NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Agenda: Trust Board Part 1
Date/Time of meeting: 25 January 2023, 09:30

	Standard Business		Lead	Time
P1-01-23	Welcome, introduction, apologies and quoracy	v	Chair	09:30
P1-02-23	Declarations of interest	v	Chair	
P1-03-23	Minutes of the last meeting – 30 November 2022	p	Chair	
P1-04-23	Matters arising / Action Log	p	Chair	
P1-05-23	Rolling programme/ Cycle of Business	p	Chair	
P1-06-23	Chair's report to the Board	v	Chair	09:35
	Reports and Action Plans			
P1-07-23	Patient Story	P	Chief Nurse	09:45
P1-08-23	Board Assurance Framework	p	Chief Exec	09:55
P1-09-23	Quality Committee Chair's Report	P	NED EA	10:05
P1-010-23	People Committee Chair's Report	p	NED AR	10:15
P1-011-23	Audit Committee Chair's report	p	NED MT	10:25
P1-012-23	Charitable Funds Committee Chair's Report	p	NED EA	10:35
P1-013-23	Integrated Performance Report Month 9	P	Exec Leads	10:45
P1-014-23	Finance Report	P	DoF	10:55
P1-015-23	Operational Planning 2023/24	P	Exec Leads	11:05
P1-016-23	NED and Governor Engagement Walk-Round - November 2023 -December 2023	P	NED AR / Chief Nurse	11:15
P1-017-23	Safer Staffing Report	p	Chief Nurse	11:30
P1-018-23	Mortality Report – Quarter 2	p	Medical Director	11:40
P1-019-23	Well-Led Review Action Plan Update	p	Director of Strategy	11:50
	For approval			
P1-020-23	Innovation Strategy	p	Clinical Lead for Innovation	12:00
P1-021-23	Review of Constitution	p	Interim AD of Corporate Governance	12:10
	System working			
P1-022-23	Cheshire and Merseyside Cancer Alliance Performance Report	P	Chief Exec	12:20
	Any other business			
P1-023-23		v	Chair	
	Date and time of next meeting hybrid MS Teams and CCC-L Board rooms: Wednesday, 1 March 2023 at 09:30			

p paper
***** presentation
v verbal report

WE ARE...
KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOAGEND
Review: July 2025
Version: 2.0

The Clatterbridge Cancer Centre NHS Foundation Trust

Minutes of: Trust Board Part 1
Date/Time of meeting: 30 November 2022

Title / Department	Name	Initials	Present / apols	Attendance record	Deputy
Core member					
Chair	Kathy Doran	KD	P	7/7	☐
Non-Executive Director	Mark Tattersall	MT	P	7/7	☐
Non-Executive Director	Geoff Broadhead	GB	P	6/7	☐
Non-Executive Director	Elkan Abrahamson	EA	P	6/7	☐
Non-Executive Director	Terry Jones	TJ	P	6/7	☐
Non-Executive Director	Anna Rothery	AR	P	4/7	☐
Non-Executive Director	Asutosh Yagnik	AY	P	5/7	☐
Chief Executive	Liz Bishop	LB	P	7/7	☐
Director of Workforce & OD	Jayne Shaw	JSh	P	7/7	☐
Medical Director	Sheena Khanduri	SK	P	6/7	☐
Chief Nurse	Julie Gray	JG	P	7/7	☐
Chief Operating Officer	Joan Spencer	JSp	P	7/7	☐
Director of Finance	James Thomson	JT	P	7/7	☐
Chief Information Officer	Sarah Barr (NV)	SB	P	7/7	☐
Director of Strategy	Tom Pharaoh (NV)	TP	P	7/7	☐
Also in attendance					
Title	**Name**	**Initials**			
Corporate Governance Manager (minutes)	Skye Thomson	ST			
Associate Director of Communications	Emer Scott	ES			
Interim Associate Director of Corporate Governance	Paul Buckingham	PB			
Staff Side Chair	Mike Varey	MV			

	Standard business
196	**Welcome, introduction & apologies:** The Chair welcomed the Board and the Staff Side Chair together with staff and members of the public observing the meeting which included Jane Wilkinson, Lead Governor and Laura Jane Brown, Staff Governor. There were no apologies for absence and the Chair confirmed that the meeting was quorate.
197	**Declarations of interest:**

	There were no declarations made in relation to any of the agenda items.
198	**Minutes of previous meeting** The minutes of the meeting held on 26 October 2022 were approved as a true and accurate record subject to the following amendments: • Minute Ref 174 - The interest of Mr G Broadhead as the Interim Chair of Clatterbridge Pharmacy Limited to be included as a declaration of interests. • Minute Ref 185 - The reference to the new General Manager for Radiology doing a deep dive to be amended to '*The Radiology Team will conduct a deep dive on imaging turnaround'.* • Minute Ref 185 – The Chief Nurse requested a re-wording of the section regarding the piece of work the clinical Associate Director of Clinical Governance is picking up regarding reviewing serious incidents over the last 5 years. New wording: *The Integrated Care Board requested Trust's complete and close any open serious incidents, the Trust don't have any outside of agreed timetables to date. The Associate Director of Clinical Governance will review the significant incidents for the last 5 years and develop a serious incident tracker which will enable the Trust to easily benchmark with other organisations.*
199	**Matters arising / outstanding actions** The Board agreed the actions marked as complete on the Action Log and noted that the remainder of the actions were on track.
200	**Rolling programme / Cycle of Business** Received and noted.
201	**Chair's Report to the Board** The Chair updated the Board on the following items which had taken place since the last meeting: • The Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) are looking at support for staff wellbeing and development to help make the Trusts in the Cheshire & Merseyside collaborative great places to work. • A 'Women Against Cancer' lunch had been held at the Hilton Hotel in Liverpool. This had been the first such event since 2019 and had been extremely successful in raising funds for the Clatterbridge Cancer Charity. The Chair had held a meeting with Mr B Barwick, the new Chair of the Charity separate to this event. • The Trust's Consultants gathered together for a successful 'away' afternoon in Liverpool, delivering some great presentations to their colleagues. The session included a presentation from Rowan Pritchard-Jones, Medical Director for NHS Cheshire and Merseyside and Jon Hayes, Managing Director for Cheshire and Merseyside Cancer Alliance, describing the Trust's important role in the wider system and all the cancer pathways. The day ended with the first Consultant Away Day Award Ceremony and the Chair congratulated the nominees and winners. • The Chair had visited the CCC Wirral site with the Chief Operating Officer and met a range of staff and managers during the visit.

	• The Chair had joined a tour of the new Royal Liverpool Hospital with the Chair and Chief Executive of Liverpool University Hospitals NHS Foundation Trust and noted how busy and frenetic the hospital appeared to be in comparison with the much calmer Cancer Centre environment. The Chair noted that Ms A Rothery planned to visit the new hospital on 7 December 2022 and advised that other Non-Executive Directors were welcome to join her. • The Chair advised that she had introduced a Core Skills development session for new and existing Governors on 17 November 2022. She noted that feedback from this session, facilitated by NHS Providers, had been very positive. • The Chair advised that she and colleagues had attended a CMAST Provider Collaborative event for Chairs and Non-Executive Directors that had been held on 29 November 2022. She noted that there had been much discussion on engagement activities to support collaborative efforts across the system. She also noted plans to establish a CMAST network of People Committee Chairs. The Board of Directors: • Received and noted the verbal briefing. Mr A Yagnik joined the meeting.	
	Reports and Action Plans	**Action**
202	**Staff Story: My Leadership Journey at CCC** The Director of Workforce and Organisational Development introduced Alex Gilbertson, Macmillan Physiotherapy Team Lead and Temporary AHP Workforce Project Lead, who presented the November Staff Story. Ms Gilbertson delivered a presentation which covered the following subject areas: • My Winding Road to Physiotherapy • Highly Specialist Oncology Physiotherapist • CCC Leadership Journey • How CCC has Helped Me • Challenges • What is Next She noted in particular the broad range of skills that the specialist oncology physio team at Clatterbridge has, and the fantastic work they do in supporting patients with a wide range of needs. She also talked about how the Trust had supported her professional development and the effectiveness of the Trust's workforce development approach compared with that of other employers she had experienced. The Chief Executive noted the importance of giving staff opportunities for progression, secondments, project work, leadership training etc and the Chair commented on discussions during the CMAST event on 29 November 2022 on means of encouraging staff retention and development which were not pay-related. In response to a question from Non-Executive Director AR, Ms Gilbertson agreed that her positive experience would make her more inclined to remain with the Trust and noted the benefit of secondment	

	opportunities for the development of both herself and others. In response to comments from Non-Executive Director TJ, which related to encouraging individuals to undertake personal development, Ms Gilbertson provided an overview of a Clinical Leaders project which had been supported by funding from Health Education England (HEE). On behalf of the Board, the Chair congratulated Ms Gilbertson on her personal development journey and thanked her for an informative presentation.	
203	**Performance Committee Chair's Report** Non-Executive Director and Chair of the Performance Committee GB presented the Chair's Report of a meeting held on 23 November 2022 and noted the following: • The Committee had received an update on winter planning and had expressed some concern about the uncertainty of funding for mutual aid beds. It was noted that a funding request to support this requirement had been made to the Integrated Care Board. • The Committee had considered the challenge of delivering efficiency targets on a recurrent basis and the need to implement a greater degree of transformational and strategic savings schemes in future. The Chief Operating Officer then referred the Board to the 'Items for Shared Learning' section of the report and noted that the Trust's assessment against the Core Standards for Emergency Preparedness, Resilience and Response (EPRR), which had been reviewed by the Board in September 2022, had been revised from a compliance rate of 91% to 77%. She advised that the outcome had been revised by NHS England due to a late change to the assessment criteria. The Chief Operating Officer assured the Board that an action plan was in place to address the additional areas of non-compliance and anticipated that a return to the higher assessment rate would be achieved during Quarter 4. She advised that a follow-up report would be presented to the Board once the action plan had been completed. The Board of Directors: • Received and noted the Performance Committee Chair's Report.	
204	**Integrated Performance Report Month 7** The Chief Operating Officer introduced the Month 7 Integrated Performance Report and each Executive Lead briefed on highlights in the SPC Charts and exception reporting for the following areas: Access, Efficiency, Quality, Research & Innovation and Workforce. The Executive Leads highlighted the following areas: <u>Access</u> The Chief Operating Officer noted the challenges around the 62-day target and late referrals. She noted that the Trust was working with partners across Cheshire & Merseyside on initiatives to reduce late referrals. <u>Efficiency</u> The Chief Operating Officer noted the issues in the system relating to delayed transfers of care. The Patient Flow Team continue to work with wider multi-disciplinary teams to aid	

	discharge planning, ensuring patients are discharged safely home or to a suitable care setting. Quality The Chief Nurse noted that the 'percentage of adult admissions with a VTE (Venous thromboembolism) risk assessment' target had not been achieved in October 2022. She assured the Board that no harm had resulted and advised that details of the missed assessments had been shared with the relevant medical teams for review and future learning. In response to a question from MT, regarding an Information Governance incident referenced on page 28 of the report, the Director of Finance provided an overview of what had been a low risk incident concerning the transmission of ESR details via email. Research and Innovation The Medical Director highlighted ongoing work with study recruitment, new studies opening and publications in line with the overall objectives of the Research and Innovation team and the wider strategic work. Workforce The Director of Workforce and Organisational Development (WOD) reported that sickness absence had been above target with the highest reason as 'cold, cough, influenza'. She advised that the Workforce team was undertaking a 'deep dive' on sickness absence with Networked Services to identify any patterns and themes in their high levels of sickness. Outcomes from the deep dive would be considered by the Workforce Advisory Group in Quarter 4. The Director of WOD also commented on the missed turnover target, noting that leavers came from a range of staff groups rather than a specific area. In response to a question from AY, regarding generic use of the reference 'achievement of target likely to be inconsistent' and potential for revising targets, the Chief Operating Officer acknowledged the comment but advised that it was not possible to change statutory targets. The Chair suggested that a review could be undertaken in advance of 2023/24 with a view to adjusting metrics where practicable and where adjustment would provide a more meaningful assessment of performance. The Board of Directors: • Received and noted the Month 7 Integrated Performance Report.	
205	**Finance Report** The Director of Finance presented a report which detailed the Trust's financial performance as at 31 October 2022. He briefed the Board on the content of the report and noted that the NHS Cheshire & Merseyside Integrated Care Board (ICB) are managing the required financial position of each Trust through a whole system approach. The Trust submitted a plan to NHSE showing a £1.621m surplus for 2022/23. The Trust is currently on plan to deliver its financial plan for 2022/23 and has considered its risk profile and it is not expected that the Trust will amend its financial forecast. The Director of Finance noted there are still areas of risk particularly around elective recovery funding (ERF). ERF has been assumed at 33% for month 7 (previously 25% months 1-6), to mitigate the cost impact of increasing capacity at Liverpool. The Trust is	

	currently reviewing activity against the plans and awaiting feedback on the ERF calculation process. He noted that the Trust's position is reliant upon receiving Elective Recovery Funding (ERF) of £9m for activity over and above 104% of 2019/20 activity levels to achieve the financial plan for the year. The Director of Finance highlighted that agency spend is £160k in month, of which £20k relates to mutual aid. While consistent with previous months, this is significantly above the £95k agency cap and is being monitored through the workforce establishment control panel and Finance Committee. In response to a question from the Chair, regarding delivery of the Capital programme given the number of schemes to be completed in Quarter 4, the Director of Finance provided an overview of the Capital scheme plans for Quarter 4 with analysis of the forecast position for delivery. In response to a question from TJ, regarding management of the ICS financial position, the Director of Finance provided an overview of the ICB management approach and noted introduction of the Protocol for changes to In-Year Financial Forecasts as detailed in the next agenda item. He noted that the ICB would be looking to Trusts to maximise their financial positions in order to facilitate delivery of the overall ICS financial plan. MT commented on the need for clarity on ERF funding in relation to delivery of the Trust's financial plan for 2022/23. The Board of Directors: • Received and noted the Month 7 Finance Report.	
206	**Protocol for changes to In-Year Revenue Financial Forecast** The Director of Finance informed the Board that guidance on the Protocol had been issued by NHS England on 7 November 2022 and provided an overview of the potential implications of submitting a revised in-year financial forecast. The Director of Finance advised the Board that it was not expected that there would be a need for the Trust to revise its financial forecast for 2022/23. The Chair commented on an assessment template prepared by PriceWaterhouseCooper which enabled Boards to understand their Trust position in response to ten key questions. She suggested that the Board should consider this approach at its next meeting in January 2023. The Director of Finance acknowledged this suggestion. MT again commented on the uncertainty around ERF funding and the Chair advised that the position should be considered at the January Board meeting with escalation to the ICB if the situation on ERF funding was still uncertain. The Director of Finance noted that he had previously advised the ICB that the Trust's position was contingent on delivery of ERF assumptions. In response to a follow-up question from the Chair, the Director of Finance confirmed that the Protocol published on 7 November 2022 was the final version of the guidance and had not been issued for consultation. The Board of Directors: • Received and noted the Protocol for changes to In-Year Revenue Financial Forecasts. **Action:**	

	• The Director of Finance will facilitate the review and discussion of the PWC assessment questions from a financial management point of view at the February 2023 Performance Committee.	
207	**NED and Governor Engagement Walk-Round** Non-Executive Director GB introduced the report as the non-Executive Director representative on the October walk-round at Floor M1 Out-Patients Department and Floor M2 Information and Support Service Centre, CCC Liverpool. GB noted patients were full of praise for the staff. They highlighted some issues that the Trust was already aware of and working on, for example not being able to get through on the phone. Overall there was very positive feedback about the Cancer Information & Support service from patients, however the staff shared how the current cost of living crisis is leaving many patients in real financial hardship with demand for benefits advice significantly increasing. The Trust is looking at enhancing access to cancer information & support across our other sites. The Board of Directors: • Received and noted the NED and Governor Engagement Report.	
208	**New Consultant Appointments** The Medical Director briefed the Board on the appointment of a new Consultant. The Board noted the report and congratulated Dr Amy Jackson on her appointment as a Consultant Clinical Oncologist.	
209	**Learning from Deaths / Mortality Quarterly Report** The Medical Director presented the Quarter 1 2022/23 Mortality Report and noted that findings indicated that there were no significant concerns. She advised that, from April 2022, the team had looked at causes of deaths to identify any discrepancies in the recording of deaths and certificates, and any lessons learned from the mortality review. She assured the Board that robust processes were in place for mortality reviews. The Board of Directors: • Received and noted the Learning from Deaths / Mortality Quarterly Report.	
210	**Guardian of Safe Working Quarterly Report** The Medical Director presented the Guardian of Safe Working report for Quarter 2, 2022/23. She briefed the Board on the content of the report and provided an overview of the seven exception reports detailed in the report. She noted the development of an action plan by Dr I Lampkin who had been newly appointed as the Guardian of safe Working with effect from 1 April 2022. In response to a question from TJ, regarding the effectiveness of national workforce planning, the Medical Director commented on an overall increase in trainee numbers nationally but with wide variations at regional level. She noted for example, 3.2 Clinical Oncologists per 100,000 population in the North West with a corresponding figure of 5.2 Clinical Oncologists per 100,000 population in London. She also commented on issues relating to late notification of trainee availability. In response to a question from EA	

	regarding shift changes and wellbeing of doctors, the Chief Operating Officer provided assurance that shift changes had been subject to agreement with the relevant medical staff. The Board of Directors: • Received and noted the Guardian of Safe Working Report.	
211	**Progress against 5 year strategy** The Director of Strategy presented a report which detailed progress with implementation of the Trust's strategic plan. He briefed the Board on the content of the report and noted that good progress had been made to date. In response to questions from MT, the Chief Operating Officer confirmed that a joint Scrutiny Committee would be established in relation to development of an 'Eastern Hub'. The Director of Strategy then provided an overview of the process for achieving Teaching Hospital / University Hospital status and advised that this particular development was on hold at present. In response to a question from the Chair, regarding interventional radiology, the Chief Operating Officer provided an overview of progress and noted action to recruit to two posts. The Chair thanked the Director of Strategy for his report and commented positively on the format of the report. The Board of Directors: • Received and noted the Trust Strategy Report.	
	For information	
212	**Non-Executive Director Champion Roles** The Interim Associate Director of Corporate Governance presented a report to inform the Board of revised arrangements for Non-Executive Director Champion Roles in accordance with NHS England guidance published in December 2021. He briefed the Board on the content of the report, including a reduction in the number of formal 'Champion' roles, and noted the Trust's position against the guidance as summarised in Appendix 1 of the report. In response to a question from the Chair, the Interim Associate Director of Corporate Governance advised that changes to relevant Committee Terms of Reference would be completed during the annual review process. The Board considered the report and agreed that oversight of Emergency Preparedness arrangements would be undertaken by the Performance Committee rather than the Quality Committee as detailed at Appendix 1. The Board of Directors: • Received the report and noted the guidance published by NHS England. • Endorsed the proposed arrangements detailed at Appendix 1 of the report. • Endorsed the arrangements for Equality & Diversity and Energy & Sustainability oversight as detailed at s4 of the report.	
213	**Corporate Governance Publications**	

	The Interim Associate Director of Corporate Governance presented a report which provided the Board with an overview of three new Corporate Governance documents published by NHS England on 27 October 2022. These were: • Code of Governance for NHS Provider Trusts • Guidance on Good Governance and Collaboration • System Working and Collaboration: Role of Foundation Trust Councils of Governors The Interim Associate Director of Corporate Governance briefed the Board on the content of report and the proposed actions in respect of each publication. The Board of Directors: • Received the report and endorsed the proposals to progress action in response to each of the guidance documents as detailed at Section 2 to Section 4 of the report.	
214	**Industrial Action** The Director of Workforce and Organisational Development (WOD) introduced the report providing an update to Board on the position of Trade Unions in regards to Industrial action and to provide assurance of preparedness of the Trust to continue to provide safe and effective essential services. The Director of WOD highlighted the current position noting the potential action dates and the work going on at a national, Cheshire and Merseyside Integrated Care Board (ICB) and local level. The Director of WOD summarised the next steps in the report noting the importance of continued engagement. The Chair invited the Staff Side Chair observing the meeting to comment. The Staff Side Chair noted that this was a dispute between staff and the Government, not with the Trust and emphasised that staff wanted to ensure that patient safety was a priority during any industrial action. He confirmed that Staff Side would work proactively with Management to achieve this. The Chair welcomed this helpful approach and commented on support for staff to act in ways which were appropriate for patients. In response to a question from EA, regarding crossing of picket lines, the Staff Side Chair advised that he would seek to clarify the position with the Royal College of Nursing (RCN). The Director of Workforce & OD advised the Board of the Trust's participation in the 'Arctic Willow' training exercise which aimed to test organisational resilience in response to a range of scenarios. In response to a question from AY, she confirmed that a risk relating to industrial action had been included on the Trust's risk register. The Chief Executive commented that the safety of patients and staff is a priority and the Trust will work closely with staff side to plan and prepare for industrial action. The Trust will await confirmation on industrial action dates, sites and derogated services. The Board of Directors: • Received and noted the Industrial Action briefing.	

The Clatterbridge Cancer Centre NHS Foundation Trust

	System Working	
215	**Cheshire and Merseyside Cancer Alliance Performance Report October 2022** The Chief Executive presented the Cheshire and Merseyside Cancer Alliance Performance Report for November 2022 and highlighted continued challenges with endoscopy. The Board of Directors: • Received and noted the Cancer Alliance Performance Report.	
	Any other business	
	The Corporate Governance Manager noted that the meeting location would change from January 2023.	
	Date and time of next meeting via MS Teams: 25th January at 09:30 – Hybrid: CCC-L Board Rooms and MS Teams	

						P1-04-23
BOARD ACTION SHEET PART 1						
		KEY: BLUE = COMPLETE / GREEN = ON TRACK / AMBER = AT RISK / RED = LATE				
Item No.	**Date of Meeting**	**Item**	**Action(s)**	**Action by**	**Date to complete by**	**Date Completed / update**
P1-160-22	28th September 2022	Formal Review of the Board Committee Governance Structure	The Board agreed to continue on this Committee governance model and review again in 6 months	**JG**	Mar-23	Included on cycle of business
P1-179-22	26-Oct-22	Board Assurance Framework	The Chief Executive to review comments from the October minutes regarding the BAF and update BAF risk 4 and 6 accordingly. Chief Executive to include the November NED CMAST event in the BAF 6 narrative.	**LB**	Jan-23	Updates completed as part of January 2023 BAF review - Full BAF included on the Jan 23 agenda
P1-179-22	26-Oct-22	Board Assurance Framework	GC to amend BAF 4 to show where the quality strategy is being scrutinised (Quality Committee).	**GC/LB**	Jan-23	Updates completed as part of January 2023 BAF review - Full BAF included on the Jan 23 agenda
P1-180-22	26-Oct-22	Patient Story	Chief Nurse to bring an update on the patient letter/ communication workstream to Quality Committee.	**JG**	Dec-22	Included on Quality Committee Cycle of Business Taken to December 2022 Quality Committee
P1-206-22	30-Nov-22	Protocol for changes to In-Year Revenue Financial Forecast	The Director of Finance will facilitate the review and discussion of the PWC assessment questions from a financial management point of view at the February 2023 Performance Committee.	**JT**	Feb-23	Added to Performance Committee Cycle of Business

Trust Board Annual Reporting Cycle 2022/23	Owner												
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Strategy & Planning													
Progress against 5 Year Strategy	TP				√				√				√
Annual Financial/Operational Planning Guidance	JT							√			√	√ Draft	√ Submission
Bright Ideas Scheme	GH											√	
Green Plan Annual Report	TP												√
Assurance: Quality, Performance													
Quality Committee Chair Report	TJ	√			√			√			√		√ inc. ToR
Performance Committee Chair Report	GB		√				√		√			√ inc. ToR	
Audit Committee Chair Report	MT	√	√	√	√			√			√ inc. ToR		
Charitable Funds Committee Chair Report	EA	√			√			√			√		
People Committee Chairs report	JSh			√ inc. ToR				√ inc. ToR			√		√ inc. ToR
Integrated Performance Report	Exec Leads	√	√	√	√		√	√	√		√	√	√
Finance Report	JB/JT	√	√	√	√		√	√	√		√	√	√
Safer Staffing Report	JG			√							√		
Gender Pay Gap	JSh												√
Workforce Race Equality Standard Data	JSh							√					
Workforce Disability Equality Standard Data	JSh							√					
Equality Diversity & Inclusion Annual Report	JSh										√		
Patient Story	JG		√		√			√			√		√
Staff Story	JSh	√		√			√		√			√	
Actions from Patient/Staff Survey Annual Report	JG												√
In-Patient Survey- embargoed	JG						√						
Patient Experience Visits / NED and Governor Engagement Walkround	JG	√	√	√	√		√	√	√		√	√	√
NED and Governor Engagement Walkround Annual Schedule	JG		√										√
Actions from NED and Governor Engagement Walk-rounds Annual Report	JG												√
New Consultant Appointments	SK	√	√	√	√		√	√	√		√	√	√
Caldicott Guardian Annual Report	SK										√		
5 year Patient Experience Engagement Inclusion & Involvement (PEEII) Commitment	JG												√
Staff Survey Results	JSh						√						√
Annual Risk Management Report	JG												√
Approval of Risk Management Strategy	JG												√
Quality strategy and Annual Report	JG												√
Board Governance													
Review of Constitution (ADHOC)	MS										√		
Board Assurance Framework Risk Appetite Statement	MS				√			√			√ Q3		
BAF Refresh (reporting on for year ahead)	MS	√											
Audit Committee Annual Report	MS				√								
Well-Led Review Action Plan Update	TP	√			√			√			√		
Annual Review of Board effectiveness	MS												√
Trust Board Annual Reporting Cycle 2022/23													

NED independence & Board register of interest	MS												√
Statutory Reporting/Compliance													
Annual Report & Accounts including the Annual Governance Statement	MS			√- extra ordinary									
External Audit Findings Report and Letter of Representation	MS			√ extra ordinary									
Self-Certification against the Provider Licence	MS			√ extra ordinary									
Regulation 5 Declarations (Fit and Proper)	MS				√ deferred		√						
Emergency Preparedness Resilience and Response (EPRR) Annual Report and core standards	JSp						√						
Learning From Deaths (Mortality Report) Quarterly	SK				√				Q1√		Q2√		
Mortality annual report	SK				√								
Revalidation Annual Report (for review)	SK						√						
Guardian of Safe Working Report (quarterly) (for review)	SK			√			√		√				√
Guardian of safe working annual report (For review)	SK			√									
Infection Prevention and Control Annual Report (For review)	JG				√								
Freedom to Speak Up Annual Report	MS				√- deferred		√-deferred	√					
Health and Safety Annual Report (For review)	JSp						√						
R&I Annual Report	SK							√					
Safeguarding annual report (For review)	SK						√						
Collaboration													
CMCA Report	LB						√						
Adhoc / Committee Requested													
Integrating specialised services within integrated care systems	JT			√									
Staff Walk-round Process Review	JG			√ - deferred	√								
Articles of association for the charity company limited by guarantee	KB						√						
Digital Annual report	SB												
Formal Review of the Board Committee Governance Structure	JG						√						√
NED Composition	PB								√				
Freedom to Speak Up Reflections and Planning Tool	PB/JG											√	
Freedom to Speak Up Policy	PB												√

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 25 January 2023

Report Lead	Julie Gray, Chief Nurse			
Paper prepared by	Nicola Heazell Head of Patient Experience and Inclusion			
Report subject/title	Welfare Benefits Patient Story – January 2023 Trust Board			
Purpose of paper	Action Plan to support Patient Story			
Background papers	A patient consented to share their story of their recent interaction with the Welfare Benefits Advice Service, after developing a relationship with the team whilst waiting for patient transport services home. The patient wished to remain anonymous therefore the Communications Team have inserted photographs over the patient audio (consent obtained by Comms Teams previously for the stock images)..			
Action required	Link to patient story: https://youtu.be/mXIDGs8dyoY 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	
	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		

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The Clatterbridge Cancer Centre NHS Foundation Trust

Patient/Staff Story Action Report

Story ID	Jan/2023	Committee	Board of Directors		
Date Presented	25.01.23	Patient Story	☒	Staff Story	☐
		In person	☐	Digital	☒
Date Consent Obtained	23/12/22	Consented by	Nicola Heazell	Consent for:	☒ Internal ☒External ☒Online Anonymized
Division/s involved	Corporate Nursing		External Organisation involved	N/A	
Formal Complaint	☐	Complaint closed	☐	Complaint Upheld	☐

1. Action Already Taken

No	Issue	Action taken	Action Lead

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

No	Issue	Action required	Action Lead	Deadline Date	Expected Evidence of Completion
1.	Lack of patient awareness regarding Clatterbridge Cancer Centre Welfare Benefits Service provision.	Staffing establishment/ resource increase to meet current service demand - strengthen awareness of the service provided at divisional level to support all patients undergoing systemic anti- cancer treatment	Head of Patient Experience and Inclusion	Apr 2023	Increased staff awareness of Welfare Benefits Service provision to support patients with the financial cost of cancer.
2.	Patient Transport Services environment	Explore opportunities to improve the transport area environment	Head of Patent Experience and Inclusion	June 2023	Review in progress to address utilization of space on Floor M2.

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.

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Board of Directors
Date of meeting: 25 January 2023

Report Lead	Liz Bishop, Chief Executive				
Paper prepared by	Skye Thomson, Corporate Governance Manager 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	Q2 BAF report presented to October Board of Directors; BAF update reports to Performance Committee (November), Quality Committee (December), People Committee (December) and Audit Committee (January)				
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		

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The Clatterbridge Cancer Centre NHS Foundation Trust

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 October, Committees of the Board have received BAF reports as follows:

- BAF2, 3, 5, 8 and 15 reviewed by the Performance Committee 23 November;
- BAF9, 10, 11 and 12 reviewed by the People Committee 21 December;
- BAF1, 7 and 13 reviewed by the Quality Committee 22 December;
- BAF14 reviewed by the Audit Committee 12 January.

1.3 Highlights from committees

1.3.1 Performance Committee

The Committee reviewed the BAF risks aligned to Performance Committee and approved the increase in targets for BAF 1 and BAF 3.

1.3.2 People Committee

Due to meeting time pressures as a result of the December 2022 industrial action, items at the People Committee were discussed by exception. The Director of Workforce and Organisational Development advised the Committee that further updates are required for the Board Assurance Framework (BAF) which will be completed in Q4 of 2022/2023 and brought to the next meeting in March 2023.

1.3.3 Quality Committee

Due to meeting time pressures as a result of the December 2022 industrial action, items at the Quality Committee were discussed by exception. The Committee approved the BAF report.

1.3.4 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.

1.4 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.

The Clatterbridge Cancer Centre NHS Foundation Trust

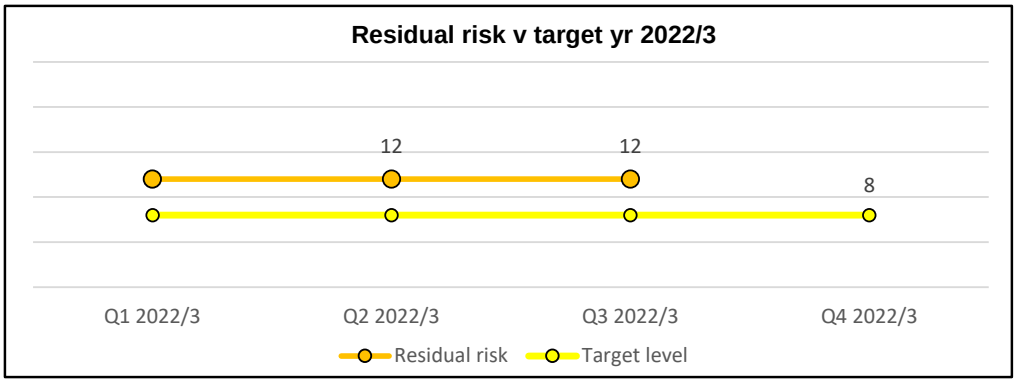
2.0 Key highlights

2.1 There have been two changes to strategic risk target scores since the Q2 report. The Performance Committee (23 November 2022) approved the increase of the target risk level for BAF2, Demand Exceeds Resources, from 6 to 12 following discussions at the August Performance Committee meeting and in light of challenging operating environment that is likely to continue into 2023. The Performance Committee also approved the increase of the target risk level for BAF3, Insufficient funding, from 4 to 8 following discussions at the August Performance Committee meeting and in recognition that 2023/24 will be a further transition year regarding commissioner process and relationships.

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 (exceeded)				
Risk title	**Residual risk**	**Assurance ratings**	**Actions**	**Target 31/03/23**
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	**12**	**ACCEPTABLE** 4 controls **PARTIAL** 3 controls (1 moved from acceptable since Q2)	Completed Q3 None Reforecast None Due Q4 -Audit improvement plan and risk management strategy review -Closing gaps in Governance team -Review of CCC Corporate Governance -Development of Quality Improvement Strategy	**8**
Commentary Good progress has been made in terms of streamlining corporate governance processes and 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 Governance (ADoCG) with outcomes forming the basis of an action plan to address any gaps in compliance. There is further work to be undertaken on the development of the Quality Strategy in 2022-23 but there has been significant improvement in the management of clinical risk. Recruitment of a substantive Associate Director of Corporate Governance is underway.				

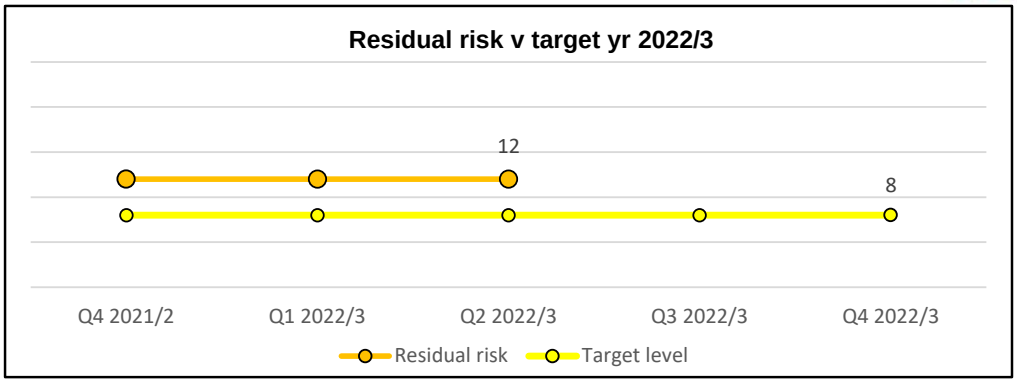
The Clatterbridge Cancer Centre NHS Foundation Trust



Summary table: BAF6 ICS				
Risk appetite: moderate				
Risk title	**Residual risk**	**Assurance ratings**	**Actions**	**Target 31/03/23**
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	**12**	**ACCEPTABLE** 4 controls **PARTIAL** 1 control	Completed Q3 Diagnostic Programme appointments Reforecast -Risk sharing agreement with ICB Due Q4 -Complete CMCA business plans for 2023-24 - Development of diagnostic business plans	**8**

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 leadership role and hosting of the Cheshire & Merseyside Diagnostics Programme on behalf of the ICB, gives greater influence over cancer diagnostics. There is work planned through the year to broaden executive directors' stakeholder engagement, and raise the profile of CCC's brand and senior leaders.



3.0 Recommendations

3.1 The Board is requested to interrogate BAF4 and BAF6 and confirm that members are satisfied with the information about key controls and assurances, and the remaining actions.

Appendix 1: Strategic risk heatmap showing initial, residual and target risk scores Q2 2022-23

Strategic aims	Outstanding					Collab-orative	Research Leaders		Great Place to Work				Digital		Innov-ative
Risks	BAF1	BAF2	BAF3	BAF4	BAF5	BAF6	BAF7	BAF8	BAF9	BAF10	BAF11	BAF12	BAF13	BAF14	BAF15
25	⊗														
20		⊗	⊗											⊗	
16			Ⓡ	⊗					⊗	⊗	⊗ Ⓡ	⊗			
15	Ⓡ				⊗		⊗	⊗					⊗		⊗
12		Ⓡ		Ⓡ	Ⓡ	⊗ Ⓡ	Ⓡ	Ⓡ	Ⓡ	Ⓡ			Ⓡ	Ⓡ ★	Ⓡ
10	★														
9					★				★	★	★	Ⓡ	★		
8				★		★	★	★							
6		★										★			
5															
4			★												★
3															

Key

⊗	Initial (inherent)
Ⓡ	Residual (current)
★	Target
→	Distance to target

BAF1 Quality governance	**BAF6** Strategic influence within ICS	**BAF11** Staffing levels
BAF2 Demand exceeds capacity	**BAF7** Research portfolio	**BAF12** Staff health and wellbeing
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** Skilled and diverse workforce	**BAF15** Subsidiaries companies and Joint Venture

BAF1 Quality governance systems
RISK APPETITE: Patient safety & experience - Regulatory compliance LOW (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	Board Assurance: External assurance	Board Assurance: Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF1 There is a risk that **quality governance systems fail to drive improvements in patient safety and experience and the effectiveness of care**, which would negatively affect the CQC's assessment of the Trust's services **Executive Risk Lead:** Julie Gray, Chief Nurse **Board Committee**: Quality **Last Update:** 9 December 2022	**Causes** 1. Insufficient and ineffective clinical governance processes 2. Failure to learn from patient feedback 3. Exceeding thresholds for harm free care indicators (falls, pressure ulcers, health care associated infections (HCAIs)) 4. Lack of coherent and sustained focus on Quality 5. National Patient Safety new ways of working 6. Nosocomial outbreaks 7. Increased patient dependency and acuity **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	5 x 5 = 25	C1) Risk Management Strategy 2022. Incident reporting and investigation policies. Dedicated Clinical Governance and Safety Team. **Control Owner**: Chief Nurse	Risk management strategy annual update report - Quality Committee and Board Annual Clinical Audit Report, reviewed by Quality Committee.	Audited Quality Account, reviewed by Quality Committee, June 22 MIAA audits of key systems: Risk Management, Substantial Assurance March 22; Incident reporting, Limited Assurance April 22; Claims, Substantial Assurance, 2021/22	Partial	3 x 5 = 15	No	G1) Requirement for further development of clinical audit programme. MIAA recommendations for incident reporting and risk management process.	1. Develop the clinical audit programme and align to clinical governance structures and processes 2. MIAA audit improvement plan 3. Review risk management strategy **Action Owner**: Chief Nurse **Due date**: 31/03/23	Review of Risk Management Strategy underway. Strategy workshops planned for Q4. Awaiting publication of Patient Safety Strategy Framework (PSIRF) national documentatin in order to align Incident Reporting Processes. Participation in regional PSIRF collaborative.	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. Complaints, PALS & Claims reports, reviewed by Risk & Quality Governance Committee monthly and quarterly by Quality Committee.	National Cancer Patient Experience Survey results, reviewed by Quality Committee, September 22 showed Trust in top decile. MIAA Sustantial Assurance for Patient Experience, 2020/21 MIAA Moderate Assurance for Complaints March 2022.	Partial			G2) Number of complaints and PALs contacts exceeds tolerance level	1. Review and restructure of complaints process 2. Quarterly (Aggregated) Patient Safety and Experience Report **Action Owner**: Chief Nurse **Due date**: 31/03/23	Complaints process review underway led by Associate Chief Nurse. Quarter 2 - Patient Safety & Experience Report published.	
			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 - internal review undertaken. Maintain low rates of catheter associated UTI's and maintain 95%+ VTE assessments. **Control Owner**: Chief Nurse	Harms Free Care Committee Data reported to Board of Directors via Integrated Performance and Quality Report	Model Hospital Data	Partial			G3) Training data, appropriateness of Waterlow Risk assessment for Oncology patients. Risk of a single room facility not adequately understood. No tangible impact for learning for improvement evident from Harms Free Care Group	Collaborative improvement projects for Falls reduction and Pressure Ulcers. Identify/gather 12 months of baseline data in order to set improvement targets. Review effectiveness of Harms Free Care Group **Action Owner**: Chief Nurse **Due date**: 31/03/23	Pressure Ulcer Collaborative supported by AQuA commenced 7/09/22 Falls/Manual Handling Lead appointed, due to start in post Q3	
			C4) Investment - Access to AQuA Expertise in PMO. 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. Bright Ideas report to Board of Directors.	Care Quality Commission (CQC) rating. Specialist commissioners oversight. Good Governance Institute Review 2022.	Partial			G4) Lack of up to date Quality Strategy. No clear system to demonstrate and celebrate quality improvement activity	Trustwide engagement and development of a Quality Improvement Strategy, including agreed prefered methodology and improvement programme **Action Owner**: Chief Nurse **Due date**: 31/03/23	Early scoping underway. Tendable functionality and efficiency options appraisal underway.	
			C5) Dedicated role - Associate Director of Clinical Governance and Patient Safety. Patient Safety champions. Newly established Executive Review Group and Patient Safety Committee with Consultant leadership. Learning from incidents internal wepage. Incident investigation training in line with the Patient Safety Syllabus published May 2021 **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	Low			G5) Patient Safety Strategy due a refresh. Newly introduced and not yet embeded incident reporting system. Limited accurate safety data to inform trends and targeted improvements. Variable levels of demonstrable risk and patient safety knowledge across the Trust	Undertake trust-wide safety culture survey and associated action plans. Foster clinical leadership in patient safety initiatives. **Action Owner**: Chief Nurse **Due date**:31/03/23	New Associate Director of Clinical Governance and Patient Safety post commenced in post November 22. Patient Safety Committee refreshed - Consultant chair appointed. Patient Safety Incident Response Framework (PSIRF) initial implementation plan drafted, participation in regional PSIRF collaborative and benchmarking to commence with The Royal Marsden Hospital and The Christie.	
			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	Established IPC Team Weekly data reported via Silver Command meeting Monthly 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	Acceptable			G6) Monthly scrutiny panel with specialist commissioner input	Establish monthly Nosocomial Infection Performance Review meeting **Action Owner**: Chief Nurse **Due date**: 31/03/23 (revised from 30/09/22)	Discussion underway with commissioning quality team. Meeting planned January 2023 to agree new ICB Quality reporting arrangements.	
			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	Patient Flow Report Bi-annual safer staffing report to Quality Committee and Board		Partial			G7) Variable levels of demonstrable patient accuity assessment knowledge across the Trust	Targeted training for inpatient service staff on the use of safer nursing care tool **Action Owner**: Chief Nurse **Due date**: 31/03/23	Data collection tool refined and data validation completed. Task & finish group established to optimise use of digital solution.	

Additional narrative

During 2022/23 existing governance stytems and processes are being reviewed and refreshed to ensure they meet the requirements to evidence a safe, caring, responsive, effective and Well-led organisation. Lack of knowledge, experience and requisit personnel within the clinical and corporate governance service has resulted in unclear and fragmented processes. The introduction of a new governance committee structure, clearer lines of responsibility and mechanisms to ensure accountability are embedding. Clinical engagement in key governance committees, the recruitment of new staff and development of a new aggregated patient safety and experience report wil all be key milestones through out this financial year.

BAF2. Demand exceeds resources
RISK APPETITE: Contractual and regulatory compliance, patient experience, KOF (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?)*	Internal assurance	Board Assurance External assurance	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 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:** **4** November 2022	**Causes** 1. Changing patterns of demand 2. Workforce gaps 3. Covid threat alters the operating environment indefinitely 4. Waiting list backlogs at referring Trusts 5. Population health needs change due to long-term effects of Covid **Consequences** 1. Ineffective restoration of services 2. Detrimental impact on patient care and experience 3. Poorer outcomes for patients 4. 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 and CCC CWT performance discussed at Trust Board via IPR	MIAA programme includes review of cancer waiting times systems and processes	**Acceptable**	**4 x 3 = 12**	**No**	G1) CCC has no control over the impact of the pandemic on activity flows from referring Trusts	Capacity & Demand monitored daily. Weekly monitoring of CMCA data **Action Owner**: COO **Due date**: 31 March 2023	Currently delivering capacity to meet demand. Weekly monitoring of activity	**4 x 3 = 12**
			C2) C&MCA activity plan cascaded to all senior managers to aid planning **Control Owner**: COO	C&MCA waiting time report is a standing agenda itemat Trust Operational Group		**Acceptable**			G2) Referring Trusts may increase their recovery activity without understanding impact on CCC	Request to COOs at referring Trust for updates on planned increases/ changes to recovery plans **Action Owner:** COO **(Complete)**	Ongoing discussions with COOs across C&M via weekly COOs meetings	
			C3) Cancer Waiting Times Dashboard updated daily, CWT team alert senior managers to any issues with flow of referrals **Control Owner**: COO	Oversight & utilisation of escalation processes demonstrated at Divisional Performance Review Groups (PRGs) and reported via COO's report to Performance Committee	C&MCA activity plans monitored by ICS, monthly reporting back to Trusts across C&M via hospital cell	**Acceptable**			G3) Further waves of increases in Covid incidence may affect workforce and therefore reduce capacity to deliver the Trust recovery plan	Monitor Trust recovery plan via Trust Operational Group **Action Owner**: COO **(Complete)**	Trust recovery Plan now monitored via TOG from 1.7.22	
			C4) Recovery and escalation plan to meet NHS System Oversight Framework Metrics **Control Owner**: COO	Progress reported monthly via Finance update at Trust Board and quarterly to Peformance Committee. Activity monitored via PRGs.	Trust activity plans monitored by ICS, monthly reporting back to Trust via hospital cell. ERP activty reports indicate CCC is deliverering according to plan.	**Acceptable**			G4) High number of late referrals to CCC due to delays in diagnostic capacity, this is creating challenge to delivery of the 62 day target for C&M	1. Refer to C&M diagnostics delivery plan **Action Owner**: CEO **Due date**: April 2023. 2. CCC to work with referring trusts with highest number of late referrals **Action Owner**: COO **Due date**: April 2023	CCC CEO is the SRO for C&M Diagnostics recovery programme, clear improvement programme in place. Monitored at ICS and via national cancer Team. Diagnostic work completed by C&MCA Oct 2022, CCC Team now engaged with LUHFT to improve most challenged pathways by March 2023.	
			C5) Live dashboard of new referrals & SACT activity available to Divisional Teams **Control Owner**: COO	Divisional Performance Review meetings held monthly and/or quarterly with outcomes reported to Performance Committee	Trust performance and activity against CWTs monitored by CMCA	**Acceptable**			G5) Referral numbers continue to rise, highest on record in Sept 2022	Site Rerence Groups (SRGs) monitoring activity, capacity challenges escalated to managers daily. Additional clinics in place across a number of tumour groups. **Action Owner:** COO **(Complete)**	Daily escalation supporting early intervention	
			C6) Daily & weekly flow monitoring via registrations team and Trust Operational Group **Control Owner**: COO	Reported and monitored via weekly Trust Ooperational Group (TOG)	MIAA review cancer waiting times	**Acceptable**			G6) Clinicians not always able to accommodate additionl activity	SRGs working as one to offer patients an appointment with alternative clinician who may have capacity within the specialist area. **Action Owner:** COO **(Complete)**	This is now an ongoing action, patients routinely offered an alternative appointment with another clinician whenever possible	
			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		**Acceptable**			G7) Late referrals to CCC make it difficult for CCC to consistently achieve 62 day target	CCC Team now engaged with all referring trusts to improve timeliness of referrals **Action Owner:** COO **Due date:** 31 March 2023	Referral data to be shared at Cheshire and Mersey Cancer Managers Group Nov 2022	
			C8) Weekly activity monitoring and escalation via Trust Operational Group and PTL meetings **Control Owner**: COO	IPR to Performance Committee quarterly and Board (monthly), Divisional PRGs		**Acceptable**						
			C9) Allocation of first appointments monitored by registrations team. Lack of capacity escalated to relevant senior manager **Control Owner:** COO	Capacity monitored via weekly TOG		**Acceptable**						
			C10) WLI clinic can be expanded to meet demand **Control Owner:** COO	Capacity monitored via weekly TOG		**Acceptable**						
			C11) CCC monitoring internal 24 day target **Control Owner**: COO	Weekly at TOG, monthly IPR to Trust Board and quarterly to Performance Committee, PRGs		**Acceptable**						
			C12) 62 day target to be 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	**Partial**						
			C13) 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. Divisonal BPs to be presented at Trust Performance Committee via a rolling programme.		**Acceptable**						

Additional narrative

Despite multiple mitigations, the risk score cannot currently be reduced below 12. Uncertainty regarding future waves of the Covid pandemic and the uncertain 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. Further to discussions regarding the likelihood of ongoing financial uncertainty at Performance Committee in August 2022, the target score has been increased from 6 to 12 to reflect this.

BAF3. Insufficient funding
RISK APPETITE: Financial LOW (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*	Board Assurance: Internal assurance	Board Assurance: External assurance	Board Assurance: Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF3 There is a risk of **available funding being insufficient** to deliver the Trust's strategic priorities **Executive Risk Lead:** James Thomson, Director of Finance **Board Committee**: Performance **Last Update:** 16 November 2022	**Causes** 1. Changes to the commissioning regime and funding process 2. Inability to meet patient demand without further investment 3. Inability to deliver further efficiencies 4. Inflationary pressure 5. Management of the ICB financial position (deficit) might negatively impact funding position or efficiency requirement **Consequences** 1. Re-evaluate cost base and resource levels 2. Review strategic ambitions if additional resource required 3. Increased performance management from NHSE/I and ICB 4. Reduced Trust board risk appetite 5. Reduced ability to invest in capital infrastructure and staff	4 x 5 = 20	C1) Divisional and departmental budget setting process **Control Owner**: DoF	Planning process managed through Finance Committee and reported quarterly to Performance Committee. Budgets approved by lead managers.	External Audit includes assessment of plan though VFM testing (reported to Audit Committee). National Financial Sustainability exercise by MIAA (HFMA checklist) - Q3 22/23.	Acceptable	4 x 4 = 16	No	G1) None identified at this stage.	Start budget setting cycle in Q3 2022/23 - in line with national financial guidance publication. Take complete budget plan to Trust Board by March 2023. **Action Owner**: DoF **Due Date**: 31/03/23	Not applicable at this stage in the financial year. Trust submitted HFMA checklist - September 22.	2 x 4 = 8
			C2) Contract position agreed and managed with commissioners **Control Owner**: DoF	Monthly formal contract meetings with commissioners. Annual planning process, with rebasing exercise.	Commissioner (NHSE/ICB) review of contract perfromance - quality and commercial.	Acceptable			G2) Need to verify NHSE's calculation of 22/23 Elective Recovery Fund	Trust to review NHSE contract data and process when available **Action Owner**: DoF **Due Date:** 31/12/22 (revised from 30/09/22)	Trust requested ERF activity data from ICB and commissioners. Trust working with RMH and The Christie on options for ERF and approach for cancer pathways	
			C3) Efficiency (CIP) and productivity plan in place - with clear cash releasing schemes **Control Owner**: DoF	Performance managed through Finance Committee (total) and Pefromance Review Groups (PRGs) and reported via Finance Report to Performance Committee and Board. Dedicated finance lead. Process for MD and CNO review.	External Audit includes assessment of plan though VFM testing. Efficiency programme monitored monthly by NHSE/I. National Financial Sustainability exercise by MIAA (HFMA checklist) - Q3 22/23.	Acceptable			G3) Assurance on recurrent CIP delivery pipeline to be confirmed. Productivity analysis of core services to be complete	1. Escalate CIP non-delivery as required through Performance Committee. 2. Produce productivity analysis for Performance Committee. 3. Deep dive requested by Performance Committee. **Action Owner**: DoF **Due date:** 31/03/23	CIP profiles agreed with operational divisions and departments. Quantum of CIP included in ICB planning. Trust providing Deep Dive report to November Performance Committee. Trust submitted HFMA checklist September 22.	
			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	Acceptable			G4) Impact of system financial position and risk management approach to be established	Trust to monitor system financial position monthly. **Action Owner:** DoF **Due date:** 31/12/22	Trust has visibility of 2022/23 financial system plans and plans of other Trusts.	
			C5) Trust included in emerging system financial planning **Control Owner:** DoF	DoF updates through Financial Planning Reports to Performance Committee and Trust Board. Chair and Executives included in ICB peer networks.	ICB receives governance score through Strategic Outcomes Framework rating.	Partial			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:** 31/12/22	Executives participate in peer ICB networks. Trust working with partners in Liverpool health system to support, following Camall 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	Acceptable			G6) Capital decision making governance for C&M ICB not established	Trust toreview multi-year capital rogramme quaterly, and escalate to ICB capital governance system as required. **Action Owner:** DoF **Due date:** 31/03/23	Trust capital plan for 2022/23 agreed with ICB. 5 year capital plan submitted as part of ICB planning exercise. Trust Capital Committee commenced future capital service need review - September 22	

Additional narrative

The financial system for 2022/23 is a transition period. This is because of structural change of ICB/system working and establishing financial income flows for the Trust. Key risks include securing sufficient funding through contractual mechanisms, including ERF, and delivering the efficiency programme.
The Target Risk Score has been increased from 4 (2x2) to 8 (2x4). The Trust recognises that 23/24 will be a further transition year regarding commissioner process and relationships. On this basis the impact assessment has been increased, as the funding impact could relate to elective and non-elective income streams. The probability remains at 2, as it remains highly likely that a financial planning process will be required, which provides a framework for managing this risk. Planning guidance is expected in December 2022 or January 2023.

BAF4. Board governance
RISK APPETITE: Mandatory compliance LOW (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	Board Assurance: External assurance	Board Assurance: Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
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:** 30 September 2022	**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	C1) Risk management strategy 2022 (RMS) and risk registers **Control Owner**: Chief Nurse	Risk management strategy annual update report - Quality Committee and Board Annual Clinical Audit Report, reviewed by Quality Committee Risks monitored through monthly Risk and Quality Governance Committee; operational risk reports to Board Committees with escalation route to Board via Chairs' reports. Annual Risk Management Report to Quality Committee and Board	Audited Quality Account, reviewed by Quality Committee, June 22 MIAA audits of key systems: Risk Management, Substantial Assurance March 22; Incident reporting, Limited Assurance April 22; Claims, Substantial Assurance, 2021/22	Partial	3 x 4 = 12	No	G1) Requirement for further development of clinical audit programme. MIAA recommendations for incident reporting and risk management process.	1. Develop the clinical audit programme and align to clinical governance structures and processes 2. MIAA audit improvement plan 3. Review risk management strategy **Action Owner**: Chief Nurse **Due date**: 31/03/23	Review of Risk Management Strategy underway. Awaiting publication of Patient Safety Strategy Framework national documentatin in order to align Incident Reporting Processes.	2 x 4 = 8
			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 reccomendations made in the Well Led Development Review (WLDR)	Acceptable			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	Additional support for corporate governance confirmed until end of the financial year. Recruitment of substantive Associate Director of Corporate Governance underway.	
			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	Partial			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)	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 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.	
			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	Acceptable						
			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	Partial			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**: 31/03/23	Early scoping underway.	
			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	Acceptable			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 (**Comolete**)	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	Acceptable						

Additional narrative

Significant changes have been made to both the corporate and clinical governance processes and teams in recent months. Good progress has been made in terms of strengthening corporate governance processes and the Well Led Development Review was largely positive with an action plan in place to close any gaps. The 2022-3 BAF is complete with clearer description of governance, controls, gaps and actions. There is further work to be undertaken on the development of the Quality Strategy in 2022-3 but there has

BAF5. Environmental sustainability
RISK APPETITE: Regulatory Compliance LOW (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	Board Assurance: External assurance	Board Assurance: Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
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:** 14 November 2022	**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 and summary version published. Board-level sustainability lead identified. **Control Owner**: Director of Strategy	First annual report on Green Plan delivery due to be presented to Performance Committee February 2023 and to Board March 2023	Quarterly national 'Greener NHS' NHS England data collection exercise	**Partial**	**4 x 3 = 12**	**No**	G1) 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)** 2. Develop short-term action plan with programme manager to deliver early priorities **Action Owner**: DoS **Due date**: 31st July 2022 **(Complete)** 3. Recruit substantive Sustainability Programme Manager	Control gap partially addressed through completion of actions 1 and 2. Substantive role advertised and vacancy closed for shortlisting on 11th November 2022.	**3 x 3 = 9**
			C2) Multidisciplinary Sustainability Action Group formed to support delivery of the Green Plan action plan - supported by interim Sustainability Manager for 6 months. **Control Owner**: Director of Strategy	Programme reports to be reviewed quarterly at Sustainability Action Group following first annual report in February 2023. Escalation of relevant issues will be through chair's report to Performance Committee.		**Partial**			G2) Sustainability Action Group not yet fully functioning	1. Engage with current members to ensure engagement and participation 2. Review terms of reference including membership, accountabilities **Action Owner**: DoS **Due date**: 5th September 2022 **(Complete)**	Additional members invited. Existing members encouraged to prioritise and engage in delivery of the action plan. Terms of reference reviewed. Group now functioning well with good engagement and work progressing. Substantive Programme Manager appointment vital to maintain progress.	
			C3) Build specification of CCC-L supports Trust's environmental sustainability commitments, with potential to improve further. **Control Owner**: PropCare Managing Director	Monitoring of CCC-L building management system (BMS)		**Partial**			G3) Development of the delivery mechanisms for key workstreams identified in the Green Plan	1. Develop green travel plan **Action Owner**: DoS **Due date**: 31st October 2022 (launch expected early 2023) 2. Develop and deliver sustainability staff engagement programme **Action Owner**: DoS **Due date**: 31st October 2022 (new date tbc) 3. Develop waste management proposals to include waste segregation facilities to support recycling **Action Owner**: DoS	Green travel plan drafted following successful green travel survey with staff. To be refined for launch early 2023. Staff enagement programme deferred to link with staff health and wellbeing engagement programme in 2023. Current waste management processes under review. Results to be set out in Green Plan annual report.	
									G4) CCC-W redevelopment plans not yet developed	1. Creation of new projects division in PropCare **Action Owner**: PropCare MD **Due date**: 31st July 2022 **(Complete)** 2. Development of proposals for redevelopment of CCC-W to include sustainability considerations **Action Owner**: DoS/PropCare MD **Due date**: 31st Dec 2022	PropCare Projects now in place. High level redevelopment options in development. Architects engaged to develop high level options over 3-week period of Nov/Dec 2022.	

Additional narrative

The Trust has previously promoted sustainability in certain areas, for example cycle to work schemes and active travel facilities. The newly-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. The current risk score reflects the opening of the new, modern CCC-L building which marks a milestone in upgrading the Trust's estate.
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) has necessitated consideration of interim solution - interim sustainability manager now in post for 6 months from July to December 2022. PropCare projects division also formed - significant contribution to green agenda, including through progressing CCC-W redevelopment.

BAF6. Strategic influence within ICS

RISK APPETITE: Partnership working MODERATE (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?)*	Internal assurance	Board Assurance External assurance	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 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:** 30 September 2022	**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		**Acceptable**	**3 x 4 = 12**	**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 Board monthly 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. Monthly CMCA performance reports are circulated to acute/ST providers CEO,COOs and Place Leads and reported fortnightly to CMAST	**Acceptable**			G2) Lack of clarity about cancer reporting to ICB (control gap closed July 2022) Additional: CMCA plans for 2023-24 to be developed and submitted by end of Q4	New action: Complete business plans for 2023-24 **Action Owner**: CEO **Due date**: March 2023	Monthly CMCA cancer performance reports are incorporated into the ICB monthly Integrated Performance Report with bi-annual deeper dive report (next due 26 Jan 2023). Weekly tier 1/2 meetings continue. CMCA also report on monthly KLOEs ahead of the Regional Elective Oversight Meeting and fortnightly to CMAST. Planning for 2023-24 underway now funding has been confirmed	
			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	Diagnostic Delivery Board established and diagnostic performance reports into CMAST (fortnightly) and ICB Integrated Performance Report (monthly)	**Partial**			G3) Risk sharing agreement with ICB not in place	Finance Manager and HR manager to be appointed for the Diagnostic Programme **Action Owner:** CEO **Due date:** 30 November 2022 (revised from July 2022) **(complete)** Complete risk sharing agreement with ICB **Action Owner**: CEO **Due date**: 1 April 2023 (revised from November 2022, revised	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	
			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)	**Acceptable**			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	By 1 April 7 CDCs will be opened, and national funding secured	
			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		**Acceptable**			G1) WLDR report highlighted need to increase senior capacity and visibility in ICS to take on greater leadership role	1. Broaden executive directors' stakeholder engagement in ICS **(complete)** 2. Develop marketing plan to strengthen CCC brand and raise profile of senior leaders **Action Owner:** Dir of Strategy **Due date:** April 2023	1. Executive directors attending respective C&M leadership fora 2.Comms and Marketing Strategy in progress, preferred marketing provider engaged	

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

BAF7. Research portfolio
RISK APPETITE: Clinical Innovation MODERATE (tolerance 9-12)
STRATEGIC OBJECTIVE: Be Research Leaders

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the*	Board Assurance: Internal assurance	Board Assurance: External assurance	Board Assurance: Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
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:** 6 December 2022	**Causes** 1. Reliance on partners to maintain Experimental Cancer Medicine Center (ECMC) status 2. Liverpool unsuccessful for BRC and CRUK 3. Service pressures impact upon research capacity **Consequences** 1. Failure to achieve status as a leading cancer research centre 2. Insufficient future funding to sustain planned research programmes 3. Failure to develop new treatments for patients 4. Reputational damage	**3 x 5 = 15**	C1) Research Strategy 2021-2026, approved by Trust Board **Control Owner**: Medical Director	Research Strategy Business Plan updates reported quarterly to Performance Committee		**Acceptable**	**3 x 4 = 12**	**Yes**	G1) ECMC status requires renewal from April 2023	Development and submission of ECMC application **Action Owner**: Medical Director **Due date**: 30 June 2022 **(Complete)**	Complete. Bid successfully submitted 30 June 2022. Outcome awaited.	**2 x 4 = 8**
			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		**Acceptable**			G2) Early Phase Trials Unit Operational Policy required and recruitment of support staff	1. Policy to be developed and approved by TIC **(Complete)** 2. Recruitment of Early Phase Clinical Research Fellow **Action Owner**: Medical Director **Due date**: 31 March 2023	1. Policy approved at July 2022 TIC. 2. Funding identified for post, and progressing through recruitment process.	
			C3) ECMC clinical trials open **Control Owner**: Medical Director	Quarterly ECMC updates to Research Strategy Committee reporting to Quality Committee		**Acceptable**			G3) Clinical trial pharmacy staffing capacity	Appointment of Deputy Clinical Trials Pharmacist **Action Owner**: Medical Director **Due date**: 30 June 2022 **(Complete)**	Deputy Clinical Trials Pharmacist appointed. Started in post July 2022. Advanced Pharmacist (0.4WTE) started August 2022.	
			C4) Successful collaborative bid securing funding as an NIHR Clinical Research Facility 2022 for 5 years **Control Owner: Medical Director**	Quarterly CRF updates to Research Strategy Committee reporting to Quality Committee		**Acceptable**			G4) CRF governance arrangements	Governance structure to be established for September Action Owner: Medical Director **Due date**: 14 October 2022 (original 31 August 2022) **(Complete)**	CRF meeting held between LUHFT and CCC CRFs June 2022. Governance structure agreed with LUHFT October 2022.	
			C5) Collaboration with major cancer centre for Biomedical Research Centre bid 2022 **Control Owner**: Medical Director	Quarterly BRC updates to Research Strategy Committee reporting to Quality Committee		**Acceptable (improved from partial)**			G5) BRC bid outcome awaited May 2022	Report outcome to Research Strategy Committee when received **Action Owner**: Medical Director **Due date**: 31 October 2022 (original 31 May 2022) **(Complete)**	Successful outcome - CCC in collaboration with Royal Marsden Hospital Biomedical research centre; steering committee established and workstreams identified.	
			C6) 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	**Acceptable**			G6) Aseptic Unit recovery reliant on Pharmacy staffing	Appointment of aseptic pharmacy staff **Action Owner**: Medical Director **Due date**: 31 October 2022 **(Complete)**	Aseptic services staffing is at establishment for current delivery model.	
			C7) Pharmacy Aseptic Unit recovery plan in place since 30 August 2021 **Control Owner**: Medical Director	Monitored monthly by Performance Review Group with exceptions only escalated to Quality Committee		**Partial**			G7) Study opening reliance on pharmacy staffing plan	See G3		
			C8) Study Prioritisation Committee meets monthly **Control Owner**: Medical Director	Monthly updates to R&I Directorate Board; studies opening in month included in Trust Board IPR with exception report		**Partial**			G8) Internal and external service pressures impacting on trials opening	1. Monitor progress against plan with Pharmacy. **Due date**: June 2023 2. Revised clinical trial portfolio leading to additional service requirements eg Interventional Radiology (IR), see below action. **Due date**: April 2023 3. Develop Research vision for the CCC IR Service to remove dependance on third party providers. **Due date**: June 2023	1. Weekly and Monthly operational meetings in place. 2. Research Priority meeting held 14/11/22 to propose priorities for CCC. Follow-up meeting January 2022 followed by wider engagement. 3. Meeting organised 19/12/22.	

Additional narrative

Key controls will provide mitigation against the likelihood of adverse outcome to current bid renewal and consequences of any adverse outcome; 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

BAF8. Research resourcing

RISK APPETITE: Clinical Innovation, financial & [0o]-[12]-[15] (tolerance 9-12)

STRATEGIC OBJECTIVE: Be Research Leaders

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	Board Assurance: External assurance	Board Assurance: Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
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:** 8 November 2022	**Causes** 1. International competition for specialist research skills 2. Reliance on partners to secure major sources of funding 3. Current vacancies 4. Funding shortfall following the Covid pandemic **Consequences** 1. Failure to develop new treatments for patients 2. Failure to achieve status as a leading cancer research centre 3. Loss of status and influence 4.Inability to deliver planned research programmes	**3 x 5 = 15**	C1) Research Strategy Funding ringfenced to support Early Phase Clinical Trial Infrastructure and future growth in capacity **Control Owner**: Medical Director	Research Strategy Business Plan update reported quarterly to Performance Committee from January 2021		**Partial**	**3 x 4 = 12**	**Yes**	G1) Early Phase staffing capacity	Recruitment of Early Phase staff **Action Owner**: Director of Clinical Research **Due date**: March 2023 (revised from 31 December 2022)	Staffing gaps identified. Financial resource agreed. Recruitment process underway. Workforce plan agreed in-line with ECMC and Research Strategy funding.	**2 x 4 = 8**
			C2) Monitoring of use of funding (£2M allocated to the Research Strategy for year 2) **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	**Acceptable**			G2) ECMC funding until March 2023	ECMC bid submission 2023-27 **Action Owner**: Medical Director **Due date**: 30 June 2022 **(Complete)**	**Bid submitted** within due date with CCC and UoL oversight; funding contribution from CCC identified from R&I envelope; outcome due December 2022	
			C3) Required research establishment is set out in Board approved Research Strategy **Control Owner**: Medical Director	Quarterly updates to Research Strategy Committee and Trust Executive Group; Business Plan update quarterly report to Performance Committee		**Partial**			G3) Recruitment required to reach full establishment in line with approved Research Strategy	Identify funding sources to recruit academic posts in line with Research Strategy **Action Owner**: Medical Director **Due date**: 31 March 2023	On plan in line with Research Strategy 2022/3	
			C4) Successful collaborative bid securing funding as an NIHR Clinical Research Facility 2022 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.		**Acceptable**			G4) CRF governance arrangements	Governance structure to be established for September **Action Owner**: Medical Director **Due date**: 14 October 2022 (Original 31 August 2022) **(Complete)**	CRF meeting between LUHFT and CCC CRFs June 2022; launch meeting scheduled September 2022 moved (national mourning) to November 2022. Governance structure agreed with LUHFT October 2022	
			C5) Major bid development - Biomedical Research Centre **Control Owner:** Medical Director	Bid development monitored via Research Strategy Committee		**Partial**			G5) BRC bid outcome awaited May 2022	Report outcome to Research Strategy Committee when received **Action Owner**: Medical Director **Due date**: 31 May 2022 **(Complete)**	Outcome previously under embargo; embargo lifted October 2022 and confirmed successful bid in collaboration with Royal Marsden Hospital	
									G6) Contribution from Clatterbridge Cancer Charity in line with the Research Strategy	Delivery of 1st year fundraising activity **Action Owner:** Medical Director **Due date**: 31 March 2023	Annual activity plan in place; additional contribution to suppport BRC confirmed; Clatterbridge Research Funding Scheme 2022 announced closing March 2023; successful application from Professor Ottensmeier to enhance research into cancer and immune system	

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.

BAF9. Leadership capacity and capability
RISK APPETITE: Workforce LOW (tolerance 4-9)
STRATEGIC OBJECTIVE: Be a Great Place to Work

Risk description & information	Causes & consequences	Initial (inherent) risk score	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance	Board Assurance: External assurance	Board Assurance: Overall assurance level	Residual risk (current) score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF9 There is a risk that **leadership capacity and capability at the Trust is insufficient** to drive the changes required to achieve its strategic ambitions **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee**: People **Last Update:** 13 December 2022	**Causes** 1. Leadership development required to adapt to system reforms and strategic ambitions 2. Multiple changes in the operating environment divert leadership capacity **Consequences** 1. Inability to adapt quickly enough to keep pace with system changes 2. Inability to manage competing priorities 3. Ineffective decision-making 4. Insufficient leadership visibility to drive change and right culture 5. Reduced health, wellbeing and morale for senior staff 6. Reputational damage	4 x 4 = 16	C1) Leadership passport programme **Control Owner**: Director of WOD	Bi annual updates to Workforce Assurance Group (September). Annual Learning and Organisational Development Report People Committee (March).	National Staff Survey Report People Committee and Board (March). Improvement in national staff survey scores.	**Acceptable (improved from partia)**	3 x 4 = 12	No	G1) Lack systematic processes throughout the Trust to support leadership development	1. Further refine and enhance the leadership and development on offer, ensuring its accessibility to all staff **Action Owner**: Director of WOD **Due date**: 30/11/22 (original date 30/06/22) **(Complete)**	Learning and Development prospectus developed, alongside the Leadership and Management passport. Leadership masterclasses in place. Leadership toolkit launched and available on the intranet. Increased offering of national recognised leadership programmes via the Trust apprenticeship levy and short personal development programmes developed. Review of findings of the Messenger Review completed and reported to WAG in September 22 and awaiting next steps from ICB.	3 x 3 = 9
			C2) Leadership programme for Divisional Triumvirates - Team at the Top **Control Owner**: Director of WOD	Bi annual updates to Workforce Assurance Group (September). Annual Learning and Organisational Development Report People Committee (March).	National Staff Survey Report People Committee and Board (March).	**Partial**				2. Design and implement a range of leadership development programmes for senior leadership, ensuring they have the skills and knowledge to effectively lead and transformation services **Action Owner**: Director of WOD **Due date**: 31/08/2023 (original 30/06/22, 31/12/2022)	Team at the Team programme nearing completion. Coaching support provided to senior leaders. Head of L&OD developing a senior leaders programme for band 8a.	
			C3) Coaching programme (all levels) **Control Owner**: Head of Learning and OD	Bi annual updates to Workforce Assurance Group (September). Annual Learning and Organisational Development Report People Committee (March).	National Staff Survey Report People Committee and Board (March).	**Acceptable (improved from low)**			G2) No systematic process throughout the Trust to support Talent management	Design and implementation of a systematic approach to Talent Management **Action Owner**: Director of WOD **Due date**: 31/03/23	Shadow Board cohort 1 programme completed, with review paper provided to Trust Board. The group will continue in 2023 and a further funding application for cohort 2 will be submitted in April 2023. Appraisal paperwork redesigned to support talent management conversations and BI dashboard developed to enable ease access to talent/career ambitions data. In-house coaching network in place to support career coaching. Work on developing talent management programme delayed due	
			C4) Medical Leadership development programme of work **Control Owner**: Director of WOD	Bi annual updates to Workforce Assurance Group (September). Annual Learning and Organisational Development Report People Committee (March).	National Staff Survey Report People Committee and Board (March).	**Partial (new)**			G3) Lack of leadership development approach specific to medical staff	Develop a programme of work that increases medical leadership awareness and engagement **Action Owner**: Director of WOD **Due date**: 31/03/23 (original date 30/04/22)	Working with external company to develop framework to support medical leadership development including coaching offer. Appraisal processes for medical leaders developed. Engagement with the NW Emerging clinical leaders programme. OD diagnostic undertaken as part of Medical Leadership and Engagement review and roll out of deliver against actions to commence in 2023.	
			C5) Shadow Board programme to develop future leaders **Control Owner**: Director of WOD	Shadow Board Programme completion reported to Trust Board. Bi annual updates to Workforce Assurance Group (September). Annual Learning and Organisational Development Report People Committee (March).	National Staff Survey Report People Committee and Board (March).	**Partial (new)**						
			C6) People Commitment outlines our plans for the next five years to build an inclusive and compassionate culture and enhance our leadership skills and capacity **Control Owner**: Director of WOD	Bi monthly reports to People Committee outlining progress against plan. Quarterly updates to be linked to the strategic themes 'Be a great place to work'.	National Staff Survey Report People Committee and Board (March).	**Partial**						

Additional narrative

Leadership development programmes and some associated workstreams have been impacted by the pandemic. The target date for completion reflects the work undertaken to date and the outstanding work to be completed.

BAF10. Skilled and diverse workforce
RISK APPETITE: Workforce LOW (tolerance 4-8)
STRATEGIC OBJECTIVE: Be a Great Place to Work

Risk description & information	Causes & consequences	Initial (inherent) risk score	Key controls *(what is in place to manage the risk?)*	Internal assurance	Board Assurance External assurance	Overall assurance level	Residual risk (current) score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF10 There is a risk of being **unable to attract and develop a diverse and highly skilled workforce**, which could limit the Trust's capacity to deliver and develop further its specialist services **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee**: People **Last Update:** 13 December 2022	**Causes** 1. Different expectations of younger people entering the workforce 2. Perceived or real cultural barriers for BAME staff 3. Poor perception of NHS as a place to work 4. 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	**4 x 4 = 16**	C1) Equality, Diversity an Inclusion action plans (WRES/WDES/ EDS2) **Control Owner**: Director of WOD	Action plan updates through EDI group and People Committee. Results and action plan reported to Trust Board and People Committee.	WRES & WDES 2022 Annual Reports incl external benchmarking data, reviewed at People Committee and Trust Board	**Acceptable**	**3 x 4 = 12**	**No**	G1) No dedicated lead for EDI for the Trust	EDI lead to be appointed and service agreement to be developed **Action Owner**: Director of WOD **Due date**: 30/04/22 **(Complete)**	New EDI lead joining the Trust in January 2023 and will develop an EDI improvement plan to be reported to People Committee in March 2023.	**3 x 3 = 9**
			C2) Inclusive Recruitment processes (NHSIE framework) **Control Owner**: Director of WOD	Managed through EDI group and assurance reported quarterly though People Committee	WRES & WDES 2022 Annual Reports incl external benchmarking data, reviewed at People Committee and Trust Board	**Acceptable**			G2) Revised Recruitment policy	Full scale review of policy underway to support the NHSIE 6 Actions for Inclusive recruitment **Action Owner**: Director of WOD **Due date**: 31/10/22 (original date 31/08/22)	Review underway, WRES/ WDES annual reports to be published in October 2022 which outlines plans for next 12 months	
			C3) Retention plans of critical staff groups **Control Owner**: Director of WOD	Turnover KPIs monitored month through IPR and through Trust sub-committee structure		**Partial**			G3) Robust clinical skills/ development programme for clinical staff	Review of clinical skills offer and ensure clinical staff have access to relevent training and development oppourtunities **Action Owner**: Chief Nurse **Due date**: 29/02/23 (original date 31/07/22, 31/11/22)	Task and finish group established to review all role essential and clinical skills training. Further work need to develop clinical competency pathways to support the removal of some role essential training programmes.	
			C4) Revised Values Framework launched February 2022 **Control Owner**: Director of WOD	Annual staff survey results, to be reviewed by People Committee annually		**Acceptable**			G4) Values based recruitment framework	Embed a model of values based recruitment **Action Owner**: Director of WOD **Due date**: 31/03/23 (original date 31/12/22)	New values embedded into recruitment literature. Work commenced on developing a new vales based recruitment training programme, but implementation delayed and will now be included as a key priority in the year 2 People Commitment implementation plan. Staff Survey 2022 took place between September and November. Increase in completion rates. Results expected in early 2023.	
			C5) Recruitment Development and Improvement Plan **Control Owner**: Director of WOD	Update to Workforce Assurance Group bi-monthly		**Partial (new)**			G5) Digitally streamlined recruitment and on boarding processes	Streamline transactional processes for recruitment to ensure we adopt digital solutions **Action Owner**: Director of WOD **Due date**: 31/03/23 (original date 30/09/22, 30/10/22)	Recruitment Improvement Plan agreed at People Committee in June 2022 and new divisional model implemented. Proposal taken to RPA/ SharePoint operational group to identify areas of WOD transactional processes that can be digitised. Good progress has been made on scoping and developing blue prints for the automation of HR processes and testing is underway. There have been some delays due to vacancy gaps and absences within the Workforce Systems Team.	
			C6) Participation in ICS international recruitment campaigns for Nursing and AHPs. AHP recruitment strategy in place. **Control Owner**: Chief Nurse	Update to Workforce Assurance Group bi-monthly. Recruitment and retention updates to People Committee.		**Partial**			G6) Clinical Education Strategy requires updating for 2022 onwards	New strategy to be developed in partnership with key stakeholders **Action Owner**: Chief Nurse **Due date**: 30/09/22		
			C7) Clinical Education strategy **Control Owner**: Chief Nurse	Monitored through People Committee quarterly. Annual Clinical Education Report to People Committee in September.		**Partial (new)**						
			C8) Appraisal and personal development process **Control Owner**: Director of WOD	PADR completion report to be reviewed monthly through IPR. Reports provided to People Committee. KPI for appraisal being achieved.	MIAA Staff Appraisals & Mandatory Training audit Q1 2022/23 - substantial assurance received	**Acceptable (improved from partial)**						

Additional narrative

Recruitment challenges exist across the NHS and challenges are significant for some hard to recruit to posts. This risk is increased due to the additional recruitment underway by LUFT to support the opening of new Royal Hospital

BAF11. Staffing levels
RISK APPETITE: Workforce, Patient Safety/ QoC (Tolerance 4-8)
STRATEGIC OBJECTIVE: Be a Great Place to Work

Risk description & information	Causes & consequences	Initial (inherent) risk score	Key controls *(what is in place to manage the risk?)*	Internal assurance	Board Assurance External assurance	Overall assurance level	Residual risk (current) score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 (L x C)
BAF11 There is a risk of **insufficient staffing levels in some areas of the Trust**, which could result in disruption to services and jeopardise the quality of care **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee**: People **Last Update:** 13 December 2022	**Causes** 1. Short-term and long-term staff absences 2. Vacancies 3. Misalignment of workforce planning, activity and finance 4. Lack of accurate and up-to-date workforce information and data **Consequences** 1. Inability to plan capacity effectively 2. Disruption to service delivery 3. Poorer patient care and experience 4. Failure to maintain CQC ratings 5. Reputational damage	4 x 4 = 16	C1) Targeted recruitment campaigns for hard to recruit roles (Nurses/ Radiographers) **Control Owner**: Director of WOD	Recruitment and retention updates reported quarterly to People Committee and monitored through recruitment and retention focus group		Acceptable	4 x 4 = 16	No	G1) Dedicated lead for recruitment for Nursing and AHP	Establish Recruitment and Retention focus group with key stakeholders **Action Owner**: Director of WOD **Due date**: tbc (original date 30/06/2022)	Working in partnership with Liverpool City Region Employment and Skills Team to promote roles and opportunities to local community groups. Develop and implement Career Insight Days, focusing on Nursing, AHP, Medical and Support Services Careers from April 2023. Actively work alongside schools, colleges, universities and local communities to attract a more diverse workforce.	3 x 3 = 9
			C2) E-roster implemented in all clinical areas in line with NHSIE Levels of Attainment **Control Owner**: Director of WOD	Reported bi-monthly through Workforce Assurance Group and monitored monthly through Systems Utilisation Group	MIAA E-Roster audit 2021/22, substantial assurance	Acceptable			G2) An E-Roster work plan is in place to support the achievement of NHSIE Levels of Attainment. Work is in progress but not complete	Detailed action plans to be developed and implemented for each clinical area to address gaps/areas of focus **Action Owner**: Director of WOD **Due date**: 31/03/2023	Audit completed in Dec 2021 that identified number of key actions. Refreshed Trust-wide project plan agreed to support Level of Attainment. Divisional work groups identified to address specific gaps/areas of focus for each area.	
			C3) Implementation of E-job planning for medics and advance practice roles **Control Owner**: Director of WOD	Reported bi-monthly through Workforce Assurance Group and monitored monthly through Systems Utilisation Group	MIAA Medical Job Planning audit planned Q3 2022/23	Acceptable			G3) Procurement of new E-job planning system	Procure new system to support e-job planning **Action Owner:** Director of WOD **Due date**: 30/06/2022 **(Complete)**	Procurement process concluded Sept 2022. Workforce systems team developing implementation plans for the transition of systems. New system to go live January 2023. Backup of current system procured to support transition.	
			C4) Bank framework to support temporary gaps in the workforce **Control Owner**: Director of WOD	Reported bi-monthly through Workforce Assurance Group and Divisional Performance reports		Acceptable			G4) Implementation workforce planning model and tools for the Trust	Development and implementation of workforce planning tools **Action Owner**: Director of WOD **Due date**: 31/03/2023	National guidance received and being reviewed by WOD and finance.	
			C5) Robust workforce plans for all clinical areas **Control owner:** Director of WOD	Workforce Planning updates reported quarterly to People Committee		Acceptable			G5) Automation of ESR reporting	1. Joint working between WOD and BI to automate current reporting processes 2. Validation of data 3. Build of WOD metrics and PowerBI dashboard **Action Owner**: CIO and Director of WOD **Due date**: 31/03/2023	Member of WOD team working with BI to support automation of ESR reporting 1 day a week. ESR data is data warehouse-validation in progress.	
			C6) Real time reporting of workforce metrics including turnover and sickness **Control Owner**: Chief Information Officer	Reported bi-monthly through Workforce Assurance Group and monitored monthly through Systems Utilisation Group		Low			G6) Utilisation of Safe Care as the tool for reporting safe staffing levels at ward level	Joint working between WOD/ Digital/ Nursing teams to embed systems and ensure fit for purpose **Action Owner**: Chief nurse and Director of WOD **Due date**: 31/03/2023		

Additional narrative

BAF12. Staff health and wellbeing
RISK APPETITE: Workforce LOW (tolerance 4-9)
STRATEGIC OBJECTIVE: Be a Great Place to Work

Risk description & information	Causes & consequences	Initial (inherent) risk score	Key controls *(what is in place to manage the risk?)*	Internal assurance	Board Assurance / External assurance	Overall assurance level	Residual risk (current) score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF12 There is a risk of **decline in the health and wellbeing of staff**, which may result in increased absence and turnover, affect the Trust's ability to deliver services, and damage its reputation as an employer **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee**: People **Last Update:** 13 December 2022	**Causes** 1. Increase in mental health issues in the wake of the initial waves of Covid 2. Staff with 'long Covid' 3. Staff burn-out 4. Covid part of long-term operating environment **Consequences** 1. Loss of goodwill and staff engagement 2. Fluctuating capacity 3. Increase in long-term sickness 4. Increased staff turnover 5. Disruption to services 6. Reputational damage	**4 x 4 = 16**	C1) Occupational Health Service for staff **Control Owner**: Director of WOD	OH contract performance monitored quarterly and reported to Workforce Advisory Group annually (exceptions escalated to People Committee)		**Acceptable**	**3 x 3 = 9**	**No**	G1) Staff survey results state that only 55% of staff believe we take positive action on H&WB as a Trust	Review H&WB offer to staff **Action Owner**: Director of WOD **Due date**: 30/06/22 **(Complete)**	Review of offer complete and to be monitored on an ongoing basis. Recruited H&WB co-ordinator role. Successfully secured funding from the Charity to support Staff Wellbeing and Engagement. Developing role profile for a H&WB lead. Next step is to undertake NHSIE Health and Wellbeing Framework Diagnostic Tool by December	**2 x 3 = 6**
			C2) Employee Assistance Programme, including counselling, available for all staff **Control Owner**: Director of WOD	OH contract performance monitored quarterly and reported to Workforce Advisory Group annually Staff Survey results reported annually to People Committee		**Acceptable**			G2) MHFA are not embedded into the organisation/ routinely accesses for support	Implement Wellbeing Champions and a H&WB Champions group **Action Owner**: Director of WOD **Due date**: 30/02/23 (original date 30/09/22)	Commencement of this work delayed. New Engagement and Wellbeing coordinator to scope Wellbeing champion training offer and develop a proposal for recruitment. Role description designed and approved for champion role and will be advertised across the Trust in January 2023. New Engagement and Wellbeing Group to be set up by April 2023 to provide oversight on wellbeing activities. New MHFA group implementation. 2022 staff survey closed on 24th	
			C3) Mental Health First Aiders **Control Owner**: Director of WOD	Heath and Wellbeing Guardian meetings quarterly and annual Health & Wellbeing report to People Committee (December)		**Partial (new)**			G3) Plan required to fulfil the Board's commitment to the NW Wellbeing Pledge	Develop NW Wellbeing Pledge Action Plan **Action Owner**: Director of WOD **Due date**: 30/09/22 (on hold - to be revised)	Update provided to Workforce Advisory Group on progress of the regional projects in partnership with NW Trusts. Work on hold at regional level.	
			C4) Health & Wellbeing objectives for line managers and all staff **Control Owner**: Director of WOD	PADR compliance data monitored monthly by Workforce Advisory Group and People Committee via IPR		**Partial**						
			C5) Resilience modules in Leadership Masterclass modules **Control Owner**: Director of WOD	Bi annual updates to Workforce Assurance Group (September). Annual Learning and Organisational Development Report People Committee (March)		**Acceptable**						
			C6) Culture and Engagement Groups in each Division and for Corporate Services **Control Owner**: Director of WOD	Staff Culture and Engagement Pulse results, reviewed quarterly by People Committee as part of the Wellbeing and Engagement Update.		**Partial**						
			C7) Health and Wellbeing activities and interventions in place for 2022 **Control Owner**: Director of WOD	Quarterly Guardian meetings. Annual Health & Wellbeing report to People Committee.		**Acceptable (improved from partial)**						
			C8) Non-Executive Health & Wellbeing Guardian to hold Trust to account on ensuring H&WB is an organisational priority **Control Owner**: Director of WOD	Quarterly Guardian meetings. Annual Health & Wellbeing report to People Committee.		**Acceptable (new)**						

Additional narrative

BAF13. Development and adoption of digitisation
RISK APPETITE: Digital | MODERATE (tolerance 8-12)
STRATEGIC OBJECTIVE: 8a Digital

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Internal assurance	Board Assurance External assurance	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
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:** 13 December 2022	**Causes** 1. Lack of local published Digital Strategy. 2. Unknown national funding arrangements for Digital. 3.Lack of operational and clinical workforce digital capabability. 4.Emerging Integrated care System (ICS) and Places across Cheshire & Merseyside and developing Digital and Data strategies. 5. 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 **Control Owner**: CIO	Digital Board ensures the Trust's strategic and operational plans are supported by Digital Technology. The Digital Board will report quarterly to Quality Committee.		**Acceptable**	**4 x 3 = 12**	**YES**	G1) Digital Strategy required to set long term direction of travel	Digital Strategy to be developed and approved by Trust Board. Iterative approach planned with content to be completed by end of September 2022. Establishing a reporting cycle into Quality Committee. **Action Owner**: CIO **Due date**: 30 September 2022 Launch planned for end of January 2023.	Themes and vision of the Digital Strategy presented at Trust Board Development day 28th September. Themes presented to Digital Board in October. Engagement of mission and vision is ongoing with clinical divisions between December 22 and Jan 23 to ensure strong foundational partnership ready for launch end of January 23.	**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 workstream approach and proposed Governance to take forward the findings from the review of clinical systems optimisation	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"	**Acceptable (improved from partial)**			G2) Operational ownership for embedding technical change within clinical divisions	Agreement of roles and responsibilities of Governance between Digital Board and Transformation Improvement Committee. Additional Key Performance Indicators to be monitored via divisional performance review Groups **Action Owner**: COO **Due date**: 30 July 2022 **(Complete)**	A full governance review has taken place and governance arrangements are in place for Clinical Systems optimisation with Executive oversight from Medical Director. Workstreams will have Executive Oversight from Chief Nurse and COO. Governance approach between programme and TIC signed off at Digital Board in August 22.	
			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.	**Acceptable**			G3) Full overview of all digital programmes ensuring capture of new and emerging programmes	Review of Digital Programme reporting dashboard to be undertaken by the Head of Digital programmes **Action Owner**: CIO **Due date**: 31 October 2022 **(Complete)**	Review of digital programme reporting completed to ensure regular reporting of projects such as Robotic Process Automation (RPA), Remote Monitoring and Clinical Transformation programme work streams are captured within the reporting cycle. Reporting will continue to be monitored through the BAF as the governance processes are embedded with Transformation Improvement Commitee and Clinical Optimisation Group.	
			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		**Acceptable**			G3.1) Resource and capacity to deliver the clinical systems transformation programme of work	Recruitment of Project Manager **Action Owner**: CIO **Due date**: 04 July 2022 **(Complete)**	Member of staff in post and inaugural Clinical System Optimisation Group took place 1 September 2022.	
			C5) Strong Clinical Leadership and Engagement through Chief Clinical Information Officer (CCIO) and Chief Nursing Information Officer (CNIO) **Control Owner**: Medical Director	N/A		**N/A**			G3.2) Clinical Documentation work stream programme	Clinical Documentation work stream to be launched with Chief Nurse as Clinical Lead **Action Owner**: Chief Nurse **Due date**: 30 June 2022 **(Complete)**	Chief Nursing Information Officer presented programme of work to Risk &Quality Committee June 2022. Work is underway and the programme fits into the overarching governance. Inaugural workstream meeting arranged for 26th September. CNIO having bi-weekly operational meetings with Nursing teams to start to review the nursing documentation.	
			C6) Progress against Digital Maturity Model using the Internationally recognised tool Healthcare Information and Management Systems Society (HIMSS) approach **Control Owner**: CIO	HIMSS assessment report taken through Digital Board	HIMSS level 5 achieved (externally verified via an onsite assessment by the Regional Director HIMSS-Europe) - findings report reviewed by Digital board and NHS Digital. Level 5 was a requirement of the GDE programme.	**Acceptable**			G3.3) Pharmacy Digital work stream	Digital Pharmacy work stream led by Chief Medicines Information Officer (CMIO) with Chief Operating Officer (COO) as Operational Lead **Action Owner**: COO **Due date**: 31 August 2022 **(Complete)**	Workstream is underway, led by the COO.	
									G4) Completion of National "What Good Looks Like Framework for Nursing" (WGLL) to be undertaken	National "What Good Looks Like Framework for Nursing" (WGLL) to be undertaken by CNIO and a baseline assessment undertaken **Action Owner**: Chief Nurse **Due date**: 31 October 2022 **(Complete)**	WGLL framework assessment completed with a wide range of stakeholders across the Trust November 21 and submitted to ICS. Action plan monitored through Digital Board. The WGLL framework has now been incorporated in the new Digital Maturity Assessment (DMA).	
									G5) Education in use of BI Dashboards and monitoring of usage through Divisional Performance Review Groups (PRGs)	Further 1-1 training planned on request. Head of Performance and Planning to include within performance reviews with divisional and operational teams **Action Owner**: COO **Due date**: 30 September 2022 **(Complete)**	Training video available on intranet, face to face sessions held at divisional cabinet meetings. Head of Planning to incorporate additional divisional data into PRG as new data feeds become available at the end of Jan 23. Training with staff and teams continually offered and delivered.	
									G6) HIMMS level 6 gaps identified	Plan in place to review and close level 6 gaps is being led by the Head of Digital Programmes. **Action Owner**: CIO **Due Date**: December 2022	Nationally, Level 5 HIMSS is the standardised requirement for Digital Maturity and Level 7 is the highest. Level 6 assessment undertaken and a plan to close gaps in progress. Key work required to meet level 6 is Closed Loop Prescribing for Non-Sact Medicines, to be managed within the Medicines workstream of the Clinical Systems Optimisation Programme. NHSE launching new national digital maturity tool, expected in December 2022. The new national Digital maturity Assessment will incorporate the WGLL framework and Trusts are	

Additional narrative:

The Organisation is developing it's levels of digital maturity through use of digital systems. 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 opertaionally. 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. A number of actions have been completed since last review. The clinical optimisation programme is effectively led by executive colleagues to ensure clinical and operational buy-in for transformational change is embedded and is working well. There is significant engagement work underway with the digital strategy ensuring that strong

BAF14. Cyber security
RISK APPETITE: [RISK] MODERATE (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?)*	Internal assurance *What/where reported/when?*	Board Assurance External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 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:** 3 January 2023	**Causes** 1. Increasing sophistication and variety of malicious attacks 2. Integration of networks across the ICS 3. Increased reliance on digitised processes 4. Legacy infrastructure requiring modernization 5. Heightened national threat from Russia **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 preceeding year- whichever is highest) 4. Fraud/theft 5. Reputational damage	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 Triple A Chairs report to Digital Board. Regular quarterly report starting January 2023 to include Anti Virus posture.	NHS Digital receive real-time telemetry from Windows devices, which feeds national dashboards and triggers alerting.	Acceptable	4 x 3 = 12	Yes	G4) Adoption of enhanced standards via Cyber Essentials Plus and ISO27001	Plan in place for progress towards Cyber Essentials Plus and ISO27001 implementation **Action Owner**: CIO **Due date**: March 2023	ISO27001 - in progress. Cyber Essentials Plus certification awarded in December 2022	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.	Acceptable			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**: November 2022	Digital Security Team have undertaken Cyber Incident response courses and exams are planned. Regional meetings with preferred supplier for the SOC commenced 20/12/22. They will focus on developing a Security Operations Centre roadmap. A Blueprint will be developed to support procurement of SOC Service capability during 23/24.	
			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)	Acceptable			G7) 2% of devices not up to date due to not logging on to the Trust Virtual Private Network (VPN)	Non VPN devices will be captured over the internet **Action Owner**: CIO **Due date**: July 2022 (**Complete**)	Update: VPN policy updated to auto connect to create "Always On" connectivity back to corporate network. Group policy updated for all devices to add direct connectivity to Microsoft update servers as backup update source.	
			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 starting Jan 2023.	Cyber Essentials Plus certification awarded December 2022. Engaged with Greater Manchester Shared Services for ISO27001 compliance.	Acceptable (improved from partial)			G9) Training and development for Information Asset Owners (IAOs) and Information Asset Assistants (IAAs)	Information Governance Team to develop awareness and understanding Programme for IAOs and IAAs to be developed ready for 2024 submission of DSPT **Action Owner**: Director of Finance (SIRO) **Due date**: March 2023	New action added Jan 2023	
			C5) Network vulnerability Monitoring **Control Owner**: CIO	Security posture dashboards presented to Digital Security Committee on a monthly basis. Quarterly reporting to Audit Committee to starting Jan 2023.	External audits take place to provide independent assurance on posture. Annual external Pentration Testing is undertaken by PH Consulting (16/6/22). Plans to move to Quartely Pen Testing	Acceptable						
			C6) Patch Management process is in place to ensure any software or operating Systems (OS) updates that are released by System Vendors is managed in a robust and timely manner **Control Owner**: CIO	ITHealth Assurance Dashboard reported at monthly Data Security Committee. 98% of endpoint devices patched up to date. 100% of servers patched up to date. 100% of windows devices on fully supported operating systems. Patch management to be covered via Care cert reporting in quarterly reporting to Audit Committee starting Jan 2023.	NHS Digital National Dashboard	Acceptable						
			C7) Digital elements of Data Security Protection Toolkit **Control Owner**: CIO	Digital elements for Toolkit managed through Data Security Committee (DSC) and Data Management Group (DMG). Trust wide annual Assesment undertaken by Mersey Internal Audit. IG Board and IG Manager monitor progress against DSPT on a bi-monthly basis.	External Reporting to NHS England.	Acceptable						

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.

BAF15. Subsidiary Companies and Joint Venture

RISK APPETITE: Commercial and partnership working, financial MODERATE (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?)*	Internal assurance *What/where reported/when?*	Board Assurance External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF15 There is a risk of **inadequate governance of the Trust's Subsidiary Companies and Joint Venture**, which would result in failure to maximise the potential commercial and efficiency benefits **Executive Risk Lead:** James Thomson, Director of Finance **Board Committee**: Performance **Last Update:** 16 November 2022	**Causes** 1. Lack of clear strategy for subsidiaries 2. Lack of governance and assurance interfaces with Trust 3. Lack of signed SLA/contract agreements **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	**5 x 3 = 15**	C1) Limited Liability Partnership agreement with the Mater Private Healthcare. Renewed by both parties	Contract format and agreement reviewed by Trust Board. Also managed through joint venture	Legal advice taken on initial structuring and renewal agreement.	**Acceptable**	**4 x 3 = 12**	**Yes**	G1) Annual review of budgets to support SLA relationship to complete before Trust financial plan for year.	Commence SLA discussion in Q3 22/23	Agreed SLA postion for 2022/23. Budget for JV approved by JV Board in June 2022.	**2 x 2 = 4**
			C2) 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.	External audit required annually	**Partial**			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**: 30/11/22 (revised from 30/09/22)	Standing item on JV Board. Separate strategy session planned July 2022. Budget approved by JV Board in June 2022. Marketing and engagement plan revised and being implemented by JV Manager.	
			C3) Separate governance and Board arrangements for CPL and PropCare **Control Owner: DoF**	Internal SLA and financial reporting process managed through Finance Committee and Divisional Boards (monthly).	Governance arrangements included in MIAA audit plan Both subsidiaries subject to external audit, and for CPL professional regulatory licensing.	**Acceptable**			G3) Governance process impacted by absence of Company Secretary. Final revised SLA with CPL, not signed.	Temporary Company Secretary to be engaged. Trust/CPL to sign SLA following review. **Action Owner:** CEO **Due date**: 30/11/22 (revised from 30/09/22)	Trust engaged with experienced governance lead for temporary contract. CPL SLA is still with KPMG - review period extended due to HMRC VAT issue.	
			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.	**Partial**			G4) PropCare have developed strategy (March 2022) and required to translate into full business plan.	Trust to receive full business plan Quarter 3 (revised from Quarter 2). **Action Owner**: DoF **Due date**: 30/11/22 (revised from 31/09/22)	PropCare have started to implement the strategy, making key appointments as planned.	
			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.	**Partial**			G5) CPL to develop and present 5 year strategy to Trust Board for approval.	CPL to finalise 5 year strategy at CPL July Board. To present to Trust Board at next update. **Action Owner:** DoF **Due date:** 31/10/22	CPL Board Strategy session 13/06/22	

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 - financially, operationally - to the detriment of patient care.

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1
25th January 2023

Chairs report for: Quality committee
Date/Time of meeting: 22nd December 2022

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

Items of concern for escalation to the Board	
Items of achievement for escalation to the Board	**Patient Experience and Inclusion Annual Report** The Committee approved the report, now found here on the Trust website https://www.clatterbridgecc.nhs.uk/application/files/2716/7812/2631/Patient_Experience_Annual_Report_2021-22.pdf
Items for shared learning	**True for us - Quality and Safety of mental health, learning disability and autism inpatient service** The Board noted the report which provided evidence of assurance and identified any areas where improvement might be required following a true for us review. The review followed a letter, sent in light of the BBC panorama programme focusing on the Eden field Centre, Greater Manchester Mental Health NHS Foundation Trust to Chief Nurses, to request that Boards reflect on the content and take action to ensure that the behaviours and actions demonstrated are not present in their own services.

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1 – 25th January 2023

Chairs report for: People Committee
Date/Time of meeting: 21st December 2022

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

Items of concern for escalation to the Board	**Industrial Action Update** The Committee discussed the 2 planned strike action days, and the current status of the Trade Unions. Emergency plans were put in place together with local derogations to ensure the Trust remained in a safe position. Business Continuity Plans are updated regularly with both clinical and clerical staff being redeployed to support the strike action. The Trust awaits further communication regarding industrial action. **People Commitment Implementation Plan Update** The People Committee noted the progress of the People Commitment Implementation and actions put in place to address areas of underperformance. **Mandatory Training and PADR Performance Report** Report to be provided to Trust Board detailing historical data around ILS and BLS underperformance.
Items of achievement for escalation to the Board	**Equality, Diversity and Inclusion Report** The Committee noted the recruitment of the new Equality, Diversity and Inclusion Lead, Angie Ditchfield who is due to start at the Trust on 4th January 2023 and will cover both The Clatterbridge Centre and Alder Hey sites. **Trust Recruitment Report** The Committee noted the KPI for Time to Hire has been met with an average of 46.9 against a 60 day target and highlighted that the vacancy successes with 19% of the new recruits being from Black, Minority and Ethnic groups.
Items for shared learning	**Apprenticeship update** The Committee noted the national changes to the Apprenticeship Public Sector Act and the plans to promote apprenticeships utilising unexplored pathways.

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1 – 25 January 2023

Chair's report for: Audit Committee

Date/Time of meeting: 12 January 2023: 09.30-12.30

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

General items to note to the Board	• The Committee 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 received an Internal Audit Progress Report which provided assurance on progress to complete the 2022/23 Internal Audit Plan by 31 March 2023. There had been one Internal Audit review completed since the last meeting which had resulted in the following outcome: o Conflicts of Interest Review - Limited Assurance While noting the disappointing outcome of the review, the Committee acknowledged that progress in implementing recommendations from the previous Internal Audit review had been impacted by the extended absence of a key post holder. The Committee was assured that recommendations are now being progressed and requested an assurance report from the Executive detailing the updated position at the next meeting on 19 April 2023. • The Committee also received a report from Internal Audit which detailed the outcomes of a review of the Trust's self-assessment against the HFMA Financial Sustainability Checklist. Board members should note that NHS England had issued guidance that required organisations to commission such a review and set out the scope for internal audit review. The MIAA review provided assurance to the Audit Committee that the Trust's self-assessment against the 72 questions in the checklist had been fully completed and that the self-assessment scores in respect of the 12 NHSE-specified questions were reasonable. The review itself did not result in an audit opinion but the findings will be considered as part of the Annual Head of Internal Audit Opinion.

	• The Committee received a report from the Trust's Anti-Fraud Specialist (AFS) which detailed progress against the Anti-Fraud Plan during Quarter 3 2022/23. The AFS provided an overview of activities during the period and the Committee was assured on progress against plan. The Committee noted in particular that the NHS Counter Fraud Authority had provided the Trust with two organisation-specific feedback reports following a post-event assurance exercise on NHS procurement during the Covid-19 pandemic. The AFS advised that he would work with Trust key contacts to review the findings in each report and the Committee requested a report detailing outcomes of this review at its next meeting on 19 April 2023. The Committee also triangulated outcomes of the Internal Audit Conflicts of Interests review, referenced earlier in the report, with Component 12 of the Counter Fraud Functional Standards which for compliance purposes is currently amber-rated. In order to achieve a green rating, a minimum of 80% of Decision Makers will need to have completed their annual Conflict of Interests declaration by 31 March 2023. The Committee was advised that completion of the annual declarations is being progressed by the Corporate Governance team. • The Committee received a report from the Deputy Director of Finance which provided assurance that a comprehensive planning process and associated timetable was in place for production of the 2022/23 Annual Report & Accounts. While a definitive timetable has yet to be published by NHS England, providers have been advised of submission dates for key elements of the process as follows: o Draft PRFs / Accounts – Noon on 27 April 2023 o Audited PRFs / Accounts – Noon on 30 June 2023 The report also included a detailed plan for production of the Annual Report document which will result in an initial draft document being presented to the Committee for review on 19 April 2023. • The Chief Information Officer presented a report which provided assurance on the Trust's position across a range of Cyber Security functions. The Committee noted in particular the positive assurance provided by the Trust's achievement of Cyber Essentials Plus accreditation in December 2022 and the benefit that this accreditation will provide in relation to the Trust's Data Security Protection Toolkit assessment. • At its last meeting on 13 October 2022, the Committee had requested an assurance report from management on progress with high risk recommendations that had resulted from Internal Audit reviews on Complaints and Incident Management. The Chief Nurse presented a report which provided the Committee with assurance that outstanding actions had been completed.

	• The Committee completed the annual review of its Terms Reference. Following thorough consideration, the Committee endorsed a number of proposed amendments which aimed to provide clarity on the Committee's functions and ensure consistency with the model Terms of Reference detailed in the HFMA Audit Committee Handbook. Revised Terms of Reference are included at Annex A for approval by the Board. • The Interim Associate Director of Corporate Governance presented a report which detailed outcomes of an assessment of the Trust's compliance with the Code of Governance for Provider Trusts which comes into effect from 1 April 2023. The assessment took the form of a 'Compliance Checklist' with each element of the Code assessed as either Compliant, Partial Compliant or Non-Compliant. Actions to address any gaps were detailed against relevant requirements. The Committee was assured that a comprehensive assessment had been completed and noted that the Checklist provided a sound foundation and action plan for further development. The Committee will review an updated Checklist on a six-monthly basis in order to gain assurance on progress with actions to enhance overall compliance. • The Committee considered a report regarding a review of the Trust's Constitution and noted that outcomes of the review had originally been presented to the Committee on 1 April 2022. Progress with the review had then been impacted by the extended absence of a key post holder. The Committee noted the comprehensive nature of the review with the incorporation of Standing Orders for the Board of Directors and a general update of content throughout the document. The Committee also noted that the review had been supported by Hill Dickinson LLP, which provided an independent view and ensured that content reflected established best practice. The Committee recommended the revised document to the Board of Directors and Council of Governors for approval.
Items of concern for escalation to the Board	• 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. This followed a request by the Audit Committee at its last meeting in October 2022 as the Committee had queried whether the planned transition remained the best solution for the Trust. 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. • 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. An update on this subject will be provided by the Director of Finance at the Board meeting on 25 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.
Items of achievement for escalation to the Board	• The Committee reviewed a report which detailed performance against a range of Key Financial Assurance Indicators and noted positive performance against the range of indicators. The Committee thanked the Finance team for their efforts. The Committee noted in particular significant reductions achieved in the level of aged debt across both NHS and non-NHS debtors and congratulated the Finance team for their efforts. This performance contributed to the Accounts Receivable team being recognised as Finance Team of the Year, as voted by their departmental peers, at the inaugural Finance Department Annual Awards in December 2022.
Items for shared learning	No items for shared learning were identified.

The Clatterbridge Cancer Centre NHS Foundation Trust

Audit Committee Terms of Reference

ToR Reference	(To be provided by DCO~~CM~~)
Version	V.5
Name and designation of ToR author(s)	Paul Buckingham, Interim Associate Director of Corporate Governance
Approved by (committee, group, manager)	Board of Directors – Draft for review
Approval evidence received (minutes of meeting, electronic approval)	
Date approved	
Review date	
Review type (annual, three yearly)	Annual
Target audience	Board of Directors and Board Committees
Links to other strategies, policies, procedures	Corporate Governance Manual
Protective Marking Classification	Internal
This document replaces	V.4
Date added into Q-Pulse	For completion by DCO~~CM~~
Date document posted on the Intranet	For completion by DCO~~CM~~

Date	Version	Author name and designation	Summary of main changes
Feb 2019	V.2	Angela Wendzicha, Associate Director Corporate Governance	Full review of the current Terms of Reference
April 2021	V.3	Angela Wendzicha, Associate Director Corporate Governance	Full review with the addition of: • Authorisation for meeting via virtual means (section 1.5) • Ensuring the BAF is adapted to the response to Covid-19 (section 2.1.2) • Additional requirements relating to cyber security (sections 7.1.2-7.1.4) • Additional section relating to collaborative working (section 8)
January 2023	V.5	Interim Associate Director of Corporate Governance	Full review and update to ensure consistency with HFMA Audit Committee Handbook guidance.

The Clatterbridge Cancer Centre NHS Foundation Trust

Audit Committee	
Authority	1.1 The Audit Committee is constituted as a standing committee of The Clatterbridge Cancer Centre NHS Foundation Trust's Board of Directors ("the Board") 1.2 The Audit Committee is authorised by the Board to act and investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Audit Committee. 1.3 The Audit Committee is authorised by the Board to obtain such internal information as is necessary and expedient in the fulfillment of its functions 1.4 The Audit Committee is authorised by the Board to instruct legal or other independent professional advice and request the attendance of individuals and ~~authoriites~~ authorities from outside of the Trust with relevant experience and expertise if it considers it necessary or expedient to exercise its functions. 1.5 The Audit Committee is authorise~~e~~d to meet via a virtual/remote meeting. For the purposes of such meetings, 'communication' and 'electronic communication' shall have the meanings as set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment.
Specific work areas	The Audit Committee has specific responsibility for monitoring and reviewing financial risk and associated controls, corporate governance and financial assurance. **2. Integrated Governance, Risk Management and Internal Control** 2.1 On behalf of the Board, the Audit Committee will review the adequacy of the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical) that supports the achievement of the organisation's Strategic Priorities. 2.1.1Maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production of any risk and control related disclosure statements (in particular the Annual Governance Statement) and making recommendations to the Board for approval, where appropriate. 2.1.2 Monitor and review the Board Assurance Framework and ensure its presentation at the Board at intervals that the Board determines. ~~In addition to ensuring the Board Assurance Framework is adapted to recognize the impact of the Covid-19 Pandemic on the Strategic Priorities.~~ 2.1.3 To review the adequacy of the Trust's arrangements by which staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or any other matters of concern. The Audit Committee will receive its assurance that arrangements

	are in place for the proportionate and independent investigation of such matters and for appropriate follow up through the inclusion of the Senior Independent Director (Freedom to Speak Up Champion) on the membership of the Audit Committee. 2.1.4 To oversee a system that reviews the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements. This will involve the Audit Committee itself considering for approval on behalf of the Board specified corporate policies and procedures that, under the Trust's Standing Orders, require Board approval and fall within the scope of the Audit Committee's Terms of Reference. In addition, receive assurance from the Quality Committee around the implementation of a robust process for the review and approval of policies. 2.1.5 To review the adequacy and effectiveness of the policies and procedures for all work related to counter fraud and security 2.1.6 In carrying out this work the Audit Committee will primarily utilize, but not be limited to, the work of Internal Audit, External Audit and other assurance functions. The Audit Committee will also seek reports and assurances from Directors and Managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. **3. Internal Audit** 3.1Internal audit primarily provides an independent and objective opinion to the Accountable Officer, Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the Trust's objectives. 3.1.1 The Audit Committee will ensure that there is an effective internal audit function established by management 3.1.2 The Audit Committee will review and approve the Internal Audit Plan, ~~operational plan and more detailed proramme of work,~~ ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework. 3.1.3 Consider the ~~major~~ findings of Internal Audit reviews ~~investigations~~ and the associated management response, their implications and monitor progress on the implementation of recommendations. 3.1.4 Receive and review the Internal Audit Report and Head of Internal Audit Opinion ~~annual report of the Internal Auditor~~ and agree any appropriate actions that may be required in response~~. to this. Receive the Internal Audit statement on the effectiveness of internal control.~~ 3.1.5 Review the provision of internal audit services and its reporting systems on an annual basis. 3.1.6 Discuss any problems and reservations arising from the work of Internal Audit and any other matters that the Head of Internal Audit wishes to discuss (in the absence of executive directors

	and other management where necessary). 3.1.7 In the event of a change in provider of Internal Audit, the Audit Committee will oversee the process of selection. 3.1.8 Internal ~~audit~~ Audit will have right of direct access to the Chair of the Audit Committee. **4. External Audit** 4.1 The Audit Committee will make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of the external auditor. 4.1.1 To discuss with the external auditor, before any audit commences, the nature and scope of the audit and ensure co-ordination, as necessary, with other external auditors in the local health economy. This should include discussion regarding the local evaluation of audit risks and assessment of the Trust and impact on the audit fee. 4.1.2 To oversee the re-appointment or conduct of a market testing exercise for the appointment of an auditor at least once every 5 years, and based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor. The Committee will consider frequency for market testing during each annual review of the Terms of Reference. 4.1.3 Satisfy itself that there are no relationships between the auditor and the Trust (other than in the course of business) which could adversely affect the auditor's independence and objectivity. 4.1.4 Approve the terms of engagement, including any engagement letter issued. 4.1.5 Review the external audit reports, including the annual audit letter before submission to the Board and any work carried out outside the annual audit plan, together with the appropriateness of the management response, and monitor progress on the implementation of recommendations. 4.1.6 External audit will have right of direct access to the Chair of the Audit Committee. 5. **Annual Accounts Review/Financial Reporting** 5.1 To monitor the integrity of the financial statements of the Trust and any ~~other~~ formal announcements relating to its financial performance, reviewing significant financial reporting issues and judgments they contain. 5.1.1 ~~Review summary financial statements, significant financial returns to regulators and any financial information contained in other official documents, including the statement on internal control.~~ The Committee will ensure that the systems for financial reporting to the Board and Performance Committee, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided. 5.1.2 Review the Annual Statutory Accounts prior to presentation to

	the Board to determine their completeness, objectivity, integrity and accuracy. The aforementioned review will include, but not be limited to: • The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee~~The meaning and significance of the figures, notes and significant changes;~~ • Changes in, and compliance with, accounting policies, practices and estimation techniques ~~Areas where judgment has been exercised;~~ • Unadjusted misstatements in the financial statements~~Adherence to accounting policies and practices;~~ • Significant judgements in preparation of the financial statements ~~Explanation of estimates or provisions having material effect;~~ • Significant adjustments resulting from the audit~~Any adjusted and unadjusted audit differences;~~ • Letters of representation • Explanations for significant variances~~Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved~~ 5.1.3 Having reviewed the Annual Report, Annual Governance Statement and Annual Accounts, make recoomendations~~Review the Annual Report and Annual Governance Statement to determine completeness, objectivity, integrity and accuracy prior to making recommendations~~ to the Board for approval where appropriate. ~~5.1.4 Ensure that all accounting and reporting systems for financial reporting to the Performance Committee and Board, including in respect of budgetary control, are subject to review as to the completeness and accuracy of the information provided.~~ 6. **Standing Orders, Standing Financial Instructions and Standards of Business Conduct** 6.1 Review, on behalf of the Board, the operation of, and proposed changes to the Standing Orders and Standing Financial Instructions, the Constitution, Codes of Conduct and Standards of Business Conduct, including maintenance of registers. 6.1.1 Receive details of waivers to Standing Orders as approved by the Chief Executive or Director of Finance. 6.1.2 Approve ~~authorization~~ authorisation levels for the issue of credit notes and write off debts. 6.1.3 Review the schedules of losses and compensations and make

	recommendations to the Board as to the appropriate write offs. 6.1.4 Ensure that any other matters specifically delegated to it via the Trust's Standing Orders and Standing Financial Instructions are complied with as appropriate. 6.1.5 Review the Scheme of Delegation. 7. **Cyber Security** 7.1 The Audit Committee will provide assurance to the Board that the Trust is properly managing its cyber risk including any appropriate risk mitigation strategies. 7.1.1 Receive reports that controls are in place for, protect from, and respond to cyber-attacks including management of the consequences of a cyber-security incident. 7.1.2 In receiving the aforementioned reports the Audit Committee will evaluate the governance and controls in place in order to understand the potential threats and system weakness. 7.1.3 The Audit Committee will satisfy itself that there is capable management resource in place to deal with cyber security matters. 7.1.4 The Audit Committee will receive assurance that the Trust has an incident response plan in place to deal with cyber security matters and that the workforce have been briefed and trained about cyber security. 8. **Collaborative Working** 8.1 The Audit Committee will maintain an overview of principal risks to the Trust's strategic objectives arising from collaborative work. Such collaborative work would not necessarily be restricted to collaboration with System and/or Place partners. ~~will seek clarity and understanding around what the local arrangements are for collaborative working having regard for the Trust as the sovereign organisations and not the Integrated Care System (until it is a legal entity)~~ 8.~~1~~2 The Audit Committee will seek assurance on the effectiveness of governance arrangements which relate to the Trust's participation in collaborative working arrangements ~~In seeking clarity, the Audit Committee will understand the shared decision making arrangements.~~ 8.~~1~~3 The Audit Committee will be appraised of any changes to accounting or financial planning arrangements as a result of System developments and seek assurance that any consequent risks to the Trust are mitigated effectively. ~~seek clarity on the accounting arrangements being put in place.~~ ~~8.1.4 The Audit Committee will seek clarity on any proposals to agree risk appetites and tolerances.~~ 9. **Other Audit Related Issues**

	9.1 The Audit Committee will satisfy itself that there are adequate processes in place for dealing with the findings of other significant assurance functions, both internal and external to the Trust. This will include the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health (and social care) sector in addition to professional bodies with responsibilities that relate to staff performance and functions. 9.2 Review relevant assurances from other Board Committees, working groups and senior managers within the Trust to provide assurance relevant to the Committee's own scope of work. This will include the Quality Committee and issues around clinical risk, the Audit Committee wishing to satisfy itself on the assurance that can be gained from the clinical audit function and outcome measures from any Trust clinical benchmarking systems. ~~9.3 Review the tendering processes employed by the Trust to ensure they are appropriate and review the results of tendering exercises for banking services as carried out every 5 years.~~ ~~9.4 Receive reports on any professional charges over £50,000 incurred by the Trust or any charges incurred with the internal auditor or external auditor outside their normal audit contracts.~~ 9.3~~5~~ The Audit Committee will satisfy itself that the Trust has adequate arrangements in place for counter fraud ~~and security~~ and will review the outcomes of work in these areas. 9.4~~6~~ The Audit Committee will meet privately with the external and internal auditors and at least once a year without management being present. 9.5~~7~~ The Audit Committee will agree and implement a policy on the engagement of the external auditor to supply non-audit services. ~~review the non-audit related services provided by the External and Internal Auditors.~~
Reporting arrangements	10.1 The minutes of all meetings of the Audit Committee will be formally recorded by a member of the Corporate Governance Team. ~~Department or their nominee;~~ 10.2 The Audit Committee will report to the Board following each meeting and the Chair of the Audit Committee will bring to the attention of the Board details of any matters in respect of which actions or improvements are required. This will include details of any evidence of potentially ultra vires, unlawful or improper transactions, acts, omissions or practices or any other important

	matters. 10.3 The Audit Committee will report annually to the Board in respect of the fulfillment of its function within these Terms of Reference. Such a report will include but not be limited to functions undertaken in connection with the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework; the effectiveness of risk management within the Trust and any other pertinent matters in respect of which the Audit Committee has been engaged. 10.4 The Audit Committee will report to the Council of Governors on any matters which it considers that action or improvement is required and making recommendations as to the steps to be taken.
Membership	11.1 The Audit Committee will be appointed by the Board and will be composed of not less than three Non-Executive Directors, at least one of whom will have recent and relevant financial experience in addition to independent external members comprising internal and external audit. 11.2 The Board will appoint one of the members Chair of the Audit Committee. 11.3 The Chair of the Trust shall not be a member of the Audit Committee but may be invited to attend from time to time and as a minimum will be invited to attend where the financial accounts are presented for consideration prior to approval by the Board. Attendance 11.4 The following shall be in attendance at the Audit Committee: • Director of Finance • Chief Nurse • Chief Information Officer • Associate Director of Corporate Governance • Representatives from Internal Audit • Representatives from External Audit • Trust Anti-Fraud Specialist~~Representatives from Counter Fraud~~ 11.5 The Chief Executive may be invited to attend the Audit Committee, at least annually to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement. 11.6 Members will be expected to attend 75% of meetings. ~~11.7 In exceptional circumstances, meetings by conference call are acceptable with the approval of the Audit Committee Chair~~ 11.7~~8~~ The Chair of the Audit Committee may request the attendance of any member of staff or persons so as to assist in discussions.
Quorate	The Audit Committee will be deemed to be quorate when two of the three Non-Executive Directors (as detailed in paragraph 11.1 above) are in attendance.

The Clatterbridge Cancer Centre NHS Foundation Trust

Notice of meetings	12.1 The Associate Director of Corporate Governance will: 12.2 Agree the agenda items with the Chair of the Audit Committee and the Director of Finance 12.3 Provide the agreed agenda and supporting papers to all members and attendees no later than 5 working days before the date of the meeting 12.4 Maintain a Cycle of Business which is subject to annual approval by the Committee and is included for information on each meeting agenda. 12.5~~4~~ Extraordinary meetings can be arranged at short notice subject to approval by the members of the Audit Committee		
Standard items	Standard Agenda items will fall under the headings: • Internal Audit • External Audit • Performance and Risk~~Risk Management and Assurance~~ • Corporate Governance~~Regular Items for Review~~ • Items for Shared Learning~~Delegations from the Board~~		
Frequency	The Audit Committee will meet for a minimum of four scheduled meetings a year.		
Date Approved:		**Review Date:**	

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1
25th January 2023

Chairs report for: Charitable Funds Committee
Date/Time of meeting: 16th January 2023, 15:00

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

Items of concern for escalation to the Board	None
Items of achievement for escalation to the Board	None
Items for shared learning	**<u>Charity Annual Report and Accounts2021-22</u>** The Committee approved the 2021-22 Annual Report and accounts, subject to minor amendments of the annual report which were completed 18th January 2023. The Annual Reports and Accounts have been shared with the Trust Board for information. **<u>Independence Update Report</u>** The Independence application to the Charity Commission is in a queue which may push the start date back slightly from April 2023 The new charity board of trustees has been appointed and their names have been submitted to the Charity Commission, with their first meeting scheduled for February. The Finance Manager post is now live and being advertised. Haines Watts will be providing financial support should there be a gap. Service level agreements are currently being made with HR, IT and Propcare.

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board
Date of meeting: 25th January 2023

Report Lead	Joan Spencer, Chief Operating Officer					
Paper prepared by	Hannah Gray, Head of Performance and Planning					
Report subject/title	Integrated Performance Report M9 2022 / 2023					
Purpose of paper	This report provides an update on performance for month 9 2022/23 (December 2022). 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. Points for discussion include under performance, developments and key actions for improvement.					
Background papers						
Action required	For discussion and approval					
Link to: Strategic Direction Corporate Objectives	Be Outstanding	Y	Be a great place to work	Y		
	Be Collaborative	Y	Be Digital	Y		
	Be Research Leaders	Y	Be Innovative	Y		
Equality & Diversity Impact Assessment						
The content of this paper could have an adverse impact on:	Age	~~Yes~~/No	Disability	~~Yes~~/No	Sexual Orientation	~~Yes~~/No
	Race	~~Yes~~/No	Pregnancy/Maternity	~~Yes~~/No	Gender Reassignment	~~Yes~~/No
	Gender	~~Yes~~/No	Religious Belief	~~Yes~~/No		

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOREPO
Review: July 2025
Version: 2.0

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Integrated Performance Report
(Month 9 2022/23)

Hannah Gray: Head of Performance and Planning

Joan Spencer: Chief Operating Officer

Introduction

This report provides an update on performance for December 2022, 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.

NHSE published the '2023/24 Priorities and Operational Planning Guidance' on 23rd December 2022. Any performance target implications will be considered as part of the annual IPR review. A proposal for the KPIs to be included in the 2023/24 IPR will be taken to the February 2023 Performance Committee for approval.

Since the M7 report, for KPIs with annual targets, the monthly data has been accompanied by charts which present the cumulative total against the YTD target each month. For these KPIs, the RAG rating has been removed from the tables of monthly figures to promote focus on performance against the annual target, rather than per month. Exception reports are provided when both the monthly and YTD figures are below the respective targets.

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Interpretation of Statistical Process Control Charts

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

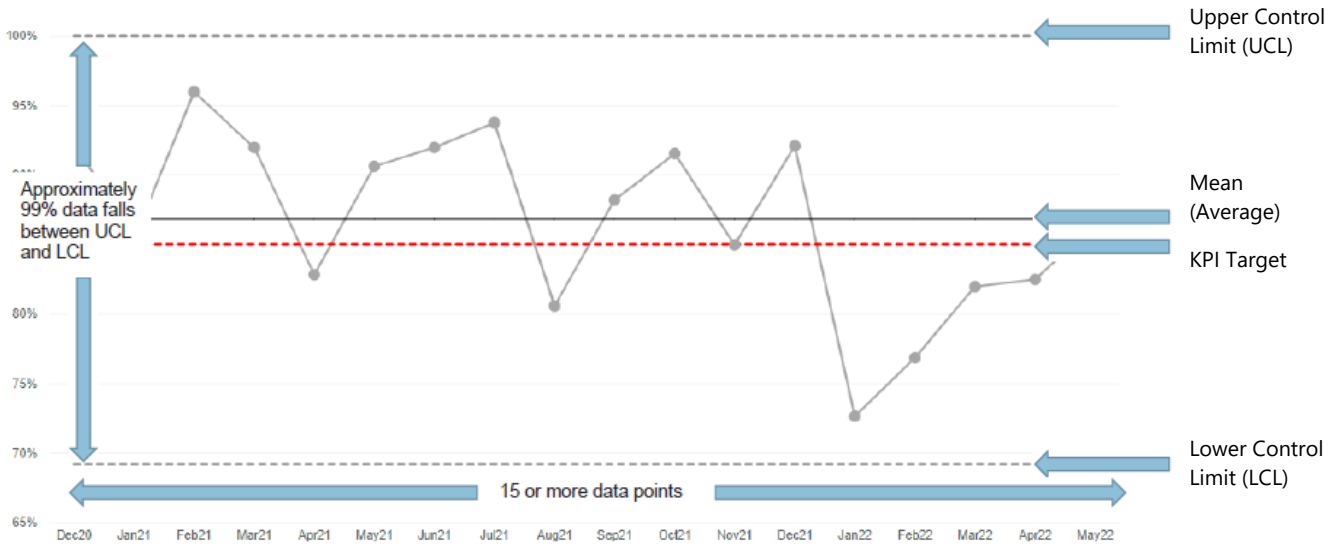
Are we improving, declining or staying the same? (Variation)			
Icon	**Variation**	Definition	Action
	Special Cause Improving Variation	Unexpected variation that results from unusual circumstances in a system or process i.e. assignable. (Blue = significant improvement/low pressure, H = high numbers,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

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Anatomy of the SPC Chart

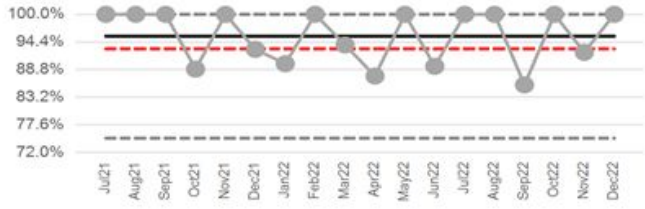


Integrated Performance Report (Jan 22 - Dec 22)

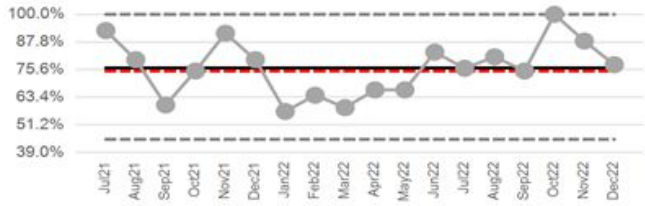
The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
CW10	2 Week Wait From GP Referral to 1st Appointment	Green ≥93% Red <93%	Contractual / Statutory		90.0%	100.0%	93.8%	87.5%	100.0%	89.5%	100.0%	100.0%	85.7%	100.0%	92.3%	100.0%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



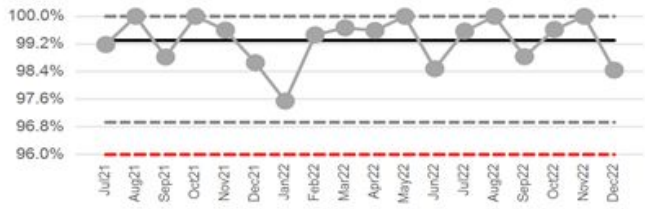
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
CW00	28 Day Faster Diagnosis - (Referral to Diagnosis)	Green ≥75% Red <75%	Contractual / Statutory		57.1%	64.3%	58.8%	66.7%	66.7%	83.3%	76.2%	81.3%	75.0%	100.0%	88.2%	77.8%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
CW47	28 Day Faster Diagnosis - (Screening)	Green ≥75% Red <75%	To Be Confirmed		-	-	-	-	100%	-	-	-	-	-	-	-		
			Narrative	There were no 28 day faster diagnosis screening patients this month.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
CW09	31 Day Firsts	Green ≥96% Red <96%	Contractual / Statutory		97.5%	99.5%	99.7%	99.6%	100.0%	98.5%	99.6%	100.0%	98.8%	99.6%	100.0%	98.4%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														

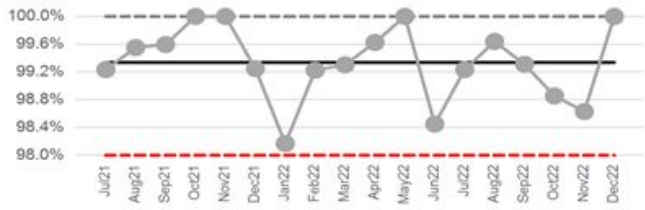


Integrated Performance Report (Jan 22 - Dec 22)

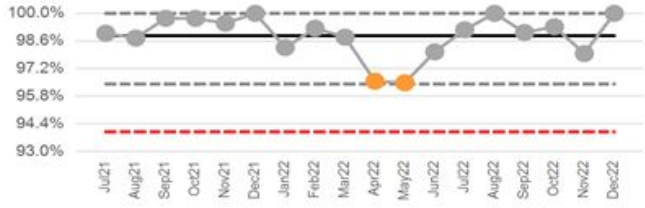
The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
CW07	31 Day Subsequent Chemotherapy	Green ≥98% Red <98%	Contractual / Statutory		98.2%	99.2%	99.3%	99.6%	100.0%	98.4%	99.2%	99.6%	99.3%	98.9%	98.6%	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.														



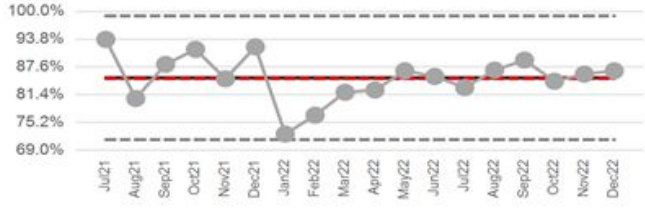
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
CW08	31 Day Subsequent Radiotherapy	Green ≥94% Red <94%	Contractual / Statutory		98.3%	99.2%	98.8%	96.6%	96.5%	98.0%	99.2%	100.0%	99.0%	99.3%	98.0%	100.0%		
			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	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
CW40	Number of 31 Day Patients Treated ≥ Day 73	Green 0 Red >0	Contractual / Statutory		1	0	0	0	0	0	0	0	0	0	1	0		
			Narrative	This month, there were no 31 day patients treated on or after day 73.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
CW90	24 Day Wait Target - Referral Received to First Treatment (62 Day Classics Only)	Green >85% Amber 80-84.9% Red <80%			72.6%	76.8%	81.9%	82.5%	86.7%	85.5%	83.0%	86.9%	89.1%	84.4%	86.0%	86.7%		
			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.														

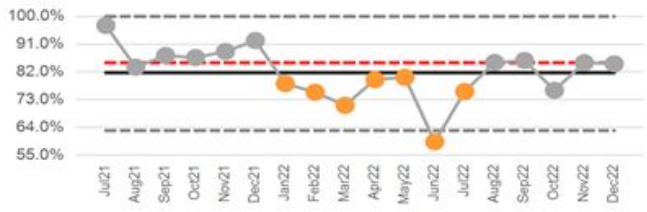


Integrated Performance Report (Jan 22 - Dec 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access

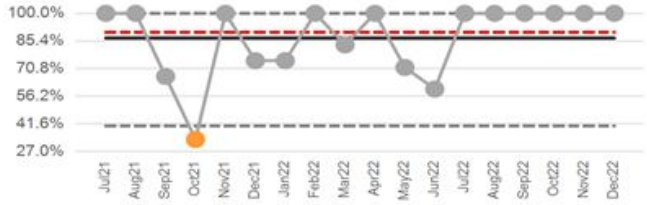
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
CW03	62 Day Classic	Green ≥85% Red <85%	Contractual / Statutory		78.2%	75.4%	71.2%	79.5%	80.3%	59.4%	75.7%	85.1%	85.7%	76.1%	85.0%	84.6%		
			Narrative	Performance is marginally below target and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Reason for Non-Compliance	Action Taken to Improve Compliance
9 patients breached the 62 day target in December; 7 were unavoidable to CCC and 2 were avoidable. The unavoidable breaches were due to patient choice, re-discussion required at MDT, medical reasons, disease progression, and 1 awaiting molecular markers. The avoidable breaches were due to the DPYD not being collected (1 patient) and the other patient was a category 1 patient; such patients have to be seen on a Monday, which often creates an element of delay, however it is possible that this patient could have been seen on the previous Monday. The breaches were in the following tumour groups: Head and Neck 3 Urology 2 Gynae 2 Lung 2	The DPYD pathway and processes are being reviewed by Matron and staff will be made aware of breaches at the safety huddle meetings. The General Manager has re circulated the pathway and escalation management process to Scheduling ASM to remind new staff members of the process.

Escalation Route & Expected Date of Compliance
Trust Operational Group, Divisional Quality and Safety Meetings, Divisional Performance Reviews, Performance Committee, Trust Board February 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
CW05	62 Day Screening	Green ≥90% Red <90%	Contractual / Statutory		75.0%	100.0%	83.3%	100.0%	71.4%	60.0%	100.0%	100.0%	100.0%	100.0%	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.														



Integrated Performance Report (Jan 22 - Dec 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Access

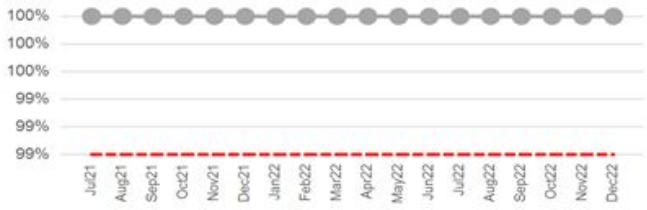
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
CW43	Number of Avoidable Breaches, Treated ≥ 104 Days and at CCC For Over 24 Days	Green 0 Amber 1 Red >1	Contractual / Statutory		0	1	4	0	1	1	3	0	1	0	0	1		
			Narrative	This month, there was 1 patient treated on or after day 104 and at CCC for more than 24 days. An exception report is provided.														

Data Not Applicable for SPC

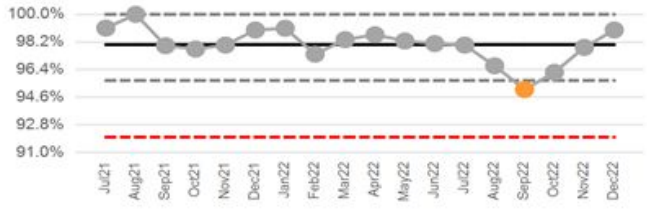
Reason for Non-Compliance	Action Taken to Improve Compliance
24 patients were treated 104+ days in December and 5 of these patients were at CCC for over 24 days. 4 of these 5 breaches were unavoidable to CCC and one was avoidable. The unavoidable breaches were due to patient choice, re-discussion required at MDT, medical reasons, disease progression, and 1 awaiting molecular markers. The avoidable breach was related to the patient being a category 1 patient; such patients have to be seen on a Monday, which often creates an element of delay, however it is possible that this patient could have been seen on the previous Monday.	The General Manager has re circulated the pathway and escalation management process to Scheduling ASM to remind new staff members of the process.

Escalation Route & Expected Date of Compliance
Trust Operational Group, Divisional Quality and Safety Meeting, Divisional Performance Reviews, Performance Committee, Trust Board February 2023

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



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
RT03	RTT Incomplete	Green ≥92% Red <92%	Contractual / Statutory		99.1%	97.4%	98.4%	98.7%	98.3%	98.1%	98.0%	96.6%	95.1%	96.2%	97.8%	99.0%		
			Narrative	The target has been achieved. There have now been 3 months of consecutive improvement and performance continues to be as expected, with assurance that this is likely to be achieved consistently.														

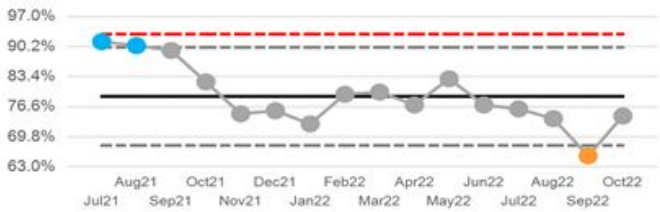


Integrated Performance Report (Jan 22 - Dec 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

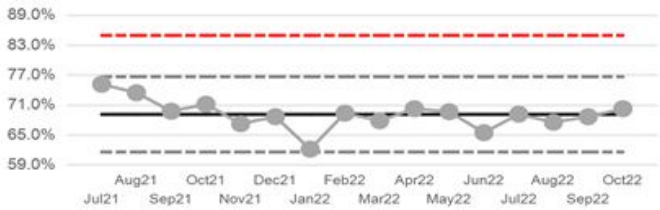
Access

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
CW44	2 Week Wait From GP Referral to 1st Appointment (Cheshire and Merseyside)	Green ≥93% Red <93%	Contractual / Statutory		72.7%	79.4%	79.9%	77.0%	82.9%	77.0%	76.1%	73.9%	65.5%	74.5%	-	-		
			Narrative	The November 2022 data is not yet available.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
CW45	28 Day Faster Diagnosis - (Referral to Diagnosis) (Cheshire and Merseyside)	Green ≥75% Red <75%	Contractual / Statutory		68.7%	68.3%	69.5%	66.6%	67.8%	69.2%	68.9%	66.0%	61.9%	65.8%	-	-		
			Narrative	The November 2022 data is not yet available.														

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
CW46	62 Day Classic (Cheshire and Merseyside)	Green ≥85% Red <85%	Contractual / Statutory		62.2%	69.4%	67.9%	70.3%	69.7%	65.5%	69.2%	67.6%	68.7%	70.3%	-	-		
			Narrative	The November 2022 data is not yet available.														

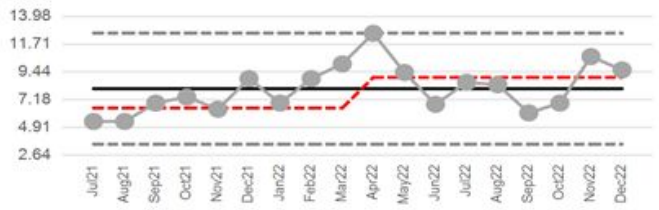


Integrated Performance Report (Jan 22 - Dec 22)

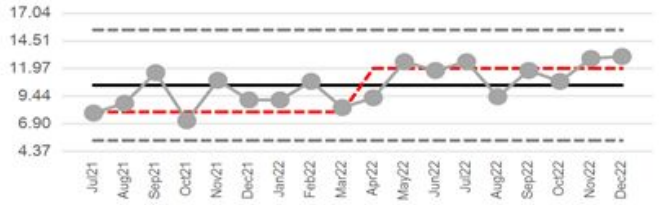
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

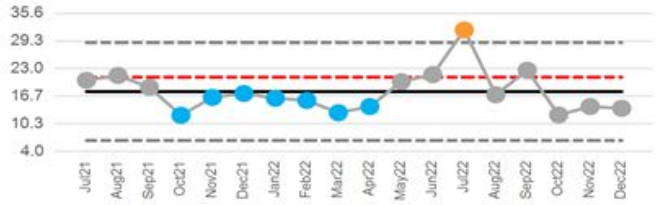
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
IP05-ST	Length of Stay Elective Care: Solid Tumour Wards (Average Number of Days On Discharge)	Green ≤9 Amber 9.1 -10.7 Red >10.7	Statutory		6.90	8.90	10.10	12.60	9.40	6.80	8.60	8.40	6.10	6.90	10.70	9.61		
			Narrative	This internal target has not been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



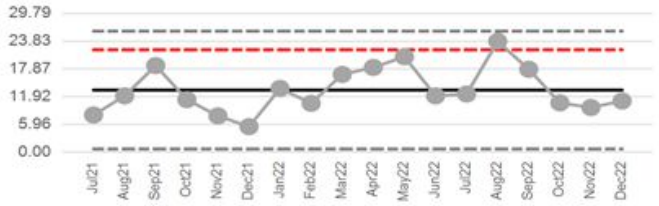
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
IP06-ST	Length of Stay Emergency Care: Solid Tumour Wards (Average Number of Days On Discharge)	Green ≤12 Amber 12.1-14.3 Red >14.3	Statutory		9.10	10.80	8.40	9.30	12.60	11.80	12.60	9.40	11.80	10.80	12.90	13.08		
			Narrative	This internal target has not been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	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		16.2	15.7	12.9	14.3	20.0	21.6	31.8	17.0	22.6	12.4	14.3	13.9		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	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		13.70	10.50	16.70	18.20	20.50	12.10	12.50	23.80	17.80	10.60	9.60	11.00		
			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.														

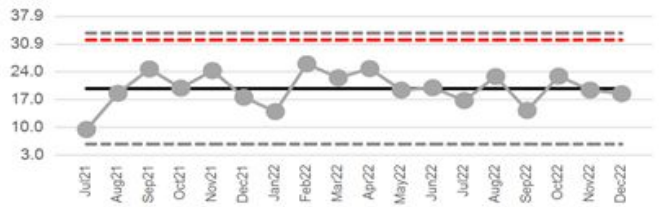


Integrated Performance Report (Jan 22 - Dec 22)

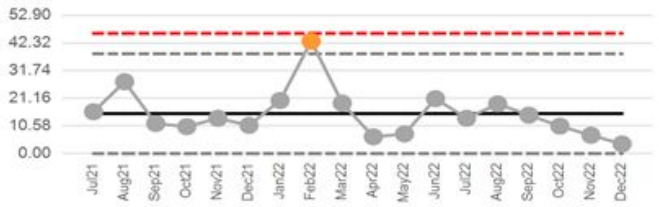
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

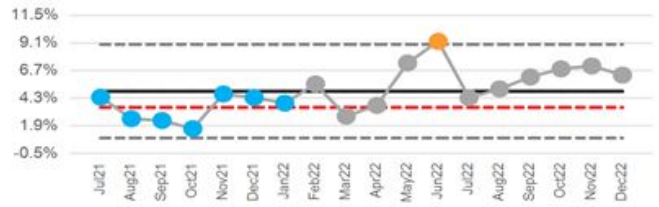
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
IP05-5	Length of Stay Elective Care: HO Ward 5 (Average Number of Days On Discharge)	Green ≤32 Amber 32.1-33.6 Red >33.6	Statutory		14.0	26.0	22.5	24.8	19.4	20.0	16.8	22.8	14.3	22.9	19.4	18.5		
			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	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	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		20.30	43.00	19.30	6.40	7.50	21.00	13.50	19.00	14.70	10.50	7.00	3.67		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
IP22	Delayed Transfers of Care As % of Occupied Bed Days	Green ≤3.5% Red >3.5%	Statutory		3.9%	5.5%	2.7%	3.7%	7.4%	9.2%	4.4%	5.1%	6.1%	6.9%	7.1%	6.3%		
			Narrative	The nationally set target of 3.5% 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 (Jan 22 - Dec 22)

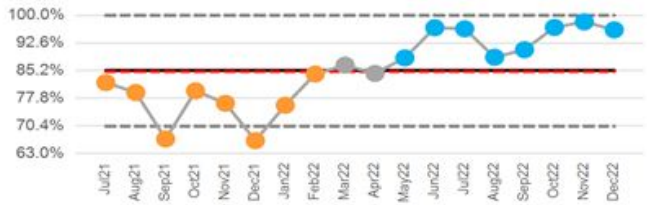
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

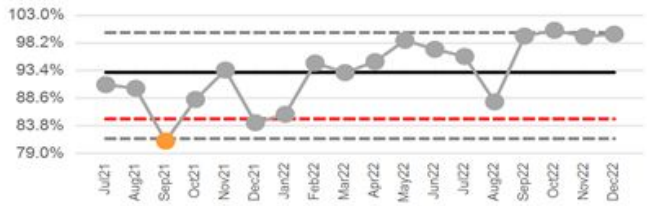
Reason for Non-Compliance	Action Taken to Improve Compliance
In December 6.3% of occupied bed days were Delayed Transfers of Care (DTOC), against the target of 3.5%. There were 18 DTOC in December, which is an increase from 16 in November. This equates to 172 extra bed days. The average length of DTOC was 9.5 days. • 6 patients awaited Fast Track Packages of care (45 extra bed days). Covid has had an impact on community services and has increased the length of time to commission a POC across all areas. • 3 patients awaited Intermediate Care Placements (53 extra bed days). 1 patient remained in hospital for the whole of December due to complex nursing needs and lack of placement availability in their local area. • 6 patients awaited Hospice placements (59 extra bed days). Some hospices have reduced day capacity due to Covid. • 3 patients awaited Social Service Package of Care (25 extra bed days).	Weekly 'Lengthened Length of Stay' meetings have continued with attendance of Matron and the Business Services Manager to ensure the flow of patients continues and any concerns can be escalated. The outcome of these meetings are forwarded to 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 the MDT. Consultant of the week (COW) MDT meetings continue, to allow discussion of all inpatients so that there is a clear plan for each patient. CHC (NHS Continuing Healthcare) are being contacted daily for an update on the availability of beds.

Escalation Route & Expected Date of Compliance	
Divisional Quality, Safety and Performance Meeting, Divisional Performance Review, Performance Committee, Trust Board April 2023	

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
IP20-4	Average Bed Occupancy at 12 Midday: Ward 4	Green ≥85% Amber 81-84.9% Red <81%	Statutory		75.9%	84.3%	86.7%	84.4%	88.6%	96.7%	96.4%	88.8%	90.8%	96.8%	98.3%	96.1%		
			Narrative	The target has been achieved. Bed occupancy is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
IP21-4	Average Bed Occupancy at Midnight: Ward 4	Green ≥85% Amber 81-84.9% Red <81%	Statutory		85.8%	94.7%	93.1%	95.0%	98.7%	97.1%	95.9%	88.0%	99.4%	100.4%	99.3%	99.7%		
			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.														

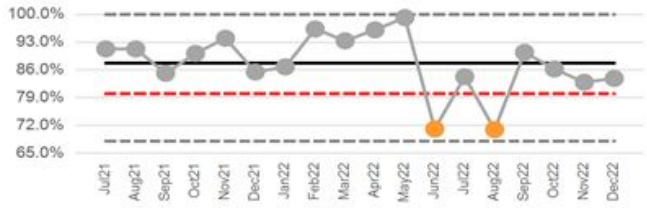


Integrated Performance Report (Jan 22 - Dec 22)

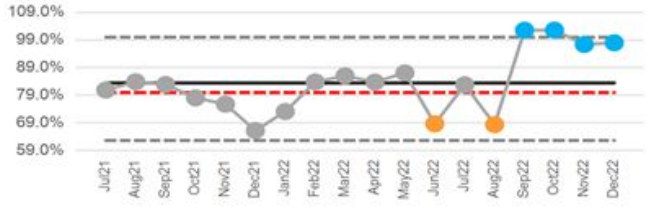
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

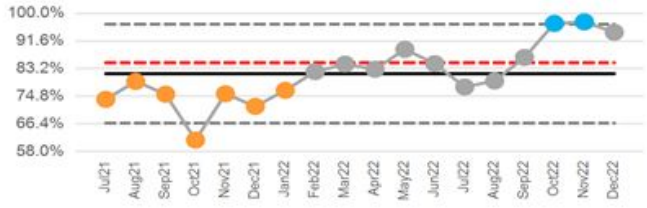
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
IP20-5	Average Bed Occupancy at 12 Midday: Ward 5	Green ≥80% Amber 76%-79.9% Red <76%	Statutory		86.8%	96.3%	93.4%	96.1%	99.2%	71.1%	84.3%	71.0%	90.4%	86.2%	82.9%	83.9%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



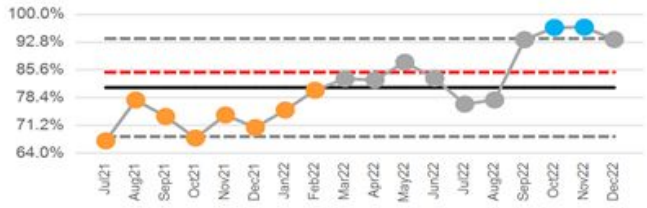
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
IP21-5	Average Bed Occupancy at Midnight: Ward 5	Green ≥80% Amber 76%-79.9% Red <76%	Statutory		73.1%	83.8%	86.0%	83.8%	87.1%	68.7%	82.8%	68.4%	102.5%	102.6%	97.4%	98.0%		
			Narrative	The target has been achieved. Bed occupancy is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
IP20-ST	Average Bed Occupancy at 12 Midday: ST Wards	Green ≥85% Amber 81-84.9% Red <81%	Statutory		76.6%	82.3%	84.6%	83.0%	89.1%	84.7%	77.6%	79.5%	86.6%	96.9%	97.4%	94.2%		
			Narrative	The target has been achieved. Bed occupancy is now as expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
IP21-ST	Average Bed Occupancy at Midnight: ST Wards	Green ≥85% Amber 81-84.9% Red <81%	Statutory		75.2%	80.3%	83.3%	83.0%	87.6%	83.4%	76.7%	77.8%	93.4%	96.6%	96.7%	93.5%		
			Narrative	The target has been achieved. Bed occupancy is now as expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														

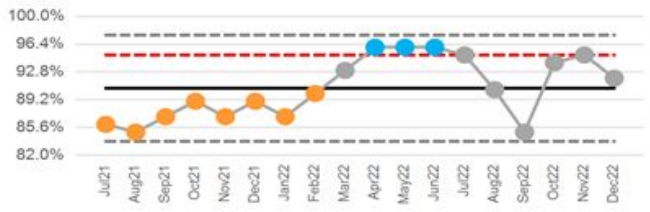


Integrated Performance Report (Jan 22 - Dec 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
IP23	% of Expected Discharge Dates Completed	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		87.0%	90.0%	93.0%	96.0%	96.0%	96.0%	95.0%	90.5%	85.0%	94.0%	95.0%	92.0%		
			Narrative	This internal target has not been achieved, however there is no significant change. The nature of variation indicates that achievement of the target is likely to be inconsistent.														



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

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	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.														

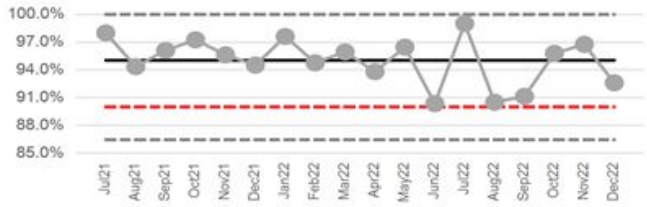
Data Not Applicable for SPC

Integrated Performance Report (Jan 22 - Dec 22)

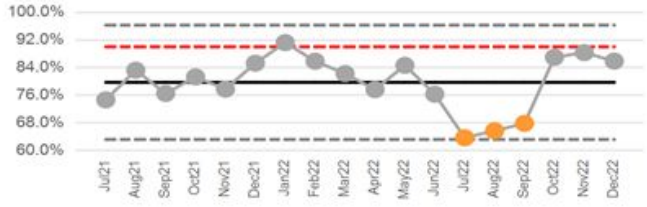
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
EF10	Imaging Reporting Turnaround (Inpatients)	Green >90% Amber 80-89.9% Red <80%			97.6%	94.8%	95.9%	93.8%	96.5%	90.4%	99.0%	90.5%	91.1%	95.8%	96.8%	92.6%		
			Narrative	The target continues to be achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



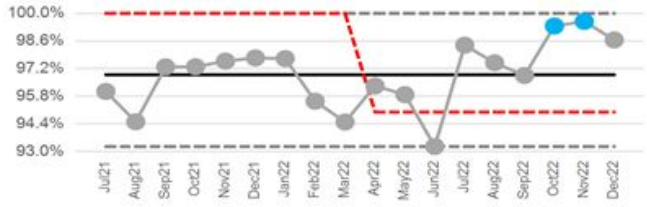
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
EF11	Imaging Reporting Turnaround (Outpatients)	Green >90% Amber 80-89.9% Red <80%			91.3%	85.9%	82.3%	77.7%	84.7%	76.3%	63.7%	65.7%	67.9%	87.0%	88.3%	85.9%		
			Narrative	The target has not been achieved. Performance is as expected, however target achievement is likely to be inconsistent. Although the target figure is internally created and performance is within normal variation, CCC is keen to provide regular updates on this issue and therefore an exception report is provided.														



Reason for Non-Compliance	Action Taken to Improve Compliance
There has been a slight reduction from 88% for November to 86% for December. • Radiology activity has increased since CCCL opened, placing increasing demands on the Radiologist team. More recently, activity has further increased by utilising some extended days in MRI and more recently CT and weekend lists in both MRI and CT • CCC Radiologists are supporting additional MDT activity • Expected new radiologist (IR and reporting) withdrew shortly before September start date. • There was reduced capacity for sending reporting to Medica from 19th December 2022 to 3rd January 2023 due to reduced reporting capacity from them.	Although Medica had reduced capacity over the Christmas period, they have agreed to increase capacity to accommodate an additional 20 scans per week, to support backlog reduction. Approval has been granted for three additional radiologists and recruitment will commence shortly.

Escalation Route & Expected Date of Compliance
Divisional Quality, Safety and Performance Meeting, Divisional Performance Review, Performance Committee, Trust Board March 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	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		97.7%	95.5%	94.5%	96.3%	95.9%	93.3%	98.4%	97.5%	96.9%	99.4%	99.6%	98.7%		
			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.														

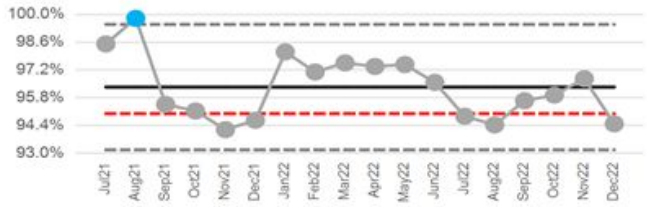


Integrated Performance Report (Jan 22 - Dec 22)

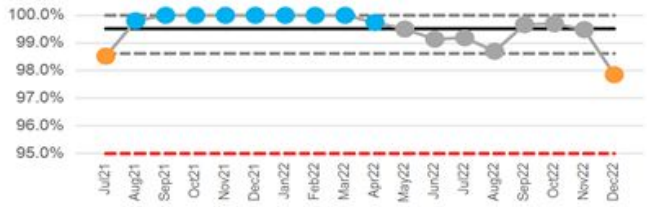
The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

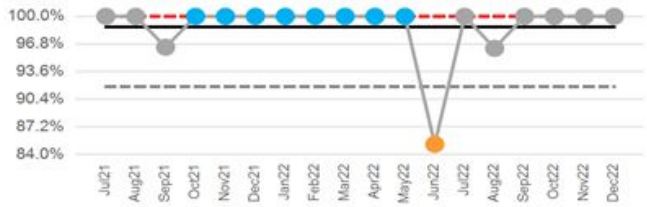
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
DQ02	Data Quality - % of Outpatients With an Outcome	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		98.1%	97.1%	97.6%	97.4%	97.5%	96.6%	94.9%	94.4%	95.6%	95.9%	96.8%	94.5%		
			Narrative	This internal target has not been achieved, however there is no significant change. The nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
DQ03	Data Quality - % of Outpatients With an Attend Status	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		100.0%	100.0%	100.0%	99.7%	99.5%	99.1%	99.2%	98.7%	99.7%	99.7%	99.5%	97.9%		
			Narrative	The target has been achieved. Although performance is lower than expected for December, the target is outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
EF01	Percentage of Subject Access Requests Responded to Within 1 Month	Green 100% Red <100%	Contractual		100.0%	100.0%	100.0%	100.0%	100.0%	85.2%	100.0%	96.3%	100.0%	100.0%	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	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	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 (Jan 22 - Dec 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU17	Never Events	Green 0 Red >0	Contractual / Statutory		0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target continues to be achieved, with no never events this month.														

Data Not Applicable for SPC

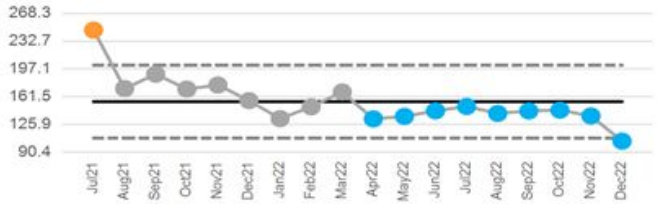
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU04	Serious Incidents (SIs)	No Target	Contractual / Statutory		0	0	0	0	0	0	2	0	1	0	0	0		
			Narrative	No SIs have been reported this month.														

Data Not Applicable for SPC

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

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU03	Incidents /1,000 Bed Days	No Target	Statutory		133.4	148.6	167.6	133.1	136.3	143.5	149.1	140.1	143.3	144.4	136.9	104.6		
			Narrative	Incident numbers are lower than 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.														

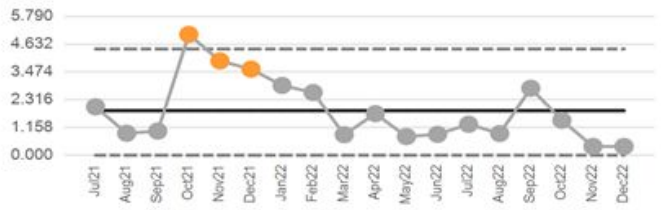


Integrated Performance Report (Jan 22 - Dec 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU05	All Incidents Resulting in Moderate Harm and Above /1,000 Bed Days	No Target	Local		2.911	2.616	0.857	1.735	0.779	0.872	1.293	0.904	2.794	1.458	0.370	0.367		
				Narrative	Numbers of incidents of this severity are as expected. Incidents are reviewed at Divisional Quality and Safety meetings and Divisional Performance Review meetings. This focus promotes a good reporting culture and analysis of themes and trends to drive improvement.													



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU06	Inpatient Falls Resulting in Harm Due to Lapse in Care	Green 0 Red >0	Contractual		0	0	0	0	1	0	0	0	0	0	0	0		
				Narrative	There were no falls resulting in harm due to a lapse in care. The harm review process has been amended and therefore figures may change retrospectively, following review.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU07	Inpatient Falls Resulting in Harm Due to Lapse in Care /1,000 Bed Days	Green 0 Red >0	Contractual		0.000	0.000	0.000	0.000	0.390	0.000	0.000	0.000	0.000	0.000	0.000	0.000		
				Narrative	There were no falls resulting in harm due to a lapse in care. The harm review process has been amended and therefore figures may change retrospectively, following review.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	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 (Jan 22 - Dec 22)

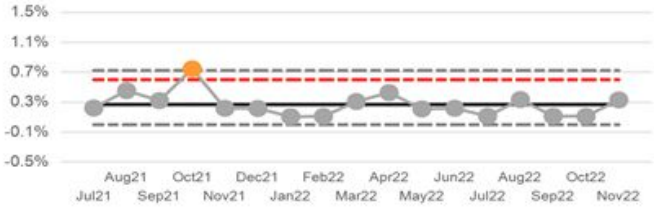
The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

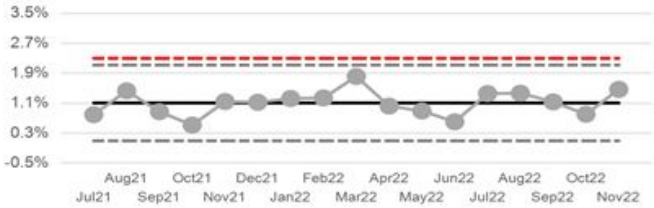
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU09	Pressure Ulcers (Hospital Acquired Grade 3/4, With a Lapse in Care) /1,000 Bed Days	Green 0 Red >0	Contractual		0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The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

Data Not Applicable for SPC

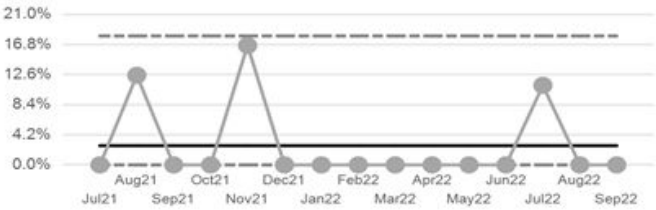
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU10	30 Day Mortality (Radical Chemotherapy)	Green ≤0.6% Amber 0.61% - 0.7% Red >0.7%	SOF		0.1%	0.1%	0.3%	0.4%	0.2%	0.2%	0.1%	0.3%	0.1%	0.1%	0.3%	-		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU12	30 Day Mortality (Palliative Chemotherapy)	Green ≤2.3% Amber 2.31% - 2.5% Red >2.5%	SOF		1.2%	1.2%	1.8%	1.0%	0.9%	0.6%	1.4%	1.4%	1.1%	0.8%	1.5%	-		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that the target is likely to be achieved.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU13	100 Day Mortality (Bone Marrow Transplant)	To Be Confirmed	SOF / NR		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%	0.0%	0.0%	-	-	-		
			Narrative	No September 2022 transplant patients died within 100 days of transplant.														

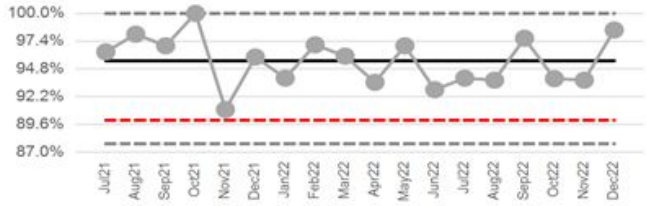


Integrated Performance Report (Jan 22 - Dec 22)

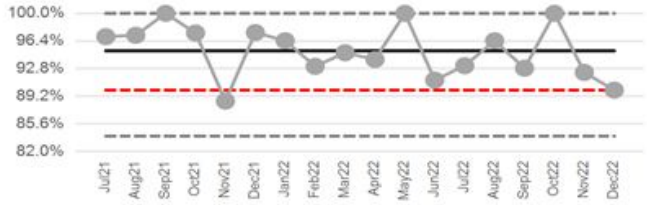
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

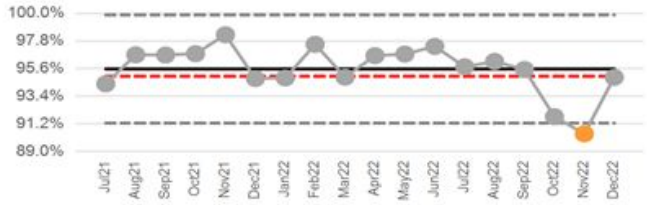
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU62	Consultant Review Within 14 Hours	Green ≥90% Red <90%	Contractual		93.9%	97.1%	96.0%	93.5%	97.0%	92.9%	93.9%	93.8%	97.7%	93.9%	93.8%	98.4%		
			Narrative	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	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU48	Sepsis IV Antibiotics Within an Hour	Green ≥90% Red <90%	Contractual		96.4%	93.1%	94.9%	94.0%	100.0%	91.3%	93.2%	96.4%	92.9%	100.0%	92.3%	90.0%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU31	Percentage of Adult Admissions With VTE Risk Assessment	Green ≥95% Red <95%	Contractual / Statutory		94.9%	97.5%	94.9%	96.6%	96.8%	97.4%	95.7%	96.2%	95.5%	91.8%	90.4%	94.9%		
			Narrative	The target has not been achieved and an exception report is provided as the 95% target is usually stated in contracts (covid reporting changes have affected this in 2022/23). Performance is as expected 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
December 2022 compliance was below target at 94.91%, with 11 out of 216 not having had a VTE risk assessment within the 24 hour timeframe. Of those 11 patients, 8 did have a VTE risk assessment performed, however this was not recorded within the 24 hour timeframe. Consultants have reviewed the care of the 3 patients who did not have a VTE risk assessment, to determine if those patients came to any harm as a result. Of the 3 patients who did not have a VTE risk assessment completed; • 1 patient had a known history of VTE and was prescribed their treatment dose on admission, although this was reviewed/altered regularly throughout the inpatient admission due to a fluctuating platelet count. No harm. • 1 patient was not for LWMH prophylaxis due to a low platelet count. No harm. • 1 patient did not have a VTE risk assessment completed, however they were prescribed VTE prophylaxis. No harm.	• An urgent meeting was held on 12/1/23 with medical, nursing and digital team to agree actions to improve compliance. • Details of the missed assessments will be shared with the relevant medical teams for review and future learning. • The medical lead for VTE is regularly visiting the inpatient wards to speak to medical staff regarding the missed VTE risk assessments. • The Post Take Proforma is being updated to include a mandatory VTE risk assessment field to increase compliance. • A poster has been developed and displayed in all the doctors' offices to reinforce the importance of VTE risk assessments and where they can be found on the Electronic Patient Records.

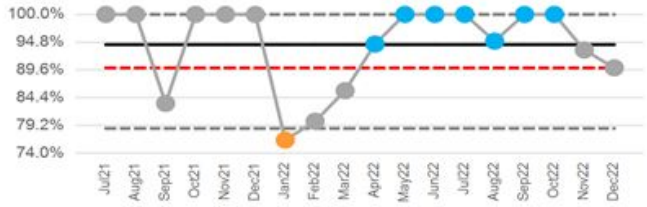
Escalation Route & Expected Date of Compliance
Divisional Quality, Safety and Performance Meetings, Divisional Performance Reviews, Patient Safety Committee, Quality Committee, Trust Board January 2023

Integrated Performance Report (Jan 22 - Dec 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU14	Dementia: Percentage to Whom Case Finding is Applied	Green ≥90% Red <90%	Contractual		76.5%	80.0%	85.7%	94.4%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%	93.3%	90.0%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



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

Data Not Applicable for SPC

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

Data Not Applicable for SPC

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU34	Clostridium Difficile Infections (HOHA and COHA)	Green ≤17 per year Red >17 per year	Contractual / Statutory		2	2	1	1	2	2	0	1	0	-	-	-		
			Narrative	There were no such infections this month and the chart shows that the total YTD is within the threshold.														

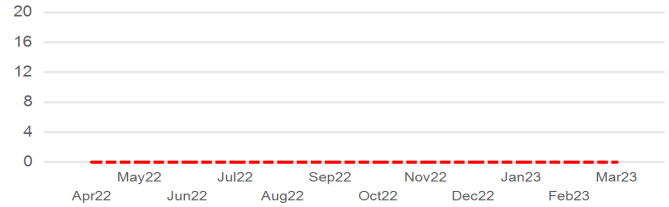
Integrated Performance Report (Jan 22 - Dec 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU40	E. Coli Bacteraemia (HOHA and COHA)	Green ≤11 per year Red >11 per year	Contractual / Statutory		2	0	2	1	1	4	1	4	0	-	-	-		
			Narrative	There were no such infections this month. The chart shows that the annual threshold of 11 was exceeded in November.														

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU36	MRSA Infections (HOHA and COHA)	Green 0 per year Red >0 per year	Contractual / Statutory		0	0	0	0	0	0	0	0	0	-	-	-		
			Narrative	The target has been achieved this month and the chart shows that the annual threshold of 0 has not been exceeded.														



Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU38	MSSA Bacteraemia (HOHA and COHA)	Green ≤4 per year Amber 5 Red >5 per year	Contractual / Statutory		1	0	0	1	0	3	0	1	5	-	-	-		
			Narrative	There were 5 such infections this month and the chart shows that the annual threshold of 4 was exceeded in September 2022. An exception report is provided.														

Reason for Non-Compliance	Action Taken to Improve Compliance
5 Hospital Onset Hospital Acquired (HOHA) MSSA bloodstream infections were identified in December 2022. • Two were related to skin/soft tissue infections. No lapses in care were identified. • One was related to an indwelling IV device that was removed prior to blood culture collection as it appeared red/inflamed. Documentation relating to the care of the devices was insufficient. • One was related to a chest infection. • One was of an unclear source.	The clinical team have been asked to produce an action plan to ensure that when sepsis is suspected, line and peripheral cultures are obtained along with other diagnostic tests such as urine specimens and chest x-rays. This will facilitate correct identification of source.

Escalation Route & Expected Date of Compliance
Executive Review Group, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board January 2023

Integrated Performance Report (Jan 22 - Dec 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

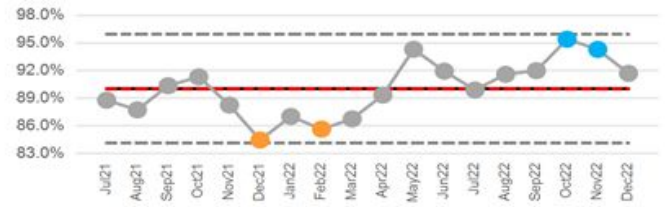
Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU43	Klebsiella (HOHA and COHA)	Green ≤8 per year Red >8 per year	Contractual / Statutory		3	1	0	1	1	1	0	3	2	-	-	-		
			Narrative	There were 2 such infections this month and the chart shows that the annual threshold of 8 was exceeded in November. An exception report is provided.														

Reason for Non-Compliance	Action Taken to Improve Compliance
1 Hospital Onset Hospital Acquired (HOHA), and 1 Community Onset Hospital Acquired (COHA) Klebsiella pneumoniae bloodstream infection were identified in December 2022. One infection was hepatobiliary in origin, the other was gastro-intestinal. No lapses in care were identified in either instance.	N/A

Escalation Route & Expected Date of Compliance
Executive Review Group, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board January 2023

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
QU45	Pseudomonas (HOHA and COHA)	Green ≤1 per year Red >1 per year	Contractual / Statutory		2	0	1	2	0	0	1	2	0	-	-	-		
			Narrative	There were no such infections this month. The chart shows that the annual threshold of 11 was exceeded in April.														

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU66	Safer Staffing: Overall Fill-Rate	Green ≥90% Red <90%	Statutory		87.0%	85.6%	86.8%	89.3%	94.3%	91.9%	89.9%	91.6%	92.0%	95.4%	94.3%	91.7%		
			Narrative	The target continues to be achieved. This month's figure is as expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.														

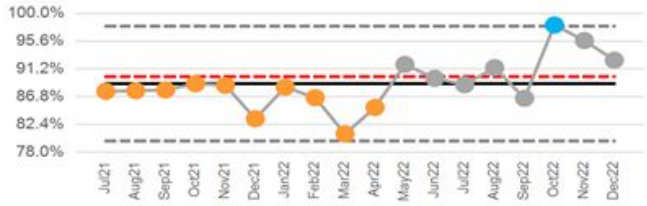


Integrated Performance Report (Jan 22 - Dec 22)

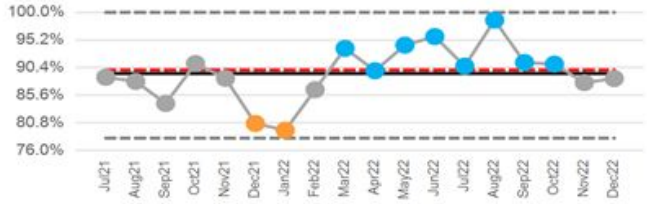
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

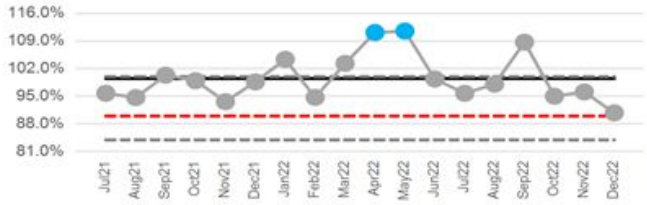
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU61	Average Number of Registered Nurses Filled Shifts - Days	Green ≥90% Red <90%	Statutory		88.3%	86.7%	80.9%	85.1%	91.9%	89.7%	88.7%	91.4%	86.6%	98.2%	95.7%	92.6%		
			Narrative	The target continues to be achieved. This month's figure is as expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



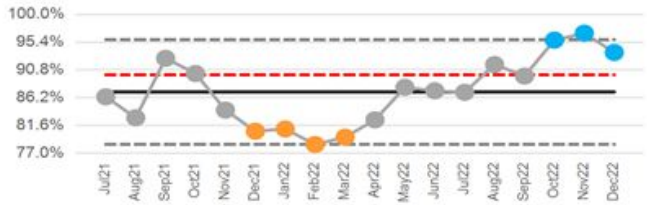
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU63	Average Number of Care Staff Filled Shifts - Days	Green ≥90% Red <90%	Statutory		79.5%	86.6%	93.7%	89.9%	94.3%	95.8%	90.7%	98.7%	91.3%	91.0%	87.8%	88.5%		
			Narrative	December performance is marginally below the internal target. 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	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU64	Average Number of Care Staff Filled Shifts - Nights	Green ≥90% Red <90%	Statutory		104.3%	94.7%	103.3%	111.1%	111.5%	99.4%	95.8%	98.1%	108.7%	95.0%	96.1%	90.8%		
			Narrative	The target continues to be achieved. This month's figure 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	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU65	Average Number of Registered Nurses Filled Shifts - Nights	Green ≥90% Red <90%	Statutory		81.0%	78.5%	79.7%	82.5%	87.9%	87.4%	87.1%	91.7%	89.8%	95.7%	96.9%	93.7%		
			Narrative	The target continues to be achieved. This month's figure is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														

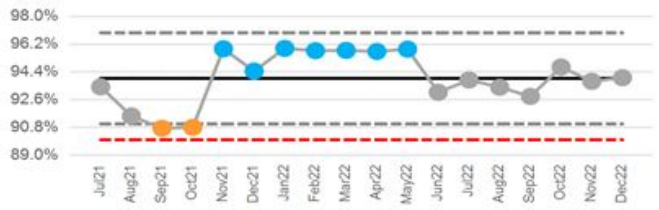


Integrated Performance Report (Jan 22 - Dec 22)

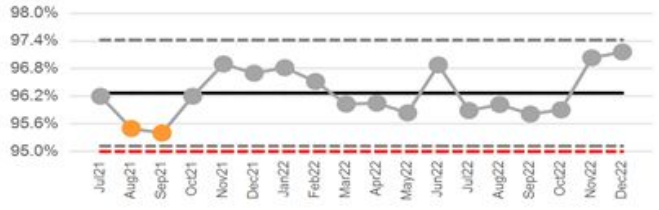
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

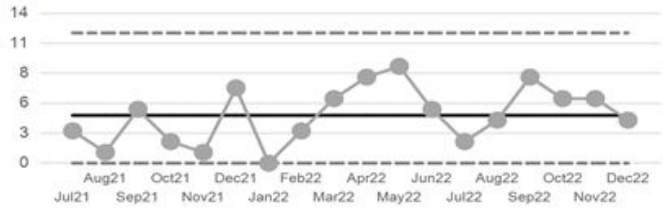
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU60	NICE Guidance Compliance	Green ≥90% Amber 85 - 89.9% Red <85%	Contractual		95.9%	95.8%	95.8%	95.7%	95.9%	93.1%	93.9%	93.4%	92.8%	94.7%	93.8%	94.0%		
			Narrative	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	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU75	Patient FFT: % of Respondents Who Had a Positive Experience	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		96.8%	96.5%	96.0%	96.1%	95.8%	96.9%	95.9%	96.0%	95.8%	95.9%	97.0%	97.2%		
			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.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU11	Number of Complaints	No Target	Contractual		0	3	6	8	9	5	2	4	8	6	6	4		
			Narrative	There were 4 complaints this month, with no significant change noted. Complaints are reviewed at Divisional Quality and Safety meetings, Divisional Performance Review meetings and RQGC. This promotes effective analysis of themes and trends to drive improvement.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU18	Number of Complaints / Count of WTE Staff (Ratio)	No Target	Contractual		0.000	0.002	0.004	0.005	0.005	0.003	0.001	0.002	0.005	0.003	0.003	0.002		
			Narrative	There were 0.002 complaints per staff WTE this month. Complaints are reviewed at Divisional Quality and Safety meetings, Divisional Performance Review meetings and RQGC. This promotes effective analysis of themes and trends to drive improvement.														

Data Not Applicable for SPC

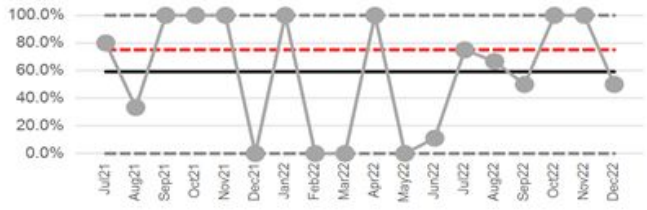
Integrated Performance Report (Jan 22 - Dec 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	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%		
			Narrative	The target continues to be achieved. There is no data for January 2022 as no complaints were received. Performance is as expected and the nature of variation indicates that the target is likely to be achieved.														

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU20	% of Routine Complaints Resolved Within 25 Working Days	Green ≥75% Amber 65% - 74.9% Red <65%	Local		100.0%	0.0%	0.0%	100.0%	0.0%	11.1%	75.0%	66.7%	50.0%	100.0%	100.0%	50.0%		
			Narrative	The target has not been achieved. Although this is an internally created target and there is no significant change, an exception report is provided as the upper and lower control limit range prevents any alerts. The control limits are therefore under review and likely to be adjusted for the 2023/24 IPR.														



Reason for Non-Compliance	Action Taken to Improve Compliance
1 routine complaint did not meet the 25 working day KPI in December. The complaint was received on 25th October 2022 with a response due date of 29th November 2022. The draft response was delayed due to further amendments being needed prior to final approval. The complainant was kept up to date with delays. The final response was sent on 9th December 2022, which was a delay of 9 working days.	Complaints approval process has now moved to a new team. Divisional teams are reminded of timescales involved in the complaint process to ensure that KPIs are met.

Escalation Route & Expected Date of Compliance
Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board January 2023

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU71	% of Complex Complaints Resolved Within 60 Working Days	Green ≥75% Amber 65% - 74.9% Red <65%	Local		-	-	-	66.7%	-	100.0%	100.0%	100.0%	50.0%	-	-	-		
			Narrative	No complex complaints were resolved this month.														

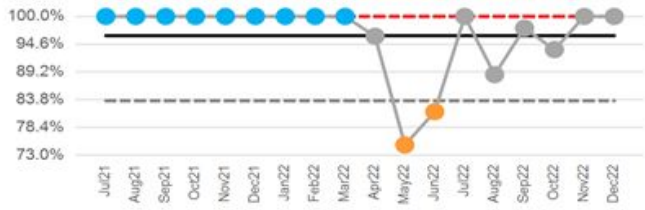
Data Not Applicable for SPC

Integrated Performance Report (Jan 22 - Dec 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

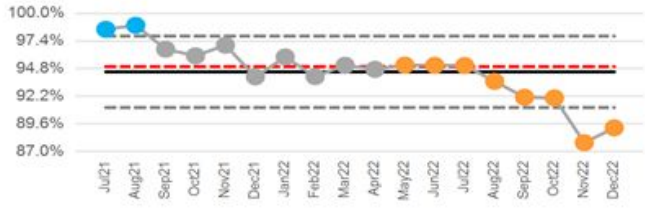
Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU21	% of FOIs Responded to Within 20 Days	Green 100% Red <100%	Contractual / Statutory		100.0%	100.0%	100.0%	96.2%	75.0%	81.5%	100.0%	88.7%	97.7%	93.5%	100.0%	100.0%		
			Narrative	The target has been achieved for the second consecutive month. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU22	Number of IG Incidents Escalated to ICO	Green 0 Red >0	Contractual / Statutory		0	0	0	0	0	0	0	0	0	1	0	0		
			Narrative	The target has been achieved. The IGC incident escalated to the ICO in October 2022 remains under review by the ICO.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU23	% of Policies in Date	Green ≥95% Amber 93.1 - 94.9% Red <93%	Contractual		95.9%	94.1%	95.1%	94.7%	95.1%	95.1%	95.1%	93.6%	92.1%	92.0%	87.8%	89.2%		
			Narrative	The target has not been achieved and an exception report is provided. Performance is lower than expected (triggering an exception report) and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Reason for Non-Compliance	Action Taken to Improve Compliance
28 of the 260 policies in the Trust have not been reviewed within the review period. 2 documents have been reviewed and are awaiting approval from the relevant forum. 20 documents are in the process of being reviewed by the authors. Document Control has not received any updates with regards to the remaining 6 documents and will continue to chase up the authors before escalating this issue.	The Document Control Officer will continue to send regular reminders for overdue items. Any policies that still continue to sit out of date for long periods without communication to Doc Control are escalated to the Information Governance Manager. The current process is due to be reviewed to identify any areas for improvement.

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

Integrated Performance Report (Jan 22 - Dec 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
QU24	NHS E/I Patient Safety Alerts: Number Not Implemented Within Set Timescale.	Green 0 Red >0	Contractual		0	0	0	0	0	0	0	0	1	0	0	0		
			Narrative	The target has been achieved. This metric has been revised to include only alerts which have a nationally set response date. Previous data has been amended.														

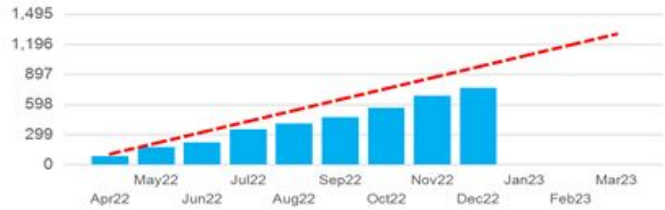
Data Not Applicable for SPC

Integrated Performance Report (Jan 22 - Dec 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month													
				Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
RI20	Study Recruitment	Green ≥1300 per year Amber 1100-1299 per year Red <1100 per	CCC Strategy	84	89	50	126	57	66	94	118	77	-	-	-		
			Narrative	YTD and December performance are both below the target. An exception report is therefore provided.													



Reason for Non-Compliance	Action Taken to Improve Compliance
761 patients have been recruited against an internal target of 972 (78% of target) at the end of Month 9. The main reasons at Month 9 for not achieving this target are: • A strategic, clinically-led decision was made in December 2021 to prioritise the set-up and opening of ECMC studies to recruitment. ECMC studies are scientifically relevant but by nature recruit lower patient numbers. This decision was taken to support the renewal of the ECMC bid. As a specialist cancer centre our portfolio does focus more on early phase trials. • Capacity impacted during December 2022 due to Sponsors closing and staff capacity during the Christmas period.	• Continuing to work collaboratively with service departments and research-active staff to open all studies types in a timely way. • We are maximising recruitment to all open trials: o Promoting early phase studies via ECMC Newsletter to all consultants to ensure opportunities for patient recruitment are promoted, o Early Phase Clinical Research Fellow post out to advert to support recruitment to early phase studies. o Portfolio Review meetings are an ideal opportunity for the research team to refresh knowledge on open and recruiting studies to ensure all potential patients are considered. o Research Delivery staff actively screening patient lists for eligible patients, o liaising with SRG Leads to promote open and recruiting studies, o regular meetings between Principal Investigators and Research Delivery staff to monitor progress against plan and devise strategies if off-plan, o using digital solutions to support referrals into the Research Delivery Team regardless of location. • To note: o CCC is currently top recruiting site for the Spruce study. Spruce is reviewing electronic versus paper based patient reported outcomes (PI Prof. Isabel Syndikus, Urology). o First patient treated on the Debio trial which is a Phase III Head and Neck study (PI Dr Ehab Ibrahim, Head and Neck). o Exceeded target for studies opened in month (n=6).

Escalation Route & Expected Date of Compliance
R&I Directorate Board, Committee for Research Strategy, Performance Committee, Trust Board March 2023

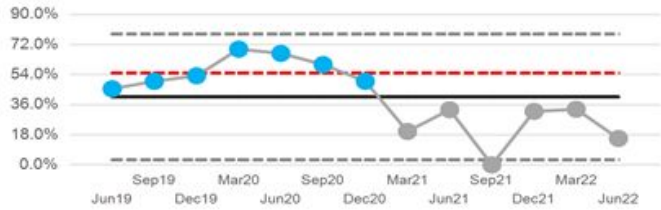
Metric ID	Metric Name	Target	Metric Type	Year & Month													
				Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
RI03	Study Set-Up Times in Days	Green ≤40 days Red >40	National Reporting	-	-	19	-	-	13	-	-	-	-	-	-		
			Narrative	Data is for the 12 month period up to the end of the month. No further data has been published nationally since the last IPR.													

Integrated Performance Report (Jan 22 - Dec 22)

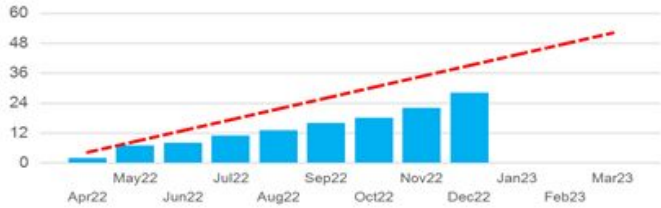
The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

Metric ID	Metric Name	Target	Metric Type	Year & Month												V	A
				Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22		
RI21	Recruitment to Time and Target	Green ≥55% Amber 45 - 54.9% Red <45%	National Reporting	-	-	33.3%	-	-	15.8%	-	-	-	-	-	-		
			Narrative	Data is for the 12 month period up to the end of the month. No further data has been published nationally since the last IPR.													



Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month												V	A
				Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23		
RI05	Number of New Studies Open to Recruitment	Green ≥52 per year Amber 45 - 51 Red <45	CCC Strategy	2	5	1	3	2	3	2	4	6	-	-	-		
			Narrative	Whilst YTD performance is below the target, the December figure is above the monthly target, therefore an exception report is not provided.													



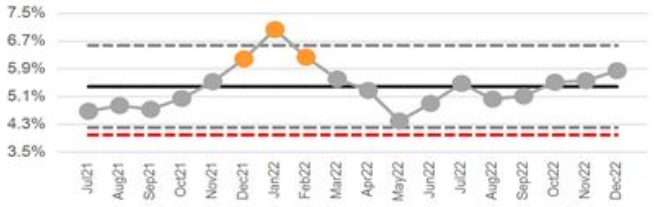
Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month												V	A
				Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23		
RI22	Publications	Green >200 per year Amber 170-200 Red <170	CCC Strategy	10	15	16	15	16	18	15	21	18	-	-	-		
			Narrative	Whilst YTD performance is marginally below the target, the December figure is above the monthly target, therefore an exception report is not provided.													

Integrated Performance Report (Jan 22 - Dec 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

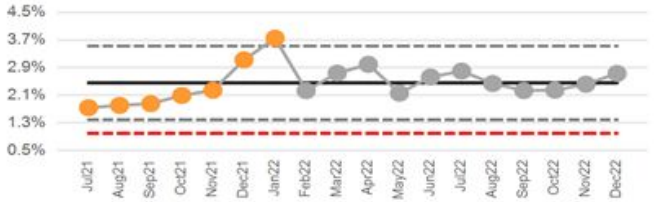
Metric ID	Metric Name	Target	Metric Type	Year & Month												V	A
				Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22		
WO01	Sickness Absence	Green ≤4% Amber 4.1 - 4.9% Red ≥5%	Contractual / Statutory	7.0%	6.2%	5.6%	5.3%	4.4%	4.9%	5.5%	5.0%	5.1%	5.5%	5.6%	5.9%		
			Narrative	The target has not been achieved. Although there is no significant change, the target is unlikely to be achieved without a significant change and an exception report is therefore provided.													



Reason for Non-Compliance	Action Taken to Improve Compliance
Sickness absence has increased again from 5.6% to 5.85%, remaining above the Trust's target of 4%. There were 402 absences in December compared with 292 in November 2022. There were 59 long term absences and 343 short term absences. The highest reasons for absence were consistent with November as 'cold, cough and influenza' however there was a significant increase from 58 episodes in November to 149 episodes in December. Gastrointestinal absences increased, to become the second highest reason with 63, followed by 'anxiety, stress and depression' with 52 episodes. Of the 52 episodes due to 'anxiety/stress/depression', 30 of these were long term which is a decrease of 5 episodes since November and 22 were short term. 31 of the total absences continued into December 2022. Research and Innovation had the highest percentage of absences in proportion to staff numbers with 30% (26 absences) followed by Acute Care with 26% (111) and Networked Services with 25% (146).	The HRBP team have commenced quarterly 'deep dives' into sickness absence across divisions to identify any patterns or themes in absence occurences and reasons. These will be reviewed quarterly with divisional leads to agree actions to reduce absence. Due to the consistently high numbers, the HRBP continue to review any open sickness absences relating to 'Anxiety/Stress/Depression' across the Divisions. The HRBP team to continue to prompt managers to record whether absences relating to 'anxiety/stress/depression' are work related or not, to provide further information for analysis.

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

Metric ID	Metric Name	Target	Metric Type	Year & Month												V	A
				Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22		
WO20	Sickness Absence (Short Term)	Green ≤1% Amber 1.1 - 1.2% Red ≥1.3%	Contractual / Statutory	3.8%	2.2%	2.7%	3.0%	2.2%	2.6%	2.8%	2.4%	2.2%	2.2%	2.4%	2.7%		
			Narrative	The target has not been achieved. Although there is no significant change, the target is unlikely to be achieved without a significant change and an exception report is therefore provided.													



Integrated Performance Report (Jan 22 - Dec 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

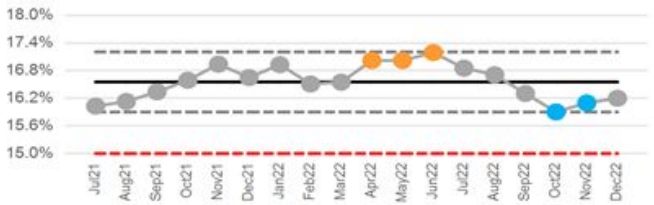
Workforce

Reason for Non-Compliance	Action Taken to Improve Compliance
There were 343 short term absences in December 2022. The highest reason was due to cold/cough/influenza with 149 occurences, followed by gastrointestinal with 61 and chest and respiratory with 44. Absences lasted on average 3 days and the highest day for staff to be absent is a Monday with 93. Research and Innovation had the highest percentage of short term absence in proportion to staff numbers, with 26% (23 absences) followed by Networked Services with 21% (123), Acute Care 21% (91) and Radiation Services 21% (83).	The HRBP team have commenced quarterly 'deep dives' into sickness absence across divisions to identify any patterns or themes in absence occurences and reasons. These will be reviewed quarterly with divisional leads to agree actions to reduce absence.

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

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
WO21	Sickness Absence (Long Term)	Green ≤3% Amber 3.1 - 3.5% Red ≥3.5%	Contractual / Statutory		3.2%	3.7%	2.9%	2.3%	2.2%	2.3%	2.7%	2.6%	2.8%	2.7%	3.0%	3.1%		
				Narrative	Performance is marginally above the internal target, however there is no significant change. The nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
WO02	% Turnover (Rolling 12 Months)	Green ≤15% Amber 14.1%-14.9% Red ≥14%			16.9%	16.5%	16.6%	17.0%	17.0%	17.2%	16.9%	16.7%	16.3%	15.9%	16.1%	16.2%		
				Narrative	The target has not been achieved. Although performance is lower than expected, the nature of variation indicates that the target is unlikely to be achieved without a significant change and an exception report is therefore provided.													



Integrated Performance Report (Jan 22 - Dec 22)

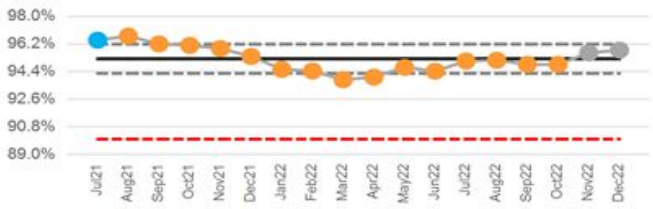
The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

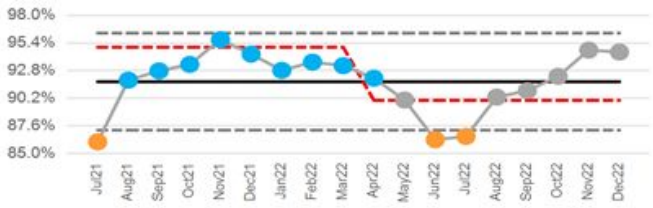
Reason for Non-Compliance	Action Taken to Improve Compliance
The Trust turnover figure increased slightly from 16.1% to 16.2% and remains above target. This includes all leavers from the Trust, regardless of reason for leaving. Leavers linked to retirement and end of fixed term contracts (FTC) were removed from the list of leavers up until the end December 2022 in order to try and understand whether the Trust would still be above target. With these removed, the Trust would be at 14.08%, which is only slightly above target. This amounts to 10 leavers due to end of FTC and 31 due to retirement. There were 6 more leavers this month, with 19 in total. Work life balance was the highest reason for leaving in December with 5 in total followed by promotion (3), retirement (3) and Other/Not Known (3). The Corporate division had the highest percentage of leavers in proportion to staff numbers with 7.69% (3 leavers), followed by Acute Care with 1.4% (6) and Research and Innovation with 1.1% (1). 5 exit interviews were completed for staff leaving in December, which is consistent with 5 in November 2022. From analysis of the exit interviews, in addition to their main reasons for leaving, the following categories of reasons were cited as factors that influenced their decision: Relocation, New post within the NHS, retirement age, staff morale, line management.	The HRBP team have commenced undertaking quarterly 'deep dives' into turnover in the Divisions in order to better understand the reasons and to identify any themes or patterns. The HRBP Team continue to push for exit interviews to be completed to ensure the collation of useful information which can drive futher analysis and improvements. The HRBP Team continue to work with line managers during HR Surgeries to ensure that they are recording the correct reason, as there is evidence that the most appropriate reason is not always being recorded. Training for line managers may be required if this continues to be a concern.

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

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
WO07	Statutory Mandatory Training Compliance	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual / Statutory		94.6%	94.4%	93.9%	94.0%	94.7%	94.4%	95.1%	95.1%	94.9%	94.9%	95.6%	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	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
WO22	Performance Development Reviews (PADR) Snapshot Month End	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual		92.8%	93.6%	93.3%	92.1%	90.0%	86.3%	86.6%	90.3%	90.9%	92.3%	94.7%	94.6%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														

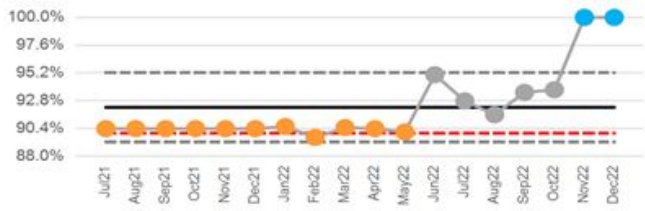


Integrated Performance Report (Jan 22 - Dec 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
WO23	Medical Appraisal	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual / Statutory		90.6%	89.6%	90.5%	90.4%	90.1%	95.0%	92.8%	91.6%	93.5%	93.8%	100.0%	100.0%		
			Narrative	The target has been achieved, at 100%. Performance is better than expected although the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
WO24	Pulse Staff Survey: Employee Engagement Score	To Be Confirmed	Contractual		-	-	7.00	-	-	6.90	-	-	7.20	-	-	-		
			Narrative	There are no new results to report this month as there was no survey in December 2022.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
WO25	Pulse Staff Survey: Advocacy Score	To Be Confirmed	Contractual		-	-	7.40	-	-	7.10	-	-	7.60	-	-	-		
			Narrative	There are no new results to report this month as there was no survey in December 2022.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
WO26	Pulse Staff Survey: Involvement Score	To Be Confirmed	Contractual		-	-	6.80	-	-	6.80	-	-	6.90	-	-	-		
			Narrative	There are no new results to report this month as there was no survey in December 2022.														

Data Not Applicable for SPC

Integrated Performance Report (Jan 22 - Dec 22)

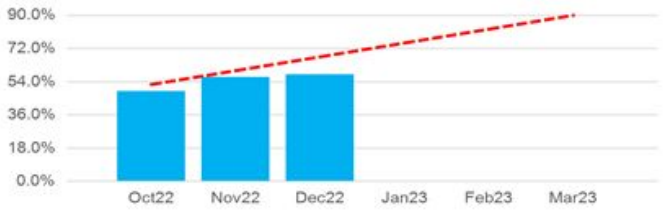
The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Metric ID	Metric Name	Target	Metric Type	Year & Month	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	V	A
WO27	Pulse Staff Survey: Motivation Score	To Be Confirmed	Contractual		-	-	6.80	-	-	6.90	-	-	6.90	-	-	-		
			Narrative	There are no new results to report this month as there was no survey in December 2022.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	V	A
WO33	Staff Flu Vaccination: % of Frontline Staff Who Have Been Vaccinated	Green ≥90% Red <90% Ending Feb 2023	CQUIN		-	-	-	-	-	-	48.9%	56.5%	58.0%	-	-	-		
			Narrative	Uptake is lower than in previous years, mirroring the regional and national picture. Changes to the national documentation system mean that it is no longer possible to identify if staff have received the vaccination elsewhere and such data is not included in the figures. Actions have been implemented to encourage uptake.															



Integrated Performance Report (Jan 22 - Dec 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Finance

Metric (£000)	In Mth 9 Actual	In Mth 9 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	191	135	56		1,308	1,215	93	
CPL/Propcare Surplus/ (Deficit)	107	0	107		1,083	0	1,083	
Control Total Surplus/ (Deficit)	298	135	163		2,391	1,215	1,176	
Trust Cash holding	67,410	54,033	13,377		67,410	54,033	13,377	
Capital Expenditure	1,303	2,055	752		2,419	2,888	469	
Agency Cap	152	95	(57)		1,253	855	(398)	

For 2022/23 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 showing a £1.621m surplus for 2022/23. The Trust position was reliant upon receiving Elective Recovery Funding (ERF) of £9m for activity over and above 104% of 2019/20 to achieve the plan. The national team confirmed in December there will be no ERF payments transacted for activity above 104%. To mitigate this the ICS have agreed systems funding of £3.5m for the Trust. While this is not the full amount included in the financial plan the Trust had only required £1.6m of ERF to achieve plan to month 8, the Trust had been able to mitigate the shortfall through non recurrent means. The assumption is this will continue for the final quarter.

The Trust financial position to the end of December is a £1.308m surplus, which is £93k above plan. The group position to the end of December is a £2.391m surplus.

The Trust cash position is a closing balance of £67.4m, which is £13.3m above plan. Capital spend is currently reporting below plan, with the majority of spend expected in the last quarter of the year.

The Trust is over the agency cap in December by £57k and £398k year to date. Further controls have been put in place by NHSE/I to monitor agency spend and the Divisions have provided exit strategies for all agency spend, these are being monitored regularly throughout the year.

Trust Board
25th January 2023

Report Lead	James Thomson – Director of Finance					
Paper prepared by	Jo Bowden – Deputy Director of Finance					
Report subject/title	Finance Report – Month 9 2022/23 (P1-013-23)					
Purpose of paper	Present the Trust's financial position					
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 December 2022, the ninth month of the 2022/23 financial year.

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

2. Summary Financial Performance

2.1 For December the key financial headlines are:

Metric (£000)	In Mth 9 Actual	In Mth 9 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	191	135	56		1,308	1,215	93	
CPL/Propcare Surplus/ (Deficit)	107	0	107		1,083	0	1,083	
Control Total Surplus/ (Deficit)	298	135	163		2,391	1,215	1,176	
Trust Cash holding	67,410	54,033	13,377		67,410	54,033	13,377	
Capital Expenditure	1,303	2,055	752		2,419	2,888	469	
Agency Cap	152	95	(57)		1,253	855	(398)	

2.2 For 2022/23 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 showing a £1.621m surplus for 2022/23. The Trust position was reliant upon receiving Elective Recovery Funding (ERF) of £9m for activity over and above 104% of 2019/20 to achieve the plan.

In December, NHS England stated that ERF payments above 104% would not be transacted for 2022/23. To mitigate this the ICS have agreed systems funding of £3.5m for the Trust. While this is not the full amount included in the financial plan the Trust had only required £1.6m of ERF to achieve plan to month 8, the Trust had been able to mitigate the shortfall through a number of non-recurrent means. The assumption is that these non-recurrent benefits will continue for the final quarter.

3. Operational Financial Profile – Income and Expenditure

Overall Income and Expenditure Position

3.1 The Trust financial position to the end of December is a £1,308k surplus, which is £93k above plan. The group position to the end of December is a £2,391k surplus. The Trust cash position is a closing balance of £67.4m, which is £13.4m above plan. Capital spend is currently reporting below plan, with the majority of spend expected in the last quarter of the year.

3.2 The Trust is over the agency cap in December by £57k and £398k year to date. Further controls have been put in place by NHSE/I to monitor agency spend and the Divisions have provided exit strategies for all agency spend, these are being monitored regularly throughout the year. Further detail has been provided below.

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

Metric (£000)	Actual M9	Trust Plan M9	Variance	Actual YTD	Trust Plan YTD	YTD Variance	Trust Annual Plan
Clinical Income	20,548	19,586	962	174,719	170,505	4,214	226,388
Other Income	1,256	2,202	(946)	15,393	19,296	(3,903)	25,178
Total Operating Income	**21,805**	**21,789**	**16**	**190,112**	**189,801**	**311**	**251,566**
Total Operating Expenditure	(21,351)	(21,307)	(45)	(186,406)	(185,465)	(940)	(245,785)
Operating Surplus	**453**	**482**	**(28)**	**3,706**	**4,336**	**(630)**	**5,781**
PPJV	52	67	(16)	569	603	(35)	804
Finance Costs	(314)	(414)	100	(2,966)	(3,723)	757	(4,964)
Trust Surplus/Deficit	**191**	**135**	**56**	**1,308**	**1,216**	**93**	**1,621**
Subsiduaries	107	0	107	1,083	0	1,083	**0**
Consolidated Surplus/Deficit	**298**	**135**	**163**	**2,391**	**1,216**	**1,175**	**1,621**

The table below summaries the consolidated financial position:

December 2023 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	109	573
Donated Depreciation	82	735
Trust Retained Surplus / (Deficit)	**191**	**1,308**
CPL	6	516
Propcare	101	567
Consolidated Financial Position	**298**	**2,391**

3.4 The bridge below shows the key drivers between the £191k in month surplus and £135k surplus plan, which is a variance of £56k:

- The Trust is no longer assuming any income for Elective Recovery Fund (ERF) for activity over 104% of 2019/20 and so is showing a £751k under recovery against the ERF income plan in month. The Trust has, however, agreed a fixed amount of £3.5m systems funding from the ICS. As at M9 the Trust has included 9/12ths of this income in the position, which equates to £2.625m. £884k is profiled in M9 and so overall there is a positive variance of £133k.

- Cost and Volume Drugs are under spent by £47k and are offset by an under recovery of income. As part of the 2022/23 funding agreement with commissioners high cost drugs remain on a pass-through basis. Block drugs are at plan in month 9.

- Trust Pay costs are under spent by £85k. Run rate and staff numbers are consistent with the previous month. The underspend has increased due to reprofiling of pay budgets for in year investments.

- Bank spend has reduced further in month to £114k. This is due to a number of substantive posts starting, mainly on the wards and a reduction in the requirements for 1:1 care.

- Agency spend is £152k in month. While consistent with previous months, this is significantly above the £95k agency cap and is being monitored through the workforce establishment control panel and Finance Committee.

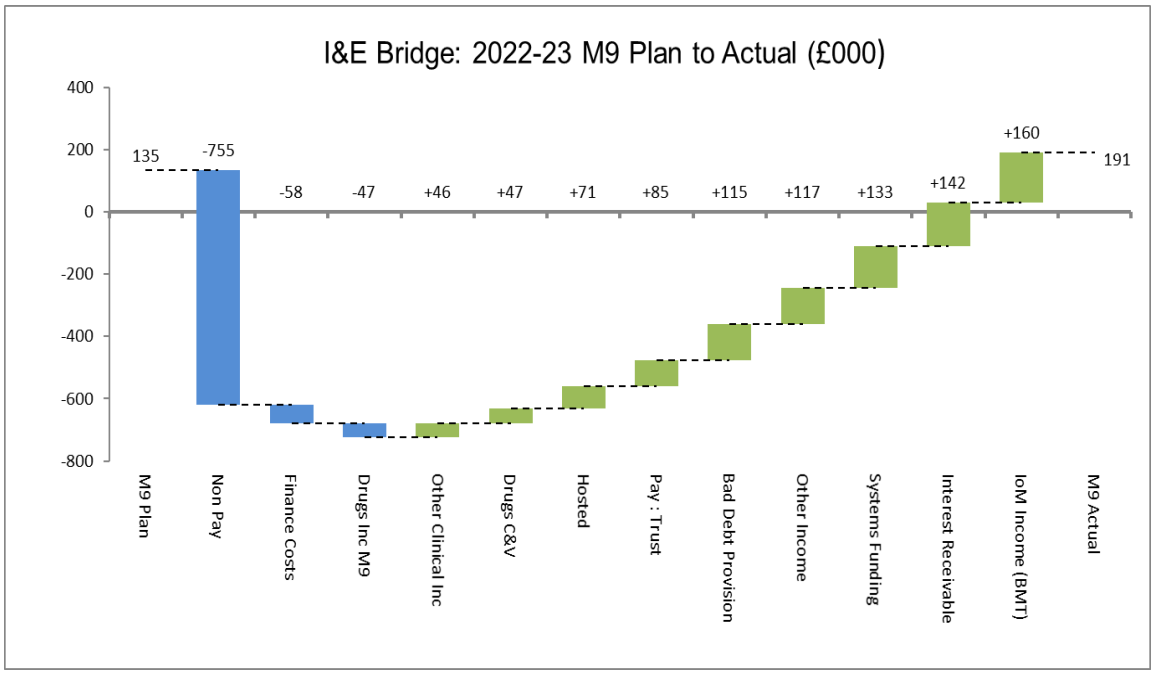
- Non pay is overspent by £755k. The Trust has reviewied the level of accrual in month relating to the LUFT SLA and energy costs to reflect the latest information provided, this has resulted in an increased level of accrual. There have also been additional costs incurred relating to PET CT reporting, these are however offset by additional income .

- Other income includes £85k for additional PET CT activity, as mentioned above, which is expected to continue.

- Interest receivable is over plan by £142k, this relates to increasing interest rates.

- Due to the improvement in debt collection the bad debt provision has been reduced in month, giving a positive impact of £115k.

- There has been additional income included in Month 9 for BMT activity undertaken for IoM of £160k. Further increases in activity with IoM are under review.



3.5 Elective Recovery Fund Position

The CCG and NHSE Contracts include an element of block income block for Elective Recovery activity up to 104% of 2019/20 activity level. We will receive £701k from CCGs and £3.1m from NHSE if the Trust achieve this level of activity. For month 9 reporting the Trust has assumed receipt of the ERF income up to 104% of activity.

For activity over and above 104% of 2019/20 the Trust had included a plan of £9.021m based on activity assumptions.

It was confirmed in December there will be no ERF payments transacted for activity above 104%. To mitigate this the ICS have agreed systems funding of £3.5m for the Trust. While this is not the full amount included in the financial plan the Trust had only required £1.6m of ERF to achieve plan to November (Month 8), the Trust had been able to mitigate the shortfall through a number of non-recurrent means. The assumption is that these non-recurrent benefits will continue for the final quarter.

3.6 Forecasting

The Trust is reporting an improved forecast outturn position of £2.012m, which is an increase of £400k. This improvement is due to the increase in interest receivable expected for M9-12. This approach has been applied consistently across the ICS to support the overall position.

3.7 Bank and Agency Reporting

Bank spend has reduced significantly in month to £114k, a reduction of £26k. This is due to a number of permanent staff starting in post, mainly on the wards and a reduction in the requirements for 1:1 care. The main area of bank spend is the inpatient wards.

Agency spend is £152k in month. While consistent with previous months, this is significantly above the £95k agency cap and is being monitored through the workforce establishment control panel and Finance Committee.

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.

3.8 Cost Improvement Programme (CIP)

The Trust CIP requirement for 2022/23 is £6.765m, representing 4.5% of turnover.

This is broken down into £4.4m recurrent and £2.3m non-recurrent.

The £2.3m non-recurrent element will be met centrally by the Trust. Of the remaining £4.4m recurrent element, £1m will be met by reserves and the remaining £3.4m allocated to the Divisions.

Target		**6,765,000**
NR Contingency		2,300,000
Balance		**4,465,000**
Reserves		1,000,000
Divisional Allocation		3,465,000

Against the full year CIP target of £6.7m, £6.6m of schemes have been identified (98%), the Trust is on plan to deliver the target by the end of the year. Only £2.7m has been identified recurrently against the £4.4m recurrent target (61%).

The majority of schemes have been identified centrally, Divisions continue to work on developing a number of recurrent opportunities that are currently being worked through and savings likely to be realised in future months. There are currently £0.2m of ideas that are being worked up not included in the figures above and a number of schemes being worked on for next financial year.

Given the significant increase in CIP target for the year there has been really positive engagement across the Trust to achieve this challenging target.

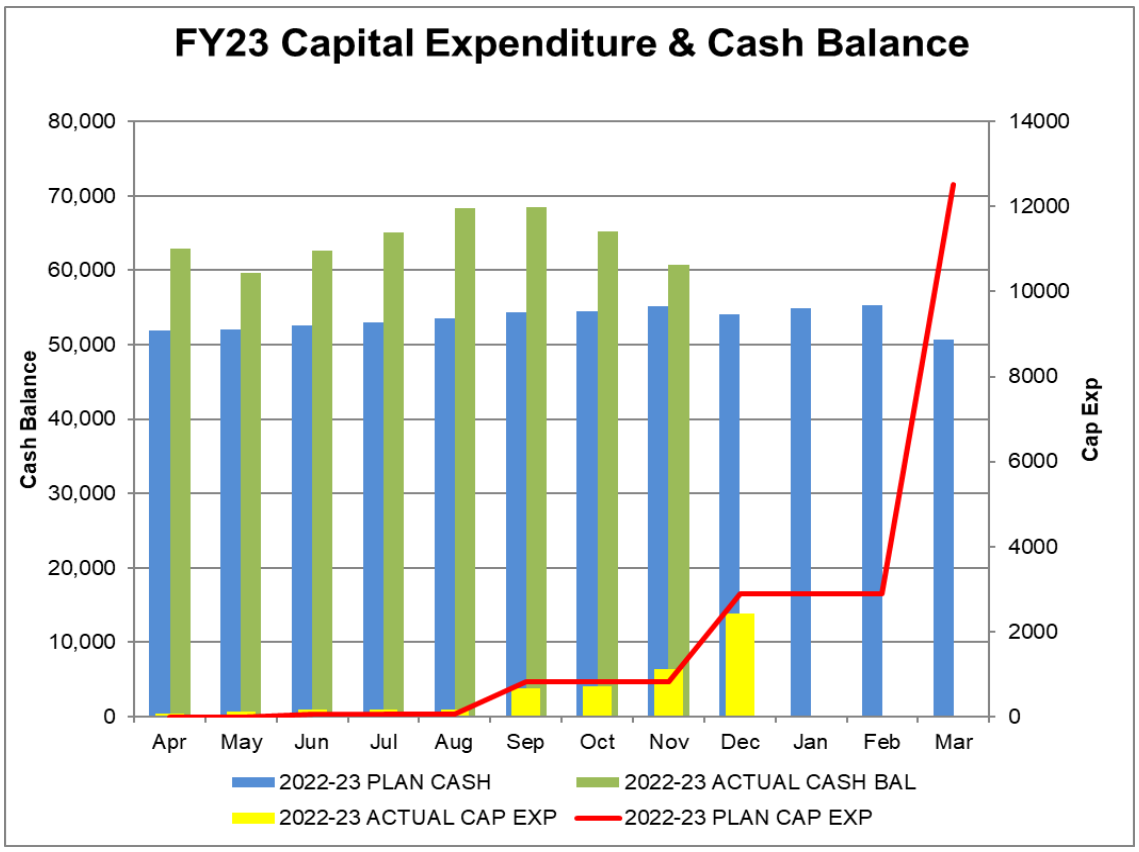
4. Cash and Capital

4.1 The 2022/23 capital plan approved by the Board in March was £7.013m. Since this national PDC funding of £5.5m have been approved to support the CDC facility. We have however agreed with Wirral University Teaching Hospital NHS FT that they will lead the CDC capital programme and that the PDC will be transferred to them, this has not yet been transacted by the ICS.

4.2 Capital expenditure of £2.4m has been incurred to the end of December. The majority of capital spend is profiled to be spent in the final quarter of the year. Capital Investment Group closely monitor the position to ensure any slippage risk is identified and mitigated.

4.3 The capital programme is supported by the organisation's cash position. The Trust has a current cash position of £67.4m, which is a positive variance of £13.4m to the cash-flow plan.

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 2022/23.

5. Balance Sheet Commentary

5.1 Current Assets

The Trust's cash balance at the end of December is £67.4m, this is £13.4m above plan figure of £54m. There is £9.6m in deferred income and around £5m for capital funds not yet spent.

Receivables are below plan, demonstrating that debt is being collected promptly.

5.2 Current Liabilities

Payables (non-capital creditors) are £2.2m below plan.

Deferred Income is £9.6m 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 reported surplus position for December 2022, and the improved year end forecast position.
- The agreement with the ICS to support the non-receipt of ERF over and above 104%
- The continuing strong liquidity position of the Trust

Appendix A – Statement of Comprehensive Income (SOCI)

(£000)	Month 9			Cumulative YTD				2022-2023
	Plan	Actual	Variance	Plan	Actual	Variance	%	Annual Plan
Clinical Income	18,532	18,825	293	167,342	169,398	2,056		223,012
Other Income	893	1,010	117	6,837	8,170	1,333		9,171
Hosted Services	2,364	1,969	(394)	15,623	12,544	(3,079)		19,383
Total Operating Income	**21,789**	**21,805**	**16**	**189,801**	**190,112**	**311**	**0%**	**251,566**
Pay: Trust (excluding Hosted)	(6,630)	(6,545)	85	(58,623)	(57,795)	828		(78,227)
Pay: Hosted	(904)	(740)	164	(7,494)	(6,239)	1,254		(9,837)
Drugs expenditure	(7,694)	(7,648)	47	(69,247)	(71,625)	(2,377)		(92,330)
Other non-pay: Trust (excluding Hosted)	(4,566)	(5,207)	(641)	(41,453)	(44,324)	(2,872)		(55,167)
Non-pay: Hosted	(1,513)	(1,212)	301	(8,648)	(6,422)	2,226		(10,225)
Total Operating Expenditure	**(21,307)**	**(21,351)**	**(45)**	**(185,465)**	**(186,405)**	**(940)**	**-1%**	**(245,785)**
Operating Surplus	**482**	**453**	**(28)**	**4,336**	**3,707**	**(629)**	**15%**	**5,781**
Profit /(Loss) from Joint Venture	67	52	(15)	603	569	(34)		804
Interest receivable (+)	386	528	142	3,470	4,132	662		4,626
Interest payable (-)	(434)	(423)	11	(3,910)	(3,847)	62		(5,213)
Interest right of use (-)	0	(65)	(65)	0	(65)	(65)		0
PDC Dividends payable (-)	(365)	(354)	11	(3,283)	(3,186)	97		(4,377)
Trust Retained surplus/(deficit)	**135**	**191**	**56**	**1,216**	**1,309**	**93**	**8%**	**1,621**
CPL/Propcare	0	107	107	0	1,083	1,083		0
Consolidated Surplus/(deficit)	**135**	**298**	**163**	**1,216**	**2,391**	**1,176**	**8%**	**1,621**

Appendix B – Balance Sheet

£'000	Audited 2022 (Group Ex Charity)	Plan 2023 (Trust only)	Year to date Month 9		
			YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	3,211	3,162	2,693	2,967	275
Property, plant & equipment	184,599	173,627	174,356	179,535	5,180
Right of use assets	0	0		9,086	9,086
Investments in associates	977	800	800	796	(4)
Other financial assets	0	115,276	0	0	0
Trade & other receivables	449	434	433	508	75
Other assets	0	0	0	0	0
Total non-current assets	**189,236**	**293,298**	**296,990**	**192,893**	**(104,097)**
Current assets					
Inventories	5,640	3,000	2,459	4,281	1,822
Trade & other receivables					
NHS receivables	7,749	7,084	6,882	6,398	(484)
Non-NHS receivables	6,278	10,915	10,603	9,165	(1,438)
Cash and cash equivalents	80,726	50,708	53,041	75,214	22,173
Total current assets	**100,393**	**71,707**	**72,985**	**95,058**	**22,073**
Current liabilities					
Trade & other payables					
Non-capital creditors	6,918	32,207	32,697	30,458	(2,238)
Capital creditors	36,547	1,958	1,987	2,082	95
Borrowings					
Loans	1,908	1,730	1,730	1,808	78
Lease liabilities		0	0	162	162
Provisions	4,214	94	99	5,008	4,909
Other liabilities:-					
Deferred income	15,669	5,577	5,504	15,184	9,680
Other	0	0	0	0	0
Total current liabilities	**65,255**	**41,565**	**42,017**	**54,703**	**12,686**
Total assets less current liabilities	**224,374**	**323,440**	**327,958**	**233,248**	**(94,710)**
Non-current liabilities					
Trade & other payables					
Capital creditors	120	0	0	0	0
Borrowings					
Loans	32,090	30,360	31,350	30,485	(865)
Lease liabilities	0	0	0	8,942	8,942
Other liabilities:-					
Deferred income	0	1,018	(0)	0	0
Provisions	197	115	527	197	(330)
PropCare liability	(1)	113,436	(776)	0	776
Total non current liabilities	**32,406**	**144,929**	**149,810**	**39,624**	**8,522**
Total net assets employed	**191,968**	**178,511**	**178,148**	**193,624**	**15,476**
Financed by (taxpayers' equity)					
Public Dividend Capital	72,219	72,219	72,219	72,219	0
Revaluation reserve	4,558	2,699	2,699	4,558	1,859
Income and expenditure reserve	115,191	103,593	103,230	116,847	13,618
Total taxpayers equity	**191,968**	**178,511**	**178,148**	**193,624**	**15,476**

Appendix C – Cash Flow

December 2022 (M9) £'000	FT	Group	Group (exc Charity)
Cash flows from operating activities:			
Operating surplus	2,960	5,551	4,357
Depreciation	7,195	7,195	7,195
Amortisation	529	529	529
Impairments	0	0	0
Movement in Trade Receivables	(1,954)	(1,539)	(1,594)
Movement in Other Assets	1,701		
Movement in Inventories	2,058	1,359	1,359
Movement in Trade Payables	(10,917)	(6,318)	(6,232)
Movement in Other Liabilities	(446)	(484)	(484)
Movement in Provisions	730	794	794
CT paid	0	(189)	(189)
Net cash used in operating activities	**1,855**	**6,897**	**5,734**
Cash flows from investing activities			
Purchase of PPE	(6,968)	(7,087)	(7,087)
Purchase of Intangibles	(285)	(285)	(285)
ROU Assets	(9,086)	(9,086)	(9,086)
Proceeds from sale of PPE	11	11	11
Interest received	4,132	743	719
Investment in associates	750	750	750
Net cash used in investing activities	**(11,447)**	**(14,955)**	**(14,979)**
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	(1,705)	(1,560)	(1,560)
Capital element of finance lease	9,104	9,104	9,104
Interest paid	(3,847)	(562)	(562)
Interest element of finance lease	(65)	(65)	(65)
PDC dividend paid	(3,186)	(3,186)	(3,186)
Finance lease - capital element repaid	0	0	0
Net cash used in financing activities	**301**	**3,732**	**3,732**
Net change in cash	**(9,290)**	**(4,327)**	**(5,513)**
Cash b/f	**76,701**	**82,815**	**80,726**
Cash c/f	**67,410**	**78,488**	**75,214**

Appendix D – Capital

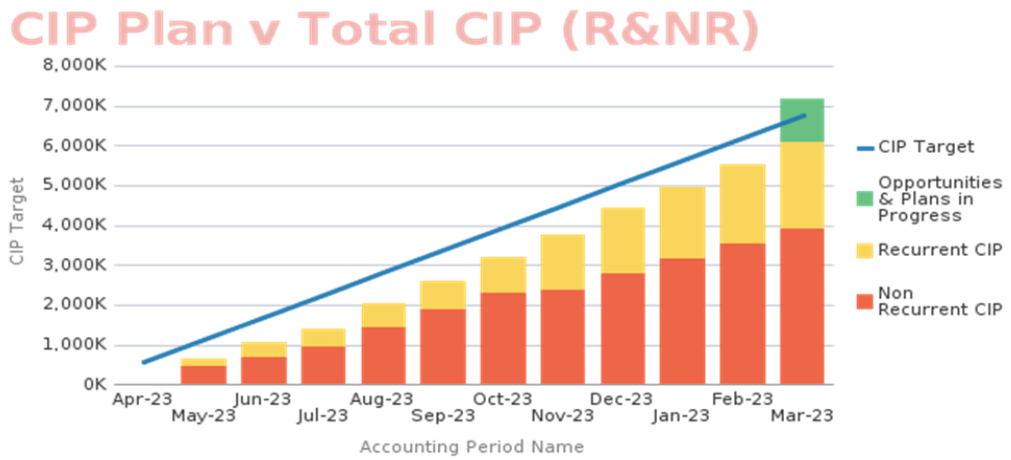
Capital Programme 2022-23
Month 9

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Code	Scheme	Lead	BUDGET (£'000) NHSI plan 22-23	Approved Adjustments	Budget 22-23	ACTUALS (£'000) Actuals @ Month 9	Variance to Budget	FORECAST (£'000) Forecast 22-23	Variance to Budget	Ordered?	Complete?	Comments
4142	***(21/22)*** TCC - Liverpool	Peter Crangle	0	0	0	0	(0)	0	(0)			
4142	***(21/22)*** TCC - Liverpool - Artwork	Sam Wade	0	0	0	2	(2)	2	(2)			
4142	***(21/22)*** TCC - Link Bridge installation	Peter Crangle	0	0	0	699	(699)	699	(699)			
4300	***(21/22)*** CCCW CT Simulator (Brilliance 2)	Louise Bunby	0	0	0	0	(0)	1	(1)			
4306	***(21/22)*** CCCL Ward 2 Sluice	Jeanette Russell	0	0	0	0	(0)	0	(0)			
4307	***(21/22)*** CCCL Ward 4/5 bathroom conv	Pris Hetherington	0	60	60	69	(9)	69	(9)	✓	✗	£59,804 approved charity funding
4313	***(21/22)*** CCCL Terraces		0	0	0	10	(10)	10	(10)	✓	✓	Additional cost on prior year scheme
4323	***(21/22)*** CCCL Ward 2 blood room conv		0	0	0	3	(3)	3	(3)	✓	✓	Additional cost on prior year scheme
4401	CCC-L Ward 3 bathroom conversion	Kathryn Williams	0	32	32	0	32	32	0	✗	✗	Delayed, awaiting update
4407	CCC-A Cherry linac replacement		160	(120)	40	31	9	40	0	✓	✗	Awaiting revised forecast
	Major roofing works	Peter Crangle	500	(500)	0	0	0	0	0	✗	✗	Replaced with below Propcare plan
	6 Facet lifecycle	Peter Crangle	533	(533)	0	0	0	0	0	✗	✗	Replaced with below Propcare plan
4420	Propcare 22-23 Capital Plan	Peter Crangle	0	817	817	0	817	817	0	✗	✗	Urgent update required
4414	CCC-L Fridge	Peter Crangle	0	9	9	9	0	9	0	✓	✓	Electrical works
4419	CCC-W PPU Refurb	Peter Crangle	0	0	0	15	(15)	15	(15)	✓	✗	
4428	CCC-L M1 Service Counter Chilled Beam	Installation	0	0	0	34	(34)	34	(34)	✓	✗	
	Contingency	*n/a*	200	295	495	0	495	0	495	-	-	
	Estates		**1,393**	**60**	**1,453**	**872**	**580**	**1,732**	**(279)**			
4180	***(19/20)*** CCCL HDR & Papillon tfr costs		0	0	0	4	(4)	4	(4)	✓	✓	
4189	***(19/20)*** Draeger IACS Monitoring C700		0	0	0	(2)	2	(2)	2	✓	✓	Refund received due to overcharge
4192	***(19/20)*** Cyclotron	Carl Rowbottom	450	0	450	253	197	450	0	✓	✗	
4303	***(20/21)*** CCCA Linear Accelerator - Maple		0	0	0	0	(0)	0	(0)	✓	✓	
4331	***(21/22)*** Donated Scalp Cooler - Wirral		0	(2)	(2)	(2)	0	(2)	0	✓	✓	VAT recovery on charitably funded asset
4332	***(21/22)*** Donated Scalp Cooler - Halton		0	(2)	(2)	(2)	0	(2)	0	✓	✓	VAT recovery on charitably funded asset
4309	Voltage Stabilisers	Martyn Gilmore	0	60	60	71	(11)	71	(11)	✓	✗	Delivery delayed until December
	CCC-A Cherry linac replacement		2,460	(2,460)	0	0	0	0	0	✗	✗	Not going ahead in year
4404	HDR Brachytherapy equip (Applicators)	Chris Lee	110	24	134	140	(6)	140	(6)	✓	✗	Receipted Sept, additional parts on order
	Varian - Aria Software	Carl Rowbottom	500	0	500	0	500	1,185	(685)	✗	✗	Ongoing negotiations
	Varian - Truebeam	Carl Rowbottom	0	0	0	0	0	1,010	(1,010)	✗	✗	Ongoing negotiations
4400	Hand Hygiene Scanner		0	0	0	12	(12)	12	(12)	✓	✓	Transferred from revenue
4402	Moving and Handling Training Equipment	Kate Greaves	0	29	29	29	0	29	0	✓	✗	Awaiting final invoices
4406	Ultrasound CCC-L	Julie Massey	0	80	80	0	80	85	(5)	✓	✗	Requsition with procurement. 8 wk lead time
4415	RFID Asset Tracking System	Julie Massey	0	200	200	0	200	200	0	✗	✗	Approved at TEG 3rd October
4416	Donated Scalp Cooler - Liverpool	Fiona Courtnell	0	10	10	10	0	10	0	✓	✓	Identified in revenue
4417	Additional Pilot Systems for CIT	Julie Massey	0	12	12	12	0	12	0	✓	✗	Delivery expected in December
4418	CCC-L MRI Acceleration Software	Marc Rea	0	40	40	0	40	40	0	✓	✗	New PDC funded scheme. Order 20/10
4426	Suncheck server hardware	Simon Temple	0	16	16	16	0	16	0	✓	✗	
	CPL Q-Pulse		0	0	0	0	0	50	(50)	✗	✗	
	Contingency	*n/a*	400	1,468	1,868	0	1,868	(134)	2,002	-	-	
	Medical Equipment		**3,920**	**(525)**	**3,395**	**539**	**2,856**	**3,172**	**222**			
4138	***(21/22)*** Infrastructure	James Crowther	0	0	0	70	(70)	70	(70)	✓	✓	
4190	***(20/21)*** Digital Aspirant Programme	James Crowther	0	0	0	16	(16)	16	(16)	✓	✓	
4316	***(21/22)*** Digital Diagnostics Capability Prg	James Crowther	0	0	0	(35)	35	(35)	35	✓	✓	VAT review on prior year invoices
4317	***(21/22)*** Intelligent Automation (RPA)	James Crowther	0	0	0	(0)	0	(0)	0	✓	✓	
4320	***(21/22)*** Digital Infrastructure	James Crowther	0	0	0	(129)	129	(129)	129	✓	✓	VAT review on prior year invoices
4403	Server/Citrix/Cyber upgrade	James Crowther	360	0	360	344	16	368	(8)	✓	✗	Revised IT plan approved Sept CIG
4408	Sharepoint	James Crowther	0	360	360	0	360	360	0	✓	✗	Revised IT plan approved Sept CIG
4409	VDI expansion	James Crowther	455	422	877	614	263	877	0	✓	✗	Ordered 31/10/22
4410	Digital Transformation & Optimisation	James Crowther	0	175	175	25	150	175	0	✓	✗	Revised IT plan approved Sept CIG
4411	Windows Upgrade	James Crowther	0	49	49	0	49	49	0	✗	✗	Revised IT plan approved Sept CIG
4412	Security Hardening	James Crowther	0	170	170	0	170	170	0	✓	✗	Revised IT plan approved Sept CIG
4413	Structured Cabling	James Crowther	0	10	10	5	5	10	0	✗	✗	Revised IT plan approved Sept CIG
4423	Rapid7 Vulnerability Manager	James Crowther	0	186	186	0	186	186	0	✓	✗	Additional scheme approved Oct CIG
4424	Mobile Computer Devices (Carts)	James Crowther	0	50	50	0	50	50	0	✓	✗	Additional scheme approved Oct CIG
4425	MS Teams meeting rooms	James Crowther	0	49	49	0	49	49	0	✓	✗	Additional scheme approved Oct CIG
	Core IT programme	James Crowther	785	(785)	0	0	0	0	0	✗	✗	Revised IT plan approved Sept CIG
4422	DDCP 22-23	James Crowther	0	747	747	17	730	747	0	✓	✗	New PDC funded scheme
4427	Cyber Capital Access Management	James Crowther	0	37	37	0	37	37	0	✗	✗	New PDC funded scheme
4405	Website	Emer Scott	100	0	100	0	100	0	100	✗	✗	Expected to slip into 2022/23
	Contingency	*n/a*	0	(114)	(114)	0	(114)	0	(114)	-	-	
	IM&T		**1,700**	**1,355**	**3,055**	**927**	**2,128**	**2,999**	**56**			
	CDC National PDC		5,500	(5,500)	0	0	0	0	0			
	IFRS 16 - Chemo Cars		0	49	49	49	0	49	0			
	IFRS 16 - CCC-L Fridge Freezer		0	32	32	32	0	32	0			
4421	Liverpool CDC	James Thomson	0	0	0	0	0	0	0			
	Other		**5,500**	**(5,419)**	**81**	**81**	**0**	**81**	**0**			
	TOTAL		**12,513**	**(4,529)**	**7,984**	**2,419**	**5,565**	**7,984**	**0**			

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix E – CIP



Division	Target	Total CIP	Recurrent CIP	In Year Shortfall/Over Recovery	Delivery % to date
CENTRAL CIP	3,300,000	4,084,656	1,652,043	784,656	124%
NETWORKED SERVICES	1,096,368	787,641	130,136	(308,727)	72%
ACUTE CARE	877,743	982,376	391,376	104,633	112%
RADIATION SERVICES	880,168	519,689	204,982	(360,479)	59%
CORPORATE	610,721	237,185	308,915	(373,536)	39%
Total	**6,765,000**	**6,611,547**	**2,723,590**	**(153,453)**	
Full Year Plan (Recurrent & Non-Recurrent Split)					
Recurrent	4,465,000	2,687,452	2,687,452	(1,777,548)	60%
Non-Recurrent	2,300,000	3,924,095	0	1,624,095	171%
Total	**6,765,000**	**6,611,547**	**2,687,452**	**(153,453)**	

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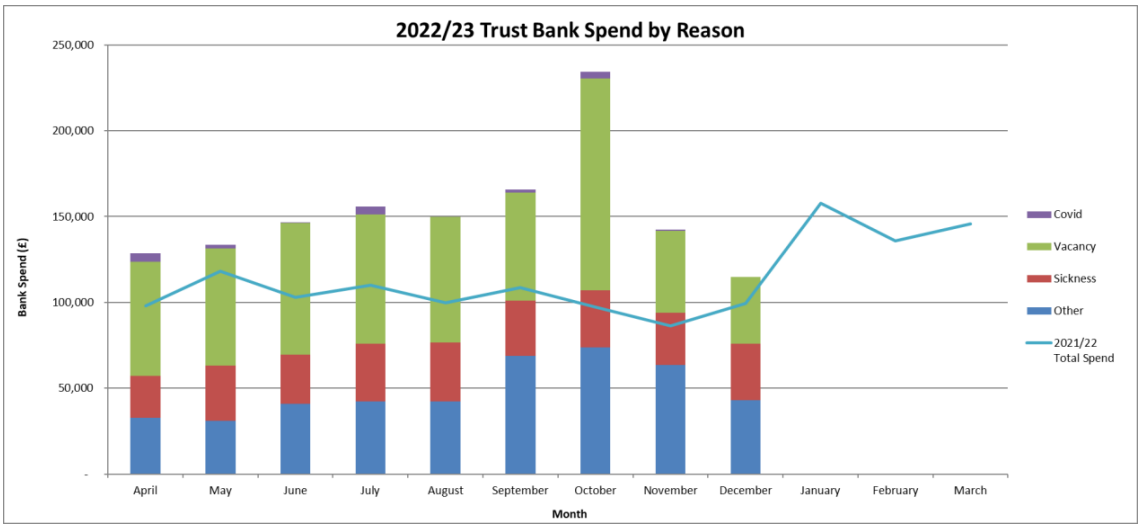
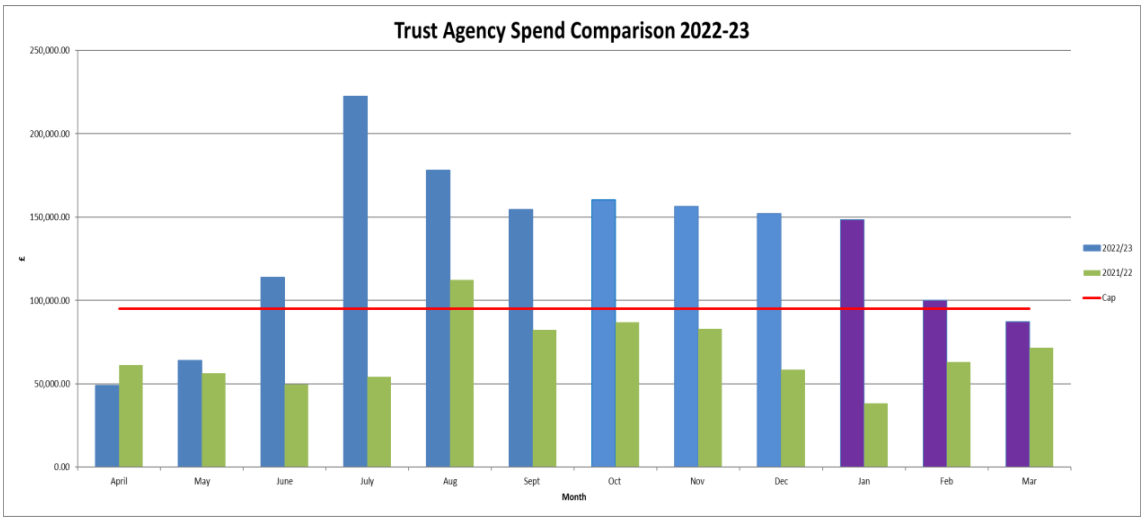
The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix F – Bank and Agency





Trust Board
25th January 2023

Report author	Trust Executives					
Paper prepared by	James Thomson – Deputy Director of Finance Joan Spencer – Chief operating Officer Thomas Pharaoh – Director of Strategy					
Report subject/title	Operational Planning 202/23 (P1-015-23)					
Purpose of paper	Present key features of the NHS Operational and Financial planning guidance for 2023/24 and 2024/25					
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	X		
	Be Collaborative		Be Digital	X		
	Be Research Leaders		Be Innovative			

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

The Clatterbridge Cancer Centre
NHS Foundation Trust

Operational Planning 2023/24

(Issued 23rd December 2022)

Trust Executives
Trust Board (P1-015-23)
25th January 2023

Contents

The following presentation summarises the key requirements of the recently published NHS England operational and financial guidance for 2022/23.

NHS England's Summary Ambitions and Assumptions

The Clatterbridge Cancer Centre NHS Foundation Trust

Overarching Ambitions

- Recover our core services and productivity;
- Progress in delivering the key ambitions in the Long Term Plan (LTP), and;
- Continue transforming the NHS for the future.

Planning Approach

- System and provider activity targets will be agreed through local planning

Growth Assumptions

- National expectation for:
  - 25% increase in diagnostic capacity required for cancer and a
  - 13% increase in cancer treatment capacity.

CCC Related Goals and Targets (1 of 3)

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Elective:

- Reduce adult general and acute (G&A) bed occupancy to 92% or below.
- Increase utilisation of virtual wards towards 80% by the end of September 2023.
- Increase physical capacity (to reflect changes in demographics and health demand) and permanently sustain the equivalent of the 7,000 beds of capacity that was funded through winter 2022/23.
- Reduce the number of medically fit to discharge patients in our hospitals, addressing NHS causes as well as working in partnership with Local Authorities.
- The goals for elective recovery are set out in the 'Delivery plan for tackling the COVID-19 backlog of elective care'. These include delivery of around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance. Meeting this goal of course still depends on returning to and maintaining low levels of COVID-19, enabling the NHS to restore normalised operating conditions and reduce high levels of staff absence. We will agree targets with systems for 2023/24 through the planning round towards that goal on the basis that COVID-19 demand will be similar to that in the last 12 months.

Cancer Waiting Times:

- Continue to reduce the number of patients waiting over 62 days.
- Achieve the 28 Day Faster Diagnosis standard.

Outpatients and Day Case:

- Deliver an appropriate reduction in outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024.
- Increase productivity and meet the 85% day case expectations, using GIRFT and moving procedures to the most appropriate settings.

CCC Related Goals and Targets (2 of 3)

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Diagnostics:

- Achieve the 28 Day Faster Diagnosis standard.
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.
- Maximise the pace of roll-out of additional diagnostic capacity, delivering the second year of the three-year investment plan for establishing Community Diagnostic Centres (CDCs) and ensuring timely implementation of new CDC locations and upgrades to existing CDCs.

Health Inequalities:

- Take a quality improvement approach to addressing health inequalities and reflect the Core20PLUS5 approach in plans
- Have due regard to the government's Women's Health Strategy.
- Consider the specific needs of children and young people and reflect the Core20PLUS5 – An approach to reducing health inequalities for children and young people in plans.

Digital:

- Use forthcoming digital maturity assessments to measure progress towards the core capabilities set out in What Good Looks Like (WGLL) and identify the areas that need to be prioritised in the development of plans. Specific expectations will be set out in the refreshed WGLL in early 2023.
- Put digital tools in place so patients can be supported with high quality information that equips them to take greater control over their health and care.

CCC Related Goals and Targets (3 of 3)

The Clatterbridge Cancer Centre NHS Foundation Trust

Finance:

- ICBs and NHS primary and secondary care providers are expected to work together to plan and deliver a balanced net system financial position in collaboration with other ICS partners. Further details will be set out in the revenue finance and contracting guidance for 2023/24.
- 2.2% efficiency target.
- Purchase medicines at the most effective price point by realising the opportunities for price efficiency identified by the Commercial Medicines Unit, and ensure we get the best value from the NHS medicines bill.

Workforce:

- Improved staff experience and retention through systematic focus on all elements of the NHS People Promise and implementation of the Growing Occupational Health Strategy, improving attendance toolkit and Stay and Thrive Programme.
- Increased productivity by fully using existing skills, adapting skills mix and accelerating the introduction of new roles.
- Flexible working practices and flexible deployment of staff across organisational boundaries using digital solutions (e-rostering, e-job planning, Digital Staff Passport).
- Support a productive workforce taking advantage of opportunities to deploy staff more flexibly. Systems should review workforce growth by staff group and identify expected productivity increases in line with the growth seen.
- Reduce agency spending across the NHS to 3.7% of the total pay bill in 2023/24 which is consistent with the system agency expenditure limits for 2023/24 that are set out separately.
- Develop integrated, workforce plans for the learning disability and autism workforce to support delivery of the objectives set out in this guidance.
- Implementation of the Kark recommendations and Fit and Proper Persons (FPP) test.

Corporate Services and Procurement :

- Reduce corporate running costs with a focus on consolidation, standardisation and automation to deliver services at scale across ICS footprints.
- Reduce procurement and supply chain costs by realising the opportunities for specific products and services.
- Improve inventory management. NHS Supply Chain will lead the implementation of an inventory management and point of care solution.

The Clatterbridge Cancer Centre NHS Foundation Trust

NHS Financial Planning – 2023-25

Funding Format
- **Fixed** for non-elective
- **Variable** for elective
- Contracts managed through North West NHSE Specialised Commissioning
- High cost drug pass through is maintained
- CQUIN included 0.25

Cancer Service Specifics
- Radiotherapy included in Fixed element + £Quality
- Outpatient Follow-Up in Fixed element
- Chemotherapy included in Variable element
- Recognised radiotherapy and chemo tariffs are work in progress

Key Numbers
- Expected 13% cancer increase
- Expected 25% diagnostic increase
- Assumed de minimus 2.2% efficiency
- 100% tariff for elective
- 1.8% net tariff uplift (inflation-efficency)

Planning Issues
- ICB approach to overall financial position to be determined
- New format for cancer treatment reimbursement
- Ensuring sufficient income to increase resources to match activity

Joint Forward Plans - Overview

The Clatterbridge Cancer Centre NHS Foundation Trust

- ICBs and their 'partner trusts' have a duty to prepare a first *joint forward plan* (JFP) before the beginning of 2023/24
- NHSE expects systems to produce 'a version' by **31st March** (as 1st year)
- Consultation on further versions can continue – final plan by **30th June**
- Guidance sets out minimum requirements but flexibility to locally design and determine scope, structure and development
- ICBs and partner trusts should expect to be held account for delivering the plan
- ICBs and their partner trusts to publish an updated plan prior to the start of each financial year

JFP Principles

The Clatterbridge Cancer Centre NHS Foundation Trust

Three principles in guidance to describe the nature and function of the joint forward plan – it should:

1. Be fully aligned with the wider system partnership's ambitions
2. Support subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments
3. Be delivery-focused, including specific objectives, trajectories and milestones as appropriate

JFP Consultation

The Clatterbridge Cancer Centre NHS Foundation Trust

- ICBs and trusts must consult the public in a ‘proportionate’ way – not full formal public consultation unless significant reconfiguration or major service change
- Joint forward plans must include the following:
  - A summary of views expressed by those that the ICB has a duty to consult
  - An explanation of how they took account of these views
- NHSE will support the development of plans by reviewing a draft – no formal assurance process (formal assurance on operational planning returns instead)
- ICBs and partner trusts have legal duty to involve HWBs within the ICB area
- Share draft and consult the HWB on whether it takes proper account of the joint local health and wellbeing strategy

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board
Date of meeting: December 2022

Report of	Non-Executive Directors and Governors				
Paper prepared by:	Claire Smith - Quality Improvement Manager Nicola Heazell - Head of Patient Experience and Inclusion Non-Executive Director – Mark Tattersall Governor – Nancy Whittaker				
Report subject/title	Patient Experience Visit November 2022				
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 8th November 2022 on Floor 00 Pre-treatment, PET and Floor M3 Radiotherapy, CCC Liverpool				
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		

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOREPO
Review: July 2025
Version: 2.0

The Clatterbridge Cancer Centre NHS Foundation Trust

Division	Radiation Services	Location Out-Patient Department	CCC Liverpool	Date	8th November 2022
In attendance – Panel			In attendance – Patient & Staff		
Governor	Nancy Whittaker		Senior Manager facilitating the walk round		Linda Williams Claire Atkinson Kim Wilson Jill Jones
Non-Executive	Mark Tattersall		Number of Patients		3
Patient Experience Team	Nicola Heazell Claire Smith		Number of Staff		4

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:

Floor 00;

- Clinical staff 100% superb.
- No waiting around, brought straight through for appointment.
- Staff very friendly and approachable.
- Environment very relaxed.
- Happy to travel to CCC as it is a specialist centre.

Floor M3;

- Staff are brilliant, very nervous first visit but staff were amazing.
- Administration and reception staff great.
- Appreciate having access to lots of specialist staff throughout treatment.
- Communication has been brilliant; text message, email and letters.
- Consultant explained treatment in an easy to understand manner.

Areas where immediate action was taken on the day:

- NIL

Areas for improvement:	Service response: *Highlight in **Bold** actions to be added to PEIC action plan*
Floor 00; • Administration – letters have arrived late and unclear.	• Work stream already addressing patient appointment letters and text messages

• Signposting/wayfinding – signage difficult to navigate without the help of volunteers. **Floor M3;** • Hospital taxi transport difficult – living in a block of flats means I have to wait outside in the car park to ensure I do not miss the taxi (sometimes between 20 – 60 mins).	• Radiotherapy Pre- treatment – working with the Digital Project Team to enable a Text message reminder to be sent with the patient's appointment details. • **ACTION** Work stream to be established to address signage throughout the trust. • **ACTION** - Booking desk advised that when they are made aware that patients live in flats/ gated premises, a comment is required on the online booking system. Transport drivers are asked to call the patient directly when they are at their residence. Radiographers to reiterate this when requesting hospital transport for patients living in flats/gated premises.

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: **Floor 00;** • Staff member has been working as a locum in a number of trusts over an 8-year period. However, on the day of the visit they had successfully interviewed and accepted a job at CCCL, stating it is the only place they would ever consider working permanently. The department is well run, the environment is very relaxing for patients who frequently fall asleep during scans. • Staff are able to personalise care for individual patients depending on their particular needs. • Although the summer months were a struggle, there is now only a two week wait which is very positive. • Despite the level of change over the past 2 years, the pre-treatment team work strongly together as a team to ensure patients feel like they are the only patient the team have treated that day. The team acknowledge that they are frequently the first

The Clatterbridge Cancer Centre NHS Foundation Trust

staff members that patients come face to face with, priding themselves in making it a positive experience.

Floor M3;

- Work is underway with the Business Intelligence Department to improve communication regarding potential delays with patients in the department. The work will include all 3 sites to ensure parity.
- Complaints are rare, staff try to ensure any issues are addressed to prevent them becoming a bigger problem.
- Love my job as it gives me lots of variety and allows me to make a real difference.
- The department has a relatively small turnover of staff as its lovely place to work.

Areas where immediate action was taken on the day: None

Areas for improvement:	Service response:
Floor 00;	
• Patients frequently report that the chairs are uncomfortable.	• **ACTION** - a review of the seating arrangements has taken place, new seats to be ordered. Led by Natalie Wilson.
• Porter Service – shortage of porters can impact the service, frequently causing a bottleneck at the end of day. This can reduce patient experience if patients are waiting as they are required to fast before the scan.	• **ACTION -** ongoing talks with regards to the portering service in both the Pre-Treatment and Radiotherapy areas. Led by Michelle Foreshaw.
• Not all staff have a car-parking pass.	• **ACTION** - HR response; There is a monthly review of car park usage and additional passes are issued whenever possible. There are currently 18 people on the waiting list (none have been waiting more than a few weeks at present). The number of passes available to the Trust is limited and therefore priority is given to those who meet the eligibility criteria. The eligibility criteria has

• Staffing levels can be a challenge and be a pressure point. Staff support the team even on days off. Staff highlighted concerns around the current future proofing of the Service from a staffing perspective.	been reviewed recently to increase eligibility. • There is a national shortage of diagnostic and therapeutic radiographers creating recruiting challenges. There is an overarching AHP workforce strategy approved by the Trust which includes working on recruitment and retention and international recruitment. Two international recruits have started this autumn. • **ACTION -** a further piece of work is underway to calculate the correct number of staff ratio required within the Pre-Treatment department. Led by Louise Bagley and Kim Wilson.
Observations on the day • Both floors 00 and M3 felt calm and relaxed.	

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board
Date of meeting: January 202**3**

Report of	Non-Executive Directors and Governors				
Paper prepared by:	Claire Smith - Quality Improvement Manager Non-Executive Director – Cllr Anna Rothery Governor – Anne Olsson				
Report subject/title	Patient Experience Visit December 2022				
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 8th December 2022 at the Marina Dalglish Chemotherapy Clinic Aintree.				
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		

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOREPO
Review: July 2025
Version: 2.0

The Clatterbridge Cancer Centre NHS Foundation Trust

Division	Networked Services	Location Marina Dalglish Clinic	Aintree	Date	8th December 2022
In attendance – Panel			In attendance – Patient & Staff		
Governor	Anne Olsson		Senior Manager facilitating the walk round		Matron Ruth Selvan
Non-Executive	Cllr Anna Rothery		Number of Patients		2
Patient Experience Team	Claire Smith		Number of Staff		2

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

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

Positive Patient Comments:	
• Patient considers the clinic staff to be his second family. • Staff know all the patients by name and looked after really well. • Treated fantastic, staff can't do enough. • Feel like a number when attending other hospitals, feel like a person when I attend Marina Dalgish. • The pharmacist is amazing • All the staff regularly go above and beyond • Attended without an appointment due to sever skin reaction, pharmacist saw me and sorted it • Weirdly I look forward to coming as they are keeping me alive. • Never had a bad experience • Treatment reduced from 5 to 3 hours • I see the same staff which is helpful • Emergency situations are handled very calmly, almost unaware they are happening which is very reassuring.	N/A

Areas where immediate action was taken on the day:

- The staff were able to show the visit both their recent Patient Experience Award and thank you wall with letters of thanks from many past patients.

The Clatterbridge Cancer Centre NHS Foundation Trust

Areas for improvement:	Service response: *Highlight in **Bold** actions to be added to PEIC action plan*
Both patients made the same comments regarding the appointment system; It used to work very well, two staff on the desk were able to give the next appointment. This was very helpful in order to make plans. The system has changed recently, the desk staff have been moved and now appointment letters arrive via post, more recently they arrive close to or after the date. Occasionally there are multiple letters, some saying different things which means I need to call to clarify. The previous system was quicker, cheaper and this feels like a backward step for patients.	• Matron to liaise with Admin lead to review making of appointments and communications to patients.

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

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

Positive Comments:

- When new to the clinic the support was amazing which allowed everything to click into place. The team are really lovely and supportive. The addition of Haem-onc has provided lots of learning opportunities and being able to spend time with the CNS team is invaluable.
- Although the clinics are very busy and sometimes we run overtime, we always get our breaks and are able to take the time back.
- The hours are great and the role is very rewarding.
- The ANP role in the clinic has made such a positive difference to the clinic. If they are not there it is really difficult and time consuming to get drugs prescribed.
- Having a pharmacist on site is vital, she is a key member of the team, she is really supportive and often puts on quick sessions to educate staff on new chemotherapy regimes.

Areas where immediate action was taken on the day: None

The Clatterbridge Cancer Centre NHS Foundation Trust

Areas for improvement:	Service response:
• Most staff also cover the Ormskirk clinic too, however this is not as well staffed and sometimes it can be really difficult to escalate issues there and have someone make a decision quickly.	• Team to review staffing and process for escalating issues.
• Although there is lots to learn and develop in the band 5 and 6 roles, to progress any further you need to move out of the clinics as there are so few band 7 roles.	• Staff are well supported in development. Team to continue to support and discuss progression opportunities as part of PADRs
• The clinic is running out of space due to the demand. Especially now that we can welcome visitors back, the treatment area can become very noisy and cramped.	• Space is at a premium in the department, the upgrading of the patient waiting area has provided a nice relaxing environment for patients to wait. Clinic chairs are used appropriately to ensure maximum capacity is utilised.
• Some patients who have also been treated in CCCL complain that the chairs at Marina Dalglish are not as comfortable, they are also manual recliners.	• Review replacement of chairs when appropriate

Observations on the day

- The clinic was very welcoming; although clearly very busy it felt relaxed and controlled.
- The panel noticed a lack of signposting to the clinic on the Aintree site. Some had struggled to find it as it was their first visit in a while, especially whilst the building work is ongoing on the Aintree site. – **review signposting to department and ensure appropriate signs in place.**

Meeting of the Board of Directors
25th January 2023

The Clatterbridge Cancer Centre NHS Foundation Trust

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

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

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

Equality & Diversity Impact Assessment

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

Meeting of the Board of Directors
25th January 2023
Six Monthly Compliance with NICE Safe Staffing Guidelines

Executive Summary

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

- The budgeted registered nursing establishments for wards 2, 3, 4 & 5 were confirmed as correct and appropriate by the ward managers and met NICE Guidance. All ward establishments are better than the recommended one nurse to eight patients' ratio (1:8).
- The budgeted HCSW establishments for wards 2, 3, 4, and 5 were confirmed as correct and appropriate by the ward managers.
- 11 additional mutual aid in-patient beds were opened in order to support the LUHFT with the move to the New Royal Liverpool Hospital.
- On a shift by shift basis, where the actual staff numbers were less than the planned staff numbers the ward teams followed an agreed escalation process based on the acuity and dependency of care required and a review of bed occupancy. The information is shared via email to operational staff, medical staff and executives twice a day by the patient flow team.
- Nurses on the hospital bank (NHSP) and approved nursing agencies have been deployed to support patient acuity levels when thresholds have been reached and all other internal staff movements have been actioned. There are twice daily reviews of planned staffing as well as a review of hospital-wide activity.
- For the 6 month review period April 2022 to September 2022 the expenditure across the total nursing spend was £11.903m, of which £117k was spent on agency staff, which equates to 1.26% of the nursing pay spend.
- Recruitment of staff to meet turnover continues to be a well published national challenge, however the ward managers and Matrons manage their pressures through a structured approach to over-recruitment when there are suitable candidates.
- A large proportion of the newly recruited staff are newly qualified nurses, who require a period of supernumerary status and ongoing preceptorship. Therefore whilst vacancies are filled there continues to be a short term pressure on experienced staff to induct and support the newly qualified nurses.
- Our second cohort of internationally recruited nurses joined the organisation in August taking the total up to 12.
- The narrative output of individual ward reviews has been captured in a summary table and can be viewed at Appendix 1. The information is provided on an individual ward basis and any areas of underperformance are managed through the usual weekly/monthly performance management review process at both divisional and corporate level.

1. Background

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

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

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

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

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

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

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

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

2. Introduction

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

From 26th September the in-patients wards opened 11 additional mutual aid beds in order to support LUHFT with the opening of the New Royal Hospital site. This was enabled by the use of additional, approved Pulse Agency shifts.

Following the last review in June 2022 the process for planned verses actual staffing data collection and validation has been refreshed to ensure a consistent approach is applied across all stakeholders. This review has resulted in a leaner process with all wards utilising the same data collection tool, therefore ensuring a single version of the truth, this is utilised by the business intelligence team to process the monthly data return with sign off from the senior nursing team.

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

3. Methodology for calculating Nurse Staffing

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

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

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

4. Ensuring the correct staff with the correct skills

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

5. Data summary

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

The table in appendix 3 shows the percentage fill rate of shifts broken down into registered nurses and care staff, day shift and night shift. This data (for the period April – September) has undergone a validation process by the Business Intelligence Team Principal Information Analyst in order to gain assurance that the revised process is providing a true representation of the actual fill rate.
Where the fill rate is less than planned (less than 100%) this is addressed during the staffing huddles, as described in section 4 & appendix 4.

6. Recommendations from previous report

Recommendation	Action Taken
Re-introduce monthly safe staffing data into the integrated performance and quality report by	Validated data included from Q4
Acute Division Matrons with the support of Workforce and Corporate nursing will review establishments based on maximum number of bed availability. This will include skill mix to take into consideration the added complexity of the new layout and the additional fundamental care needs of patients that can be safely addressed by health care support workers	Task and finish group established to optimise the use of Health roster. Establishment and skill mix requirements reviewed and data cleanse completed December 2022. Optimisation of Health Roster underway during Q4.
The established recruitment and retention steering group will continue to identify opportunities to maximise the nursing pipeline and make CCC a great place to work in line with our 5 year strategic plan	29th June 2022 attended an open event at Liverpool John Moores University (LJMU). Nursing recruitment event held on the 23th August 2022 for LJMU students. From this 10 student nurses are in the pipeline for recruitment March-August 2023
We will collaborate and engage with any new and emerging system wide and national reviews of nursing requirements for single occupancy room model organisations, in order to inform best practice and lead change.	Connection re-established with NHS England safe staffing lead and additional training for Safer Nursing Care Tool (SNCT) to be rolled out Q2 2023/24.
In collaboration with ward managers, matrons, workforce and corporate nursing evolve the bi-annual staff staffing review to ensure accurate and meaningful quantitative data is included to support the qualitative professional nursing judgement narrative	Data reviewed and quality assured, see Appendix 2.

7. Recommendations from this review

- Optimise the e-roster system to ensure the auto-roster function is consistently utilised and accurate staffing data is recorded by Q2 supported by the Workforce and Organisational Development team.
- Cohort of senior in-patient nursing staff to be agreed to undertake training for Safer Nursing Care Tool (SNCT) by Q2 supported by NHS England.
- Support the leadership development programme for Band 6 nurses
- Continue to identify opportunities to benchmark with other centres in relation to acuity and safe staffing, via links with the national team and the Specialist Oncology Trust Deputy Chief Nurse group (CCC, The Royal Marsden & The Christie).

Conclusion

The in-patient services continue to demonstrate exemplary team work when coordinating nurse to patient ratios across the trust to keep patients safe. Staff across all areas of the service collaborated and supported the utilisation of an additional 11 beds to support our colleagues to safely open the new Royal Liverpool Hospital, ensuring people with cancer were treated in a timely manner and in an appropriate setting. Whilst there continue to be challenges nursing in a single occupancy room model, where visibility is reduced, staff are adapting to new ways of working with a positive professional attitude, with kindness, resilience and care and compassion for our patients.

This review confirms that whilst the budgeted nursing establishments set for the trust's in-patient wards align with the current care needs of patients in the context of other workload sensitive factors, it is evident that filling vacancies, managing sickness and appropriate skill mix due to the inexperienced workforce continues to be a daily challenge.

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

Appendix 1

Individual ward/area key aspects

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

Ward 2 – Factors to support professional judgement

Ward Factors

Ward 2 is a 26-bedded single room ward, with 1-clinical/ medication prep room and 2-sluice rooms, a leadership office, a doctor's office, a beverage bay and a patient social space.

The ward is split into two teams A and side B which is then further split again into 2 smaller teams, each nurse taking care of 6/7 patients. There is a band 6 coordinator on shift who does not take a team of patients.

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

The ward has recently reduced the student allocation in order to support the number of junior staff. However, we have received positive feedback from students who have recently been on placement on ward 2, as we really made them feel part of the team. 1 of our new recruits that started in October completed her management placement on ward 2 during the summer, she loved the placement so much she has chosen to start her career with us.

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

Patient Factors

Our designated tumour groups cared for on ward 2 are those with a diagnosis of sarcoma, Lung cancer, Breast cancer, Brain tumours, Lower GI cancers, Prostate cancer and Cancer of Unknown Primary (CUP).

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

Other reasons for admission are patients with Metastatic Spinal Cord Compression (MSCC) who require specialist nursing.

At times the ward staff care for patients in their last days and weeks of life. This involves liaising with the medical team and the palliative care team to meet the needs of the patients and their

families. The nursing team have to respond the physical and psychological needs of the patients. At times this can become challenging and emotionally draining.

Nursing staff liaise with the MDT to organise complex discharge plans. Often the condition and prognosis of the patient means that 'home' is not in their best interest, so this can be challenging when patients and their families have different expectations.

Often patients are at risk of falling, and therefore require close supervision or 1:1 nursing by our dedicated team of HCA's to prevent and reduce their harm. Due to the large footprint of the ward and the single side rooms it is difficult to observe patients who are at risk of falling, however, we locate these patients in rooms directly opposite staff bases and use supportive devices such as 'Rambleguards' which alert staff if an at risk patient moves out of set parameters.

Nursing Factors

We have had a high number of vacancies on ward 2, the management team have worked hard to fill these vacancies and we are now starting to see our new recruits come in to their posts. We are developing the role of the clinical practice facilitator to ensure we have staff providing high quality care on the ward. Each new recruit gets a 4 week supernumerary period to develop their skills and embed into the team on the ward. With a more robust induction period we hope that investing in these staff will lead to staff retention.

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

The turnover of nurses in the past few months has led to a shortage of chemotherapy trained nurses on the ward. A number of nurses are currently in the final stages of completing their SACT passport, this will relieve some of the pressure on the current chemo trained staff.

Evolution/Development of Service

The 6 months of this review have been challenging for ward 2 due to the high turnover of staff. Whilst waiting for our new recruits to come into post shifts have often been dependent on the use of NHSP and agency staff to ensure that we have had safe staffing numbers.

In the coming 6 months we are looking to increase the numbers of housekeepers working on the ward so we can have a 7 day service. We are hoping that they will be able to work alongside the ISS team to improve the meal service to patients. The ward has seen a number of hospital acquired infections, increasing the number of housekeepers will also assist the staff/ISS to improve our Infection control audit results.

With the new recruits coming into post I am keen to have at least 1 band 6 nurse on each shift to be able to provide the senior support on the ward.

We have recruited 2 nurses to the Clinical Practice Facilitator team. Their support in developing the induction programme for our new recruits has been appreciated by the ward manager and the recruits. They will also be supporting our established staff to ensure that they have the required competencies to provide high quality nursing care. Working with the ward management team to ensure that staff are compliant with role essential and mandatory training.

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

Senior Ward Nurse Review

Ward 2 are transitioning out of a very challenging 6 months with changes in ward manager, deputy ward managers and many new recruits joining the team. Staff morale has been low at times especially when shifts have been short on a regular basis. Where possible staff have been flexible and changed shifts at very short notice, many have picked up additional shifts to help with staffing. Nursing staff have always strived to provide high quality nursing care despite that challenges they have faced. We have received a number of thank you cards, and large donations to the ward in my mind this evidences that we have made a positive impact on our patients journey despite the adversity the staff were facing.

With some of our new recruits in post and more joining us in the coming weeks the ward is feeling a much more positive. The staff morale is increasing. The existing staff are really encouraging the new recruits and welcoming them in to the team.

Ideally I would like to have some more experienced staff recruited to the remaining positions left to fill. We are finding that the majority of applicants continue to be newly qualified nurses. This will mean that the skill mix on the ward will continue to be dominated by junior staff.

PADR compliance is high, the senior management team worked hard to complete all outstanding appraisal. Role essential and mandatory training is an area for improvement.

The band 6 team are not always able to fulfil aspects of the management side of their role due to the pressures on the ward. This has led to frustrations on their side, and added pressure for the ward manager. This has been addressed with a band 6 training week in January, focusing on the fundamentals of management and leadership.

As a senior nursing team we will continue to work on reducing over-due incidents. We have a weekly incident meeting to discuss the incidents for wards 2, 3 and CDU, this is an opportunity for shared learning between managers, and highlight training needs of staff.

Professional Judgement

WARD MANAGER VIEW; In my professional judgement staffing budget is sufficient to staff the ward safely. However, I would like to use the budget differently to ensure that we are able to facilitate the desired nurse patient ratio – Senior Sister - Sarah Smith

Ward 3 – Factors to support professional judgement

Ward Factors

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

The ward is divided into two sides, which is split again into two further smaller teams with each nurse taking care of up to 6 to 8 patients. Currently the co-ordinator on shift takes a team of patients to meet this nurse:patient ratio.

The ward has its own beverage bay with lockers, a fridge and a microwave. Ward staff take their breaks off the ward in the shared staff room which is located on 2nd floor, however there are plans to turn the unused ward bathroom into a staff room.

We currently have a new housekeeper that covers the ward 4 days a week. It has always been difficult to manage the wards housekeeping service over 4 days and since opening to full capacity it has highlighted the need to look at the housekeeping team and to develop a 7 day service.

Patient Factors

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

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

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

Nursing Factors

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

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

The use of bank and agency staff has increased to support the additional beds. These shifts have not always been covered, which had put added pressure on the established staff, which has affected staff morale.

Evolution/Development of Service

If the number of beds on ward 3 remains open to full capacity there needs to be a few areas of development to maintain a safe service.

We plan to review the budget to identify what is needed to achieve an appropriate nurse to patient ratio with the full bed base. With the development of the CPF team this will provide more support to the team and ensure staff are trained and competent in their role.

The CPF team will also be critical in reporting and monitoring staff competencies, which will help identify where support and training is required. They will also be an essential support to the ward managers, organising new starters' induction programmes and monitoring the teams' competencies.

Going forward there is a plan to review the roles of our healthcare assistants and housekeepers, as there needs to be improvements with meal service delivery, stock management and Nursing support.

With the expansion of ward 3 Band 6 development is required to support the ward manager. A Band 6 management week is planned for January to teach the current, and new band 6s, the management requirements of the role and the importance of leadership. We will need to make sure that the band 6s get time to utilise the new skills they have learnt.

Senior Ward Nurse Review

For the last 6 months Ward 3 has been manageable. Our budgeted establishment meets our requirements and vacancies have been well managed. Challenges arise when extra beds have had to be opened at short notice and the shifts can't be covered by bank or agency staff, adding pressure to the existing staff. This has, at times, affected morale.

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

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

As a senior nursing team we will continue to work on reducing over-due incidents. We have a weekly incident meeting to discuss the incidents for wards 2, 3 and CDU. This is an opportunity for shared learning between managers, and highlight training needs of staff.

Professional Judgement

WARD MANAGER VIEW; In my professional judgement the past 6 months our budgeted establishment has met our requirements but with the permanent opening of the additional beds at the end of September will require our budget to be reviewed – Senior Charge Nurse - Paul Hewitt

Ward 4 – Factors to support professional judgement

Ward Factors

Ward 4 has 28 inpatient beds - 24 are predominantly for the use of Haemato-Oncology patients and 4 beds for early phase clinical trials. The clinical trial staff should be on the ward between the hours of 8am and 4pm.

There is also one room that has been adapted for apheresis and is managed by the NHS Blood &Transplant team, including the maintenance and cleaning of the room.

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

It can take approximately 10 minutes to check, prepare and administer and IV medication to a patient. Most of the patients are on at least 3 IV medications a day, at the same times, which

can take up an hour, excluding oral medications which can take a further hour to administer. Often this can result in a delay in administering medications at the exact time they are due.

In order to ensure more efficient working and mitigate risk, the ward is split into two teams, a team A and a team B. Staff receive handover for their 'team', all staff then convene for the safety huddle where we discuss any issues from each team, and vital information such as chemotherapies, DNAR's. The patient rooms do not currently have computers in to enable the staff to complete documentation whilst with the patient. Instead, this is done at the staff bases, 3 of which are available on the ward.

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

We have recently opened our new staff rooms based on the ward which has improved staff morale as they now have somewhere to enjoy their breaks.

Ward 4 has one Housekeeper employed as part of the ward team. Due to the size of the ward and the high stock turnover, we have recently employed a second housekeeper. They will also take responsibility of the south side of Ward 5, which has recently opened as the post stem cell transplant day ward. Having two housekeepers in post will ensure the cleanliness of the ward remains of a high standard, and that stock is available when required. Housekeepers provide a vital level of support to both staff and patients, and are very much part of the team, and with their support and organisation, staff are able to locate equipment in a timely manner.

Patient factors

The patients are categorised as acuity levels 1a, 1b, or 2 in line with the safer care tool. This is completed 3 times a day by the nurse in charge. Following the official integration with the North-Mersey HO, we often have patients with CNS lymphoma requiring 1:1 care due to the fluctuating capacity and confusion. This can often lead to the involvement of the safeguarding team and the patient requiring a Deprivation of Liberty Safeguards (DOLS). We have recently had this added onto the safe care tool, meaning the most accurate information on staffing is available.

High intensity chemotherapy can result in an onset of sepsis, requiring intense monitoring and nursing interventions. Patients often require 1:2 nursing and at times 1:1 nursing prior to transfer to ICU. We work very closely with the LUHFT ICU Outreach Team and receive very positive feedback about the level of expertise and skills our nurses have attained. This enables

them to provide a high standard of care to this group of acutely unwell patients often preventing the need for transfer to ICU due to their swift response to the deteriorating condition.

Each day is different, but on the whole there are multiple patients requiring chemotherapy. This can range between 1-10 patients on some days, with 1 patient needing multiple infusions. This takes 2 nurses to check and administer the chemotherapy, the nurse in charge and another nurse who will also be looking after a team of patients.

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

We offer a wide variety of treatment regimes and patients can be attached to a drip for numerous hours, requiring staff to change IV drips multiple times. Often patient's first day of chemotherapy involves a monoclonal antibody, an example of which is Rituximab. During the infusion, 30 minute observations are required in order to recognise signs of reactions and act quickly to treat. An infusion such as Rituximab could take between 3-8 hours to complete, depending on the patients tolerance.

Patients requiring specialist intrathecal chemotherapy is administered on the ward, which can take the band 6 or 7 nurse up to an hour or more.

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

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

The ward cares for patients at risk of falls. These patients require high levels of care which consists of close supervision or 1:1 nursing by our dedicated team of HCA's to prevent and reduce their harm. Due to the large footprint of the ward and the single side rooms it is difficult

to observe patients who are at risk of falling. To mitigate the risk of falling, we try and keep these patients in rooms directly opposite staff bases. Rambleguards are used to support these patients and alert staff if an at risk patient moves. An information leaflet is in each patient room with information about the ward and also some information to reduce the risk of falls. Where possible, we try and cohort patients needing 1:1 supervision, and utilise extra staff where we can so not impact the planned staffing for the floor. This can lead to decreased morale and the staff who are supervising feel that they aren't fulfilling their role or supporting the staff, and equally the staff members on the floor have an increased workload.

Other Nursing Factors

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

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

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

Senior Ward Nurse Review

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

Compliance of PADR's has improved but it could be better. As staffing numbers increase and the management team become more familiar with policies and procedures, staff will be supported further in order to complete PADR's in a timely and in depth fashion.

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

There are variables in acuity on the ward due to different specialities and the variety of SACT we provide. The current nurse to patient ratio on Ward 4 is 1:5.

After reviewing all of the above and the establishment for ward 4, I feel that the ward could benefit from a change in a change of nursing model to reflect the additional needs and provision of 1:1 for the CNS lymphoma patients and the opening of the additional beds. This would allow the staff more time with each patient and to maintain the safe and effective care that I know they can give, and ensuring that quality is not compromised in any aspect. This would also reflect the size of the ward. The team deliver excellent patient care day in day out. However, this can be deflated due to the workload. I believe this change would boost morale and also reflect the staff views and ensure that they know they have been listened to. I believe this would also have a positive impact on the patients, the workload of the staff, ensuring the safety and effective care of the highest standard.

Professional Judgement

WARD MANAGER VIEW; In my professional judgement in the past 6 months, there were occasions where the nursing model did not reflect the high acuity. There is a need to review the budgeted establishment to assess if the current nursing model is reflective of the requirement to nurse the increased intensity of inpatients and requirement of additional 1:1 patient care for patients CNS lymphoma. Currently these patients are cohorted if possible to one area to allow for safe management. This can be challenging at times due to bed availability and if not possible additional staff are requested via NHSP. Senior Sister – Nicky Gulwell

Ward 5 – Factors to support professional judgement

Ward Factors

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

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

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

The Stem Cell Transplant unit was the last ward in the Trust to relax restrictions on visiting for our transplant patients this year, due to their increased vulnerability as highly immunocompromised patients. The average length of stay for these patients is 4 weeks but can be longer depending on clinical condition. Only patients who were receiving end of life care, were acutely unwell or suffering severe anxiety were permitted visitors. Staff experienced higher levels of anxiety as a result of witnessing increased anxiety and loneliness in the patients. Staff spent an increased amount of time listening to and emotionally supporting patients. This added to the acuity of the ward. Now that patients are permitted 2 named visitors on a regular basis this has reduced patient stress and as a result increased staff morale.

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

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

2 part time Housekeepers are employed as part of the ward team. They support the existing housekeepers on wards 4 and 5 and support the hostess at mealtimes with presentation and patient requests as well as ensuring patients are offered mid –morning and afternoon snacks. They ensure that water flushing of all outlets is carried out daily in order to reduce the risk of legionella infection. They maintain the efficient running of the ward by ensuring that stock levels are kept at a safe level and highlight any risks concerning vital equipment that may be getting discontinued.

Patient Factors

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

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

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

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

Nursing Factors

We have successfully continued to recruit into vacant posts throughout the pandemic via means of a rolling advert. Setting up interviews and interviewing on MS teams was challenging for the nursing team but now, since restrictions have been eased, we can interview face to face.

Although stem cell transplant activity slowed during the first wave of the pandemic, activity continued adhering to BSBMT guidelines and delayed patients have since been accommodated. Stem cell transplantation requires expert nursing knowledge and training to administer stem cells and to safely and effectively care for the patient. This has been a challenge at times due to staff sickness both COVID and Non-COVID related and we have

been strongly supported by our specialist nursing team, two stem cell transplant co-ordinators and one specialist nurse.

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

Evolution/Development of Service

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

Currently the stem cell transplant programme is preparing for its JACIE inspection. A full on-site inspection will take place sometime in early 2023 which when passed will result in a four-year accreditation.

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

Senior Ward Nurse Review

It is 2 and a half years since the start of the pandemic and 26 months since the move to the new hospital. The staff continue to adapt to new ways of working, continue to really step up, working with professionalism and a can do attitude. They have tirelessly swapped shifts at short notice and undertaken additional NHSP shifts to ensure the ward is adequately covered to provide safe and effective care and the service we provide has remained at a high standard. This is evident from the positive patient feedback received.

There continues to be a need to help staffing shortages within the Trust due to the pandemic and vacancies, but I am grateful there has been recognition and protection to safe staffing levels on Ward 5 to ensure safety is maintained given our area of speciality and guidance on national staffing: patient ratios.

This has been particularly important given the on-going challenges with sickness, higher than usual staff turnover and changes in ward factors:

- The integration of TYA patients on the ward and new ways of working
- New oncology SACT regimens
- The appointment of a new BMT Programme director and the implementation of new BMT protocols

- Significant changes to admission criteria due to COVID-19
- Increased acuity levels, a proportion of our patients are categorised as level 2 using the safe care tool.

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

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

Professional judgment

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

Appendix 2 - Ward Summary Data

	Ward 2	Ward 3	Ward 4	Ward 5
Budgeted WTE Nursing Establishment	42.02 (excludes Housekeeper and CPF)	42.96 (excludes Housekeeper and CPF)	47.45 (excludes 1 WTE Housekeeper and 1 WTE CPF)	**BMT** 35.97 **TYA** 8 (excludes 1 WTE Housekeeper and 1 WTE CPF)
SNCT WTE Nursing Requirement Using alternative acuity tool (Rota only)	34.20 WTE (based on 26 beds)	37.27 WTE (based on 25 beds)	41.64 WTE (Based on 25 Beds)	38.19 WTE
Current Skill Mix (RN-Non RN)	RN = 61.5% Non RN = 38.5%	RN = 72.4% Non RN =27.6%	RN = 71.65% Non RN = 30.45%	**BMT** RN = 72.28% Non RN = 22.15% **TYA** RN = 87.5% Non RN = 12.5%
Patient Flow/bed occupancy- 6 months	91%	92%	94%	80%
Supervisory Status of Band 7 required	80:20	80:20	80:20	80:20
% Sickness Rate (since last review)	5.73%	4.81%	10.50%	BMT = 4.91% TYA = 10.34% (% impacted by small team numbers)
% Staff Turnover (since last review)	31%	32.60%	12.63%	BMT & TYA COMBINED = 15.76%
Bank Use (since last review) 7.5 hr shift	RN = 305 HCA = 267.5	RN = 478.5 HCA = 317.3	RN = 274 Non RN = 845	RN = 53 Non RN = 41
% Mandatory Training Compliance	79%	75.1%	86.74%	85.85%

% PADR Compliance (at time of report)	95.8%	100%	86.67%	BMT = 93.75% TYA = 100%
Nurse Sensitive Indicator – grade 2 (or above) pressure ulcers	14	10	3	1
Nurse Sensitive Indicator – Moderate (or above) Falls	0	0	0	0
Nurse Sensitive Indicator – medication administration errors attributable to nurses	11	5	3	7
Nurse Sensitive Indicator – complaints regarding nursing care	1	1	0	0
Nurse Sensitive Indicator – MRSA bacteraemia	0	0	0	0
Nurse Sensitive Indicator – avoidable Clostridium Difficile	3	1	3	0
Friends & Family Test – Patients (average since last review)	23.3% (response rate) 88% Positive 2.3% Negative	29.5% (response rate) 98% Positive 1.2% Negative	26.02% (response rate) 93.94% Positive 3.03% Negative	28.17% (response rate) 95% Positive 5% Negative

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

		Apr-22		May-22		Jun-22		Jul-22		Aug-22		Sep-22		Months >= 90% Target	
		Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night
Registered Nurses	Ward 2	81.6	90.7	98.3	95.2	92.3	97.0	94.9	100.0	96.6	97.4	99.6	100.0	5/6	6/6
	Ward 3	87.3	98.0	97.5	99.1	95.4	98.1	97.2	100.0	98.9	100.0	98.9	99.1	5/6	6/6
	Ward 4*	95.8	80.9	98.8	83.8	98.4	87.4	98.8	86.2	101.0	91.1	79.0	90.8	5/6	2/6
	Ward 5	86.9	99.2	93.0	100.0	93.1	94.6	86.4	91.9	91.8	94.4	94.0	97.5	4/6	6/6
Care Staff	Ward 2	86.8	95.0	96.9	96.7	95.7	95.3	93.5	92.6	94.7	95.6	99.3	100.0	5/6	6/6
	Ward 3	94.0	95.5	97.1	94.6	95.2	95.4	83.1	90.1	91.9	100.0	98.1	100.0	5/6	6/6
	Ward 4*	79.7	161.9	87.1	168.8	96.7	118.7	100.2	105.4	113.9	121.5	98.8	136.7	4/6	6/6
	Ward 5	89.7	86.7	86.8	100.0	94.7	96.7	96.5	96.8	98.3	90.0	96.0	100.0	4/6	5/6

*Due to historical data access issues this data was not subject to additional validation.

Appendix 4 – Staffing Escalation Process

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

Title of meeting: The Board
Date of meeting: 25th January 2023

Report Lead	Sheena Khanduri, Medical Director			
Paper prepared by	Helen Wong, Quality Manager (Audit & Statistics)			
Report subject/title	Mortality Dashboards & Summary Report 2022-2023 Q2			
Purpose of paper	To present Q2 22/23 Mortality report Public mortality dashboard & Summary report Mortality lesson Learned BMT mortality 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		

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: October 2021 – September 2022 for comparison to previous quarters

Year	2021/22		2022/23		Total
	Q3	Q4	Q1	Q2	
Total Patient Deaths	166	185	168	200	**719**
Number of Inpatient Deaths	34	38	40	47	**159**
Number of Outpatient Deaths	132	147	128	153	**560**
Outpatient (Requiring Review)	106	125	104	126	**461**
No. Cases Requiring Review	140	163	144	173	**620**
No. Cases Reviewed Phase 1	119	114	107	100	**440**
% Cases Reviewed Phase 1	85%	70%	74%	58%	**71%**
No. Cases Requiring Phase 2	166	185	90	86	**527**
No. Cases Reviewed at Phase 2	90	76	82	56	**304**
% Cases Reviewed Phase 2	76%	67%	77%	56%	**69%**
No. Cases Selected Phase 3	11	13	8	3	**35**
No. Cases Discussed Phase 3	11	9	6	3	**29**
% Cases Discussed Phase 3	100%	69%	75%	100%	**83%**

**Process takes a minimum of 6 months to complete*

- 69% (304/527) of cases had completed an independent peer review (Phase II) from October 2021 – September 2022 deaths. The process can take a minimum of 6 months to complete.
- From this, 35 cases have been selected for discussion out of which, 29 cases have been discussed (x8 inpatients and x21 Community/Other Hospital).

  The scores for these cases are:

  - Inpatient SJR RCP Scores: All x8 cases were scored 6.
  - Community/Other hospital inpatient RCP Scores: All x21 cases were scored 6.

  Of the remaining x6 cases awaiting discussion:

  - x5 are due to be discussed at the January 2023 Mortality Review Meeting and the remaining x1 is to be discussed at the February 2023 Mortality Review Meeting.
- 1 mortality case was subject to LeDeR review (Learning Disability), LeDeR form has been submitted to national team, no further information was requested. Local avoidability score is yet to be finialised.
- 1 mortality case was subject to a Child Death Overview Panel review (CDOP), CDOP form has been submitted to national team (required for in scope patients <=18). Local review confirmed it was an appropriate decision to treat but unfortunately disease was aggressive and resistant which caused the death. Not selected for formal discussion.

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.

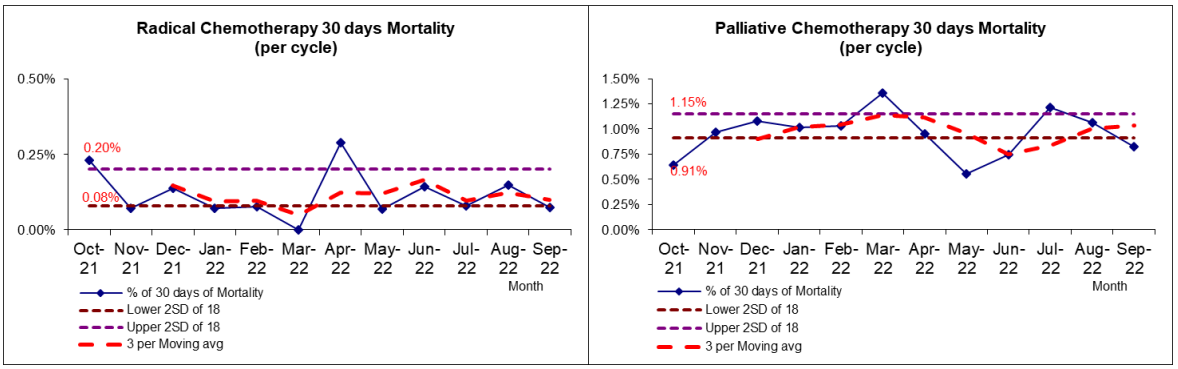
The control limits (lower & upper 2 standard deviation – brown dash line on chart) are reviewed annually and are set by the best performing annual figures from 2009 onward. All data points fallen inside the control limits are deemed to be within tolerance.

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).

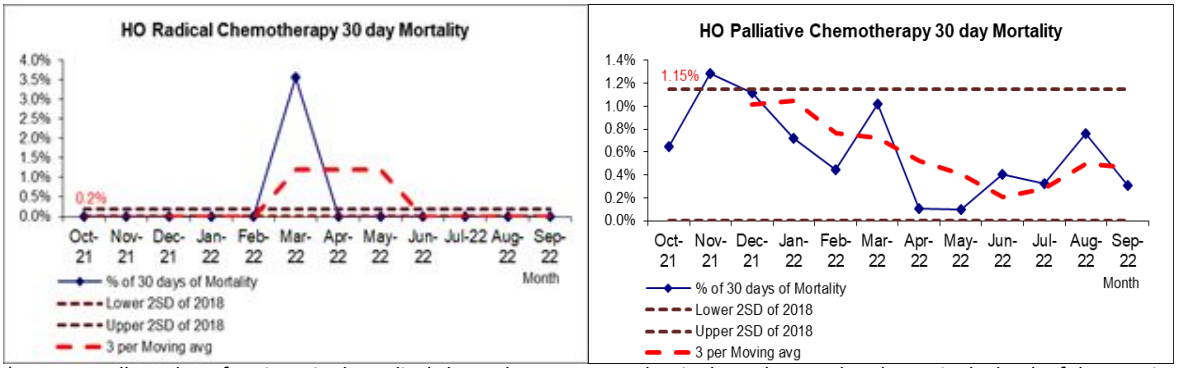
October 2021 – September 2022 treatment activities

- Results showed the 3 monthly moving average mortality for each of the areas were within tolerance.

6.1 Chemotherapy 30 day mortality (Solid Tumour)

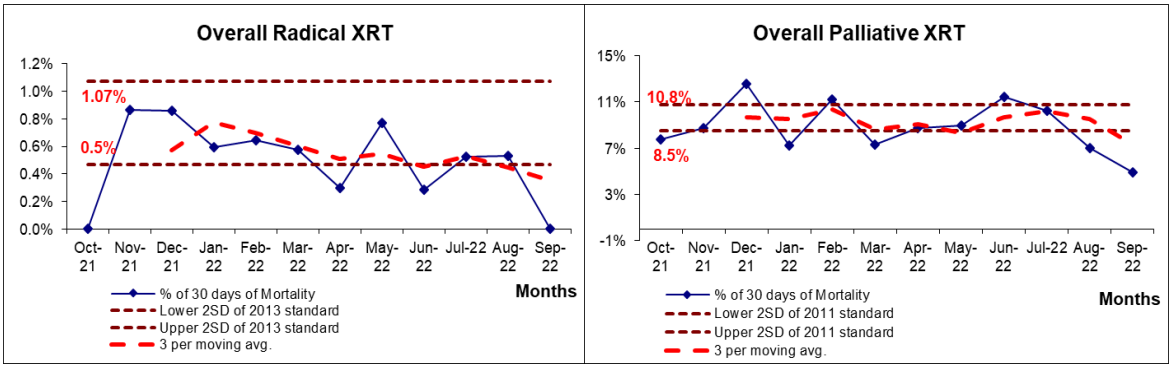


6.2 Chemotherapy 30 day mortality (Haemato-oncology)

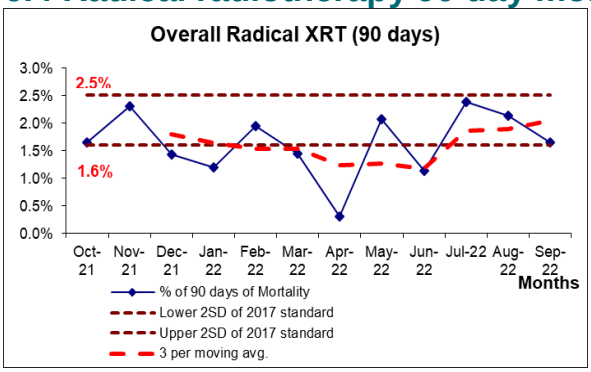


**Due to small number of patients in the radical chemotherapy group, the single peak was related to a single death of that particular month.*

6.3 Radiotherapy 30 day mortality



6.4 Radical radiotherapy 90 day mortality



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

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)	% Deaths Reviewed (Phase 2)	Total Deaths Selected for Review (Phase 3)	Total Deaths Discussed (Phase 3)	% Discussed (Phase 3)
2022/23	**368**	**317**	**207**	**65%**	**138**	**67%**	**11**	**9**	**82%**
Q2	**200**	**173**	**100**	**58%**	**56**	**56%**	**3**	**3**	**100%**
Q1	**168**	**144**	**107**	**74%**	**82**	**77%**	**8**	**6**	**75%**
Total	**368**	**317**	**207**	**65%**	**138**	**67%**	**11**	**9**	**82%**

Total Number of Learning Disabilities in Scope

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

Total Number of Children in Scope

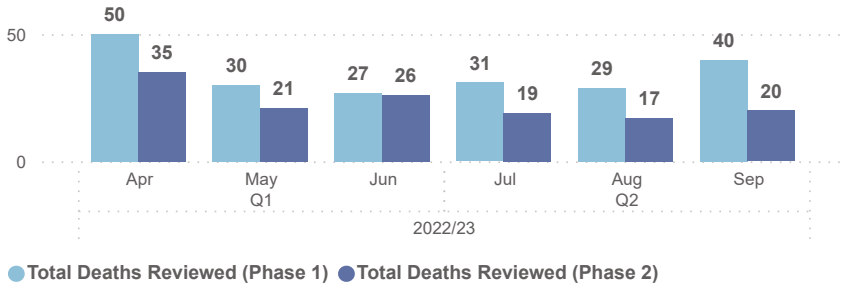
Year	No.	CDOP Completed	Potentially Avoidable (Score <= 3)
2022/23	**1**	**1**	**0**
Q2	1	1	0
Q1	0	0	NaN
Total	**1**	**1**	**0**

NaN = No case for the quarter / case score 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**	**56**
Q2	0	0	0	0	0	23
Q1	0	0	0	0	0	33
Total	**0**	**0**	**0**	**0**	**0**	**56**

Number of cases reviewed at Phase 1 & Phase 2



Lessons Learned from Mortality Review

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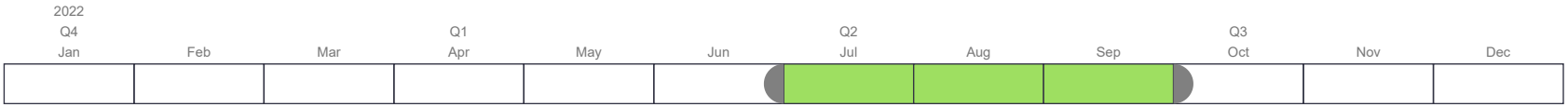

QTR	Year	ID	Background	Action	CCC Lessons learned	Closure date
Q2	2022/23	153	An inpatient at CCCL died of sepsis. During admission they had a blood culture and catheter urine sample taken that identified E Coli infection. The most likely source of the infection was a catheter associated urinary tract 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.	09/08/2022
Q2	2022/23	163	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.	19/07/2022
Q2	2022/23	125	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.	17/08/2022
Q2	2022/23	148	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 StH&K 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.	24/08/2022
Q2	2022/23	161	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.	18/08/2022
Q2	2022/23	160	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.	19/07/2022
Q2	2022/23	157	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.	01/09/2022
Q2	2022/23	164	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.	09/08/2022

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Risk and Quality Governance Committee
Date of meeting: 10th January 2023

Report author	Dr Mohammed Saif, Priscilla Hetherington			
Paper prepared by	Clinical Effectiveness Team, Dr Mohammed Saif, Priscilla Hetherington			
Report subject/title	Quality Surveillance and Specialised Services: Haemopoietic Stem Cell Transplants Dashboard			
Purpose of paper	To provide an overview of national benchmarking of 100 day Bone Marrow Transplant mortality for Quarter 2 2022/23			
Background papers	NA			
Action required	Report 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		

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The Clatterbridge Cancer Centre NHS Foundation Trust

1.0 Background

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.

The dashboards makes use of spine chart and SPC spark lines to be interpreted as follows:

2.0 SSQD Q1 2022-2023 Overall Summary

These results indicate that successful engraftment in our BMT patient is well above average.

Deaths within 100 days of allogeneic stem cell transplantation remains well below national average showing excellent results for the centre. This was consistent for all quarters in 2021-2022. For autologous stem cell transplantation, percentage of patients dying within first 100 days and alive at 1 year post transplant is above national average but below the national upper value for this quarter. For QTR1 Overall there are no negative indicators, 1 positive indicator and 0 neutral indicators.

Summary: Outcome of patients receiving stem cell transplantation in Liverpool shows well above average outcomes for allogeneic transplant and well within average (2SD) outcome for autologous transplantation despite COVID pandemic. There are no concerns in these data.

It is also worth noting that since 25th March 2020 submission of data to the dashboard has been voluntary and it is not known how many centres have continued to submit data, this may impact national figures and averages.

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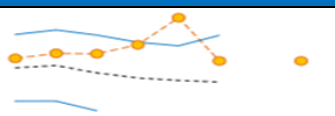
3.0 BMT02a-A -Proportion of patients with successful engraftment

*• 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	National Average	Chart	Trend
QTR 2 21-22	Apr 21 - Sep 21	30	30	100	97.8		
QTR 3 21-22	Jul 21 - Dec 21	43	44	97.7	97		
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		

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	National Average	Chart	Trend
QTR 2 21-22	Oct 20 - Sep 21	14	70	20	10.6		
QTR 3 21-22	Jan 21 - Dec 21	20	74	27	10.6		
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		

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Version: 2.0

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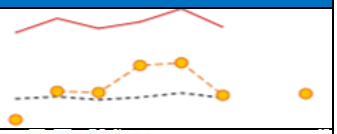
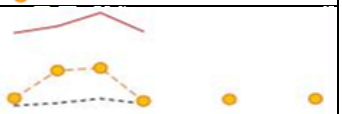
3.2 BMT08a-A – Percentage of patients dying within 100 days of transplant

The table below demonstrates the numbers in the numerator and denominator for Quarters 2-4 2022-2022 & QTR 1 2022-2023. We had two deaths in Quarter 4 which explains the drop. One patient was transferred to HDU in LUHFT and died there. The other patient was reviewed in our Mortality & Morbidity meeting and the team did not identify anything that we could have done differently.

It should be taken into account that because of the small numbers with short term data capture and the way it is calculated the numbers can look worse. Also this is not a mandatory requirement and we don't know how accurate the national average because a limited number of centres may be submitting data.

• 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	National Average	Chart	Trend
QTR 2 21-22	Oct 20 - Sep 21	*(1)	*(47)	2.1	1.7		
QTR 3 21-22	Jan 21 - Dec 21	*(1)	*(46)	2.2	1.7		
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		

The graph below is a taken from the BSBMT report for our centre and overall, this is the gold standard data against which we are assessed by BSBMT and EBMT. This is long term mandatory robust data submitted by all centres. From this data we are one of best performing centres in the country.

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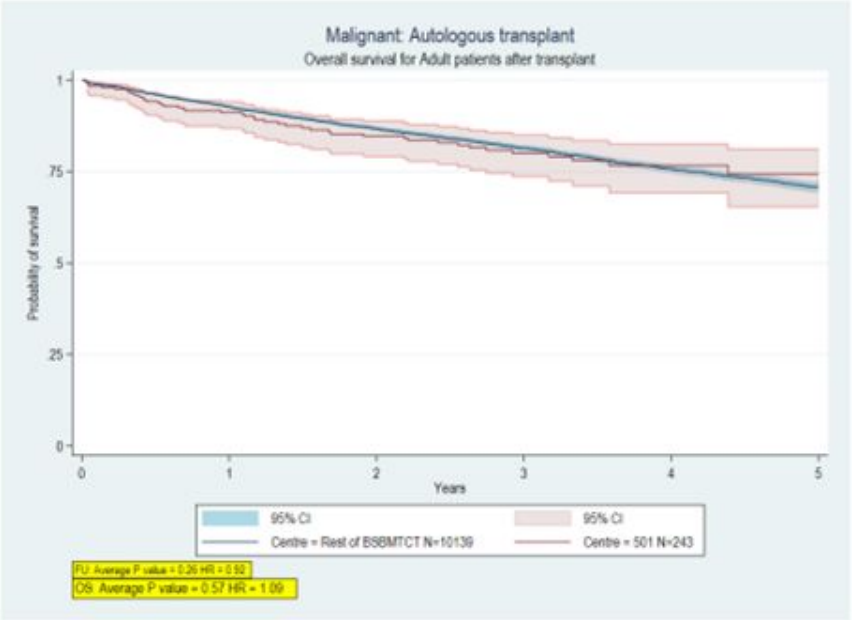
Figure 5: Malignant Adult patients: overall survival after Autologous transplant



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	National Average	Chart	Trend
QTR 2 21-22	Oct 20 - Sep 21	29	30	96.7	93.9		
QTR 3 21-22	Jan 21 - Dec 21	41	43	95.3	93.2		
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		

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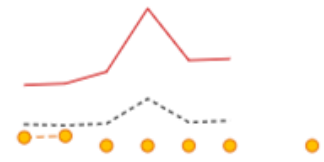
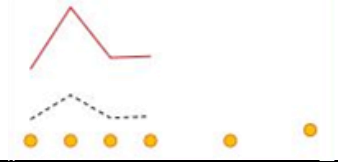
3.4 BMT13-A – Percentage of patients dying within 100 days of transplant

- *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	National Average	Chart	Trend
QTR 2 21-22	Oct 20 - Sep 21	0	18	0	8.3		
QTR 3 21-22	Jan 21 - Dec 21	*	*	4.2	8.6		
QTR 4 21-22	Apr 21 - Mar 22	*	*	6.5	8.1		
QTR 1 22-23	Jul 21 - Jun 22	*(2)	*(33)	6.1	7.1		

4.0 Haemopoietic Stem Cell Transplant Alerts

QTR	Detail
QTR 2 21-22	• For Quarter 2 2021.22 the Haematopoietic Stem Cell Transplant Programme had 0 Negative alerts, 2 Positive alerts, 1 neutral alert SSQD description: SSQD Q2 2021/2022 Last AA Outcome (AA 2019/2020): Routine surveillance Last SD Score (SD 2019/2020): 100.0 Latest SSQD Alerts (SSQD Q2 2021/2022): Positive Alerts: 2, Negative Alerts: 0, Neutral Alerts: 1 Submission Audit Log Negative Alerts 0 Positive Alerts 2 Neutral Alerts 1

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QTR 3 21-22	**• For Quarter 3 2021.22 the Haematopoietic Stem Cell Transplant Programme had 0 Negative alerts, 0 Positive alerts, 1 neutral alert** Submission Audit Log Negative Alerts 0 Positive Alerts 0 Neutral Alerts 1
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 2021.22 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

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board
Date of meeting: 25th January 2023

Report Lead	Tom Pharaoh, Director of Strategy				
Paper prepared by	Tom Pharaoh, Director of Strategy				
Report subject/title	Update report on the Good Governance Institute (GGI) well-led review action plan				
Purpose of paper	The report from the developmental well-led review undertaken by GGI between November 2021 and February 2022 was presented to the Trust Board at its meeting in April 2022. The report made a number of recommendations and these were picked out an associated action plan, also presented to the Trust Board in April 2022. This report provides an update on progress against each of the agreed actions following the last Board update in October 2022. It is noted that the majority of actions are complete and that others have extended timelines. It is proposed that the oversight of the remaining actions is picked up through business as usual processes.				
Background papers	Well-led Review: Report from the Good Governance Institute (GGI)				
Action required	The Trust Board is asked to note the progress made with the majority of actions as well as the challenges faced in other areas. The Trust Board is asked to approve the proposal that this is the final standalone GGI well-led review update report presented to it				
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	~~Yes~~/No	Disability	~~Yes~~/No	Sexual Orientation	~~Yes~~/No
	Race	~~Yes~~/No	Pregnancy/Maternity	~~Yes~~/No	Gender Reassignment	~~Yes~~/No
	Gender	~~Yes~~/No	Religious Belief	~~Yes~~/No		

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ACTION PLAN

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GGI well-led review action plan

Last updated: January 2023
Updated by: Tom Pharaoh

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

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
KLOE 1 – Leadership capacity and capability						
R1	The trust should consider how it can use trust communications and engagement events to raise the profile of non-executive directors inside the organisation, and awareness of the important work they do.	• Develop and deliver a post-covid NED profile raising programme	Corporate Governance, Communications	By end January 23		• Complete • Took place alongside Governor profile raising actions and was monitored by Membership Engagement and Communications Committee • Action target date amended to January 23 in October 22 • 'Meet the NED' messages on screensavers and CCC-L comms screens each month starting from November 2022 • 'Meet the NED' posts each month on Trust social media from November 2022 • NEDs attending Trust Board meetings at CCC-L from January 2023 and will use the opportunity to informally engage with staff • Communications Team continue to raise awareness of Non-Executive Directors

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
		• Restart on-site NED visits	Corporate Governance, Patient Experience Team	By end July 22		• Complete • First on-site visit took place in June
KLOE 2 – Strategy, vision and values						
R2	Communication of the new trust values to the entire workforce – and to patients and partners – should be a corporate priority in the coming months.	• Stock-take of comprehensive ongoing trust values communication and engagement programme	Workforce & OD, Communications	By end May 22		• Complete • Values communicated through divisional listening events, team meetings, staff groups and engagement events • Walkabouts at all sites to raise awareness of values and associated behaviours • Promotional materials produced including screen savers, staff quotes, staff videos, lanyards
		• Ensure new values are fully incorporated into key trust processes: PADR, recruitment, induction, staff achievement awards, etc.	Workforce & OD	By end July 22		• Trust induction, new starter welcome pack, PADR and monthly awards have all been updated to incorporate the new values • Job adverts, on-boarding and other recruitment documentation has been updated • Learning and OD programmes have been updated to reflect the values • The new values will also form part of the criteria for the Trust Annual Staff Awards, due to take place on 14/10/22

ACTION PLAN

NHS
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NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
		• Develop plan for further values awareness raising and review of impact	Workforce & OD	2023		• Values feature in the new manager induction programme • Introduction of values based recruitment is included in the People Commitment and will be implemented in 2023 • Ongoing work to embed the values into everything we do (green agenda, education, staff networks, EDI, celebration event, innovation) • More staff videos about the values e.g. Ethnic Diversity Staff Network on being Inclusive
KLOE 3 - Cultures						
R3	The trust should consider how it can raise the profile of the freedom to speak up service among its workforce.	• Stock-take of current awareness of freedom to speak up (FTSU), ongoing communications plans, and uptake of service	Corporate Governance	By end September 22		• Complete • Led by Interim Associate Director of Corporate Governance in conjunction with FTSU Guardians • Chief Nurse now FTSU executive lead
		• Develop plan for further FTSU awareness raising and review of impact	Corporate Governance	By end September 22		• Complete • Implementation of plan throughout FTSU month in October • Awareness raising through all comms channels: screensavers, Team Brief, intranet, CEO video message, etc. • FTSU NED Lead walkaround • FTSU pens distributed • FTSU policy and annual report to Trust Board in October • *Addendum 01/23: recruitment of a dedicated FTSU Guardian in progress*

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
R4	Work on organisational development and culture should take account of the fact that staff who are new or who have transferred from other organisations may be accustomed to different cultures and ways of working.	• Inform Learning & Organisational Development team of the recommendation and the relevant context in the GGI report	Director of Workforce & OD, Director of Strategy	By end June 22		• Complete
R5	The trust should review the induction process for new directors, both executive and non-executive.	• Develop and agree outline induction processes for new Executive and Non-Executive Directors (to inform detail induction packages to be developed as new Directors are appointed)	Corporate Governance, Director of Workforce & OD	By July 23		• Lower priority – no new directors expected imminently • New Associate Director of Corporate Governance to lead once in post • Target date amended from Nov 22 to Jul 23
KLOE 4 – Roles, responsibilities and accountability						
R6	The agenda of the quality committee should be reviewed with the intention of condensing the agenda pack, and reporting for assurance, i.e. by highlighting positive and negative exceptions and planned actions, and summarising themes and trends, as opposed to detailed operational reporting.	• Review Quality Committee agenda as part of wider review of governance and Board sub-committees	Chief Nurse	By end Apr 22		• Complete • Board sub-committee arrangements to be reviewed again in quarter 4 of 2022/23
R7	When corporate policies are next due for review, the policy owners should ensure that they make clearer how they will be monitored	• Develop a checklist for future review of corporate policies – to include training and monitoring of compliance	Information Governance Team	To be confirmed in January 2023		• Full document control process for policies and other key documents currently under review • Proposal to go beyond original action and transfer ownership of all documents (1,000+) to committees

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
	for compliance, and what training different groups of staff require.					rather than individuals and systematise review and quality control • Target date to be amended to reflect the fact that this proposal is significantly different to the original action • Information governance function now reports to Chief Information Officer • Programme to be tracked at Risk and Quality Governance Committee
R8	The trust should consider reviewing the structure of operational management committees which feed into board assurance committees, as it has already done for the groups which report to the quality committee. This will ensure that every group is serving its intended purpose and may allow some meetings to be eliminated or streamlined. GGI can recommend a way to do this.	• Review operational management committees	Chief Operating Officer	By September 22		• Complete • Session in September to ensure operational structures are aligned with clinical governance arrangements
R9	The trust should ensure that when it reviews its policy for managing conflicts of interest in July 2022, it identifies the team or individual with responsibility for providing advice training and support for staff on how interests should be managed. The policy should also	• Review conflict of interests policy, taking into account the GGI feedback	Corporate Governance	By end September 22		• Complete • Policy has been reviewed and is compliant with national guidance • Some minor changes to guidance and processes included • Policy outlines responsibilities for advice, training and support

ACTION PLAN

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Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
	say how the trust will audit compliance with its own policy and associated processes and procedures on an annual basis and subsequently in line with the review cycle of the policy.					• Reviewed policy approved at all necessary committees and Trust Board in October • Compliance to be monitored at Audit Committee following MIAA internal audit
R10	We recommend that the trust publishes a conflicts of interest register that reflects the current membership and attendance at the board. The conflicts of interest register should be included in meeting packs for all future meetings.	• Update and republish conflicts of interest register	Corporate Governance	By end June 22		• Complete – published on CCC website
		• Consider inclusion of conflicts of interest register at all future Trust Board meetings (and Board Committee meetings)	Corporate Governance	By end September 22		• Complete • Register currently publicly available on internet and members declare interests linked to agenda items • Inclusion of conflicts register with meeting packs considered but not pursued
KLOE 5 – Managing risks and performance						
R11	The risk management strategy should be reviewed and updated, in terms of content, style and format. The intention should be to make the document more succinct and visual and to remove outdated or unnecessary supporting information.	• Review risk management strategy, taking into account the GGI feedback	Associate Director of Clinical Governance and Patient Safety	By end May 22		• Complete • Reviewed strategy approved at April 22 Risk and Quality Governance Committee • Strategy scheduled for further review and broad engagement in 12 months • *Addendum 01/23: Review of Risk Management Strategy underway – awaiting publication of Patient Safety Strategy Framework national documentation in order to align Incident Reporting Processes*

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
R12	The board assurance framework should differentiate more clearly between gaps in control or assurance, and the actions required to close those gaps.	• Review BAF in full as part of ongoing review of Board risks for 2022/23	Corporate Governance (supported by Conway Bloomfield Ltd)	By end July 22		• Review complete • Approved at Audit Committee and Trust Board in July
R13	The board assurance framework should be used actively as a tool to shape the work of the board and ensure that the right information is going to the right places within the governance structure.	• Develop plans for improvement of the use of the BAF in the Trust's governance structures	Executive Team	By end September 22		• Complete • Relevant BAF risks reviewed at sub-committees of Trust Board and key Exec-led forums (TEG, Risk & Quality Governance Committee, Digital Board) • BAF review systematised by inclusion on committee rolling programmes
R14	The trust should consider adopting a more standardised definition of risk, in place of the current division between risks and issues on the risk register. Alternatively, it should ensure that the difference between risks and issues is clearly understood by all.	• Adopt a standardised definition of risk	Chief Nurse	By end April 22		• Complete • All issues on risk register converted to risks or closed • Additional risk management training ran in April/May • Monthly Risk & Quality Governance Committee – chaired by CEO – reviews all 15+ risks
KLOE 6 – Data and information						
R15	In the forthcoming refresh of the IPR, the trust should consider presenting the report in a more visual manner.	• Take into account GGI feedback as part of ongoing IPR review	Head of Performance & Planning, Head of Business Intelligence	By end May 22		• Complete • A reviewed more visual IPR was presented during April/May for comment and refinement • IPR will continue to develop

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
KLOE 7 – Stakeholder engagement						
R16	The trust should consider how it can grow, and involve, its foundation membership	• Stock-take of membership position	Corporate Governance	By end May 22		• Complete
		• Develop plans to grow and involve membership	Corporate Governance	By end May 22		• Complete • Membership strategy approved by Membership Engagement and Communications Committee • Membership position monitored quarterly through membership engagement and communications committee I would say this is complete
KLOE 8 – Learning, improvement and innovation						
R17	The trust should develop a new / revised quality strategy and ensure that the resources, methodology and training that are needed to implement it are in place.	• Develop a new quality strategy	Chief Nurse, Director of Strategy	Development underway in Q4 22/23		• Development of meaningful clinical quality strategy will require broad engagement across the trust • Target date amended • New target date reflected in BAF • Quality strategy development to be overseen at Risk and Quality Governance Committee
R18	The clinical governance and communications teams should work together to find and implement new ways of spreading learning from patient safety incidents and	• Stock-take of current methods for spread of learning from incidents and complaints	Clinical Governance	By end August 22		• Complete • Lessons learnt shared through general communications channels e.g. Team Brief • New Associate Director of Clinical Governance started in November

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
	complaints across the whole organisation.	• Develop plans to improve the spread of learning from incidents and complaints (as part of new quality strategy)	Clinical Governance, Communications	Development underway in Q4 22/23 (in line with quality strategy development)		• Proposals for 'Safety News Flash in development' • New Associate Director of Clinical Governance started in November • Quality strategy development to be overseen at Risk and Quality Governance Committee • Target date amended

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board
Date of meeting: 25 January 2023

Report Lead	Dr Séamus Coyle, Clinical Lead for Innovation Dr Gillian Heap, Director of Research & Innovation Operations				
Paper prepared by	Drew Norwood-Green, Innovation Manager				
Report subject/title	Innovation Strategy (2023 – 2025)				
Purpose of paper	To share with Trust Board the proposed Trust Innovation Strategy (2023-2025) for approval. Presented and approved at Research Strategy Committee October 2022. Presented and approved at Trust Executive Group November 2022. Presented and approved at Quality Committee December 2022 - To outline Trust Innovation Strategy				
Background papers	None				
Action required	Discuss				
	Information/Noting				
	Approval				X
Link to: Strategic Direction Corporate Objectives	Be Outstanding		Be a great place to work		
	Be Collaborative		Be Digital		
	Be Research Leaders		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		

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

The Clatterbridge Cancer Centre
NHS Foundation Trust

INNOVATION STRATEGY

2023-2025

CONTENTS

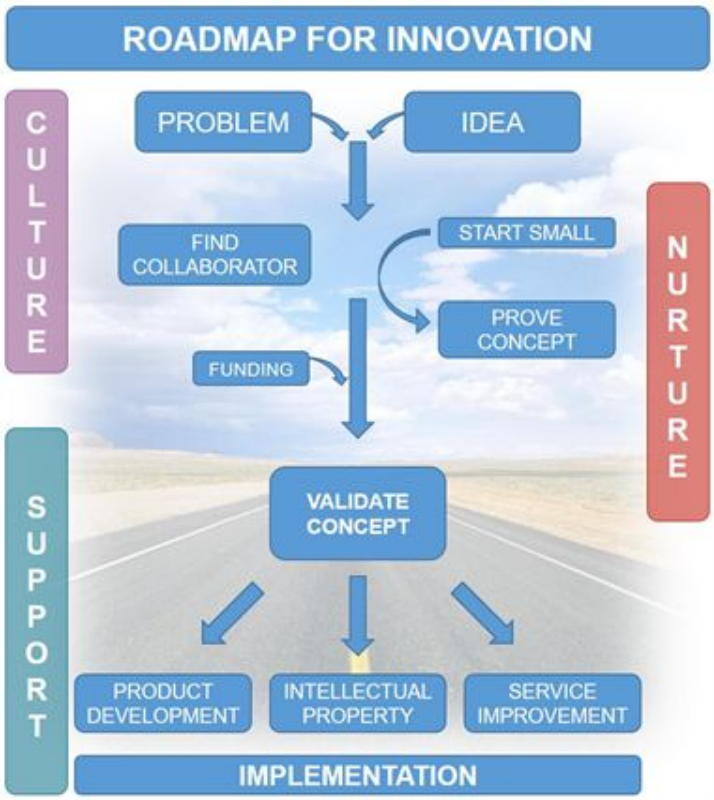
FOREWORD

The Clatterbridge Cancer Centre NHS Foundation Trust (CCC) has a rich history spanning over 160 years, with a commitment to delivering world class cancer care through pioneering and early adoption of new techniques and ways of delivering care. The Clatterbridge Cancer Centre – Liverpool opened in 2020 and positioned its flagship 'state-of-the-art' hospital at the heart of Knowledge Quarter Liverpool, demonstrating the Trust's commitment to taking its place at the forefront of healthcare and innovation.

By focusing on innovation we can seek opportunities within the organisation and in collaboration with patients and partners to improve patient experiences and outcomes.

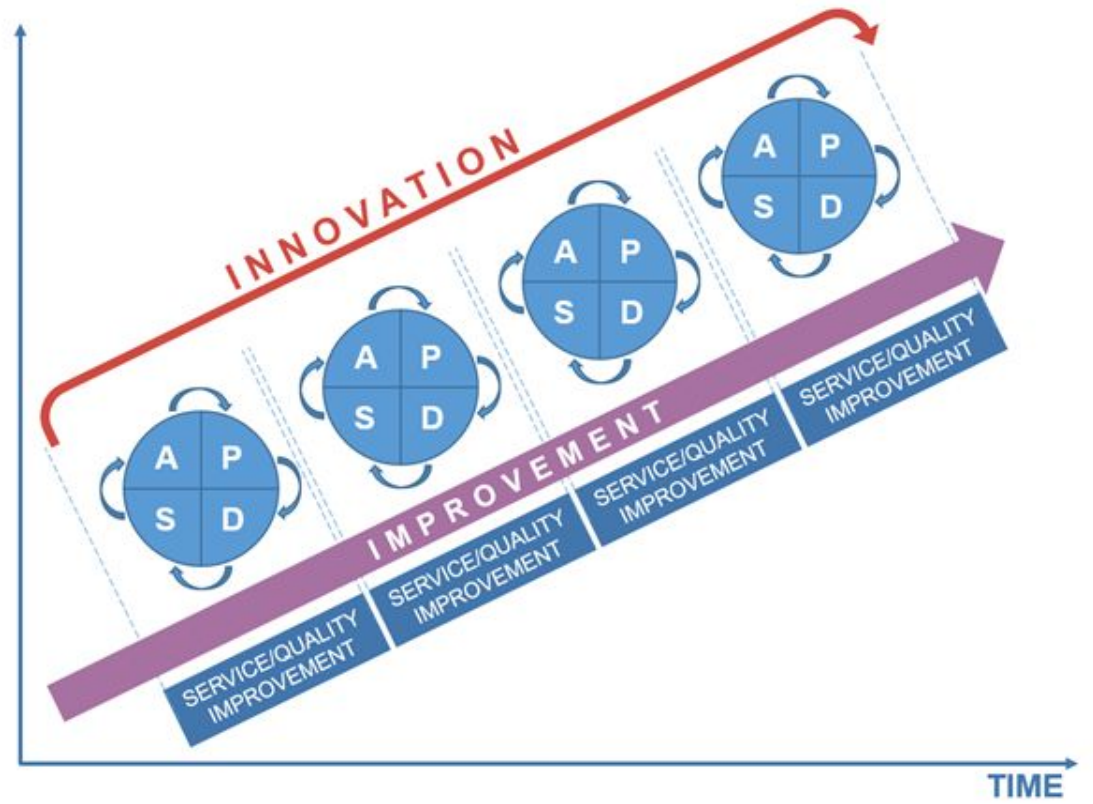
CCC INNOVATION DEFINITION

Innovation is the successful exploitation of new ideas to overcome a problem by creating, developing and implementing a new product, process or service, with the goal of improving the choices, experience and outcomes for patients.



INNOVATION & QUALITY IMPROVEMENT

“All innovation is quality improvement, not all quality improvement is innovation”



Improvement is iterative and usually incremental, each PDSA (Plan, Do, Study, Act) cycle builds on the next, optimising a system and eliminating defects.

Innovation by definition, creates something fundamentally new from a previous system, resulting in a different process or end result.

Adoption of innovation is the incorporation of innovations that originated outside of the organisation, this can occur at different stages of the innovation journey.

Adoption will range from CCC being part of any validation process, acting as a test bed for newly developed concepts, or accessing fully-tested products that are just coming onto the market.

CCC INNOVATION CASE STUDIES

"Healthcare Innovation is the creation and development of new ideas into real-world applications with the goal of improving patient care"

It is helpful to think of different types of innovation, for example new improved ways of doing things or providing a service, improvements building on existing expertise or the introduction of new technology.

At CCC we have introduced innovations with local, national and international impact, examples of these are included in Appendix I.

Clatterbridge set up commercial companies (PharmaC, PropCare) and a joint venture supporting the work it delivers.

- PropCare was established by the Trust with the main aim of delivering the build programme required to achieve our Transforming Cancer Care programme, including the construction of CCC-Liverpool and the redevelopment of CCC-Wirral.
- Since 2013 PharmaC has supported the Trust in bringing pharmacy procurement and dispensing services in-house and delivering exceptional quality of service to our inpatients and outpatients both at home and at hospital.
- The Clatterbridge Private Clinic has been a joint venture between the Trust and the Mater Private since 2012. The private clinic in the new CCC-Liverpool opened in 2020 and the investment in new capacity in Liverpool attracts additional income into the joint venture through haemato-oncology and new privately medical insured patients from the North Mersey part of the region.

INNOVATION MISSION STATEMENT

At CCC we will make a difference to improve choices, experiences and outcomes for patients with cancer by accelerating adoption and development of innovations.

This innovation strategy outlines how we as an organisation will systematically generate novel solutions to problems and translate those ideas into a business concept for internal development or external collaboration. Having a clearly defined approach and mechanism for innovation facilitates a carefully considered approach and thoughtful use of public resources for the betterment of the patient experience at CCC.

Our focus in line with the NHS Long Term Plan continues to pledge its commitment to innovation, aiming to speed up the pipeline for developing innovations in order to bring proven and affordable innovations to patients faster.

The Clatterbridge Cancer Charity recognises this priority and supports innovation through the provision of the Innovation Fund. The Charity provides seed funding for innovative projects to improve patient outcomes and experience.

The Innovation Strategy is aligned with CCC's Five Year Plan; therefore this strategy covers the next three years in order to line up with the Trust.

This strategy has been developed in consultation with staff, patients and members of the public through a series of engagement sessions that took place between March and April 2022.

All innovations need to centre on improving patient outcomes and experience. As CCC staff we each have a duty and responsibility to identify ways to improve daily practice. It is crucial we are inclusive of everyone within the Trust, ensuring those who understand the work and challenges are empowered to share their ideas and have their voices heard.

Embedding innovation within CCC over the next three years will be guided by three strategic themes:

- Culture for innovation
- Nurture new innovations from within CCC
- Support adoption of innovation

By encouraging an innovative mind-set, we will ensure innovation is a core function of the way we work. A Trust strategic priority is 'Be Innovative' therefore, fully supported by the organisation. The strategy will be supported within the Trust through a programme of work dedicated to increasing awareness, education, and developing an innovative mind-set.

Supporting adoption of existing external innovative practices is a priority for CCC. We will deploy a rapid assessment and piloting programme to accelerate improvement of patient outcomes and experience at Clatterbridge.

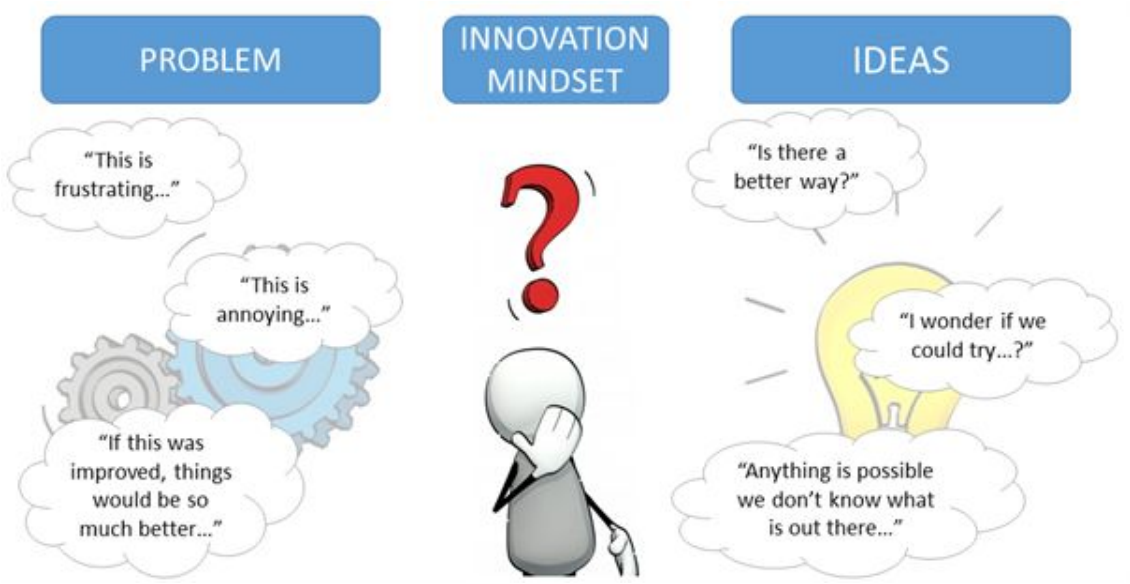
STRATEGIC THEMES

Culture of Innovation

"Innovation is everyone's job"

"If we only focus on what we think or know is possible, then there may be missed opportunities"

For CCC to be truly innovative we need staff and patients to share their challenges and ideas; it is from these challenges and problems we regularly face that innovation arises. This strategy is not only for everyone to have a say in Innovation but to emphasise that the input of all staff and patients is important; without it innovation will not thrive. It is crucial we are inclusive of everyone within the Trust and, that those who know the work and challenges involved are empowered and enabled to have their voice heard.



CCC's culture is embracing the innovative mind-set as a core function of the way we work. 'Be Innovative' is a key Trust strategic priority that is embedded within the Trust's business plans, therefore, our journey has already begun. We will continue to fully integrate innovation into the Trust's business as usual activity, supported by a systematic approach to innovation.

There will be a programme of work dedicated to education, increasing awareness, and support for individuals to act as local innovation champions. This combined approach will accelerate an innovative mind-set. Staff will have 'permission to explore' new ways of doing things, and 'permission to embrace failure whilst learning' if something appears unsuccessful.

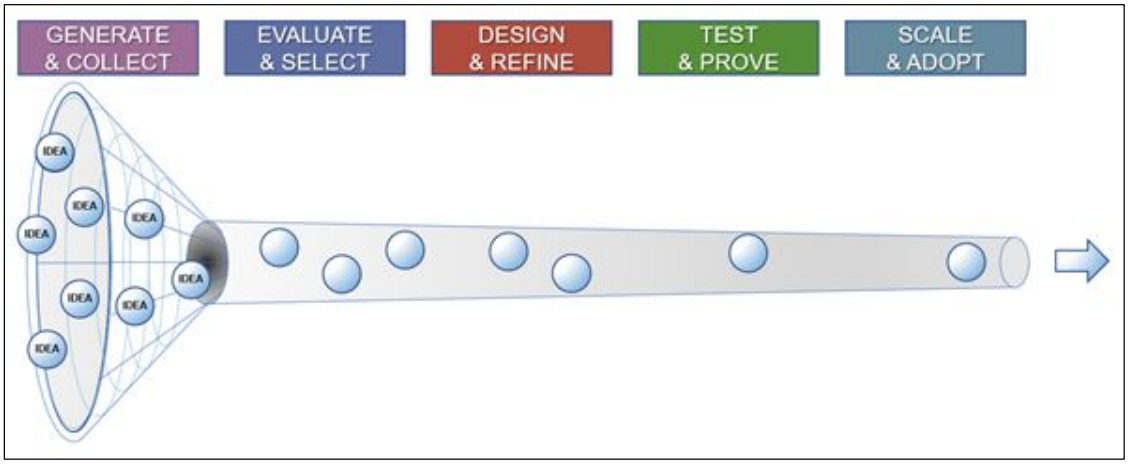
The Bright Ideas Scheme was established to give staff from all areas of the Trust an easy-to-use and easy-to-access platform to submit their ideas and suggestions. This has proven successful since its launch in August 2021, with a continuous flow of submissions received.

Promoting a culture of innovation within CCC will happen through multiple channels:

- Delivery of education centred on innovative practices.
- Active engagement through collaboration events of key staff groups with external partners.
- Launch of an Innovation Funding Call for larger scale projects and entirely novel concepts.
- Further integrating with Trust practices and incorporation of innovation into the personal learning of all staff via the Performance Appraisal and Development Review (PADR) process.
- We will promote the spread of innovation and good practices across organisational boundaries.
- Celebration of innovation successes enabling wider gains to be realised through shared learning and best practices.

Nurturing New Innovation

"Everything and everyone can make a difference"

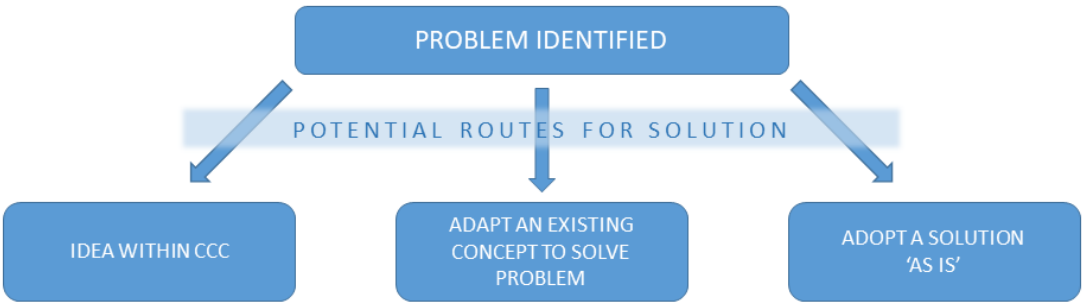


An important priority for this strategy is to establish a system of processes acting as a conduit for innovative ideas to be collated, developed, shared, and translated into practice. These ideas must come from our staff and patients, we will empower staff and source funding streams to nurture ideas with the most potential and processes in place to support them.

The Innovation Team will establish a framework to assess and select projects for further development based on their potential, feasibility and alignment with the Trust's strategic objectives and priorities.

The Clatterbridge Cancer Centre established an Innovation Fund in 2021 in partnership with The Clatterbridge Cancer Charity, providing seed funding for projects with potential to enhance outputs and generate external income.

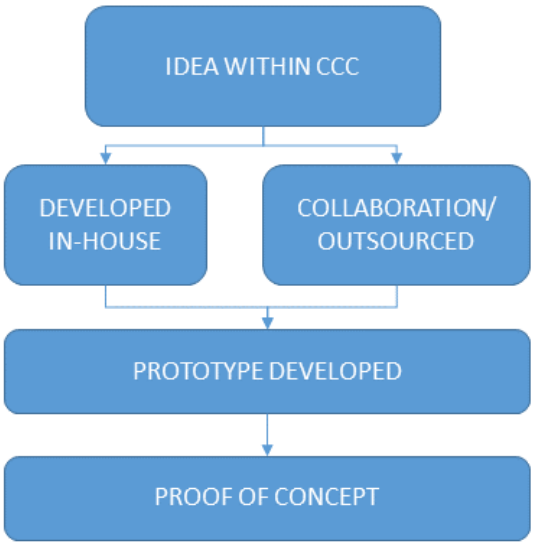
Staff will have access to coaching, to develop the necessary skills to effectively work up and implement an initial concept. In addition to empowering our staff, the Innovation Team will work with them to connect each concept with any specific skills, knowledge, and expertise required to maximise the potential for each stage of development.



Our approach to innovation focuses on problem-solving, creating new concepts, or re-purposing existing ones to overcome challenges and address an existing need within the Trust. Collaboration is vital to the success of any project, and we will cultivate partnerships with academic, commercial, and other NHS organisations both regionally and nationally.

If innovation is a global first, there is an opportunity to develop this into a marketable product or service. This will generate income for the organisation and over time be used to grow the Innovation Service and to support the development of new innovations.

Innovation can take many forms and depending on the nature of the concept or product created, may include intellectual property. These may be eligible for protection through various methods, e.g. patents, copyrights, know-how, and trademarking. The nature of the innovation will determine which protections are applicable. The process of protecting intellectual property, the hiring of external legal expertise, and resources to develop a prototype are all examples of steps in the process that require funding before reaching a point where any financial gains can be realised.



The aim is to become a self-sustainable service generating its own income to further progress innovative work by the staff at CCC. Whilst financial goals are important, the focus will always remain centred on what will make a difference to improve the choices, experience and outcomes for patients.

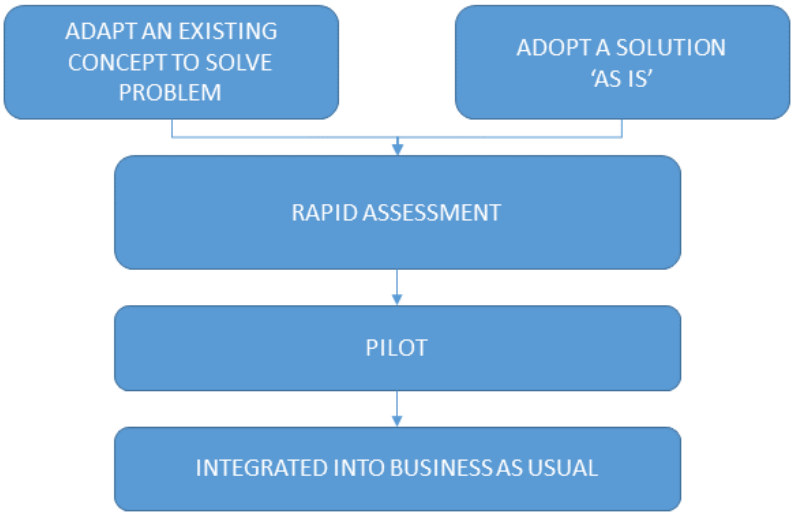
Supporting Adoption of Innovation

"What are the latest developments in technology and practice that we can leverage to improve things here?"

"Can you see good practice out there that we can bring in?"

We will provide faster access to novel treatments and innovative ways of working, optimising patient outcomes and experience. A solution to a problem may already exist such as a better treatment or a more efficient process in place. We will adopt these solutions and adapt them to improve our services and patient care at Clatterbridge.

Adoption will occur at different development stages, ranging from CCC being part of the validation process, acting as a test bed for newly developed concepts, or accessing fully-tested products that are just coming onto the market. The importance of partnerships runs through all aspects of successful innovation. Adoption needs collaboration with academic, commercial, and other NHS organisations. Accelerating adoption requires a flexible and agile approach to change, which will result in external innovations enhancing business as usual practice.



The rapid assessment framework will assess newly proven concepts for adoption in the organisation, with a risk-proportionate initial pilot. The pilot will determine the feasibility and safety of the concept. This informs the decision to scale up the adoption and spread it across the organisation. A governance framework and clearly defined process will be established to safely and quickly facilitate transformation.

A commercial evaluation service will be established in order to support the validation and subsequent adoption of newly developed products. This will facilitate collaboration with external partners to increase our access to novel concepts whilst providing our partners with a test bed and opportunity for feedback and product refinement.

ALIGNMENT WITH THE TRUST STRATEGIC PRIORITIES

Be Outstanding

Ensure that all innovations centre on improving patient outcomes and experience through maximising performance, and supporting Trust priorities such as improving urgent and unplanned care.

We will ensure innovation is a core function of the way we work. We will educate, coach, encourage and support to create ideas, develop solutions and make improvements a reality.

Be Collaborative

Development of our innovations and adoption of external novel solutions will only succeed through the shared learning, collaboration, and cooperation with our partners across the region commercially, academically and with other NHS organisations.

Our strategy reinforces this priority and outlines collaborations are crucial during the development and implementation of innovative solutions.

Be a Great Place to Work

Develop and empower our staff to be the driving force of positive change in the organisation, providing a supportive forum for their ideas and engaging closely in any transformative work undertaken.

By empowering staff with an innovative mind-set and encouraging their development we give staff ‘permission to explore’ new ways of doing things, and ‘permission to embrace failure whilst learning’ until we can improve.

Be Digital

Working close with Digital to identify and leverage the latest technologies to create our own digital innovations as well transforming the organisation through the adoption of new digital technology.

Be Research Leaders

Supporting our researchers in identifying practical real-world applications to their theoretical research; promoting CCC as a key test-bed for novel practices and interventions for patients.

We recognise that there is much conceptual overlap between innovation and research, where research generates the novel data and then leads to innovation by implementation. We propose close communication between the Innovation and Research teams at CCC, which is facilitated by the position of both strands in R&I, and thus enabling us to join up these two strands of improvements in healthcare in an optimal way.

Be Innovative

Continue to support staff with their Bright Ideas and facilitate idea generation with staff to find ways to continually evolve the services we provide to patients.

This strategy document outlines our approach to systematically developing an innovation culture, nurturing great innovative ideas and supporting the adoption of existing external innovations.

OVER THE NEXT THREE YEARS

Culture of Innovation

- Facilitate a shift in culture to encourage all staff to spot problems and suggest solutions
- Facilitate access for all staff to have the skills, experiences and permissions to innovate and become self-improving
- Facilitate the development of education resources to train staff on the protection of their intellectual property
- Raise awareness of Innovation at CCC across all staff groups and business areas
- Establish an Innovation governance structure across the Trust.
- Establish CCC as a centre for Culture of Innovation regionally and nationally.

Nurturing Innovation

- Establish a process for the development, evaluation and commercialisation of innovations
- Establish a scheme to facilitate the submission of large-scale innovation projects to the Innovation Service also supported by the Innovation Fund
- Help to secure funding for innovations with significant commercial potential and/or benefit to patients or staff

Support Adoption of Innovation

- Establish routes to link adoption of innovation and transformation
- Establish routes to link innovation and continuous improvement
- Cultivation of partnerships with academic, commercial and other NHS organisations both regionally and nationally

CONCLUSION

All innovation needs to centre on improving patient outcomes and experience. As CCC staff we all have a duty and a responsibility to identify ways to improve the way we do things. It is crucial we are inclusive of everyone in the Trust and that those who know the work and the challenges involved are empowered and their voices heard. The new Innovation Service in the Trust builds upon the existing innovative and pioneering spirit that defines CCC.

The next three years will see a step change in innovation across the Trust and crucially a structured approach. By first focussing on a culture and mind-set for innovation, we will encourage the voicing of where challenges are and invite staff and service users to bring their ideas for solutions. Providing a nurturing environment in collaboration with external partners to develop potential solutions is vital to develop a 'proof of concept' and take ideas forward ensuring they become implemented in practice. Support is needed to help staff adopt and adapt existing innovations or innovative practice so that they are applied in practice. By deliberately harnessing the unique knowledge, desire to improve and innovative spirit of the staff within Clatterbridge we can create even more opportunities to make a difference, thereby improving the choices, experience and outcomes for our patients.

APPENDIX I – CASE STUDIES

Clatterbridge in the Community

Summary

CiC Team Assembled by their Transport Fleet

Clatterbridge in the Community (CiC) was one of the first cancer centres in the UK to provide at-home cancer treatments to patients. Today CiC delivers 20 different types of treatment across Merseyside, Cheshire, Lancashire, and North Wales providing over 500 treatments a month.

About Clatterbridge in the Community

Launched in 2015 as an 18 month pilot on the Wirral, to allow patients to receive a safe and efficient service in their own homes to improve cancer patient experience by offering independence of choice over treatment settings.

The service has been widely recognised, winning The Service Delivery Award in 2016 at the Health Collaboration Awards, finalists of the RCNi Cancer Nursing Award in 2019 and also winning the Nursing Times Awards in the same year.

CiC Team Winning Award for Nursing in the Community, The Nursing Times Awards

The Challenge

Before CiC was introduced, patients would have to travel (in some cases long distances) to the hospital and spend time waiting in clinic for the appointment to receive treatment. This was challenging for patients with mobility issues, patients who also had caring responsibilities of their own or having to take time off work to attend appointments.

Actions Taken

The first treatments delivered were subcutaneous Herceptin injections to breast cancer patients in their homes. The service quickly expanded to deliver immunotherapy at home in 2016, followed by the establishment of a model for SACT delivery in the workplace in 2018 which was the first of its kind in the UK. In response to COVID, the compassionate-use programme to support patients was expanded during 2020. In March 2022, a second hub was opened in Aintree to give equity of service patients in North Merseyside reaching patients as far as Southport. This second hubs provides more efficiency with travel, therefore enabling the treatment of more patients in the North Merseyside region.

Impact

This has resulted in increased capacity within clinics, saving over 420 hours of chair and appointment time from clinical hubs and phlebotomy.

Testimonials

CiC received 100% patient satisfaction in the most recent patient survey.

Next Steps

CiC plans to continue expansion both in treatments offered and areas covered. This includes plans for a third site based in Halton and exploring CiC for the HM Prison Service.

Enhanced Supportive Care Service

Summary

The Enhanced Supportive Care (ESC) pilot demonstrated significantly improved treatment outcomes and quality of life of patients, with reduced attendance or admissions to hospital. The ESC service saw 775 patients during the pilot, saving £2.4m from avoided hospital admissions and reduced length of stay.

About the Enhanced Supportive Care Service

In 2016, the NHS England Commissioning for Quality and Innovation (CQUIN) scheme focused on providing earlier supportive care for people with treatable but not curable cancer. The service was offered to everyone with a new diagnosis of incurable cancer. The ESC service offers timely holistic assessment, symptom management, psychological support and care for families of patients undergoing cancer treatment.

The Challenge

Prior to the introduction of the ESC patients normally received palliative care expertise covering advice and support for nutrition, wellbeing, pain management at a later stage in their treatment. This was possibly due to the perception that palliative care was associated with end of life care.

Actions Taken

ESC was first established in 2016 in response to the national objectives of the CQUIN, regular measurements of quality of life were instigated using the Integrated Palliative Care Outcome Scale (IPOS). ESC initially started with upper GI, CNS, melanoma, and head & neck patients. Now patients across all tumour groups have access to ESC, with a gradual increase of clinics over the past five years. Positive patient feedback has driven the growth of the service, leading to increased engagement from consultant groups and support from the SRGs. In response to COVID, telephone based consultations and an ambulatory-based care model was developed in 2020, further supporting reduced hospital admissions.

Impact

Over 2500 outpatients have received ESC since its launch, with patients reporting improved quality of life, and a reduction in pain and symptoms. In 2019/2020 over 450 non-elective hospital admissions were avoided, with a reduction in length of stay by over 1110 bed days. This led to a total cost saving of £2.2M for the NHS in that one year alone. Chemo care was reduced by 31% for HPB patients receiving ESC, with no negative impact to survival. ESC has expanded to 22 centres in the UK.

The HSJ Awards 2nd September 2021 – Photographer Neil O'Connor

A multicentre study in 2021-22 led by CCC demonstrated for over 4500 patients seen, there was universal improvement of quality of life. This resulted in the prevention of 576 A&E attendances, and a reduction of 4578 bed days in length of stay, leading to cost savings totalling £8.4M.

Testimonials

"*Without Dr Monnery and his team, I'd still be on the sofa, in pain. They've also been a huge support to Julie, who has become my full time carer. If she needs to talk or some advice, Dr Monnery, Justine and the rest of the team are always there. The care I've receive right through Clatterbridge Cancer Centre has been absolutely amazing and I'm very grateful to them all*".

Brian McKenna – CCC Patient, read the full story here.

Next Steps

The ESC service plans to continue expansion and improve equity of service across the region, with multi-hub clinics planned – a clinic has already opened on the Wirral and Aintree currently in planning.

Our ESC team is also working with the UK Association for Supportive Care in CANCER (UKASCC) to develop a service specification for ESC to enable NHS England to commission these services across England.

The Biology of Dying

Summary

"How long have I got?" is a question oncologists and palliative medicine clinicians are commonly asked. It is often a difficult question to answer. Not only is it difficult to predict if people are in the last months of life, it is difficult to recognise when people are actively dying (in the last days).

Early recognition that a person may be dying underpins all the priorities for improving people's experience of care in the last days and hours of life. It enables an individual care plan to be developed, appropriate discussions with the patient and families to take place, treatment decisions to be made and the needs of the family to be considered.

No diagnostic test is currently available and we do not know how people die from cancer. Knowing when a person is dying is crucial to provide the best care possible.

The Challenge

There are no objective tests recognising when people are dying and no prognostic tools that predict within the last two weeks of life. The current prognostic standard to predict dying is the best guess by at least two members of the Multi-Disciplinary Team. Doctors' predictions are often inaccurate and overoptimistic. A recent survey of palliative medicine consultants in the North West reported significant difficulty in recognising the last two weeks (78%) and last days of life (47%). Validated prognostic tools have been developed, such as: PPI, PaP Score and PiPS. However, they are not objective, do not predict closer than 2 weeks and are not used in clinical practice.

Actions Taken

Our previous work in patients with lung cancer has enabled us to identify metabolites (chemicals) that change in the last weeks of a patient's life. This work has enabled us to identify pathways altered during the dying process. This data has allowed us to develop a model or 'test' predicting the last weeks and months of life. A patent application for this was submitted in March 2022. This is the only test predicting dying within the last two weeks of life.

Impact

There is currently no diagnostic test available for prediction of death in terminally ill cancer patients. WHO statistics for 2020 show 9.9 million people died worldwide from cancer, 1.8 million from lung cancer alone (35,100 in the UK in 2018). For a large percentage of these patients in first world health care systems, there would be multiple tests per patient over time to inform patient management. It is anticipated a potential

test would be available to all patients regardless of their setting (hospital, hospice, nursing home, home).

Next Steps

The model is now being developed into a commercially viable test that can be readily available to hospital laboratories. Funding is being sourced to enable this product to be brought to market.

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Board of Directors
Date of meeting: 25 January 2023

Report Lead	Paul Buckingham, Interim Associate Director of Corporate Governance			
Paper prepared by	Paul Buckingham, Interim Associate Director of Corporate Governance			
Report subject/title	Review of Trust Constitution			
Purpose of paper	To seek approval of proposed amendments to the Trust's Constitution following a review which was originally carried out in March 2022.			
Background papers	Not applicable			
Action required	The Board of Directors is recommended to: • Receive the report and note the proposed amendments to the Trust's Constitution, primarily resulting from an externally-facilitated review. • Approve amendments identified by the use of track changes as detailed in the Constitution document at Annex A to 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		

The Clatterbridge Cancer Centre NHS Foundation Trust

Review of Trust Constitution

1. Introduction

The purpose of this report is to seek approval of proposed amendments to the Trust's Constitution following a review which was originally carried out in March 2022.

2. Background

The outcomes of a review of the Trust's Constitution were originally reported to the Audit Committee on 1 April 2022. In considering the outcomes, the Committee requested a number of further amendments prior to reconsideration of the updated Constitution at the next scheduled Committee meeting in July 2022. However, the action was not progressed, due to the unplanned extended absence of a key post holder, and the planned review of the Constitution remained an outstanding action on the Audit Committee Action Log.

3. Current Situation

Clearly, there is a need for the Trust to have in place an up to date Constitution which has been approved by both the Board of Directors and the Council of Governors. The Interim Associate Director of Corporate Governance followed up the outstanding action and confirmed that the amendments requested by the Committee on 1 April 2022 had not been incorporated in a revised Constitution document. This was then addressed and the additional amendments have now been incorporated in the draft document included for reference at Annex A to this report.

It should be noted that the original review was comprehensive in nature with the aim of incorporating Standing Orders for the Board of Directors in the Constitution and generally updating content throughout the document. The review itself was supported by Hill Dickinson LLP to provide both an independent view and ensure that content reflected established best practice. The main outcomes of the original review are summarised as follows:

- Incorporation of Standing Orders for the Board of Directors at Annex 8
- Fundamental review of the Standing Orders of the Council of Governors at Annex 7 to incorporate relevant updates and ensure consistency with content of the Board Standing Orders where appropriate.
- Removal of Annex 3, which related to Appointed Governors, which is not required as there is no Appointed Governor constituency referenced in the legislation.
- Amendments to provisions regarding the management of conflicts of interest for both Directors and Governors to comply with regulations and ensure consistency with the Trust's Managing Conflicts of Interest Policy.
- General amendments throughout the document to ensure consistency with the Model Core Constitution and reflect best practice.

In addition to incorporating amendments originally requested by the Audit Committee, the Interim Associate Director of Corporate Governance has made further minor amendments, primarily to amend references from NHS Improvement to NHS England to reflect the current situation.

Board members are requested to note the content of Annex 2, which relates to the Staff Constituency. One of the Classes within the Staff Constituency had originally been titled 'Volunteers, Service Providers, Contracted Staff'. In terms of individuals who would fall within this Class, Volunteers are self-explanatory, but there was no further definition of what would comprise Service Providers or Contracted Staff. Enquiries with the Executive Team concluded that this was intended to include staff who are directly employed by the Trust's wholly-owned subsidiaries and a further amendment to Annex 2 is proposed to provide appropriate clarification.

4. Conclusion

It is clear from the volume of tracked changes in the draft document at Annex A that the Constitution was/is seriously in need of updating. Board members should note that there is a likelihood that further amendments may be required as a result of the recently published Code of Governance for NHS Provider Trusts, and it is anticipated that an updated Model Core Constitution will be published in due course. Trying to objectively conduct a further assessment of content is extremely difficult at present due to the volume of tracked changes in the document which make it very difficult to read.

It is recommended that the original review is completed, as detailed at Annex A, so that amendments can be actioned and any further reviews can be undertaken on the basis of a 'clean' document. The revised Constitution was reviewed by the Audit Committee at a meeting held on 12 January 2023 and the Committee recommended the proposed amendments to the Board of Directors and the Council of Governors for approval. Board members should note that amendments to the Constitution require approval by both the Board of Directors and the Council of Governors. The Council of Governors is scheduled to consider the proposed amendments at a Council meeting on 25 January 2023.

5. Recommendation

The Board of Directors is recommended to:

- Receive the report and note the proposed amendments to the Trust's Constitution, primarily resulting from an externally-facilitated review.
- Approve amendments identified by the use of track changes as detailed in the Constitution document at Annex A to the report.

The Clatterbridge Cancer

Centre NHS Foundation

Trust Constitution

CONSTITUTION OF

THE CLATTERBRIDGE CANCER CENTRE

NHS FOUNDATION TRUST

(A PUBLIC BENEFIT ORGANISATION)

Version 1~~2~~3
~~July 2021~~ January 2023

The Clatterbridge Cancer Centre NHS Foundation Trust Constitution

TABLE OF CONTENTS

1. Interpretation and Definitions

1.1 Unless the contrary intention appears or the context otherwise requires ~~otherwise stated~~, words or expressions contained in this constitution and its Annexes shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012. References to legislation include all amendments, replacements, or re-enactments made.

1.2 Headings are for ease of reference only and are not to affect interpretation. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.~~Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.~~

1.3 In this Constitution and its Annexes:

the 2006 Act	means the National Health Service Act 2006
the 2012 Act	means the Health and Social Care Act 2012
Accounting Officer	~~-~~means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act~~-~~
Appointed Governor	means those Governors appointed by the appointing organisations
Appointing Organisations	means those organisations named in this Constitution who are entitled to appoint Governors
Areas of the Trust	means the areas of the Public Constituencies in Annex 1
Authorisation	means an authorisation given by NHS England ~~Improvement (NHSI)~~ which incorporates Monitor, the statutory entity that remains the regulator of NHS foundation trusts
Board of Directors	means the Board of Directors as constituted in accordance with this Constitution and the 2006 Act
Chairman	means the Chair of the Trust ~~organisation~~ (the expression "the Chairman" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the relevant meeting or is otherwise unavailable)

~~**Company Secretary** means the Secretary of the Trust or any other person appointed to perform the duties of the Company Secretary including a joint, assistant of deputy Secretary or such other person as may be appointed by the Trust to perform the functions of the Company Secretary under this Constitution~~

Contracting and Procuring	means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets
Council of Governors	means the Council of Governors as constituted in accordance with this Constitution and ~~which shall have the same meaning as the Council of Governors in~~ the 2006 Act
Dispute Resolution Procedure	means the dispute resolution procedure as set out in Annex ~~8~~9 of this Constitution

External Auditor	means any external auditor other than the financial auditor appointed to review and report upon other aspects of the Trust's performance
Financial Auditor	means the person appointed to audit the accounts of the Trust, who is referred to as the auditor in the 2006 Act
Financial Year	means eachany period of 12 months beginning on 1 April
Lead Governor	means the Governor appointedelected by the Council of Governors in accordance with paragraph 22 of this Constitution as the main link between the Governors and the Chair of the Trust
Member	means a member of the Trust
Monitor	means the body corporate known as Monitor (as provided by Section 61 of the 2012 Act) and incorporated into NHSEngland), the statutory entity that remains the regulator of NHS foundation trusts
Nominations Committee	means a Committee of the Council of Governors established in accordance with Paragraph 276 of this Constitution
Public Governor	means a Governor elected by the members of one of the public constituencies
Registered Dentist	means a Registered Dentist within the meaning of the Dentists Act 1984
Registered Medical Practitioner	means a fully registered person within the meaning of the Medicalines Act 1983 who holds a licence to practice under that Act
Registered Nurse or Midwife	means a Nurse or Midwife registered in accordance with the Nursing and Midwifery Order 2001es, Midwives and Health Visitors Act 1997
Senior Independent Director Director	means thea Non-Executive Director appointed in accordance with paragraph 24.9 of this Constitution by the Board of Directors in consultation with the Governors, who supports the Chair and serves as an intermediary for other directors.
Significant Transaction	has the meaning as defined in Paragraph 465 of this Constitution
Staff Governor	means a Governor elected by the members of one of the classes of the staff constituency
the **Trust**	means tThe Clatterbridge Cancer Centre NHS Foundation Trust

7

Trust Secretary means the Secretary of the Trust or any other person appointed to perform the duties of the Secretary including a joint, assistant or deputy Secretary or such other person as may be appointed by the Trust to perform the functions of the Secretary under this Constitution

2. Name

The name of the foundation trust is The Clatterbridge Cancer Centre NHS Foundation Trust (the Trust).

3. Principal Purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England[1].

3.2 The trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. Membership and Constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 a public constituency; or

5.1.2 a staff constituency.

5.2 The Trust shall at all times strive to ensure that taken as a whole its actual membership is representative of those eligible for membership. To this end the Trust shall at all times have in place and pursue a Membership Strategy which shall be approved by the Council of Governors, and shall be reviewed by them from time to time, and at least every three years,

~~appointed constituency~~

Commented [ES1]: There is no provision for this constituency in statute – see comments on Annex 3.

6. Application for Membership

An individual who is eligible to become a member of the Trust may do so on application to the trust.

7. Public Constituency

7.1 An individual who lives in the areas specified in Annex 1 as the areas for a public constituency may become or continue as a member of the trust.

7.2 Those individuals who live in the areas specified for a public constituency are referred to collectively as a Public Constituency.

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8. Staff Constituency

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 They are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 They have been continuously employed by the trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into six descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. Automatic membership by default – staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency, shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

10

10. Restriction on Membership

10.1 An individual who is a member of a constituency, or of a class within a constituency, may not while ~~a~~ membership of that constituency or class continues, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 An individual must be at least 16 years old to become a member of the Trust.

10.4 A member shall cease to be a member if:

10.4.1 they resign by notice to the Trust~~Company~~ Secretary
10.4.2 they die
10.4.3 they are expelled from membership under this Constitution
they cease to be entitled under this Constitution to be a member of the P~~p~~ublic Constituency or any classes of the S~~s~~taff C~~c~~onstituenc~~y~~ies~~.~~

10.5 A member may be expelled by a resolution approved by not less than two-thirds of the Governors present and voting at a meeting of the Council of Governors.

10.6 Any complaint made about a member must be sent to the member no less than one calendar month before the meeting of the Council of Governors where the complaint will be considered with an invitation to attend to answer the complaint.

10.7 If the member complained of fails to respond and fails to attend the meeting without due cause, the meeting may proceed in their absence.

~~10.7~~10.8 At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them. The Council of Governors may either dismiss the complaint and take no further action, or for a period not exceeding twelve months suspend the rights of the member complained of to attend members meetings and vote under the Constitution, or arrange for a resolution to expel the member complained of to be considered at the next general meeting of the Council of Governors.

~~10.8~~10.9 A member expelled from membership will cease to be a member upon the declaration of the Chair of the meeting that the resolution to expel them was carried.

~~10.9~~10.10 No person who has been expelled from membership is to be re-admitted except by a resolution carried by two-thirds of the Council of Governors voting.

11. Annual Members' Meeting

11.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public and will be held within 9 months of the end of each financial year. All members meetings other than the Annual Members' Meeting are called special members meetings.

11.2 The Annual Members' M~~m~~eeting~~s~~ is~~are~~ open to all members of the Trust, Governors, Directors and representatives of the Trust Financial~~External~~ Auditors.

11.3 All Annual M~~m~~embers' M~~m~~eetings shall be convened by the Trust~~Company~~ Secretary.

11.4 At the Annual Members' M~~m~~eeting:

11.4.1 The Board of Directors shall present to the members:

11.4.1.1 the annual accounts
11.4.1.2 any report of the Trust's Financial~~External~~ Auditor
11.4.1.3 the annual report.

11.4.2 The Council of Governors shall present to the members:

11.4.2.1 a report on steps taken to secure that (taken as a whole) the actual membership of its public constituencies and of the classes of the S~~s~~taff C~~e~~onstituenc~~y~~ies~~s~~ is representative of those eligible for such membership
11.4.2.2 the progress of the membership strategy which it has approved and any changes to the membership strategy
11.4.2.3 any proposed changes to the composition of the Council of Governors and of Non-Executive Directors.

11.4.3 The results of the election and appointment of Governors and the appointment of any Non-Executive Directors will be announced.

11.5 Notice of the Annual~~a~~ ~~m~~Members' M~~m~~eeting is to be given:

11.5.1 by notice prominently displayed at the Trust Headquarters and at all of the Trust's places of business; and
11.5.2 by notice on the Trust website

a~~A~~t least 14 clear days before the date of the meeting. ~~-~~The notice must:

11.5.3 be given to the Council of Governors and the Board of Directors and to the Financial ~~External~~ Auditor;
11.5.4 state whether the meeting is an annual or a special members meeting;
11.5.5 give the time, date and place of the meeting; and
11.5.6 indicate the business to be dealt with at the meeting.

11.6 The Chairman of the Trust, or in their absence the Lead Governor, shall act as Chair at all members meetings of the Trust. If neither are present, the Governors present shall elect one of the Governors to Chair.

11.7 Before a members meeting can do business there must be a quorum present. A quorum is ten~~twenty~~ members present from any of the Trust's constituencies. If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

11.8 The Trust may make arrangements for members to vote by post or by using electronic communications.

11.9 It is the responsibility of the Council of Governors, the Chair of the meeting and the Trust Secretary to ensure that at any members meeting:

11.9.1 the issues to be decided are clearly explained,
11.9.2 sufficient information is provided to members to enable rational discussion to take place,
11.9.3 where appropriate, experts in relevant fields or representatives of special interest groups are invited to address the meeting.

11.10 A resolution put to the vote at a members meeting shall be decided upon by a poll.

11.11 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the Chair of the meeting is to have a second or casting vote.

11.12 The Trust shall ensure that minutes are maintained of members meetings. The result of any vote will be declared by the Chair and entered in the minutes of the meeting. The minutes will be conclusive evidence of the result of the vote.

12. Council of Governors – Composition

12.1 The Trust is to have a Council of Governors, which shall comprise both Elected and Appointed Governors.

12.2 The composition of the Council of Governors is specified in Annex 4.

12.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

12.4 The Council of Governors represents the interests of members of the Trust and appointed organisations, regularly feeding back information about the Trust, its vision and its performance to the constituency they represent.

12.5 The Council of Governors, subject to the 2006 Act, shall seek to ensure that through the composition of the Council of Governors the interests of the community served by the Trust are appropriately represented, and the level of representation of the public constituencies, the classes of the staff constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs, and to this end, the Council of Governors shall:

12.5.1 at all times maintain a policy for the composition of the Council of Governors which takes account of the membership strategy,

12.5.2 from time to time and not less than every three years review the policy for the composition of the Council of Governors, and

~~12.3.1~~12.5.3 when appropriate propose amendments to the Constitution.

13. Council of Governors – Election of Governors

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

13.2 The Model Election Rules as published from time to time by NHS Providers ~~the Department of Health~~, form part of this constitution. The Model Election Rules current at the date of the T~~t~~rust's Authorisation are attached at Annex 5.

13.3 A subsequent variation of the Model Election Rules by NHS Providers~~the Department of Health~~ shall not constitute a variation of the terms of this C~~c~~onstitution for the purposes of Paragraph 44 of the C~~c~~onstitution (amendment of the C~~c~~onstitution).

13.4 An election, if contested, shall be by secret ballot.

13.5 Governors must be at least 16 years of age at the closing date for nomination for their election or appointment.

~~13.5~~13.6 A member of a public constituency may not vote at an election for a Public Governor unless within twenty-one days before they vote they have made a declaration in the form specified by the Trust Secretary that they are qualified to vote as a member of the relevant public constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material

particular.

15

14. Council of Governors - Tenure

14.1 An elected governor may hold office for a period of up to 3 years commencing immediately after the Annual Members' Mmeeting at which their election is announced.

14.2 An elected governor shall cease to hold office if theyhe ceases to be a member of the constituency or class by which they were elected.

14.3 An elected governor shall be eligible for re-election at the end of theirhis term but shall serve for no more than and be allowed to serve a maximum of 9 years in total (3 consecutive terms if so elected).

14.4 If a vacancy arises on the Council of Governors for any other reason other than expiry of term of office, the following provisions will apply:

14.4.1 Where the vacancy arises amongst the Appointed Governors, the TrustCompany Secretary shall request that the Appointing Oorganisation appoints a replacement to hold office for the remainder of the term of office.

14.4.2 Where the vacancy arises amongst the elected Governors, the Trust Secretary Council of Governors shall, having consulted the Chairman, be at liberty to either:

14.4.2.1 call an election within three months to fill the seat for the remainder of the term;
14.4.2.2 invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election; or
14.4.2.3 to leave the seat vacant until the next elections are held for any unexpired period of the term of office.

14.5 An appointed governor may hold office for a period of up to 39 years.

14.6 An appointed governor shall cease to hold office if the Aappointing Oorganisation withdraws its sponsorship of hthemim.

14.7 An appointed governor shall be eligible for re-appointment at the end of theirhis term but shall serve for no more than three consecutive terms of office (9 years).

14.714.8 Appointed governors shall be appointed in accordance with a process agreed with the Trust Secretary.

15. Council of Governors – Disqualification and Removal

15.1 The following may not become or continue as a member of the Council of Governors:

15.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
15.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, theirhis creditors and has not been discharged in respect of it;
15.1.3 a person in relation to whom a moratorium period under a debt relief

16

order applies (under Part 7A of the Insolvency Act 1986);

15.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on themhim.

15.2 Further provisions as to the circumstances in which an individual may not become or continue as a member of the CouncilBoard of Governors are set out in Annex 6.

16. Council of Governors – Duties of Governors

16.1 The general duties of the Council of Governors are:

16.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

16.1.2 to represent the interests of the members of the Tt~~t~~rust as a whole and the interests of the public.

16.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

~~16.2~~16.3 Governors must comply with the Trust's Code of Conduct for Governors.

17. Council of Governors – Meetings of Governors

17.1 The Chairman of the Trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 26 below) or, in their~~his~~ absence the Deputy~~Vice~~ Chair (appointed in accordance with the provisions of paragraph 27 below), shall preside at meetings of the Council of Governors. If the Chair and Deputy~~Vice~~ Chair are absent, another Non-Executive Director shall preside as chosen by the Directors present.

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. The Chair may exclude any member of the public from a meeting of the Council of Governors if they are interfering or preventing the proper conduct of the meeting.

17.3 For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

~~17.3~~17.4 The Council of Governors may invite a representative of the Financial A~~a~~uditor or other advisors to attend a meeting of the Council of Governors.

18. Council of Governors – Standing Orders and Committees

18.1 The standing orders for the practice and procedure of the Council of Governors are attached at Annex 7.

18.2 The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees consisting of its members, Directors, and other persons to assist the Council of Governors in carrying out its functions. The Council of Governors may, through the Trust Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

19. Council of Governors – Support/Advice~~Referral to the Panel~~

19.1 ~~In this paragraph, the "Panel" means a panel of persons appointed by NHSI~~ Paragraph 39A of the 2006 Act provides Monitor with the ability to appoint a panel of persons to which a Governor of an NHS Foundation Trust may refer a question as to whether the Trust has failed or is failing:

19.1.1 to act in accordance with its constitution, or
19.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

~~19.2~~ As such a panel does not presently exist, the Trust must take steps to secure that the governors are able to access support and/or advice, as and where necessary, to enable them to fulfil the duties set out at paragraph 16 above. ~~A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.~~

20. Council of Governors - Conflicts of Interest of Governors

20.1 If a Governor has a pecuniary, professional, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors and to the Trust Secretary as soon as they~~he~~ become~~s~~ aware of it.

~~The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.~~

20.2 The Trust shall adopt a policy for the management of conflicts of interest, including the declaration of interests and declarations of gifts and hospitality. Governors shall comply with any such policy and with provisions in the standing orders for the Council of Governors which relate to the management of conflicts of interest.

21. Council of Governors – ~~Travel~~ Expenses

21.1 The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust. These are to be disclosed in the annual report.

~~21.1~~21.2 Governors are not to receive remuneration.

22. Lead Governor

22.1 The Council of Governors shall appoint one of the governors as the Lead Governor. Subject to the below, such governor shall fulfil the role of the Lead Governor for a period of 12 months.

~~Any Governor who, immediately after the Annual Members meeting, and having~~

19

Commented [ES2]: This paragraph now reflects and is consistent with the Council's standing orders and the Trust's conflicts policy.

Commented [ES3]: I would suggest this process is much easier to manage and gives more flexibility on the appointment.

~~[illegible]~~ The Council of Governors shall vote on the nomination of the Lead Governor.

22.2 The Council of Governors may reappoint a governor to the position of Lead Governor at the end of any 12 month period, if they wish to be so reappointed.

~~22.2~~22.3 If the Lead Governor notifies the Council of Governors, prior to the end of their term in office, that they no longer wish to be the Lead Governor then the Council of Governors shall appoint another governor as the Lead Governor.

~~22.3~~22.4 The Lead Governor's duties shall include:

~~22.3.1~~22.4.1 facilitating communication between Governors and members of the Board of Directors

~~22.3.2~~22.4.2 contributing to the appraisal of the Chairman in such manner and to such extent as the person conducting the appraisal may see fit

~~22.3.3~~22.4.3 initiating proceedings to remove a Governor where circumstances set out in this Constitution for removal have arisen.

22.4.4 ~~l~~liaising, as appropriate, with the Council of Governors for other NHS Foundation Trusts;

~~22.3.4~~22.4.5 liaising with NHS England~~Monitor~~ where it would be inappropriate for the Chairman to do so.

22.5 The Lead Governor shall lead the Council of Governors in the event that:

22.5.1 neither the Chairman or Deputy Chair is present at a meeting; or

22.5.2 both the Chairman and the Deputy Chair are disqualified from voting by virtue of a conflict of interest.

23. Council of Governors – Further Provisions

Further provisions with respect to the Council of Governors are set out in Annex 6.

24. Board of Directors – Composition

24.1 The Trust is to have a Board of Directors, which shall comprise both Eexecutive and Non-Executive Directors.

24.2 The Board of Directors is to comprise:

24.2.1 a Non-Executive Chairman
24.2.2 up to 6 other Non-Executive Directors; and and
24.2.3 up to 6 Executive Directors. .
A Director of Strategy (non-voting)

24.3 One of the Executive Directors shall be the Chief Executive.

24.4 The Chief Executive shall be the Accounting Officer.

24.5 One of the Executive Directors shall be the Finance Director

24.6 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

24.7 One of the Executive Directors is to be a registered nurse or a registered midwife.

24.8 The operation of the Board of Directors, shall be such that, at all times, at least half of the voting members of the Board of Directors, excluding the Chair, shall be Non-Executive Directors.

24.9 The Chairman shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors to be the Senior Independent Director. The Senior Independent Director shall make themselveshimself available to Directors and Governors who have concerns that they do not feel they can raise with the Chairman or any Executive Director of the Trust.

24.824.10 Officers of the Trust may be referred to from time to time as non-voting Directors. Such individuals are not a member of the Board of Directors, but may attend meetings of the Board of Directors and may participate in discussions at such meetings, with the agreement of the Chairman. For the avoidance of doubt, such individuals do not have any voting rights at any such meetings, unless they are acting up for an Executive Director at any such meeting and therefore have a vote in accordance with the Board of Directors standing orders.

25. Board of Directors – General Duty

The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

26. Board of Directors – Qualification for Appointment as a Non-Executive Director

A person may be appointed as a Non-Executive Director only if –

26.1 They are a member of a Public Constituency, and

26.2 They are not disqualified by virtue of Paragraph 30 below.

27. Board of Directors – Appointment and Removal of Chairman and other Non-Executive Directors

27.1 The Council of Governors will maintain a policy for the composition of the Non-Executive Directors which takes account of the membership strategy, and which they shall review from time to time and not less than every three years.

Commented [ES5]: Amended to reflect the content of the governance manual/standing orders which was inconsistent.

~~27.1~~27.2 The Council of Governors shall create a duly authorised Nominations Committee consisting of the Chair (or the Deputy~~Vice~~ Chair if the Committee is considering the appointment of the Chair, unless they are standing for appointment, in which case ~~it will be~~ the Senior Independent Director) and at least three Elected Governors.

~~27.2~~27.3 The Nominations Committee shall seek the views of the Board of Directors as to the skills and experience required for Non-Executive Directors ~~their recommended criteria and process for the selection of candidates~~ and, having regard to those views and the policy referred to above, shall then seek, shortlist and interview such candidates as the Nominations Committee considers appropriate and shall make recommendations to the Council of Governors as to the potential appointments of the Chairman and~~as~~ Non-Executive Directors and shall advise the Board of Directors of those recommendations.

~~27.3~~27.4 The Nominations Committee shall be at liberty to request the attendance of and seek advice and assistance from persons other than members of the Nominations Committee or other Governors in arriving at its said recommendations.

~~27.4~~27.5 The Nominations Committee shall provide advice to the Council of Governors on the levels of remuneration for the Chairman and the Non-Executive Directors.

~~27.5~~27.6 The Nominations Committee shall receive reports on behalf of the Council of Governors on the process and outcomes of appraisal for the Chairman and Non-Executive Directors.

~~27.6~~27.7 The Council of Governors at a general meeting of the Council of Governors shall resolve to appoint such candidate or candidates as they consider appropriate and shall have regard to the recommendation of the Nominations Committee and views of the Chief Executive and Board of Directors in reaching that decision.

27.8 Removal of the Chairman or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors ~~.~~ and shall be in accordance with the following procedures.

Commented [ES6]: Amended to reflect content of governance manual.

27.8.1 Any proposal for removal must be proposed by a Governor and seconded by not less than half of the Governors including at least one appointed Governor.

27.8.2 Written reasons for the proposal shall be provided to the Non-Executive Director in question, who shall be given the opportunity to respond to such reasons.

27.8.3 In making any decision to remove a Non-Executive Director, the Council of Governors shall take into account the annual appraisal carried out by the Chair.

~~Written reasons for the proposal to remove shall be provided to the Non-Executive Director in question, who shall be given the opportunity to respond to such reasons.~~

~~27.7~~27.9 If any proposal to remove a Non-Executive Director is not approved at a meeting of the Council of Governors, no further proposal can be put forward to remove such Non-Executive Director based upon the same reasons within 12 months of the meeting.

28. Board of Directors – Appointment of a DeputyVice Chair

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as DeputyVice Chair.

28.2 If the Chairman is unable to discharge their office as Chairman of the Trust, the Deputy Chair shall be acting Chair of the Trust until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in this Constitution and in standing orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair.

29. Board of Directors - Appointment and Removal of the Chief Executive and other Executive Directors

29.1 The Non-Executive Directors shall appoint or remove the Chief Executive. The appointment of the Chief Executive shall require the approval of the Council of Governors.

29.2 A cCommittee comprising the Chairman, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

30. Board of Directors – Disqualification

30.1 The following may not become or continue as a member of the Board of Directors:

30.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

30.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, theirhis creditors and has not been discharged in respect of it.

30.1.3 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986).

30.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on themhim.

30.1.5 a person who is a member of the Council of Governors of the Trust or a governor ~~or director~~ of another health service body.

30.1.6 a person who is the spouse, civil partner, partner, parent or child of a member of the Board of Directors of the Trust.

30.1.7 a person who is currently a member of an independent scrutiny body whose role includes or will include independent scrutiny of the Trust.

30.1.8 a person who is subject to a sex offender order.

30.1.9 a person who is the subject of a disqualification order made under the Company Directors Disqualification Act 1986.

30.1.10 in the case of a Non-Executive Director, a person who is no longer a

25

member of one of the public constituencies.

30.1.11 a person whose tenure of office as a Chair or as a member or director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non attendance at meetings, or for non-disclosure of a pecuniary interest.

30.1.12 a person who within the preceding two years has been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS body.

30.1.13 a person who is incapable by reason of a mental disorder, illness of injury, of managing and administering their property and affairs.

30.1.14 in the case of a Non-Executive Director, a person who has refused without reasonable cause to fulfil any training requirement established by the Board of Directors.

30.1.15 a person who has refused to sign and deliver to the Trust Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors.

~~30.1.4~~30.1.16 a person who has had their name removed or been suspended from any list (including any performers list maintained by NHS England) prepared under the 2006 Act or under any related subordinate legislation or who has otherwise been suspended or disqualified from any healthcare profession, and has not subsequently had their name included in such a list or had their suspension lifted or qualification reinstated.

~~30.1.5~~30.1.17 a medical practitioner who~~that~~ has been removed from the professional register by the General Medical Council or a nursing professional who has been removed from the professional register by the Nursing and Midwifery Council.

~~30.1.6~~30.1.18 In the opinion of a majority of the voting members of the Board,~~;~~ a person whose conduct has caused, or is likely to cause, material prejudice to the best interests of the Trust or the proper conduct of the Board of Directors or has otherwise acted in a manner inconsistent with continued membership of the Board of Directors.

30.2 Directors must meet the fit and proper person requirement set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and must comply with any policy established by the Trust to give effect to the fit and proper person requirement.

31. Board of Directors – Meetings

31.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a ~~Part 2~~ meeting for special reasons and having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

31.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

32. Board of Directors – Standing Orders

The standing orders for the practice and procedure of the Board of Directors are attached at Annex 8~~set out in the Trust Standing Orders incorporated into the Corporate Governance Manual~~.

33. Board of Directors - Conflicts of Interest of Directors

Commented [ES7]: This paragraph now reflects and is consistent with the statutory provisions (Schedule 7 of the NHS Act 2006), the Trust's conflicts policy and the standing orders for the Board.

33.1 The duties that a Director of the Trust has by virtue of being a Director include in particular:

33.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

33.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

33.2 The duty referred to in sub-paragraph 33.1.1 ~~and 33.1.2~~ is not infringed if:

33.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

33.2.2 The matter has been authorised in accordance with the Constitution.

33.3 The duty referred to in sub-paragraph 33.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

33.4 In sub-paragraph 33.1.2, "third party" means a person other than:

33.4.1 The Trust, or

33.4.2 A person acting on its behalf.

33.5 If a Director~~s~~ of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust or has any pecuniary, professional, personal, or family interest (whether that interest is actual or potential and whether that interest is direct or indirect) in any other matter that is under consideration or to be considered by the Director or the Board of Directors, they must declare the nature and extent of the interest to the Board of

Directors and Trust Secretary as soon as they become aware of it and in accordance with any policy adopted by the Trust for the declaration of interests and management of conflicts of interest. Any such interests must be appropriately recorded in the register of interests maintained in accordance with this constitution.

33.6 If a declaration under this paragraph proves to be, or becomes inaccurate or incomplete, a further declaration must be made.

33.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

33.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

33.9 A Director need not declare an interest –

33.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

33.9.2 If, or to the extent that, the Directors and Trust Secretary are already aware of it;

33.9.3 If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

33.9.3.1 By a meeting of the Board of Directors, or

33.9.3.2 By a committee of the Directors appointed for the purpose under this~~e~~ Constitution.

33.10 A matter shall have been authorised for the purposes of paragraph 33.2.2 if the interest has been declared by the Director in accordance with any policy adopted by the Trust for the declaration of interests and management of conflicts of interest, and approved by the Board of Directors at a meeting, and the minutes of the meeting shall be conclusive evidence of such approval having been given. Conflicts or potential conflicts arising from any such interests shall be managed in accordance with the relevant policy.

~~33.10~~33.11 The Trust shall adopt a policy for the management of conflicts of interest, including the declaration of interests and declarations of gifts and hospitality. Directors shall comply with any such policy. Conflicts of interest shall be managed in accordance with any such policy and the standing orders of the Board of Directors.

34. Board of Directors – Remuneration and Terms of Office

34.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other Non-Executive Directors.

34.2 The Chairman and the Non-Executive Directors shall be eligible for appointment for three consecutive~~,~~ ~~-~~three year terms of office, and in exceptional circumstances a further term of one year subject to a satisfactory appraisal. The Chairman or the Non-Executive Directors shall not be appointed to that office for a total period which exceeds ten years in aggregate.

34.3 The Trust shall establish a c~~C~~ommittee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

35. Registers

The Trust shall have:

35.1 a register of members showing, in respect of each member, the constituency to which they belong and, where there are classes within it, the class to which they belong;

35.2 a register of members of the Council of Governors;

35.3 a register of interests of governors;

35.4 a register of directors; and

35.5 a register of interests of the directors.

36. Admission to and Removal from the Registers

36.1 The Trust Secretary shall be responsible for establishing registers and for keeping these registers up-to-date.

~~The Company Secretary shall add to the confidential register of members the name of any member who is accepted under the provisions of this Constitution.~~

37. Registers – Inspection and Copies

37.1 The Trust shall make the registers specified in Paragraph 35 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed ~~by regulations~~.

37.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the

member so requests.

37.3 So far as the registers are required to be made available:

37.3.1 they are to be available for inspection free of charge at all reasonable times; and

37.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

37.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

30

38. Documents Available for Public Inspection

38.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

38.1.1 a copy of the current Constitution

38.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

38.1.3 a copy of the latest annual report.

38.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

38.2.1 a copy of any order made under Section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act.

38.2.2 a copy of any report laid under Section 65D (appointment of Trust special administrator) of the 2006 Act.

38.2.3 a copy of any information published under Section 65D (appointment of Trust special administrator) of the 2006 Act.

38.2.4 a copy of any draft report published under Section 65F (administrator's draft report) of the 2006 Act.

38.2.5 a copy of any statement provided under Section 65F (administrator's draft report) of the 2006 Act.

38.2.6 a copy of any notice published under Section 65F (administrator's draft report), 65G (consultation plan); 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision); 65KB (Secretary of State's response to Monitor's decision); 65KC (action following Secretary of State's rejection of the final report or, 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

38.2.7 a copy of any statement published or provided under Section 65G (consultation plan) of the 2006 Act.

38.2.8 a copy of any final report published under Section 65I (administrator's final report).

38.2.9 a copy of any statement published under Section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of the final report) of the 2006 Act.

38.2.10 a copy of any information published under Section 65M (replacement of Trust special administrator) of the 2006 Act.

38.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

38.4 If the person requesting a copy or extract is not a member of the Trust, the trust may impose a reasonable charge for doing so.

39. Auditor

39.1 The Trust shall have a Financialn Aauditor.

39.2 The Council of Governors shall appoint or remove the aFinancial Auuditor at a general meeting or extraordinary meeting of the Council of Governors.

39.3 The Financial Auditor is to carry out his duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by NHS England (NHSE) Improvement (NHSI) the organisation that incorporates Monitor, the statutory entity that remains the regulator of NHS Foundation Trusts.

40. Audit committee

The Trust shall establish a cCommittee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

41. Accounts

41.1 The Trust must keep proper accounts and proper records in relation to the accounts.

41.2 NHS ImprovementEnglandEngland may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

41.3 The accounts are to be audited by the Trust's Financial aAuditor.

41.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS Improvement, the organisation that incorporates Monitor may with the approval of the Secretary of State direct.

41.5 The functions of the Trust with respect to the preparation of the Annual Accounts shall be delegated to the Accounting Officer.

42. Annual Report, Forward Plans and Non-NHS Work

42.1 The Trust shall prepare an Annual Report and send it to NHS England~~Improvement~~.

42.2 The Trust shall give information as to its forward planning in respect of each financial year to NHS England~~Improvement~~, the organisation that incorporate~~s~~d Monitor, the statutory entity that remains the regulator of NHS Foundation Trusts. The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.

42.3 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

42.4 Each forward plan must include information about:

42.4.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

42.4.2 the income it expects to receive from doing so.

42.5 Where a forward plan contains a proposal that the T~~t~~rust carry on an activity of a kind mentioned in sub-paragraph 42.4.1 the Council of Governors must:

42.5.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the T~~t~~rust of its principal purpose or the performance of its other functions, and

42.5.2 notify the Directors of the Trust of its determination.

42.6 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the C~~c~~ouncil of G~~g~~overnors of the Trust voting approve its implementation.

43. Presentation of the Annual Accounts and Reports to the Governors and Members

43.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

43.1.1 the Annual Accounts

43.1.2 any report of the auditor on them

43.1.3 the Annual Report.

43.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

43.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1 with the Annual Members' Meeting.

44. Instruments

44.1 The Trust shall have a seal.

44.2 The seal shall not be affixed except under the authority of the Board of Directors.

45. Amendment of the constitution

45.1 The Trust may make amendments of its Constitution only if:

45.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments~~notices~~; and

45.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

45.2 Amendments made under Paragraph 45.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with S~~s~~chedule 7 of the 2006 Act.

45.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

45.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

45.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

45.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the T~~t~~rust must take such steps as are necessary as a result.

45.5 Amendments by the Trust of its Constitution are to be notified to NHS Improvement. For the avoidance of doubt, NHS Improvement's functions do not include a power or duty to determine whether or not the C~~c~~onstitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

46. Mergers etc. and Significant Transactions

46.1 The Trust may only apply for a merger, acquisition, separation or dissolution (in accordance with the provisions of the 2006 Act) with the approval of more than half of the members of the Council of Governors.

46.2 The Tt~~t~~rust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

46.3 "Significant transaction" means a transaction which is either an investment or a divestment whose value equates to 25% of either the Trust's Gross Assets, Income or Gross Capital (inclusive of the transaction), calculated with reference to the Trust's opening Balance Sheet for the Financial Year in which approval is being sought.

46.4 If more than half of the members of the Council of Governors voting at a meeting of the Council decline to approve a significant transaction or any part of it, the meeting must provide an agreed written Statement of Reasons for its rejection to the Board of Directors.

~~that equates to:~~

ANNEX 1 – THE PUBLIC CONSTITUENCIES

Name of the Public Constituency	Minimum Number of Members	Number of Governors
Liverpool	10	3
St Helens and Knowsley	10	2
Sefton	10	2
Cheshire West and Chester	10	2
Warrington and Halton	10	2
Wirral and the Rest of England	10	3
Wales	10	1
Total Public Governors		15

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~~Name of Areas within the Constituency~~	~~Number of Governors~~
~~Liverpool~~	~~3~~
~~St Helen's and Knowsley~~	~~2~~
~~Sefton~~	~~2~~
~~Cheshire West and Chester~~	~~2~~
~~Warrington and Halton~~	~~2~~
~~Wirral and the Rest of England~~	~~3~~
~~Wales~~	~~1~~
~~**Total**~~	~~**15**~~

Commented [ES8]: This should be the minimum number of members in each public constituency not the number of Governors which is set out in Annex 4. You may want to adopt the table headings above to reflect the legislation which clarifies the areas should be based on electoral wards.

36

ANNEX 2 – THE STAFF CONSTITUENCY

Staff Classes within the Staff Constituency	Minimum number of members	Number of governors
Doctor	10	1
Non-Clinical	10	1
Nurse	10	1
Other Clinical	10	1
Radiographer	10	1
Volunteers and Service Providers	10	1
Total Staff Governors		6

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~~Name of Constituency~~	~~Class of Staff Membership~~	~~Number of Governors~~
~~Staff~~	~~Doctor~~	~~1~~
	~~Non-Clinical~~	~~1~~
	~~Nurse~~	~~1~~
	~~Other Clinical~~	~~1~~
	~~Radiographer~~	~~1~~
	~~Volunteers, Service Providers, Contracted Staff~~	~~1~~
	~~**Total**~~	~~**6**~~

Commented [ES9]: This should be the minimum number of members in each class of the Constituency not the number of Governors which is set out in Annex 4. You may want to adopt the table headings above.

In the case of any query as to which class of the Staff Constituency a member of staff is eligible to be a member of, the Trust Secretary shall be responsible for determining which one of the classes of the Staff Constituency, shown in this Annex, the member of staff is eligible to be a member of. If any member of staff is eligible to be a member of more than one class of the Staff Constituency, they shall select one class to be a member of or, where they fail to do so (including where they fail to notify the Trust Secretary of their selection), the Trust Secretary shall determine the class that the member of staff shall be a member of and shall notify the member of that determination in writing.

For the avoidance of doubt, Service Providers referred to above relates to staff directly employed by the Trust's wholly owned subsidiaries i.e. Propcare and Clatterbridge Pharmacy Ltd.

~~47. ANNEX 3 – THE APPOINTED CONSTITUENCY~~

Commented [ES10]: This is not required as there is not an appointed constituency in legislation. The appointed governors are already set out in Annex 4.

~~NAME OF APPOINTED CONSTITUENCY~~	~~NUMBER OF APPOINTED GOVERNORS~~
~~Liverpool University~~	~~1~~
~~Macmillan Cancer Support~~	~~1~~
~~MCH Psychological Services~~	~~1~~
~~Liverpool University Hospital NHS Foundation Trust~~	~~1~~
~~Cancer Alliance~~	~~1~~
~~NHS England: Cheshire and Merseyside sub regional team~~	~~1~~
~~Liverpool Council~~	~~1~~
~~Wirral Council~~	~~1~~
~~Department of Health - Isle of Mann~~	~~1~~
~~**Total**~~	~~**9**~~

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

29~~30~~ Governors in Total - The aggregate number of Public Governors is to be more than half of the total number of members of the Council of Governors.

Commented [ES11]: You may need to tweak the numbers to reflect this as this is a statutory requirement.

Elected Governors

Public Constituency	Number of Governors
Liverpool	3
St Helen's and Knowsley	2
Sefton	2
Cheshire West and Chester	2
Warrington and Halton	2
Wirral and the Rest of England	3
Wales	1
Total	**15**

Appointed Governors

Appointing Organisation	Number of Governors
Liverpool University	1
Macmillan Cancer Support	1
~~MCH Psychological Services~~	~~1~~
Liverpool University Hospital NHS Foundation Trust	1
Cancer Alliance	1
NHS England: Cheshire and Merseyside sub regional team	1
Wirral Council	1
Liverpool Council	1
Isle of Man~~n~~ Department of Health	1
Total	**~~8~~9**

Staff Governors

Name of Constituency	Class of Staff Membership	Number of Governors
Staff	Doctor	1
	Non-Clinical	1
	Nurse	1
	Other Clinical	1
	Radiographer	1
	Volunteers, Service Providers, Contracted Staff	1
Total		**6**

39

ANNEX 5 –THE MODEL ELECTION RULES

MODEL ELECTION RULES 2014

PART 1: INTERPRETATION

PART 2: TIMETABLE FOR ELECTION

PART 3: RETURNING OFFICER

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

PART 5: CONTESTED ELECTIONS

Action to be taken before the poll

The poll

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

PART 10: ELECTION EXPENSES AND PUBLICITY

Expenses

Publicity

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

PART 12: MISCELLANEOUS

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for

return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) the paper does not include a declaration of eligibility as required by rule 12, or

(e) the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of

candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[2]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

[2] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as “disqualified” all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

63

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:
  (iii) ballot papers that have been returned; and
  (iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and
(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

65

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV49.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are

71

deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of

vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with “rejected in part”,

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

~~**Eligibility to be a Member of the Council of Governors**~~
~~2.~~1. Council of Governors – Further Provisions on Disqualification ~~and Removal~~:

Further to the provisions set out in Paragraph ~~-~~15 the following may not become or continue as a Governor of the Council of Governors ~~if they are~~:

~~2.1~~1.1 In the case of a Staff Governor, Public Governor or Appointed G~~g~~overnor, they~~he~~ cease~~s~~ to be a m~~M~~ember of the Constituency or the c~~C~~lass of a ~~Membership~~ Constituency by which they~~he~~ were~~as~~ elected, or the organisation which appointed them terminates their employment or contract for services or withdraws its sponsorship of them.~~or appointed.~~

~~2.2~~1.2 NHS England~~Improvement~~ (incorporating Monitor) has exercised its powers to remove that person as a Governor or has suspended them~~him~~ from office or has disqualified them~~him~~ from holding office as a Governor for a specified period.

~~2.3~~1.3 A person who has within the preceding five years been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS b~~B~~ody.

~~2.4~~1.4 A person whose tenure of office as the Chair, Non-Executive Director or as a Governor of an NHS body has previously been terminated on the grounds that their~~his~~ appointment is not in the interests of the NHS, for non-attendance at meetings or for non-disclosure of a pecuniary interest.

~~2.5~~1.5 A person who is a vexatious complainant of the Trust.

1.6 A person who has had their name removed or been suspended from any list (including any performers list maintained by NHS England) prepared under the 2006 Act or under any related subordinate legislation or who has otherwise been suspended or disqualified from any healthcare profession, and has not subsequently had his name included in such a list or had his suspension lifted or qualification reinstated;

~~person who has had his name removed from a relevant list of medical practitioners pursuant to Paragraph 10 of the National Health Service (Performers Lists) Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere), and has not subsequently had his name included in such a list.~~

~~2.6~~1.7 A person who is currently a member of an independent scrutiny body whose role includes or will include independent scrutiny of The Clatterbridge Cancer Centre NHS Foundation T~~t~~rust.

~~2.7~~1.8 A person who is under 16 years of age.

~~2.8~~1.9 A person who on the basis of disclosures obtained through an application to the Disclosure and Barring Scheme is not considered suitable by the Trust.

~~2.9~~1.10 A person who is a Director of the Trust or a director of any other NHS body (unless they are appointed by an Appointing Organisation which is an NHS body); or a person who is the spouse, partner, parent or child of a Director or the Chair of the Trust.

~~2.10~~1.11 A person who is incapable by reason of a mental disorder, illness of injury, of managing and administering their~~his~~ property and affairs.

2.111.12 A person who has failed to, and continues to refuse to make the required Declarations under this Constitution.

1.13 A person who makes a false declaration for any purpose under this Constitution or the 2006 Act.

1.14 A person who has refused without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake.

2.121.15 A person who has failed to sign and deliver to the Trust Secretary a statement in any form required by the Trust Secretary confirming acceptance of the code of conduct for Governors.

1.16 A person whose conduct has caused, or is likely to cause, material prejudice to the best interests of the Trust or the proper conduct of the Council of Governors or who has otherwise acted in a manner inconsistent with continued membership of the Council of Governors.

2.131.17 A person whose tenure of office as Governor has previously been terminated pursuant to this Constitution by the Council of Governors.

The Trust Secretary shall, at their entire discretion, determine whether an individual is eligible to become or continue as a Governor under the provisions of this Constitution.

3.2. Termination of Tenure

In addition to Paragraph 14 of this Constitution, the following will apply:

3.12.1 A Governor may resign from that office at any time during the term of that office by giving notice in writing to the TrustCompany Secretary.

3.22.2 If a Governor fails to attend 3 consecutive meetings of the Council of Governors theirhis tenure of office shall be terminated immediately unless, on application by that Governor to the Council of Governors, the Council of Governors resolves that:

3.2.12.2.1 the absence was due to reasonable cause; and

3.2.22.2.2 the Governor will be able to start attending meetings of the Council of Governors within such a specified period as the Council of Governors considers reasonable.

3.32.3 The Council of Governors may, at a Council of Governors meeting, by a rResolution approved by not less than 75% of the remaining Governors present terminate a Governor's tenure of office if for reasonable cause it considers that:

They are disqualified from becoming or continuing as a Member under this Constitution; or

3.3.12.3.1 prejudice the ability of the Trust to fulfil its principal purpose or other of its purposes under this Constitution or otherwise to discharge its duties and functions; or

3.3.22.3.2 harm the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provisions of goods and services; or

3.3.32.3.3 adversely affect public confidence in the goods or services provided by the

88

Commented [ES12]: I have added a declaration in paragraph 7.6 of the Council standing orders to reflect the declaration that was in the governance manual. There are no other declarations in the Constitution.

Trust; or

~~3.3.4~~2.3.4 otherwise bring the Trust into disrepute.

2.4 Upon a Governor resigning or, upon the Council of Governors resolving to terminate a Governor's tenure of office, or upon the Trust Secretary determining that a Governor is ineligible to continue as a Governor, that Governor shall cease to be a Governor and their~~his~~ name shall be forthwith removed from the Register of Governors notwithstanding any reference to the Dispute Resolution Procedure.

2.5 Any decision of the Trust Secretary or Council of Governors to terminate a Governor's tenure of office may be referred by that Governor to the Dispute Resolution Procedure (as set out in Annex 8) within 28 calendar days of the date upon which notice in writing of the ~~Council of Governor's~~ decision is given to the Governor.

~~2.6 A Governor whose tenure of office is terminated under this Paragraph 2 shall not be eligible for re-election.~~

Commented [ES14]: Dealt with in 1.17 above.

89

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

The following Standing Orders form part of the Constitution of The Clatterbridge Cancer Centre NHS Foundation Trust.

1. Interpretation

1.1. ~~The Chairman shall be the final authority on the interpretation of these Standing Orders.~~Save as permitted by law, the Chairman shall be the final authority on the interpretation of these Standing Orders (on which they should be advised, as necessary, by the Chief Executive or Trust Secretary). The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) shall be final.

1.2. Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

2. General~~The Trust~~

2.1. All business shall be conducted in the name of the Trust.

~~2.1.~~2.2. The purpose of these Standing Orders is to ensure that the highest standards of corporate governance and conduct are applied to all Council of Governors meetings. The Council of Governors shall at all times seek to comply with the ~~NHS Foundation Trust~~ Code of Governance for NHS Provider Trusts as may be in place from time to time, and in exercising their functions all Governors must comply with the Trust's Code of Conduct for Governors.

3. Meetings of the Council of Governors

3.1. **Admission of the public and press** – all meetings of the Council of Governors shall be open to members of the public and representatives of the press subject to the below.~~the public and representatives of the press shall be afforded facilities to attend all meetings of the Council of Governors but shall be required to withdraw upon the Council of Governors resolving as follows:~~

3.2. The Council of Governors may resolve to exclude members of the public or press from any meeting or part of a meeting on the grounds that:

3.2.1. publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

~~3.1.1.~~3.2.2. there are special reasons stated in the resolution and arising from the nature of the business of the proceedings.

~~*"That the representatives of the Press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity on which would be prejudicial to the public interest."*~~

~~3.2.~~3.3. The right of attendance referred to above carries no right to ask questions or otherwise participate in the meeting unless the Chairman (or other person presiding) allows it.

3.4. The Chairman (or other person presiding ~~under the provision of Standing Order 5[1~~) shall give such directions as they~~he~~ think~~s~~ fit in regards to the arrangements for meetings and accommodation of the public and representatives of the press to ensure that the business of the meeting shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted or for special reasons, the public and press will be required to withdraw upon the Council of Governors resolving as follows:

"*That in the interests of public order the meeting adjourn for (the period to be specified) to enable the completion of business without the presence of the public and press."*

~~3.3.~~3.5. Nothing in these Standing Orders shall require the Council of Governors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings or via social media as they take place without the prior agreement of the Council of Governors.

3.6. Where the public and press have been excluded from a meeting in accordance with standing order 3.2 above, then the matters dealt with following such exclusion shall be confidential to the Governors and Directors of the Trust. No Governor, Director, officer or employee of the Trust in attendance at such meeting shall reveal or disclose any information concerning such matters to any other person or disclose the contents of any papers presented to such meeting or minutes taken of such a meeting to any other person without the express permission of the Trust.

3.7. The Council of Governors may invite the Chief Executive, or any other director, or a representative of the Financial Auditor to attend any meeting of the Council of Governors to enable Governors to raise questions about the Trust's affairs. For the avoidance of doubt, any such attendee shall not have the right to vote at such a meeting.

3.8. The Chief Executive and/or any other member of the Board of Directors may attend and address any meeting of the Council of Governors but shall not have the right to vote at such meetings.

3.9. The Chairman and/or the Trust Secretary may introduce legal or other advisers to the Council of Governors to advise the Chairman and the Council of Governors on behalf of the Trust and such individuals may be invited to attend meetings.

~~Governors and officers or any employee of the Trust in attendance at meetings shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the meeting which may take place on such reports or papers.~~

~~3.4.~~3.10. **Calling meetings** – the Council of Governors is to meet at least four times in each financial year. Meetings of the Council of Governors shall be called by the Trust Secretary, or in the Trust Secretary's absence, by the Chairman.

~~3.5.~~3.11. Save in the case of emergencies or the need to conduct urgent business, the Trust~~Company~~ Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors to all Governors. The notice will be placed on the Trust website.

~~3.6.~~3.12. Extraordinary meetings may be called by the Trust Secretary or by the Chairman at short notice.

3.13. Meetings of the Council of Governors shall be called by the Trust Secretary on the written request of at least six governors (including at least two Elected Governors and two Appointed Governors) who shall specify the business to be carried out. The Trust Secretary shall call a meeting of the Council of Governors on at least fourteen but not more than twenty-eight days written notice to discuss the specified business. If the Trust Secretary fails to call such a meeting within fourteen days of receipt of the written notice, then the relevant Governors may call such a meeting on not less than fourteen days written notice to all Governors.

~~Meetings of the Council of Governors may be called by six Governors (including at least two Elected and two Appointed Governors) who give written notice to the Company Secretary specifying the business to be carried out. The Company Secretary shall send a written notice to all Governors as soon as practically possible following receipt of such a request.~~

3.14. The notice for each meeting of the Council of Governors shall:

3.14.1. specify the business proposed to be transacted at the meeting;

3.14.2. be signed by the Chairman or by an officer authorised by the Chair to sign on their behalf; and

3.14.3. be delivered in person to each Governor, sent by post to the usual place of residence of each such Governor or sent by electronic mail to the address provided by any Governor for such purposes.

3.15. Want of service of such a notice on any Governor shall not affect the validity of a meeting.

~~3.7.~~3.16. In the case of a meeting called by Governors in default of the Trust Secretary calling the meeting, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the notice. Failure to serve such a notice on more than three quarters of Governors will invalidate the meeting.

~~The Annual Members' Meeting of the Council of Governors will consider the Annual Accounts, any report of the Auditor on these Accounts and the Annual Report.~~

4. Agenda and Supporting Papers

4.1. The Council of Governors may determine that certain matters shall appear on every agenda. Subject to this, the Trust Secretary shall be responsible for producing the agenda for meetings in conjunction with the Chairman.

~~4.1.~~4.2. Save in the case of an emergency or the need to conduct urgent business, t~~T~~he a~~A~~genda will be provided to the Governors not less than ~~3~~5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda.

4.3. A Governor desiring a matter to be included on an agenda shall make their~~his~~ request in writing to the Chairman at least 10 ~~working~~ days before the meeting. Requests made less than 10 ~~working~~ days before a meeting may be included on the agenda at the discretion of the Chairman. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information.

~~4.2.~~4.4. No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions.

5. Chairman of the Meeting

5.1. The Chairman shall preside at meetings of the Council of Governors and shall be entitled to exercise a casting vote where the number of votes for and against a motion is equal.

5.2. If the Chairman is absent from a meeting of the Council of Governors, the DeputyVice Chair shall preside over that meeting and they shall exercise all the rights and obligations of the Chairman including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

5.3. If any matter for consideration at a meeting of the Council of Governors relates to the conduct or interests of the Chairman or of the Non-Executive Directors as a class, neither the Chairman nor any of the Non-Executive Directors shall preside over the period of the meeting during which the matter is under discussion. In these circumstances the period of the meeting shall be chaired by the Lead Governor, or in theirhis absence, by another Governor chosen by the Governors. This person shall exercise all the rights and obligations of the Chairman including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

6. Notice of, Amending or Withdrawing Motions and Notice to Rescind a Resolution

6.1. A Governor desiring to move or amend a motion or rescind a resolution shall send a written notice thereof at least 10 working days before the meeting to the Chairman, who shall insert in the agenda of the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This shalldoes not prevent a motion being moved during a meeting without notice on any business mentioned on the agenda.

6.1.6.2. Subject to the agreement of the Chair, a Governor may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Council of Governors at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

6.2.6.3. A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

6.3.6.4. Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governor who gives it and also the signature of ten other Governors. When any such motion has been disposed of by the Council of Governors, it cannot be proposed again to thet eh same effect within the next six calendar months unless the Chairman deems it to be appropriate.

6.4.6.5. The proposer of the motion shall have the right of reply at the close of any discussions on the motion or any proposed amendments.

6.5.6.6. When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

6.5.1.6.6.1. An amendment to the motion;
6.5.2.6.6.2. The adjournment of the discussion or the meeting;
6.5.3.6.6.3. That the meeting proceed to the next business;
6.5.4.6.6.4. The appointment of an ad hoc committee to deal with a specific item of

business
~~6.5.5.~~6.6.5. That the motion be now put.

6.6 Such a motion shall be disposed of before the motion which was originally under discussion or about to be discussed. No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

7. Voting

7.1. If, in the opinion of the Chairman, a vote should be required on a question at a meeting of the Council of Governors, the result shall be determined by a majority of the votes of the Governors present and voting on the question.

7.2. All questions put to the vote shall, at the discretion of the Chairman of the meeting be determined by oral expression or by a show of hands. ~~-~~A paper ballot may also be used if a majority of the Governors present so request. If a Governor so requests, their vote (other than by paper ballot) on any question shall be recorded by name.

7.3. In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

7.4. In the case of an equality of votes the person presiding at or chairing the meeting shall have a casting vote.

7.5. No resolution of the Council of Governors shall be passed if it is opposed by all of the Public Governors present.

7.6. An Elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Trust Secretary of the particulars of their qualification to vote as a member of the Trust and that they are not prevented from being a member of the Council of Governors. An Elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of Elected Governors.

~~7.3.~~7.7. All decisions taken in good faith at a meeting of the Council of Governors or of any committee where a quorum is present shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting, and even if there is any vacancy of its membership.

8. Minutes

8.1. Minutes of the proceedings of a meeting shall be drawn up and submitted for approval at the next meeting where they will be signed by the Chairman of that meeting.

8.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. ~~-~~Any amendment to the minutes shall be agreed and recorded in writing ~~at the next meeting~~.

8.3. Minutes of the meeting shall record the names of those present.

8.4. Minutes of the meetings shall be made available to the public except for those minutes relating to business conducted when members of the public or press are excluded under the terms of ~~Paragraph 3.3 of~~ these Standing Orders.

9. Quorum

9.1. No business shall be transacted at a meeting of the Council of Governors unless at least five Public Governors, one Staff Governor and one Appointed Governor are present at the meeting.

9.2. If a Governor has been disqualified from participating in the discussion on any matter and/or from voting on~~r~~ any resolution by reason of the declaration of a conflict of interest they~~he~~ shall no longer count towards the quorum. ~~-~~If a quorum is then not available for the discussion and/or passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

9.3. The Council of Governors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

10. Nominations Committee and other working groups

10.1. The Council of Governors shall create a duly authorised Nominations Committee in accordance with paragraph 27 of this Constitution.~~who shall seek the views of the Board of Directors as to their recommended criteria and process for the selection of candidates, and having regards to those views, shall then seek, shortlist and interview such candidates as the Nominations Committee considers appropriate and shall make recommendations to the Council of Governors as to potential appointments as Non-Executive Directors and shall advise the Board of Directors of those recommendations.~~

10.2. The Trust~~Company~~ Secretary shall attend the Nominations Committee and take minutes of any proceedings.

10.3. The Nominations Committee shall have such terms of reference as the Council of Governors may determine~~ and powers and be subject to such conditions (as to reporting back to the Council of Governors~~). Such terms of reference shall have effect as if incorporated into the Standing Orders.

10.4. The Council of Governors shall approve the ~~elected~~ Governor appointments to the Nominations Committee. ~~The Chairman of the Nominations Committee shall be the Trust Chairman.~~

10.5. The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint working groups and/or sub-groups consisting of members of the Council of Governors, directors, and/or other persons to assist it in carrying out its functions. The Council of Governors may, through the Trust Secretary, request that advisers assist it or any working group or sub-group it appoints in carrying out its duties. Each such working group or sub-group shall have such terms of reference and remit and be subject to such conditions (as to reporting back to the Council of Governors) as the Council of Governors shall decide. Such terms of reference shall have effect as if incorporated into these Standing Orders. The Council of Governors shall approve the membership of all working groups and sub-groups that it has formally constituted and shall appoint the chair of each such working group and sub-group.

10.6. Subject to Standing Order 10.7 below no Governor or member of any committee or sub-committee of the Council of Governors or attendee at a meeting of

the Council of Governors or any committee or sub-committee shall disclose details of any matter dealt with by, or brought before, the Council of Governors or a committee or sub-committee of the Council of Governors without the permission of the Council of Governors or the relevant committee or sub-committee (as applicable) until such matter has been concluded or in the case of a committee or sub-committee, until the committee or sub-committee has reported to the Council of Governors.

~~10.5.~~10.7. No Governor or attendee at any meeting of the Council of Governors or any committee or sub-committee of the Council of Governors shall disclose any matter dealt with by the Council of Governors or the committee or sub-committee (as applicable), notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee or sub-committee resolves that it is confidential.

11. Declarations of Interest and Register of Interests

11.1. If a Governor has a pecuniary, professional, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors and to the Trust Secretary as soon as they become aware of it, in accordance with the Trust's policy on managing conflicts of interest, and at any meetings at which the matter is to be discussed, and, unless the Chairman of any relevant meeting determines that the interest is not deemed to create a conflict of interest:

11.1.1. shall withdraw from the meeting and play no part in the relevant discussion or decision,
11.1.2. shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

11.2. In addition to the declaration of interests at meetings in accordance with standing order 11.1, interests required to be declared in accordance with the Trust's policy on managing conflicts of interest shall be declared to the Trust Secretary:

11.2.1. within 14 days of election or appointment; or
11.2.2. if arising later, as soon as the Governor becomes aware of the interest.

11.3. Interests shall be recorded in a register of interests maintained in accordance with the Trust's constitution.

11.4. Any conflicts of interest arising shall be managed in accordance with the Trust's policy for managing conflicts of interest, as may be in place from time to time.

11.5. Any Governor who fails to disclose any interest required to be disclosed under this~~e preceding~~ paragraph must permanently vacate their office if required to do so by a majority of the remaining Governors.

11.6. The exceptions which shall not be treated as interests requiring declaration are as follows:

11.6.1. an employment contract held by S~~s~~taff Governors;
11.6.2. an employment contract held with an Appointing Organisation by Governors appointed by that organisation.~~;~~

11.7. If Governors have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Trust Secretary.

11.8. Interests which ~~should be regarded as 'relevant and material' and which~~, for the avoidance of doubt, should be declared and included in the register, are:

a) Directorships, including Non-Executive directorships, held in private companies or PLCs.

b) Ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) A position of authority in a charity or voluntary organisation in the field of health and social care.

d) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.

e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.

f) Membership of clubs, societies or organisations whose purpose may include furthering the business or personal interests of their members by undeclared or informal means. Such organisations include Masonic lodges and religious societies whose membership consists of professional and business people.

g) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS.

12. Non-compliance with standing orders

12.1. If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All members of the Council of Governors have a duty to disclose any non-compliance with these Standing Orders to the Chairman and Trust Secretary as soon as possible.

13. Suspension of Standing Orders

13.1. Except where this would contravene any statutory provision or the rules relating to the quorum, any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Council of Governors are present and that at least two-thirds of those members present (including at least one Elected Governor and one Appointed Governor) signify their agreement to such suspension. The reason for the suspension shall be recorded in the Council's minutes.

13.2. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and members of the Council of Governors. No formal business may be transacted while Standing Orders are suspended. The Audit Committee shall review every decision to suspend Standing Orders.

14. Variation and Amendment of Standing Orders

14.1. These Standing Orders shall not be varied except in the following circumstances:

14.1.1. upon a notice of motion;
14.1.2. upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;
14.1.3. that two thirds of the Council of Governors are present at the meeting where the variation or amendment is being discussed; and
14.1.4. that at least half of the Trust's Public Governors vote in favour of the amendment,

providing that any variation or amendment does not contravene a statutory provision.

15. Compliance

15.1. Governors shall comply with standing financial instructions prepared by the Director of Finance and approved by the Board of Directors for the guidance of all staff employed by the Trust.

15.2. Governors shall act at all times in accordance with the Trust's schedule of reservation and delegation of powers.

15.3. Governors must conduct themselves at all times in accordance with the Trust's Code of Conduct for Governors.

~~Directorships, including Non-Executive Directorships held in private companies or PLCs.~~

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

The following Standing Orders form part of the Constitution of The Clatterbridge Cancer Centre NHS Foundation Trust.

1. Interpretation

1.1. Save as permitted by law, the Chairman shall be the final authority on the interpretation of these Standing Orders (on which they should be advised, as necessary, by the Chief Executive or Trust Secretary). The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) shall be final.

1.2. Statements of Directors~~Governors~~ made at meetings of the Board of Directors ~~Council of Governors~~ shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

2. General

2.1. All business shall be conducted in the name of the Trust.

2.2. The purpose of these Standing Orders is to ensure that the highest standards of corporate governance and conduct are applied to all Board of Directors meetings. The Board of Directors shall at all times seek to comply with the ~~NHS Foundation Trust~~ Code of Governance for NHS Provider Trusts as may be in place from time to time, and in exercising their functions all Directors must comply with the Trust's Code of Conduct for Directors.

3. Meetings of the Board

3.1. **Admission of the p~~P~~ublic and p~~P~~ress** – all meetings of the Board of Directors shall be open to members of the public and representatives of the press subject to the below.

3.2. The Board of Directors may resolve to exclude members of the public or press from any meeting or part of a meeting on the grounds that:

3.2.1. publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

3.2.2. there are special reasons stated in the resolution and arising from the nature of the business of the proceedings.

3.3. The right of attendance referred to above carries no right to ask questions or otherwise participate in the meeting unless the Chairman (or other person presiding) allows it.

3.4. The Chairman (or other person presiding ~~under the provision of Standing Order 5~~) shall give such directions as they think fit in regards to the arrangements for meetings and accommodation of the public and representatives of the press to ensure that the business of the meeting shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public and press will be required to withdraw upon the Board of Directors~~Council of Governors~~ resolving as follows:

"*That in the interests of public order the meeting adjourn for (the period to be specified) to enable the completion of business without the presence of the public and*

press."

3.5.

~~"*That in the interests of public order the meeting adjourn for (the period to be specified) to enable the completion of business without the presence of the public and press.*"~~

Nothing in these Standing Orders shall require the Board of Directors~~ Council of Governors~~ to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings or via social media as they take place without the prior agreement of the Board of Directors~~Council of Governors~~.

3.6. Where the public and press have been excluded from a meeting in accordance with standing order 3.2 above, then the matters dealt with following such exclusion shall be confidential to the Directors of the Trust. No Governor, Director, officer or employee of the Trust in attendance at such meeting shall reveal or disclose any information concerning such matters to any other person or disclose the contents of any papers presented to such meeting or minutes taken of such a meeting to any other person without the express permission of the Trust.

3.7. **Calling m~~M~~eetings** – ordinary meetings of the Board of Directors shall be held at regular intervals at such times and places as the Board may determine~~The Council of Governors is to meet at least four times in each financial year~~. Meetings of the Board of Directors shall be called by the Trust Secretary, or in the Trust Secretary's absence, by the Chairman.

3.8. Save in the case of emergencies or the need to conduct urgent business, the Trust Secretary shall give to all Directors at least fourteen ~~working~~ days written notice of the date and place of every meeting of the Board of Directors~~ Council of Governors to all Governors~~. The notice will be placed on the Trust website.

3.9. Extraordinary meetings may be called by the Trust Secretary or by the Chairman at short notice.

3.10. Meetings of the Board of Directors shall be called by the Trust Secretary on the written request of at least four Directors who shall specify the business to be carried out. The Trust Secretary shall call a meeting of the Board of Directors on at least fourteen but not more than twenty-eight days written notice to discuss the specified business. If the Trust Secretary fails to call such a meeting within fourteen days of receipt of the written notice, then the relevant Directors may call such a meeting on not less than fourteen days written notice to all Directors.

3.11. The notice for each meeting of the Board of Directors shall:

3.11.1. specify the business proposed to be transacted at the meeting;

3.11.2. be signed by the Chairman or by an officer authorised by the Chair to sign on their behalf; and

3.11.3. be delivered in person to each Director, sent by post to the usual place of residence of each such Director or sent by electronic mail to the address provided by any Director for such purposes.

3.12. Want of service of such a notice on any Director shall not affect the validity of a meeting.

3.13. In the case of a meeting called by Directors in default of the Trust Secretary calling the meeting, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice. Failure to

serve such a notice on more than three quarters of Directors will invalidate the meeting.

4. Agenda and Supporting Papers

4.1. The Board of Directors may determine that certain matters shall appear on every agenda. Subject to this, the Trust Secretary shall be responsible for producing the agenda for meetings in conjunction with the Chairman.

4.2. Save in the case of an emergency or the need to conduct urgent business, the agenda will be provided to the Directors~~Governors~~ not less than ~~3~~5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda.

4.3. A Director~~Governor~~ desiring a matter to be included on an agenda shall make their request in writing to the Chairman at least 10 ~~working~~ days before the meeting. Requests made less than 10 ~~working~~ days before a meeting may be included on the agenda at the discretion of the Chairman. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information.

4.4. Where a petition has been received by the Trust the Chair shall include the petition as an item for the agenda of the next meeting.

4.5. No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions.

5. Chairman of the Meeting

5.1. The Chairman shall preside at meetings of the Board of Directors e~~Council of Governors~~ and shall be entitled to exercise a casting vote where the number of votes for and against a motion is equal.

5.2. If the Chairman is absent from a meeting ~~of the Council of Governors~~, the Deputy Chair shall preside over that meeting and they shall exercise all the rights and obligations of the Chairman including the right to exercise a second or casting vote where the number of votes for and against a motion is equal. If the Chair and Deputy Chair are absent, such member (Non-Executive Director) as the members present shall choose shall preside.

~~If any matter for consideration at a meeting of the Council of Governors relates to the conduct or interests of the Chairman or of the Non-Executive Director as a class, neither the Chairman nor any of the Non-Executive Directors shall preside over the period of the meeting during which the matter is under discussion. In these circumstances the period of the meeting shall be chaired by the Lead Governor, or in their absence, by another Governor chosen by the Governors. This person shall exercise all the rights and obligations of the Chairman including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.~~

6. Notice of, Amending or Withdrawing Motions and Notice to Rescind a Resolution

6.1. A Director~~Governor~~ desiring to move or amend a motion or rescind a resolution shall send a written notice thereof at least 10 ~~working~~ days before the meeting to the Chairman, who shall insert in the agenda of the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This shall~~does~~ not prevent a motion being moved during a meeting without notice on any business mentioned on the agenda.

6.2. Subject to the agreement of the Chair, a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

6.3. A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

6.4. Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director ~~Governor~~ who gives it and also the signature of four ~~ten~~ other Directors~~Governors~~. When any such motion has been disposed of by the Board of Directors~~Council of Governors~~, it cannot be proposed again to the same effect within the next six calendar months unless the Chairman deems it to be appropriate.

6.5. The proposer of the motion shall have the right of reply at the close of any discussions on the motion or any proposed amendments.

6.6. When a motion is under discussion or immediately prior to discussion it shall be open to a Director~~Governor~~ to move:

6.6.1. An amendment to the motion;
6.6.2. The adjournment of the discussion or the meeting;
6.6.3. That the meeting proceed to the next business;
6.6.4. The appointment of an ad hoc committee to deal with a specific item of business
6.6.5. That the motion be now put.

6.6 ~~Such a motion shall be disposed of before the motion which was originally under discussion or about to be discussed.~~ No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

7. Voting

7.1. Subject to the following provisions of this paragraph, questions arising at a meeting of the Board of Directors shall be decided by a majority of votes.

7.2. In case of an equality of votes, the Chairman shall have a second and casting vote.

7.3. No resolution of the Board of Directors shall be passed if it is opposed by all of the Non-Executive Directors present or by all of the Executive Directors present.

7.4. All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

7.5. If at least one third of the Board members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

7.6. A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.

7.7. A manager attending the Board of Directors meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

~~If, in the opinion of the Chairman, a vote should be required on a question at a meeting of the Council of Governors, the result shall be determined by a majority of the votes of the Governors present and voting on the question.~~

~~All questions put to the vote shall, at the discretion of the Chairman of the meeting be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.~~

7.8. Save for in the circumstances above, ~~I~~in no circumstances may an absent Director~~Governor~~ vote by proxy. Absence is defined as being absent at the time of the vote.

~~In the case of an equality of votes the person presiding at or chairing the meeting shall have a casting vote.~~

~~No resolution of the Council of Governors shall be passed if it is opposed by all of the Public Governors present.~~

~~An elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Trust Secretary of the particulars of their qualification to vote as a member of the Foundation Trust and that they are not prevented from being a member of the Council of Governors. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of elected Governors.~~

7.9. All decisions taken in good faith at a meeting of the Board of Directors ~~Council of Governors~~ or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Directors~~Governors~~ attending the meeting, and even if there is any vacancy of its membership.

8. Minutes

8.1. Minutes of the proceedings of a meeting shall be drawn up and submitted for approval at the next meeting where they will be signed by the Chairman of that meeting.

8.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. ~~–~~Any amendment to the minutes shall be agreed and recorded in writing.

8.3. Minutes of the meeting shall record the names of those present.

8.4. Minutes of the meetings shall be made available to the public except for those minutes relating to business conducted when members of the public or press are excluded under the terms of ~~Paragraph 3 of~~ these Standing Orders.

9. Quorum

9.1. No business shall be transacted at a meeting of the Board of Directors ~~Council of Governors~~ unless at least ~~five Public Governors, one Staff Governor and one Appointed Governor are present at the meeting.~~six Directors including not less than three Executive Directors (one of whom must be the Chief Executive or another Executive Director nominated by the Chief Executive), and not less than three Non-Executive Directors (one of whom must be the Chair or the Deputy Chair) are present.

9.2. An officer in attendance for an Executive Director (Officer Member) but without formal acting up status may not count towards the quorum.

9.3. If the Chair or another Director ~~a Governor~~ has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

9.4. The Board of Directors ~~Council of Governors~~ may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

10. Board~~Nominations~~ Committees and Delegation

10.1. The Board of Directors may delegate any of its powers to a committee of Directors or to an Executive Director.

10.2. The powers which the Board has retained to itself within these Standing Orders may, in emergency, be exercised by the Chief Executive and the Chairman, after having consulted with at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the board in public session for ratification.

Committees

10.3. The Board shall determine the membership and terms of reference for all committees established by the Board of Directors. The Board shall approve the appointments to each of the committees which it has formally constituted.

10.4. The Board of Directors shall appoint an audit committee of Non-Executive Directors to perform monitoring, reviewing and other functions as appropriate.

10.5. The Board of Directors shall appoint a remuneration committee of the Chair and other Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Executive Directors.

10.6. In addition to the statutory requirements, the Board of Directors may establish other committees as required for the conduct of their business. Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.

10.7. These Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to Board meetings and any meetings of committees established by the Board, in which case the term “Chair” is to be read as a reference to the Chair of the meeting or committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits.

10.8. Subject to Standing Order 10.9 below no Director or member of any committee or sub-committee of the Board of Directors or attendee at a meeting of the Board of Directors or any committee or sub-committee shall disclose details of any matter

dealt with by, or brought before, the Board of Directors or a committee or sub-committee of the Board without the permission of the Board or the relevant committee or sub-committee (as applicable) until such matter has been concluded or in the case of a committee or sub-committee, until the committee or sub-committee has reported to the Board.

10.9. No Director or attendee at any meeting of the Board of Directors or any committee or sub-committee of the Board shall disclose any matter dealt with by the Board of Directors or the committee or sub-committee (as applicable), notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee or sub-committee resolves that it is confidential.

Delegation of Powers to Officers

10.10. The Board of Directors has powers to delegate and make arrangements for delegation.

10.11. Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust.

10.12. The Board of Directors shall prepare a Schedule of Matters Reserved to the Board and a Scheme of Delegation. The Chief Executive may periodically propose amendment to these documents, which shall be considered and approved by the Board of Directors.

10.13. Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director to provide information and advise the Board in accordance with statutory, NHS Improvement or Department of Health requirements. Outside these statutory requirements the roles of the Finance Director shall be accountable to the Chief Executive for operational matters.

10.14. The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

~~Council of Governors shall create a duly authorised Nominations Committee in accordance with paragraph 27 of this Constitution.~~

~~Confidentiality – A member of the Nominations Committee shall not disclose a matter dealt with, or brought before the Nominations Committee, to the Council of Governors without the Committee's permission until the Nominations Committee has reported to the Council of Governors or shall otherwise have concluded the matter.~~

11. Declarations of Interest and Register of Interests

11.1. If a Director has a pecuniary, professional, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Board of Directors, the Director shall disclose that interest to the members of the Board of Directors and to the Trust Secretary as soon as they become aware of it, in accordance with the Trust's policy on managing conflicts of interest, and at any meetings at which the matter is to be discussed, and, unless the Chairman of any relevant meeting determines that the interest is not deemed to create a conflict of interest:

11.1.1. shall withdraw from the meeting and play no part in the relevant discussion or

decision,

11.1.2. shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

11.2. In addition to the declaration of interests at meetings in accordance with standing order 11.1, interests required to be declared in accordance with the Trust's policy on managing conflicts of interest shall be declared to the Trust Secretary:

11.2.1. within 14 days of appointment as a Director; or
11.2.2. if arising later, as soon as the Director becomes aware of the interest.

11.3. Interests shall be recorded in a register of interests maintained in accordance with the Trust's constitution.

11.4. Any conflicts of interest arising shall be managed in accordance with the Trust's policy for managing conflicts of interest, as may be in place from time to time.

11.5. The exception which shall not be treated as an interest requiring declaration is an employment contract or contract of appointment with the Trust held by a Director.

11.6. If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Trust Secretary.

11.7. Interests which, for the avoidance of doubt, should be declared and included in the register are:

- Directorships, including Non-Executive directorships, held in private companies or PLCs.
- Ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or voluntary organisation in the field of health and social care.
- Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
- Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.
- Membership of clubs, societies or organisations whose purpose may include furthering the business or personal interests of their members by undeclared or informal means. Such organisations include Masonic lodges and religious societies whose membership consists of professional and business people.
- Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS.

12. Non-compliance with standing orders

12.1. If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive

as soon as possible.

13. Suspension of Standing Orders

13.1. Except where this would contravene any statutory provision or the rules relating to the quorum, any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board of Directors are present and that at least two-thirds of those members present (including at least one member who is an Executive Director of the Trust and one member who is not) signify their agreement to such suspension. The reason for the suspension shall be recorded in the Board's minutes.

13.2. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and members of the Board of Directors. No formal business may be transacted while Standing Orders are suspended. The Audit Committee shall review every decision to suspend Standing Orders.

14. Variation and Amendment of Standing Orders

14.1. These Standing Orders shall not be varied except in the following circumstances:

14.1.1. upon a notice of motion;

14.1.2. upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;

14.1.3. that two thirds of the Board of Directors are present at the meeting where the variation or amendment is being discussed; and

14.1.4. that at least half of the Trust's Non-Executive Board members vote in favour of the amendment,

providing that any variation or amendment does not contravene a statutory provision.

15. Compliance

15.1. Directors shall comply with standing financial instructions prepared by the Director of Finance and approved by the Board of Directors for the guidance of all staff employed by the Trust.

15.2. Directors shall act at all times in accordance with the Trust's schedule of reservation and delegation of powers.

15.3. Directors must conduct themselves at all times in accordance with the Trust's Code of Conduct for Directors.

~~Any Governor who has a relevant and material interest in a matter shall declare such interest to the Council of Governors and:~~

ANNEX 9~~8~~ – DISPUTE RESOLUTION PROCEDURE

1. In the event of a dispute with:

a) A member or prospective mMember in relation to eligibility or disqualification; or

b) A governor or prospective governor in relation to matters of eligibility, disqualification or termination of tenure;

tThe individual concerned shall be invited to an informal meeting with the TrustCompany Secretary or with one or more of the Directors. If not resolved, the dispute shall be referred to a panel comprising the Chairman, at least one Elected Governor, and ewither the TrustCompany Secretary or one of the Directors. The decision of the panel shall be final.

2. A dispute arising between the Council of Governors and the Board of Directors shall be referred to a panel comprising the Chairman, the Chief Executive and two Ggovernors who have been nominated by the Council of Governors. The panel shall use all reasonable endeavours to facilitate the resolution of the dispute.

3. In the event resolution is not reached under Paragraph 2 above, the panel shall consult the Council of Governors and the Board of Directors to determine whether the matter should be referred to mediation. In the event the decision is to refer to mediation, an external mediator shall be appointed by the Centre for Dispute Resolution or such other organisation as the panel shall agree.

Cheshire & Merseyside Cancer Alliance

Performance Report

January 2023

Version 1

Contents

Section I: Summary

Restoration of cancer services

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

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

Measure	% of pre-Covid level
2WW referrals*	90%
Cancer treatment activity*	86%
SACT (inc chemo) delivery**	135%

Measure	% of pre-Covid level
Radiotherapy planning**	141%
Radiotherapy treatment**	94%
Endoscopy activity♀	120%

- Referrals and cancer treatment activity dropped below 100% but this was expected due to the Christmas and New Year bank holidays, and therefore still rated green.
- The sustained increase in SACT continues to present challenges to service delivery, however CCC continues to take action to meet demand, including detailed capacity, demand and workforce planning.
- Whilst Radiotherapy treatments reduced significantly in early 2020/2021 due to a change in fractionation, despite the continuation of this change, activity increased and has been between 88% and 99% (except for 1 month at 78%) of pre covid-19 levels since April 2022.

Cheshire & Merseyside Cancer Alliance

*Data as of 8th January – Cancer treatment activity taken from national PTL from August 2022 onwards – prior to this surgical activity was reported by Trusts
** Solid tumour only (not inc. Haemato-oncology): reliable Haemato-oncology figures pre covid are unavailable – data as of December 2022
♀Assessment based on monthly DM01 endoscopy returns - latest update November 2022. Activity is used as an indication of capacity.

Section I: Summary

- Endoscopy activity increased to 7,951 procedures (from 7,112 procedures in October). This the highest number of procedures in a month in the last four financial years. It is more procedures than November 2019 (7,090 procedures) and changes to casemix (more colonoscopies and fewer flexi sigmoidoscopies) mean it represents more clinical activity (120% vs November 2019). In particular, 15% more colonoscopies have been performed in April-November 2022 than in April-November 2019.

- Endoscopy waiting list increased to 13,243 procedures (from 13,100 procedures in October). This increase was primarily at Mid Cheshire (165 additional patients on waiting list) and St Helens and Knowsley (175 additional patients on waiting list). For other trusts, the endoscopy waiting list remained steady. We know there may still be one trust who are yet to add their overdue surveillance patients to the DM01 waiting list (St Helens and Knowsley).

- Trusts are being encouraged to increase patients booked on existing lists, as productivity analysis suggests achieving 120% of pre-pandemic activity (as required by the 2022-23 planning guidance) may be achievable if this is implemented. The Alliance has an established endoscopy network and an endoscopy operational recovery team (EORT) to oversee and co-ordinate restoration activities.

Cheshire & Merseyside Cancer Alliance

Summary

Cancer waiting times performance*

The latest published 14 day, 28 day, 62 day and 31 day 1st treatment cancer waiting times performance data relate to **November 2022**.

The Alliance failed the **14 day standard** for urgent suspected cancer referrals, achieving 77.3%. This is higher than 74.5% the previous month.
The England average was 78.8%.
Nine trusts and all nine historic CCGs failed to meet the 14 day standard of 93%.
Cheshire and Merseyside was the 15th best performing Alliance in England out of 21 against this standard.

The Alliance failed the **28 day standard** for all referral routes achieving 66.0%. This is higher than 65.8% the previous month.
The England average was 69.7%.
Ten trusts and all nine historic CCGs failed to meet the 28 day standard of 75%.
Cheshire and Merseyside was the 17th best performing Alliance in England out of 21 against this standard.
This new standard came into force from October 2021.

The Alliance failed the **62 day standard**, achieving 69.1%. This is lower than 70.3% the previous month.
The England average was 61.0%.
Nine trusts and eight historic CCGs failed to meet the 62 day standard of 85%.
Cheshire and Merseyside was the 4th best performing Alliance in England out of 21 against this standard.

The number of urgent referral patients waiting **over 62 days** is significantly higher than pre-Covid levels. On 8th January 2022 there were 2,352 patients waiting more than 62 days for a diagnosis or treatment. This has increased from 1,897 reported last month (12th December). Of these, 608 have waited **over 104 days**. This is higher than the 532 patients reported last month.

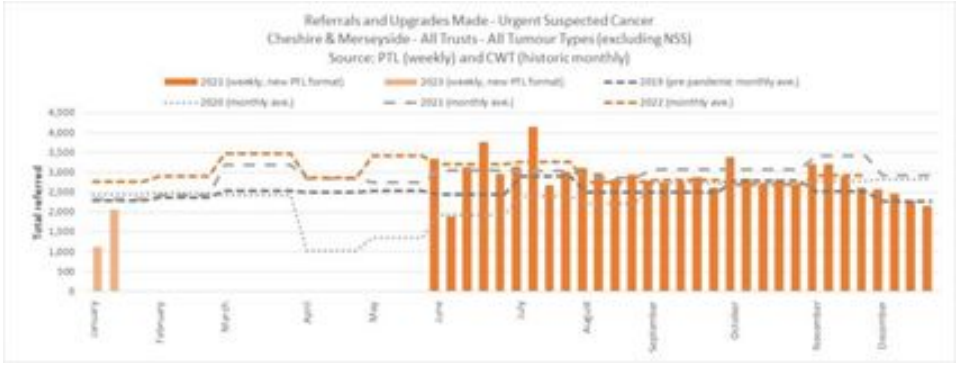
The Alliance failed the **31 day 1st treatment standard**, achieving 94.3%. This is lower than 94.6% the previous month.
The England average was 91.6%.
Five trusts and four historic CCGs failed to meet the 31 day 1st treatment standard of 96%.
Cheshire and Merseyside was the 7th best performing Alliance in England out of 21 against this standard.

Cheshire & Merseyside Cancer Alliance

* Overall figures are based on commissioners within Cheshire and Merseyside.
CCGs refer to the historic 2022 Clinical Commissioning Groups prior to the implementation of the Integrated Care Board (ICB)

Section II: Restoration of Cancer Services – Core Metrics

1. Urgent cancer referrals and upgrades made in last 7 days



Referrals were higher than previous week at 2,054 patients (BH week). 26% lower than previous year; 10% lower than pre-pandemic.

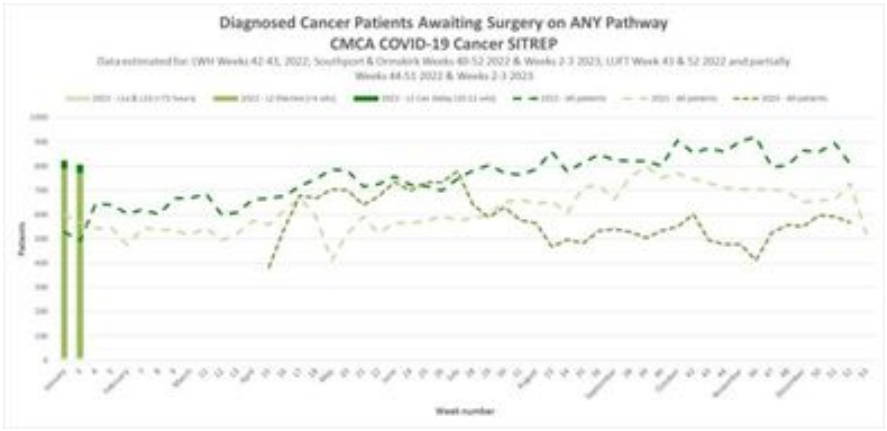
Data note: In Aug 2022, data source changed from weekly SITREP to national PTL. This metric covers all trusts. Missing data from Wirral week ending 24/07/22.

2. Urgent suspected cancer pathway PTL

Currently 13,213 patients on urgent suspected cancer waiting lists (12% above same time last year).

Data note: In Aug 2022, data source changed from weekly SITREP to national PTL. This metric covers all trusts. Missing data from Wirral week ending 24/07/22.

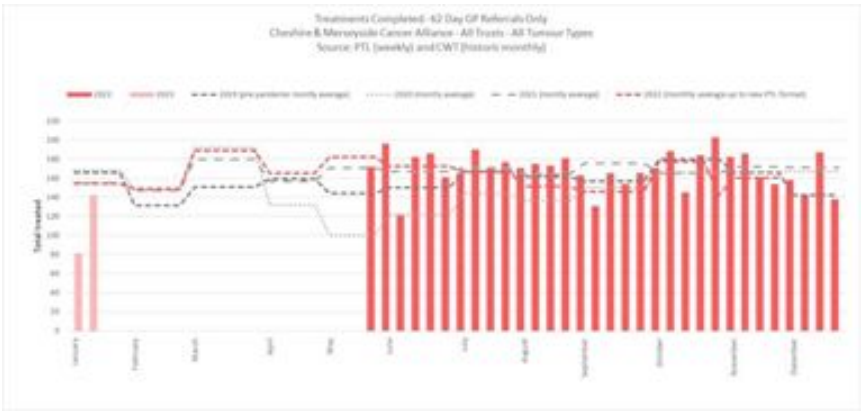
3. Cancer patients awaiting surgery



807 patients with a surgical DTT. 773 at L1&L2 and 34 at L3.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. Countess of Chester data estimated for 09/08/21. Missing data from LUHFT for 26/12/21, 02/01/22 and 09/01/22, 10/10/22. Liverpool Women's estimated for 13/09/21, 20/09/21, 07/02/22, 14/02/22, 23/05/22 & 18/07/22, 10/10/22, 17/10/22. Bridgewater estimated for 29/08/22. Southport and Ormskirk estimated for 26/09/22- 06/01/23. LUFT fully or partially estimated for 26/09/22 to 08/01/23.

4. Cancer treatments for urgent GP referrals in last 7 days



142 first treatments for patients with urgent GP referrals on 62 day pathway (BH week, 8% below last year; 14% below pre-pandemic).

Data note: In Aug 2022, data source changed from weekly SITREP to national PTL. This metric covers all trusts but ONLY 62 day GP referrals (not all 62 day referrals or all first treatments). Missing data from Wirral week ending 24/07/22.

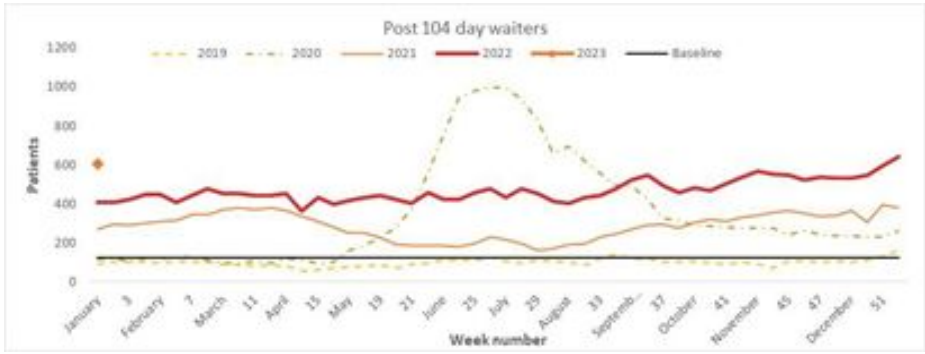
Section II: Restoration of Cancer Services – Core Metrics

5. Patients waiting over 62 days

2,352 patients have waited over 62 days
- Lower than 2,467 patients last week

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. Also, waiters with non-specific symptoms are not included in these national data. No data for Wirral 04/04/2021; Countess of Chester 01/08/2021, 08/08/2021. No data for Warrington & Halton and Wirral 19/12/21, 17/07/22 (later data copied from previous week). Incorrect data submitted by Countess of Chester 10/04/22. No data for Mid Cheshire 25/07/2021.

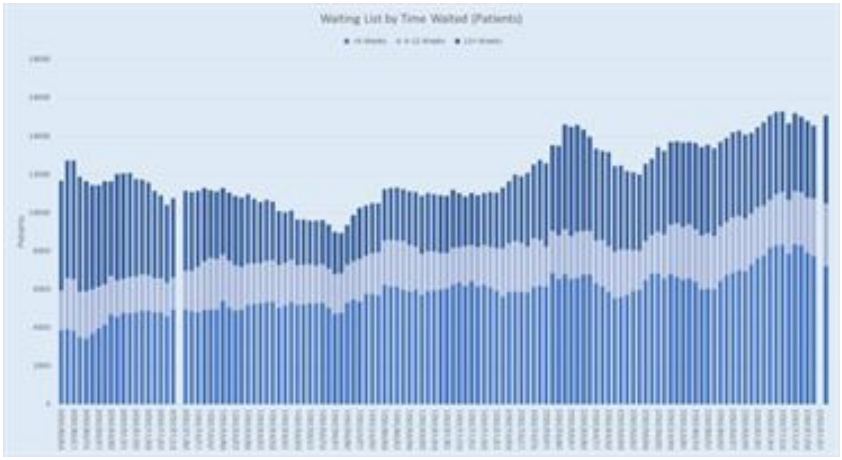
6. Patients waiting over 104 days



608 patients have waited over 104 days
- Lower than 642 patients last week

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. Also, waiters with non-specific symptoms are not included in these national data. No data for Wirral 04/04/2021; Countess of Chester 01/08/2021, 08/08/2021. No data for Warrington & Halton and Wirral 19/12/21, 17/07/22 (later data copied from previous week). Incorrect data submitted by Countess of Chester 10/04/22. No data for Mid Cheshire 25/07/2021.

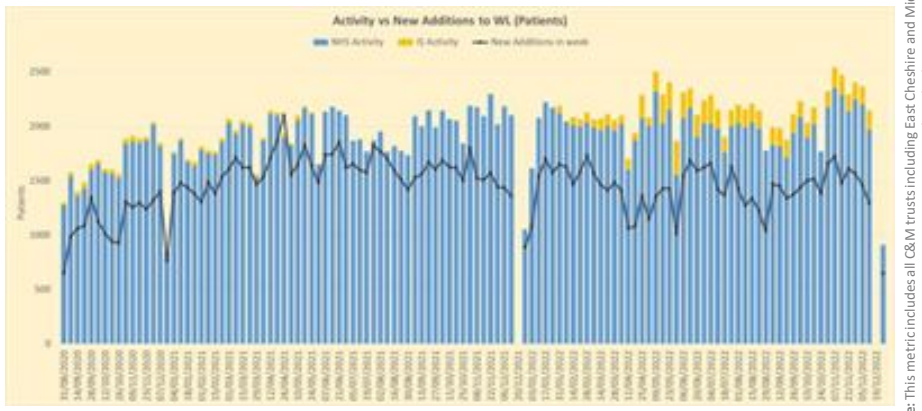
7. Endoscopy waiting list



Endoscopy waiting list increased to 15,064 patients (Christmas week)

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. No data from East Cheshire or Mid Cheshire w/b 14/12/20; No collection 21/12/20. LUFT Aintree and LUFT Royal estimated for 24/05/21. Warrington and Halton estimated for 31/05/21. Southport and Ormskirk estimated for 05/07/21, 06/09/21, 16/05/22 and 06/06/22. Countess of Chester estimated for 26/07/21 to 31/01/22 inclusive, 21/03/22, 11/04/22 and 18/04/22. LUFT Aintree estimated for 01/02/21, 03/05/21, 21/06/21, 08/08/22 to 22/08/22, 05/09/22, 19/10/22. Wirral estimated for 03/01/22, 05/09/22 and 12/09/22. East Cheshire estimated for 16/05/22, 28/11/22.

8. Endoscopy activity



Endoscopy activity decreased to 908 patients (Christmas week).

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. No data from East Cheshire or Mid Cheshire w/b 14/12/20; No collection 21/12/20. LUFT Aintree and LUFT Royal estimated for 24/05/21. Warrington and Halton estimated for 31/05/21. Southport and Ormskirk estimated for 05/07/21, 06/09/21, 16/05/22 and 06/06/22. Countess of Chester estimated for 26/07/21 to 31/01/22 inclusive, 21/03/22, 11/04/22 and 18/04/22. LUFT Aintree estimated for 01/02/21, 03/05/21, 21/06/21, 08/08/22 to 22/08/22, 05/09/22, 19/10/22. Wirral estimated for 03/01/22, 05/09/22 and 12/09/22. East Cheshire estimated for 16/05/22, 28/11/22.

9. Patients waiting between 63 and 103 days by provider

PTL data from week ending 08 January

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total	Change from last week
Bridgewater																
Clatterbridge							6						16		39	-13
Countess Of Chester			9		10	32					5		21		86	-16
East Cheshire		12	5			65						11			95	14
Liverpool Foundation Trust		21			85	299		18			39	77	93		645	-132
Liverpool Heart & Chest							5								5	
Liverpool Women's			129												129	8
Mid Cheshire		6	6			201		5			7	8	21		264	
Southport & Ormskirk			8			30					37	5	7		91	0
St Helens & Knowsley			12		6	162		5			9	24	24		249	49
Walton Centre																
Warrington & Halton													22		41	-5
Wirral				5		48					9	6	54		131	8
Grand Total		**49**	**176**	**16**	**112**	**852**	**18**	**28**		**8**	**106**	**142**	**260**		**1772**	**-88**

Cheshire & Merseyside Cancer Alliance

Tables from national Cancer PTL

10. Patients waiting over 104 days by provider

PTL data from week ending 08 January

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total	Change from last week
Bridgewater																
Clatterbridge															18	-5
Countess Of Chester						12									26	0
East Cheshire						23									28	0
Liverpool Foundation Trust		5			12	108						39	48		231	-45
Liverpool Heart & Chest																0
Liverpool Women's			36												36	
Mid Cheshire						78									89	
Southport & Ormskirk			5			20									30	4
St Helens & Knowsley			5			52						6			74	8
Walton Centre																
Warrington & Halton													11			4
Wirral						28							35		72	-12
Grand Total		**8**	**53**	**7**	**21**	**330**	**8**	**15**			**15**	**54**	**110**		**623**	**-48**

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

- Data no longer split out for acute leukaemia or testicular
- New data for non site specific symptoms referrals (not included in national totals in graphs 5 and 6)

= fewer than 5 patients or hidden to prevent disclosure (fewer than 3 for change from last week)

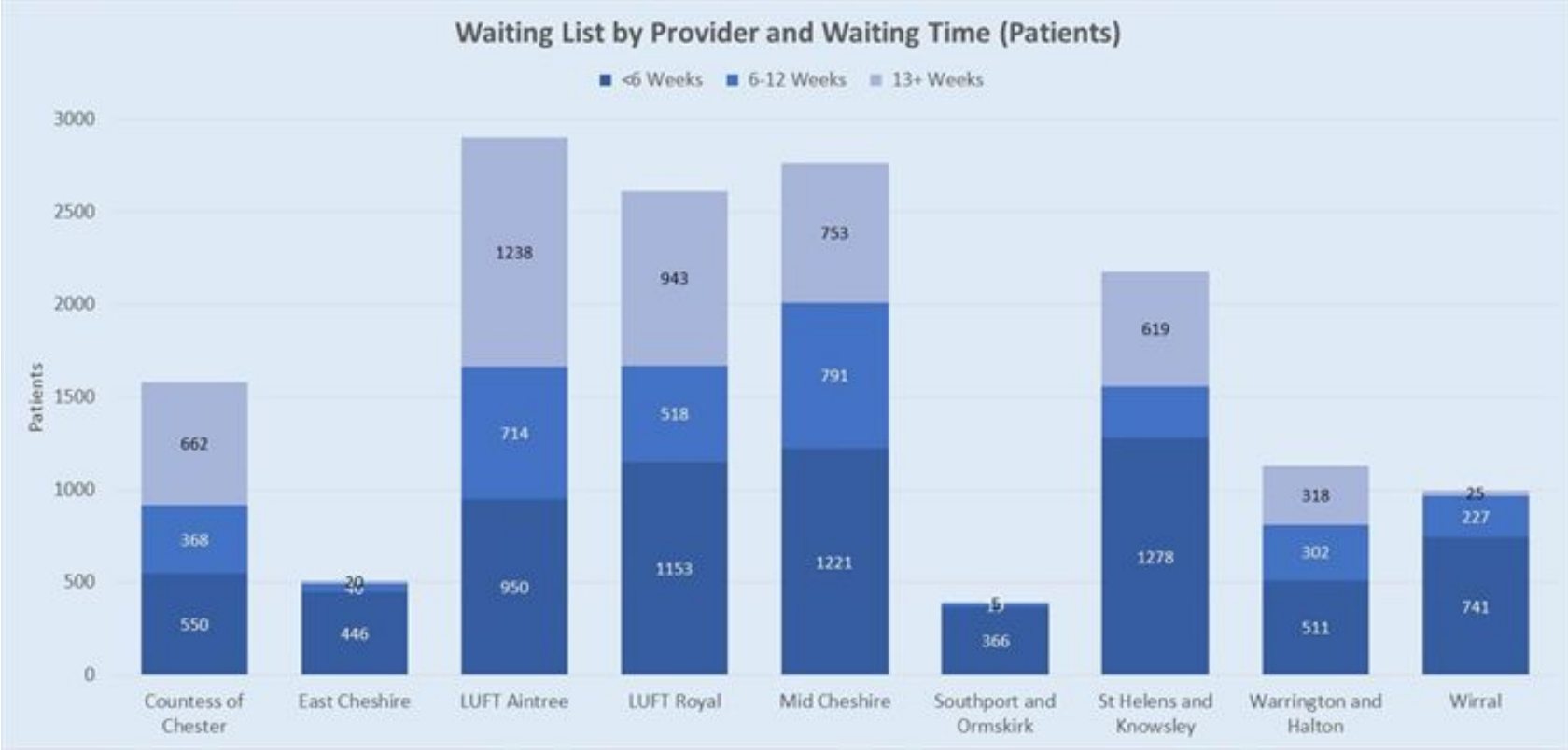
= No national PTL submission this week

Section II: Restoration of Cancer Services – Core Metrics

Endoscopy (cancer and non-cancer pathways)

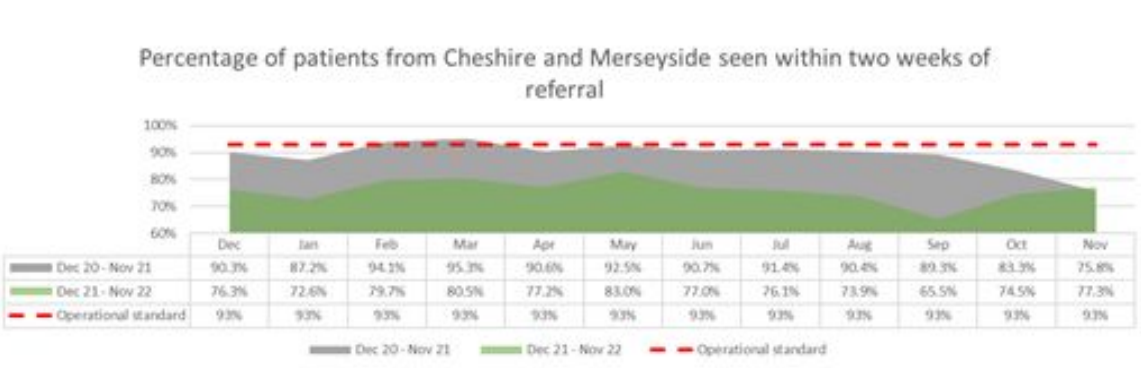
There are currently 15,064 patients waiting for an endoscopy. 7,848 have waited more than six weeks, and of these 4,583 have waited 13 or more weeks (30% of the total).

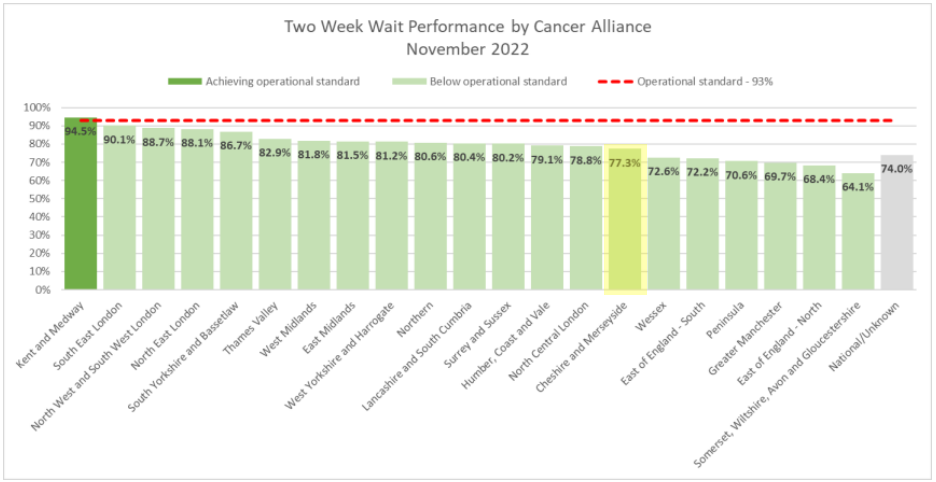
There is significant variation across units. In terms of patients waiting over 13 weeks the highest proportions are seen in LUFT Aintree (43%) and CoCH (42%).
Other units experiencing challenges are LUFT Royal (36%), Warrington and Halton (28%), St Helens and Knowsley (28%), and Mid Cheshire (27%).



Endoscopy data at 01 January 2023

Section III: 14 day standard





In November 2022, 77.3% of patients were seen within 2 weeks compared to 74.5% in the previous month. This is below the operational standard.

In November 2022, Cheshire and Merseyside Cancer Alliance ranked 15 out of 21 for Two week wait performance (CCGs).

Providers not achieving the national operational standard were:

- Liverpool University Hospitals 54.3% (1654 breaches)
- Countess Of Chester Hospital 66.4% (477 breaches)
- East Cheshire 67.9% (217 breaches)
- St Helens and Knowsley Hospitals 85.2% (307 breaches)
- Southport and Ormskirk Hospital 88.2% (159 breaches)
- Warrington and Halton Teaching Hospitals 88.4% (127 breaches)
- Mid Cheshire Hospitals 91.1% (148 breaches)
- Wirral University Teaching Hospital 92% (160 breaches)
- The Clatterbridge Cancer Centre 92% (2 breaches)

CCGs not achieving the national operational standard were:

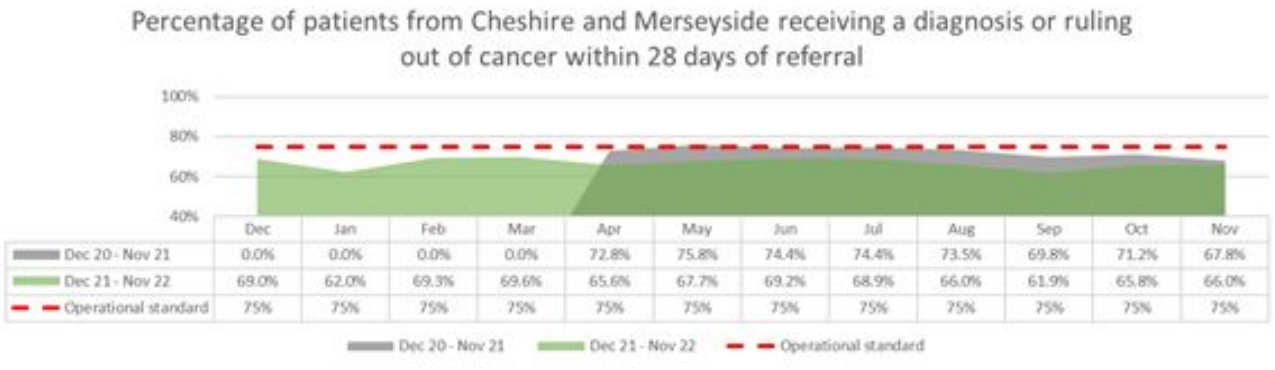
- NHS Liverpool CCG 58.7% (1055 breaches)
- NHS South Sefton CCG 67.5% (305 breaches)
- NHS Knowsley CCG 67.5% (330 breaches)
- NHS Cheshire CCG 78.5% (846 breaches)
- NHS Southport and Formby CCG 82.5% (145 breaches)
- NHS St Helens CCG 86% (157 breaches)
- NHS Halton CCG 87.3% (92 breaches)
- NHS Warrington CCG 90.5% (102 breaches)
- NHS Wirral CCG 91.5% (158 breaches)

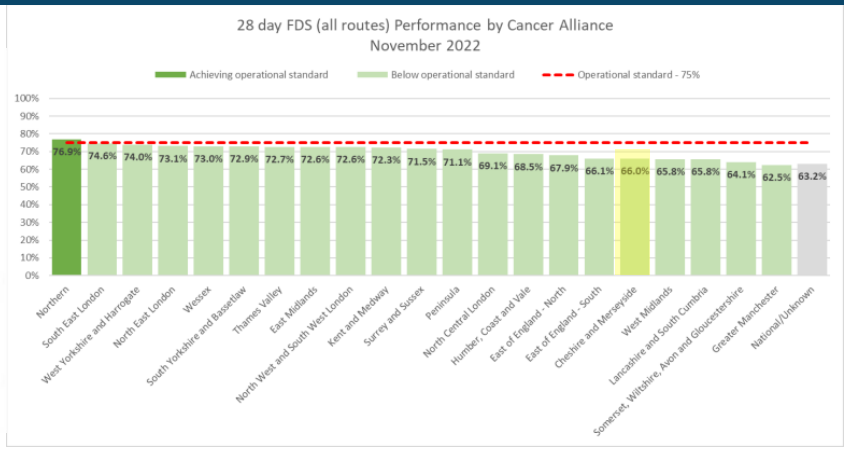
Cancer pathways* not achieving the national operational standard were:

- Suspected skin cancer 66.7% (1048 breaches)
- Suspected breast cancer 71.3% (701 breaches)
- Suspected lower gastrointestinal cancer 78.8% (690 breaches)
- Suspected head and neck cancer 79.6% (255 breaches)
- Suspected upper gastrointestinal cancer 81.1% (213 breaches)
- Suspected brain/central nervous system tumours 84.6% (2 breaches)
- Other suspected cancer (not listed) 85.3% (5 breaches)
- Suspected gynaecological cancer 85.5% (194 breaches)
- Suspected sarcoma 86.4% (6 breaches)
- Suspected children's cancer 88.9% (5 breaches)

*CCG based data – CADEAS source CCGs refer to the historic 2022 Clinical Commissioning Groups prior to the implementation of the Integrated Care Board (ICB)

Section III: 28 day standard





In November 2022, 66% of patients were diagnosed or ruled out within 28 days compared to 65.8% in the previous month. This is below the operational standard.

In November 2022, Cheshire and Merseyside Cancer Alliance ranked 17 out of 21 for 28 day FDS (all routes) performance (CCGs).

Providers not achieving the national operational standard were:

- Liverpool Heart And Chest 44.4% (5 breaches)
- Liverpool Women's 55.9% (154 breaches)
- Liverpool University Hospitals 61.4% (1356 breaches)
- Countess Of Chester Hospital 62.2% (597 breaches)
- Mid Cheshire Hospitals 62.4% (652 breaches)
- St Helens and Knowsley Hospitals 67.5% (702 breaches)
- East Cheshire 67.9% (183 breaches)
- Southport and Ormskirk Hospital 69% (410 breaches)
- Warrington and Halton Teaching Hospitals 71.4% (335 breaches)
- Wirral University Teaching Hospital 73.9% (534 breaches)

CCGs not achieving the national operational standard were:

- NHS Liverpool CCG 58.8% (1015 breaches)
- NHS Cheshire CCG 63.2% (1475 breaches)
- NHS South Sefton CCG 63.8% (307 breaches)
- NHS Knowsley CCG 66.8% (319 breaches)
- NHS Southport and Formby CCG 67.9% (265 breaches)
- NHS St Helens CCG 68% (382 breaches)
- NHS Warrington CCG 71.3% (314 breaches)
- NHS Halton CCG 72.7% (208 breaches)
- NHS Wirral CCG 73.5% (517 breaches)

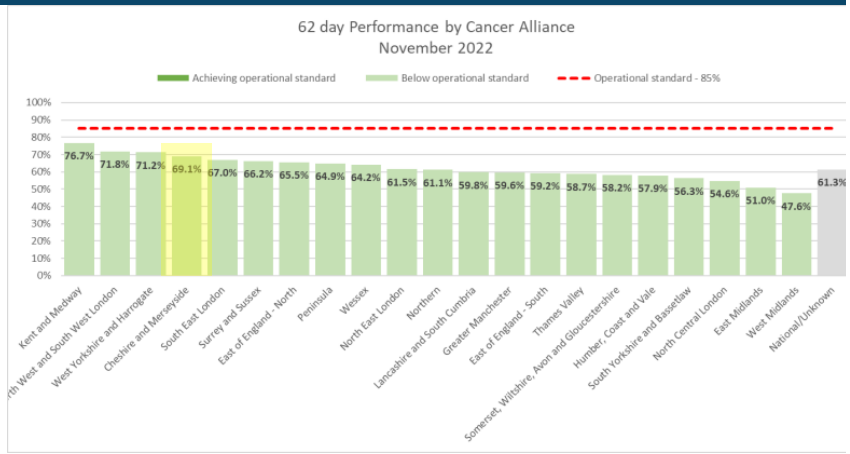
Cancer pathways* not achieving the national operational standard were:

- Suspected lower gastrointestinal cancer 38.8% (1933 breaches)
- Suspected urological malignancies (excluding testicular) 45.7% (539 breaches)
- Suspected haematological malignancies (excluding acute leukaemia) 46.7% (48 breaches)
- Referral from a National Screening Programme: Unknown Cancer Report Category 54% (116 breaches)
- Suspected upper gastrointestinal cancer 59.7% (451 breaches)
- Suspected gynaecological cancer 61.4% (513 breaches)
- Suspected sarcoma 67.5% (13 breaches)
- Suspected testicular cancer 69.8% (13 breaches)
- Other suspected cancer (not listed) 74.1% (7 breaches)

*CCG based data – CADEAS source

CCGs refer to the historic 2022 Clinical Commissioning Groups prior to the implementation of the Integrated Care Board (ICB)

Section IV: 62 day standard



In November 2022, 69.1% of patients were treated within 62 days compared to 70.3% in the previous month. This is below the operational standard.
In November 2022, Cheshire and Merseyside Cancer Alliance ranked 4 out of 21 for 62 day performance (CCGs).

Providers not achieving the national operational standard were:

- Liverpool Women's 20% (8 breaches)
- Liverpool University Hospitals 46.4% (73.5 breaches)
- East Cheshire 61.5% (12.5 breaches)
- Mid Cheshire Hospitals 63.6% (38 breaches)
- Warrington and Halton Teaching Hospitals 69.6% (17.5 breaches)
- Southport and Ormskirk Hospital 69.6% (20.5 breaches)
- Liverpool Heart And Chest 73.3% (2 breaches)
- Wirral University Teaching Hospital 74.4% (30.5 breaches)
- St Helens and Knowsley Hospitals 83.3% (18 breaches)

CCGs not achieving the national operational standard were:

- NHS Liverpool CCG 48.2% (44 breaches)
- NHS South Sefton CCG 56.5% (20 breaches)
- NHS Warrington CCG 66.1% (19 breaches)
- NHS Cheshire CCG 69.9% (75 breaches)
- NHS Halton CCG 71.4% (12 breaches)
- NHS Knowsley CCG 72.7% (9 breaches)
- NHS Wirral CCG 74.6% (31 breaches)
- NHS Southport and Formby CCG 77.6% (11 breaches)

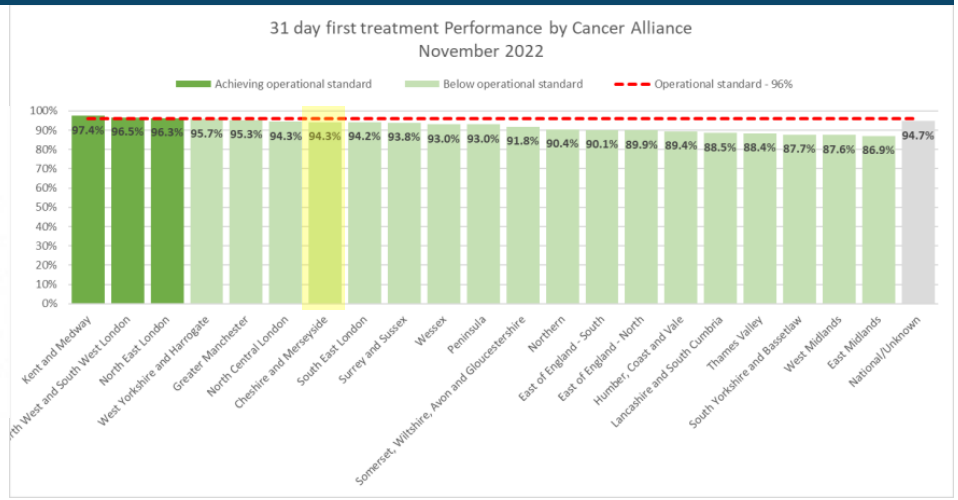
Cancer pathways* not achieving the national operational standard were:

- Head & Neck 28.9% (27 breaches)
- Lower Gastrointestinal 33.9% (37 breaches)
- Other 40% (3 breaches)
- Gynaecological 45.5% (24 breaches)
- Sarcoma 50% (3 breaches)
- Haematological (Excluding Acute Leukaemia) 60% (14 breaches)
- Urological (Excluding Testicular) 66.7% (59 breaches)
- Lung 70.9% (16 breaches)
- Upper Gastrointestinal 71.4% (14 breaches)
- Breast 78% (24 breaches)

*CCG based data – CADEAS source

CCGs refer to the historic 2022 Clinical Commissioning Groups prior to the implementation of the Integrated Care Board (ICB)

Section V: 31 day standard



In November 2022, 94.3% of patients were treated within 31 days compared to 94.6% in the previous month. This is below the operational standard.
In November 2022, Cheshire and Merseyside Cancer Alliance ranked 7 out of 21 for 31 day first treatment performance (CCGs).

Providers not achieving the national operational standard were:
- East Cheshire 72.9% (16 breaches)
- Southport and Ormskirk Hospital 81.9% (13 breaches)
- Liverpool Women's 82.1% (5 breaches)
- Mid Cheshire Hospitals 87.8% (16 breaches)
- Liverpool University Hospitals 88.3% (29 breaches)

CCGs not achieving the national operational standard were:
- NHS Southport and Formby CCG 91.3% (7 breaches)
- NHS Liverpool CCG 91.7% (16 breaches)
- NHS Cheshire CCG 92.1% (34 breaches)
- NHS South Sefton CCG 94.5% (5 breaches)

Cancer pathways* not achieving the national operational standard were:
- Skin 89.1% (30 breaches)
- Gynaecological 89.6% (8 breaches)
- Sarcoma 92.3% (1 breaches)
- Urological 92.6% (21 breaches)
- Lower Gastrointestinal 93.8% (7 breaches)
- Breast 94.6% (13 breaches)
- Other 95% (1 breaches)
- Head & Neck 95.6% (2 breaches)

12

*CCG based data – CADEAS source

CCGs refer to the historic 2022 Clinical Commissioning Groups prior to the implementation of the Integrated Care Board (ICB)

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