AGENDA

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Trust Board of Directors Meeting held in Public

Date: Wednesday 26 May 2021	Location: via MTeams
Start Time: 09:00	Finish Time: 11:15

Timings	Item No		Lead	Paper/Verbal
Opening Matters				
09:00	**P1-073-21**	Welcome & Apologies:	KD	**Verbal**
	P1-074-21	Declarations of Committee Members' and other attendees' interests concerning agenda items:	KD	**Verbal**
	P1-075-21	Minutes of last meeting:28 April 2021	KD	**Verbal**
	P1-076-21	Matters arising/Action Log	KD	**Verbal**
	P1-077-21	Chair's Report to the Board	KD	**Verbal**
Risk and Assurance				
09:15	**P1-078-21**	Performance Committee Chair's Report	GB	**Paper**
09:25	**P1-079-21**	Quality Committee Chair's Report	TJ	**Paper**
09:35	**P1-080-21**	Patient Story	JSp	**Verbal**
10:10	**P1-081-21**	Update on Walkabouts	SK/JSp	**Paper**
	P1-082-21	New Consultant Appointments		**None to note**
10:20	**P1-083-21**	Guardian of Safe Working: Quarter 4 Report	SK	**Paper**
10:30	**P1-084-21**	Integrated Performance Report: Month 01	JSp/JSh SK	**Paper**
10:40	**P1-085-21**	Cheshire & Merseyside Cancer Alliance Performance Report	LB	**Paper**
10:50	**P1-086-21**	Finance Report: Month 01	JT	**Paper**
Corporate Governance				

AGENDA

The Clatterbridge Cancer Centre NHS Foundation Trust

11:00	**P1-087-21**	Board Assurance Framework	AW	**Paper**
11:10	**P1-088-21**	Board Meeting Review	ALL	**Verbal**
		Any other business		

Next Meeting:

Date: Wednesday 30 June 2021	Location: TBC
Start Time: 09:00	Finish Time:

Agenda Item: P1-xxx-21

The Clatterbridge Cancer Centre NHS Foundation Trust

The Clatterbridge Cancer Centre NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART ONE – PUBLIC SESSION

Wednesday 28 April 2021 at 09:00am
Via MS Teams

Present:	Mark Tattersall (MT)	Non-Executive Director (Vice Chair)
	Geoff Broadhead (GB)	Non-Executive Director
	Elkan Abrahamson (EA)	Non-Executive Director
	Terry Jones (TJ)	Non-Executive Director
	Anna Rothery (AR)	Non-Executive Director
	Asutosh Yagnik (AY)	Non-Executive Director
	Liz Bishop (LB)	Chief Executive Officer
	James Thomson (JT)	Director of Finance
	Jayne Shaw (JSh)	Director of Workforce & OD
	Joan Spencer (JSp)	Chief Operating Officer & Interim Chief Nurse
	Sheena Khanduri (SK)	Medical Director
	Sarah Barr (SB)	Chief Information Officer
	Tom Pharaoh (TP)	Director of Strategy
In Attendance:	Angela Wendzicha (AW)	Associate Director of Corporate Governance
	Emer Scott (ES)	Associate Director of Communications
	Jane Wilkinson (JW)	Lead Governor *(from 10:00)*
	Mike Varey (MV)	Staff Side Chair
(Item P1-064-21)	James Crowther (JC)	Head of IT Operations
	Jenny Bradshaw (JB)	Digital Programme Manager
	Peter Matthews (PM)	Digital Systems Technical Manager

Item No.	Item	Action
	Opening Matters	
	Board Role Essential Training: Anti Bribery and Corruption Compliance Training. Prior to the Board meeting, the Board received Anti Bribery and Corruption Compliance Training delivered by Ms Aoife Ryan, Senior Associate at Hill Dickinson Solicitors. Following a detailed discussion around the subject, the Board agreed that the same training should be delivered to the Trust's subsidiary companies in addition to the Joint Venture and the Charity with AW confirming she will facilitate this. Presentation slides to be circulated to the Board.	**AW** **AW**
P1/58/21	**Chair Welcome and Note of Apologies** MT welcomed all to the Board meeting highlighting that as apologies had been received from Kathy Doran, MT, will Chair the Board meeting.	

P1/59/21	**Declaration of Board Members' and other attendees interests concerning agenda items** Declarations of interests were received from the following: • Mark Tattersall – Nominated Non-Executive Director for PropCare • Terry Jones – Director of Liverpool Head and Neck Centre and Associate Medical Director for Research, Liverpool University Hospital NHS Foundation Trust. • Geoff Broadhead –Nominated Non-Executive Director of CPL • James Thomson – Executive Lead for PropCare and CPL • Angela Wendzicha – Company Secretary for PropCare and CPL	
P1/60/21	**Minutes of Previous Meetings:** The Board approved the minutes of the meeting held on Wednesday 31 March 2021 as an accurate record of the meeting subject to the following amendment: **P1-048-21**: Patient Story: …..*the patient due to attend Board was able….* Should read…..*the patient due to attend Board was unable….* **The Trust Board:** • **Approved** the minutes subject to the amendment detailed above.	
P1/61/21	**Action Log/ Matters Arising** The Board noted that actions were either complete, on the agenda or not due. AR informed the Board that she had received the information AW circulated relating to how the Trust deals with Equality Impact Assessments. AR added that she was impressed with the information provided and assured the Trust has a robust process in place to manage Equality Impact Assessments. **The Trust Board:** • **Noted** the position with the Action Log	
P1/62/21	**Quality Committee Chair Report** TJ informed the Board that the Quality Committee has started to re-position some items on the agenda given the issues they raise and the need to keep some items high on the agenda for the Committee. In providing a summary of the report, TJ informed the Board that the issues relating to the Aseptic Unit continue and although mitigations are in place, the Committee has requested monthly updates until full assurance has been received. TJ further highlighted the impact on clinical trials and the future ECMC submission with the Committee seeking a review of the risk register relating to Pharmacy and the Aseptic Unit around these issues. TJ added that the Committee had received a further re-iteration of the overview of all incidents in addition to the medicine safety report. The	

	Committee expressed the need to better understand the medication incidents and had therefore requested the planned seminar around medicine management be brought forward. TJ informed the Board that the Committee received the deep dive report into the Datix ICloud upgrade, agreeing that whilst the decision should be made by the Executive team, the Committee was minded to recommend that the Trust move forward with the Datix ICloud project, requesting an update in June 2021. The Committee received a presentation on the findings of the Management of Complaints review with the Committee agreeing that the Trust has a process in place to deal with complaints and that the action plan will be monitored through the Committee. JSp added that the action plan from the complaints review has been amalgamated into the clinical governance review action plan. TJ further informed the Board that JSp had provided the Committee with a verbal overview of her initial findings relating to clinical governance and that a review is being undertaken around the committees and groups that report into the Integrated Governance Committee; a report is expected at the Quality Committee in June. MT highlighted that it is evident the Board Committees are working together and that challenging issues are being dealt with. In addition, MT welcomed the review of the clinical governance related groups and committees that underpin the Quality Committee. **The Trust Board:** • **Discussed and noted** the content of the report.	**AW**
P1/63/21	**Audit Committee Chair Report** MT introduced the Chair's report from the Audit Committee held in April noting the meeting had been a positive one and highlighting the following: a) The Committee received the full report following completion of the review relating to the Management of Complaints. An update will be provided on progress against the action plan to the July Audit Committee. MT added that a review of Complaints and PALs has been added to the Internal Audit Plan for 2021/22. b) Audit Tracker: The Committee recognised the progress that had been made in relation to the Audit Tracker. Given the issues raised around the sign off of evidence to support completion of actions following Internal Audit reviews highlighted by the review into the management of complaints, the Committee welcomed the proposal to monitor the action plans via the Divisional Performance Reviews. c) MIAA: Internal Audit Progress Report: The Committee received the progress report and noted that despite the restrictions posed by the Pandemic, an acceptable number of audits had been completed.	

	d) MIAA: Internal Audit Annual Report and Head of Internal Audit Opinion: MT highlighted that Substantial Assurance had been provided on the Head of Internal Audit Opinion in that there is a good system of internal control which is an important finding for the Annual Governance Statement. e) MIAA: Internal Audit Plan 2021/22: The Committee approved the Internal Audit Plan for the next financial year subject to the Executives reviewing the timescales relating to three of the planned reviews. f) MIAA: Anti-Fraud: MT highlighted that the agreed plan for the next financial year included the subsidiary companies although it was not yet clear in terms of the scope which was yet to be defined. g) Terms of Reference: The Committee reviewed and approved the revised Terms of Reference. JW noted that in the years that she has been involved with the Audit Committee she has not seen such positive Internal Audit Reports. MT added that it was necessary to recognise the audit work that had been completed and the positive progress made despite the difficulties experienced during the last year. AY sought clarity on whether it was normal for all Committees of the Board to receive the same reports citing the example of the report from the Review of the Management of Complaints. In addition, AY sought clarity on where the action plan would be monitored. MT confirmed that detailed monitoring of the action plan would be at the Quality Committee and that the Audit Committee's function is to seek independent assurance on systems and processes. TJ added that the issues that have been recently raised have demonstrated the interface between all the Board Committees and that it is reasonable for the Audit Committee to seek further audits and independent assurance where required. **The Trust Board:** • **Discussed and noted** the content of the report.	
P1/64/21	**Staff Story** SB introduced JC, JB and PM to the Board informing the Board that representatives from the IT team will provide an overview of what the team have experienced over the last 12 months. JC informed the Board that the last 12 months have been a unique period of time for the IT department as they have worked to prepare the organisation for the move into the new hospital. This included commissioning a new network, introduction of 'tap and go' technology, automated check-in kiosks and the on- boarding of the Haemato-oncology department. JC went onto add that in early 2020 the department invoked its business continuity plans in order to test the	

	Trust's ability and resilience in working from home and there was no doubt that the new hospital put pressure on the IT team. JB added that the impact of Covid-19 changed how the Trust conducted business highlighting that some of the processes that we implemented immediately previously had 6 months planned lead in times. The Trust went from beginning to discuss the use of MTeams to being one of the top users. However, JB confirmed that whilst it was hard work for the department, the experience brought the team together. PM concurred adding that a combination of Covid and the new hospital changed the way in which the team worked. The Digital team pulled together to facilitate working from home and to effectively manage the challenges of opening the new hospital. The difficulties of managing business as usual in addition to Covid and opening the new hospital were clear to the team but the team continued to pull together to make it work. JSh thanked the team and highlighted that the Digital team had worked very hard and did a great job supporting the organisation through Covid. JT added that the Digital team very quickly mobilised staff to support them in agile working with JC adding that Covid was a catalyst for staff to really harness digital. Both MT and TJ commended the team for the progress that has been made and work completed within the organisation around Digital. On behalf of the Board, MT thanked JC, JB and PM for attending Board to share their experiences of the last year. **The Trust Board:** • **Welcomed and noted** the content of the staff story.	
P1/65/21	**Updates on Walkabouts** A number of joint walkabouts had been facilitated during the past month as follows: a) SK had visited Ward 3 at CCC-L with Steve Sanderson, one of our Governors and Geoff Broadhead who were both able to join on the mobile device. b) Discussions were held with staff who were able to share their experiences of working in the 'red' area on the ward which they found demanding but that staff were able to get sufficient breaks and rest. In addition we spoke to a GP trainee who was very complimentary about staff training. GB added that whilst it was good to see the environment and speak to both patients and staff and he would recommend others to join the walkabouts, it is not a substitute for physically being on the site. c) JSp informed the Board that she and EA had visited the Teenage and Young Adult unit with two Governors, JW and Glen Crisp. The unit has two facilities in use, the inpatient and day care facilities. Both areas were noted to be bright and spacious with the added social area for the patients.	

	EA added that it was quiet when the visit took place but he found the visit very helpful. Given the ICS will have some focus on diet, EA sought clarity on whether there will be any facilities for learning about diet and cooking skills outside of the hospital environment. LB confirmed that she was not aware of anything through the ICS but the Cancer Alliance has appointed Macmillan support staff to look at the concept of 'staying well' in life which is also being picked up by Public Health. d) LB summarised her walkabout to Ward 4 with two Governors, Andy Waller and Steve Sanderson. They spoke to patients who reported that they had received excellent care with positive comments relating to the facilities and food, especially the provision of snacks. Patients were reporting good connectivity to family and friends and were positive about the nurses, doctors and therapists. LB further informed the Board that they had been able to speak to staff who described good team work and good facilities. However, the staff reported that they would benefit from a rest facility on the ward and costings are currently being carried out to convert one of the rooms to a rest facility for staff. The ward had a total of 6 nurse vacancies but 8 potential recruits are being interviewed imminently. The ward is recruiting more experienced staff rather than newly qualified staff as it generally takes 3-6 months to upskill a nurse to administer treatment. Andy Waller had requested more information on our practice educators which we will provide. Staff reported that they found the Meditech system 'clunky' but did like to have all the relevant information in one place. SB added that the Trust is currently in year 6 of a 10 year contract with Meditech and a full review is taking place around how the system interfaces with work procedures and processes the outcome of which will report into Digital Board, Integrated Governance Committee and ultimately Quality Committee. LB concluded that whilst we are awaiting national guidance on the principles of emerging from lockdown, we will review how we conduct the walkabouts going forward and bring the proposal back to Board in May. **The Trust Board:** • **Noted and welcomed** the feedback from the walkabouts.	**JSp** **AW**
P1/66/21	**New Consultant Appointments** SK introduced Dr Saif and Dr Floisand to the Board both of whom have joined the Transplant team. Dr Saif will be our new Bone Marrow Transplant Director and brings a wealth of experience which will ensure that we are prepared for our JACIE accreditation. Dr Floisand is an established Consultant with experience in research.	

	SK added with TJ concurring that both appointments are very welcome additions to the Trust. **The Trust Board:** • **Noted and welcomed** Drs Saif and Floisand to the Trust.	
P1/67/21	**Mortality Dashboard** SK provided an overview of the Mortality Dashboard for Quarter 3 noting that one inpatient death was currently under review. SK further highlighted the additional section to the report relating to lessons learned as a result of reviews from deaths. **The Trust Board:** • **Discussed and approved** the Mortality Dashboard for publication on the Trust public facing website.	
P1/68/21	**Integrated Performance Exception Report: Month 12** JSp introduced the report, informing the Board that the report had been discussed in detail at the Quality Committee and highlighted the following: **Access and Efficiency** a) Overall performance against the Cancer Waiting Times Standards has been good during March 2021. b) Challenges have been experienced as a result of Consultant annual leave which the administrative team are now monitoring closely; however, despite the leave the Trust continued to meet the 24 day target. c) The Trust has seen excellent performance (93.7% against a target of 85%) in relation to the 62 day wait from GP referral to treatment. MT highlighted that the Trust has previously experienced challenges as a result of Consultant leave impacting on performance, suggesting this was becoming a theme. JSp agreed that this had been a challenge especially when there are bank holidays and confirmed that an improved system is in place whereby the operational team work with medical workforce to ensure leave is covered. d) In terms of efficiency, JSp highlighted that bed occupancy, although improving, remains below the Trust target of 92%. Ward 4 is above target at 93.7% with Ward 5 at 78.5% although Ward 5 occupancy is improving due to the increasing numbers of transplants being carried out. e) Radiology reporting: We have not met our out-patient reporting target due to a combination of annual leave and increased activity. We have stopped mutual aid to Liverpool University Hospital and the team are undertaking a capacity and demand review which will be discussed at the Performance Committee when complete. f) Covid-19 Recovery: In terms of Covid-19 recovery, we are seeing an increase in referrals, stem cell transplants and delivery of SACT.	

Quality
JSp provided an overview of the Quality section of the report highlighting that the Trust declared one Serious Incident in March and the investigation remains ongoing. We had one IRMER reportable incident resulting in no harm to the patient. The Trust did not meet the sepsis target in March and full reviews of all 7 breaches are underway.
JSp added that discussions are underway with the Commissioners in relation to Clostridiodes difficile as the current target is a stretch target and that we are likely to see an increase in the future as we increase the number of bone marrow transplants.

It was noted that the Trust did not meet the target for responding to complaints and that five complaints are currently in the system that have breached the 25 day target.

Research
SK provided an overview of the Research section of the report highlighting that although 46 studies have been opened to recruitment year to date, we have been unable to open any new studies due to the issues relating to the Aseptic Unit.

Workforce
JSh provided an overview of the workforce section highlighting the following:

g) Sickness absence: Excellent performance in relation to sickness which is 3.25% in March and the lowest the Trust has seen since June 2018.
h) Turnover: It was noted that turnover is currently above our target with the reasons for leaving cited as promotion, end of fixed term contract, improved reward package and further education.
i) Statutory and Mandatory Training: It was noted that a deep dive into ILS and BLS training compliance had been requested by the Performance Committee and additional detail has been added into the report this month. Although we are meeting the target for BLS there is further work to do in relation to ILS with a review taking place around the role essential element of ILS. The Learning and Development team are supporting managers in those areas where compliance needs improving.
j) PADR: Compliance is currently at 90% with an expectation that with the new framework, in addition to support for managers compliance will improve. Furthermore, pay progression will be linked to completion of the PADR from June.
k) Staff Friends and Family Test: The results for Quarter 4 were disappointing with 33% of staff completing the survey with the corporate services performing better than the clinical services. Work has commenced to explore how we can improve the response rates.

GB added that there has been a steady decline over the year in staff recommending the Trust for care and treatment and questioned whether there is a need for a deeper dive into the results or to run the survey more frequently? JSh confirmed that we could do pulse surveys and culture checks but the key for Friends and Family is to improve the

	response rates as we have a requirement to carry out the survey every quarter. JSh also highlighted that there are still some members of staff who are struggling with the move to Liverpool which is impacting the survey results. JW sought clarity on the better reward package as a reason cited for leaving and asked if other organisations were offering benefits we did not. JSh confirmed that we are limited in what we can offer in terms of a pay package. EA asked whether any other incentives are available with JSh again confirming that we are limited in what we can offer financially but can broaden the non-monetary offer for example in terms of health and wellbeing. MT acknowledged the additional information provided around BLS and ILS training but expressed disappointment that the Matrons within Integrated Care had zero compliance. JSp confirmed that this has been discussed in detail with the individual teams who are clear in terms of their targets for compliance. LB added that a recent presentation given by the North West Regional Director of Workforce, highlighted that we are doing very well and showing significant improvements in relation to Equality, Diversity and Inclusion. LB also highlighted that it is likely that the requirements and approach around the staff survey will change going forward although as yet the detail is not available. **The Trust Board:** • **Discussed and noted** the content of the report.	
P1/69/21	**Integrated Performance Report Annual Review** MT informed the Board that the Audit Committee had requested MIAA to undertake a review of the Integrated Performance Report which resulted in a finding of Substantial Assurance around the data that we receive through the Integrated Performance Report. JSp informed the Board that in addition to the MIAA review, an annual review is carried out with any proposals for the next financial year discussed and agreed at Performance Committee and Quality Committee. **The Trust Board:** • **Noted** the updates to future Integrated Performance Reports.	
P1/70/21	**Cheshire and Merseyside Cancer Alliance Performance Report** LB provided an overview of the report summarising the Cheshire and Merseyside Cancer Alliance performance as follows: a) The number of patients waiting over 62 days for a diagnosis or treatment is higher than pre-Covid levels at 1,042 with 337 of these patients waiting over 104 days. Conversations have taken place with individual Chief Executives in the region who are all working hard to confirm treatment dates. b) Variation in performance across the standards continues with surgery and diagnostics being the focus for the Alliance.	

	The Trust Board: • **Discussed and noted** the content of the report.	
P1/71/21	**Finance Report: Month 12** JT introduced the report highlighting the following: a) The Trust is reporting good financial performance for the year with a consolidated surplus of £1.2m at the end of March 2021. JW sought clarity on why PharmaC did not pay a dividend to the Trust with JT confirming that it was agreed that a dividend would not be paid this year to allow reserves to be retained in PharmaC for re-investment back into the Company. GB noted that the year-end financials are positive and that the forecasts over the year have been accurate. EA sought clarity on the year-end receipt of £278k relating to the under recovery of non-NHS income with JT confirming this relates to income generated from the Isle of Man, Wales and the Joint Venture. Discussion ensued in relation to the surplus and the future plans across the ICS with a recognition that further detail remains outstanding with regards to how the ICS will respond to any surplus going forward. **The Trust Board:** • **Noted** the content of the report and the strong financial position of the Trust.	
P1/72/21	**Board meeting (including Quality)** MT invited JW to comment. JW confirmed that the walkabouts had given the Governors the opportunity to see the new hospital and that it is hoped by July they will be able to attend in person. The Board observed a minute silence at midday in acknowledgement of Workers Memorial Day.	
	Any Other Business None raised.	
	End of the meeting held in public. The Board is asked to resolve that in accordance with Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudiced to the public interest.	
	Date of the next meeting: Wednesday 26 May 2021.	

Signed:

Mark Tattersall
Vice Chair

Dated:

BOARD ACTION SHEET PART 1						
KEY: BLUE = COMPLETE / GREEN = ON TRACK / AMBER = AT RISK / RED = LATE						
Item No.	**Date of Meeting**	**Item**	**Action(s)**	**Action by**	**Date to complete by**	**Date Completed / update**
P1-155-20	28-Oct-20	Matters Arising - Unconscious bias training for Board	An independent EDI specialist to carry out unconscious bias training.	**JSh**	TBC	**The Trust will be joining the Specialist Trusts for joint training: Date to be confirmed**
P1-32-21	24-Feb-21	Cheshire & Merseyside Cancer Alliance	Information relating to inequity of access to services to be presented at a future Board	**LB**	Jun-21	
P1-34-21	24-Feb-21	Gender Pay Gap Report	Paper setting out the options to reduce the gender pay gap to a future Board meeting.	**JSh**	Jun-21	
P1-50-21	31-Mar-21	Staff Survey Results	Action Plan from the Staff Survey Results to Board in due course	**JSh**	Jul-21	
	28-Apr-21	Anti Bribery Training	Training to be delivered to the subsidiay companies, Chairty and Joint Venture. Slides to be circulated to the Board.	**AW**	Jun-21	**Training slides circulated to the Board on 11 May 2021.**
P1-65-21	28-Apr-21	Walkabouts	Paper seting out the future conduct of walkabouts to be presented to the May Board	**AW**	May-21	**On the Agenda**
P1-065-21	28-Apr-21	Walkabouts	Andy Waller to be provided with information realting to Practice Educators	**JSp**	May-21	

The Clatterbridge Cancer Centre NHS Foundation Trust

Committee/Group 'Triple A' Chair's Report

Name of Committee/Group	Performance Committee	Reporting to:	Trust Board
Date of the meeting:	19 May 2021	Parent Committee:	
Chair:	Geoff Broadhead	Quorate (Y/N)	Y

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Performance Committee Risk Register		The Committee received and discussed the Performance Committee Risk Register noting the following: • Further commentary was required on open actions in order to provide adequate assurance on mitigations • A review of all operational risks on the Datix system currently in progress with divisional leads to ensure appropriate scoring and narrative, particularly around risks showing no open actions. • The potential for lower scoring financial risks, that cumulatively could be significant be considered as a BAF risk.	A revised risk report including a summary and further commentary on actions to be presented to the committee in July.	NB	July 2021

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Operational and Financial Planning		The Committee received and discussed the Trust's operational and financial plan for 2021/2022 noting the following: • Cheshire & Merseyside ICS had submitted an overall position 'break-even position' (6th May). CCC had agreed that the ICS would submit a break-even position on its behalf • The financial plan required a £2m CIP for the 2021-22 financial year. CCC had submitted an income and cost profile to the ICS, relating to the predicted cash-flows resulting from activity recovery. • Not all of the planning variables had been fully worked through. Specifically, the ICS approach to how the Elective Recovery Fund (ERF) would be managed with further detail awaited.	Planning in progress for May 26th submission.	JT	May 2021
Review of the Clinical Decisions Unit		The Committee received and discussed the progress of service improvements undertaken within the Clinical Decisions Unit (CDU). • The CCC-L site was seeing patients with different cancer types and acuity compared to those experienced at CCC-W • Work had been undertaken to ensure more effective collection and future reporting of CDU and Hotline performance data. • The committee was assured that divisional resourcing levels were adequate to deliver the services effectively. • Delivery of KPIs would be monitored at Acute Care Divisional quality safety and performance meetings	An update on progress to be presented to the July Committee.	JSp	July 2021
Research & Innovation Business Plan		The Committee received and discussed the progress made on the Research Strategy Business Plan 2021 – 2026 and noting the following: • Progress had been made on each of the four work streams • The risk around reduction commercial funding as a result of Covid-19 and the capacity issues within	R&I Business Plan progress to be reported to the committee again in September.	GH	September 2021

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
		the Aseptic Unit. No new trials had opened in April however re-start plans were being developed with operational teams, it was forecasted that recovery would be possible. • Alignment of funding streams was necessary to manage risk and support planned recruitment and forecasted research capacity.			
CPL Reporting		Following approval of the revised reporting structure relating to the Trust's subsidiary companies, the Committee received and discussed the first report from CPL highlighting the following: • Activity and performance of CPL for 2020/21: the Committee noted the difficulties experienced in relation to senior staffing. The Committee thanked Jo Bowden for stepping into the role of Director for CPL alongside her substantive role at CCC. • An unexpected increase in required stock levels following the opening of the Liverpool site and impact of Covid-19 had led to cash flow shortages during the year, requiring cash advances from CCC – this had been added to the risk register for 2021/22 and mitigations were in place to prevent a reoccurrence. Overall the year ended with positive liquidity. • The Committee approved the proposed CPL budget for 2021/22. It was noted that work was required to redefine trading between the Company and the Trust.	CPL will report to the Trust Board in June 2021.	JB/JT	June 2021

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

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Committee/Group 'Triple A' Chair's Report

Name of Committee/Group	Quality Committee	Reporting to:	Trust Board
Date of the meeting:	20 May 2021	Parent Committee:	
Chair:	Terry Jones	Quorate (Y/N)	Y

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Risk Register		The committee discussed the need to see more detail around outstanding actions and also more consistency in reporting across divisions. Assurance was received on the work in progress with divisional leads on improving data within Datix, which would enable more effective extraction of high scoring risk data, for reporting into board committees. The committee discussed the necessity to differentiate emerging risks from current issues, it was agreed this was a required area of focus and would be reflected in future reports.	Revised Risk Register report to be presented to the committee.	NB/JSp	June 2021
Medicines Management Report		The committee received the revised Medicines Management report and welcomed the new categorisation reporting framework. The committee noted that discussions were in place with comparable organisations with a view to streamline reporting to allow for benchmarking.	Monthly Medicines Management reports to be provided to the committee adjacent to pharmacy Aseptic Unit Updates.	JSp	June 2021

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
		It was agreed that monthly Pharmacy Aseptic Unit Updates and Medicines Management reports would be provided to the committee adjacent to each other to allow for joint consideration of the two topics.			
Pharmacy Aseptic Unit: Update &		The committee received an update on the progress to date. The key discussion points were as follows: • A future move to digital dispensing, would enhance the quality and efficiency. Project planning with Meditec was to take place and progress would be reported into the committee. • Assurance was received that the issues surrounding cleaning of the unit had been mitigated, the service was currently being outsourced with a view to internalise once quality assurance was re-established. • The impact on clinical trials was discussed, it was noted that capacity had increased and the unit was now able to support new trials. The RCA for cold storage issues had been identified and an effective interim solution was in place, long term plans were being considered.	The Committee to receive monthly progress reports until sufficient assurance received.	KF/JSp	June 2021
Hematology-Oncology Ambulatory Pathways of Care – Project Update		The committee received and discussed the paper which provided an update as requested in November 2020. The committee were informed of the next steps involving the formal approval of the project through the Clinical Operational Group (COG) in May 2021 and project start up in June 2021. There was some concern raised on the 6 month time frame to implement the project, however, the complexity of the project was	The committee to receive Bone Marrow Transplant paper A further Hematology-Oncology Ambulatory Pathways of Care – Project Update scheduled	JSp JSp	June 2021 October 2021

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
		discussed and it was agreed the time frame was realistic. The Committee welcomed and noted the addition of two new consultants and the outline plan to develop ambulatory pathways of care and treatment within acute leukaemia.			
HEE		The Committee received a presentation on the planned HEE visit 6th July 2021, outlining the structure of the visit, the key lines of enquiry and the expected timelines for receipt of the outcomes report. It was noted that the outcome report would be received no earlier than October 2021.	Verbal update to be presented to the committee HEE outcome report to be presented to the committee	SK /KG SK/KG	July 2021 October 2021
Clinical Governance Proposal for Revised Structure & Action Plan		The committee welcomed the improved clarity on the structure of reporting arrangements of IGC and the relevant sub-groups. The committee discussed the complexity of ICG and agreed the proposed cycle of business would facilitate more effective floor to board communication The committee received the action plan and noted the work underway, with lead personnel and timescales for implementation. It was agreed that R&I should report directly into both the Quality Committee and the Integrated Governance Committee.	Monthly R&I Chair reports to Quality Committee Monthly updates on progress of progress on the action plan	GH	June 2021

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

The Clatterbridge Cancer Centre NHS Foundation Trust

Report Cover Sheet

Report to:	Trust Board	
Date of the Meeting:	26 May 2021	
Agenda Item:	P1-081-21	
Title:	Joint Walkabouts	
Report prepared by:	Angela Wendzicha	
Executive Lead:	Liz Bishop	
Status of the Report:	Public	
	X	

Purpose of the Paper/Key Points for Discussion:	The following paper illustrates the Board's commitment to ensuring that leaders across the Trust are visible and approachable. The joint Non-Executive/Governor and Executive walk rounds are opportunities to meet with patients and their families (dependent upon Covid restrictions) in addition to staff to enable them to talk about their experiences, the care we provide and discuss any concerns they may have. The attached paper illustrates the proposed schedule for 2021.

Action Required:	Discuss	x
	Approve	
	For Information/Noting	x

Next steps required	

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

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

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

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

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

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

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Joint Walkabouts: Update

Angela Wendzicha, Associate Director of Corporate Governance

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Introduction

The case for effective interaction between ward to Board and vice versa is well made and established within the NHS. This direct engagement allows the Board to directly experience quality of services, assists staff to get to know Board members and Governors thus allowing staff, patients and their families to speak honestly about their experiences.

The importance of Board visibility in the organization has long been recognized and a more interactive process allows Board members, Governors, service users and staff to shape culture through direct engagement.

The last financial year has been unprecedented insofar as the requirement to respond to the Covid resulted in pausing the joint walkabouts with Executives, Non-Executives and Governors. Latterly the Trust has been able to utilise digital technology to enable Non-Executive Directors and Governors to attend some walkabouts.

The Trust has recently appointed a new Patient Experience Manager who will take the lead in facilitating the joint walkabouts and subsequent reporting to Board. The following schedule has been proposed for the remainder of the calendar year.

Thursday 17 June	CCC-W
Monday 12 July	CCC-L
Tuesday 17 August	CCC-A
Friday 17 September	CCC-L
Tuesday 5 October	CCC-W
Tuesday 16 November	CCC-A
Thursday 9 December	CCC-L

The Board is asked to note the above schedule and inform Angela Wendzicha of any dates the Board would wish to be included in the patient and staff walkabouts.

The Clatterbridge Cancer Centre NHS Foundation Trust

Report Cover Sheet

Report to:	Trust Board	
Date of the Meeting:	26 May 2021	
Agenda Item:	P1-083-20	
Title:	Guardian of Safe Working Hours – Q4 Report Jan – March 2021	
Report prepared by:	Chris Thompson, Medical Workforce Manager	
Executive Lead:	Sheena Khanduri, Medical Director	
Status of the Report:	Public	Private
	X	

Paper previously considered by:	Workforce and Organisational Development Committee
Date & Decision:	

Purpose of the Paper/Key Points for Discussion:	To brief the Board and provide assurance the Trust maintains compliance with the Junior Doctor's 2016 Terms and Conditions. To assure the Board where Exception Reports have been raised, the Trust has taken the correct steps to rectify the issues.

Action Required:	Discuss	
	Approve	
	For Information/Noting	x

Next steps required	The committee is asked to discuss and note the content of the report

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

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

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

BAF Risk	Please Tick
1. If we do not optimise quality outcomes we will not be able to provide outstanding care	
2. If we do not prioritise the costs of the delivering the Transforming Cancer Care	

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

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

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

Quarterly Report on Safe Working Hours:

Doctors and Dentists in Training – Quarter 4

January – March 2021

1. Introduction

This report covers the period .

Since August 2017, The Clatterbridge Cancer Centre has had junior doctors who are working under the 2016 Junior Doctor contract and its associated Terms and Conditions of Service. There are also junior doctors on the 2002 contract working alongside them and on the same rotas who are not on this contract. Information is being collected from both sets of doctors on issues of working hours to ensure patient safety and for completeness, but only significant breaches for doctors on the 2016 contract could incur financial penalties.

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 new 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.

2. High level data

Number of doctors/dentists in training (total):	33
Number of doctors/dentists in training on 2016 TCS (total):	33
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

Exception reports (with regard to working hours)

There were no Exception Reports raised by trainees during this period.

Hours Monitoring

Because all doctors in training are on the 2016 Terms and Conditions of service, monitoring of hours is no longer undertaken and has been replaced by Exception Reporting which offers trainees the ability to raise concerns as-and-when they occur.

Work schedule reviews

There have not been any requests from trainees for work schedule reviews.
Medical Workforce are in the process of reviewing the ST3+rota as a redesign is required to better accommodate our Less Than Full Time trainees and reduce the number of known gaps due to non-working days.

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	Shifts worked by agency doctors	Patchwork shifts
Clinical Oncology / Medical Oncology	2	2	28
General Medicine	1	148	3
Haemato Oncology	154	198	0

Vacancies

We maintain a 1:20 ST3+ rota. This rota is fully staffed but has regular known gaps caused by Less Than Full Time trainees non-working days. Medical Workforce are liaising with these trainees and hope to engage some of them in slot shares to help reduce the number of gaps. These gaps end up being worked as additional locum duties by their colleagues.

On the Junior Doctor's rota,this is currently a 1:12 pattern which is currently supported by agency locums where there are gaps.

We are actively advertising and recruitment Junior and Senior Clinical Fellows to fill vacancies we have and vacancies we know we have from August 2021.

Fines

There were no fines incurred in this quarter.

All Trainees who require access to Exception Reporting, have passwords and log in details for exception reporting have been reissued.

Actions taken to resolve issues

- Carry on encouraging Trainees to record their exception reports when necessary.

Summary

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 both the 2002 and 2016 contracts. Locums were used appropriately to cover on-call shifts during this time period to ensure all critical out of hours shifts were covered..

Within this organisation, working hours for doctors in training are considered safe at the current time. The information collected and documented in this report provides assurance for this.

Dr Madhuchanda Chatterjee

Guardian of Safe Working Hours

The Clatterbridge Cancer Centre NHS Foundation Trust

Report Cover Sheet

Report to:	Board of Directors	
Date of the Meeting:	26th May 2021	
Agenda Item:	P1-084-21	
Title:	Integrated Performance Report M1 2021/2022	
Report prepared by:	Hannah Gray, Head of Performance and Planning	
Executive Lead:	Joan Spencer, Chief Operating Officer / Interim Chief Nurse	
Status of the Report:	Public	Private
	X	

Paper previously considered by:	Quality Committee and Performance Committee
Date & Decision:	19th and 20th May 2021

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

Action Required:	Discuss	X
	Approve	
	For Information/Noting	

Next steps required	

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

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

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

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

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

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

Integrated Performance Report (Month 1 2021/22)

Introduction

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

In April 2021, members of the Quality Committee and Trust Board approved the proposed content of the 2021/22 IPR. All agreed changes are included in this M1 2021/22 report.

Covid-19 vaccination KPIs have been extended to include second dose data this month; these will be reported alongside first dose data until the end of the vaccination campaign. The only national target regarding Covid-19 vaccination delivery is that (100%) all staff have been offered the vaccine, against which we are compliant.

Although national Covid-19 guidance recommended the suspension of data collection for several KPIs / metrics, the Trust has maintained internal monitoring and reporting to ensure oversight and good performance.

1. Performance Scorecards

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

1.1 Access

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Apr-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
L	**7 days** from referral to first appointment	↑	G: ≥90% A: 80-89.9% R: <85%	85.6%	85.6%	
C/S	**2 week wait** from GP referral to 1st appointment	↔	93%	100.0%	100.0%	
L	**24 days** from referral to first treatment	↓	G: ≥85% A: 80-84.9% R: <80%	82.8%	82.8%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	↓	75% (shadow monitoring)	75.0%	75.0%	
S	**31 day** wait from diagnosis to first treatment	↔	96%	99.5%	99.5%	
C/S	**31 day** wait for subsequent treatment (Drugs)	↔	98%	98.9%	98.9%	
C/S	**31 day** wait for subsequent treatment (Radiotherapy)	↔	94%	99.0%	99.0%	
S	Number of **31 day** patients treated ≥ **day 73**	↔	0	0	0	
C/S	**62 Day** wait from GP referral to treatment	↔	85%	86.7%	86.7%	
C/S	**62 Day** wait from screening to treatment	↔	90%	100.0%	100.0%	
L	Number of patients treated between **63 and 103 days** (inclusive)	↓	No Target	32	32	
S	Number of patients treated => **104 days**	↓	No Target	12	12	
L	Number of patients treated => **104 days AND at CCC for over 24 days (Avoidable)**	↔	G: 0 A: 1 R: <1	0	0	
C/S	Diagnostics: **6 Week Wait**	↔	99%	100%	100%	
C/S	**18 weeks** from referral to treatment (RTT) Incomplete Pathways	↔	92%	98.3%	98.3%	

Notes:

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

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

Cheshire and Merseyside Performance

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Mar-21	YTD 2020/21	Last 12 Months
Executive Director Lead: Liz Bishop, CMCA SRO						
C/S	**2 week wait** from GP referral to 1st appointment	↔	93%	94.8%	91.9%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	↑	75% (shadow monitoring)	78.1%	74.9%	
C/S	**62 Day** wait from GP referral to treatment	↔	85%	76.5%	76.1%	

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

1.2 Efficiency

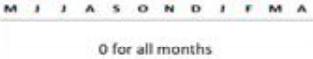
Scorecard Directive Key: S = Statutory | C = Contractual | L = Local

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Apr-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
S	Length of Stay: Elective (days): Solid Tumour	↑	G: ≤6.5 A: 6.5-6.8 R: >6.8	8.1	8.1	M J J A S O N D J F M A
S	Length of Stay: Emergency (days): Solid Tumour	↔	G: ≤8 A: 8.1-8.4 R: >8.4	5.8	5.8	M J J A S O N D J F M A
S	Length of Stay: Elective (days): HO Ward 4	↔	G: ≤21 A: 21.1-22.1 R: >22.1	17.4	17.4	M J J A S O N D J F M A
S	Length of Stay: Emergency (days): HO Ward 4	↔	G: ≤22 A: 22.1-23.1 R: >23.1	13	13	M J J A S O N D J F M A
S	Length of Stay: Elective (days): HO Ward 5	↓	G: ≤32 A: 32.1-33.6 R: >33.6	22.7	22.7	M J J A S O N D J F M A
S	Length of Stay: Emergency (days): HO Ward 5	↔	G: ≤46 A: 46.1-48.3 R: >48.3	10	10	M J J A S O N D J F M A
S	Delayed Transfers of Care as % of occupied bed days (now CCC)	↔	≤3.5%	1.7%	1.7%	M J J A S O N D J F M A
S	Bed Occupancy: Midnight (Ward 4: HO)	↓	G: ≥85% A: 81-84.9% R: <81%	81.8%	81.8%	M J J A S O N D J F M A
S	Bed Occupancy: Midnight (Ward 5: HO)	↓	G: ≥80% A: 76-79.9% R: <76%	57.8%	57.8%	M J J A S O N D J F M A
S	Bed Occupancy: Midday (Solid Tumour)	↔	G: ≥85% A: 81-84.9% R: <81%	79.4%	79.4%	M J J A S O N D J F M A
S	Bed Occupancy: Midnight (Solid Tumour)	↔	G: ≥85% A: 81-84.9% R: <81%	71.4%	71.4%	M J J A S O N D J F M A
C/S	% of elective procedures cancelled on or after the day of admission	↔	0%	0%	0%	0% for all months
C/S	% of cancelled elective procedures (on or after the day of admission) rebooked within 28 days of cancellation	↔	100%	None cancelled	N/A	No elective procedures have been cancelled on or after the day of admission
C/S	% of urgent operations cancelled for a second time	↔	0%	0%	0%	0% for all months
L	Imaging Reporting: Inpatients (within 24hrs)	↔	G: ≥90% A: 80-89.9% R: <80%	98.7%	98.7%	M J J A S O N D J F M A
L	Imaging Reporting: Outpatients (within 7 days)	↔	G: ≥90% A: 80-89.9% R: <80%	82.8%	82.8%	M J J A S O N D J F M A
C/Phase 3 Covid-19 Guidance	Data Quality - % Ethnicity that is complete (or patient declined to answer)	↔	100%	94.0%	94.0%	M J J A S O N D J F M A
C	Data Quality - % of outpatients with an outcome	↔	G: ≥95% A: 90-94.9% R: <90%	96.3%	96.3%	M J J A S O N D J F M A
C	Data Quality - % of outpatients with an attend status	↔	G: ≥95% A: 90-94.9% R: <90%	97.3%	97.3%	M J J A S O N D J F M A
Executive Director Lead: James Thomson, Director of Finance						
S	Percentage of Subject Access Requests responded to within 1 month	↔	100%	100%	100%	M J J A S O N D J F M A
C	% of overdue ISN (Information Standard Notices)	↔	0%	0%	0%	0% for all months

Blue bars are included for months with no target

1.3 Quality

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Apr-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
C/S	Never Events	⟷	0	0	0	0 for all months
C/S	Serious Untoward Incidents (month reported to STEIS)	⟷	0	1	1	
C/S	Serious Untoward Incidents: % submitted within 60 working days / agreed timescales	⟷	100%	100.0%	100%	
S	RIDDOR - number of reportable incidents	↑	0	1	1	
S	Significant accidental or unintended exposure (SAUE); Radiotherapy delivered dose or Radiotherapy geographical miss - Treatment Errors	⟷	G: ≤3 A: 4-5 R: >5	0	0	
S	Significant accidental or unintended exposure (SAUE); Radiotherapy delivered dose or Radiotherapy geographical miss - Imaging Errors	⟷	G: ≤8 A: 9-12 R: >12	0	0	
S	Incidents /1,000 Bed Days	↑	No target	209.5	209.5	
L	Incidents resulting in harm /1,000 bed days	↑	No target	18	18	
C/S	Inpatient Falls resulting in harm due to lapse in care	⟷	0	0	0	
S	Inpatient falls resulting in harm due to lapse in care /1,000 bed days	⟷	0	0	0	
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care)	⟷	0	0	0	0 for all months
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care) /1,000 bed days	⟷	0	0	0	0 for all months
S	Consultant Review within 14 hours (emergency admissions)	⟷	90%	100.0%	100.0%	
C/S	% of Sepsis patients being given IV antibiotics within an hour*	⟷	90%	97.0%	97.0%	
C/S	VTE Risk Assessment	⟷	95%	95.0%	95.0%	
S	Dementia: Percentage to whom case finding is applied	⟷	90%	100.0%	100.0%	
S	Dementia: Percentage with a diagnostic assessment	-	90%	No patients	N/A	
S	Dementia: Percentage of cases referred	-	90%	No patients	N/A	No patients were referred
C/S	Clostridiodes difficile infections (attributable)	⟷	≤4 (pr yr)	1	1	
C/S	E Coli (attributable)	⟷	G: ≤9, A: 10 R: >10 (pr yr)	0	0	
C/S	MRSA infections (attributable)	⟷	0	0	0	0 for all months
C/S	MSSA bacteraemia (attributable)	⟷	G: ≤4, A: 5 R: >5 (pr yr)	0	0	
C	Klebsiella (attributable)	↑	G: ≤9, A: 10 R: >10 (pr yr)	1	1	
C	Pseudomonas (attributable)	⟷	G: ≤4, A: 5 R: >5 (pr yr)	0	0	
C/S	FFT score (% positive)	-	G: ≥95% A: 90-94.9% R: <90%	96%	96%	

The Quality KPI scorecard continues on page 5

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Apr-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
C	Number of formal complaints received	↓	No target	3	3	
S	Number of formal complaints / count of WTE staff (ratio)	↓	No target	0.002	0.002	
C	% of formal complaints acknowledged within 3 working days	↔	100%	100%	100%	
L	% of routine formal complaints resolved in month, which were resolved within 25 working days	↓	G: ≥75% A: 65-74.9% R: <65%	25%	25%	
L	% of complex formal complaints resolved in month, which were resolved within 60 working days	N/A	G: ≥75% A: 65-74.9% R: <65%	None to resolve	N/A	1 complex complaint in this period. This was not resolved within 60 working days
C/S	% of FOIs responded to within 20 days	↔	100%	100.0%	100.0%	
C/S	Number of IG incidents escalated to ICO	↔	0	0	0	0 for all months
C	NICE Guidance: % of guidance compliant	↔	G: ≥90% A: 85-89.9% R: <85%	93%	93%	
L	Number of policies due to go out of date in 3 months	↑	No target	38	N/A	
L	% of policies in date	↓	G: ≥95% A: 93.1-94.9% R: <93%	94%	94%	
C/S	NHS E/I Patient Safety Alerts: number not implemented within set timescale.	↔	0	0	0	

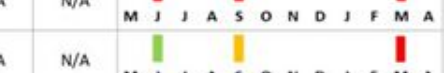
NB: blue arrows (and bars) are included for KPIs with no target and show the movement from last month's figure.
The C diff target is subject to change, as these have not yet been agreed with Commissioners for 2021/22
*Sepsis data is subject to change following final validation.
The NHS complaints process timelines have been relaxed to allow Trusts to prioritise the necessary clinical changes required to respond to the Covid-19 pandemic.
The Trust Policy currently allows more than 25 days with patients' consent

1.4 Research and Innovation

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Apr-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Sheena Khanduri, Medical Director						
L (Strategy)	Study recruitment	↓	G: ≥1300 A: 1100-1299 R: <1100 (pr yr)	38	38	
National	Study set up times (days)	-	=<40 days	N/A	N/A	Latest reporting period is Q2 2020/21: median = 34 days
L (Strategy)	Recruitment to time and target	-	G: ≥55% A: 45-54.9% R: <45%	N/A	N/A	Latest reporting period is Q2 2020/21: 60%
L (Strategy)	Studies Opened	↔	G: ≥52 A: 45-51 R: <45 (pr yr)	1	1	
L (Strategy)	Publications	-	G: ≥130 A: 110-129 R: <110 (pr yr)	5	5	

1.5 Workforce

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Apr-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Jayne Shaw, Director of Workforce and Organisational Development						
S	Staff Sickness	⟷	G: ≤4% A: 4.1-4.9% R: ≥5%	3.6%	3.6%	
S	Staff Turnover	⟷	G: ≤1.2% A: 1.21-1.24% R: ≥1.25%	1.66%	1.66%	
S	Statutory and Mandatory Training	⟷	G: ≥90% A: 75-89% R: ≤75%	95.3%	N/A	
L	PADR rate	⟷	G: ≥95% A: 75-94.9% R: ≤74%	90.1%	N/A	
S	FFT staff: Recommend as a place to work (Quarterly survey)	-	G: ≥95% A: 90-94.9% R: ≤90%	N/A	N/A	
S	FFT staff: Recommend care and treatment (Quarterly survey)	-	G: ≥95%, A: 90 - 94.9%, R: ≤90%	N/A	N/A	
L	% of Staff who have had the **first** dose Covid-19 vaccination (at month end)	↑	No national target	91.7%	N/A	
L	% of BAME Staff who have had the **first** dose Covid-19 vaccination (at month end)	↑	No national target	89.6%	N/A	
L	% of Staff who have had the **first** dose Covid-19 vaccination or have refused the vaccination (at month end)	↑	No national target	95.4%	N/A	
L	% of BAME Staff who have had the **first** dose Covid-19 vaccination or have refused the vaccination (at month end)	↑	No national target	92.5%	N/A	
L	Covid-19 vaccinations: **Second** dose received as % of first dose received (at month end)	-	No national target	91.1%	N/A	
L	Covid-19 vaccinations: BAME staff, **Second** dose received as % of first dose received (at month end)	-	No national target	90.5%	N/A	

There is no CCC FFT staff survey in Q3 due to the National Staff Survey running at this time.

1.6 Finance

For April the key financial headlines are:

Metric	Mth 1 Actual	Mth 1 Plan	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit) (£000)	31	35	(4)		(31)	(35)	4	
Cash holding (£000)	52,160	42,608	9,552		52,160	42,608	9,552	
Capital Expenditure (£000)	7	0	7		7	0	(7)	

*The plan for M1 reflects 1/6th of the plan agreed with Cheshire and Mersey ICS for M1-6 21.22 of £211k surplus. Please note subsidiaries are not included in the report due to timing.

The month 1 financial position to the end of April is £4m over spent. Cash is showing a closing balance of £52.2k which is £9.5k above planned cash. Capital spend is £7k in month.

2. Exception Reports

2.1 Access

7 days from referral to first appointment	Target	April 21	YTD	Last 12 Months
	G: ≥90% A: 85-89.9% R: <85%	85.6%	85.6%	

Reason for non-compliance

19 patients breached the Trust's internal 7-day target in April; This was due to consultant availability within certain Tumour teams over the Easter break.

The breaches span a number of Tumour groups including H&N, Lung and Upper GI.

Action taken to improve compliance

- Additional clinics were held to support achievement of the target.
- The Business Managers are working closely with SRG Leads and are also conducting a review of approval for Consultants' Annual leave.
- A further exercise is being completed by Administrative Services to look at capacity and demand for access to first appointments.

Expected Date of Compliance	Q2 2021/22
Escalation Route	CWT Target Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer/ Interim Chief Nurse

24 days from referral to first treatment	Target	April 21	YTD	Last 12 Months
	G: ≥85% A: 80-84.9% R: <80%	82.8%	82.8%	

Reason for non-compliance

There were 17 breaches of the 24-day target in April 21 (5 chemotherapy patients, 10 radiotherapy patients and 2 HO patients).

10 patients breached the 24-day target but achieved the 62-day target (4 chemotherapy patients, 5 radiotherapy and 1 HO patient). 4 patients were deemed to be avoidable breaches due to a delay to first appointment, awaiting bone marrow results and DYPD not completed timely.

The unavoidable breaches were all due to medical reasons.

Action taken to improve compliance

- Further work is being completed around capacity and demand for access to first appointments.
- Capacity challenges have been escalated to the Divisional Directors.
- Templates have been developed and shared with all SRG leads to support the recovery principles, as the Trust plans for an increase in referrals following COVID.
- DYPD issues are discussed monitored at the CWT Target Operational Group.

Expected Date of Compliance	July 2021
Escalation Route	CWT Target Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer/ Interim Chief Nurse

62 Cancer Standard (Alliance-level)	Target	Mar 21	YTD	12 month trend (to March)
	85%	76.47%	76.18%	

Reason for non-compliance

Non-compliance with the 62 day standard in March 2021 was largely driven by underperformance in the following tumour groups:

- Urology 41.5% (down from 62.83% last month)
- Lower Gastrointestinal 67.13% (up from 44.5%)
- Upper GI 49.5% (down from 65.75%)
- Gynaecology 49.35% (up from 29.58%)

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

Lower GI pathways were particularly affected with performance falling from 73.27% in February 2020 (pre-pandemic) to a low of 25% in May. In May the British Society of Gastroenterology advised

a six-week pause in endoscopy services due to the risk of Covid-19 transmission, affecting lower GI, upper GI and urology pathways. There is a large backlog of patients waiting for endoscopy with patients being prioritised based on clinical need.

Gynae performance was largely driven by a number of breaches at Liverpool Womens Hospital..

March's 62 day performance was also impacted by a large number of referrals received in December and January. First appointments were 25% higher than normal in December (higher than any other Alliance) and are currently approximately 20% higher.

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

Action Taken to improve compliance

- Continuation of surgical and diagnostics hubs as part of CMCA's response to Covid-19.
- The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group.
- The endoscopy operational recovery team, in collaboration with the C&M Hospital has produced a clear, prioritised plan to increase capacity.
- The Alliance has secured £5.4m capital investment to increase endoscopy capacity and improve productivity.
- £600,000 investment to support full implementation of symptomatic faecal immunochemical testing (sFIT) in primary care. This builds on the existing secondary care sFIT model. Implementation will reduce demand for endoscopy services.
- Further £400k invested in using FIT to validate and risk stratify LGI endoscopy waiting lists and surveillance lists.
- Patient and public communications to improve patient confidence to attend for appointments.
- 2ww referrals are now higher than pre-pandemic levels

Expected date of compliance	Compliance with the 62 day standard is expected in Q3 2021/2022.
Escalation route	NHS England, North West CCC Performance Committee, Trust Board
Executive Lead	Liz Bishop, CMCA SRO

2.2 Efficiency

Length of Stay: Elective Solid Tumour (days)	**Target**	**April 21**	**YTD**	**Last 12 months**
	G: ≤6.5 A: 6.5-6.8 R: >6.8	**8.1**	**8.1**	

Reason for non-compliance

The LoS for elective admissions on ST wards was 2.4 days above target at 8.1 days. All other LoS targets were achieved in April 2021.

Two patients were admitted from the Isle of Man and required inpatient stay during treatment.

In addition, there were a number of patients who attended for planned chemotherapy who then required IV antibiotic due to developing Sepsis during admission. This led to a longer LOS for these patients.

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

Action taken to improve compliance

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

Expected date of compliance	May 2021
Escalation route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Integrated Governance Committee, Quality Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

	Wards	Target	April 21	YTD	Last 12 Months
Bed Occupancy	**Solid Tumour** (Midday)	G: ≥85% A: 81-84.9% R: <81%	79%	79%	
	Solid Tumour (Midnight)	G: ≥85% A: 81-84.9% R: <81%	71%	71%	
	Ward 4 (HO) (Midnight)	G: ≥85% A: 81-84.9% R: <81%	82%	82%	
	Ward 5 (HO) (Midnight)	G: ≥80% A: 76-79.9% R: <76%	58%	58%	

Reason for non-compliance

Bed occupancy for April 2021 is below target in all areas. The target has been amended from 92% to 85% for solid tumour wards and Ward 4. This has been agreed with commissioners and is in line with Covid-19 recovery plans.

Occupancy has reduced since March 2021 in all areas. Reasons for this decrease include:

- The opening of the TYA unit in April 2021; with this cohort of patients transferred from other wards.
- A reduction in transplants, from 11 in March to 6 in April
- The Easter bank holiday was on 4th April.

These figures are calculated on a total bed base of 83 beds. There are a further 4 beds on ward 3 which have been agreed to be used as 'escalation beds' to help the Trust with winter/covid-19 pressures. These beds have not been used at all during April 2021.

The Trust has been predominantly on OPEL 1(Green) during April 2021, however OPEL 3 has been recorded on 3 separate occasions; 1 occasion for solid tumour wards and 2 occasions for HO wards.

The bed pressures from the Covid-19 pandemic have continued to ease, with the number of Covid-19 positive patients also being reduced at CCC-Liverpool. No Mutual Aid patients have been transferred across to CCC Liverpool in April 2021. The Patient Flow Team and the wider MDT continue to proactively discharge plan to ensure that patients are in the safest place for them during the COVID-19 pandemic.

Action taken to improve compliance

- The Patient Flow Team continue to liaise with Acute Oncology to ensure that we are offering oncology beds to our patients when they are required.

Expected date of compliance	Q1 2021/22
Escalation route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Integrated Governance Committee, Quality Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

Radiology Reporting: Outpatients (within 7 days)	Target	April 21	YTD	Last 12 Months
	G: ≥90% A: 80-89.9% R: <80%	82.8%	82.8%	

Reason for non-compliance

The outpatient target has not been met, at 82.8% against a target of 90%. This has fallen from 87.7% in March 2021. The inpatient target has been achieved every month since May 2020. Reasons for the fall in compliance include:

- An increase in activity levels; placing increasing demands on the existing Radiology team.
- Loss of reporting capacity due to Radiologists supporting the IR and US clinical services.
- Increase in Radiologists' annual leave over the Easter period.

Action taken to improve compliance

- An increased number of cases for outsourcing to Medica is underway to try to keep the turnaround times within target.
- Capacity and demand work underway to inform future service needs
- Additional sessions held at weekends and evenings
- Clinical prioritisation process reactivated
- Recruitment is underway for Radiologists. Interviews were held last week, with offers made to 2 candidates; one of whom has accepted.
- A Radiologist recruited in December has been delayed further due to COVID and the current situation in India.
- Bi-weekly report received by senior Radiology team to allow for timely monitoring of the reporting levels.

Expected date of compliance	May 2021
Escalation route	Divisional Performance Review, Performance Committee, Trust Board.
Executive lead	Joan Spencer, Chief Operating Officer/ Interim Chief Nurse

Data Quality - % Ethnicity that is complete (or patient declined to answer)	Target	April 21	YTD	Last 12 Months
	G: 100% R: <100%	94%	94%	

Reason for non-compliance

Performance has dropped this month across all areas with the exception of Radiation Services, which has improved. The drop in performance is likely due to the push for face to face patients to use self-check-in machines which bypass reception desks. The Digital team have confirmed that

ethnicity cannot currently be included in the check-in questions, however there is a Digital work stream around reviewing how the Trust is using the self-check-in system.
Action taken to improve compliance • Continue with pre-clinic clerks obtaining this data • Patients' ethnicity has been included in the revised IPT form which is due for rollout as part of the Digital Referral project (go-live Summer 2021) • Recruitment to fill clerical posts has commenced, one of these posts will be placed within HO area which has the lowest score of 89.2%

Expected date of compliance	September 2021
Escalation route	Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

2.3 Quality

Serious Untoward Incidents (month reported to STEIS)	**Target**	**April 21**	**YTD**	**Last 12 Months**
	R: >0 G: 0	1	1	

Reason for non-compliance

A patient received 2 cycles of chemotherapy at a higher dosage than required and was admitted to another Trust suffering from extreme side effects. The patient fully recovered and is now on the correct dose.

An issue with Meditech has been identified that did not record a change made to a patient's weight in the prescribing module.

Action taken to improve compliance

- A 72 hour review was completed.
- Duty of Candour stage 1 has been completed with the patient.
- Statements have been requested from all staff involved in the care of the patient.
- All relevant policies, protocols and documents have been requested for review.
- Review of Meditech documentation for the patient was undertaken which identified anomalies in the weight information stored for this patient in different modules of the system.
- The issue has been flagged to Meditech; remedial work completed and in testing phase.
- A communication has been sent out to clinical staff, to remind them of vigilance when inputting and checking height and weight due to the issue identified.
- An SI review panel meeting was held on 6th May 2021 to discuss the issues, agree terms of reference and start to consider the recommendations and actions.

• A wider review has been undertaken to identify any further instances of this issue. The outcome provides assurance that this issue has caused no harm to other patients.	
Expected Date of Compliance	SUI report is due for submission on 15/07/2021
Escalation Route	Divisional Quality, Safety and Performance Meetings, LIRG, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Director Lead	Joan Spencer: Chief Operating Officer / Interim Chief Nurse

RIDDOR	**Target**	**April 21**	**YTD**	**Last 12 Months**
	R: >0 G: 0	1	1	

Reason for non-compliance

A patient sustained a fractured arm after falling outside the CCCL building.

The incident has been reported to the HSE as the fracture occurred on Trust property. An investigation has been carried out, however the Trust has been unable to confirm the exact mechanism of injury.

Action taken to improve compliance

A drain pipe has been further secured with plastic ties and photographic evidence has been uploaded to Datix.

Expected date of compliance	April 2021
Escalation route	Divisional Quality, Safety and Performance Meetings, LIRG, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive lead	Joan Spencer: Chief Operating Officer / Interim Chief Nurse

Clostridioides difficile infections (attributable)	**Target**	**April 21**	**YTD**	**Last 12 Months**
	R: >4 per year G: ≤4 per year	1	1	

Reason for non-compliance

The patient was admitted on to Ward 4; a stool sample was obtained, which identified CDI. The patient was commenced on IV Tazocin for suspected sepsis in line with Trust Formulary. An episode of loose stool was documented on 14th April 2021; however, a sample was not obtained until 15th April 2021.

The Consultant Microbiologist determined that the infection was likely to be as a result of anti-microbial exposure. As anti-microbials were prescribed in line with Trust formulary, the infection could not have been avoided. An identified learning point from this episode of infection was that the sample should have been obtained following the first episode of loose stool on 14th April 2021, as per CDI Policy.
Action taken to improve compliance Ward 4 are developing an action plan to improve compliance with timely stool sampling.

Expected Date of Compliance	May 2021
Escalation Route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Director Lead	Joan Spencer: Chief Operating Officer / Interim Chief Nurse

Klebsiella (attributable)	**Target**	**April 21**	**YTD**	**Last 12 Months**
	R: >10 per year A: 10 per year G: ≤9 per year	1	1	

Reason for non-compliance

The patient was admitted to Ward 3; blood cultures were collected and identified mixed gram negative bacteria (klebsiella pneumoniae, klebsiella oxytoca and Enterobacter clocae).

The patient was admitted with locally advanced pancreatic cancer and worsening ascites, complicated by liver abscesses, requiring 6 weeks of antibiotic therapy.

The patient was reviewed by the Consultant Microbiologist, who determined that the liver abscesses were the most likely source of infection and in keeping with identification mixed gram negative bacteria.

Action taken to improve compliance	
This infection was a result of the liver abscesses associated with the patients' deteriorating condition and could not have been avoided. The Consultant Microbiologist's review identified no lapses in care.	
Expected Date of Compliance	May 2021
Escalation Route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Director Lead	Joan Spencer: Chief Operating Officer / Interim Chief Nurse

% of routine formal complaints resolved in month, which were resolved within 25 working days	**Target**	**April 21**	**YTD**	**Last 12 Months**
	R: <65% A: 65-74.9% G: 75%	**25%**	**25%**	

Reason for non-compliance

The management of complaints is significantly improving, with 4 complaints closed in April 2021. However, only 1 of these complaints was closed within the 25 working day target. Details of the 3 complaints which were not closed in time are as follows:

Complaint 1:

- Complaint received 02/02/2021 with response due on 09/03/2021.
- Patient was contacted on 11/02/2021 to discuss the complaint and to clarify the issues to be reviewed.
- On 16/03/2021 the Consultant requested further input to the response.
- The final response was sent to the patient on 06/04/2021.

Complaint 2:

- Complaint received 16/02/2021 with response due on 24/03/2021.
- Due to consultant leave, no medical input was obtained until 02/03/2021.
- There were delays in drafting the final response.
- Final response letter signed and sent to patient on 21/04/2021.
- Complainant was kept informed of the delays on a regular basis throughout the investigation.

Complaint 3:

- Complaint received 08/03/2021 with response due on 14/04/2021.
- The complainant was a relative who lived abroad. As the patient's health deteriorated, the focus for the team was supporting the complainant to return home during the covid pandemic to be with the patient.
- A resolution meeting was held with the complainant on 19/04/2021 and complaint closed.

Action taken to improve compliance

- Complaints are now discussed on a regular basis within the divisions to monitor timescales and potential barriers to completion.
- The following changes are being made to the Complaints Policy:
  - Introduction of a KPI of complainants being contacted within 2 working days of receiving the complaint
  - The draft final response will be submitted directly from the divisional team to the CEO for sign off.

Expected Date of Compliance	June 2021
Escalation Route	Divisional Quality, Safety and Performance meetings, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Director Lead	Joan Spencer: Chief Operating Officer / Interim Chief Nurse

% of Policies in Date	Target	April 21	YTD	Last 12 Months
	R: <93% A: 93-94.9% G: =>95%	94.3%	94.3%	

Reason for non-compliance

Out of a total of 264 policies, fifteen were out of date at the end of April 2021, resulting in a compliance figure of 94.3%

All fifteen of the policies are between one and three months out of date. A summary of the status of the policy reviews is as follows:

- One policy has been assigned a new author after a member of staff has left the Trust and is therefore currently under review
- Five policies have been reviewed and approved but have not yet been sent through to document control; further reminders have been sent
- Four policies are awaiting virtual approval
- Five policies are currently under review

Action taken to improve compliance

- Policy review reminders and instructions are sent to individual authors in advance of the review due dates
- Weekly out of date policies report provided to Associate Director of Corporate Governance, and escalation of any major issues
- Out of date policy information is provided for review at monthly Divisional meetings and Performance Reviews.
- Bi-monthly Document Control update reports are presented at the Information Governance Board

Action taken to improve compliance • Promotion of policy self-management with Document Owners - ongoing • Targeted meetings being held between Information Governance staff and Document Owners - ongoing • Undertake comprehensive training/overview of QPulse functionality with Ideagen to investigate greater use of automation e.g. policy review reminders to Document Owners – Initial training cancelled April 2020 due to COVID-19 and rescheduled for May 2021.	
Expected Date of Compliance	May 2021
Escalation Route	Associate Director of Corporate Governance, Information Governance Board, Integrated Governance Committee, Divisional Performance Review, Quality Committee, Trust Board
Executive Director Lead	Liz Bishop, Chief Executive

2.4 Research and Innovation

Study Recruitment	**Target**	**April 21**	**YTD**	**Last 12 Months**
	1300	**38**	**38**	

Reason for non-compliance

38 patients have been recruited against an internal target of 108 at the end of Month 1. R&I have not met target for a number of reasons including:

- R&I remain in business continuity for solid tumour research nursing staff.
- Issues relating to the Aseptic Pharmacy Service means that open studies using this service have been paused and no new studies have opened since 5th March 2021.
- A number of studies that were paused were closed to recruitment early by the sponsor as they had met the national target.
- A number of the higher recruiting studies have recently closed to recruitment.
- Trial pipeline not as high as usual due to aseptic studies not opening.
- Radiotherapy studies impacted due to staff sickness.
- No Site Qualification Visits have taken place.

Action Taken to improve compliance

- A number of new solid tumour research nursing staff are starting in May 2021 at which point R&I will be out of business continuity.
- Once out of business continuity Site Qualification Visits will be reinstated for new studies (not involving pharmacy) initially.
- Unpause 'open' aseptic studies as there is a 4-6 week time lag before patients will need treatment. Agreed with Interim Chief Pharmacist.
- Exploring opening 'new' studies whilst not putting pressure on the system.
- Exploring diversifying the portfolio: Observational / real world studies.
- Radiotherapy studies continue to recruit well particularly for Urology. Additional resource recently approved from the new Research Strategy to support this workstream. Recently opened a number of new radiotherapy studies.
- Increased Research Officer support to see increased recruitment.
- Number of nursing and psychology studies in the pipeline.
- Number of observational data studies previously put on hold by sponsor are due to have a Site Initiation Visit in May/June 2021.

Expected date of compliance	Q3 21/22
Escalation route	SRG Research Leads, Committee for Research Strategy, Performance Committee, Trust Board
Executive Lead	Sheena Khanduri, Medical Director

Studies opening to recruitment	**Target**	**April 21**	**YTD**	**Last 12 Months**
	52	1	1	

Reason for non-compliance

One study has been opened to recruitment during April 2021 against an internal target of four. We have not met target for the following reasons:

- Currently there is a halt to opening new studies to recruitment that use the Pharmacy Aseptic Service. This started on 5th March 2021.
- However, CCC has issued Confirmation of Capacity and Capability (C&C) for three additional studies in April 2021 and we are waiting on Sponsor Greenlight for two.
- There is currently a total of seven studies where CCC has issued C&C that we have Sponsor Greenlight outstanding.

Action Taken to improve compliance • Work with Interim Chief Pharmacist to start opening new studies that use the Aseptic Service. • Work with the SRG Research Leads and the Network to optimise opportunities. • Work with Sponsors to greenlight studies where local approval has been given one capacity has been agreed with Pharmacy.	
Expected date of compliance	Q3 21/22
Escalation route	SRG Research Leads, Committee for Research Strategy, Performance Committee, Trust Board
Executive Lead	Sheena Khanduri, Medical Director

Publications	**Target**	**April 21**	**YTD**	**Last 12 Months**
	130	5	5	This is a new KPI. The chart will be shown from M2
Reason for non-compliance Five publications have been registered during April 2021 against an internal target of nine. There will be peaks and troughs with the number of publications throughout the year. This is dependent on journal review, journal publication and validation of outcome data. We would expect to see an increase around conference season.				
Action Taken to improve compliance • Work with the Library Services to ensure all publications are captured. • Work with the SRG Research Leads and academics to ensure the list is accurate. • Encourage staff to submit publications as part of the 'Achievements' request that is sent out each month.				
Expected date of compliance	Q3 21/22			
Escalation route	SRG Research Leads, Committee for Research Strategy, Performance Committee, Trust Board			
Executive Lead	Sheena Khanduri, Medical Director			

2.5 Workforce

Turnover	Target (in month)	April 21	Target (12 month rolling)	12 month rolling	Last 12 Months (monthly figures)
	G: ≤1.2%, A: 1.21– 1.24%, R: ≥1.25%	1.66%	G: ≤14%, A: 14.1 - 14.9%, R: ≥15%	14.76%	

Reason for non-compliance

There were 28 leavers across the Trust in April 2021. This is an increase of 8 leavers since March 2021.

Reasons for leaving in April 2021 are displayed below:

Reason for leaving:	Number of leavers:
Work life balance	7
Retirement	5
End of Fixed Term Contract	3
Health	3
Promotion	3
To undertake further education/ training	2
Incompatible working relationships	1
Better reward package	1
Relocation	1
Child dependents	1
Other/ not known	1

Work life balance was the highest reason for leaving. The areas with the highest number of leavers due to this were Pharmacy (2) and CDU/ Hotline (2). Retirement was the second highest reason for leaving with 5 in total from a number of areas all with one leaver each (Diagnostic Imaging, ICD Managers, Safeguarding, Physics and Radiotherapy).

A breakdown of leavers from each Division is displayed below:

Division:	Number of leavers:
Acute Care	11
Networked Services	9
Radiation Services	4
Support Services	3
Corporate Services	1

Acute Care had the highest number of leavers with 11 in total. The team within Acute Care with the highest number of leavers was Inpatient Care with 9 leavers followed by Pharmacy with 2.

Ward 2 and CDU/ Hotline had the highest number of leavers within Inpatient Care both with 3 leavers each followed by Ward 3, Ward 4 and ICD Managers with 1 leaver each.

Reasons for leaving within Inpatient Care is displayed below:

Reason for leaving:	Number of leavers:
Work life balance	4
End of Fixed Term Contract	3
Retirement	1
Relocation	1

CDU/ Hotline had the highest number of leavers due to work life balance with 2 followed by Ward 2 and Ward 4 with 1 leaver.

There has been an increase in leavers due to End of Fixed Term Contract in Inpatient Care. These are all student nurse posts that were introduced to help support the Trust during the peak of the Covid-19 pandemic.

Networked Services had the second highest number of leavers in April 2021. Day Care and Network experienced the highest with 4 leavers in total followed by Outpatients and Clinical Support with 3. The Admin team had just one leaver.

Reasons for leaving within Networked Services are displayed below:

Reason for leaving:	Number of leavers:
Health	3
Promotion	3
Better Reward Package	1
Child dependents	1
Other/ Not known	1

Day Care and Network had the highest number of leavers due to Health with 2 in total followed by Admin with 1 leaver.

Of the 28 leavers in April 2021, 11 completed an exit interview. The reasons for leaving recorded on their exit interviews varied from; New post within the NHS (6) Other (11), Due to child care reasons (1) Personal reasons (1) and Retirement (1).

Factors that influenced their decision to leave can be found below:

Factors that influenced decision to leave (as per exit interview):	Number of leavers who cited reason:
Bullying & Harassment	2
Lack of Career Opportunities	3
Relocation	2
Management Style	1
Workload pressures	3
Work life balance	5
Career Change	1
Full time childcare	1
Full time education	1
Retirement	1
Due to move to CCCL	1

Action Taken to improve compliance

- Amendment made to the Exit Interview process (WOD Apprentice now sends reminders to complete Exit Interviews as well as line managers) to improve data received from leavers.
- Amendments made to Exit Interview questions to ensure appropriate data is gathered.

- Exit Interviews are reviewed monthly by the HR Business Partnering team to ensure that concerns are addressed, and improvements made if necessary.
- Temperature Checks surveys are reviewed monthly by staff who have been in post for 3 and 9 months to ensure that any concerns that are raised are addressed in order to help retain staff.
- Nursing retention plan continues to be monitored via the Workforce Transformation Committee

Action Taken to improve compliance

- In line with the NHS People Plan, the HR Business Partnering Team plan to develop a Flexible Working Promise and launch more communications across the Trust about the positives of flexible working to ensure managers understand the benefits and flexible working is being offered where appropriate in order to recruit and retain staff.

Expected date of compliance	September 2021
Escalation route	Divisional Performance Reviews, Workforce Transformation Committee, Quality Committee, Trust Board
Executive Lead	Jayne Shaw, Director of Workforce and OD

PADR	**Target**	**April 21**	**Last 12 Months**
	G: ≥95% A: 75% - 94.9% R: ≤74%	90.14%	

Reason for non-compliance

Overall Trust compliance for PADRs has not been achieved since September 2020 but is now higher than the same period in both 2020/21 and 2019/20.

As previously highlighted, alignment of PADR dates to pay progression dates has now been implemented and as of 1st April, the Trust has formally removed the window approach to PADR completion and moved to the rolling 12-month cycle (in line with the NHS Terms and Conditions for pay progression).

Action taken to improve compliance

- Continue to issue managers and staff with a personalised email, 3 months before their appraisal is due.
- Continue to provide comprehensive training and support to both staff and managers on all aspects of PADRs.
- Issue Divisions with a 12-month roadmap for PADR completions in May 2021 to further support compliance planning and achievement of KPI.

• Continue to educate staff and managers on the new pay progression implications of staff not having an in-date appraisal. • Divisions underperforming against the KPI will be required to add this to their divisional risk register

Expected date of compliance	30th June 2021
Escalation route	Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Cheshire & Merseyside Cancer Alliance

Performance Report

May 2021

Version 1

Contents

Section I: Summary

Restoration of cancer services

The Cheshire and Merseyside Cancer Alliance is providing system leadership and operational oversight for the restoration of cancer services. The restoration is focusing on three objectives, namely:

- To create sufficient **capacity** to ensure that patients who have had their care pathways disrupted are delayed no further, and ensure that all newly referred patients are diagnosed and treated promptly;
- To ensure **equity of access** across the system so that patients are not disadvantaged because of local capacity constraints;
- To build **patient confidence** – patients need to be reassured that their diagnosis and treatment will take place in an environment and manner that is safe.

Measure	% of pre-Covid level
2WW referrals	120%
Cancer surgery activity	105%
SACT (inc chemo) delivery	118%

Measure	% of pre-Covid level
Radiotherapy planning	94%
Radiotherapy treatment	78%
Endoscopy capacity*	80%

- There is sufficient capacity within SACT and radiotherapy to manage current demand. Lower levels of radiotherapy treatment reflect the adoption of new treatment regimes such as hypofractionation.
- Endoscopy capacity has more than doubled since August 2020, but further capacity is required in order to clear the backlog of patients on the endoscopy waiting list. The Alliance has established an endoscopy operational recovery team (EORT) to oversee and co-ordinate restoration activities.

Cheshire & Merseyside Cancer Alliance

*Assessment based on monthly DM01 endoscopy returns only. Previous board reports compared local weekly sitrep to pre-pandemic DM01.

Summary

Cancer waiting times performance

The latest published 14 day and 62 day cancer waiting times performance data relate to **March 2021**.

The Alliance achieved the **14 day standard** for urgent suspected cancer referrals in March, with just three trusts and two CCGs falling below the 93% threshold. The overall performance of the Alliance was 94.87%, up from 93.53% last month. The England average was 91.25%. CMCA was the 7th best performing Alliance in England out of 19 against this standard.

The Alliance failed the **62 day standard**, achieving 76.47% (up from 71.23% last month) against a standard of 85% (England average was 73.94%). Seven trusts and six CCGs failed to meet the 62 day standard. Cheshire and Merseyside is the 11th best performing Alliance in England out of 19 against this standard.

The number of patients waiting **over 62 days** is significantly higher than pre-Covid levels. On 10th May 2021 there were 966 patients waiting more than 62 days for a diagnosis or treatment. This has decreased from 1,042 reported last month.

Of these, 250 have waited **over 104 days**. This has decreased from 337 reported last month.

Cheshire & Merseyside Cancer Alliance

Section II: Restoration of Cancer Services – Core Metrics

1. TWW referrals received in last 7 days

Referrals were similar to Easter bank holiday weeks and to non-bank holiday pre-pandemic average levels.

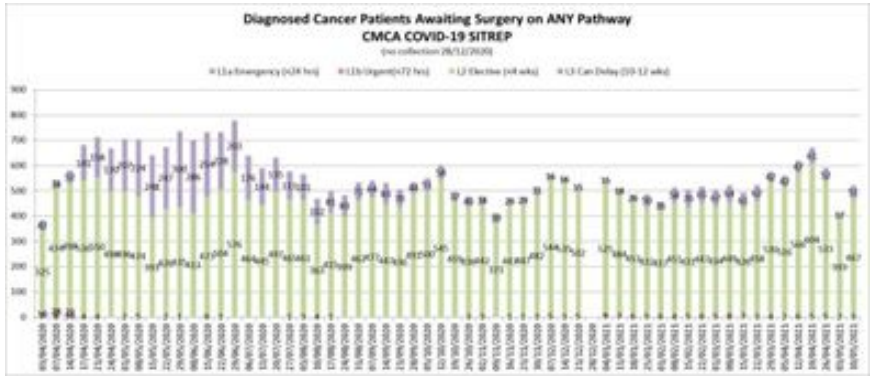
Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP.

2. Diagnostic backlog (referrals without a DTT)

Currently 9,258 active patients, of which 9 are suspended.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. No collection 28/12/2020.

3. Cancer patients awaiting surgery



521 patients with a surgical DTT. 470 at L1&L2 and 51 at L3.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. No collection 28/12/2020. Very limited LUTH data for 03/05/2021

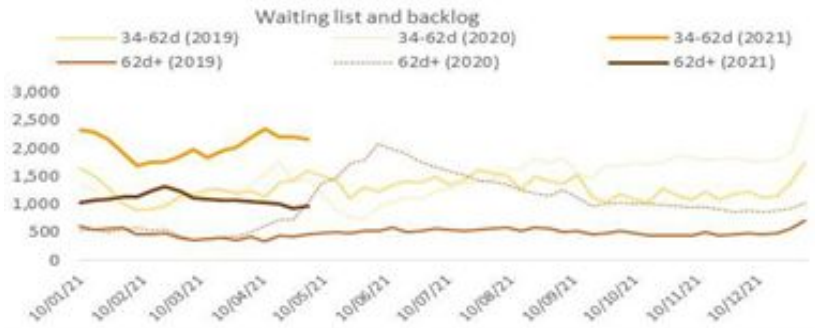
4. Cancer surgery performed in last 7 days

264 cancer operations, of which 6 were through the surgical hub.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. No collection 28/12/2020. Very limited LUTH data for 03/05/2021

Restoration of Cancer Services – Core Metrics

5. Patients waiting over 62 days



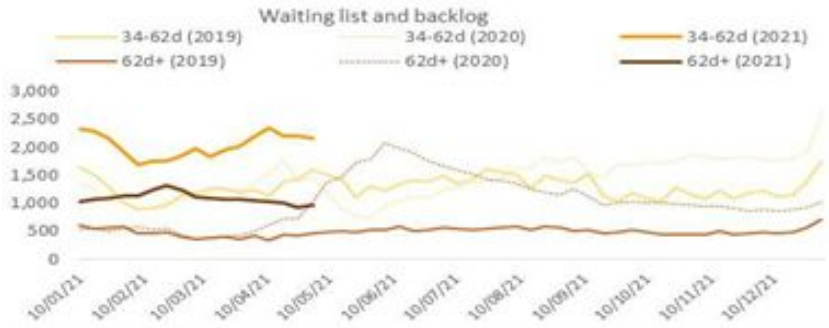
966* patients have waited over 62 days

- Up from 933 in previous week

*Bridgewater PTL estimated from previous week due to non-submission

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. For w/e 04/04/2021, Wirral data not submitted nationally but added locally

6. Patients waiting over 104 days



298* patients have waited over 104 days

- Up from 280 in previous week

*Bridgewater PTL estimated from previous week due to non submission

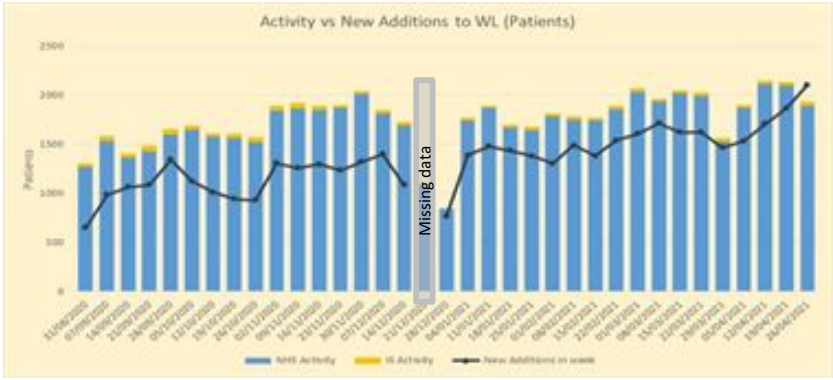
Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. For w/e 04/04/2021, Wirral data not submitted nationally but added locally

7. Endoscopy waiting list

Endoscopy waiting list similar to previous weeks at 10,103.

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. No data from East Cheshire or Mid Cheshire 14/12/20; No collection 21/12/2020

8. Endoscopy activity



Activity fell slightly, with 1,928 patients seen. However new additions to the waiting list rose sharply (to 2,102).

Data Quality Issues: No data from East Cheshire 14/12/20; no new additions collection 21/12/20

9. Patients waiting between 63 and 103 days by provider

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total
Bridgewater															
Clatterbridge						5							7		**29**
Countess Of Chester		5	8			25					9	9	13		**72**
East Cheshire						14									**21**
Liverpool Foundation Trust		5			17	130					10	50	13		**232**
Liverpool Heart & Chest															
Liverpool Women's			22												**22**
Mid Cheshire						13							6		**40**
Southport & Ormskirk			14			11							11		**44**
St Helens & Knowsley			9		11	22					6	5	11		**69**
Walton Centre															
Warrington & Halton			5			38							15		**63**
Wirral						18							13		**36**
Grand Total		**16**	**66**	**12**	**44**	**276**	**12**			**5**	**31**	**74**	**89**		**629**

Cheshire & Merseyside Cancer Alliance

Tables from national Cancer PTL
Up to 02 May 2021

10. Patients waiting over 104 days by provider

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total
Bridgewater															
Clatterbridge													5		**12**
Countess Of Chester						12					5				**28**
East Cheshire															
Liverpool Foundation Trust					9	75						15	15		**122**
Liverpool Heart & Chest															
Liverpool Women's			14												**14**
Mid Cheshire						7									**8**
Southport & Ormskirk															**10**
St Helens & Knowsley						7									**15**
Walton Centre															
Warrington & Halton						9							9		**23**
Wirral													7		**15**
Grand Total		**7**	**27**		**11**	**122**					**12**	**21**	**45**		**250**

From 29 November 2020, data source changed from CMCA SITREP to national weekly PTL

- Data no longer split out for acute leukaemia or testicular
- New data for non site specific symptoms referrals

= fewer than 5 patients or hidden to prevent disclosure

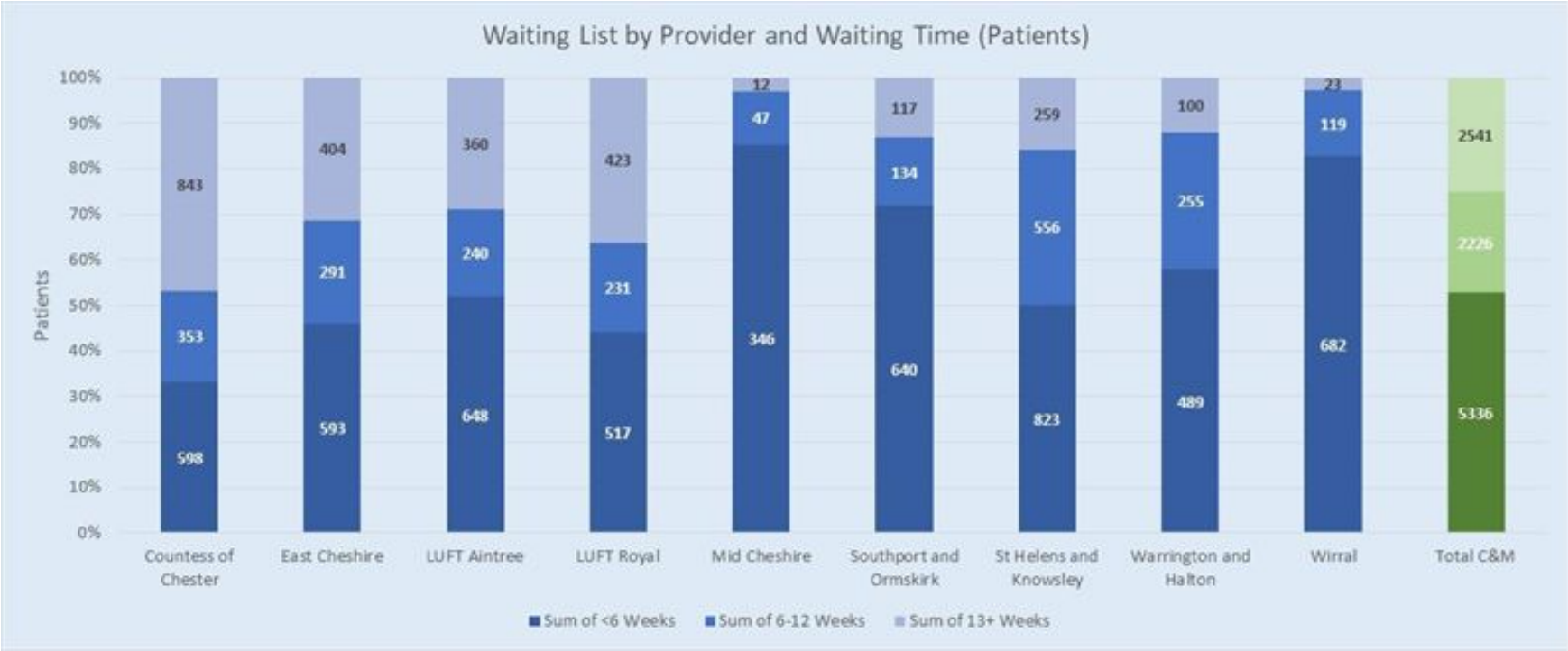
= No PTL submission this week

Restoration of Cancer Services – Core Metrics

Endoscopy (cancer and non-cancer pathways)

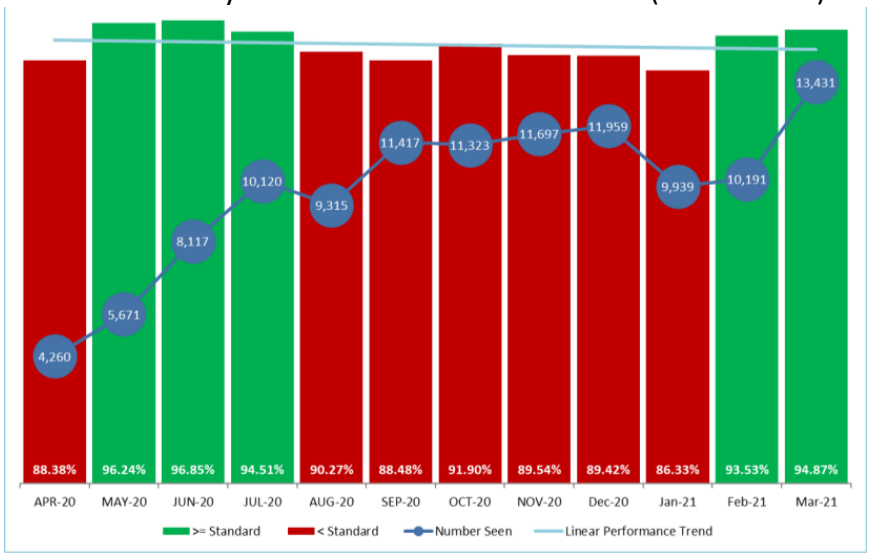
There are currently 10,103 patients waiting for an endoscopy. 4,767 have waited more than six weeks, and of these 2,541 have waited 13 or more weeks (25% of the total).

There is significant variation across units, with CoCH, LUFT and East Cheshire having the greatest proportion of their waiting list made up of patients waiting 13 weeks or more (47%, 32% and 31% respectively).



Section II: 14 day and 28 day standards

14 Day Referral to First Seen Standard (March 2021)



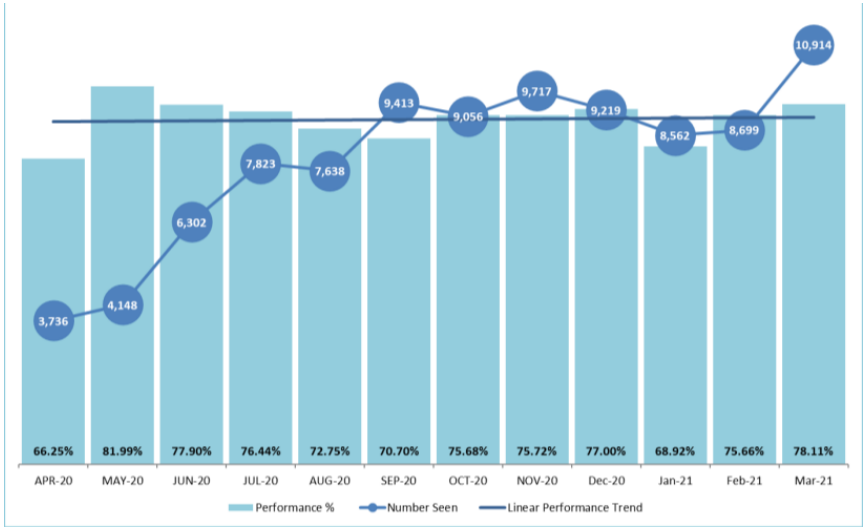
The following trusts did not meet the standard (93%):

- Countess of Chester (74.46%)
- East Cheshire (90.43%)
- Southport and Ormskirk (90.6%)

The following CCGs did not meet the standard:

- NHS Cheshire CCG (89.74%)
- NHS Southport and Formby CCG (91.23%)

28 Day Faster Diagnosis Standard (March 2021)



The 28 day FDS standard is still being shadow monitored. The standard is expected to be 75%. The following providers did not achieve 75%:

- Bridgewater (65.71%)
- Countess of Chester (67.27%)
- Liverpool University (74.77%)
- Liverpool Women's (68.89%)
- Southport and Ormskirk (72.96%)

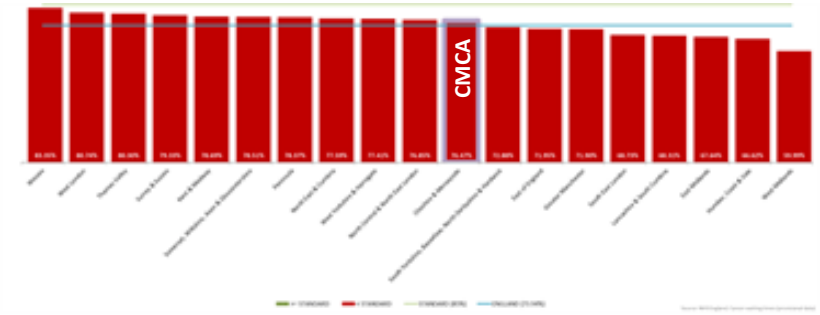
The following CCGs did not achieve 75%:

NHS South Sefton CCG (72.05%)
NHS Liverpool CCG (74.38%)

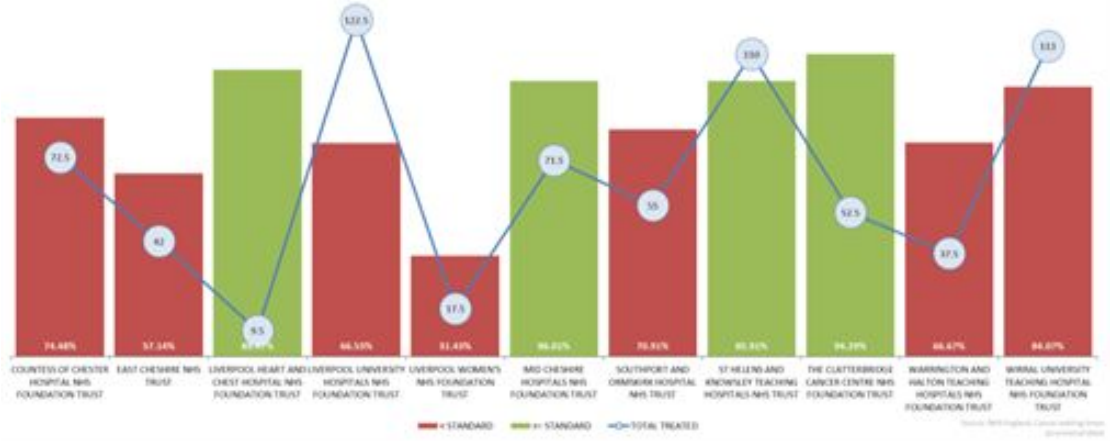
- NHS Southport & Formby CCG (73.65%)

Section III: 62 Day Standard

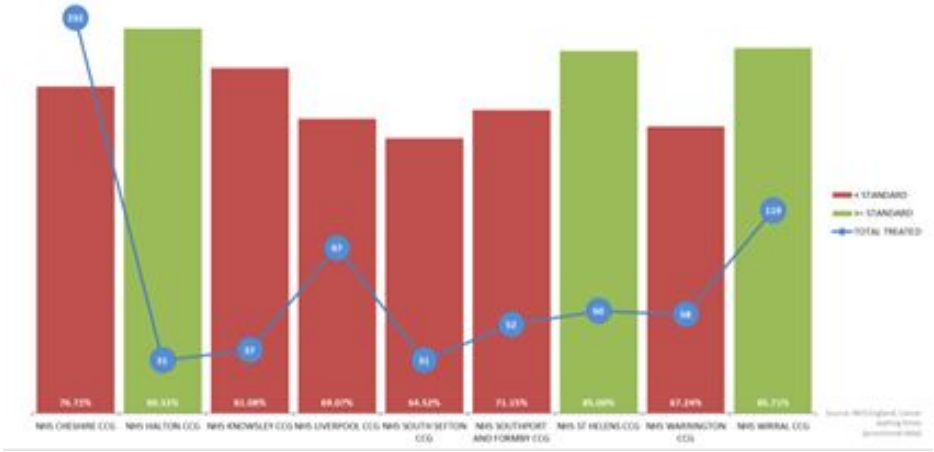
62 Day Performance by Cancer Alliance (March 2021)



CMCA achieved 76.47% against a standard of 85%.
CMCA was the eleventh best performer. The England average was 73.94%



62 Day Performance by CCG (March 2021)



Most Challenged Pathways (March 2021)

Non-compliance with the 62 day standard in March 2021 was largely driven by underperformance in the following tumour groups:

- Urology 41.5% (down from 62.83% last month)
- Lower Gastrointestinal 67.13% (up from 44.5%)
- Upper GI 49.5% (down from 65.75%)
- Gynaecology 49.35% (up from 29.58%)

Cheshire & Merseyside Cancer Alliance

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Cheshire and Merseyside Cancer Alliance is an NHS organisation that brings together NHS providers, commissioners, patients, cancer research institutions and voluntary & charitable sector partners to improve cancer outcomes for our local population.

The Clatterbridge Cancer Centre NHS Foundation Trust

Report Cover Sheet

Report to:	Trust Board	
Date of the Meeting:	26 May 2021	
Agenda Item:	P1-086-21	
Title:	Finance Report Month 1	
Report prepared by:	Lucy Blackhurst, Head of Financial Planning	
Executive Lead:	James Thomson, Director of Finance	
Status of the Report:	Public	Private
	X	

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

Purpose of the Paper/Key Points for Discussion:	To present the Trust's financial performance for the month 1 of financial year 2021/22

Action Required:	Discuss	X
	Approve	
	For Information/Noting	X

Next steps required	The Trust Board will be informed of progress against the plan on a regular basis in accordance with the Board Reporting Cycle.

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

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

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

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

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

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

Finance Board Paper
26th May 2021

Financial Performance Report

1. Introduction

1.1 This paper provides a summary of the Trust's financial performance for April 2021, the first month of the 2021-22 financial year.

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

2. Summary Financial Performance

2.1 For April the key financial headlines are:

Metric	Mth 1 Actual	Mth 1 Plan	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit) (£000)	31	35	(4)		(31)	(35)	4	
Cash holding (£000)	52,160	53,451	(1,291)		52,160	53,451	(1,291)	
Capital Expenditure (£000)	7	0	7		7	0	(7)	

*The plan for M1 reflects 1/6th of the plan agreed with Cheshire and Mersey ICS for M1-6 2021-22 of £211k surplus.

3. Operational Financial Profile – Income and Expenditure

3.1 Overall Income and Expenditure Position

The month 1 financial position to the end of April is £4k over spent. Cash is showing a closing balance of £52.2m which is £1.3m below planned cash. Capital spend is £7k in month.

**Please note subsidiaries are not included in the report due to timing.*

3.1.1 The table below summarises. Please see Appendix 1 for the more detailed Income & Expenditure position.

Metric (£000)	YTD Actual M1	Trust Plan YTD	Variance	Trust Annual Plan
Clinical Income	15,914	16,275	(360)	195,282
Other Income	1,515	1,666	(151)	19,911
Total Operating Income	**17,430**	**17,941**	**(511)**	**215,194**
Total Operating Expenditure	(17,008)	(17,584)	576	(210,912)
Operating Surplus	**422**	**357**	**65**	**4,281**
JV Profit		67	(67)	804
Finance Costs	(391)	(389)	(2)	(4,663)
Trust Surplus/Deficit	**31**	**35**	**(4)**	**422**

3.2 Expenditure position

3.2.1 Highlights in relation to the in month position for April are as follows:

- Drug expenditure reduced by £370k against plan, however, this is offset with a reduction in income. As part of the 21-22 commissioner agreement high cost drugs remain pass through.
- Pay costs are £215k under plan. Budgets have been set to reflect fully established staffing levels, however, there are still a number of vacancies and pay underspends can be seen across all Direcorates.
- JV profit has not been assumed in M1 causing a pressure of £67k.

3.2.2 In terms of directorate budgetary performance, the April position is shown in the table below.

The in month directorate pay position for April shows that operational departments are operating below plan. Pay is underspent against all Directorates, excluding corporate where the CIP target is currently being held centrally. Drugs spend is showing an overall underspend of £374k, offset by an under recovery of PBR income against plan. In general, excluding drugs, the Directorates are near break-even against non- pay budgets, excluding our corporate budgets where the non-pay element of CIP is being held centrally.

£000	Pay			Non-Pay			Total Expenditure
	Budget	Actual	Variance	Budget	Actual	Variance	Variance
ACUTE CARE DIRECTORATE	1,606	1,492	**(114)**	683	668	**(16)**	**(130)**
CORPORATE DIRECTORATE	820	1,003	**183**	2,505	2,742	**237**	**421**
NETWORK DIRECTORATE	1,620	1,539	**(81)**	580	586	**6**	**(75)**
RADIATION SERVICES DIRECTO	1,515	1,489	**(26)**	327	331	**4**	**(22)**
RESEARCH DIRECTORATE	367	262	**(105)**	41	68	**27**	**(78)**
DRUGS	0	0	**0**	6,745	6,372	**(374)**	**(374)**
Sub-Total Operating	**5,929**	**5,785**	**(143)**	**10,882**	**10,767**	**(115)**	**(258)**
HOSTED SERVICES DIRECTORA	199	126	**(72)**	606	396	**(210)**	**(282)**
NON OPERATING COSTS	0	0	**0**	322	324	**2**	**2**
TOTAL	**6,127**	**5,912**	**(216)**	**11,809**	**11,487**	**(323)**	**(538)**

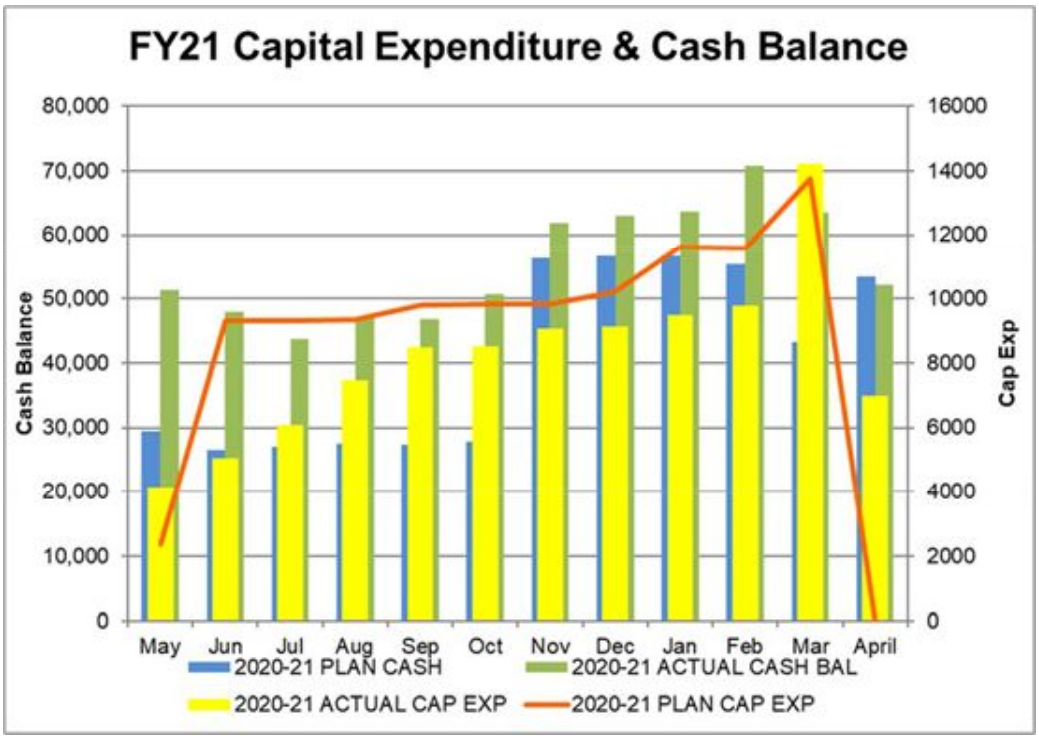
3.3 Bank and Agency Reporting

Bank spend as at month 1 is £91k, a decrease compared to previous months. Agency spend in month is £61k which is similar to previous months. See appendix C for further detail.

3.4 Cost Improvement Programme (CIP)

CIP has been set at 2.0% which equates to £1.9m (excluding drugs and hosted services). This is the requirement to bridge the planning gap and allow critical investments to be funded. Appendix B shows the indicative split by Directorate.

4. Cash and Capital



This chart shows monthly planned and actual Cash Balances and Planned Capital Expenditure for a rolling 12 month to April 2021. It shows that for April the Trust has slightly less cash than planned.

5. Recommendations

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

- The Trust financial plan for 2021-22
- The April financial position
- The continuing strong liquidity position of the Trust

Appendix A – Capital

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

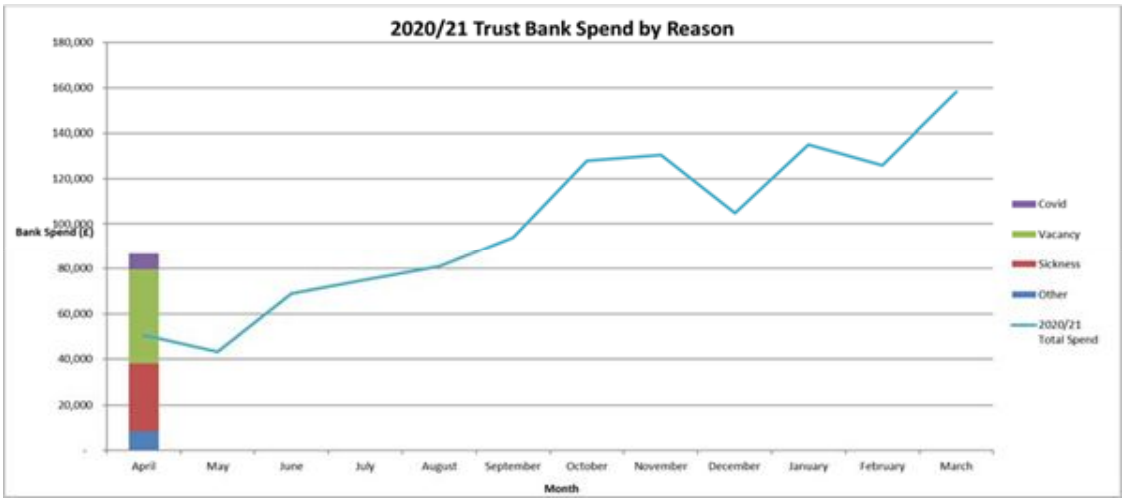
Capital Programme 2021-22
Month 1

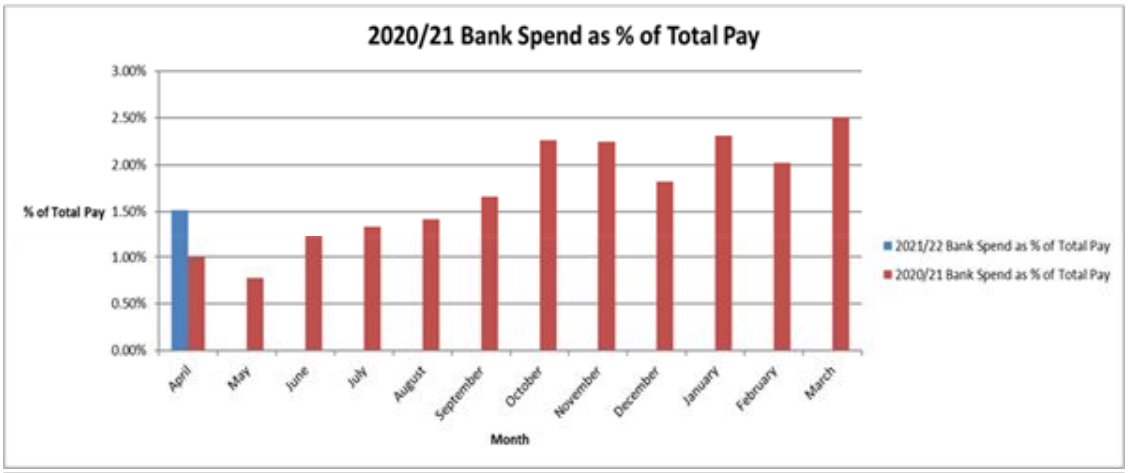
Code	Scheme	Lead	BUDGET			ACTUALS		FORECAST		Comments
			NHSI plan 21-22	Approved Adjustments	Budget 21-22	Actuals @ Month 1	Variance to Budget	Forecast 21-22	Variance to Budget	
4195	(20/21) CCCA Linacc Oak refurb		0	0	0	-4	4	0	0	
tbc	CCCA Linac Bunker - Maple	Richard Clements	420	0	420	0	420	420	0	
4300	CCCW CT Simulator (Brilliance 2)	Julie Massey	300	0	300	0	300	300	0	
	Contingency		200	0	200	0	200	200	0	
	Estates		**920**	**0**	**920**	**-4**	**924**	**920**	**0**	
tbc	CCCA Linear Accelerator - Maple	Richard Clements	2,460	0	2,460	0	2,460	2,460	0	
tbc	CCCL Mobile Imagine Intensifier	Julie Massey	138	0	138	0	138	138	0	
tbc	Minor medical equipment	Julie Massey	227	0	227	0	227	227	0	
4192	Cyclotron	Carl Rowbottom	742	0	742	7	735	742	0	PDC Funded
4300	CCCW CT Simulator (Brilliance 2)	Julie Massey	500	0	500	0	500	500	0	
	Contingency		200	0	200	0	200	200	0	
	Medical Equipment		**4,267**	**0**	**4,267**	**7**	**4,260**	**4,267**	**0**	
4190	(20/21) Digital Aspirant	James Crowther	0	0	0	3	-3	0	0	
tbc	Infrastructure	James Crowther	1,350	0	1,350	0	1,350	1,350	0	
tbc	Other minor programmes	James Crowther	250	0	250	0	250	250	0	
	IM&T		**1,600**	**0**	**1,600**	**3**	**1,597**	**1,600**	**0**	
4142	Wirral	Propcare	400	0	400	0	400	400	0	
4142	CCC-L Link Bridge installation	Propcare	0	0	0	0	0	0	0	
	Building for the Future		**400**	**0**	**400**	**0**	**400**	**400**	**0**	
	TOTAL		**7,187**	**0**	**7,187**	**6**	**7,181**	**7,187**	**0**	

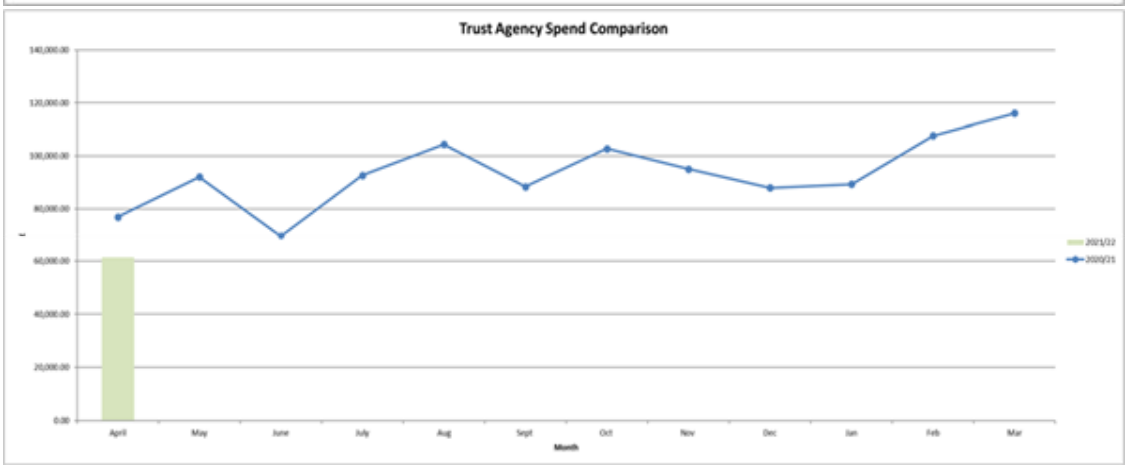
Appendix B – Indicative CIP Targets by Directorate

Directorate	Indicative Budget	CIP	
	£	£	%
ACUTE CARE	27,154,787	582,641	2.1%
NETWORKED	26,531,294	569,263	2.1%
RADIATION SERVICES	22,103,637	474,262	2.1%
COMMUNICATIONS	429,444	9,214	2.1%
EDUCATION	694,608	14,904	2.1%
EXECUTIVE OFFICE	2,948,754	63,269	2.1%
FINANCE	1,876,920	40,272	2.1%
INFORMATICS & IT	5,644,992	121,121	2.1%
PROJECT MANAGEMENT OFFICE	671,184	14,401	2.1%
WORKFORCE & OD	1,986,835	42,630	2.1%
QUALITY	486,780	10,444	2.1%
SAFEGUARDING	454,428	9,750	2.1%
SERVICE IMPROVEMENT TEAM	77,688	1,667	2.1%
OTHER TO BE ALLOCATED	2,151,438	46,162	2.1%
Total Expenditure Budget (excl drugs)	**93,212,789**	**2,000,000**	**2.1%**
Proposed reduction due to lower investments		**(120,000)**	
Potential CIP Figure		**1,880,000**	2.0%

Appendix C – Bank Graphs







The Clatterbridge Cancer Centre NHS Foundation Trust

Report Cover Sheet

Report to:	Trust Board	
Date of the Meeting:	26 May 2021	
Agenda Item:	P1-087-21	
Title:	Board Assurance Framework	
Report prepared by:	Angela Wendzicha, Associate Director of Corporate Governance	
Executive Lead:	Angela Wendzicha, Associate Director of Corporate Governance	
Status of the Report:	Public	Private
	X	

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

Purpose of the Paper/Key Points for Discussion:	The purpose of this report is to give an overview of the revised BAF and to make strategic risks visible to the Board. The report includes: - Risk Appetite Summary - BAF Summary - Overview

Action Required:	Discuss	X
	Approve	X
	For Information/Noting	

Next steps required	Regular reporting of BAF risks to the Board.

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

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

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

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

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

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

Risk Appetite Statement 2021
The Clatterbridge Cancer Centre NHS Foundation Trust recognises that its long term sustainability depends upon the delivery of Strategic Priorities and ambitions in addition to its relationships with service users, staff, public, regulators and strategic partners. As such, The Clatterbridge Cancer Centre NHS Foundation Trust will not accept risks that materially provide a negative impact on patient safety.
In contrast, The Clatterbridge Cancer Centre NHS Foundation Trust has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust has a greater appetite to pursue partnerships, commercial gain and clinical innovation in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment; this includes the development of our Subsidiary Companies. In addition, in pursuit of its Strategic Priorities, The Clatterbridge Cancer Centre NHS Foundation Trust is willing to accept, in some limited circumstances, risks that may result in some limited financial loss or exposure.

BAF Summary						
BAF ID	**Risk**	**Owner**	**Oversight Committee**	**Q1 2021/22**	**Target Risk**	**Risk Appetite**
B1	If we do not have robust Trust-wide quality and clincial governance arrangments in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	CN/MD	Quality Committee	3x4=12	2x1=2	Regulatory compliance, patient safety: **Low (4-8)**
B2	Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against heatlhcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	COO	Quality Committee & Performance Committee	3x3=9	2x2=4	Contractual and regualtory compliance: **Low (4-8)**
B3	Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	DofF	Performance Committee	3x4=12	2x2=4	Financial: **Low (4-8**), but in limited circumstances **Moderate (9-12)**
B4	If we do not build upon the work with the Cancer Alliance and other partners, this will adversely affect the Trust's ability to positivley influence prevention, early diagnosis, standardisation of care and performance in cancer care services.	CEO/DofS	Performance Committee	3x4=12	2x4=8	Partnerships: **Moderate (9-12)**
B5	If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Reserach Strategy and academic oncology in Liverpool.	MD	Quality Committee & Performance Committee.	3x5=15	2x4=8	Patient experience: **Low (4-8);**
B6	Issues within Pharmacy Aseptic Unit adversely impacting on the manufacturing and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan, adversely impacting on patient accessibility to research and reputational damage with Sponsors.	MD	Quality Committee	3x5=15	2x2=4	Patient experience: **Low (4-8)**;
B7	If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	Dof W&OD	Quality Committee	3x4=12	2x3=6	Workforce: **Low (4-8)**

B8	If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	Dof W&OD	Quality Committee	3x4=12	2x3=6	Workforce: **Low (4-8)**
B9	If we do not invest a clear vision, sufficeint capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve it's digital ambition.	CIO	Performance Committee & Quality Committee	3x3=9	2x2=4	Digital: **Low (4-8)**
B10	If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	CIO	Performance Committee & Quality Committee	3x4=12	3x3=9	Digital: **Low (4-8)**
B11	If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	DofF	Performance Committee	4x3=12	2x3=6	Commercial and Partnership working: **Moderate (9-12)**

Strategic Priority	BAF ID	Risk	Risk Owner	Committee Oversight	Initial Risk Score			Q1 Risk Score			Target Risk		Score
					L	C	Score	L	C	Score	L	C	
Be Outstanding: which means that we will deliver safe, high quality care and outstanding operational and financial performance	**B1**	If we do not have robust Trust-wide quality and clinical governance arrangements in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	CN/MD	Quality Committee	4	3	**12**	4	3	12	2	1	2
	B2	Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	COO	Quality Committee & Performance Committee	3	3	9	3	3	9	2	2	4
	B3	Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	DofF	Performance Committee	3	3	9	3	4	12	2	2	4
Strategic Priority	**BAF ID**	**Risk**	**Risk Owner**	**Committee Oversight**	**Initial Risk Score**			**Q1 Risk Score**			**Target Risk**		**Score**
					L	C	Score	L	C	Score	L	C	
Be Collaborative: which means we will drive better outcomes for cancer patients, working with our partners across our unique network of care.	**B4**	If we do not build upon the work with the Cancer Alliance and other partners this will adversely affect the Trust's ability to positively influence prevention, early diagnosis, standardisation of care and performance in cancer services.	CEO/DofS	Performance Committee	3	4	12	3	4	12	2	4	8
Strategic Priority	**BAF ID**	**Risk**	**Risk Owner**	**Committee Oversight**	**Initial Risk Score**			**Q1 Risk Score**			**Target Risk**		**Score**
					L	C	Score	L	C	Score	L	C	
Be Research Leaders: which means we will be leaders in cancer research to improve outcomes for patients now and in the future	**B5**	If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Research Strategy and academic oncology in Liverpool.	MD	Quality Committee & Performance Committee	3	5	15	3	5	15	2	4	8

	B6	Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	MD	Quality Committee	3	5	15	3	5	15	2	2	4
Strategic Priority	**BAF ID**	**Risk**	**Risk Owner**	**Committee Oversight**	**Initial Risk Score**			**Q1 Risk Score**			**Target Risk**		**Score**
					L	**C**	**Score**	**L**	**C**	**Score**	**L**	**C**	
Be a Great Place to Work: which means that we will attract, develop and retain highly skilled, motivated and inclusive workforce to deliver the best care.	**B7**	If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	DofW&OD	Quality Committee	3	4	12	3	4	12	2	3	6
	B8	If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	DofW&OD	Quality Committee	3	4	12	3	3	9	2	3	6
Strategic Priority	**BAF ID**	**Risk**	**Risk Owner**	**Committee Oversight**	**Initial Risk Score**			**Q1 Risk Score**			**Target Risk**		**Score**
					L	**C**	**Score**	**L**	**C**	**Score**	**L**	**C**	
Be Digital: which means we will deliver digitally transformed services, empowering patients and staff.	**B9**	If we do not invest a clear vision, sufficeint capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve it's digital ambition.	CIO	Quality Committee & Performance Committee	3	3	9	3	3	9	2	2	4
	B10	If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	CIO	Quality Committee & Performance Committee	3	4	12	3	4	12	3	3	9
Strategic Priority	**BAF ID**	**Risk**	**Risk Owner**	**Committee Oversight**	**Initial Risk Score**			**Q1 Risk Score**			**Target Risk**		**Score**
					L	**C**	**Score**	**L**	**C**	**Score**	**L**	**C**	
Be Innovative: which means we will be enterprising and innovative, exploring opportunities that improve or support patient care.	**B11**	If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	DofF	Performance Committee	3	3	9	4	3	12	2	3	6