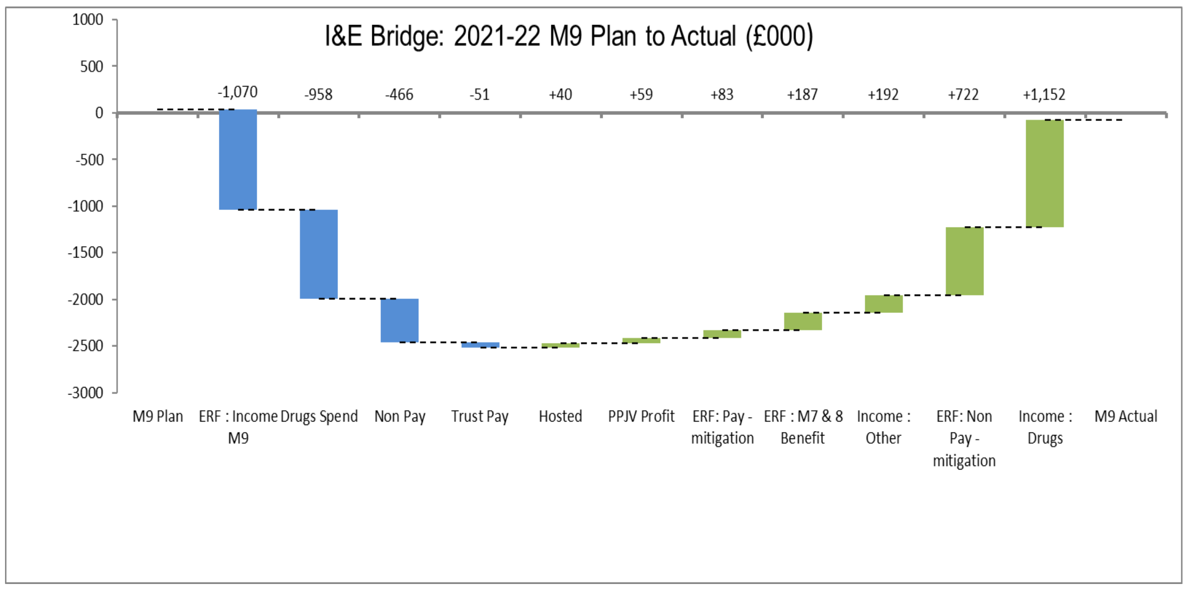
December 2021 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	(156)	(1,241)
Donated Depreciation	81	725
Trust Retained Surplus / (Deficit)	**(76)**	**(516)**
CPL	34	200
Propcare	17	314
Consolidated Financial Position	**(25)**	**(2)**

3.3 Expenditure Position

3.3.1 The bridge below shows the key drivers between the actual monthly deficit position and the surplus plan, a variance of £110k.

- In Month 9 we have not included any ERF income. Although the Trust has delivered activity levels above its target it is not able to recover income because the Cheshire and Merseyside system has not met achieved its planned level of activity in aggregate. This is driving a negative income variance of £1.07m. The variance is partly mitigated by unspent recovery budget of £805k. Overall, this is driving a negative variance in the position of £265k.
- A further mitigation is the notified ERF income that relates to October and November performance. The Trust has accounted for this in month, with a value of £187k.
- Pay costs have increased over the last quarter, as expected, and the Trust is now showing a £51k overspend in month in the Divisions. The run rate has increased by £100k compared to the H1 average. Also, the increased H2 CIP requirement has increased in pay by £100k per month reducing the overall variance.
- Drugs spend is over plan by £958k. This is offset by an increase in drugs income.
- Non-Pay costs are showing an overspend of £436k – this is predomiantly driven by un-met CIP of £169k.

- The PPJV position is above plan by £59k. This relates to the increased expected dividend payment at the end of month 9.



3.4 **Bank and Agency Reporting**

Bank spend in December is £82k, which is in line previous months. The largest user of bank staff the Acute Division whose spend in month is £71k. The main reasons for bank spend is to cover vacancies and increased sickness due to covid.

Agency spend in month is £58k, which is a reduction to previous months. We are reporting £37k below the agency cap in month and £210k cumulatively.

See Appendix F for further detail.

3.5 **Cost Improvement Programme (CIP)**

The Trust CIP requirement was £1.423m for the first six months of the year (H1).

As previously reported CIP requirement for the second 6 months of the year (H2) is £2.716m, 2.5% of plan. This gives an annual CIP requirement of £4.1m.

CIP targets allocated to the Divisions remains at 2.0% which equates to £1.9m (excluding drugs and hosted services). The remainder of the CIP target will be managed centrally.

As at month 9 of the required £1.9m Divisional target, a total of £1.278m of schemes have been identified, of which £782k are recurrent. The central CIP has been met for H1 through the achievement

of a break-even position and is being met non-recurrently in H2 through slippage in expenditure. A summary is provided at Appendix E.

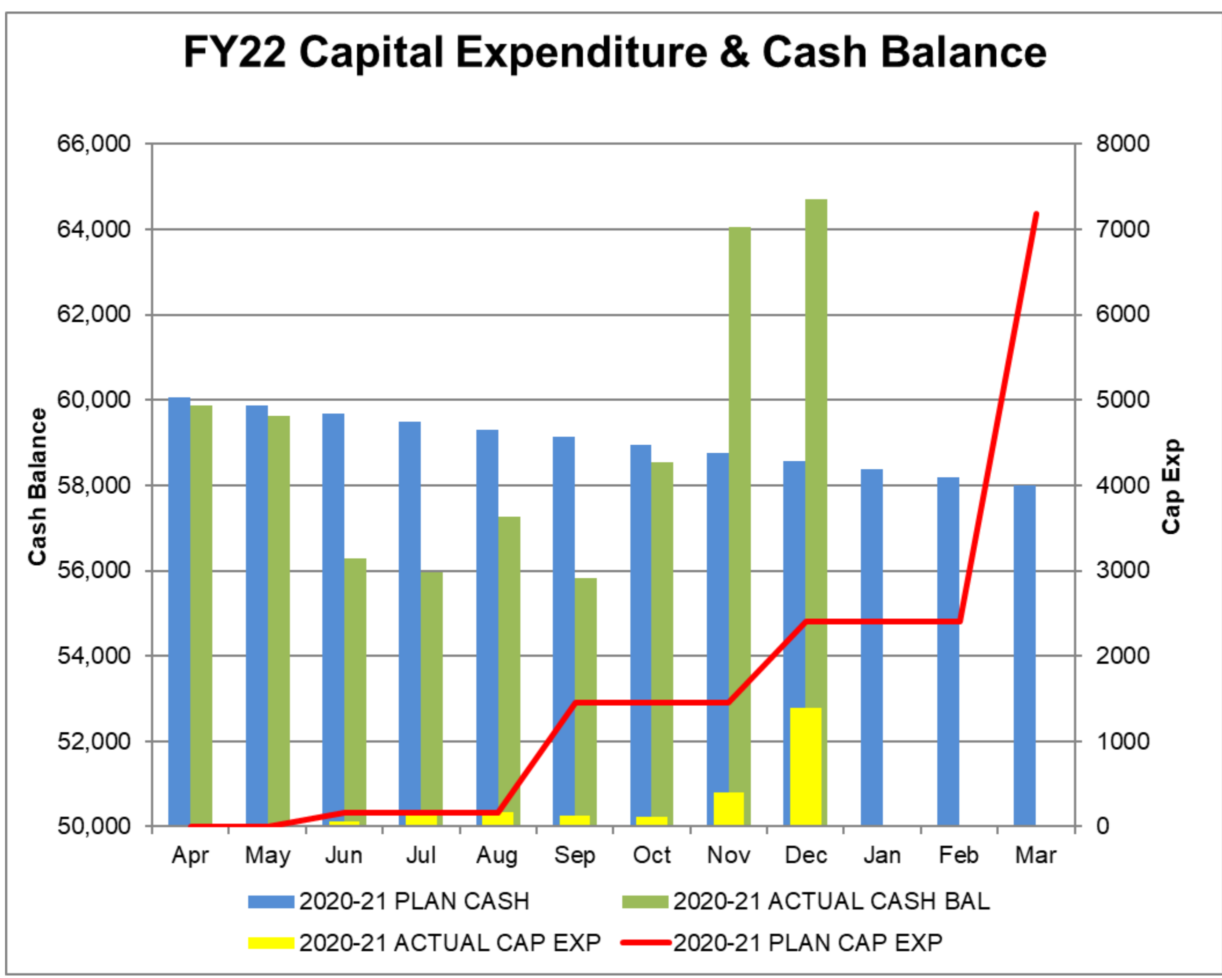
4. Cash and Capital

4.1 The original 2021/22 capital plan approved by the Board in March was £7.187m. Subsequently, due to additional national capital funding sources being made available the Trust has received confirmation of a successful bid of £1.9m towards a Linear Accelerator and £300k funding for a remote patient monitoring system. The revised annual plan is £9.233m. There is pressure in the overall Cheshire and Merseyside plan to stay within the required capital limit (CDEL) and the Trust has deferred schemes by £500k to support this position. It has been agreed in principal that this underspend will be returned to the Trust in 2022/23.

4.2 Capital expenditure of £1.4m has been incurred to the end of December, this is below the original planned spend profile for the year to date. The majority of the Trust expenditure is expected to occur towards the end of the year, and a large number of orders have now been placed. Capital Investment Group are closely monitoring the position to ensure any slippage risk is identified and mitigated.

4.3 The capital programme is supported by the organisation's cash position. The Group has a current cash position of £64.7m, which is a positive variance of £6.2m to the cash-flow plan. This is mainly due to the profiling of the original cash plan, the majority of capital resource continues to be held in the Trust's bank account.

4.4 The Balance Sheet (Statement of Financial Position) is included in Appendix B and Cash flow in Appendix C.



This chart shows monthly planned and actual Cash Balances and Planned Capital Expenditure for 2021/22. It shows that for December the Trust more cash than originally planned.

5. Recommendations

6.1 The Performance Committee is asked to note the contents of the report, with reference to:

- The reported deficit position for the month and cumulatively
- The impact on the non-receipt of ERF Income
- The continuing strong liquidity position of the Trust

Appendix A – Statement of Comprehensive Income (SOCI)

(£000)	Month 9			Cumulative YTD			%	2021/22 Annual Plan
	Plan	Actual	Variance	Plan	Actual	Variance		
Clinical Income	17,328	17,267	(61)	153,304	154,002	697		205,289
Other Income	511	1,032	521	4,497	7,203	2,706		5,989
Hosted Services	1,344	1,671	327	12,587	11,180	(1,407)		16,814
Total Operating Income	**19,183**	**19,970**	**787**	**170,389**	**172,385**	**1,997**	**1%**	**228,092**
Pay: Trust (excluding Hosted)	(5,730)	(5,699)	32	(52,430)	(50,393)	2,037		(69,567)
Pay: Hosted & R&I	(680)	(517)	164	(5,779)	(4,425)	1,353		(7,836)
Drugs expenditure	(7,064)	(8,022)	(958)	(61,665)	(67,815)	(6,150)		(82,857)
Other non-pay: Trust (excluding Hosted)	(4,640)	(4,373)	267	(40,579)	(40,528)	51		(54,745)
Non-pay: Hosted	(713)	(1,163)	(450)	(6,940)	(6,632)	308		(9,228)
Total Operating Expenditure	**(18,827)**	**(19,773)**	**(946)**	**(167,393)**	**(169,793)**	**(2,401)**	**1%**	**(224,233)**
Operating Surplus	**356**	**197**	**(159)**	**2,996**	**2,592**	**(404)**	**-13%**	**3,859**
Profit /(Loss) from Joint Venture	67	126	59	603	662	59		804
Interest receivable (+)	401	388	(12)	3,606	3,527	(79)		4,809
Interest payable (-)	(439)	(437)	3	(3,954)	(3,965)	(11)		(5,272)
Loss on disposal of assets	0	0	0	0	(182)	(182)		
PDC Dividends payable (-)	(350)	(350)	0	(3,150)	(3,150)	0		(4,200)
Trust Retained surplus/(deficit)	**34**	**(76)**	**(110)**	**102**	**(516)**	**(618)**	**-608%**	**(0)**
CPL/Propcare	0	51	51	0	514	514		0
Consolidated Surplus/(deficit)	**34**	**(25)**	**(59)**	**102**	**(2)**	**(104)**	**-102%**	**(0)**

Appendix B – Balance Sheet

£'000	Unaudited 2021	Plan 2022	Year to date Month 9 YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	2,488	2,100	2,424	2,251	(173)
Property, plant & equipment	177,180	174,267	175,680	171,085	(4,595)
Investments in associates	181	181	181	181	(0)
Other financial assets	1,364	0	0	0	0
Trade & other receivables	161	100	281	460	179
Other assets	0	0			0
Total non-current assets	**181,374**	**176,648**	**178,566**	**173,978**	**(4,588)**
Current assets					
Inventories	4,201	4,200	4,201	4,922	721
Trade & other receivables					
NHS receivables	4,621	4,500	4,621	5,613	992
Non-NHS receivables	4,484	4,500	7,779	4,037	(3,742)
Cash and cash equivalents	63,533	58,000	59,875	64,719	4,844
Total current assets	**76,839**	**71,200**	**76,476**	**79,291**	**2,815**
Current liabilities					
Trade & other payables					
Non-capital creditors	28,222	30,000	28,222	25,744	(2,477)
Capital creditors	3,544	2,000	2,000	1,884	(116)
Borrowings					
Loans	1,916	1,730	1,730	1,813	83
Obligations under finance leases	0	0	0	0	0
Provisions	2,160	1,535	2,160	2,479	319
Other liabilities:-					
Deferred income	5,974	4,000	5,974	8,765	2,791
Other	0	0	0	0	0
Total current liabilities	**41,816**	**39,265**	**40,086**	**40,685**	**600**
Total assets less current liabilities	**216,398**	**208,583**	**214,957**	**212,583**	**(2,373)**
Non-current liabilities					
Trade & other payables					
Capital creditors	970	0	970	970	0
Borrowings					
Loans	33,820	32,090	33,080	32,216	(865)
Obligations under finance leases	0	0	0	0	0
Other liabilities:-					
Deferred income	0	0	0	0	0
Provisions	1,270	110	1,270	1,270	0
Total non current liabilities	**36,060**	**32,200**	**35,320**	**34,455**	**(864)**
Total net assets employed	**180,338**	**176,383**	**179,637**	**178,129**	**(1,508)**
Financed by (taxpayers' equity)					
Public Dividend Capital	67,374	68,116	67,374	67,374	(0)
Revaluation reserve	2,700	2,600	2,700	2,699	(1)
Income and expenditure reserve	110,264	105,667	109,563	108,056	(1,507)
Total taxpayers equity	**180,338**	**176,383**	**179,637**	**178,129**	**(1,508)**

Appendix C – Cash Flow

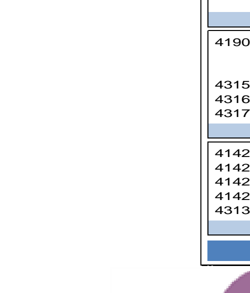
December 2021 (M9) £'000	FT	Group	Group (exc Charity)
Cash flows from operating activities:			
Operating surplus	1,867	3,253	2,566
Depreciation	6,935	6,935	6,935
Amortisation	608	608	608
Impairments			
Movement in Trade Receivables	(2,897)	4,306	1,153
Movement in Other Assets	1,658		0
Movement in Inventories	(730)	(721)	(721)
Movement in Trade Payables	898	(5,786)	(2,501)
Movement in Other Liabilities	2,820	2,700	2,700
Movement in Provisions	49	410	410
CT paid	0	(170)	(170)
Net cash used in operating activities	**11,208**	**11,534**	**10,980**
Cash flows from investing activities			
Purchase of PPE	(730)	(736)	(736)
Purchase of Intangibles	(373)	(373)	(373)
Proceeds from sale of PPE	(182)	(182)	(182)
Interest received	3,527	26	1
Investment in associates	1,248	1,248	1,248
Net cash used in investing activities	**3,490**	**(17)**	**(43)**
Cash flows from financing activities			
Public dividend capital received	0	0	0
Public dividend capital repaid			
Loans received			
Movement in loans	(2,875)	(2,875)	(2,875)
Capital element of finance lease	0	0	0
Interest paid	(3,965)	(441)	(441)
Interest element of finance lease	0	0	0
PDC dividend paid	(3,150)	(3,150)	(3,150)
Finance lease - capital element repaid	0	0	0
Net cash used in financing activities	**(9,990)**	**(6,465)**	**(6,465)**
Net change in cash	**4,707**	**5,052**	**4,471**
Cash b/f	**53,765**	**63,533**	**60,248**
Cash c/f	**58,472**	**68,584**	**64,719**

Appendix D – Capital

Capital Programme 2021-22
Month 9

The Clatterbridge Cancer Centre NHS Foundation Trust

Code	Scheme	Lead	BUDGET (£'000) NHSI plan 21-22	BUDGET (£'000) Approved Adjustments	BUDGET (£'000) Budget 21-22	ACTUALS (£'000) Actuals @ Month 9	ACTUALS (£'000) Variance to Budget	FORECAST (£'000) Forecast 21-22	FORECAST (£'000) Variance to Budget	Ordered?	Complete?	Comments
4194	***(20/21)*** Cyclotron refurb		0	0	0	8	(8)	8	(8)	✓	✓	
4195	***(20/21)*** CCCA Linacc Oak refurb		0	0	0	(3)	3	(3)	3	✓	✓	
4199	***(20/21)*** CCCW Crest refurb		0	0	0	(1)	1	(1)	1	✓	✓	
4201	***(20/21)*** Spine		0	0	0	(3)	3	(3)	3	✓	✓	
4303	CCCA Linacc Bunker - Maple	Julie Massey	420	0	420	68	352	120	300	✓	✗	In progress
4305	CCCW Linacc Bunker - Beech	Julie Massey	0	300	300	0	300	300	0	✗	✗	At planning stage. £Forecast uncertainty.
4300	CCCW CT Simulator (Brilliance 2)	Louise Bunby	300	(191)	109	0	109	109	0	✓	✗	Due to go live on 17th Jan
4302	CCCL Air Handling Unit Upgrade	Mel Warwick	0	28	28	31	(3)	31	(3)	✓	✓	
4306	CCCL Ward 2 Sluice	Jeanette Russell	0	33	33	2	31	33	0	✓	✗	Expect to start in Jan and take circa 4 wks
4307	CCCL Ward 4 and 5 bathroom conversion	Pris Hetherington	0	56	56	0	56	65	(9)	✓	✗	Vinci to confirm timescales. o/spend forecast
4312	Cyclotron Fire Works	Propcare	0	90	90	0	90	90	0	✓	✗	Need to confirm forecast costs/timescales
	Contingency	*n/a*	200	(408)	(208)	0	(208)	0	(208)	-	-	
	Estates		**920**	**(91)**	**829**	**102**	**727**	**749**	**80**			
4180	***(19/20)*** CCCL HDR & Papillon tfr costs		0	0	0	(12)	12	(12)	12	✓	✓	
4001	***(20/21)*** CCCL Pet CT		0	0	0	7	(7)	7	(7)	✓	✓	
4006	***(20/21)*** CCCL Linear Accelerator		0	0	0	4	(4)	4	(4)	✓	✓	
4010	***(20/21)*** CCCL Diagnostic CT		0	0	0	1	(1)	1	(1)	✓	✓	
4303	CCCA Linear Accelerator - Maple	Julie Massey	2,460	(155)	2,305	0	2,305	2,305	0	✓	✗	Delivery due 5th February
4305	CCCW Linear Accelerator - Beech (PDC)	Julie Massey	0	2,305	2,305	0	2,305	2,305	0	✓	✗	Delivery due 12th March
4318	CCCL Mobile Imagine Intensifier	Sam Wilde	138	0	138	0	138	138	0	✗	✗	Business case approved 10th Dec
	MEME - Acute - Patient Monitor	Julie Massey	9	0	9	0	9	0	9	✗	✗	Not required
	MEME - Acute - 2x Ultrasound	Julie Massey	25	0	25	0	25	33	(8)	✗	✗	Bus case to Finance Committee 14/01
4314	MEME - Networked - Scalp Coolers	Julie Massey	97	0	97	0	97	97	(0)	✓	✗	Ordered 16th Dec
	MEME - Rad - Infinity Monitor M540	Julie Massey	9	0	9	0	9	0	9	✗	✗	Postponed to 23/24
	MEME - Rad - 3x Patient Monitor C500	Julie Massey	33	0	33	0	33	0	33	✗	✗	Postponed to 23/24
	MEME - Rad - 6x Patient Monitor M540	Julie Massey	54	0	54	0	54	0	54	✗	✗	Postponed to 23/24
4192	Cyclotron	Carl Rowbottom	742	0	742	47	695	742	0	✓	✗	PDC Funded
4300	CCCW CT Simulator (Brilliance 2)	Louise Bunby	500	166	666	601	65	666	0	✓	✗	Delivered and due to go live 17th Jan
4301	Stand Aids		0	0	0	14	(14)	14	(14)	✓	✓	
4304	CCCL Cardiac Monitors W4&5	Julie Massey	0	26	26	0	26	26	0	✓	✗	Ordered 08/12
4308	2x Rhinolaryngo Videoscopes	Richard Lacey	0	64	64	0	64	64	0	✓	✗	Ordered 17/11
4309	Linac Voltage Stabilisers	Martyn Gilmore	0	130	130	0	130	130	0	✗	✗	Update requested
4310	CCCA QA3 Dosimeter	Martyn Gilmore	0	12	12	0	12	9	3	✗	✗	Req 16/12/21
4311	Interventional Radiology Pressure Injector	Samantha Wilde	0	20	20	0	20	15	5	✗	✗	Req 20/12/21, re-req on 24/12, Susan Wright
4319	Omniboard mounting adaptors		0	47	47	0	47	47	0	✗	✗	
	Contingency	*n/a*	200	(366)	(166)	0	(166)	52	(219)	-	-	
	Medical Equipment		**4,267**	**2,248**	**6,515**	**663**	**5,852**	**6,644**	**(129)**			
4190	***(20/21)*** Digital Aspirant	James Crowther	0	0	0	14	(14)	14	(14)	✓	✓	
	Infrastructure	James Crowther	1,350	(400)	950	389	561	936	14	✗	✗	£400k pushed back to 22/23
	Other minor programmes	James Crowther	250	0	250	98	152	250	0	✗	✗	
4315	CM Elective Fund - Remote Monitoring	James Crowther	0	300	300	0	300	300	0	✗	✗	New PDC funded scheme
4316	Digital Diagnostics Capability Programme	James Crowther	0	877	877	0	877	877	0	✗	✗	New PDC funded scheme
4317	Intelligent Automation (RPA)	James Crowther	0	311	311	0	311	311	0	✗	✗	50% PDC funded
	IM&T		**1,600**	**1,088**	**2,688**	**502**	**2,186**	**2,688**	**(0)**			
4142	Liverpool	Peter Crangle	0	0	0	(69)	69	(69)	69	✓	✓	
4142	Liverpool - Artwork	Sam Wade	0	66	66	0	66	66	0	✗	✗	Balance of original £250k allocation
4142	Wirral	Peter Crangle	400	(400)	0	0	0	0	0	✗	✗	Not expected to happen in 2021-22
4142	CCCL Link Bridge installation	Peter Crangle	0	0	0	19	(19)	19	(19)	✗	✗	
4313	CCCL Terraces	Peter Crangle	0	195	195	180	15	195	0	✓	✗	Charity Funded
	Building for the Future		**400**	**(139)**	**261**	**131**	**131**	**212**	**50**			
	TOTAL		**7,187**	**3,106**	**10,293**	**1,397**	**8,896**	**10,293**	**(0)**			

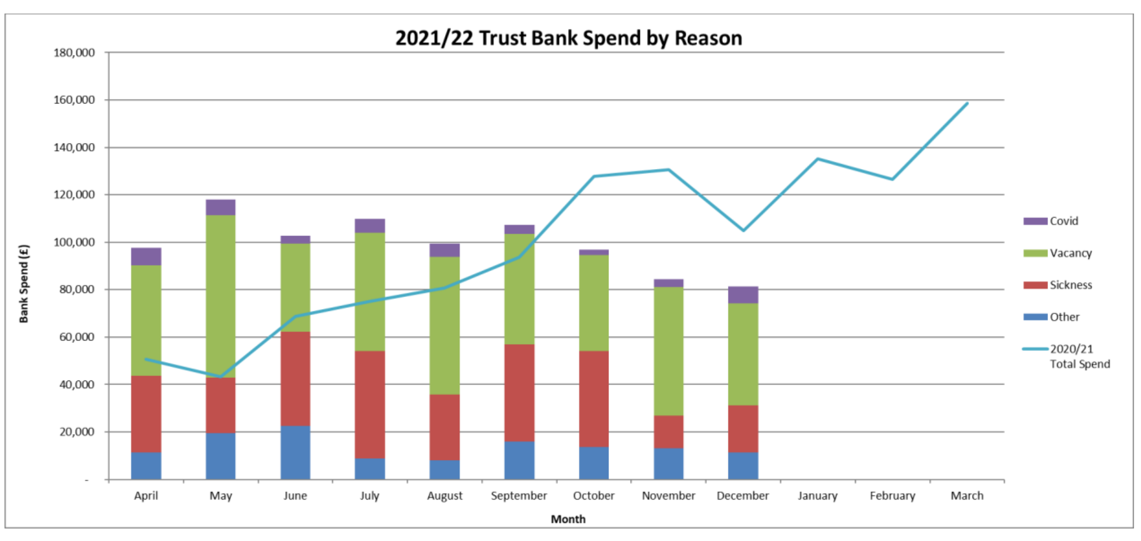


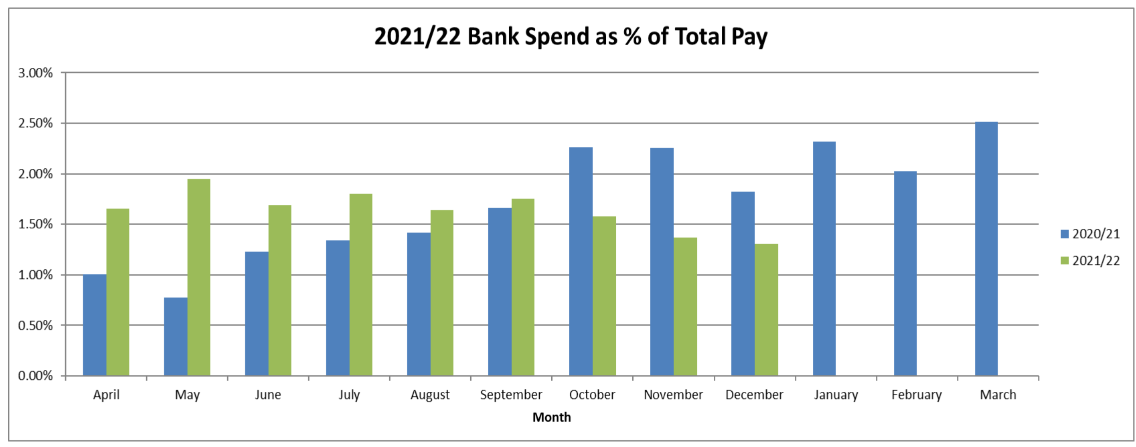
Appendix E – CIP

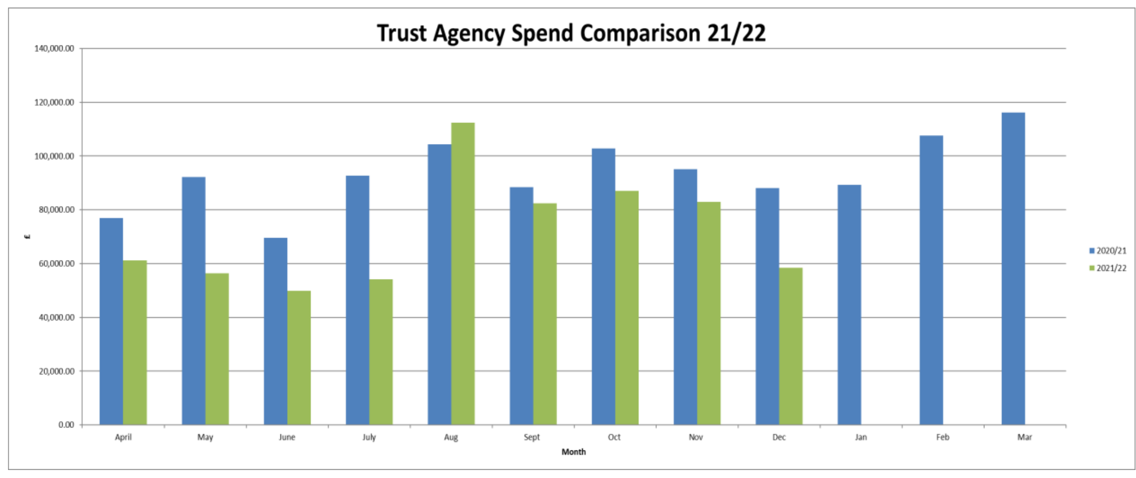
Directorate	Target	In Year 21.22	Full Year (Recurrent)	In Year Shortfall	Delivery % to date
ACUTE CARE	559,692	240,278	220,278	(319,414)	43%
CORPORATE	319,068	237,101	302,931	(81,968)	74%
NETWORKED SERVICES	547,860	466,817	78,150	(81,043)	85%
RADIATION SERVICES	453,380	334,301	180,709	(119,079)	74%
Divisional Total	**1,880,000**	**1,278,496**	**782,068**	**(601,504)**	
H1 Central	485,000	485,000	0	0	
H2 Central	1,776,000	631,000	0	(1,145,000)	
Central Total	**2,261,000**	**1,116,000**	**0**	**(1,145,000)**	
Overall Trust Total	**4,141,000**	**2,394,496**	**782,068**	**(1,746,504)**	

Version: 1.0 Ref: FCGOREPO Review: May 2024

Appendix F – Bank and Agency







Version: 1.0 Ref: FCGOREPO Review: May 2024

REPORT COVER

Report to:	Trust Board
Date of meeting:	26th January 2022
Agenda item:	P1-015-22
Title:	Nursing Safer Staffing Report & Dashboards
Report prepared by:	Karen Kay – Deputy Director of Nursing
Executive Lead:	Julie Gray – Chief Nurse
Status of the report: (please tick)	Public ☐ Private ☒

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

Purpose of the paper/key points for discussion:	The purpose of this report is to provide assurance to Trust Board that Clatterbridge Cancer Centre (CCC) NHS Foundation Trust is compliant with safer staffing guidance : • Compliant with key measures for safe nurse staffing across the adult inpatient bed base, in line with national and professional obligations. • The current funded nursing workforce establishment when compared with other patient safety indicators is sufficient to deliver safe staffing compliance. • Staffing levels are safe, there are robust systems and processes in place to manage safer staffing and that safer staffing has not been compromised during the pandemic or during the restoration phase In 2018 NHSI released new guidance; 'Developing Workforce Safeguards'. This builds on the NQB 2016 guidance and indicated that as part of any workforce review trust compliance must be measured using a triangulated approach, evidence based tools, professional judgement and patient outcomes. Trusts should be able to monitor from ward to board and be assured that the right staff, with the right skills, are in the right place at the right time.

REPORT COVER

	This report demonstrates that despite the subsequent waves of the Covid 19 pandemic and the challenges this has brought such as staff redeployment, staff shielding and staff self-isolation, the organisation has maintained safer staffing in line with our national and professional obligations.

Action required: (please tick)	Discuss ☐
	Approve ☐
	For information/noting ☒

Next steps required:	Integrated Governance Committee are requested to; • Note CCC has a sufficient nursing staff resource to achieve safe staffing across all inpatient wards • Request further updates as required

The paper links to the following strategic priorities and Board Assurance Framework (BAF) Risks (please select)

☐ BE **OUTSTANDING**

BAF Risk	Please select
If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	☒
Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	☒
Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☐

☐ BE **COLLABORATIVE**

BAF Risk	Please select
If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	☐

☐ BE **RESEARCH LEADERS**

BAF Risk	Please select
If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	☐
Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	☐

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☐
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	☒

REPORT COVER

If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	☐

☐ BE **A GREAT PLACE TO WORK**

☐ BE **DIGITAL**

BAF Risk	
If we do not invest a clear vision, sufficient capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve its digital ambition.	☐
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	☐

☐ BE **INNOVATIVE**

BAF Risk	
If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	☐

EQUALITY & DIVERSITY IMPACT ASSESSMENT								
Are there concerns that the policy/service could have an adverse impact on:								
Age	Yes ☐	No ☒	**Disability**	Yes ☐	No ☒	**Gender**	Yes ☐	No ☒
Race	Yes ☐	No ☒	**Religious/belief**	Yes ☐	No ☒	**Sexual orientation**	Yes ☐	No ☒
Gender Reassignment	Yes ☐	No ☒	**Pregnancy/maternity**	Yes ☐	No ☒			

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

Version 1.1 Ref: FCGOREPCOV Review: July 2024

Bi-Annual Safer Staffing Review

Jackie Rooney Divisional Nurse Director
Liz Furmedge Divisional Director
Pris Hetherington Matron Haemato-oncology
Jeanette Russell Matron Solid Tumour
Karen Kay Deputy Director of Nursing

September 2021

Bi- Annual Safer Staffing Nurse Review September 2021

1. Purpose

The purpose of this report is to provide assurance to Trust Board that Clatterbridge Cancer Centre (CCC) NHS Foundation Trust is compliant with safer staffing:

- Trust compliant with key measures for safe nurse staffing across the adult inpatient bed base, in line with national and professional obligations.
- The current funded nursing workforce establishment when compared with other patient safety indicators is sufficient to deliver safe staffing compliance.
- Staffing levels are safe, there are robust systems and processes in place to manage safer staffing and that safer staffing has not been compromised during the pandemic or during the restoration phase
- In addition, this report provides assurance against these key requirements for adult in patient wards at CCCL across Q1 and Q2 2021.

2. Background

The Francis Report (2013) led to fundamental changes in how NHS provider boards are expected to assure safe staffing decisions are undertaken.

In 2014 the National Institute for Health and Care Excellence (NICE) published comprehensive guidance on nurse staffing for adults in inpatient areas.

The National Quality Board (NQB 2016) Safe Sustainable and Productive staffing guidance issued to support this process further, alongside evidenced based tools and best practice examples.

In addition to strengthen governance and oversight, NHS providers required a framework to evaluate safe staffing information and data. Since May 2016, shift fill rate % and care hours per patient day (CHPPD) have been used in a consistent way to record and report nursing and health care support worker staff deployment.

In 2018 NHSI released new guidance; 'Developing Workforce Safeguards'. This builds on the NQB 2016 guidance and indicated that as part of any workforce review trust compliance must be measured using a triangulated approach, evidence based tools, professional judgement and patient outcomes. Trusts should be able to monitor from ward to board and be assured that the right staff, with the right skills, are in the right place at the right time.

This report demonstrates that despite the subsequent waves of the Covid 19 pandemic and the challenges this has brought such as staff redeployment, staff shielding and staff self-isolation, the organisation has maintained safer staffing in line with our national and professional obligations.

3. Local Context

Nursing staff establishments are formally reviewed biannually, in line with NICE recommendations and reported to Trust Board, to ensure that the nursing workforce meets the demands of clinical care provision and delivers safe care with a positive patient experience.

The assessment process for safer staffing at CCC is formed using a triangulated approach as recommended by the NQB and involves the use of an evidence based tool, professional judgment model, environmental considerations, patient safety indicators and comparison with peer organisations.

The Safer Nursing Care Tool (SNCT) is the evidence based tool in use at CCC that is endorsed by NICE and NQB. SNCT tool takes into consideration the activity in a service alongside with the acuity and dependency level of the patients.

4. Methodology

The SNCT is used to estimate the optimal establishment for the inpatient wards.
The Acuity and Dependency level of each patient is assessed and recorded on SafeCare® twice daily.

The validity of data entered onto SafeCare® is verified by the Acute Care Divisional Matrons. Any discrepancies are escalated for verification to the Divisional Nurse Director.

For the purpose of this review, data was collected from Electronic Staff Record (ESR), HealthRoster®, Datix, SafeCare® and CCC Integrated Performance Report 2021.

The SNCT was utilised to compare the activity and dependency data of all inpatients over a four week period between 6 September 2021 and 1 October 2021. During the study, data was collected Monday to Friday at 3.00 pm to allow for the capture of data during busy periods. The application and analysis of data using the SNCT includes registered nurse to patient ratio and care hours per patient day.

The SNCT contains defined classifications of care levels and measures the acuity and dependency of those patients whose needs are met through normal ward care (Level 0), through to those

patients who require advanced respiratory support and therapeutic support of multiple vital organs (Level 3). Basic definitions of levels of care are outlined in Appendix 1.

This data is tabulated to analyse the results using the set algorithm, this determines the patient acuity and recommendations for WTE staffing numbers against current WTE staffing numbers. Supplementary acuity data including bed occupancy, harms and complaints are also included to provide further narrative to the results.

It is important to note the SNCT acuity tool does not include increased demand on nurse time regarding environmental impact including the single room occupancy model of care evident at Clatterbridge Cancer Centre Liverpool (CCCL).

Supplementary to the bi annual acuity review, other elements are assessed and applied to ensure context and a full overarching assessment of safer staffing is undertaken. This includes;

- The application and analysis of data using the SNCT which includes registered nurse to patient ratio and care hours per patient day
- Patient Environment
- Professional judgement – discussion and data review undertaken to enable a professional opinion to be sought re appropriate staffing levels evident to deliver all patient care requirements including single room nurse model.
- Patient Safety/Nurse sensitive indicators – review of and cross referencing to any harm indicators such as falls or pressure ulcers which have a correlation to any reduction in nursing resources. The information and analysis supports establishment reviews to ensure staffing requirements and budgets are aligned.
- Recruitment data provision and analysis

5. Results

5.1 Bi Annual 20 Day Safe Staffing Review (6th September 2021 – 1 October 2021)

SNCT was used to capture the acuity and dependency data of all inpatients over a bi annual four week period (20 days).

The Ward Manager scored the acuity of the patients under their care. To remove potential individual nurse interpretation bias of the scoring system the acuity scores were reviewed once a day by the Matrons from the Acute Care Division.

The report compares the actual funded whole time equivalent (RN & HCSW) nursing staff with the assessed whole time equivalent required during the 20 day acuity audit.
The audit figure is a baseline against which to set nurse staffing levels; wards have varying degrees of activity therefore nursing professional judgment is vital to ensure that establishments are adjusted appropriately under these circumstances triangulated with the patient safety indicators.

A full breakdown of patient acuity and dependency by ward is shown below in Table 1. This data represents the outputs of the acuity tool, but does not take into account the recommended triangulated approach and thus should be considered as a **singular** measure of safe staffing to inform future workforce plans.

Table 1: Acuity assessment (Across 20 day timeframe: 6th Sept - 1st October 2021)

CCC – Solid Tumour (ST) and Haemato-oncology (HO) Wards							
Ward	Levels of Care Daily Average over 4 week audit					Nursing Establishment WTE	
	L0	L1a	L1b	L2	L3	Funded *	Recommended
Ward 2	9.1	3.3	9.2	0	0	41.40WTE	34.50
Ward 3	10.5	1.29	11.1	0	0	41.40WTE	35.25
Ward 4	3.95	5.05	6.4	0	0	38.99 WTE	22.42
Ward 5	2.55	2.65	7.3	0	0	35.34 WTE	21.65

**This funded figure is the budget for trained nurses and health care support workers delivering direct patient care. The funded figure is based on workforce plans to deliver 26 beds Ward 2, 25 beds Ward 3, and 25 beds Ward 4. Ward 5 data is based on 12 BMT Beds and 3 TYA (ST and HO) Beds plus 4 TYA out-patients chairs.*

5.2 Patient Safety/Nurse Sensitive Indictor Data

The acuity data detailed above in Table 1 is reviewed and assessed alongside the added dimensions of nurse sensitive indicators and local context, to produce a triangulated overview of staffing requirements. Whilst utilising a combination of objective and subjective measures, the triangulated figure then represents the appropriate level of staff and skill mix for the wards.

This data includes; Care Hours Per Patient per Day data (CHPPD) bed occupancy, sickness, bank usage, incidents and Patient Safety/Nurse Sensitive Indicators (NSI).

Patient Safety/Nurse Sensitive Indicators include; infection rates (eg hospital acquired C.diFF and MRSA infection), formal complaints relating to nursing care, falls, medication errors and attributable pressure ulcers related to each ward area and contribute to the quality of care delivered.

All patient safety indicators are investigated and discussed in depth on a monthly basis at the Harm Free Care Collaborative meeting to determine the level of potential harm, any associated lapse in care and any lessons learnt to support improvements in care delivery and patient experience.

A breakdown of the safe staffing review (6 Sept - 1 Oct 2021) nurse sensitive indicator dataset is detailed in Appendix 2.

6. Review/Triangulation of Evidence

Safe staffing is defined as having sufficient staff with the appropriate skill mix for the acuity and dependency of the patient group, in the right place and time. The size and complexity of the wards of CCCL are important factors to be considered in this review. Also the ability to flex at short notice and use temporary staff when there are short term gaps and or an un-planned rise in patient acuity. It should be noted that the level of patient care can be subjective and professional judgement must be used alongside any acuity results.

7. Conclusion

As clearly demonstrated within this report, based on reported SNCT data, CHPPD and Patient Safety/Nurse Sensitive Indicators, all wards at CCCL are safely staffed and support the single room model of care.

8. Actions and Next Steps

- Ongoing review of nursing establishments as part of Covid 19 recovery and in line with winter planning 2021/22 preparedness.
- Develop together with our peer Trusts, standardised cancer specific elements to support the SNCT.

9. Recommendations

Board is requested to:

- Receive the report and acknowledge its content
- Be assured that any gaps/additional nurse staffing requirements are being managed and actioned effectively
- Based on the Bi-Annual Safer Staffing Audit results, receive assurance that all inpatient wards are safely staffed at CCCL.

APPENDIX 1 - Basic Definitions of Levels of Care

Level of Care	Definition
Level O	Patient requires hospitalisation but needs are met through normal ward care.
Level 1a	Appropriately managed on inpatient wards but requires more than baseline resources. These patients may be acutely ill requiring intention, or may be unstable with a greater potential to deteriorate, triggering on the NEWS. Severe infection or sepsis.
Level 1b	Appropriately managed on inpatient wards but require more than baseline resources. These patients are in a stable condition but have an increased dependence on nursing support. Complex dressings or VAC. Spinal cord injury or instability. Patients on End of Life Care guidelines. Confused patients requiring constant Vision or DOLS. Complex discharge
Level 2	Patients who are unstable and at risk of deteriorating and who should not be cared for in areas currently resourced as general wards. These patients may be managed within clearly identified, designated Level2 beds, resourced with the required staffing level OR may require transfer to a High Dependency Unit. CPAP or BiPAP, continuous 50% oxygen. Drug infusions requiring intensive monitoring e.g. gtn, amiodarone.
Level 3	Patients needing advanced respiratory support and therapeutic support of multiple organs. These patients should be managed within the ITU setting.

Progress since last report

During the previous 6 months the following has being undertaken to support the continued improvement and review of safe staffing models of care within the Trust Acute Care Division.

- May 21: Shelford Acuity scoring tool training delivered by national SNCT nursing team to inpatient senior staff
- July 21: Interface between NHSP/e-roster implemented across all in patient wards. Training in Sunburst graphic (part of Safe Care dashboard that highlights potential surplus staff) by the Trust Safe Care lead with Ward Managers from Wards 2 and 3.
- August 21: Oversight and responsibility to ensure Safe Care is embedded across all in patient wards/CDU including training on acuity scoring delegated to Solid Tumour Matron. Sunburst graphic to be implemented to support safe staff movement across wards on a daily basis
- August 21: Collaboration with Workforce Information and Operational Team to strengthen the functionality of Safe-care and E-roster for ward staff
- September 21: Ongoing training with wards 4 and 5 staff on application of SNCT acuity levels. Continued education to all staff about escalation and raising the red flag is in progress.

- October 21: Development of Standard Operational Policy to support additional staffing requirements via NHS Professionals (NHSP)

- Development of the twice daily operational safe staffing process (Appendix 5) to include weekend recording.

- Improved reporting, documentation and implementation of lessons learnt from Harm Free Care Collaborative.

APPENDIX 2

Table 3 Nurse Sensitive Indicators Data

(Across 20 day timeframe: 6 September - 1s October 2021)

Ward and No. beds	Bed Occupancy	Skill Mix RN: HCSW % ratio ——— Pt:RN	CHPPD	Turnover Rate 12 months	Sickness %	NHSP spend	Shifts not covered RGN & HCSW	Falls	Pressure Ulcers	Medication Errors	Red flag events
								Attributable	Attributable		
								Lapse in Care	Lapse in Care		
Ward 2 26 beds	77%	62:38 5:3	11.9	16.65%	6.90%	£ 19,305.25	182 shifts	1	3	x5 (drug not supplied) x1 (wrong dose) x1 (delay in dispensing)	0
		1:5						0	0		
								0	0		
Ward 3 25 beds	76 %	62:38 5:3	12.3	6.38 %	5.76%	£15,991.32	60 shifts	1	3	0	0
		1:5						0	0		
								0	0		
Ward 4 20 beds	81.2 %	69:31 5:3	9.2	8.87%	5.87%	£24, 422	38 shifts	3	1	x1 (No harm) Px error –cross over of medications at the point where TTO was written	0
		1:4						0	0		
								0	0		
Ward 5 15 beds	82.9 %	55:44 5:3	17.5	10.89%	3.71%	£7,881	24 shifts	1	O	x3 (No harm) x1-accidental spike cytotoxic bag 1-Px error – IV phosphate prescribed incorrectly. Identified by nursing staff prior to administration and Px amended x1-drug administered too soon	0
		1:3						0	0		
								0	0		

APPENDIX 3

ACUTE CARE DIVISIONAL NURSE SENSITIVE INDICATOR DATA

1. Bed Occupancy /Activity

Table 1 below notes the average bed occupancy per month (at midnight) across Q1 and Q2 2021.

Table 1 Bed Occupancy (April-Sept 21)

	April 21	May 21	June 21	July 21	Aug 21	Sept 21
Ward 2 26 beds	70.1%	67.5%	69.2%	58.4%	74.2%	69.4%
Ward 3 25 beds	72.7%	77.5%	79%	76.3%	81.5%	77.9%
Ward 4 20 beds	81.8%	81.6%	89.5%	91%	90.3%	81.2%
Ward 5 15 beds	57.8%	61%	72.7%	80.9%	83.9%	82.9%

Data Source IPR dashboard 2021

2. Acuity

The SNCT contains defined classifications of levels of care and measures the acuity and dependency of those patients whose needs are met through normal ward care (Level 0), to those who require advanced respiratory and therapeutic support of multiple vital organs (Level 3). Tables 2-5 below demonstrate the fluctuating average in patient acuity score by individual wards.

Table 2: Ward 2 Patient Acuity

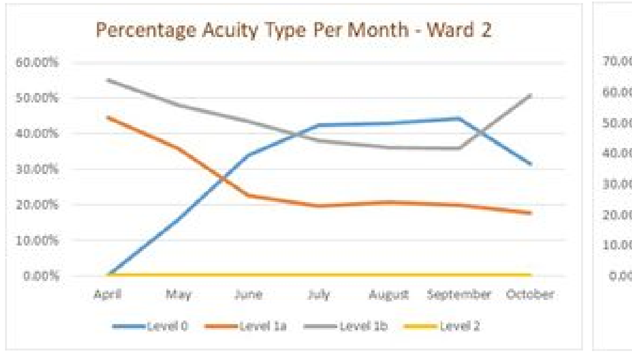


Table 3: Ward 3 Patient Acuity

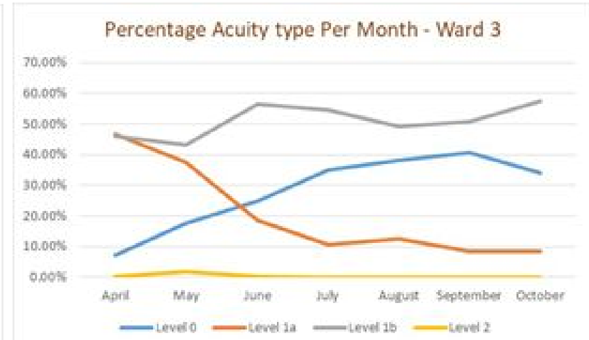


Table 4: Ward 4 Patient Acuity

Table 5: Ward 5 Patient Acuity

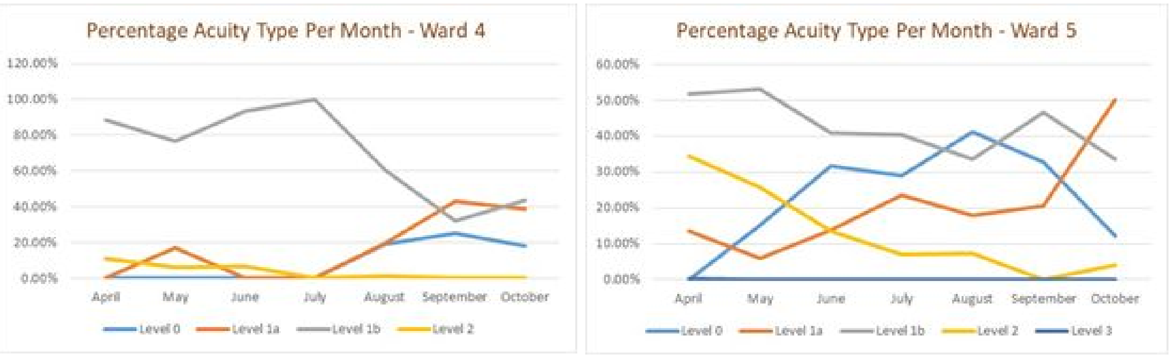
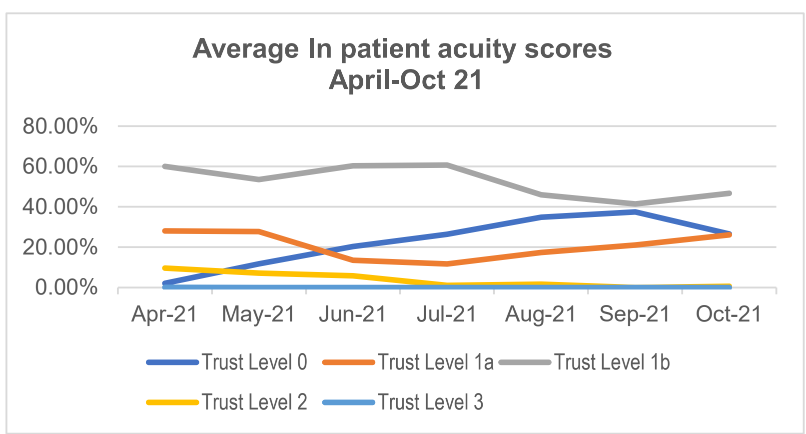


Table 6: Trust average in Patient Acuity Scores



Data Source SafeCare 2021

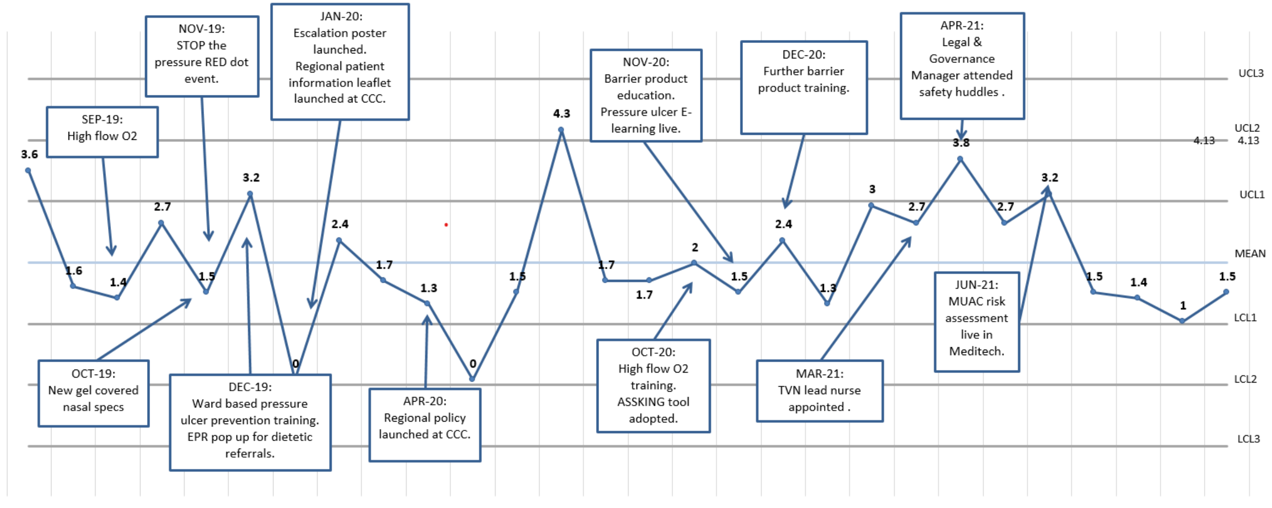
3. Patient Safety/Nurse Sensitive Indictors

The patient safety indicators, for example falls, pressure ulcers etc are investigated and discussed in depth on a monthly basis at the Harm Free Care Collaborative meeting to determine the level of potential harm, any associated lapse in care and lessons learnt to support improved care delivery and patient experience.

3.1 Pressure Ulcer and Falls

The SPC charts 1 and 2 provide information relating to the incidence of pressure ulcers and falls (per 1000 bed days) over the previous 6 months (April – Sept 2021), together with initiatives implemented to improve patient safety. Data provided enables a wider timescale than the mandated 20 day audit period to be analysed.

Chart 1 Pressure Ulcers per 1000 bed days



ASSKING TOOL: Assessing Risk, Skin Assessment, Surface Consideration, Keep Moving, Incontinence, Nutrition and Hydration and Giving information

MUAC Assessment: Mid Upper Arm Circumference to check nutritional status.

Table 1 Total number of all Category 2 and above pressure ulcers April 2021 – September 2021

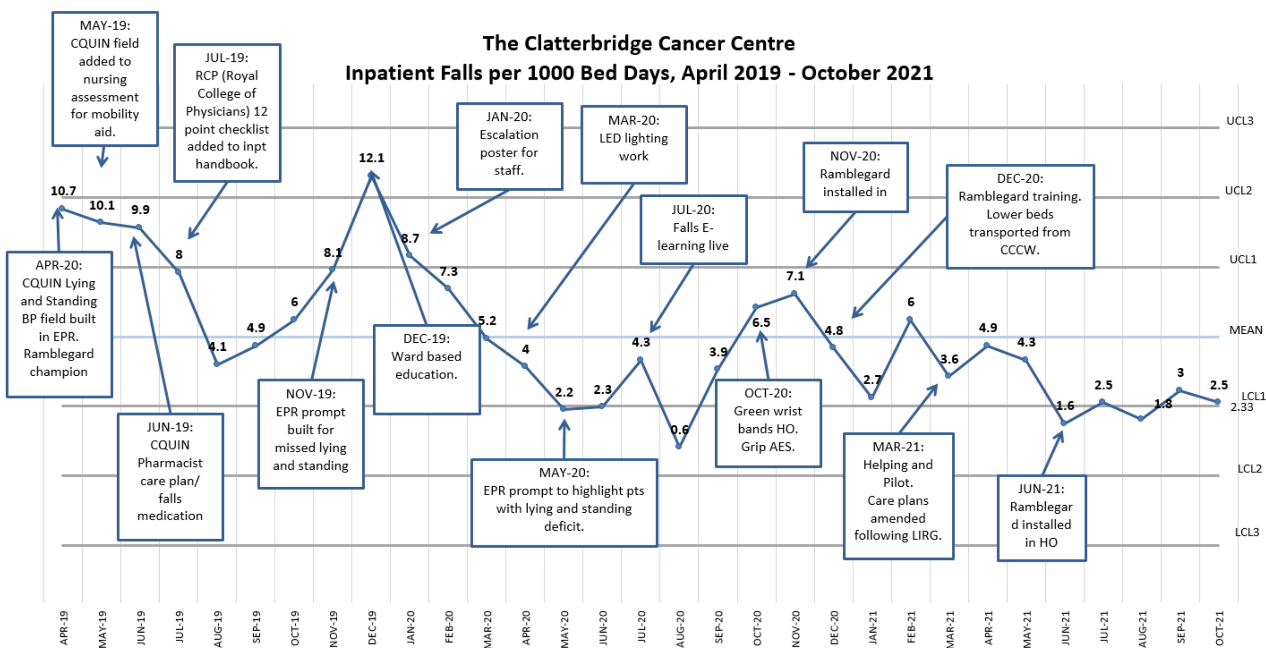
Pressure ulcers Category 2 and above						
	April 21	May 21	June 21	July 21	Aug 21	Sept 21
Ward 2	2	3	4	1	1	3
Ward 3	2	1	2	2	1	3
Ward 4	1	2	1	0	0	1
Ward 5	2	0	0	0	1	0

All inpatient pressure ulcers are discussed at the monthly Harm Free Care Collaborative meeting. A total of 33 PU were recorded during April – September 2021 as noted above in Table 1.

Table 2 Pressure Ulcers Category 2 and above level of harm (April-Sept 21) ***Data Source Datix***

PU Cat 2 and above : Level of harm	Total number
No harm	0
Low harm	32
Moderate harm	1
Severe harm	0

Chart 2: Falls per 1000 bed days



All inpatient falls are discussed at the monthly Harm Free Care Collaborative meeting and LIRG (Learning from Incidents Review Group). A total of 35 inpatient falls were recorded during April - Sept 2021 as noted in Table 3 below;

Table 3: Total number of reported in patient falls

In patient Falls	April 21	May 21	June 21	July 21	Aug 21	Sept 21
Ward 2	0	2	0	1	2	1
Ward 3	1	2	1	2	2	1
Ward 4	5	2	1	0	2	3
Ward 5	2	1	1	1	1	1

Data Source Datix 2021

Table 4: Falls level of harm (April - Sept 2021) ***Data Source Datix 2021***

Falls: Level of harm	Total number falls
No harm	30
Low harm	3
Moderate harm	1
Severe harm	1

Moderate Harm Ward 3

Summary - 88 year old female admitted for radiotherapy (10 fractions). Patient independent and mobile was walking towards chair to go down to radiotherapy with the porter. Patient was wearing slippers, turned to get her phone and had a witnessed fall onto right side. Patient reported pain to right leg and hip. Patient reviewed and attended for hip x-ray. Confirmed fracture to right neck of femur. Patient accepted to Aintree Hospital for surgery. Lesson learnt: Ensure patient footwear is appropriate for mobilising,

Severe Harm Ward 4

Summary: Patient found on the floor in her bedroom at the door, evidence of blood loss. Initially the patient was conscious but became drowsy. The patient was transferred to Liverpool University Hospital Foundation Trust. CT scan showed a subdural haematoma. Decision made for conservative management due to likelihood of fall being a pre-terminal event. Declared as a serious incident with severe harm. Full investigation completed. Coroner involved and reported as accidental death. No lapse in care identified.

All inpatients receive a falls risk assessment on admission to CCCL. Compliance with completing the fa

lls risk assessment across all wards during September was 99.49%.

3.2 Healthcare Associated Infections (HCAI)

CCC provides mandatory surveillance and reporting of the following pathogens to Public Health England on a monthly basis:

During the time period under review (April-Sept 21) the following HCAI were identified;

Table 6 Healthcare Associated Infections (HCAI)

Reportable Infection Thresholds		
Clostridiodes difficile infection (CDI)	CCC Threshold - **11**	Total cases Q1 & Q2 – **8**
Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia	CCC Threshold - **0**	Total cases Q1 & Q2 – **0**
Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia	CCC Threshold – **4** (internal objective)	Total cases Q1 & Q2 – **0**
Escherichia coli (E.coli)	CCC Threshold - **6**	Total cases Q1 & Q2 – **5**
Klebsiella sp.	CCC Threshold - **6**	Total cases Q1 & Q2 – **2**
Pseudomonas aeruginosa	CCC Threshold - **6**	Total cases Q1 & Q2 - **0**

Data Source IPC Team/IPR Dashboard

Clostridiodes Difficile Infection (CDI)

1 hospital acquired CDI was identified during a Period of Increased Incidence (PII) on Ward 2. A CDI PII was declared on Ward 2 in September 2021 as 3 potentially linked cases were identified; 1 CDI and 2 Toxin Gene positive patients. All patients were situated within adjacent rooms during the same period of time. A full RCA has been undertaken and minor remedial actions identified.

The completed PIR documents are sent to the clinical teams involved in the care of the patient along with an action plan if any lapses in care or learning points have been identified. The following themes have been identified from PIR's undertaken:

3.4 Complaints

There have been no formal complaints during the audit relating specifically to nursing care.

3.5 Care Hours Per Patient Day (CHPPD)

CHPPD is calculated by dividing the total number of nursing hours on a ward by the number of patients in beds at the midnight census. This calculation provides the average number of care hours available

for each patient on the ward. Table 7 illustrates the required CHPPD and compares this to the actual hours provided for the reporting time period (April – September 2021).

(Please Note: Table 7 is the average CHPPD over a full calendar month.)

Table 7 Average Monthly Care Hours Per Patient Day (CHPPD) by Ward

Data Item	Level (from M1 21/2	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Care hours per patient day: Ward 2	Ward 2		8.8	9	10.1	10	7.9	8.5	9.5
Care hours per patient day: Ward 3	Ward 3		9.3	8.9	8.4	9	8	8.2	8.4
Care hours per patient day: 7Y then Ward 4 / CCCL Ward 4	Ward 4	8.1 (based on Peer GP - Model Hospital)	10.1	10.9	9.3	9	8	9.6	9.4
Care hours per patient day: 10Z & 7X / CCCL Ward 5	Ward 5	8.1 (based on Peer GP - Model Hospital)	20.8	20.7	16.9	13	11	11.1	12.5

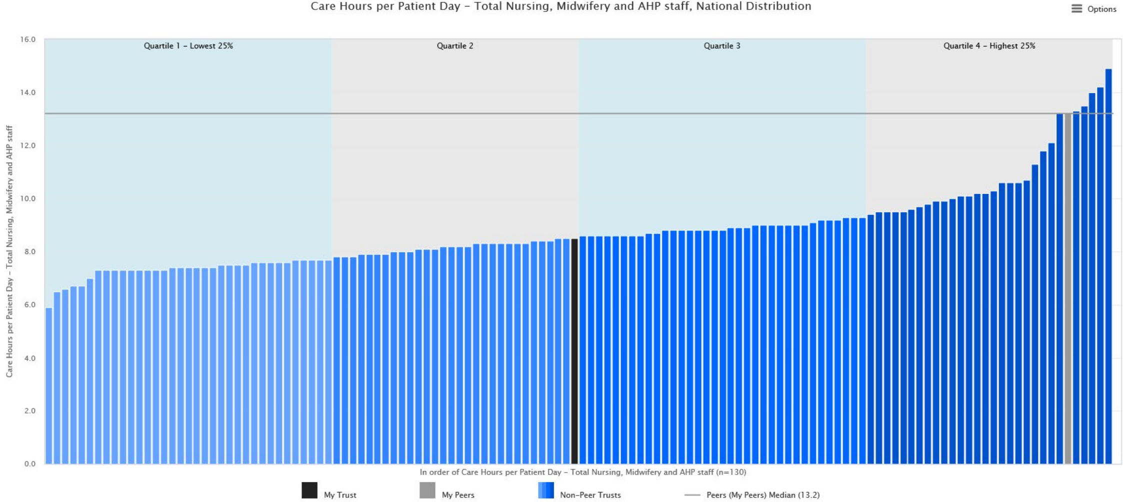
Data source CCC BI team

No National CHPPD targets exist as trends are more indicative of achieving a safe staffing position. Trusts can set an internal threshold as required.

Comparison of CHPPD with cancer peer (Royal Marsden) is noted below in Tables 8 and 9:

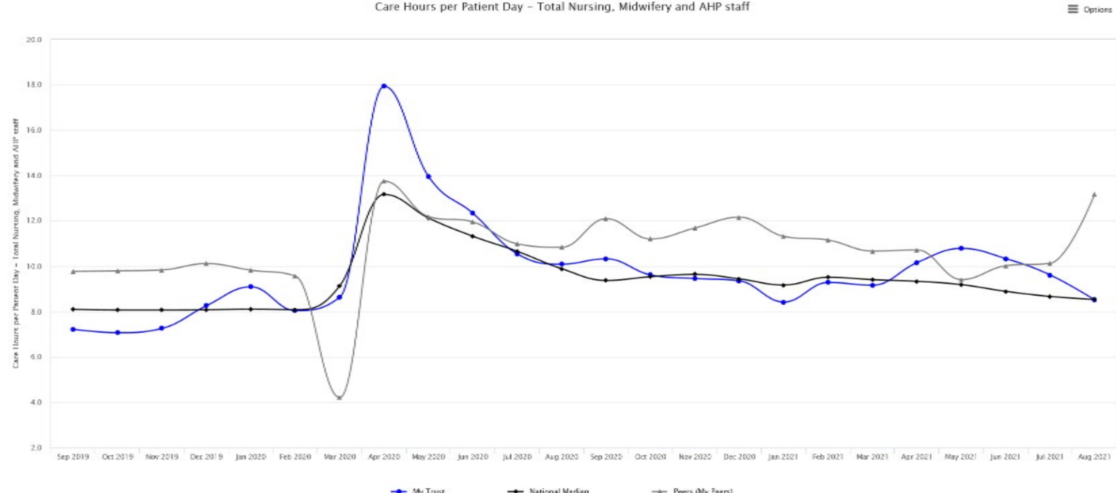
Table 8 CHPPD Peer Comparison

Note: No data noted for The Christie during 2021; Royal Marsden furthest grey bar to right of graph



Data Source NHS Digital August 2021 (last data available)

Table 9



Data Source NHS Digital August 2021 (last data available).

Table 9 demonstrates an increase in CHPDD at CCC since September 2019 and improved alignment with the national average and Peer Trust. The March/April 2020 spike is indicative of the Covid 19 pandemic.

4. NHS Professionals (NHSP)

Since implementation, NHSP has been used to support safe staffing, vacancies, short and long-term sickness, maternity leave or increased activity/1:1 care. It has allowed the leadership team to respond to fluctuations in patient need and ensure safe staffing can be provided.

Table 10 NHSP utilisation by shift, WTE and spend

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
	NHSP Shifts (Hours)					
	NHSP Shifts (WTE)					
	NHSP Spend (£)					
Ward 2	1225.4	1091.8	764.24	682.76	956.52	1021.7
	7.52	6.7	4.69	4.19	5.87	6.27
	£19,381	£19,956	£11,031	£14,907	£20,214	£19,305
Ward 3	1010.3	826.16	387.82	477.44	617.58	265.61
	6.2	5.07	2.38	2.93	3.79	1.63
	£8,649	£11,091	£12,598	£9,630	£11,622	£15,991
Ward 4	1370.4	1104.8	1360.6	1491	1280.79	1447
	8.41	6.78	8.35	9.15	7.86	8.88
	£16,571	£22,207	£22,768	£27,842	£27,843	£24,422
Ward 5	438.34	379.67	456.26	410.63	254.2	395.97
	2.69	2.33	2.8	2.52	1.56	2.43
	£8,104	£5,558	£7,196	£7,583	£4,607	£7,881

Data Source Finance budges/NHSP budgets 2021

5. Sickness Absence

Table 11 Sickness absence

Absence FTE%	April 21	May 21	June 21	July 21	August 21	Sept 21
Ward 2	2.16%	5.99%	7.99%	9.04%	7.14%	6.90%
Ward 3	6.81%	7.27%	10.32%	12.06%	11.51%	5.76%
Ward 4	8.05%	6.07%	7.27%	10.60%	7.24%	5,97%
Ward 5	1.46%	2.78%	2.28%	8.77%	7.72%	3.71%

Data Source ESR/IPR dashboard 2021

Ward 3 & 4 consistently above Trust target of 4%

Ward 2 below Trust target 1 month

Ward 5 below Trust target 4 months

6. Recruitment

To achieve a full inpatient nursing establishment is challenging, especially in the unprecedented times we are experiencing due to the global pandemic. We are recruiting in a highly competitive market and need to ensure that we can proactively recruit the best nurses to CCC to enable staffing stability to be achieved in all areas.

Table 12 Staff Turnover

Turnover FTE %	April 21	May 21	June 21	July 21	August 21	Sept 21
Ward 2	6.45%	6.36%	6.24%	6.24%	12.19%	16.65%
Ward 3	1.74%	3.89%	3.94%	3.94%	3.98%	6.38%
Ward 4	2.39%	4.29%	4.31%	4.31%	4.30%	8.87%
Ward 5	0.00%	2.18%	3.76%	3.76%	8.01%	10.89%

Data Source ESR/IPR dashboard 2021

The recruitment of experienced Registered Nurses (RNs) to CCC is particularly challenging and we predict will situation will continue due to the current national shortage of RN’s.

CCC has filled a significant number of vacancies with newly qualified nurses (NQN) which has increased the pressure on our experienced staff; this is further complicated by the length of time (recruitment pipeline) it takes for successful candidates to commence in post – on average 4-6 months lead time. Recruitment has improved following the move to CCCL. Staff who did not want to travel over to Liverpool have been supported and realigned within CCC services or left the Trust to achieve a better work/life balance.

It is noted from the current turnover rate (16.65 %) that Ward 2 have lost a number of experienced chemotherapy nurses to promotion or CNS posts at CCC.

In support of recruitment the Trust is involved in two national recruitment initiatives:

6.1 Pan Mersey Collaborative;

Recruitment of International Registered nurses from Europe and across the world, ensuring a sustainable process that benefits the nurse, their country of origin and the NHS system A cohort of 6 international nurses registered in their own country and with experience in Oncology/Haematology/Palliative Care and are due to commence in post across the Trust in early January 2022. Four of whom will be employed within the inpatient wards.

6.2 Health Care Support Workers (HCSW):

National recruitment of HCSW via a robust recruitment and retention process, facilitating individuals to be recruited who have no previous health/social care experience. Strengthened levels of pastoral support, induction, clinical education/supervision and supernumerary status are incorporated in the new programme.

APPENDIX 4

1. **Environment**

Since moving to CCCL in June 2020, in-patient nursing teams on all 4 in patient wards have had to adapt to new ways of working with 100% single room occupancy for all patient stays.

As a result the ward environment has brought about significant changes for staff, with each ward having a slightly different layout and single room occupancy making observation of patients much more challenging. Nursing staff continue to familiarise themselves with the new environment and are using technology eg Rambleguards to reduce the risk of patient falls where available, to enhance safer care.

A significant reduction in visitor support to patients as a result of Covid 19 pandemic had also had an impact on the workload of the nursing staff.

2. Activity

This bi-annual review has continued to note bed occupancy rates below the national average of 85%. However we envisage bed occupancy to increase as part of the Covid19 Pandemic Cancer Recovery Programme.

3. Safe Rosters

Despite the pressures of Covid 19, no critical understaffing 'Red Flag' incidents have been reported by the inpatient teams during Q1 or Q" 2021.

Sickness levels across all 4 wards have fluctuated with a spike in recorded sickness absence between June and August 21 correlating with an increased on NHSP temporary staffing.

Sickness absence for 3 out of the 4 in patient wards is above the Trust average of 4%.

The top 3 absence reasons across the inpatient wards are:

- Cold, coughs and Flu
- Chest and respiratory (which includes Covid 19)
- Gastrointestinal.

The sickness absence rates include both long and short term absences. Staff sickness is managed at ward level by the Ward Manager, via the sickness management policy and guidance from HR

Staff turnover rates remain high and have increased month on month during Q1 and Q2 2021 with Ward 2 significantly above the Trust average turnover rate of 14%.

4. Acuity

It is well understood that different patients will have different levels of care requirements, referred to as acuity. The Safer Nursing Care Tool (SNCT) contains defined classifications of levels of care and measures the acuity and dependency of those patients whose needs are met through normal ward care (Level 0), through to those patients who require advanced respiratory support and therapeutic support of multiple vital organs (Level 3). Data noted in Appendix 3, Tables 2-5 demonstrate the fluctuating average in patient acuity score by individual wards over the previous six month period (April – September 2021).

Ward 2 Common and Rare Cancers

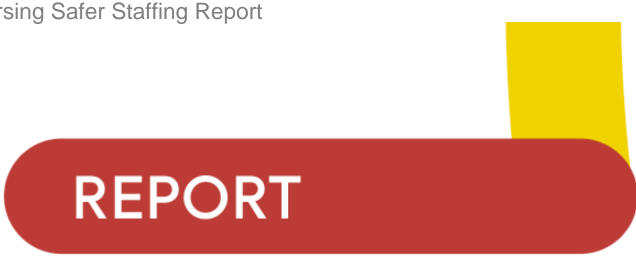
Ward 2 data illustrates a reporting trend of Level 0 and Level 1b patients (Sept 21) compared to levels captured in the previous bi-annual audit (Jan 21). This may be due to improved understanding of the SNCT and more accurate reporting of acuity levels by staff on Ward 2 following additional education and support. No Level 2 patients were reported during this audit, however an increase in level 1b patients has been noted for October 21 (Appendix 2, Table 2).

Occupancy and acuity levels continue to fluctuate as elective admissions are generally higher at the beginning of the week.

Ward 3 Intermediate Cancer

Ward 3 data illustrates a reporting trend of Level 0 and Level 1b patients (Sept 21), consistent with previous reports.

Like Ward 2, no Level 2 patients were reported on ward 3 during this cohort area for Covid 19 positive high risk patients. This is likely to be explained by the decreasing use of the ‘red zone’ on Ward 3 as the Trust continues to recover from the Covid 19 pandemic. As per current Trust



guidelines, any Covid 19 positive patient is now nursed within their own bedroom with appropriate infection control precautions in place.

Ward 4 – Haemato-oncology

Ward 4 has shown consistency with predominantly Level 1a and 1b patients reported. There were no Level 2 patients during this audit (Sept 21), in correlation with the reduced transplant programme resulting in less post-transplant patients being admitted to Ward 4. A high number of these patients would be reported at a higher acuity (Level 1b/2). Compared to previous reports a number of level 0 patients have been reported. This may demonstrate improved training on acuity recording on Ward 4, newly admitted patients or patients prior to their treatment/complete of their treatment.

It should be noted that Ward 4 has continued to admit Acute Leukaemia patients (AL) from the region and an increasing number of CNS Lymphoma patients from Aintree (mutual aid). Both these patient cohorts are vulnerable and complex due to the aggressive chemotherapy regimens, immune-suppression and treatment complications. CNS Lymphoma patients often have a significant degree of cognitive impairment resulting in the need for 1:1 close observation A number of these patients can often require a transfer to critical care services.

Ward 5 – Stem Cell Transplant Unit

Ward 5 has shown an increase in the number of Level 1b patients and a decrease in the number of Level 2 patients reported during the audit period (Sept 21); consistent with the reduction in the number of stem cell transplant admissions during Covid 19 pandemic.

As a result, the number of Level 2 patients in this review is significantly below that reported in the previous review. It is noted that patient acuity on Ward 5 will continue to increase as the stem cell transplant programme returns to full capacity following temporary cease of programme during the Covid pandemic as reflected in increasing acuity trend (Appendix 2, Table 5).

5. Care Hour Per Patient Day (CHPPD)

CHPPD is a simple calculation which divides the number of actual nursing/midwifery (both registered and unregistered) hours available on a ward per 24 hour period by the number of patients on the ward that day. It therefore nominally represents the average number of nursing hours that are available to each patient on that ward.

With the exception of Ward 4, all wards reported an increase in CHPPD compared to the previous report (Jan 21). Disparity in CHPPD reported in Sept 21(Table 3) was noted compared to the Trust wide average (Appendix 3, Table 7).

However a note of caution is required when comparing the CHPPD calculated during the 20 day period (Sept 21) reported in this bi annual report compared to the average full calendar month CHPPD reported by BI team (Appendix 3, Table 7).

CHPPD can be used as a measure to compare available staffing with peers, however this needs to be undertaken with caution as the specific configuration of services in any organisation will determine what level of CHPPD a Trust would require. The peer CHPPD data identified for this report is limited. (Appendix 3, Tables 8&9)

6. Nursing Establishment 2021

Nursing staff establishments take into account the need to allow nursing and health care support worker time to undertake Continuous Professional Development and fulfill leadership and supervision roles.

Core principles re; nursing establishments are:

- Ward Manager is supervisory to enable them to provide direct care, undertake frontline clinical leadership and support unfilled shifts.
- 23% uplift 'headroom' is allocated to ward establishments to allow for annual leave, sickness maternity, training and development.

Ward 2 staffing establishment is set for a 26 bedded ward, although a number of beds are given over to elective day case activity where a different staffing ratio may be required.

In addition to being the designated Red Zone for Covid 19 positive patients, a respiratory area has been identified on Ward 3 for use during the winter period, associated staffing requirements will be mobilised if this area is needed for escalation.

The planned staffing level is based on optimal staffing levels and where actual staff is below this on a shift, the Trust has a number of mechanisms to ensure staffing remains at a safe and appropriate level as outlined in Appendix 5.

APPENDIX 5

DAILY OPERATIONAL SAFER STAFFING PROCESS

- Staffing levels are RAG rated at the start of each shift (Red/Amber/Green) according to the professional judgment of the nurse in charge.
- Green shifts are determined by the nurse in charge to be safe staffing levels.
- Amber shifts are considered, by the nurse in charge via professional judgment, to require minor adjustment to bring the ward to a safe staffing level. Staff will prioritise their work and adjust their workload through the shift accordingly. The Matron will be alerted and mitigating actions would be put in place and recorded on the database.
- If the shift is rated red the nurse in charge will alert the Matron that action is required, as potentially the shift will present a shortfall of staff that is below minimum levels to give safe care. Mitigating actions will be taken, and documented, which may constitute the movement of staff from another ward, or temporarily reducing the ward capacity and activity to match the staff availability.
- Red shifts will be escalated to the Divisional Nurse Director who will monitor the actions being undertaken, the Deputy Director of Nursing is also notified. The use of NHSP staff for high acuity patients/periods is identified by the Ward Manager and approved by the Matron. Extra Health Care Support Workers (HCSWs) are utilised to support changes in acuity. Continued education to all staff about escalation and raising the red flag is in progress.

Safe staff escalation process highlighted below:

Staffing ratios, together with bed occupancy, patient acuity, planned admissions and Trust OPEL status (Operational Pressures Escalation Levels) is recorded on a spreadsheet. A section to capture professional judgement is included and disseminated twice daily key leaders.

SAFE STAFFING ESCALATION STATUS	Below minimum levels to deliver safe care RED FLAG EVENT DATIX ESCALATE	Review by Ward Manager and minor adjustments to ensure safe staffing +/- inadequate skill mix	Full establishment
AMBER ACTION OVERVIEW	Amber areas due to staffing levels below the set establishment and/or patient acuity are all manageable due to internal fixes, remain safe and are under constant review from the Managers/Matrons		
RED FLAG EVENT	Staffing numbers below minimum levels (see matrix below) to deliver safe care (all internal/external fixes exhausted) . A shortfall of more than 8 hours per shift or 25% of RGN time available compared to minimum actual requirement. Escalate to Divisional Nurse Directors and Deputy Director of Nursing		

REPORT COVER

Report to:	Trust Board	
Date of meeting:	26th January 2022	
Agenda item:	P1-016-22	
Title:	Caldicott Guardian Annual Report 2019-2021	
Report prepared by:	Peter Case-Upton, MIAA	
Executive Lead:	Dr Sheena Khanduri, Medical Director	
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	The Information Governance Board
Date & decision:	26th October 2021 – report noted

Purpose of the paper/key points for discussion:	To provide an update to the IG Board on the status and performance of Caldicott related issues within the Trust

Action required: (please tick)	Discuss	☐
	Approve	☐
	For information/noting	☒

Next steps required:	

REPORT COVER

The paper links to the following strategic priorities and Board Assurance Framework (BAF) Risks (please select)

☐ BE **OUTSTANDING**

BAF Risk	Please select
If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	☒
Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	
Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	

☐ BE **COLLABORATIVE**

BAF Risk	Please select
If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	☒

☐ BE **RESEARCH LEADERS**

BAF Risk	Please select
If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	
Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	

☐ BE **A GREAT PLACE TO WORK**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	
If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	

☐ BE **DIGITAL**

BAF Risk	
If we do not invest a clear vision, sufficient capacity and investment6 in our digital programme and teams there is a risk that the Trust will not achieve its digital ambition.	
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	

☐ BE **INNOVATIVE**

BAF Risk	
If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	

EQUALITY & DIVERSITY IMPACT ASSESSMENT								
Are there concerns that the policy/service could have an adverse impact on:								
Age	Yes ☐	No ☒	Disability	Yes ☐	No ☒	Gender	Yes ☐	No ☒
Race	Yes ☐	No ☒	Religious/belief	Yes ☐	No ☒	Sexual orientation	Yes ☐	No ☒
Gender Reassignment	Yes ☐	No ☒	Pregnancy/maternity	Yes ☐	No ☒			

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

Version 1.0 Ref: FCGOREPCOV Review: May 2024

Caldicott Guardian Annual Report 2019-2021

Peter Case-Upton

Version: 1.0   Ref: FCGOREPO   Review: May 2024

Caldicott Guardian Report
April 2019 to March 2021

Executive Summary:

The Caldicott Guardian has a key role in ensuring that the Trust achieves the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and issues at Board Level, and wherever appropriate within the Trust's overall governance framework.

The key Caldicott Guardian responsibilities as defined in the Department of Health Caldicott Guardian Manual (2017) are:

1. Strategy and Governance
2. Confidentiality and Data Protection expertise
3. Internal Information Processing
4. Information Sharing

The appointment of a Caldicott Guardian was mandated for the NHS by a Health Service Circular: HSC 1999/012 and was subsequently introduced into Social Care in 2002, mandated by Local Authority Circular: LAC 2002/2. Since the mandates, all NHS organisations and local authorities providing social services must have a Caldicott Guardian, who must be registered on the publicly available Caldicott Guardian Register, available on the NHS Digital website at: https://digital.nhs.uk/organisation-data-service/our-services.

It is also a requirement within the NHS Standard Contract; *section GC21 - Patient Confidentiality, Data Protection, Freedom of Information and Transparency* for "providers" to……

"*…… nominate a **Caldicott Guardian** and Senior Information Risk Owner, each of whom must be a member of the Provider's Governing Body"*

*"…….ensure that the Co-ordinating Commissioner is kept informed at all times of the identities and contact details of the Information Governance Lead, Data Protection Officer, **Caldicott Guardian** and the Senior Information Risk Owner"*

*"…….ensure that NHS England and NHS Digital are kept informed at all times of the identities and contact details of the Information Governance Lead, Data Protection Officer, **Caldicott Guardian** and the Senior Information Risk Owner via the NHS Data Security and Protection Toolkit."*

This report is required annually as a summary of the work undertaken in this role.

1. Introduction

The Caldicott Guardian (named after the Chair of a Committee which defined the required patient confidentiality standards and processes in the NHS) has a key role in ensuring that the Trust achieves the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and issues at Board Level, and wherever appropriate within the Trust's overall governance framework.

The key Caldicott Guardian responsibilities as defined in the Department of Health Caldicott Guardian Manual (2017) are:

Strategy & Governance: the Caldicott Guardian should champion confidentiality issues at Board/senior management team level, should sit on an organisation's Information Governance Board/Group and act as both the 'conscience' of the organisation and as an enabler for appropriate information sharing.

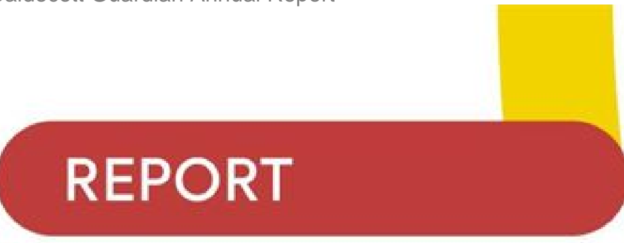
Confidentiality & Data Protection expertise: the Caldicott Guardian should develop a knowledge of confidentiality and data protection matters, drawing upon support staff working within an organisation's Caldicott function but also on external sources of advice and guidance where available.

Internal Information Processing: the Caldicott Guardian should ensure that confidentiality issues are appropriately reflected in organisational strategies, policies and working procedures for staff. The key areas of work that need to be addressed by the organisation's Caldicott function are detailed in the Data Security & Protection Toolkit.

Information Sharing: the Caldicott Guardian should oversee all arrangements, protocols and procedures where confidential patient information may be shared with external bodies both within, and outside, the NHS and CSSRs. This includes flows of information to and from partner agencies, sharing through the NHS Care Records Service (NHS CRS) and related new IT systems, disclosure to research interests and disclosure to the police.

2. The Caldicott Guardian role at The Clatterbridge Cancer Centre

Up until 28th February 2018 the role of Caldicott Guardian at the Trust was part of the Executive Director of Nursing & Quality's portfolio. Up until that date this role was occupied by Helen Porter. From the 1st April 2018, the role was transferred to the portfolio of the Trust's Medical Director, currently occupied by Dr. Sheena Khanduri.



3. Report on Compliance

The Caldicott Function is an integral part of the Trust's Information Governance Framework. The Caldicott Guardian works closely with the Information Governance Manager (Data Protection Officer)

As part of the Information Governance work plan, an annual Caldicott Function Plan is a documented which sets out the approach the Trust will take for the forthcoming year ahead in order to discharge its Caldicott responsibilities.

The Caldicott Guardian attends the Information Governance Board.

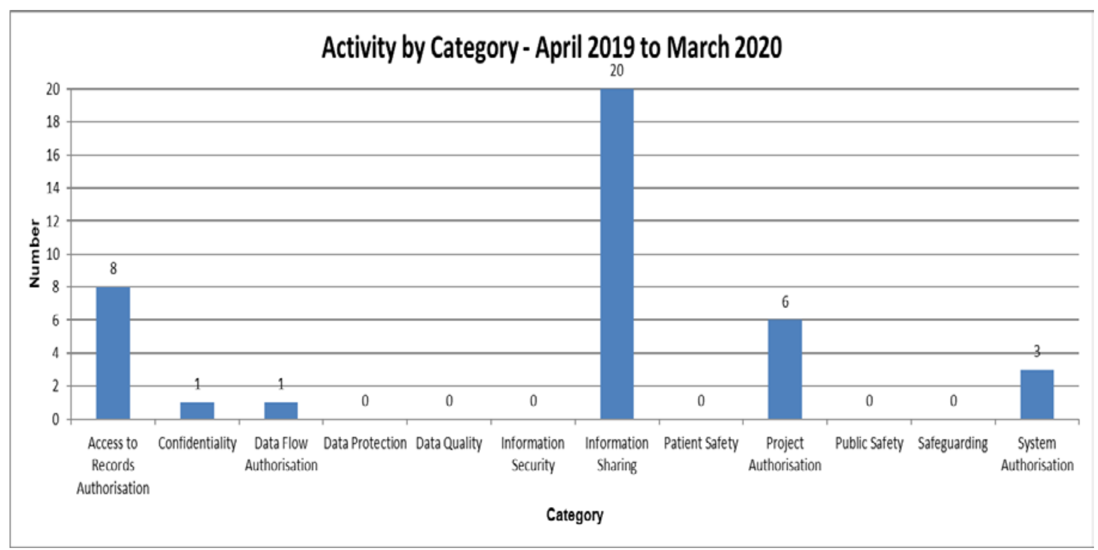
a. Caldicott Log

All interventions requiring Caldicott input are recorded in a Caldicott Log. The Caldicott Log is included on the Information Governance Board Meeting agendas and reviewed as standing agenda item.

In total, between April 2019 and March 2020, **39** Caldicott interventions were logged.

Caldicott Activity by Category

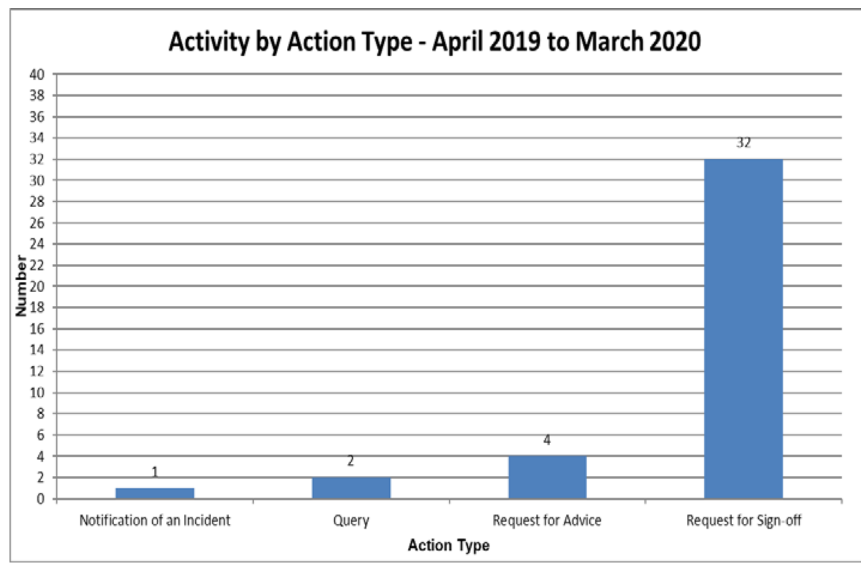
	Access to Records Authorisation	Confidentiality	Data Flow Authorisation	Data Protection	Data Quality	Information Security	Information Sharing	Patient Safety	Project Authorisation	Public Safety	Safeguarding	System Authorisation	TOTAL
April	3	0	0	0	0	0	1	0	0	0	0	2	6
May	0	0	0	0	0	0	2	0	0	0	0	0	2
June	1	0	0	0	0	0	2	0	0	0	0	0	3
July	0	0	0	0	0	0	3	0	0	0	0	0	3
August	0	0	1	0	0	0	2	0	0	0	0	0	3
September	0	0	0	0	0	0	3	0	0	0	0	0	3
October	1	0	0	0	0	0	1	0	0	0	0	0	2
November	0	0	0	0	0	0	0	0	0	0	0	0	0
December	0	0	0	0	0	0	2	0	1	0	0	0	3
January	2	1	0	0	0	0	2	0	1	0	0	0	6
February	1	0	0	0	0	0	0	0	1	0	0	0	2
March	0	0	0	0	0	0	2	0	3	0	0	1	6
Totals	8	1	1	0	0	0	20	0	6	0	0	3	39



The majority of the interventions logged related to **Information Sharing** (**20**), in particular Information Sharing Agreements, followed by **Access to Record Authorisations** (**8**), which included complex Subject Access Requests, Access to Health Record Act Requests and disclosures to law enforcement agencies.

Caldicott Activity by Action Type

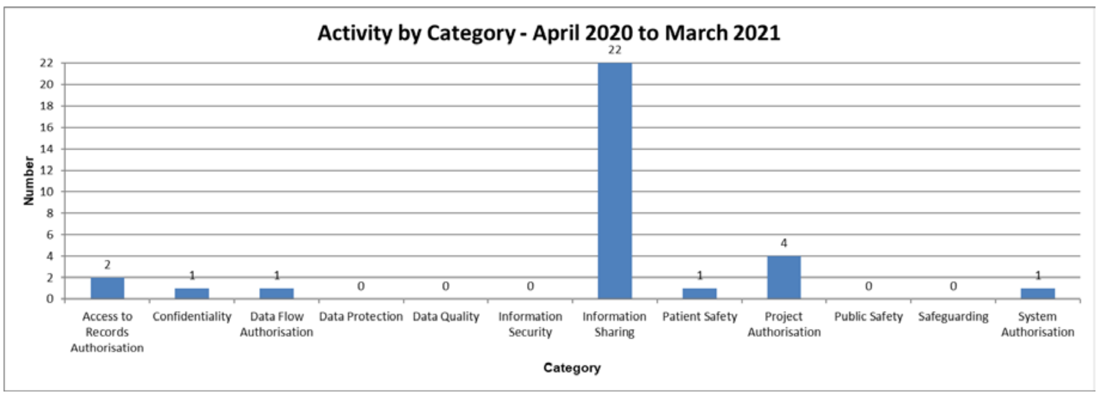
	Notification of an Incident	Query	Request for Advice	Request for Sign-off	TOTAL
April	0	0	0	6	6
May	0	0	0	2	2
June	0	0	1	2	3
July	0	0	0	3	3
August	0	1	0	1	2
September	0	0	0	4	4
October	0	0	1	1	2
November	0	0	0	0	0
December	0	1	0	2	3
January	1	0	1	4	6
February	0	0	1	1	2
March	0	0	0	6	6
Totals	1	2	4	32	39



The majority of the actions performed as a result of an intervention being logged were **Requests for Sign-off** (**32**), in particular Information Sharing (**20**) and Project Authorisations **(6)**

In total, between April 2020 and March 2021, **32** Caldicott interventions were logged.

	Access to Records Authorisation	Confidentiality	Data Flow Authorisation	Data Protection	Data Quality	Information Security	Information Sharing	Patient Safety	Project Authorisation	Public Safety	Safeguarding	System Authorisation	TOTAL
Totals	2	1	1	0	0	0	22	1	4	0	0	1	32
April	0	0	0	0	0	0	2	1	2	0	0	0	5
May	1	0	0	0	0	0	2	0	0	0	0	0	3
June	0	0	0	0	0	0	4	0	0	0	0	0	4
July	1	0	0	0	0	0	0	0	0	0	0	1	2
August	0	1	0	0	0	0	2	0	0	0	0	0	3
September	0	0	0	0	0	0	1	0	0	0	0	0	1
October	0	0	0	0	0	0	1	0	1	0	0	0	2
November	0	0	0	0	0	0	5	0	0	0	0	0	5
December	0	0	0	0	0	0	1	0	1	0	0	0	2
January	0	0	1	0	0	0	2	0	0	0	0	0	3
February	0	0	0	0	0	0	0	0	0	0	0	0	0
March	0	0	0	0	0	0	2	0	0	0	0	0	2

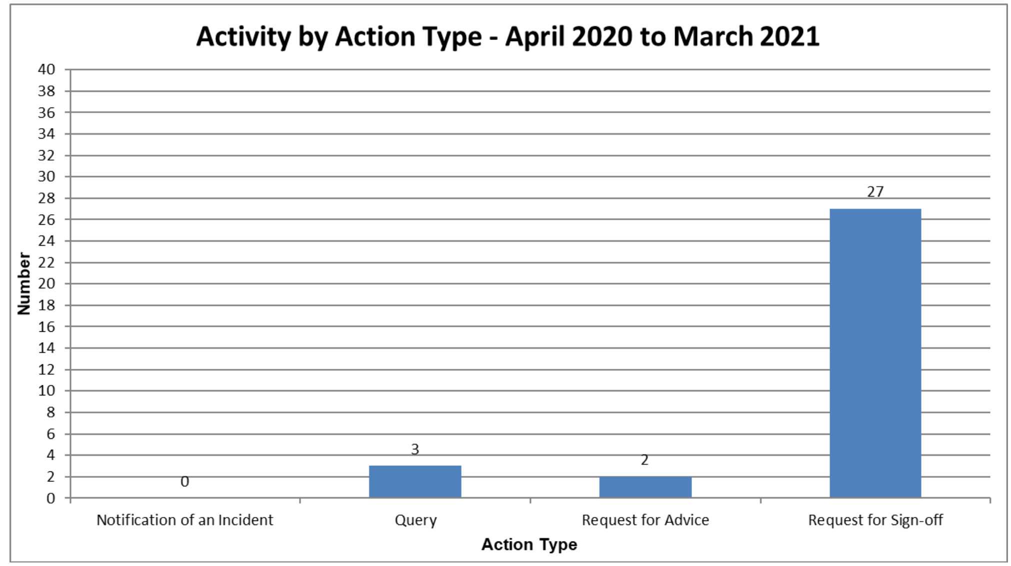


The majority of the interventions logged related to **Information Sharing** (**22**), in particular Information Sharing Agreements, followed by **Project Authorisation (4).**

Caldicott Activity by Action Type

	Notification of an Incident	Query	Request for Advice	Request for Sign-off	TOTAL
Totals	0	3	2	27	32
April	0	1	0	4	5
May	0	0	0	3	3
June	0	0	0	4	4
July	0	0	1	1	2
August	0	0	0	3	3
September	0	0	0	1	1
October	0	0	0	2	2
November	0	0	1	4	5
December	0	1	0	1	2
January	0	1	0	2	3
February	0	0	0	0	0
March	0	0	0	2	2

The majority of the actions performed as a result of an intervention being logged were **Requests for Sign-off** (**32**), in particular Information Sharing (**20**) and Project Authorisations **(6)**



The majority of the actions performed as a result of an intervention being logged were **Requests for Sign-off** (27), followed by Caldicott related Queries **(3)**

b. Information Sharing Agreements

Between April 2019 and March 2021 Information Sharing Agreements were kept under review, updated as necessary, and reported through the Information Governance Board. As at the end of March 2021, the Trust has **46** active Information Sharing Agreements, which is an increase of **6** from the previous Caldicott Guardian Report. An abridged version of the Trust's Information Sharing Agreement register is published on the Trust's public facing internet website - https://www.clatterbridgecc.nhs.uk/patients/your-rights/confidentiality-data-protection/information-sharing-agreements.

c. Information Governance Related Incidents

All reported confidentiality incidents are subject to timely investigation and review of mitigating action. All SUIs are reported directly to the Caldicott Guardian. All incidents are reviewed at the Information Governance Board.

In total, during the reporting period 2019/20, there were **120** reported Information Governance related/tagged incidents, summarised by Datix Incident Category Tier 3 below:

Incident Type Tier Three 2019/20	Number of Incidents
Incorrect patient	46
Unintentional breach	16
Other communication incident	8
Other documentation incident	8
Other	7
Ambiguous/incorrect/incomplete	6
Confidentiality breach	4
Unauthorised access to personal data without consent	4
Unauthorised disclosure of personal data without consent	4
Temporarily unavailable/delay in accessing	3
Data/information	2
Incorrect/insufficient handover	2
Permanently unavailable	2
Dispensed to incorrect patient	1
Incorrect information/data entry	1
Loss of data/information	1
Misfiled	1
Non-compliance with fair processing requirement	1
Not Recorded	1
Other administration incident	1
Referral insufficient/incorrect/incomplete	1

There was one Serious Incident during the period 2019/20 which was reported to the Information Commissioner's Office (ICO):

Summary incidents reported to the Information Commissioner's Office				
Date of incident	**Nature of Incident**	**Nature of data involved**	**Number of subjects potentially affected**	**Outcome of Incident**
12th September 2019 - Data Breach occurred **20 September 2019** – Identification a breach had occurred and Notification of Data Breach to the ICO	During an Integrated Care Performance Review Meeting confidential and personal information of a financial nature was disclosed regarding a member of staff within a management report which was shared with everyone at the meeting by e-mail	Personal Identifiable Information and Sensitive Personal Information	**1** staff member	**8th October 2010** Conclusion of ICO investigation – No enforcement action taken As a result of the incident, Staff were reminded about sensitivity of information used in meeting papers and only use the necessary amount for the purpose and function of the meeting.

Incident Type Tier Three 2020/21	Number of incidents
Data disclosed in error	96
Unauthorised access or disclosure	12
Lost or stolen paperwork	8
Non-secure disposal - Paperwork	7
Data uploaded to website in error	4
Identifiable data lost in transit	2
Technical security failing	1
Corruption or inability to recover data	1
Grand Total	131

With regard to the IG incidents, the most prevalent type was data disclosed in error.

There were no serious Incidents during the period 2020/21 that required reporting to the Information Commissioner's Office (ICO):

A summary of incidents requiring notification to the Information Commissioner's Office since 2016 is detailed below:

Year	Number of ICO Reportable Incidents
2016 - 2017	**1**
2017 – 2018	**0**
2018 – 2019	**1**
2019 - 2020	**1**
2020 - 2021	**0**

On each occasion the Information Commissioner's resolved that they would not take any further action against the Trust as a result of the breach

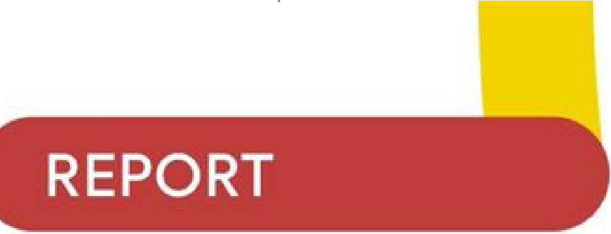
4. Information Governance/Data Security & Protection Toolkit Annual Submissions

The Data Security and Protection Toolkit replaced the previous Information Governance toolkit during April 2018.

The Data Security and Protection Toolkit is an online self-assessment tool that enables organisations to measure and publish their performance against the National Data Guardian's ten data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

For 2019-2020 the Toolkit comprised of 179 requirements which are either met or not met. Of these, 116 are mandatory and 63 are not mandatory. Organisations are expected to achieve 'Standards Met' where they have provided evidence for all the mandatory evidence items and confirmed the assertions

Information Governance Toolkit Annual Submissions (up until March 2018)				
Assessment	**Stage**	**Overall Score**	**Grade**	**MIAA Information Governance Toolkit Audit Assurance**
Version 8 (2010-2011)	Published	78%	Satisfactory	N/A
Version 9 (2011-2012)	Published	78%	Satisfactory	Limited Assurance
Version 10 (2012-2013)	Published	80%	Satisfactory	Limited Assurance
Version 11 (2013-2014	Published	80%	Satisfactory	Significant Assurance
Version 12 (2014-2015	Published	80%	Satisfactory	Significant Assurance
Version 13 (2015-2016	Published	80%	Satisfactory	Significant Assurance
Version 14. (2016-2017)	Published	80%	Satisfactory	Significant Assurance
Version 14.1 (2017-2018)	Published	83%	Satisfactory	Significant Assurance



Data Security & Protection Toolkit Annual Submissions (from April 2018)						
Assessment	**Stage**	**Requirement Type**	**Total Number**	**Complete**	**Not Complete**	**MIAA Information Governance Toolkit Audit Assurance**
2018-2019	Published	Mandatory	101	101	0	Substantial Assurance
		Non - Mandatory	47	20	27	
2019-2020		Mandatory	116	116	0	Substantial Assurance
		Non - Mandatory	63	29	34	
2020 - 2021		Mandatory	110	110	0	Substantial Assurance
		Non - Mandatory	38	16	22	

The Trust achieved all 110 mandatory evidence requirements by 29th June 2021 which resulted in a “Standards Met” assurance level.

To fully comply with the Trust’s NHS England Standard Contract, General Conditions 21.6 which states that the Trust must ensure that its NHS Data Security & Protection Toolkit submission is audited in accordance with Information Governance Audit Guidance the Trust’s internal auditor, Mersey Internal Audit Agency (MIAA) complete an annual review and assign an assurance level against the Trust’s Data Security & Protection Toolkit compliance. This assurance level is show in the table above.

Whilst the Trust gained a substantial level of assurance for the DSP Toolkit in 20/21 there was improvement required when the toolkit evidence was compared to the 10 National Data Standards. Work has commenced to improve the position for the next submission.

It is known that the Trust's IT department is working towards gaining Cyber Essential Plus and ISO27001 levels of assurance in the coming months – this should assist in increasing the number of non-mandatory evidence requirements achieved for the 21-22 version of the Toolkit.

5. Training

In the reporting period the Caldicott Guardian completed the following role specific training:

- Annual Data Security/Information Governance Awareness training–2019
- Annual Data Security/Information Governance Awareness training–2020

REPORT COVER

Report to:	Board of Directors	
Date of meeting:	Wednesday 26th January 2022	
Agenda item:	P1-17-22	
Title:	The CCC Green Plan: 2022-2027 A sustainability strategy and action plan for The Clatterbridge Cancer Centre NHS Foundation Trust	
Report prepared by:	Tom Pharaoh – Director of Strategy	
Executive Lead:	-	
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	The Performance Committee
Date & decision:	19 January 2022 – recommend for approval by Trust Board

Purpose of the paper/key points for discussion:	This paper sets out the sustainability strategy for the Trust for the next five years. The strategy has been developed with the support of sustainability consultants WRM Sustainability in response to the national requirement for all provider trusts to develop a Board-approved Green Plan for submission to ICSs in January 2022. The Green Plan sets out the Trust's current carbon footprint and the high level strategy for the reduction of our carbon emissions across the organisation in line with national NHS ambitions. The document also begins to set out the developments and innovations at a regional and national level that will be essential for the Trust's achievement of net zero. The Green Plan finally introduces the detailed Sustainable Action Plan that sits underneath the high-level strategy. The Sustainable Action Plan requires further development as our sustainability programme emerges but is provided in its current state as an appendix. The Board is asked to approve the Trust Green Plan.

Action required: (please tick)	Discuss	☐
	Approve	☒
	For information/noting	☐

Next steps required:	Submission to ICSs in January 2022.

Version 1.1 Ref: FCGOREPCOV Review: July 2024

REPORT COVER

The paper links to the following strategic priorities and Board Assurance Framework (BAF) Risks (please select)

☒ BE **OUTSTANDING**

BAF Risk	Please select
If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	☐
Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	☒
Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☐

☒ BE **COLLABORATIVE**

BAF Risk	Please select
If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	☒

☐ BE **RESEARCH LEADERS**

BAF Risk	Please select
If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	☐
Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	☐

☒ BE **A GREAT PLACE TO WORK**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☐
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	☐
If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	☒

☒ BE **DIGITAL**

BAF Risk	
If we do not invest a clear vision, sufficient capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve its digital ambition.	☒
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	☐

☐ BE **INNOVATIVE**

BAF Risk	
If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	☐

EQUALITY & DIVERSITY IMPACT ASSESSMENT								
Are there concerns that the policy/service could have an adverse impact on:								
Age	Yes ☐	No ☒	Disability	Yes ☐	No ☒	Gender	Yes ☐	No ☒
Race	Yes ☐	No ☒	Religious/belief	Yes ☐	No ☒	Sexual orientation	Yes ☐	No ☒
Gender Reassignment	Yes ☐	No ☒	Pregnancy/maternity	Yes ☐	No ☒			

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

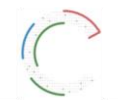
Version 1.1 Ref: FCGOREPCOV Review: July 2024

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

The CCC Green Plan: 2022-2027

A sustainability strategy and action plan for The Clatterbridge Cancer Centre NHS Foundation Trust

January 2022



Foreword

Climate change has been widely recognised as one of the greatest threats to public health of the 21st century. In looking to the future as a specialist healthcare provider, we understand both the significant threat that climate change presents to the people in our region and our responsibility to take action.

The NHS is leading by example globally and has set an ambitious target to reach net zero carbon emissions by 2040. We have already started work within our Trust to make ourselves more environmentally sustainable and this *Green Plan* will act as the central strategy to ensure that we are taking a proactive approach and working with our partners to ensure that sustainability is embedded throughout our organisation. This plan demonstrates our commitment to supporting the local and national efforts to achieve net zero emissions.

The aim of our Green Plan over the next five years is to drive sustainable changes across the Trust and prepare the organisation for the transition to net zero healthcare over the next two decades. Implementing the actions set out in this plan will enable us to make incremental reductions in our carbon emissions, air pollution and waste over the next five years. The strategy focusses on implementing ambitious and effective actions, such as the redevelopment of CCC-Wirral and promoting efficiency through staff engagement.

As one of three specialist cancer centres in the UK, our mission is to drive improved outcomes and experience through our unique network of specialist cancer care across Cheshire and Merseyside. The strategy considers sustainability holistically and will enable us to drive environmental, economic and social performance to ensure we can provide the highest quality of care now, and in the future.

"The aim of our Green Plan over the next 5 years is to drive sustainable changes across our organisation and prepare the organisation for the transition to net zero healthcare over the next two decades."

Liz Bishop – Chief Executive Officer
January 2022

Contents

1. The need for sustainable healthcare organisations 4

2. Carbon baseline and pathway analysis 7

3. The road to carbon net zero 8

4. Our commitment to sustainability 13

5. Introducing our sustainable action plan 16

6. Glossary of terms 20

Appendix – Our Sustainable Action Plan

About this document

This *Green Plan* sets out the organisational strategy for sustainability at The Clatterbridge Cancer Centre NHS Foundation Trust. The document will act as the central sustainability strategy for the Trust over the next five years.

This strategy has been developed using a structured process in which we have considered local and national drivers, legislative and contractual requirements, and the risks that inaction on addressing sustainability present. To inform the plan and shape our sustainability strategy we have undertaken extensive engagement with senior leaders and colleagues throughout the organisation.

This strategy comprises two sections. The *Green Plan* document sets out the strategic objectives and targets that we will adopt to drive sustainable development throughout our organisation. Secondly, our *Sustainable Action Plan* provides a plan of actions that the Trust will implement over the next five years. This action plan will act as the framework to guide the implementation of this strategy and will enable the Trust to monitor and report the progress made. In addition to these two sections a separate *Carbon Baseline Monitoring Tool* underpins the strategy.

The development of the plan has been undertaken throughout late 2021 with approval by the Board in January 2022. The provisions of this plan will therefore start to be implemented in early 2022, with the five year timeframe for this document being 2022-27.

BE **OUTSTANDING** BE **COLLABORATIVE** BE **A GREAT PLACE TO WORK** BE **RESEARCH LEADERS** BE **DIGITAL** BE **INNOVATIVE**

1. The need for sustainable healthcare organisations

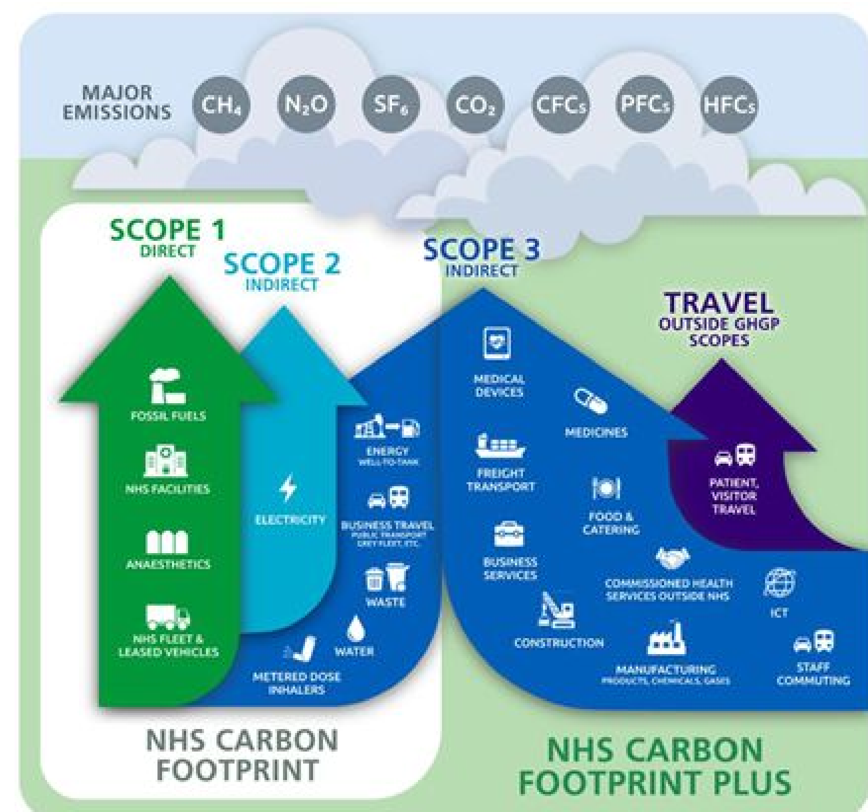
A recent report published by the UN's Intergovernmental Panel on Climate Change continued to stress the threats that climate change poses to the environment and the implications for human health. The World Health Organisation, British Medical Association, the Royal College of Nursing, and the Royal College of Physicians are just some of the organisations that view climate change as the greatest threat to global health of the 21st century.

The need to act on sustainability is reflected across various items of guidance and legislation to which our Trust and this *Green Plan* responds.

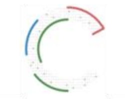
The net zero transition

In line with the Climate Change Act 2008, the UK has established a mandatory target to reduce carbon emissions to net zero by 2050. The NHS is the UK's largest public sector employer and contributes to approximately 4-5% of the nation's carbon emissions. As an organisation the NHS therefore plays a crucial role in supporting this national target.

In 2020, NHS England/Improvement released *Delivering A Net Zero National Healthcare Service.* Alongside a range of guidance the plan sets two net zero targets for the NHS in England – to achieve net zero for directly controlled emissions by 2040 (the NHS Carbon Footprint) and net zero for indirectly controlled emissions by 2045 (the NHS Carbon Footprint Plus). The figure displayed reveals the scope of these two carbon footprints.



- ✓ Achieve net zero by 2040 for the NHS Carbon Footprint (directly controlled emissions)
- ✓ Achieve net zero by 2045 for the NHS Carbon Footprint Plus (indirectly controlled emissions)



Actions to drive sustainability in healthcare

The *For a Greener NHS Campaign* was announced by NHS England in 2020, and provides support to trusts to decarbonise their operations, reduce their impact on the environment, and improve health. The campaign builds upon the work already being carried out within the NHS to improve sustainability.

To become a net zero health service, reduce air pollution, and reduce waste the NHS requires the commitment of all trusts, staff, and partners.

An expert panel has subsequently been formed to map the best path for the NHS to become carbon net zero, the findings of which will be kept under review and used to update this plan as required.

National drivers

National drivers for sustainability in the NHS are established in the following NHS-specific documents:

- NHS Long Term Plan
- NHS Standard Service Contract 2021/22
- NHS Operational Planning and Contracting Guidance
- Delivering a Net Zero National Health Service

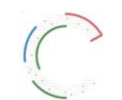
The *NHS Long Term Plan* includes considerations relevant to sustainable development, such as new models of care. The *NHS Standard Service Contract* highlights several targets and objectives associated with sustainability within the NHS, including the reduction of waste and water usage.

The *NHS Operational Planning and Contracting Guidance* provides advice on the actions required to assist the organisation in achieving the UK's carbon reduction targets and to improve the NHS's resilience.

Delivering a Net Zero National Healthcare Service provides details on the modelling and analytics that have been used to determine the NHS carbon footprint and future projections. It also covers the actions that will be implemented by the NHS to reduce emissions, including the immediate actions that must be taken to meet the 2040 carbon net zero target. To ensure that the NHS is on track to meet its long-term commitments and retains the ambition it requires to achieve them, this report will be continuously reviewed.

The documents above establish the following targets:

- For carbon emissions controlled directly by the NHS (the NHS Carbon Footprint), achieve net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- For carbon emissions the NHS can influence (the NHS Carbon Footprint Plus), achieve net zero by 2045, with an ambition to reach 80% reduction by 2036 to 2039
- Deliver a 4% reduction (in carbon emissions) by shifting to lower carbon inhalers
- Deliver a 2% reduction (in carbon emissions) by transforming anaesthetic practices
- Transition to zero-emission vehicles by 2032



Increasing requirements and increasing urgency

Significant progress has been made towards NHS sustainability targets. A 62% reduction in carbon emissions was achieved between 1990 and 2020 through the implementation of a number of strategies.

However, as we near a critical stage for addressing climate change the number and scope of drivers for change are expected to increase. The NHS is continually updating guidance to ensure that it is tackling climate change effectively. The new *Net Zero Carbon Hospital Standard*, for example, will establish best practice requirements for capital projects and energy efficiency to help meet the net zero targets.

The Trust will continue to engage with the NHS's sustainability agenda and will monitor legislation and guidance changes as we progress towards net zero.

Local drivers

The authorities across our region are also responding to the increasing pressure to act on climate change. In 2019, Liverpool City Council, Wirral Metropolitan Borough Council, and the Metropolitan Borough of Sefton formally declared a climate emergency. All organisations have also set targets to achieve net zero carbon emissions in their respective constituencies, with a region-wide target of net zero by 2040.

The Trust's key partner organisations have also established targets to achieve net zero carbon emissions. For example, Liverpool University Hospitals NHS Foundation Trust (LUHFT) aims to reduce its NHS Carbon Footprint by 50% by 2025 from a baseline year of 2007/08.

There is a clear commitment to reducing carbon emissions to net zero throughout the region but achieving these targets will require all sectors to make a sustained effort. The Trust will engage in the collaborative approach that will need to be taken to reducing emissions across the region to help achieve the regional target of net zero by 2040.

Our targets

In accordance with national and local drivers, the Trust will adopt the following targets:

Carbon reduction

- We will achieve a 100% reduction of direct carbon dioxide equivalent (CO2e) emissions by 2040. An 80% reduction will be achieved by 2032 at the latest.
- We will achieve a 100% reduction of indirect CO2e emissions by 2045. An 80% reduction will be achieved by 2039 at the latest.

Air pollution

- We will convert 90% of our fleet to low, ultra-low and zero-emission vehicles by 2028.
- We will cut air pollution emissions from business mileage and fleet by 20% by March 2024.

Waste

- We will adopt a Zero to Landfill policy.

2. Carbon baseline and pathway analysis

Addressing our direct and indirect emissions

We have developed our carbon baseline in line with the NHS Carbon Footprint. This footprint includes the emissions which can be directly controlled by the Trust. The following aspects are included in the scope of our baseline:

- Fossil fuels
- Electricity
- Fleet travel
- Water
- Anaesthetic gases
- Business travel
- Waste

The interventions established in this plan will target our direct emissions and help bring our organisation closer to our net zero target. As we progress with this strategy we will also seek to quantify our indirect emissions, including emissions relating to our supply chain and patient and staff travel. We will work to use accurate and reliable methods to monitor our indirect emissions, so we can achieve the NHS Carbon Footprint Plus target by 2045.

Performance and direct carbon emission baseline

2020-21 has been used as our carbon baseline year, which is the year against which we will compare all subsequent annual carbon emissions (CO_2e). We have calculated our emissions for each aspect by multiplying our consumption data (e.g. kWh for electricity) with the national carbon conversion factors provided by the Department for Business, Energy, and Industrial Strategy (BEIS) for greenhouse gas reporting.

Year	Fossil Fuels	Anaesthetic Gases	Electricity	Business Travel	Fleet	Waste	Water	Total
2018-19	494	5	1,771	102	107	0	19	2,498
Baseline (Current) 2020-21	1,046	4	2,257	40	133	29	49	3,558
Change	+551	-1	+486	-62	+26	+29	+30	+1,061

2018-19 is the earliest year that we have reliable data to quantify our emissions. However, the Trust’s carbon emissions increased significantly through the opening of Clatterbridge Cancer Centre – Liverpool in June 2020. A baseline year of 2020-21 is more suitable than 2018-19 to reflect the full scope of our emissions.

CCC-Liverpool is highly efficient and has been built to allow us to provide the best possible patient experience. Located centrally for the population we serve, the hospital has also reduced the required travel distance for many of our patients. Being positioned near to the Royal Liverpool University Hospital and the University of Liverpool, means we have onsite access to medical specialties and we are able to provide specialist treatment and carry out pioneering research.

Despite an increase in our overall emissions due to the expansion of our services, the efficiency and location of the new Liverpool centre will help drive a reduction in carbon per patient treated.

BE **OUTSTANDING** BE **COLLABORATIVE** BE **A GREAT PLACE TO WORK** BE **RESEARCH LEADERS** BE **DIGITAL** BE **INNOVATIVE**

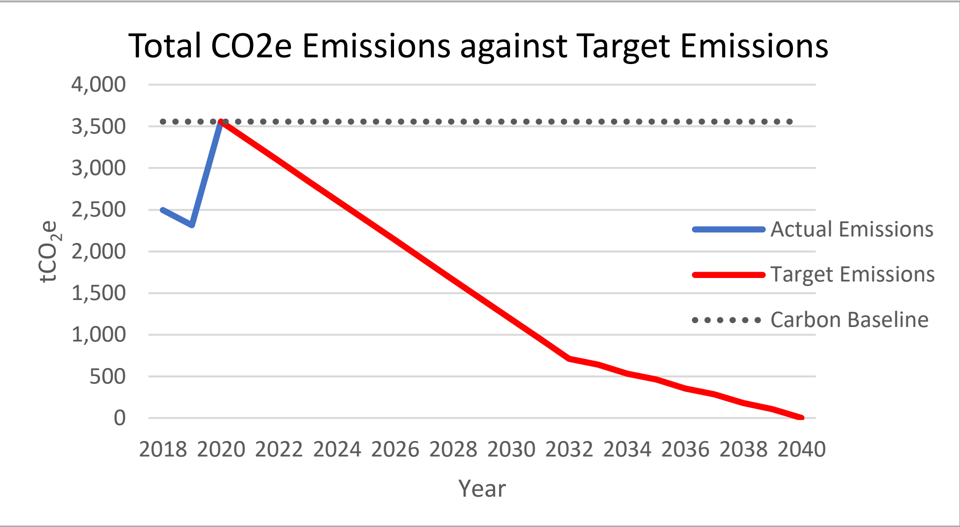
3. The road to carbon net zero

Following our increase in emissions in 2020-21, a continued effort will be required if we are to reduce our emissions to net zero by 2040. This section sets out our trajectory to meet the 2040 target and outlines several local and national scale interventions which may help us to further reduce our emissions.

To guide trusts towards the 2040 net zero target, the NHS has established an interim target for an 80% reduction in scope 1 emissions by 2028 to 2032. These targets are not legally binding but form a national commitment by NHS England/Improvement to encourage NHS organisations to achieve net zero emissions as soon as possible and to ensure that the mandatory national net zero target of 2050 is met.

The carbon emissions that we must reduce to reach these targets are shown in summary below. As shown, the Trust will be required to significantly reduce emissions from 3,358 tCO2e to 712 tCO2e if we are to meet the 80% interim reduction target by 2032.

Year	Baseline / 2020	2032	2040
Target Emission Reduction (%)	n/a	80	100
Target Emissions (tCO_2e)	3,558	712	0



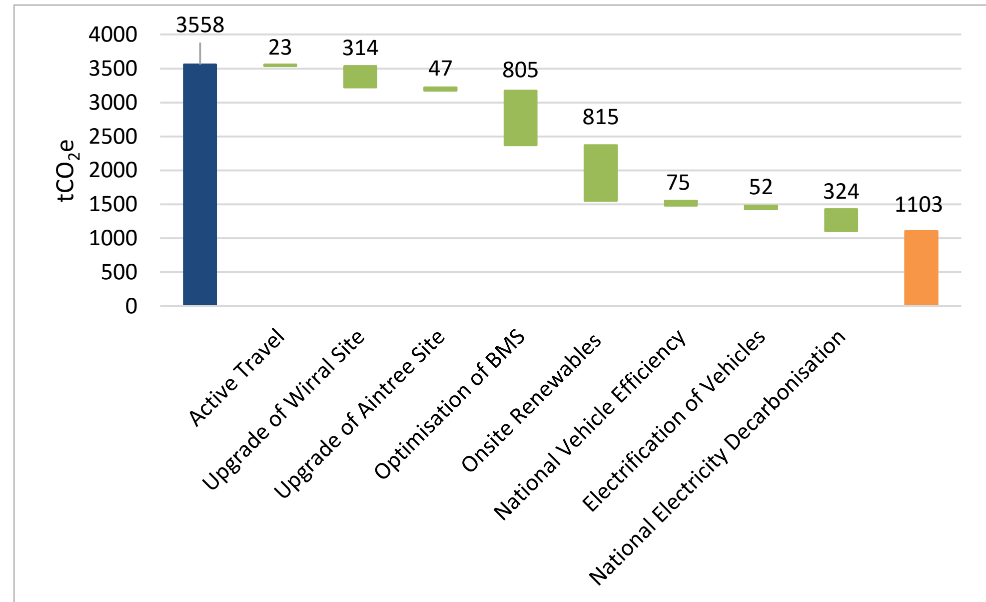
The figure provides a visualisation of the Trust's carbon emissions since 2018-19 and reduction in emissions required from the baseline year of 2020-21 against the NHS targets. We will continue to monitor our emissions against these targets and publish our progress on a yearly basis.

Through the development of our carbon baseline tool, we will now be able to closely monitor CO2e emissions and track our progress against our target trajectory for reaching net zero. The implementation of our *Sustainable Action Plan* will enable us to make incremental reductions in our carbon emissions over the next five years. It is essential that we take significant action over the next ten years to address our emissions if we are to achieve our next interim target of an 80% emission reduction by 2032. This will require a 237 tonne reduction in CO2e emissions annually over the next 10 years.

BE **OUTSTANDING** BE **COLLABORATIVE** BE **A GREAT PLACE TO WORK** BE **RESEARCH LEADERS** BE **DIGITAL** BE **INNOVATIVE**

Delivering a Net Zero National Healthcare Service provides guidance as to which actions are likely to create the most impactful reductions in carbon emissions. A number of these actions have been included within our Sustainable Action Plan, including: the upgrade of the Clatterbridge Cancer Centre – Wirral site, the encouragement of active travel, and the optimisation of our building management systems (BMSs) on all sites to ensure that our estate is efficient by regulating aspects such as temperature, lighting, and ventilation.

An assessment of the possible reductions that could be delivered by longer-term schemes indicates that interventions could be made to reduce our direct carbon emissions to approximately 31% of our of our baseline emissions, as shown below.



To reduce the estimated residual 1,103 tCO2e annual emissions to net zero we will rely on further market innovation and the commercialisation of disruptive technologies (such as conversion of the natural gas grid to hydrogen). We will therefore ensure that we monitor innovation and the development of new technologies and seek out funding opportunities to capitalise on further reductions in emissions. This will be necessary to reduce our need for future carbon offsetting to meet the net zero target.

Several local and national schemes will also be crucial in supporting our transition to net zero carbon emissions.

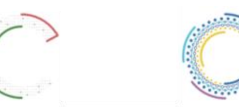
Local considerations

Wirral redevelopment

Prior to the opening of CCC-Liverpool, CCC-Wirral was the Trust's main hospital site. The coming years will see the redevelopment of our Wirral site and through this process we will address sustainability through various carbon reduction measures.

Some areas of CCC-Wirral, for example some of the radiotherapy bunkers, are therefore now vacant. We will therefore rationalise our estate as we redevelop the site and thereby reduce our carbon emissions.

We will modernise our remaining estate and make our buildings more energy efficient. The increased installation of new technologies, such as solar panelling on empty roofs, will provide a renewable source of energy from which our services can draw, whilst the optimisation of the site's BMS will ensure the energy currently being used is not wasted.



Where possible we will increase the green space and biodiversity on the site. This will not only reap the benefits of carbon reduction, but also lead to increased mental wellbeing amongst our staff and patients.

Staff engagement

One of our key strategic priorities is to be a great place to work by attracting, developing, and retaining a highly skilled and motivated workforce to deliver the best quality care. A limiting factor to reducing our emissions to-date has been the absence of programme to involve and engage staff in the sustainability agenda.

Our ambition is to harness the enthusiasm and support of colleagues from across the Trust to drive the implementation of our sustainable actions and reduce emissions. To do this, we will develop and launch a Trust-wide engagement campaign. We will use our existing engagement groups and other methods to raise awareness amongst staff of the work already being done to reduce carbon emissions across the Trust and also highlight what can be done on an individual basis. We will increase awareness of sustainability issues across the Trust and encourage and enable staff to make changes in their own working lives, in their wider service areas and away from work.

> “The Government has an ambition to support a sustainable recovery from the COVID-19 pandemic through the creation of 250,000 new jobs by 2030 in green energy and zero-carbon technologies.”

National considerations

Once all practicable actions to reduce emissions have been implemented the Trust will require national scale actions to reduce our final residual emissions and achieve net zero by 2040. This section will set out the key national schemes that have the potential to reduce CO2e emissions and air pollution over the next three decades and which could help the Trust achieve net zero.

The UK Government’s *Ten Point Plan* outlines the commitment to achieving net zero by 2050. The Government has also recently published its *Net Zero Strategy: Build Back Greener*, which establishes specific policies and proposals to ensure the UK economy becomes fully decarbonised by 2050. Both documents will act as frameworks to guide the nation’s transition towards a net zero economy and will be supported by £5 billion to trigger a ‘green industrial revolution’ in the UK. The Government has an ambition to support a sustainable recovery from the COVID-19 pandemic through the creation of 250,000 new jobs by 2030 in green energy and zero-carbon technologies including offshore wind farms, nuclear plants, hydrogen power and carbon capture and storage technologies.

Renewable energy

The carbon intensity of electricity consumed in the UK decreases every year due to the increasing percentage of the nation’s energy mix generated from renewable sources. To achieve net zero emissions, the UK must completely decarbonise the national grid.

BE OUTSTANDING BE COLLABORATIVE BE A GREAT PLACE TO WORK BE RESEARCH LEADERS BE DIGITAL BE INNOVATIVE

The Government plans to power the whole of the UK with clean electricity by 2035 through an increase to the amount of renewable energy generated by additional offshore wind farms, expected to generate 40 GW of energy. This will be enough to power every home in the country and will be supplemented with carbon capture technology and battery storage so that this renewable energy can meet demand. The increasing availability of electricity sourced from renewable energies will significantly reduce our carbon emissions associated with the electricity we import from the national grid, our largest source of emissions.

Emerging technologies and opportunities

The Government's *Net Zero Strategy* also details its intention to decarbonise heating through the transition to low-carbon hydrogen. 5GW of low-carbon hydrogen production capacity will be created by 2030 which would be used for heating and would halve fossil fuel related emissions. The conversion of the gas grid to hydrogen has been estimated to reduce UK carbon emissions by 73%.

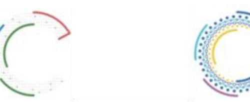
The transition to hydrogen will be supported by the Net Zero Hydrogen Fund which will provide £240million of capital co-investment by 2024-25. Over the next few years, hydrogen technologies will be trialled on a wide scale, with large village heating trials to be undertaken by 2025 and a potential Hydrogen Town by 2030. Privately funded schemes such as the H21 City Gate Project will also begin converting the gas grid to hydrogen in the short-term.

"5GW of low-carbon hydrogen production capacity will be created by 2030 which would be used for heating and would halve fossil fuel related emissions."

To prepare for the potential conversion of the gas grid, the Government is consulting on 'hydrogen ready appliances' and, subject to the outcomes of the trials, will work to enable up to 20% hydrogen blending in the gas grid by 2023.

Carbon capture will be used in conjunction with hydrogen heating to enable hydrogen to be rolled out across the gas grid at prices that can compete with the costs of natural gas but without emitting carbon. The successful transition from natural gas to hydrogen would enable the Trust to reduce the emissions associated with heating on a large scale. This would go some way to reducing our Trust's carbon emissions, which gas-fired heating systems are a primary contributor towards.

Further opportunities may present themselves through a series of enabling actions highlighted in the Government's plans to support the net zero transition. An additional £1.5billion of funding will be made available to support net zero innovation projects, whilst the UK Infrastructure Bank (UKIB) will be used to provide over £40billion of investment for the roll-out and maturity of low carbon technologies. Over the next 20 years, the Trust will continue to monitor new and emerging technologies and funding opportunities which could support the decarbonisation of our operations towards achieving net zero CO2e emissions.



Transport

A fundamental aspect of the Government's *Net Zero Strategy* is the potential for active travel and public transport to reduce carbon emissions and air pollution. Due to the positive impacts observed throughout the COVID-19 pandemic on air pollution, the Government aims to continue reducing transport-related emissions through the provision of additional funding for public transport, infrastructure, and active travel schemes.

Investment of £2billion will be provided to allow 50% of town and city-based journeys across the UK to be cycled or walked by 2030. £620million will be made available for zero emission vehicle grants and electric vehicle infrastructure, with a focus on creating more nation-wide charging points. £350million of a total £1billion from the Automotive Transformation Fund (ATF) will also be allocated to support the electrification of UK vehicles and supply chains. On a local scale, the Trust will seek to influence investment in public and active travel to meet the needs of our staff and patients.

Country-wide rail and bus networks will also be improved through additional funding. More rail lines will be electrified with an ambition to remove all diesel-only trains by 2040 and have a net zero rail network by 2050. Meanwhile, bus and rail networks will be integrated and introduce smart ticketing to make the use of public transport more convenient. The publication of a *National Bus Strategy* also lays out plans to create 4,000 zero-emission buses and infrastructure which will provide a cheaper, more frequent, and reliable bus network – supported by a £3billion investment into the bus sector.

"The Government aims to continue reducing transport-related emissions through the provision of additional funding for public transport, infrastructure, and active travel schemes."

Alongside public transport changes, the Government will promote active travel, with plans to facilitate safer cycling through the construction of thousands of miles of segregated cycling lanes across England. A dedicated active travel body will track the progress of these schemes and distribute funding accordingly. Encouraging active travel across the country will have many benefits for the Trust, by supporting the reduction our emissions, improving air quality, and improving the health and wellbeing of local people.

The sale of all new petrol and diesel vehicles will be banned from 2030, followed by a ban on hybrid models five years later. This ban has been brought forward by a decade to accelerate the nation's transition to electric vehicles. The Government has committed to the development of 'gigafactories' to produce batteries to accommodate the expected increase in electric vehicle manufacturing and support this transition. The provision of electric vehicle charging points will subsequently be increased.

The shift created by these schemes will assist the Trust in reducing Scope 3 emissions. Scope 3 emissions are difficult for the Trust to quantity and reduce as they lie outside our direct control. The increased provision of public transport methods and active travel schemes will help to reduce staff and patient travel emissions and improve air quality. The transition towards electric vehicles will then assist the Trust in reducing transport emissions including commuting, business travel, and the transportation of products.

BE **OUTSTANDING** BE **COLLABORATIVE** BE **A GREAT PLACE TO WORK** BE **RESEARCH LEADERS** BE **DIGITAL** BE **INNOVATIVE**

4. Our commitment to sustainability

Our organisation's inclination to sustainability

The Clatterbridge Cancer Centre has a strong commitment to sustainability and to providing high-quality care in a way which does not negatively impact the environment, achieves positive financial performance, and adds value to our communities. We have previously worked to make our organisation more sustainable through both environmental initiatives and the construction of our modern eco-friendly facilities at CCC-Liverpool. Our commitment to the sustainability agenda is reflected in our organisation's strategic priorities.

The urgency of acting on climate change

This *Green Plan* sets out how we will achieve a set of ambitious targets which truly embed sustainability at the heart of our operations. The creation of this new strategy is a recognition of the scale of the urgency and change required to take action on carbon emission reduction and tackle climate change as a core element of achieving better health for patients and communities.

Our strategic priorities

Our environmental obligations align closely with out six strategic priorities to provide examples of how and why sustainability can be successfully integrated within our services:

- **Be outstanding** – delivering high-quality care and a strong operational and financial performance allows sustainability to be addressed in patient-first ways while reducing energy and resource use and wastage.
- **Be collaborative** – driving better outcomes for patients through collaboration with partners offers the opportunity to make progress on sustainability by leveraging their support and encouraging wider changes to the practices of our suppliers.
- **Be a great place to work** – attracting, developing, and retaining a highly-skilled and motivated workforce can be supported by engaging staff in sustainability.
- **Be research leaders** – being research leaders to improve current and future patient outcomes means learning more about the wider environmental determinants of health for our cancer patients.
- **Be digital** – delivering digitally-transformed services which empower staff and patients presents the post-pandemic opportunity to continue agile working arrangements alongside telecare where appropriate.
- **Be innovative** – by being innovative, the Trust can improve patient care through the exploration of sustainable alternative equipment and practices.

Embedding targets within the Trust

Like all NHS trusts, The Clatterbridge Cancer Centre is bound to several legislative and contractual obligations relating to sustainability. We will adopt this series of national targets to guide our progress in reducing carbon emissions and improving our sustainability performance.

In 2020 we started on the way to purchasing 100% of our electricity requirements from renewable sources

We will adopt the NHS Single Use Plastics Pledge

By 2032 we will transition to zero emission vehicles

By 2032 we will achieve an 80% baseline reduction in our direct carbon emissions

By 2039 we will achieve an 80% baseline reduction in our indirect carbon emissions

By 2040 we will achieve net zero carbon emissions in our directly controlled scopes

By 2045 we will achieve net zero carbon emissions in our indirectly controlled emission scopes

BE OUTSTANDING BE COLLABORATIVE BE A GREAT PLACE TO WORK BE RESEARCH LEADERS BE DIGITAL BE INNOVATIVE

Our sustainability objectives

Our commitment to sustainability and the national targets is reflected in twelve sustainability objectives. These objectives, shown below against our wider strategic objectives, have been developed through extensive colleague engagement and will enable us to meet our wider targets and ambitions.

We commit to taking a range of actions to achieve these objectives. These are detailed further in our *Sustainable Action Plan*, the delivery of which will require the support of all staff throughout the organisation.

	Be outstanding	Be collaborative	Be a great place to work	Be digital	Be innovative
Sustainability objectives	We will ensure CCC-Liverpool is run efficiently through a re-examination of the BMS.	We will collaborate with external partners and industry on the implementation of sustainable projects.	We will launch a green travel plan, including making electric bicycles more affordable for our staff.	We will continue to promote agile working arrangements and the use of teleconferencing where appropriate.	We will make efficiency upgrades to our estate, including replacing old lighting and air conditioning units with sustainable alternatives.
	We will introduce a waste management, recycling, and compactor system across the Trust.	We will reach out to external partners, social enterprises, and industry to realise mutual sustainability opportunities.	We will develop and launch a sustainability champions initiative.	We will go paperless through the digitisation of paper documents and shift to recyclable alternatives where necessary.	We will find recyclable solutions for consumables, such as bottled cleaning products and chemotherapy pump batteries.
	We will set ambitious targets for sustainability and waste minimisation across different departments.	We will pursue contracts with sustainable and ethical service and product suppliers.	We will raise awareness amongst staff of how they can address sustainability in their professional lives.	We will engage with furniture re-use applications such as Warp-It.	We will source staff uniforms made from more sustainable materials and set up a uniform re-use scheme.

BE **OUTSTANDING** BE **COLLABORATIVE** BE **A GREAT PLACE TO WORK** BE **RESEARCH LEADERS** BE **DIGITAL** BE **INNOVATIVE**

5. Introducing our Sustainable Action Plan

We will deliver the sustainability objectives and meet the targets outlined in this *Green Plan* through the implementation, monitoring and ongoing refinement of a *Sustainable Action Plan*. The plan contains a total of 97 actions, divided across themes of work in accordance with the *Greener NHS programme* and the Sustainable Development Assessment Tool (SDAT).

The actions have been developed through staff engagement and a review of best practice amongst NHS Trusts. A summary of the actions and the short-term interventions to be achieved by 2025 follows in this document. The full action plan, comprising actions to be implemented beyond 2025, can be found separately, and will be used by the Trust to monitor progress.

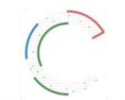
The full *Sustainable Action Plan* also will be developed to contains detail regarding accountable staff, estimated timescales, and indications of monitoring frequency. Taken together, our actions will collectively support the delivery of our sustainability objectives and national carbon reduction targets.

Sustainable Action Plan themes

Corporate approach
Asset management & utilities
Travel and logistics
Adaptation
Capital projects
Green space and biodiversity
Sustainable care models
Our people
Sustainable use of resources
Carbon and greenhouse gases

Corporate approach

The commitment and support of the Trust Board will be vital to achieve a reduction in carbon emissions. Our corporate approach to sustainability will involve the inclusion of environmental criteria within procurement processes, collaboration with external partners, and setting ambitious targets across our sites and departments.



BE **OUTSTANDING** BE **COLLABORATIVE** BE **A GREAT PLACE TO WORK** BE **RESEARCH LEADERS** BE **DIGITAL** BE **INNOVATIVE**

Asset management and utilities

As a provider of cancer care services, energy consumption is responsible for most of our carbon footprint and in many cases remains unavoidable. To improve the energy efficiency of our activities, we will focus on pursuing contracts with sustainable suppliers.

Travel and logistics

The Covid-19 pandemic has cast light on the potential to reduce carbon emissions through agile working arrangements. We will continue to support teleconferencing where possible, and develop a green travel plan with an emphasis on new electric vehicle infrastructure and cycling facilities.

Adaptation

Climate change is the biggest environmental threat to health of the 21st century and some of its impacts are inevitable. In acknowledgment of this, we will create a contingency plan to ensure our services remain resilient to extreme climatic phenomena such as heatwaves and flooding.

Capital projects

A core action amongst our capital projects plan centres around the integration of sustainability within Wirral's redevelopment, involving solar panelling and estate rationalisation measures.

Green space

Green space has positive impacts for both the environment and mental health, a particular area of importance for cancer patients.

We will work to incorporate additional biodiversity across our sites and in the redevelopment of CCC-Wirral.

Sustainable use of resources

As a provider of cancer care and chemotherapy, we use a significant number of resources and produce a lot of waste. We will tackle this by pursuing estate efficiency improvements, recycling and the application of circular economy principles, and sustainable solutions for consumable products.

Sustainable care models

We will optimise the delivery of sustainable care models through the use of an on-site chemotherapy product manufacturer, video consultations for outpatients patients where appropriate, and re-examined prescribing processes.

Our people

We will need the support and participation of our staff across all departments to achieve net zero carbon emissions. We will harness existing enthusiasm with the creation of sustainability champions, whilst raising awareness among other staff to gain support on a wider scale.

Carbon and greenhouse gases

Carbon emissions must be reduced from all areas of our organisation to meet net zero targets and ensure that progress is being made on wider environmental concerns like air pollution. We will optimise business travel by enhancing the connectivity of regional services, and run a joined-up procurement service through Health Procurement Liverpool which aims to reduce emissions and share best practice.

BE **OUTSTANDING** BE **COLLABORATIVE** BE **A GREAT PLACE TO WORK** BE **RESEARCH LEADERS** BE **DIGITAL** BE **INNOVATIVE**

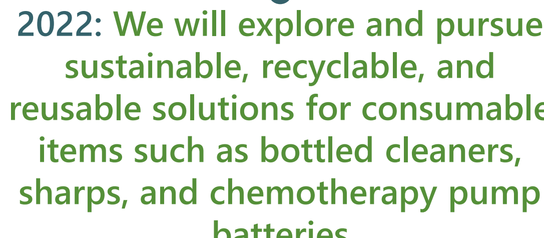
The Clatterbridge Cancer Centre
NHS Foundation Trust

Our short term focus on driving incremental improvements

Throughout the years covered by this *Green Plan* we will pursue several short-term actions to address pressing concerns, and start to create a culture of sustainability amongst staff. Other actions included within our *Sustainable Action Plan* are long-term in nature and will be implemented from 2025 and beyond.

2022: We will launch a Trust-wide engagement campaign and Green Travel Plan to encourage participation in sustainable practices and link this to the importance of tackling air pollution for the improvement of cancer care

Longer term: Interventions detailed in our sustainable action plan will be carried forward from 2025 and beyond



2022: We will explore and pursue sustainable, recyclable, and reusable solutions for consumable items such as bottled cleaners, sharps, and chemotherapy pump batteries

2025: Our Wirral estate will have been rationalised and redeveloped to incorporate net zero features such as rooftop solar panelling

Trust Board - 26 January 2022-26/01/22

Implementing our *Sustainable Action Plan*

In order to ensure the actions within our sustainable action plan are successfully implemented, each intervention will be led by an accountable and dedicated individual.

The nominated leads will lead in the implementation of our *Sustainable Action Plan* and continue to review our *Green Plan* over next five years. This will include making regular progress reports to the Trust Board and updating colleagues across the Trust of the progress being made through the most appropriate communication channels.

Board approval and leadership

This *Green Plan* was formally approved and adopted as the Trust's sustainability strategy by the Trust Board in January 2022 [tbc]. The delivery of this strategy will be led at Board level by the Director of Strategy who will oversee the implementation of the plan and advocate for sustainability at Board level. The Board lead will ensure that resources and leadership support are made available to aid our transition towards becoming a net zero organisation.

Monitoring, evaluation and continuous improvement

We recognise the urgent requirement for action on climate change and we will monitor our performance against the emissions trajectory that we have outlined in this *Green Plan*.

We will work to develop key sustainability metrics to ensure that we can continually monitor and report on our progress to our senior leaders and other stakeholders. These metrics will align to our organisational strategic ambitions and could include:

- ✓ The quantity of CO_2 emitted per patient treated
- ✓ The absolute carbon emissions of the Trust
- ✓ The proportion of sustainable action plan items which have been completed, are in progress, or are outstanding.

The information provided by these metrics will provide the basis for regular progress reviews to the Board and to the Greener NHS programme, as well as annual reporting in the progress against our strategic objectives and targets.

BE OUTSTANDING BE COLLABORATIVE BE A GREAT PLACE TO WORK BE RESEARCH LEADERS BE DIGITAL BE INNOVATIVE

6. Glossary of terms

Air pollution – the presence and introduction into the air of a substance which is harmful to human health

Carbon Intensity – a means of calculating the amount of carbon generated for a specific energy source (e.g. electricity)

Carbon net zero – a state in which an organisation emits no carbon emissions from its activities. Or a state in which all carbon emissions are offset

CO2e (Carbon dioxide equivalent) – a unit used to express total greenhouse gas emissions. There are multiple GHGs, each with a different impact on climate change. CO2e equates all GHGs to the impact of carbon dioxide. CO2e is used to report all GHG emissions

Greenhouse gas (GHG) – a gas that contributes to the greenhouse effect, leading to climate change (for example, carbon dioxide)

kWh – Kilowatt-hour, a unit of measurement for energy usage

Direct emissions – CO2e emissions from sources which are owned or controlled by the Trust

Indirect emissions – CO2e emissions from sources which are not owned or controlled by the Trust, but are generated due to the Trust's activities (e.g. purchase of electricity, procurement, waste disposal)

Scope 1 emissions – direct emissions from owned or controlled sources (e.g. on-site fuel combustion, company vehicles, anaesthetic gases)

Scope 2 emissions – indirect emissions from the generation of purchased electricity, steam, heating, and cooling

Scope 3 emissions – all other indirect emissions that occur in an organisation's supply chain (e.g. purchased goods, employee commuting, waste disposal)

Overview

Clatterbridge Cancer Centre Sustainable Action Plan				
Module	**Reference**	**Nominated Lead**	**Number of Actions**	**Completed Actions**
Corporate Approach	CA		7	
Asset Management & Utilities	AM		10	
Travel & Logisitics	TL		9	
Adaptation	A		8	
Capital Projects	CP		10	
Greenspace & Biodviersity	GB		7	
Sustainable Care Models	SC		11	
Our People	OP		11	
Sustainable Use of Resources	SR		16	
Carbon & GHGs	CG		8	
Total			97	0

Corporate Approach

Corporate Approach							
Reference	**Green Plan Intervention**	**Action Detail**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
CA-01	**The Trust shall mainstream sustainability into procurement processes.**	*We will introduce minimum environmental specifications for products.*					
		We will introduce environmental and sustainability criteria, metrics, and considerations into procurement processes and business cases alongside a focus on cost and availability.					
		We will develop a process to ensure that our procurement team understand and can maximise the benefits of whole life costing and circular economy.					
CA-02	**The Trust shall ensure that staff have visibility over the Green Plan and its aims.**	*We will communicate the Green Plan to all relevant stakeholders.*					
		We will set ambitious, detailed, and specific targets for sustainability and waste minimisation across different areas and departments.					
CA-03	**The Trust shall extend its partnership working.**	*We will seek to collaborate with external partners and industry on the implementation of sustainable projects.*					
CA-04	**The Trust shall integrate sustainability into its corporate statements.**	*We will incorporate sustainability into our organisational values, mission, and principles.*					
CA-05	**The Trust will prioritise sustainability at Board level.**	*A standing section on sustainability will be added to our board papers.*					
		Progress on sustainability, including progress against our targets and Green Plan implementation will be reviewed and reported at least annually at Board level.					
CA-06	**The Trust shall continually review legislative drivers and examples of best practice.**	*We will develop a process for scanning for best practice, changes to mandatory and legislative drivers and adopt these early.*					
CA-07	**The Trust shall develop a communications plan to promote the publication of the Green Plan.**	*We shall communicate our Green Plan to patients, visitors and the local community. The plan shall be published on our website and publicised through the relevant channels.*					

Asset Management & Utilities

Asset Management and Utilities							
Reference	**Green Plan Intervention**	**Action Detail**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
AM-01	**The Trust shall use its purchasing power to put pressure on suppliers to adopt more sustainable practices.**	*We will put pressure on our partners through which we access electricity to transition to green tariffs offered by sustainable energy providers.*					
		We will put encourage our catering suppliers to adopt more sustainable practices and resources, including through the launching of meat-free events.					
		We will ensure that our cleaning contractors are accountable for efforts towards environmental improvement and sustainability.					
		We will work with our product suppliers to identify the environmental impacts of the products and services we procure and work collaboratively to identify solutions to reduce these impacts.					
AM-02	**The Trust shall consider sustainability when renewing contracts.**	*We will move away from the use of gas and oil towards steam and explore more sustainable energy options.*					
		We will pursue contracts with sustainable and ethical product suppliers e.g. for Fairtrade items.					
AM-03	**The Trust shall work with suppliers to improve efficiency.**	*We will work with our on-site contractors and suppliers to ensure they help reduce our waste and energy usage where relevant.*					
AM-04	**The Trust will run a Switch-Off Campaign to reduce energy wastage.**	*We will run a Trust-wide switch off campaign which will encourage all staff to switch off lights and equipment in non clinical areas when not in use, for example overnight.*					
AM-05	**The Trust will upgrade lighting across the Trust to improve efficiency.**	*We will continue to upgrade lighting to more efficient LEDs as and when lights require replacement.*					
AM-06	**The Trust will increase monitoring of energy consumption.**	*We will improve sub-metering throughout the Trust and when building new buildings to improve the accuracy of our meter data and allow for more specific reduction interventions.*					
AM-07	**The Trust shall integrate sustainability into the Estates Strategy.**	*We will create a clear policy and process for our estates strategy and/site master plan that clearly demonstrates our commitment to sustainability.*					
		We will review our building stock and use this to inform our Estates Strategy. We will communicate any strategies clearly to staff and key partners (e.g. PFI contractors, NHS Property services and other landlords and maintainers).					
AM-08	**The Trust shall engage the board with our ambition to reduce energy and water consumption.**	*We will regularly report our energy and water usage/performance progress to our Board.*					
AM-09	**The Trust will explore alternative methods for heating and powering the site.**	*We will explore ways of generating our own onsite renewable or ultra low carbon energy (e.g. solar PV, Solar heating, heat pumps or biomass/biogas/fuel cell CHP).*					
AM-10	**The Trust shall encourage staff to be mindful of energy and water consumption.**	*We will support staff relevant to their role to help conserve energy and water at work, managing energy usage and reporting leaks and faults.*					

Travel & Logistics

Travel and Logistics							
Reference	**Green Plan Intervention**	**Action Detail**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
TL-01	**The Trust shall facilitate a hybrid working approach where appropriate.**	*We will continue to capitalise on the positive environmental impact made through agile working arrangements and teleconferencing, used in response to the Covid-19 pandemic, by enabling a hybrid working approach where possible.*					
		We will re-assess and review people's job roles and plans to determine whether their work can be done remotely or at the Trust site and formalise our policies on remote working.					
TL-02	**The Trust shall launch a sustainable staff travel plan.**	*We will launch a sustainable staff travel plan focused on encouraging staff to shift from the use of personal cars to more sustainable modes of transport such as public transport, active travel or low-carbon vehicles.*					
		We will re-engage with our salary-sacrifice scheme to open up opportunities for staff to particpate in the travel plan.					
		We will launch car-sharing, parking permits, and travel pass campaigns, encouraging staff to organise more sustainable journeys to work.					
		We will engage our comms team and region-wide partners in the promotion of the staff travel plan.					
TL-03	**The Trust shall maintain its cycling facilities.**	*We will ensure that cycling facilities across the Trust are well-maintained and secure as to avoid bicycle theft and enable safer active travel.*					
TL-04	**The Trust shall provide infrastructure to support the transition to low-carbon transport.**	*We will review our estate and identify opourtunites to install electric vehicle charging points across our sites.*					
TL-05	**The Trust shall optimise business travel arrangements.**	*We will enhance the connectivity of the services within our region to ensure that lab work is only done once and not repeated, saving scans and transport-related emissions.*					
		We will optimise the deliveries of our aseptic items and drugs so that the number of taxis and emergency journeys taken are reduced.					
TL-06	**The Trust shall work with local authorities to improve our sites.**	*We will work with local authorities to improve the surrounding area around our sites so that staff feel comfortable using public transport to travel to work.*					
TL-07	**The Trust shall set targets to improve travel impacts.**	*We shall set a local carbon reduction target for our business mileage emissions, which is aligned to/or exceed the Climate Change Act 2030 target.*					
TL-08	**The Trust shall monitor and try to reduce the environmental impacts associated with our suppliers.**	*Transport impacts shall be considered when procuring key products and services, and efforts will be made to ensure that contracts are locally sourced.*					
		We shall engage with suppliers frequently to find solutions to minimise their environmental impacts, such as planning deliveries efficiently and using low-emission vehicles.					
TL-09	**The Trust will monitor the transport choices made by staff and patients and help them to reduce their impacts.**	*We will support staff to make lower carbon options (e.g. information on cost and air pollution benefits of salary sacrifice low carbon vehicles).*					
		We will provide staff with information about the cost savings and personal benefits of sustainable modes of commuting (e.g. personal travel planning advice, health benefits of active travel, potential personal savings of different modes of transport).					
		We will monitor the travel choices of our visitors, patients and staff and carry out an annual staff travel survey to measure the shifts in modes of transport.					

Adaptation

Adaptation							
Reference	**Green Plan Intervention**	**Action Detail**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
A-01	**The Trust shall ensure that there is an adequate contingency plan for climate hazards.**	*We will create an adaptation plan to ensure the Trust has contingency plans for extreme event which could become more likely due to climate change, such as heatwaves or flooding.*					
A-02	**The Trust shall assess the risks associated with climate change and the ways to mitigate these risks.**	*We shall assess the risk to local communities from the impacts of our adaptation strategy, e.g. ensuring that flood attenuation doesn't divert water flow to residential areas.*					
A-03	**The Trust shall appoint an Adaptation Lead who shall manage the adaptation planning.**	*The Adaptation lead will be responsible for coordinating adaptation planning, resilience and emergency preparedness at the Trust.*					
		The Trust shall provide the Adaptation lead with sufficient training, CPD opportunities and access to forums to share local and national best practice information.					
A-04	**The Trust will align protocols to national adaptation plans.**	*We will develop local protocols aligned to national heat wave plans, cold weather plans and multiagency flood plans) in relation to Civil Contingencies Act, Climate Change Risk Assessment and National Adaptation Plans.*					
A-05	**The Trust shall involve staff in the creation and implementation of a climate change adaptation strategy.**	*We will involve representatives from sustainability, finance, estates management, emergency preparedness/planning, HR, business continuity and local partner organisations and communities to ensure we develop a co-ordinated and integrated adaptation plan which will be approved by the Board.*					
		We will provide training to ensure that our workforce is prepared and trained to deal with different extreme weather scenarios such as staff know how to keep clinical and ward areas cool in the event of hot weather, and how to report high indoor temperatures.					
A-06	**The Trust shall assess the financial impacts of climate change on the organisation.**	*We will assess the financial impacts of climate change to our organisation and the cost of doing nothing, and communicate this to our board.*					
A-07	**Monitor the impacts of climate change and the impacts it has on the communities served by the Trust.**	*The Trust shall maintain a record of notable and/or extreme weather events on an annual basis including health and care related impacts. The records created by this action will be used to update the trust Risk Register.*					
A-08	**The Trust shall work with suppliers to integrate our contingency plan so the delivery of care at the Trust will not be hindered by the supply chain during an extreme weather event.**	*The Trust will engage with our key suppliers to understand their resilience and contingency plans for extreme weather events and other incidents.*					
		The Trust shall develop a contingency strategy to ensure that crucial resources such as medicines can be provided during extreme events and do not impact delivery of care.					

Capital Projects

Capital Projects							
Reference	**Green Plan Intervention**	**Action Detail**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
CP-01	**The Trust shall ensure that the redevelopment of Wirral factors in sustainability as a core feature.**	*We will rationalise our estate through the re-development of our Wirral site.*					
		We will seek to use solar photovoltaic pannels in the re-development of our Wirral site.					
		We will assess the sustainability benefits of demolishing the bunkers in our radiotherapy facilities at Wirral before pursuing with estate changes.					
CP-02	**The Trust shall ensure sustainability is integrated into all new captial projects.**	*We will ensure that sustainability is considered at all stages of new capital projects by followinig suitable standards such as the BREEAM Standard or the NHS Net Zero Carbon Hospital Standard.*					
CP-03	**The Trust will consider the long-term requirements of new buildings in the design process.**	*Whole life costing will be applied to the design and construction of new buildings and refurbishments.*					
		We will consider adaptation to climate change when designing new buildings to ensure they are resilient.					
		When designing new buildings the Trust will assess projected climate and temperature profiles to ensure that the buildings can cope with changes in climate and extreme weather events.					
		We will prioritise efficiency when designing new buildings and refurbishments to reduce energy consumption.					
CP-04	**The Trust shall establish a commissioning protocol from the outset of capital projects.**	*The Trust shall use a soft landings extending commissioning protocol to ensure the building is commissioned in a way that facilitates maximum energy efficiency, building performance and maximum usability.*					
CP-05	**The Trust shall consult key stakeholders including staff, patients, visitors and the local community when embarking on a new capital project.**	*The opinions of staff, patients, visitors and the local population shall help guide the design process of key capital projects.*					
		The Trust shall engage with local health and social care organisations and the local community when designing new buildings and infrastructure to ensure the buildings will meet the needs of its users and allow high quality integrated care to be provided.					
CP-06	**The Trust will consider the use of materials in all new builds.**	*We will ensure that innovative, low carbon materials are embedded into the designs of future builds in order to reduce the embodied carbon associated with construction.*					
CP-07	**The Trust will utilise brownfield sites for developments.**	*We will ensure that it is policy to prioritise brownfield sites rather than greenfield sites for capital projects.*					
CP-08	**The Trust shall integrate green space into capital projects.**	*We will design embedded green space into access routes to buildings and surrounding buildings in new capital projects.*					
CP-09	**The Trust will conduct a strategic estates review process to identify potential energy efficient building fabric improvement**	*We shall identify priority areas where a spend to save approach could yield cost and carbon savings from estate refurbishment and upgrades.*					
CP-10	**The Trust shall ensure all staff receive adequate support to design and use Trust buildings sustainably.**	*The Trust shall ensure that all Capital Project staff are sufficiently trained to be able to achieve sustainable outcomes in the projects they contribute to. Job descriptions should specify that Capital Project staff should have experience of energy efficient technologies, space utilisation and adaptation.*					
		The Trust shall provide an induction for staff upon occupation of a new building so it can be utilised efficiently.					

Greenspace & Biodiversity

Reference	Green Plan Intervention	Action Detail	Implementation Evidence	Implementation Lead	Implementation Support	Monitoring Frequency	Timescale Implementation
Greenspace and Biodiversity							
GB-01	**The Trust shall add new biodiversity features across the estate.**	*We will maximise the biodiversity across our estate (e.g. by allocating a portion of land to greenspace in the redevelopment of our Wirral site) to realise the co-benefits of carbon reduction and increased mental wellbeing.*					
		We will continue to introduce new landscaping features such as woodland areas to replace old unused buildings.					
GB-02	**The Trust will incorporate green spaces into the design of new hospitals.**	*We will provide green and natural areas on our estate even where land is constrained e.g. window boxes, verges and potted plants.*					
		We will make our plans for maintaining and enhancing green space and biodiversity and access to such publicly available and easy to understand (e.g. with clear diagrams, images and maps).					
		We will work closely with our key partners to plan, protect and promote the use of green space across our local area (e.g. identifying and enhancing green routes to our facility).					
GB-03	**The Trust will ensure that all greenspaces provided are safe and accessible for users.**	*We will assess the health, safety, cleanliness and accessibility (Disability Discrimination Act compliance) of our green spaces with input from users, to ensure that areas are safe and pleasant to use.*					
GB-04	**The Trust will work to increase the biodiversity in our estate.**	*We will actively work to maintain and enhance biodiversity on our estates, for example through monitoring protected species and maintaining high quality green features.*					
		We will work with local greenspace and biodiversity partners such as wildlife trusts, local bee keepers or volunteers to improve biodiversity on our estate in line with local strategic plans.					
GB-05	**The Trust will develop and implement a greenspace and biodiversity strategy.**	*We will develop a board approved green space and/or biodiversity strategy and communicate it to staff, patients and stakeholders.*					
		We will communicate our strategy to staff, patients and stakeholders.					
		We shall report on the quality and accessibility of our green spaces and biodiversity regularly to the Board, emphasising the value of green space in health environments.					
GB-06	**The Trust shall ensure that the estate is managed in a way that causes minimal damage to biodiversity or the natural environment.**	*Our grounds and green spaces shall be maintained in a way that minimises negative impacts (e.g. low use of pesticides and sustainably managing organic wastes).*					
		We will engage with suppliers of high biotoxicity risk products to identify and manage these risk (e.g. extraction of raw materials and handling and transport of goods).					
GB-07	**The Trust shall integrate wellbeing schemes with our greenspace and biodiversity plans to maximise the health benefits of green spaces.**	*We will provide staff with opportunities, and encourage engagement in, local volunteering activities in maintenance of green spaces and biodiversity.*					
		We shall promote the health benefits of green space to our staff, patients and the wider community.					
		We will monitor (e.g. through staff surveys) that staff wellbeing has been improved by greater access to green space during working hours.					

Sustainable Care Models

Sustainable Care Models							
Reference	**Green Plan Intervention**	**Action Detail**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
SC-01	**The Trust shall seek to optimise its care pathways.**	*We will explore the option of returning to the use of an on-site manufacturer for our chemotherapy products, equipment, and services.*					
		We will reduce the length of time spent on pre-assessment care services by enabling blood pressure measurements to be taken at locations closer to patients.					
SC-02	**The Trust shall identify the optimal balance between in person care and telemedicine.**	*We will upscale the use of telecare/telemedicine where possible, for example for preventative methods and in making clinical decisions.*					
		We will continue to utilise video consultations to reduce the requirement for patient and staff travel, where appropriate.					
SC-03	**The Trust shall stress the benefits to industry of working together on sustainability.**	*We will continue to collaborate with external partners, social enterprises, and industry in an attempt realise sustainable opportunities and mutual organisational benefits.*					
SC-04	**The Trust shall re-examine its prescription processes.**	*We will review our prescription services to ensure medicines are not being over-prescribed or wasted in patient care.*					
SC-05	**The Trust will consider sustainability a factor in quality when designing care models.**	*We link sustainability as a dimension of quality with other dimensions of quality when we design/deliver/commission care models such as fairness/inequalities/social justice.*					
SC-06	**The Trust will ensure that staff are adequately trained to develop and implement sustainable care models.**	*We will provide training for our board on sustainable care models and how they are developed and deployed, we will also ensure that the Board level lead on Sustainable Development has an understanding of the role of sustainable care models.*					
		We will refer to more holistically sustainable (clinically, socially, environmentally as well as financially) care models (or equivalent) in our staff induction and training.					
SC-07	**The Trust shall quantify the co-benefits of adopting sustainable care models.**	*We will quantify the direct health, social and financial co-benefits of some of our emerging and more sustainable care models.*					
		We will calculate the environmental / carbon impact of a specific care model(s), to helps identify the most impactful areas or hotspots which will allow us to minimise environmental impacts.					
SC-08	**The Trust will seek the views of patients, staff and local partners to improve services.**	*We will use specific mechanisms (e.g. patient engagement, better incentives, innovative use of technology) to test more sustainable care models.*					
SC-09	**The Trust will ensure that new sustainable care models developed are resilient.**	*We will incorporate resilience and flexibility explicitly in our emerging care models.*					
SC-10	**The Trust will incorporate the sustainable use of resources into care models.**	*Sustainable use of resources will be embedded as a decision criterion in the development/commissioning of care models to measure and reduce the impact/cost of resource usage in health and care delivery (e.g. reducing volume and carbon intensive products, reducing waste and reducing toxic and hazardous substance use where possible).*					
SC-11	**The Trust will share best practice and lessons learnt with other organisations.**	*We will capture and share our learning internally and externally, including our mistakes, to support future care models.*					

Our People

Our People							
Reference	Green Plan Intervention	Action Detail	Implementation Evidence	Implementation Lead	Implementation Support	Monitoring Frequency	Timescale Implementation
OP-01	**The Trust shall launch a staff engagement campaign focusing on participation in sustainability.**	*We will harness the enthusiasm of our workforce on sustainability through the creation of roles such as Sustainability Champions and through the provision of support.*					
		We will communicate to staff messages which focus on individual level sustainable changes to be made across the Trust and emphasise the role they can play to make a significant impact.					
OP-02	**The Trust shall raise awareness amongst staff of the sustainability agenda to create a long-term cultural shift in behaviour.**	*We will raise awareness amongst staff of the work already being done at the Trust through an educative and learning piece ran by our cultural engagement groups which highlights what can be done on an individual basis, and communicate this effectively.*					
		We will ensure communication efforts highlight the links between climate change, carbon emissions, air pollution and cancer to highlight to staff the importance of the sustainability agenda.					
		We will launch more general sustainability initiatives and awareness campaigns to educate staff of the importance of carbon emission reduction and trigger conversation and discussion about why certain actions are required.					
		We will re-consider how we engage with our contracts and apprenticeship schemes to enhance the knowledge and skills associated with sustainability amongst the workforce.					
OP-03	**The Trust shall seek to make a positive impact on our local community.**	*We will support our local communities by educating people, particularly in areas of high deprivation, of the health benefits of sustainable actions.*					
OP-04	**The Trust shall educate staff on the sustainability of its current estate.**	*We will increase the understanding of our Liverpool-based colleagues on the sustainability opportunities of the new building and its facilities.*					
OP-05	**The Trust shall enhance the impact of its sustainability-related comms.**	*We will make our comms efforts more concise, efficient, and streamlined to ensure that sustainability related features are noticeable amongst staff.*					
OP-06	**The Trust will develop an engagement programme to encourage staff to make more sustainable choices.**	*We shall support healthy choices in all parts of the workplace, including off site, (e.g. an absence management policy, alcohol drugs and stress management strategies and promotion of healthy food choices).*					
OP-07	**The Trust will continue to provide initiatives to improve staff health and wellbeing.**	*We will provide support and schemes to all staff dependant on their specific needs (e.g. parents and carers and childcare vouchers, play areas, space for breastfeeding, school holiday play schemes or vouchers for these).*					
		We will monitor our staff's health and wellbeing through parameters include sickness absence, surveys and staff retention rate to ensure that our health and wellbeing strategies are improving the health and wellbeing of our staff.					
OP-08	**The Trust shall work with suppliers to ensure that they are working to improve equality and diversity in their organisation.**	*We will request access to our suppliers approaches to equality and diversity (e.g. staff diversity figures or % leaders that are female and/or from underrepresented groups).*					
OP-10	**The Trust will work to improve employment opportunities.**	*We will develop schemes to help long-term unemployed people into work.*					
		We will work with our local strategic partnership and other key partners to plan improved access to employment opportunities in our organisation.					

Our People

Our People							
Reference	**Green Plan Intervention**	**Action Detail**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
OP-11	**The Trust will develop processes to maximise the opportunities for our local community.**	We will work with volunteers and other members of the local community in the delivery of our sustainable development objectives.					
	The Trust will develop processes to maximise the opportunities for our local community.	*We will seek to work with volunteers and other members of the local community in the delivery of our sustainable development objectives.*					

Sustainable Use of Resources

Sustainable Use of Resources							
Reference	**Green Plan Intervention**	**Action Detail**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
SR-01	**The Trust shall strive to ensure the estate is managed in a way that maximises energy efficiency.**	*We will seek to ensure our new Liverpool hospital site is run efficiently through a review of the Building Management System (BMS).*					
		We will install more submetering to ensure that the carbon emissions hotspot across our estate can be identified and we can monitor energy consumption more closely.					
SR-02	**The Trust will work to improve the efficiency of the current estate through upgrades and maintenance of lighting and other technology.**	*We will continue to make energy-efficient upgrades to our estate, including replacing old compact fluorescent lighting and air conditioning units with LEDs and sustainable alternatives.*					
		We will seek to address issues concerning the automatic activation of sensor lights when not necessary.					
		We will replace the pumps on our solar plant vacuum tubes.					
SR-03	**The Trust will seek to minimise water wastage where possible.**	*We will ensure that the automated flushing facilities in our Liverpool site do not unnecessarily waste water as they do currently.*					
SR-04	**The Trust shall apply the waste hierarchy concept to its waste management operations.**	*The Trust will review areas where the production of waste can be minimised in the first instance.*					
		To ensure waste is managed correctly we will introduce recycling bins and a compactor system across the Trust.					
		We will work hard to ensure that our waste is segregated correctly at its source through increased education and training.					
		We will take a pan-organisation approach to ensure a co-ordinated action on waste minimisation (e.g. procurement. FM, Pharmacy, clinicians etc.), and set specific waste minimisation targets for each area.					
SR-05	**The Trust shall seek more sustainable solutions for its waste and resources.**	*We will pursue DMR solutions for our domestic waste.*					
SR-06	**The Trust will work to reduce the impact of staff uniforms and PPE.**	*We will maintain our stock of staff unforms with eco-friendly laundering services and a storage facility so that new kit doesn't have to be purchased.*					
		We will seek to source staff uniforms made from more sustainable materials.					
		We will move away from single-use plastics and PPE.					
SR-07	**The Trust will review the waste created due to new agile working arrangement.**	*We will re-evaluate the use of kit provided for staff during work-from-home arrangements and ensure that IT equipment is being used efficiently alongside ongoing agile working arrangements, finding appropriate solutions for excess resources such as donating to social enterprises or charities.*					
SR-08	**The Trust will look to reuse items where possible instead of disposing of them as waste.**	*We will look to engage with item and furniture re-use schemes such as Warp-It in order to save money and environmental impact.*					
SR-09		*We will develop a rolling programme of equipment replacement to ensure sustainability is covered in the long-term.*					
SR-10	**The Trust will review waste in clinical areas and identify solutions to reduce this.**	*We will seek to adopt reusable sharps for our surgical procedures. To do so we will collaborate with Infection Control and Theatres colleagues to review the feasibility of reusable items.*					
		We will find a recyclable solution for batteries used in our chemotherapy pumps.					
		We will seek to minimise and find solutions for the waste resulting from consumables such as bottles of alcohol used for cleaning our aseptic preparation units (e.g. sending unused alcohol to bioethanol and re-using bottles).					
		We will go paperless through the continued digitisation of notes to be accessed from online, and shift to recyclable paper alternatives where necessary.					

Sustainable Use of Resources

Sustainable Use of Resources							
Reference	**Green Plan Intervention**	**Action Detail**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
SR-11	**The Trust shall engage staff in discussions regarding sustainable waste solutions.**	*We will facilitate conversations between departments regarding a socially sustainable solution for the unused and outdated equipment's, consumables, and technology being stored across the Trust, e.g. through provision of goods to charitable organisations.*					
SR-12	**The Trust will seek to reduce the amount of hazardous chemicals used on our estate.**	*We will work to minimise the use of harmful chemicals such as in cleaning products, and seek to find alternatives.*					
		We will undertake an audit to understand how many of the products we procure contain hazardous substance and use our findings to develop initiatives to replace these where possible with non-toxic or less hazardous alternatives.					
		We will work with our onsite contractors to ensure they also help reduce our use of hazardous/toxic chemicals.					
SR-13	**The Trust will work to reduce waste across all areas of the organisation.**	*We will continue to use stock management and streamlining of products to reduce waste produced across all areas of the organisation (e.g. Pharmacy, Catering - e.g. the Green Kitchen Standard, FM etc.).*					
SR-14	**The Trust shall work collaboratively with our supply chain to reduce waste and improve resource management.**	*We will work with our supply chain to maximise repair and reuse onsite of durable goods within our organisation (e.g. furniture, IT, building materials, walking aids and reusable medical devices).*					
		We will collaborate and engage with other local organisations to share best practice of sustainable use of resources and maximise opportunities (e.g. through frameworks that assess sustainability, combined procurement processes and furniture/equipment re-use scheme).					
SR-15	**The Trust will encourage staff to make sustainable decisions at home.**	*We will engage with our staff to support them to minimise waste and expense at home (e.g. through swap shops, repair facilities, encouragement to recycle or reuse).*					
		We will communicate the benefits of sustainable products and services to our employees, to encourage staff to maximise similar benefits at home.					
SR-16	**The Trust will work with the Nutrition Team to improve the sustainability of food at the Trust.**	*We will set targets to increase the amount of healthy and sustainable food choices in our organisation, including from catering services as well as on sale to staff, patients and public in vending machines and retail outlets located within our estate.*					
		We will review our catering contracts to include a requirement to maximise the use of fresh and seasonal food to reduce the need for transportation.					
		We will track the food miles, consumption patterns and disposal of food and drink products for staff and patients to reduce the environments of catering and food.					

Carbon & GHGs

Carbon and Greenhouse Gases							
Reference	**Green Plan Intervention**	**Action Detail**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
CG-01	**The Trust shall report progress against the Green Plan at least annually to staff, patients and the public.**	*We will report our carbon emissions and trend data to staff, patients and the public annually through annual sustainability reporting.*					
CG-02	**The Trust shall develop a communications plan to raise awareness of the importance of sustainability and encourage behaviour change.**	*We will communicate the value we place on being a low carbon organisation due to the adverse effects of climate change on human health to staff and patients.*					
		We will consistently encourage our staff and patients to consider reducing their carbon emissions from high impact activities such as air travel, vehicle use, energy use and food supply.					
CG-03	**The Trust will work to understand the emissions from procurement of goods and services and implement actions to reduce them.**	*We will monitor updates from the Greener NHS on supply chain emissions and collect the necessary data to enable us to estimate the carbon emissions of our procurement once a suitable methodology has been provided.*					
		We will identify which of the products and services that we source make the largest contributions to our overall carbon footprint (in use and/or embedded) and will identify interventions to reduce their impacts (e.g. by specifying lower carbon alternatives).					
		We will identify our strategic suppliers and work with them to reduce the overall carbon impacts of the goods and services that they provide to our organisation.					
		We will invite our providers and suppliers to disclose/share their organisation-wide carbon and other environmental impacts (e.g. NO2 and PM2.5) with us and encourage/support them to reduce these.					
CG-04	**The Trust shall begin to collect data to enable the quantification of scope 2 and 3 emissions.**	*We will work to quantify our 'citizen' footprint; the carbon impact we have some influence over such as staff commuting habits and patient and visitor travel.*					
CG-05	**The Trust shall encourage staff and patients to make choices that consider the environmental impact, where appropriate.**	*We will make carbon emissions 'visible' in key identified high carbon activities where patient and staff choice is available to encourage behaviour change (e.g. choice of lease car, options for travel mode, use of dry power rather than metered dose inhalers, data heavy IT use, turning off lights/equipment).*					
CG-06	**The Trust shall integrate sustainability plans with other local organisations' plans.**	*We will work closely with other local agencies such as our ICS, partner organisations, local authority, universities and third sector organisations to contribute to the delivery of area wide carbon reduction strategies and plans.*					
CG-07	**The Trust shall expand the scope of the Carbon Baseline.**	*We shall improve reporting of emissions from across our sites to ensure our carbon emissions reporting is robust.*					
		We will work to include Scope 2 and 3 emissions in our carbon baseline so that we can monitor our progress against the NHS carbon reduction targets more effectively.					
CG-08	**The Trust shall switch to renewable tariffs.**	*We will change to a green electricity tariff at all Trust owned sites and encourage our partner organisations to do the same.*					

REPORT COVER

Report to:	Trust Board
Date of meeting:	26th January 2022
Agenda item:	P1-18-22
Title:	Our People Commitment- Implementation plan update
Report prepared by:	Zoë Hatch – Deputy Director of Workforce & OD
Executive Lead:	Jayne Shaw – Director of Workforce & OD
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	
Date & decision:	

Purpose of the paper/key points for discussion:	We recognise that our people are our greatest asset. Their dedication, talent, knowledge and experience are at the heart of everything we do and have a big impact on the care that we provide. Following the launch of the Trust 5 Year Strategy, the Workforce and OD team have developed 'Our People Commitment' which outlines our plans for the next 5 years to build on our successes so far and to continue to build an inclusive and compassionate culture where all our staff can thrive. 5 key commitments have been developed based on feedback from staff and the national and local Workforce context. These are; 1. Looking after our people 2. Developing our people 3. Workforce for the future 4. Our digital workforce 5. Valuing our people This paper provides an update on the implementation plan and priorities to date

Action required: (please tick)	Discuss	☒
	Approve	☒
	For information/noting	☐

Next steps required:	

REPORT COVER

The paper links to the following strategic priorities and Board Assurance Framework (BAF) Risks (please select)

☐ BE **OUTSTANDING**

BAF Risk	Please select
If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	☐
Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	☐
Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☐

☐ BE **COLLABORATIVE**

BAF Risk	Please select
If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	☐

☐ BE **RESEARCH LEADERS**

BAF Risk	Please select
If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	☐
Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	☐

☐ BE **A GREAT PLACE TO WORK**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☒
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	☒
If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	☒

☐ BE **DIGITAL**

BAF Risk	
If we do not invest a clear vision, sufficient capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve its digital ambition.	☐
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	☐

☐ BE **INNOVATIVE**

BAF Risk	
If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	☐

EQUALITY & DIVERSITY IMPACT ASSESSMENT								
Are there concerns that the policy/service could have an adverse impact on:								
Age	Yes ☐	No ☒	Disability	Yes ☐	No ☒	Gender	Yes ☐	No ☒
Race	Yes ☐	No ☒	Religious/belief	Yes ☐	No ☒	Sexual orientation	Yes ☐	No ☒
Gender Reassignment	Yes ☐	No ☒	Pregnancy/maternity	Yes ☐	No ☒			

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

Version 1.1 Ref: FCGOREPCOV Review: July 2024

Our People Commitment
Implementation plan

Update January 2022

Zoë Hatch
Deputy Director of Workforce and OD

ACTION PLAN

People Commitment Year 1 Implementation Plan

Last updated: January 2022

Updated by: Zoë Hatch, Deputy Director of Workforce & OD

Looking after our people | Developing our people | Workforce for the future | Our Digital Workforce | Valuing our people

Aim	Objective	Owner	2021/2022		2022/2023				Comments/progress
			Q3	Q4	Q1	Q2	Q3	Q4	
LOOKING AFTER OUR PEOPLE									
Develop a revised health and wellbeing support that champions the physical, mental, and financial wellbeing of everyone at CCC	Work in partnership with the NW HR network to embed a person-centered approach to sickness absence focusing on wellbeing	JS/ZH					X	X	• Signed up to NW H&WB pledge Nov 2021 • Progress on hold due to current system pressures
	Work in partnership with the Be Well Charity to provide access to training and support on mental health and wellbeing	L&OD		X	X				• Commissioning H&WB programmes for 2022 in line with H&WB calendar of events • MHFA training programmes undertaken. 18 MFHA currently trained including 2 'trainers'
	Develop and pilot wellbeing huddles into clinical areas to support staff health and wellbeing	Business Support Team			X				

ACTION PLAN

	Develop and implement H&WB support plan that supports the achievement of NHSI/E Board objectives and HWB Guardian initiative	ZH	X	X					• Health and Wellbeing update being provided to January Board. • H&WB commitment in development • Undertaking diagnostic in line with the relaunched national H&WB framework • Signed up to NW H&WB pledge Nov 2021 • H&WB calendar of events in place for next 12 months
Continue to promote and support flexible ways of working	Launch refreshed guidance on flexible and hybrid working	Business Support Team	X	X					• Guidance and training launched • Management sessions on hold for January due to current operational pressures
	Run workshops with divisions on the approach to flexible and hybrid working	Business Support Team	X	X					• Sessions developed- to start in February 2022
	Begin recording flexible working arrangements on ESR to ensure oversight and monitoring	Systems team			X				• Process developed for capturing arrangements across Divisions. Audit to take place in April
DEVELOPING OUR PEOPLE									
Develop a programme for identifying and nurturing talent which provides opportunities for development, celebrates success and supports individual aspirations	95% of staff to have received a quality PADR and wellbeing conversation aligned to the Trust Strategy by March 2022	L&OD	X	X	X	X	X	X	• L&OD continuing to support PADR compliance as part of BAU • Wellbeing conversations incorporated into PADR process

ACTION PLAN

									• Reviewing ESR functionality to support process
	For all staff to be compliant in mandatory and statutory training and to maintain compliance	L&OD	X	X	X	X	X	X	• L&OD continuing to support training compliance as part of BAU • Medical staffing a priority and reviewing options for improving position • 2022 training plan in place
	Support the development of career pathways for ANP/CNS nurses	ZH		X	X	X			• Trust working group established and action plan in place
Develop effective leadership and management training for all leaders	Work in partnership with C&M workforce network to further enhance our Leadership Development offer	L&OD					X	X	
	Launch reciprocal mentorship in partnership with Specialist Trusts EDI collaboration	EDI Lead			X	X			• EDI Lead in post from January • EDI priorities for the first 6 months being established in collaboration with Specialist Trusts
	Develop refreshed management support for HR policy and processes including bite size case study sessions				X	X			• Review of all current training programmes underway • Leadership and management passport to be relaunched in April 2022 • Development prospectus developed- e-version live on Intranet
Embed a framework of coaching and mentoring	Grow coaching and mentoring offer to Trust and relaunch offer	L&OD					X		

ACTION PLAN

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

WORKFORCE FOR THE FUTURE									
Continue to develop new roles and career pathways that support sustainable services for the future	Support the planning and recruitment of advanced practice roles to support the delivery of clinical care	WOD	X	X	X	X	X	X	• Business planning process in progress including Workforce priorities • Recruitment strategy being developed
	Develop and implement apprenticeship pathways to support the development of the future non-clinical workforce	WOD			X	X			• National apprentice week in February • Myth-busting process/ engagement underway • Update of current position provided to WTC in November 2022 • Supporting wider system through Levy Transfer process
	Support the development of clinical apprenticeship roles within nursing and AH to develop future workforce	WOD			X	X	X	X	• Reviewing opportunities to implement RN apprentice programme • AHP workforce lead in place
	Explore the opportunities to develop Specialty Doctor roles to support the delivery of clinical care	ZH			X	X			• Medical staffing deep dive undertaken and being discussed at PC
Grow our relationships with local communities, schools and colleges to explore how we engage with health workers of the future	Work with LCR to develop access to health pathways and opportunities to support development of our future workforce	L&OD			X	X	X	X	• LCR have developed a recruitment platform- to work with LCR to advertise posts through them
	Launch traineeships with Wirral Met and Liverpool City College to provide opportunities for work experience and development to local community	L&OD			X				• On hold due to COVID-19 restrictions

ACTION PLAN

	Launch DWP Kickstarter programme to provide work experience to our local community in 'alternative' health roles i.e., Communications, IT and Workforce	L&OD		X	X				• Applications submitted to DWP for Kickstarter roles in Communications and WOD • Delays in process with DWP • Part of Talent for Care national work stream
	Work with local system to embed national Talent for Care agenda						X		• Supporting NW widening participation data pilot including funding • Policy being reviewed to support agenda
Develop workforce plans for all services that are fully integrating with clinical strategies and financial plans	Support the development and delivery of divisional plans to embed the clinical division structure			X	X				• Business planning process underway • Final Business plans to be signed off in March 2022
	Develop a Trust approach to Workforce Planning to support clinical areas with future planning including the incorporation and training of new roles	Systems and Business Support Team			X	X	X	X	
Refresh our recruitment opportunities to raise the profile of the Trust as an employer of choice	Review Recruitment Services and demand and capacity to ensure we can meet the operational needs of the Trust and recruit high quality candidates	ZH/KG		X	X				• Increased capacity within recruitment to support recruitment processes • Working in partnership with Digital to implement RPA processes to streamline recruitment pathway
OUR DIGITAL WORKFORCE									
Embed digital solutions that will enable our people to work to their full potential through the automation of systems and processes	Streamline transactional workforce systems to ensure timely and effective service delivery	Systems team					X	X	• Working in partnership with Digital to implement RPA processes to streamline transactional processes

ACTION PLAN

	Work in partnership with Digital team to embed RPA processes to support transactional services	Systems team			X	X			• Working in partnership with Digital to implement RPA processes to streamline transactional processes
	Improve accuracy and utilisation of ESR to ensure we have accurate staff records and details	Systems team	X	X					• ESR improvement plan developed and being progressed by WOD Systems team
	Implement a digital system for the management and coordination of medical education	Medical Education Team		X	X				
Embed e-rostering and e-job planning to support flexible and agile ways of working	Full embed e-roster across all clinical areas in line with the LOA priorities	Systems team			X	X			• Internal audit of E-Roster implementation plan receive Moderate Assurance in December 2021 • LOA priorities reviewed to align with Divisional priorities • Pharmacy and Diagnostic Imaging implementing E-Roster in Q4 • Medics transitioning to Allocate systems from April 2022
	Implement e-job planning system and process for all non-rostered clinical groups	Systems team			X	X			• Developing a multi-disciplinary e-job planning policy to support with process • Development of procurement process for E-job planning solution underway

ACTION PLAN

Utilise digital solutions and technology to improve our recruitment process, enabling us to attract the brightest and best people	Implementation of digital processes for HR transactional work flows to support payroll and recruitment	Recruitment Team			X	X			• Working in partnership with Digital to implement RPA processes to streamline transactional processes
VALUING OUR PEOPLE									
Embed our refreshed values and behaviors	Launch and embed the refreshed Trust values	L&OD		X	X	X	X		• Development of branding for Trust Values completed • Soft launch of values in February 2022 • Plan being developed to undertake roadshows and workshops from April 2022 • Delayed due to current COVID restrictions
	Develop a Trust approach to values based recruitment including training and awareness session recruiting managers	L&OD			X	X			
	Refresh PADR and Induction processes to reflect refreshed values	L&OD		X	X				• Branding for Values developed • Induction processes to be refreshed from February induction • New values to be embedded into PADR process from April 2022
Ensure all staff have a voice that counts by growing our Culture and Engagement groups and Staff Networks	Launch staff networks and identify priorities for the next 12 months to support improving staff experiences at CCC	EDI Lead		X					• EDI Lead in post from January • EDI priorities for the first 6 months being established in collaboration with Specialist Trusts

ACTION PLAN

	Launch reciprocal mentorship in partnership with Specialist Trusts EDI collaboration	EDI Lead			X				• EDI Lead in post from January • EDI priorities for the first 6 months being established in collaboration with Specialist Trusts
Develop a workforce that is truly representative of the population we support	Establish EDI collaboration with specialist trusts to ensure our workforce is reflective of our local population and to promote equality, diversity and inclusion in everything we do	EDI Lead		X					• EDI Lead in post from January • EDI priorities for the first 6 months being established in collaboration with Specialist Trusts
	Develop a suite of EDI training and development	EDI Lead			X	X			• EDI Lead in post from January • EDI priorities for the first 6 months being established in collaboration with Specialist Trusts
	Implement WRES, WDES and Gender Pay gap action plans to improve the experiences of staff working at CCC	EDI Lead			X	X			• EDI Lead in post from January • EDI priorities for the first 6 months being established in collaboration with Specialist Trusts

REPORT COVER

Report to:	Trust Board
Date of meeting:	26th January 2022
Agenda item:	P1-19-22
Title:	Health and Wellbeing at CCC
Report prepared by:	Zoe Hatch
Executive Lead:	Jayne Shaw
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	
Date & decision:	

Purpose of the paper/key points for discussion:	Our ambition, as set out in Our People Commitment, is to create an environment where everyone feels supported and empowered to lead healthy lives and make informed choices about their wellbeing. This report provides an overview of the national and regional health and wellbeing initiatives and provides an update on our Health and Wellbeing Action plan

Action required: (please tick)	Discuss	☒
	Approve	☐
	For information/noting	☒

Next steps required:	Implementation of nine board level principles for wellbeing Review and refresh our wellbeing offer to ensure we are supporting a person centred approach Develop and implement our wellbeing plan for the next 12-18 months

REPORT COVER

The paper links to the following strategic priorities and Board Assurance Framework (BAF) Risks (please select)

☐ BE **OUTSTANDING**

BAF Risk	Please select
If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	☐
Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	☐
Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☐

☐ BE **COLLABORATIVE**

BAF Risk	Please select
If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	☐

☐ BE **RESEARCH LEADERS**

BAF Risk	Please select
If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	☐
Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	☐

☒ BE **A GREAT PLACE TO WORK**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☒
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	☒
If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	☒

☐ BE **DIGITAL**

BAF Risk	
If we do not invest a clear vision, sufficient capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve its digital ambition.	☐
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	☐

☐ BE **INNOVATIVE**

BAF Risk	
If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	☐

EQUALITY & DIVERSITY IMPACT ASSESSMENT

Are there concerns that the policy/service could have an adverse impact on:

Age	Yes ☐	No ☒	Disability	Yes ☐	No ☒	Gender	Yes ☐	No ☒
Race	Yes ☐	No ☒	Religious/belief	Yes ☐	No ☒	Sexual orientation	Yes ☐	No ☒
Gender Reassignment	Yes ☐	No ☒	Pregnancy/maternity	Yes ☐	No ☒			

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

Health and Wellbeing at CCC

Zoe Hatch
Deputy Director of Workforce and OD

1.0 Introduction

Staff Health and Wellbeing in the NHS has become an increasing priority over the last five years following the publication of the first NHS Health and Wellbeing Framework in 2018. The NHS People Plan and subsequent People Promise highlights the need to 'look after our people' and focuses on the actions all NHS employers must take to keep our staff safe, healthy and well – both physically and psychologically and this is reflected in our Trust People Commitment.

This paper provides an overview of the on national and regional Health and Wellbeing initiatives, including the role of Wellbeing Guardians, and provides details of our health and wellbeing action plan and priorities.

2.0 Health and Wellbeing Initiatives

2.1. Health and Wellbeing Guardians

In 2019, Health Education England (HEE) published a Mental Wellbeing Commission Report that introduced the idea of a wellbeing guardian. The report highlighted the importance of having a board member that is responsible for questioning decisions and challenging behaviours that impact on the health and wellbeing of staff.

Following the publication of this report the NHS People Plan introduced the requirement for all NHS employers to introduce a wellbeing guardian into their organisation. In 2021, Elkan Abrahamson (Non-executive Director) took on this role for the Trust.

The role of the Health and Wellbeing Guardian is to champion wellbeing, seek assurance that it is an organisational priority and encourage a model of wellbeing leadership. NHSIE identified nine board level principles to ensure that our workforce is physically and psychologically safe and healthy, and able to provide excellent, high quality care for patients.

The nine principles are:

1. The health and wellbeing of NHS People will not be compromised by the work they do
2. The Board and Guardian will check the wellbeing of any staff member exposed to distressing clinical events
3. All new staff will receive a wellbeing induction
4. NHS people will have ready access to self-referral and confidential occupational health services
5. Death by suicide of any member of staff will be independently examined
6. The NHS will ensure a supportive, safe environment to promote physiological and physical wellbeing

7. The NHS will protect the cultural and spiritual needs of its people, ensuring appropriate support is in place for overseas staff
8. Necessary adjustments for the nine groups under the Equality Act 2010 will be made
9. The wellbeing guardian will suitably challenge the board

To date we have implemented a number of these principles including health and wellbeing inductions, wellbeing conversations for all staff and access to staff support through occupational health and Vivup. The Health and Wellbeing action plan (Appendix 1) identifies our key priorities for the next 12-18 months to further implement these principles.

2.2. The North West Health and Wellbeing pledge

In November 2021, the Trust signed up to the North West *Our Pledge for the Wellbeing of our NHS People* to support improvements in wellbeing of staff and the aim of fostering a workforce that is healthy and engaged. The pledge is formed of three main areas of focus;

2.3. Preparing our Board for the change:

- Having equal focus on addressing presenteeism as well as sickness absence
- Reframing our policy to focus on holistic well-being through a person centred & flexible approach
- Considerations for ethics, equality, diversity and inclusion - moving away from treating everyone ‘equally’ to supporting the individual
- Develop approach as part of embedding a just and fair learning culture

2.4. Evidencing that well-being is a priority at our Trust Board by:

- Understanding the well-being of our people and how we are meeting their needs and giving staff a safe voice
- Showing how a well-being lens is applied to all decisions
- Understanding our organisation’s culture, including taking positive action to address the issues and support our People

2.5. Committing to the three NW themes of enabling work:

- Well-being services that support the 100%
- A new person-centred well-being and attendance management policy framework
- Leadership development that supports managers in our new approach

To date regional work has been paused due to system wide pressures as a result of COVID-19, however our Health and Wellbeing Action plan (Appendix 1) incorporates these areas of focus and identifies key actions to support the delivery of the pledge.

2.6. NHS Health and Wellbeing Framework

The NHS Health and Wellbeing Framework was first published in 2018 and was revised in November 2021. The framework sets out the standards for supporting staff to feel well, healthy and happy at work.

The framework is an interactive tool that makes the case for staff health and wellbeing, sets out clear actionable steps and provides guidance on how we can understand what 'good' health and wellbeing looks like and how it can be achieved.

The revised framework focuses on:

- placing emphasis on a positive health and wellbeing culture
- place greater emphasis on the preventative health and wellbeing interventions
- embedding equality, diversity and inclusion
- providing a clear rational and case for change

The Framework identifies a number of factors that influence the health and wellbeing of our staff and teams. Some, such as physical and mental health, are well understood and support and initiatives are in place. However, other factors such relationships, management skills and the environment have previously had less focus. The model provides numerous resources and best practice initiatives to support the health and wellbeing of staff focusing on seven health and wellbeing domains that have influenced our health and wellbeing action plan (Appendix 1);

1. **Improving personal health and wellbeing** – the proactive interventions and services that empower our staff to manage their own health and wellbeing
2. **Relationships** - the ways our teams work together with civility, respect and care
3. **Fulfilment at work** – how our work at the inspires our staff and how we support their growth and passion
4. **Managers and leaders -** how our leaders define, implement and embody a positive health and wellbeing culture and how they provide health and wellbeing support as part of their role
5. **Environment** - physical workspaces and the facilities available to our staff to rest, recover and succeed
6. **Data insights** - understanding our health and wellbeing needs and then measuring our effectiveness in supporting them
7. **Professional wellbeing support** - the teams and services, like occupational health, who are available to support our staff's health and wellbeing

3.0 Conclusion and recommendations

Our ambition, as set out in Our People Commitment, is to create an environment where everyone feels supported and empowered to lead healthy lives and make informed choices about their wellbeing. The work we have planned over the next 12- 18 months includes, but is not limited to, a review and refresh of our health and wellbeing support for staff, including a review of our offer through Vivvup and occupational health, introduction of wellbeing champions and a full scale review to our approach to absence management.

Our Health and Wellbeing action plan identifies our key priorities for the next 12-18 months which will support the achievement of national and regional initiatives as well as support the implementation of Our People Commitment.

Trust Board are asked to note the contents of this paper and support the actions identified as our priorities for the next 12-18 months.

ACTION PLAN

Appendix 1- Health and Wellbeing Action Plan

Last updated: January 2022

Updated by: Zoe Hatch

Recommendation	Action	Owner	Target date	Comments/progress
Strategy	Develop Health and Wellbeing Commitment to support the delivery of regional and national health and wellbeing initiatives in line with the Trust People Commitment	ZH	April 2022	Following the sign off of the People Commitment a H&WB commitment is being developed that incorporates the H&WB initiatives and the priorities identified within the NHS H&WB framework
	Develop a business case for a H&WB lead for the Trust	ZH	Feb 2022	Develop a business case to support investment in a dedicated H&WB lead to support the Trust ambitions and priorities in relation to staff H&WB
Understanding our data	Undertake HWB diagnostic tool to establish our current position and undertake an comparison exercise to identify key achievements	ZH	Jan 2022	NHSI/E Health and Wellbeing Framework updated November 2021. Refreshed diagnostic being undertaken with aim to complete in January 2022
	Review current KPI’s and look to include attendance and wellbeing data as part of core KPI’s	ZH	April 2022	Following launch of national people metrics, local KPI’s being reviewed with aim of launching refreshed WOD KPI framework for April 2022
	Undertake establishment and workforce plan reviews in partnership with divisions to ensure workforce models meet service needs	HRBP	April 2022	Support workforce planning as part of budget setting to ensure establishment meets service needs and appropriate R&R plans are in place

ACTION PLAN

Staff support	All staff to have at least 1 H&WB objective as part of PADR	L&OD	Ongoing	H&WB conversations embedded into PADR process. Team reviewing the digital solutions to support conversations
	Develop and implement wellbeing conversation training for managers	L&OD	April 2022	Following national training programme local training to be developed and introduced as part of the leadership and management passport
	All staff to have a meaningful wellbeing conversation as part of ongoing 1:1 support structures	L&OD	Ongoing	H&WB conversations embedded into PADR process. Team reviewing the digital solutions to support conversations
	Host H&WB event with support from C&M resilience hub	TBC	TBC	Event to be developed for 2022 in line with COVID guidance. Given current restrictions not progress has been made in relation to this
	Refresh staff offer and review Vivup contract	WOD SMT	April 2022	Contract review underway to ensure we are balancing quality of service with value for money. User feedback being sort from staff
	Develop H&WB champion roles to support H&WB guardian (including quarterly catch ups)	L&OD	April 2022	Role profile developed and recruitment of champions to commence in January 2022. All MHFA to be invited be a champion. Champions to become members of Divisional C&E groups
	Launch event for Health and Wellbeing champions	L&OD	March 2022	To be confirmed once champions have been identified. To include access to national training resources and information
	Develop H&WB quarterly steering group chaired by H&WB guardian	ZH	March 2021	Once H&WB champions have been recruited, quarterly steering group to be established. TOR to be drafted and shared with H&WB guardian
Policy and Process refresh	Review Sickness Absence policy to ensure clear focus on wellbeing and person centred support	HRBP's	March 2022	Policy to be reviewed in line with regional work on developing a person centred approach to sickness management. Regional policy discussion have not yet commenced, HRBP team to review Trust policy in the

ACTION PLAN

				interim to ensure support mechanisms are clearly defined and language is reflective of our approach
	Develop and implement reasonable adjustment training for managers as part of absence management/ wellbeing support	HRBP's	March 2022	In line with review of policy, guidance on reasonable adjustments to be reviewed and incorporated into training and support materials for staff and managers
	Refresh and reframe sickness/ wellbeing absence training to focus of wellbeing conversations and person-centred approaches	HRBP's	March 2022	Training to be refreshed as 'bite size' case studies following policy review
Culture and Engagement	Host HWB engagement sessions through divisional Culture and Engagement groups to review HWB offer	TBC	TBC	Session to be arranged following development and implementation of H&WB champion roles and training
	Develop manager and leadership skills around effective and empathetic conversations	HRBP/ L&OD	March 2022	Leadership and management passport to be relaunched with refreshed training materials focusing on 'bite size' case studies
	Embed flexible and agile working from day 1 and educate managers and staff on the benefits of agile working	HRBP's	April 2022	Guidance and training for managers launched December 2021. Wider Trust communications to be developed for publication in January 2022
	Educate managers and the importance of EDI- more than just the Equality Act	EDI lead	April 2022	Development of managers training on Inclusive Leadership

ACTION PLAN

Equality Diversity and inclusion	Work as part of Specialist Trust EDI collaboration to develop training and awareness sessions for managers	EDI Lead	June 2022	Develop training and support for managers to support staff health and wellbeing including implementing reasonable adjustments and management of long term health conditions
	Include staff networks updates as a standing item at Board annually	EDI Lead	April 2022	Include Trust networks as a staff story at Trust Board annually

REPORT COVER

Report to:	Trust Board
Date of meeting:	27 January 2022
Agenda item:	P1-20-22
Title:	Shadow Board Development Programme
Report prepared by:	Stephanie Thomas, Head of Learning and OD
Executive Lead:	Jayne Shaw, Director of Workforce and OD
Status of the report: (please tick)	Public ☒ Private ☐

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

Purpose of the paper/key points for discussion:	This paper provides an overview of the Shadow Board Programme and proposes a number of next steps for consolidating the individual and team learning.

Action required: (please tick)	Discuss	☐
	Approve	☒
	For information/noting	☐

Next steps required:	The Board of Directors is asked to note the contents of this paper and support the next steps

REPORT COVER

The paper links to the following strategic priorities and Board Assurance Framework (BAF) Risks (please select)

☐ BE **OUTSTANDING**

BAF Risk	Please select
If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	☐
Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	☐
Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☐

☐ BE **COLLABORATIVE**

BAF Risk	Please select
If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	☐

☐ BE **RESEARCH LEADERS**

BAF Risk	Please select
If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	☐
Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	☐

☒ BE **A GREAT PLACE TO WORK**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☒
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	☐
If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	☒

☐ BE **DIGITAL**

BAF Risk	
If we do not invest a clear vision, sufficient capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve its digital ambition.	☐
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	☐

☐ BE **INNOVATIVE**

BAF Risk	
If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	☐

EQUALITY & DIVERSITY IMPACT ASSESSMENT								
Are there concerns that the policy/service could have an adverse impact on:								
Age	Yes ☐	No ☒	Disability	Yes ☐	No ☒	Gender	Yes ☐	No ☒
Race	Yes ☐	No ☒	Religious/belief	Yes ☐	No ☒	Sexual orientation	Yes ☐	No ☒
Gender Reassignment	Yes ☐	No ☒	Pregnancy/maternity	Yes ☐	No ☒			

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

Version 1.1 Ref: FCGOREPCOV Review: July 2024

Shadow Board Development Programme

Stephanie Thomas
Head of Learning and OD

Version: 1.0 Ref: FCGOREPO Review: May 2024

1. Introduction

There is a strong body of evidence and research that demonstrates the link between the skills and behaviours of leaders and patient outcomes. Having the right leadership structure in place which is supported by a comprehensive leadership and management development offer that evolves to meet the changing needs of leaders and managers as the context and environment in which they operate changes is also essential.

Our new clinical structure, which is built on a triumvirate model, has been in place since January 2020. To support the implementation of the new model and the individuals working to newly defined job descriptions as well as individuals working in corporate roles, the development offer for senior leadership roles was reviewed.

As part of this review two new programmes have been introduced. The first of these is the 3 month Shadow Board Development Programme aimed at ‘deputy’ level posts which commenced September 2021. The second is the Team @The Top Programme specifically for individuals in the new senior triumvirate teams as well as the Executive Team. The programme has been commissioned internally and commenced November 2021, concluding in May 2022.

This paper provides an overview of the Shadow Board Programme and proposes a number of next steps for consolidating the individual and team learning.

2. Background

The Shadow Board Programme is a national leadership development programme for aspirant board members and senior management in health and social care, offering both experiential (practice) and modular (theory) learning which supports participants in developing the right level of knowledge and understanding of working at board level.

The objectives of the shadow board programme are:

- To identify the top end of the talent pool within the Trust and more broadly within the NHS.
- To support the integration of more diversity of thought and perspective into Trust boards.
- Delivering future value to the NHS.
- To create a pool of potential strategic leaders across the Trust who are able to work with the board to shape and deliver the Trust’s strategic objectives.

- To provide an insight into executive responsibilities and develop strategic leadership thinking for future potential leaders.

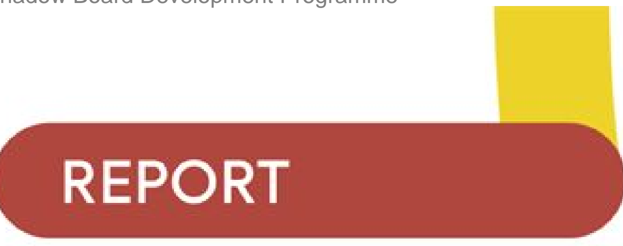
Funding for the programme was secured via a bidding process to an external funding stream.

3. CCC shadow board programme

(i) Involvement

Individuals for the programme were nominated, in consultation with them, by the Executive Team as follows:

Rosie Lord	Deputy Medical Director	Completed
Julie Massey	Divisional Director	Completed
Zoë Hatch	Deputy Medical Director	Completed
Emer Scott	Associate Director of Communications	Completed
Fran Ashley	Divisional Director	Completed
Gillian Heap	Director of Research and Innovation Operations	Completed
Karen Kay	Deputy Director of Nursing	Completed
James Crowther	Head of IT Operations	Completed
Liz Furmedge	Divisional Director	Completed
Mel Warwick	Head of Transformation, Strategy & Programme Management	Completed
Lynny Young	Associate Medical Director	Unable to complete due to prior commitments
Jo Bowden	Deputy Director of Finance	Unable to complete due to prior commitments



Chris Lube	Associate Director of Clinical Governance and Patient Safety	Already completed the programme at another Trust

(i) Commitment

As part of the application process Trusts are required to commit to the programme in a number of ways including:

- Nomination of a NED chair – this was confirmed as Mark Tattersall
- Provision of secretarial/administration support for the chair and shadow board meetings
- 3 Board members to share their personal career journeys with the group – James Thomson, Sarah Barr and Thomas Pharaoh

(i) Content and structure

The programme structure and content is nationally defined and takes place across 6 days over 3 consecutive months. It includes 3 full day taught modules and 3 shadow board meetings. The taught modules are designed to further develop strategic knowledge and understanding and covered the areas set out below.

- corporate governance and strategy,
- strategic finance and corporate risk management
- leadership, culture and workforce

The modules were externally facilitated by the Inspiring Leaders Network, commissioned to deliver the programme on behalf of the NHS Leadership Academy, and were designed to further develop participants strategic knowledge and understanding around these key areas. The facilitators also attended the shadow board meetings.

The facilitators for the modules were Keven Taylor, Marie Thompson, Ismail Hafeji and Nicky Ingham. All the facilitators have extensive experience of working at board level within a health and social care settings. Biographies for the facilitators can be viewed in appendix 1.

The shadow board meetings took place the day immediately before the Board of Directors meetings in September, October and November. These meetings ran as a ‘real’ board meeting, using an agreed sub-set of board papers which participants were required to present and debate. Although running as a ‘real’ board the

meeting provided a ‘safe space’ for participants to adapt to the formalities of board etiquette and to practise using the language and behaviours expected as board members.

Following each shadow board meeting, participants were provided with verbal and written feedback by the facilitator, extracts of this feedback can be viewed in appendix 2. Feedback on individual performance was also made available.

A summary of the shadow board discussion was shared at Board of Director meetings by the shadow board chair. This provided the opportunity for participant’s insights and perspectives on the challenges and opportunities facing the trust to be shared, enhancing board members diversity of thinking.

A number of participants also took the opportunity to observe Board of Directors and sub Board Committee meetings to gain a wider awareness and context.

(ii) Evaluation

Written feedback from participants was provided at the end of the programme. This shows they evaluated the programme very highly, with the strategic finance and corporate risk management module being highlighted as most beneficial of the taught modules.

The opportunity to come together as a senior leadership group, was also highlighted in terms of benefits around networking, peer support and increased collaboration.

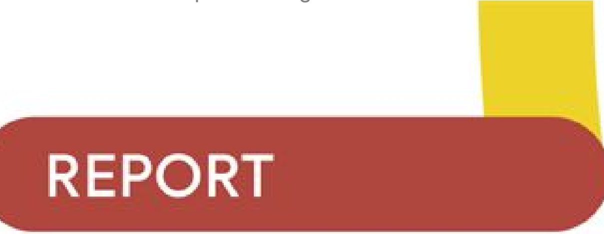
Whilst the overall contents and structure of the programme has been highly evaluated, lessons can be learnt around the need for administrative support for the shadow board meetings.

4. Net steps

As with all development programmes, it is the process of transferring learning into the workplace that lasting value can be harnessed.

In conjunction with participants, the following next steps are proposed;

I. **Presentation to the Board of Directors**: Participants will share their experiences and learning from the programme as part of Februarys staff story



II. **Membership of the group**: this will be extended to those individuals not able to complete the original programme

III. **Continue to run a shadow board meeting**: shadow board meetings will be held bi monthly, chaired by a NED on a rotational basis. Feedback from the meeting will be shared by the NED chair and a representative from the group.

IV. **Transformation action learning set**: an action learning set will be introduced as a forum to provide ongoing support and challenge with the implementation of key strategic projects/strategies.

V. **Personal development**: Participants have all been offered coaching support and individual development conversations to support their ongoing career development.

5. Recommendations

The Board of Directors is asked to note the contents of this paper and support the next steps.

Appendix 1 - Inspiring Leaders Network: Facilitator Biography

Kevan Taylor

Kevan has extensive experience within health and care. A Social Care Practitioner by background, he started his career in the Voluntary Sector and Local Authority, initially as a mental health Practitioner and latterly in Service Development and Planning.

He joined the NHS within primary care and commissioning, eventually being Director of Commissioning for a Health Authority. He joined a Community, mental health and learning disability Trust as an Executive Director and was Chief Executive of Sheffield Health and Social Care NHS Foundation Trust for 18 years.

Having worked in both the Local Authority and the NHS, and having been both a Commissioner and a Provider CEO, Kevan has considerable insight to the “politics” and behaviours behind system working – how we all need to lead beyond our specific Organisational authority and the opportunities and challenges that brings.

Building on this experience Kevan was the lead Chief Executive for the Sheffield Accountable Care Partnership and latterly the System Lead for Workforce and Health for South Yorkshire Integrated Care System, leading on the people plan, work and health, the Voluntary Sector and liaison with Sheffield City Region.

He has extensive experience of mentoring and coaching and a particular interest in issues of diversity. Developing and maintaining personal and organisational resilience is key to his approach as he believes most of us show nothing like the compassion to ourselves that we consistently give to others.

Ten years ago he established the partnership between mental health services in Sheffield and Gulu in Northern Uganda. This partnership is now very well established and benefiting both communities in Sheffield and Uganda.

Ismail Hafeji

Ismail Hafeji is a strategic and operational Director of Finance with over 14 years of board level experience with an outstanding track record of implementing financial strategies, delivering statutory duties, and building organisational resilience. Ismail has worked in all levels of NHS finance in his 36 year career. He has an excellent understanding of health systems having operated as a Commissioner, Provider and at regional level. He is

respected and recognised across the North West NHS finance community for leading change and setting strategic direction.

Ismail was Director of Finance and IM&T for Bolton PCT before joining Greater Manchester Mental Health Foundation Trust. He played a major role in the Trust's successful acquisition of Manchester Mental Health and Social Care Trust. The financial strategy underpinning the bid was highly commended by the Regulators and Manchester Clinical Commissioning Group. He also led the two year programme to implement the electronic Patient Administration System.

Ismail has an engaging personal style with highly developed communication skills and the ability to rise to a challenge. Continually striving for quality improvement, he is confident and skilled in developing relationships with clinicians and managing stakeholders to build effective partnerships. Ismail has a philosophy of developing and empowering teams. He is a strong supporter of staff development having been a NW Leadership Academy mentor and coach.

Nicky Ingham

Nicky is the Executive Director for the Healthcare People Management Association (HPMA) and Chief Executive of her own successful HR and OD Consultancy.

Nicky has 24 years' experience working with organisations in a variety of workforce roles. With over 15 years as Executive Director of Workforce and OD, Nicky has significant experience in leading organisational transformation, change programmes, developing organisational models, organisational turnaround, development of strategy and underpinning strategic engagement and communications strategies.

Nicky is adept at providing constructive challenge and being a critical friend to support transition, both on an individual and team level. Recent experience includes working with ambiguity across organisational boundaries in supporting system change across the Fylde Coast Local Delivery Plan with commissioners and local authorities.

A focused values-driven individual who can quickly grasp the strategic, operational and organisational issues involved in an organisation. A self-starter with excellent interpersonal skills, a good communicator who can establish credibility at all levels of an organisation. Highly motivated and results focused. With strong leadership skills and experience, Nicky is agile and passionate about supporting others to realise their full potential and inspire change in themselves and for themselves.

Leading and implementing cultural change programmes, Nicky provides a holistic approach to transformation using her unique style and partnership approach to best effect ensuring ownership at all levels. An experienced coach and mentor to a broad range of stakeholders from board level to grassroots staff, Nicky's approach is refreshing, vibrant and forward thinking. An accomplished Chair working nationally, regionally and locally to effect system wide change. Previous HPMA HRD of the Year 2010.

Marie Thompson

Marie joined the NHS in 1985 and qualified as a Registered Nurse in 1988.

She has worked in the NHS for 34 years in a variety of clinical, educational and senior leadership roles spanning Acute, Acute & Community and Higher Education.

In 2009 Marie was appointed as Executive Director of Nursing & Quality in a large integrated Acute & Community Foundation Trust. She served on the board for more than 10 years and gained significant experience of working as a corporate board director in a challenged trust. She has considerable experience of leading people and bringing about change and improvement; one of her passions is supporting people to be at their best so they can provide excellent service and care to the people they serve.

Marie is also an independent director of a Lancashire based social housing company. She left her full time employment with the NHS to pursue new opportunities that would offer greater flexibility whilst enabling her to 'give back' to the NHS.

Appendix 2 - Extracts of feedback from the shadow board meetings.

- A great shadow board with full participation from all of the members, demonstrating preparation of reading the papers, asking well-structured questions and appropriate challenge.
- It was great to hear the feedback from the input of the shadow board to the actual board illustrating real influence and input. The Chair shared honest and reflective input to the group which helped set the context and he engaged well with all participants.
- It was good to hear the suggestions of the group as to how to improve the programme of visits by undertaking trend analysis so that more information could be provided, giving more assurance. All contributions felt informed illustrating the preparation that everyone had put into prior to the meeting, and this felt like an increase in confidence building on the previous shadow boards.
- Everyone was again very well prepared both in terms of presenting and challenging their own understanding, clarifying areas to aid understanding and support debate.
- Remember the importance of body language, especially with virtual meetings.
- The group provided good support to each other, demonstrating working as a team, providing additional information to enhance the discussion and take it to the next level, allowing for increased debate and discussion. Building on the feedback from last time there was more questioning on the data rather than the person fully demonstrating the feedback had been taken on board.
- Great questions, seeking assurance, suggesting improvements in the topic area that would be of benefit to the board and wider organisation. Discussion on system working was fully demonstrated and the challenges this provides to individuals and the board as a whole and the dilemma of balancing views.
- A couple of things to note with regards to the use of acronyms and where you may have public in the meeting, just be mindful to explain what they are and to be mindful of 'language' that you use be assertive in what words you use to explain, don't leave any doubt for anyone.

Cheshire & Merseyside
Cancer Alliance

Performance Report

January 2022

Contents

I. Summary
II. Restoration of cancer services – core metrics
III. 14 day standard and 28 Faster diagnosis standard
IV. 62 day standard

Version 1

Section I: Summary

Restoration of cancer services

The Cheshire and Merseyside Cancer Alliance is providing system leadership and operational oversight for the restoration of cancer services. The restoration is focusing on three objectives, namely:

- To create sufficient **capacity** to ensure that patients who have had their care pathways disrupted are delayed no further, and ensure that all newly referred patients are diagnosed and treated promptly;
- To ensure **equity of access** across the system so that patients are not disadvantaged because of local capacity constraints;
- To build **patient confidence** – patients need to be reassured that their diagnosis and treatment will take place in an environment and manner that is safe.

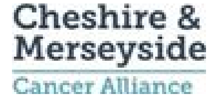
Measure	% of pre-Covid level
2WW referrals*	120%
Cancer surgery activity*	143%
SACT (inc chemo) delivery**	128%

Measure	% of pre-Covid level
Radiotherapy planning**	126%
Radiotherapy treatment**	93%
Endoscopy activity♀	87%

- The sustained increase in SACT continues to present challenges to service delivery, however CCC continues to take the following steps to ensure that demand continues to be met. This includes detailed capacity and demand planning, enabling targeted WLI clinics. Additional SACT nurses are being recruited, however this impact is unlikely to be made for several months due to recruitment and training.

- Radiotherapy planning activity has been approximately 20% higher than pre covid levels for the last 2 months.

- Radiotherapy treatments are lower than 2019/20 and are likely to remain so, due to a change in fractionation in early 2020/2021, which equates to fewer treatments per patient in some tumour groups. They are however the highest compared to the same month in 2019, since June 2021.
- Endoscopy activity had more than doubled between July 2020 (3,300 procedures) and March 2021 (6,600 procedures). Activity remains at around 6,200 procedures. Current activity levels are influenced unusually low reporting from WHH which is not supported in the weekly SITREP reporting. It is estimated that if WHH levels were in line with normal reporting the activity would be around 93% of pre-Covid levels. Further capacity is required in order to clear the backlog of patients on the endoscopy waiting list, which has stabilised. The Alliance has established an endoscopy operational recovery team (EORT) to oversee and co-ordinate restoration activities.



*Data as of 18th October
** Solid tumour only (not inc. Haemato-oncology): reliable Haemato-oncology figures pre covid are unavailable – data as of December 2021
♀Assessment based on monthly DM01 endoscopy returns - latest update November 2021. Activity is used as an indication of capacity.

Summary

Cancer waiting times performance

The latest published 14 day, 28 day and 62 day cancer waiting times performance data relate to **November 2021**.

- The Alliance failed the **14 day standard** for urgent suspected cancer referrals in November, with seven trusts and all CCGs falling below the 93% threshold. The overall performance of the Alliance was 74.1%*, reducing from 82.2%* last month. The England average was 77.4%. CMCA was the 13th best performing Alliance in England out of 19 against this standard.

- The Alliance failed the **28 day standard** for urgent suspected cancer referrals in November (the new standard has now come into force from October 2021), with nine trusts and seven CCGs falling below the 75% threshold. The overall performance of the Alliance was 67.8%*, decreasing from 71.2%* last month. The England average was 71.3%.

- The Alliance failed the **62 day standard**, achieving 75.6%* (increasing from 73.1%* last month) against a standard of 85% (England average was 67.5%). Ten trusts and all nine CCGs failed to meet the 62 day standard. Cheshire and Merseyside is the 2nd best performing Alliance in England out of 19 against this standard.

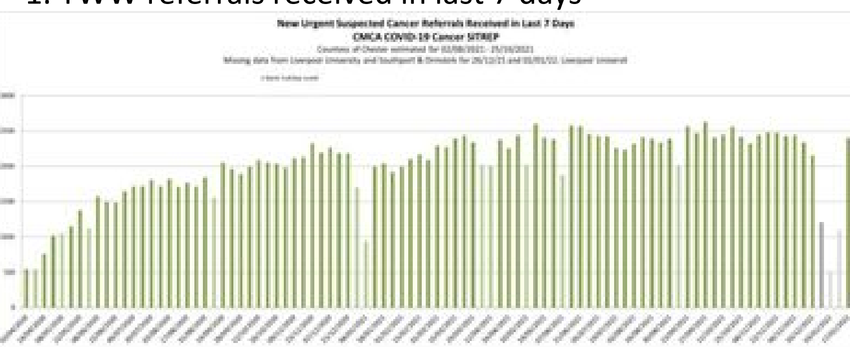
- The number of urgent referral patients waiting **over 62 days** is significantly higher than pre-Covid levels. On 17th January 2021 there were 1,692 patients waiting more than 62 days for a diagnosis or treatment. This has increased from 1,413 reported last month (13th December). Of these, 409 have waited **over 104 days**. This is higher than the 343 patients reported last month.

  The proportion of patients on urgent suspected cancer pathways who have already been on the pathway for over 62 days is in line with the England average.

* Overall figures are based on commissioners within Cheshire and Merseyside.

Section II: Restoration of Cancer Services – Core Metrics

1. TWW referrals received in last 7 days



Referrals high with 2,402 patients referred this week (20% above pre-pandemic weekly average; 17% above same week in 2021).

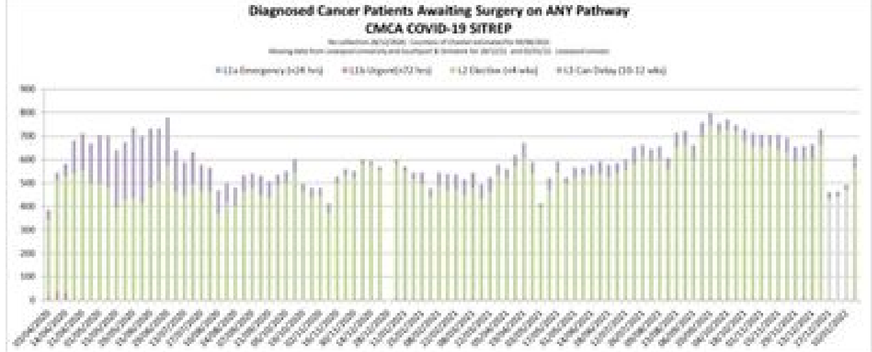
Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. Countess of Chester data estimated for all weeks 02/08/21 to 25/10/21 inclusive. Liverpool Women's Hospital estimated for 13/09/21, 20/09/21. Missing data from LUHFT and Southport & Ormskirk for 26/12/21 & 02/01/22. LUHFT missing data for 09/01/22.

2. Diagnostic backlog (referrals without a DTT)

Currently 10,714 active patients (of which 19 are suspended). This 34% above the same week in 2021.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. Countess of Chester data estimated for 9/08/21. LWH estimated for 13/09/21, 20/09/21. Missing data from LUHFT and S&O for 26/12/21 & 02/01/22. LUHFT missing data for 09/01/22.

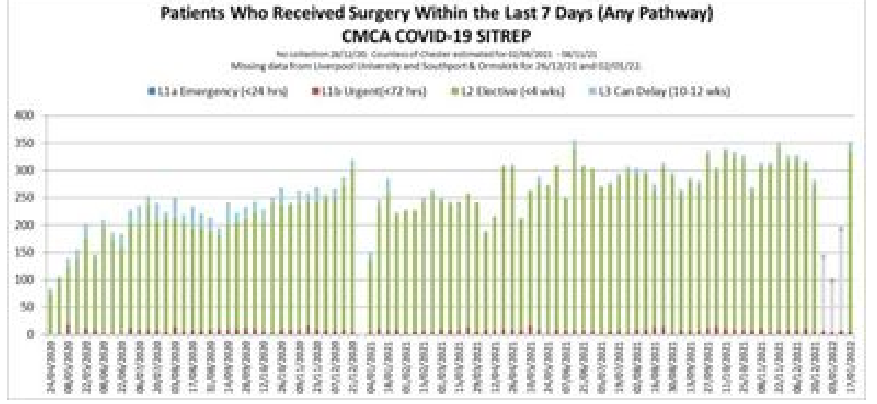
3. Cancer patients awaiting surgery



620 patients with a surgical DTT. 563 at L1&L2 and 57 at L3.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. Countess of Chester data estimated for 09/08/21. Liverpool Women's Hospital estimated for 13/09/21, 20/09/21. Missing data from LUHFT and Southport & Ormskirk for 26/12/21 & 02/01/22. LUHFT missing data for 09/01/22.

4. Cancer surgery performed in last 7 days

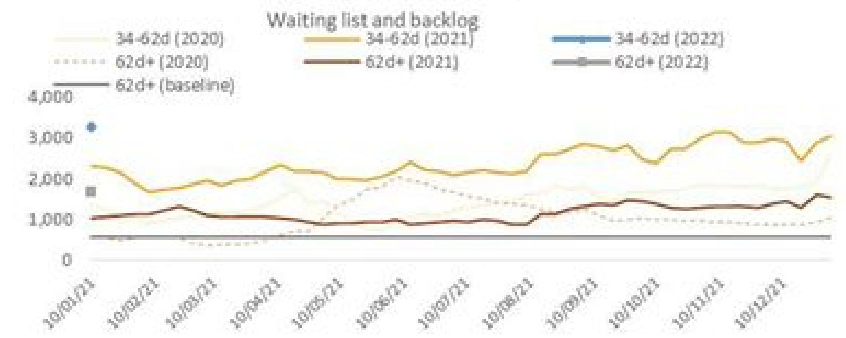


350 cancer operations performed last week.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. Countess of Chester data estimated for 02/08/21 to 13/12/21 inclusive. LWH estimated for 13/09/21, 20/09/21. Missing data from LUHFT and S&O for 26/12/21 & 02/01/22. LUHFT missing data for 09/01/22.

Restoration of Cancer Services – Core Metrics

5. Patients waiting over 62 days

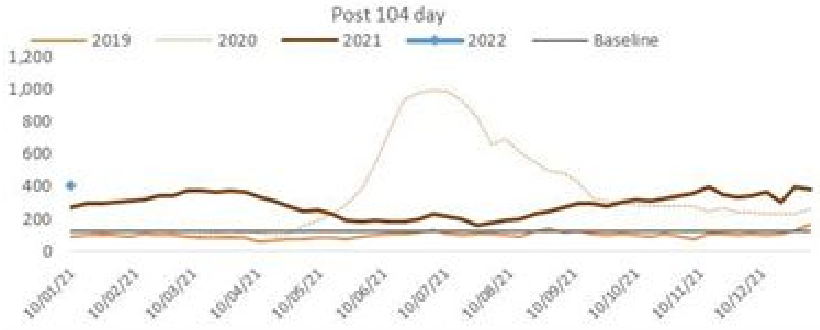


1,692 patients have waited over 62 days

- Higher than 1,541 patients last week and higher than 1,073 this week in 2021

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. Also, waiters with non-specific symptoms are not included in these national data. No data for Wirral 04/04/2021; Mid Cheshire 25/07/2021, Countess of Chester 01/08/2021 and 08/08/2021. No data for Warrington & Halton and Wirral 19/12/21.

6. Patients waiting over 104 days



409 patients have waited over 104 days

- Higher than 380 patients last week and higher than 297 this week in 2021

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. Also, waiters with non-specific symptoms are not included in these national data. No data for Wirral 04/04/2021; Mid Cheshire 25/07/2021, Countess of Chester 01/08/2021 and 08/08/2021. Value for Southport & Ormskirk 14/11/2021 incorrectly reported as 34 instead of 3. No data for Warrington & Halton and Wirral 19/12/21.

7. Endoscopy waiting list

Endoscopy waiting list increased to 11,630 patients.

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. No data from East Cheshire or Mid Cheshire 14/12/20; No collection 21/12/20. Aintree estimated for 01/02/21, 03/05/21, 21/06/21. Aintree and Royal estimated for 24/05/21. Warrington and Halton estimated for 31/05/21 and 11/10/21. Southport and Ormskirk estimated for 05/07/21 and 06/09/21. Countess of Chester estimated for 26/07/21 to 20/12/21 inclusive. Warrington & Halton estimated for 20/12/21. Wirral estimated for 06/01/22.

8. Endoscopy activity

Activity increased with 1,613 patients seen (new year BH week).
New additions increased with 1,077 patients added (BH week).

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. No data from East Cheshire or Mid Cheshire 14/12/20; No collection 21/12/20. Aintree estimated for 01/02/21, 03/05/21, 21/06/21. Aintree and Royal estimated for 24/05/21. Warrington and Halton estimated for 31/05/21 and 11/10/21. Southport and Ormskirk estimated for 05/07/21 and 06/09/21. Countess of Chester estimated for 26/07/21 to 13/12/21 inclusive. Warrington & Halton estimated for 20/12/21. Wirral estimated for 06/01/22.

Cheshire & Merseyside
Cancer Alliance

9. Patients waiting between 63 and 103 days by provider

PTL data from W/E 09 January

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total
Bridgewater															
Clatterbridge						7							9		31
Countess Of Chester		23	9		16	152					14	24			251
East Cheshire		14				39							6		66
Liverpool Foundation Trust		32			17	251					10	81	31		431
Liverpool Heart & Chest															
Liverpool Women's			22												22
Mid Cheshire						73						13			101
Southport & Ormskirk			45			86		16			22	13	17		203
St Helens & Knowsley					9	61					8	8	11		104
Walton Centre															
Warrington & Halton			5			12							9		30
Wirral						22							16		48
Grand Total		**79**	**97**	**10**	**49**	**703**	**10**	**16**			**64**	**149**	**114**		**1,299**

Tables from national Cancer PTL

10. Patients waiting over 104 days by provider

PTL data from W/E 09 January

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total
Bridgewater											6				6
Clatterbridge															
Countess Of Chester			8		6	59						7	5		89
East Cheshire						6									12
Liverpool Foundation Trust		9			8	98						32	9		164
Liverpool Heart & Chest															
Liverpool Women's			10												10
Mid Cheshire						11									
Southport & Ormskirk			23			23									54
St Helens & Knowsley						21							5		34
Walton Centre															
Warrington & Halton															
Wirral						9							5		14
Grand Total		**14**	**47**		**19**	**230**					**15**	**44**	**30**		**409**

From 29 November 2020, data source changed from CMCA SITREP to national weekly PTL

- Data no longer split out for acute leukaemia or testicular
- New data for non site specific symptoms referrals (not included in national totals in graphs 5 and 6)

= fewer than 5 patients or hidden to prevent disclosure

= No PTL submission this week,

Restoration of Cancer Services – Core Metrics

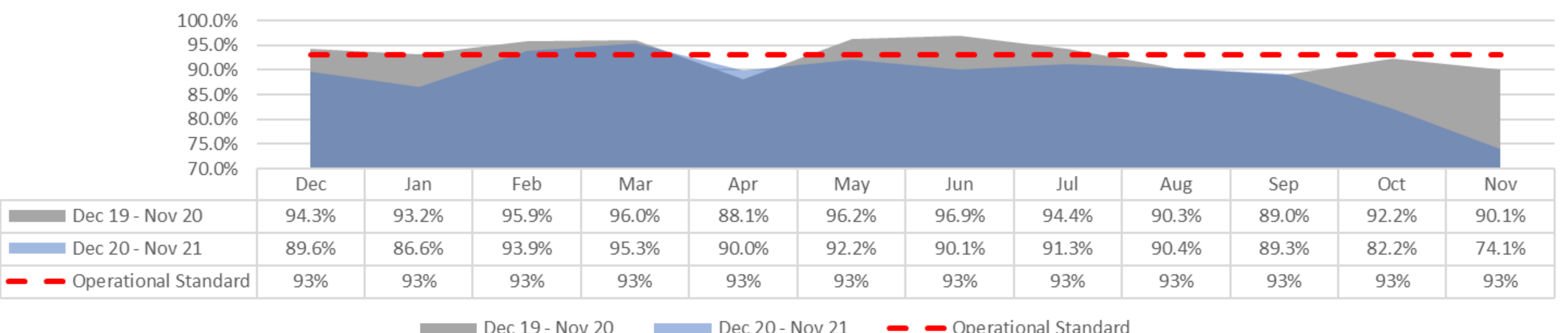
There are currently 11,630 patients waiting for an endoscopy. 5,786 have waited more than six weeks, and of these 3,217 have waited 13 or more weeks (28% of the total).

There is significant variation across units, with CoCH, LUFT & Southport and Orskirk, having the greatest proportion of their waiting list made up of patients waiting 13 weeks or more (43%, 40%, 37% respectively).

Endoscopy (cancer and non-cancer pathways)

Endoscopy data at 03 January 2022

Section II: 14 day standard



	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Dec 19 - Nov 20	94.3%	93.2%	95.9%	96.0%	88.1%	96.2%	96.9%	94.4%	90.3%	89.0%	92.2%	90.1%
Dec 20 - Nov 21	89.6%	86.6%	93.9%	95.3%	90.0%	92.2%	90.1%	91.3%	90.4%	89.3%	82.2%	74.1%
Operational Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

In November 2021, 74.1% of patients were seen within 2 weeks compared to 82.2% in the previous month. This is below the national target.

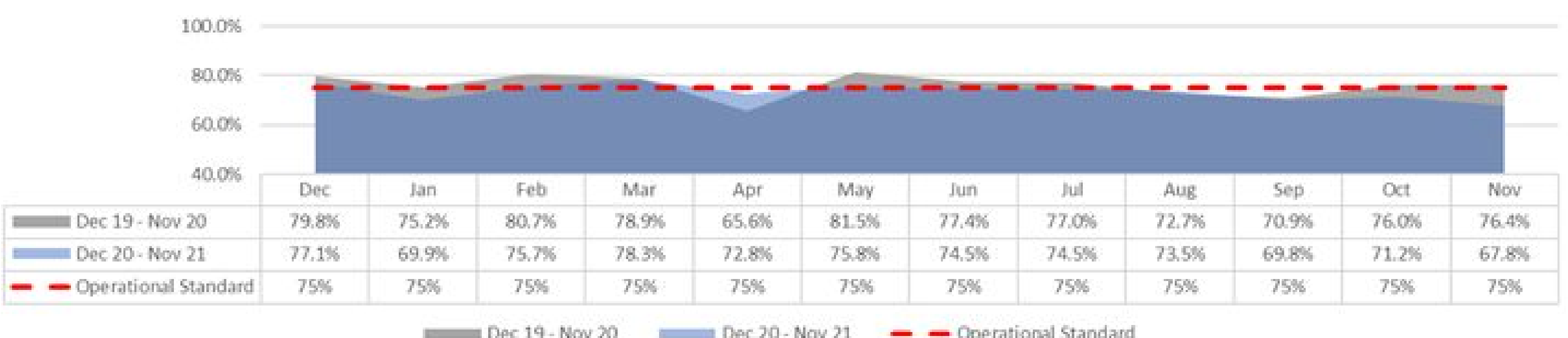
Providers not achieving the national operational standard were:

- Countess Of Chester Hospital 57% (613 breaches)
- East Cheshire 59.1% (284 breaches)
- Liverpool University Hospitals 65% (1240 breaches)
- St Helens and Knowsley Hospitals 73.9% (550 breaches)
- Warrington and Halton Teaching Hospitals 75.7% (264 breaches)
- Southport and Ormskirk Hospital 78.5% (266 breaches)
- Mid Cheshire Hospitals 79% (310 breaches)
- Wirral University Teaching Hospital 87.9% (242 breaches)

CCGs not achieving the national operational standard were:

- NHS Southport and Formby 62.8% (292 breaches)
- NHS Cheshire 69.7% (1162 breaches)
- NHS Liverpool 71.4% (717 breaches)
- NHS South Sefton 72.4% (263 breaches)
- NHS Knowsley 73.8% (237 breaches)
- NHS St Helens 74.8% (293 breaches)
- NHS Halton 76% (163 breaches)
- NHS Warrington 79.6% (214 breaches)
- NHS Wirral 87.8% (233 breaches)

Section II: 28 day standard



	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Dec 19 - Nov 20	79.8%	75.2%	80.7%	78.9%	65.6%	81.5%	77.4%	77.0%	72.7%	70.9%	76.0%	76.4%
Dec 20 - Nov 21	77.1%	69.9%	75.7%	78.3%	72.8%	75.8%	74.5%	74.5%	73.5%	69.8%	71.2%	67.8%
Operational Standard	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

The 28 day FDS standard is now live at 75%. In November 2021, 67.8% of patients were diagnosed or ruled out within 28 days compared to 71.2% in the previous month. This is below the national target.

Providers not achieving the expected standard were:

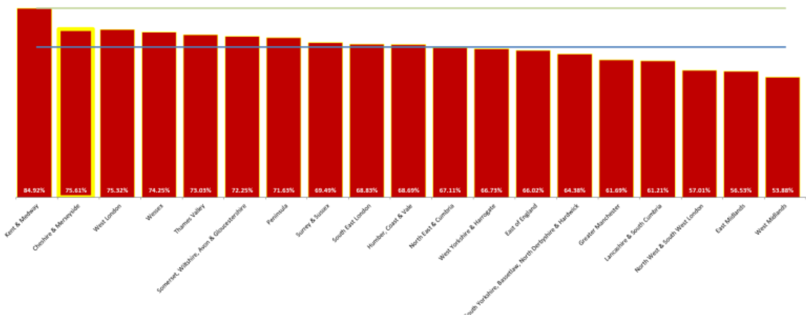
Countess Of Chester Hospital 43.3% (732 breaches)
Liverpool Heart And Chest 48% (13 breaches)
Bridgewater Community Healthcare 62% (79 breaches)
Liverpool University Hospitals 66.9% (1203 breaches)
St Helens and Knowsley Hospitals 74% (538 breaches)
East Cheshire 46% (400 breaches)
Liverpool Womens 60.5% (143 breaches)
Southport and Ormskirk Hospital 66.1% (366 breaches)
Mid Cheshire Hospitals 72.2% (412 breaches)

CCGs not achieving the expected standard were:

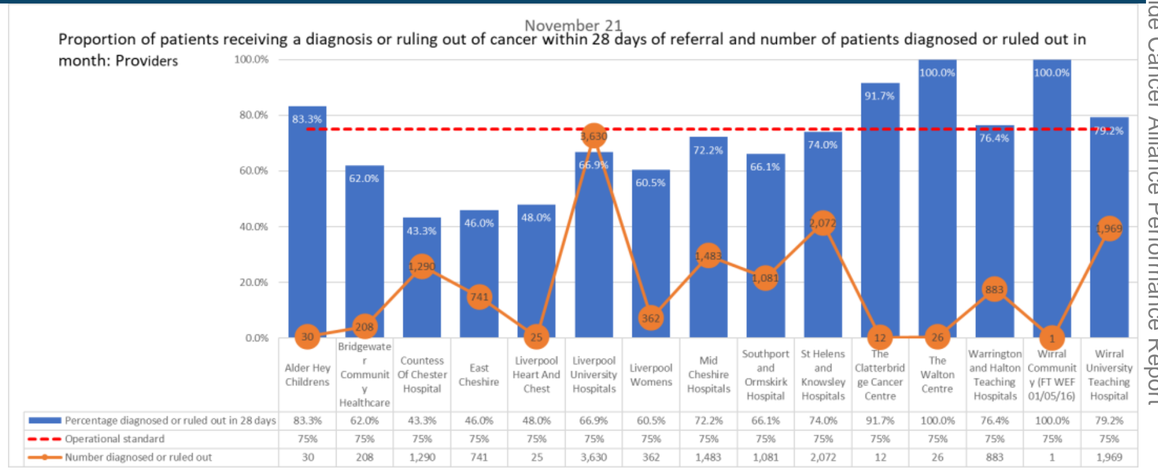
Cheshire 58.9% (1530 breaches)
Southport And Formby 64.4% (277 breaches)
Liverpool 69.3% (747 breaches)
St Helens 73.2% (313 breaches)
South Sefton 63.7% (353 breaches)
Knowsley 69.2% (284 breaches)
Warrington 71.7% (249 breaches)
Halton 74.5% (160 breaches)

Section III: 62 Day Standard

62 Day Performance by Cancer Alliance – CCG based (November 2021)



CMCA achieved 75.6% against a standard of 85%.
CMCA was the second best performer. The England average was 67.5%

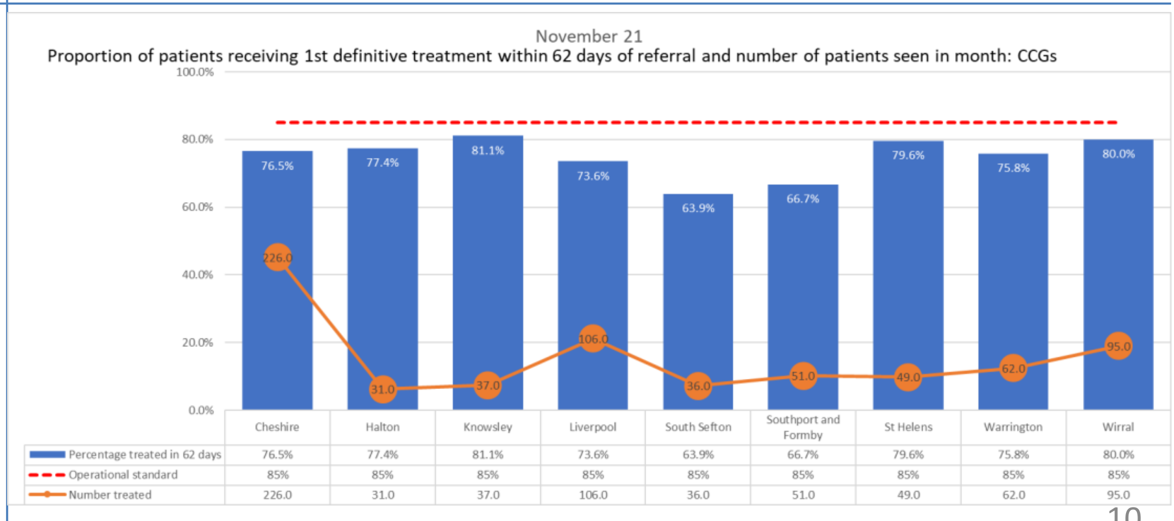


	Alder Hey Childrens	Bridgewater Community Healthcare	Countess Of Chester Hospital	East Cheshire	Liverpool Heart And Chest	Liverpool University Hospitals	Liverpool Womens	Mid Cheshire Hospitals	Southport and Ormskirk Hospital	St Helens and Knowsley Hospitals	The Clatterbridge Cancer Centre	The Walton Centre	Warrington and Halton Teaching Hospitals	Wirral Community (FT WEF 01/05/16)	Wirral University Teaching Hospital
Percentage diagnosed or ruled out in 28 days	83.3%	62.0%	43.3%	46.0%	48.0%	66.9%	60.5%	72.2%	66.1%	74.0%	91.7%	100.0%	76.4%	100.0%	79.2%
Operational standard	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
Number diagnosed or ruled out	30	208	1,290	741	25	3,630	362	1,483	1,081	2,072	12	26	883	1	1,969

Most Challenged Pathways (November 2021)

Cancer pathways not achieving the national objective were:

Lower Gastrointestinal 42.6% (35 breaches)
Haematological (Excluding Acute Leukaemia) 42.9% (12 breaches)
Head & Neck 46.2% (14 breaches)
Gynaecological 48.8% (22 breaches)
Upper Gastrointestinal 59.5% (15 breaches)
Other 71.4% (2 breaches)
Urological (Excluding Testicular) 72.4% (32 breaches)
Breast 81% (16 breaches)
Lung 81.3% (9 breaches)



	Cheshire	Halton	Knowsley	Liverpool	South Sefton	Southport and Formby	St Helens	Warrington	Wirral
Percentage treated in 62 days	76.5%	77.4%	81.1%	73.6%	63.9%	66.7%	79.6%	75.8%	80.0%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	226.0	31.0	37.0	106.0	36.0	51.0	49.0	62.0	95.0

Report prepared by Jenny Hampson
Performance Information Analyst
jenny.hampson@nhs.net

Cheshire & Merseyside
Cancer Alliance

Dr Liz Bishop
Senior Responsible Officer
liz.bishop1@nhs.net

Jon Hayes
Managing Director
jon.hayes1@nhs.net

General enquiries: ccf-tr.admin.cmca@nhs.net

www.cmcanceralliance.nhs.uk

Cheshire and Merseyside Cancer Alliance is an NHS organisation that brings together NHS providers, commissioners, patients, cancer research institutions and voluntary & charitable sector partners to improve cancer outcomes for our local population.

Cheshire & Merseyside
Cancer Alliance

Cancer Inequalities in Cheshire and Merseyside: *Second Report*

January 2022

Version 1

Contents

i. Introduction
ii. The impact of COVID-19 on cancer inequalities
iii. Our approach to addressing cancer inequalities in C&M

Section I: Introduction

Cheshire and Merseyside Cancer Alliance published its first report on the impact of COVID-19 on cancer health inequalities in July 2021. That report explored available data to assess the impact of the pandemic on suspected cancer referrals and treatments for new cancers in the 12 months following the start of the first national lockdown, analysed by geography, tumour group, age, gender, deprivation and ethnicity. It showed that there had been a significant increase in inequities particularly in relation to a reduction in referrals from the most deprived neighbourhoods and amongst the elderly.

This second report considers an additional six months' worth of data, and includes new intelligence, such as data relating to the stage of disease at the time of diagnosis, which was not mature enough to be considered in the first report. It shows that many of the inequities highlighted in the first report are still evident, but the impact is flattening out as time progresses.

This new report also looks to the future, setting out in more detail the Alliance's approach to tackling health inequalities in cancer, including those inequalities that existed before the impact of COVID-19.

The impact of COVID-19 on cancer inequalities - Summary

In Cheshire and Merseyside:

- The impact of the COVID-19 pandemic has been greater on referrals than first treatments.
- Referral and first treatment rates have rebounded and are now above pre-pandemic levels.
- However, the cumulative impact on both referrals and treatments is still evident.
- The impact upon referrals was disproportionate in terms of gender, deprivation and age:
  - Men more affected than women
  - People living in the most deprived neighbourhoods more affected than those in less deprived neighbourhoods
  - Older people more affected than younger people
- First treatments showed no significant inequity in terms of age, deprivation, gender or ethnicity.
- Routes to diagnosis have returned to pre-pandemic norms.
- There is currently no evidence of a statistically significant shift in the stage of disease at diagnosis.

Section II:
The impact of COVID-19 on cancer inequalities

Cheshire & Merseyside
Cancer Alliance

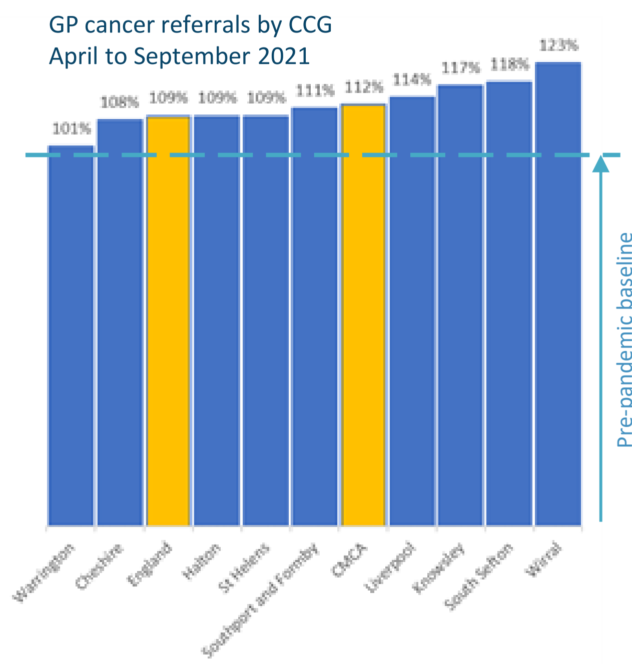
In this section we compare data relating to urgent suspected cancer referrals, treatments for new cancers, and the stage of disease at the point of diagnosis in the period immediately before the COVID-19 pandemic with data from various periods in the 18 months thereafter.

Cancer referrals

Urgent suspected cancer referrals reduced by over 70% in the first weeks of the first national lockdown but then fully recovered by September 2020. The number of patients seen following an urgent suspected cancer GP referral more recently, between April and September 2021 was 12% higher than between April and September 2019. This was a larger increase than in England as a whole, where referrals rose by 9%.

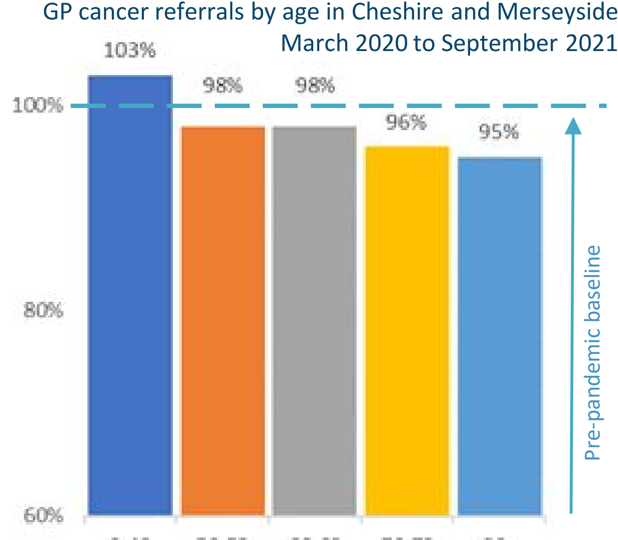
However, there was variation by CCG area, with Wirral seeing the greatest rise in referrals (23%) and Warrington witnessing little change (1% increase).

Halton CCG, which experienced the largest reduction in referrals in the first 12 months of the pandemic (between April 2020 and March 2021) of all Cheshire and Merseyside CCGs, saw referrals rise by 9% (the same as the national average) during April and September 2021 above the same period in 2019.



Variation was also seen at tumour level. Urgent GP referrals for suspected urological, lung and haematological cancers in the first six months of 2021/22 were 8 to 9% below the numbers received in the first six months of 2019/20. All other common tumour groups had referrals above pre-pandemic levels. The greatest rise in referral levels were for suspected lower and upper gastrointestinal cancers (increases of 23% and 19% respectively).

The cumulative impact of the pandemic can be seen through a comparison of the period from March 2020 to September 2021 to a pre-pandemic baseline period (using the equivalent months from March 2019 to February 2020). This shows that the impact (cumulative reduction) of referrals was greatest in the most deprived areas (Quintile 5). Referrals have now increased above pre-COVID-19 levels for all deprivation quintiles.



The cumulative impact on referrals increased with age. Between March 2020 and September 2021, referrals for patients under 50 rose by 3%, whereas there was a 5% reduction in referrals for patients 80+ compared with the pre-pandemic baseline.

Between March 2020 and September 2021 the cumulative impact on referrals for males was significantly greater than for females. Compared with the pre-pandemic baseline, male referrals fell by 5%, but female referrals rose by 1%.

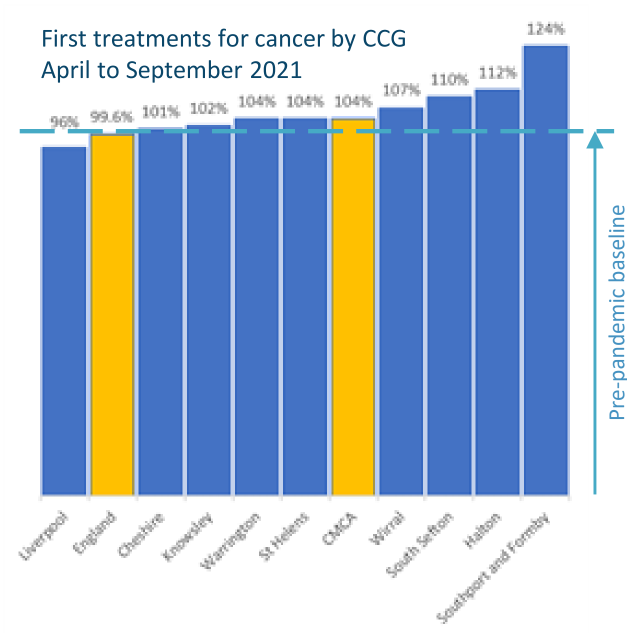
The impact of the pandemic on referrals for patients from different ethnic backgrounds is more difficult to assess due to small numbers in some communities. The cumulative impact during the period March 2020 to September 2021 was a 2% reduction in referrals for individuals identifying as white British, compared to a 3% increase in referrals for patients from diverse ethnic groups.

Whilst the impact of the pandemic is still evident in these cumulative data, referrals have now increased above pre-pandemic levels for all ages, gender, and all ethnic groups. Over time, the inequalities exacerbated by the pandemic are being flattened out.

First treatments

The number of patients treated for a new cancer in Cheshire and Merseyside was 3.9% higher in April to September 2021, compared to April to September 2019. This is in contrast to England as a whole, where the number of first treatments was 0.4% lower than before.

There was variation at CCG-level, with the greatest rise being in Southport and Formby (24%). Only Liverpool CCG saw a reduction in first treatments between April and September 2021 compared to the same period in 2019 (4% reduction).



During the same period, first treatments for skin, lower gastrointestinal and gynaecological cancers were significantly higher (21%, 16% and 9% respectively), whereas treatments for urological, head & neck and breast cancers were lower (by 5%, 4% and 4% respectively).

The referral routes leading to a first treatment between April and September 2021 were very similar to those between April and September 2019. In both periods, half of all treatments were the result of an urgent GP cancer referral. In the first few months of the crisis, most cancer screening programmes were paused, but data from April to September 2021 show that referrals from the screening programmes accounted for 7% of first treatment, which is the same proportion as was seen in 2019.

From April 2021 onwards, first treatment level have been similar to pre-pandemic levels across all deprivation quintiles. However the legacy of the early phase of the crisis can still be seen in the cumulative data from March 2020 to September 2021, which shows a disproportionate impact upon patients from the most deprived neighbourhoods. Curiously, patients from the second most deprived neighbourhoods were impacted the least. However, it should be noted that the differences between the quintiles in Cheshire and Merseyside are not statistically significant.

As of September 2021, the proportional impact of the pandemic on first treatments shows no clear pattern in relation to age, gender or ethnicity.

Stage of disease

Outcomes for patients treated for early stage cancers are significantly better than for those whose disease has progressed. The NHS Long Term Plan ambition for cancer is for 75% of cancers to be diagnosed at an early stage (stage I or II) by 2028. Nationally published staging data is currently available up to and including 2018. At that time, 53.0% of patients in Cheshire and Merseyside were diagnosed at stages I or II compared with 53.9% for England as a whole.

Unpublished, rapid cancer registration data (RCRD) is now available up to and including 2020 to NHS staff to assist with assessing the impact of the COVID-19 pandemic. These data are provisional, and have not been through the rigorous quality checks required for publication. When the Cancer Alliance produced its first report into the impact of COVID-19 in July 2021 the RCRD was too incomplete to be appropriately interpreted. Six months on, the dataset has matured and, albeit tentatively, conclusions can be drawn.

RCDC data for Cheshire and Merseyside suggest that the proportion of patients diagnosed at an early stage in 2020 was statistically similar to 2018 and 2019.

Section III:

Our approach to addressing cancer inequalities in Cheshire and Merseyside

Cheshire & Merseyside Cancer Alliance

Cheshire & Merseyside Cancer Alliance brings together organisations, patients and others affected by cancer to drive improvements in clinical outcomes and patients' experience of the care and treatment they receive.

We aim to achieve:

- **Better cancer services**, by providing access to expertise and learning; leading change in care pathways, and in piloting new scientific innovations.
- **Better cancer care**, by sharing and building on good patient experience practice.
- **Better cancer outcomes**, by increasing early detection, early diagnosis, enabling early access to cancer services and pathways, and ensuring cancer patients have access to the support they need to live long fulfilling lives beyond cancer.

To achieve these three aims it is essential that we are focussed on, and committed to, addressing health inequalities on all levels.

We know that there are health inequalities when comparing Cheshire and Merseyside's cancer outcomes with other regions in England. Our population has higher rates of cancer incidence and mortality that the England average, and there is a need to speed up our rate of improvement to close the gap. We also know that there are inequalities within our own population, with deprivation being not the only, but probably the biggest, pre-existing (i.e. pre-COVID) cause of variation.

Over the course of the last 18 months, the Cancer Alliance has developed its thinking and approach to addressing inequalities. We are now clear that we will not close the gap by simply addressing inequalities at the point of access to health services, as has been, perhaps, the traditional NHS approach. We need to work with communities and partner organisations to address – indeed prevent – inequalities upstream, as well as when they are observed in NHS services.

With support from Macmillan, the Cancer Alliance has established a new team focussing specifically on patient experience and health inequalities. The team members are facilitators, supporting and enabling others to identify and resolve inequalities, rather than being solely responsible themselves. This approach will help to embed a culture of awareness throughout the Alliance's work programme. Ultimately, all decisions that the Alliance makes on the deployment of resources should be made on the basis of reducing inequity.

Improvement is all about partnerships. Coordinated action, based on sound evidence and informed by people from within the communities themselves, is key. The Alliance works closely with the Directors of Public Health through the Champs Public Health Collaborative, and is a key stakeholder in developing the C&M Marmot Community.

Marmot Community

In 2021, University College London's Institute of Health Equity, headed by Professor Sir Michael Marmot, was commissioned by the Cheshire and Merseyside Health & Care Partnership and the Directors of Public Health to support the reduction of health inequalities through action on the social determinants of health.

Cheshire and Merseyside Cancer Alliance has been closely involved in the development of the Marmot Community from the outset and is represented on the Advisory Board.

The Community involves organisations outside the health care system which have an impact on health – including local government, public services, business, the voluntary and community sector, and the public. These partnerships are vital for reducing health inequalities but are often difficult to establish and sustain, due to different priorities, lack of resources, and different ways of working. Aligning different sectors and organisations' priorities, budgets, levers, and incentives is an essential next step for Cheshire and Merseyside and there is great ambition to achieve this. The development of the Integrated Care Board in Cheshire and Merseyside provides an opportunity to forge a system which generates greater health equity in the region based on partnerships with other sectors.

https://www.champspublichealth.com/wp-content/uploads/2021/10/Briefing-Note-Institute-of-Health-Equity-FINAL.pdf

In parallel to our involvement in the Marmot Community and focus on the wider determinants of health, the Cancer Alliance has developed a comprehensive health inequalities strategy based around nine locally-developed pillars, namely:

1. Understanding health inequity
2. Building confidence and awareness amongst staff
3. Adapting processes
4. Accessibility to information
5. Building a community against cancer
6. Sharing individual experience
7. Sharing group experience
8. Making health inequalities everyone's business
9. Creating and sharing resources

These CMCA pillars are described in the appendix. In short, the aims are to make inequalities visible (we can't tackle what we can't see), and ensure that everyone has the skills, confidence and commitment to address them on a daily basis.

The Alliance has set aside a dedicated budget to support the delivery of its health inequalities strategy.

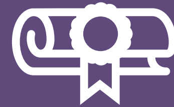
Appendix: The Nine Pillars of CMCA's Health Inequalities Strategy

1. Understanding Health Inequity

Ensuring access to good quality intelligence so we can 'see' and understand inequity in order to address it.

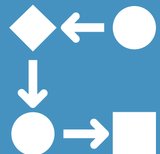
We will build a greater range of reliable data sources and link in with initiatives such as CIPHA.

2. Building Confidence and Awareness



Delivering a mandatory three hour workshop to all CMCA staff to shift perception. Possible offer to roll out to other NHS organisations. Will form part of the Cancer Academy to ensure HI awareness is built into all training programmes. Training on HI added to advance communications skills for cancer support workers.

3. Adapting Process

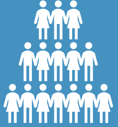


Adapting the Alliance's programme management office (PMO) and governance frameworks to ensure that all projects and programmes are 'hard wired' to address inequalities.

4. Accessibility to Information

Ensuring all patient/public facing materials from the Alliance are accessible, including being available in five languages, easy read and British Sign Language. The Alliance has set aside a budget to support this.

5. Building a Community Against Cancer

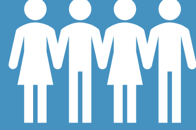


Working with over 200 organisations in Cheshire and Merseyside to become affiliated through a *foundation of engagement.* This community against cancer asks community groups to commit to a range of offers, from sharing social media to co-producing services.

6. Sharing Individual Experience

Recording the stories of individuals whose lives have been impacted by cancer to form a patient experience library. From one minute statements, to whole stories, podcasts and quotes, we will bring the experience of patients and their carers to life.

7. Sharing Group Experience



Developing a resource of experiences shared by groups with protected characteristics, through videos made by local communities and support groups.

8. Making Health Inequalities Everyone's Business

The Alliance's Health Inequalities Team work as facilitators, encouraging and skilling staff to listen to communities, patients and support groups, and to work with them to address inequity.

9. Creating and Sharing Resources

https://www.cmcanceralliance.nhs.uk/work/patient-experience-and-health-inequalities

The Alliance will maintain a library of resources. Current examples:

- National Cancer Patient Experience Survey Toolkit
- Quality of Life Survey Toolkit
- Religion and Cancer Reference
- Barriers by Protected Characteristic
- Resources by Protected Characteristic

Online resources

Online resources designed to support healthcare professionals in tackling health inequality can be found on the Cheshire and Merseyside Cancer Alliance website.

www.cmcanceralliance.nhs.uk

Patient Experience and Health Inequalities

Resources to address health inequalities

Acknowledgements:
Jenny Hampson, Performance Information Analyst, CMCA
Jo Trask, Macmillan Patient Experience and Health Inequalities Manager, CMCA
Ellie Gunner-Taylor, Macmillan Patient Experience and Health Inequalities Officer, CMCA

Dr Liz Bishop
Senior Responsible Officer
liz.bishop1@nhs.net

Jon Hayes
Managing Director
jon.hayes1@nhs.net

General enquiries: ccf-tr.admin.cmca@nhs.net

www.cmcanceralliance.nhs.uk

Cheshire and Merseyside Cancer Alliance is an NHS organisation that brings together NHS providers, commissioners, patients, cancer research institutions and voluntary & charitable sector partners to improve cancer outcomes for our local population.

REPORT COVER

Report to:	Board of Directors	
Date of meeting:	Wednesday 26th January 2022	
Agenda item:	P1-23-22	
Title:	BAF Risks – Quarter 3	
Report prepared by:	Emily Kelso – Corporate Governance Manager	
Executive Lead:	Liz Bishop – Chief Executive	
Status of the report: (please tick)	Public ☐	Private ☒

Paper previously considered by:	Audit Committee - October 2021
Date & decision:	

Purpose of the paper/key points for discussion:	The following paper illustrates the Board Assurance Framework, with an update on Controls and Mitigations, Assurance/Evidence and Gaps in Controls/Assurances to reflect the Quarter 3 position of each of the risks and their associated scoring. The scoring for the majority of the BAF Risks remain static since Quarter 2, with four exceptions: Note: **L** is Likelihood and **C** is Consequence • BAF Risk 3 has increased to from 12 (3Lx4C), **16 (4Lx4C)** given the continued uncertainty around the ERF. • BAF Risk 5 has reduced from 15 (3Lx5C) to **12 (3Lx4C).** The Trust is assured of the controls in place to mitigate impact and also the continued progress against the research strategy. • BAF Risk 8 has increased from 9 (3Lx3C) to **12 (4Lx3C)** due to the upcoming workforce challenges • BAF Risk 11 has increased from12 (3Lx4C) to **16 (4Lx4C)** following the global vulnerability known as Apache Foundation Log4j 2 vulnerability (CVE-2021-44228), Identified in December 2021. The Board has agreed that BAF reporting would be presented quarterly as opposed to bi-monthly to Board Committees and Trust Board from January 2022. Executive Directors are responsible for monitoring completion of actions under BAF Risks. Meetings take place quarterly with Executive Risk owner and the Corporate Governance Team to update individual BAF risk reports, these updates are reflected within the report and are highlighted in yellow.

Action required: (please tick)	Discuss	☒
	Approve	☐
	For information/noting	☒

Next steps required:	

Version 1.0 Ref: FCGOREPCOV Review: May 2024

REPORT COVER

The paper links to the following strategic priorities and Board Assurance Framework (BAF) Risks (please select)

☐ BE **OUTSTANDING**

BAF Risk	Please select
If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	☐
Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	☒
Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☒

☐ BE **COLLABORATIVE**

BAF Risk	Please select
If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	☒

☐ BE **RESEARCH LEADERS**

BAF Risk	Please select
If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	☒
Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	☐

☐ BE **A GREAT PLACE TO WORK**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☐
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	☐
If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	☐

☐ BE **DIGITAL**

BAF Risk	
If we do not invest a clear vision, sufficient capacity and investment6 in our digital programme and teams there is a risk that the Trust will not achieve its digital ambition.	☒
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	☒

☐ BE **INNOVATIVE**

BAF Risk	
If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	☒

EQUALITY & DIVERSITY IMPACT ASSESSMENT								
Are there concerns that the policy/service could have an adverse impact on:								
Age	Yes ☐	No ☒	Disability	Yes ☐	No ☒	Gender	Yes ☐	No ☒
Race	Yes ☐	No ☒	Religious/belief	Yes ☐	No ☒	Sexual orientation	Yes ☐	No ☒
Gender Reassignment	Yes ☐	No ☒	Pregnancy/maternity	Yes ☐	No ☒			

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

Version 1.0 Ref: FCGOREPCOV Review: May 2024

Risk Appetite Statement 2021

The Clatterbridge Cancer Centre NHS Foundation Trust recognises that its long term sustainability depends upon the delivery of Strategic Priorities and ambitions in addition to its relationships with service users, staff, public, regulators and strategic partners. As such, The Clatterbridge Cancer Centre NHS Foundation Trust will not accept risks that materially provide a negative impact on patient safety.

In contrast, The Clatterbridge Cancer Centre NHS Foundation Trust has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust has a greater appetite to pursue partnerships, commercial gain and clinical innovation in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment; this includes the development of our Subsidiary Companies. In addition, in pursuit of its Strategic Priorities, The Clatterbridge Cancer Centre NHS Foundation Trust is willing to accept, in some limited circumstances, risks that may result in some limited financial loss or exposure.

BAF Summary								
BAF ID	**Risk**	**Owner**	**Oversight Committee**	**Q1 2021/22**	**Q2 2021/22**	**Q3 2021/22**	**Target Risk**	**Risk Appetite**
B1	If we do not have robust Trust-wide quality and clincial governance arrangments in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	CN/MD	Quality Committee	**3x4=12 ↔**	**3x3=9↓**	**3x3=9 ↔**	2x1=2	Regulatory compliance, patient safety: **Low (4-8)**
B2	Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against heatlhcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	COO	Quality Committee & Performance Committee	**3x3=9 ↔**	**3x3=9 ↔**	**3x3=9 ↔**	2x2=4	Contractual and regualtory compliance: **Low (4-8)**
B3	Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	DofF	Performance Committee	**3x4=12 ↑**	**3x4=12 ↔**	**4x4 =16↑**	2x2=4	Financial: **Low (4-8)**, but in limited circumstances **Moderate (9-12)**
B4	If we do not build upon the work with the Cancer Alliance and other partners, this will adversely affect the Trust's ability to positivley influence prevention, early diagnosis, standardisation of care and performance in cancer care services.	CEO/DofS	Performance Committee	**3x4=12 ↔**	**3x4=12↔**	**3x4=12↔**	2x4=8	Partnerships: **Moderate (9-12)**
B5	If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Reserach Strategy and academic oncology in Liverpool.	MD	Quality Committee & Performance Committee.	**3x5=15↔**	**3x5=15↔**	**3x4=12↓**	2x4=8	Patient experience: **Low (4-8);**
B6	Issues within Pharmacy Aseptic Unit adversely impacting on the manufacturing and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan, adversely impacting on patient accessibility to research and reputational damage with Sponsors.	MD	Quality Committee	**3x5=15↔**	**3x3=9↓**	**3x3=9 ↔**	2x2=4	Patient experience: **Low (4-8)**;
B7	If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	Dof W&OD	Quality Committee	**3x4=12↔**	**3x4=12↔**	**3x4=12↔**	2x3=6	Workforce: **Low (4-8)**
B8	If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	Dof W&OD	Quality Committee	**3x3=9↓**	**3x3=9↔**	**4x3 = 12↑**	2x3=6	Workforce: **Low (4-8)**
B9	if we do not support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	DofW&OD	Quality Committee	**3x3=9↓**	**3x3=9↔**	**3x3=9↔**	2x3=6	Workforce: **Low (4-8)**
B10	If we do not invest a clear vision, sufficeint capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve it's digital ambition.	CIO	Performance Committee & Quality Committee	**3x3=9↔**	**3x3=9↔**	**3x3=9↔**	2x2=4	Digital: **Low (4-8)**

B11	If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	CIO	Performance Committee & Quality Committee	**3x4=12↔**	**3x4=12↔**	**4x4 =16↑**	3x3=9	Digital: **Low (4-8)**
B12	If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	DofF	Performance Committee	**4x3=12↔**	**4x3=12↔**	**4x3=12↔**	2x3=6	Commercial and Partnership working: **Moderate (9-12)**

Strategic Priority	BAF ID	Risk	Risk Owner	Committee Oversight	Initial Risk Score			Q1 Risk Score			Q2 Risk Score			Q3 Risk Score			Target Risk Score		
					L	C	Score	L	C	Score	L	C	Score	L	C	Score	L	C	Score
Be Outstanding: which means that we will deliver safe, high quality care and outstanding operational and financial performance	**B1**	If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	CN/MD	Quality Committee	4	3	12	4	3	12↔	3	3	9↓	3	3	9↔	2	1	2
	B2	Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	COO	Quality Committee & Performance Committee	3	3	9	3	3	9↔	3	3	9↔	3	3	9↔	2	2	4
	B3	Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	DofF	Performance Committee	3	3	9	3	4↑	12↑	3	4↔	12↔	4	4	16 ↑	2	2	4
Strategic Priority	**BAF ID**	**Risk**	**Risk Owner**	**Committee Oversight**	**Initial Risk Score**			**Q1 Risk Score**			**Q2 Risk Score**			**Q3 Risk Score**			**Target Risk**		**Score**
					L	C	Score	L	C	Score	L	C	Score	L	C	Score	L	C	Score
Be Collaborative: which means we will drive better outcomes for cancer patients, working with our partners across our unique network of care.	**B4**	If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	CEO/DofS	Performance Committee	3	4	12	3	4	12↔	3	4	12↔	3	4	12↔	2	4	8
Strategic Priority	**BAF ID**	**Risk**	**Risk Owner**	**Committee Oversight**	**Initial Risk Score**			**Q1 Risk Score**			**Q2 Risk Score**			**Q3 Risk Score**			**Target Risk**		**Score**
					L	C	Score	L	C	Score	L	C	Score	L	C	Score	L	C	Score
Be Research Leaders: which means we will be leaders in cancer research to improve outcomes for patients now and in the future	**B5**	If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	MD	Quality Committee & Performance Committee	3	5	15	3	5	15↔	3	5	15↔	3	4	12↓	2	4	8
	B6	Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	MD	Quality Committee	3	5	15	3	5	15↔	3	3	9↓	3	3	9↔	2	2	4
Strategic Priority	**BAF ID**	**Risk**	**Risk Owner**	**Committee Oversight**	**Initial Risk Score**			**Q1 Risk Score**			**Q2 Risk Score**			**Q3 Risk Score**			**Target Risk**		**Score**

					L	C	Score	L	C	Score	L	C	Score	L	C	Score	L	C	Score
Be a Great Place to Work: which means that we will attract, develop and retain highly skilled, motivated and inclusive workforce to deliver the best care.	**B7**	If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	DofW&OD	Quality Committee	3	4	12	3	4	**12↔**	**3**	**4**	**12↔**	**3**	**4**	**12↔**	2	3	6
	B8	If we are unable to recruit and retain high calibre and diverse staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	DofW&OD	Quality Committee	3	4	12	3	3	**9↓**	**3**	**3**	**9↔**	**4**	**3**	**12↑**	2	3	6
	B9	If we do not support and promote employee health and wellbeing, this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence	DofW&OD	Quality Committee	3	4	12	3	3	**9↓**	**3**	**3**	**9↔**	**3**	**3**	**9↔**	2	3	6
Strategic Priority	**BAF ID**	**Risk**	**Risk Owner**	**Committee Oversight**	**Initial Risk Score**			**Q1 Risk Score**			**Q2 Risk Score**			**Q3 Risk Score**			**Target Risk**		**Score**
					L	**C**	**Score**	**L**	**C**	**Score**	**L**	**C**	**Score**	**L**	**C**	**Score**	**L**	**C**	**Score**
Be Digital: which means we will deliver digitally transformed services, empowering patients and staff.	**B10**	If we do not invest a clear vision, sufficeint capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve it's digital ambition.	CIO	Quality Committee & Performance Committee	3	3	9	3	3	**9↔**	**3**	**3**	**9↔**	**3**	**3**	**9↔**	2	2	4
	B11	If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	CIO	Quality Committee & Performance Committee	3	4	12	3	4	**12↔**	**3**	**4**	**12↔**	**4**	**4**	**16↑**	3	3	9
Strategic Priority	**BAF ID**	**Risk**	**Risk Owner**	**Committee Oversight**	**Initial Risk Score**			**Q1 Risk Score**			**Q2 Risk Score**			**Q3 Risk Score**			**Target Risk**		**Score**
					L	**C**	**Score**	**L**	**C**	**Score**	**L**	**C**	**Score**	**L**	**C**	**Score**	**L**	**C**	**Score**
Be Innovative: which means we will be enterprising and innovative, exploring opportunities that improve or support patient care.	**B12**	If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	DofF	Performance Committee	3	3	9	4	3	**12↑**	**4**	**3**	**12↔**	**4**	**3**	**12↔**	2	3	6

BAF 1	If we do not have robust Trust-wide quality and clinical governance arrangements in place, we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.						
Current Risk Score 3x3 = 9 ↔							
	Controls and Mitigation ***(what are we currently doing about this risk)***		**Assurances/Evidence** ***(how do we know we are making an impact)***		**Gaps in Controls/Assurances** ***(actions to achieve target risk scores)***	**Deadline for Action to Close Gap**	**Action Lead**
Ref							
C1	Quality Committee has an annual work plan of expected reports	A1	Reports to Integrated Governance Committee and Quality committee provide assurance to the respective Committee members.	G1	Review of existing clinical governance function ongoing. Key changes have been made but further refinement required	Q4 21/22	CL
C2	Mortality Review and Mortality Surveillance Groups established.	A2	Regular engagement meetings with the CQC	G3	Implementation of Incident Investigation Training in line with the Patient Safety Syllabus published May 2021.	Q4 21/22	CL
C3	Integrated Governance Committee work plan in place	A3	Audit Committee receives the Annual Clinical Audit Report.	G4	Quality Improvement Programme in development	Q4 21/22	TP/CL
C4	Re-defined reporting structure into Integrated Governance Committee.	A4	Financial sustainability and ability to invest in services	G5	Transition onto Datix Cloud IQ making excellent progress against schedule additional modules to go live Jan 2022	31- Jan - 22	CL
C5	Patient Experience Strategy in place.	A5	We continue to be in the top decile for National Cancer Patient Experience Survey results.				
C6	Quality & Safety meetings in Divisions monthly	A6	Monthly quality section in Integrated Performance Report				
C7	In date Quality Strategy in place.	A7	Deep dive reports completed in relation to the Aseptic Unit, Datix Cloud IQ, incidents relating to communication issues and the Management of Complaints with associated action plans.				
C8	Associate Director for Clinical Governance and Patient Safety in post	A8	Quarterly Clinical Audit and NICE compliance reports to Integrated Governance committee.				
C9	Approved Quality Account in place.	A9	Quarterly updates to Quality committee on progress against Action Plans relating to Patient Experience Surveys.				
C10	Named Patient Safety Leads across Divisions.	A10	Review of robust Quality Assurance Process at IGC and Quality Committee.				
C11	All Divisions have a Matron or Quality and Safety Lead in post to lead on this agenda	A11	Medicine Incident Reports to IGC and Quality Committee monthly.				
		A12	Actions from Litigation and Inquest reports to IGC and Quality Committee Quarterly				

		A13	Actions from complaints reported through Divisional Quality and Safety Meetings				
		A14	Regulatory Compliance Register approved on 19 July 2021				
		A15	Monthly Quality and Safety meetings within each Division				
		A16	Weekly Exec Review Group meetings to triangulate moderate harms, complaints, claims & mortality data				

BAF 2	Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk for failing to deliver against healthcare standards which will impact on our ability to recovery performance to the required levels within the agreed timeframes.						
Current BAF Risk Score: 3x3 = 9 ↔							
	Controls and Mitigation (what are we currently doing about this risk)		***Assurances/Evidence (how do we know we are making an impact)***		***Gaps in Controls/Assurances (actions to achieve target risk scores)***	***Deadline for Action to Close Gap***	***Action Lead***
REF							
C1	Divisional Performance Reviews in place.	A1	Internal Audit Reports (MIAA) on performance metrics. Action log and action plan progress monitored at each PR Triple A report to Performance Committee demonstrates progress	G1	Reaction to frequent changes to national guidance and targets.	Ongoing due to the current position nationally and regionally	HG
C2	Receipt of Cheshire and Merseyside Cancer Alliance weekly cancer waiting time performance reports to enable planning.	A2	Deep dive reports received through Performance Committee.	G2	No control over the flow of activity from referring Trusts	Ongoing due to the current environment regionally	JSp
C3	Investment business cases approved to increase capacity in radiology activity.	A3	Robust monthly IPR presented at Board and Board Committees.	G3	Capacity & Demand Exercise	To commence Dec 2021 expected completion 31 March 2022	JSp
C4	The Trust is fully engaged with regional and national meetings	A4	Recovery plan progress monitored via IPR.	G4	Reassessment and reconfiguration of SACT capacity	Jan 2022	FA
C5	Established internal targets to monitor flow.	A5	Scrutiny of reports presented at Divisional Performance Reviews.	G4	Business planning for 22/23 financial year commenced	31st March 22	JSp
C6	Recovery and escalation plan in place to meet NHS Oversight Metrics 2021/22	A6	Action plans in place to improve any non-compliance with national targets.	G5	Negotiating with commissioners in regards to income & activity for 22/23	March 22	JSp/JT
C7	Trust Operational Group monitors Trust activity on a weekly basis	A7	Clear escalation of the monitoring process in the event of under performance against key metrics.	G6	Impact of pandemic on referring trusts	March 2022	JSp/JT
C8	Additional clinics in response to increase in demand	A8	Implementation of national and regional guidance				

BAF 3	Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block Funding.						
Current BAF Risk Score 4x4=16↑							
	Controls and Mitigation ***(what are we currently doing about this risk)***		**Assurances/Evidence** ***(how do we know we are making an impact)***		**Gaps in Controls/Assurances** ***(actions to achieve target risk scores)***	**Deadline for Action to Close Gap**	**Action Lead**
REF							
C1	Standard monthly reporting to Trust Board and Board Committees.	A1	Detailed reports both internally and externally, throughout the Trust's governance structure.	G1	N/a	Ongoing with continued monthly updates.	JT
C2	Divisional and departmental budget setting	A2	Subject to both Internal and External Audit. Divisional performance reported at Trust Board level, with issues managed through Performance Review Groups.	G2	Inability to plan for activity and resource due to clarity of recurrent contracting / funding regime.	Planning for 2022-23 to be taken to Trust board March 2022.	JT&JSp
C3	Block funding received for H1 and H2	A3	Balanced position planned for H1, with associated cash transactions. ERF payments received for M1-M3. Internal cross discipline H2 Planning team focused on H2 planning submission.	G3	Final H2 income and expenditure position not known. Final allocation for H2 not known – subject to CM ICS system process and risks. Outcome of changes to ERF calculations / thresholds to be understood. Trust Planning for break-even income & expenditure position. This is conflict with ICS Plan. The Trust Plan includes ERF income which is subject to overall recovery requirements.	Trust H2 planning submission to NHSE submitted 16th November. Routine monitoring on financial risk ongoing with final Trust position for 21/22 due March 2022.	JT
C4	Receive activity benchmarking from Cheshire and Merseyside	A4	Covid recovery activity and performance managed through the Hospital Cell and Cheshire and Merseyside Cancer Alliance (CMCA)	G4	H2 planning guidance may result in additional reporting and benchmarking issues. System response to current wave and any changes in underlying referrals.	Planning paper taken to October 2021 Trust Board and monitored monthly.	JS
C5	Reports through Finance Committee, and Performance Review Groups.	A5	Detailed reports produced monthly, covering all primary statements.	G5	Increased reporting regarding efficiency programme for Q4.	Ongoing with continued monthly updates.	JT
C6	Utilise intelligence from Cheshire and Merseyside Cancer Alliance to understand likely activity flows from Secondary care.	C6	Trust Board takes monthly updates from CMCA. Trust H1/H2 activity planning uses CMCA data set as evidence.	G6	Impact of pandemic and non-elective demand is variable, and can have an impact on secondary care outside of reporting cycle.	Ongoing with continued monthly updates.	JS

BAF 4	If we do not build upon the work with the Cancer Alliance and other partnersthis will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.

Current BAF Risk Score 3x4 =12 ↔

Ref	**Controls and Mitigation** ***(what are wecurrently doing about this risk)***	Ref	**Assurances/Evidence** ***(how do weknow we are making an impact)***	Ref	**Gaps in Controls/Assurances** ***(actions to achieve target riskscores)***	**Deadline for Action toClose Gap**	**Action Lead**
C1	The Trust is host to the Cheshire and Merseyside Cancer Alliance.	A1	Monthly reports from Cancer Alliance to Trust Board	G1	Not applicable, no expected change in arrangements.	N/a	LB
C2	The Trust CEO is the SRO for the Cheshire and Merseyside Cancer Alliance (CMCA). Trust CEO is ICS System Lead for all diagnostics. A Diagnostic Programme Director has been appointed.	A2	Trust CEO system lead for Community Diagnostic Centres and endoscopy recovery. Trust CEO reports CMCA activity and programme to Trust Board and provides reports for Cheshire & Merseyside Boards	G2	Not applicable, no expected change in arrangements. Governance and management arrangements for diagnostics across the ICS are being refined for approval in due course.	Ongoing monthly monitoring and monthly reporting to national team and Cheshire & Merseyside CDC programme board April 2022	LB LB
C3	Funding has been approved until 2024.	A3	Commitment to Cancer Alliance role in delivering improved cancer services is included in NHSE planning guidance.	G3	Detailed planning guidance for 2022-23 has yet to be published.	2022-23 planning guidance expected Q4 2021-22. Trust planning submission for 2022-23 expected at Trust Board March 2022.	LB/JT

BAF 5	If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.						
Current BAF Risk Score 3x4=12↓							
Ref	**Controls and Mitigation** ***(what are we currently doing about this risk)***		**Assurances/Evidence** ***(how do we know we are making an impact)***		**Gaps in Controls/Assurances** ***(actions to achieve target risk scores)***	**Deadline for Action to Close Gap**	**Action Lead**
C1	Approved Research Strategy in place.	A1	Progress against the Research Strategy Business Plan reported to Performance Committee quarterly.	G1	Completed ECMC application paper: Call opens March 2022, Closes July 2022. Panel meets September 2022, Decision communicated January 2023. Next funding term is a 4 year term (April 2023-March 2027).	Application to be submitted by July 2022.	DP/GH
C2	Funding for the Research Strategy has been approved to support early phase clinical trial infrastructure to ensure access can be Maintained.	A2	Progress against targets monitored at Directorate Board	G2	Inability to generate sufficient Charitable funds to support the Research Strategy. Optimising external funding opportunities through R&I.	Mar-22	KB/GH
C3	Appointment of one academic Consultant and one clinical Consultant with early phase expertise.	A3	Trials un-paused to recruitment from 17 May 2021.	G3	ECMC studies prioritised for opening when clinical trial pharmacy staffing capacity available.	Recruitment commenced. Mitigation plan in place to enable the opening of some studies	KF/GH
C4	ECMC update through Directorate Board on any operational issues.	A4	ECMC Clinical Translation meetings held monthly as oversight.	G4	Secure early phase trial in-patient beds at CCCL. Present paper at Acute Service Board.	February 2022	GH/EW
C5	Dedicated and prioritised ECMC study set up in place.	A5	Clinical Director for ECMC provides quarterly updates to the Research Strategy Committee on progress.				
C6	ECMC Research Practitioner and Clinical Trials Support Officer in place.	A6	Performance against plan monitored at regular performance reviews				
C7	Dedicated Early Phase Trial Clinic at CCC.	A7	Explore opportunities to increase recruitment to studies already open				
C8	Further opportunities of national Research collaboration with major cancer centres, bid submitted as part of a national research	A8	First study using the aseptic service opened 17th September 2021				

	collaboration – outcome anticipated 2022.
C9	Collaboration with other providers to strengthen research facilities. Eg Clinical Research Facility bid submitted 29th September 2021 in collaboration with two Liverpool hospitals. Outcome anticipated 2022.

A9	Monthly meetings held between ECMC and CCC R&I Operational teams to discuss metrics progress against plan.

BAF 6	Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture anddispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan, adversely impacting on patient accessibility to research and reputational damage with Sponsors.

Current BAF Risk Score: 3x3=9 ↔

Ref	**Controls and Mitigation** ***(what are wecurrently doing about this risk)***		**Assurances/Evidence** ***(how dowe know we are making an impact)***		**Gaps in Controls/Assurances** ***(actions to achieve target riskscores)***	**Deadline for Action to Close Gap**	**Action Lead**
C1	Mutual aid in place in Pharmacy.	A1	Monthly reports on progress to Quality Committee. Aseptic unit relocated to Liverpool, expect to open to full capacity by end-Feb-2022	G1	Pharmacy recovery plan to enable capacity to open new trials	Recovery plan in place 30 August 2021 Ongoing monitoring of key milestones required 31st Jan 2021	KF/GH
C2	Clear communication with Sponsors	A2	Pharmacy has aseptic capacity to support open and new trials.	G2	Gaps in Clinical Trials Pharmacycapacity	Lead pharmacist commenced 01-Jan-2021 (Interim support provided until then). Support pharmacist role remains vacant but actively seeking to recruit. All other posts filled. Benchmarking with The Christie and The Royal Marsden to establish appropriate staffing requirement.	KF
C3	New structure within the Pharmacy Clinical Trials Team agreed. Recruitment plan underway.	A3	Full action plan and daily sit rep in place				
C4	IMP Transportation Standard Operating Procedure completed.	A4	As of 9 June 2021, the issues Relating to the cold chain have been resolved.				
C5	Timeline of trials to be progressed throughset up to opening as a staggered approach	A5	Pharmacy monthly Performance Review				

C6	New Lead Pharmacist appointed, and commenced in post January 2022.	A6	Monthly Pharmacy Move Programme Board in place-aseptic unit in CCCL opened December 2021					

BAF 7	If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the 5-Year Strategy.						
Current Risk Score 3x3=9							
	Controls and Mitigation *(what are we currently doing about this risk)*		**Assurances/Evidence *(how do we know we are making an impact)***		**Gaps in Controls/Assurances *(actions to achieve target risk scores)***	**Deadline for Action to Close Gap**	**Action Lead**
Ref							
C1	Leadership passport programme in place	A1	High calibre appointments completed.				
C2	Bespoke leadership and OD programme in place for Divisional triumverates –Team at the Top	A2	National staff survey results	G1	Competency framework for AHPs	30-Nov-21	LW
C3	Coaching available for staff	A3	Quarterly Culture & Engagement Pulse	G2	Launch and implement People Commitment	31-Mar-2022	ZH
C4	Competency framework for nursing staff	A4	Workforce KPIs monitored at PRGs, subcommittees and Board	G3	Talent mapping for critical posts across all staff groups	31-Mar-2022	ZH
C6	Clinical Education Strategy	A5	Completion of PADRs	G4	EDI objectives to be developed	31-Jan-2022	AO
C7	Leadership masterclasses in place with external keynote speakers			G5	Medical leadership framework to be developed	31-Mar-2022	ZH
C8	Shadow Board programme to support future leaders development						
C9	People Commitment approved						
C10	Board Development session on inclusive leadership						
C11	Establishment of EDI collaboration with Specialist Trusts						

BAF 8	If we are unable to recruit and retain high calibre and diverse staffthere is a risk of an adverse impact on the quality of care and reputation of the Trust.						
Current Risk Score 4x3= 12 ↑							
	Controls and Mitigation *(what arewe currently doing about this risk)*		**Assurances/Evidence *(how do weknow we are making an impact)***		**Gaps in Controls/Assurances *(actions to achieve target riskscores)***	**Deadline for Action to Close Gap**	**Action Lead**
Ref							
C1	Workforce Transformation Committee established.	A1	Turnover KPI monitored at PRGs, sub-committees and Board	G1	EDI targets to be agreed	31-Jan-22	AO
C2	EDI Steering group in place	A2	PADR process in place and compliance monitored at sub-committees and Board	G2	Workforce Dashboard that will establish trajectories.	28 Feb-22	ZH
C3	BAME and LGBT staff networks in place	A3	WRES completion and action plan	G3	EDI service agreement to be developed	31-Mar-22	ZH
C4	Joint EDI lead appointment and shared service with TWC and AH	A4	WDES completion and action plan	G4	Launch and embed refreshed values and behaviours	31-Mar-2022	ST
C5	Retention plans in place for nursing and A&C staff	A5	Annual staff survey results	G5	Values based recruitment model	31-Mar-22	ZH
C6	Revised Values framework – approved by Board October			G6	Vaccination as a Condition of Deployment	1st April 2022	ZH
C7	People Commitment – Board October 2021			G7	Overhaul of Recruitment Policy and Process	1st April 2022	KG

BAF 9	If we do not support and prioritise employee health andwellbeing this will adversely impact on the stability of ourworkforce in terms of recruitment, retention and absence.						
Current Risk Score 3x3=9							
	Controls and Mitigation ***(what are we currently doing about this risk)***		**Assurances/Evidence** ***(how do we know we aremaking an impact)***		**Gaps in Controls/Assurances** ***(actions to achieve target risk scores)***	**Deadline for Action to CloseGap**	**Action Lead**
Ref							
C1	Culture & Engagement Groups in place in each Division and for Corporate Services	A1	Annual staff surveyresults	G1	Culture and EngagementSteering Committee to be established	30-Sep-21	JSh
C2	OH and counselling service in place for all staff	A2	Quarterly Staff Culture and Engagement Pulseresults	G3	H&WB Guardian role to be embedded	31-Mar-22	ZH
C3	EAP service available for all staff	A3	Contract monitoring forOH, counselling and EAP	G4	Implementation plan for health and wellbeing	30-Jan-22	ST
C4	Trained Mental Health First Aiders in place along with Trainthe Trainers	A4	All staff have a personal H&WB objective includedin their PADR	G5	Review H&WB offer to staff	31-Dec-2021	ZH
C5	H&WB Guardian in place	A5	Leadership programmeincludes wellbeing modules	G6	Implementing & recruiting wellbeing champions	March 2022	ST
C6	H&WB objectives for line managers and all staff	A7	Workforce KPIs monitored at PRGs, sub-committees and Trust Board				
C7	Leadership masterclassprogramme including resilience modules						
C7	Commitment to NW Health and Wellbeing pledge approved by Board						

BAF 10	If we do not invest a clear vision, sufficient capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve it's digital ambition.						
Current BAF Risk Score 3x3 = 9 ↔							
Ref	**Controls and Mitigation** ***(what are we currently doing about this risk)***		**Assurances/Evidence** ***(how do we know we are making an impact)***		**Gaps in Controls/Assurances** ***(actions to achieve target risk scores)***	**Deadline for Action to Close Gap**	**Action Lead**
C1	Engagement with the Trust on the relevance and importance of Digital and commitment to "buy in" to transformational change	A1	Facilitated engagement sessions in place, "Be Digital"(Dec 2020,) "Day in your Life" interviews May 2021. Iterations of strategy to come through Digital Board and appropriate Governance committees up to Trust Board	G1	Digital Strategy in development	March 22	SB
C2	Digital Board Chaired by Medical Director with Trust wide membership with oversight of progress. Triple A reporting through to Quality Committee and Trust Board	A2	Externally accredited through completion of Global Digital Exemplar Fast Follower programme (NHS Digital). Awarded NHS Leader status. (certification) Strong Digital Governance approach through Digital Board, Medical Director as Senior Responsible Owner (SRO). Governance route through Quality Committee to Trust Board	G2	External reviews underway for Healthcare Information and Management Systems Society (HIMSS) level 6. Working towards HIMSS level 7	March 22	AW
		A4	Operational and Clinical engagement in place. Clinical Digital Leadership is in place, with Chief Clinical Information Officer (CCIO) and Chief Nursing information Officer (CNIO) embedded with Digital. Governance mechanisms via divisional performance reviews, Clinical and Operational meetings (COG). Strenghened Clinical Leadership with new Associate Chief Clinical information officer Role appointed to				
		A5	Excellence in Informatics award – Levels 1 & 2 (2019 & September 2021)				
		A6	Digital Maturity Healthcare Information and Management Systems Society (HIMSS)				

	level 5 achieved
A7	Health Care International (HCI) review complete. An extensive findings document has been received. Findings and recommendations presented to Digital Board in December 21, highlighting a focus on six key areas within the Electronic Patient record. Work has commenced around ambitions within the 5 year plan, namely Robotic Process Automation (RPA) and Remote Monitoring work.

BAF 11	If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in Potential loss of data and delayed care.							
Current BAF Scoring 4x4 ↑ 16								
Ref	**Controls and Mitigation** ***(what are we currently doing about this risk)***		**Assurances/Evidence** ***(how do we know we are making an impact)***		**Gaps in Controls/Assurances** ***(actions to achieve target risk scores)***		**Deadline for Action to Close Gap**	**Action Lead**
C1	Anti- Virus Software up to date across server and PC estate and regularly monitored and maintained.	A1	Trust was an early adopter of NHS Digital Care Cert reporting for assurance of all patching requirements. Tasks logged and regular assurance back to NHSD. NHSD Gold Start images used on workstation image, deployed with SCCM, with good practice group policies. Workstations integrated with Windows Advanced threat projection for telemetry data collection. Digital Board subcommittee has been commissioned (Digital Security Committee) with representation across the Trust. Triple A/Chairs report feeds up to Digital Board, providing assurances on digital security posture. Anti-virus posture is a standing agenda item on Digital Security Committee, to review the latest position of trust asset compliance.	G1	Constant review and liaison with NHSD NHSx Cyber Security attacks are ever changing and will be unknown and unplanned, Constantly changing sources of attack.		Ongoing	RP
C2	Domain migration and new enterprise back- up solution, including an air-gaped "vault"	A2	Substantial Assurance MIAA review New backup infrastructure implemented, spanning 2 diverse data centres (copy located in both) with a 3rd location containing an air-gaped copy, as part of a "cyber vault" Working closely with NHS Digital for regular external audits. Backup reports/audits are presented to	G2	Constant review of new vulnerabilities. Cyber Security attacks are ever changing and will be unknown and unplanned, Constantly changing sources of attack. A vulnerability has been found within "Log4j". Log4j is used by software developers as they create applications. It is used to process logs of activity on systems. This is a **global vulnerability**		Ongoing Dec 22	RP RP

				Digital Security Committee, and assurance, alert, advise are reported to Digital Board.			that will be present in applications and organisations around the world. NHSx informed Ministers and TOTO at 22:19, 10/12/2021 that NHS Digital had issued a High Severity Alert in relation to this latest critical cyber vulnerability. All NHS organisations including CCC received that alert. CCC, have confirmed receipt of alerts and that they are acting upon it. Vendors are working through patch cycle release processes and NHSx have informed this could be a 12 month programme .		
C3	Windows Advanced Threat Protection (ATP) fully implemented in line with NHS Digital Windows 10 upgrade Programme.		A3	Assurance of progress from NHS Digital Leader board on progress of implementation and posture score. All Windows devices on the network are running on fully supported & patched versions, and Clatterbridge is currently deploying the latest Windows 10 ring ATP posture is a standing agenda item on Digital Security Committee and status is review monthly		G3	Continue to work under national direction – plan continuous programme cycle to keep Windows OS in line with supported versions.	Ongoing	JC
C4	Cyber Essentials Accreditation		A4	Externally certified achieved in 2019 (Cyber Essentials)		G4	Working towards Cyber Essentials Plus Accreditation and IS27001. - programme of work established.	Sep-22	JC
C5	Active monitoring in place via the following tools: 1) **ITHEALTH Dashboard** monitoring all devices on the network along with active directory activity. Automatically reports on care certs and vulnerabilities.		A5	“significant assurance” awarded from external audit review (MIAA Cyber Security Review) Active Dashboards are presented monthly to Digital Security Committee		G5	Trust's Digital Security team undertaking NSCS Cyber Incident Planning and response course with examinations.	Aug-22	RP

	2) **LEPIDE**: categorises files on the network and who accesses them. 3) **ARMIS** medical device monitoring in place								
C6	Digital Maturity HIMSS level 5 achieved		A6	Externally accredited Level 5 HIMSS		G6	External reviews underway for HIMMs level 6. working towards HIMMs level 7	Dec-22	AW
			A7	Log4J Cyber Security Response: Briefing paper to Trust Board 15.12.21 on the global vulnerability present in applications and organisations worldwide. Paper outlined national and local plans. The Trust remains working with local vendors and NHSx in its approach. Robust internal process in place with reporting into Information Governance Committee and Digital Board.					

BAF 12	If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS

Current BAF Risk Score 4x3 = 12 ↔

Ref	**Controls and Mitigation *(what are we currently doing about thisrisk)***	Ref	**Assurances/Evidence *(how do we know weare making an impact)***	Ref	**Gaps in Controls/Assurances *(actions to achieve target risk scores)***	**Deadline for Actionto Close Gap**	**Action Lead**
C1	Renewed Contract between theTrust and the Mater Private Healthcare in the form of a Limited Liability Partnership.	A1	Contractual arrangements in place with JointBoard between the Trust and the Mater. Performance reports to Performance Committee.	G1	Interim JV Manager arrangements remain in place via the Trust	New JV manager due to commence 8th December 2021, however did not take up post. Recruitment process to be re-run. Deadline of Feb 2022	JT
C2	Financial Business modeldeveloped by the Mater.	A2	Subsidiary companies report to PerformanceCommittee and Trust Board	G2	Current service provision/model in Liverpool, under review and to be costed with the Trust continuing to hold the risk pending transition.	JV Board from January 2022 to March 2022	JT
C3	Separate Governance arrangements for CPL and PropCare with separate Boards	A3	Established monthly Board meetings. CPL undertaking process review currently, with feedback to TEG. Completed Phase 1, Phase 2 now in progress MD recruitment for PropCare complete October 2021, commenced in post 10 January 2022	G3	Each Board to develop and approve medium term business strategy and implementation plan.	March 2022	JB/JM/GA
C4	Additional CPL Director approvedJuly 2021		All CPL Directors and Company Secretary notified on Companies House Register.	G4	CPL director position filled with appointment of New Director of Pharmacy to commence in post from 1 April 2022.	31 October 2021	JT

REPORT COVER

Report to:	Trust Board	
Date of meeting:	26 January 2022	
Agenda item:	P1-24-22	
Title:	Constitution Amendments for Approval	
Report prepared by:	Emily Kelso – Corporate Governance Manager	
Lead:	Kathy Doran – Chair Margaret Saunders – Associate Director of Corporate Governance	
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	Not applicable
Date & decision:	7 July 2021

Purpose of the paper/key points for discussion:	The last review and update was carried out in July 2021, where it was presented to and later approved by the Council of Governors. Since then is has been recognised that given the removal of an appointed Governor representative from MCH Psychological Services (previously known as MANX Cancer Help), the Council of Governors was left with a gap in representation from the Isle of Mann. Representation from the Isle of Mann on is valued by the Trust as a percentage of our patients reside on the Isle of Mann, along with the Trusts ongoing commitment supporting chemotherapy and immunotherapy in the Eric & Marion Scott Oncology Unit based at Noble's Hospital – Isle of Mann. The revised Constitution was presented to the Council of Governors at its meeting 12th January 2022, where it was approved. The amended constitution is attached, the following amendments are to be approved: - Page 29. THE APPOINTED CONSTITUENCY, additional appointed governor from Department of Health & Social Care – Isle of Mann. Increasing the number of appointed Governors from 8 to 9 - Page 30. COMPOSITION OF THE COUNCIL OF GOVERNORS, Total number of Governors increasing from 29 to 30.

Action required: (please tick)	Discuss	☒
	Approve	☒
	For information/noting	☐

Next steps required:	The Trust Board is asked to approve the revised version.

Version 1.0 Ref: FCGOREPCOV Review: May 2024

REPORT COVER

The paper links to the following strategic priorities and Board Assurance Framework (BAF) Risks (please select)

☒ BE **OUTSTANDING**

BAF Risk	Please select
If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	☒
Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	☐
Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☐

☒ BE **COLLABORATIVE**

BAF Risk	Please select
If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	☒

☒ BE **RESEARCH LEADERS**

BAF Risk	Please select
If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	☐
Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	☐

☐ BE **A GREAT PLACE TO WORK**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☐
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	☐

☐ BE **DIGITAL**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☐
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	☐

☐ BE **INNOVATIVE**

BAF Risk	
If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	☐

EQUALITY & DIVERSITY IMPACT ASSESSMENT								
Are there concerns that the policy/service could have an adverse impact on:								
Age	Yes ☐	No ☒	Disability	Yes ☐	No ☒	Gender	Yes ☐	No ☒
Race	Yes ☐	No ☒	Religious/belief	Yes ☐	No ☒	Sexual orientation	Yes ☐	No ☒
Gender Reassignment	Yes ☐	No ☒	Pregnancy/maternity	Yes ☐	No ☒			

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

The Clatterbridge Cancer

Centre NHS Foundation

Trust Constitution

CONSTITUTION OF

THE CLATTERBRIDGE CANCER CENTRE

NHS FOUNDATION TRUST

(A PUBLIC BENEFIT ORGANISATION)

Version 12
July 2021

The Clatterbridge Cancer Centre NHS Foundation Trust Constitution

\- - - - - - - - - - - - - - - - - -

TABLE OF CONTENTS

\- - - - - - - - - - - - - - - - - -

1. Interpretation and Definitions 5
2. Name....6
3. Principal Purpose 6
4. Powers 7
5. Membership and Constituencies 7
6. Application for Membership....7
7. Public Constituency....7
8. Staff Constituency 8
9. Automatic membership by default – staff 8
10. Restriction on Membership....9
11. Annual Members' Meeting....10
12. Council of Governors – composition 11
13. Council of Governors – Election of Governors 11
14. Council of Governors - Tenure 12
15. Council of Governors – Disqualification and Removal 12
16. Council of Governors – Duties of Governors....13
17. Council of Governors – Meetings of Governors 13
18. Council of Governors – Standing Orders....13
19. Council of Governors – Referral to the Panel....13
20. Council of Governors - Conflicts of Interest of Governors 14
21. Council of Governors – Travel Expenses....14
22. Lead Governor 14
23. Council of Governors – Further Provisions....14
24. Board of Directors – Composition....15
25. Board of Directors – General Duty 15
26. Board of Directors – Qualification for Appointment as a Non-Executive Director....15
27. Board of Directors – Appointment and Removal of Chairman and other Non-Executive Directors 16

28. Board of Directors – Appointment of a Vice Chair 17

29. Board of Directors - Appointment and Removal of the Chief Executive and other Executive Directors 17

30. Board of Directors – Disqualification 17

31. Board of Directors – Meetings 18

32. Board of Directors – Standing Orders 18

33. Board of Directors - Conflicts of Interest of Directors 18

34. Board of Directors – Remuneration and Terms of Office 20

35. Registers 20

36. Admission to and Removal from the Registers 20

37. Registers – Inspection and Copies 21

38. Documents Available for Public Inspection 22

39. Auditor 23

40. Audit committee 23

41. Accounts 23

42. Annual Report, Forward Plans and Non-NHS Work 24

43. Presentation of the Annual Accounts and Reports to the Governors and Members 24

44. Instruments 25

45. Amendment of the constitution 25

46. Mergers etc. and Significant Transactions 26

47. ANNEX 1 – THE PUBLIC CONSTITUENCIES 27

48. ANNEX 2 – THE STAFF CONSTITUENCY 28

49. ANNEX 3 – THE APPOINTED CONSTITUENCY 29

50. ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS 30

51. ANNEX 5 –THE MODEL ELECTION RULES 31

52. ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS ...78

53. ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF 80

54. ANNEX 8 – DISPUTE RESOLUTION PROCEDURE 85

1. Interpretation and Definitions

1.1 Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012

1.2 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

1.3 In this Constitution:

Accounting Officer	means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.
Appointed Governor	means those Governors appointed by the appointing organisation
Appointing Organisations	means those organisations named in this Constitution who are entitled to appoint Governors
Areas of the Trust	means the areas of the Public Constituencies in Annex 1
Authorisation	means an authorisation given by NHS Improvement (NHSI)
Board of Directors	means the Board of Directors as constituted in accordance with this Constitution and the 2006 Act
Chairman	means the Chair of the organisation
Company Secretary	means the Secretary of the Trust or any other person appointed to perform the duties of the Company Secretary including a joint, assistant of deputy Secretary or such other person as may be appointed by the Trust to perform the functions of the Company Secretary under this Constitution
Council of Governors	means the Council of Governors as constituted in accordance with this Constitution which shall have the same meaning as the Council of Governors in the 2006 Act
Dispute Resolution Procedure	means the dispute resolution procedure as set out in Annex 8

Elected Governors means those Governors elected by the public constituencies and staff constituencies

Financial Year means any period of 12 months beginning on 1 April

Lead Governor means the Governor elected by the Council of Governors as the main link between the Governors and the Chair of the Trust

Monitor means the body corporate known as Monitor (as provided by Section 61 of the 2012 Act) and incorporated into NHSI, the statutory entity that remains the regulator of NHS foundation trusts

Nominations Committee means a Committee of the Council of Governors established in accordance with Paragraph 26

Senior Independent Director means a Non-Executive Director appointed by the Board of Directors in consultation with the Governors, supports the Chair and serves as an intermediary for other directors.
Director

Significant Transaction as defined in Paragraph 45

2. Name

The name of the foundation trust is The Clatterbridge Cancer Centre NHS Foundation Trust (the Trust).

3. Principal Purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England[1].

3.2 The trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and
3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

[1] The principal purpose is as set out in sub-section 43(1) of the 2006 Act and must be included in the constitution by virtue of paragraph 2(2). The paragraphs which follow reflect other provisions in section 43

4. Powers

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. Membership and Constituencies

The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1 a public constituency

5.2 a staff constituency

5.3 appointed constituency

6. Application for Membership

An individual who is eligible to become a member of the Trust may do so on application to the trust.

7. Public Constituency

7.1 An individual who lives in the areas specified in Annex 1 as the areas for a public constituency may become or continue as a member of the trust.

7.2 Those individuals who live in the areas specified for a public constituency are referred to collectively as a Public Constituency.

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8. Staff Constituency

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 They employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 They have been continuously employed by the trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into six descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. Automatic membership by default – staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency, shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

10. Restriction on Membership

10.1 An individual who is a member of a constituency, or of a class within a constituency, may not while a member of that constituency or class continue, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 An individual must be at least 16 years old to become a member of the Trust.

10.4 A member shall cease to be a member if:

10.4.1 they resign by notice to the Company Secretary
10.4.2 they die
10.4.3 they are expelled from membership under this Constitution
10.4.4 they cease to be entitled under this Constitution to be a member of the public or any classes of the staff constituencies.

10.5 A member may be expelled by a resolution approved by not less than two-thirds of the Governors present and voting at a meeting of the Council of Governors.

10.6 Any complaint made about a member must be sent to the member no less than one calendar month before the meeting of the Council of Governors where the complaint will be considered with an invitation to attend to answer the complaint.

10.7 If the member complained of fails to respond and fails to attend the meeting without due cause, the meeting may proceed in their absence.

10.8 A member expelled from membership will cease to be a member upon the declaration of the Chair of the meeting that the resolution to expel them was carried.

10.9 No person who has been expelled from membership is to be re-admitted except by a resolution carried by two-thirds of the Council of Governors voting.

11. Annual Members' Meeting

11.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public and will be held within 9 months of the end of each financial year.

11.2 Members meetings are open to all Members of the Trust, Governors, Directors and representatives of the Trust External Auditors.

11.3 All Annual members' meetings shall be convened by the Company Secretary.

11.4 At the Annual Members' meeting:

11.4.1 The Board of Directors shall present to the members:
11.4.2 the annual accounts
11.4.3 any report of the Trust's External Auditor
11.4.4 the annual report

11.5 The Council of Governors shall present to the members:

11.5.1 a report on steps taken to secure that (taken as a whole) the actual membership of its public constituencies and of the classes of staff constituencies is representative of those eligible for such membership.
11.5.2 the progress of the membership strategy
11.5.3 any proposed changes to the composition of the Council of Governors and of Non-Executive Directors.
11.5.4 the results of the election and appointment of Governors and the appointment of any Non-Executive Directors will be announced.

11.6 Notice of a members' meeting is to be given:

11.6.1 by notice prominently displayed a the Trust Headquarters and at all of the Trust's places of business; and
11.6.2 by notice on the Trust website

At least 14 clear days before the date of the meeting. The notice must:

11.6.3 be given to the Council of Governors and the Board of Directors and to the External Auditor;
11.6.4 state whether the meeting is an annual or a special members meeting;
11.6.5 give the time, date and place of the meeting; and
11.6.6 indicate the business to be dealt with at the meeting**.**

11.7 The Chairman of the Trust, or in their absence the Lead Governor shall act as Chair at all members meetings of the Trust. If neither are present, the Governors present shall elect one of the Governors to Chair.

12. Council of Governors – Composition

12.1 The Trust is to have a Council of Governors, which shall comprise both Elected and Appointed Governors.

12.2 The composition of the Council of Governors is specified in Annex 4.

12.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

12.4 The Council of Governors represents the interests of members of the Trust and appointed organisations, regularly feeding back information about the Trust, its vision and its performance to the constituency they represent.

13. Council of Governors – Election of Governors

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

13.2 The Model Election Rules as published from time to time by the Department of Health, form part of this constitution. The Model Election Rules current at the date of the trust's Authorisation are attached at Annex 5.

13.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of Paragraph 44 of the constitution (amendment of the constitution).

13.4 An election, if contested, shall be by secret ballot.

13.5 Governors must be at least 16 years of age at the closing date for nomination for their election or appointment.

14. Council of Governors - Tenure

14.1 An elected governor may hold office for a period of up to 3 years commencing immediately after the Annual Members' meeting at which their election is announced.

14.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which they were elected

14.3 An elected governor shall be eligible for re-election at the end of his term and be allowed to serve a maximum of 9 years (3 consecutive terms if so elected).

14.4 If a vacancy arises on the Council of Governors for any other reason other than expiry of term of office, the following provisions will apply:

14.4.1 Where the vacancy arises amongst the Appointed Governors, the Company Secretary shall request that the Appointing organisation appoints a replacement to hold office for the remainder of the term of office.

14.4.2 Where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty to either, call an election within three months to fill the seat for the remainder of the term; or invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office.

14.5 An appointed governor may hold office for a period of up to 9 years.

14.6 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

14.7 An appointed governor shall be eligible for re-appointment at the end of his term.

15. Council of Governors – Disqualification and Removal

15.1 The following may not become or continue as a member of the Council of Governors:

15.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
15.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;
15.1.3 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
15.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

15.2 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Board of Governors are set out in Annex 6.

16. Council of Governors – Duties of Governors

16.1 The general duties of the Council of Governors are:

16.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and
16.1.2 to represent the interests of the members of the trust as a whole and the interests of the public.

16.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

17. Council of Governors – Meetings of Governors

17.1 The Chairman of the Trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 26) or, in his absence Vice Chair (appointed in accordance with the provisions of paragraph 27 below), shall preside at meetings of the Council of Governors. If the Chair and Vice Chair are absent, another Non-Executive Director shall preside as chosen by the Directors present.

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. The Chair may exclude any member of the public from a meeting of the Council of Governors if they are interfering or preventing the proper conduct of the meeting.

17.3 For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

18. Council of Governors – Standing Orders

The standing orders for the practice and procedure of the Council of Governors are attached at Annex 7.

19. Council of Governors – Referral to the Panel

19.1 In this paragraph, the "Panel" means a panel of persons appointed by NHSI to which a Governor of an NHS Foundation Trust may refer a question as to whether the Trust has failed or is failing:

19.1.1 to act in accordance with its constitution, or
19.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

19.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Council of Governors - Conflicts of Interest of Governors

20.1 If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it.

20.2 The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21. Council of Governors – Travel Expenses

The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

22. Lead Governor

22.1 Any Governor who, immediately after the Annual Members meeting, and having at least one year of his term remaining may nominate himself for the office of Lead Governor by giving notice to the Chairman at least ten working days before the Annual Members meeting.

22.2 The Council of Governors shall vote on the nomination of the Lead Governor.

22.3 If more than one nomination has been received, the Council of Governors shall choose the Lead Governor by paper ballot. If there is equality of votes, the tied nominees shall be subject to a second vote by paper ballot.

22.4 The Lead Governor's duties shall include:

22.4.1 facilitating communication between Governors and members of the Board of Directors
22.4.2 contributing to the appraisal of the Chairman in such manner and to such extent as the person conducting the appraisal may see fit
22.4.3 initiating proceedings to remove a Governor where circumstances set out in this Constitution for removal have arisen.
22.4.4 Liaising, as appropriate with Council of Governors for other NHS Foundation Trusts.

23. Council of Governors – Further Provisions

Further provisions with respect to the Council of Governors are set out in Annex 6.

24. Board of Directors – Composition

The Trust is to have a Board of Directors, which shall comprise both executive and Non-Executive Directors.

24.1 The Board of Directors is to comprise:

24.1.1 a Non-Executive Chairman
24.1.2 up to 6 other Non-Executive Directors; and
24.1.3 up to 6 Executive Directors.
24.1.4 a Director of Strategy (non-voting)
24.1.5 a Chief Information Officer (non-voting)

24.2 One of the Executive Directors shall be the Chief Executive.

24.3 The Chief Executive shall be the Accounting Officer.

24.4 One of the Executive Directors shall be the Finance Director

24.5 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

24.6 One of the Executive Directors is to be a registered nurse or a registered midwife.

24.7 The operation of the Board of Directors, shall be such that, at all times, at least half of the voting members of the Board of Directors, excluding the Chair, shall be Non-Executive Directors

25. Board of Directors – General Duty

The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

26. Board of Directors – Qualification for Appointment as a Non-Executive Director

A person may be appointed as a Non-Executive Director only if –

26.1 They are a member of a Public Constituency, and

26.2 They are not disqualified by virtue of Paragraph 30 below.

27. Board of Directors – Appointment and Removal of Chairman and other Non-Executive Directors

27.1 The Council of Governors shall create a duly authorised Nominations Committee consisting of the Chair (or the Vice Chair unless they are standing for appointment, in which case it will be the Senior Independent Director) and at least three Elected Governors.

27.2 The Nominations Committee shall seek the views of the Board of Directors as to their recommended criteria and process for the selection of candidates and, having regard to those views, shall then seek, shortlist and interview such candidates as the Nominations Committee considers appropriate and shall make recommendations to the Council of Governors as to the potential appointments as Non-Executive Directors and shall advise the Board of Directors of those recommendations.

27.3 The Nominations Committee shall be at liberty to request the attendance of and seek advice and assistance from persons other than members of the Nominations Committee or other Governors in arriving at its said recommendations.

27.4 The Nominations Committee shall provide advice to the Council of Governors on the levels of remuneration for the Chairman and the Non-Executive Directors.

27.5 The Nominations Committee shall receive reports on behalf of the Council of Governors on the process and outcomes of appraisal for the Chairman and Non-Executive Directors.

27.6 The Council of Governors at a general meeting of the Council of Governors shall resolve to appoint such candidate or candidates as they consider appropriate and shall have regard to the recommendation of the Nominations Committee and views of the Chief Executive and Board of Directors in reaching that decision.

27.7 Removal of the Chairman or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors. Written reasons for the proposal to remove shall be provided to the Non-Executive Director in question, who shall be given the opportunity to respond to such reasons.

27.8 If any proposal to remove a Non-Executive Director is not approved at a meeting of the Council of Governors, no further proposal can be put forward to remove such Non-Executive Director based upon the same reasons within 12 months of the meeting.

28. Board of Directors – Appointment of a Vice Chair

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as Vice Chair.

29. Board of Directors - Appointment and Removal of the Chief Executive and other Executive Directors

29.1 Non-Executive Directors shall appoint or remove the Chief Executive.

29.2 A Committee comprising the Chairman, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

30. Board of Directors – Disqualification

The following may not become or continue as a member of the Board of Directors:

30.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

30.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

30.3 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986)

30.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

30.5 a medical practitioner that has been removed from the professional register by the General Medical Council or a nursing professional who has been removed from the professional register by the Nursing and Midwifery Council.

30.6 In the opinion of a majority of the voting members of the Board; a person whose conduct has caused, or is likely to cause, material prejudice to the best interests of the Trust or the proper conduct of the Board of Directors or otherwise in a manner inconsistent with continued membership of the Board of Directors.

31. Board of Directors – Meetings

31.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a Part 2 meeting for special reasons and having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

31.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

32. Board of Directors – Standing Orders

The standing orders for the practice and procedure of the Board of Directors are set out in the Trust Standing Orders incorporated into the Corporate Governance Manual.

33. Board of Directors - Conflicts of Interest of Directors

33.1 The duties that a Director of the Trust has by virtue of being a Director include in particular:

33.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

33.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

33.2 The duty referred to in sub-paragraph 33.1.1 and 33.1.2 is not infringed if:

33.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

33.2.2 The matter has been authorised in accordance with the Constitution.

33.3 The duty referred to in sub-paragraph 33.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

33.4 In sub-paragraph 33.1.2, “third party” means a person other than:

33.4.1 The Trust, or

33.4.2 A person acting on its behalf.

33.5 If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

33.6 If a declaration under this paragraph proves to be, or becomes inaccurate or incomplete, a further declaration must be made.

33.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

33.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

33.9 A Director need not declare an interest –

33.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

33.9.2 If, or to the extent that, the Directors are already aware of it;

33.9.3 If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

33.9.3.1 By a meeting of the Board of Directors, or
33.9.3.2 By a committee of the Directors appointed for the purpose under the Constitution.

34. Board of Directors – Remuneration and Terms of Office

34.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other Non-Executive Directors.

34.2 The Chairman and the Non-Executive Directors shall be eligible for appointment for three, three year terms of office, and in exceptional circumstances a further term of one year subject to a satisfactory appraisal. The Chairman or the Non-Executive Directors shall not be appointed to that office for a total period which exceeds ten years in aggregate.

34.3 The Trust shall establish a Committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

35. Registers

The Trust shall have:

35.1 a register of members showing, in respect of each member, the constituency to which they belong and, where there are classes within it, the class to which they belong;

35.2 a register of members of the Council of Governors;

35.3 a register of interests of governors;

35.4 a register of directors; and

35.5 a register of interests of the directors.

36. Admission to and Removal from the Registers

36.1 The Company Secretary shall add to the confidential register of members the name of any member who is accepted under the provisions of this Constitution.

37. Registers – Inspection and Copies

37.1 The Trust shall make the registers specified in Paragraph 35 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

37.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

37.3 So far as the registers are required to be made available:

37.3.1 they are to be available for inspection free of charge at all reasonable times; and

37.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract

37.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

38. Documents Available for Public Inspection

38.1 The trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

38.1.1 a copy of the current Constitution

38.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

38.1.3 a copy of the latest annual report.

38.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

38.2.1 a copy of any order made under Section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act.

38.2.2 a copy of any report laid under Section 65D (appointment of Trust special administrator) of the 2006 Act.

38.2.3 a copy of any information published under Section 65D (appointment of Trust special administrator) of the 2006 Act.

38.2.4 a copy of any draft report published under Section 65F (administrator's draft report) of the 2006 Act.

38.2.5 a copy of any statement provided under Section 65F (administrator's draft report) of the 2006 Act.

38.2.6 a copy of any notice published under Section 65F (administrator's draft report), 65G (consultation plan); 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision); 65KB (Secretary of State's response to Monitor's decision); 65KC (action following Secretary of State's rejection of the final report or, 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

38.2.7 a copy of any statement published or provided under Section 65G (consultation plan) of the 2006 Act.

38.2.8 a copy of any final report published under Section 65I (administrator's final report).

38.2.9 a copy of any statement published under Section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of the final report) of the 2006 Act.

38.2.10 a copy of any information published under Section 65M (replacement of Trust special administrator) of the 2006 Act.

38.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

38.4 If the person requesting a copy or extract is not a member of the Trust, the trust may impose a reasonable charge for doing so.

39. Auditor

39.1 The Trust shall have an auditor.

39.2 The Council of Governors shall appoint or remove the auditor at a general meeting or extraordinary meeting of the Council of Governors.

39.3 The Auditor is to carry out his duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by NHS Improvement (NHSI) the organisation that incorporates Monitor, the statutory entity that remains the regulator of NHS Foundation Trusts.

40. Audit committee

The Trust shall establish a Committee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

41. Accounts

41.1 The Trust must keep proper accounts and proper records in relation to the accounts.

41.2 NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

41.3 The accounts are to be audited by the Trust's auditor.

41.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS Improvement, the organisation that incorporates Monitor may with the approval of the Secretary of State direct.

41.5 The functions of the Trust with respect to the preparation of the Annual Accounts shall be delegated to the Accounting Officer.

42. Annual Report, Forward Plans and Non-NHS Work

42.1 The Trust shall prepare an Annual Report and send it to NHS Improvement.

42.2 The Trust shall give information as to its forward planning in respect of each financial year to NHS Improvement, the organisation that incorporated Monitor, the statutory entity that remains the regulator of NHS Foundation Trusts. The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.

42.3 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

42.4 Each forward plan must include information about:

42.4.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

42.4.2 the income it expects to receive from doing so.

42.5 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 42.4.1 the Council of Governors must:

42.5.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the trust of its principal purpose or the performance of its other functions, and

42.5.2 notify the Directors of the Trust of its determination.

42.6 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the council of governors of the Trust voting approve its implementation.

43. Presentation of the Annual Accounts and Reports to the Governors and Members

43.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

43.1.1 the Annual Accounts

43.1.2 any report of the auditor on them

43.1.3 the Annual Report.

43.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

43.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1 with the Annual Members' Meeting.

44. Instruments

44.1 The Trust shall have a seal.

44.2 The seal shall not be affixed except under the authority of the Board of Directors.

45. Amendment of the constitution

45.1 The Trust may make amendments of its Constitution only if:

45.1.1 More than half of the members of the Council of Governors of the Trust voting approve the notices, and

45.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

45.2 Amendments made under Paragraph 45.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

45.3 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

45.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

45.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

45.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

45.5 Amendments by the Trust of its Constitution are to be notified to NHS Improvement. For the avoidance of doubt, NHS Improvement's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

46. Mergers etc. and Significant Transactions

46.1 The Trust may only apply for a merger, acquisition, separation or dissolution (in accordance with the provisions of the 2006 Act) with the approval of more than half of the members of the Council of Governors.

46.2 The trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

46.3 “Significant transaction” means a transaction that equates to:

46.3.1 the value equates to 25% of either the Trust’s Gross Assets, Income or Gross Capital (inclusive of the transaction), calculated with reference to the Trust’s opening Balance Sheet for the Financial Year in which approval is being sought.

47. ANNEX 1 – THE PUBLIC CONSTITUENCIES

Name of Areas within the Constituency	Number of Governors
Liverpool	3
St Helen's and Knowsley	2
Sefton	2
Cheshire West and Chester	2
Warrington and Halton	2
Wirral and the Rest of England	3
Wales	1
Total	**15**

48. ANNEX 2 – THE STAFF CONSTITUENCY

Name of Constituency	Class of Staff Membership	Number of Governors
Staff	Doctor	1
	Non-Clinical	1
	Nurse	1
	Other Clinical	1
	Radiographer	1
	Volunteers, Service Providers, Contracted Staff	1
	Total	**6**

49. ANNEX 3 – THE APPOINTED CONSTITUENCY

NAME OF APPOINTED CONSTITUENCY	NUMBER OF APPOINTED GOVERNORS
Liverpool University	1
Macmillan Cancer Support	1
MCH Psychological Services	1
Liverpool University Hospital NHS Foundation Trust	1
Cancer Alliance	1
NHS England: Cheshire and Merseyside sub regional team	1
Liverpool Council	1
Wirral Council	1
Department of Health - Isle of Mann	1
Total	**9**

50. ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

30 Governors in Total

Elected Governors

Public Constituency	**Number of Governors**
Liverpool	3
St Helen's and Knowsley	2
Sefton	2
Cheshire West and Chester	2
Warrington and Halton	2
Wirral and the Rest of England	3
Wales	1
Total	**15**

Appointed Governors

Appointing Organisation	**Number of Governors**
Liverpool University	1
Macmillan Cancer Support	1
MCH Psychological Services	1
Liverpool University Hospital NHS Foundation Trust	1
Cancer Alliance	1
NHS England: Cheshire and Merseyside sub regional team	1
Wirral Council	1
Liverpool Council	1
Isle of Mann Department of Health	1
Total	**9**

Staff Governors

Name of Constituency	**Class of Staff Membership**	**Number of Governors**
Staff	Doctor	1
	Non-Clinical	1
	Nurse	1
	Other Clinical	1
	Radiographer	1
	Volunteers, Service Providers, Contracted Staff	1
Total		**6**

51. ANNEX 5 –THE MODEL ELECTION RULES

MODEL ELECTION RULES 2014

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote

28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)
33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text message

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

36. Receipt of voting documents
37. Validity of votes
38. Declaration of identity but no ballot (public and patient constituency)
39. De-duplication of votes
40. Sealing of packets

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6
42. Arrangements for counting of the votes
43. The count
STV44. Rejected ballot papers and rejected text voting records
FPP44. Rejected ballot papers and rejected text voting records
STV45. First stage
STV46. The quota
STV47 Transfer of votes
STV48. Supplementary provisions on transfer
STV49. Exclusion of candidates
STV50. Filling of last vacancies
STV51. Order of election of candidates
FPP51. Equality of votes

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections
STV52. Declaration of result for contested elections
53. Declaration of result for uncontested elections

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll
55. Delivery of documents
56. Forwarding of documents received after close of the poll
57. Retention and public inspection of documents
58. Application for inspection of certain documents relating to election

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate
STV59. Countermand or abandonment of poll on death of candidate

PART 10: ELECTION EXPENSES AND PUBLICITY

Expenses

60. Election expenses
61. Expenses and payments by candidates
62. Expenses incurred by other persons

Publicity

63. Publicity about election by the corporation
64. Information about candidates for inclusion with voting information
65. Meaning of “for the purposes of an election”

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

66. Application to question an election

PART 12: MISCELLANEOUS

67. Secrecy
68. Prohibition of disclosure of vote
69. Disqualification
70. Delay in postal service through industrial action or unforeseen event

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for

return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) the paper does not include a declaration of eligibility as required by rule 12, or

(e) the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of

candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

 (i) the voter's voter ID number;

 (ii) the voter's declaration of identity (where required);

 (iii) the candidate or candidates for whom the voter has voted; and

 (iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

 (i) enter his or her voter ID number in order to be able to cast his or her vote; and

 (ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

 (i) the name of the corporation,

 (ii) the constituency, or class within a constituency, for which the election is being held,

 (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

 (iv) instructions on how to vote and how to make a declaration of identity,

 (v) the date and time of the close of the poll, and

 (vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

 (i) the voter's voter ID number;

 (ii) the voter's declaration of identity (where required);

 (iii) the candidate or candidates for whom the voter has voted; and

 (iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[2]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

[2] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as “disqualified” all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV49.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are

deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

  (i) the total value of votes, or

  (ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

  (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

  (ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of

vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation’s consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate’s election, whether on that candidate’s behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

52. ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

Eligibility to be a Member of the Council of Governors

1. Council of Governors – Further Provisions on Disqualification and Removal:

Further to the provisions set out in Paragraph 15 the following may not become or continue as a Governor of the Council of Governors if they are:

1.1 In the case of a Staff Governor, Public Governor or Appointed governor, he ceases to be a Member of the Constituency or the Class of a Membership Constituency by which he was elected, or appointed.

1.2 NHS Improvement (incorporating Monitor) has exercised its powers to remove that person as a Governor or has suspended him from office or has disqualified him from holding office as a Governor for a specified period.

1.3 A person who has within the preceding five years been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS Body.

1.4 A person whose tenure of office as the Chair, Non-Executive Director or as a Governor of an NHS body has previously been terminated on the grounds that his appointment is not in the interests of the NHS for non-attendance at meetings or for non-disclosure of a pecuniary interest.

1.5 A person who is a vexatious complainant of the Trust

1.6 A person who has had his name removed from a relevant list of medical practitioners pursuant to Paragraph 10 of the National Health Service (Performers Lists) Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere), and has not subsequently had his name included in such a list.

1.7 A person who is currently a member of an independent scrutiny body whose role includes or will include independent scrutiny of The Clatterbridge Cancer Centre NHS Foundation trust.

1.8 A person who is under 16 years of age.

1.9 A person who on the basis of disclosures obtained through an application to the Disclosure and Barring Scheme is not considered suitable by the Trust.

1.10 A person who is a spouse, partner, parent or child of a Director or the Chair of the Trust.

1.11 A person who is incapable by reason of a mental disorder, illness of injury, of managing and administering his property and affairs.

1.12 A person has failed to, and continues to refuse to make the required Declarations.

1.13 A person who makes a false declaration for any purpose under this Constitution or the 2006 Act.

1.14 A person whose conduct has caused, or is likely to cause, material prejudice to the best interests of the Trust or the proper conduct of the Council of Governors or otherwise in a manner inconsistent with continued membership of the Council of Governors.

2. Termination of Tenure

In addition to Paragraph 14, the following will apply:

2.1 A Governor may resign from that office at any time during the term of that office by giving notice in writing to the Company Secretary.

2.2 If a Governor fails to attend 3 consecutive meetings of the Council of Governors his tenure of office shall be terminated immediately unless, on application by that Governor to the Council of Governors, the Council of Governors resolves that:

2.2.1 the absence was due to reasonable cause; and

2.2.2 the Governor will be able to start attending meetings of the Council of Governors within such a specified period as the Council of Governors considers reasonable.

2.3 The Council of Governors may, at a Council of Governors, by a Resolution approved by not less than 75% of the remaining Governors present terminate a Governor's tenure of office if for reasonable cause it considers that:

2.3.1 They are disqualified from becoming or continuing as a Member under this Constitution; or
2.3.2 They have knowingly or recklessly made a false declaration for any purpose provided under this Constitution or in the 2006 Act; or
2.3.3 Their continuing as a Governor would or would be likely to:

2.3.3.1.1 prejudice the ability of the Trust to fulfil its principal purpose or other of its purposes under this Constitution or otherwise to discharge its duties and functions; or
2.3.3.1.2 harm the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provisions of goods and services; or
2.3.3.2 adversely affect public confidence in the goods or services provided by the Trust; or
2.3.3.3 otherwise bring the Trust into disrepute.

2.4 Upon a Governor resigning or, upon the Council of Governors resolving to terminate a Governor's tenure of office, that Governor shall cease to be a Governor and his name shall be forthwith removed from the Register of Governors notwithstanding any reference to the Dispute Resolution Procedure.

2.5 Any decision of the Council of Governors to terminate a Governor's tenure of office may be referred by that Governor to the Dispute Resolution Procedure (as set out in Annex 8) within 28 calendar days of the date upon which notice in writing of the Council of Governor's decision is given to the Governor.

2.6 A Governor whose tenure of office is terminated under this Paragraph 2 shall not be eligible for re-election.

53. ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

The following Standing Orders form part of the Constitution of The Clatterbridge Cancer Centre NHS Foundation Trust

1. Interpretation

1.1 The Chairman shall be the final authority on the interpretation of these Standing Orders.

1.2 Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

2. The Trust

2.1 All business shall be conducted in the name of the Trust

3. Meetings of the Council of Governors

3.1 Admission of the Public and Press – the public and representatives of the press shall be afforded facilities to attend all meetings of the Council of Governors but shall be required to withdraw upon the Council of Governors resolving as follows:

"That the representatives of the Press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity on which would be prejudicial to the public interest."

3.2 The right of attendance referred to above carries no right to ask questions or otherwise participate in the meeting.

3.3 The Chairman (or other person presiding under the provision of Standing Order [ ]) shall give such directions as he thinks fit in regards to the arrangements for meetings and accommodation of the public and representatives of the press to ensure that the business of the meeting shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public and press will be required to withdraw upon the Council of Governors resolving as follows:

"*That in the interests of public order the meeting adjourn for (the period to be specified) to enable the completion of business without the presence of the public and press."*

Nothing in these Standing Orders shall require the Council of Governors to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings r via social media as they take place without the prior agreement of the Council of Governors.

3.4 Calling Meetings – The Council of Governors is to meet at least four times in each

financial year. Save in the case of emergencies or the need to conduct urgent business, the Company Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors to all Governors. The notice will be placed on the Trust website.

3.5 Extraordinary meetings may be called by the Chair at short notice.

3.6 Meetings of the Council of Governors may be called by six Governors (including at least two Elected and two Appointed Governors) who give written notice to the Company Secretary specifying the business to be carried out. The Company Secretary shall send a written notice to all Governors as soon as practically possible following receipt of such a request.

3.7 Prior to each meeting of the Council of Governors, a public notice of the time and place of the meeting and the public agenda shall be displayed on the Trust website at least three working days prior to the meeting.

3.8 The Annual Members' Meeting of the Council of Governors will consider the Annual Accounts, any report of the Auditor on these Accounts and the Annual Report.

4. Agenda and Supporting Papers

4.1 The Agenda will be provided to the Governors not less than 3 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda.

4.2 A Governor desiring a matter to be included on an agenda shall make his request in writing to the Chairman at least 10 working days before the meeting. Requests made less than 10 working days before a meeting may be included on the agenda at the discretion of the Chairman.

5. Chairman of the Meeting

5.1 The Chairman shall preside at meetings of the Council of Governors and shall be entitled to exercise a casting vote where the number of votes for and against a motion is equal.

5.2 If the Chairman is absent from a meeting of the Council of Governors, the Vice Chair shall preside over that meeting and they shall exercise all the rights and obligations of the Chairman including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

5.3 If any matter for consideration at a meeting of the Council of Governors relates to the conduct or interests of the Chairman or of the Non-Executive Director as a class, neither the Chairman nor any of the Non-Executive Directors shall preside over the period of the meeting during which the matter is under discussion. In these circumstances the period of the meeting shall be chaired by the Lead Governor, or in his absence, by another Governor chosen by the Governors. This person shall exercise all the rights and obligations of the Chairman including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

6. Notice of, Amending or Withdrawing Motions and Notice to Rescind a Resolution

6.1 A Governor desiring to move or amend a motion shall send a written notice thereof at least 10 working days before the meeting to the Chairman, who shall insert in the

agenda of the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This does not prevent a motion being moved during a meeting without notice on any business mentioned on the agenda.

6.2 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

6.3 Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governor who gives it and also the signature of ten other Governors. When any such motion has been disposed of by the Council of Governors, it cannot be proposed again tot eh same effect within the next six calendar months unless the Chairman deems it to be appropriate.

6.4 The proposer of the motion shall have the right of reply at the close of any discussions on the motion or any proposed amendments.

6.5 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

6.5.1 An amendment to the motion;
6.5.2 The adjournment of the discussion or the meeting;
6.5.3 That the meeting proceed to the next business;
6.5.4 The appointment of an ad hoc committee to deal with a specific item of business
6.5.5 That the motion be now put.

6.6 No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

7. Voting

7.1 If, in the opinion of the Chairman, a vote should be required on a question at a meeting of the Council of Governors, the result shall be determined by a majority of the votes of the Governors present and voting on the question.

7.2 All questions put to the vote shall, at the discretion of the Chairman of the meeting be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

7.3 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

8. Minutes

8.1 Minutes of the proceedings of a meeting shall be drawn up and submitted for approval at the next meeting where they will be signed by the Chairman of that meeting.

8.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

8.3 Minutes of the meeting shall record the names of those present.

8.4 Minutes of the meetings shall be made available to the public except for those

minutes relating to business conducted when members of the public or press are excluded under the terms of Paragraph 3.3 of these Standing Orders.

9. Quorum

9.1 No business shall be transacted at a meeting of the Council of Governors unless at least five Public Governors, one Staff Governor and one Appointed Governor are present at the meeting.

9.2 If a Governor has been disqualified from participating in the discussion on any matter and/or from voting or any resolution by reason of the declaration of a conflict of interest he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

9.3 The Council of Governors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

10. Nominations Committee

10.1 The Council of Governors shall create a duly authorised Nominations Committee who shall seek the views of the Board of Directors as to their recommended criteria and process for the selection of candidates, and having regards to those views, shall then seek, shortlist and interview such candidates as the Nominations Committee considers appropriate and shall make recommendations to the Council of Governors as to potential appointments as Non-Executive Directors and shall advise the Board of Directors of those recommendations.

10.2 The Company Secretary shall attend the Nominations Committee and take minutes of any proceedings.

10.3 The Nominations Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Council of Governors). Such terms of reference shall have effect as if incorporated into the Standing Orders.

10.4 The Council of Governors shall approve the appointments to the Nominations Committee. The Chairman of the Nominations Committee shall be the Trust Chairman.

10.5 Confidentiality – A member of the Nominations Committee shall not disclose a matter dealt with, or brought before the Nominations Committee without its permission until the Nominations Committee have reported to the Council of Governors or shall otherwise have concluded the matter.

11. Declarations of Interest and Register of Interests

11.1 Interests which should be regarded as ‘relevant and material’ and which, for the avoidance of doubt should be included in the register are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs.

b) Ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) A position of authority in a charity or voluntary organisation in the field of health and social care.

d) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.

e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.

f) Membership of clubs, societies or organisations whose purpose may include furthering the business or personal interests of their members by undeclared or informal means. Such organisations include Masonic lodges and religious societies whose membership consists of professional and business people.

g) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS

54. ANNEX 8 – DISPUTE RESOLUTION PROCEDURE

1. In the event of a dispute with:

a) A member or prospective Member in relation to eligibility or disqualification; or

b) A Governor or prospective governor in relation to matters of eligibility, disqualification or termination of tenure;

The individual concerned shall be invite to an informal meeting with Company Secretary or with one or more of the Directors. If not resolved, the dispute shall be referred to a panel comprising the Chairman, at least one Elected Governor, and wither the Company Secretary or one of the Directors. The decision of the panel shall be final.

2. A dispute arising between the Council of Governors and the Board of Directors shall be referred to a panel comprising the Chairman, the Chief Executive and two governors who have been nominated by the Council of Governors. The panel shall use all reasonable endeavours to facilitate the resolution of the dispute.
3. In the event resolution is not reached under Paragraph 2 above, the panel shall consult the Council of Governors and the Board of Directors to determine whether the matter should be referred to mediation. In the event the decision is to refer to mediation, an external mediator shall be appointed by the Centre for Dispute Resolution or such other organisation as the panel shall agree.