AGENDA

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Trust Board of Directors Meeting held in Public

Date: Wednesday 30 June 2021	Location: via MS Teams
Start Time: 09:00	Finish Time: 11:40

Timings	Item No		Lead	Paper/Verbal
Opening Matters				
09:00	**P1-089-21**	Welcome & Apologies:	KD	**Verbal**
	P1-090-21	Declarations of Committee Members' and other attendees' interests concerning agenda items:	KD	**Verbal**
	P1-091-21	Minutes of last meeting: 26 May 2021	KD	**Paper**
	P1-092-21	Matters arising/Action Log	KD	**Paper**
	P1-093-21	Chair's Report to the Board	KD	**Verbal**
Risk and Assurance				
09:15	**P1-094-21**	Quality Committee Chair's Report	TJ	**Paper**
09:25	**P1-095-21**	Audit Committee Chair Report	MT	**Paper**
09:35	**P1-096-21**	Staff Story: Research	GH/MM/EW	**Verbal**
09:55	**P1-097-21**	Patient Experience Visits	JSp	**Paper**
10:05	**P1-098-21**	New Consultant Appointments	SK	**Paper**
10:15	**P1-099-21**	Safer Staffing Report	JSp	**Paper**
10:25	**P1-100-21**	Integrated Performance Report: Month 02	JSp/JSh	**Paper**
10:35	**P1-101-21**	Cheshire & Merseyside Cancer Alliance Performance Report	LB	**Paper**
10:45	**P1-102-21**	Finance Report: Month 02	JT	**Paper**
Strategy Implementation				
10:55	**P1-103-21**	5 Year Strategy: Implementation Plan	TP	**Paper**

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Corporate Governance				
11:15	**P1-104-21**	Board Assurance Framework	AW	**Paper**
11:25	**P1-105-21**	Board Annual Work Plan	AW	**Paper**
11:30	**P1-106-21**	Board Meeting Review	ALL	**Verbal**

Next Meeting:

Date: Wednesday 28 July 2021	Location: TBC
Start Time: 09:00	Finish Time:

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Minutes of the Trust Board of Directors held in Public

Held on: Wednesday 26 May 2021	Location: The Spine & via MSTeams
Start time: 09:00 hours	Finish time:

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 (Partial)
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

Angela Wendzicha (AW)	Associate Director of Corporate Governance
Jane Wilkinson (JW)	Lead Governor (Partial)
Alun Evans (AE)	Staff Side Representative
Kirsteen Scowcroft (KS)	Head of Patient Experience & Inclusion (Item P1-80-21)
Emma Bond (EB)	Patient Story (Item P1-80-21)

Observer

Steve Sanderson	Public Governor
Lynne Barnes	Member of the public

Item no.	Agenda item	Action
P1/73/21	**Chair Welcome and Note of Apologies** The Chair welcomed all to the meeting with apologies noted from Anna Rothery and Mike Varey. KD further thanked MT for Chairing the Board meeting in her absence last month.	

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P1/74/21	**Declarations of Board Members and other attendees' interests concerning agenda items:** • Mark Tattersall – Nominated Non-Executive Director for PropCare • Terry Jones – Director of Liverpool Head and Neck Centre and Associate Medical Director for Research, Liverpool University Hospital NHS Foundation Trust • Geoff Broadhead – Nominated Non-Executive Director for CPL • James Thomson – Executive Lead for PropCare and CPL • Angela Wendzicha – Company Secretary for PropCare and CPL	
P1/75/21	**Minutes of Previous Board Meeting: 28 April 2021** The Board approved the minutes of the Board meeting held on 28 April 2021. **The Trust Board:** • **Approved** the minutes of the Board meeting held on 28 April 2021	
P1/76/21	**Matters Arising/Action Log** The Board noted that actions were either complete, om the Agenda or not yet due. **The Trust Board:** • **Noted** the position in relation to the Action Log.	
P1/77/21	**Chair's Report to the Board** KD informed the Board that she had recently attended the North West Regional Chair meeting which discussed the plans for the Integrated Care System (ICS) with the Bill receiving a second reading in Parliament in June. The Chair noted that the current Chair and Chief Executive Officer for the Cheshire and Merseyside ICS have indicated that they do not wish to continue in their current roles and that the recruitment process has been launched to source replacements.	
P1/78/21	**Performance Committee Chair's Report** GB provided an overview of the report alerting the Board to the discussion at Performance Committee in relation to the Risk Register, acknowledging the work that has been completed and recognising the	

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	work that remains to be completed. The Performance Committee had requested additional commentary to support the open actions in order to provide sufficient assurance to the Committee that mitigations are adequate. In addition, GB informed the Board that the Performance Committee had highlighted the potential for lower scoring financial risks to cumulatively become significant. GB advised the Board that the Committee has received the Operational and Financial Plan for 2021/22 noting the continually changing financial guidance. The Committee had previously recognised issues within the Clinical Decisions Unit and received an update on the progress relating to service improvements with a further update requested at the July committee. GB further advised the Board that the Committee received an update on the progress made on the Research Strategy Business Plan noting that some progress had been made however, there is a continuing risk to commercial funding as a result of the issues within the Aseptic Unit. No new trials had opened since April but re-start plans were being developed. The Committee will continue to receive quarterly updates on progress. **The Trust Board:** • **Discussed and noted** the content of the report.	
P1-79-21	**Quality Committee Chair Report** TJ provided an overview of the report, alerting the Board to the following: a) Risk Register: TJ informed the Board that the Quality Committee acknowledged that although it is improving, the work needs to be completed to separate 'risks' from 'issues'; with a revised risk register planned for the June Committee. b) Medicine Management: A revised Medicine Management Report was received with the welcome inclusion of revised categorisations. The Committee will continue to receive monthly reports. c) Aseptic Unit: The Committee received an update on the progress in relation to the Aseptic Unit and monthly reports will continue until sufficient assurance has been received. TJ advised the Board that an update around the Ambulatory Pathways of Care in Haemato-Oncology was welcomed with a further update scheduled for October. TJ further advised the Board that Health Education England will be carrying out a planned visit early	

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	July 2021; whilst it is unlikely that the report will be received before October 2021, the Committee will receive a verbal update on the visit at the July meeting. TJ concluded that the Committee welcomed the masterplan in providing clarity on the Clinical Governance arrangements and thanked JSp for her work in relation to this. KD concluded that, given the detail discussed on both the Performance and Quality Committee reports that the Board Committees are working well. **The Trust Board:** • **Discussed and noted** the content of the report.	
P1-80-21	**Patient Story** KS attended the Board and introduced EB who also joined the Board to tell of her experiences. EB informed the Board that she had been diagnosed in 2019 with a brain tumour for which she had surgery at The Walton Centre; the tumor being diagnosed after she began hearing music. EB described how the staff at both CCC and The Walton Centre have been so supportive and kind throughout her treatment. EB described how when she began her Radiotherapy, the staff used to ask her which music she wanted to listen to and eventually, the staff were very supportive of her father's suggestion that family and friends compile the 'song list' for her that she didn't know what was on the list until the music started during treatment. EB described how her current Consultant makes her feel cared for and that she appreciates her honesty and that she feels very supported, safe and cared for as soon as she walks into the hospital. EB informed the Board that as both her and her fiancé were so grateful for the care and treatment she had received; her fiancé ran a mile a day during 2020 to raise money for CCC, The Walton Centre and Brain Tumour Research. In addition, the company EB works for will be embarking on a cycle ride from CCC-L to Snowden which they will climb as they are all so grateful for what the staff have done for her. KD thanked EB for her inspiring story and asked if there was anything that we could improve on. EB suggested that it would be helpful if all MRI scanners could have mirrors in them as they really help. MT added his thanks to EB for her story which made him proud to be part of CCC. TJ further thanked EB for her story and sought clarity on her experiences of appointments and how important face to face	

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	appointments were to her. EB added that in her experience, it was fine to have a phone call when discussing and prescribing the chemotherapy but when results are being shared, it was better for her to have a face to face appointment. LB thanked EB for her story and informed the Board that KS had just been appointed as the full time substantive Patient Experience Manager that will strengthen the patient voice. Furthermore, this story has highlighted the importance of diagnostic and therapeutic radiographers. KD concluded by thanking EB for attending Board this morning and telling her inspiring story in addition to thanking her partner for all the fundraising he has done. On behalf of the Board, KD wished her and her fiancé well for the future. *EB and KS left the Board meeting.* KD requested a letter be drafted on her behalf to send to the Chair of The Walton Centre. EA requested that the story be shared with other colleagues; in addition, can mirrors be put in all the MRI scanners and then feedback to EB. **The Trust Board:** • **Noted and welcomed** the patient story to Board. *JW joined the meeting at this point.*	**AW** **AE**
P1-81-21	**Update on Walkabouts** AW provided a summary to the background relating to the recent walkabouts in addition to an overview of the proposal to schedule monthly joint walkabouts with Non-Executive Directors and Governors. AW requested that Board members inform her of the dates on which they would be available to join the walkabouts which will be facilitated by KS. MT sought clarity on how the walkabouts will be conducted with AW confirming that we will take our lead from the national guidance around Covid restrictions and conduct them via MTeams if necessary. JSp informed the Board that she carried out a walkabout on 17 May with two Governors (Glen Crisp and Laura Brown via MTeams), visiting Haemato-oncology. During the walkabout they spoke to a Band 6 nurse who talked about recruitment plans and how they are developing robust induction programmes whilst enabling new starters to spend time in the department. In addition, JSp informed the Board that she had completed a shift on	

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	Ward 3 where she was able to carry out a medicine round with one of the Band 5 nurses which was particularly important given the recent reports though Quality Committee. JSp was pleased to see that protocols were followed and that there was good patient engagement with staff discussing side effects with the patients. JSp added that she and Karen Kay, Deputy Director of Nursing have shifts booked in across all sites and will feed back to future Boards. **The Trust Board:** • **Noted** the content of the report and feedback.	
P1-82-21	**New Consultant Appointments** The Board noted there were no new Consultant appointments this month.	
P1-83-21	**Guardian of Safe Working: Quarter 4 Report** SK provided an overview of the report informing the Board that the Trust remains compliant with the junior doctor's safe working hours. SK highlighted that during Quarter 4, no exception reports had been raised by our trainees and no fines had been incurred during this time. SK further informed the Board that in response to feedback from trainees we are currently looking at their ability to get away for training sessions. EA sought clarity on the reliance of trainees themselves to complete the exception reports and whether there was confidence they were doing this. SK confirmed that all trainees were encouraged to report and that the trainees are aware the Guardian of Safe Working sits independently and that any reports are confidential. TJ noted the numbers of trainees are set by Health Education England and sought clarity as to whether there are any pressures around the numbers available. SK added that we recently took advantage of the increase in trainee posts and have increased our radiology posts. MT sought clarity as to whether the Trust had any doctors on 2002 contracts with SK confirming they have all migrated across to the 2016 contract. **The Trust Board:** • **Noted** the content of the report.	
P1-84-21	**Integrated Performance Report: Month 01** JSp introduced the report providing an overview of the Performance	

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	section noting that performance has been good across the 7 and 24 day targets. The Board noted that two pieces of work are ongoing in relation to capacity and demand in order to maintain the targets support the recovery programme. JSp added that bed occupancy remains low but we are starting to see more patients that require in-patient treatment. *JT joined the Board at this point.* **Quality** JSp highlighted that one Serious Incident was reported in month which is currently being investigated and the Trust reported one RIDDOR relating to a patient fall. JSp informed the Board that discussions were ongoing with the Commissioners in relation to the targets for Clostidiodes difficile and the Infection Prevention and Control team have been asked to carry out a deep dive in relation to this and a paper will be presented at the July Quality Committee. A total of four complaints were closed in month with one being signed off within the 25 working day deadline. The Board were informed that the revised Complaints Policy is about to go live which is expected to improve the process. AW provided an overview of the position around policies highlighting that an improving position is emerging with the team continuing to work closely with staff to ensure policies are reviewed in a timely manner and remain in date. **Research** SK provided an overview of the research section of the report highlighting the effects of the Aseptic Unit on research trials noting that recently some studies have been able to be un-paused and that we are currently planning to increase the number. TJ sought clarity as to whether there had been any negative feedback from our sponsors with SK confirming that the trials team has been very proactive in keeping sponsors informed. However, we are aware of some studies where the trials have closed as we were not able to put patients forward. **Workforce** JSh highlighted the two exception reports relating to turnover and compliance with PADR's as follows: • Turnover: The Trust has seen a slight increase in turnover in month with work life balance being the top reason for staff leaving. JSp added that work is ongoing to improve the uptake of the exit interviews as we have found some discrepancies between detail in the exit interview and detail recorded on ESR.	

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	• PADR compliance: JSp informed the Board that the workforce team are currently working with the Divisions to improve performance. In addition, the alignment of pay progression dates to PADR dates commenced from 1 April 2021. JSp further informed the Board that improvements have been seen in BLS mandatory training but compliance with ILS training remains a challenge and discussions are taking place with the Divisional Director of Acute Services in order to understand what needs to be done to improve compliance. JW sought clarity on some of the reasons that staff are leaving noting that for some, the Trust does not have any control over them but for others such as lack of career opportunity, bullying and harassment and management style, is there anything we can improve on. JSh confirmed that exit interviews are key within the process and that we are not seeing any trends in any particular areas. JSh informed the Board of the recognition for staff in the form of a £25 voucher and a Health and Wellbeing pass that has now been arranged. KD thanked the team for putting the recognition award in place and noted that the Performance Committee had reviewed the full Integrated Performance Report in detail. **The Trust Board:** • **Noted** the content of the report.	
P1-85-21	**Cheshire and Merseyside Cancer Alliance Performance Report** LB introduced the report highlighting that recovery is going well although the number of patients waiting for diagnostics is fluctuating. In addition, the number of patients who are waiting for cancer surgery is fluctuating with 260-280 having had their surgery. The number of patients who are waiting over 62 days remains higher than pre-Covid levels but is slowly reducing. LB highlighted that the narrative to graph 6 was correct but the graphics were a repeat of graph 5. In addition, LB informed the Board that the Cancer Alliance was currently funding cancer management support in one organisation and concluded that the recovery is slow and steady against the restoration plan. TJ added that generally the impact on staff is hard and that the absence rate is significant at the moment in other organisations. LB added that although there is a need to increase the throughput in	

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	diagnostics, there is recognition that staff are tired and that we need to look after staff. KD sought commentary from AE in relation to the thoughts of staff with AE highlighting that staff do feel tired and there is a backlog of work to get through in addition to the mutual aid that we are providing to other Trusts. On behalf of the Board, KD thanked all staff for their hard work adding that we need to keep the supportive messages going to staff. **The Trust Board:** • **Noted** the content of the report.	
P1-86-21	**Finance Report: Month 01** JT introduced the finance report for Month 01 highlighting that the Trust's financial position is on plan and budgets are now locked down for the next financial year. JT added that we have an efficiency plan and whilst this has not affected our H1 position, we do have a plan for H2 recognising that some of the efficiencies will be non-recurrent. In addition, the capital schemes will mature over the coming year. JW sought clarity on the funding for the work to be carried out on the terraces at CCC-L with JT confirming that a procurement process has been completed for the work required on the terraces which is subject to the final due diligence stage. JW asked the total final cost with JT confirming this at £230K plus VAT. EA sought clarity on how the CIP targets are allocated to each department with JT confirming that departments go through a simple allocation process based on expenditure and costs. **The Trust Board:** • **Discussed and noted** the financial position at Month 01.	
P1-87-21	**Board Assurance Framework** AW introduced the revised Board Assurance Framework that has been developed as a result of the new 5 Year Strategic Plan. Discussion ensued in relation to the detail and how the Board Assurance Framework will be used going forward with AW confirming that the section relating to controls, assurances and gaps will be completed over the coming weeks and those risks aligned to the Board Committees will start to feature on the agendas to facilitate this being a working document. AY sought clarity on how the new risks link with the cover sheets for papers with AW advising that the report cover sheets are in the	

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	process of being re-designed and will feature the new risks. GB requested that as the risks are reviewed, it would be helpful to see arrows in the summary section to enable the Board to see at a glance any movement in risk rating. The Board further discussed the risk appetite statement and all agreed they remained content with the statement as drafted. TJ added that it is helpful to see how the Strategy and the Board Assurance Framework fit together as a working document. **The Trust Board:** • **Discussed and approved** the new Board Assurance Framework.	
P1-88-21	**Board Meeting Review** In reviewing the Board, KD highlighted, and the Board agreed that continuing to receive the reports from the Committees at the beginning provides a good framework for the Board. KD sought comments from the Board as to anything that could be done differently with none noted. KD thanked the Executive team for a good Board meeting.	
Any other business		
	SS wished to say thank you for the flowers he received at the time of his mother's death, wished JW a happy birthday and highlighted that he used to receive Board agendas and minutes; AW confirmed that they are all available on the public facing website in advance of the Board.	

Next meeting:

Date: Wednesday 30 June 2021	Location: MTeams
Start time: 09:00 hours	Finish time:

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

						P1-076-21
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	Deferred to July 2021
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 July 2021
P1-50-21	31-Mar-21	Staff Survey Results	Action Plan from the Staff Survey Results to Board in due course	**JSh**	Jul-21	
P1-80-21	26-May-21	Patient Story	Letter to be drafted from KD to the Chair of The Walton Centre	**AW**	Jun-21	**Completed**
			Detail of the patient story to be shared with the wider Trust in addition to putting mirrors in all MRI scanners.	**AE**	Jul-21	

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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:	24 June 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: Update QC-115-21		The committee received an update on the progress to date. The committee were assured that work was progressing in line with plans. There had been a minor disruption in Environmental Monitoring, the root cause had been identified and mitigated, the overall planned timescale for mobilisation to CCC-L should not be affected. The impact on clinical trials was again discussed, it was noted that capacity had increased since 9th June due to cold chain issues being resolved. There had been no issues with late or expired drugs due to the approved extension of expiration times to one week. It was noted that 54 studies were sitting in the backlog due to the impact of the issues within the Unit, and that no new studies had been opened for 16 weeks.	The Committee would continue to receive monthly progress reports until sufficient assurance was received.	KF/JSp	Ongoing
Research & Innovation Chair's Reports QC-133-21		The committee discussed the risks surrounding the ECMC, It was requested that further detail could be provided, in order for the committee understand and quantify the	The committee requested a further deep dive on the risks surrounding the ECMC, to be presented at the July meeting.	GH	July

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
		key risks impacting the renewal application and the mitigations in place.			
Annual Risk Report QC-122-21		The committee received the report highlighting a 37% increase in incident reporting, following the move to CCC-L, and remaining at a high level. It was noted there had been no increases in harm which was a positive indicator of a cultural change in incident reporting. The committee sought assurance on the high levels of incidents being reported under the communications category, it was agreed that subcategories were to be introduced to enable identification of the exact issues/risks. The committee requested further clarification on the reported increases in pressure ulcers particularly in Wards 2 & 3. It was agreed further details would be sought from the divisional nurses and reported back to the committee.	Two separate papers were requested by the committee: I. A deep dive on those risks/issues recorded under the Communications category. II. A paper on trends within the Communications category relating to virtual consultations. Clarification on pressure Ulcer increases to be provided to the committee	NB/JSp NB/SK JSp	July July
JACIE Accreditation Preparedness QC-127-21		The committee received an assurance 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. Details were provided on the progress to date and further actions required. The committee received assurance that the risks surrounding JACIE accreditation were being captured on Datix, however were currently scoring below 12, and not currently requiring escalation to Board committees.	none		
Risk Register QC-120-21		The committee welcomed the revised format of the Risk Register which clearly separated current issues from emerging risks.	Revised Risk Register would continue to be presented to the committee monthly.	NB/JSp	Ongoing

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
		The committee noted that risks could now been viewed across multiple divisions and ownership could be shared across Board Committees. The committee discussed the cultural changes being implemented across the Trust and noted it would take some time for all divisions to adjust to the new reporting standards, training would continue with divisional leads.			
Clinical Governance - Action Plan Progress QC-119.21		The committee received the action plan and noted the current position, progress and key actions. The committee agreed sufficient assurance was received on the progress and that future reports could move to quarterly	It was agreed that action plan progress reports could now be provided quarterly	MW/JSp	Sept 2021
Datix Cloud IQ Update Report		The committee received the progress report, providing sufficient assurance that implementation on the Datix Cloud IQ was within the planned timescales and that targets were being met, following the development of workstreams at the stakeholder event.	Progress report on Datix Cloud IQ progress to next be presented to the committee in September	MW/JSp	Sept 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

CHAIR'S REPORT

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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: 23 June 2021	Parent Committee:
Chair: Mark Tattersall	Quorate:Yes

Agenda item	RAG	Key points	Actions required	Action lead	Expected date of completion
External Audit Findings Report		The Audit Committee was concerned to note that, despite assurances received at the first extra-ordinary Audit Committee on 26 May 2021, the audit of the Accounts and Annual Report had not been completed.	Representatives from Grant Thornton to complete the audit work. The planned extra ordinary Trust Board meeting has been stood down and re-scheduled for Monday 28 June 2021.	CW (of GT) AW	Prior to 28 June 2021. Board re-scheduled.
Draft Annual Accounts		The Audit Committee was not in a position to recommend to Trust Board approval of the Annual Accounts as the audit has not been completed. However, the Committee noted there were no material changes to the draft Accounts from the previous meeting in May when the Committee reviewed the draft Accounts.	For further consideration following completion of the audit and consideration at the Audit Committee on 28 June 2021.	CW (of GT)	Prior to 28 June 2021
Going Concern: Management Assessment		The Committee received and discussed Managements' Going Concern assessment, confirming that the Audit committee was content with the Trust confirming that it considers there is sufficient liquidity in year that the requirements of the going concern test are met.	Recommend for approval.	JT	28 June 2021

CHAIR'S REPORT

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Draft Annual Report and Annual Governance Statement		The Committee reviewed the draft Annual Report and Annual Governance Statement noting the amendments that had been completed. The Audit Committee was content to recommend to Trust Board approval of the Annual Report and Annual Governance Statement.	Recommend approval at the extra-ordinary Trust Board.	AW	28 June 2021
Provider Licence Conditions: Compliance		The Audit Committee noted and discussed the self-certification against: a) Condition G6 – the Trust's systems for compliance with Provider licence conditions and related obligations; b) Condition FT$ - compliance with governance arrangements; c) Training of Governors. The Audit Committee approved the self-certification and recommend Trust Board approve the same.	Recommend approval at the next extra-ordinary Trust Board.	AW	28 June 2021

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	30th June 2021
Agenda item:	P1-097-21
Title:	Patient Experience Visits
Report prepared by:	Kirsteen Scowcroft – Head of Patient Experience & Inclusion
Executive Lead:	Joan Spencer – Chief Operating Officer/ Interim Chief Nurse
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	
Date & decision:	

Purpose of the paper/key points for discussion:	The purpose of this report is to provide Trust Board with oversight and key summary observations during the Patient Experience 'rounds' conducted on the 17th June 2021 at the CCC Wirral site.

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

Next steps required:	Quality Committee are requested to; • Note contents of report • Recognise the achievements to date in the current challenging climate • Request further updates as required

REPORT COVER

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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

Patient Experience Visits 17.06.2021

Kirsteen Scowcroft, Head of Patient Experience and Inclusion

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

1. Summary

Patient Experience 'rounds' were conducted on the 17th June 2021. Visiting Delamere chemotherapy unit, main reception, radiotherapy and radiology imaging main waiting areas at CCC Wirral site. Unfortunately, due to the recent Covid restrictions across all CCC sites to reduce footfall and visitors announced on the 16th June 2021. Kathy Doran, Chair and Myfanwy Borland, Governor, were unable to accompany the Head of Patient Experience 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

- Praise and compliments for all the staff working on Delamere, no matter how busy they are, they treat patients with kindness and compassion from those visiting for the first time to those who have visited a number of times.
- Patients shared their experiences and frustrations with poor communication across the NHS in general. Examples include, waiting for scan result feedback from Consultants, long waiting times and often with no update provided as to how long their wait will be, having to tell and painfully relive their cancer diagnosis and journey due to another organisation not having access to their records, with Organisations not being more joined up and sharing patient care records effectively and cohesive integrated care across the local health and social care system. Although one patient did add that in CCC's case they felt that communication with secondary care hospitals had been particularly excellent in comparison with other hospitals.
- In particular, two female patients on Delamere stood out, during the visit. They shared how difficult it has been for them over the past year and struggling with their own mental health and the impact of their cancer diagnosis. One patient was attending CCC for the very first time and another with a terminal diagnosis, who has attended frequently. It was heart-warming to hear from both, how the patient visiting for the first time had been taken under the others 'wing' and that peer patient support had helped to reduce anxieties and make the chemotherapy appointment and first encounter at CCC a much more enjoyable one. They plan to keep in touch and hopefully will have their next cycle of chemotherapy, on the same day and time in a few weeks. In their own words, giving them both something to look forward to and helping in part to help each other's mental health and wellbeing together.
- Consequences of the recent visitor closure re-imposed on the 16th June 2021 speaking to staff, volunteers and patients is that it is causing additional anxiety

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

and stress for all involved and some verbal abuse directed towards the main reception staff. I witnessed a patient attend for their appointment with two visitors, the main reception staff calmly and professionally challenged and checked Meditech electronic patient record to ascertain that the patient had a flag on the system requiring assistance from visitors to their appointment and directed them towards Radiotherapy 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

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	30th June 2021
Agenda item:	P1-099-21
Title:	Bi Annual Safer Staffing Nurse Review – Inpatient wards Q4
Report prepared by:	Karen Kay – Deputy Director of Nursing
Executive Lead:	Joan Spencer – Interim Director of Nursing & Quality
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Quality Committee
Date & decision:	24 June 2021

Purpose of the paper/key points for discussion:	The purpose of this report is to provide the Trust Board with oversight and assurance regarding the Clatterbridge Cancer Centre safe staffing position. This is a mandated report that provides a Bi-Annual position regarding safe staffing achieved across inpatient wards during Q4 This piece of work provides assurance to Trust Board that CCC Matrons are 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 report content adheres to the guidance set out in the National Quality Board (NQB) – Safe, sustainable and productive staffing (2018). The Board is requested to: • Note CCC is compliant with safe staffing • Receive the report and acknowledge the content • Note progress/work undertaken to date re safe staffing • Recognise the impact on the nursing model due to the extended footprint and environmental challenges evident at CCCL • Request further updates as required

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

Next steps required:	Continue six monthly reporting to Board.

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.

The Clatterbridge Cancer Centre
NHS Foundation Trust

2020 - 2021 Bi-Annual Safe Staffing Nurse Review

Inpatient Wards; Quarter 4 Position

Author:

Karen Kay – Deputy Director of Nursing
Emma Daley – Matron, Inpatients Acute Services
Priscilla Hetherington – Matron, Inpatients Acute Services

Presented to Quality Committee on 24 June 2021

Appendix 1

Safe Staffing Review - 4 week study; Acuity Measurement, Triangulation and report re CCC Inpatient Areas

1. Purpose of report

To provide Quality Committee with oversight and assurance regarding Clatterbridge Cancer Centre NHSFT (CCC) safe staffing position.

2. Context

This report provides the bi-annual strategic update regarding the inpatient wards during quarter 4 (Q4), 2021 at Clatterbridge Cancer Centre. The purpose of this piece of work is to provide assurance to Trust Board that Matrons are taking a patient-centred, evidence-based and systematic approach to determine the number and skill mix of staff required in order to deliver safe care to our patients. This, along with exercising professional judgement to meet specific local needs, ensure that arrangements are in place to safely staff our wards, providing the right number of nurses, with the right skills, at the right time.

The report content adheres to the guidance set out in the National Quality Board (NQB) - Safe, sustainable and productive staffing, 2018. It is important to take a rigorous, evidence based approach to workload and workforce planning, to ensure safe and effective staffing that reflects patient care needs and promotes a safe environment for staff and patients. All wards vary and the leaders must take into account factors such as ward layout, geography and estate when calculating staffing needs. This information will be utilised as part of the nursing workforce planning process going forward.

High patient acuity and dependency linked to low staffing levels can have a profound impact on the quality of patient care, as demonstrated through enquiries into failures at Mid-Staffordshire NHS Foundation Trust and the Keogh Reviews.

3. Local Context

There is a requirement post publication of the Francis Report 2013 and Safe Staffing in Adult inpatient wards in acute hospital (NICE, 2014) that all NHS organisations will make a bi annual report to their Board on staffing levels and whether they are adequate to meet the acuity and dependency of their patient population. During the last 12 months the Trust has experienced unprecedented times. The Clatterbridge Cancer Centre (CCC) has responded to the International Covid-19 pandemic as well as opening our new flagship hospital June 2020 in Liverpool.

Monitoring the acuity and dependency on the inpatient wards ensures processes are in place to support the provision of high quality care, continuous improvement and transparency in workforce planning. This fosters an open and honest culture where staff feel safe to raise concerns regarding safe and effective staffing, using the Datix process and Red Flag Event (RFE). There is growing research evidence linking nurse staffing levels and patient outcomes.

In addition, staff experience and the efficiency of care delivery is dependent upon the right number and mix of staff in the right place, with the right skills to enable the provision of high quality care – first time, every time.

4. Methodology

4.1 20 Day Acuity Audit

The 'Safer Nursing Care Tool' (SNCT) was used to capture the acuity and dependency data of all inpatients over a four week period between 11th January 2021 and the 5th February 2021 (20 days). During the study the data was collected Monday-Friday at 3pm, to allow for the capture of data during periods of increased activity.

The Ward Leader scored the acuity of the patients under their care. The scores were then assessed by the Matron to avoid individual bias. The SNCT contains defined classifications of levels of care and measures the acuity and dependency of those patients whose needs are met through normal ward care (Level 0), through to those patients who require advanced respiratory support and therapeutic support of multiple vital organs (Level 3). (Appendix 1)

A key principle of the Trust's framework for assessing nurse staffing requirements is the *triangulation* of SNCT data with professional judgment and clinical quality indicators. This then creates an acuity and dependency diagnostic for each ward. The acuity report is not used in isolation as experience tell us that when reviewing the data it is important to take into account the skill mix, strength of ward leadership and occupancy, as well as acuity, patient activity and dependency.

The report compares the actual funded whole time equivalent (RGN & HCA) nursing staff with the assessed whole time equivalent needed during the 20 day acuity audit. The audit figure is a baseline against which to set nurse staffing levels; wards have varying degrees of activity therefore nursing professional judgment is vital to ensure that establishments are adjusted appropriately under these circumstances along with the clinical quality indicators.

Professional Judgement could include:-

- Ward layout/facilities
- Escort duties
- Shift pattern
- MDT working
- Family support required

Critical understaffing

This is defined as 25% or 8 hours per shift below the required level or patient to nurse ratio exceeding 8:1 under normal circumstances. This should be recorded on Datix as a red flag event. As workforce flexibility is key to responding to these shortfalls in staffing due to vacancies, sickness or increased acuity, all efforts are made daily by the nursing leadership team to ensure patients are cared for in a safe environment. Temporary staffing (bank/overtime/agency) is being used to fill gaps in rosters to support this as well as nurse deployment from across the Trust.

4.2 Safer Nursing Care Tool

The Safer Nursing Care Tool (SNCT) provides a multiplier to translate patient acuity and dependency into a staffing requirement which supports the Matron and Ward Leaders to assess safety on the wards.

This needs to be used in conjunction with the triangulation approach utilising all available data that has an impact on safe staffing. Bed occupancy alone is not a robust measure of safe nursing numbers, as it does not reflect the complexities of patient care.

When this tool is used to undertake a safe staffing audit at a particular point in time (eg 20 day period), it does not provide leaders with the ability to robustly flex the workforce when required – to achieve this dynamic, daily acuity assessment is necessary.

Daily acuity recording and monitoring is evident across all inpatient areas via the implementation of the “Allocate” module as a component of the E-Roster Safe Care Project. This system utilises the Safer Nursing Care Tool (SNCT) to determine patient acuity on a daily basis (recorded 3 x per day) which will ensure a more robust, accurate overview is provided to nurse leaders. This enables enhanced triangulation of safe staffing data to be undertaken. The methodology incorporates complexities of care, which will help to support nurse leaders to flex their workforce with improved resilience and safety.

4.3 Covid-19 Pandemic – Emergency safer staffing

The coronavirus pandemic required NHS staff to work in new ways and in new settings. At times it has also been a necessity that staff work beyond their existing scope of practice or in a context that was unfamiliar. During these unprecedented times further clinical considerations were required to "current staffing ratios" to enable them to be "fit for purpose" during times of emergency.

An extensive piece of detailed work was undertaken across CCC in collaboration with matrons, senior nursing/management teams across the directorates, led by the Deputy Director of Nursing (DDoN). In conjunction with; skill mix, service sustainability, guidance from professional/external regulators and professional judgement, revised registered and non-registered emergency nurse staffing ratios were agreed.

There is currently no recognised emergency nursing workforce planning tool therefore directorate Matrons, together with the DDoN agreed that the safe staffing review would be undertaken in Q2 2020/2021 utilising the Professional Judgement Model (PJM).

The PJM draws on the experience of skilled staff and promotes engagement and ownership of workforce plans. Its application is recommended by national nurse leaders as a critical component of the workforce planning process.

A national benchmarking exercise was undertaken and assurance was gained regarding revised ratios. The amended emergency safer staffing patient to registered nurse ratios were in line/superior to the other two principle cancer centres and more favourable than our local acute sector colleagues.

5. Conclusion

During the last 12 months (including the challenges of managing a global pandemic whilst moving our main hospital over to CCCL) there have been a plethora of focused work undertaken to ensure our inpatient areas achieve safe staffing levels, however there is not one data measurement alone that can achieve this outcome. CCC going forward is now in a much stronger position with the launch of Safe Care (3x day patient acuity monitoring), the support from NHSP regarding filling ad hoc staffing gaps and strengthened recruitment and retention processes.

In the current unprecedented climate, safe staffing has been a major concern across the country (and internationally) and a myriad of initiatives have been implemented nationally, regionally and locally to enable a sufficiently skilled nursing workforce to be available to support patients at their time of need.

The move to CCCL has added further complexities into this scenario and (as with the majority of new hospital build projects) already staff have faced the significant challenge of adapting to new ways of working, having lost the organisational intelligence they previously had, whilst becoming familiar with a new hospital that has all single en-suite inpatient rooms.

It is expected that safe staffing/workforce reviews will be taking place across the organisation for a period of 12-18 months whilst services embed within the new environment. Patient acuity data provided by Safe Care will support the reviews and determine "real time" staffing information for the matrons and ward leaders, to enable dynamic, informed decision making re: staff allocation to be undertaken.

6. Recommendations

Quality Committee is requested to:

- Note CCC compliant with safe staffing
- Receive the report and acknowledge the content
- Note progress/work undertaken to date re safe staffing
- Recognise the impact on the nursing model due to extended footprint and environmental challenges evident at CCCL
- Continue with current nursing model to ensure the Trust is prepared for the expected increase in activity as part of recovery plans.
- Request further updates as required

APPENDIX 1 – Safe Staffing Review – 4 week study; Acuity Measurement and Triangulation CCC Inpatient Areas

A full breakdown of patient acuity and dependency by ward is shown below. This data represents the outputs of the acuity tool and does not take into account the recommended triangulated approach and thus **should be considered as a singular measure of safe staffing**.

Table 2: Acuity assessment (Across 20 days Jan/Feb 2021)

CCC – Liverpool (CCCL)								
Ward	**Levels of Care Daily Average over 4 week audit**					**Nursing Establishment WTE**		
	L0	**L1a**	**L1b**	**L2**	**L3**	**Funded**	**Recommended**	**Gap**
Ward 2	0.20	13.1	21.2	0	0	41.40WTE	34.5	+6.9
Ward 3	0.40	12.7	17.4	4.8	0	41.40WTE	35.25	+6.15

*****The funded figure is the budget for trained nurses and health care assistant's delivering direct patient care

CCC – Liverpool (CCCL)								
Ward	**Levels of Care Daily Average over 4 week audit**					**Nursing Establishment WTE**		
	L0	**L1a**	**L1b**	**L2**	**L3**	**Funded**	**Recommended**	**Gap**
Ward 5*	0	0.6	12.64	5.3	0	42.98 wte****	24.7	+18.28
Ward 4**	0	0	28.81	1.3	0	40.99 wte***	35.88	+5.11

*Ward 5 data is based on reduced number of stem cell transplants admissions during the audit period due to COVID-19. Stem Cell Transplant patients are considered Level 2 patients.
** Ward 4 data is based on 20 Beds
***The funded figure is the budget for trained nurses and health care assistant's delivering direct patient care and includes the ward manager.
****The funded figure is based on workforce plans to deliver 15 in-patient beds (12 BMT beds and 3 TYA beds) plus 4 TYA out-patient chairs.

The positive gap highlighted for Wards 2,3,4 was created through the triangulation of other safe staffing data, predominantly professional judgement and environmental influences. It is anticipated that these figures will be amended further over the next 12-18 months. Ward 5 positive gap includes staff for inpatient and daycase TYA beds/chairs.

Divisional Safety Data

The above acuity data is reviewed and assessed alongside the added dimensions of nurse sensitive indicators and local context to produce an overview of staffing requirements. Whilst utilising a combination of objective and subjective measures, the triangulated figure then represents the appropriate level of staff and skill mix for the wards. (During 20 day audit)

Safe Staffing Review Jan/Feb 2021

Division	Ward	No. Beds	Bed Occupancy	Skill Mix RGN:HCA %	CHPPD	Turnover Rate 12 months	Sickness %	Shifts covered by NHSP/Overtime/Agency	Shifts not covered RGN & HCA	Falls		Pressure Ulcers		Medication Errors	Formal Complaint linked to ward based care	Incidents forms related to safe care (RED FLAG EVENTS)
										Attrib-utable	Lapse in Care	Attrib-utable	Lapse in Care			
Acute Services	Ward 2	26	84%	62:38	6.2	37%	8.61%	95 NHSP £0 overtime spend £0 Agency spend	45	3 0 0		3 1 0		1 (Prescription error)	1	0 **No RED FLAG EVENTS**
Acute Services	Ward 3	25	88%	62:38	7.0	30.6%	5.53%	64 NHSP £0 overtime spend £0 Agency spend	76	2 0 0		3 2 0		4 (2 Admin errors) x1 Local review	0	4 **RED FLAG EVENTS** (None escalated to DDoN)
Acute Services	Ward 4	17	< 90%	67:33	9.6	14%	10.84%	85 £0 overtime spend £0 Agency spend	8	0 0 0		1 1 0		11*	0	0
Acute Services	Ward 5	15	< 80%	77:23	13.9	7.6%	7.97%	47 £0 overtime spend £0 Agency spend	0	2 0 0		0 0 0		0	0	0

*Medication errors are across Wards 4 and 5

Bed occupancy fluctuated across the 20 day audit with reduced numbers of Bone Marrow Transplant patients admitted. Skill mix ratios reflect workforce plans and care hours per patient day and remain similar to previous audit demonstrating a stable staffing picture despite a high turnover rate on Wards 2 & 3. Sickness is above Trust target on all wards, reflected in the demand for NHSP shifts. Only Ward 3 reported red flag staffing incidents although zero were escalated to the DDoN, as all were safely addressed at Divisional level.

Patient Safety Indicators

Pressure Ulcers

- 7 Grade 2 pressure ulcers identified during this time period. 4 attributable to the CCC, zero lapses in care identified following investigation.

Lessons learned highlighted:-

Documentation:

- Robust information to be captured on the interventional rounding chart as well as Meditech.
- Ensure Waterlow Score is consistent across documentation.
- Skin inspection to be completed and documented on admission.
- Wound assessments to be completed.

Falls

- 7 Falls identified during this time period, zero lapses in care identified following investigation.
- Ensure food and drink is placed within easy reach of patient
- Falling leaf not in place to indicate falls risk.
- Remind patients to always use nurse call bell for assistance when directed
- Consider earlier use of rambleguard.

Good Practice Identified

- All appropriate interventions undertaken for two patients.
- Nursing care required was delivered to all patients.

Clatterbridge Cancer Centre (CCCL) Inpatient Safe Care Review

1. Introduction

Safe staffing is about having enough staff with the appropriate skill mix for the acuity and dependency of the patient group. It needs to take into account the size and complexity of the unit (CCCL) and should have the ability to flex at short notice to fill with temporary staff when there are unplanned vacancies and/or an un-planned rise in patient acuity. It should be noted that the level of patient care can be subjective and professional judgement must be used alongside any acuity results.

When assessing safe staffing levels it is important that the focus is not just on the acuity results but other factors such as ward layout, general environment, and patient specific care needs alongside professional judgment. It should be noted that the measurement of a patient's level of need can also be subjective, dependent on any given set of circumstances.

Whilst we are aware there are slight differences in the measurements undertaken by Solid Tumour and Haemato-oncology for the purpose of this report we have maintained consistency with previous reviews. Following further planned engagement with Shelford Safer Nursing Care Tool (SNCT) national team, we will have a CCC model going forward which will ensure standardisation, specifically for cancer patients across all areas.

2. Environment

Following the move to CCCL all patients are now being cared for in single en-suite rooms for the duration of their stay. Where possible patient cohorts have remained:

- Ward 2- Common and Rare Solid Tumour Cancers
- Ward 3- Intermediate Solid Tumour Cancers
- Ward 4 - Haemato-Oncology Cancers
- Ward 5 BMT - Stem cell transplant unit

Each ward has a similar layout. The wards are generally larger and resources less favourably positioned. All wards have single bedrooms only, which make observations of patients more challenging. In addition there has also been a significant reduction of visitors, as a response to Covid-19 Government guidance which has required nurses to increase their time spent and visibility with each of their patients in their own rooms.

Nursing teams have started to familiarise themselves with the new environment and are using technology where available to enhance safer care. The Covid-19 pandemic has further impacted nursing care models on Ward 3. Segregation within one area of patients on 'Amber and 'Red' Covid-19 pathways, has resulted in a spread of the nursing workforce. This has regularly left higher ratios of patients to Registered Nurses and noted during the audit period nurse redeployment from across the trust was initiated to support, (4 Red Flag Events).

3. Activity

This review has continued to note bed occupancy figures below the national average:

Ward 2 - 84% and Ward 3 - 88%. Occupancy levels have been below the average Covid-19 National Directive Target of 92%.

Ward 2 and 3. Occupancy has generally showed an upward trend throughout the year. Non-elective admissions, including mutual aid admissions from local trusts, have been admitted to both wards and elective admissions predominately Ward 2. The nursing workforce has had to adapt at pace to changes in clinical pathways, working relationships and new services.

Ward 4 occupancy levels have been below the average Covid-19 National Directive Target of national average of 92%. Ward 5 occupancy is below the National Target at 80%.

Reduced Bed occupancy on ward 5 is a reflection of the reduced number of transplants carried out in the CCC Bone Marrow Transplant Programme in line with national guidance. This is comparable nationally as a result of the Covid-19 pandemic. Nationally in the first six months of 2020 there was a 60% reduction in allogeneic transplants and a 50% reduction in autologous transplants (British Society Bone Marrow Transplant Data). Wards 4 and 5 have also taken mutual aid admissions from other trusts to ensure patients across Cheshire and Mersey have access to timely Haemato-oncology care.

4. Safe Rosters

Sickness levels across all inpatient areas were above trust target during this period, which has been the general trend over the year and likely to be related to the Covid-19 Pandemic. Annual nursing workforce turnover rates have remained under trust target on Ward 4 and 5, and on Ward 2 and 3 significantly higher.

There were 4 incidents related to staffing issues reported for Ward 3 during the audit period. Patient to Registered Nurse ratio was ‘Amber’ on each occasion. This was largely as result of the nursing team segregation in the ‘Red Zone’. They were escalated appropriately to the clinical leadership team. Leadership presence was increased on the Ward where possible and the staff were redeployed from other areas to ensure patient care was not compromised. Unfilled duties were offered to NHSP bank staff as per safe staffing process; however there was a number of shifts unfilled however safe staffing was achieved following local resolution.

5. Patient Safety Incidents

There has been an increase noted in the number of pressure ulcers (improved reporting and increase in patients with known PU admitted from home/community facilities) and falls during this audit period compared to the previous audit in August 2019/September 2020 although there is no increase trend noted over the year and all incidents relating to safe patient care are monitored and investigated through the Harm Free Collaborative and clinical governance structure.

6. Leadership Review of Acuity Findings:

Ward 2 - Common and Rare Cancers

The results of the acuity study on Ward 2 generally show a trend of Level 1a and Level 1b patients. Occupancy levels and acuity levels can rapidly change as elective admissions are generally higher at the beginning of the week and curtail towards the end of the week. It should be noted that coordinating complex chemotherapy regimens demands a minimum of x1 Registered Nurse per shift, whilst also supporting increasingly high level of vulnerable and complex patient care.

Ward 3- Intermediate Cancer

The results of the acuity study on Ward 3 again show a trend of Level 1a and Level 1b patients, however a number of Level 2 patients is also evident (19 in total across a 9 day period).

This is likely to be explained by utilisation of closer monitoring beds (previously known as Step Up) and patients on a 'Red Covid pathway'. These patients are acutely ill, have complex care needs and require closer supervision with higher levels of registered nurse intervention required, including a Registered Nurse escort when leaving the department for any required intervention.

Ward 4 – Haemato-oncology

The results of the acuity study during the audit period have shown consistency with previous studies demonstrating high levels of Level 1B patients. The number of Level 2 patients is reduced, which correlates with the reduced transplant programme resulting in less post-transplant patients being admitted to ward 4. These patients would normally be high acuity patients.

The number of Level 2 patients in this review is consistent with the number of acute leukaemia patients (AL) from the region (mutual aid) and the number of CNS Lymphoma patients from Aintree. Both these patient cohorts are vulnerable and complex due to the aggressive chemotherapy regimens, immune-suppression and treatment complications. A number of these patients can often require a transfer to intensive care services.

Ward 5 – Stem Cell Transplant Unit

The results of the acuity study during the audit period show an increase in the number of Level 1B patients and a decrease in the number of Level 2 patients. This is consistent with the reduction in the number of stem cell transplant admissions. As a result the number of Level 2 patients in this review is significantly below (33%) of the previous audit total, the number in the last review.

The funded WTE for Ward 5 includes 10.16 WTE for 3 in-patient TYA beds and 4 TYA out-patient chairs (Solid Tumour and Haemato-oncology). TYA patients are currently being cared for across all of the inpatient wards and patients are placed dependent upon need. Due to Covid-19 the opening of the TYA inpatient beds and Outpatient chairs had been paused. TYA unit opened in June 2021.

7. Matrons' - Professional Judgment and Recommendation

The inpatient nursing workforce has adapted too many changes over the last 6 months. The move to CCCL has brought about significant changes in environment, in particular single room nursing care model, new services and new working relationships. In addition the impact of the constantly revised Infection Prevention and Control rules influenced new ways of care delivery.

The senior nurse team monitor gaps in workforce and successfully recruit to vacant posts as they arise. Higher sickness levels have been challenging and the support from the wider nursing team across the organisation has been welcomed. The SNCT is embedded across all inpatient wards and acuity data is reported thrice daily. There have been a number of delays in the roll out of training in the use of the SNCT across the nursing workforce due to Covid-19 that may have influenced the accurate recording of data. It should also be noted that the tool is only one of the measures utilised to ensure safe staffing is achieved.

As the landscape in nursing will continue to evolve and change in response to the pandemic it is recommended that bi-annual safe staffing audits should continue.

As the NHS attempts to recover from the impact of the pandemic on cancer services our Trust is preparing for a significant increase in activity, therefore it is advisable to continue with the workforce models as planned, to ensure adequate nurse to patient ratios for the coming year.

This will be continuously monitored and revised according to need.

Medicine, technology and healthcare is continually changing and evolving. Safe staffing levels aren't just about numbers, they are also about ensuring staff are equipped with the skills and knowledge to deliver safe, effective, evidence based care. The quality of our education and training has a huge impact on outcomes for patients as well as on our ability to attract, recruit and retain experienced staff. This includes supporting the trainee nursing associate programme and the care certificate for health care assistants.

We know that healthcare practice is only as good as its staff, regardless of the reasons; low morale in staff requires a proactive response. One of the simplest ways to boost staff morale is through effective communication, letting them know that their opinions are appreciated, including them into matters that directly affect their team and creating a sense of purpose, giving them room to grow and develop.

8. Actions

Mitigation plans include:

The Matrons across inpatient wards use the safe staffing daily spreadsheet to monitor staffing levels and take corrective actions. This includes the following process:

- Staffing levels are RAG rated at the start of each shift (Red/Amber/Green) according to the professional judgment of the nurse in charge of each shift.

- Green shifts are determined by the nurse in charge to be safe levels as these constitute the levels expected through the ward establishment or not as expected but professionally judged as clinically safe according to the current ward workload.
- Amber shifts are considered, by the nurse in charge via professional judgment, to require minor adjustment to bring the ward to a safe staffing level, as staff numbers are not as expected or staffing numbers are as expected, but additional staff are required due to an increase in acuity workload. Staff will prioritize their work and adjust their workload through the shift accordingly. The matron will be alerted and mitigating actions would be put in place and recorded on the database.
- If the shift is rated red the nurse in charge will alert the matron that action is required, as potentially the shift will present a shortfall of staff that is below minimum levels to deliver safe care. Mitigating actions will be taken, and documented, which may constitute the movement of staff from another ward, or temporarily reducing the ward capacity and activity to match the staff availability.

Red shifts will be escalated to the General Manager who will monitor the actions being undertaken. The use of NHSP staff for high acuity patients/periods are also identified by the Ward Manager and Matron. Continued education to all staff about escalation and raising the red flag is in progress. Extra HCA's on night duty are utilised to support changes in acuity.

9. Challenges & Risks

Nurse Bank/Flexibly to variations in patient care: The successful implementation of NHSP has been completed. The Deputy Director of Nursing and Workforce and Organisational Department (WOD) worked collaboratively to review and plan a new process to support safe staffing; to cover vacancies, short and long term sickness, maternity leave or increased activity/1:1 care. Operationalisation of NHSP has supported a more robust temporary staffing position. This process supported the leadership team to respond to fluctuations in patient care and ensure safe staffing can be provided. Collaborative working with NHSP has demonstrated increased availability of RNs and HCSW support to the Trust, from staff outside of CCC.

10. Recruitment

Effective recruitment is a key priority for the Trust and a strong recruitment and retention plan has been produced to support staff turnover and future workforce planning. Challenges continue to enable a full inpatient nursing establishment to be achieved with the national vacancies for Registered and Non-Registered nurse >35%. We are recruiting in a highly competitive market and need to ensure that we can proactively recruit the best nurses to CCC to enable staffing stability to be achieved in all areas. Robust recruitment and retention plans are in place and the DDoN is leading the organisational recruitment drive with the aim to achieve a zero vacancy factor across our inpatient (registered/non registered) nursing workforce.

Challenges continue in recruiting experienced Registered Nurses to CCC which we predict will continue due to the current national shortage of RN's. We have filled a significant number of vacancies with newly qualified nurses (NQN) which has increased the pressure on our experienced staff; this is further complicated by the length of time (recruitment pipeline) it takes

to recruit successful candidates into post – on average 4-6 months lead time. Recruitment has improved following the move to CCCL. Staff who did not want to travel over to Liverpool have been supported and realigned within CCC services or left the Trust to achieve a better work/life balance.

The Trust is involved in two national recruitment initiatives:

Pan Mersey Collaborative;	Recruitment of registered nurses from Europe and across the world, ensuring a sustainable process that benefits the nurse, their country of origin and the system.
Health Care Support Workers (HCSW):	National recruitment of HCSW via a robust recruitment and retention process, facilitating individuals to be recruited who have no previous health/social care experience. Strengthened levels of pastoral support, clinical education/supervision and supernumerary status are incorporated in the new programme. The delivery of Trust and local induction is also undertaken in a timelier manner.

11. CCCL New Build

The footprint for the new wards at CCC Liverpool are all single rooms with en-suite facilities. It is recognised that nursing patients in single rooms increases acuity and required staffing levels. The workforce plan for all areas has taken this into account as much as possible, however the staff on the wards are still finding the new layout challenging. A number of different nursing models have been implemented and work remains ongoing to ensure an optimal model is achieved.

12. Conclusion and Profession Judgment recommendations

If the current recommended nursing establishments were met then the leadership teams are assured that care delivery on the inpatient wards would remain safe but consequences associated with using temporary staff or unfilled shifts on effective team working, consistency of care delivery and patient experience is always a concern. Safe care needs to be monitored over the next 12-18 months, along with the review of Harm Free Care data, to ensure safe care is delivered consistently. Action will be required if acuity, occupancy and patient harm increases.

Robust utilisation of the Safe Care Module provides an electronic system which enables the constant and consistent monitoring of staffing levels aligned within patient acuity and bed occupancy. It demonstrates the alignment between staffing levels available and the staffing levels required to support acuity requirements.

Safe Care also illustrates how often the wards are over or under established. More accurate data will be available from 2021/2022 with improved integration of the NHSP system.

Acuity measurement cannot be used alone to determine safe staffing levels, without a structure to record or respond to the variation in workload, it could lead to shortfalls in the staffing establishment and unsafe staffing. Dynamic use of the Safe Care Module allows leaders to respond to peaks in patient need or unanticipated staffing shortages. Bed occupancy and professional judgement also need to be triangulated to inform robust workforce planning. The Trust is now in a strong position to utilise this information to ensure efficient, effective planning of the nursing workforce is implemented in 2021/22.

13. Next Steps:

As well as specific action planning for each ward, the directorates will also undertake the following to ensure that other methodology and quality assurance measures are in place:

1. Continue with the Monthly Directorate Quality and Safety Meetings to review and discuss improvements to patient safety and reduction in preventable harm to patients.
2. Continue with monthly Harm Free Collaboration Group to review incidents/harm with the aim to reduce inpatient falls and attributable pressure ulcer development.
3. All incidents are reviewed and actioned via the Trust daily clinical incident call. This process has been implemented to ensure timely review and early identification of all patient safety incidents. It is undertaken to allow for early intervention and lessons learned to be shared.
4. A strengthened Trust recruitment process has been implemented, (including an agreed over-recruitment to Band 5 posts) to ensure staff are recruited and available in a timely manner to support the achievement of safe staffing levels
5. Review mandatory/role essential training requirements for ward based staff to ensure it is timely, robust and optimal delivery is achieved.
6. Continue to strengthen engagement of NHS Professionals (NHSP) management team to support all ad hoc nursing requirements with a robust and managed service.
7. Review all ward nursing establishments and create an annual workforce plan that meets current needs.
8. Collaborative work with Workforce leads to implement and operationalize the overarching nurse recruitment and retention plan.

14. Actions:

• DDoN to facilitate/support trust wide recruitment events to increase trust access to trained staff to support vacancy/workforce gap. • Edge Hill nurses fair 9th April 2019 • Nursing Times Liverpool 18th May 2019 • Edge Hill June 2019 • Edge Hill Oct 2019 • John Moores Nov 2019 • CCC Liverpool Nov 2019	**Sept 2019 Completed.**
• DDoN to develop the Nursing recruitment and retention plan to support safe care and nurse retention.	**June 2019 Completed.**
• Matrons and DDoN to Review CHPPD monthly and benchmark with other similar specialist trusts to better understand its significance on patient care.	**May 2019 Completed**
• HR with support from DDoN to expedite the engagement of NHS-Professionals to support all ad hoc nursing requirements/ resilience in provision of health care assistants (HCA's) in a robust and managed service.	**Nov 2019 Completed**
• Matrons/GMs Continue to review staffing levels daily and assess RAG status based on professional judgement.	**Daily Safety Huddles now in place Completed**
• DDoN to work with WOD to review electronic acuity/safe staffing module and outline its benefits for safe staffing. E-roster safe Care Project Implementation Plan agreed.	**Sept 2019 Completed**
• Matrons and GMs to monitor patient harms and occupancy in their directorate, highlight and review trends and respond promptly to ensure safe care	**Daily incident meeting Monthly Harm Free/Q&S meeting Completed**
• DDON and Matrons; Review and agree Emergency CV19 Pandemic Safe Staffing Ratios.	**April 2020 Completed**
• DDoN and DDHR engage/participate in NHSI Cohort 5 National Retention Programme.	**As required In progress – Paused due to Covid 19.**
• DDoN Leading Cheshire and Merseyside (C&M) Workforce workstream. Aim to produce C & M offer for registered nurses to improve recruitment and retention of staff across the region.	**In progress Completed Nov 2020**
• DDoN/WOD to implement Pilot Project Safe Care including baseline training.	**June 2020 Completed**
• DDoN/WOD to implement Live Safe Care Module.	**July 2020 Completed**
• DDoN /WOD facilitate extended training – Safe Care re: practicalities daily use.	**Sept 2020 Completed**
• DDoN/WOD alignment of NHSP with Safe Care and ESR to provide robust ad hoc staff that are captured in the electronic Safe Care data.	**Nov 2020 Completed**

• DDoN engage and lead International Nurse Recruitment initiative to provide experienced Registered Nurses to CCC following a period of training, OSCE and NMC registration.	**Nov 2020 Completed**
• DDoN engage and lead National Healthcare Support Worker recruitment and retention initiative. Development of a fit for purpose Recruitment and Retention package with strengthened clinical supervision/teaching/induction/development/pastoral support and supernumerary status.	**Jan 2021 Completed**

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	Wednesday, 30th June 2021
Agenda item:	P1-100-21
Title:	Integrated Performance Report M2 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:	Quality Committee
Date & decision:	Thursday, 24th June 2021

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

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

Next steps required:	

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

Integrated Performance Report (Month 2 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 two; May 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.

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

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

1. Performance Scorecards

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

1.1 Access

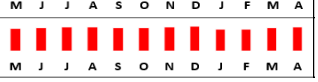
Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	May-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
L	**7 days** from referral to first appointment	↓	G: ≥90% A: 85-89.9% R: <85%	84.4%	85.0%	
C/S	**2 week wait** from GP referral to 1st appointment	↔	93%	100.0%	100.0%	
L	**24 days** from referral to first treatment	↑	G: ≥85% A: 80-84.9% R: <80%	90.6%	87.0%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	↑	75% (shadow monitoring)	83.3%	78.6%	
S	**31 day** wait from diagnosis to first treatment	↔	96%	98.8%	99.1%	
C/S	**31 day** wait for subsequent treatment (Drugs)	↔	98%	99.2%	99.0%	
C/S	**31 day** wait for subsequent treatment (Radiotherapy)	↔	94%	95.9%	97.2%	
S	Number of **31 day** patients treated **≥ day 73**	↔	0	0	0	
C/S	**62 Day** wait from GP referral to treatment	↔	85%	91.2%	88.8%	
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	42	74	
S	Number of patients treated => **104 days**	↑	No Target	15	27	
L	Number of patients treated => **104 days AND at CCC for over 24 days (Avoidable)**	↔	G: 0 A: 1 R: <1	0	0	
C/S	Diagnostics: **6 Week Wait**	↔	99%	100%	100%	
C/S	**18 weeks** from referral to treatment (RTT) Incomplete Pathways	↔	92%	98.7%	98.5%	

Notes:

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

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

Cheshire and Merseyside Performance

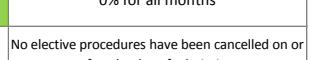
Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Apr-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Liz Bishop, CMCA SRO						
C/S	**2 week wait** from GP referral to 1st appointment	↓	93%	89.9%	89.9%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	↓	75% (shadow monitoring)	72.6%	72.6%	
C/S	**62 Day** wait from GP referral to treatment	↔	85%	79.1%	79.1%	

Notes:

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

1.2 Efficiency

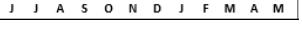
Scorecard Directive Key: S = Statutory | C = Contractual | L = Local

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	May-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	5.5	6.5	
S	Length of Stay: Emergency (days): Solid Tumour	↔	G: ≤8 A: 8.1-8.4 R: >8.4	7.4	6.6	
S	Length of Stay: Elective (days): HO Ward 4	↔	G: ≤21 A: 21.1-22.1 R: >22.1	12.5	15.1	
S	Length of Stay: Emergency (days): HO Ward 4	↔	G: ≤22 A: 22.1-23.1 R: >23.1	10.5	11.8	
S	Length of Stay: Elective (days): HO Ward 5	↔	G: ≤32 A: 32.1-33.6 R: >33.6	11.4	17	
S	Length of Stay: Emergency (days): HO Ward 5	↔	G: ≤46 A: 46.1-48.3 R: >48.3	0	5	
S	Delayed Transfers of Care as % of occupied bed days (now CCC)	↔	≤3.5%	2.2%	1.9%	
S	Bed Occupancy: Midnight (Ward 4: HO)	↔	G: ≥85% A: 81-84.9% R: <81%	81.6%	81.7%	
S	Bed Occupancy: Midnight (Ward 5: HO)	↔	G: ≥80% A: 76-79.9% R: <76%	61.0%	59.4%	
S	Bed Occupancy: Midday (Solid Tumour)	↔	G: ≥85% A: 81-84.9% R: <81%	78.6%	79.0%	
S	Bed Occupancy: Midnight (Solid Tumour)	↔	G: ≥85% A: 81-84.9% R: <81%	72.4%	71.9%	
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%	97.6%	98.2%	
L	Imaging Reporting: Outpatients (within 7 days)	↔	G: ≥90% A: 80-89.9% R: <80%	83.6%	83.2%	
C/Phase 3 Covid-19 Guidance	Data Quality - % Ethnicity that is complete (or patient declined to answer)	↔	100%	99.2%	96.7%	
C	Data Quality - % of outpatients with an outcome	↔	G: ≥95% A: 90-94.9% R: <90%	96.7%	96.5%	
C	Data Quality - % of outpatients with an attend status	↔	G: ≥95% A: 90-94.9% R: <90%	96.6%	96.9%	
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

Blue bars are included for months with no target

1.3 Quality

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	May-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	2	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	0	0	
S	Incidents /1,000 Bed Days	↑	No target	221	215.31	
L	Incidents resulting in harm /1,000 bed days	↑	No target	22	20	
C/S	Inpatient Falls resulting in harm due to lapse in care	⟷	0	0	0	
S	Inpatient falls resulting in harm due to lapse in care /1,000 bed days	⟷	0	0	0	
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care)	⟷	0	0	0	0 for all months
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care) /1,000 bed days	⟷	0	0	0	0 for all months
S	Consultant Review within 14 hours (emergency admissions)	⟷	90%	98.2%	98.0%	
C/S	% of Sepsis patients being given IV antibiotics within an hour*	⟷	90%	97.0%	97.0%	
C/S	VTE Risk Assessment	↓	95%	94.0%	95.0%	
S	Dementia: Percentage to whom case finding is applied	⟷	90%	92.0%	97.0%	
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)	2	3	
C/S	E Coli (attributable)	↑	G: ≤9, A: 10 R: >10 (pr yr)	1	1	
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)	0	1	
C	Pseudomonas (attributable)	⟷	G: ≤4, A: 5 R: >5 (pr yr)	0	0	
C/S	FFT score (% positive)	⟷	G: ≥95% A: 90-94.9% R: <90%	96%	96%	

The Quality KPI scorecard continues on page 5

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	May-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
C	Number of formal complaints received	↑	No target	4	7	
S	Number of formal complaints / count of WTE staff (ratio)	↑	No target	0.003	0.002	
C	% of formal complaints acknowledged within 3 working days	↓	100%	75%	86%	
L	% of routine formal complaints resolved in month, which were resolved within 25 working days	↔	G: ≥75% A: 65-74.9% R: <65%	50%	33%	
L	% of complex formal complaints resolved in month, which were resolved within 60 working days	N/A	G: ≥75% A: 65-74.9% R: <65%	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	24	N/A	
L	% of policies in date	↑	G: ≥95% A: 93.1-94.9% R: <93%	95%	95%	
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	May-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)	74	112	
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	4	
L (Strategy)	Publications	↔	G: ≥130 A: 110-129 R: <110 (pr yr)	8	13	

1.5 Workforce

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	May-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Jayne Shaw, Director of Workforce and Organisational Development						
S	Staff Sickness	↑	G: ≤4% A: 4.1-4.9% R: ≥5%	4.2%	3.86%	
S	Staff Turnover	↓	G: ≤1.2% A: 1.21–1.24% R: ≥1.25%	1.06%	2.76%	
S	Statutory and Mandatory Training	↔	G: ≥90% A: 75-89% R: ≤75%	95.6%	N/A	
L	PADR rate	↔	G: ≥95% A: 75-94.9% R: ≤74%	82.3%	N/A	
S	FFT staff: Recommend as a place to work (Quarterly survey)	-	G: ≥95% A: 90-94.9% R: ≤90%	N/A	N/A	
S	FFT staff: Recommend care and treatment (Quarterly survey)	-	G: ≥95%, A: 90 - 94.9%, R: ≤90%	N/A	N/A	
L	% of Staff who have had the **first** dose Covid-19 vaccination (at month end)	↑	No national target	92.4%	N/A	
L	% of BAME Staff who have had the **first** dose Covid-19 vaccination (at month end)	↑	No national target	90.6%	N/A	
L	% of Staff who have had the **first** dose Covid-19 vaccination or have refused the vaccination (at month end)	↑	No national target	95.8%	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	93.4%	N/A	
L	Covid-19 vaccinations: **Second** dose received as % of first dose received (at month end)	↑	No national target	95.7%	N/A	
L	Covid-19 vaccinations: BAME staff, **Second** dose received as % of first dose received (at month end)	↑	No national target	94.8%	N/A	

1.6 Finance

For key financial headlines for May 2021 are:

Metric	In Mth 2 Actual	In Mth 2 Plan*	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit) (£000)	2	0	2		33	0	33	
CPL/Propcare Surplus/ (Deficit) (£000)	121	0	121		234	0	234	
Control Total Surplus/ (Deficit) (£000)	123	0	123		267	0	267	
Cash holding (£000)	52,835	53,451	(616)		52,835	53,451	(616)	
Capital Expenditure (£000)	20	0	20		26	0	(26)	

The month 2 Trust financial position to the end of May is £33k surplus, the consolidated position is showing a £267k surplus, against a break even plan. Cash is showing a closing balance of £52.8m, which is £0.6m below planned cash. Capital spend is £20k in month.

2. Exception Reports

2.1 Access

7 days from referral to first appointment	Target	May 21	YTD	Last 12 Months
	G: ≥90% A: 85-89.9% R: <85%	84.4%	85%	

Reason for non-compliance

21 Patients breached the Trust's internal 7-day target in May; this was due to lack of consultant availability over the two May Bank holidays.

The breaches span across a number of Tumour groups, with the majority falling under the Urology Team.

No patients who breached the 7-day target went on to breach a national standard.

Action taken to improve compliance

- The Head of Admin Services is currently undertaking a piece of work to manage capacity and demand more effectively for all first appointments. As part of this work, the Business Intelligence team are developing an outpatient online dashboard, which will support the ability to forecast clinic capacity and ensure Consultant availability.
- To maintain capacity, the option of opening outpatient departments for clinics on the Bank Holidays is being reviewed.

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

2 week wait from GP referral to 1st appointment (Alliance-level)	Target	April 21	YTD	Last 12 Months (to Apr)
	93%	89.9%	89.9%	

Reason for non-compliance

Non-compliance with the Two Week Wait (TWW) standard in April 2021 was largely driven by underperformance in the following tumour groups:

- Suspected breast cancer 77.3% (548 breaches)
- Exhibited (non-cancer) breast symptoms - cancer not initially suspected 77.9% (130 breaches)

- Suspected gynaecological cancer 88.5% (125 breaches)
- Suspected lower gastrointestinal cancer 88.8% (243 breaches)
- Suspected upper gastrointestinal cancer 89.7% (117 breaches)
- Suspected haematological malignancies (excluding acute leukaemia) 90.9% (6 breaches)
- Other suspected cancer (not listed) 92.3% (1 breaches)

Outpatient capacity issues were recorded as the most frequent breach reason (66%), followed by patient choice (23%).

TWW referral rates were exceptionally high in April, 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.

Expected date of compliance	Compliance with the TWW standard is expected in to return in June 2021.
Escalation route	NHS England, North West CCC Performance Committee, Trust Board
Executive Lead	Liz Bishop, CMCA SRO

62 Cancer Standard (Alliance-level)	**Target**	**April 21**	**YTD**	**Last 12 Months** (to Apr)
	85%	**79.1%**	**79.1%**	

Reason for non-compliance

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

- Gynaecological 47.4% (20 breaches)
- Haematological (Excluding Acute Leukaemia) 60% (12 breaches)
- Lower Gastrointestinal 61% (24 breaches)
- Upper Gastrointestinal 69.4% (11 breaches)
- Sarcoma 75% (1 breaches)
- Head & Neck 75.3% (9 breaches)
- Lung 77.3% (10 breaches)
- Other 77.8% (2 breaches)
- Urological (Excluding Testicular) 77.9% (23 breaches)

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

diagnostics.
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

	Wards	Target	May 21	YTD	Last 12 Months
Bed Occupancy	**Solid Tumour** (Midday)	G: ≥85% A: 81-84.9% R: <81%	**78.6%**	**79%**	
	Solid Tumour (Midnight)	G: ≥85% A: 81-84.9% R: <81%	**72.4%**	**71.9%**	
	Ward 4 (HO) (Midnight)	G: ≥85% A: 81-84.9% R: <81%	81.6%	81.7%	
	Ward 5 (HO) (Midnight)	G: ≥80% A: 76-79.9% R: <76%	**61.0%**	**59.4%**	

Reason for non-compliance

Bed occupancy for May 2021 is below target in Solid Tumour and Ward 5 (Stem cell transplants). Ward 4 has remained static over April and May 2021.

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

Reasons for reduction in bed occupancy include:

- Impact of additional bed capacity with the opening of the TYA units in April 21.
- There was a continued reduction in transplants, from 6 in April to 3 in May 21. This is due to protocol revision undertaken by the Stem Cell Director.
- Both May bank holidays were also a contributing factor.
- A reduction in mutual aid referrals for AO from LUHFT (offered support during COVID).
- A reduction in COVID patients admitted to our Ward 3 Red Zone.

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

The Trust has been predominantly OPEL Green during May 2021.

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.
- Re-evaluating day case models of care, specifically brachytherapy services, to assess whether the most appropriate model of care would be facilitated within day case or within the inpatient area. Previous model of care prior to the move to Liverpool for this cohort of patients was to admit patients.
- The Acute Care Division is working in collaboration with the Networked Services Division to support COVID 19 recovery plans to offer flexible capacity support for any increase in day

care activity experienced.	
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**	**May 21**	**YTD**	**Last 12 Months**
	G: ≥90% A: 80-89.9% R: <80%	83.6%	83.2 %	

Reason for non-compliance

The inpatient target has been achieved in all months in 2021/2022 so far. The outpatient target has not been met, at 83.6% against a target of 90%. This has increased marginally from 82.8% in April 2021. Reasons for non-compliance include:

- Activity levels continue to increase, placing increasing demands on the Radiology team.
- Loss of reporting capacity due to Radiologists supporting clinical services – Interventional Radiology and Ultrasound.
- CCC Radiologists' annual leave.
- Current issues with the CRIS system interface between CCC and LUHFT, which are negatively affecting workflow and capacity in Radiology.

Action taken to improve compliance

- Increased outsourcing of reporting to Medica.
- Recruitment underway for an additional Radiologist.
- Radiologist recruited in December 2019 has been delayed further due to COVID and the current situation in India.
- Bi-weekly report received by senior Radiology team to allow for timely monitoring of the reporting levels.
- CCC Digital team are reviewing the CRIS system interface between CCC and LUHFT to identify a solution to the issue.

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

Data Quality - % Ethnicity that is complete (or patient declined to answer)	**Target**	**May 21**	**YTD**	**Last 12 Months**
	G: 100% R: <100%	**99.2%**	**96.7%**	

Reason for non-compliance

Compliance with the 100% target has improved from 94% in April 2021 to 99.2% in May 2021. The work to improve compliance remains on-going, however the time taken to recruit staff (who will make the calls to fill in the gaps in the data) is a barrier to improvement. Enquiries have been made to Somerset to include ethnicity in the minimum data set and a change form request will be submitted.

Action taken to improve compliance

- Recruitment of Band 2 clerical staff
- Submit change request for amendment to Somerset MDS

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

2.3 Quality

Serious Untoward Incidents (month reported to STEIS)	**Target**	**May 21**	**YTD**	**Last 12 Months**
	0	**2**	**3**	

Reason for non-compliance

2 SUIs were reported to STEIS in May 2021.

SUI 1:
Following an unwitnessed fall in their room, a patient became unresponsive and drowsy and was transferred to LUHFT for stabilisation. A CT scan identified a left sided subdural haematoma and following discussion with the neurosurgery team, a decision was made for conservative management and the patient was transferred back to CCC. The patient passed away soon afterwards. The scan report suggests there may have been a prior bleed which may have caused the fall. The death was reported to the coroner, however no inquest was opened. No care issues have been identified.

SUI 2:
Following a fall on the main corridor of CCC-L the patient was reviewed, but declined to stay for observation. The patient was unable to weight bear and complained of pain in the right hip. An ambulance was called and the patient was transferred to A&E. The patient proceeded to have a total hip replacement as a result of hip fracture following the fall. Further conversations with the patient and relative indicate that patient did not fall but felt suddenly dizzy and unwell and may have fainted. The investigation is still in progress.

Action taken to improve compliance

SUI 1:

- 72-hour review completed and SUI declared
- No care issues have been identified

SUI 2:

- 72-hour review completed and SUI declared.
- The investigation is still in progress

Expected date of compliance	SUI 1 report is due for submission 30/07/2021 SUI 2 report is due for submission 17/08/2021
Escalation route	Divisional Quality, Safety and Performance meetings, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive lead	Joan Spencer: Chief Operating Officer / Interim Chief Nurse

VTE Risk Assessment	**Target**	**May 21**	**YTD**	**Last 12 months**
	R: <95% G: 95%	**94%**	95%	

Reason for non-compliance:

May 2021 compliance was 1% below target at 94%. 13 out of 224 patients did not have an appropriate VTE risk assessment pro-forma completed.

On 13th May 2021, the Trust experienced a period of unplanned Meditech downtime. This was identified as a business continuity incident for the Trust, with the relevant processes enacted, including the prioritisation of specific clinical activities e.g. administering unplanned patient medications. Four of the 13 patients were admitted during this time and may have had delayed assessments as per Trust policy in such situations.

An in depth review of these 13 patients reveals that no patients developed a VTE at CCC and/or there were no VTE concerns on discharge.

Action taken to improve compliance

- The fall in compliance has been escalated to Medical divisional leads, Matrons and ward

managers. • Each missed assessment 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.	
Expected Date of Compliance	July 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**	**May 21**	**YTD**	**Last 12 Months**
	R: >4 per year G: ≤4 per year	2	3	

Reason for non-compliance

There were 2 attributable Clostridioides difficile infections in May 2021.

The patient presented with loose stools upon admission to Ward 2, however a sample was not obtained at this time and a stool chart was not commenced. A stool sample was collected four days after admission and this identified Clostridioides difficile. It is likely that CDI was present upon admission and this case was therefore not in fact hospital attributable. An action plan has been sent to the clinical team to act on these learning points.

A patient with neutropenic sepsis deteriorated and was transferred from Ward 4 to LUHFT. Following the transfer to LUHFT, a stool sample was obtained which identified CDI. A stool chart was completed throughout the inpatient stay at CCC and there was no evidence of loose stools until the day of transfer. The patient had had recent treatment with IV Tazocin for neutropenic sepsis, however all antimicrobials were prescribed within Trust guidelines. No learning points were identified from this episode of infection.

The second patient also had an attributable E coli infection.

Action taken to improve compliance

- Education to be provided by Infection Prevention and Control Team on the importance of prompt sampling
- Implementation of the action plan
- The Wards will use morning safety huddles to raise awareness of the lessons learnt and review sampling requirements of current inpatients.

Expected date of compliance	July 2021

Escalation route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive lead	Joan Spencer: Chief Operating Officer / Interim Chief Nurse

***Escherichia coli* infections (attributable)**	**Target**	**May 21**	**YTD**	**Last 12 Months**
	G: ≤9, A: 10 R: >10 (per year)	**1**	1	

Reason for non-compliance

A patient with neutropenic sepsis deteriorated and was transferred from Ward 4 to LUHFT. Blood cultures collected at this point identified *E.coli*. The PICC line was removed after the Sepsis was thought to be line related. Review by microbiology determined that a line would be an unlikely source for *E.coli* infection; an opinion is supported by a lack of clear clinical improvement following line removal. Following further discussion with microbiology, the source has been identified as gut translocation.

This patient also had an attributable C diff infection.

Action taken to improve compliance

- No learning points have been identified from this episode of infection.

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

Complaints	**KPI**	**Target**	**May 21**	**YTD**	**Last 12 Months**
	% of routine formal complaints resolved in month, which were resolved within 25 working days	R: <65% A: 65-74.9% G: 75%	**50%**	**33%**	
	% of formal complaints acknowledged within 3 working days	100%	**75%**	**86%**	

Reason for non-compliance

One of the two routine complaints resolved in May 2021 was not resolved within 25 working days; the details are as follows:

- Complaint response was sent out 55 days after receipt into the Trust
- Complaint had been investigated and was in the process of divisional approval but required further investigation to be undertaken.
- The complainant was informed of the reasons for the delay.

The complex complaint resolved in May was within the 60 working day target.

There are currently no open complaints over 25 working days from receipt and all are being well managed.

One out of four complaints received in May 2021 was not acknowledged within 3 working days. This was due to a single point of failure in the process.

Action taken to improve compliance

- The process has been amended so any complaints not received directly into the PALS inbox will be forwarded to the PALS inbox and not to individual staff
- The amended PALS and Complaints policy and complaint management process has now been approved. This will continue to improve compliance with the targets.

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

2.4 Research and Innovation

Study Recruitment	Target	May 21	YTD	Last 12 Months
	G: ≥1300 A: 1100-1299 R: <1100 (per year)	74	112	

Reason for non-compliance

112 patients had been recruited against an internal target of 216 (52% of target) at the end of May 2021. The reasons for not achieving the target include:

- Issues relating to the Aseptic Pharmacy Service have continued particularly around the cold chain. The cold chain issue was resolved from 9th June 2021.
    - Studies using this service were paused on 5th March 2021 and unpaused on 17th May 2021. The pause lasted for a 10-week period.
    - No new studies that use this service have opened since 5th March 2021. The agreed plan was to start looking at opening new studies from 7th June 2021, this has not happened yet due to Clinical Trial Pharmacy capacity. As of 11th June 2021, no new studies have opened for 14 weeks.
- A number of studies that were paused, were closed to recruitment early by the sponsor as they had met the national target.
- A number of the higher recruiting studies have recently closed to recruitment.
- The trial pipeline is not as high as usual due to aseptic studies not opening.
- No Site Qualification Visits have taken place.

Action Taken to improve compliance

- Agreed with Interim Chief Pharmacist to unpause 'open' aseptic studies on 17th May 2021, as there is a 4-6-week time lag before patients will need treatment.
- Exploring Clinical Trial Pharmacy capacity with Interim Chief Pharmacist to allow 'new' studies to open whilst not putting pressure on the system.
- Site Qualification Visits will be reinstated for new studies (not involving pharmacy) initially. Studies involving Pharmacy still need to be considered in light of capacity issues.
- Exploring diversifying the portfolio: Observational / real world studies.
- Radiotherapy studies continue to recruit well particularly for Urology. Additional resource recently approved from the new Research Strategy to support this work stream. Recently opened a number of new radiotherapy studies.
- Increased Research Officer support to see increased recruitment.
- Number of nursing and psychology studies in the pipeline.
- Number of observational data studies previously put on hold by sponsor are due to have a Site Initiation Visit in June 2021.

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**	**May 21**	**YTD**	**Last 12 Months**
	52	3	4	

Reason for non-compliance

Four studies have opened to recruitment during April and May 2021 against an internal target of eight at the end of Month 2 (50% of target). We have not met target for the following reasons:

- Currently there is a halt to opening new studies to recruitment that use the Pharmacy Aseptic Service which started 5th March 2021. The initially agreed date of 7th June 2021 to open new studies has been delayed due to capacity issues within Clinical Trials Pharmacy.
- CCC has issued local approval for five additional studies, for which we are awaiting Sponsor Greenlight.

Action Taken to improve compliance

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

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

Publications	Target	May 21	YTD	2021/22 trend
	130	8	13	A M

Reason for non-compliance

Thirteen publications have been registered during April and May 2021, against an internal target of twenty-two (59% 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

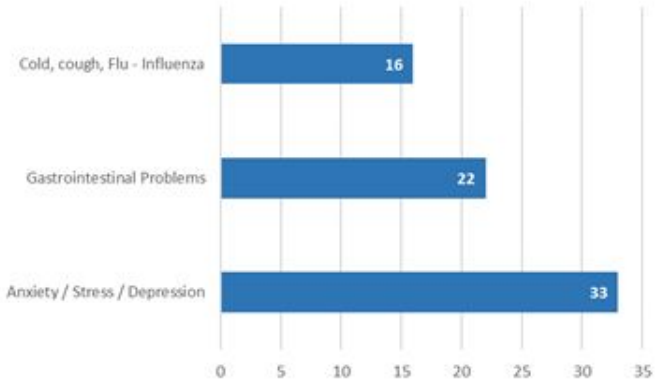
- Work with the Library Services to ensure all publications are captured.
- Work with the SRG Research Leads and academics to ensure the list is accurate.
- Encourage staff to submit publications as part of the 'Achievements' request that is sent out each month.

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

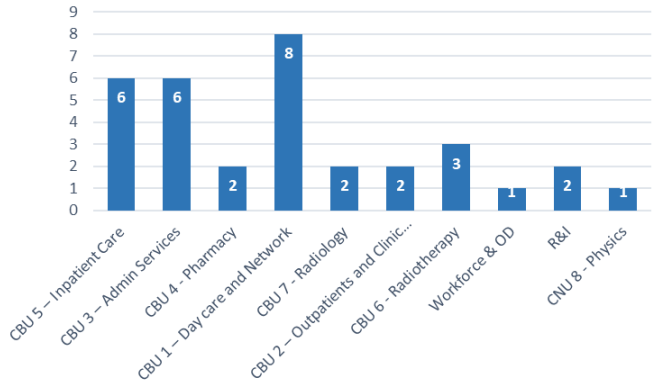
2.5 Workforce

Sickness Absence	Target	May 21	YTD	Last 12 Months
	G: ≤4% A: 4.01–4.99% R: ≥ 5%	4.16%	3.86%	J J A S O N D J F M A M

Reason for non-compliance



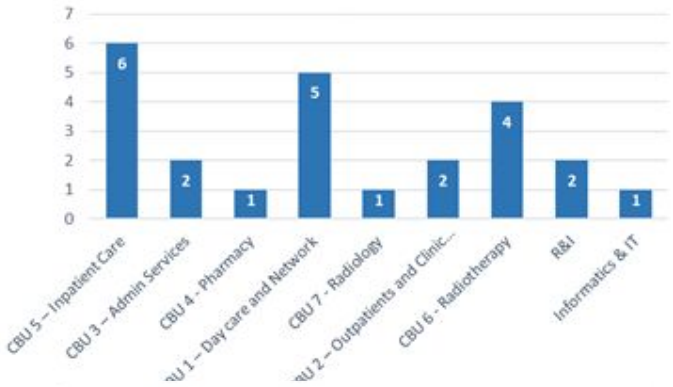
This chart shows the top three reasons for sickness absence in May 2021.



Anxiety/Stress/Depression

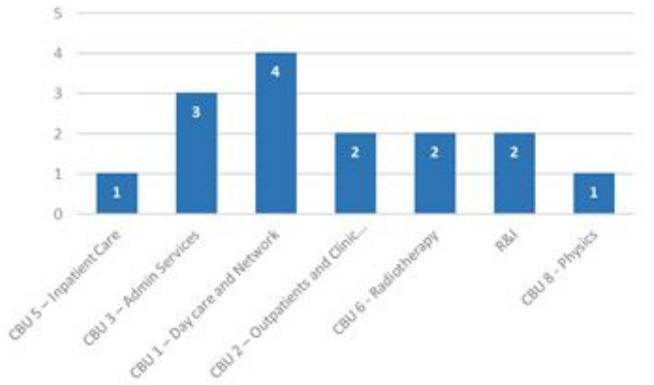
Absences due to have decreased from 44 in April 2021 to 33 in May 2021. 19 of which are due to personal related reasons, 6 work related and 7 are unknown.

CBU 1 has the highest number of absences due to Anxiety/Stress/Depression with 8 episodes; 5 due to personal circumstances, 1 work related and 2 unknown.



Gastrointestinal Problems

Inpatient wards had the highest number of absences due to this reason. Ward 3 had the most absences with 3, followed by Ward 2, 5 and the Advanced Nursing Team with 1 each.



Cold/Cough/Influenza

The highest number of absences was within the Day Care and Network Team.

Action taken to improve compliance

- 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 and decrease the number of these absences each month.
- 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 staff to appropriate support mechanisms.
- The annual stress audit is currently underway; this 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 is due to take place in June 2021 in order to increase the pool of MHFA's who can offer support to staff experiencing anxiety/stress/depression, helping them to remain in work.

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

PADR	**Target**	**May 21**	**Last 12 months**
	G: ≥95% A: 75% - 94.9% R: ≤74%	82.26%	

Reason for non-compliance

Overall Trust compliance for PADRs has not been achieved for 8 consecutive months and this month has seen a significant decline of 7.88%.

A full breakdown of performance as at 31st May is detailed below;

Org L4	Assignment Count	Reviews Completed	Reviews Completed %
158 CBU1 - Day Care & Network	177	156	88.14
158 CBU2 - Outpatients & Clinical Support	62	49	79.03
158 CBU3 - Admin Services	205	162	79.02
158 CBU4 - Pharmacy	67	49	73.13
158 CBU5 - Inpatient Care	227	181	79.74
158 CBU6 - Radiotherapy	181	152	83.98
158 CBU7 - Radiology Services	60	48	80.00
158 CBU8 - Physics	59	58	98.31
158 Cancer Alliance	28	18	64.29
158 Communications	5	5	100.00
158 Executive Office	13	11	84.62
158 Finance	26	22	84.62
158 Informatics & IT	67	50	74.63
158 Project Management Office	6	5	83.33
158 Quality	18	17	94.44
158 Recharges	15	14	93.33
158 Research & Innovation	56	47	83.93
158 Safeguarding	8	7	87.50
158 Service Improvement	1	1	100.00
158 Workforce & Organisational Development	38	33	86.84
Grand Total	1,319	1,085	82.26

As previously highlighted, alignment of PADR dates to pay progression dates has now been

implemented and as of 1st April, the Trust has formally removed the window approach to PADR completion and moved to the rolling 12-month cycle to support managers in having quality PADR conversations with staff.

It was anticipated that this new approach may take time to be embedded. Therefore, additional data, communication and training has been provided to managers to support the effective implementation of this change in practice, with the target date for achieving compliance set as 30th June 2021. Based on current performance data it is now unlikely this target will be achieved and a revised target of 1st August has been set.

The L&OD Team are working closely with Divisions to understand and support to resolve any barriers or issues that are preventing them in achieving compliance.

Feedback has been received in connection to new starters and duplication of effort linked to PADR and probationary sign off. The Workforce and OD Team will review this to ensure a seamless and efficient process is in place and make any changes necessary to processes.

Performance review meetings have been escalated in June, to focus specifically on underperformance against PADR targets. Divisions underperforming against the target are required to produce an Improvement Plan to ensure compliance is achieved by 1st August.

Action taken to improve compliance

- Divisional Improvement Plans to be developed by 18th June 2021 detailing planned dates for all outstanding PADRs and those due in June and July to ensure effective trajectory of achieving compliance by 1st August. Improvement Plans will be monitored weekly via the L&OD Team
- Workforce and OD Team to review approach to new starters undertaking PADRs to ensure process is seamless and doesn't duplicate probationary period processes. Implement any agreed changes to processes by July 2021
- Review access issues for new starters with Digital Team by end of July to ensure auto access to system for new starters
- Continue to issue managers and staff with a personalised email, 3 months before their appraisal is due to support the effective and timely completion of PADRs
- Continue to provide bespoke monthly PADR compliance reports to Divisions to enable effective management and planning of PADRs. Positive feedback has been received from the Divisions about the value of these reports
- Divisions underperforming against the target will be required to add this to their divisional risk register. This escalation process will be managed via the monthly Performance Review Meetings.

Expected date of compliance	Extended from 30th June 2021 to 01st August 2021
Escalation route	Divisional Performance Reviews, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Cheshire & Merseyside Cancer Alliance

Performance Report

June 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	118%
Cancer surgery activity	101%
SACT (inc chemo) delivery	118%

Measure	% of pre-Covid level
Radiotherapy planning	93%
Radiotherapy treatment	78%
Endoscopy capacity*	88%

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

Cheshire & Merseyside Cancer Alliance

*Assessment based on monthly DM01 endoscopy returns.

Summary

Cancer waiting times performance

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

- The Alliance failed the **14 day standard** for urgent suspected cancer referrals in April, with five trusts and five CCGs falling below the 93% threshold. The overall performance of the Alliance was 89.1%%, down from 94.9% last month. The England average was 85.4%. CMCA was the 6th best performing Alliance in England out of 19 against this standard.

- The Alliance failed the **62 day standard**, achieving 78.4% (up from 76.5% last month) against a standard of 85% (England average was 75.37%). Eight trusts and nine CCGs failed to meet the 62 day standard. Cheshire and Merseyside is the 6th 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 30th May 2021 there were 948 patients waiting more than 62 days for a diagnosis or treatment. This has decreased from 966 reported last month (10th May).
- Of these, 185 have waited **over 104 days**. This has decreased from 250 reported last month.

Cheshire & Merseyside Cancer Alliance

Section II: Restoration of Cancer Services – Core Metrics

1. TWW referrals received in last 7 days

Referrals fell slightly to 1,878 which is slightly below earlier bank holidays this year.

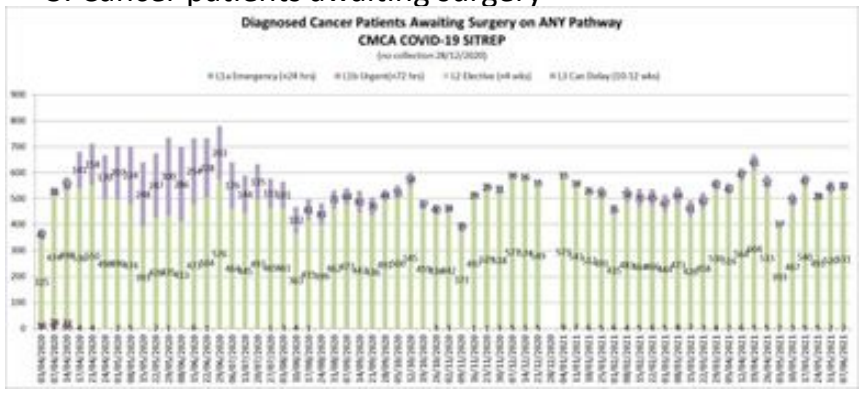
Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP.

2. Diagnostic backlog (referrals without a DTT)

Currently 10,169 active patients, of which 5 are suspended.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. No collection 28/12/2090.

3. Cancer patients awaiting surgery



565 patients with a surgical DTT. 533 at L1&L2 and 32 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

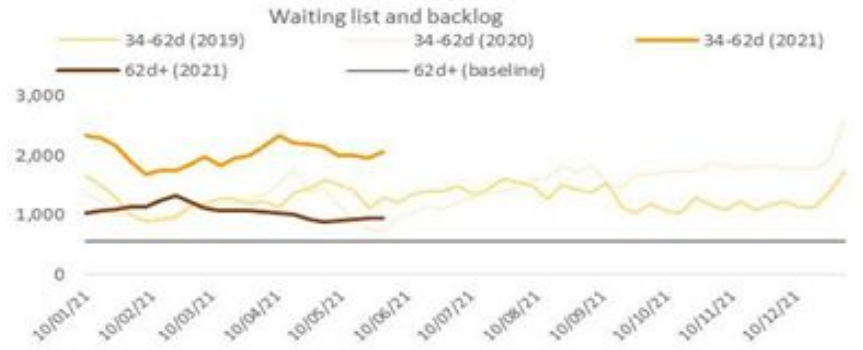
4. Cancer surgery performed in last 7 days

248 cancer operations, of which 4 were through the surgical hub.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. No collection 28/12/2090. Very limited LUTH data for 03/05/2021

Restoration of Cancer Services – Core Metrics

5. Patients waiting over 62 days

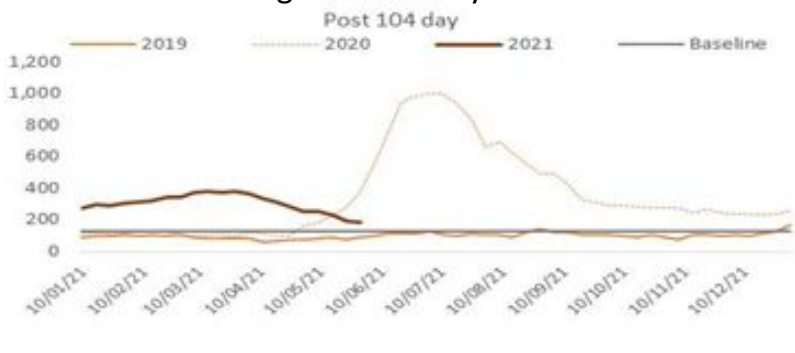


948 patients have waited over 62 days

- Up from 942 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



185 patients have waited over 104 days

- Down from 194 in previous week

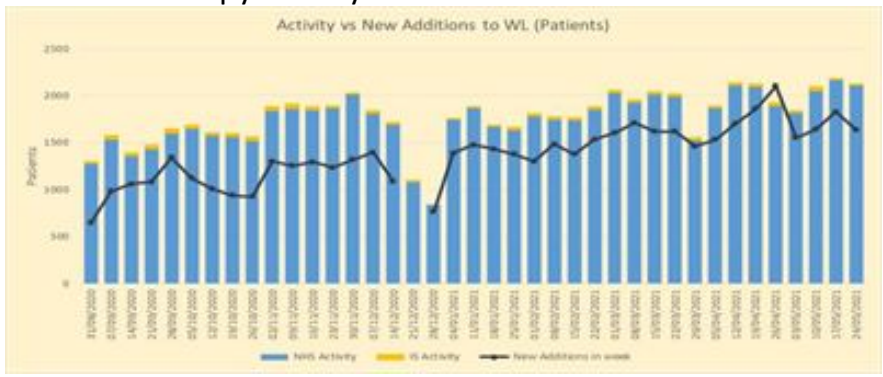
Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. For w/e 04/04/2021, Wirral data not submitted.

7. Endoscopy waiting list

Endoscopy waiting list increased very slightly to 9591 (two units estimated).

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. Aintree and Royal data estimated for 24/05/21.

8. Endoscopy activity



Activity remained high, with 2,127 patients seen. New additions rose slightly to 1,639 (two units estimated).

Data Quality Issues: No data from East Cheshire 14/12/20; no new additions collection 21/12/20. Aintree data estimated for 03/05/2021. Aintree and Royal data estimated for 24/05/21.

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													9		**22**
Countess Of Chester			7			37						12			**70**
East Cheshire						13									**20**
Liverpool Foundation Trust		11			31	198					5	82	23		**356**
Liverpool Heart & Chest															
Liverpool Women's			24												**24**
Mid Cheshire						17									**31**
Southport & Ormskirk			14									6	12		**47**
St Helens & Knowsley			7		16	33					7	7	17		**93**
Walton Centre															
Warrington & Halton			10			25							14		**56**
Wirral						19							15		**38**
Grand Total		**19**	**70**	**13**	**60**	**353**	**6**				**20**	**117**	**101**		**763**

Cheshire & Merseyside Cancer Alliance

Tables from national Cancer PTL
Up to 30 May 2021

10. Patients waiting over 104 days by provider

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total
Bridgewater															
Clatterbridge															**5**
Countess Of Chester						10					5				**19**
East Cheshire															
Liverpool Foundation Trust						47						15	7		**78**
Liverpool Heart & Chest															
Liverpool Women's			14												**14**
Mid Cheshire															**5**
Southport & Ormskirk			5												**14**
St Helens & Knowsley						8									**15**
Walton Centre															
Warrington & Halton						6							5		**16**
Wirral						6							5		**12**
Grand Total			**28**		**7**	**85**	**6**				**9**		**24**		**185**

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

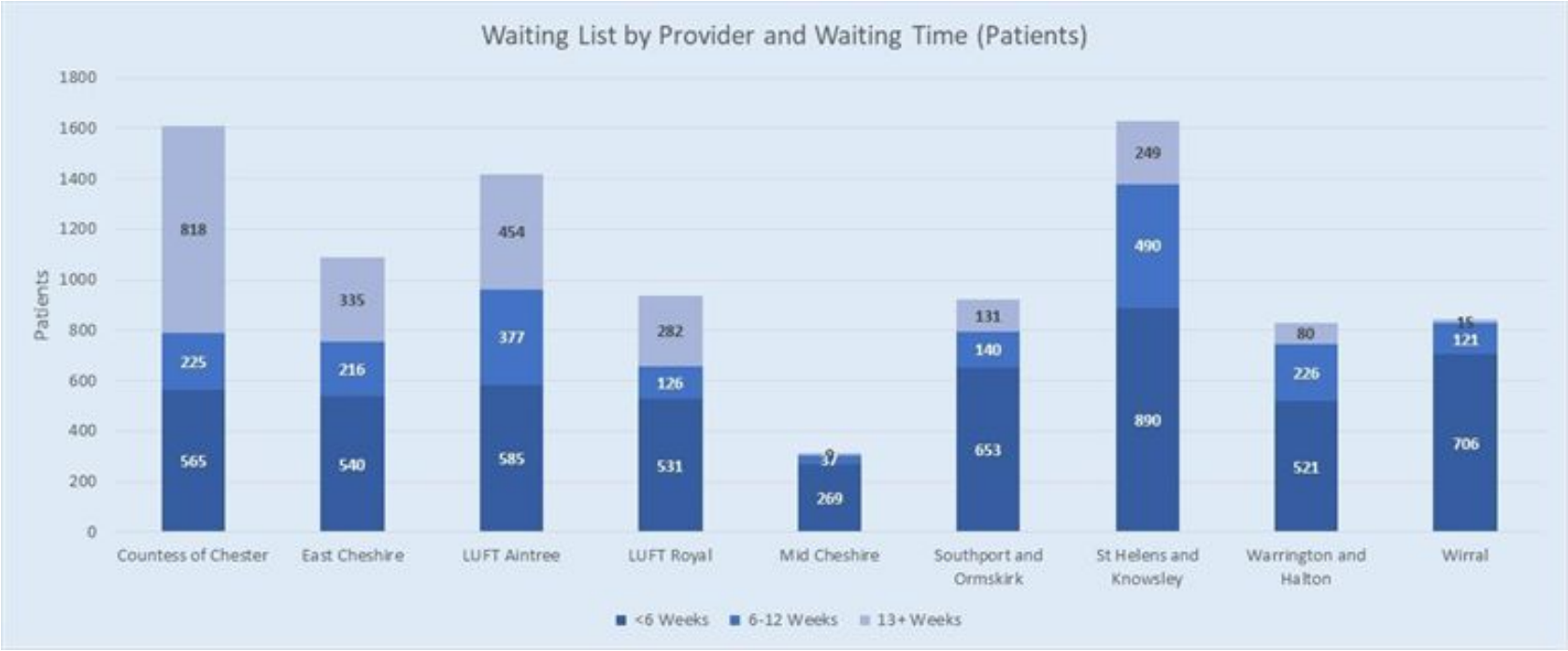
Restoration of Cancer Services – Core Metrics

There are currently 9,591 patients waiting for an endoscopy. 4,331 have waited more than six weeks, and of these 2,373 have waited 13 or more weeks (25% of the total).

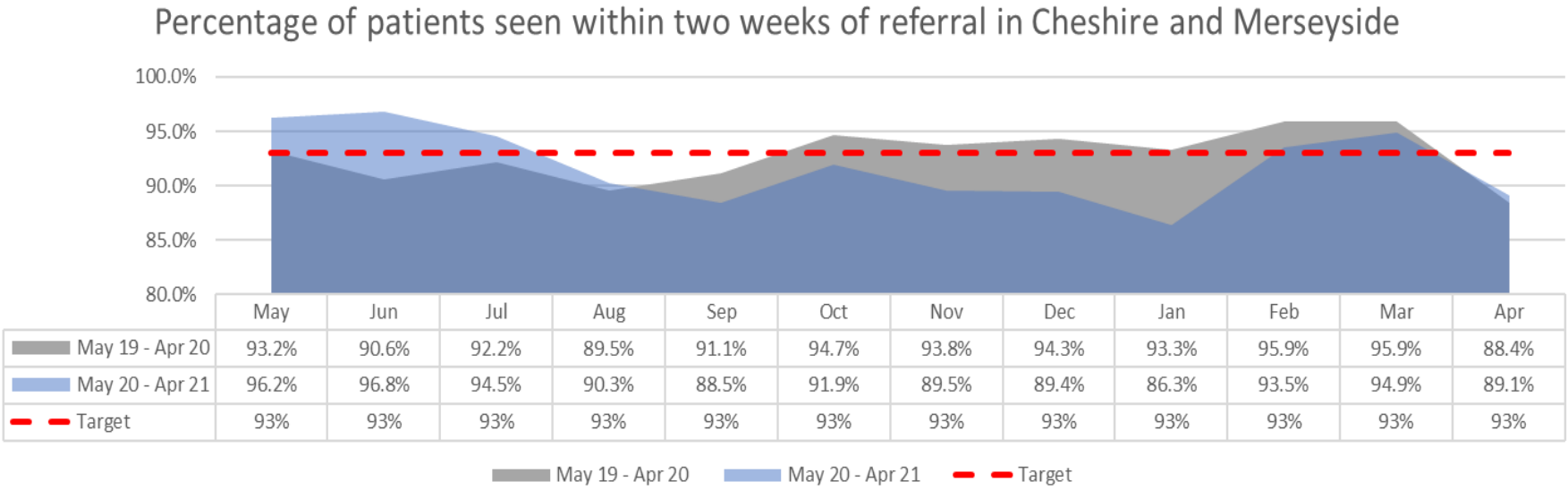
There is significant variation across units, with CoCH, LUFT and East Cheshire having the greatest proportion of their waiting list made up of patients waiting 13 weeks or more (51%, 31% and 31% respectively).

Endoscopy (cancer and non-cancer pathways)

(LUFT Aintree and LUFT Royal estimated)



Section II: 14 day standard



	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
May 19 - Apr 20	93.2%	90.6%	92.2%	89.5%	91.1%	94.7%	93.8%	94.3%	93.3%	95.9%	95.9%	88.4%
May 20 - Apr 21	96.2%	96.8%	94.5%	90.3%	88.5%	91.9%	89.5%	89.4%	86.3%	93.5%	94.9%	89.1%
Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

In April 2021, 89.1% of patients were seen within 2 weeks compared to 94.9% in the previous month. This is below the national target.

Providers not achieving the national operational standard were:

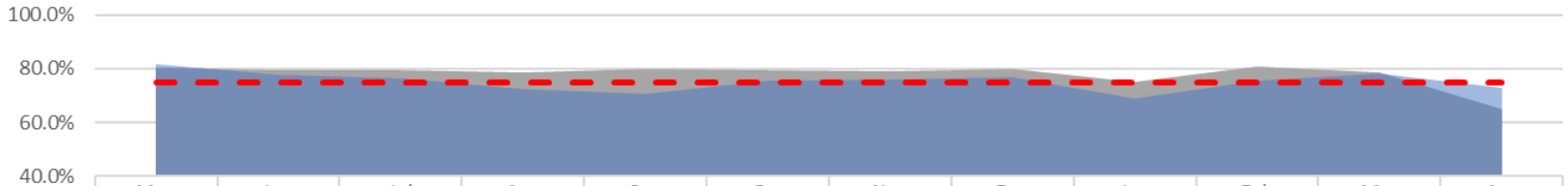
- East Cheshire 58.3% (248 breaches),
- Countess Of Chester Hospital 72.7% (311 breaches),
- St Helens and Knowsley Hospitals 84.6% (263 breaches),
- Southport and Ormskirk Hospital 87% (125 breaches),
- Warrington and Halton Teaching Hospitals 92.9% (71 breaches)

CCGs not achieving the national operational standard were:

- Cheshire CCG (82.73%)
- Halton CCG (87.78%)
- Knowsley CCG (87.94%)
- Southport and Formby CCG (87.89%)
- St Helen's CCG (86.83%)

Section II: 28 day standard

Percentage of patients receiving a diagnosis or ruling out of cancer within 28 days of referral in Cheshire and Merseyside (Two week waits)



	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
May 19 - Apr 20	80.5%	79.5%	79.4%	78.4%	80.0%	79.3%	79.0%	80.1%	75.2%	80.6%	78.8%	64.7%
May 20 - Apr 21	81.8%	77.5%	76.4%	72.5%	70.7%	75.7%	75.7%	77.0%	68.9%	75.7%	78.1%	72.6%
Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

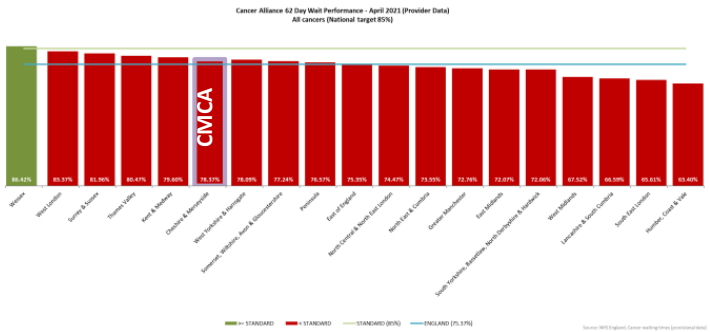
The 28 day FDS standard is still being shadow monitored. The standard is expected to be 75%.
In April 2021, 72.6% of 2ww patients were diagnosed or ruled out within 28 days compared to 78.1% in the previous month. This is below the expected standard.

Providers not achieving the expected standard were:
Bridgewater Community Healthcare 58.2% (76 breaches),
Liverpool Womens 63% (84 breaches),
East Cheshire 63.8% (182 breaches),
St Helens And Knowsley Hospitals 71.9% (429 breaches),
Countess Of Chester Hospital 61.7% (378 breaches),
Liverpool Heart And Chest Hospital 63.6% (4 breaches),
Liverpool University Hospitals 71.8% (719 breaches),
Southport And Ormskirk Hospital 72.5% (238 breaches)

CCGs not achieving the expected standard were:
Cheshire CCG (70.73%), Knowsley CCG (70.71%), Liverpool CCG (72.07%), South Sefton CCG (66.13%), Southport and Formby CCG (73.68%), St Helen's CCG (71.57%), Warrington CCG (71.24%)

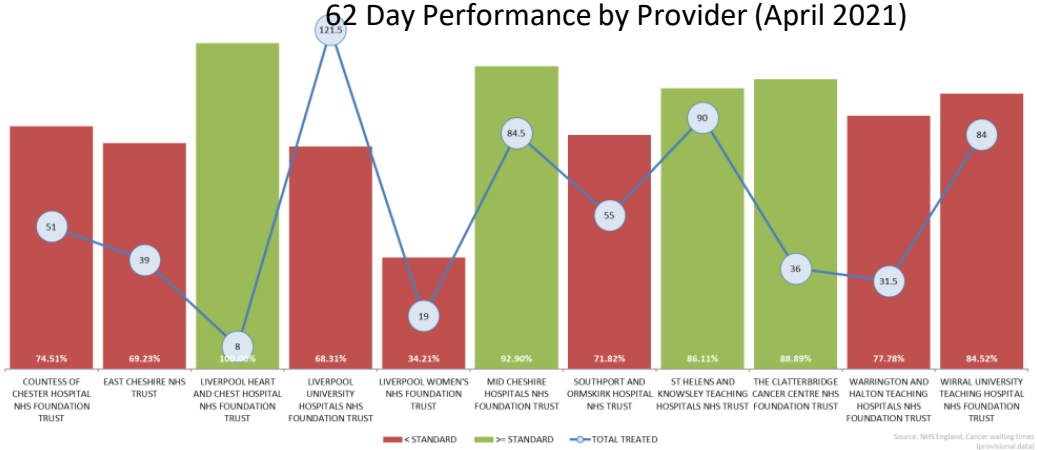
Section III: 62 Day Standard

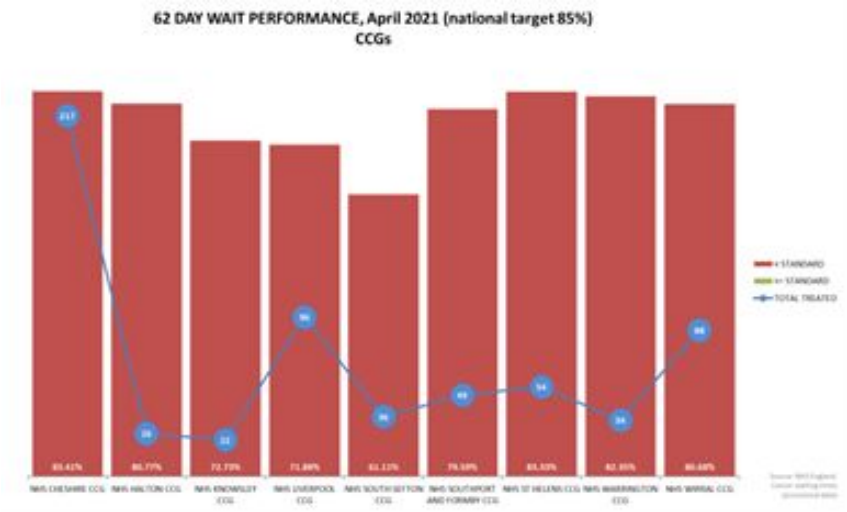
62 Day Performance by Cancer Alliance (March 2021)



CMCA achieved 78.37% against a standard of 85%.
CMCA was the sixth best performer. The England average was 75.37%

62 Day Performance by Provider (April 2021)





Most Challenged Pathways (April 2021)

Cancer pathways not achieving the national target were:

- Gynaecological 47.4% (20 breaches),
- Haematological (Excluding Acute Leukaemia) 60% (12 breaches),
- Lower Gastrointestinal 61% (24 breaches),
- Upper Gastrointestinal 69.4% (11 breaches),
- Sarcoma 75% (1 breaches),
- Head & Neck 75.3% (9 breaches),
- Lung 77.3% (10 breaches),
- Other 77.8% (2 breaches),
- Urological (Excluding Testicular) 77.9% (23 breaches)

Report prepared by Jenny Hampson
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Cancer Alliance

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Managing Director
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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 & charitable sector partners to improve cancer outcomes for our local population.

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board	
Date of meeting:	30 June 2021	
Agenda item:	P1-102-21	
Title:	Finance Report, Month 2	
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 May 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
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.

Trust Board
30th June 2021

Financial Performance Report

1. Introduction

1.1 This paper provides a summary of the Trust's financial performance for May 2021, the second 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 May the key financial headlines are:

Metric	In Mth 2 Actual	In Mth 2 Plan*	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit) (£000)	2	0	2		33	0	33	
CPL/Propcare Surplus/ (Deficit) (£000)	121	0	121		234	0	234	
Control Total Surplus/ (Deficit) (£000)	123	0	123		267	0	267	
Group Cash holding (£000)	59,629	59,875	(246)		59,629		(246)	
Capital Expenditure (£000)	20	0	20		26	0	(26)	

2.2 For 2021-22 the Cheshire & Merseyside ICS are managing the required financial position of each Trust through a whole system approach. The Trust was originally asked by the ICS to plan on the basis of a £211k surplus for the first six months of the year (H1). It therefore set a plan which identified a £422k surplus for the full year in line with this requirement. Subsequent to this, in May the C&M ICS revised the request to a break-even position for H1. This revision removed non-recurrent system Covid funding and replaced it with the Elective Recovery Fund (ERF). The Trust's revised plan for the year is currently 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 £33k surplus, the group consolidated position is a £267k surplus, against a break-even plan. The cash position for the group is showing a closing balance of £59.6m which is £246k below plan. Capital spend is £20k in month.

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

Metric (£000)	Actual M2	Trust Plan M2	Variance	Actual YTD	NHSI Plan YTD	NHSI Variance	Trust Annual Plan
Clinical Income	17,429	16,275	1,154	33,343	32,550	**793**	195,301
Other Income	2,030	1,663	367	3,546	3,330	**216**	20,105
Total Operating Income	**19,459**	**17,939**	**1,521**	**36,889**	**35,880**	**1,009**	**215,406**
Total Operating Expenditure	(19,164)	(17,617)	(1,547)	(36,172)	(35,237)	**(935)**	(211,547)
Operating Surplus	**295**	**322**	**(27)**	**717**	**643**	**74**	**3,859**
PPJV	114	67	47	114	134	**(20)**	804
Finance Costs	(407)	(389)	(18)	(798)	(777)	**(21)**	(4,663)
Trust Surplus/Deficit	**2**	**(0)**	**2**	**33**	**0**	**33**	**0**
Subsiduaries	121	0	121	234	**0**	**234**	**0**
Consolidated Surplus/Deficit	**123**	**(0)**	**123**	**267**	**0**	**267**	**0**

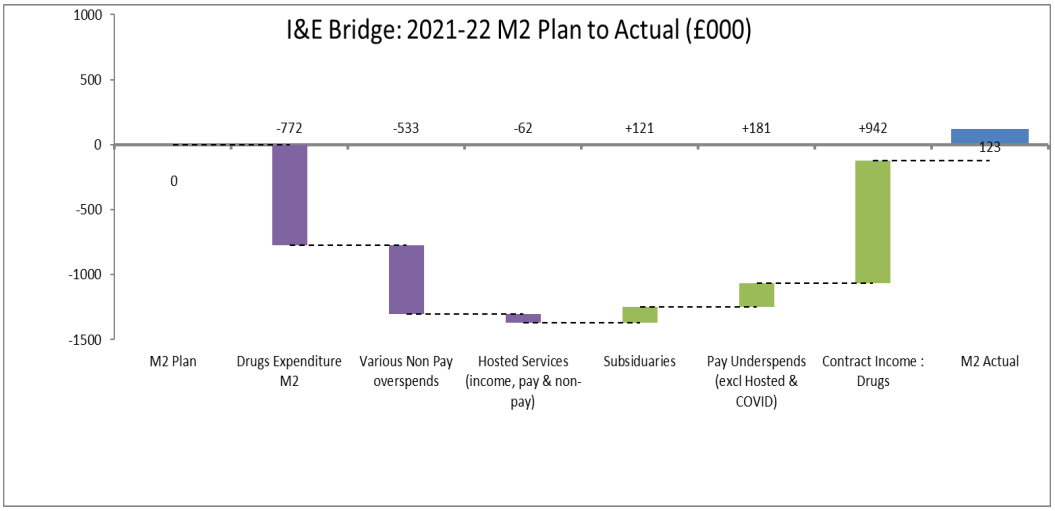
The table below summaries the consolidated financial position:

Metric (£000)	In Month Actual £'000s	YTD Actual £'000s
Trust Surplus/ (Deficit)	(78)	(128)
Donated Depreciation	80	161
Trust Retained Surplus/(Deficit)	**2**	**33**
CPL	43	74
Propcare	78	160
Consolidated Financial Position	**123**	**267**

3.3 Expenditure position

3.3.1 The bridge below shows the key drivers between the £123k in month surplus and break-even plan.

- Drugs spend is over plan by £772k. 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 £181k 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 £533k – 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 subsidiary companies are showing an aggregate £121k profit in month. This is above the profile for both companies. For PharmaC this is due to pay savings due to both vacancies and delays in the recruitment to some new posts. For Propcare this is due to lower spending on some contract areas than planned, but is expected to increase later in the year.



3.3.2 In terms of Divisional budgetary performance, the May position 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 £776k, 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 £401k, driven by the central CIP allocation. As CIP is being met non-recurrently through the pay underspend, with the target sat in non-pay there is a misalignment. The Cancer Alliance position is balanced overall as the overspend is being offset by additional income.

£000	Pay			Non-Pay			Total Expenditure
	Budget	Actual	Variance	Budget	Actual	Variance	Variance
ACUTE CARE DIVISION	1,546	1,588	**42**	655	651	**(4)**	**38**
CORPORATE DIVISION	1,073	1,009	**(63)**	2,438	2,838	**401**	**337**
NETWORK DIVISION	1,640	1,523	**(117)**	523	607	**84**	**(33)**
RADIATION SERVICES DIVISION	1,497	1,454	**(42)**	280	343	**62**	**20**
RESEARCH DIVISION	354	260	**(94)**	51	34	**(17)**	**(111)**
DRUGS	0	0	**0**	6,745	7,522	**776**	**776**
Sub-Total Operating	**6,109**	**5,835**	**(275)**	**10,693**	**11,995**	**1,302**	**1,027**
HOSTED - CANCER ALLIANCE	199	228	**29**	606	1,107	**501**	**530**
FINANCE COSTS	0	0	**0**	322	293	**(29)**	**(29)**
TOTAL	**6,308**	**6,062**	**(246)**	**11,621**	**13,395**	**1,774**	**1,528**

21-22 WTE M2	WTE		
	Budget	Actual	Variance
ACUTE CARE DIVISION	385.98	371.68	**(14.30)**
CORPORATE DIVISION	240.50	208.67	**(31.83)**
NETWORK DIVISION	507.33	445.28	**(62.05)**
RADIATION SERVICES DIVISION	325.30	308.67	**(16.63)**
RESEARCH DIVISION	92.72	69.87	**(22.85)**
HOSTED SERVICES DIVISION	0.00	30.22	**30.22**
TOTAL	**1,551.83**	**1,434.39**	**(117.44)**
Of which substantive	1,551.83	1398.16	**(153.67)**
Of which temporary	0.00	36.23	**36.23**
TOTAL	**3,521.68**	**3,277.54**	**(117.44)**

3.4 Elective Recovery Fund – H1 2021-22

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

EFR Plan H1	Total	April	May	June	July	August	Sept
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
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	0						
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	0						
Non Pay - costs to deliver planned activity in excess of monthly thresholds	(2,130)	(355)	(355)	(355)	(355)	(355)	(355)
Profit/Contribution	**6,341**	**1,465**	**1,228**	**1,047**	**867**	**867**	**867**

As outlined earlier, the Trust plan includes the contribution of £6,341k to achieve a break-even position for H1. In April and May the Trust has delivered a level of activity above the planned level.

3.5 Bank and Agency Reporting

Bank spend in May is £102k, a slight increase compared to last month. The largest user of bank staff the Acute Division whose spend in month 2 is £86k. The biggest reason for bank spend is to cover vacancies which was £56k in month 2.

Agency spend in month is £54k which is similar to previous months.

See appendix E for further detail.

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 C&M ICS and NHSI with a requirement to break even in H1. The revised plan has generated a higher level of CIP required for H1 of £1.423m. This is broken down as:

- £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.

CIP targets allocated to the Divisions remains at 2.0% which equates to £1.9m (excluding drugs and hosted services). The remainder will be held and managed centrally. Appendix D shows the CIP requirement by Divisions. Progress on the achievement of this will be monitored on a monthly basis through Finance Committee.

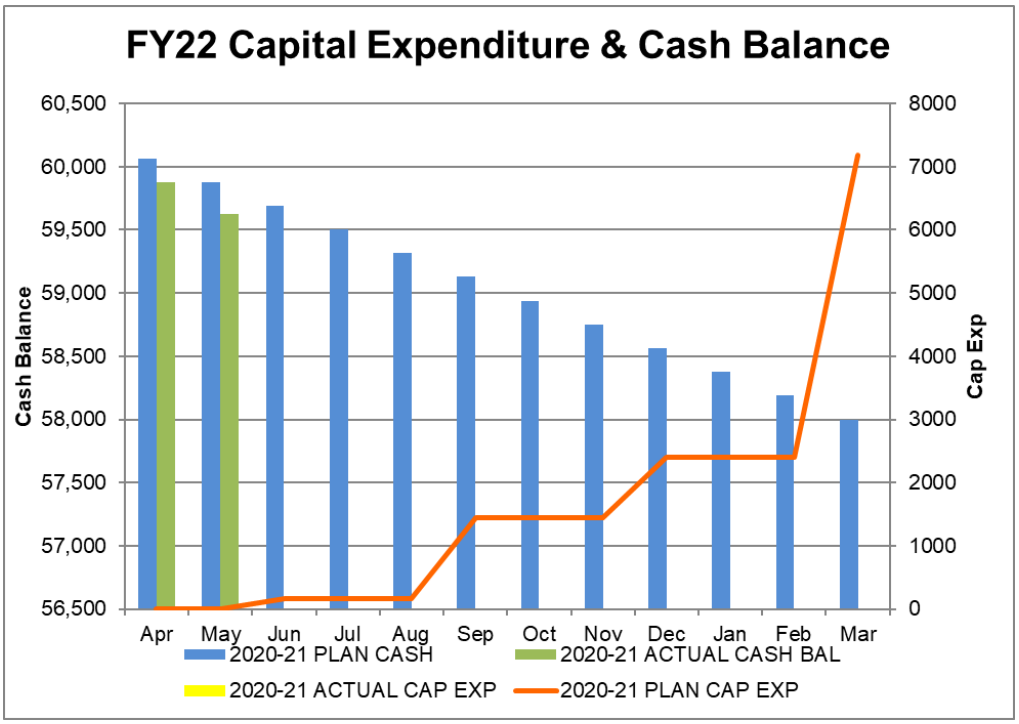
4. Cash and Capital

4.1 The capital plan approved by the Board is £7.187m for 2021-22.

4.2 Capital expenditure of £26k has been incurred to the end of May. This is in line with the planned spend profile for the year. 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 £59.6m, which is a negative variance of £0.2m to the cash-flow plan of £59.8m. Trust cash is slightly below plan due to the higher levels on both receivables and payables in month.

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 May the Trust has slightly less cash than planned.

5. Balance Sheet Commentary

5.1 Current assets

Receivables are in line with plan.

5.2 Current liabilities

Payables are in line with plan.

6. Recommendations

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

- The May financial position
- The continuing strong liquidity position of the Trust

Appendix A – SOCI

	Month 2			Cumulative YTD				Annual Plan (£000)
	Plan (£000)	Actual (£000)	Variance (£000)	Plan (£000)	Actual (£000)	Variance (£000)	%	
Clinical Income	**16,233**	**17,371**	**1,138**	**32,455**	**33,170**	**715**	**2%**	**194,682**
Other Income	506	532	26	1,008	1,215	207		5,948
Hosted Services	1,200	1,556	357	2,417	2,503	87		14,776
Total Operating Income	**17,939**	**19,459**	**1,520**	**35,880**	**36,889**	**1,009**	**3%**	**215,406**
Pay: Trust (excluding Hosted)	(5,748)	**(5,567)**	181	(11,591)	(11,083)	509		(67,757)
Pay: Hosted	(552)	**(487)**	65	(1,118)	(876)	242		(7,057)
Drugs expenditure	(6,745)	**(7,522)**	(776)	(13,491)	(13,893)	(402)		(80,946)
Other non-pay: Trust (excluding Hosted)	(3,914)	(4,447)	(533)	(7,733)	(8,715)	(982)		(47,965)
Non-pay: Hosted	(657)	(1,141)	(484)	(1,304)	(1,605)	(301)		(7,822)
Total Operating Expenditure	**(17,617)**	**(19,164)**	**(1,547)**	**(35,237)**	**(36,172)**	**(935)**	**3%**	**(211,547)**
Operating Surplus	**322**	**295**	**(27)**	**642**	**717**	**74**	**12%**	**3,859**
Profit /(Loss) from Joint Venture	67	114	47	134	114	(20)	-15%	804
Interest receivable (+)	401	394	(7)	801	787	(14)	-2%	4,809
Interest payable (-)	(439)	(451)	(11)	(878)	(885)	(7)	1%	(5,272)
PDC Dividends payable (-)	(350)	(350)	0	(700)	(700)	0	0%	(4,200)
Trust Retained surplus/(deficit)	**(0)**	**2**	**2**	**(0)**	**33**	**33**		**(0)**
CPL/Propcare	0	121	121	0	234	234		0
Consolidated Surplus/(deficit)]	**(0)**	**123**	**123**	**(0)**	**267**	**267**		**(0)**

Appendix B – Balance Sheet

	Unaudited 2021 (£000)	Plan 2022 (£000)	Year to date Month 2 YTD Plan (£000)	Actual YTD (£000)	Variance (£000)
Non-current assets					
Intangible assets	2,488	2,100	2,424	2,421	(3)
Property, plant & equipment	177,180	174,267	175,680	175,756	76
Investments in associates	181	181	181	295	114
Other financial assets	1,364	0	0	0	0
Trade & other receivables	161	100	134	139	5
Other assets	0	0	147	0	(147)
Total non-current assets	**181,374**	**176,648**	**178,566**	**178,611**	**45**
Current assets					
Inventories	4,201	4,200	4,201	4,225	24
Trade & other receivables					
NHS receivables	4,621	4,500	4,621	5,137	516
Non-NHS receivables	4,484	4,500	7,779	7,217	(562)
Cash and cash equivalents	63,533	58,000	59,875	59,629	(246)
Total current assets	**76,839**	**71,200**	**76,476**	**76,208**	**(268)**
Current liabilities					
Trade & other payables					
Non-capital creditors	28,222	30,000	28,222	28,581	360
Capital creditors	3,544	2,000	2,000	2,114	114
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	2,160	0
Other liabilities:-					
Deferred income	5,974	4,000	5,974	5,777	(197)
Other	0	0	0	0	0
Total current liabilities	**41,816**	**39,265**	**40,086**	**40,363**	**277**
Total assets less current liabilities	**216,398**	**208,583**	**214,957**	**214,457**	**(500)**
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**	**179,125**	**(512)**
Financed by (taxpayers' equity)					
Public Dividend Capital	67,374	68,116	67,374	67,374	(0)
Revaluation reserve	2,700	2,600	2,700	2,699	(1)
Income and expenditure reserve	110,264	105,667	109,563	109,052	(511)
Total taxpayers equity	**180,338**	**176,383**	**179,637**	**179,125**	**(512)**

Appendix C – Cash Flow

	FT	Group (exc Charity)
Cash flows from operating activities:		
Operating surplus	558	864
Depreciation	1,486	1,486
Amortisation	65	65
Impairments		
Movement in Trade Receivables	(1,933)	(10,152)
Movement in Other Assets	0	0
Movement in Inventories	642	(24)
Movement in Trade Payables	1,411	10,268
Movement in Other Liabilities	(280)	(288)
Movement in Provisions	0	104
CT paid	0	(25)
Net cash used in operating activities	**1,947**	**2,298**
Cash flows from investing activities		
Purchase of PPE	13	(27)
Purchase of Intangibles	0	0
Proceeds from sale of PPE	0	0
Interest received	787	0
Investment in associates	0	0
Net cash used in investing activities	**800**	**(27)**
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	(885)	(98)
Interest element of finance lease	0	0
PDC dividend paid	(700)	(700)
Finance lease - capital element repaid	0	0
Net cash used in financing activities	**(3,678)**	**(2,891)**
Net change in cash	**(930)**	**(620)**
Cash b/f	**53,765**	**60,248**
Cash c/f	**52,835**	**59,629**

Appendix D – Capital

Capital Programme 2021-22
Month 2

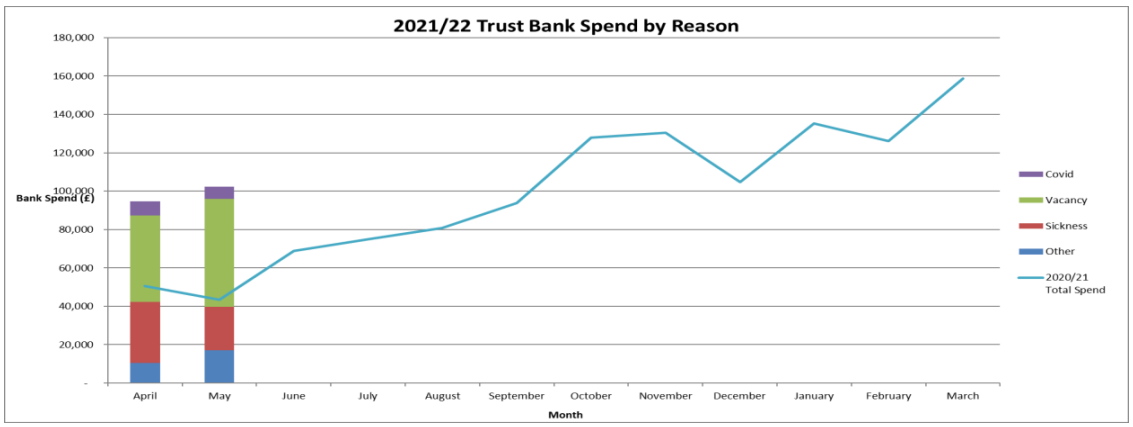
The Clatterbridge Cancer Centre NHS Foundation Trust

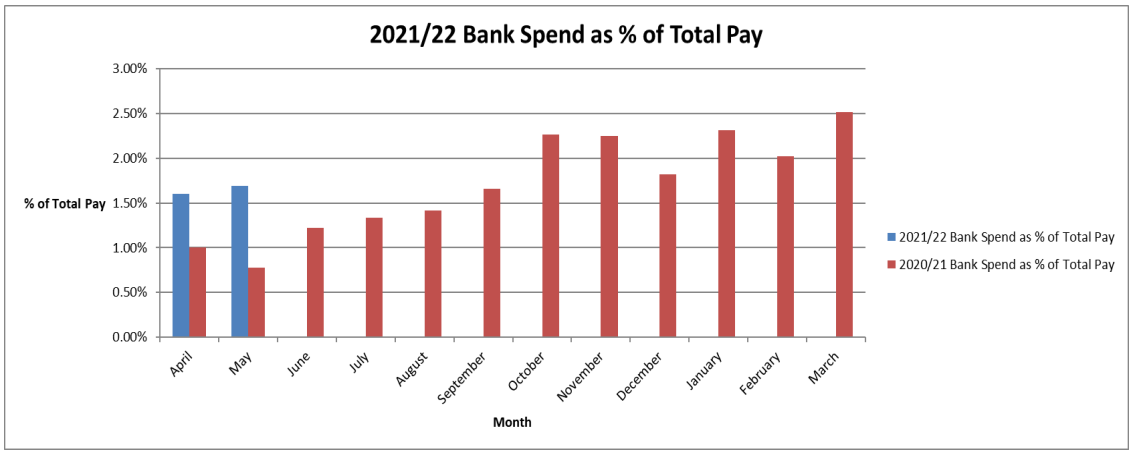
Code	Scheme	Lead	BUDGET			ACTUALS		FORECAST		Ordered?	Complete?	Comments
			NHSI plan 21-22	Approved Adjustments	Budget 21-22	Actuals @ Month 2	Variance to Budget	Forecast 21-22	Variance to Budget			
4194	***(20/21)*** Cyclotron refurb		0	0	0	3	3	0	0	✓	✓	
4195	***(20/21)*** CCCA Linacc Oak refurb		0	0	0	-3	-3	-4	-4	X	X	VAT recovery on 20/21 transaction
4201	***(20/21)*** Spine		0	0	0	-3	-3	0	0	X	X	
4303	CCCA Linac Bunker - Maple	Julie Massey	420	0	420	0	-420	420	0	X	X	BC approved at Finance Committee 11/06
4300	CCCW CT Simulator (Brilliance 2)	Louise Bunby	300	0	300	0	-300	109	-191	✓	X	BC approved at Finance Committee 11/06
4302	Air Handling Unit Upgrade	Mel Warwick	0	0	0	0	0	0	0	X	X	BC approved at Finance Committee 11/06
	Contingency	n/a	200	0	200	0	-200	394	194	-	-	
	Estates		**920**	**0**	**920**	**-3**	**-923**	**920**	**0**			
4303	CCCA Linear Accelerator - Maple	Julie Massey	2,460	0	2,460	0	-2,460	2,305	-155	X	X	BC approved at Finance Committee 11/06
	CCCL Mobile Imagine Intensifier	Sam Wilde	138	0	138	0	-138	138	0	X	X	
	MEME - Acute - Patient Monitor	Julie Massey	9	0	9	0	-9	11	2	X	X	
	MEME - Acute - 2x Ultrasound	Julie Massey	25	0	25	0	-25	30	5	X	X	
	MEME - Networked - 3x Scalp Cooler (I)	Julie Massey	28	0	28	0	-28	34	6	X	X	
	MEME - Networked - 6x Scalp Cooler (II)	Julie Massey	69	0	69	0	-69	83	14	X	X	
	MEME - Rad - Infinity Monitor M540	Julie Massey	9	0	9	0	-9	11	2	X	X	
	MEME - Rad - 3x Patient Monitor C500	Julie Massey	33	0	33	0	-33	40	7	X	X	
	MEME - Rad - 6x Patient Monitor M540	Julie Massey	54	0	54	0	-54	65	11	X	X	
4192	Cyclotron	Carl Rowbottom	742	0	742	8	-734	742	0	X	X	PDC Funded
4300	CCCW CT Simulator (Brilliance 2)	Louise Bunby	500	0	500	0	-500	666	166	✓	X	BC approved at Finance Committee 11/06
4301	Stand Aids		0	0	0	14	14	14	14	X	X	Ordered against revenue, not in cap plan
	Contingency	n/a	200	0	200	0	-200	129	-71	-	-	
	Medical Equipment		**4,267**	**0**	**4,267**	**22**	**-4,245**	**4,267**	**0**			
4190	***(20/21)*** Digital Aspirant	James Crowther	0	0	0	0	0	0	0	X	X	
	Infrastructure	James Crowther	1,350	0	1,350	0	-1,350	1,350	0	X	X	
	Other minor programmes	James Crowther	250	0	250	0	-250	250	0	X	X	
	IM&T		**1,600**	**0**	**1,600**	**0**	**-1,600**	**1,600**	**0**			
4142	Wirral	Peter Crangle	400	0	400	0	-400	400	0	X	X	
4142	CCC-L Link Bridge installation	Peter Crangle	0	0	0	6	6	0	0	X	X	
	Building for the Future		**400**	**0**	**400**	**6**	**-394**	**400**	**0**			
	TOTAL		**7,187**	**0**	**7,187**	**26**	**-7,161**	**7,187**	**0**			

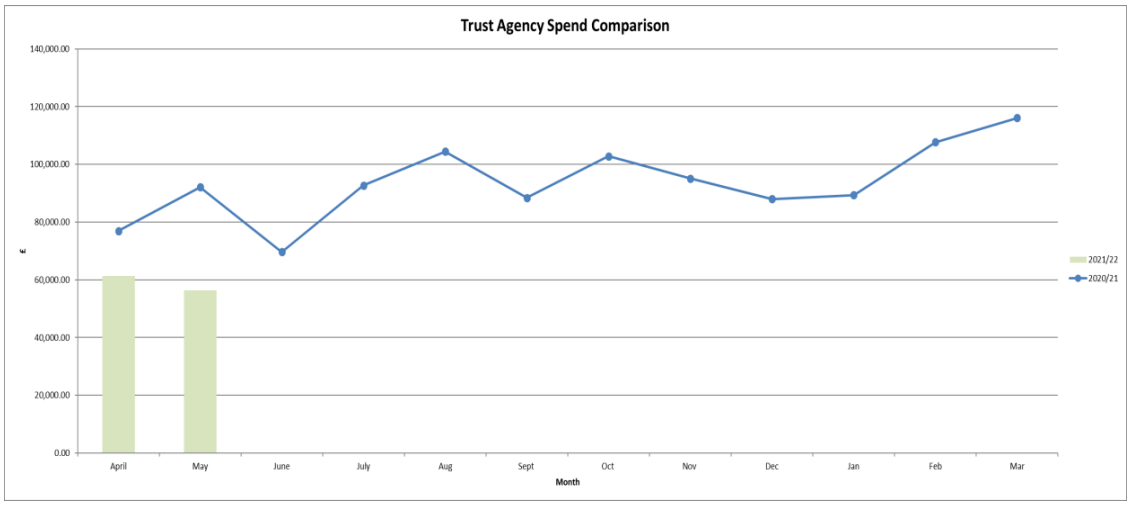
Appendix D –CIP Targets by Directorate

DIVISION/ CBU	Total Expenditure Budget	Final CIP Target	Target%
CBU4 - PHARMACY	6,451,883	132,339	2%
CBU5 - INPATIENT CARE	21,013,524	431,022	2%
ACUTE CARE DIRECTORATE	**27,465,407**	**563,360**	**2%**
COMMUNICATIONS	409,612	8,402	2%
EDUCATION	694,608	14,248	2%
EXECUTIVE OFFICE	2,948,754	60,484	2%
FINANCE	1,716,612	35,211	2%
IM&T CCC	5,834,988	119,685	2%
PMO	671,184	13,767	2%
QUALITY	486,780	9,985	2%
SAFEGUARDING	727,905	14,931	2%
SERVICE IMPROVEMENT TEAM	77,688	1,594	2%
WORKFORCE & OD	1,986,835	40,753	2%
CORPORATE DIRECTORATE	**15,554,966**	**319,058**	**2%**
CBU1 - DAY CARE & NETWORK	18,416,070	377,744	2%
CBU2 - OP & CLIN SUPPORT	2,700,176	55,385	2%
CBU3 - ADMIN SERVICES	5,415,048	111,071	2%
NETWORK DIRECTORATE	**26,531,294**	**544,200**	**2%**
CBU6 - RADIOTHERAPY	13,369,108	274,222	2%
CBU7 - RADIOLOGY SERVICES	4,006,677	82,183	2%
CBU8 - PHYSICS	4,727,852	96,976	2%
RADIATION SERVICES DIRECTORATE	**22,103,637**	**453,382**	**2%**
DIVISIONAL TOTAL	**91,655,304**	**1,880,000**	**2%**
CENTRAL CIP ALLOCATION		966,000	
FULL YEAR CIP 2021-22		**2,846,000**	
H1 2021-22 CIP TARGET		**1,423,000**	

Appendix E – Bank Graphs







REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	30th June 2021
Agenda item:	P1-103-21
Title:	Five-year strategic plan – strategy implementation report
Report prepared by:	Tom Pharaoh, Director of Strategy
Executive Lead:	-
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	-
Date & decision:	-

Purpose of the paper/key points for discussion:	This report provides a high-level update on early progress in the implementation if the new five-year strategic plan. The report draws out the commitments made in the strategy against the six strategic themes and provides an update on each of them. The report is intended to be a working document, to be developed throughout the life of the strategic plan. It is proposed that over time the information in this report is supplemented by more detailed updates on key projects and in-depth reporting on each of the strategic themes. The Board is asked to: • Note the contents of the report • Consider the regularity with which it would like to receive this report over the coming years, and • Consider in what other ways it would like to receive assurance on the implementation of the five-year strategy.

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

Next steps required:	Agreement of ongoing reporting against the implementation of the five-year strategy.

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.

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

FIVE-YEAR STRATEGIC PLAN 2021-2025

Strategy implementation report - JUNE 2021

Introduction

Our new five-year strategic plan sets out our aims and ambitions for the coming years against six strategic themes.

The strategic plan sets out a number of commitments for each strategic theme. This report draws out these commitments and provides an update on each of them.

This report is intended to be a working document, to be developed throughout the life of the strategic plan, that provides a high-level update on our progress and challenges in its implementation.

It is proposed that over time the information in this report is supplemented by more detailed updates on key projects and in-depth reporting on each of the strategic themes. The final section of the report begins to set out how this might be achieved, subject to discussion and agreement.

Strategy implementation report

Be outstanding

Deliver safe, high quality care and outstanding operational and financial performance

Work stream in strategy		Commitment in strategy	Latest	Next
Quality and safety	Clinical quality strategy	Implement clinical quality strategy	Current clinical quality strategy expires 2021.	Strategy to be revised - draft to be prepared in advance of the arrival of new Chief Nurse.
	Patient safety	Empower staff to report near misses and incidents	Following a review of the Trust's clinical governance structure a Patient Safety Group will be formed and led by new Associate Director of Clinical Governance. Group will lead the delivery of the national patient safety agenda in the Trust and report to Integrated Governance Committee.	Group to meet for the first time in July 2021. Terms of reference to be drafted in preparation.
	Patient experience and involvement	Implement our dementia and learning disability strategies	Implementation of the dementia strategy (2019-2021) remains on track as it enters its third year. The Trust has over 45 Dementia/Learning Disability and Autism Champions who support the delivery of the strategy ensuring robust provision and monitoring of work plans.	Awaiting the outcome of a recent submission of the NHS Improvement Learning Disability Standards which will help highlight any areas of improvement during 2021-2022 and inform the new strategy from 2022 onwards.
		Implement our patient involvement and engagement strategy	The Trust is engaged in the NHS Improvement Learning Disability Standards to measure the quality of service provision to those with a Learning Disability and/or autism. We also contribute to the LeDeR programme and have a Safeguarding Practitioner who is the Lead for this work plan.	The Trust continues to engage with external stakeholders such as Service Users Reference Forum (SURF) for dementia and Pathways Associates who are our Confirm and Challenge Group for Learning Disabilities and/or Autism.
	Quality improvement	Review and refresh our quality improvement methodology	Work undertaken with Advancing Quality Alliance (AQuA) to refresh our approach to quality improvement and build a culture and system for improvement.	A session will be held with the senior leadership team in Q4 of 2021/22, to be facilitated by AQuA. Session will allow reflection on the learning from the programme of masterclasses (set out below) and agreement of the CCC approach to QI and its interrelation to our other endeavours.

Strategy implementation report

Be outstanding

Deliver safe, high quality care and outstanding operational and financial performance

Work stream in strategy		Commitment in strategy	Latest	Next
		Provide training for staff in quality improvement skills to equip staff to lead change and improvement	Work with AQuA also includes the building of QI capacity across the Trust, initially through the development of a programme of masterclasses to take place during the rest of 2021/22.	Schedule of sessions now agreed. First of six sessions will take place in September 2021 with further sessions monthly until February. Focus at this stage will be divisional and business unit leadership teams as well as corporate leadership.
	Clinical governance	Embed new clinical governance structure	Staff turnover in clinical governance leadership positions has prompted a further review of the Trust's clinical governance structures in May and June 2021.	Review now complete. Conclusions presented to and approved by Quality Committee - changes to be implemented from June 2021 and monitored through QC.
	Regulation and accreditation	Maintain good CQC rating while striving for outstanding	CQC now using 'transitional monitoring approach' (TMA) that sees inspection targeted when monitoring of risks and key lines of enquiry raises concerns.	Ongoing engagement and maintenance of position with CQC through TMA discussions. New Chief Nurse to lead relationship on arrival.
		Maintain key clinical accreditations and compliance with regulatory standards	Register of regulatory and advisory relationships developed following recent clinical governance review. Includes dates of upcoming visits, inspections, accreditations and submissions. Also details who lead contacts are and current status of relationships.	Maintenance and update of register. Head of Risk and Compliance has Trust wide oversight. Monitored by sub committees that report to IGC.
	Supporting quality of care	Work with the charity to develop a quality of care grant	General plans in development to align fundraising plans with the implementation of the five-year strategy.	Develop and refine plans through Trust Executive Group.
Operational performance	Clinical structure	Reorganise clinical divisions to underpin SRG model	Reorganisation undertaken and now complete. New clinical structure in place and communicated across the Trust.	Outstanding clinical director vacancies to be filled.

Strategy implementation report

Be outstanding

Deliver safe, high quality care and outstanding operational and financial performance

Work stream in strategy	Commitment in strategy	Latest	Next
Maximising the benefits of CCC-Liverpool	Fully integrate services for haemato-oncology and solid tumour patients in the chemotherapy unit and non-chemotherapy day case area	Project group forming to progress. Work to be based on an assessment of activity following move plus changes to patient pathways.	Project group to be formed and work programme developed.
	Further integrate our haemato-oncology services with those in the North Mersey area	Programme underway to integrate Aintree University Hospital haemato-oncology service into CCC. Steering group in place with representation of CCC, LUHFT, commissioners. Business case drafted. Comprehensive program of public engagement led by CCC.	Conclude public engagement and develop conclusions. Finalise business case finances and TUPE arrangements for staff from LUHFT. Governance through TEG. Transfer to take place in October 2021.
	Manage the comprehensive service level agreement	Regular oversight group in place between LUHFT and CCC. Suggested changes to clinical services in SLA to be developed through Clinical and Operational Group and Trust Executive Group before discussion at joint oversight group with LUHFT.	Ongoing management of relationship and SLA.
	Report on delivery of benefits of CCC-L	Work not yet begun.	Project to be timetabled for an appropriate future date.
Developing our services	Fully open our teenage and young adult (TYA) unit in CCC-L	The TYA day case unit opened in February 2021 providing chemotherapy and other supportive cancer care in a dedicated day case facility. The TYA in-patient unit opened in April 2021 with four beds staffed with a mix of Haemato-oncology and Solid Tumour nursing staff trained in the delivery of SACT.	Acute Care Division to review TYA unit staffing model in light of levels of activity.

Strategy implementation report

Be outstanding

Deliver safe, high quality care and outstanding operational and financial performance

Work stream in strategy	Commitment in strategy	Latest	Next
	Develop an interventional radiology service	Project group formed to lead the development of the service in CCC-L. Service will support service delivery and research. Joint working needed with interventional radiology service at Royal Liverpool.	Timetable for project group to take progress updates to TEG now established.
	Upgrade the National Centre for Eye Proton Therapy	Contract with external contractor agreed to upgrade safety critical control system. Commercial treatment planning system procured. Engineering programme manager recruited and in post.	Kick-off project meeting with external contractor in early June. Timescale for project completion to be agreed (likely 18+ months). Commissioning of commercial system for clinical use (timescale 4 months). Review and development of component level upgrades (timescale 6 months).
	Develop a sustainable and high quality model of care for the Isle of Man	CCC clinicians formerly provided an element of service on island. Covid-19 expedited an ongoing review of the service. New service model developed of remote care with face-to-face consultation on mainland. Supported by digital team and electronic prescribing.	Improved pathway now agreed by Trust Board and in place. Service appropriately funded by Isle of Man. Ongoing monitoring of KPIs.
	Fully open aseptic pharmacy production unit in CCC-L. (Not a commitment in the five-year strategy but a key project that emerged following its completion)	Preparations for opening unit continue. New Aseptic Pharmacy Move Programme Board created with executive leadership to oversee and scrutinise preparations. Plans in place or in development for both facility readiness (including estate readiness and unit cleanliness) and service mobilisation (transition plan and workforce/training plans).	Programme Board to meet monthly up to an beyond transition into CCC-L unit. Current estimate for transition is September, subject to timetable of testing and quality assurance. Monthly updates from Programme Board to TEG.
Embedding our clinical model	Develop plans to ensure that we continue to deliver and develop services based on the principles of the clinical model	SRG recovery plans and divisional business plans developed.	Implementation and ongoing monitoring.

Strategy implementation report

Be outstanding

Deliver safe, high quality care and outstanding operational and financial performance

Work stream in strategy		Commitment in strategy	Latest	Next
		Continue to work with our partners on the development of the CCC eastern sector hub	Progress delayed by covid-19 pandemic. Ongoing engagement with commissioners. Recent positive correspondence received.	Continued engagement with commissioners and Cheshire & Merseyside Health and Care Partnership to conclude the process and establish an Eastern hub.
	Improving urgent and unplanned care	Develop a comprehensive and coordinated approach to urgent cancer care	Programme Board developed by CCC with partners from across the system. Clinical, executive and programme leadership for programme board come from CCC. Aim of board is to draw together relatively disparate activity into coherent programme.	Programme board updates on progress to TEG according to timetable.
		Support coordinated expansion of acute oncology services across the region	Project manager in place and funded by Cheshire and Merseyside Cancer Alliance. Recent extension of project manager term.	Project driven by Urgent Care Programme Board. Updates on progress to TEG as per timetable.
		Consider whether the operating hours of CDU should be extended to cover the weekend	Reviews of Hotline service and CDU in early 2021 resulted in service improvements and further action plans. Consideration of extended hours now in context of wider service review and entire urgent cancer care system.	Ongoing CDU work is reported operationally to Clinical and Operational Group. Monitoring of progress through Programme Board and up to TEG.
	Meeting operational targets	Support the regional delivery of the new 28-day Faster Diagnosis Standard and the revised cancer waiting time standards	See Cheshire and Merseyside Cancer Alliance update in 'Be collaborative'.	-
		Minimise waiting times for face-to-face appointments through good capacity and demand planning	Capacity and demand work underway. Led by Admin Services team with the support of Business Intelligence.	Conclude capacity and demand work and develop action plan accordingly.

Strategy implementation report

Be outstanding

Deliver safe, high quality care and outstanding operational and financial performance

Work stream in strategy	Commitment in strategy	Latest	Next
High quality environments	Redevelop the CCC-Wirral site	First phase of refurbishment and consolidation of office accommodation to allow removal of portakabins now complete. Joint estates masterplanning process underway with WUTH for Clatterbridge campus.	Continue to support joint estates masterplanning process up until its conclusion (August 2021). Presentation of conclusions to TEG and Trust Board and consideration of next steps.
	Work with the charity to develop a plan for the upgrade if priority patient environments across our sites	General plans in development to align fundraising plans with the implementation of the five-year strategy.	Develop and refine plans through Trust Executive Group.
	Move relevant staff into The Spine and develop the our relationship with RCP	Spine opened in 05/2021. Corporate departments, charity team and divisional management now located in building. Meet and greet with senior RCP team in May 2021. Site visits have taken place for key staff to RCP event and education floors.	Review use of accommodation after 3 months. Raise awareness of hot desking capacity when Covid restrictions allow or review opportunity to accommodate other corporate/support teams on site. Develop firm proposals for education and events to take place in RCP accommodation.
Financial performance	Deliver a productivity improvement programme	Cost improvement programme launched in May 2021 with a focus on recurrent savings to support critical investments.	Schemes in development. Monitoring of development and delivery of cost improvement programme schemes through TEG and Performance Committee.
	Deliver an effective capital programme	Five-year capital programme in place. Business case process to ensure investment in the areas that deliver sustainable services and the latest care for patients.	Ongoing process delivered through TEG, Finance Committee and Capital Committee.

Strategy implementation report

Be outstanding

Deliver safe, high quality care and outstanding operational and financial performance

Work stream in strategy	Commitment in strategy	Latest	Next
	Deliver our partner programme, increasing charitable income and continuing to grow the private clinic	Building charitable programme to recover following impact of Covid. Linking fundraising plan with strategy implementation. Strong focus on research & innovation and patient environments. Private clinic growth focused on new services (like interventional radiology) and new markets (Liverpool following the move to CCC0L, and haemato-oncology).	Review of private clinic leadership ensure that growth is supported. Continue to build charitable programme develop new opportunities.
Sustainability	Develop plans to continue to create social value in our local communities and reduce our waste, water consumption and carbon footprint in line with the ambitions set out in the NHS Long Term Plan	Sustainability group in formation to lead the development of a Green Plan for the Trust. Led by Director of Strategy. Representatives from PropCare, Workforce, Procurement and Communications initially.	Develop action plan and draft Green Plan for engagement.

Strategy implementation report

Be collaborative

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

Work stream in strategy	Commitment in strategy	Latest	Next
Cheshire & Merseyside Cancer Alliance	Play a full part in the work of the Cancer Prevention Steering Group	Cancer alliance prevention steering group has been affected by covid-19 pandemic. Due to restart in summer 2021.	Director of Strategy to represent the Trust on the steering group when it is reconvened.
	Work through the alliance to explore whether any of our sites could be used to develop an RDC model	Cancer alliance programme focuses on Rapid Diagnostic Services (rather than 'Centres') to emphasise pathways rather than buildings. CCC teams currently involved in development of two RDSs - one for primary liver cancer patients (with LUHFT colleagues) and one for haemato-oncology patients.	CCC to continue to lead or contribute to RDS development with cancer alliance colleagues as appropriate. RDS development to report through TEG.
	Continue to support the delivery of the 28-day Faster Diagnosis Standard and faster diagnosis pathways	Development of Rapid Diagnostic Services (see above) will support the delivery of the faster diagnosis pathways.	As above.
Cheshire & Merseyside Health & Care Partnership	Play a full and active role in the partnership	CCC CEO is SRO for Cancer Alliance (the cancer vehicle for the Partnership) and endoscopy network. CEO has also led the development of the Community Diagnostic Hub (CDH) programme for Cheshire and Merseyside with input from others at CCC.	Continue to lead CDH programme and engage in the development of the Health & Care Partnership.
	Explore whether we can offer imaging capacity to support our partners in the region	Trust has undertaken significant amounts of mutual aid in imaging for partners in the system during Covid pandemic (WUTH and LUHFT). Clatterbridge health campus (which includes CCC-W) has been agreed as an early adopter CDH site. Trust teams now working with WUTH to implement CDH by July.	Work with WUTH and C&M Partnership to further develop Clatterbridge campus CDH model over the rest of 2021.

Strategy implementation report

Be collaborative

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

Work stream in strategy	Commitment in strategy	Latest	Next
Radiotherapy Operational Delivery Network	Play a full and active role in the ODN	CCC CEO is chair of the ODN and members of the team are actively involved in its work programme. Work to date has focused on clinical sustainability of low volume services.	Continue to actively participate in ODN and its work programme.
	Support and mentor services outside of the North West to develop their SABR services	CCC has been allocated 3 stereotactic ablative radiotherapy (SABR) centres to mentor. Each is at a different point in its development. ODN team has coordinated.	Work is ongoing.
Genomics	Ensure molecular diagnostic testing is available and access to molecular testing is embedded into pathways	Ongoing engagement with nascent North West Genomic Medicine Service Alliance hosted in Manchester. Creation of Genomics Steering Group to lead the genomics agenda within the Trust. Also liaison with cancer alliance as whole system approach necessary.	Position paper to be prepared for TEG and Quality Committee in July 2021.
Other partnerships	Explore where there will be benefits to working together with specialist trusts in areas like estates, innovation and research	Ongoing collaborative working with Liverpool's other specialist trusts.	Further areas of sustainability and equality, diversity and inclusion recently added to the specialist trust work programme.

Strategy implementation report

Be a great place to work

Attract, develop and retain a highly skilled, motivated and inclusive workforce to deliver the best care

BE A GREAT PLACE TO WORK

Work stream in strategy	Commitment in strategy	Latest	Next
Leadership	Enhance leadership skills and capacity across all levels of the trust, with an increased focus on supporting middle managers and developing a pipeline of talent	Launch of the Trust Leadership and management passport and coaching framework. Leadership and management apprentice programmes.	Relaunch leadership and management offers. Increase coaching capacity within the trust. Implementation of talent management plan by Q3 2021. Establish a process to support Peer Leadership and reverse mentoring.
	Reorganise the directorate structures to ensure the SRGs are embedded	Reorganisation complete. Implementation of new structure onto all workforce systems.	Workforce model and workforce planning for the future. OD support to divisions to embed new teams and support MDT working and increased collaboration.
	Develop an AHP strategy to harness the potential and enhance the value of AHPs	Linda Williams (Lead AHP) leading on development. Draft developed and engagement with AHP staff taking place.	Refinement, agreement and communication of strategy. Development of action plan to support its delivery.
Recruitment	Promote a compelling employer proposition placing emphasis on the harder to recruit groups		Development of recruitment and retention strategy.
	Focus on the recruitment of a research workforce for the future, including academic clinicians and clinician scientists		Development of recruitment and retention strategy.
	Work with schools, colleges, universities and community groups to improve access routes for local people into Trust jobs	Links developed across Liverpool city region with schools, colleges and employability programmes to support TfC agenda. Work paused due to Covid.	Paper due at Education Governance Committee in July around programme restart. Key areas of focus for year one will be developing structured work experience placements with school and colleges and implementing traineeship programmes (2 cohorts in year 1).
Workforce transformation	Continue to develop our innovative approach to workforce planning, creating new roles and new career pathways		

Strategy implementation report

Be a great place to work

Attract, develop and retain a highly skilled, motivated and inclusive workforce to deliver the best care

Work stream in strategy	Commitment in strategy	Latest	Next
	Sustain agile ways of working in support of our multi-site clinical model beyond Covid-19		Review of agile/flexible and home working options.
Retention	Provide a comprehensive reward and recognition package	Trust will be gifting all staff with a 'wellbeing pass' and a £25 gift voucher in recognition of hard work and support during the pandemic.	
	Continue and refine the e-PADR process	Health and Wellbeing conversation aligned to 2021/22 PADR (in line with People Plan). Draft specification sent to Informatics Merseyside for enhancements to talent management process and reporting.	
Culture and engagement	Foster an open, transparent and high performing culture, where staff feel valued and recognised, actively participate and feel empowered to raise concerns	Divisional Culture and Engagements Groups implemented to support increased staff engagement. AQuA QI programme delivery scoped for September 21-March 22. Review of values and behaviours work commencing in June.	Further work needed around Freedom to Speak Up.
	Develop an inclusive and healthy environment where everyone is treated with respect and dignity		Re-launch our Trust values and behaviours underpinned by a Trust compact, including staff involvement on implementing our values and behaviours in action.
	Actively engage with and involve our diverse communities, ensuring that seldom-heard groups are included from a patient and staff perspective	Staff network implemented.	Recruitment of equality, diversity and inclusion (EDI) lead in collaboration with specialist trust alliance.
	Work proactively to increase the diversity of our workforce		Recruitment of EDI lead in collaboration with specialist Trusts and development of EDI action plan.

Strategy implementation report

Be a great place to work

Attract, develop and retain a highly skilled, motivated and inclusive workforce to deliver the best care

Work stream in strategy	Commitment in strategy	Latest	Next
	Review our trust values	Review taking place during June and July. This will include open staff sessions, SmartSurvey, targeted engagement sessions and floor walking.	Re-launch our Trust values underpinned by a Trust compact. Embedded new values and behaviours into recruitment, PADRs, development programmes, induction etc.
Health and wellbeing	Implement our health and wellbeing plan	Work continues on embedding and enhancing our health and wellbeing support for staff. Significant improvement in the theme of health and wellbeing was seen in 2020 national staff survey.	Continue with health and wellbeing work.
Education and training	Achieve teaching hospital status	Initial working group formed to complete self assessment against teaching hospital criteria. Assessment revealed that requirements are largely met, with gaps in research that will be addressed through the implementation of the new research strategy.	Develop plan and timeline for achievement of full teaching hospital status and explore what can be achieved during research strategy implementation.
	Implement our education strategy	Delivery of the implementation plan led by Associate Director of Clinical Education on behalf of the Trust.	Progress against the delivery plan reported into Education Governance Committee biannually as the formal monitoring and oversight committee.

Strategy implementation report

Be research leaders

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

Work stream in strategy	Commitment in strategy	Latest	Next
Research strategy	Implement our research strategy	Strategy endorsed by Trust Board 10/2020. Associated operational Business Plan approved 01/2021. Research Strategy started 04/2021.	Research Strategy currently with the designers. Once finalised it will be officially launched through Communications and sent out to key stakeholders.
Clinical trials delivery and infrastructure	Strengthen key aspects of the research and innovation staffing infrastructure and the core team, such as additional research nurses and biobanking staff	Appointed 1 x Senior Research Practitioner, 2 x Research Practitioner, 1 x R&I Communications Lead. Contributed to 1 x Chair post. Maintained 14 x SRG Research Leads posts.	Research Delivery, Governance and Finance teams preparing job descriptions for additional approved infrastructure. Next appointments 3 x clinical trials administrators, July 2021.
	Develop clinical job plans with protected time for research activities and recruit research active clinicians	8 x Research PAs available during 2021/22.	Process to allocate PAs is being discussed and will be developed.
	Submit our renewal bid for the ECMC in 2022	Clinical Director of ECMC provided assurance at May 2021 Clatterbridge Committee for Research Strategy (CCRS) that the renewal is on track.	Work towards renewal submission June 2022.
Academic research	Increase the number of academic staff within the trust with the aim of securing a future BRC and CRUK Centre status	1 x Senior Lecturer to be appointed 09/2021	CRUK Centre Liverpool bid - expression of interest successful, invited to submit a full-stage application in May 2021.
	Support and foster an environment for growth in academic oncology	Research Rounds' fortnightly seminars by CCC researchers, and University scientists to foster and re-invigorate a research community at CCC.	Clatterbridge Research Funding Scheme 2021/22 to be launched 09/2021. Planning for the Research@Clatterbridge day.
	Expand the clinical research fellow programme	1 x Clinical Research Fellow to be appointed 09/2021.	Process to appoint the post to be developed.

Strategy implementation report

Be research leaders

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

Work stream in strategy	Commitment in strategy	Latest	Next
	Increase research in advanced radiotherapy techniques	Radiotherapy Research Strategy under development.	Strategy ready for review 30th June 2021.
Liverpool Cancer Research Institute	Support the implementation of the LCRI	LCRI endorsed by Trust Board October 2021. Continue to support LCRI activities through representation on the LCRI Partnership Board and Leadership Committee.	Support LCRI symposium/launch. Support establishment of LCRI Advisory Board.
	Contribute to the delivery of the LHP cancer programme	Supporting the development of the Programme.	Supporting the development of the Programme.
Allied health professional research	Expand medical physics based research in line with development in imaging and radiotherapy techniques	Increased trials using imaging and radiotherapy.	Initiate discussions through the CCRS.
	Invest to promote research awareness and participation within other non-medical areas such as pharmacy, nursing, AHPs and IM&T	Research Rounds' fortnightly seminars by CCC researchers, and University scientists to foster and re-invigorate a research community at CCC.	Clatterbridge Research Funding Scheme 2021/22 to be launched 09/2021. Planning for the Research@Clatterbridge day.
Genomics, biobanking and digital developments	Establish and embed genomics as routine care	Genomic testing already routine in clinical trials.	To be developed through the Genomics Steering Group.

Strategy implementation report

Be digital

Deliver digitally transformed services, empowering patients and staff

Work stream in strategy	Commitment in strategy	Latest	Next
Digital strategy	Develop our digital strategy	Be Digital sessions facilitated by Cube Creative November and December 2020. "Day in your Life" sessions with Health Care International (HCI) with staff around systems and processes. HCI Group have spoken to over a hundred staff in the Trust covering clinical and administration roles in Meditech.	Drafting of Digital Strategy is underway. Work of Cube Creative and HCI group will help. HCI work will identify key themes from interviews, feeding into a wider piece of work, including changes to current processes and ways of working, training, and the reconfiguration of the current build in Meditech. The HCI group will support identification of functionality in Expanse (next generation Meditech), to support the delivery of patient care for CCC.
	Achieve HIMSS level 7 status	Work commenced with HIMSS for self assessment of level 7 requirements. The Digital Team have engaged with the Electronic Medical Record Adoption Model (ERAM) Team to undertake at level 6 and 7 HIMSS gap analysis.	The initial assessment to be conducted using an online self-assessment tool focusing on level 6. The gaps identified will help set some of the Digital and EPR development priorities within the Trust for the next year and steps required to achieve level 7.
Delivering digital for patients	Engage with our patients to design solutions through co-production	Co-production pre Covid taken place with our patients around Patient Held Records (PHR) to codesign solutions.	Specific review of PHR functionality with Teenage and Young Adult cohort of staff to test communication of letters. Planned engagement with Patient Involvement and Engagement (PIEG). Planned work with Patient Volunteer Group. Digital staff to be involved in corporate nursing team "Walking in your shoes" initiative.

Strategy implementation report

Be digital

Deliver digitally transformed services, empowering patients and staff

Work stream in strategy	Commitment in strategy	Latest	Next
	Expand use of telehealth and other new technologies to keep individuals connected with health professionals and support the delivery of care closer to home	Attend Anywhere is fully rolled out and training complete with all clinicians and administration staff. Patient feedback in review along with clinician feedback. CCC early adaptor of Patient Held Record.	To work with clinical, operational and patient groups to determine where the role of remote consultation fits in within the patient choice agenda. To work with the Cheshire and Merseyside Health and Care partnership (C&M HCP) around existing telemonitoring solutions already in place across Cheshire and Merseyside with a view to support care closer to home initiative.
	Work with other to develop a single digital access point for patients across Cheshire and Merseyside that gives patients access to their electronic records	The Trust is feeding data into e-xchange, also known as share2Care which contains patient level data for Trusts across Cheshire & Merseyside. CCC has been an early adopter of this platform which can be accessed, within patient context from Meditech. The Trust is also feeding data into CIPHA (Combined Intelligence for Public Health Action) The Trust is also an early adopter of system wide Patient Held Record (PHR) initiative that will, in the future, utilise the data that is currently within Share2Care. The PHR will be accessed via a single NHS login, enabling patients to access their own health records, correspondence and appointments. It will also include an ecosystem of apps- so that the patient has one place to go to access all of the health care records.	Continue to be part of the C&M strategic review of current shared records platforms. Continue sharing data sets to CIPHA and Share2Care. Commence TYA pilot with PHR.
	Give patients access to assistive technology, including remote monitoring	CCC patients are linked into early adopter of the Patient Held Record (PHR) solution, giving patients access, through a single NHS log in, to an ecosystem of apps.	Ongoing engagement of C&M pilot. Full review of outcomes of the CCC TYA pilot. Further engagement with clinical and operational teams for further opportunities of remote monitoring.

Strategy implementation report

Be digital

Deliver digitally transformed services, empowering patients and staff

Work stream in strategy	Commitment in strategy	Latest	Next
Delivering digital for our people	Empower and equip our workforce with digital skills to become fully agile and digitally connected to the wider health and social care environment	Trust wide digital champions identified departmentally for MS Teams. Training plan with workforce and OD around Meditech in development ensuring clinical skills is aligning to clinical systems. Workforce & OD offer of digital skills passport to support basic generic competencies.	Full review of Meditech training, and digital skills, aligned with workforce and OD and Clinical skills educators. Action Plan in development and reviewed at Digital Board.
	Enable our people to make intelligence-driven decisions and have access to the right digital tools	Roll out of BI Tools/Dashboards in progress.	Create a space for education and innovation to enable optimum usage and prioritisation of these products.
	Embed strong clinical digital leadership	The Digital Team works closely with the Trusts Chief Clinical Information Officer (CCIO) and has recently recruited to a new post of Chief Nursing Information Officer (CNIO) role who will join the team in July 2021. The team hosts a Digital Pharmacy team that is led by the Chief Medicines Information Officer.	Associate CCIO and other clinical roles to be outlined and supported within Job planning in clinical divisions.
Be driven by intelligence	Establish a true business intelligence function	The Business Intelligence (BI) function has now been created and all positions have been filled. Engagement is taking place to embed BI into all working day practices.	Review the role of the Clinical Effectiveness Team (CET) and its fit into BI/Digital and improving efficiency within the Trust.
	Deliver a new data warehouse and a single set of data visualisation tools	Single Data Warehouse delivered which currently includes data from ESR, Datix-Web, Meditech, IPM and CUR Systems. Power BI and SSRS are the chosen visualisation tool in place. The roll out and awareness and engagement of dashboards is in progress.	Additional data sources to be added into the data warehouse including, Safecare, Datix iCloud, Telephony, PADR, Perfect Ward etc. Full work plan of next dashboards completed and work in progress to deliver.

Strategy implementation report

Be digital

Deliver digitally transformed services, empowering patients and staff

Work stream in strategy	Commitment in strategy	Latest	Next
	Share data across Cheshire & Merseyside as part of the CIPHA programme	Feeds are going into CIPHA which include real time HL7 messages for Demographics, Inpatient ADT and Outpatient appointments. Vaccine workforce data also being included for vaccination programme.	Potential pilot use case on cancer being explored with CIPHA and Consultant Clinical Oncologist for lung cancer and sarcoma to help improve quality of life in Lung Cancer patients through using combined data to predict health outcomes.
Secure and robust digital infrastructure	Work with partners to deliver a 'cloud first' approach to our digital infrastructure	A private cloud has been developed with Alder Hey and Liverpool Women's, is now live and serving the Meditech environment.	Complete the migration of the corporate environment to hybrid cloud solution.
	Achieve Cyber Essentials Plus status	The Trust has renewed its cyber highway subscription and the Cyber team are undertaking a gap analysis of steps to achieve Cyber Essentials Plus (CE+) accreditation.	Continue the work towards CE+ and ISO27001 accreditation, with the objective to be as secure as we possibly can be, promoting good security principles and practices.
	Embed collaboration tools to support better communication and collaboration across our sites	Microsoft Teams deployed to all workstations in the organisation. CCC are leaders in the use of Microsoft Teams. All meeting rooms are now furnished with collaboration technology.	Continue promoting the use of Microsoft Teams across our organisation, using facilities such as 'Digital Tip of the Week'.

Strategy implementation report

Be innovative

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

Work stream in strategy	Commitment in strategy	Latest	Next
Build the capacity, capability and culture to support innovation	Develop an innovation strategy to encapsulate how we will build the capacity, capability and culture to support innovation	Funding secured through the Research Strategy for a Innovation Manager and Clinical Director of Innovation. Intellectual Property Policy approved at May 2021 TEG.	Develop job description for both posts. Strategy will be written following appointment.
	Establish an Innovation Fund	£150k secured through The Clatterbridge Cancer Charity.	Bright Ideas' scheme being developed alongside QI training for Trust Staff. Documentation to support the process to be developed.
Improving patient care through innovation	Expand the Clatterbridge in the Community programme	Expanding from 5wte up to 10wte nurses this year and opening additional hub at CCC-A.	Second hub at CCC-A to open towards end of Q3. Clinical teams to identify additional patients who would be appropriate for the service.
	Introduce model of stratified outpatient follow-up	Patient-initiated follow-up based on risk stratification. Stratified outpatient follow-up in place for breast cancer. Now extended to prostate.	Extend stratified follow-up to haemato-oncology and develop further with other SRGs.
	Sustain and embed the use of telemedicine in outpatient care beyond Covid-19	SRG recovery plans produced outlining return to activity and the proportion that will remain virtual.	Delivery and monitoring of recovery plans.
	Develop an 'innovation bunker' on the CCC-Liverpool site	Work yet to begin.	Small group to be formed to explore the concept and the work required to progress.
Subsidiaries and joint venture	Develop and grow our subsidiaries and joint venture	PropCare is developing a 3-5 year business plan to include succession planning and further explore opportunities to support partner trusts. CPL currently supported by project manager with scope to review internal processes and consider opportunities to optimise logistics and productivity.	PropCare to complete and begin to deliver business plan. Potential case for investment to be developed in CPL to increase automisation and thereby reduce risk of errors. Private patient joint venture growth as per update under 'Be outstanding'.

Strategy implementation report

Be innovative

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

Work stream in strategy	Commitment in strategy	Latest	Next
Explore opportunities	Explore commercial opportunities as they arise	Ongoing process.	
	Take opportunities that enhance and strengthen our national and international reputation and brand	Ongoing process.	

Strategy implementation: governance timetable

Trust Executive Group

A forward plan is in development to regularise the frequency at which updates on key clinical services projects are given at the Trust Executive Group. This will help teams manage their workloads and ensure that there is clarity about what is expected by when.

DRAFT: Project updates to Trust Executive Group (TEG)

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Urgent Cancer Care Programme Board		07-Jun			06-Sep						
Genomics Steering Group			05-Jul				01-Nov				
Interventional Radiology Project Group		07-Jun				04-Oct					
Pharmacy Move Programme Board		07-Jun	05-Jul		06-Sep	04-Oct					
Aintree Haemato-oncology Integration Steering Group	04-May		05-Jul		06-Sep		01-Nov				
Further key projects tbc.											

Trust Board

The Board is asked to consider:
- the regularity with which it would like to receive this report over the coming years, and
- in what other ways it would like to receive assurance on the implementation of the five-year strategy.

The latter could take the form of regular focus sessions on one of the strategy's six strategic themes (similar to the focus on 'Be collaborative' at the May 2021 Trust Board meeting) or a focus instead on the progress in key projects and work streams.

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board	
Date of meeting:	30 June 2021	
Agenda item:	P1-104-21	
Title:	Board Assurance Framework: Quarter 1	
Report prepared by:	Angela Wendzicha	
Executive Lead:	Liz Bishop	
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	Trust Board
Date & decision:	26 May 2021

Purpose of the paper/key points for discussion:	The Board Assurance Framework relating to Quarter 1 is presented to the Board with the inclusion of the section relating to controls, assurance and gaps in controls. From June 2021, each Board Committee will review the Board Assurance Risks aligned to each respective Committee.

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

Next steps required:	For ongoing development of the Board Assurance Framework.

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.

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

BAF Summary													
BAF ID	**Risk**	**Owner**	**Oversight Committee**	**Q1 2021/22**	**Target Risk**	**Risk Appetite**							
B1	If we do not have robust Trust-wide quality and clincial governance arrangments in place we will not deliver safe and effective care resulting in poor outcomes for our patients and negative regulatory outcomes.	CN/MD	Quality Committee	**3x4=12 ↔**	2x1=2	Regulatory compliance, patient safety: **Low (4-8)**							
B2	Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk of failing to deliver against heatlhcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.	COO	Quality Committee & Performance Committee	**3x3=9 ↔**	2x2=4	Contractual and regualtory compliance: **Low (4-8)**							
B3	Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	DofF	Performance Committee	**3x4=12 ↔**	2x2=4	Financial: **Low (4-8**), but in limited circumstances **Moderate (9-12)**							
B4	If we do not build upon the work with the Cancer Alliance and other partners, this will adversely affect the Trust's ability to positivley influence prevention, early diagnosis, standardisation of care and performance in cancer care services.	CEO/DofS	Performance Committee	**3x4=12 ↔**	2x4=8	Partnerships: **Moderate (9-12)**							
B5	If we do not maintain our ECMC status this will adversely affect patient access to the latest novel therapies, CCC research reputation, acquiring CRUK status which in turn will have an impact on CCC's ability to support early phase trial research, progress against the Reserach Strategy and academic oncology in Liverpool.	MD	Quality Committee & Performance Committee.	**3x5=15↔**	2x4=8	Patient experience: **Low (4-8);**							
B6	Issues within Pharmacy Aseptic Unit adversely impacting on the manufacturing and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan, adversely impacting on patient accessibility to research and reputational damage with Sponsors.	MD	Quality Committee	**3x5=15↔**	2x2=4	Patient experience: **Low (4-8)**;							
B7	If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	Dof W&OD	Quality Committee	**3x4=12↔**	2x3=6	Workforce: **Low (4-8)**							
B8	If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	Dof W&OD	Quality Committee	**3x4=12↔**	2x3=6	Workforce: **Low (4-8)**							
B9	if we do not support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	DofW&OD	Quality Committee	**3x3=9↔**	2x3=6	Workforce: **Low (4-8)**							
B10	If we do not invest a clear vision, sufficeint capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve it's digital ambition.	CIO	Performance Committee & Quality Committee	**3x3=9↔**	2x2=4	Digital: **Low (4-8)**							
B11	If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	CIO	Performance Committee & Quality Committee	**3x4=12↔**	3x3=9	Digital: **Low (4-8)**							
B12	If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	DofF	Performance Committee	**4x3=12↔**	2x3=6	Commercial and Partnership working: **Moderate (9-12)**							

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

	B6	Issues within the Pharmacy Aseptic Unit adversely impacting on the manufacture and dispensing of drugs resulting in some trials not being set up or re-opened as part of the recovery plan adversely impacting on patient accessibility to research and reputational damage with Sponsors.	MD	Quality Committee	3	5	15	3	5	15↔	2	2	4
Strategic Priority	**BAF ID**	**Risk**	**Risk Owner**	**Committee Oversight**	**Initial Risk Score**			**Q1 Risk Score**			**Target Risk**		**Score**
					L	**C**	**Score**	**L**	**C**	**Score**	**L**	**C**	
Be a Great Place to Work: which means that we will attract, develop and retain highly skilled, motivated and inclusive workforce to deliver the best care.	**B7**	If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	DofW&OD	Quality Committee	3	4	12	3	4	**12↔**	2	3	6
	B8	If we are unable to recruit and retain high calibre and diverse staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	DofW&OD	Quality Committee	3	4	12	3	3	**9↔**	2	3	6
	B9	If we do not support and promote employee health and wellbeing, this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence	DofW&OD	Quality Committee	3	4	12	3	3	**↔9**	2	3	6
Strategic Priority	**BAF ID**	**Risk**	**Risk Owner**	**Committee Oversight**	**Initial Risk Score**			**Q1 Risk Score**			**Target Risk**		**Score**
					L	**C**	**Score**	**L**	**C**	**Score**	**L**	**C**	
Be Digital: which means we will deliver digitally transformed services, empowering patients and staff.	**B10**	If we do not invest a clear vision, sufficeint capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve it's digital ambition.	CIO	Quality Committee & Performance Committee	3	3	9	3	3	**9↔**	2	2	4
	B11	If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	CIO	Quality Committee & Performance Committee	3	4	12	3	4	**12↔**	3	3	9
Strategic Priority	**BAF ID**	**Risk**	**Risk Owner**	**Committee Oversight**	**Initial Risk Score**			**Q1 Risk Score**			**Target Risk**		**Score**
					L	**C**	**Score**	**L**	**C**	**Score**	**L**	**C**	
Be Innovative: which means we will be enterprising and innovative, exploring opportunities that improve or support patient care.	**B12**	If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS.	DofF	Performance Committee	3	3	9	4	3	**12↔**	2	3	6

BAF 1	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.

	Controls and Mitigation *(what are we currently doing about this risk)*
Ref	
C1	Deep dive reports completed in relation to the Aseptic Unit, Datix Icloud and the Management of Complaints with associated action plans.
C2	Mortality Review and Mortality Surveillance Groups established.
C3	Quarterly Clinical Audit and NICE compliance reports to Integrated Governance committee.
C4	Quarterly updates to Quality committee on progress against Action Plans relating to Patient Experience Surveys .
C5	Patient Experience Strategy in place.
C6	Quality & Safety meetings in Divisions monthly

	Assurances/Evidence *(how do we know we are making an impact)*
A1	Reports to Integrated Governance Committee and Quality committee provide assurance to the respective Committee members.
A2	Regular engagement meetings with the CQC
A3	Audit Committee receives the Annual Clinical Audit Report.
A4	Financial sustainability and ability to invest in services
A5	We will be in the top decile National Cancer Patient Experience Survey results.
A6	Monthly quality section in Integrated Performance Report

	Gaps in Controls/Assurances *(actions to achieve target risk scores)*	**Deadline for Action to Close Gap**	**Action Lead**
G1	Review of existing clinical governance function ongoing.	Jul-21	Interim CN
G2	Development work ongoing in relation to the Medicine Incident Report: Reports monthly to the Quality Committee	Monthly - ongoing	Interim Chief Pharmacist
G3	Regulatory Compliance Register to be approved.	Jun-21	Head of Risk & Compliance

BAF 2	Operational sustainability: If the demand for treatment exceeds the resources available, we are at risk for failing to deliver against healthcare standards which will impact on our ability to recover performance to the required levels within the agreed timeframes.

REF	Controls and Mitigation *(what are we currently doing about this risk)*
C1	Robust monthly Integrated Performance Report presented at Board and Board Committees.
C2	

	Assurances/Evidence *(how do we know we are making an impact)*
A1	Internal Audit Reports (MIAA) on performance metrics.
A2	Deep dive report received through Performance Committee.

	Gaps in Controls/Assurances *(actions to achieve target risk scores)*	Deadline for Action to Close Gap	Action Lead
G1	Further development of the IPR in line with national guidance.	Ongoing	Head of Planning and Performance
G2			

BAF 3	Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.

	Controls and Mitigation *(what are we currently doing about this risk)*		Assurances/Evidence *(how do we know we are making an impact)*		Gaps in Controls/Assurances *(actions to achieve target risk scores)*	Deadline for Action to Close Gap	Action Lead
REF							
C1	Standard monthly reporting to Trust Board and Board Committees.	A1	Detailed reports both internally and externally.	G1	The funding mechanism for H2 2021-22 is unknown.		
C2	Divisional and departmental budget setting	A2	Subject to both Internal and External Audit.	G2	Inability to plan for activity and resource due to G1 above.		
C3	Block funding received for H1			G3	The approach in Cheshire and Merseyside ICS to ERF is unknown.		
C4	Receive activity predictions from Cheshire and Merseyside						
C5	Reports through Finance Committee, and Performance Review Groups.						
C6	Utilise intelligence from Cheshire and Merseyside Cancer Alliance to understand likely activity flows from secondary care.						

BAF 4 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.

Ref	Controls and Mitigation *(what are we currently doing about this risk)*
C1	The Trust is host to the Cheshire and Merseyside Cancer Alliance.
C2	The Trust CEO is the SRO for the Cheshire and Merseyside Cancer Alliance
C3	Funding has been approved until 2024.

	Assurances/Evidence *(how do we know we are making an impact)*
A1	Monthly reports from Cancer Alliance to Board
A2	Cheshire and Merseyside Cancer Alliance is lead for Radiology ODN

	Gaps in Controls/Assurances *(actions to achieve target risk scores)*	Deadline for Action to Close Gap	Action Lead
G1			
G2			

BAF 5 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.

	Controls and Mitigation *(what are we currently doing about this risk)*
Ref	
C1	Approved Research Strategy in place.
C2	Monthly ECMC Clinical Translation meetings held monthly.
C3	ECMC update through Directorate Board on any operational issues.
C4	Dedicated ECMC study set up in place.
C5	ECMC Research Practitioner and Clinical Trials Support Officer in place.
C6	Dedicated Early Phase Trial Clinic at CCC.

	Assurances/Evidence *(how do we know we are making an impact)*
A1	Progress against the Research Strategy Business reported to Performance Committtee quarterly.
A2	Trials unpaused to recruiment from 17 May 2021.

	Gaps in Controls/Assurances *(actions to achieve target risk scores)*	Deadline for Action to Close Gap	Action Lead
G1	Completed ECMC application paper		
G2	Project Plan required to assure resouces are available for renewal.		
G3	Establsih regular meetings of ECMC Senior Management Team for renewal planning and outputs.		
G4	Inability to generate sufficent Charitable funds to support the Research Strategy.		

BAF 6	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.

Ref	Controls and Mitigation *(what are we currently doing about this risk)*
C1	Full action plan and daily sit rep in place
C2	Mutual aid in place in Pharmacy.
C3	Clear communication with Sponsors

	Assurances/Evidence *(how do we know we are making an impact)*
A1	Monthly reports on progress to Quality Committee
A2	Some trials have been upaused

	Gaps in Controls/Assurances *(actions to achieve target risk scores)*	Deadline for Action to Close Gap	Action Lead
G1			
G2			

BAF 7 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 5 Year Strategy.

Ref	Controls and Mitigation *(what are we currently doing about this risk)*
C1	Leadership programme in place
C2	Bespoke leadership and OD programme in place for Divisional triumverates
C3	Coaching available for staff
C4	Competency framework for nursing staff
C6	Clinical Education Strategy

	Assurances/Evidence *(how do we know we are making an impact)*
A1	High calibre appointments completed.
A2	National staff survey results
A3	Quarterly Culture & Engagement Pulse
A4	Workforce KPIs monitored at PRGs, subcommittees and Board
A5	PADR process

	Gaps in Controls/Assurances *(actions to achieve target risk scores)*	Deadline for Action to Close Gap	Action Lead
G1	Talent mapping for critical posts		
G2	Competency framework for AHPs		
G3	Workforce Strategy in development		

BAF 8	If we are unable to recruit and retain high calibre and diverse staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.

Ref	Controls and Mitigation *(what are we currently doing about this risk)*
C1	Workforce Transformation Committee established.
C2	EDI Steering group in place
C3	BAME and LGBT staff networks in place
C4	Joint EDI lead appointment and shared service with TWC and AH
C5	Retention plans in place for nursing and A&C staff

	Assurances/Evidence *(how do we know we are making an impact)*
A1	Turnover KPI monitored at PRGs, subcommitees and Board
A2	PADR process in place and compliance monitored at sub-committees and Board
A3	WRES completion and action plan
A4	WDES completion and action plan
A5	Annual staff survey results
A6	Recruitment Policy up dated and in place

	Gaps in Controls/Assurances *(actions to achieve target risk scores)*	Deadline for Action to Close Gap	Action Lead
G1	EDI targets to be agreed		
G2	Workforce Dashboard that will establish trajectories.		
G3	EDI service agreement to be developed		
G4	Values based recruitment model		

BAF 9	If we do not support and prioritise employee health and wellbeing this will adversely impact on the stability of opur workforce in term sof recruitment, retention and absence.									
	Controls and Mitigation *(what are we currently doing about this risk)*				Assurances/Evidence *(how do we know we are making an impact)*			Gaps in Controls/Assurances *(actions to achieve target risk scores)*	Deadline for Action to Close Gap	Action Lead
Ref										
C1	Culture & Wellbeing Groups in place in each Div and for Corporate Servives			A1	Annual staff survey results		G1	Culture and Engagement Steering Committee to be established		
C2	OH and counselling service in place for all staff			A2	Quarterly Staff Culture and Engagement Pulse results		G2	H&WB objectives for line managers		
C3	EAP service avilable for all staff			A3	Contract monitoring for OH, counselling and EAP		G3	H&WB Guardian role to be embedded		
C4	Trained Mental Health First Aiders in place along with Train the Trainers			A4	All staff have a personal H&WB objective included in their PADR		G4	Implentation plan for health and wellbeing		
C5	H&WB Guardian in place			A5	Leadership programme includes wellbeing modules					
				A6	Leadership masterclass programme includes resilince modules					
				A7	Workforce KPIs monitored at PRGs, sub-committees and Trust Board					

BAF 10	If we do not invest a clear vision, sufficient capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve it's digital ambition.

Ref	Controls and Mitigation *(what are we currently doing about this risk)*
C1	Digital Strategy In development
C2	Digital Maturity HIMs level 5 achieved
C3	Global Digital Exemplar (GDE) Fast Follower programme completed
C4	Engagement with the Trust on the relevance and importance of Digital and commitment to "buy in" to transformational Change
C5	Digital Board Chaired by Medical Director with Trust wide membership with overight of progress. Reporting of progress via Trust strategy implementation reporting process.

	Assurances/Evidence *(how do we know we are making an impact)*
A1	Faciliated engagement sessions in place, "Be Digital" Dec 2020, "Day in your Life" interviews scheduled until 21.05.21. Iterations of strategy to come through Digital Board and appropriate Governance commitees up to Trust Board
A2	Externally accredited. Governance through Digital Board
A3	Organisation to be endorsed as National Digital Leader status from NHSx/NHSD
A4	Operational and Clinical engagement in place. Clinical Digital Leadership is in place. Governance mechanisms via divisional performace reviews, Clinical and operational meetings.

	Gaps in Controls/Assurances *(actions to achieve target risk scores)*	Deadline for Action to Close Gap	Action Lead
G1	Lack of Digital Strategy		
G2	External reviews underway for HIMs level 6. Working towards HIMs level 7		
G3	Final accrediation presentation pending.		

BAF 11	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.

Ref	Controls and Mitigation *(what are we currently doing about this risk)*		Assurances/Evidence *(how do we know we are making an impact)*		Gaps in Controls/Assurances *(actions to achieve target risk scores)*	Deadline for Action to Close Gap	Action Lead
C1	Anti Virus Software up to date across server and PC estate and regualarly maintained	A1	Trust was an early adopter of NHS Digital Care Cert reporting for assurance of all patching requirements. Tasks logged and regular assurance back to NHSD	G1	Constant review and liason with NHSD NHSx Cyber Security attacks are ever changing and will be unknown and unplanned, Constantly changing sources of attack.		
C2	Domain migration and new enterprise back up solution	A2	Substantial Assurance MIAA review	G2	Constant review of new vulnerabilities. Cyber Security attacks are ever changing and will be unknown and unplanned, Constantly changing sources of attack.		
C3	Windows Advanced Threat Protection (ATP) fully implemented in line with NHS Digital Windows 10 upgrade programme	A3	Assurance of progress from NHS Digital Leaderboard on progress of implemtation	G3	Continue to work under national direction (windows 10 complete)		
C4	Cyber essentials Accrediataion	A4	Externally certified	G4	Working towards Cyber Eseentials Plus Accrediation and IS27001.		
C5	Active monitoring in place via the following tools: 1) ITHEALTH Dashboard monitoring all devices on the network alonmg with active directory activity. Automtically reports on care certs and vulnerabilites. 2) LEPIDE: categorises files on the network and who accesses them. 3) ARMIS mediacl device monitoring in place	A5	significant assurance MIAA Cyber Security Review	G5	Trust's Digital Security team undertaking NSCS Cyber Incident Planning and response course with examinations pending		
C6	Digital Maturity HIMs level 5 achieved	A6	Externally accredited	G6	External reviews underway for HIms level 6. working towards HIMs level 7		

BAF 12 If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS

Ref	Controls and Mitigation *(what are we currently doing about this risk)*
C1	Renewed Contract between the Trust and the Mater Private Healthcare in the form of a Limited Liability Partnership.
C2	Financial Business model developed by the Mater.
C3	Separate Governance arrangements for CPL and PropCare with separate Boards

	Assurances/Evidence *(how do we know we are making an impact)*
A1	Governance arrangements in place with Joint Board between the Trust and the Mater.
A2	Subsidiaries reports to Performance Committee and Trust Board
A3	Continued growth in Subsidiary Companies.

	Gaps in Controls/Assurances *(actions to achieve target risk scores)*	Deadline for Action to Close Gap	Action Lead
G1	Joint Venture Board to meet on a monthly basis		
G2	Currently one CPL Director on long term sick with one newly appointed Director - succession planning and backfill proposal required.		
G3			

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board	
Date of meeting:	30 June 2021	
Agenda item:	P1-105-21	
Title:	Trust Board Reporting Cycle	
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 paper represents the current cycle of business for the Trust Board. The Board will note that progress against the 5 Year Strategy will be completed following discussions at the June Board in line with Agenda Item P1-103-21.

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

Next steps required:	For completion of the Strategy section and implementation.

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.

Trust Board Annual Reporting Cycle 2021/22														
		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	
Strategy & Planning														
Progress against 5 Year Strategy														
Be Outstanding														
Be Collaborative														
Be Research Leaders														
Be A Great Place to Work														
Be Digital														
Be Innovative														
Progress against OD Strategy							√				√			
Annual Financial/Operational Planning Guidance								Commence discussions				√ Draft	√ Submission	
Assurance: Quality, Performance														
Quality Committee Chair Report		√	√	√	√		√	√	√		√	√	√	
Performance Committee Chair Report		√	√	√	√		√	√	√		√	√	√	
Audit Committee Chair Report		√		√	√			√			√			
Charitable Funds Committee Chair Report					√			√			√			
Integrated Performance Report		√	√	√	√		√	√	√		√	√	√	
Safer Staffing Report				√							√			
Gender Pay Gap													√	
WRES													√	
WDES													√	
EDI Annual Report													√	
Patient/Staff Narrative		√	√	√	√		√	√	√		√	√	√	
In-Patient Survey					√									
Staff Survey Results							√							
Board Governance														
Review of Constitution (every 3 years)					√									
Board Assurance Framework				√	√			√			√			
Risk Appetite Statement								√						
Board Committee Annual Reports					√									
Statutory Reporting/Compliance														
Annual Report & Accounts including the Annual Governance Statement				√										
External Audit Findings Report and Letter of Representation				√										
Quality Report					√									
Self-Certification against the Provider Licence				√										
Regualtion 5 Declarations (Fit and Proper)					√									
Emergency Preparedness Resilience and Response (EPRR) Annual Report							√							
Learning From Deaths (Mortality Report)					√				√			√		
Revalidation Annual Report							√							
Guardian of Safe Working Report				√				√				√		
Infection Prevention and Control Annual Report					√									
Freedom to Speak Up Annual Report					√									
Health and Safety Annual Report							√							