The Clatterbridge Cancer Centre NHS Foundation Trust

Agenda: Trust Board Part 1
Date/Time of Meeting: 28th June 2023, 09:30am

	Preliminary Business		Lead	Time
43-23/24	Welcome, Introduction, Apologies and Quoracy	v	K Doran	09:30
44-23/24	Declarations of Interest	v	K Doran	
45-23/24	Minutes of the Last Meeting – 31st May 2023	p	K Doran	
46-23/24	Matters Arising / Action Log	p	K Doran	
47-23/24	Cycle of Business	p	K Doran	
48-23/24	Chair and Chief Exec's Report to the Board	p	K Doran / L Bishop	
	Our People			
49-23/24	Staff Story – The Power of Schwartz Rounds	v	J Shaw	09:45
50-23/24	Guardian of Safe Working Annual Report	p	S Khanduri	09:55
	Our Patients			
51-23/24	NED and Governor Engagement Walk round	p	A Yagnik	10:05
52-23/24	Safer Staffing Report	p	J Gray	10:15
	Our Performance			
54-23/24	People Committee Chairs Report	p	K Doran	10:25
55-23/24	Quality Committee Chairs Report	p	T Jones	10:35
56-23/24	Integrated Performance Report	p	Exec Leads	10:45
57-23/24	Finance Report	p	J Thomson	11:00
	Our Strategy			
58-23/24	Cancer Alliance Quarterly Report	p	L Bishop	11:10
59-23/24	Liverpool Joint Provider Chairs Report and Terms of Reference	p	K Doran	11:20
60-23/24	Joint Site Committee Chairs Report	p	K Doran	11:30
	Our Governance			
61-23/24	NHSE Elective Care Priorities 2023/24 – Board Checklist	p	J Thomson / J Spencer	11:40
62-23/24	Annual Self-Certification NHS Provider License	p	J Hindle	11:50
	Items for Inclusion on the Board Assurance Framework			
63-23/24	*To confirm if there are any additional items for inclusion on the BAF*	v	K Doran	12:00
	Questions from Governors and members of the public			
64-23/24	*Governors and members of the public to raise any questions in relation to the agenda*	v	K Doran	12:05
	Any Other Business			
65-23/24		v	K Doran	12:15
	Reflections on the Meeting			
66-23/24		v	K Doran	12:25
	Date and time of next meeting: 26th July 2023, 09:30am			
	Resolution: *"To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".*			
	Close			

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOAGEND
Review: July 2025
Version: 2.0

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

p paper
***** presentation
v verbal report

WE ARE...
KIND EMPOWERED RESPONSIBLE INCLUSIVE

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The Clatterbridge Cancer Centre NHS Foundation Trust

Draft Minutes of Trust Board Part 1
31st May 2023 at 10am

Kathy Doran	Chair
Mark Tattersall	Non-Executive Director
Geoff Broadhead	Non-Executive Director
Elkan Abrahamson	Non-Executive Director
Terry Jones	Non-Executive Director
Asutosh Yagnik	Non-Executive Director
Liz Bishop	Chief Executive
Jayne Shaw	Director of Workforce & Organisational Development
Sheena Khanduri	Medical Director
Julie Gray	Chief Nurse
Joan Spencer	Chief Operating Officer
James Thomson	Director of Finance
Tom Pharaoh	Director of Strategy (non-voting)
Sarah Barr	Chief Information Officer (non-voting)

In attendance:

Jane Hindle	Associate Director of Corporate Governance
Anne Mason	Corporate Governance & Governor Engagement Officer
Jane Wilkinson	Lead Governor
Laura Jane Brown	Staff Governor (Nurses)
Allan Evans	Staffside
Johanna Wynne	Freedom to Speak Up Lead
Susan King	Communications Manager

Observing

Rupert Brereton	Healthcare Partnerships (Pfizer)

Item No.	Standard Business
22-23	**Welcome, Introduction, Apologies & Quoracy:** Kathy Doran welcomed the Board members, observing Governors, members of the public and staff. Apologies were noted from Anna Rothery, who was unable to join the meeting due to technical issues. Kathy Doran confirmed the meeting was quorate.
23-23	**Declarations of Interest** There were no declarations made in relation to any of the agenda items. The Boards register of interests is published on the Trust website: https://www.clatterbridgecc.nhs.uk/application/files/2316/8233/2399/The_Clatterbridge_Cancer_Centre_Register_of_Interests_2022-23.pdf

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The Clatterbridge Cancer Centre NHS Foundation Trust

24-23	**Minutes of Previous Meeting** The minutes of the meeting held on 26th April 2023 were approved as a true and accurate record subject to the following amendments: • Geoff Broadhead to be removed as an attendee as he sent apologies • 13-23 the last 2 bullet points need to be re-written for clarity • 12-23 The numbers of staff outstanding for Immediate Life Support (ILS) and Basic Life Support (BLS) training for May 2023 to be updated to 117 BLS and 55 ILS • The title for BAF 1 to be changed as per the discussion– Skye Thomson/Julie Gray • BAF 15 – to reflect that substantial assurance has been received
25-23	**Matters Arising / Action Log** There were no matters arising. The Board noted that the following updates regarding the action log: **P1-045-23/24 Board Assurance Framework Refresh** Following comments by the Board, changes to descriptions of the BAF will go through June Trust Board with the following clarification on the BAF risk scores: BAF 9 – score reduced from 12 to 9 BAF 11 – score confirmed as 16 BAF 10 – no changes to the score
26-23	**Cycle of Business** The Board noted the Cycle of Business and that the next Trust Board meeting has moved from July 2023 to 28th June 2023.
27-23	**Chair's report** Liz Bishop provided the following report highlights to the Board: **NHS Assembly** Feedback from the successful staff engagement session held on 18 May 2023 for the NHS Assembly was sent to NHS England on 26th May 2023. T**he Cheshire & Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative** CMAST are aligning approaches to the industrial action by working closely with the unions and local Trusts. Focus is on national planning for outpatients waiting for treatment for 2023/2024. **Liverpool University Hospital Foundation Trust Visit** David Flory, Chairman of Liverpool University Hospital Foundation Trust (LUHFT) visited The Clatterbridge Cancer Centre Liverpool site for an overview of the Trust's services. The meeting was positive and strengthens the collaborative work between the Trusts. David will be chairing the Liverpool Joint Committee and is very experienced and action focussed. **Paddington Village Community Diagnostic Centre** Dr Vin Diwakar Director of Transformation for NHS England, visited the new Paddington Village Community Diagnostic Site accompanied by James Thomson and Dr Diwakar's physicist colleagues. The group discussed how the networks are working together, sharing good practice, and how community diagnostic centres fit in to the Integrated Care System. Dr Diwakar noted the community spirit and supportive network and left with a good impression to feed back to NHS England.

	Freedom to Speak Up Lead The new Freedom to Speak Up Lead Johanna Wynne has been appointed and Liz Bishop welcomed her to the meeting. **Never Event** Liz Bishop informed the Board that a Never Event had occurred and an investigation is underway which will lead to full report that will be presented to a future meeting of the Quality Committee. Early indications are that no harm was caused to the patient concerned and the incident has been reported to the regulators. Liz Bishop confirmed that there were no issues relating to the Trust process. Kathy Doran advised the Board that other items from the Chair's Report were on the agenda under 37-23-24 Joint Committee and 36-23-24 Charitable Funds. **The Board:** • **noted the contents of the report.**
	Our Patients
28-23	**Patient Story** Julie Gray presented an overview the story, regarding a patient with a background in the healthcare sector, who has prostate cancer. The patient was very happy with the care received and was keen to ensure each person who provided care was mentioned in his story. The patient highlighted only one area of improvement around the appointment scheduling process. The Business Intelligence Team are currently working on a waiting time dashboard to improve the process to make it more streamlined. Julie Gray confirmed that patient stories are shared at the Trust Executive Group and then shared throughout the organisation. Geoff Broadhead commented that the story was remarkably positive and interesting to learn from patients when experiences go well. Kathy Doran commented that the waiting time dashboard is a really good idea which should help prevent patient frustrations. Joan Spencer agreed and mentioned that patients are sometimes worried about missing their appointment slot if they leave to get refreshments. Tom Pharaoh added that feedback from the clinical teams, is that patient experience begins from the time the patient enters the car park, therefore every aspect of their appointment is an important part of the whole experience. **The Board:** • **noted the contents of the report.**
29-23	**NED & Governor Engagement Walk-Round** Caroline Pelham-Lane, Public Governor for Cheshire West and Chester, and Non-Executive Director, Terry Jones, took part in the May Walk-Round at The Clatterbridge Cancer Centre Wirral. They noted that staff were universally happy, and the hospital had a calm and relaxed atmosphere. Staff commented that they did not feel at a disadvantage working on site due to being rotated across all three Clatterbridge sites. One issue was raised regarding the consequences of the main site being situated in Liverpool relating to patients who become acutely unwell and the staff being reliant on the Northwest

	Ambulance service which has occasionally put additional pressure on both staff and the department. Julie Gray advised that patients are considered to be in a safe place until the Northwest Ambulance Service arrive and little can be done by the Trust to improve ambulance waiting times. A delay in Pharmacy delivery issues from Liverpool University Hospital Foundation Trust, was also highlighted however, staff are looking into alternative solutions, including collaborations with other Trusts to address this issue. Discussions took place with three patients who gave positive reviews with one choosing to be treated on the Wirral site despite living closer to the Christie Hospital. One issue raised was the appointment system whereby the patients feel they need to closely monitor their appointments themselves. This may be due to recent sickness and vacancies within the administrative teams however the vacancies have now been filled which should improve the issue. Another issue highlighted was the patient surveys which appear to be confusing and poorly timed. The Patient Experience Team are working closely with the Communications Team to address this issue, however, overall, the patients felt happy and hugely supported. Terry Jones commented that potential issues relating to equality of treatment across the sites needs to be closely monitored. **The Board:** • **noted the contents of the report.**
	Our Strategy
30-23	**Progress against the 5 Year Strategy** Tom Pharaoh presented the report and highlighted the following: <u>Be Outstanding</u> • Positive Northwest Pharmaceutical Quality Assurance (NWPQA) audit of aseptic pharmacy in January 2023 – unit rated as low risk • Programme in place to develop cutting edge CAR-T cell therapy service for Cheshire & Merseyside with a target date of Sep 2023 • First annual report of Green Plan delivery showed positive progress <u>Be Collaborative</u> • Programme in place with programme director overseeing multiple work streams to prepare for mobilisation of Paddington CDC • Clatterbridge Cancer Centre is engaging in Joint Committee of Liverpool providers and site-specific subcommittee focused on joint working between The Clatterbridge Cancer Centre and Liverpool University Hospital Foundation Trust • Paediatric radiotherapy service transferred to Christie in March 2023 <u>Be Research Leaders</u> • Success of Liverpool Experimental Cancer Medicine Centre (ECMC) renewal bid was announced in January 2023 – investment over the next 5 years • Seven successful bids for Clatterbridge Research Funding Scheme 2022 <u>Be Digital</u> • Digital strategy has been developed and approved through Trust's governance for presentation at Trust Board of Directors in May 2023 • Trust achieved Cyber Essentials Plus status in Dec 2022

	Be Innovative • Former Rutherford Cancer Centre has been purchased and will operate as Clatterbridge Cancer Centre-Paddington with further opportunities to be explored after the Community Diagnostic Centre opens. Be a Great Place to Work • A 65% response rate achieved in 2022 from the NHS staff survey - results showed steady progress and listening events being held to inform action plans Current Challenges Challenges relate to vacancies and competing priorities in key corporate services, which continue to mean limited capacity to deliver the strategy in those areas and the development of the Paddington Village Community Diagnostic Centre is complex and is in addition to business as usual. Key Activities • Successfully open Paddington Community Diagnostic Centre and explore further opportunities for development of services • Progress refurbishment/development of The Clatterbridge Cancer Centre Wirral site • Commence CAR-T cell therapy service for patients across Cheshire and Merseyside • Progress the workplan for collaboration between The Clatterbridge Cancer Centre Liverpool and Liverpool University Hospital Trust Tom Pharaoh clarified that the Clinical Research Facility collaboration was omitted from the highlights; however, has been included in the body of the report and will be included in the revised edition. Regarding the Quality Strategy, Julie Gray added that there is currently a stand in the foyer of The Clatterbridge Cancer Centre Liverpool where patients, staff and visitors can add their comments for improving quality which can be added into the strategy. James Thomson commented that the focus is on achieving the milestones, including discussions relating to the demolition of the old Royal Liverpool Hospital, and the emergence of Integrated Care Boards, which will be incorporated into the next plan. Elkan Abrahamson commented on the Equality Impact Assessment on the cover sheet stating that the five-year plan may have an impact in the future. Jayne Shaw advised that the Equality Impact Assessment is under review and a new assessment form is currently being trialled and referred the Board to the new Equality Impact Assessment attached to the Digital Strategy. The Board noted the contents of the report
	Digital Strategy

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31-23	Sarah Barr introduced a PowerPoint Presentation for the new Digital Strategy covering 2023-2025 and seeks approval from the Board today Overview The digital team are committed to "Being Digital" and the mission is to harness the power of digital technology and data to transform care, improve patient outcomes and experiences. Sarah outlined the National, Regional, and The Clatterbridge Cancer Centre priorities. The team are further developing the digital infrastructure to ensure there are solid foundations that will improve digital maturity regarding electronic patient records to meet the national requirements and expand the shared care records and digital programmes in the region. How the strategy was developed In alignment with the Trusts Strategic 5-year plan, the digital team gathered multiple views from across the organisation, Integrated Care Systems, and partners within the digital team. Public engagement is aligned with Cheshire and Merseyside, and every patient facing initiative will be managed through engagement plans with the appropriate groups. Independent user-researchers were used to support the strategy from engagement with front-line services and leaders across the Trust, resulting in considered and more refined programmes, roadmaps, principles, and delivery approaches. Once drafted the strategy was reviewed and refined by staff and leaders across the services with examples to bring it to life. The strategy has been reviewed and recommended for approval by Digital Board, Trust Executive Group and Quality Committee. The Plan The Digital team have four main themes to deliver: • Digitally transform cancer services – by bringing people together to implement usable, efficient workflows through modern solutions from diagnostics to medicines • Empowering cancer patients and carers – by delivering care remotely, delivering information and advice through mobile apps and portals, and improving the inpatient experience • Empowering staff – by supporting user-friendly digital tools, delivering training programmes, improving collaboration, and developing digital champions. • Data-driven cancer research and innovation – by providing data platforms, advanced analytics and Artificial Intelligence, support services to plan, improve and innovate using data. The digital team are committed to enabling great care across the Trust and will support staff to make the most of the digital tools and to develop their knowledge to best serve colleagues and patients. Each of the themes has a delivery roadmap as part of the work to optimise the electronic patient record. This will be expanded and strengthened to enable the strategy to be delivered. The Digital Board will monitor the progress monthly to provide assurance to the Trust Executive Group with regular updates being brought before the Board. Sarah Barr confirmed that the plan aligns with the capital plan for the year, with the next key issue being the challenge of the Electronic Patient Record convergence, however workshops are taking place across Liverpool to address to the national funding challenge. Mark Tattersall asked if interdependencies will have an effect on the plan. Sarah Barr replied that the team are aware of the interdependencies and are working closely with the Transformation

	Team to align with the 5-year strategy, and a Business Intelligence Dashboard will be developed to inform services and outcomes which will lead to an update to the annual strategy. Jane Hindle advised the Board that a new Equality Impact Assessment (EIA) has been created using models from other organisations, in liaison with the Equality Diversity and Inclusion Lead, and has been completed for the Digital Strategy. Sarah Barr commented that the EIA demonstrated the engagement that had taken place throughout the development of the Strategy and the tool was more intuitive than the previous version. **The Board:** • **commended Sarah Barr on the clarity of the presentation and** • **approved the Digital Strategy.**
	Our Performance
32-23	**Performance Committee Chairs Report** Geoff Broadhead presented the Performance Committee Chairs Report noting the following: There was a lengthy discussion regarding the Board Assurance Framework (BAF) and alignment with the Key Performance Indicators. The Committee went on to discuss risk 361, Southeast corner, which can now be reduced in score following successful conversations with the Council. The Committee proposed closing the risk as the short-term issues have now been resolved and creating a new risk detailing the longer-term issues relating to the old Royal Liverpool University Hospital site. The Integrated Performance Report highlighted delays with molecular testing turnaround times; however, the Committee were assured that is being monitored through the Trust Operational Group. The Committee noted a theme arising around capacity and has requested a deep dive report to be presented at the next Committee meeting. The Committee received an overview of the final approved financial plan for 2023/24. The Committee noted the Trust has increased the score of BAF risk 3, associated with financial delivery, from 9 (3x3) to 12 (4x3). The Trust has a high level of Cost Improvement Programme (CIP) to achieve in order to deliver the overall financial plan which will be challenging. The Committee commented on the excellent Green Plan Assurance Report. **The Board:** • **noted the contents of the report**
33-23	**Integrated Performance Report** Each Executive Lead provided brief highlights from the Statistical Process Chart (SPC) and exception reporting for the following areas: <u>Access and Efficiency</u> Joan Spencer informed the Board that excellent progress had been made in the past month with a successful recruitment plan put in place incorporating a talent pool for essential roles within the Trust. Service Review Groups are working with the Transformation and Improvement Committee which is helping with planning and investment. The team continue to work on the Trust's Outpatient strategy to expand Patient Initiated Follow Up and Patient Stratified Follow Up, which should create further capacity.

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The transfer of the laboratory service provision on 1st April 2023 has resulted in much longer molecular test turnaround times. This is having a significant negative impact on the Trust's ability to achieve this target from April 2023 and the 62-day target from May 2023. This is on the risk register and the Trust is reviewing solutions to resolve the issue as quickly as possible.

Weekly 'Lengthened Length of Stay' meetings have continued with attendance of Matron and the Business Services Manager to ensure the flow of patients continues, and any concerns can be escalated. The outcome of these meetings is forwarded to the General Manager for review.

Quality
Julie Gray advised the Board that the Serious Incident declared in April relates to an extravasation from a cannular and will be reviewed by a clinical panel in June, where it will be determined whether the incident is classed as a Serious Incident or stood down.

The Trust continues to have a low number of complaints which is due to early face to face resolution meetings, however there are two complaints that have not met the target dates, but revised targets have both been agreed with the patients and their families.

The target for policies has not been achieved with 24 of the 259 policies yet to be reviewed. 10 documents await approval via meetings and committees, which will take place over the next month and 4 await sign off. Work is being carried out by the Associate Director of Clinical Governance and the Information Governance Manager to investigate how the process can be streamlined to ensure policies are reviewed in a timely manner.

Research and Innovation
Sheena Khanduri advised that there were 62 patients recruited at the end of month 1 against an internal annual target of 1500 (50% of target). Of the 62 patients recruited, 12 were recruited onto interventional studies, 39 onto observational and 11 into the Biobank. The majority of the studies currently in set-up are complex, supporting the Biomedical Research Centre (BRC), and Experimental Cancer Medicine Centre strands of the research portfolio. A clinical trial capacity gap analysis paper is being written with wide consultation with an anticipated review at June 2023 Trust Executive Group.

Regular operational meetings are taking place with the Clinical Trial Pharmacy and Research and Innovation teams to progress/open new drug studies. A recovery plan is in place with Pharmacy monitored through the Research and Innovation Directorate Board. Studies opened are currently capped by Pharmacy staffing capacity, which is due to improve from June 2023 onwards.

Liz Bishop confirmed that there were 27 recommendations following the Lord O'Shaughnessy review into clinical trials which will result in a defined approach to increase trials across the region and nationally.

Workforce
Jayne Shaw explained that sickness absence has decreased from 4.82% in March to 4.58% in April. This remains above the Trust target of 4% and compares well against the Cheshire and Merseyside figures. The Learning and Development Team have an action plan regarding long-term and short-term sickness which will be monitored through the Workforce Advisory Group.

The Trust turnover has decreased in April from 16% in to 14.93% and although above the Trust target, is the lowest since March 2021. This includes all leavers from the Trust, regardless of

	reason for leaving. Leavers due to retirement and end of fixed term contracts (FTC) were removed from the list of leavers up until the end of April 2023, which takes the Trust below target. Intermediate and Basic Life Support Mandatory Training remains below target and letters are being sent out on 5th June 2023 to individuals who are non-compliant. **The Board:** • **noted the contents of the report.**
34-23	**Finance Report** James Thomson provided an overview of the finance report and highlighted the following: The Trust financial position to the end of April is a £67k deficit, which is £97k below plan. The group position at the end of April is a £31k surplus, £1k above plan. Cost and Volume drugs are underspent by £285k and this is offset by a reduction to income. Bank spend is £155k in month due to the number of patients requiring one to one care on the inpatient wards, escalation beds remaining open and bank payments to cover the junior doctor strike. Non pay spend is overspent by £390k, of which £330k relates to unmet CIP for month 1. The CIP plan profile is in twelfthes, however, CIP achievement is expected to increase incrementally during the year. The Trust cash position has a closing balance of £63.1m, which while below plan by £2.4m is a healthy cash position and does not raise any concern. Capital spend is £77k in month with the majority of spend profiled in future months. The Trust put an agency plan forward as part of the planning submission based on previous year spend, which it will be monitored against for the 2023/24 financial year. In month 1 agency spend is below plan by £53k **The Board:** • **noted the contents of the Report**
	Our Governance
35-23	**Extra-ordinary Audit Committee** Mark Tattersall advised the Board that the focus of the Committee has been on the 2022/23 Annual Reports and Accounts. The report evidenced the basis for the assessment and the Committee endorsed the Going Concern Assessment and can meet its financial obligations during 2023/24. The Committee reviewed the updated Significant Accounting Estimates regarding valuation of the property plan and equipment, the annual depreciation, and provision for Research and Innovation Strategy support. The year-end audit work is underway and is on track to be completed on time. Discussions are on-going with the Trust on several points but there is currently nothing of significance to raise to the Audit Committee.

	The Committee reviewed the draft Annual Report, including the Annual Governance Statement (AGS). It was noted that the revised draft had addressed the recommendations identified by the Head of Internal Audit in relation to the content of the AGS. The Committee also noted the final version of the AGS would need to reflect the Head of Internal Audit Opinion, which had previously been reported to the Committee, together with updated information relating to the Internal Audit reviews that had been completed since the initial draft. **The Board:** • **noted the contents of the report**
36-23	**Charitable Funds** Elkan Abrahamson informed the Board that approval is to be sought regarding the Charity Asset Transfer agreement, Data Transfer agreement and Services agreement. The Charity raised £3,409,623 income which is 4% increase on the previous year. The new Charity is registered with the Charity Commission and Companies House, and the model of The Clatterbridge Cancer Centre made out of Lego is now installed in the foyer of the Liverpool site. **The Board:** • **noted the contents of the Report**
37-23	**Joint Committee – Liverpool University Hospital Foundation Trust (LUHFT) and Clatterbridge Cancer Centre (CCC) Chair's Reports including Terms of Reference.** Kathy Doran advised the Board that a meeting took place between LUHFT and CCC on 21st April 2023 involving representatives from both Trusts. The revised Joint Committee Terms of Reference are in line with The Walton Centre and Liverpool Heart and Chest's respective Joint Committees. The Terms of Reference were approved at the meeting with a recommendation to be approved at both LUHFT and CCC Board of Directors. The Joint Committee Work Plan includes the following workstreams: • Emergency Pathways • Radiology • Pharmacy • Service Lever Agreement Management • Workforce and Education • Estates The work streams have CCC leads, and the Committee agreed to share organograms to support the identification of LUHFT work stream leads. There will be a Joint Partnership Group which will report into the Joint Committee with the first meeting to be held in May. Terms of Reference for the Joint Partnership Group were approved subject to the inclusion of workforce and education, in the specific areas of work and membership. It is envisaged that the Joint Partnership Group and Joint Committee will meet on an alternate bi-monthly basis.

	The next Joint Committee will take place on 9th June 2023 and will report to the Liverpool Joint Committee chaired by David Flory (Chairman of LUHFT) on the 16thJune 2023. **The Board:** • **noted the contents of the report and** • **approved the Terms of Reference for the Joint Committee.**
38-23	**Actions from Board Development** The Board recognises that understanding Equality, Diversity and Inclusion improves communication, supports staff to build better relationships and therefore feel more valued; and enhances the experience of patients. The following actions will be progressed through the People Committee: a) A review of the external resources available to Staff and a reflection of these via internal Leadership materials b) Review current Committee reporting to ensure that it provides an appropriate level of data in terms of the diversity of staff and the population c) Review the Equality Impact Assessment Tool and training to ensure that it supports staff in decision making. The Board noted that the use of the term "Equity" had been discussed as a better way of describing and recognising the needs of individuals however, recognised that the use of "Equality" is linked to the legal duty defined within the Equality Act 2010.
	Items for Inclusion on the Board Assurance Framework
39-23	There were no items for inclusion for the Board Assurance Framework
	Questions from Governors and members of the public
40-23	Jane Wilkinson asked if the Trust's research trials figures are echoed by other Trusts Sheena Khanduri confirmed that the figures are in line with other organisations and reflect the impact of the Covid pandemic and there are no specific themes identified.
	Any Other Business
41-23	No other Business was discussed
	Reflections on the Meeting
42-23	The Board reiterated that the Digital Strategy was an excellent document and was both succinct and extremely helpful.
	Date and time of next meeting: 28th June 2023, 09:30am till 12:30pm, The Spine Level 12

Trust Board Part 1 Action Log

KEY	
	Complete
	On Track
	At Risk
	Late

Item No.	Date of Meeting	Item	Action(s)	Action By	Date to Complete By	RAGB	Status Update/Assurance
P1-160-22	28-Sep-22	Formal Review of the Board Committee Governance Structure	The Board agreed to continue on this Committee governance model and review again in 6 months	**JG**	Jul-23		Included on cycle of business Deferred - Awaiting new ADoCG starting 26 April 23: Board agreed new date for completion od July 2023, to be completed as part of Committee Effectiveness review.
P1-013-23	26-Jan-23	Integrated Performance Review	The Medical Director to take data on VTE incidents to Quality Committee	**SK**	Jun-23		Added to Quality Committee Cycle of Business for March 23 Deferred until June 23 26.04.23 Board acknowldged deferred reporting to Quality Committee and agreed revised June 2023 deadline
P1-045-23/	26-Apr-23	Board Assurance Framework Refresh	Further review of BAF refresh to take place in light of AY comments. Clarification to be provided on People Committee BAF score discussions. Wording from Risk Management Strategy in relation to risk appetite to be reflected in BAF	**JH**	May-23		Following comments at April's meeting the wording of each risk and the risk levels has been reviewed and will be presented to each respective committee in May and June prior to coming to Board in July. Confirmation has been received on the BAF risks within the remit of the People Committee: BAF 9 reduced in score from 12 to 9, BAF11 was 16 in Q3 and remains at 16 following discussion at People Committee. BAF 10 and BAF 12 had no proposed score changes.

Trust Board Cycle of Business 2023/24																	
Item	**Lead**	**Frequency**	**Item For**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**2024**	**Jan-24**	**Feb-24**	**Mar-24**	
Standard Items																	
Welcome, Introductions, Apologies and Quoracy	Chair	Monthly	Standard Business	√	√	√	√		√	√	√			√	√	√	
Declarations of Interest	Chair	Monthly	Standard Business	√	√	√	√		√	√	√			√	√	√	
Matters Arising / Action Log	Chair	Monthly	Standard Business	√	√	√	√		√	√	√			√	√	√	
Cycle of Business	Chair	Monthly	Standard Business	√	√	√	√		√	√	√			√	√	√	
Chair and Chief Executive Update	Chair / Chief Exec	Monthly	Standard Business	NA	√	√	√		√	√	√			√	√	√	
Strategy & Planning																	
Progress against 5 Year Strategy	Director of Strategy	6 monthly	For information/noting		√						√						
Annual Financial/Operational Planning Guidance	Director of Finance	Q3 and Q4	For information/noting							√				√	√ Draft	√ Submission	
Progress against Innovation Strategy (Inc. Bright Ideas) Annual Report	Medical Director	Annually	For information/noting											√			
Progress against Research Strategy Annual Report	Medical Director	Annually	For information/noting							√							
Progress against Green Plan Annual Report	Director of Strategy	Annually	For information/noting												√		
Digital Strategy	Chief Information Officer	Annually	For approval		√ (deferred to May 23)												
Quality Strategy	Chief Nurse	Annually	For approval				√										
Risk Management Strategy	Chief Nurse	Annually	For approval	√													
Assurance: Quality & Performance																	
Patient Story	Chief Nurse	Every other meeting	For information/noting		√		√			√				√		√	
Staff Story	Director of WOD	Every other meeting	For information/noting	√		√			√		√				√		
Quality Committee Chair Report	NED TJ	Quarterly	For information/noting	√		√				√				√		√	
Performance Committee Chair Report	NED GB	Quarterly	For information/noting		√				√		√				√		
Audit Committee Chair Report	NED MT	6 times a year	For information/noting	√	√		√			√				√			
Charitable Funds Committee Chair Report	NED EA	Adhoc	For information/noting		√ (deferred to May 23)												
People Committee Chairs Report	NED AR	Quarterly	For information/noting	√ (inc ToR - deferred from Mar 23)		√				√				√		√	
Integrated Performance Report	Exec Leads	Monthly	For discussion For approval	√	√	√	√		√	√	√			√	√	√	
Finance Report	Director of Finance	Monthly	For information/noting	√	√	√	√		√	√	√			√	√	√	
Safer Staffing Report	Chief Nurse	6 monthly	For approval			√								√			
Gender Pay Gap	Director of WOD	Annually	For discussion For approval													√	
Workforce Race Equality Standard Data	Director of WOD	Annually	For information/noting							√							
Workforce Disability Equality Standard Data	Director of WOD	Annually	For information/noting							√							
Equality Diversity & Inclusion Annual Report	Director of WOD	Annually	For approval				√										
In-Patient Survey	Chief Nurse	Annually	For information/noting				√										
NED and Governor Engagement Walk round	NED attended	Monthly	For information/noting	√	√	√	√		√	√	√			√	√	√	
Actions from NED and Governor Engagement Walk-rounds Annual Report	Chief Nurse	Annually	For information/noting	√													
Caldicott/SIRO Annual Report	Medical Director / Director of Finance	Annually	For approval						√								
Staff Survey Results	Director of Workforce	Annually	For information/noting													√	
Statutory Reporting / Compliance																	
Self-Certification against the Provider Licence	Associate Director of Corporate Governance	Annually	For approval				√ (deferred to July 23)										
Regulation 5 Declarations (Fit and Proper)	Associate Director of Corporate Governance	Annually	For approval				√										
Emergency Preparedness Resilience and Response (EPRR) Annual Report and Core Standards	Chief Operating Officer	Annually	For approval						√								
Mortality Report (Learning from Deaths)	Medical Director	Quarterly	For information/noting	√			√				√			√			
Mortality Annual report	Medical Director	Annually	For approval				√										
Revalidation Annual Report	Medical Director	Annually	For approval						√								
Guardian of Safe Working Report	Medical Director	Quarterly	For information/noting						√		√					√	
Guardian of Safe Working Annual Report	Medical Director	Annually	For approval			√											
Infection Prevention and Control Annual Report	Chief Nurse	Annually	For approval				√										
Freedom to Speak Up Annual Report	Associate Director of Corporate Governance	Annually	For approval						√								
Health and Safety Annual Report	Chief Operating Officer	Annually	For approval						√								
Safeguarding Annual report	Chief Nurse	Annually	For approval						√								
Collaboration																	
CMCA Report	Chief Executive		For information/noting			√	√		√		√				√		
Joint Committee - LUHFT and CCC Chair's Report	Chair	tbc	For information/noting		√	√											
Board Governance																	
Review of Constitution (ADHOC)	Associate Director of Corporate Governance	Adhoc	For discussion For information/noting For approval														
Board Assurance Framework	Associate Director of Corporate Governance	Quarterly	For information/noting For approval	√			√			√				√			
Board Assurance Framework Refresh	Associate Director of Corporate Governance	Annually	For approval	√													
Audit Committee Annual Report and Annual Review of Board Effectiveness	Associate Director of Corporate Governance	Annually	For discussion For information/noting				√										
Trust Board Annual Cycle of Business	Associate Director of Corporate Governance	Annually	For discussion For approval													√	
NED Independence & Board Register of Interest	Associate Director of Corporate Governance	Annually	For information/noting													√	
Use of Trust Seal Report	Associate Director of Corporate Governance	Annually	For information/noting	√													
Adhoc / Committee Requested																	
Formal Review of the Board Committee Governance Structure	Associate Director of Corporate Governance	Adhoc	For discussion				√ (deferred from March 22)									√	
Freedom to Speak Up Reflections and Planning Tool	Associate Director of Corporate Governance	One-off	For information/noting						√								
Freedom to Speak Up Policy	Associate Director of Corporate Governance	One-off	For information/noting						√								
Palliative Care End of Life Strategy		One-off	For information/noting				√										

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of Meeting: Trust Board Part 1
Date of Meeting 28th June 2023

Report lead	Kathy Doran Chair, Liz Bishop CEO			
Paper prepared by	Jane Hindle, Associate Director of Corporate Governance			
Report subject/title	Chair and Chief Executive report to Trust Board			
Purpose of paper	This is a combined Chair's and Chief Executive's report containing an update on items of national, regional and local significance.			
Background papers	N/A			
Action required	The Board is requested to: • Note the report			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work	X
	Be Collaborative	X	Be Digital	X
	Be Research Leaders	X	Be Innovative	

Equality & Diversity Impact Assessment						
The content of this paper could have an adverse impact on:	Age	No	Disability	No	Sexual Orientation	No
	Race	No	Pregnancy/Maternity	No	Gender Reassignment	No
	Gender	No	Religious Belief	No		

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

The Clatterbridge Cancer Centre NHS Foundation Trust

Chair's Update

System Update

Following the publication of the NHS England Equality, Diversity and Inclusion Improvement Plan and guidance System Leaders received a presentation regarding the actions that NHS Trusts can take to demonstrate their commitment. This includes the publication of an Anti-Racism statement and specific objectives for Board members. This has been reflected in the recent appraisals and objective setting round.

Leaders also received an update regarding the impact of Covid-19 on the population of the North West and the region was more severely impacted than average. These included:

- The **highest numbers** of coronavirus cases in the deadliest wave of disease (**wave 1**)
- The **highest crude mortality rate of any region** over the whole pandemic (by both mortality methodologies)
- The sub-region with the **longest period of restrictive measures**
- Worse than average impacts on education and the care sector

Liverpool Joint Committee

The Committee met on 16th June to review the draft terms of reference and receive updates from each of the site-specific sub-committees. It was recognised that a more detailed discussion is required regarding the estate across the City. An update was received regarding the work around the Electronic Patient Record and it was agreed that John Llewellyn, Chief Information Officer for the ICB would be invited to a future meeting.

Non-Executive Appraisals

Meetings have taken place during June with each of the Non-Executive Directors to review their performance during 2022/23 and my own will be completed by the Senior Independent Director by the end of June. The output will be reported to the Council of Governors Nomination and Remuneration Committee in July 2023.

CEO Update

Integrated Care systems – Autonomy and Accountability

The government's formal response to the recommendations contained within the Hewitt Review and those relating to Integrated Care Systems made by the Health and Social Care Committee has recently been published.

A number of overlapping themes have been identified including ICS oversight, national targets and role of the Care Quality Commission (CQC). The comprehensive response also covers the additional distinct recommendations in relation to digital and data sharing and primary and social care workforce. Government response to the House of Commons Health and Social Care Committee's 'Integrated care systems: autonomy and accountability'

The Clatterbridge Cancer Centre NHS Foundation Trust

New Sustainability Manager

The Trust's new Sustainability Manager, Kerry Gibbons, started in post on 20th June 2023. Kerry joins the Trust from Alder Hey, where she was part of the innovation team. The Sustainability Manager is a key post to allow the Trust to continue to deliver the Trust's Green Plan commitments in the coming year and start to measure the impact of our work on our overall carbon footprint.

Refurbishment and redevelopment of CCC-Wirral

There are multiple projects of varying sizes underway this year as part of the refurbishment and redevelopment of the CCC-Wirral site:

- The first phase of the Wirral Woodland Glade is complete, with site clearance and hard landscaping having taken place. Phase 2 will involve the installation of furniture and the planting of the area over summer and autumn
- The refurbishment this summer of what was the second café space into a dedicated staff break lounge with kitchen facilities
- The refurbishment of the main staff change spaces near the main entrance
- A major refurbishment of the former Medical Physics building to create a modern office hub while retaining and upgrading the staff welfare facilities on the first floor and installing a lift to make these accessible to all
- A procurement process underway to engage architects to develop early proposals and sketch designs for a possible long term development of a new chemotherapy unit on the site

Paddington Community Diagnostic Centre

The programme to open the Paddington Community Diagnostic Centre in CCC-Paddington is progressing well. The team is working to a target date of 24th July for the delivery of the first diagnostic tests in the facility. The programme is made up of a range of distinct work stream and is being delivered through a dedicated programme board. On Friday 23rd June an extended session took place to allow each of the programme's work streams to share their progress and areas of remaining work. On Friday 30th July the Programme Board will make an assessment of the overall readiness to open the CDC and will make a recommendation to the Trust Executive Group on whether the Trust should proceed with the target opening date.

Industrial action

The most recent round of industrial action by the BMA (junior doctors) took place from 0700 14 June to 0700 17 June 2023.

The usual planning and preparation took place in advance and daily meetings were held during the course of the action. There are no issues to report.

The Clatterbridge Cancer Centre NHS Foundation Trust

Ballots

A number of industrial action ballots are currently underway as follows:

RCN; closes 23 June 2023.

(SOR) Society of Radiographers; closes 28 June. If industrial action is supported this is planned for 24 and 25 July 2023

BMA (consultants); closes 28 June. If industrial action is supported this is planned for 20 and 21 July 2023

BMA (juniors doctors); closes 31 August 2023.

Monthly Star Award

The monthly staff awards programme has recently been reviewed culminating in the launch of the of the Star Awards. The Awards recognise a team, staff member or volunteer who go above and beyond to make a difference to patients, visitors, colleagues or a service. I presented the May Star Award to Jo Francis, Metastatic Breast Clinical Nurse Specialist, who was nominated by the husband of one of our patients who said that Jo has provided the most outstanding support for his wife over the last 8 years which has helped, not only his wife but also himself and the wider family.

Executive Director Appraisals

The appraisals for each of the Executive Directors have been completed, including SMART objectives on EDI for 2023-24.

NHS75

A number of events are taking place locally and nationally during July as part of the NHS75 celebrations to recognise the significant contribution made by staff, particularly over recent years. One of the key national events is a multi-faith service for NHS staff at Westminster Abbey when CCC will be represented by 5 members of staff.

At a Trust level we have arranged a variety of staff engagement activities to take place across all sites week commencing 3 July 2013.

Recommendations:

The Trust Board are requested to:

- Note the report

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 28th June 2023

Report lead	Sheena Khanduri Medical Director				
Paper prepared by	Ian Lampkin Guardian of Safe Working				
Report subject/title	Guardian of Safe Working Annual Report				
Purpose of paper	This Annual Report on Safe Working Hours for doctors in training (2021-22) is presented to the Board with the aim of providing context and assurance around safe working hours for Doctors in Training at the Clatterbridge Cancer Centre, to provide an annual update on the work of the Guardian of safe working, and to note areas of concern in terms of exception reporting, work schedules and fines paid.				
Background papers					
Action required	For information and noting				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	x	Be a great place to work	x	
	Be Collaborative	x	Be Digital	x	
	Be Research Leaders		Be Innovative		

Equality & Diversity Impact Assessment						
The content of this paper could have an adverse impact on:	Age	No	Disability	No	Sexual Orientation	No
	Race	No	Pregnancy/Maternity	No	Gender Reassignment	No
	Gender	No	Religious Belief	No		

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Guardian of Safe Working – Annual Report 2022/23

Dr Ian Lampkin MBCHB MRCP FRCR
Consultant Clinical Oncologist
Guardian of Safe Working

Version: 1.0 Ref: FCGOREPO Review: May 2024

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

1.0 Introduction

This report covers the period April 2022 - April 2023.

The 2016 Contract for doctors in training ('Junior Doctors') sets out terms and conditions regarding Working Hours (Schedule 03), Work Scheduling (Schedule 04) and Exception Reporting and Work Schedule Reviews (Schedule 05). These are a system of checks and balances to ensure doctors in training work fixed numbers of hours in a 24 hour period, fixed numbers of consecutive days of work and have designated break times in a work period, to try to ensure they are never so fatigued from work as to be a risk to patient safety, which is of paramount importance. The contract also has schedules outlining the training opportunities the junior doctors should be receiving to ensure appropriate development of skills and knowledge.

From 1st April 2022, Dr Ian Lampkin took over the role of Guardian of Safe Working

With effect from December 2019, all doctors in training transferred to the 2016 Terms and Conditions of service. Eight current ST3+ trainees have their previous pay and banding protected on their existing salaries. Significant breaches on working hours can incur financial penalties.

Since August 2021, Haematology doctors in training officially come under ourselves as opposed to Liverpool University Hospitals. We liaise with this group of trainees around attendance at Junior Doctors Forum and issues related to Exception Reports raised at each Trust.

Regarding Haematology, From July 2022 a pathway has been established where the LUFHT Guardian shares any relevant exception reports for systematic oversight review to the CCC Guardian. Individual exceptions are still currently signed off from the LUFHT system and remain the responsibility of the individual's Educational Supervisor/LUFHT Guardian at the time of this report. We liaise with this Haematology trainees around attendance at Junior Doctors Forum and issues related to Exception Reports raised when working directly at Clatterbridge

Ongoing work is being undertaken with CCC and LUFHT for the ongoing management/oversight of the Haematology rotas.

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Exception reporting in the Trust:

There were 20 exception reports for IMT/GP trainees and fellows and 2 for oncology specialist trainees for the period this period, April 2022 – April 2023. These were all related to working hours/rota issues and have all been managed accordingly with 14 as TOIL and 8 as additional pay. Across the timeframe of this report there has been a progressive improvement in the actioning timeframe for reports to be dealt with within 7 to 14 days and sites at 100% (target 90%).

The number of exception reports for this year are comparable with 2021-2022 when 17 exceptions were made.

For Haemtology trainees during April 2022 to April 2023 there were 26 exception reports made. Responsibility for actioning these still sit with LUFHT at the time of this report.
Of the reports, 18 were related to out of hours work in other organisations and therefore beyond the control of CCC.
The other 8 involved ward staffing related issues/staying late/ward acuity. These were reviewed with the Haemtology Training programme director and CCC Management with rota designha, ndover times reviewed and adapted according. Haematology fellows have also been recruited along with Oncology Fellows. A monitoring exercise for Haemtology trainees was also recently undertaken at LUFHT which the outcome is awaited at time of report.

Work schedule reviews

There have been 0 requests from trainees or supervisors for work schedule review related to Junior trainee rotas/staffing issues.

All Trainees who require access to Exception Reporting, have passwords and log in details for exception reporting have been reissued. Trainees and Junior Fellows have been sent reminds of this on a regular basis.

Fines:

There were no fines incurred in this annual year (2022/23).

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Vacancies/Gaps as of May 2023:

The Trust operates a 1 in 14 junior doctor ward rota and a 1 in 19 senior (registrar) rota, which both feature out of hours work in CDU.

The 1 in 14 junior Ward Rota currently comprises 5 x Junior Clinical Fellows and 9 x junior Doctors in Training (IMT and GPST). One trainee works Less Than Full Time at 80%, creating a gap on their non-working day.

Our 1 in 19 Registrar Rota currently has 2 gaps due to a doctor going out of programme for 12 months from April 2023 and another gap following a secondment being undertaken at The Christie until 01/07/2023.

Rota designs are taking place for the August 2023 intake and new Work Schedules will be issued no later than 07/06/2023 (8 weeks prior to their start date). The new Work Schedule/Exception report policy is being present to JLNC aiming to be approved for September/October 2023 in conjunction with this

Locum bookings

All 'Patchwork' shifts are the additional locum duties worked by our doctors in training. These are a result of known gaps in the rota plus last minute cover due to absences.

Quarter 1 – April to June 2022

Specialty	Shifts worked by bank doctors	Shifts worked by agency doctors	Patchwork shifts
Clinical Oncology / Medical Oncology	0	0	35
General Medicine	46	178	31
Haemato Oncology	0	69	0

Quarter 2 – July to September 2022

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Specialty	Shifts worked by bank doctors (previous number)	Shifts worked by agency doctors (prev number)	Patchwork shifts (prev number)
Clinical Oncology / Medical Oncology	0	0	42 (35)
General Medicine	23 (46)	180 (178)	19 (31)
Haemato Oncology	0	89 (69)	0

Quarter 3 - October to December 2022

Specialty	Shifts worked by bank doctors (previous number)	Shifts worked by agency doctors (prev number)	Patchwork shifts (prev number)
Clinical Oncology / Medical Oncology	0	0	18 (42)
General Medicine	24 (23)	647 (180)	14 (19)
Haemato Oncology	0	194 (89)	0

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Quarter 4 – January to March 2023

Specialty	Shifts worked by bank doctors (previous number)	Shifts worked by agency doctors (prev number)	Patchwork shifts (prev number)
Clinical Oncology / Medical Oncology	0	52	18 (18)
General Medicine	9 (24)	127 (647)	9 (14)
Haemato Oncology	0	26 (194)	2

Actions taken to resolve issues

See GOSW Action plan

Summary

The information in this report confirms for this annual year, the working hours of Ward - based doctors in training IMT/CMT, GP trainees and Oncology trainee doctors remain compliant with the 2016 contract. Locums were used appropriately to cover on-call shifts during this time period to ensure all critical out of hours shifts/ward numbers were covered.

Within this organisation, working hours for doctors in training are considered safe at the current time based upon rotas and rostered hours.

Ongoing work continues with new workforce rota co-ordinator for rota designs for upcoming intake of junior doctors in August 2023.

There remains ongoing work with CCC and LUFHT regarding Haematology trainee rota management/design.

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Although it is strickly outside the remit of this report, the recent trade union/pay dispute with junior doctors and the UK Government is recognized. The Trust recognizes the legal rights of junior doctors to take lawful strike action, and has communicated this to the JDF.

It should be recognized that the Trust has made no hindrance or objections to strike action and has worked successful with the rest of the workforce to maintain patient safety during junior doctor strike action.

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Guardian of Safe Working Hours – Q4 Report January - March 2023

Ian Lampkin, Guardian of Safe Working

Version: 1.0 Ref: FCGOREPO Review: May 2024

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

1.0 Introduction

This report covers the period 1st January – 31st March 2023.

On 1st April 2022, Dr Ian Lampkin was appointed to the Guardian of Safe Working (GoSW) role, succeeding Dr Madhuchanda Chatterjee.

The 2016 Contract for doctors in training ('Junior Doctors') sets out terms and conditions regarding Working Hours (Schedule 03), Work Scheduling (Schedule 04) and Exception Reporting and Work Schedule Reviews (Schedule 05). These Schedules provide a system of checks and balances to ensure doctors in training work fixed numbers of hours in a 24 hour period, fixed numbers of consecutive days of work and have designated break times in a work period. This is to ensure they are never so fatigued from work as to be a risk to patient safety, which is of paramount importance. The contract also has schedules outlining the training opportunities the junior doctors should be receiving to ensure appropriate development of skills and knowledge.

With effect from December 2019, all doctors in training transferred to the 2016 Terms and Conditions of service. Eight current ST3+ trainees have their previous pay and banding protected on their existing salaries. Significant breaches on working hours can incur financial penalties but there has been no indication for this recently.

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REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

1. High level data

Number of doctors/dentists in training (total):	41
Number of doctors/dentists in training on 2016 TCS (total):	41
Amount of time available in job plan for guardian to do the role:	0.5 PA (2 hours per week)
Admin support provided to the guardian (if any):	As required by Medical Workforce
Amount of job-planned time for educational supervisors:	0.25 PA per trainee

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Exception Reports (with regard to working hours)

There were 2 Exception Reports submitted during the period. 1 report was submitted by an IMT trainee and the other was from a ST3 trainee. The IMT report was related to staying late following their shift and resulted in TOIL being approved. The ST3 report related to service support and a late notification of a gap on the rota. This incident was investigated by our Chief Registrar and Medical Workforce Rota Co-ordinator, with an action plan for improvement which was discussed at JDF.

It is recommended in the 2016 Junior Doctor Contract that exceptions are actioned by the Supervisor within 7 days of the report being raised. The aim for the Trust is to have all exceptions actioned ideally within 7 days (with flexibility to 14 days in line with Trusts in the local region). The current action plans and graduated targets are aimed at reaching this in a timely manner.

Of the 2 Exception Reports, all have been reviewed and marked as complete. Of these 2 reports (100%) were actioned by Supervisors within 28 days meeting the target for exceptions to be actioned in 28 days.

Regarding Haematology, From July 2022 a pathway has been established where the LUFHT Guardian shares any relevant exception reports for systematic oversight review to the CCC Guardian. Individual exceptions are still currently signed off from the LUFHT system and remain the responsibility of the individual's Educational Supervisor/LUFHT Guardian at the time of this report.

In the period of this report Haematology trainees/junior doctors made 8 exception reports on the Royal Liverpool exception report system related to workload/rota issues/working overtime with 3 related directly to CCC which are being addressed with rota design/handover/ward allocation/junior fellow allocation. On going work is being undertaken

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

with the CCC and LUFHT the LUFHT Medical Compliance team on the ongoing management/oversight of the Haematology rotas

Work Schedule reviews

There have been no requests for Work Schedule reviews during this period.

Locum bookings

All 'Patchwork' shifts are the additional locum duties worked by our doctors in training. These are a result of known gaps in the rota plus last minute cover due to absences.

Specialty	Shifts worked by bank doctors (previous number)	Shifts worked by agency doctors (prev number)	Patchwork shifts (prev number)
Clinical Oncology / Medical Oncology	0	52	18 (18)
General Medicine	9 (24)	127 (647)	9 (14)
Haemato Oncology	0	26 (194)	2

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Vacancies as of 19.05.2023

The Trust operates a 1 in 14 junior doctor ward rota and a 1 in 19 senior (registrar) rota, which both feature out of hours work in CDU.

The 1 in 14 junior Ward Rota currently comprises 5 x Junior Clinical Fellows and 9 x junior Doctors in Training (IMT and GPST). One trainee works Less Than Full Time at 80%, creating a gap on their non-working day.

Our 1 in 19 Registrar Rota currently has 2 gaps due to a doctor going out of programme for 12 months from April 2023 and another gap following a secondment being undertaken at The Christie until 01/07/2023.

Rota designs are taking place for the August 2023 intake and new Work Schedules will be issued no later than 07/06/2023 (8 weeks prior to their start date).

Fines

There were no fines incurred in this quarter (1st January – 31st March 2023).

Actions taken to resolve issues – See Action Plan Summary attached

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Conclusion

The information in this report confirms for this quarter, the working hours of Ward - based doctors in training IMT/CMT, GP trainees and Oncology trainee doctors remain compliant with the 2016 contract.

Within this organisation, working hours for doctors in training are considered safe at the current time based upon rotas and rostered hours.

Trust Management, Medical Workforce and junior doctor leads continue to address any issues appropriately and proportionally.

Dr Ian Lampkin

Guardian of Safe Working

ACTION PLAN

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Guardian of Safe Working (GOSW) Report

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

Last updated: 30/05/2023

Updated by: Dr Lampkin GOSW / Medical Workforce

Ref	Action	Measure	Owner	Start date	Due date	RAGB	Comments/progress
GOSW-1	Escalation of Exception Reports	Completed SOP	IL/CT	April 2022	August 2023		To Produce SOP for escalation of ERs to management/committee
GOSW-2	Junior Doctor Forum/Trainee engagement	Evidenced by feedback in local surveys/attendance at teaching and reported to Trust Board via People Committee in the GoSW Quarterly/annual report	IL	April 2022	August 2023		to develop a workplan of engagement with trainees to educate and promote on the work of the GoSW and reporting.
GOSW-3	Improving Exception Report processing delays		IL	May 2022	August 2023		Training session to Educational Supervisors on Exception reporting/Work Schedules on 10th June – Completed Exception Report sign off within 14 days - to improve to 90% by 30th April 2023 and 80% actioned within 28 days . Currently improved to 100% at Q4
GOSW-4	Exception Reporting/Work Schedule Policy		IL/CT	June 2022	August 2023		To write a new trust policy for Exception Reporting/Work Schedule – ongoing
GOSW-5	Haematology trainee engagement/exception reports		IL/CT	April 2022	August 2023		Links established for Haematology exceptions with Royal GOSW. Ongoing discussions with LUFHT and Haemtology over rota management/oversight

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

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

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 28th June 2023

Report lead	Julie Gray, Chief Nurse				
Paper prepared by: In attendance at the visit	Quality Improvement Manager - Claire Smith Non-Executive Director – Asutosh T. Yagnik Governor – Abhishek Mahajan				
Report subject/title	Patient Experience Visit May 2023				
Purpose of paper	The purpose of this report is to provide Trust Board with a summary of the NED & Governor Patient Experience virtual visit conducted on the 11th May 2023. The panel visited Inpatient wards 4 and 5 at CCCL.				
Background papers	n/a				
Action required	To approve content/preferred option/recommendations				
	To discuss and note content				X
	To be assured of content and actions				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	x	Be a great place to work		X
	Be Collaborative		Be Digital		
	Be Research Leaders		Be Innovative		

Equality & Diversity Impact Assessment						
The content of this paper could have an adverse impact on:	Age	Yes/No	Disability	Yes/No	Sexual Orientation	Yes/No
	Race	Yes/No	Pregnancy/Maternity	Yes/No	Gender Reassignment	Yes/No
	Gender	Yes/No	Religious Belief	Yes/No		

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The Clatterbridge Cancer Centre NHS Foundation Trust

Division	Acute Services	Location	Ward 4	Date	11th May 2023
In attendance – Panel			In attendance – Patient & Staff		
Governor	Abhishek Mahajan		Senior Manager facilitating the walk round		Priscilla Hetherington
Non-Executive	Asutosh T. Yagnik		Number of Patients		2
Patient Experience Team	Claire Smith		Number of Staff		2

Patient Feedback: The patients were asked to describe their experience of care at CCC

NB: *This is not a verbatim record but an overview of the key themes raised during the conversation.*

Positive Patient Comments:

- The staff at CCC saved me; they are wonderful.
- I cannot thank the team here enough, everyone from the consultant to cleaning staff have been unreal.
- The consultant explained everything, even when things are not working well he always has a backup plan.
- CCC is a home from home, so I do not worry about coming in for treatment.
- Feels like a family here.
- Very positive experience despite the awful diagnosis.
- Feel very lucky to be treated here.
- Even when I am not here, I can call with any symptoms and get the advice that I need.
- Feeling privileged to be in this hospital, very different to the experience I had in the Isle of Man. The speciality team here with their expertise are amazing.
- Doctors engage with patients and explain what is happening; nursing staff reinforce the information. I feel much happier when I am fully informed.
- Now I am at CCCL things seem to be moving at pace.
- Treatment isn't great to experience but they always seem to have backup plans if it doesn't work
- No improvement needed, I have everything I need here.

Areas where immediate action was taken on the day:

- None

Areas for improvement:	Service response: *Highlight in **Bold** actions to be added to PEIC action plan*
• Neither patient on ward 4 highlighted anything they felt could be improved.	• N/A

The Clatterbridge Cancer Centre NHS Foundation Trust

Staff Feedback: Staff were asked to describe their experience of providing patient care at CCC

NB: *This is not a verbatim record but an overview of the key themes raised during the conversation.*

Positive Comments:

- One member of staff was positive about the opportunities at CCC forstaff as he had worked on the ward previously as a cleaner, transferred to a HCA role and interviewed the morning of the visit for a band 3 role.
- Although there are occasional staffing issues like most trusts nationally, the ward works well as a team and the morale is good. The ward has a staff wellness planner which has 2 events each month to encourage staff to get together outside of the ward to build relationships with each other.
- It is lovely when patients pop back to say hello so we can see how well they are doing.
- The positive aspects of the role by far outweigh any negatives.
- We are lucky to have a great management team.
- Since moving to CCCL, the patients have benefited from the activities organised by the arts coordinator, which were not available to them before.
- Over the past 6 months the ward team are much more settled within CCC which is lovely to see.
- Not being a small department in an acute Trust really helps – here at CCC concerns are listened to and business cases are supported.
- Although initially the move to CCC from LUHFT was a challenge, we can now see the benefits the patient receive being treated in a specialist cancer centre, especially in Ward 5.
- The out of hours provision from other departments has improved recently.
- There is good psychological/mental wellness help and support

Areas where immediate action was taken on the day: None

Areas for improvement:	Service response:
• Food quality and choice needs improving. Patients do not always get their first or second choice. Dedicated ward hostesses are required for patient continuity.	• This is a priority for the division and an area of focus. • A new meal supplier is expected to start week commencing 5th June 2023

The Clatterbridge Cancer Centre NHS Foundation Trust

	• The number of hostesses dedicated to each ward is currently under review
Observations on the day • Although clearly busy, the ward appeared calm and organised. • Comment by patient that the ward feels like a home from home.	

Division	Acute Services	Location	Ward 5	Date	11th May 2023
In attendance – Panel			In attendance – Patient & Staff		
Governor	Abhishek Mahajan		Senior Manager facilitating the walk round		Emma Parsons Priscilla Hetherington
Non-Executive	Asutosh T. Yagnik		Number of Patients		2
Patient Experience Team	Claire Smith		Number of Staff		2

Patient Feedback: The patients were asked to describe their experience of care at CCC NB: *This is not a verbatim record but an overview of the key themes raised during the conversation.*	
Positive Patient Comments: • Patient received their diagnosis in the Isle of Man, no explanation given, no leaflet or other information. The patient researched stem cell transplant himself. Once in contact with CCC the care and information he received could not have been more different than what he experienced locally. • I became more poorly with the treatment than I expected, cannot praise the nursing team enough for care they have given. Although often embarrassed by the level of help	• Sometimes the treatment is overwhelming, it feels like just you and the room. Nursing staff constantly checked on my wellbeing, it has been a privilege to get to know them all and will miss them when I go home. • Staff are just a button away and are always so friendly, staff remembered me from a previous stay a few months ago which was lovely. • Staff 11/10 • Consultant and nurses are very good at CCC.

needed, the staff always made me feel it was ok. • I was depressed at one point but was able to talk to staff and nurses which has really helped me.	
Areas where immediate action was taken on the day: • N/A	
Areas for improvement: • Both patients reported that the food needs improving, they consistently did not get their first choice, the presentation and taste was pretty poor and misrepresented what it looked like on the menu.	Service response: *Highlight in **Bold** actions to be added to PEIC action plan* • This is a priority for the division and an area of focus for the division • A new meal supplier is expected to start week commencing 5th June 2023 • The number of hostesses dedicated to each ward is currently under review
• Sometimes the patient TV shuts down in the evening when you have been watching a programme, this can be really very frustrating.	• There is a known on-going issue with the TV's. Every evening either the picture goes off but the sound continues and the TV shuts down completely. I have been informed it has been going on for a number of months and the network team are aware. Escalated by matron to trust chief technology officer
• The IV pumps beeping is one of the most frustrating things on the ward, there should be a way of silencing them until the staff can reprogram them as they often really busy.	• Will discuss this with ward staff to explore if there is anything else that can be done to minimise the disruption to patients

Staff Feedback: Staff were asked to describe their experience of providing patient care at CCC

NB: *This is not a verbatim record but an overview of the key themes raised during the conversation.*

The Clatterbridge Cancer Centre NHS Foundation Trust

Positive Comments: • Patients report they are happy with the single side rooms. • Patients receive lots of psychological support. • Lovely for staff to see some patients coming through the day care unit on floor 5 and seeing some of them doing so well. • Happy that patients felt safe coming to the unit throughout the pandemic. • Some of the initial teething problems following the move to CCC are resolving. • The team work together really well, since moving the CCCL the team have made strong relationships with the other disciplines. • A few months ago the ward was experiencing some chemotherapy delays, there has since been some massive improvements to this. • The hospital has a lovely vibe, I am happy in this role with no plans to move in the near future. • Staff are lucky to have the palliative care team who often provide support with difficult and sad cases.	
Areas where immediate action was taken on the day: None	
Areas for improvement: • Sometimes there can be delays in obtaining X-rays/Scans out of hours. Overnight and weekend it is sometimes difficult to get scans done and reviewed (e.g. to do septic screen). This has a potential risk in that it might lead to avoidable incidents. This comment was made by two members of staff but we then also told by the Matron that it isn't an issue. It would be good to get more clarity on whether this is just a perception and if so, how to change that with staff. • Food can sometime be an issue; it does not always resemble what the menu looks like.	Service response: • There has been improvement in the access to X-rays and scans out-of-hours but will continue to monitor and escalate and DATIX it. • This is a priority for the division and an area of focus • A new meal supplier is expected to start week commencing 5th June 2023 • The number of hostesses dedicated to each ward is currently under review

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• There is a counsellor service for patients; however, this service is only available virtually. It would be useful if the service could also do face-to-face appointment for patients.	• If a face-to-face appointment is preferred, arrangements can be made to facilitate this. Email sent to ward managers to make them aware
Observations on the day • The ward as busy but felt calm. • All staff very friendly and smiling.	

Meeting: Trust Board Part 1
28th June 2023

The Clatterbridge Cancer Centre NHS Foundation Trust

Report lead	Julie Gray, Chief Nurse				
Paper prepared by	Lindsey Dawson, Deputy Chief Nurse				
Subject/Title	Safer Staffing Report: To review and approve the nurse staffing levels as assessed using the Safer Nursing Care Tool in line with recommendations within NICE Guidance.				
Purpose of paper	To endorse the findings and conclusion of this six monthly nursing establishment review and approve the nurse staffing levels covering the period from October 2022 – March 2023.				
Background papers	NHSEI Winter 2021 Preparedness: Nursing and Midwifery Safer Staffing (Nov 2021) National Quality Board (Jan 2019): Safe sustainable & productive staffing. NHS Improvement (June 2018) Care Hours per Patient Day (CHPPD) Guidance for Acute and Acute Specialist Trusts NICE Safe staffing guideline [SG1]; NHS England November 2014: Safer Staffing, a guide to care contact time National Quality Board (July 2016): Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time				
Action required	To approve content/preferred option/recommendations				√
	To discuss and note content				
	To be assured of content and actions				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	√	Be a great place to work		√
	Be Collaborative		Be Digital		
	Be Research Leaders		Be Innovative		

The use of abbreviations within this paper is kept to a minimum, however, where they are used the following recognised convention is followed:

Full name written in the first instance and follow immediately by the abbreviated version in brackets.

Equality & Diversity Impact Assessment

The content of this paper could have an adverse impact on:	Age	Yes/**No**	Disability	Yes/**No**	Sexual Orientation	Yes/**No**
	Race	Yes/**No**	Pregnancy/Maternity	Yes/**No**	Gender Reassignment	Yes/**No**
	Gender	Yes/**No**	Religious Belief	Yes/**No**		

Meeting of the Board of Directors

28th June 2023

Six Monthly Compliance with NICE Safe Staffing Guidelines

Executive Summary

Following the six monthly review against the safe staffing guidelines the following outcomes were confirmed:

- The budgeted registered nursing establishments for wards 2, 3, 4 & 5 were confirmed as correct and appropriate by the ward managers and met NICE Guidance. All ward establishments are better than the recommended one nurse to eight patients' ratio (1:8).
- The budgeted HCSW establishments for wards 2, 3, 4, and 5 were confirmed as correct and appropriate by the ward managers.
- 11 additional mutual aid in-patient beds were opened in order to support the LUHFT with the move to the New Royal Liverpool Hospital. These mutual aid in-patient beds remain open.
- On a shift by shift basis, where the actual staff numbers were less than the planned staff numbers the ward teams followed an agreed escalation process based on the acuity and dependency of care required and a review of bed occupancy. The information is shared via email to operational staff, medical staff and executives twice a day by the patient flow team.
- Nurses on the hospital bank (NHSP) and approved nursing agencies have been deployed to support patient acuity levels when thresholds have been reached and all other internal staff movements have been actioned. There are twice daily reviews of planned staffing as well as a review of hospital-wide activity.
- For the 6 month review period October 2022 to March 2023 the expenditure across the total nursing £11.573m, the total nursing spend for inpatient wards (2,3,4,5) was 4.01m, of which £172k was spent on agency staff and £722k NHSP which equates to 22.28% of the nursing inpatient spend and 9.22% of total nursing pay spend.
- Recruitment of staff to meet turnover continues to be a well published national challenge, however the ward managers and Matrons manage their pressures through a structured approach to over-recruitment when there are suitable candidates.
- A large proportion of the newly recruited staff are newly qualified nurses, who require a period of supernumerary status and ongoing preceptorship. Therefore, whilst vacancies are filled there continues to be a short-term pressure on experienced staff to induct and support the newly qualified nurses.
- Our third cohort of international nurses have been recruited, 1 nurse commenced in February 2023 and 3 commence in post at the beginning of April. This takes our total up to 16. We are hopeful a further 6 international nurses will be recruited by Q2 23/24.
- The narrative output of individual ward reviews has been captured in a summary table and can be viewed at Appendix 1. The information is provided on an individual ward basis and any areas of underperformance are managed through the usual weekly/monthly performance management review process at both divisional and corporate level.

1. Background

The Trust has carried out a bi-annual audit of patient acuity and dependency for a number of years using the Safer Nursing Care Tool© (SNCT). The SNCT is embedded within the e-rostering system and calculates the baseline nursing establishment required to meet patient care need and has been used successfully to inform and support workforce planning over this period.

In the wake of the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry published in February 2013 and the Government's commitment to safe staffing requirements outlined in a succession of publications, NICE Safe Staffing Guidelines were published in July 2014 and updated by NHS Improvement in January 2018.

The NICE guidance on safe staffing addresses five overarching elements which need to be met:

- Organisational strategy;
- Principles for determining nursing staff requirements;
- Setting the ward nursing establishment;
- Assessing availability of nursing staff on the day to meet patient need;
- Monitoring and evaluation of nursing staff establishments.

The Trust continues to meet the expectations of the National Quality Board relating to nursing, midwifery and care staffing capacity and capability, which were published in 2013. It is also compliant with the NICE guidance and publishes this data publically including the care hours per day on a monthly basis on The Model Hospital website via returns to the Strategic Data Collection Service (SDCS).

The Chief Nursing Officer's paper Safer Staffing: A Guide to Care Contact Time published in November 2014, sets out the expectations of commissioners and providers to optimise nursing, midwifery and care staffing capacity and capability so that they can deliver high quality care and the best possible outcomes for their patients. The Trust meets this expectation.

In February 2018 NHS Improvement updated their guidance on agency staffing rules, these rules set a ceiling on total agency spending by each trust.

As a requirement of the guidance, the Board of Directors has monthly review of the details and summary of planned and actual staffing on a ward-by-ward basis through the integrated performance and quality report. During the pandemic this requirement was paused but following validation of the process has been re-instated for Quarter 4. Furthermore, the guidance requires that organisational responsibility and accountability for budgeted nurse staffing establishments sits with the Board of Directors and must encompass a formal board level review. This paper provides the board with the information required for it to discharge this duty.

2. Introduction

In June 2020 the organisation opened its new site in Liverpool where the in-patient wards are located. The new centre provides single room occupancy for patients, ensuring privacy, space and an overall improved experience for patients. However, a single room occupancy model provides different challenges for the nursing team in order to provide visible and safe care.

In September 2022 the in-patients wards opened 11 additional mutual aid beds in order to support LUHFT with the opening of the New Royal Hospital site. These additional beds remain open to provide ongoing support to LUHFT and staffing is supported by the use of approved Agency and NHSP shifts.

In June 2022 the process for planned verses actual staffing data collection and validation was refreshed to ensure a consistent approach is applied across all stakeholders. This

review has continued with a leaner process with all wards utilising the same data collection tool, therefore ensuring a single version of the truth, this is utilised by the business intelligence team to process the monthly data return with sign off from the senior nursing team.

This paper will describe how nurse staffing has been monitored throughout this 6 month period, together with the ward managers overall professional judgement of staffing during that time and any recommendations they wish to make. It will also offer recommendations to further refine the internal safe staffing process and the associated data within this report.

3. Methodology for calculating Nurse Staffing

This review routinely considers a range of data including the nursing care requirement of patients determined by acuity and dependency data (Safer Nursing Care Tool (SNCT) data). It also includes consideration of all the other factors that can influence the nursing staff requirement including patient flow, the care environment, staff turnover, sickness rates, patient harm and patient experience data.

A new element was introduced in the June 2022 data collection period which provides the ward managers and matrons the opportunity to share directly with the chief nurse their professional view of their ward nursing establishment, any pressures they are managing and what developments they have planned. This process is designed to support the ward managers to be empowered, to lead and advocate on behalf of their teams and their patients.

Professional consensus suggests no single tool meets every area's needs, so NHSEI recommend combining methods. To ensure a triangulated evidence-based approach, the Ward Managers, Matrons and Divisional Directors provide ward summary data (Appendix 2). The completed templates are then reviewed and discussed at a panel with the Chief Nurse and Deputy Chief Nurse.

4. Ensuring the correct staff with the correct skills

Twice daily meetings continue to take place with the divisional nurse directors, ward managers, matrons and patient flow. Ward level staffing, patient acuity, required skill mix and any other clinical concerns were reviewed and immediate actions put into place. This might include moving staff from an area of lower acuity to an area of higher acuity, the ward managers taking a cohort or patients and additional ward based support being provided by the Matrons and clinical practice facilitators. The full escalation process is in appendix 4

5. Data summary

Ward summary data for the four in-patient wards is tabled in appendix 2. This enables comparative quantitative data to be seen across all ward and key nurse sensitive indicators. In order to easily identify any anomalies and/or area of concern.

The table in appendix 3 shows the percentage fill rate of shifts broken down into registered nurses and care staff, day shift and night shift. This data (for the period October - March) has undergone a validation process by the Business Intelligence Team Principal Information Analyst in order to gain assurance that the revised process is providing a true representation of the actual fill rate.

Where the fill rate is less than planned (less than 100%) this is addressed during the staffing huddles, as described in section 4 & appendix 4.

6. Recommendations from previous report

Recommendation	Action Taken
Optimise the e-roster system to ensure the auto-roster function is consistently utilised and accurate staffing data is recorded by Q2 supported by the Workforce and Organisational Development team.	Education and training undertaken supported by Workforce and Organisational Development team. Optimisation of the e-roster system is being utilised and continually reviewed.
Cohort of senior in-patient nursing staff to undertake training for Safer Nursing Care Tool (SNCT) by Q2 supported by NHS England.	NHS England are facilitating a training day for Safer Nursing Care Tool (SNCT) on 3rd July 2023 for senior in-patient staff at CCC staff lead by the Deputy Chief Nurse. This will be undertaken jointly with Senior Nursing Staff at The Christie.
Support the leadership development programme for Band 6 nurses.	Leadership development programme commenced and will be an ongoing programme.
Continue to identify opportunities to benchmark with other centres in relation to acuity and safe staffing, via links with the national team and the Specialist Oncology Trust Deputy Chief Nurse group (CCC, The Royal Marsden & The Christie).	The Deputy Chief Nurses at CCC, The Royal Marsden and The Christie are working closely to identify opportunities with CCC DCN visiting the Royal Marsden in June 2023.

7. Recommendations from this review

- Confirmation of commissioner approval for permanent funding for additional beds opened to support LUHFT. Permanent recruitment will negate the reliance on Agency and NHSP (many staff already employed by CCC)
- Undertake a trend analysis of medication errors and develop a training programme that will reduce the number of nurse attributable errors
- Review process of administration of IV medication to streamline and reduce delays to patients
- Undertake a review of ICT equipment including mobile computers or tablets to ensure that patient documentation is completed in the most appropriate place
- Review of staffing ratios within Haemoto-oncology including the modelling of the impact of the proposed development of CAR-T therapy
- Review of 12-month NHSP and agency spend and undertake a cost / benefit analysis of permanent recruitment.

8. Conclusion

The in-patient services continue to demonstrate exemplary teamwork when coordinating nurse to patient ratios across the trust to keep patients safe.

Staff across all areas of the service continued to and support the utilisation of an additional 11 beds to support our colleagues to safely open the new Royal Liverpool Hospital, ensuring people with cancer were treated in a timely manner and in an appropriate setting. Confirmation of commissioner approval is awaited to support the permanent funding for the staffing of these beds. This will significantly benefit the co-ordination and planning of staffing and have a direct impact upon patient and staff experience.

Whilst it continues to be challenging nursing in a single occupancy room model, where visibility is reduced, staff are adapting to new ways of working with a positive professional attitude, with kindness, resilience and care and compassion for our patients.

This review confirms that, due to successful recruitment, the budgeted nursing establishments set for the trust's in-patient wards align with the current care needs of patients. However, it is recognised that many of the newly recruited staff are newly qualified nurses and require ongoing support and development to enable them to gain the relevant experience needed.

Further work is ongoing to assess the acuity and staffing ratios within the Haemoto-oncology wards including the modelling of the impact of the proposed development of CAR-T therapy.

The review has also identified other potential areas of further improvement and there will now be a focus on the processes around the administration of medication to streamline processes to reduce medication errors and delays.

The Board of Directors is asked to support the findings and recommendations of this six-monthly nursing establishment review

Appendix 1

Individual ward/area key aspects

The following tables provide the Board with feedback from the ward managers, in order to hear about their services from their perspective.

Ward 2 – Factors to support professional judgement

Ward Factors

Ward 2 is a 26-bedded ward, all single room, two of which are negative pressure rooms. The Ward is used to treat inpatient solid tumour patients, sometimes haematology patients outlie on the ward.

The Ward is divided into two sides side A and side B. The Ward is made up of 26 single rooms, 1-clinical/ medication prep room and 2-sluice rooms and a leadership office, a doctor's office, a beverage bay and a patient social space.

The Ward is split into two teams which is then further split again into 2 smaller teams, each nurse taking care of 6/7 patients. There is a coordinator on shift who does not take a team of patients, this is usually one of the band 6 nurses. Our ideal nurse to patient ratio would be 1:5, so currently we do not meet this due to the introduction of the coordinator role.

The ward has its own beverage bay with lockers and a microwave. Ward staff must take their breaks off the ward in the trust staff room which is located on 2nd floor as there is no designated staff room on the ward.

Ward 2 had to temporarily reduce their student allocation from April to November 2022 due to the workforce being very junior heavy. During this time, the senior staff were able to dedicate more time to the junior staff, enabling them to gain confidence on the ward and get competencies signed off. We are now back to full allocation, and able to have up to 9 students at any one time. We have had several excellent student nurse evaluations at the end of their placements. Since October 2022 we have had 2 nurses join the team in a substantive post who completed their management placement on the ward.

1 Housekeeper is employed as part of the ward team, she is also covering for CDU as they do not have a housekeeper in their workforce plan. Her main roles and responsibilities are to ensure that the ward is fully stocked of all necessary stores. She ensures maintenance and servicing of medical devices is up to date.

Patient Factors

Ward 2 is a solid tumour ward. Our designated tumour groups cared for on ward 2 are those with a diagnosis of Sarcoma, Lung cancer, Breast cancer, Brain tumours, Lower GI cancers, Prostate cancer, and Cancer of Unknown Primary. It is also the area where TYA (Teenage and Young Adult) patients are admitted if they cannot be accommodated on Ward 5.

Ward 2 admits patients via the planned route for Systemic Anti-Cancer Treatment (SACT) and/or radiotherapy. Common treatment regimens administered on the ward are VDC/IE, TIP, Ifosphamide/doxyorubicin.

Other reasons for admission are patients with MSCC who require specialist nursing this cohort of patients also includes those patients admitted as a treat and transfer.

At times, the ward staff care for patients in their last days and weeks of life. This involves liaising with the medical team and the palliative care team to meet the needs of the patients and their families. The nursing team must respond the physical and psychological needs of the patients. At times this can become challenging and emotionally draining.

Also, being the designated area for TYA patients to be admitted to, if they are unable to be accommodated on Ward 5, also adds some complexity around the level of nursing care the patient and their family often require. The nurse: patient ratio required to look after these patients is different to our current model, which adds pressure to the existing junior team.

It is a common occurrence that the Nursing staff must liaise with the MDT (multidisciplinary team) to organise complex discharge plans. Often the condition and prognosis of the patient means that 'home' is not in their best interest, so this can be challenging when patients and their families have unrealistic expectations.

Many of the patients cared for on the ward are at risk of falls, these patients require high levels of care and close supervision or 1:1 nursing by our dedicated team of HCAs to prevent and reduce their harm. Due to the large footprint of the ward and the single side rooms it is difficult to observe patients who are at risk of falling. We try and keep these patients in rooms directly opposite staff bases. Ramble guards are used to support these patients and alert staff if an at-risk patient moves.

Nursing Factors

We have had a number of band 5 vacancies on ward 2, the management team have worked hard to fill these vacancies, and most recruits came into post in September and October 2022. We have seen several HCA vacancies more recently and we are working through filling these vacancies, often having to go out to advert twice. With the help of the Clinical Practice Facilitator our new recruits have a structured 4-week induction timetable. This period is used to develop their skills and embed into the team on the ward. With a more robust induction period we hope that investing in these staff will lead to staff retention.

A substantial proportion of the new recruits to the ward are newly qualified nurses, they have all been assigned a preceptor and will be supported by the in-house preceptorship programme. They are being supported by the PEF team and the senior management team on the ward.

The turnover of nurses we saw in the previous 6 months led to a shortage of chemotherapy trained nurses on the ward, on some shifts there is only 1 chemo trained nurse to administer all chemotherapy treatments on the ward. We now have several nurses who have completed their SACT passport, and a SACT trained nurse transfer from floor 6 which has alleviated some of this pressure. The SACT lead nurse has introduced SACT study days, those nurses currently in the process of completing their SACT passport have been given time off the ward to attend these study days.

Evolution/Development of Service

In the past 6 months we have seen our reliance on NHSP, and agency, significantly reduce now our new recruits are in post. This allows the patients to have better continuity of care as most shifts are now filled by substantive staff.

We currently only have 1 Clinical Practice Facilitator (PEF) supporting the ward, she covers 3 days a week and this role is shared with ward 3 currently. We are recruiting a further CPF to cover a 5 day service across wards 2 & 3. Our CPF developing the induction programme for our new recruits has been appreciated by the ward manager and the recruits. Now the influx of new recruits has calmed down they have been looking at our established staff to ensure that they have the required competencies to provide high quality nursing care. Working with the ward management team to ensure that staff are compliant with role essential and mandatory training.

Now our band 6 team is fully recruited I can put a band 6 on most shifts. This ensures that there is chemo trained nurse on every shift, and the junior staff on the ward have a senior member of the team to escalate to.

The band 6 team on the ward are taking on link nurse roles, these are in areas of interest to them or areas of improvement needed on the ward. They will have training days in their topic areas, and then disseminate their findings back to the ward team to improve care on the ward.

During this 6-month period the band 6s have attended the first band 6 training week, which allowed them time to learn all aspects of being a band 6, including Healthroster training, incident investigation and nurse leadership. Being able to facilitate protected management time for the band 6 team has given them greater fulfilment in their role and allows them to put into practice what they have learnt during their training week. They have been able to support the manager with tasks and attended meeting as ward representative. This has allowed them to have a greater understanding of the management side of their role, it has also made them more comfortable taking it in turns covering as ward manager for the week to cover annual leave.

Senior Ward Nurse Review

Ward 2 have had a significant change in workforce over the past 6 month, our new recruits have settled into the ward environment and becoming more confident and competent practitioners. Their hard work at trying to provide high quality care has been recognised by receiving a number of thank you cards, a thank you Thursday, and donations to the ward.

The skill mix on the ward can be problematic at times due to the number of recruits to the ward being newly qualified nurses. Two nurses have returned from maternity leave in the past few months which has helped this. We have also had a new international nurse join the team, although it has taken her a while to settle into the ward, her experience is valuable. When recruiting to staff nurse positions we are continuing to see most applicants being newly qualified nurses

PADR compliance remains high, the senior management team work hard to complete all appraisal before they go out of date, we are currently working through our recruits that have joined in the past 6 months. Role essential and mandatory training is high, there are some areas for improvement. Most staff are booked on to the required training, at times this has been cancelled due to external agencies and sickness with the trainers. Some areas of training outstanding have also been when the requirements for staff have changed when they have been promoted.

The band 6 team participating in management side of role has relieved pressure for the ward manager. They each take it in turns to complete the off-duty, we have been able to release the off-duty with an 8 week lead time as suggested by workforce team. The band 6s have also helped to investigate datix's reported on the ward, this has helped to reduce over-due incidents. We have a weekly incident meeting to discuss the incidents for wards 2, 3 and CDU, this is an opportunity for shared learning between managers, and highlight training needs of staff.

Professional Judgement

WARD MANAGER VIEW; In my professional judgement staffing ratio of 1:5 is correct and is sufficient to staff the ward safely. However, I would like to use the budget differently to ensure that we are able to facilitate the desired nurse patient ratio by having a coordinator on shift. Senior Sister - Sarah Smith

Ward 3 – Factors to support professional judgement

Ward Factors

Ward 3 is a 32- bedded unit, all single side rooms. Originally the ward was made up of 25 patient rooms, 6 step up rooms and a stabilisation bay. In September, these rooms were all made into inpatient rooms and opened to support the LUFT move into the new hospital. These remain open due to increased demand.

The Ward is divided into two sides, which is split again into two further smaller teams with each nurse taking care of up to 6 to 8 patients. Currently the co-ordinator on shift must take a team of patients to meet this nurse: patient ratio. Ideally the nurse-to-patient ratio would be 1:5, which we have been trying to achieve due to the increased use of regular agency staff and NHSP workers.

The ward has its own beverage bay with lockers, a fridge, and a microwave. It is not large enough for a break room, so currently the ward social space is used as a break room and there are plans to turn the unused ward bathroom into a staff room.

We currently have 2 housekeepers that cover the ward 7 days a week, and support ward 2 and the Clinical Decisions Unit when needed. Ward 3 has been without a ward clerk for almost a year, but now one has been appointed on a permanent basis from a recent recruitment event which will be of great support to the nursing team.

Patient Factors

Ward 3 is a ward that cares for solid tumour oncology patients and is the designated ward for all patients with a head and neck cancer and those patients who have an artificial airway. Admissions come via the planned route for Systemic Anti-Cancer Treatment (SACT) and/or radiotherapy, via CDU as an emergency admission, or transferred in from another hospital to manage symptoms from their SACT or complications from their diagnosis.

Ward staff care for patients from initial diagnosis, all the way through to their last days of life. It is common for patients to be regular attenders of the ward and staff get to know the patients well. Caring for our patients involves liaising with a variety of MDT members to ensure the patient, and their families, needs are met. Some situations can be challenging and emotionally draining for some staff members.

Due to the footprint of the ward and the single side room model we ensure our patients have a falls risk assessment completed on admission, and regularly throughout their stay. The enhanced supervision policy is used to keep any patients at high risk of falls safe and provides guidance on when to provide 1:1 supervision to our patients.

As we are the designated area for patients with altered airways it means that some haematology patients require care on the ward. This can add some complexity around the level of nursing care that the patient requires. The nurse: patient ratio required to look after these patients is different to our current model, which adds pressure to the existing team.

Nursing Factors

There have been many vacancies on Ward 3, but these have been managed through regular recruitment drives. The ward managers of wards 2 & 3 have worked closely to keep on top of recruitment for both areas. The role of the clinical practice facilitator has become established to ensure we have staff providing high quality care on the ward. Each recruit gets a 4-week supernumerary period to develop their skills and embed into the team on the ward. With a more robust induction period we hope that investing in these staff will lead to staff retention.

A substantial proportion of the new recruits to the ward are newly qualified nurses, they have all been assigned a preceptor and will be supported by the in-house preceptorship programme. They will be supported by the PEF team and the senior management team on the ward.

Once the extra beds have been opened the use of bank and agency staff has increased. These shifts have not always been covered, which had put added pressure on the established staff. This has affected staff morale and the coming 6 months will see staff vacancies increase.

Evolution/Development of Service

If the number of beds on ward 3 remains open to full capacity (32), there needs to be an increase in WTE to maintain a safe service. The increase of the budget would ensure that the current model of 1:5 nurse to patient ratio could be achieved.

The development of the CPF nursing team will be instrumental in providing skilled, experienced support and training to the clinical team. The majority of new starter are either newly qualified or new to cancer care so the CPF role is there to ensure staff experience a robust induction and training plan, the team then provide ongoing training to maintain staff competencies in their role.

A new working relationship has been formed with the Tracheostomy Clinical Nurse Specialist from LUHFT to help support the delivery of care to patients with an artificial airway, who are not cared for by the Head & Neck Team. This will involve an enhanced delivery of education to support staff in the theoretical care of this patient cohort.

The CPF team will also be critical in reporting and monitoring staff competencies, which will help identify where support and training is required. They will also be an essential support to the ward managers, organising new starters' induction programmes and monitoring the teams' competencies. This role is also now supported by the introduction of a Ward Managers

Assistant. This role will reduce the pressure of many administrative tasks to enable time to be focused on other clinical aspects of the role.

With the expansion of ward 3 Band 6 development is required to support the ward manager. The Band 6 team undertook a leadership training week in May to teach the current, and new band 6s, the management requirements of the role and the importance of leadership. The band 6's get time to consolidate the new skills they have learnt.

Senior Ward Nurse Review

For the last 6 months Ward 3 has faced some challenges including the opening of an additional 6 beds. A new ward manager was introduced in late November 2022. Our budgeted establishment meets our requirements of a 26 bedded ward but not that of the additional 6 beds.

The vacancy position has improved with the support of international and newly qualified recruits, and we now have staff allocated to start for all vacancies on the ward. The main challenge that Ward 3 has faced is staffing to the capacity of 32 beds with the existing ratio of 1:5 with no additional budget. To achieve this there has been a need to use agency and NHSP staff daily to ensure a safe ratio is in place. This has helped provide a good level of continuity to the patient cohort. This may be difficult to maintain as the majority of NHSP shifts are filled by CCC substantive staff and with this adds a pressure on them to work additional hours to support safe patient care.

Despite the challenges faced by staff on a daily basis, the ward has received several messages of positive feedback from patients, their families, student nurses and other allied health professionals. Our international nurse colleagues have integrated flawlessly into the team. They have also been the recipients of positive feedback individually from patient's, medical staff, and their allied health colleagues.

The introduction of the CPF team has been very beneficial in providing support and guidance to the new starters. They also help the established staff members in maintaining competencies and support with their development. This should help improve current training compliance but also help improve motivation and morale.

A listening event is currently underway in order to assess the feelings of the staff given there has been a recent turnover of several staff including the ward manager.

The management team have worked hard to meet our PADR targets, and the up-and-coming management week for band 6s will allow them to learn the importance of completing PADRs in a timely manner and hopefully maintain our compliance going forward.

As a senior nursing team, we have addressed all overdue incidents and now have zero outstanding. We have a weekly incident meeting to discuss the incidents for wards 2, 3 and

CDU. This is an opportunity for shared learning between managers and highlight training needs of staff.

We are awaiting the outcome of commissioner approval for the permanent funding of the 6 additional beds opened in 2022, this will ensure that permanent staff can be recruited to continue with current ratio and reduce NHSP and agency spend.

Professional Judgement

WARD MANAGER VIEW; In my professional judgement the past 6 months our budgeted establishment has met our requirements for 26 beds but with the permanent opening of the additional 6 beds at the end of September this will now require the established budget to be reviewed to allow for a safe nursing model that does not rely on NHSP and agency– This requires an additional 5.50 WTE RN and 5.50 WTE HCSW to support a safe model based on nurse to patient ratio and acuity data.

Ward Manager-Paul Hewitt

Ward 4 – Factors to support professional judgement

Ward Factors

Ward 4 has 29 beds, 28 of which are inpatient beds. 24 of these are predominantly for the use of Haemato-Oncology patients, with the remaining 4 beds used for early phase clinical trials. The clinical trial staff should be on the ward between the hours of 8am and 4pm, handing over the patient to the ward staff at this time to be nursed overnight. The ward staff are expected to admit the trials patient to the ward and complete the nursing assessments despite the trials team being present.

The 29th bed belongs to the NHSBT team, who use the room to complete apheresis for patients belonging to many different specialities. This bed space is not counted in our bed base, the room has been adapted and is managed by the NHSBT team, including the maintenance and cleaning of the room.

The ward is a U shape with no cut through from one side to the other, meaning the length of time it takes to get from one end to the other can exceed 2 minutes. This could be vital in medical emergencies. At the top of the ward there is one clinical treatment room, and the MDT room where the medical team are based. We have one sluice on each end of the ward, which again, can be timely to get to.

It can take approximately 10 minutes to check, prepare and administer an IV medication to a patient. Most of the patients are on at least 3 IV medications a day, at the same times, which can take up an hour, excluding oral medications which can take a further hour to administer. Often this can result in a delay in administering medications at the exact time they are due.

In order to ensure more efficient working and mitigate some risk, the ward is split into two teams, team A and team B, which consist of being placed on one side of the ward. Each morning, staff receive handover for their 'team', and we try to place the floater & myself in opposite handovers. We then all convene for the safety huddle where we discuss any issues from our team, and vital information such as chemotherapies, DNAR's. Prior to splitting the ward into two teams, handovers would exceed 08.30am, meaning the night staff leaving extremely late, and day staff having a delay in commencing their morning medication rounds. Furthermore, none of the patient rooms have computers in to enable the staff to complete documentation whilst with the patient. Instead, this is done at the staff bases, 3 of which are available on the ward. Staff must find a mobile computer prior to starting rounds, and take this into each room. Batteries in these are often needed to be changed prior to commencing. In between patients, staff are required to wash their hands and change their PPE before moving on to the next patient as per infection control. Administering medications and completing checks required such as pressure areas, observations, disconnecting IV medications and answering questions could take 20 minutes per patient. Furthermore, if a patient is on a controlled drug, the nurse has to go and get this from clean utility, along with a second nurse to check which can add further time onto medication rounds.

Alongside this, we offer student placements on the ward, from 1st year to management placements. Staff are required to schedule time in their day to teach and engage the students on the ward, as well as completing comprehensive documentation on time, and ensuring the students are exposed to the skills needed to ensure they pass their placement. Feedback from students is highly positive, with many of them going on to apply for jobs on the ward and being successful. This is a reflection of the dedication of staff in ensuring the students are well supported on the ward and given the best opportunities.

We have recently opened our new staff rooms based on the ward which has improved staff morale as they now have somewhere to enjoy their breaks. Staff are expected to keep this area clean and tidy and take responsibility for the use of any cutlery, cups etc.

Ward 4 has two Housekeeper's employed as part of the ward team, due to the size of the ward and the high stock turnover. Having both housekeepers in post ensure the cleanliness of the ward remains of a high standard, and that stock is available to the nursing staff. Housekeepers provide a vital level of support to both staff and patients, and are very much part of the team, and with their support and organisation, nurses are able to locate equipment in a timely manner.

Patient factors

The patients are categorised as acuity levels 0, 1a, 1b, or 2 in line with the safe care tool. This is completed 3 times a day by the nurse in charge. Following the official integration with the North-Mersey HO, we often have patients with CNS lymphoma requiring 1:1 care due to the

fluctuating capacity and confusion. This can often lead to the involvement of the safeguarding team and the patient requiring a Deprivation of Liberty Safeguards (DOLS). We have recently had this added onto the safe care tool, meaning the most accurate information on staffing is available.

High intensity chemotherapy can often result in an onset of sepsis, requiring frequent monitoring and nursing interventions. Patients often require 1:2 nursing and at times 1:1 nursing prior to transfer to ICU. We work very closely with the LUHFT ICU Outreach Team and frequently receive very positive feedback about the level of expertise and skills our nurses have attained. This enables them to provide a high standard of care to this vulnerable group of acutely unwell patients often preventing the need for transfer out to ICU due to their swift response to the deteriorating condition.

Each day is different, but on the whole there are multiple patients requiring chemotherapy. This can range between 1-10 patients on some days, with 1 patient needing multiple infusions. For example, a common Lymphoma regime can include 5 chemotherapy drugs needing to be administered. This takes 2 nurses to check and administer the chemotherapy, the nurse in charge and another nurse who will also be looking after a team of patients, or alternatively if they are busy, two nurses will administer.

The ward takes post-transplant re-admissions if there is no capacity on ward 5. These patients are often re-admitted with graft versus host disease, viral or bacterial infection. They are severely immune-compromised with the requirement for complex drug regimes, close monitoring and frequent nursing interventions. These patients experience severe side effects such as frequent loose stool, lethargy and decreased mobility and full nursing care is required for them.

We offer a wide variety of treatment regimens on the ward, and often patients can be attached to a drip for numerous hours, requiring staff to change IV drips multiple times. Often patient's first day of chemotherapy involves a monoclonal antibody, an example of which is Rituximab. During the infusion, 30 minute observations are required in order to recognise signs of reactions and act quickly to treat. An infusion such as Rituximab could take between 3-8 hours to complete, depending on the patients tolerance. We also go to intensive care when needed to administer chemotherapy to our patients over there, often with a specialist nurse but if they are unavailable the ward staff attend to ensure timely administration of treatment.

Furthermore, many patients require intrathecal chemotherapy which is completed on the ward, and occasionally in interventional radiology. Completing an IT chemo could take the band 6 or 7 on shift away from the ward for up to an hour or more, ensuring that the correct equipment is set up for the administering Doctor, completion of bedside checks, and the procedure itself.

Whilst this is being undertaken, we are unable to be visible to staff, or be disturbed due to the nature of the procedure.

Ward 4 cares for patients at all stages of treatment, including when the difficult decision has been made to palliate the patient due to disease progression/infection/or a sudden deterioration where all options have been exhausted and there are no reversible causes. We offer support not only to patients, but to the families too. If a patients preferred place of care is at home, we facilitate complex fast track or rapid discharges with the support of patient flow and palliative care, ensuring that the patient remains as comfortable as possible prior to and on transfer. These types of discharges can be a stressful and emotional time for us as we want to ensure that the patients last days or hours are as peaceful and undisturbed as possible, not only for them but their families too.

We also facilitate complex discharges to nursing homes, ICB beds and 28 day placements. This can often involve multiple meetings with members of the MDT along with patients and their families, and can take up a considerable amount of time to organise.

The ward cares for patients at risk of falls. These patients require high levels of care which consists of close supervision or 1:1 nursing by our dedicated team of HCA's to prevent and reduce their harm. Due to the large footprint of the ward and the single side rooms it is difficult to observe patients who are at risk of falling. To mitigate the risk of falling, we try and keep these patients in rooms directly opposite staff bases. Rambleguards are used to support these patients and alert staff if an at risk patient moves. An information leaflet is in each patient room with information about the ward and also some information to reduce the risk of falls. Where possible, we try and cohort patients needing 1:1 supervision, and utilise extra staff where we can so not impact the planned staffing for the floor. If not possible, this can often mean that we have 1 HCA along with staff completing beds and personal care, whilst others are providing the 1:1 supervision. This can often lead to decreased morale and the staff who are supervising feel that they aren't fulfilling their role or supporting the staff, and equally the staff members on the floor have an increased workload and often feel that their care is rushed because they are aware of the extra patient ratio.

Nursing Factors

We have been able to hold a ward meeting most months, ensuring staff are up to date with information and developing changes to the service. In addition to this, a monthly newsletter is sent out via TEAMS with snapshots of information on. Staff are also encouraged to put forward any ideas for the newsletter. These are also shared with the managers of the directorate so they are kept up to date with the ward. We have also reintroduced time out days for the management team, which has recently become a new team. These are vital to ensure that we are consistent and supportive to the staff on the ward.

Evolution/Development of Service

Over the past year, we have successfully continued to recruit into vacant posts, and recently we have been able to reintroduce face to face interviews instead of TEAMS, which allows us to gain a more accurate representation of the candidate and ensure their suitability for the role. Often we are unable to obtain a true representation of a person via TEAMS. Once recruited, the staff are given a robust and effective orientation programme, consisting of spending time within the different specialities of the ward, practical training sessions, and also time to complete mandatory training. Trust induction has been a challenge at times, with staff having completing their orientation prior to induction, however more recently, there have been set dates for staff to ensure they start induction on day 1 in the trust, which has been a more effective and efficient process from feedback we have had.

We also have a successful in-house education programme with regular offerings of training relevant to Haemato-oncology and stem cell transplantation. Nursing staff are encouraged to put forward topics for the sessions and/or prepare a short session to present themselves for their own professional development, which can also be used for revalidation.

Senior Ward Nurse Review

The ward has undergone some changes over the past year, with a new ward manager in post, and a change in the deputy team. Despite this, the team have continued to work professionally, with determination and commitment, even when times have been tough due to staff shortages or other reasons. In addition to contracted shifts, many staff have picked up additional shifts, sometimes at extreme short notice in order to help out and provide safe and effective care to patients, ensuring standards remain high.

Compliance of PADR's has improved greatly with links being sent out to staff in advance to ensure their PADR is completed prior to it lapsing. As staffing numbers increase and the management team become more familiar with policies and procedures, staff will be supported further in order to complete PADR's in a timely and in depth fashion.

We continue to review DATIX and incidents, aiming to reduce the number of overdue incidents, and ensure that investigations are completed thoroughly and outcomes accurate.

The nationally recommended nurse to patient ratio for Haemato-oncology patients is described in the National Institute for Health and Care Excellence (NICE) guideline *Haematological Cancers: improving outcomes* (May 25 2016) page 12;

1.2.21 In haematology units that provide care for adults and young people who are receiving high-intensity chemotherapy:

• There should be adequate nursing staff to provide safe and effective care [new 2016]

• The 2003 NICE cancer service guidance on improving outcomes in haematological cancers recommended that 'The level of staffing required for neutropenic patients is equivalent to that in a high dependency unit'. [2003]

1.2.22 Nursing staff in haematology units that care for adults and young people who are receiving high-intensity chemotherapy should be competent to care for people with a severe and unpredictable clinical status. The nursing staff should be able to deal with indwelling venous catheters, recognise early symptoms of infection, and respond to potential crisis situations at all times. [new 2016]

There are variables in acuity on the ward due to different specialities and the variety of SACT we provide. It is expected that once we start admitting patients to Ward 5 for CAR-T treatment the number of post-transplant re-admissions on ward 4 will increase. The current nurse to patient ratio on Ward 4 is 1:5.

Professional Judgement

WARD MANAGER VIEW;

After reviewing all of the above and the establishment for ward 4, I feel that the ward could benefit from a review of the trained nurse: patient ratio. I propose that this is changed from the current 1:5 to 1:4 based on clinical acuity. Although the ratio is 1:5, often the day staff have 7 patient to look after, and at times the night staff can have up to 9 patients each due to the opening of additional beds last September. The establishment if reviewed could allow for an additional RN on days but in order to have the same ratio on nights I would need an additional 4.80 WTE investment.

Following a review of the HCSW budget at 13.45 WTE there is a gap in the provision of the baseline safe staffing of 2.95 WTE to allow for 3 HCSW per shift and additionally due to the increase in patients requiring 1:1 care and off set our NHSP spend would require an additional 5.50 WTE. I propose increasing the number of health care support workers (HCSW) in our current establishment to enable us to have 4 HCSW per shift we would need an uplift of 8.45 WTE. This equates to our current NHSP spend.

The change in the ratio would allow the staff more time with each patient and to maintain the safe and effective care that I know they can give, and ensuring that quality is not compromised in any aspect. This would also reflect the size of the ward. The team deliver excellent patient care day in day out. However, this can be deflated due to the workload. I believe a change in ratio would boost morale and also reflect the staff views and ensure that they know they have been listened to. I believe this would also have a positive impact on the patients, the workload

of the staff, ensuring the safety and effective care of the highest standard, and increasing the time that staff can spend with each patient

Ward Manager – Nicky Gulwell

Ward 5 – Factors to support professional judgement

Ward Factors

Ward 5 is a Level 3 tertiary referral centre for Stem Cell Transplant patients in Cheshire & Merseyside and the Isle of Man and the primary treatment centre for TYA patients in Cheshire & Merseyside. It is a 15 bedded unit, all single room, 12 of which are specialist Hepa-filtered positive pressure rooms for Stem Cell Transplant patients. All staff are required to wash their hands and don fresh PPE each time they enter one of these rooms. PPE dispenser and handwashing facilities are present in the anteroom of each patient room. They must also wash hands on leaving the room.

There are 3 in-patient Teenage and Young Adult rooms and a bespoke 4 chair day unit which is located adjacent to the in-patient ward and a social space. There is 1-clinical/ medication prep room and 1-sluice room.

The patient rooms do not currently have computers in to enable the staff to complete documentation whilst with the patient. Instead, staff have to exit the room to either use a Mob cart in the anteroom or use one of the staff bases on the ward.

The ward now has a designated staff room that allows staff to relax and have a safe space for them to have their break. Previously, when staff had to leave the ward in order to take a break, this deterred some staff from taking a break when the acuity of the ward was high because they did not like to be too far away from the patients should help be needed. Now they have more opportunity to take a break but be on hand for any situation that arise. This has improved staff morale.

The ward is a popular student placement area with excellent feedback and recruitment opportunities. A number of 3rd year student nurses request to return to the ward to complete their management placement and some are now employed permanently since qualifying. We have capacity for 9 students at any one time. We have recruited a number of new nurses in the last 6 months, some newly qualified but all requiring in depth support to such a specialised area. We have recently appointed a clinical practice facilitator to Ward 5 who as

part of their role undertakes planning of an orientation programme to give the new starters an overview of the department and the important information they need to know.

2 part time Housekeepers are employed as part of the ward team. They support the hostess at mealtimes with presentation and patient requests as well as ensuring patients are offered mid–morning and afternoon snacks. They ensure that water flushing of all outlets is carried out daily in order to reduce the risk of legionella infection. They maintain the efficient running of the ward by ensuring that stock levels are kept at a safe level and highlight any risks concerning vital equipment that may be getting discontinued.

Patient Factors

A large majority of our patients are categorised as either level 1a, 1b or 2 using the safe care tool as stem cell transplant patients receive high-intensity conditioning chemotherapy, immune-ablative therapy and complex drug regimes. Severe sepsis results in the requirement for close monitoring and frequent nursing interventions. The post-transplant phase is equivalent to 'single organ failure' and patients often require 1:2 nursing and at times 1:1 nursing prior to transfer to ICU. We work very closely with the LUHFT ICU Outreach Team and receive very positive feedback about the level of expertise and skills our nurses have attained. This enables them to provide a high standard of care to this group of acutely unwell patients often preventing the need for transfer to ICU due to their swift response to the deteriorating condition.

There are variables in acuity on the ward due to the types of transplant, specialities and the variety of SACT we provide but it is expected that nursing acuity levels will increase within 10-14 days post stem cell transplant infusion and it is vital we are staffed adequately to reflect this in order to respond safely and effectively.

It is difficult to observe patients who are at risk of falling as all patients are accommodated in single rooms. Although BMT nursing is used to single rooms the footprint of the in-patient ward in CCC-L is more of a challenge. Patients with confusion or who are at risk of falls require close observation or 1:1 nursing by our dedicated team of HCA's. Rambleguards are used to support these patients and alert staff if an at risk patient moves.

Since the onset of COVID-19, all donor cells whether received from overseas or locally are now frozen prior to patient admission to mitigate risk of unsuccessful cell delivery. This has had a significant increase in nursing time to administer the cells and it is noted that although infusion reactions are generally mild, they occur more frequently with frozen than fresh cells and requires more time for the nurse to remain with the patient in a side room.

Nursing Factors

We have successfully continued to recruit into vacant posts via means of a rolling advert. Recently we have been able to reintroduce face to face interviews instead of TEAMS, which allows us to gain a more accurate representation of the candidate and ensure their suitability for the role. Often we are unable to obtain a true representation of a person via TEAMS.

Stem cell transplantation requires expert nursing knowledge and training to administer stem cells and to safely and effectively care for the patient. This has been a challenge at times due to staff sickness both COVID and Non-COVID related and we have been strongly supported by our specialist nursing team, two stem cell transplant co-ordinators and one specialist nurse.

We have a successful in-house education programme with sessions every other week relevant to Haemato-oncology and stem cell transplantation. Nursing staff are encouraged to put forward topics for the sessions and or prepare a short session to present themselves. These sessions have received very positive feedback and met the requirement set by JACIE standards to ensure nurse training is compliant with our accreditation.

Evolution/Development of Service

The team have responded very effectively to numerous changes over the last two and half years, several unplanned and have continued to utilise resources wisely.

Currently the stem cell transplant programme is preparing for its JACIE inspection. A full on-site inspection will take place on the 18th and 19th July 2023, when passed will result in a four-year accreditation.

At the same time, the programme is working towards the development of a CAR-T service and preparing a business case to support the request for additional resources to meet the needs of the service.

Senior Ward Nurse Review

The staff continue to really step up, working with professionalism, determination and commitment. They have tirelessly swapped shifts at short notice and undertaken additional NHSP shifts to ensure the ward is adequately covered to provide safe and effective care and the service we provide has remained at a high standard. This is evident from the positive patient feedback received.

Compliance of PADR's has improved greatly with links being sent out to staff in advance to ensure their PADR is completed prior to it lapsing. As staffing numbers increase and the

management team become more familiar with policies and procedures, staff will be supported further in order to complete PADR's in a timely and in depth fashion.

PADR's and essential training compliance remains steady but there is room for improvement. This year we appointed two ward sisters in addition to our two existing ward sisters. We have allocated each sister a number of staff members due their PADR so that these can be planned in a timely manner. We currently have recruited into all but one of our vacancies and look forward to new staff starting over the next few months.

As a senior nursing team we will continue to work on reducing over-due incidents. The team deliver excellent patient care and are motivated to improve patient experience and the service they deliver and I am incredibly proud of them. Within the next 12 months, we aim to sustain this motivation, always working to improve patient care and make improvements driving our service forward. We aim to offer learning opportunities to our team, facilitating attendance at national and international study days and conferences and by collaborating and sharing experiences with other centres on a national and international platform.

Professional judgment

WARD MANAGER VIEW; In my professional judgement having reviewed the establishment for Ward 5 I feel the ward is safe and provides effective quality care. Maintaining the nurse: patient ratio is important to continue to deliver safe effective care whilst not compromising on quality, which is a fundamental part of what we as a team are proud we provide. There have been several months where we have had to reduce the number of staff on night duty in order to support the days but once we are fully established our staffing numbers can change accordingly - Senior Sister - Chris Muir

Appendix 2 - Ward Summary Data

	Ward 2	Ward 3	Ward 4	Ward 5
Budgeted WTE Nursing Establishment	43.02 (excludes Housekeeper and CPF)	41.96 (excludes Housekeeper and CPF)	43.45 (excludes 1 WTE Housekeeper and 1 WTE CPF)	**BMT** 34.15 **TYA** 8.8 (excludes 1 WTE Housekeeper and 1 WTE CPF)
SNCT WTE Nursing Requirement Using alternative acuity tool (Rota only)	Median-41.27 Max- 44.79	Median-41.27 Max- 44.79	Median-41.27 Max- 44.79	Median-41.27 Max- 44.79
Current Skill Mix (RN-Non RN)	RN = 62.0% Non RN = 38.0%	RN = 61.0% Non RN =39.0%	RN = 66.74% Non RN = 33.26%	**BMT** RN = 74.38% Non RN = 25.62% **TYA** RN = 79.55% Non RN = 20.45%
Patient Flow/bed occupancy- 6 months	92%	94%	92%	84%
Supervisory Status of Band 7 required	80:20	90:10	30:70	30:70
% Sickness Rate (since last review)	7.27%	11.03%	7.30%	BMT & TYA COMBINED = 7.03%
% Staff Turnover (since last review)	32.37%	8.22%	9.84%	BMT & TYA COMBINED = 0%
Bank Use (since last review) 7.5 hr shift	RN = 256 HCA = 762	RN = 786 HCA = 880	RN = 631 Non RN = 1827	RN = 43 Non RN = 10.16
% Mandatory Training Compliance	91.2%	81.39%	93%	95.54%
% PADR Compliance (at time of report)	100%	50%	95.3%	93%
Nurse Sensitive Indicator – grade 2 (or above) pressure ulcers	13	17	2	0

Nurse Sensitive Indicator – Moderate (or above) Falls	0	1	1	0
Nurse Sensitive Indicator – medication administration errors attributable to nurses	24	16	13	12
Nurse Sensitive Indicator – complaints regarding nursing care	0	0	1	0
Nurse Sensitive Indicator – MRSA bacteraemia	0	0	0	0
Nurse Sensitive Indicator – avoidable Clostridium Difficile	2	0	0	0
Friends & Family Test – Patients (average since last review)	99% Positive 1% Negative	95% Positive 5% Negative	91% Positive 9% Negative	100% Positive 0% Negative

Appendix 3 - Safer Staffing Figures for three Wards Apr-22 to Sept-22 by Staff and Shift Types

		Oct-22		Nov-22		Dec-22		Jan-23		Feb-23		Mar-23		Months >= 90% Target	
	Ward	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night
Registered Nurses	Ward 2	100.0%	100.0%	96.8%	94.8%	96.2%	97.2%	97.1%	100.0%	98.1%	99.2%	97.5%	100.0%	6/6	6/6
	Ward 3	98.1%	95.9%	95.9%	100.8%	93.4%	96.2%	81.7%	94.3%	100.0%	94.3%	78.2%	83.9%	4/6	5/6
	Ward 4	96.5%	94.2%	93.6%	100.0%	92.0%	89.8%	95.2%	95.8%	88.6%	92.8%	92.0%	94.2%	4/6	5/6
	Ward 5	98.2%	92.3%	96.6%	91.8%	88.7%	90.7%	90.9%	96.5%	90.9%	98.2%	96.4%	83.1%	5/6	5/6
Care Staff	Ward 2	83.9%	94.3%	78.2%	93.7%	93.2%	92.9%	88.5%	100.0%	94.6%	98.8%	95.4%	98.0%	3/6	6/6
	Ward 3	85.7%	93.0%	98.5%	100.0%	92.2%	100.0%	88.5%	95.2%	100.0%	100.0%	82.3%	95.4%	3/6	6/6
	Ward 4	92.5%	95.8%	82.4%	93.7%	79.9%	77.5%	81.9%	91.8%	80.1%	101.6%	95.1%	99.2%	2/6	5/6
	Ward 5	103.8%	100.0%	94.8%	100.0%	88.9%	90.3%	84.4%	100.0%	94.5%	97.6%	88.2%	93.5%	4/6	6/6

Appendix 4 – Staffing Escalation Process

Escalation levels	Level	Staffing Level	Actions	Response
Level 1-2 – Escalate to Matron Manage and resolve within IP Ward areas (de-escalate to level 1 when resolved)	**Level 1**	Registered Nurse to patient ratio maintained: Optimal/Business as usual* in IP areas. Workforce levels within safe staffing requirements.	No escalation required. All care and routine tasks will be carried out. Nurse in Charge to escalate if situation changes unexpectedly. Reassess situation at next staffing huddle.	Managed locally within IP Ward areas Matron oversight
	Level 2	A shortfall has occurred e.g. due to staff absence and or increased acuity. Registered Nurse to patient ratio maintained at least at Optimal/Business as usual * in IP areas.	A short term increase in activity/acuity to be resolved by provision of additional resources: Ward Managers to work clinically Prioritise need and adjust workload throughout shift accordingly. Continual review of any changes to staffing/acuity and dependency until situation resolved or need to increase workforce aniticipated: Request additional NHSP cover, own staff to swap shifts, work additional hours (start early/finish late). Reassess situation at next staffing huddle. Gaps in ability to provide care should be logged on Datix in line with the safe staffing/ Red flag requirements.	
Level 3 – Escalate to Divisional Director of Nursing (DDN)	**Level 3**	Reduced Registered Nurse:patient ratio due to staff abscences: Intermediate ratios* in IP areas and or increased acuity.	Increase workforce as available: Matrons to work clinically, request NHSP, deploy staff across IP Wards to resolve RN shortfall Some non-essential activities may be postponed/cancelled until situation is resolved. Gaps in ability to provide care should be logged on Datix in line with the safe staffing/ Red Flag requirements On-going reassessment by Matron/DDN	Divisional responsibility and oversight
Level 4 - Escalate to Divisional Director (DD)	**Level 4**	Reduced Registered Nurse:Patient ratio RED Ratios* in IP areas Unable to maintain safe staffing ratios	DDN to inform Divisional Director Increase as available: request NHSP, agency, deploy staff across Trust as required to resolve RN shortfall Business continuity trigerred: non-essential activities postponed/cancelled, some annual leave/study leave may be cancelled until situation resolved Gaps in ability to provide care should be logged on Datix in line with the safe staffing/ Red Flag requirements. On-going reassessment by DDN/DD DD to escalate to Executive level/Chief Nurse/Chief Operating Officer	Divisional responsibility and oversight Divisional Director oversight
Level 5 - Escalate to Executive Level	**Level 5**	Unable to resolve Registered Nurse shortages following escalation to Divisional Director Unable to maintain safe staffing ratios.	Review amber and red actions taken Discuss with Chief Nurse/Chief operating Officer if cancellation of appointments and elective activity should be considered In liaison with the Executive on call will; - Consider closing beds - Consider closing CDU to admissions - Consider implementing critical incident/ major incident plan - Inform the Chief Executive - Inform Commissioners Staff will prioritise their work and adjust their workload through the shift accordingly, with a continual review of any changes to the acuity and dependence This level can also be used to highlight an area where it would be deemed unsafe due to Quality and risk issues to move staff from an area	Divisional Director / Executive responsibility and oversight

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1 – 28th June 2023

Chairs report for: People Committee

Date/Time of meeting: 20th June 2023

			Yes/No
Chair	Kathy Doran	**Was the meeting Quorate?**	Y
Meeting format	MS Teams		
Was the committee assured by the quality of the papers (if not please provide details below)			Y
Was the committee assured by the evidence and discussion provided (if not please provide details below)			Y

Items of concern for escalation to the Board	**Integrated Performance Report** The Committee noted that sickness absence has improved overall with short-term sickness at 3.9% against the 4% target however long-term sickness remains above the target of 2% at 2.4%. HR Business Partners continue to support the Divisions with the highest number of absences to ensure they are being managed in line with policy. Staff turnover has increased in month with 21 leavers in May compared to 16 in April with work life balance cited as the main reason for leaving, together with promotion opportunities and relocation. Leaver questionnaires are providing useful information which is being used to make improvements to reduce turnover. **Workforce Advisory Group Report** The Committee noted that Basic Life Support, Intermediate Life Support and Manual Handling training compliance remains under target. An escalation process has been agreed and all those who are non-compliant will receive letters to complete the training by the end of August 2023 when a more formal process will begin for those who remain non-compliant. A national directive to review Clinical Support Worker bands 2 and 3 to be carried out due to inconsistencies with duties and pay across Cheshire and Merseyside, which may lead to financial implications for the Trust. **Education Governance Committee Report** The Committee noted the growing demand for the two Clinical Education Training Rooms at CCCL, with insufficient availability for mandatory training bookings, particularly with manual handling where compliance is below target. This issue has been escalated and added to the Risk Register.
Items of achievement for escalation to the Board	**Staff Story – Disability and Long-Term Condition Network** The Committee noted the aim of the Disability and Long-Term Condition Network presentation was to raise awareness and promote equality for staff with disabilities and long-term health conditions. There will be a number of awareness campaigns taking place to inform people of the number of staff with different conditions, to demonstrate how change can impact different staff groups, promote the skills of people with disabilities; and to promote the Trust as an attractive employer. The Network is working together with the Equality Diversity and Inclusion Lead to review current policies, access to

	reasonable adjustments and provision of training for all staff. **People Commitment Progress Report** The Committee noted good progress being made overall, and highlighted the key priorities in the Equality, Diversity and Inclusion (EDI) Improvement Plan, including a review of the EDI programmes, review of staff networks and reverse mentoring. A full review of the plan will take place when the National Workforce Plan is released and will be presented at the next Committee meeting. **Equality Diversity & Inclusion Report/EDS2/22** The Committee noted that this year's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) is currently being analysed and compared to 2022 data which will result in the creation of an action plan in collaboration with stakeholders. A new Equality Impact Assessment (EIA) is being developed together with a toolkit to provide colleagues with a better understanding of the positive use of Equality Impact Assessments. Staff Networks - The LGBTQIA+ Network will be taking part in the Pride March in Liverpool at the end of July and are working together with the Communications Team to promote this event. The Ethnic Diversity Staff Network is launching reciprocal mentoring in July starting with the executive team and they are also planning to launch a piece of abstract artwork in line with the reciprocal mentoring programme. The Committee noted that the Equality Delivery System 2022 (EDS22) will be implemented this year with the first meeting to be held in June 2023. The system helps NHS organisations improve the services they provide for local communities and provide better working environments, free of discrimination in line with the Equality Act 2010. Three of the Trust services will be evaluated and will provide evidence relating to the organisations position in meeting the Public Sector Equality Duty. Equality objectives will be set and will be tracked through People Committee with support from Executive Leads Julie Gray and Jayne Shaw **Staff Wellbeing & Engagement** The Committee noted that the number of Pulse surveys completed had increased and the Trust came top in three of the categories, across the Northwest. An 8% increase was seen in recommending the Trust as a place to work and a 7% increase for patients/services users being the Trusts top priority. The Trust was noted as the highest performing Northwest Trust for employee engagement, advocacy and involvement and was ranked 14th out of 32 for motivation. The Committee also noted the introduction of the new appraisal system which has already received positive feedback. A Day in your Shoes will commence in July where the executive team will shadow/work alongside staff to improve their understanding of issues facing staff and improve visibility. Big Conversation events will commence to seek insight and views from colleagues on key issues raised through staff engagement channels and will

	support engagement with colleagues on Trust wide interventions. This will be supported by both Executives and Non-Executives. **Annual Guardian of Safe Working Report** The Committee noted the Annual Report for 2022/2023. There were 22 exception reports for the year, 20 for Internal Medical Trainees (IMT) /General Practitioner (GP) Trainees and 2 for Oncology Specialist Trainees, all of which have been managed accordingly with 14 as TOIL and 8 as additional pay. There were no fines for the year or work schedule reviews. The Committee also noted the Q4 January-March report. Two exception reports were submitted in Q4, one from an IMT trainee regarding staying late after the end of their shift and resulted in TOIL being approved and the other from an ST3 trainee relating to service support and a late notification of a gap in the rota, resulting in an improvement action plan being implemented. Overall, the report demonstrates that working conditions are safe. **Recruitment Update** The Committee noted the report and highlights including, the recruitment of 3 international nurses in April 2023 with plans to recruit a further 6 nurses in Q2. There were 3 newly qualified nurses who also commenced employment in April 2023 with a further 5 due to start in Q2. There are 29.6WTE staff currently being processed for the new Paddington Village Community Diagnostic Centre. The team also had a recruitment stand at the UK Imaging and Oncology Congress in Liverpool to engage with delegates, raise the profile the Trust and provide awareness of current vacancies. **Board Assurance Framework (BAF)** The Committee noted the changes to the BAF following a comprehensive refresh of the risk scores in June 2023. The controls and assurances relating to BAF 9 around leadership are now reflected within BAF 10 and operational risks regarding staffing in BAF 11 are captured and monitored within the Divisional and Corporate Services Risk Registers. The two remaining risks link in with the KPI's and better reflect the strategic risks. BAF 10, (recruit retain and develop sufficient numbers of staff), has a risk score of 16 with a target of 9 and BAF 12, (Positive, Supportive and Inclusive Culture), has a risk score of 12 with a target of 9. **People Committee Risks** The Committee noted that there are currently no people risks with a score of 12 or above, however, a review will be carried out following the outcome of the ballot results from the latest industrial action, which may result in the continuation of the strike action for over 6 months and may affect the scores. **Workforce Advisory Group Report and Terms of Reference** The Committee noted the progress against the clinical skills and competencies project and the development of the clinical passport. The Workforce Advisory Group Terms of Reference were approved subject to clarification regarding policy ratification.

	Education Governance Committee Report The Committee noted the development of the Systemic Anti-Cancer Therapy (SACT) Passport Theory Study Day which was created to support new starters and provide uniformity of knowledge across all hubs which staff found helpful. Following this a 2-day programme has now been launched. **Actions from internal Audit** The Committee noted the substantial assurance received from the Mersey Internal Audit Agencies report. Two recommendations from the report are due to be completed at the end of June 2023. **People Committee Annual Report and Review of Committee Effectiveness** The Committee noted the report and the scope of duties covered in the last 12 months. A review of the Cycle of Business has taken place to ensure this aligns with the Committee Terms of Reference. The report will be presented to Audit Committee in July.
Items for shared learning	No Shared Learning was identified

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1 – 28th June 2023

Chair's Report for: Quality Committee

Date/Time of meeting: 21st June 2023, 13:30pm till 16:30pm

			Yes/No
Chair	Terry Jones	**Was the meeting Quorate?**	Yes
Meeting format	MS Teams		
Was the committee assured by the quality of the papers (if not please provide details below)			Yes
Was the committee assured by the evidence and discussion provided (if not please provide details below)			Yes

General items to note to the Board	• The Committee received the Board Assurance Framework (BAF) Report and the revised wording of BAF following discussion at Trust Board and agreed that the wording of BAF1 now provided greater clarity • The Committee received the Integrated Performance Report for month 2. The report provided an update on performance in the categories of access, efficiency, quality, workforce, research and innovation and finance. The Committee requested that Trust trial set-up and recruitment to time and target data are included within the Integrated Performance Report for future meetings, but accepted the data will not have been externally ratified. • The Committee received the CQC Regulatory Compliance Report. The Trust have agreed to a 12-month secondment opportunity to lead on inspection preparedness. The Committee noted a more robust regulatory compliance paper will be presented at future meetings detailing accountability for each regulation. • The Committee received the Medicines (Controlled Drugs) Annual Report and noted the assurance received. • The Committee requested the Director of Pharmacy to explore using controlled drug benchmarking data within future reports but noted this may not be possible. • The Committee received April and May's Quality and Safety Walk-round reports and noted the positive experience of staff. Specific areas of improvement included a request to review the kitchen equipment/cleanliness and the provision of toilet facilities. • The Committee received the Infection Prevention & Control Annual

The Clatterbridge Cancer Centre NHS Foundation Trust

	Report and noted the assurance received. • The Committee received the Mortality Annual Report and noted the assurance received. • The Committee received the Quality Accounts for noting. The Quality Accounts will be published on the Trust website later this month. • The Committee received the Quality Improvement and Learning Strategy but noted minor amendments are still being made. The Committee agreed with the combining of the two strategies and approved the strategy. • The Committee received the Extravasation Serious Incident Report and noted the assurance received. The Chair advised that he chaired the panel and noted the robust processes in place. • The Committee received the Risk & Quality Governance Committee Assurance Report and noted the assurance received. • The Committee agreed full assurance has now been received from the leads of the MIAA Quality Spot Checks (Audits) and can now be de-escalated from the Committee to back to the appropriate operational governance mechanisms. • The Committee accepted the Annual Report and Annual Review of Committee Effectiveness and agreed to consider the impacts of the cost improvement programme (CIP) on quality at a future meeting. • The Committee discussed increasing the frequency of the meetings from quarterly to bi-monthly but agreed for this to be incorporated as part of the Corporate Governance meeting review in July. • The Committee noted that the Patient Safety and Experience Quarterly Assurance Report and the VTE Incidents Report were deferred to the next meeting.
Items of concern for escalation to the Board	No items to escalate.
Items of achievement for escalation to the Board	• The Committee received the Palliative Care End of Life Strategy. The Committee approved the strategy and requested this is presented at July's Trust Board meeting as a showcase item.
Items for shared learning	No items for shared learning.

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WE ARE...
KIND EMPOWERED RESPONSIBLE INCLUSIVE

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 28th June 2023

Report lead	Joan Spencer, Chief Operating Officer					
Paper prepared by	Hannah Gray, Associate Director of Performance and Operational Improvement					
Report subject/title	Integrated Performance Report M2 2023 / 2024					
Purpose of paper	This report provides an update on performance for month 2 2023/24 (May 2023). This report provides an update on performance in the categories of access, efficiency, quality, workforce, research and innovation and finance. RAG rated data and statistical process control (SPC) charts (with associated variation and assurance icons) are presented for each KPI. Exception reports are presented below the relevant KPI against which the Trust is not compliant / alerting on SPC charts.					
Background papers						
Action required	For discussion and approval					
Link to: Strategic Direction Corporate Objectives	Be Outstanding	Y	Be a great place to work	Y		
	Be Collaborative	Y	Be Digital	Y		
	Be Research Leaders	Y	Be Innovative	Y		

Equality & Diversity Impact Assessment						
The content of this paper could have an adverse impact on:	Age	~~Yes~~/No	Disability	~~Yes~~/No	Sexual Orientation	~~Yes~~/No
	Race	~~Yes~~/No	Pregnancy/Maternity	~~Yes~~/No	Gender Reassignment	~~Yes~~/No
	Gender	~~Yes~~/No	Religious Belief	~~Yes~~/No		

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOREPO
Review: July 2025
Version: 2.0

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Integrated Performance Report
(Month 2 2023/24)

Hannah Gray: Associate Director of Performance and Operational Improvement

Joan Spencer: Chief Operating Officer

Introduction

This report provides an update on performance for May 2023, in the categories of access, efficiency, quality, workforce, research and innovation and finance.

KPI data is presented with a RAG rating and statistical process control (SPC) charts and associated variation and assurance icons. Further information on SPC charts is provided in the SPC Guidance section of this report. Exception reports are presented for key performance indicators (KPIs) against which the Trust is not compliant.

For KPIs with annual targets, the monthly data is accompanied by charts which present the cumulative total against the YTD target each month. For these KPIs, exception reports are provided when both the monthly and YTD figures are below the respective targets.

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Interpretation of Statistical Process Control Charts

The following summary icons describe the Variation and Assurance displayed in the Chart.

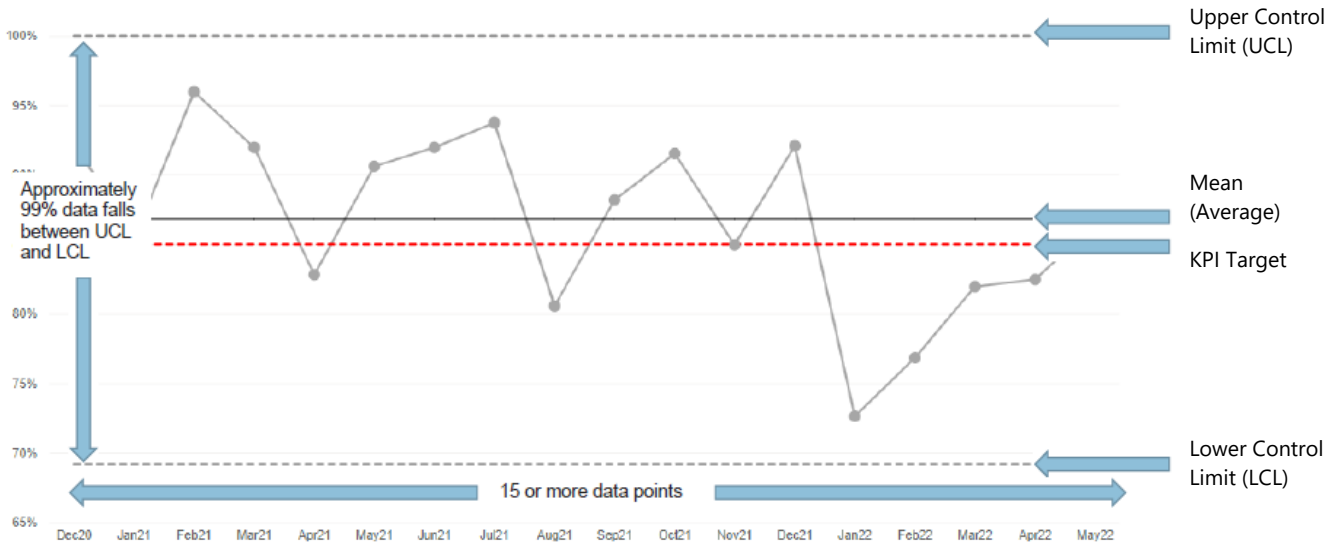
Are we improving, declining or staying the same? (Variation)			
Icon	**Variation**	Definition	Action
	Special Cause Improving Variation	Unexpected variation that results from unusual circumstances in a system or process i.e. assignable. (Blue = significant improvement/low pressure, H = high numbers, L = low numbers).	External cause should be identified and understood. Analyse whether change is attributable to service redesign or not.
	Special Cause Concerning Variation	Unexpected variation that results from unusual circumstances in a system or process i.e. assignable. (Orange = significant concern/high pressure, H = high numbers, L = low numbers).	Process is unstable and unpredictable. External cause should be identified and tackled. Develop contingency plans.
	Common Cause Variation	A natural or expected variation in a system or process i.e. random. (Grey = no significant change)	Process is stable and predictable. If the current performance is acceptable, do nothing. If it is not acceptable, redesign your processes.

	Can we reliably hit the target? (Assurance)		
Icon	**Assurance**	Definition	Action
	Consistently hitting target	The current target is outside the process or control limits in the direction to improvement. (Blue = will reliably hit target)	Be assured that without significant change, the system would be expected to continue to hit the target, regardless of natural variation.
	Consistently failing target	The current target is outside the process/control limits in the opposite direction to improvement. (Orange = system change required to hit target)	Be aware that without significant change, the system would be expected to consistently miss the target, regardless of natural variation.
	Hitting and missing target	The current target is in between the process/control limits. (Grey = subject to random)	Without significant change, the system would be expected to inconsistently hit the target in future. The difference between success and failure may be down to the natural variation of the system and may have no underlying significance.

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Anatomy of the SPC Chart



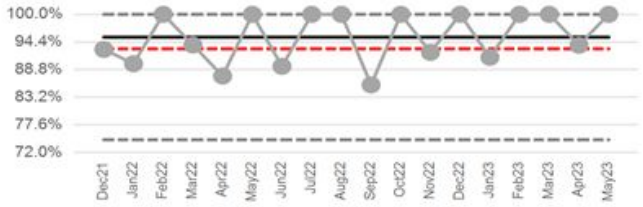
Integrated Performance Report (June 22 - May 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

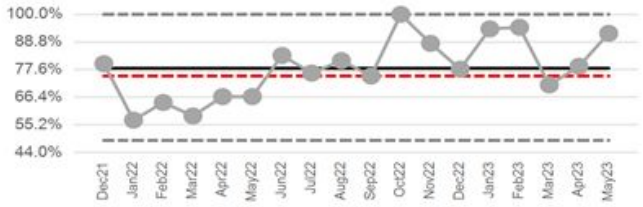
Access

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
CW10	2 Week Wait From GP Referral to 1st Appointment	Green ≥93% Red <93%	Contractual / Statutory		89.5%	100.0%	100.0%	85.7%	100.0%	92.3%	100.0%	91.3%	100.0%	100.0%	93.8%	100.0%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



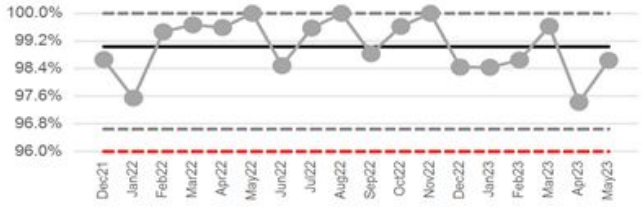
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
CW00	28 Day Faster Diagnosis - (Referral to Diagnosis)	Green ≥75% Red <75%	Contractual / Statutory		83.3%	76.2%	81.3%	75.0%	100.0%	88.2%	77.8%	94.1%	94.7%	71.4%	78.9%	92.3%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
CW47	28 Day Faster Diagnosis - (Screening)	Green ≥75% Red <75%	To Be Confirmed		-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	There were no 28 day faster diagnosis screening patients this month.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
CW09	31 Day Firsts	Green ≥96% Red <96%	Contractual / Statutory		98.5%	99.6%	100.0%	98.8%	99.6%	100.0%	98.4%	98.4%	98.6%	99.6%	97.4%	98.6%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



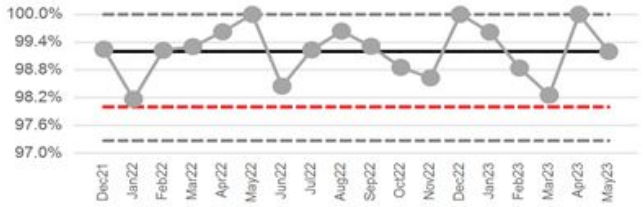
Integrated Performance Report (June 22 - May 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

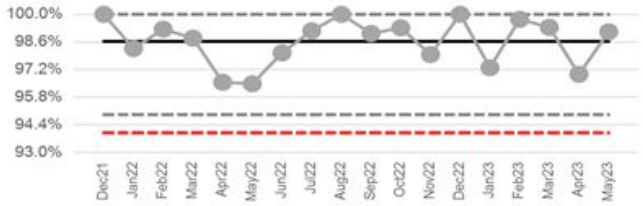
Access

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
CW07	31 Day Subsequent Chemotherapy	Green ≥98% Red <98%	Contractual / Statutory		98.4%	99.2%	99.6%	99.3%	98.9%	98.6%	100.0%	99.6%	98.8%	98.3%	100.0%	99.2%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
CW08	31 Day Subsequent Radiotherapy	Green ≥94% Red <94%	Contractual / Statutory		98.0%	99.2%	100.0%	99.0%	99.3%	98.0%	100.0%	97.3%	99.7%	99.3%	97.0%	99.1%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
CW40	Number of 31 Day Patients Treated ≥ Day 73	Green 0 Red >0	Contractual / Statutory		0	0	0	0	0	1	0	0	0	0	0	1		
			Narrative	This month, there was 1 x 31 day patient treated on or after day 73. An exception report is provided.														

Data Not Applicable for SPC

Reason for Non-Compliance	Action Taken to Improve Compliance
There was one patient in this category in May. The breach was avoidable, with a delay by a Consultant in completing the message and task to initiate treatment booking.	The Consultant has been made aware of delay and a harms review is underway, which is routine for 31 day patients who breach 73 days.

Escalation Route & Expected Date of Compliance
Trust Operational Group, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board June 2023

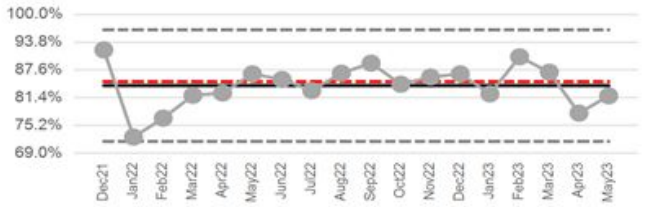
Integrated Performance Report (June 22 - May 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Responsible Forum: Performance Committee

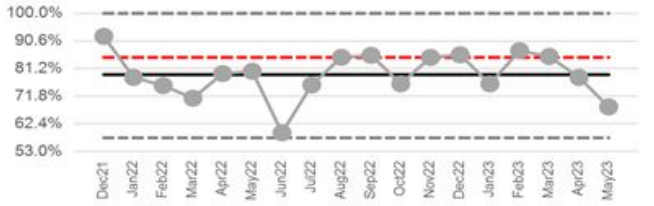
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
CW90	24 Day Wait Target - Referral Received to First Treatment (62 Day Classics Only)	Green >85% Amber 80-84.9% Red <80%			85.5%	83.0%	86.9%	89.1%	84.4%	86.0%	86.7%	82.3%	90.5%	87.1%	78.0%	81.8%		
			Narrative	The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Reason for Non-Compliance	Action Taken to Improve Compliance
25 of 134 patients treated in May, breached the 24 day target. The median wait was 37 days and the longest wait was 65 days (Delay reasons for this longest wait: patient choice of 1st app date, delay awaiting BRAF results and further review required prior to commencing treatment). 22 of the 25 patients breached 62 days; these breach details are provided in the 62 day exception report. Of the 3 patients for whom we achieved the 62 day target, 1 breach was avoidable and 2 were unavoidable to CCC. The breach reasons are as follows: Avoidable breaches: Delay to 1st app due to capacity (1 x Lung) Unavoidable breaches: Molecular markers delay (2 x Lung)	Please see the 62 day exception report actions.

Escalation Route & Expected Date of Compliance
Trust Operational Group, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board June 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
CW03	62 Day Classic	Green ≥85% Red <85%	Contractual / Statutory		59.4%	75.7%	85.1%	85.7%	76.1%	85.0%	85.9%	76.0%	87.3%	85.3%	78.2%	68.2%		
			Narrative	The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Integrated Performance Report (June 22 - May 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access

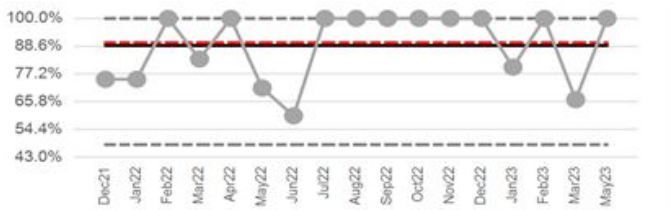
Responsible Forum: Performance Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
22 patients breached the 62 day target in May. 18 of the breaches were unavoidable to CCC, due to: - Patient choice x 9 (1 x Breast, 3 x Lung, 1 x Sarcoma, 1 x Skin and 3 x UGI) - Delay to 1st appointment as awaiting molecular markers (4 x Lung) - Medical reason (1 x H&N, 1 x UGI and 1 x Urology) - Patient DNA'd 1st apppointment - Patient requested second opinion at other trust. The 4 avoidable breaches were due to: - Delay to 1st appointment due to capacity (2 x LGI) - Chemotherapy was booked outside of the target, this was identified and the patient contacted, however they declined an earlier start date (LGI). - Consultant admin delay to advising on the clinic outcome, which delayed treatment booking (Urology).	The delays to 1st appointment in LGI were due to capacity, with planned and unplanned absence coinciding. Refresher training has been provided to the chemotherapy scheduling team. The recently introduced online CWT escalation tracker has also strengthened this process. Urology avoidable breach: The Consultant has been made aware of the delay. The Trust continues to collaborate with the CMCA and laboratories to expedite molecular testing.

Escalation Route & Expected Date of Compliance

Trust Operational Group, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board
June 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
CW05	62 Day Screening	Green ≥90% Red <90%	Contractual / Statutory		60.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	66.7%	-	100.0%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
CW43	Number of Avoidable Breaches, Treated ≥ 104 Days and at CCC For Over 24 Days	Green 0 Amber 1 Red >1	Contractual / Statutory		1	3	0	1	0	0	1	5	2	1	2	1		
			Narrative	This month, there was 1 patient treated on or after day 104, at CCC for more than 24 days and with an avoidable breach to CCC. An exception report is provided.														

Data Not Applicable for SPC

Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

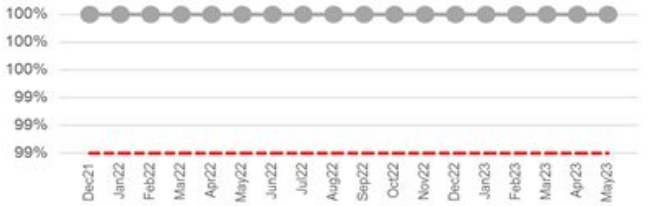
Access

Responsible Forum: Performance Committee

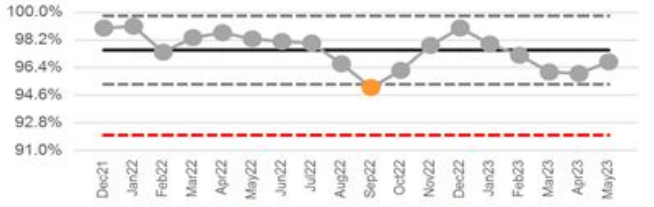
Reason for Non-Compliance	Action Taken to Improve Compliance
There was one patient in this category in May; at CCC for 29 days prior to treatment. This breach and related action is also described in the 62 Day Classic exception report. The delay was due to a Consultant admin delay to advising on the clinic outcome, which delayed treatment booking (Urology).	Please see the 62 day exception report actions.

Escalation Route & Expected Date of Compliance
Trust Operational Group, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board June 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
DI01	Diagnostic Imaging Waitlist - Within 6 Weeks	Green ≥99% Red <99%	Contractual / Statutory		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
RT03	RTT Incomplete	Green ≥92% Red <92%	Contractual / Statutory		98.1%	98.0%	96.6%	95.1%	96.2%	97.8%	99.0%	97.9%	97.2%	96.1%	96.0%	96.8%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



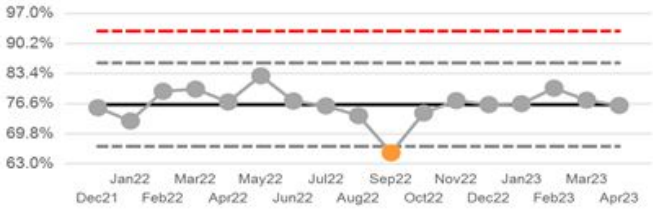
Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Access: Cheshire and Merseyside

Responsible Forum: Acute and Specialist Trust Provider Collaborative

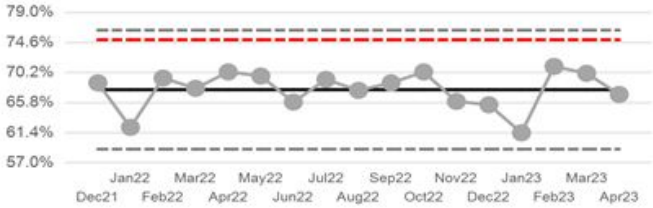
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
CW44	2 Week Wait From GP Referral to 1st Appointment (Cheshire and Merseyside)	Green ≥93% Red <93%	Contractual / Statutory		77.2%	76.1%	73.9%	65.5%	74.5%	77.3%	76.4%	76.6%	80.1%	77.4%	76.2%	-		
			Narrative	The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that the target is unlikely to be achieved without this change.														



Reason for Non-Compliance	Action Taken to Improve Compliance
Non-compliance with the 14 day standard was largely driven by underperformance in the following tumour groups: Suspected breast cancer 62.3% (823 breaches), Suspected gynaecological cancer 65.1% (423 breaches), Suspected lower gastrointestinal cancer 70.4% (811 breaches), Exhibited (non-cancer) breast symptoms - cancer not initially suspected 76.4% (87 breaches), Suspected head and neck cancer 77.9% (245 breaches), Suspected upper gastrointestinal cancer 84.9% (159 breaches), Suspected skin cancer 86.2% (379 breaches), Suspected sarcoma 90.6% (3 breaches), Suspected urological malignancies (excluding testicular) 91% (76 breaches), Suspected testicular cancer 91.1% (4 breaches) Providers not achieving the national standard were: Liverpool Womens 47.4% (151 breaches), Warrington and Halton Teaching Hospitals 62.9% (376 breaches), East Cheshire 63.1% (206 breaches), Countess Of Chester Hospital 73.5% (291 breaches), St Helens and Knowsley Hospitals 75.9% (364 breaches), Liverpool University Hospitals 76.1% (747 breaches), Southport and Ormskirk Hospital 77.2% (263 breaches), Wirral University Teaching Hospital 77.4% (376 breaches), Mid Cheshire Hospitals 89.9% (153 breaches) Outpatient capacity issues were recorded as the most frequent breach reason (76%), followed by patient choice (16%).	• CMCA primary care programme – improvement team established including investment in GP clinical leadership for each of the nine places in Cheshire and Merseyside. • Productivity gains have increased weekly capacity to see new patients by 25%. • The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group to identify areas of service pressure. • Increased use of appropriate filter tests in primary care including FIT.

Escalation Route & Expected Date of Compliance
NHS England, North West, CMAST CCC Performance Committee, Trust Board October 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
CW45	28 Day Faster Diagnosis - (Referral to Diagnosis) (Cheshire and Merseyside)	Green ≥75% Red <75%	Contractual / Statutory		65.9%	69.2%	67.6%	68.7%	70.3%	66.0%	65.5%	61.4%	71.1%	70.1%	67.0%	-		
			Narrative	The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that the target is unlikely to be achieved without this change.														



Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

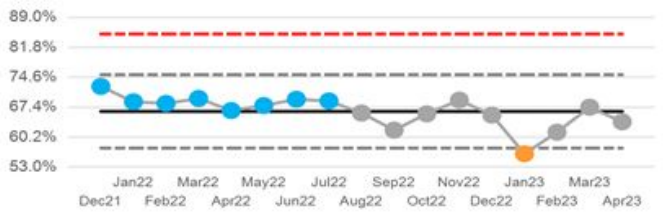
Access: Cheshire and Merseyside

Responsible Forum: Acute and Specialist Trust Provider Collaborative

Reason for Non-Compliance	Action Taken to Improve Compliance
Non-compliance with the 28 day FDS was driven by underperformance in the following tumour groups: Referral from a National Screening Programme: Unknown Cancer Report Category 36% (199 breaches), Suspected urological malignancies (excluding testicular) 41% (465 breaches), Suspected lower gastrointestinal cancer 41.9% (1524 breaches), Suspected gynaecological cancer 50% (645 breaches), Suspected haematological malignancies (excluding acute leukaemia) 53.4% (34 breaches), Suspected lung cancer 63.3% (58 breaches), Suspected sarcoma 68.6% (11 breaches), Suspected upper gastrointestinal cancer 69.8% (331 breaches), Suspected testicular cancer 71.2% (15 breaches) Providers not achieving the national standard were: Liverpool Womens 38.7% (193 breaches), Liverpool Heart And Chest 50% (7 breaches), East Cheshire 60.2% (262 breaches), Southport and Ormskirk Hospital 65.8% (338 breaches), Mid Cheshire Hospitals 66% (437 breaches), Countess Of Chester Hospital 66.1% (423 breaches), Liverpool University Hospitals 66.4% (1195 breaches), Warrington and Halton Teaching Hospitals 68.8% (313 breaches), St Helens and Knowsley Hospitals 69% (488 breaches), The Clatterbridge Cancer Centre 73.7% (5 breaches) The main reasons for breaches were outpatient capacity (27%), 'other' (17%), administrative delay (12%) and healthcare provider initiated delay to diagnostic test (12%).	• Continuation of surgical and diagnostics hubs as part of CMCA's response to Covid-19. • The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group. • Alignment with the C&M diagnostic programme with a clear, prioritised plan to increase capacity. • CMCA primary care programme – improvement team established including investment in GP clinical leadership for each of the nine places in Cheshire and Merseyside. • Increased use of appropriate filter tests in primary care including FIT. • Productivity gains have increased capacity to seen new patients by 25%.

Escalation Route & Expected Date of Compliance
NHS England, North West, CMAST CCC Performance Committee, Trust Board March 2024

Metric ID	Metric Name	Target	Metric Type	Year & Month												V	A
CW46	62 Day Classic (Cheshire and Merseyside)	Green ≥85% Red <85%	Contractual / Statutory	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23		
				69.3%	68.9%	66.0%	61.9%	65.8%	69.1%	65.5%	56.2%	61.4%	67.4%	63.9%	-		
			Narrative	The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that the target is unlikely to be achieved without this change.													



Integrated Performance Report (June 22 - May 23)

Access: Cheshire and Merseyside

Responsible Forum: Acute and Specialist Trust Provider Collaborative

Reason for Non-Compliance	Action Taken to Improve Compliance
Non-compliance with the 62 day standard was driven by underperformance in the following tumour groups: Gynaecological 24% (19 breaches), Lower Gastrointestinal 36.9% (47 breaches), Sarcoma 50% (2 breaches), Urological (Excluding Testicular) 51.3% (74 breaches), Head & Neck 56.3% (14 breaches), Haematological (Excluding Acute Leukaemia) 62.8% (8 breaches), Other 66.7% (2 breaches), Lung 70.5% (13 breaches), Breast 70.8% (31 breaches), Upper Gastrointestinal 75.7% (9 breaches) Providers not achieving the national standard were: Liverpool Womens 33.3% (4 breaches), Southport and Ormskirk Hospital 44.1% (28.5 breaches), Liverpool University Hospitals 48.2% (64.5 breaches), Warrington and Halton Teaching Hospitals 48.2% (22 breaches), East Cheshire 59% (12.5 breaches), Mid Cheshire Hospitals 65.8% (25 breaches), Wirral University Teaching Hospital 69.2% (33 breaches), Countess Of Chester Hospital 72.3% (16.5 breaches), The Clatterbridge Cancer Centre 77.5% (9 breaches), Bridgewater Community Healthcare 77.8% (2 breaches), St Helens and Knowsley Hospitals 82.3% (18 breaches) The main reasons for breaches were complex diagnostic pathways (18%), elective capacity inadequate (9%), healthcare provider initiated delay to diagnostic test or treatment planning (15%) and 'other' (39%).	• Continuation of surgical and diagnostics hubs as part of CMCA's response to Covid-19. • The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group. • Alignment with the C&M diagnostic programme with a clear, prioritised plan to increase capacity. • CMCA primary care programme – improvement team established including investment in GP clinical leadership for each of the nine places in Cheshire and Merseyside. • Increased use of appropriate filter tests in primary care including FIT. Patient and public communications to improve patient confidence to attend for appointments.
Escalation Route & Expected Date of Compliance	
NHS England, North West, CMAST CCC Performance Committee, Trust Board March 2024	

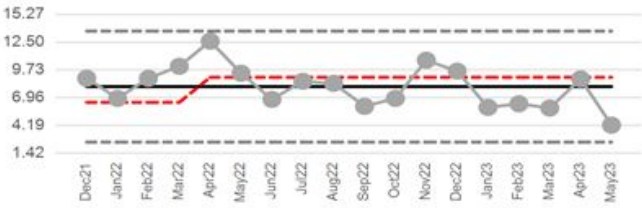
Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

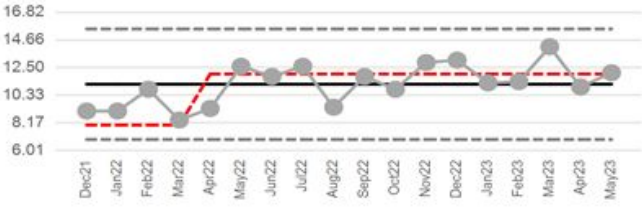
Efficiency

Responsible Forum: Performance Committee

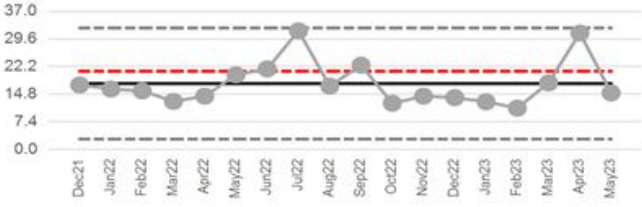
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
IP05-ST	Length of Stay Elective Care: Solid Tumour Wards (Average Number of Days On Discharge)	Green ≤9 Amber 9.1-10.7 Red >10.7	Statutory		6.80	8.60	8.40	6.10	6.90	10.70	9.61	6.00	6.36	5.93	8.84	4.22		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



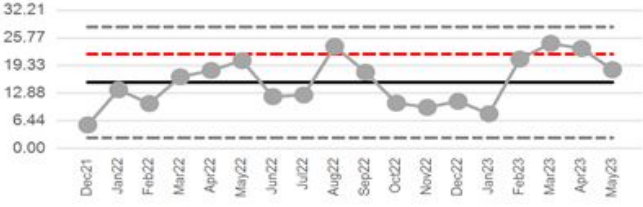
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
IP06-ST	Length of Stay Emergency Care: Solid Tumour Wards (Average Number of Days On Discharge)	Green ≤12 Amber 12.1-14.3 Red >14.3	Statutory		11.80	12.60	9.40	11.80	10.80	12.90	13.08	11.30	11.40	14.13	10.99	12.10		
			Narrative	LoS is marginally above target this month, however there is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
IP05-4	Length of Stay Elective Care: HO Ward 4 (Average Number of Days On Discharge)	Green ≤21 Amber 21.1-22.1 Red >22.1	Statutory		21.6	31.8	17.0	22.6	12.4	14.3	13.9	12.8	11.1	17.9	31.2	15.2		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
IP06-4	Length of Stay Emergency Care: HO Ward 4 (Average Number of Days On Discharge)	Green ≤22 Amber 22.1-23.1 Red >23.1	Statutory		12.10	12.50	23.80	17.80	10.60	9.60	11.00	8.10	20.86	24.50	23.31	18.36		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



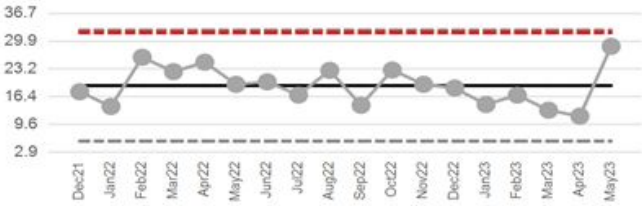
Integrated Performance Report (June 22 - May 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

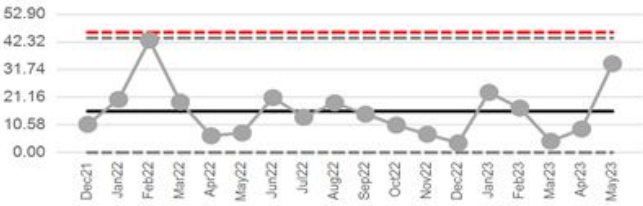
Efficiency

Responsible Forum: Performance Committee

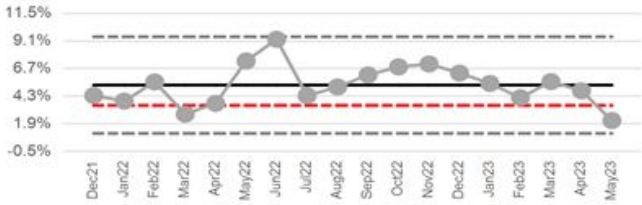
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
IP05-5	Length of Stay Elective Care: HO Ward 5 (Average Number of Days On Discharge)	Green ≤32 Amber 32.1-33.6 Red >33.6	Statutory		20.0	16.8	22.8	14.3	22.9	19.4	18.5	14.5	16.8	13.1	11.6	28.7		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



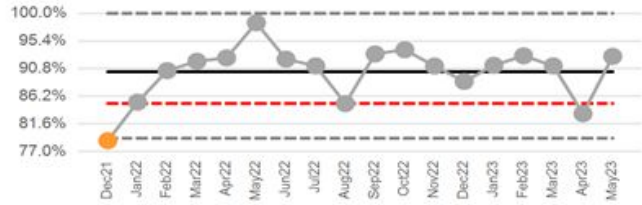
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
IP06-5	Length of Stay Emergency Care: HO Ward 5 (Average Number of Days On Discharge)	Green ≤46 Amber 46.1-48.3 Red >48.3	Statutory		21.00	13.50	19.00	14.70	10.50	7.00	3.67	23.00	17.00	4.33	9.00	34.00		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
IP22	Delayed Transfers of Care As % of Occupied Bed Days	Green ≤3.5% Red >3.5%	Statutory		9.2%	4.4%	5.1%	6.1%	6.9%	7.1%	6.3%	5.4%	4.2%	5.6%	4.8%	2.2%		
			Narrative	The nationally set target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
IP20	Average Bed Occupancy - Midday	Green 85% - ≤92% Amber 81-84.9% Red <81% or >92%	Statutory		92.4%	91.3%	85.0%	93.2%	93.9%	91.2%	88.7%	91.4%	92.9%	91.3%	83.3%	92.8%		
			Narrative	Midday bed occupancy is marginally above the National NHS ambition of below 92%. A single bed occupancy exception report is provided below the midnight occupancy KPI. The SPC chart indicates no significant change and that achievement of the target is likely to be inconsistent.															



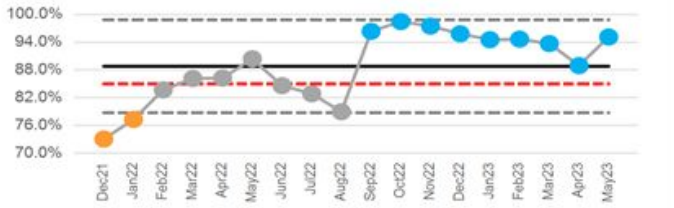
Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

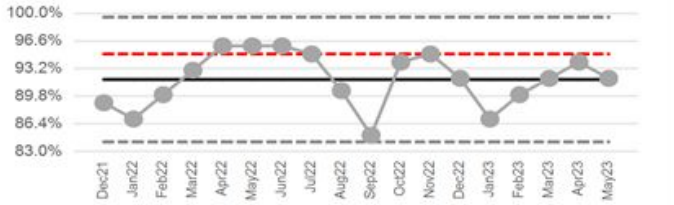
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
IP21	Average Bed Occupancy - Midnight	Green 85% - ≤92% Amber 81-84.9% Red <81% or >92%	Statutory		84.6%	82.9%	79.0%	96.3%	98.5%	97.5%	95.8%	94.5%	94.7%	93.7%	88.9%	95.1%		
			Narrative	Bed occupancy at midnight is above the 92% target. An exception report is provided. The SPC chart indicates that occupancy is higher than expected and that achievement of the target is likely to be inconsistent.														



Reason for Non-Compliance	Action Taken to Improve Compliance
Trustwide midday bed occupancy for May was just over the national ambition of ≤92%, at 92.8%. Occupancy at midnight was higher, at 95.1%. This rise reflects the recovery following Easter and early May Bank Holidays, with higher referrals and new and follow up appointments, which drive the chemotherapy schedules and therefore the numbers of inpatients, who are having chemotherapy, or admitted with post chemotherapy complications.	A patient flow project is reviewing the flow of patients from home (concentrating on avoiding admission), to discharge. A project initiation document (PID) is being finalised and working groups will be identified. A separate project (in collaboration with LUHFT) will focus on inpatient and out patient frailty. The ToR of the Trust Operational Group are being revised to widen the scope from CWT performance to all aspects of operational performance, including bed occupancy, LoS and DTOC.

Escalation Route & Expected Date of Compliance
Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board August 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
IP23	% of Expected Discharge Dates Completed	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		96.0%	95.0%	90.5%	85.0%	94.0%	95.0%	92.0%	87.0%	90.0%	92.0%	94.0%	92.0%		
			Narrative	This internal target has not been achieved this month. There is however no significant change. The nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
IP24	% of Elective Procedures Cancelled On or After The Day of Admission	Green 0% Red >0%	Contractual		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
			Narrative	No procedures have been cancelled on or after the day of admission.														

Data Not Applicable for SPC

Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

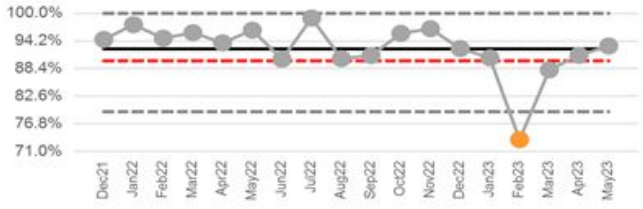
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
IP25	% of Cancelled Elective Procedures (On or After The Day of Admission) Rebooked Within 28 Days of Cancellation	Green 100% Red <100%	Contractual		-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	There is no data to display, as no procedures were cancelled.														

Data Not Applicable for SPC

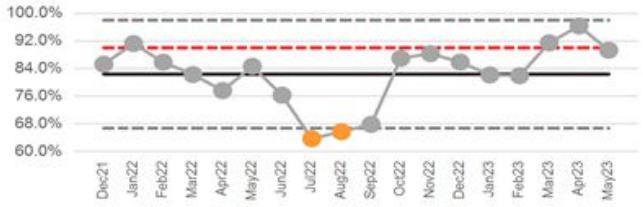
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
IP26	% of Urgent Operations Cancelled For a Second Time	Green 0% Red >0%	Contractual		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
			Narrative	No procedures have been cancelled for a second time.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
EF10	Imaging Reporting Turnaround (Inpatients)	Green >90% Amber 80-89.9% Red <80%			90.4%	99.0%	90.5%	91.1%	95.8%	96.8%	92.6%	90.7%	73.5%	88.1%	91.2%	93.1%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
EF11	Imaging Reporting Turnaround (Outpatients)	Green >90% Amber 80-89.9% Red <80%			76.3%	63.7%	65.7%	67.9%	87.0%	88.3%	85.9%	82.2%	82.0%	91.5%	96.3%	89.3%		
			Narrative	Performance is marginally below target and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

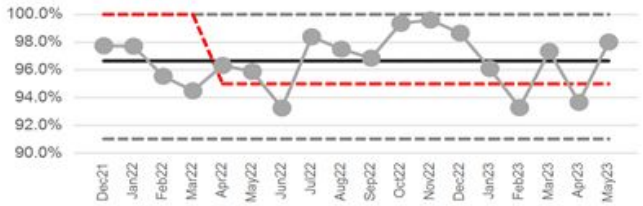
Efficiency

Responsible Forum: Performance Committee

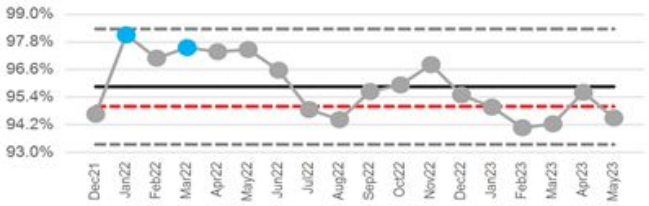
Reason for Non-Compliance	Action Taken to Improve Compliance
Increased CT and MR demand continues across CCC sites. There are vacancies and increased sickness absence in the team, with cross cover in place e.g. for sonography, which has and continues to result in reduced reporting capacity.	Recruitment for additional radiologists is at the short listing stage and locum cover is being arranged in the interim. Additonal Sonographers have been appointed and the first is due to start on 2nd August 2023.

Escalation Route & Expected Date of Compliance
Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board June 2023

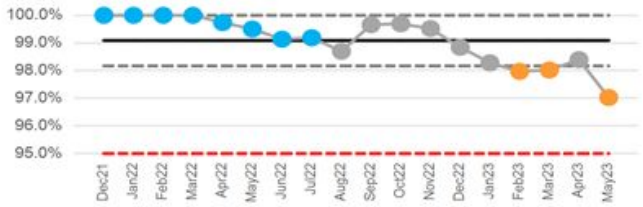
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
DQ01	Data Quality - % Ethnicity That is Complete (or Patient Declined to Answer)	Green ≥95% Amber 90-94.9% Red <90%	Covid-19 Recovery		93.3%	98.4%	97.5%	96.9%	99.4%	99.6%	98.7%	96.1%	93.3%	97.3%	93.7%	98.0%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
DQ02	Data Quality - % of Outpatients With an Outcome	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		96.6%	94.9%	94.4%	95.6%	95.9%	96.8%	95.5%	95.0%	94.1%	94.2%	95.6%	94.5%		
			Narrative	This internal target has not been achieved, however here is no significant change. The nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
DQ03	Data Quality - % of Outpatients With an Attend Status	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		99.1%	99.2%	98.7%	99.7%	99.7%	99.5%	98.8%	98.3%	98.0%	98.0%	98.4%	97.0%		
			Narrative	The target has been achieved. Although performance is lower than expected, the target is outside SPC limits and therefore likely to be achieved consistently.														



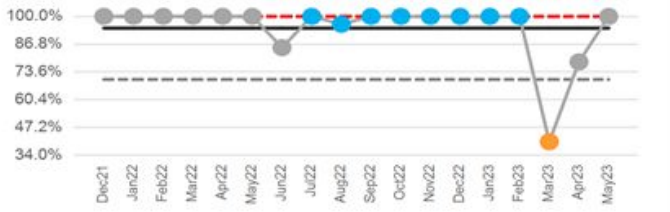
Integrated Performance Report (June 22 - May 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
EF01	Percentage of Subject Access Requests Responded to Within 1 Month	Green 100% Red <100%	Contractual		85.2%	100.0%	96.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	40.4%	78.4%	100.0%		
			Narrative	The target has been achieved. Performance is now as expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
EF02	% of Overdue ISN (Information Standard Notices)	Green 0% Red >0%	Contractual		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
			Narrative	The target continues to be achieved.														

Data Not Applicable for SPC

Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU17	Never Events	Green 0 Red >0	Contractual / Statutory	0	0	0	0	0	0	0	0	0	0	0	1		
			Narrative	1 Never Event was reported in May and an exception report is provided.													

Data Not Applicable for SPC

Reason for Non-Compliance	Action Taken to Improve Compliance
This event was an inadvertant connection to wall piped medical air via a flowmeter, instead of intended connection to wall piped medical oxygen. The event concerned 1 patient. The investigation into the incident concluded that the 1 patient affected suffered a low level of harm from this event.	All air flow meters have been removed from wall piped air outlets across all inpatient areas, where not required to support niche equipment. All niche equipment has integral flowmeters (3 situated at CCCL). A risk assessment has been completed for the 3 remaining air outlets in use. All air outlets not required are now capped. A review of all CCC wall piped medical air supply outlets across the CCC estate has concluded and all air outlets evident have been capped. The Trust has reported this to STEIS and is following the never event reporting procedures.

Escalation Route & Expected Date of Compliance
Medical Gas Group, Health and Safety Committee, ERG, Patient Safety Committee, Risk & Quality Governance Committee, Quality Committee, Trust Board. June 2023

Metric ID	Metric Name	Target	Metric Type	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU04	Serious Incidents (SIs)	No Target	Contractual / Statutory	0	2	0	1	0	0	0	1	0	0	1	0		
			Narrative	No SIs were reported to STEIS this month.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU01	Serious Incidents: % Submitted Within 60 Working Days / Agreed Timescales	Green 100% Red <100%	Contractual / Statutory	-	-	-	-	-	100%	-	-	-	-	100%	-		
			Narrative	No SI reports were submitted this month.													

Data Not Applicable for SPC

Integrated Performance Report (June 22 - May 23)

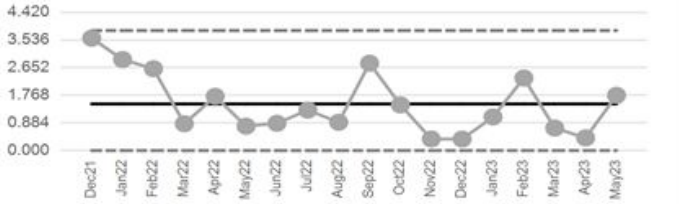
The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU03	Incidents /1,000 Bed Days	No Target	Statutory		143.5	149.1	140.1	143.3	144.4	136.9	104.6	123.0	127.1	134.2	117.8	107.4		
			Narrative	Incident numbers are as expected. Incidents are reviewed at Divisional Quality and Safety meetings and Divisional Performance Review meetings. This focus promotes a good reporting culture and analysis of themes and trends to drive improvement.														

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU05	All Incidents Resulting in Moderate Harm and Above /1,000 Bed Days	No Target	Local		0.872	1.293	0.904	2.794	1.458	0.370	0.367	1.076	2.318	0.719	0.405	1.767		
			Narrative	Numbers of incidents of this severity are as expected. Incidents are reviewed at Divisional Quality and Safety meetings and Divisional Performance Review meetings. This focus promotes a good reporting culture and analysis of themes and trends to drive improvement.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU06	Inpatient Falls Resulting in Harm Due to Lapse in Care	Green 0 Red >0	Contractual		0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	There were no falls resulting in harm due to a lapse in care. The harm review process has been amended and therefore figures may change retrospectively, following review.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU07	Inpatient Falls Resulting in Harm Due to Lapse in Care /1,000 Bed Days	Green 0 Red >0	Contractual		0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	There were no falls resulting in harm due to a lapse in care. The harm review process has been amended and therefore figures may change retrospectively, following review.														

Data Not Applicable for SPC

Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

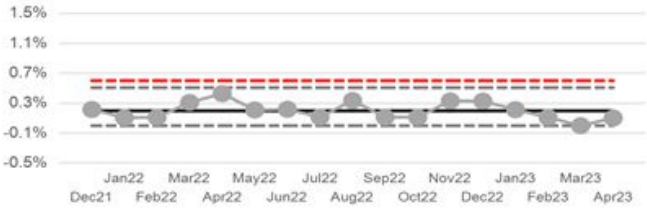
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU08	Pressure Ulcers (Hospital Acquired Grade 3/4, With a Lapse in Care)	Green 0 Red >0	Contractual		0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target continues to be achieved, with no such pressure ulcers this month. The harm review process has been amended and therefore figures may change retrospectively, following review.														

Data Not Applicable for SPC

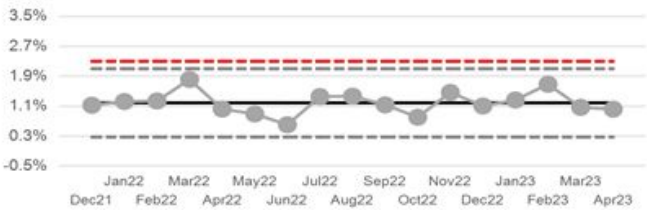
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU09	Pressure Ulcers (Hospital Acquired Grade 3/4, With a Lapse in Care) /1,000 Bed Days	Green 0 Red >0	Contractual		0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target continues to be achieved, with no such pressure ulcers this month. The harm review process has been amended and therefore figures may change retrospectively, following review.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU10	30 Day Mortality (Radical Chemotherapy)	Green ≤0.6% Amber 0.61% - 0.7% Red >0.7%	SOF		0.2%	0.1%	0.3%	0.1%	0.1%	0.3%	0.3%	0.2%	0.1%	0.0%	0.1%	-		
			Narrative	The target has been achieved. There is no significant change and the target is now outside SPC limits and therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU12	30 Day Mortality (Palliative Chemotherapy)	Green ≤2.3% Amber 2.31% - 2.5% Red >2.5%	SOF		0.6%	1.4%	1.4%	1.1%	0.8%	1.5%	1.1%	1.3%	1.7%	1.1%	1.0%	-		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and therefore likely to be achieved consistently.														



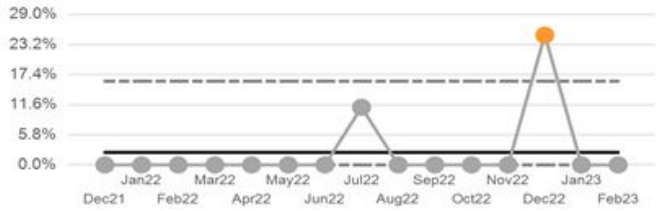
Integrated Performance Report (June 22 - May 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

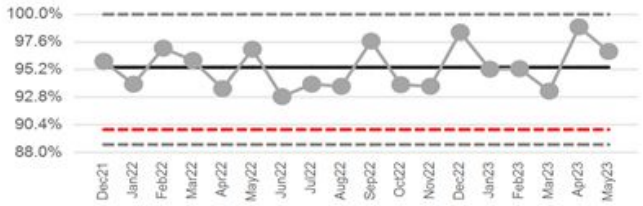
Quality

Responsible Forum: Quality Committee

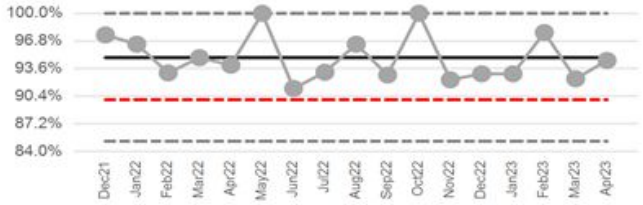
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU13	100 Day Mortality (Bone Marrow Transplant)	To Be Confirmed	SOF / NR		0.0%	11.1%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	-	-	-		
			Narrative	There were no deaths within 100 days of transplants taking place in January.														



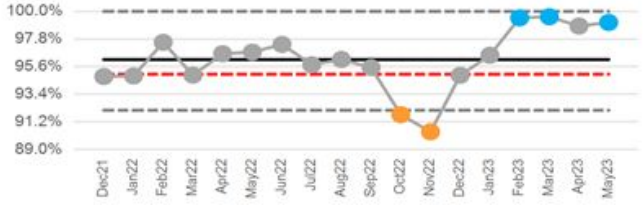
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU62	Consultant Review Within 14 Hours	Green ≥90% Red <90%	Contractual		92.9%	93.9%	93.8%	97.7%	93.9%	93.8%	98.4%	95.2%	95.3%	93.3%	98.9%	96.8%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU48	Sepsis IV Antibiotics Within an Hour	Green ≥90% Red <90%	Contractual		91.3%	93.2%	96.4%	92.9%	100.0%	92.3%	93.0%	93.0%	97.8%	92.4%	94.5%	-		
			Narrative	May data is still being validated; delayed due to unexpected staff absences in the coding team.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU31	Percentage of Adult Admissions With VTE Risk Assessment	Green ≥95% Red <95%	Contractual / Statutory		97.4%	95.7%	96.2%	95.5%	91.8%	90.4%	94.9%	96.5%	99.5%	99.6%	98.8%	99.1%		
			Narrative	The target has been achieved. Performance is higher than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



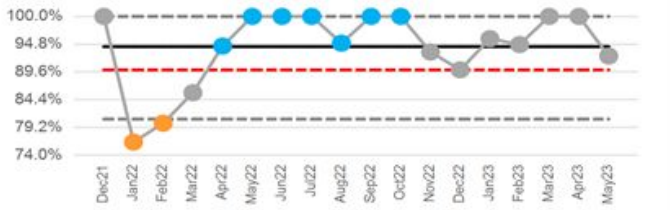
Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU14	Dementia: Percentage to Whom Case Finding is Applied	Green ≥90% Red <90%	Contractual		100.0%	100.0%	95.0%	100.0%	100.0%	93.3%	90.0%	95.8%	94.7%	100.0%	100.0%	92.6%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



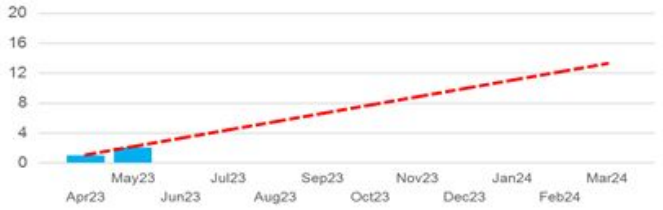
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU15	Dementia: Percentage With a Diagnostic Assessment	Green ≥90% Red <90%	Contractual		-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	No patients have required a diagnostic assessment.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU16	Dementia: Percentage of Cases Referred	Green ≥90% Red <90%	Contractual / Statutory		-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	No patients have required a referral.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU34	Clostridium Difficile Infections (HOHA and COHA)	Green ≤ 13 per year Red >13 per year	Contractual / Statutory		1	1	-	-	-	-	-	-	-	-	-	-		
			Narrative	There was 1 such infection this month, however figures to date are below the threshold YTD.														



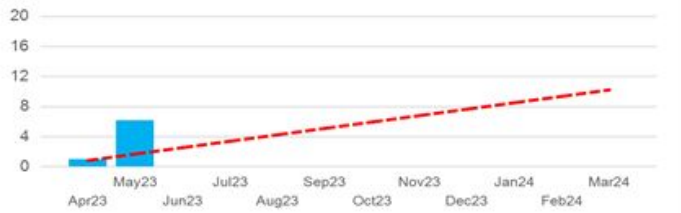
Integrated Performance Report (June 22 - May 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

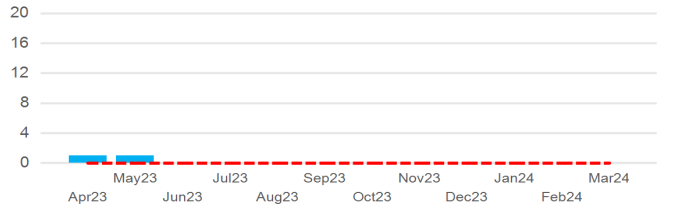
Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month													
				Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU40	E. Coli Bacteraemia (HOHA and COHA)	Green ≤ 10 per year Red >10 per year	Contractual / Statutory	1	5	-	-	-	-	-	-	-	-	-	-		
			Narrative	There were 5 such infections this month and an exception report is provided.													



Reason for Non-Compliance	Action Taken to Improve Compliance
3 HOHA E.coli bloodstream infections were identified in May 2023: Patient 1. Infection was likely to be skin/soft tissue in origin. No lapses were identified, however blood cultures were only obtained from the patients Peripheral Invasive Central Catheter (PICC) line. Paired peripheral cultures were not obtained as per policy. Paired cultures support prompt identification of source and appropriate interventions. Patient 2. Infection is likely to be related to an intra-abdominal collection. No learning points were identified from this episode of infection. Patient 3. Infection is likely to be to be skin/soft tissue in origin. No learning points were identified from this episode of infection 2 COHA E.coli bloodstream infections were identified in May 2023: Patient 1. Infection is an unknown source. No lapses were identified, however additional microbiological samples were not collected with blood cultures. Microbiological specimens collected at the time of blood culture collection would have supported prompt identification of source and appropriate interventions. Patient 2. Infection is likely to be related to a Hepatobiliary source. No learning points were identified from this episode of infection.	Findings from post infection reviews discussed with nursing and medical teams. Ward Manager and patient Consultant will cascade learning to all staff regarding the need to obtain peripheral cultures and additional microbiological samples when collecting blood cultures.

Escalation Route & Expected Date of Compliance
Harm Free Care Meeting, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board June 2023

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month													
				Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU36	MRSA Infections (HOHA and COHA)	Green 0 per year Red >0 per year	Contractual / Statutory	1	0	-	-	-	-	-	-	-	-	-	-		
			Narrative	There were no such infections this month.													



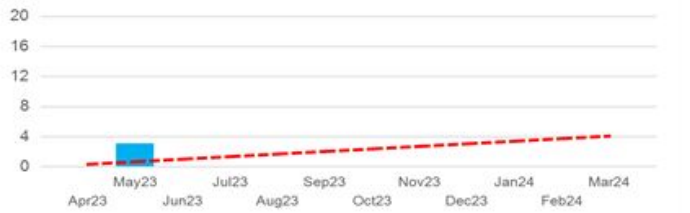
Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

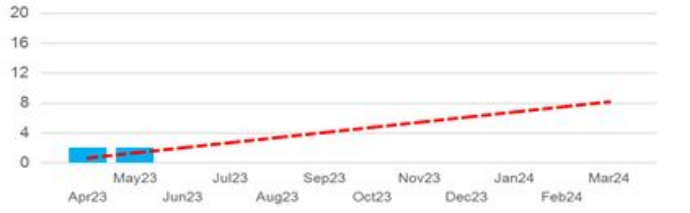
Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month													
				Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU38	MSSA Bacteraemia (HOHA and COHA)	Green ≤ 4 per year Amber 5 Red >5 per year	Contractual / Statutory	0	3	-	-	-	-	-	-	-	-	-	-		
			Narrative	There were 3 such infections this month and an exception report is provided.													



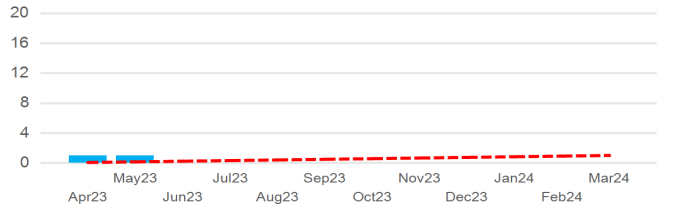
Reason for Non-Compliance	Action Taken to Improve Compliance
1 HOHA and 2 COHA Staphylococcus aureus bloodstream infections were identified in May 2023: Patient 1 (COHA). Source: Unknown – Medical microbiology treated infection as Perpherial Inavisve Centeral Catheter (PICC) line vs Community Assoicated Pueumonia (CAP) . No learning points were identified from this episode of infection. Patient 2 (COHA). Source: Query chest port infection. No learning points were identified from this episode of infection. Patient 3 (HOHA). Source: Query line / gut translocation? Case not yet coded. To be discussed at IPC MDT 08/06/2023 to establish any lapses in care.	No lapses in care identified from the cases thus far. Work is currently ongoing by ward staff to improve ANTT compliance across the wards.

Escalation Route & Expected Date of Compliance
Harm Free Care Meeting, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board June 2023

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month													
				Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU43	Klebsiella (HOHA and COHA)	Green ≤ 8 per year Red >8 per year	Contractual / Statutory	2	0	-	-	-	-	-	-	-	-	-	-		
			Narrative	There were no such infections this month.													



Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month													
				Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU45	Pseudomonas (HOHA and COHA)	Green ≤ 1 per year Red >1 per year	Contractual / Statutory	1	0	-	-	-	-	-	-	-	-	-	-		
			Narrative	There were no such infections this month.													



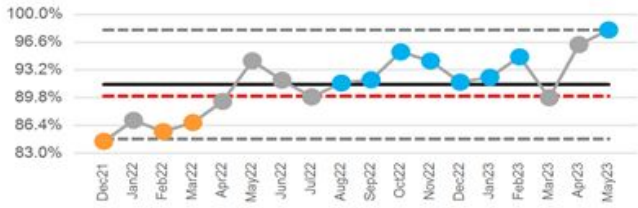
Integrated Performance Report (June 22 - May 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

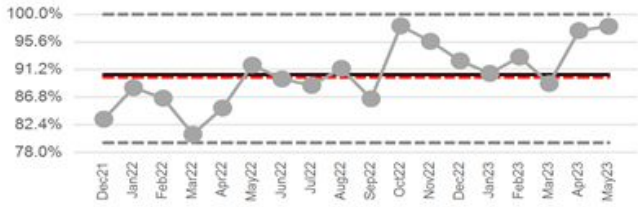
Quality

Responsible Forum: Quality Committee

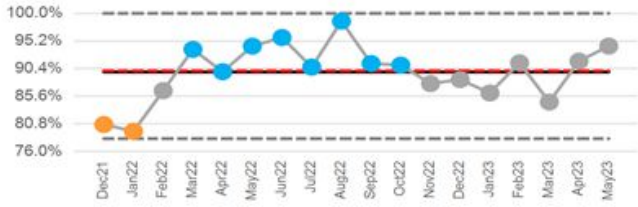
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU66	Safer Staffing: Overall Fill-Rate	Green ≥90% Red <90%	Statutory		91.9%	89.9%	91.6%	92.0%	95.4%	94.3%	91.7%	92.3%	94.8%	89.8%	96.3%	98.1%		
			Narrative	The target has been achieved. Performance is higher than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



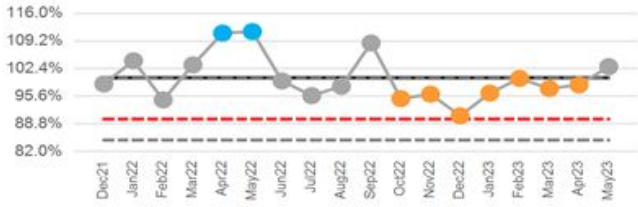
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU61	Average Number of Registered Nurses Filled Shifts - Days	Green ≥90% Red <90%	Statutory		89.7%	88.7%	91.4%	86.6%	98.2%	95.7%	92.6%	90.6%	93.2%	89.0%	97.4%	98.1%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU63	Average Number of Care Staff Filled Shifts - Days	Green ≥90% Red <90%	Statutory		95.8%	90.7%	98.7%	91.3%	91.0%	87.8%	88.5%	86.2%	91.4%	84.6%	91.7%	94.3%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU64	Average Number of Care Staff Filled Shifts - Nights	Green ≥90% Red <90%	Statutory		99.4%	95.8%	98.1%	108.7%	95.0%	96.1%	90.8%	96.4%	100.0%	97.5%	98.4%	102.9%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



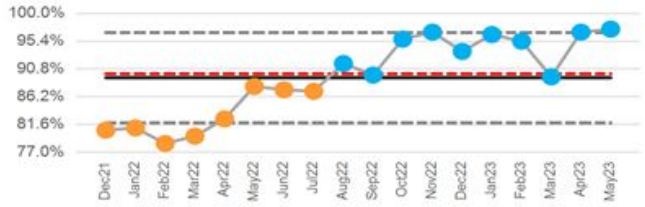
Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

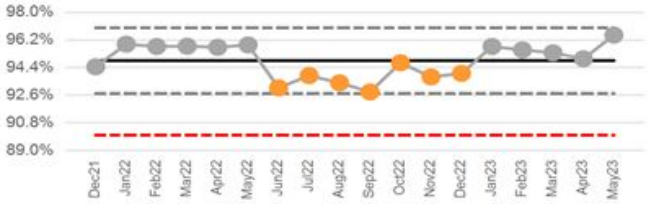
Quality

Responsible Forum: Quality Committee

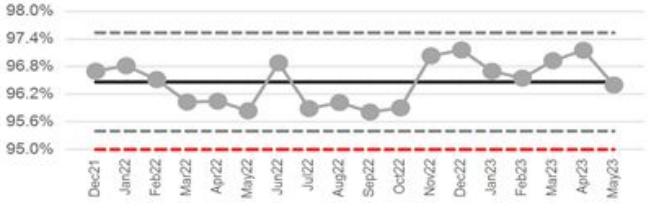
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU65	Average Number of Registered Nurses Filled Shifts - Nights	Green ≥90% Red <90%	Statutory		87.4%	87.1%	91.7%	89.8%	95.7%	96.9%	93.7%	96.5%	95.4%	89.5%	96.9%	97.4%		
			Narrative	The target has been achieved. Performance is higher than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



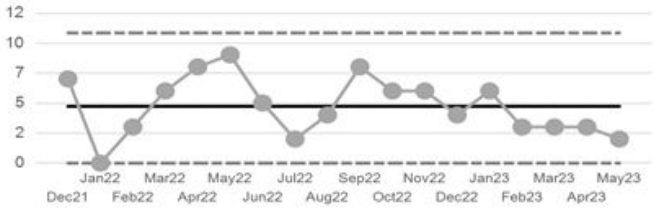
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU60	NICE Guidance Compliance	Green ≥90% Amber 85 - 89.9% Red <85%	Contractual		93.1%	93.9%	93.4%	92.8%	94.7%	93.8%	94.0%	95.8%	95.6%	95.4%	95.0%	96.5%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU75	Patient FFT: % of Respondents Who Had a Positive Experience	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		96.9%	95.9%	96.0%	95.8%	95.9%	97.0%	97.2%	96.7%	96.6%	96.9%	97.2%	96.4%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU11	Number of Complaints	No Target	Contractual		5	2	4	8	6	6	4	6	3	3	3	2		
			Narrative	There were 2 complaints this month, with no significant change noted. Complaints are reviewed at Divisional meetings, Divisional Performance Reviews and RQGC. This promotes effective analysis of themes and trends to drive improvement.														



Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

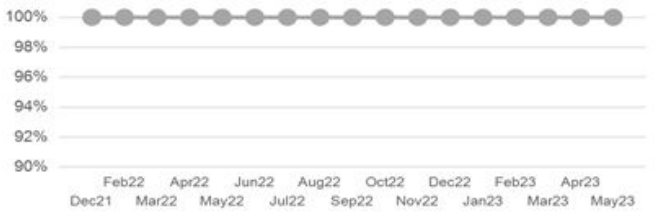
Quality

Responsible Forum: Quality Committee

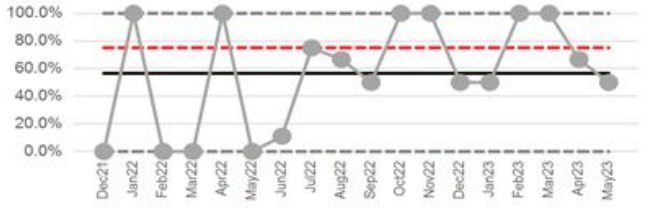
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU18	Number of Complaints / Count of WTE Staff (Ratio)	No Target	Contractual		0.003	0.001	0.002	0.005	0.003	0.003	0.002	0.003	0.002	0.002	0.002	0.001		
			Narrative	There were 0.001 complaints per staff WTE this month. Complaints are reviewed at Divisional meetings, Divisional Performance Reviews and RQGC. This promotes effective analysis of themes and trends to drive improvement.															

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU19	% of Formal Complaints Acknowledged Within 3 Working Days	Green 100% Red <100%	Contractual		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
			Narrative	The target continues to be achieved. Performance is as expected and the nature of variation indicates that the target is likely to be consistently achieved.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU20	% of Routine Complaints Resolved Within 25 Working Days	Green ≥75% Amber 65% - 74.9% Red <65%	Local		11.1%	75.0%	66.7%	50.0%	100.0%	100.0%	50.0%	50.0%	100.0%	100.0%	66.7%	50.0%		
			Narrative	The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Reason for Non-Compliance	Action Taken to Improve Compliance
One of two routine complaints were not resolved within the 25 days target. The delay was caused by complaint lead capacity issues due to infection outbreak on the ward. The family were kept up to date with the delays.	Divisional team have been reminded of the timescales involved in routine complaints. A new process has been implemented whereby extensions to timescales of complaint response can be obtained with approval from the complainant and Complaints Manager. This must be agreed prior to the response deadline.

Escalation Route & Expected Date of Compliance
Information Governance Board, Risk and Quality Governance Committee, Quality Committee, Trust Board June 2023

Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU71	% of Complex Complaints Resolved Within 60 Working Days	Green ≥75% Amber 65% - 74.9% Red <65%	Local		100.0%	100.0%	100.0%	50.0%	-	-	-	66.7%	100.0%	50.0%	50.0%	50.0%		
			Narrative	1 out of 2 complex complaints resolved this month, were resolved within 60 working days. An exception report is provided.														

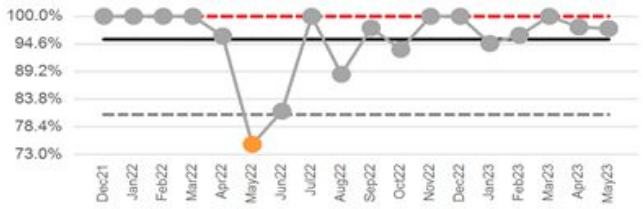
Data Not Applicable for SPC

Reason for Non-Compliance	Action Taken to Improve Compliance
One of two complex complaints was not resolved within the 60 day timescale. The delay was caused by the time required to gather information across Divisions. The complainant was kept up to date with the 10 day delay in responding.	The Divisional team have been reminded to escalate any delays due to staff engagement to the Trust Complaints Manager for review to ensure adherence to response timescales.

Escalation Route & Expected Date of Compliance

Information Governance Board, Risk and Quality Governance Committee, Quality Committee, Trust Board
June 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU21	% of FOIs Responded to Within 20 Days	Green 100% Red <100%	Contractual / Statutory		81.5%	100.0%	88.7%	97.7%	93.5%	100.0%	100.0%	94.7%	96.3%	100.0%	97.9%	97.6%		
			Narrative	This national target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Reason for Non-Compliance	Action Taken to Improve Compliance
41 of the 42 FOIs responded to in May were within the 20 working day period. In regards to the one FOI which exceeded the 20 working day period, there had been a delay in response from a department, leading to a 27 day turnaround. The FOI requester was kept informed.	No further action. Routine reminders were sent to involved parties, and extensions were communicated to the requester.

Escalation Route & Expected Date of Compliance

Information Governance Board, Risk and Quality Governance Committee, Quality Committee, Trust Board
June 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU22	Number of IG Incidents Escalated to ICO	Green 0 Red >0	Contractual / Statutory		0	0	0	0	1	0	0	0	1	0	0	0		
			Narrative	No IG incidents were escalated to the ICO this month.														

Data Not Applicable for SPC

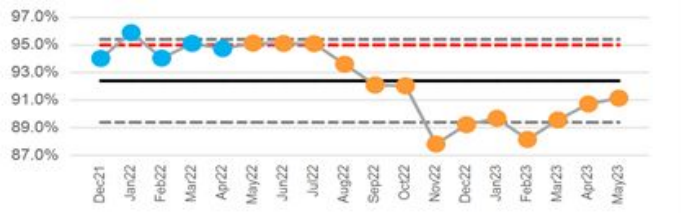
Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU23	% of Policies in Date	Green ≥95% Amber 90.1 - 94.9% Red <90%	Contractual		95.1%	95.1%	93.6%	92.1%	92.0%	87.8%	89.2%	89.7%	88.2%	89.6%	90.7%	91.2%		
			Narrative	The target has not been achieved and an exception report is provided. Performance is lower than expected (triggering an exception report) and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Reason for Non-Compliance	Action Taken to Improve Compliance
23 of the 260 policies in the Trust have not been reviewed within the review period. • 7 Documents are waiting for approval via meetings/committees which will take place over the next month. • 11 Documents are currently in the process of being updated by their authors. • 4 Documents have previous authors which have either left the trust or moved department and are being assigned to a different staff member to review and update. • 1 Document is being changed from a policy to an SOP. Once the new SOP has been completed this will replace the currently policy which will be archived.	The Document Control Officer will continue to send regular reminders for overdue items. Any policies that still continue to sit out of date for long periods without communication to Document Control are escalated to the Information Governance Manager. It has been agreed with the Information Governance Manager that Document Control can encourage remote approval outside of committees or meetings in order to expedite the approval process and prevent policies from sitting out of date for an extended period of time.

Escalation Route & Expected Date of Compliance
Information Governance Board, Risk and Quality Governance Committee, Quality Committee, Trust Board July 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
QU24	NHS E/I Patient Safety Alerts: Number Not Implemented Within Set Timescale.	Green 0 Red >0	Contractual		0	0	0	1	0	0	0	0	0	0	0	0		
			Narrative	1 alert was implemented in time, however the submission deadline was missed.														

Data Not Applicable for SPC

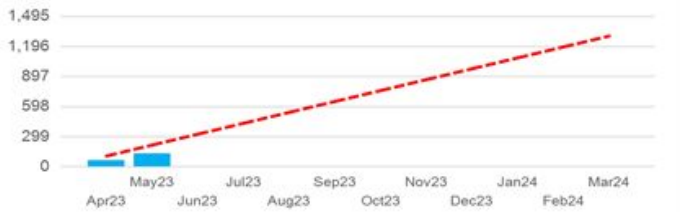
Integrated Performance Report (June 22 - May 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month												V	A
RI20	Study Recruitment	Green ≥1300 per year Amber 1100-1299 per year Red <1100 per year	CCC Strategy	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24		
				62	69	-	-	-	-	-	-	-	-	-	-		
			Narrative	The monthly and YTD performance is below the target, therefore an exception report is provided.													



Reason for Non-Compliance	Action Taken to Improve Compliance
131 patients have been recruited between April and May 2023 against an internal target of 250 (52% of target) at the end of Month 2. Of the 69 patients recruited 17 were recruited onto interventional studies and 52 onto observational. The main reasons at Month 2 for not achieving the overall target are: • Concentrated focus needed on interventional clinical trial recruitment which has not yet fully recovered. Director of Clinical Research to address this via the Research Study Prioritisation Committee. • A high number of complex, low recruiting studies have been opened since December 2021 when the Research Study Prioritisation Committee was initiated. • A number of our larger observational studies have closed or will be closing to recruitment soon.	• Clinical Research gap analysis paper is complete and was presented to June 2023 Trust Executive Group (TEG). Progress against plan will be monitored monthly via R&I Directorate Board and an update to TEG every 4 months. • Director of Clinical Research to review strategy for trial selection at Research Study Prioritisation Committee. • Continue to work collaboratively with service departments and research-active staff to open all studies types in a timely way. • Research Priorities meeting taken place to determine where resource will be focused. Workshop to take place at Research@Clatterbridge Day on 13th June 2023. • Initiate clinically-led programme of work to increase home grown research to boost recruitment numbers. To note: - First patient recruited to the Target National study. This is a study to undertake genetic testing and then allocate patients within a National Molecular Tumour Board to the most suitable matched experimental medicine therapies based on molecular and clinical characteristics. (P.I. Prof Dan Palmer, Multi tumour group). - 5 new clinical research studies opened meeting monthly target.

Escalation Route & Expected Date of Compliance
R&I Directorate Board, Committee for Research Strategy, Performance Committee, Trust Board March 2024

Metric ID	Metric Name	Target	Metric Type	Year & Month												V	A
RI03	Study Set-Up Times in Days	Green ≤40 days Red >40	National Reporting	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23		
				13	-	-	11	-	-	-	-	-	-	-	-		
			Narrative	Due to 'current pressures on workforce and capacity' The National Institute for Health and Care Research have paused publication of this data until further notice.													

Integrated Performance Report (June 22 - May 23)

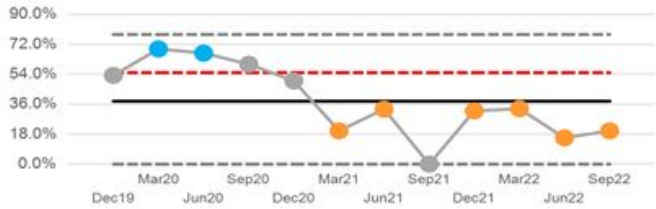
The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

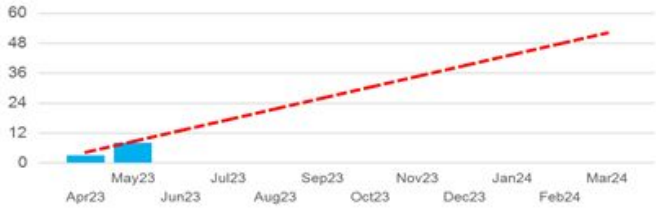
Responsible Forum: Performance Committee

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	V	A
RI10	Number of Patients Recruited (Non-Commercial, Portfolio Studies)	Green ≥500 per year Amber 425-499 Red <425			78	24	45	121	93	62	55	82	-	-	-	-		
			Narrative	Both the monthly and YTD targets have been achieved. The reporting period for this KPI is Oct - Sept rather than April - March.														

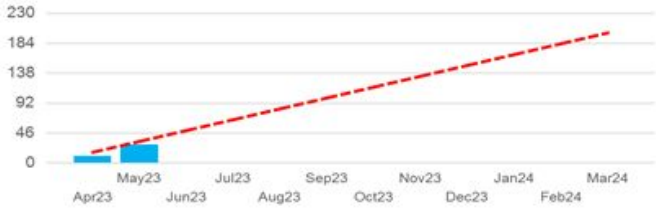
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
RI21	Recruitment to Time and Target	Green ≥55% Amber 45 - 54.9% Red <45%	National Reporting		15.8%	-	-	20.0%	-	-	-	-	-	-	-	-		
			Narrative	Due to 'current pressures on workforce and capacity' The National Institute for Health and Care Research have paused publication of this data until further notice.														



Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
RI05	Number of New Studies Open to Recruitment	Green ≥52 per year Amber 45 - 51 Red <45	CCC Strategy		3	5	-	-	-	-	-	-	-	-	-	-		
			Narrative	Whilst performance is marginally below the YTD target, the monthly performance is above target, therefore an exception report is not provided.														



Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
RI22	Publications	Green >200 per year Amber 170-200 Red <170	CCC Strategy		11	17	-	-	-	-	-	-	-	-	-	-		
			Narrative	Whilst performance is marginally below the YTD target, the monthly performance is above target, therefore an exception report is not provided.														



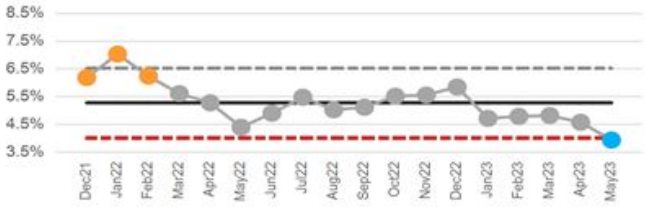
Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

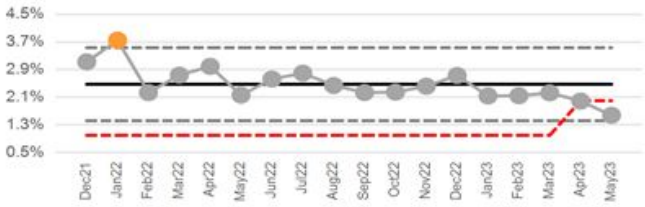
Workforce

Responsible Forum: People Committee

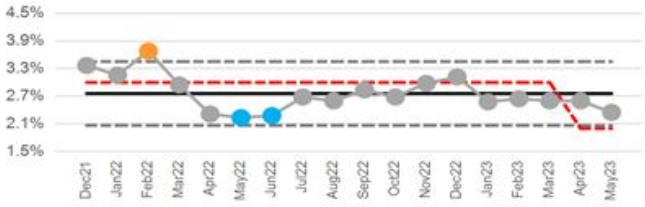
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
WO01	Sickness Absence	Green ≤4% Amber 4.1 - 4.9% Red ≥5%	Contractual / Statutory		4.9%	5.5%	5.0%	5.1%	5.5%	5.6%	5.9%	4.7%	4.8%	4.8%	4.6%	3.9%		
			Narrative	The target has been achieved. Although there is no significant change, the target is unlikely to be achieved without significant change.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
WO20	Sickness Absence (Short Term)	Green ≤2% Amber 2.1-2.9% Red ≥3%	Contractual / Statutory		2.6%	2.8%	2.4%	2.2%	2.2%	2.4%	2.7%	2.1%	2.1%	2.2%	2.0%	1.6%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
WO21	Sickness Absence (Long Term)	Green ≤2% Amber 2.1-2.9% Red ≥3%	Contractual / Statutory		2.3%	2.7%	2.6%	2.8%	2.7%	3.0%	3.1%	2.6%	2.6%	2.6%	2.6%	2.4%		
			Narrative	The target has not been achieved. Although there is no significant change, the target is unlikely to be achieved without significant change and an exception report is therefore provided.														



Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

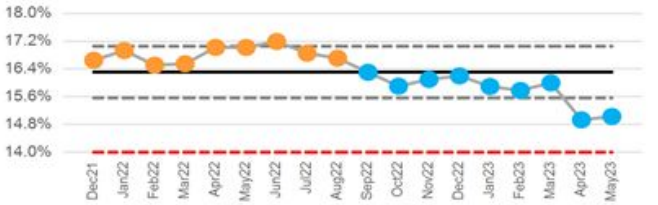
Workforce

Responsible Forum: People Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
There were 56 long term absences in May compared with 60 in April. 24 absences ended in May and 32 continue into June. The top reason for long term absences was anxiety/stress/depression with 24 occurrences (a decrease since last month) followed by 'Other known causes not elsewhere classified' with 10 (consistent with last month) and musculoskeletal problems with 6 occurrences. R&I had the highest percentage of absence compared with number of staff in the department with 5% which amounts to 4 absences. This was followed by Networked Services with 4.6% which totals 27 absences. Corporate had the third highest percentage of absence in proportation to staff with 4.3% which totals 2 absences. On average, the long term absences lasted 89 days.	As a result of the quarterly deep dives, the HRBP team continue to review long term sickness absences paying particular attention to areas with increasing absences due to anxiety/stress/depression. Due to sickness overall still being high, the HRBP team ask managers during monthly surgeries to evidence that absences are being managed in line with policy, e.g. what support has been offered, RTW documentation and management of policy stages. This is fed back at Divisional meetings. The HRBP team are due to undertake a review of the Trust's Attendance Management policy which will concentrate on what further support and monitoring can be provided by the organisation and managers in order to reduce sickness absence.

Escalation Route & Expected Date of Compliance
Divisional Meetings, Divisional Performance Reviews, Workforce Advisory Committee, People Committee, Trust Board October 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month												
				Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
WO02	% Turnover (Rolling 12 Months)	Green ≤14% Amber 14.1%-14.9% Red ≥15%		17.2%	16.9%	16.7%	16.3%	15.9%	16.1%	16.2%	15.9%	15.8%	16.0%	14.9%	15.0%		
			Narrative	The target has not been achieved. Whilst performance is lower than expected, the target is unlikely to be achieved without significant change and an exception report is therefore provided.													



Reason for Non-Compliance	Action Taken to Improve Compliance
The Trust turnover has increased in May from to 14.93% to 15.03% and is above the Trust target. However if leavers due to retirement and end of fixed term contracts (FTC) were removed from the data set, the Trust would be at 13.04%, which is below target. There were 21 leavers in May compared with 16 in April. Work life balance remains the highest reason for leaving with 5 in total this month followed by promotion with 4 leavers and relocation also with 3 leavers. Research had the highest percentage of leavers for the second month in a row in proportion to staff numbers at 2.5% (2 leavers) followed by Networked Services at 1.3% (8 leavers)	The HRBP Team to continue to push for exit interviews to be completed to ensure that we are receiving useful information which can drive improvements and reduce turnover. The HR Team will link in with managers to understand reasons for non-completion of exit interviews/ questionnaires as there has been a reduction in May. The HRBP team to work with managers to try to understand further the reasons that staff are leaving due to 'work life balance' and to ensure that it is being accurately recorded. The HRBP team discuss flexible working regularly with managers to ensure that staff are supported to work flexibly where possible. The HRBPs are currently developing the programme of work around Stay and Grow conversations across the divisions. This will focus on areas with the highest turnover initially with a view to support those who are leaving due to career progression or development opportunities.

Escalation Route & Expected Date of Compliance
Divisional Meetings, Divisional Performance Reviews, Workforce Advisory Committee, People Committee, Trust Board July 2023

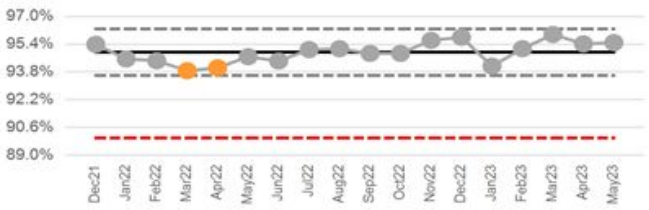
Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

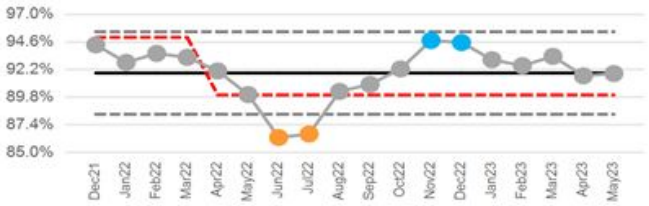
Workforce

Responsible Forum: People Committee

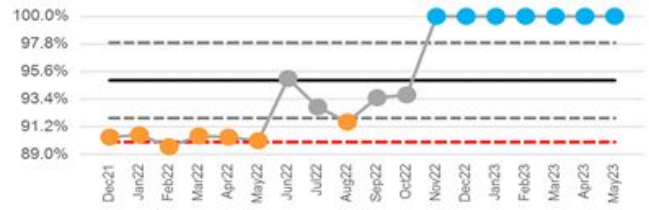
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
WO07	Statutory Mandatory Training Compliance	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual / Statutory		94.4%	95.1%	95.1%	94.9%	94.9%	95.6%	95.8%	94.1%	95.1%	96.0%	95.4%	95.5%		
			Narrative	The target has been achieved. Performance is as expected and the target is likely to be achieved consistently. NB: There are specific courses for which we are not compliant. This is closely monitored at People Committee and in Divisional PRGs, with actions identified to improve compliance.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
WO22	Appraisal	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual		86.3%	86.6%	90.3%	90.9%	92.3%	94.7%	94.6%	93.1%	92.5%	93.4%	91.7%	91.9%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
WO23	Medical Appraisal	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual / Statutory		95.0%	92.8%	91.6%	93.5%	93.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
			Narrative	The target has been achieved. Performance is better than expected and the nature of variation indicates that achievement of the target is likely to be consistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
WO24	Pulse Staff Survey: Employee Engagement Score	Green text Amber text Red National Average	Contractual		6.90	-	-	7.20	-	-	-	-	-	7.10	-	-		
			Narrative	There is no data this month for this quarterly survey.														

Data Not Applicable for SPC

Integrated Performance Report (June 22 - May 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Responsible Forum: People Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
WO25	Pulse Staff Survey: Advocacy Score	Green text Amber text Red National Average	Contractual		7.10	-	-	7.60	-	-	-	-	-	7.40	-	-		
			Narrative	There is no data this month for this quarterly survey.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
WO26	Pulse Staff Survey: Involvement Score	Green text Amber text Red National Average	Contractual		6.80	-	-	6.90	-	-	-	-	-	7.00	-	-		
			Narrative	There is no data this month for this quarterly survey.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
WO27	Pulse Staff Survey: Motivation Score	Green text Amber text Red National Average	Contractual		6.90	-	-	6.90	-	-	-	-	-	6.80	-	-		
			Narrative	There is no data this month for this quarterly survey.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	V	A
WO40	Bame Staff Representation	Green ≥8% Amber 6-7.9% Red ≤6%			6.9%	7.2%	7.3%	7.8%	8.2%	8.1%	8.2%	8.1%	8.2%	8.2%	8.2%	8.4%		
			Narrative	The target has been achieved.														

Data Not Applicable for SPC

Integrated Performance Report (June 22 - May 23)

Finance | Responsible Forum: Performance Committee

Metric (£000)	In Mth 2 Actual	In Mth 2 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	(61)	30	(91)		(128)	61	(189)	
CPL/Propcare Surplus/ (Deficit)	91	0	91		189	0	189	
Control Total Surplus/ (Deficit)	30	30	0		61	61	0	
Trust Cash holding	65,546	64,509	1,037		65,546	64,509	1,037	
Capital Expenditure	15	0	15		92	92	0	
Agency Cap	118	149	31		214	298	84	

For 2023/24 NHS Cheshire and Mersey ICB are managing the required financial position of each Trust through a whole system approach. The Trust submitted a plan to NHSE/I on 4th May 2023 showing a £363k surplus for 2023/24.

The Trust financial position to month 2 (May 2023) is a deficit of £128k, which is £189k behind plan. The group position is a £61k surplus and is in line with the plan.

The Trust cash position is £65.5m, which is above plan by £1m. Capital spend is £92k in the year to date, with the majority of capital spend profiled later in the year.

The agency cap has been re-set based on prior year spend and in May 2023 the Trust is reporting below the agency cap by £84k.

Trust Board Part 1
28th June 2023

Report lead	James Thomson – Director of Finance					
Paper prepared by	Jo Bowden – Deputy Director of Finance					
Report subject/title	Finance Report – Month 2 2023/24					
Purpose of paper	To present the Trust's financial position at the end of May 2023					
Background papers	N/A					
Action required	To note the contents of the report					
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work			
	Be Collaborative		Be Digital			
	Be Research Leaders		Be Innovative			

Equality & Diversity Impact Assessment						
The content of this paper could have an adverse impact on:	Age	No	Disability	No	Sexual Orientation	No
	Race	No	Pregnancy/ Maternity	No	Gender Reassignment	No
	Gender	No	Religious Belief	No		

1. Introduction

1.1 This paper provides a summary of the Trust's financial performance for May 2023, the second month of the 2023/24 financial year.

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

2. Summary Financial Performance

2.1 For May the key financial headlines are:

Metric (£000)	In Mth 2 Actual	In Mth 2 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	(61)	30	(91)		(128)	61	(189)	
CPL/Propcare Surplus/ (Deficit)	91	0	91		189	0	189	
Control Total Surplus/ (Deficit)	30	30	0		61	61	0	
Trust Cash holding	65,546	64,509	1,037		65,546	64,509	1,037	
Capital Expenditure	15	0	15		92	92	0	
Agency Cap	118	149	31		214	298	84	

2.2 For 2023/24 NHS Cheshire & Merseyside ICB are managing the required financial position of each Trust through a whole system approach. The Trust submitted a plan to NHSE/I on 4th May 2023 showing a £363k surplus for 2023/24.

3. Operational Financial Profile – Income and Expenditure

Overall Income and Expenditure Position

3.1 The Trust financial position to the end of May is a £128k deficit, which is £189k below the planned surplus of £61k. The group is showing a balanced position to the end of May.

3.2 The Trust cash position is a closing balance of £65.5m, which is above plan by £1m. Capital spend is £92k for the year to date, with the majority of spend profiled in future months.

3.3 As part of the financial plan submission the Trust set out an agency cost plan, which is being used to monitor performance for 2023/24. To the end of May, agency spend is below plan by £84k.

3.4 The table below summarises the financial position. Please see Appendix A for a detailed Income & Expenditure analysis.

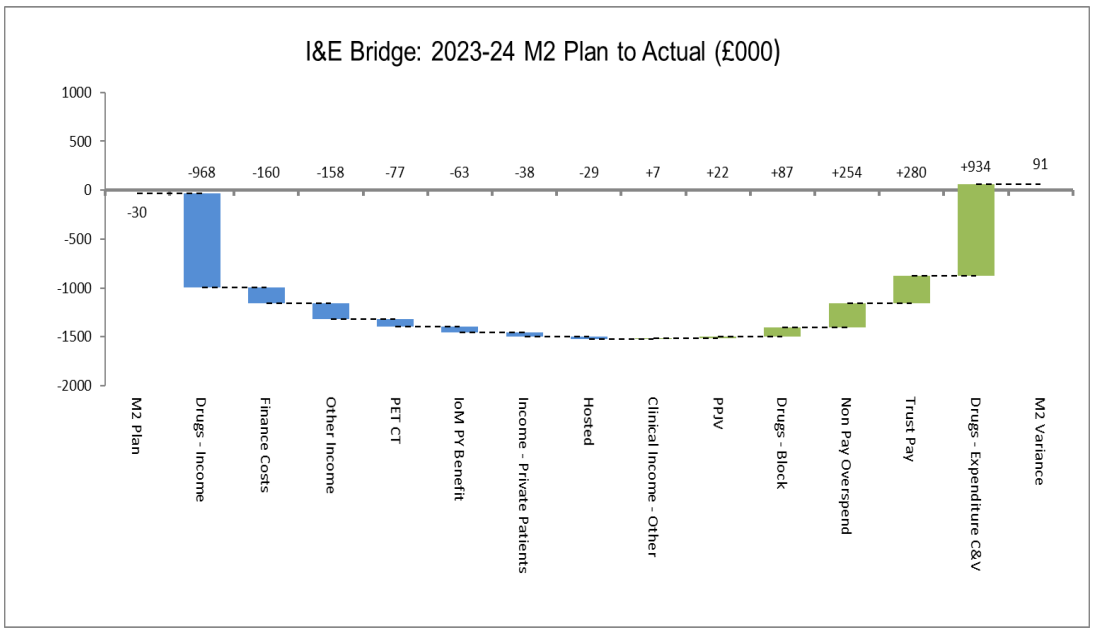
	Actual M2	Trust Plan M2	Variance	Actual YTD	YTD Budget	Variance	Plan 23.24
Clinical Income	20,804	20,970	(166)	42,360	43,298	(938)	247,646
Other Income	2,647	1,978	668	4,100	3,493	606	13,618
Total Operating Income	**23,451**	**22,949**	**502**	**46,460**	**46,791**	**(331)**	**261,264**
Total Operating Expenditure	(23,386)	(22,655)	(731)	(46,384)	(46,203)	(181)	(257,741)
Operating Surplus	**65**	**293**	**(229)**	**76**	**588**	**(512)**	**3,523**
PPJV	45	67	(22)	112	134	(22)	804
Finance Costs	(171)	(330)	160	(316)	(661)	345	(3,964)
Trust Surplus/(Deficit)	**(61)**	**30**	**(91)**	**(128)**	**61**	**(189)**	**363**
Subsidiaries	91	0	91	189	0	189	-
Consolidated Surplus/Deficit	**30**	**30**	**(0)**	**61**	**61**	**(0)**	**363**

The table below summaries the consolidated financial position:

May 2023-24 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	(144)	(294)
Donated Depreciation	83	166
Trust Retained Surplus / (Deficit)	**(61)**	**(128)**
CPL	42	91
Propcare	49	98
Consolidated Financial Position	**30**	**61**

3.5 The bridge below shows the key drivers between the £128k in month deficit and £61k surplus plan, which is a variance of £189k:

- As part of the financial plan the Trust has assumed an additional £1.6m of income for activity over and above 2023/24 activity levels. As part of month 2 the Trust has made an assumption that the income will be received, and has included income of £133k.
- Cost and Volume drugs are overspent by £938m and are offset by an increase to income. Block drugs are overspent by £87k in month 2. As part of the 2023/24 funding agreement with commissioners high cost drugs remain on a pass-through basis.
- Trust Pay costs are over spent by £280k, this including unmet CIP of £356k.
- Non pay is overspent by £254k, of which £260k relates to unmet CIP for month 2.
- Interest receivable is over plan by £142k, despite the plan value being increased in 2023/24 by £1m. This relates to increasing interest rates.



3.6 **Bank and Agency Reporting**

For May, Bank costs were £203k, which is a significant increase from April. This is mainly due to 1:1 care required on the wards, escalation beds remaining open and bank payments to cover industrial action. A detailed piece of work is currently being scoped to understand the costs which are directly attributable to the escalation beds remaining open.

Agency spend is £118k in month, which while higher than month 1 by £20k is below the Trust plan of £149k. The Trust submitted a plan for agency spend as part of the national planning submission which was based on 2022.23 spend and this is the target the Trust will be monitored against for the 2023.24 financial year

There is a focus on the reduction of agency usage across the Trust and this is reported and monitored through both the Trusts Establishment Control Panel and Finance Committee.

See Appendix F for further detail.

3.7 **Cost Improvement Programme (CIP)**

The Trust CIP requirement for 2023/24 is £8.249m, representing 5% of turnover.

Both NHSE and C&M ICB are expecting this to be achieved recurrently.

CIP has been allocated as below:

	Value (£m)
CIP Target 2023/24	8.249
Allocation	
Central	3.000
Propcare	0.730
CPL	0.168
Unmet CIP 22/23	2.558
Divisional split by budget 23/24	1.793

£3m will be met centrally, though a number of corporate initiatives, £0.86 has been allocated to the Trust subsidiaries and Trust subsidiaries and £4.4m has been allocated to the Divisions. Of the £4.4m allocated to Divisions £2.6m is carry forward of unmet recurrent CIP, the new allocation if £1.8m represents 1.3% of budgets.

There has been £575k (7%) achievement of the CIP target to May, these are all recurrent savings. There are also a further £522k (6.3%) of opportunities and plans in progress.

While the CIP is profiled equally in twelves in budgets and the plan, it is expected that a higher proportion of CIP will be found as we progress the financial year.

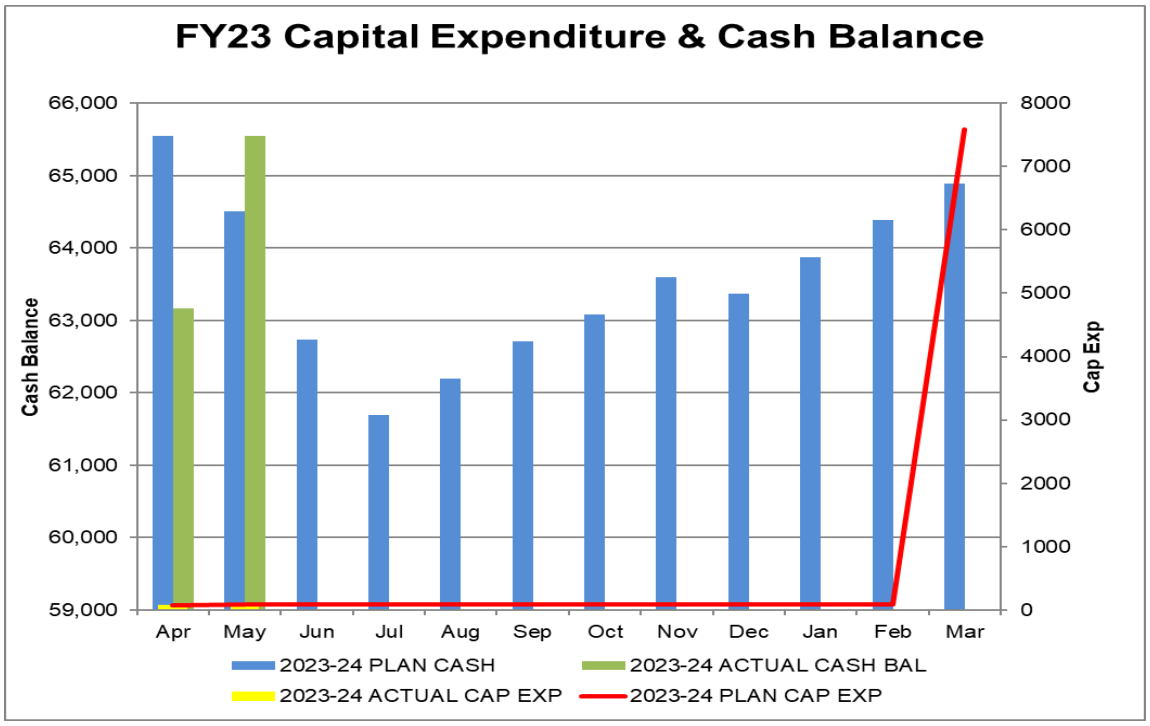
4. Cash and Capital

4.1 The 2023/24 capital plan approved by the Board in March was £7.407m. There was a further £175k of approved adjustments bringing the plan to £7.582m.

4.2 Capital expenditure of £92k has been incurred to the end of May. With the majority of capital spend profiled for future months.

4.3 The capital programme is supported by the organisation's cash position. The Trust has a current cash position of £65.5m.

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 2023/24.

5. Balance Sheet Commentary

5.1 Current Assets

The Trust's cash balance at the end of May is £65.5m, this is £1m above the plan figure of £64.5m. Receivables are lower than plan by £1.6m, demonstrating that debt continues to be collected promptly.

5.2 Current Liabilities

Payables (non-capital creditors) are above plan by £5.1m. This is due to a number of outstanding invoices within Propcare related to steam and R&I invoices that are under query.

Deferred Income is £4.2mm above plan. This relates in the main to R&I income and Cancer Alliance both of which have a number of multi-year schemes which are ongoing.

6. Recommendations

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

- The May Trust and group position
- The continuing strong liquidity position of the Trust

Appendix A – Statement of Comprehensive Income (SOCI)

(£000)	Month 2			YTD				2023/24
	Plan	Actual	Variance	Plan	Actual	Variance	%	Annual Plan
Clinical Income	19,273	20,272	999	38,520	39,226	705		231,051
Other Income	1,100	1,398	298	1,689	2,029	340		6,077
Hosted Services	2,576	1,781	(795)	6,582	5,205	(1,377)		24,136
Total Operating Income	**22,949**	**23,451**	**502**	**46,791**	**46,460**	**(331)**	**1%**	**261,264**
Pay: Trust (excluding Hosted)	(7,326)	(7,606)	(280)	(14,171)	(14,430)	(258)		(81,458)
Pay: Hosted & R&I	(1,012)	(916)	97	(1,932)	(1,651)	280		(10,832)
Drugs expenditure	(8,061)	(9,081)	(1,021)	(16,138)	(16,873)	(735)		(96,828)
Other non-pay: Trust (excluding Hosted)	(4,681)	(4,935)	(254)	(9,288)	(9,939)	(651)		(54,749)
Non-pay: Hosted	(1,575)	(848)	727	(4,674)	(3,491)	1,183		(13,874)
Total Operating Expenditure	**(22,655)**	**(23,386)**	**(731)**	**(46,203)**	**(46,384)**	**(181)**	**0%**	**(257,741)**
Operating Surplus	**293**	**65**	**(229)**	**588**	**76**	**(512)**		**3,523**
Profit /(Loss) from Joint Venture	67	45	(22)	134	112	(22)		804
Interest receivable (+)	469	611	142	938	1,247	309		5,626
Interest payable (-)	(434)	(417)	17	(869)	(833)	36		(5,213)
PDC Dividends payable (-)	(365)	(365)	0	(730)	(730)	0		(4,377)
Trust Retained surplus/(deficit)	**30**	**(61)**	**(91)**	**61**	**(128)**	**(189)**		**363**
CPL/Propcare	0	91	91	0	189	189		0
Consolidated Surplus/(deficit)	**30**	**30**	**(0)**	**61**	**61**	**(0)**	**0%**	**363**

Appendix B – Balance Sheet

£'000			Unaudited 2223 (Group Ex Charity)	Year to date Month 2 (May 2024)		
				Plan 2324 (Trust Only)	Actual YTD	Variance
Non-current assets						
	Intangible assets		6,741	3,486	6,473	2,987
	Property, plant & equipment		201,605	189,187	200,035	10,848
	Right of use assets		11,177	9,947	11,174	1,226
	Investments in associates		1,304	455	1,416	961
	Other financial assets		1,328	114,324	0	(114,324)
	Trade & other receivables		448	2,382	837	(1,545)
	Other assets		0	0	0	0
Total non-current assets			**222,603**	**319,782**	**219,935**	**219,935**
Current assets						
	Inventories		4,175	2,000	5,447	3,447
	Trade & other receivables					0
		NHS receivables	18,989	5,642	3,971	(1,672)
		Non-NHS receivables		9,299	9,375	76
	Cash and cash equivalents		73,591	65,733	67,895	2,162
Total current assets			**96,754**	**82,675**	**86,687**	**86,687**
Current liabilities						
	Trade & other payables					
		Non-capital creditors		23,211	28,387	5,177
		Capital creditors	32,986	2,493	2,355	(138)
	Borrowings					0
		Loans	2,233	1,892	1,762	(130)
		Lease liabilities		0	334	334
	Provisions		2,533	761	1,549	788
	Other liabilities:-					0
		Deferred income	13,531	7,822	12,112	4,290
		Other	0	0	0	0
Total current liabilities			**51,283**	**36,179**	**46,499**	**46,499**
Total assets less current liabilities			**268,074**	**366,278**	**260,123**	**(106,155)**
Non-current liabilities						
	Trade & other payables		2,189			
		Capital creditors		0	0	0
	Borrowings					0
		Loans	40,714	37,627	29,620	(8,007)
		Lease liabilities	0	0	10,354	10,354
	Other liabilities:-					0
		Deferred income	1,110	972		(972)
		Provisions	273		1,275	1,275
		PropCare liability	0	115,633		(115,633)
Total non current liabilities			**44,286**	**154,233**	**41,249**	**(112,984)**
Total net assets employed			**223,788**	**212,046**	**218,874**	**6,828**
Financed by (taxpayers' equity)						
		Public Dividend Capital	88,793	87,242	88,793	1,551
		Revaluation reserve	7,374	4,558	7,373	2,815
		Income and expenditure reserve	127,621	120,246	122,708	2,461
Total taxpayers equity			**223,788**	**212,046**	**218,874**	**6,828**

Appendix C – Cash Flow

May 2024 (M2)	Plan	Actuals		
	FT	FT	Group	Group (exc Charity)
Cash flows from operating activities:				
Operating surplus	3,032	(90)	526	179
Depreciation	12,440	1,660	1,660	1,660
Amortisation		266	266	266
Impairments				
Movement in Trade Receivables		1,812	5,031	4,939
Movement in Other Assets			(0)	(0)
Movement in Inventories	(120)	(794)	(1,271)	(1,271)
Movement in Trade Payables		(427)	145	145
Movement in Other Liabilities		724	(2,529)	(2,529)
Movement in Provisions		(1)	17	17
CT paid	(480)	0	(49)	(49)
Impairements /revaluations Annual				
All other movements in operating cash flows (including working capital movements)		1	0	1
Charity funds				
Net cash used in operating activities	**14,872**	**3,150**	**3,797**	**3,359**
Cash flows from investing activities				
Purchase of PPE	(12,045)	(4,320)	(4,320)	(4,320)
Purchase of Intangibles		(1)	(1)	(1)
ROU Assets		0	3	3
Proceeds from sale of PPE		0	0	0
Interest received	5,626	1,247	521	516
Investment in associates		0	0	0
Cash movement from disposals of business units and subsidiaries (not absorption transfers)	1,248			
Net cash used in investing activities	**(5,171)**	**(3,074)**	**(3,797)**	**(3,802)**
Cash flows from financing activities				
Public dividend capital received	23	0	0	0
Public dividend capital repaid				
Loans received				
Movement in loans	(1,730)	(877)	(877)	(877)
Capital element of finance lease		(0)	0	0
Interest paid	(5,213)	(833)	(89)	(89)
Interest element of finance lease- rou		0	(0)	(0)
PDC dividend paid	(4,377)	(730)	(730)	(730)
Finance lease - capital element repaid	(8)	0	0	0
Net cash used in financing activities	**(11,305)**	**(2,440)**	**(1,695)**	**(1,695)**
Net change in cash	**(1,604)**	**(2,364)**	**(1,695)**	**(2,138)**
Cash b/f	**67,150**	**61,246**	**73,591**	**70,033**
Cash c/f	**65,546**	**58,882**	**71,896**	**67,895**

Appendix D – Capital

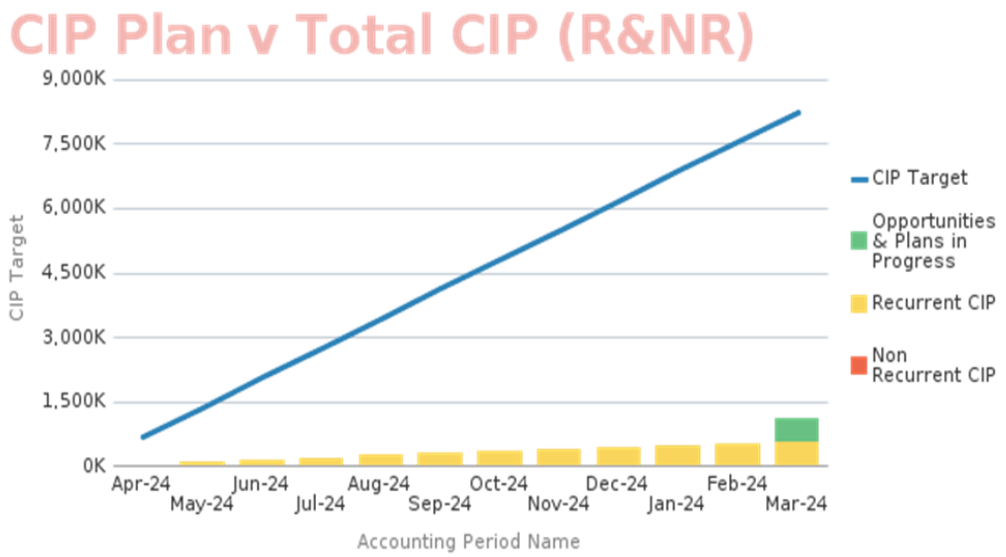
Capital Programme 2023-24
Month 2

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Code	Scheme	Lead	BUDGET (£'000) NHSI plan 23-24	Approved Adjustments	Budget 23-24	ACTUALS (£'000) Actuals @ Month 2	Variance to Budget	FORECAST (£'000) Forecast 23-24	Variance to Budget	Complete?	Comments
4401	CCC-L Ward 3 bathroom conversion	Kathryn Williams	32	0	32	0	32	32	0	✕	Delayed from prior year
4433	CCC-A Estates Work and Rebranding	Emer Scott	0	0	0	17	(17)	17	(17)	✕	Approved at CIG 31/1/23
	Wirral site redevelopment	Propcare	200	0	200	0	200	200	0	✕	Consultancy/Design works
	Electric vehicle charging points	Propcare	100	0	100	0	100	100	0	✕	May not proceed - power load/supply issue
	CCC-W Propcare Plan:	Propcare	968	(968)	0	0	0	0	0	-	Plan figure now allocated to below schemes
	- Building - external fabric	Propcare	0	24	24	0	24	24	0	✕	
	- Building - internal	Propcare	0	360	360	0	360	360	0	✕	
	- M&E	Propcare	0	472	472	0	472	472	0	✕	
	- Physics building	Propcare	0	800	800	0	800	800	0	✕	Potential to scale back spec/spend
	- Fire compartmentation	Propcare	0	300	300	0	300	300	0	✕	Significant unknowns - surveys in progress
	- Tea bar	Propcare	0	40	40	0	40	40	0	✕	
	- Ground floor changing area	Propcare	0	52	52	0	52	52	0	✕	
	- Roofing	Propcare	0	800	800	0	800	800	0	✕	
	CCC-A Linac bunker	Louise Bunby	220	0	220	0	220	220	0	✕	Likely to be significantly less - TBC
	Estates		**1,520**	**1,880**	**3,400**	**17**	**3,382**	**3,417**	**(17)**		
4192	Cyclotron	Carl Rowbottom	0	0	0	4	(4)	280	(280)	✕	Ongoing scheme
4309	Voltage Stabilisers	Martyn Gilmore	0	0	0	0	0	0	0	✕	Installation delayed
4415	RFID Asset Tracking System	Tony Marsland	0	25	25	0	25	25	0	✕	Extra tags approved May Finance Com'tee
4451	CCC-A Linac	Louise Bunby	2,460	(82)	2,378	0	2,378	2,378	0	✕	Ordered 5th June. c10mth lead time.
	Brachy line applicators	Louise Bunby	30	0	30	0	30	30	0	✕	
	Radionuclide calibrator	Louise Bunby	10	0	10	0	10	10	0	✕	
	2D array x2	Louise Bunby	80	0	80	0	80	80	0	✕	
	Concealement trolley	Mel Warwick	17	1	18	0	18	18	0	✕	
4448	BMT Sharepoint App	Priscilla Hetherington	0	11	11	0	11	11	0	✕	Approved in March
4449	Whole body phantom	?	0	0	0	33	(33)	33	(33)	✓	Moved from revenue
4450	Flojack flat lifting kits	Pauline Pilkington	0	35	35	0	35	35	0	✕	Requisitions 1st June
	Medical Equipment		**2,597**	**(11)**	**2,586**	**37**	**2,550**	**2,899**	**(313)**		
4422	DDCP 22-23	James Crowther	0	0	0	0	0	0	0	✕	New PDC funded scheme
4427	Cyber Capital Access Management	James Crowther	0	0	0	0	0	0	0	✕	New PDC funded scheme
4405	Website	Emer Scott	100	0	100	1	99	100	0	✕	Expected to slip into 2022/23
	EPMA Stock Control & Pharmacy RPA	James Crowther	419	181	600	0	600	600	0	✕	
	Digital Literacy & Capability Programme	James Crowther	300	0	300	0	300	300	0	✕	
	HealthData Programme	James Crowther	400	0	400	0	400	400	0	✕	
	PatientHealth Programme	James Crowther	400	0	400	0	400	400	0	✕	
	Patient Education System	James Crowther	250	0	250	0	250	250	0	✕	
	Patient Flow Solution	James Crowther	175	0	175	0	175	175	0	✕	
	DigiFlow	James Crowther	190	0	190	0	190	190	0	✕	
	PoC Medical Devices & Device Integration	James Crowther	250	0	250	0	250	250	0	✕	
	DDCP (PDC Funded)	James Crowther	23	0	23	0	23	23	0	✕	
	Digital		**2,507**	**181**	**2,688**	**1**	**2,687**	**2,688**	**0**		
4421	Paddington CDC - costs		0	0	0	37	(37)	37	(37)	✕	
	Paddington CDC - costs (PDC funded)		0	175	175	0	175	175	0	✕	Approved PDC bid
	Pharmacy - VHP commissioning	Tori Young	350	0	350	0	350	280	70	✕	In discussions with procurement
	Pharmacy - Automated Medicines Cabinets	Tori Young	300	0	300	0	300	300	0	✕	Requirements under review
	Pharmacy - Prescriptions/medicines tracke	Tori Young	50	0	50	0	50	50	0	✕	
	IFRS16 - Pharmacy vehicles		28	0	28	0	28	28	0	✕	
	IFRS16 - Portakabins		55	0	55	0	55	55	0	✕	
	Other		**783**	**175**	**958**	**37**	**921**	**925**	**33**		
	Contingency		**0**	**(2,050)**	**(2,050)**		**(2,050)**	**(2,347)**	**297**		
	TOTAL		**7,407**	**175**	**7,582**	**92**	**7,490**	**7,582**	**0**		

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix E – Cost Improvement Programme



Divisional CIP Against Full Year Plan

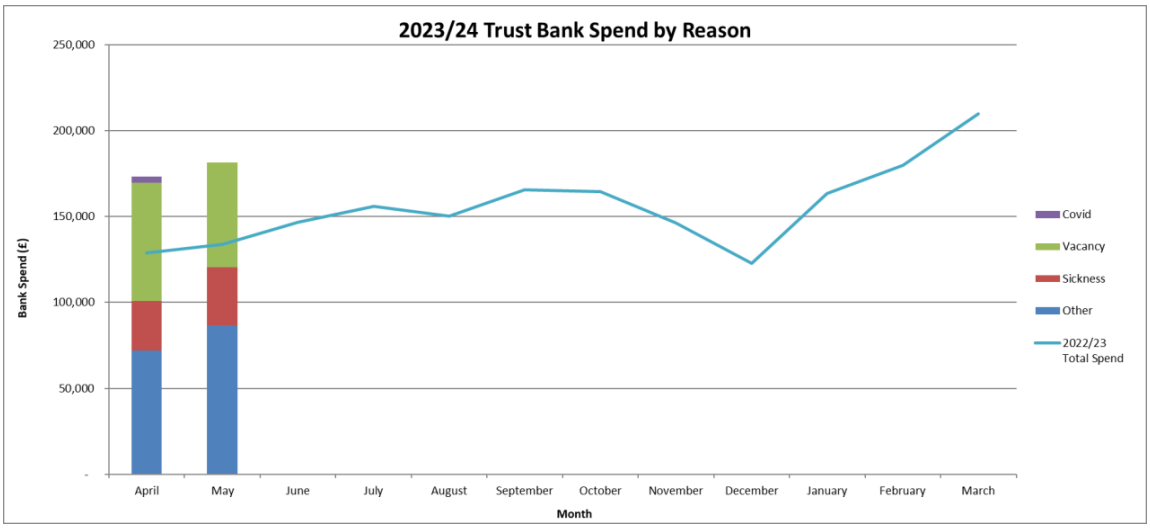
Division	Target	Total CIP	Recurrent CIP	Variance	Delivery % to date	Opportunities & Plans in Progress	Total Forecast CIP
CENTRAL CIP	3,898,000	0	0	(3,898,000)	0%	168,000	168,000
NETWORKED SERVICES	1,368,777	50,243	50,243	(1,318,534)	4%	0	50,243
ACUTE CARE	980,125	282,500	282,500	(697,625)	29%	354,363	636,863
RADIATION SERVICES	1,013,426	167,615	167,615	(845,811)	17%	0	167,615
CORPORATE	988,672	74,808	74,808	(913,864)	8%	0	74,808
Total	**8,249,000**	**575,166**	**575,166**	**(7,673,834)**		**522,363**	**1,097,529**

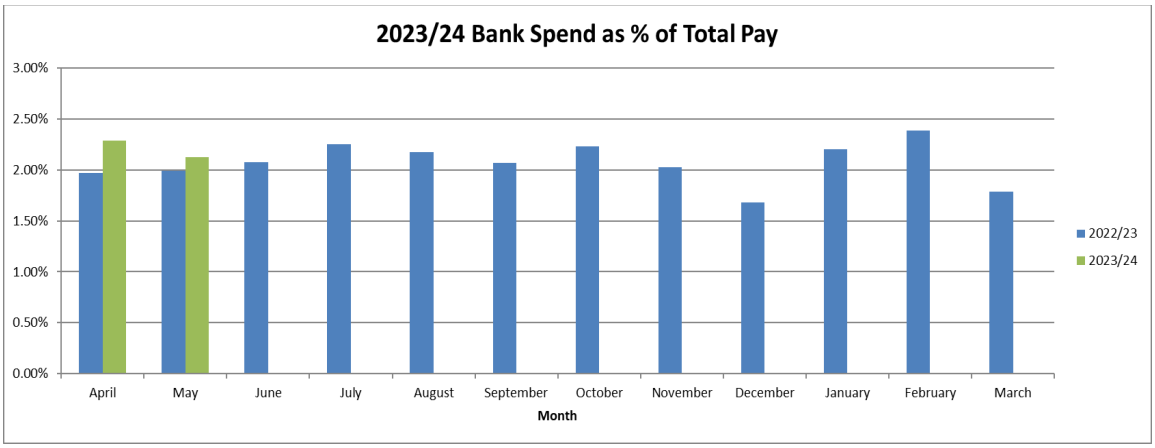
Full Year Plan (Recurrent & Non-Recurrent Split)

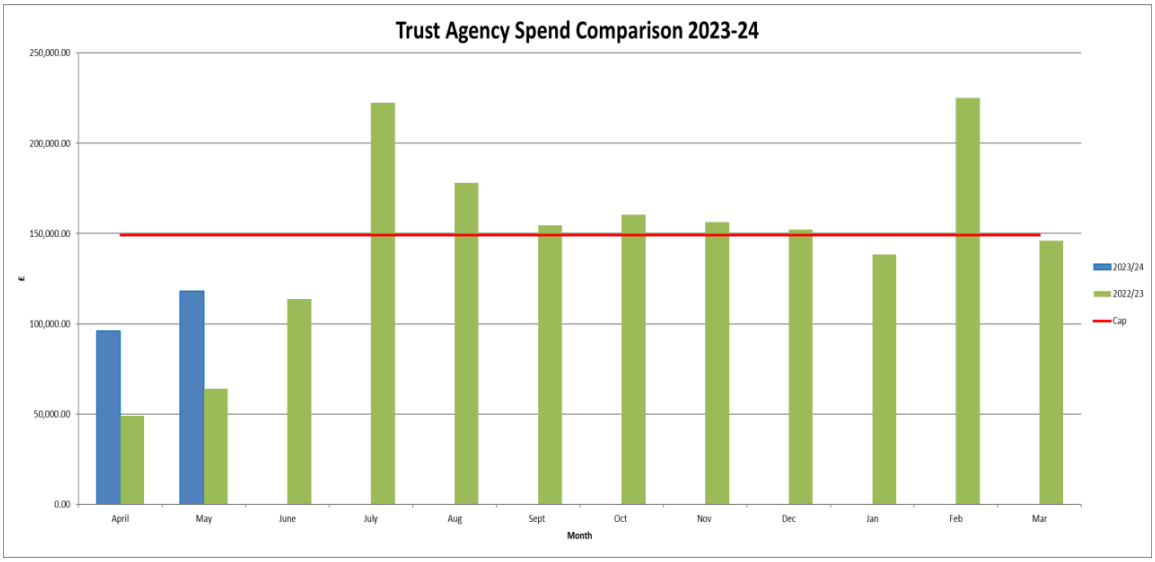
Recurrent	8,249,000	575,166	575,166	(7,673,834)	7%	522,363	1,097,529
Non-Recurrent	0	0	0	0	0%	0	0
Total	**8,249,000**	**575,166**	**575,166**	**(7,673,834)**		**522,363**	**1,097,529**

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix F – Bank and Agency







The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 28th June 2023

Report lead	Jon Hayes, Managing Director, Cheshire and Merseyside Cancer Alliance			
Paper prepared by	Jenny Hampson, Senior Analyst, Cheshire and Merseyside Cancer Alliance			
Report subject/title	Cheshire and Merseyside Cancer Alliance Performance Board Report			
Purpose of paper	To provide the Board with an update on Performance			
Background papers				
Action required	For information/noting			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	√	Be a great place to work	
	Be Collaborative	√	Be Digital	
	Be Research Leaders		Be Innovative	√

Equality & Diversity Impact Assessment						
The content of this paper could have an adverse impact on:	Age	No	Disability	No	Sexual Orientation	No
	Race	No	Pregnancy/Maternity	No	Gender Reassignment	No
	Gender	No	Religious Belief	No		

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOREPO
Review: July 2025
Version: 2.0

Cheshire and Merseyside Cancer Alliance

Performance Update

- June 2023
- Cancer Wait Times data relate to April 2023

NHS

Overall performance April 2023

Cancer Wait Times											
Pathway		Operational Standard	Performance vs Operational standard	Performance vs England	England	Cheshire and Merseyside					
					Latest month		Previous month	Direction of travel	Rolling 12 month period	Trend	Trend range: (Min-Max)
					Apr-23		Mar-23		May-22 to Apr-23		
Two week waits	Two week waits	93%	🔴	🔴	77.7%	76.2%	77.4%	↓	76.1%		65.5% - 83%
	Two week waits: Breast Symptoms	93%	🔴	🟢	72.2%	77.3%	66.3%	↑	62.7%		54.3% - 77.3%
28 day Faster diagnosis standard	FDS All referral routes	75%	🔴	🔴	71.35%	67.0%	70.1%	↓	66.7%		61.4% - 71.1%
62 Day	62 day referral to 1st treatment	85%	🔴	🟢	61.0%	63.9%	67.4%	↓	66.3%		56.2% - 70.3%
	62 day referral to 1st treatment: Screening	90%	🔴	🟢	67.8%	71.4%	72.4%	↓	73.2%		65.4% - 86.1%
	62 day referral to 1st treatment: Consultant upgrade	N/A	⚫	🟢	74.4%	77.5%	79.4%	↓	78.5%		72% - 82.3%
31 day	31 day diagnosis to 1st treatment	96%	🔴	🟢	90.5%	94.2%	94.1%	↑	94.5%		91.7% - 96.3%
	31 day diagnosis to subsequent treatment: Surgery	94%	🔴	🟢	76.8%	83.3%	83.7%	↓	87.9%		81% - 92.9%
	31 day diagnosis to subsequent treatment: Radiotherapy	94%	🟢	🟢	86.3%	98.9%	98.4%	↑	99.2%		98.3% - 100%
	31 day diagnosis to subsequent treatment: Chemotherapy	98%	🟢	🟢	97.4%	99.7%	99.5%	↑	99.4%		99.1% - 99.7%

Performance in April **improved** compared to the previous month in:

Two Week Wait breast symptomatic referrals **77.3%**
(↑ 11.0 percentage points)

31 day first definitive treatments **94.2%**
(↑ 0.1 percentage points)

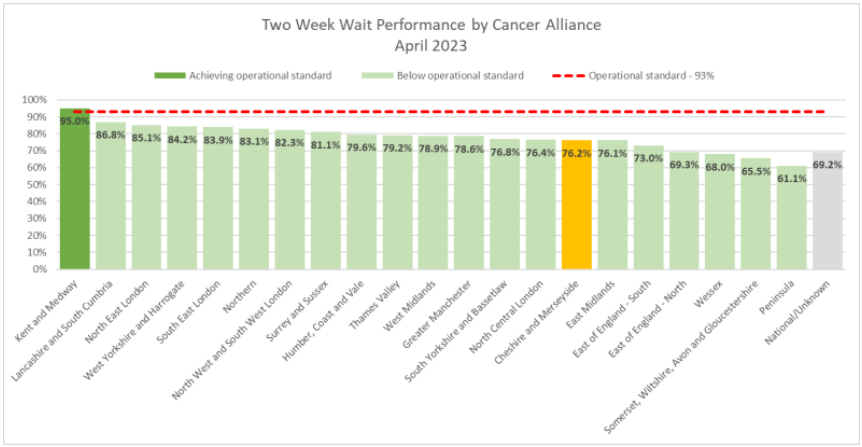
Performance in April **reduced** compared to the previous month in:

Two Week Wait performance **76.2%** (↓ 1.2 percentage points)
Faster Diagnosis standard **67.0%** (↓ 3.1 percentage points)
62 day first definitive treatments **63.9%** (↓ 3.5 percentage points)
62 day screening **71.4%** (↓ 1.0 percentage point)

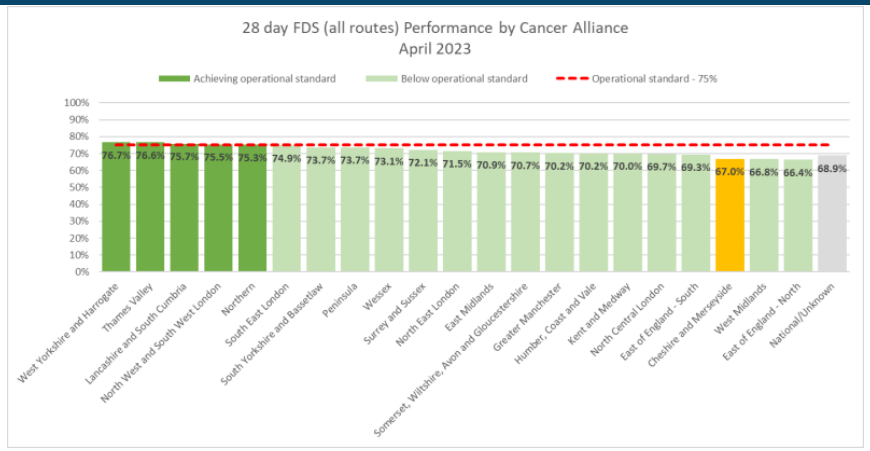
The alliance performs better than England as a whole for treatment indicators and breast symptomatic Two Week Waits, but worse than England as a whole for standard Two Week Wait and 28 day indicators

Source: NHS England Cancer Wait Times data

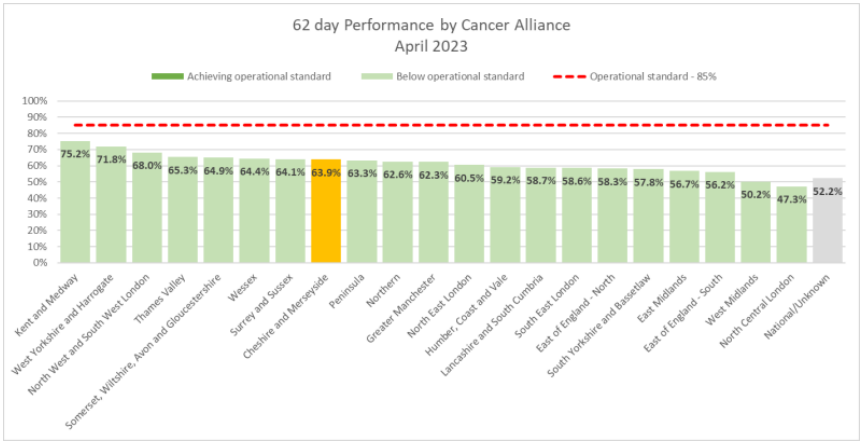
Alliance rankings April 2023



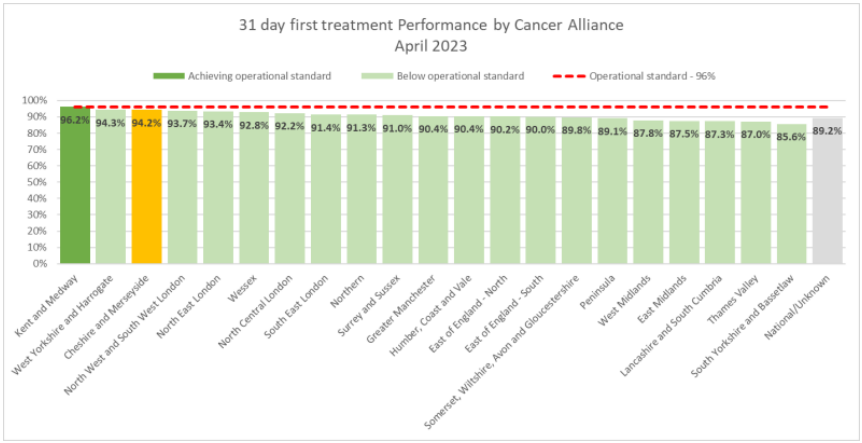
Two week wait: 15th



28 day: 19th



62 day: 8th



31 day: 3rd

Source: NHS England Cancer Wait Times data

Summary measures

Measure	Additional detail	Value	Commentary
Volume of 2WW referrals seen	Latest three months vs 12 months previously %	107%	These indicators have moved to quarterly reporting based on publicly available NHS England Cancer Wait Times data. 2WW referrals seen and 31 day first treatments relate to patients registered with Cheshire and Merseyside GPs. Data are from Cancer Wait Times Dataset.
Cancer treatment activity: 31 day first treatments		103%	
SACT (inc chemo) delivery*	Latest month vs 12 months previously %	117%	The sustained increase in activity continues to present challenges to service delivery, however CCC continues to take action to meet demand, including detailed capacity, demand and workforce planning. RT data refer to May 2023, as % of May 2022 SACT data refer to April 23 as % of April 22: 99% In future reports these data will move to quarterly reporting in line with CWT and Endoscopy data.
Radiotherapy planning**		154%	
Radiotherapy treatment**		127%	
Endoscopy activity♀	Latest three months vs 12 months previously %	108% (116% excluding CoCH)	Endoscopy activity for February-April 2023 increased by 8% to 21,017 procedures (from 19,377 procedures in February-April 2022). This is also a 1% increase on the previous quarter (November 2022 - January 2023, 20,781 procedures). Note however that Countess of Chester did not submit any activity data in March or April 2023. **When activity without Countess of Chester is compared, activity increased by 16% from the previous year and 4% from the previous quarter.**

* Solid tumour only (not inc. Haemato-oncology): reliable Haemato-oncology figures pre covid are unavailable – data as of March 2023
♀Assessment based on monthly DM01 endoscopy returns - latest update April 2023. Activity is used as an indication of capacity.

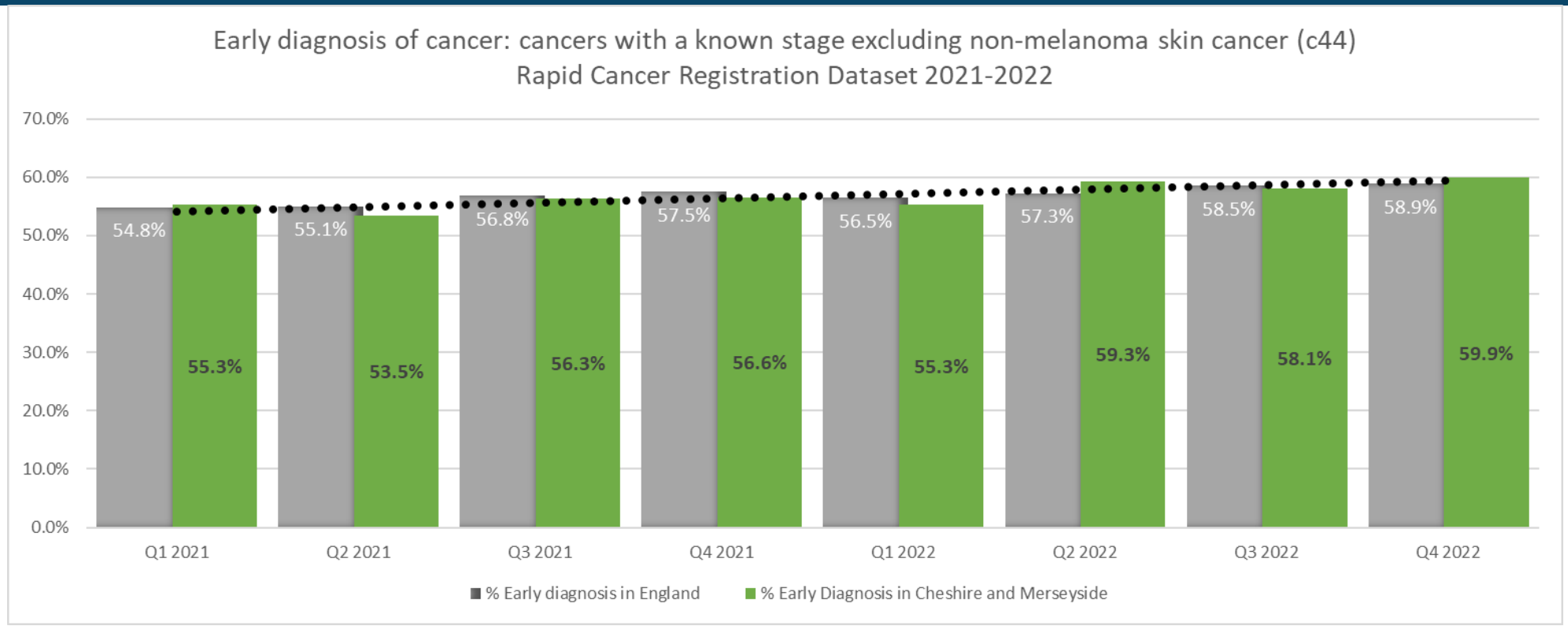
Summary measures: programme specific

Programme area	Measure			Value	Commentary
Transformation and Partnerships Programme	Personalised Stratified Follow Up (PSFU): Number of trusts with live and operational protocols	Breast		7/8 plus 1 specialist service	CCC provide a specialist service in addition to the seven main trusts. Southport do not provide a breast service.
		Endometrial		8/8	Two trusts provide PSFU locally, six trusts provide PSFU via Liverpool Women's Hospital.
		Prostate		8/8 plus 1 specialist service	CCC provide a specialist service in addition to the eight main trusts.
		Colorectal		8/8	-
		Other additional PSFU pathways		10 additional PSFU services	There are currently 10 additional services across six main trusts and two specialist trusts (CCC and Liverpool Women's). In July 23 this will increase to 12 additional services across seven main trusts and two specialist trusts.
	Targeted Lung Health Checks (TLHC)	Uptake of TLHC Target 50%	Phase 1&2	41.6%	Halton, Knowsley and Liverpool have been fully operational for 21 months (Phases 1&2). South Sefton and St Helens have been operational since December 2022 (Phase 3). The England averages for comparison are: • Uptake of offered Lung Health Checks 42% (all phases) . • Lung health Checks which result in a Low Dose CT scan 41.4% (all phases).
			Phase 3	43.8%	
		Conversion LHC to LDCT scan	Phase 1&2	70.4%	
			Phase 3	69.5%	
	Quality of Life Survey	Percentage uptake		42%	Uptake of invites sent April-October 2022. The alliance is working towards a planned uptake of 50% for 2023/24.

Summary measures: programme specific

Programme area	Measure			Value	Commentary
Faster Diagnosis Programme	Faster Diagnosis Standard by Tumour (Last full Quarter)	Percentage of patients diagnosed or ruled out in 28 days	Lower GI	41.2%	Data are based on GP practice of registration. Alternative "targets" for 23/24 have been suggested by NHSE, with a view to achieving the overall target of 75% for all tumour groups: Lower GI 62% Urology 63% Skin 85% Breast 92%
			Urology	42.8%	
			Skin	86.4%	
			Breast	90.9%	
	Best Practice Timed Pathways (BPTP)	Number of Trusts submitting data	Colorectal	4/8	Expected to be 7/8 trusts by end of Q1 (excluding Wirral University Hospitals NHS Foundation Trust)
			Urology (Prostate)	6/8	
	Non Specific Service coverage	Number of trusts with live pathways		6/8	On track to be 8/8 by March 2024
		Number of actuals vs planned		321 actual vs 353 planned	February 23-April 23: Southport and Ormskirk did not submit data for April 23. On average S&O saw around 26 patients per month during 22/23. Using this modelled figure, actuals increase to 347.
	Faecal Immunochemical Test (FIT) rollout	Number of Trusts with live pathways		8/8	The Wirral University Hospitals NHS Foundation Trust pathway went live in June 2023
	FIT impact	Percentage of Two Week Wait referrals for Lower GI cancer accompanied by FIT • Target of 54% in Q1 23/24		58%	March 2023 data from primary care (PCN IIF)

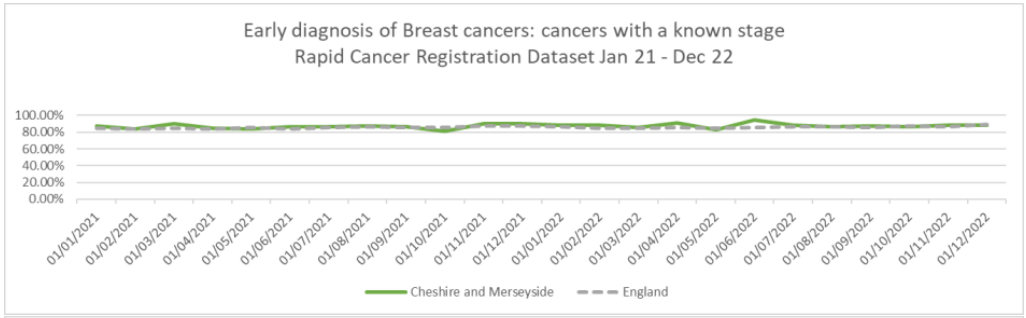
Cancer stage at diagnosis: Rapid Cancer Registration Database (RCRD)

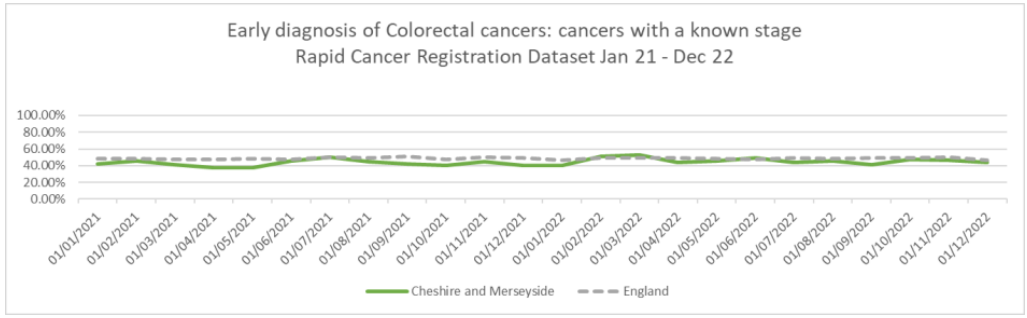


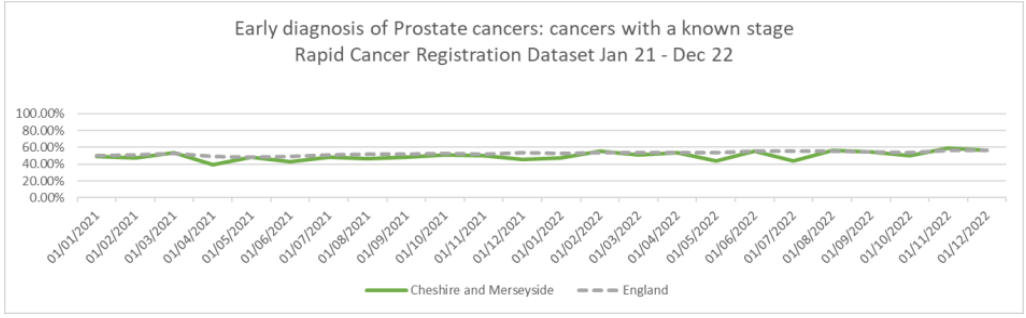
- Quarterly Early Diagnosis proportions have increased overall in the past two years.
- **56.8%** of Cheshire and Merseyside cancers were diagnosed at an early stage in the last two years, this is **statistically similar to England** (57.0%)
- Using current trajectories, neither England or Cheshire and Merseyside will achieve the NHS ambition of 75% Early Diagnosis by 2028 (RAG Rated Amber).

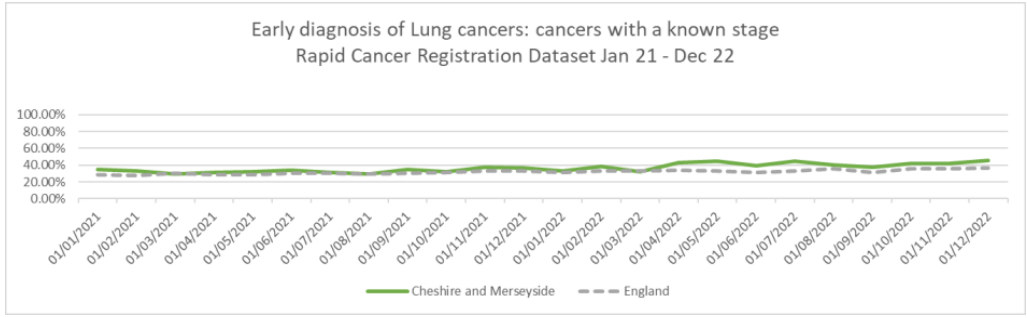
Source: Rapid Cancer Registration Dataset, CancerStats2 (see appendix for dataset caveats)

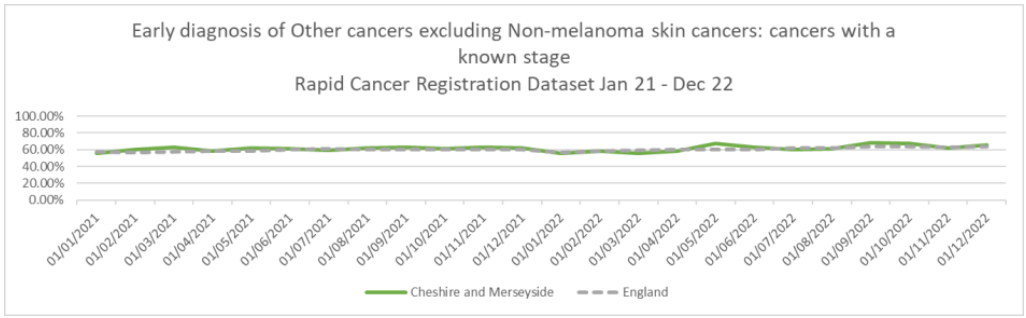
Cancer stage at diagnosis: Rapid Cancer Registration Database (RCRD)











Average percentage early diagnosis: Jan 21 – Dec 22

Area	Breast	Colorectal	Prostate	Lung	Other
Cheshire and Merseyside	87.3%	44.4%	50.1%	36.8%	61.5%
England	85.6%	48.6%	53.0%	32.0%	60.2%

Source: Rapid Cancer Registration Dataset, CancerStats2 (see appendix for dataset caveats)

Appendix: data quality notes

The Rapid Cancer Registration Dataset (RCRD) is aimed at supporting near-real time analysis in relation to COVID-19. It contains proxy tumour registrations and some associated events on the cancer patient pathway (e.g. surgery, radiotherapy and chemotherapy) from January 2018 to the most recently available data on cancer diagnoses.

This rapid dataset provides a quicker, indicative source of cancer data compared to the gold standard registration process, which relies on additional data sources, enhanced follow-up with trusts and expert processing by cancer registration officers. Due to the lower quality of the rapid registration data, the data will not match the eventual National Statistics published on the full registration data.

The data is based on a rapid processing of cancer registration data sources, in particular on Cancer Outcomes and Services Dataset (COSD) information. National cancer registration data is not yet available for much of this time period as it relies on additional data sources, enhanced follow-up with trusts and expert processing by cancer registration officers.

The most recent update, released on 27 April 2023, is based on the data available by 1 April 2023. Data is estimated to be near-complete for:

- Diagnoses up to the end of January 2023, although with slightly lower completeness from November 2022 onwards
- Surgical tumour resections received up to the end of October 2022
- Chemotherapy received up to the end of October 2022
- Radiotherapy received up to the end of December 2022

It is therefore important to note that the data is not 100% complete, particularly for diagnoses and treatments in more recent months.

Appendix: data quality notes

Stage at diagnosis data in the RCRD are only available for:

Breast (C50)

Colorectal (C18-C20) – Colon, Rectosigmoid, Rectum

NOT included: C21 (Anus and anal canal)

Prostate (C61 – men only)

Lung (C33-C34) – Trachea, Bronchus and Lung

NOT included: C37-C39 (Thymus, Heart Mediastinum and pleura, other and ill-defined sites in the respiratory system and intrathoracic organs), C45 (Mesothelioma)

Combined in the other categories which give the overall Early Diagnosis proportions are:

Gynaecological (C54-C57) – Corpus uterus, ovaries and unspecified female genital organs.

NOT included: C48 (Retroperitoneum and Peritoneum), C51-53 (Vulva, Vagina, Cervix) not included in stage data

As cervical data are not available – gynae cervical screening routes to diagnosis are not available

Haematological (C81-86, C88)- Hodgkin lymphoma, Follicular lymphoma, Non-follicular lymphoma, Mature T/NK – cell lymphomas, Other and unspecified types of non-hodgkin lymphoma, Malignant immunoproliferative diseases

NOT included: C90-C96 (Lymphoid leukaemia, Myeloid leukaemia, Monocytic leukaemia, Other leukaemias of specified cell type, Leukaemia of unspecified cell type, Other and unspecified malignant neoplasms of lymphoid, haematopoietic and related tissue

Melanoma (C43)

Oesophago-gastric (OG) (C15-16) – Oesophageal, Stomach

Upper GI excluding OG (C25) – Pancreas only

NOT included: C17 (Small intestine), C22-C24 (liver and intrahepatic bile ducts, gallbladder, other and unspecified parts of biliary tract), C26 (other and ill-defined digestive organs)

Urological excluding prostate (C64, C67) - kidney except renal pelvis, bladder

NOT included: C60 (men only) (penis), C62-C63 (men only) (Testis, Other and unspecified male genital organs), C65-C66 (Renal pelvis, Ureter), C68 (Other and unspecified urinary organs)

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 28th June 2023

Report lead	Kathy Doran, Chair			
Paper prepared by	Jane Hindle, Associate Director of Corporate Governance			
Report subject/title	Draft Liverpool Trusts Joint Committee Terms of Reference			
Purpose of paper	To provide the Board with the draft terms of reference for approval			
Background papers	Liverpool Care Services Review			
Action required	For approval			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	√	Be a great place to work	
	Be Collaborative	√	Be Digital	
	Be Research Leaders		Be Innovative	√

Equality & Diversity Impact Assessment						
The content of this paper could have an adverse impact on:	Age	No	Disability	No	Sexual Orientation	No
	Race	No	Pregnancy/Maternity	No	Gender Reassignment	No
	Gender	No	Religious Belief	No		

The Clatterbridge Cancer Centre NHS Foundation Trust

EXECUTIVE SUMMARY

1. All NHS provider trust Boards across Liverpool are being asked to consider and approve the attached terms of reference for the Liverpool Trusts Joint Committee (LTJC), which has been established oversee the delivery of some of the recommendations of the *Liverpool Clinical Services Review*.

BACKGROUND

2. As members of the Board will be aware, Cheshire and Merseyside Integrated Care System (ICS) were asked in 2022 by NHS England to commission an independent review to:

   a) identify and provide recommendations to realise opportunities for greater collaboration between acute and specialised trusts to optimise the model of acute care in Liverpool and beyond; and

   b) considered alignment and interdependencies with *One Liverpoo*l, the city's health and wellbeing strategy, and the wider Cheshire and Merseyside system.

3. This outcome of this work was the *Liverpool Care Services Review* which the Cheshire and Merseyside Integrated Care Board (ICB) received and approved at its Board meeting on 26 January 2023. A copy of this *Review* is available on the ICS's website by clicking here (from page 144), although separate papers for information would have been taken to each of the member NHS provider's Boards.

4. In order to ensure the delivery of six of the recommendations of the *Review*, a Liverpool Trusts Joint Committee (LTJC) has been set up, with terms of reference under development since May 2023. Following a meeting of the LTJC on 16 June 2023, the attached terms of reference are now being recommended for approval by the Boards of member organisations.

LTJC TERMS OF REFERENCE

5. The LTJC is responsible for leading and overseeing the development and implementation of the Liverpool Acute (Provider) Strategy and the six *Review* recommendations that fall into the scope of the LTJC (see section 3 of the attached terms of reference).

6. The membership of the LTJC comprises of the following NHS provider trusts across Liverpool, who are each represented on the LTJC by the Chair and Chief Executive:

   a) Alder Hey Children's NHS Foundation Trust (AHCH);

   b) The Clatterbridge Cancer Centre NHS Foundation Trust (CCC);

   c) Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH);

d) Liverpool Women's NHS Foundation Trust (LWFT);

e) Liverpool University Hospitals NHS Foundation Trust (LUHFT);

f) Mersey Care NHS Foundation Trust (MCFT).

7. Appendix 1 of these terms of references also provides a useful organogram outlining the governance arrangements to oversee all of the *Review's* recommendations, and not solely the six overseen by the LTJC.

NEXT STEPS

8. Members will note that the Appendix 2 (Template Delegation) of the terms of reference has yet to be completed. The company secretaries of the member NHS provider trusts will be working together over the next few months to address this, with any recommendations going to both the LTJC and member NHS provider trust Boards for approval where necessary.

9. In future a summary set of minutes will also be produced on behalf of the LTJC that will allow member NHS provider trusts to share them with their Public Boards and Council of Governors.

RECOMMENDATION

10. Members of the Board of Directors are asked to:

a) consider and approve the terms of reference for the Liverpool Trusts Joint Committee.

Liverpool Trusts Joint Committee

Terms of Reference

Version	DRAFT 1.5
Implementation Date	16/06/2023
Review Date	December 2023
Approved By	Trust boards
Approval Date	[ ]

REVISIONS

Date	Reason for Change	Author
2 May 2023	Version 1.0 – first draft	HD
2 May 2023	Version 1.1 – second draft	HD
3 May 2023	Version 1.2 – third draft (to align with Sub-Committee TORs)	HD
3 May 2023	Version 1.3 – fourth draft	HD
12 June 2023	Version 1.4 – fifth draft – feedback from LTJC member trusts	DS
16 June 2023	Version 1.5 – comments from LTJC meeting/Approved	DS

1	Name	**Liverpool Trusts Joint Committee (LTJC)**
2	General	Capitalised terms have the meaning set out below: "**2006 Act**" means the National Health Service Act 2006 (as amended); "**Chair**" means the chair of the LTJC; "**C&M MHLDC**" means the Cheshire and Merseyside Mental Health, Learning Disability & Community Collaborative; "**CMAST**" means the Cheshire and Merseyside Acute and Specialist Trusts Collaborative; "**Delegation**" means the terms of any delegation to the LTJC including any associated delegation agreement as agreed by the relevant board(s) and appended to these Terms of Reference at Appendix 2 and "Delegated" shall be construed accordingly;

		"**ICB**" means the NHS Cheshire and Merseyside Integrated Care Board, including any individual, organisation or committee to which its powers or responsibilities are delegated; "**LCSR**" means the Liverpool Clinical Services Review "**LCSR Recommendations**" means the six recommendations from the Liverpool Clinical Services Review which come within the scope of the LTJC, as set out in paragraph 4; "**LTJC**" means the Liverpool Trusts Joint Committee; "**LTJC Sub-Committees**" means the three sub-committees of the LTJC, being • LUHFT and TWCFT (Aintree site) • CCC and LUHFT (Royal Liverpool site) • LHCH and LUHFT (Broadgreen site) "**Member**" refers to a member of the LTJC listed in paragraph 7; "**Purpose**" the purpose of the LTJC as set out in paragraph 3; "**Trusts**" are Alder Hey Children's NHS Foundation Trust (**AHFT**); Liverpool Heart and Chest NHS Foundation Trust (**LHCH**); Liverpool University Hospital NHS Foundation Trust (**LUHFT**); Liverpool Women's NHS Foundation Trust (**LWFT**); Mersey Care NHS Foundation Trust (**MCFT**); The Clatterbridge Cancer Centre NHS Foundation Trust (**CCC)**; and The Walton Centre NHS Foundation Trust (**TWCFT**); and "**Work Plan**" means the rolling plan of work to be carried out by the LTJC over a 12-month period (or such longer period as may be agreed by the Trusts). For the avoidance of doubt the Work Plan does not form part of these Terms of Reference. All references to legislation are to that legislation as updated from time to time.
3	Purpose	The Liverpool Clinical Services Review was commissioned in 2022 to realise opportunities for greater collaboration between acute and specialist trusts, to optimise acute care clinical pathways in Liverpool and beyond. A diagram setting out the various governance groups and organisations involved in overseeing and implementing the recommendations from the LCSR is set out at Appendix 1. Through delivering its Work Plan (via the LTJC Sub-Committees), the LTJC will be responsible for leading and overseeing the development and implementation of the Liverpool Acute (Provider) Strategy and the six LCSR Recommendations within the scope of LTJC.

		The six LCSR Recommendations within the scope of the LTJC are as follows: • R3 - Improving outcomes and access to emergency care using existing co-adjacencies • R5 - Providing timely access to high-quality elective care through existing estates/assets • R7 - Combining expertise in clinical support services to provide consistent services (Liverpool) • R9 - Attracting and retaining talent in Health and Social Care within Liverpool City Region • R11 - Integrating digital systems to improve care delivery • R12 - Making best use of resources to secure financial sustainability for all organisations in Liverpool. Should the LTJC identify further opportunities to improve clinical services in Liverpool through collaboration, these additional workstreams will be agreed to and overseen by the LTJC as part of the Work Plan. The following principles will inform the work of the LTJC in delivering the Work Plan: • Ensure that proposals are underpinned by demand and capacity analysis • Ensure that clinicians are at the forefront of the development of the envisaged approach on each site, with appropriate clinical leadership from each organisation to oversee the work and facilitate involvement from the clinical community • Ensure engagement with partners in the urgent care pathway, including General Practice, community and mental health providers, North West Ambulance Service NHS Trust, to incorporate pre- and post-hospital elements of the pathway • Ensure engagement with wider system partners who may be impacted or have the potential to mitigate the impact of any proposed pathway changes including the ICB, neighbouring Place systems, CMAST, NHS Commissioning: Specialist Services, and the C&M MHLDC • Ensure that programmes of work are resourced to deliver, securing a dedicated team from relevant Trusts to support the LTJC to develop and implement the operating model for each site, undertaking design work and modelling for operational and proposed service transformation.

		• Ensure that the Work Plan complies with statutory duties and best practice standards in delivering service change • Ensure that any need for patients, public and stakeholders' involvement are identified as a core part of the Work Plan and form part of a planned engagement approach with patients, public and stakeholders • Ensure no detriment to patients within a wider geography to Liverpool.
4	Scope	The LTJC shall identify the projects and areas it will work on to achieve its Purpose in its Work Plan. The LTJC may add and remove projects and areas from the Work Plan from time to time provided that they are linked to the LTJC's Purpose. The LTJC shall hold to account the LTJC Sub-Committees which shall be responsible for delivering elements of the Work Plan and associated priorities through delegations from the LTJC and reporting back to the LTJC, as set out in their respective terms of reference.
5	Status and legal basis	The LTJC is established by the Trusts as a joint committee pursuant to sections 65Z5 and 65Z6 of the 2006 Act in respect of those functions within its scope which are formally delegated by the Trusts to the LTJC in accordance with paragraph 6 below. The Trusts have the power to arrange for any of their functions to be exercised by the other or jointly with each other under section 65Z5 of the 2006 Act. Where the Trusts have arranged for functions to be exercised jointly, they have the power to form a joint committee for this purpose under section 65Z6 of the 2006 Act, and to establish and maintain a pooled fund. The Trusts must have regard to the guidance published by NHS England in March 2023 (and any subsequent/replacement guidance) about the exercise of these powers.
6	Decision-Making	• Decision-making by each Trust Chief Executive Member of the LTJC The Chief Executive of each Trust sits on the LTJC. Where a Chief Executive has delegated authority from their Trust to take decisions, they are able to take decisions on behalf of their Trust while sitting on the LTJC. Other members of the LTJC cannot require a Chief Executive to exercise their delegated authority in a particular way. The Trusts will work towards having consistency in the levels of delegated authority held by each of the Chief Executives when sitting on the LTJC. Where the Chief Executive does not have delegated authority from their Trust to

		take a decision which the Trusts wish to take in the LTJC (outside of the formal delegations to the LTJC) then that decision will need to be referred back to the relevant Trust board for determination unless it has been delegated to the LTJC as outlined below. • Decision-making by the LTJC as a joint committee The Trusts may formally delegate decision-making to the LTJC in relation to particular projects or workstreams within the Work Plan. Such delegations will be in accordance with the guidance given by NHS England. Delegations will be appended to these Terms of Reference and must be delivered in accordance with these Terms of Reference and the Delegation. If there is any conflict between these Terms of Reference and a Delegation, the Delegation will prevail. Where functions of the Trusts have been delegated, the LTJC acts as a joint committee of the relevant Trusts. The LTJC shall make decisions by consensus of all Members, with the Chair and Chief Executive Members from each Trust seeking to make consensus decisions on behalf of their own Trust. If consensus cannot be reached between all Members, the matter will be referred to the Trust boards for further consideration.
7	Accountability	The LTJC is accountable to each Trust board.
8	Reporting arrangements	The Members from each Trust shall be responsible for ensuring that appropriate reporting is made to their Trust board and their Trust's Council of Governors and that feedback from their Trust is fed through to the LTJC. The LTJC shall submit a summary of the minutes from the LTJC Chair to each Trust board meeting in public. The LTJC shall ensure that the work of the LTJC Sub-Committees is reflected in its own minutes. The LTJC shall provide regular reports on its work to the ICB. The LTJC shall provide an annual report to the Trusts and the ICB.
9	Membership	The Members of the LTJC are: • Chair of AHFT • Chief Executive of AHFT • Chair of LHCH • Chief Executive of LHCH • Chair of LWFT • Chief Executive of LWFT • Chair of LUHFT • Chief Executive of LUHFT • Chair of MCFT • Chief Executive of MCFT • Chair of CCC • Chief Executive of CCC

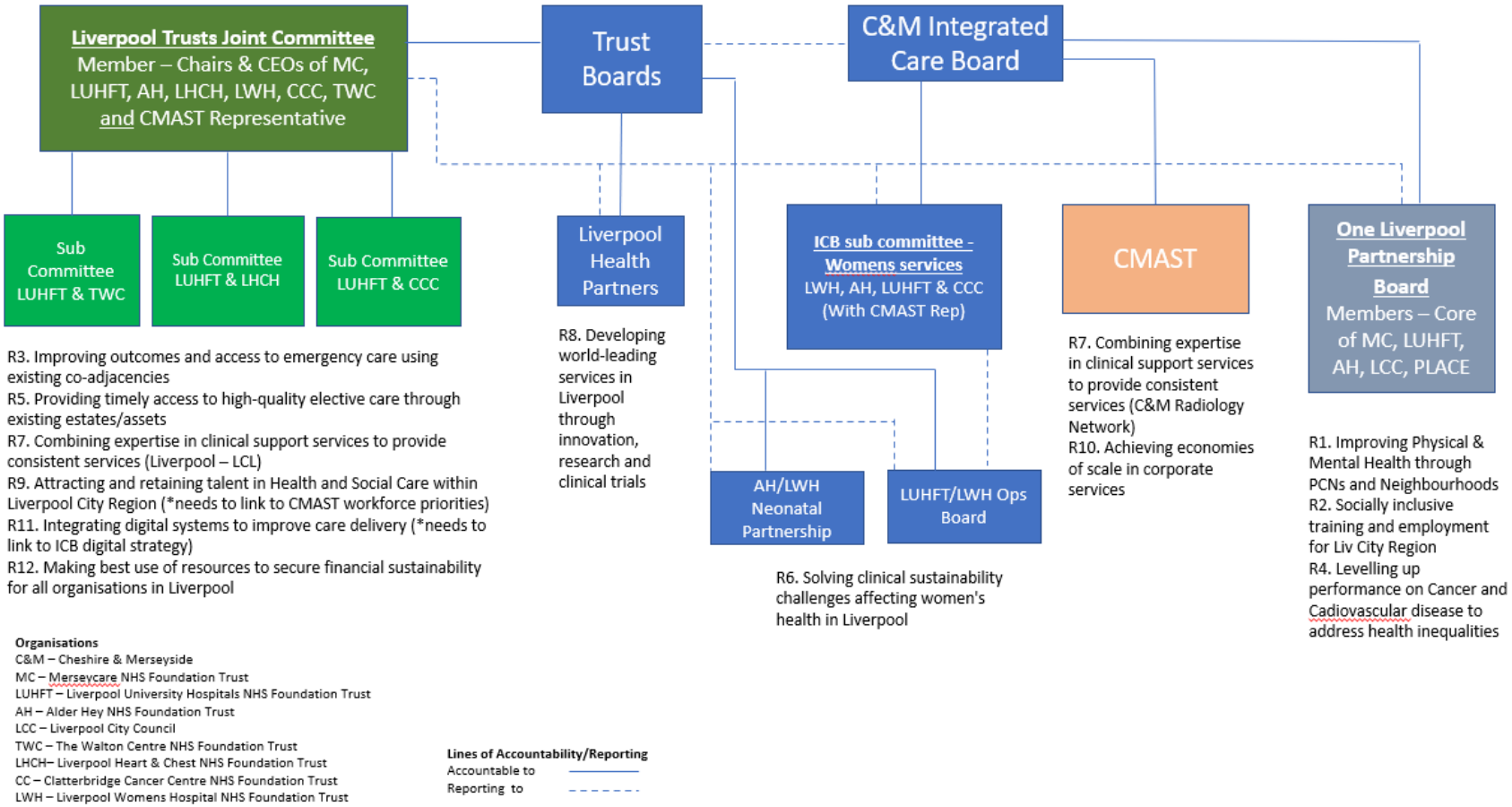
		• Chair of TWCFT • Chief Executive of TWCFT Decisions are taken by the Members as set out in paragraph 6 above.
10	Attendees	The Chair of the LTJC may invite such attendees to LTJC meetings to provide information or be involved in discussion as the Chair considers appropriate. The following shall be invited to attend every meeting of the LTJC: • Representative from CMAST A representative from C&M MH&CC may also where appropriate to the agenda be invited to attend meetings of the LTJC. The Trusts agree to make any of their officers who are involved in delivery of the Work Plan available to attend the LTJC as requested.
11	Deputies	With the permission of the Chair, Members may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf and count in the quorum. The decision of the Chair regarding authorisation of nominated deputies is final. Should permission not be granted, the Chair will provide details of the rationale to the respective organisation. Such nominations should usually be received five working days before the date of the meetings and should always include a short explanation as to why the nomination of a deputy is necessary. The nominated deputy must ensure that they understand the extent to which they are able to take decisions on behalf of their Trust.
12	Chair	The first Chair of LTJC (the "**Chair**") shall be the Chair of LUHFT who will remain in this position unless otherwise agreed by a majority of the remaining Members. Meetings of the LTJC will be run by the Chair. The decision of the Chair on any point regarding the conduct of the LTJC shall be final. The first Deputy Chair of LTJC shall be the Chair of LWFT who will remain in this position unless otherwise agreed by a majority of the remaining Members. If the Chair is not in attendance, then reference to Chair in these Terms of Reference shall be to the Deputy Chair.
13	Quoracy	As a minimum, one Member from each Trust, or their authorised deputy, must be in attendance for the LTJC to be quorate. If any Member of the LTJC has been disqualified from participating on an item

		in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. Members may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting provided all Members are able to hear and speak to one another.
14	Frequency of Meetings	The LTJC will meet at least monthly in private. Additional meetings may take place as required by giving not less than 14 calendar days' notice in writing to all Members. The Chair may call an additional meeting at any time by giving not less than 14 calendar days' notice in writing to Members. Three of the Members may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all Members specifying the matters to be considered at the meeting. In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.
15	Declaration of Interests	If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the NHS England guidance on managing conflicts of interest in the NHS as applicable from time to time. The Chair of the meeting will determine how a conflict of interest should be managed. The Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.
16	Support to the LTJC	The Lead Officer for the LTJC is the Director of Corporate Affairs of LUHFT and is responsible for managing LTJC agendas and all governance arrangements

		for the Work Plan. The LTJC will be provided support by LUHFT. This will include: • Seeking agenda items from Members two weeks in advance of each meeting; development and agreement of the agenda with the Chair in consultation with the Lead Officer; • Sending out agendas and supporting papers to Members at least five working days before the meeting. • Liaising with attendees invited to LTJC meetings under paragraph 10 • Drafting minutes including an updated version of the Work Plan for approval by the Chair within five working days of any LTJC meeting. • Distributing approved minutes (including updated Work Plan) to all attendees following within 10 working days of Chair's approval. • Maintaining an on-going list of actions, specifying which Members are responsible, due dates and keeping track of these actions. • Publicising LTJC meetings, minutes and associated documents as appropriate • Providing such other support as the Chair requests, for example advice on the handling of conflicts of interest.
17	Authority	The LTJC is authorised to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires within its remit, from any officer of a Trust. The Trusts shall ensure that their officers co-operate fully and promptly with any such request made by the LTJC. The LTJC is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations provided it ensures that full funding is available to meet the associated costs. The LTJC is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary provided it ensures that full funding is available to meet the associated costs.

		The LTJC is authorised to create sub-committees or working groups as are necessary to achieve its Purpose. The LTJC is accountable for the work of any such group. The LTJC may delegate decision-making to the LTJC Sub-Committees in relation to particular projects or workstreams. Such delegations will be in accordance with the guidance given by NHS England and will be appended to the relevant Sub-Committee Terms of Reference.
18	Conduct of the LTJC	Members must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity. Members of the LTJC will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct. The LTJC shall undertake an annual self-assessment of its own performance against the Work Plan and these Terms of Reference. This self-assessment shall form the basis of the annual report from the LTJC to the Trusts and the ICB Board.
19	Amendments	These Terms of Reference may only be amended by resolution of each of the Trust boards. Any amendments shall only take effect upon all Trust boards agreeing the change to the Terms of Reference or on such date as all Trust boards agree, whichever is the later.
20	Review date	These Terms of Reference will be reviewed at least annually and earlier if required. Any proposed amendments to the Terms of Reference will be required to be approved by all Trust boards.

APPENDIX 1 – LIVERPOOL CLINICAL SERVICES REVIEW GOVERNANCE ORGANOGRAM



APPENDIX 2 – TEMPLATE DELEGATION

[To be determined]

CHAIRS REPORT

Meeting of LUHFT and CCC Joint Committee held on Friday 9th June 2023 at 13:45, via MS Teams

Introduction

The meeting of the LUHFT and CCC Joint Committee took place on Friday 9th June 2023. The meeting involved representatives from The Clatterbridge Cancer Centre (CCC) and Liverpool University Hospitals NHS Foundation Trust (LUHFT).

A summary of the key agenda items and discussions is provided below.

Agenda Item	Key Discussions/ Decisions/ Actions
Minutes of Previous Meeting – 21st April 2023	The Committee **approved** the minutes from the Shadow Joint Committee on 21st April 2023.
Action Log	The Committee reviewed the rolling action tracker, last updated following the meeting 21st April 2023. The Committee **agreed** to close all outstanding actions following the updates.
Any Urgent Matters Arising	The Committee understood that the Liverpool Provider Joint Committee would be meeting next on Friday 16th June, where the terms of reference would be approved. It was acknowledged that there will then be a requirement for a subsequent review of all sub-committee and sub-group terms of reference to ensure they are aligned appropriately. This will not have an impact on the work being carried out currently. The Committee **noted** the update.
Joint Partnership Group Report	The Committee received the Joint Partnership Group Report from the meeting held 22nd May 2023, which included an update on the following areas: • Terms of Reference • Governance • Workstream Reporting Structure • Workstream Updates • Items for Escalation The Joint Partnership Group approved the terms of reference and governance structure, including the Chair and confirmation of the workstreams and workstream leads. The Workstream Reporting Structure was agreed, with the following to be presented to the July meeting: • A prioritised list of opportunities for collaboration and which were in and out of scope • For those opportunities prioritised to be implemented first workstream leads asked to identify; ○ A brief outline of the project,

Agenda Item	Key Discussions/ Decisions/ Actions
	○ Ensure plans were developed with due consideration to the CF recommendations • The cross Trust working group for delivery, • Risks / issues and associated mitigation, • Enablers required and how to implement • Key metrics to measure successful project delivery and how these would be gathered • For each priority workstream a detailed workplan of delivery with SMART objectives to allow the group to track workstream progress After each meeting the chair will develop a progress report for the Joint Committee including key areas of achievement and items for escalation for each workstream. Due to challenging timescales the workstreams are at a differing level of maturity. As a result, there will be an additional meeting held in June 2023. This will maintain pace and ensure more detailed plans are available for discussion and agreement. The Committee **agreed** to invite the workstream leads to future meetings, on a rotational basis, to give a deep dive into progress against workplans. The Committee **requested** that the first deep dives be from Pharmacy and Urgent Care. The Committee **agreed** to share the template the report was provided on with the other Joint Committees for use. The Committee **agreed** that a standardised Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) will be produced for each of the workstreams.
Draft Agenda for the next meeting	The Committee **agreed** the following items will be included on the August agenda: • Deep Dive from Pharmacy and Urgent Care workstreams • Joint Partnership Group Exception Report The Committee **requested** that the meeting in August be brought forward a week to allow for greater attendance.
Next meeting: tbc	

Recommendations for the Board of Directors

The Board of Directors is asked to:

- note the contents of the report

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 28th June 2023

Report lead	Joan Spencer, Chief Operating Officer					
Paper prepared by	Hannah Gray, Associate Director of Performance and Operational Improvement					
Report subject/title	Elective care 2023/24 priorities - Board Checklist					
Purpose of paper	All Trust chairs, CEOs, MDs and COOs received the following letter from NHS England on 23rd May 2023, setting out the elective care priorities for 2023/24, and the focus on the top three metrics: • Virtually eliminate waits of >65w by March 2024 • Continue to reduce the number of cancer patients waiting over 62d • Meet the 75% cancer FDS ambition by March 2024 NHSE has requested that Trust boards review the completed checklist. NHSE have not mandated this, but suggest that Trust Boards use it as an ongoing assurance tool. Trust have been asked to submit the completed checklist by 14th June 2023 (this has been submitted) in order to provide a quick informal baseline across C&M and to identify areas where we could work together to even better effect and where needed access further support.					
Background papers						
Action required	For discussion and approval					
Link to: Strategic Direction Corporate Objectives	Be Outstanding	Y	Be a great place to work	Y		
	Be Collaborative	Y	Be Digital	Y		
	Be Research Leaders	Y	Be Innovative	Y		

Equality & Diversity Impact Assessment						
The content of this paper could have an adverse impact on:	Age	~~Yes~~/No	Disability	~~Yes~~/No	Sexual Orientation	~~Yes~~/No
	Race	~~Yes~~/No	Pregnancy/Maternity	~~Yes~~/No	Gender Reassignment	~~Yes~~/No
	Gender	~~Yes~~/No	Religious Belief	~~Yes~~/No		

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

Classification: Official

Publication reference: PRN00496

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS regional directors
- Cancer alliance managing directors
- ICB chief executives

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

23 May 2023

Dear Colleagues,

Elective care 2023/24 priorities

Thanks to your continued focus and effort on elective care and cancer recovery we have managed, through the exceptional efforts of your teams, to drive a significant reduction in the number of long waiting patients over recent months.

Despite a very challenging environment, where ongoing industrial action has seen planned care particularly hard hit, the number of patients waiting over 78 weeks has decreased from 124,911 in September 2021 to 10,737 at the end of March 2023, and the number of patients with urgent suspected cancer waiting longer than 62 days has decreased from a peak of 33,950 last summer to 19,023 at the end of March 2023.

We now look ahead to further reduction in 78 week waits, following the disruption from industrial action and delivering our next ambitions, as set out in Operational Planning Guidance, of virtually eliminating 65 week waits, reducing the 62-day backlog further, and meeting the Faster Diagnosis Standard, by March 2024. This letter sets out our priorities, oversight and support for the year ahead as well as including a checklist for trust boards to assure themselves across the key priorities (annex 1).

First, we should acknowledge the progress made over the last year or so:

- Since the beginning of February 2022, the NHS has treated more than 2m people who would otherwise have been waiting 78 weeks by the end of March 2023 (ie: the “cohort”).
- The number of patients waiting 65 weeks has reduced from 165,885 in September 2021 to 95,001 in March 2023.

- The cancer 62 day backlog has reduced year-on-year for the first time since 2017.
- The NHS has seen a record 2.8 million referrals for urgent suspected cancer, with the early diagnosis rate now higher than before the pandemic.
- In February 2023, the NHS achieved the faster diagnosis standard (FDS) for the first time since it was created.

Your leadership, collaboration with colleagues and across providers, innovation and tenacity has led to these improvements for patients and should give confidence for the future, despite the continued complexity of the environment that we are all working in.

Recognising the challenges and the complexity you are all dealing with, we thought it would help to set out the key priorities for the year ahead:

1. **Excellence in basics**
   - Maintaining a strong focus on data quality, validation, clinical prioritisation and maximising booking rates have contributed massively to our progress. We need to retain a clear focus on these things.

2. **Performance and long waits**
   - Continue to reduce waits of over 78 weeks and those waiting over 65 weeks.
   - Make further progress on the 62-day backlog where this is still required in individual providers, whilst pivoting towards a primary focus on achieving the Faster Diagnosis Standard.
   - To support this, we have reviewed and refreshed our tiering approach to oversight, so that we can be sure that we are focusing on those providers most in need of support. This refresh has been communicated to tiered providers.

3. **Outpatients (productivity actions annex 2)**
   - We know there is massive potential in our outpatient system to adjust the approach, engage patients more actively and significantly re-focus capacity towards new patients.

4. **Cancer pathway redesign**
   - In 2023/24 Cancer Alliances have received a funding increase to support implementation of priority changes for lower GI, skin and prostate pathways (included in annex 1). All trusts should now have clear, funded plans in place with their Alliance for implementation.

5. **Activity**
    - Ensure that the increasing volume of diagnostic capacity now coming online is supporting your most pressured cancer pathways. ICBs have been asked to prioritise CDC and acute diagnostic capacity to reduce cancer backlogs and improve the FDS standard, as set out in the letter from Dame Cally Palmer and Dr Vin Diwakar.
    - Generally, we all need to see a step up in activity over the coming months, as we recover from the ongoing impact of industrial action.

6. **Choice**
    - A major contributor to our collective progress over this last year has been the way organisations and systems have worked together to accelerate treatment for long waiting patients. This includes work with the Independent Sector (IS) who have stepped up to help in this endeavour. We know this will continue to be important this year and we encourage all systems and providers to crystalise their plans to work together (including IS) early in the financial year to give us the best chance of success.
    - We expect that patient choice will be an increasingly important factor this year, as set out in the Elective Recovery Plan, with some technological advances to support this. We will communicate this more fully when plans have been finalised.

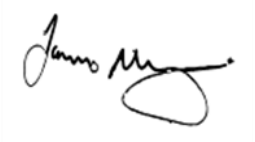
Moreover, it is crucial that we continue to recover elective services inclusively and equitably.

- Systems are expected to outline health inequality actions put in place and the evidence and impact of the interventions as part of their planning returns. Disaggregated elective recovery data should support the development of these plans.
- A collective effort is needed to continue to address the recovery of paediatric services. Provider, system, and regional-level elective recovery plans should set out actions that will be put in place to accelerate CYP recovery and ensure that elective activity gap between CYP and adults is reduced, a best practice toolkit has now been published to help achieve this.
- Systems are expected to continue to recover specialised service activity at an equitable rate to that of less complex procedures, ensuring a balance between high volume and complex patient care requirements.

Included with this letter is the board checklist (annex 1). This tool has been designed to be the practical guide for boards to ensure they are delivering against the ambitious objectives set out in the letter above.

Thank you again for all your efforts since the Elective Recovery Plan was published. Together, we have made laudable progress in reducing long waits and transforming services, as set out in the plan. We can all take confidence in this as we move on to the next stages of the recovery plan and continue to improve care for patients. If any support is required with these actions, please let us know.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Dame Cally Palmer
National Cancer Director
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
NHS England

Chair
Getting It Right First Time (GIRFT) programme

Annex 1: Board checklist

We ask that boards review the checklist below to assure plans to deliver our elective and cancer recovery objectives over the coming year. There is national support available in each of these areas, please contact england.electiverecoverypmo@nhs.net to discuss any support needs.

The three key performance deliverables and metrics we need to focus on are:

- Virtually eliminate waits of >65w by March 2024
- Continue to reduce the number of cancer patients waiting over 62d
- Meet the 75% cancer FDS ambition by March 2024

	Assurance statement	Support/materials
1	**Excellence in basics**	
	Has any patient waiting over 26 weeks on an RTT pathway (as at 31 March 2023) not been validated in the previous 12 weeks? Has the 'Date of Last PAS validation' been recorded within the Waiting List Minimum Data Set?	
	Are referrals for any Evidence Based Interventions still being made to the waiting list?	Release 3 will be published on 28 May. It focuses on the following specialties: breast surgery, ophthalmology, vascular, upper gastrointestinal surgery, cardiology, urology, and paediatric urology
2	**Performance and long waits**	
	Are plans in place to virtually eliminate RTT waits of over 104w and 78w (if applicable in your organisation)?	
	Do your plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024?	
3	**Outpatients**	
	Are clear system plans in place to achieve 25% OPFU reduction, enabling more outpatient first activity to take place?	NHSE GIRFT guidance

	Assurance statement	Support/materials
	Do you validate and book patients in for their appointments well ahead of time, focussing on completing first outpatient appointments in a timely way, to support with diagnostic flow and treatment pathways?	Validation toolkit and guidance NHS England » Validation toolkit and guidance published on 1st December 2022
4	**Cancer pathway re-design**	
	Where is the trust against full implementation of FIT testing in primary care in line with BSG/ACPGBI guidance, and the stepping down of FIT negative (<10) patients who have a normal examination and full blood count from the urgent colorectal cancer pathway in secondary care?	Using FIT in the Lower GI pathway published on 7*th* October 2022 BSG/ACPGBI FIT guideline and supporting webinar
	Where is the trust against full roll-out of teledermatology?	Suspected skin cancer two week wait pathway optimisation guidance
	Where is the trust against full implementation of sufficient mpMRI and biopsy capacity to meet the best practice timed pathway for prostate pathways?	Best Practice Timed Pathway for Prostate Cancer
5	**Activity**	
	Are clear system plans in place to prioritise existing diagnostic capacity for urgent suspected cancer activity?	Letter from Dame Cally Palmer and Dr Vin Diwakar dated 26 April 23.
	Is there agreement between the Trust, ICB and Cancer Alliance on how best to ensure newly opening CDC capacity can support 62 day backlog reductions and FDS performance?	
	How does the Trust compare to the benchmark of a 10-day turnaround from referral to test for all urgent suspected cancer diagnostics?	

	Assurance statement	Support/materials
	Are plans in place to implement a system of early screening, risk assessment and health optimisation for anyone waiting for inpatient surgery? Are patients supported to optimise their health where they are not yet fit for surgery? Are the core five requirements for all patients waiting for inpatient surgery by 31 March 2024 being met? 1. Patients should be screened for perioperative risk factors as early as possible in their pathway. 2. Patients identified through screening as having perioperative risk factors should receive proactive, personalised support to optimise their health before surgery. 3. All patients waiting for inpatient procedures should be contacted by their provider at least every three months. 4. Patients waiting for inpatient procedures should only be given a date to come in for surgery after they have had a preliminary perioperative screening assessment and been confirmed as fit or ready for surgery. 5. Patients must be involved in shared decision-making conversations.	NHS England » 2023/24 priorities and operational planning guidance NHS England » Revenue finance a contracting guidance for 2023/24 Perioperative care pathways guidance
	Where is the trust/system against the standards of 85% capped Theatre Utilisation and 85% day case rate?	
	Is full use being made of protected capacity in Elective Surgical Hubs?	
	Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo and Endoscopy?	https://future.nhs.uk/NationalCommunityDiagnostics/groupHome
	Are any new Community Diagnostic Centres (CDCs) on track to open on agreed dates, reducing DNAs to under 3% and ensuring that they have the workforce in place to provide the expected 12 hours a day, 7 day a week service? Are Elective Surgical Hub patients able to make full use of their nearest CDC for all their pre and post-op tests where this offers the fastest route for those patients??	

	Assurance statement	Support/materials
6	**Choice**	
	Are you releasing any Mutual Aid capacity which may ordinarily have been utilised to treat non-urgent patients to treat clinically urgent and long-waiting patients from other providers? Is DMAS being used to offer or request support which cannot be realised within the ICB or region?	www.dmas.nhs.uk
	Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?	
7	**Inclusive recovery**	
	Do recovery plans and trajectories ensure specialised commissioned services are enabled to recover at an equitable rate to non-specialised services? Do system plans balance high volume procedures and lower volume, more complex patient care	
	Have you agreed the health inequality actions put in place and the evidence and impact of the interventions as part of your operational planning return? Was this supported by disaggregated elective recovery data?	
	Are children and young people explicitly included in elective recovery plans and actions in place to accelerate progress to tackle CYP elective waiting lists?	CYP elective recovery toolkit

Supporting guidance and materials are available on the Elective Recovery Futures site: https://future.nhs.uk/ElectiveRecovery

Annex 2: Outpatients (OP) productivity action

As set out in the 2023/24 Priorities and Operational Planning Guidance, systems are expected to deliver in line with the national ambition to reduce follow-ups by 25% against the 2019/20 baseline by March 2024. To note this excludes appointments where a procedure takes place. Further technical guidance (that covers other exclusions) is here.

Expected actions

In order to work towards achieving the 25% follow-up reduction target, trusts are expected to focus on the following within the first quarter of the year:

- Embed OP follow-up reduction in trust governance mechanisms
- Engage with clinical leads for specialties about the significance of the 25% follow-up reduction target, building on GIRFT guidance
- Review clinic templates to ensure they are set up to enable a 25% reduction in follow-up appointments
- Validate patients waiting for follow-ups to identify any who do not need to be seen
- Ensure continued and expanded delivery of patient initiated follow up (PIFU) in all major OP specialties, particularly accelerating uptake in specialties with the longest waits (ENT, gynaecology, gastroenterology and dermatology)
- Ensure patients who no longer need to be seen in secondary care are appropriately discharged, in line with clinical guidelines
- Work to reduce appointments that are missed by patients (DNAs), in line with NHS England guidance, including by:
  - Understanding the most common reasons why patients miss appointments, building on available national support
  - Making it easier for patients to cancel or reschedule appointments they don't need eg through sending a response to an appointment reminder
- Local analysis of patients on multiple pathways or those with multiple follow-ups.
- Consider conducting a retrospective clinical review of a sample of OP follow-up activity in at least two specialties with the longest waits, to identify where an alternative pathway of care could have been used (eg discharge, PIFU, appointment met through alternate means).

Payment

Reducing OP follow-ups is incentivised by the NHS payment scheme, where follow-up appointments are covered by a fixed payment element, and first appointments are covered by a variable element.

Support available

Competing priorities will always make it difficult to focus on making these changes. Continued support will be available through:

- Data packs for each tiered trust, and top ten other trusts with high OP follow up reduction opportunity
- Clinically-led conversations with tiered trusts from National Clinical Directors, GIRFT clinical leads, and OP clinical leads
- Operational support to amend clinic templates
- Support to improve equity of access through the national Action on Outpatients programme.

Elective care 2023/24 priorities - Board Checklists

CHOOSE PROVIDER NAME: *THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST*

	Assurance Statement	*Support/materials*	Trust response
1	**Excellence in basics**		
	Has any patient waiting over 26 weeks on an RTT pathway (as at 31 March 2023) not been validated in the previous 12 weeks? Has the 'Date of Last PAS validation' been recorded within the Waiting List Minimum Data Set?		All patients waiting over 26 weeks on an RTT pathway (as at 31 March 2023) have been validated in the previous 12 weeks. As The CCC have few patients waiting over 26 weeks, we are able to validate them at least weekly. On 14/6/23, there were 7 patients waiting over 26 weeks in total. For these 7 patients, the median week of referral to The CCC was 27 weeks. As the 'Date of Last PAS validation' is not a mandatory field in the Waiting List Minimum Data Set (WLMDS), this is not included. *Added post submission to ICB on 14/6/23 for CCC BoD assurance:* The wait at The CCC for the 7 patients was a mean average of 57 days and a median of 30 days. There were no CCC related delays, with patients either on active monitoring, admitted to other Trusts with other medical conditions which delayed cancer treatment or patients required repeat tests.
	Are referrals for any Evidence Based Interventions still being made to the waiting list?	*Release 3 will be published on 28 May. It focuses on the following specialties: breast surgery, ophthalmology, vascular, upper gastrointestinal surgery, cardiology, urology, and paediatric urology*	Not Applicable
2	**Performance and long waits**		
	Are plans in place to virtually eliminate RTT waits of over 104w and 78w (if applicable in your organisation)?		The CCC had no patients who waited over 78 weeks or 104 weeks in 2022/23.
	Do your plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024?		As The CCC is a tertiary centre, we are subjected to late referrals. We have robust systems in place to monitor national and internal cancer waiting times. Waits over 65 weeks are rare and occur as a result of late referrals E.g. The CCC had only 1 patient who waited over 65 weeks in 2022/23; 66 weeks in total, referred to The CCC in week 65.

	Assurance Statement	*Support/materials*	Trust response
3	**Outpatients**		
	Are clear system plans in place to achieve 25% OPFU reduction, enabling more outpatient first activity to take place?	*NHSE GIRFT guidance*	As the majority of our OPFUs are treatment appointments, it is impossible to reduce these by 25%. This has been acknowledged by the ICB. We do however have a focussed Outpatient Transformation Project, to exploit the opportunity for Patient Initiated Follow Up (PIFU) in the true OP setting, and have shared our plans with the ICB.
	Do you validate and book patients in for their appointments well ahead of time, focussing on completing first outpatient appointments in a timely way, to support with diagnostic flow and treatment pathways?	*Validation toolkit and guidance NHS England » Validation toolkit and guidance published on 1st December 2022*	Patients referred to The CCC have their first appointment booked as soon as possible. We aim to achieve an internal 9 day target, from referral to 1st appointment. We achieved over 89% in all quarters of 2022/23. From 1/4/23 this 9 day figure has fallen, due to longer waits for molecular test results.
4	**Cancer pathway re-design**		
	Where is the trust against full implementation of FIT testing in primary care in line with BSG/ACPGBI guidance, and the stepping down of FIT negative (<10) patients who have a normal examination and full blood count from the urgent colorectal cancer pathway in secondary care?	*Using FIT in the Lower GI pathway published on 7th October 2022 BSG/ACPGBI FIT guideline and supporting webinar*	Not Applicable
	Where is the trust against full roll-out of teledermatology?	*Suspected skin cancer two week wait pathway optimisation guidance*	Not Applicable
	Where is the trust against full implementation of sufficient mpMRI and biopsy capacity to meet the best practice timed pathway for prostate pathways?	*Best Practice Timed Pathway for Prostate Cancer*	Not Applicable

	Assurance Statement	*Support/materials*	Trust response
5	**Activity**		
	Are clear system plans in place to prioritise existing diagnostic capacity for urgent suspected cancer activity?	*Letter from Dame Cally Palmer and Dr Vin Diwakar dated 26 April 23.*	Yes, via HO Rapid Diagnostic Service and Fast Track referrals into The CCC Radiology Services.
	Is there agreement between the Trust, ICB and Cancer Alliance on how best to ensure newly opening CDC capacity can support 62 day backlog reductions and FDS performance?		The CCC is expecting to open 'CCC Paddington' CDC on 24th July 2023; working in partnership with the Cancer Alliance and other Trusts within the ICB to reduce the backlog.
	How does the Trust compare to the benchmark of a 10-day turnaround from referral to test for all urgent suspected cancer diagnostics?		The CCC only diagnose for a small proportion of all patients treated. These Haemato-oncology patients have blood tests initially; these are performed by the GP or on the day of the first appointment at CCC.
	Are plans in place to implement a system of early screening, risk assessment and health optimisation for anyone waiting for inpatient surgery? Are patients supported to optimise their health where they are not yet fit for surgery? Are the core five requirements for all patients waiting for inpatient surgery by 31 March 2024 being met? 1. Patients should be screened for perioperative risk factors as early as possible in their pathway. 2. Patients identified through screening as having perioperative risk factors should receive proactive, personalised support to optimise their health before surgery. 3. All patients waiting for inpatient procedures should be contacted by their provider at least every three months. 4. Patients waiting for inpatient procedures should only be given a date to come in for surgery after they have had a preliminary perioperative screening assessment and been confirmed as fit or ready for surgery. 5. Patients must be involved in shared decision-making conversations.	*NHS England » 2023/24 priorities and operational planning guidance*	Not Applicable
	Where is the trust/system against the standards of 85% capped Theatre Utilisation and 85% day case rate?		Not Applicable
	Is full use being made of protected capacity in Elective Surgical Hubs?		Not Applicable
	Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo and Endoscopy?	https://future.nhs.uk/NationalCommunityDiagnostics/groupHome	Standards: CT: 2-4 scans per hour, MRI: 2-3 per hour, NOUS: 3 per hour. The CCC are meeting the standards for CT and MRI. Data is being reviewed for NOUS, as we do not deliver standard US; all patients requiring US at CCC have complex conditions and therefore require a longer appointment.
	Are any new Community Diagnostic Centres (CDCs) on track to open on agreed dates, reducing DNAs to under 3% and ensuring that they have the workforce in place to provide the expected 12 hours a day, 7 day a week service? Are Elective Surgical Hub patients able to make full use of their nearest CDC for all their pre and post-op tests where this offers the fastest route for those patients??		The CCC is expecting to open 'CCC Paddington' CDC on 24th July 2023. The working hours (10 per day) have been agreed with central CDC. The service will run 7 days a week. Referral patterns are being confirmed with Trusts within the ICB. The CCC will accept all patients referred for CT, MRI or ultrasound.

	Assurance Statement	*Support/materials*	Trust response
6	**Choice**		
	Are you releasing any Mutual Aid capacity which may ordinarily have been utilised to treat non-urgent patients to treat clinically urgent and long-waiting patients from other providers? Is DMAS being used to offer or request support which cannot be realised within the ICB or region?	*www.dmas.nhs.uk*	We have already repatriated any imaging linked to non-surgical oncology activity back to CCC.
	Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?		Not applicable.
7	**Inclusive Recovery**		
	Do recovery plans and trajectories ensure specialised commissioned services are enabled to recover at an equitable rate to non-specialised services? Do system plans balance high volume procedures and lower volume, more complex patient care		The CCC have no waiting lists.
	Have you agreed the health inequality actions put in place and the evidence and impact of the interventions as part of your operational planning return? Was this supported by disaggregated elective recovery data?		The Trust level operational planning templates did not require the inclusion of any information on health inequalities. As stated in the NHS Standard Contract 2023/24, by 21st October 2023 The CCC will have prepared an outline plan setting out the activities already undertaken and those planned for the remainder of the year to target and proactively reduce health inequalities and improve health outcomes for the most disadvantaged and vulnerable groups.
	Are children and young people explicitly included in elective recovery plans and actions in place to accelerate progress to tackle CYP elective waiting lists?	*CYP elective recovery toolkit*	The CCC have no waiting lists for CYP.
	Supporting guidance and materials are available on the Elective Recovery Futures site:		
	https://future.nhs.uk/ElectiveRecovery		

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 28th June 2023

Report lead	Jane Hindle, Associate Director of Corporate Governance			
Paper prepared by	Jane Hindle, Associate Director of Corporate Governance			
Report subject/title	NHS Provider Licence Annual Self-Certification			
Purpose of paper	A review has been carried against for the Corporate Governance Statement as can be seen in the Appendix a, and based on the evidence presented in the current arrangements the proposal is that the Board makes a positive declaration and declares 'Confirmed' to each clause and also confirms that no material risks have been identified.			
Background papers	N/A			
Action required	For Approval			
Link to: Strategic Direction / Corporate Objectives	Be Outstanding	x	Be a great place to work	x
	Be Collaborative	x	Be Digital	x
	Be Research Leaders	x	Be Innovative	x

Equality & Diversity Impact Assessment – **an EDIA is not required for this item**.

The content of this paper could have an adverse impact on:	Age	No	Disability	No	Sexual Orientation	No
	Race	No	Pregnancy/Maternity	No	Gender Reassignment	No
	Gender	No	Religious Belief	No		

The Clatterbridge Cancer Centre NHS Foundation Trust

NHS Provider Licence Annual Self-Certification

1.0 Background

As a provider of health-care services, the Trust is required to be licenced by the Care Quality Commission and as Foundation Trust, the Trust is also required to hold a Provider Licence issued by Monitor (now part of NHS England/ Improvement).

Part of the Licence Conditions are requirements to make declarations of compliance on an annual basis against the following conditions:

- Condition G6(3): The provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution.
- Condition G6(4): Publication of the above G6(3) self-certification.
- Condition CoS7 (3): The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement. This only applies to foundation trusts that are providers of Commissioner Requested Services (CRS)

- Condition FT4 (8): The provider has complied with required governance arrangements – Corporate Governance Statement

- Training of Governors: The provider has reviewed whether their Governors have received enough training and guidance to carry out their roles

2.0 Self-Assessment

The evidence of compliance can be found at Appendix a. It is recommended that the Chair and Chief Executive sign the enclosed declarations as ‘Confirmed’ prior to publication on the Trust’s website.

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix a

NHS Provider Licence conditions declaration 2022/23

Declaration	Recommendation	Evidence
GS 6 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirm	Head of Internal Audit Opinion and the opinion of the External Auditor. .
After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirm	The Trust's financial plan has been accepted by NHS Cheshire and Merseyside ICB and NHS England. The Annual Accounts for 2022/23 have been prepared on a Going Concern basis. The Audit Committee endorsed the Trust's Going Concern Assessment at its meeting in May 2023. The opinion of the External Auditor. .
FT 4 1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as	Confirm	The Trust has followed corporate governance guidance issued by NHS Improvement in respect of the Accounts process the NHS Foundation Trust Annual Reporting Manual 2022/23 and the Quality Account Guidance.

The Clatterbridge Cancer Centre NHS Foundation Trust

appropriate for a supplier of health care services to the NHS.		The Trust has completed a self-assessment against the Foundation Trust Code of Governance and compliance has been monitored via the Audit Committee. The Trust commissioned an Independent Well-Led review in 2021 and the Trust Board has monitored the resultant action plan. The Board receives regular updates regarding the external environment via the Chair and Chief Executives report.
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirm	
3. The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirm	The Board of Directors and has established a committee structure with associated reporting lines, performance, and risk management systems. Each committee is chaired by a Non-Executive Director and has associated Executive Leads. Clear terms of reference detail the duties of the committees and this structure is kept under regular review. The Trust has a divisional structure for clinical services and clear structures are in place within each directorate, led by Directors. Individual Director roles are described within the Scheme of Reservation and Delegation.
4. The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	Confirm	The Trust has well established systems and processes for setting financial plans and ensuring that these are met. The Trust's financial position is reviewed in detail at the Trust's Performance Committee meetings and at the Board of Directors meeting through the mechanism of the Integrated Performance Report and the Finance Report.

(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		The Board approves the Trust's Annual Operation Plan and budget. In addition the Trust Board receives a separate Finance Report. Responsibilities for decision making are detailed in: • The Trust's Constitution and Standing Orders • Scheme of Reservation and Delegation (SoRD) • Standing Financial Instructions (SFIs) The Trust's Internal auditors play a key role in providing assurance that the financial systems are operating adequately. The Board is made aware of major risks to the organisation's strategic objectives by a quarterly report of the Board Assurance Framework. The Board and Board Committees meet on a regular basis and are provided with accurate, timely and up to date information for decision making. The Trust reviews business plans via Performance Review Group meetings and the outcome of these is reported to The Annual Governance Statement submitted to the Audit Committee summarises and confirms the robustness of the Trust's internal control and risk management system.

		The Trust has a Constitution and relevant policies and procedure to ensure compliance with all applicable legal requirements.
5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirm	The Board keeps its skills and experience under review via the annual appraisal process. The outcome of the appraisals of the Non-Executive Directors is reported to the Council of Governors. The Board and Board Committees meet on a regular basis and are provided with accurate, timely and up to date information for decision making is produced via comprehensive data collation systems. The Board and the Quality Committee review and monitor the Trust's performance in respect of quality, safety and patient experience. The Trust has in place a Patient Experience Programme that ensures the views of patients are considered. The Trust seeks the views of patients and wider stakeholders in the development of its quality account priorities. The Trust also receives feedback via national surveys and external visits. The Director of Chief Nurse is the Executive Director with responsibility for Quality. Structures, systems and processes are in place for escalating and resolving quality issues.

The Clatterbridge Cancer Centre NHS Foundation Trust

		The Quality Committee is responsible for ensuring the Board obtains assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust. The Trust's Senior Independent Director is a named NED whom staff can contact should they wish to raise concerns via the Trust's Raising Concerns (Whistleblowing) policy. The Trust also has a Freedom to Speak Up Guardian in post
6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirm	The Trust has a Workforce Strategic Plan and has sufficient and suitably qualified personnel to ensure compliance with the Conditions of the Licence. Data on the Trust's workforce is reported in the Annual Report. Workforce data is included in the monthly Integrated Performance Report and oversight is provided via the People Committee.
Skills and experience of Governors The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirm	The Trust has in place a Governor Handbook that outlines the statutory duties of governors and this is provided to all governors. New governors attend training developed and provided by NHS Providers which covers the role of governors in detail The Trust promotes national and regional training events to governors and seeks feedback on their effectiveness.

The Clatterbridge Cancer Centre NHS Foundation Trust

Information Pack

The Clatterbridge Cancer Centre NHS Foundation Trust Board of Directors
Register of Interests 2022-2023

Name and Position	Declared Interests
Kathy Doran Chair	• Chair of Local Governing Body of Birkenhead High School Academy and therefore ex officio • Member of the Academy Trust Board of the Girls Day School Trust
Liz Bishop Chief Executive	• Director on the Clattterbridge Private Clinic Board (Joint venture with The Mater) • Attended HSJ Partnership Awards table was purchased by Attain
Sheena Khanduri Medical Director	• Member of Private Practice Joint Venture Board • Trustee of Clatterbridge Cancer Charity
Julie Gray Chief Nurse	• Director on the Clattterbridge Private Clinic Board (Joint venture with The Mater)
Joan Spencer Chief Operating Officer	• My sister Ann Ford is the Deputy Chief Inspector of Hospitals with the CQC • Member of the Private Patient Venture Board
Jayne Shaw Director of Workforce & OD	• Nil
James Thomson Director of Finance	• I am the Trust representative for the 2 subsidiary companies - PropCare Limited, and Clatterbridge Pharmacy Limited • Trust representative for the Clatterbridge Private Clinic LLP. This is a joint venture with the Matter Private Limited (Republic of Ireland). I am a member of the LLP Board
Sarah Barr Chief Information Officer	• Nil
Tom Pharaoh Director of Strategy	• My brother-in-law is a partner within the Liverpool office of Hill Dickinson - a law firm that CCC uses for legal advice
Mark Tattersall Vice Chair	• Nominated Non-Executive Director for the Trust's subsidiary PropCare • Director and Board Chair of MHM Ltd, a private limited company engaged in providing consultancy and market research services to the cultural, heritage and charitable sectors in the UK and overseas
Geoff Broadhead Senior Independent Director	• Chair of Clatterbridge Pharmacy Ltd • Member of Merseyside Pension Fund Pension Board • Member of the Merseyside Police and PCC Joint Audit Committee • Wife held Senior Position in Warrington and Halton CCG and subsequently Cheshire and Merseyside ICB

David Elkan Abrahamson Non-Executive Director	• Chair of Trustees of the Bloom Appeal, a blood cancer charity • Solicitor with Broudie Jackson Canter solicitors - I deal with major Inquests and Inquiries. In that capacity I currently represent the Covid 19 Bereaved Families for Justice, a representative group of bereaved which has core participant status in several modules of the Covid Inquiry • Director of 'Hillsborough Law Now Ltd.', a company whose aim is to get a Duty of Candour law enacted
Terry Jones Non-Executive Director	• Director, Liverpool Head and Neck Centre (LHNC). LHNC was formed as a formal collaboration between LUHFT, CCC, The Walton Centre and the University of Liverpool to facilitate the enhancement of head and neck cancer research and treatment in Cheshire & Merseyside. The Directorship is one of my core employment roles • Director of Research, Liverpool University Hospitals NHS Foundation Trust (LUHFT). This role, to lead the research strategy for LUHFT is another of my core employment roles • Director of Research, Cheshire and Merseyside Integrated Care System
Anna Rothery Non-Executive Director	• Elected Member Leader of Liverpool Community Independents Party
Asutosh Yagnik Non-Executive Director	• Founder and Managing Director, AdSidera Ltd, UK • Director, Leigh Court (Harrow) Ltd, UK • Senior Fellow, Institute for Strategy, Resilience and Security (ISRS), University College London, UK. • Senior Partner, Aura Capital Partners, Iceland.

Acronyms

AHP	Allied Health Professional
ALS	Advanced life support
AO	Acute oncology
AQuA	Advancing Quality Alliance
AMM	Annual Members Meeting
BLS	Basic life support
BRC	Biomedical Research Centre
BAF	Board assurance framework
BMA	British Medical Association
BAME	Black Asian Minority Ethnic
BoD	Board of Directors
C&M	Cheshire and Merseyside
CAMRIN	Cheshire and Merseyside Radiology and Imaging Network
CAR-T	Chimeric antigen receptor T-cell
CCG	Clinical commissioning group
CCIO	Chief Clinical Information Officer
CCRS	Clatterbridge Committee for Research Strategy
CDC	Community diagnostic centre (was community diagnostic hub - CDH)
CDU	Clinical Decisions Unit
CE+	Cyber essentials plus
CEO	Chief Executive Officer
CET	Clinical effectiveness team
CIC	Clatterbridge in the Community
CIP	Cost Improvement Plan
CIPHA	Combined Intelligence for Public Health Action
CIO	Chief Information Officer
CMAST	Cheshire & Merseyside Acute and Specialist Trust Provider Collaborative
CMCA	Cheshire and Merseyside Cancer Alliance
CMIO	Chief Medicines Information Officer
CNIO	Chief Nursing Information Officer
CNS	Clinical nurse specialist
CPL	Clatterbridge Pharmacy Limited
CQC	Care Quality Commission
CoG	Council of Governors
COO	Chief Operating Officer
CRF	Clinical Research Facility
CRFS22	Clatterbridge Research Funding Scheme 2022
CCC-W	Clatterbridge Cancer Centre Wirral
CCC-L	Clatterbridge Cancer Centre Liverpool
CCC-A	Clatterbridge Cancer Centre Aintree
DoF	Director of Finance
DBS	Disclosure and barring service
DPA	Data Protection Act
ECMC	Experimental Cancer Research Centre
EDI	Equality, diversity and inclusion
EPR	Electronic patient record
ESR	Electronic staff record
EHR	Electronic health record
EPR	Electronic patient record
FoSH	Federation of Specialist Hospitals
FFT	Friend and family test
FTSU	Freedom to speak up
FOI	Freedom of information
GDPR	General data protection regulations
GMC	General Medical Council
HCI	Health Care International
HCP	(Cheshire & Merseyside) Health and Care Partnership
HEE	Health Education England
HIMSS	Healthcare Information and Management Systems Society
HO	Haemato-oncology
HR	Human Resources
ICS	Integrated Care System
ICB	Integrated Care Board
IM&T	Information management and technology
IoM	Isle of Man
IPR	Integrated Performance Report
ILS	Intermediate life support
JACIE	Joint Accreditation Committee of the International Society for Cellular Therapy (ISCT) and the European Group for Blood and Marrow Transplantation (EBMT)
KLOE	Key line of enquiry
KPI	Key performance indicator
L&OD	Learning and organisational development
LCR	Liverpool city region
LCRI	Liverpool Cancer Research Institute
LeDeR	A service improvement programme for people with a learning disability and autistic people
LFPSE	Learn From Patient Safety Events
LHCH	Liverpool Heart and Chest Hospital NHS Foundation Trust
LHP	Liverpool Health Partners
LUHFT	Liverpool University Hospitals NHS Foundation Trust
MDT	Multidisciplinary team
MECC	Membership engagement communications committee
NHSE/I	NHS England/Improvement
NHSP	NHS Professionals
NIHR	National Institute for Health and Care Research
NMC	Nursing and Midwifery Council
NRLS	National Reporting and Learning System
NWPQA	North West Pharmaceutical Quality Assurance
NED	Non-Executive Director
OD	Organisational development
ODN	Operational delivery network
OSC	Overview and scrutiny committee
PA	Programmed activity (a block of time in a consultant job plan)
PADR	Performance appraisal and development review
PEIG	Patient Experience and Inclusion Group
PHR	Patient held record
PIFU	Patient initiated follow-up
PMO	Programme Management Office
PPJV	Private patient joint venture
PREMs	Patient reported experience measures
PSIRF	Patient Safety Incident Response Framework
PALS	Patient Advice & Liaison Service
PHE	Public Health England
PPI	Patient and Public Involvement

QI	Quality improvement
RCP	Royal College of Physicians
RDS	Rapid diagnostic service
R&I	Research and innovation
RPA	Robotic process automation
RAG	Red, Amber, Green classifications
SABR	Stereotactic ablative radiotherapy
SACT	Systemic anti-cancer therapy
SDEC	Same day emergency care
SLA	Service level agreement
SPC	Statistical process control
SRG	Site reference group
SRO	Senior responsible officer
SFI	Standing financial instructions
SIRO	Senior Information Risk Officer
SRO	Senior Responsible officer
SLA	Service Level Agreement
SUI	Series Untoward Incident / Serious Incident
StEIS	Strategic Executive Information System
STHK	St Helens and Knowsley Teaching Hospitals NHS Trust
TEG	Trust Executive Group
TOG	Trust Oversight Group
ToR	Terms of Reference
TfC	Together for Children
TIC	Transformation and Improvement Committee
TMA	Transitional monitoring approach
TUPE	Transfer of Undertakings (Protection of Employment)
TYA	Teenage and young adult
UoL	University of Liverpool
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole time equivalent
WUTH	Wirral University Teaching Hospital NHS Foundation Trust