AGENDA

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Trust Board of Directors Meeting held in Public

Date: Wednesday 28 July 2021	Location: via MS Teams
Start Time: 09:00	Finish Time: 12:00

Timings	Item No		Lead	Paper/Verbal
Opening Matters				
09:00	**P1-107-21**	Welcome & Apologies:	KD	**Verbal**
	P1-108-21	Declarations of Committee Members' and other attendees' interests concerning agenda items:	KD	**Verbal**
	P1-109-21	Minutes of last meeting: 30 June 2021	KD	**Paper**
	P1-110-21	Matters arising/Action Log	KD	**Paper**
	P1-111-21	Chair's Report to the Board	KD	**Verbal**
Risk and Assurance				
09:15	**P1-112-21**	Quality Committee Chair's Report	TJ	**Paper**
09:25	**P1-113-21**	Performance Committee Chair's Report	GB	**Paper**
09:35	**P1-114-21**	Charitable Funds Committee Chair's Report	EA	**Paper**
09:45	**P1-115-21**	Audit Committee Chair's Report	MT	**Paper**
09:55	**P1-116-21**	Audit Committee Annual Report to the Board	MT	**Paper**
10:05	**P1-117-21**	Patient Story	KS	**Verbal**
10:25	**P1-118-21**	Patient Experience Visits	JSp	**Paper**
10:35	**P1-119-21**	New Consultant Appointments: None to note		
10:40	**P1-120-21**	Integrated Performance Report: Month 03	JSp/JSh	**Paper**
10:50	**P1-121-21**	Finance Report: Month 03	JT	**Paper**
11:00	**P1-122-21**	a)Mortality Annual Report	SK	**Paper**

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		b) Mortality Dashboards		
11:10	**P1-123-21**	Safeguarding Annual Report	JSp	**Paper**
11:20	**P1-124-21**	Freedom to Speak Up Annual Report	AW	**Paper**
11:25	**P1-125-21**	Infection, Prevention and Control Annual Report	JSp	**Paper**
System Working				
11:30	**P1-126-21**	Cheshire & Merseyside Cancer Alliance Performance Report	LB	**Paper**
11:35	**P1-127-21**	Inequalities of Access to Services	LB	**Paper**
11:45	**P1-128-21**	Cheshire & Merseyside Cancer Alliance Annual Report	LB	**Paper**
Corporate Governance				
11:55	**P1-129-21**	Board Development	AW	**Paper**
12:00	**P1-130-21**	Regulation 5 Declarations (Fit and Proper)	AW	**Paper**
	P1-131-21	Board Meeting Review	ALL	**Verbal**

Next Meeting:

Date: Wednesday 29 September 2021	Location: TBC
Start Time: 09:00	Finish Time: 12:30

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Minutes of the Trust Board of Directors held in Public

Held on: Wednesday 30 June 2021	Location: The Spine & via MS Teams
Start time: 09:00 hours	Finish time: 11:20

Present

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

In attendance

Emily Kelso (EK)	Corporate Governance Manager (minutes)
Jane Wilkinson (JW)	Lead Governor
Maria Maguire (MM)	Head of Research Governance & Sponsorship
Emma Whitby (EW)	Head of Research Deliver
Alun Evans (AE)	Staff Side Representative

Observer

Myfanwy Borland	Public Governor

Item no.	Agenda item	Action
P1/89/21	**Chair Welcome and Note of Apologies** The Chair welcomed all to the meeting with apologies noted from Anna Rothery Non-Executive Director and Angela Wendzicha Associate Director of Corporate Governance.	
P1/90/21	**Declarations of Board Members and other attendees' interests concerning agenda items:** • Mark Tattersall – Nominated Non-Executive Director for PropCare	

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	• Terry Jones – Director of Liverpool Head and Neck Centre and Associate Medical Director for Research, Liverpool University Hospital NHS Foundation Trust • Geoff Broadhead – Nominated Non-Executive Director for CPL • James Thomson – Executive Lead for PropCare and CPL	
P1/91/21	**Minutes of Previous Board Meeting: 26 May 2021** The Board approved the minutes of the Board meeting held on 26 May 2021. **The Trust Board:** • Approved the minutes of the Board meeting held on 26 May 2021	
P1/92/21	**Matters Arising/Action Log** The Board noted that actions were either complete, on the Agenda or not yet due, in addition the following update was provided: JSh confirmed that the Trust would be working with an external provider on Unconscious Bias Training instead of the Specialist Trust Alliance; dates for training were to be confirmed. **The Trust Board:** • Noted the position in relation to the Action Log.	
P1/93/21	**Chair's Report to the Board** KD informed the board of two senior appointments made: • Julie Gray Chief Nurse, who would start on the 1st October 2021 • Margaret Saunders – Associate Director of Corporate Governance, who would start at the Trust on the 1st September 2021 KD informed the Board that she had recently attended the North West Regional Chair meeting, which was the last meeting for Bill McCarthy, as he would be retiring in July, it was noted that his replacement would be Amanda Doyle originally a GP from Blackpool, who had spent considerable time in senior management within the NHS. The vaccine programme was discussed and vaccination rates within the region were noted. Vaccine education and engagement programmes targeting underrepresented communities were now a key focus. Long Covid services were being set up with £11m funding being allocated to the region. Integrated Care System implementation was still anticipated for April 2022.	
P1/94/21	**Quality Committee Chair Report** TJ provided an overview of the report, alerting the Board to the following: • The committee had received an update on progress in relation to the Aseptic Unit and monthly reports will continue until sufficient assurance was received. • The committee had requested a deep dive on the risks surrounding the ECMC, which was to be presented in July. TJ Alerted the Board to the two separate papers requested by the committee; A deep dive on those risks/issues recorded under the Communications category and a paper on trends within the Communications category relating to virtual consultations.	

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	TJ further advised of the JACIE Accreditation Preparedness report presented by Dr Muhammad Saif. The report detailed the complex nature of stem cell transplants and the highly robust accreditation quality standards set out by JACIE. Assurance was provided on the progress to date. KD enquired into the expected timescale for JACIE Accreditation. LB responded that an exact time scale had not been confirmed. It was expected that the inspection would take place before the end of the 21/22 financial year. MT sought clarity on the level of assurance the committee had received on the two Alert items on the Chairs report, which also featured on the BAF. TJ confirmed that progress on the Aseptic Unit was within the planned timescales, the impact on Research and clinical trials was to be investigated further and would be addressed in the ECMC deep dive. GB added that the Aseptic Unit issues and the impact on Research were also a focus for the Performance Committee ; Research Business Plan report had been received and was now a quarterly standing agenda item, in order for the committee to quantify the impacts on income. SK gave assurance that those studies not requiring aseptic unit input were progressing well and that the Trust had recently been the first to gain approval for a radiotherapy brain tumor study along with transgene studies as reported in the media. JW queried the percentages of trials affected because of the Aseptic Unit issues. TJ confirmed this figure could be provided in July and had been requested by the committee as an exception report from the IPR. **Medicine Management Seminar -** TJ provided feedback from the seminar which had been requested by the Quality Committee in response to medicines management risks and issues. An overview of the principles around medicines management and assurances on the processes in place had been provided by subject matter experts. The format and facilitation of the session was valued and further sessions on topics of interest would be well received. KD confirmed that that the Board work plan was to be further developed to include developmental & information sessions. **The Trust Board:** • **Discussed and noted** the content of the report.	
P1/95/21	**Audit Committee Chair's Report** MT provided an overview of the report, alerting the Board that despite the assurances given at the 26 May 2021 meeting, the auditors had missed the deadline and as a result, the planned extra ordinary Trust Board meeting had been rescheduled to 28th June prior to the Board meeting. It was noted that the CCC team had delivered to timescales and the delay was not attributable to any internal failures. The Board discussed the upcoming appointment process for the Trust's External Auditors and the considerable market gap. MS confirmed there were a number of new suppliers and that exploratory conversations would take place to determine suitability. It was noted that as per the constitution, the Council of Governors would meet and make the final decision on the appointment of the external auditor; this meeting was scheduled for September and that the Trust would follow a stringent procurement process to shortlist. MT further informed the Board of the difficulties experienced across sectors in auditing, because of the financial reporting council revised regulatory regimes, putting	

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	pressure on Auditors, along with the rigorous deadlines across the public sector including the NHS. GB highlighted the exceptional work of the CCC Finance team, in meeting the required deadlines given the difficulties experienced. JT added that the finance context around Covid had led to additional work, which raised a risk for the Auditors given the funding regime as well as this being the first year CCC had been required to account for the new hospital. However, the Board should take assurance following the receipt of the final audited accounts that CCC was accounting for these aspects accurately. **The Trust Board:** • **Discussed and noted** the content of the report.	
P1/96/21	**Staff Story: Research** The Chair welcomed Gillian Heap, Maria Maguire and Emma Whitby to the meeting. EW shared a patient story with the board demonstrating how governance and delivery roles worked closely together to give patients at CCC the best possible outcomes. A male lung cancer patient was one of the first people to have treatment at the new CCC-L. He joined the IMpower 030 clinical trial and after a few months of being treated with a combination of immunotherapy and chemotherapy his tumor had reduced by half – shrinking so much that he could have keyhole surgery at Liverpool's Broadgreen Hospital to remove it, meaning a shorter recovery time. Typically, chemotherapy treatment is rarely offered before surgery and never with immunotherapy as enough evidence to support the pathway was not yet available. In June 2021, 18 months after his original diagnosis the patient rang the ceremonial bell at Clatterbridge Cancer Centre – Liverpool, signaling the successful end to his treatment. Several quotes from the patient were shared, which gave positive feedback on the new facilities at CCC-L praising both the facilities and staff, noting that his move from CCC-W to CCC-L mid treatment was seamless and the site was much closer to home. MM explained research from a governance perspective and the importance of building multi-stakeholder relationships with patients, clinical departments, partner organisations (in this case surgical teams at LUHFT and LHCH) & sponsors. Also noted was the key focus of the team to ensure all legislative processes and policies were adhered to. The Board discussed the differential patient pathways followed by patients on clinical trials and regular patients. It was noted that the commitment to the strategic priority 'To Be Research Leaders' was obvious across the Trust. Wherever possible patients were put into trials, these trials enabled rapid learning from trial protocols and inclusion of these practices into normal standards of care. KD asked whether similar results had been observed from other patients on the same trial as the patient whose story had been shared. EA explained that this was a global study looking for 300 patients. CCC had recruited 2, and outcomes of the study were yet to be published. However, evidence suggests that the combination treatment had patient benefit. It was noted that results of this phase-3 trail could take between 2 -5 years to be devolved into approved treatments.	

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	The Trust Board: • Noted and welcomed the staff story to Board.	
P1/97/21	**Patient Experience Visits** KD explained that the planned June Walkabout had not taken place due to increased Covid-19 transmission rates and the government decision to extend the timeline on restrictions. JSp explained that Kirsteen Scowcroft Head of Patient Experience had visited CCC-W. Those areas visited were the Chemotherapy Unit, Main Entrance & Receptions, Radiotherapy and Imaging. The key finding and observations as noted within the report were highlighted. SB queried if there was any additional work the digital team could do to assist with the issues around communication and shared records. JSp confirmed a review of the holistic needs assessment of patients was underway, so that patients would not have to repeat their information. JSp confirmed that the implementation of the electronic shared care record would mitigate much of the need for repetition. SK confirmed the SRGs were looking at base line data to be included as part of the referral process, however rechecking and reconfirming was still often necessary to ensure safe practice. SB added that work was ongoing around patient held records which was a national ambition to enable patients to have partial control of their records. It was further noted that CCC was part involved in an early pilot of the E-Exchange portal enabling access to appointments and letters electronically. AY sought clarity on the experience of agitated patients and visitors. JSp explained this was in relation to the re-imposed visitor closure on the 16th June 2021, which had been confusing for patients and visitors. It was noted that there were some exceptions but in order to adhere to government guidance and promote safety of staff and patients the Trust was not able to accommodate visitors. KD added that volunteers across sites were able to step in when support was required. KD confirmed that if the current restrictions on visiting were to continue, Walkabouts would revert to virtual visits until lifted. **The Trust Board:** • **Noted** the content of the report and feedback.	
P1/98/21	**New Consultant Appointments** The Board noted there were no new Consultant appointments this month.	
P1/99/21	**Safer Staffing Report:** JSp introduced the report providing the Bi-Annual position regarding safe staffing achieved across inpatient wards during Q4. Matrons and ward managers were taking a patient centred, evidence based and systematic approach to determine the number and skill mix of staff required to deliver safe care to patients. The following key points were highlighted: I. Overstaffing reported on Ward 5 was attributable to the reduced number of transplants carried out in line with national guidance; however, an increase in transplants was imminent.	

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	II. Low incidences of pressure ulcers and falls had been reported with no lapse in care, which was a reflection of the safe staffing levels III. Acuity level reports of patients were received 3 times per day, enabling timely oversight. JSp explained that although some areas were reporting overstaffing, these levels would be essential to support the increased activities as part of the Covid-19 recovery plan. JSp further noted that the following would be monitored carefully: • The use of bank staff through NHSP • Ward managers focus on retention plans, particularly in acute care. MT sought clarity on patient staff ratios and actual staffing on wards, which was not included in the report. JSp confirmed that the data was available and could be included in future reports. **The Trust Board:** • Noted the content of the report. • Supported the current workforce model and reporting style with the addition of actual staffing figures on wards.	**JSP**
P1/100/21	**Integrated Performance Report: Month 01** JSp introduced the report providing an overview of the Performance section noting that performance had been good across the 7 and 24 day targets. with a slight under performance on 7 days however, none of those patients went on to miss the 62 day target. JSp added that bed occupancy remained low but activity was increasing as expected in line with the recovery programme. The Trust was supporting the Cheshire and Mersey approach, outreaching to acute oncology services particularly LUHFT to relocate those patients to CCC-L which would help with pressures in the system. Radiology reporting target had been missed and the clinical prioritization plan had been reintroduced to ensure timely availability of reports, a business case was also in development for radiology to expand the service. **Quality** JSp highlighted that two Serious Incidents had been reported in month relating to falls. No lapses in care had been identified. Both incidents were undergoing a full investigation. Two cases of C. Diff had been reported. It was noted that the target of 4 was a considerable challenge, particularly with the expected increase of bone marrow transplant patients. Commissioners were to review and consider an adjustment. Sampling delays had been identified as a theme and mitigation actions were in place. One complaint had not been resolved in 25 days. Overall, the new policy was having a positive impact on complaints management and response times. **Research** SK provided an overview of the Research section noting that numbers for research recruitment were sitting at 50% of target. A detailed breakdown of trials being impacted by the aseptic unit had been requested to further analyse the specifics. Reasons for non-compliance were outlined, several studies remained on pause, plans were being established with the pharmacy team to address the backlog.	

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	TJ queried if there was data available on the number of patients offered the opportunity to participate in research programs. SK confirmed that the total was not recorded, however the function existed within meditech to track and some metrics were available around neurology. Further data capture possibilities would be sought and updates would be provided to the Board. **Workforce** JSh provided an overview of the workforce section noting that sickness absence showed in increase in May, reporting above target. However when benchmarked against national and local comparable organisations the Trust was comparing well. It was noted that the NW was recording the highest sickness absence levels nationally and was an area of concern. JSp added that PADR compliance continued to see a decline. Additional support was in place with divisions to improve the position and it was expected compliance would be delayed until 1st September. **The Trust Board:** • **Noted** the content of the report.	**SK**
P1/101/21	**Cheshire and Merseyside Cancer Alliance Performance Report** LB introduced the report highlighting that recovery is going well, continued focus remained on endoscopy capacity. Waiting lists were decreasing and an upturn in activity continued. A business plan for the additional £1m recovery funding received by the Alliance had been submitted with a focus on Endoscopy; a decision was expected within the next fortnight. The Alliance had underperformed on the 14 day standard, the reasoning behind this was explained as considerable pressure across organisations with elective recovery continuing at pace. The number of urgent referral patients waiting over 62 days remained steady however significantly higher than pre-Covid levels. Good progress had been made on the 104 day waiting target and was expected to continue. MT queried system work and support being offered to those regional organisations under significant pressure. LB explained that the needs of organisations were assessed and coordinated by the CMCA working together with COO network across the region and promoting an open and transparent approach to support and funding allocation, which was reported up to the Alliance Board and national team. LB further explained her role as SRO for the Endoscopy Network recovery. TJ sought clarity on the relationship between the Cancer Alliance and the ICS. LB explained that the Alliance was well placed, being a mature system working collaboration and the move toward more system-based working was apparent in Board members across organisations working together and having a positive impact on the Alliance functionality. LB further added that the ICS framework confirmed that CMCA funding would be direct and not via the ICS funding route. AY sought clarity on the 14 day wait times figures reported in comparison to the previous month, it was confirmed that the difference in performance was in relation to the increase in volumes and the demands on the system not only in relation to cancer. JSp added that clinical prioritization panels across organisations had been introduced to manage the issue. **The Trust Board:**	

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	• **Noted** the content of the report.	
P1/102/21	**Finance Report: Month 02** JT introduced the finance report for Month 02 highlighting that the Trust was performing well reporting a surplus and remaining on trajectory to achieve the financial plan. JT added that workforce establishment and run rate was under the budgeted plan. Planned recruitment would lead to figures reporting closer to budget in future months. An increase in drugs expenditure had caused some pressure, due to increased activity and recovery. It was further noted that there had been some increase in NHSP bank spend, which would be closely monitored. Cash and Capital was as planned, reporting a cash surplus. However, capital schemes were scheduled for later in the year including new accelerator devices and IT spends. GB sought clarity on the manageability of the 2.8M CIP target. JT provided assurance that the CIP should be manageable in year and that planning for H2 was taking into account the management of non-recurrent risk, becoming more productive and where possible releasing savings, so that by the end of the year a balanced position would be achieved. Targets had been shared with divisions and divisional CIP plans would be shared with performance committee in July. MT sought further clarity on the elective recovery fund figures. JT confirmed that for April and May recovery had been assumed for the pay cost and non-pay cost line of 1M. JT further added that that there was some risk attached, and that a return had been submitted to explain how the local number was achieved to the ICS, however average prices had been applied, exact prices were yet to be confirmed and would be a month in arrears. EA enquired into the impact of underperforming Trusts in the region on the CIP plan, JT confirmed that the Cheshire and Mersey return for month 2 was balanced across providers. However as the year progressed emerging pressure may be identified. AY sought clarity on the cost impact of the Aseptic Unit issues, and the effect on income from clinical trials. JT confirmed that whilst full details of costs were not avaiable, the weekly Aseptic Unit Programme Board meeting received updates and were monitoring costs, which could be presented to the Board in context with the proposed investment case. **The Trust Board:** • **Discussed and noted** the financial position at Month 02.	**JT**
P1/103/21	**5 Year Strategy: Implementation Plan** TP introduced the report updating the Board on the implementation progress on the five-year strategic plan setting out the aims ambitions for the coming years against six strategic themes: • Be Outstanding • Be Collaborative • Be a Great Place to Work • Be Research Leaders	

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	• Be Digital • Be Innovative It was noted that the intention was for the report to be a working document, to be developed throughout the life of the strategy and to provide a high-level update to the Board and its committees on progress and challenges in implementation. GB referred to the formatting of the columns in relation to the progress steps, specifically the next steps and whether future reports could split short-medium term and long term to enable a more critical analysis, and a greater focus on short-term steps and outcomes. TP confirmed that future reports could provide this split. MT referred to the underlying projects, critical to achieving the strategy and how these were to be reported up into Board and suggested a hybrid of focus sessions on key projects and formal business cases on certain projects. AY sought clarity on project updates as detailed on the final slide. TP explained that the plan illustrated the monthly TEG meetings where key projects were identified along with forward planning and reporting on implementation would take place. It was also requested that a summary of key millstones was included in future reports along with key issues/risks. EA requested that updates on the strategy be uploaded onto the Diligent platform for reference. **The Trust Board agreed** • **Agreed** that the report should be presented to Board - 6 monthly • **Agreed** the Performance Committee should receive a quarterly reports on progress • **Requested** a summary page of key millstones was included in future reports along with key issues/risks. • **Agreed** that the Board work plan should incorporate Board Development Sessions/Away Day on Strategic Themes	**TP** **TP** **TP** **TP** **TP** **TP** **AW/TP**
P1/104/21	**Board Assurance Framework** LB introduced the Board Assurance Framework report for Quarter 1, including the section relating to controls, assurance and gaps in controls. MT referenced the key risks within the BAF and the discussion that had taken place throughout Agenda items within the Board meeting relating to those BAF risks which had been identified. MT asked that some further review of gaps in controls and assurances took place prior to the next Board meeting to ensure these were populated with all relevant assurances. It was also noted that further work was required to ensure actions were inserted for those risks performing below target. **The Trust Board:** • **Noted** the report	
P1/105/21	**Trust Board Reporting Cycle** LB introduced the report outlining the current cycle of business for the Trust Board. It was noted that following discussions under agenda Item P1-103-21 the 5 Year Strategy: Implementation Plan would be reported into Board 6-monthly going forward.	

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	The Board were asked for their views on ICS progress reporting into Board. It was agreed that a Systems Working sub-heading be added to the Board agenda to house the Cheshire and Merseyside Cancer Alliance Performance Report and any other items in related to system working including ICS. **The Trust Board:** • **Agreed** a System Working agenda sub-heading would be introduced for future Board Agendas.	**AW**
P1/106/21	**Board Meeting Review** In reviewing the Board meeting, KD highlighted that the linking of agenda items and discussions with both the BAF and the 5 Year Strategy was clear and welcomed. KD thanked the Executive team for their input.	

Next meeting:

Date: Wednesday 28 July 2021	Location: MS Teams
Start time: 09:00 hours	Finish time: 11:30

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

						P1-110-21
BOARD ACTION SHEET PART 1						
		KEY: BLUE = COMPLETE / GREEN = ON TRACK / AMBER = AT RISK / RED = LATE				
Item No.	**Date of Meeting**	**Item**	**Action(s)**	**Action by**	**Date to complete by**	**Date Completed / update**
P1-155-20	28-Oct-20	Matters Arising - Unconscious bias training for Board	An independent EDI specialist to carry out unconscious bias training.	**JSh**	TBC	**The Trust will be joining the Specialist Trusts for joint training: Date to be confirmed**
P1-32-21	24-Feb-21	Cheshire & Merseyside Cancer Alliance	Information relating to inequity of access to services to be presented at a future Board	**LB**	Jun-21	On the Agenda
P1-34-21	24-Feb-21	Gender Pay Gap Report	Paper setting out the options to reduce the gender pay gap to a future Board meeting.	**JSh**	Jun-21	Deferred to September 2021
P1-50-21	31-Mar-21	Staff Survey Results	Action Plan from the Staff Survey Results to Board in due course	**JSh**	Sep-21	
P1-99-21	30-Jun-21	Safer Staffing Report	To include data on actual staffing numbers on Wards in future reports	**JSp**	Sep-21	
P1-102-21	30-Jun-21	Finance Report: Month 02	Cost impact of the Aseptic Unit issues in context with the proposed investment case, to be presented to the Board	**JT**	Sep-21	
P1-103-21	30-Jun-21	5 Year Strategy: Implementation Plan	To revise formatting of the Report as discussed including a summary of key milestiones . Furture progress reports to be presented to the Board 6-monthly.	**TP**	01/11/2021	
P1-103-21	30-Jun-21	5 Year Strategy: Implementation Plan	Board Work Plan to include Board Development Sessions/Away day on Strategic Theme	**AW**	Jul-21	Completed
P1-15-21	30/06/2021	Trust Board Reporting Cycle	Future Board agendas to Include a subheading System Working	**AW**	Jul-21	Completed

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Committee/Group 'Triple A' Chair's Report

Name of Committee/Group	Quality Committee	Reporting to:	Trust Board
Date of the meeting:	22 July 2021	Parent Committee:	
Chair:	Terry Jones	Quorate (Y/N)	Y

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Pharmacy Aseptic Unit		The Quality Committee received an update on the Aseptic Production Unit noting: ➢ Executive Led oversight meetings are in place and a robust action plan in progress relating to the recommissioning of aseptic production to Liverpool. ➢ The date of recommissioning of the new unit is dependent upon the reports for active air sampling from Quality Control North West and the outcome of a review of the air handling system. Recommissioning is also dependent upon the approved staffing model being in place.	Monthly updates will continue to be provided to the Quality Committee.	KF	Ongoing
Experimental Cancer Medicine Centre (ECMC)		Following discussion around Board Assurance Risk 5, the Quality Committee requested and received a deep dive report illustrating the infrastructure for renewal and the progress made to date in developments and collaborations.	Continue management via the Directorate Board with assurance to the Quality Committee through the Board Assurance Framework Risk discussions on a monthly basis.	GH	Ongoing

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
		The Committee noted that the ECMC renewal submission dates commence in 2022 for 2023. The Committee discussed the continuing risks, acknowledging that some studies have been opened and the operational risks have been mitigated and continue to be managed via the Directorate Board, further progress is dependent upon delivery of the capacity plan from Pharmacy. The Committee noted that the reputational risk remains.			
Ocular Proton Facility: Update		The Committee received an update on the work undertaken in order to upgrade the ocular proton facility noting the following: ➢ Ancillary hardware: A new CNC milling machine has been used within the clinical service since March 2021. ➢ Software upgrade: The commercial treatment planning system was purchased in January 2021; delays in delivery and installation of the dedicated hardware resulted in installation in May 2021; following training, the new system is expected to be in clinical service in October 2021. ➢ Communications have been carried out with NHS England commissioners in addition to the external refers from the ocular community.	Continue to completion of system hardware upgrade.	CR	October 2022.
Medicine Management Report		The Committee received the monthly report relating to medicine management and noted the positive progress made in relation to the inclusion of an additional seven new categories.	The Quality Committee will continue to receive the Medicine Management Report monthly.	JR	Monthly

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Controlled Drugs Deep Dive Progress Report and Annual Report		The Committee received a progress report on actions from the deep dive into incidents relating to controlled drugs. The Committee was sufficiently assured of the progress made and was content to revert back to receiving the Annual Report. The Committee received and approved the Annual Controlled Drug Report.	For the Quality Committee to continue to receive the Controlled Drug Annual Report.	KF	July 2022
Annual Reports:		The Committee received the following Annual Reports as follows: ➢ Infection, Prevention and Control Annual Report ➢ Safeguarding Annual Report ➢ Mortality Annual Report and Mortality Dashboard ➢ Freedom to Speak Up Annual Report	The Quality Committee recommends Trust Board approve the aforementioned Annual Reports.	AW	July 2021

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

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Committee/Group 'Triple A' Chair's Report

Name of Committee/Group	Performance Committee	Reporting to:	Trust Board
Date of the meeting:	21July 2021	Parent Committee:	
Chair:	Geoff Broadhead	Quorate (Y/N)	Y

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Operational and Financial Planning 2021-22		The Performance Committee received a presentation on the Financial and Operational Planning for 2021-22 and had a detailed discussion in relation to the following: ➢ Key Points ➢ Planning context ➢ Workforce Resource Planning ➢ H1 forecast ➢ Commissioner Planning for 2022-23 and ➢ Financial and Operational risks. The Committee noted the following: ➢ The Trust continues to deliver and plan for increasing activity ➢ The Elective Recovery Fund (ERF) threshold has changed to 95% for Quarter 2 ➢ H2 funding basis has not yet been published ➢ The 2022-23 planning framework is being developed by NHSE.	Additional emerging detail to be presented at Trust Board.	JT	Ongoing
Review of Capital Investments		The Performance Committee noted the Board approved annual capital plan and received an update on the progress against the Trust's capital plan.	The Performance Committee to receive an update on progress against the capital plan every six months.	JB	January 2022

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Finance Report		The Performance Committee received and discussed the Finance report noting that for 2021-22, Cheshire and Merseyside ICS are managing the required financial position through a whole system approach and the requirement for the Trust for the first six months of the year (H1) is to achieve a break-even position.	None required	N/A	N/A
PropCare Report to the Performance Committee		In accordance with the agreed reporting cycle and format, the Performance Committee received the first report from PropCare detailing assurance around: ➢ Strategy development ➢ Risk management ➢ Compliance and ➢ Financial performance	PropCare will report to Performance Committee every six months. PropCare will report to the Trust Board as Shareholder.	FJ FJ	January 2022 July 2021
Clinical Decisions Unit (CDU): Update on the Service Development		The Performance Committee received an update on progress of the actions from the service review of the CDU and Hotline in improve patient flow noting that: ➢ Significant progress has been made but further work required to ensure robust collation of performance data relating to the CDU and Hotline. ➢ Delivery of Key Performance Indicators will be monitored at the Acute Care Divisional Quality, Safety and Performance meetings.	Further update on progress against the action plan to Performance Committee in six months.	JSp	January 2022

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

The Clatterbridge Cancer Centre NHS Foundation Trust

Committee/Group 'Triple A' Chair's Report

Name of Committee/Group	Charitable Funds Committee	Reporting to:	Trust Board
Date of the meeting:	01 July 2021	Parent Committee:	
Chair:	Elkan Abrahamson for Anna Rothery	Quorate (Y/N)	Y

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Fundraising and Finance Report – Income and Expenditure		The Charitable Funds Committee noted the challenges for the Charity due to the impact of Covid on fundraising. The Committee acknowledged the financial position at the end of the financial year as income of £2,230,525 representing 102% pf the revised year to date target.	The Charity has plans in place for a strong return to active fundraising aiming to achieve pre Covid levels by the end of the year.	KB	Ongoing
Serious Incident: Bogus Collector		The Committee noted that the individual involved in a previous Serious Incident had been sentenced to a 12 month Community Order and 120 hours of unpaid work at the Magistrates Court for three attempts to commit fraud by false representation and being in possession of an article for use in fraud.	None required – the matter is now closed.	N/A	N/A
Staffing and Recruitment		The Committee were informed that, given the pandemic, the Charity has tested	Complete recruitment process.	KB	Ongoing

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
		other means of fundraising such as utilising the digital platform. The Charity has recognised the skills gap and intends to recruit a skilled digital fundraiser.			
Review of Independent Status of the Charity.		The Committee re-visited the issue of Independent Charity Status and agreed that further work and discussion was required. The Committee requested an extra-ordinary Charitable Funds Committee in September prior to taking to proposal to Trust Board in September.	Detailed proposal to be developed. Extra-Ordinary Charitable Funds Committee to arranged prior to September Board.	KB AW	September 2021 September 2021
Policies Approved		The Committee approved the following policies: ➢ Complaints Policy ➢ Onsite Activity by Other Charities (EA left the meeting for this item and AR took over as Chair).	None required	N/A	N/A

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

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Committee/Group 'Triple A'

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

Name of Committee/Group: Audit Committee	Reporting to: Trust Board
Date of meeting: 13 July 2021	Parent Committee:
Chair: Mark Tattersall	Quorate:Yes

Agenda item	RAG	Key points	Actions required	Action lead	Expected date of completion
Review of External Audit Process 2020/21		The Audit Committee noted that the work relating to Value for Money was yet to be completed and the Chair sought commitment from Grant Thornton to work in conjunction with the Finance team to complete this.	Grant Thornton to work with the finance team to complete the Value for Money work. A review of the audit process to take place to identify any lessons learned during the process and for the action plan to be presented at the next Audit Committee.	CW/JB AS/CW/JB	August 2021 October 2021
External Audit Tender		The Audit Committee discussed the requirement to tender for the External Audit services this year.	Draft Invitation to Tender document in progress. The process will involve representatives from the Governors as part of the appointment process.	JT/JB	September 2021
Baseline Assessment: Anti-Fraud		The Audit Committee discussed and noted the outcome of the Trust's self-assessment against the functional Standard GovS 013: counter Fraud (Functional Standard). It was noted that the Trust was rated 'green' for ten out of twelve components. The Audit Committee further noted two areas for further development out of twelve components as follows:	Completion of the Conflicts of Interest review by MIAA	SD/JT	August 2021

		• Fraud, Bribery and corruption risk assessment • Policies and registers for gifts and hospitality and conflicts of interest. The Audit Committee acknowledged that MIAA have commenced a review on this aspect.			
Data Security and Protection Toolkit 2020-21		The Audit Committee welcomed the report detailing the submission of the 2020-21 Data Security and Protection Toolkit on a 'Standards Met' basis on 29 June 2021 prior to the deadline of 30 June 2021. The Committee further noted that in line with previous years, MIAA have undertaken a review of the Data Security and Protection Toolkit and it was noted that report remained outstanding. Information Governance Training was noted to be at 95.3 compliance against a target of 95%.	Completion of the MIAA review of the Data Security and Protection Toolkit.	SD	July 2021
Annual Reports to the Audit Committee		The Audit Committee received and welcomed the Annual Reports from the Quality Committee and the Performance Committee.	The Audit Committee will provide an Annual Report to the Trust Board.	AW/MT	July 2021

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Report to:	Trust Board	
Date of meeting:	28 July 2021	
Agenda item:	P1-116-21	
Title:	Audit Committee Annual Report 2020-21	
Report prepared by:	Mark Tattersall & Angela Wendzicha	
Executive Lead:		
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	
Date & decision:	

Purpose of the paper/key points for discussion:	In accordance with its current Terms of Reference, the Audit Committee is required to present an Annual Report to the Trust Board providing assurance that the Committee has fulfilled its duties in accordance with the Terms of Reference. The following Annual Report provides assurance to the Trust Board that the functions and requirements of the Audit Committee have been met for 2020-21.

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

Next steps required:	

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

☒ BE **OUTSTANDING**

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

☒ BE **COLLABORATIVE**

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

☒ BE **RESEARCH LEADERS**

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

☒ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☒ BE **INNOVATIVE**

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

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

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

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Audit Committee Annual Report 2020-21

Mark Tattersall, Non-Executive Director and Chair of the Trust Audit Committee
Angela Wendzicha, Associate Director Corporate Governance

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1. Introduction

1.1 The requirement for the Trust to have an Audit Committee is set out in the Monitor's Code of Governance[1]. The Audit Committee provides an independent and objective review of the Trust's internal controls and has a key role in ensuring the adequacy and effectiveness of systems, governance (corporate and clinical), risk management and internal control (both financial and non-financial), all of which support the Trust's Strategic Priorities. In carrying out its function the Audit Committee predominantly utilises the work of Internal and External Audit functions.

1.2 In accordance with the approved Terms of Reference (section 8.2), the Audit Committee will review relevant assurances from other Board Committees and provide an annual report to the Trust Board (section 9.3) in respect of its fulfilment of its function within the approved Terms of Reference. The following report illustrates the work of the Audit Committee during the period 2020-21.

2. Terms of Reference

2.1 The purpose of the Audit Committee is clearly set out within its approved Terms of Reference. In summary, the Audit Committee is a fully constituted standing committee of the Trust Board tasked with providing support and in-year assurance to the Board by carrying out a critical review of the governance and assurance processes that the Board relies upon.

2.2 The Audit Committee has specific work areas with which it is responsible for namely:

a) Integrated Governance, Risk Management and Internal Control.

b) Internal Audit: ensure there is an effective Internal Audit function established by management in addition to reviewing and approving the Internal Audit Plan. In the event the Internal Audit function carry out any non-audit work, the Audit Committee has responsibility for ensuring that their independence is maintained.

c) External Audit: responsibility for making recommendations to the Council of Governors in respect of the appointment, re-appointment and removal of the Trust's External Auditors. In addition, the Audit Committee reviews all external audit reports

[1] Monitor (2014) The NHS Foundation Trust Code of Governance

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d) Monitor the integrity of the financial statements and Annual Statutory Accounts prior to presentation at the Trust Board.
e) Review of the Annual Report and Annual Governance Statement and recommend approval to the Trust Board.
f) Review the operation of the Trust's Standing Orders and Standing Financial Instructions and the associated registers.
g) Cyber Security: the Audit Committee provides assurance to the Trust Board that the Trust is properly managing cyber risk.

2.3 The Audit Committee reviewed its Terms of Reference in January 2021 and subsequently approved the following amendments:

a) Authority: the Audit Committee is authorised to meet via remote and virtual means.
b) Cyber Security: the Audit Committee will satisfy itself that there is capable management resource in place to deal with cyber security matters and that the Trust has an incident response plan in place to deal with cyber security matters and that staff have received the required training.
c) Collaborative working: the Audit Committee will seek clarity and understanding in relation to collaborative working.

3. Membership of the Audit Committee

3.1 The Audit Committee membership comprises three Non-Executive Directors, and two of those Non-Executive Directors have recent relevant financial experience.

3.2 Representation from Internal Audit and Anti-Fraud is provided by MIAA and representation from External Audit is provided by Grant Thornton.

3.3 In addition to the above, the following are in attendance at the Audit Committee; Director of Finance, Chief Nurse, and Associate Director of Corporate Governance. The Audit Committee has the authority within its Terms of Reference to request the attendance of any member of staff or persons to assist with any discussions.

4. Meetings and Quoracy

4.1 The last financial year has been unprecedented as a result of the Covid-19 Pandemic, however this has not impacted on the ability of the Audit Committee to fulfil its functions.

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4.2 In accordance with its Terms of Reference, the Audit Committee meets for a minimum of four scheduled meetings a year. During the last financial year, the Audit Committee met a total of five times with one of those meetings being an extra-ordinary meeting to approve the Annual Accounts and Annual Report under delegated authority from the Trust Board.

4.3 For the Audit Committee to be quorate, two of the three Non-Executive Directors are required to attend Committee meetings. The Audit Committee was quorate at every meeting during 2020-21.

5. Audit Committee Business 2020-21

5.1 During the period reviewed, the Audit Committee Chair and members of the Audit Committee confirm that the Audit Committee has reviewed the following matters:

a) Internal Audit:
- Reviewed the Head of Internal Audit Annual Report and Head of Internal Audit Opinion 2020-21
- Approved the Internal Audit Plan for 2020-21
- Reviewed the findings from individual reviews carried out by MIAA

b) Anti-Fraud:
- Received the Anti-Fraud Annual Report
- Approved the Anti-Fraud Work Plan for 2020-21

c) Under delegated authority from the Trust Board, approved the Annual Accounts and Annual Report for 2019-20 and submissions in relation to compliance with the Provider Licence.

d) Reviewed the ongoing development of the Board Assurance Framework, acknowledging that whilst this was work in progress, the Audit Committee agreed that the visibility of risks within the Trust had been enhanced during the last year.

e) Monitored responses by management to the recommendations made by Internal Audit through associated reviews.

f) Received assurance around the Trust's Clinical Audit function.

g) Received assurance in relation to the Trust's processes for managing litigation and inquests in addition to progressing any actions arising from litigation.

h) Maintained oversight of the Trust's schedule of losses and compensations.

i) Maintained oversight and scrutiny of the Trust's Tender Waiver Register.

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j) Received and considered the implications of ISA 540: accounting estimates and the potential implications for Audit Committee members and the Trust Board.

k) Reviewed the lessons learned and action plan that resulted from the challenges experienced during the External Audit and year-end process for 2019-20.

6. Reports to the Trust Board

6.1 The Chair of the Audit Committee provides a Chair Report to Trust Board following every meeting. During the period reviewed, the Audit Committee alerted the Trust Board to the following issues/challenges:

a) MIAA Internal Audit Report: Medical Devices (IM&T focus)

b) Delays incurred in the completion of the External Audit work

c) Schedule of outstanding debt (July 2020)

6.2 The Audit Committee also provided assurance via the Chair's Report to Board in relation to the following:

a) Head of Internal Audit Opinion

b) Progress against the Audit Tacker

c) Progress against the Board Assurance Framework

d) Anti-Fraud Annual Report and the content thereof

e) Processes in place to manage litigation and inquests

6.3 In addition, the Audit Committee has received annual reports from the Performance Committee and Quality Committee and was assured that both Committees have fulfilled their respective Terms of Reference during 2020-21.

7. Conclusion

7.1 As the predominant governance committee of the Trust Board, the Audit Committee maintained its independence from operational management throughout the period of review by not including management within the membership with voting rights.

7.2 The Audit Committee has maintained an open and professional relationship with both Internal and External Audit and the Anti-Fraud Service.

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7.3 The Chair of the Audit Committee concludes that the Committee has fulfilled its role in accordance with its approved Terms of Reference and alerted the Board to matters requiring escalation in addition to providing assurance where necessary and relevant.

7.4 The Audit Committee members would like to thank all those who have contributed to the work of the Audit Committee throughout the year.

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Report to:	Trust Board
Date of meeting:	28/07/2021
Agenda item:	P1-118-21
Title:	Patient Experience Visits 12.07.2021
Report prepared by:	Stephen Sanderson, Governor and Kirsteen Scowcroft, Head of Patient Experience and Inclusion
Executive Lead:	Joan Spencer, Director of Operations and Interim Director of Nursing
Status of the report: (please tick)	Public ☒ Private ☐

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

Purpose of the paper/key points for discussion:	The purpose of this report is to provide Trust Board with oversight and a summary of the recent NED & Governor Patient Experience visit conducted on the 12th July 2021 at CCC Liverpool.

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

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

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

☐ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☒ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

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☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

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Patient Experience Visits 12.07.2021

Stephen Sanderson, Governor
Kirsteen Scowcroft, Head of Patient Experience and Inclusion

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

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1. Summary

Patient Experience 'rounds' were conducted on the 12th July 2021. Visiting level 6 chemotherapy unit, ward 4, M2 main entrance and M3 radiotherapy at CCC Liverpool site. Due to the recent Covid restrictions across all CCC sites to reduce footfall and visitors announced on the 16th June 2021. Stephen Sanderson, Governor, was able to accompany the Head of Patient Experience virtually on this occasion as scheduled.

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

2. Key Findings and Observations

- Two patients were receiving chemotherapy on Level 6, both patients for the first time at CCCL and one patient who was accompanied by a relative who had driven from Hull. Both patients first impressions were that the hospital was clean and the staff very caring. Thank you to Sarah and Josie working on the unit who took the time to speak to us, and shared that because of the spacious layout and nurses station in the middle, it is easier to view all patients being cared for.
- On ward 4 we spoke to the matron, Pris, and Vicky and Sheila nursing staff. They explained that it had been busy recently and staffing of the rota was proving a challenge, due to staff either having to self-isolate, due to being contacted by NHS Track and Trace and staff on scheduled annual leave.
- Two patients on ward 4 shared their experiences, one patient hoping to have good news to be able to go home, but their stay had been made better by a bit of normality at the weekend watching the Euro finals match in the social space made special by the staff.
- The other patient on ward 4 was hoping to commence treatment. This patient raised an issue relating to the temperature control in the bedrooms as at times it was cold however room temperature controls didn't seem to make a difference, ward staff were kind enough to provide blankets. In addition, this patient was delighted at the vast difference and improvement to their environment of care compared to their inpatient stay at the neighbouring trust. Stating that the food was better, despite it being provided by the same kitchen and ISS (and wondered why this would be – what are CCC doing differently), having a single room was luxury, however they did share that this added to their loneliness especially whilst family are unable to visit and what mattered to the patient was ward staff improving communication about next steps with the patients about their care and treatment plans stating "it may be routine for the ward staff, but it's not routine for me and it's a big deal". The patient asked at the nurse's station on Friday to find out more about their treatment plans the Doctor had

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visited whilst the patient was receiving diagnostic tests elsewhere in the hospital building. The Doctor had hoped to discuss and include the patient in their update on treatment plans, however as the patient was receiving diagnostic tests this shared decision making discussion with the patient did not take place. Resulting in the patient taking the initiative themselves to ask the ward staff at the nurses station, so they were not feeling anxious and worrying unnecessarily over the weekend. The patient added that they could not fault the attentive care they had received from all the staff on ward 4.

- The other patient settings visited were M3 Radiotherapy and M2 main entrance to speak to the volunteers Sue and Jess, who we observed meeting and greeting patients upon arrival and safely taking them to the correct floor for their appointment.

3. Next Steps and Recommendations

- Discuss report findings at Trust Board
- Note content of report
- Acknowledge the need for further action to share observations based on the feedback received with relevant Divisional leaders and teams
- Request further updates as required

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Board of Directors:	Board of Directors
Date of meeting:	Wednesday, 28th July 2021
Agenda item:	
Title:	Integrated Performance Report M3 2021/2022
Report prepared by:	Hannah Gray: Head of Performance and Planning
Executive Lead:	Joan Spencer: Chief Operating Officer / Interim Chief Nurse
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Performance Committee / Quality Committee
Date & decision:	Wednesday 21st July 2021 / Thursday, 22nd July 2021

Purpose of the paper/key points for discussion:	This report provides the Board of Directors with an update on performance for month three 2021/22 (June 2021). The access, efficiency, quality, research and innovation, workforce and finance scorecards are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant. Further detail then follows in each section, including full actions in place. The new NHS System Oversight Framework metrics applicable to CCC are presented for information. A proposal for the reporting of these metrics (including existing reporting) will be included in the M4 IPR. Points for discussion include under performance, developments and key actions for improvement.

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

Next steps required:	

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

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BAF Risk	Please select
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☒ BE **A GREAT PLACE TO WORK**

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

☒ BE **DIGITAL**

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

☒ BE **INNOVATIVE**

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

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

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

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Integrated Performance Report (Month 3 2021/22)

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

Introduction

This report provides an update on performance for month three; June 2021. The access, efficiency, quality, workforce, research and innovation, and finance scorecards are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant. Further detail then follows in each section, including full actions in place.

As described in section 3.5.8, NHSE/I has expanded the Staff Friends and Family Test from the two questions on 'place to work' and 'treatment and care', to feature nine engagement theme questions. The Trust is currently reviewing its reporting arrangements for the new survey, including within the IPR. The first survey is taking place in July 2021 and the results will be reported in the M4 IPR.

The new NHS System Oversight Framework was issued by NHS England and NHS Improvement on 25th June 2021. This Framework includes a set of oversight metrics, monitored at ICSs, CCGs and / or Trust level. These metrics will be used by NHS England and NHS Improvement and ICSs to flag potential issues and prompt further investigation of support needs with ICSs, place-based systems and/or individual Trusts and commissioners.

The following table presents all SOF metrics which are applicable to CCC. Detail regarding methodology and targets has not yet been published for all metrics. For any metrics not currently reported, we will ensure the data is captured and reported as appropriate through existing governance structures, including via the IPR to Performance Committee and Quality Committee and to Trust Board. A proposal for the reporting of these metrics (including existing reporting) will be included in the M4 IPR.

NHS System Oversight Framework Metrics: Applicable to CCC

NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
Oversight Theme: Quality, access and outcomes					
Restoration of elective and cancer services*	Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services	Elective activity levels	✓	✓	✓
		Overall size of the waiting list	✓	✓	✓
		Patients waiting more than 52 weeks to start consultant-led treatment	✓	✓	✓
	Restore full operation of all cancer services	Cancer referral treatment levels	✓	✓	✓
		People waiting longer than 62 days	✓	✓	✓
		% meeting faster diagnosis standard	✓	✓	✓
	Maximise diagnostic activity focused on patients of highest clinical priority	Diagnostic activity levels	✓	✓	✓
Improve cancer outcomes: early diagnosis and survival		Proportion of people who survive cancer for at least 1 year after diagnosis	✓		✓
		Proportion of cancers diagnosed at stages 1 or 2	✓		✓
Outpatient reform: avoidance of up to a third of outpatient appointments	Embed outpatient transformation	Advice and guidance and patient initiated follow-up activity levels	✓	✓	✓
Implementation of agreed waiting times		% of all outpatient activity delivered remotely via telephone or video consultation	✓	✓	✓
Delivering safe, high quality care overall		Summary hospital-level mortality indicator		✓	
		Overall CQC rating (provision of high-quality care)		✓	
		Acting to improve safety (safety culture theme in NHS Staff survey)		✓	
		Potential under-reporting of patient safety incidents		✓	
		National Patient Safety Alerts not completed by deadline		✓	
		Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia infection rate		✓	
		Clostridium difficile infection rate		✓	
		E. coli bloodstream infections	✓	✓	✓
		Venous thromboembolism (VTE) risk assessment		✓	
Oversight Theme: Preventing ill health and reducing inequalities					
Reducing Inequalities	Restoring NHS services inclusively	Ethnicity and most deprived quintile proportions across service restoration and NHS Long Term Plan metrics	✓	✓	✓
	Ensuring datasets are complete and timely	Proportions of patient activities with an ethnicity code	✓	✓	✓
Oversight Theme: Leadership and capability					
Leadership		Quality of leadership†	✓	✓	✓
		Aggregate score for NHS Staff Survey questions that measure perception of leadership culture††	✓	✓	✓

NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
Oversight Theme: People					
People Promise	Supporting the health and wellbeing of staff and taking action on recruitment and retention	People promise index††	✓	✓	✓
Looking after our people		Health and wellbeing index††	✓	✓	✓
		Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (a) managers, (b) other colleagues, (c) patients/ service users, their relatives or other members of the public in the last 12 months	✓	✓	✓
		Proportion of people who report that in the last three months they have come to work despite not feeling well enough to perform their duties	✓	✓	✓
		Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns	✓	✓	✓
		% of jobs advertised as flexible	✓	✓	✓
		Staff retention rate (all staff)	✓	✓	✓
		Sickness absence (working days lost to sickness)	✓	✓	✓
		Proportion of staff who say they have a positive experience of engagement	✓	✓	✓
		Number of people working in the NHS who have had a 'flu vaccination	✓	✓	✓
Belonging in the NHS		Proportion of staff in senior leadership roles who are (a) from a BME background, (b) women	✓	✓	✓
		Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	✓	✓	✓
Oversight Theme: Finance and use of resources					
The NHS will return to financial balance: NHS in overall financial balance each year	Systems to manage within financial envelopes	Performance against financial plan	✓	✓	✓
		Underlying financial position	✓	✓	✓
		Run rate expenditure	✓	✓	✓
		Overall trend in reported financial position	✓	✓	✓

Note: This list may be updated in year to reflect planning guidance for the second half of the year.
* A response to the consultation to the UEC clinically-led review of standards will be published in due course.
** We will also monitor delivery against the other priorities set out in the planning guidance, including progress against implementing the immediate and essential actions from the Ockenden report.
† Based on CQC leadership rating for trusts and GP practices, and NHS England and NHS Improvement assessment for CCGs and ICSs.
†† Metric under development

NB: the SHMI is not used for some specialist Trusts, including CCC. We have developed in house methods to monitor mortality.

1. Performance Scorecards

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

1.1 Access

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Jun-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
L	**7 days** from referral to first appointment	↑	G: ≥90% A: 80-89.9% R: <85%	86.6%	85.6%	
C/S	**2 week wait** from GP referral to 1st appointment	↔	93%	100%	100%	
L	**24 days** from referral to first treatment	↔	G: ≥85% A: 80-84.9% R: <80%	92.0%	88.7%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	↑	75% (shadow monitoring)	87.5%	81.8%	
S	**31 day** wait from diagnosis to first treatment	↔	96%	99.6%	99.3%	
C/S	**31 day** wait for subsequent treatment (Drugs)	↔	98%	98.8%	99.0%	
C/S	**31 day** wait for subsequent treatment (Radiotherapy)	↔	94%	97.8%	97.4%	
S	Number of **31 day** patients treated **≥ day 73**	↔	0	0	0	
C/S	**62 Day** wait from GP referral to treatment	↔	85%	91.8%	89.9%	
C/S	**62 Day** wait from screening to treatment	↔	90%	100.0%	100.0%	
L	Number of patients treated between **63 and 103 days** (inclusive)	↓	No Target	35	109	
S	Number of patients treated => **104 days**	↓	No Target	7	34	
L	Number of patients treated => **104 days AND at CCC for over 24 days (Avoidable)**	↑	G: 0 A: 1 R: >1	2	2	
C/S	Diagnostics: **6 Week Wait**	↔	99%	100%	100%	
C/S	**18 weeks** from referral to treatment (RTT) Incomplete Pathways	↔	92%	98.8%	98.6%	

Notes:

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

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

Cheshire and Merseyside Cancer Waiting Times Performance:

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	May-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Liz Bishop, CMCA SRO						
C/S	**2 week wait** from GP referral to 1st appointment	↔	93%	92.2%	91.0%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	↑	75% (shadow monitoring)	76.0%	74.3%	
C/S	**62 Day** wait from GP referral to treatment	↔	85%	76.9%	77.9%	

1.2 Efficiency

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Jun-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
S	Length of Stay: Elective (days): Solid Tumour	⟷	G: ≤6.5 A: 6.5-6.8 R: >6.8	4	5.9	
S	Length of Stay: Emergency (days): Solid Tumour	↑	G: ≤8 A: 8.1-8.4 R: >8.4	8.4	7.2	
S	Length of Stay: Elective (days): HO Ward 4	⟷	G: ≤21 A: 21.1-22.1 R: >22.1	10.3	13.5	
S	Length of Stay: Emergency (days): HO Ward 4	⟷	G: ≤22 A: 22.1-23.1 R: >23.1	8.5	11	
S	Length of Stay: Elective (days): HO Ward 5	⟷	G: ≤32 A: 32.1-33.6 R: >33.6	24.9	20	
S	Length of Stay: Emergency (days): HO Ward 5	⟷	G: ≤46 A: 46.1-48.3 R: >48.3	14.8	12.4	
S	Delayed Transfers of Care as % of occupied bed days (now CCC)	↑	≤3.5%	4.3%	2.7%	
S	Bed Occupancy: Midnight (Ward 4: HO)	↑	G: ≥85% A: 81-84.9% R: <81%	89.5%	84.3%	
S	Bed Occupancy: Midnight (Ward 5: HO)	⟷	G: ≥80% A: 76-79.9% R: <76%	72.7%	63.9%	
S	Bed Occupancy: Midday (Solid Tumour)	⟷	G: ≥85% A: 81-84.9% R: <81%	72.1%	77.9%	
S	Bed Occupancy: Midnight (Solid Tumour)	⟷	G: ≥85% A: 81-84.9% R: <81%	74.8%	72.8%	
C/S	% of elective procedures cancelled on or after the day of admission	⟷	0%	0%	0%	0% for all months
C/S	% of cancelled elective procedures (on or after the day of admission) rebooked within 28 days of cancellation	⟷	100%	None cancelled	None cancelled	No elective procedures have been cancelled on or after the day of admission
C/S	% of urgent operations cancelled for a second time	⟷	0%	0%	0%	0% for all months
L	Imaging Reporting: Inpatients (within 24hrs)	⟷	G: ≥90% A: 80-89.9% R: <80%	97.3%	97.9%	
L	Imaging Reporting: Outpatients (within 7 days)	⟷	G: ≥90% A: 80-89.9% R: <80%	85.5%	84.0%	
C/Phase 3 Covid-19 Guidance	Data Quality - % Ethnicity that is complete (or patient declined to answer)	⟷	100%	98.2%	97.2%	
C	Data Quality - % of outpatients with an outcome	⟷	G: ≥95% A: 90-94.9% R: <90%	96.2%	96.4%	
C	Data Quality - % of outpatients with an attend status	⟷	G: ≥95% A: 90-94.9% R: <90%	96.1%	96.6%	
Executive Director Lead: James Thomson, Director of Finance						
S	Percentage of Subject Access Requests responded to within 1 month	⟷	100%	100%	100%	
C	% of overdue ISN (Information Standard Notices)	⟷	0%	0%	0%	0% for all months

1.3 Quality

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Jun-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
C/S	Never Events	⇔	0	0	0	0 for all months
C/S	Serious Untoward Incidents (month reported to STEIS)	↓	0	0	3	
C/S	Serious Untoward Incidents: % submitted within 60 working days / agreed timescales	⇔	100%	0 requiring submission	100%	
S	RIDDOR - number of reportable incidents	⇔	0	0	1	
S	Significant accidental or unintended exposure (SAUE); Radiotherapy delivered dose or Radiotherapy geographical miss - Treatment Errors	⇔	G: ≤3 A: 4-5 R: >5	0	0	
S	Significant accidental or unintended exposure (SAUE); Radiotherapy delivered dose or Radiotherapy geographical miss - Imaging Errors	⇔	G: ≤8 A: 9-12 R: >12	1	1	
S	Incidents /1,000 Bed Days	↓	No target	201.1	210.54	
L	Incidents resulting in harm /1,000 bed days	↓	No target	21	21	
C/S	Inpatient Falls resulting in harm due to lapse in care	⇔	0	0	0	0 for all months
S	Inpatient falls resulting in harm due to lapse in care /1,000 bed days	⇔	0	0	0	0 for all months
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care)	⇔	0	0	0	0 for all months
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care) /1,000 bed days	⇔	0	0	0	0 for all months
S	Consultant Review within 14 hours (emergency admissions)	⇔	90%	98.1%	98.1%	
C/S	% of Sepsis patients being given IV antibiotics within an hour*	⇔	90%	94.0%	96.0%	
C/S	VTE Risk Assessment	⇔	95%	93.0%	94.0%	
S	Dementia: Percentage to whom case finding is applied	⇔	90%	100.0%	98.0%	
S	Dementia: Percentage with a diagnostic assessment	-	90%	No patients	N/A	
S	Dementia: Percentage of cases referred	-	90%	No patients	N/A	No patients were referred
C/S	Clostridiodes difficile infections (attributable)	⇔	≤4 (pr yr)	1	4	
C/S	E Coli (attributable)	⇔	G: ≤9, A: 10 R: >10 (pr yr)	2	3	
C/S	MRSA infections (attributable)	⇔	0	0	0	0 for all months
C/S	MSSA bacteraemia (attributable)	⇔	G: ≤4, A: 5 R: >5 (pr yr)	0	0	
C	Klebsiella (attributable)	↑	G: ≤9, A: 10 R: >10 (pr yr)	1	2	
C	Pseudomonas (attributable)	⇔	G: ≤4, A: 5 R: >5 (pr yr)	0	0	
C/S	FFT score (% positive)	⇔	G: ≥95% A: 90-94.9% R: <90%	96%	96%	

The Quality KPI scorecard continues on page 7

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	J	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
C	Number of formal complaints received	↑	No target	6	13	
S	Number of formal complaints / count of WTE staff (ratio)	↑	No target	0.004	0.003	
C	% of formal complaints acknowledged within 3 working days	↑	100%	100%	92%	
L	% of routine formal complaints resolved in month, which were resolved within 25 working days	↑	G: ≥75% A: 65-74.9% R: <65%	100%	50%	
L	% of complex formal complaints resolved in month, which were resolved within 60 working days	↔	G: ≥75% A: 65-74.9% R: <65%	100%	100%	
C/S	% of FOIs responded to within 20 days	↔	100%	100%	100%	
C/S	Number of IG incidents escalated to ICO	↔	0	0	0	0 for all months
C	NICE Guidance: % of guidance compliant	↔	G: ≥90% A: 85-89.9% R: <85%	95%	94%	
L	Number of policies due to go out of date in 3 months	↓	No target	16	N/A	
L	% of policies in date	↔	G: ≥95% A: 93.1-94.9% R: <93%	97%	96%	
C/S	NHS E/I Patient Safety Alerts: number not implemented within set timescale.	↔	0	0	0	0 for all months

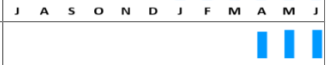
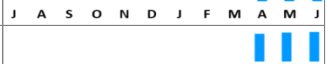
NB: blue arrows (and bars) are included for KPIs with no target and show the movement from last month's figure.
The C diff target is subject to change, as these have not yet been agreed with Commissioners for 2021/22
*Sepsis data is subject to change following final validation.
The NHS complaints process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

1.4 Research and Innovation

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Jun-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Sheena Khanduri, Medical Director						
L (Strategy)	Study recruitment	↔	G: ≥1300 A: 1100-1299 R: <1100 (pr yr)	44	156	
National	Study set up times (days)	-	≤40 days	N/A	N/A	Latest reporting period is Q2 2020/21: median = 34 days
L (Strategy)	Recruitment to time and target	-	G: ≥55% A: 45-54.9% R: <45%	N/A	N/A	Latest reporting period is Q2 2020/21: 60%
L (Strategy)	Studies Opened	↔	G: ≥52 A: 45-51 R: <45 (pr yr)	3	7	
L (Strategy)	Publications	↑	G: ≥130 A: 110-129 R: <110 (pr yr)	10	23	

1.5 Workforce

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Jun-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Jayne Shaw, Director of Workforce and Organisational Development						
S	Staff Sickness Absence	⟷	G: ≤4% A: 4.1-4.9% R: ≥5%	4.88%	4.20%	
S	Staff Turnover*	↑	G: ≤1.2% A: 1.21–1.24% R: ≥1.25%	1.22%	4.01%	
S	Statutory and Mandatory Training	⟷	G: ≥90% A: 75-89% R: ≤75%	96.25%	N/A	
L	PADR rate	⟷	G: ≥95% A: 75-94.9% R: ≤74%	86.39%	N/A	
S	FFT staff: Recommend as a place to work (Quarterly survey)	-	G: ≥95% A: 90-94.9% R: ≤90%	N/A	N/A	CCC's survey schedule has been amended due to national changes to the Staff FFT survey. The next survey results will be reported in the M4 IPR.
S	FFT staff: Recommend care and treatment (Quarterly survey)	-	G: ≥95%, A: 90 - 94.9%, R: ≤90%	N/A	N/A	CCC's survey schedule has been amended due to national changes to the Staff FFT survey. The next survey results will be reported in the M4 IPR.
L	% of Staff who have had the **first** dose Covid-19 vaccination (at month end)	↑	No national target	93.2%	N/A	
L	% of BAME Staff who have had the **first** dose Covid-19 vaccination (at month end)	↑	No national target	91.5%	N/A	
L	% of Staff who have had the **first** dose Covid-19 vaccination or have refused the vaccination (at month end)	↑	No national target	96.0%	N/A	
L	% of BAME Staff who have had the **first** dose Covid-19 vaccination or have refused the vaccination (at month end)	↑	No national target	94.3%	N/A	
L	Covid-19 vaccinations: **Second** dose received as % of first dose received (at month end)	↑	No national target	96.7%	N/A	
L	Covid-19 vaccinations: BAME staff, **Second** dose received as % of first dose received (at month end)	↑	No national target	95.9%	N/A	

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

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

1.6 Finance

For key financial headlines for June 2021 are:

Metric	In Mth 3 Actual	In Mth 3 Plan*	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit) (£000)	44	0	44		77	0	77	
CPL/Propcare Surplus/ (Deficit) (£000)	7	0	7		241	0	241	
Control Total Surplus/ (Deficit) (£000)	51	0	51		318	0	318	
Group Cash holding (£000)	56,290	59,688	(3,398)		56,290	59,688	(3,398)	
Capital Expenditure (£000)	39	156	117		65	156	91	

For 2021/22 the Cheshire and Merseyside ICS are managing the required financial position of each Trust through a whole system approach. The requirement for the Trust for the first six months of the year (H1) is to achieve a break-even position.

2. Exception Reports

2.1 Access

7 days from referral to first appointment	Target	June 21	YTD	Last 12 Months
	G: ≥90% A: 85-89.9% R: <85%	86.6%	85.6%	

Reason for non-compliance

19 Patients breached the Trust's internal 7-day target in June; This was mainly due to capacity issues within the urology team and consultant availability. 14 of the 19 patients were seen within 8-9 days. None of the 19 patients breached 24 days or the 62 day target.

Action taken to improve compliance

The Business Intelligence Team have been working with Admin Services to understand the capacity and demand for first appointments. This piece of work has been included in a new online dashboard that is due for release in July. This new outpatient dashboard will include slot utilisation for all outpatient clinics as well as other key data that will be used for planning and monitoring outpatient activity.

The Admin Services Team continue to work closely with the Divisions; escalating patients appropriately.

A Cancer Waiting Times report (which includes the 7-Day performance) is shared with the SRG leads and Divisions each week to highlight issues for them to address within their teams.

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

Number of patients treated ≥104 days AND at CCC for over 24 days (Avoidable breaches)	Target	June 21	YTD	Last 12 Months
	G: 0 A: 1 R: >1	2	2	

Reason for non-compliance

2 patients breached the target in June 2021. As the patients were not treated within 24 days, they are classed as half breaches against the 62-day standard.

The reasons for the breaches are as follows. Patient reference numbers align to those used in the breach details table in section 3.1.1.

Patient 2 – Delay to first appointment due to capacity over the May Bank Holiday (107 days at referring Trust and 33 at CCC).
Patient 3 – Slight delay to first appointment, patient required a planning scan and was a CAT 1 patient, which means they need to start their treatment on a Monday (84 days at referring Trust and 26 at CCC).

Action taken to improve compliance

The Business Intelligence Team have been working with Admin Services to understand the capacity and demand for first appointments. This piece of work has been included in a new online dashboard that is due for release in July. This new outpatient dashboard will include slot utilisation for all outpatient clinics as well as other key data that will be used for planning and monitoring outpatient activity.

The Admin Services Team continue to work closely with the Divisions; escalating patients appropriately.

A Cancer Waiting Times report (which includes the 7-Day performance) is shared with the SRG Leads and Divisions each week to highlight issues for them to address within their teams.

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

2 week wait from GP referral to 1st appointment (Alliance-level)	Target	May 21	YTD	Last 12 Months
	93%	92.2%	91%	

Reason for non-compliance

Non-compliance with the 14 day standard in May 2021 was largely driven by underperformance in the following tumour groups:

- Suspected breast cancer 81.2% (405 breaches),
- Exhibited (non-cancer) breast symptoms - cancer not initially suspected 81.9% (100 breaches),
- Suspected gynaecological cancer 89.5% (112 breaches),
- Suspected lower gastrointestinal cancer 91.5% (179 breaches),
- Suspected upper gastrointestinal cancer 91.8% (86 breaches).

Providers not achieving the national standard were:

- East Cheshire 62.6% (214 breaches),
- Countess of Chester Hospital 79.7% (207 breaches),
- Southport and Ormskirk Hospital 85.7% (134 breaches),
- St Helens and Knowsley Hospitals 90% (176 breaches).

Outpatient capacity issues were recorded as the most frequent breach reason (69%), followed by patient choice (21%).

TWW referral rates were exceptionally high in May, being 20% above pre-pandemic levels.

Action Taken to improve compliance

- Additional consultant recruitment at CoCH (breast)
- The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group to identify areas of service pressure.
- £600,000 investment to support full implementation of symptomatic faecal immunochemical testing (sFIT) in primary care. This builds on the existing secondary care sFIT model. Implementation will reduce demand for endoscopy services.
- Patient and public communications to improve patient confidence to attend for appointments.
- 2ww referrals are now back to pre-pandemic levels

Expected date of compliance	Compliance with the 14 day standard is expected in to return by the end of Q2 2021/22.
Escalation route	NHS England, North West CCC Performance Committee, Trust Board
Executive Lead	Liz Bishop, CMCA SRO

62 Cancer Standard (Alliance-level)	Target	May 21	YTD	Last 12 Months
	85%	76.9%	77.9%	

Reason for non-compliance

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

- Gynaecological 31.5% (25 breaches),
- Other 40% (3 breaches),
- Haematological (Excluding Acute Leukaemia) 51.4% (8.5 breaches),
- Lower Gastrointestinal 55.7% (35 breaches),
- Sarcoma 60% (2 breaches),
- Head & Neck 64.7% (9 breaches),
- Upper Gastrointestinal 72.2% (10 breaches),
- Urological (Excluding Testicular) 72.8% (34 breaches),
- Lung 73.6% (14 breaches).

Providers not achieving the national standard were:

- Liverpool Womens 20% (8 breaches),
- East Cheshire 56.9% (14 breaches),
- Warrington and Halton Teaching Hospitals 64.1% (21 breaches),
- Countess Of Chester Hospital 71.9% (22.5 breaches),
- Liverpool University Hospitals 72.1% (30 breaches),
- Southport and Ormskirk Hospital 73% (15.5 breaches),
- Bridgewater Community Healthcare 83.3% (2 breaches),
- Wirral University Teaching Hospital 84.1% (14.5 breaches),
- Mid Cheshire Hospitals 84.1% (13 breaches).

The main reasons for breaches were complex diagnostic pathways (19%), healthcare provider initiated delay to diagnostic test or treatment planning (19%) and ‘other’ (33%).

Action Taken to improve compliance

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

• Additional £1m secured to accelerate recovery especially in lower GI pathways	
Expected date of compliance	Compliance with the 62 day standard is expected in Q3 2021/2022.
Escalation route	NHS England, North West CCC Performance Committee, Trust Board
Executive Lead	Liz Bishop, CMCA SRO

2.2 Efficiency

Length of Stay: Non-Elective Solid Tumour (days)	**Target**	**June 21**	**YTD**	**Last 12 Months**
	G: ≤8 A: 8.1-8.4 R: >8.4	8.4	7.2	

Reason for non-compliance

Length of stay (LoS) for non-elective ST admissions was 0.4 days above target at 8.4 days. The median is 7 days and the longest is 48 days.

There was a 52 % increase in DTOC (delayed transfers of care) from May, to 14 DTOC in June. The discharge delay reasons include:

- Repatriation to a local Acute Trust
- Awaiting Hospice, Intermediate care and Nursing Home placements
- Continual Healthcare funded Packages of Care at home

All delays are monitored by the Acute Care Division and any emerging trends are identified.

Action taken to improve compliance

- Working with wider MDT to ensure patients are discharged in a prompt manner avoiding avoidable delays.
- Patient Flow coordinated boards rounds, attended by the wider multi-disciplinary team
- Weekly Longer length of stay meetings

Expected date of compliance	31/07/2021
Escalation route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Integrated Governance Committee, Quality Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

Delayed Transfers Of Care (DTOC) as % of occupied bed days	Target	June 21	YTD	Last 12 Months
	≥3.5%	4.3%	2.7%	

Reason for non-compliance

Delayed Transfers of Care (DTOC) as a % of occupied bed days was above the Trust target of 3.5%, with 4.3% reported this month.

14 patients had a DTOC in June. This affected both HO and ST patients. The delays totalled 84 days, with an average of 6.3 days. Delays were mainly due to patients awaiting fast track funded packages of care (POC) at home with 1 patient waiting 20 days in the Warrington area. 1 patient waited for 7 days for an intermediate care bed. COVID-19 continues to add pressure on hospices, with reduced bed capacity and some hospices closed to new admissions, resulting in delayed transfers of care from CCC.

COVID-19 has had an impact on community services, with some staff that provide POC at home having to isolate. This has resulted in delays to commission POC with care agencies.

Action Taken to improve compliance

- 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 Divisional Director for review.
- The Patient Flow Team (PFT) continue to work with the wider MDT to aid discharge planning during the COVID-19 pandemic, ensuring patients are discharged safely home or to a suitable care setting. Weekly complex discharge meetings occur with the MDT.
- Daily COW MDT meetings include a discussion of all inpatients, ensuring that there is a clear plan for each patient.
- The PFT leader and CCC Social Worker has met with local area Social Work team to identify their new way of working in response to the Government's hospital service discharge requirements and monthly engagement meetings continue.

Expected date of compliance	31/08/2021
Escalation route	Directorate Quality, Safety and Performance Meeting, Integrated Governance Committee, Divisional Performance Review Group, Quality Committee, Trust Board
Executive Lead	Joan Spencer: Chief Operating Officer / Interim Chief Nurse

Bed Occupancy	Wards	Target	June 21	YTD	Last 12 Months
	Solid Tumour (Midday)	G: ≥85% A: 81-84.9% R: <81%	72.1%	77.9%	
	Solid Tumour (Midnight)	G: ≥85% A: 81-84.9% R: <81%	74.8%	70.2%	
	Ward 4 (HO) (Midnight)	G: ≥85% A: 81-84.9% R: <81%	89.5%	84.3%	
	Ward 5 (HO) (Midnight)	G: ≥80% A: 76-79.9% R: <76%	72.7%	63.9%	

Reason for non-compliance

Bed occupancy for June 2021 remains below target for Solid Tumour (ST) wards and Ward 5 (Stem cell transplants). Ward 4 occupancy is above target for June 2021.

Reasons for below target bed occupancy include:

- The low numbers of transplants continue into June, with 3 again this month. This is due to protocol revision undertaken by the Stem Cell Director. The transplant activity is however increasing and this will be reflected in the Ward 5 occupancy figures for July 2021.
- Occupancy rates rose marginally for ST wards; this is likely to be due to the 100% occupancy of Ward 2 for 9 days when the ward was closed to new admissions due to a Covid-19 outbreak and the associated opening of 6 beds on Ward 3 to mitigate this fall in capacity.
- LUHFT have made no inpatient mutual aid referrals this month.

Proactive discharge planning by the Patient Flow Team and the wider MDT to ensure that patients are in the safest place for them during the COVID-19 pandemic.

The Trust has been predominantly on OPEL 1 (Green) during June 2021, however OPEL 3 has been recorded for the ST wards on 2 occasions and Haemato-oncology on 6 occasions. There were no occasions on which we were on OPEL 3 (Red) bed status across the whole trust.

The bed pressures from the Covid-19 pandemic have started to increase in DGHs; communication continues between Acute Oncology and the Patient Flow Team.

Action taken to improve compliance

- The Division is undertaking a piece of work with LUHFT in relation to outreach support to A&E and AMU (Acute Medical Unit) for early identification of patients who meet CCC admission requirements. Four work streams have now been identified; these include Patient flow between LUHFT and CCCL, AED Triage and AMAU outreach, LUHFT AO service and Weekend/24/7 emergency admission service provision across both organisations.
- The project to re-evaluate day case models of care is in progress and the Acute Care Division is working in collaboration with the Networked Services Division to review higher acuity day care, to identify the most appropriate place for this service provision; Ward 1 day care or inpatient wards.

Expected date of compliance	Q4 2021/22
Escalation route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Integrated Governance Committee, Quality Committee, Trust Board.
Executive lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

Radiology Reporting: Outpatients (within 7 days)	**Target**	**June 21**	**YTD**	**Last 12 Months**
	G: =>90% A: 80-89.9% R: <80%	85.5%	84.0 %	

Reason for non-compliance

The outpatient target has not been met, but compliance has improved marginally compared with April (83%) and May (84%), to 85.5% against a target of 90%. Reasons for failure to meet the target include:

- Activity levels in Radiology have increased, placing increasing demands on the Radiologist team.
- Loss of reporting capacity due to Radiologists supporting clinical services – Interventional Radiology and Ultra Sound.
- CCC Radiologists' planned and unplanned absence.
- Issues with the CRIS system interface between CCC and LUFHT, which are negatively affecting workflow and capacity in Radiology.

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

Action taken to improve compliance

- A business case has been approved to expand the workforce and extend the working day to increase capacity. In lieu of this, staff are working extra shifts to meet demand.
- On-going increased number of cases outsourced to Medica to improve the turnaround times for outpatient reports.
- One additional Radiologist has been recruited with a start date of September 2021.
- Radiologist recruited in December 2019 has been delayed further due to COVID.
- Bi-weekly activity report received by senior Radiology team to support clinical prioritisation.
- Clinical Imaging Fellow has been recruited, with a start date to be confirmed.
- CCC Digital team have reviewed the CRIS system interface between CCC and LUFHT to identify a solution to the issue. The Walton Centre are experiencing the same slowness. Virgin Media have identified a problem and have fixed a fault in the fibre cable for the Community of Interest network (COIN). CCC users are now seeing marked improvement. The Digital team will continue to monitor this.

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

Data Quality - % Ethnicity that is complete (or patient declined to answer)	**Target**	**June 21**	**YTD**	**Last 12 Months**
	G: 100% R: <100%	**98.2%**	**97.2%**	

Reason for non-compliance

Compliance remains just short of the 100% target, but is maintained at a high level. Gaps in the data continue to be filled by:

- Clerical staff calling patients to obtain this information ahead of appointments.
- Obtaining access to more host hospitals' systems, so that ethnicity information can be extracted from these.

Although additional recruitment of clerical staff has taken place, we are awaiting start dates and until these posts are filled, 100% compliance will remain challenging to achieve.

Action taken to improve compliance

- Work with WOD to expedite the start dates of clerical staff.
- A request has been made to the Somerset system providers to include ethnicity as a mandatory field. The inclusion of this will be reviewed during the next upgrade.

Expected date of compliance	31/08/21
Escalation route	Divisional Quality, Safety and Performance Meetings, Divisional Performance Reviews, Quality Committee, Trust Board.
Executive lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

2.3 Quality

VTE Risk Assessment	Target	June 21	YTD	Last 12 Months
	R: <95% G: ≤95%	93.20%	94.14%	

Reason for non-compliance:

June 2021 compliance was below target with 14 out of 206 patients not having an appropriate VTE risk assessment pro-forma completed within the 24-hour time frame.

Of those 14 patients, 11 patients did have a VTE risk assessment performed, however this was not within the 24-hour time frame.

Therefore 3 patients did not have a VTE risk assessment performed during their inpatient episode;

- Patient 1 – Patient was transferred from WUTH. The VTE risk assessment was not completed on admission however the patient was already prescribed VTE prophylaxis* which was continued on admission to CCC. No doses missed.
- Patient 2 – Patient was transferred from COCH for a single treatment of radiotherapy. The patient was planned to return to COCH on the same day, however the ambulance service was unable to transfer the patient back, so they were subsequently admitted overnight and returned to COCH the following day.
- Patient 3 – Patient admitted late afternoon, VTE risk assessment was not completed on admission, however VTE prophylaxis was prescribed and administered. The patient was transferred to LHCH the following day.

An in depth review of these 14 patients reveals that no patients developed a VTE at CCC and/or there were no concerns on discharge.

*For the patients who have already been prescribed prophylaxis, the assessment should still be completed as this guides medics to whether they need to prescribe prophylaxis or not, or whether the patient has contraindications.

Action taken to improve compliance:

- The fall in compliance has been escalated to Medical divisional leads, Matrons and Ward Managers.
- Compliance is monitored (and pro at both Divisional Quality, Safety and Performance meetings and Divisional Performance Reviews.
- Each missed assessment has been reviewed for further themes and trends.
- ANPs to continue supporting completion of assessment on weekends and bank holidays.
- Work continues on development of the ward status board to highlight missed assessments in real-time – planned go live September 2021.
- The Digital team are exploring the possibility of adding a prompt within Meditech, as a reminder for medical staff to complete the VTE risk assessment before prescribing VTE prophylaxis.

Expected Date of Compliance	August 2021

Escalation Route	Divisional Quality, Safety and Performance Meetings, LIRG, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Director Lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

Clostridioides difficile infections (attributable)	**Target**	**June 21**	**YTD**	**Last 12 Months**
	≤4 per year	**1**	**4**	

Reason for non-compliance

There was 1 attributable Clostridioides difficile infection (CDI) in June 2021. This takes the YTD total to 4, which is the Trust threshold for the year.

The patient was previously CDI positive 7 weeks earlier and was treated with fidaxomycin as per Trust policy. Recurrence of diarrhoea within 8 weeks of a positive sample does not require a specimen, but should be treated as a re-infection. According to national guidance, any infection identified 28 days after initial infection is classed as a new hospital acquired infection. A post infection review has been completed and is awaiting review by the antimicrobial pharmacist. An action plan will be sent to the clinical team when this review is complete.

Action taken to improve compliance

- Re-education regarding sampling continues to be rolled out due to previous failures to collect samples in a timely manner.
- Discussions with Commissioners are ongoing regarding the target of 4 per year, due to the susceptibility of our patients.

Expected date of compliance	1st August 2021
Escalation route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Quality, Safety and Performance Meetings, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

***Escherichia coli* infections (attributable)**	**Target**	**June 21**	**YTD**	**Last 12 Months**
	G: ≤9, A: 10 R: >10 (pr yr)	**2**	**3**	

Reason for non-compliance

There were 2 attributable E.coli difficile infections in June 2021.

There was no suspicion of sepsis on admission, however the patient became pyrexial 4 days after admission and blood cultures were then collected, which identified E.coli. and Klebsiella

pneumonia. Necrotising pancreatitis and toxic megacolon were present upon admission; this clinical picture and mixed bacteremia make it likely that the source was gastrointestinal/biliary. Following review, this was determined to be an unavoidable infection.

A second E.coli bacteremia was identified in a patient 3 days after admission. Following review by the Consultant Microbiologist, it was identified that this was likely due to gut translocation. No learning points were identified.

Action taken to improve compliance

- Following review, no learning points were identified from this episode of infection.

Expected date of compliance	August 2021
Escalation route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Quality, Safety and Performance Meetings, Divisional Performance Reviews, Quality Committee, Trust Board.
Executive lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

Klebsiella (attributable)	**Target**	**June 21**	**YTD**	**Last 12 Months**
	G: ≤9, A: 10 R: >10 (pr yr)	1	2	

Reason for non-compliance

There was 1 attributable Klebsiella infection in June 2021.

There was no suspicion of sepsis on admission, however the patient became pyrexial 4 days after admission and blood cultures were then collected, which identified E.coli. and Klebsiella pneumonia. Necrotising pancreatitis and toxic megacolon were present upon admission; this clinical picture and mixed bacteremia make it likely that the source was gastrointestinal/biliary. Following review, this was determined to be an unavoidable infection.

Action taken to improve compliance

- Following review, no learning points were identified from this episode of infection.

Expected Date of Compliance	August 2021
Escalation Route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board

Executive Director Lead	Joan Spencer, Chief Operating Officer / Interim Chief Nurse

2.4 Research and Innovation

Study Recruitment	**Target**	**June 21**	**YTD**	**Last 12 Months**
	G: ≥1300, A: 1100-1299, R: <1100 (per year)	**44**	**156**	

Reason for non-compliance

156 patients have been recruited against an internal target of 324 (48% of target) at the end of Month 3. The main reason at Month 3 for not achieving this target is:

- No new studies that use the Aseptic Service have opened since 5th March 2021. As of 9th July 2021, no new studies have opened for 18 weeks.

Action Taken to improve compliance

- Exploring Clinical Trial Pharmacy capacity with Interim Chief Pharmacist to allow new studies to open whilst not putting pressure on the system.
  - Costings for new trials has commenced.
  - Agreed with Interim Chief Pharmacist to progress studies requiring green light in parallel to study costings being completed. Anticipate opening these studies from July 2021.
- Agreed to open new studies requiring full Pharmacy review from September 2021 when the aseptic service is repatriated to CCC-L.
- Diversification of portfolio into real world, psychosocial, radiotherapy and nursing research studies.
- Secured funding and appointed a new Clinical Fellow, funded by the NWC CRN, to concentrate solely on recruitment to cancer portfolio clinical trials.
- Engaging with the SRG Research Leads to prioritise portfolios and identify which trials not requiring the aseptic facility can be opened.
- Recovery plan requested from Pharmacy to ensure capacity and capability is in place to open studies in-line with the above timelines.

Expected date of compliance	Q3 2021/22
Escalation route	SRG Research Leads, Committee for Research Strategy
Executive Lead	Sheena Khanduri, Medical Director

Studies opening to recruitment	Target	June 21	YTD	Last 12 Months
	G: ≥52 A: 45-51 R: <45 (per year)	3	7	

Reason for non-compliance

7 studies have opened to recruitment against an internal target of 13 at the end of Month 3 (54% of target). We have not met target for the following reasons:

- Since 5th March 2021 there has been a halt to opening new studies that use the Pharmacy Aseptic Service.
- CCC has issued local approval for eight additional studies, for which we are awaiting Sponsor Greenlight. If all had been greenlighted we would have opened 15 studies (115% of target at Month 3).

Action Taken to improve compliance

- Work with Interim Chief Pharmacist to start opening new studies that use the Aseptic Service.
- Work with the SRG Research Leads and the Network to optimise opportunities.
- Once capacity has been agreed with Pharmacy, work with Sponsors to greenlight studies where local approval has been given.

Expected date of compliance	Q3 2021/22
Escalation route	SRG Research Leads / Committee for Research Strategy
Executive Lead	Sheena Khanduri, Medical Director

Publications	Target	June 21	YTD	2021/22 trend
	G: ≥130 A: 110-129 R: <110 (per year)	10	23	

Reason for non-compliance

At the end of Month 3, twenty-three publications have been registered year to date, against an internal target of thirty-three (70% of target). There will be peaks and troughs with the number of publications throughout the year. This is dependent on journal review, journal publication and validation of outcome data. We would expect to see an increase around conference season.

Action Taken to improve compliance

- Work with the Library Services to ensure all publications are identified and reported.
- Work with the SRG Research Leads and academics to ensure the list is accurate.
- Encourage staff to submit publications as part of the 'Achievements' request that is sent out each month.

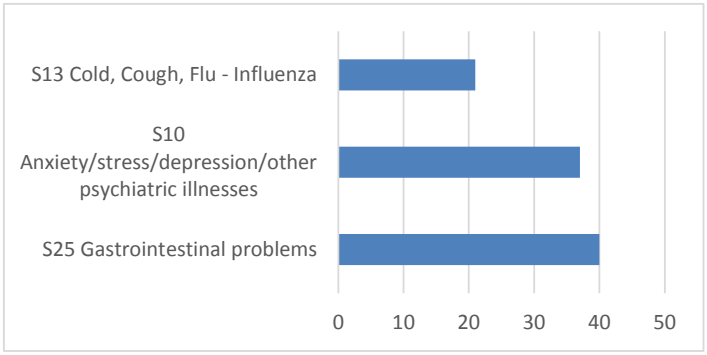
Expected date of compliance	Q3 2021/22
Escalation route	SRG Research Leads / Committee for Research Strategy
Executive Lead	Sheena Khanduri, Medical Director

2.5 Workforce

Sickness Absence	Target	June 21	YTD	Last 12 Months
	G: ≤4% A: 4.01– 4.99% R: ≥ 5%	4.88%	4.28%	

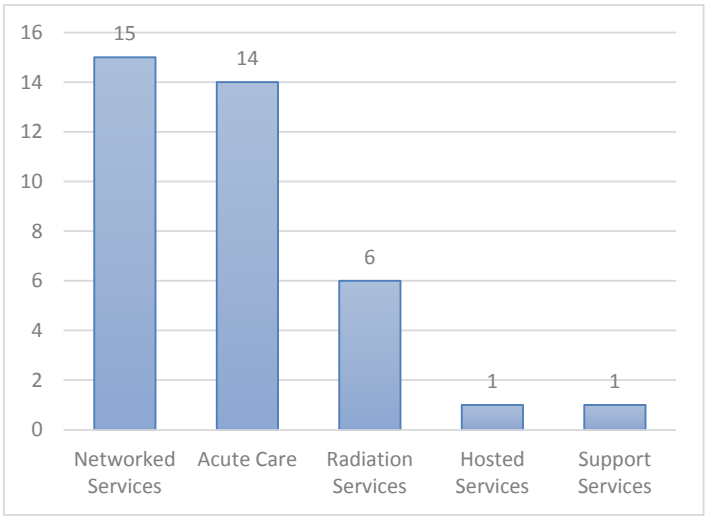
Reason for non-compliance

Absence has increased across the Trust from 4.16% to 4.88% in month.



This chart shows the top three reasons for sickness absence in June 2021.

- Gastrointestinal – 40
- Anxiety/ Stress/ Depression – 37
- Cold/ Cough/ Influenza - 21

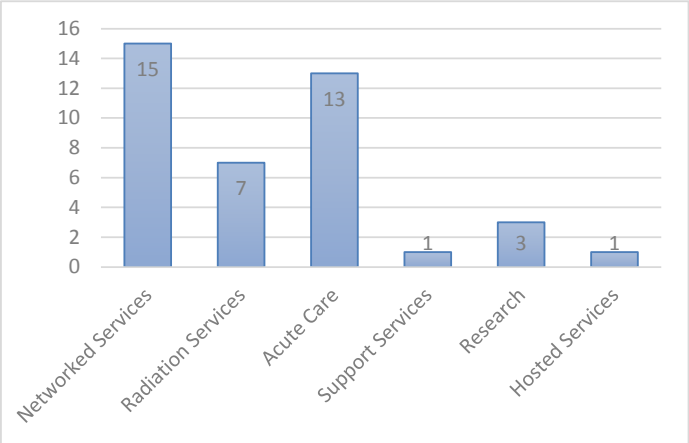


Anxiety/ Stress/ Depression

Absences due to anxiety/ stress/ depression have increased in June from 33 to 37. 22 of these absences were due to personal circumstances, 5 where due to work related reasons and 10 are unknown.

Networked Services Division experienced the highest number of stress related absences followed by Acute Care.

CBU3 Admin Services within Networked Services Division experienced the joint highest number of episodes with 8. CBU 5 Inpatient Care within the Acute Care Division experienced the joint highest number of episodes, also with 8.

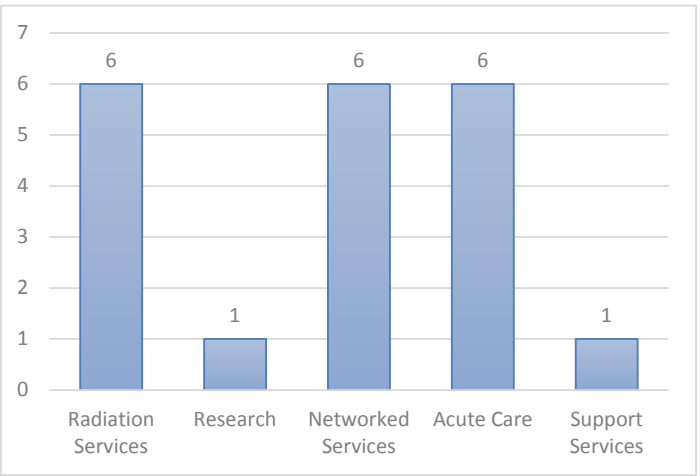


Gastrointestinal Problems

Gastrointestinal problems was the highest reason for absence in June with an increase of 22 episodes since May.

Networked Services experienced the highest number of episodes with 15 in total followed by Acute Care with 13.

Within Networked Services, CBU1 Day Care and Networked Services had the highest amount of episodes with 6. Within Acute Care, CBU5 Inpatient Care had the most occurrences with 10 episodes.



Cold/ Cough/ Influenza

Absences due to cold/ cough/ influenza have also increased in June from 16 to 21. Networked Services, Radiation Services and Acute Care all experienced the highest number of absences due to this reason with 6 in total.

Action taken to improve compliance

- A 12-month review of absence has recently taken place, which identified that Gastrointestinal Problems was the Trust's highest reason for absence, despite the pandemic. Further analysis is due to take place to understand this and explore if possible whether these absences can be avoided.
- HR Business Advisors continue to meet with departmental managers monthly to discuss sickness absence and explore ways to manage and support staff in order to improve compliance.
- All episodes of absence due to anxiety/stress/depression are reviewed monthly and staff members are managed and supported appropriately in order to facilitate a return to work.
- HR Business Advisors explore each month which members of staff are absent due to anxiety/stress/depression and whether it is due to work or personal related circumstances and ensure managers have sign posted to appropriate support mechanisms.
- The annual stress audit is currently underway, which explores absences due to work related stress over the last 12 months to identity if there has been an increase or decrease in stress related absences. The audit reviews how individuals have and continue to be supported in

the work place by their line manager and ensures that managers continue to follow Trust policy and process.

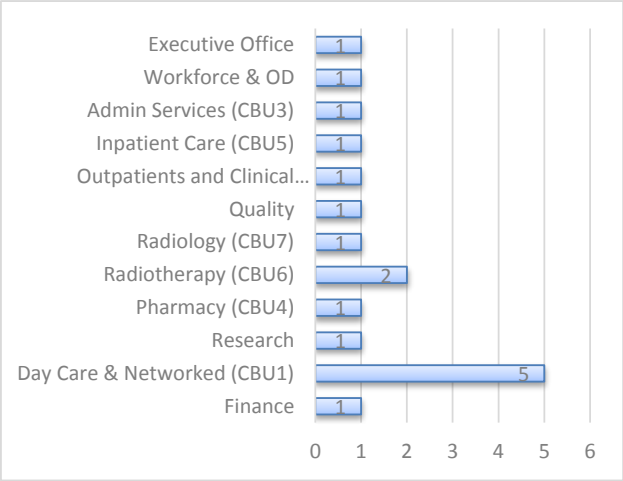
- Additional Mental Health First Aider (MHFA) Training took place in June 2021 in order to increase the pool of MHFA's who can offer support to staff experiencing anxiety/stress/depression and reduce the number of episodes of absence due to these reasons and help staff remain in work.

Expected date of compliance	September 2021
Escalation route	Divisional Quality, Safety and Performance Meetings, WOD Committee, Performance Review Meetings, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Staff Turnover	**Target**	**June 21**	**YTD**	**Last 12 Months**
	G: ≥1.2% A: 1.21 – 1.24% R: ≤1.25%	1.21%	4.01%	

Reason for non-compliance

The turnover for June is 0.1% over the Trust target, at 1.21%.



There were 20 leavers in June, an increase of 4 leavers since May.

CBU 1 Day Care and Networked Services had the highest number of leavers in the month with 5 in total followed by CBU 2 Outpatients and Clinical Support with 4.

Work life balance continues to be the Trust's highest reason for leaving, with 7 leavers in June. The area with the highest amount due to this reason was CBU 1 Day Care and Networked Services with 2 leavers.

Of the 20 leavers, 13 completed an Exit Questionnaire. This is a significant increase on last month's figure, in which just 3 people completed the survey. The factors cited as influencing their decision to leave included:

- Lack of career opportunities
- Work life balance
- Work load pressures
- The move to CCCL

- Values and culture
- Lack of equipment
- New career
- Relocation
- Education and training
- Car parking

6 of the leavers who completed an exit questionnaire left in their first year of employment, followed by 5 who left within 2-5 years.

Action taken to improve compliance

- Continue to encourage staff to complete exit interviews. HR Business Advisors and WOD Apprentice contact leavers personally when they are informed.
- Exit Interviews are reviewed monthly by the HR Business Partnering team to ensure that any concerns are addressed and improvements made.

- Temperature Check surveys are reviewed monthly by staff who have been in post for 3 and 9 months to ensure that any concerns that are raised are addressed in order to help retain staff and reduce the number of leavers in their first 12 months of employment.
- In line with the NHS People Plan, the HR Business Partnering Team plan to review the Trust's current approach to Flexible, Agile and Home working and launch more communications across the Trust about the positives of flexible and hybrid working in order to ensure managers understand the benefits. This piece of work will encourage and ensure that flexible working is being offered where appropriate in order to recruit and retain staff and see a decrease in the number of leavers due to Work Life Balance each month.

Expected date of compliance	December 2021
Escalation route	Divisional Quality, Safety and Performance Meetings, WOD Committee, Performance Review Meetings, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

PADR	**Target**	**June 21**	**Last 12 Months**
	G: ≥95% A: 75% - 94.9% R: ≤74%	86.39%	

Reason for non-compliance

Whilst PADR compliance is still underperforming against the target of 95%, there has been an in month increase of 4.13%

A full breakdown of performance as at 30th June is as follows:

Area	Reviews Completed %
158 CBU1 - Day Care & Network	88.15
158 CBU2 - Outpatients & Clinical Support	92.98
158 CBU3 - Admin Services	88.40
158 CBU4 - Pharmacy	70.69
158 CBU5 - Inpatient Care	81.28
158 CBU6 - Radiotherapy	83.43
158 CBU7 - Radiology Services	85.19
158 CBU8 - Physics	98.00
158 Cancer Alliance	89.47
158 Communications	100.00
158 Executive Office	83.33
158 Finance	85.71
158 Informatics & IT	83.10
158 Networked Leadership	90.91
158 Project Management Office	100.00
158 Quality	85.71
158 Recharges	93.33
158 Research & Innovation	95.45
158 Safeguarding	100.00
158 Service Improvement	100.00
158 Workforce & Organisational Development	96.77
Grand Total	86.39

As at 30th June 2021, there are 155 staff who are non-complaint for PADRs and a further 118 who are due to have a PADR during July. To support proactive management of PADRs, all divisions have been issued with detailed reports containing this information, alongside information on staff who are due PADRs in August, September and October.

At Performance Review Groups (PRG) in June, divisions were tasked with ensuring PADR compliance is achieved by 01st September 2021 and this will be managed and monitored via PRGs.

The L&OD Team will continue to work with divisions to support them in achieving compliance, but more importantly to ensure that all staff have a meaningful and purposeful annual appraisal conversation.

As highlighted in last month's exception report, changes to new starter PADR requirements have now been implemented. This will reduce duplication with the probationary processes and provide a more efficient and seamless approach for new starters and managers.

Issues relating to automated access to the e-PADR system for new starters have now also been resolved.

Action Taken to improve compliance

- Underperforming divisions to provide monthly updates and assurance that PADR compliance will be achieved by 1st September 2021. This will be managed by the Divisional Directors / Corporate Directors with processes reported to the PRGs in July and August.
- Divisional leads to provide assurance via PRGs that plans and processes are in place to ensure PADR compliance is proactively managed to ensure long term compliance is maintained
- L&OD to continue to provide bespoke monthly PADR compliance reports to divisions to enable effective management and planning of PADRs. These reports will be issued monthly and will detail the names of non-compliant staff, alongside the staff due to became non-compliant over the next 3 months.

Expected date of compliance	1st September 2021
Escalation route	Divisional Quality, Safety and Performance Meetings, Divisional Performance Reviews, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

3. Detailed Reports

3.1 Access

3.1.1 Cancer Waiting Times Standards: CCC Performance

Whilst the 7-day performance remains challenging, this has improved in June. A new online outpatient dashboard is due for release at the end of July; this will include slot utilisation for all outpatient activity including new and follow up appointments, which will help with planning capacity to meet demand.

Templates have been developed and shared with all SRG leads to support the recovery principles as the Trust plans for an increase in referrals following COVID.

A Trust wide Business case has been developed to support the increase in referrals. This is awaiting approval at Finance Committee in August. Ad hoc clinics have taken place to address capacity issues and prevent any delays to the patient pathway.

Outpatient clinic delivery remains split between virtual Telehealth clinics and face to face clinics across all peripheral sites.

The Business Manager for CBU 3 is working closely with the peripheral Trusts to ensure rooms are being utilised and service level agreements reflect the changes.

Delays with EGFR Mutation status tests being sent to Manchester continue. The Cancer Alliance is completing an audit to better understand the impact on the patient pathway. CCC have shared a number of examples where patients have experienced delays waiting for the results.

2 Week Wait

The 93% target has been achieved, with performance for June at 100%

28-day Faster Diagnosis Standard (FDS)

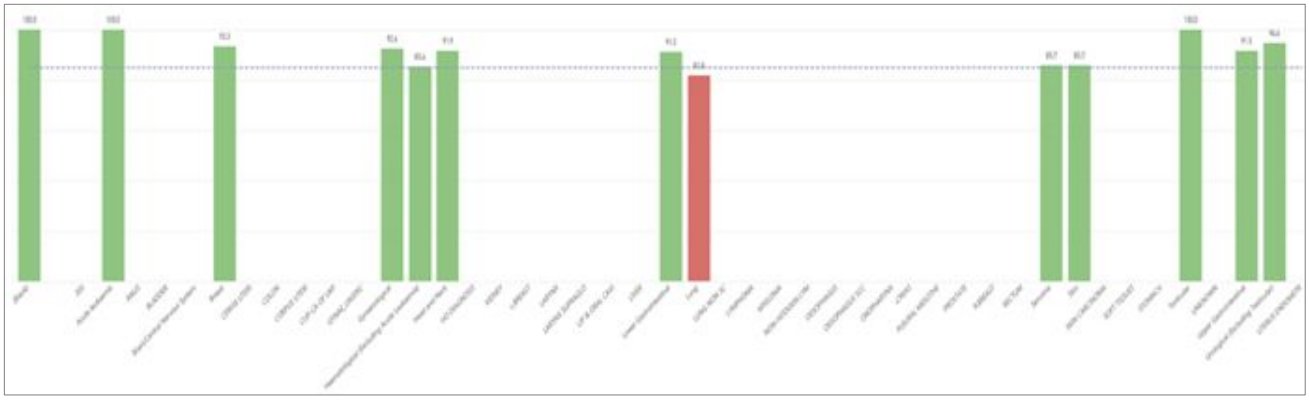
The NHS Operational Planning and Contracting Guidance 2021/2022 states that the 28-day Faster Diagnosis Standard will be subject to formal performance management from Q3 2021/22, with a target of 75%. Data has been published since April 2021.

The 28 day FDS target was achieved in June at 87.5%.

62 Day wait from GP Referral to treatment

The 85% target is currently being achieved at 91.8% for June (final validation via national system 2nd August 2021).

62 Day breaches by tumour group:



62 Day Screening

There were no 62 Day screening breaches for June 2021.

7 Day Performance (Internal Target)

Performance for June 2021 is 86.6% against a stretch target of 90%.

19 Patients breached the internal 7 day target and none these patients breached the 24 day target. The following table provides a summary of these breaches:

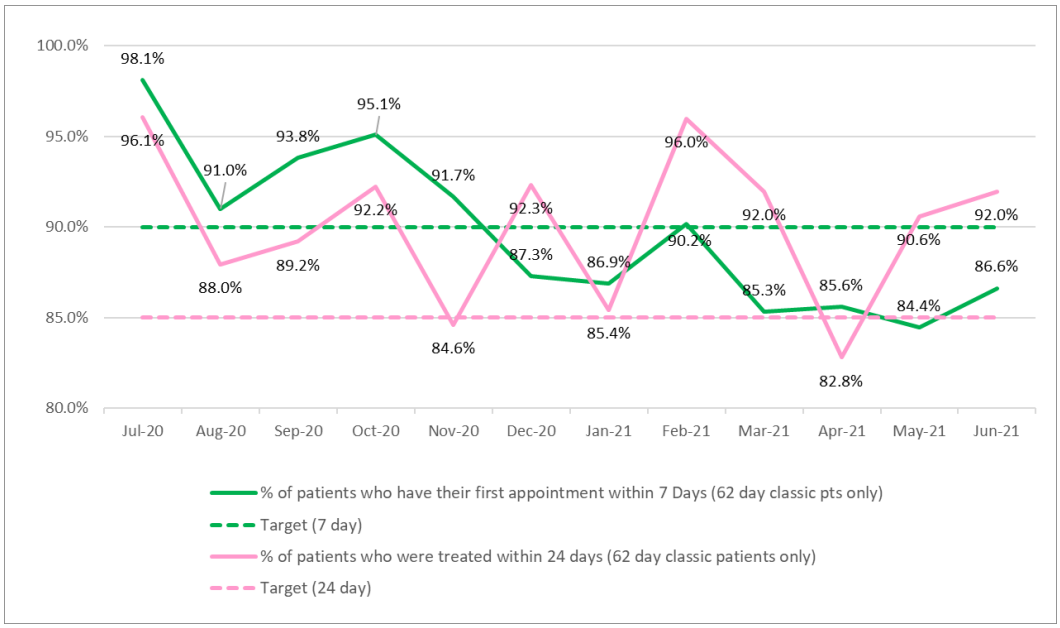
Tumour Grp	No. missing 7 Day	Clinic Full	Capacity Next Clinic	Next Clinic	'MDT	'Awaiting Results	Patient isolating
Breast	1	1					
Gynae	1		1				
H&N	1			1			
LGI	3		3				
Lung	4			3			**1**
Upper GI	3			2	1		
Urology	6		5			1	
Grand Total	**19**	**1**	**9**	**6**	**1**	**1**	**1**

The 'Next clinic' category is used when the referral arrives on the day of, or the day before a weekly clinic.

24 Day (Internal Target)

This was achieved for June 2021, with 92% against a stretch target of 85%.

The following chart shows 24 day and 7 day performance by month against the targets:



CCC continues to monitor 24 day performance for patients on the 62-day pathway. This is an internal target that aids breach avoidance for the system. 24 day awareness sessions continue to be available to all staff.

31 day long waiters 73 days +

There were no 31 Day long waiting breaches for June 2021.

62 Day long waiters 104 days +

7 patients breached the 104+ day target in June; referred in between day 84 and 128 to CCC. 3 of the 7 patients were at CCC for more than 24 days between referral and treatment. 2 of the patients (patients 2 and 3 below) were avoidable accountable breaches to CCC. Patient reference numbers align to those used in the table below.

Patient 2 – Delay to first appointment due to capacity over the May Bank Holiday.
Patient 3 – Slight delay to first appointment, patient required a planning scan and was a CAT 1 patient which means they need to start their treatment on a Monday.
Patient 6 – Oncologist requested an additional biopsy with the surgical team, patient also required staging scan to confirm treatment plan.

There are no harm reviews requiring presentation to the Clinical Harm review panel in June 2021.

Breach Details

									Internal Targets		National Standards					Long Waiters	
Patient	Day into CCC	Days at CCC / to Diagnosis (28DFDS)	Treated on Day	Tumour	Referring Trust	Treatment	Reason	Avoidable Breach	7 Day	24 Days (treated within 62 days)	2 Week Wait	28 Day FDS2	62 Day GP: Full breaches*	62 Day GP: Half breaches**	62 Day Screening	31 Day ≥73 Days	≥104 days AND >24 at CCC
1	37	41	78	Lung	Whiston	Pall RT	Medical reason as patient required admission to another Trust for treatment of a tumour related condition before commencing treatment.	No					Y				
2	107	33	140	Bladder	WHH	Radical RT/chemo	Delay to first appointment due to capacity over the May Bank Holiday.	Yes						Y			Y
3	84	26	110	LGI	Wirral	Radical RT/chemo	Slight delay to first appointment; patient required a planning scan and was a CAT 1 patient which means that the patient needed to start treatment on a Monday.	Yes						Y			Y
4	42	48	90	Urology	Wirral	Hormones	Delay due to patient choice for thinking time regarding treatment and choice of Oncology appointment dates.	No						Y			
5	66	25	91	H&N	Aintree	Pall Chemo	Medical reason as patient required investigation for another condition prior to commencing treatment.	No						Y			

									Internal Targets		National Standards					Long Waiters	
Patient	Day into CCC	Days at CCC / to Diagnosis (28DFDS)	Treated on Day	Tumour	Referring Trust	Treatment	Reason	Avoidable Breach	7 Day	24 Days (treated within 62 days)	2 Week Wait	28 Day FDS2	62 Day GP: Full breaches*	62 Day GP: Half breaches**	62 Day Screening	31 Day ≥73 Days	≥104 days AND >24 at CCC
6	128	33	161	Kidney	COC	Active monitoring	Oncologist requested an additional biopsy with the surgical team before oncology appointment. Patient also required staging scan to confirm treatment plan. Pathway under review.	No						Y			Y
7	0	36	36	Haem	GP	Active Monitoring	Patient choice of diagnostic test appointment dates.	No				Y					

*Full breach to CCC: Patient received by CCC before day 38, but not treated within 24 days
**Half breach to CCC: Patient received by CCC after day 38 and not treated within 24 day

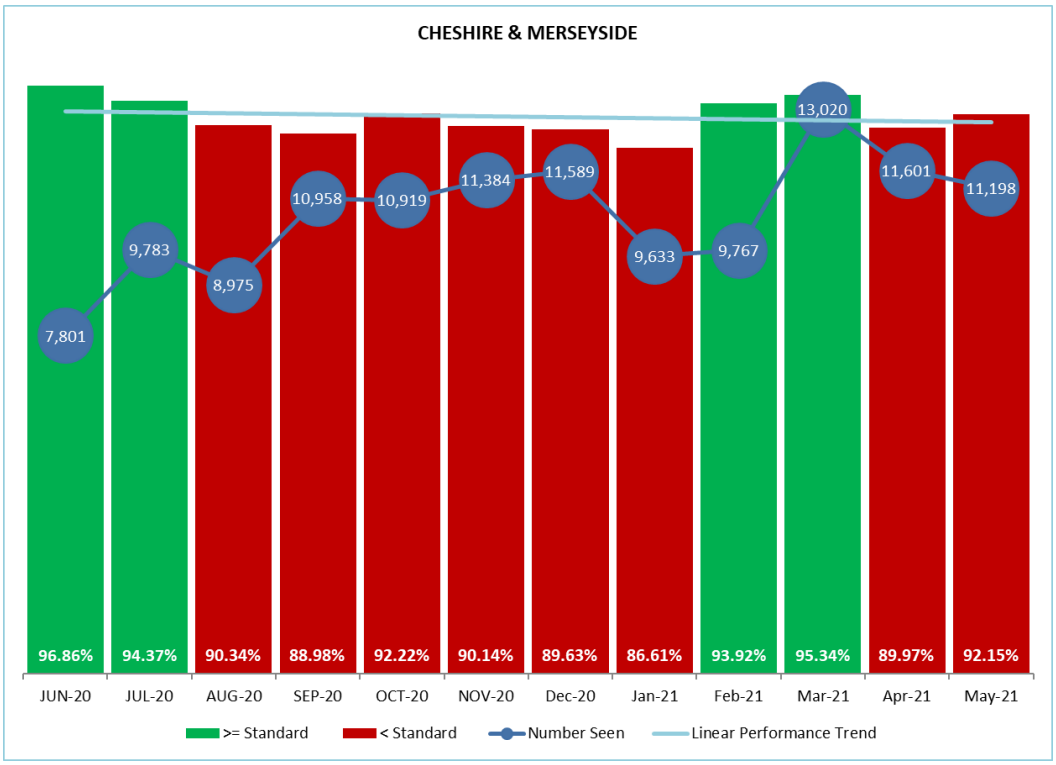
3.1.2 Cancer Waiting Times Standards: Cheshire and Merseyside Performance

This section focusses on the last 12 month's performance for Cheshire and Merseyside, against the standards of 2 Week Wait, 28 day Faster Diagnosis Standard (FDS) and 62 Day wait from GP Referral to Treatment. The latest available data for this wider regional performance is May 2021.

The difference between the figures in this Cheshire and Merseyside section and the following National section is due to the timing of the reports run.

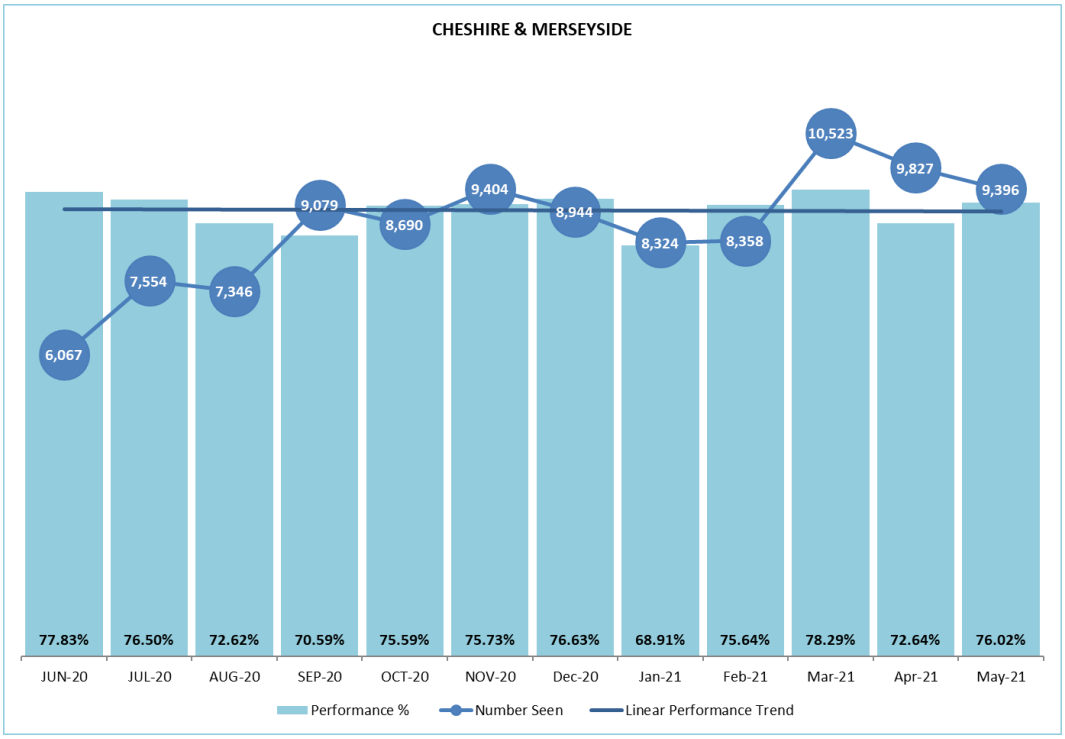
2 Week Wait

This chart shows the performance by month for Cheshire and Mersey and states the numbers of patients seen each month in the blue circles. Whilst there has been an improvement since April 2021, the 93% target has not been achieved in May 2021, at 92.15%.



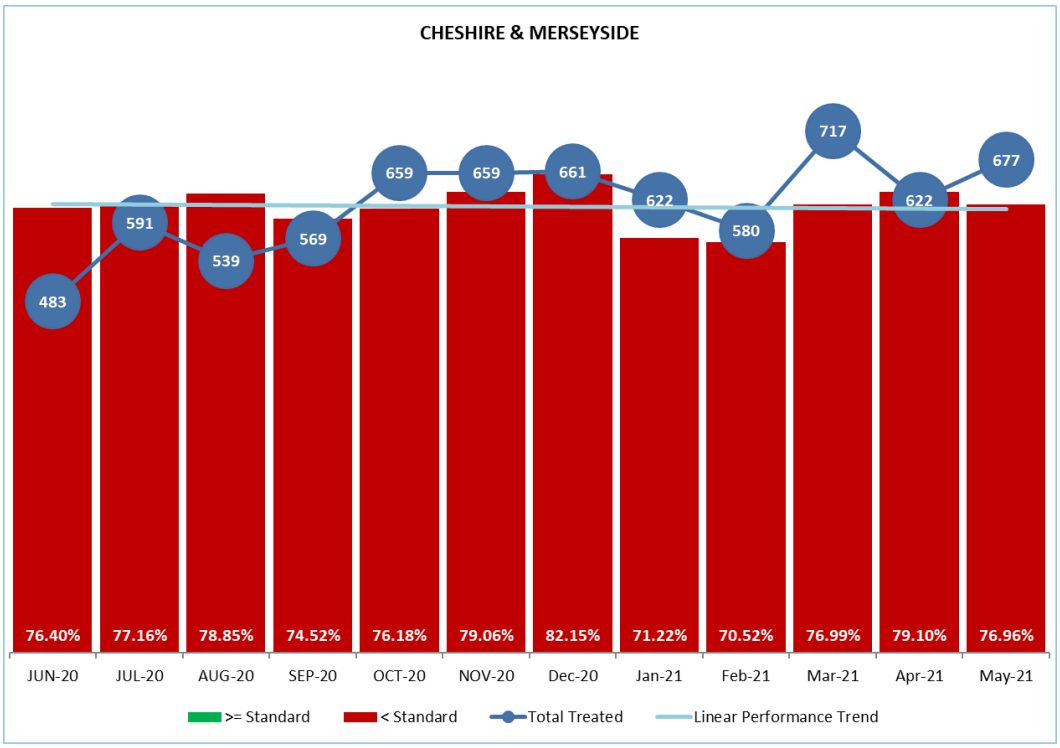
28-day Faster Diagnosis Standard (FDS)

This chart shows the performance by month for Cheshire and Mersey, with a trend line and states the numbers of patients seen each month in the blue circles. There is no RAG rating, as this standard is not subject to formal monitoring until Q3 2021/22, with the target confirmed as 75%. This has been achieved in May 2021, at 76.02%.



62 Day wait from GP Referral to treatment

This chart shows the performance by month in Cheshire and Mersey, with a trend line and the numbers of patients seen each month in the blue circles. The 85% target has not been achieved in the last 12 months. Performance in May 2021 is 76.96%.

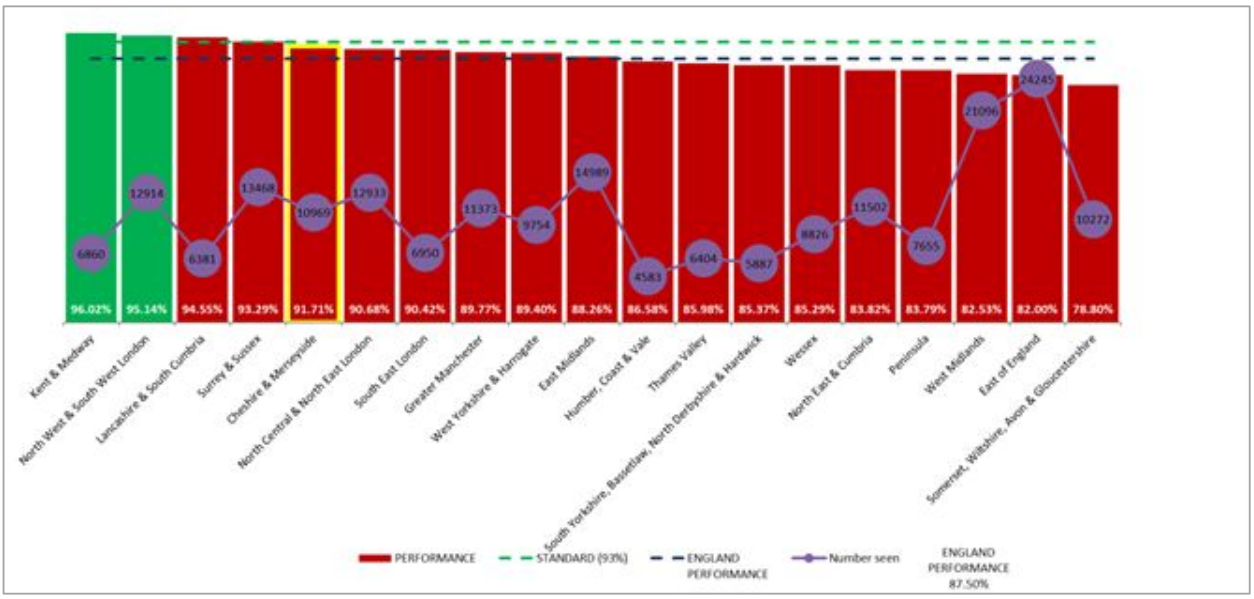


3.1.3 Cancer Waiting Times Standards: National Performance

This section focusses on National performance by Cancer Alliance, against the standards of 2 week wait and 62 Day wait from GP Referral to treatment. The latest available data for this national performance is May 2021. National data is not yet available for the 28 Day FDS as this is not yet subject to formal monitoring.

Two-week wait

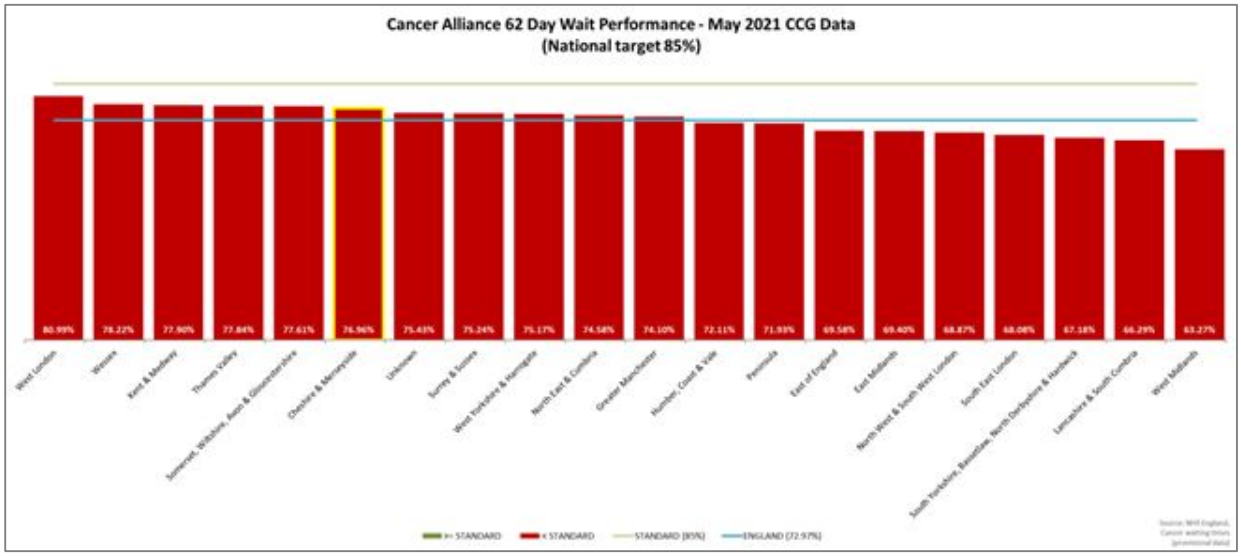
This chart shows the performance by Cancer Alliance for May 2021. Cheshire and Merseyside were the 5th best performing Alliance in May 2021 with 91.7% (up from 89.6% and 7th position in April). The dashed blue line shows the May 2021 figure for England (87.5%).



Source: NHS England, Cancer waiting times (provisional data)

62 Day wait from GP Referral to treatment

This chart shows the performance by Cancer Alliance for May 2021. Cheshire and Merseyside remain the 6th best performing Alliance in May 2021, falling from 78.37% in April 2021 to 76.96% in May 2021. The blue line shows the figure for England for May 2021 (72.97%).



This table shows the same data as in the chart above, by Alliance (A-Z), including numbers of patients treated within and outside of the 62 days and the numbers of breaches.

62 Day Wait Performance - NHS England CCG data - Cancer Alliances - April 2018-May 2021 (National target 85%)

Cancer Alliance	Total Treated	Treated within 62 days	Breaches	Performance	
Cheshire & Merseyside	677	521	156	76.96%	
East Midlands	964	669	295	69.40%	
East of England	1394	970	424	69.58%	
Greater Manchester	556	412	144	74.10%	
Humber, Coast & Vale	484	349	135	72.11%	
Kent & Medway	448	349	99	77.90%	◄ Third best performer
Lancashire & South Cumbria	448	297	151	66.29%	
North East & Cumbria	834	622	212	74.58%	
North West & South West London	212	146	66	68.87%	
Peninsula	481	346	135	71.93%	
Somerset, Wiltshire, Avon & Gloucestershire	813	631	182	77.61%	
South East London	260	177	83	68.08%	
South Yorkshire, Bassetlaw, North Derbyshire & Hardwick	579	389	190	67.18%	
Surrey & Sussex	723	544	179	75.24%	
Thames Valley	388	302	86	77.84%	
Wessex	326	255	71	78.22%	◄ Second best performer
West London	263	213	50	80.99%	◄ Top performer
West Midlands	667	422	245	63.27%	◄ Lowest performer
West Yorkshire & Harrogate	447	336	111	75.17%	

CHESHIRE AND MERSEYSIDE
POSITION = 6/19

3.2 Efficiency

3.2.1 Inpatient Flow

Bed Occupancy

Bed occupancy for June 2021 remains below target for Solid Tumour (ST) wards and Ward 5 (Stem cell transplants). Ward 4 occupancy is above target for June 2021.

Reasons for below target bed occupancy include:

- The low numbers of transplants continue into June, with 3 again this month. This is due to protocol revision undertaken by the Stem Cell Director. The transplant activity is however increasing and this will be reflected in the Ward 5 occupancy figures for July 2021.
- Occupancy rates rose marginally for ST wards; this is likely to be due to the 100% occupancy of Ward 2 for 9 days when the ward was closed to new admissions due to a Covid-19 outbreak and the associated opening of 6 beds on Ward 3 to mitigate this fall in capacity.
- LUHFT have made no inpatient mutual aid referrals this month.
- Proactive discharge planning by the Patient Flow Team and the wider MDT to ensure that patients are in the safest place for them during the COVID-19 pandemic.

These figures are calculated on a total bed base of 83 beds, with variation to this during the month due to the closing of beds on Ward 2 for 9 days (from 26 beds to an average of 6), and the opening of 6 escalation beds on Ward 3 to provide mitigation.

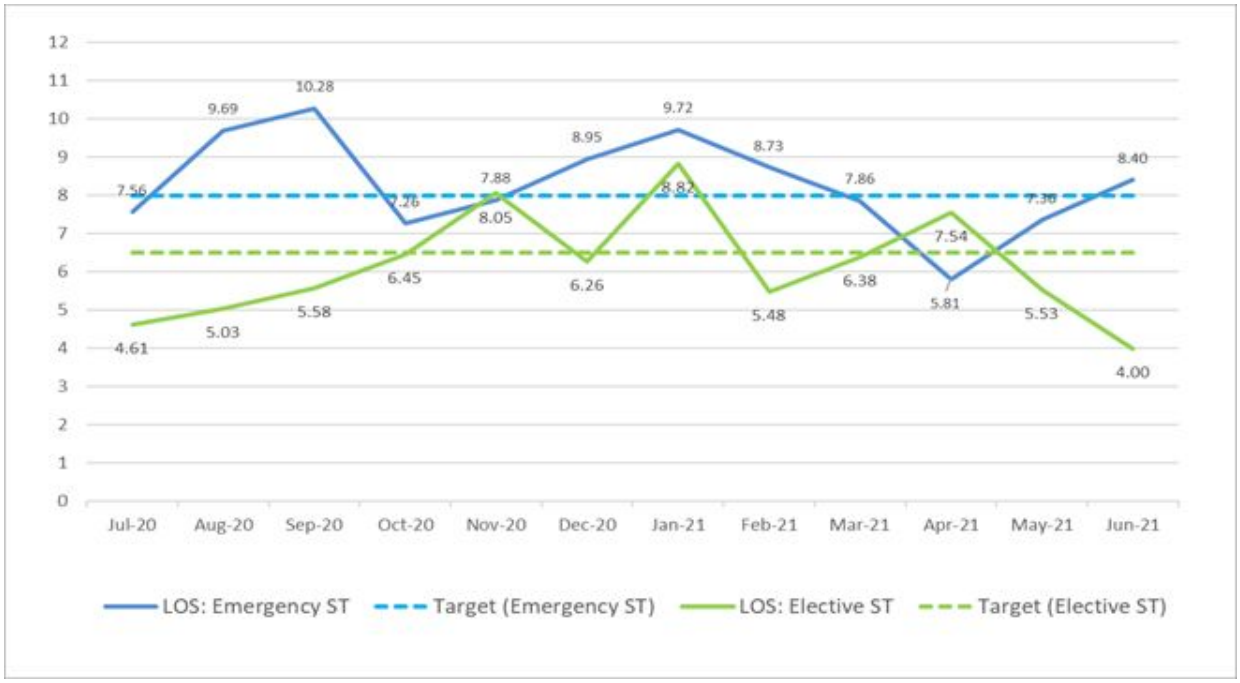
The Trust has been predominantly on OPEL 1 (Green) during June 2021, however OPEL 3 has been recorded for the ST wards on 2 occasions and Haemato-oncology on 6 occasions. There were no occasions on which we were on OPEL 3 (Red) bed status across the whole trust.

The bed pressures from the Covid-19 pandemic have started to increase in DGHs; communication continues between Acute Oncology and the Patient Flow Team.

Length of Stay (LoS)

Solid Tumour Wards:

This chart shows the elective and non-elective LoS for Solid Tumour Wards against the targets.



The trust target for ST Wards' non-elective LoS is 8 days. Non-elective LoS for June 2021 is marginally above the target at 8.4 days.

The trust target for ST Wards' elective LoS is 6.5 days. Elective LoS for June 2021 is within the target at 4 days.

There was a 52 % increase in DTOC (delayed transfers of care) from May, to 14 DTOC in June. The discharge delay reasons include:

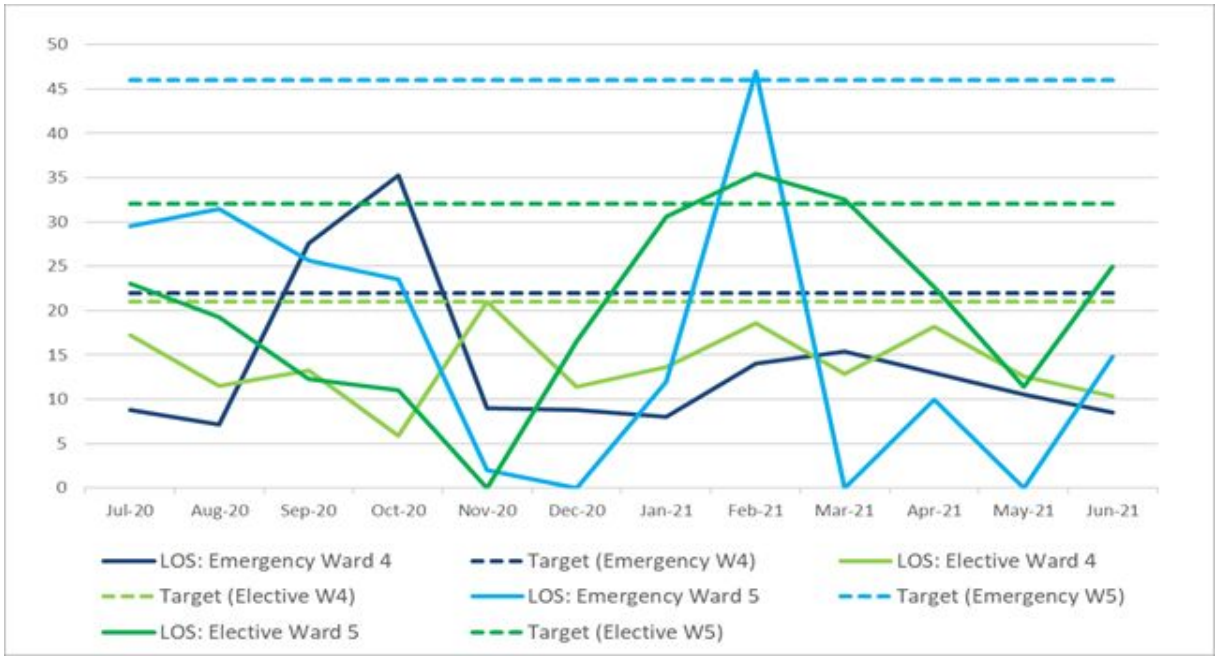
- Repatriation to a local Acute Trust
- Awaiting Hospice, Intermediate care and Nursing Home placements
- Continual Healthcare funded Packages of Care at home

All delays are monitored by the Acute Care Division and any emerging trends are identified.

The CUR non-qualifying rate for June is 5.8%. This is the highest since September 2020 (6.9%) and reflects the challenges faced in discharging patients in June.

HO Wards:

This chart shows the elective and non-elective LoS for HO Wards against the targets.



All HO LoS targets were achieved in June 2021.

Delayed transfers of care:

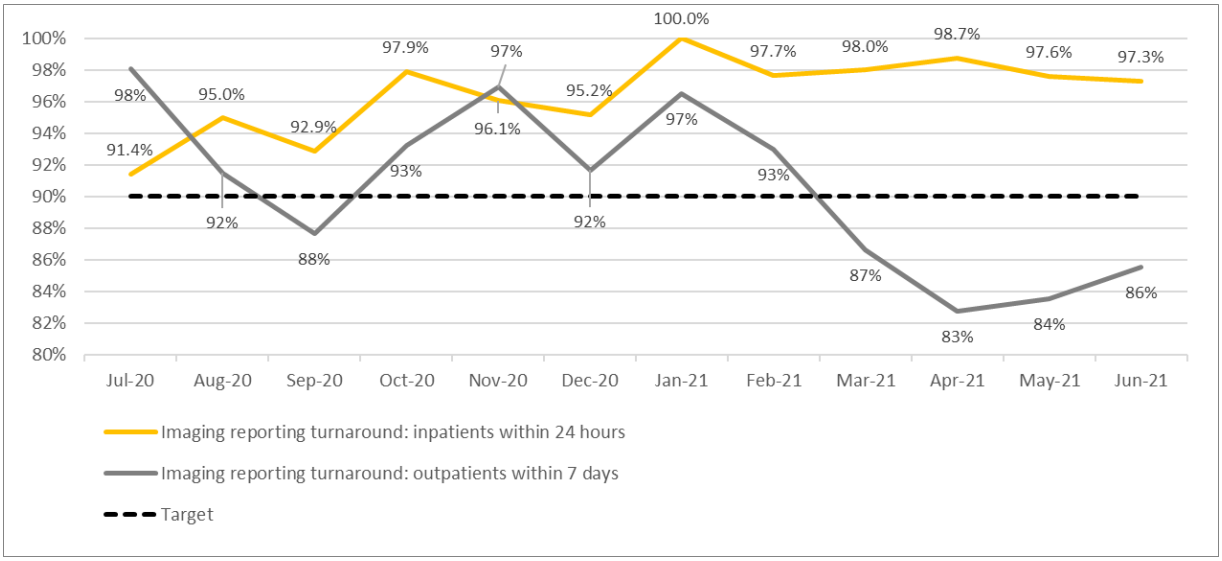
Delayed Transfers of Care (DTOC) as a % of occupied bed days for the month of June was above the Trust target of 3.5% at 4.3%.

14 patients had a DTOC in June. This affected both HO and ST patients. The delays totalled 84 days, with an average of 6.3 days. Delays were mainly due to patients awaiting fast track funded packages of care (POC) at home (7 patients) with 1 patient waiting 20 days in the Warrington area. 1 patient waited for 7 days for an intermediate care bed. COVID-19 continues to add pressure on hospices, with reduced bed capacity and some hospices closed to new admissions, resulting in delayed transfers of care from CCC.

COVID-19 has had an impact on community services, with some staff that provide POC at home having to isolate. This has resulted in delays to commission POC with care agencies.

3.2.2 Radiology Reporting

The targets for inpatient reporting turnaround have been met every month in the last 12 months. The out-patient target was not achieved in 5 of the last 12 months, however compliance has improved in the last 2 months.



Despite a new radiologist starting in February 2021 and an increase in outsourcing reporting, we have failed to meet our out-patient reporting turnaround time targets again during June. Increased activity and a developing IR service and ultrasound service support have contributed to this, alongside CRIS system issues regarding the interface between CCC and LUHFT. These CRIS system issues are now resolved, as of 13th July 2021.

An additional radiologist was recruited in December 2019, however their start date has been delayed due to Covid-19 pressures in their home country and the inability to travel from oversees to complete an essential examination. They may therefore not commence in post until 2022.

Radiologist Interviews have now been held; 1 candidate accepted an offer and will start with us in September 2021. A Clinical Imaging Fellow has also been recruited, with a start date to be confirmed. This increase in Radiologist support will ensure our reporting turnaround times are more robust.

A business case has been approved to expand the workforce and extend the working day to increase capacity. In lieu of this, staff are working extra shifts to meet demand.

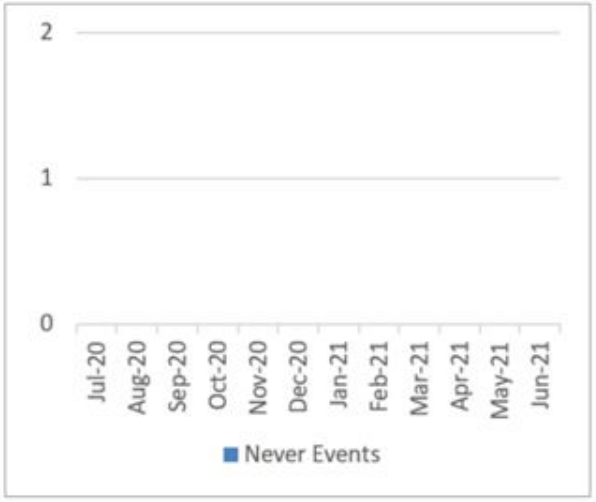
We continue to monitor the reporting situation through a bi-weekly sitrep.

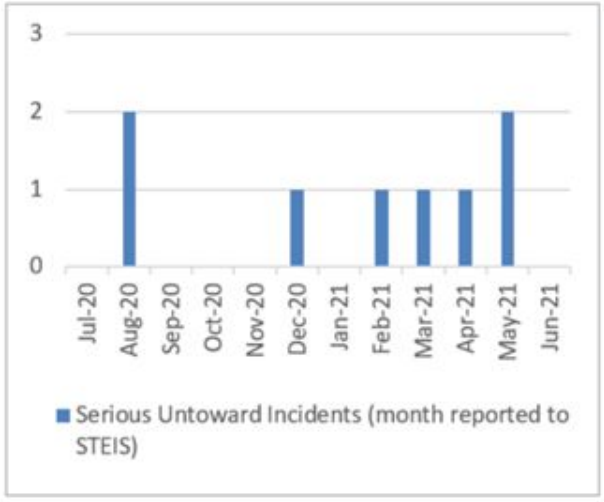
3.3 Quality

This section provides an overview of performance and associated actions in the following areas:

- Incidents
- Health Care Acquired Infections
- Inpatient Assessments
- Harm Free Care
- Complaints
- Patient Experience

Incidents





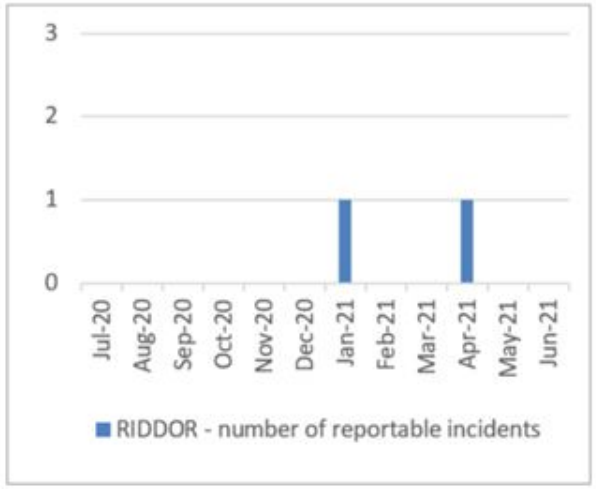
June 2021:

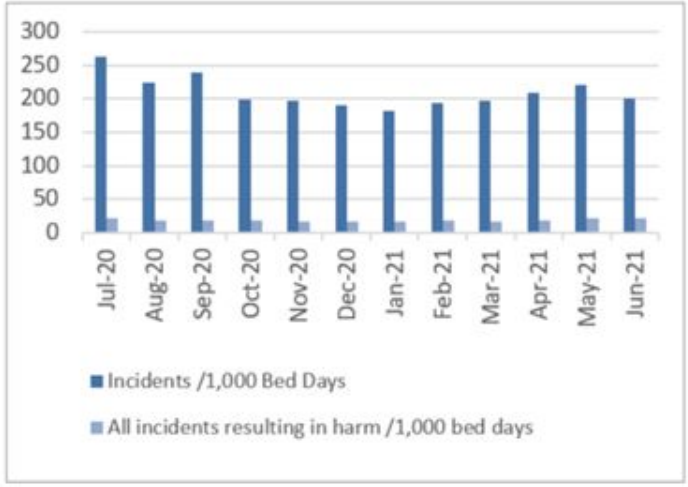
Targets:
- Never Events, SUI and RIDDOR targets are 0.
- SAUE targets are shown on the chart.

There was one SAUE imaging error and no SAUE treatment errors. Targets for both KPIs were achieved.

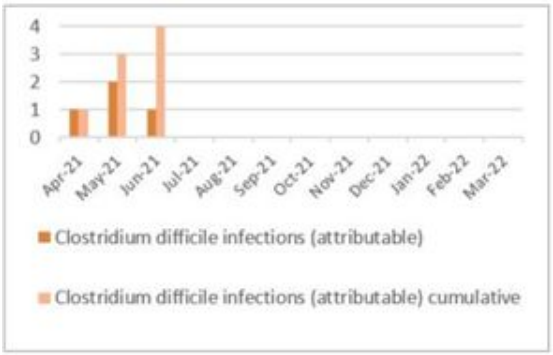
There have been no RIDDOR reportable incidents.

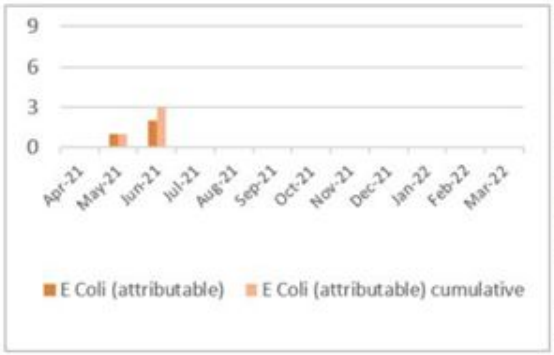
There were no SUIs.





Health Care Acquired Infections





June 2021:

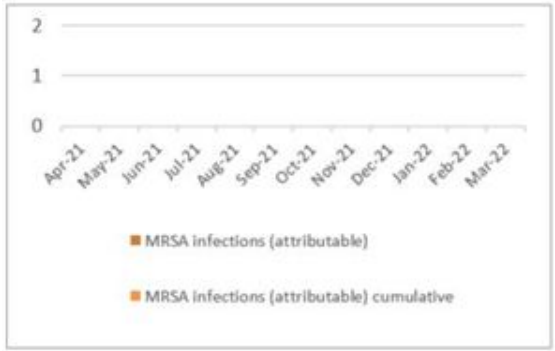
Thresholds (per year):
C diff: 4 | E Coli: 9 | MRSA: 0 | MSSA: 4 | Klebsiella: 9 | Pseudomonas: 4

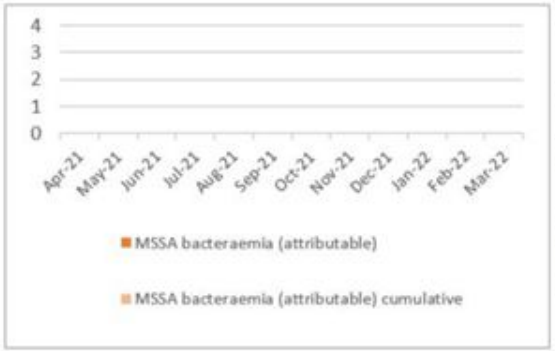
There was 1 Clostridiodes difficile infection in June which was attributable to CCC. This takes the total to 4 YTD, which is the annual threshold. The patient had recieved antibiotics and had previously been CDI positive 7 weeks earlier. Review by Consultant Microbiologist identified that antibiotic choices were within Trust Formulary.

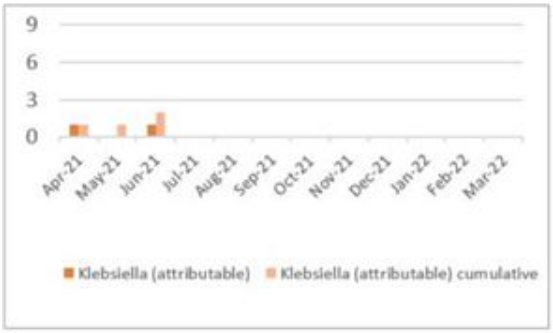
Two hospital acquired Escherichia coli blood stream infections were also identified. Following Consultant Microbiologist review, it was idenitified that both were likley gastro-intestinal in orgin. No learnining points were identified from either infection.

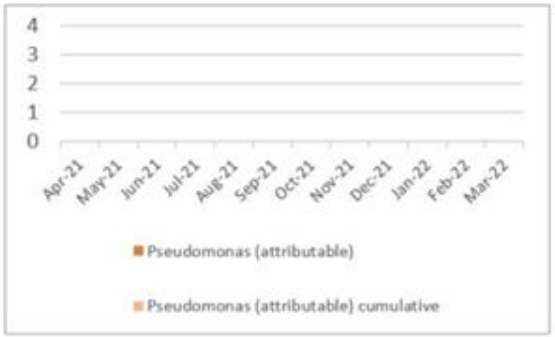
One hospital acquired klebsiella pneumoniae infection was identified. Following Consultant Microbiologist review it was determined that the source was likley to be gut translocation. No learning points were identified from this episode of infection.

Whilst there were no Definite Healthcare Associated Covid-19 infections in June, there were 2 classed as Hospital-Onset Probable Healthcare Associated and 1 classed as Hospital-Onset Indeterminate Healthcare Associated.

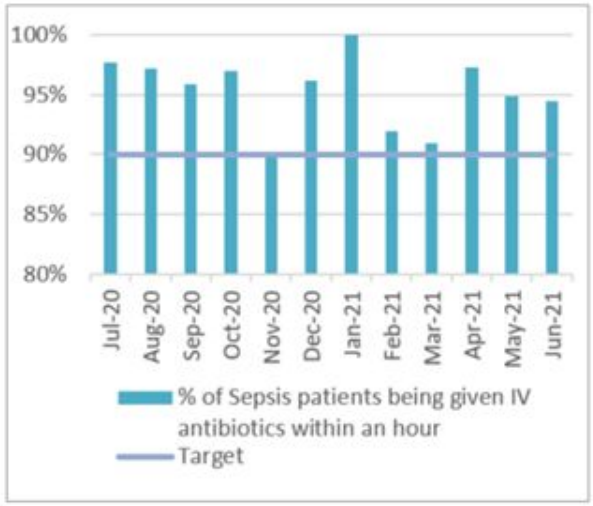


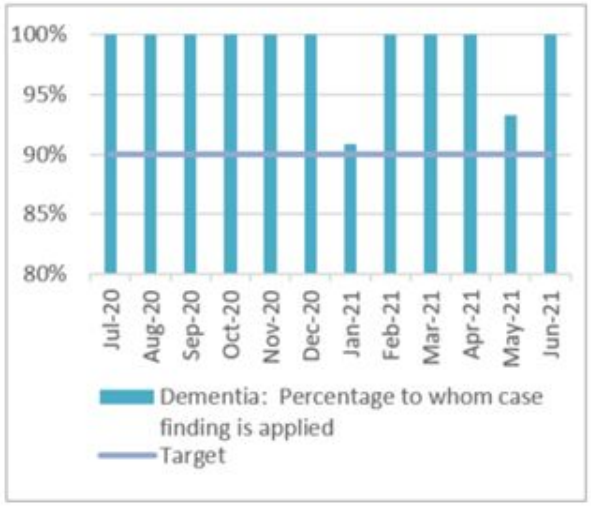






Inpatient Assessments





June 2021:

Consultant review within 14 hours is compliant at 98%.

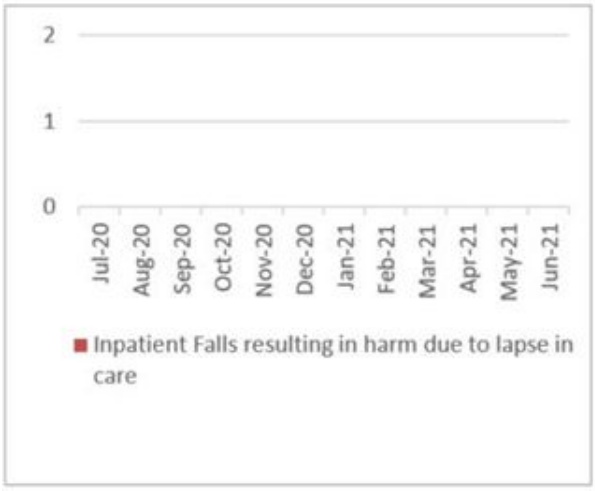
Dementia screening tool assessment compliance is 100%.

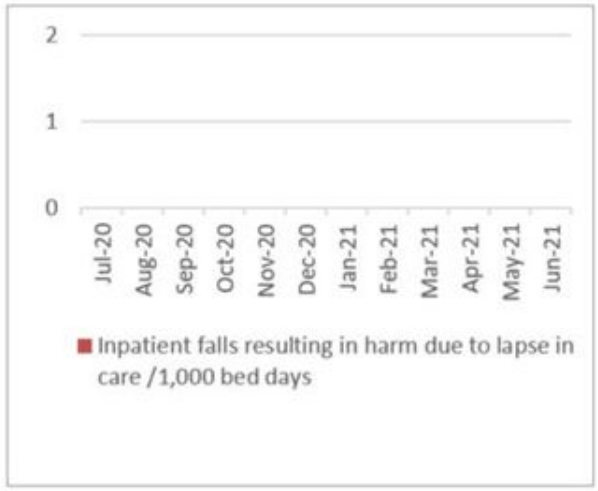
The Dementia/LD and Autism Collaborative group which consists of Champions across the various divisions continue to meet bi-monthly, however May's meeting was cancelled due to lack of attendees and not being quorate. This has been picked up with divisional managers and advised we need to support staff to attend these meetings to share information which supports the Dementia Strategy (2019-2022). All managers are supportive in ensuring the barriers to attendance are reviewed and addressed going forward.

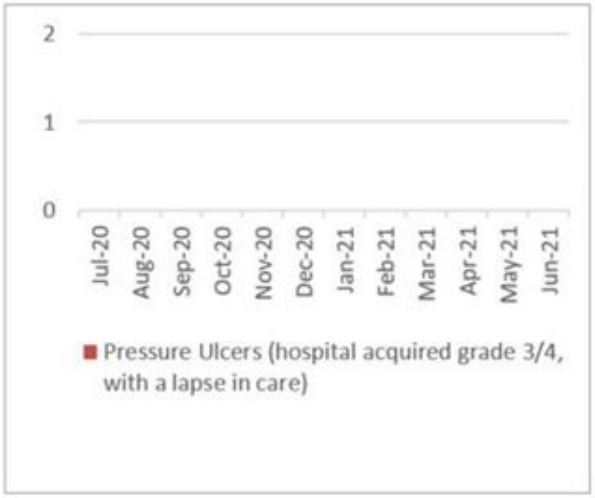
The Photobook has received positive feedback and the Liverpool Dementia Action Alliance which to share it with 94 organisations which support them to show the work we have undertaken towards our dementia-friendly status. A private linkhas been shared via email to support this action.

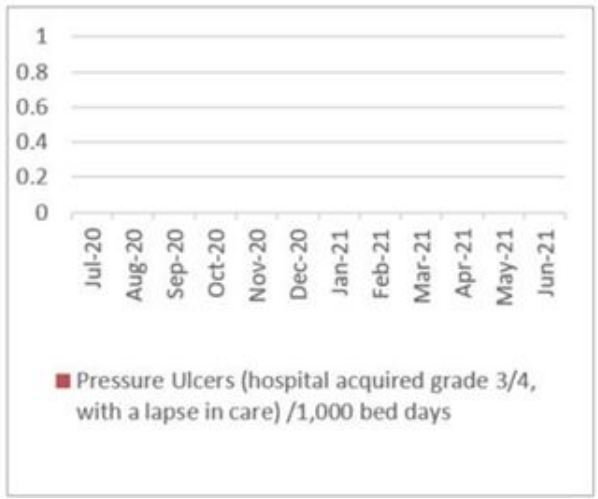
VTE risk assessment compliance is 93.20%. The slight reduction in compliance has been escalated to divisional medical leads and matrons. Focused actions are in progress to improve the current position. A further thematic review is in progress regarding missed VTE risk assessments.

Harm Free Care







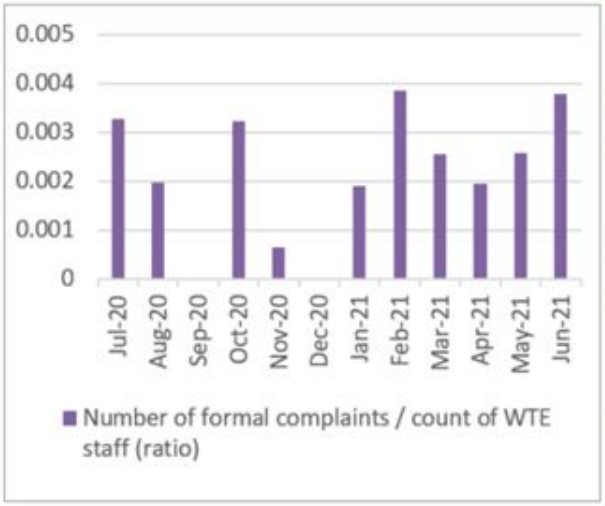


June 2021:

Pressure ulcers – There have been no CCC attributable pressure ulcers category 3 or 4 with a lapse in care identified for June 2021. Some lessons learnt were identified regarding inconsistencies with Waterlow risk assessment scores. The TVN will be providing ward based training over the coming weeks to increase staff knowledge. Overall the group noted an improvement with pressure ulcer documentation.

Falls – There have been no inpatient falls which resulted in harm with a lapse in care identified in June 2021. The group noted increased compliance with falls prevention interventions e.g. green wrist bands and falling leaf magnets. Compliance with the falls risk assessments was 100% for June 2021. A quality improvement programme continues to reduce the occurrence of both pressure ulcers and falls.

Complaints

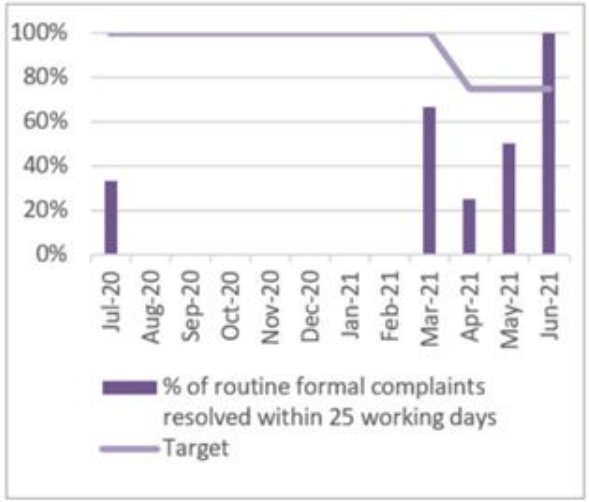


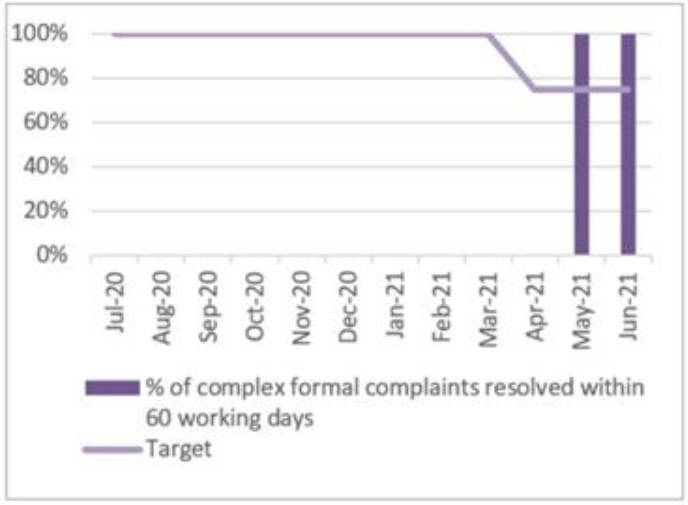
June 2021:

6 complaints were received in May 2021. All were acknowledged within the 3 day target.

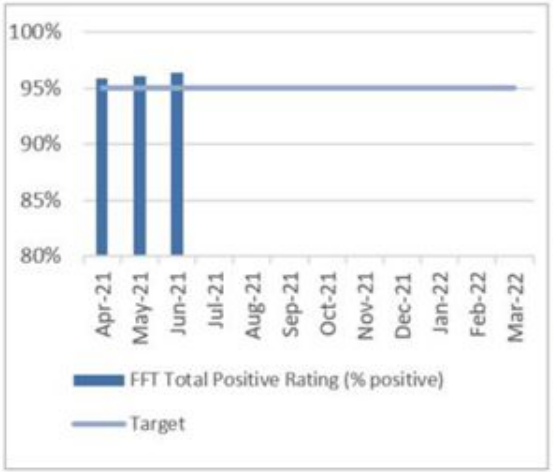
2 routine compliants were resolved; all within 25 days.
1 complex complaint was resolved; this was within the 60 day target.

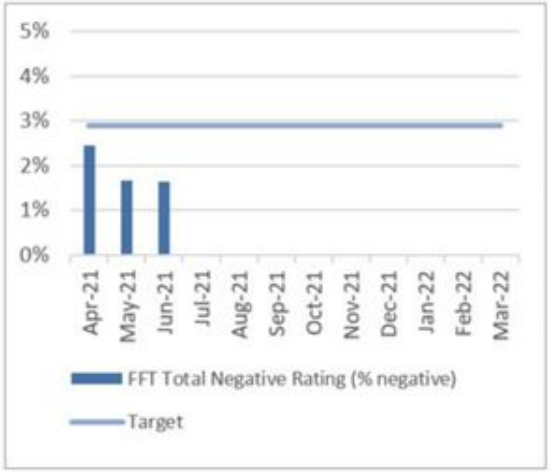
There are currently 9 open complaints and all responses are within the KPI timescales.





Patient Experience





June 2021:

The Patient Survey FFT targets continue to be achieved.

Completion of the National Cancer Patient Experience Survey (NCPES) action plan was achieved in Q1 2021/22.

Both national mandated surveys are being analysed by Picker, CQC and NHSE&I for 20/21; published reports anticipated late Summer/Early Autumn 2021.

FFT has demonstrated that 96.41% of patients who responded in June confirmed a positive patient experience at CCC with an improvement visible month on month.

Poor outpatient waiting times for blood tests and appointments across CCCL continues to be a theme associated with the negative feedback. Further work continues to address and improve this issue.

Strengthening of the Volunteer workforce at CCC is ongoing; including the implementation of the "Chatter Buddy" initiative in June 2021 (halted due to recent Covid restrictions) as part of the establishment of a Family Volunteer Service and delivery of the first Always Events project. There is an inpatient online contact form set up on the Trust website, for families to keep in touch and for the Family Volunteers to action. These initiatives will assist communication, support reduction of patient loneliness and improve experience across all inpatient areas.

CCC supported National Volunteer week 1-7th June and is supporting a regional approach to adopting a Carers passport and Trust wide Carers policy in August/September.

The Patient Experience Improvement framework report and action plan (which was shared with the PPG for final comment) will be presented at PEIG in July, before going to Trust Board in September 2021.

By early Q2 2021/22, the Trust will apply to VCHA to become the first cancer specialist Trust to be awarded Veteran Aware status. The outcome is expected in Q3 2021/22. We are also involved in the regional pilot to implement a Veterans and Armed Forces Community passport, that will support individuals, families and carers.

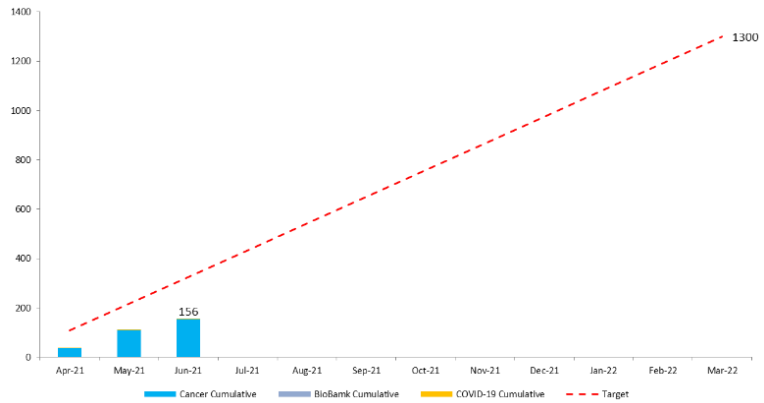
3.4 Research and Innovation

3.4.1 Achievements

- CCC remains top recruiter for the IMPACTOR study (PI: Prof Palmieri, Breast).
- CCC are the second highest recruiter in the UK for the ACTICCA trial. Congratulations were expressed to the team in the ACTICCA-A Newsletter. (PI: Prof Palmer, Hepatobiliary).
- The Proact team have recruited their first patient into this study. It is the first cardiac study that CCC has participated in (PI: Prof Kalakonda, non-hodgkins lymphoma).
- CCC was the first site to open in the UK for the Brioche Trial and received positive feedback from the sponsor (Dr Mehta, Brain).
- The first patient has been recruited to the Transgene trial. Professor Ottensmeier has been interviewed by BBC Merseyside breakfast and morning shows and BBC North West breakfast news. It has also been shared by the Liverpool Echo (PI: Prof Ottensmeier, Head and Neck).
- Professor Ottensmeier has had a paper published in Nature Immunology, June 2021. Helping to understand why current checkpoint inhibitor treatment often does not work, how to use our drugs better and how to make better drugs to help immunotherapy work.
- R&I had an abstract accepted for the NCRI Conference 2021: ‘Research, Response and Recovery: Clatterbridge Cancer Centre and the COVID-19 pandemic’.

3.4.2 Monthly Recruitment

A target of 1300 patients recruited to research studies for 2021/22 has been set in-line with the new Research Strategy. Currently we have recruited 156 patients from April to June 2021 against a target of 324 (48% of target).



Graph 1: Recruitment Against Time: Cumulative recruitment against internal target (n=1300). Month on month split between Cancer (total Int&Obs), BioBank, COVID-19 (total UPH&Non-UPH). Cumulative stacked.

The main reason recruitment is low is because no new studies that use the aseptic pharmacy service have opened since 5th March 2021. We continue to work with the Interim Chief Pharmacist to resolve the issue relating to clinical trial pharmacy capacity as this is currently the rate limiting step in trial set-up.

	Cancer		CCC BioBank	COVID-19		Other Activity (SE/PICC)
	Interventional	Observational		UPH	Non-UPH	
April	20	15		1	2	
May	14	60		0	0	
June	31	13		0	0	
July						
August						
September						
October						
November						
December						
January						
February						
March						
Total(s)	65	88	N/A	1	2	0
	153			3		
	156					
	156					

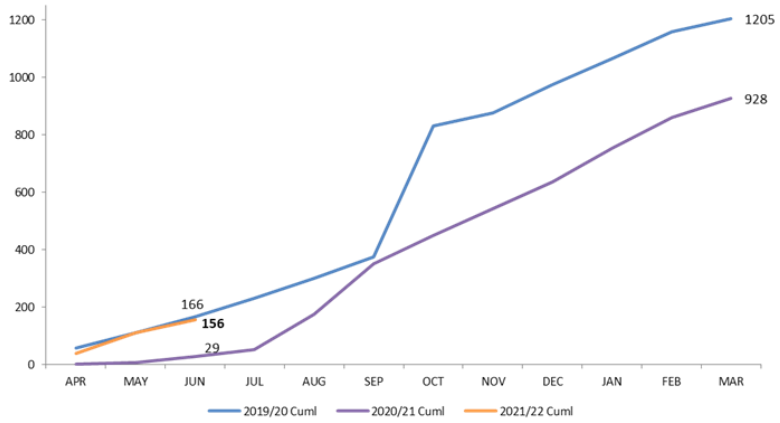
Table 1. – Recruitment breakdown: Cancer (Interventional, Observational), Biobank, COVID-19 (UPH, Non-UPH) and Other Research Activities (Service Evaluation, PICC) from 01/04/2021 to Data cut-off 30/06/2021.

A timeline of trials to be progressed through set-up to opening has been collated and agreed between R&I and Pharmacy in a staggered approach. This is to reflect progress made and to protect workloads for both the Pharmacy teams and Clinical Delivery Team.

3.4.2.1 Comparison of Recruitment to previous years

Comparing recruitment cumulative data from this year 21/22 to 20/21 (COVID-19 pandemic, target reached n=928) and 19/20 (best recruiting year, target reached n=1205) you can see:

- Comparing 21/22 to 20/21 overall we have higher recruitment to date.
- Comparing 21/22 to 19/20 overall we have similar recruitment to date.



Graph 2: Comparison of recruitment data from 19/20, 20/21 and 21/22 for 12 month period.

3.4.2.2 Progress made with Pharmacy

Good progress has been made by Pharmacy to support clinical trials. This progress has enabled us to start recruiting to some studies again in-line with sponsor requirements. Highlighted progress includes:

- The SOP on IMP transportation has been written and approved by Pharmacy.
- The cold chain issue is now resolved.
- Assurance has been provided by Pharmacy for aseptics capacity to support open and new trials going forward.
- New clinical trials lead pharmacist has been appointed.

3.4.2.3 Diversification of the research portfolio

In light of the aseptic issues experienced, we are progressing and opening an increased portfolio of real world, psychosocial, radiotherapy and nursing research studies.

A reflection of the diversification of the trial portfolio can be seen in the current screening activity. The different types of studies that are being progressed have a higher decline rate meaning we are seeing more patients but this may not be reflected in the patients consented figures.

Screening total in April 2021 = 94, May 2021 = 144 and June 2021 = 203.

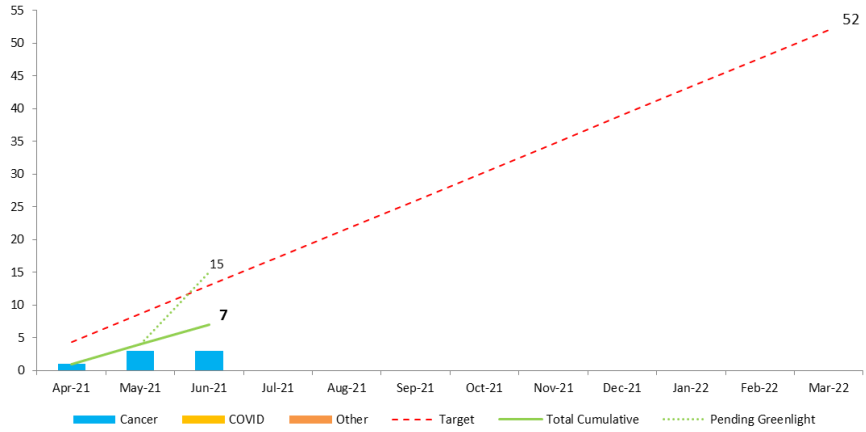
3.4.2.4 Recruitment against Research Capability Funding requirements

To qualify for Research Capability Funding against recruitment Trusts need to recruit 500 non-commercial, portfolio badged patients onto research studies between 1st October 2020 and 31st August 2021. As of 8th July 2021 we have recruited 500 patients; well in advance of the target which means CCC R&I will secure an additional £20k in income from the Department of Health.

3.4.3 Number of new studies open to recruitment

Seven studies have been opened to recruitment between April and June 2021 against an internal target of thirteen (54% of target). There is a halt to opening new studies that use the Pharmacy Aseptic Service which started 5th March 2021 and this has impacted the number of studies that could have opened. We continue to work with the Interim Chief Pharmacist to get to a position where we can open studies again.

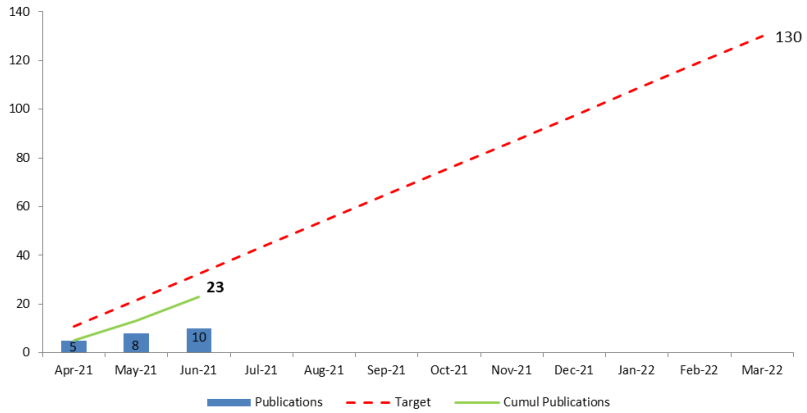
In total, there are currently an additional eight studies where CCC have issued local site approval where we have Sponsor Greenlight outstanding (dotted green line on Graph 4).



Graph 4 – NEW Studies Opened: Number of studies opened month by month against internal target (n=52) with cumulative total. Split between Cancer (Int&Obs), COVID-19 (UPH&Non-UPH) and Other Activity (SE&PICC).

3.4.4 Publications

Twenty-three papers have been published between April and June 2021, which is below the internal target of thirty-three (70% of target). R&I are working with the library services, SRG Research Leads and the academics to ensure the information presented is capturing all relevant information.



Graph 5 – New publications registered by month.

3.4.5 Study set-up times

No new set-up time data have been received since the last report to the Quality Committee.

Q3 20/21 and Q4 20/21 data have been submitted and validated data are expected later in the year.

3.5 Workforce

3.5.1 Workforce Overview

This table presents an overview of staff numbers and movements by month. Total Trust headcount at 30th June is 1570 (1431.70 FTE).

	2020 / 07	2020 / 08	2020 / 09	2020 / 10	2020 / 11	2020 / 12	2021 / 01	2021 / 02	2021 / 03	2021 / 04	2021 / 05	2021 / 06
Leavers Headcount	14	25	18	15	17	22	23	20	23	29	17	19
Leavers FTE	11.57	20.80	16.06	13.51	14.91	20.26	18.88	18.41	20.53	24.25	15.57	17.40
Starters Headcount	28	20	32	25	29	17	38	24	21	19	28	31
Starters FTE	27.04	19.40	31.23	23.50	26.78	15.12	33.35	21.08	20.76	18.52	25.65	28.00
Maternity	44	49	50	55	54	54	53	52	49	47	46	47
Turnover Rate (Headcount)	0.91%	1.63%	1.17%	0.98%	1.11%	1.44%	1.50%	1.30%	1.50%	1.89%	1.11%	1.24%
Turnover Rate (FTE)	0.83%	1.49%	1.15%	0.96%	1.06%	1.45%	1.35%	1.32%	1.47%	1.73%	1.11%	1.24%

Workforce Profile

Division	FTE
158 Acute Care Division	346.20
158 Corporate Division	18.80
158 Hosted Services Division	41.67
158 Networked Division	461.80
158 Radiation Services Division	323.85
158 Research Division	64.80
158 Support Services Division	174.58
Total	**1431.70**

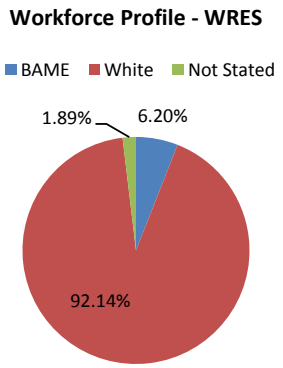
Staff Group	FTE
Add Prof Scientific and Technic	81.88
Additional Clinical Services	196.61
Administrative and Clerical	480.77
Allied Health Professionals	204.06
Healthcare Scientists	38.55
Medical and Dental	76.78
Nursing and Midwifery Registered	353.04
Total	**1431.70**

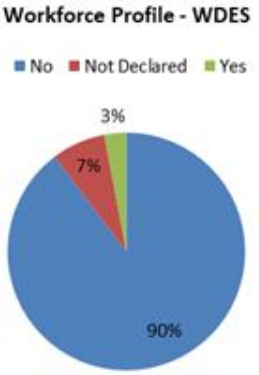
Assignment Category	FTE
Fixed Term Temp	61.76
Non-Exec Director/Chair	7.00
Permanent	1362.94
Total	**1431.70**

Assignment Status	FTE
Acting Up	16.80
Active Assignment	1315.74
Career Break	4.52
Internal Secondment	39.89
Maternity & Adoption	43.19
Out on External Secondment - Paid	7.00
Out on External Secondment - Unpaid	1.00
Suspend No Pay	3.56
Total	**1431.70**

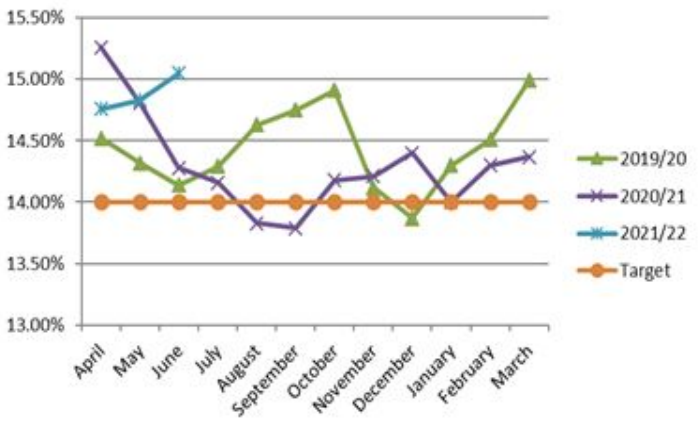
These tables present an overview of the current workforce profile held in ESR.

3.5.2 Workforce WRES (Workforce Race Equality Standard) & WDES (Workforce Disability Equality Standard) Profile

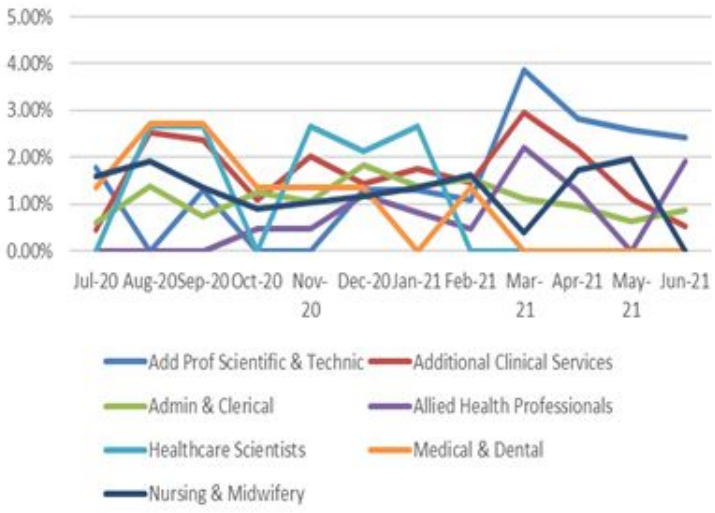




3.5.3 Workforce Turnover



The graph shows the rolling 12 month turnover figures across the Trust against the Trust target of 14%. The Turnover in June 2021 was 15.05%.



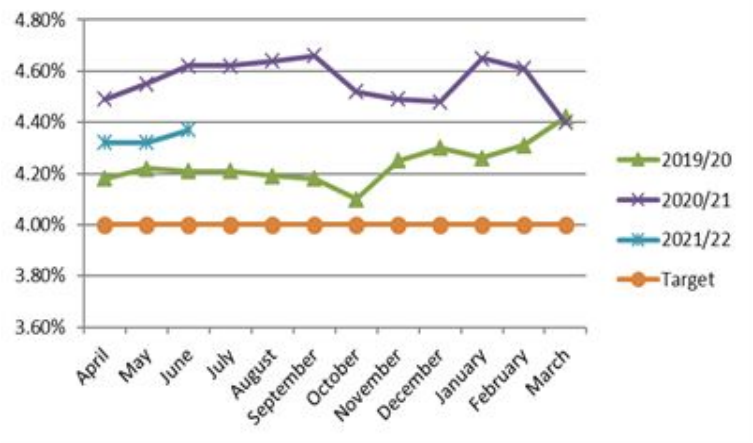
This chart shows the in-month turnover for the previous 12 months by staff group. The monthly target is 1.17% (annual target is 14% which is then divided by 12 months to provide a monthly target).

3.5.4 Recruitment Activity

The table below shows the recruitment activity by WTE, Division and Staff Group as at 30th June 2021.

Division	Staff Group	Advert	Interview	Offer	Total
Acute Care Division	Additional Clinical Services	2.00	4.00	1.00	**7.00**
	Additional Prof Scientific and Technic	4.00	1.00	11.00	**16.00**
	Administration & Clerical	0.00	0.00	0.00	**0.00**
	Allied Health Professional	0.00	0.00	0.00	**0.00**
	HealthCare Scientists	0.00	0.00	0.00	**0.00**
	Medical & Dental	3.00	0.00	6.00	**9.00**
	Nursing & Midwifery	1.00	40.50	17.36	**58.86**
Corporate Division	Additional Clinical Services	0.00	0.00	0.00	**0.00**
	Additional Prof Scientific and Technic	0.00	0.00	0.00	**0.00**
	Administration & Clerical	0.00	0.00	1.00	**1.00**
	Allied Health Professional	0.00	0.00	0.00	**0.00**
	HealthCare Scientists	0.00	0.00	0.00	**0.00**
	Medical & Dental	0.00	0.00	0.00	**0.00**
	Nursing & Midwifery	0.40	0.00	1.00	**1.40**
Hosted Services Division	Additional Clinical Services	0.00	0.00	0.00	**0.00**
	Additional Prof Scientific and Technic	0.00	0.00	0.00	**0.00**
	Administration & Clerical	3.00	2.00	11.00	**16.00**
	Allied Health Professional	0.00	0.00	0.00	**0.00**
	HealthCare Scientists	0.00	0.00	0.00	**0.00**
	Medical & Dental	0.00	0.00	0.00	**0.00**
	Nursing & Midwifery	0.00	0.00	0.00	**0.00**
Networked Services Division	Additional Clinical Services	0.00	0.00	3.12	**3.12**
	Additional Prof Scientific and Technic	0.00	0.00	0.00	**0.00**
	Administration & Clerical	0.00	0.00	12.52	**12.52**
	Allied Health Professional	1.00	1.00	3.22	**5.22**
	HealthCare Scientists	0.00	0.00	0.00	**0.00**
	Medical & Dental	1.00	0.00	1.00	**2.00**
	Nursing & Midwifery	3.60	10.00	14.40	**28.00**
Radiation Services Division	Additional Clinical Services	0.00	1.00	1.60	**2.60**
	Additional Prof Scientific and Technic	0.00	0.00	0.00	**0.00**
	Administration & Clerical	0.00	0.00	0.00	**0.00**
	Allied Health Professional	0.00	4.50	8.40	**12.90**
	HealthCare Scientists	0.00	1.00	3.00	**4.00**
	Medical & Dental	0.00	0.00	3.00	**3.00**
	Nursing & Midwifery	0.00	1.00	2.60	**3.60**
Research Division	Additional Clinical Services	0.00	0.00	0.00	**0.00**
	Additional Prof Scientific and Technic	0.00	0.00	0.00	**0.00**
	Administration & Clerical	1.00	1.00	1.00	**3.00**
	Allied Health Professional	0.00	0.00	0.00	**0.00**
	HealthCare Scientists	0.00	0.00	0.00	**0.00**
	Medical & Dental	0.00	0.00	0.00	**0.00**
	Nursing & Midwifery	0.00	0.00	1.00	**1.00**
Support Services Division	Additional Clinical Services	0.00	0.00	0.00	**0.00**
	Additional Prof Scientific and Technic	0.00	0.00	0.00	**0.00**
	Administration & Clerical	4.00	5.80	9.50	**19.30**
	Allied Health Professional	0.00	0.00	0.00	**0.00**
	HealthCare Scientists	0.00	0.00	0.00	**0.00**
	Medical & Dental	0.00	0.00	0.00	**0.00**
	Nursing & Midwifery	0.00	0.00	2.00	**2.00**
	TOTAL				**211.52**

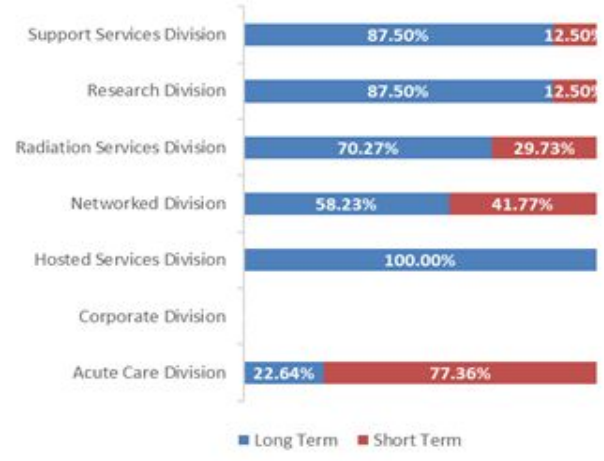
3.5.5 Sickness Absence



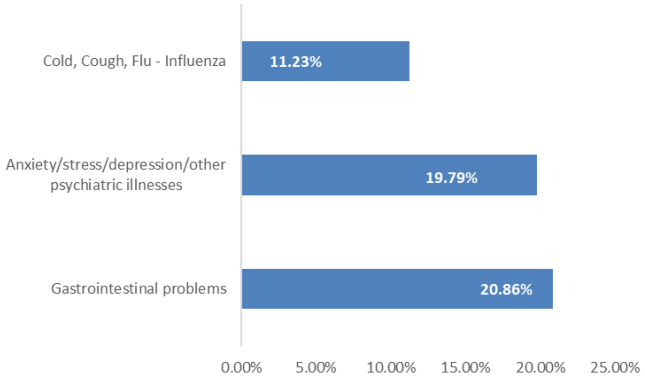
In June, the sickness absence was 4.88%; this is above the Trust target of 4%. The 12 month rolling sickness absence is 4.37%.

Sickness Absence by Division:

Division	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend
Acute Care Division	4.71%	4.00%	4.70%										
Corporate Division	5.73%	1.24%	0.00%										
Hosted Services Division	1.56%	0.00%	1.84%										
Networked Division	4.32%	6.57%	7.42%										
Radiation Services Division	3.11%	3.84%	4.50%										
Research Division	2.18%	1.57%	2.93%										
Support Services Division	0.37%	0.84%	1.19%										



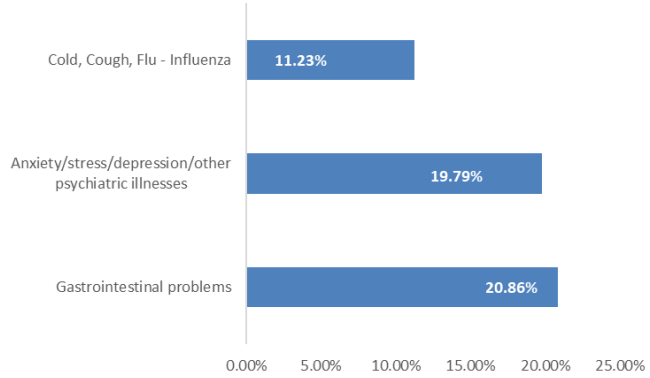
This graph shows the breakdown of long term and short term sickness absence in month, by Division.



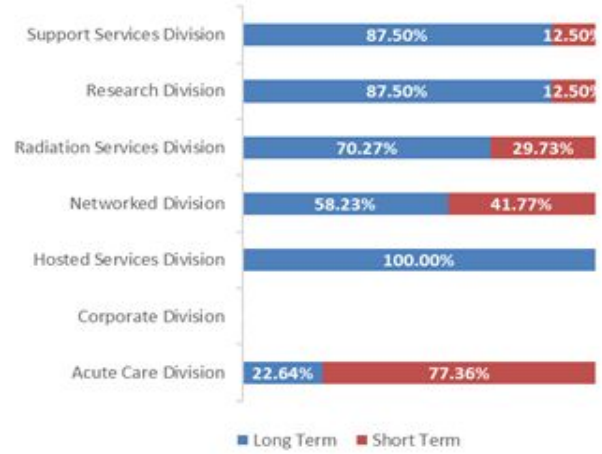
This chart identifies the top 3 reasons for absence by percentage of the overall in month sickness absence.

Sickness Absence by Division:

Division	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend
Acute Care Division	4.71%	4.00%	4.70%										
Corporate Division	5.73%	1.24%	0.00%										
Hosted Services Division	1.56%	0.00%	1.84%										
Networked Division	4.32%	6.57%	7.42%										
Radiation Services Division	3.11%	3.84%	4.50%										
Research Division	2.18%	1.57%	2.93%										
Support Services Division	0.37%	0.84%	1.19%										



This graph shows the breakdown of long term and short term sickness absence in month, by Division.



This chart identifies the top 3 reasons for absence by percentage of the overall in month sickness absence.

3.5.6 Statutory and Mandatory Training

Overall Trust compliance is 96.25%, which is a small in month increase of 0.65%.

The national compliance target for Information Governance (IG) is set at 95% whilst the Trust target for all other subjects is 90%.

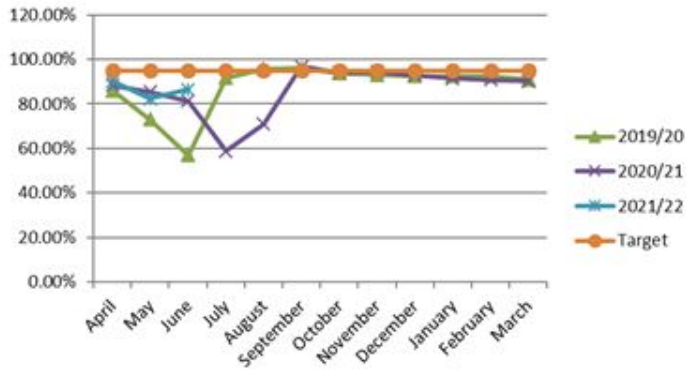
All subjects are achieving above the target with the exception of ILS, which although is underperforming against its target, has seen an in month increase of 4.92%. Based on future enrolment data, if all staff who are booked to attend sessions in July do so and pass, compliance will be achieved by 01st August.

Statutory & Mandatory Training Compliance by Division

Division	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend
Acute Care Division	90%	94.08%	94.51%	94.76%										
Corporate Division	90%	94.92%	99.36%	99.05%										
Hosted Services Division	90%	91.08%	92.79%	96.77%										
Networked Division	90%	95.61%	96.18%	96.73%										
Radiation Services Division	90%	96.96%	96.59%	96.63%										
Research Division	90%	96.93%	96.15%	97.76%										
Support Services Division	90%	92.71%	93.23%	96.38%										

All divisions are currently performing above the 90% target for overall mandatory training compliance.

3.5.7 PADR Compliance



The overall Trust in month compliance for PADRs is 86.39% which is below the target of 95%, however is a significant increase of 4.13% from May 2021.

PADR Compliance by Division

Division	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend
Acute Care Division	95%	86.45%	78.23%	78.78%										
Corporate Division	95%	92.59%	92.59%	92.86%										
Hosted Services Division	95%	82.50%	74.42%	91.18%										
Networked Division	95%	90.93%	82.66%	89.06%										
Radiation Services Division	95%	94.26%	86.00%	86.45%										
Research Division	95%	94.34%	83.93%	95.45%										
Support Services Division	95%	87.50%	81.29%	87.59%										

All Divisions have seen an in month increase in compliance.

The L&OD Team continue to work with managers to support the achievement of compliance and additional monitoring via PRGs has now been implemented. All divisions have been set a target of achieving compliance by 1st September 2021.

3.5.8 Staff Engagement

In June 2021 NHSI/E announced that it would be a requirement for all NHS provider organisations to undertaken a new quarterly staff survey that asks all staff nine engagement theme questions. This survey will replace the quarterly Staff Friends and Family Test and will take place in July, January and April, with the National Staff Survey conducted in Q3.

The nine questions, which make up the staff engagement score on the annual staff survey are;

- I often/always look forward to going to work
- I am often/always enthusiastic about my job
- Time often/always passes quickly when I am working
- There are frequent opportunities for me to show initiative in my role
- I am able to make suggestions to improve the work of my team/department
- I am able to make improvements happen in my area of work
- Care of patients/service users is my organisation's top priority
- I would recommend my organisation as a place to work
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

This new Culture and Engagement Survey was launched by Jayne Shaw, Director of Workforce and OD on the 01st July and will close on 31st July.

The new survey will be managed internally by the Learning and OD Team.

The trust is currently reviewing its reporting method for the new survey, alongside staff related metrics within the new NHSE/I System Oversight Framework.

3.5.9 Covid-19 Vaccination

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Jun-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Jayne Shaw, Director of Workforce and Organisational Development						
L	% of Staff who have had the **first** dose Covid-19 vaccination (at month end)	↑	No national target	93.2%	N/A	J A S O N D J F M A M J
L	% of BAME Staff who have had the **first** dose Covid-19 vaccination (at month end)	↑	No national target	91.5%	N/A	J A S O N D J F M A M J
L	% of Staff who have had the **first** dose Covid-19 vaccination or have refused the vaccination (at month end)	↑	No national target	96.0%	N/A	J A S O N D J F M A M J
L	% of BAME Staff who have had the **first** dose Covid-19 vaccination or have refused the vaccination (at month end)	↑	No national target	94.3%	N/A	J A S O N D J F M A M J
L	Covid-19 vaccinations: **Second** dose received as % of first dose received (at month end)	↑	No national target	96.7%	N/A	J A S O N D J F M A M J
L	Covid-19 vaccinations: BAME staff, **Second** dose received as % of first dose received (at month end)	↑	No national target	95.9%	N/A	J A S O N D J F M A M J

3.6 Finance

For key financial headlines for June 2021 are:

Metric	In Mth 3 Actual	In Mth 3 Plan*	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit) (£000)	44	0	44		77	0	77	
CPL/Propcare Surplus/ (Deficit) (£000)	7	0	7		241	0	241	
Control Total Surplus/ (Deficit) (£000)	51	0	51		318	0	318	
Group Cash holding (£000)	56,290	59,688	(3,398)		56,290	59,688	(3,398)	
Capital Expenditure (£000)	39	156	117		65	156	91	

For 2021/22 the Cheshire & Merseyside ICS are managing the required financial position of each Trust through a whole system approach. The requirement for the Trust for the first six months of the year (H1) is to achieve a break-even position.

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board	
Date of meeting:	28th July 2021	
Agenda item:	P1-121-21	
Title:	Finance Report, Month 3	
Report prepared by:	Jo Bowden	
Executive Lead:	James Thomson	
Status of the report: (please tick)	Public ☒	Private ☐

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

Purpose of the paper/key points for discussion:	To present the Trust's financial position for June 2021 (Month 2), noting; • Income and expenditure performance • Capital and cash performance

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

Next steps required:	Ongoing monitoring to ensure financial performance is maintained

REPORT COVER

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

☒ BE **OUTSTANDING**

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

☒ BE **COLLABORATIVE**

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

☒ BE **RESEARCH LEADERS**

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

☒ BE **A GREAT PLACE TO WORK**

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

☒ BE **DIGITAL**

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

☒ BE **INNOVATIVE**

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

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

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Finance Report: Month 3

James Thomson, Director of Finance

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

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1. Introduction

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

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

2. Summary Financial Performance

2.1 For June the key financial headlines are:

Metric (£000)	In Mth 3 Actual	In Mth 3 Plan*	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit)	44	0	44		77	0	77	
CPL/Propcare Surplus/ (Deficit)	7	0	7		241	0	241	
Control Total Surplus/ (Deficit)	51	0	51		318	0	318	
Group Cash holding	56,290	59,688	(3,398)		56,290	59,688	(3,398)	
Capital Expenditure	39	156	117		65	156	91	

2.2 For 2021/22 the Cheshire & Merseyside ICS are managing the required financial position of each Trust through a whole system approach. The requirement for the Trust for the first six months of the year (H1) is to achieve a break-even position.

3. Operational Financial Profile – Income and Expenditure

3.1 Overall Income and Expenditure Position

The Trust financial position to the end of May is a £77k surplus, the group consolidated position is a £318k surplus, against a break-even plan. The cash position for the group shows a closing balance of £56.2m which is £3.4m below plan. Capital spend is £39k in month.

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

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Metric (£000)	Actual M3	Trust Plan M3	Variance	Actual YTD	NHSI Plan YTD	NHSI Variance	Trust Annual Plan
Clinical Income	18,718	17,615	1,102	52,061	50,173	**1,888**	200,657
Other Income	1,247	1,669	(422)	4,793	4,991	**(198)**	20,191
Total Operating Income	**19,965**	**19,284**	**680**	**56,854**	**55,164**	**1,690**	**220,848**
Total Operating Expenditure	(19,590)	(18,963)	(627)	(55,762)	(54,199)	**(1,563)**	(216,989)
Operating Surplus	**375**	**322**	**53**	**1,092**	**965**	**127**	**3,859**
PPJV	67	67	0	181	201	**(20)**	804
Finance Costs	(398)	(389)	(9)	(1,196)	(1,166)	**(30)**	(4,663)
Trust Surplus/Deficit	**44**	**(0)**	**44**	**77**	**0**	**77**	**0**
Subsiduaries	7	0	7	241	**0**	**241**	**0**
Consolidated Surplus/Deficit	**51**	**(0)**	**51**	**318**	**0**	**318**	**0**

The table below summaries the consolidated financial position:

June 2021 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	(36)	(164)
Donated Depreciation	80	241
Trust Retained Surplus / (Deficit)	**44**	**77**
CPL	52	126
Propcare	(45)	115
Consolidated Financial Position	**51**	**318**

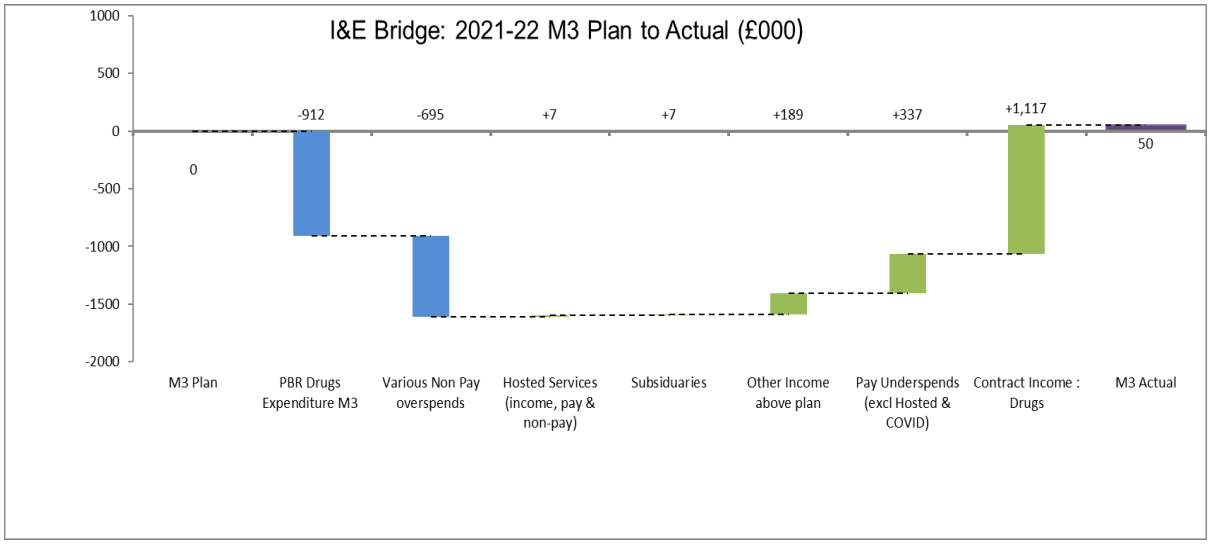
3.3 Expenditure Position

3.3.1 The bridge below shows the key drivers between the £50k in month surplus and break-even plan.

- Drugs spend is over plan by £912k. This is offset by an increase in drugs income. As part of the 2021/22 funding agreement with commissioners high cost drugs remain on a pass-through basis.
- Pay costs are £337k under plan. Workforce budgets have been set to reflect fully established staffing levels. However there are a number of vacancies across the Trust and pay underspends can be seen across all Divisions.
- Non Pay is showing an overspend of £685k – driven by the allocation of the annual CIP target. The majority of CIP targets are being met non-recurrently mainly through pay savings
- The two subsiduary companies are showing an aggregate £7k profit in month.

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust



3.3.2 The June Divisional performance is shown in the table below.

The divisional pay position shows that operational departments are largely operating below plan. Drugs spend is showing an overall overspend of £912k, offset by an over recovery of income against plan. In terms of other non-pay costs the Divisions are in the main showing slight overspends, the Corporate Division is showing a significant overspend of £376k, driven by the central CIP allocation. The Cancer Alliance position is balanced overall by income.

June 2021 (M3) £(000)	Pay			Non-Pay			Total Expenditure
	Budget	Actual	Variance	Budget	Actual	Variance	Variance
Acute Care	1,515	1,574	(59)	687	714	(27)	(86)
Corporate	1,310	1,025	285	3,451	3,828	(376)	(91)
Networked	1,659	1,595	64	571	665	(95)	(30)
Radiation Services	1,488	1,440	48	320	441	(121)	(73)
Research	365	281	84	46	27	19	103
Drugs	0	0	0	6,745	7,658	(912)	(912)
Sub-Total Operating	**6,338**	**5,916**	**423**	**11,820**	**13,332**	**(1,512)**	**(1,089)**
Hosted - Cancer Alliance	199	171	27	606	104	502	529
Finance Costs	0	0	0	322	398	(76)	(76)
TOTAL	**6,537**	**6,087**	**450**	**12,748**	**13,834**	**(1,086)**	**(636)**

June 2021 (M3) WTE	Pay			
	Budget	Actual	Variance	M2 Actual
Acute Care	385	377	(8)	372
Corporate	242	205	(36)	209
Networked	494	449	(45)	445
Radiation Services	325	309	(16)	309
Research	93	74	(19)	70
Hosted - Cancer Alliance	0	30	30	30
TOTAL	**1,538**	**1,445**	**(93)**	**1,434**
Of which substantive	1,538	1,408	(130)	1,398
Of which temporary	0	37	37	36
TOTAL	**1,538**	**1,445**	**(93)**	**1,434**

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The Clatterbridge Cancer Centre NHS Foundation Trust

3.4 Elective Recovery Fund – H1 2021/22

The table below shows the ERF plan submitted to the Cheshire & Merseyside ICS and NHSI:

Metric £(000)	Total	April	May	June	July	August	Sept
ERF Income generated	9,441	1,935	1,754	1,573	1,393	1,393	1,393
Expenditure							
Pay - costs to deliver to national monthly thresholds							
Pay - costs to deliver planned activity in excess of monthly thresholds	(970)	(115)	(171)	(171)	(171)	(171)	(171)
Non Pay - costs to deliver to national monthly thresholds							
Non Pay - costs to deliver planned activity in excess of monthly thresholds	(2,127)	(355)	(355)	(355)	(355)	(355)	(355)
Profit/Contribution	**6,344**	**1,466**	**1,229**	**1,048**	**867**	**867**	**868**

As reported last month the Trust plan includes the net contribution from the EFR of £6,344k to achieve a break-even position for H1. In the period April to June the Trust has delivered a level of activity above plan. This over-performance has not yet been reflected in the financial position due to the uncertainty over the actual level of additional income this will generate. NHSI are due to issue actual ERF achieved income figures for April imminently, once this information has been received the Trust would be able to more accurately forecast its level of income for H1.

Subsequent to the above, on 8th July 2021 NHSI issued a letter to all Trusts which amended the threshold the Trust is required to achieve before ERF is payable. The threshold for July to September was originally 85% and has now been increased to 95% of 2019/20 activity levels. The Trust is calculating the impact of this change together with any potential mitigations. This needs to be understood in the context of the Cheshire & Mersey ICS ability to achieve this increased activity threshold.

3.5 Bank and Agency Reporting

Bank spend in June is £93k, which is consistent to previous months. The largest user of bank staff the Acute Division whose spend in month 3 is £66k. The main reasons for bank spend is to cover vacancies and sickness. Agency spend in month is £50k which is similar to previous months.

3.6 Cost Improvement Programme (CIP)

In April, the Trust reported a CIP requirement of £1.9m for the full year. However, since this the Trust have been required to submit an updated plan to the CM ICS and NHSI, this revised plan required a higher level of CIP required of £1.423m for the first six months of the year (H1). The CIP requirement is broken down as follows:

- £1,224k allocated by C&M ICS
- £199k internal target to cover critical investments

The revised full year plan assumes the £1.4m will continue into the second half of the year and has been set at an annual target of £2.8m. As part of the on-going discussions around the planning process for the second half of the year it has been indicated by NHSI that a higher level of CIP may be required.

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The Clatterbridge Cancer Centre NHS Foundation Trust

CIP targets allocated to the Divisions remains at 2.0% which equates to £1.9m (excluding drugs and hosted services).

As at Month 3, a total of £727k of schemes have been identified by the Divisions, of which £522k are recurrent. The central CIP is being met non-recurrently through slippage.

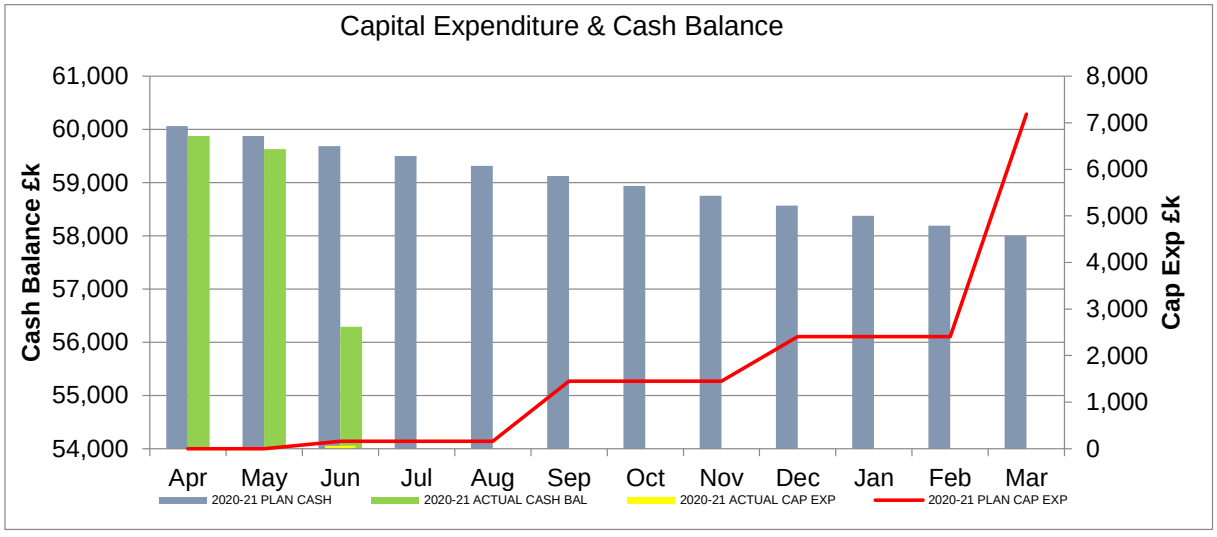
4. Cash and Capital

4.1 The capital plan approved by the Board is £7,187k for 2021/22.

4.2 Capital expenditure of £65k has been incurred to the end of June. This is slightly below the planned spend profile for the year to date. The plan is profiled such that expenditure will occur towards the end of the year. This is being monitored through the Capital Committee to ensure any slippage risk is identified and mitigated.

4.3 The capital programme is supported by the organisation's cash position. The Group has a current cash position of £56.3m, which is a negative variance of £3.4m to the cash-flow plan of £59.7m. Cash is below plan due to the Trust not receiving income in relation to net ERF for the first quarter of £5.2m, it was assumed for cash planning that this would be received on a more timely basis.

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



This chart shows monthly planned and actual Cash Balances and Planned Capital Expenditure for 2021/22. It shows that for June the Trust has less cash than planned, however, it is still considered a robust cash position.

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

5. Recommendations

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

- The June financial position
- The emerging issue regarding the anticipated ERF income
- The continuing strong liquidity position of the Trust

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix A – Statement of Comprehensive Income (SOCI)

(£000)	Month 3			Cumulative YTD				2021/22
	Plan	Actual	Variance	Plan	Actual	Variance	%	Annual Plan
Clinical Income	17,562	18,651	1,088	50,017	51,821	1,803		200,038
Other Income	514	731	217	1,522	1,946	424		6,003
Hosted Services	1,208	583	(625)	3,625	3,086	(539)		14,808
Total Operating Income	**19,284**	**19,965**	**680**	**55,164**	**56,853**	**1,689**	**3%**	**220,849**
Pay: Trust (excluding Hosted)	(5,964)	(5,627)	337	(17,242)	(16,710)	533		(68,993)
Pay: Hosted	(564)	(452)	111	(1,682)	(1,328)	354		(7,089)
Drugs expenditure	(6,745)	(7,658)	(912)	(20,236)	(21,551)	(1,315)		(80,946)
Other non-pay: Trust (excluding Hosted)	(5,037)	(5,722)	(685)	(13,083)	(14,436)	(1,353)		(52,139)
Non-pay: Hosted	(652)	(131)	521	(1,956)	(1,736)	220		(7,822)
Total Operating Expenditure	**(18,963)**	**(19,590)**	**(627)**	**(54,199)**	**(55,761)**	**(1,561)**	**3%**	**(216,989)**
Operating Surplus	**322**	**375**	**53**	**965**	**1,092**	**128**	**13%**	**3,859**
Profit /(Loss) from Joint Venture	67	67	0	201	181	(20)		804
Interest receivable (+)	401	394	(7)	1,202	1,181	(21)		4,809
Interest payable (-)	(439)	(442)	(3)	(1,318)	(1,327)	(9)		(5,272)
PDC Dividends payable (-)	(350)	(350)	0	(1,050)	(1,050)	0		(4,200)
Trust Retained surplus/(deficit)	**0**	**43**	**43**	**0**	**77**	**77**	**0%**	**0**
CPL/Propcare	0	7	7	0	241	241	0	0
Consolidated Surplus/(deficit)	**0**	**50**	**50**	**0**	**318**	**318**	**0%**	**0**

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Appendix B – Balance Sheet

£'000	Unaudited 2021	Plan 2022	Year to date Month 3 YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	2,488	2,100	2,424	2,389	(35)
Property, plant & equipment	177,180	174,267	175,680	175,053	(627)
Investments in associates	181	181	181	295	114
Other financial assets	1,364	0	0	0	0
Trade & other receivables	161	100	134	124	(11)
Other assets	0	0	147	0	(147)
Total non-current assets	**181,374**	**176,648**	**178,566**	**177,860**	**(707)**
Current assets					
Inventories	4,201	4,200	4,201	3,818	(383)
Trade & other receivables					
NHS receivables	4,621	4,500	4,621	9,629	5,008
Non-NHS receivables	4,484	4,500	7,779	7,780	1
Cash and cash equivalents	63,533	58,000	59,875	56,290	(3,585)
Total current assets	**76,839**	**71,200**	**76,476**	**77,517**	**1,041**
Current liabilities					
Trade & other payables					
Non-capital creditors	28,222	30,000	28,222	28,584	362
Capital creditors	3,544	2,000	2,000	1,568	(432)
Borrowings					
Loans	1,916	1,730	1,730	1,730	0
Obligations under finance leases	0	0	0	0	0
Provisions	2,160	1,535	2,160	2,076	(84)
Other liabilities:-					
Deferred income	5,974	4,000	5,974	6,973	999
Other	0	0	0	0	0
Total current liabilities	**41,816**	**39,265**	**40,086**	**40,931**	**846**
Total assets less current liabilities	**216,398**	**208,583**	**214,957**	**214,446**	**(511)**
Non-current liabilities					
Trade & other payables					
Capital creditors	970	0	970	970	0
Borrowings					
Loans	33,820	32,090	33,080	33,080	0
Obligations under finance leases	0	0	0	0	0
Other liabilities:-					
Deferred income	0	0	0	0	0
Provisions	1,270	110	1,270	1,283	13
Total non current liabilities	**36,060**	**32,200**	**35,320**	**35,333**	**13**
Total net assets employed	**180,338**	**176,383**	**179,637**	**179,114**	**(523)**
Financed by (taxpayers' equity)					
Public Dividend Capital	67,374	68,116	67,374	67,394	20
Revaluation reserve	2,700	2,600	2,700	2,699	(1)
Income and expenditure reserve	110,264	105,667	109,563	109,021	(542)
Total taxpayers equity	**180,338**	**176,383**	**179,637**	**179,114**	**(523)**

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NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Appendix C – Cash Flow

June 2021 (M3) £'000	FT	Group (exc Charity)
Cash flows from operating activities:		
Operating surplus	917	1,241
Depreciation	2,229	2,229
Amortisation	97	97
Impairments		
Movement in Trade Receivables	(5,698)	(5,626)
Movement in Other Assets	0	0
Movement in Inventories	436	383
Movement in Trade Payables	2,941	727
Movement in Other Liabilities	917	908
Movement in Provisions	0	20
CT paid	0	(25)
Net cash used in operating activities	**1,839**	**(46)**
Cash flows from investing activities		
Purchase of PPE	(579)	(622)
Purchase of Intangibles	(0)	(0)
Proceeds from sale of PPE	0	0
Interest received	1,181	0
Investment in associates	0	0
Net cash used in investing activities	**602**	**(622)**
Cash flows from financing activities		
Public dividend capital received	0	0
Public dividend capital repaid		
Loans received		
Movement in loans	(2,092)	(2,092)
Capital element of finance lease	0	0
Interest paid	(1,327)	(147)
Interest element of finance lease	0	0
PDC dividend paid	(1,050)	(1,050)
Finance lease - capital element repaid	0	0
Net cash used in financing activities	**(4,469)**	**(3,289)**
Net change in cash	**(2,028)**	**(3,957)**
Cash b/f	**53,765**	**60,248**
Cash c/f	**51,737**	**56,290**

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	28 July 2021
Agenda item:	P1-122-21
Title:	Mortality Annual Report 2020-2021
Report prepared by:	Helen Wong, Quality Manager (Audit & Statistics)
Executive Lead:	Dr. Sheena Khanduri, Medical Director
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	The Integrated Governance Committee & Quality Committee
Date & decision:	6th July 2021 & 22 July 2021

Purpose of the paper/key points for discussion:	The Mortality Annual Report 2020-2021 were approved by the Mortality Surveillance Group. The Trust Board is asked to approve the Mortality Annual Report.

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

Next steps required:	

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The Clatterbridge Cancer Centre
NHS Foundation Trust

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

☒ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

The Clatterbridge Cancer Centre NHS
NHS Foundation Trust

Mortality Surveillance Group Annual Report 2020-2021

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

Dr. Dan Monnery (Consultant Palliative Care)

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

Helen Wong (Quality Manager –Audit & Statistics)

Marie McKay (Clinical Audit and Information Specialist)

Andrea Law (Clinical Audit and Information Specialist)

on behalf of Mortality Surveillance Group

Members: Elkan Abrahamson (Non-Executive Director), Arpad Toth (Consultant Haemato-Oncologist & Consultant Mortality Lead), Safeguarding representative, Chemotherapy, Radiotherapy, Haemato-oncology, Pharmacy, Integrated Care Representatives

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Mortality Surveillance Group Annual Report 2020-2021

Executive Summary

Putting People first

- Families and carers actively involved in shaping our care following deaths by undertaking a local Care of the Dying Evaluation (CODE) audit to seek the views of bereaved relatives and friends about their experience, and the quality of care that was provided for someone close to them during their last hours or days of life

Achieving Excellence

- The Trust received its own bespoke NACEL dashboards which demonstrated improvements for the Wirral site which was already above average in round 1
- Continued compliance against all National Requirements as set out by the National Quality Boards guidance on "National Guidance on Learning from Deaths"
- CCC is above the National average for the majority of indicators for the Quality Surveillance Specialist Service Dashboard for Haematopoietic Stem Cell Transplantation (Adult) during 2020/21
- National Systemic Anti Cancer treatment body published 30 day mortality benchmarking for a number of tumour groups, the Trust is compariable or better than the national average figure for majority of tumour groups
- We attended 4 virtual conferences during 2020/21, namely; The essentials in Palliative and End of Life Care conference, the NACEL warm up event, the Public Health England screening inequalities conference and the Early Palliative Care for Patients with Cancer webinar
- Dr Daniel Monnery has been named the NHSE/I National Clinical Advisor for ESC in recognition of the work CCC have undertakenfor the ESC project nationally

Passionate about what we do

- The Trust adapted its Mortality Review Process during the COVID pandemic in order to continue to provide assurance
- The Trust were highly commended in the 'Changing Culture' category of the HSJ Patient Safety Awards 2020 in recognition for its work to learn from deaths to keep improving the quality and safety of the care it provides
- The Trust undertook 4 local audits from actions arising from the Mortality Review Process

Always improving our care

- Mortality review lessons learnt are disseminated Trust-wide through the Trust quarterly Shared Learning Newsletter
- Continued evolution of the 15 year Trust Mortality Review programme
- Consultant attendance at review meetings (30% local standard) has increased from 36% to 45% in the last year and the solid tumour and HO meetings have aligned
- Continued increase in learning from case record reviews and investigations conducted in relation to deaths (inpatient and outpatient deaths)
- CCC responded to a nationwide request from the Department of Health & Social Care and Care Quality Committee to undertake a local audit into DNACPR decisions during COVID 19. The audit provided assurance.

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

Looking to the future 19/20 - We Said, We Did

Completed during 2019-2020

- Further integration of HO mortality review process and reporting
  - There is now 1 unified mortality review process across the Trust
  - One unified reporting tool for solid tumour and HO

- We undertook a local Care of the Dying Evaluation (CODE) audit to seek the views of bereaved relatives and friends about their experience, and the quality of care that was provided for someone close to them during their last hours or days of life

- Digital solution for mortality process
  - Mortality Review Meetings & Mortality Surveillance Meetings have evolved onto the MS Teams platform and are now 100% virtual
  - Mortality Review Proforma's are completed 100% electronically
  - Structured Judgement Reviews are completed 100% electronically

Developments commenced during 2019-2020

- Mortality Reduction Strategy is in development
  - Measures have been identified to support the strategy

- Participate in NACEL audit round 3
  - Project was put on hold due to COVID-19 pandemic and data collection resumes on 1st June 2021

Virtual Conferences / Events Attended - HSJ Patient Safety Awards 2020

CCC were highly commended in the 'Changing Culture' category of the HSJ Patient Safety Awards 2020 in recognition for its work to learn from deaths to keep improving the quality and safety of the care it provides. Doctors and other healthcare professionals meet to reflect on every inpatient's death and consider whether anything could have been done differently.

The day after a patient has died, their family or carers has a sit-down conversation with a senior nurse where they receive practical and emotional support and can provide any feedback - positive or negative - about the care their loved one received.

Dr Sheena Khanduri said: "*This is a hugely important initiative that has involved staff from across the Trust, including our patient safety and mortality leads, the palliative care team and the clinical effectiveness team. It is fantastic to see it recognised in this way. Sadly, although there has been immense progress in cancer treatment, people do die. Reflecting on any lessons we can learn enables us to continually improve our care and continue to improve cancer outcomes.*"

Pictured left (from left to right): Dr Zafar Malik (Consultant in Clinical Oncology & Trust Mortality Lead), Dr Dan Monnery (Consultant in Palliative Medicine) & Claire Cadwallader (Palliative Care Nurse and AMBER Care / Advance Care Planning Lead) watch the virtual HSJ award ceremony live from the CCCL building

Virtual Conferences / Events Attended – Essentials in Palliative and EoL (End of Life) Care & Early Palliative Care for Patients

Dr Daniel Monnery attended Essentials in Palliative & EoL hosted by the School of Oncology at Christie to present 'Rethinking conversations and Enhanced Supportive Care (ESC). Dan also attended the Early Palliative Care for Patients webinar to present "Early Palliative care: outcomes and business case planning". Dr Monnery explained at both events that the Enhanced Supportive Care initiative promotes earlier implementation of supportive and palliative care within cancer care and focusses on the management of physical and psychological symptoms and controlling side effects from anti-cancer treatment.

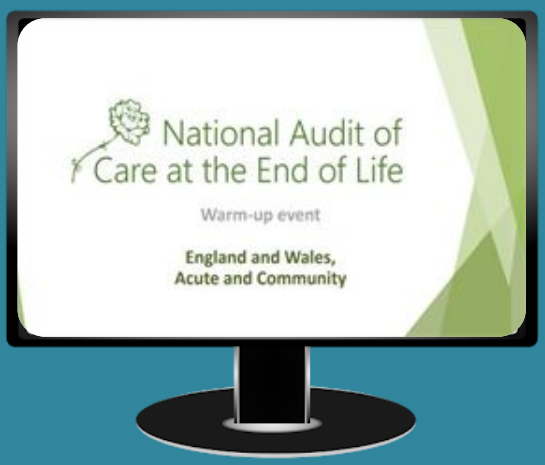
One patient said of the service: *"With their support and advice, we have been able to adapt and make the most of the family time we have. Without the ESC team I doubt we would have coped so well."*

Dr Monnery said: "*ESC is one of The Clatterbridge Cancer Centre's biggest successes of recent times in palliative care and is now being rolled out across the country. This project highlights the huge contribution it is making to patient outcomes while at the same time reducing demand on services".*

In recognition of the work undertaken at CCC, Dr Monnery has been named the NHSE/I National Clinical Advisor for ESC. Dan is scheduled to present further work on the ESC project at the MASCC/ISOO Annual meeting during 2021.

Virtual Conferences / Events Attended – NACEL Warm Up Event January 2021

Dr D Monnery (Consultant in Palliative Medicine) and M McKay (Clinical audit & Information specialist) virtually attended the NACEL warm up event in January 2021.
The event was held to outline the audit process and elements for NACEL round three and covered the organisation level audit, case note review, the quality survey and the new staff reported measure in detail.



Virtual Conferences / Events Attended - Public Health England Screening Inequalities Conference

Emma Richards, the CCC safeguarding practitioner joined more than 800 people online via a Microsoft Teams conference to attend the Virtual the Public Health England Screening Inequalities Conference. The conference focused on learning to reduce screening inequalities for people with learning disabilities. The University of Bristol's LeDeR Programme Lead presented a presentation entitled 'Screening people with Learning Disabilities: What do we know?'

Local context
Following the conference, the safeguarding team have undertaken the following across CCC to support learning from LeDeR reviews:

- → Access to training by the safeguarding team for clinical staff on MCA/DoLs processes
- → Safeguarding Team member attended MS Teams session regarding STOMP agenda and disseminated learning
- → Dissemination of easy-read public information from NHSE regarding Coronavirus and the need to get vaccinated.

National Mortality Benchmarking

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

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

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

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

Evolution of the Trust's Mortality Review Programme

The Trust's internal mortality review programme has gone from strength to strength over the last 13 years commencing with a local interest audit on 30 day mortality in lung cancer patients, to the introduction of the multi-disciplinary mortality review meeting in 2012. 2017 saw the introduction of a trust wide mortality review policy and the inception of a new mortality surveillance group. A Structured Judgement Review form based on documentation from the Royal College of Physicians was introduced in March 2018 for all inpatient deaths, allowing a thorough and structured investigation of specific phases of inpatient care delivered within the trust.

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

During 2019, further dissemination of Trust-wide shared learning was emphasised with actions and learning from mortality cases in each directorate data pack for discussion at each Directorate Quality and Safety Meeting as well as the Trust Shared Learning Newsletter.

Roadmap of Trust's Mortality Review Programme

2005

Lung cancer 30 day Systemic Anti-Cancer Therapy mortality audit

2008

NCEPOD "Systemic Anti-Cancer Therapy: For better, for worse?"

2009

Statistical Analysis of 30 day treatment mortality

2010

Global Trigger Tool Introduced

2012

Mortality Review Meeting Established

2017

- Mortality Surveillance Group
- Established & Mortality Policy Introduced

2018

- Structured Judgement Review introduced
- Mortality Dashboard Developed
- HO join Mortality Dashboard, having own section
- LeDeR & CDOP
- compliance added

2019

Inclusion of Mortality Review actions in each Directorate data pack

Learning from mortality included in Trust wide shared learning newsletter

HO and CCC-W data combined forming new Trust wide Mortality Dashboard

2020

Following COVID19 lockdown, the Mortality review programme was digitised with MRM & MSG meetings being hosted on Microsoft teams and paperwork being completed electronically.

2021

Datix®

Implementing Datix Mortality software for managing MRM programme digitally

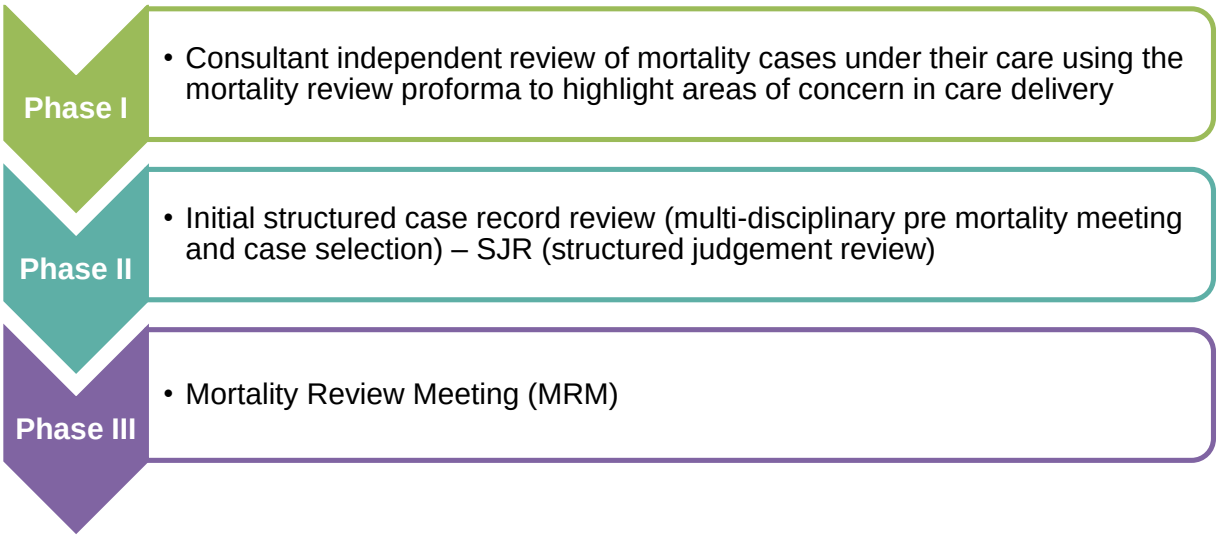
Mortality Review Scrutiny 2020/2021

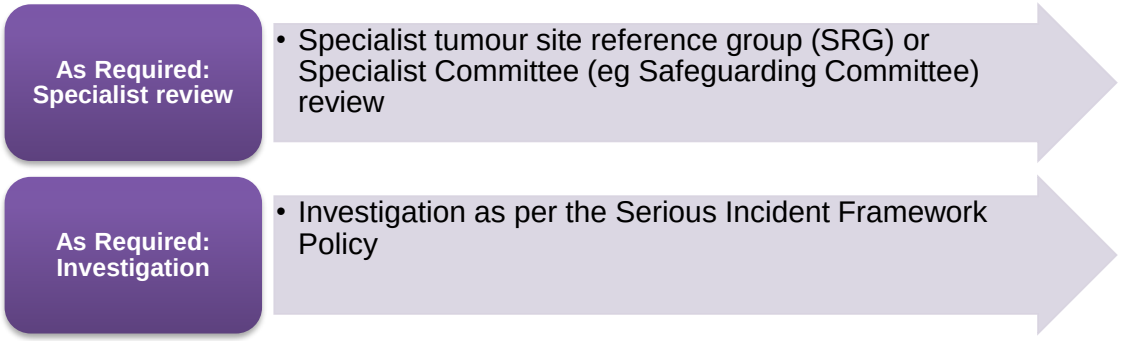
The Mortality Review Meetings are a forum for both improving practice as well as celebrating best practice. They form part of the existing Trust wide mortality review process and underpin the Trust's strategic goal to prioritise patient safety, prevent avoidable deaths and improve patient care.

This is a multidisciplinary review meeting looking at

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

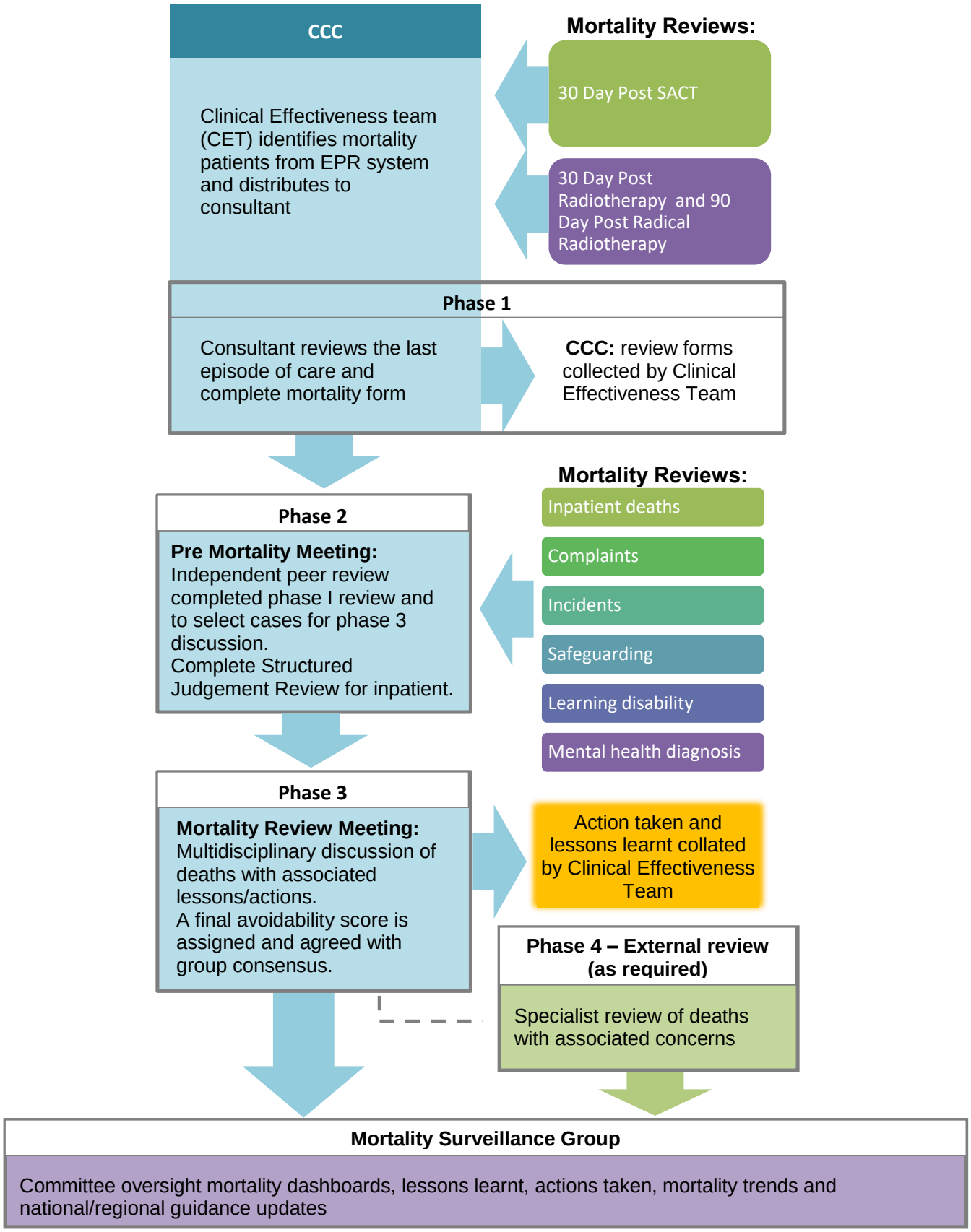
One or more of five levels of scrutiny for identified cases:





Detailed Mortality Review Process for CCC

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

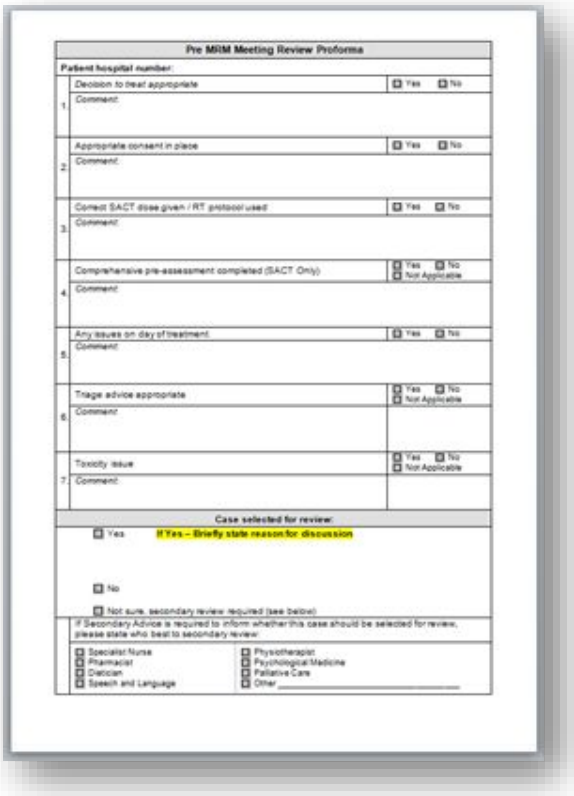


How the Mortality review process adapted to the COVID 19 pandemic:

On 23rd March 2020, the United Kingdom entered a national lockdown. CCC adapted quickly to the challenge in order to safety reduce footfall on site. Face-to-face meetings instead took place via Microsoft Teams a new virtual collaboration app which facilitated video calling, shared team areas and the scheduling of virtual meetings.

The Mortality review became even more multidisciplinary and well attended as a result, it was demonstrated that consultants who could previously not attend due to clinic commitments were now able to dial into the meeting because they did not need to cancel full clinics or commute from satellite sites.

The phase 2 case selection meeting was changed to a peer review form as pictured (right)



Pre MRM Meeting Review Proforma

Patient hospital number:

1. Decision to treat appropriate ☐ Yes ☐ No
   Comment:
2. Appropriate consent in place ☐ Yes ☐ No
   Comment:
3. Correct SACT dose given / RT protocol used ☐ Yes ☐ No
   Comment:
4. Comprehensive pre-assessment completed (SACT Only) ☐ Yes ☐ No ☐ Not Applicable
   Comment:
5. Any issues on day of treatment ☐ Yes ☐ No
   Comment:
6. Triage advice appropriate ☐ Yes ☐ No ☐ Not Applicable
   Comment:
7. Toxicity issue ☐ Yes ☐ No ☐ Not Applicable
   Comment:

Case selected for review:

☐ Yes — If Yes – Briefly state reason for discussion

☐ No

☐ Not sure, secondary review required (see below)

If Secondary Advice is required to inform whether this case should be selected for review, please state who best to secondary review:

☐ Specialist Nurse ☐ Physiotherapist
☐ Pharmacist ☐ Psychological Medicine
☐ Dietician ☐ Palliative Care
☐ Speech and Language ☐ Other _____

Multidisciplinary attendance at MRM during 2020-21:

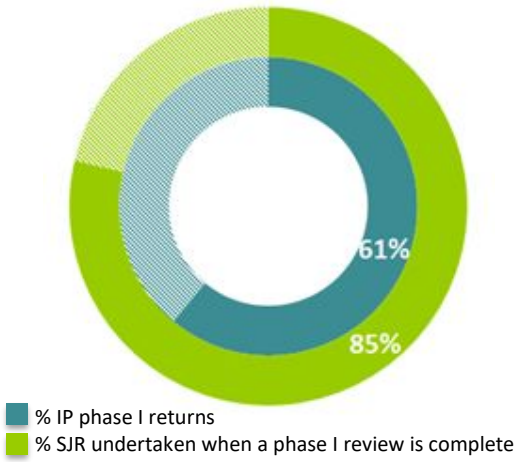
Compliance against National Guidance on Learning from Deaths 2020/2021

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

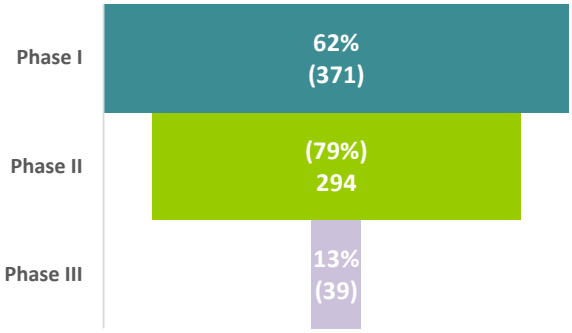
Structured Judgement Review

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

There were 102 inpatient deaths during 2020-21 out of which 62 have had a phase 1 review (61%). Out of the 62 which have had a phase 1 review, we have conducted 53 SJR's (85%). The remaining 49 cases would be carried over to the next financial year for completion.



Engagement with Trust Mortality Process



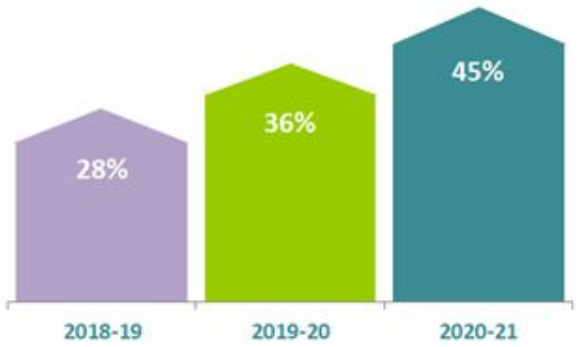
Out of the 548 cases identified as requiring review at Phase I, the graph on the left demonstrates that 371 were reviewed at Phase I which equates to 68%. Of the 371 forms completed, 294 were reviewed at the Mortality Pre-meeting (Phase II) equating to 79%.

Out of the 294 reviewed at the pre-meeting 39 were selected for further discussion at the Multidisciplinary Mortality Review Meeting (Phase III) which equates to 13% of cases.

Attendance at the Trust Mortality Review Meetings

During 2020-21 we held 10 Mortality Review Meetings (with CCC HO holding 3 meetings prior to aligning to the solid tumour process in December 2020)

30 out of 66 (45%) consultants achieved the target of 30% attendance at the mortality meeting, an improvement on 2019/20 were 36% and 2018/19 were 28% of consultants met this target.



Lessons Learnt from Mortality Review Process

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

Background	Action	CCC Lesson Learned
Palliative care consultant was unaware that we had an inpatient with persistent vomiting on the ward	DJM undertook a review of this case in terms of the escalation process within the palliative care team.	Cases where symptoms are difficult to manage despite initial interventions should be raised for medical SPCT review and this has been disseminated to the team. The weekly MDT should also cover physical symptoms in detail to ensure adequate management plans are in place.
An inpatient death should have been discussed with the coroner but was not. The ward team were not aware that the death in question met the new legislation requirements for reporting to the coroner.	The MRM asked that the new legislation regarding reporting inpatient deaths to the coroner be recirculated. Guidance was shared at the consultant away day and via email communication.	New legislation requires any patient who has a treatment which may have been a factor in their death is checked with the coroner before issuing the medical certificate of cause of death. This includes people dying of infections whilst on chemotherapy whether or not they die of neutropenic sepsis.
Patient was an inpatient at LUHFT 5 days prior to his admission to CCC, where he died of COVID-19. LUHFT was suspected as being the location where the patient contracted COVID-19	CCC Infection control team and reported to LUHFT that patient on admission on 19th Oct was found to be COVID positive and to investigate whether the patient could have contracted COVID19 from LUHFT prior to discharge.	LUHFT Infection Control Team will investigate this and report as part of their nosocomial infection review and reporting process. No lessons for CCC.

Background	Action	CCC Lesson Learned
Patient was reviewed over the telephone and their performance status was not accurately represented. They went on to have stereotactic radiotherapy. The treating consultant wished to discuss the case at MRM to highlight the pitfalls in assessment via phone/video during the COVID19 pandemic	The MRM team stated that video / face to face should be considered alongside telephone consultation when needed. The MRM also stated that performance status (PS) assessment for telephone consultation should be standardised and this has been fed back to the CNS SRG	Face to face and video consultations should be used to assess performance status in situation when it is not clear from a telephone consultation. A standardised approach to the monitoring of performance status during telephone consultations has been suggested to the SRG.
Patient's apixaban was stopped at LWH prior to ascitic drain and no evidence was found by CCC to evidence that replacement low molecular weight heparin was started following the procedure.	Inform the Women's hospital of the case and check whether patient was on therapeutic dose prior to treatment of ascites. Risk & Patient safety manager at LWH has been tasked with responding accordingly	Shared learning between Trusts is beneficial to strengthening partnership working. LWH Governance Team launched their own independent review of this case following CCC alerting via the Trust Mortality Review Meeting.
A patient receiving Carboplatin, Pemetrexed and Pembrolizumab developed myelotoxicity. As this is a new regime, the decision was taken to audit this closely to look for excess associated morbidity and mortality	Prospective audit of 30 patients on the new regime completed and found the regime to be safe. Results fed back to Mortality Surveillance Group and abstract submitted to the British Thoracic Oncology Group.	Carboplatin, Pemetrexed and Penbrolizumab is a safe regime in lung cancer. Continued analysis on this treatment regime through a prospective audit has been agreed with oversight by the lung SRG.
A patient was receiving Dexamethasone at 4mg for over a month and developed steroid induced diabetes with a blood sugar of 27. There was no plan for review or taper of the steroid.	A document pertaining to Management of Hyperglycaemia and Steroid (Glucocorticoid) Therapy was uploaded to the CCC Extranet under the medical guidelines section and new training for new doctors will be delivered.	All steroids MUST be frequently reviewed and a plan made and documented for tapering them down, or the level at which they should be maintained. If steroid-induced diabetes develops despite this, there is available guidance on how to manage this which has been adopted now by the Trust.

Background	Action	CCC Lesson Learned
A patient was admitted to CCC with a surgical problem unrelated to his cancer. There was no documented consultation with a surgeon about the patient.	Admission policy has been updated to ensure that patients presenting with surgical problems are discussed with the surgical team and transferred to a surgical centre rather than admitted.	Patients presenting with surgical problems must be discussed with the surgical team and the plan of where they should be admitted should be made collaboratively. This has been fed back to CDU teams.
A patient being treated for sarcoma received high dose radiotherapy to their hemi-thorax. This was not in line with usual practice and transpired to be a new treatment specific to Sarcoma in the last 1-2 years. Prospective auditing of toxicity was recommended to gauge toxicity.	The chair of the specialist care SRG communicated with colleagues national to benchmark toxicity.	It is good practice to benchmark new treatment outcomes with others when treatment regimes are new. In cases of rare cancer, e.g. Sarcoma, a national benchmarking exercise can ensure that care and treatment outcomes are reviewed and optimised locally. CCC actively participates in these benchmarking exercises.
Chemotherapy matron cascaded to all treatment hubs that all patients attending for chemotherapy who are receiving antibiotics must be discussed with a member of the medical team before treatment is given.	Chemotherapy matron cascaded to all treatment hubs that all patients attending for chemotherapy who are receiving antibiotics must be discussed with a member of the medical team before treatment is given.	Decisions whether to proceed with chemotherapy when the patient is receiving antibiotics are to be made by the medical team and documented prior to chemotherapy being given. All treatment hubs have been informed not to administer until the documentation has been done.
An Advanced Nurse Practitioner (ANP) had a conversation with a patient about resuscitation. The communication was excellent but the policy stated that these conversations were only to be had by registrar grade doctors or above.	The national guidance “Decisions relating to cardiopulmonary resuscitation” by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing does allow for non-medical clinicians to have these discussions if appropriately trained. CCC policy has been updated to reflect this.	Discussions about resuscitation need not be restricted to medical members of the team of another team member is trained and confident to have these discussions. This is now reflected in CCC policy.

Background	Action	CCC Lesson Learned
The term 'Do Not Resuscitate' can be construed harshly and the trust were asked to consider alternative wording, such as 'Allow Natural Death'	The Term "Do Not Resuscitate" is used in national documentation and guidance and also within regional documentation which CCC uses in collaboration with other partner Trusts.	The term "Do Not Resuscitate" is acceptable for ongoing use.
Patient known to have probable drug induced (Sirolimus) Hypertriglyceridaemia. A referral to metabolic medicine was requested but it is unclear if this was actioned. The patient developed pancreatitis due to hypertriglyceridemia and died.	- Investigation launched into whether referral to metabolic medicine was done - Inter-disciplinary case review to share lessons including discussion as to whether risk of Hypertriglyceridaemia should be added as a risk to the Allogeneic Consent Form.	Any allogeneic transplant patient on Sirolimus must have fortnightly Lipids added to the profile of bloods checked at day case /out-patient visits Any patients with evidence of high lipids from blood results should be referred to Metabolic Medicine for review asap.
Patient reviewed in H-O Day care unit on 2 occasions. Admission was recommended on both occasions but the patient refused and did not wait for senior medical review.	Case discussed at SCT M&M meeting to determine if this could have been managed differently.	In cases where patients are refusing admission a senior clinician should be contacted to review the patient in the day case unit. In circumstances where patients refuse to do this, a mental capacity assessment should be completed and documented and the treating consultant informed. This has been shared with day case teams.
Liver function tests should have been undertaken for a patient who presented to a DGH within the network. They were later found to be deranged.	Case reviewed with the mortality lead at the DGH to ascertain what their standard suite of tests is for patients receiving immunotherapy. Refresher training was also delivered to this team.	The sharing of guidelines across the network enables a safe and consistent approach to patient care and CCC should continue to actively work in collaboration to ensure that immunotherapy patients are managed appropriately on presentation by delivering refresher training packages to DGH in timely intervals.

Background	Action	CCC Lesson Learned
A patient suffered a PE during neoadjuvant treatment for muscle invasive bladder cancer. This case raised the question of whether the Khorana risk score for VTE prophylaxis should be used in this cohort of patients.	The treating consultant conducted an audit of VTE occurrence in this treatment population in order to ascertain risk and review current practice.	The conclusion of the audit highlighted that there remains no specific guidance regarding primary prophylaxis from NICE. Reference was made to the recommendation from ASCO (2020) that patients with Khorana score ≥2 may be offered thromboprophylaxis. At CCC, 14% of all patients had DVT/PE during neoadjuvant chemotherapy (both standard care and trials) - of those with Khorana score ≥2, 13% developed DVT/PE - At CCC, 9% of patients had DVT/PE during standard care chemotherapy - A retrospective multicentre study (published in 2016) suggested 8% of pts had DVT/PE during standard of care chemotherapy. Audit lead confirmed that there were no actions from this audit and that it had improved knowledge to the treating team, the audit confirmed good practice at CCC.
A patient was transferred between wards at CCC whilst in pain. It was not essential that the patient be transferred given the discomfort it caused them.	MRM asked that the patient flow team review the transfer policy. The discharge and transfer policy was re-written after formal review of this case by Matron and Ward Manager.	Transferring of clinically unwell patients between wards is not good practice and the transfer policy has been updated to reflect this

Background	Action	CCC Lesson Learned
25% of HER2 positive breast patients may develop brain metastases. Clinician suggested scanning HER2 positive patients at diagnosis, giving a possibility for resection when metastases are small, enhancing patient's QOL.	MRM asked that the Breast SRG discuss the potential benefits of scanning this cohort of patients.	Patients receive brain scans when they are symptomatic. Scanning all patients does not add value in this setting because some patients can live for 10years+ before developing brain metastases, therefore subjecting them to numerous unnecessary scans.
Sepsis was not recognised or managed appropriately in a patient with 5 of the sepsis 6 red flags present.	This case was flagged for incident review by the mortality review process.	• All clinical staff are to use the SBAR tool to communicate with offsite clinicians in order to ensure pertinent information is not missed • The O2 policy was shared with the ward staff to ensure they are aware that a decision to manage a patient under SpO2 scoring system 2 in NEWS2 can be made by the admitting clinician on the basis of the atrial blood gas readings. However this must be confirmed by a ST3 or above doctor. Every effort should be made to contact an ST3 doctor or above at the earliest opportunity to confirm the decision - but the decision must be confirmed within 14 hours of admission. • Ward staff need to fully understand the NEWS2 policy and follow it correctly- this is covered in mandatory training • On call staff from home should use remote access to Meditech to triangulate information and document their advice.
Patient had fibrinous pericarditis with massive pericardial effusion. Treating consultant concluded that this was very likely a side effect of toxicity from Pembrolizumab immunotherapy.	Treating consultant shared this case with the wider immunotherapy team and to cascade learning to teams who also treat with immunotherapy	This learning was disseminated to immunotherapy team and newly appointed Consultant Cardiologist in Imaging & Cardio-Oncology. Future such cases can be treated as myocarditis using existing protocols

Background	Action	CCC Lesson Learned
A patient was admitted to CCC for NG feeding having developed mucositis during radical radiotherapy. To his neck. He was not prescribed appropriate analgesia and staff believed the patient was 'Nil-By Mouth' and did not give the patient his oral medication. As a result the patient did not get his furosemide which he has been taking for heart failure prior to admission. The patient died with congestive cardiac failure as a contributory cause.	Audit undertaken of prevalence of medications being missed in patients presenting with dysphagia SUI declared and investigation undertaken.	• The Trust had different polices for different aspects of Dysphagia care. This in turn led to confusion when looking for guidance. A single unified policy addressing all of the factors in this case has been developed. • System changes have been conducted to allow identification of critical medicines on Meditech and escalation process for when critical medications cannot be administered has been developed • CDU and ward nurses have received update training to be fully compliant with training on assessing swallow and insertion of uncomplicated NG. Further training has been delivered to junior doctors at induction as to how to conduct a ward round and ward pharmacists have received updated job role information to include the review of medications missed on the ward.
Patient had one lung removed and the mortality group queried whether constraints for radiotherapy should be amended in these scenarios.	Lung SRG Consultant undertook a comprehensive literature review to determine best practice.	CCC currently follows best practice as supported by the literature evidence on this topic
An inpatient deteriorated rapidly but there was a lack of communication with the family about how unwell the patient had become. The patient's family were therefore not present when patient died and were informed of death over the telephone. Amber care bundle tool to be implemented	Trust appointed a new Amber Care & Advance Care Planning Project Lead to implement Amber Care Bundle and Advance Care Planning across the Trust	Early recognition of deteriorating patients with uncertain recovery is essential for timely and accurate communication with patients and families, including arranging for family to be present if they wish. This will be supported by the Launch of the AMBER care bundle

Background	Action	CCC Lesson Learned
End of life care documentation was not fully completed for a patient.	The ward Manager confirmed this issue is now routinely discussed in morning safety huddles on the ward. Palliative Care consultant conducted a teaching session for the registrars on 9/5 covering documentation at end of life.	It is important to complete End of life documentation completely. Further training and awareness of paperwork was delivered.
There were no next of kin (NOK) telephone details recorded in the electronic patient record for a patient.	The electronic patient record training was adjusted to reinforce how to document NOK details.	Next of kin details must be completed for new patients presenting to CCC. It is important for the hospital to be able to contact the patients NOK for urgent matters and for this to be obtainable out of hours and this now forms part of EPR training.
SACT assessment was not completed for a patient receiving Carboplatin on Delamere day ward	MRM asked that a Datix be raised regarding the assessment not being completed. A Datix was raised and an investigation conducted	The importance of documentation of assessments in real time is now reinforced during safety huddles.
A recent audit by the Lower GI SRG into Capecitabine related deaths recommending greater awareness of side effects by patients due to toxicities noted in mortality reviews.	Lower GI SRG conducted a review of the consent form and importance of documentation of toxicity including life threatening side effects. The Lower GI SRG discussed the Capecitabine consent documentation and agreed to absorb the recommendations into practice.	Consent forms in lower GI regimes have been updated to reflect additional toxicities discussed in the consent process

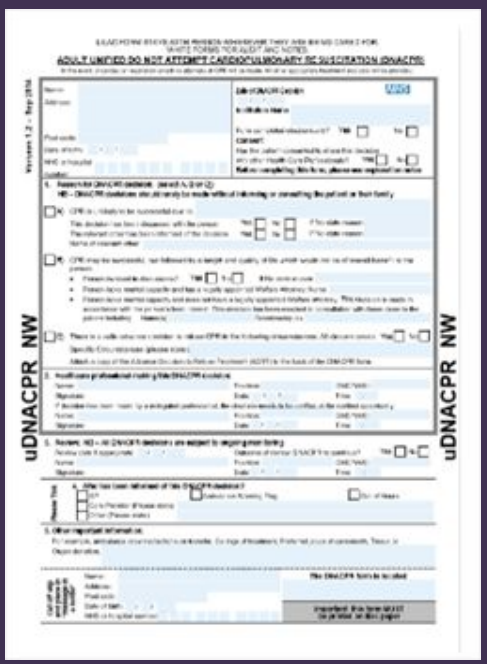
Background	Action	CCC Lesson Learned
A patient's consent form did not appear to be scanned into the correct place, as there are two places it could be found.	MRM asked that the administration team clarify the area that Consent form should be uploaded to in Meditech – is this Evolve or Reports?	Within Meditech the consent form is visible in both the reports section on Meditech and within the consent form section on Evolve, all paper documents are scanned into Evolve.
A patient's blood results undertaken at a DGH did not appear to be captured within Meditech.	CCC IM&T team were asked to clarify the mechanism for processing outside results into Meditech.	Currently Meditech is linked to the labs at LCL and Wirral. All other results require input manually – either by treatment staff (in Chemo clinic) or medical staff (no change in process). Work is ongoing to digitally link Meditech with other labs. In the meantime printed results can be scanned into evolve.
Patient was admitted to CCC and remained on MSCC pathway for 6 weeks awaiting treatment.	CCC MSCC Coordinator was asked to audit the delays in this case and general delays in the service. Results showed delays involved in this patient's care were at DGH, at all points CCC had acted within process and network agreed timeframes. Despite this, CCC host the pathway and have taken a proactive approach to improve the service across the network. The MSCC coordinator raised Datix alerts with DGHs involved and asked them to conduct internal investigations. CCC MSCC team have also increased their resource to facilitate better "chasing" after initial referral as a safety net. Going forwards all patients in this category will receive a review from the MSCC coordinator and linked into mortality review process for further discussion where further lessons are identified.	As the host of the MSCC pathway, the MSCC team have oversight of the wider pathway to further direct local learning in other hospitals when needed.

Review of DNACPR decisions during the COVID-19 Pandemic

Review undertaken by Dr Daniel Monnery (Consultant in Palliative Medicine) and Sinead Benson (Palliative Care Clinical Nurse Specialist)

Introduction: The purpose of a do not attempt cardio pulmonary resuscitation (DNACPR) decision is to provide immediate guidance to those present on the best actions to take or not take should a person suffer cardiopulmonary arrest. Discussions are an area of great sensitivity and potentially distressing for patients and those who are closest to them. It is a legal requirement for clinicians to discuss this with patients or those closest to the patient should they not have mental capacity. Excellent communication skills and timing of these discussions are of the upmost importance. Hall et al (2018) highlight that patients and those important to them prefer discussions sooner rather than later in their disease trajectory, and wishes to involve those who are important to the patient varies from patient to patient. With the increase in COVID- 19 rates and deaths clinicians have been encouraged to discuss DNACPR early on in the patient's admission.

In October of this year the Department of Health and Social Care asked the Care Quality Commission (CQC) to review how DNACPR orders were used during the COVID- 19 pandemic as there was growing concerns regarding the elderly and vulnerable people, that they may be being subjected to DNACPR decisions without their consent or with little information to allow them to make an informed decision. There had also been concern raised about apparent 'blanket use' of DNACPRs without the appropriate assessment and communication to support this decision making specific for each individual affected. It was recommended therefore that each Trust review the DNACPRs undertaken during the COVID-19 pandemic and when these were still in place for living patients, consideration be given to rescinding inappropriate DNACPR decisions where there is a lack of evidence that it is in the best interests of the patient or fails to meet the standards expected to ascertain the best interests of the patients. This prompted Clatterbridge Cancer Centre (CCC) to look at the practice of their clinicians regarding DNACPR decisions and discussions.



Findings:
It was clear from this audit that all DNACPR decisions audited in the time period were made on the basis of an individualised assessment and appropriate discussion with either the patient or (less commonly) with those important to them. The only instances where this was discussed with those important to the patient instead of the patient were instances where the patient was too unwell and lacked capacity to have the discussion.

One error was described in which the patient's discharge letter documented that they had a DNACPR in place when they did not. However this patient did have incurable disease and went on to receive end of life care at home, so his care was unaffected by this documentation error. This was addressed promptly with junior doctors at induction and the importance of checking this information (present in the header bar on Meditech) when they complete discharge summaries was discussed.

National Audit of Care at the End of Life (NACEL) – Bespoke Dashboards

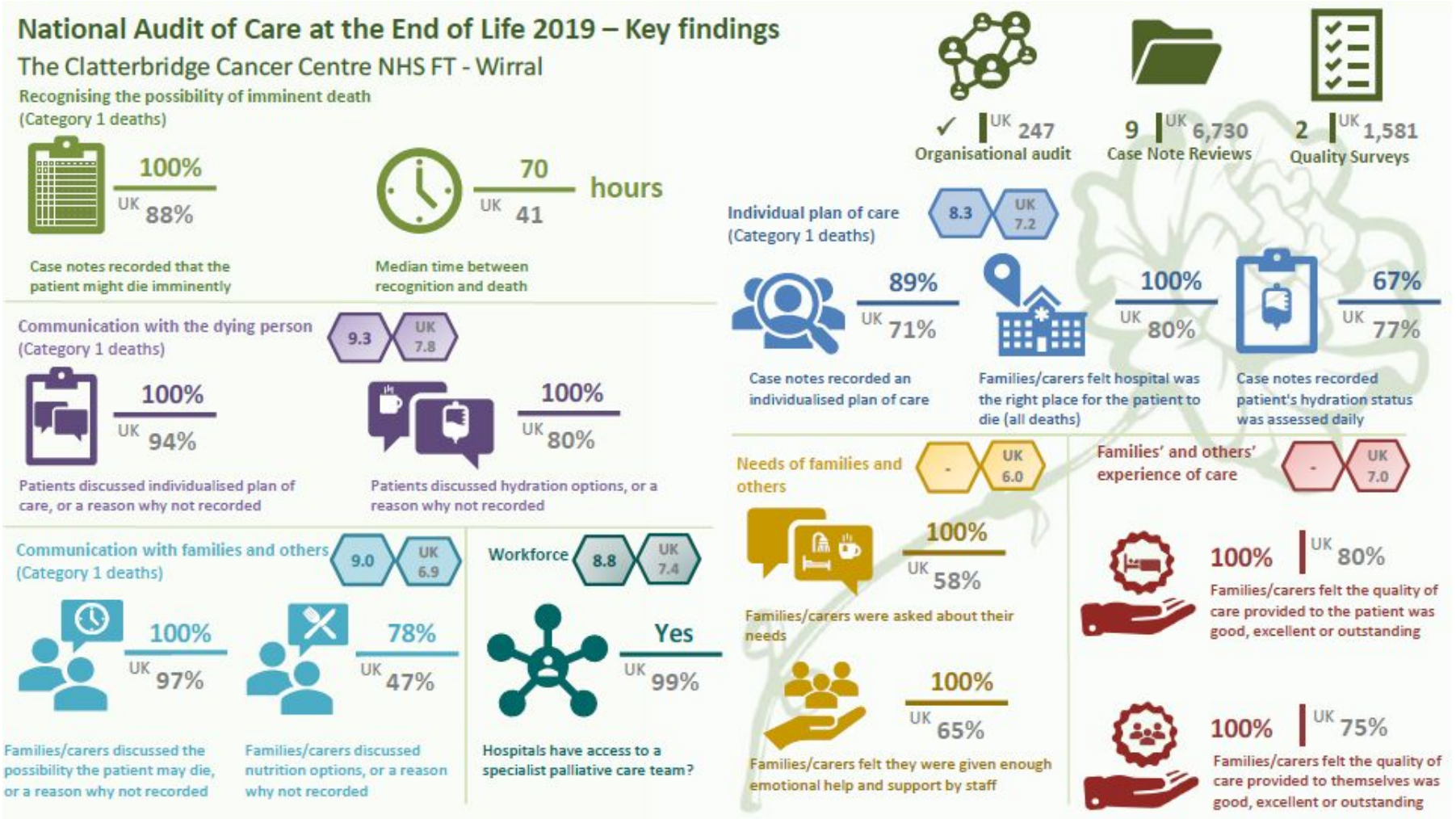
NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission before death in acute, community hospitals and mental health inpatient providers in England, Wales and Northern Ireland.

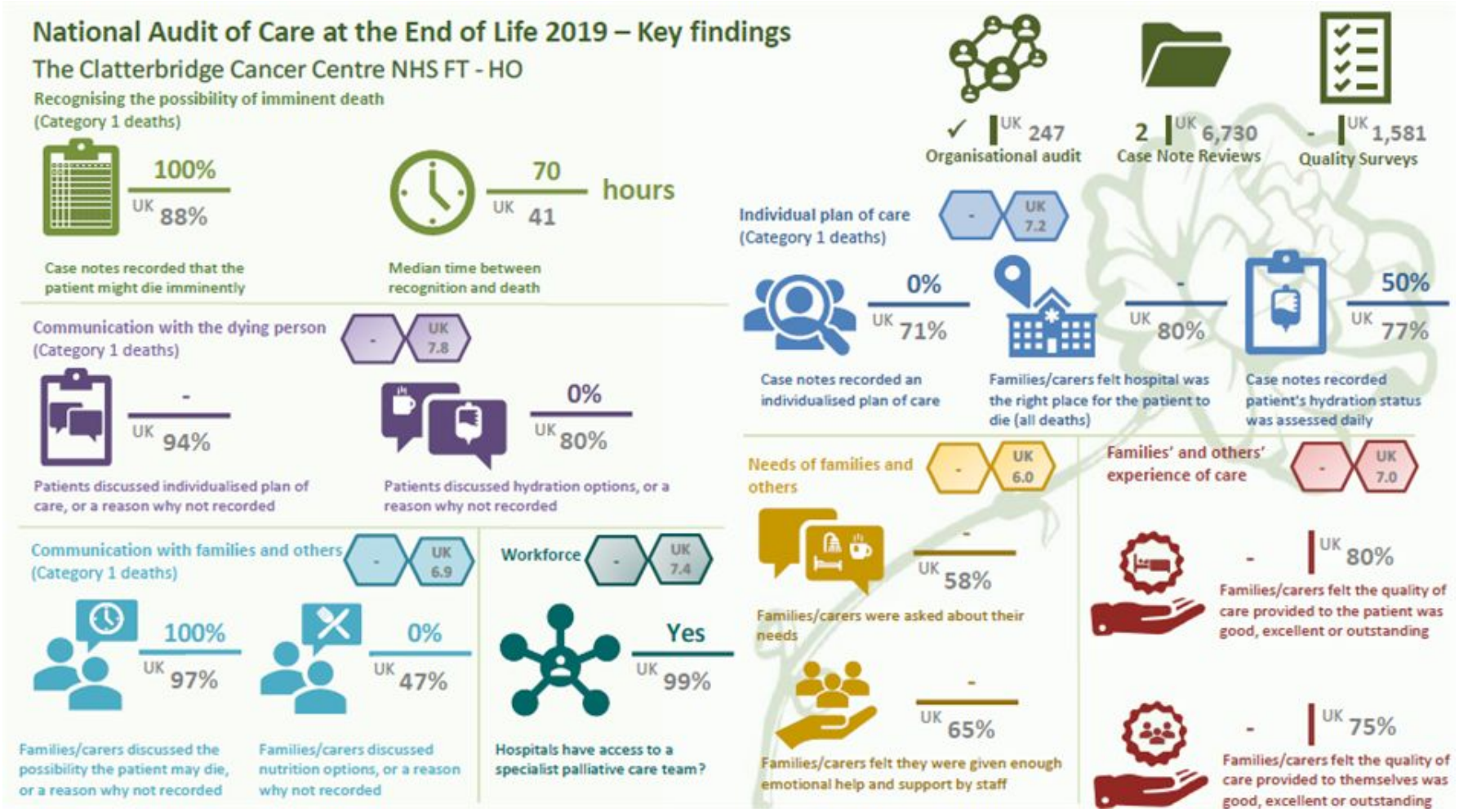
NHS Benchmarking Network were commissioned by HQIP to provide NACEL. The audit consists of three cycles undertaken over three consecutive years. The aim of the audit is to improve the quality of care at the end of their life. NACEL covers NHS funded inpatient care provided to adults (18+).

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

- ✓ To refine the tools for assessing compliance with national guidance on care at the end of life – One Chance To Get It Right, NICE guidelines and the NICE Quality Standards for end of life care.
- ✓ To measure the experience of care at the end of life for dying people and those important to them.
- ✓ To provide audit outputs which enable stakeholders to identify areas for service improvement.
- ✓ To provide a strategic overview of progress with the provision of high-quality care at the end of life in England, Wales and Northern Ireland.

A comprehensive action plan was formulated after NACEL round 1 and all actions have now been implemented. In May 2020 the Trust received its own bespoke dashboards which demonstrated improvements for the Wirral site which was already above average in round 1. The Haemato-oncology Liverpool site dashboard showed room for improvement and a formal response was developed, implemented and presented to the Mortality Surveillance Group.


National Audit of Care at the End of Life 2019 – Key findings
The Clatterbridge Cancer Centre NHS FT - Wirral
Recognising the possibility of imminent death
(Category 1 deaths)
100%
UK 88%
Case notes recorded that the patient might die imminently
70
UK 41
hours
Median time between recognition and death
Communication with the dying person
(Category 1 deaths)
9.3
UK 7.8
100%
UK 94%
Patients discussed individualised plan of care, or a reason why not recorded
100%
UK 80%
Patients discussed hydration options, or a reason why not recorded
Communication with families and others
(Category 1 deaths)
9.0
UK 6.9
100%
UK 97%
Families/carers discussed the possibility the patient may die, or a reason why not recorded
78%
UK 47%
Families/carers discussed nutrition options, or a reason why not recorded
Workforce
8.8
UK 7.4
Yes
UK 99%
Hospitals have access to a specialist palliative care team?
✓ UK 247
Organisational audit
9 UK 6,730
Case Note Reviews
2 UK 1,581
Quality Surveys
Individual plan of care
(Category 1 deaths)
8.3
UK 7.2
89%
UK 71%
Case notes recorded an individualised plan of care
100%
UK 80%
Families/carers felt hospital was the right place for the patient to die (all deaths)
67%
UK 77%
Case notes recorded patient's hydration status was assessed daily
Needs of families and others
-
UK 6.0
100%
UK 58%
Families/carers were asked about their needs
100%
UK 65%
Families/carers felt they were given enough emotional help and support by staff
Families' and others' experience of care
-
UK 7.0
100%
UK 80%
Families/carers felt the quality of care provided to the patient was good, excellent or outstanding
100%
UK 75%
Families/carers felt the quality of care provided to themselves was good, excellent or outstanding


National Audit of Care at the End of Life 2019 – Key findings
The Clatterbridge Cancer Centre NHS FT - HO
Recognising the possibility of imminent death
(Category 1 deaths)
100%
UK 88%
Case notes recorded that the patient might die imminently
70
UK 41
hours
Median time between recognition and death
Communication with the dying person
(Category 1 deaths)
-
UK 7.8
-
UK 94%
Patients discussed individualised plan of care, or a reason why not recorded
0%
UK 80%
Patients discussed hydration options, or a reason why not recorded
Communication with families and others
(Category 1 deaths)
-
UK 6.9
100%
UK 97%
Families/carers discussed the possibility the patient may die, or a reason why not recorded
0%
UK 47%
Families/carers discussed nutrition options, or a reason why not recorded
Workforce
-
UK 7.4
Yes
UK 99%
Hospitals have access to a specialist palliative care team?
✓
UK 247
Organisational audit
2
UK 6,730
Case Note Reviews
-
UK 1,581
Quality Surveys
Individual plan of care
(Category 1 deaths)
-
UK 7.2
0%
UK 71%
Case notes recorded an individualised plan of care
-
UK 80%
Families/carers felt hospital was the right place for the patient to die (all deaths)
50%
UK 77%
Case notes recorded patient's hydration status was assessed daily
Needs of families and others
-
UK 6.0
-
UK 58%
Families/carers were asked about their needs
-
UK 65%
Families/carers felt they were given enough emotional help and support by staff
Families' and others' experience of care
-
UK 7.0
-
UK 80%
Families/carers felt the quality of care provided to the patient was good, excellent or outstanding
-
UK 75%
Families/carers felt the quality of care provided to themselves was good, excellent or outstanding

HO NACEL Round 2 response and action plan

Perceived causative factors	Action identified to enhance our service
Consultant Workload	Recruitment of additional Specialist interest consultants to share the complexity and volume of workload allowing more time for sharing of sensitive concerns between the patient and his or her medical team
Limited Dietetic support	We have been able to vastly improve the dietetic support made available to all our patients, especially those at the end of life following relocation into the new Clatterbridge Cancer Centre (CCC) as we now have access to a highly motivated and experienced team of dietitians in the new CCC
Lack of Advanced Nurse Practitioners	It was felt the absence of regular cover from a team of advanced nurse practitioner would not only provide support and continuity for nursing staff and patients but their renowned ability to deliver non-medical complex decision-making would have almost certainly negated a great number of failings that occurred. HO is proud to say that from 1st July 2020 the inpatient ward has been assigned two ANP's to cover 8 till 8 Monday to Friday and one ANP to cover Saturday and Sunday 9 till 5
Electronic case notes	Meditech an IT system designed for cancer care. Meditech has an end of life care package built in to it. This package will help us to measure end of life care we provide in the future
The need for the newly appointed ANP's to receive specific training surrounding palliative and end of life care	Bespoke learning package has been developed with mentorship from our Palliative Care consultant body

Audits arising from Mortality Review Process

The following audits arose from discussions at either the Mortality Review meeting or the Mortality Surveillance Group.

Missed Medication Audit

Background

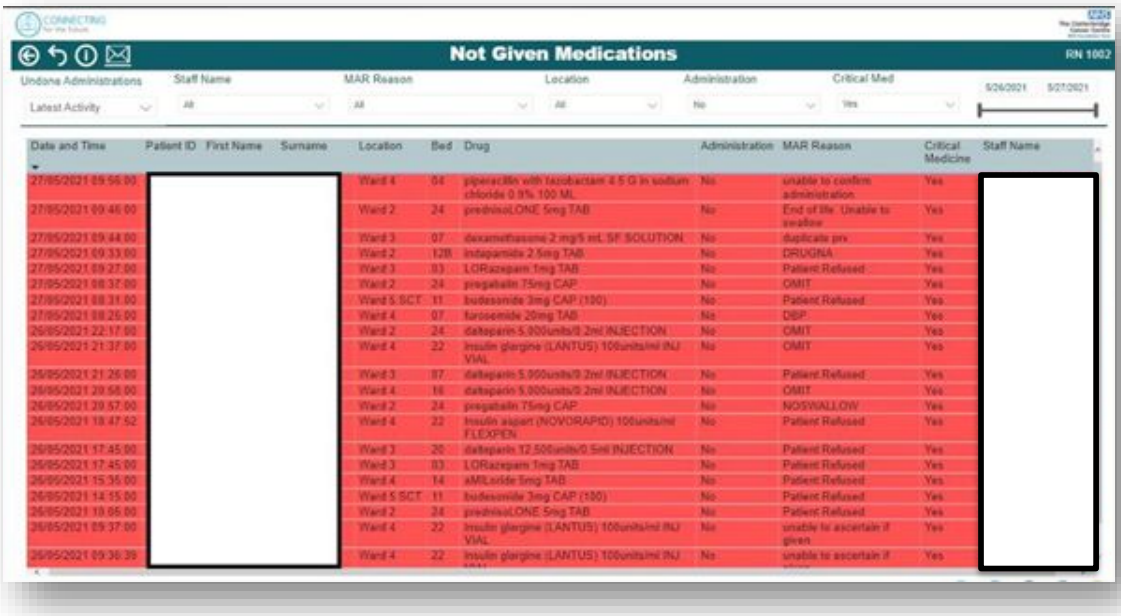
A recent complaint and mortality review (structured judgement review) highlighted failings in care relating to patients missing crucial medications when they are admitted with dysphagia (difficulty swallowing). The reasons for missing medications were multifactorial but prompted an audit into the commonality of this occurring in patients who are admitted with dysphagia.

Conclusions

50 patients were identified. All 50 cases were reviewed by case note audit. Out of 50 patients, 38 did have dysphagia during their admission requiring intervention such as enteral medication administration. Of the 38 patients who developed dysphagia on or during admission, 26 had been taking regular medication prior to the development of dysphagia.

It was agreed as a result of the audit that significant improvements needed to be made:

- The Trust had different polices for different aspects of Dysphagia care. This in turn led to confusion when looking for guidance. A single unified policy addressing all of the factors in this case has been developed.
- System changes have been conducted to allow identification of critical medicines on meditech and escalation process for when critical medications cannot be administered has been developed (see below missed medications dashboard developed by the CCC Business Intelligence Team)
- CDU and ward nurses have received update training to be fully compliant with training on assessing swallow and insertion of uncomplicated NG.
  Further training has been delivered to junior doctors at induction as to how to conduct a ward round and ward pharmacists have received updated job role information to include the review of medications missed on the ward.



Audits arising from the mortality review process continued

Hypersensitivity reactions to Paclitaxel

Background
Paclitaxel is a mainstay of cancer treatment for breast cancer and gynaecological cancer. It accounts for approximately 9.6% of all cycles of systemic anticancer treatment given to the patients at Clatterbridge Cancer Centre. Following a serious incident that occurred in December 2020, the medicines safety advisory group requested an audit of hypersensitivity reactions, the audit was fed into the Medicines Safety Advisory Group, the Mortality Review Meeting & The Drugs & Therapeutics Committee.

Conclusions
The audit provided assurance. Results demonstrated that rates of reaction were reported to be 0.6% for mild to moderate hypersensitivity (compared to 10-30% in literature), 0.5% for severe hypersensitivity (compared to 1% in literature) and 0.07% for anaphylactic reactions (compared to 0.1% in literature).

6 Weekly Pembrolizumab

Background
Pembrolizumab is licensed for patients with programmed cell death ligand (PD-L1) positive tumours in NSCLC, as both 1st line treatment & as subsequent treatment following platinum combination chemotherapy as per the KEYNOTE-024/KEYNOTE-010 clinical trials. Based on the interim data from KEYNOTE-555 trial, the FDA gave approval for Pembrolizumab to be given 6 weekly rather than 3 weekly.

Conclusions
Our experience shows that the 6 weekly schedule is well-tolerated and will endeavour to improve patient care, reduction in hospital visits and costs. Prospective studies are needed to evaluate further. The audit lead submitted these findings to the European Society of Medical Oncology (ESMO)

ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

Carboplatin, Pemetrexed & Pembrolizumab Safety & Efficacy Audit

Background
The MRM asked the Lung SRG to audit the newly introduced regimen Carboplatin, Pemetrexed & Pembrolizumab. The audit lead with the help if CET audited all patients from January 2019 when the regimen was started at CCC in NSCLC and prospectively collected data throughout 2020.

Conclusions
The audit compared safety data to trial for the first 30 NSCLC patients receiving the regimen and deduced that the regimen was safe to use and findings were comparable to trial data. The findings were presented to The British Thoracic Oncology Group (BTOG). The audit continues and the team are now investigating patient outcomes.

BTOG Annual Conference

Quality Surveillance and Specialised Services

What is Quality Surveillance?
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 most important dashboard indicators are BMT 08a-A which shows the percentage of patients dying at 100 days of the transplant. This shows that in the period from Jan-2020 to Dec 2020 CCC had a mean average of 4.4 100 day mortality in autologous transplants, whereas the national figure is 1.8. This is higher than the national average. The second data to emphasise is the BMT13-A relates to allogeneic transplant patients dying within 100 days of transplant. The national average is 17.8%. Our data is 0% which is better than the national average. All other parameters, like engraftment percentage is satisfactory as well. No concerns at the time of data collection.

It is worth to note that the COVID19 related changes in the transplant practice will influence 2020 data. This is partially likely due to the impact of COVID related deaths. At the moment a according to international data there is a 10% risk with autograft and 20% risk of allograft patient to die from a coronavirus pneumonia. This is higher than any other chest infection risk. Secondly the relatively lower risk myeloma patients have been deferred from autograft as this is not a curative treatment plan. Missing these patients in the cohort will likely increase the morbidity/mortality data of BMT patients.

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 average.

Haemopoietic Stem Cell Transplant Positive Alerts
For Q1-Q3 of 2020-2021 the Haemopoietic Stem Cell Transplant Programme had 0 Negative alerts, 2 Positive alerts, 1 neutral alerts

QTR1

QTR2

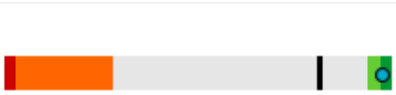
QTR3

Haemopoietic Stem Cell Transplants full Dashboard and Interpretation

CCC is above the National average for the majority Quality Surveillance Specialist Service Dashboard indicators for Haematopoietic Stem Cell Transplantation (Adult) during 2020

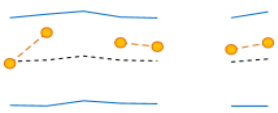
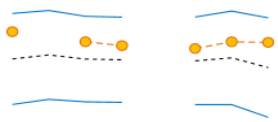
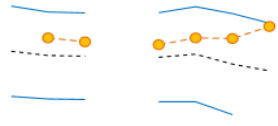
BMT02a-A - Relating to Autograft Stem Cell Transplant Patients

- 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
- Value – CCC SCT Programme
- Interpretation Guidance - Higher is better

QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
1	Jan 20 – Jun 20	22	22	100	98.2		
2	Apr 20 – Sep 20	28	28	100	97.7		
3	Jul 20 – Dec 20	35	35	100	97.5		

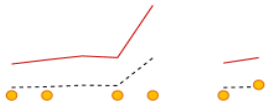
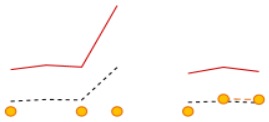
BMT06-A – Relates to ALL both Autograft and Allogeneic where applicable

- 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
- Value – CCC SCT Programme
- Interpretation Guidance – Non-discriminatory indicator

QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
1	Jul 19 – Jun 20	17	74	23	18.2		
2	Oct 19 – Sep 20	13	57	22.8	15.3		
3	Jan 20 – Dec 20	15	57	26.3	13.4		

BMT08a-A – Relates to Autograft Stem Cell Transplant Patients

- 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
- Value – CCC SCT Programme
- Interpretation Guidance – Lower is better

QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
1	Jul 19 – Jun 20	*	*	2.3	1.9		
2	Oct 19 –Sep 20	*	*	2.2	1.6		
3	Jan 20 – Dec 20	*	*	4.4	1.8		

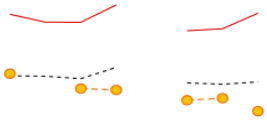
BMT09a-A – Relates to Allogeneic Stem Cell Transplant Patients

- 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
- Value – CCC SCT Programme
- Interpretation Guidance – Higher is better

QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
1	Jul 19 – Jun 20	49	51	96.1	93.4		
2	Oct 19 – Sep 20	51	54	94.4	93.3		
3	Jan 20 – Dec 20	52	55	94.5	93.4		

BMT13-A – Relates to Allogeneic Stem Cell Transplant Patients

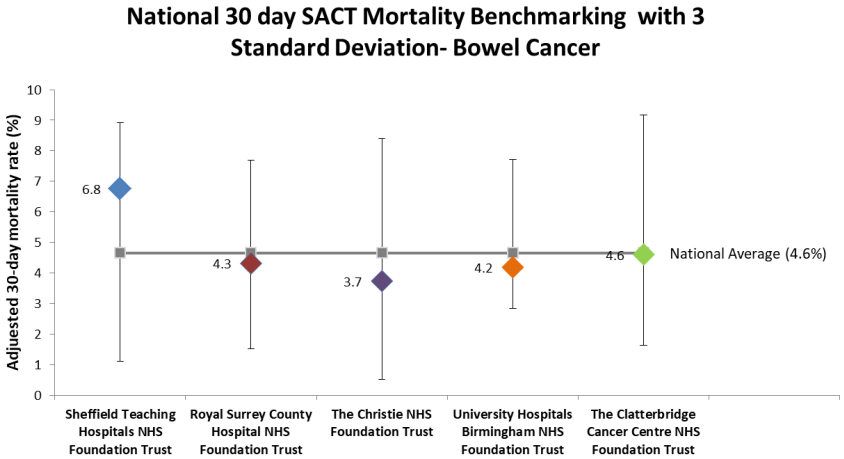
- Numerator Description – Number of patients in denominator who died within 100 days of allogenic transplant
- Denominator Description – Total number of allogenic transplants in the first 365 days of the previous 465 day reporting period
- Value – CCC SCT Programme
- Interpretation Guidance – Lower is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

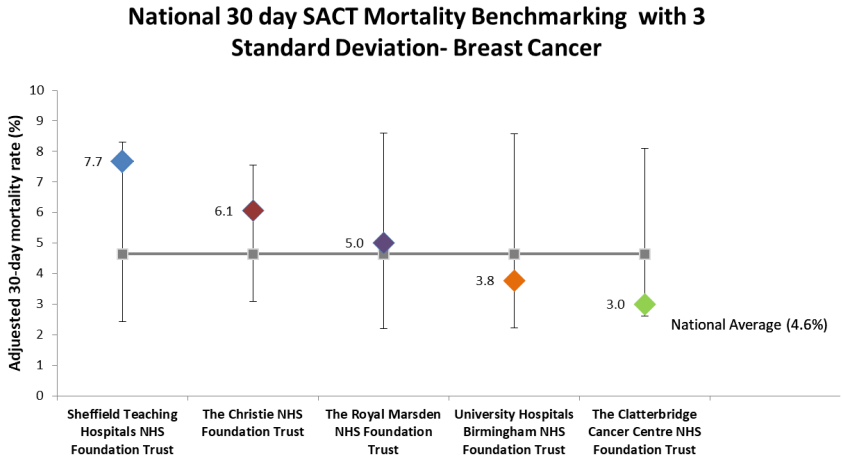
QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
1	Jul 19 – Jun 20	*	*	3.7	7.7		
2	Oct 10 – Sep 20	0	19	0	8.4		
3	Jan 20 – Dec 20	0	12	0	17.8		
4	Apr 20 - Mar 21						

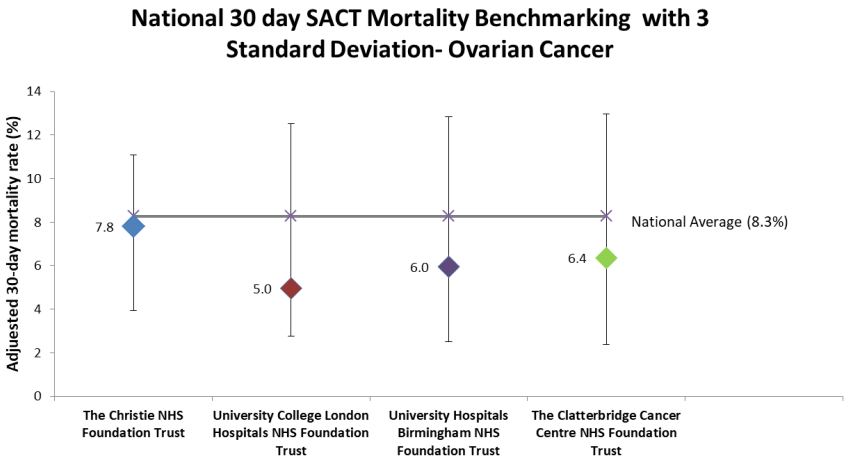
30 Day SACT Treatment Mortality Benchmark

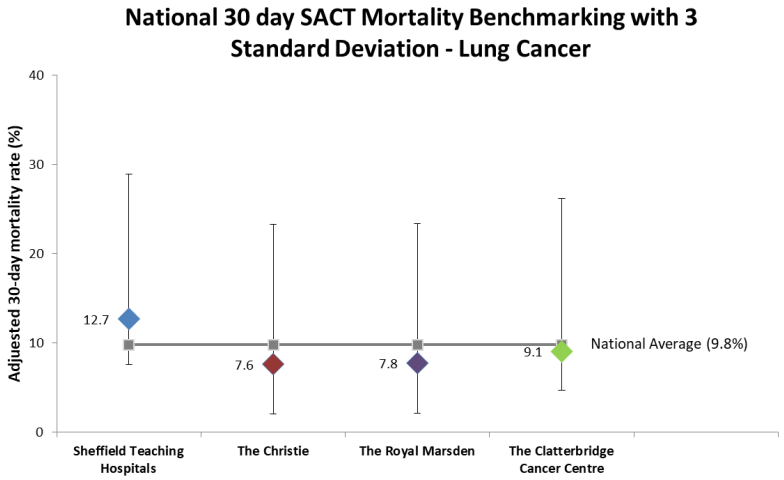
National Systematic Anti-Cancer Treatment (SACT) body published 30 day SACT 30 day mortality benchmarking by treating NHS hospitals for Bowel, Breast, Ovarian, Lung, Pancreas, Gastric, Unknown primary, Myeloma, prostate, Acute myeloid leukaemia (AML) and Acute lymphoblastic leukaemia (ALL) cancer In April 2020 – March 2021, utilising data submitted between 2017 - 2019.

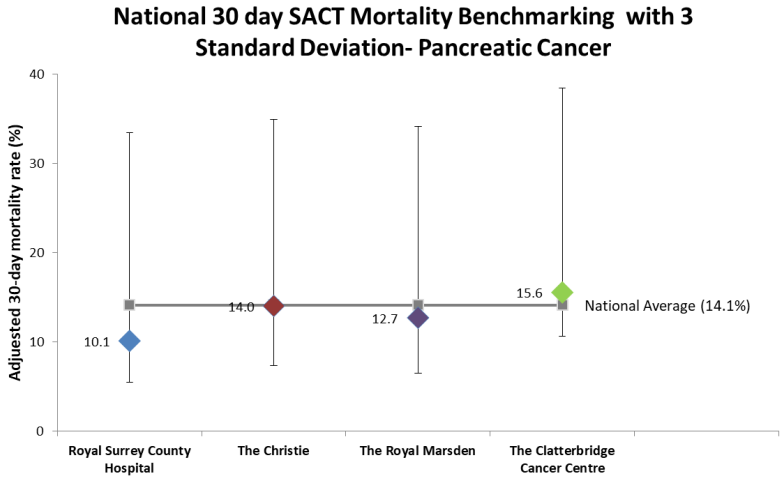
Trust performance is comparable to peer hospitals and below national average in most of cases. The Trust was excluded from reporting for Myeloma was due to insufficient data. AML and ALL are also excluded from report was due to high level of missing data. As from December 2019, the collection of Haemato-oncology SACT data for the Trust has been consolidated by electronic prescribing of Meditech system and also handed over to the designated team of experts who has been collecting solid tumour SACT since 2003. The Haemato-oncology SACT data collection has been since improved in terms of completeness and consistency.

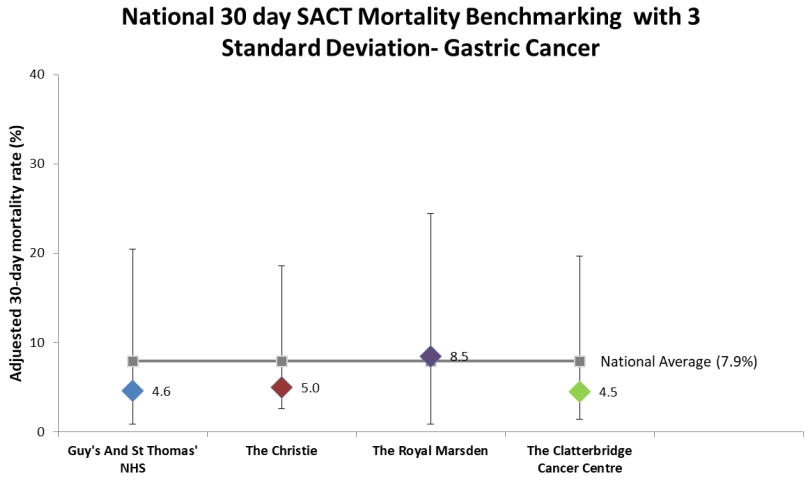


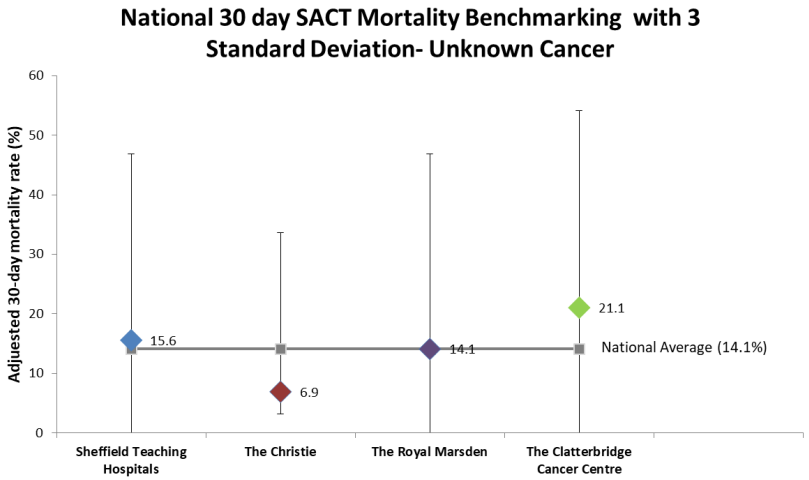


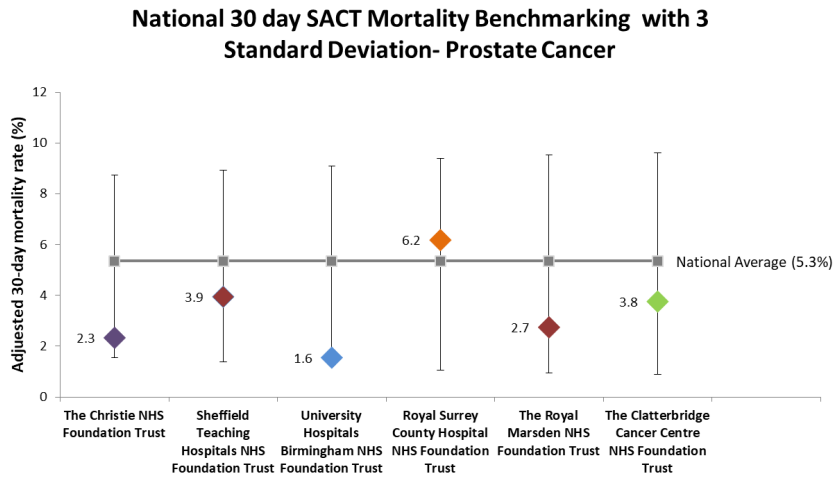

National 30 day SACT Mortality Benchmarking with 3 Standard Deviation- Ovarian Cancer
Adjusted 30-day mortality rate (%)
14
12
10
8
6
4
2
0
7.8
5.0
6.0
6.4
National Average (8.3%)
The Christie NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
The Clatterbridge Cancer Centre NHS Foundation Trust


National 30 day SACT Mortality Benchmarking with 3 Standard Deviation - Lung Cancer
Adjusted 30-day mortality rate (%)
40
30
20
10
0
12.7
7.6
7.8
9.1
National Average (9.8%)
Sheffield Teaching Hospitals
The Christie
The Royal Marsden
The Clatterbridge Cancer Centre


National 30 day SACT Mortality Benchmarking with 3 Standard Deviation- Pancreatic Cancer
Adjusted 30-day mortality rate (%)
40
30
20
10
0
10.1
14.0
12.7
15.6
National Average (14.1%)
Royal Surrey County Hospital
The Christie
The Royal Marsden
The Clatterbridge Cancer Centre


National 30 day SACT Mortality Benchmarking with 3 Standard Deviation- Gastric Cancer
Adjusted 30-day mortality rate (%)
40
30
20
10
0
4.6
5.0
8.5
4.5
National Average (7.9%)
Guy's And St Thomas' NHS
The Christie
The Royal Marsden
The Clatterbridge Cancer Centre


National 30 day SACT Mortality Benchmarking with 3 Standard Deviation- Unknown Cancer
Adjusted 30-day mortality rate (%)
60
50
40
30
20
10
0
15.6
6.9
14.1
21.1
National Average (14.1%)
Sheffield Teaching Hospitals
The Christie
The Royal Marsden
The Clatterbridge Cancer Centre


National 30 day SACT Mortality Benchmarking with 3 Standard Deviation- Prostate Cancer
Adjusted 30-day mortality rate (%)
12
10
8
6
4
2
0
2.3
3.9
1.6
6.2
2.7
3.8
National Average (5.3%)
The Christie NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
Royal Surrey County Hospital NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
The Clatterbridge Cancer Centre NHS Foundation Trust

In House 30 Day Treatment Mortality Analysis - 2020 data

Methodology

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

Chemotherapy

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

Solid Tumour Chemotherapy Mortality Analysis

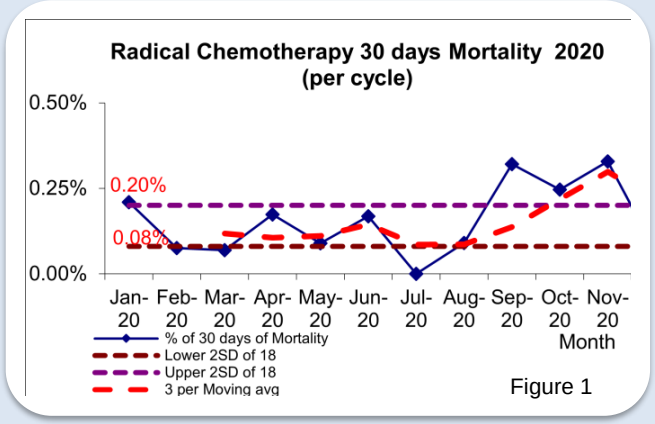


Figure 1

Radical Chemotherapy

- The overall 30 day mortality rate for patients treated with radical chemotherapy in 2019 was 0.97% which was slightly higher than patient treated in 2019 (0.8%), but it is not a statistical significant.
- Figure 1 shows the monthly 30 day mortality percentages with 3 months moving average and the set control limit. Results showed 2 mortality data points were above upper limit . however the 3 months moving averages

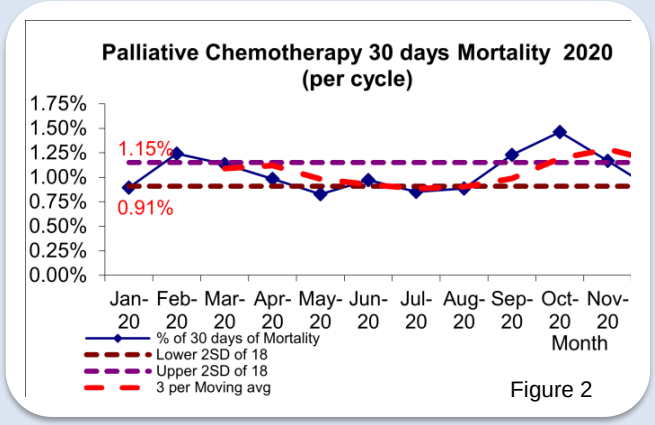


Figure 2

Palliative Chemotherapy

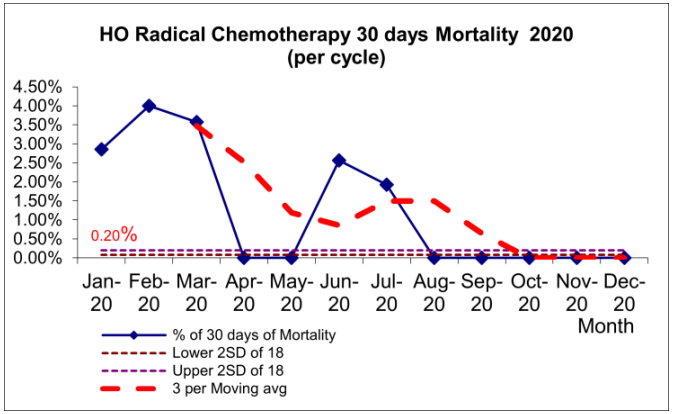
- The overall 30 day mortality rate for patients treated with palliative chemotherapy in 2020 was 7.1% which was slightly higher than patient treated in 2018 (6.2%), but it is not a statistical significant.
- Figure 2 shows 2 mortality data points above the upper limit however the 3 months moving averages were within the control limits, therefore there was no concern raised.

Trends Identified

From the in-depth mortality analysis, 10 chemotherapy regimens were identified as having a high mortality rate, hence were added to CCC monitoring list, out of which 4 regimens requested to be audited by the corresponding Tumour Specific Site Reference Group.

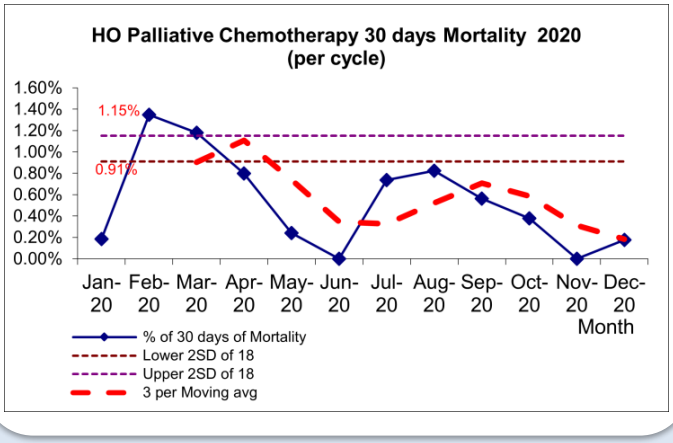
Overall 2020 results showed consistent mortality rate comparing to the previous year under the shadow of COVID-19 pandemic.

Haemato-oncology Chemotherapy Mortality Analysis



Radical HO Chemotherapy

- The overall 30 day mortality rate for patients treated with radical chemotherapy in 2020 was 4.9% (4/101 patients). The figure may seems to be high but it was due to small patient numbers.
- Figure 1 shows the monthly 30 day mortality percentages with 3 months moving average and the set control limit. Results showed 2 mortality data points were above upper limit , however the 3 months moving averages were within control limits, therefore there was no concern raised.



Palliative HO Chemotherapy

- The overall 30 day mortality rate for patients treated with palliative chemotherapy in 2020 was 4.6%.
- Figure 2 shows the monthly mortality rate is below the control limits.

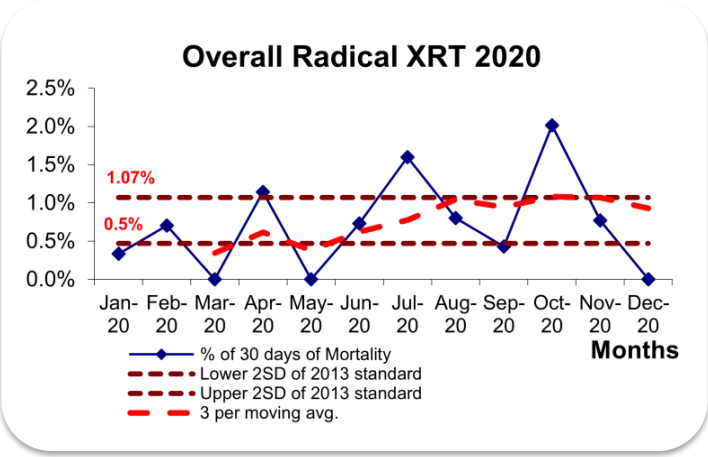
Trends Identified

This is the first report of HO chemotherapy in-depth analysis of full 12 months.

Palliative chemotherapy is below the control limits that were set. No concern was raised.

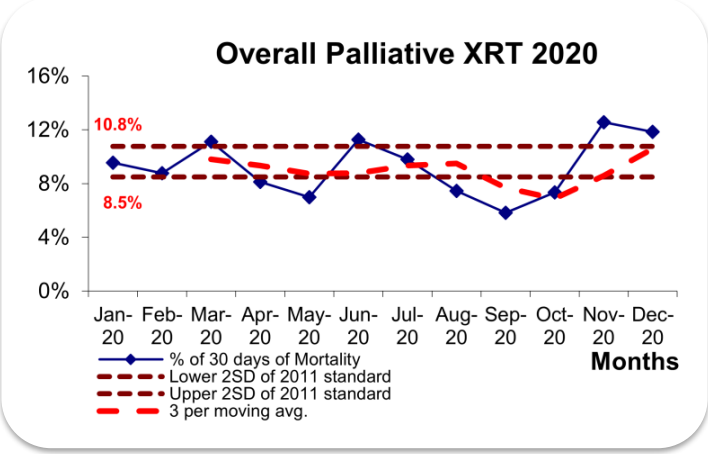
Radiotherapy

There was no significant difference in mortality performance observed in 2020 radiotherapy data compared to the previous year's performance. The overall CCC performance for Radiotherapy 30 day mortality is as follows:



Radical Radiotherapy

- The overall 30 day mortality rate for patients treated with radical radiotherapy in 2019 was 0.69%, a decrease from 0.9% from previous year.

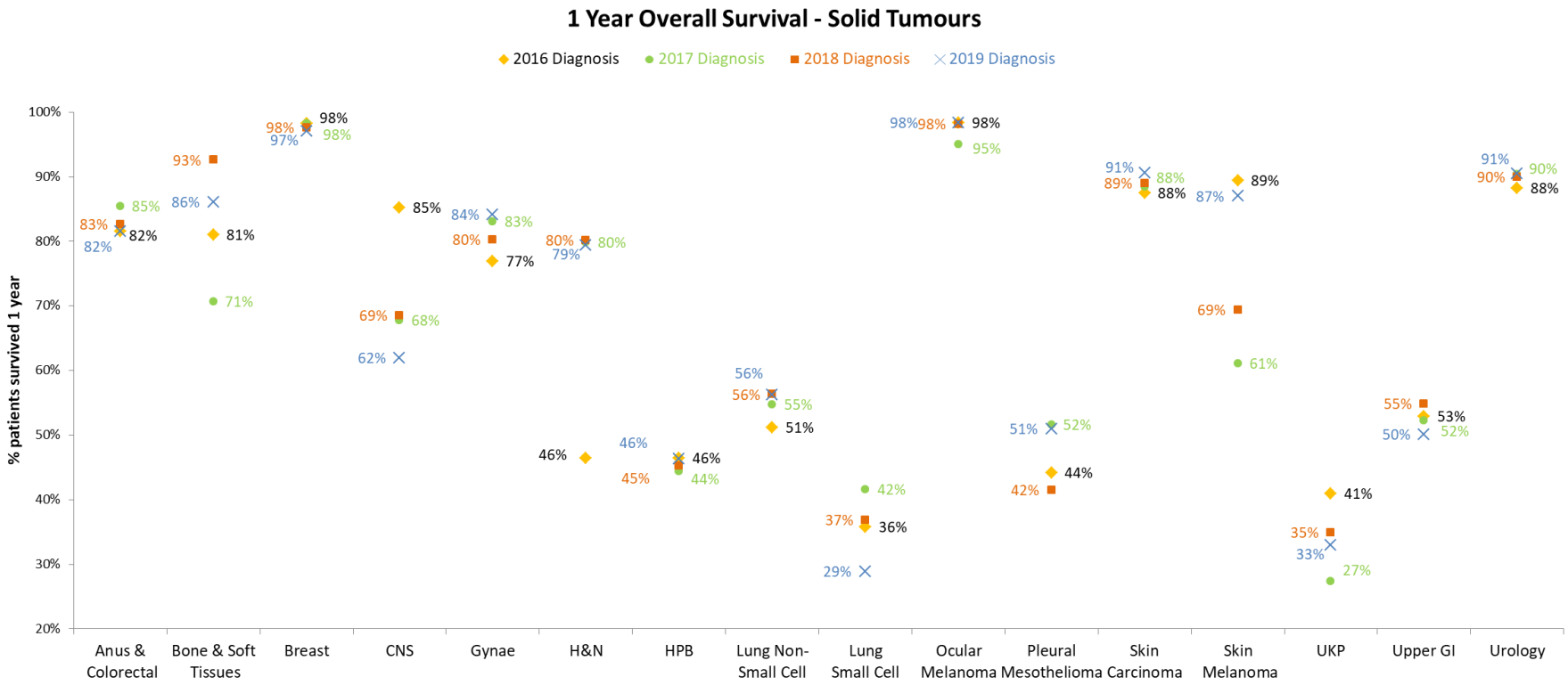


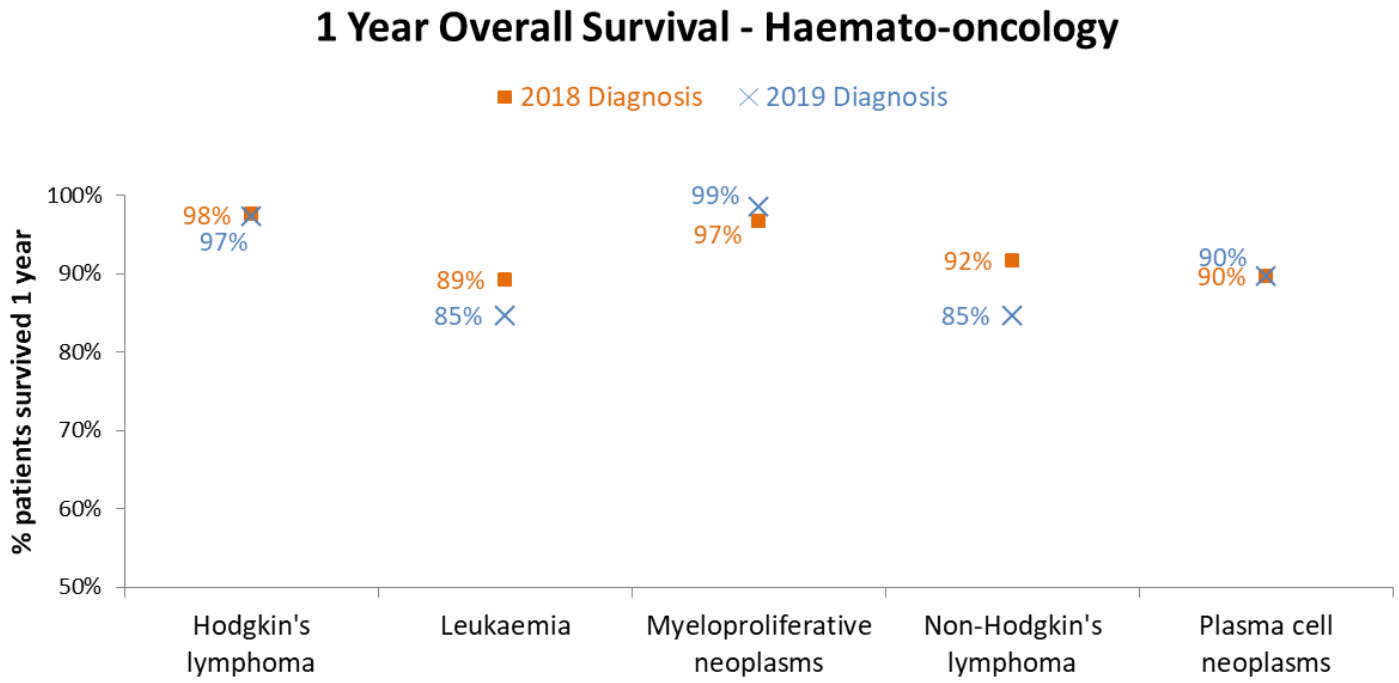
Palliative Radiotherapy

- The overall 30 day mortality rate for patients treated with palliative radiotherapy in 2020 was 10.2%, also a decrease from 12.6% of previous year.

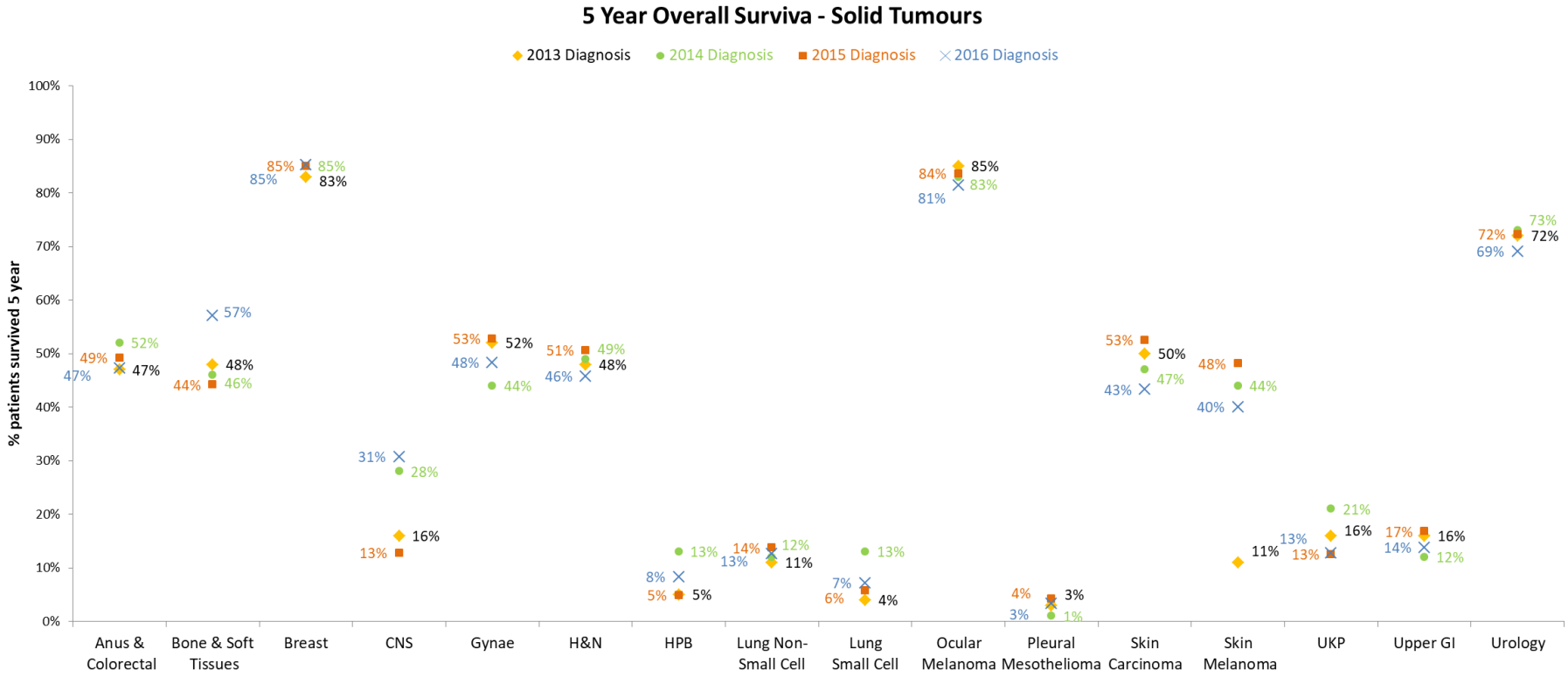
CCC Cancer patient survival rate by Specific Tumour Group

Graphs below showed percentage of patient survived 1 year and 5 years. One year survival is based on patient diagnosed in 2016 - 2019 (2018-2019 for Haemato-oncology) to show short term outcome, whilst 5 year survival is based on patient diagnosed in 2013 - 2016 to show long term outcome. Majority of figures are comparable with some showing improvement and some showing reduced survival. Understanding the differences requires an in-depth analysis which is included in the SRG dashboard development and will be discussed in SRG meetings.




1 Year Overall Survival - Haemato-oncology
2018 Diagnosis
2019 Diagnosis
% patients survived 1 year
100%
90%
80%
70%
60%
50%
98%
97%
89%
85%
99%
97%
92%
85%
90%
90%
Hodgkin's lymphoma
Leukaemia
Myeloproliferative neoplasms
Non-Hodgkin's lymphoma
Plasma cell neoplasms

*


5 Year Overall Surviva - Solid Tumours
2013 Diagnosis
2014 Diagnosis
2015 Diagnosis
2016 Diagnosis
% patients survived 5 year
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Anus & Colorectal
Bone & Soft Tissues
Breast
CNS
Gynae
H&N
HPB
Lung Non-Small Cell
Lung Small Cell
Ocular Melanoma
Pleural Mesothelioma
Skin Carcinoma
Skin Melanoma
UKP
Upper GI
Urology

Looking to the future [21/22]

- Participating in NACEL round 3
- Continue to develop a Mortality Reduction Strategy
- Continue to digitise the mortality review process by embedding a Datix system to support the data collection and reporting process

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	28 July 2021
Agenda item:	
Title:	Mortality dashboard
Report prepared by:	Helen Wong, Quality Manager (Audit & Statistics)
Executive Lead:	Dr. Sheena Khanduri, Medical Director
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Quality Committee
Date & decision:	22 July 2021: Recommend approval to Trust Board.

Purpose of the paper/key points for discussion:	The mortality dashboard and mortality lesson learnt were approved by the Mortality Surveillance Group and Quality Committee. The Board is asked to approve the mortality dashboard, mortality lesson learnt and summary report.

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

Next steps required:	

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

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The Clatterbridge Cancer Centre
NHS Foundation Trust

☐ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

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☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

Q4 2020/2021 Mortality Dashboard Executive Summary

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.

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.

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

Dashboard Interpretation

Data coverage: April 2020 – March 2021 for comparison to previous quarter

	Apr – Jun 20	July – Sept 20	Oct – Dec 20	Jan – Mar 21
No. of inpatient death	12**	24	35	31
No. of outpatient death post treatment	120	120	159	131
No. of cases requiring review	107	121	174	140
No. of cases reviewed (Phase I)	95(89%)	85(70%)	121 (69%)	70 (50%)
No. of case(s) discussed (Phase III)	1	15	6	17

**Process takes a minimum of 3 months to complete*
*** No. of inpatient death for April – June 2020 was low comparing to the same period of 2019 (23 patients) due to low bed occupancy during COVID period.*

- The face to face peer review process (phase II) has been interrupted by COVID-19 pandemic, a new process has been agreed, of which mortality cases are now randomly allocated to consultants for peer review. This had helped to share out workloads and speed up the process. The efficiency is continuously monitored and shared with the Site Reference Group Chairs.
- During Q4 20/21, a total of 162 cases were in scope, 140 cases required a review (phase I), of which 40 (28%) cases has completed phase II process, leaving 100 cases were in process (72%).
- 39 (11%) cases were discussed in April 2020 – March 2021 and rolled over 21 cases to 2021-2022 for discussion.
- 1 case was scored less than 6 of avoidability
- 0 cases required a LeDar (Learning Disability) submission
- 1 mortality case was subject to a Child Death Overview Panel (CDOP) form (required for in scope patients <=18).

SJR Score (avoidability score <6) case description

1 case was scored a 5.

This patient successfully underwent 6 months of chemotherapy before developing an infection including an acute peripancreatic abscess which resulted in an admission to Wirral University Teaching Hospital for intravenous antibiotics. The patient was discharged from APH on antibiotics.

Unfortunately the patient was admitted to CCC shortly afterwards, and recommenced on intravenous antibiotics following microbiology advice.

COVID19 swab was negative on admission and also on day 3, but a positive result was returned on day 11. CCC infection control team had reviewed this case and suggested that the initial swab may have been a false negative. The group agreed that the case should be scored as 5 given the uncertainty as to whether the patient had potentially acquired COVID19 at CCC.

The Clatterbridge Cancer Centre NHS Foundation Trust: Learning from Deaths Dashboard (Public)

The Clatterbridge Cancer Centre NHS Foundation Trust

Summary of total number of inpatient, 30 day SACT, 30 day RT, 90 day radical RT & BMT deaths	Date Range for data	April 20	-	March 21

Trust Mortality Programme QTR 1 - QTR 4

Total Number of Deaths in Scope	No.
QTR 1	135
QTR 2	145
QTR 3	196
QTR 4	162
YTD	638

Total Deaths Requiring Phase 1 Review (excluding not applicable eg bone mets, MSCC)	No.
QTR 1	109
QTR 2	122
QTR 3	177
QTR 4	140
YTD	548

Total Deaths Reviewed (Phase 1)	No.	%
QTR 1	95	*87%*
QTR 2	85	*70%*
QTR 3	121	*68%*
QTR 4	70	*50%*
YTD	371	*68%*

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

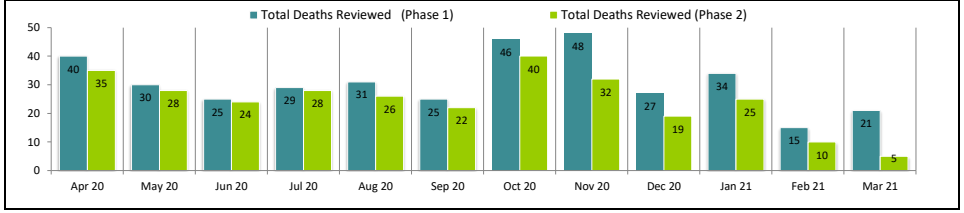
	Score 1 - Definitely avoidable	Score 2 - Strong evidence of avoidability	Score 3 - Probably avoidable (more than 50:50)	Score 4 - Probably avoidable but not very likely	Score 5 - Slight evidence of avoidability	Score 6 - Definitely not avoidable
QTR 1	0	0	0	0	0	10
QTR 2	0	0	0	0	0	11
QTR 3	0	0	0	0	1*	19
QTR 4	0	0	0	0	0	8
YTD	0	0	0	0	1	48

***Score 5 - Slight evidence of avoidability**
COVID-19 Related death. Very good care on the whole. MRM agreed that the case should be scored as 5 given the uncertainty as to whether the patient had potentially acquired COVID19 at CCC and so whether this was a nosocomial death at CCC.

Total Deaths Reviewed (Phase II)	No.	%
QTR 1	87	92%
QTR 2	76	89%
QTR 3	91	75%
QTR 4	40	57%
YTD	294	*79%*

Total Deaths Reviewed (Phase III)	No.	%
QTR 1	1	1%
QTR 2	15	18%
QTR 3	6	5%
QTR 4	17	24%
YTD	39	13%

Percentage of cases reviewed at Phase 1 & Phase 2



Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable: Learning Disabilities

Total Number of Deaths in Scope	No.
QTR 1	0
QTR 2	0
QTR 3	0
QTR 4	0
YTD	0

LeDaR Submission Completed	No.	%
QTR 1	0	-
QTR 2	0	-
QTR 3	0	-
QTR 4	0	-
YTD	0	-

considered to have been potentially avoidable <=3	No.
QTR 1	0
QTR 2	0
QTR 3	0
QTR 4	0
YTD	0

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable: Children

Total Number of Deaths in Scope	No.
QTR 1	0
QTR 2	0
QTR 3	1
QTR 4	0
YTD	1

CDOP Forms Completed	No.	%
QTR 1	0	-
QTR 2	0	-
QTR 3	1	*100%*
QTR 4	0	-
YTD	1	-

considered to have been potentially avoidable <=3	No.
QTR 1	0
QTR 2	0
QTR 3	0
QTR 4	0
YTD	0

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board	
Date of meeting:	28th July 2021	
Agenda item:		
Title:	Safeguarding Annual Report 2020 - 2021	
Report prepared by:	Clare James, Named Nurse for Safeguarding Karen Kay, Deputy Director of Nursing	
Executive Lead:	Joan Spencer, Interim Director of Nursing	
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	Integrated Governance Committee/Quality Committee
Date & decision:	6th July 2021 and 22nd July - Noted

Purpose of the paper/key points for discussion:

The Clatterbridge Cancer Centre NHS Foundation Trust Safeguarding Annual report for 2020/21 is in line w Working Together to Safeguard Children 2018 and the Care Act 2014.

It meets the requirement for Trust Boards to produce an annual report with an analysis of the effectiveness of local safeguarding arrangements.

It provides a summary of the key issues, activity and performance of the Safeguarding Team and wider Trust during 2020/21 and assurance that CCC is fulfilling its statutory, regulatory and contractual responsibilities with reference to the Children's Act 2004 and Care Act 2014

As a Trust, CCC is compliant with the following standards:

Standard	Compliance
Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (amended 2007)	✓
CQC Regulation 13:Safeguarding service users from abuse and improper treatment	✓
CQC Regulation 12: Safe Care and treatment	✓
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13	✓
CQC national standards of quality and safety Outcomes 7-11; Essential standards of quality and safety	✓
Safeguarding vulnerable people in the NHS – Accountability and Assurance Framework 2015	✓
Working Together to Safeguard Children and Young People 2018	✓
Promoting the Health and Wellbeing of Looked After Children 2015	✓
PREVENT Duty (2015)	✓
Counter Terrorism and Security Act (2015)	✓
Female Genital Mutilation Act (2003)	✓

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NHS Foundation Trust

	Intercollegiate Document (2019) Safeguarding Children and young people: roles and competencies for health care staff	✓
	Safeguarding Adults Intercollegiate Document (2018): roles and competencies for health care staff	✓

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

Next steps required:	Trust Board are requested to; • Note content of the Annual Report. • Approve the Safeguarding Annual Report 2020-2021

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

☐ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

☐ BE **DIGITAL**

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

☐ B

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

BE **INNOVATIVE**

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

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

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Safeguarding Annual Report 2020-2021

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1. Executive Summary

The Clatterbridge Cancer Centre NHS Foundation Trust Safeguarding Annual report for 2020/21 is in line with Working Together to Safeguard Children 2018 and the Care Act 2014.

It meets the requirement for Trust Boards to produce an annual report with an analysis of the effectiveness of local safeguarding arrangements.

It provides a summary of the key issues, activity and performance of the Safeguarding Team and wider Trust during 2020/21 and assurance that CCC is fulfilling its statutory regulatory and contractual responsibilities with reference to the Children's Act 2004 and Care Act 2014.

As a Trust, CCC is compliant with the following standards:

Standard	Compliance
Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (amended 2007)	✓
CQC Regulation 13:Safeguarding service users from abuse and improper treatment	✓
CQC Regulation 12: Safe Care and treatment	✓
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13	✓
CQC national standards of quality and safety Outcomes 7-11; Essential standards of quality and safety	✓
Safeguarding vulnerable people in the NHS – Accountability and Assurance Framework 2015	✓
Working Together to Safeguard Children and Young People 2018	✓
Promoting the Health and Wellbeing of Looked After Children 2015	✓
PREVENT Duty (2015)	✓
Counter Terrorism and Security Act (2015)	✓
Female Genital Mutilation Act (2003)	✓
Intercollegiate Document (2019) Safeguarding Children and young people: roles and competencies for health care staff	✓
Safeguarding Adults Intercollegiate Document (2018): roles and competencies for health care staff	✓

This report acknowledges the work and diligence of all staff that plays a vital part in safeguarding children, young people and adults who access treatment across the Trust together with support for staff employed by Clatterbridge Cancer Centre NHS Foundation Trust.

2. Summary of key achievements during 2020/21

- ✓ The Trusts Safeguarding Team have continued to enable the Clatterbridge Cancer Centre to have robust systems and processes that meet the requirements of 'Working Together to Safeguard Children 2018 and the Care Act 2014.
- ✓ Strategic leadership continues to enable robust relationships both internally across all Clatterbridge Cancer Centre sites and externally with safeguarding partners and commissioners.
- ✓ Strengthening of the Safeguarding Team by the inclusion of Safeguarding Practitioner in September 2020.
- ✓ Maintained the mandatory and contractual compliance rate of 90% for levels 1 and 2 and 3 for children and adults safeguarding training
- ✓ Maintained mandatory and contractual compliance rate of 90% for basic prevention awareness (level 1&2) training and 85% for WRAP (level 3&4) training
- ✓ Achievement of mandatory compliance rate of 90% for learning disability awareness and dementia awareness training
- ✓ Introduction of role specific e learning module on domestic abuse / violence in February 2021.
- ✓ Achieving assurance from Liverpool CCG Safeguarding service with the Trust Safeguarding KPI.
- ✓ Continuing to co-produce easy read patient information with service users, families and self-advocates as part of Trust Learning Disability and Autism Strategy
- ✓ Working in partnership with Patient Experience Team and Clinical Staff to develop a Trust Carers Policy
- ✓ Supporting and providing expert advice to staff developing Trust Delirium Guidelines
- ✓ Development of a photobook for patients with learning disability / autism and dementia to help desensitise their anxiety when coming into CCC-L
- ✓ Updating and ratification of a number of key polices/strategies at Safeguarding Committee during 2020/21
- ✓ Continued with safeguarding as business as usual during Covid 19 pandemic
- ✓ Signposting the Trust Mental Health First Aiders to aid and support patients and staff with mental health concerns

3. Safeguarding Leadership &Trust Roles in Safeguarding

Safeguarding is everyone's responsibility. All staff has a duty to recognise and act to ensure patients are safeguarded. However, there are also specific roles and duties for the following staff in the organisation

Role	Safeguarding Responsibility
Chief Executive Officer	Ultimate responsibility for ensuring that any patient using the Trust services are provided with safe, good quality care
Non-Executive Director (with lead for Safeguarding)	To challenge the Board on safeguarding provision, activity and performance
Executive Director of Nursing and Quality	Board level Director for safeguarding adults and children
Named Nurse for Safeguarding	Operational lead for safeguarding, supervision of staff, training development and delivery, sub groups attendance, oversight of safeguarding inquiries, ensuring attendance at strategy meetings. On-going support and advice in safeguarding, Mental Capacity Act and Prevent, training delivery to staff, Section 42 enquiries
Named Doctor	Support and advise colleagues in the clinical assessment and care of children and young people where there are safeguarding/child protection concerns, as part of own clinical role, supporting and advising other professionals and partner agencies on the management of all forms of child maltreatment
General Managers/ Divisional Leads/Matrons	It is the responsibility of the General Managers/ Divisional Leads/Matrons to ensure staff complete safeguarding training at the required level and make the appropriate referrals under safeguarding as required. Monitoring of compliance through PDAR's.

The following named professionals were in post during the period of April 2020-March 2021;

- ✓ Trust Executive Lead - Director of Nursing and Quality - Sheila Lloyd was in post until March 2021. Joan Spencer was appointed Interim Chief Nurse in April 2021. The organisation has appointed a new Chief Nurse due to commence in post in October 2021.
- ✓ Head of Safeguarding – Jackie Rooney was in post until February 2021. This role has been removed from the Team as planned following consultation in December 2020.

- ✓ Named Nurse for Children, Young People and Adults – Clare James
- ✓ Named Doctor for Children and Young People – Dr Farida Alam and Dr Nicky Thorp

Their roles and functions provide strategic direction, leadership, advice and support, safeguarding supervision, training, delivery and assurance of Clatterbridge Cancer Centres safeguarding provision; ensuring the Trust is meeting its regulatory and statutory safeguarding functions.

Trust Non-Executive Director (NED), Terry Jones has been nominated by the Board as the NED Safeguarding Champion

In September 2020, a Safeguarding Practitioner was welcomed into the team bringing further expertise in safeguarding advice and support and will lead on learning disabilities/ autism, dementia and prevent.

4. Safeguarding response during Covid 19 pandemic

In March 2020, the World Health Organization declared the outbreak of Covid 19 a national pandemic which had an unprecedented effect on the NHS.

During the COVID-19 pandemic, delivering cancer care has been challenging and we have been balancing the risk of contracting COVID-19 for patients with cancer and health-care workers with the need to continue to provide effective treatment and care.

However, the key messages remained unchanged for safeguarding. Safeguarding patients and staff remained an important and essential role for the Clatterbridge Cancer Centre.

All clinical and non-clinical staff were reminded that due to the ‘lockdown’, there were potentially isolating groups of families and people that may be in closer contact with potential victims and perpetrators of safeguarding concern/ sexual / domestic abuse and we must remain vigilant to any safeguarding concerns.
Detailed information/ guidance on safeguarding during COVID19 pandemic and the potential for domestic abuse to occur during lockdown was developed and shared in the daily Trust wide Covid 19 communication bulletins.

Timely responses to the national Covid 19 safeguarding directives and guidance were provided via the Trusts daily internal Covid 19 emergency incident reporting meetings, together with regular internal briefings for staff regarding access to domestic abuse and mental health support systems.

Commissioners postponed the submission of quarterly key performance indicators and we provided assurance of safeguarding service verbally as required. The submissions have recommenced and feedback from Liverpool CCG in Q4 2021 is highlighted later in the report.

Whilst safeguarding training was not a priority during Covid 19 pandemic, the safeguarding training programme was changed were possible to e- learning.

5. Safeguarding Governance and Assurance Arrangements

5.1 Internal

5.1.1 Safeguarding Committee

The Safeguarding Committee is chaired by the Deputy Director of Nursing and Quality supported by Named Nurse for Safeguarding which meets on a quarterly basis.

The role of the Safeguarding Committee is to ensure processes within the Trust are in line with the current legal framework and national guidance, promoting the well-being and safeguarding of children and adults at risk whilst in the care of the Trust.

In addition to Trust wide members, there is also representation from external partners from Liverpool Clinical Commissioning Group (CCG). This Committee seeks to provide assurance on all matters relating to safeguarding and reports to the Board of Directors via the Trusts Quality and Integrated Governance Committees.

5.1.2 Safeguarding Operational Group

This group is chaired by the Named Nurse for Safeguarding supported by the Safeguarding Practitioner and consisting of key Trust wide operational and clinical leads.

It continues with the operational delivery of the Trusts safeguarding work plan with a focus on the development of a safeguarding culture, lessons learnt, improved safeguarding training compliance and safeguarding audit within service areas. Progress, oversight and assurance against the delivery of the Trusts safeguarding work plan is reported and monitored by the Safeguarding Committee.

The Safeguarding Operational group meetings were cancelled during 2020 -21 so staff could prioritise their time as part of the Trust emergency response caring for patients during the Covid 19 pandemic. The meetings are due to restart in Q2, 2021.

5.2 External

5.2.1 Partnerships

The Clatterbridge Cancer Centre Safeguarding Team continues to work with external partners to ensure all statutory safeguarding requirements are met. Clatterbridge Cancer Centre is a key partner agency in the local safeguarding arrangements across Liverpool. This is achieved through:

- ✓ Membership of Merseyside Safeguarding Provider Clinical Network
- ✓ Active contribution to safeguarding adult reviews (SAR) and domestic homicide reviews (DHR) as required.

Changes to the Merseyside Safeguarding Adult Board & Sub Groups

In January 2020, a peer review was undertaken and discussions around whether local safeguarding boards should be developed. It was agreed that the local authorities are to set up their own adult safeguarding boards. This has an implication for the Trust as it covers more than one local authority.

The local authority adult safeguarding boards are up and running in June 2021 and the Merseyside safeguarding adult board has disbanded. The Quality Assurance and Performance Groups and the Serious Adult Review Group will continue across the Merseyside footprint.

The Trust will be invited to join the Liverpool Safeguarding Adult Board sub groups and will link in with other local authorities as required.

5.2.2 Key Performance indicators

The key performance indicators for Health Provider Organisations are outlined in Section 11 of the Children's Act 2004 and NHS Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2019 (SAF).

Clatterbridge Cancer Centre is registered with Liverpool CCG and robust processes are in place to enable the Trust to undertake a Section 11 self-assessment and submission of evidence within the expected timescales.

The SAF has been embedded within the Clatterbridge Cancer Centre Quality schedule. The Deputy Director of Nursing provides assurance of compliance against the SAF at the NHS England/Improvement Specialised Commissioners and CCG bi-monthly quality contract review meetings.

The submission of the quarterly evidence against key performance indicators outlined in the NHS England/Improvement Specialised Commissioners and Liverpool CCG Safeguarding Commissioning Standards has been maintained in 2020-21.
The Clatterbridge Quarterly Analysis Report for Quarter 4 in 2021 is attached in appendix 1.

6. Safeguarding Activity

6.1 Safeguarding Training: Programme delivery

The Trusts Safeguarding Training Matrix has been reviewed and revised in 2020/21 to ensure that the Clatterbridge Cancer Centre has a programme of training delivery that will take the Trust workforce to full compliance in safeguarding training.

The Safeguarding Team have continually revised and developed an enhanced training programme consisting of both face to face and e-learning modules on ESR (in line with Intercollegiate Safeguarding Guidance 2019) to ensure mandatory and role specific compliance of safeguarding training by 31 March 2021.

The revised programme of safeguarding training continues to be offered for all volunteers in line with the recommendations from the Lampard (Saville) Enquiry.

The Trust has introduced level 2 training on Domestic Abuse via ESR for all patient facing staff in February 2021 which has been added to the Matrix.

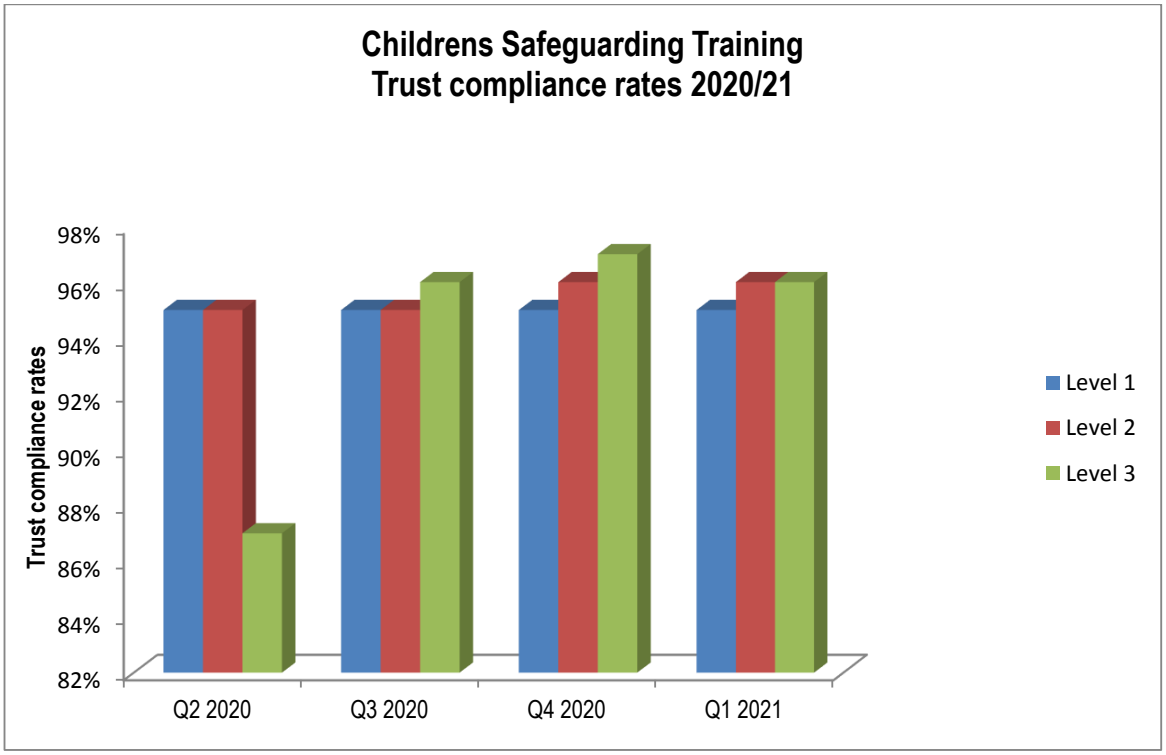
The addition of `Children in Care` role specific training is underway within the Trust following the revision of the intercollegiate document Looked after Children: Roles and competencies of healthcare staff in December 2020 and as per KPI requirements in 2021-22. It is planned for roll out in Q3 2021.

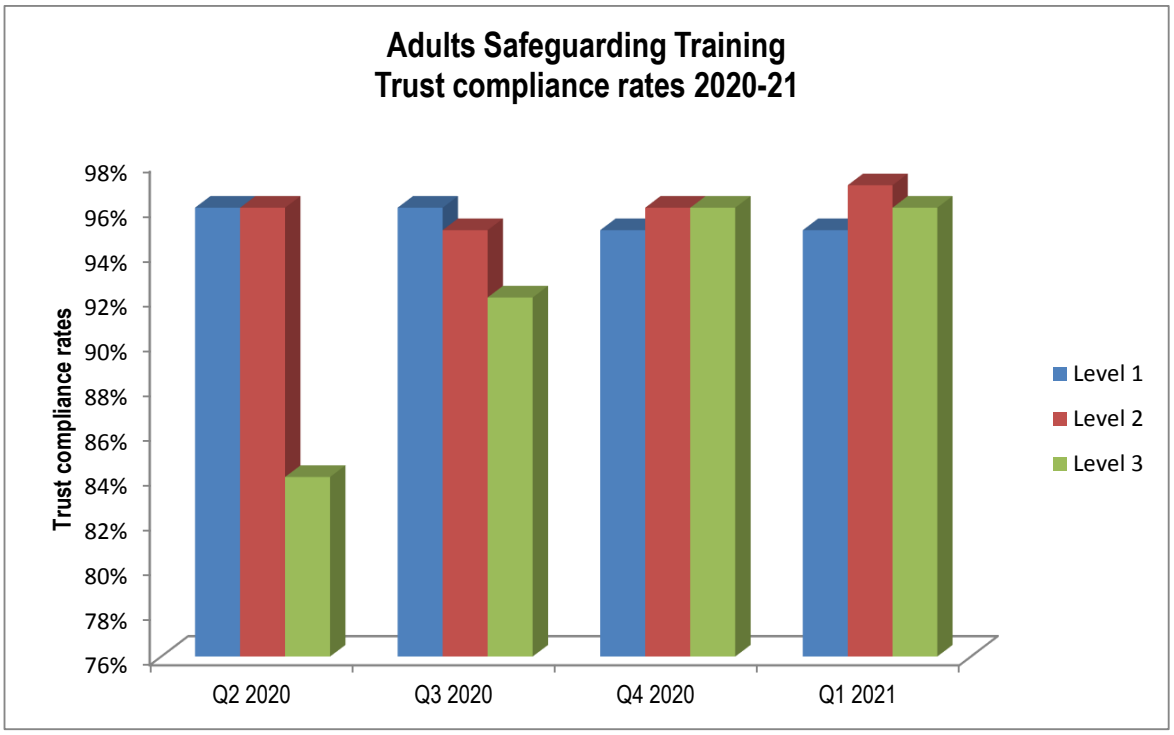
The Trust mandatory & role specific safeguarding training matrix is available in Appendix 2.

6.2 Safeguarding Training compliance

The Trust has consistently achieved the required 90% compliance rate for both adult and children levels 1, 2 and 3 training during the reporting period (April 20-March 21).

Following the impact of Covid 19 pandemic on staff undertaking training, the Trust compliance rate for level 3 safeguarding adults and children dropped during quarter 2 (2020-21). However, with a comprehensive recovery plan, it has improved by quarter 3 2020 in reaching the target of over 90%.The evidence of compliance in all levels of safeguarding training are outlined below;


Childrens Safeguarding Training
Trust compliance rates 2020/21
Trust compliance rates
98%
96%
94%
92%
90%
88%
86%
84%
82%
Q2 2020
Q3 2020
Q4 2020
Q1 2021
Level 1
Level 2
Level 3


Adults Safeguarding Training
Trust compliance rates 2020-21
Trust compliance rates
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
78%
76%
Q2 2020
Q3 2020
Q4 2020
Q1 2021
Level 1
Level 2
Level 3

The Learning and Development Team continues to regularly report comprehensive detail on non-compliance. Oversight and monitoring of compliance continues to be monitored via the Safeguarding Committee and divisional leads.

The Named Doctors and the Named Nurse for Safeguarding have both attended level 4 safeguarding training ensuring the continued compliance with the Intercollegiate Document training requirements for Named Professionals.

Annual safeguarding board bespoke training was delivered to all the Trust Board members and NEDs in February 2021.

6.3 PREVENT

The Counter Terrorism & Security Act (2015) places a legal duty on NHS Trusts and Foundation Trusts to consider the Prevent Strategy when delivering their services. These obligations are reinforced by Clause 32 of the Standard NHS Contract.

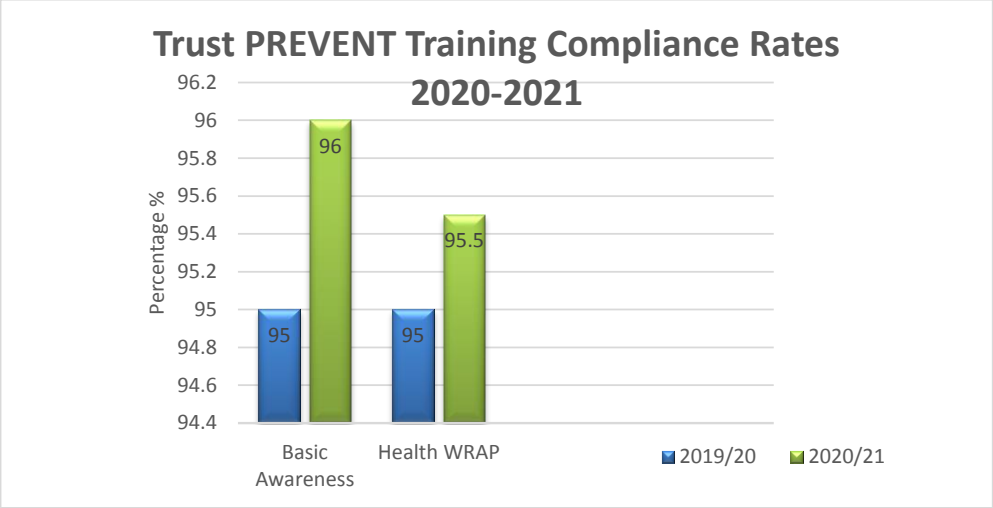
Prevent is a Government strategy that was set up as part of a wider counter-terrorism strategy called Contest and seeks to:

- Respond to the ideological challenge of terrorism and aspects of extremism, and the threat we face from those who promote these views.
- Provide practical help to prevent people from being drawn into terrorism and ensure they are given appropriate advice and support.
- Work with a wide range of sectors where there are risks of radicalisation.

In line with statutory and contractual requirements the Trust has:

- Organisational/Board Lead
- Trust Prevent Lead
- Registered with NHS Digital to submit quarterly Prevent data
- Up to date Trust Prevent Policy available on the intranet
- Promoted the use of an NHS England approved and accredited level 3 Prevent e-learning module available on ESR

- Achieved compliance with mandatory and a contractual compliance rate of 90% basic prevention awareness training (level 1&2) and WRAP training (level 3&4) during the reporting period as outlined below:



Activities in relation to Prevent during 2020/21

- Trust did not submit any referrals under the Prevent Strategy in line with National and Trust policy
- Trust Prevent Policy was reviewed and revised due to change in process from the Local Authority
- Prevent referral process has changed to local authority integrated front door instead of Counter Terrorism Police Team
- During the pandemic in 2020-21, a decision was made to defer the regional Prevent forums and national guidance has been circulated in a monthly newsletter during this time which provides updates locally on the Prevent work being undertaken. These newsletters have been disseminated through the quarterly Trust Safeguarding Committee.

6.4. Mental Capacity Act/ Deprivation of Liberty Safeguards (MCA/DoLS)

The Mental Capacity (Amendment) Act 2019 received the Royal Assent on 16th May 2019. The purpose of the Act is to abolish the Deprivation of Liberty Safeguards (DoLS)

and to replace them with a completely new system, the Liberty Protection Safeguards (LPS).

LPS will authorise deprivation of liberty in order to provide care or treatment to an individual who lacks capacity to consent to their arrangements, in England and Wales. It will replace a system that many agree is overly bureaucratic and complicated.

The main points of the new LPS are;

- One scheme will apply in all settings (e.g. care homes, nursing homes, hospitals, supported living, people's own homes, day services, sheltered housing, extra care, Shared Lives.
- The LPS will apply to anyone aged 16+.
- There will be no statutory definition of "deprivation of liberty" under LPS; therefore, the "Acid Test" set by the Supreme Court in the "Cheshire West" case remains.
- The role of "Supervisory Body", which authorises deprivations of liberty, will be abolished. It will be replaced by the "Responsible Body". There will be different Responsible Bodies in different settings. For some cases the Responsible Body will be the NHS Trust; in other cases, the role will be filled by the Clinical Commissioning Group (or Local Health Board in Wales); and in other cases still it will be the local authority.
- There will only be 3 assessments: the "Capacity" assessment, the "Medical" assessment and the "Necessary and Proportionate" assessment.
- There will be a brand new role of Approved Mental Capacity Professional to deal with more complex cases.
- There will be an expansion of the role of the Independent Mental Capacity Advocate.

The implementation of the new LPS has been delayed from the original date of October 2020 to April 2022 due to the impact of the Coronavirus pandemic.

An update on the proposed changes and implementation required by Clatterbridge Cancer Centre was provided to Trust Board via Quality and Integrated Governance Committees in 2020.

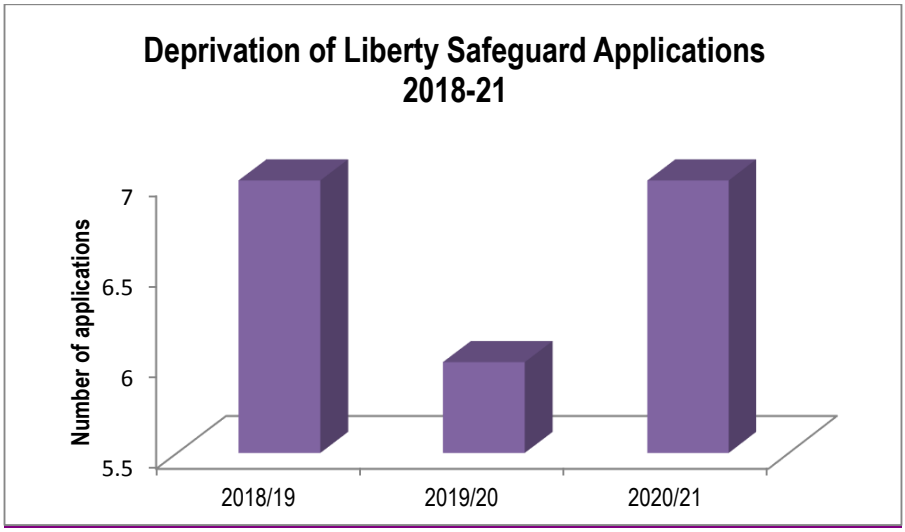
The current progress of the national implementation plan is;

- The national team is undertaking a public consultation on the draft regulations and Code of Practice for LPS.
- The next step after consultation is the updated Code and regulations will need to be laid in Parliament to allow for proper scrutiny.

Publication of the national regulations and Code of Practice for LPS is planned for the autumn of 2021.In the meantime, the Trust is expected to continue to use the current code of practice for DoLS within Trust practices.

Key Achievements

During 2020/21 the Trust has seen a slight increase in the number of applications from previous years as demonstrated in the table below:



During the reporting period (April 20-March 21), 7 patients were identified as requiring a Deprivation of Liberty Safeguards applications which was submitted to their local authority.

Due to low numbers, bespoke DoLS application training is currently provided to ward staff on a one to one basis and covered as part of levels 2 and 3 adults safeguarding training. The safeguarding team current holds a data base of staff trained in DoLS application process

During 2020/21 the following actions were undertaken to improve the Trust's MCA and DoLS practice;

- ✓ Continue to utilise Datix incident reporting in the event of submission of DoLS application and any delay in the assessment by the local authority
- ✓ The Trust MCA/DoLS leads/ safeguarding team have completed all DoLS applications for any patient who meets the DoLS criteria, submitting applications to the relevant local authority of the patient
- ✓ Training support and advice for staff to recognise the need for a Mental Capacity assessment and completion of a DoLS application
- ✓ Support and advice for staff to recognise the need for a best interest meeting
- ✓ Maintenance of the Trust DoLS electronic database within the shared safeguarding folder
- ✓ Trust Safeguarding team members attend relevant LPS training sessions to ensure team are updated on LPS
- ✓ Development of a `best interest` meeting template within Meditech

Aims and next steps

- Continue to use the current code of practice for DoLS within Trust practice.
- Await publication of the national regulations and Code of Practice for LPS planned for the autumn of 2021.
- Review current Trust policies following receipt of new code and regulations for LPS to ensure CCC pathway is in line with national guidance and legislative changes.

6.5 Domestic Abuse /Harmful Practice

Domestic abuse affects almost two million victims every year. The government understands that growing up in a household with domestic abuse can have a detrimental impact on children, which lasts into adulthood. We know that domestic abuse affects all parts of society, both men and women can be victims of domestic abuse and that disproportionately the numbers of victims are women, especially in the most severe cases.

The Domestic Abuse Act 2021 received Royal Assent on the 29th April 2021.
The Acts provision will be brought into force in due course in line with the commencement schedule.
The new Domestic Abuse Commissioner will hold both local and national government to account; and set out detailed legislative proposals for new Domestic Abuse Protection Orders.

During 2020/21the following actions were undertaken to ensure the Trust meets its responsibilities in relation to Domestic Abuse and Harmful Practices.

- ✓ CCC can participate as a key stakeholder in Wirral Multi Agency Risk Assessment Conference (MARAC) if required
- ✓ Senior clinical staff identified and trained to complete CAADA-DASH Risk Identification Checklist (RIC) and multiagency risk assessment conference (MARAC) referral process.
- ✓ Discussions with staff groups who attended level 3 training has enabled the process of incorporating `routine enquiry` questions as part of outpatient and inpatient consultation/contact to ensure the patient is 'safe'. Work will continue to ensure the inclusion of `routine enquiry` questions are included in Trust process and documentation.
- ✓ Introduction of level 2 e-learning modules in Domestic Abuse in February 2021 for all patient facing staff.
- ✓ Trust policy will be revised for October 2021 following the new Domestic Abuse Act 2021 passed in Parliament.

Due to Covid 19 pandemic, all multiagency training was put on hold and members of the Human Resources/Workforce team were unable to access the Domestic Abuse Workplace Scheme to enable appropriate management of staff who are victims of domestic abuse. This training has recommenced in April 2021 and will be an area of priority for 2021/22.

6.6 Female Genital Mutilation

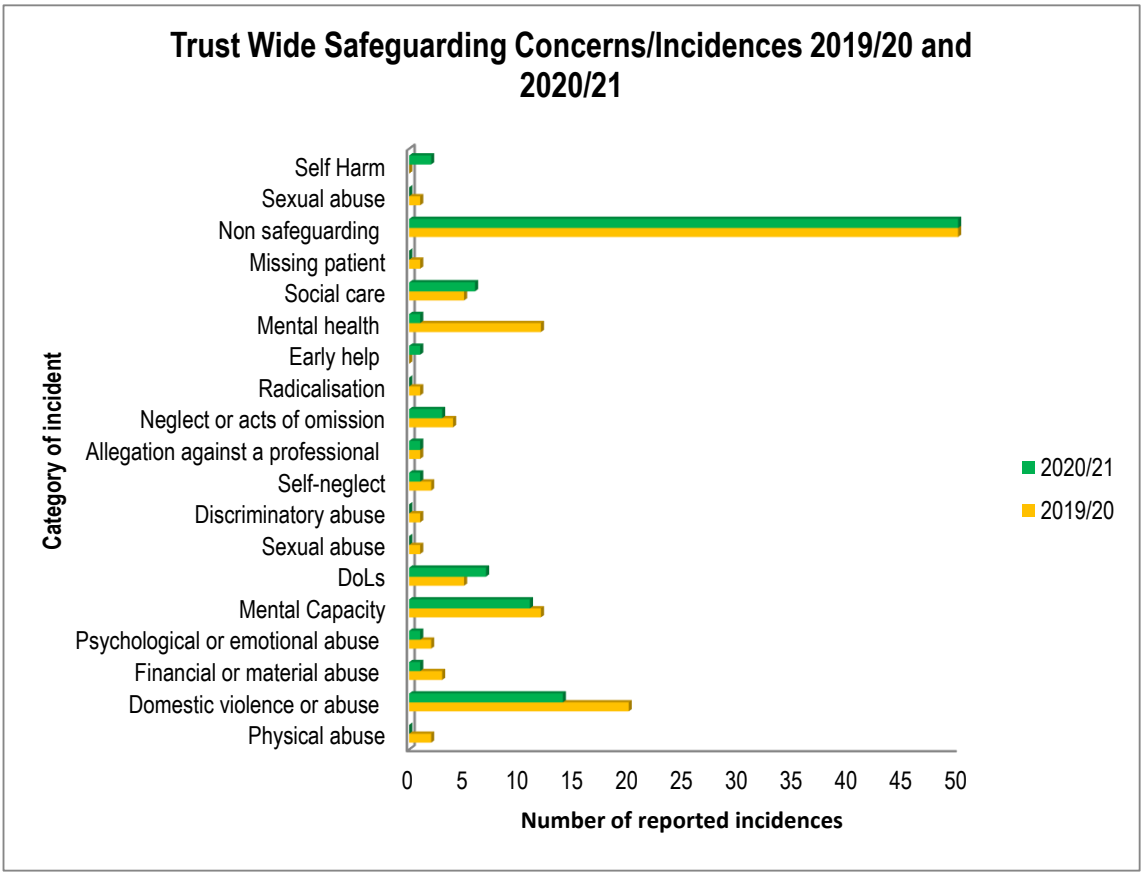
Female Genital Mutilation (FGM) is child abuse and illegal. Healthcare professionals must report to the police any cases of female genital mutilation (FGM) in girls under 18 that they come across in their work. This duty came into force on 31 October 2015.

Staff have been notified of the need for mandatory reporting and there has been an increased focus on FGM in all levels of safeguarding children training.

During the reporting period 2020/21, the Trust reported 0 FGM cases to NHS England.

7. Safeguarding Incidences, Concerns and Referrals

Safeguarding incidences and concerns are captured via the safeguarding duty line, referrals to the safeguarding team and DATIX incident reporting system. The total number of safeguarding incidences recorded and referrals made during the reporting timeframe are outlined in the graphs below;



7.2 Adults

During the reporting period (April 20-March 21) only **4** of the reported adult's incidences met the safeguarding threshold for onwards referral to local authority. These were:

- ✓ Patient experiencing domestic abuse and patient as the perpetrator of domestic abuse
- ✓ Patient being a carer and requiring social care assessment to support their needs

An increase in the number of incidences /queries were reported by staff as safeguarding during 2020/21 compared to the previous year but were found not to be of a safeguarding nature. For example:

- ✓ Mental health and well-being of patients and employees
- ✓ Clinical staff reporting concerns if patients not answering phone for welfare checks
- ✓ Disagreements between family members / breakdown of relationships

It is encouraging to note the increase in reporting of incidences across all directorates during 2020/21 since the introduction of the safeguarding duty line, safeguarding referral form and advice to report onto Datix.

However, the safeguarding incidences detailed above still demonstrate gaps in safeguarding activity data reporting. The level of safeguarding concerns/incidences 'reported' fall far short of the numbers that would be expected in an organisation comparative to Clatterbridge Cancer Centre.

7.3 Children

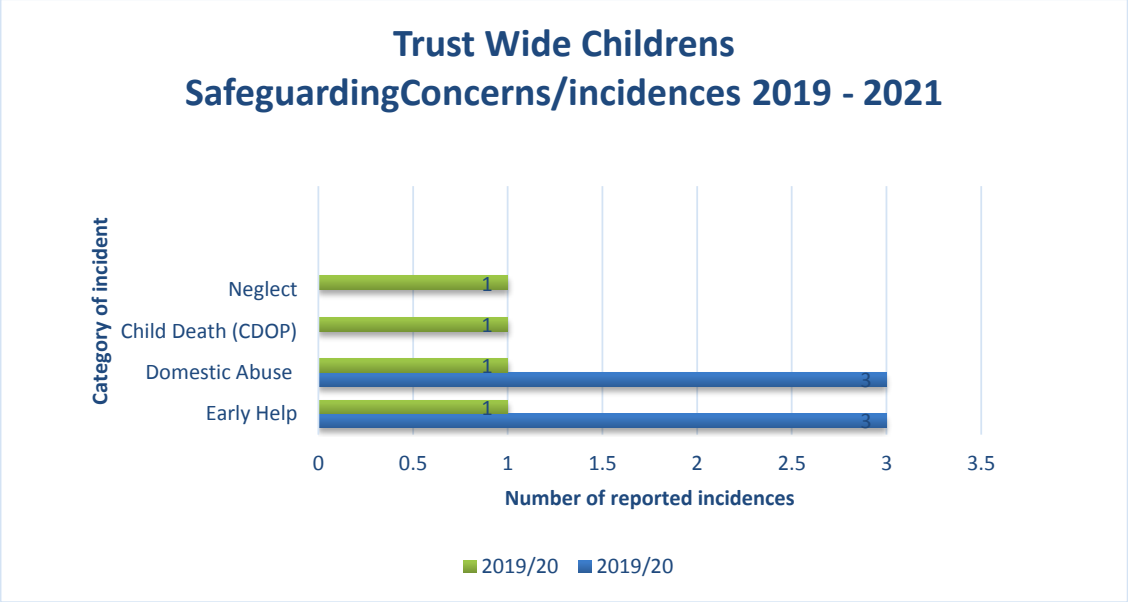
During the reporting period (April 20-March 21) **4** potential children's safeguarding concerns were reported.

1 of the reported children's incident met the Children's Act (2004) threshold for onward referral to local early help services not safeguarding services; demonstrating early intervention in preventative measures thereby reducing any potential safeguarding risk.

1 of the reported children's incident met the safeguarding threshold for referral to children social services due to reported domestic abuse of a patient`s young sibling at Clatterbridge Cancer Centre.

1 of the reported children's incident met the safeguarding threshold for referral to children social services due to anonymous reporting of an employee care of her children.

1 of the reported children's incident met the threshold for reporting to the Child Death Overview Panel (CDOP) as a 17-year-old patient had died in Clatterbridge Cancer Centre in Liverpool in October 2020.



There is wide variation in the number of adult concerns/incidences versus children concerns/incidences; however, this does fit with the case mix of the Trust.

During 2020/21the safeguarding team has actively worked with the teenage and young adult team (TYA, including Clic Sargent) to further improve safeguarding processes. An example of this work is described below by the Lead in TYA;

A young patient was in Clatterbridge Cancer Centre for a number of months and transitioned over during the hospital move from Wirral. Her end of life care was challenging due to the complexities and history of the family circumstance including a significant language barrier. However, the teams worked together to meet the cultural, spiritual and safeguarding needs of the young patient and her family. The COVID pandemic added in additional challenge with visiting restrictions and safety measures particularly in the last days of life however the staff responded and accommodated the end of life practices of the her Muslim faith.

Prior to the young patient's cancer diagnosis the family were supported by her local authority social workers as she was a child in need. Throughout her time at Clatterbridge, the TYA team kept in close communication with the external social work team and Trust Safeguarding Team to ensure the patient would be safe when discharged to the home environment and to support the younger siblings with their understanding of the situation. This working together was particularly evident as the young patient transitioned from child in need to on a child protection plan during her stay.

The Trust also received positive feedback from the external social worker as below;

I cannot express to you the depth of my gratitude for how well you looked after the young patient. I have been worried about her for a long time, prior to her becoming ill, and it was such a relief to me when she was in the care of you all, an I could see, and hear from her, that she was settled with you all and felt cared for, seen, respected and valued. That was all she ever really wanted from the people around her. I know that will have meant the world to her. I think the fact that she said her 17th birthday was the best she ever had is all credit to you all, and says how comfortable she was with you all. You have both advocated strongly and kept the young patient at the focus of all your work, and that is not easy with the family, or the situation.

8 Safeguarding Risks

All safeguarding risks are overseen by the Trust Safeguarding Committee. At the time of reporting there are 1 safeguarding risk on the Trust risk register.

The risk ID 1410 was in relation to the doctors in training who are on rotation at

Clatterbridge Cancer Centre were not compliant with safeguarding adult and children training at levels 1 and 2. A comprehensive action plan was commenced by the Medical Workforce Team with the support of the Named Professionals within the Trust upon recognition of the low compliance by this staff group.

An improvement in compliance was noted at the Safeguarding Committee in April 2021. Compliance of 90% for this staff group is reported to be on target by the next meeting in July 2021.

9 Guidelines/Policies

A number of key polices are in place for Safeguarding and are available to staff on the Trust Intranet site. The following key polices/strategies have been updated and ratified at Safeguarding Committee throughout 2020/21:

- ✓ Prevent Policy
- ✓ Domestic Abuse in the Workplace Policy
- ✓ Safeguarding Duty Line SOP
- ✓ Deprivation of Liberty Safeguards Policy
- ✓ Additional Needs Policy
- ✓ Restraint Guidelines
- ✓ Delirium Guidelines are awaiting Acute Care Division approval.

10 Safeguarding Adults Reviews and Domestic Homicide Reviews

During the reporting year (2020/21) CCC has not been directly involved in any commissioned safeguarding adults review (SAR) or children's serious case review (SCR).

11 Safer Recruitment

Trust has agreed to undertake DBS check (Standard or enhanced depending on role) on initial appointment and when and individual changes their role within the Trust.

The Trust Workforce Committee continue to review the Trust wide decision as part of the safer employment checks policy review process.

12 Managing Allegations against People in Position of Trust

Managing safeguarding allegations against staff working with children's is required under the Children Act (2004) and Care Act 2014 to protect adults.

If an allegation of abuse towards a child or adult is raised against any member of staff, Clatterbridge Cancer Centre NHS Foundation Trust is obliged to report the potential allegation to the relevant Local Authority Designated Officer (LADO).

In some circumstances, the allegation of abuse may not directly impact on the work role of the staff member, but may impact on children or adults who are dependent on the individual away from the work setting. In these cases, the LADO can be contacted for advice in relation to making a referral.

During the reporting period, CCC referred 0 cases to Local Authority for LADO consideration.

13 Safeguarding supervision

The Laming report (2009) states that regular, high-quality supervision is critical. Effective safeguarding supervision reduces risk to children and young people while identifying their needs. Safeguarding supervision also helps front-line practitioners to provide high-quality care, risk analyses and individual action plans and has proved important in promoting good standards of practice and supporting individual staff members. In line with contractual and professional requirements:

- ✓ The Named Nurse for Safeguarding Children and Adults receives supervision through the Designated Nurses for Children at Liverpool CCG and Designated Adults Nurse at Liverpool CCG.
- ✓ The Named Doctors for Safeguarding Children receive supervision from Designated Doctor for Safeguarding Children Liverpool Clinical Commissioning Group

14 Learning Disabilities

NHS Improvement Learning Disability Standards

The Trust has participated in 2020-21 submitting evidence to show compliance with the NHS Improvement (NHSI) Learning Disability Improvement Standards for NHS Trusts. The standards are intended to help the NHS measure the quality of service provided to people with learning disabilities, autism or both.

Following the Trusts previous submission in November 2019, we received the final report in July 2020 from NHS/I which provided a baseline for the quality of care being delivering to patients with a learning disability, autism or both. This report facilitated the creation of a Learning Disability work plan which was implemented and monitored by the Trust Safeguarding Committee on a quarterly basis.

There has been great progress and achievements associated with the measures within the Learning Disability Improvement Standards since receiving our report. The details of this progress and these achievements are detailed below;

- Continued awareness of Learning Disability across the Trust via mandated E-Learning.
- Learning Disability Champions continue to support the learning disability agenda via the Learning Disability Collaborative Group.
- On-going collaboration and engagement with Cheshire and Merseyside Learning Disabilities and/or Autism confirm and challenge group to address delivery of the national Learning Disability Standards by Clatterbridge Cancer Centre NHS Foundation Trust.
- Co-Production of a film following a patient's journey through radiotherapy with Confirm & Challenge.
- Audit of the disability distress assessment tool (DISDAT) following the tool being digitalised in Meditech (December 2020)
- The Trust continues to be active members of the Cheshire and Merseyside Learning Disability Network
- Refresh of benchmarking against learning disability standards for 2020/21 completed

- An internal audit on the use of Reasonable Adjustments was completed in December 2020 and presented to the Safeguarding Committee meeting on 7th January 2021.
- Introduction of learning disability/autism training for Learning Disability Champions via The Oliver McGowan Trust.
- Development of an 'Easy Read' appointment letter and a complaint letter in collaboration with Pathways Associates
- Recruitment of approximately 46 Learning Disability Champions.

During 2020/21, the Trust continued to collaborate with Cheshire and Merseyside Service users/carers and advocates with Learning disability and/or autism.

It is envisaged that the above group will continue during 2021/22 to support the Trust and work in partnership in;

- Developing a feedback process for patients and carer/family with learning disability and or autism such as an Easy-Read Digital Friends and Family Test
- The addition of a reasonable adjustments 'special indicator' in Meditech
- Collaborate in the implementation of the Learning Disability Standards Framework
- Support and assist with the embedding of Trust wide recognition of the support required by patients with a learning disability
- Hold the Trust to account for delivery of the Learning Disability standards via regular confirm and challenge sessions

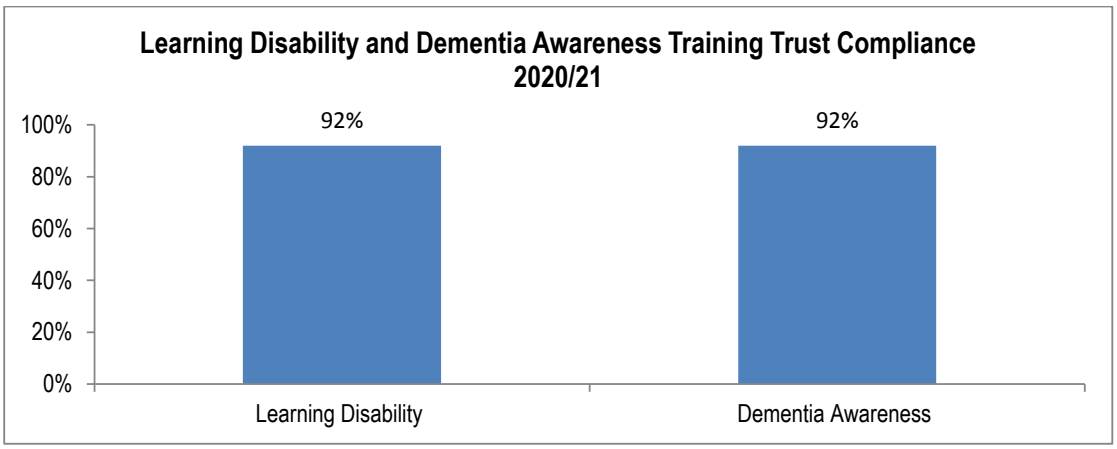
The Learning Disability Standards annual progress report is attached in appendix 4

15 Dementia

Launched in 2019, the Dementia Strategy (2019-2022) sets out a three-year strategic plan for Clatterbridge Cancer Centre to improve the care of those people living with cancer and dementia and provide support to their carer's and families.

As we enter Year 3 of the strategy, the following progress against key objectives has been made:

- Mandatory dementia awareness training compliance for all patient-facing staff at 92% at end of March 2021.



- Members of the Dementia Collaborative Group have accessed additional bespoke training from The Oliver McGowan training in Learning Disability & Autism for NHS staff
- Bespoke training sessions are available to any staff groups who have difficulty accessing an e-learning module available on ESR
- ✓ Maintained a Trust wide dementia collaborative with over 45 staff meeting on a bi-monthly basis to drive forward the work of the strategy
- ✓ Completion of Dementia Action Alliance benchmarking across the Trust including all hubs.
- ✓ Members of Service Users Reference Forum (SURF) were to be invited to visit CCC-L and complete the Kings Fund Dementia Environment Tool however, this remains on hold due to the current Covid-19 restrictions. The Trust is therefore has looked at alternative ways of completing the Environmental Tool virtually through digital means and completed a photobook which has been approved by SURF and completes the trust environmental tool.
- ✓ The Safeguarding Practitioner has continued to attend monthly SURF meetings and Liverpool DAA meetings to liaise with services users about the

work being completed in CCC and been an active participant in Dementia Awareness Week 17th-24th May 2021.

- ✓ During the Covid 19 pandemic, a visiting policy has been implemented at the Trust. It includes patients who are identified with additional needs such as dementia to be offered visiting through reasonable adjustments if required. This is identified following the completion of an Additional Needs assessment on Meditech by staff.
- ✓ Regular updates have been published within the Trust weekly communication E-bulletin to ensure staff are updated on the work in relation to the Trust Dementia Strategy and the guidance for effects of coronavirus.

The Dementia Strategy Annual Progress Report is attached in Appendix 5.

16 Complaints

All complaints are reviewed at entry to the Trust and the safeguarding team is informed of any complaints where safeguarding concerns are identified.

During 2020/21 the Trust received no complaints related directly to safeguarding.

17 Priorities and future developments 2021/2022

Priority	Action
Safeguarding team service delivery	To sustain a comprehensive work programme to ensure the Trust is complaint with statutory regulatory and contractual safeguarding requirements To continue to achieve all the safeguarding Commissioning Standards and Key Performance Indicators and maintain the improvement
To provide stability of safeguarding vision, leadership and direction at all levels across all CCC sites	To continue to raise and embed the profile of safeguarding as everyone's responsibility to safeguard children and adults at risk through safeguarding walkabouts and visits across all sites
Education and safeguarding supervision	To continue to deliver safeguarding education and supervision in line with Trust objectives and statutory and contractual safeguarding requirements

	To maintain 90% compliance with safeguarding training To embed a safeguarding learning framework including ward and department based learning events and supervision
Strengthen HR processes with regard to safeguarding	Support HR with the recommendations outlined within the Lampard Enquiry. Ensure HR staff have access robust multiagency training on dealing with Domestic Abuse and managing allegations training
Pathway develop and revision	To utilise themes and trends from safeguarding incidences to inform and improve pathway development. I.e. Domestic abuse, Mental health, children in care Implementation of recommendations and learning from local DHR once report published
Domestic Abuse and Harmful Practices	To provide clear direction and policy for the organisation's response to the domestic abuse and harmful practices agenda
MCA/DoLS/LPS	Continue to plan for national changes from MCA/DoLS to LPS process ensuring CCC pathway is in line with national guidance and legislative changes
Embed systems that will underpin effective and efficient safeguarding data collection and retrieval	Continue to improve the quality of reporting of safeguarding concerns and incidences Continue to utilise themes and trends from safeguarding incidences to inform and improve patient and pathway development.
Continued delivery of Dementia Strategy	Work in co-production with our dementia champions and patients to deliver and evaluate delivery of the dementia work plan via the dementia collaborative
Continued delivery of the national Learning Disability standards	Continue to work in co-production with patients, families and self-advocates to develop work plan and evaluation process for delivery of national learning disability standards
Audit & Surveillance	To continue with the planned audit programme and on-going surveillance of safeguarding

18 Summary

Whilst safeguarding agendas continue to be a challenging area for all health agencies and multi-agency partners, the Trust continues to actively respond and contribute to regional and national developments.

This Annual Report demonstrates that safeguarding vulnerable people remains a significant priority for the Trust and offers assurance that the annual work programme has been delivered, and the Trust continues to meet its statutory duties as well as proactively developing safeguarding provision and implementing learning from adverse events into frontline practice.

It evidences the successes and service improvements achieved through the leadership of the safeguarding strategic leads and safeguarding team during 2020/21.

However, we recognise there is much more to achieve and to this end the development and delivery of the future priorities will help ensure that the Trust is fully engaged in the effective prevention and response to safeguarding concerns. The underpinning message, however, remains the same in that safeguarding is everyone's business irrespective of role or position. It is everyone's responsibility to safeguard and protect the most vulnerable adults and children in our society. The child and vulnerable adult must remain at the centre and be the motivation of our actions.

The Safeguarding Committee will continue to provide assurance on all matters relating to safeguarding and report to the Board of Directors via the Trusts Quality and Integrated Governance Committees.

Appendix 1 - Clatterbridge Quarterly Analysis Report in Quarter 4 (2020-21)

This document provides an overview of the data submitted in line with the agreed Key Performance Indicators. (KPI)

The data submitted within the Commissioning Standards will be analysed and Key Lines of Enquiry reviewed at the Safeguarding Assurance Visit.

Action plans will be monitored via individual provider business and/or supervision and quarterly KPI submission.

Rating Key:

	Significant (Green) – Data submitted, Target met
	Limited (Red) – No data submitted, Target not met

Safeguarding Training	Safeguarding Training	Target	%	Rating	Comments
	Adults Level 1	90%	95.7%		Q4 2020/21 Compliance threshold achieved
	Adults Level 2	90%	97.8%		Q4 2020/21 Compliance threshold achieved
	Adults Level 3	90%	96.7%		Q4 2020/21 Compliance threshold achieved
	Adults Level 4	90%	100%		Q4 2020/21 Compliance threshold achieved
	Children Level 1	90%	95.3%		Q4 2020/21 Compliance threshold achieved
	Children Level 2	90%	96.9%		Q4 2020/21 Compliance threshold achieved
	Children Level 3	90%	96.2%		Q4 2020/21 Compliance threshold achieved
	Children Level 4	90%	100%		Q4 2020/21 Compliance threshold achieved
	Health Visitor Level 3	90%	0%		Not Applicable

	Children in Care Level 1	0%	0%		Detailed discussions with LCCG Designated Nurse CIC with plans for implementation during 201/22 reporting year.
	Children in Care Level 2	0%	0%		As Above
	Children in Care Level 3	0%	0%		As Above
	Children in Care Level 4	0%	0%		As Above
	Executive/ Board Training	90%	90%		Q4 2020/21 Compliance threshold achieved
	Prevent Awareness	90%	96.6%		Q4 2020/21 Compliance threshold achieved
	Prevent Health Wrap	90%	95.4%		Q4 2020/21 Compliance threshold achieved
	Mental Capacity Act & Deprivation of Liberty Safeguards (2005)	90%	97.8%		Q4 2020/21 Compliance threshold achieved
	Child Exploitation Awareness	90%	96.9%		Q4 2020/21 Compliance threshold achieved
	Child Exploitation targeted	90%	96.2%		Q4 2020/21 Compliance threshold achieved
	Domestic Abuse	90%	96.7%		Q4 2020/21 Compliance threshold achieved

Referrals	**Comments**	**Rating**
Local Authority Children	Data submitted for Q2, Q3 & Q4 2020/2021 indicate there have been 0 safeguarding children referrals.	
Local Authority Adults	Data submitted for Q2, Q3 & Q4 2020/2021 indicate there have been 0 safeguarding adult referrals.	

Mental Capacity Act/ Deprivation of Liberty Safeguards	DoLS application 2020/21 data submitted to the CCC safeguarding team indicated Q2. 3, Q3. 1, Q4. 3 however the DoLS application did not progress to the Local authority for authorisation due to either: Patient regaining capacity, being discharged home or having died.	
Commissioning Standards 2019-2020 including Children in Care	Comments	**Rating**
Standards submitted	Commissioning Standards 2019/20 completed with evidence submitted in Q3 2020/21.	
Action plan **Q 1 onwards**		
Quality Visit 2019/20 Action Plan		
Covid-19 Reset and Recovery plan	Clatterbridge Cancer Centre (CCC) Safeguarding team provided a safeguarding service throughout the Pandemic period with additional support provided to ward staff with safeguarding concerns/issues. CCC contributed to the Merseyside Health Provider Safeguarding Training workshop to review and share best practices during the Pandemic with a particular focus on alternative ways of delivering safeguarding training. CCC was able to maintain safeguarding training throughout although face to face training initially had been stepped down and re introduced taking into account social distancing principles. Business meeting and safeguarding supervision has continued and internally the safeguarding named nurse has provided this for CCC staff.	
Overall		

Summary Analysis and Actions	Clatterbridge Cancer Centre maintained the Safeguarding Service throughout the Pandemic period and supported front line staff with safeguarding concerns. Have achieved compliance for Safeguarding Children and Adult Training levels 1-4, Prevent Awareness, Prevent Health Wrap, Mental Capacity Act & Deprivation of Liberty Safeguards (2005), Domestic Abuse and Child Exploitation. CCC reviewed the implications of the Intercollegiate document: Looked after Children (2020) with the Designated Nurse for CiC and have developed a CiC training plan for 2021/22 i.e. Children in Care level 1 training to be included in CCC Safeguarding Training offer and Children in Care level 2-4 will be introduced into safeguarding training as required and set out in the Intercollegiate document (2020). Commissioning Standards 2019/20 submission Q3 2020/21 provided a well-rounded overview of the progress CCC have made to integrate safeguarding across the Organisation. Commissioning Standards 2019/20 and evidence provided has been reviewed by LCCG. Some areas have been identified that would benefit from further discussion and exploration. This can be addressed prior to Q1 2021/22 submission and during Business/Supervision meetings. CCC will develop an action plan following this review and submit Q1 2021/22.	
Designated Nurse Safeguarding Children	Chantelle Carey	**10/05/21**
Designated Nurse Children in Care (CiC)		
Designated Nurse Adults	Carmel Hale	**05.05.21**
Head of Safeguarding QA		

Appendix 2 - Trust Mandatory & role specific Safeguarding Training Matrix

Levels	Trust Staff allocated to each Group	How to access safeguarding training	How often do I need to update my Training?	How long will the Training take?
Safeguarding Awareness	All staff employed by Clatterbridge Cancer Centre including volunteers and contractors.	Via Corporate Induction	One off session	30 minutes
Level 1 Children & Adults	All staff employed by Clatterbridge Cancer Centre including Contractors.	E-learning via ESR	On commencing at the Trust and then every 3 years	Refresher training equivalent to a minimum of two hours.
	Volunteers	E-learning via ESR		
	Trust Board Members including Non-Executive Directors	E-learning via ESR		
Level 2 Children & Adults All clinical and non-clinical staff who have some degree of contact with children, young people and adults at risk Topics included within this level of training • Mental Capacity Act • Deprivation of Liberty Safeguards(DoLS)	All patient facing staff including: • Trained nurses, health care assistants and trainee nurse associates (Bands 1-5) • Teenage and Young Adults (TYA) admin staff • Ward Pharmacists • Allied Healthcare Professionals (Bands 5-6) • Doctors/Dentists	E-learning module via ESR	Every 3 years NOTE: Training at level 2 will include the training required at level 1 and will negate the need to undertake refresher training at level 1 in addition to level 2.	Refresher training equivalent to a minimum of 3-4 hours.
Level 2 Domestic Abuse	All patient facing staff including: • Trained nurses, health care assistants and trainee nurse associates (Bands 1-5)	E-learning module via ESR	Every 3 years	4 Modules required to be completed for compliance to be gained

	• Teenage and Young Adults (TYA) admin staff • Ward Pharmacists • Allied Healthcare Professionals (Bands 5-6) • Doctors/Dentists • HR Team • Line Managers			
Level 3 Children & Adults All clinical staff who could potentially contribute to assessing planning , intervening or evaluating the needs of a child or young person or adult at risk	Patient facing staff as outlined below: • Nursing Staff at Band 6 and above • Teenage and Young Adults clinical staff • Doctors/dentists involved in children, teenage and young adult services • Radiographers at Band 7 and above • Matrons and Lead Nurses • Social Worker/s • Physio/ OT/ Dietician at band 6 and above • Safeguarding Practitioner • Nurses working in the Home Treat Team (Out-patients) • Nurses working in Private Clinic at CCC.	E-learning module via ESR for Children and/or 3 hour face to face session for Adults & Children Note: L3 adults training is face to face only	Every 3 years NOTE: Training at level 3 will include the training required at level 1 and 2 and will negate the need to undertake refresher training at levels 1, and 2 in addition to level 3.	Refresher training equivalent to a minimum of 8 hours

Levels	Trust Staff allocated to each Group	How to access prevent training	How often do I need to update my Training?	How long will the Training take?
Level 3 Domestic Abuse	Patient facing staff as outlined below: • Nursing Staff at Band 6 and above • Teenage and Young Adults clinical staff • Doctors/dentists involved in children, teenage and young adult services • Radiographers at Band 7 and above • Matrons and Lead Nurses • Social Worker/s • Physio/ OT/ Dietician at band 6 and above • Safeguarding Practitioner • Nurses working in the Home Treat Team (Out-patients) • Nurses working in Private Clinic at CCC.	Face to face session included within Level 3 for Adults & Children training programme	Every 3 years NOTE: Training at level 3 will include the training required at level 2 and will negate the need to undertake refresher training at level 2 in addition to level 3.	Training incorporated within Level 3 adults and children training sessions
Level 4 Children & Adults Named Professionals only.	• Named Nurse for Safeguarding Adult/ Children • Named Doctors for Safeguarding • Trusts Prevent Lead	Multi agency safeguarding training including attendance at relevant safeguarding health sub groups, case conferences, strategy meetings etc.	Every 3 years NOTE: Training at level 4 will include the training required at level 1 ,2 and 3 and will negate the need to undertake refresher training at levels 1, 2 and 3.	Refresher training equivalent to a minimum of 24 hours

Children in Care – Level 1	Patient facing staff as outlined below: • Nursing Staff at Band 6 and above • Doctors/dentists involved in children, teenage and young adult services • Radiographers at Band 7 and above • Matrons and Lead Nurses • Social Worker/s • Physio/ OT/ Dietician at band 6 and above • Safeguarding Practitioner • Nurses working in the Home Treat Team (Out-patients) • Nurses working in Private Clinic at CCC.	Initially a Face to face session until training is developed as e learning module in ESR.	On commencing at the Trust and then every 3 years	Refresher training equivalent to a minimum of two hours as part of safeguarding children.
Children in Care – Level 2	• Teenage and Young Adult Team • Safeguarding Team • Named Professionals	Face to face session	Every 3 years NOTE: Training at level 2 will include the training required at level 1 and will negate the need to undertake refresher training at level 1 in addition to level 2.	Refresher training equivalent to a minimum of 3-4 hours as part of safeguarding children

Levels	Trust Staff allocated to each Group	How to access training	How often do I need to update my Training?	How long will the Training take?
Prevent Level 3 & 4 All clinical staff who could potentially contribute to assessing planning , intervening or evaluating the needs of a child or young person or adult at risk	Patient facing staff as outlined below: • Nursing Staff at Band 6 and above • Teenage and Young Adults clinical staff • Doctors/dentists involved in children, teenage and young adult services • Radiographers at Band 7 and above • Matrons and Lead Nurses • Social Worker/s • Physio/ OT/ Dietician at band 6 and above • Clinical Specialist Practitioner for Additional needs • Nurses working in the Home Treat Team (Out-patients) • Nurses working in Private Clinic at CCC • Safeguarding team	E-learning via ESR	Every 3 years	No specified time requirements
Prevent Level 5 Trust Prevent Leads only	Trust Prevent Leads only.	Level 3 E-learning via ESR plus; Attendance at NHS England annual PREVENT conference and a minimum of two NHS England Regional Prevent Forums	Every 3 years Annual	No specified time requirements

Trust Board	Trust Board Members including Non-Executive Directors	Bespoke Board Training Session	Annual	Up to 1 hour
Learning Disability (LD) Awareness	All patient facing staff including: • Trained nurses, health care assistants and trainee nurse associates (Bands 1-5) • Teenage and Young Adults (TYA) admin staff • Ward Pharmacists • Allied Healthcare Professionals (Bands 5-6) • Doctors/Dentists	E-learning via ESR	On commencing at the Trust and then every 3 years	No specified time requirements
Dementia Awareness	All patient facing staff including: • Trained nurses, health care assistants and trainee nurse associates (Bands 1-5) • Teenage and Young Adults (TYA) admin staff • Ward Pharmacists • Allied Healthcare Professionals (Bands 5-6) • Doctors/Dentists	E-learning via ESR	On commencing at the Trust and then every 3 years	No specified time requirements

Monitoring of Compliance

It is the responsibility of each team and directorate to identify which level of training their staff require and ensure this is

completed and updated within the recommended timeframes. An ESR workforce data and compliance rate for all staff is

provided to each division from the learning and development team on a monthly basis team.

Division leads are responsible for monitoring the uptake and compliance with both mandatory and role specific safeguarding training requirements at their monthly Division meetings and providing assurance of compliance at safeguarding committee meetings.

All line managers are responsible for ensuring that their members of staff are compliant with the relevant mandatory and role specific levels of safeguarding training at their regular one to one meetings/ annual PADR process and that uptake and compliance is recorded.

Please note: We encourage all staff that have completed Safeguarding training in previous organisations/roles to bring their training passport to demonstrate compliance with safeguarding training. On submission of certificate of completion or evidence this will be recorded on ESR by learning and development team.

Any queries please contact the Safeguarding Team on 07787 277802

COVID 19 Pandemic

As part of the NHS response to COVID-19, CCC took the decision to ensure clinicians have the necessary skills and knowledge to deliver safe care for our population during these extremely challenging times. We have therefore been recommending that staff access online training on ESR to meet the social distancing requirements.

Face to face training sessions are only available in those topics such as safeguarding adults level 3 in which there is not an equivalent e learning module available yet in ESR.
These sessions are delivered with social distancing requirements in place.

Appendix 3 - Deprivation of Liberty Safeguards Applications in 2020-21

Number of DOLS Applicatons	Date of admission and Ward	Date of Dols Application submission	Local Authority	Mental Capacity Assessed on Meditech?	Datix incident completed?	Dols Application added to patient records?	Note added to Meditech?	Patient seen within 14 days of application?	DOLS Authorisation added to patient records?	CQC notified?
1	03/07/2020 Ward 2	08/07/2020	Liverpool	Yes Meditech	Yes ID 10369	Yes Meditech	Yes Safeguarding Note	No COVID	Withdrawn on 22/07/20 Resumed capacity	Yes on 06/08/2020 Added to datix
2	08/07/2020 Ward 3	10/07/2020	Liverpool	Yes Meditech	Yes ID 10403	Yes Meditech	Yes Safeguarding Note	No COVID	Withdrawn on 29/07/20 Discharged home	Yes on 06/08/2020 Added to datix
3	05/09/2020 Ward 2	07/09/2020	St Helens	Yes Meditech	Yes ID 23145	Yes Evolve	Yes Social Worker Note	No COVID	Withdrawn on 11/09/20 Transferred to another hospital	Yes on 18/09/2020 Added to datix
4	06/10/2020 Ward 3	08/10/2020	Liverpool	Yes Meditech	Yes ID 12671	Yes Meditech	Yes Safeguarding Note	No COVID	Withdrawn on 22/10/20 Discharged home	Yes on 22/12/2020 Added to datix
5	11/01/2021 Ward 2	15/01/2021	Sefton	Yes Meditech	Yes ID 13068	Yes Meditech	Yes Safeguarding Note	No COVID	Withdrawn on 25/01/21 Discharged to a nursing home	Yes on 25/01/21 Added to datix
6	28/01/2021 Ward 4	09/02/2021	Liverpool	Yes Meditech	YES ID 13592	Yes Meditech	Yes Safeguarding note	No COVID	Withdrawn on 18/03/21 Discharged home	Yes on 18/03/21 Added to datix
7	12/03/2021 Ward 4	17/03/2021	Liverpool	Yes Meditech	Yes ID 14154	Yes Meditech	Yes Safeguarding note	No COVID	Withdrawn on 24/03/21 Patient passed away.	Yes on 25/03/21 Added to datix

Appendix 4 – NHSI Learning Disability Improvement Standards Annual Progress Report 2020-2021

1.0 Introduction

The purpose of this report is to provide Clatterbridge Cancer Centre (CCC) Safeguarding Committee with an annual update and progress to date against delivery of the NHS Learning Disability (LD) Improvement Standards across the Trust.

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2.0 Background

In June 2018, the Learning Disability Improvement Standards for NHS Trusts were developed. The standards, the first of their kind aimed solely at NHS Trusts, are intended to help the NHS measure the quality of service provided to people with learning disabilities, autism or both.

People with learning disabilities, autism or both, along with their families and carers, should expect high quality care across all NHS services. However, numerous investigations and inquiries have found that all too often, this vulnerable group of people has a much poorer experience than the general population when accessing NHS care.

These standards provide a necessary benchmark against which all NHS trusts, be they universal or specialist and will be able to measure the level and quality of their services. This will provide the Trust with a range of assurance as they continue to improve the services they provide.

There are three standards which apply to CCC each aimed at improving the care people receive; these include:

1. Respecting and Protecting Rights,
2. Inclusion and Engagement,
3. Workforce

Submission to NHSI

In November 2020, the Trust submitted data to the NHSI Learning Disability Improvement Standards project. It included information on policies, activity, the impact of the care delivered, service quality and outcomes, staff and patient surveys in relation to CCC patients with a learning disability and/or autism

In July 2020, a report was produced by NHSI providing a baseline for the quality of care CCC is delivering to patients with a learning disability, autism or both. This report facilitated the creation of a LD work plan which has been implemented and the monitoring of this work plan is undertaken by the CCC Safeguarding Committee on a quarterly basis.

There has been great progress and achievements associated with the measures within the Learning Disability Improvement Standards since receiving our report in July 2020. The details of this progress and these achievements are detailed below;

Standard 1 - Respecting and protecting rights

Measure:
Trusts must demonstrate they have made reasonable adjustments to care pathways to ensure people with learning disabilities, autism or both can access highly personalised care and achieve equality of outcomes.

Achievements/Progress:
The Trust are routinely offering the autism or LD Health passport to all patients identified to assist with reasonable adjustment care plans

Measure
Trusts must have mechanisms to identify and flag patients with learning disabilities, autism or both from the point of admission through to discharge; and where appropriate, share this information as people move through departments and between services.

Achievements/Progress

- The addition of the Autism flag in the special indicators has been implemented in October 2020.
- This reasonable adjustment Special Indicators has been shared across the organisation via the weekly communications bulletin to ensure divisions are aware how to put this in place.
- An application has been made to the Trusts IT department to include the addition of Reasonable Adjustments flag in the 'Special Indicators' electronic flag. Plans are in place to implement by end of Q2.

Measure

Trusts must have processes to investigate the death of a person with learning disabilities, autism or both while using their services, and to learn lessons from the findings of these investigations.

Achievements/Progress

- Trust continues to participate in the LeDeR reporting process. CCC reported the death of a person with an LD in Q4 who was known to CCC, but died at different NHS Trust.
- Monthly reports have been shared across the organisation and via the Mortality Surveillance Group and Safeguarding Committee.
- Trust continue to engage with Liverpool CCG following the transition of LeDeR from University of Bristol in May 2021

Measure

Trusts must demonstrate that they vigilantly monitor any restrictions or deprivations of liberty associated with the delivery of care and treatment to people with learning disabilities, autism or both.

Achievements/Progress

- The DoLS audit was completed in March 2021 and presented to Safeguarding Committee in April 2021.
- Trust are regularly monitoring any updates regarding the introduction of LPS in April 2022.

Measure

Trusts must have measures to promote anti-discriminatory practice in relation to people with learning disabilities, autism or both.

Achievements/ Progress

- The Trust has developed a short film detailing the radiotherapy journey of a person with a learning disability and/or autism. The aim is to develop a short film of a person's journey receiving chemotherapy next as the outcome was so positive.
- The Trust employs a Safeguarding Practitioner who will support and advise staff that care for patients with a learning disability and/or autism to complete a reasonable adjustment assessment and appropriate care plan in order to promote anti-discriminatory practice and support the patient in receiving the correct treatment for their disease.
- Staff have mandatory training and adhere to guidelines set out in the DoLS Policy and Mental Capacity Act policy.
- Safeguarding arrangements are supported by the Trust Safeguarding Team.

Standard 2 - Inclusion and Engagement

Measure

Trusts must demonstrate processes that ensure they work and engage with people receiving care, their families and carers, as set out in the NHS Constitution.

Achievements/Progress

- The Trust continues to engage with Cheshire & Merseyside Confirm and Challenge Group to provide their services in relation to care and treatment that patients with a learning disability receive at Trust.
- Cheshire & Merseyside Confirm and Challenge Group continue to support our on-going work plan for LD/Autism which is involving members of the group engaging in the co-production of a chemotherapy journey which can be utilised as part of the reasonable adjustments we offer to our patients.

Measure

Trusts must demonstrate that their services are 'values-led'; for example, in service design/improvement, handling of complaints, investigations, training and development, and recruitment.

Achievements/Progress

- No complaints or investigations have been recorded 2019-2020 from patient groups with LD/Autism.
- The Trust has shared with the LD Collaborative group the Oliver McGowan training in order they can access the tier 1 awareness training. The Trust has been offered a selection of dates for face-face training via The Oliver McGowan group which will be accessible to the LD and Autism Champions, with support from Line Managers.
- An Easy Read version of a patient appointment letter has been co-produced with Merseyside and Cheshire Confirm & Challenge Group and approved for use within Trust.

Measure

Trusts must demonstrate that they co-design relevant services with people with learning disabilities, autism or both and their families and carers.

Achievements/Progress

- There is on-going collaboration between Cheshire and Merseyside Confirm and Challenge Group.
- Safeguarding Practitioner attends their local meeting on a monthly basis and this is fed back into the Trusts Patient Experience and Engagement Group (PEIG) bi-monthly.

Measure

Trusts must demonstrate that they learn from complaints, investigations and mortality reviews, and that they engage with and involve people, families and carers throughout these processes.

Achievements/Progress

- The Cheshire & Merseyside Learning Disability Network is currently sharing outcomes of local LeDeR reviews across the network. The trust has representation at these meetings.
- Trust has not received any complaints, been involved in any investigations or mortality reviews within 2020-2021 involving patients with a Learning Disability or Autism.

Measure

Trusts must be able to demonstrate they empower people with learning disabilities, autism or both and their families and carers to exercise their rights.

Achievements/Progress

- Strategy and work plan continues in conjunction with Cheshire and Merseyside Confirm and challenge group
- Safeguarding team continue to liaise with other Trusts in relation to mutual patients who have LD/Autism.

Standard 3 - Workforce

Measure

Based on analysis of the needs of the local population, trusts must ensure staff have the specialist knowledge and skills to meet the unique needs of people with learning disabilities, autism or both who access and use their services, as well as those who support them.

Achievements/Progress

- The addition of Autism in the 'Special Indicators' electronic flag has been completed.
- The Trust LD/Dementia Champions have access to The Oliver McGowan training to develop their knowledge in LD/Autism.
- An application has been made to the Trusts IT department to include the addition of Reasonable Adjustment in the 'Special Indicators' electronic flag.

- The Safeguarding Practitioner as Lead for Learning Disabilities and Autism has the specialist knowledge and skills to meet the unique needs of people with learning disabilities, autism or both who access and use CCC services, as well as those who support them.
- The Trust has over 45 members of staff who have become Learning Disability Champions and meets on a bi-monthly basis with Safeguarding Practitioner as Lead for Learning Disabilities and Autism to discuss supporting patients with a learning disability.

Measure

Staff must be trained and then routinely updated in how to deliver care to people with learning disabilities, autism or both who use their services, in a way that takes account of their rights, unique needs and health vulnerabilities; adjustments to how services are delivered are tailored to each person's individual needs.

Achievements/Progress

The Trust's Learning and Development department uploaded the Cheshire and Merseyside wide approved 'LD/Autism Training' onto ESR. As of Jan 2021 compliance is currently 98% against target compliance of 90%.

Measure

Trusts must have workforce plans that manage and mitigate the impact of the growing, cross-system shortage of qualified practitioners with a professional specialism in learning disabilities.

Achievements/ Progress

- The Trust has supported 4 LD student nurses on placement.
- Safeguarding practitioner has outlined the role including that of LD and Autism and how it fits in with the safeguarding role.

Measure

Trusts must demonstrate clinical and practice leadership and consideration of the needs of people with learning disabilities, autism or both, within local strategies to ensure safe and sustainable staffing.

Achievements/Progress

- The Trust has recruited in September 2020 a safeguarding practitioner whose role and experience is in supporting patients and staff with considerations for the needs of patients with LD/autism.
- The safeguarding practitioner has recently completed a supervision course and is able to offer supervision to support staff who care for patients at CCC with LD and autism.

3.0 Key priorities for 2021/2022

The following key priorities have been highlighted for the focus of learning disability and autism work in 2021/22;

- The Trust Safeguarding Committee will continue to drive and monitor the progress of the Learning Disability Improvements Standards.
- The Safeguarding team will review the recommendations from the NHSI Learning Disability Improvements when they are published later in 2021 and facilitate an action plan based on the recommendations of the report.
- The Safeguarding Committee will continue to monitor the compliance of LD training

4.0 Recommendations

The report demonstrates that overall very good progress is being made against the objectives of the NHSI Learning Disability Improvement Standard.

The Safeguarding Committee are asked to note the progress being made with the Learning Disability Improvement Standards progress report.

Appendix 5 –The Dementia Strategy (Year 2) Progress Report: 2020/2021

Introduction

The Trust Dementia Strategy was ratified in April 2019 and it set out a three-year strategic plan for The Clatterbridge Cancer NHS Foundation Trust (CCC). The strategy included an action plan of the key developments which are required to be able to achieve the vision outlined in the strategy and they are underpinned by the national framework.

This report highlights the work undertaken in the second year and our achievements to improve the care of those people living with cancer and dementia and support their carers and families.

1. Progress so Far

This report provides assurance of the actions achieved so far and a review of some of the current objectives in progress in 2021.

Overall, the current strategy is progressing well with key achievements including:

- The Dementia/Learning Disability and Autism Collaborative Group continuing to focus and achieve on the actions within the Strategy utilizing the Dementia Champions across all 3 sites
- Dementia Awareness training compliance achieved the target of 90% for all patient-facing staff and continues to be maintained at 97% in Q3.
- Dementia Action Alliance benchmarking work was completed across the Trust including all hubs.

The main focus of the current work plan in the last six months has been:

- Improving the experience for patients with cancer and dementia and their carers/families whilst facing ongoing challenges due to Covid-19 pandemic
- The planned move to new building in Liverpool in May 2020
- Progressing actions with the Trust Dementia Strategy and associated work plan

2. Key Areas of Progress

The sections below provide key areas of progress on the 7 objectives of the strategy.

a. Governance and Assurance

- An associated work plan has continued to progress the delivery of the key these objectives and feeds into Patient Experience and Inclusion Group on a quarterly basis
- The Dementia/ Learning Disability and Autism Collaborative Group continue to drive and monitor the progress of the strategy.

b. Training and Education

- Dementia Awareness training compliance achieved the target of 90% for all patient-facing staff and continues to be maintained at 97% in Q3.
- Dementia champion training offered for staff wishing to become champions in their area.
- Members of the Dementia /Learning Disability and Autism Collaborative Group have accessed training from the Oliver McGowan training in Learning Disability & Autism for NHS staff
- Bespoke training sessions are available to any staff groups who have difficulty accessing an e-learning module available on ESR

c. An Improved Patient Journey

- The Additional Needs Policy has been revised due to changes in role responsibility and is due to be ratified at the Trust Safeguarding Committee in April 2021.
- Reasonable Adjustments and DisDAT audits were presented in January 2021 however further assurance was requested therefore re- audits are planned in 6 months.
- The De-Escalation: Principles and Guidance including Restraint guidelines were developed and ratified in August 2020

d. Dementia Friendly Environment

- Members of Service Users Reference Forum (SURF) were to be invited to

visit CCC-L and complete the Kings Fund Dementia Environment Tool; however, this remains on hold due to the current Covid-19 restrictions. The Trust is therefore looking at alternative ways of completing the Environmental Tool virtually through digital means.

- Members of the Dementia/Learning Disability and Autism Collaborative Group have completed Dementia Action Alliance benchmarking work across Halton, CCC-W and CCC-A. The subsequent action plans were developed and being progressed by the Group and monitored by the Trust Safeguarding Committee.
- Patient-Led Assessments of the Care Environment (PLACE) are deferred due to Covid-19 pandemic; however, the Trust agreed to complete a PLACE Lite in the interim as a self-assessment in December 2020.

e. Partnership Working

- The Safeguarding Practitioner continues to meet virtually with the Liverpool Dementia Action Alliance (DAA) to be updated about dementia friendly projects and local facilities available in Merseyside and to meet virtually the monthly SURF meetings to liaise with patients, carers and families about the work being completed in CCC.

- The Liverpool DAA has asked the safeguarding practitioner to support the Dementia Awareness Week activities during the week commencing 17th May 2021.

f. Caring for Carers

- The Oncology Social Worker and Safeguarding Practitioner can support and address the needs of carers of patients with additional needs. The Trust is in the process of developing a Carers Policy to meet the criteria of the NICE guidance on Carers.

- During the Covid 19 pandemic, the Trust visiting policy has been revised to meet national guidance, however patients identified with additional needs such as dementia have been offered visiting through reasonable adjustments if required.

g. Raising Standards and promoting activities

- The Helping Hands is a new inpatient process on the TV which is due to be piloted on ward 2 which allows patients to access snacks, newspapers remotely during their stay. The pilot is due to commence w/c 15th March 2021.
- The CCC-L Familiarisation App is utilised for Chemotherapy and Radiotherapy patients and it reduces anxiety before arriving for their treatment at CCC Liverpool.
- Regular updates have been published within the Trust weekly communication

  E-bulletin to ensure staff is updated on guidance on dementia and coronavirus.

3. Focus for Year 3

The key areas of work to be undertaken in the final year of the strategy will be;

- The Dementia Collaborative Group will continue to drive and progress the objectives within the Trust Dementia Strategy.
- We will continue to engage with the Dementia Action Alliance [DAA] and adoption of the Dementia Friendly Hospital Charter.
- We will continue to develop and implement a Trust's Carers Policy**,** which will reflect the Johns Campaign
- An easy read leaflet about patient attending as an outpatient and easy read complaints leaflet is to be introduced within the Trust.
- We will review and revise the current Dementia Strategy in 2022.

4. Recommendations & Actions Required by the Group

The report demonstrates that overall very good progress is being made against the objectives of the Dementia Strategy (2019 – 2022).

The Patient Experience and Inclusion Group are asked to note the progress being made with the Dementia Strategy and the areas for further focus.

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	28 July 2021
Agenda item:	P1-124-21
Title:	Freedom to Speak Up Annual Report
Report prepared by:	Angela Wendzicha
Executive Lead:	James Thomson
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Quality Committee
Date & decision:	22 July 2021

Purpose of the paper/key points for discussion:	The purpose of the report is to provide the Trust Board with an overview of the activity relating to Freedom to Speak Up during the last financial year. The main positive development has been the increase in the number of Freedom to Speak Up Champions recruited and the training established through the ESR system.

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

Next steps required:	

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

☒ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☒ BE **RESEARCH LEADERS**

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

☒ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

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Freedom to Speak Up Annual Report 2020-21

Angela Wendzicha, Associate Director of Corporate Governance
Lead Freedom to Speak Up Guardian
July 2021

Version: 1.0 Ref: FCGOREPO Review: May 2024

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

1. Introduction

1.1 Effective Freedom to Speak Up arrangements help to protect patients and improve the experience of staff. It is well known through various published Reviews by the National Guardian Office that the reasons that staff do not speak up is because they fear they might be victimised or because they do not believe anything will change.

1.2 Speaking up and the issues that speaking up highlights should be welcomed and seen as an opportunity to learn.

1.3 Trusts are required, under the NHS Contract to have in place a Freedom to Speak Up Guardian who is appointed by the Chief Executive. In addition, there is a requirement to have a Non-Executive Director with responsibility for providing guidance and oversight to the Trust on matters relating to speaking up.

1.4 The following report provides a summary of the activity relating to Freedom to Speak Up during the last financial year 1 April 2020 to 31 March 2021.

2. The Team

2.1 The Trust has a Lead Freedom to Speak Up Guardian (Angela Wendzicha) supported by three Local Guardians (Derry Sinclair, Paul Callister and Vanda Fitchett) who all play an important role in being an independent and impartial source of advice for staff.

2.2 In addition, the Trust has developed the Freedom to Speak Up Champion role that also plays an important role in encouraging staff to in raising concerns at the earliest opportunity. Throughout this process, a total of seventeen Freedom to Speak Up Champions were in place across various disciplines and sites. The Freedom to Speak Up Champions are Julie Holemans, Alun Evans, Abdul Oayum, Rupali Gleeson, Helen Vanston, Andrew Garner, Jackie Rooney, Nicola Brown, Anna Severgnini, Petrina O'Hallaran. Sam Wilde, Helen Purslow, Susan Wright, Sarah Downey, Emily Smith, Catherine Noble and Hayle Finegan.

2.3 The Trust previously had a series of visual materials across all sites detailing the Guardians. Given the on boarding of the additional Champions, additional publicity will be

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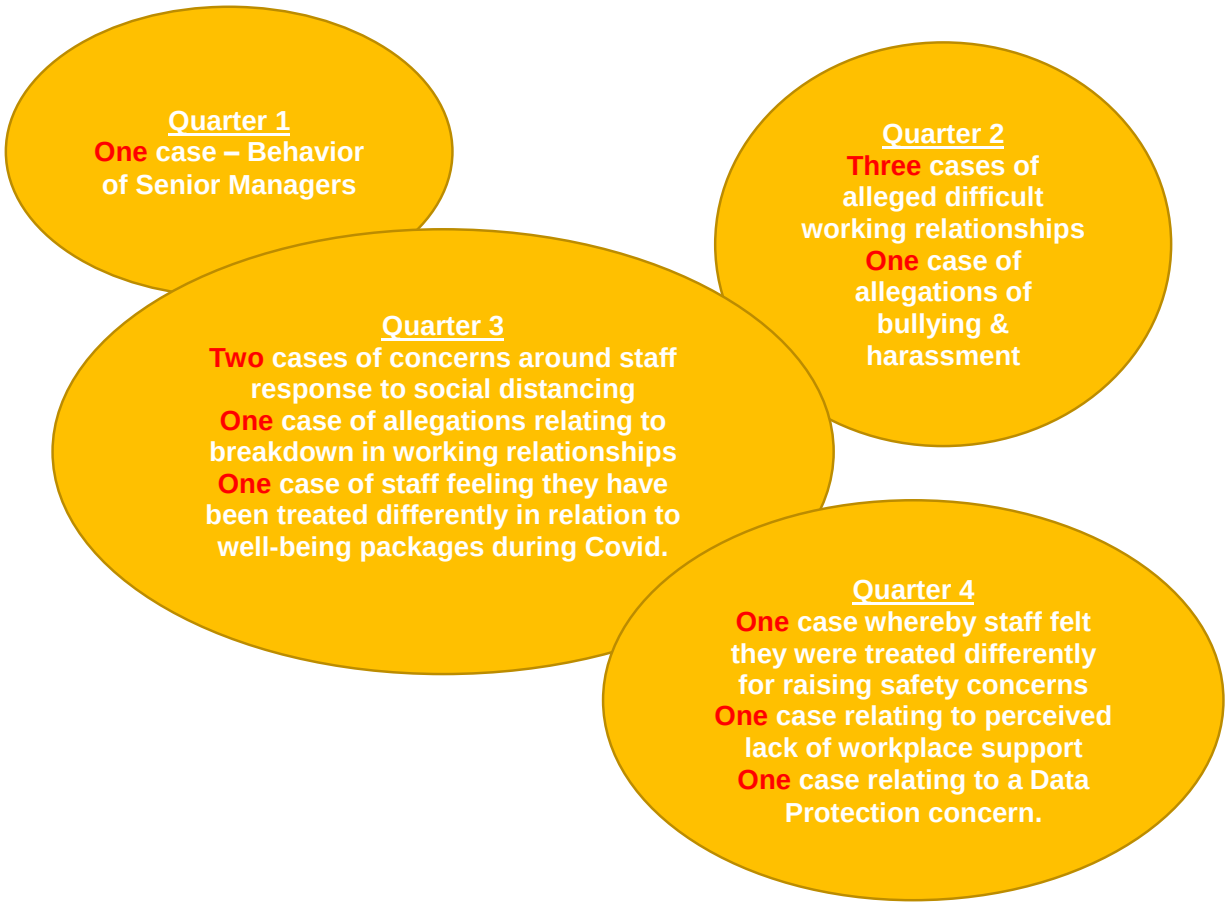
arranged for early 2021/22 to ensure staff have visibility of all who can support the speaking up process.

2.4 The Local Guardian and Champion roles are voluntary and undertaken in conjunction to existing roles within the Trust.

2.5 In addition, the Trust has the benefit of Non-Executive Director (Alison Hastings until 31 December 2020 then Geoff Broadhead) who acts as an alternative source of advice and support for the Guardian and an Executive Director Lead (Sheila Lloyd until 31 March 2021 then James Thomson) who ensures the Freedom to Speak Up role has been implemented in addition to providing oversight and guidance.

3. Speaking Up Data

3.1 During 2020-21, a total of twelve cases were raised to either the Lead Guardian or Local Guardians as follows:



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3.2 Of the cases referred to in 3.1 above, all have been resolved to the satisfaction of the individual raising the concern with the exception of the Data Protection concern which remains ongoing. The staff raising concerns were signposted and supported through the existing processes to enable resolution.

4. Freedom to Speak Up Index Report 2021

4.1 The Freedom to Speak Up Index is an indicator developed by the National Guardian Office to assist organisations in further assessing the speaking up culture. It is a metric for NHS Trusts, drawn from four questions in the NHS Annual Staff Survey as follows:

- %age of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly
- %age of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents
- %age of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it
- %age of staff "agreeing" or "strongly agreeing" that they would feel secure raining concerns about unsafe clinical practice

In addition, there was an additional question added to the 2020 Staff survey as follows:

- %age of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation.

4.2 The Trust was listed 16th out of 220 with a Freedom to Speak Up Index of 84.1% with the highest Index being 87.6% and the national average being 79%. Based on the aforementioned result, the Trust is demonstrating a good speaking up culture.

4.3 The following table illustrates, where available, the comparison in responses from the 2019 Staff Survey and the 2020 Staff Survey to questions in the Staff Survey that relate to speaking up.

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Question	2019 Score	2020 Score	Sector Score
My organisation treats staff who are involved in an error, near miss or incident fairly	64.7%	70.8%↑	65.9%
I would feel secure raising concerns about unsafe clinical practice	73.8%	80.2%↑	75.6%
I am confident that my organisation would address my concern	66.1%	73.2%↑	65.8%
My organisation encourages to report errors, near misses or incidents	90.1%	89.8%↓	Average score 89.8%
I feel safe to speak up about anything that concerns me in this organisation	Not asked	72.9%	Average score 69.3%

5. Training and Resources

5.1 The Trust has an in-date Raising Concerns at work Policy setting out the process for staff in order to raise concerns within the workplace. All staff have access to the Lead and Local Guardians in addition to use of a dedicated confidential e-mail address whereby staff can raise their concerns. In addition, confidential, secure boxes will be distributed across all three sites in July.

5.2 There is a continuing training programme in place and all staff can access the speaking up E-Learning module 'Speak Up' on ESR which has been created by Health Education England. This module is for all staff working within the healthcare setting. In addition, the Lead and Local Guardians have carried out bespoke training within the Trust on the importance of Speaking Up and how staff can be supported through the process. The module provides a clear and consistent way what speaking up is and the importance of creating an environment whereby staff are supported to raise concerns.

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5.3 NHS Improvement developed, in conjunction with the National Guardian's Office, a self-review tool completed by the Board in 2018 and associated action plan was completed in 2018. Given the development over the last financial year, it is recommended the Board repeat the self-review tool in the next financial year.

6. Conclusion

The Trust's Freedom to Speak Up programme continues to progress and develop. Whilst the numbers of cases brought through the Freedom to Speak Up route is relatively low, it is encouraging that the Trust has maintained a good speaking up culture as demonstrated by the results of the Freedom to Speak Up Index. It is acknowledged that further work is required to continue to raise the profile of the Guardian role and embed the training modules within all departments.

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Report to:	Trust Board
Date of meeting:	28th July 2021
Agenda item:	P1-125-21
Title:	IPC Annual Report 2020 - 2021
Report prepared by:	Lauren Gould, Infection Prevention and Control Matron, Karen Kay, Deputy Director of Nursing
Executive Lead:	Joan Spencer, Interim Director of Nursing
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Integrated Governance Committee/Infection Prevention and Control Committee/Quality Committee
Date & decision:	6th July 2021, 20th and 22nd July 2021- Noted

Purpose of the paper/key points for discussion:

The purpose of this report is to provide Trust Board with oversight of Infection Prevention and Control (IPC) Annual Report for 2020/2021.

It meets the requirement for Trust Boards to produce and Annual Report with an analysis of the effectiveness of local Infection Prevention and Control arrangements.

The report provides a summary of the key issues, activity and performance of the Infection Prevention and Control Team and wider Trust during 2020/2021 and assurance that CCC is fulfilling its statutory, regulatory and contractual responsibilities.

An overview of Trust performance against the national ambition to reduce the incidence of healthcare acquired infections and the proposed objectives for improvements in infection prevention and control practice for 2021/2022 are included.

The report highlights the additional challenge experienced at the Trust for patients, families, staff and IPC systems and processes, due to the Covid-19 global pandemic.

As a Trust CCC are compliant with the following standards

Standard	Compliant
NHSEI Infection Prevention and Control (IPC-BAF) Board Assurance Framework. National Guidance July 2021	√
Public Health England. Covid 19 Infection Prevention and Control Guidance. June 2021	√
CQC Regulation 12: Safe Care and Treatment	√
Health and Social Care Act (2008) (updated 2015)	√
Infection prevention and control. NICE Quality standard [QS61]. April 2014	√

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	Standard infection control precautions: national hand hygiene and personal protective equipment policy. NHSI 2019	√

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

Next steps required:	Trust Board are requested to; • Note content of the Annual Report and 10 Point Forward Plan. • Approve the Infection Prevention and Control Annual Report 2020-2021

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

☐ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

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☐ BE **DIGITAL**

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

☐ B

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

BE **INNOVATIVE**

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

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

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The Clatterbridge Cancer Centre NHS Foundation Trust

Infection Prevention and Control Annual Report 2020-2021

Lauren Gould, Infection Prevention and Control Matron

Karen Kay, Deputy Director of Nursing

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1. Executive Summary

This report sets out the arrangements for Infection Prevention and Control (IPC) within the Clatterbridge Cancer Centre (CCC) and summarises the work and projects implemented during 2020-2021 to ensure that CCC is compliant with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (updated 2015) and associated Care Quality Commission (CQC) guidance.

The report acknowledges the work and diligence of all grades of staff who play a vital role in improving the quality of patient experience as well as assisting to reduce the risk of infections. This has proved particularly challenging in 2020/21 in the context of a global SARS-CoV-2 pandemic. In addition, CCC relocated all in-patient services and the majority of out-patient services from its existing Wirral site to a new 110 bedded, single en-suite room facility in Liverpool. Haemato-oncology services previously situated within the Royal Liverpool Hospital building were also transferred into the new hospital.

A zero tolerance approach is taken by the Trust towards all avoidable Health Care Associated Infections (HCAI's). Table 1 summarises performance against Key Performance Indicators (KPI's) for 2020-2021.

Table 1

KPI	Annual Objective	Performance (case numbers)
Meticillin resistant *Staphylococcus aureus* (MRSA) bloodstream infections	**0**	**0**
Clostridiodes difficile infections (CDI)	**<4**	**5**
Meticillin sensitive *Staphylococcus aureus* (MSSA) bloodstream infections	**<5**	**4**
Escherichia coli (E.coli) bloodstream infections	**<10**	**5**
Klebsiella spp. bloodstream infections	**<10**	**2**
Pseudomonas aeruginosa bloodstream infections	**<5**	**1**

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CCC has performed well against the national HCAI objectives for 2020/2021 achieving zero MRSA Blood Stream infections (reduction from the previous year) and reducing the number of CDI's from 11 (previous year) to 5. This is a major achievement as Oncology patients are classed as clinically extremely vulnerable and highly susceptible to developing these infections.

All HCAI's are subject to a Post Infection Review (PIR). This is undertaken by the Infection Prevention and Control Team, Infection Control Doctor and Anti-microbial Pharmacist in conjunction with clinical teams with the aim of identifying any lapses in care or lessons learned from an episode of infection.

A strengthened, targeted and enhanced Aseptic Non-Touch technique (ANNT) education programme has commenced to support reduction in all blood stream infections in CCC patients going forward.

The Trust has had no outbreaks identified in staff or patients during 2020/2021

2. Achievements against the national HCAI objectives

In 2020/21 the national HCAI objectives set by NHS England and Improvement (NHSEI) were:

- MRSA – a continued zero tolerance approach to MRSA blood stream infections (BSI)
- CDI – objectives continued to include all healthcare associated infections including hospital and community onset cases

2.1 MRSA Blood Stream Infections

Nationally there continues to be a zero tolerance approach to MRSA BSI. Figure 1 below demonstrates that CCC did not identify any Trust attributable MRSA blood stream infections in 2020-21. This is reflective of a well-established, vigorous screening process for all in-patients across the organisation to identify MRSA colonisation at the point of admission, along with the use of nasal and skin decolonisation treatment where this is identified.

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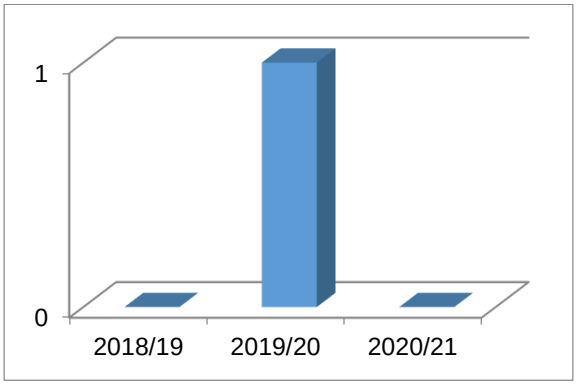
Figure 1 - Trust Attributable MRSA BSI



There were no lessons learned identified due to zero cases, however regular reviews of regional and national examples of best practice are undertaken to ensure continuous improvement is achieved.

2.2 *Clostridiodes Difficile* Infection

In April 2019 the *Clostridiodes difficile* national objective changed to include all health care associated CDIs;

- Hospital onset healthcare associated (HOHA) cases detected in the hospital three or more days after admission
- Community onset healthcare associated (COHA); cases that occur in the community (or within 2 days of admission) when the patient has been in the Trust reporting cases in the previous 4 weeks.
- Community onset indeterminate association (COIA) = cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks
- Community onset community associated (COCA) =cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks. (90 days)

The national objective (maximum threshold) for the Trust is no more than four avoidable CDI cases associated with a lapse in care. A total of nine cases of CDI were reported by the Trust during 2020-21, all of which were investigated via the Post Infection Review (PIR) process. Of these cases, five were

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attributed by definition to CCC as HOHA cases. No COHA or COIA cases were identified in 2020-2021.

CDI PIR Findings

- All cases were reviewed by a Consultant Microbiologist; of the five HOHA cases, all were considered to be unavoidable with no lapses in care identified that contributed to the development of infection.
- All five patients had received anti-microbials to treat other infections prior to developing CDI.
- Two patients had received anti-microbials which were prescribed outside of Trust Formulary. Trust Formulary indicates the most appropriate anti-microbial medication for specific infections. However, both had been prescribed on the advice of a Consultant Microbiologist following patient referral to the Microbiology service. No evidence of cross-infection was found during the review.

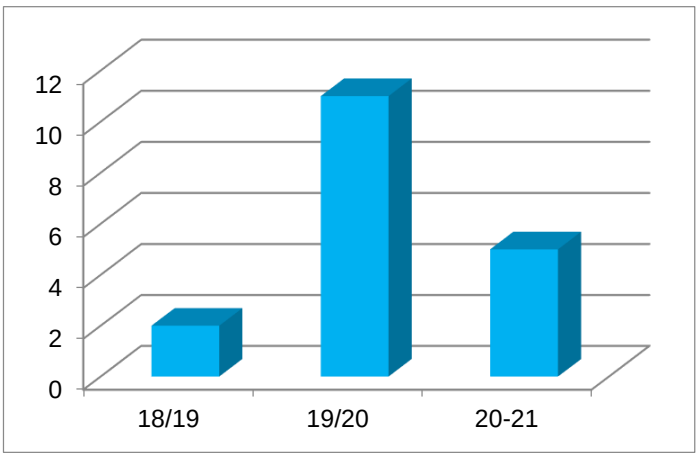

Figure 2 - *Clostridiodes Difficile* Cases by Financial Year

The infection rates demonstrated in Figure 2 is supported by current evidence; that oncology patients are at a high risk of developing CDI, particularly as anti-microbials are widely used within this patient group.

However, the IPC Team, Consultant Microbiologist and Anti-microbial Pharmacist have continued to work closely with all clinical staff to ensure that all anti-microbial use is appropriate and that unexplained diarrhoea is identified promptly and specimens obtained to support timely diagnosis and treatment of CDI.

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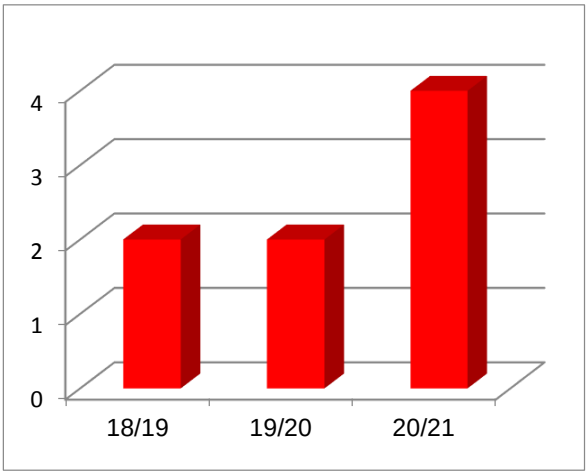
3.0 External Reporting

3.1 Meticillin Sensitive *Staphylococcus Aureus* (MSSA)

There is no national objective set for MSSA bacteraemia. The Trust reported four attributable cases of MSSA in 2020/21 compared to two cases being reported in 2019/20.

Figure 3 -Trust apportioned MSSA cases by financial year



Following investigation, there was no evidence that cases were linked and all infections were subject to a post infection review (PIR) undertaken by the IPC Team and Consultant Microbiologist. The PIR process identified that care and documentation of indwelling intra-venous devices may have contributed to the development of infection in 2 cases.

As a result of this finding, to improve practice, a strengthened Aseptic Non Touch Technique (ANTT) training programme supported by the Clinical Interventions Team (CIT) was implemented, with mandatory written and practical assessments for staff who undertake any clinical activities that require ANTT. An audit programme has been implemented (High Impact Interventions) to assure compliance across all areas. Peer reviewers receive an annual update to ensure competence and staff assigned an ANTT role undertake annual theoretical and practical competency assessments.

3.2 Vancomycin Resistant Enterococcus (VRE)

VRE are strains of *Enterococci* bacteria that are resistant to the glycopeptide antibiotics (Vancomycin and Teicoplanin). *Enterococci* are bacteria normally found in the gut that may cause infections including blood stream infections, particularly in

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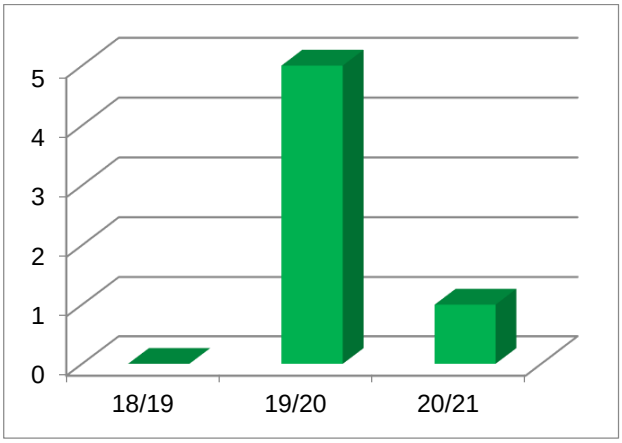
complex or immunocompromised patients such as those receiving Chemotherapy treatments.

Figure 4 - Trust apportioned VRE cases by financial year



One VRE blood stream infection was identified during 2020/21 compared to five in 2019/20. The infection occurred within the Haemato-oncology (H-O) patient population and considered to be unavoidable following a post infection review (PIR). No new learning points were identified.

3.3 Gram negative blood stream infections

There was a national ambition to reduce healthcare associated Gram negative blood stream infections (GNBSI's) by 50% by March 2021. Gram-negative bloodstream infections are believed to have contributed to approximately 5,500 NHS patient deaths in 2015 and have continued to increase (*E.coli* in particular), despite a reduction in other HCAI's. GNBSI's include;

- *E.coli*
- *Klebsiella spp.*
- *Pseudomonas aeruginosa*

E.coli

E.coli is a bacterium that forms part of the natural gut flora and is in most instances harmless. The majority of E.coli infections are either urinary or hepatobiliary in origin. Five healthcare associated E.coli blood stream infections were identified in 2020-21, a reduction of 3 on the previous year.

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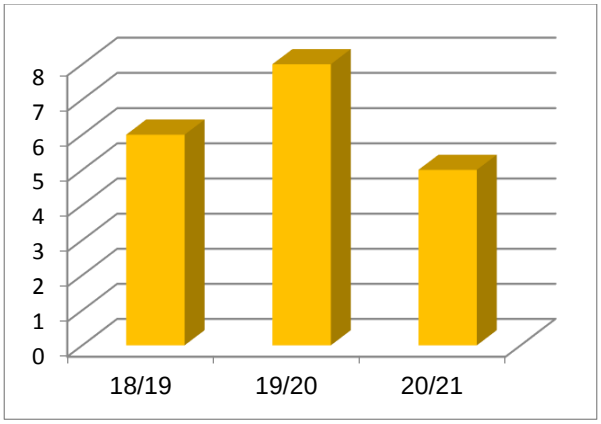
Figure 5 - Trust apportioned E.coli cases by financial year



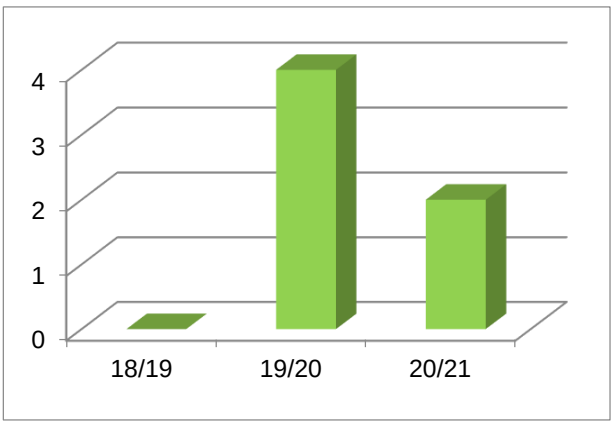
All five cases were subject to the PIR process demonstrating that cases were unavoidable and linked to the clinical condition of the patient with no new learning points identified.

CCC continues to be part of the E.coli Cancer Care Collaborative, alongside The Christie NHS Foundation Trust, The Royal Marsden NHS Foundation Trust, Barts Health NHS Trust and Imperial College Healthcare NHS Trust, to gain a better understanding of the aetiology of E.coli infection in cancer patients and risk factors specific to this patient group.

***Klebsiella* blood stream infections**

Klebsiella bacteria are commonly associated with a range of healthcare associated infections including pneumonia, wound and blood stream infections.

Figure 6 -Trust apportioned *Klebsiella* cases by financial year



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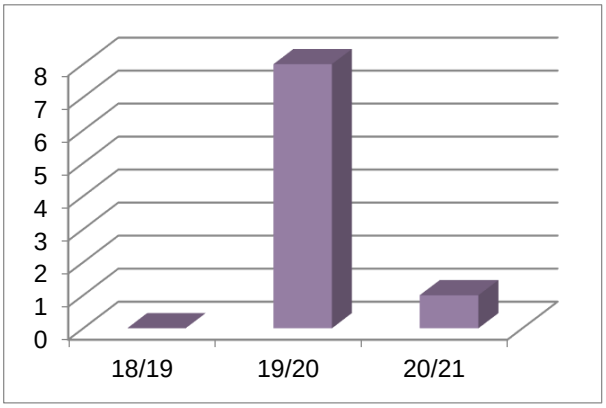
A total of two healthcare associated *Klebsiella* infections were identified during 2020-21 compared to four in 2019-20. The PIR process identified that care and documentation of indwelling devices may have contributed to the development of infection in both instances. This learning has been addressed with the implementation of the ANTT process as described in section 3.1.

Pseudomonas aeruginosa

Pseudomonas is a bacterium commonly found in the environment including in soil and water and can cause infections in immunocompromised patients.

Figure 7 - Trust apportioned *Pseudomonas aeruginosa* cases by financial year



One healthcare associated *Pseudomonas aeruginosa* blood stream infection reported during 2020-21, compared to eight in 2019-20. This infection was deemed unavoidable following post infection review (PIR). The IPC strategy for the prevention of *Pseudomonas* infections focuses upon water safety as this would be the most likely source in healthcare settings, with an emphasis on the flushing of all outlets, cleaning of hand wash basins and sampling of outlets to identify any microbiological growth.

CCC Water Safety Group meets quarterly to ensure the robust management of any water safety issues across the Trust. Sampling takes place monthly, undertaken by an external company who notify FM provider of results. Any positive results are then reviewed by the IPC Team to agree actions required to ensure patient safety.

All positive results are retested following remedial action. This cycle is repeated until a negative result is confirmed.

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3.4 Respiratory viruses

Influenza

There were no confirmed cases of Influenza identified during 2020 - 2021. Patients displaying any respiratory symptoms were swabbed for both SARS-CoV-2 and other respiratory viruses between September 2020 - March 2021.

A reduction in Influenza cases was identified nationally, potentially as a result of measures introduced to reduce the spread of SARS-CoV-2.

A staff influenza vaccination programme commenced in October 2020 led by the IPC Team and supported by Occupational Health Service providers to offer the vaccine to 100% of the CCC workforce. This national target was achieved.

An uptake figure of 90.5% of frontline staff at CCC had received a flu vaccine before 31.12.20. This incorporated 91.7% of medical staff, 90.3% of nursing staff, 94.7% of Allied Health Professionals and 87.1% of patient facing support staff.

SARS - CoV-2 (Covid-19)

In March 2020, the World Health Organisation (WHO) declared a global pandemic in response to the increasing number of cases of SARS-CoV-2., (commonly known as Covid-19). Multiple changes were made to national guidance during the year as evidence began to emerge.

In June 2020, NHSEI produced guidance to support the definition of hospital acquired SARS-CoV-2 infections;

Hospital-Onset Indeterminate Healthcare associated (HO-iHA)	First positive specimen **3-7 days** after admission
Hospital-Onset Probable Healthcare Associated (HO-pHA)	First positive specimen **8-14 days** after admission
Hospital-Onset Definite Healthcare Associated (HO-dHA)	First Positive specimen **15 days or more** after admission
Community Onset Community Acquired (COCA)	First positive specimen identified within **3 days** of admission

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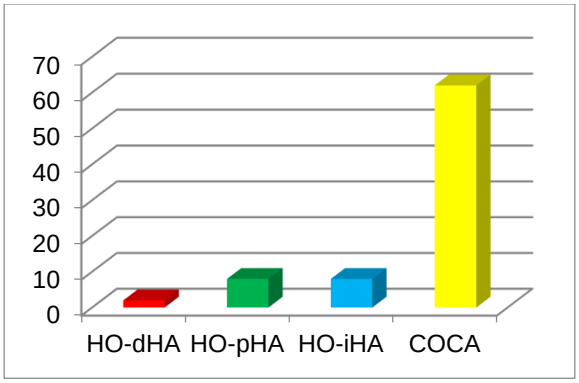
Figure 8 – SARS-CoV-2 cases by definition



All probable and definite hospital onset cases are subject to a post infection review to determine the likely source of infection. The following themes were identified;

- Delays to the collection of admission swabs, indicating that SARS-CoV-2 was likely present on admission but not detected
- Patients leaving the wards to meet with friends/family
- Patients receiving treatment or interventions in other healthcare facilities

Since the beginning of the pandemic no outbreaks of SARS-CoV-2 were identified amongst either patients or staff at CCC. The Infection Prevention and Control Team undertook a comprehensive programme of audit and education to address delays in the collection of swabs. Following delivery of this effective process, only one definite and no probable healthcare associated cases were identified.

All patient deaths meeting the criteria below were reviewed to ascertain whether the deaths were due to nosocomial infection.

- death within 28 days of the first SARS-CoV-2 positive swab date, or
- death of someone with a laboratory confirmed positive SARS-CoV-2 test who either died within 60 days of the first swab or, if SARS-CoV-2 is mentioned on the death certificate, died more than 60 days after the first swab.

Six Solid Tumour (ST) patient deaths were reviewed by the Trust IPC Team; No definite nosocomial infections were identified. The 6 in-patient deaths were externally reported by CCC.

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A further six Haemato-oncology (HO) patient deaths were also reviewed by the IPC Team; one definite nosocomial infection was identified. The 6 in-patient deaths were externally reported by Liverpool University Hospitals NHS FT (LUHFT), as the patients were or had been admitted to wards at LUHFT.

All in-patients are swabbed for SARS-CoV-2 on day of admission, then additionally at days 3 and 5 of admission, or routinely if symptoms develop. Elective admissions are swabbed 72 hours prior to admission so that the result is known prior to admission/treatment. All out-patients are screened for SARS-CoV-2 symptoms when attending for appointments.

Asymptomatic SARS-CoV-2 testing is available to all staff via several different mechanisms;

- PCR testing is available to all Haemato-oncology staff on a weekly basis
- PCR testing is also available to staff enrolled in the SIREN study on a fortnightly basis
- Weekly LAMP testing is available to all staff

A CCC drive-through testing facility was made available to all staff and household contacts from May 2020.

Public Health England guidance aimed at reducing transmission of Sars-CoV-2 is followed across all CCC sites including;

- Wearing of fluid resistant face masks; masks are available at the entrances to all CCC buildings
- Encouraging hand hygiene; alcohol based hand rub is available at the entrances to all sites and throughout all wards and departments
- Maintaining social distancing; waiting rooms and lift capacities have been reduced, offices and staff spaces are clearly marked with maximum occupancy figures

CCC has undertaken a Covid-19 compliance self-assessment using the NHS England Board Assurance Framework (BAF) tool. The IPC BAF is reviewed and updated by the IPC Team to reflect all new national, regional and local guidance received, in conjunction with clinical teams and subject matter experts, to provide assurance to the Trust Board that high quality IPC standards are achieved.

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4.0 The Infection Prevention and Control Team (IPC Team)

The IPC Team is led by the Director of Nursing & Quality in the role of Director of Infection Prevention and Control (DIPC) and Deputy Director of Nursing supported by:

- Infection Prevention and Control Matron
- One Clinical Nurse Specialist for Infection Prevention and Control
- One Infection Prevention and Control Practitioner
- Consultant Microbiologist / Infection Control Doctor
- Antimicrobial Pharmacist

The Infection Prevention and Control Nursing team provided a support service during weekdays from 8.00 am – 4.00 pm. An on call service for urgent infection prevention and control advice is provided by medical microbiologists and virologists out of hours, via the hospital switchboard.

A Consultant Microbiologist / Infection Control Doctor is provided by Liverpool Clinical Laboratories (LCL) to Clatterbridge through a service level agreement (SLA). LCL also provide a Consultant Virologist service that is available to the Trust as required.

5.0 Governance and Monitoring

The Board of Directors has collective responsibility for minimising the risks of infection. The DIPC and Deputy Director of Nursing (Deputy DIPC) deliver the annual plan to the Board of Directors based on local and national quality goals.

5.1 Infection Prevention and Control Committee (IPCC)

Quarterly IPCC meetings take place and provide a forum to support the delivery of a zero tolerance approach to Health Care Associated Infections (HCAIs). The committee is chaired by the DIPC or Deputy DIPC.

IPCC receives reports from Water Safety Group, Antimicrobial Stewardship Group and Hotel Services. Clinical Divisions report to IPCC via a quarterly IPC Operational Group.

IPCC reports directly to Integrated Governance (IGC) Committee detailing Internal Performance Reports and PIR findings as necessary, and provides exception reports to Quality Committee as requested.

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5.2 Audit and surveillance

The IPC Team undertakes continuous surveillance of both reportable organisms and any other pathogenic organisms that may present a particular risk to our patient group. Since relocation to Liverpool in June 2020, the Trust has used the ICNet surveillance system in conjunction with Liverpool Clinical Laboratory Service (LCL). This allows the IPC Team to identify and examine trends and advise clinical teams on appropriate transmission based precautions at pace.

The IPC Team provides a monthly report on any HCAI's and learning points identified to the Harm Free Care Collaborative meeting. This meeting reports into the Integrated Governance Committee, to ensure clear escalation and assurance processes are achieved.

6.0 External Reporting

6.1 Mandatory Surveillance

In addition to the data submitted to support national HCAI objectives, the trust also submits data to PHE on a monthly basis on the blood stream infections detailed below;

- MSSA
- VRE
- *E.coli*
- *Klebsiella*
- *Pseudomonas aeruginosa*

The data is submitted to PHE via an online HCAI Data Capture System (DCS) and is signed off each month by the Deputy DIPC and Infection Prevention and Control Matron, providing openness and transparency regarding CCC infection rates and assurance to patients and public.

7.0 Education

The IPC Team has delivered numerous teaching programmes across the Trust including mandatory training and induction for all staff. During the SARS-CoV-2 pandemic, these teaching sessions have been delivered on-line. Overall compliance with Level 1 IPC training (all staff was 96.7%, and compliance with Level 2 training (clinical staff only) was 96.2%. Additional training provided included;

- SARS-CoV-2 mandatory training. This training was delivered to all grades of staff and includes donning and doffing of PPE. Overall compliance was 97.81% for clinical staff and 94.3% for non-clinical staff.

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- Admission screening for MRSA to reflect changes in policy associated with relocation to Liverpool. The IPC Team have continued to support and prompt clinical teams to adhere to the swabbing schedule. An annual audit of policy compliance is due in July 2021.
- SARS-CoV-2 swabbing schedule. The IPC Team have continued to support and prompt clinical teams to adhere to the swabbing schedule. An electronic prompt is in development to support with compliance and auditing.
- Fundamentals of IPC for Domestic and Portering Staff. This was a stand-alone teaching session ahead for new Domestic and Portering staff ahead of relocation to Liverpool and is now delivered by the Hotel Services provider.
- Aseptic non touch technique (ANTT) updates in conjunction with the Clinical Interventions Team (CIT). This was launched in February 2021 with the identification and training of 9 peer reviewers. Additional peer reviewer training sessions are scheduled to increase the number of ANTT peer reviewers available across the organisation and improve compliance.

8.0 Policies and Guidelines

Ahead of relocation to Liverpool, all IPC polices were reviewed and updated where required to reflect the SLA with LCL. All IPC policies align to the Health and Social Care Act (2008, updated 2015). A number of Standards Operating Procedures (SOP's) have been developed to support clinical practice in relation to IPC during 2020/2021 as a result of the pandemic eg Inpatient Visiting SOP, IPC Red Zone SOP and Covid-19 Screening pathways SOP.

9.0 Audit programme

There is a robust audit plan in place across all CCC sites. Audits of practice and the environment are undertaken by the IPC Team. Additional audits are undertaken by clinical staff within their work areas. This audit programme was reduced in 2020-2021 in response to the SARS-CoV-2 pandemic, however all clinical areas undertook a weekly Covid-19 compliance audit. The aim of this audit was to identify any issues within the clinical areas that may contribute to SARS-CoV-2 transmission. Audit findings indicated that staff were compliant with measures to reduce transmission. This is reflected in the number of nosocomial cases identified.

The IPC practice and environmental audit plan was reduced as business continuity plans were initiated in response to the SARS-CoV-2 pandemic, however the audit programme was reinstated in November 2020.

The Trust launched the Perfect ward audit platform in March 2021. This will host all IPC audits, including High Impact Interventions and allow for comprehensive monitoring of compliance with IPC practices.

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9.1 Anti-microbial stewardship audits

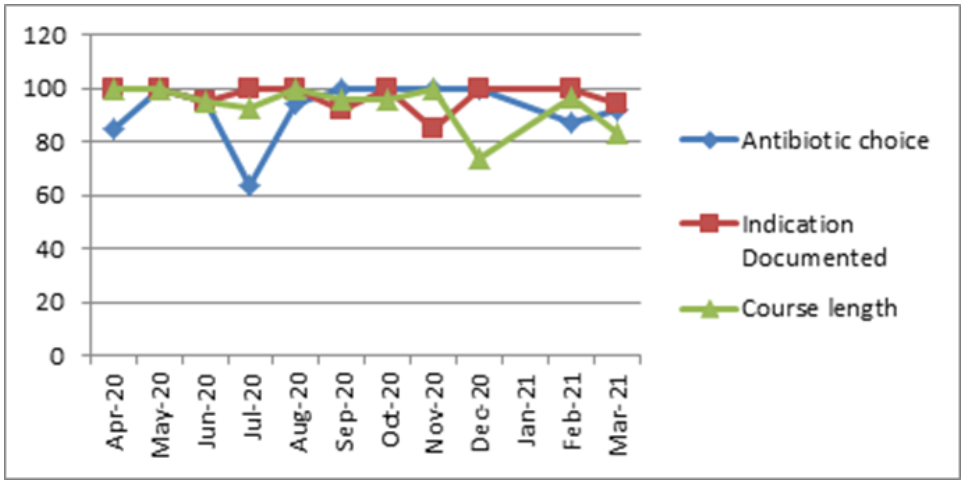
The Trust completes monthly antibiotic point prevalence surveys compiled by the Antimicrobial Pharmacist and based on the self-assessment toolkit from PHE's publication. Specifically, pharmacists assess the prescriptions for the following:

- Choice of antimicrobial in line with the Trust's antibiotic formulary
- Evidence of documentation of the indication of treatment
- Evidence of documentation of the intended treatment duration or review

Results are escalated to the IPC Committee via the Antibiotic Stewardship group on a quarterly basis and also via the Drugs and Therapeutics Committee (DTC).

The audits identified within the Haemato-oncology (HO) patient group, compliance with antibiotic choice, indication and stop/review date documented remained at 100%.

Within the Solid Tumour Group, compliance with antibiotic choice remained consistently above 80%, with the exception of July 2020, where compliance was reported as 64%. This was likely due to relocation to Liverpool and change of Trust formulary in June 2020.



Overall compliance with documentation regarding indication was good, with the exception of November 2020 when 2 patients had the incorrect indication on the prescription. The purpose of the indication is to enable us to stop antibiotics when clinically appropriate.

Compliance with course length was also good with the exception of December 2020 and March 2021. On-going microbiology input was documented on Meditech,

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indicating that antibiotic treatments were discussed, however no official documented review date was captured on Meditech.

A strengthened induction process for newly appointed medical staff regarding Trust formulary, importance of accurate documentation and the use of the antibiotic surveillance section in ward round documentation, has been delivered to support improved compliance going forward.

10.0 Water Safety

The Water Safety Group met on a quarterly basis to ensure that the trust was fully compliant with HTM 04-01.This included the Liverpool site as part of the commissioning process ahead of relocation. The programme of planned maintenance (PPM) tested and maintained activities relating to safety for water systems included;

- Twice weekly flushing of infrequently used all outlets across all hospital sites undertaken by staff within the areas or by Estates teams in unoccupied areas
- Monthly microbiological testing of outlets for Legionella and Pseudomonas
- Monthly sentinel temperature checks
- Annual thermostatic mixing valve inspection and maintenance
- Implementation of the Hydrop system, an electronic monitoring system that records flushing activity and identifies any themes or issues.

Where any positive microbiology results were identified, outlets were immediately taken out of use and remedial maintenance works undertaken to rectify the issue. Outlets are only returned to use following identification of a negative microbiological sample.

Following the relocation to CCCL, additional education was put in place to support staff in identifying the risks associated with healthcare water systems as there is no mechanism for auto-flushing at this location and an increased number of hand wash basins. This education included ensuring that all outlets were flushed twice weekly and the correct process for cleaning hand wash basins was implemented.

There have been no cases of patients developing infections related to CCC water systems.

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The Clatterbridge Cancer Centre NHS Foundation Trust

11.0 Conclusion

The NHS has faced one of the most challenging years in history during the global SARS-CoV-2 pandemic, experiencing a significant impact across all patient services. The safety of staff and patients during this time has remained a priority at CCC. The IPC Team has ensured that strong, effective processes have remained in place throughout this challenging time, to balance the measures required to prevent SARS-CoV-2 transmission and the need to maintain standard precautions, to prevent other HCAI's.

During this unprecedented time Clatterbridge Cancer Centre also relocated all in-patient services and the majority of out-patient services from the Wirral site, to a new 110 bedded hospital facility in Liverpool. The new hospital footprint, together with unfamiliar surroundings including single en-suite rooms provided within the inpatient facility, has provided an additional challenge for staff, as they adapted to new ways of working.

Despite these challenges, a zero tolerance approach has been maintained across the Trust towards all avoidable HCAI and strong, cohesive infection prevention and control practice is embedded throughout the organisation. The work and diligence of all grades of staff, clinical and non-clinical played a vital role in ensuring that people who used Trust services received safe and effective care, improving the quality of the patient experience and assisting to reduce the risk of infection.

CCC has performed well against the national HCAI objectives for 2020/2021 achieving zero MRSA Blood Stream infections (reduction from the previous year) and reducing the number of CDI's from 11 (previous year) to 5. Oncology patients are classed as clinically extremely vulnerable and this patient cohort are immuno-compromised and experience high exposure to antimicrobial use, which leaves them highly susceptible to developing these infections.

The majority of infections that developed in our patient cohort were deemed unavoidable with no lapses in care identified.

A strengthened, targeted and enhanced ANTT education programme is delivered to staff, to support reduction of MSSA and Klebsiella infection in CCC patients for 2021/2022.

The Trust has had no outbreaks identified in staff or patients during 2020/2021

Robust, safe and effective IPC practice is delivered to all patients, families and staff across all Clatterbridge Cancer Centre sites.

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The Clatterbridge Cancer Centre NHS Foundation Trust

12.0 Forward Plan 2021-22

Infection Prevention and Control will continue to remain a high priority for CCC. The IPC Team have set out a programme of work over 2021-22 aimed at patient and staff safety. A 10 point HCAI reduction plan has been developed to support this programme as outlined below;

10 Point HCAI Reduction Plan

1.	Ensure strategy is visible and communicated to achieve CDI objective 2021-22 (Establish new threshold limits following discussion with NHSEI) Q1 2021/22
2.	Ensure zero tolerance for MRSA bacteraemia
3.	Continued reduction in all gram negative bacteraemia
4.	Ensure compliance with NICE Quality Standard 113 HCAI
5.	Ensure continued strategies to minimise transmission of airborne pathogens
6.	Ensure compliance with staff Influenza and Covid-19 vaccination delivery programme
7.	Support with the delivery of a robust anti-microbial stewardship programme
8.	Ensure compliance with Water Safety
9.	Support with the delivery of a robust cleaning programme
10.	Development of a robust multi-modal education and training programme

Cheshire & Merseyside Cancer Alliance

Performance Report

July 2021

Version 1

Contents

Section I: Summary

Restoration of cancer services

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

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

Measure	% of pre-Covid level
2WW referrals	121%
Cancer surgery activity	111%
SACT (inc chemo) delivery	132%

Measure	% of pre-Covid level
Radiotherapy planning	112%
Radiotherapy treatment	99%
Endoscopy capacity*	81%

- The significant increase in SACT and radiotherapy planning activity continues to present challenges to service delivery, however CCC is taking a number of steps to ensure that demand continues to be met. Whilst lower levels of radiotherapy treatment could previously be explained by the adoption of new treatment regimes such as hypofractionation, the radiotherapy treatment levels have now returned to pre covid levels.
- Endoscopy capacity has more than doubled since August 2020, but further capacity is required in order to clear the backlog of patients on the endoscopy waiting list. The Alliance has established an endoscopy operational recovery team (EORT) to oversee and co-ordinate restoration activities.

Cheshire & Merseyside Cancer Alliance

*Assessment based on monthly DM01 endoscopy returns.

Summary

Cancer waiting times performance

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

- The Alliance failed to meet the **14 day standard** for urgent suspected cancer referrals in May, with four trusts and six CCGs falling below the 93% threshold. The overall performance of the Alliance was 91.2%, improving from 89.1% last month. The England average was 87.5%. CMCA was the 5th best performing Alliance in England out of 19 against this standard.

- The Alliance failed to meet the **62 day standard**, achieving 76.8% (down from 78.4% last month) against a standard of 85% (England average was 73.0%). Nine trusts and seven CCGs failed to meet the 62 day standard. Cheshire and Merseyside is the 7th best performing Alliance in England out of 19 against this standard.

- The number of urgent referral patients waiting **over 62 days** is significantly higher than pre-Covid levels. On 4th July 2021 there were 974 patients waiting more than 62 days for a diagnosis or treatment. This has increased from 948 reported last month (30th May). Of these, 231 have waited **over 104 days**. This has increased from 185 reported last month.

Cheshire & Merseyside Cancer Alliance

Section II: Restoration of Cancer Services – Core Metrics

1. TWW referrals received in last 7 days

Referrals were similar to last week at 2,426, still 20% above pre-pandemic weekly average.

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. Walton Centre data for w/e 21/06/2021 same as previous week.

2. Diagnostic backlog (referrals without a DTT)

Currently 9,966 active patients, of which less than 5 are suspended.

3. Cancer patients awaiting surgery

600 patients with a surgical DTT. 556 at L1&L2 and 44 at L3.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. No collection 28/12/2090. Very limited LUTH data for 03/05/2021. Walton Centre data for w/e 21/06/2021 same as previous week.

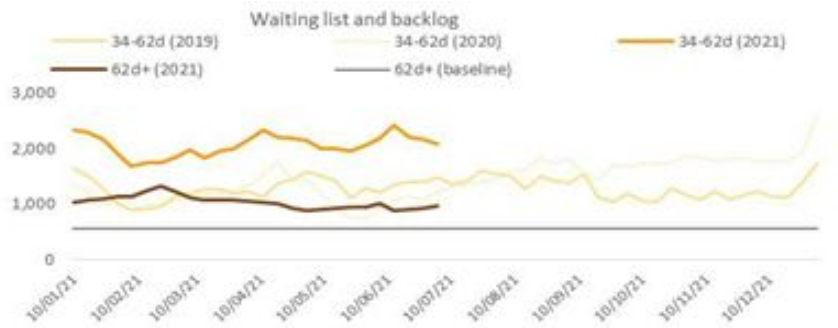
4. Cancer surgery performed in last 7 days

278 cancer operations, of which less than 5 were via the surgical hub.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. No collection 28/12/2090. Very limited LUTH data for 03/05/2021. Walton Centre data for w/e 21/06/2021 same as previous week.

Restoration of Cancer Services – Core Metrics

5. Patients waiting over 62 days

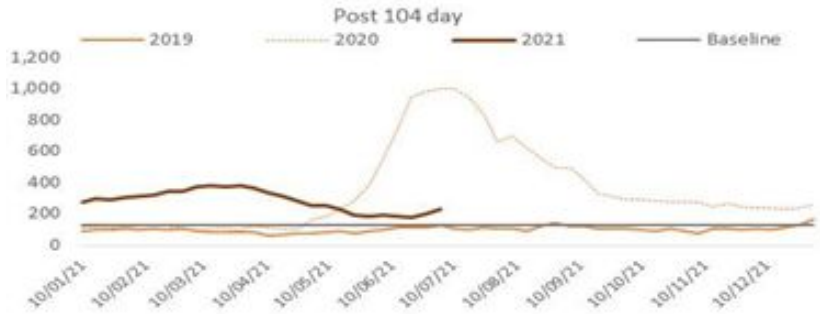


974 patients have waited over 62 days

- Up from 944 in previous week

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

6. Patients waiting over 104 days



231 patients have waited over 104 days

- Up from 197 in previous week

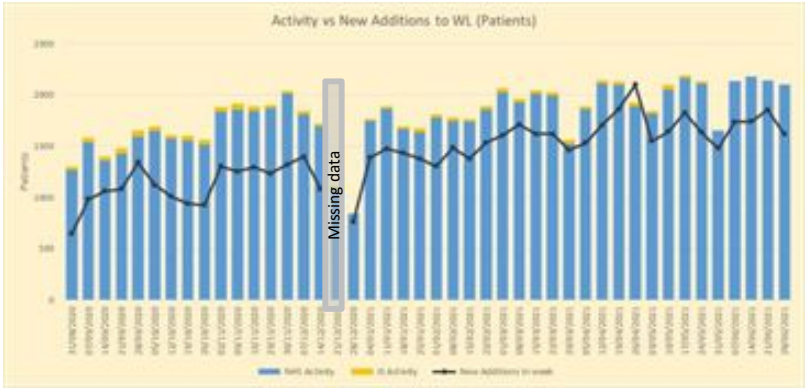
Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. For w/e 04/04/2021, Wirral data not submitted.

7. Endoscopy waiting list

Endoscopy waiting list increased to 9,353.

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. No data from East Cheshire or Mid Cheshire 14/12/20; No collection 21/12/2090. Aintree data estimated for 03/05/2021and 21/06/2021. Aintree and Royal data estimated for 24/05/21. Warrington and Halton estimated for 31/05/21

8. Endoscopy activity



Activity steady, with 2,101 patients seen. New additions fell to 1,617.

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. No data from East Cheshire or Mid Cheshire 14/12/20; No collection 21/12/2090. Aintree data estimated for 03/05/2021 and 21/06/2021. Aintree and Royal data estimated for 24/05/21. Warrington and Halton estimated for 31/05/21

9. Patients waiting between 63 and 103 days by provider

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total
Bridgewater															
Clatterbridge					8	8						13			42
Countess Of Chester			12			32						7			66
East Cheshire						10									16
Liverpool Foundation Trust		7			18	214					5	71	23		342
Liverpool Heart & Chest															
Liverpool Women's			24												24
Mid Cheshire						12						10			35
Southport & Ormskirk			19			13	5					8	7		58
St Helens & Knowsley			6	5	11	30					5	7	12		78
Walton Centre															
Warrington & Halton			8			15							10		39
Wirral						16							14		38
Grand Total		**15**	**78**	**15**	**44**	**350**	**12**	**5**			**24**	**119**	**78**		**743**

Cheshire & Merseyside Cancer Alliance

Tables from national Cancer PTL
Up to 04 July 2021

10. Patients waiting over 104 days by provider

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total
Bridgewater															
Clatterbridge															10
Countess Of Chester						12					5				23
East Cheshire						5									6
Liverpool Foundation Trust					10	61						17	13		102
Liverpool Heart & Chest															
Liverpool Women's			13												13
Mid Cheshire						5									8
Southport & Ormskirk													6		15
St Helens & Knowsley						6							6		24
Walton Centre															
Warrington & Halton													7		13
Wirral						5							5		12
Grand Total			**22**	**5**	**16**	**101**					**12**	**24**	**43**		**231**

From 29 November 2020, data source changed from CMCA SITREP to national weekly PTL
- Data no longer split out for acute leukaemia or testicular
- New data for non site specific symptoms referrals

= fewer than 5 patients or hidden to prevent disclosure

= No PTL submission this week

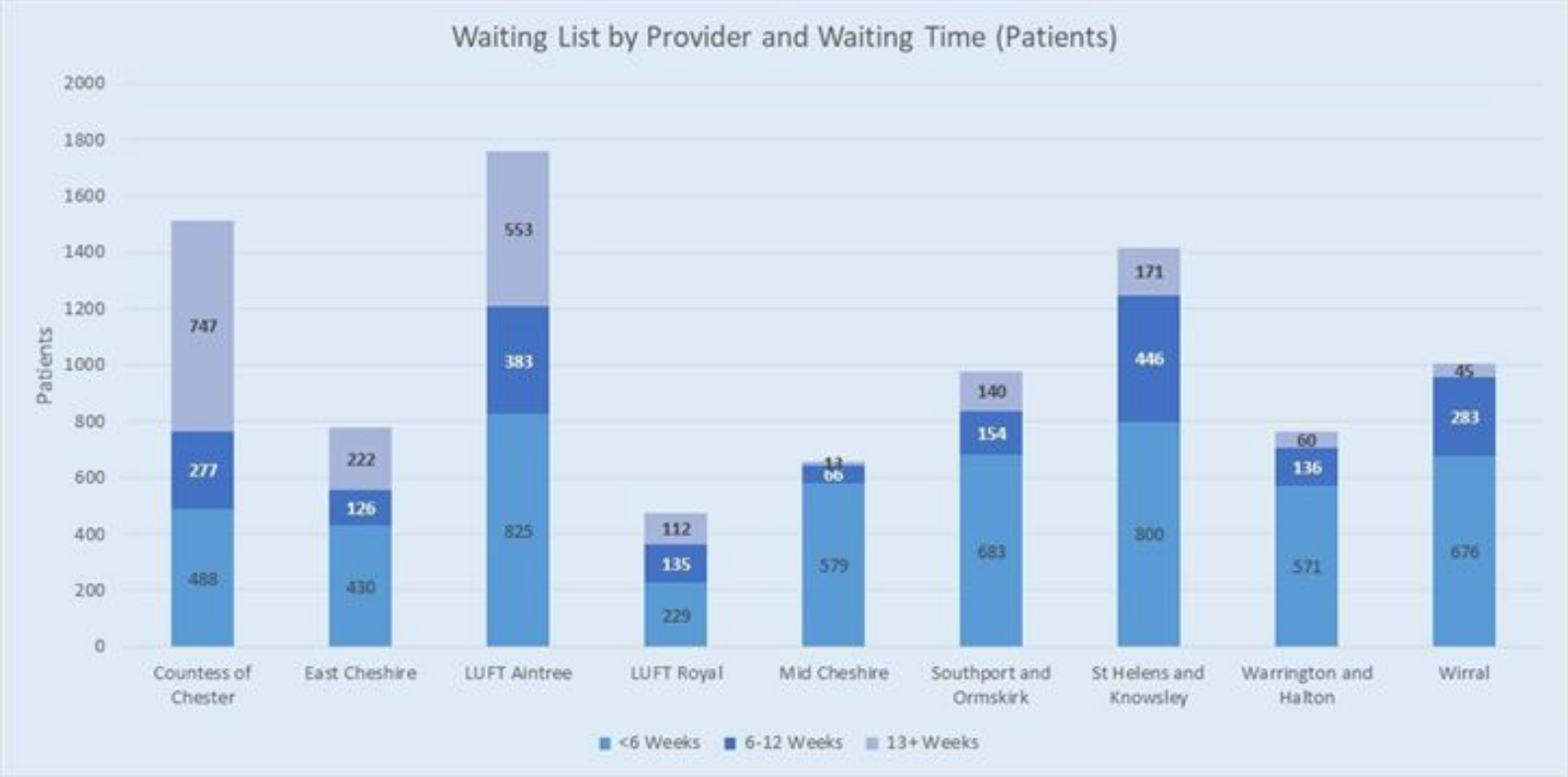
Restoration of Cancer Services – Core Metrics

There are currently 9,350 patients waiting for an endoscopy. 4,069 have waited more than six weeks, and of these 2,063 have waited 13 or more weeks (22% of the total).

There is significant variation across units, with CoCH, LUFT and East Cheshire having the greatest proportion of their waiting list made up of patients waiting 13 weeks or more (49%, 29% and 31% respectively).

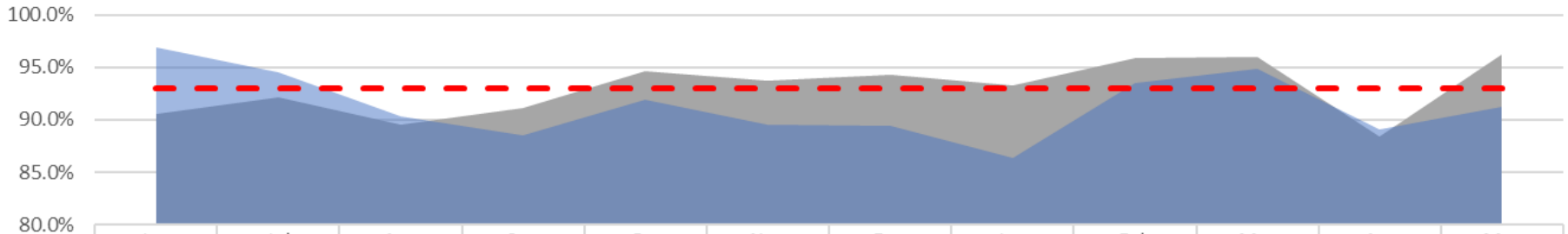
Endoscopy (cancer and non-cancer pathways)

(LUFT Aintree and LUFT Royal estimated)



Section II: 14 day standard

Percentage of patients seen within two weeks of referral in Cheshire and Merseyside



	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Jun 19 - May 20	90.6%	92.2%	89.5%	91.1%	94.7%	93.8%	94.3%	93.3%	95.9%	95.9%	88.4%	96.2%
Jun 20 - May 21	96.8%	94.5%	90.3%	88.5%	91.9%	89.5%	89.4%	86.3%	93.5%	94.9%	89.1%	91.2%
Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

Jun 19 - May 20 Jun 20 - May 21 Target

In May 2021, 91.2% of patients were seen within 2 weeks compared to 89.1% in the previous month. This is below the national target.

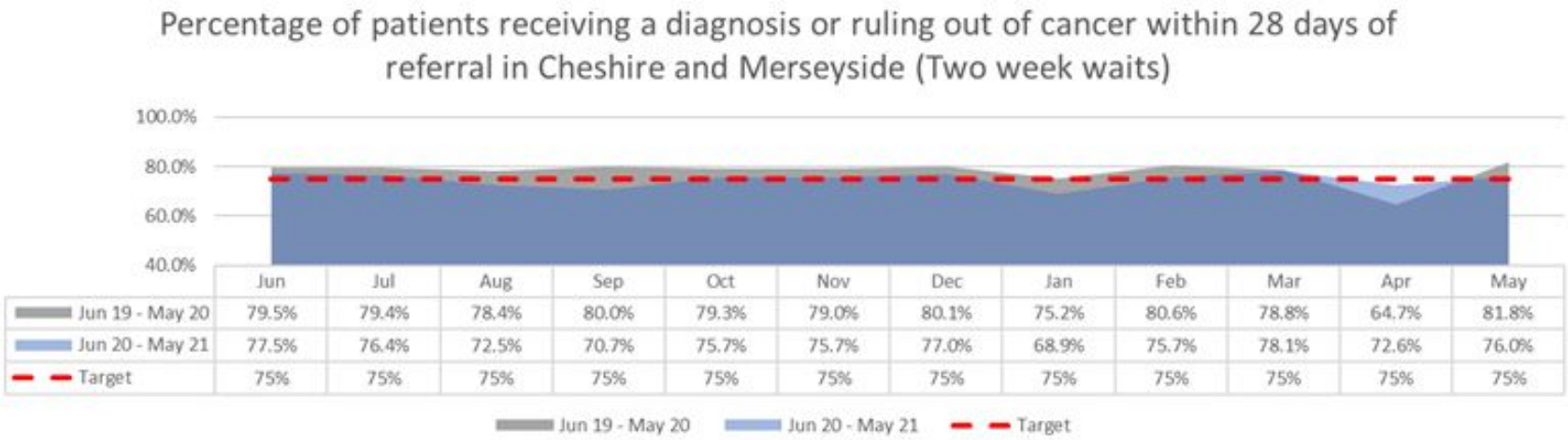
Providers not achieving the national operational standard were:

- East Cheshire 62.6% (214 breaches)
- Countess Of Chester Hospital 79.7% (207 breaches)
- Southport and Ormskirk Hospital 85.7% (134 breaches)
- St Helens and Knowsley Hospitals 90% (176 breaches)

CCGs not achieving the national operational standard were:

- Cheshire CCG (87.35%)
- Halton CCG (92.31%)
- Knowsley CCG (91.00%)
- South Sefton CCG (91.89%
- Southport and Formby CCG (85.45%)
- St Helen's CCG (89.80%)

Section II: 28 day standard



	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Jun 19 - May 20	79.5%	79.4%	78.4%	80.0%	79.3%	79.0%	80.1%	75.2%	80.6%	78.8%	64.7%	81.8%
Jun 20 - May 21	77.5%	76.4%	72.5%	70.7%	75.7%	75.7%	77.0%	68.9%	75.7%	78.1%	72.6%	76.0%
Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

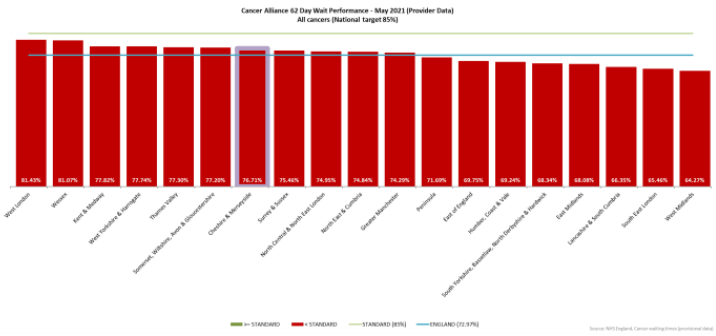
The 28 day FDS standard is still being shadow monitored. The standard is expected to be 75%.
In May 2021, 76.0% of 2ww patients were diagnosed with cancer or had cancer ruled out within 28 days compared to 72.6% in the previous month. This is above the expected standard.

Providers not achieving the expected standard were:
Liverpool Women's 58.1% (117 breaches),
Countess Of Chester Hospital 69.2% (296 breaches),
Southport And Ormskirk Hospital 74.8% (200 breaches)
East Cheshire 66.4% (158 breaches),
Liverpool University Hospitals 74.7% (581 breaches),

CCGs not achieving the expected standard were:
Cheshire CCG (74.34%), Knowsley CCG (73.29%), South Sefton CCG (68.00%), St Helen's CCG (74.25%)

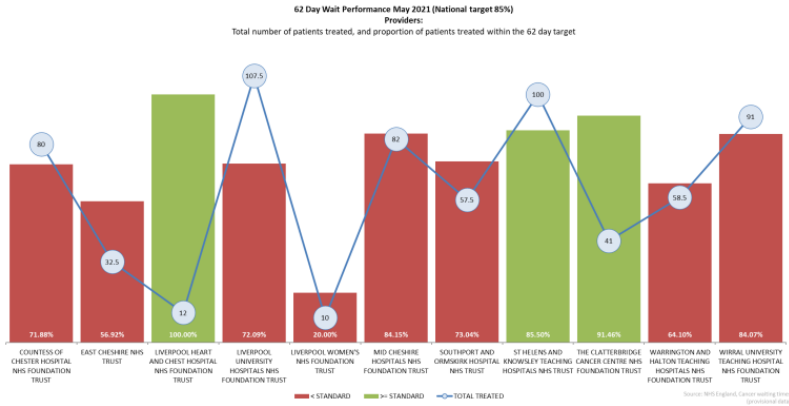
Section III: 62 Day Standard

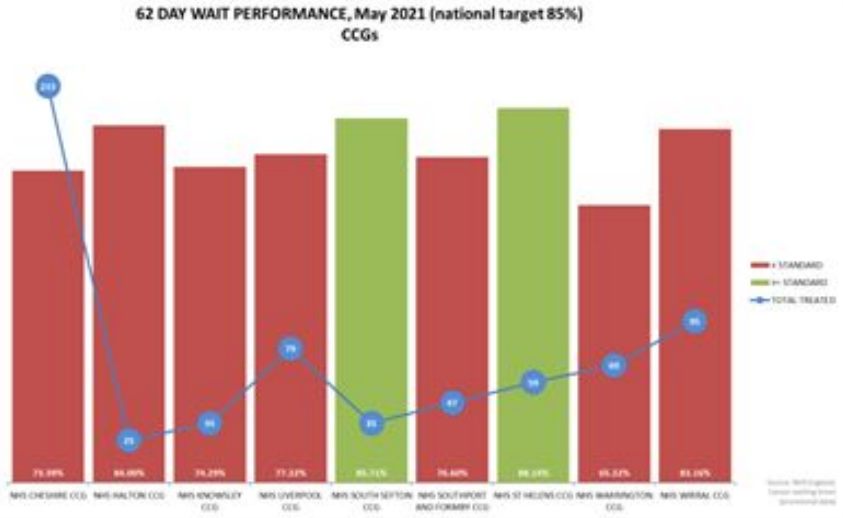
62 Day Performance by Cancer Alliance (May 2021)



CMCA achieved 76.71% against a standard of 85%.
CMCA was the seventh best performer. The England average was 72.97%

62 Day Performance by Provider (April 2021)





Most Challenged Pathways (April 2021)

Cancer pathways not achieving the national target were:

- Gynaecological 31.5% (25 breaches),
- Other 40% (3 breaches),
- Haematological (Excluding Acute Leukaemia) 51.4% (8.5 breaches),
- Lower Gastrointestinal 55.7% (35 breaches),
- Sarcoma 60% (2 breaches),
- Head & Neck 64.7% (9 breaches),
- Upper Gastrointestinal 72.2% (10 breaches),
- Urological (Excluding Testicular) 72.8% (34 breaches),
- Lung 73.6% (14 breaches)

Report prepared by Jenny Hampson
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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.

Cheshire & Merseyside Cancer Alliance

Cancer Inequalities in Cheshire and Merseyside: Covid-19 impact analysis

July 2021

Version 1.1

Contents

Section I: Introduction

The Covid-19 pandemic has presented the NHS with perhaps its most challenging period in its 73 year history. Clinical and non-clinical healthcare professionals have gone to extraordinary lengths to maintain cancer services in Cheshire and Merseyside throughout the crisis.

This document explores available data to understand the impact of the pandemic on cancer services and specifically to see whether the impact has been felt disproportionally by different patient groups. It looks at the impact on suspected cancer referrals and treatments for new cancers, analysed by geography, tumour group, age, gender, deprivation and ethnicity. It does not yet include an analysis of the impact on the stage of disease at the point of diagnosis as cancer registration data for 2020/21 is not yet available[1].

The findings will inform the focus of ongoing work to fully recover cancer services in an equitable way.

[1] The latest published cancer staging data is for April – June 2019. Provisional ('rapid') registration data for 2020 is available but has not been used for analysis due to a very high proportion of records with unknown stage which makes analysis problematic, especially when split by characteristics such as deprivation, ethnicity, gender and age.

Section II: Impact on cancer referrals

At the start of the pandemic the number of people seeking advice from their GP regarding symptoms that could be cancer, and hence the number of urgent suspected cancer referrals to hospitals, fell dramatically. Referrals were lower than expected between April and September 2020 but have since recovered and are now approximately 20% greater in number each week than before the pandemic. This is positive because it means that the public's confidence to seek medical advice from their GP about potential signs of cancer has, in general, been restored. However, there are some differences at tumour level. Referrals for suspected urological cancers (primarily suspected prostate cancer), suspected lung cancers and suspected haematological (blood) cancers remain lower than expected.

Although referral rates have, in most cases, returned to at least pre-pandemic levels, the impact of the dramatic fall in referrals at the beginning of the crisis means that the total number of referrals received in the year from April 2020 to March 2021 was 8% lower than the previous 12 month period (i.e. the year before the pandemic). The biggest shortfalls are in the tumour groups that still have not returned to normal referral levels, i.e. urological, lung and haematology and, to a lesser degree, skin (although skin referrals are now 28% higher than pre-Covid-19). Whilst 8% is the average shortfall in referrals in 2020/21 compared to 2019/20 across Cheshire and Merseyside, there is variation by CCG. NHS Halton CCG has seen the greatest shortfall with 17% fewer referrals across the year.

During 2020/21, the reduction in referrals was significantly greater amongst people living in the most deprived areas, with a 9% reduction in the Quintile 5 (most deprived) compared to a 5% reduction in Quintile 1 (least deprived). However, by April 2021 referrals from all five deprivation quintiles had returned to pre-pandemic levels.

The proportional impact on referrals during 2020/21 increased with age. Referrals for patients aged 0-49 reduced by 1%, compared to a 13% drop for those aged over 80. Referrals for men fell by 11% compared to 5% for women.

The impact of Covid-19 on referrals from different ethnic backgrounds is more difficult to assess due to small numbers in some ethnic communities. Suspected cancer referrals for people from ethnic diversity groups fell by 6% during 2020/21 compared to 2019/20, and by 8% for White British. Referrals for people of all ethnic backgrounds have now returned to at least pre-pandemic levels.

Section III: Impact on cancer treatments

In total, 14% fewer patients were treated for a new cancer in 2020/21 compared to 2019/20 in Cheshire and Merseyside. Beneath this headline figure there are differences between CCGs, tumour groups and routes to diagnosis, but no statistically significant variation by gender, deprivation, age or ethnicity.

In all cases, first treatment rates have now returned to pre-Covid-19 levels.

In Cheshire and Merseyside, 13,384 new patients were treated for cancer between April 2020 and March 2021. This was 14% fewer than were treated in the previous year. The reduction varies by CCG with NHS Liverpool CCG and NHS St Helens CCG experiencing the biggest reductions (19% and 22% respectively).

Treatments for prostate cancer reduced by the greatest proportion, dropping 30% in 2020/21 compared to 2019/20. Breast (-24%) and other urological cancers (excluding prostate) (-20%) saw the next largest proportional reductions.

Cheshire & Merseyside Cancer Alliance

The route to diagnosis had a big impact upon the number of first treatments delivered in 2020/21. For several months the cancer screening programmes were paused in Cheshire and Merseyside due to the pandemic, as they were across England, other than for high risk patients. Consequently, the number of new cancer patients diagnosed and referred for treatment by the screening programmes reduced by 52% compared with 2019/20. In comparison, the number of patients diagnosed and treated following an urgent suspected cancer referral from a GP fell by 9% (which is in line with the previously mentioned 8% drop in GP referrals).

There was a 14% reduction in the number of first treatments for patients in the most deprived neighbourhoods (Quintile 5) during 2020/21 compared to a 9% reduction in the least deprived (Quintile 1). The smallest reduction (5%) was in the second most deprived neighbourhoods (Quintile 4) The differences are not considered statistically significant primarily because the number of first treatments are relatively small compared to the number of referrals.

Three percentage points separate the reduction in treatments for males and females. This is not considered to be statistically significant.

With regard to the age of patients, the greatest reduction in first treatments during 2020/21 was seen in the 60 to 69 year olds (13%) and the smallest reduction was in the 50 to 59 year olds (6%). The variation is not considered statistically significant.

Approximately 4% fewer patients from ethnic diversity groups received first treatments in 2020/21 compared to 2019/21. Eleven percent fewer White British patients received first treatments in the same period. The difference is not considered statistically significant due to the small numbers in the non-White British group.

Section IV: Next steps

The Cancer Alliance will continue to monitor the ongoing impact of Covid-19 on cancer services and follow the mantra of 'building back fairer'[1] in acknowledgement that inequalities existed before the pandemic and these still need to be addressed.

In partnership with Macmillan, the Cancer Alliance has established a dedicated health inequalities and patient experience team. The initial focus of the team is to provide structure, learning and support to ensure that addressing health inequalities is core to all Alliance-sponsored activities. A key aim is to build a network of diverse community links, to consult with, in all stages of project development and delivery. For example, the health inequalities team is currently working with NHS E/I NW on a social media campaign co-designed with members of local Muslim communities, aimed at increasing participation in the bowel cancer screening programme.

[1] Build Back Fairer: The COVID-19 Marmot Review, Sir Michael Marmot et al, The Health Foundation, Dec 2020

Cheshire & Merseyside Cancer Alliance

Cheshire & Merseyside Cancer Alliance

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

ANNUAL REPORT

2020-21

Cheshire & Merseyside Cancer Alliance

NHS

Contents

Introduction

The last 12 months have been a challenging and difficult time for everyone across the globe, especially those in healthcare.

The pandemic has impacted on all our lives, in many different ways, and NHS organisations have experienced disruption as they focussed on preventing the spread of the virus, keeping patients and staff safe, caring for those affected by COVID-19 and ensuring that the delivery of vaccines happens at pace.

Dedicated cancer professionals across our region have been determined to keep cancer services running as near to normal as possible and are increasing their workload as we enter the recovery phase of the pandemic.

Cancer alliances were established across England and Wales in 2016, creating collaboration between healthcare organisations, public and social care bodies and cancer-related charities to transform the diagnosis, treatment and care of cancer patients in the regions they serve.

These partnerships lead to more effective planning of services and initiatives, with the ultimate aim of improving outcomes for everyone who experiences cancer.

The pandemic brought incredible challenges and threatened to derail some of the huge gains we have made during the first five years of the life of Cheshire & Merseyside Cancer Alliance (CMCA). However, the groundwork put in before March 2020 meant we were able to flex and adapt in order to continue with our aim to improve cancer services across Cheshire and Merseyside.

During the pandemic, CMCA engaged with primary care to restore the level of referrals; promoted early diagnosis 'Help Us Help You' messaging to the public and took steps to embed projects which supported early diagnosis, including FIT testing and our Cheshire and Merseyside Cancer Surgical Hub.

This report will detail the achievements CMCA has made during the 2020/21 financial year right across the cancer 'journey' – from prevention and early detection, to faster diagnosis, improved care and treatment, and personalised follow-up. All these diverse initiatives are designed to end up at one destination – the improvement of cancer outcomes, the reduction in inequalities and variation of cancer outcomes across the whole of our region and create the very best patient experience for those facing cancer within the population we serve.

That is the Cancer Alliance's vision and goal, but we would not have been able to accomplish what we already have done, nor will we be able to achieve this ambition, without close collaboration with our partners, stakeholders, community organisations, charities, and every healthcare and public health professional with whom we work.

By striving together to create the very best deliverable and quantifiable outcomes for the whole of Cheshire and Merseyside in relation to cancer, we can achieve that vision.

Dr Liz Bishop, CMCA Senior Responsible Officer

Jon Hayes, CMCA Managing Director

Dr Chris Warburton, CMCA Medical Director

Tobacco control

Smoking is the biggest preventable cause of cancer in the UK so helping smokers to give up is crucial. The CURE Project is a treatment programme to help smokers with their addiction and support them to quit. Started in Liverpool in 2020/21, it is now fully operational there and launched in Mid Cheshire in November 2020. Smoking in pregnancy is a £500,000 project commissioned to improve smoking cessation rates in pregnant women, which is due to start in 2021/22.

CURE: 3,384 Royal Liverpool Hospital in-patient smokers or vapers offered intervention advice

39% quit within 4 weeks

71% agreed to Nicotine Replacement Therapy (NRT)

CURE: 527 referrals made in Mid Cheshire in six months

390 agreeing to NRT

151 quit within 4 weeks

The CURE team at Crewe's Leighton Hospital helped a married couple quit after more than 100 years of smoking between them. The project launched at Mid Cheshire Hospitals NHS Foundation Trust, which manages Leighton Hospital, in November 2020, and is supporting more than 150 smokers.

"Tobacco addiction is a chronic and relapsing disease which sadly often begins in childhood.

"The CURE Project is about hospital teams working together to tackle this disease and has already demonstrated what can be achieved when we offer dedicated support to every patient.

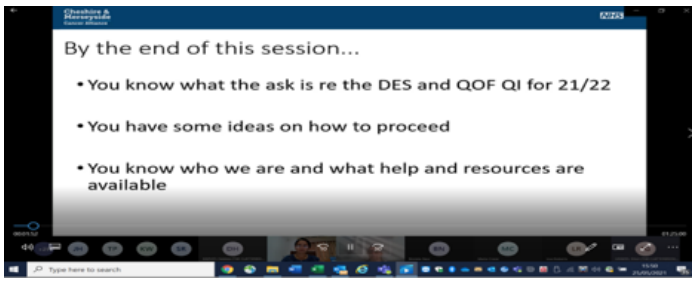
"There really is no greater step a smoker can take to improve their health than to stop smoking, and the benefits start almost immediately."

Duncan Fullerton, Respiratory Consultant and Clinical Lead for the CURE Project at Mid Cheshire Hospitals

Early detection

Detecting cancers early means they are easier to treat and more people survive the disease. During 2020/21, relationships were established with Primary Care Networks (PCNs) – which include groups of GP practices – to promote detection of cancer at an early stage. Support has been offered to primary care professionals in delivering the DES contractual requirements relating to early cancer diagnosis and the guidelines around the delivery of QOF QI targets. This involved hosting webinars (pictured right), developing tools and resources – including videos – publishing bulletins and jointly funding a Cancer Research UK facilitator.

Engagement with approx 50 PCNs



"I found this a very useful summary of both the PCN DES and QOF QI for cancer. The links to resources and PCN dashboard were particularly beneficial. The new primary care site is also a really useful resource. Dr Octavia Stevens, webinar attendee

Faecal immunochemical testing

Faecal immunochemical testing (FIT) is a simple test that detects hidden blood in a stool sample, which could be an early sign of cancer. It reduces the need for invasive tests and may increase the number of early stage bowel cancers found. As a response to COVID-19, CMCA mobilised a rapid implementation programme to ensure that patients with high-risk symptoms were FIT tested in secondary care, built on existing pilot projects.

FIT was established across six acute trusts in eight weeks, supporting the reduction in the number of suspended two-week referrals by 50%. Tests have been sent to 12,000 patients with low and high risk of cancer. Primary Care FIT testing for low risk patients has gone live across seven trusts in Cheshire and Merseyside (C&M) in 2020/21. GPs are now also able to order high risk FIT tests when they refer patients on a suspected cancer referral. In May, Wirral became the first area to sustain FIT and it is hoped that other areas will follow during 2021/22. To date, four laboratories have received funding for FIT analysers and additional workforce to support testing.

This supported the development of the new long-term laboratory model for C&M, which has more than quadrupled FIT testing capacity. Trusts have also received additional funding for FIT and to increase their workforce to support the process and, importantly, colorectal cancer services.

> **The main reason for the success of the FIT rollout across Cheshire and Merseyside was the huge amount of close collaboration between organisations, including CMCA, key people in the secondary care trusts and in our CCGs.**
>
> **Supportive and directive project management and people working together towards a common goal for our patients, in the midst of a pandemic, was a great example of what can be achieved by multidisciplinary professionals.**
>
> Dr Debbie Harvey,
> GP and Primary Care Lead, CMCA

Approx. **60%** of patients identified as having a **<1.1%** risk of colorectal cancer

12,000 FIT tests sent to patients since April 2020

Two week wait patients in St Helens did not require a scope **28%**

STH&K Interim Evaluation report: 101 patients

Targeted lung health checks

Due to the high incidence of lung cancer across parts of C&M, targeted lung health checks (TLHCs) focus on high-risk populations, offering a low dose CT scan to at-risk people with the aim of identifying early stage lung cancer. After the checks were paused in 2020/21 because of COVID-19, they are being launched in July 2021 after significant planning in Halton, Knowsley and Liverpool, including a comprehensive public promotion of the checks (pictured).

Cancer screening

Cancer screening plays a vital role in detecting disease early so that more effective treatment can be given. Routine cancer screening was affected during 2020/21 by COVID-19 but plans were progressed to establish patient screening navigators in each breast and bowel screening centre across C&M. Navigators engage with service users and promote screening to low uptake groups. A text messaging project to improve the level of cervical screening was commissioned from Champs Public Health Collaborative and is due to begin in 2021/22. Work began on a cancer screening toolkit for primary care professionals, which is due for completion mid-2021.

> **The role of the support worker allows continuity of care and better relationships between acute primary care settings. Patients feel empowered because they know there is a support network that is easily accessed if it's ever needed.**
>
> Cassandra Garner, EDSW Southport and Ormskirk Hospital NHS Trust

Early diagnosis support workers

Early diagnosis support workers (EDSWs) improve patient experience by liaising with clinicians, providing advice, support and a point of contact during a person's cancer journey. CMCA has funded another year of these roles, which total 48 across a number of tumour types and FIT testing. These roles have made a demonstrable and positive impact on patient experience by reducing anxiety, providing reassurance, helping people to negotiate NHS systems and reducing time to diagnosis.

Total of **48** Early Diagnosis Support Workers

Potential annual saving of: **700** diagnostic procedures in colorectal services alone

Equivalent **£350,000** pa in C&M

Rapid diagnostic services

Rapid diagnostic services (RDSs, also known nationally as rapid diagnostic centres) are a priority in the NHS Long Term Plan (LTP) for delivery by 2024. They are designed to speed up cancer diagnosis, including for patients presenting with non-specific symptoms, such as unexplained weight loss. For these patients, there may be a concern there is an underlying malignancy but the cause is hard to determine. CMCA is well on the way to achieve this through a three-year delivery plan. In 2020/21, CMCA implemented non-specific RDSs and began implementation of the first site-specific pathway in head and neck at Liverpool University Hospitals NHS Foundation Trust. The approach for an oesophago-gastric and sarcoma RDS were agreed in February 2021 and a clinical lead identified for liver and breast RDSs. This will expand to deliver RDS pathways across all site-specific cancer pathways and nine non-specific services over the next three years.

Planning for approx. **90** RDS site specific teams

Non-specific symptoms RDSs live at: **5** trusts

Optimal pathways

Optimal cancer pathways outline the best cancer care for specific tumour types so patients can be diagnosed earlier, with treatment and care progressed more quickly and effectively. Pathways have been agreed with clinical leads across C&M for gynaecological and prostate cancers this year to add to head & neck, colorectal, lung and oesophago-gastric. An optimal pathway for dietetic support is currently being developed as well, with funding established for specialist upper GI dietitians. Further pathways in development include sarcoma and liver, with further improvements identified for breast services to support RDS development.

We know how important prehab is to the success of a patient's cancer treatment and One Wirral CIC will be delivering a comprehensive prehabilitation programme.

We will be supporting people in the community and at leisure centres, so people don't have to travel.

We are really excited to get people physically fitter for not only their cancer journey, but through their recovery and beyond.

We have recruited a lovely new team and set to launch in July, and we can't wait to start supporting our patients and helping them to have the best possible recovery they can from their treatment.

Lucy Holmes, One Wirral CIC

Prehabilitation

Prehabilitation is a way to improve patient health through information and education so people can better withstand cancer treatment. In 2020/21, CMCA offered support for the scoping out of a prehabilitation project at Liverpool University Hospitals NHS Foundation Trust and to see how an existing project at Aintree University Hospital could be expanded to the Royal Liverpool University Hospital. Resources were secured to fund these. In 2020/21, CMCA worked with One Wirral CIC to develop a community based approach to prehabilitation to optimise patients prior to treatment for cancer. This has now been funded and launches in June 2021.

Health inequalities and patient experience

Health inequalities and patient experience related to cancer are high on CMCA's agenda. In 2020/21, CMCA funded two new quality improvement posts, in partnership with Macmillan Cancer Support, with a focus on these areas. To ensure equity of access to treatment across the C&M, CMCA has established the Cheshire and Merseyside Cancer Surgical Hub, which aims to ensure people have access to urgent cancer surgery irrespective of where they live. In 2020/21, CMCA embedded the hub, which oversees a single waiting list for cancer patients and ensures they are offered treatment at another regional hospital if this is preferable.

600

Cancer patient operations were facilitated through Cheshire and Merseyside Cancer Surgical Hub in 2021

Our partners at The Clatterbridge Cancer Centre NHS Foundation Trust, which hosts CMCA, improved the patient experience and the trust's ability to carry out vital cancer research with the opening of its flagship hospital in Liverpool's Knowledge Quarter.

"The opening of this crucial facility will be of huge benefit to the people of the city region.

"It adds to our city region's strengths in health and life sciences and is yet another world-leading asset for the growing Knowledge Quarter.

Steve Rotheram, Metro Mayor of the Liverpool City Region

Personalised stratified follow-up

Personalised stratified follow-up (PSFU) adapts care to the personal needs of patients after cancer treatment to improve outcomes and enhance their wellbeing. The pandemic impacted on the development of this, with appointments pausing and staff redeployed. In response, CMCA instigated a programme to provide PSFU virtually, including digital training packages for staff. CMCA is one of the first cancer alliances to have in place breast, prostate and colorectal PSFU pathways across all sites in C&M. Further work is progressing to roll this out for other cancer pathways.

8 out of 8 breast sites
6 out of 8 prostate sites
8 out of 8 colorectal sites

1 advanced bowel cancer

2 haematology sites

At end of 2021: **27,500** * outpatient appointments released over five years due to PSFU

Pathology Network

Pathology services are a vital step in the cancer diagnostic process to ensure stage of disease is determined and to inform the best possible treatment for patients. The Pathology Network is a collaboration of seven NHS trusts working together with the aim of driving improvement in pathology diagnostic services. The Pathology Network has played a key role in the successful implementation of FIT testing across Cheshire and Merseyside both during the initial COVID-19 response and also in support of Primary Care FIT testing with a long-term pathology model for FIT now in place.

Strong clinical leadership and collaboration between laboratories has contributed significantly to the network's success. CMCA will be working with the network in 2021/22 to support testing of seven-day working and the optimisation of pathology pathways.

Genetic Surveillance:

1,048 patients reviewed to date:

8,000 appropriately discharged

8,000 slots available for potential cancer patients

Endoscopy Network

Endoscopy services are vital in the diagnosis of cancers and restoring them after being paused due to COVID-19 has been a key priority for CMCA. This included establishing a system-wide Endoscopy Operational Recovery Team and strategy with clear priorities to plan, oversee and support this recovery, including symptomatic diagnostics and screening programmes.

The Endoscopy Network – a grouping of services across C&M – is supporting this recovery and transformation. Endoscopy capacity has more than doubled since August 2020, including development of a shared networked endoscopy reporting and booking system. After a successful pilot, the Thrive reporting tool is being funded for a further year. The Cheshire and Merseyside Endoscopy Network Procurement Group, formed of eight NHS trusts, negotiates reduced prices for endoscopy equipment and has saved more than £300,000 in 2020/21.

Post Polypectomy Surveillance:

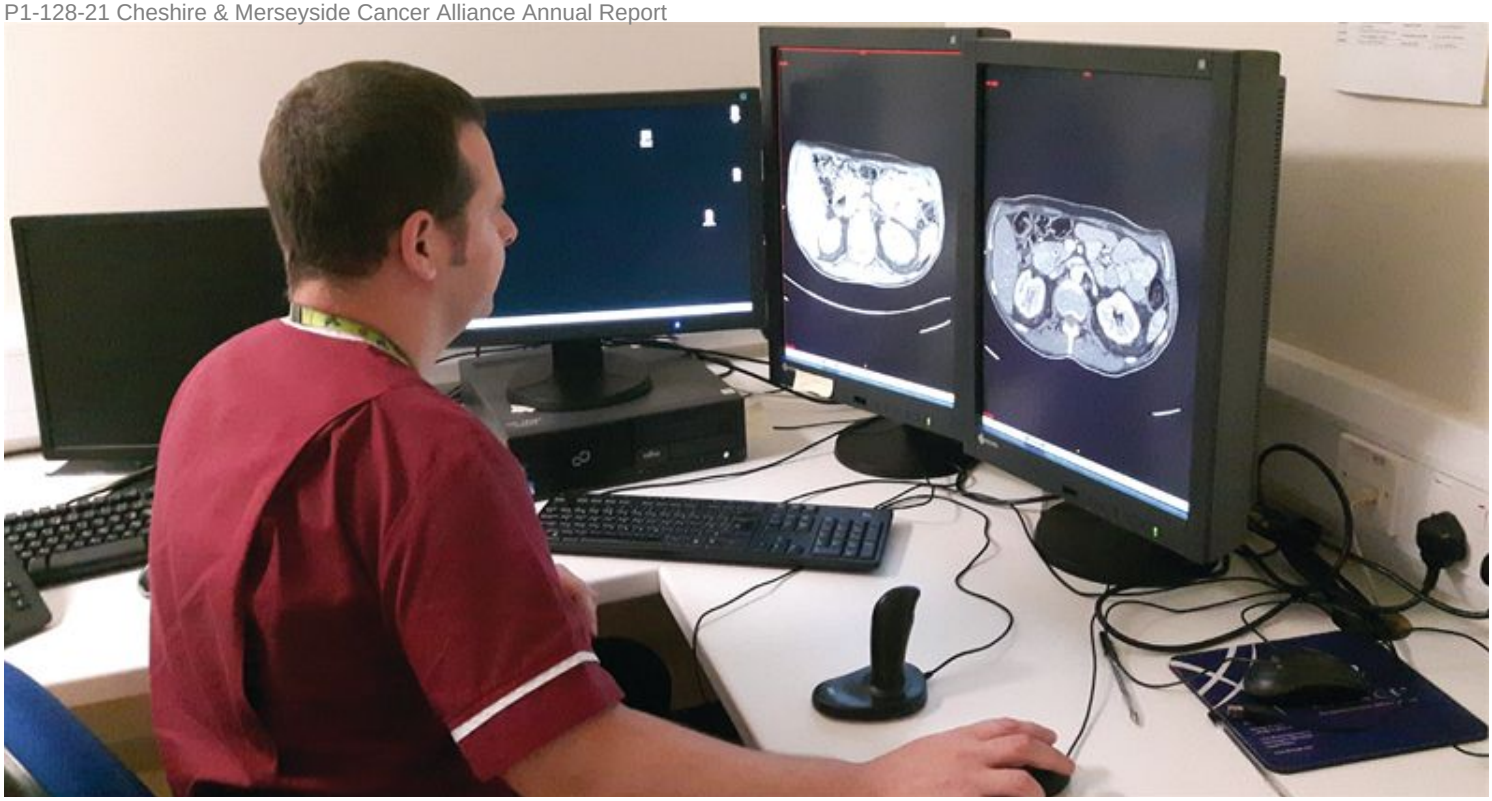
17,500 patients reviewed with:

293 provided slots for other patients

224 referred to genetics

293 potentially discharged

Endoscopy Network Procurement Group has made savings of **£317,818**



Imaging Network

Radiology imaging are tests which take pictures or images of the body to diagnose and treat cancers, including X-rays and MRI, CT and PET scans. Facing higher demand, an ageing population and an increase in the complexity of imaging examinations, the Cheshire and Merseyside Radiology Imaging Network (CAMRIN) works to make radiology services sustainable across Cheshire and Merseyside.

Twelve trusts are members of the network which aims to reduce variation across services, support digital solutions, enhance the imaging workforce and optimise procurement. Working in collaboration with CMCA to implement priority cancer pathways in lung, prostate and colorectal cancers, Imaging Delivery Groups have worked to standardise and streamline processes across C&M. They support earlier diagnosis, aided the development of RDSs and reduced variation in radiology practice in lung and prostate cancers. 2021 will see the Imaging Network carry out a review of gynaecological cancer radiological processes, continue to improve processes for urology imaging and support the development of optimal pathways for sarcoma and head and neck.

2021 will see the Imaging Network carry out a review of gynaecological cancer radiological processes, continue to improve processes for urology imaging and support the development of optimal pathways for sarcoma and head and neck.

“Imaging plays a crucial part in early diagnosis of cancer. However, imaging services are facing a range of issues such as the significant growth in demand for services, lack of workforce, ageing and lack of equipment, changing technologies and new service delivery models.

CAMRIN are supporting the development of specific and non-specific Rapid Diagnostic Services across Cheshire and Merseyside as part of their wider transformation programme. The future vision for CAMRIN is ‘World class imaging services for the people of Cheshire and Merseyside’ and the aim is ‘Striving for sustainable quality in Cheshire and Merseyside radiology imaging services’. The transformation programme has been developed with a view to achieving the vision and aim and therefore providing the solution to the multifaceted issues that radiology imaging services are currently experiencing.”

Alexi Shenton, Senior Programme Manager

CAMRIN: Summary of the benefits achieved

Cold COVID sites
Three additional CT scanners placed on 'cold' COVID sites

Brainomix AI
The first artificial intelligence support tool for stroke implemented across C&M

Reduction in variation
Implementation of best practice cancer pathways

Improved patient access
Implementation of the technical solution for cross site working

Improved out of hours service
Formalised funding for the Radiology out of hours hub

Home reporting work stations
An additional 100 workstations purchased via network funds

Workforce development
Successfully awarded monies for three proposals by Health Education England

Reduction in variation
Alignment of radiology information system alert codes

Radiology clinical reference group
Established a radiology clinical reference group to support C&M

Three additional network CT scanners
Increased capacity by up to 30,000 scans a year

Additional reporting capacity
Home reporting stations provide system capacity during self isolation

Radiology out of hours hub
New infrastructure to be put in place to support the operational processes within the hub

Network scanning
Trusts with additional scanning capacity within C&M now share it with Trusts who have a lack of capacity

Formalised funding of the C&M radiology out of hours hub
Cost avoidance approx. £2,500,000

Single price for outsourced radiology reporting across C&M
Cost saving approx. £80,000

Procurement savings
Saving of approx. £330,000 on the purchase of two network CT scanners

New funding
Awarded funding from the Health and Care Partnership and the Cancer Alliance to continue network development and transformation

Workforce

Improving the skills, experience and training of the cancer workforce across C&M is a priority, supporting the recovery of cancer care and NHS Long Term Plan ambitions. Since the start of the pandemic, there has been a rapid and significant shift to online training instead of face-to-face with more than 100 cancer support workers (CSWs) and clinical nurse specialists (CNSs) joining virtual training sessions.

A networked approach to delivery of specialist speech and language therapy was established. The network of CSWs was embedded, with more posts added for breast and bowel. All CSWs/CNSs were offered resilience training and grants. The creation of a CMCA Cancer Academy – a hub of specialist information, tools, resources and training for all cancer professionals across Cheshire and Merseyside – was approved in December 2020 with ambitions to launch in summer 2021.

The Cancer Academy
Excellence in cancer education

Over **100** CSWs/CNSs on group workshop training sessions

Grants support development of **60** CNSs

x2 Specialist Speech and Language Therapist training posts funded

Liverpool Cancer Research Institute

Transforming cancer research in Liverpool for patient benefit

Research

COVID-19 has not held back many achievements in cancer research across C&M. Despite the global pandemic, it has been a busy year as Cheshire and Merseyside scientists continue to work on cancer prevention, screening, diagnostics and therapeutics to benefit cancer patients. Their vital work has been strengthened by the launch of the Liverpool Cancer Research Institute (LCRI), a partnership between the region's three biggest stakeholders in cancer research – the University of Liverpool (UoL), The Clatterbridge Cancer Centre NHS Foundation Trust (CCC) and North West Cancer Research, working alongside Liverpool Health Partners. LCRI enhances existing excellence in biomedical and translational cancer research in our region, which furthers the translation of this into improved patient outcomes and has close links with CMCA and NIHR Clinical Research Network North West Coast. The opening of the Clatterbridge Cancer Centre – Liverpool in June 2020, brought together cancer experts from the NHS and academia in the city's Knowledge Quarter for even greater collaboration, with CCC researchers recruiting almost 1,000 new clinical trials participants across Cheshire and Merseyside in 2020-21. Due to COVID-19, CCC research studies were paused but restarted in May 2020, with 85 relaunching and 46 new ones opening. In April 2020, researchers from the Liverpool Head and Neck Centre joined an international research collaboration which confirmed that operating on head and neck cancers during the pandemic was safe for patients and clinical staff. In September, UoL researchers launched a 12-month study to assess the impact of COVID-19 on people with cancer, including different mortality rates for varying types of cancer and treatment. In November, UoL and local NHS partners announced a major new programme of immunology cancer research, headed by world-leading experimental cancer researcher Professor Christian Ottensmeier, chair of Immuno-Oncology at UoL and CCC consultant oncologist.

Performance

In common with other parts of England, performance against the national cancer waiting times standards was very challenging throughout 2020/21 in Cheshire and Merseyside. Despite not meeting the standards for all patients through the year, C&M performed slightly better than the England average.

13,384

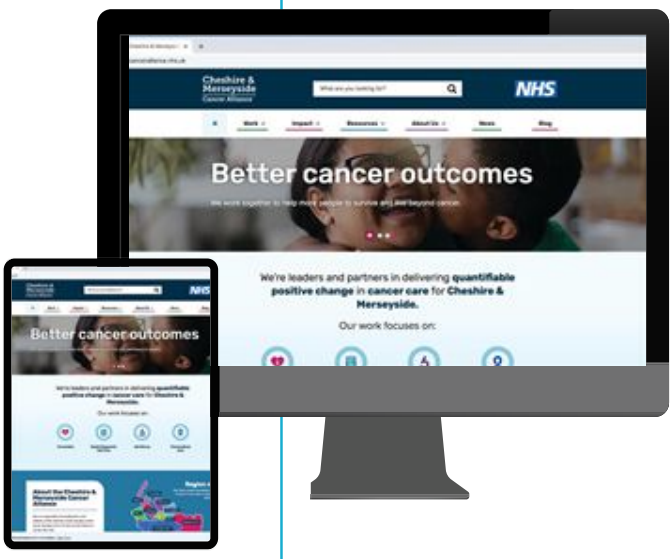
Number of patients newly diagnosed & treated for cancer (April 2020 - March 2021)

62 day referral to the first treatment standard
(April 2020 - March 2021)

14 day referral to the first appointment standard
(April 2020 - March 2021)

Communications

During 2020/21, there has been an emphasis of improving communications to professionals, stakeholders, patients and the public. A new Communications Strategy was agreed in November 2020 and an updated CMCA website (pictured right) went live at the end of April 2021. A communications lead was appointed and further communications initiatives are planned in 2021/22 to promote the work of CMCA and increase the amount of resources and information available to cancer professionals and the public.



Corporate

CMCA has grown during 2020/21, reflecting its increasing activities and future demands in order to create better cancer services, better cancer care and better cancer outcomes. There has been an increase in project management, analytical and support roles due to these requirements. A Project Management Office (PMO) function was established alongside the creation of new governance arrangements, which are due to be consolidated in 2021/22.

Cheshire & Merseyside Cancer Alliance

Dr Liz Bishop Senior Responsible Officer
liz.bishop1@nhs.net

Jon Hayes Managing Director
jon.hayes1@nhs.net

General enquiries: ccf-tr.admin.cmca@nhs.net
www.cmcanceralliance.nhs.uk

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

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board	
Date of meeting:	28 July 2021	
Agenda item:	P1-129-21	
Title:	Board Development	
Report prepared by:	Angela Wendzicha	
Executive Lead:	Liz Bishop	
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	
Date & decision:	Not Applicable

Purpose of the paper/key points for discussion:	The following report sets out the proposed schedule for Board Development aligned to the Strategy and Board Assurance Framework for 2021-22. It is envisaged that the sessions will take place following Part 1 of the Board and a full record of the session will be obtained.

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

Next steps required:	Following Board approval, the development sessions will be added to the Board Plan and implemented.

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

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

☒ BE **OUTSTANDING**

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

☒ BE **COLLABORATIVE**

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

☒ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

☒ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Board Development 2021-22

Angela Wendzicha, Associate Director of Corporate Governance

Version: 1.0 Ref: FCGOREPO Review: May 2024

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

1. Introduction

1.1 It is well recognised that the development of the Board is a key element of good corporate governance in addition to being accepted as best practice within NHS Improvement's Well-Led Governance Review Framework.

1.2 A successful development session took place in October 2020 during which, the Board considered, discussed and agreed the Trust Risk Appetite. In addition, the Non-Executive Directors attended a seminar relating to medicine management in June 2021.

2. Board Development Schedule 2021-22

2.1 The following illustrates the proposed Board Development schedule for 2021-22. It is envisaged that each session will align to the Strategy and Board Assurance Framework and a record will be kept of the session.

2.2 It is proposed that the development sessions will follow Part 1 of the Trust Board as detailed below:

Date	Session	Lead
27 October 2021	Clinical Horizon Scanning in Oncology (Be Outstanding and Be Collaborative)	Medical Director and Clinical Directors
26 January 2022	Research and Development (Be Research Leaders)	Medical Director, Director of Research and Director of Research (Operations)
25 May 2022	Quality Improvement (Be Outstanding)	Chief Nurse and Director of Strategy
27 July 2022	Digital Developments and Strategy (Be Digital)	Chief Information Officer

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

3. Recommendation

3.1 The Board is asked to discuss the proposed Board Development Schedule as detailed in Section 2.2 above and approve the approach.

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	28 July 2021
Agenda item:	P1-130-21
Title:	Regulation 5 Declarations (Fit and Proper)
Report prepared by:	Angela Wendzicha
Executive Lead:	Liz Bishop
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Not Applicable: Board matter only.
Date & decision:	

Purpose of the paper/key points for discussion:	Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced to ensure that all Board level appointments are fit for their role in addition to ensuring that individuals are of good character. The Trust has an in date policy that governs this process, namely the Fit and Proper Person Requirement Policy. In order to ensure ongoing compliance with the above, an annual self-declaration and review will be undertaken and the Register will be presented to the Board. The Associate Director of Corporate Governance holds the relevant Register for this. The purpose of the paper is to update the Board on the annual fit and proper person self-declaration and process regarding the Board of Directors. The self-declarations have been completed and a hard copy retained on individual files. All returns have been reviewed and no issues have been identified that may impact on individual's ability to perform their role as a member of the Trust Board.

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

Next steps required:	This is an ongoing annual process.

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

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

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Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☒

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

BAF Risk	Please select
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Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	☐

☒ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

Register for Fit and Proper Requirements 2021-22								
	Recruitment checks completed with evidence in HR file	Professional Body Registration (if applicable)	DBS Check (if applicable)	Appraisal date	Date of Annual Self-Declaration	Date of Companies House Disqualified Director check	Date of Register of Disqualified Trustees check	Date of Insolvency Register check
Non-Executive Directors								
Kathy Doran, Chair	Checks completed by Consultancy - held on file	N/A	08/3/2019 Clean	23 June 2021	23 July 2021	24 July 2021 Clean	24 July 2021 Clean	24 July 2021 Clean
Mark Tattersall, NED (Vice-Chair)	Checks completed by Consultancy - held on file	N/A	06/02/2019 Clean	10 June 2021	22 July 2021	22 July 2021 Clean	22 July 2021 Clean	22 July 2021 Clean
Geoff Broadhead, NED	Checks completed by Consultancy - held on file	N/A	06/02/2019 Clean	16 June 2021	20 July 2021	21 July 2021 Clean	21 July 2021 Clean	21 July 2021 Clean
Terry Jones, NED	Checks completed – held on file	N/A	30 November 2019 Clean	10 June 2021	19 July 2021	20 July 2021 Clean	20 July 2021 Clean	20 July 2021 Clean
Elkan Abrahamson, NED	Checks completed – held on file	SRA: No restrictions	24 July 2019 Clean	9 June 2021	25 July 2021	25 July 2021 Clean	25 July 2021 Clean	25 July 2021 Clean
Asutosh Yagnik, NED	Checks completed – held on file	N/A	On appointment January 2021 Clean	9 June 2021 (Objective setting)	On appointment January 2021	On appointment January 2021 Clean	On appointment January 2021 Clean	On appointment January 2021 Clean

Anna Rothery, NED	Checks completed – held on file	N/A	On appointment January 2021 Clean	29 July 2021 (Objective setting)	7 December 2020	On appointment January 2021 Clean	On appointment January 2021 Clean	On appointment January 2021 Clean

Register for Fit and Proper Requirements 2021-22								
	Recruitment checks completed with evidence in HR file	Professional Body Registration (if applicable)	DBS Check (if applicable)	Appraisal date	Date of Annual Self Declaration	Date of Companies House Disqualified Director check	Date of Register of Disqualified Trustees check	Date of Insolvency Register check
Executive Directors								
Liz Bishop, CEO	Checks completed – held on file	N/A	05/09/2018 Clean	19 July 2021	20 July 2021	21 July 2021 Clean	21 July 2021 Clean	21 July 2021 Clean
James Thomson, Director of Finance	Checks completed – held on file	CIPFA Register: Qualified Member	26/01/2019	16 August 2021	19 July 2021	21 July 2021 Clean	21 July 2021 Clean	21 July 2021 Clean
Joan Spencer, COO and Chief Nurse (from 01 April 2021)	Checks completed – held on file	NMC: No Restrictions	3 January 2014 Clean	17 August 2021	9 November 2020	26 July 2021 Clean	26 July 2021 Clean	26 July 2021 Clean
Jayne Shaw, Director of Workforce and OD	Checks completed – held on file	N/A	17/12/2018	19 August 2021	19 July 2021	21 July 2021 Clean	21 July 2021 Clean	21 July 2021 Clean
Sheena Khanduri, Medical Director	Checks completed – held on file	GMC: Specialist Register – No Restrictions	11/10/2017	23 August 2021	22 July 2021	24 July 2021 Clean	24 July 2021 Clean	24 July 2021 Clean
Sarah Barr, CIO	Checks completed – held on file	N/A	Role not eligible	31 August 2021	14 May 2021	24 July 2021 Clean	24 July 2021 Clean	24 July 2021 Clean
Tom Pharaoh, Director of Strategy	Checks completed – held on file	N/A	Role not eligible	24 August 2021	14 May 2021	24 July 2021 Clean	24 July 2021 Clean	24 July 2021 Clean