Agenda: Trust Board Part 1
Date/Time of Meeting: 26th July 2023, 09:00am

	Preliminary Business		Lead	Time
67-23/24	Welcome, Introduction, Apologies and Quoracy	v	K Doran	09:30
68-23/24	Declarations of Interest	v	K Doran	
69-23/24	Minutes of the Last Meeting – 28 June 2023	p	K Doran	
70-23/24	Matters Arising / Action Log	p	K Doran	
71-23/24	Cycle of Business	p	K Doran	
72-23/24	Chair and Chief Exec's Report to the Board	p	K Doran / L Bishop	09:40
	Our Patients			
73-23/24	Patient Story	p	J Gray	09:50
74-23/24	NED and Governor Engagement Walk round	p	M Tattersall	10:00
75-23/24	Mortality Report (Learning from Deaths)	P	S Khanduri	10:10
76-23/24	Mortality Annual report	P	S Khanduri	10:20
77-23/24	Palliative Care End of Life Strategy	p	D Monnery	10:30
	Our People			
78-23/24	NHS North-West Black, Asian and Minority Ethnic Anti-racist Framework	p	J Shaw	10:40
	Our Performance			
79-23/24	Integrated Performance Report	p	Exec Leads	10:50
80-23/24	Finance Report	p	J Thomson	11:00
	Our Strategy (for information)			
81-23/24	Quality Improvement and Learning Strategy	p	J Gray	11:10
82-23/24	Communications Strategy 2023 – 2025: Six-monthly implementation progress report	p	E Scott	11:20
83-23/24	Cheshire and Merseyside Cancer Alliance Quarter 1 report	*	L Bishop	11:30
	Our Governance			
84-23/24	Audit Committee Chairs Report	p	M Tattersall	11:40
85-23/24	Board Assurance Framework	p	L Bishop	11:50
86-23/24	Trust Board Effectiveness and Governance Review	p	K Doran	12:00
87-23/24	Committee Annual Reports and Effectiveness Review 2022-23	p	J Hindle	12:10
	Items for information			12:20
These items are provided for consideration by the Board of Directors. Members are asked to read the papers prior to the meeting and, unless the Chair / Trust Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items will be noted without debate at the meeting. The noting will then be recorded in the minutes of the meeting.				
88-23/24	Infection Prevention and Control Annual Report	P	J Gray	
89-23/24	Chair's Declaration - (Fit and Proper)	P	K Doran	
	Concluding Business			12:25
90-23/24	Governors and members of the public to raise any questions in relation to the agenda	v	K Doran	
91-23/24	Items for Inclusion on the Board Assurance Framework	v	K Doran	
92-23/24	Reflections on the Meeting	v	K Doran	
93-23/24	Any Other Business	v	K Doran	
	Date and time of next meeting: 27th September 2023, 09:30am			

Ref: FCGOAGEND
Review: July 2025
Version: 2.0

	Resolution: *"To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".*
	Close

p paper
***** presentation
v verbal report

Ref: FCGOAGEND
Review: July 2025
Version: 2.0

Draft Minutes of Trust Board Part 1
28 June 2023 at 9.30am

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

In attendance:

Jane Hindle	Associate Director of Corporate Governance
Anne Mason	Corporate Governance & Governor Engagement Officer
Jane Wilkinson	Lead Governor
Mike Varey	Staffside
Laura Jane Brown	Staff Governor (Nurses)
Tazeen Khatib	Quality Lead and Operational Manager
Jane Younger	Consultant in Psychological Medicine
Kate Edwards	Clinical Psychologist, Teenage and Young Adult Team
Emer Scott	Associate Director of Communications

Observing

Megan Clayton	Cheshire and Merseyside Diagnostics Programme
Kerry Gibbons	Sustainability and Programme Manager

Item No.	Standard Business
43-23	**Welcome, Introduction, Apologies & Quoracy:** Kathy Doran welcomed the Board members, observing Governors, and staff. Apologies were noted from Elkan Abrahamson and Sarah Barr Kathy Doran confirmed the meeting was quorate.
44-23	**Declarations of Interest** There were no declarations made in relation to any of the agenda items. The Boards register of interests is published on the Trust website: https://www.clatterbridgecc.nhs.uk/application/files/2316/8233/2399/The_Clatterbridge_Cancer_Centre_Register_of_Interests_2022-23.pdf

V2

45-23	**Minutes of Previous Meeting** The minutes of the meeting held on 31st May 2023 were approved as a true and accurate record subject to the following amendments: • 37-23 amendment to spelling to Service Level Agreement • 31-23 add Asutosh Yagnik requested that the Digital Innovation Roadmap incorporates more of a focus on Research and Innovation and asked Sarah Barr if the roadmap is budgeted. Sarah Barr confirmed that the plan is aligned with the capital plan for the year.
46-23	**Matters Arising / Action Log** There were no matters arising. The Board noted that the following updates regarding the action log: P1-160-22 – Due for review in July's meeting P1-013-23 – VTE paper deferred to next Quality Committee Meeting P1-045-23 – Amendments made, next BAF paper scheduled for July Meeting
47-23	**Cycle of Business** The Board noted the Cycle of Business and that the next Trust Board meeting was brought forward from July 2023 to 28th June 2023.
48-23	**Chair's and CEO's report** The Chair provided the following report highlights to the Board: A paper regarding the impact of the Covid-19 on the Northwest population revealed a more severe impact with the highest numbers of coronavirus cases in the first wave, the highest mortality rate of any region and longest periods of restrictive measure with worse than average impacts on education and the care sector. All Non-Executive Director Appraisals have taken place and include Equality, Diversity, and Inclusion objectives, with the outcomes being reported to the Council of Governors via Nomination and Remuneration Committee in July 2023. The government's formal response to the Hewitt Review and those relating to the Integrated Care Systems made by the Health and Social Care Committee have been published. Liz Bishop welcomed the new Sustainability Manager, Kerry Gibbons, who is observing the meeting today and will be supporting the Trust to deliver the Green Plan. Tom Pharaoh will be presenting a live update regarding the development of the Wirral site on Monday 3 July. Development of the Paddington Village Community Diagnostic Centre continues, and a meeting is scheduled with the Programme Board on 30th June 2023 to assess the overall progress in readiness for the target date of 24th July for the first delivery of diagnostic tests. Liz Bishop assured the Board that planning, and preparation is underway in anticipation of the forthcoming consultant industrial action. This month's Star Award was presented to Jo Francis, Metastatic Breast Clinical Nurse Specialist, who was nominated by the husband of one of the Trust's patients.

	The NHS celebrates its 75th anniversary this year with a number of events taking place locally and nationally to recognise the significant contribution made by staff. A selection of staff will be representing the Trust at a multi-faith event in Westminster Abbey. **The Board:** • **noted the contents of the report.**
	Our People
49-23	**Staff Story – The Power of Schwartz Rounds** Kate Edwards, Tazeen Khatib, and Jane Younger presented the Schwartz Rounds. Kate Edwards opened the presentation with an overview of the history of the Schwartz Rounds, named after Kenneth Schwartz, who was an American Health Care Attorney and lung cancer patient. The Schwartz Rounds were introduced at The Clatterbridge Cancer Centre Wirral in 2015 and there are now 147 out of 219 NHS Trusts in England offering Schwartz Rounds to staff. The Rounds follow a standard model to ensure that they are replicable across settings. The Rounds are designed for staff to provide their accounts of an experience they have had and the impact it had on them, then an open discussion takes place. It is a confidential space for staff to reflect on their emotional experiences. The underlying premise for Rounds is that the compassion shown by staff can make all the difference to a patient's experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work and evidence shows that 85% of staff who participate in Schwartz Rounds feel better able to care for patients. Stories shared in Schwartz Rounds have the ability to empower staff and their organisation. Staff can reconnect with their values and reaffirm their motivation to work in healthcare. They facilitate an open and transparent culture and reflect the Trust as a good place to work. During the pandemic, Schwartz rounds were facilitated across the Trust through team rounds, and pop ups were facilitated at Aintree. Funding for the Rounds has been confirmed which will support the renewal of the contract and training of new facilitators. Managers are asked to encourage and support their teams to attend the rounds which are generally held at lunchtimes and lunch is provided. It was confirmed to the Board that the themes from the Schwartz rounds are chosen by those presenting their experiences which could be a day they never forget or a particular patient experience. The theme for July 2023 will tie in with the Trust 75th anniversary and will be "What keeps us doing what we do" and will include those who retire and return. It was also confirmed that the Rounds are open to all staff not just patient facing staff. Jane Younger confirmed that advertising the Rounds is improving with the assistance of the Communications Team, on the screensavers, bulletins and via the intranet. Tazeen Khatib advised that the success of the Rounds is measured qualitatively with questionnaires carried out following the Rounds where participants are asked to provide feedback. The group currently have 2 facilitators with 2 more being trained however, 2 further facilitators would enable the team to run the rounds monthly instead of bi-monthly across all sites.

	Anna Rothery complimented the team noting that the Rounds are an opportunity for staff to share experiences related to Equality, Diversity, and Inclusion. A Schedule of meeting dates and venues will be communicated to staff to enable wider attendance with support from management to identify suitable venues. **Action: Jayne Shaw to link in with the Schwartz team to confirm a schedule of meeting dates and venues to be communicated to staff. Management to provide support in identifying suitable venues** **The Board:** • **Noted the contents of the presentation**
50-23	**Guardian of Safe Working Annual Report** Sheena Khanduri presented the Annual Report to the Committee, noting the following: There were 22 exception reports for the year, 20 for Internal Medical Trainees (IMT) /General Practitioner (GP) Trainees and 2 for Oncology Specialist Trainees, all of which have been managed accordingly with 14 as TOIL (Time off in Lieu) and 8 as additional pay. There were no fines for the year or work schedule reviews. Sheena Khanduri presented the Q4 January-March report highlighting that two exception reports were submitted in Q4, one from an IMT trainee regarding staying late after the end of their shift and resulted in TOIL being approved and the other from an ST3 trainee relating to service support and a late notification of a gap in the rota, resulting in an improvement action plan being implemented. Overall, the report demonstrates that working conditions are safe. Mark Tattersall queried the increase in agency spend in quarter three. Sheena Khanduri confirmed that this relates to lapsed qualifications in Advanced Life Support for the new intake of doctors, which has since been addressed, with a more sustainable plan. **The Board:** • **Noted the contents of the report**
	Our Patients
51-23	**NED and Governor Engagement Walk Round** Asutosh Yagnik introduced the report noting the following from Wards 4 and 5: Ward 4 Following discussion with a couple of patients it was apparent how much staff can make a difference to patient lives. Patients commented that the staff make them feel like family when they undergo difficult treatment and keep them informed. Staff commented that they feel positive about development opportunities at Clatterbridge. Patients did not identify any areas of improvement, but staff highlighted issues with food quality and choice, with patients not always receiving their first choice. Ward 5 Comments from patients on Ward 5 were similar to Ward 4, with staff keeping patients informed and supporting them through difficult times. Both patients and staff reported that the food quality requires improvement. Other issues raised were patients' TVs shutting off in the evening and IV pumps beeping.

WE ARE...
KIND EMPOWERED RESPONSIBLE INCLUSIVE

V2

	Other items to note were delays with obtaining x-rays and scans out of hours. Julie Gray commented that the IV Pumps do have a night mode which turns off the sound and a new meal supplier commenced at the Trust on 5th June, and early indicators show an improvement in the food quality. Joan Spencer added that there is a good system in place for out of hours scans/x-rays and suspected the issue may be with Liverpool University Hospital Foundation Trust (LUHFT), as all calls for Clatterbridge go through their switchboard system who may be misdirecting the calls, however, they are provided with a comprehensive on-call list every week. **Action: Joan Spencer to review on-call arrangements provided to the LUHFT switchboard in order to ensure that they understand who to contact during CCC out of hours.** **The Board:** • **noted the contents of the report.**
52-23	**Safer Staffing Report** Julie Gray presented the six-month review of staffing measured against the safe staffing guidelines and highlighted the following: All managers are now optimising utilisation of the e-roster system, supported by the Workforce and Organisational Development team, to coordinate patient ratios, and confirm this has helped to achieve sufficient staff cover for 1-1 patient care. Staff across all areas of the service continue to cover the additional 11 beds that were introduced to support LUHFT to ensure people with cancer were treated in a timely manner and in an appropriate setting. Confirmation of commissioner approval is awaited to support the permanent funding for the staffing of these beds. This will significantly benefit the coordination and planning of staffing and have a direct impact upon patient and staff experience. A review of IT equipment will take place, including mobile computers and tablets to ensure patient documentation is completed in the most appropriate place. Following a safer staffing event attended by the Deputy Chief Nurse, a review of single room occupancy and patient acuity tool will be carried out to ensure the correct level of care is in place. The review has also identified other potential areas of further improvement and there will now be a focus on the processes around the administration of medication to streamline and reduce medication errors and delays. Mark Tattersall commented that the additional beds issue needs resolving and raised concerns about staff morale and as well as cost to the Trust. Joan Spencer advised that the team are reviewing patient flow which will be reported through Performance Committee and will include preparation for winter planning. There is also a workstream looking at patient care, which will go through the Joint Committee. Asutosh Yagnik queried the role of the coordinator not having a cohort of patients which may help towards the ratios. Julie Gray advised that recommended staffing ratios are 1-8 and Trust ratios are lower than this and advised that the role of the coordinator ensures that there is a single point of contact and senior nurse on shift to provide support.

	Asutosh Yagnik queried the turnover of staff on Ward 2. Julie Gray advised that this has now stabilised, and Ward 3 is also expected to improve with focus around streamlining the administration of medication process, to reduce medication errors and delays. Joan Spencer will be leading a Board Development session on urgent emergency care to achieve a better understanding of system pressures. **Action: Joan Spencer to provide an update regarding additional bed capacity in order to understand patient flow.** **The Board:** • **noted the contents of the report and approved the recommendations**
	Our Performance
54-23	**People Committee Chairs Report** Kathy Doran presented the report and highlighted the following: Staff turnover has increased in month with 21 leavers in May compared to 16 in April with work life balance cited as the main reason for leaving, together with promotion opportunities and relocation. Leaver questionnaires are providing useful information which is being used to make improvements to reduce turnover. Basic Life Support, Intermediate Life Support and Manual Handling training compliance remains under target. An escalation process has been agreed and all those who are non-compliant will receive letters to complete the training by the end of August 2023 when a more formal process will begin for those who remain non-compliant. There is growing demand for the two Clinical Education Training Rooms at CCCL, with insufficient availability for mandatory training bookings, particularly with manual handling where compliance is below target. This issue has been escalated and added to the Risk Register. The Disability and Long-Term Condition Network gave a presentation to raise awareness and promote equality for staff with disabilities and long-term conditions. A number of awareness campaigns will be carried out with support from the Equality, Diversity, and Inclusion Lead. **The Board:** • **Noted the contents of the report**
55-23	**Quality Committee Chairs Report** Terry Jones presented the report highlighting the following: The Committee received the Board Assurance Framework (BAF) Report and the revised wording of BAF 1 following discussion at Trust Board and agreed that the wording of BAF1 now provided greater clarity. The Integrated Performance Report for month two provided an update on performance in the categories of access, efficiency, quality, workforce, research and innovation and finance. The Committee requested that Trust trial set-up and recruitment to time and target data is included within the Integrated Performance Report for future meetings but accepted the data will not have been externally ratified.

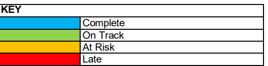
	Full assurance has now been received from the leads of the MIAA Quality Spot Checks (Audits) and can now be deescalated from the Committee to back to the appropriate operational governance mechanisms. The Committee accepted the Annual Report and Annual Review of Committee Effectiveness and agreed to consider the impacts of the cost improvement programme (CIP) on quality at a future meeting. The Committee received the Palliative Care End of Life Strategy. The Committee approved the strategy and requested this is presented at July's Trust Board meeting as a showcase item. **Action: Julie Gray to present Palliative Care End of Life Strategy at July Trust Board** **The Board:** • **Noted the contents of the report**
56-23	**Integrated Performance Report** Each Executive Lead provided brief highlights from the Statistical Process Chart (SPC) and exception reporting for the following areas: <u>Access</u> 28-day and 62-day targets have not been achieved due to late referrals and capacity issues. The Trust continues to collaborate with Cheshire and Merseyside Cancer Alliance and laboratories to expedite molecular testing. <u>Efficiency</u> Bed occupancy is above the 92% target therefore a patient flow project is being carried out which will incorporate scheduling, planned discharges and urgent cancer care patients. Recruitment for additional radiologist will improve imaging turnaround, additional Sonographers have been appointed and will commence at the Trust in August. <u>Quality</u> A never event was declared resulting in a review of all piped medical air supply outlets across the Clatterbridge estates, all air outlets that are not required have been capped. There are low numbers of complaints due to the early resolution conversations taking place. Policy reviews are improving following work being carried out within the divisions, to ensure policies are up to date. Out of date policies are escalated to the Information Governance Manager and it has been agreed that remote approval outside of the committees can take place in order to expedite the approval process. <u>Research and Innovation</u> Year to date recruitment is under target but not representative of the year with more trials opening at an improved rate. Clinical research gap analysis is complete and was presented to Trust Executive Group, a progress plan will be monitored through the Research and Innovation Directorate with a quarterly report going to Trust Executive Group. <u>Workforce</u> There has been an increase in turnover in May, but the Trust remains below target when the "retire and return" and "fixed term contracts" are removed from the numbers. Exit interviews continue to provide valuable information to help the Trust reduce turnover. The new MyAppraisal system has received great feedback from those who have used it so far. Mandatory training continues to be monitored with an escalation process being implemented for those staff who remain non-compliant.

	All managers are meeting with those who are non-compliant to support them to complete the training, to prevent escalation. **The Board:** • **Noted the contents of the report**
57-23	**Finance Report** James Thomson introduced the report noting the following: For 2023/24 NHS Cheshire & Merseyside Integrated Care Board are managing the required financial position of each Trust through a whole system approach. The Trust submitted a plan to NHSE/I on 4th May 2023 showing a £363k surplus for 2023/24 however the industrial action and ability to maintain activity may have an impact on the plan. The Trust reports a deficit on the plan overall with £128k deficit, which is £189k below the planned surplus of £61k. Trust pay costs are overspent by £280k including unmet Cost Improvement Programme (CIP) of £356k. Non pay costs are overspent by £280k which includes unmet CIP of £356k. A quality impact assessment for CIP will be carried out at the end of the first quarter and will go through Performance Committee. James Thomson commented that there has been great engagement from colleagues for ideas with CIP and advised that the Trust is fully aligned with the Integrated Care Board financial recovery programme. Joan Spencer added that the teams are doing a lot more whilst trying to save on costs. **Action: Board Development Session to be scheduled during 2023/24 that will provide detail on the efficiency at scale programme led by CMAST (Cheshire and Merseyside Acute and Specialist Trust alliance) and ICB arrangement for financial recovery to be incorporated into Board Development Session.** **The Board:** • **Noted the contents of the report**
	Our Strategy
58-23	**Cancer Alliance Quarterly Report** Liz Bishop presented the report and asked for feedback and comments: The focus of the report covers 3 of the 10 cancer standards: 1. 28-Day faster diagnosis 2. 62-day referral to treatment 3. 31-day diagnosis to treatment The report demonstrates benchmarking against other alliances behind on the 28-day diagnostic programme. A request has been made for the addition of first treatment percentages within the summary measures to keep the pressure on surgical acuity. The Cancer Alliance will be delivering a Board Development Session regarding the transformation programme including information on long-ranging cancer projects, to inform the Board about the care standards and delivery on the long-term aims. Programme specific areas include targeted lung health checks which has a fully operational model in place with Liverpool Heart and Chest Hospital, increase in Quality-of-Life survey uptake, faster

	diagnosis standards by tumour group and roll out of the Faecal Immunochemical Test (FIT) in Wirral University Hospital Foundation Trust in June 2023. The Board requested if the report could feature a highlights page to identify highlights and areas of improvement **Action: Liz Bishop to refresh the quarterly report in order to ensure that it is meaningful at Place level and to audiences within individual Providers.** **The Board:** • **Noted the contents of the report**
59-23	**Liverpool Joint Provider Chairs Report and Terms of Reference** Kathy Doran presented the draft Terms of Reference pertinent to all the relevant Trusts, for approval of the Board. Kathy Doran explained that the Trusts may formally delegate decision-making to the Liverpool Trusts Joint Committee (LTJC), in relation to particular projects or workstreams within the Work Plan. Such delegations will be in accordance with the guidance given by NHS England. Asutosh Yagnik asked if the projects will align with Trust Strategies and Kathy Doran commented that the Committee is accountable to Trust Board where any misalignments can be discussed. Kathy also clarified that all Trust Company Secretaries are currently working through budgets and will bring the details back to the Board. **The Board:** • **Approved the Terms of Reference**
60-23	**Joint Site Committee Chairs Report** Kathy Doran presented the report from the meeting in June involving representatives from The Clatterbridge Cancer Centre and Liverpool University Hospital Foundation Trust. The Committee have developed a format that focuses on working through each of the milestones and will share the format with other Joint Site Committees. The next Committee will feature a Deep Dive from Pharmacy and Urgent Care workstreams, and Joint Partnership Group Exception Report. The next meeting date is 7 August but may be rearranged for maximum attendance due to the summer annual leave period. **The Board:** • **Noted the contents of the report**
	Our Governance
61-23	**NHSE Elective Care Priorities 2023/24 – Board Checklist** James Thomson and Joan Spencer presented the Board Checklist highlighting that some of the priorities noted within the report are not applicable to The Clatterbridge Cancer Centre. Asutosh Yagnik queried the vague language used in the assurance statements and Joan Spencer clarified that the Trust does have specified targets that are detailed in the Trust responses. **The Board:** • **Approved the Checklist**
62-23	**Annual Self-Certification NHS Provider Licence**

	Jane Hindle presented the NHS Provider Licence, which was reviewed at Audit Committee and requires publication by 30th June 2023 on the Trust website. The report demonstrates evidence of compliance within Appendix a of the report. **Action: Self-Certification to be added to the Trust Website once approved** **The Board:** • **Accepted the Report, confirmed compliance and accepted there were no material risks.**
	Items for Inclusion on the Board Assurance Framework
63-23	There are no further items for inclusion on the Board Assurance Framework.
	Questions from Governors and members of the public
64-23	There were no questions from the Governors or members of the public
	Any Other Business
65-23	There was no other business to note
	Reflections on the Meeting
66-23	The Board agreed a good discussion took place at today's meeting that incorporated a good balance between strategy, staff, and coalition work.
	Date and time of next meeting: 26th July 2023 @ 9.30am

Trust Board Part 1 Action Log



KEY	
	Complete
	On Track
	At Risk
	Late

Date of Meeting	Item No.	Agenda Item	Action(s)	Action By	Date to Complete By	RAGB	Status Update/Assurance
28-Sep-22	P1-160-22-23	Formal Review of the Board Committee Governance Structure	The Board agreed to continue on this Committee governance model and review again in 6 months	**J Gray / J Hindle**	Jul-23		Included on cycle of business Deferred - Awaiting new ADoCG starting 26 April 23: Board agreed new date for completion od July 2023, to be completed as part of Committee Effectiveness review. Item is n agenda July 2023
26-Jan-23	P1-013-23-24	Integrated Performance Review	The Medical Director to provide a report on VTE incidents to Quality Committee	**S Khanduri**	Jun-23		Added to Quality Committee Cycle of Business for March 23 Deferred until June 23 26.04.23 Board acknowldged deferred reporting to Quality Committee and agreed revised June 2023 deadline 28.06.23 - Deferred to next meeting of the Quality Committee.
26-Apr-23	P1-045-23/24	Board Assurance Framework Refresh	To further review of BAF refresh to take place in light of AY comments. Clarification to be provided on People Committee BAF score discussions. Wording from Risk Management Strategy in relation to risk appetite to be reflected in BAF	**J Hindle**	May-23		Following comments at April's meeting the wording of each risk and the risk levels has been reviewed and will be presented to each respective committee in May and June prior to coming to Board in July. Confirmation has been received on the BAF risks within the remit of the People Committee: BAF 9 reduced in score from 12 to 9, BAF11 was 16 in Q3 and remains at 16 following discussion at People Committee. BAF 10 and BAF 12 had no proposed score changes.
28-Jun-23	P1-055-23-24	Staff Story - Schwartz Round	To link in with the Schwartz team to confirm a schedule of meeting dates and venues to be communicated to staff. Management to provide support in identifying suitable venues	**J Shaw**	Jul-23		
28-Jun-23	P1-052-23-24	Safer Staffing Report	To review the on-call arrangements provided via the LUHFT Switchboard in order to ensure that they understand who to contact within CCC out of hours.	**J Spencer**	Jul-23		19/07/23 SLA for the provision of switchboard is under review and the Radiology Department are exploring a single contact point for on-call arrangements.
28-Jun-23	P1-052-23-24	Safer Staffing Report	To provide an update regarding the additional bed capacity to Performance Committee in order to understand utilisation and patient flow.	**J Spencer**	Aug-23		01/07/2023 This has been added to the agenda of Performance Committee for August.
28-Jun-23	P1-057-23-24	Finance Report	To schedule a Board Development Session during 2023/24 that will provide detail on the efficiency at scale programme led by CMAST and ICB arrangement for financial recovery to be incorporated into Board Development Session	**J Hindle**	Nov-23		**July 2023** This has been added to the Board Development Programme for October.
28-Jun-23	P1-057-23-24	Quality Committee Chairs Report	To present the Palliative Care Strategy to Trust Board.	**J Gray**	Jul-23		Item is on the agenda July 2023.
28-Jun-23	P1-052-23-24	Cancer Alliance Quarterly Report	To refresh the quarterly report in order to ensure that it is meaningful at Place level and to audiances within individual Providers.	**L Bishop**	Jul-23		Item is on the agenda July 2023
28-Jun-23	P1-062-23-24	Provider Licence - Self-Certification	To ensure the Provider Licence Self-Certificates are uploaded to the Trust Website by 30th June.	**J Hindle**	Jul-23		Signed Self-Certificates uploaded to the website 29/06/23

Trust Board Cycle of Business 2023/24

Item	Lead	Author	Frequency	Item For	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	2024	Jan-24	Feb-24	Mar-24
Standard Items																	
Welcome, Introductions, Apologies and Quoracy	Chair	NA	Monthly	Standard Business	√	√	√	√		√	√	√			√	√	√
Declarations of Interest	Chair	NA	Monthly	Standard Business	√	√	√	√		√	√	√			√	√	√
Matters Arising / Action Log	Chair	NA	Monthly	Standard Business	√	√	√	√		√	√	√			√	√	√
Cycle of Business	Chair	NA	Monthly	Standard Business	√	√	√	√		√	√	√			√	√	√
Chair and Chief Executive Update	Chair / Chief Exec	Kathy Doran Liz Bishop	Monthly	Standard Business	NA	√	√	√		√	√	√			√	√	√
Strategy & Planning																	
Progress against 5 Year Strategy	Director of Strategy	Tom Pharaoh	6 monthly	For information/noting		√						√					
Annual Financial/Operational Planning Guidance	Director of Finance	James Thomson	Q3 and Q4	For information/noting							√				√	√ Draft	√ Submission
Progress against Innovation Strategy (Inc. Bright Ideas) Annual Report	Medical Director	Drew Norwood-Green	Annually	For information/noting											√		
Progress against Research Strategy Annual Report	Medical Director	Gillian Heap	Annually	For information/noting							√						
Progress against Green Plan Annual Report	Director of Strategy	Tom Pharaoh	Annually	For information/noting												√	
Digital Strategy	Chief Information Officer	Sarah Barr	Annually	For approval	√ (deferred)	√											
Quality Strategy	Chief Nurse	Julie Gray	Annually	For approval				√									
Risk Management Strategy	Chief Nurse	Julie Gray	Annually	For approval	√												
Assurance: Quality & Performance																	
Patient Story	Chief Nurse	Depends on area of patient story	Every other meeting	For information/noting		√		√			√				√		√
Staff Story	Director of WOD	Stephanie Thomas	Every other meeting	For information/noting	√		√			√		√				√	
Quality Committee Chair Report	NED TJ	Skye Thomson	Quarterly	For information/noting	√		√				√				√		√
Performance Committee Chair Report	NED GB	Abby Ashcroft	Quarterly	For information/noting		√				√		√				√	
Audit Committee Chair Report	NED MT	Jane Hindle	6 times a year	For information/noting	√	√		√			√				√		
Charitable Funds Committee Chair Report	NED EA	Katrina Bury	Adhoc	For information/noting	√ (deferred)	√											
People Committee Chairs Report	NED AR	Anne Mason	Quarterly	For information/noting	√ (inc ToR - deferred from Mar 23)		√				√				√		√
Integrated Performance Report	Exec Leads	Hannah Gray	Monthly	For discussion For approval	√	√	√	√		√	√	√			√	√	√
Finance Report	Director of Finance	Jo Bowden Lucy Blackhurst	Monthly	For information/noting	√	√	√	√		√	√	√			√	√	√
Safer Staffing Report	Chief Nurse	Julie Gray	6 monthly	For approval			√								√		
Gender Pay Gap	Director of WOD	Angela Ditchfield	Annually	For discussion For approval													√
Workforce Race Equality Standard Data	Director of WOD	Angela Ditchfield	Annually	For information/noting							√						
Workforce Disability Equality Standard Data	Director of WOD	Angela Ditchfield	Annually	For information/noting							√						
Equality Diversity & Inclusion Annual Report	Director of WOD	Angela Ditchfield	Annually	For approval				√ (moved to Feb in line with publishing schedule)								√	
In-Patient Survey	Chief Nurse	Julie Gray	Annually	For information/noting				√ (deferred to Oct)									
NED and Governor Engagement Walk round	NED attended	Claire Smith	Monthly	For information/noting	√	√	√	√		√	√	√			√	√	√
Actions from NED and Governor Engagement Walk-rounds Annual Report	Chief Nurse	Nikki Heazell	Annually	For information/noting	√												
Caldicott/SIRO Annual Report	Medical Director / Director of Finance	Peter Case-Upton, MIAA James Thomson	Annually	For approval						√							
Staff Survey Results	Director of Workforce	Stephanie Thomas	Annually	For information/noting													√
Statutory Reporting / Compliance																	
Self-Certification against the Provider Licence	Associate Director of Corporate Governance	Jane Hindle	Annually	For approval		√ (deferred)		√ (went in June)									
Regulation 5 Declarations (Fit and Proper)	Associate Director of Corporate Governance	Jane Hindle	Annually	For approval				√									
Risk Management Strategy (including Risk Appetite Statement)	Chief Nurse	Julie Gray	Annually	For approval													√
Emergency Preparedness Resilience and Response (EPRR) Annual Report and Core Standards	Chief Operating Officer	Julie Gray	Annually	For approval						√							
Mortality Report (Learning from Deaths)	Medical Director	Helen Wong	Quarterly	For information/noting	√			√				√			√		
Mortality Annual report	Medical Director	Helen Wong	Annually	For approval				√									
Revalidation Annual Report	Medical Director	Chris Thompson	Annually	For approval						√							
Guardian of Safe Working Report	Medical Director	Chris Thompson Ian Lampkin	Quarterly	For information/noting						√		√					√
Guardian of Safe Working Annual Report	Medical Director	Chris Thompson Ian Lampkin	Annually	For approval			√										
Infection Prevention and Control Annual Report	Chief Nurse	Julie Gray	Annually	For approval				√									
Freedom to Speak Up Annual Report	Chief Nurse	Jo Wynne	Annually	For approval						√							
Health and Safety Annual Report	Chief Operating Officer	Derry Sinclair	Annually	For approval						√							
Safeguarding Annual report	Chief Nurse	Julie Gray	Annually	For approval						√							
Collaboration																	
CMCA Report	Chief Executive	Liz Bishop	Quarterly	For information/noting			√	√		√		√				√	
Liverpool Joint Committee Sub-Committee - LUHFT and CCC Chair's Report	Chair	Skye Thomson	Bi-monthly	For information/noting		√	√										
Board Governance																	
Review of Constitution (ADHOC)	Associate Director of Corporate Governance	Jane Hindle	Adhoc	For discussion For information/noting For approval													
Board Assurance Framework	Associate Director of Corporate Governance	Skye Thomson	Quarterly	For information/noting For approval	√			√			√				√		
Board Assurance Framework Refresh	Associate Director of Corporate Governance	Skye Thomson	Annually	For approval	√												
Audit Committee Annual Report and Annual Review of Board Effectiveness	Associate Director of Corporate Governance	Jane Hindle	Annually	For discussion For information/noting				√									
Trust Board Annual Cycle of Business	Associate Director of Corporate Governance	Skye Thomson	Annually	For discussion For approval													√
NED Independence & Board Register of Interest	Associate Director of Corporate Governance	Jane Hindle	Annually	For information/noting													√
Use of Trust Seal Report	Associate Director of Corporate Governance	Jane Hindle	Annually	For information/noting	√												
Adhoc / Committee Requested																	
Formal Review of the Board Committee Governance Structure	Associate Director of Corporate	Jane Hindle	Adhoc	For discussion				√									√
Freedom to Speak Up Reflections and Planning Tool	Associate Director of Corporate Governance	Jane Hindle	One-off	For information/noting						√							
Freedom to Speak Up Policy	Associate Director of Corporate Governance	Jane Hindle	One-off	For information/noting						√							
Palliative Care End of Life Strategy	Chief Nurse	Daniel Monnery	One-off	For information/noting				√									

Title of Meeting: Trust Board Part 1
Date of Meeting: 26 July 2023

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

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

Ref: FCGOREPO
Review: July 2025
Version: 2.0

Chair's Update

NHS Providers National Meeting for Chairs and Chief Executives
I attended this meeting on 29 June, We received a strategic policy update from Sir Julian Hartley covering plans for publication of the NHS Workforce Plan, discussions with national politicians re NHS, planned publication of a National Major Conditions Strategy (to include cancer) NHS England restructuring/downsizing and plans for NHS Impact (continuous improvement). He referred to a time of "unprecedented challenge" for Boards with stretched capacity, industrial action leading to increased strategic risk.

Chair's Meeting
On 19 July, I attended the CMAST Chairs meeting. The main presentation was on the work of the Children and Young People's Partnership Board, which is a sub-Committee of the ICB. Work includes the Beyond Programme tackling wider determinants of ill health and inequality, Improving access to mental health services for young people and Delivering better standards of care to young people's acute and specialist services. We heard about cutting edge work with young victims of sexual abuse. Chairs also received an update from the latest Integrated Care Partnership Board.

Consultant Appointments
On 10th July interviews took place for Radiologist and a Clinical Oncology Head and Neck and Lymphoma Consultant. The Radiologist position has been offered and the Oncologist has accepted the position.

Governor Elections
Nominations for our vacant Governor positions came to an end on 3rd July and none of the positions were contested, therefore we shall be welcoming the new Governors to the Trust at the Annual Members meeting in October 2023. A new appointed Governor, Tony Murphy from Metropolitan Borough of Wirral will be introduced as a new Governor at the Council of Governors meeting on 26th July 2023, taking over from Yvonne Nolan.

Nominations and Remunerations Committee – 3rd July
The Committee met to review the Non-Executive Director and Chair appraisals and a report will go to the Council of Governors on 26th July 2023.

CCCL Charity tea party and NHS 75th birthday celebration
I attended this event in the Winter Garden at CCCL. Thanks to the Charity team for organising. They also organised an event at CCCWirral

Paddington Visit
I had the pleasure of a tour of CCCPaddington. Preparations to receive patients are well advanced. The facilities are very impressive.

CEO Update

Cheshire & Merseyside Acute and Specialist Trusts (CMAST) Provider Collaborative Update (report provided by CMAST)
The Leadership Board met on 7th July and considered a number of important issues which included an update on the progress being made through the Diagnostics Programme Board and a number of upcoming key infrastructure decisions which relate to:

- Prioritisation of multi-year system imaging capital allocations
- Process for managing system bids for endoscopy hubs and prioritisation of funding
- Pathology consolidation options appraisal and laboratory information management systems (LIMS) development

In addition the Leadership Board received an update on the ICS and ICB CYP agendas and considered and supported proposals for the establishment of a CMAST paediatrics network which will enhance the collaborative's focus and delivery of this agenda.

Finally the Board considered the dialogue taking place in different parts of the country in respect fo bank workers and pay awards and the preparation for and approach to managing industrial action.

The Board also received the following documents:
- C&M ICS Activity Summary Report
- C&M ICS Finance Report

Paddington Community Diagnostic Centre
At the time of drafting this report, Paddington Community Diagnostic Centre (CDC) is scheduled to open on 21 July. The clinical governance arrangements were approved at Risk & Quality Governance Committee on 11 July. The CDC is phase one of the new CCC Paddington site.

Industrial action
Further dates have been confirmed as follows:

The British Medical Association (junior doctors) has confirmed a further round of industrial action lasting for five days from 07:00 on Thursday 13th July 2023 until 07:00 on Tuesday 18th July 2023

The British Medical Association (consultants) has announced that industrial action will take place for two days on Thursday 20th July 2023 and Friday 21st July followed by a second round on 24 August to 25 August 2023 following their ballot which closed on 27 July.

The Society of Radiographers has announced industrial action for two days from 08:00 on Tuesday 25 July 2023 until 08:00 on Thursday 27th July 2023 following their ballot which closed on 28 June.

The Royal College of Nursing (RCN) has confirmed that the national ballot on whether to take further industrial action did not achieve the required threshold needed for the result to be recognised as lawful.

Sexual Safety for NHS Staff and Patients
On the 23rd June 2023, following reports of sexual assault, harassment and abuse in the NHS, ICB (Integrated Care Board) Chief Executives and NHS Trust and Foundation Trust Chief Executives received a letter from Steve Russell, NHS England Chief Divery Officer regarding sexual safety for NHS staff and patients. The NHS takes a systematic zero-tolerance approach to tackle this issue which encompasses prevention, support and decisive action against perpetrators, and is redoubling its efforts focusing on supporting staff, national leadership and improving data collection.
Clatterbridge has appointed Sheena Khanduri, Medical Director as our Domestic Abuse and Violaence Executive to lead the work on the Domestic Abuse and Sexual Violence (DASV) Programme and act as advocates who can prioritise this important work to help build a network of leaders to share good practice, identify issues and develop solutions to tackling these crimes with as wide a group as possible.

We will also review our policies and to support staff and patients who experience these crimes in the course of contact with our organisation, as well as our data collection, reporting and analysis.

Digital Away Day 12 July
The recent digital away day marked the launch of our organisation's ambitious digital strategy, set to unfold the digital transformative vision from 2023 to 2025. The day began with an inspiring presentation by our CEO, Liz Bishop, who outlined the strategic importance the digital initiative to The Clatterbridge Cancer Centre FT. Following that, John Llewellyn, the CDIO of Cheshire & Merseyside ICB, broadened our perspective by discussing the larger impact of this strategy across the Cheshire and Merseyside region.
One of the highlights of the day was an emotional patient story that reminded us of the real-world impact of our work. As a team, we engaged in an exercise, collaborating to deliver a hyper-accelerated solution, leveraging cutting-edge technology to address multiple challenges identified in the patient story.

After a productive morning of strategising and problem-solving, the afternoon session allowed our dedicated staff to unwind and bond through a series of engaging activities. From mindfulness sessions to foster well-being, to the creative and team-building exercise of egg-engineering. A lively quiz added a dash of friendly competition, while the minefield activity brought out our collective problem-solving skills and unity. Overall, the digital away day proved to be an invigorating experience that left us motivated and equipped to embark on this digital transformative journey, armed with the power of technology to shape a better future for our organisation and the patients we serve.

Finance Away Day 12 July
The team took a full day out to focus on the both the development of the finance business plan and the longer term finance strategy. The focus of the morning was on the key deliverables required by the team over the next 6-9 months, looking at required areas of focus and looking at ways in which the team can standardise and improve processes. The afternoon session was supported by an external facilitator and was a great interactive

session using the principles of SUMO (shut up move on) to give the team practical ways to support both themselves and each other as a team.

Monthly Star Award – June 2023
It was a pleasure to present the June Star Award to Andrea Law who is a clinical audit and information specialist. Andrea was nominated by one of her colleagues who described her as an exceptional member of staff with a real ‘ can do’ attitude who consistently goes above and beyond to support patients and also her colleagues who very much appreciate the difference she makes.

NHS75
A number of staff events took place across the Trust earlier this month to recognise and celebrate NHS75 including tea parties, ice creams and staff participation.

In addition, the Trust was represented by five members of staff at the multi-faith service at Westminster Abbey on 5 July 2023.

A day in your shoes
As part of our staff survey action planning to improve visibility of the senior team executive directors are planning to shadow/work alongside members of staff as part of a new initiative to ‘spend time in their shoes’. The first dates have been scheduled for early August and the programme will be evaluated after 6 months before being rolled out to wider members of the senior team including non-executive directors.

Reverse mentoring
To support our inclusive leadership journey, members of the executive team attended an introductory training session on our approach to Reverse Mentoring Programme which will formally launch in September. The session was facilitated by Stepping Up which is an external organisation specialising in diversity in inclusion. The Programme will initially be available for BAME staff before rolled out across other groups.

BBC
The BBC is due to broadcast a report on cancer vaccines research at Clatterbridge 4th July as part of its coverage of the 75th anniversary of the NHS.
BBC North West News visited CCC-L last week to interview our patient Adrian Taylor and our Medical Director, Dr Sheena Khanduri. Health correspondent Gill Dummigan spent the morning in CCC-L’s research ward filming Adrian’s treatment, which is part of a UK-first clinical trial at Clatterbridge.

You can catch up with it on iplayer here:
https://www.bbc.co.uk/iplayer/episodes/b006pfjx/north-west-tonight

You can read a news report on this story on the BBC website here:
https://www.bbc.co.uk/news/uk-england-merseyside-66096301

NHS Long Term Workforce Plan

The NHSE Long Term Workforce Plan was launched on 5 July. The CEO attended an North West Regional (NWR) Roadshow where there was an opportunity for leaders in the NWR to discuss the plan with the NHSE leadership team. The implications and plans will be worked through during the coming months at Trust, CMAST and ICB level and will be reported through the People Committee
Read the full plan at https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/

Liverpool Provider Joint Committee
The Chief Operating Officer and Director of Strategy will attend the Liverpool Provider Joint Committee on 21 July 2023.

Recommendations:
The Trust Board are requested to:

- Note the report

Title of meeting: Trust Board
Date of meeting: 26.07.2023

Report author	Heulwen Sheldrick (Principal SLT) Poppi Dickens (SLTA) Julie Crane (UoL)			
Paper prepared by	Heulwen Sheldrick (Principal SLT) Poppi Dickens (SLTA) Julie Crane (UoL)			
Report subject/title	Integrated SLT H&N team – July 2023 Trust Board			
Purpose of paper	Action Plan to support Patient Story. The board story showcases the work of an integrated approach to workforce. The SLT team is working across organisations to ensure that clinical decision making, pathways and patient experience are led by patient need. Whilst this board story is not rooted in a specific complaint, there have been historical issues relating to fragmentation and uncoordinated care pathways for patients with H&N cancer & this video highlights the good progress made to date.			
Background papers	SLT integrated workforce project – plan on a page & TIC paper HNC SLT Integrated Network Project, Draf HNC SLT Integrated Network Project Boar			
Action required	Link to patient story: https://www.youtube.com/watch?v=Kq4fj5j56eM See attached Action Report			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work	x
	Be Collaborative	X	Be Digital	X
	Be Research Leaders	X	Be Innovative	x
Equality & Diversity Impact Assessment				

Ref: FCGOREPO
Review: July 2025
Version: 2.0

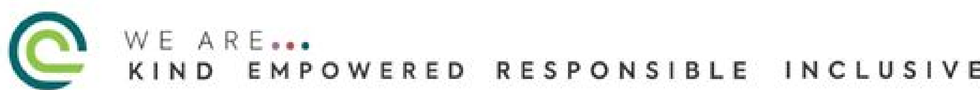
The content of this paper could have an adverse impact on:	Age	No	Disability	No	Sexual Orientation	No
	Race	No	Pregnancy/Maternity	No	Gender Reassignment	No
	Gender	No	Religious Belief	No		

Patient/Staff Story Action Report

Story ID	July 2023	Committee	Board of Directors		
Date Presented	TEG	Patient Story	☒	Staff Story	☐
		In person	☐	Digital	☒
Date Consent Obtained	30/06/23	Consented by	Poppi Dickens (SLTA) Heulwen Sheldrick (SLT)	Consent for:	☒ Internal ☒External ☒Online Anonymized
Division/s involved	CBU2		External Organisation involved	LUFHT – Aintree Liverpool H&N Centre	
Formal Complaint	☐	Complaint closed	☐	Complaint Upheld	☐

1. Action Already Taken

No	Issue	Action taken	Action Lead
1.	**Integration of teams – 'Joining the dots' across services in C&M**	Working in an integrated fashion means that the C&M H&N SLT Team are naturally better placed to 'join the dots' and offer a cohesive service across C&M. This means that patients have an improved and relatively seamless access to services. At this beginning or of patient story, we have embedded a presentation – and this highlights the demonstrated & measurable differences made – for example 1) reducing waits for patients when being transferred across teams, 2) reducing time taken for clinical decision making and 3) speed of onward referrals (eg to lymphoedema therapy services)	
2	**Co-creation & co-development of clinical services with patients**	The C&M H&N SLT Team are currently working with patients to co-create and co-develop the service, as evidenced by 'John' in the patient story who was delighted to be included in the development of patient leaflets.	



Ref: FCGOREPO
Review: July 2025
Version: 2.0

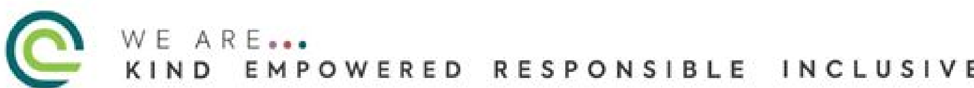
3	**Improving communication about clinical issues/actions**	Patients have described the 'overwhelm' when trying to absorb the enormity of clinical issues/impacts. As the pandemic restrictions have passed, we are encouraging patients to bring a supporter with them, and to consider their specific questions in advance – evidence from the Patient Story demonstrates the importance of this.	

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

No	Issue	Action required	Action Lead	Deadline Date	Expected Evidence of Completion
1.	Formal evaluation of the outcomes and impact of the integrated SLT workforce approach for H&N cancer	The SLT team are undertaking formal evaluation of this work – with the University of Liverpool. This work includes a range of methods to capture experiences of patients, staff and leaders, as well as demonstrating impact on care pathways and clinical outcomes. The Trust leadership team are asked for continued support to : - undertake evaluation interviews with relevant staff - Continue to capture patient stories - Support the required HR & IM&T flexibilities - Support data capture of clinical pathways & outcomes.	Heulwen Sheldrick	Jan 2024	Evaluation Interviews Patient narratives of experiences Performance Reports

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

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



Title of meeting: Trust Board
Date of meeting: July 2023

Report of	Chief Nurse
Paper prepared by: In attendance at the visit	Quality Improvement Manager - Claire Smith Non-Executive Director – Mark Tattersall Governor – Andy Waller
Report subject/title	NED and Governor Engagement Walk-round June 2023
Purpose of paper	The purpose of this report is to provide Trust Board with a summary of the NED & Governor Patient Experience visit conducted on the 13th June 2023. The panel visited the Brachytherapy unit and Clatterbridge Private Clinic both on level 1, CCCL.
Background papers	n/a

Action required		
	To approve content/preferred option/recommendations	
	To discuss and note content	X
	To be assured of content and actions	

Link to: Strategic Direction Corporate Objectives				
	Be Outstanding	x	Be a great place to work	X
	Be Collaborative		Be Digital	
	Be Research Leaders		Be Innovative	

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

Ref: FCGOREPO
Review: July 2025
Version: 2.0

Division	Radiation Services	Location	Brachytherapy unit. Level 1, CCCL.	Date	13th June 2023
In attendance – Panel			In attendance – Patient & Staff		
Governor	Andy Waller		Senior Manager facilitating the walk round		Louise Bagley Kate Rossiter
Non-Executive	Mark Tattersall		Number of Patients		1
Patient Experience Team	Claire Smith		Number of Staff		8

Patient Feedback: The patients were asked to describe their experience of care at CCC NB: *This is not a verbatim record but an overview of the key themes raised during the conversation.*	
Positive Patient Comments: • The patient explained as a very anxious person the staff have been amazing, nothing is too much trouble for them. • Although not a nice reason to be here the experience has been wonderful. • The staff are very calming without knowing it and they make the best 'toast' 5 stars, much better than the café!	• All appointments are arranged to run concurrently, therefore if one is running over staff can call and rejig the others which is great. • I feel safe here, staff are always honest with me which helps with my anxiety. • One of the volunteers in radiotherapy remembered my name after one visit, which meant the world to me.
Areas where immediate action was taken on the day: • None	
Areas for improvement: • N/A	Service response: *Highlight in **Bold** actions to be added to PEIC action plan* • N/A

Staff Feedback: Staff were asked to describe their experience of providing patient care at CCC NB: *This is not a verbatim record but an overview of the key themes raised during the conversation.*

Senior staff from the Brachytherapy team gave a tour of the theatre and explained different patient pathways and treatments throughout the department. The team discussed collaborative working with other teams and their relationship with LUFHT. Despite challenges in the immediate months following the move to Liverpool, the team explained how they felt the unit was potentially one of the best facilities for patients nationally. The team had recently facilitated a visit with staff from Velindre Hospital who were very impressed by the unit. The team highlighted a number of quality improvement projects that they have identified and implemented that have reduced patient treatment times and therefore time spent in the department.

The team highlighted that CCC is one of the largest skin services in the country, currently the moulds required to treat patients are made with wax. This is a labour-intensive method; however, the team are looking to move to 3D printing in the future.

The team explained that they not only deliver treatments but also facilitate general anaesthetic for TYA/patients with additional learning needs. Recently the team were able to co-ordinate the care of a patient enabling them to have a CT scan, PET scan, bone marrow aspiration and insertion of a catheter during one appointment.

The staff informed the visit of a couple of concerns, firstly with the new Papillion machine which frequently drops Wi-Fi connectivity. The CCC team are working closely with the manufacturer and have invited them into the department on a number of occasions to observe the problems they are experiencing first-hand. The problems have caused some delays for patients as capacity has been reduced and patients' appointments have occasionally been re-arranged. Staff also showed the visit the staff break area which can only accommodate 3-4 staff at any one time, however there can be more than 20 staff on duty. This can occasionally cause an issue as staff are encouraged to stay within the unit during breaks for infection prevention reasons.

Positive Comments: from a group discussion with staff on duty

- Most staff who spoke to the visit also works or has worked in other areas, however all staff expressed a view that this was their favourite area to work in. The team is brilliant and working with a live source of radiation has meant that staff learn different skills during their rotation into the department.
- The team is very supportive of one another, staff are able to work both collaboratively but also autonomously.
- The experience behind the scenes is invaluable, lots of opportunity for staff to get involved in project work, audits, developing work processes etc.
- Staff explained how they felt they had a say and influence in quality improvements with their views and opinions being valued.
- In summary staff said, “they love working in the department”.

Areas where immediate action was taken on the day: None	
Areas for improvement: • Issue raised with the Papillion machine	Service response: • The team have put a number of mitigations in place to support the service whilst there are issues with the equipment so patients can continue to access this type of treatment. There are issues with the equipment which are regularly fed back to the manufacturer to resolve and the impact of this is being managed within the Department / Division.
Observations on the day • The department appeared very calm and organised. • All staff encountered were friendly and smiling.	

Division	Clatterbridge Private Clinic	Location	Clatterbridge Private Clinic, Level 1, CCCL.	Date	13th June 2023
In attendance – Panel			In attendance –Staff		
Governor	Andy Waller		Senior Manager facilitating the walk round		Duncan Armfield
Non-Executive	Mark Tattersall		Number of Patients		0
Patient Experience Team	Claire Smith		Number of Staff		1

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

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

The general manager who met the panel explained he is new in post (7 weeks) and he went on to briefly outline the current issues facing the private clinic and the potential solutions. Currently the clinic on the CCCL site is achieving lower activity levels than the clinic at CCCW. Ideally, the clinic will be able to increase its number of consultants, in particular consultants specialising in eye, brain and gynaecological cancers are required. The

manager highlighted the close working relationship the clinic is afforded with CCC, providing much support. In addition to the above, immediate future challenges include recruiting to the lead nurse post which is currently vacant and identifying those NHS patients who have private healthcare cover which could potentially release capacity within the NHS.
No patients were interviewed during this visit.
Areas where immediate action was taken on the day: • N/A

Staff Feedback: Staff were asked to describe their experience of providing patient care at CCC NB: *This is not a verbatim record but an overview of the key themes raised during the conversation.*	
Positive Comments: • Staff were not interviewed during this visit.	
Areas where immediate action was taken on the day: None	
Areas for improvement; • Recruiting to the Lead nurse post • Recruiting additional consultants.	Service response: • An advert will be posted on the 23rd June to recruit a modified Lead Nurse for the Clinic. Until then this will be mitigated by support from the senior nursing team at Network in CCC • Since the visit 5 further Consultants are now going through registration and 2 further considering Private Practice.
Observations on the day • The department appeared calm, staff encountered very friendly and smiling.	

Title of meeting: The Board
Date of meeting: 26th July 2023

Report author	Helen Wong, Quality Manager (Audit & Statistics)			
Paper prepared by	Helen Wong, Quality Manager (Audit & Statistics)			
Report subject/title	Mortality Dashboards, Summary Report 2022-2023 Q4 and Mortality annual report			
Purpose of paper	To present Q4 22/23 Mortality dashboard and reports including: 1) Mortality review dashboard 2) Mortality summary report 3) Mortality lesson learnt 4) Mortality annual report			
Background papers				
Action required	For noting			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work	
	Be Collaborative		Be Digital	
	Be Research Leaders		Be Innovative	

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

Total Number of Inpatient, 30 day SACT, 30 day RT and 90 day Radical RT Deaths

The Clatterbridge Cancer Centre NHS Foundation Trust

Number of Deaths in Scope and Phase 1, 2 & 3 Reviews between Apr 2022 and Mar 2023

Year	Number of Deaths in Scope	Total Deaths Requiring Phase 1 Review	Total Deaths Reviewed (Phase 1)	% Deaths Reviewed (Phase 1)	Total Deaths Reviewed (Phase 2)	% Phase 1 Reviews Reviewed (Phase 2)	Total Deaths Selected for Review (Phase 3)	Total Deaths Discussed (Phase 3)	% Discussed (Phase 3)
2022/23	**794**	**687**	**517**	**75%**	**423**	**82%**	**41**	**23**	**56%**
Q4	218	189	104	55%	60	58%	4	0	0%
Q3	213	186	147	79%	120	82%	17	8	47%
Q2	197	170	132	78%	116	88%	11	6	55%
Q1	166	142	134	94%	127	95%	9	9	100%
Total	**794**	**687**	**517**	**75%**	**423**	**82%**	**41**	**23**	**56%**

Total Number of Learning Disabilities in Scope

Year	No.	LeDaR Completed	Potentially Avoidable (Score <= 3)
2022/23	**1**	**1**	0
Q4	0	0	-
Q3	0	0	-
Q2	1	1	0
Q1	0	0	-
Total	**1**	**1**	0

Total Number of Children in Scope

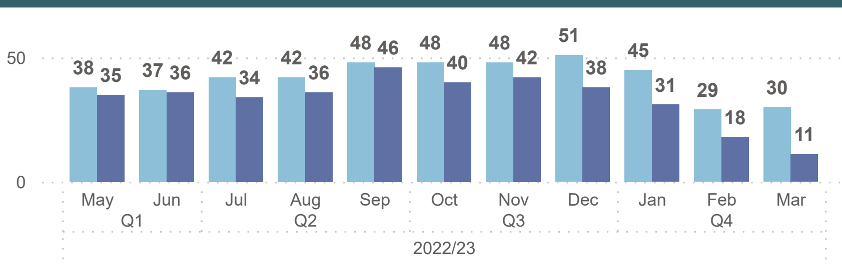
Year	No.	CDOP Completed	Potentially Avoidable (Score <= 3)
2022/23	**1**	**1**	**0**
Q4	0	0	-
Q3	0	0	-
Q2	1	1	0
Q1	0	0	-
Total	**1**	**1**	**0**

"-" occurs when the quarter/ case score is yet to be finalised

Total Structured Judgement Reviews completed and avoidability scored against RCP Methodology (Conducted for inpatient deaths only)

Year	Score 1 - Definitely Avoidable	Score 2 - Strong Evidence of Avoidability	Score 3 - Probably Avoidable (more than 50:50)	Score 4 - Probably Avoidable but not very likely	Score 5 - Slight evidence of avoidability	Score 6 - Definitely Not Avoidable
2022/23	**0**	**0**	**0**	**0**	**0**	**127**
Q4	0	0	0	0	0	20
Q3	0	0	0	0	0	36
Q2	0	0	0	0	0	34
Q1	0	0	0	0	0	37
Total	**0**	**0**	**0**	**0**	**0**	**127**

Number of cases reviewed at Phase 1 & Phase 2



1.0 Background

The National Guidance on Learning from Deaths published in March 2017 requires Trusts to collect and publish specified information on inpatient deaths on a quarterly basis. This should be tabled via a paper to a public Board meeting including learning points of data.

The data should include the total number of the Trust's inpatient deaths i.e. those deaths that the Trust has subjected to case record review. Of these, Trusts will need to provide how many deaths were judged more likely than not to have been due to problems in care.

2.0 Mortality Review Inclusion Criteria

Trust mortality review process started in June 2012. Patients who fit the following criteria are included:

- All inpatient deaths
- 30 day post chemotherapy or radiotherapy mortality (excluding spinal, bone metastases cases and those treated with one fraction of eight gray)
- 90 day post radical radiotherapy mortality
- 100 day or 1 year post bone marrow transplant mortality

All inpatient deaths are assessed using a Structured judgement review (SJR) proforma, which is an evidence-based methodology provided by the Royal College of Physicians.

3.0 Case Review and Selection Process

Phase I - Responsible consultants independently review the care patients to highlight areas of concern
Phase II – An in-depth SJR is conducted for all inpatient deaths. A multidisciplinary review of cases that may have concerns or good practice to highlight are brought for discussion at the Trust mortality review meeting to enable lessons to be learned
Phase III – A multidisciplinary mortality review meeting is held to discuss those cases selected in Phase II, and re-score the SJR score if necessary.

SJR score
Score 1: definitely avoidable
Score 2: strong evidence of avoidability
Score 3: Probably avoidable (more than 50:50)
Score 4: Possibly avoidable but not very likely (less than 50:50)
Score 5: Slight evidence of avoidability
Score 6: definitely not avoidable

4.0 Dashboard Interpretation

Data coverage: April 2022 – March 2023 for comparison to previous quarters

Year				2022/23	Total
	Q1	Q2	Q3	Q4	
Total Patient Deaths	166	197	213	218	**794**
Number of Inpatient Deaths	39	47	50	53	**189**
Number of Outpatient Deaths	127	150	163	165	**605**
Outpatient (Requiring Review)	103	123	136	136	**498**
No. Cases Requiring Review	142	170	186	189	**687**
No. Cases Reviewed Phase 1	134	132	147	104	**517**
% Cases Reviewed Phase 1	94%	78%	79%	55%	**75%**
No. Cases Allocated for Phase 2	134	129	146	93	**502**
No. Cases Reviewed at Phase 2	127	116	120	60	**423**
% Cases Reviewed Phase 2	95%	88%	82%	58%	**82%**
No. Cases Selected Phase 3	9	11	17	4	**41**
No. Cases Discussed Phase 3	9	6	8	0	**23**
% Cases Discussed Phase 3	100%	55%	47%	0%	**56%**

N.B Process takes a minimum of 6 months to complete

- 82% (423/502) of cases had completed an independent peer review (Phase II) from April 2022 – March 2023 deaths. The process can take a minimum of 6 months to complete.

- From this, 41 cases have been selected for discussion out of which, 23 cases have been discussed (x9 inpatients and x14 Community/Other Hospital).

  The scores for these cases are:

  - Inpatient SJR RCP Scores: All x9 cases were scored 6.
  - Community/Other hospital inpatient RCP Scores: All x14 cases were scored 6.

  Of the remaining x18 cases awaiting discussion:

  - x9 are due to be discussed in Q1 2023/24, x4 will be discussed in Q2 2023/24 and the remaining x5 are awaiting a convenient date for discussion from the responsible consultant

- 0 mortality cases this quarter were subject to LeDeR review (Learning Disability)

- 0 mortality cases this quarter were subject to a Child Death Overview Panel review (CDOP

5.0 Inpatient SJR Score (avoidability score <6) case description

There were no new Inpatient SJR scores <6 reported during the period

5.1 Community/Other hospital inpatient RCP Score (avoidability score <6) case description

There were no new community/other hospital inpatient RCP scores <6 reported during the period

6.0 Statistical Deep Dive Analysis of Chemotherapy (30 day) and Radiotherapy (30 day / 90 day) mortality

In addition to the mortality review of individual cases, the Trust has been performing a deep dive analysis on chemotherapy mortality drilled down by intent and consultant in the form of Statistical Process Control (SPC) charts since 2009.

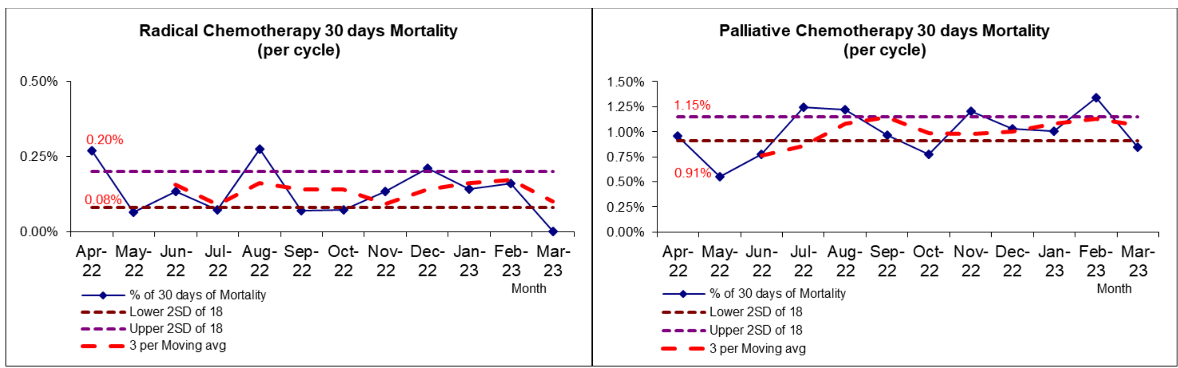
The control limits (lower & upper 2 standard deviation – brown dash line on chart) are reviewed annually and are set by the best performing annual figures from 2009 onward. All data points fallen inside the control limits are deemed to be within tolerance.

The trend is displayed by the three months moving average (red dash line on chart). If increasing trend is identified on the chart, these are audited by the Site Reference Group (SRG).

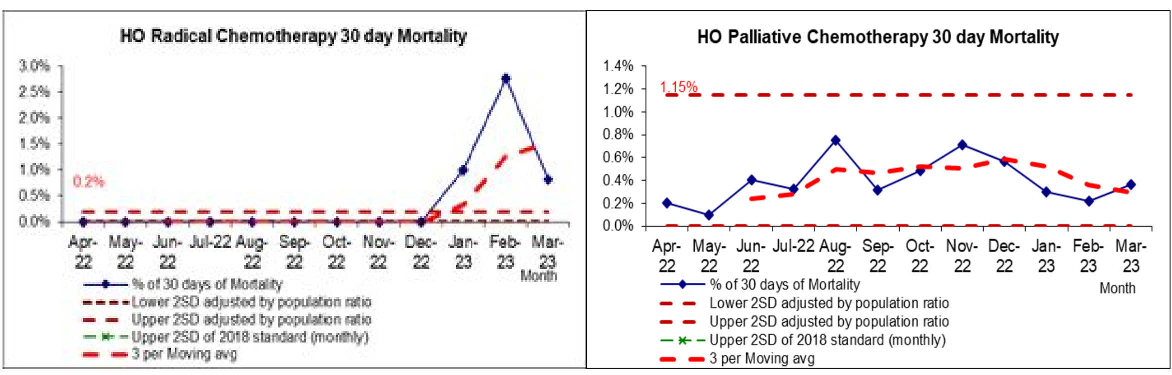
April 2022 – March 2023 treatment activities

- Results showed the 3 monthly moving average mortality for solid tumour SACT & RT 30 day mortality were within tolerance, as well as RT 90-day mortality.
- There were 3 deaths in February 2023 in radically treated HO patients. The Team will ensure mortality review process is followed.

6.1 Chemotherapy 30 day mortality (Solid Tumour)

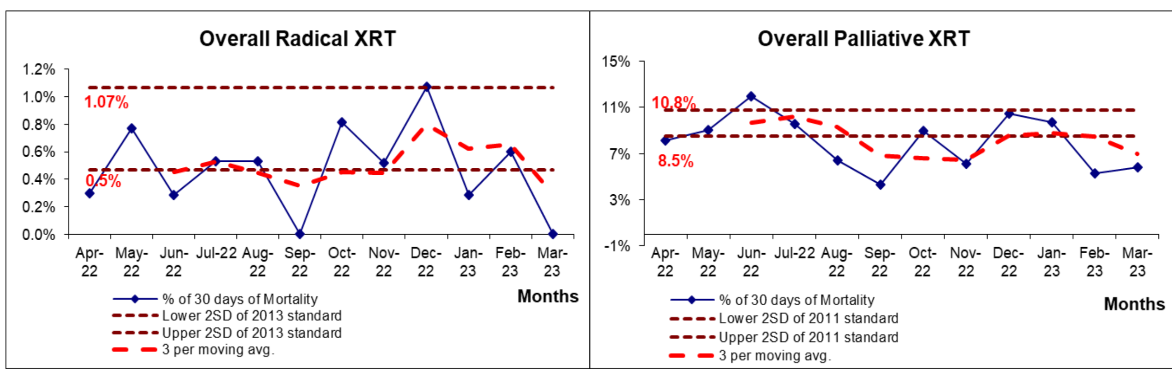


6.2 Chemotherapy 30 day mortality (Haemato-oncology)

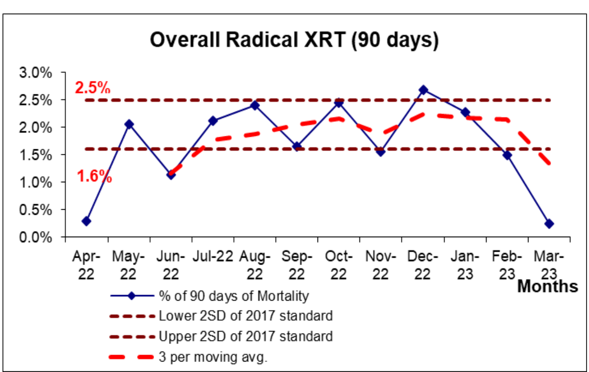


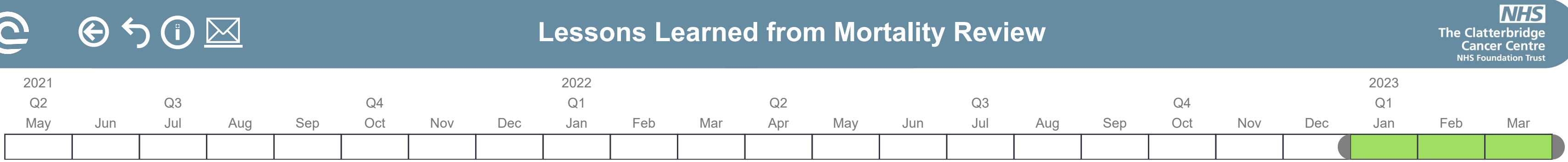
**Due to small number of patients in the radical chemotherapy group, the single peak was related to a single death of that particular month.*

6.3 Radiotherapy 30 day mortality



6.4 Radical radiotherapy 90 day mortality





ID	Year	QTR	Background	Action	CCC Lessons learned	Closure date
130	2022/23	Q4	Dabrafenib + Trametinib was commenced in a frail melanoma patient with a PS 4. The patients PS measured 4 as he was on strict bed rest and was in a lot of pain. At the time of the decision to treat it was felt this was appropriate as this regime has a high response rate with a likelihood of improving the patient's symptoms quickly (70-80%). In melanoma patients PS 3-4 is almost irrelevant.	The MRM asked for a prospective audit to be completed for patients on this regimen looking at symptom improvement, QOL, toxicity and survival.	A prospective review of 6 cases was undertaken. Results demonstrated in frail patients in whom this treatment regime was used there was frequent partial response and symptom improvement which provides assurance that this treatment can be an appropriate treatment even in poor performance status.	22/03/2023
162	2022/23	Q4	A patient's hydrophronephrosis was commented on in December and was potentially missed as the scan was sent to the consultant, but the patient subsequently met with a Nurse consultant. The MRM asked whether the report had an actionable alert as this would be dealt with by the on-call registrar. The patient was not harmed.	The group asked that an action be assigned to the Quality Manager for Radiation Services to investigate why an alert was not attached to the scan in this case.	This scan did not have an alert attached as the Trust's policy: 'Communication of Critical and Urgent Radiological Findings' (OIMPCRITF) does not include hydronephrosis as a critical or urgent finding requiring an alert. The group asked whether hydronephrosis should be added to the Urgent or Critical alerts- the need for this varies across SRGs. It has been left as an optional standard and SRGs have been invited to opt in if this is a relevant standard for their patients.	21/02/2023
165b	2022/23	Q4	A patient died of neutropenic sepsis whilst receiving complex chemotherapy on the Isle of Man. This case highlighted the challenges of remotely supervising patients' treatment on IOM. The group recommended that complex regimes post COVID should be administered locally and to depart from that would be at the consultant's discretion and should be documented. The group also suggested a collective discussion between consultants who treat IOM patients and the associate medical director of network services as chair of the network chemotherapy group to decide on the safest way to deliver this service.	A collective discussion to be had between consultants who treat IOM patients and the associate medical director of network services (Chair of the network chemotherapy group) to decide on a way to deliver a safe service.	Complex chemotherapy regimens for patients from the Isle of Man should be delivered locally unless documented otherwise by the treating consultant. A clinical working group with a focus on the development of the model of care has been established to determine the pathway for this.	14/03/2023
166a	2022/23	Q4	A patient died without their escalation status having been reviewed and they received CPR. The treating consultant reviewed the notes and could not find a documented discussion and stated that deterioration was expected and resuscitation decision and end of life care should have been discussed earlier as this would have avoided CPR being commenced.	Updated training including DNACPR discussion was requested for the haemato-oncology team.	The Haemato-oncology team have now attended their mandatory training in EOLC.	22/01/2023
173	2022/23	Q4	A patient became increasingly fatigued and when assessed his pro BNP was significantly elevated so he was admitted with a presumptive diagnosis of IO induced Myocarditis. He was reviewed by the IO team. Investigations were not entirely consistent with Myocarditis. The question raised by the independent reviewer was that the patient had a raised pro BNP when he started to develop symptoms but there was no baseline for colleagues to assess if this had changed in relation to the therapy.	The MRM asked that the baseline management flow diagram be circulated to the SRG Chairs meeting and consideration given to the need for baseline pro-BNP.	The Pre-Assessment Baseline Cardiac Pathway was included in the SRG chairs meeting agenda. Also as a result of this case requests are now made for a baseline pro BNP prior to starting treatment. This is now Trust standard practice for all IO treatments. MRIs of the heart are also ordered for patients if they have had a recent cardiac event. A pathway is now available on the intranet which stipulates which baseline information is required prior to commencing IO, there is also a panel in Meditech and a hyperlink is included in treatment protocols.	21/02/2023
176	2022/23	Q4	A patient's family raised concerns with the medical examiner regarding the management of low BMs in a patient at the end of life.	Mortality Review Meeting chair asked treating consultant to meet with the clinical director of acute care, consultant in palliative medicine, pharmacy and the ward matron to discuss care pathways for patients with advanced disease, who are dying and what monitoring is undertaken.	Hypoglycaemia is not uncommon in dying patients and is often refractory to management at the end of life. Closer monitoring does not provide more effective treatments and comes at the cost of being more invasive and uncomfortable for those receiving end of life care. The need to review BMs as part of the dying process already exists within the trust's end of life care and communication record. There have also been recent changes in the diabetes service provision for inpatients at CCC; there is now daily availability of a diabetes specialist nurse on site at CCCL. They will be beneficial in advising on the diabetes management for inpatients and reviewing medication, insulin dosage and administration where these are complicated in those receiving end of life care.	31/03/2023
176b	2022/23	Q4	A patient's family raised concerns with the medical examiner regarding the management of low BMs in a patient at the end of life.	Mortality Review Meeting chair requested confirmation that all medications administered including insulin are recorded to reassure clinicians and patients/families alike that there is a record of appropriate processes being followed and documentation.	Pharmacy are reviewing options for digital record keeping within meditech to ensure correct and contemporaneous oversight of medications such as digoxin, KCl and insulin where there is the potential for harm. Currently all medications are supplied on a named patient basis which enables tracking of medications within practical limits.	31/03/2023
179	2022/23	Q4	Concerns were raised regarding a patient's morphine prescription. On transfer to CCC a patient was on a drug called MXL which is a once daily preparation of morphine sustained release and is not used at CCCL. As a consequence this prescription was changed to a BD preparation resulting in double the usual daily dose being prescribed. The patient was not harmed as a result.	Pharmacy were asked to review their processes for handling unfamiliar medications and the process for supporting junior colleagues.	Pharmacy have action in place regarding the technicians and what they communicate to the ward pharmacists around any potential unusual doses or unusual drugs that they don't recognize. The pharmacists have been advised to use non-formulary on the drug history for items that aren't used in Meditech rather than using brands that are not interchangeable.	22/03/2023
76	2022/23	Q4	A patient was treated with sorafenib despite her platelets being below 50. Whilst this did not lead to death, the MRM requested an audit and updated protocol relating to treatment with sorafenib in the presence of low platelets. Given the presence of splenomegaly in the hepatobiliary population it was felt this was potentially not an uncommon caution with this medication.	Pharmacy & The HPB team reviewed the Sorafenib protocol regarding neutrophil and platelet counts in relation to prescriptions in patients with splenomegaly Retrospective audit of platelet levels in patients treated with sorfenib was undertaken by CET.	The Clinical Effectiveness team examined 5 years' worth of cycles of Sorafenib and identified 126 patients with Liver cancer. Out of the 217 platelet results there were 4 below 50 (3 patients all in 2018) and out of the 216 neutrophil results zero were below 1. No harm was caused from these treatments. The sorafenib protocol has been updated and circulated detailing that this treatment should be discussed with a consultant before administration if platelets are below 50.	31/03/2023

Mortality Surveillance Group Annual Report 2022-2023

Prepared by: Dr. Sheena Khanduri (Medical Director & Chair of Mortality Surveillance Group)

Dr. Dan Monnery (Consultant Palliative Care)

Dr. Zaf Malik (Consultant Clinical Oncologist & Consultant Mortality Lead)

Helen Wong (Quality Manager –Audit & Statistics)

Marie McKay (Clinical Audit and Information Specialist)

Andrea Law (Clinical Audit and Information Specialist)

on behalf of Mortality Surveillance Group

Members: Elkan Abrahamson (Non-Executive Director), Vikram Singh (Consultant Haemato-Oncologist & Consultant Mortality Lead), Safeguarding representative, Legal & Governance Manager and Associate Director of Clinical Governance and Patient Safety.

Table of Contents

A message from the medical director 3
A message from the Consultant Mortality Lead 3
Executive Summary 4
Progress against previous year's annual report 'looking to the future' objectives 5
Clinical Audit / QUIP Project Award Winner 6
Board Development Session: Mortality – Learning from Deaths 7
The Specialist Palliative Care Team Published Articles 8
End of life & Symptom Control Education Delivery 9
National Mortality Benchmarking 10
Evolution of the Trust's Mortality Review Programme 11
Roadmap of Trust's Mortality Review Programme 12
Mortality Review Scrutiny 2022/2023 13
Detailed Mortality Review Process for CCC 14
Digitised Mortality Review Process 2022/2023 16
Compliance against National Guidance on Learning from Deaths 2022/2023 19
Medical Examiner System Roll out at CCC 20
Lessons Learnt from Mortality Review Process 21
National Audit of Care at the End of Life (NACEL) – Round 4 28
Audits arising from Mortality Review Process 32
Quality Surveillance and Specialised Services 33
National 30 Day Mortality after Palliative Radiotherapy Benchmarking 40
National 30 Day SACT Treatment Mortality Benchmarking 43
In House 30 Day Treatment Mortality Analysis 44
CCC Cancer patient survival rate by Specific Tumour Group 48
Looking to the future 2023/24 51
Glossary 52

A message from the medical director

The annual mortality report brings together the achievements of 2022-23 , with our continued focus on learning to improve our care. The year has brought challenges as patients and our services recover from the impact of Covid 19 on a background of areas of known health inequalities and rising demand. In spite of these we are able to demonstrate the high quality of care through National benchmarking and compliance with our National and regulatory requirements.

This can only be achieved through the hard work and dedication of our teams who work above and beyond to provide the very best care and to seek to reflect and learn from the deaths of our patients and the feedback of relatives to improve our care.

I would like to thank all colleagues for their contribution and care they provide.

Dr Sheena Khanduri

A message from the Consultant Mortality Lead

2022-23 has been another year of progress and achievement for the team supporting the mortality review process. Our achievements include implementation of a bespoke mortality module in Datix as well as integration of the haemato-oncology team into our mortality review process.

The mortality review meeting is a multidisciplinary educational and learning environment for all medical colleagues and allied health professionals. We aim to review and celebrate good practice and identify any areas where we could improve our service and the quality of care for our patients.

The mortality review meeting provides a safe and open forum for discussion and I wish to take this opportunity to thank all of my colleagues for their participation, reflection and valued comments.

These lessons learnt will shape improvement of our service and patient care.

Dr Zafar Malik

Executive Summary

BE OUTSTANDING

- Dr Dan Monnery won the Trust Best Quality Improvement of the year award for the care of the dying evaluation re-audit (CODE)
- Best ever results received for round 4 of the national audit of care at end of life (NACEL)
- Palliative Care Team in conjunction with Clinical Education launched a New masters module in EOLC at University of Liverpool
- Outcomes for Haematopoietic Stem Cell Transplantation (Adult) were monitored using the Quality Surveillance Specialist Services dashboards and are now monitored using the newly launched Model Health System
- Compared favourably against the newly launched National 30 day Radiotherapy Mortality benchmarking and the National SACT for Breast Cancer

BE COLLABORATIVE

- Board development session delivered by the Medical Director, Mortality Consultant lead, Consultant in Palliative Medicine/Patient Safety Chair & Quality Manager (Audit & Statistics) and was well received
- National Systemic Anti Cancer treatment body published 30 day mortality benchmarking for a number of tumour groups, the Trust is compariable or better than the national average figure for majority of tumour groups
- The CCC Palliative Care Team published 3 articles in collaboration with other Trusts
- The CCC Palliative Care Team launched a national webinar on symptom control and advanced care planning

BE A GREAT PLACE TO WORK

- Delivery of end of life care training to tumour specific site reference groups and junior doctors
- The mortality review process continues to be an open and safe environment for consultants to reflect, share learning and highlight excellence
- The CET team provide Datix training videos to consultants at the Trust alongside bespoke one-on-one training on request
- External and Internal Symptom Control Teaching was launched
- The Supportive Care SRG deliver bi-weekly education
- End of Life Care forms part of clinicians mandated education programme
- Lessons learned from cases are cascaded throughout the Trust

BE RESEARCH LEADERS

The CCC Palliative Care Team published 3 articles on Enhanced Supportive Care:

- Multidisciplinary supportive care in cancer: cost analysis – The BMJ
- Palliative care clinical nurse specialists leading enhanced supportive care in hepatopancreatobiliary cancer - International Journal of Palliative Nursing
- Delivery Models and Health Economics of Supportive Care Services in England: A Multicentre Analysis - The Royal College of Radiologists: Clinical Oncology

BE DIGITAL

- Datix Mortality Module was designed, built and launched on 16th May 2022 alongside bespoke training videos. The digitisation of the process enables a more efficient system for clinicians to engage
- Launched the Trust Mortality Dashboard using Power BI
- Launched Trust Mortality Compliance Dashboards using Power BI

BE INNOVATIVE

- Continued evolution of the Trust Mortality Review Programme
- Continued development of local in house benchmarking (Deep Dive Analysis) as SHMI & HSMR indicators are not applicable to CCC

Progress against previous year's annual report 'looking to the future' objectives

Looking to the future 21/22 - We Said, We Did

Completed during 2022-2023

✓ Participated in NACEL Round 4
- All data was uploaded on 14th September 2022 within the agreed timescale
- Bespoke dashboard received in March 2023
- Trust individual action plan has been developed

✓ Digitised the mortality review process by embedding a Datix system to support the data collection and reporting process
- New Datix Mortality Module went live May 2022

✓ Strengthened integration of the medical examiner role into CCC processes
- Embedded process now in place for medical examiner feedback
- Regular report fed into Mortality Surveillance Group Meeting

✓ Digitised the Mortality Review Dashboard
- Power BI Dashboard went live December 2022

Developments continuing during 2022-2023

∞ Mortality Management Strategy is in development (formerly Mortality Reduction Strategy)
- Consultant in Palliative Medicine conducted an audit of all inpatient deaths between 2020-2022 with the aim of identifying trends and whether any interventions might be appropriate to prevent unwarranted admission for patients at the end of life.
- The audit was discussed at the mortality surveillance group. It was noted there had been increased admissions to CCCL, this was congruent with the role of the Trust in supporting the wider system in the delivery of urgent care for our patients and reflected an expected increase in the acuity of patient illness since the move to Liverpool. The group were satisfied that these admissions were appropriate and that the care being given is within the core service offer of the Trust.
- The audit is to be repeated in January 2024.

∞ Continued to investigate means of cascading lessons learned Trust wide
- Awaiting establishment of Trust wide shared learning mechanism

∞ Continue to work with tumour Specific Site Reference Groups to develop outcome measures/benchmarking
- 30 and 90 day chemotherapy deaths now included in new Lung SRG dashboard.

Clinical Audit / QUIP Project Award Winner

Dan Monnery, Consultant in Palliative Medicine was presented the award for Best Quality Improvement and Clinical Audit of the Year at The Clatterbridge Cancer Centre for his project 'Care of the Dying Evaluation (CODE)'.

The project, which the Palliative Care Team has conducted over the past two years, asks bereaved people about their experience of the care Clatterbridge provides to end of life patients.

This project proved very valuable as feedback has identified changes that can be made to improve care for future patients. Some key improvements that have already been enforced as a result of this audit include:

- Improved discussions about artificial hydration and nutrition for people at the end of life.
- New training in spiritual and emotional care for all clinical staff
- Documentation changes to prompt all clinicians to involve families more in treatment decisions and communicate regularly about what to expect in the coming hours to days.

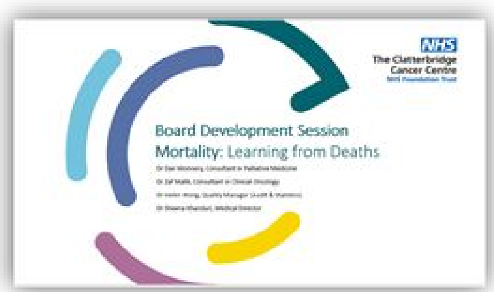
Dan said: "This is an important award for us as it recognises the value in asking for feedback from people during a difficult time, and while it is a difficult topic to talk about, people have been generous in sharing their thoughts to help us improve. We are grateful to everyone who participated."

The award pays tribute not only to Dan's hard work and dedication but also to the rest of the Palliative Care Team who have gone above and beyond for patients facing the end of life. In fact, the team also won the 2nd and 3rd prize in this award category.

Board Development Session: Mortality – Learning from Deaths

A board development session was delivered by the Medical Director, Mortality Consultant lead, Consultant in Palliative Medicine/Patient Safety Chair & Quality Manager (Audit & Statistics) and was well received. The presentation covered all aspects of the mortality review process at CCC and strove to provide assurance and highlight the excellent practice undertaken across the Trust in all aspects of Mortality.

Some examples of the presentation are included below:



The Specialist Palliative Care Team Published Articles

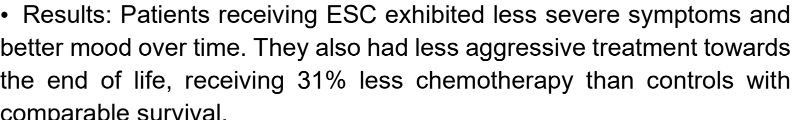
The Clatterbridge Cancer Centre Palliative Care Team had 3 articles published in relation to the Enhanced Supportive Care Service:

Multidisciplinary supportive care in cancer: cost analysis - Monnery D, Liu Y, Griffiths A, Lockhart J, Coyle S, Olsson-Brown A.

- Purpose: Enhanced supportive care (ESC) is the early implementation of supportive care in cancer. In England, this model is being developed to support patients with treatable but not curable cancer and implements a multiprofessional approach.
- Results: Our ESC service required the input of seven professional groups and cost £125 542 for 12 months. ESC patients had an average of 1.72 fewer admissions per patient per last year of life than the national average. Length of stay was reduced from an average of 9.2 days to 4.78 days per admission in the last year of life. The reduced secondary care usage saved £2 398 537.68.
- Conclusions: Outpatient ESC in this cohort required an multidisciplinary team approach and saved money through secondary care use reduction.

Palliative care clinical nurse specialists leading enhanced supportive care in hepatopancreatobiliary cancer - Benson S, Wong H, Olsson-Brown A, Coyle S, Monnery D.

- Purpose: Integration of care between palliative care and oncology can improve patient outcomes and is increasingly recommended. Enhanced supportive care (ESC), led and delivered by palliative care clinical nurse specialists, is a potential model to achieve this but evidence about it is lacking. This research aimed to evaluate a nurse-led integrated ESC model within hepatopancreatobiliary cancer care.



- Results: Patients receiving ESC exhibited less severe symptoms and better mood over time. They also had less aggressive treatment towards the end of life, receiving 31% less chemotherapy than controls with comparable survival.
- Conclusion: An integrated, nurse-led ESC model can be effective in improving outcomes for patients with hepatopancreatobiliary cancer.

Delivery Models and Health Economics of Supportive Care Services in England: A Multicentre Analysis - Monnery D, Tredgett K, Hooper D, Barringer G, Munton A, Thomas M, Vijeratnam N, Godfrey N, Summerfield L, Hawkes K, Staley P, Holyhead K, Liu Y, Lockhart J, Bass S, Tavabie S, White N, Stewart E, Droney J, Minton O.

- Aims: Improvements in cancer treatment have led to more people living with and beyond cancer. These patients have symptom and support needs unmet by current services. The development of enhanced supportive care (ESC) services may meet the longitudinal care needs of these patients, including at the end of life. This study aimed to determine the impact and health economic benefits of ESC for patients living with treatable but not curable cancer.
- Results: In total, 4594 patients were seen by ESC services, of whom 1061 died during follow-up. Mean IPOS scores improved across all tumour groups. In total, £1,676,044 was spent delivering ESC across the eight centres. Reductions in secondary care usage for the 1061 patients who died saved a total of £8,490,581.

- Conclusions: People living with cancer suffer with complex and unmet needs. ESC services appear to be effective at supporting these vulnerable people and significantly reduce the costs of their care.

End of life & Symptom Control Education Delivery

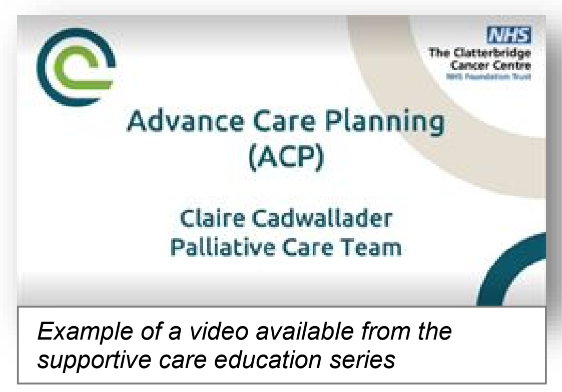
Dr Dan Monnery delivers end of life training to SRGs and junior doctors. He also delivers symptom control teaching internally to junior doctors and externally to the GP training schools and delivers national webinars on symptom control and advanced care planning including for charities such as Pancreatic Cancer UK, Lymphoma Action and The Royal College of Emergency Medicine

Master's module in palliative & end of life care

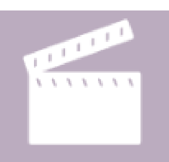
Dr Monnery and his team in partnership with clinical education also launched a new Master's Module in Palliative and End of Life Care at the University of Liverpool.

Education series on supportive care

The Supportive Care SRG has also launched an education series on supportive care which runs biweekly on a Wednesday morning and has now been running successfully over the last year. The education series cover common symptom management, holistic care for patients approaching end of life and a wealth of supportive care approaches and strategies delivered by the whole SRG. The sessions are recorded and posted on the intranet site for CCC staff to access using the following link:



Example of a video available from the supportive care education series



Click the clapper board to view the Supportive Care Teaching Sessions.

National Mortality Benchmarking

There are 2 indicators available for Trusts to measure whether their mortality performance is higher or lower than expected, Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indictor (SHMI). The statistical calculations behind these 2 indicators are different; both have their strengths and weaknesses, complementing each other.

The Trust is not subscribed to these 2 indicators for the following reasons:

HSMR – focuses on in-hospital deaths. The majority of CCC activities are out-patient based, resulting in the majority of records being excluded.
– focuses on 56 diagnoses (85% of death), excluding rare cancers.
– CCC in-hospital mortality measure is not comparable with peers, as peers hospitals carry out diagnostic and surgical procedures.

SHMI – Specialist trusts, mental health trusts, community trusts and independent sector providers are excluded from the SHMI because there are important differences in the case-mix of patients treated there compared to non-specialist acute trusts and the SHMI has not been designed for these types of trusts. Integrated trusts which provide both acute and community services are included in the SHMI

Clatterbridge Cancer Centre undertook their own internal analysis, set out local bencmarking matix. Result can be found on page 43-45.

Evolution of the Trust's Mortality Review Programme

The Trust's internal mortality review programme has gone from strength to strength over the last 18 years commencing with a local interest audit on 30 day mortality in lung cancer patients, to the introduction of the multi-disciplinary mortality review meeting in 2012. 2017 saw the introduction of a trust wide mortality review policy and the inception of a new mortality surveillance group. A Structured Judgement Review form based on documentation from the Royal College of Physicians was introduced in March 2018 for all inpatient deaths, allowing a thorough and structured investigation of specific phases of inpatient care delivered within the trust.

April 2018 saw the introduction of the Trust Mortality Dashboard for CCC Wirral to aid in headline discussions and give executive oversight of the Trust Mortality programme. In December 2018 HO data was added to the dashboard in a new section along with compliance to newly introduced reporting on Learning Disabilities Mortality Review Programme (LeDeR) & Child death overview panels (CDOP).

During 2019, further dissemination of Trust-wide shared learning was emphasised with actions and learning from mortality cases in each directorate data pack for discussion at each Directorate Quality and Safety Meeting as well as the Trust Shared Learning Newsletter. As a result of the COVID 19 national lockdown, the mortality review process was digitised utilising Microsoft teams to host virtual meetings and previously paper mortality review forms being sent to consultants using email.

During 2021, CET devised a bespoke mortality module inside the Datix system which would allow clinicians to complete forms for all aspects of the mortality review programme directly in the Datix system. The bespoke Datix module went live at the start of the 2022-23 financial year. The CET team provided Datix training videos to all consultants at the Trust alongside bespoke one-on-one training on request. The training package continues to be delivered to newly appointed consultants and those who require refresher training on request.

During December 2022, with the support of the Business Intelligence Team the Mortality Dashboard was digitised using power BI and contained data from the new Datix Mortality Module. CET designed and launched a Mortality Compliance dashboard utilising Power BI visualisations for submission to Divisional Quality & Safety Meetings and Site Reference Group Meetings.

Roadmap of Trust's Mortality Review Programme

Mortality Review Scrutiny 2022/2023

The Mortality Review Meetings are a forum for both improving practice as well as celebrating best practice. They form part of the existing Trust wide mortality review process and underpin the Trust's strategic goal to prioritise patient safety, prevent avoidable deaths and improve patient care.

This is a multidisciplinary review meeting looking at

- 30 day post treatment mortality
- 90 day post radical radiotherapy mortality
- All inpatient deaths
- Formal incident related deaths
- Concerns raised from the Global Trigger Tool extracted deaths
- Any other concerns raised by individual Consultants

One or more of five levels of scrutiny for identified cases:

Phase I
- Consultant independent review of mortality cases under their care using the mortality review proforma to highlight areas of concern in care delivery

Phase II
- Initial structured case record review (multi-disciplinary pre mortality process and case selection) – SJR (structured judgement review)

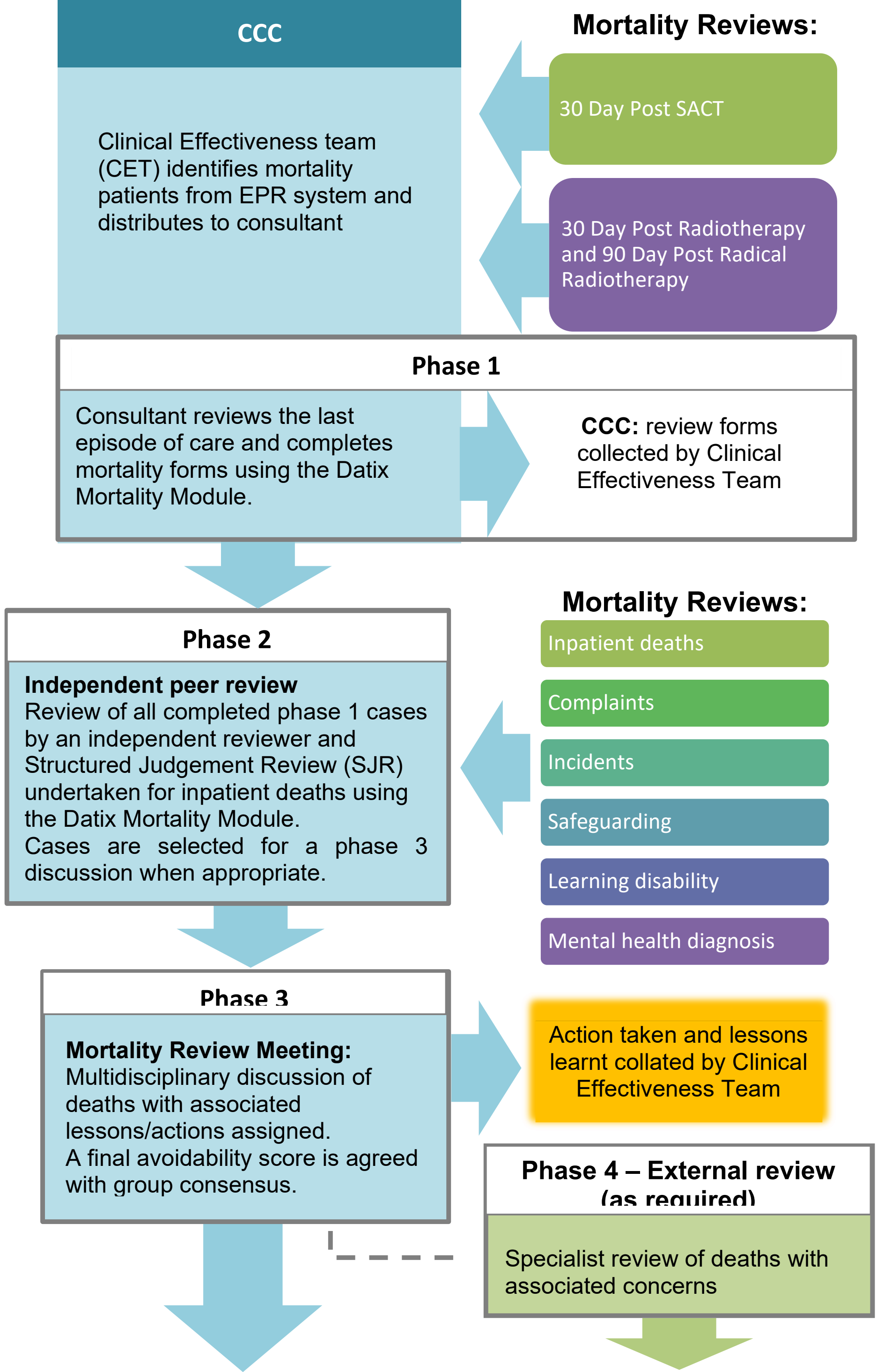
Phase III
- Mortality Review Meeting (MRM)

As Required: Specialist review
- Specialist tumour site reference group (SRG) or Specialist Committee (eg Safeguarding Committee) review

As Required: Investigation
- Investigation as per the Serious Incident Framework Policy

Detailed Mortality Review Process for CCC

As from December 2020, the Haemato-oncology mortality review process has been merged with the solid tumour process. Now the Trust has a single process to review mortality cases to ensure consistency and robustness.

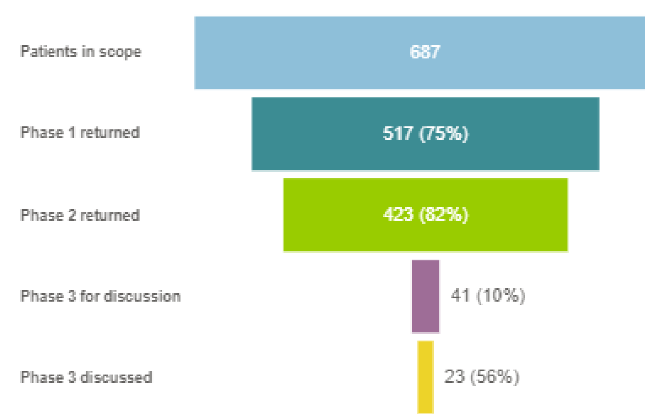


Structured Judgement Review

The Structured Judgement Review (SJR) process introduced in March 2018 has been strengthened by the introduction of dedicated time allocated within the Consultant in Palliative Medicine's job plan. CCC have always strived to review all inpatient deaths utilising structured judgement review rather than a sample. SJRs take place once a phase 1 review is completed by the treating/admitting consultant.

There were 189 inpatient deaths during 2022-23 out of which 139 have had a phase 1 review (74%). Out of the 139 which have had a phase 1 review, we have conducted 132 SJR's (95%).

Engagement with the Trust Mortality Process

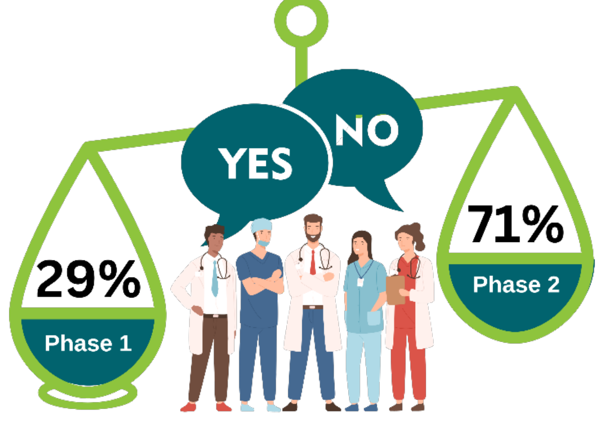


Out of the 687 cases identified as requiring review at Phase I, the graph below demonstrates that 517 were reviewed at Phase I which equates to 75%. Of the 517 forms completed, 423 were reviewed at Phase II equating to 82%.

Out of the 423 reviewed at Phase 2, 41 were selected for further discussion at the Multidisciplinary Mortality Review Meeting (Phase III) which equates to 10% of cases, of which 23 have been discussed (56%).

The Importance of the Phase 2 Process

Out of cases selected for Phase III discussion during 2022-23, 71% of cases were selected via the independent mortality peer review (phase 2) process. The remaining 29% were selected by the treating clinician during phase 1.

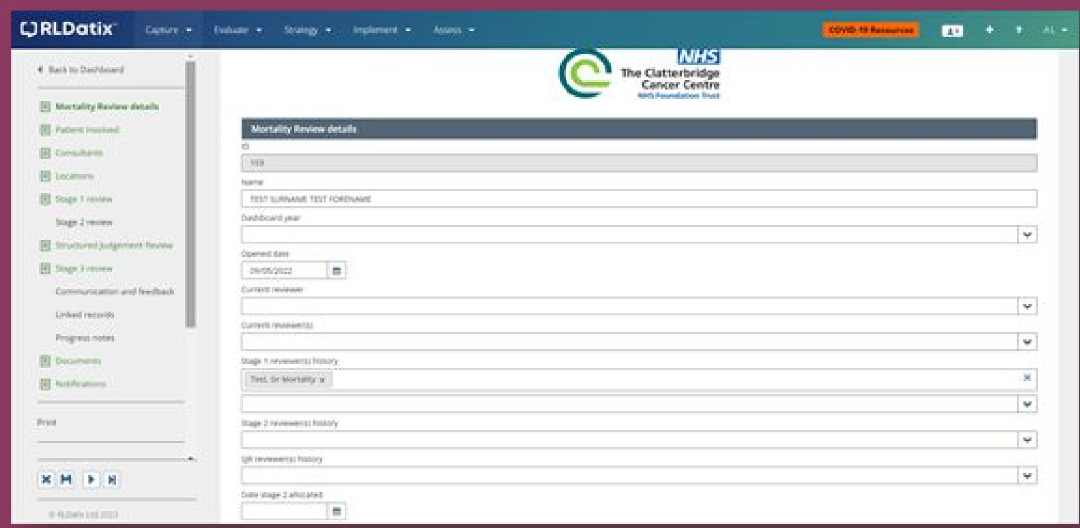


Digitised Mortality Review Process 2022/2023

Datix Mortality Module

A new bespoke Datix mortality module (Fig 1) was launched during 2022-23. The new module allows clinicians to complete Phase 1, 2 & SJRs online utilising Datix. Phase 3 discussion, associated actions and learning are also documented on Datix.

Fig 1. Datix Mortality Module



Mortality Compliance Dashboard

A new suite of Power BI Dashboards were devised during 2022-23. The new dashboards demonstrate clinician compliance to aspects of the mortality review process (Fig 2, Fig 3 & Fig 4), these dashboards are agenda items on all Site Reference Group Meetings and included in Divisional Quality and Safety Meetings.

Fig 2. Mortality Compliance Dashboard – Phase 1

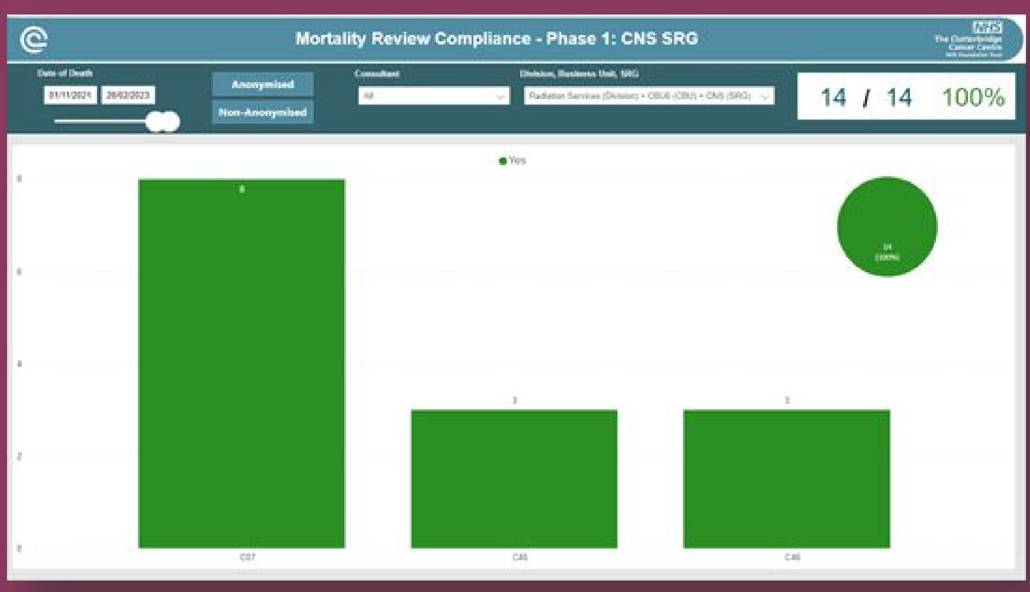


Fig 3. Mortality Compliance Dashboard – Phase 2

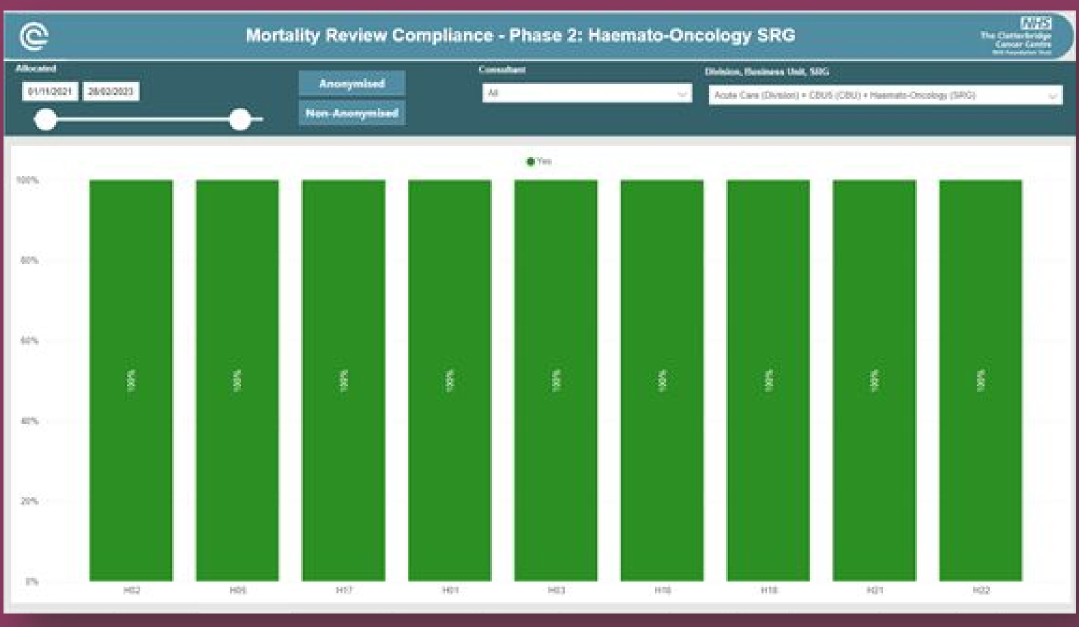
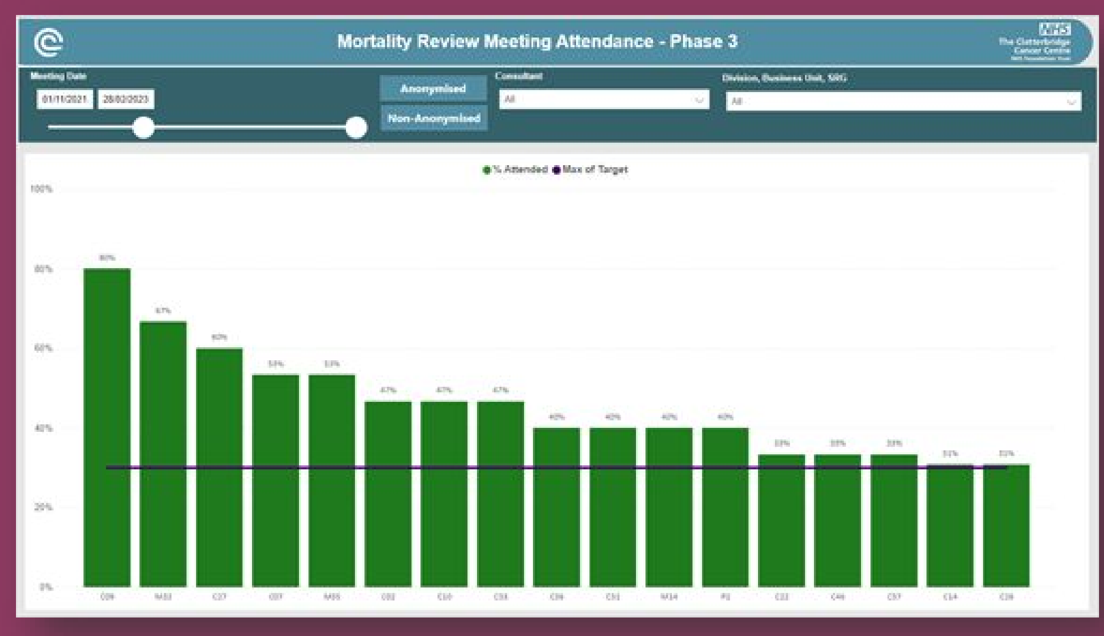


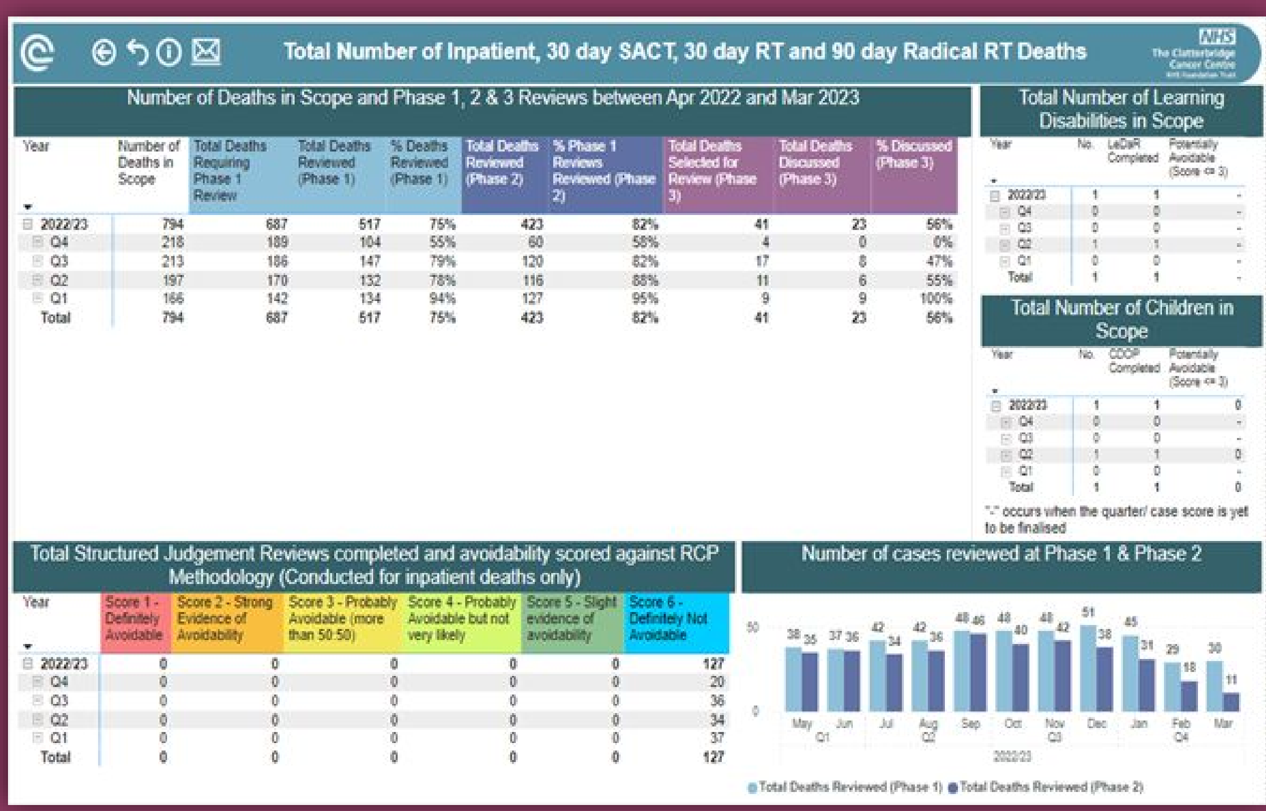
Fig 4. Mortality Compliance Dashboard – Phase 3



Mortality Surveillance Group Dashboard

The Mortality Surveillance Group Dashboard (Fig 5) is now automatically calculated using the new Power BI Dashboard which has been produced in collaboration with the Business Intelligence (BI) Team. The dashboard demonstrates a live snap shot of Trust mortality process and compliance with the Learning from Deaths in the NHS National framework published by NHS England which is monitored quarterly at the Mortality Surveillance Group Meeting and included in the publicly available Trust Board papers.

Fig 5. Mortality Surveillance Group Dashboard



Total Number of Inpatient, 30 day SACT, 30 day RT and 90 day Radical RT Deaths

Number of Deaths in Scope and Phase 1, 2 & 3 Reviews between Apr 2022 and Mar 2023

Year	Number of Deaths in Scope	Total Deaths Requiring Phase 1 Review	Total Deaths Reviewed (Phase 1)	% Deaths Reviewed (Phase 1)	Total Deaths Reviewed (Phase 2)	% Phase 1 Reviews Reviewed (Phase 2)	Total Deaths Selected for Review (Phase 3)	Total Deaths Discussed (Phase 3)	% Discussed (Phase 3)
2022/23	794	687	517	75%	423	82%	41	23	56%
Q4	218	189	104	55%	60	58%	4	0	0%
Q3	213	186	147	79%	120	82%	17	8	47%
Q2	197	170	132	78%	116	88%	11	6	55%
Q1	166	142	134	94%	127	95%	9	9	100%
Total	794	687	517	75%	423	82%	41	23	56%

Total Number of Learning Disabilities in Scope

Year	No.	LeDeR Completed	Potentially Avoidable (Score <= 3)
2022/23	1	1	-
Q4	0	0	-
Q3	0	0	-
Q2	1	1	-
Q1	0	0	-
Total	1	1	-

Total Number of Children in Scope

Year	No.	CDOP Completed	Potentially Avoidable (Score <= 3)
2022/23	1	1	0
Q4	0	0	-
Q3	0	0	-
Q2	1	1	0
Q1	0	0	-
Total	1	1	0

"-" occurs when the quarter/ case score is yet to be finalised

Total Structured Judgement Reviews completed and avoidability scored against RCP Methodology (Conducted for inpatient deaths only)

Year	Score 1 - Definitely Avoidable	Score 2 - Strong Evidence of Avoidability	Score 3 - Probably Avoidable (more than 50:50)	Score 4 - Probably Avoidable but not very likely	Score 5 - Slight evidence of avoidability	Score 6 - Definitely Not Avoidable
2022/23	0	0	0	0	0	127
Q4	0	0	0	0	0	20
Q3	0	0	0	0	0	36
Q2	0	0	0	0	0	34
Q1	0	0	0	0	0	37
Total	0	0	0	0	0	127

Compliance against National Guidance on Learning from Deaths 2022/2023

Mortality governance is a key priority for the CCC Trust board. Executives and nonexecutive directors have the capability and capacity to understand the issues affecting mortality in our Trust. CCC continues to remain compliant with the following key requirements from the National Guidance on learning from deaths issued by The NHS Quality Board published in March 2017 and updated in February 2018:

The Trust is required by The NHS Quality Board to publish information on death quarterly to the Trust Public board. CCC publishes information via the Mortality Surveillance Group papers (which includes the mortality dashboard) to the Trust public board. The MSG at CCC is multi-disciplinary and multi-professional.

Outputs of the mortality governance process including investigations of deaths are communicated to frontline clinical staff, CCC compile a quarterly mortality dashboard and this is a standing agenda item on MRM. All learning from deaths are included within monthly directorate data packs and within the Trust shared learning newsletter.

The Trust is required by The NHS Quality Board to have a policy in place that sets out how it responds to the patients who die under its management and care, CCC has had a policy in place for learning from deaths since Sept 2017.

Providers should engage meaningfully and compassionately with bereaved families and carers. CCC have a bereavement service for families and carers of people who die under our management and care; this includes a day after death service and access to a bereavement advisor to help families and carers through the practical aspects following a death.

The Trust is required by The NHS Quality Board to publish an annual summary of mortality data via Trust Quality Accounts. CCC includes an annual summary of mortality data via Quality Accounts.

The Trust is required to have a definition of an avoidable/unavoidable death and this is outlined in the policy. CCC have utilised the Royal College of Physicians (RCP) definition of avoidable deaths, this is contained within the CCC learning from deaths policy and the Structured Judgement Review (SJR) form.

All in-patient, out-patient and community patient deaths of those with learning disabilities require a LeDeR. At CCC all inpatient, 30 day systemic anti-cancer therapy, 30 day radiotherapy or 90 day radical radiotherapy deaths for patients identified as having a learning disability are submitted for LeDeR.

All in-patient, out-patient and community patient deaths of children receive a CDOP review. At CCC all inpatient, 30 day systemic anti-cancer therapy, 30 day radiotherapy or 90 day radical radiotherapy deaths requiring a CDOP form at CCC are submitted for CDOP review.

All deaths where an 'alarm' has been raised with the provider through whatever means receive a case record review or a SJR. At CCC all cases identified through the following means; serious untoward incidents, inquests, complaints, concerns, cases raised via audit results, consultant concerns or statistical analysis, receive a case record review.

The National Mortality Case Record Review Programme from the RCP outlines use of the SJR and all professionals have attended training on how to conduct a SJR. CCC conducts SJR on all inpatients and those conducting SJR have all attended the relevant training.

All deaths where learning will inform the provider's existing or planned improvement work should be shared to maximise learning. At CCC lessons learned from deaths are shared across the Trust through multiple platforms; Site reference group meetings, Shared Learning Newsletters and Directorate data packs.

Providers should review an investigation they undertake following any linked inquest and issue of a "Regulation 28 Report to Prevent Future Deaths". CCC adheres to the NHS England North, Cheshire and Merseyside Local Agreement for the Management of Reports to Prevent Future Deaths as described in the Trust Inquest Policy.

Medical Examiner System Roll out at CCC

A new medical examiner system has been rolled-out across England and Wales to provide greater scrutiny of deaths. In February 2021, the government published Working together to improve health and social care for all, the white paper which includes provisions for medical examiners to be put on a statutory footing. During 2021/22, the role of these offices is being extended to include all non-coronial deaths, wherever they occur.

The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data

The Clatterbridge cancer centre medical examiner service is provided by the Royal Liverpool and Broadgreen University Hospitals due to the small number of deaths which occur in the Trust.

To support the new medical examiner initiative, the Trust reviewed and streamlined the documentation for deceased patients within the electronic patient record (EPR). The medical examiners have direct read-only access to the EPR in order to review documentation.

The new process commenced in October 2021, with all deaths occurring on the Trust's inpatient wards (aside from those being directly referred to the coroner) being reported to the medical examiner office. The patient's cause of death was agreed with the next of kin/informant and any concerns with care prior to the patient's death can be discussed.

The Trust also integrated the medical examiner feedback into the Trust structured judgement review which strengthened the process further.

A quarterly report is now produced to compare the initially proposed cause of death by CCC with the finalised cause of death confirmed by the medical examiner. There has not been any disagreement noted, also no concerns has been flagged,

Lessons Learnt from Mortality Review Process

Learning from case reviews and investigations conducted in relation to deaths (inpatient and outpatient deaths) along with description of actions taken in the reporting period

Background	Action	CCC Lesson Learned
A patient developed skin cancer whilst being treated with Ruxolitinib- this is a known complication. The patient's family asked whether Ruxolitinib should have been discontinued when the patient developed skin cancer. The family were also concerned about potential haematological delays in discontinuing treatment and whether there were any delays in the surgical pathway. The treating consultant advised that the drugs company advice was to continue treatment, and that in this case he had recommended discontinuation of Ruxolitinib once the cancer had recurred following surgery. The MRM group suggested that it may be helpful that clear guidelines are provided for stopping treatment.	Haemato-Oncology team and Skin SRG reviewed and agreed that no protocol change was necessary. It was confirmed that there were no surgical delays in the pathway	HO lead had undertaken and presented an audit nationally at BSH (April 2020) regarding 2nd malignancy. Regional incidents were much higher than published literature, with a definite 2nd primary malignancy seen with this treatment in 20% of cases. This abstract was shared with the MAC, the SRG teams & the wider Network • Consent forms have amended to reflect this new understanding. • A process for peer review of cases has been established
A patient died following administration of treatment despite an abnormal NEWS2 score. This treatment was delivered in a peripheral hub staffed by a neighbouring trust and triggered a serious incident investigation. This was a case flagged for discussion following a review conducted by the neighbouring Trust. The investigation highlighted the following points of learning: • Documentation needs to be completed fully and accurately • Training to be undertaken for management of sepsis • More robust pathway required to get a face to face senior review by a Consultant prior to treatment go ahead if a concern is raised • To work with CCC to review the Meditech system to ensure NEWS is recorded at each treatment to enable alerts if abnormal The group discussed the findings of the review and agreed to a letter of response to the neighbouring Trust, due areas of inaccuracy within the narrative of the report provided.	CCC reviewed the investigation findings and clarification was sought regarding some of the findings and conclusions Further assurance in relation to evidence that all staff who access Meditech are trained in the accurate recording of the NEWS2 early warning system was sought. The CCC Digital Training Leader confirmed that within the previous 6 months, two training sessions on NEWS2 were delivered to the neighbouring Trust in this case (one of which was a refresher course)	All staff using Meditech regardless of location are trained in the accurate recording of NEWS2 Staff administering treatment in any hub should not administer treatment when patients have an elevated NEWS2 score without discussion with a senior doctor.

Background	Action	CCC Lesson Learned
A patient was due to be transferred to hospice. On the way to the hospice, the patient's blood pressure dropped and the ambulance team took the decision to commence fluids and divert the patient to the nearest acute hospital – where the patient subsequently died. The patient's preference was to die either at home or in the hospice. The group asked the CET team to ascertain whether a Unified DNACPR was in place, as this would have informed the paramedics decision.	The hospice had provided feedback about this case to the ambulance team and education sessions had followed. Review of transfer documentation confirmed that there was no DNACPR in place and the MRM group concurred that the correct decision had been made by the paramedics.	Patients being transferred to hospice for end of life care must have a unified DNACPR in place prior to transfer. Ambulance crews must divert clinically unstable patients to A&E if this is not present.
Concerns were raised that patient's platelet refractoriness was demonstrated and it took 3 days for the HLA Ab screen to be requested. When the screen was sent and marked as requiring expedited analysis there was no direct communication with the laboratory requesting this to be done.	A literature review was undertaken of other NHS England Trusts policies and none explained what to do in the context of platelet refractoriness. The blood transfusion practitioner amended the transfusion policy to include platelet refractoriness and the HLA-Ab test. Education updates to Haemato-Oncology trainees on the BCSH platelet refractoriness guidelines. This is now included in annual registrar teaching and an appendix has been added to the protocol	Better education in early recognition of platelet refractoriness Identification of the need to stipulate in our hospital transfusion policy that a HLA Ab screen should be requested if platelet increments are refractory. Education on how to request the HLA Ab screen be expedited and understanding of communication required with the transfusion. The transfusion policy and surrounding education has been updated to reflect the actions taken.
A baseline CT scan showed widespread visceral and spinal metastases with compression fracture at L3. No alert was raised. The patient telephoned the clinical nurse specialist at St Helen' sand Knowsley Hospitals with new back pain for which they were requesting stronger analgesia. The CNS reviewed the CT scan report in CRIS and referred the patient to the MSCC team and to CDU for review. MRM group acknowledged concerns regarding CT reporting but does not feel any harm was caused to the patient due to the missing alert. MRM agreed to feedback to CCC radiology to review the case and assess whether an alert should have been issued.	The MRM concluded that no harm had been caused but asked the CCC radiology team whether this should have been a red alert. The team responded that this compression fracture was not associated with significant neural compression within the adjacent spinal canal, and so would not have been flagged as a critical alert.	Spinal disease resulting in neural compression is flagged by radiology as a critical alert and practice here was in keeping with policy.

Background	Action	CCC Lesson Learned
A patient receiving radical treatment died of decompensated heart failure with severe aortic stenosis at 1B. Prior to treatment the diagnosis of aortic stenosis had been suspected by the treating team and an urgent referral had been made to acute Trust for a cardiology opinion. Whilst the MRM agreed with the decision to treat the patient had not seen the cardiology team prior to treatment as requested.	The MRM requested clarification of the quickest process for obtaining cardiology review for patients.	CCC have access to a cardiac-oncologist who responds quickly. If a patient is already referred to another cardiology team then the Cardio-Oncologist can contact this team to offer to see the patient more urgently. Furthermore, there is a weekly cardio-oncology MDT, a referral form and a centralised referral generic email which can be used to request urgent review. Email contacts for the cardio-oncology MDT was shared with the group and the referral form made available on the Trust intranet.
A patient with known diabetes was admitted to Southport hospital and died of an ischaemic limb and subsequent multi-organ failure shortly after receiving cycle 8 of chemotherapy. The case was brought for peer review which confirmed best practice and correct involvement of endocrinology in the management of this patient's diabetes. Further clarity was however sought regarding support available for patients with diabetes being treated in CCCL.	Confirmation received from Clinical Director for Acute Services that CCC use all LUHFT treatment protocols for the management of diabetes (available via the intranet) and we have been building an SLA for a full time diabetic nurse specialist for CCC and 1.5pa endocrine support.	Support in the management of diabetes for patients at CCCL is provided by the endocrinology team at LUHFT. This information has been cascaded to the consultant body.
A patient's case was reviewed in which the treatment was deemed appropriate but there was a concern raised about an undiagnosed learning difficulty and the safeguarding team asked why this was not assessed by the relevant team at CCC and discussed with patient and family members. The safeguarding team also stated that if the patient lacked mental capacity, then an assessment of capacity and a best interest meeting would be recommended to ensure that the patient was making informed consent to treatment choices.	The MRM ascertained that there was evidence that the treating consultant conducted a capacity assessment and involved the patient in all aspects of care. The group however requested further instruction of how to facilitate a diagnosis of learning disability if suspected in clinical practice. The MRM group requested guidance on who the named team member is for safeguarding.	The lead safeguarding nurse attended the medical advisory committee (MAC) to state that the Safeguarding Team are available to support and advise any staff caring for patients with a learning disability, autism or dementia in pursuit of appropriate diagnoses. The lead nurse shared the team email address to the committee.
A patient's death at another trust was reported to the coroner as suspected pneumonitis secondary to Palbociclib. The patient also has confirmed COVID-19 at the time of death. The coroner's inquest ruled the cause of death as1a. Palbociclib induced pneumonitis & COVID19 pneumonia with 1b. Metastatic breast cancer. The case was brought to MRM to peer review the treatment plan	The MRM confirmed best practice in this case with appropriate short interval scans to monitor for pneumonitis changes. Palbociclib induced pneumonitis is a rare but recognised complication of treatment	Palbociclib can rarely cause pneumonitis. Best practice in these circumstances where pneumonitis develops is to shorten intervals between scans to ensure resolution or stop treatment if worsening. This was discussed and confirmed at MRM and this case followed best practice.

Background	Action	CCC Lesson Learned
An inpatient at CCCL died of sepsis. During admission they had a blood culture and catheter urine sample taken that identified E Coli infection. The most likely source of the infection was a catheter associated urinary tract infection (CAUTI)/Urosepsis due to the paired blood and urine culture results. A finding from the local review was that CCC did not have a formal tool (catheter bundle) for documentation of catheter care. The post infection review reflects this was not a failure of the catheter care, but a failure of the documentation of the catheter care due to the absence of an appropriate tool.	The group asked that a Catheter care tool be built into the patient electronic record Meditech. The Catheter care tool has now gone live on Meditech and business intelligence dashboards are now being utilised by the team.	Catheter use must be supported by a catheter care bundle to ensure safe practice in accordance with infection prevention and control. This is now facilitated by a new bundle on Meditech.
It was noted that prior to cycle 2 of chemotherapy that a patient's liver function was deranged and was given chemotherapy treatment. The patient was subsequently admitted with fatigue and died in hospital due to rapid disease progression. This case is an example where the protocol was not followed, because if it had, chemotherapy would not have been given in the presence of such deranged liver function. If there was any doubt or clarification necessary then the patient should have been discussed with the treating clinician. The group agreed that the patient died from rapid disease progression and concurred with the subsequent structured judgement review which concluded that the delivery of chemotherapy did not contribute to death in this case.	The group asked the lead SACT nurse to undertake the following actions: Lead SACT nurse will review training and follow-up treatment protocols. Check the availability of blood results from external units recorded and signed off Check whether staffing levels may have contributed to this case The lead SACT nurse implemented documentation training for all chemotherapy hub staff. This was rolled out with the support of the legal and governance manager and includes a separate section on what needs to be documented including recording that the blood results have been seen. . A new process was agreed with SRG chairs and includes instructions of what to do and who to contact when blood results are deranged.	The decision whether to deliver chemotherapy in the presence of deranged blood results is protocol driven- this has been re-cascaded to clinical teams. In cases where further clinical advice is needed, a new process clarifying how to do this has been developed and cascaded to support clinical teams. Training on correct and full documentation of treatment decisions has also been delivered across chemotherapy hubs.
The case was selected for discussion as there was no evidence of a letter to the GP communicating a secondary diagnosis and treatment decisions. There was however documentation on evolve from the surgeon when the patient was seen in the joint clinic. The MRM discussed whether this was sufficient or whether CCC specific letters need to be sent in instances where the patient has been seen in a joint clinic.	Clarification was sought from the Medical Director and cascaded to consultants whilst in a joint clinic it might be acceptable for one of the clinicians to document and dictate correspondence to the patient and GP, there must be sufficient information within that communication. An alternative would be for the oncologist to dictate the letter having agreed to take over care of the patient.	The treating clinician is best placed to provide the letter from clinic, from a governance perspective clinically and legally given CCC are a separate Trust from the surgeons. This information has been cascaded to consultants.

Background	Action	CCC Lesson Learned
A patient was noted to be unwell when she attended for blood transfusion. A review was requested and the symptoms ascribed to anaemia. On the subsequent Monday treatment was delivered and there was no documentation as to the clinical state of the patient. The patient was subsequently admitted to an acute Trust that night with SOB and PE's and died sometime later following fast-track discharge home to die.	The MRM group stated that note keeping on the day of treatment was inadequate and asked the ward manager to investigate. The lead SACT nurse conducted an audit looking at 12 separate patients who this staff member had treated over a one month period and all documentation was present in Meditech. The audit lead was assured that this was a one off incident of missed documentation but arranged further training on essential documentation for the SACT delivery team.	Essential documentation training has been delivered to all SACT administration staff and the individual has received appropriate support following this error.
A patient was treated with Sorafenib despite their platelets being below 50. Whilst this did not lead to death, the MRM requested an audit and updated protocol relating to treatment with Sorafenib in the presence of low platelets. Given the presence of splenomegaly in the hepatobiliary population it was felt this was potentially not an uncommon caution with this medication	Pharmacy & The HPB team reviewed the Sorafenib protocol regarding neutrophil and platelet counts in relation to prescriptions in patients with splenomegaly Retrospective audit of platelet levels in patients treated with Sorfenib was undertaken by CET.	The Clinical Effectiveness team examined 5 years' worth of cycles of Sorafenib and identified 126 patients with Liver cancer. Out of the 217 platelet results there were 4 below 50 (3 patients all in 2018) and out of the 216 neutrophil results zero were below 1. No harm was caused from these treatments. The Sorafenib protocol has been updated and circulated detailing that this treatment should be discussed with a consultant before administration if platelets are below 50.
Dabrafenib + Trametinib was commenced in a frail melanoma patient with a PS 4. The patients PS measured 4 as he was on strict bed rest and was in a lot of pain. At the time of the decision to treat it was felt this was appropriate as this regime has a high response rate with a likelihood of improving the patient's symptoms quickly (70-80%). In melanoma patients PS 3-4 is almost irrelevant.	The MRM asked for a prospective audit to be completed for patients on this regimen looking at symptom improvement, QOL, toxicity and survival.	A prospective review of 6 cases was undertaken. Results demonstrated in frail patients in whom this treatment regime was used there was frequent partial response and symptom improvement which provides assurance that this treatment can be an appropriate treatment even in poor performance status
A patient died without their escalation status having been reviewed and they received CPR. The treating consultant reviewed the notes and could not find a documented discussion and stated that deterioration was expected and resuscitation decision and end of life care should have been discussed earlier as this would have avoided CPR being commenced.	Updated training including DNACPR discussion was requested for the haemato-oncology team	The Haemato-oncology team have now attended their mandatory training in EOLC

Background	Action	CCC Lesson Learned
A patient's hydrophronephrosis was commented on in December and was potentially missed as the scan was sent to the consultant, but the patient subsequently met with a Nurse consultant. The MRM asked whether the report had an actionable alert as this would be dealt with by the on-call registrar. The patient was not harmed.	The group asked that an action be assigned to the Quality Manager for Radiation Services to investigate why an alert was not attached to the scan in this case.	This scan did not have an alert attached as the Trust's policy: 'Communication of Critical and Urgent Radiological Findings' (OIMPCRITF) does not include hydronephrosis as a critical or urgent finding requiring an alert. The group asked whether hydronephrosis should be added to the Urgent or Critical alerts- the need for this varies across SRGs. It has been left as an optional standard and SRGs have been invited to opt in if this is a relevant standard for their patients
A patient died of neutropenic sepsis whilst receiving complex chemotherapy on the Isle of Man. This case highlighted the challenges of remotely supervising patients' treatment on IOM. The group recommended that complex regimes post COVID should be administered locally and to depart from that would be at the consultant's discretion and should be documented. The group also suggested a collective discussion between consultants who treat IOM patients and the associate medical director of network services as chair of the network chemotherapy group to decide on the safest way to deliver this service.	A collective discussion to be had between consultants who treat IOM patients and the associate director of network services (Chair of the network chemotherapy group) to decide on a way to deliver a safe service	Complex chemotherapy regimens for patients from the Isle of Man should be delivered locally unless documented otherwise by the treating consultant. A clinical working group with a focus on the development of the model of care has been established to determine the pathway for this.
A patient became increasingly fatigued and when assessed his pro BNP was significantly elevated so he was admitted with a presumptive diagnosis of IO induced Myocarditis. He was reviewed by the IO team. Investigations were not entirely consistent with Myocarditis. The question raised by the independent reviewer was that the patient had a raised pro BNP when he started to develop symptoms but there was no baseline for colleagues to assess if this had changed in relation to the therapy.	The MRM asked that the baseline management flow diagram be circulated to the SRG Chairs meeting and consideration given to the need for baseline pro-BNP.	The Pre-Assessment Baseline Cardiac Pathway was included in the SRG chairs meeting agenda. Also as a result of this case requests are now made for a baseline pro BNP prior to starting treatment. This is now Trust standard practice for all IO treatments. MRIs of the heart are also ordered for patients if they have had a recent cardiac event. A pathway is now available on the intranet which stipulates which baseline information is required prior to commencing IO, there is also a panel in Meditech and a hyperlink is included in treatment protocols.

Background	Action	CCC Lesson Learned
A patient's family raised concerns with the medical examiner regarding the management of low BMs in a patient at the end of life.	Mortality Review Meeting chair asked treating consultant to meet with the clinical director of acute care, consultant in palliative medicine, pharmacy and the ward matron to discuss care pathways for patients with advanced disease, who are dying and what monitoring is undertaken.	Hypoglycaemia is not uncommon in dying patients and is often refractory to management at the end of life. Closer monitoring does not provide more effective treatments and comes at the cost of being more invasive and uncomfortable for those receiving end of life care. The need to review BMs as part of the dying process already exists within the trust's end of life care and communication record. There have also been recent changes in the diabetes service provision for inpatients at CCC; there is now daily availability of a diabetes specialist nurse on site at CCCL. They will be beneficial in advising on the diabetes management for inpatients and reviewing medication, insulin dosage and administration where these are complicated in those receiving end of life care.
	Mortality Review Meeting chair requested confirmation that all medications administered including insulin are recorded to reassure clinicians and patients/families alike that there is a record of appropriate processes being followed and documentation.	Pharmacy are reviewing options for digital record keeping within meditech to ensure correct and contemporaneous oversight of medications such as digoxin, KCl and insulin where there is the potential for harm. Currently all medications are supplied on a named patient basis which enables tracking of medications within practical limits.
Concerns were raised regarding a patient's morphine prescription. On transfer to CCC a patient was on a drug called MXL which is a once daily preparation of morphine sustained release and is not used at CCCL. As a consequence this prescription was changed to a BD preparation resulting in double the usual daily dose being prescribed. The patient was not harmed as a result.	Pharmacy were asked to review their processes for handling unfamiliar medications and the process for supporting junior colleagues.	Pharmacy have action in place regarding the technicians and what they communicate to the ward pharmacists around any potential unusual doses or unusual drugs that they don't recognize. The pharmacists have been advised to use non-formulary on the drug history for items that aren't used in Meditech rather than using brands that are not interchangeable.

National Audit of Care at the End of Life (NACEL) – Round 4

NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission before death in acute, community hospitals and mental health inpatient providers in England, Wales and Northern Ireland.

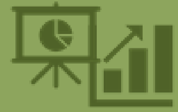
NACEL was commissioned by HQIP on behalf of NHS England and the Welsh Government in October 2017 and commissioned separately by Northern Ireland Public Health Agency in July 2018. The commission was for four rounds of data collection, with the 2022 audit being round four.

The aim of the audit is to improve the quality of care at the end of their life. NACEL covers NHS funded inpatient care provided to adults (18+).

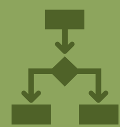
The audit objectives for the fourth round of NACEL encompassed the following:

To refine the tools for assessing compliance with national guidance on care at the end of life – One Chance To Get It Right (2014), NICE guidelines (NG31) and the NICE Quality Standards for end of life care (QS13 and QS144).

To measure the experience of care at the end of life for dying people and those important to them



To provide outputs which enable stakeholders to identify areas for service improvement.



To provide a strategic overview of progress with the provision of high-quality care at the end of life in England, Wales and Northern Ireland.

NACEL Round 4

Data was collected between June and October 2022 and the full report was published in February 2023. Overall the Trust results of the 2022/23 round of NACEL are positive and **our best results to date** with significant improvements made in many areas and compare favourably with end of life care delivered throughout England. There are however always areas to develop and a comprehensive action plan has been drawn up and implementation of the action plan has commenced.

Audit elements

Organisational Level Audit

- Comprises of the trust/HB overview and the hospital/site overview
- Trust/HB overview: Policies and guidelines
- Hospital/site overview: Activity, workforce, training, quality and outcomes

Case Note Review (CNR)

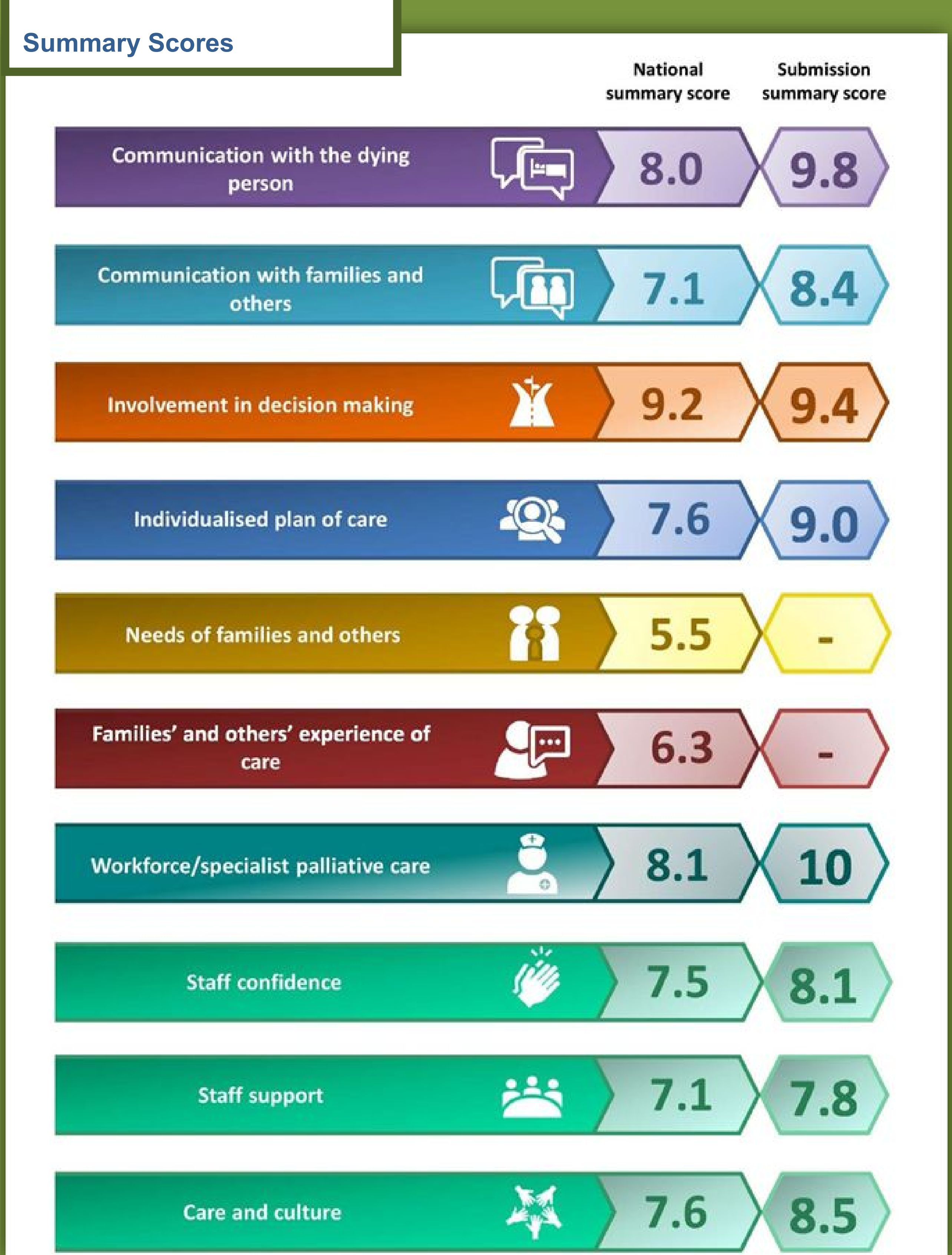
- Completed by acute and community providers
- Patient demographics, final admission details, recognition of imminent death, communication, involvement in decision-making and individualised EoL care planning

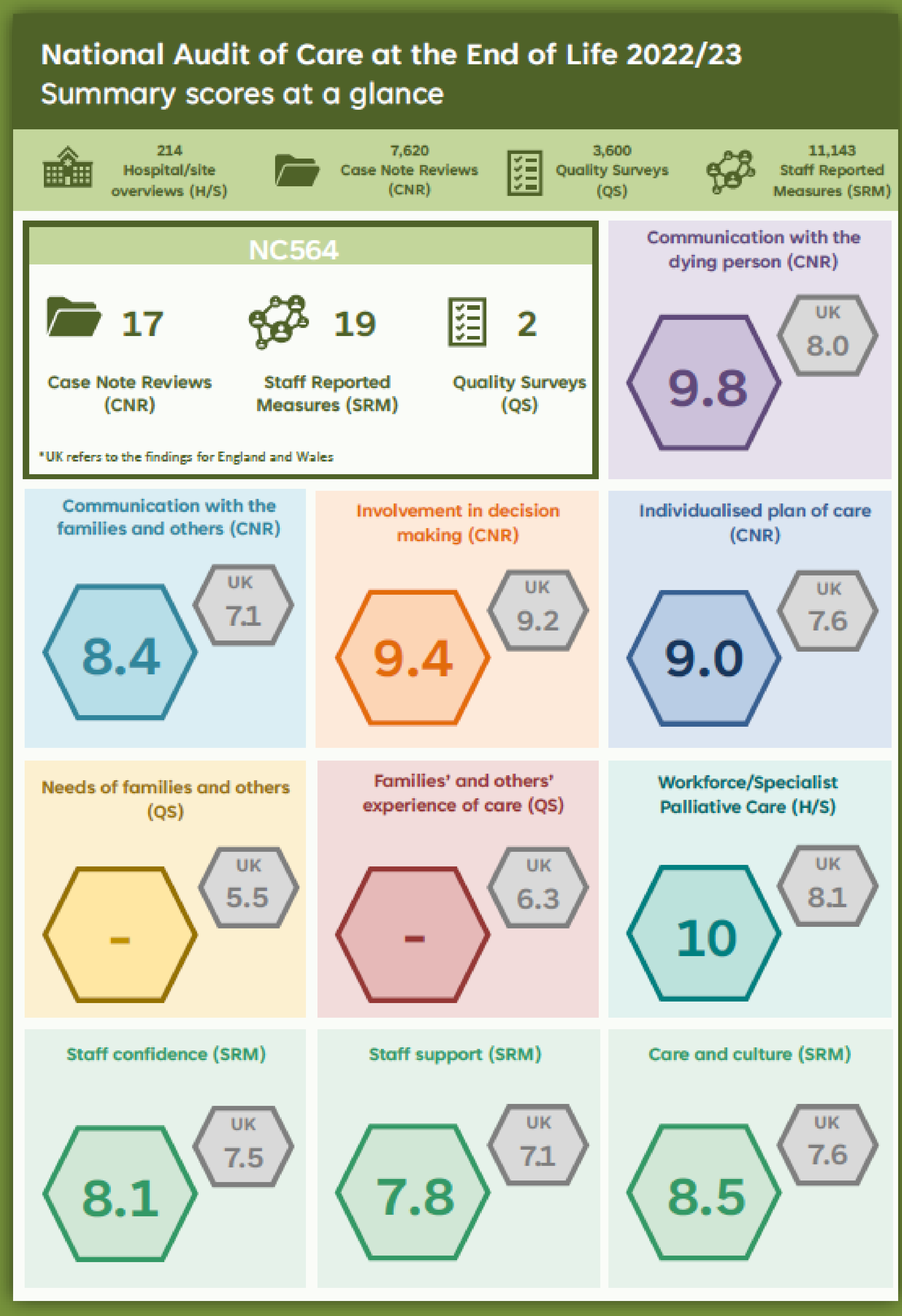
Quality Survey (QS)

- Developed with the assistance of the Patients Association
- Online survey completed by bereaved carers with the option to complete over the telephone

Staff Reported Measure (SRM)

- Staff who are most likely to come into contact with dying patients and those important to them
- Staff confidence and experience in delivering care at the end of life

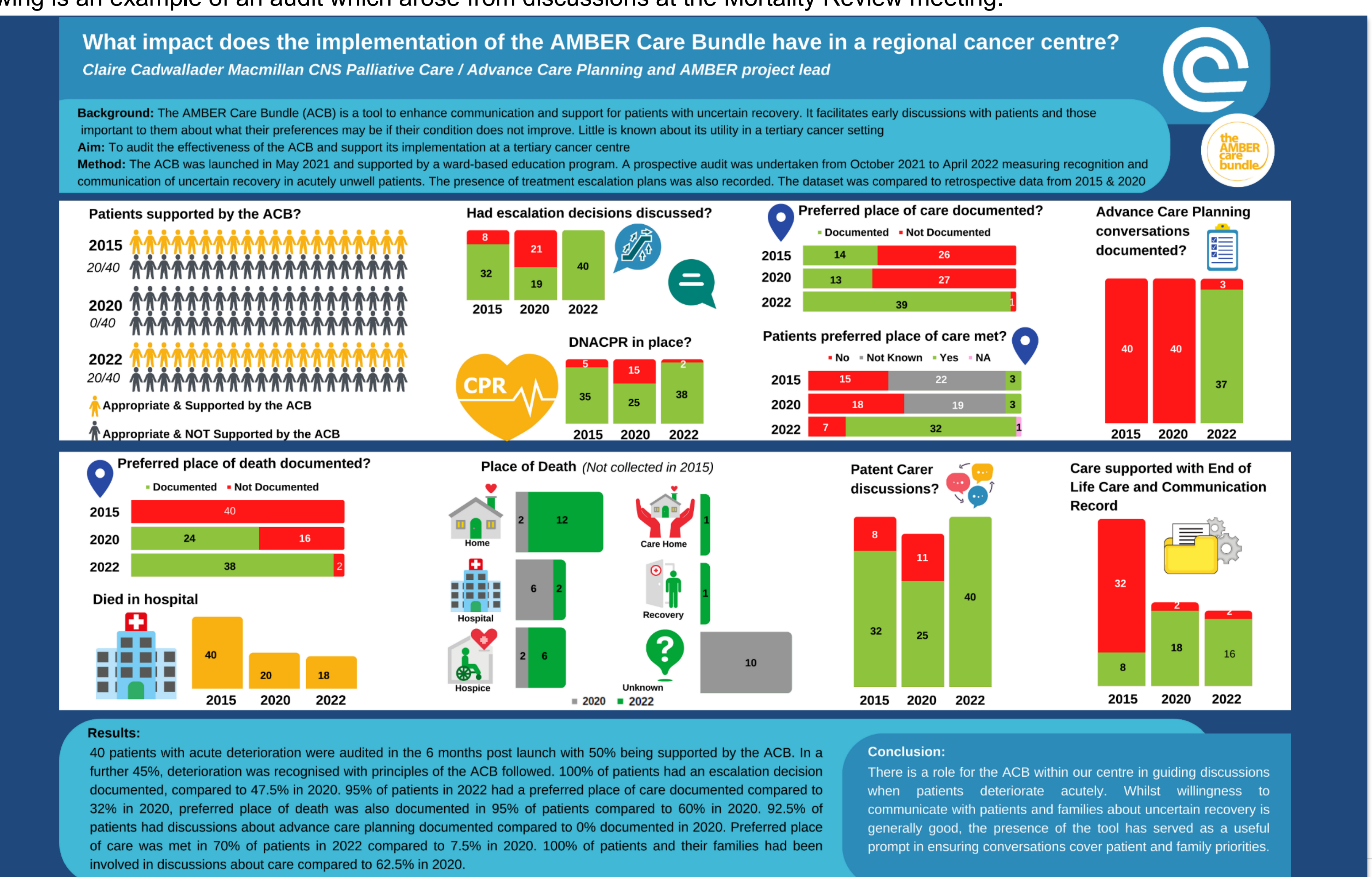

Summary Scores
National summary score
Submission summary score
Communication with the dying person
8.0
9.8
Communication with families and others
7.1
8.4
Involvement in decision making
9.2
9.4
Individualised plan of care
7.6
9.0
Needs of families and others
5.5
-
Families' and others' experience of care
6.3
-
Workforce/specialist palliative care
8.1
10
Staff confidence
7.5
8.1
Staff support
7.1
7.8
Care and culture
7.6
8.5



National Audit of Care at the End of Life 2022/23
Summary scores at a glance
214 Hospital/site overviews (H/S)
7,620 Case Note Reviews (CNR)
3,600 Quality Surveys (QS)
11,143 Staff Reported Measures (SRM)
NC564
17 Case Note Reviews (CNR)
19 Staff Reported Measures (SRM)
2 Quality Surveys (QS)
*UK refers to the findings for England and Wales
Communication with the dying person (CNR)
9.8
UK 8.0
Communication with the families and others (CNR)
8.4
UK 7.1
Involvement in decision making (CNR)
9.4
UK 9.2
Individualised plan of care (CNR)
9.0
UK 7.6
Needs of families and others (QS)
-
UK 5.5
Families' and others' experience of care (QS)
-
UK 6.3
Workforce/Specialist Palliative Care (H/S)
10
UK 8.1
Staff confidence (SRM)
8.1
UK 7.5
Staff support (SRM)
7.8
UK 7.1
Care and culture (SRM)
8.5
UK 7.6

Audits arising from Mortality Review Process

The following is an example of an audit which arose from discussions at the Mortality Review meeting.



Quality Surveillance and Specialised Services

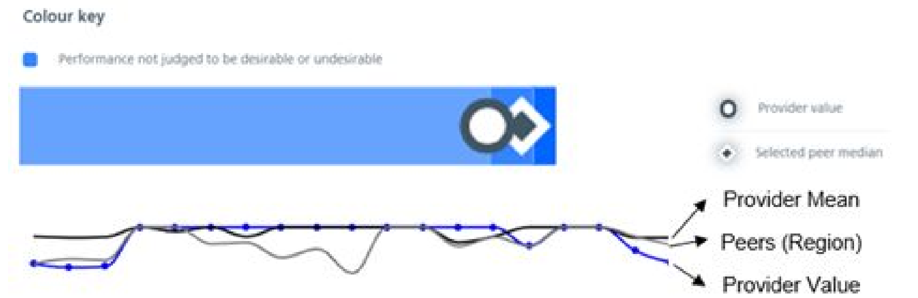
The Quality Surveillance Team (QST), formerly National Peer Review Programme, lead an Integrated Quality Assurance Programme for the NHS and is part of the National Specialised Commissioning Directorates, Quality Assurance and Improvement Framework (QAIF).

The role of the QST is to improve the quality and outcomes of clinical services by delivering a sustainable and embedded quality assurance framework for all cancer services and specialised commissioned services within NHS England.

Previously data was supported by the SSQD dashboards via Quality Surveillance Programme. From Quarter 3 2022-23, Data is now collected and reported via The Model Health System which is a data-driven improvement tool that supports health and care systems to improve patient outcomes and population health. It provides benchmarked insights across the quality of care, productivity and organisational culture to identify opportunities for improvement. The Model Health System incorporates the Model Hospital, which provides hospital provider-level benchmarking.

The SSQD dashboards (Q4 21-22 – Q2 22-23) make use of spine chart and SPC spark lines to be interpreted as follows:

The Model Health System (Q3 22-23 onwards) makes use of a spine chart and trend lines to be interpreted as follows:



<u>Summary</u>: The data shows that the outcome of patients receiving stem cell transplantation in Liverpool remains fairly consistent and well on average compared to national outcomes. This data also gives us additional reassurance that we are well positioned against our peers.

This data is short-term and submission is not mandatory, this affects national figures and averages and means data becomes unreliable. Short-term data is subject to fluctuation in smaller and medium sized transplant centres.

It should be noted that for Quarter 3 (2022-2023) there are no negative indicators and this has been consistent over previous quarters.

Priscilla Hetherington
Acute Care Matron

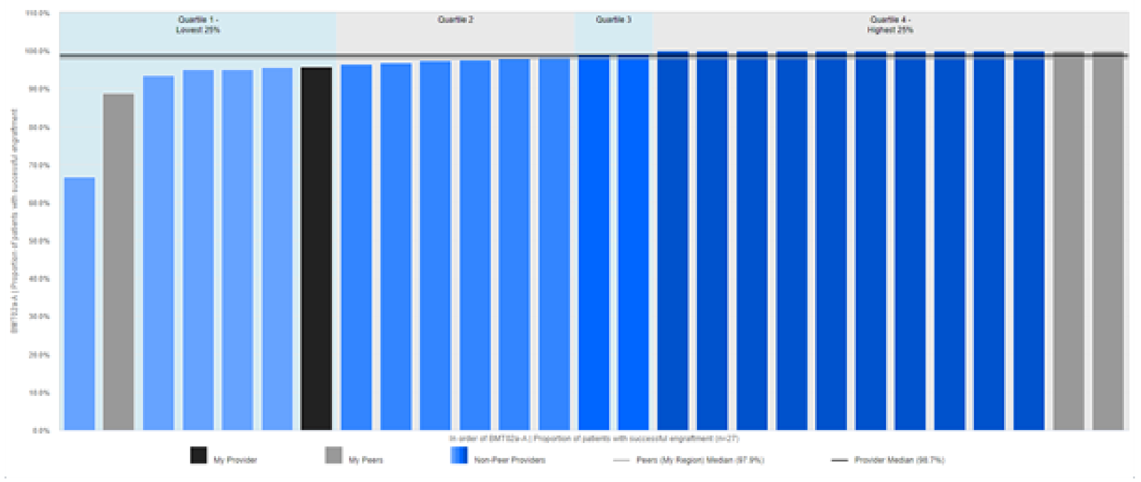
3.0 BMT02a-A -Proportion of patients with successful engraftment

- *Numerator Description - Number of patients where engraftment was successful (successful defined as neutrophil count of > 0.5 * 10^9 per litre for three consecutive days by day plus 28)*
- *Denominator Description - Total number of patients transplanted in the first 6 months of the previous 7 month reporting period*
- *Interpretation Guidance - Higher is better*

QTR	Period	Num	Denom	Value	Peer Average	National Average	Chart	Trend
QTR 4 21-22	Oct 21 - Mar 22	45	45	100	-	94.7		
QTR 1 22-23	Jan 22 - Jun 22	37	37	100	-	97		
QTR 2 22-23	Apr 22 - Sep 22	34	35	97.1	-	97.1		
QTR 3 22-23	Jul 22 - Dec 22	45	47	95.7	97.9	97.9		

QTR 3 Drill Down:

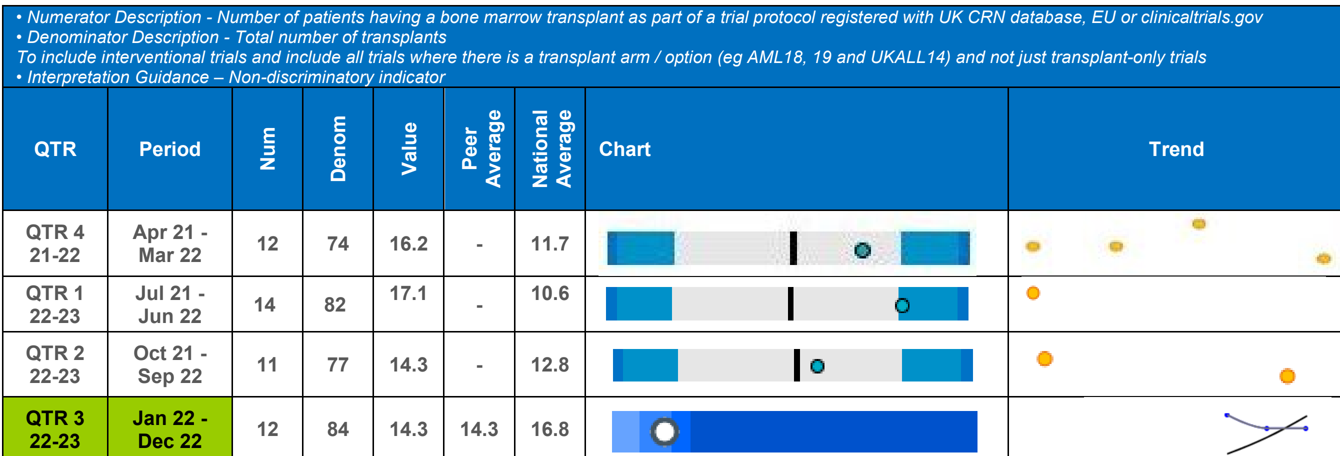
95.7% is in quartile 1 - Lowest 25%



Peer Quartiles:

Organisation Name	My Peer (My Region)	Reporting Date	Organisation Value	Organisation Raw Value	Quartile	Notes	Peer Median	Provider Median
Blackpool Teaching Hospitals NHS Foundation Trust	Yes	Q3 2022/23	88.9%	88.9	Quartile 1	In quartile 1 - Lowest 25% [blue]	97.9%	98.7%
Clatterbridge Cancer Centre NHS Foundation Trust	Yes	Q3 2022/23	95.7%	95.7	Quartile 1	In quartile 1 - Lowest 25% [blue]	97.9%	98.7%
Manchester University NHS Foundation Trust	Yes	Q3 2022/23	100.0%	100	Quartile 4	In quartile 4 - Highest 25% [blue]	97.9%	98.7%
Christie NHS Foundation Trust	Yes	Q3 2022/23	100.0%	100	Quartile 4	In quartile 4 - Highest 25% [blue]	97.9%	98.7%

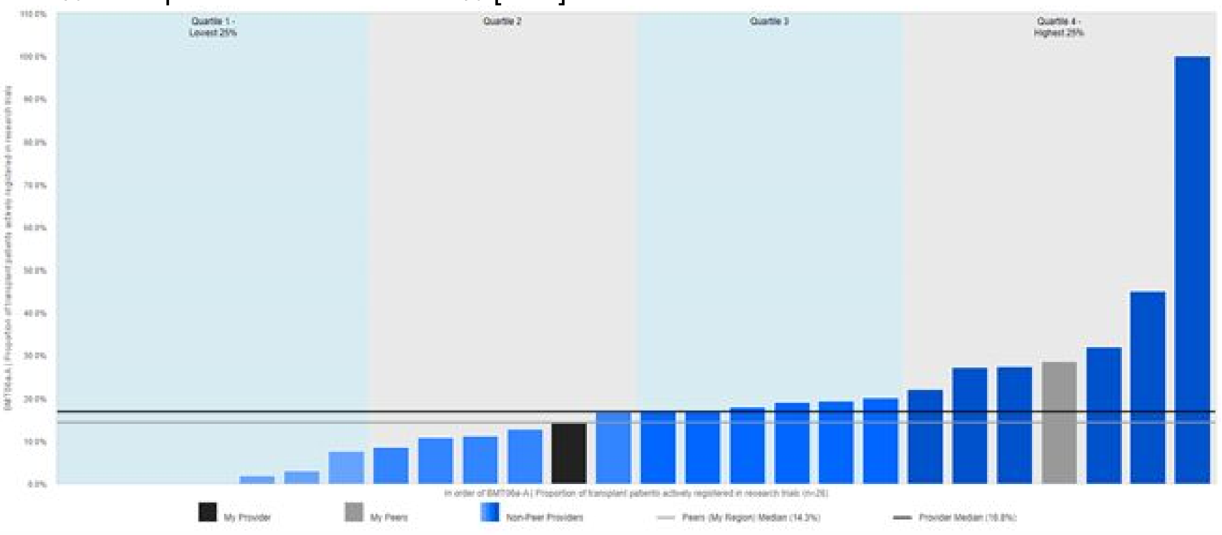
3.1 BMT06-A – Percentage of transplant patients registered in research trials



• *Numerator Description - Number of patients having a bone marrow transplant as part of a trial protocol registered with UK CRN database, EU or clinicaltrials.gov* • *Denominator Description - Total number of transplants* *To include interventional trials and include all trials where there is a transplant arm / option (eg AML18, 19 and UKALL14) and not just transplant-only trials* • *Interpretation Guidance – Non-discriminatory indicator*								
QTR	**Period**	**Num**	**Denom**	**Value**	**Peer Average**	**National Average**	**Chart**	**Trend**
QTR 4 21-22	Apr 21 - Mar 22	12	74	16.2	-	11.7		
QTR 1 22-23	Jul 21 - Jun 22	14	82	17.1	-	10.6		
QTR 2 22-23	Oct 21 - Sep 22	11	77	14.3	-	12.8		
QTR 3 22-23	Jan 22 - Dec 22	12	84	14.3	14.3	16.8		

QTR 3 Drill Down:

14.3% is in quartile 2 - Mid-Low 25% [blue]



Peer Quartiles:

Organisation Name	My Peer (My Region)	Reporting Date	Organisation Value	Organisation Raw Value	Quartile	Notes	Peer Median	Provider Median
Christie NHS Foundation Trust	Yes	Q3 2022/23	0.0%	0	Quartile 1	In quartile 1 - Lowest 25% [blue]	14.3%	16.8%
Clatterbridge Cancer Centre NHS Foundation Trust	Yes	Q3 2022/23	14.3%	14.3	Quartile 2	In quartile 2 - Mid-Low 25% [blue]	14.3%	16.8%
Manchester University NHS Foundation Trust	Yes	Q3 2022/23	28.6%	28.6	Quartile 4	In quartile 4 - Highest 25% [blue]	14.3%	16.8%

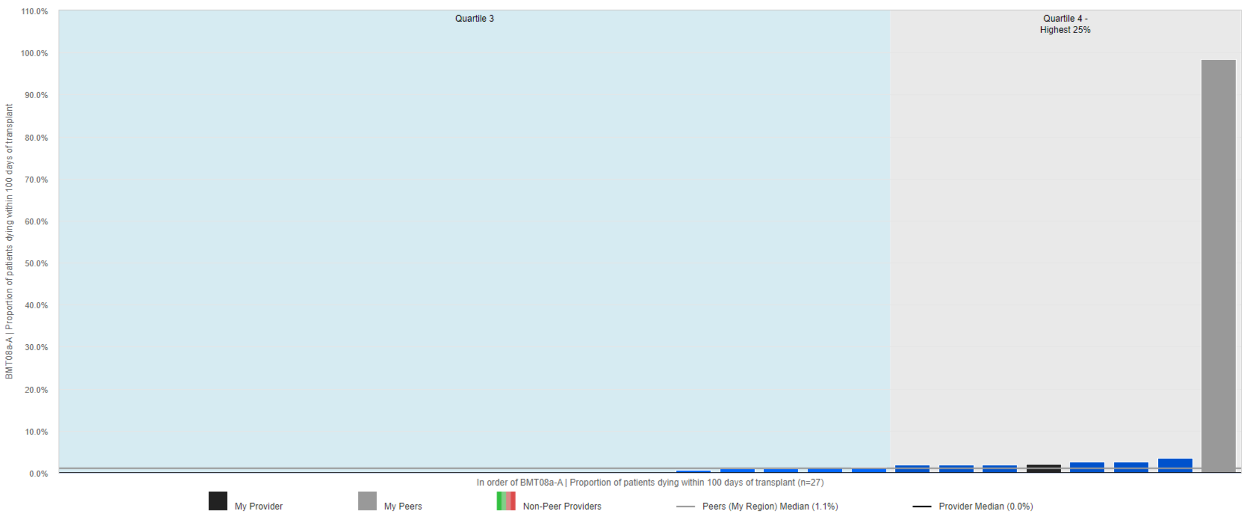
3.2 BMT08a-A – Percentage of patients dying within 100 days of transplant

	• Numerator Description – Number of patients in denominator who dies within 100 days of transplant • Denominator Description – total number of autologous transplants in the first 365 days of the previous 465 day reporting period Interpretation Guidance – Lower is better

QTR	Period	Num	Denom	Value	Peer Average	National Average	Chart	Trend
QTR 4 21-22	Apr 21 - Mar 22	2	46	4.4	-	1.5		
QTR 1 22-23	Jul 21 - Jun 22	1	42	2.4	-	1.3		
QTR 2 22-23	Oct 21 - Sep 22	1	48	2.1	-	1.5		
QTR 3 22-23	Jan 22 - Dec 22	1	47	2.1	1.1	0.0		

QTR 3 Drill Down:

2.1% is in quartile 4 - Highest 25% [blue]



Peer Quartiles:

Organisation Name	My Peer (My Region)	Reporting Date	Organisation Value	Organisation Raw Value	Quartile	Notes	Peer Median	Provider Median
Blackpool Teaching Hospitals NHS Foundation Trust	Yes	Q3 2022/23	0.0%	0	Quartile 3	In quartile 3 - Mid-High 25% [blue]	1.1%	0.0%
Christie NHS Foundation Trust	Yes	Q3 2022/23	0.0%	0	Quartile 3	In quartile 3 - Mid-High 25% [blue]	1.1%	0.0%
Clatterbridge Cancer Centre NHS Foundation Trust	Yes	Q3 2022/23	2.1%	2.1	Quartile 4	In quartile 4 - Highest 25% [blue]	1.1%	0.0%
Manchester University NHS Foundation Trust	Yes	Q3 2022/23	98.5%	98.5	Quartile 4	In quartile 4 - Highest 25% [blue]	1.1%	0.0%

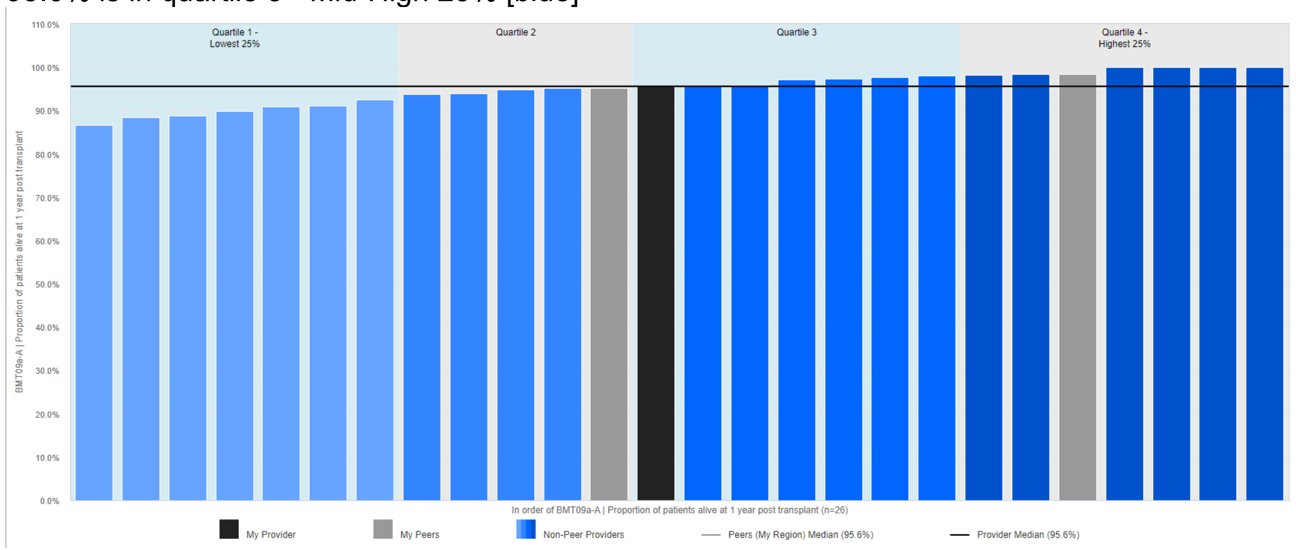
3.3 BMT09a-A – Percentage of patients alive at 1 year post transplant

• Numerator Description – Number of patients in denominator alive 1 year after transplant
• Denominator Description – Total number of autologous transplants in the first 12 months of the previous 24 month reporting period
Interpretation Guidance – Higher is better↑

QTR	Period	Num	Denom	Value	Peer Average	National Average	Chart	Trend
QTR 4 21-22	Apr 21 - Mar 22	48	50	96	-	92.7		
QTR 1 22-23	Jul 21 – Jun 22	45	47	95.7	-	93.6		
QTR 2 22-23	Oct 21 - Sep 22	44	45	97.8	-	92.8		
QTR 3 22-23	Jan 22 - Dec 22	43	45	95.6	95.6	95.6		

QTR 3 Drill Down:

95.6% is in quartile 3 - Mid-High 25% [blue]



Peer Quartiles:

Organisation Name	My Peer (My Region)	Reporting Date	Organisation Value	Organisation Raw Value	Quartile	Notes	Peer Median	Provider Median
Christie NHS Foundation Trust	Yes	Q3 2022/23	95.2%	95.2	Quartile 2	In quartile 2 - Mid-Low 25% [blue]	95.6%	95.6%
Clatterbridge Cancer Centre NHS Foundation Trust	Yes	Q3 2022/23	95.6%	95.6	Quartile 3	In quartile 3 - Mid-High 25% [blue]	95.6%	95.6%
Manchester University NHS Foundation Trust	Yes	Q3 2022/23	98.5%	98.5	Quartile 4	In quartile 4 - Highest 25% [blue]	95.6%	95.6%

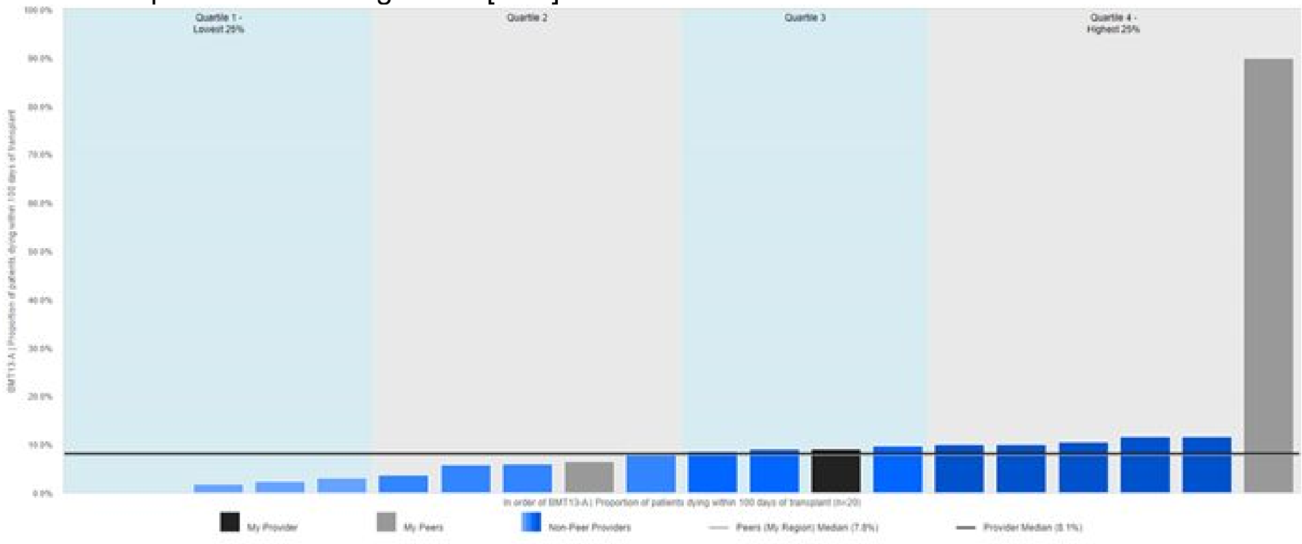
3.4 BMT13-A – Percentage of patients dying within 100 days of transplant

• Numerator Description – Number of patients in denominator who died within 100 days of allogenic transplant
• Denominator Description – Total number of allogenic transplants in the first 365 days of the previous 465 day reporting period
Interpretation Guidance – Lower is better

QTR	Period	Num	Denom	Value	Peer Average	National Average	Chart	Trend
QTR 4 21-22	Apr 21 - Mar 22	2	31	6.5	-	8.1		
QTR 1 22-23	Jul 21 - Jun 22	2	33	6.1	-	7.1		
QTR 2 22-23	Oct 21 - Sep 22	3	34	8.8	-	7.1		
QTR 3 22-23	Jan 22 - Dec 22	3	33	9.1	7.8	8.1		

QTR 3 Drill Down:

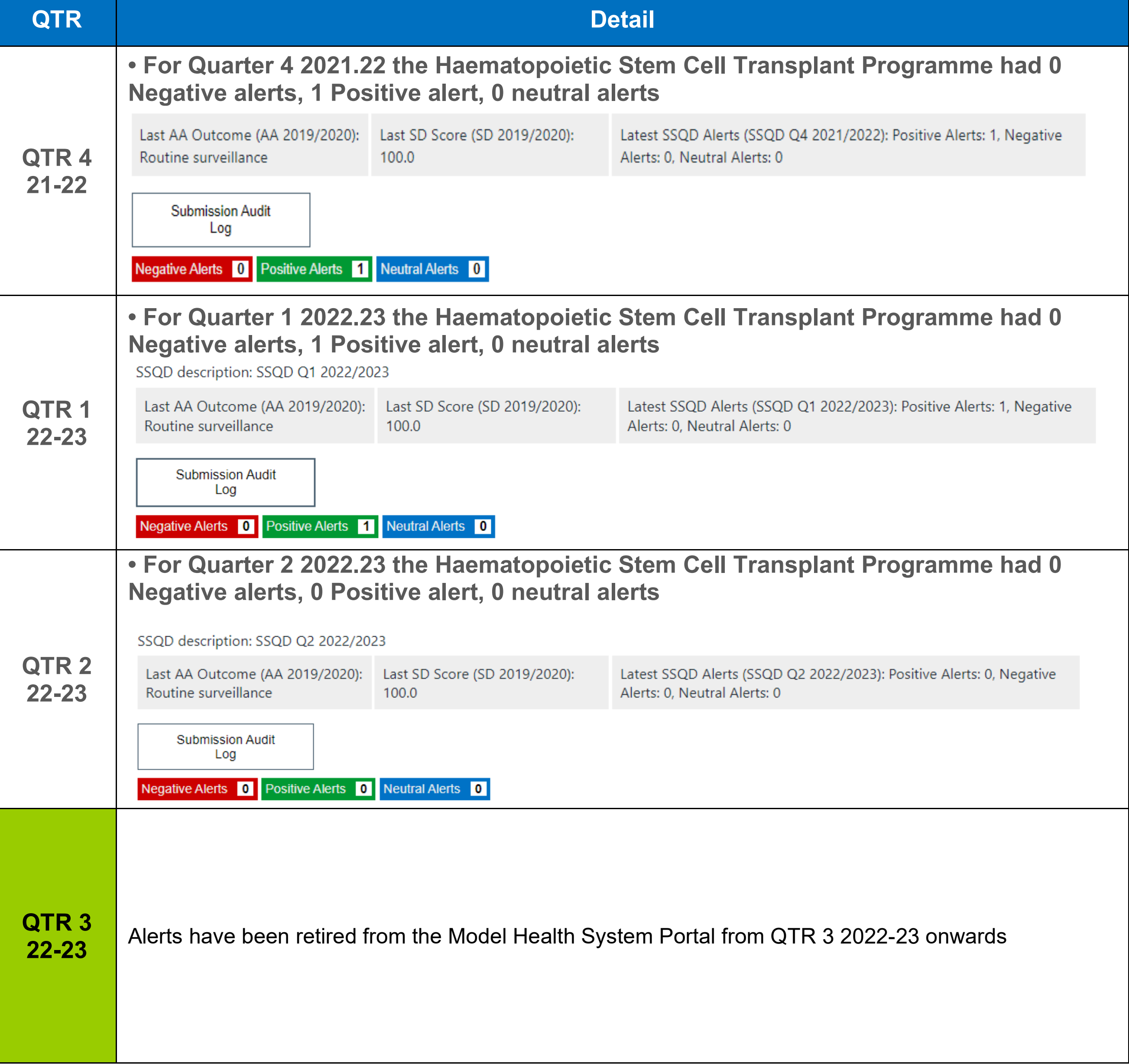
9.1% is in quartile 3 - Mid-High 25% [blue]



Peer Quartiles:

Organisation Name	My Peer (My Region)	Reporting Date	Organisation Value	Organisation Raw Value	Quartile	Notes	Peer Median	Provider Median
Blackpool Teaching Hospitals NHS Foundation Trust	Yes	Q3 2022/23	0.0%	0	Quartile 1	In quartile 1 - Lowest 25% [blue]	7.8%	8.1%
Christie NHS Foundation Trust	Yes	Q3 2022/23	6.5%	6.5	Quartile 2	In quartile 2 - Mid-Low 25% [blue]	7.8%	8.1%
Clatterbridge Cancer Centre NHS Foundation Trust	Yes	Q3 2022/23	9.1%	9.1	Quartile 3	In quartile 3 - Mid-High 25% [blue]	7.8%	8.1%
Manchester University NHS Foundation Trust	Yes	Q3 2022/23	89.9%	89.9	Quartile 4	In quartile 4 - Highest 25% [blue]	7.8%	8.1%

4.0 Haemopoietic Stem Cell Transplant Alerts



QTR	Detail
QTR 4 21-22	• For Quarter 4 2021.22 the Haematopoietic Stem Cell Transplant Programme had 0 Negative alerts, 1 Positive alert, 0 neutral alerts Last AA Outcome (AA 2019/2020): Routine surveillance | Last SD Score (SD 2019/2020): 100.0 | Latest SSQD Alerts (SSQD Q4 2021/2022): Positive Alerts: 1, Negative Alerts: 0, Neutral Alerts: 0 Submission Audit Log Negative Alerts 0 Positive Alerts 1 Neutral Alerts 0
QTR 1 22-23	• For Quarter 1 2022.23 the Haematopoietic Stem Cell Transplant Programme had 0 Negative alerts, 1 Positive alert, 0 neutral alerts SSQD description: SSQD Q1 2022/2023 Last AA Outcome (AA 2019/2020): Routine surveillance | Last SD Score (SD 2019/2020): 100.0 | Latest SSQD Alerts (SSQD Q1 2022/2023): Positive Alerts: 1, Negative Alerts: 0, Neutral Alerts: 0 Submission Audit Log Negative Alerts 0 Positive Alerts 1 Neutral Alerts 0
QTR 2 22-23	• For Quarter 2 2022.23 the Haematopoietic Stem Cell Transplant Programme had 0 Negative alerts, 0 Positive alert, 0 neutral alerts SSQD description: SSQD Q2 2022/2023 Last AA Outcome (AA 2019/2020): Routine surveillance | Last SD Score (SD 2019/2020): 100.0 | Latest SSQD Alerts (SSQD Q2 2022/2023): Positive Alerts: 0, Negative Alerts: 0, Neutral Alerts: 0 Submission Audit Log Negative Alerts 0 Positive Alerts 0 Neutral Alerts 0
QTR 3 22-23	Alerts have been retired from the Model Health System Portal from QTR 3 2022-23 onwards

National 30 Day Mortality after Palliative Radiotherapy Benchmarking

Introduction

The Radiotherapy Data Set (RTDS) is the national standard for collecting consistent and comparable data across all English NHS providers of radiotherapy (or private facilities where delivery is funded by the NHS) to provide timely data to inform the planning, provision, commissioning and improvement of radiotherapy services across the NHS.

This report has been produced by the National Disease Registration Service (NDRS) team as part of the RTDS Partnership with NHS England (NHSE) to support the NHS Long Term Plan and the Radiotherapy Transformation Plan, enable clinicians to understand their palliative radiotherapy practice and outcomes, and provide opportunities for data quality improvement. It presents the 30-day mortality after palliative radiotherapy metric relating to patients treated in England. This metric is a quality indicator intended for assessing the appropriate use of palliative radiotherapy. Palliative radiotherapy is not expected to contribute to the patient’s death, with the 30-day mortality metric providing a proxy for treatment burden near the end of life and thus being a marker of possible over or indeed, underuse, of radiotherapy as a palliative treatment modality. The metric does not specifically measure mortality caused by palliative radiotherapy.

The analysis presented in this report considers all palliative external beam radiotherapy episodes delivered at English NHS Trusts between 1st April 2018 and 31st March 2021. It includes only palliative radiotherapy episodes used for the treatment of cancer (ICD10 C00-C97, excl C44 (non-melanoma skin cancer)). Crude and adjusted 30-day mortality rates were calculated based on all palliative radiotherapy episodes a patient had in a year and are reported for each financial year and individual NHS Trust. The crude 30-day mortality rate is the percentage of palliative episodes where the patient died within 30 days of the start of the radiotherapy episode. The adjusted 30-day mortality rate is the rate after the differences in the radiotherapy treatment fractionation patterns between the Trusts have been accounted for. This latter providing recognition that a single fraction treatment where death occurs within 30 days, whilst likely to reflect a treatment delivered with limited benefit, is not as burdensome as one delivered using a fractionated course. In this way the variation in fractionation patterns between providers can be incorporated.

Metrics included:

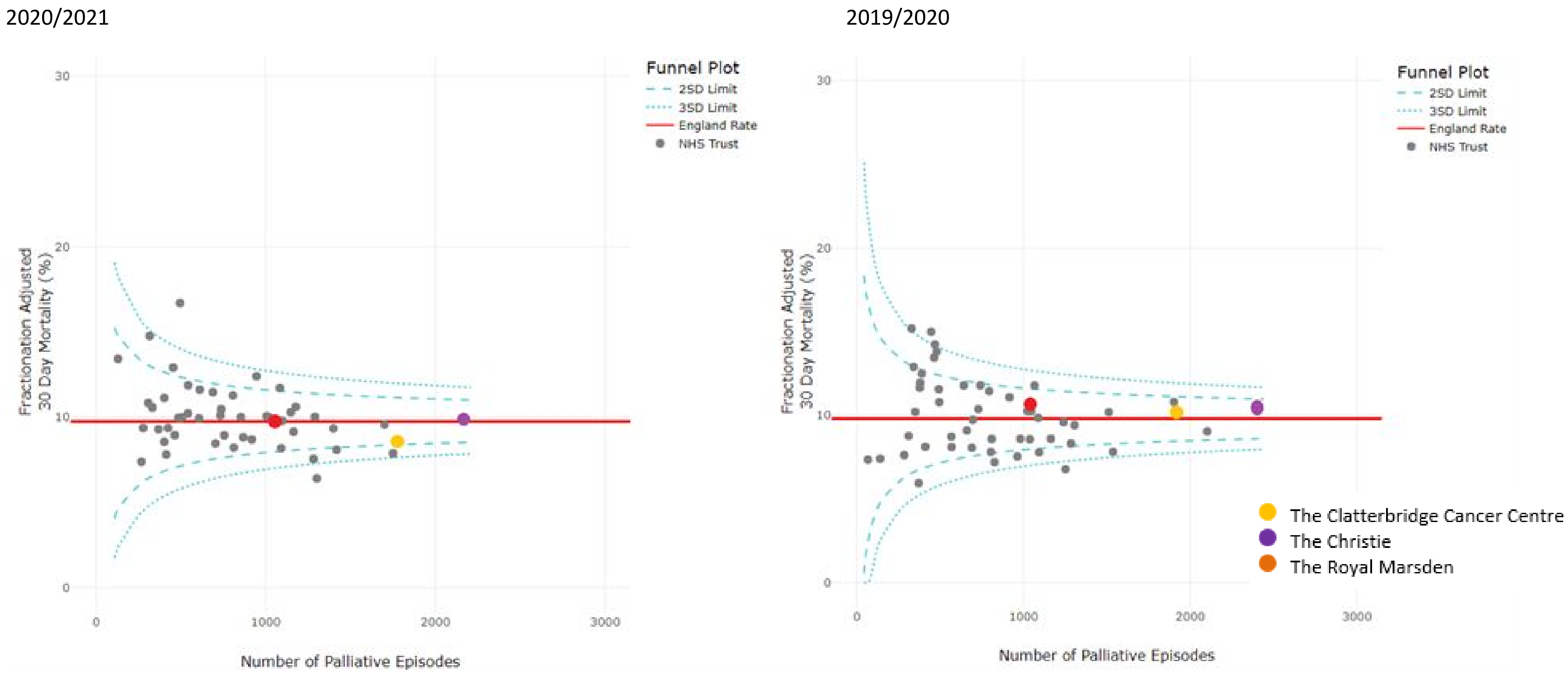
- Yearly crude rate for 30-day mortality after palliative radiotherapy
- Yearly adjusted rate for 30-day mortality after palliative radiotherapy (adjusted for fractionation pattern)

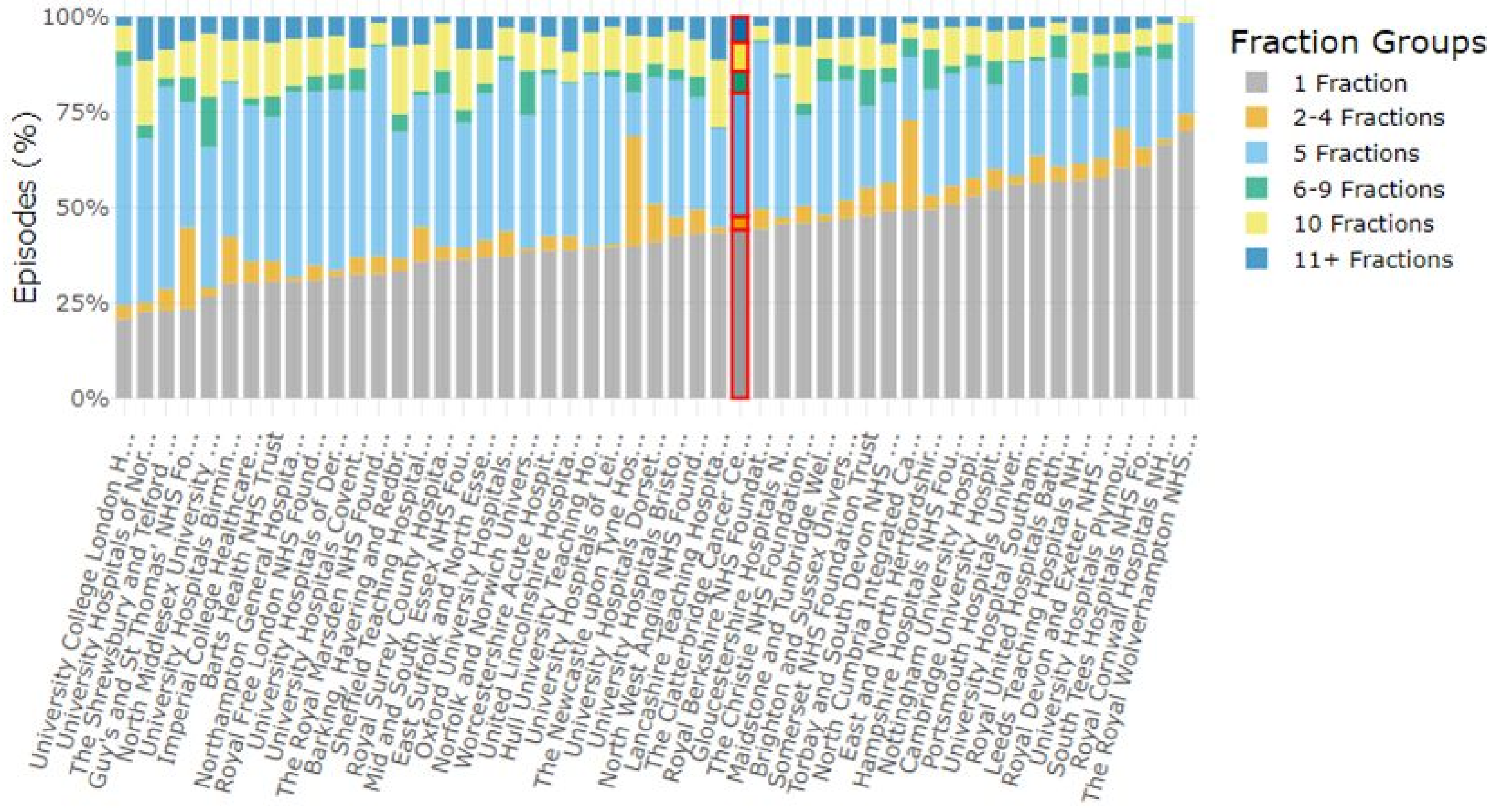
Analyses have been presented as funnel plots and in data tables.

Key messages

- In total there were 125,773 palliative episodes entered into the analysis
- The English average crude 30-day mortality rate after palliative radiotherapy was 10.6% for cancer patients treated during 2018/19. This decreased to 9.8% for patients treated during 2019/20 and for patients treated during 2020/21

- The crude 30-day mortality rates by Trust varied from 5.8% to 16.2% for 2020/21
- The adjusted 30-day mortality rates by Trust varied from 6.4% to 16.7% for 2020/21
- Across all Trusts included in the analysis, some Trusts were identified as outliers on the basis of their adjusted 30-day mortality rate. There were six outlier Trusts identified for 2018/19, four for 2019/20 and two for 2020/21. Three Trusts were outliers in more than one year
- The yearly number of palliative radiotherapy episodes included in the analysis varied by Trust from 61 to 2,409
- Between 50 and 51 Trusts were included in the analysis each year, with one Trust ceasing activity and not contributing to the calculations of the 2020/21 rates.



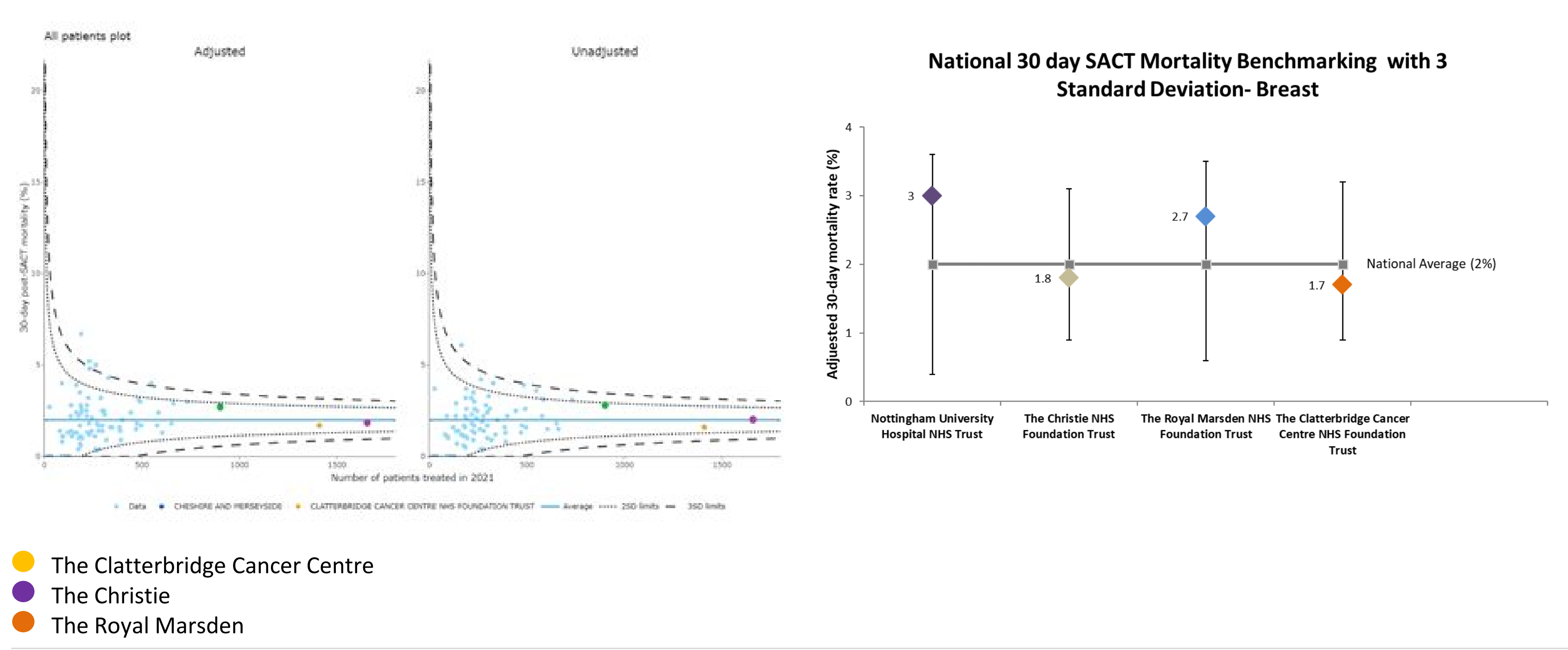


Episodes (%)
100%
75%
50%
25%
0%
Fraction Groups
1 Fraction
2-4 Fractions
5 Fractions
6-9 Fractions
10 Fractions
11+ Fractions

National 30 Day SACT Treatment Mortality Benchmarking

The National Disease Registration Service published the National Systematic Anti-Cancer Treatment (SACT) 30 day mortality benchmarking for Breast Cancer patients who were treated in 2021. The report shows rates of deaths within 30 days of SACT treatment, both unadjusted (observed) and adjusted for key patient factors. Overall 30-day mortality rates are presented for each NHS Trust identified. Overall rates are supplemented with rates broken down by age group, deprivation quintile, ethnicity group, and intent of treatment.

Trust performance is comparable to peer hospitals within the 2 standard deviation limits after case-mix adjustment. The same performance is consistent across other sub analysis by age group, deprivation quintile, ethnicity group, and intent of treatment.



In House 30 Day Treatment Mortality Analysis

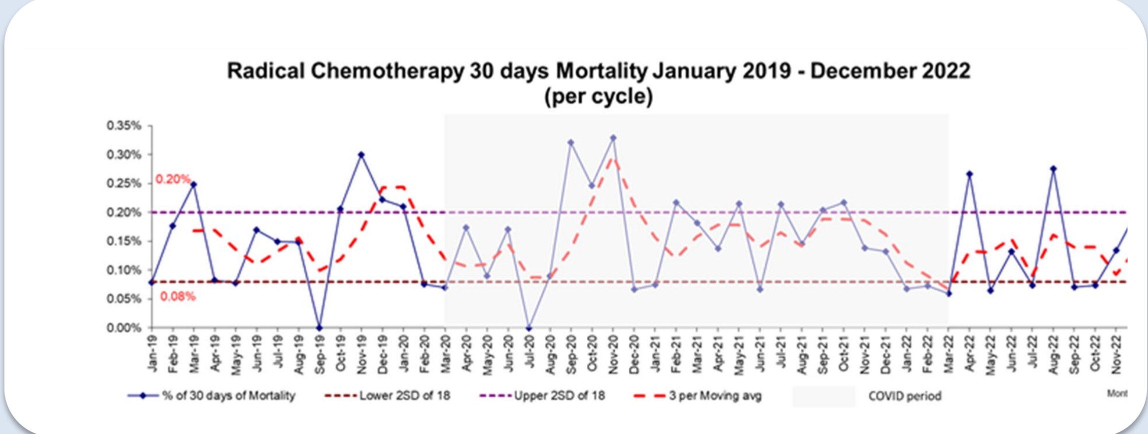
Methodology

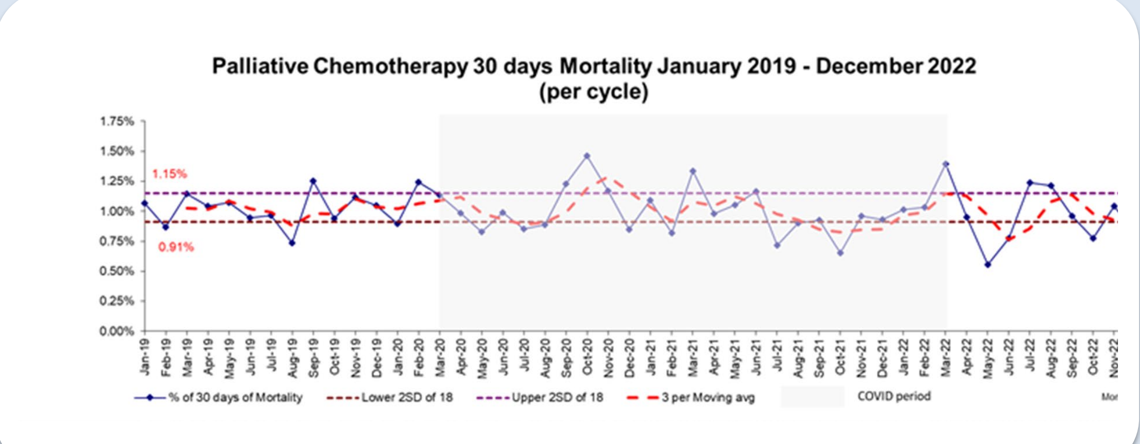
Treatment mortality analysis is presented in a Statistical Process Control (SPC) chart and split by intent; Radical and Palliative. A set of acceptable limits (upper and lower limits) is derived from historic data since 2009 (purple dotted lines). Monthly actual Trust mortality performance is presented as a blue line, averages of every 3 data points (moving averages) are also employed to gauge the direction of the current trend (red dotted line). HO is excluded from this analysis as control limits are based on CCC solid tumour historic data.

Chemotherapy

Treatment mortality performance reported to the Trust Board as part of the Quality Report. At year end, an individualised performance report was distributed to all consultants, presented in the format of control charts.

Solid Tumour Chemotherapy Mortality Analysis 2019-2022



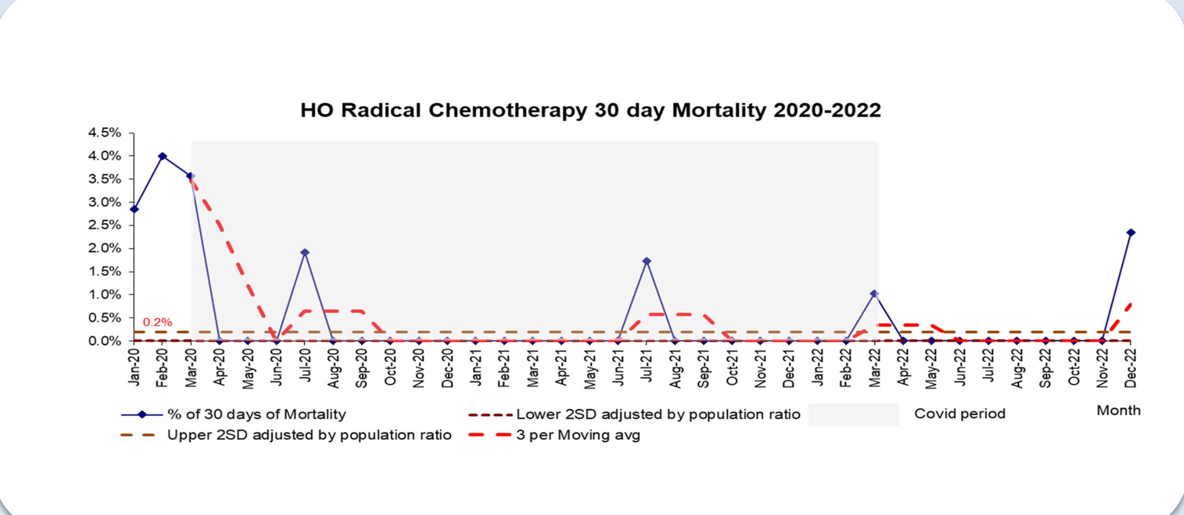


Solid Tumour SACT

CCC 2019-2022 solid tumour SACT 30-day mortality control chart demonstrated fairly consistent mortality performance pre and post COVID period for both radical and palliative treatment.

There was an unsettle period of 3 months in the radical intent setting, between September 2020 to November 2020, mortality rate was above upper limits which was at the early period of COVID-19 pandemic. The moving average for period after COVID-19 pandemic was well within control limits.

Haemato-oncology Chemotherapy Mortality Analysis 2020-2022



HO Palliative Chemotherapy 30 day Mortality 2020-2022

1.6% 1.4% 1.2% 1.0% 0.8% 0.6% 0.4% 0.2% 0.0%

1.15%

Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22

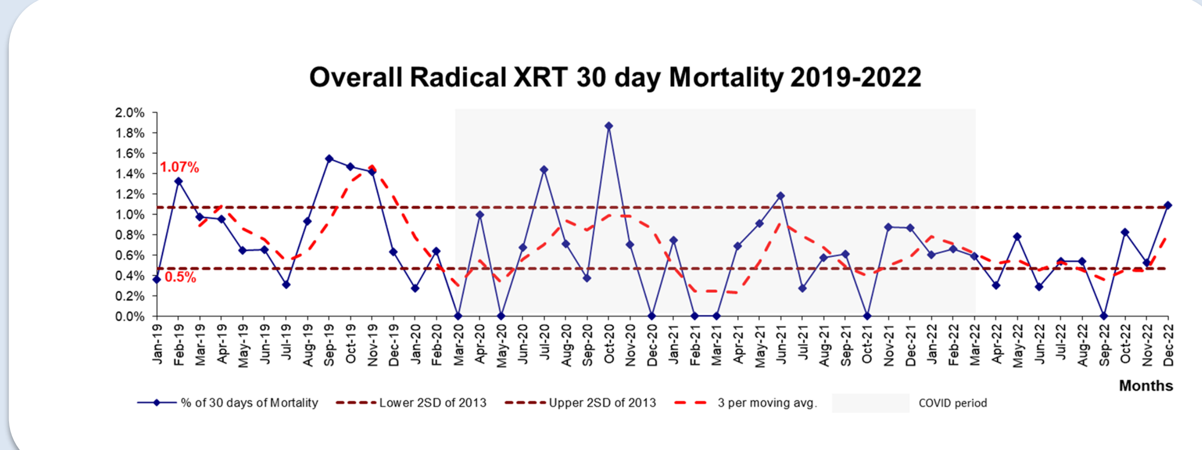
% of 30 days of Mortality — Lower 2SD adjusted by population ratio — Covid period — Month

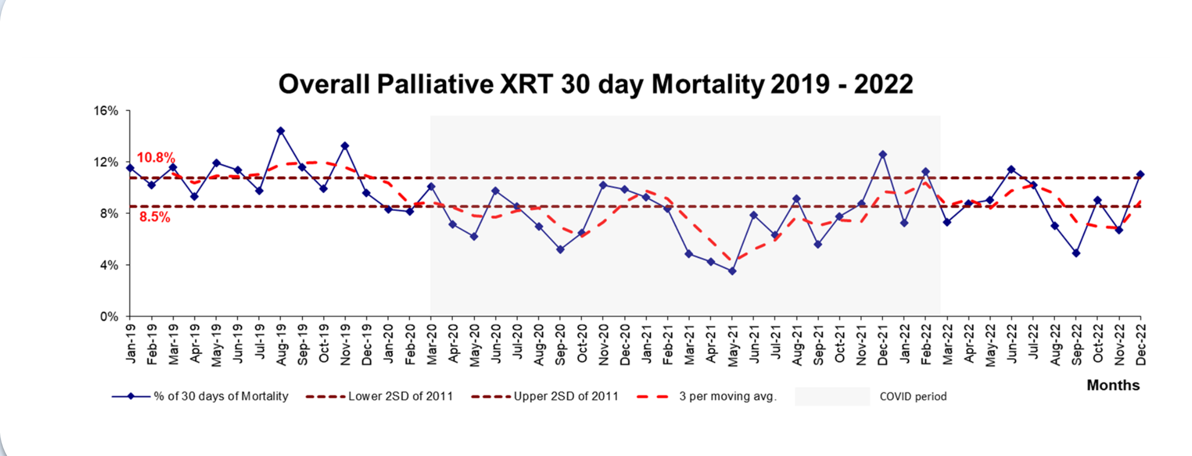
Upper 2SD adjusted by population ratio — 3 per Moving avg

Haemato-oncology SACT

CCC 2020-2022 Haemato-oncology 30 day mortality performance were within tolerance during and post COVID-19 period for both radical and palliative intent.

Radiotherapy 30-day Mortality Analysis 2019-2022



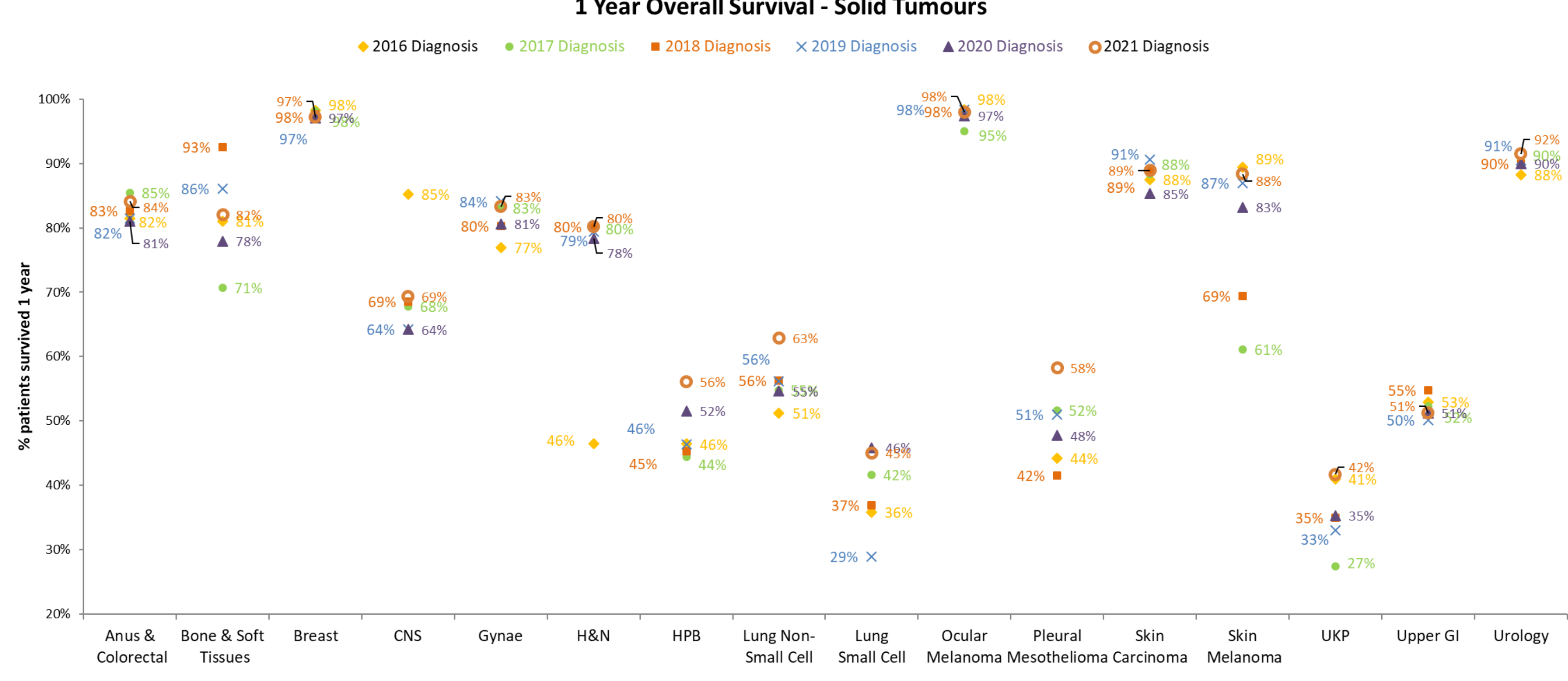


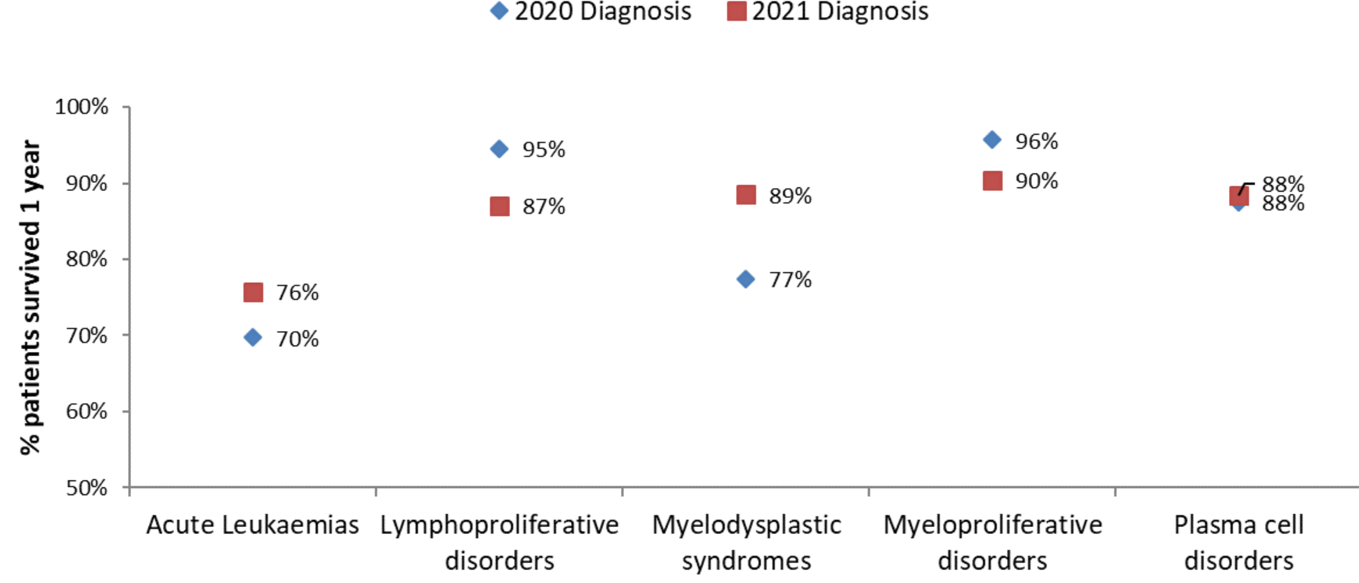
Radiotherapy 30-day Mortality

CCC 2019-2022 radiotherapy 30 day mortality performance was within tolerance during and post COVID-19 period for both radical and palliative intent.

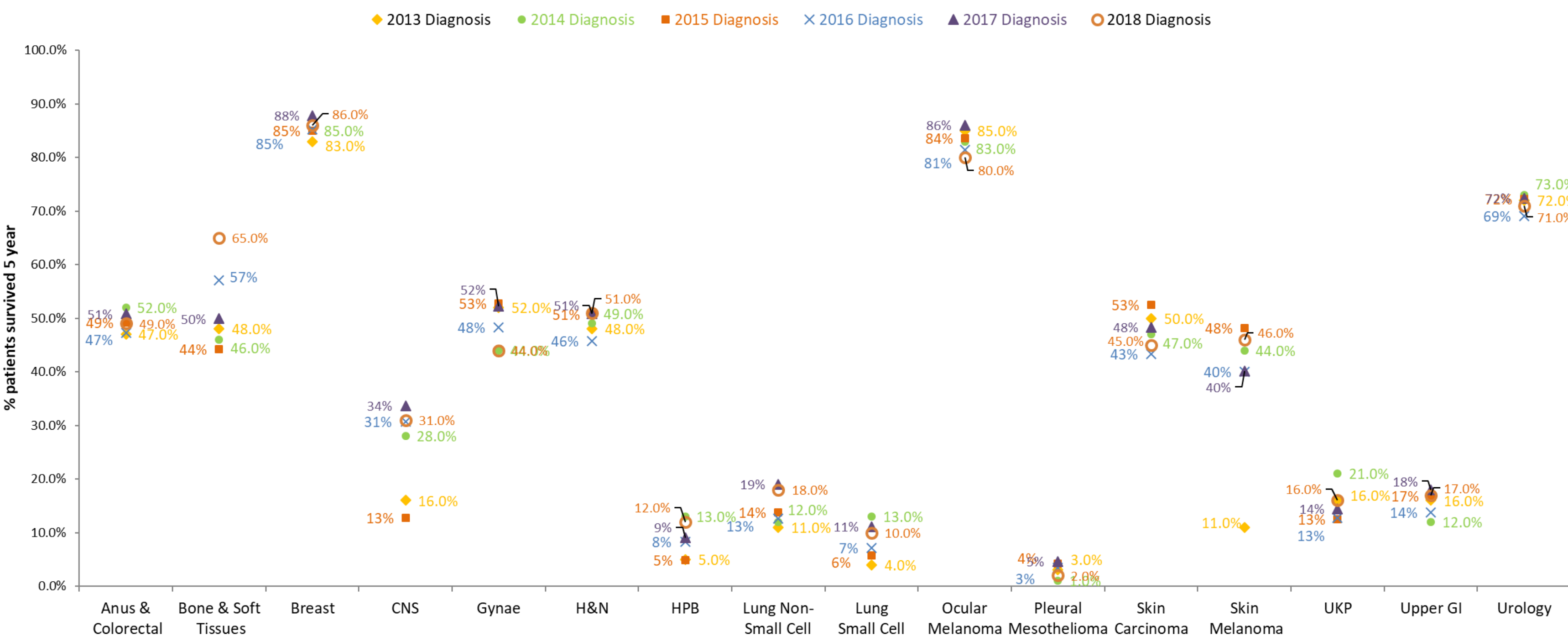
CCC Cancer patient survival rate by Specific Tumour Group

Graphs below showed percentage of patient survived 1 year and 5 years. One year survival is based on patient diagnosed in 2016 - 2021 (2020-2021 only for Haemato-oncology due to regrouping of disease groups, leading to comparison with previously calculated survival figures not comparable) to show short term outcome, whilst 5 year survival is based on patient diagnosed in 2013 - 2018 to show long term outcome. Majority of figures are comparable with some showing improvement and some showing reduced survival. Understanding the differences requires an in-depth analysis which is included in the SRG dashboard development and will be discussed in SRG meetings.




1 Year Overall Survival - Haemato-oncology
2020 Diagnosis
2021 Diagnosis
% patients survived 1 year
100%
90%
80%
70%
60%
50%
76%
70%
95%
87%
89%
77%
96%
90%
88%
88%
Acute Leukaemias
Lymphoproliferative disorders
Myelodysplastic syndromes
Myeloproliferative disorders
Plasma cell disorders

*


5 Year Overall Survival - Solid Tumours
2013 Diagnosis
2014 Diagnosis
2015 Diagnosis
2016 Diagnosis
2017 Diagnosis
2018 Diagnosis
% patients survived 5 year
Anus & Colorectal
Bone & Soft Tissues
Breast
CNS
Gynae
H&N
HPB
Lung Non-Small Cell
Lung Small Cell
Ocular Melanoma
Pleural Mesothelioma
Skin Carcinoma
Skin Melanoma
UKP
Upper GI
Urology

Looking to the future [23/24]

- Continue to develop a Mortality Management Strategy
- Continue to investigate means of cascading lessons learned Trustwide
- Continue to work with tumour Specific Site Reference Groups to develop outcome measures/benchmarking
- Intergrate existing 100 day Bone Marrow Transplant mortality reviews into the Mortality process utilising Datix
- Incorporate mortality review cases with incidents, concerns and complaints electronically utilising Datix

Glossary

Abbreviation	Description
2SD	Two standard deviation
ACB	Amber care bundle
CCC	The Clatterbridge Cancer Centre
CCC-W	The Clatterbridge Cancer Centre - Wirral
CDOP	Child death overview panels
CDOP	Child Death Overview Panel
CDU	Clinical Descision Unit
CET	Clinical Effectiveness Team
CNR	Case note review
CSCI	Continuous Subcutaneous Infusion
CT	Computerized Tomography
D & T	Dabrafenib + Trametinib
Datix	Software company
DGH	District General Hospital
DNACPR	Do not attempt cardiopulmonary resuscitation
EAPC	Europeam Association of Palliative Care
eGFR	Estimated glomerular filtration rate
EPR	Electronic Patient Record
ESC	Enhanced supportive care
Evolve	Sofware for scanning information into the patient record
GCSF	Granulocyte colony stimulating factor
GI	Gastrointestinal
GP	General Practitioner
HO	Haemato-Oncology
HPB	Hepatobiliary
HPB	Hospital Board
HQIP	Healthcare Quality Improvement Partnership
HSJ	Health Service Journal
HSMR	Hospital Standardised Mortality Ratio
IO	Immuno-oncology
IOM	Isle of Man
IPOS	Integrated palliative care outcome scale
LeDeR	Learning Disabilities Mortality Review
LUHFT	Liverpool University Hospital Foundation Trust
MDT	Multidisciplinary teams
Meditech	Electronic Patient Record system
MET	Medical Emergency Team
MRM	Mortality Review Meeting
MSCC	Metastatic spinal cord compression
MSG	Mortality Surveillance Group
NACEL	National Audit of Care at the End of Life
NCEPOD	National Confidential Enquiry into Patient Outcomes and Death

NICE	The National Institute for Health and Care Excellence
PA	Physician associate
PE	Pulmonary Embolism
PM	Post mortem
PR	Rectal bleeding
PS	Performance Status
QAIF	Quality Assurance and Improvement Framework
QS	Quality Survey
QST	Quality Surveillance Team
RCP	Royal College of Physicians
SACT	Systemic Anti-Cancer Therapy
SCLC	Small cell lung cancer
SHMI	Summary Hospital-Level Mortality Indictor
SJR	Structured Judgement Review
SPC	Statistical Process Control
SPCT	Specialist Palliative Care Team
SRG	Site Reference Group
SRM	Staff Reported Measure
UKONS	UK Oncology Nurses Society
VTE	Venous thromboembolism

Title of meeting: Trust Board
Date of meeting: 26th July 2023

Report author	Daniel Monnery, Palliative Medicine Consultant			
Paper prepared by	Daniel Monnery, Palliative Medicine Consultant			
Report subject/title	Palliative and End of Life Care 5 Year Strategy 2023-28			
Purpose of paper	To outline the strategic plan for palliative and end of life care services at CCC over the next 5 years			
Background papers				
Action required	For noting			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	x	Be a great place to work	x
	Be Collaborative	x	Be Digital	x
	Be Research Leaders	x	Be Innovative	x

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

Ref: FCGOREPO
Review: July 2025
Version: 2.0

Palliative and End of Life Care Strategy 2023-28

Contents

Executive Summary 3
Introduction 3
Our Strategy 2018-23: Where are we now? 4
Table 1: What have we achieved? 5
Table 2: What are we still working on? 7
Table 3: Abandoned actions 8
Clinical Activity 9
Key Performance Indicators 11
Our Vision 13
Our Drivers 14
Each person is seen as an individual 15
Each person gets fair access to care 16
Maximising comfort and wellbeing 17
Care is coordinated 18
All staff are prepared to care 19
Each community is prepared to help 19
Local and National Partners 20
Action Plan 21
Key Performance Indicators 27
Next Steps 28
References 29

Executive Summary

Personalised care, improving quality, ensuring equity of access and striving for continuous improvement is at the heart of our palliative and end of life care strategy. At The Clatterbridge Cancer Centre NHS Foundation Trust, we are at the end of an ambitious five year strategy which has seen the expansion of palliative and supportive care services, diversification of clinical services including ambulatory care, the launch of a family support service and international accreditation as a MASCC centre of excellence in supportive care in cancer. Our previous strategy was underpinned by a 32-point action plan which we have almost completed despite COVID-19 and we have made good progress against our key performance indicators.

We have more to do however and this strategy for 2023-28 outlines the next steps for palliative care end of life care. It is underpinned by the Trust strategy and the national ambitions framework and focusses for the next five years on collaboration to achieve the best clinical outcomes, innovation and research to drive improvement and education for patients and professionals.

Introduction

The Clatterbridge Cancer Centre NHS Foundation Trust is one of the UK's leading providers of non-surgical cancer treatment, caring for a population of 2.4 million people across Cheshire & Merseyside, North Wales, the Isle of Man and parts of Lancashire. Our flagship specialist cancer hospital in Liverpool opened in June 2020, supported by our hospital on the Clatterbridge Health Park in Wirral providing outpatient cancer treatment and supportive care, and our radiotherapy treatment centre on the Aintree Hospital site.

Palliative and Supportive care is provided alongisde anticancer treatment in all three of these hubs and the development of these services over the last five years has been driven by the Trust's previous Palliative and End of Life Care Strategy 2018-23. This ambitious strategy underpinned the development of supportive care in cancer in Cheshire and Merseyside as well as improving the end of life care for patients approaching the end of their lives. As the term of that strategy is approaching its end, it is time for us to look to the future and the next steps for ongoing development.

Approximately 3,000 people per year are diagnosed with incurable cancer in Cheshire and Merseyside and it is our ongoing mission to ensure that those people receive the highest quality care throughout their cancer journey and that their families receive the support they need before and after the loss of a loved one. As well as caring for those at the end of life, the development of supportive care for patients with treatable but not curable cancer and those with curable cancer has been a key success of our previous strategy which continues to feature in our goals for the future.

It has been a difficult five years. The move to the new hospital in Liverpool and COVID-19 have posed significant challenges to the services we deliver. However these challenges have stimulated progress and innovation in the way we deliver palliative and end of life care and the way these services now meet patients' needs is more responsive, effective and holistic than ever before. We are proud of where we are now and enthusiastic about the future.

Our Strategy 2018-23: Where are we now?

The 2018-23 Palliative and End of Life Care Strategy outlined a five year plan for service developments and improvements which aimed to:

- Address unmet regulatory requirements
- Improve access to our services across Cheshire and Merseyside
- Demonstrate quality in our clinical outcomes
- Implement systems of quality improvement
- Develop our research and academic outputs
- Whilst keeping care at the centre of what we do

In order to achieve these goals we proposed a five year, 32 point action plan. Tables 1, 2 and 3 outline that action plan split by those which have been achieved (table 1), those which remain in progress (table 2) and those which have been abandoned (table 3).

Table 1: What have we achieved?

Action	Supporting evidence
Form a working group to deliver AMBER care across the Trust, and deliver all training and electronic resources to support its use	AMBER lead appointed, work undertaken under SRG governance structure. AMBER care bundle and all tools launched and maintained with ongoing audit.
Deliver key elements of communication skills and having supportive conversations as part of mandatory training for nurses	A new session on spiritual and emotional care and supportive conversations is now delivered as part of role-essential training for all staff. Hints and tips study day offered to medical staff
Re-launch advance care planning processes including documentation throughout all of CCC inpatient and outpatient departments	ACP lead appointed, ACP system set up and embedded and maintained with ongoing audit.
Adopt robust processes for liaising with GPs and community services when patients are identified as approaching end of life, i.e. Gold Standards Framework	Gold Standard's Framework was launched in December 2019 and is currently in use in both inpatient and outpatient settings.
Extend mandatory training sessions to allow symptom control teaching for clinical staff after generic skills training which includes non-clinical staff	Re-launched tiered approach to mandatory training. Symptom control teaching now mandated for medical staff
Recruit a second social worker with a shared role for family support (1 WTE).	Second appointment due to take up post in November
Deliver consultant-led specialist palliative care into the clinical decisions unit (CDU)	The Specialist Palliative Care Team now responds to referrals from the CDU on the same day
Recruit a substantive consultant in palliative medicine (1 WTE)	Recruited July 2019
Recognition of dying to be made part of mandatory training in palliative and end of life care for all clinical staff	Recognising dying now forms part of role essential end of life training for all clinical staff including consultants.
Recruit a specialty doctor in palliative medicine to assist delivery of Enhanced Supportive Care to more primary tumour sites	A Specialty doctor has been appointed

Recruit an additional Clinical nurse Specialist in palliative care to assist delivery of expanding inpatient and outpatient services as well as support the delivery of 7 day working (1 WTE)	2x 0.8WTE band 7 Clinical Nurse Specialists have been appointed and started in May/June 2020.
Deliver debrief sessions on the wards following the death of each patient and use this as an opportunity to feedback about the use and quality of the end of life care and communication record	Debrief opportunities have been merged with psychological medicine support and offered to staff when needed
Deliver key elements of communication skills and having supportive conversations as part of mandatory training for nurses and mandate advanced communication skills training for band 6 nurses	A new session on spiritual and emotional care and supportive conversations is now delivered as part of role-essential training for all staff. In addition, advanced communication skills training forms a core competency within the new CCC staff competency Framework.
Expand GP trainee numbers rotating through CCC by widening the scope of their training to include more outpatient and supportive care experience	We have successfully been allocated 4 more GP trainees per rotation on the basis of an expanded Specialist Palliative Care Experience.
Specialist Palliative Care representation should be present within the mortality surveillance group and actively undertaking structured judgement reviews of inpatient deaths	Dr Monnery is a core member of the mortality surveillance group and undertakes the majority of the Trust's Structured Judgement Reviews (SJRs)
Recruit further supportive and palliative care team members as determined by the outcome of the regional discussions about enhanced supportive care and what services will be provided by CCC versus local hubs	Our current recruitment is sufficient to meet the needs of our patients based on current predicted numbers.
Develop mandatory training in palliative and end of life care for doctors with annual refreshment training	This is role essential for consultants and delivered to all rotating junior doctors. These sessions are delivered at least quarterly for consultants.
Develop robust processes for CReST collaboration within the new building including opportunities for shared working, regular meeting and shared care of inpatients and outpatients	Co-located teams in clinical business lounge, easy inter-team collaboration through Meditech referrals and shared governance under Supportive Care SRG

Return to tiered approach to mandatory training in palliative and end of life care to ensure appropriate delivery of training to non-clinical as well as clinical staff	Role-essential training in end of life care has returned to a tiered approach to ensure appropriate level training according to staff involvement with patients in the last 12 months of life.
Specialist Palliative Care should join the haemato-oncology MDT and liaise closely with haematology to direct the supportive care of haemato-oncology patients	SPCT presence in myeloma and lymphoma MDTs with upcoming meeting to discuss involvement in myeloid.
Develop referral pathways for patients to their local palliative care teams when their care at CCC has ended, regardless of whether they are seen as part of Enhanced Supportive Care or not	Referral pathways for all patients in all areas have been established. Further regional work over time will aim to streamline this process.
Develop a research portfolio in collaboration with Research and Innovation focusing on qualitative research into caring	• CCC has recruited for DISCERN, iLive and Burdett studies • Expression of Interest submitted for Nannabis trial • 12 National &International Abstracts presented in 2021 • 3 International journal publications • A patent has been submitted for a urine test predicting dying March 2022 • £100K Funding received 2022 for 'Biology of dying' project • One national and one international oral presentations at conferences

Table 2: What are we still working on?

Action	Supporting evidence
Deliver education and training to all staff who deliver the day after death service. Training to include updated bereavement policy, and how to escalate those people with a high bereavement risk	Training delivered but people have left and the role is currently split between wards and SPCT pending transfer to bereavement team at RLUH

Support robust link nurse education to ensure that the most up to date standards of care are disseminated across all inpatient areas	Initial difficulties with link nurses having left but now becoming re-established
Mandate the completion of AMBER care documentation on Meditech for all patients	AMBER is established. The tool is not mandated but recognised as best practice.
Develop a regional model for the delivery of Enhanced Supportive care in collaboration with local supportive and palliative care teams	The regional delivery of Enhanced Supportive Care is supported by our team delivering ESC across 3 hubs. Our regional partners have established IMPACT services to provide more ongoing support for patients allowing earlier transfer of care

Table 3: Abandoned Actions

Action	Supporting evidence
Embed Serious Illness Care Programme within the Trust	Initial pilot data did not support the further roll out of this initiative
Develop a simulation training schedule and teaching content to be delivered four times per year by CCC specialist palliative care team	Simulation training days were costed and found to require £5,000 per training day for 10 people so was not financially sustainable.
Specialist palliative care team to be involved in 4 regional audits per year with author representation on ALL NICE accredited regional guidelines	Local audit work required further focus so a shift was made to focus on internal audits. Furthermore regional collaboration suffered as a result of lockdown rules through COVID-19 making many collaborative projects unworkable.
Adopt EPACCs (Electronic Palliative Care Coordination System) to facilitate digital information sharing about patients, their priorities and preferences for care	EPACCS has not been launched anywhere in C&M so there is no one to collaborate with on this
Evaluate commercial opportunities for simulation training and advanced symptom control teaching delivered at CCC	Simulation training was explored and discovered it would cost £5,000 per day to run it

Train clinical staff in completing bereavement risk assessment	Training people to fill in a paper form was less effective than embedding it electronically as part of the end of life care and communication record, which was done instead.

Overall, of 32 actions we set, 22 have been achieved, six have been abandoned and four remain in progress.

Clinical Activity

Alongside the implementation of the action plan, the establishment of new systems and services has facilitated the growth of our palliative and end of life care services. Over the last five years we have been able to provide care for more patients than ever before. Our responsiveness is at an all-time high with 99.5% of inpatients being seen within 24 hours of referral and the proportion of inpatients who are able to get home at the end of their admission to CCC is higher than it has ever been.

Figure 1: Inpatient activity over five years

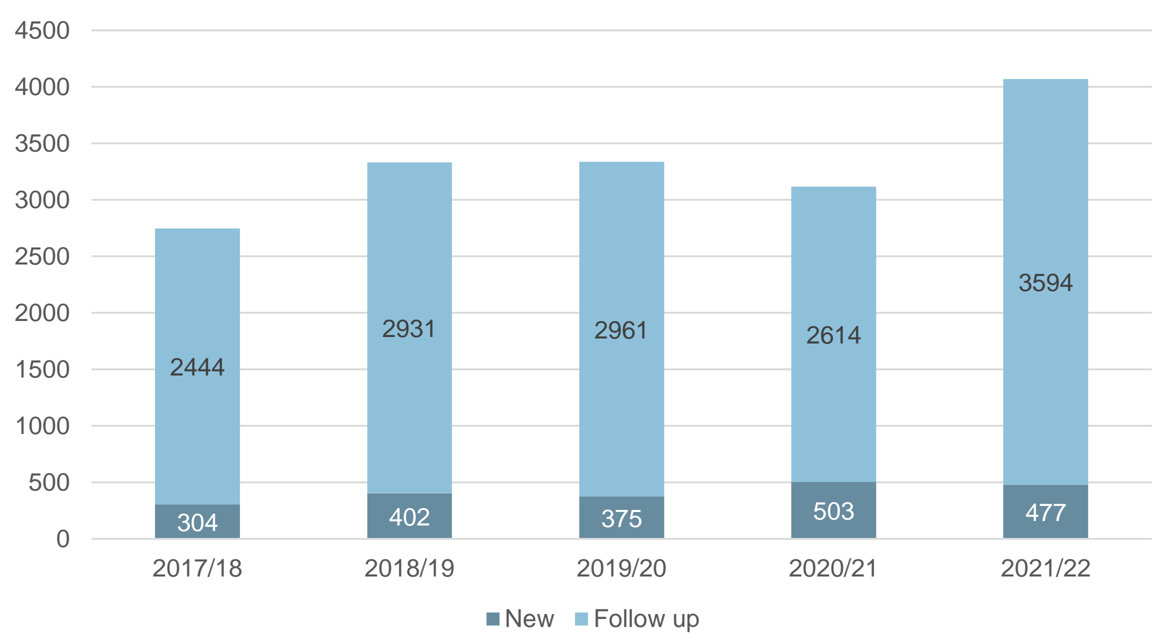


Figure 2: Outpatient activity over five years (including Enhanced Supportive Care)

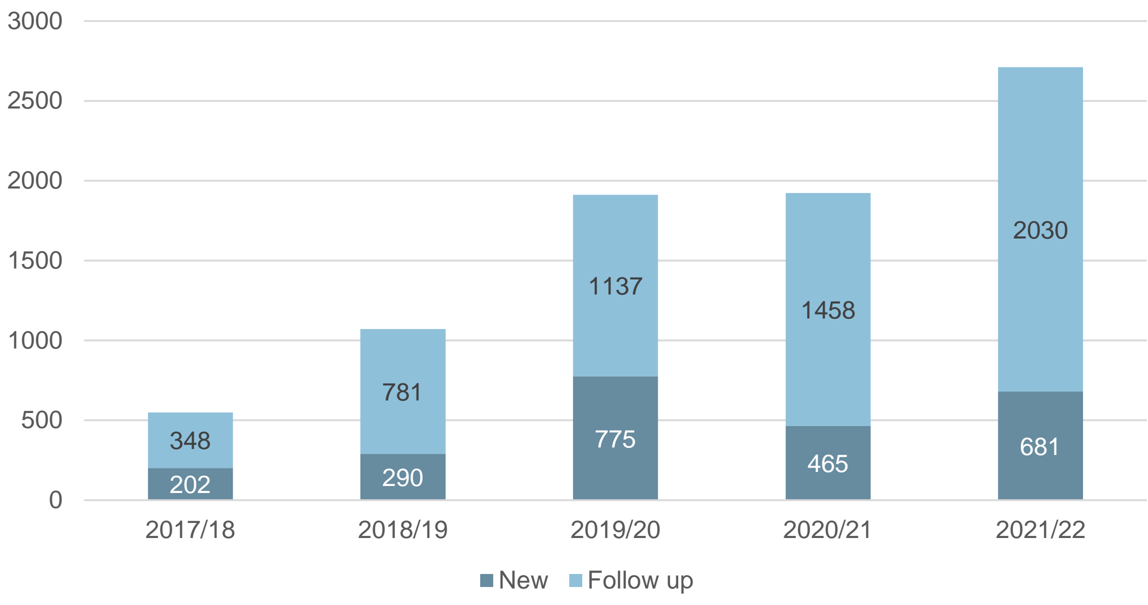


Figure 3: Percentage of inpatients seen within 24 hours of referral

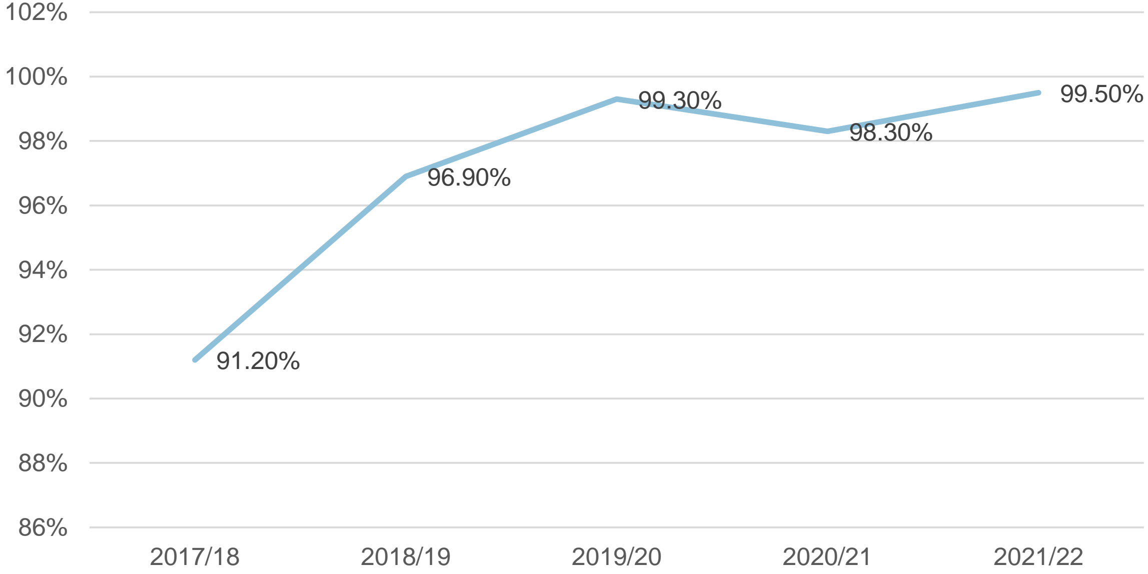
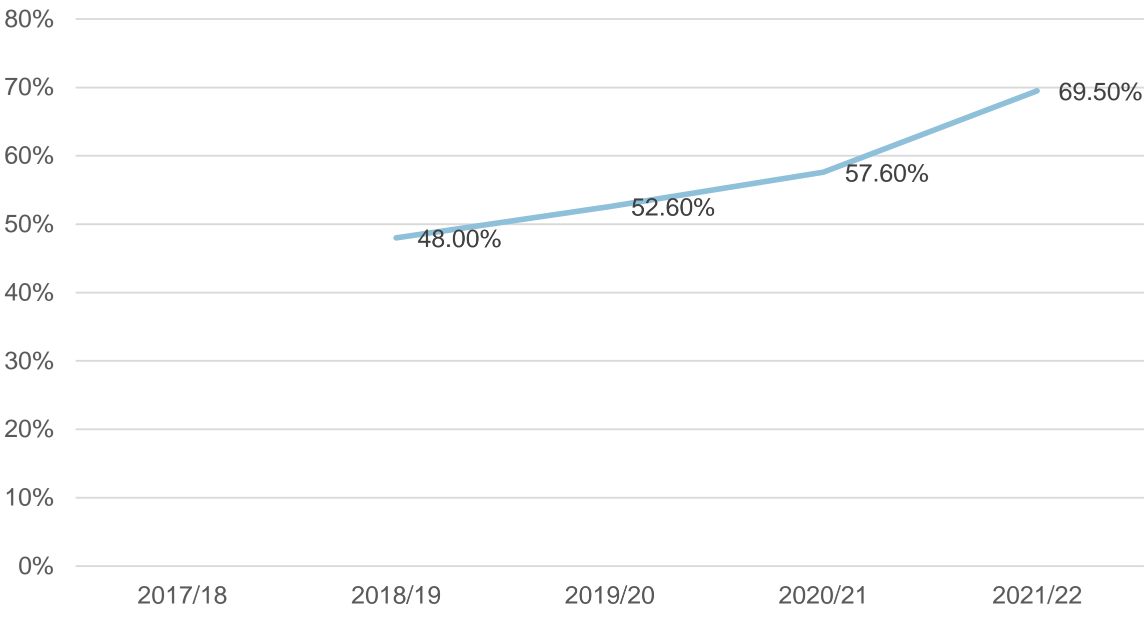


Figure 4: Percentage of people getting home from hospital once seen by the Palliative Care Team



Key Performance Indicators

To further drive progress in quality of care and improved outcomes for patients, our 2018-23 strategy contained a number of key performance indicators to track the impact of our actions. The five year overview of these key performance indicators is shown in table 4. Whilst many have improved substantially over the years, some are just beginning and will continue to be monitored in our KPIs of the future.

Key Performance Indicator	2017/18	2018/19	2019/20	2020/21	2021/22	Comments
Proportion of patients who have an expected death at CCC and who have completed End of Life Care and Communication Record	74%	80%	87%	95%	89%	The launch of digital end of life care records has improved this metric over the 5 years
The proportion of patients who died in the year who had a GSF notification	0	0	1.30%	1.50%	3.00%	This process has been launched and is used in outpatient setting but required further embedding for inpatients

The proportion of patients dying in hospital who were not admitted for end of life care with a completed AMBER care bundle	0	0	0%	0%	23%	This reached 23% in its first year of launch- the usual expected rate for a new tool is 15% per year
Proportion of patients with incurable disease offered referral to Enhanced Supporting Care (ESC)		23%	16.60%	17.70%	20.00%	We see 20% of all patients in the year they are diagnosed with incurable cancer. Many of the patients we see are not new diagnoses.
The proportion of inpatients in the last 12 months of their life who were offered Advance Care Planning discussions increased by	0	0	7.50%	7.50%	11.00%	This is an under-estimate and is expect to increase now we have arranged digital capture of this taking place
Proportion of patients dying at CCC who do so as their preferred place of death:		Yes: 66% No: 16% Unknown: 18%	Yes: 56% No: 12% Unknown: 33%	Yes: 48% No: 20% Unknown: 30%	Yes: 60% No: 18% Unknown: 22%	We are getting better at knowing where people want to die, but we cannot always get people home if there is not care in the community to support them
We have continued to ensure 100% of patients receiving palliative care input have completed IPOS scores		100%	100%	100%	100%	
The proportion of inpatient deaths reviewed as part of the mortality review process	0%	88%	90%	98%	95%	
Proportion of patients receiving palliative treatment and/or their families offered referral to the Family Support Worker	0%	0%	0%	0%	15%	The family support service cared for 15% of all patients in its first year
The proportion of bereaved family/carers who have a completed bereavement risk assessment		63%	68%	42%	64%	This is part of the day after death conversation now to improve uptake

Undertake a CODE review every 2 years to obtain feedback from bereave relatives/carers		100%	100%	100%	100%	
Proportion of staff compliant with role-essential training in End of Life Care	68%	73%	78.10%	91.74%	88.70%	This metric is now compliant with CQC recommendations
The proportion of eligible staff who received communication skills training in the year		8.50%	8.50%	2.80%	8.00%	We are training about 8% of our staff in advanced comms each year, gradually building up the knowledge among all our staff.

Our Vision

- Every patient living with treatable but not curable cancer has access to timely, personalised holistic support aimed at supporting them to live as well as possible regardless of prognosis.
- Every patient approaching end of life has access to responsive 24/7 specialist support when needed to help address their physical, psychological, spiritual and social needs.
- Patients with complex needs receiving curative treatment or with late effects of treatment can choose to access holistic support through Enhanced Supportive Care.

Our Drivers

As with the 2018-23 strategy, this strategy is built on both local and national drivers. Firstly The Clatterbridge Cancer Centre's trust-wide strategy 2021-25 makes a commitments for us to:

These goals are therefore at the heart of our action plan for the coming five years and our action plan is framed within these five areas.

The development of many of the actions themselves however is based on the Ambitions for Palliative and End of Life Care: National Framework for Local Action (2021-2026) which sets the national agenda for palliative and end of life care services. This framework outlines six key ambitions for palliative and end of life care services which need to be addressed in our action plan:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and well being
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help

Each ambition is underpinned by 'building blocks'. Many of these building blocks have already been addressed in the last 5 year strategy and our existing systems and processes. However, below we describe additional actions which can be derived from the building blocks for this strategy:

Each person is seen as an individual

Honest conversations	Systems for person centred care
Everybody should have the opportunity for honest and well-informed conversations about dying, death and bereavement.	Effective systems need to reach people who are approaching the end of life, and ensure effective assessment, care coordination, care planning and care delivery.

Clear expectations	Access to social care
People should know what they are entitled to expect as they reach the end of their lives.	People must be supported with rapid access to needs-based social care.

Helping people take control	Integrated care
Personal budgets and integrated personalised commissioning are some of the potentially powerful tools for delivering tailored and personal care for many more people.	End of life care is part of new models of integrated health and social care being promoted across the health and social care system.

Good end of life care includes bereavement
Caring for the individual includes understanding the need to support their unique set of relationships with family, friends, carers, other loved ones and their community, including preparing for loss, grief and bereavement.

Actions:

- Grow systems for advance care planning and the way this is trained and coordinated between settings
- Develop information resources for patients outlining services which can support them at each stage of their illness
- Facilitate needs-based social care access
- Work with commissioners to support access to care which delivers personalised care for patients
- Develop robust networks of bereavement care and support across Cheshire and Merseyside

Each person gets fair access to care

Using existing data	Community partnerships
Local end of life care organisations must use aggregate data to understand and remedy the partial reach of their services.	Local plans should include partnerships between different faith groups and cultural communities, as well as the diverse organisations that support children and young adults, people living with different life shortening illness, and those managing the difficulties of older age.
Generating new data	**Unwavering commitment**
Individual organisations and local systems of care should engage with initiatives to generate much more robust and useful statistical data. This can guide care, drive organisational strategies and inform local and national progress.	To achieve equity in access, provision and responsiveness requires unwavering commitment. This should be backed up by local contracts that embed evidence-based measures of equity in provision.
Population based needs assessment	**Person centred outcome measurement**
Locally, Health and Wellbeing Boards should lead the development of population based needs assessment for end of life care services. Commissioners and providers need to use this to influence their organisation of care so that they can demonstrate increasingly equitable outcomes.	The comprehensive use of person centred outcome measures will enable services to be held to account. With independent analysis of a consistent data set, improvement can be tracked and regulatory actions taken to ensure all providers are enabling fair access to care.

Actions:

- Use data to drive improvements in access and quality and ensure equity of outcomes
- Form partnerships with organisations which support patients with different needs including children, young adults, frail adults and faith groups
- Continue to develop equity of access for patients requiring palliative and end of life care across Cheshire and Merseyside
- Establish person centred metrics which are reported across all patients

Maximising comfort and wellbeing

Recognising distress whatever the cause	Addressing all forms of distress
It is important to recognise all sources of distress quickly, to acknowledge distress and to work with people to assess its extent, its cause and what might be done.	The experience of suffering associated with physical symptoms may be exacerbated, or sometimes caused, by emotional, or psychological anguish, or social or spiritual distress. Addressing this requires professionals to recognise, understand and work to alleviate the causes.
Skilled assessment & symptom management	**Specialist palliative care**
Attending to physical comfort, pain and symptom management is the primary obligation of clinicians at this time of a person's life and their skills and competence to do so must be assured and kept up to date.	People approaching the end of life should have access to Specialist Palliative Care when this is needed. This should include a clear understanding of how to access medicines and equipment as part of the rapid response to changing needs.
Priorities for care of the dying person	**Rehabilitative palliative care**
People approaching death should expect local systems to accord with the priorities identified by the Leadership Alliance for the Care of Dying People.	Maximising the person's independence and social participation to the extent that they wish requires professionals to work with, and support, the person in helping them to achieve their personal goals.

Actions:

- Develop team competencies which enable all causes of distress to be recognised and addressed
- Educate the wider workforce on priorities for the dying person
- Collaborate with other professional groups to support a rehabilitative (or prehabilitative) approach to supporting patients to achieve their goals

Care is coordinated

Shared records

Care records for all people living with a long term condition must encompass their needs and their preferences even as they approach the end of life. With the person's consent, these records should be shared with all those involved in their care.

Clear roles and responsibilities

Organisational leadership is vital and information for families, carers and individuals should be joined up in a way that provides a clear oversight of the respective roles and responsibilities of providers within that system.

A system-wide response

As new models of care emerge approaches have to develop to enable a better system-wide response to dying people, using a full range of coordinated services deployed in the community.

Everyone matters

Local systems of care have to put the needs of dying children and young adults, those living with frailty including at older age, and the need to anticipate and support those who will have to live with loss, at the centre of their thinking.

Continuity in partnership

Joined up care requires joined up thinking and working by individuals and by organisations. This will require active partnerships particularly between the NHS, social care and the voluntary sector.

Actions:

- Advance care plans and patient records which record patients' needs and preferences should be made available across settings when patients are approaching end of life (and when consent is obtained from patients)
- Use patient information resources to communicate which services which are available to patients and the roles and responsibilities of the people in those teams
- Join community MDTs to be part of a wider system involved in the support of patients and their families across Cheshire and Merseyside.

All staff are prepared to care

Professional ethos	Support and resilience
To ensure people receive the care they need paid carers and clinicians at every level of expertise need to be trained, supported and encouraged to bring a professional ethos to that care.	To give care day in and day out requires organisational and professional environments that ensure psychological safety, support and resilience.
Knowledge based judgement	**Using new technology**
Only well-trained, competent and confident staff can bring professionalism, compassion and skill to the most difficult and intensely delicate physical and psychological caring.	Professionals have to adapt to new ways of learning and of interacting with the people they are supporting and they need help and guidance to do so. Technology can also play a significant role in enhancing the professionals' own learning and development.
Awareness of legislation	**Executive governance**
All those who provide palliative and end of life care must understand and comply with legislation that seeks to ensure an individualised approach.	Every organisation should have clear governance at Board level for high quality palliative and end of life care and environments in which all staff can provide the best of their professionalism and humanity.

Actions:

- Embed psychological safety in the core business of specialist palliative care business meetings
- Use technology to facilitate support and clinical care of patients and education and development for staff

Each community is prepared to help

Compassionate and resilient communities	Public awareness
Public health approaches to palliative and end of life care need to be accelerated and support given to people and communities who can provide practical help and compassion.	Those who share our ambition should work to improve public awareness of the difficulties people face and create a better understanding of the help that is available.
Practical support	**Volunteers**
Local health, care and voluntary organisations should find new ways to give the practical support, information and training that enables families, neighbours and community organisations to help.	To achieve our ambition more should be done locally and nationally to recruit, train, value and connect volunteers into a more integrated effort to help support people, their families and communities.

Actions:

- Collaborate with other organisations to improve the awareness of patients and those important to them of what services are available to them
- Work with other organisations including voluntary organisations in the delivery of practical support to patients
- Develop the training and support of volunteers to facilitate a volunteer-delivered family support initiative.

Local And National Partners

Local Partners

- The Clatterbridge Cancer Centre NHS FT
- The Walton Centre NHS FT
- The University of Liverpool
- Cheshire and Merseyside Cancer Alliance
- The Cancer Academy
- Liverpool University Hospitals NHS FT, Marie Curie Hospice, Woodlands Hospice and IMPACT
- Southport and Ormskirk NHS FT, Queenscourt Hospice and Community Palliative Care Team
- Wirral University Teaching Hospital, Wirral Hospice St John's and Community Palliative Care Team
- Countess of Chester Hospital, Hospice of the Good Shepherd and Community Palliative Care Team
- Warrington Hospital, St Rocco's Hospice and Community Palliative Care Team
- St Helens and Knowsley NHS FT, Willowbrook Hospice and Community Palliative Care Team

National Partners UK

- The Clatterbridge Cancer Centre NHS FT
- The Christie NHS FT
- The Walton Centre NHS FT
- The Royal Marsden NHS FT
- The Royal Sussex NHS FT
- International observatory on End of Life Care University of Lancaster
- UK Association for Supportive Care in Cancer (UKASCC)

Action Plan

	Actions	Timeline
BE OUTSTANDING	Deliver an inpatient SPCT service with patients under named palliative care consultants	2023/24
	Establish an inpatient supportive care unit for patients with symptom control needs	2024/25
	Establish a clinical service delivering capsaicin for patients with peripheral neuropathy *Working with: Commissioners and other capsaicin clinics in tertiary cancer care*	2024/25

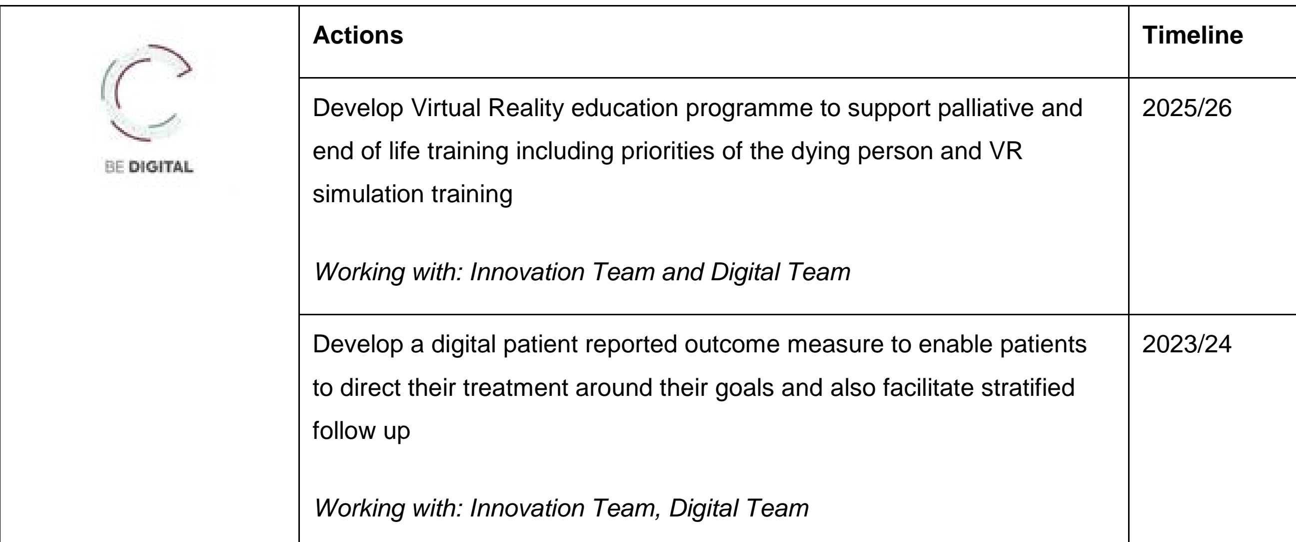
	Deliver accredited palliative care masters module in partnership with University of Liverpool *Working with: University of Liverpool and CCC Clinical Education*	2023/24
	Members of SPCT to participate in the delivery of the regional advance communications skills training *Working with: CCC Clinical Education*	2024/25
	Re-instigate SPCT business meetings with rotating agenda to cover abstract writing, conference feedback, project updates, education agenda and promoting psychological safety	2023/24
	Deliver training on supportive care to a cancer alliance footprint *Working with: C&M Cancer Alliance and Cancer Academy*	2025/26
	Establish a reflexology service for peripheral neuropathy	2023/24
	Establish gold standard of mouth care by making oralieve gel available on inpatient wards *Working with: Pharmacy*	2023/24
	Collaborate with other professional groups to support a rehabilitative (or prehabilitative) approach to supporting patients to achieve their goals *Working with: Supportive Care SRG*	2024/25

BE COLLABORATIVE	**Actions**	**Timeline**
	Attend Liverpool and Wirral community MDTs to facilitate coordinated care across settings *Working with: Community SPCTs*	2023/24
	Collaborate with other services in Cheshire and Merseyside to facilitate single referral process for all services *Working with: PEOLC Network*	2023/24

	Collaborate with other services in Cheshire and Merseyside to facilitate the adoption of an ESC approach in other centres including Isle of Man *Working with: Other SPCT providers including Isle of Man*	2025/26
	Develop advanced clinical practice in supportive care external education in collaboration with clinical education and or other tertiary centres-including exploring commercial opportunities *Working with: UKASCC, other tertiary centres*	2025/26
	Develop a collaborative teaching programme with other palliative care providers in Cheshire and Merseyside *Working with: Other SPCT providers*	2024/25
	Develop a palliative care presence in neuro-oncology clinics *Working with: CNS SRG*	2024/25
	Launch an area teaching programme for specialist palliative care providers which learns from the experience of others in other centres and maintains team competencies	2024/25
	Join regional journal club	2023/24
	Deliver advance care planning training in collaboration with other regional centres to enable this information to cross settings when patients give consent *Working with: Other tertiary cancer centres*	2024/25
	Develop a peer review process with other tertiary cancer centres to enable peer accreditation in end of life frameworks *Working with: Other tertiary cancer centres*	2024/25
	Develop robust networks of bereavement care and support across Cheshire and Merseyside *Working with: Bereavement charities and other SPCT providers*	2024/25

	Form partnerships with organisations which support patients with different needs including children, young adults, frail adults and faith groups *Working with: Community groups and third sector organisations via Patient Experience Team*	2024/25

	Actions	**Timeline**
	Develop a pathway for career progression to band 8 in SPCT in line with trust nursing review *Working with: Acute Directorate*	2023/24
	Develop a training offer for Band 6 associate CNS as a 2 year training pathway *Working with: Acute Directorate and Clinical Education*	2025/26
	Re-launch the link nurse programme with structured progression into eligibility for associate CNS role *Working with: Ward matrons and senior nurses*	2024/25
	Protect CNS non-clinical time (1 day per week pro-rata)	2023/24
	Develop Cancer Support Worker role within ESC to support patient flow and follow up	2023/24
	Explore role of Education facilitator in palliative and supportive care to develop courses and link nurses *Working with: Clinical Education and Practice Education Facilitators*	2026/27
	Develop the training and support of volunteers to facilitate a volunteer-delivered family support initiative. *Working with: Volunteer services*	2024/25
	Develop training and shadowing offer for clinical nurse specialists in site specific tumour groups to develop palliative care knowledge and skills.	2024/25



BE DIGITAL	**Actions**	**Timeline**
	Develop Virtual Reality education programme to support palliative and end of life training including priorities of the dying person and VR simulation training *Working with: Innovation Team and Digital Team*	2025/26
	Develop a digital patient reported outcome measure to enable patients to direct their treatment around their goals and also facilitate stratified follow up *Working with: Innovation Team, Digital Team*	2023/24

BE RESEARCH LEADERS	**Actions**	**Timeline**
	Develop public engagement options for the Specialist Palliative Care Team including external facing communication (e.g. websites) patient information resources and involving third sector partners *Working with: Communications Team*	2023/24
	Use the above public engagement options to develop information resources for patients outlining services which can support them at each stage of their illness and the roles and responsibilities of the people in those teams *Working with: Communications Team, patient representatives and patient council*	2024/25
	Evaluate the impact of inpatient specialist unit in tertiary cancer centre	2025/26
	Undertake successful research grant applications *Working with: R&I*	2026/27
	Undertake research collaborations with at least 1 other trust *Working with: R&I*	2023/24

	Use IPOS as a PROM to underpin evidence of clinical impact and equity of outcomes across groups	2023/24
	Use data captured in palliative care dashboard to demonstrate quality, access and equity of care *Working with: Business Intelligence*	2023/24
	Commercial development of the urine test predicting dying *Working with: Innovation Team*	2024/25
	Publications in leading research journals	2023/24
	Deliver National and International presentations (oral and written)	2025/26

	Actions	**Timeline**
BE **INNOVATIVE**	Evaluate the use of technology to improve clinical care for patients e.g. heated vibration pads for peripheral neuropathy *Working with: Innovation Team*	2024/25
	Develop podcasts to disseminate education *Working with: Clinical Education*	2024/25
	Work with CHC to develop a “Clatterbridge to Home” carers service for patients requiring rapid discharge home to die, thereby addressing the gap in needs-based social care access *Working with: Commissioners and CHC, Workforce and OD.*	2025/26

Key Performance Indicators

We have amended our key performance indicators for 2023-28. Some are the same as previous to ensure completion of ongoing work streams and there are some additional areas which reflect new priorities.

KPI Description	Numerator	Denominator	Data Sources	Exclusion	Target
Proportion of patients who have an expected death at CCC and who have a completed End of Life Care and Communication Record*.	Total number of patients who have an expected death at CCC with a completed End of Life Care and Communication Record.	All patients who have an expected death at CCC	SPCT MDT	None	95%
Average Pain Score on biannual patient survey	Average score on pain survey	-	Pain question on biannual survey	None	100%
Proportion of staff attending role-essential training in End of Life Care*.	Total number of eligible staff attending role-essential training in End of Life Care.	All eligible CCC staff	L and D data	None	80%
Proportion of inpatients in last 12 months of life offered Advance Care Planning discussions	All patients who die within 12 months of discharge having being offered Advance Care Planning discussions during their most recent admission	All patients who die within 12 months of their most recent admission to CCC	Trust electronic data and audit	Patients who die from non-cancer diagnoses	100%
The proportion of patients dying in hospital, who were not admitted for end of life care, with a completed AMBER care bundle	All patients dying in hospital AND who were not admitted for end of life care with completed AMBER Care Bundle	All patients dying in hospital who were not admitted for end of life care	Trust electronic data.	None	100% of those not supported by EOLCCR

Proportion of patients seen at CCC within the last 12 months of their life who have a GSF notification sent to their GP	All patients who had an appointment at CCC within the last 12 months of their life who had a GSF notification sent to their GP.	All patients who had an appointment at CCC within the last 12 months of their life	Trust electronic data	None	80%
Proportion of patients dying at CCC who do so as their preferred place of death.	All patients who die at CCC with an expressed Preferred Place of Death as CCC.	All patients who die at CCC.	Trust electronic data and end of life care audit	Patients declining to nominate a preferred place of death	80%
Survey of bereaved persons using the Care of the Dying Evaluation (CODE) completed every two years*	CODE evaluation completion	Years between CODE evaluations	CODE evaluation	None	100%

Next Steps

This document will undergo a trust-wide consultation process and peer review from specialist palliative care colleagues in Cheshire and Merseyside, including the Palliative and End of Life Care Network.

The final version will be reviewed through the Trust governance process and will require ratification by the Trust Board prior to its operationalisation in April 2023.

References

1. Palliative and End of Life Care Strategy 2018-2023. The Clatterbridge Cancer Centre NHS Foundation Trust. Available at: https://nhs.sharepoint.com/sites/REN_CCC_HUB/DocumentHub/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FREN%5FCCC%5FHUB%2FDocumentHub%2FShared%20Documents%2FQP4616%5FPalliative%20and%20End%20of%20Life%20Care%20Strategy%202018%2D2023%20V2%2E0%2Epdf&parent=%2Fsites%2FREN%5FCCC%5FHUB%2FDocumentHub%2FShared%20Documents [Accessed 1 October 2022]
2. FIVE-YEAR STRATEGIC PLAN 2021-2025. The Clatterbridge Cancer Centre NHS Foundation Trust. Available at: https://nhs.sharepoint.com/sites/REN_CCC_HUB/About_Us/Strategic%20Plan%2020212025/Forms/AllItems.aspx?id=%2Fsites%2FREN%5FCCC%5FHUB%2FAbout%5FUs%2FStrategic%20Plan%2020212025%2FFive%2DYear%20Strategic%20Plan%202021%2D2025%2Epdf&parent=%2Fsites%2FREN%5FCCC%5FHUB%2FAbout%5FUs%2FStrategic%20Plan%2020212025 [Accessed 1 October 2022]
3. Ambitions for Palliative and End of Life Care: National Framework for Local Action (2021 - 2026). Available from: Ambitions for Palliative and End of Life Care: National Framework for Local Action (2021 - 2026) | Association of Chartered Physiotherapists in Oncology and Palliative Care (csp.org.uk) [Accessed 1 October 2022]
4. Royal College of Physicians. Designing Services: Palliative medicine services: Hospital palliative care. 2018. Available from: http://www.rcpmedicalcare.org.uk/designing-services/specialties/palliative-medicine/services-delivered/hospital-palliative-care/ [Last Accessed 1 October 2022]

Title	Palliative and End of Life Care Strategy 2023-28		
What is being considered?	Ratification of the new 5 year strategy for palliative and end of life care at The Clatterbridge Cancer Centre		
Who will be affected?	Patients [✔] Staff [✔] Public [ ] Partner agencies [✔]		
What engagement is taking place or has already been undertaken?	**Public** In progress courtesy of Angie Ditchfield	**Partners** *Partners have been engaged in items of the strategy relating to partnership working- the areas of shared working appear in this strategy as these have been in discussion previously. Key examples include:* • *The Christie NHS foundation trust has reviewed proposal for peer to peer accreditation and wishes to engage in this.* • *Community and hospice based palliative care teams in Cheshire and Merseyside have extended invites to join community MDTs* • *Partner third sector organisations are agreeable to closer working to establish bereavement support network* • *Early conversations with CHC have given a*	**Staff** • *Draft strategy circulated for consultation within all directorates, communications team, R&I, and SRG leads December 2022-January 2023.* • *Presented and discussed at November 2022 consultant's away day.* • *Discussed at TIC and TEG committees.* • *Ward managers involved in the creation of education elements of the strategy as they relate to ward based training* *Angie Ditchfield is current facilitating a consultation with CCC staff networks*

		favourable response to the 'Clatterbridge to home' proposal to facilitate earlier discharge from hospital	
What evidence has been analysed?	**Evidence / Research :** This strategy is aligned to the trust priorities and the national priorities as outlined in the Ambitions for Palliative and End of Life Care: National Framework for Local Action (2021 - 2026). The latter document sets the national strategy for palliative and end of life care. The strategy is not underpinned by further research outside of nationally agreed priorities.		

What is the result of the analysis? Will there be an impact against the protected groups below? • Age • Disability • Gender Reassignment • Marriage and Civil Partnership • Pregnancy and Maternity • Race • Religion and Belief • Sex (Gender) • Sexual Orientation • Human Rights articles ✔	There are no foreseeable impacts related to any of the specific protected groups listed. The service developments described in the strategy are accessible to all of these groups and does not discriminate.

Do further steps in the following areas need to be taken to mitigate or safeguard these impacts - *Involvement & Consultation, Data collection & Evidence, Assessment & Analysis, Procurement & Partnerships, Education and Workforce?* If so complete the action plan below:			
Outcome	**Actions required**	**Time scale**	**Responsible officer(s)**
			▪

How will we monitor this and to whom will we report outcomes?	

Author	**Dr Dan Monnery**	**Title**	**Consultant in Palliative Medicine**	**Date**	**13/6/23**
Equality Analysis assessed by		**Title**		**Date**	

The Equality Act (2010) has brought a Public Sector Equality Duty to all Public Authorities. This Equality Analysis provides assurance of the steps that Clatterbridge Cancer Centre NHS Foundation Trust is taking in meeting its statutory obligation to pay due regard to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

This equality analysis also provides evidence of discharging Public Sector statutory obligations under the Human Rights Act (1998).

For further information or guidance please contact the EDI Lead – angie.ditchfield@nhs.net

Title of meeting: Trust Board
Date of meeting: Wednesday 26th July 2023

Report author	Jayne Shaw, Director of Workforce and Organisational Development			
Paper prepared by	Angie Ditchfield, Head of Equality, Diversity, and Inclusion			
Report subject/title	NHSNW Black, Asian and Minority Ethnic Anti-racist Framework			
Purpose of paper	To share the recently developed Anti-Racist Framework, developed by the North West Black Asian and Minority Ethnic Assembly and seek approval to formally adopt the Framework.			
Background papers				
Action required	For approval			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work	X
	Be Collaborative	X	Be Digital	
	Be Research Leaders		Be Innovative	X

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

Ref: FCGOREPO
Review: July 2025
Version: 2.0

1. Introduction and purpose

The purpose of this paper is to share with the Board the North West Black, Asian and Minority Ethnic Anti-racist Framework issued by the North West Black, Asian and Minority Ethnic Assembly in June 2023 and seek formal approval from the Board to adopt the Framework within the Trust as well as a commitment to support the ambition and necessary work to achieve and maintain the gold level of the Framework.

A copy of the Framework is attached as appendix 1.

2. Background

In June 2023 the North West Black, Asian, and Minority Ethnic Assembly contacted all NHS trusts and Integrated Care Boards in the North West to support organisations on their journey towards becoming intentionally anti-racist. It has been developed by the North West Black, Asian and Minority Ethnic Assembly in conjunction with the Northern care Alliance's Inclusion Centre of Excellence and NHSE North West. It is not a standalone document and very much supports other ongoing work including the Workforce Race Equality Standard (WRES), Equality Delivery System (2022), as well as the National NHS Equality, Diversity, and Inclusion Improvement Plan which was also recently launched by NHS England.

The framework is constructed around five anti-racist principles:

- Prioritising anti-racism
- Understanding lived experience
- Growing inclusive leaders
- Act to tackle inequalities
- Review progress regularly

It provides a mechanism for NHS organisations to work towards the ambition of becoming anti-racist organisations and is structured around three levels of achievement: Bronze, Silver, and Gold with each level building on the next encouraging organisations to make incremental changes and take positive actions towards eradicating racial discrimination in their organisations.

By making a commitment to implement the framework we will be encouraged to challenge racism and discrimination through collaboration, reflective practice, accountability, and action. Working together to embed these objectives into our organisation will help transform our processes, policies, and culture, embedding meaningful change.

3. Organisational planning and next steps

Organisations are asked to undertake an initial self-assessment using the tool provided. This will form the basis for the necessary action plan to achieve the first stage within the Framework and inform the further action required. Once completed the assessment and associated action plan will be shared with, and monitored by the People Committee with regular reports to the Board.

Formal applications to the NW Assembly will be necessary for their assessment and recognition.

4. **Recommendation**
The Board is asked to note the Anti-racist Framework and approve the adoption within the Trust.

Appendix 1: NHSNW Black, Asian and Minority Ethnic Anti-racist Framework

NORTH WEST
Black, Asian and Minority Ethnic Assembly

NORTH WEST BLACK, ASIAN, AND MINORITY ETHNIC ASSEMBLY

Anti-racist Framework

NHS
England
North West

Contents

Foreword

As partners in championing this ambition, the North West Black, Asian and Minority Ethnic Assembly (the Assembly) and NHS England (NHSE) North West believe that the NHS in our region should be unapologetically anti-racist. We also believe that the NHS should take positive action to eliminate racism in our organisations, stand with our colleagues when they experience racism, and eradicate the inequalities in access, outcomes and experience of health care that some of our communities face.

This document provides a framework for all NHS organisations across the North West to work towards the ambition of becoming actively anti-racist organisations. It aims to embrace both the spirit of our commitments and provide NHS organisations with guidance to put into action quickly, the steps needed to reduce the inequalities we still see every day across our workforce and to become intentionally anti-racist.

We all recognise the history and impact of institutional racism across our organisations and the harm caused to both our colleagues and communities through the continued inequalities that we still see across our society. From higher rates of bullying and harassment, disproportionate referrals into disciplinary processes, recruitment and selection where ethnicity still impacts your chance of appointment after shortlisting, all of these issues and many more needed to be tackled intentionally and as a priority by all our organisations.

We are asking our NHS partners across the North West to make a commitment to embrace the intentionally inclusive language and the approach of becoming actively anti-racist organisations. As intentionally inclusive leaders it is vital that we all look at each of the areas set out in this anti-racist framework and seek to embed the change needed to transform our own departments and teams into places where this activity is not seen as just a nice to do, but is seen as mission critical to all that we stand for; and that messaging is backed up by senior colleagues across the region, being clear that actions to tackle inequalities are a priority in all that we do.

Leaders should use the practical steps and suggested actions to support existing change activity, to add focus to future equality action plans and to build on any long-term inclusion strategies you may have. While there is not a one size fits all solution to advancing equity within any one organisation, we hope that the guidance and structure provided will help with the task of co-creating the solutions that will work for your organisation easier.

This document has been produced by The Assembly, the Northern Care Alliance's Inclusion Centre of Excellence, and NHSE North West.

Richard Barker
Co-chair of the North West Black, Asian, and Minority Ethnic Assembly and Regional Director for the North East and Yorkshire & North West regions

Evelyn Asante-Mensah OBE
Co-chair of the North West Black, Asian, and Minority Ethnic Assembly and Pennine Care NHS Foundation Trust

Why does an intentionally anti-racist approach matter?

Racism is very real, both in society and across our NHS organisations. Yet, despite a large number of reports and pledges over the years we have seen inequalities persist and some areas even get worse.

- The NHS is built on a founding principle of equality and social justice. That the service is free at the point of need anchors the NHS in social egalitarianism and makes equal rights part of our core business.
- We have seen a growth of hate incidents and racism across our communities in the UK despite existing equality and human rights legislation. It is more important than ever that as public sector organisations, we contribute to ensuring racism has no place in our society and is addressed across the communities we serve.
- Racism and discrimination are major drivers behind the health inequalities we still see today. It is our role as a health care system to be intentional in tackling those inequalities we see across our communities, but we should also be ensuring discrimination experienced by our staff is not further contributing to the problems.

Our anti-racism journey

Becoming an intentionally anti-racist organisation is a continuous journey that involves leaders and organisations continually reviewing their progress and being intentional about their actions for change.

The Fear, Learning, Growth Zone tool can help you both as an individual and as an organisation to consider honestly where you are on the path to become more anti-racist.

Approaches to move through the zones

FEAR ········ LEARNING ····· GROWTH

Fear: Provide clear factual information that challenges and supports the overcoming of any fears that individuals and teams may have with talking about racism and what is needed to address this issue.

Learning: Consider more development building on any existing learning; steps and opportunities that increase confidence with existing learning.

Growth: Empower inclusive leaders through allyship programmes and activities.

The five anti-racist principles

1. Prioritise anti-racism

As the NHS we have always been instinctively supportive of equality as social justice is the bedrock and foundation of our creation as an institution back in 1948. However, prioritising anti-racism work is more than simply caring about equality or stating support for inclusion; it is about ensuring we are giving it the same attention and response as other mission critical work we manage across the NHS.

The two main commodities we give to a task or area of work when we prioritise it are both time and resources. When equality activity is seen as an add-on or a nice to do, other mission critical work is seen as more important; time and resources are directed elsewhere and progress around tackling inequalities slows and stops.

Organisations need to commit to the principle that anti-racism work matters and their leaders need to see it as a priority for them as well. There will always be competing time and resource pressures when it comes to managing any large organisation, but anti-racist organisations understand that investing the time and resources needed to tackle the inequalities that exist across their workforce and services is more effective in the long term and will support them in meeting their other long-term goals.

What does this look like?

Leading from the front

Leadership matters and while being a leader often involves the management of multiple priorities, the amount of dedicated time we give to an issue is a key indicator of how much we have prioritised that area of work.

Dedicated EDI Resource

The amount of dedicated resource we have allocated to focus on an area of work is a key indicator of how much it has been prioritised. Equality, diversity and inclusion (EDI) professionals are experienced experts who can support leaders with this work. They must, however, be considered an important part of the organisation's leadership for their activity to be impactful and transformational over the longer term.

Mission Critical

Anti-racism activity needs to be at the heart of all work across an organisation, not simply a central equality action plan. Organisations that have got this right can clearly demonstrate how anti-racist practice is considered mission critical in plans around service delivery and the development of their workforce.

Actions Not Words

Organisations that are committed to anti-racism do more than the minimum ask; their work is driven by a desire to transform and have a big impact on the inequalities they see. This should be clearly visible in the activity and actions of any anti-racist organisation.

The five anti-racist principles

2. Understand lived experience

It is everyone's responsibility to tackle racism not just Black, Asian and Minority Ethnic colleagues, but meaningful involvement of people who experience racism and inequalities across your organisation will ensure decisions on how to tackle it are informed by real insights that reflect the different challenges people may face.

Meaningful involvement of people you would like to share their lived experiences involves committing to acting on what you hear and embedding their voices into change focused activity and decision making. Leaders need to be intentional in seeking out lived experience perspectives and considering what may be preventing some people feeling able to be involved.

When reaching out to seek the lived experiences of Black, Asian and Minority Ethnic communities it is important that leaders acknowledge and value intersectionality and understand the need to get more than a single person's perspective. When engaging others to hear their lived experiences, we should be intentional in ensuring we are hearing from a diverse range of voices rather than simply identifying a single individual to invite into a space.

Sharing lived experiences can have a weathering effect on people's wellbeing. Any activity that looks to involve and encourage others to share their lived experiences to support leaders and an organisation make better decisions should also include a clear and intentional focus around the wellbeing of those involved.

What does this look like?

Listen and Learn

Leadership matters and while being a leader often involves the management of multiple priorities, the amount of dedicated time we give to an issue is a key indicator of how much we have prioritised that area of work.

Empowering Your Talent

As well as hearing the lived experiences of staff, it is important that the underutilised potential of talented leaders from ethnic minorities is considered and empowered to support decision making. A key consideration is where you can diversify the decision makers in a space and how you can ensure the full talent potential of your diverse workforce is used.

Growing Cultural Competency

Connecting a diverse range of lived experiences with leaders is vital to improving the cultural competency of an organisation over a longer period of time. Leaders who understand their colleagues, service users and local communities are better placed to make decisions that are fair for all.

Data Plus

Organisations need to be intentional about understanding the experiences of Black, Asian and Minority Ethnic staff and service users.

The five anti-racist principles

3. Grow inclusive leaders

Inclusive leadership is vital if an organisation aims to be anti-racist in all that it does and aims to tackle the inequalities it sees across its workforce and services.

Where an organisation has a mature, inclusive leadership culture you will see diversity clearly represented at all levels across the workforce and colleagues will feel they belong and are included at work. On that journey to growing an inclusive leadership culture it is vital that there is an approach and strategy for reducing inequalities, not just at the top of the hierarchy, but also a commitment to increase diversity and reduce inequalities across middle leadership.

Too often the focus around developing Black, Asian and Minority ethnic leaders has been on providing them with more skills and academic development to help them move up to the next level in the leadership ladder; this reinforces a deficit stereotype rather than tackling the institutional racism that has been holding them back. Positive action measures should be targeted on the bias and prejudice that has led to ethnic minority colleagues not being given the opportunities to demonstrate the skills they have.

Inclusive leadership is not a destination. It is a continuous journey to look at how you can do more to reflect and own your own privilege, understand others more, act to tackle bias in the decisions you make, and ensure that change is seen as a positive step to tackle inequalities and injustice rather than simply a threat to the status quo.

What does this look like?

Visibility matters

Our most senior public sector leaders should come from a wider diverse range of backgrounds and should broadly represent the communities they serve. This diversity and visibility help to build communities' trust in our institutions and also lead to better decision-making overall.

Where is your talent?

Understanding your talent trajectory in respect to Black, Asian and Minority Ethnic colleagues helps an organisation know where actions need to be to increase diversity and tackle departmental or structural inequalities. Diversity should be visible across all levels of an organisation.

Levelling up middle leadership and inclusion

If we only focus development on our most senior leaders, commitment to change is often not followed through by those leaders tasked with implementing decisions across the organisation.

Real opportunities

For some time we have seen sending colleagues on dedicated learning programmes as the solution to under representation in leadership roles. However, it is often the case that development does not lead to an opportunity for promotion and reinforces the idea that Black, Asian and Minority Ethnic colleagues need to work harder and earn more to achieve the same as their white peers.

The five anti-racist principles

4. Act to tackle inequalities

“Let my actions speak for themselves” is a famous saying that represents the mantra by which an organisation truly committed to anti-racism needs to run.. Words alone can often become a shield through which organisations are able to justify, consciously or unconsciously, their inaction over time, and determine whether they have followed through with meaningful actions to tackle an inequality.

Initiatives like the Workforce Race Equality Standards (WRES), Model Employer plans and others are not a solution in themselves, but can be a positive tool to measure existing inequalities and target actions to have the biggest impact. These tools need to be used actively to support equality activity across an organisation rather than simply as an assurance framework completed once a year and not looked at again.

The inequalities we see across our communities today will only be addressed when organisations use their resources collectively in partnership to tackle their main causes. Building a critical mass of activity around neighbourhoods, localities and our region as a whole is key to the numerous health inequalities and social injustices that harm so many being relegated to history, instead of being a painful reality of today that many are forced to live with.

The amount of action needed to tackle inequalities is large. It reflects the generations of institutional racism and injustice developed over decades in this country. However, when viewed as mission critical and delivered through embedded priorities across all areas of an organisation’s structure, the task is not insurmountable and the outcomes will be transformational for our communities as a whole.

What does this look like?

More than a tick box

While assurance frameworks have at times been labelled as just a tick box for an organisation to deliver against, this does not have to be the case. Tools like the WRES and others can be used to prioritise, leverage and monitor real change. Anti-racist organisations use all the resources and tools available to them to achieve their goals of reducing inequalities and tackling discrimination.

Zero tolerance matters

Being anti-racist is an active stance and means more than simply not acting to do harm, but actively tackling the harm we see. Organisations that are on the journey to getting this right are clear in the zero tolerance they have for racism from anyone, including colleagues and service users. It is vital that organisations consider how they handle these types of incidents and constantly learn to do more to tackle racist abuse.

We do this together

Many inequalities are too big to tackle on your own as a single organisation. It is vital that organisations work in partnership to tackle the racial inequalities we see across our communities. When looking at health inequalities, NHS organisations should work with their local community and other statutory sector bodies to tackle these collectively rather than them staying in the too hard to do pile.

Fair and just

The processes that exist across an organisation to look at grievances and disciplinaries for staff should feel fair and equitable for all. Where this is not the case, the outcomes experienced by colleagues lead to mistrust and a clear weathering effect on the wellbeing of Black, Asian and Minority Ethnic staff.

The five anti-racist principles

5. Review progress regularly

The NHS is no stranger to performance measures and the need to be intentional about tracking progress with a clear and detailed approach.

However, when it comes to anti-racism and wider equality, diversity and inclusion activity, this often lacks the same rigour in monitoring performance as other areas of our organisations.

Research from the USA has shown us that one of the most important aspects to diversity and equality activity is grounding this work in social accountability and taking time to measure and be clear about whether progress is being made.

While an organisation may have implemented actions elsewhere to tackle and reduce the impact on bias within decision processes and decision making, it is vital that the same consideration is taken when reviewing an organisation's overall performance around anti-racism and equality as a whole. What this means in practice is ensuring progress is reviewed by not just the people who have led or commissioned any activity, and that there is intentional consideration to the diversity of those involved in the reviewing and monitoring progress.

The NHS is the biggest employer in the country. However, as we are split up into hundreds of separate organisations we often look inward for ideas and feedback around change. Through the work of the BAME Assembly, we in the North West have an opportunity to collaborate and ensure reviewing organisational progress is a task that we are able to support each other with; this can be done through ideas and the sharing in equal measure of success and failure to support our anti-racism journey.

What does this look like?

How are we performing?

It is vital that organisations consider the management of performance around inclusion as seriously as they monitor performance of other areas of work. Leaders at all levels should understand how their area is doing in relation to key targets.

What is our approach?

Becoming an anti-racist organisation takes a clear intention to deliver a range of actions and measures consistently over a prolonged period of time. Understanding where the organisation is on its journey to become anti-racist is vital.

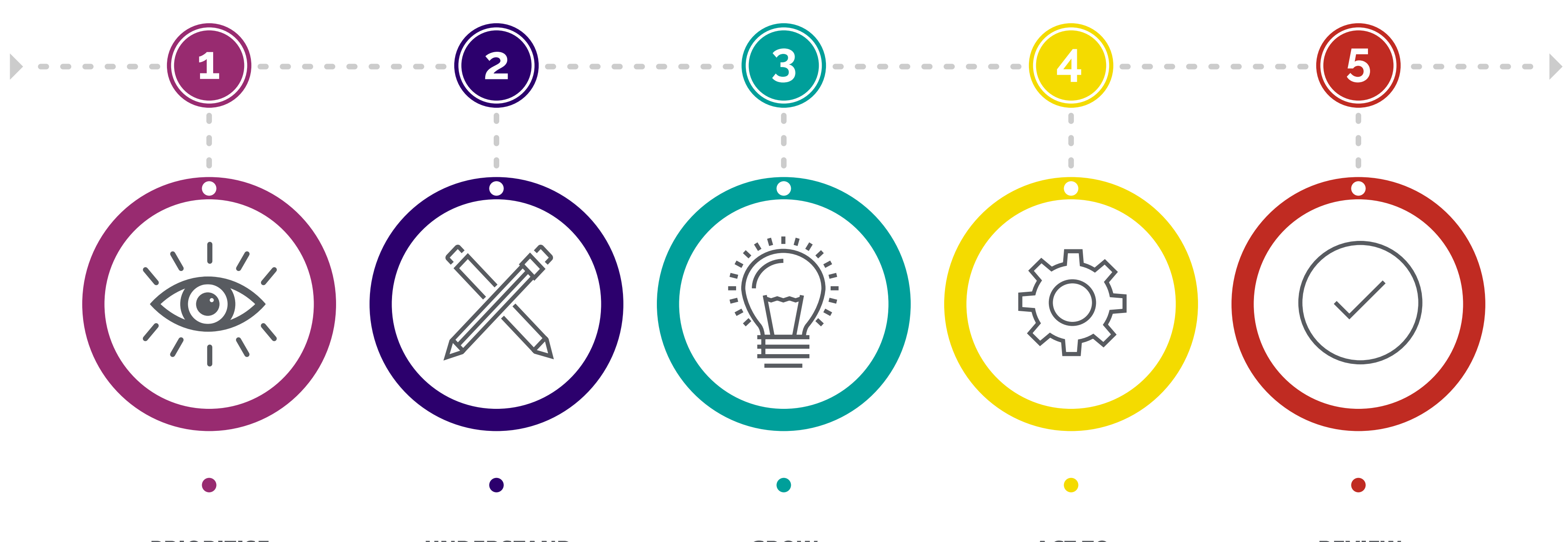
Our voices matter

The voices of Black, Asian and Minority Ethnic people should be at the heart of an organisation considering where they are on their journey to become anti-racist. This helps ensure actions that have been meaningful and impactful are prioritised, and where progress has not been made, this is not hidden.

Open and transparent

To have credibility around a statement that an organisation is anti-racist, it is vital the label is not just coming from the organisation itself but that the statement is supported by the community it serves.

The 5 anti-racist principles - Reflection questions



PRIORITISE ANTI-RACISM

How much of my time have I actually spent on anti-racism work in the last month?

UNDERSTAND LIVED EXPERIENCE

Whose voice and experience is not present, what have I done to address this, and how have I supported others to share their lived experience?

GROW INCLUSIVE LEADERS

What does the diversity of my organisation look like and how have I created opportunities for colleagues from ethnic minority backgrounds to grow and be included?

ACT TO TACKLE INEQUALITIES

What actions have I taken towards addressing racial inequalities and what impact has been made?

REVIEW PROGRESS REGULARLY

How has my organisation built anti-racism into their EDI targets and how is progress being measured?

Framework overview

This framework aims to support organisations on the journey to becoming intentionally and unapologetically anti-racist. The framework encourages the tackling of structural racism and discrimination through collaboration, reflective practice, accountability and action. Through the embedding of the themes, deliverables and actions outlined into structures, processes, policies and culture, organisations will create meaningful and measurable change within their workforce and service delivery.

The framework is organised into three levels of achievement: Bronze, Silver and Gold. Each level builds on the next, encouraging organisations to make incremental changes and take consistent actions towards eliminating racial discrimination in their organisations.

Bronze status

Bronze status signifies that an organisation has taken initial steps towards becoming an intentionally anti-racist organisation. These deliverables are those that embed structures and accountability for the delivery of racial equity in an organisation.

Key Drivers	Direct Deliverables	Supporting Actions
Leading from the front	The appointment of an executive or director level EDI sponsor with a commitment to advancing anti-racism within the organisation.	• This senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism. • Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.
Anti-racism as Mission Critical	Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.	• An anti-racism statement to be produced and published detailing organisational commitment to racial equity.
Actions Not Words	An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.	• Implementation of equality and inclusion KPIs with a focus on addressing race-based disparities.
We do this together	The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.	• The organisation can demonstrate working in partnership to reduce a specific health inequality through an anti-racism lens and publish progress within the organisational annual report.
Zero Tolerance	The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.	• Explicit processes for addressing instances of racist abuse, discrimination and harassment should be developed within or in addition to current organisational disciplinary procedures.

Silver status

The silver status shows that organisations have embedded structures to ensure commitment and accountability towards achieving anti-racism and have also developed actions to nurture and empower Black, Asian and Minority Ethnic talent, encourage culture change, and improve data collection, quality and reporting.

Key Drivers	Direct Deliverables	Supporting Actions
Empowering Your Talent	Set up a local Black, Asian and Minority Ethnic leadership council within your organisation.	• Ensure Black, Asian and Minority Ethnic talent is intentionally included across organisational talent programmes. Numbers should reflect the need for positive action to increase diversity within leadership roles. • Must have set targets and a published talent trajectory for Black, Asian and Minority Ethnic representation across every level of the organisation. • An organisation should have a dedicated positive action secondment or stretch projects programme in place to give Black, Asian and Minority Ethnic colleagues the chance to gain experience to support with career progression.
Levelling Up Middle Leadership & Inclusion	All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion, and a process to report annually the percentage of these goals that have been met.	• Leaders / managers to identify actions and create plans within their work to advance anti-racism.
Growing Cultural Competency	Evidence of inclusive leadership education for all executive directors.	• Further education for leaders, including inclusive recruitment, cultural awareness / competency, inclusive leadership, equality strategy and direction. • 75% of executive and non-executive directors and their direct reports have been part of a racial equality reverse mentoring programme over the past three years.
Listen and Learn	An executive director must attend Black, Asian and Minority Ethnic staff network meetings at least four times a year.	• A reciprocal arrangement with Black, Asian and Minority Ethnic staff network chair to attend and contribute to committee / board meetings.
Data Plus	WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.	• A detailed breakdown by ethnicity of the staff survey report should be presented to the board annually, including the involvement of Black, Asian and Minority Ethnic staff network members to ensure more than just data is presented. • Quarterly monitoring and review of WRES data, workforce data and action plans by executive EDI lead and presented to board and staff networks.

Gold status

To obtain Gold status, the organisation must demonstrate that anti-racism has been embedded throughout all levels of the organisation, with diverse representation at the most senior levels and parity in staff experience, as well as ensuring anti-racism is seen as everyone's business through performance and engagement.

Key Drivers	Direct Deliverables	Supporting Actions
Visibility Matters	An organisation's board of directors diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (which ever figure is higher).	• Creation and implementation of talent development and pipeline plan for Black, Asian or Minority Ethnic directors or associate non-executive director programme. • Partner with the North West Black Asian and Minority Ethnic Assembly to create a mentorship programme for Black, Asian or Minority Ethnic talent within the organisation.
How are we performing	An organisation must use an EDI performance dashboard that is presented quarterly to board and include performance against the race disparity ratio, WRES, and other race specific targets as appropriate.	• Organisation should record and publish their ethnicity pay gap annually • Intersectional data collection and analysis (by ethnicity, sex, gender, disability and sexual orientation) to be published and presented annually. • Chairs and non-executive directors to be updated annually on the progress on anti-racism plans.
More than a tick box	The organisation must be able to demonstrate two years of consecutive improvements against at least five WRES measures.	• Creation of a cross-departmental WRES actions working group to support and challenge progress on WRES data.
Fair and Just	The organisation can evidence diverse representation within their disciplinary and grievance processes.	• Freedom to Speak Up Champions within the organisation to support in incidents involving racial discrimination.
Our Voices Matter	The organisation should bring together annually Black, Asian and Minority Ethnic staff to review EDI progress and any learning be built into the following year's plans.	• WRES and anti-racism action plans to be co-produced with staff networks.

Regular review

Key Drivers	Deliverables	Supporting Actions
What's our approach	Organisations should review progress against each of the key drivers and direct deliverables within the NHS North-West Anti-Racism Framework at least annually.	Draft an annual action plan to attain initial or next accreditation that is reported on at board to ensure delivery and commitment.
Open and Transparent	The organisation should apply to the North West Black, Asian and Minority Ethnic Assembly to receive feedback against their anti-racism framework at least every two years.	Organisations should liaise with the Assembly / their Assembly member regarding progress and support in attaining recognition.

Support

The North-West BAME Assembly is here to support you in the implementation of this framework in your organisations.

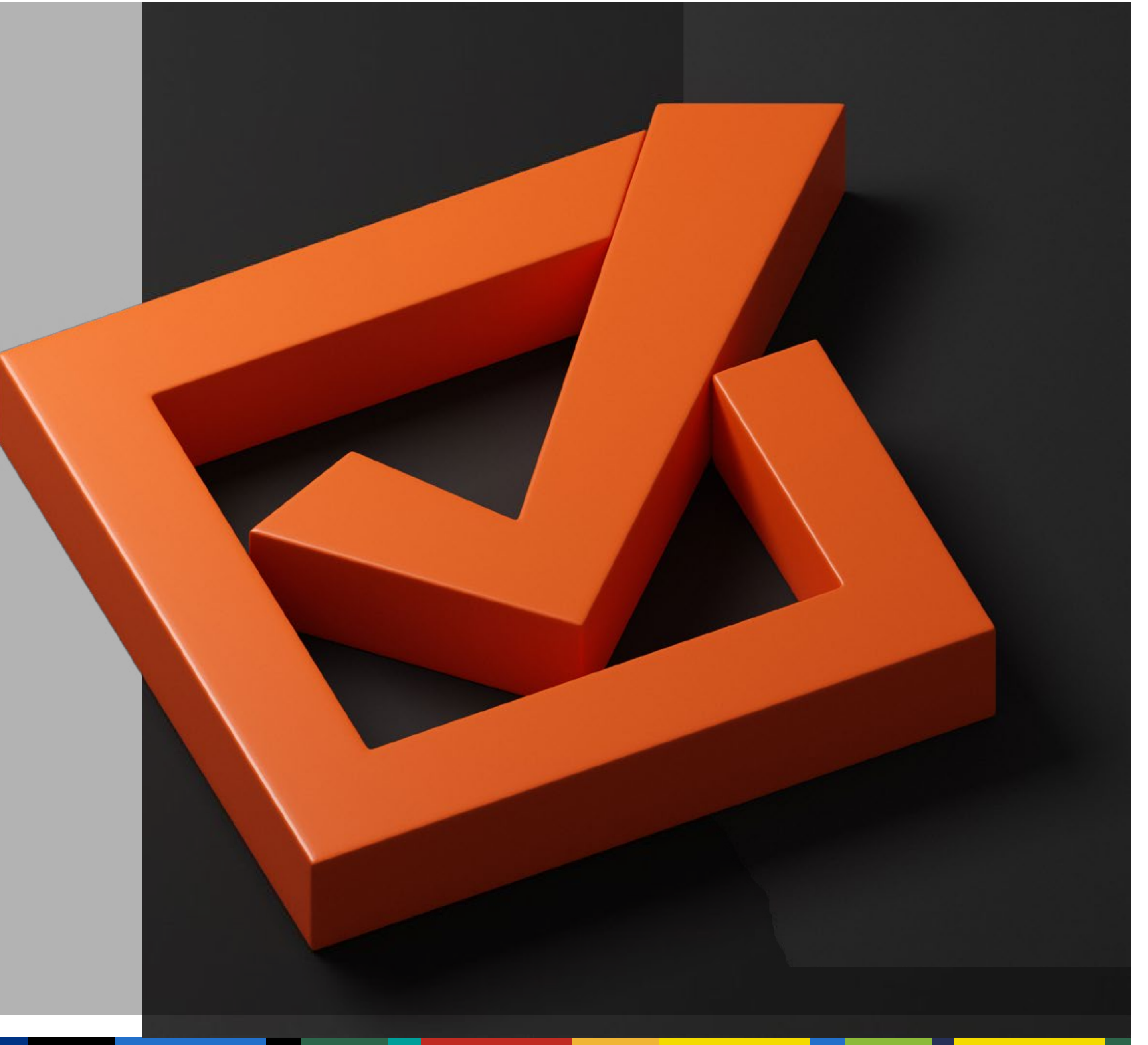
We have a dedicated resource who can assist with strategy, queries, and troubleshooting any issues you may come across on your journey.

Please contact **england.nwbame_assembly@nhs.net** to discuss further.

Recognition

1. Assess your organisation's current progress using the self-assessment tool.
2. Draft action plan towards achieving either Bronze, Silver or Gold status, and implement necessary strategies to achieve the deliverables.
3. Apply to the North West Assembly for recognition. A small panel of Assembly members will review applications, make assessments and recognise successful organisations.

Self-assessment tool



The self-assessment tool has been designed as an assurance checklist. The checklist should be used by organisations as they begin to implement the Anti-Racist Framework to identify which of the key deliverables from the framework are already in place and which are the development areas for the organisation.

When an organisation has identified their gaps using the checklist, actions can then be developed to support the implementation of the framework fully prior to moving towards requesting recognition.

Anti-racist framework checklist

Summary of direct deliverables

Bronze

The appointment of a senior director level EDI lead with a commitment to advancing anti-racism within the organisation.

Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.

An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.

The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.

The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.

Silver

Set up a local BAME leadership council within your organisation.

Evidence of inclusive leadership education for all executive directors.

All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion and a process to report annually the percentage of these goals that have been met.

An executive director must attend Black, Asian and Minority Ethnic staff network meeting at least four times a year.

WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.

Gold

An organisation's board of directors' diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (whichever figure is higher).

An organisation must use an EDI performance dashboard that is presented quarterly to at least a sub-group of the board and include performance against the race disparity ratio, WRES and other race specific targets.

The organisation must be able to demonstrate two years of consecutive improvements against at least five WRES measures.

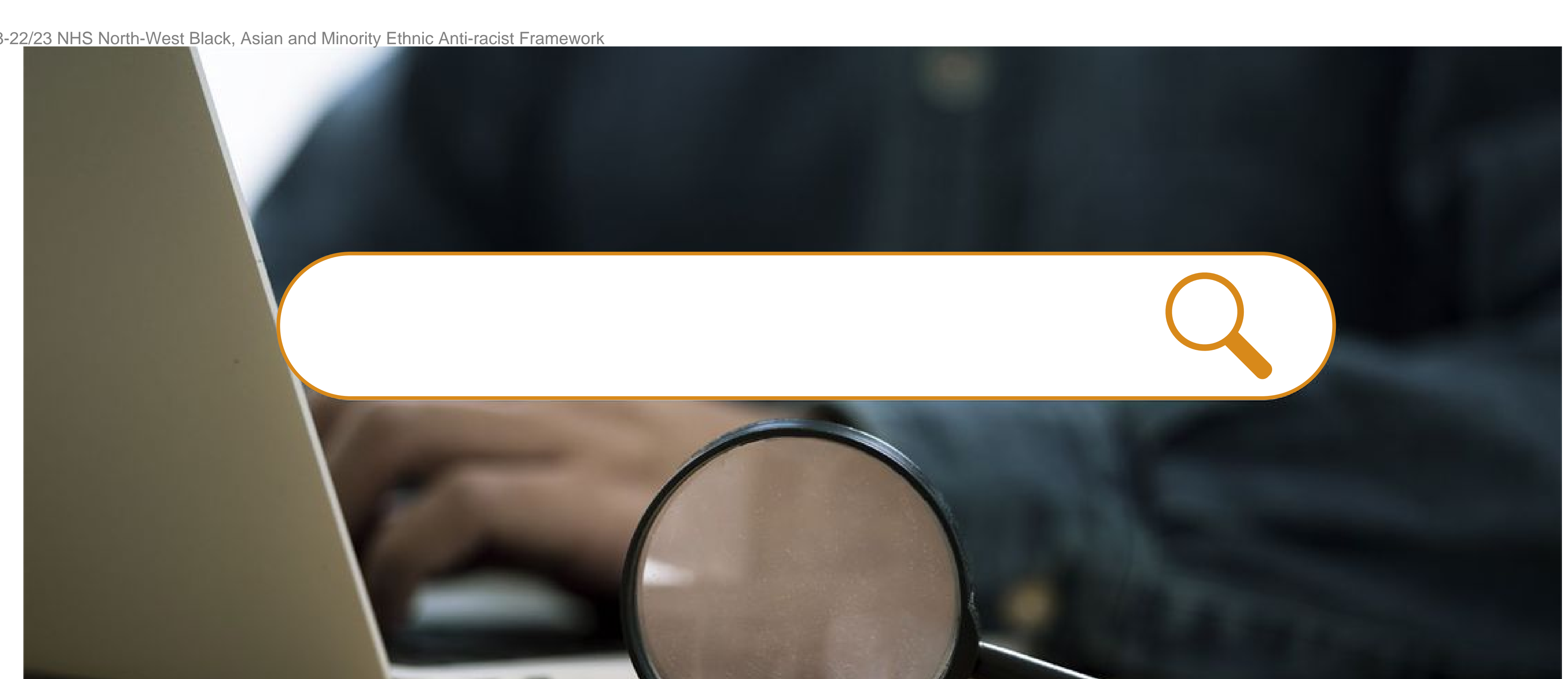
The organisation can evidence diverse representation within their disciplinary and grievance processes.

The organisation should bring together annually Black, Asian and Minority ethnic staff to review EDI progress and any learning be built into the following year's plans.

Sample action plan

Once the self-assessment is complete, an action plan to address the gaps should be developed. The action plan should identify a responsible person or team, a target completion date, and progress updates.

Level	Action	Person/ Team	Timescale	Target completion date	Progress	Comments
Bronze	The appointment of an executive / director level EDI sponsor.	HR	6 months		Ongoing	Proposal taken to board; nominated sponsor to be appointed at next meeting.
	Senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism.	HR	12 months		Ongoing	HR to explore the addition on an anti-racism PDP goal to role descriptions; meeting to discuss progress and next steps scheduled for 07/08.
	Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.	HR	6 months		Ongoing	Once senior sponsor appointed, meetings with Exec directors and chief executive to be scheduled on a six monthly basis to provide updates.



To support your journey towards becoming an unapologetically anti-racist organisation, we have compiled a list of resources to assist in the development of your strategies, plans and actions.

NHS North West Black, Asian and Minority Ethnic Strategic Advisory Group

National Education Union Anti Racism Framework

NHS Leadership Academy Allyship Toolkit

NHS Leadership Academy Resources on Racism

NHS Employers Resources to Tackle Racism

NHS England WRES 2022 Data Analysis Report

NHS England Patient Carer Race Equality Framework

NHS Race and Health Observatory

NHS Confederation BME Leadership Network

Change the Race Ratio Guidance - KPMG

Board Diversity More Action Less Talk

Why companies Need a Chief Diversity Officer

Competency Framework for Equality and Diversity Leadership

Diversity Management That Works - CIPD

Embed Anti-Racism in the NHS

Guide to Establishing Staff Networks - CIPD

WRES Board Briefing BAME Leadership Council Case Study - NHS England

Building Narrative Power for Racial Justice and Health Equity

Lived Experiences of Ethnic Minority Staff in the NHS - The Kings Fund

A Case for Diverse Boards - NHS England

Taskforce on Increasing Non-Executive Director Diversity in the NHS - NHS Confederation

Develop a Strong Talent Pipeline from Entry Level to Executive Roles - CBI

Practical Guide Bridging the Gap - CBI

Six Traits of Inclusive Leadership - Deloitte

Northern Care Alliance NHS Foundation Trust Intentional Inclusion Model

Black Jobs Matter - Personnel Today

Health Inequalities Hub Case Studies - NHS England

BMA Charter for Medical Schools to Prevent and Address Racial Harassment

Hospital CEO on Zero Tolerance - BBC News

Addressing Race Inequalities Needs Engagement - The Kings Fund

A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce - NHS England and NHS Improvement

Health Education England Diversity Performance Dashboard

Civil Service Diversity and Inclusion Dashboard
The Value of Lived Experience - HPMA Newsletter

Diversity and the Case for Transparency - PWC

Shattered hopes: Black and minority ethnic leaders' experiences of breaking the glass ceiling in the NHS - BME Leadership Network NHS Confederation

No more tick boxes: a review on the evidence on how to make recruitment and career progression fairer - NHS England

If your face fits: exploring common mistakes to addressing equality and equity in recruitment- NHS England

Title of meeting: **Trust Board**
Date of meeting: **26th July 2023**

Report author	Joan Spencer, Chief Operating Officer			
Paper prepared by	Hannah Gray, Associate Director of Performance and Operational Improvement			
Report subject/title	Integrated Performance Report M3 2023 / 2024			
Purpose of paper	This report provides an update on performance for month 3 2023/24 (June 2023). This report provides an update on performance in the categories of access, efficiency, quality, workforce, research and innovation and finance. RAG rated data and statistical process control (SPC) charts (with associated variation and assurance icons) are presented for each KPI. Exception reports are presented below the relevant KPI against which the Trust is not compliant / alerting on SPC charts.			
Background papers				
Action required	For discussion and approval.			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	Y	Be a great place to work	Y
	Be Collaborative	Y	Be Digital	Y
	Be Research Leaders	Y	Be Innovative	Y

Equality & Diversity Impact Assessment

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

Ref: FCGOREPO
Review: July 2025
Version: 2.0

Integrated Performance Report
(Month 3 2023/24)

Hannah Gray: Associate Director of Performance and Operational Improvement

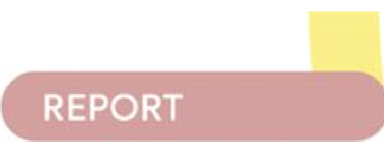
Joan Spencer: Chief Operating Officer

Introduction

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

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

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



Interpretation of Statistical Process Control Charts

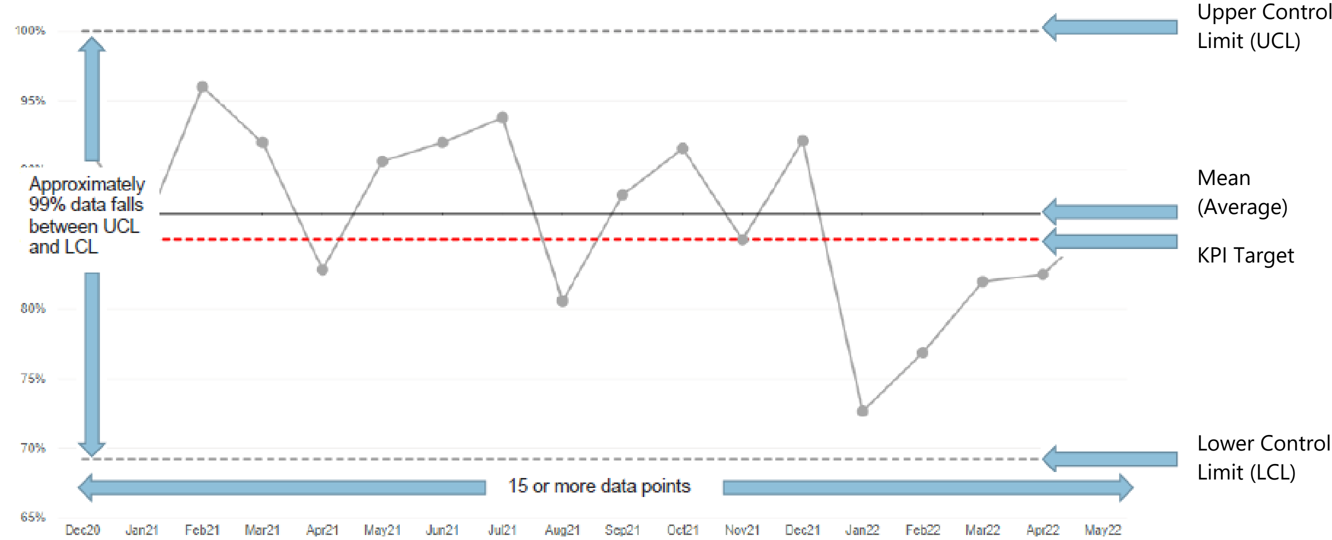
The following summary icons describe the Variation and Assurance displayed in the Chart.

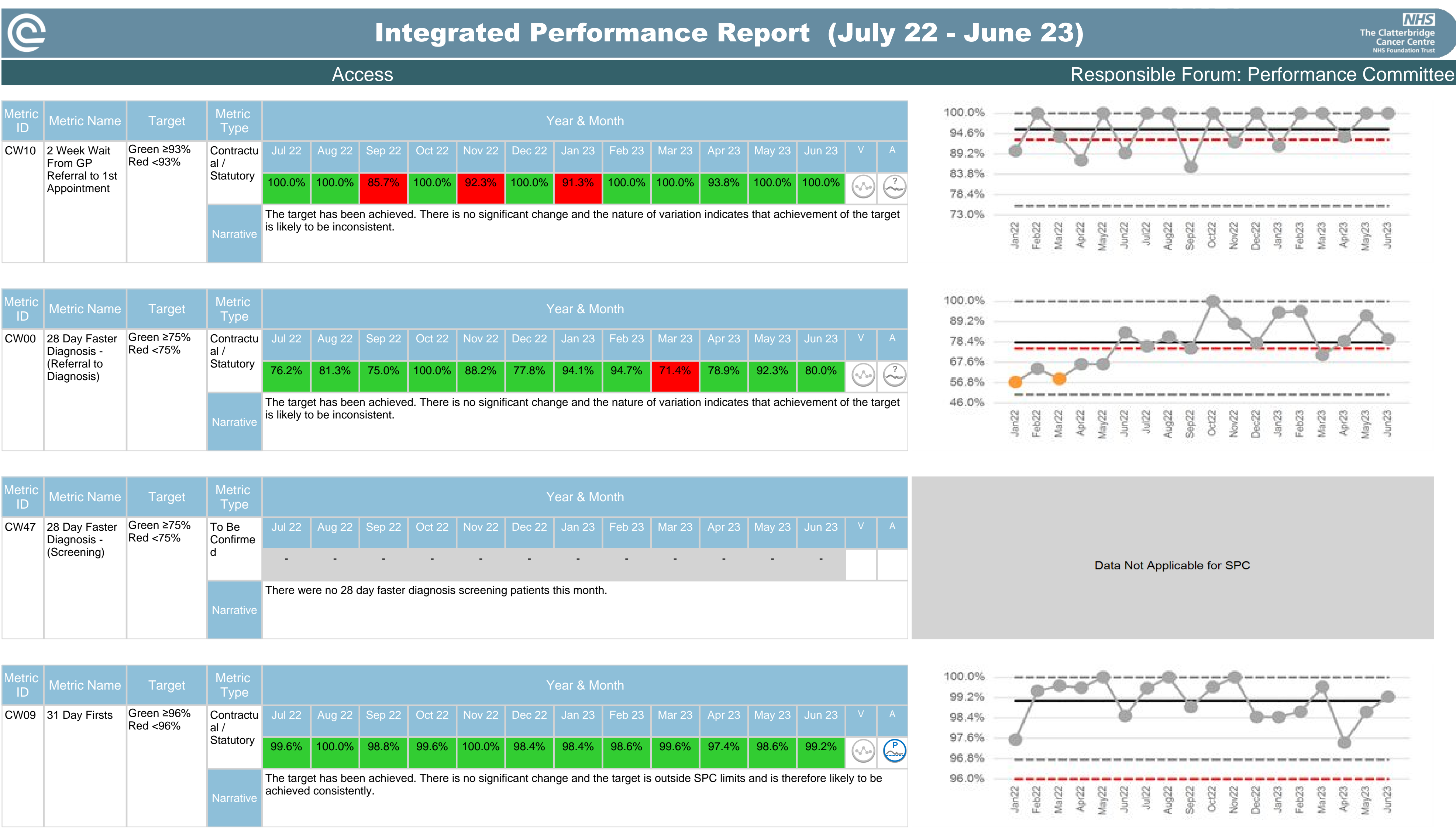
Are we improving, declining or staying the same? (Variation)			
Icon	Variation	Definition	Action
	Special Cause Improving Variation	Unexpected variation that results from unusual circumstances in a system or process i.e. assignable. (Blue = significant improvement/low pressure, H = high numbers, L =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

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

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Anatomy of the SPC Chart





Integrated Performance Report (July 22 - June 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access | Responsible Forum: Performance Committee

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

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
CW00	28 Day Faster Diagnosis - (Referral to Diagnosis)	Green ≥75% Red <75%	Contractual / Statutory	76.2%	81.3%	75.0%	100.0%	88.2%	77.8%	94.1%	94.7%	71.4%	78.9%	92.3%	80.0%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

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

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
CW09	31 Day Firsts	Green ≥96% Red <96%	Contractual / Statutory	99.6%	100.0%	98.8%	99.6%	100.0%	98.4%	98.4%	98.6%	99.6%	97.4%	98.6%	99.2%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.													

Integrated Performance Report (July 22 - June 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
CW07	31 Day Subsequent Chemotherapy	Green ≥98% Red <98%	Contractual / Statutory	99.2%	99.6%	99.3%	98.9%	98.6%	100.0%	99.6%	98.8%	98.3%	100.0%	99.2%	98.7%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
CW08	31 Day Subsequent Radiotherapy	Green ≥94% Red <94%	Contractual / Statutory	99.2%	100.0%	99.0%	99.3%	98.0%	100.0%	97.3%	99.7%	99.3%	97.0%	99.1%	99.5%		P
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.													

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

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
CW90	24 Day Wait Target - Referral Received to First Treatment (62 Day Classics Only)	Green >85% Amber 80-84.9% Red <80%		83.0%	86.9%	89.1%	84.4%	86.0%	86.7%	82.3%	90.5%	87.1%	78.0%	81.8%	78.3%		
			Narrative	The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

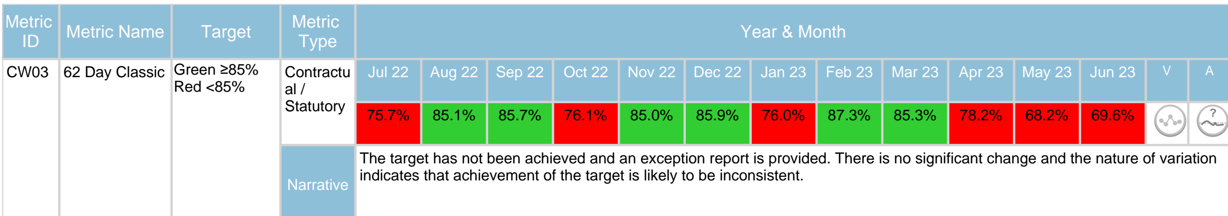
Integrated Performance Report (July 22 - June 23)

Access

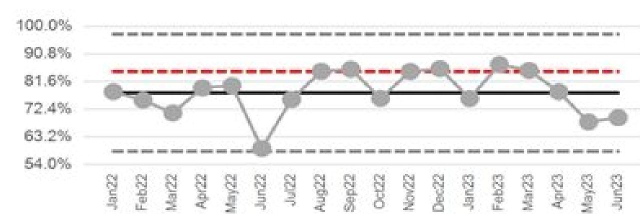
Responsible Forum: Performance Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
25 of 130 patients treated in June, breached the 24 day target. For these 25 patients, the longest wait was 566 days (Patient choice: they required an up to date diagnostic test after referral to CCC and the patient was very anxious about treatment) and the median wait was 35 days. 19 of these 25 patients breached 62 days; breach details are provided in the 62 day exception report. For the 6 patients for whom we achieved the 62 day target, 4 breaches were avoidable and 2 were unavoidable to CCC. The breach reasons are as follows: Unavoidable breaches: - Molecular markers delay (2 x Lung) Avoidable breaches: - Delay to 1st appointment due to capacity (Breast) - Treatment was escalated but PICC appointment not rearranged (Breast) - Treatment initially booked out of target and when an earlier start date was arranged, the patient chose to retain their initial appointment (UGI) - SABR MDT - Unable to meet 24 day target due to tight turnaround (Lung)	Admin team to support escalation with moving appointments for breast patients. Ongoing delays to ECHO has been escalated to Aintree. Refresher CWT awareness sessions have been held for the Scheduling Team. The implementation and ongoing refinement of the escalation tracker tool and associated process will assist earlier escalations when appropriate. A meeting will be held to review the process for making clinicians aware of patients awaiting outlining and for escalating delays in outlining that may impact on planned start date for target patients. Further to the routine review of all 62 day breaches at TOG, a deep dive has been conducted and the findings presented at TOG, with actions agreed. All 24 day breaches (regardless of whether this results in a 62 day breach) are now reviewed in detail monthly at TOG, to identify trends and actions. The CWT dashboard is being further refined to enable easier reporting of breach reason themes. CCC continue to collaborate with all stakeholders regarding the expedition of molecular testing.

Escalation Route & Expected Date of Compliance
Trust Operational Group, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board July 23



Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
CW03	62 Day Classic	Green ≥85% Red <85%	Contractual / Statutory	75.7%	85.1%	85.7%	76.1%	85.0%	85.9%	76.0%	87.3%	85.3%	78.2%	68.2%	69.6%		
			Narrative	The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Integrated Performance Report (July 22 - June 23)

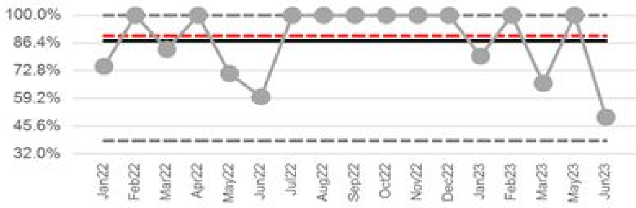
Access

Responsible Forum: Performance Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
19 patients breached the 62 day target in June. 14 of the breaches were unavoidable to CCC, due to: - Patient choice x 4 (1 x Gynae, 1 x Lung, 1 x UGI and 1 x Urology) - Delay to 1st appointment, awaiting molecular markers x 3 (Lung) - Medical reason (1 x Breast) - Delay due to Anaesthetist capacity (1 x LGI) - Complex SABR RT Plan patient required re-scan (1 x Lung) - Delay to diagnostic test and reporting of results at other trust and patient required further test prior to treatment (1 x Haem) - Patient required face to face follow up to assess fitness for treatment and an ECHO prior to treatment (Breast) - Patient required repeat biopsy to confirm histology and CT (1 x Lung) - Patient required further diagnostic test after referral to CCC (1 x Haem) The 5 avoidable breaches were due to: - Delay to 1st appointment due to capacity x 3 (1 x Haem and 2 x Sarcoma) - Delay to 1st appointment due to SABR capacity x 1 (Lung) - Clinical process error - DPYD not sent for testing x1 (LGI)	A Sarcoma SRG capacity and demand review will be undertaken. Review of process for OPD 1st appointment booking for HO patients to align with 9 day KPI for solid tumour. A meeting will be held to review the process for making clinicians aware of patients awaiting outlining and for escalating delays in outlining that may impact on planned start date for target patients. DPYD: Additional checking step added to process before bloods are sent to labs. Phlebotomist responsible for taking blood is required to say check complete. Process reiterated at morning huddles. Further to the routine review of all 62 day breaches at TOG, a deep dive has been conducted and the findings presented at TOG, with actions agreed. All 24 day breaches (regardless of whether this results in a 62 day breach) are now reviewed in detail monthly at TOG, to identify trends and actions. The CWT dashboard is being further refined to enable easier reporting of breach reason themes. CCC continue to collaborate with all stakeholders regarding the expedition of molecular testing.

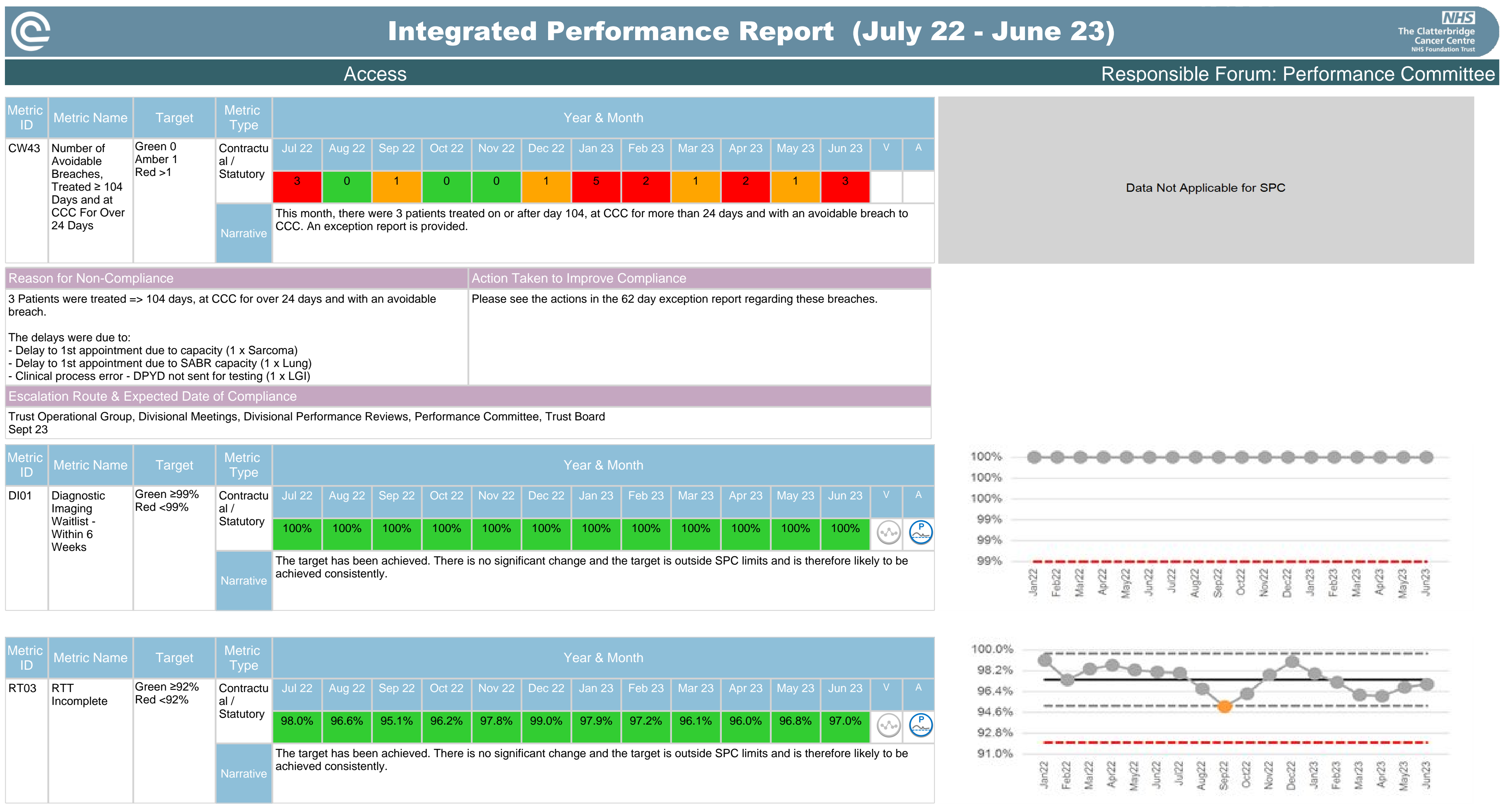
Escalation Route & Expected Date of Compliance
Trust Operational Group, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board August 23

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
CW05	62 Day Screening	Green ≥90% Red <90%	Contractual / Statutory	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	66.7%	-	100.0%	50.0%		
			Narrative	The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Reason for Non-Compliance	Action Taken to Improve Compliance
1 patient breached the screening target in June; the patient was referred on day 50 and had 32 days to treatment at CCC. The breach was avoidable due to delay to 1st appointment due to capacity (LGI)	This was due to Consultant annual leave in April along with Bank Holidays (Easter) and Bank Holiday Mondays in May. Also reduced capacity and half day clinic closed due to consultant COW commitments. More proactive planning required to ensure additional capacity available during consultant leave.

Escalation Route & Expected Date of Compliance
Trust Operational Group, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board July 23



Integrated Performance Report (July 22 - June 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Responsible Forum: Performance Committee

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

Data Not Applicable for SPC

Reason for Non-Compliance	Action Taken to Improve Compliance
3 Patients were treated => 104 days, at CCC for over 24 days and with an avoidable breach. The delays were due to: - Delay to 1st appointment due to capacity (1 x Sarcoma) - Delay to 1st appointment due to SABR capacity (1 x Lung) - Clinical process error - DPYD not sent for testing (1 x LGI)	Please see the actions in the 62 day exception report regarding these breaches.

Escalation Route & Expected Date of Compliance

Trust Operational Group, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board
Sept 23

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

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
RT03	RTT Incomplete	Green ≥92% Red <92%	Contractual / Statutory	98.0%	96.6%	95.1%	96.2%	97.8%	99.0%	97.9%	97.2%	96.1%	96.0%	96.8%	97.0%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.													

Integrated Performance Report (July 22 - June 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Access: Cheshire and Merseyside | Responsible Forum: Acute and Specialist Trust Provider Collaborative

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
CW44	2 Week Wait From GP Referral to 1st Appointment (Cheshire and Merseyside)	Green ≥93% Red <93%	Contractual / Statutory	76.1%	73.9%	65.5%	74.5%	77.3%	76.4%	76.6%	80.1%	77.4%	76.2%	-	-		
			Narrative	May data is not yet available.													

97.0% 90.2% 83.4% 76.6% 69.8% 63.0%
Jan22 Feb22 Mar22 Apr22 May22 Jun22 Jul22 Aug22 Sep22 Oct22 Nov22 Dec22 Jan23 Feb23 Mar23 Apr23

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
CW45	28 Day Faster Diagnosis - (Referral to Diagnosis) (Cheshire and Merseyside)	Green ≥75% Red <75%	Contractual / Statutory	69.2%	67.6%	68.7%	70.3%	66.0%	65.5%	61.4%	71.1%	70.1%	67.0%	-	-		
			Narrative	May data is not yet available.													

78.0% 74.0% 70.0% 66.0% 62.0% 58.0%
Jan22 Feb22 Mar22 Apr22 May22 Jun22 Jul22 Aug22 Sep22 Oct22 Nov22 Dec22 Jan23 Feb23 Mar23 Apr23

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
CW46	62 Day Classic (Cheshire and Merseyside)	Green ≥85% Red <85%	Contractual / Statutory	68.9%	66.0%	61.9%	65.8%	69.1%	65.5%	56.2%	61.4%	67.4%	63.9%	-	-		
			Narrative	May data is not yet available.													

89.0% 81.8% 74.6% 67.4% 60.2% 53.0%
Jan22 Feb22 Mar22 Apr22 May22 Jun22 Jul22 Aug22 Sep22 Oct22 Nov22 Dec22 Jan23 Feb23 Mar23 Apr23

Integrated Performance Report (July 22 - June 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
IP05-ST	Length of Stay Elective Care: Solid Tumour Wards (Average Number of Days On Discharge)	Green ≤9 Amber 9.1-10.7 Red >10.7	Statutory	8.60	8.40	6.10	6.90	10.70	9.61	6.00	6.36	5.93	8.84	4.22	7.17		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
IP06-ST	Length of Stay Emergency Care: Solid Tumour Wards (Average Number of Days On Discharge)	Green ≤12 Amber 12.1-14.3 Red >14.3	Statutory	12.60	9.40	11.80	10.80	12.90	13.08	11.30	11.40	14.13	10.99	12.10	13.98		
			Narrative	LoS is marginally above target this month, however there is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
IP05-4	Length of Stay Elective Care: HO Ward 4 (Average Number of Days On Discharge)	Green ≤21 Amber 21.1-22.1 Red >22.1	Statutory	31.8	17.0	22.6	12.4	14.3	13.9	12.8	11.1	17.9	31.2	15.2	14.5		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
IP06-4	Length of Stay Emergency Care: HO Ward 4 (Average Number of Days On Discharge)	Green ≤22 Amber 22.1-23.1 Red >23.1	Statutory	12.50	23.80	17.80	10.60	9.60	11.00	8.10	20.86	24.50	23.31	18.36	23.36		
			Narrative	LoS is marginally above target this month, however there is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Integrated Performance Report (July 22 - June 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
IP05-5	Length of Stay Elective Care: HO Ward 5 (Average Number of Days On Discharge)	Green ≤32 Amber 32.1-33.6 Red >33.6	Statutory	16.8	22.8	14.3	22.9	19.4	18.5	14.5	16.8	13.1	11.6	28.7	22.4		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
IP06-5	Length of Stay Emergency Care: HO Ward 5 (Average Number of Days On Discharge)	Green ≤46 Amber 46.1-48.3 Red >48.3	Statutory	13.50	19.00	14.70	10.50	7.00	3.67	23.00	17.00	4.33	9.00	34.00	7.40		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
IP22	Delayed Transfers of Care As % of Occupied Bed Days	Green ≤3.5% Red >3.5%	Statutory	4.4%	5.1%	6.1%	6.9%	7.1%	6.3%	5.4%	4.2%	5.6%	4.8%	2.2%	7.2%		
			Narrative	The nationally set target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Integrated Performance Report (July 22 - June 23)

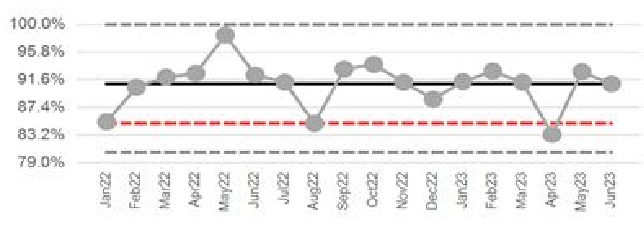
Efficiency

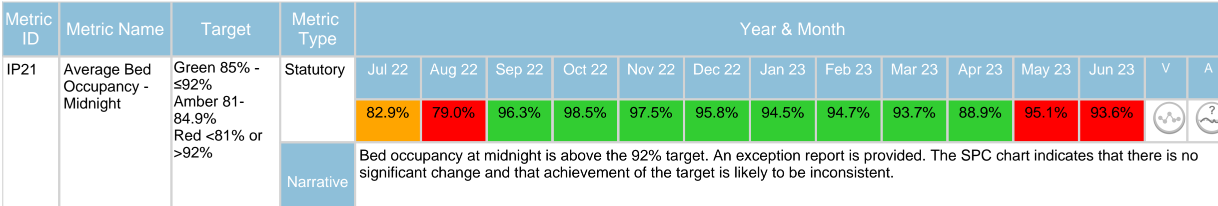
Responsible Forum: Performance Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
Delayed Transfers of Care (DTOCs) as a % of occupied bed days for the month of June was above the Trust target of <= 3.5%, with 7.2% reported this month. There were 19 DTOCs in June, equating to 502 extra bed days. The average length of DTOC was 10.7 days. 2 patients awaited Fast Track Packages of care resulting in 3 extra bed days. 5 patients awaited Hospice placement resulting in 61 extra bed days. One hospice has reduced bed capacity due to being unable to recruit staff. 10 patients awaited Social Packages of Care resulting in 83 extra bed days. 1 patient lacked capacity and required significant input via MDT from an external agency to ensure that they and their family were able to make a safe choice around discharge planning (28 extra bed days).	• Weekly 'Lengthened Length of Stay' meetings have continued, to ensure the efficient flow of patients and for any concerns to be escalated. The outcome of these meetings are sent to the General Manager for review. • The Patient Flow Team continue to work with wider MDT to aid discharge planning , ensuring patients are discharged safely home or to a suitable care setting. Weekly complex discharge meetings occur with MDT. • Daily COW MDT meetings continue to allow discussion of all inpatients so there is a clear plan for each patient.

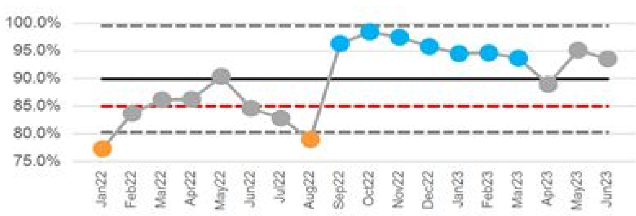
Escalation Route & Expected Date of Compliance
Length of stay meeting, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board July 2023

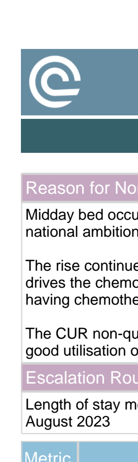
Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
IP20	Average Bed Occupancy - Midday	Green 85% - ≤92% Amber 81-84.9% Red <81% or >92%	Statutory	91.3%	85.0%	93.2%	93.9%	91.2%	88.7%	91.4%	92.9%	91.3%	83.3%	92.8%	91.0%		
			Narrative	The target has been achieved. The SPC chart indicates no significant change and that achievement of the target is likely to be inconsistent.													





Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
IP21	Average Bed Occupancy - Midnight	Green 85% - ≤92% Amber 81-84.9% Red <81% or >92%	Statutory	82.9%	79.0%	96.3%	98.5%	97.5%	95.8%	94.5%	94.7%	93.7%	88.9%	95.1%	93.6%		
			Narrative	Bed occupancy at midnight is above the 92% target. An exception report is provided. The SPC chart indicates that there is no significant change and that achievement of the target is likely to be inconsistent.													





Integrated Performance Report (July 22 - June 23)

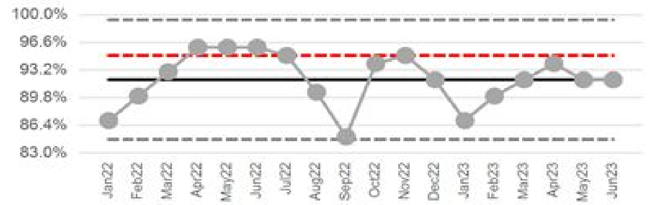
Efficiency

Responsible Forum: Performance Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
Midday bed occupancy is within target for June and midnight is marginally above the national ambition of <92%. The rise continues to reflects the higher outpatient and SACT delivery activity which drives the chemotherapy schedules and therefore the numbers of inpatients, who are having chemotherapy, or admitted with post chemotherapy complications. The CUR non-qualifying rate was 6% for June 2023 which indicates the continuation of good utilisation of beds.	A patient flow project is reviewing the flow of patients from home (concentrating on avoiding admission), to discharge. A project initiation document (PID) is being finalised and working groups will be identified. A separate project (in collaboration with LUHFT) will focus on inpatient and out patient frailty.

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

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



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

Data Not Applicable for SPC

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

Data Not Applicable for SPC

Integrated Performance Report (July 22 - June 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
IP26	% of Urgent Operations Cancelled For a Second Time	Green 0% Red >0%	Contractual	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		

Narrative: No procedures have been cancelled for a second time.

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
EF10	Imaging Reporting Turnaround (Inpatients)	Green >90% Amber 80-89.9% Red <80%		99.0%	90.5%	91.1%	95.8%	96.8%	92.6%	90.7%	73.5%	88.1%	91.2%	93.1%	84.1%		

Narrative: The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.

100.0% 94.2% 88.4% 82.6% 76.8% 71.0%

Jan22 Feb22 Mar22 Apr22 May22 Jun22 Jul22 Aug22 Sep22 Oct22 Nov22 Dec22 Jan23 Feb23 Mar23 Apr23 May23 Jun23

Reason for Non-Compliance	Action Taken to Improve Compliance
Ongoing vacancies within the radiologists' team, along with sickness absence has negatively affected performance. Radiologists have also been supporting the ultrasound scanning service due to vacancies and sickness.	Recruitment of consultant radiologists; with interviews on 10th July and 1 post offered. Full time Sonographer is due to commence in post 2nd August and new PT vacancy in the process of recruitment.

Escalation Route & Expected Date of Compliance

Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board
July 2023

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
EF11	Imaging Reporting Turnaround (Outpatients)	Green >90% Amber 80-89.9% Red <80%		63.7%	65.7%	67.9%	87.0%	88.3%	85.9%	82.2%	82.0%	91.5%	96.3%	89.3%	86.9%		

Narrative: The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.

100.0% 92.0% 84.0% 76.0% 68.0% 60.0%

Jan22 Feb22 Mar22 Apr22 May22 Jun22 Jul22 Aug22 Sep22 Oct22 Nov22 Dec22 Jan23 Feb23 Mar23 Apr23 May23 Jun23

Integrated Performance Report (July 22 - June 23)

Efficiency

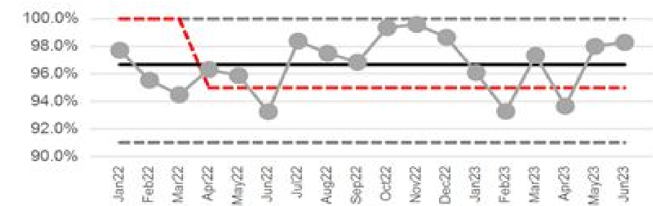
Responsible Forum: Performance Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
The demand for all imaging modalities continues to increase.	Recruitment of consultant radiologists, with interviews on 10th July and 1 post offered.
Radiologists have also been supporting the ultrasound scanning service due to vacancies and sickness.	Full time sonographer is due to commence in post 2nd August and new PT vacancy in the process of recruitment.
Outsourcing to Medica continues, however the turnaround times can be up to 5 days from receipt to report.	Utilising Medica to full capacity for CCC for reporting.

Escalation Route & Expected Date of Compliance

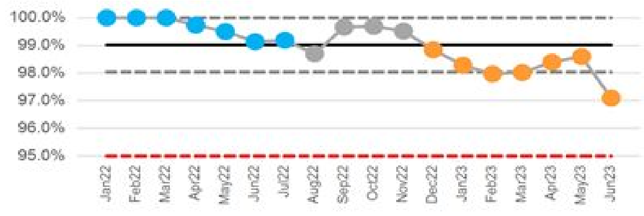
Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board
July 2023

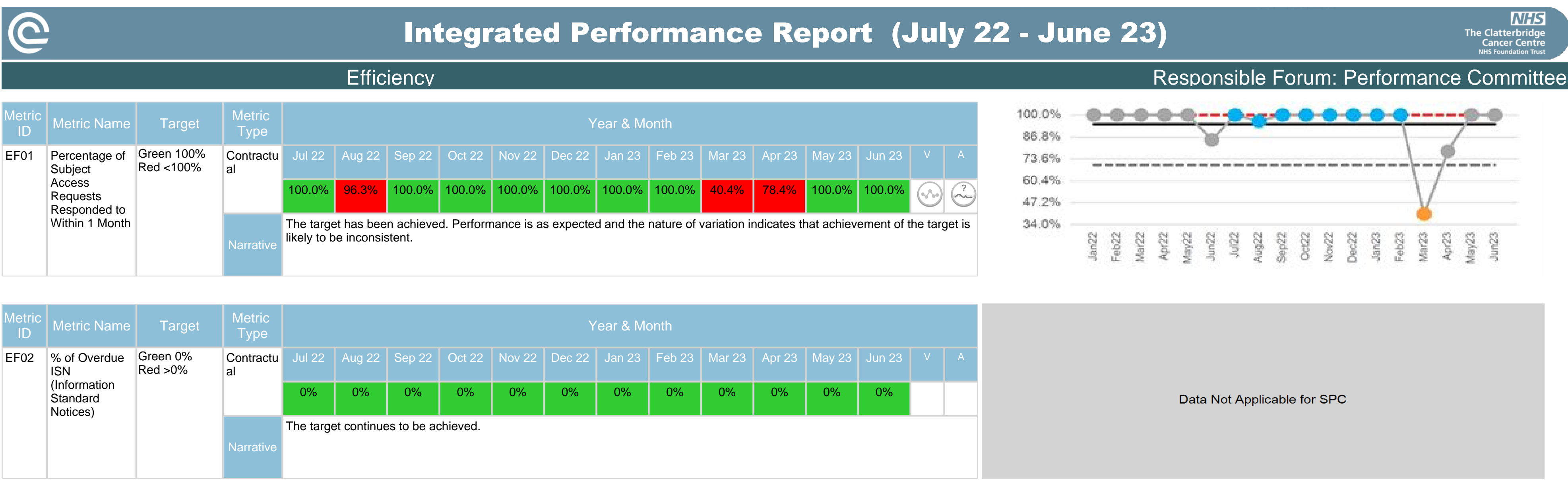
Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
DQ01	Data Quality - % Ethnicity That is Complete (or Patient Declined to Answer)	Green ≥95% Amber 90-94.9% Red <90%	Covid-19 Recovery	98.4%	97.5%	96.9%	99.4%	99.6%	98.7%	96.1%	93.3%	97.3%	93.7%	98.0%	98.3%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
DQ02	Data Quality - % of Outpatients With an Outcome	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual	94.9%	94.4%	95.6%	95.9%	96.8%	95.5%	95.0%	94.1%	94.2%	95.6%	96.1%	94.5%		
			Narrative	Whilst performance is marginally below the target, there is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
DQ03	Data Quality - % of Outpatients With an Attend Status	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual	99.2%	98.7%	99.7%	99.7%	99.5%	98.8%	98.3%	98.0%	98.0%	98.4%	98.6%	97.1%		
			Narrative	The target has been achieved. Although performance is lower than expected, the target is outside SPC limits and therefore likely to be achieved consistently.													





Integrated Performance Report (July 22 - June 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

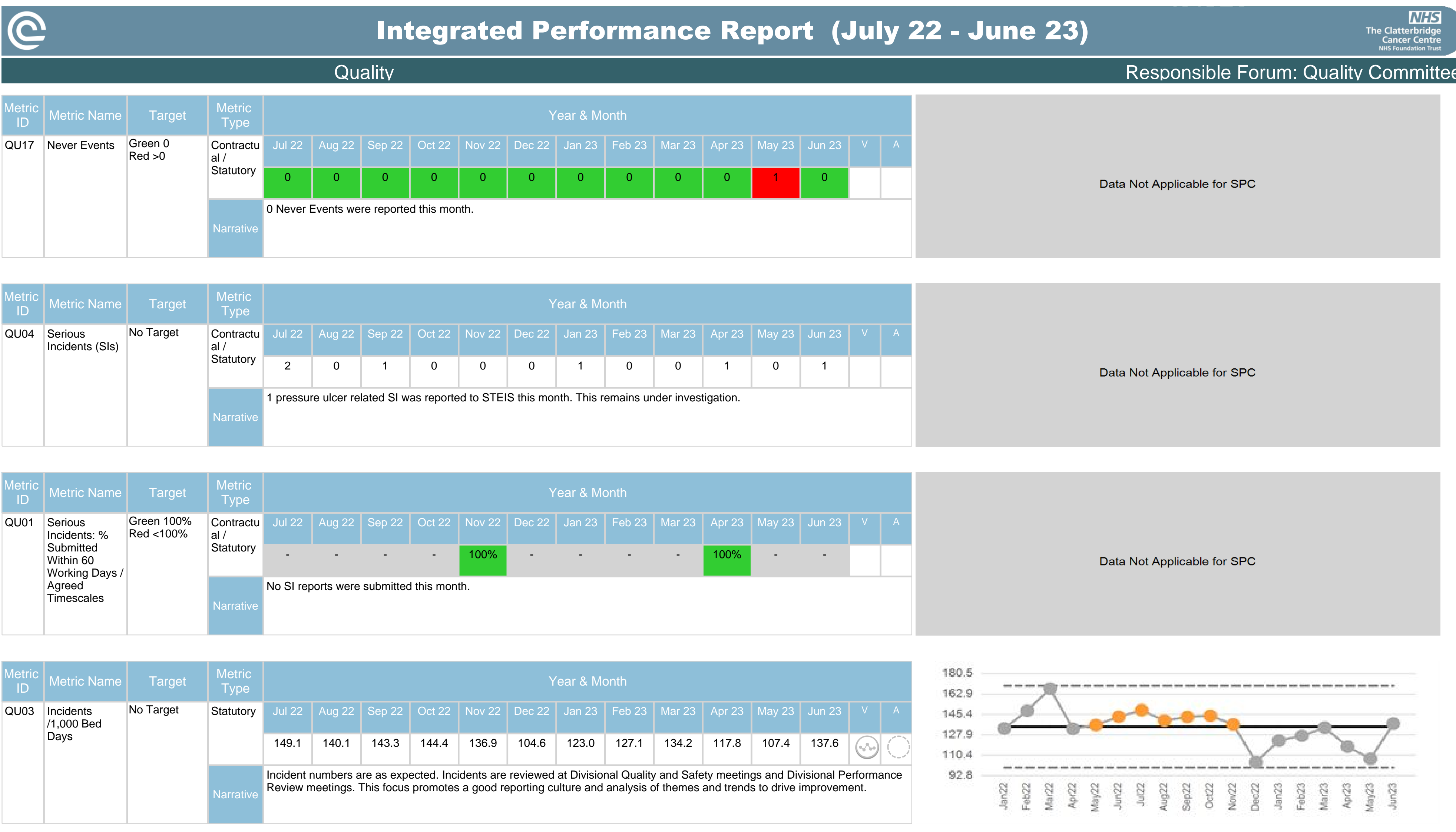
Efficiency

Responsible Forum: Performance Committee

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

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

Data Not Applicable for SPC



Integrated Performance Report (July 22 - June 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality | Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU17	Never Events	Green 0 Red >0	Contractual / Statutory	0	0	0	0	0	0	0	0	0	0	1	0		
			Narrative	0 Never Events were reported this month.													

Data Not Applicable for SPC

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

Data Not Applicable for SPC

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

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU03	Incidents /1,000 Bed Days	No Target	Statutory	149.1	140.1	143.3	144.4	136.9	104.6	123.0	127.1	134.2	117.8	107.4	137.6		
			Narrative	Incident numbers are as expected. Incidents are reviewed at Divisional Quality and Safety meetings and Divisional Performance Review meetings. This focus promotes a good reporting culture and analysis of themes and trends to drive improvement.													

Integrated Performance Report (July 22 - June 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality | Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU05	All Incidents Resulting in Moderate Harm and Above /1,000 Bed Days	No Target	Local	1.293	0.904	2.794	1.458	0.370	0.367	1.076	2.318	0.719	0.405	1.767	1.110		

Narrative: Numbers of incidents of this severity are as expected. Incidents are reviewed at Divisional Quality and Safety meetings and Divisional Performance Review meetings. This focus promotes a good reporting culture and analysis of themes and trends to drive improvement.

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU06	Inpatient Falls Resulting in Harm Due to Lapse in Care	Green 0 Red >0	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		

Narrative: There were no falls resulting in harm due to a lapse in care. The harm review process has been amended and therefore figures may change retrospectively, following review.

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU07	Inpatient Falls Resulting in Harm Due to Lapse in Care /1,000 Bed Days	Green 0 Red >0	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		

Narrative: There were no falls resulting in harm due to a lapse in care. The harm review process has been amended and therefore figures may change retrospectively, following review.

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU08	Pressure Ulcers (Hospital Acquired Grade 3/4, With a Lapse in Care)	Green 0 Red >0	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		

Narrative: The target continues to be achieved, with no such pressure ulcers this month. The harm review process has been amended and therefore figures may change retrospectively, following review.

Data Not Applicable for SPC

Integrated Performance Report (July 22 - June 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

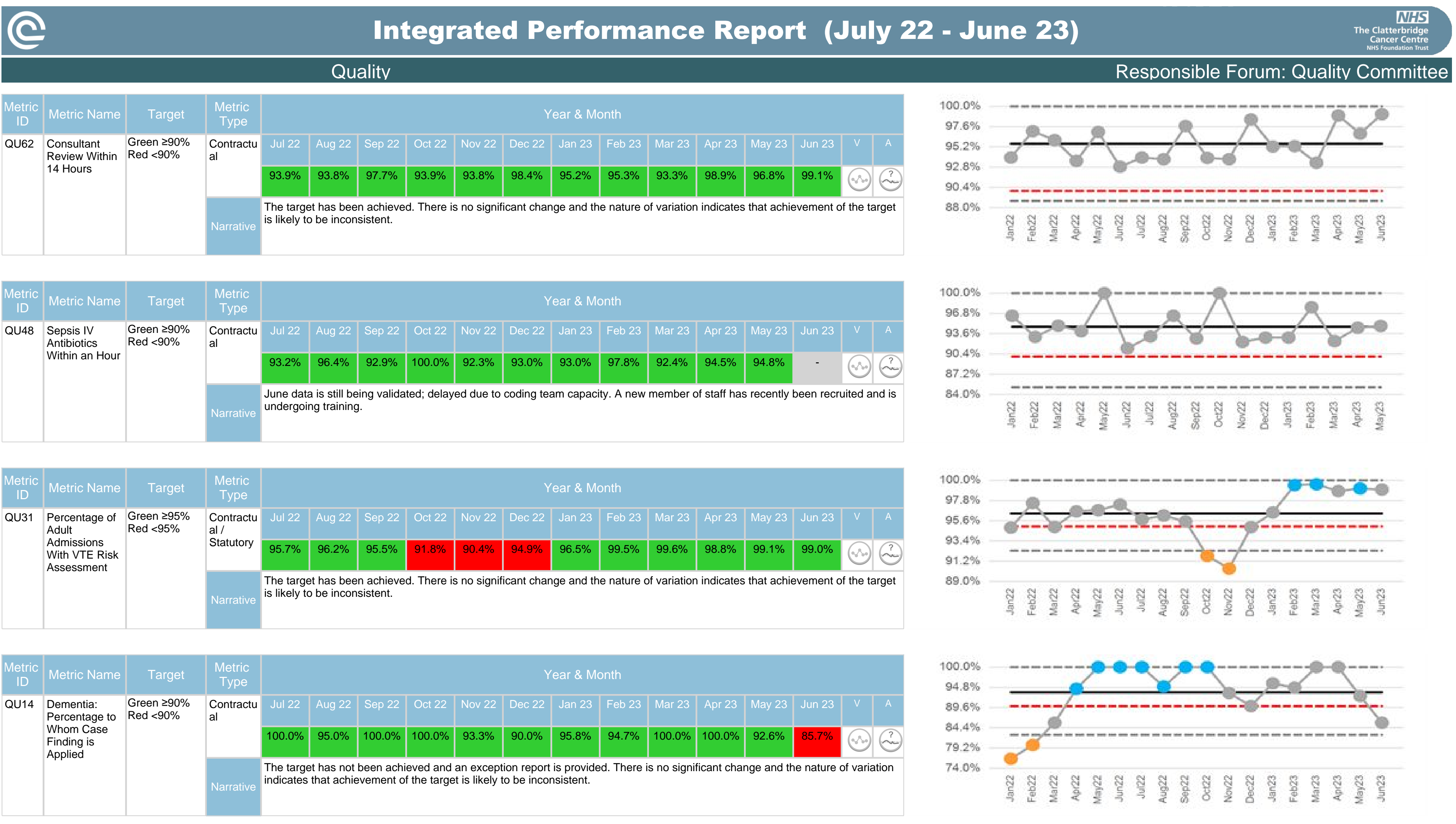
Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU09	Pressure Ulcers (Hospital Acquired Grade 3/4, With a Lapse in Care) /1,000 Bed Days	Green 0 Red >0	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target continues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

Data Not Applicable for SPC

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

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

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



Integrated Performance Report (July 22 - June 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality | Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU62	Consultant Review Within 14 Hours	Green ≥90% Red <90%	Contractual	93.9%	93.8%	97.7%	93.9%	93.8%	98.4%	95.2%	95.3%	93.3%	98.9%	96.8%	99.1%		

Narrative: The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU48	Sepsis IV Antibiotics Within an Hour	Green ≥90% Red <90%	Contractual	93.2%	96.4%	92.9%	100.0%	92.3%	93.0%	93.0%	97.8%	92.4%	94.5%	94.8%	-		

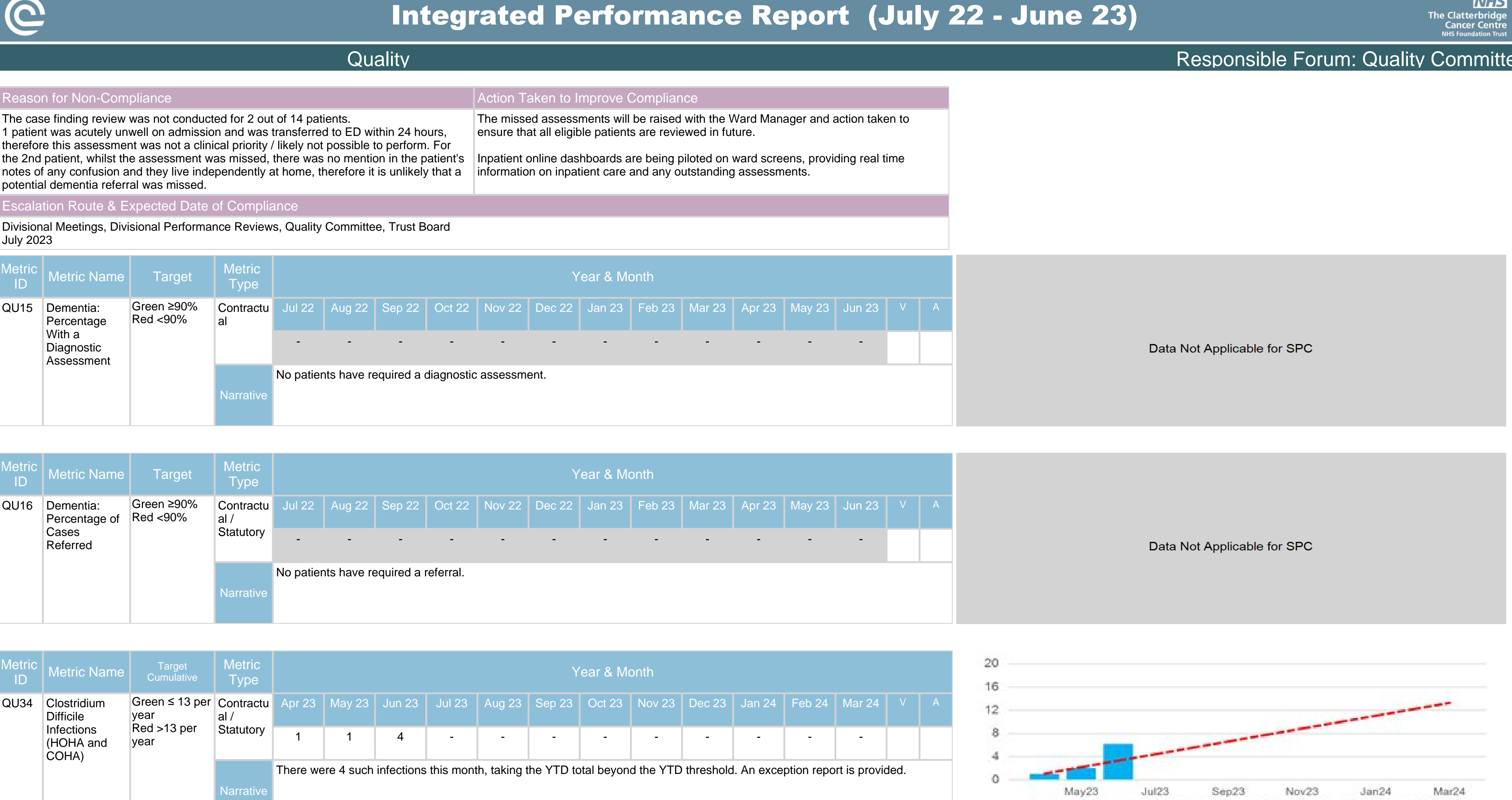
Narrative: June data is still being validated; delayed due to coding team capacity. A new member of staff has recently been recruited and is undergoing training.

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU31	Percentage of Adult Admissions With VTE Risk Assessment	Green ≥95% Red <95%	Contractual / Statutory	95.7%	96.2%	95.5%	91.8%	90.4%	94.9%	96.5%	99.5%	99.6%	98.8%	99.1%	99.0%		

Narrative: The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU14	Dementia: Percentage to Whom Case Finding is Applied	Green ≥90% Red <90%	Contractual	100.0%	95.0%	100.0%	100.0%	93.3%	90.0%	95.8%	94.7%	100.0%	100.0%	92.6%	85.7%		

Narrative: The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.



Integrated Performance Report (July 22 - June 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality | Responsible Forum: Quality Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
The case finding review was not conducted for 2 out of 14 patients. 1 patient was acutely unwell on admission and was transferred to ED within 24 hours, therefore this assessment was not a clinical priority / likely not possible to perform. For the 2nd patient, whilst the assessment was missed, there was no mention in the patient's notes of any confusion and they live independently at home, therefore it is unlikely that a potential dementia referral was missed.	The missed assessments will be raised with the Ward Manager and action taken to ensure that all eligible patients are reviewed in future. Inpatient online dashboards are being piloted on ward screens, providing real time information on inpatient care and any outstanding assessments.

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

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

Data Not Applicable for SPC

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

Data Not Applicable for SPC

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU34	Clostridium Difficile Infections (HOHA and COHA)	Green ≤ 13 per year Red >13 per year	Contractual / Statutory	1	1	4	-	-	-	-	-	-	-	-	-		
			Narrative	There were 4 such infections this month, taking the YTD total beyond the YTD threshold. An exception report is provided.													

Integrated Performance Report (July 22 - June 23)

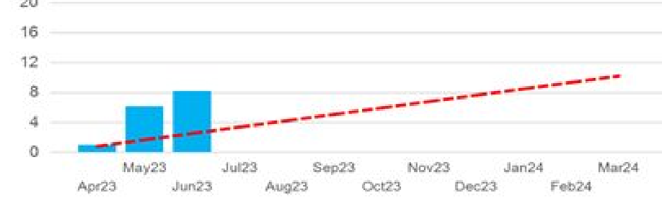
Quality | Responsible Forum: Quality Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
One COHA and three HOHA C.diff infections were identified in June 2023. In all instances, delays in sampling and gaps in documentation were identified. Whilst this did not contribute to the development of the infections, we are unable to demonstrate optimal care. Definitions: HOHA: Hospital-Onset Healthcare Associated, where days from admission to specimen date is equal to or greater than 3 days COHA: Community Onset Healthcare Associated, cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks	Matrons and Divisional Director of Nursing met with Director of Infection Prevention and Control, Infection Control Doctor and Infection Control Lead Nurse. A trial of paper stool charts was agreed with space for documentation when samples are sent as concerns were raised that samples are lost between the wards and LCL.

Escalation Route & Expected Date of Compliance

Harm Free Care Meeting, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board
August 2023

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU40	E. Coli Bacteraemia (HOHA and COHA)	Green ≤ 10 per year Red >10 per year	Contractual / Statutory	1	5	2	-	-	-	-	-	-	-	-	-		
			Narrative	There were 2 such infections this month and the YTD total remains above the YTD threshold. An exception report is provided.													

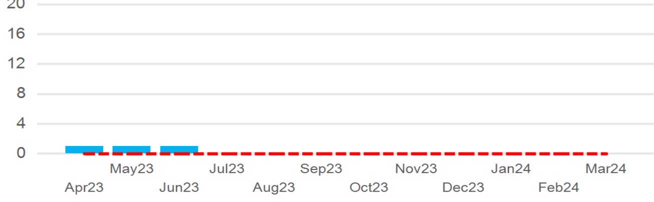


Reason for Non-Compliance	Action Taken to Improve Compliance
1 COHA E.coli bloodstream infection was identified in June. Cultures were obtained in an outpatient setting, but the patent had recently had an admission to CCC. Source was likely to be urinary in origin. No lapses in care identified. 1 HOHA E.coli bloodstream infection was identified. This was likely to be gastro-intestinal in origin. No lapses in care identified.	N/A

Escalation Route & Expected Date of Compliance

Harm Free Care Meeting, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board
July 2023

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



Integrated Performance Report (July 22 - June 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

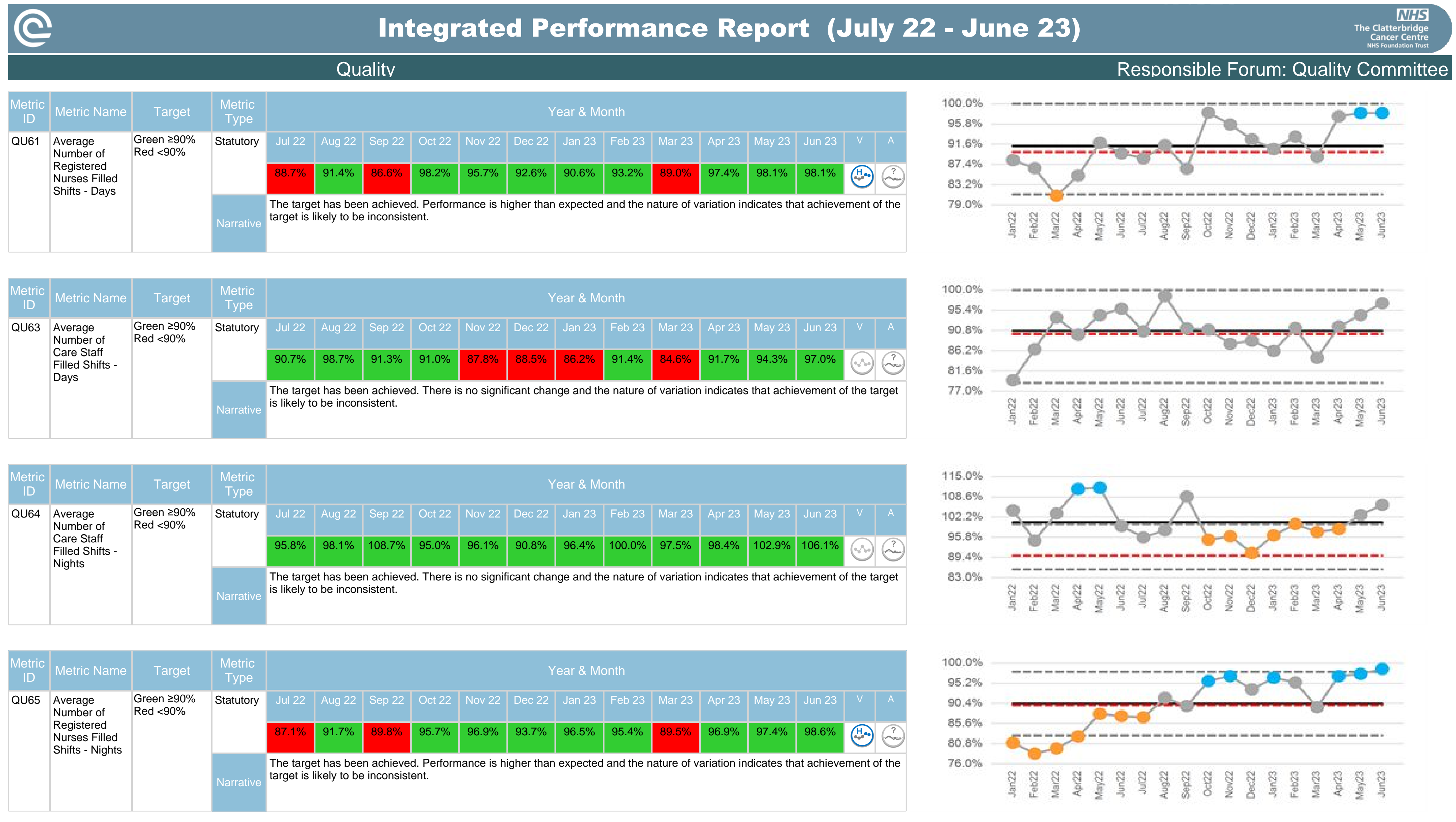
Responsible Forum: Quality Committee

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU38	MSSA Bacteraemia (HOHA and COHA)	Green ≤ 4 per year Amber 5 Red >5 per year	Contractual / Statutory	0	3	0	-	-	-	-	-	-	-	-	-		
			Narrative	There were no such infections this month.													

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

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

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU66	Safer Staffing: Overall Fill-Rate	Green ≥90% Red <90%	Statutory	89.9%	91.6%	92.0%	95.4%	94.3%	91.7%	92.3%	94.8%	89.8%	96.3%	98.1%	99.4%		
			Narrative	The target has been achieved. Performance is higher than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Integrated Performance Report (July 22 - June 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU61	Average Number of Registered Nurses Filled Shifts - Days	Green ≥90% Red <90%	Statutory	88.7%	91.4%	86.6%	98.2%	95.7%	92.6%	90.6%	93.2%	89.0%	97.4%	98.1%	98.1%		
			Narrative	The target has been achieved. Performance is higher than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU63	Average Number of Care Staff Filled Shifts - Days	Green ≥90% Red <90%	Statutory	90.7%	98.7%	91.3%	91.0%	87.8%	88.5%	86.2%	91.4%	84.6%	91.7%	94.3%	97.0%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU64	Average Number of Care Staff Filled Shifts - Nights	Green ≥90% Red <90%	Statutory	95.8%	98.1%	108.7%	95.0%	96.1%	90.8%	96.4%	100.0%	97.5%	98.4%	102.9%	106.1%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU65	Average Number of Registered Nurses Filled Shifts - Nights	Green ≥90% Red <90%	Statutory	87.1%	91.7%	89.8%	95.7%	96.9%	93.7%	96.5%	95.4%	89.5%	96.9%	97.4%	98.6%		
			Narrative	The target has been achieved. Performance is higher than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Integrated Performance Report (July 22 - June 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality | Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU60	NICE Guidance Compliance	Green ≥90% Amber 85 - 89.9% Red <85%	Contractual	93.9%	93.4%	92.8%	94.7%	93.8%	94.0%	95.8%	95.6%	95.4%	95.0%	96.5%	97.6%		
			Narrative	The target has been achieved. Performance is higher than expected and the target is outside SPC limits and is therefore likely to be achieved consistently.													

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

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

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

Data Not Applicable for SPC

Integrated Performance Report (July 22 - June 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

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

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU20	% of Routine Complaints Resolved Within 25 Working Days	Green ≥75% Amber 65% - 74.9% Red <65%	Local	75.0%	66.7%	50.0%	100.0%	100.0%	50.0%	50.0%	100.0%	100.0%	66.7%	50.0%	33.3%		?
			Narrative	The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

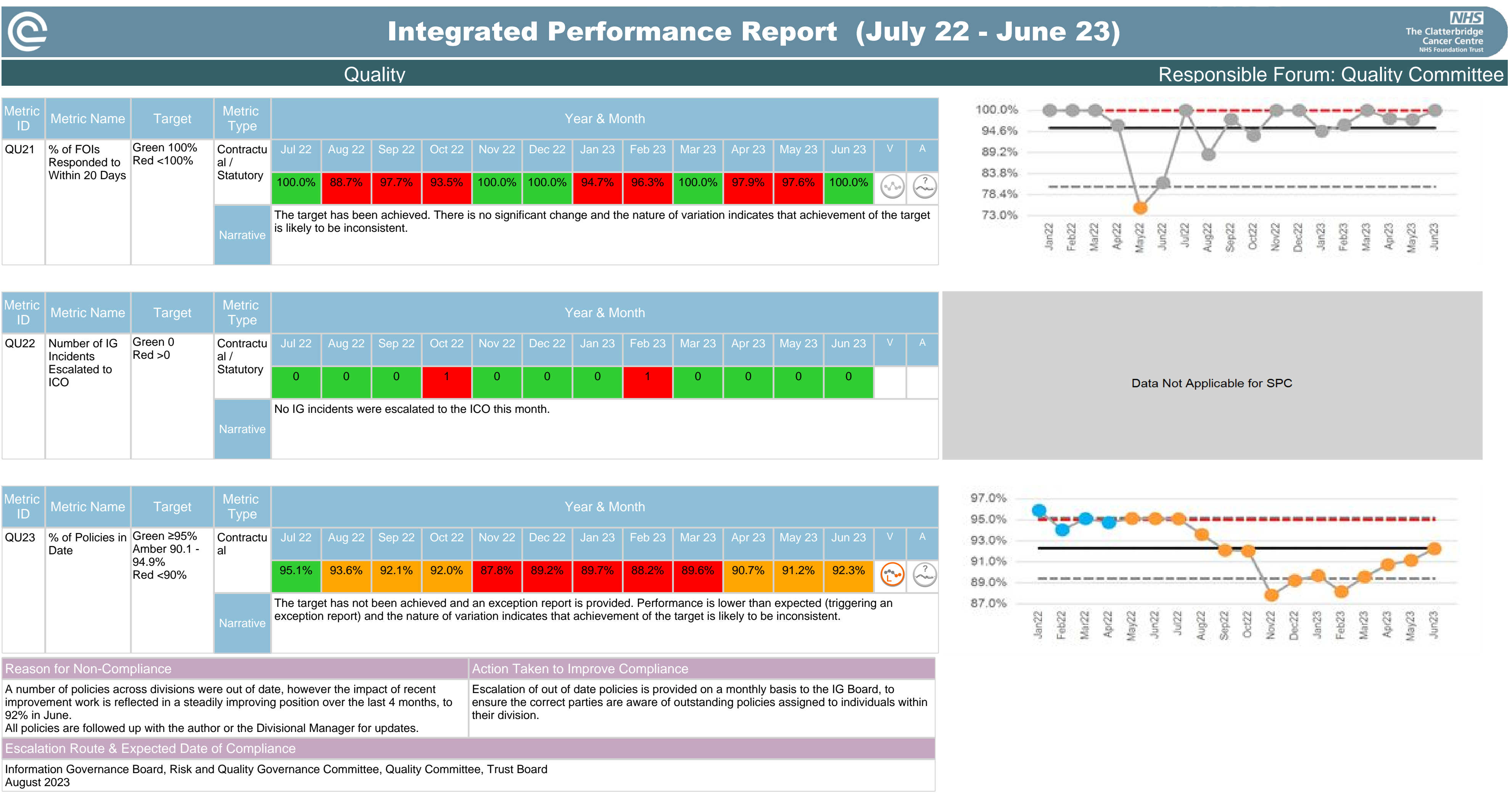
Reason for Non-Compliance	Action Taken to Improve Compliance
Two of three complaints were not resolved within the 25 working day timescale. A three day extension was required on one response due to unexpected leave and a ten day extension was agreed on the second as additional clarification was required in respect of some points within the response before final approval. All extensions were agreed with complainants prior to approval.	As part of the complaints process review, the Complaints Manager is identifying a timeframe matrix to ensure that the appropriate time for investigation and response is allocated to complaints that are received by the organisation.

Escalation Route & Expected Date of Compliance

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

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU71	% of Complex Complaints Resolved Within 60 Working Days	Green ≥75% Amber 65% - 74.9% Red <65%	Local	100.0%	100.0%	50.0%	-	-	-	66.7%	100.0%	50.0%	50.0%	50.0%	100.0%		
			Narrative	The target has been achieved this month.													

Data Not Applicable for SPC



Integrated Performance Report (July 22 - June 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU21	% of FOIs Responded to Within 20 Days	Green 100% Red <100%	Contractual / Statutory	100.0%	88.7%	97.7%	93.5%	100.0%	100.0%	94.7%	96.3%	100.0%	97.9%	97.6%	100.0%		

Narrative: The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU22	Number of IG Incidents Escalated to ICO	Green 0 Red >0	Contractual / Statutory	0	0	0	1	0	0	0	1	0	0	0	0		

Narrative: No IG incidents were escalated to the ICO this month.

Data Not Applicable for SPC

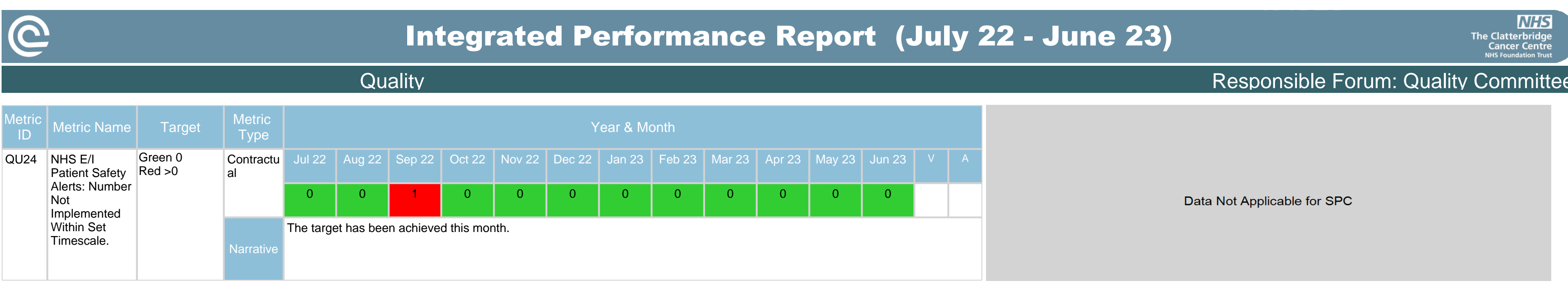
Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU23	% of Policies in Date	Green ≥95% Amber 90.1 - 94.9% Red <90%	Contractual	95.1%	93.6%	92.1%	92.0%	87.8%	89.2%	89.7%	88.2%	89.6%	90.7%	91.2%	92.3%		

Narrative: The target has not been achieved and an exception report is provided. Performance is lower than expected (triggering an exception report) and the nature of variation indicates that achievement of the target is likely to be inconsistent.

Reason for Non-Compliance	Action Taken to Improve Compliance
A number of policies across divisions were out of date, however the impact of recent improvement work is reflected in a steadily improving position over the last 4 months, to 92% in June. All policies are followed up with the author or the Divisional Manager for updates.	Escalation of out of date policies is provided on a monthly basis to the IG Board, to ensure the correct parties are aware of outstanding policies assigned to individuals within their division.

Escalation Route & Expected Date of Compliance

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



Integrated Performance Report (July 22 - June 23)

Quality | Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
QU24	NHS E/I Patient Safety Alerts: Number Not Implemented Within Set Timescale.	Green 0 Red >0	Contractual	0	0	1	0	0	0	0	0	0	0	0	0		
			Narrative	The target has been achieved this month.													

Data Not Applicable for SPC

Integrated Performance Report (July 22 - June 23)

Research & Innovation

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
RI20	Study Recruitment	Green ≥1500 per year Amber 1275-1499 per year Red <1275 per year	CCC Strategy	62	69	116	-	-	-	-	-	-	-	-	-		
			Narrative	The monthly and YTD performance is below the target, therefore an exception report is provided.													

Reason for Non-Compliance

249 patients have been recruited between April and June 2023 against an internal target of 375 (66% of target) at the end of Month 3. Of the 116 patients recruited 20 were recruited onto interventional studies, 59 onto observational studies and 37 into the Biobank. To note, 29 patients recruited into the Biobank were recruited during April and May 2023 but could not be uploaded onto the information system. These data have been added to the June 2023 data. The main reasons at Month 3 for not achieving the overall target are:

- Concentrated focus needed on interventional clinical trial recruitment which has not yet fully recovered. Research Study Prioritisation Committee to address this.
- A high number of complex, low recruiting studies have been opened since December 2021 when the Research Study Prioritisation Committee was initiated.
- A number of our larger observational studies have closed or will be closing to recruitment soon.
- To note, recruitment is higher at Month 3 23/24 than pre-pandemic levels during 19/20.

Action Taken to Improve Compliance

- Clinical Research Gap Analysis paper to be monitored monthly via R&I Directorate Board and an update to TEG every 4 months.
- Research Study Prioritisation Committee to review strategy for trial selection.
- Continue to work collaboratively with service departments and research-active staff to open all studies types in a timely way.
- Research Priorities meeting taken place to determine where resource will be focused. Workshop took place at Research@Clatterbridge Day on 13th June 2023.
- Initiate clinically-led programme of work to increase home grown research to boost recruitment numbers.

To note:

- Recruitment has started onto the strategically important, recently opened, BNT122 colorectal cancer vaccine study (PI: Dr Mantazeri, lower GI).
- 6 new clinical research studies opened meeting monthly target. Two are non-interventional/ observational. Four are interventional, of which two are phase III trials in the haemato-oncology portfolio. We have opened the first early phase trial as part of the Liverpool CRF which is also a First-in-Human trial and an exciting new commercial trial in the brain portfolio testing a new device plus radiotherapy in newly diagnosed gioblastoma.

Escalation Route & Expected Date of Compliance

R&I Directorate Board, Committee for Research Strategy, Performance Committee, Trust Board
March 2024

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

Integrated Performance Report (July 22 - June 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

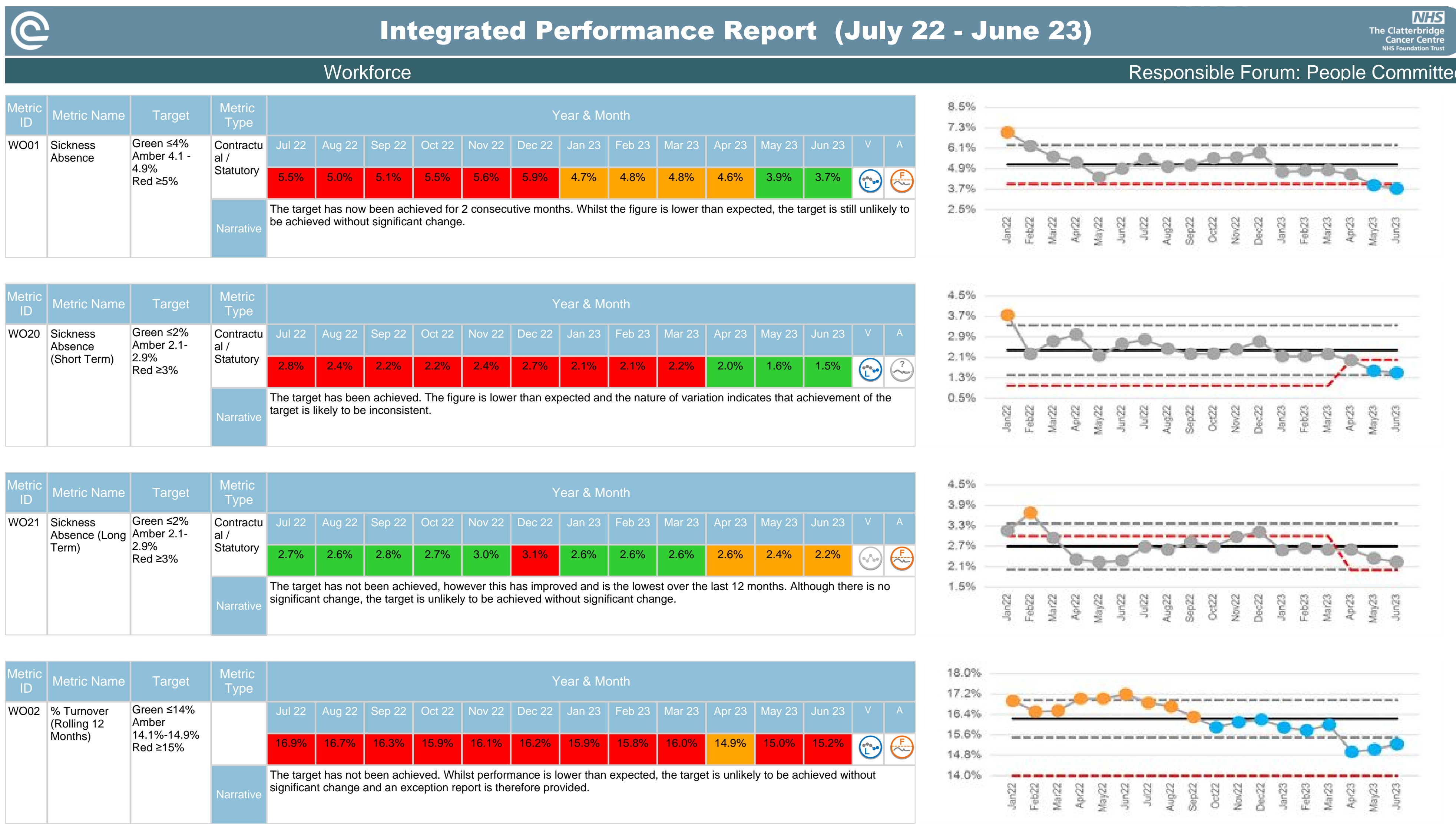
Responsible Forum: Performance Committee

Metric ID	Metric Name	Target Cumulative	Metric Type	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	V	A
RI10	Number of Patients Recruited (Non-Commercial, Portfolio Studies)	Green ≥500 per year Amber 425-499 Red <425		78	24	45	121	93	62	55	82	74	-	-	-		
			Narrative	Both the monthly and YTD targets have been achieved. The reporting period for this KPI is Oct - Sept rather than April - March.													

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

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
RI05	Number of New Studies Open to Recruitment	Green ≥52 per year Amber 45 - 51 Red <45	CCC Strategy	3	5	6	-	-	-	-	-	-	-	-	-		
			Narrative	The monthly and YTD targets have been achieved.													

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
RI22	Publications	Green >200 per year Amber 170-200 Red <170	CCC Strategy	11	17	31	-	-	-	-	-	-	-	-	-		
			Narrative	The monthly and YTD targets have been achieved.													



Integrated Performance Report (July 22 - June 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Responsible Forum: People Committee

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
WO01	Sickness Absence	Green ≤4% Amber 4.1 - 4.9% Red ≥5%	Contractual / Statutory	5.5%	5.0%	5.1%	5.5%	5.6%	5.9%	4.7%	4.8%	4.8%	4.6%	3.9%	3.7%		
			Narrative	The target has now been achieved for 2 consecutive months. Whilst the figure is lower than expected, the target is still unlikely to be achieved without significant change.													

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
WO20	Sickness Absence (Short Term)	Green ≤2% Amber 2.1-2.9% Red ≥3%	Contractual / Statutory	2.8%	2.4%	2.2%	2.2%	2.4%	2.7%	2.1%	2.1%	2.2%	2.0%	1.6%	1.5%		
			Narrative	The target has been achieved. The figure is lower than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
WO21	Sickness Absence (Long Term)	Green ≤2% Amber 2.1-2.9% Red ≥3%	Contractual / Statutory	2.7%	2.6%	2.8%	2.7%	3.0%	3.1%	2.6%	2.6%	2.6%	2.6%	2.4%	2.2%		
			Narrative	The target has not been achieved, however this has improved and is the lowest over the last 12 months. Although there is no significant change, the target is unlikely to be achieved without significant change.													

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
WO02	% Turnover (Rolling 12 Months)	Green ≤14% Amber 14.1%-14.9% Red ≥15%		16.9%	16.7%	16.3%	15.9%	16.1%	16.2%	15.9%	15.8%	16.0%	14.9%	15.0%	15.2%		
			Narrative	The target has not been achieved. Whilst performance is lower than expected, the target is unlikely to be achieved without significant change and an exception report is therefore provided.													

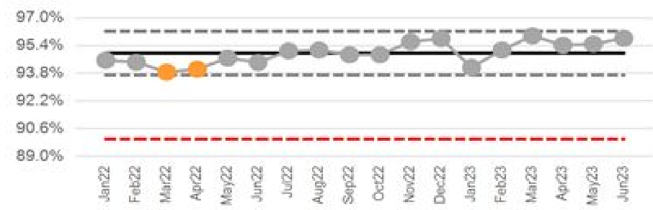
Integrated Performance Report (July 22 - June 23)

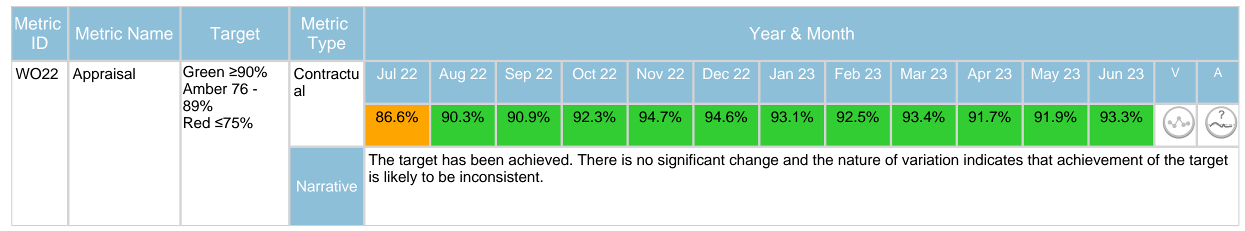
Workforce | Responsible Forum: People Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
The Trust turnover has increased in June from 15.03% to 15.24% and continues to be above the Trust target. However if leavers due to retirement and end of fixed term contracts (FTC) were removed from the data set, the Trust would be at 13.37%, which is below target. (7.60 wte FTC and 22.67 wte for Retirement). There were 34 leavers in June compared with 24 in May, 2 were due to retirement / end of fixed term contract. The top three reasons for leaving in June were; 1.Employee Transfer – this related to the TUPE transfer of 18 staff in Charity as of 1st July 2023, 2. Promotion – 4 staff 3. Relocation – 3 Staff Hosted services had the highest percentage of leavers with 22% in total and this is due to the TUPE transfer. Quality then had the highest percentage in relation to staff numbers with 2% amounting to 1 leaver. Networked Services was the third highest with 1.3% amounting to 8 leavers.	The HRBP Team to continue to push for exit interviews to be completed to ensure that we are receiving useful information which can drive improvements and reduce turnover. The HRBP team to work with managers to try to understand further the reasons that staff are leaving due to 'work life balance' and to ensure that it is being accurately recorded. The HRBP team discuss flexible working regularly with managers to ensure that staff are supported to work flexibly where possible. The Trust has recruited an APH and Nursing Development Lead (start date October 2023) who will take a lead role in supporting retention innervations for clinical staff.

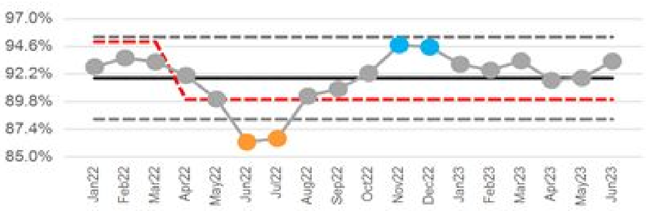
Escalation Route & Expected Date of Compliance
Divisional Meetings, Divisional Performance Reviews, Workforce Advisory Committee, People Committee, Trust Board July 2023

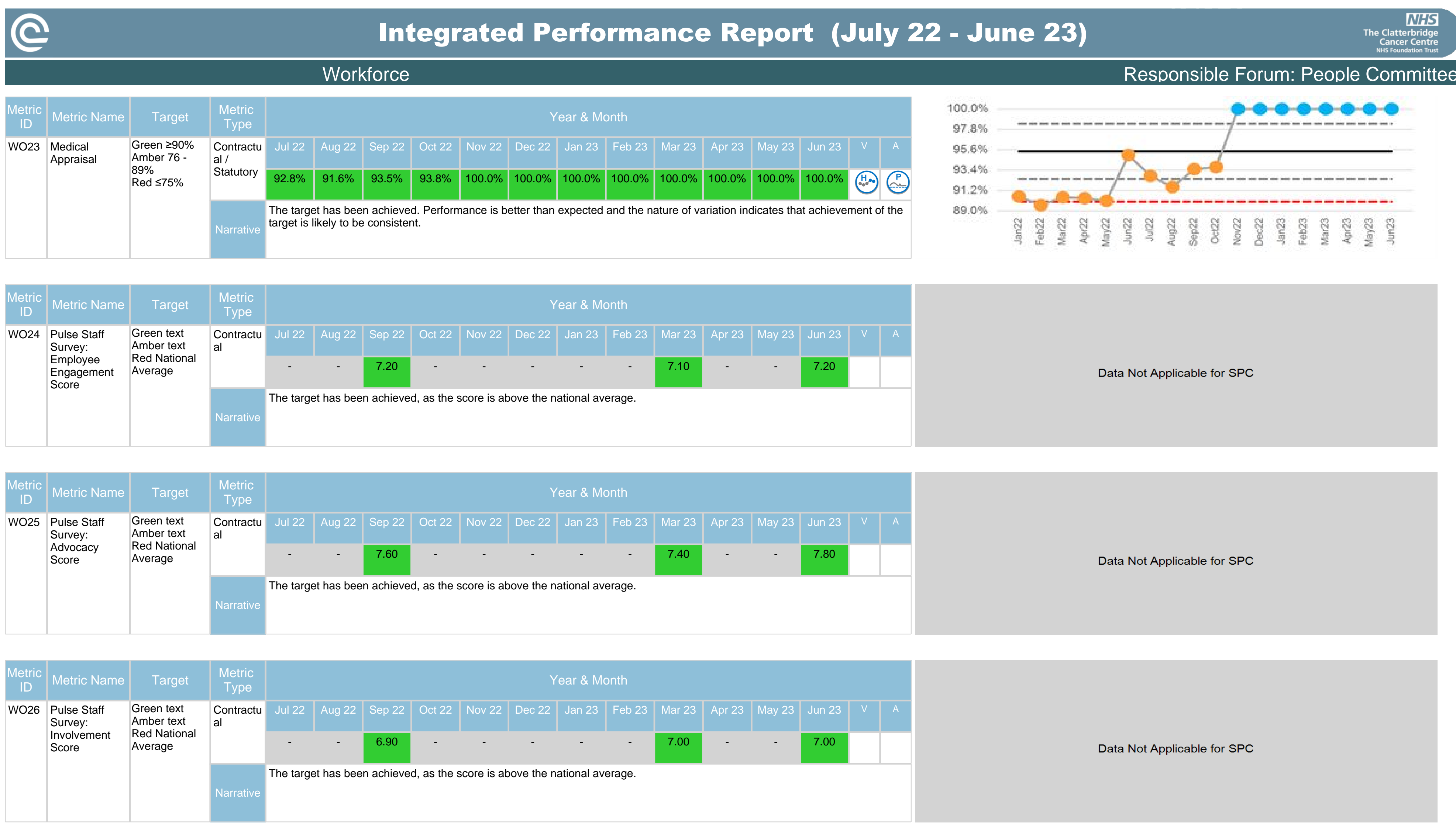
Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
WO07	Statutory Mandatory Training Compliance	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual / Statutory	95.1%	95.1%	94.9%	94.9%	95.6%	95.8%	94.1%	95.1%	96.0%	95.4%	95.5%	95.8%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





Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
WO22	Appraisal	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual	86.6%	90.3%	90.9%	92.3%	94.7%	94.6%	93.1%	92.5%	93.4%	91.7%	91.9%	93.3%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													





Integrated Performance Report (July 22 - June 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Responsible Forum: People Committee

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

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
WO24	Pulse Staff Survey: Employee Engagement Score	Green text Amber text Red National Average	Contractual	-	-	7.20	-	-	-	-	-	7.10	-	-	7.20		
			Narrative	The target has been achieved, as the score is above the national average.													

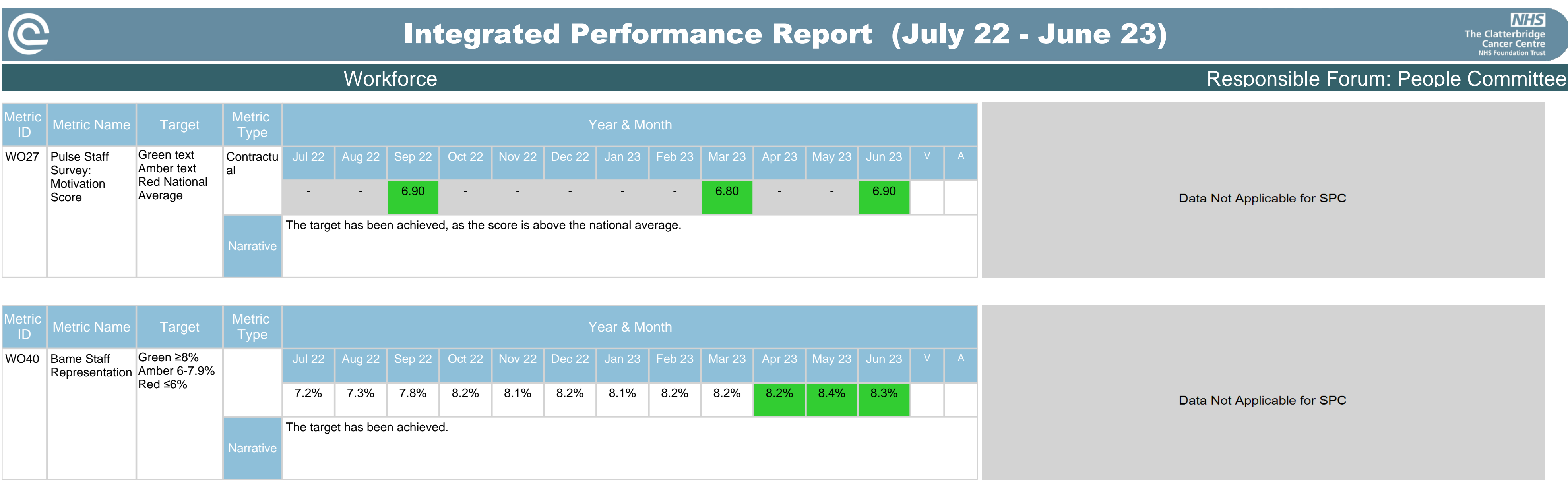
Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
WO25	Pulse Staff Survey: Advocacy Score	Green text Amber text Red National Average	Contractual	-	-	7.60	-	-	-	-	-	7.40	-	-	7.80		
			Narrative	The target has been achieved, as the score is above the national average.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
WO26	Pulse Staff Survey: Involvement Score	Green text Amber text Red National Average	Contractual	-	-	6.90	-	-	-	-	-	7.00	-	-	7.00		
			Narrative	The target has been achieved, as the score is above the national average.													

Data Not Applicable for SPC



Integrated Performance Report (July 22 - June 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Responsible Forum: People Committee

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
WO27	Pulse Staff Survey: Motivation Score	Green text Amber text Red National Average	Contractual	-	-	6.90	-	-	-	-	-	6.80	-	-	6.90		
			Narrative	The target has been achieved, as the score is above the national average.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	V	A
WO40	Bame Staff Representation	Green ≥8% Amber 6-7.9% Red ≤6%		7.2%	7.3%	7.8%	8.2%	8.1%	8.2%	8.1%	8.2%	8.2%	8.2%	8.4%	8.3%		
			Narrative	The target has been achieved.													

Data Not Applicable for SPC

Integrated Performance Report (July 22 - June 23)

Finance

Responsible Forum: Performance Committee

Metric (£000)	In Mth 3 Actual	In Mth 3 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	(50)	30	(80)		(178)	91	(269)	
CPL/Propcare Surplus/ (Deficit)	81	0	81		271	0	271	
Control Total Surplus/ (Deficit)	31	30	1		93	91	2	
Trust Cash holding	61,664	62,731	(1,067)		61,664	62,731	(1,067)	
Capital Expenditure	102	102	0		194	194	0	
Agency Cap	88	149	61		302	447	145	

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

The Trust financial position to month 3 (June 2023) is a deficit of £178k, which is £269k behind plan. The group position is a £93k surplus and is £2k better than plan.

The Trust cash position is £61.6m, which is behind plan by £1.1m. Capital spend is £194k in the year to date, with the majority of capital spend profiled later in the year.

The agency cap has been re-set based on prior year spend and for the year to date the Trust is reporting below the agency cap by £145k.

Trust Board
July 2023

Report author	James Thomson – Director of Finance
Paper prepared by	Jo Bowden – Deputy Director of Finance
Report subject/title	Finance Report – Month 3 2023/24 80-23/24
Purpose of paper	To present the Trust's financial position at the end of June 2023.
Background papers	N/A
Action required	To note the contents of the report

Link to: Strategic Direction Corporate Objectives				
	Be Outstanding	X	Be a great place to work	
	Be Collaborative		Be Digital	
	Be Research Leaders		Be Innovative	

Equality & Diversity Impact Assessment

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

1. Introduction

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

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

2. Summary Financial Performance:

2.1 For June the key financial headlines are:

Metric (£000)	In Mth 3 Actual	In Mth 3 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	(50)	30	(80)		(178)	91	(269)	
CPL/Propcare Surplus/ (Deficit)	81	0	81		271	0	271	
Control Total Surplus/ (Deficit)	31	30	1		93	91	2	
Trust Cash holding	61,664	62,731	(1,067)		61,664	62,731	(1,067)	
Capital Expenditure	102	102	0		194	194	0	
Agency Cap	88	149	61		302	447	145	

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

3. Operational Financial Profile – Income and Expenditure

Overall Income and Expenditure Position

3.1 The Trust financial position to the end of June is a £178k deficit, which is £269k below plan. The group is showing a £2k surplus to the end of June.

3.2 The Trust cash position is a closing balance of £61.6m, which is below plan by £1.07m. Capital spend is £194k for the year to date, with the majority of spend profiled in future months.

3.3 The Trust put an agency plan forward as part of the planning submission based on previous year spend, which it will be monitored against for the 2023/24 financial year. To month 3 agency spend is below plan by £145k.

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

	Actual M3	Trust Plan M3	Variance	Actual YTD	YTD Budget	Variance	Plan 23.24
Clinical Income	22,395	22,271	124	64,755	65,569	(814)	251,122
Other Income	895	861	34	4,994	4,354	640	15,031
Total Operating Income	**23,290**	**23,132**	**158**	**69,749**	**69,923**	**(174)**	**266,153**
Total Operating Expenditure	(23,284)	(23,246)	(38)	(69,668)	(69,450)	(218)	(263,938)
Operating Surplus	**5**	**(114)**	**120**	**81**	**473**	**(392)**	**2,215**
PPJV	104	67	37	216	201	15	804
Finance Costs	(159)	78	(236)	(475)	(583)	108	(2,656)
Trust Surplus/(Deficit)	**(50)**	**30**	**(80)**	**(178)**	**91**	**(269)**	**363**
Subsidiaries	81	0	81	271	0	271	-
Consolidated Surplus/Deficit	**31**	**30**	**1**	**93**	**91**	**2**	**363**

The table below summaries the consolidated financial position:

June 2023-24 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	(133)	(427)
Donated Depreciation	83	249
Trust Retained Surplus / (Deficit)	**(50)**	**(178)**
CPL	54	144
Propcare	28	126
Consolidated Financial Position	**31**	**93**

3.5 The bridge below shows the key drivers between the £178k in month deficit and £91k surplus plan, which is a variance of £269k:

- As part of the financial plan the Trust has assumed an additional £1.6m of income for activity over and above 2023/24 activity levels. As part of month 3 the Trust has made an assumption that the income will be received as so has included income of £133k.

- Cost and Volume drugs are overspent by £843k and are offset by an increase to income. Block drugs are underspent by £18k in month 3. As part of the 2023/24 funding agreement with commissioners high cost drugs remain on a pass-through basis.

- Trust Pay costs are over spent by £325k, this including unmet CIP of £314k. There has been an increase of 27.7wte compared to month 2, which is reducing vacancy gap.

- The national payaward including 2022-23 backpay has been received in month 3. The backpay relating to 2022-23 financial year as been offset by additional income received from comissioners based on an exercise completed last financial year. For 2023-24 there was 2% included in the inflationary uplift relating to pay, since the announcement of 5% contracts have been increased by 1.6% to reflect this. The Trust has increased income and pay expenditure budgets to reflect the changes.

- Bank spend is £207k in month 3, which is similar to month 2. £18k of this is backpay due to the payaward. The spend is mainly due to 1:1 care required on the wards and escalation beds remaining open.

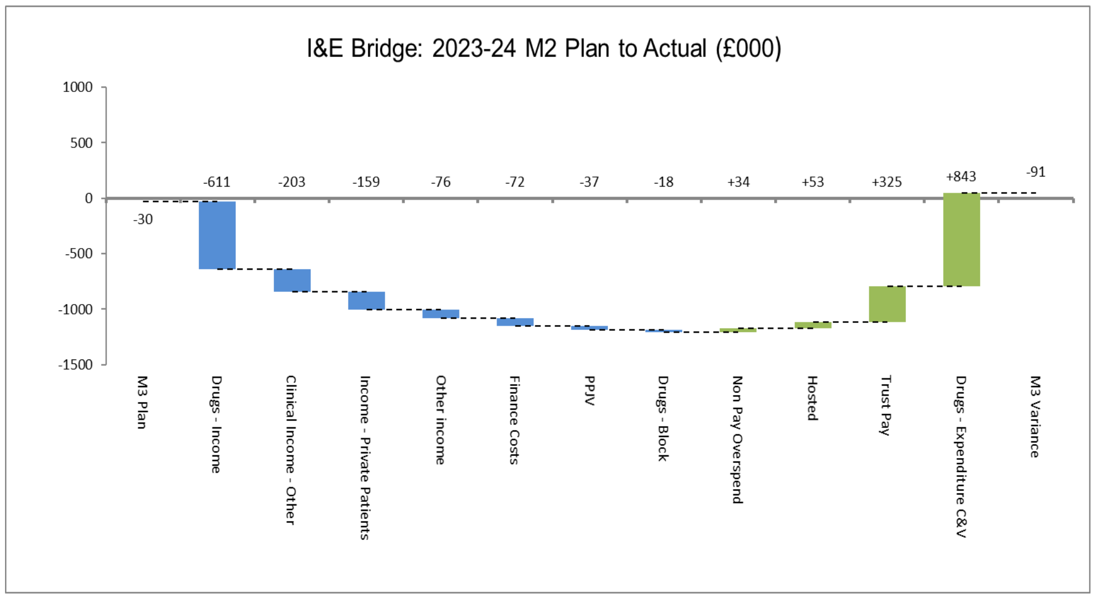
- Agency spend is £88k in month, which is a reduction from last month. Agency spend is lower than plan by £61k.

- Private patients income is above plan by £159k, this will be reviewed as part of the CIP programme.

- Other income includes PET CT Income which above plan and will be reviewed as part of the Trust CIP programme.

- Non pay is overspent by £34k. CIP in month is showing as over achieved for non-pay by £84k, this is due to profiling with CIP schemes being taken from a budgetary point of view that relate to months 1 and 2.

- Interest receivable is over plan by £54k in month 3, this relates to increasing interest rates.



3.6 **Bank and Agency Reporting**

Bank spend remains high at £207k in month 3, of which £18k relates to the national payaward backdated to April. The spend is mainly due to 1:1 care required on the wards and escalation beds remaining open. A detailed piece of work is currently being scoped to understand the costs which are directly attributable to the escalation beds remaining open.

Agency spend is £88k in month, which is a reduction compared to month 2. The Trust is reporting below plan in month by of £61k. The Trust submitted a plan for agency spend as part of the national planning submission which was based on 2022.23 spend and this is the target the Trust will be monitored against for the 2023.24 financial year

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

See Appendix F for further detail.

3.7 **Cost Improvement Programme (CIP)**

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

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

CIP has been allocated as below:

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

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

There has been £3.5m (42.7%) of the CIP target identified at month 3. £1.7m of these savings are recurrent. There are also a further £304k (3.3%) of schemes with submitted forms.

There are 51 potential schemes at the initial idea stage that are currently being worked through and the Trust is forecasting to achieve the full CIP target, although an element through non-recurrent means.

The Trust has introduced pipeline reporting categories from initial idea (red), costed (amber), start date (green) and transacted (blue). This will help to demonstrate progression and support conversations relating to the schemes.

The Trust has also introduced escalation thresholds as follows:

	Escalation Threshold	CIP Value £m
End Q1	25% Amber/Green 25% Blue	£2.1m £2.1m
End Q2	50% Amber/Green 40% Blue	£4.2m £3.3m
End Q3	40% Amber/Green 60% Blue	£3.3m £5.0m
End Q4	100% Blue	£8.3m

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

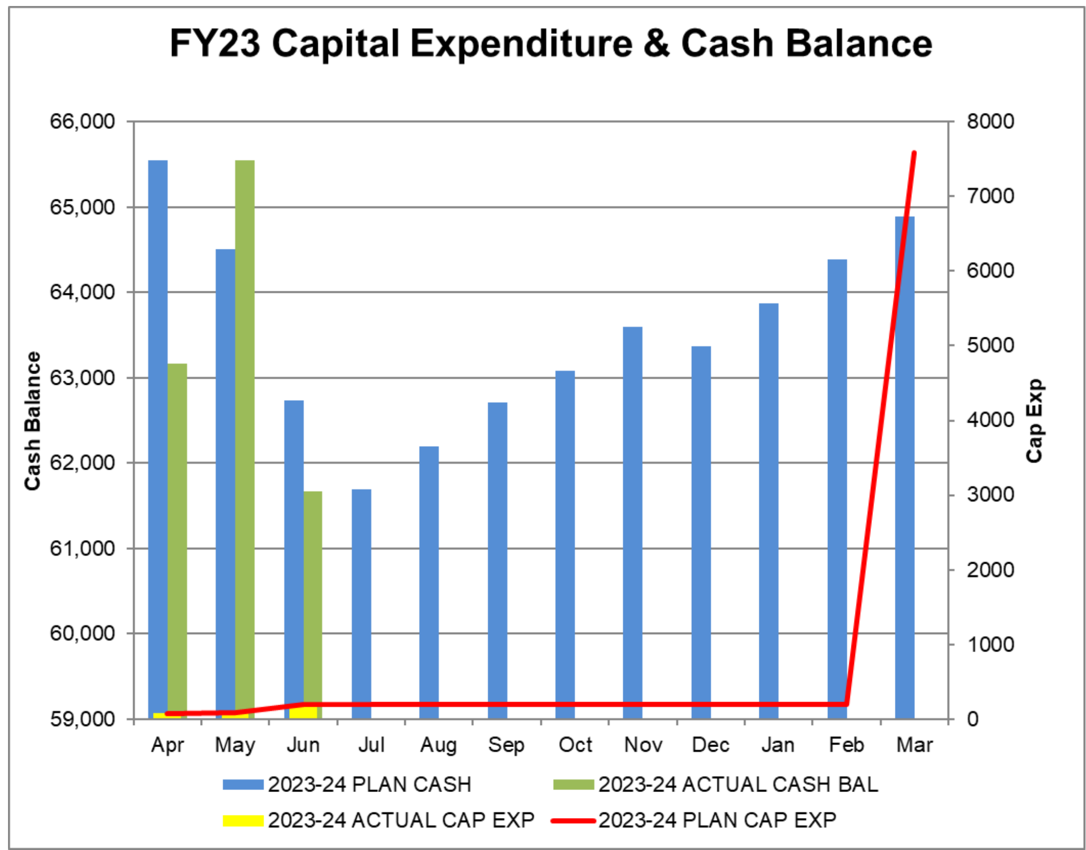
4. Cash and Capital

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

4.2 Capital expenditure of £194k has been incurred to the end of June. With the majority of capital spend profiled for future months.

4.3 The capital programme is supported by the organisation’s cash position. The Trust has a current cash position of £61.7m. The cash position is behind plan by £1m, part of this being due to no income being received from commissioners in relation to Cancer Alliance for the first quarter.

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



This chart shows monthly planned and actual Cash Balances and Planned Capital Expenditure for 2023/24.

5. Balance Sheet Commentary

5.1 Current Assets

The Trust's cash balance at the end of June is £61.7m, this is £1m behind the plan figure of £62.7m.

Receivables are lower than plan by £1.6m, demonstrating that debt continues to be collected promptly.

5.2 Current Liabilities

Payables (non-capital creditors) are above plan by £13.2m. This is due to a number of outstanding invoices within Propcare related to steam and R&I invoices that are under query.

Deferred Income is £11.9m above plan. This relates in the main to R&I income and Cancer Alliance both of which have a number of multi-year schemes which are ongoing.

6. Recommendations

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

- The Month 3 Trust and group position.
- The continuing strong liquidity position of the Trust.

Appendix A – Statement of Comprehensive Income (SOCI)

	Month 3			YTD			%	2023/24 Annual Plan
	Plan	Actual	Variance	Plan	Actual	Variance		
Clinical Income	19,806	20,779	973	58,326	60,004	1,678		233,243
Other Income	211	286	76	1,899	2,315	416		7,414
Hosted Services	3,115	2,225	(890)	9,697	7,430	(2,267)		25,496
Total Operating Income	**23,132**	**23,290**	**158**	**69,923**	**69,749**	**(174)**	**0%**	**266,153**
Pay: Trust (excluding Hosted)	(6,871)	(7,195)	**(325)**	(21,042)	(21,625)	(583)		(84,291)
Pay: Hosted & R&I	(1,244)	(1,097)	147	(3,175)	(2,748)	427		(11,411)
Drugs expenditure	(8,069)	(8,894)	**(825)**	(24,207)	(25,767)	(1,560)		(96,828)
Other non-pay: Trust (excluding Hosted)	(5,109)	(4,835)	274	(14,398)	(14,773)	(375)		(56,500)
Non-pay: Hosted	(1,954)	(1,264)	690	(6,628)	(4,755)	1,873		(14,908)
Total Operating Expenditure	**(23,246)**	**(23,284)**	**(38)**	**(69,450)**	**(69,668)**	**(218)**	**0%**	**(263,938)**
Operating Surplus	**(114)**	**5**	**120**	**473**	**81**	**(392)**		**2,215**
Profit /(Loss) from Joint Venture	67	104	37	201	216	15		804
Interest receivable (+)	877	622	(255)	1,814	1,868	54		6,934
Interest payable (-)	(434)	(416)	19	(1,303)	(1,249)	54		(5,213)
PDC Dividends payable (-)	(365)	(365)	0	(1,094)	(1,094)	0		(4,377)
Trust Retained surplus/(deficit)	**30**	**(50)**	**(80)**	**91**	**(178)**	**(269)**		**363**
CPL/Propcare	0	81	81	0	271	271		0
Consolidated Surplus/(deficit)	**30**	**31**	**1**	**91**	**93**	**2**	**2%**	**363**

Appendix B – Balance Sheet

£'000	Unaudited 2223 (Group Ex Charity)	Plan 2324 (Trust only)	Year to date Month 3	
			Actual YTD	Variance
Non-current assets				
Intangible assets	6,741	3,486	6,344	2,857
Property, plant & equipment	201,605	189,187	199,304	10,116
Right of use assets	11,177	9,947	11,172	1,225
Investments in associates	1,304	455	769	314
Other financial assets	1,328	114,324	0	(114,324)
Trade & other receivables	448	2,382	821	(1,561)
Other assets	0	0	0	0
Total non-current assets	**222,603**	**319,782**	**218,410**	**14,852**
Current assets				
Inventories	4,175	2,000	5,017	3,016
Trade & other receivables				0
NHS receivables	18,989	5,642	12,736	7,094
Non-NHS receivables		9,299	10,897	1,598
Cash and cash equivalents	73,591	65,733	75,220	9,487
Total current assets	**96,754**	**82,675**	**103,869**	**12,673**
Current liabilities				
Trade & other payables				
Non-capital creditors		23,211	36,434	13,224
Capital creditors	32,986	2,493	2,348	(145)
Borrowings				0
Loans	2,233	1,892	1,805	(87)
Lease liabilities		0	334	334
Provisions	2,533	761	1,553	792
Other liabilities:-				0
Deferred income	13,531	7,822	19,728	11,907
Other	0	0	0	0
Total current liabilities	**51,283**	**36,179**	**62,203**	**24,861**
Total assets less current liabilities	**268,074**	**366,278**	**260,076**	(106,202)
Non-current liabilities				
Trade & other payables	2,189			
Capital creditors		0	0	0
Borrowings				0
Loans	40,714	37,627	29,620	(8,007)
Lease liabilities	0	0	10,354	10,354
Other liabilities:-				0
Deferred income	1,110	972		(972)
Provisions	273		1,275	1,275
PropCare liability	0	115,633		(115,633)
Total non current liabilities	**44,286**	**154,233**	**41,249**	**(112,984)**
Total net assets employed	**223,788**	**212,046**	**218,827**	**6,781**
Financed by (taxpayers' equity)				
Public Dividend Capital	88,793	87,242	88,793	1,551
Revaluation reserve	7,374	4,558	7,373	2,815
Income and expenditure reserve	127,621	120,246	122,661	2,415
Total taxpayers equity	**223,788**	**212,046**	**218,827**	**6,781**

Appendix C – Cash Flow

June 2023-24 (M3) £'000	FT	Group	Group (exc Charity)
Cash flows from operating activities:			
Operating surplus	(168)	562	215
Depreciation	2,490	2,490	2,490
Amortisation	399	399	399
Impairments	0	0	0
Movement in Trade Receivables	(5,556)	(5,240)	(5,332)
Movement in Other Assets	0	(0)	(0)
Movement in Inventories	(760)	(841)	(841)
Movement in Trade Payables	700	8,167	8,166
Movement in Other Liabilities	8,303	5,088	5,088
Movement in Provisions	(1)	21	21
CT paid	0	(64)	(64)
All other movements in operating cash flows		4	4
Net cash used in operating activities	**5,407**	**10,585**	**10,146**
Cash flows from investing activities			
Purchase of PPE	(4,425)	(4,425)	(4,425)
Purchase of Intangibles	(5)	(5)	(5)
ROU Assets	0	4	4
Proceeds from sale of PPE	0	0	0
Interest received	1,868	781	776
Investment in associates	750	750	750
Net cash used in investing activities	**(1,811)**	**(2,894)**	**(2,899)**
Cash flows from financing activities			
Public dividend capital received	0	0	0
Public dividend capital repaid	0	0	0
Loans received	0	0	0
Movement in loans	(834)	(834)	(834)
Capital element of finance lease	0	0	0
Interest paid	(1,249)	(132)	(132)
Interest element of finance lease	0	(0)	(0)
PDC dividend paid	(1,094)	(1,094)	(1,094)
Finance lease - capital element repaid	0	0	0
Net cash used in financing activities	**(3,177)**	**(2,061)**	**(2,061)**
Net change in cash	**418**	**5,630**	**5,186**
Cash b/f	**61,246**	**73,591**	**70,033**
Cash c/f	**61,664**	**79,221**	**75,220**

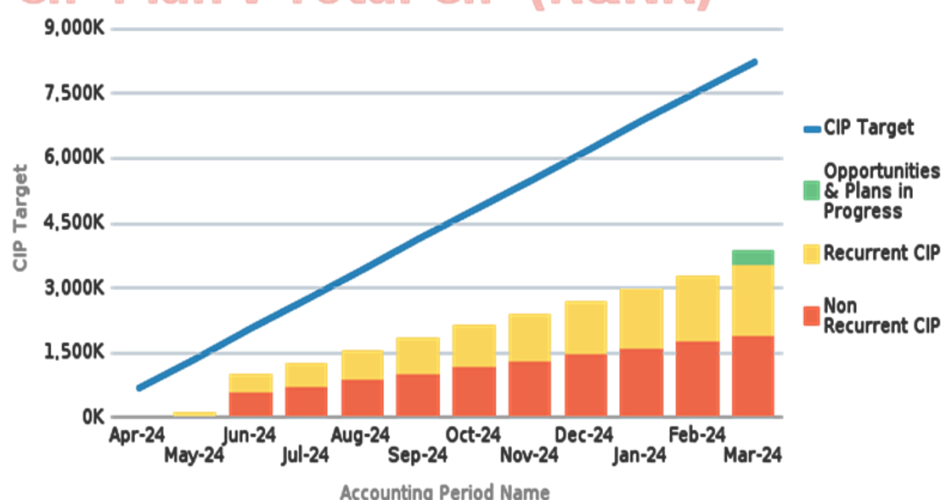
Appendix D – Capital

Capital Programme 2023-24
Month 3

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Code	Scheme	Lead	BUDGET (£'000) NHSI plan 23-24	BUDGET (£'000) Approved Adjustments	BUDGET (£'000) Budget 23-24	ACTUALS (£'000) Actuals @ Month 3	ACTUALS (£'000) Variance to Budget	FORECAST (£'000) Forecast 23-24	FORECAST (£'000) Variance to Budget	Complete?	Comments
4401	CCC-L Ward 3 bathroom conversion	Kathryn Williams	32	0	32	0	32	32	0	✗	Delayed from prior year
4433	CCC-A Estates Work and Rebranding	Emer Scott	0	0	0	17	(17)	17	(17)	✗	Approved at CIG 31/1/23
	Wirral site redevelopment	Propcare	200	0	200	0	200	200	0	✗	Consultancy/Design works
	Electric vehicle charging points	Propcare	100	0	100	0	100	100	0	✗	May not proceed - power load/supply issue
	CCC-W Propcare Plan:	Propcare	968	(968)	0	0	0	0	0	-	Plan figure now allocated to below schemes
	- Building - external fabric	Propcare	0	24	24	0	24	24	0	✗	
	- Building - internal	Propcare	0	360	360	0	360	360	0	✗	
	- M&E	Propcare	0	472	472	0	472	472	0	✗	
	- Physics building	Propcare	0	800	800	0	800	800	0	✗	Potential to scale back spec/spend
	- Fire compartmentation	Propcare	0	300	300	0	300	300	0	✗	Significant unknowns - surveys in progress
	- Tea bar	Propcare	0	40	40	0	40	40	0	✗	
	- Ground floor changing area	Propcare	0	52	52	0	52	52	0	✗	
	- Roofing	Propcare	0	800	800	0	800	800	0	✗	
4454	CCC-L Level 4 storage room conversion	Propcare	0	16	16	0	16	16	0	✗	
	CCC-A Linac bunker	Louise Bunby	220	0	220	0	220	220	0	✗	Likely to be significantly less - TBC
	Estates		**1,520**	**1,896**	**3,416**	**17**	**3,398**	**3,433**	**(17)**		
4192	Cyclotron	Carl Rowbottom	0	0	0	5	(5)	280	(280)	✗	Ongoing scheme
4309	Voltage Stabilisers	Martyn Gilmore	0	0	0	0	0	0	0	✗	Installation delayed
4415	RFID Asset Tracking System	Tony Marsland	0	25	25	0	25	25	0	✗	Extra tags approved May Finance Com'tee
4451	CCC-A Linac	Louise Bunby	2,460	(82)	2,378	0	2,378	2,378	0	✗	Ordered 5th June. c10mth lead time.
	Brachy line applicators	Louise Bunby	30	0	30	0	30	30	0	✗	
	Radionuclide calibrator	Louise Bunby	10	0	10	0	10	10	0	✗	
	2D array x2	Louise Bunby	80	0	80	0	80	40	40	✗	Budget halved as only 1 now required
	Concealement trolley	Mel Warwick	17	1	18	0	18	18	0	✗	
4448	BMT Sharepoint App	Priscilla Hetherington	0	11	11	0	11	11	0	✗	Approved in March
4449	Whole body phantom	?	0	0	0	33	(33)	33	(33)	✓	Moved from revenue
4450	Flojack flat lifting kits	Pauline Pilkington	0	35	35	19	16	35	0	✗	Requisitions 1st June
4455	Cyclotron X-Ray panels	Stephen Elmer	0	0	0	26	(26)	26	(26)	✗	Moved from revenue
	Medical Equipment		**2,597**	**(11)**	**2,586**	**84**	**2,503**	**2,886**	**(299)**		
4422	DDCP 22-23	James Crowther	0	0	0	0	0	0	0	✗	New PDC funded scheme
4427	Cyber Capital Access Management	James Crowther	0	0	0	0	0	0	0	✗	New PDC funded scheme
4405	Website	Emer Scott	100	0	100	5	95	100	0	✗	Expected to slip into 2022/23
	EPMA Stock Control & Pharmacy RPA	James Crowther	419	181	600	0	600	600	0	✗	
4452	Digital Literacy & Capability Programme	James Crowther	300	0	300	0	300	300	0	✗	
	HealthData Programme	James Crowther	400	0	400	0	400	400	0	✗	
	PatientHealth Programme	James Crowther	400	0	400	0	400	400	0	✗	
	Patient Education System	James Crowther	250	0	250	0	250	250	0	✗	
	Patient Flow Solution	James Crowther	175	0	175	0	175	175	0	✗	
	DigiFlow	James Crowther	190	0	190	0	190	190	0	✗	
	PoC Medical Devices & Device Integration	James Crowther	250	0	250	0	250	250	0	✗	
	DDCP (PDC Funded)	James Crowther	23	0	23	0	23	23	0	✗	
	Digital		**2,507**	**181**	**2,688**	**5**	**2,683**	**2,688**	**0**		
4421	Paddington CDC - costs		0	0	0	0	0	0	0	✗	
4421	Paddington CDC - costs (PDC funded)		0	175	175	88	87	175	0	✗	Approved PDC bid
4453	Pharmacy - VHP commissioning	Tori Young	350	0	350	0	350	290	60	✗	Work to commence around Sept-Nov
	Pharmacy - Automated Medicines Cabinets	Tori Young	300	0	300	0	300	300	0	✗	Requirements under review
	Pharmacy - Prescriptions/medicines tracker	Tori Young	50	0	50	0	50	50	0	✗	
	IFRS16 - Pharmacy vehicles		28	0	28	0	28	28	0	✗	
	IFRS16 - Portakabins		55	0	55	0	55	55	0	✗	
	Other		**783**	**175**	**958**	**88**	**870**	**898**	**60**		
	Contingency		**0**	**(2,066)**	**(2,066)**		**(2,066)**	**(2,323)**	**257**		
	TOTAL		**7,407**	**175**	**7,582**	**194**	**7,388**	**7,582**	**0**		

Appendix E – Cost Improvement Programme



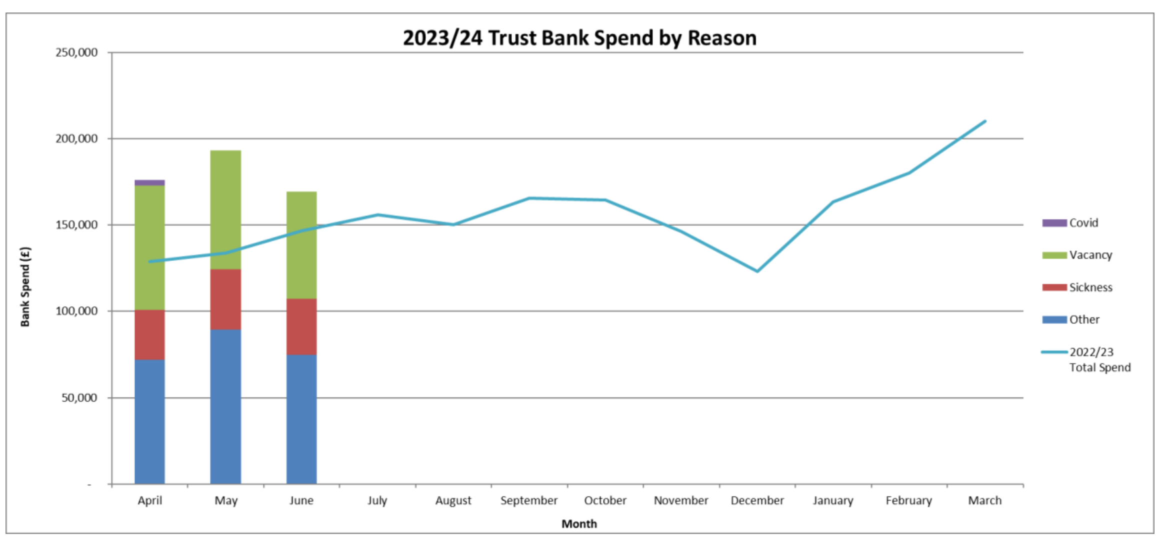
Divisional CIP Against Full Year Plan

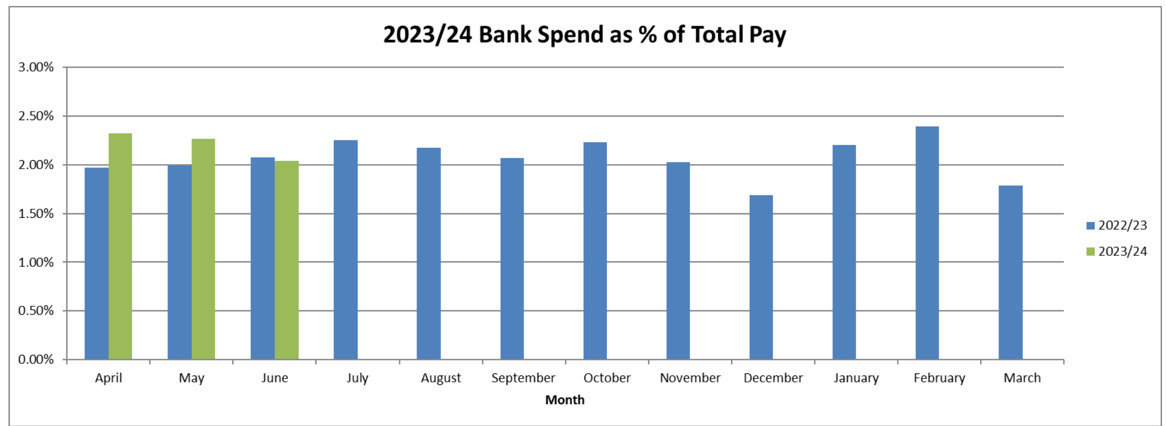
Division	Target	Total CIP	Recurrent CIP	Variance	Delivery % to date	Opportunities & Plans in Progress	Total Forecast CIP
CENTRAL CIP	3,898,000	2,103,409	500,000	(1,794,591)	54%	0	2,103,409
NETWORKED SERVICES	1,368,777	71,052	71,052	(1,297,725)	5%	237,580	308,632
ACUTE CARE	980,125	1,061,999	804,863	81,874	108%	0	1,061,999
RADIATION SERVICES	1,013,426	167,615	167,615	(845,811)	17%	0	167,615
CORPORATE	988,672	116,497	116,497	(872,175)	12%	66,996	183,493
Total	**8,249,000**	**3,520,572**	**1,660,027**	**(4,728,428)**		**304,576**	**3,825,148**

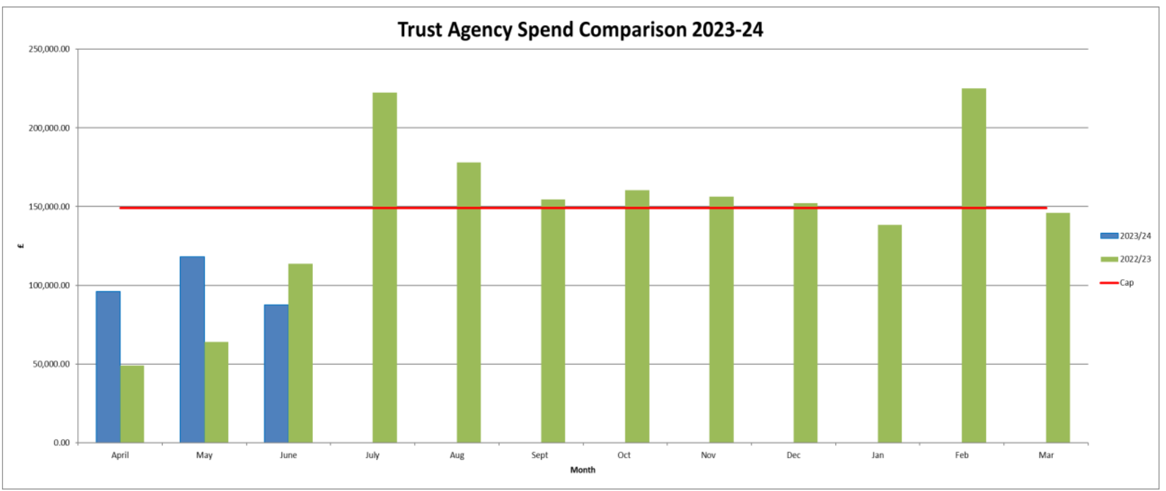
Full Year Plan (Recurrent & Non-Recurrent Split)

	Target	Total CIP	Recurrent CIP	Variance	Delivery % to date	Opportunities & Plans in Progress	Total Forecast CIP
Recurrent	8,249,000	1,660,027	1,660,027	(6,588,973)	20%	176,728	1,836,755
Non-Recurrent	0	1,860,545	0	1,860,545	0%	127,848	1,988,393
Total	**8,249,000**	**3,520,572**	**1,660,027**	**(4,728,428)**		**304,576**	**3,825,148**

Appendix F – Bank and Agency







Meeting of the Board of Directors
26th July 2023

Report of	Julie Gray, Chief Nurse
Paper prepared by	Chief Nurse Palliative Medicine Consultant
Subject/Title	Quality Improvement and Learning Strategy 2023 - 2025
Purpose of paper	To share the strategy with the Board of Directors for approval
Background papers	NHS Impact Framework (2023) NHS England, (2017) ‘Next steps on the NHS five year forward’, NHS England. CQC, (2017) ‘Driving improvement: Case studies from eight NHS trusts’, Care Quality Commission. CQC, (2017) ‘Key lines of enquiry, prompts and ratings characteristics for healthcare services’ NHS Improvement, (2016) ‘Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services’, NHS Improvement.

Action required	To approve content/preferred option/recommendations	√
	To discuss and note content	
	To be assured of content and actions	

Link to: Strategic Direction Corporate Objectives	Be Outstanding	√	Be a great place to work	√
	Be Collaborative	√	Be Digital	√
	Be Research Leaders	√	Be Innovative	√

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

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

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

Meeting of the Board of Directors

26th July 2023

Quality Improvement and Learning Strategy 2023 – 2025

1. Background

The Clatterbridge Cancer Centre NHS Foundation Trust is committed to improving quality, delivering safe, effective and personal care, within a culture of learning and continuous improvement. We already have a culture which encourages innovation, experimentation and change and empowers staff to give improvement a go and learn from what does and doesn't work but we are always keen to do more.
We recognise that all staff, regardless of role or experience, are capable of influencing change, either by offering suggestions for improvement or participating in initiatives to enhance services. We strive to strengthen professional leadership, empower doctors, nurses, allied health professionals and all our other clinical and non-clinical staff to lead and deliver quality care and world leading treatment

This Quality Improvement and Learning Strategy provides a structured approach for the ongoing adoption of quality improvement science, how we identify areas for improvement, how we demonstrate the impact of our actions and develop a capable and enquiring workforce.

This 2023-2025 strategy supersedes any previous quality strategies. It includes key deliverables over a two year period to coincide with the timeframe for the overarching Trust strategy.

2. Introduction

The focus of this strategy is to build our quality improvement capability in order to achieve the key deliverables. This 2023 – 2025 strategy has at its heart the promotion of continuous learning and improvement. The content has been developed using national guidance and local intelligence regarding achievable and stretch ambitions. It is written in an easy to follow format, in plain language and free from jargon, with the intension that staff at all areas of the organisation can access it and understand the organisations commitment to continuous quality improvement, learning from our extensive data and how we promote the impact of our actions. The key themes throughout the strategy were developed in collaboration with a cross section of staff from different divisions and grades from across the organisation.

3. Quality Ambitions

Four quality ambitions, aligned to our 6 strategic priorities, set the expectations for staff and managers in relation to quality improvement and learning:

- To widely share learning, success and excellence to improve patient safety culture and staff experience
- To use digital real-time data and system-wide collaboration to drive outstanding care
- To discover and implement new knowledge in order to achieve the best outcomes for patients
- To promote and reward innovation and continuous quality improvement initiatives to build safer systems and improve patient experience

4. Measurable objectives 2023 to 2025

This strategy includes clearly articulated and measurable objectives which set out the actions to be undertaken over the coming two years.

The benefits of this approach are:

- To demonstrate the organisations commitment to the adoption of continuous quality improvement science
- To enhance quality of care and patient experience
- To build staff capability and skill in quality improvement methodology
- To celebrate staff innovation and achievements
- Cost efficient practice/processes
- Financial savings from the adoption of lean processes
- Enhanced staff morale and organisational reputation

Achievement of these objectives will be monitored by an annual review paper presented to the Board of Directors, with clinical presentations on key areas to the Quality Committee.

5. Conclusion

The 2023 – 2025 Quality Improvement and Learning Strategy clearly defines the strategic direction for continuous improvement and shared learning within the organisation, taking a proactive approach to building capability and celebrating success.

Quality Improvement & Learning Strategy

2023 – 2025

Contents

1. Foreword - Chief Executive Officer	3
2. Introduction & Context	4
3. Our Strategy	5
4. Measurable objectives	7
6. How we show our learning	12
7. Monitoring and Involvement	16

Foreword

Everything we do at The Clatterbridge Cancer Centre is directed at achieving the best quality care and outcomes for our patients and I am delighted to launch our quality improvement and learning strategy for 2023-25.

As an organisation we are committed to improving quality, delivering safe, effective and personal care, within a culture of learning and continuous improvement. We already have a culture which encourages innovation, experimentation and change and empowers staff to give improvement a go and learn from what does and doesn't work but we are always keen to do more.

We recognise that all staff, regardless of role or experience, are capable of influencing change, either by offering suggestions for improvement or participating in initiatives to enhance services. We strive to strengthen professional leadership, empower doctors, nurses, allied health professionals and all our other clinical and non-clinical staff to lead and deliver quality care and world leading treatment. This builds on the positive and proactive work that has already been undertaken to maintain patient safety, deliver effective treatments and enhance the patient experience. Opening our landmark hospital in the centre of Liverpool in 2020 has enabled us to continue to 'Drive improved outcomes and experience through our unique network of specialist cancer care across Cheshire and Merseyside' by working with our academic and healthcare partners across the region to ensure that the care, treatment and outcomes of our patients continuously improve in the future.

This strategy will outline our plan for the next 2 years, focused around 4 key priorities for improving quality linked directly to the Trust's strategic objectives. This strategy also contains key objectives to facilitate close monitoring of our progress and a structured approach to disseminating what we, as an organisation, learn from the improvements we make. Whilst this strategy is not intended to be exhaustive, it contains key milestones to enable us to make the best use of digital resource, research evidence, national policy and our dedicated staff to drive continuous improvement. I would like to take this opportunity to say thank you to everyone in The Clatterbridge Cancer Centre NHS Foundation Trust for their continued commitment to providing the very best innovative treatment and for their compassion and dedication in our shared goal of providing the very best care for our patients.

Dr Liz Bishop

Chief Executive Officer (CEO)

Introduction & Context

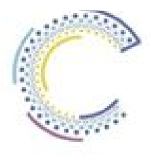
About The Clatterbridge Cancer Centre

The Clatterbridge Cancer Centre is one of the UK's leading cancer centres providing highly specialist cancer care to a population of 2.4m people across Cheshire, Merseyside and surrounding areas including the Isle of Man. Our unique multi-site care model includes radiotherapy at our three main Clatterbridge Cancer Centres (Aintree, Liverpool and Wirral), systemic anti-cancer therapy at six sites and outpatient care at 13 hospitals.

Together, this enables us to provide a comprehensive range of inpatient care, acute oncology, radiology, advanced radiotherapy, chemotherapy and other systemic anti-cancer therapies (SACT) including gene therapies and immunotherapies. We are the only facility in the UK providing low-energy proton beam therapy to treat rare eye cancers and we host the region's Teenage and Young Adult Unit. We are also a leading research centre with an extensive portfolio of clinical trials including early phase and first-in-human (Phase 1). We are an associate partner with the NIHR Biomedical Research Centre at The Royal Marsden and the ICR, NHS partner in the Liverpool Experimental Cancer Medicine Centre and a collaborator in the NIHR Liverpool Clinical Research Facility.

With almost 1,800 specialist staff, we are one of the largest NHS providers of non-surgical cancer treatment and we are consistently rated as one of the best performing hospitals in the Care Quality Commission's national inpatient survey. We host Cheshire and Merseyside Cancer Alliance and the NHS Diagnostics programme for Cheshire and Merseyside.

Our Values



BE COLLABORATIVE

BE RESEARCH LEADERS

BE A GREAT PLACE TO WORK

BE DIGITAL

BE INNOVATIVE

National Context

Delivery of 'Next Steps on the NHS Five Year Forward View', (NHS England, March 2017), calls for a leadership that is confident and competent in change management and the transformation of systems; who recognise the value of improvement approaches to support the delivery of that change.

The Clatterbridge Cancer Centre NHS Foundation Trust already drives collaborative working across the region in many ways, including hosting the Cheshire and Merseyside Cancer Alliance. We are committed to ensuring that we work with colleagues across the healthcare economy to drive transform of the delivery of Cancer services, address health inequality gaps and increase the years of life that people live in good health.

This Strategy is not a stand-alone document; it is aligned to existing strategies and work streams to ensure a united approach to meeting this commitment.

These include transformation, leadership, workforce, organisational culture and staff behaviours. The **Digital Strategy**, **People Plan** and the **Patient Safety Incident Response Framework** provide greater detail on the organisation's approach to these elements.

This **new Strategy** builds upon previous successes and is intended to set the direction for the future quality improvement and learning processes.

It has been informed by engagement with a wide range of stakeholders who have provided very helpful input. Early planning meetings with key individuals in the organisation and responses to consultations with patient, staff and visitors have contributed greatly to its' contents.

Our Five-Year Strategic Plan 2021 - 2025

Launched in 2021, the Trust's Five-Year Strategic Plan outlines six priorities:

Be outstanding - deliver safe, high-quality care and outstanding operational and financial performance

Be collaborative - Drive better outcomes for cancer patients, working with our partners across our unique network of care

Be a great place to work - Attract, develop and retain a highly-skilled, motivated and inclusive workforce to deliver the best care

Be research leaders - Be leaders in cancer research to improve outcomes for patients now and in the future

Be digital - Deliver digitally-transformed services, empowering patients and staff

Be innovative - Be enterprising and innovative, exploring opportunities that improve or support patient care.

Quality Definition

The common and enduring definition of quality care is that of Darzi (2008) who stated that; *"High quality care should be as **safe** and **effective** as possible, with patients treated with **compassion**, **dignity** and **respect**. As well as clinical quality and safety, quality means care that is **personal** to each individual."*

This Quality Improvement and Learning Strategy is written within the context of this definition whilst also acknowledging the national guidance 'Developing People, Improving Care' published by NHS Improvement in 2016 which urged NHS organisations to nurture compassionate and inclusive leadership and to invest at scale in improvement skills across the workforce as a whole.

Our Strategy

Design

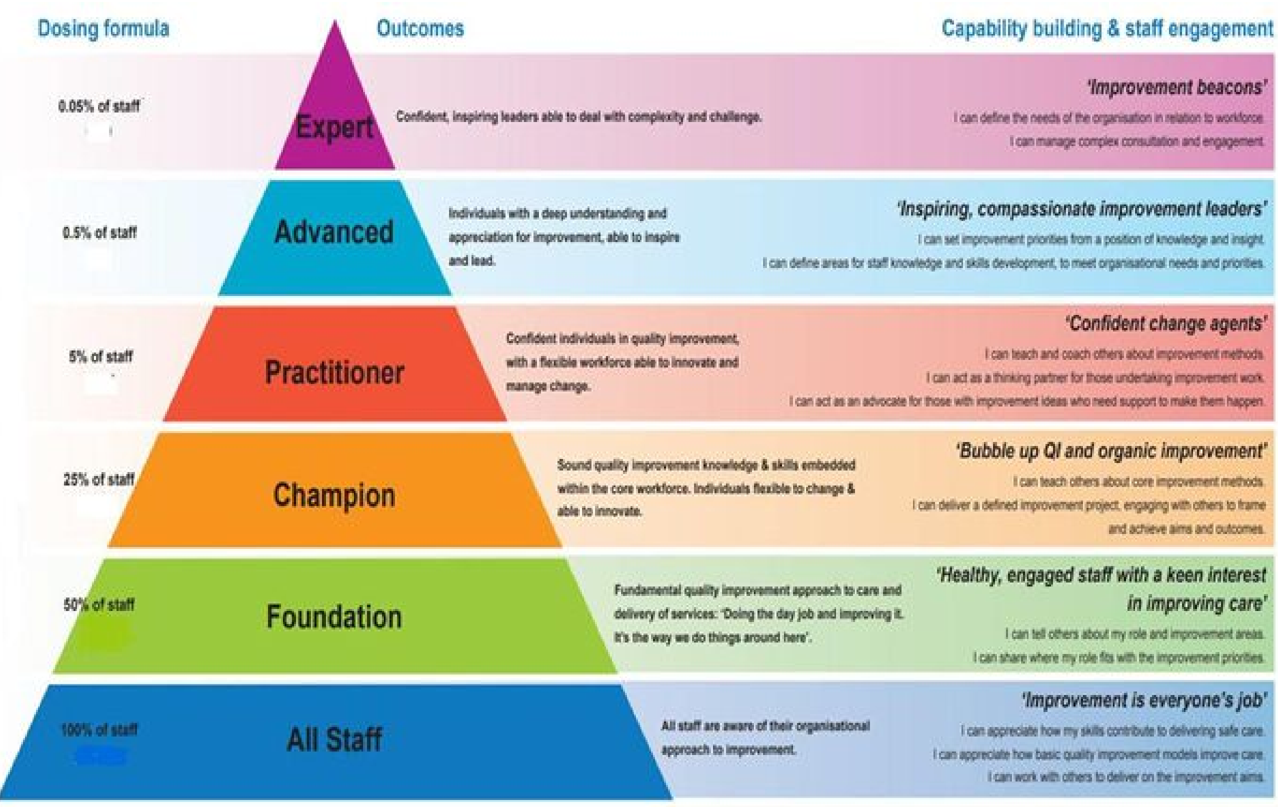
Our quality improvement and learning strategy has been designed, not only around national principles but also to build on our strengths by equipping our staff with the skills and tools to deliver quality patient care, every day. This will contribute to the delivery of our strategic goals.

Improving quality and achieving our aims will take a consistent approach to improvement and learning taking account of a number of different factors. One improvement methodology is not prescribed above another, but rather we aim to build our capability so leaders can select the most appropriate methodology for the improvement aim.

Building Capability and Confidence

We will support the whole workforce to attain skills, capability and confidence in improvement science.
This will include the Board and senior leaders who will engage actively in the clear and well managed programmes of improvement. Everyone is accountable for making their part of the patient pathway better through the act of continuous improvement.

The model below is the Advancing Quality Alliance (AQuA) adapted dosing formula taken from the original work of Kaiser Permanente. This will be used as a guide as we continue to build our capability.



Our Quality Ambitions

1. To widely share learning, success and excellence to improve patient safety culture and staff experience
2. To use digital real-time data and system-wide collaboration to drive outstanding care
3. To discover and implement new knowledge in order to achieve the best outcomes for patients
4. To promote and reward innovation and continuous quality improvement initiatives to build safer systems and improve patient experience

Our Measurable Objectives

Objective 1

To widely share learning, success and excellence to improve patient safety culture and staff experience

Current Position

- CEO's monthly video message for staff
- Ward to Board presentations at Quality Committee
- Established ward safety huddles
- Monthly executive director quality and safety walk-rounds
- Screen savers providing regular updates and important information for staff
- Swartz Rounds to provide an open forum for learning and sharing of staff experience and support
- Site Reference Group (SRG) Lead Forum enabling regular discussion of learning opportunities, changes affecting the organisation and feedback from clinical teams
- Staff Awards recognising outstanding contributions to quality and care from staff and teams
- 6-monthly audit presentation events recognising excellence in audit and quality improvement activities

Short Term Deliverables 2023 - 2024

- Undertake a patient safety culture questionnaire in order to establish a baseline data set
- To develop resources which provide staff with an awareness of our organisational approach to improvement.
- To establish improvements required to enhance the quality, effectiveness and experience of patients through the inpatient, outpatient and Trust-wide transformation programmes
- To undertake quarterly multi-professional Care Quality Commission style inspection programmes based on the new methodology
- To engage in peer to peer 'mock' inspections to ensure a continuous focus on learning
- To create a mechanism for sharing critical alerts to all staff in a timely manner

Long Term Aspirations 2024 - 2025

- To embed Quality Improvement (QI) processes and documentation across the organisation
- To embed a quality accreditation framework on all inpatient wards
- To develop an interactive centrally located tool for sharing learning
- To establish a trust wide network of improvement practitioners with access to training on quality improvement, linked with the NHS England Impact Framework

Objective 2

To use digital real-time data and system-wide collaboration to drive outstanding care

Current Position

- Established dedicated Business Intelligence Team focussed on making the best use of real-time data
- Multiple live dashboards to inform clinically relevant decision making in real time
- Hosting the Cheshire and Merseyside Cancer Alliance since 2017 to facilitate collaboration between all services in Cheshire and Merseyside
- Supra-regional & a range of specialist & metastatic MDTs to enable access to specialists between organisations
- Metastatic Spinal Cord Compression service covering Cheshire and Merseyside
- Digital Strategy which sets new standards for use of digital resources to drive improvements in care

Short Term Deliverables 2023 - 2024

- To double the number of live dashboards available to clinicians across the organisation
- To roll out ward specific patient level dashboards to minimise risk
- To upgrade all wards & department dashboards to ensure that contemporaneous high quality data is available to encourage and drive improvement
- To actively participate in Cheshire & Merseyside regional Falls prevention collaborative
- To drive collaboration and benchmarking of standardised data between the three oncology centre Infection Prevention and Control teams

Long Term Aspirations 2024 - 2025

- To realise an electronic system for all data capture and analysis
- To collaborate with the Cancer Academy to support the education agenda
- To embed the use of live dashboards within our committee structure
- To identify opportunities for peer to peer review of key areas of service
- Develop digital resources to enable remote monitoring and patient reported outcome measures in real-time across multiple SRGs

Objective 3

To discover and implement new knowledge in order to achieve the best outcomes for patients

Current Position

- Published the outcomes of our Mortality reviews in the quality accounts with benchmarking against peer organisations
- 30 day SACT mortality process and other related projects fully embedded, driving detailed reviews of care by clinical teams and identification of changes to minimise treatment related mortality alongside best possible care
- Full internal clinical audit program with administrative and statistical support
- Participants in national audit programme for all tumour types
- Launched a trust-wide innovation strategy to drive innovations within the trust which improve patient experience and quality of care
- All new patient data has been made available to all consultants using an interactive format
- Launch of the Trust Research Strategy
- Active recruitment of patients into clinical trials
- CCC research grant scheme

Short Term Deliverables 2023 - 2024

- Establishment by clinicians of defined measures of 'clinical excellence' for each disease site that can be measured and continuously monitored to ensure that any changes are immediately apparent
- Continue the improvement in comprehensive new patient data collection so that more than 90% of all new patients are included
- Continue to work with clinical staff to improve access to and direct use of available data and to encourage 'ownership' of their data to improve data quality
- To continue to use the Safer Nursing Care Tool (SNCT) model of patient acuity to inform on-going workforce succession planning
- To lead on the national drive to fully integrate clinical audit methodology alongside other quality improvement initiatives so that the focus is on improvement rather than measurement only
- Ensure 100% of patients have a performance status recorded at first consultation

Long Term Aspirations 2024 - 2025

- 95% of patients will receive treatment summaries after significant phases of cancer treatment
- Access to clear and concise outcome & population data that will inform best practice.
- Having a portfolio of clinical measures of excellence for all disease groups published on the website
- Clinical staff have the confidence to access clinical data that is both meaningful and enhances their work activities

Objective 4

To promote and reward innovation and continuous quality improvement initiatives to build safer systems and improve patient experience

Current Position

- Established Bright idea scheme in 2021, enabling clinical teams to make the changes they feel will make the biggest difference
- Big ideas scheme for larger initiatives was launched in 2023
- Quality improvement projects monitored via Quality Improvement and Clinical audit Committee
- NICE assurance monitored in the Clinical Effectiveness Committee and linked to SRGs as appropriate

Short Term Deliverables 2023 - 2025

- To scope the benefits of a smart hydration system
- To establish a quarterly multi-professional inspection programme
- To evidence a patient centred and patient led approach to care that includes keeping patients informed and involved in decisions about their care

Long Term Aspirations 2023 - 2025

- Co-design and develop a ward accreditation programme to celebrate excellence in care
- To embed Quality Improvement in the PDR process to ensure that staff who work for us understand their role in improving patient care and experience
- To look at new and innovative ways to recruit and retain the best staff
- To retain a workforce that continually strives for excellence as demonstrated through their performance, attitudes and behaviours and on-going commitment to the organisation

  To support people who have led quality improvement to attend conferences to present their work and project outcomes
- To establish a CCC Improvement hub for access training and resources to support our staff leading quality improvement as well as sharing examples of excellence from within the organisation

How we will show our shared learning and impact

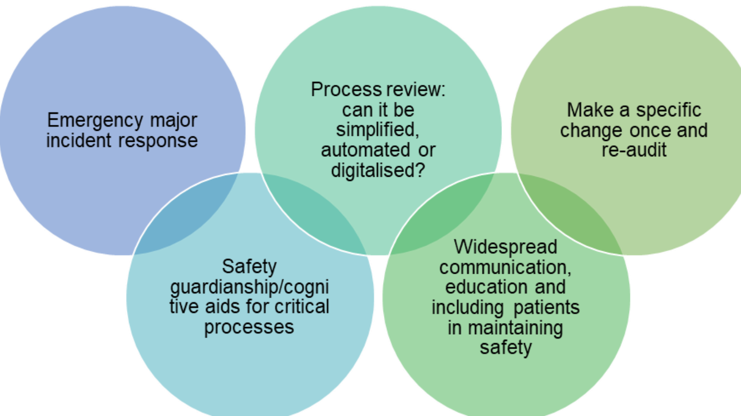
This document has outlined our strategic ambitions with regards to quality improvement and key objectives to achieve in delivering those ambitions. As an organisation we need to know when those objectives are met and when we have successfully implemented an improvement.

Implementing and sharing what we have learnt in a rigorous, measurable and demonstrable way is vital. However sharing what we have learnt from an event, project or investigation is broader than telling people and delivering training. Making a sustained system-wide change shows we have learnt as a whole organisation: training everyone not to use a broken system is not as good as fixing it. Our strategy for handling lessons therefore needs to reflect that whilst some lessons need to be widely disseminated and form the basis of further education, others need to be definitively addressed using system-based approaches.

The below model describes a tiered approach to managing lessons which emerge in the organisation through existing governance routes.

Step 1- How lessons are generated

The lessons we learn in our organisation are generated in a number of ways. These can include audits and quality improvement initiatives, feedback from patients, staff or external agencies, lessons picked up through standing governance processes or external lessons e.g. national alerts which are fed into the organisation. Whilst there needs to be a central oversight of lessons and decisions taken about how to act upon them, different lessons will require different responses. Additionally, in line with the national patient safety strategy The Clatterbridge Cancer Centre will adopt the national framework for identifying local areas of focus and improvement and adopt a risk-based approach to incident investigations to ensure that the lessons we learn are based around local needs, risks and priorities and do not expend excessive resource on areas which are already the subject of improvement or where further actions and lessons would not improve the outcome further. These priorities will be formalised in the organisation's Patient Safety Incident Response Policy.



Step 2- Who decides what to do with the lessons we learn?

Oversight of lessons and decisions of how these should be acted upon and disseminated should fall within the scope of work of the three governance domains: patient safety, patient experience and clinical effectiveness. Each of these streams has a governing committee with a reporting structure into and out of the committee and should have oversight of all lessons in these domains. It will be the responsibility of these committees to determine what level of action is required (see step 3 for guide), or if an alternative approach is needed. As the central point for overseeing lessons these committees will also be responsible for monitoring trends as multiple lessons relating to the same process, department, clinic etc. may require further in depth quality assessment.

Step 3- how do we act on lessons?

The action required for the lessons to be learnt may be bespoke. Not every lesson requires an organisation-wide response although some will. Not all lessons need to be restricted to staff, some will. Therefore the model described here enables different actions to be assigned to each lesson. Of note, this model is not exhaustive and committees can opt to pursue a difference avenue for learning a lesson and each lesson may have more than 1 type of action assigned to it.

Make a Specific Change Once and Re-audit

This action relates to when a lesson learnt relates to a specific and rapidly amendable process or procedure such as a faulty piece of equipment or estates. The whole organisation does not need to be involved in the lesson if it can be dealt with more efficiently by a focussed and immediate intervention which ensures a faulty process cannot recur.

Widespread Communication, Education and Including Patients in Maintaining Safety

This action relates to lessons which are a matter of getting knowledge to the right people, including patients where appropriate to ensure mistakes are not made in routine practice which could foreseeably occur if the information does not reach the right people. This should include disseminating information where people cannot miss it, e.g. in common thoroughfares in the organisation and by using technology to enhance the transfer of information. Using mass email or banners on computer screen savers are unlikely to stand out enough for the information to be received- a bolder approach which is not over-used should be considered.

The involvement of patients in receiving this information should be considered when there is a lesson relating to the general population over which Clatterbridge Cancer Centre has no oversight but which they may need to act upon.

Process Review: Can it be Simplified, Automated or Digitalised?

This action relates to when lessons are learnt about processes which are complex, error prone or have resulted in human error. The event of human error in a process may be addressed by removing as many of the human steps in that process as possible, so an in depth review of the process considering which elements can be automated or digitalised removes that risk.

Safety Guardianship/Cognitive Aids for Critical Processes

This action relates to lessons which emerge from complex processes which can only be done by humans, and errors in that process have led to learning events. The process cannot be automated and one-time (or limited) (re)training is unlikely to have lasting impact or address the complexity of the process in action. This action therefore requires a subject expert be released to supervise the process as it occurs, offering corrective feedback in real time and constructing cognitive aids to challenge people at key points in the process where common mistakes are made to ensure longer term change in practice.

Clinical Emergency Major Incident Response

This action relates to a major event which requires high level senior oversight of actions. It requires members of the trust executive team to meet at short notice and create a bespoke action plan, delegate actions appropriately and hold responsibility for overseeing completion.

An example might be a breach of the law occurring on the organisation's premises where patient care and/or staff safety are impacted.

What about trust-wide communications?

The trust intranet and a patient safety bulletin should still be used to disseminate learning across the whole organisation. However, these tools should be issued quarterly as a record of the actions in step three which have already been undertaken that quarter. This way it serves as a reminder to be vigilant rather than the first or only response to a lesson learnt.

Monitoring & Involvement

Monitoring arrangements

Progress against the objectives set out in this strategy will be monitored annually by the Quality Committee. However the specific actions and progress of each work stream will be captured on a more regular basis through the well-established governance committees (Patient Safety, Patient Experience and Inclusion and Clinical Effectiveness) and the Transformation Boards.

Quality improvement is everyone's business – but there are some specific ways that you can get involved:

- Join a quality and improvement session where we will look at how to identify an improvement project and how you can use tools to measure deliverable improvements
- Sign up for a training session which will offer frontline teams a variety of training on how to develop improvement skills that apply in a real life work context
- Gather a team together an apply for an improvement collaborative to focus on a specific issue
- Support one of the established pathway improvement boards or join an improvement collaborative

Quality improvement Hub

Let's create an improvement movement – look out for the opening of the **Improvement Hub**

Promoting good practice across the trust – celebrating and learning from the great things staff are doing.

References

NHS Impact Framework (2023)

NHS England, (2017) 'Next steps on the NHS five year forward', NHS England.

CQC, (2017) 'Driving improvement: Case studies from eight NHS trusts', Care Quality Commission.

CQC, (2017) 'Key lines of enquiry, prompts and ratings characteristics for healthcare services'

NHS Improvement, (2016) 'Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services', NHS Improvement.

Ham, C. (2014) 'Reforming the NHS from within: beyond hierarchy, inspection and markets' The King's Fund: London.

Berwick D. (2013) A promise to learn– a commitment to act: Improving the Safety of Patients in England

Cavendish C. (2013) An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings

Francis R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Keogh B. (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England

<table>
<tr><td>Title</td><td colspan="3">Quality Improvement and Learning Strategy</td></tr>
<tr><td>What is being considered?</td><td colspan="3">The impact of this strategy on Patients/ Public, Partner agencies and staff, within the context that this strategy beening developed for immediate implementation, setting clear quality aims over the next 2 years and clear objectives to meet in the implementation and embedment of quality improvement processes within the organisation.</td></tr>
<tr><td>Who will be affected?</td><td colspan="3">Patients [✔] Staff [✔] Public [✔] Partner agencies [✔]</td></tr>
<tr><td>What engagement is taking place or has already been undertaken?</td><td>Public
Public consultation has taken place across three sites, CCCL, CCCA and CCCW. Patients and those important to them have been asked to feedback what they want to see in future strategies aimed at improving the quality of our care and how we disseminate learning within the organisation. This feedback has been amalgamated and included in the recommendations and objectives within this strategy.</td><td>Partners
The strategy has been shared with the Advancing Quality Alliance (AQuA) as key stakeholders in the delivery of our quality improvement training and deliverables.

Representatives from the Council of Governors have been consulted and reviewed the draft strategy.

Planned
Review by C&M specialist commissioners via the established quality review process.</td><td>Staff
Staff across three sites have been involved in the consultation exercise across three sites and asked to contribute changes they wish to see in the way the organisation develops and supports quality improvement and how we disseminate learning.

Key staff groups involved in quality improvement have been involved in the consultation process and this has enabled us to align this strategy with existing work streams (where present) and formalize the governance arrangements surrounding existing QI initiatives. This strategy brings everything together in terms of QI work currently being</td></tr>
</table>

			undertaken within the organisation and sets a clear direction for future development. **Planned** Review by staff networks
What evidence has been analysed?	**Evidence / Research :** This strategy is written to align with key national strategies and the AQuA Embedding a Culture and System for Continuous Improvement in delivering quality improvement capabilities and capacity within our organisation. We have reflected on the role of QI in driving patient safety and therefore the close interlink between this strategy and the national patient safety strategy and the emphasis on QI outcomes leading to observable changes in practice and lessons learned. Existing references in the field of quality improvements have been used and referenced in the creation of this strategy: • NHS Impact Framework (2023) • NHS England, (2017) 'Next steps on the NHS five year forward', NHS England. • CQC, (2017) 'Driving improvement: Case studies from eight NHS trusts', Care Quality Commission. • CQC, (2017) 'Key lines of enquiry, prompts and ratings characteristics for healthcare services' • NHS Improvement, (2016) 'Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services', NHS Improvement. • Ham, C. (2014) 'Reforming the NHS from within: beyond hierarchy, inspection and markets' The King's Fund: London. • Berwick D. (2013) A promise to learn– a commitment to act: Improving the Safety of Patients in England • Cavendish C. (2013) An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings • Francis R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry		

	• Keogh B. (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England

What is the result of the analysis? Will there be an impact against the protected groups below? • Age • Disability • Gender Reassignment • Marriage and Civil Partnership • Pregnancy and Maternity • Race • Religion and Belief • Sex (Gender) • Sexual Orientation • Human Rights articles ✔	The development of this strategy will positively impact on all staff including those within a protected group. By consciously focusing on quality improvement, accessibility via the development of an improvement hub, education and support, an inclusive culture will be fostered. Utilsing multimedia methods to share impact and learning means that different approaches can be adopted to support different learning styles and requirements. To date no negative impact on protected groups is expected.

Do further steps in the following areas need to be taken to mitigate or safeguard these impacts - *Involvement & Consultation, Data collection & Evidence, Assessment & Analysis, Procurement & Partnerships, Education and Workforce?* If so complete the action plan below:			
Outcome	**Actions required**	**Time scale**	**Responsible officer(s)**
			▪

How will we monitor this and to whom will we report outcomes?	The implementation and achievement of this strategy will be monitored annually by a report to the Board of Directors based on the explicit deliverables noted within each of the four overarching aims. Further assurance will be achieved by quality presentations to Quality Committee on selected items within the strategy. The Chief Nurse and Palliative Care Consultant are accountable for reporting achievement of this strategy.

Author	**Julie Gray and Dan Monnery**	**Title**	**Chief Nurse & Consultant in Palliative Medicine**	**Date**	**18/7/23**
Equality Analysis assessed by	**Angie Ditchfield**	**Title**	**EDI Lead**	**Date**	**19/7/23**

The Equality Act (2010) has brought a Public Sector Equality Duty to all Public Authorities. This Equality Analysis provides assurance of the steps that Clatterbridge Cancer Centre NHS Foundation Trust is taking in meeting its statutory obligation to pay due regard to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

This equality analysis also provides evidence of discharging Public Sector statutory obligations under the Human Rights Act (1998).

For further information or guidance please contact the EDI Lead – angie.ditchfield@nhs.net

Equality Analysis

Title of meeting: Trust Board
Date of meeting: 26 July 2023

Report author	Emer Scott, Associate Director of Communications			
Paper prepared by	Emer Scott, Associate Director of Communications			
Report subject/title	Communications Strategy 2023 – 2025: Six-monthly implementation progress report			
Purpose of paper	This report provides details of progress made in delivering the Trust's Communications Strategy 2023 – 2025 since it was approved in January 2023. Updates will be presented to TEG every six months. This report covers progress made in the last six months against the strategy's implementation plan and priorities for the next three months.			
Background papers	Communications Strategy 2023 – 2025			
Action required	The Trust Executive Group is asked to: • Note the contents of this paper and progress made in delivering the strategy			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work	X
	Be Collaborative	X	Be Digital	X
	Be Research Leaders	X	Be Innovative	X

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

Ref: FCGOREPO
Review: July 2025
Version: 2.0

Communications strategy 2023 – 2025

Delivery progress report: July 2023

Contents	
Highlights and challenges	2
Media and social media	3
Be Outstanding	6
Be Collaborative	8
Be a Great Place to Work	9
Be Research Leaders	10
Be Digital	11
Be Innovative	12

Introduction

- Our Communications Strategy 2023 – 2025 set out a new approach and clear priorities for communications and engagement to support delivery of the Trust's Five Year Strategic Plan 2021 – 2025 and its supporting strategies.
- The strategy and accompanying delivery plan were approved in January 2023. They included clear actions linked to the Trust's six strategic objectives and the Communications Team's core purpose supporting delivery of those objectives by using its skills towards:
- Establishing CCC as a leading voice on cancer care
- Enabling excellence in CCC services and quality of care
- Creating a community of engaged, motivated and high-achieving people
- This paper reports on what has been delivered in the first six months of the plan and priorities for the next period.

Highlights and challenges (Jan-Jun 2023)

Be Outstanding

- Marketing Strategy has been agreed
- Speaking slots at national conferences
- Multiple awards entries shortlisted as finalists
- 4 cohorts of media training completed
- TV and radio coverage including research trials, patient experience at CCC and CCC-W 65th birthday

Be Collaborative

- Comms and events support for visits incl Clatterbridge CDC
- Clatterbridge CDC comms incl 50k tests
- Paddington CDC initial announcement
- Ongoing comms support for Cancer Alliance
- Highlighting Diagnostics work in Cheshire and Merseyside

Be a Great Place to Work

- Staff survey results comms
- Organised Eurovision, NHS75 celebrations and ice cream day
- Comms and events support for multiple staff celebration days incl International Nurses Day and CNS Day
- Industrial action communications

Be Research Leaders

- Media coverage incl MODIfy, MOAT, biology of dying, and blood cancer and COVID
- Comms for ECMC announcement
- Clinical trials awareness campaign and animation
- Comms slot on recent CCC Research Study Day

Be Digital

- Promoting launch of digital appointment letters, resulting in rapid take-up by patients
- Orlo social media platform now in place
- Website development underway
- Comms support for digital projects incl Meditech and cybersecurity

Be Innovative

- Comms for launch of Innovation Strategy
- Ongoing Bright Ideas and Big Ideas comms

Challenges

- Industrial action and workload associated with events or new developments e.g CDC
- Programme timescale changes e.g. progress with Green Plan, CCC-W

Social media (Jan-Jun 2023)

Twitter

Q1 (1st Jan – 30th Mar)

175.5k impressions:
- **1.5k** likes
- **333** retweets without comment
- **674** clicks
- **112** replies

Q2 (1st Apr – 26th Jun)

166.4k impressions:
- **1.6k** likes
- **392** retweets without comment
- **602** clicks
- **55** replies

Facebook

H1 (1st Jan – 26th Jun)

187,122 reach
26,995 page visits

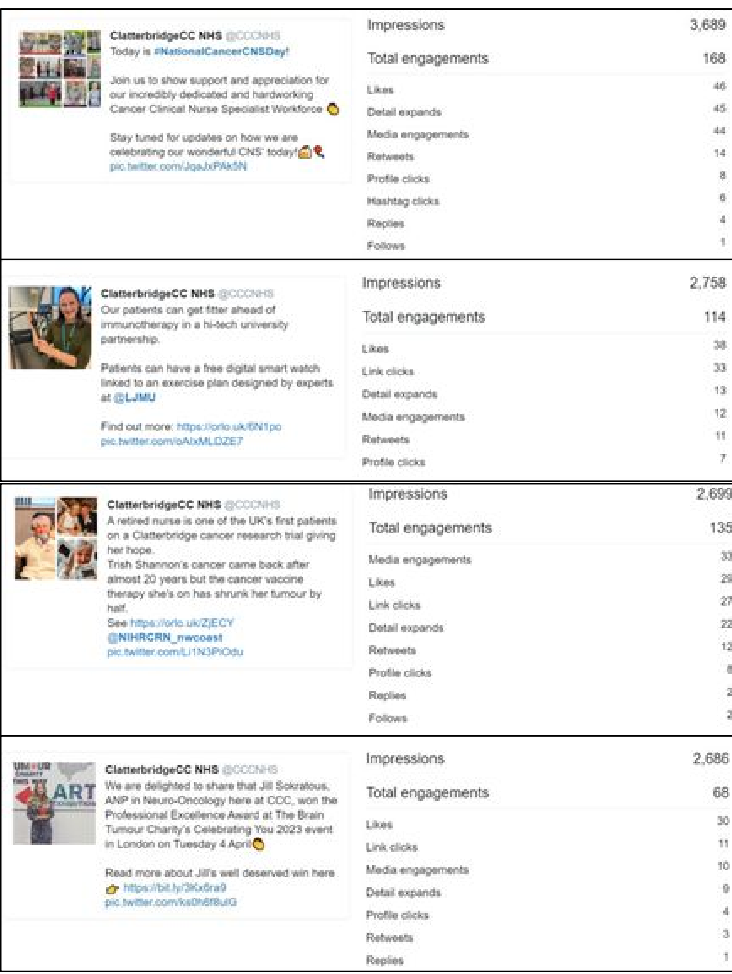
Instagram

H1 (1st Jan – 26th Jun)

10,980 reach
5,320 profile visits

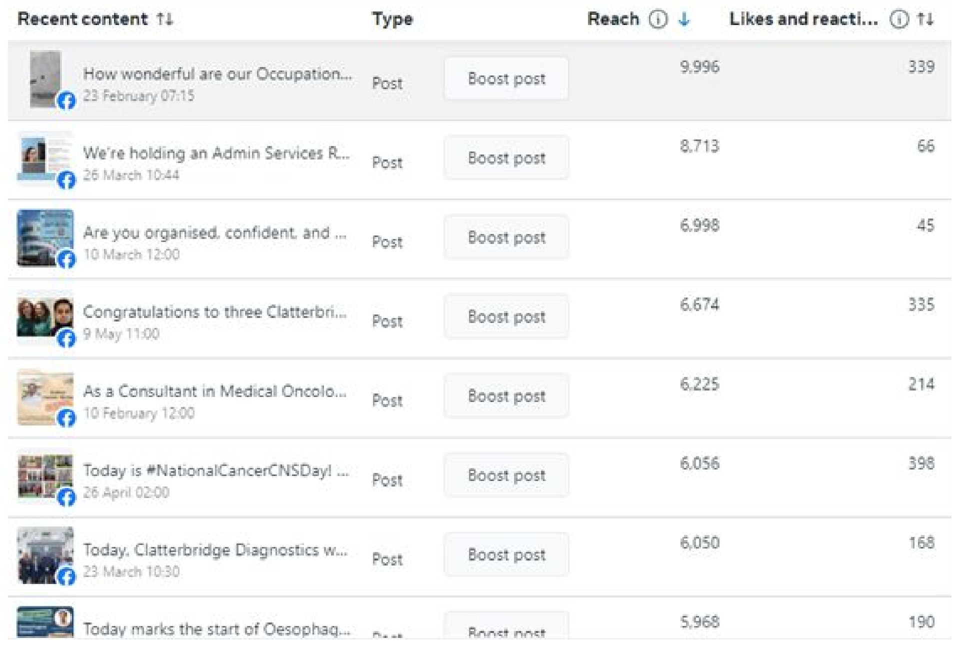
Other popular Twitter content (Apr-Jun) included:
International Nurses Day
Radiotherapy VR virtual tour
Rachel Brooker and colleagues achieving PhDs
Staff achievement award winners – Jo Francis, Steph Robinson

Top tweets (1st April to 26th June)



Social media (Jan-Jun 2023)

Facebook: Top content



Recent content	Type		Reach	Likes and reacti...
How wonderful are our Occupation... 23 February 07:15	Post	Boost post	9,996	339
We're holding an Admin Services R... 26 March 10:44	Post	Boost post	8,713	66
Are you organised, confident, and ... 10 March 12:00	Post	Boost post	6,998	45
Congratulations to three Clatterbri... 9 May 11:00	Post	Boost post	6,674	335
As a Consultant in Medical Oncolo... 10 February 12:00	Post	Boost post	6,225	214
Today is #NationalCancerCNSDay! ... 26 April 02:00	Post	Boost post	6,056	398
Today, Clatterbridge Diagnostics w... 23 March 10:30	Post	Boost post	6,050	168
Today marks the start of Oesophag...			5,968	190

Instagram: Top content

Recent content	Type	Reach	Likes and reacti...
How wonderful are our Occupation... 23 February 07:08	Reels	3,094	101
Tomorrow is #LessSurvivableCance... 10 January 12:00	Post	1,813	50
We'd like to say a HUGE congratula... 12 April 11:00	Post	1,753	313
Congratulations to our April Star A... 4 May 10:00	Post	1,735	135
Our Deputy Chief Nurse Lindsey D... 16 March 10:02	Reels	1,652	98
After being diagnosed with a brain... 6 April 11:00	Post	1,608	148
A day at our Teenage and Young A... 25 April 07:25	Reels	1,567	102
A new clinical research trial is signi...		1,537	46

Some differences between top posts on Facebook and Instagram:
Admin Services recruitment campaign did very well on Facebook
Patient and staff stories and ‘day in the lifes’ more popular on Instagram

Media (Jan-Jun 2023)

Proactive news coverage in the last six months has included:

TV
- 65 years of The Clatterbridge Cancer Centre (Granada TV, Mar 2023)
- Lindsey Dawson on patient experience at CCC (BBC Breakfast, Mar 2023)
- MOAT trial (Granada TV, Jan 2023)

Radio
- Prehabilitation with Anna Olsson-Brown and Jess Hale (BBC Radio Merseyside, May 2023)
- Carlo Palmieri on metastatic breast cancer (BBC Radio 4 Woman's Hour, Apr 2023)

Newspapers (print and online)
- HSJ Awards shortlisting (Wirral Globe, Jun 2023)
- Myeloma patient story (Mirror, Echo, May 2023)
- MODIfy trial (Echo, May 2023)
- Radiotherapy VR virtual tour (Birkenhead News, Mar 2023)
- Paddington CDC (National Health Executive, Mar 2023)
- 65 years of CCC (Wirral Globe, Mar 2023)
- 50k patients at Clatterbridge Diagnostics (Wirral Globe, Mar 2023)
- Biology of dying (Mirror, Star, Echo, Feb 2023)

Merseyside mum amongst first in the world to receive pioneering cancer therapy

GRANADA | HEALTH | CANCER TREATMENT | CLATTERBRIDGE CENTRE | Friday 27 January 2023 at 4:39pm

Be Outstanding

Theme	Progress	Next steps
Marketing	• Marketing Strategy in place. Market research vox pops completed, speaker profiles in development • Branded conference stand and giveaways at UKIO • National conference keynote speakers incl HSJ Cancer Forum and RCNi breast cancer • Hosted visits including global estates design conference, ICB leaders and NHS England Medical Director • CCC-Aintree site branding completed • Awards entries submitted with teams shortlisted for HSJ Patient Safety Awards and Nursing Times Awards	• ‘Hero’ film promoting the Trust • Further support for teams doing awards entries • Scoping for CCC podcast • Development of case studies on our key strengths and USPs • Halton branding • Proactive engagement with national and regional audiences • CAR-T launch communications
Quality of care	• Successful staff vaccination campaign compared with peers • Extensive work to enhance patient experience including video guides on what to expect (e.g. cervical brachytherapy, breast radiotherapy), publicity and comms for radiotherapy VR tour, chemotherapy video Q&A, etc • Patient and staff comms to promote launch of digital appointment letters, resulting in one of the fastest take-ups the provider has seen in any hospital • Work with ward teams on ward signage and information • Comms support for Dying Matters Week, Spring into Action and other quality initiatives • New social media monitoring tool to help us share patient and relative feedback more easily with Quality Team • Initial scoping and costs for risk management animation • Patient Experience Walkrounds annual highlights report	• Stem cell transplant and CAR-T patient videos • Support prehab team with video and website content • Further patient videos for new website with clinical teams • Templates for monthly comms on quality walkrounds and patient experience walkrounds • Comms for further quality initiatives • Progress risk management comms • Staff vaccination campaign

Be Outstanding

Theme	Progress	Next steps
Comms efficiency and performance	• Quarterly team away day for forward planning (April) • Orlo social media scheduling and monitoring platform now in place, enhancing efficiency and analytics • Monthly performance report discussed at team meetings – incl media, social media, internal etc • Workflow in place for logging and approving design requests • Initial work with BI to develop performance dashboard	• Develop and launch performance dashboard with BI • Workflow for logging and approving video requests • Enhance Comms Hub on intranet with further photos, guidance and toolkits to support teams • Begin developing workflow for logging and approving all Comms Team requests, including signposting to other resources (e.g. intranet templates)
Media	• First 4 cohorts of media training successfully completed with excellent feedback • TV coverage including MODIfy (Granada TV), CCC-Wirral 65th birthday (Granada TV). Radio coverage including prehabilitation (Radio Merseyside) – see media highlights • Spokesperson press packs and case studies in development • Forward plan developed • Continued media work for cancer alliance and R&I	• NHS75 media stories • Comms Team to attend operational group, TIC, TEG to feed pipeline of good news stories • Spinal oncology service • Ramp engagement meetings and proactive pitches with national and regional media
Estates	• Paddington CDC initial announcement and ongoing comms as part of mobilisation plan including staff comms, branding and signage, patient information, stakeholder • Some internal comms on CCC-Wirral	• Paddington CDC: Patients, staff, stakeholder comms on countdown to launch, opening day and beyond • CCC-Wirral comms • Halton refurb comms?

Be Collaborative

Theme	Progress	Next steps
Cancer Alliance	• Comms for high-profile cancer alliance programmes incl rollout of Targeted Lung Health Checks in South Sefton and St Helens • Comms for GRAIL Galleri trial continued rollout • Bowel cancer screening awareness comms • Promotion of Cancer Alliance public engagement roadshows • Media coverage of Cancer Alliance champions raising awareness of bowel cancer and breast cancer • Comms on launch of cancer screening website • Regular website articles and blogs • Work on Cancer Alliance annual report	• Further promotion of roadshows • Further promotion of Cancer Alliance work programmes • Planning and comms for Cancer Alliance conference
Cancer Academy	• Blogs for Cancer Academy website	• Further blogs and promotion
Regional and national networks	• Joint work with NHS England and Equitix on Paddington CDC transaction and continued work with NHSE on launch comms planning • Clatterbridge CDC comms in partnership with WUTH • Case studies and spokespeople provided for NHS England requests incl CCC brain tumour patient story and COVID video with Lynny Yung – shared on NHS England channels • Collaboration with NHS partners on strike comms in Cheshire and Merseyside, helping raise awareness of 111 online etc • Full participation in regional and national cancer comms calls, sharing best practice from Cheshire and Merseyside	• Launch Paddington CDC with key stakeholders • Launch stakeholder bulletin • Provide content for NHS75
Partnerships	• Inclusion of CEO's diagnostics role and work of Cancer Alliance in key comms incl HSJ Cancer Forum speech • Radiotherapy VR tour comms with The City of Liverpool College • Research comms incl ECMC announcement and trials in collaboration with others	• Continue promoting key partnerships incl Diagnostics and social value

Be a Great Place to Work

Theme	Progress	Next steps
Internal comms	• Multiple daily news stories, screensavers and digital screens to raise awareness of key information • Monthly CEO videos and Team Brief, weekly e-bulletins and Thank You Thursday and other BAU comms • Staff and patient comms on key events and incidents incl industrial action, outages and downtime • CCC Lives on Green Plan and staff survey results 2022 • Comms on major projects affecting staff incl Liverpool review, Paddington CDC, CCC-Wirral refurbishment, Green Plan etc	• Full review of internal comms and development of new internal comms strategy • CCC Lives on topics incl CCC-Wirral, Green Plan and Paddington CDC • Comms to promote national staff survey 2023 • C3 magazine 2023
Recognition	• Extensive internal and external comms celebrating staff incl International Nurses Day, CNS Day, dietitians week, our staff networks, staff speaking at conferences, staff shortlisted / winning awards, remembering CCC-Aintree staff • Relaunch of monthly staff awards – now handed over to Workforce and OD	• Relaunch of 'hidden heroes' celebrating behind-the-scenes teams and individuals • Work with Learning and OD to plan 2023 annual staff awards
Feelgood events	• Planning and/or supporting multiple events incl CCC-Wirral 65th birthday, Eurovision, Coronation, IND, CNS Day • Preparations for NHS75 and ice cream day	• Delivering NHS 75 and ice cream day • Consultant away day • Christmas
Staff campaigns	• Staff survey results comms • Cybersecurity comms campaign (May 2023) • Industrial action • Vaccination campaign 2022/23 • Campaigns on behalf of individual teams e.g. blood stock awareness, Meditech changes, health and wellbeing	• Freedom To Speak Up campaign • Launch of staff survey 2023 • Staff vaccinations 2023/24
Recruitment	• Comms campaign to promote Admin Services recruitment events • Weekly jobs round-up on social media • UKIO conference stand	• Continue weekly posts and support any big new events • Support Trudy Guinan speech at RCNi careers event

Be Research Leaders

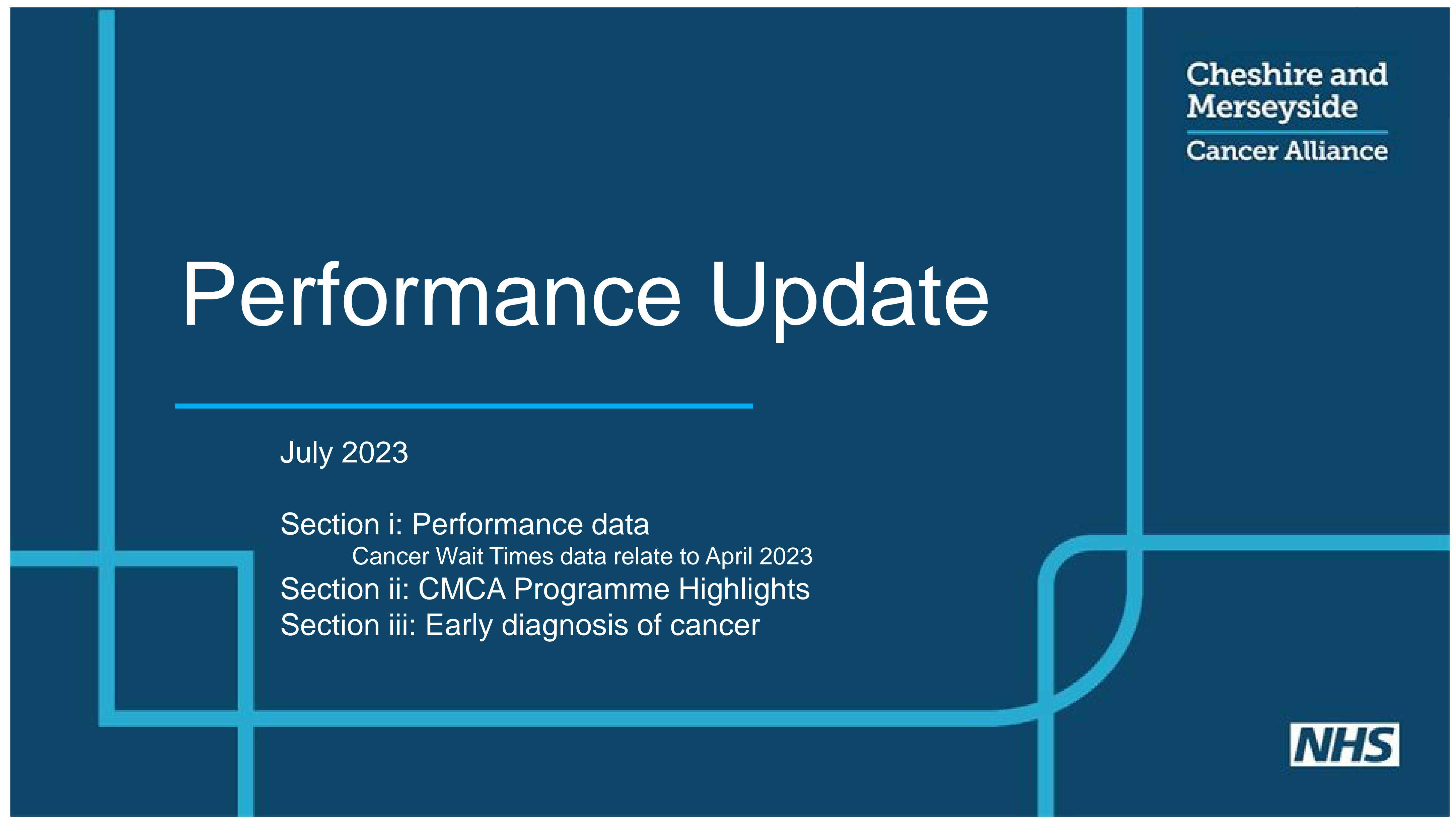
Theme	Progress	Next steps
Marketing	• BRC, ECMC, CRF now incl in key messaging, media release boiler plate and new vinyl branding at CCC-Aintree • Comms promoting CCC Research Day	• Roll out BRC, ECMC, CRF branding on all sites as and when estates works completed
Clinical trials	• Extensive comms and media coverage for key trials incl MODIfy, MOAT, blood cancer and COVID • Creation and launch of clinical trials awareness campaign incl video testimonials from patients on trials and an animation demystifying trials for patients and public	• Continue rolling out clinical trials awareness campaign • Continue promoting clinical trials via news stories and media coverage
R&I strategy	• Editing and design for annual report • Development with research colleagues of PPI newsletters updating patients and public	• Develop structure and content for research section of new Trust website

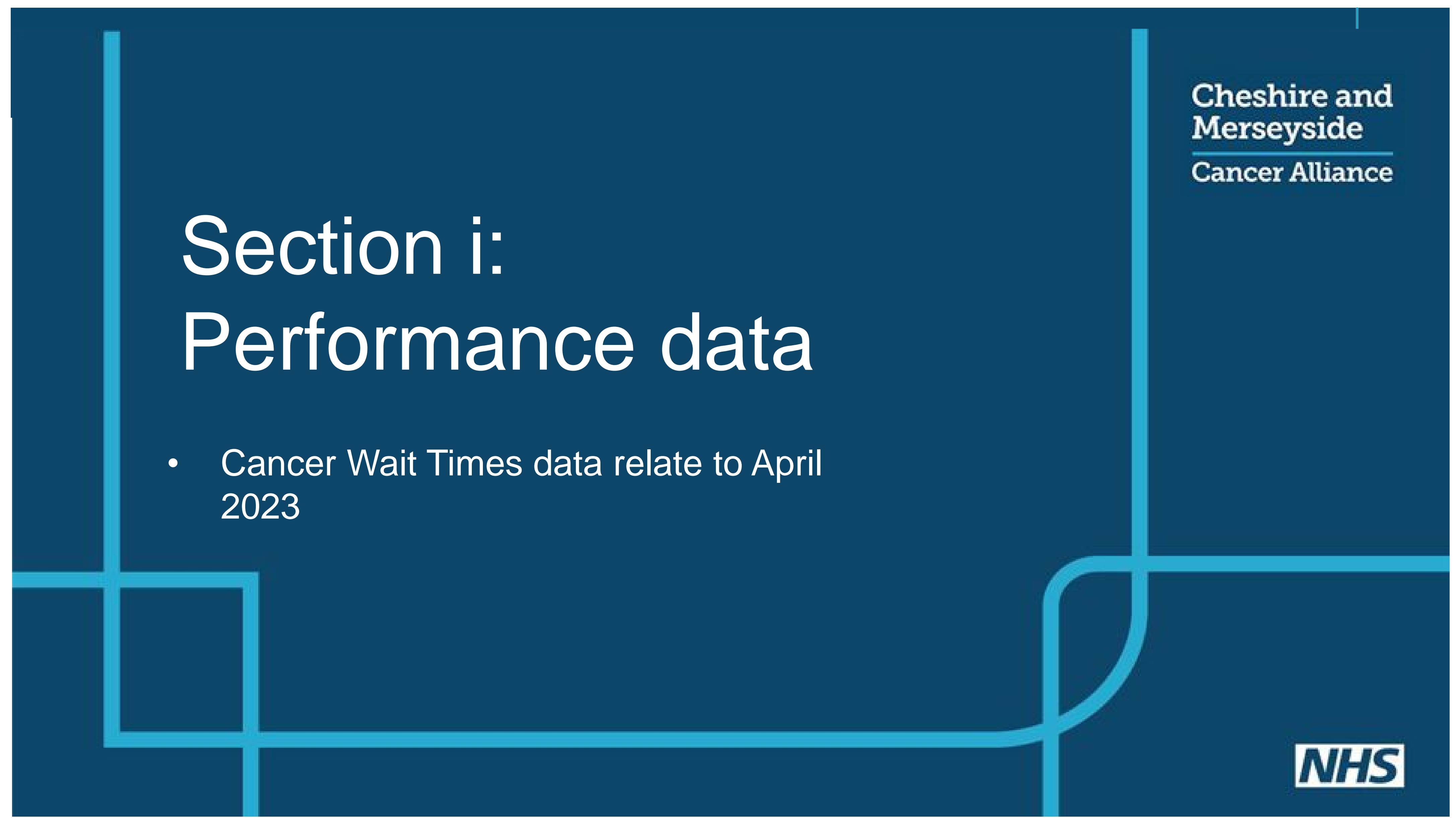
Be Digital

Theme	Progress	Next steps
Website	• New provider appointed and contract signed • Stakeholder engagement and user research completed • Page templates nearly complete • Site structure and content in development	• Website build by developers • Continue developing site structure and content • Begin populating new website • User testing, feedback and revisions • Security testing and readiness for go-live
Intranet	• Initial discussions as part of new Sharepoint workstream – identifying areas for development as part of Phase 2	• Progress Phase 2 of intranet – updates to enhance features, remove glitches and improve analytics capabilities (dependent on Digital Team's Sharepoint contract and workstream)
Projects	• CCC digital comms screens are now live in CCC-Aintree for patients and staff • Successful launch of digital outpatient appointment letters, resulting in one of fastest take-ups the provider has seen • Initial comms for 'Getting the most from Meditech' project • Ongoing comms for updates on Meditech and other key projects • Cybersecurity awareness staff campaign in May	• Review and replace / renew contract for digital comms screens at CCC-Liverpool • Ramp up 'Getting the most from Meditech' comms as changes begin to take shape • Comms support for multi-factor authentication (MFA) rollout and return of unused mobile phones • Support further rollout of digital appointment letters • Expand digital screens to CCC-Wirral, Halton and Marina as and when appropriate (linked to estates upgrades and capital)

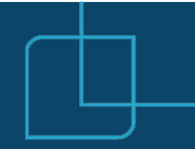
Be Innovative

Theme	Progress	Next steps
Strategy	• Design and launch of Innovation Strategy was completed	• Continue promoting progress delivering the strategy
Services	• Initial comms planning for launch of CAR-T • Initial comms planning for launch of spinal oncology service and new NICE guidance	• Full comms plan and patient, staff and stakeholder comms to promote the new service – incl patient experience video on 'what to expect' and guidance for referrers • Launch comms for spinal oncology service • Continue promoting innovative services in marketing and media incl podcasts and conferences
Bright Ideas	• Regular comms promoting news on Bright Ideas and Big Ideas	• Continue this work aiming for bigger ideas with more impact to help promote the Trust and Charity
Greener CCC	• Comms promoting our first Green Plan annual report and progress made over the last year, incl short summary, news story and social media and CCC Live event for staff • Green Plan section developed on Trust intranet • Extensive comms on results of our green travel survey and how it will shape our green travel plan • Comms launching new salary sacrifice offer for staff season ticket loans • Comms promoting other green travel offers e.g. bus and e-bikes	• Announcement / welcome to new Sustainability Manager • Further Green Plan comms as work progresses e.g. when travel plan is published • Remind staff about Green Plan section of intranet and keep updated with news from Sustainability Manager


Cheshire and Merseyside
Cancer Alliance
Performance Update
July 2023
Section i: Performance data
Cancer Wait Times data relate to April 2023
Section ii: CMCA Programme Highlights
Section iii: Early diagnosis of cancer
NHS


Cheshire and
Merseyside
Cancer Alliance
Section i:
Performance data
• Cancer Wait Times data relate to April 2023
NHS

Summary measures:
Most recent 12 months vs previous 12 months (%)



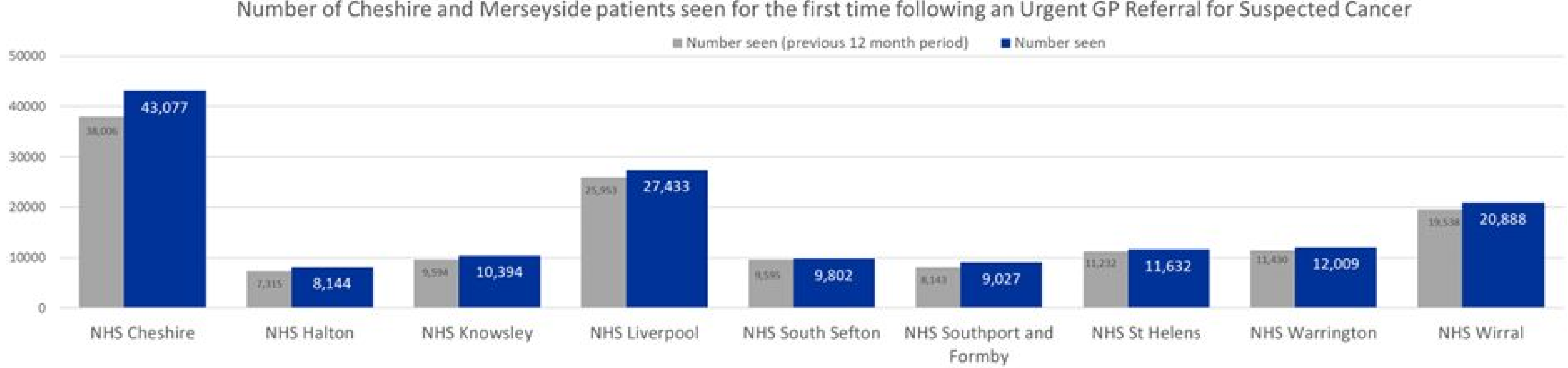
Measure	Value	Commentary
Volume patients seen for the first time following an urgent GP referral for suspected cancer	108%	Data relate to patients registered with Cheshire and Merseyside GPs. Data are from Cancer Wait Times Dataset, most recent month April 23.
Cancer treatment activity: Volume of first definitive treatments for all diagnosed cancers	103%	
Cancer treatment activity: Volume of surgical treatments for all diagnosed cancers (all surgical treatments whether first or subsequent)	103%	
Systemic-Anti Cancer Therapies (SACT) (inc chemo) referrals to Clatterbridge Cancer Centre	111%	The sustained increase in activity continues to present challenges to service delivery, however CCC continues to take action to meet demand, including detailed capacity, demand and workforce planning. SACT and RT data refer to July 22-June 23 as a % of July 21-June 22.
Radiotherapy (RT) planning volumes at Clatterbridge Cancer Centre	115%	

Urgent GP referrals for suspected cancer: Activity

Patients registered with GP Practices in Cheshire and Merseyside:

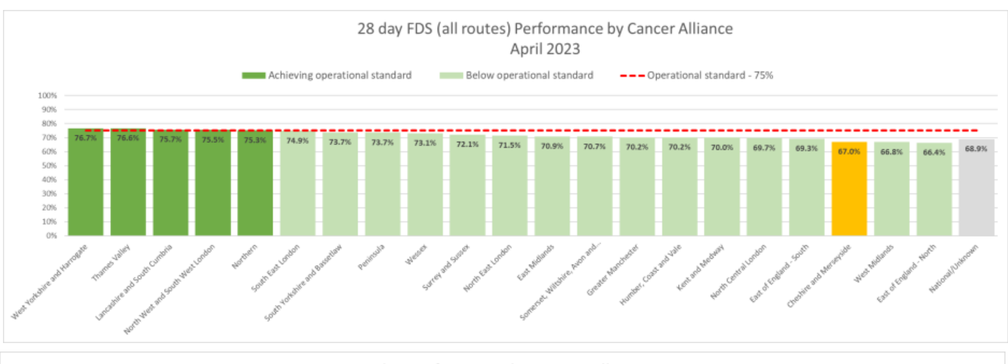
- Between May 22 - Apr 23 **152,400** patients were seen for the first time following an urgent GP referral for suspected cancer, compared to 140,800 in the previous 12 month period.

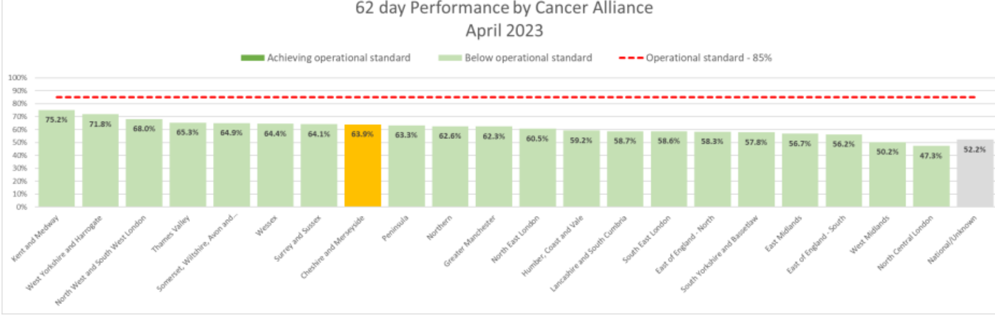
- On average this is **12,700** patients per month.

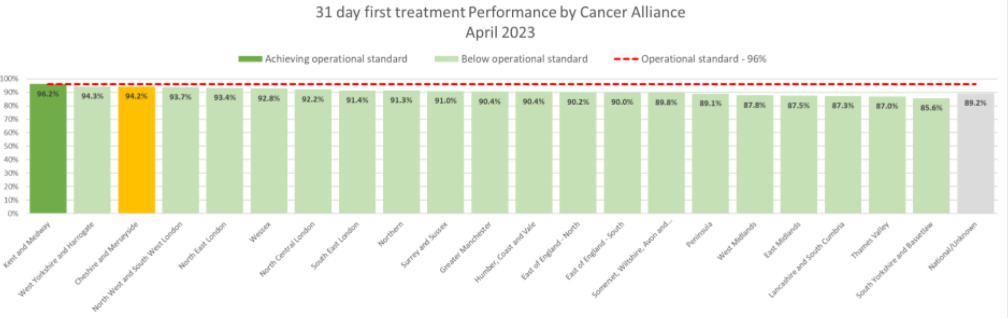


Source: NHS England Cancer Wait Times data

National comparisons: Operational Standards







Data refer to patients registered in Cheshire and Merseyside

75% of patients should receive a diagnosis or ruling our of cancer within 28 days of referral*

CMCA ranks **19th** out of 21 (April 2023): **67.0%**
England average (71.3%) North West average (70.2%)

*Referral may be via urgent GP referral for suspected cancer, breast symptoms where cancer is not initially suspected or referral from a screening programme.

85% of patients should receive their first definitive treatment for cancer within 62 days of an urgent referral from a GP for suspected cancer.

CMCA ranks **8th** out of 21 (April 2023): **63.9%**
England average (61.0%) North West average (61.9%)

96% of patients should receive their first definitive treatment for cancer within 31 days of a decision to treat.

CMCA ranks **3rd** out of 21 (April 2023): **94.2%**
England average (90.5%) North West average (91.2%)

Source: NHS England Cancer Wait Times data

Place level vs operational standards: 12 months rolling
May 2022 to April 2023

Operational standard	Cheshire and Merseyside	Cheshire	Halton	Knowsley	Liverpool	South Sefton	Southport and Formby	St Helens	Warrington	Wirral
28 day diagnosis / ruling out of cancer (75%)	66.7%	65.5%	72.3%	65.5%	59.4%	61.3%	64.4%	69.9%	72.8%	75.2%
62 day first definitive treatment (85%)	66.3%	66.7%	72.0%	66.3%	54.8%	52.9%	62.4%	78.2%	67.3%	74.3%
31 day first definitive treatment (96%)	94.5%	93.6%	95.7%	95.7%	93.3%	93.1%	91.9%	96.6%	96.0%	96.4%

Highest Lowest

Patients registered with GP Practices in Cheshire and Merseyside

Source: NHS England Cancer Wait Times data

Trust level vs operational standards: 12 months rolling
May 2022 to April 2023

Operational standard	Cheshire and Merseyside Trusts	CCC	Alder Hey	Bridgewater	COCH	East Cheshire	Liverpool Heart and Chest	LUHFT	LWH	Mid Cheshire	Mersey and West Lancashire: S&O sites	Mersey and West Lancashire: StHK sites	The Walton Centre	Warrington And Halton Hospitals	WUTH
28 day diagnosis / ruling out of cancer (75%)	67.0%	83.1%	100.0%	77.4%	62.6%	62.4%	40.9%	60.0%	53.3%	70.2%	66.9%	70.0%	98.7%	72.7%	76.1%
62 day first definitive treatment (85%)	66.1%	80.4%	100.0%	81.3%	69.9%	51.0%	67.4%	50.8%	18.0%	71.6%	57.8%	80.2%	28.6%	65.1%	74.0%
31 day first definitive treatment (96%)	94.4%	99.1%	100.0%	93.9%	96.6%	82.0%	93.6%	89.6%	81.3%	92.3%	88.6%	97.4%	98.9%	97.8%	95.8%

Highest Lowest

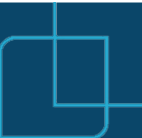
Patients attending Trusts in Cheshire and Merseyside

CCC: The Clatterbridge Cancer Centre
LWH: Liverpool Women's Hospital
WUTH: Wirral University Teaching Hospitals
COCH: Countess of Chester Hospital
S&O: Southport and Ormskirk*
LUHFT: Liverpool University Hospitals NHS Foundation Trust
StHK: St Helens and Knowsley*

Southport and Ormskirk, and St Helens and Knowsley Trusts merged in July 23 to form Mersey and West Lancashire Teaching Hospitals NHS Trust. Data from April still refer to original trusts.

Source: NHS England Cancer Wait Times data

Patients waiting over 62 days on the Cancer PTL



Cheshire and Merseyside Cancer Alliance Over 62 day cancer PTL

Cheshire and Merseyside Plan (2023/24) — Cheshire and Merseyside Actual (2023/24)

Number of patients waiting over 62 days

2,000
1,500
1,000
500
0

31/03/2024
1,095

09/07/2023
1,377

02/04/2023 02/05/2023 02/06/2023 02/07/2023 02/08/2023 02/09/2023 02/10/2023 02/11/2023 02/12/2023 02/01/2024 02/02/2024 02/03/2024

Week ending date

Over 62 day PTL	Cheshire and Merseyside Trusts	CCC	Bridgewater	COCH	East Cheshire	Liverpool Heart and Chest	LUHFT	LWH	Mersey and West Lancashire	Mid Cheshire	The Walton Centre	Warrington And Halton Hospitals	WUTH
End of March 2024 goal	1095	50	0	102	47	5	264	65	239	128	0	55	143
Latest Week: 09 Jul 23	1,377	73	0	78	51	12	290	163	239	244	0	64	163
Distance from Plan	-263	13	0	-32	-12	3	-244	53	-64	52	0	5	-37
Distance from end of March 2024 target	282	23	0	-24	4	7	26	98	3	116	0	9	20

Highest — Lowest

Patients on Cheshire and Merseyside Trust PTL lists, waiting over 62 days

Trusts have agreed Patient Tracking List (PTL) trajectories, to reduce the number of patients waiting over 62 days by the end of 2023/24. The number of patients waiting over 62 days is planned to reduce gradually during 2023/24.

- Cheshire and Merseyside over 62 day PTL is **lower than** trajectory as of 09 July 23. The current number of patients waiting over 62 days is **84%** of the number planned for 09 July 23.
- As of 09 July 23 the current over 62 day PTL is 126% of the volume planned for the end of 2023/24.

Source: Cancer 62 Day Patient Tracking List (PTL)

Southport and Ormskirk, and St Helens and Knowsley Trusts merged in July '23 to form Mersey and West Lancashire Teaching Hospitals NHS Trust.

Section ii:
CMCA Programme Highlights
Cheshire and Merseyside
Cancer Alliance
NHS

Transformation and partnerships: Highlights since last report

Personalised Stratified Follow Up (PSFU)

PSFU is an effective way of adapting care to the needs of patients after cancer treatment.
The seven applicable CMCA trusts have PSFU services for breast, endometrial, prostate and colorectal cancer patients, in line with national requirements.
In total there are 47 live and operational PSFU pathways across different cancer types in Cheshire and Merseyside.
Two new PSFU services are due to launch during 2023/24:

- PSFU for haematology cancer patients at Mid Cheshire Hospitals is due to launch in July.
- PSFU for lung cancer patients at Southport and Ormskirk sites of Mersey and West Lancashire Teaching Hospitals is due to launch later in the year.

Grail: Galleri Trial

The Galleri test, developed by GRAIL, can detect early stage cancers through a simple blood test. In the first year of the NHS-Galleri trial, Cheshire and Merseyside recruited over 22,000 participants of the total 140,000 across England. The retention target for year one of the trial is 92% and Cheshire and Merseyside are on track to meet this. The region is seen as an exemplar for implementation of the trial and is supporting with planning for the pilot phase due to commence in late 2024.

Challenges since last report

- PSFU: The Southport and Ormskirk / St Helens and Knowsley merger has delayed the launch of the lung cancer PSFU service at S&O sites.
- TLHC: Challenges with both procurement and the new national payment structure for TLHCs are impacting Phase 4 TLHC planning and could delay go-live in 23-24.

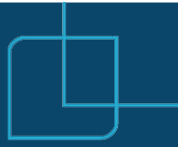
Targeted Lung Health Checks (TLHC)

Targeted Lung Health Checks invite people aged 55-74 who are identified on GP Practice registers as current or ex-smokers for a Lung Health Check and, if appropriate, refer them onwards for a low dose CT scan and spirometry. The programme aims to identify lung cancers at an earlier stage.
Cheshire and Merseyside has participated in all phases of the national TLHC trial, which has resulted in the Department for Health and Social Care announcing in June, the introduction of a national targeted lung cancer screening programme aiming to reach 40% of the eligible population by March 2025 and 100% coverage by March 2030.
Knowsley, Halton and Liverpool (phases 1 and 2) have been in the programme since July 2021 with St Helens and South Sefton (phase 3) joining in December 2022.
The national cancer programme has approved phase 4 expansion of the Cheshire and Merseyside TLHC footprint to Wirral, Warrington and North Sefton (Southport and Formby) during 2023/24.
As of June '23, uptake of offered TLHCs in Cheshire and Merseyside was 41.6% in phase 1 and 2 areas and 43.8% in phase 3 areas, similar to the England average of 42.0%.
On average 41.4% of Lung Health Checks (LHCs) result in a Low Dose CT scan in England. In Cheshire and Merseyside, proportions are higher, with 70.4% of LHCs in phase 1 and 2 areas resulting in Low Dose CT scans, and 69.5% in phase 3 areas.
People who live in deprived areas are more likely to experience health inequalities. In Cheshire and Merseyside 23.4% neighbourhoods are identified as being in the 10% most deprived neighbourhoods in England (Decile 1). High rate of conversion from LHC to CT scan is in line with the relatively high levels of deprivation in Cheshire and Merseyside.
Early diagnosis of Lung cancer in Cheshire and Merseyside has increased from 32.2% in Q1 2021 to 43.0% in Q4 2022, a 10.8 percentage point increase. This is a larger increase than in England overall (7.1 percentage point increase). The notable improvement in Cheshire and Merseyside has been influenced by the THLC programme, and the previous healthy lung programme in Liverpool.

Key activities in the next six months

- Launch of PSFU for haematology at Mid Cheshire Hospitals.
- Procurement process for TLHC Phase 4 to commence according to the outcome of ICB finance committee decision in July.

Faster Diagnosis: Highlights since last report



Faster Diagnosis Standard (FDS)

Overall 75% of patients should receive a diagnosis or ruling our of cancer within 28 days of referral, however some cancer pathways consistently achieve above 75% (e.g. skin and breast), whilst other, more complex pathways consistently achieve below 75% (e.g. urology and lower GI).
NHS England has suggested some tumour specific goals for FDS performance for these four main cancer types. Performance against these goals is shown below for the most recent full financial quarter (Jan-Mar '23).

- Breast: **90.9%** diagnosed / ruled out in 28 days (goal 92%)
- Lower GI: **41.2%** diagnosed / ruled out in 28 days (goal 62%)
- Skin: **86.4%** diagnosed / ruled out in 28 days (goal 85%)
- Urology: **42.8%** diagnosed / ruled out in 28 days (goal 63%)

Faecal immunochemical test (FIT)

FIT is a home test which checks faeces for tiny amounts of blood, a strong indicator for colorectal cancer. If FITs accompany urgent GP referrals for suspected colorectal cancer (lower GI), unnecessary endoscopies can be avoided and patients can be ruled out for cancer sooner.
All main trusts in Cheshire and Merseyside have live FIT pathways. Wirral University Teaching Hospital's pathway went live in June '23.
In 2022/23, 57.9% of lower GI referrals were accompanied by a FIT in Cheshire and Merseyside. This is lower than the England average of 68.8%

Challenges since last report

- Long term sustainability of NSS service and individual site-specific transformation funding remains a challenge.
- Increase in national requests for trust data submissions (e.g. tele-dermatology, liver surveillance new for 23/24).
- Challenges in achieving 75% FDS target in urology, lower GI and gynae.

Best Practice Timed Pathways (BPTP)

Best practice timed pathways support the ongoing improvement effort to shorten diagnosis pathways and meet the 28 day Faster Diagnosis Standard.
In 2023/24 CMCA is monitoring BPTP steps for six pathways: prostate, colorectal, lung, oesophageal, gynae and head and neck. NHSE only require monitoring of prostate and lower GI.
In May new data were received from Mid Cheshire, COCH and StHK, meaning all trusts who are submitting BPTP data are now submitting data for all relevant pathways with the exception of WUTH which has not yet submitted any BPTP data as of July '23.

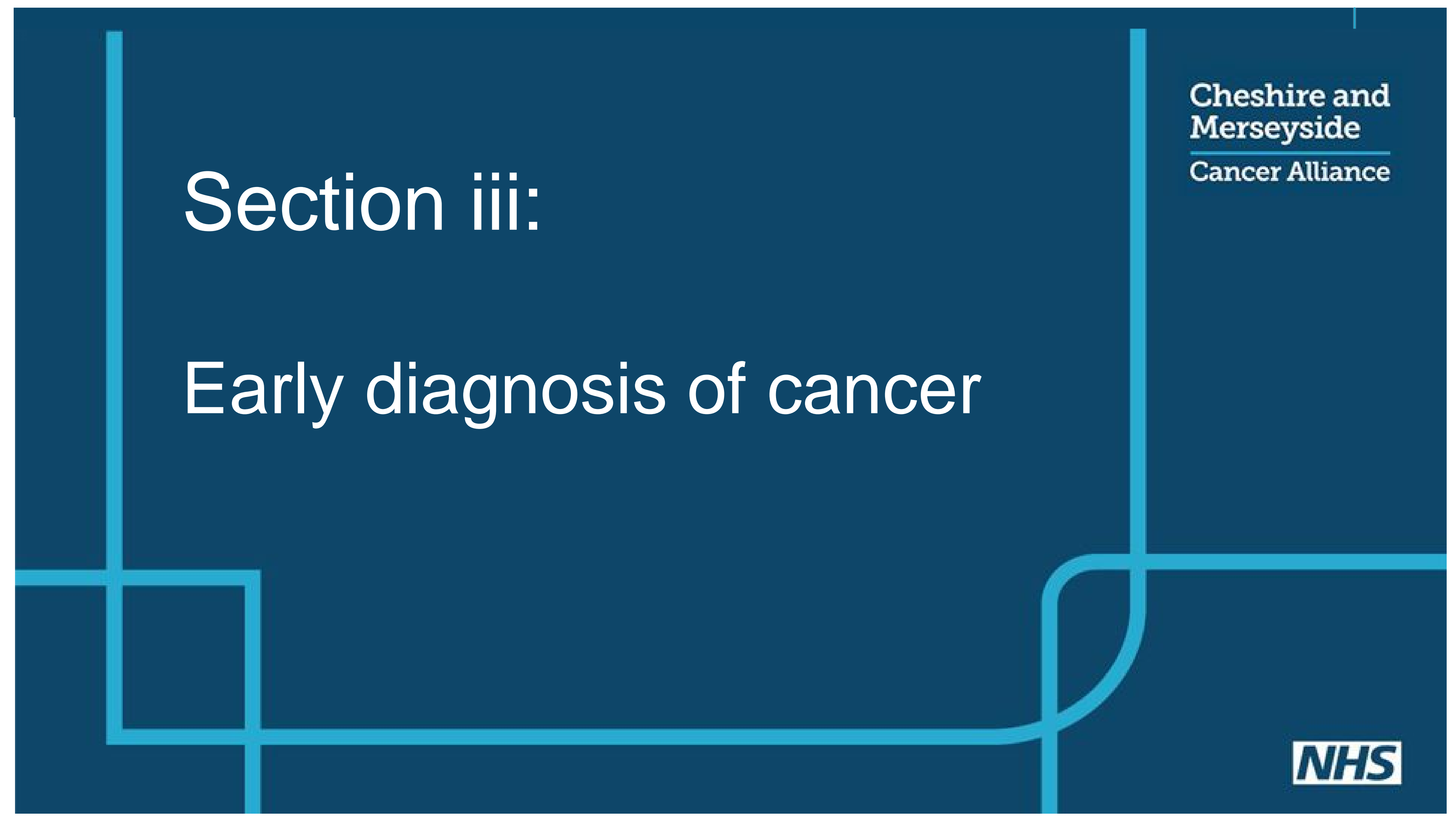
Non Specific Service (NSS)

NSS pathways are for patients who do not fit into a single 'urgent cancer' referral pathway, as defined by NICE guidance NG12, but who are, nonetheless, at risk of being diagnosed with cancer. Symptoms include unexplained weight loss, fatigue, abdominal pain or nausea; and / or GP 'gut feeling' about cancer. Numbers of NSS patients first seen in trusts on a 28 day pathway are compared against planned numbers from ICS level trajectories. In the last three months (March 23-May 23), 390 patients were seen. This is higher than the 364 patients planned in the ICS trajectory*. From July '23 NSS patients are included in the Faster Diagnosis Standard and Cancer Wait Times data.

*Higher than planned is good

Key activities in the next six months

- Options appraisals for tele-dermatology and NSS to establish future service models.
- Continued monitoring of the impact of FIT on lower GI pathway.
- Further lower GI programme development to commence to address FDS performance challenges.


Section iii:
Early diagnosis of cancer
Cheshire and Merseyside
Cancer Alliance
NHS

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

Early diagnosis of cancer: cancers with a known stage excluding non-melanoma skin cancer (c44)
Rapid Cancer Registration Dataset 2021-2022

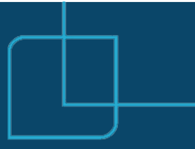
	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022
% Early diagnosis in England	54.8%	55.1%	56.8%	57.5%	56.5%	57.3%	58.5%	58.9%
% Early Diagnosis in Cheshire and Merseyside	55.3%	53.5%	56.3%	56.6%	55.3%	59.3%	58.1%	59.9%

The NHS Long Term Plan (LTP) sets an ambition that by 2028, 75% of people with cancer will be diagnosed at an early stage (stage one or two).

- Quarterly early diagnosis proportions have increased overall in the past two years.
- Overall, **56.8%** of Cheshire and Merseyside cancers were diagnosed at an early stage in the last two years, this is **statistically similar to England** (57.0%)
- Early diagnosis in Cheshire and Merseyside has increased from 55.3% in Q1 2021 to 59.9% in Q4 2022.

Source: Rapid Cancer Registration Dataset, CancerStats2

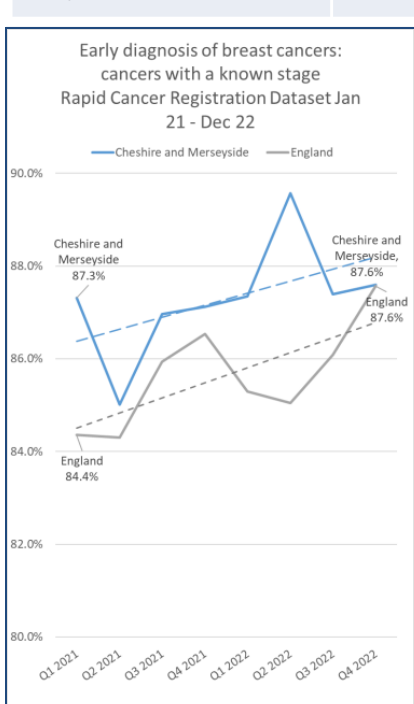
Cancer stage at diagnosis: Rapid Cancer Registration Database (RCRD)

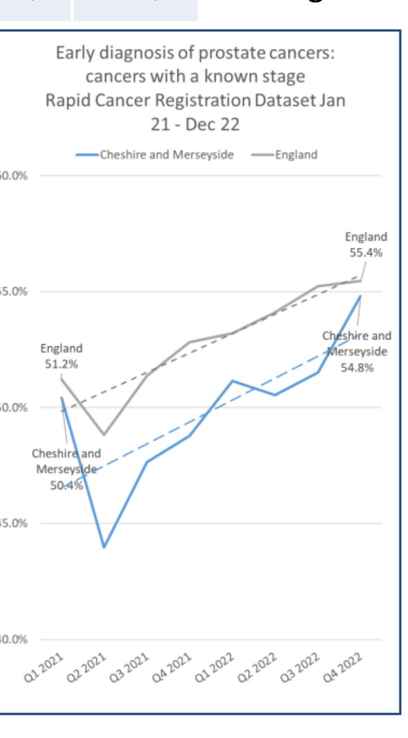


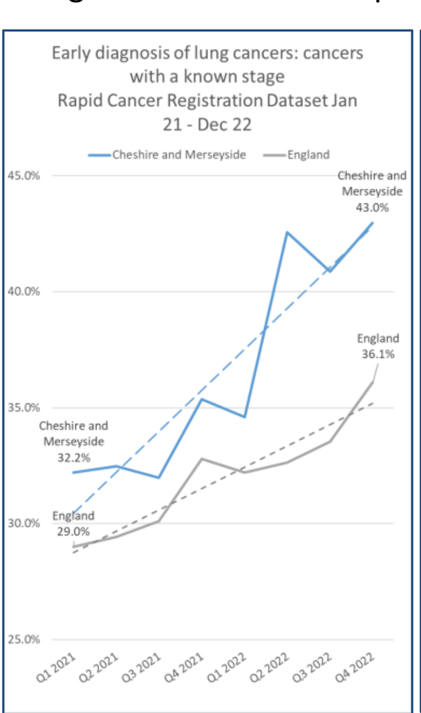
Average percentage early diagnosis: Jan 21 – Dec 22

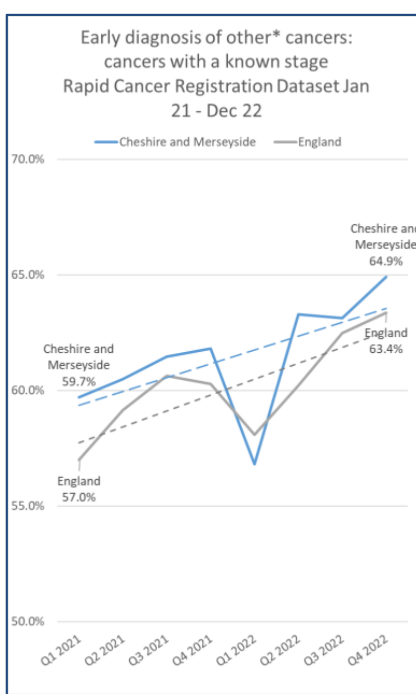
Area	Breast	Colorectal	Prostate	Lung	Other
Cheshire and Merseyside	87.3%	44.4%	50.1%	36.8%	61.5%
England	85.6%	48.6%	53.0%	32.0%	60.2%

The most recent data from RCRD is up to December 2022. Over the past two years (24 months), early diagnosis rates in Cheshire and Merseyside have been above the England average for breast, lung and other* cancers, but below the England average for colorectal and prostate cancers.









Source: Rapid Cancer Registration Dataset, CancerStats2

*Other excluding non-melanoma skin cancer

Trust Board Part 1 – 26th July 2023

Chair's Report for: Audit Committee

Date/Time of meeting: 13th July 2023, 09.30pm till 12:30pm

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

General items to note to the Board	The Committee received the Internal Audit Progress Report which provided details of the following audits: • Data Protection & Security Toolkit – Substantial Assurance • Provider Collaborative – Procurement – Substantial Assurance • Critical Apps (Estates) – Limited Assurance • The audit of Critical Apps (Estates) at CCCL identified that work is required to formalise the responsibilities of the Information Asset Owner and Information Asset Administrator for the CCTV and physical access systems. Furthermore, that the protocols in place for the storage and transit of data within those systems need documenting and the CCTV Policy needs reviewing to ensure it reflects current practice. The key actions arising from the audit relate to cyber security, but the Committee was assured by the Chief Information Officer (CIO) as the CCTV and physical access systems are third party systems there are no implications for the Trust's systems and thus have no impact on BAF Risk 14. However, the CIO highlighted that the Trust's Digital Team are assisting PropCare and the relevant third-party service provider to ensure the audit recommendations are actioned. The audit also highlighted the need to ensure lessons learnt from this review are applied to other Trust locations and that contracts with third parties managed by the Trust's subsidiaries need reviewing to provide assurance that responsibilities and roles are clearly defined. • A detailed report detailing the governance arrangements for the Trust's subsidiaries was also received and the Committee noted that an opinion of substantial assurance was provided for both Propcare and the Clatterbridge Private Joint Venture. • The Committee received an update on the progress of the work of the Trust's Anti-Fraud Specialist (AFS), against the Anti-Fraud Plan, which detailed the work undertaken in quarter 1 2023/24. This included the submission of the

Counter Fraud Functional Standard Return (CFFSR) for which the Trust received an overall green rating and achieved green ratings across all 12 components. In terms of Counter Fraud activities, twelve Fraud Prevention Checks (FPCs) have been issued for intelligence and preventative purposes and three national Intelligence Bulletins were issued to the Trust for action and related to potential supplier fraud.

- The Committee noted the NHS Counter Fraud Authority Strategy 2023-26 and Business Plan 2023-24 which sets out the vision for the NHS CFA and provides details of the newly launched Fraud Hub which will focus on supporting, enabling, assisting, and guiding health bodies regarding fraudulent matters.

- The Committee reviewed the key performance indicators for financial assurance indicators and noted the positive position across the range of indicators:

  - **Better Payment Practice Code** performance remains high at 100% for both volume and value for NHS and 100% for non-NHS value and 99.6% for volume. The national standard requires that the NHS pays at least 95% of all invoices in line with contract terms, typically 30 days. This KPI is closely monitored both nationally and by the Cheshire and Merseyside ICB. The Trust is currently the highest performing Trust within C&M.

  - **Aged Creditors** - both the NHS and Non-NHS position are positive. *NHS-there were only* 4 invoices over 90 days totalling <£1k. For *Non-NHS* the level of creditors over 90 days has reduced further to 2 invoices totalling <£1k.

  - **Cash -** The cash balance has reduced slightly but the Trust continue to have a healthy balance of 67 days' working capital cash balance.

- The Committee noted the Tender Waiver Register which provided details of waivers approved in Q1 23/24. Four tender waivers were signed off in Q1 23/24 where the value of the contract exceeded £50k (inc. VAT) and four retrospective tender waivers totalling £323,626.31 were also approved.

- An Internal Audit report following a review of the Health Procurement Liverpool (HPL) by Merseyside Internal Audit Agency (MIAA) was received by the Committee and provided substantial assurance that HPL has processes in place for operating in line with Partner Trust requirements whilst ensuring local processes are underpinned by Standard Operating

	Procedures. The Procurement Board, made up of the Directors of Finance from partner trusts, will oversee the implementation of the recommendations. • The Committee received a quarterly update on Cyber Security that outlined the work completed in the reporting period. The ISO27001 auditors (British Standards Institution (BSI) Group) performed audits at CCCW and CCCA at the beginning of June 2023 and recommended approval of certification for these two sites. The audit of CCCL will now need to be completed to enable the Trust's overall certification to be progressed. The Trust recently achieved the second-best rating in the region for Microsoft Defender Endpoint (MDE) status and the Trust's Data Security & Protection Toolkit (DSPT) submission received an award of standards exceeded by NHS England. • The Committee received a summary of a report in relation to a recent national audit of the Electronic Staff Record and noted that there had been no implications for the Trust. • The Committee reviewed the Board Assurance Framework risk BAF14 that relates to Cyber Security. The Committee confirmed that they remain satisfied with the key controls and assurances provided and endorsed the residual risk score of 12 and noted due to the dynamic external environment the target risk also remains at 12. • The Committee reviewed the Annual Report of the Audit Committee and the Committee Effectiveness Reviews undertaken by the Quality Committee, Performance Committee and the People Committee. The Audit Committee was satisfied that the committees had discharged their responsibilities in line with their terms of reference. The Committee noted that the Annual Report will be considered by the Board at its July meeting alongside the Committee's Effectiveness Review. • The Committee noted the changes to the Provider Licence that came into effect from 1st April 2023. The three new conditions relate to collaboration, the triple aim, and digital maturity together with changes to existing conditions. The Trust's existing governance arrangements have been reviewed to ensure that there is sufficient oversight of compliance with the new and revised conditions and there are no gaps.
Items of concern for escalation to the Board	• The Report from the Director of Finance highlighted the Trust's financial position at month 2 and the £8.3m, Cost Improvement Plan (CIP) target for the year.

	• To support CIP delivery the Trust have reviewed its process and governance. The CIP process was presented to the Trust Improvement Committee and Finance Committee in June. The Trust have profiled savings to support the transition from basic idea through to delivery, based on completion criteria. This is consistent with the risk profile used for reporting to NHSE and includes the executive Quality Impact Assessment process. The Committee discussed the significant financial risk associated with CIP delivery and requested the Director of Finance to produce a detailed progress report for the Audit Committee in October. It was also noted that MIAA have been progressing a review of the Trust's CIP processes/arrangements and will be reporting the results of their review at the October meeting. • The Committee received an update on the emerging governance arrangements for finances across the Cheshire and Merseyside System including the tiered approach to segregation of providers based on risk levels. The Director of Finance informed the Committee he will be providing a report to the Board in July outlining the arrangements and the implications in terms of the Trust's future governance and reporting to the ICB. • The process will be implemented where a Trust has a deficit plan or reports a deficit in the financial year. This approach is consistent with the additional cost controls advocated by NHS England for deficit positions.
Items of achievement for escalation to the Board	• The Committee noted positive progress in relation to the follow-up actions from previous audits. Two remain outstanding and two are partially implemented from a previously reported position of 23 outstanding actions.
Items for shared learning	There were no items for shared learning.

Title of meeting: Board of Directors
Date of meeting: 26 July 2023

Report lead	Liz Bishop, Chief Executive			
Paper prepared by	Updates to strategic risks provided by the Executive Risk Leads			
Report subject/title	Board Assurance Framework (BAF) updates			
Purpose of paper	To provide an update on the sections of the BAF under direct oversight of the Board (strategic risks BAF4 and BAF6)			
Background papers	Q4 BAF report presented to April Board of Directors; BAF update reports to Performance Committee (May), Quality Committee (June), People Committee (June) and Audit Committee (July)			
Action required	Confirm level of assurance provided about key controls for BAF4 and BAF6. Note the current risk exposure across the set of strategic risks (Appendix 1).			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	x	Be a great place to work	
	Be Collaborative	x	Be Digital	
	Be Research Leaders		Be Innovative	

Equality & Diversity Impact Assessment

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

Ref: FCGOREPO
Review: July 2025
Version: 2.0

1.0 Introduction

1.1 This report provides key updates about the Trust's strategic risks. It includes key highlights about strategic risks under direct oversight of the Board: BAF4 and BAF6 relating to Board governance and system working. A one-page summary of risk levels aligned to the Trust's strategic priorities is provided in Appendix 1, and the full BAF detailing risks, controls, assurances and actions is provided in Appendix 2 for reference.

1.2 Since the last update to the Board in April, Committees of the Board have received BAF reports as follows:

- BAF2, 3, 5, 8 and 15 reviewed by the Performance Committee 24 May;
- BAF9, 10, 11 and 12 reviewed by the People Committee 20 June;
- BAF1, 7 and 13 reviewed by the Quality Committee 21 June;
- BAF14 reviewed by the Audit Committee 13 July.

1.3 The Board should use the BAF as a tool to:

- keep updated about the strategic risk and where the Trust is operating outside of the Board's risk appetite;
- gain an overview of the effectiveness of risk controls through the assurance information provided;
- track progress towards the target risk level as planned actions are completed,
- check and challenge the management of risks.

2.0 Key highlights

2.1 Highlights from committees

2.1.1 **Performance Committee**

The Committee had a thorough discussion on the five Board Assurance Framework entries aligned to the Performance Committee. The Committee received assurance that a full review has been undertaken with the Executive Leads to update the controls and refresh all the actions. The Committee noted measures had been included to be reviewed in line with the BAF risks. There were no changes to the residual (current) risk scores for BAF 2, 3, 5 and 15 from Q4 to Q1. BAF 8 (Research Resourcing) increased from an (2 x 4) 8 to a (3 x 4) 12 following a full refresh of the risk, further narrative of this increase was requested by the Committee and distributed to members post meeting and added to the additional narrative section of BAF8 in Appendix 2.

2.1.**2 People Committee**

During quarter 1 2023/24 the Workforce Team completed a comprehensive refresh of the 4 People BAF risks. This led to the merging of risks and resulted in the re statement of the risks as follows:

BAF 9 – Leadership capacity and capability - Removed

BAF 10 - Ability to ensure provision of sufficient workforce capacity and capability

If the Trust is unable to recruit, train and retain staff sufficiently then there is a risk that workforce capacity and capability will not meet demand resulting in undue pressure on

staff and adverse impacts on patient safety, effectiveness of care and patient and staff experience

BAF 11- Staffing Levels - Removed

BAF 12 - Ability to promote and embed a positive, inclusive and healthy workplace culture

If the Trust is unable to provide a positive, supportive and inclusive culture, where individuals wellbeing needs are met and individuals feel valued and rewarded for their contributions there is a risk that this will result in an adverse impact on staff performance, wellbeing, engagement, retention, trust reputation, and the ability to deliver services and patient care.

The controls and assurances relating to BAF 9 around leadership are now reflected within BAF 10 and operational risks regarding staffing in BAF 11 are captured and monitored within the Divisional and Corporate Services Risk Registers. The two remaining risks link in with the Trusts key performance indicators and better reflect the strategic risks. BAF 10, has a residual (current) risk score of (4 x 4) 16 with a target of (3 x 3) 9 and BAF 12, has a residual risk score of (3 x 4) 12 with a target of (2 x 3) 6. The Committee noted the changes to the BAF and recommend the revisions and merging to the Trust Board.

2.1.3 **Quality Committee**

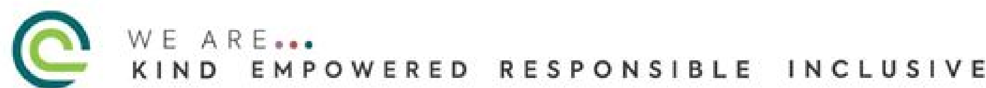
The Committee received the Board Assurance Framework (BAF) Report and the revised wording of BAF 1 following discussion at Trust Board and agreed that the wording of BAF1 now provided greater clarity. There were no changes to the residual (current) risk scores for BAF 1, 7 and 13 from Q4 to Q1.

2.1.4 **Audit Committee**

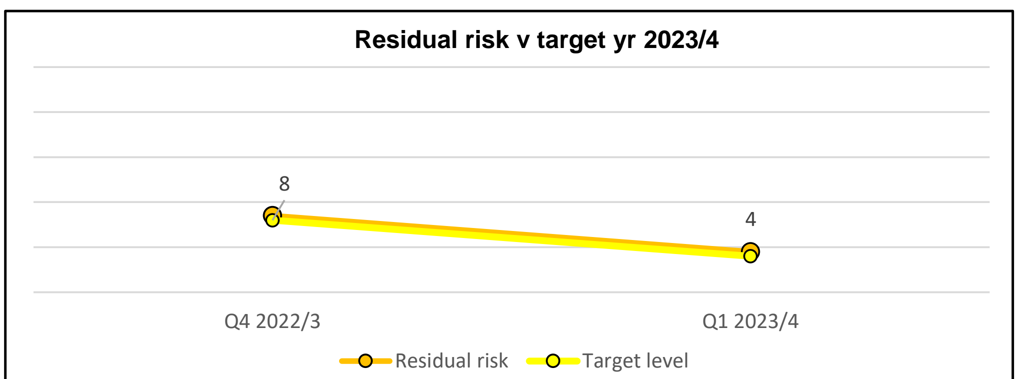
The Committee reviewed BAF entry 14 Cyber Security and noted that the residual risk score remains at 12, which is the target score to be achieved by 31 March 2023. The Committee also noted that the residual risk score was not likely to reduce further given the changing nature of cyber threats. The Committee were pleased with the Cyber Security Assurance Report which supports the narrative in BAF14.

2.2 The following tables provide summarised information about the two strategic risks under direct oversight of the Board of Directors, BAF4 and BAF6. The full detail can be found in Appendix 2.

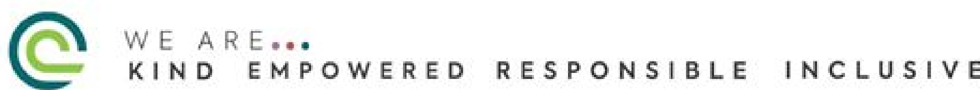
Summary table: BAF4 Board Governance		
Risk appetite: low		
Risk title	**Q1 risk score**	**Update**



There is a risk that **corporate and clinical governance arrangements** do not provide comprehensive **Board oversight and assurance**, leading to inadequate visibility of critical issues and failure to meet regulatory expectations **Executive Risk Lead**: Liz Bishop Chief Executive **Last Updated:** 11 July 2023	**4**	Following discussions at the Trust Board meeting in April 2023 BAF 4 has been reviewed to ensure the controls and assurances are separate from BAF1 (Quality). Upon review, nearly all gaps have been closed for BAF 4 and the residual score has been decreased from (2 x 4) 8 to (2 x 2) 4, now meeting the 2023/24 target. Good progress has been made in terms of streamlining corporate governance processes. The one remaining action on the BAF relates to the work following the assessment of compliance against the new Code of Governance for NHS Provider Trusts, which came into effect from 1 April 2023. An action plan is in place to address any gaps in compliance and progress is monitored by the Audit Committee. Since the last update in Q4, The Quality Improvement and Learning Strategy has been reviewed by the Quality Committee and recommended for Board approval on 26th July. The Risk Management Strategy was approved by the Board in April 2023. A substantive Associate Director of Corporate Governance has been in place for 4 months. The Board approved the self-assessment against the Provider Licence in relation to corporate governance arrangements in June 2023. The Board is recommended to approve the removal of BAF 4 from the Board Assurance Framework as it is no longer considered a strategic risk and is managed through Audit Committee and Quality Committee.



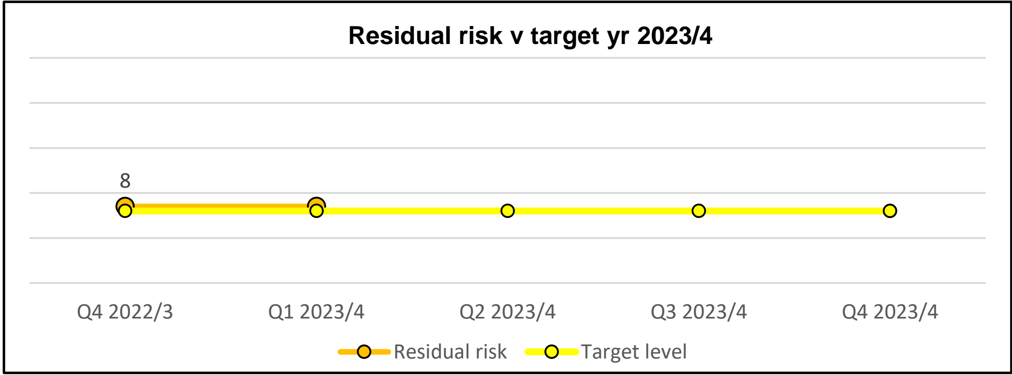
Summary table: BAF6 ICS				
Risk appetite: moderate				
Risk title	**Residual risk**	**Measure**	**Actions**	**Target 31/03/24**
There is a risk that the Trust fails to achieve sufficient **strategic influence within the ICS** to maximise collaboration around cancer prevention, early	**8**	1. Early cancer diagnosis improvement data as per quarterly Board report 2. Achieve Faster diagnosis standard 75% by March 2024 3. Have no more than 1,095 patients on cancer pathways	Due Q2 - Complete risk sharing agreement with ICB	**8**



diagnosis, care and treatment **Executive Risk Lead**: Liz Bishop Chief Executive **Last Updated:** 11 July 2023		beyond day 62 by the end of March 2024 4. 31-day performance standard 96% 5. Diagnostic dashboard reported through CMAST performance: 90% of patients waiting for a diagnostic test will be seen within 6 weeks by the end of March 2024 and CCC will be in the top decile of ICB performance		

Commentary

This risk is largely mitigated through the CCC hosting of the Cheshire & Merseyside Cancer Alliance, to enable CCC to influence prevention, early diagnosis and cancer surgery. The recent leadership role and hosting of the Cheshire & Merseyside Diagnostics Programme on behalf of the ICB, gives greater influence over cancer diagnostics, although it is appreciated the diagnostics programme covers non cancer work. Formal channels through the CMAST/ICB governance and reporting arrangements are established.



3.0 Recommendations

3.1 The Board is requested to:

- Approve the removal BAF 4 (Board Governance) from the Board Assurance Framework.
- Interrogate BAF6 (ICS) and confirm that members are satisfied with the information about key controls and assurances, and the remaining actions.
- Approve the revisions and merging of BAF 9, 10, 11 and 12, into the new BAF 10 and BAF 12, as recommended by the People Committee.
- Note the full Board Assurance Framework

Appendix 1: Strategic risk heatmap showing initial, residual and target risk scores Q1 2023-24

Strategic aims	Outstanding					Collab-orative	Research Leaders		Great Place to Work				Digital		Innov-ative
Risks	**BAF1**	**BAF2**	**BAF3**	**BAF4 removed**	**BAF5**	**BAF6**	**BAF7**	**BAF8**	**BAF9 removed**	**BAF10**	**BAF11 removed**	**BAF12**	**BAF13**	**BAF14**	**BAF 15**
25	✕														
20		✕	✕											✕	
16			®							✕ ®		✕			
15	®				✕								✕		✕
12		® ★	★		®	✕	✕ ®	✕ ®				®		® ★	
10	★														
9					★					★			® ★		®
8						® ★									
6							★	★				★			
5															
4															★
3															

Symbol	Meaning
✕	Initial (inherent)
®	Residual (current)
★	Target (31.03.24)
→	Distance to target

BAF1 Quality governance	**BAF6** Strategic influence within ICS	**BAF11** Staffing levels
BAF2 Demand exceeds capacity	**BAF7** Research portfolio	**BAF12** Workplace culture
BAF3 Insufficient funding	**BAF8** Research resourcing	**BAF13** Development and adoption of digitisation
BAF4 Board governance	**BAF9** Leadership capacity and capability	**BAF14** Cyber security
BAF5 Environmental sustainability	**BAF10** Workforce capacity and capability	**BAF15** Subsidiaries companies and Joint Venture

Board Assurance Framework (BAF) Key

Risk Appetite Level	Definition
NONE (1-3)	Avoidance of risk and uncertainty is a key organisational objective
MINIMAL (4-8)	As little as reasonably possible (ALARP). Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
CAUTIOUS (9-12)	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
OPEN (12-15)	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward and Value for Money (VfM)
SEEK (16-20)	Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk
SIGNIFICANT (25)	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Term	**Definition**
RISK APPETITE	The level of risk that the Trust is prepared to accept in relation to an event/situation, after balancing the potential opportunities and threats that situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings
INHERENT RISK SCORE	An 'inherent' risk is one that is unmitigated or changed by any risk management action we might decide to take.
RESIDUAL (CURRENT) RISK SCORE	A 'residual' risk is the risk that remains once the inherent risk has been subjected to risk mitigation or management.
TARGET RISK SCORE	The risk score the Trust aims to achieve by the end of the financial year.
CONTROL	Process, plan, policy, practice, tool or mechanism that is used to manage a risk. For the BAF risks, the key organisational controls are identified, which are the main tools that provide direction, define expected activity/behaviours, and that drive compliance/performance
ASSURANCE	Evidence that conveys information about the effectiveness of controls. In the context of the BAF, this would ordinarily be some form of written report providing, for example, compliance data, performance information, progress updates, audit results, evaluation findings etc.
RISK TOLERANCE	The range of risk score which the Trust is prepared to accept, temporarily or permanently within the risk appetite category, eg 4-8.

BAF1. Quality

RISK APPETITE: Patient safety & experience - Regulatory compliance MINIMAL(tolerance 4-8)

STRATEGIC OBJECTIVE: Be Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24 L x C
BAF1 There is a risk that a **lack of organisational focus on patient safety and quality of care** will lead to an increased incidence of avoidable harm, higher than expected mortality, and significant reduction in patient satisfaction. **Executive Risk Lead: Julie Gray, Chief Nurse** **Board Committee: Quality** **Last Update: 23 May 2023**	**Causes** 1. Insufficient and ineffective clinical governance processes 2. Failure to learn from patient feedback 3. Lack of coherent and sustained focus on Quality 4. Failure to implement National Patient Safety Incident Response Framework 5. Increased patient dependency and acuity 6. Unsafe staffing levels and skill mix **Consequences** 1. Increased levels of patient harm 2. Negative impact on patient experience 3. Quality standards not met 4. Poorer outcomes for patients 5. Lower CQC rating 6. Reputational damage 7. Exceeding thresholds for harm free care indicators (falls, pressure ulcers, nosocomial outbreaks, health care associated infections (HCAIs))	5 x 5 = 25	C1) Risk Management Strategy 2023-26. Incident reporting and investigation policies. Dedicated Clinical Governance and Safety Team. **Control Owner**: Chief Nurse	Risk management strategy annual update report - Trust Board (April) Quarterly aggregated patient safety and experience report to Quality Committee	Audited Quality Account, reviewed by Quality Committee, June 23 MIAA audits of key systems: Risk Management, Substantial Assurance March 22; Incident reporting, Limited Assurance April 22; Claims, Substantial Assurance, 2021/22	3 x 5 = 15	No	G1) Implementation of year one Risk Management Strategy objectives	Complete Risk Management Strategy year one objectives **Action Owner:** Chief Nurse **Due Date:** 31/03/24		2 x 5 = 10
			C2) Patient Experience & Inclusion Strategy. Established Patient Experience & Inclusion Committee and dedicated Head of Patient Experience Role. Action plans developed and monitored from national surveys. Complaints and PALs procedures in place. **Control Owner**: Chief Nurse	Patient Experience and Inclusion Annual Report to Quality Committee. Annual Complaints, PALs and Claims Report to Quality Committee Quarterly aggregated data patient safety and experience report to Quality Committee. Overview of complaints process reported to quality committee	National Cancer Patient Experience Survey results, reviewed by Quality Committee, September 22 showed Trust in top decile. MIAA Substantial Assurance for Patient Experience, 2020/21 MIAA Moderate Assurance for Complaints March 2022.			G2) Current PALs service delivered remotely	Increase responsive face to face PALs service at CCC-L **Action Owner**: Chief Nurse **Due date**: 31/03/24	PALs officer onsite part of the week at CCC-L.	
			C3) All falls, Pressure Ulcers and HCAIs are reviewed via Harm Free Care group. Call don't fall initiative & falling leaf symbol in place. Ramble guard TAB system in place. Waterlow system for assessment of risk used. NHSI criteria for assessment & expectations around pressure ulcers. Maintain low rates of catheter associated UTI's and maintain 95%+ VTE assessments. Dedicated falls prevention Lead and Tissue Viability Nurse. **Control Owner**: Chief Nurse	Harms Free Care Committee Data reported to Board of Directors via Integrated Performance and Quality Report	Quality metrics reviewed at Commissioners Quality meetings quarterly.			G3) Minimal impact of learning for improvement evident from Harms Free Care Group	Collaborative improvement projects for Falls reduction and Pressure Ulcers supported by Aqua. Deliver falls reduction and skin damage quality priorities identified within quality accounts. **Action Owner:** Chief Nurse **Due date:** 31/03/24	New investigation templates developed for pressure ulcers and falls	
									Relaunch Harms Free Care scrutiny process under the leadership of the Deputy chief nurse **Action Owner:** Chief Nurse **Due date:** 31/03/24	New meeting launched in July	
	Measure 1. Thresholds for: - Avoidable hospital acquired c. dificile - Falls with moderate harm - Avoidable hospital acquired skin damage - Avoidable VTE 2. Safe staffing levels 3. Implementation of Risk Management Strategy annual objectives 4. Implementation of the Quality Strategy annual objectives 5. Performance in NCPES		C4) Investment - Access to AQuA Data expertise in BI/Digital/CNIO 'Bright Ideas' and Innovation Centre to capture areas for improvement. Dedicated Quality Improvement Nurse and investment in Tendable - formerly Perfect Ward **Control Owner**: Chief Nurse	Integrated performance and quality report reported to QC and TB Bright Ideas report to Board of Directors.	Care Quality Commission (CQC) rating. Specialist commissioners oversight.			G4.1) Lack of up to date Quality Strategy. No clear system to demonstrate and celebrate quality improvement activity	Draft Quality Strategy to Quality Committee **Action Owner**: Chief Nurse **Due date**: 21/06/23	Engagement event on 31/05/23, draft quality strategy in progress.	
								G4.2) CQC preparedness	Recruit a governance lead for inspection preparedness **Action Owner:** Chief Nurse **Due date:** July 2023		
			C5) Dedicated role - Associate Director of Clinical Governance and Patient Safety. Established Executive Review Group and Patient Safety Committee with Consultant leadership. **Control Owner**: Chief Nurse	Improvement actions from incident investigations report to Risk and Quality Governance committee monthly. Quarterly patient safety and experience report to Quality Committee	MIAA Quality spot checks to start Q2 and updates provided to Quality Committee			G5) Patient Safety Incident Response Framework (PSIRF) work stream	Secure funding to recruit dedicated patient safety lead **Action Owner**: Chief Nurse **Due date**: 31/05/23	Job Description written for new Patient Safety Lead	
			C6) Single room occupancy so all patients are isolated. Antimicrobial prescribing policy and lead pharmacist. Post infection review (PIR) undertaken for each known case. **Control Owner:** Chief Nurse	Quarterly IPC Committee Established PIR process in place with expert microbiology/virology support Antimicrobial pharmacist	Quality Accounts. ICNet benchmarking data. Monthly C&M and NW nosocomial benchmarking report with oversight from regional IPC team. Collaboration/peer scrutiny with other specialist oncology centres			G6) Monthly scrutiny panel with specialist commissioner input	Establish monthly Nosocomial Infection Performance Review meeting **Action Owner**: Chief Nurse **Due date**: 30/09/23	IPC strategy day Q1/2 2023/24 -discussion meeting on the 2nd June and a study day on the 11th July	
			C7) Twice daily patient flow meetings. Utilisation of the safer Nursing Care assessment Tool. Bi-annual Safer Staffing Report to Board of Directors. Visible leadership at ward level from Matrons. **Control Owner**: Chief Nurse	Bi-annual safer staffing report to Trust Board				G7) Variable levels of demonstrable patient acuity assessment knowledge across the Trust due to newly recruited staff	Ward Managers and DNDs attending NHSEI education event. **Action Owner**: Chief Nurse **Due date**: 30/06/23	Targeted training for inpatient service staff on the use of safer nursing care tool completed (date)	

Additional narrative

During 2023/24 recruitment will take place to support key roles, this will provide the additional resource, knowledge and experience required to drive the systems and processes needed to ensure the requirements to evidence a safe, caring, responsive, effective and Well-led organisation are met. The governance committee structure, clearer lines of responsibility and mechanisms to ensure accountability are embedding. The implementation of the year 1 objectives of the Risk Management Strategy, the publication of the Quality Improvement and Learning Strategy and the roll out of the Patient Safety Incident Response Framework will all be key milestones throughout this financial year. The target risk score for the financial year 2023/24 stands at 10, which exceeds the low tolerance range of 4-8 for this risk. In order to mitigate this risk and ensure greater assurance, long-term strategies have been established, the risk management strategy, patient experience and inclusion strategy, patient safety incident response framework, and quality improvement and learning strategy. These strategies incorporate specific actions aimed at enhancing risk controls and offering supplementary assurance, thereby gradually reducing the risk score and aligning it more closely with the desired tolerance level. It should be noted that the implementation and integration of these actions will require a considerable amount of time.

BAF2 Demand Exceeds Resources

RISK APPETITE: Contractual and regulatory compliance, patient experience MINIMAL (tolerance 4-8)

STRATEGIC OBJECTIVE: Be Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)* Internal assurance *What/where reported/when?*	External assurance *What/where reported/when?*	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Progress update	Target risk score by 31/03/24 L x C
BAF2 There is a risk of **demand exceeding available resources**, that could impact the quality and safety of services and patient outcomes **Executive Risk Lead:** Joan Spencer, Chief Operating Officer **Board Committee:** Performance **Last Update:** 15 May 2023	**Causes** 1. Changing pattern in demand as referring Trusts recover post Covid 2. Workforce gaps 3. Population health needs change due to long-term effects of Covid **Consequences** 1. Detrimental impact on patient care and experience 2. Poorer outcomes for patients 3. Regulatory and reputational impact	4 x 5 = 20	C1) Planning process based on Cheshire & Merseyside Cancer Alliance weekly cancer waiting time reports **Control Owner**: COO	C&MCA waiting time report monthly to Board via IPR and Trust Operational Group. CCC CWT performance discussed at Trust Board via IPR.	MIAA programme includes review of cancer waiting times systems and processes (Substantial Assurance Q3 2022/23)	4 x 3 = 12	No	G1) CCC has no control over referring Trust recovery plans and therefore the volume of referrals for CCC	Capacity & Demand monitored daily. Weekly monitoring of CMCA data **Action Owner**: COO **Due date**: Ongoing Ongoing discussions with COOs across C&M via weekly COOs meetings **Action Owner:** COO **Date Due:** Ongoing	Currently delivering capacity to meet demand. Weekly monitoring of activity. Late referral data shared with referring trust on a monthly basis	4 x 3 = 12
			C2) Trust monitoring Cancer Waiting Times (CWT) through Dashboard updated daily, CWT team alert senior managers to any capacity issues with flow of referrals **Control Owner:** COO	Oversight & utilisation of escalation processes demonstrated at weekly Patient Tracking List Meeting, weekly Trust Operational Group, quarterly Divisional Performance Review Groups (PRGs) reported via Chair's report to Performance Committee	C&MCA activity plans monitored by ICS, monthly reporting back to Trusts across C&M via hospital cell Cancer Performance reviewed by CMCA and ICB						
			C3) Recovery and escalation plan meets NHS System Oversight Framework Metrics **Control Owner**: COO	Progress reported monthly via Finance and activity update at Trust Board and quarterly to Performance Committee. Activity monitored via PRGs. Trust recovery plan monitored via Trust Operational Group	Trust activity plans monitored by ICS, monthly reporting back to Trust via hospital cell. Elective recovery plan activity reports indicate CCC is delivering according to plan.			G3), G4), G5) High number of late referrals to CCC due to delays in diagnostic capacity, this impacts the delivery of the 62 day target for CCC and C&M	1. Refer to C&M diagnostics delivery plan **Action Owner**: CEO **Due Date**: April 2024.	CCC CEO is the SRO for C&M Diagnostics recovery programme, clear improvement programme in place. Monitored at ICS and via national cancer Team.	
	Measure 1. 62 day classic target >85% 2. 2 Week Wait from GP referral to 1st Appointment target >93%		C4) CCC monitoring internal 24 day target and 62 day target performance managed alongside 78ww **Control Owner**: COO	Weekly TOG, Monthly IPR to Trust Board and quarterly to Performance Committee. CCC CEO is SRO for diagnostics for C&M	Weekly Monitoring via C&MCA, ICS & National Cancer Team						
			C5) CCC working with referring trusts with highest number of late referrals **Control owner:** COO	Late referral activity data shared with all referring trusts monthly (when, where)							
			C6) CCC monitoring referrals, daily & weekly patient flow Live dashboard of new referrals & SACT activity and allocation of first appointments within Trust's internal targets **Control Owner**: COO	Divisional Performance Review meetings held monthly and/or quarterly with outcomes reported to Performance Committee Daily & weekly flow Reported and monitored via weekly Trust Operational Group (TOG) Allocation of first appointments monitored by registrations team. Lack of capacity escalated to relevant senior manager Capacity monitored via weekly TOG	Trust performance and activity against CWTs monitored by CMCA MIAA review cancer waiting times (assurance level and date)			G6) Referral numbers continue to rise, highest on record in March 2023	Site Reference Groups (SRGs) monitoring activity, capacity challenges escalated to managers daily. Additional clinics in place across a number of tumour groups. Starting work to review SRG membership and structure to improve productivity **Action Owner:** COO **Due Date:** all reviews completed by 31.03.24	Started membership review Q1, time needed to review across the Board.	
			C7) Flexible Consultant job plans that enable additional Waiting List Initiative clinics to be held at short notice **Control Owner**: COO	Job plans are agreed and signed off by Divisional Teams				G7) Clinicians not always able to accommodate additional activity	SRGs working as one to offer patients an appointment with alternative clinician who may have capacity within the specialist area. Outpatient transformation programme with key focus on patient initiated follow up - starting to be rolled out **Action Owner:** COO **Due Date:** 30.09.2023	Transformation programme started to roll out with several work streams. Focus on breast SRG and aim to see impact by end of Q2	
			C8) Wait List Initiative clinics to be utilised to meet demand **Control Owner:** COO	Capacity monitored via weekly TOG							
			C9) Divisional business plans detailing response to increased demand via expansion of the workforce & changes to operational hours across a number of services **Control Owner**: COO	Work programmes to improve service delivery (detailed in Business plans) are reviewed at Trust Transformation and Improvement committee. Divisional BPs to be presented at Trust Performance Committee via a rolling programme.				G9) Expansion of workforce is limited by the availability of the budget	Prioritisation process in place and funding allocated to areas with pressure. To do a benefits relation process. **Action Owner**: COO **Due Date:** 31.12.2023		

Additional Narrative:
Despite multiple mitigations and a low risk appetite, the risk score cannot currently be reduced below 12. Uncertainty regarding the financial environment maintains the likelihood score as 4, however, there are sufficient controls in place to ensure that the predicted impact would be 'moderate' rather than 'catastrophic' as indicated by the inherent risk level. The BAF has been updated to include key performance indicators which can reviewed in line with the BAF risk.

BAF3 Insufficient Funding

RISK APPETITE: Financial MINIMAL (4-8)

STRATEGIC OBJECTIVE: Be Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance Internal assurance *What/where reported/when?*	 External assurance *What/where reported/when?*	Residual (current) risk score	Within risk tolerance?	Gaps in Control / Assurance	Actions Planned action	 Progress update	Target risk score by 31/03/24
BAF3 There is a risk that the Trust does not deliver its finanical target because it has either insuffucent income to cover costs, and/or it does not achieve the required level of recurrent efficiency savings. **Executive Risk Lead:** James Thomson, Director of Finance **Board Committee**: Performance **Last Update:** 15 May 2023	**Causes** 1. Changes to the commissioning regime and funding process 2. Inability to meet patient demand without further investment or productivity gains 3. Inability to recurrently identify and deliver the cost improvement programme (CIP) 4. Inflationary pressures 5. Management of the system financial position (deficit) might negatively impact funding position or efficiency requirement **Consequences** 1. Identify drivers of financial risk - review cost base, resource and productivity levels 2. Increased CIP requirement in future years if target not recurrently achieved 3. Review strategic ambitions if additional resource required 4. Reduced ability to invest in operational capital infrastructure and staff 5. Reduction in liquidity position 6. Increased performance management from NHSE/I and ICB - and associated regulatory action 7. Reduced Trust board risk appetite	4 x 5 = 20	C1) Divisional and departmental budget management process **Control Owner**: DoF	Budget setting process managed through Finance Committee (monthly) and reported to Performance Committee (quarterly). Budgets approved by lead managers. Monthly budgetary performance in place through Performance Review Groups and Finance Committee to ensure cost control.	External Audit includes assessment of plan though VFM testing (reported to Audit Committee). National Financial Sustainability exercise by MIAA (HFMA checklist) - Q3 22/23. Reference Cost Index position reported to Performance Committee - Q2 23/24.	4 x 4 = 16	No	G1) Timing of budgeting process 23/24 determined by ICS timetable, and approvals not in place before 1st April 2023.	Ensure that Trust Board is informed throughout the financial planning process, such that overall plan was approved per the NHSE timetable. The Trust management has also been kept informed of the planning and budgetary process through Finance Committee. Final budgets approved by budget holders May 2023. **Action Owner**: DoF **Due Date**: 31/05/23	Finance Committee, 12th May, finalised all elements of the budget plan for 2023/24 - including pressures and developments.	3 x 4 = 12 ⬆
			C2) Contract position agreed and managed with commissioners **Control Owner**: DoF	Monthly formal contract meetings with commissioners. Annual planning process, with rebasing exercise undertaken for 2023/25 to reflect new contracting methodology (API).	Commissioner (NHSE/ICB) review of contract performance - quality and financial.			G2) Impact of 23/25 API funding methodology and contracting round to be finally determined. Recognised that 2023/24 is a transition year for contracting, as NHSE Specialised Commissioning is devolved to ICS, with final structures and implications to be determined	Trust reviewing its contract performance position monthly, and aligning to 2023/5 NHSE guidance. Any risks to the contract and income position, will be monitored through Finance Committee and Performance Committee. **Action Owner**: DoF **Due Date:** 31/12/23	Trust has established methodology to understand contract performance, this will be tested through Q1 and issues raised.	
			C3) Efficiency (CIP) and productivity plan in place - with clear cash releasing schemes **Control Owner**: DoF	Performance managed through Finance Committee (total) and Performance Review Groups (PRGs) and reported via Finance Report to Performance Committee and Board. Process for MD and CNO review and approval.	CIP process is included on internal audit review plan for 2023/24 - to take place Q3. ICB financial programme includes review of CIP plans.			G3) Assurance on recurrent CIP delivery pipeline to be confirmed. Productivity analysis of core services to be complete and benchmarked against peers.	1. Escalate CIP risk approach through Performance Committee. 2. Produce productivity process for Performance Committee. 3. Additional finance support for CIP programme **Action Owner:** DoF **Due Date:** 31/07/23	CIP profiles agreed with operational divisions and departments. Quantum of CIP included in ICB planning. Approach to CIP targets communicated at May Finance Committee. Trust has achieved [c.£1m] CIP in Q1 - operational pipeline and central schemes	
			C4) Trust Board approved financial plan, and ICB approved target financial position **Control Owner**: DoF	Finance report quarterly to Performance Committee and monthly to Trust Board	Audited accounts annually. Financial performance managed by ICB and NHSE/I. ICB receives governance score through Strategic Outcomes Framework rating.			G4) Impact of system financial position and risk management approach to be established	Trust is developing its financial plan for 2023/5. It is in active discussions with partners in the ICS to identify approach to organisational finance risk for 2023/5. **Action Owner:** DoF **Due Date:** 31/09/23	ICB is developing a financial programme approach to recovery. This will be approved by the ICB Board with input from DoFs. DoF meetings every fortnight to progress actions from programme. Trust to feedback through Performance Committee (May 2023 onwards).	
	Measure 1. Trust financial performance to target (monthly) 2. Trust CIP performance to target (monthly) 3. Trust activity/income performance to target (monthly) 4. Trust paybill to target (monthly)		C5) Trust included in emerging system financial planning **Control Owner:** DoF	DoF updates through Financial Planning Reports to Performance Committee, Audit Committee and Trust Board. Chair and Executives included in ICB peer networks.	ICB receives governance score through Strategic Outcomes Framework rating. NHSE approach to regulation for deficit ICS is to be determined.			G5) ICB financial governance and programme structures in development.	Trust participating in finance system governance development - through DoF and senior finance teams interactions with peers. **Action Owner:** DoF **Due Date:** 31/06/23	Executives participate in peer ICB networks. Trust working with partners in Liverpool health system to support, following Carnal Farrar report - November 22.	
			C6) Trust 5 year capital plan identifies capital and cash requirement **Control Owner:** DoF	Capital plan managed through Capital Committee. Input from divisions and departments.	Audited accounts annually. Financial performance managed by ICB and NHSE/I			G6) Capital decision making governance for C&M ICB not embedded. Impact of medium term capital allocation on asset base to be identified.	Trust to review multi-year capital programme quarterly. Lifecycle and asset replacement programme to be reviewed. **Action Owner:** DoF **Due Date:** 31/06/23	Trust capital plan for 2023/24 agreed with Trust Board and ICB. 5 year capital plan submitted as part of ICB planning exercise. PropCare developing lifecycle programme for all sites-31/06/23.	

Additional Narrative:
The financial system for 2023/24 is based on a new funding methodology - (Aligned Payment Incentive, API). This holds for 2023/24 and 2024/25, and establishes fixed and variable elements of commissioner contracts (ICB/NHSE).
Key risks for the Trust include securing sufficient funding through contractual mechanisms, including variable elements of commissioning contracts, and recurrently delivering the efficiency programme.
Given the risks, at this stage of the financial year, the Target Risk Score has been increased from 8 (2x4) to 12 (3x4). The probability has increased as the finance plan includes a historic high level of efficiency and also expected increases in income due to patient activity.

BAF4. Board governance

RISK APPETITE: Regulatory compliance MINIMAL (tolerance 4-8)

STRATEGIC OBJECTIVE: Be Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score	Key controls *(what is in place to manage the risk?)*	Board Assurance – Internal assurance *What/where reported/when?*	Board Assurance – External assurance *What/where reported/when?*	Residual (current) risk score	Within risk tolerance?	Gaps in Control / Assurance	Actions – Planned action	Actions – Progress update	Target risk score by 31/03/24
BAF4 There is a risk that **corporate and clinical governance arrangements** do not provide comprehensive **Board oversight and assurance**, leading to inadequate visibility of critical issues and failure to meet regulatory expectations **Executive Risk Lead:** Liz Bishop, Chief Executive **Board Committee**: Board **Last Update:** 11 July 2023	**Causes** 1. Development areas identified in WLDR 2. Increased complexity in operating environment and system context 3. Governance models including risk management need to take account of ICS developments **Consequences** 1. Poor decision making 2. Failure to manage key risks 3. Failure to improve CQC well-led rating	4 x 4 = 16	C2) Revised governance structure approved by Board April 2022; Board and Committees keep their workplans under regular review **Control Owner**: Ass Dir of Corp Gov	Committee effectiveness evaluations reported to Board annually via Audit Committee Annual Report	New structure aligns with the recommendations made in the Well Led Development Review (WLDR)	2 x 2 = 4 ↓	Yes	G2) Potential gap in Corporate Governance Team whilst recruiting substantive post	Interim plans to cover governance gaps (gaps in clinical governance closed) **Action Owner**: CEO **Due date**: March 2023 **(complete)**	Additional support for corporate governance confirmed until end of the financial year. Recruitment of substantive Associate Director of Corporate Governance underway. ADOCG in post from April	2 x 2 = 4 ↓
			C3) Corporate Governance framework **Control Owner**: Ass Dir of Corp Gov	Annual Governance Statement approved by the Board	Well Led Development Review report to Board March 2022 with a number of recommendations			G3) NHSE draft Guidance on Good Governance and Collaboration (May 2022) sets out expectations for Trusts under the Provider Licence to reflect 5 key characteristics in their governance arrangements	Review CCC corporate governance in light of new guidance **Action Owner**: CEO **Due date**: March 2023 (revised from 31 July 2022)- **(Complete)**	An assessment of compliance against the new Code of Governance for NHS Provider Trusts, which comes into effect from 1 April 2023, has been completed by the Interim Associate Director of Corporate	
									Close gaps identifies from the code of governance review **Action Owner:** ADoCG **Due Date:** 31/10/23	Governance (ADoCG) with outcomes scheduled to be reviewed by the Audit Committee on 12 January 2023. Outcomes will form the basis of an action plan coordinated by the ADoCG to address any gaps in compliance. Ongoing compliance will be monitored by the Audit Committee on a six-monthly basis. Board received compliance against new Code of Governance and agreed actions. Progress to be reviewed by Audit Committee quarterly	
			C4) Trust Strategy implementation plans **Control Owner:** Director of Strategy	Progress updates 6 monthly to Board	WLDR report highlighted the robustness of strategic planning and strength of engagement with plans						
			C5) Delegated authority for oversight of quality care by the quality committee **Control Owner:** Chief Nurse	Quality reporting to Quality Committee and Board via IPR and quality reports to monthly Risk and Quality Governance Committee. Quality and Safety oversight at Divisional PRGs. NED and Governor Engagement Walk-rounds with action plans monitored through PEIG and oversight at Trust Board.	WLDR report to Board March 2022 with a number of recommendations			G4) Lack of up to date Quality Strategy. No clear system to demonstrate and celebrate quality improvement activity	Trust wide engagement and development of a Quality Improvement Strategy, including agreed preferred methodology and improvement programme **Action Owner**: Chief Nurse **Due date**: 30/09/2023	Early scoping underway. Quality Improvement Board Development Session planned for July Quality Improvement and Learning Strategy to be approved at Trust Board 26 July 2023	
			C6) Board Assurance Framework (BAF) - strategic risks assigned to Board/Committees for oversight **Control Owner:** Ass Dir of Corp Gov	Quarterly reporting cycle at Committees and Board	MIAA annual review of BAF, small number of recommendations; WLDR review highlighted improvements to be made			G6) BAF improvements	Revised BAF 2022-23 to be drafted and embedded to direct the agendas and work programmes for Board and Sub-Committees **Action owner:** CEO **Due date:** 31 July 2022 (**Complete**)	Handover of ongoing management and reporting of the BAF from external support to Corporate Governance team in progress.	
			C7) Performance management arrangements - IPR refresh completed May 2022 to include SPC charts **Control Owner:** Chief Nurse	Oversight at Performance Committee and Board	MIAA IPR audit 2021 gave substantial assurance						

Additional narrative
Following discussions at the Trust Board meeting in April 2023 BAF 4 has been reviewed to ensure the controls and assurances are separate from BAF1 (Quality). Upon review, nearly all gaps have been closed for BAF 4 and the residual score has been decreased from (2 x 4) 8 to (2 x 2) 4, now meeting the 2023/24 target. Good progress has been made in terms of streamlining corporate governance processes. The one remaining action on the BAF relates to the work following the assessment of compliance against the new Code of Governance for NHS Provider Trusts, which came into effect from 1 April 2023. An action plan is in place to address any gaps in compliance and progress is monitored by the Audit Committee. Since the last update in Q4, The Quality Improvement and Learning Strategy has been reviewed by the Quality Committee and recommended for Board approval on 26th July. The Risk Management Strategy was approved by the Board in April 2023. A substantive Associate Director of Corporate Governance has been in place for 4 months.

BAF5 Environmental Sustainability

RISK APPETITE: Regulatory compliance MINIMAL (tolerance 4-8)

STRATEGIC OBJECTIVE: Be Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Residual (current) risk score	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24
BAF5 If the **Trust does not integrate environmental sustainability considerations into delivery of its strategic priorities**, it will fail to realise the potential benefits and contribute to the NHS Net 0 target **Executive Risk Lead:** Tom Pharaoh, Director of Strategy **Board Committee**: Performance **Last Update:** 15th May 2023	**Causes** 1. Lack of environmental sustainability strategy/plan 2. Environmental considerations not embedded in policy and decision-making processes 3. Limited understanding of the potential benefits 4. Up-front investment required **Consequences** 1. Failure to reduce waste and realise efficiencies 2. Failure to contribute toward improving local environment, e.g. air quality 3. Failure to meet public, staff and regulatory expectations as a responsible healthcare provider	5 x 3 = 15	C1) Green Plan approved by Board (Jan/Feb 2022) and summary version published. Board-level sustainability lead identified. **Control Owner**: Director of Strategy	Quarterly assurance reporting to TEG and Performance Committee (based on selected Green Plan themes at each meeting) Annual report on whole programme of Green Plan delivery to TEG, Performance Committee and Trust Board in February each year.	Quarterly national 'Greener NHS' NHS England data collection exercise. Green plan annual report shared with ICB sustainability team.	4 x 3 = 12	No	G1.1) Substantive Green Plan programme management arrangements not yet in place	1. Source interim Sustainability Programme Manager resource **Action Owner**: DoS **Due Date**: 14th July 2022 **(Complete)**	Control gap partially addressed through completion of action.	3 x 3 = 9
									2. Develop short-term action plan with programme manager to deliver early priorities **Action Owner**: DoS **Due Date**: 31st July 2022 **(Complete)**	Control gap partially addressed through completion of action.	
									3. Recruit substantive Sustainability Programme Manager **Action Owner**: DoS **Due Date**: 30th June 2023 (Revised from 31st Jan 2023)	Further attempt in late 2022 to recruit to role for fixed term unsuccessful. Substantive role readvertised as a permanent position in January 2023. Appointment made - start date 19th June 2023. Action date updated.	
								G1.2) Delivery mechanisms for key Green Plan workstreams not yet developed	1. Develop and publish green travel plan **Action Owner**: DoS **Due Date**: 30th June 2023 (date revised)	Green travel plan drafted by interim sustainability manager following successful green travel survey with staff. To be refined by DoS for launch in 2023. Action delayed due to limited capacity within sustainability team - date changed to June 2023 - date will not change further.	
	Measure 1. The Green Plan sets the following targets in line with the national NHS targets: - 20% reduction in air pollution from business mileage and fleet by March 2025 - Waste - zero to landfill policy by March 2026 - 90% of our fleet will be low or zero emission vehicles by 2029 - We will achieve a 100% reduction of direct carbon dioxide equivalent (CO_2e) emissions by 2040. An 80% reduction will be achieved by 2032 at the latest - We will achieve a 100% reduction of indirect CO_2e emissions by 2045. An 80% reduction will be achieved by 2039 at the latest. 2. The Green Plan sets out our baseline carbon footprint and we will repeat the carbon baselining two years following the Green Plan's publication 3. As part of the development and delivery of the sustainability programme, the substantive sustainability manager will propose additional targets, measures and milestones to the Sustainability Action Group for agreement								2. Develop and deliver sustainability staff engagement programme **Action Owner**: DoS **Due Date**: 30th September 2023 (date revised)	Staff engagement programme deferred to link with staff health and wellbeing engagement programme in 2023. To be delivered by substantive programme manager - action date changed to reflect.	
									3. Develop full communications plan to communicate with staff and stakeholders on key sustainability issues - incl. energy efficiency, waste management arrangements and rates of recycling - using comms to outline further plans and seek staff behaviour change **Action Owner**: Sustainability manager **Due Date**: 31st August 2023 (date revised)	Comms plan in place and key channels developed (e.g. staff intranet site). Sustainability manager to work with comms team to build on existing work to develop schedule thematic updates throughout the year as part of regularised programme. For example current waste management processes reviewed by Sustainability Action Group. Positive current situation and steps to improve to be communicated to staff as part of wider comms plan.	
			C2) Multidisciplinary Sustainability Action Group formed to support delivery of the Green Plan action plan **Control Owner**: Director of Strategy	Quarterly internal programme reporting from Sustainability Action Group as set out above (put in place following first annual report in February 2023). Annual Green Plan report as above.				G2.1) Sustainability Action Group not yet fully functioning	1. Engage with current members to ensure engagement and participation **Action Owner**: DoS **Due Date**: 5th September 2022 **(Complete)**	Control gap partially addressed through completion of actions 1 and 2. Additional members invited. Existing members encouraged to prioritise and engage in delivery of the action plan. Group now functioning well with good engagement and work progressing.	
									2. Review terms of reference including membership, accountabilities **Action Owner**: DoS **Due Date**: 5th September 2022 (**Complete** - further review scheduled - see below)		
								G2.2) Sustainability Action Group does not have programme management support to fully function	1. Establish substantive Sustainability Programme Manager as lead officer for the Sustainability Action Group **Action Owner**: DoS **Due Date:** 30th June 2023	Group now functioning well with good engagement and work progressing. Substantive Programme Manager vital to maintain progress and allow the group to fully function. Start date scheduled as above.	
									2. Further review of Sustainability Action Group terms of reference in context of substantive programme management **Action Owner**: Sustainability Manager **Due Date**: 31st July 2023		
			C3) Quality of the Trust's building stock: build specification of CCC-L supports Trust's environmental sustainability commitments, with potential to improve further. **Control Owner**: PropCare Managing Director	Internal monitoring of CCC-L building management system (BMS) and PropCare performance reporting.				G3) Quality of the Trust's building stock: CCC-W requires improvement and long term redevelopment	1. Creation of new projects division in PropCare **Action Owner**: PropCare MD **Due Date**: 31st July 2022 **(Complete)**	Control gap partially addressed by completion of action. PropCare projects division now in place.	
									2. Form CCC-Wirral Development Group to oversee progress on refurbishment, improvement and redevelopment of CCC-Wirral site. **Action Owner**: DoS **Due Date**: 31st January 2023 **(Complete)**	Control gap partially addressed by completion of action. CCC-W development group formed and functioning.	
									3. Develop 2023/24 capital plan to include significant investment in the maintenance and refurbishment of the CCC-W site to increase sustainability profile of buildings **Action Owner**: PropCare Senior Projects Manager **Due Date**: 30th April 2023 **(Complete)**	Control gap partially addressed by completion of action. Capital plan agreed.	
									4. Deliver CCC-W improvements and maintenance set out in 2023/24 capital plan **Action Owner**: PropCare Senior Projects Manager **Due Date**: 31st March 2024	Concerted effort required to deliver ambitious range of capital projects at CCC-W in year.	
									5. Launch a procurement process (with sustainability as a key scoring component) to engage architectural services to begin development of longer term plans for CCC-W site redevelopment **Action Owner**: DoS/Senior Projects Manager **Due Date**: 31st May 2023	Architects initially engaged to develop high level sketches in Nov/Dec 2022. Results presented to Trust Board and charity. Preparations being made to launch procurement process to develop next stage of proposal.	

Additional Narrative:
The Trust has previously promoted sustainability in certain areas, for example cycle to work schemes and active travel facilities. The Board-approved Green Plan clarifies the Trust's overarching aims and states key targets to be achieved. The Green Plan also sets out the early, short-term priorities and the main initiatives that will be implemented in the longer term.
A key part of future delivery depends on establishing effective programme management arrangements. Two unsuccessful attempts to appoint substantively to Sustainability Programme Manager role (12 months fixed term) necessitated the consideration of an interim solution. The interim sustainability manager (part time) was in post for 6 months from July to December 2022. Following a further unsuccessful attempt to recruit to the post on a fixed term basis it was advertised as a permanent role in January 2023. A substantive sustainability manager appointment has now made with a start date of 20th June 2023. The post holder will be a dedicated resource to drive the delivery of the programme, working with the Director of Strategy, and operate as lead officer for the Sustainability Action Group.
The quality of the Trust's building stock is a key component of our sustainability position. The current risk score reflects the opening of the new, modern CCC-L building which marks a milestone in upgrading the Trust's estate. PropCare has formed a projects division to support its significant contribution to the green agenda, including through making capital improvements to CCC-Wirral estate and supporting the longer term work to redevelop the site. Fully addressing the gap in control caused by condition of CCC-Wirral is a long term objective, as clearly is the general move towards net zero. This is reflected in the target score.

BAF6. Strategic influence within ICS

RISK APPETITE: Partnership working CAUTIOUS (tolerance 9-12)

STRATEGIC OBJECTIVE: Be Collaborative

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24 L x C
BAF6 There is a risk that **the Trust fails to achieve sufficient strategic influence within the ICS** to maximise collaboration around cancer prevention, early diagnosis, care and treatment **Executive Risk Lead:** Liz Bishop, Chief Executive **Board Committee**: Board **Last Update:** 11 July 2023	**Causes** 1. Organisational politics 2. Senior capacity and relevant experience 3. Shared goals and plans still in development 4. Lack of single data sources across the system 5. Immature ICS **Consequences** 1. Failure to improve population health and cancer outcomes 2. Disjointed care pathways 3. Failure to realise efficiencies 4. Failure to innovate at scale 5. Reduced CQC rating 6. Reputational damage	**3 x 4 = 12**	C1) Trust hosting the Cheshire and Merseyside Cancer Alliance (CMCA) with CEO as SRO **Control Owner**: CCC CEO	Board oversight of CMCA employee contracts becoming substantive (last reported to Board June 2022) Overview of business plans approval for 23/24 by National Cancer Team and NHS England included in Chief Executive report to Trust Board (April 2023) Business Plan approved at CMCA Board (March 2023)		**2 x 4 = 8**	**Yes**				**2 x 4 = 8**
			C2) CMCA Business Plan 2022-23 submitted and approved December 2022 by National Cancer Team; funding confirmed for 2023-25 **Control Owner**: Managing Director, CMCA	CMCA performance reports to CCC Board quarterly and distributed to CMAST members and ICB quarterly. Overview of business plans approval for 23/24 by National Cancer Team and NHS England included in Chief Executive report to Trust Board (April 2023)	Weekly sit reps produced by CMCA for COOs. Quarterly CMCA performance reports are circulated to acute/ST providers CEO,COOs and Place Leads and reported fortnightly to CMAST						
	Measure 1. Early cancer diagnosis improvement data as per quarterly Board report 2. Achieve Faster diagnosis standard 75% by March 2024 3. Have no more than 1,095 patients on cancer pathways beyond day 62 by the end of March 2024 4. 31-day performance standard 96% 5. Diagnostic dashboard reported through CMAST performance: 90% of patients waiting for a diagnostic test will be seen within 6 weeks by the end of March 2024 and CCC will be in the top decile of ICB performance		C3) Trust CEO is ICS System Lead for all diagnostics; governance and management arrangements established and delivered via bi-monthly Diagnostic Delivery Board **Control Owner**: CEO	Update to CCC Board at Strategy Away Day 28 July 2022. CMAST reports incorporates into Chair and CEO report to Trust Board monthly.	Diagnostic Delivery Board established and diagnostic performance reports into CMAST (fortnightly) and ICB Integrated Performance Report (monthly)			G3) Risk sharing agreement with ICB not in place	Complete risk sharing agreement with ICB **Action Owner**: CEO **Due date**: 1 August 2023 (revised from, 1 April 2023, November 2022, July 2022)	Recruitment/ interims in place. Contracts to be held by CCC and risk sharing agreement in progress with ICB (led by ICB DoW) CCC DoW following up with ICB DoW **July:** Draft risk sharing agreement received from ICB, CCC reviewing	
			C4) Funding to 2024 to deliver CDCs and C&M Diagnostics Recovery Plan **Control Owner**: CEO	Update to CCC Board at Strategy Away Day 28 July 2022	Diagnostic Delivery Board established and diagnostic performance reports into CMAST (fortnightly) and ICB Integrated Performance Report (monthly)			G4) No confirmation for funding of diagnostic programmes other than CDCs, but will be overseen by Diagnostic Delivery Board.	Business plan being developed in order to bid to both national and ICB teams **Action Owner**: CEO **Due date**: 31 March 2023 **(closed)**	By 1 April 7 CDCs will be opened, and national funding secured ICB Transformation Board approved the ICB funding for the diagnostic programme 9th March 2023. Acquired Paddington CDC - implementation planning underway - 1st patient due in June **July:** funding now being drawn down and overseen by CCC DoF CCC Paddington due to open 24th July	
			C5) Trust involvement with CMAST Provider Collaborative and ICS **Control Owner**: CEO	Update to CCC Board at Strategy Away Day 28 July 2022. Chair and CEO updates at monthly Board meetings. NED involvement and oversight at CMAST level via quarterly NED CMAST events. CEO and Chair attendance at CMAST Leadership Board				G1) WLDR report highlighted need to increase senior capacity and visibility in ICS to take on greater leadership role	Broaden executive directors' stakeholder engagement in ICS **(complete)** **Action Owner:** Dir of Strategy **Due date:** April 2023 **(Complete)**	Executive directors attending respective C&M leadership fora **July:** Director of Strategy and COO attend CCC LUHFT Joint Committee Sub Committee, chaired by CCC Chair	
									2. Develop marketing plan to strengthen CCC brand and raise profile of senior leaders **Action Owner:** Dir of Strategy **Due date**: April 2023 **(Complete)**	In progress, preferred marketing provider engaged Communications Strategy approved at TEG. Marketing strategy complete and implementation commenced e.g.. Media training April **July**:Comms and Marketing Strategy in place and implementation underway	

Additional narrative

This risk is largely mitigated through the CCC hosting of the Cheshire & Merseyside Cancer Alliance, to enable CCC to influence prevention, early diagnosis and cancer surgery. The recent leadership role and hosting of the Cheshire & Merseyside Diagnostics Programme on behalf of the ICB, gives greater influence over cancer diagnostics, although it is appreciated the diagnostics programme covers non cancer work. Formal channels through the CMAST/ICB governance and reporting arrangements are established.

BAF7 Research Portfolio

RISK APPETITE: Clinical innovation CAUTIOUS (tolerance 9-12)

STRATEGIC OBJECTIVE: Be Research Leaders

Risk description & information	Causes & consequences	Initial (inherent) risk	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance	Board Assurance: External assurance	Residual (current)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by
BAF7 If the **Trust is unable to increase the breadth and depth of research**, it will not achieve its research ambitions as a specialist cancer centre **Executive Risk Lead:** Sheena Khanduri, Medical Director **Board Committee**: Quality **Last Update:** 07 June 2023	**Causes** 1. Reliance on partners to maintain National funding bids 2. Liverpool unsuccessful for BRC and CRUK Centre status 3. Service pressures impact upon research capacity 4. Adequate research active workforce 5. Adequate clinical trial access across sites. **Consequences** 1. Failure to develop new treatments for patients 2. Failure to achieve status as a leading cancer research centre 3. Insufficient future funding to sustain planned research programmes 4. Reputational damage	**3 x 4 = 12**	C1) Research Strategy 2021-2026, approved by Trust Board **Control Owner**: Medical Director	Research Strategy Business Plan updates reported quarterly to Performance Committee. Annual Research Strategy Updates to Trust Board.		**3 x 4 = 12**	**Yes**				**2 x 3 = 6**
			C2) Dedicated Early Phase Trials Unit at CCC operational from 5 April 2022 **Control Owner**: Medical Director	Occupancy is reported monthly through R&I Directorate Board and to Risk & Quality Governance Committee. Research updates reported to TEG and metrics reported in Integrated Performance Report at Quality Committee (quarterly) and Trust Board (monthly).				G2) Study opening reliance on service support departments	1. Increase number of trials clinical trial pharmacy can open. **Action owner:** Medical Director **Due date:** June 2023 2.Develop Research vision for the CCC IR Service to remove dependence on third party providers. **Action owner:** Medical Director **Due date:** February 2024	1. Capacity will increase from June 2023. 2. Radiology Business Case approved at Finance Committee 12th May 2023 to be reviewed at TEG June 2023.	
			C3) Strategic Partnership Groups for National funding bids established. **Control Owner**: Medical Director	Quarterly ECMC, BRC, CRF updates to Research Strategy Committee. Research updates reported to TEG and metrics reported in Integrated Performance Report at Quality Committee (quarterly) and Trust Board (monthly).				G3) Additional staff required to develop, deliver and support research trials.	1. Full review of R&I senior leadership team infrastructure. 2. Review NHS consultant job plans for appropriate research time allocation 3. Wider engagement with medical, nursing and AHP staff. **Action owner:** Medical Director **Due date:** March 2024	1. Full review completed and funding available. 2. Research PA allocation under review with AMDs.	
			C4) Research Activity Policies **Control Owner**: Medical Director	Internal audit plan monitored at monthly R&I Directorate Board through to Risk and Quality Governance	Regulatory compliance evidenced external audit MIAA - January 2022			G4) Current processes/staffing need to be aligned to periphery sites.	Resource mapping from R&I and service support departments across all sites. **Action Owner:** Medical Director **Due date**: March 2024		
	Measure 1. Yearly study recruitment target (>1300) met 2. Number of new studies open target (>52 per year) met 3. Interventional Radiology Service implemented (due February 2024 - enabling more early phase trials to open and more biopsies to be completed.) 4.Research infrastructure in place (G3) 5. Patients being recruited at periphery sites (G4) 6. Funding will reduce likelihood and staffing/infrastructure, grant awards will reduce the consequence (link to BAF 8 Research Funding)		C5) Clinical trial service support departments fit for purpose. **Control Owner**: Medical Director	Monitored monthly by Performance Review Group with exceptions only escalated to Quality Committee							
			C6) Appointment of research active staff. **Control Owner: Medical Director**	Monthly updates to R&I Directorate Board and quarterly updates to Research Strategy Committee. Research updates reported to TEG and metrics reported in Integrated Performance Report at Quality Committee (quarterly) and Trust Board (monthly).							
			C7) Access to clinical trials for patients across all sites. **Control Owner: Medical Director**	Monthly updates to R&I Directorate Board and quarterly updates to Research Strategy Committee. Research updates reported to TEG and metrics reported in Integrated Performance Report at Quality Committee (quarterly) and Trust Board (monthly).							

Additional Narrative:

ECMC bid renewal was successful and will be renewed in April 2023 for a further 5 years ; the ability of CCC to continue to deliver high quality research will be strengthened, providing access to novel treatments and enhancing reputation through increased capacity and capability. Likelihood of future successful bids will be increased. Gaining Clinical Research Facilities status with a collaborative bid involving CCC and 2 other Trusts within the region secured £5.3m for local regional facilities. The successful outcome of the BRC bid will help demonstrate further research capability and ensure access to high quality research. The risk score is 12 as the Trust is ambitious in its targets for increasing the breadth and depth of research there are gaps in infrastructure and resource mapping across sites which will be addressed in year.

BAF8 Research Resourcing

RISK APPETITE: Clinical innovation, financial CAUTIOUS (tolerance 6-8

STRATEGIC OBJECTIVE: Be Research Leaders

Risk description & information	Causes & consequences	Initial (inherent) risk score	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Residual (current) risk score	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24
BAF8 Competition for talent and research sponsorship means that **the research programme is at risk of being under-resourced**, which would hinder the Trust's ambition to be research leaders **Executive Risk Lead:** Sheena Khanduri, Medical Director **Board Committee**: Performance **Last Update:** 15 May 2023	**Causes** 1. International competition for specialist research and academic skills 2. Reliance on partners to secure major sources of funding 3. Current vacancies relating to the Research Strategy 4. Funding shortfall from National Funding bids **Consequences** 1. Failure to develop new treatments for patients 2.Inability to deliver planned research programmes 3. Failure to achieve status as a leading cancer research centre 4. Loss of status and influence	3 x 4 = 12	C1) Research Strategy Funding ring-fenced to support Infrastructure and future growth in capacity **Control Owner**: Medical Director	Research Strategy Business Plan update reported quarterly to Performance Committee from January 2021		**3 x 4 = 12** ⬆	**Yes**	G1) Research staffing capacity. Reliance on external partners for academic recruitment.	Recruitment of Research staff. CCC/UoL joint working via recruitment company to appoint academic staff. **Action Owner**: Medical Director **Due Date**: March 2024	Staffing gaps identified. Financial resource agreed. Recruitment process underway Early Phase Clinical Research Fellows appointed, start date August 2023.	**2 x 3 = 6** ⬇
			C2) Monitoring of use of funding (£1M allocated to the Research Strategy for year 3) **Control Owner:** Medical Director	Monthly reporting to R&I Directorate Board; Business Plan update quarterly report to Performance Committee	MIAA R&I Audit of finance and governance arrangements 2022 - substantial assurance received						
			C3) Contribution from Clatterbridge Cancer Charity to support research opportunities.	Reporting through R&I Directorate Board through to Performance Committee.				G3) No process to apply for Charity funding via Research. Communication plan with Charity.	Developing a SOP for the Research application to the Charity Develop a Communication Plan. **Action Owner:** Medical Director **Due date:** 09/2023		
	Measure 1. When funding to covered the funding gap is reduced. 2. When staffing to meet the requirements as outlined in the Research Strategy are recruited 3. Funding will reduce likelihood and staffing/infrastructure, grant awards will reduce the consequence		C4) Successful collaborative bids securing funding for National funding bids for 5 years **Control Owner:** Medical Director	Quarterly monitoring of use of funding via Research Strategy Committee. Operational Oversight through new joint ECMC/CRF Operational meeting.				G4) Process to acquire full funding	Review alternative income streams. **Action Owner:** Medical Director **Due date:** 12/2023		

Additional Narrative:
The Research Strategy has a fully costed Business Plan (Research Strategy Business Plan 2021-2026) which is monitored at Performance Committee; the Business Plan outlines bid developments, commercial funding opportunities and charitable funding to deliver the strategy. The target risk should be achieved, ensuring no shortfall between planned vs actual funding for National Funding bids. Recruitment of research infrastructure in-line with Research Strategy. At the end of 22/23 we had achieved or were well on the way to achieving all our planned actions hence the full review in Q1 2023/24. This included securing or retaining national funding bids (ECMC, BRC, CRF). As BAF 8 is still relevant, and we're now looking to deliver on the national funding bids, we added extra causes and associated controls, assurances, gaps in control and planned actions to be completed during 23/24. This increased the residual risk up to 12. The target risk reduced from 8 to 6 to highlight we want to be more ambitious with the risk reduction as detailed within the BAF.

BAF10. Ability to ensure provision of sufficient workforce capacity and capability

RISK APPETITE: Workforce MINIMAL (tolerance 4-8)

STRATEGIC OBJECTIVE: Be a Great Place to Work

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Residual risk (current) score	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24 L x C
BAF10 If the Trust is **unable to recruit, train and retain staff sufficiently** then there is a risk that **workforce capacity and capability will not meet demand** resulting in undue pressure on staff and adverse impacts on patient safety, effectiveness of care and patient and staff experience **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee**: People **Last Update:** 9 June 2023	**Causes** 1. Retention of staff who are in post. 2. Ability to recruit sufficient numbers and skill mix of staff, including impact of Brexit 3. Misalignment of workforce planning, activity and finance 4. Lack of accurate and up-to-date workforce information and data 5. Poor perception of NHS as a place to work 6. Competition within NHS and from private sector **Consequences** 1. Failure to improve services 2. Widening vacancy gaps 3. Inability to plan capacity effectively 4. Reduced workforce morale 5. Damage to reputation as an employer 6. Failure to maintain CQC ratings 7. Reputational damage 8. Reduced staff wellbeing and morale **Measures** 1. Turnover greater than 14% 2. Statutory Mandatory Training Compliance over 90%	4 x 4 = 16	People commitment 2023/24 implementation plan developed, with key deliverables identified against the 5 workforce pillars Base line assessments in place to support full implementation of e-roster New job planning system implemented in April 2023 Engagement and collaborative working with trade union colleagues, via monthly meetings and bi monthly Strategic Partnership Forum Divisional & Trust Workforce Dashboards provided to support the proactive management of workforce data. Vacancy management process (ECP) in place to manage, monitor and control vacancies Implementation of e-roster and safe care to plan and monitor safe staffing Health and wellbeing support including OH services to support staff absence and wellbeing Appraisal system in place to support career development, training and wellbeing conversations Exit interviews to monitor reasons for leaving and to gather any workforce intelligence Robust suite of leadership, personal development and clinical education and training programmes available to staff NHSI Workforce Plan developed	2023/24 People Commitment implementation plan approved at People Committee (April 2023), with bi monthly progress updates reported to WAG and quarterly assurance reports reported to People Committee Workforce key performance indicators monitored quarterly at People Committee Workforce Dashboard - Monthly workforce dashboards provided to divisions detailing workforce KPI performance. Data reported in monthly dashboards Bi monthly Workforce Advisory Group to provide operational overview and assurance of workforce and OD activities and performance. Reports received in April 23 include; Retention update, Sickness deep drive, e-roster, staff engagement report, Trust Workforce Dashboard. Board oversight of workforce KPIs via the IPR WOD operational performance KPIs reported quarterly via Workforce and OD PRGs Leadership and Organisational Development annual report received and approved at People Committee in April 2023	MIAA audit - E-Roster 2021/22, substantial assurance received MIAA audit – Recruitment and Retention 2023, substantial assurance received MIAA audit - Medical Job Planning 2022/23, substantial assurance received MIAA audit – Mandatory Training and Appraisal June 2022, substantial assurance received National NHS Staff Survey results 2022 – Increase in 7 out of 9 People Promise scores. Full report reported to Board and People Committee in April 2023 Pulse results reported quarterly on Model Hospital. Q1 2023/24 results show Trust as top performing Northwest trust for 3 out of the 4 themes (engagement, involvement and advocacy) and ranked 14th out of 32 for motivation HEE Nursing Retention tool submitted and positive assurance received	4 x 4 = 16	No	G1 Achievement of sickness KPI across all division G2 Achievement of turnover KPI G3 Gaps in the roll out of e-roster across all clinical areas / achievement of e-roster KPI G4 bespoke recruitment and retention plan for nursing and AHP workforce G5 Delay in publication of the national NHS People Plan leading to uncertainty around national priorities G6 Full scale review of policy underway to support the NHSIE 6 Actions for Inclusive recruitment G7 Reduced funding for Learning and OD activities with could lead to a reduction in staff training and support G8 Effective use of apprenticeship levy to supporting workforce transformation / workforce planning G9 Ability to define critical roles within the Trust with associated succession plans G10 Trust wide understanding of work planning to support workforce transformation to meet service needs G11 Clear and consistence recruitment branding to promoting the trust as an employer of choice G12 Engagement with widening participation activities to promote the Trust as an employer of choice and to connect with the local community to support inclusive recruitment practices	Action 1 - (G2, G4, G9) Provide support to the divisions in ensuring effective succession plans are in place for critical roles and develop effective mechanisms for identifying and managing talent Owner: HRBPs / Head of L&OD Date due: 01st March 2024 Action 2 – (G4) Recruitment of Nursing and APH workforce development Lead Owner: DDWOD Date due: 30th Aug 2023 Action 3 (G3) Fully optimise e-rostering systems to improve productivity and make significant savings through better management of the substantive and temporary workforces Owner: Head of Workforce Transformation Date Due: 30th December 2023 Action 4 (G1, G3) Alignment of ESR with other key trust systems (e.g. finance, e-roster) to enable a comprehensive and accurate representation of the Trust workforce Owner: Head of Workforce Transformation Date Due: 30th December 2023 Action 5 (G1) Provide a targeted action on improving the Health, Wellbeing and Engagement of all staff by ensuring staff have access to services and support that will help them manage their physical, mental and financial wellbeing Owner: Head of L&OD Date Due: September 2023 Action 6 (G6) Development of EDI work plan, including review of recruitment processes and practice support to ensure we provide inclusive recruitment opportunities Owner: Head of EDI Date Due: Aug 2023 Action 7 (G7) Funding bid to be submitted via charitable funds Owner: Head of L&OD Date Due: September 2023 Action 8 (G4) Development of robust KPIs for medical workforce Owner: Head of Medical Workforce Date due: August 2023 Action 9 (G4) Increase number of postgraduate placements Owner: DDWOD Date due: April 2024 Action 10 (G8) Increase in engagement in apprenticeships as a means for supporting workforce / role transformation and attracting candidates into the Trust Owner: Head of L&OD Date due: March 2023 Action 11 (G12) Further develop our employer brand to attract the best talent and promote CCC, this includes delivery of traineeship/Princes Trust programme and increased engagement with local schools/ colleges to promote the roles available Owner: Head of L&OD / DDWOD Date due: December 2023 Action 12 (G7) Delivery of leading and OD programmes outlined in the 2023 prospectus and the commissioning of a bespoke leadership programme of staff in band 8b and above Owner: Head of L&OD Date due: March 2024	People Commitment 2023/24 Implementation plan approved at People Committee L2PJob planning system launched – April 2023 Nursing and AHP Development Lead post out to advert Improvement in sickness data shown in April and May e-roster divisional trajectories in development and to be reported to WAG in June 2023 2023 Leadership and Personal Development offer launched and approved at People Committee in April 2023 New processes implemented for proactively supporting work experience and careers events HEE Nursing retention return completed and positive feedback received from HEE (Reported to WAG March 23) New appraisal system launched in June 2023 to support managing performance, supporting wellbeing conversations and managing career progression and development needs	3 x 3 = 9

BAF12. Ability to promote and embed a positive, inclusive and healthy workplace culture

RISK APPETITE: Workforce MINIMAL(tolerance 4-8)

STRATEGIC OBJECTIVE: Be a Great Place to Work

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance Internal assurance *What/where reported/when?*	Board Assurance External assurance *What/where reported/when?*	Residual risk (current) score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions Planned action	Actions Progress update	Target risk score by 31/03/24 L x C
BAF12 If the Trust is unable to provide a positive, supportive and inclusive culture, where individuals wellbeing needs are met and individuals feel valued and rewarded for their contributions there is a risk that this will result in an adverse impact on staff performance, wellbeing, engagement, retention, trust reputation, and the ability to deliver services and patient care **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee**: People **Last Update:** 9 June 2023	**Causes** 1. Staff burn out 2. Increased pressure on staff due to high turnover / sickness 3. Lack of inclusivity 4. Staff not feeling a sense of belonging to the trust 5. Lack of reward and recognition 6. Lack of investment in staff development and wellbeing **Consequences** 1. Loss of goodwill and staff engagement 2. Increased sickness 3. Increased turnover 4. Reputational damage **Measure** 1. Sickness Absence greater than 4% 2. Turnover greater than 14% 3. Pulse Staff Survey Employee Engagement Score 4. BAME Staff representation	4 x 4 = 16	Occupational Health Service for staff Employee Assistance Programme, including counselling and virtual resources Non-Executive Health & Wellbeing Guardian to hold Trust to account on ensuring H&WB is an organisational priority Divisional improvement plans in place OD interventions to support developing team culture Divisional Culture and Engagement Groups Mental Health First Aiders Live Well, Work Well Health and Wellbeing programme Staff networks ensuring an inclusive staff voice is heard Trust values embedded into annual appraisal process Divisional Culture and Engagement Improvement Plans Quarterly Pulse surveys providing a temperature check for organisational culture & engagement levels	OH contract performance monitored quarterly and reported to Workforce Advisory Group annually Staff Survey results reported annually to People Committee and Board Pulse survey results reported to PRGs, WAG, People Committee and in IPR Quarterly Wellbeing and Engagement reports to People Committee EDI bi annual reports to People Committee Bi annual Leadership and OD report to People Commitment Bi annual updates to be linked to the strategic themes 'Be a great place to work' to Trust Board Gender Pay Gap report – Trust Board and People Committee April 202	Staff Survey Results 2022 – Increase in 7 out of 9 People Promise scores. Increases in all wellbeing scores. Full report reported to Board and PC in April 2023 WRES & WDES Annual Reports incl external benchmarking data reviewed at Trust Board (April) and PC (April) Model hospital data for Q1 2023/24 Pulse results - Top performing Trust for engagement, involvement and advocacy in Q1 and 14th out 32 for motivation.	3 x 4 = 12	No	G1 MHFA are not embedded into the organisation/ routinely accesses for support G2 Lack of invest in wellbeing & engagement, including physical environment G3 Wellbeing champions role to be implemented G4 No formal trust wide wellbeing and engagement group G5 Gaps in the provision of wellbeing workforce metrics / KPI G6 Decline across some areas for staff feeling valued and recognised G7 Lower quartile in staff survey for staff recommending the Trust as a place to work in compared to C&M Trusts G8 Reduction in funding for leadership and staff development G9 Structured process, engagement and reporting for Freedom to Speak up	Action 1 (G7, G6) Develop systems and processes that enable high quality appraisal conversations with their manager that supports performance, wellbeing and career development Owner: Head of L&OD Due date: November 2023 Action 2 (G3) Develop a role description and recruit voluntary Wellbeing Champions across the organisation Owner: Head of L&OD Due date: July 2023 Action 3 (G4) Implement a Trust wide wellbeing and engagement group chaired by the Deputy Director of Workforce and feeding into Workforce Advisory Group Owner: DDWOD Due date: September 2023 Action 4 (G9, G7, G6) Full review of Freedom to Speak up processes and relaunch across the organisation. Quarterly reporting into People Committee Owner: FTSU Lead Due date: December 2023 Action 5 (G1) Allocate trust lead for MHFA, re-engage with trained mental health first aiders and introduce formal reporting of activities into Wellbeing and Engagement Group Owner: Head of L&OD Due date: December 2023 Action 6 (G6) Celebrate diversity and promote an environment of openness and inclusion free from discrimination and bullying Owner: Head of EDI Due date: January 2024 Action 7 (G4) Develop KPI and metrics for wellbeing and engagement to support with the triangulation of workforce intelligence Owner: DDWOD / HRBPs Date due: November 2023 Action 8 (G6, G7) Provide opportunities for the staff voice to be heard and to act on the feedback given Owner: Head of L&OD / Head of EDI Due date: March 2023	Charitable funds bid for 2023/24 successful achieved Wellbeing and engagement champion role developed and going out in Trusts comms w/c 19th June New appraisal system launched in June 2023 to support managing performance, supporting wellbeing conversations and managing career progression and development needs Q1 pulse survey completed, with an increase in completion rate and improvements seen in 7 out of the 9 questions, including recommending the Trust as a place to work. A day in your shoes initiative approved and commencing in July Divisional culture and engagement plans received and will be reported to Julys WAG	2 x 3 = 6

BAF13. Development and adoption of digitisation

RISK APPETITE: Digital CAUTIOUS (tolerance 8-12)

STRATEGIC OBJECTIVE: Be Digital

Risk description & information	Causes & consequences	Initial (inherent) risk score	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Residual (current) risk score	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24
BAF13 There is a risk of **limited development and adoption of digitisation across the Trust**, which would constrain service improvements and reduce the benefits for patients **Executive Risk Lead:** Sarah Barr, Chief Information Officer **Board Committee**: Quality **Last Update:** 05 June 2023	**Causes** 1. Unknown national funding arrangements for Digital. 2.Lack of operational and clinical workforce digital capability. 3. Inconsistent and unreliable data recording at source. **Consequences** 1. Inability to achieve intended benefits for patient care and safety 2. Inability to ensure data-driven decision making 3. Lost opportunity to modernise 4. Inefficient use of resources 5. Unsustainable operating costs 6. Reputational damage	4 x 4 = 16	C1) Digital Board established with Medical Director as Senior Responsible Owner (SRO). Digital Board is the single governance for Trust wide Digital assurance. Digital Board ensures the Trust's strategic and operational plans are supported by Digital Technology. **Control Owner**: CIO	The Digital Board reports monthly to Trust executive Group (TEG) with 6 monthly strategy updates to Quality Committee and quarterly Cyber reports to Audit Committee Committee.		3x 3 = 9	Yes				3 x 3 = 9
			C2) Clinical System Transformation Programme to ensure clinical systems are operationalised and embedded to improve quality and safety **Control Owner**: CIO	Digital Board signed off the work stream approach and proposed Governance to take forward the findings from the review of clinical systems optimisation - July 22	CCC nationally ranked within group 3 for Electronic Patient Record (EPR) Capability Levels as part of the work undertaken by National Frontline Digitisation Team. Group 3 classifies as an EPR that "already meets the national core capabilities"			G2) Operational ownership for transformational change prior to digitisation	Progress of operational transformational programmes will be monitored via Transformation Improvement Committee (TIC) and digital dependencies will be managed via Digital Board **Action Owner**: COO **Due date**: 31st march 2024	Alignment of roles and responsibilities has commenced with The Outpatient Transformation Programme (TOTP) which is being led operationally but is dependant on digital systems and digital resources once process redesign has taken place	
			C3) Digital Programme plan **Control Owner**: CIO	Full Digital Programme plan is monitored monthly through Digital Board. Monitoring a broad range of projects across all disciplines within the Digital Services function.	Number of work streams in line with national initiatives and reported to Integrated care System or NHS Transformation Team.			G3) Full overview of all digital programmes needed to ensure capture of new and emerging programmes and is fully aligned to Digital Strategy	Review of existing and new digital programmes and alignment to Digital strategy themes. **Action Owner**: CIO **Due date**: 30th July 2023	All programmes and projects currently aligned and to be reviewed at programme Board in June 23	
			C4) Data Warehouse and Interactive Power Bi Dashboards in place **Control Owner**: CIO	Data Management Group chaired by the Director of Finance monitors progress and feeds into Digital Board							
	Measure 1. The National Digital Maturity Assessment sets levels of digital maturity scores between 0-5 (5 being the highest) against the 7 domains of the What Good looks like Framework. We will report on progress of all 52 questions where scores fall below 5. Progress update December 23 2. Key KPIs will be aligned to the new Digital Strategy as part of its implementation plan and additional measures will be developed and added to BAF 13 KPIs		C5) Strong Clinical Leadership and Engagement through Chief Clinical Information Officer (CCIO) and Chief Nursing Information Officer (CNIO) **Control Owner**: Medical Director	N/A				C5) Strong clinical Leadership required to embed and deliver Digital Strategy themes	Continued clinical leadership in digital optimisation programmes and clinical involvement for key deliverables within the strategy. To be monitored via digital board. **Action Owner**: Medical Director **Due date**: 31st March 2024	Clinical leaders in place to support clinical systems optimisation work streams, presenting at Digital Board.	
			C6) Trust Digital Strategy in place to set organisation strategic direction. **Control Owner: CIO**	Digital Strategy endorsed by Digital Board and Quality Committee and approved at Trust Board on 31 May 2023				C6) Strong operational Leadership required to embed and deliver Digital Strategy themes	Continued alignment of programmes and dependencies through Transformation Improvement Committee and Digital Board. TIC leading on process change. **Action Owner**: COO **Due Date**: 31st March 2024	The Outpatient Transformation Programme (TOTP) has updated TIC and Digital Board and progress will be monitored by both meetings. TIC for process optimisation and Digital Board for digitisation.	
			C7) C&M Digital & Data Strategy in place to support ICB digital direction **Control Owner: CIO**	CCC Clinical and digital involvement in development of C&M digital and Data strategy through a series of interactive and formation workshops, Summer 23.							
			C8) National Digital Maturity Assessment completed, establishing a digital maturity baseline for 23/24 for all seven domains of the What Good Looks like Framework (WGLL) Well Led, Ensure Smart Foundations, Safe Practice, Support People, Empower Citizens, Improve care and Health Populations. **Control Owner: CIO**	National Self assessment completed collaborative and assured via digital Board	National baseline expected Summer 2023 to measure improvements			C8.1) Trust wide ownership and engagement with the What good Looks like framework to support improvements in Digital maturity, particularly in "Empowering Citizens"	Present "Empower Citizens" Digital maturity Scores to Patient Inclusion and Engagement Group developing a co-produced action plan for any areas of improvement **Action owner**: Chief Nurse **Due date** 31st December 2023	C&M Digital Inclusion Lead scheduled to present best practice and tools for digital inclusion in July2023. Chief Nursing Information Officer to present Digital maturity scores and develop action plan with Head of Patient Experience . Overall progress to be monitored by Digital Board	
								C8.2) Trust wide ownership of the What good Looks like framework to support improvements in Digital maturity, particularly "Support People"	"Support People" digital maturity scores to be presented to Workforce Advisory Group (WAG) and a joint plan developed for any areas of improvement **Action Owner** : HRD **Due date** 31st December 2023	Digital maturity scores for "Supporting People to be presented to Workforce Advisory group (WAG) with a joint plan developed to increase levels of Digital maturity. Overall progress of all domains to be monitored via Digital board	

Additional narrative

The Organisation is developing it's levels of digital maturity through better use of digital systems and data. It is essential that the addition of any new technologies is embedded for the right reasons and to support clinical and operational processes to its best effect. It is essential that process change and embedding of new ways of working is owned clinically and operationally. The Inherent risk score is high as, if uncontrolled there is a risk the organisation could fall behind. There is considerable change management aspect of the work required in the development and adoption of digitisation which is cross-cutting and requires different parts of the organisation to own and lead alongside the Digital services team. The Digital Strategy for the organisation has been approved by Trust Board in June 2023 . Along with implementation plans of the Strategy, further KPs will be added to measure BAF 13. There are a number of actions to complete within year , which will add to our controls .. A number of the actions are dependant on transformational change and it is expected that the risk will maintain a score of 9 throughout the year.

BAF14. Cyber security

RISK APPETITE: Digital CAUTIOUS (tolerance 8-12)

STRATEGIC OBJECTIVE: Be Digital

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls (*what is in place to manage the risk?*)	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24 L x C
BAF14 There is a risk of **major security breach** arising from increasing digitisation and cyber threats, which could disable the Trust's systems, disrupt services and result in data loss **Executive Risk Lead:** Sarah Barr, Chief Information Officer **Board Committee**: Audit **Last Update:** 04 July 2023	**Causes** 1. Increasing sophistication and variety of malicious attacks 2. Integration of networks across the ICB 3. Increased reliance on digitised processes 4. Legacy infrastructure requiring modernization 5. Heightened national and international threat **Consequences** 1. Disruption to services 2. Loss of data 3. ICO fines (Highest maximum amount is £17.5m or 4% of the annual turnover in preceding year- whichever is highest) 4. Fraud/theft 5. Reputational damage **Measure:** 1. The National Digital Maturity Assessment sets levels of digital maturity scores between 0-5 (5 being the highest) against the 7 domains of the What Good looks like Framework. We will report on progress of specific Cyber related questions within Safe Practice domain. 2. Data Security and Protection Toolkit scores (annual) 3. Microsoft Defender endpoint scores (Monthly) ISO27001 (annually)	4 x 5 = 20	C1) Anti-virus software up to date across server and PC estate, regularly monitored and maintained **Control Owner**: CIO	Anti-virus posture reported monthly to Digital Security Committee (DSC). Forms part of the Chairs report to Digital Board. Regular quarterly report to Audit Committee including security posture	NHS Digital receive real-time telemetry from Windows devices, which feeds national dashboards and triggers alerting.	4 x 3 = 12	Yes				4 x 3 = 12
			C2) Enterprise Backup Solution **Control Owner**: CIO	Backups checked daily. Reported monthly to Digital Security Committee. Restores tested on a quarterly basis. All backups are immutable and can not be altered.	MIAA , substantial assurance for Cyber Security Audit. (12th March 2022) NHSD/MTI - Full backup review performed in Feb 2021. All recommendations now in place.						
			C3) Windows Advanced Threat Protection (ATP) **Control Owner**: CIO	ATP deployed to all applicable assets.	All CCC devices have Windows ATP and are continuously monitored by NHSD Security Operations Centre (SoC)						
			C4) Adherence to Cyber Essentials standard **Control Owner**: CIO	CE & CE+ accreditations and compliance progress tracked via Digital Security Committee. Quarterly reporting to Audit Committee	Cyber Essentials Plus certification awarded December 2022. External audit process underway to support ISO27001 compliance.			G4) Adoption of enhanced standards via ISO27001	Plan in place for progress towards ISO27001 implementation **Action Owner**: CIO **Due date**: July 2023 (revised from March 2023	ISO27001 - remains in progress and on track. Several divisions have now had preliminary audits. Physical audits for ISO have taken place at CCC-w and CCC_A with CCC-L planned for. Phase one audits underway in April with phase two expecting completion at the end of July 2023. Cyber Essentials Plus certification action complete. Certification awarded in December 2022. Reaccreditation due in Dec 23	
			C5) Network vulnerability Monitoring **Control Owner**: CIO	Security posture dashboards presented to Digital Security Committee on a monthly basis. Quarterly reporting to Audit Committee	External audits take place to provide independent assurance on posture. Annual external Penetration Testing is undertaken by an external body.			G5) Cyber incident response in-house skills - details SOC 24/7 monitoring not available	Digital Security Team taking Cyber Incident Response exams Cheshire& Merseyside Regional 24/7 Security Operations Centre (SOC) being developed. CCC Leading on this. **Action Owner**: CIO **Due date**: March 2024 (revised from November 2022)	Digital Security Team have undertaken Cyber Incident response courses. ICS working with external supplier and NHS England to develop a regional Cyber Security Strategy and a Regional Security Operations Centre (SOC) Roadmap for C&M. It is anticipated this will include an underpinning Blueprint to support the procurement of a SOC during 23/24- subject to regional funding.	

Additional narrative

Cyber is a risk that will always score high on a Trust Risk Register due to the fluctuating nature of this type of risk and new and emerging risks to Cyber Security happening at all times. There are a number of national approaches to control Cyber Risks which this Trust is fully immersed in. The Trust has been awarded Cyber Essentials + certification in December 2022. This is a significant achievement for the organisation. The Trust continues with plans for ISO27001 accreditation, a number of physical audits have already been completed, with full external review completed in CCC-W and CCC-A. The final external audit will take place during July 23 at CCC-L and accreditation is expected after that review. Operational level cyber risks continue to be managed through monthly Data Security Committee Meetings and IG Board. The 2023 submission of the Data Security and Protection Toolkit (DSPT) has received substantial assurance.

BAF15 Subsidiary Companies and Joint Venture											
RISK APPETITE: Commercial and partnership working, financial CAUTIOUS (9-12)											
STRATEGIC OBJECTIVE:	Be Innovative										
Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance		Residual (current) risk score	Within risk tolerance?	Gaps in Control / Assurance	Actions		Target risk score by 31/03/24
				Internal assurance *What/where reported/when?*	External assurance *What/where reported/when?*				Planned action	Progress update	
BAF15 There is a risk of **inadequate management and governance of the Trust's Subsidiary Companies and Joint Venture**, which would result in failure to maximise the potential commercial and efficiency benefits for the Trust. **Executive Risk Lead:** James Thomson, Director of Finance **Board Committee**: Performance **Last Update:** 15 May 2023	**Causes** 1. Lack of clear strategy for subsidiaries 2. Lack of sufficient governance and assurance interfaces with Trust 3. Lack of signed SLA/contract agreements 4. Insufficient management capability/capacity **Consequences** 1. Failure to realise efficiencies 2. Failure to maximise commercial income 3. Subsidiaries and JV do not invest in business and reduce growth/market share **Measure** 1. Subsidiary financial performance updates to Trust Board (Part 2) 2. JV financial performance updates to Trust Board (Part 2) 3. Risk ratings above 15 to have mitigations in place	5 x 3 = 15	C1) Limited Liability Partnership agreement with the Mater Private Healthcare. Renewed by both parties 2020. **Control Owner: DoF**	Contract format and agreement reviewed by Trust Board. Also managed through joint venture Board.	Legal advice taken on initial structuring and renewal agreement. Internal audit review of governance arrangements complete May 2023 - substantial assurance received.	3 x 3 = 9	Yes	G1) Annual review of budgets to support SLA relationship to complete before Trust financial plan for year.	Commence SLA discussion in Q4 22/23 **Action Owner:** DoF **Due Date:** 30/09/23	Agreed SLA position for 2022/23. 2023/24 budget for JV to be finalised at June Board.	2 x 2 = 4
			C2) Strategy and financial plan set by The Mater and approved by Trust **Control Owner: DoF**	JV performance reports and finance results reported to Performance Committee - twice per year. JV reports to Trust Board - twice per year (Part 2)	External audit required annually.			G2) Revised multi-year marketing and growth plan to be developed and approved.	JV producing revised multi-year strategy for growth. **Action Owner:** DoF **Due Date:** 30/06/23	Marketing and engagement plan revised and being implemented by JV Manager. New JV Manager started April 23.	
			C3) Separate governance and Board arrangements for CPL and PropCare **Control Owner: DoF**	Internal SLA and financial reporting process managed through Finance Committee and Performance Committee. Also, operational performance managed through subsidiary specific Performance Review Groups.	Internal audit review of PropCare governance arrangements complete May 2023 - substantial assurance received. Both subsidiaries subject to external audit, and for CPL professional regulatory licensing.			G3) Final revised SLA for corporate services provided by the Trust to CPL, not approved between the parties.	CPL DoF has established a work stream to finalise Trust to CPL SLA for services. Trust/CPL to sign SLA following review. **Action Owner:** CPL Executive **Due Date:** 30/09/23	CPL DoF has established a work stream to finalise Trust to CPL SLA for services. Revised CPL SLA signed January 2023 for dispensary and procurement services. New Chair of CPL appointed by Trust Board.	
			C4) PropCare approved business strategy and medium term plans March 2022 **Control Owner: DoF**	PropCare performance reports to Performance Committee and Trust Board - bi-annually. Trust Board Non Executive Directors named as Directors of subsidiaries.	PropCare subject to external audit.			G4) PropCare business development plan to be embedded	Trust to receive full business development plan Quarter 2, through Performance Committee. **Action Owner:** DoF **Due Date:** 30/09/23	PropCare have produced a strategy, and are pursuing opportunities with other NHS organisations.	
			C5) CPL approved business strategy and medium term plans March 2022 **Control Owner**: DoF	CPL performance reports to Performance Committee and Trust Board - bi-annually. Trust Board Non Executive Directors named as Directors of subsidiaries.	Subsidiaries subject to external audit. CPL corporate tax structure advised by KPMG.			G5) CPL to develop and present 5 year strategy to Trust Board for approval.	CPL to present strategy to Trust Board at next update. **Action Owner:** CPL Executive **Due Date:** 31/11/23	CPL has completed its draft strategy. Final version to be taken to CPL Board session 24th May 2023.	

Additional Narrative:
The Trust recognises that the subsidiary companies and JV add commercial value to the Trust. They have separate management teams and there is a risk that if clear governance and strategy is not established the benefits of the Group will not be maximised, to the detriment of patient care.
The governance structures are routinely reviewed and arrangements are in place for performance monitoring. These have been strengthened recently due to input from new subsidiary/JV appointments.
Recent strategy developments (CPL/PropCare) and implementation will be reviewed through Trust Board meetings.

Title of meeting: Trust Board Part 1
Date of meeting: 26th July 2023

Report Lead	Jane Hindle, Associate Director of Corporate Governance			
Paper prepared by	Jane Hindle, Associate Director of Corporate Governance			
Report subject/title	Board Effectiveness and Governance Review			
Purpose of paper	The purpose of the report is to provide the Board with the outcome of the recent effectiveness review and identify areas for improvement.			
Background papers	N/A			
Action required	The Board is requested to: • Discuss the findings of the review • Approve the proposed amendments to the terms of reference			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work	
	Be Collaborative		Be Digital	
	Be Research Leaders		Be Innovative	

Equality & Diversity Impact Assessment

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

Ref: FCGOREPO
Review: July 2025
Version: 2.0

1.0 Introduction

Following a review in 2022, new governance arrangements were introduced that saw a reduction in the frequency of committee meetings whilst retaining monthly Board meetings with the exceptions of August and December.

1.1 This paper seeks to assess the effectiveness of those arrangements, identifies some areas for improvement and opens up areas for discussion. This has been informed by the committee effectiveness reviews that have been discussed at each respective committee and reported to Audit Committee. In addition, Board members were asked to complete a questionnaire to assess the effectiveness of the Board. The detail of the review of Board Effectiveness can be found at appendix c

2.0 Current delegation

2.1 In line with schedule 7, of the NHS Act 2006 the Board has 2 statutory Committees, Audit and Remuneration Committee. In addition to these arrangements the Board has established 3 committees Quality, Performance and People Committee. Each established with terms of reference and membership approved by the Board.

2.2 The terms of reference are derived from the Scheme of Reservation and Delegation approved by the Board in January 2022 and set out the powers of each committee, underpinned by a cycle of business.

2.3 Each Committee receives delegated authority from the Board to investigate any matter within it terms of reference and to seek any information it requires from any member of staff. Committees are also empowered to establish time limited working groups on specific subjects requiring detailed review.

2.4 Whilst principally each committee operates as an assurance committee, there are a small number of items that have been delegated by the Board for approval. Table a below provides a reminder of the details. Outside of these matters the Committees of the Board have no power to approve items unless authority has been formally delegated, with a corresponding minute, for a specific item in year e.g approval of the operational plan .

Name of the Committee	Matter delegated
Audit Committee	Review and approve the Internal Audit Plan, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework Approve the terms of engagement of the External Auditor, including any engagement letter issued. Approve authorisation levels for the issue of credit notes and write off debts. The Audit Committee will agree and implement a policy on the engagement of the external auditor to supply non-audit services.

Remuneration Committee	Where appropriate, to authorise any contractual or non-contractual payments to the Chief Executive and Executive Directors.
Quality Committee	To approve the annual Clinical Audit Programme on behalf of the Board, ensuring it is consistent with the audit requirements of the Trust.
Performance Committee	Approve the progression of Invitation to Tender (ITT) stage for strategically significant tenders or tenders requiring the commitment of resources above the limit set in the Trust's Scheme of Delegation.
People Committee	None

2.5 This limited delegation means that the Board has retained the following principal matters to itself for decision:

- Setting the Strategic Direction – and therefore approving the five year strategy and enabling strategies
- Approval of the operational plan
- Monitoring of performance -
- Approval of Human Resources policies incorporating the arrangements for the appointment, removal and remuneration of staff.

2.6 Appendix b provides the full schedule of matters reserved to the Board.

3.0 **Frequency of meetings**

3.1 The Code of Governance, section 2.17 states, The board of directors should meet sufficiently regularly to discharge its duties effectively. The review of Board effectiveness does not identify any issues in relation to the frequency of meetings nor does the cycle of business suggest that agendas are unnecessarily burdensome.

3.2 The emerging system governance arrangements have placed an additional time commitment on some board members and therefore the Board may wish to consider if there is an opportunity to reduce the number of Board meetings and delegate more to the Committees. This approach is in keeping with the recent guidance from NHS Providers that states, "The purpose of a committee is to do work for the board, providing more in-depth and focussed scrutiny and assuring the board as well as escalating risk and sharing good practice."

3.3 The Committee Effectiveness reviews identified one area of incongruence which related to the frequency of committee meetings. A comment was made regarding the Quality Committee which currently meets on a quarterly basis. . Whilst this was discussed at the meeting of the Committee in May there was no consensus.

3.4 A review of other trusts governance arrangements has been undertaken to determine how the Trust compares with others in the local system and specialist areas. Appendix b provides a summary.

4.0 Relationship with the Trust Executive Group

4.1 Under the powers delegated to the Chief Executive, the Trust Executive Group provides a forum to enhance clinical engagement and inform decision making within the Trust.

4.2 The meetings take place on a monthly basis and also provide an opportunity for the Chief Executive and Directors to discuss strategic and operational aspects of business delivery, whilst also undertaking horizon scanning of the regional and national agenda. Members of the Executive Team can make decisions within the delegations made to them as individuals, as outlined in the scheme of reservation and delegation.

4.3 This meeting also provides a transparent forum by which the Chief Executive discharges her role in respect of delegated financial authority i.e £500k.

4.4 Whilst there is no formal report from the Trust Executive Group to the Board matters of significance are reported via the Chief Executives Report to the Trust Board. In effect this means that there is already a mechanism to raise issues of concern on a regular basis.

5.0 Areas for improvement

5.1 The current terms of reference for the People Committee do not provide authority for the Committee to approve HR policies. It is therefore proposed that the following clause is included:

The Committee is authorised to approve Human Resources policies incorporating the arrangements for the appointment, removal and remuneration of staff

5.2 The Equality Act 2010 places a responsibility on public authorities in the exercise of their functions. It is proposed that the following wording is included in the terms of reference for each of the committees:

In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and the public, including those who have protected characteristics and vulnerable members of our community.

6.0 Conclusions and recommendations

6.1 The Board has completed a review of its own effectiveness and that of its committees for 2022/23. The review has been largely positive with minor areas of improvement identified for 2023/24.

6.2 This juncture provides an opportunity to consider the number and frequency of Board meetings and those of the committees.

6.3 The Board is requested to:

- Discuss the Board effectiveness review
- Discuss the frequency of meetings and whether there is a need to change this
- Consider if additional matters should be delegated to committees
- Approve the proposals to amend the terms of reference of committees

Appendix A – Scheme of Reservation and Delegation

3.4 Regulations and Control

The Trust Board remains accountable for all of its functions, even those delegated to individual committees, sub-committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

The following are decisions reserved to the board:

1. Approval of Standing Orders (SOs), a schedule of matters reserved to the Board of Directors and Standing Financial Instructions for the regulation of its proceedings and business.

- Suspend Standing Orders.
- Vary or amend the Standing Orders.
- Ratification of any urgent decisions taken by the Chair and Chief Executive in accordance with the Standing Orders.
- Approval of a scheme of delegation of powers from the Board of Directors to Committees.
- Requiring and receiving the declaration of Board members' interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration.
- Requiring and receiving the declaration of officers' interests which may conflict with those of the Trust.
- Approval of arrangements for dealing with complaints.
- Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.
- To receive reports from committees including those which the Trust is required by the Constitution and the National Health Service Act 2012 or other regulation to establish and to take appropriate action thereon.
- To confirm the recommendations of the Trust's committees where the committees do not have executive powers.
- Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.
- To establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board of Directors.
- Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.
- Authorise use of the seal.
- Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with Standing Orders.
- Disciplining Board members' or employees who are in breach of Statutory Requirements or Standing Orders.
- Approval of arrangements relating to the discharge of the Trust's responsibilities as shareholder in relation to any of its subsidiaries / joint venture entities.
- Approval of matters which may significantly impact the Trust in relation to the subsidiaries or joint venture entities.

3.5 Appointments / Dismissal

- Appointment of the Vice Chair of the Board of Directors.
- The appointment and dismissal of committees (and individual members) that are directly accountable to the Board of Directors. – Major policies, recruit, disciplinary payment of staff. Delegate – to People Committee.
- The appointment, appraisal, disciplining and dismissal of Executive Directors.

- Confirm the appointment of members of any committee of the Trust as representatives on outside bodies.

3.6 Policy Determination

The approval of Trust management policies including:

- Human Resources policies incorporating the arrangements for the appointment, removal and remuneration of staff.
- Approve procedure for declaration of hospitality and sponsorship.
- Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
- Approve a list of employees authorised to make short term borrowings on behalf of the Trust.

3.7 Strategy and Business Plans and Budgets

- Definition of the strategic aims and objectives of the Trust.
- Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State or the Independent Regulator.
- Approval and monitoring of the Trust's policies and procedures for the management of risk.
- Approve Outline and Final Business Cases for Capital Investment in line with specified delegated limits.
- Approve budgets.
- Approve annually Trust’s proposed operating plan / Strategic Plan
- Ratify proposals for acquisition, disposal or change of use of land and/or buildings
- .Approve proposals on individual contracts, including purchase orders (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £500,000 per annum or £1,500,000 in total if the period of the contract is longer than 3 years.
- Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Finance Director.
- Approve proposals for action on litigation against or on behalf of the Trust where the likely financial impact is expected to exceed £10,000 or contentious or novel or likely to lead to extreme adverse publicity, excluding claims covered by the NHS risk pooling schemes.
- Review use of NHS risk pooling schemes (NHS Resolution).
- Approve the opening of bank accounts.
- Approve individual compensation payments.

3.8 Audit Arrangements

To receive recommendations regarding the appointment (and where necessary dismissal) of the internal and external auditors. Responsibility for the appointment or removal of the external auditors is held by the Council of Governors.

The Board are required to:

- Receive the External Auditors annual report and agreement of proposed actions, taking account of the advice, where appropriate, of the Audit Committee.
- Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.

3.9 Annual Report and Accounts (inc Quality Report)

- Receipt and approval of the Trust's Annual Report (inc Quality Report) and Annual Accounts

prior to:
  - being laid before parliament, which is prior to presentation to the Council of Governors at a Members Meeting.
- Receipt and approval of the Annual Report and Accounts for funds held on trust (Charitable funds).

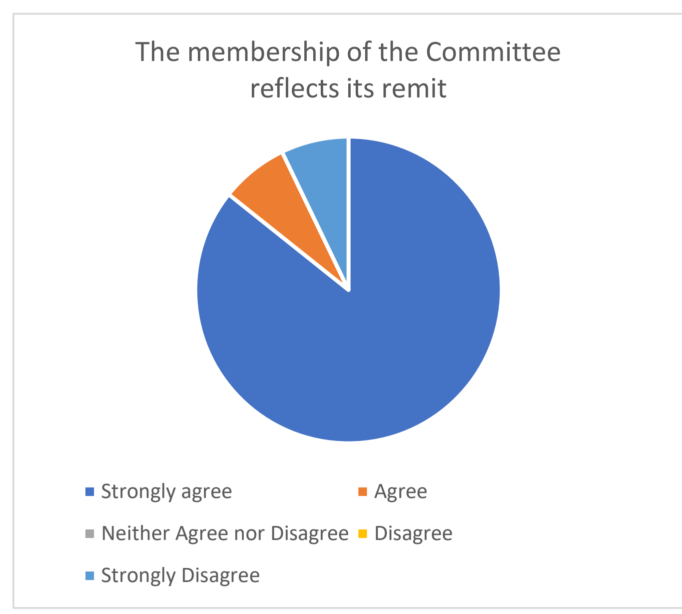
3.10 Monitoring

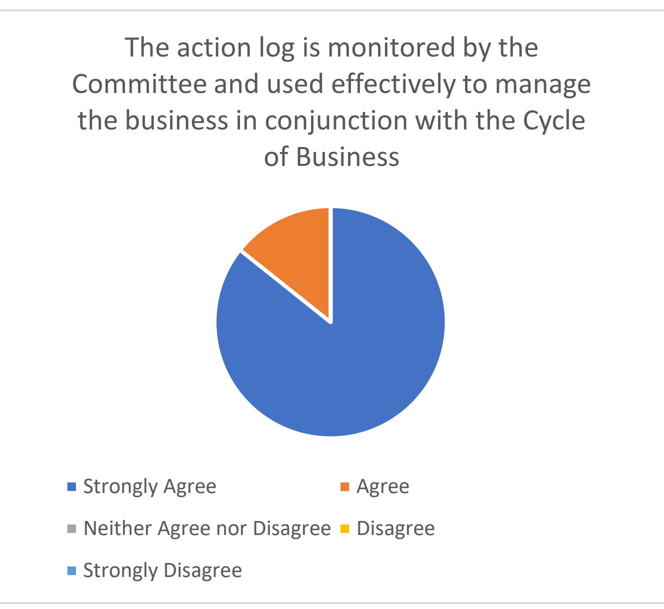
- Receive such reports as the Board of Directors sees fit from committees in respect of their exercise of powers delegated.
- Continuous appraisal of the affairs of the Trust by means of the provision to the Board of Directors as the Directors may require from directors, committees, and officers of the Trust as set out in management policy statements.
- Receive reports from Finance Director on financial performance against budget and business plan / delivery plan.
- Receive reports from subsidiaries / joint venture entities on financial and contractual performance.

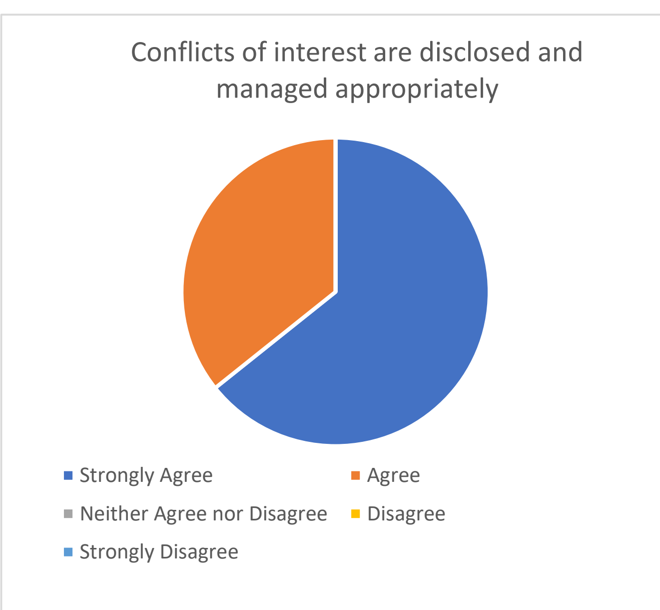
Appendix B – Governance Arrangements of other trusts

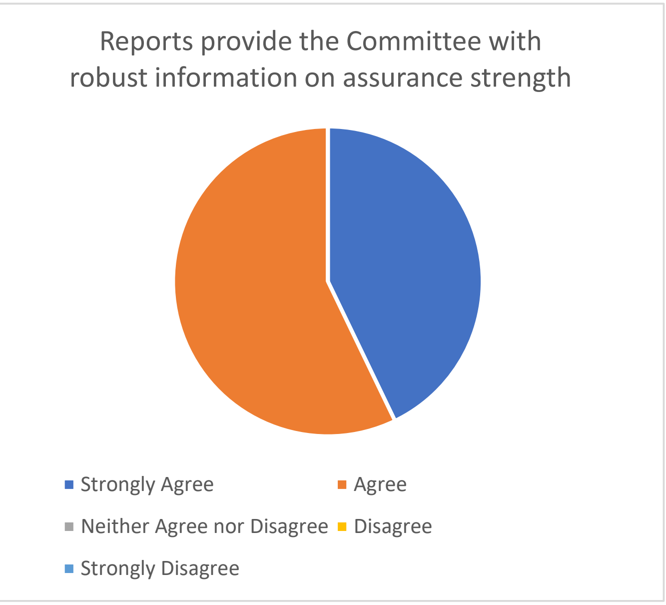
Trust	Frequency of Board Meetings	Committee Structure
Trust A	**7 times per year** Apr May July Sept Nov Feb Mar	Audit Committee - 4 per year with 1 extra-ordinary People Committee - 4 per year Quality Committee - 4 per year Integrated Performance Committee - 4 per year
Trust B	**7 per year** • Apr • May • July • Sept • Nov • Jan • Mar	Audit Committee – 7 per year Charitable Funds – 5 per year Executive Risk and Assurance Committee – monthly
Trust C	**8 times a year** • April • May • June • September • October • November • January • March	Audit Committee – 4 per year Quality Assurance Committee – bi monthly Management Board – monthly
Trust D	**9 meetings** June July Sept Oct Nov Dec Jan Feb Mar	Audit & risk Committee – 5 per year Resource & Business Development Committee – monthly Safety & Quality Committee – monthly People & Wellbeing Committee – bi-monthly Innovation Committee – bi-monthly

Appendix C - Trust Board Effectiveness Review 2022-2023 Results

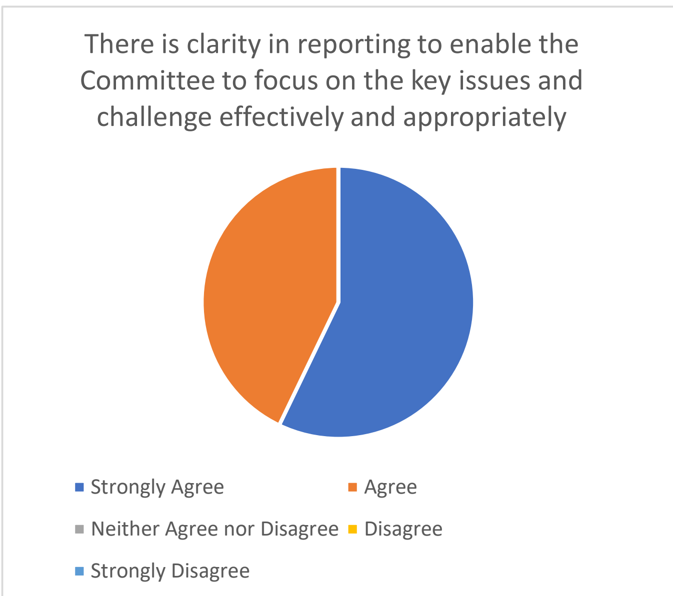


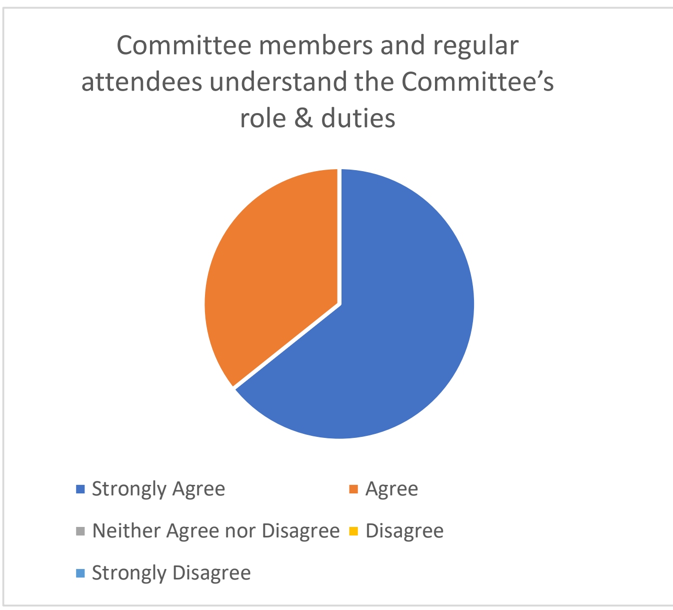


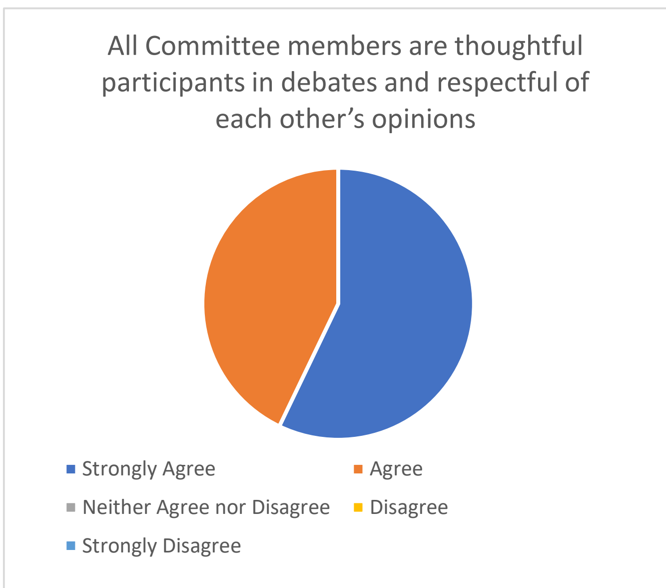


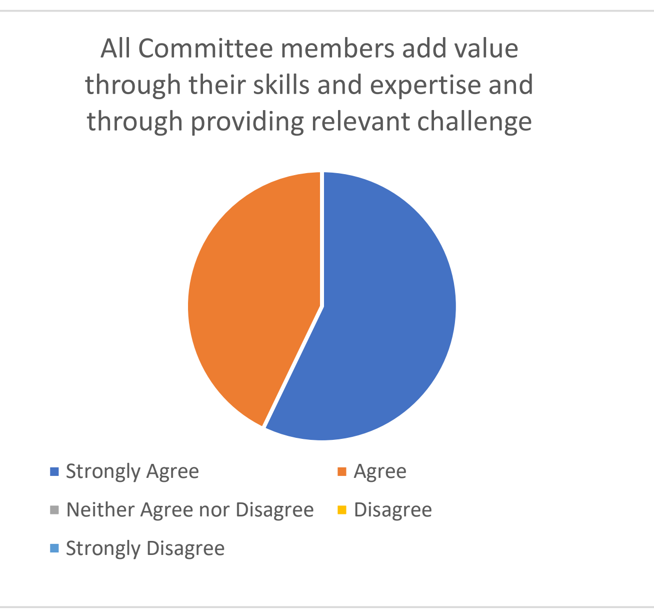


Ref: FCGOREPO
Review: July 2025
Version: 2.0



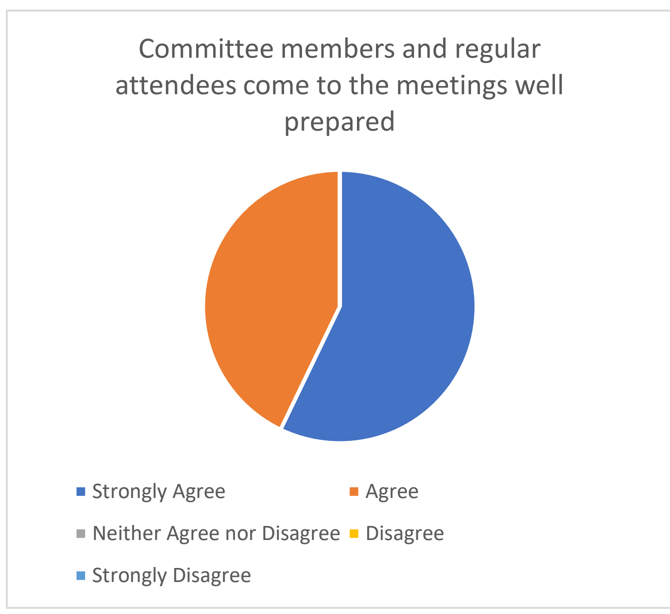


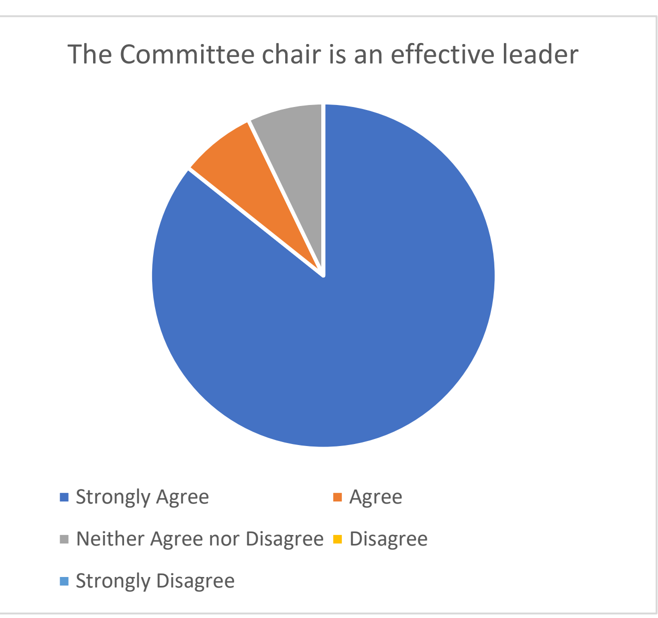


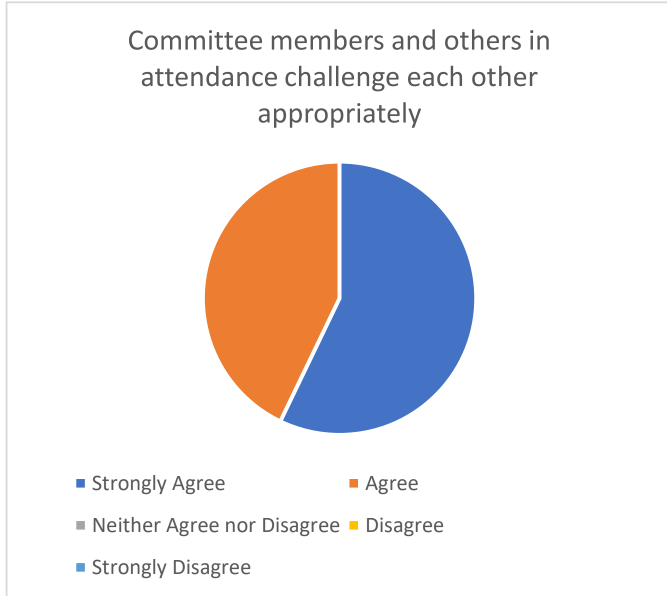


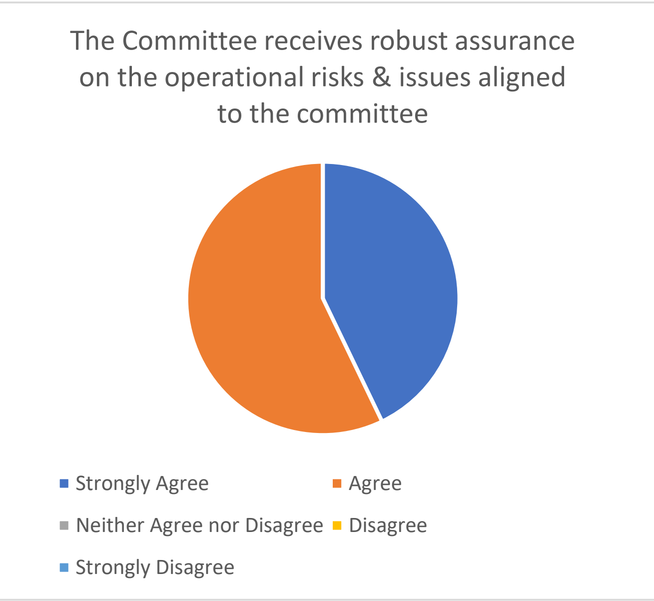
Ref: FCGOREPO
Review: July 2025
Version: 2.0

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust


Committee members and regular attendees come to the meetings well prepared
Strongly Agree
Agree
Neither Agree nor Disagree
Disagree
Strongly Disagree

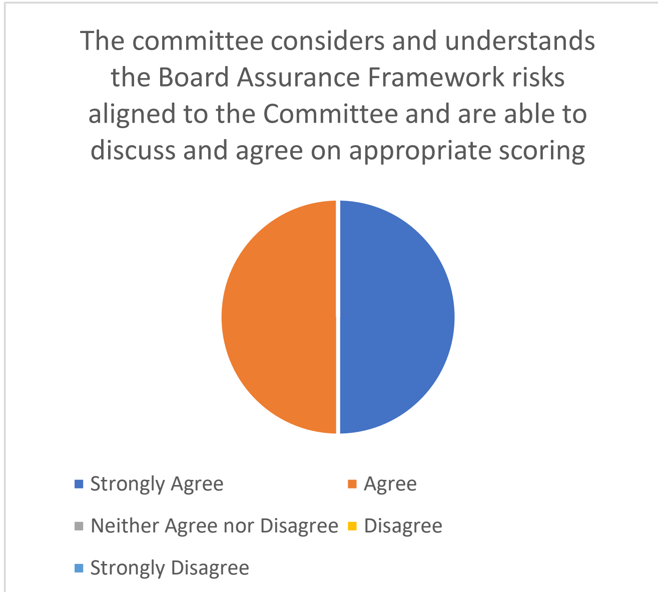

The Committee chair is an effective leader
Strongly Agree
Agree
Neither Agree nor Disagree
Disagree
Strongly Disagree

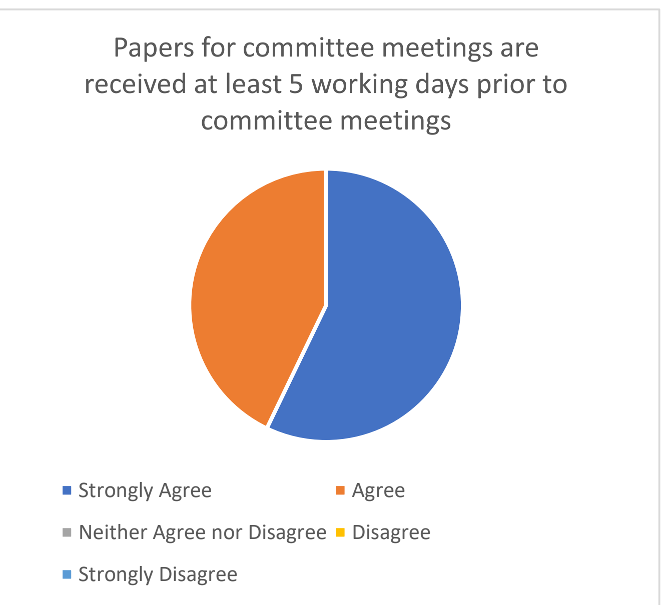

Committee members and others in attendance challenge each other appropriately
Strongly Agree
Agree
Neither Agree nor Disagree
Disagree
Strongly Disagree

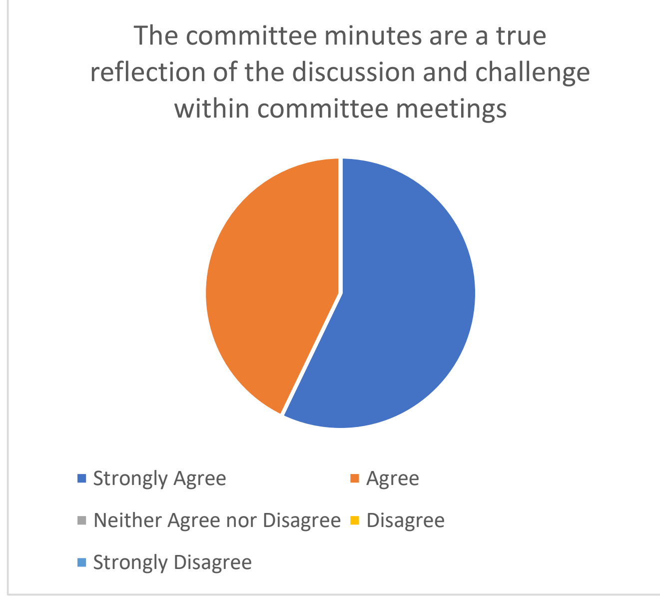

The Committee receives robust assurance on the operational risks & issues aligned to the committee
Strongly Agree
Agree
Neither Agree nor Disagree
Disagree
Strongly Disagree

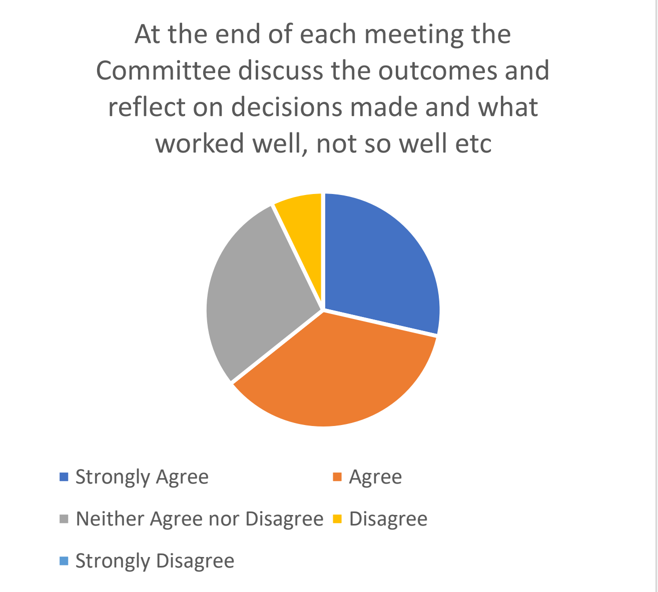
WE ARE...
KIND EMPOWERED RESPONSIBLE INCLUSIVE

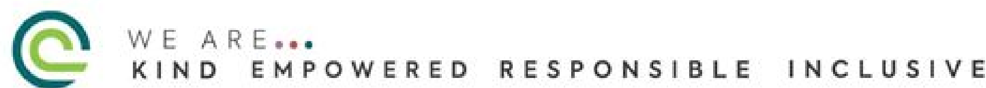
NHS
The Clatterbridge
Cancer Centre
NHS Foundation Trust


The committee considers and understands the Board Assurance Framework risks aligned to the Committee and are able to discuss and agree on appropriate scoring
Strongly Agree
Agree
Neither Agree nor Disagree
Disagree
Strongly Disagree


Papers for committee meetings are received at least 5 working days prior to committee meetings
Strongly Agree
Agree
Neither Agree nor Disagree
Disagree
Strongly Disagree


The committee minutes are a true reflection of the discussion and challenge within committee meetings
Strongly Agree
Agree
Neither Agree nor Disagree
Disagree
Strongly Disagree


At the end of each meeting the Committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc
Strongly Agree
Agree
Neither Agree nor Disagree
Disagree
Strongly Disagree


WE ARE...
KIND EMPOWERED RESPONSIBLE INCLUSIVE

Please write any additional Comments you would like to make:

- We do not discuss the outcomes and reflect on decisions made, or what worked well/not so well at the end of meetings
- Highly effective Chair and NED input at the committee. Improved governance in the year. Consistent focus on key issues and triangulation to other committees/Boards by members. Committee has had to be flexible in approach due to external timings on some issues - e.g. historic external audit reports

Title of meeting: Trust Board
Date of meeting: 26th July 2023

Report lead	Jane Hindle, Associate Director of Corporate Governance			
Paper prepared by	Skye Thomson, Corporate Governance Manager Abby Ashcroft, Corporate Governance Administrator			
Report subject/title	**Committee Annual Reports and Effectiveness Review 2022-23**			
Purpose of paper	To provide evidence that the Board Committees have discharged their role in line with the delegated authority and identify opportunities for improvement.			
Background papers	Committee Terms of Reference Committee Cycle of Business 2022-23			
Action required	**The Board is requested:** • Note that the committee effectiveness review process has identified that each committee has met its terms of reference • Note the areas for focus during 2023/24			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	√	Be a great place to work	
	Be Collaborative		Be Digital	
	Be Research Leaders		Be Innovative	

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

Ref: FCGOREPO
Review: July 2025
Version: 2.0

Committee Annual Report and Effectiveness Review 2022-2023

1.0 Introduction

1.1 In line with good governance, Committees of the Board should undertake an annual review of their effectiveness.

1.2 The purpose of this paper is to formally report on the work of the Board committees during the period 1st April 2022 to 30th April 2023 and to set out how they have met their terms of reference and priorities.

2.0 Scope

2.1 The review undertaken by the Corporate Governance Team focused on a review of the papers presented to the committees in line with the agreed Terms of Reference. The review has been broken down into responsibilities, membership and attendance, reporting, and areas for focus in 2023/24.

2.2 Due to the infrequency of meetings the Remuneration Committee has not been included within the scope of this review but will consider its terms of reference and reporting requirements at a future meeting.

2.2 In April / May 2023 members where given the opportunity to complete the electronic committee effectiveness survey based upon the self-assessment checklist within the HFMA NHS Audit Handbook.

2.3 Comments on the performance of committee Chair's has been taken into account as part of the annual appraisal process.

3.0 Assessment

3.1 The evidence demonstrates that each of the committees has discharged its role in line with its terms of reference during 2022/23.

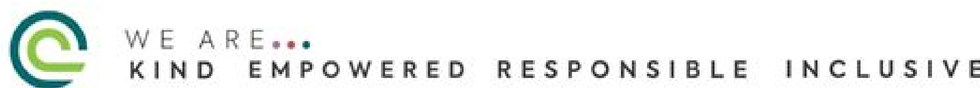
3.2 The Audit Committee reviewed the Annual Reports from each of the Committees at its meeting in July and confirmed that the Committees have met their terms of reference during 2022/23.

3.2 Areas for improvement include items that were not explicitly reported or where increased focus would be beneficial during 2023/24. These can be found in the appendices.

3.3 The Corporate Governance Team will work with each executive lead to ensure that the Cycle of Business for each Committee captures the areas of focus for 2023/24 and that the scheduling of meetings supports the timely distribution of papers.

4.0 Recommendations

4.1 The Board is requested to:



- Note the Annual Reports and Effectiveness Review 2022/23
- Note the areas of focus for 2023/24

Appendix A – People Committee

1.0 Role of the People Committee

1.1 The role of the People Committee is to provide the Board with assurance on the quality, delivery and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust.

2.0 Membership and Attendance Record

2.1 The Q4 People Committee meeting scheduled for March 2023 was deferred until April 2023, therefore April is included in the attendance recorded for 2022-23 meetings in table 1 below.

2.2. The table below demonstrates that every meeting of the Committee during the year was quorate. The quorum for any meeting of the Committee is attendance of a minimum of four members of which two will be Non-Executive Directors, the Director of Workforce and OD and one other Executive Director. This was attained through the year.

Name	Attendance
Anna Rothery – Non-Executive Chair	3/4
Geoff Broadhead – Non Executive Director	3/4
Elkan Abrahamson – Non Executive Director	4/4
Jayne Shaw, Director of Workforce and Organisational Development	4/4
Joan Spencer, Chief Operating Officer	4/4
Julie Gray – Chief Nurse	3/4
Sheena Khanduri , Medical Director	3/4
Sarah Barr, Chief Information Officer	3/4

Table 1

3.0 Responsibilities.

3.1 During 2022/23 the Committee has delivered the key responsibilities as set out in the terms of reference. Compliance is evidenced by the routine presentation and consideration of the following:

<table>
<tr><th>Terms of Reference</th><th>Key Responsibilities/Agenda Items</th></tr>
<tr><td colspan="2">2.2, 2.3
The People Committee is responsible for providing assurance to the Board in relation to the delivery of the Trust’s People Commitment, ensuring that the cultural identity, values and behaviours framework is aligned to the delivery of corporate objectives and compliance with legislation.</td></tr>
<tr><td colspan="2">3.14
Oversee the development of the cultural identity, values and behaviors of the Trust, seeking assurance on the alignment with the delivery of workforce improvements

• People Commitment Implementation Update</td></tr>
<tr><td colspan="2">2.4, 3.6
The Committee will ensure that the Trust’s workforce has the capacity and capability to deliver the Trust’s objectives through effective leadership and development, workforce planning and organisation development.

• Workforce Planning Update</td></tr>
<tr><td colspan="2">3.11
Oversee the development of Leadership skills and Capacity across all levels of the Trust

• Learning, Leadership & Organisational Development Report</td></tr>
<tr><td colspan="2">2.5
The Committee will ensure that risks relevant to the Committee’s purpose are minimised through the application of the Trust’s risk management system.

• People Committee Risk Report
• People Committee Board Assurance Framework</td></tr>
<tr><td colspan="2">3.1
Review and recommend to the Board workforce key performance indicators and targets.

• Review of Workforce & Organisational Development KPIs</td></tr>
<tr><td colspan="2">3.2, 3.4
Monitor and review performance against key performance indicators and any action plans to deliver improved performance.

• People Committee Integrated Performance Report</td></tr>
<tr><td colspan="2">3.4
Ensure that all staff are receiving an effective annual appraisal and that robust succession plans and talent management processes are in place.

• Mandatory Training and PADR Performance Report</td></tr>
</table>

3.5 Receive and consider the national Staff Survey and Culture and Engagement survey results for the Trust and oversee the implementation and effectiveness of improvement plans on staff experience and engagement. • **Staff Survey Results and Action Plan**
3.5, 3.8, 3.16 Monitor the effectiveness of staff engagement processes. • **Staff Wellbeing & Engagement Update**
3.6 Ensure that the Trust has adequate staff with the necessary skills and competencies to meet the current and future needs of patients and service users. • **Recruitment & Development Plan**
3.7 Monitor and evaluate compliance with the public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics (i.e. Workforce Race Equality Standards, Workforce Disability Equality Standards and Gender Pay Gap reporting). • **Gender Pay Gap** • **Workforce Race Equality Standard Report** • **Workforce Disability Standard**
3.10, 3.11 Oversee the development and delivery of a workforce education and development plan. • **Clinical Education Annual Report**
4.3 The following sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, the Committee and any report or briefing requested by the Committee: • **Education Governance Committee Report** • **Workforce Advisory Group Assurance Report**
2.1 To provide assurance that the Trust is monitoring management, quality, delivery and impact of people and managing them appropriately • **Staff Story** • **Confidential Staff Matters**

3.10, 3.12 To provide assurance that the Trust is investing in people by developing the workface by providing opportunities for progression and career progression • **Apprenticeship Update**
3.6 To provide assurance that rotas, staffing and vacancies across the junior doctor workforce are at safe levels for the Trust for the past 12months, highlighting any breaches and actions put in place to address the breaches • **Guardian of Safe working Quarterly and Annual Report**
3.7 To provide assurance that the Trust has taken action during the previous 12 months to address the inequalities faced by staff with protected characteristics as defined by the Equality Act 2010 and identify actions for the forthcoming 12 months. • **Equality Diversity and Inclusion Report**

3.2 In addition to its regular reports the Committee also undertook its responsibilities under its terms of reference through review of the following:

- NHSEI Enabling the Workforce for Elective Recovery
- Employee Relations Case Update
- HEE Placement Provider Annual Self-Assessment Report 2022
- GMC Annual Trainee Survey 2022
- AHP Workforce Supply Strategy
- Role Description – Health & Wellbeing Guardian
- Workforce systems update

4.0 Reporting

4.1 The Committee reported to the Board after each meeting during the year. Reports included a description of the agenda items discussed, risks identified and key actions agreed.

4.2 Key items of concern highlighted to the Trust Board and monitored by the Committee included:

- Non-Compliant Mandatory Training – June 2022
- 2022 Pay award and its impact to the pension scheme for on staff bands 3, 5 and particularly 8a. – September 2023
- December 2022 Industrial Action and emergency planning
- December 2022 Actions in place to address underperformance in People Commitment
- Non-Compliance in ILS and BLS Mandatory Training – December 2022

- Board Assurance Framework risk scores waiting reduction following embedding of actions – April 2023
- Non-Compliance in ILS and BLS Mandatory Training, letters being sent to individuals – April 2023
- Guardian of Safeworking report April 2023 - agency staff brought in to cover three new junior doctor trainees/fellows due to not having up to date ALS training upon recruitment
- Industrial Action, junior doctor strike – April 2023

5.0 Survey Results

5.1 All survey statements received unanimous agreement, with a few marked as 'neither agree nor disagree'. It is recognised that the Committee is relatively new and has therefore been working to establish its role through the past 12 months.

6.0 Areas for focus in 2023/24

6.1 The 2022/23 Annual Effectiveness Review highlighted the following areas for improvement during 2023/24 –

- **Freedom to Speak Up Guardian Reporting** – This has been reported directly to the Trust Board during 2022/23. A new Guardian has recently been appointed and this will form an area of focus in 2023/24 once a baseline assessment has been made
- **Anchor Institute Programme Update** in line with Cheshire and Merseyside Requirements
- Ensure that the **relevant policies** referred to in the Scheme of Reservation and Delegation are received by the Committee to review/approve
- **Cycle of Business** - in order to ensure that members are clear of the Committee's role the terms of reference will be kept under review and the cycle of business expanded to provide clarity regarding the content of agenda items.
- **Meeting Preparation** – Agenda setting meetings between the Chair and Lead Executive Director provide an opportunity to review the actions and cycle of business to ensure that the Committee is discharging its role. This should be re-visited.
- **Reporting to Trust Board** – ensure that the Committee Chair's Report reflects the full agenda, the elements where assurance has been gained, where gaps have been identified and matters that require escalation.

Appendix B – Performance Committee

1.0 Role of the Performance Committee

1.1 The role of the Performance Committee is to provide the Board with in-year assurance concerning the development and delivery of the Trust's Strategic Plan.

2.0 Membership and Attendance Record

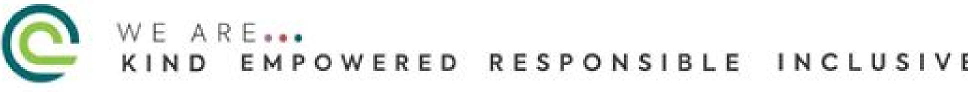
2.1 The table below demonstrates that every meeting of the Committee during the year was quorate. The quorum for any meeting of the Committee is attendance of a minimum of four members of which two will be Non-Executive Directors, and two will be Executive Directors.

Name	Attendance
Geoff Broadhead, Chair – Non Executive Director	4/4
Mark Tattersall, Non-Executive Director	4/4
Elkan Abrahamson, Non-Executive Director	4/4
Joan Spencer, Chief Operating Officer	4/4
James Thomson, Director of Finance	4/4
Jayne Shaw, Director of Workforce and Organisational Development	2/4
Sarah Barr, Chief Information Officer (Non-voting)	3/4
Tom Pharoah, Director of Strategy (Non-voting)	4/4

3.0 Responsibilities.

3.1 During 2022/23 the Committee has delivered the key responsibilities as set out in the terms of reference. Compliance is evidenced by the routine presentation and consideration of the following:

Terms of Reference	Key Responsibilities/Agenda Items
2.1, 2.2, 2.3, 3.1, 3.3, 3.4, 3.5, 4.5, 5.1, 5.2 Responsibilities in the following areas: Capitol Investments, Financial performance and sustainability of the Trust, Trust's reference costs, Managing assets and capital projects, material contracts, Oversight of cash position – payroll and non-pay costs, payments, receipts, loan arrangements and treasurer management • **Annual 5-Year Strategy Implementation – Progress Report** • **Finance Report**	



Ref: FCGOREPO
Review: July 2025
Version: 2.0

2.4, 6.1 Exception based monitoring of operational and financial performance. Oversee and seek assurance that the Trust is delivering against the key performance indicators. • **Integrated Performance Report**
2.5, 6.2, 6.3 Oversee the performance (Key Performance Indicators) of any subsidiary Companies and Joint Ventures established by the Trust as set out in the agreed service specification/strategic partnership agreement. • **CPL Performance Report** • **PropCare Performance Report** • **Private Practice Joint Venture Performance report**
2.5 Oversee the performance (Key Performance Indicators) of any subsidiary Companies and Joint Ventures established by the Trust.
2.6 For the areas it is accountable for, the Performance Committee will seek to mitigate risks and address any gaps in controls identified in the Board Assurance Framework and the risk register. • **Board Assurance Framework** • **Performance Risk register**
6.1 Oversee and seek assurance that the Trust is delivering against the key performance indicators • **Cancer Wait Times** • **Performance Dashboard**
3.1 The Performance Committee will oversee the Trust's business planning process and agree the principles and approach for internal budget setting and the development of Directorate business plans linked to the Trust's Strategic Priorities. • **Divisional Business Plans**
3.1, 3.3 Take an overview of implementation of the Trust's strategic plans and performance against associated financial, operational and workforce objectives (including delivery of recovery and transformation plans, Cost Improvement Plans and research and innovation plans) ensuring that resources are being appropriately managed to deliver effective services and receiving advice regarding remedial action being taken as necessary by the Executive Team. • **Research & Innovation Business Plan**
3.1, 3.2 Review the Annual Business Plan, including medium and long term plans required by NHS England, to confirm that the financial plan supports the Trust's wider clinical

services strategy; to scrutinise assumptions underpinning the financial modelling and advise the Board accordingly • **2023-24 Financial Planning**
3.6 Seek assurance that the Trust has appropriate strategies and plans relating to environment, energy and sustainability and that any associated policies are effectively implemented and monitored. The Committee will seek assurance on delivery of the Trust's Green Plan • **Green Plan Annual Report**
3.7 Seek assurance on the effectiveness of the Trust's Emergency Preparedness, Resilience and Response (EPRR) arrangements. • **EPRR Quarterly report, annual report, core standards**
2.2, 4.1 Scrutinise business cases for all major capital investments (all material and significant investments) to provide assurance to the Board that in reaching its decision on the business case it has complied with any associated regulatory requirements and that it has considered any other factors which the Performance Committee feels is relevant to the decision. • **Review of Capital Investment**
8.3, 8.4 The Finance Committee will provide assurance and performance management reports which have been agreed with, and any other report or briefing required by, the Performance Committee • **Finance Committee Chair's Report**
8.5 The Performance Committee will consider matters referred to it for action by the Audit Committee and report back in writing. • **Performance Committee Annual report to Audit Committee**

3.2 In addition to its regular reports the Committee also undertook its responsibilities under its terms of reference through the following:

- CIP Deep dive
- Covid Response Tiers Update
- New Royal Liverpool Hospital Programme Updates
- Nurse Staffing Deep Dive
- Community Diagnostic Hubs Update

- Cancer Genomics and Molecular Testing Update
- Business Intelligence demo of the new Cancer Wait Times dashboards and cancer tracking systems
- Update on low energy proton beam facility at CCCW
- Elective Recovery Funding Deep Dive
- Winter Planning Update
- Clinical decisions unit (CDU) / Acute Medical Model at CCC

4.0 Reporting

4.1 The Committee reported to the Board after each meeting during the year. Reports included a description of the agenda items discussed, items of concern, achievement or for shared learning

4.2 Key items of concern highlighted to the Trust Board and monitored by the Committee included:

- April 2022 infection rates
- Change in acuity of patients & challenges around genomic/molecular testing turnaround times
- 2022/23 Finance Planning - Notification that the system plan was not accepted and therefore a, potential risk to CCC
- Catering work stream of the new royal programme
- System agency reduction
- Elective Recovery Funding unknown factors
- Cost Improvement Programme (CIP) assurance
- Recurrent CIP findings
- Letter from NHS England on capacity and operational resilience in urgent and emergency care
- Cost of mutual aid beds
- Down turn in the 62 day cancer standard in January 2023
- Continuously missing the 95% target for number of in-date Trust policies
- 2023/34 Financial Planning
- National and local changes impacting investment plans meaning the Trust need capital to cover depreciation

5.0 Survey Results

5.1 The results of the survey demonstrated that members were in agreement with the statements with two exceptions which related to the timeliness of papers and the opportunity to reflect on the meeting.

6.0 Areas for focus in 2023/24

6.1 The 2022/23 Annual Effectiveness Review highlighted the following areas for improvement/focus during 2023/24 –

- Ensuring the timely distribution of papers
- Ensure that all Trust policies and procedures with respect to the investment strategy in line with current NHS guidance and relevant accounting standards have a planned review
- Include the Trust’s Marketing Strategy in the Cycle of Business for review
- Oversee the Trust’s insurance arrangements
- Create space to reflect on the meeting, decisions made, what worked well and what not so well

Appendix C Quality Committee

1.0 Role of the Quality Committee

1.1 The role of the Quality Committee is to provide the Board with assurance that high standards of care and governance are provided by the Trust and, in particular, that adequate and appropriate controls are in place

2.0 Membership and Attendance Record

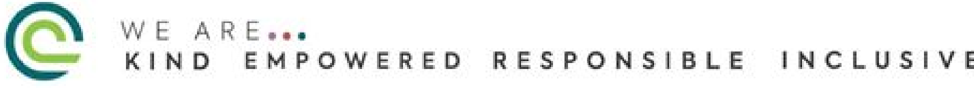
2.1 The table below demonstrates that every meeting of the Committee during the year was quorate. The quorum for any meeting of the Committee is attendance of a minimum of three members of which at least two will be Non-Executive Directors, one of whom shall Chair the Committee and the Chief Nurse **or** the Medical Director.

Name	Attendance
Terry Jones, Chair – Non-Executive Director	4/4
Asutosh Yagnik, – Non-Executive Director	3/4
Elkan Abrahamson, Non-Executive Director	3/4
Julie Gray, Chief Nurse	4/4
Sheena Khanduri, Medical Director	4/4
Joan Spencer, Chief Operating Officer	4/4
Jayne Shaw, Director of Workforce and OD	2/4
Sarah Barr, Chief Information Officer (Non-voting)	4/4

<table>
<tr><th>Agenda Item</th><th>Key Responsibilities/Agenda Items</th></tr>
<tr><td colspan="2">2.1, 2.2
Promote continuous improvement in patient safety, effectiveness and excellence in patient care.

Ensure the effective and efficient use of resources through evidence-based clinical practice.

• Safer Staffing report
• Infection Prevention Annual Report
• Mortality Report (learning from deaths
• Health safety & security annual report
• Patient Experience & Inclusion Annual report
• Caldicott Guardian Annual report</td></tr>
</table>



2.1, 4.2, 4.5, 4.6,4.7, 4.11, 4.12 Promote continuous improvement in patient safety, effectiveness and excellence in patient care. To ensure the Trust has a robust system in place for the management of national patient safety alerts and ensure that appropriate action is taken in respect of these. • **Patient Safety & Experience Quarterly Report**
2.3, 3.6, 3.8 To review the Trust against the national standards of quality and safety of the Care Quality Commission and Foundation Trust Licence conditions that are relevant to the Committee's area of responsibility; subsequently receive advice regarding remedial action being taken as necessary by the Executive Team and provide assurance to the Board. • **Integrated Performance and Quality Report**
2.5 Ensure that appropriate arrangements and responsibilities are in place from 'Board to Ward'. • **Divisional Ward to Board presentations**
3.1, 3.7, 3.8, 4.2 To review the Trust against the national standards of quality and safety of the Care Quality Commission and Foundation Trust Licence conditions that are relevant to the Committee's area of responsibility; subsequently receive advice regarding remedial action being taken as necessary by the Executive Team and provide assurance to the Board. • **CQC Preparedness / CQC Compliance**
3.9, 3.2 To receive and review the Trust's Annual Quality Report and make recommendations as appropriate for Board approval. • **Quality Accounts**
3.3, 4.2, 5.4 To consider matters escalated to the Committee by its own sub-committees. • **Risk and Quality Governance Committee Briefing**
3.4, 3.5 To approve the annual Clinical Audit Programme on behalf of the Board, ensuring it is consistent with the audit requirements of the Trust. • **Clinical Audit annual report / clinical audit plan**

4.3, 4.4 To ensure that robust arrangements are in place for the review of patient safety incidents (including near misses), complaints, claims and reports from HM Coroner from within the Trust and the wider NHS to identify similarities or trends and areas for focused or organisation-wide learning • **Claims & Inquests report**.
4.9 Ensure that any areas of concern identified from the Committee's review of clinical quality are entered onto the Trust risk register as appropriate and any identified gaps in controls in relation to delivery of relevant Trust strategic objectives are reflected and escalated to the Board Assurance Framework. • **Board Assurance Framework**
4.13 Ensure robust arrangements are in place for safeguarding adults and children within the Trust. • **Safeguarding Annual Report**
2.4, 4.9 Promote visible leadership with regard to quality and risk management. • **Risk Management strategy**
4.2 To oversee the system within the Trust for obtaining and maintaining licences or accreditation relevant to clinical activity in the Trust, receiving such reports as the Committee considers necessary • **Nice Compliance Report**
4.5, 4.6 To identify areas for improvement in respect of complaints / PALS / Friends and Family Test and ensure appropriate action is taken. • **Complaints Report**
4.8 To escalate to the Audit Committee any identified unresolved risks arising within the scope of these terms of reference that require Executive action or that pose a significant threat to the operation, resources or reputation of the Trust. • **Items for escalation**

5.0 Survey Results

5.1 The results of the survey demonstrated that members were in agreement with the statements with one exception regarding the opportunity to reflect on the meeting. In addition, a comment was made regarding the frequency of meetings and whether the committee needs to meet more frequently.

6.0 Areas for focus in 2023/24

6.1 The 2022/23 Annual Effectiveness Review highlighted the following areas for improvement/focus during 2023/24 –

- Quality Strategy – regular review of progress
- Cost Improvement Programmes – review the processes in place to assess the impact of efficiency savings and service reviews on the quality of care.
- Ensuring the timely distribution of papers
- Create space to reflect on the meeting, decisions made, what worked well and what not so well

Appendix D Audit Committee

1.0 Introduction

1.1 The purpose of this report is to formally report on the work of the Audit Committee during the period 1st April 2022 to 31st March 2023 and to set out how it has met its terms of reference and priorities.

1.2 In line with best practice Committees of the Board should undertake an annual review of effectiveness.

1.3 In line with the Committee terms of reference the annual reports (including Committee effectiveness reviews) have been reviewed by the Audit Committee.

2.0 Scope

2.1 The review undertaken by the Corporate Governance Team focused on a review of the papers presented to the Audit Committee and by the Committee to the Trust Board in line with the agreed Terms of Reference. The review has been broken down into Responsibilities, Reporting, and Membership and Attendance.

2.2 In addition in April / May 2023 members participated in an MIAA Committee effectiveness assessment, which has been shared with members of the Committee, which was positive with no significant areas of improvement.

3.0 Assessment

3.1 **Responsibilities**.
During 2022/23 the Committee has delivered the key responsibilities as set out in the terms of reference. Compliance is evidenced by the routine presentation and consideration of:

- Annual Governance Statement
- Annual Report and Accounts
- Review of External Audit Progress
- External Audit Findings Report
- Post Audit Review of Annual Report & Accounts Process
- External Auditors Annual report
- Going Concern Assessment
- External Audit Letter of Representation
- Review of Accounting standards and policies
- Internal Audit Plan
- Internal Audit progress Report
- Internal Audit Follow-up Report
- Internal Audit Annual Plan
- Internal Audit Internal Charter
- Internal Audit Anti-Fraud Plan
- Internal Audit Annual Report and Head of Internal Audit Opinion

- Board Assurance Framework
- Director of Finance Report
- Key Financial Assurance Indicators
- Data Security and Protection Toolkit
- Tender Waiver Register
- Register of Interests
- Provider License Conditions
- Cyber Security Assurance Report
- Code of Governance Compliance Checklist

3.2 In addition to its regular reports the Committee also undertook its responsibilities under its terms of reference through the following:

- Constitution incorporating Standing Orders
- Corporate Governance Manual
- IFRS16 Update
- Health Procurement Liverpool Governance Arrangements
- Oversight Framework
- Board Assurance Framework Project Update
- Review of HFMA Improving Financial Sustainability Checklist
- Fit and Proper Person Compliance
- Managing Conflicts of Interest Policy
- Progress Report against the high level recommendations from the Complaints and Serious Incident Review

3.3 **Reporting**
The Committee reported to the Board after each meeting during the year. Reports included a description of the agenda items discussed, risks identified and key actions agreed.

3.4 Key items of concern highlighted to the Trust Board and monitored by the Committee included:

- July 2022: Further development required on the delivery of the audit tracker which provides assurance regarding the timely completion of agreed actions and in particular relating to limited assurance reviews and high-level control risks.

- October 2022: The progression of the Board Assurance Framework development and discussions regarding a pilot exercise for the transfer of the BAF to the Datix UCould IQ system.

- October 2022: The Director of Finance presented a report to support the Committee's understanding of the Trust's financial and governance risk profile by means of updates on progress against statutory duties and any emerging accounting and financial issues. The Committee noted in particular the Trust's participation in a Shared Business Services (SBS) Review, along with other provider trusts in Cheshire

and Merseyside, which involves review of financial services processes and separately assessing procurement capabilities to assess the levels of maturity and effectiveness of current arrangements. The Director of Finance agreed to keep Committee members updated on progress and outcomes of the SBS review.

- January 2023: The Committee considered a report which detailed outcomes of a review of plans by the BAF project scoping team to transition the BAF to the Datix Cloud IQ system. The report assured the Committee that a comprehensive review had been undertaken and the Committee endorsed the conclusion that there was value to be gained from continuing to embed usage of the BAF in its current format and that testing of BAF reporting through Datix should be de-prioritised.

- January 2023: The Director of Finance presented a report to support the Committee's understanding of the Trust's financial and governance risk profile by means of updates on progress against statutory duties and any emerging accounting and financial issues. The Committee was advised that, while a decision had been taken nationally that the additional ERF funding mechanism for activity in excess of 104% would not be processed in 2022/23, the Cheshire & Mersey system had agreed that the level of planned ERF to meet the Trust's financial plan will be supported by the Integrated Care Board (ICB). While detailed arrangements have yet to be confirmed, this is a significant development given the concerns raised previously by the Board in relation to the level of risk associated with the lack of clarity on ERF funding arrangements.

- January 2023: The report from the Director of Finance also detailed the publication of planning guidance for 2023/24 by NHS England on 23 December 2022 and provided summaries of the Operational Guidance, Financial Guidance and the Joint Forward Plan. The Committee was advised that management were holding weekly planning meeting to progress requirements and it was noted that detailed Trust plans would be developed in the coming weeks with scrutiny and review by Committees and the Trust Board as required.

4.0 Membership and Attendance Record

4.1 During 2022/23 the Audit Committee met nine times with attendance recorded in table 1 below.

4.2. The table below demonstrates that every meeting of the Committee during the year was quorate. The quorum for any meeting of the Committee is attendance of a minimum of two members of which two will be Non-Executive Directors. This was attained through the year.

Area/Role	Name	1 April 2022 Extra-Ordinary	14 April 2022	11 May 2022 Extra-Ordinary	16 June Extra-Ordinary	14 July 2022	18 July 2022 Extra-Ordinary	13 October 2022	12 January 2023	31 March 2023	Attendance		Total Meetings	Attendance Rate (%)
Members														
Non-Executive Director/Chair	Mark Tattersall	1	1	1	1	1	1	1	1	1	9	/	9	100%
Non-Executive Director	Geoff Broadhead	1	1	1	1	1	1	1	1	A	8	/	9	89%
Non-Executive Director	Asutosh Yagnik	1	1	A	1	1	1	A	1	1	7	/	9	78%
In Attendance														
Director of Finance	James Thomson	A	1	1	1	1	1	1	1	1	8	/	9	89%
Chief Nurse	Julie Gray	0	1	A	0	0	0	A	1	0	2	/	9	22%
Chief Information Officer	Sarah Barr	1	0	0	0	1	0	1	1	0	4	/	9	44%
Interim Associate Director of Corporate Governance	Paul Buckingham							1	1	1	2	/	9	33%
MIAA (Internal Audit)	Simon Davies	1	1	1	1	1	0	1	1	0	7	/	9	78%
MIAA (Internal Audit)	Anne-Marie Harrop	0	1	A	A	A	0	1	1	0	3	/	9	33%
Ernst & Young (External Auditor)	Hassan Rohimum	1	A	1	1	A	1	1	1	0	6	/	9	67%
Ernst & Young (External Auditor)	Faizan Muhammad	1	1	1	1	1	1				6	/	9	67%
Ernst & Young (External Auditor)	Sanchita Rai							1	1	1	2	/	9	33%
MIAA (Anti-Fraud)	Darrell Davies	0	0	0	0	0	0	1	1	0	2	/	9	22%
MIAA (Anti-Fraud)	Roger Causer	0	1	0	0	1	0				2	/	9	22%
Corporate Governance Manager	Skye Thomson	0	1	1	1	1	0	1	1	0	6	/	9	67%

5.0 Committee Reports

5.1 The Audit Committee received the annual report of Committee Effectiveness from the People Committee, Quality Committee and Performance Committee and acknowledge the work that has taken place in the development of the Committees in not only scrutinizing the required core business, but in addition by requesting deep dive reports on matters where the Committee has not received full assurance.

Title of meeting: Trust Board
Date of meeting: 26 July 2023

Report lead	Julie Gray, Chief Nurse		
Paper prepared by	Lauren Gould, Matron for IPC and Tissue Viability Services		
Report subject/title	Infection Prevention and Control Annual Report 2022-23		
Purpose of paper	To provide a summary of Infection Prevention and Control activity within The Clatterbridge Cancer Centre during 2022-23.		
Background papers	N/A		
Action required	To note the assurances that evidence compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (updated 2015)		

Link to: Strategic Direction Corporate Objectives				
	Be Outstanding	√	Be a great place to work	
	Be Collaborative	√	Be Digital	
	Be Research Leaders		Be Innovative	

Equality & Diversity Impact Assessment

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

Ref: FCGOREPO
Review: July 2025
Version: 2.0

Executive Summary

This report sets out the arrangements for Infection Prevention and Control (IPC) within the Clatterbridge Cancer Centre (CCC) during 2022-23. It summarises the work and projects implemented during the year to ensure that CCC is compliant with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (updated 2015) and associated Care Quality Commission (CQC) guidance.

The report acknowledges the work and diligence of all grades of staff who play a vital role in improving the quality of patient experience as well as assisting to reduce the risk of infections.

An overview of CCC performance against Key Performance Indicators (KPI's) for infection is outlined in Figure 1 below.

Figure 1

KPI	Annual Objective	Performance (case numbers)
Meticillin resistant *Staphylococcus aureus* (MRSA) bloodstream infections	**0**	**0**
Clostridiodes difficile (C.difficile) infections (CDI)	**17**	**14**
Meticillin sensitive *Staphylococcus aureus* (MSSA) bloodstream infections	**<5** (internal KPI)	
Escherichia coli (E.coli) bloodstream infections	**11**	**24**
Klebsiella spp. bloodstream infections	**8**	**17**
Pseudomonas aeruginosa bloodstream infections	**1**	

HCAI's are subject to a Post Infection Review (PIR) depending upon attribution. This is led by the Infection Prevention and Control Team, Consultant in Infection Control and Anti-microbial Pharmacist in conjunction with clinical teams. The aim of the PIR is to identify any lapses in care or lessons learned from an episode of infection. The performance against each individual KPI is discussed further in Section 2 of this report.

1. Achievements against the national HCAI objectives

This section of the report describes CCC's performance against the national HCAI objectives set by NHS England. Infections are reported externally via the UK Health Security Agency (UKHSA) Data Capture System (DCS) using the definitions outlined below:

Clostridiodes difficile infections:

- Hospital onset healthcare associated (HOHA) cases detected in the hospital three or more days after admission
- Community onset healthcare associated (COHA); cases that occur in the community (or within 2 days of admission) when the patient has been in the Trust reporting cases in the previous 4 weeks.
- Community onset indeterminate association (COIA) = cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks
- Community onset community associated (COCA) =cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks. (90 days)

Gram negative bloodstream infections:

- Hospital-onset, healthcare associated (HOHA) - Specimen date is ≥3 days after the current admission date (where day of admission is day 1)
- Community-onset healthcare-associated (COHA) - Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)
- Community-onset, community associated (COCA) - Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)

All HOHA infections are subject to the PIR process; COHA infections are reviewed by the IPC Team and a PIR is undertaken if there are any learning outcomes related to the episode of infection for CCC.

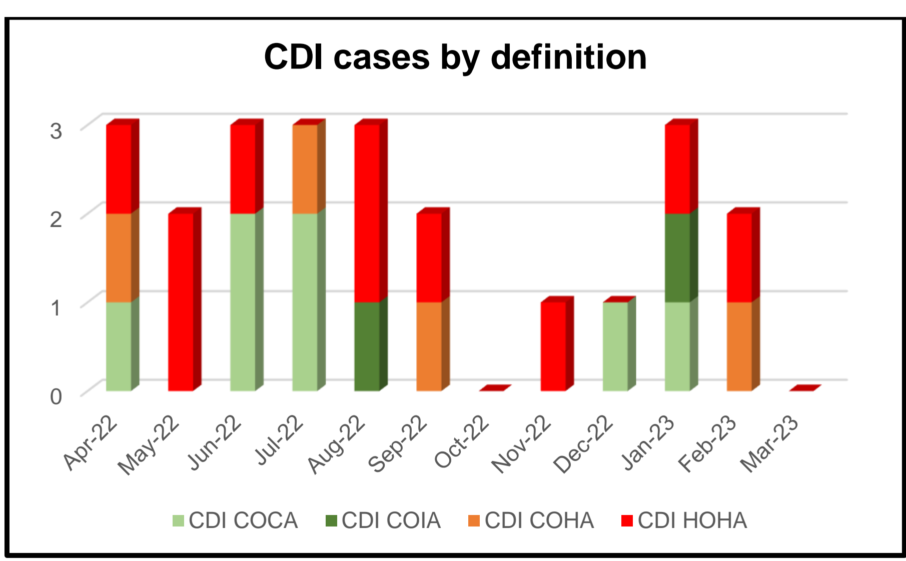
1.1 MRSA Blood Stream Infections

Nationally, there continues to be a zero tolerance approach to MRSA BSI. CCC did not identify any MRSA blood stream infections in 2022-23.

1.2 *Clostridiodes Difficile* Infection

The national objective (maximum threshold) for the Trust is no more than 17 avoidable CDI cases. A total of 10 HOHA cases and 4 COHA cases of CDI were reported by the Trust during 2022-23 (Figure 2).

Figure 2 CDI cases by definition



1.2.1 CDI PIR Themes

The following themes were identified from PIR process:

- Delays in obtaining samples. In these instances, patients have had more than 1 episode of diarrhoea prior to samples being obtained. Whilst this has not contributed to the development of infection, delays in obtaining samples will lead to delays in commencing treatment, increasing the risk of complications associated with CDI.
- Anti-microbial usage. Anti-microbial usage is frequently linked with the development of CDI. The use of anti-microbials is reviewed following each episode of infection. In each case, anti-microbial usage was in line with Trust Formulary. However, the use of anti-microbials is often necessary within oncology and haematology patient groups, and whilst each infection is reviewed to ensure that usage is appropriate, CDI may continue to be a complication.

- Equipment cleanliness. The IPC Team have continued a programme to audit the cleanliness of shared patient equipment using Adenosine Tri-Phosphate (ATP). Where equipment does not meet the required standard, of programme of education will be commenced to include both the role of shared equipment in the transmission of infection, and the correct cleaning techniques to be utilised.

1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA)

There is no national objective set for MSSA bacteraemia, however CCC established an internal KPI of less than 5 cases per year. The Trust reported 12 HOHA cases and 1 COHA case of MSSA in 2022-23.

Figure 3 - MSSA cases by definition

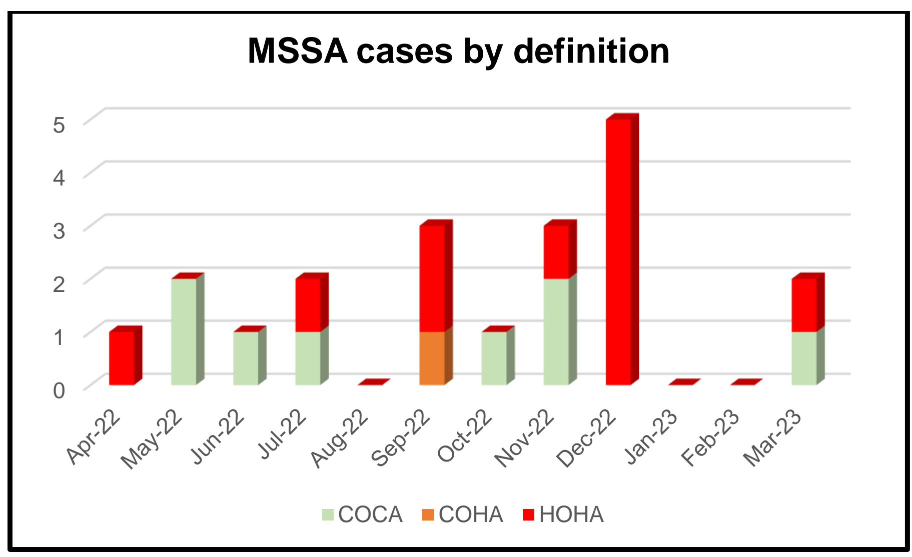
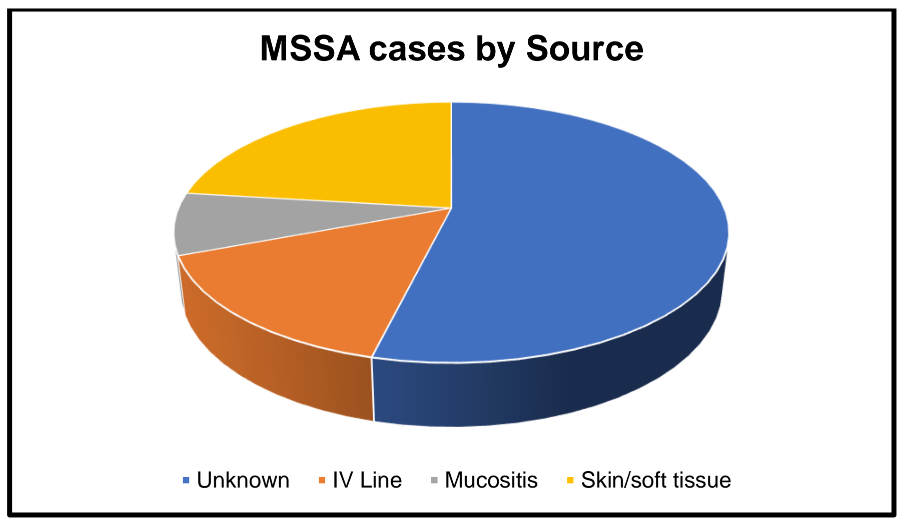


Figure 4 – MSSA cases by source



1.4 Gram negative blood stream infections

The NHS Long Term Plan sets out an aim reduce healthcare associated Gram negative blood stream infections (GNBSI's) by 50% by 2024-25. Gram-negative bloodstream infections are believed to have contributed to approximately 5,500 NHS patient deaths in 2015 and have continued to increase (*E.coli* in particular), despite a reduction in other HCAI's. GNBSI's include;

- *E.coli*
- *Klebsiella spp.*
- *Pseudomonas aeruginosa*

1.4.1 *Escherichia coli (E.coli)*

E.coli is a bacterium that forms part of the natural gut flora and is in most instances harmless. The majority of *E.coli* infections are either urinary or hepatobiliary in origin. Twenty four HOHA *E.coli* blood stream infections were identified in 2022-23 within CCC.

Figure 6 - *E.coli* cases by definition

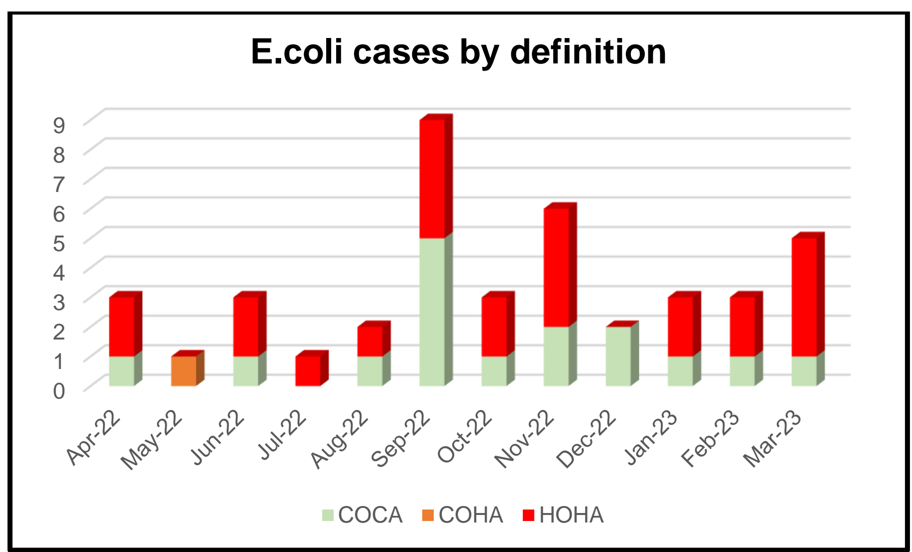
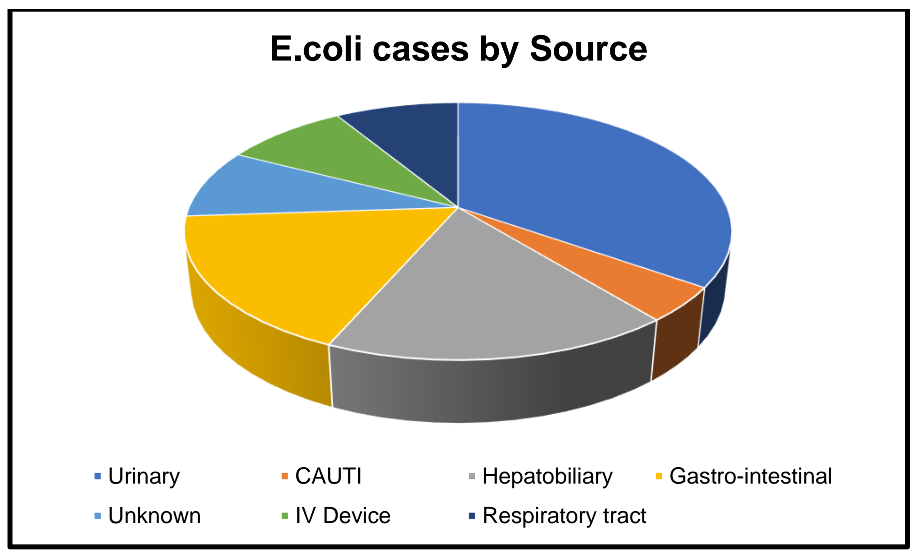


Figure 7 – E.coli cases by source



1.4.2 *Klebsiella sp.*

Klebsiella sp. bacteria are commonly associated with a range of healthcare associated infections including pneumonia, wound and blood stream infections. Seventeen HOHA *klebsiella sp.* bloodstream infections were identified at CCC during 2022-23.

Figure 8 –*Klebsiella sp.* cases by month

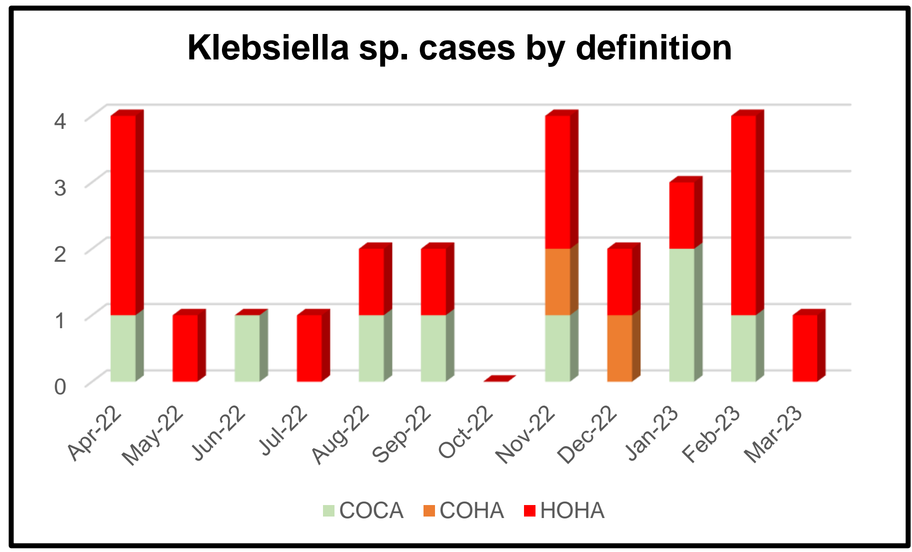
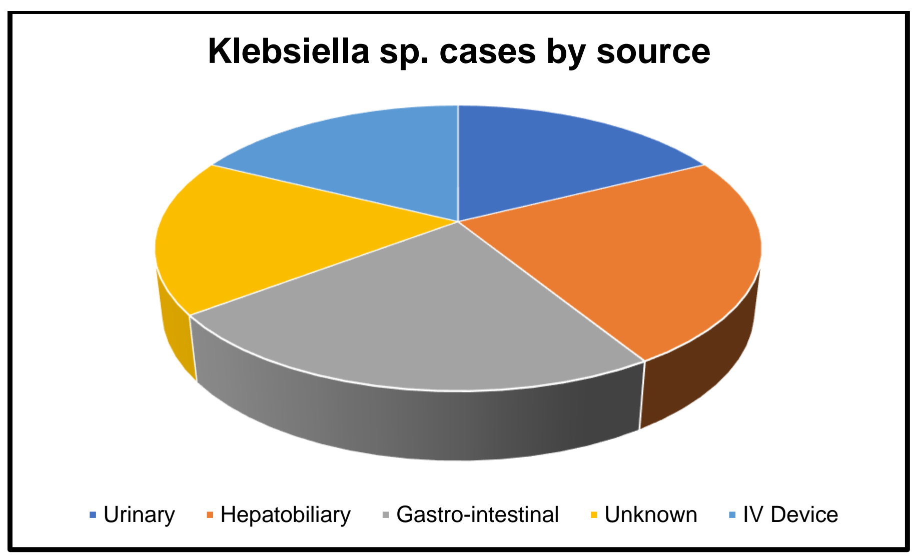


Figure 9 *Klebsiella sp*. cases by source



1.4.3 Pseudomonas aeruginosa (*P.aeruginosa*)

Pseudomonas is a bacterium commonly found in the environment including in soil and water and can cause infections in immunocompromised patients. Eleven *P.aeruginosa* cases were identified within CCC during 2022-23. Four cases related to the same patient with a deep seated infection. There have been no *P.aeruginosa* cases identified that link to the water systems within CCC.

Figure 10 – *P.aeruginosa* cases by definition

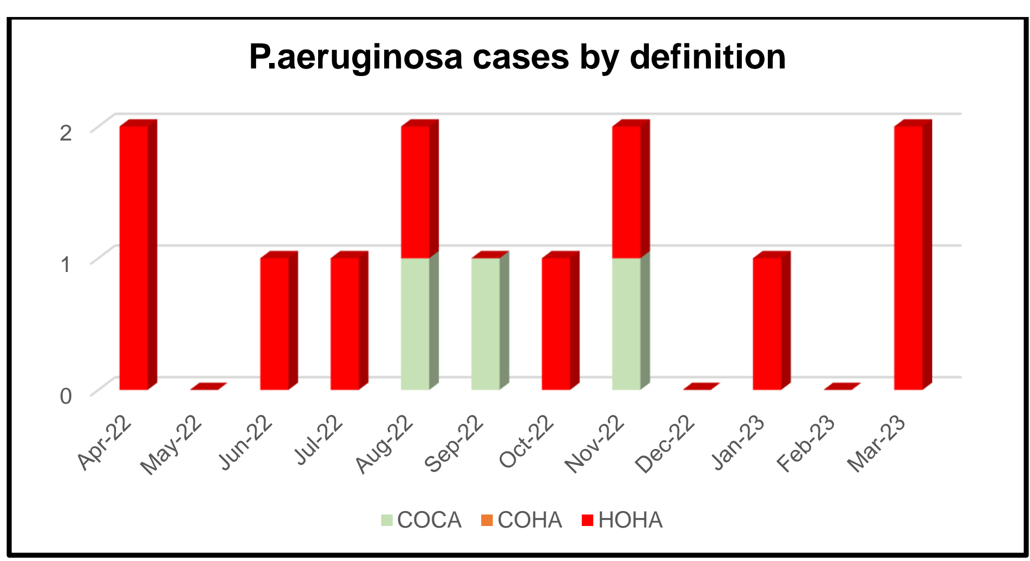
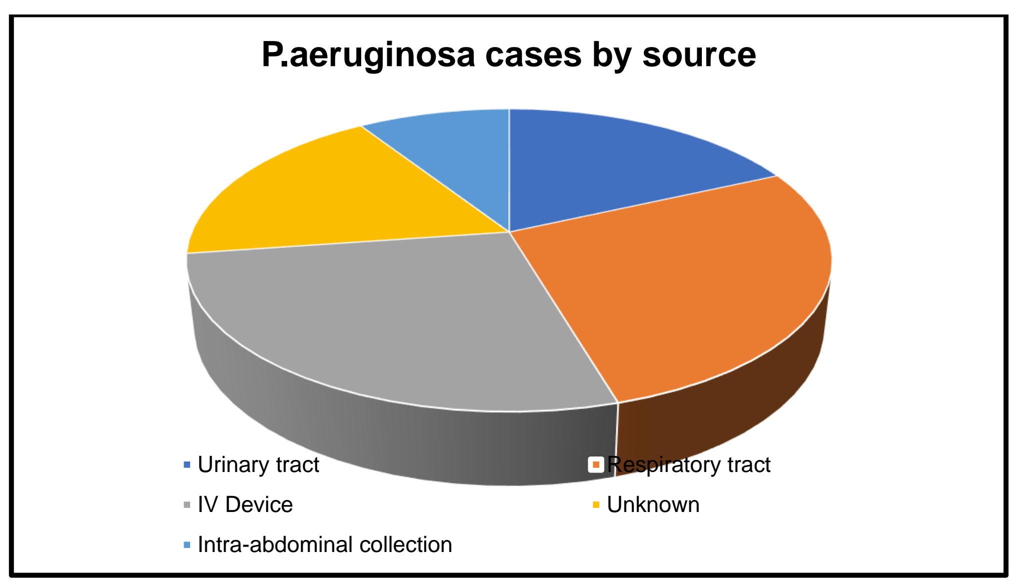


Figure 11 – *P.aeruginosa* infections by source



Ref: FCGOREPO
Review: July 2025
Version: 2.0

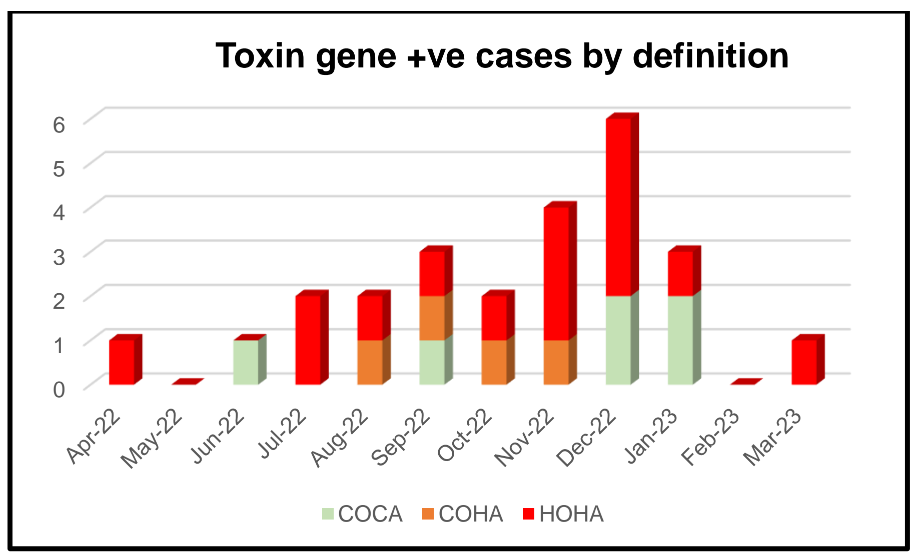
2.0 Non-reportable infections

In addition to reportable infections, the IPC Team also undertake surveillance on non-reportable pathogens that may be of clinical significance to cancer patients.

2.1 *C.difficile* toxin gene positive, free toxin negative cases.

C.difficile toxin gene positive, free toxin negative refers to individuals who carry the *C.difficile* gene and experiencing diarrhoea but are not producing the toxin present in CDI at the time of testing. Toxin gene positive cases present a risk to CCC patients as the bacteria is transmitted in the same manner as, and may result in *C.difficile* infection. Therefore, any toxin gene positive cases identified are treated as *C.difficile* infection. Figure 12 provides an overview of cases using the attribution outlined for *C.difficile*.

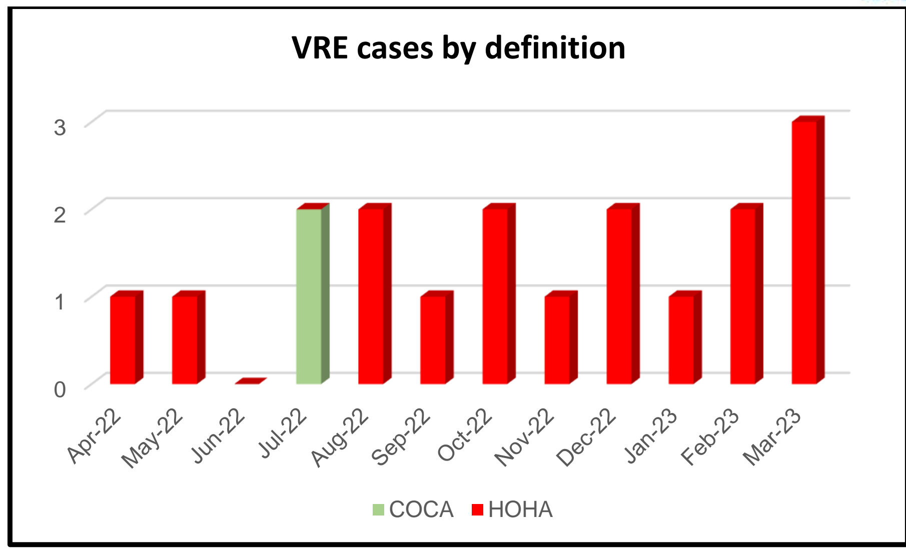
Figure 12 – Toxin gene positive cases by attribution



2.2 Vancomycin Resistant Enterococcus (VRE)

VRE are strains of *Enterococci* bacteria that are resistant to the glycopeptide antibiotics (Vancomycin and Teicoplanin). *Enterococci* are bacteria normally found in the gut that may cause infections including blood stream infections, particularly in complex or immunocompromised patients such as those receiving Chemotherapy treatments. Although external reporting of VRE infections is not mandated, all infections are subject to an internal PIR process.

Figure 13 - Trust apportioned VRE cases by definition.



3.0 Post Infection Review (PIR) process

The PIR process seeks to not only identify sources of infection, but also any learning points that arise during the process. There are several stages to the process:

1. The IPC Team undertake a 72 hour surveillance review of all confirmed or suspected HCAI.
2. Findings of the 72 hour surveillance review are discussed at a weekly IPC multi-disciplinary team (MDT) meeting comprising of IPC Team, IPC Doctor and Anti-microbial Pharmacist

All attributable infections are designated as red, amber, or green as below:

Red	Lapses in care have been identified that may have contributed to the development of infection • PIR to be requested from clinical team with corresponding action plan • Clinical team invited to weekly IPC MDT to discuss PIR findings • PIR & action plan to be reviewed at Divisional Assurance Board • Clinical team to determine level of harm via Datix system
Amber	Learning points have been identified that did not contribute to the development of infection but need to be addressed by the clinical team • No PIR required • Clinical team will be asked to produce an action plan to address learning points • Action plan to be reviewed at Divisional Assurance Board • Clinical team to determine level of harm via Datix system
Green	No lapses in care or learning points have been identified • No further action required

	• Infection to be noted at Divisional Assurance Board

3.1 Themes identified during PIR process

3.1.1 Documentation

Gaps in documentation including stool charts, IV device charts, Urinary Catheter Care Pathways and Fluid Balance Charts have been identified during the PIR process. Whilst this has not contributed to the development of infection, we are unable to demonstrate optimal care.

3.1.2 Hepatobiliary/gastro-intestinal sources

Approximately half of *E.coli* and *klebsiella sp* infections identified were related to hepatobiliary or gastro-intestinal sources linked to cancer site with no clear learning outcomes. Gastro-intestinal complications are particularly common within the Haemato-Oncology (HO) patient population. This can lead to pathogens such as VRE entering the bloodstream via the gut; as such these infections are difficult to avoid.

3.1.3 Additional diagnostic specimens

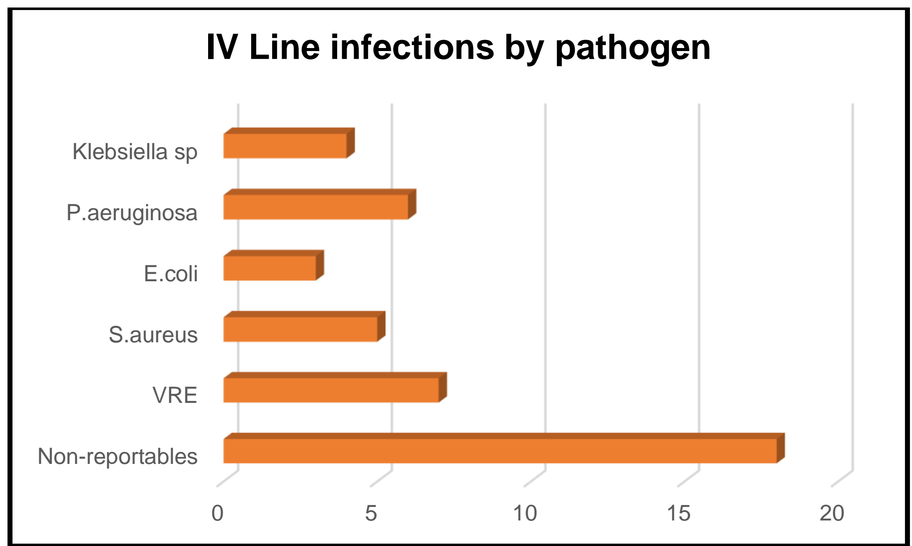
Additional diagnostic tests such as urine specimens and chest x-rays were not always obtained when commencing antimicrobials as per CCC Antimicrobial Prescribing Policy. Whilst this did not contribute to the development of infection, identification of a clear source of infection was not always possible.

3.1.4 Skin/soft tissue

Skin/soft tissue infections associated with cancer site have been identified as a theme. Whilst this is frequently unavoidable, the IPC Team and Tissue Viability Nurse have worked in collaboration to ensure that skin issues are promptly identified and treated appropriately.

3.1.5 IV Devices

Figure 14 IV line infections by pathogen



IV devices are frequently removed upon identifying infection, particularly in the absence of any other clear source. The IPC Team are working with clinical teams to ensure that additional specimens and investigations are undertaken when infection is suspected to identify a clear source.

3.2 Actions resulting from PIRs

The IPC Team has continued to offer bespoke education and support to clinical teams to address the actions resulting from PIR's.

3.2.1 IPC Masterclass

The IPC Masterclass was a pilot scheme undertaken in collaboration with the Clinical Education Team, Clinical Interventions Team, Acute Care Team and representatives from The University of Chester. The aim of the Masterclass was to address the fundamentals of IPC including documentation, hand hygiene, Aseptic Non-Touch Technique (ANTT), device care and fluid balance monitoring. The Masterclass offered staff of all disciplines time away from clinical areas to undertake both theoretical and practical learning. The Masterclass was well evaluated by those who attended, and the aim is to continue to offer IPC education and training in this format.

3.2.2 Blood Culture Working Group

Established in September 2022, the Blood Culture Working Group is a collaboration between IPC, Clinical Interventions Team and Clinical Education Facilitators. The aim of the group is to ensure that blood culture collection practice is evidence based and standardised across the Trust and that staff are peer-reviewed and up to date with ANTT practice to reduce the risk of contaminants. Figure 15 below provides a trend analysis demonstrating an overall downward trend in the number of blood culture contaminants identified since the group was established.

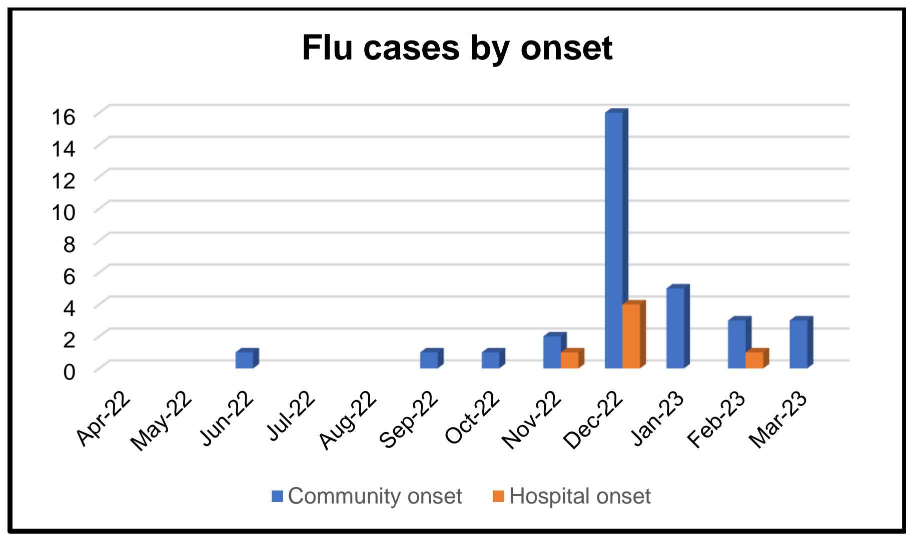
Figure 15 Trend analysis of blood culture contaminants

4.0 Respiratory viruses

4.1 Influenza

All in-patients have a respiratory swab for influenza collected on admission. Further swabbing is indicated in the presence of influenza syptoms Figure 16 demonstrates a peak in cases in December 2022. This is reflective of an increase in cases within the community at this time. All patients who tested positive for influenza were treated with Oseltamivir on the advice of a Consultant Virologist.

Figure 16 Influenza cases by onset



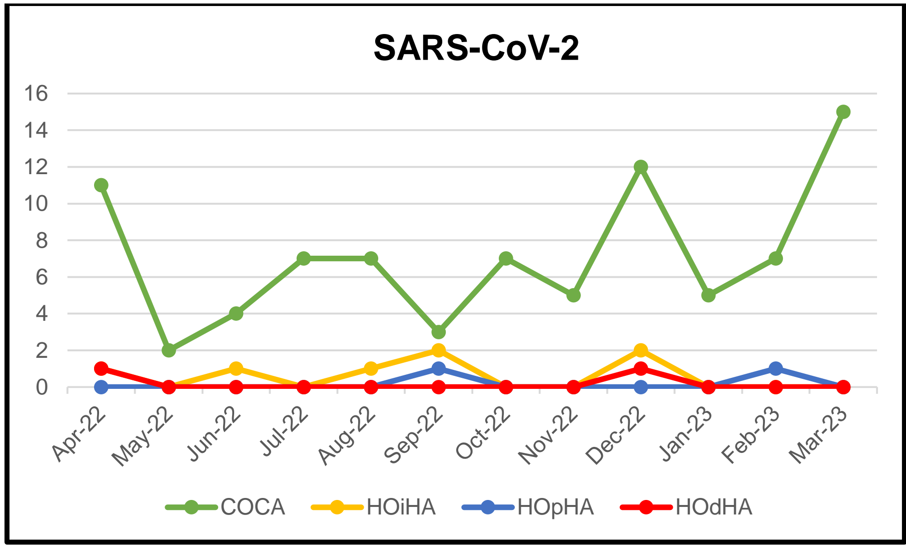
A staff influenza vaccination programme commenced in October 2021 led by the IPC Team to offer the vaccine to 100% of the CCC workforce. This national target was achieved with an uptake 57% of staff at CCC who received a vaccine.

4.2 SARS - CoV-2 (Covid-19)

SARS-CoV-2 cases have continued to be identified during 2022-23. CCC has continued to use the NHSE definitions of hospital acquired SARS-CoV-2 infections;

Hospital-Onset Indeterminate Healthcare associated (HO-iHA)	First positive specimen **3-7 days** after admission
Hospital-Onset Probable Healthcare Associated (HO-pHA)	First positive specimen **8-14 days** after admission
Hospital-Onset Definite Healthcare Associated (HO-dHA)	First Positive specimen **15 days or more** after admission
Community Onset Community Acquired (COCA)	First positive specimen identified within **3 days** of admission

Figure 17 – SARS-CoV-2 cases by definition



All probable and definite hospital onset cases are subject to a post infection review to determine the likely source of infection. The following themes were identified;

- Delays to the collection of admission swabs, indicating that SARS-CoV-2 was likely present on admission but not detected
- Patients leaving the ward areas to go outside of the hospital

All in-patients were swabbed for SARS-CoV-2 on day of admission, then additionally at days 3 and 5 of admission, or routinely if symptoms develop. Elective admissions were swabbed 72 hours prior to admission so that the result was known prior to admission/treatment. All out-patients were screened for SARS-CoV-2 symptoms when attending for appointments.

Asymptomatic SARS-CoV-2 testing was available to all staff using lateral flow devices.

Fluid resistant face masks continued to be worn in all clinical and public areas of all CCC sites; masks were available at the entrances to all CCC buildings. Patients and staff were encouraged to undertake hand hygiene on entering/leaving departments; alcohol based hand rub is available at the entrances to all sites and throughout all wards and departments.

A Covid-19 booster vaccination programme for staff commenced in September 2022. As of January 2023, 53 % of CCC staff had received a booster of vaccine.

5.0 Outbreaks/Periods of Increased Incidence (PII)

CCC identified 3 PII's of *Clostridiodes difficile* infection and 1 outbreak of influenza during 2022-23. In each instance, a PII/outbreak was declared and meetings were held with Ward Managers, Matron, Divisional Lead Nurse, Consultants, IPC Doctor, IPC Matron, Cleaning Managers and the Director of Infection Prevention and Control (DIPC).

5.1 Themes from *Clostridiodes difficile* PII's

- Poor hand hygiene practice
- Staff not bare below the elbows
- Misuse of PPE
- Ward cluttered
- Issue with battery operated soap & gel dispensers
- Delays to discharge cleans
- Confusion over mattress cleaning
- Inadequate cleaning of patient meal trays

5.2 Actions from *Clostridiodes difficile* PII's

- Prolonged educational intervention from IPC Team
- Introduction of a chlorine based detergent/disinfectant for all mattress cleaning
- Replacement of battery operated dispensers with manual
- A business case for increased rapid response cleaning service was agreed
- Routine ATP audit of meal trays – sustained improvement in scores has been identified
- All rooms on affected wards cleaned and Hydrogen Peroxide misted

5.3 Influenza outbreak

In December 2022, two patients on the same ward tested positive for Influenza A (Flu A). Investigation identified that a staff member had also tested positive for Flu A during the same time period. The staff member had provided care to both affected patients. All patients and staff were screened for influenza, enhanced cleaning was undertaken and all doors to patient rooms were kept closed. No further cases were identified within a 14 day surveillance period, therefore the outbreak was closed.

6.0 The Infection Prevention and Control Team (IPC Team)

The IPC Team is led by the Chief Nurse in the role of Director of Infection Prevention and Control (DIPC) and the Associate Chief Nurse supported by:

- Infection Prevention and Control Matron
- One Clinical Nurse Specialist for Infection Prevention and Control
- One Infection Prevention and Control Practitioner
- One Administration and Surveillance Officer
- Consultant Microbiologist / Infection Control Doctor
- Antimicrobial Pharmacist

The Infection Prevention and Control Nursing team provided a support service during weekdays from 8.00 am – 4.00 pm. An on call service for urgent infection prevention and control advice is provided by medical microbiologists and virologists out of hours, via the hospital switchboard.

A Consultant Microbiologist / Infection Control Doctor is provided by Liverpool Clinical Laboratories (LCL) to Clatterbridge through a service level agreement (SLA). LCL also provide a Consultant Virologist service that is available to the Trust as required.

6.1 Governance and Monitoring

The Board of Directors has collective responsibility for minimising the risks of infection. The DIPC and Associate Chief Nurse (Deputy DIPC) deliver the annual plan to the Board of Directors based on local and national quality goals.

6.2 Infection Prevention and Control Committee (IPCC)

Quarterly IPCC meetings take place and provide a forum to support the delivery of a zero tolerance approach to Health Care Associated Infections (HCAIs). The committee is chaired by the DIPC or Deputy DIPC.

IPCC receives reports from Water Safety Group, Antimicrobial Stewardship Group and Hotel Services. Clinical Divisions report to IPCC via a quarterly IPC Operational Group.

IPCC reports directly to Quality Committee detailing Internal Performance Reports and PIR findings as necessary, and provides exception reports as requested.

7.0 Audit and surveillance

The IPC Team undertakes continuous surveillance of both reportable organisms and any other pathogenic organisms that may present a particular risk to our patient

group. This is coupled with a programme of audit to preempt and action issues as they may arise.

7.1 Surveillance

The Trust uses the ICNet surveillance system in conjunction with Liverpool Clinical Laboratory Service (LCL). This allows the IPC Team to identify and examine trends and advise clinical teams on appropriate transmission based precautions at pace. Individual learning and themes highlighted for each organism are included in this report in section 3.

The IPC Team provides a monthly report on any HCAI's and learning points identified to the Harm Free Care Collaborative meeting and to Divisional Assurance Board.

7.2 Clinical Audits

The IPC Team undertake bi-annual audits in all clinical areas of CCC. The audit comprises of an assessment of the clinical environment coupled with the safe management of specific patient risks such as indwelling devices. The audits are scored using the matrix below.

Figure 18

Audit scoring matrix		
90% or more	**89%-70%**	**<69%**
This demonstrates excellent application of IPC practices. No action is required until next scheduled audit	This demonstrates good application of IPC practices but some improvements are required. Re-audit will take place within 8 weeks.	This demonstrates that poor IPC practices that require immediate improvements. Re-audit will take place within 4 weeks

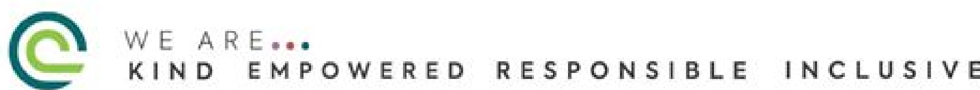
7.3 High Impact Interventions

All clinical areas were required to undertake the following audits:

- Hand hygiene (monthly)
- Insertion and ongoing care of peripheral vascular devices (undertaken by Clinical Interventions Team)
- Insertion and ongoing care of urinary catheters (undertaken by IPC Team)

Additional covert hand hygiene audits are also undertaken in ward areas.

7.4 ATP audits



The IPC Team undertake ad-hoc ATP audits within in-patient areas to monitor the cleanliness of shared patient equipment. The audits are accompanied by an education package relating to correct technique and frequency for cleaning of shared equipment.

8.0 Anti-microbial Stewardship

All antimicrobial prescriptions for acute infections, excluding prophylactic antimicrobial prescriptions, are reviewed by ward pharmacists on a designated date each month to determine the appropriateness of agents prescribed within the Trust. Specifically, the pharmacists assess the prescriptions for the following:

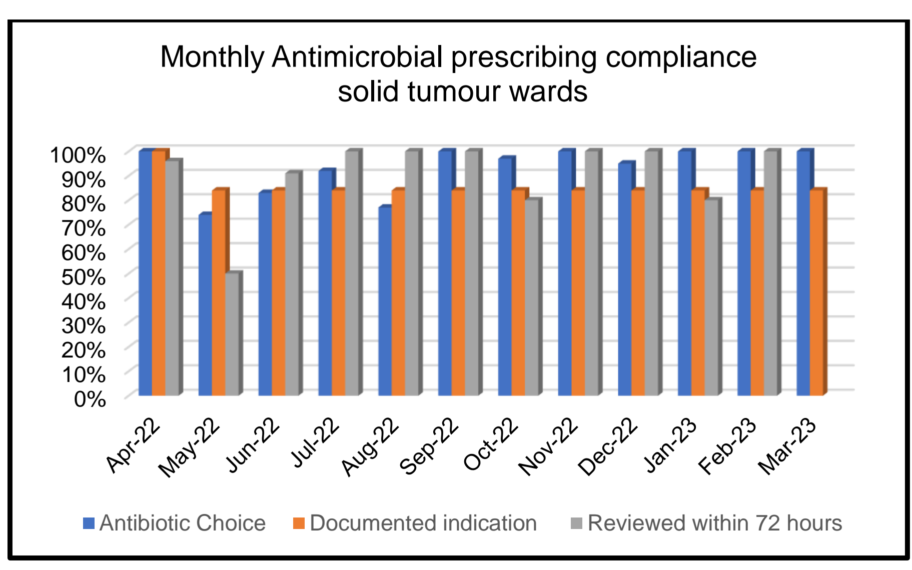
- Choice of antimicrobial in line with the Trust's antibiotic formulary, or otherwise advised by culture and sensitivity
- Evidence of documentation of the indication of treatment
- Evidence of documentation of the intended treatment duration or review date

This is as per the recommendations of the Public Health England "Start Smart then Focus" campaign.

8.1 Audit results from solid tumour wards.

The solid cohort of patient's compliance with recommendations reduced with the months of May and June. During these months there were pharmacy and clinical microbiology staff shortages leading to inconsistent pharmacist cover of the solid tumour wards and annual leave, preventing the antimicrobial ward rounds. From July onwards the compliance to the objectives of the audit improved, this may have been secondary to increased staffing and microbiology support with the introduction of microbiology ward rounds from November 2022.

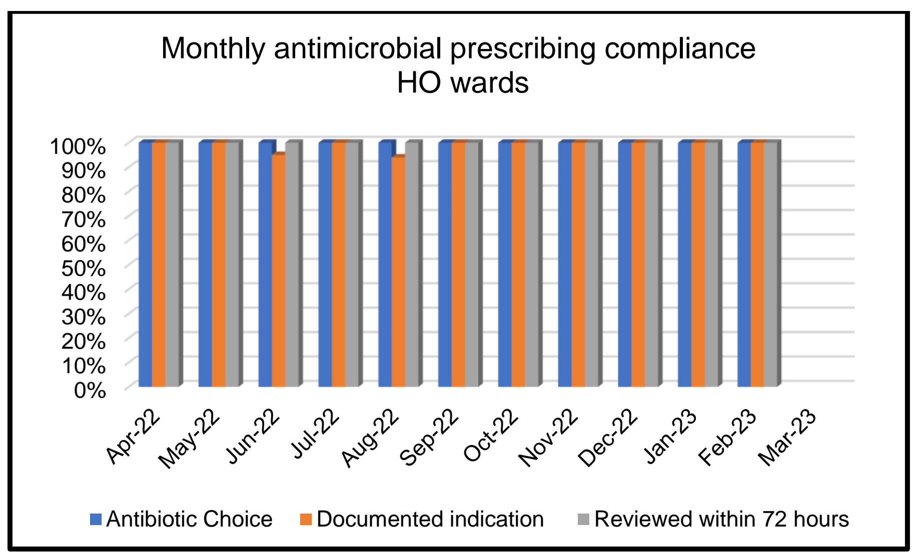
Figure 19 Monthly anti-microbial prescribing on solid tumour wards



8.2 Antimicrobial prescribing on Haemato-oncology (HO) wards

Overall, compliance with antimicrobial compliance has remained above 90% on HO wards.

Figure 20 Monthly anti-microbial prescribing on HO wards



8.3 Recommendations and actions to improve antimicrobial prescribing compliance

- Microbiology team continue to attend MDT meetings for the haemato-oncology cohort and weekly antimicrobial stewardship ward rounds on the solid tumour wards. Outside of these ward rounds/meeting the clinical staff can contact the microbiology service through the advice line, if further guidance is required.

- Encourage clear documentation of antimicrobial usage on the prescription, providing training to pharmacists and clinical staff on the ward.

- Review the trust process of collecting data and consider implementing business intelligence support. To be reviewed at next antimicrobial stewardship group.

- Continue to collect data on antifungal and antiviral usage within the trust via the quarterly point prevalence audit.

- Focus on supporting and empowering clinical teams in both cohorts when clinically appropriate when reviewing antibiotics to step down to oral or stop antibiotics.

Overall within the haemto-oncology cohort the compliance with the recommendations of the Public Health England “Start Smart then Focus” campaign for antibiotics is very good.

This can be contributed to the working relationship and engagement of HO staff and the consultant microbiologist/antimicrobial pharmacist at weekly MDTs.

The solid cohort of patient’s compliance with recommendations has improved with the commencement of weekly ward rounds. Additionally the microbiology team provided communication to the medical team of our attendance encouraging engagement with the weekly ward round.

9.0 Education

The IPC Team has continued to deliver education programmes across the Trust, including;

- Trust Induction for new starters
- Bespoke training sessions within clinical areas
- ANTT Peer Reviewer training

In addition to this a Link Practitioner Programme has been established with quarterly face to face teaching and update sessions available to all link staff or anyone with an interest in IPC.

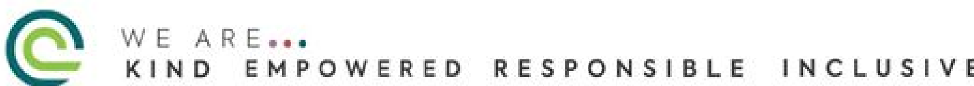
The IPC Team also undertake teaching on an annual level 6 undergraduate course entitled ‘Infection Control for Healthcare’ hosted by Liverpool John Moores University.

10.0 Collaborative working

The IPC Team have been, and continue to be involved in several collaborations, both within and externally to CCC. Those within CCC include the IPC MDT, IOC Masterclass and Blood Culture Working Group as described in sections 2 and 3 of this report.

10.1 Collaboration with other cancer centres

The IPC Team at CCC are actively involved in an IPC Cancer Collaborative with The Royal Marsden and The Christie hospitals. The collaborative meets on a monthly



basis. The meetings have focused on benchmarking current IPC practice and policy within all three centres, in particular a review of universal mask wearing which was undertaken in March 2023 to ensure a standardisation in guidance across the three centres. Future plans for 2023-24 include:

- Review of gram negative bactereamias within cancer patients to determine additional risks associated with cancer.
- Review and alignment of policies were practicable.
- Review and alignment of PIR process.
- Peer review visits to all 3 centres.

11.0 Policies and Guidelines

The IPC Team are responsible for nineteen different policies within CCC. All IPC policies align to the Health and Social Care Act (2008, updated 2015) and are underpinned by an overarching Infection Prevention and Control Policy. In addition to this number of Standard Operating Procedures (SOP's) have been developed to support clinical practice in relation to IPC. Both existing and new policies are approved by the IPC Committee and are document controlled to ensure accuracy.

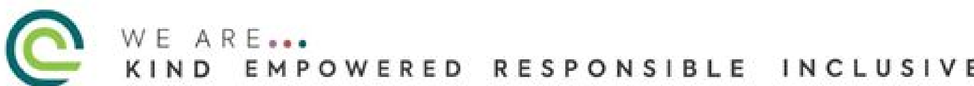
12.0 Water Safety

The Water Safety Committee met on a quarterly basis to ensure that the trust was fully compliant with HTM 04-01 across all sites. A programme of planned maintenance (PPM) tested and maintained activities relating to safety for water systems included;

- Twice weekly flushing of infrequently used all outlets across all hospital sites undertaken by staff within the areas or by Estates teams in unoccupied areas
- Monthly microbiological testing of outlets for Legionella or Pseudomonas
- Monthly sentinel temperature checks
- Annual thermostatic mixing valve inspection and maintenance

Where positive microbiology results were identified, outlets were immediately taken out of use and remedial maintenance works undertaken to rectify the issue. Outlets are only returned to use following identification of a negative microbiological sample. A review and gap analysis of compliance with HTM 04-01 was undertaken and updated risk assessments are planned for each CCC site.

There have been no instances of patients developing infections related to CCC water systems.



13.0 Conclusion

SARS-CoV-2 has continued to provide challenges across all patient services in 2022-23. The safety of staff and patients has remained a priority at CCC. The IPC Team have ensured that strong, effective processes have remained in place to balance the measures required to prevent SARS-CoV-2 transmission and the need to maintain standard precautions to prevent other HCAI's.

A zero tolerance approach has been maintained across the Trust towards all avoidable HCAI and strong, cohesive infection prevention and control practice is embedded throughout the organisation. The work and diligence of all grades of staff, clinical and non-clinical played a vital role in ensuring that people who used Trust services received safe and effective care, improving the quality of the patient experience and assisting to reduce the risk of infection.

Where HCAI are identified, a robust post infection review process strives to identify learning points with clinical teams invited to engage from the beginning.

Safe, effective evidence based IPC practice is delivered to all patients, families and staff across all Clatterbridge Cancer Centre sites.

Title of meeting: Trust Board Part 1
Date of meeting: 26th July 2023

Report lead	Kathy Doran, Chair			
Paper prepared by	Jane Hindle, Associate Director of Corporate Governance			
Report subject/title	Annual Fit and Proper Declaration of the Chair			
Purpose of paper	To confirm that the Trust Board continues to meet the requirements of the Fit and Proper Person Test (Regulation 5).			
Background papers	N/A			
Action required	To note			
Link to: Strategic Direction Corporate Objectives	Be Outstanding		Be a great place to work	
	Be Collaborative		Be Digital	
	Be Research Leaders		Be Innovative	

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

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

Ref: FCGOREPO
Review: July 2025
Version: 2.0

Annual Fit and Proper Declaration of the Chair

In line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust is required to ensure that all individuals appointed to or holding the role of Executive Director (or equivalent) or Non-Executive Director meet the requirements of the Fit and Proper Persons Test (Regulation 5).

The report sets out the Chair's annual declaration of compliance and has been informed by compliance with the agreed Board procedure; individual declarations of interest and an annual individual declaration of compliance with the regulations

The Fit and Proper Persons Test will apply to Directors (both executive and non-executive, whether existing, interim or permanent and whether voting or non-voting) and individuals "**performing the functions of, or functions equivalent or similar to the functions of a director".**

Regulation 5 states that a provider must not appoint or have in place an individual as a director who:

• is not of good character;

• does not have the necessary qualifications, competence, skills and experience;

• is not physically and mentally fit (after adjustments) to perform their duties. Regulation 5 also decrees that directors cannot have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity.

These requirements play a major part in ensuring the accountability of Directors of NHS bodies and outline the requirements for robust recruitment and employment processes for Board level appointments. [In exceptional circumstances, Trusts may allow an individual to continue as Director without having met the requirements following approval of the Chairman and following an assessment of all elements of risk.

As Chair of The Clatterbridge Cancer Centre, I confirm that all existing Executive and Non-Executive Directors meet the requirements of the Fit & Proper Persons Test.

My declaration has been informed by: The application of the Board approved Policy on Fit and Proper Persons Requirements including:

- Pre-employment checks for all new appointments undertaken in line with the NHS Employment Standards and including the following:
  - Proof of identity
  - Disclosure and Barring Service check undertaken at a level relevant for the post
  - Occupational Health clearance
  - Evidence of the right to work in the UK
  - Proof of qualifications, where appropriate

- ➢ Checks with relevant regulators, where appropriate
- ➢ Appropriate references, covering at least the last three years of employment, including details of gaps in service.

- Additional checks for all Directors on the following appropriate registers:
  - o Disqualified directors
  - o Bankruptcy and insolvency
- Confirmation from the Chair of appointment panels of compliance with the checks process
- Assessment of the Ongoing Independence of Non-Executive Directors carried out by the Interim Associate Director of Corporate Governance
- Annual and on-going Declarations of Interest for all Board members.
- Annual Fit & Proper Persons Test self-declarations completed by all Executive and Non-Executive Directors.
- Completion of annual appraisals
- If there have been any individual concerns raised regarding Directors during the previous year, the outcome of any investigations is reviewed to provide continuing assurance that Directors remain ‘Fit and Proper’.

Kathy Doran

Chair

July 2023

Information Pack

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

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

David Elkan Abrahamson Non-Executive Director	• Chair of Trustees of the Bloom Appeal, a blood cancer charity • Solicitor with Broudie Jackson Canter solicitors - I deal with major Inquests and Inquiries. In that capacity I currently represent the Covid 19 Bereaved Families for Justice, a representative group of bereaved which has core participant status in several modules of the Covid Inquiry • Director of 'Hillsborough Law Now Ltd.', a company whose aim is to get a Duty of Candour law enacted
Terry Jones Non-Executive Director	• Director, Liverpool Head and Neck Centre (LHNC). LHNC was formed as a formal collaboration between LUHFT, CCC, The Walton Centre and the University of Liverpool to facilitate the enhancement of head and neck cancer research and treatment in Cheshire & Merseyside. The Directorship is one of my core employment roles • Director of Research, Liverpool University Hospitals NHS Foundation Trust (LUHFT). This role, to lead the research strategy for LUHFT is another of my core employment roles • Director of Research, Cheshire and Merseyside Integrated Care System
Anna Rothery Non-Executive Director	• Non-Executive Director Elected Member Leader of Liverpool Community Independents Party – interest ended May 2023
Asutosh Yagnik Non-Executive Director	• Founder and Managing Director, AdSidera Ltd, UK • Director, Leigh Court (Harrow) Ltd, UK • Senior Fellow, Institute for Strategy, Resilience and Security (ISRS), University College London, UK • Senior Partner, Aura Capital Partners, Iceland
Jane Hindle Associate Director of Corporate Governance	• Partner is a Director of the Walton Centre Foundation Trust • Company Secretary of Clatterbridge Pharmacy Ltd • Company Secretary of PropCare Services Ltd

Acronyms

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

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

StEIS Strategic Executive Information System