AGENDA

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Trust Board of Directors Meeting held in Public

Date: Wednesday 29 September 2021	Location: via **MS Teams**
Start Time: 09:00	Finish Time: 12:30

Timings	Item No		Lead	Paper/Verbal
Opening Matters				
09:00	**P1-132-21**	Welcome & Apologies:	**KD**	**Verbal**
	P1-133-21	Declarations of Committee Members' and other attendees' interests concerning agenda items:	**KD**	**Verbal**
	P1-134-21	Minutes of last meeting: 28 July 2021	**KD**	**Paper**
	P1-135-21	Matters arising/Action Log	**KD**	**Paper**
	P1-136-21	Chair's Report to the Board	**KD**	**Verbal**
Risk and Assurance				
9:15	**P1-137-21**	Quality Committee Chair's Report	**TJ**	**Paper**
9:25	**P1-138-21**	Performance Committee Chair's Report	**GB**	**Paper**
09:35	**P1-139-21**	Staff Story – Trudy Guinan Immunotherapy	**TG**	**Presentation**
9:50	**P1-140-21**	Patient Experience Visits	**JSp**	**Paper**
10:00	**P1-141-21**	New Consultant Appointments	**SK**	**Paper**
10:10	**P1-142-21**	Integrated Performance Report: Month 05	**JSp/JSh**	**Paper**
10:30	**P1-143-21**	Finance Report: Month 05	**JT**	**Paper**
10:50	**P1-144-21**	Health & Safety Annual Report	**JSp**	**Paper**
11:00	**P1-145-21**	Emergency Preparedness Resilience and Response (EPRR) Annual Report	**JSp**	**Paper**
10:40	**P1-146-21**	Core Standards for Emergency Planning	**JSp**	**Paper**

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11:10	**P1-147-21**	Gender Pay Gap	**JSh**	**Paper**
11:20	**P1-148-21**	Workforce Race Equality Standards	**JSh**	**Paper**
11:30	**P1-149-21**	Workforce Disability Equality Standards	**JSh**	**Paper**
11:40	**P1-150-21**	Staff Survey & Culture and Engagement Update	**JSh**	**Paper**
11:50	**P1-151-21**	Appraisal and Revalidation- Annual Board Report and Statement of Compliance	**SK**	**Paper**
System Working				
12:00	**P1-152-21**	Cheshire & Merseyside Cancer Alliance Performance Report	**LB**	**Paper**
Corporate Governance				
12:10	**P1-153-21**	Constitution: For Final Approval	**MS**	**Paper**
12:20	**P1-154-21**	Board Meeting Review	**ALL**	**Verbal**

Next Meeting:

Date: Wednesday 27 October 2021	Location: TBC
Start Time: 09:00	Finish Time: 12:30

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Minutes of the Trust Board of Directors held in Public

Held on: Wednesday 28 July 2021	Location: The Spine & via MS Teams
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
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
Alun Evans (AE)	Staff Side Representative

Observer
None

Item no.	Agenda item	Action
P1/107/21	**Chair Welcome and Note of Apologies** The Chair welcomed all to the meeting and no apologies were noted.	
P1/108/21	**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 Medical Director of Research, Liverpool University Hospital NHS Foundation Trust • Geoff Broadhead – Nominated Non-Executive Director for CPL • Asutosh Yagnik – Declared the MHRA has become a client of his Company. • James Thomson – Executive Lead for PropCare and CPL	

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P1/109/21	**Minutes of Previous Board Meeting: 30 June 2021** The minutes of the Board meeting held on 30 June 2021 were approved subject to the following amendment: **P1-95-21:** In the second paragraph, "MS" should read "MT. **The Trust Board:** • **Approved** the minutes of the previous meeting subject to the above amendment.	
P1/110/21	**Matters Arising/Action Log** The Board noted that actions were either complete, on the Agenda or not yet due, in addition the following update was provided: **P1-155-21:** JSh confirmed that, subject to the availability of the speaker, the Board will receive unconscious bias training prior to the September Board. **The Trust Board:** • Noted the position in relation to the Action Log.	
P1/111/21	**Chair's Report to the Board** KD informed the Board that the interviews for the new Chair of the Cheshire and Merseyside ICS have taken place and no appointment was made. David Flory will act as the interim Chair and introductory meetings have been arranged with all Trust Chairs from the region. The interim Chief Officer for the ICS has been announced as Sheena Cumiskey. **The Trust Board:** • **Noted** the update provided.	
	Risk and Assurance	
P1/112/21	**Quality Committee Chair Report** TJ provided an overview of the report, alerting the Board to continuing issue relating to the Aseptic Unit, acknowledging the progress that had been made to date. However, the recommissioning of the new unit is dependent upon the reports from Quality Control North West and the outcome from the review of the air handling system and the Quality Committee is keeping both matters under review. TJ further alerted the Board to the discussion relating to the ECMC risk on the Board Assurance Framework. The Quality Committee noted that the operational risk had been reduced but the BAF risk remained at 15 and the committee will continue to monitor this. TJ advised the Board of an update received relating to the ocular proton facility noting that both hardware and software upgrades are in progress. A question was raised on the timescales provided in the report relating to the commercial treatment planning	

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	being in clinical operation service by October 2021 and the expected date for completion being October 2022. AW clarified that the Committee noted two timeframes, October 2021 for the system being in operation and October 2022 being component level replacements for the system hardware upgrade is October 2022. TJ further advised the Board that the report relating to medicine management continues to evolve and will continue to review this on a monthly basis. The Board was assured in relation to management of controlled drugs and noted the annual reports approved by the Quality Committee. MT sought clarity on the staffing model relating to the Aseptic Unit; TJ confirmed the staffing issues relate to the clinical trials team and JSp provided assurance that following the two resignations, people are in post. **The Trust Board:** • **Discussed and noted** the content of the report.	
P1/113/21	**Performance Committee Chair Report** GB provided an overview of the report advising the Board that a detailed discussion had taken place in relation to the Financial and Operational Planning for 2021-22 and in particular noting the guidance changes on an almost daily basis. GB assured the Board that the Committee received the first performance report from PropCare and whilst good performance was noted by the Committee, the report would benefit from further development. In addition, GB highlighted that the Performance Committee received assurance in relation to the update on the service development within the Clinical Decisions Unit. **The Trust Board:** • **Discussed and noted** the content of the report.	
P1/114/21	**Charitable Funds Committee Chair Report** EA provided an overview of the report highlighting that the update relating to the bogus collector and the policies approved should be RAG rated green. In addition, EA highlighted the discussions around independent status, advising the Board that although this has been an ongoing issue, a proposal will be presented at the September Board on this matter. **The Trust Board:** • **Discussed and noted** the content of the report.	**AW (to add to part 2 agenda)**
P1/115/21	**Audit Committee Chair Report** MT provided an overview of the report alerting the Board to the re-scheduling of the Value for Money work which is an important piece of work by the Trust External Auditors which is now expected to be received in September 2021. In addition, given	

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	the difficulties encountered during the audit process, a review has been requested which may be challenging given the contract with Grant Thornton ends in September. MT further advised that the tender process is underway in relation to our External audit provision with consideration being given to a direct award. MT assured the Board the Data Security and Protection Toolkit submission was completed on 29 June 2021 on a 'standards met' basis. Acknowledgment was given to all those who were instrumental in completing this work on behalf of the Trust. MT further assured the Board of the Annual Reports the Committee had received from the Performance Committee and the Quality Committee, both of which provided assurance of not only the scope of the work carried out by the Committees but the cross Committee working that has been developed. JW sought clarity as to whether it is out-with the normal process to use a direct award. MT confirmed that ongoing advice is being provided and an exercise is being carried out whereby the market is being tested. **The Trust Board:** • **Discussed and noted** the content of the report.	
P1/116/21	**Audit Committee Annual Report to the Board** MT informed the Board that, in accordance with its Terms of Reference, the Audit Committee is required to provide an Annual Report to the Board that assures the Board the Committee has fulfilled its role as an Audit Committee. In providing an overview of the report, MT highlighted the following: a) Section 2 describes the Committee Terms of Reference b) Section 5 details the business carried out by the Audit Committee during the last year c) Section 6 describes the detail of the reports provided by the Audit Committee to the Trust Board in addition to the annual reports received by the Performance Committee and Quality Committee whereby assurance was received that both Committees have fulfilled their respective Terms of Reference. MT further stated, taking account of the above, and all other items within the report, as Chair of the Audit Committee he was content to conclude that the Audit Committee has fulfilled its role for 2021-22. GB added that he is a member of the Audit Committee and informed the Board that despite the busy year for the Audit Committee, MT has done an excellent job as Audit Committee chair. MT acknowledged and thanked AW for her diligent work in drafting the report. EA commented on the Audit Committee chair providing the report and the committees reporting into the Audit Committee. AW provided clarity on the Audit Committee as an 'independent' function that is required to scrutinise internal processes and provide assurances to the Board. On behalf of the Board, KD thanked MT for all his work with the Audit Committee acknowledging the Committee is in sage hands.	

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	The Trust Board: • **Discussed and noted** the content of the report.	
P1/117/21	**Patient Story** KD informed the Board that the gentleman due to attend Board today had hoped to attend to tell his story but is too poorly to attend today. It is evident from the document he provided and circulated in advance that most of what he wanted to say to the Board is supportive and complimentary although he has provided some commentary around car parking for both patients and staff. LB added that in relation to staff car parking, staff are still adjusting to the walk from the car park and informing the Board that the new car park is due to open on 6 September. On behalf of the Board, KD thanked the gentleman for taking the time to share his thoughts with the Board, concluding that as a Board we wish him well. LB further informed the Board that as the majority of our patients are ambulatory, the Board also needs to hear from patients who travel in for their treatment and are not in-patients. JSp confirmed that she will work with the Deputy Director of Nursing and the Head of Patient Experience to ensure the Board hears from all our patient cohorts. **The Trust Board:** • **Discussed and acknowledged** the content of the narrative provided to Board and • **Thanked** the patient for taking the time to provide his story to the Board and passed on good wishes to him.	**JSp**
P1/118/21	**Patient Experience Visits** JSp provided an overview of the report informing the Board the visit took place on 12 July and one of our Governors, Steve Sanderson joined our Head of Patient Experience (via virtual technology) for the visit to Level 6, chemotherapy unit and ward 4. JSp highlighted the following from the visit: a) One of the patients on ward 4 commented on the variation in temperature control with the need for additional blankets being purchased. b) Positive comments had been received in relation to the food and the choices available. c) The issue of loneliness was raised again by some the patients and the work of the volunteers was acknowledged in supporting patients. TJ commented that the issue of communication has been picked up by the Quality Committee and a deep dive has been requested on this particular topic. MT added that it was pleasing to see positive comments relating to food as this has been on the Board agenda for a while. AR sought clarity on the range of food available for our patients and KD requested that information relating to the menus be circulated to the Non-Executive Directors for their information.	**AW**

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	SB raised the question of whether more could be done with the patient carts to try and alleviate the feeling of loneliness for our patients. JSp confirmed that the technology is already utilised but it is the personal contact patients are missing. GB asked whether the volunteers have a role in helping reduce the feeling of isolation and loneliness for patients with JSp confirming that a 'buddying' programme has been established in addition to the volunteers visiting the wards on a daily basis. In addition, the winter garden is being used for named visitors to attend with EA added caution to that KD sought clarity on any changes to our rules around visiting given the emerging national guidance. JSp confirmed that none of the Trusts within Cheshire and Merseyside have relaxed the rules on visiting and further guidance is awaited once the prevalence of infection has reduced. SK added that with some of our vulnerable patient groups, it may still be some time before we can lift some of the restrictions. AR noted that some hospitals have a radio station which lifts patients spirits; JSp confirmed we do not have a hospital radio in place. KD concluded that it is important that the Board focuses on how our patients are experiencing our services and looks forward to further reports. **The Trust Board:** • **Discussed and noted** the content of the report and • **Requested** information around menu choices is circulated to the Non-Executive Directors for information.	
P1/119/21	**New Consultant Appointments** KD acknowledged that no new Consultants have commenced at the Trust in month but appointments have been made and they will have started by September and will therefore feature in the September report.	
P1/120/21	**Integrated Performance Report: Month 04** JSp provided an overview of the report highlighting that both the Performance Committee and Quality Committee had reviewed it in detail. JSp noted the new NHS System Oversight Framework metrics published in June have been included for information and that the Trust is waiting to receive the targets which are expected to be available for month 4. JSh further highlighted that the friends and family test for staff is now open with a focus around culture and to date, 350 responses have been received. MT raised the question relating to completion of VTE risk assessments with JSp confirming that a note has been added to Meditech reminding staff the prescription should not be completed unless the assessment has been carried out. EA sought clarity on the 60 members of staff who had neither received nor refused the covid-19 vaccination. JSh confirmed that the Infection, Prevention and Control team are currently reviewing this as when the figures were reviewed they had been static for a period of time therefore a data cleanse is being carried out to ensure the figures are up to date. JW added that it was pleasing to see that the complaint response times had improved.	

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	KD concluded that the Board Committees have had the opportunity to discuss the report in detail which is the correct approach. **The Trust Board:** • **Discussed and noted** the content of the report.	
P1/121/21	**Finance Report: Month 03** JT provided an overview of the financial position for month 3, highlighting an overall break even position in line with the plan. JT further highlighted the following: a) Pay costs are £337K under plan which is an ongoing reflection of vacancies across the Trust. b) Elective Recovery Fund (ERF) – To achieve the break-even position for H1, the Board is aware of the £6,344K contribution from the ERF included in our plan. JT informed the Board that data received on 27 July refers to £300K more than planned for with an overall £2.5m ERF income. c) Good progress has been made on the CIP with £700K worth of schemes identified of which £522K are recurrent. Discussion ensued in relation to ensuring that the Chief Operating Officers group is aligned with the financial planning. AY sought clarity on the recent announcement relating to the pay award and how that is likely to impact on the Trust finances. JT confirmed that the Treasury is not covering this fully and this is a corporate risk for the Trust. JT further informed the Board that discussions have commenced around contract planning with NHSE/I looking at productivity measures; a more detailed discussion will take place at the Performance Committee. **The Trust Board:** • **Discussed and noted** the financial position of the Trust.	
P1/122/21	**a) Mortality Annual Report** SK introduce the report highlighting the good progress made in year and in particular relating to learning and further integration of Haemato-oncolgy mortality review process and reporting. In addition, SK confirmed there are no outliers within the tumor groups. GB noted at page 3 the acronym “ESC” is used but is not explained until later in the report. In addition, at page 14 – “engagement with the Trust mortality process” the phase 1 narrative refers to 68% whereas the graphic refers to 62% and requested the accuracy of the data be checked.	**SK**

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	JW observed that whilst Consultant attendance at the mortality reviews is pleasing, is it good enough and questioned whether targets should be set. SK confirmed that the timetable has been varied to accommodate consultant availability to help facilitate attendance. LB added that the attendance and input from EA at the Mortality Surveillance Group is greatly appreciated. **b) Mortality Dashboard** SK provided and overview of the mortality dashboard demonstrating good practice and learning. **The Trust Board:** • **Discussed** the content of the reports and • **Approved** the mortality dashboard for publication.	
P1/123/21	**Safeguarding Annual Report** JSp provided an overview of the report highlighting it as a positive reflection of the work that has been undertaken in year and that a detailed discussion had taken place at the Quality Committee. **The Trust Board:** • **Approved** the Safeguarding Annual Report.	
P1/124/21	**Freedom to Speak Up Annual Report** AW highlighted that the report had been discussed at the Quality Committee and further noted the successful recruitment of Freedom to Speak Up Champions and the Trust position on the Freedom to Speak Up Index that demonstrates a good speaking up culture in the Trust. **The Trust Board:** • **Noted** the content of the report.	
P1/125/21	**Infection, Prevention and Control Annual Report** JSp provided an overview of the report highlighting that during the last year the Trust has not had any MRSA infections but has recorded 5 Clostridiodes difficle infections against a target of 4. JSp further highlighted the strengthened enhanced Aseptic Non-Touch Technique education programme that has commenced to support the reduction in blood stream infections. MT noted that the report does not include performance relating to Covid such as vaccinations. JSp confirmed this will be added to the report.	**JSp**

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	The Trust Board: • **Approved** the report subject to the addition of the vaccination data.	
	System Working	
P1/126/21	**Cheshire & Merseyside Cancer Alliance Performance Report** LB provided an overview of the report highlighting that restoration of cancer services continues to go well although there continues to be pressure within the endoscopy service with both upper and lower gastrointestinal pathways continuing to experience challenges. The Alliance failed to meet the 14 day standard for urgent referrals with four Trusts and six CCG's falling below the 93% threshold; however, overall performance has improved. The report has been shared with commissioners and providers across Cheshire and Merseyside. **The Trust Board:** • **Discussed and noted** the content of the report.	
P1/127/21	**Inequalities of Access to Services** LB reminded the Board of the previous question posed by EA in relation to variation of access to cancer treatments which has resulted in the report as presented. LB further confirmed that the report has been shared with all CEO's to share with their respective Boards. LB highlighted that the report illustrates the pressure the system has been under due to the pandemic in addition to the variation by tumor group with referrals for suspected urological cancer, lung cancer and blood related cancers remaining lower than expected and that further variation is seen by region. It was noted that the reduction in referrals has been greater in the most deprived areas and it is recognised that work through the primary care networks is required. In addition, LB added that there had been a significant reduction in referrals relating to the over 80 year olds with the impact of Covid-19 on referrals from different ethnic backgrounds more difficult to access due to the small numbers. LB highlighted that a total of 14% fewer patients were treated for a new cancer in 2020-21 with variations seen between regions. In addition, the impact of halting the screening programme in response to Covid-19 has been noted and there is now an increased focus on returning to the full screening programme. Discussion ensued in relation to the importance at both national and regional level to carry out targeted work in order to address the variations as described above. GB commented on the data relating to the over 80's age group and the effect Covid-19 had on that age group initially in addition to the need for early diagnosis and referral. LB added that a large proportion of that population group was affected by Covid-19 but that in addition, the importance of face to face appointments cannot be underestimated. LB highlighted that a GP feeds into the Cancer Alliance and has	

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	reported that they do not received feedback on their data and the national cancer team will be picking this up. MT sought clarity on whether there is an increase in new cases presenting though Accident and Emergency with LB confirming that data has not been seen in relation to that specific point. SK added that anecdotally we are hearing that patients are presenting in the higher stages but we are not seeing that flowing through in our activity although generally our patients are sicker. TJ added that a paper published recently related to emergency presentations of head and neck cancer and TJ will provide a copy for circulation to the Board for information. TJ added that social inequality is an important factor in access and queried whether it would be useful to consider the social inequalities pertinent to CCC in relation to access to treatment and treatment breaks. SK confirmed that it would be feasible to look at pathways by tumor groups and provide data. EA added that the Cancer Alliance have a Health Inequality Patient Experience Group and questioned whether there was a need for the Trust to have a Health Inequalities Officer. LB clarified that the partnership with Macmillan had just begun and the link should be through the patient groups in the neighborhoods and the regions. These groups should then make connections with the Trust Patient Experience Group. KD added that, from her perspective, once the patient has been diagnosed and in our system, they would be treated in an equitable way and if there was concern that they were not, it is at that point we would consider the need for a Health Inequalities Officer. EA raised the question of the role of CCC in preventative medicine with LB adding that the CCC brand is being used within the communications from the Cancer Alliance and ES added that the Communications Manager for the Cancer Alliance is also working with NHS England on the national cancer campaigns. LB noted that the ICS will be the vehicle to interpret public health prevention but that we will continue to work with the various neighborhoods with the intelligence we glean from GP's. AR raised the issue of some GP's and communities not having access to the appropriate digital solutions with KD agreeing that digital poverty has been an issue for many years and queried whether the Cancer Alliance can help with this. KD concluded by welcoming the timeliness of the report and the debate it subsequently generated requesting a further report from the Cancer Alliance within 3-6 months setting out the plan relating to prioritistation. **The Trust Board:** • **Discussed** the contents of the report and • **Requested** an update in 3-6 months with timescale to be advised.	**AW** **LB/JH**
P1/128/21	**Cheshire & Merseyside Cancer Alliance Annual Report** LB provided an overview of the first Annual Report from the Cancer Alliance highlighting that the transformation funding has been agreed and the team is continuing with the programme of work. The Annual Report illustrates working across	

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	the system with the biggest success story being the rollout of the Faecal Immunochemical Testing. **The Trust Board:** • **Noted** the content of the Report.	
Corporate Governance		
P1/129/21	**Board Development** AW provided an overview of the report setting out the proposed Board development programme intended to align with the Strategy. AW informed the Board that Research and Development scheduled for 26 January will now take place on 27 October and the Clinical Horizon Scanning in Oncology will take place in January 2022. **The Trust Board:** • **Approved** the Board development programme.	
P1/130/21	**Regulation 5 Declarations: (Fit and Proper)** AW provided an overview of the background to the requirement for compliance against Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 confirming that following the recent checks completed as described, the Trust Regulation 5 Compliance Register is clean. **The Trust Board:** • **Noted** full compliance against Regulation	
P1/131/21	**Board Meeting Review** KD acknowledged that this was the last Board meeting for AW and thanked her for all her work over the last two years in developing and implementing good corporate governance practices within the Trust and wished her well in her new role.	

Next meeting:

Date: Wednesday 29 September 2021	Location: MS Teams
Start time: 09:00 hours	Finish time: 11:30

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

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board

Last updated: 20 September 2021

Updated by: Emily Kelso

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

Item Ref	Date of Meeting	Item	Actions	Owner	Completion Date	RAGB	Status 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**	Sep-21		
P1-34-21	24-Feb-21	Gender Pay Gap Report	Paper setting out the options to reduce the gender pay gap to a future Board meeting.	**JSh**	Sep-21		Deferred to September 2021
P1-50-21	31-Mar-21	Staff Survey Results	Action Plan from the Staff Survey Results to Board in due course	**JSh**	Sep-21		
P1-99-21	30-Jun-21	Safer Staffing Report	To include data on actual staffing numbers on Wards in future reports	**JSp**	Sep-21		
P1-103-21	30-Jun-21	5 Year Strategy: Implementation Plan	To revise formatting of the Report as discussed including a summary of key milestones . Future progress reports to be presented to the Board 6-monthly.	**TP**	Nov-21		
P1-114-21	28-Jul-21	Charitable Funds Committee Chair Report	Paper to be presented to Part 2 Board in September relating to the status of the Charity.	**AW**	Sep-21		Added to the Agenda for Part 2 September Board.
P1-117-21	28-Jul-21	Patient Story	Meeting with the Deputy Director of Nursing and the Head of Patient Experience to ensure representation from all patient	**JSp**	Sep-21		

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

			cohorts involved in the patient story at Board.				
P1-118-21	28-Jul-21	Patient Experience Visits	Information relating to menu choices to be circulated to the Non-Executive Directors for information.	**AW**	Sep-21		
P1-125-21	28-Jul-21	Infection, Prevention and Control Annual Report	Data relating to Covid vaccinations to be added to the report.	**JSp**	Jul-21		
P1-127-21	28-Jul-21	Inequalities of Access to Services	Cancer Alliance to provide an update report on prioritisation of access	**JH/LB**	Jan-22		

Guidance Notes:

This word document contains a basic template for an action plan. It can be used for most purposes and can be adapted to meet your specific needs. For example, extra columns can be added to show which department(s) actions relate to, or to add the names of clinical and executive leads.

Your action plan will be more effective if you try to adhere to S.M.A.R.T principles:

S - Be **Specific** about what you want to achieve. Do not be ambiguous and communicate clearly.
M - Ensure your result is **Measurable**. Have a clearly defined outcome and ensure this is measurable (KPIs).
A - Make sure it is **Appropriate**. Is it an **Achievable** outcome? Does everyone **Agree**?
R - Check that it is **Realistic.** It must be possible taking account of time, ability and finances.
T - Make sure it is **Time** restricted. Set yourself an achievable timeframe. Set deadlines and milestones to check your progress.

Use the RAGB (red, amber, green and blue) traffic light system to make it easy to see progress at a glance.

Key:

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

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Committee/Group 'Triple A' Chair's Report

Name of Committee/Group	Quality Committee	Reporting to:	Trust Board
Date of the meeting:	23 September 2021	Parent Committee:	
Chair:	Terry Jones	Quorate (Y/N)	Y

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Pharmacy Aseptic Unit		The Quality Committee received an update on the Aseptic Unit, noting the following: - Whilst positive progress had continued, a review against planned timescales taking into account the risks including; environmental, staffing, LUHFT mutual aid, air handling alarms, indicated a delay to the September target date. - Whilst delays in the initiation of new trials was ongoing the committee were pleased note progress on the opening of clinical trials and were assured of the continued delivery of clinical trial treatments for existing patients.	Monthly updates will continue to be provided to the Quality Committee.	KF	Ongoing
R&I Directorate Board Chair's Report Experimental Cancer Medicine Centre (ECMC)		The Committee discussed the continuing risks, acknowledging that some studies have been opened and the operational risks have been mitigated and continue to be managed via the Directorate Board, further progress was dependent upon delivery of the capacity plan from Pharmacy. The Committee noted that the reputational risk remains.	Continue management via the Directorate Board with assurance to the Quality Committee through the Board Assurance Framework Risk discussions on a monthly basis.	GH	Ongoing

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Medicine Management Report		The Committee noted the positive progress made in relation to reporting within the seven new categories. The committee discussed in detail the upward trend in prescribing incidents, taking assurance of the continued monitoring and mitigations in place to address. Further discussion took place around longer-term solutions such as automation, which was supported by the committee.	The Quality Committee will continue to receive the Medicine Management Report monthly.	KF	Monthly
CQC Preparedness		The committee received the report providing an overview of the original action plan following the CQC inspection in 2018/19, its progress and any areas of concern. The committee supported the development and implementation of a robust internal system for review and monitoring of compliance with CQC core standards.	The Quality Committee to receive a progress report alongside Clinical Governance Action Plan Update Reports.	JSp/CL	January 2022
Clinical Governance Action Plan Update		The committee received the report detailing the progress on actions. Assurance was received that the governance action plan would compare and contrast against the CQC action plan to ensure all recommendations were aligned and fully embedded.	Further update and assurance on progress to be provided to Quality Committee in January.	JSp/CL	January 2022
Deep Dive - Communications		The report was presented to the Committee following the request for a Deep Dive to review the themes and trends following a spike in communication incidents. The following key points were highlighted & actions noted:	The Committee to receive an update/progress report in 6 months' time.	CL/NB/SK	March 2022

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
		- Assurance was received that no themes were identified around Telemedicine and the use of virtual consultations - The development of communications subcategories within Datix would be actioned for more robust reporting and theme identification			
Workforce & OD Strategy		The committee received the presentation and supported the Workforce & OD Strategy 'Our People Commitment' and plans for the next 5 years. It was noted that the next steps would involve development of communication plans & operational delivery plans to support the strategy.	The committee approved the ongoing work plans. Progress updates to be provided to the Committee quarterly.	JSh/ZC	January - 2022
Values & Behaviours Framework Update - Refreshing our Trust Values		The committee received the presentation and supported the ongoing programme of work commissioned to review and develop the Trust Values. It was noted that the next steps would include patient engagement sessions Development of communication plans, test and challenge of draft values and engagement plans to embed Values.	Progress updates to be provided to the Committee Bi-annually	JSh/ZC	March 2021
Annual Reports		The Committee received the following Annual Reports as follows: - Emergency Preparedness, Resilience and Response - Health & Safety	The Quality Committee recommends Trust Board approve the aforementioned Annual Reports.	MS/EK	September 2021

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

The Clatterbridge Cancer Centre NHS Foundation Trust

Committee/Group 'Triple A' Chair's Report

Name of Committee/Group	Performance Committee	Reporting to:	Trust Board
Date of the meeting:	22 September 2021	Parent Committee:	
Chair:	Geoff Broadhead	Quorate (Y/N)	Y

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Operational and Financial Planning 2021-22		The Performance Committee received a presentation on the Financial and Operational Planning for 2021-22 and had a detailed discussion in relation to the following: • Key Points • Planning Context and Timetable • H1 Forecast – Best, Likely, Worst • H2 Planning • Workforce Resource Planning • Commissioner Planning for 2022/23 • Financial and Operational Risks The Committee noted the following: • The Trust continues to deliver and plan for increasing activity. • Cheshire & Merseyside ICS has not achieved the 95% Elective Recovery Fund (ERF) threshold in Q2. • NHSE planning guidance for H2 is expected 24th Sept • The Trust was analysing workforce costs and activity profile to achieve CIP • The 2022-23 commissioning framework was emerging for next cycle, with the income quantum to be determined	Updates will continue to be shared with the committee bi-monthly.	JT	Ongoing

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Finance Report – Month 5		The Performance Committee received and discussed the report noting that; for 2021/22 the Cheshire & Merseyside ICS are managing the required financial position of each Trust through a whole system approach. The requirement for the Trust for the first six months of the year (H1) is to achieve a break-even position. The committee further discussed the uncertainty of the ERF position going forward particularly the impact of the increased threshold from 85% to 95% of 2019/20 activity levels. It was noted that levels of funding available to the Trust were reliant on all CM Trusts achieving the increased activity threshold. In addition, the committee discussed the risks associated with CIP planning for the second half of the year. It was anticipated a higher level of CIP would be required.	Bi-monthly updates to the Committee	JT	ongoing
Risks & Issues Summary Report		The committee received the paper outlining those high scoring risks aligned to the committee and an update on each. It was noted that the move to the Datix Cloud IQ system was imminent and would improve reporting efficiency. The committee discussed in detail the risk surrounding medical workforce staffing levels. Assurance was given that work was ongoing to ensure gaps were identified early and mitigations were in place to address capacity risks, including the introduction of the Medical Transformation Group.	It was agreed a paper would be bought back to the committee with details of the progress on the workstreams in place.	JSp	November- 21

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Research & Innovation Business Plan – Progress on Implementation		The committee received the paper, which gave assurance on the progress made to date on each of the four Workstreams. The pressures surrounding the financial plans were highlighted, which had resulted from the pause in recruitment to studies during the Covid-19 pandemic and issues within the Aseptic Pharmacy Unit. The Committee were pleased to receive an update that one new study had opened in month. It was hoped this would be the start of a steady stream of studies opening in H2 and an improved commercial income position.	Updates to continue to be reported into the committee quarterly	GH	January
System Oversight Framework		The committee received a paper outlining a proposal for the reporting of the new NHS System Oversight Framework metrics. It was noted that metrics were monitored at ICSs, CCGs and / or Trust level and used by NHSE/I and ICSs to flag potential issues and prompt further investigation of support needs with ICSs, place-based systems and/or individual Trusts and commissioners. The committee supported the introduction of the identified metrics into the IPR by the timescales started within the framework. It was noted that for a number of metrics, detail regarding methodology and targets had not yet been published by NHSE/I.	Updates to be provided quarterly to the Committee, detailing reporting progress and identifying reporting mechanisms for metrics as the definitions are published.	HG/JSp	ongoing
28 Day Faster Diagnosis & Development of the Haematology-Oncology Rapid Diagnostic Service (RDS)		The committee received a report providing an update on the 28 day Cancer Performance Standard within Haemato –Oncology. With a particular focus on the issues and challenges noted in January 2021 and subsequent improvements and progress made. The committee supported the implementation of a working group to develop a proposal for a localised H-O RDS in collaboration with CCC, LUHFT and Cancer Alliance colleagues in order to develop a sustainable regional service.	A progress update to be presented to the committee in Q4 to include target KPIs, following the go live date.	JSp	Q4

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
		The committee agreed that sufficient assurance had been received on the progress to date and noted the go live date of January 2022.			
Sustainability & Developing a Green Plan		The committee received the paper setting out the proposal to develop a Green Plan for CCC by the end of 2021 given the increasingly high-profile green agenda within the NHS The committee welcomed the contents of the paper and supported the ambition to develop sustainability plans. The committee further noted and supported: • the formation of the CCC Sustainability Group and the proposed line of accountability to Performance Committee • the proposal to engage external support develop a Green Plan by November Trust Board	The committee to receive a progress report and the Green Plan in full in November.	TP	November-21

	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

NHS
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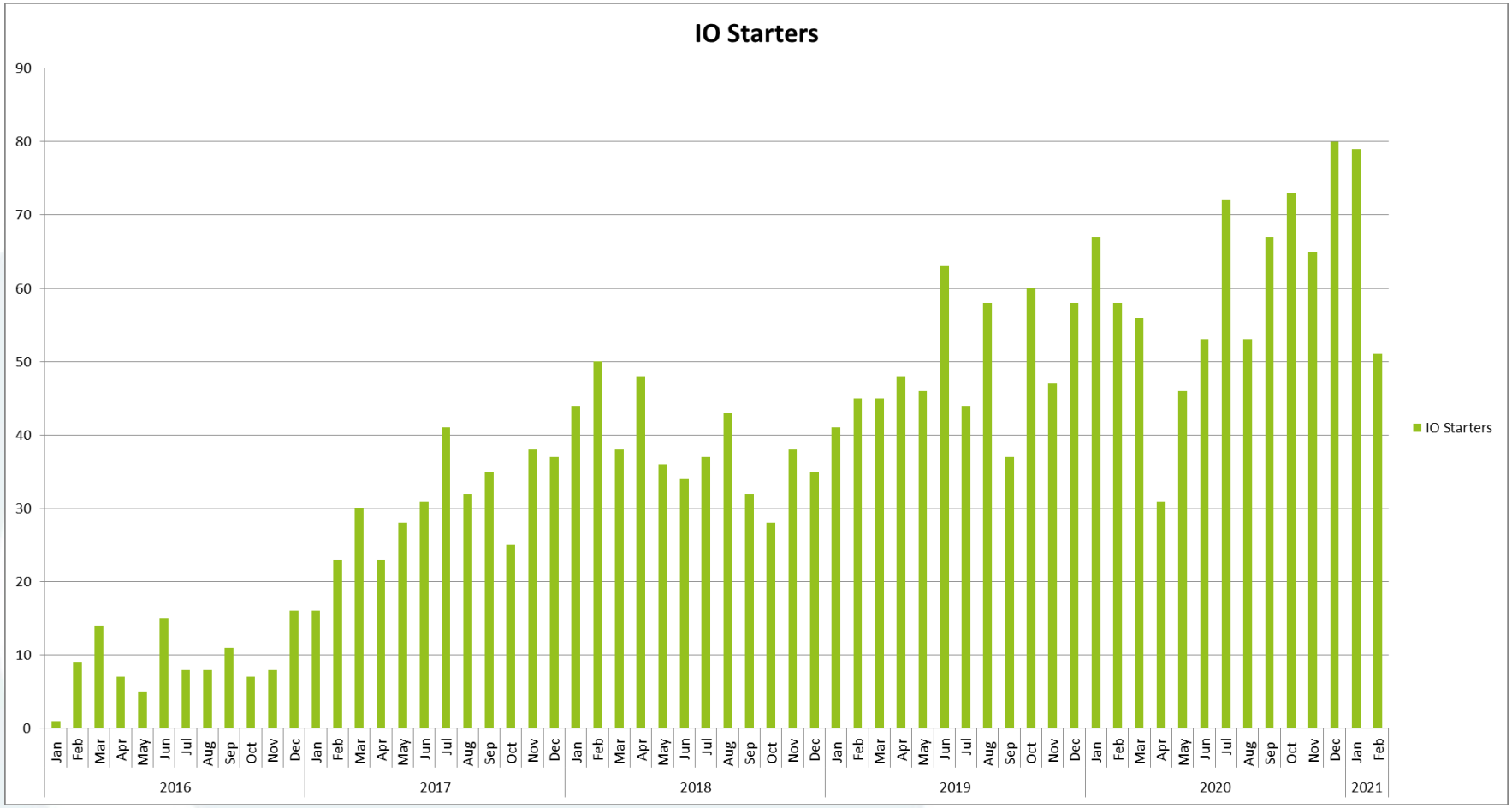
Trudy-Jane Guinan

The Immuno-oncology service

IO Usage at CCC.

The Clatterbridge Cancer Centre NHS Foundation Trust



Aims and Objectives of the service

The Clatterbridge Cancer Centre NHS Foundation Trust

- Develop a streamlined service, coordinated and managed by a team of experts.
- Collaborative working with medical specialities.
- Develop outpatient management, allowing admission avoidance in certain cases and the expedition of discharge for those whom admission is necessary.
- Provide a specialist sub-acute toxicity management pathway.
- Coordination of outpatient delivery, promoting treatment closer to home.
- Improve patient experience/quality of life.
- Maintain an open dialogue for all involved in the care of patients receiving Immunotherapy.
- Provide education about IO to both healthcare workers and patients.

Innovation

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NHS Foundation Trust

New service

Pan tumour

Nurse led

Patient focused

CCC is at the forefront in the development of IO services and is the first pan tumour IO service in the UK

Cardio-oncology clinic

Patient self-care app

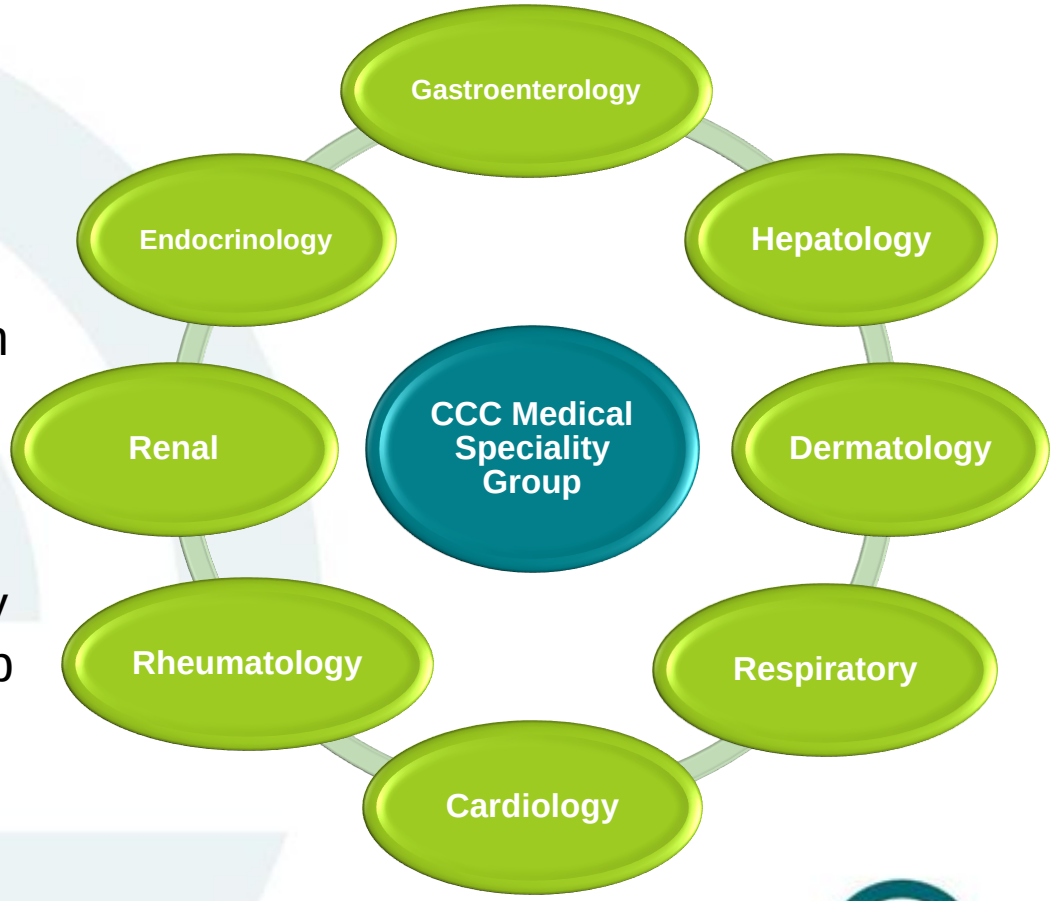
Outpatient toxicity management

Infliximab pathway

Collaboration

The Clatterbridge Cancer Centre NHS Foundation Trust

- Regular meetings with Medical Specialities group.
- Medical Speciality clinics – Cardiology, Dermatology.
- Rapid access to investigations such as tissue biopsies and Flexi sigmoidoscopy.
- Joint working with Gastroenterology to develop and implement Infliximab pathway at CCC
- Information sharing group for patients in collaboration with Maggie's Centres – on hold due to COVID.



Workforce

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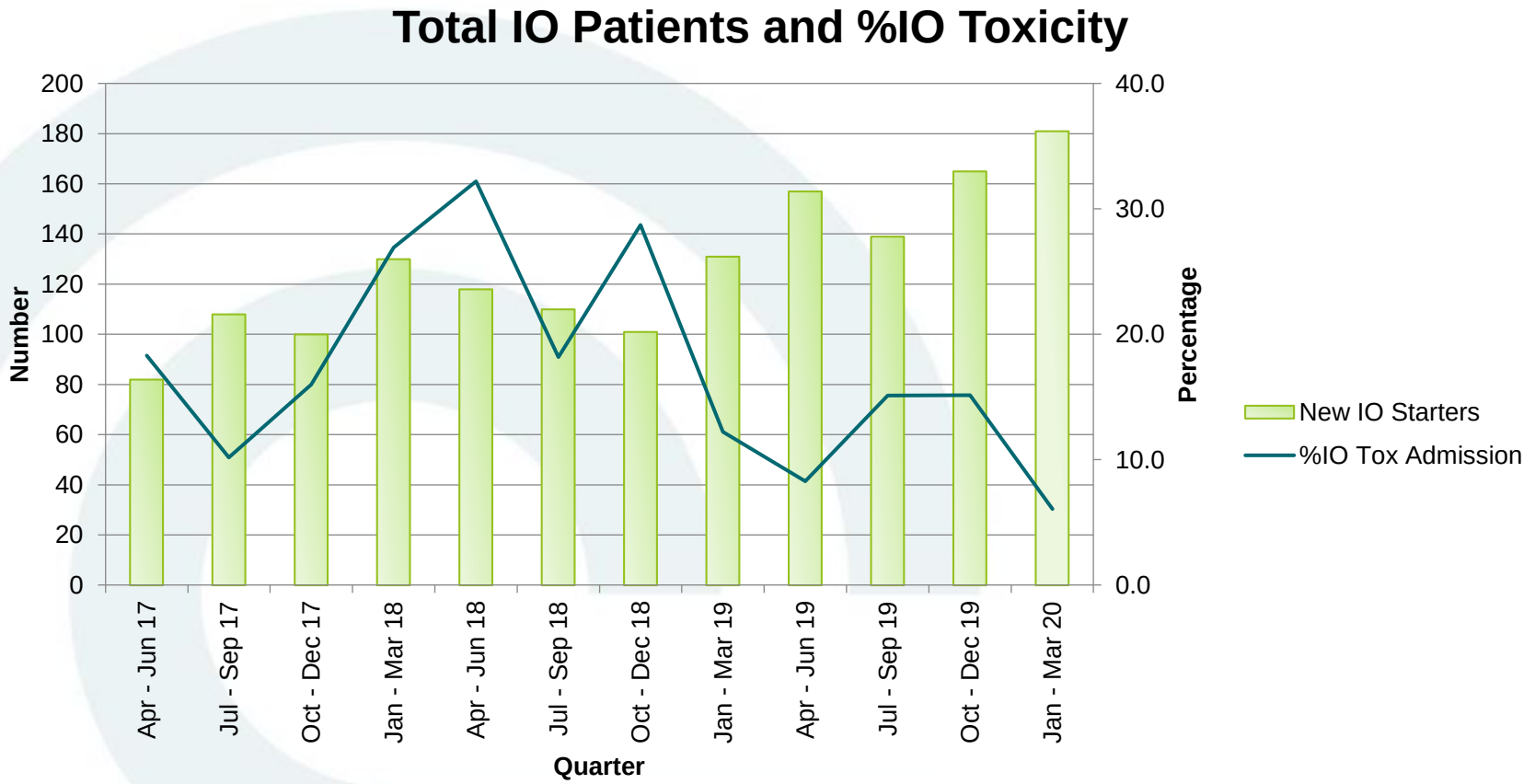
- IO Lead Nurse (Band 8a).
- IO ANP x 2 (Band 7).
- IO Clinical Nurse Specialist (Band 7) currently out to recruitment.
- IO Toxicity Nurse Specialists x 4 (Band 6).
- IO/OTR Nurse Specialists x 2 (Band 6).
- IO Project Support Officer.
- IO Coordinator (Band 4).
- Further Band 6 IO/OTR Nurse to be recruited in new financial year (approved by Finance committee and TEG)

Key Performance Indicators

The Clatterbridge Cancer Centre NHS Foundation Trust

- Reduced admission rates for patients experiencing IO toxicity.
- Reduction in number of patients experiencing Grade 3/4 (severe/life threatening) toxicity.
- Total bed days saved.
- Outpatient activity –
  - Day case attenders.
  - Telephone follow up.
  - Face to face reviews.
- Referrals to CiC.

Admissions due to IO Toxicity



Reduction in Toxicity Incidence

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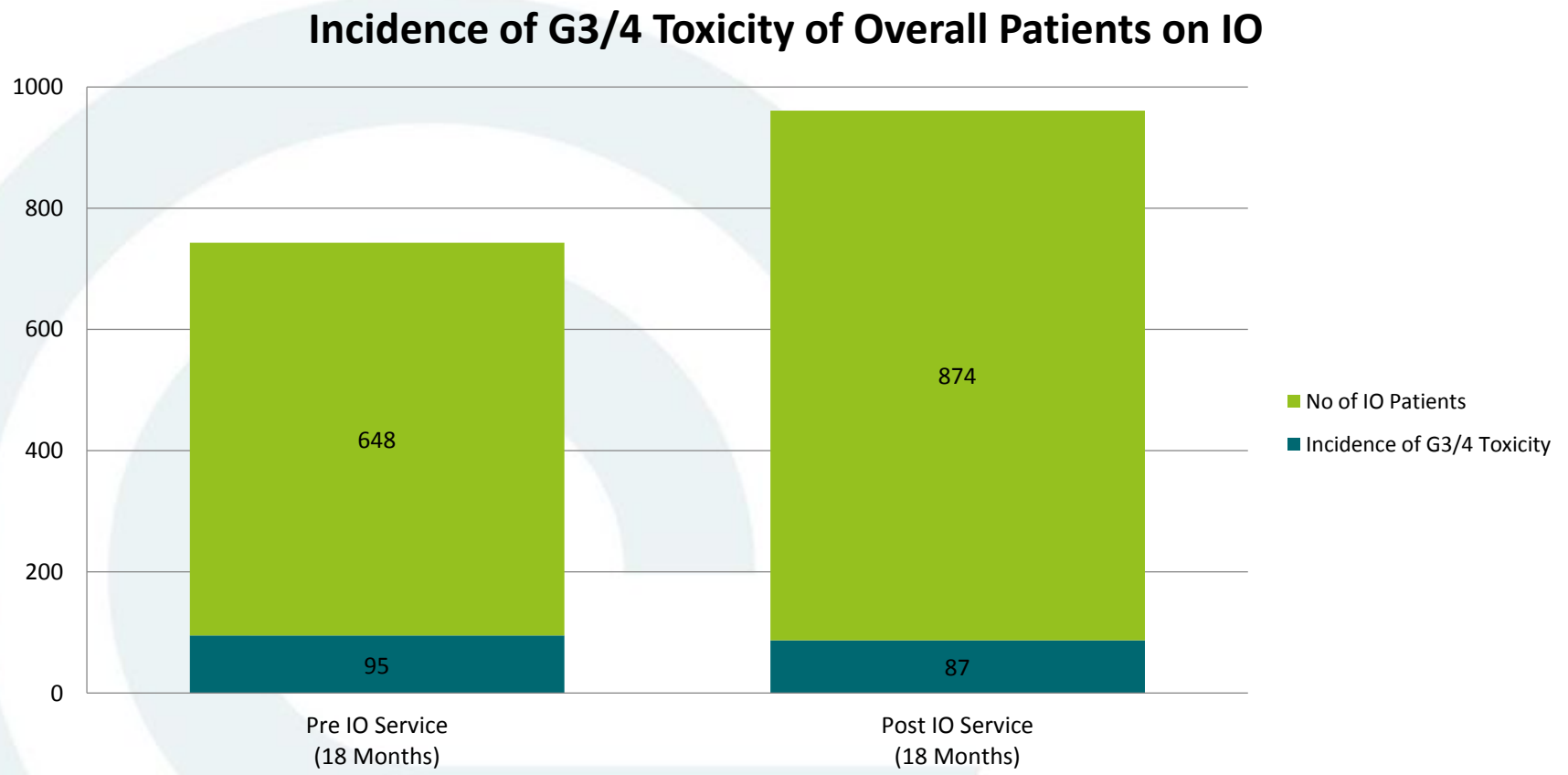

Bed Days Saved

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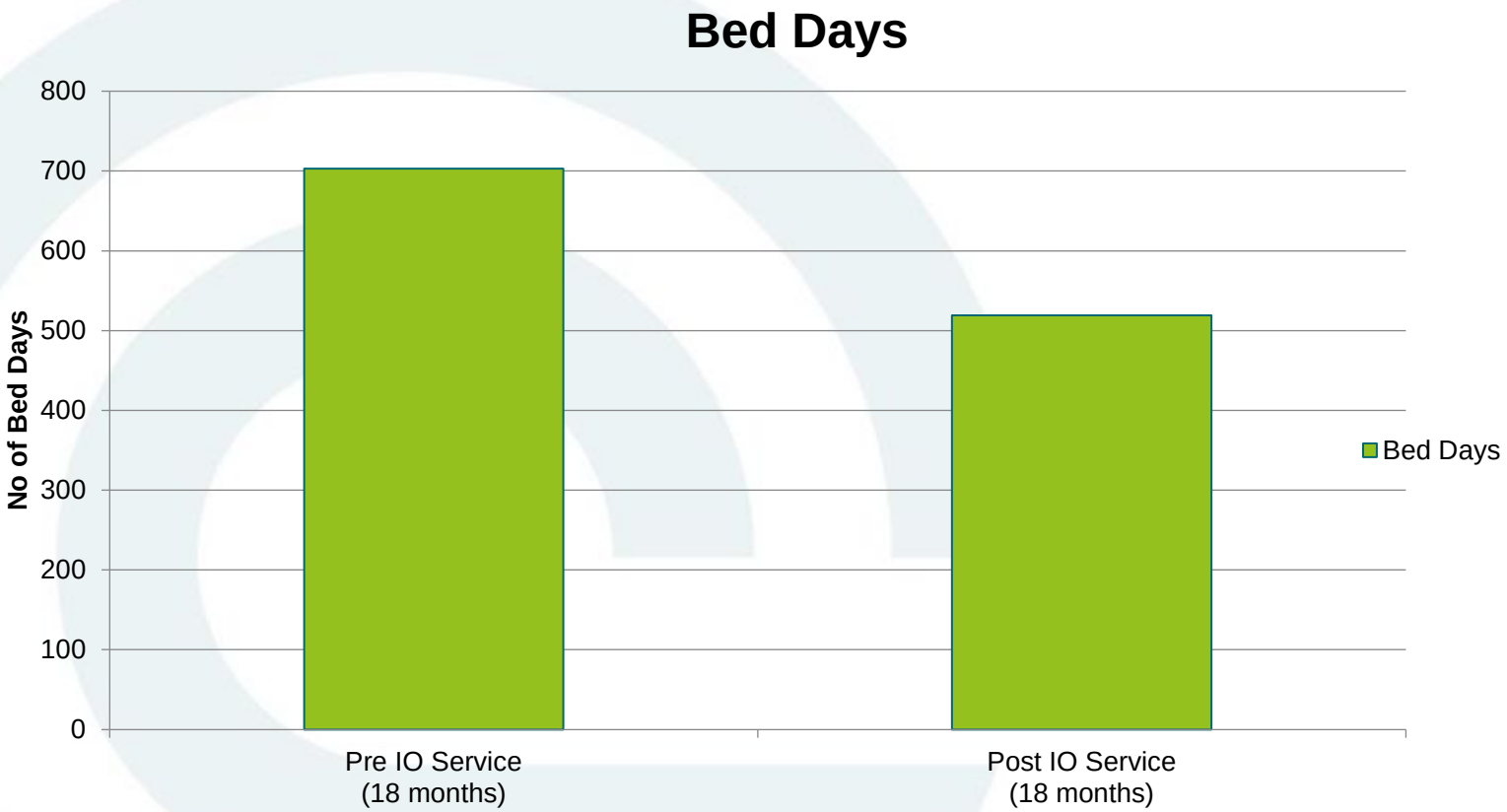

The Patient Experience

The Clatterbridge Cancer Centre NHS Foundation Trust

- Generally well whilst receiving treatment
- Can often continue working
- Episodes of significant morbidity if a grade 3-4 toxicity is experienced
- Hospital stays do occur (particularly in combination therapy)
- Often prolonged courses of steroids
- Steroid doses are confusing and patients often find this challenging
- Often experience more than one toxicity over the course of treatment
- Find the reality of toxicity very challenging
- The impact of toxicity is very efficacy dependant!

Patient Focus

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NHS Foundation Trust

"Thanks for all the support you have given us over the last 8 months. I know I have been a pain in the bum but if it wasn't for you both things would have been a lot harder for us. We appreciate everything you do for me."

"Provides specialist experience over and above the usual Oncology team. A very useful service that provides help and reassurance when going through a complex set of circumstances."

"Exceptional, supportive, professional and understanding. The service has made me except what is happening to me and allayed my fears of the unknown".

"I have felt reassured by the service I have been given and received any necessary attention without delay. I think the speedy response and consistent personal contact is immeasurable."

"I have had an issue with colitis and peripheral neuropathy following my immunotherapy treatment. I feel particularly lucky to have received such wonderful professional care from all of the team."

Patient journey pre and post service

The Clatterbridge Cancer Centre NHS Foundation Trust

Example of patient experiencing Immune mediated Colitis

	Time to Gastro referral	Time to Flexi-sigmoidoscopy	Time to Infliximab	Second dose required	Length of stay	Total Days of IV steroids	Time to resolution of symptoms
Pre IO service	**2 days**	**8 days**	**12 days**	**Yes**	**21 days**	**9 days**	**30 days**
Post IO service	**At initial presentation**	**2 days**	**5 days**	**No**	**1 day**	**5 days**	**14 days**

The Future

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- Continuous audit of IO activity via the IO prospective database to enable early identification of future workforce requirements.
- Research projects focusing on IO Toxicity.
- Horizon scanning for new regimes/indications.
- Amalgamation of the SACT services with the IO service to promote business as usual.
- Collaborative working with Acute Oncology to evaluate the impact of IO and the IO service to Acute trusts within the cancer network.
- Continued Education and Training.
- Develop and promote a CCC National IO conference.
- Implementation of a patent alert system for patients who present to Acute trusts/Primary healthcare settings with suspected IO toxicity.

REPORT COVER

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Report to:	Trust Board
Date of meeting:	29 September 2021
Agenda item:	P1-140-21
Title:	Patient Experience Visits 17.09.2021
Report prepared by:	Karen Kay, Deputy Director of Nursing
In attendance at visit:	Dr. Andrew Waller, Governor, Asutosh Yagnick, Non Executive Director, Claire Smith, Quality Improvement Manager
Executive Lead:	Joan Spencer, Director of Operations and Interim Director of Nursing
Status of the report: (please tick)	Public ☒ Private ☒

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

Purpose of the paper/key points for discussion:	The purpose of this report is to provide Trust Board with oversight and a summary of the recent NED & Governor Patient Experience visit conducted on the 17th September 2021 at CCC Liverpool. Due to time constraints this report has not been reviewed by all attendees prior to Trust Board.

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

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

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 17.09.2021

Andy Waller, Governor
Asutosh Yagnik, Non-Executive Director
Claire Smith, Quality Improvement Manager

Report prepared by, Karen Kay, Deputy Director of Nursing

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 September 2021, visiting level 6 chemotherapy unit and ward 2 at CCC Liverpool site. Due to Covid-19 restrictions across all CCC sites Andy Waller, Governor and Asutosh Yagnik, Non-Executive Director were able to accompany Claire Smith, Quality Improvement Manager virtually on this occasion as scheduled.

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

2. Key Findings and Observations

- Patient Feedback -Two patients receiving chemotherapy on Level 6, (3rd cycle chemo for breast cancer and cycle 54 (3 years) for bowel cancer;
  Both patients impressions were that it was a beautiful building, the hospital was clean and the staff fantastic and very caring. One patient commenced treatment at Linda McCartney clinic was "grim" compared to CCCL. Plenty of refreshments at CCCL were available during treatment. Following an inpatient stay one patient also commented that the food is great but the coffee is no good. Appointment system could be improved, waiting times and treatment time can vary sometimes takes 4-5 hours and other times 7-8 hours because of delays with other patients or pharmacy.
  Waiting for transport home following a late appointment is problematic, access to an early appointment is not always possible.
  Access to parking at the hospital site is a difficult , there is limited space to park for pick- ups and drop off.

  Staff discussed;
  Patient experience feels much better than in previous role in Aintree. Feel more valued as a member of staff at CCC than in other previous roles, I love my job. Patients are always really grateful for their treatment and generally understand when delays occur. Pharmacy delays is the main issue impacting on patient experience. There is an imbalance of patients through the unit eg) Monday small numbers however extremely busy on Tuesdays. Nurses spend a significant amount of time trying to liaise with other staff members.
  Not having a non-medical prescribers on the unit at all times can cause delays, often the doctor is in OPD clinic and cannot prescribe straight, and Registrars are also busy in clinic. CTU needs its own doctor/prescribers. Laboratory results are often delayed which means occasionally patients may need to go

REPORT

NHS
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NHS Foundation Trust

home and come back the following day for their treatment which is not great for patients.

Ward 2 Visit

- No appropriate patients (due to high levels of acuity) available on ward 2 to share their experiences. The 3 patients highlighted were unavailable due to various reasons. Staff reported mixed feedback from patients regarding single rooms. Some patients loved them and some patients found them lonely and isolating. Patients are not able to develop the strong bonds with other patients and the visiting situation is difficult for everyone however, there are great facilities in the patient rooms eg, large space and free TV.

  Staff feedback - it has taken some time for staff to settle following the move to CCCL and it is better now than in the early days. Car parking remains an issue. The lab service is not as robust as previously on the Wirral site.
  Aseptic pharmacy issues impact on patient experience – in patients often start Chemotherapy in the evening as day case is prioritised . Mixed feedback regarding inpatient food; some patients do not like it and others say it is lovely.

- Staff feedback -What does CCC do well?
  Very strict with Covid-19 rules which has helped to keep patients and staff safe
  Scheduling is getting better.
  Pharmacy Technicians are amazing and pharmacy provision is improving
  Ward staff work together as a team
  Patients come first
  Staff work hard to make each day a good day for patients
  EOL care is very good for patients and families

- Staff feedback – What can CCC do better?
  Improve skill mix, lots of new staff in the team
  Easier access to further education opportunities
  Review visiting policy – more controlled testing may allow visitors to access CCC, this would relieve loneliness for patients and the volume of telephone calls to the ward and reduce stress levels

3. Next Steps and Recommendations

- Discuss report findings at Trust Board
- Note content of report

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

- Feedback shared with areas during the visit
- Acknowledge the need for further action required to share feedback received with relevant Divisional leaders and teams, by Head of Patient Experience
- Request further updates as required

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board	
Date of meeting:	29 September 2021	
Agenda item:	P1-141-21	
Title:	New Consultant Appointments	
Report prepared by:	Catherine Hignett- Jones – Resourcing Manager	
Executive Lead:	Sheena Khanduri - Medical Director	
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	Not applicable
Date & decision:	

Purpose of the paper/key points for discussion:	To provide an overview of new consultant appointments in August/September 2021

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

Next steps required:	The Trust Board is asked to note the appointments

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

The Clatterbridge Cancer Centre NHS Foundation Trust

New Consultant Appointments

To provide an overview of new consultant appointments in August/September 2021.

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

New Consultant Appointments – August/September 2021

Name	**Nuria Santamaria Guinea -16 September 2021**
Job Title	Consultant Radiologist
Qualifications	Degree in Medicine- University of the Basque country Spain Degree as Medical Doctor specialised in Radiology- Madrid
Speciality	Radiology
GMC number	7574869
Membership/Appointments	Oncology Imaging
Details	Previously employed as consultant radiologist with Liverpool University Hospitals NHS foundation Trust with a specialist interest in oncology imaging.

Name	**Dr Anna Olsson-Brown 11 September 2021**
Job Title	Consultant Medical Oncologist Melanoma and Sarcoma
Qualifications	PhD University of Liverpool PGCert Cancer Studies, Newcastle University MRCP SCE Medical Oncology MBChB, University of Liverpool
Speciality	Melanoma and Sarcoma
GMC number	7038081
Membership/Appointments	
Details	Recently been employed by St Helens and Knowsley NHS Trust as Specialist Registrar in Medical Oncology. Prior to that employed by University of Liverpool as Clinical Research Fellow to undertake PhD project ' An investigation into the immunological mechanisms of immune related adverse events associated with oncological checkpoint:

Name	**Dr Matthew Wells -23 August 2021**
Job Title	Consultant Haematologists with a specialist interest in Lymphoid Disorders and Autologous Stem Cell Transplantation
Qualifications	FRCpath MRCP
Speciality	Lymphoma
GMC number	6167060
Membership/Appointments	
Details	Recently employed as a locum consultant at Gloucester Royal Hospital. Part of the leadership group restructuring of the lymphoma service in Gloucestershire - with the move from separate, local general malignant clinics to new regional (Cheltenham & Gloucester combined) specialist lymphoma clinics - along with the integration of the lymphoma patient cohort previously under the oncology team.

REPORT COVER

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Report to:	Trust Board
Date of meeting:	Wednesday 29th September
Agenda item:	P!-142-21
Title:	Integrated Performance Report M5 2021/2022
Report prepared by:	Hannah Gray: Head of Performance and Planning
Executive Lead:	Joan Spencer: Chief Operating Officer / Interim Chief Nurse
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Performance Committee / Quality Committee
Date & decision:	Wednesday 22nd September 2021 / Thursday, 23rd September 2021

Purpose of the paper/key points for discussion:	This report provides the Board of Directors with an update on performance for month 5 2021/22 (August 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:	

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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.	☒
If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	☒

☒ BE **DIGITAL**

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

☒ BE **INNOVATIVE**

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

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

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Integrated Performance Report (Month 5 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 five; August 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.

A new KPI; 'Percentage of expected discharge dates (EDD) completed' has been in testing phase with the Acute Care Division for several months and is now included in this M5 IPR.

It is proposed that the target for the following KPI 'Data Quality - % Ethnicity that is complete', is amended from 100% to G: ≥95%, A: 90-94.9%, R: <90%. Whilst we remain strongly committed to recording the ethnicity of all our patients, and initially set our target at 100% to reflect this, we propose that the target is now amended to be more realistic and aligned to the guidance from NHSE/I, which does not dictate a target of 100%.

An update on reporting NHS System Oversight Framework metrics is included in a separate paper, presented to Performance Committee in September 2021.

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	Aug-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
L	**9 days** from referral to first appointment	Replaces 7 Day KPI	G: ≥90% A: 85-89.9% R: <85%	90.4%	90.4%	
C/S	**2 week wait** from GP referral to 1st appointment	⟷	93%	100%	100%	
L	**24 days** from referral to first treatment	↓	G: ≥85% A: 80-84.9% R: <80%	80.9%	88.2%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	↓	75% (shadow monitoring)	88.9%	87.5%	
S	**31 day** wait from diagnosis to first treatment	⟷	96%	99.6%	99.2%	
C/S	**31 day** wait for subsequent treatment (Drugs)	⟷	98%	99.6%	99.1%	
C/S	**31 day** wait for subsequent treatment (Radiotherapy)	⟷	94%	98.7%	98.0%	
S	Number of **31 day** patients treated **≥ day 73**	⟷	0	0	0	
C/S	**62 Day** wait from GP referral to treatment	↓	85%	78.4%	88.9%	
C/S	**62 Day** wait from screening to treatment	⟷	90%	100.0%	100.0%	
L	Number of patients treated between **63 and 103 days** (inclusive)	↑	No Target	51	194	
S	Number of patients treated => **104 days**	↑	No Target	20	71	
L	Number of patients treated => **104 days AND at CCC for over 24 days (Avoidable)**	↓	G: 0-1 A: 1 R: >1	0	3	
C/S	Diagnostics: **6 Week Wait**	⟷	99%	100%	100%	
C/S	**18 weeks** from referral to treatment (RTT) Incomplete Pathways	⟷	92%	100.0%	99.0%	

Notes:

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

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

Cheshire and Merseyside Cancer Waiting Times Performance:

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Jul-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%	91.3%	90.1%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	↑	75% (shadow monitoring)	75.2%	74.5%	
C/S	**62 Day** wait from GP referral to treatment	⟷	85%	76.1%	77.0%	

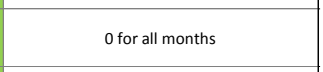
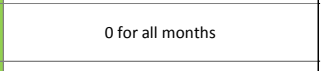
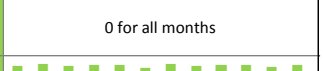
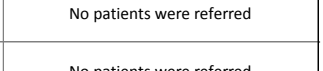
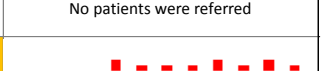
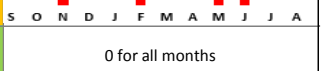
1.2 Efficiency

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

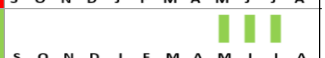
Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Aug-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
S	Length of Stay: Elective (days): Solid Tumour		G: ≤6.5 A: 6.5-6.8 R: >6.8	5.4	5.7	
S	Length of Stay: Emergency (days): Solid Tumour		G: ≤8 A: 8.1-8.4 R: >8.4	8.6	7.5	
S	Length of Stay: Elective (days): HO Ward 4		G: ≤21 A: 21.1-22.1 R: >22.1	21.4	16.2	
S	Length of Stay: Emergency (days): HO Ward 4		G: ≤22 A: 22.1-23.1 R: >23.1	12.1	10.7	
S	Length of Stay: Elective (days): HO Ward 5		G: ≤32 A: 32.1-33.6 R: >33.6	18.6	17.4	
S	Length of Stay: Emergency (days): HO Ward 5		G: ≤46 A: 46.1-48.3 R: >48.3	27.5	15	
S	Delayed Transfers of Care as % of occupied bed days		≤3.5%	2.5%	3.0%	
S	Bed Occupancy: Midnight (Ward 4: HO)		G: ≥85% A: 81-84.9% R: <81%	90.3%	86.9%	
S	Bed Occupancy: Midnight (Ward 5: HO)		G: ≥80% A: 76-79.9% R: <76%	83.9%	72.0%	
S	Bed Occupancy: Midday (Solid Tumour)		G: ≥85% A: 81-84.9% R: <81%	79.3%	72.3%	
S	Bed Occupancy: Midnight (Solid Tumour)		G: ≥85% A: 81-84.9% R: <81%	77.8%	72.7%	
C	% of expected discharge dates completed	New from M5	G: ≥95% A: 90-94.9% R: <90%	85.0%	84.0%	
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%	94.4%	97.1%	
L	Imaging Reporting: Outpatients (within 7 days)		G: ≥90% A: 80-89.9% R: <80%	83.3%	81.8%	
C/Phase 3 Covid-19 Guidance	Data Quality - % Ethnicity that is complete (or patient declined to answer)		100%	94.5%	96.2%	
C	Data Quality - % of outpatients with an outcome		G: ≥95% A: 90-94.9% R: <90%	95.6%	96.3%	
C	Data Quality - % of outpatients with an attend status		G: ≥95% A: 90-94.9% R: <90%	95.4%	96.8%	
Executive Director Lead: James Thomson, Director of Finance						
S	Percentage of Subject Access Requests responded to within 1 month		100%	100%	100%	
C	% of overdue ISN (Information Standard Notices)		0%	0%	0%	0% for all months

1.3 Quality

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Aug-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer/ Interim Chief Nurse						
C/S	Never Events	⟷	0	0	0	0 for all months
C/S	Serious Untoward Incidents (month reported to STEIS)	↑	0	1	4	
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	1	
S	Incidents /1,000 Bed Days	↓	No target	172	209.32	
L	Incidents resulting in harm /1,000 bed days	↓	No target	11	18	
C/S	Inpatient Falls resulting in harm due to lapse in care	⟷	0	0	0	0 for all months
S	Inpatient falls resulting in harm due to lapse in care /1,000 bed days	⟷	0	0	0	0 for all months
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care)	⟷	0	0	0	0 for all months
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care) /1,000 bed days	⟷	0	0	0	0 for all months
S	Consultant Review within 14 hours (emergency admissions)	⟷	90%	98.1%	97.7%	
C/S	% of Sepsis patients being given IV antibiotics within an hour*	⟷	90%	93.9%	93.6%	
C/S	VTE Risk Assessment	↑	95%	97.0%	94.8%	
S	Dementia: Percentage to whom case finding is applied	⟷	90%	100.0%	99.0%	
S	Dementia: Percentage with a diagnostic assessment	-	90%	No patients	N/A	No patients were referred
S	Dementia: Percentage of cases referred	-	90%	No patients	N/A	No patients were referred
C/S	Clostridiodes difficile infections (attributable)	⟷	≤11 (pr yr)	1	7	
C/S	E Coli (attributable)	⟷	≤6 (pr yr)	0	3	
C/S	MRSA infections (attributable)	⟷	0	0	0	0 for all months
C/S	MSSA bacteraemia (attributable)	⟷	G: ≤4, A: 5 R: >5 (pr yr)	0	0	
C	Klebsiella (attributable)	⟷	≤6 (pr yr)	0	2	
C	Pseudomonas (attributable)	⟷	≤10 (pr yr)	0	0	
C/S	FFT score: Patients (% 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	Aug-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	1	17	
S	Number of formal complaints / count of WTE staff (ratio)	↓	No target	0.001	0.002	
C	% of formal complaints acknowledged within 3 working days	↔	100%	100%	94%	
L	% of routine formal complaints resolved in month, which were resolved within 25 working days	↓	G: ≥75% A: 65-74.9% R: <65%	33%	56%	
L	% of complex formal complaints resolved in month, which were resolved within 60 working days	-	G: ≥75% A: 65-74.9% R: <65%	None to resolve	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%	92%	94%	
L	Number of policies due to go out of date in 3 months	↑	No target	28	N/A	
L	% of policies in date	↔	G: ≥95% A: 93.1-94.9% R: <93%	99%	97%	
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.
*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	Aug-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Sheena Khanduri, Medical Director						
L (Strategy)	Study recruitment	↔	G: ≥109 A: 92-108 R: <92 (pr month)	80	279	
National	Study set up times (days)	↔	≤40 days	N/A	N/A	Latest reporting period is Q4 2020/21: median = 29.5 days
L (Strategy)	Recruitment to time and target	↔	G: ≥55% A: 45-54.9% R: <45%	N/A	N/A	Latest reporting period is Q4 2020/21: 20%
L (Strategy)	Studies Opened	↓	G: ≥5 A: 4-5 R: <4 (pr month)	2	14	
L (Strategy)	Publications	↔	G: ≥11 A: 10-9 R: <9 (pr month)	23	69	

1.5 Workforce

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Aug-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Jayne Shaw, Director of Workforce and Organisational Development						
S	Staff Sickness Absence	⟷	G: ≤4% A: 4.1-4.9% R: ≥5%	4.8%	4.43%	
S	Staff Turnover*	⟷	G: ≤1.2% A: 1.21–1.24% R: ≥1.25%	1.37%	7.34%	
S	Statutory and Mandatory Training	⟷	G: ≥90% A: 75-89% R: ≤75%	96.72%	N/A	
L	PADR rate	⟷	G: ≥95% A: 75-94.9% R: ≤74%	91.90%	N/A	
L	% of Staff who have had the **first** dose Covid-19 vaccination (at month end)	↑	No national target	94.8%	N/A	
L	% of BAME Staff who have had the **first** dose Covid-19 vaccination (at month end)	↑	No national target	93.6%	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	97.0%	N/A	
L	% of BAME Staff who have had the **first** dose Covid-19 vaccination or have refused the vaccination (at month end)	↑	No national target	96.4%	N/A	
L	Covid-19 vaccinations: **Second** dose received as % of first dose received (at month end)	↑	No national target	97.2%	N/A	
L	Covid-19 vaccinations: BAME staff, **Second** dose received as % of first dose received (at month end)	↑	No national target	98.1%	N/A	

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

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

1.6 Finance

For August 2021, the key financial headlines are:

Metric (£000)	In Mth 5 Actual	In Mth 5 Plan*	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit)	1	0	1		99	0	99	
CPL/Propcare Surplus/ (Deficit)	(72)	0	(72)		347	0	347	
Control Total Surplus/ (Deficit)	(72)	0	(72)		446	0	446	
Group Cash holding	57,271	59,314	(2,043)		57,271	59,314	(2,043)	
Capital Expenditure	(4)	0	4		168	156	(12)	
Agency Cap	112	95	(17)		334	475	141	

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

To achieve a break-even position for H1 the Trust is reliant on non-recurrent EFR income. The Cheshire & Mersey HCP provided indicative values to include in the month 5 financial position. April and May showed an increase in activity and income against plan, this is based on freeze data and the figure is final. June to September is based on indicative activity values provided by all

Trusts. As not all Trusts have met the necessary activity threshold there is a significant reduction of income across the C&M system. For the Trust this is showing an overall H1 value of £5.769m against the original plan of £9.441m, a shortfall of £3.672m.

The Trust has mitigated the ERF risk to month 5 by recognising that costs associated with the extra activity have yet to materialise. A key factor is that forecast block drugs expenditure has not increased as predicted. Further mitigations include an expected improvement of system performance as freeze data is used for the calculation.

2. Exception Reports

2.1 Access

24 days from referral to first treatment	Target	Aug 21	YTD	Last 12 Months
	G: ≥85% A: 80-84.9% R: <80%	80.6%	88.1%	

Reason for non-compliance

There were 21 breaches of the 24-day target in August 21 (10 chemotherapy patients and 9 radiotherapy patients, 1 on active monitoring and 1 patient receiving hormone treatment).

Of the 21 patients, 9 breached the 24-day target but achieved the 62-day target (5 chemotherapy patients and 4 radiotherapy patients). 4 patients were deemed to be avoidable breaches due to a delay to first appointment as awaiting molecular test results and Pharmacist request to defer chemo appointment as the treatment was unavailable at that time.

The unavoidable breaches were due to patient choice and medical reasons.

Breach details for the remaining 12 patients are included in the 62 day exception report below. The additional patient (patient 3) was a HO patient and they are excluded from the 24 day report.

Action taken to improve compliance

A Genomics Clinical Quality Group has been established to review the pathway of the molecular test results. The first meeting is due to take place in September.

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

62 Day wait from GP referral to treatment	Target	Aug 21	YTD	Last 12 Months
	G: ≥85% R: <85%	78.4%	88.9%	

Reason for non-compliance

The 62 Day Target has been exceptionally challenging for August mainly due to patient choice and medical reasons.

13 patients breached the 62 Target, 11 of these breaches were unavoidable; due to patient choice and medical reasons. The remaining 2 patients had an avoidable breach due to a delay to first appointment and a delay in receiving molecular test results.

Action taken to improve compliance

Consultant availability has been challenging over the summer months.

- To ensure effective management of capacity, the Medical Workforce Manager is working with Divisional management teams on the management of consultant leave. Two papers were presented to the Clinical Operational Group on 18/8/21; 'Medical annual leave process' and 'medical unplanned absence process' to support the improved management of such leave.
- Business Unit Manager to support Lung SRG with assessment of capacity and demand.
- A new Outpatient dashboard has been developed and is due to be launched week commencing 13th September. This will support the management of clinic capacity.
- A Genomics Clinical Quality Group has been established, to review the pathway of the molecular test results. The first meeting is due to take place in September.

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

2 week wait from GP referral to 1st appointment (Alliance-level)	Target	July 21	YTD	12 month trend (to July)
	93%	91.3%	90.1%	

Reason for non-compliance

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

- Suspected breast cancer 85.9% (321 breaches)
- Exhibited (non-cancer) breast symptoms - cancer not initially suspected 86.3% (71 breaches)
- Suspected lower gastrointestinal cancer 86.6% (327 breaches)
- Suspected upper gastrointestinal cancer 88.3% (144 breaches)
- Suspected gynaecological cancer 91.9% (95 breaches).

Providers not achieving the national standard were:

- East Cheshire 70.7% (184 breaches)
- Southport and Ormskirk Hospital 82.5% (204 breaches)
- Countess Of Chester Hospital 84% (185 breaches)
- St Helens and Knowsley Hospitals 91.1% (170 breaches)
- Warrington and Halton Teaching Hospitals 91.3% (91 breaches).

Outpatient capacity issues were recorded as the most frequent breach reason (53%), followed by patient choice (31%).

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

Action Taken to improve compliance

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

Expected date of compliance	End of Q3
Escalation route	NHS England, North West CCC Performance Committee, Trust Board
Executive Lead	Liz Bishop, CMCA SRO

62 Cancer Standard (Alliance-level)	**Target**	**July 21**	**YTD**	**12 month trend** (to July)
	85%	**76.1%**	**77%**	

Reason for non-compliance

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

- Other 25% (3 breaches)
- Gynaecological 35% (26 breaches)

- Lower Gastrointestinal 44.1% (35.5 breaches)
- Haematological (Excluding Acute Leukaemia) 54% (14.5 breaches)
- Head & Neck 59% (12.5 breaches)
- Urological (Excluding Testicular) 70.9% (34 breaches)
- Upper Gastrointestinal 72.1% (14.5 breaches)
- Sarcoma 75% (1 breaches)
- Lung 79.5% (11.5 breaches).

Providers not achieving the national standard were:

- Liverpool Womens 16.1% (13 breaches)
- Liverpool University Hospitals 64.4% (52.5 breaches)
- Countess of Chester Hospital 70.4% (18.5 breaches)
- East Cheshire 70.9% (11.5 breaches)
- Warrington and Halton Teaching Hospitals 74.3% (13.5 breaches)
- Mid Cheshire Hospitals 76.7% (17.5 breaches)
- Southport and Ormskirk Hospital 77.1% (12 breaches)
- Wirral University Teaching Hospital 84.7% (13.5 breaches).

The main reasons for breaches were complex diagnostic pathways (23%), healthcare provider initiated delay to diagnostic test or treatment planning (16%) and 'other' (40%).

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	Q4 2021/2022.
Escalation route	NHS England, North West CCC Performance Committee, Trust Board
Executive Lead	Liz Bishop, CMCA SRO

2.2 Efficiency

	KPI	Target	Aug 21	YTD	Last 12 Months
Length of Stay (days)	Solid Tumour: Emergency	G: ≤8 A: 8.1-8.4 R: >8.4	**8.6**	7.5	
	HO Ward 4: Elective	G: ≤21 A: 21.1-22.1 R: >22.1	21.4	16.2	

Reason for non-compliance

The LoS for emergency admissions on ST wards was 0.6 days above target at 8.6 days.

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

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

One covid positive patient who was elderly and lived alone, required a full package of care and there were delays in arranging this.

Due to community staffing reductions, there are significant delays to commissioning social and fast track packages of care, leading to increased lengths of stay.

The CUR non-qualifying rate for August is 3%, which provides assurance that there was a low incidence of inappropriate utilisation of beds. This initiative was rolled out to HO wards on 2/8/21 and this provides full oversight of appropriate bed utilisation across all CCC wards.

The LoS for elective admissions on HO Ward 4 was 0.4 days above target at 21.4 days.

One patient was ready for discharge then developed Sepsis and required a further 7-day stay.

Action taken to improve compliance

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

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

Bed Occupancy	Wards	Target	Aug 21	YTD	Last 12 Months
	Solid Tumour (Midday)	G: ≥85% A: 81-84.9% R: <81%	**79.3%**	**72.3%**	
	Solid Tumour (Midnight)	G: ≥85% A: 81-84.9% R: <81%	**77.8%**	**72.7%**	

Reason for non-compliance

Solid tumour inpatient ward occupancy continues to be below the Trust's target of 85%, however it is the highest is has been since March 2021. HO ward occupancy is above target; for the third consecutive month for Ward 4 and the second consecutive month for Ward 5.

The figures are calculated on a total bed base of 86 beds. An additional 4 beds on Ward 3 have been designated as 'escalation beds' to help the Trust and the wider system with winter/Covid-19 pressures. These beds have not been used during August. No mutual aid patients have transferred across to CCC Liverpool from LUHFT in August 2021.

The Trust has been predominantly on OPEL 1 (Green) during August 2021, however OPEL 3 has been recorded for the solid tumour wards on 10 occasions.

Bed occupancy is noted to be higher during the week than the weekend. The Patient Flow Team (PFT) are in the process of reviewing this data together with the BI Team to inform future LoS and bed occupancy improvement. Work is also underway regarding the provision of ambulatory chemotherapy for HO and ST patients.

The PFT and the wider MDT continue to proactively discharge plan to ensure that patients are in the safest place for them during the COVID-19 pandemic.

Action taken to improve compliance

- The PFT continue to work with the wider MDT to aid discharge planning during the COVID-19 pandemic, and work closely with the CDU and Hotline to maximise access to acute oncology beds at CCC.
- Review of daily occupancy data to inform LoS and bed occupancy improvements.
- The ST inpatient / day case coding review continues.

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

% of expected discharge dates (EDD) completed	**Target**	**Aug 21**	**YTD**	**Last 12 Months**
	G: ≥95% A: 90-94.9% R: <90%	**85%**	**84%**	

Reason for non-compliance

In August 2021, 85% of patients' expected discharge dates were recorded on Meditech.

Some focused work regarding HO admissions is required to improve compliance.

Action taken to improve compliance

- The Digital team are working with HO staff to review admission documentation to ensure EDD data fields are recorded
- The Patient Flow Team will monitor data to ensure that all EDDs are completed within 24 hours of admission
- The Patient Flow Team are also working with the Digital team on the 'virtual ward round' system to ensure EDDs are regularly reviewed and that the rationale is captured for any variations noted, to inform service improvement requirements

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

Radiology Reporting: Outpatients (within 7 days)	**Target**	**Aug 21**	**YTD**	**Last 12 Months**
	G: ≥90% A: 80-89.9% R: <80%	83.3%	81.8%	

Reason for non-compliance

Compliance has risen from 74.7% in July to 83.3% in August, against a target of 90%

Reasons for non-compliance include:

- A sustained rise in radiology activity, placing increasing demands on the Radiologist team.
- Loss of reporting capacity due to Radiologists supporting clinical services; Interventional Radiology and Ultrasound.
- CCC Radiologist unplanned absence.
- Operational issues with CRIS and PACS continue to be reported. The Radiology team is collaborating with the Digital Team to resolve this. This is a technical issue external to CCC.

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

Action taken to improve compliance • On-going increased number of cases outsourced to Medica. • 1 additional Radiologist has been recruited and due to start on 15th September 2021. • Clinical Imaging Fellow started on 1st September 2021. • Radiologist recruited in December 2019 continues to be delayed due to COVID. • Bi-weekly report received by senior Radiology team enabling continuous monitoring of the outstanding reports.	
Expected date of compliance	October 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**	**Aug 21**	**YTD**	**Last 12 Months**
	G: 100% R: <100%	**94.5%**	**96.2%**	

Reason for non-compliance Compliance remains below the 100% target and has dipped slightly this month due to reporting issues. Gaps in the data continue to be filled by: • Clerical staff calling patients to obtain this information ahead of appointments. • Obtaining access to more host hospitals' systems, so that ethnicity information can be extracted from these.	
Action taken to improve compliance • Now that the Trust's online Admin Dashboard is available, staff will be trained to access the data and monitor the target. • Weekend reception staff will be trained on how to access the dashboard and will call patients to obtain this information. • The Trust is reviewing potential future use of the Somerset Cancer Registry, which will give access to such patient details, entered by secondary care.	
Expected date of compliance	October 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	Aug 21	YTD	Last 12 Months
	R: >0 G: 0	1	4	

Reason for non-compliance

- A patient with CNS lymphoma and swallowing difficulties was placed on a modified diet and level 1 thickened fluids
- Following a PET CT scan the patient was given a drink, as per usual process. The drink was not thickened, however there were no obvious signs of aspiration noted by the radiology staff
- On return to the ward the patient acutely deteriorated, aspiration was initially diagnosed and appropriate treatment commenced
- Later the same day and following further deterioration, a CT head was completed which identified new areas of haemorrhage within the pons
- The patient passed away the following week

It has not yet been determined if an aspiration did in fact occur or contribute to the death of the patient as there were other medical issues to take into account. The incident has however highlighted communication issues between the departments involved.

Action taken to improve compliance

- Radiology staff were informed to ask all patients about any swallowing difficulties prior to giving drinks
- Head of Patient Experience was informed of the incident, with a request to ensure all volunteers are asking patients about swallowing difficulties prior to giving drinks
- The PET CT safety checklist has been updated to specifically ask about swallowing

Expected Date of Compliance	SUI report is due for submission 18/10/2021
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

Clostridiodes difficile infections (attributable)	Target	Aug 21	YTD	Last 12 Months
	≤11 per yr	1	7	

Reason for non-compliance

There was 1 case of Clostridiodes difficile (CDI), which was attributable to CCC, in August 2021. There have now been 7 cases in 2021/22 against a threshold of 11 for the year.

The patient was admitted with diarrhoea and a sample collected on the day of admission did not identify CDI. The patient was commenced on Tazocin for a suspected chest infection on admission. Due to worsening diarrhoea, another sample was taken on day 4 of admission; this identified CDI.

Action taken to improve compliance

No learning points were identified and review by Anti-microbial Pharmacist confirms that there were no issues with prescribing.

Expected date of compliance	November 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

% of routine formal complaints resolved in month, which were resolved within 25 working days	**Target**	**Aug 21**	**YTD**	**Last 12 Months**
	R: <65% A: 65-74.9% G: 75%	**33%**	**56%**	

Reason for non-compliance

Two of the three complaints resolved in August were not resolved within 25 working days. The target was narrowly missed in both instances, with responses being sent on days 26 and 28.

Delays occurred due to annual leave of key contributors and in one case, due to queries raised during the final approval process.

Action taken to improve compliance

Divisions to ensure the investigation and draft letter is ready for final approval within the timescales stated in the policy.

Expected Date of Compliance	October 2021

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

2.4 Research and Innovation

Study Recruitment	**Target**	**Aug 21**	**YTD**	**Last 12 months**
	G: ≥109 A: 92-108 R: <92 (pr month)	**80**	279	

Reason for non-compliance

279 patients have been recruited against an internal target of 542 (52% of target) at the end of Month 5. The main reason at Month 5 for not achieving this target is:

- No new studies that use the Aseptic Service have opened since 5th March 2021.

Two new observational studies have however opened in month and two additional studies have been greenlighted by Pharmacy to recruitment in month.

Action Taken to improve compliance

- Exploring Clinical Trial Pharmacy capacity with Interim Chief Pharmacist to allow new studies to open whilst not putting pressure on the system.
  - Agreed priority list with SRGs and with Interim Chief Pharmacist to progress studies requiring green light.
- Aiming to open three top priority studies in September 2021. Local site approval given by R&I, Pharmacy greenlight required.
- Diversification of portfolio into real world, psychosocial, radiotherapy and nursing research studies continues. Engaging with the PIs for these studies to maximise recruitment. This is evidenced by the positive increase in recruitment this month, up from 43 in July 2021 to 80 in August 2021.
- Clinical Trial Nursing team have diversified the way they work with internal and external service departments to ensure optimal recruitment.

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

Recruitment to Time and Target	Target	Q4 2020/21	Previous quarterly figures
	G: ≥55% A: 45-54.9% R: <45%	20%	Q2 = 60% Q3 = 50%

Reason for non-compliance

Recruitment of the contracted number of patients in the contracted time only happened in 20% of cases for Q4 2020/21 data. The target is an internal metric, no national metric is available.

- This is due to the studies pausing to recruitment in light of the pandemic and then going through a period of recovery where studies were unpaused.
- CCC is the first Trust in Liverpool to achieve 85% studies unpaused to recruitment pre-COVID. Currently 90%+ studies have now been unpaused to recruitment pre-COVID.
- Patient pathway, including diagnostics and surgery, had not fully recovered at the acute Trusts, which will have impacted on recruitment.
- A small number of commercial studies closed during this time period, n=5, and only one met Time and Target.
- Comparing sites nationally, a large number have shown a reduction in the number of studies submitted from Q4 2019/20 to Q4 2020/21. It would be expected that this number should remain consistent. This is most likely due to the impact of the pandemic and sites not opening new studies.
- The recruitment to Time and Target has shown as a reduction at CCC and at other large cancer centres, however other non-cancer centres have seen an increase or maintained. Potentially this is due to:
  - National pause to trial recruitment.
  - Cancer patients throughout the pandemic were identified as a vulnerable group and advised to self-isolate or minimise contact for non-essential healthcare, leading to them not presenting for participation on trials.
  - Cancer research study recovery being slower than other disease sites.

Action Taken to improve compliance

- Full review of current trial information to predict and manage Time and Target data.

Expected date of compliance	Q4 2021/22
Escalation route	SRG Research Leads, Committee for Research Strategy
Executive Lead	Sheena Khanduri, Medical Director

Studies opening to recruitment	Target	Aug 21	YTD	Last 12 Months
	G: ≥5 A: 4-5 R: <4 (pr month)	2	14	

Reason for non-compliance

Fourteen studies have opened to recruitment against an internal target of twenty-two at the end of Month 5 (65% of target). We have not met target for the following reasons:

- Since 5th March 2021 there has been a halt to opening new studies to recruitment that use the Pharmacy Aseptic Service.
- CCC has issued local approval for eight additional studies, for which we are awaiting Sponsor Greenlight. If all studies had been greenlighted, we would have opened 22 studies (102% of target at Month 5).

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

2.5 Workforce

Staff Sickness Absence	Target	Aug 21	YTD	Last 12 Months
	G: ≤4% A: 4.01– 4.99% R: ≥ 5%	4.84%	4.56%	

Reason for non-compliance

The in-month figure for absence has increased from 4.64% to 4.84% in August 2021. The 12-month figure has also increased from 4.41% to 4.65%.

In August there were 209 episodes of absence across the Trust. Of these, 23 were COVID related; this equates to 11% of all Trust sickness absence.

The top three reasons for absence are Gastrointestinal problems (39), Anxiety/ Stress/ Depression (36) and Chest and Respiratory problems (34).

Gastrointestinal problems continues to be the Trust's highest reason for absence. This has been consistent since June 2021. There were 3 long-term absences due to gastrointestinal problems in August and these will continue into September. All other episodes were short term with only four episodes still ongoing.

Of the absences due to Anxiety/ Stress/ Depression, 27 of the absences were due to personal circumstances and 9 were work related. This is an increase of 4 work related stress related absences since July.

Absences due to Chest and Respiratory problems has remained high in August, although there has been a decrease of one episode from 35 to 34. 11 of these absences are long term and 4 ended in August. There were 23 short-term absences, 7 of which continue into September.

Action taken to improve compliance

- A 12-month review of absence has recently taken place, which identified that Gastrointestinal Problems was the Trust's highest reason for absence, despite the pandemic. Further analysis is due to take place to understand this and explore if possible whether the high number of absences due to this reason can be avoided.
- HR Business Advisors continue to meet with departmental managers monthly to discuss sickness absence and explore ways to manage and support staff.
- All episodes of absence due to anxiety/stress/depression are reviewed monthly and staff members are managed and supported appropriately in order to facilitate a return to work.
- HR Business Advisors explore each month which members of staff are absent due to anxiety/stress/depression and whether it is due to work or personal related circumstances and ensure managers have sign posted to appropriate support mechanisms.
- The recent annual stress audit identified an increase in the number of stress related absences over the past 12 months. It also identified that it is not routinely recorded whether a stress related absence is due to work or personal reasons, nor is a level 2 reason always recorded. The HR Business Partnering team have a number of actions to take forward following this audit in order to improve these outcomes.
- Following completion of the annual stress audit, the HR Business Partnering team plan to contact members of staff who have been absent recently due to anxiety/stress/depression for feedback on their experience and the support they received. The aim is to identify if the management of stress absences can be improved; to reduce the number and lengths of such absences.

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

Staff Turnover	Target	Aug 21	YTD*	Last 12 months
	G: ≥1.2% A: 1.21 – 1.24% R: ≤1.25%	1.37%	7.35%	

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

Reason for non-compliance

The number of leavers in August has remained the same as July, with 21 in total.

The highest reasons for absence in August was 'to undertake further education/ training' and 'work life balance', both with 5 leavers.

Ward 2 and 4, the AHP team, R&I and Pharmacy all had one leaver each due to work life balance reasons.

Leavers due to 'to undertake further education/ training' was also split across departments with one leaver each including Medical and Dental, R&I, Admin Services, Outpatients and Radiology.

The Acute Care division had the highest number of leavers in August with 8 in total, with Ward 2 having the most leavers within the division with 2. 5 of the leavers within Acute Care were from the Nursing staff group.

Networked Services had the second highest number of leavers with 6 in total. 3 of these leavers were from Admin Services.

Of the 21 leavers in August 2021, just 5 completed an exit interview questionnaire, this is a decrease from the 8 received the month prior. Reasons cited as influencing their decision to leave were:

- Offered a Nurse Apprenticeship
- Offered progression and better support
- Better pay and education
- Better training (clinical systems in particular)

Action taken to improve compliance

- Continue to encourage staff to complete exit interviews – HR Business Advisors and WOD Apprentice contact leavers personally when they are informed
- Exit Interviews are reviewed monthly by the HR Business Partnering team to ensure that concerns are addressed and improvements made if necessary in order to reduce the number of leavers.
- Temperature Checks surveys are reviewed monthly by staff who have been in post for 3 and 9 months to ensure that any concerns that are raised are addressed in order to help retain staff and reduce the number of leavers in their first 12 months of employment.
- The HR Business Partnering Team have recently reviewed the Trust's Flexible Working Policy in line with the changes made to Section 33 of the NHS Terms and Conditions handbook in line with the NHS People Plan. The changes to this policy will encourage and ensure that flexible working is being offered where appropriate, in order to recruit and retain staff and see a decrease in the number of leavers due to Work Life Balance each month.

- The HR Business Partnering team are currently developing a Hybrid Working Guidance document which will establish the Trust's approach to home and agile working following the changes the Trust had to undertake to due to the Covid-19 pandemic. The document will support managers in establishing which roles can work under a hybrid model and how best to support them remotely in order to continue to offer flexibility to staff to improve work life balance.
- Following feedback regarding staff training in clinical systems, work is now underway to ensure that clinical teams have more input into IT training in order to improve staff experience during their induction to the Trust.

Expected date of compliance	December 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**	**Aug 21**	**Last 12 Months**
	G: ≥95% A: 75% - 94.9% R: ≤74%	91.90%	

Reason for non-compliance

The overall Trust's in month compliance for PADRs is 91.90% which, whilst below the KPI of 95% it is a significant increase of 5.80% from July 2021

A breakdown at department level is shown below.

Org L4	Reviews Completed %
158 CBU1 - Day Care & Network	95.65
158 CBU2 - Outpatients & Clinical Support	100.00
158 CBU3 - Admin Services	96.07
158 CBU4 - Pharmacy	95.92
158 CBU5 - Inpatient Care	83.60
158 CBU6 - Radiotherapy	99.39
158 CBU7 - Radiology Services	78.18
158 CBU8 - Physics	98.46
158 Cancer Alliance	88.89
158 Communications	100.00
158 Executive Office	90.00
158 Finance	65.22
158 Informatics & IT	80.88
158 Networked Leadership	100.00
158 Project Management Office	100.00
158 Quality	71.43
158 Recharges	100.00
158 Research & Innovation	88.89
158 Safeguarding	83.33
158 Service Improvement	100.00
158 Workforce & Organisational Development	100.00

12 out of 21 departments are now achieving compliance, in comparison to 3 departments in the previous month, with the remaining 9 departments having action plans in place to achieve compliance by 30th September 2021. All divisions have been issued with detailed reports to support the proactive management of PADR compliance. Compliance is currently been monitored at PRG meetings with divisional leads committing to achieving compliance by 30th September 2021. The L&OD Team will continue to work with divisions to support them in achieving compliance, but more importantly to ensure that all staff have a meaningful and purposeful annual appraisal conversation.
• Underperforming departments to achieve compliance by 30th September. • Divisional leads to provide assurance via PRGs that plans and processes are in place to ensure PADR compliance is proactively managed to ensure long term compliance is maintained • L&OD to continue to provide bespoke PADR compliance reports to divisions to enable effective management and planning of PADRs

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

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board	
Date of meeting:	29th September 2021	
Agenda item:	P1-143-21	
Title:	Finance Report - Month 5	
Report prepared by:	Jo Bowden, Deputy Director of Finance	
Executive Lead:	James Thomson, Director of Finance	
Status of the report: (please tick)	Public ☒	Private ☐

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

Purpose of the paper/key points for discussion:	To present the financial position of the Trust to August (month 5) 2021-22.

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

Next steps required:	N/A

REPORT COVER

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
29th September 2021

Financial Performance Report

1. Introduction

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

Metric (£000)	In Mth 5 Actual	In Mth 5 Plan*	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit)	1	0	1		99	0	99	
CPL/Propcare Surplus/ (Deficit)	(72)	0	(72)		347	0	347	
Control Total Surplus/ (Deficit)	(72)	0	(72)		446	0	446	
Group Cash holding	57,271	59,314	(2,043)		57,271	59,314	(2,043)	
Capital Expenditure	(4)	0	4		168	156	(12)	
Agency Cap	112	95	(17)		334	475	141	

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

3. Operational Financial Profile – Income and Expenditure

3.1 Overall Income and Expenditure Position

The Trust financial position to the end of August is a £99k surplus, the group consolidated position is a £447k surplus, against a break-even plan. The cash position has improved by £1.3m since month 4. For the group the cash is showing a closing balance of £57.2m, which is £2.0m below plan. Capital spend has reduced by £4k in month.

The agency cap has been re-introduced as a metric in this financial year. In month 5 we are slightly over cap by £17k, however, we are £141k under in the year to date.

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

Metric (£000)	Actual M5	Trust Plan M5	Variance	Actual YTD	NHSI Plan YTD	NHSI Variance	Trust Annual Plan
Clinical Income	14,754	16,727	(1,972)	84,424	83,620	**804**	200,651
Other Income	2,060	1,684	375	8,237	8,450	**(212)**	20,393
Total Operating Income	**16,814**	**18,411**	**(1,597)**	**92,661**	**92,069**	**592**	**221,044**
Total Operating Expenditure	(16,481)	(18,089)	1,609	(90,902)	(90,461)	**(441)**	(217,185)
Operating Surplus	**333**	**322**	**12**	**1,759**	**1,608**	**151**	**3,859**
PPJV	67	67	0	335	335		804
Finance Costs	(400)	(389)	(11)	(1,995)	(1,943)	**(52)**	(4,663)
Trust Surplus/Deficit	**1**	**0**	**1**	**99**	**0**	**99**	**0**
Subsiduaries	(72)	0	(72)	347	**0**	**347**	**0**
Consolidated Surplus/Deficit	**(72)**	**0**	**(72)**	**446**	**0**	**446**	**0**

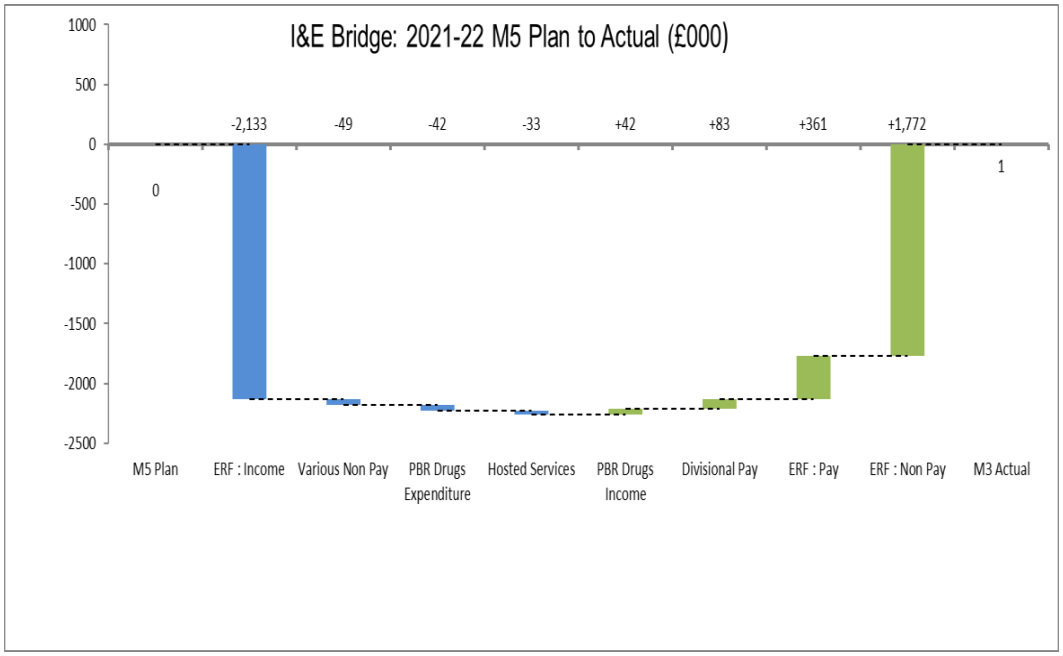
The table below summaries the consolidated financial position:

August 2021 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	(80)	(303)
Donated Depreciation	80	402
Trust Retained Surplus / (Deficit)	**1**	**99**
CPL	(27)	195
Propcare	(46)	153
Consolidated Financial Position	**(72)**	**446**

3.3 Income and Expenditure Position

3.3.1 The bridge below shows the key drivers between the £1k in month surplus and break-even plan.

- Elective Recovery Funding (ERF) income has reduced by £2.1m compared to Trust plan. This is based on indicative Cheshire & Mersey figures provided to the Trusts and specifically relates to July and August system performance. This has been offset by non recurrent ERF expenditure slippage – Pay £0.4m and non pay £1.7m.
- Drugs spend is over plan by £42k. 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.
- Divisional Pay budgets are £83k 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 £49k – driven by the allocation of the annual CIP target. The majority of CIP targets are being met non-recurrently mainly through pay savings.



3.3.2 The August Divisional financial performance is shown in the table below.

The overall Trust pay position is £232k underspent, there is an over spend of £212k for R&I which is offset with income and there is an under spend in relation to ERF of £361k, which reports into Corporate. The remainder of the under spend, £83k, relates directly to Divisions. Drugs is showing an overall over spend of £43k, 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 under spend of £1.5m. £1.8m of this relates to the under spend on non-recurrent ERF funding to support reduced income. The remaining pressure is driven by the central CIP allocation. The Cancer Alliance position is balanced overall by income.

August 2021 (M5) £(000)	Pay			Non-Pay			Total Expenditure
	Budget	Actual	Variance	Budget	Actual	Variance	Variance
Acute Care	1,591	1,585	6	694	768	(74)	(68)
Corporate	973	667	306	2,776	1,322	1,454	1,760
Networked	1,663	1,517	146	557	639	(82)	64
Radiation Services	1,480	1,495	(14)	352	360	(8)	(22)
Research	380	592	(212)	46	107	(61)	(273)
Drugs	0	0	0	6,745	6,788	(43)	(43)
Sub-Total Operating	**6,087**	**5,855**	**232**	**11,170**	**9,985**	**1,185**	**1,418**
Hosted - Cancer Alliance	204	206	(3)	628	435	194	191
Finance Costs	0	0	0	322	333	(11)	(11)
TOTAL	**6,291**	**6,061**	**230**	**12,120**	**10,752**	**1,368**	**1,597**

Aug 2021 (M5) WTE	Pay			
	Budget	Actual	Variance	M4 Actual
Acute Care	380	371	(8)	372
Corporate	236	210	(26)	211
Networked	496	450	(46)	451
Radiation Services	326	312	(15)	307
Research	101	72	(28)	75
Hosted - Cancer Alliance	42	37	(6)	36
TOTAL	**1,580**	**1,452**	**(128)**	**1,452**
Of which substantive	1,580	1,423	(157)	1,421
Of which temporary	0	29	29	31
TOTAL	**1,580**	**1,452**	**(128)**	**1,452**

3.4 Elective Recovery Fund – H1 2021-22

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

Metric £(000)	Total	April	May	June	July	August	Sept
Original ERF Income Plan	9,441	1,935	1,754	1,573	1,393	1,393	1,393
Updated ERF Income Plan M3	8,356	1,935	1,754	1,573	1,031	1,031	1,031
Month 5 indicative ERF Values	5,769	2,069	2,106	1,370	94	94	36
Shortfall against original plan	**(3,672)**	**134**	**352**	**(203)**	**(1,299)**	**(1,299)**	**(1,357)**
ERF Pay plan to deliver additional activity	970	115	171	171	171	171	171
ERF Non Pay plan to deliver additional activity	2,127	355	355	355	355	355	355
Total Expenditure plan	**3,097**	**470**	**526**	**526**	**526**	**526**	**526**

The H1 Trust plan includes income from the ERF of £9.4m to achieve a break-even position. In the period April to August the Trust has delivered a level of activity above plan.

On 8th July 2021 NHSI issued a letter to all Trusts which amended the threshold the Trust is required to achieve before ERF is payable. The threshold for July to September was originally 85% and has now been increased to 95% of 2019/20 activity levels. The Trust calculated the impact of this which showed an expected reduction of £1.1m in H1. Levels of funding available to the Trust are reliant on all Cheshire and Mersey Trusts achieving this increased activity threshold.

On 8th Sept 2021 the Cheshire & Mersey HCP provided indicative values to include in the month 5 financial position. April and May showed an increase in activity and income against plan, this is based on freeze data and the figure is final. June to September is based on indicative activity values provided by all Trusts. As not all Trusts have met the necessary activity threshold there is a significant reduction of income across the C&M system. For the Trust this is showing an overall H1 value of £5.769m against the original plan of £9.441m, a shortfall of £3.672m.

The Trust has mitigated the ERF risk to month 5 by recognising that costs associated with the extra activity have yet to materialise. A key factor is that forecast block drugs expenditure has not increased as predicted. Further mitigations include an expected improvement of system performance as freeze data is used for the calculation.

3.5 **Bank and Agency Reporting**

Bank spend in August is £82k, which is consistent to previous months. The largest user of bank staff the Acute Division whose spend in month 5 is £64k. The main reasons for bank spend is to cover vacancies and sickness in ward areas.

Agency spend in month is £112k which has doubled compared to previous months. This takes us above the £95k agency cap in month, however, year to date we are reporting significantly under cap.

See Appendix F 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, this revised plan required a higher level of CIP required of £1.423m for the first six months of the year (H1). The CIP requirement is broken down as follows:

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

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

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

As at month 5 of the required £1.9m, a total of £807k of schemes have been identified by the Divisions, of which £528k are recurrent. The central CIP is being met non-recurrently through slippage. Please refer to Appendix E for further breakdown.

4. Cash and Capital

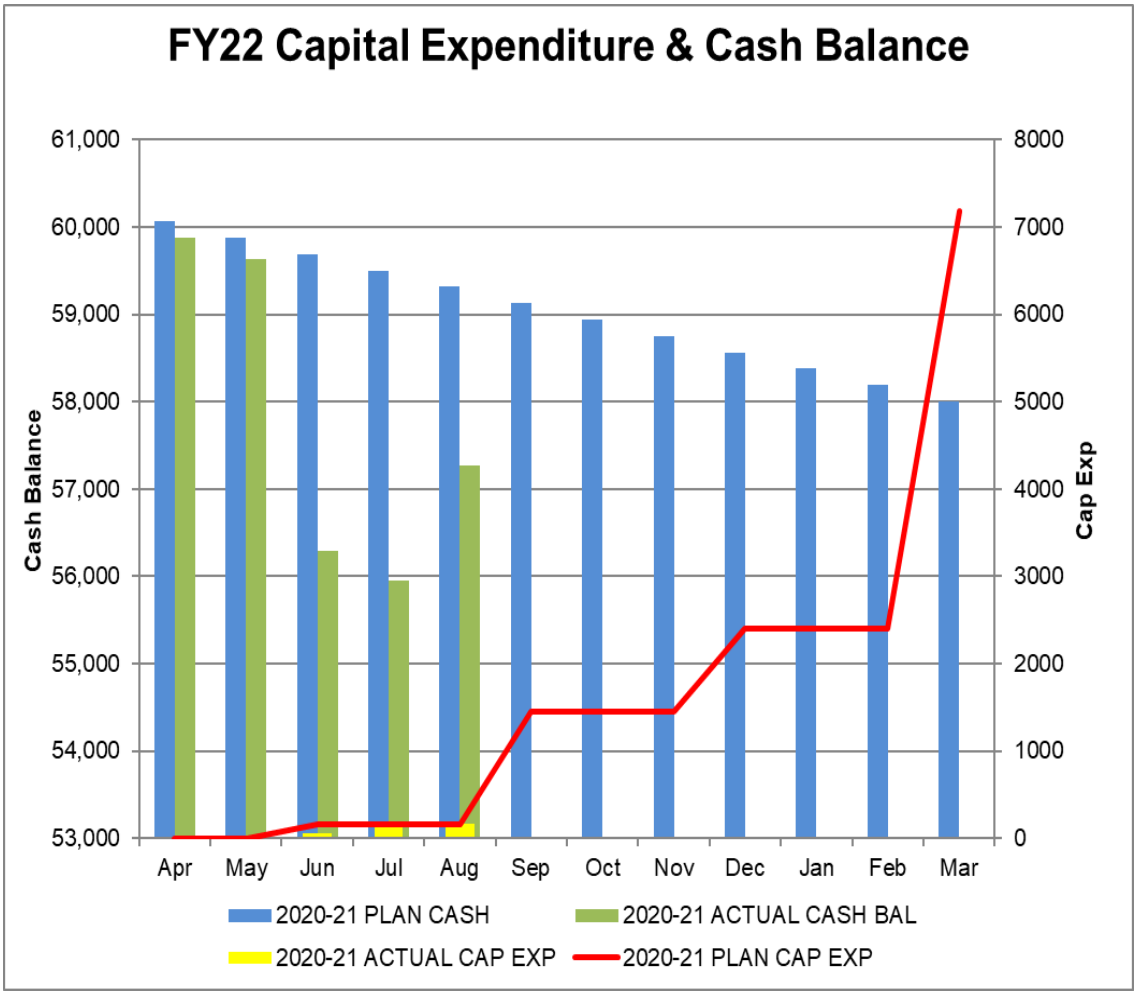
4.1 The capital plan approved by the Board is £7.187m for 2021-22.

4.2 Capital expenditure of £168k has been incurred to the end of August. This is slightly above the planned spend profile for the year to date. The plan is profiled such that expenditure will occur towards the end of the year. This is being monitored through the Capital Committee to ensure any slippage risk is identified and mitigated. Detailed capital report is included in Appendix D.

4.3 The capital programme is supported by the organisation's cash position. The Group has a current cash position of £57.2m, which is a negative variance of £2.0m to the cash-flow plan of £59.3m. Cash is below plan due to the Trust not receiving income in relation

to ERF for the first five months, it was assumed for cash planning that this would be received on a more timely basis.

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



This chart shows monthly planned and actual Cash Balances and Planned Capital Expenditure for 2021/22. It shows that for August the Trust has less cash than planned, however, still a very healthy cash position.

5. Balance Sheet Commentary

5.1 Current Assets

Receivables are above plan by £4.2m, this relates in part to the estimated ERF funding which is being accrued into the position.

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 August financial position
- The risk and mitigations around the ERF income
- The continuing strong liquidity position of the Trust

Appendix A – Statement of Comprehensive Income (SOCI)

(£000)	Month 5			Cumulative YTD				2021/22
	Plan	Actual	Variance	Plan	Actual	Variance	%	Annual Plan
Clinical Income	16,674	14,729	(1,945)	83,358	84,087	728		200,032
Other Income	470	769	300	2,583	3,465	882		6,109
Hosted Services	1,267	1,316	49	6,128	5,110	(1,019)		14,904
Total Operating Income	**18,411**	**16,814**	**(1,597)**	**92,069**	**92,661**	**592**	**1%**	**221,044**
Pay: Trust (excluding Hosted)	(5,699)	(5,256)	443	(28,613)	(27,589)	1,024		(68,688)
Pay: Hosted	(583)	(798)	(215)	(2,832)	(2,602)	230		(7,167)
Drugs expenditure	(6,745)	(6,788)	(43)	(33,727)	(35,831)	(2,104)		(80,946)
Other non-pay: Trust (excluding Hosted)	(4,387)	(3,097)	1,290	(22,007)	(22,393)	(386)		(52,544)
Non-pay: Hosted	(674)	(542)	132	(3,282)	(2,487)	795		(7,840)
Total Operating Expenditure	**(18,089)**	**(16,481)**	**1,609**	**(90,461)**	**(90,902)**	**(441)**	**0%**	**(217,185)**
Operating Surplus	**322**	**333**	**12**	**1,608**	**1,759**	**151**	**9%**	**3,859**
Profit /(Loss) from Joint Venture	67	67	0	335	335	0		804
Interest receivable (+)	401	394	(7)	2,004	1,968	(35)		4,809
Interest payable (-)	(439)	(443)	(4)	(2,197)	(2,213)	(17)		(5,272)
PDC Dividends payable (-)	(350)	(350)	0	(1,750)	(1,750)	0		(4,200)
Trust Retained surplus/(deficit)	**0**	**1**	**1**	**0**	**99**	**99**	**0%**	**(0)**
CPL/Propcare	0	(72)	(72)	0	347	347		
Consolidated Surplus/(deficit)]	**0**	**(72)**	**(72)**	**0**	**446**	**446**	**0%**	**0**

Appendix B – Balance Sheet

£'000	Unaudited 2021	Plan 2022	Year to date Month 5		
			YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	2,488	2,100	2,424	2,324	(100)
Property, plant & equipment	177,180	174,267	175,680	173,621	(2,059)
Investments in associates	181	181	181	95	(86)
Other financial assets	1,364	0	0	0	0
Trade & other receivables	161	100	134	360	226
Other assets	0	0	147	0	(147)
Total non-current assets	**181,374**	**176,648**	**178,566**	**176,400**	**(2,167)**
Current assets					
Inventories	4,201	4,200	4,201	4,386	185
Trade & other receivables					
NHS receivables	4,621	4,500	4,621	8,822	4,201
Non-NHS receivables	4,484	4,500	7,779	7,573	(206)
Cash and cash equivalents	63,533	58,000	59,875	57,271	(2,604)
Total current assets	**76,839**	**71,200**	**76,476**	**78,052**	**1,576**
Current liabilities					
Trade & other payables					
Non-capital creditors	28,222	30,000	28,222	27,507	(715)
Capital creditors	3,544	2,000	2,000	2,078	78
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	2,139	(21)
Other liabilities:-					
Deferred income	5,974	4,000	5,974	6,767	793
Other	0	0	0	0	0
Total current liabilities	**41,816**	**39,265**	**40,086**	**40,220**	**135**
Total assets less current liabilities	**216,398**	**208,583**	**214,957**	**214,232**	**(725)**
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**	**178,900**	**(737)**
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	108,827	(736)
Total taxpayers equity	**180,338**	**176,383**	**179,637**	**178,900**	**(737)**

Appendix C – Cash Flow

August 2021 (M5) £'000	FT	Group (exc Charity)
Cash flows from operating activities:		
Operating surplus	1,357	1,830
Depreciation	3,726	3,726
Amortisation	162	162
Impairments		
Movement in Trade Receivables	(8,554)	(4,906)
Movement in Other Assets	0	0
Movement in Inventories	(48)	(185)
Movement in Trade Payables	3,184	(477)
Movement in Other Liabilities	715	703
Movement in Provisions	49	83
CT paid	0	(25)
Net cash used in operating activities	**590**	**910**
Cash flows from investing activities		
Purchase of PPE	(214)	(220)
Purchase of Intangibles	0	0
Proceeds from sale of PPE	0	0
Interest received	1,968	0
Investment in associates	421	421
Net cash used in investing activities	**2,176**	**201**
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	(2,213)	(247)
Interest element of finance lease	0	0
PDC dividend paid	(1,750)	(1,750)
Finance lease - capital element repaid	0	0
Net cash used in financing activities	**(6,056)**	**(4,089)**
Net change in cash	**(3,290)**	**(2,978)**
Cash b/f	**53,765**	**60,248**
Cash c/f	**50,475**	**57,271**

Appendix D – Capital

Capital Programme 2021-22
Month 5

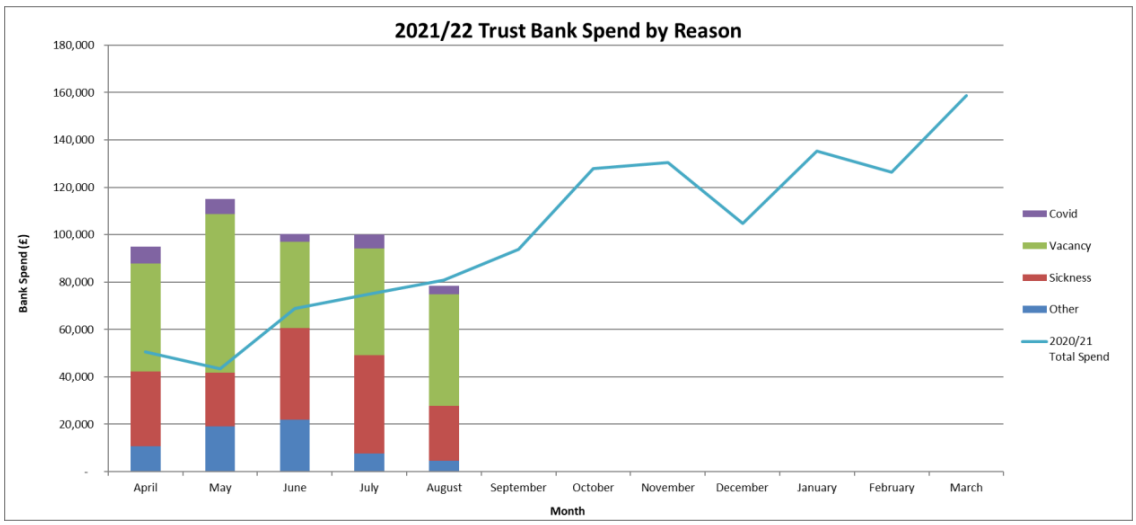
The Clatterbridge Cancer Centre NHS Foundation Trust

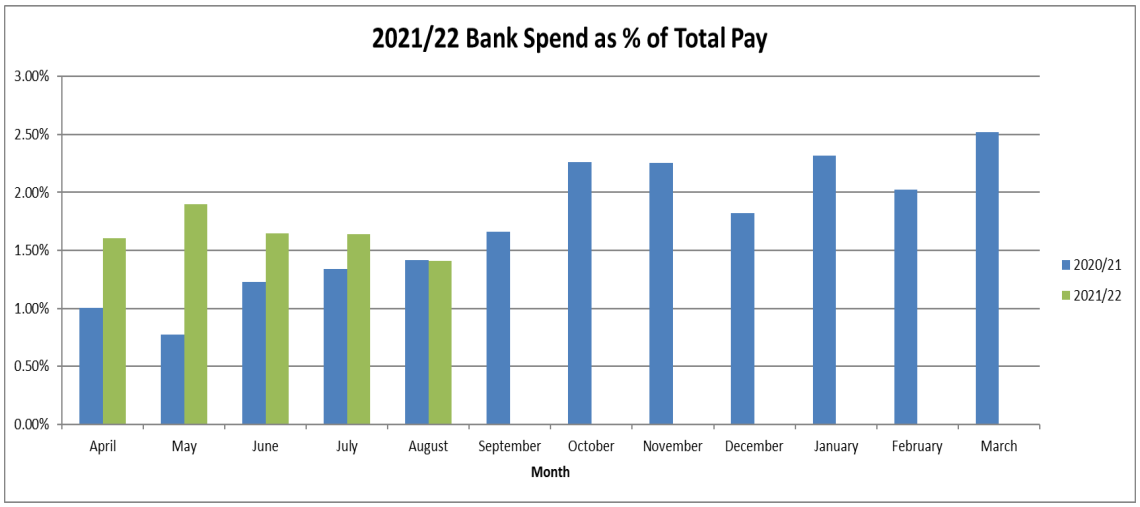
Code	Scheme	Lead	BUDGET (£'000) NHSI plan 21-22	Approved Adjustments	Budget 21-22	ACTUALS (£'000) Actuals @ Month 5	Variance to Budget	FORECAST (£'000) Forecast 21-22	Variance to Budget	Ordered?	Complete?	Comments
4194	***(20/21)*** Cyclotron refurb		0	0	0	8	(8)	8	(8)	✔	✔	
4195	***(20/21)*** CCCA Linacc Oak refurb		0	0	0	(3)	3	(3)	3	✔	✔	
4199	***(20/21)*** CCCW Crest refurb		0	0	0	(1)	1	(1)	1	✔	✔	
4201	***(20/21)*** Spine		0	0	0	(3)	3	(3)	3	✔	✔	
4303	CCCA Linac Bunker - Maple	Julie Massey	420	0	420	0	420	420	0	✘	✘	BC approved at Finance Committee 11/06
4300	CCCW CT Simulator (Brilliance 2)	Louise Bunby	300	(191)	109	0	109	109	0	✔	✘	BC approved at Finance Committee 11/06
4302	Air Handling Unit Upgrade	Mel Warwick	0	28	28	0	28	28	0	✘	✘	BC approved at Finance Committee 11/06
	Contingency	*n/a*	200	162	362	0	362	324	39	-	-	
	Estates		**920**	**0**	**920**	**1**	**919**	**882**	**38**			
4180	***(19/20)*** CCCL HDR & Papillon tfr costs		0	0	0	(12)	12	(12)	12	✔	✔	
4001	***(20/21)*** CCCL Pet CT		0	0	0	7	(7)	7	(7)	✔	✔	
4006	***(20/21)*** CCCL Linear Accelerator		0	0	0	4	(4)	4	(4)	✔	✔	
4010	***(20/21)*** CCCL Diagnostic CT		0	0	0	1	(1)	1	(1)	✔	✔	
4303	CCCA Linear Accelerator - Maple	Julie Massey	2,460	(155)	2,305	0	2,305	2,305	0	✘	✘	BC approved at Finance Committee 11/06
	CCCL Mobile Imagine Intensifier	Sam Wilde	138	0	138	0	138	138	0	✘	✘	
	MEME - Acute - Patient Monitor	Julie Massey	9	0	9	0	9	11	(2)	✘	✘	
	MEME - Acute - 2x Ultrasound	Julie Massey	25	0	25	0	25	30	(5)	✘	✘	
	MEME - Networked - 3x Scalp Cooler (I)	Julie Massey	28	0	28	0	28	34	(6)	✘	✘	
	MEME - Networked - 6x Scalp Cooler (II)	Julie Massey	69	0	69	0	69	83	(14)	✘	✘	
	MEME - Rad - Infinity Monitor M540	Julie Massey	9	0	9	0	9	0	9	✘	✘	MEME 14/7 - postpone to 23/24
	MEME - Rad - 3x Patient Monitor C500	Julie Massey	33	0	33	0	33	0	33	✘	✘	MEME 14/7 - postpone to 23/24
	MEME - Rad - 6x Patient Monitor M540	Julie Massey	54	0	54	0	54	0	54	✘	✘	MEME 14/7 - postpone to 23/24
4192	Cyclotron	Carl Rowbottom	742	0	742	30	712	742	0	✔	✘	PDC Funded
4300	CCCW CT Simulator (Brilliance 2)	Louise Bunby	500	166	666	0	666	666	0	✔	✘	BC approved at Finance Committee 11/06
4301	Stand Aids		0	0	0	14	(14)	14	(14)	✔	✔	Ordered against revenue, not in cap plan
	Contingency	*n/a*	200	(11)	189	0	189	244	(55)	-	-	
	Medical Equipment		**4,267**	**0**	**4,267**	**45**	**4,222**	**4,267**	**0**			
4190	***(20/21)*** Digital Aspirant	James Crowther	0	0	0	1	(1)	1	(1)	✔	✔	
	Infrastructure	James Crowther	1,350	0	1,350	2	1,348	1,349	1	✘	✘	
	Other minor programmes	James Crowther	250	0	250	82	168	250	0	✘	✘	
	IM&T		**1,600**	**0**	**1,600**	**84**	**1,516**	**1,600**	**(0)**			
4142	Liverpool	Peter Crangle	0	0	0	24	(24)	24	(24)	✔	✔	
4142	Wirral	Peter Crangle	400	0	400	0	400	400	0	✘	✘	
4142	CCCL Link Bridge installation	Peter Crangle	0	0	0	14	(14)	14	(14)	✘	✘	
	Building for the Future		**400**	**0**	**400**	**38**	**362**	**438**	**(38)**			
	TOTAL		**7,187**	**0**	**7,187**	**168**	**7,019**	**7,187**	**0**			

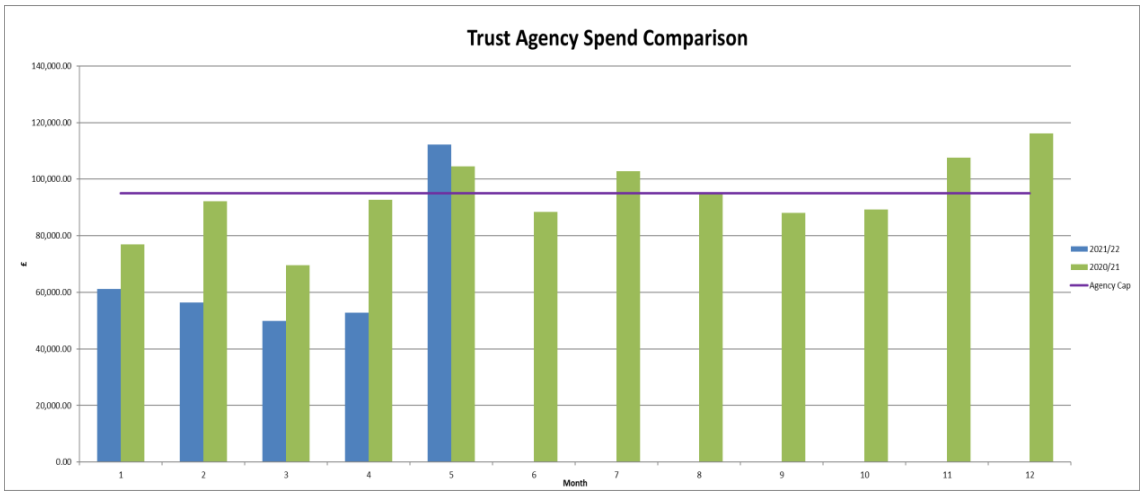
Appendix E – CIP

CIP (£000)	Target	In Year 21.22	Full Year (Recurrent)
Acute Care	560	251	251
Corporate	319	137	21
Networked Services	548	67	76
Radiation Services	453	352	181
Grand Total	**1,880**	**807**	**529**

Appendix F – Bank and Agency







REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to	Trust Board
Date of meeting:	29th September 2021
Agenda item:	P1-144-21
Title:	Health ,Safety and Security Annual Report
Report prepared by:	Derry Sinclair/Steve Povey Health and Safety Advisers
Executive Lead:	Joan Spencer Chief Operating Officer /Interim Chief Nurse.
Status of the report: (please tick)	Public ☒ Private ☒

Paper previously considered by:	Risk Management Committee
Date & decision:	19th July 2021 Report approved

Purpose of the paper/key points for discussion:	The annual report provided, assures the Trust that its proactive approach to Health and Safety ensures compliance with health and safety legislation. The report will also assure that all departmental annual H&S/Security risk assessments have been completed. Risks identified have controls in place to prevent were possible any injuries, ill health or damage to patient, staff or visitors property. This report demonstrates there is high level compliance with H&S training and that additional training is provided throughout the year. Polices have also been reviewed to provide assurance they are relevant to all Clatterbridge Cancer Centre sites and audits have been completed to ensure compliance.

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

Next steps required:	Presented to the Trust Board as part of the annual reporting 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.

The Clatterbridge Cancer Centre NHS
NHS Foundation Trust

Health, Safety & Security

Annual Report 2020-21

Derry Sinclair – H&S Adviser & LSMS
Steve Povey – H&S Adviser & EPO

Executive Summary

The safety of the Trust's patients, staff and visitors is paramount and therefore CCC continues to encourage a proactive approach to health and safety to ensure the Trust complies with health and safety legislation.

All staff groups have access to our specialist training including health and safety, moving and handling, fire safety, emergency preparedness, resilience and response, security and conflict resolution. In addition, advice is available from radiation protection, infection control and occupational health staff.

A comprehensive fire training programme continues to be implemented which includes fire marshal training, evacuation chair use for non-ambulant persons, and ward evacuations, both horizontal and vertical, being delivered. All activated fire alarm responses, including false alarms, are reported and assessed.

To support staff with knowledge and information for health and safety, fire, security and manual handling, training sessions are provided annually, bi-annually or 3 yearly, as appropriate, for all staff groups. Workbooks are also used as an alternative form of learning alongside face to face and e-learning.

The Trust continues to provide conflict resolution training to staff.

Staff incidents in 2020/21 are categorised as follows: Slip, Trip & Fall, Violence & Aggression, Equipment/Medical Devices, Inoculation, Infection Control, Information Governance, Security, IT, Staff Radiation Badge, Manual Handling and 'Other' causes.

Regular reports on all accidents, dangerous occurrences and ill health are presented at the Health and Safety Committee Meeting where action plans are agreed and implemented. The committee also review all Central Alert System Alerts (CAS Alerts) and Estates & Facilities Alerts received throughout the year.

During 2020/21 there have been no planned or unannounced regulatory visits for Health & Safety on any of the Trust sites.

The year 2020/21 has been a challenging year for all and during this time the Trusts Health & Safety Team have been able to continue their vital work and continue to achieve and exceed goals.

Compliance with H&S training has been achieved in line with targets and the team have completed and arranged an increase in training for staff.

The national target for NHS Staff flu vaccinations 2020-21 (90%) was exceeded across the Trust which was led by the Health and Safety Team supported by other Trust Staff.

As part of the Covid-19 pandemic response all appropriate staff across the Trust have been fit tested and have had access to an appropriate FFP3 Mask as required.

The H&S/Emergency Preparedness, Resilience & Response Lead has been stationed in the Covid-19 incident room since February 2020 supporting and advising the senior team in the management of the Trust response to the pandemic.

Introduction

The Clatterbridge Cancer Centre NHS Foundation Trust is a Specialist Hospital with over 1700 employees. The safety of patients, staff and visitors is paramount and therefore the Trust continues to encourage a pro-active approach to health and safety to ensure we comply with existing and new health and safety legislation.

All staff groups have access to our specialist team with expertise in health and safety, moving and handling, fire, security and Emergency Preparedness, Resilience & Response. In addition, advice is available from radiation protection, infection control and occupational health via other specialist teams.

As part of a pro-active approach to Health and Safety, risk assessments are completed by all departments to identify any potential risks and to put controls in place to prevent, where possible, any injuries, ill health or damage to patients, staff, visitors and property. These risk assessments are reviewed as part of the annual environmental risk assessment.

Regular reports on all accidents, dangerous occurrences and ill health are presented on a quarterly basis to the Health and Safety Committee where action plans are agreed for implementation. The purpose of this committee is to assist the Trust Board in the effective discharge of its responsibilities for health, safety and environmental governance management and internal control.

The Health & Safety at Work Act sets out employer's duties, Section 2(1) states:

"It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees".

Within the Trust, the Health and Safety lead responsibilities are in the portfolio of the Executive Team, via the Director of Nursing & Quality. The Health and Safety agenda is ultimately overseen by the Health and Safety Advisers and the Health and Safety Committee.

The Health and Safety Advisers have a split role, with Local Security Management Specialist (LSMS) and Emergency Preparedness Officer (EPO) duties encompassed into the roles.

Polices and Audits

Policy Review for Move to CCC-L

During quarter one of 2020-21 the Health and Safety team worked to ensure that all the Health & Safety and security policies were suitable and sufficient for the move to CCC-L in the summer of 2020. The following polices were all reviewed:

- COSHH
- Display Screen Equipment
- Falls –Prevention of Slip/trips/falls

- First Aid
- Management of Dermatitis and Latex
- Lone Working

These polices did not need any changes following review in relation to the move to CCC-L and their original review dates were maintained.

- Violence and Aggression (Zero Tolerance)

This policy did not need any initial change for the move to CCC-L and received a review post move to ensure that now issues with the new environment had not been identified and mitigation put in place.

- Security
- Lockdown Policy
- CCTV Policy
- Security of Patient Property

These policies were also reviewed, but required updates in relation to key aspects related to the move to CCC-L and the new environment.

Health, Safety and Security Audits

During 2020-21 7 audits were undertaken as part of an annual audit plan to review compliance and identify are areas where action needs to be taken to improve Health and Safety.

- Security
- Inoculation
- Violence & Aggression
- Falls
- Lone working
- Property & Assets
- Environmental risk assessments.

No significant issues were identified from the audits and all related polices were in line with national legislation.

Fire

As part of the current fire safety system PropCare is the operational lead with the Fire Manager role sitting within their service and supporting CCC.

As part of their fire safety role PropCare undertake a comprehensive rolling program of fire drills to ensure that the Trust is compliant with Fire legislation. No significant issues have been identified for the 2020-21 audit period.

All fire drills and unwanted fire alarms are recorded by PropCare and any actions raised are addressed at departmental level and reported through the Fire Safety Sub Committee to the Health and Safety Committee as a standing item on the agenda.

Further Fire Marshal training sessions have been arranged during the report period, these have been delivered by an external training provider and by the

31st March 2021, 183 members of staff have been trained to cover all 3 sites. Further training is planned throughout 2021-2022 and all fire marshals complete a monthly checklist within their area. The Trust also has a trained Trainer for the Evac+ Chairs which are positioned on main stairways. Please see the Health & Safety Training section for further information.

Fire Safety training is provided to all staff as part of new starter induction. When face to face training was cancelled due to Covid-19 pandemic, restrictions staff completed an e-learning package. Along with other subjects, sessions have been aligned to North West and National Core Skills Standards to ensure training delivered is consistent with other Trusts.

Fire evacuation equipment training has continued to take place over the last year including training using Albac Mats and Bed Straps for vertical evacuation of patients.

Environmental Risk Assessment Tool

This documentation is completed on an annual rolling basis by all departments through the calendar year. The purpose of this documentation is to act as a guide for all areas to help identify any shortfalls in compliance with relevant Health and Safety Legislation. Following completion, compliance is audited by the Health and Safety Advisers alongside the department head with an action plan developed to ensure that any risks are controlled. A follow up visit is agreed to check on Action Plan progress.

The document is divided into different sections and if hazards are identified, a full Risk Assessment must be completed under the Trust Risk Management Strategy.

Areas covered by the Environmental Risk Assessment are:

- Environment
- Work Equipment
- Waste Arrangements
- Substances Hazardous to Health
- Fire Precautions
- Manual Handling
- First Aid
- Infection Control
- Display Screen Equipment
- Latex
- Security
- Radiation
- Chemotherapy
- Legionella (Water System Management)
- Slips, Trips & Falls
- Medical Devices
- Safer Sharps
- Emergency Preparedness
- Medicine Security

Departments & directorates self-assess using the Trust template, these are then audited by the Health & Safety Advisers the areas are then given a RAG rating for each of the areas listed above. Following this they then agree a review date to correct any shortfalls and eliminate any Red or Amber scores to improve compliance.

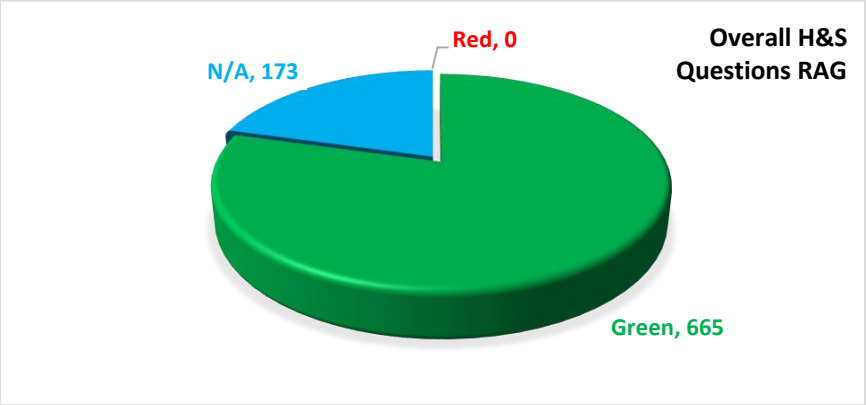
Due to Covid-19 restrictions, changes to the process were implemented during this report year; the Health & Safety advisor was not able to visit each area and departments using the Perfect ward application completed their annual audits electronically.

The other departments not using Perfect ward were sent paper versions of the assessments for completion and asked to return to the Health & Safety advisors to ensure compliance.

Thirty eight departments/directorates were sent the appropriate audit documents to complete and all departments returned their completed annual audits (100% return rate).

Following this process, the chart below, shows the overall ratings for those 38 departments with total scores of:

Green	38
Red	0



The audit has confirmed that departments have completed risk assessments as part of the annual risk assessment process, and identified whether these assessments were up to date, suitable and sufficient as required by the Management of Health & Safety at Work Regulations 1999.

From the adults departments identified the areas where they would like additional training and this is being factored into the 2021-22 training plan and will be provided by a mix of in-house and external trainers as identified below

- Fire Marshal Training
- Fire lift Training
- Fire Evacuation Training
- DSM (Duty Site Manager)

- First Aid Training

Health and Safety Training

Health and Safety Training continues to be provided in a structured format to enable compliance with Health & Safety legislation.

Health & Safety, Fire Safety and Inanimate Load Training is provided to all new staff on induction and maintained within the Core Skills framework, on an ongoing basis. Patient handling training is provided to clinical staff at Induction and Core Skills, and where possible is provided face-to-face following Covid-19 restrictions and use of PPE.

There is a comprehensive package of training for staff at all levels includes:

- On Call training for Senior Managers
- Fit Testing (correct fitting of masks)
- Fire Marshall (provided by an external company)
- Fire lift Training
- First Aid Training (provided by an external company and all non-clinical areas have first aiders and equipment to ensure compliance).
- Evac+ Chair Training
- Vertical & Horizontal Evacuation of Patients (Use of albac mats and bed straps)
- Emergency Planning
- Duty Site Manager

These training courses are provided on an ongoing basis with repeat dates throughout the calendar year and are monitored by the Health and Safety Committee.

Fire Evacuation Training Using the Albac Mat and Bed Straps.

This training is delivered via a training video to all staff on induction. Face to face sessions will recommence when Covid-19 restrictions are lifted.

First Aid Course

Due to Covid-19 restrictions no first aid courses were delivered but going forward in 21/22 more courses will be offered as these need to be delivered on a face-to-face basis.

Patient handling

The Trust Manual Handling Trainer leads on all manual handling training within the classroom and clinical areas. Their role also includes investigating manual handling incidents and reviewing and auditing the policy.

Patient handling training at the time of this report was 94% as a result of restrictions in the class size that are permitted due to its practical nature. A

significant number of additional sessions have been required and provided across all CCC sites.

Inanimate Loads

Inanimate Loads training is completed initially on a face to face basis, followed by e-learning refresher training. Compliance at the time of this report was 97%.

Health & Safety Training Compliance

Health & Safety Training is provided via e-learning at Induction training and end of year overall compliance was at 95%. Fire Safety compliance is currently at 95% and training is currently delivered 4 times per month for Induction, Mandatory Training, Nurses week and new Doctor Induction. Since March 2020 all fire training and Health and safety training has been online only, including for induction.

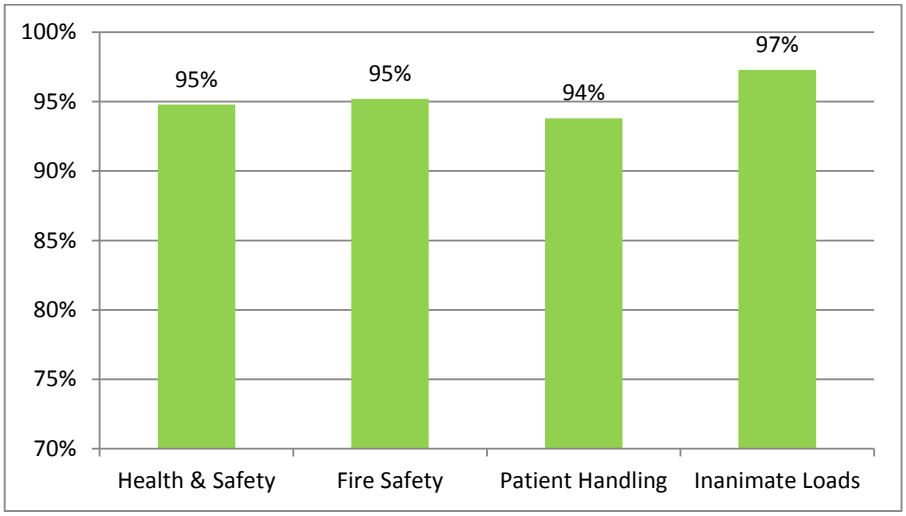


Chart 2. H&S training Compliance

Health and Safety Incidents.

The chart below shows the numbers of Health and Safety incidents that have occurred over the past three financial years. The chart shows that there has been a decrease in violence and aggression incidents whilst there has been an increase in inoculation incidents.

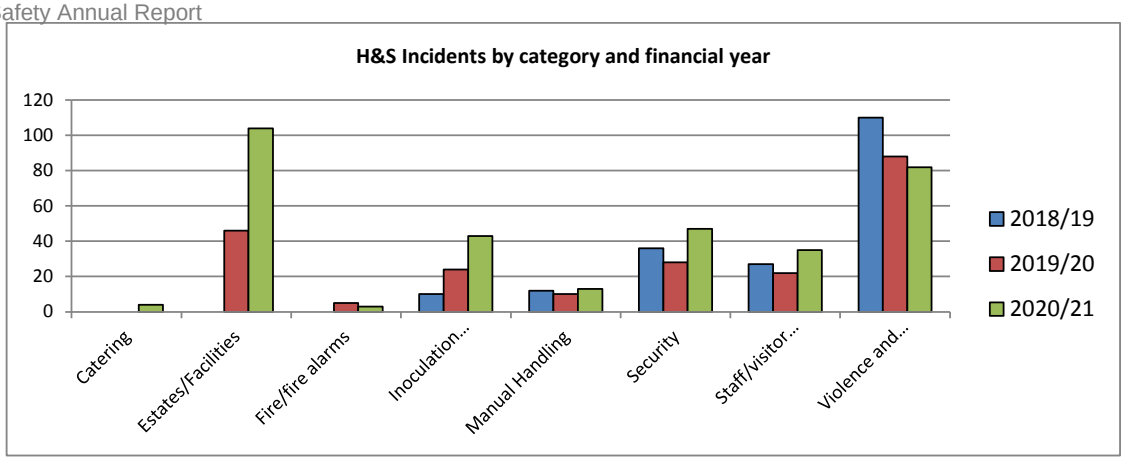


Chart 3. H&S Incidents

The number of inoculation incidents increased to 43 in 2020/21 from 24 in 2019/20. Thirty seven of these incidents had an RCA completed with the outcomes shown below in chart 4. As a result of this increase, further investigation will be undertaken to understand why the number of inoculation incidents has increased. The further investigation did not identify any theme or trends leading to an increase in the number of incidents and it also confirmed that the trust remain compliance with the Safer Sharps CAS Alert and the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

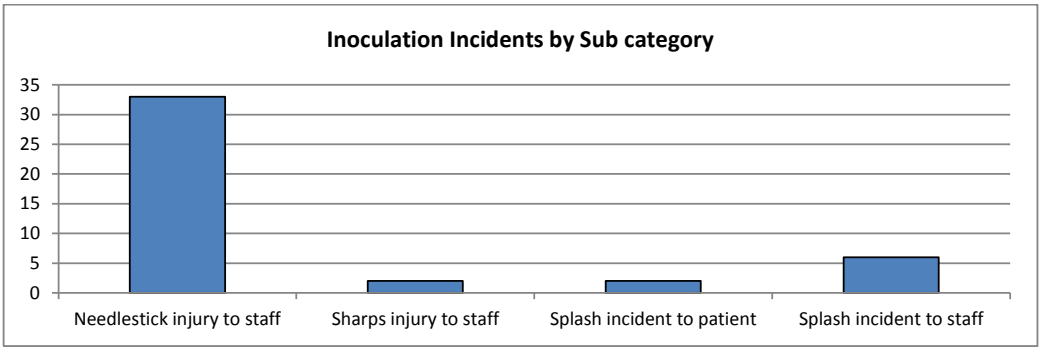


Chart 4. Inoculation incidents

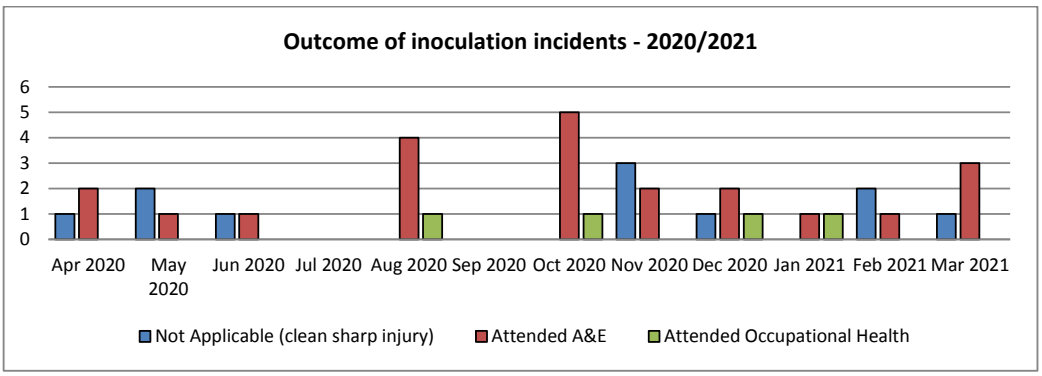


Chart 5. Outcome of Inoculation incidents

Charts 4 and 5 above look inoculation incidents and contact with hazardous materials this shows that there are no obvious trends in the incidents.

All inoculation incidents are discussed on the daily incident call and comparison report is sent to all of the divisions to help identify trends and prevention of further incidents s part of their Quality and Safety Meetings.

Manual Handling incidents

There were 13 incidents relating to Manual Handling in 2020/2021 which was an increase from 10 in 2019/2020. Following further review there are no apparent themes in either the sub category selected or the month in which they occurred, see Chart 6. The Trust Manual Handling trainer regularly reviews the provision of manual handling equipment in all relevant areas of the Trust sites and advises when more equipment or updates are required.

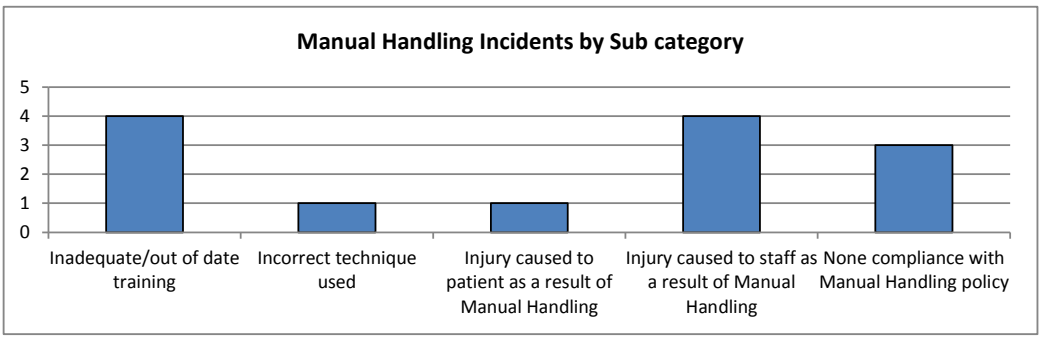


Chart 6. Manual Handling incidents

RIDDOR Incidents

Under the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations there is a requirement to report work related and accidents which result in staff being absent from work for more than seven days.

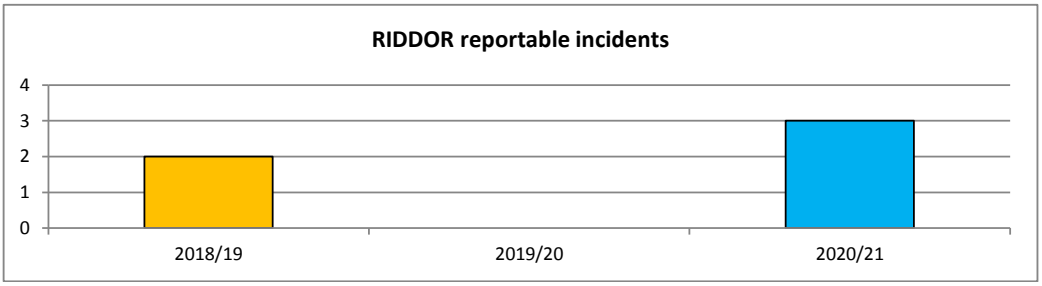


Chart 8 RIDDOR Reportable Incidents by year

There were 3 incidents reported to RIDDOR in 2020/2021

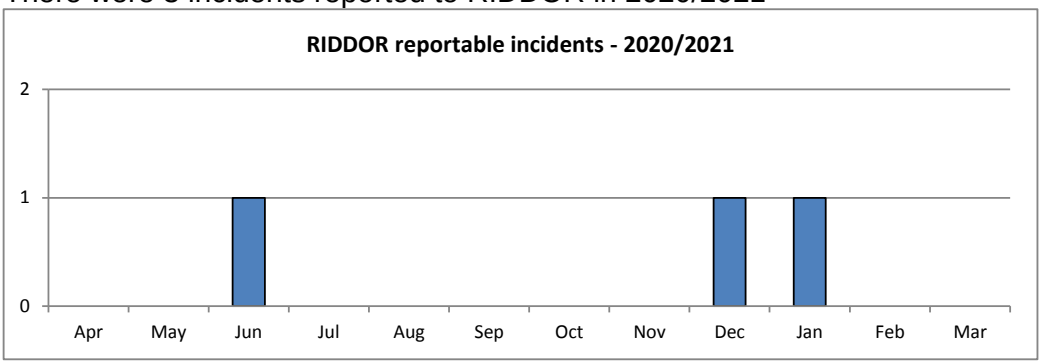


Chart 9. RIDDOR incidents by month

Incidents reported involved all staff and the criteria for reporting as below.

- Slip/trip/fall over 7 day absence
- Manual handling over 7 day absence
- Struck by object over 7 day absence

There were no themes or trends identified on review and no significant risks to other staff identified or requiring mitigations.

COVID -19 Response

The Trust established a fit testing system and process to ensure all staff received a fit test and the appropriate mask to provide the maximum protection.

The Trust used both qualitative and quantative fit test processes to assess the individual. The Trust invested in a Portacount fit testing machine which is a quantitative process. The testing machine has a 99% success rate and can fit test staff more quickly. The qualitative method is still available whilst more training on the Portacount machine takes place.

To date 342 staff have been fit tested so they are safe to deliver care to suspected or confirmed Covid-19 patients. Fit testing will continue as required during the pandemic with a plan for a new rolling programme being developed to maintain safety and a steady process which can be flexed up and down as required. Staff are required to be tested on two or more masks to ensure stocks are available and to rotate mask fits to reduce skin issues.

Security

Policies

The following policies have been reviewed, updated and were submitted to the Health and Safety Committee during 2020-2021:

- Security
- Lockdown Policy
- CCCTV Policy
- Security of Patient Property

All departments have completed risk assessments in the above areas which were checked as part of the Environmental Risk Assessment by the Health and Safety Adviser & Local Security Management Specialist (LSMS). Any shortfalls were then followed up through further checks.

The Trust has upgraded the CCTV system, a new server was installed and a review of cameras throughout CCC-W was undertaken. CCC-L has a designated control room with 24 hour monitoring of CCTV and alarm response. The Trust has also continued to develop a positive relationship with Merseyside Police to ensure access for advice and information.

The Trust adheres to the annual standards originally set by NHS Protect standards are below:-

Strategic Governance

This section sets out the standards in relation to the organisations strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.

Inform and Involve

This section sets out the requirements in relation to raising awareness of crime risks against the NHS and work with NHS staff, stakeholders and the public to highlight the risks and consequences of crime against the NHS.

Prevent and Deter

This section sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS and ensuring that opportunities for crime to occur are minimised.

Hold to Account

This section sets out the requirements in relation to detecting and investigating crime, prosecuting those who have committed crimes and seeking redress.

The annual action plan is included as Appendix A within this report which identifies work streams required over the next 12 months. The report is divided into the four categories.

The Trust completed a site security risk assessment, in line with the nationally agreed security management principles and an action plan developed which is continuously reviewed and monitored through the Health and Safety Committee and includes all 3 sites.

- The following areas were identified as high risk and extra CCTV swipe access has been installed.
    - Cash handling departments
    - Server rooms
    - Switch gear rooms
    - Areas that store drugs.

- Panic buttons have been installed in areas that are deemed high risk such as those with public facing staff or that handle money.

- The Trust continues to work hard to reduce the risk of security incidents by a combination of preventative measures, increased training, investigation and raising awareness of the role of the LSMS.

Violence and Aggression incidents.

There were 82 violence & aggression incidents in 2020/2021 which was a decrease from 88 in 2019/2020. 50 of the 82 incidents in 2020/2021 were categorised as verbal abuse patient/3rd to staff whilst 6 were categorised as physical abuse patient/3rd party to staff.

All violence and aggression incidents are reviewed by the Local Security Management Specialist and are managed as per Trust policy. No sanctions were issued by the Trust during 20/21.

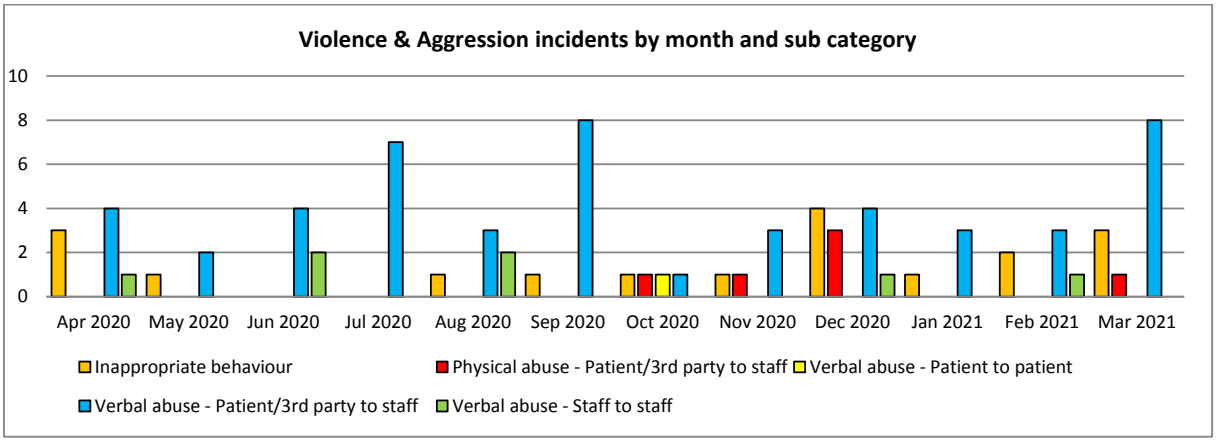


Chart 10. Violence & Aggression Incidents

Security incidents

There were 47 security incidents reported in 2020/2021 which is an increase from 28 in 2019/2020. The most frequently used sub category was 'Suspected theft'. Seven of the security incidents occurred in Radiotherapy Services

All security incidents are discussed on the daily incident call meeting and are investigated fully. In some circumstances it is difficult to investigate when there is an absence of CCTV coverage to identify who is responsible.

When the investigation is being completed the LSMS will utilise the support from the security team and other staff to identify possible suspects.

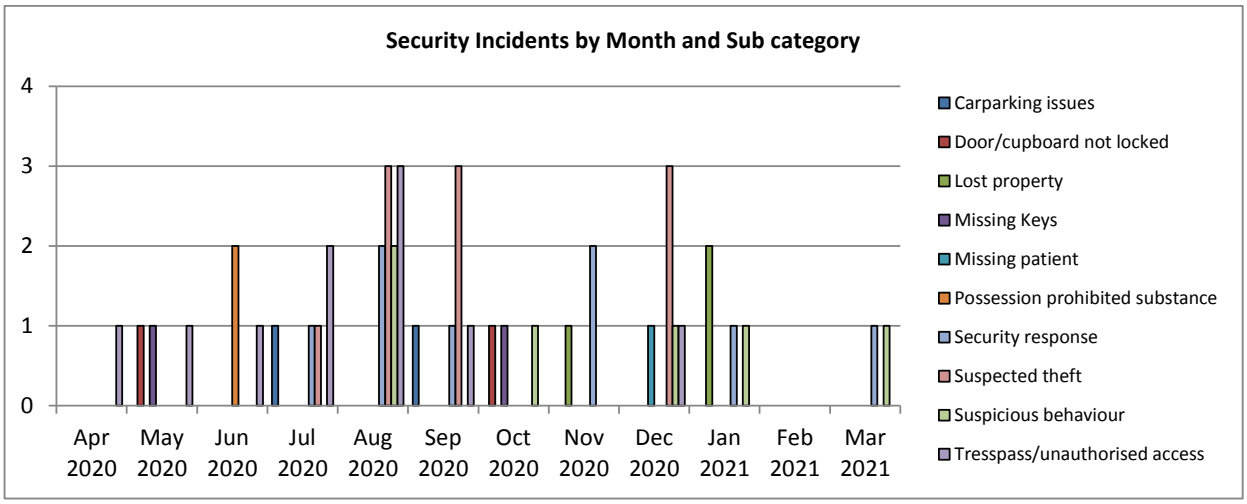


Chart 11. Security Incidents by month & category

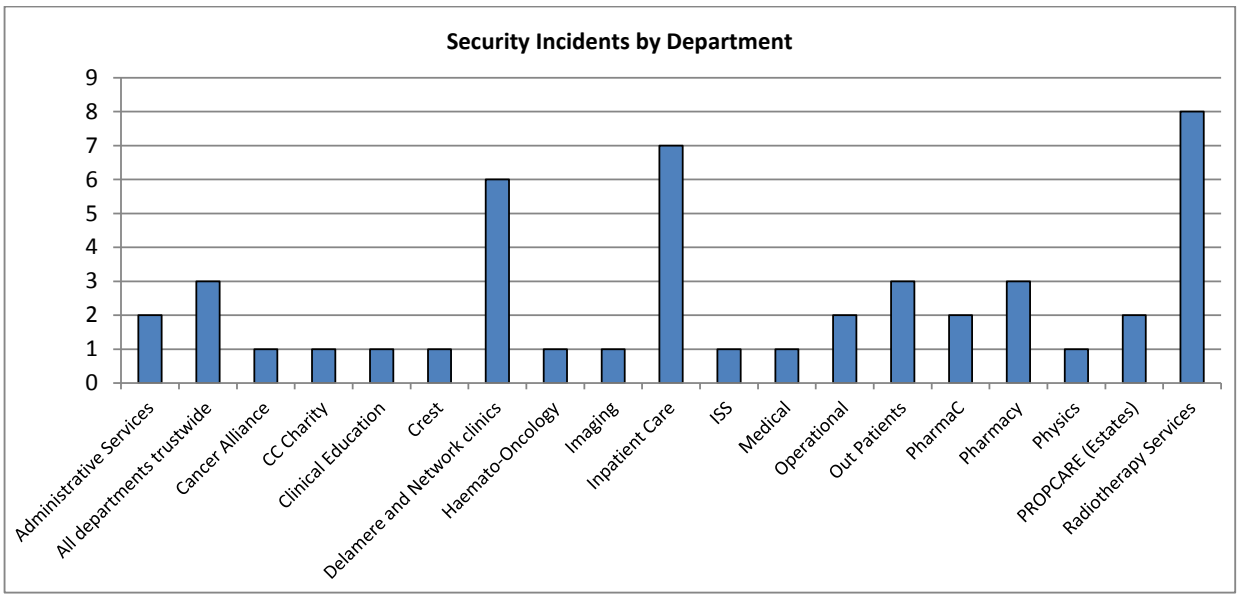


Chart 12. Security Incidents by Department

Lone Worker Devices

This system enables staff to discreetly call for assistance in a potentially dangerous situation and has the ability to quickly and accurately locate the whereabouts and movements of lone workers when an alert is activated.

The Trust continues to provide lone worker devices where a lone worker risk has been identified. The appropriate training and escalation information is provided to Reliance, the device monitoring company.

The LSMS receives monthly reports from Reliance to indicate usage and alerts and this is reported to the Health and Safety Committee.

The report below shows that usage of the lone worker devices has improved. There are some occasions when there are low recordings which has been investigated and the cause attributed to changes of staff, faulty devices and staff not visiting patient homes on a regular basis.

The planned policy update has included a standard operating procedure to include weekly testing of device even if not in continuous use.

Lone Worker Risk Assessments & Devices

The chart below demonstrates compliance with the lone worker risk assessments being completed and risk identified. Where the risk has been deemed high, a lone worker device has been provided for staff that are away from the Trust premises and working in patients homes or isolated locations.

The chart also shows that although lone working staff have been identified they are working within the Trust premises and behind swipe access, and other controls have been put in place as documented in the departmental risk assessment

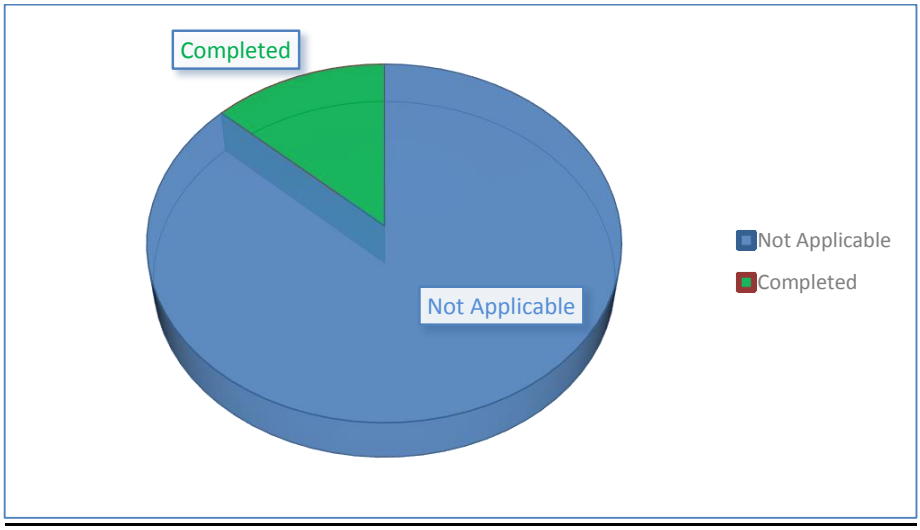


Chart 13. Lone Worker Risk Assessment Completion

TYA Lone Working Devices – Monitoring April 20- March 21

There are 4 devices TYA /Social workers, there have been no Red Alerts

Month	Amber Alerts	False Alarms	Red Alerts	Genuine Closed Safely	Escalated to Emergency Services	Status Checks of Signal Strength	User Total	Low battery
Apr 20	3	0	0	0	0	3	4	0
May 20	2	0	0	0	0	1	4	0
Jun 20	0	0	0	0	0	0	4	0
Jul 20	0	0	0	0	0	0	4	0
Aug 20	0	0	0	0	0	0	4	0
Sept 20	0	0	0	0	0	0	4	0
Oct 20	0	0	0	0	0	0	4	0

Nov 20	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**
Dec 20	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**
Jan 21	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**
Feb 21	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**
Mar 21	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**

Chart 14. TYA Lone Worker Devices Report

There are 6 devices Delamere/charity office, there were no Red Alerts

Month	Amber Alerts	False Alarms	Red Alerts	Genuine Closed Safely	Escalated to Emergency Services	Status Checks of Signal Strength	User Total	Low battery
Apr 20	**188**	**0**	**0**	**0**	**0**	**143**	**7**	**0**
May 20	**177**	**0**	**0**	**0**	**0**	**115**	**7**	**0**
Jun 20	**222**	**0**	**0**	**0**	**o**	**132**	**6**	**0**
Jul 20	**181**	**0**	**0**	**0**	**0**	**99**	**6**	**0**
Aug 20	**134**	**0**	**0**	**0**	**0**	**83**	**6**	**0**
Sept 20	**216**	**0**	**0**	**0**	**0**	**133**	**6**	**0**
Oct 20	**206**	**2**	**0**	**0**	**0**	**97**	**6**	**0**
Nov 20	**172**	**0**	**0**	**0**	**0**	**78**	**6**	**0**
Dec 20	**150**	**1**	**0**	**0**	**0**	**103**	**6**	**0**
Jan 21	**42**	**0**	**0**	**0**	**0**	**53**	**6**	**0**
Feb 21	**57**	**0**	**0**	**0**	**0**	**59**	**6**	**0**
Mar 21	**58**	**0**	**0**	**0**	**0**	**90**	**6**	**0**

Chart 15. Delamere/Charity Office Lone Worker Devices Report

The review highlighted some issues with the usage of devices and the following actions were identified and undertaken:

- Users advised again re low battery and false alarms.
- Users again advised to ensure status checks are completed.
- All reports will continue to be sent to managers each month to review and action.
- The number of devices being used has reduced to a maximum so 3 as staff have either left or are on maternity leave /long term sickness. More staff are to be recruited into the role and the usage will improve.
- The 4 devices assigned to CREST have not been used as there have not been any home visits since March 2020 due to Covid restrictions.

Conflict Resolution Training

To reduce the incidence of verbal and physical abuse against staff, Conflict Resolution Training (CRT) is mandatory for all frontline staff that comes into contact with members of the public.

Conflict resolution training compliance at the time of the report was 96% against a preferred target of 100%, which is slightly down from 97% last year. Any staff member out of date with their CRT training is prompted by the Electronic Staff Record system (ESR) which is monitored by department managers.

The training is usually 4 hours face to face but due to Covid-19 restrictions this has been completed via e-learning on induction to new staff and all staff are to complete an e-learning refresher training course every 3 years.

Security Training Compliance

As part of Security awareness for staff, a training presentation is delivered to all new and existing staff as part of Induction and Core Skills. This covers physical and non-physical (verbal) assaults, the importance of incident reporting to help identify trends and the potential risk of unauthorised people 'tailgating' staff into access controlled areas. The training advocates a Pro-security culture for all staff. This has been delivered via e-learning during 20/21.

Security awareness training is at 97% and is now only delivered on induction as a once only training requirement.

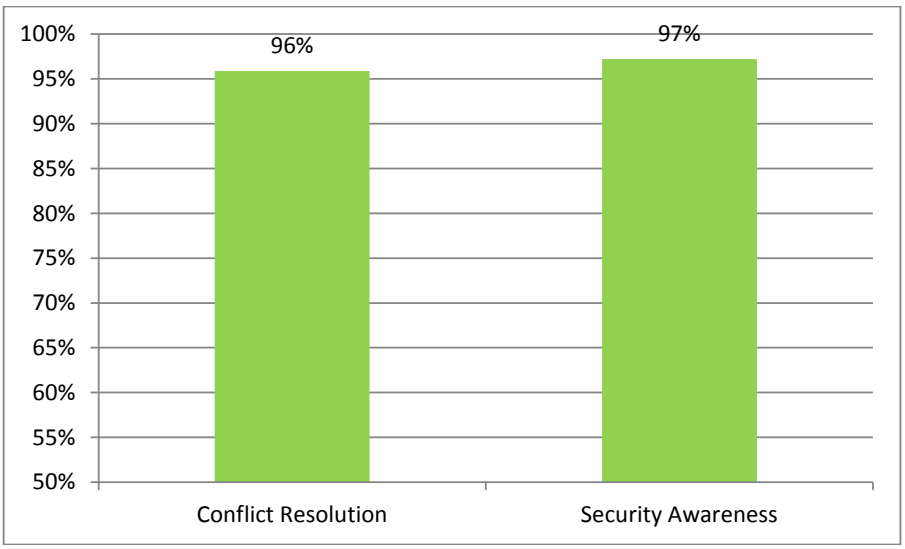


Chart 16. Training Compliance – Conflict Resolution & Security Awareness

Looking Forward to 2021/22

Due to the proactive approach to health and safety and the achievements of the team during 2020/21, the Trust is now in an excellent position to move into 2021/22 and the exciting times ahead with the redevelopment of the CCC-W and move to the Spine.

The H&S team has had to adapt to the new ways of working and recognise that new methods of gathering information such as the H&S audits will need to be implemented. The plan going forward is for clinical areas to use Perfect ward to electronically complete their risk assessments and non-clinical areas will use Microsoft Teams to complete the relevant documentation and ensure compliance.

The Health & Safety team will work to introduce an electronic COSHH system which would make the process of completing and maintaining COSHH risk assessments more user friendly and easier to ensure compliance.

Over the last 12 months Trust staff have had to adjust how they work and the Health & Safety team will be instrumental in ensuring staff are safe and supported with agile working.
The Health & Safety team supported WOD by ensuring staff complete an assessment whilst working from home to identify any additional workstation equipment needed, thus reducing the risk of muscular skeletal injuries.

The team will continue to support staff knowledge and understanding of Health and Safety. Some external training which was paused due to Covid -19 will resume as soon as advised. The Health and Safety of our staff remains paramount and the team are supporting managers to implement Covid – 19 working safely guidance across all areas.

Appendix A – Security Management Work Plan

Security Management Work Plan for: The Clatterbridge Cancer Centre NHS Foundation Trust						
				November Nov 2020-21		
	Area	Task/Objective	Target Dates	Completed Date	Days/Time Allocated	Actual Days
SRT LEVEL	**STRATEGIC GOVERNANCE**					
Green	1.1	A member of the executive board or equivalent body is responsible for overseeing and providing strategic management and support for all security management work within the organisation.		Completed Director of Nursing /NED are responsible persons		
Green	1.2	The organisation employs or contracts in a qualified person to undertake and/or oversee the delivery of the full range of security management work.		Completed LSMS in post since 2009	30 days	
Green	1.3	The organisation allocates resources and investment to security management in line with its identified risks.		Completed Continuous monitoring and resources provided as required.		
Green	1.4	The organisation reports annually to its executive board, or equivalent body, on how it has met the standards set by NHS Protect in relation to security management, and its local priorities as identified in its work plan.	30/06/21	Completed	2-3 days	
Green	1.5	The organisation has a security management strategy. The strategy has been approved by the executive body or senior management team and is reviewed, evaluated and updated as required.		Completed		

INFORM & INVOLVE						
Green	2.1	The organisation undertakes risk assessments in relation to: a) protecting NHS staff and patients b) security of premises c) protecting property and assets d) security preparedness and resilience. The organisation uses its identified risks to develop inclusive policies in respect of the above (a-d) and can demonstrate implementation of these policies. The policies are monitored, reviewed and communicated across the organisation.	Completed	Annual assessments reviewed and audited as a rolling program Polices reviewed when scheduled New Violence Prevention and reduction standard to be adhered to and ensure the Trust is aligned to them in polices and risk assessments.	15 days	
Green	2.2	The organisation develops and maintains effective relationships and partnerships with local and regional anti-crime groups and agencies to help protect NHS staff, premises, property and assets.	Nov 21	Continuous Monitoring of security incidents LSMS to join anti-crime group for move to CCC-L Meetings held with LUHFT/Liverpool University	4 days	
Green	2.3	The organisation demonstrates effective communication between risk management, capital projects management, estates, security management and external agencies to discuss security weaknesses and to agree a response.	Nov 21		12 days	
Green	2.4	The organisation has an ongoing programme of work to raise awareness of security measures and security management in order to create a pro-security culture among all staff, across all sites. This programme of work will be reviewed, evaluated and		Completed Training delivered monthly.	2days	

		updated as appropriate to ensure that it is effective.				
Green	2.5	All staff know how to report a violent incident, theft, criminal damage or security breach. Their knowledge and understanding in this area is regularly checked and improvements in staff training are made where necessary.		Completed Delivered in monthly Awareness sessions	2 days	
Green	2.6	All staff who have been a victim of a violent incident have access to support services should they require it.		Completed Discussed on daily incident call and contact made with the individual if required for support.		

PREVENT & DETER						
Amber	3.1	The organisation risk assesses job roles and/or undertakes training needs analyses for all employees, contractors and volunteers whose work brings them into contact with NHS patients and members of the public. As a result, the appropriate level of prevention of violence and aggression training is delivered to them in accordance with NHS Protects guidance on conflict resolution training and/or the prevention and management of clinically related challenging behavior. The training is monitored, reviewed and evaluated for effectiveness	Nov 21	CRT face to face on induction and e-learning As a refresher.	7 days	
Green	3.2	The organisation undertakes an assessment of the risks to its lone workers including the risk of reasonably foreseeable violence. Where appropriate, it takes steps to avoid or control the risks and these measures are regularly and soundly monitored, reviewed and evaluated for their effectiveness.	Completed	Risk assessment Reviewed and completed by all departments on an annual rolling program	6-7 days	

Green	3.3	The organisation ensures that the provision of a secure environment is a key criterion for any new build projects, or the modification and alternation (e.g. refurbishment or refitting) of existing premises.	Nov 21	LSMS attends meetings as required for new projects	7days	
Green	3.4	The organisation has arrangements in place to manage access and control the movement of people within its premises, buildings and any associated grounds.		Completed Swipe access to all unauthorised areas. Access to some areas for staff can only be obtained during specified hours.	4 days	
Green	3.5	The organisation has systems in place to protect its assets from the point of procurement to the point of decommissioning or disposal.		Completed		
Green	3.6	The organisation has clear policies and procedures in place for the security of medicines and controlled drugs (CDs).	Nov 21	LSMS Attends when required drug and therapeutic committee for security of medicines Participates in security of medicines audit.		
Green	3.7	The organisation operates a corporate asset register for assets worth £5,000 or more.		Completed		

Green	3.8	The organisation has in place departmental asset registers and records for assets worth less than £5,000.		Completed		
Green	3.9	Staff and patients have access to safe and secure facilities for their personal property.	Nov 21	Security risk assessments completed on annual rolling annual program		
Green	3.10	The organisation maintains comprehensive and systematic records of security breaches and incidents, acts of violence and incidents of theft or criminal damage affecting its property and assets and, where appropriate, these inform security management priorities and the development of security policies.	Nov21	Datix system used and trends identified. Reports sent to H&S committee quarterly.	Continuous Monitoring	
Green	3.11	The organisation takes a risk based approach to identifying and protecting its critical assets and infrastructure. This is embedded in policy and can be evidenced.	Nov 21	Annual Organisational Risk Review Completed and monitored with actions through the H&S committee.	3 days	
Green	3.12	In the event of an increased security threat level, the organisation is able to increase its security resources and responses.	Nov21	Polices in place LSMS attends emergency planning committee	4 days	
Green	3.14	The organisation has in place suitable lock down arrangements for each of its sites, or for other specific buildings/areas of priority.	Nov21	Lock Down Policy Lockdown exercise to be arranged	3-4 days	

HOLD TO ACCOUNT						
Amber	4.1	The organisation is committed to applying all appropriate sanctions (i.e. police/prosecution) against those responsible for acts of violence, security breaches, theft and criminal damage. Cannot achieve green until the Trust has experienced the need to apply a sanction. (i.e. Police/Prosecution)	Nov 21			
Green	4.2	The organisation has arrangements in place to ensure that allegations of violence, theft and criminal damage are investigated in a timely and proportionate manner and these arrangements are monitored, reviewed and evaluated.	Nov21	Continuous Monitoring via datix and daily incident call . All security incidents reported and reviewed through the H&S committee.	8 days	
Green	4.3	Where appropriate, the organisation publicises successful prosecutions of cases relating to a) denying unnecessary access to premises b) the consequences of assaulting NHS staff c) breaching the security of NHS premises and property d) acts of theft and criminal damage.	Nov21	In the event of a successful prosecution the Trusts security policy states that any prosecutions will be publicised		
Green	4.4	The organisation has a clear policy on the recovery of financial losses incurred due to theft of, or criminal damage to, its assets and can demonstrate its effectiveness.	Nov21	Within the Trusts security policy.		

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Report to:	Trust Board
Date of meeting:	29th September 2021
Agenda item:	P1-145-21
Title:	EPPR- Annual Report
Report prepared by:	Christopher Lube, AD of Clinical Governance and Patient Safety
Executive Lead:	Joan Spencer, COO and Interim Director of Nursing
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	
Date & decision:	

Purpose of the paper/key points for discussion:	The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a terrorist attack. The Civil Contingencies Act 2004 (CCA 2004) specifies that responders to such incidents must be classified as either Category 1 - (primary responders) or Category 2 (responders supporting agencies). The Clatterbridge Cancer Centre is a Category 1 responder and has a statutory and moral obligation to be prepared to respond to major incidents and have appropriate plans in place.

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

Next steps required:	Trust Board are asked to note the excellent work delivered by the CCC EPRR Team during the Covid 19 pandemic. Approve the proposed actions set out in section 9.0 - Next Steps

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

☒ BE **OUTSTANDING**

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

☒ BE **COLLABORATIVE**

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

☒ BE **RESEARCH LEADERS**

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

☒ BE **A GREAT PLACE TO WORK**

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

☒ BE **DIGITAL**

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

☒ BE **INNOVATIVE**

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

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

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

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Emergency Preparedness, Resilience & Response Annual Report 2020- 2021

Steve Povey, Emergency Planning Officer

Version: 1.0 Ref: FCGOREPO Review: May 2024

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1.0 Introduction

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a terrorist attack.

The Civil Contingencies Act 2004 (CCA 2004) specifies that responders to such incidents must be classified as either Category 1 - (primary responders) or Category 2 (responders supporting agencies). The Clatterbridge Cancer Centre is a Category 1 responder and has a statutory and moral obligation to be prepared to respond to major incidents and have appropriate plans in place.

In addition, the Health & Social Care Act places a duty on Category 1 organisations to have to have in place a Director of Emergency Preparedness, Resilience & Response (EPRR) who is known as the Accountable Emergency Officer (AEO).Currently this responsibility sits with the Chief Nurse.

Support to this role is provided by the Emergency Planning Officer (EPO) who operates at practitioner level and attends meetings of the Practitioners Sub Group in Cheshire or Merseyside subject to operational requirements. This role is fulfilled by the Health & Safety Adviser/EPO at Clatterbridge Cancer Centre (CCC).

The Trust must also have an Incident Control Centre (ICC) and a backup ICC location.
For the entire period of this report the trust has been required to have an operational ICC in response to Covid-19. This is located in the R&I Building meeting rooms at CCC Wirral and opened on Monday 9th March 2020 until present. The backup location is the Clinical Education Suite at the CCC site in Liverpool.

During the period of this report the NHS has stood down a vast amount of non-essential work and meetings to concentrate on the national response to Covid-19.
Consequently the Covid -19 pandemic, along with EU Exit have been the two main areas of focus for the Trust EPRR Team during the financial year 2020-2021.

2.0 Context

EU Exit

The UK finally left the EU with a deal in place on the 31st December 2020 and begun an 11-month transition period. During this time the UK has adhered to EU rules and remained a member of the single market and customs union, while negotiating a new long-term trading relationship with the EU. As a result the Trust did not experience any disruption to

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the supply of medicines or medical devices and staffing. However as the transition period comes to an end the full impact of the EU Exit is yet to be seen, potential risks regarding the supply of medicine, medical devices and maintenance of the NHS workforce remain.

Covid-19

At the end of January 2020 the trust received the first email relating to an emerging situation in the Wuhan region of China regarding the Wuhan Novel Coronavirus Virus that was infecting large numbers of the population. In February it was established that cases were emerging within the UK, the NHS was on high alert and a national response was launched. Trust EPRR planning was prioritised to ensure an appropriate and proportionate response was established and services were maintained as much as possible.

3.0 Response to Covid-19

The onset of Covid-19 led to a Level 4 Incident being declared that subsequently switched between Levels 3 and 4, regionally and nationally see Figure 1 below.

Figure 1 – NHSE Incident Levels

Incident level	
Level 1	An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners.
Level 2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office.
Level 3	An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.
Level 4	An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.

As required, the trust set up an operational Incident Co-ordination Centre. This was staffed by the Accountable Emergency Officer (AEO), Emergency Planning Officer (EPO), key Managers and administration support. As the response has progressed the ICC has remained active (as required by NHSE) with a core staff of the EPO, ICC Coordinator and administrative support.

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The ICC operates under Command & Control with Strategic/Tactical & Operational response levels (formerly Gold/Silver/Bronze). EPRR Meetings were held daily to begin with until the Operational/Bronze meetings were replaced with a daily Situation Report (SitRep).This enabled operational staff continue with the day to day management and delivery of services whilst Senior Managers and Executive Team members took the lead on operational and strategic planning. Consequently Tactical/Silver and Strategic/Gold continue to take place twice weekly.

Throughout the response incoming correspondence from the North West ICC has been received and distributed, at the end of the reporting year (31st March 2021) the NWICC had issued 7291 items of communication. Other agencies and parts of NHS England have also added to this number.

The trust ICC completed mandatory SitReps throughout the period with responses provided daily, seven days a week according to the subject matter. The records show files, at various times, for:

10	x	Daily SitRep Returns
10	x	Weekly SitRep Returns
1	x	Fortnightly SitRep Return

In addition there were 85 requests from region and national teams for specialist SitReps some of which required considerable input from the Business Intelligence and Operational Teams. May had very short deadlines. The Trust successfully delivered all SitRep requests within the timescales given.

A new On Call policy was also developed and implemented in May 2020. This enabled a highly effective Strategic/Tactical & Operational on call rota that supported the move to Liverpool and the demands of the Covid-19 pandemic. Duty Site Managers during core hours and a 1st and 2nd On Call structure out of hours has provided greater resilience and clear lines of escalation.

The ICC Command Structure was also utilised as the forum to discuss and approve revised working practices, Standard Operating Procedures and Business Continuity responses. Departmental responses were phenomenal with radical changes to working practices and clinical policies delivered in a timely way. Supporting departments rapidly evolved to ensure that patient services and quality of care were maintained. The support received by the ICC and the EPRR team during the response to Covid-19 is also testament to those departments and their staff.

In addition the trust also delivered the Seasonal Flu Vaccination campaign from the end of September 2020 and finishing on the 15th December 2020. This provided a clear two week break between the Seasonal Flu Campaign and the commencement of Covid-19

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vaccinations. The Seasonal Flu Campaign proved to be the most successful the trust has ever delivered, uptake is shown in Figure 2.

The trust ICC also led on the arrangements for staff to receive two doses of the Astra Zeneca/Oxford Covid-19 vaccinations which commenced on the 14th January 2021 and ran until the 26th February 2021. This required the setting up of a training plan to manage the new booking systems, ordering of vaccine, training in the administration of the vaccine to staff and ensuring vaccine centres at both Wirral and Liverpool sites met all infection prevention and control standards. This was a highly successful campaign with excellent uptake, shown in Figure 3.

As an approved AZ/Oxford vaccine hub we were also able to assist other trust, notably Alder Hey and Wirral Community with vaccinations for their staff who were unable to receive Pfizer vaccines. At the end of the report period first doses had been completed with second dose scheduled for April commencement.

Figure 2 – Seasonal Flu Vaccine Uptake

Trust Uptake	
Doctors	91.7%
Nurses	90.6%
AHP Staff	94.7%
Patient Facing Support	87.1%
Non patient facing	75.1%

Clinical Uptake	**90.6%**
All Staff Uptake	85.6%

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Figure 3 – Covid-19 AZ/Oxford Vaccine uptake

Cohort	Vaccinated	Refusals/ not vaccinated	Total	%
1a - BMT	38	5	43	88.37%
1a - VacTeam	51	2	53	96.23%
1a - W3	31	7	38	81.58%
1b - Patient Contacts	754	96	850	88.71%
2a - Priority non Patient	223	33	256	87.11%
2b - All other non patient	454	26	480	94.58%
X - Done Elsewhere	251	0	251	100.00%
Trust Total	**1802**	**169**	**1971**	**91.43%**
Alder Hey NHS FT	27			
Wirral Community NHS FT	61			
Mutual Aid Total	**88**			

4.0 National Core Standards

For 2020/2021 the National Core Standards in full were stepped down. However, Trusts were asked to provide any progress on their Action Plans from 2019. At CCC we had two actions that had been completed. Details are in Figure 4.
The response was shared at Quality Committee and Trust Board in September 2020

Figure 4 – Action Plan Progress 2019 to 2020

Action	Trust Response
Compliance 2019 Progress made 2020 on partially compliant areas identified last year. (Return N/A if fully compliant)	The Trust had two areas of partial compliance in 2019: **Core Standard 30** The trusts second (backup) ICC location had not been tested within the previous twelve months. The backup location was used for a Director On Call training session on Tuesday 1st October 2019 to test its suitability as a backup ICC. **Current self-assessment - Compliant** **Core Standard 55** The trust did not have robust procedures to check the business continuity plans of commissioned providers and suppliers. This has been improved as part of the preparation for EU Exit and this

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	process has now been adopted as a standard approach to ensure suppliers resilience is audited. **Current Self-assessment - Compliant**

5.0 EPRR External Audits

Following an independent audit of the trust EPRR arrangements by MIAA in 2015 and with a re-audit not yet scheduled, the trust invited the NHS England Head of Emergency Preparedness, Jim Deacon, to audit the trust arrangements. Following a visit in January 2020 the trust received a letter confirming all arrangements were satisfactory. This was reported to the Trust Board in February 2020.

Following this the trust received notification that a repeat MIAA visit would also take place between March and May 2020 this resulted in the Trust receiving 'Significant Assurance', a repeat of the 2015 result.

6.0 Local Health Resilience Partnership

Due to Covid-19 the Local Health Resilience Partnership (LHRP) meetings at both Strategic and Practitioner level were suspended, resuming later in the year as MS Teams meetings. The trust have been continued to be represented at both levels of the meetings.

7.0 Counter Terrorism Response

Throughout the response to Covid-19 the trust have continued to receive Counter Terrorism bulletins from the Local Resilience Forum (LRF) and the LHRP, these have been distributed as appropriate to their content and have also been made a standing agenda item on the trust Emergency Planning Committee.

The trust also employs a PREVENT lead within the Safeguarding Team who works closed with the Emergency Planning Officer and the Local Security Management Specialist,

Figure 5 – PREVENT Training Compliance

	Staff Headcount	Staff Trained	% Compliance
Basic PREVENT Awareness	1326	1288	98.47%
PREVENT Awareness	235	189	93.83%

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8.0 Incidents, Events & Exercises

During the reporting period the trust has successfully responded to two major incidents alongside the Covid-19 response. Both, incidents have been reviewed and action plans implemented with any lessons learnt shared across the Trust.
The incidents were:

- Bomb Threat – Liverpool July 2020
- Loss of mains power – Liverpool March 2021

These incidents tested the major incident plan for evacuation and the new backup generator at the CCC site in Liverpool

In addition table top exercises/training sessions were put in place following the occupation of the new hospital in Liverpool. The training was for On Call Managers and took place on the on the 30th July and 27th August 2020.
Training was well attended as it was delivered via MS Teams. Mangers participated in the management of a number of EPRR scenarios.
Feedback from managers was extremely positive and enabled testing of the emergency planning handbook and action cards available on MS Teams.

9.0 Next steps

Covid-19 has been and continues to be the biggest challenge the health and care system has faced in living memory.
As we learn to live alongside the virus there is an imperative to restore service provision whilst remaining prepared for possible future waves of the virus.
To ensure CCC is successful in this quest the following actions to further improve the EPRR will be implemented in 2021-2022;

- The Executive responsibility for emergency planning and preparedness will transfer to the Chief Operating Officer, following the appointment of the new Chief Nurse on the 1st Oct 2021.
- A new EPRR work plan for 2021-2022 will be developed, this will include a full review of action cards, on call handbook and emergency planning training to managers.
- A review of roles and responsibilities within the team will be conducted, this may result in a restructure of the team.

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- A review of compliance with the new Core Standards will be conducted any non-compliance/ partial compliance will be identified and managed via an action plan that will be monitored via the EPRR committee.
- A plan to deliver the Flu vaccine and the Covid-19 booster vaccine will be developed and delivered in Quarter 3 2021-22.

10.0 Recommendations

The Trust Board to note the excellent work delivered by the CCC EPRR Team during the Covid 19 pandemic.
Approve the proposed actions set out in section 9.0 - Next Steps.

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Report to:	Trust Board
Date of meeting:	29th September 2021
Agenda item:	P1-146-21
Title:	Core Standards for Emergency Planning
Report prepared by:	Steve Povey - Emergency Planning Officer/H&S Adviser
Executive Lead:	Joan Spencer – Chief Operating Officer/Interim Chief Nurse
Status of the report: (please tick)	Public ☐ Private ☒

Paper previously considered by:	Emergency Planning Committee
Date & decision:	8th September 2021, Accepted

Purpose of the paper/key points for discussion:	To assure the Trust Board that the trust has in place the EPRR arrangements required by NHS England and to give site of the evidential process. Core Standards 3 & 5 require the Board to be sighted on EPRR arrangements which a combination of these standards and the EPRR Annual Report ensure compliance.

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

Next steps required:	Statement of Compliance to be updated with details of the Board meeting the standards have been presented to and returned to the Trust EPO for submission to NHSE.

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

☐ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

☐ 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

EPRR Annual Core Standards 2021-22

Stephen Povey, Emergency Planning Officer

Emergency Preparedness , resilience and response annual assurance process for 2021-22

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Due to the national response to COvid-19, the Annual Core Standards for Emergency preparedness have been adjusted to take account of the live response trusts are undertaking. As a result a number of individual; standards have been suspended, as can be seen below using Training and exercising as an example, there is currently no requirement to exercise any responses in the midst of a live incident.

The overall number of standards for a specialist trust has reduced from 55 to 38. The table below shows the trust performance against these standards and the subsequent information shows the two standards which are partially compliant and the actions that have been put in place to address these.

Overall assessment:	Substantial Assurance

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	5	5	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	9	9	0	0
Command and control	1	1	0	0
Training and exercising	0	0	0	0
Response	3	3	0	0
Warning and informing	3	3	0	0
Cooperation	2	2	0	0
Business Continuity	7	5	2	0
CBRN	6	6	0	0
Total	38	36	2	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Oxygen Deep Dive	7	6	1	0
Ambulance Resilience	0	0	0	0
Total	7	6	1	0

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Ref	Domain	Standard	Detail	Specialist Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	The Trust EPRR policies are subject to periodic review routinely or when any changes are identified following an activation or exercise of the plan. These policies pass through an approval process at Emergency Planning Committee then through Risk Committee up to Board. Learning from the COvid-19 de-brief will be incorporated into the next review of these policies which have been given a temporary extension.	Partially compliant	Full review of all policies to take place post Covid-19	Steve Povey	Jun-22
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	All essential suppliers have been contacted as part of the preparation for EU Exit and integrity of supply in relation to Covid-19 response. Specific requirements are to be included in the updated Emergency, Contingency and Business Continuity Policy and a review of procurement procedures and suppliers undertaken following the transfer to a new Materials Management provider.	Partially compliant	Embed supplier checks into trust policy.	Steve Povey	Jun-22

The full Sore Standards which the trust will return to NHS England are attached as Appendix 1.

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Ref	Domain	Standard	Detail	Specialist Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance											
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Joan Spencer, Chief Operating Officer is the Board Level Accountable Emergency Officer	Fully compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	The Trust's main EPRR Policy describes the organisation's commitment to delivering EPRR and the mechanisms for achieving this. The trust has a suite of documents covering all aspects of EPRR preparation and response.	Fully compliant				
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	EPRR performance is reported in the Annual Report to the board. Additionally, Core Standards performance is also reported to Board and within the Trust Annual Report. AEO attendance at Strategic LHRP meetings is documented and distributed.	Fully compliant				
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Trust policies detail the resources required to prepare and respond to an incident and include the roles, structures and governance for emergency response.	Fully compliant				
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	The EPRR Response and Recovery Policy contains the process for de-briefing of incidents and the provision of an Action Plan to agree and progress learning.	Fully compliant				
Domain 2 - Duty to risk assess											
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	The trust assesses risks and by being part of the LHRP considers wider healthcare risks and through the LRF wider community risks. The Trust EPO is part of the working group updating the LHRP Risk Register.	Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	The escalation for risks is documented within the trust policy. There are specific EPRR risks on the Trust Risk Register and these also include specific Covid-19 and vaccination risks. This was exercised in 2018 and again in 2019 due to the number of new On Call Directors at the trust. As risks evolve there is also a process for re-evaluation with escalation and de-escalation.	Fully compliant				
Domain 3 - Duty to maintain plans											
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust meets all requirements of the NHS England Framework for EPRR and has an On Call Rota to ensure a 24 hour 7 day response.	Fully compliant				

12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust meets all of the requirements in current guidance to enable response to a major incident. A Duty Site Manager is in place during core hours and an On Call rota with 1st and 2nd On Call out of hours.	Fully compliant				
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust has a dedicated Adverse Weather Policy, subscribes to the Met Office Alerts services and contingencies in place in the event of a heatwave.	Fully compliant				
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust has a dedicated Adverse Weather Policy, subscribes to the Met Office Alerts services and contingencies to mitigate the effects of snow and cold weather on the population the organisation serves	Fully compliant				
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	This is not directly applicable to the Trust. The trust would offer mutual aid to neighbouring acute trusts in the event of a major incident. Plans are in place in Cheshire & Mersey for the distribution of P1 and P2 patients. The trust is further investigating how it may assist the regional P1/P2 allocation by taking appropriate patients from the Royal Liverpool to free up additional capacity.	Fully compliant				
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	This is not directly applicable to the Trust. The Trust would offer mutual aid to neighbouring acute trusts in the event of a major incident. Currently the trust is not included in the regional allocation of P1 and P2 patients in an emergency or major incident.	Fully compliant				
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has an evacuation plan in place and an exercise is scheduled jointly to test this with North West Ambulance Service and Mersey Fire & Rescue Service. This is scheduled to take place in late 2021/early 2022. The move to a newly built hospital in June 2020 involved the transfer of all inpatients from Wirral to Liverpool in conjunction with NWAS and tested collaborative working with partner organisations. MOMB THREAT	Fully compliant				
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a policy for Lockdown of its premises and exercises to test this are scheduled. Following the move to Liverpool in June 2021 a security incident tested the lockdown capability of the hospital and involved the invoking of contingenty plans to horizontally evacuate areas of the hospital that were vulnerable.	Fully compliant				
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust includes the management of VIP's as patients in its day to day policies for wards and departments. The EPRR Communications Strategy covers visits from VIP's during, and in the aftermath, of a major incident.	Fully compliant				
Domain 4 - Command and control												
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	The Trust on call arrangements are documented within its EPRR policies and the Trust has a 24/7 arrangement to deal with notifications received. There is a 1st On Call Manager and a 2nd On Call Director.	Fully compliant				
Domain 5 - Training and exercising												
Domain 6 - Response												
30	Response	Incident Co-ordination Centre (ICC)	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		The Trust is currently operating a dedicated ICC in response to Covid-19	Fully compliant				
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	The Trust has response arrangements within the EPRR Response and Recovery Policy.	Fully compliant				
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps	The Trust policies contain response to SitReps and how these are managed. For incidents that are likely to take place over an extended period, there are a number of staff with NHS Digital accounts who can respond.	Fully compliant				
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.		• Guidance is available to appropriate staff either electronically or hard copies	N/A					
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.		• Guidance is available to appropriate staff either electronically or hard copies	N/A					

Domain 7 - Warning and informing											
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	The Emergency Response and Recovery Policy contains details of how the Trust would respond to an incident. This includes liaison with other providers and organisations and mutual aid arrangements. The EPRR Communications Strategy details all the communication routes to be used during an incident. Policies are in place within the wider trust regarding the use of social media.	Fully compliant				
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	The Trust Emergency Response and Recovery plan and the EPRR Communications Strategy cover all communications and the methods by which messages can be passed from the Trust to other providers, stakeholders and the public.	Fully compliant				
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	The Trust has a specific EPRR Communications Strategy that covers all levels of communications and includes debrief arrangements to facilitate learning. In addition, the Communications Team provides Media training to Executive Directors who may be interviewed by the media. This is ongoing training and forms part of the Executive On Call Training Portfiolio maintained by the trust Emergency Planning Officer.	Fully compliant				
Domain 8 - Cooperation											
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	The Trust Emergency Response and Recovery Policy contains a specific section on requesting and receiving requests for mutual aid. MACA Requests are included with the procedure detailed as approach via the trust AEO or EPO.	Fully compliant				
43	**Cooperation**	**Arrangements for multi-region response**	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs	N/A					
44	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency	N/A					
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	The Trust Emergency Response and Recovery Policy along with the Communications Strategy contains arrangements for sharing information. In addition, guidelines for sharing information in an emergency that may normally be restricted are contained on MS Teams and Resilience Direct.	Fully compliant				
Domain 9 - Business Continuity											
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	The Trust Emergency, Contingency and Business Continuity Plan contains the Trust BC statement of intent. See Q48 for information on compliance of BCMS.	Fully compliant				
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	The Trust Emergency, Contingency and Business Continuity Plan, Emergency Response and Recovery plan are based around ISO22301 - Business Continuity Management Systems to ensure all statutory obligations are covered, alongside the specific health requirements contained within NHS England's EPRR Framework.	Fully compliant				
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	The Trust IT department are compliant with the toolkit and this is regularly audited. The trust have in post a Chief Information Officer and also a SIRO at Executive level.	Fully compliant				

51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	The Trust Emergency, Contingency and Business Continuity Plan along with the Emergency Response and Recovery plan contain all arrangements to prepare, respond and recover from an incident.	Fully compliant			
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	The Trust uses the Annual Core Standards to check that it is performing as required. In both 2015 and 2020 the Trust were independently audited by MIAA and received Significant Assurance for both Audits.In addition the trust were audited by NHS England and a letter sent to the Chief Executive & AEO confirming trust arrangements met requirements . All audits and Core Standards reports are sent to Board via the Emergency Planning Committee and the Risk Committee.	Fully compliant			
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	The Trust EPRR policies are subject to periodic review routinely or when any changes are identified following an activation or exercise of the plan. These policies pass through an approval process at Emergency Planning Committee then through Risk Committee up to Board. Learning from the COvid-19 de-brief will be incorporated into the next review of these policies which have been given a temporary extension.	Partially compliant	Full review of all policies to take place post Covid-19	Steve Povey	Jun-22
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	All essential suppliers have been contacted as part of the preparation for EU Exit and integrity of supply in relation to Covid-19 response. Specific requirements are to be included in the updated Emergency, Contingency and Business Continuity Policy and a review of procurement procedures and suppliers undertaken following the transfer to a new Materials Management provider.	Partially compliant	Emded supplier checks into trust policy.	Steve Povey	Jun-22
Domain 10: CBRN										
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	The Trust has a CBRN Policy containing information and advice plus where to get specific advice from where the general information is inadequate. The CBRN Policy is written by the Physics Department and has input from both the Imaging and Radiotherapy Radiation Protection Advisers (RPA). In addition there is a nuber of Radiation Protection Supervisors for day to day advice.	Fully compliant			
57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	The Trust has a specific CBRN Policy which contains all information and arrangements necessary. The trust has specific policies and training in place for delaing with cytotixic spillage in the manufacturing Pharmacy, cold chain delivery and chemotherapy wards. The trust follows existing procedures for the transport of hazardous materials and all trust vehicles carry a spill kit in case of a leak of cytotoxic drugs.	Fully compliant			
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	The Trust does not have decontamination arrangements as it is a Specialist Trust with no Emergency Department. The exception is the disposal of the sealed source which is done in a controlled manner with known contractors under the supervision of the trust Radiation Protection Advisers. This process is audited by the trust Dangerous Goods Safety Adviser, Ecostar Environmental	Fully compliant			
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.		• Rotas of appropriately trained staff availability 24 /7	N/A				
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Completed equipment inventories; including completion date	The Trust does not have decontamination arrangements as it is a Specialist Trust with no Emergency Department. We are reviewing the Liverpool site to review arrangements should any contaminated person enter the building instead of the new Royal Liverpool site when it opens next door to our own buidling.	Fully compliant			

62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks		• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	N/A							
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment		• Completed PPM, including date completed, and by whom	N/A							
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.		• Organisational policy	N/A							
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training		• Maintenance of CPD records	N/A							
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		• Maintenance of CPD records	N/A							
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	The Trust does not have decontamination arrangements as it is a Specialist Trust with no Emergency Department.	Fully compliant						
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		The Trust trains all clinical staff in the use of FFP3 masks and IPC procedures, there is also an emergency back up store which contains reserves of FFP3 and other protective equipment including quantities of equipment not normally used day to day..	Fully compliant						

Ref	Domain	Standard	Detail	Evidence - examples listed below	Acute Providers	Mental Health Providers	Community Service Providers	Organisational Evidence	Self assessment RAG **Red (not compliant)** = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant)** = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant)** = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Oxygen Supply **Domain: Oxygen Suuply**													
DD1	**Oxygen Supply**	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	•.Committee meets annually as a minimum •.Committee has signed off terms of reference •.Minutes of Committee meetings are maintained •.Actions from the Committee are managed effectively •.Committee reports progress and any issues to the Chief Executive •.Committee develops and maintains organisational policies and procedures •.Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) •.Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate •.The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board	Y	If applicable	If applicable	The trust has Medical Gases Committee that meets at least annually, the terms of reference for this committee are due for sign off in Spetember 2021. Minutes of meetings are maintained as per the requirement of this standard along with Action Points which are escalated through the Trust Triple A Report. The new TOR will see the trust report through to the CEO via the IGC COmmittee. Site resilience plans are in development at the present time in conjunction with our SLA partners who oxygen is supplied from. Risks are escalated onto the trust risk register. The AUthorising Engineers annual report has been received and is an agenda item for the next committee meeting.	Partially compliant	Approve TOR, Receive Authorising Engineers Report at next meeting. Develop Contingency Plans. Minutes and Triple A of the committee to be submitted to IG Committee.	Jo McCaughey	TOR, Engineers Report & escalation through IGC by October 2021. Development of Contingency Plans March 2022 subject to SLA Partners	
DD2	**Oxygen Supply**	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	•.The organisation has reviewed and updated the plans and are they available for view •.The organisation has assessed its maximum anticipated flow rate using the national toolkit •.The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. •.The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site •.The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) •.Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies •.The organisation has breaching points available to support access for additional equipment as required •.The organisation has a developed plan for ward level education and training on good housekeeping practices •.The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases	Y	If applicable	If applicable	The trust receives oxygen at its two main locations (Liverpool and Wirral) from Liverpool University Hospital Foundation Trust and Wirral University Teaching Hospital Foundation Trust via Service Level Agreements with those two trusts. All supply and distribution is managed by the two trusts named. Representatives from these trusts are present on the CCC Committee.	Fully compliant				
DD3	**Oxygen Supply**	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	•.The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries •.The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms •.The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes •.Organisation has utilised the checklist retrospectively as part of an assurance or audit process	Y	If applicable	If applicable	The trust receives oxygen at its two main locations (Liverpool and Wirral) from Liverpool University Hospital Foundation Trust and Wirral University Teaching Hospital Foundation Trust via Service Level Agreements with those two trusts. All supply and distribution is managed by the two trusts named. Representatives from these trusts are present on the CCC Committee.	Fully compliant				
DD4	**Oxygen Supply**	**Medical gasses -workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	•.Job descriptions/person specifications are available to cover each identified role •.Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. •.Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements •.Medical gas training forms part of the induction package for all staff.	Y	If applicable	If applicable	The trust receives oxygen at its two main locations (Liverpool and Wirral) from Liverpool University Hospital Foundation Trust and Wirral University Teaching Hospital Foundation Trust via Service Level Agreements with those two trusts. All supply and distribution is managed by the two trusts named. Representatives from these trusts are present on the CCC Committee. Medical Gas training is part of induction training for all clinical staff.	Fully compliant				
DD5	**Oxygen Supply**	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	•.SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds •.Staff are informed and aware of the requirements for increasing de-icing of vaporisers •.SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO	Y	If applicable	If applicable	Any escalation in demand is discussed with the supplying Trust and documented in the SLA for the provision of oxygen from that trust.	Fully compliant				
DD6	**Oxygen Supply**	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	•.Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report	Y	If applicable	If applicable	Technical files for the systems are held by the host organisations who supply the CCC sites, i.e LUHFT and WUTH.	Fully compliant				
DD7	**Oxygen Supply**	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	•.Organisation has a risk assessment as per section 6.6 of the HTM 02-01 •.Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)	Y	If applicable	If applicable	The trust receives oxygen at its two main locations (Liverpool and Wirral) from Liverpool University Hospital Foundation Trust and Wirral University Teaching Hospital Foundation Trust via Service Level Agreements with those two trusts. All supply and distribution is managed by the two trusts named. Representatives from these trusts are present on the CCC Committee.	Fully compliant				

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

The Clatterbridge Cancer Centre has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, The Clatterbridge Cancer Centre will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
38	0	2	36
Acute providers: **46** Specialist providers: **38** Community providers: **37** Mental health providers:**37** CCGs: **29**			

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

_____

Date signed

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

REPORT COVER

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Report to:	Trust Board
Date of meeting:	29th September 2021
Agenda item:	P1-147-21
Title:	Gender Pay Gap
Report prepared by:	Catrin Wilde – HR Business Partner
Executive Lead:	Jayne Shaw
Status of the report: (please tick)	Public ☐ Private ☒

Paper previously considered by:	
Date & decision:	

Purpose of the paper/key points for discussion:	The Trust's The Gender Pay Gap for year ending 31 March 2020 was published in October 2020. Our 2020 report summarised that in real terms there remains a significant gender pay gap difference within the Trust of 25.5%, in terms of average hourly pay, although this had decreased from 28.6% in previous years, and a median pay gap of 19.2%, which is a decrease from 22.9%. There was a request by the Board to look at options that could be implemented to reduce the pay gap further and in order to do this there is a need to better understand the data in order to be able to focus on appropriate actions This paper provides a further breakdown of the Trusts position in order to identify the main contributing factors to our Gender Pay Gap. The paper also provides an update on actions previously identified in addition to a number of additional recommendations for consideration.

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

Next steps required:	To implement recommendations To work in partnership with EDI collaboration to further inform our approach

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

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☐ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☒ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Gender Pay Gap Report - Further Analysis

Catrin Wilde, HR Business Partner

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

1. Introduction

The Five Year Strategy outlines our commitment to creating a diverse and inclusive culture where everyone is treated with respect and dignity. Our staff are our community and we recognise the importance of ensuring our workforce is representative of our local population. We believe that by continuing to champion a culture of equality, diversity and inclusion we will positively impact the experience of our staff, nurture an environment where staff feel able to speak up and raise concerns and ultimately improve the services we deliver to our patients.

The Gender Pay Gap for year ending 31 March 2020 was published in October 2020 in accordance with of duty as a public body under The Equality Act 2010 (Specific Duties) Regulations (2017) (Appendix 1). These regulations require relevant organisations to publish their gender pay gap data annually by 30 March. The data must include:

- the mean and median gender ordinary pay gaps;
- the mean and median gender bonus gaps;
- the proportion of men and women who received bonuses
- the proportions of male and female employees in each pay quartile

Our 2020 report summarised that in real terms there remains a significant gender pay gap difference within the Trust of 25.5%, in terms of average hourly pay, although this had decreased from 28.6% in previous years, and a median pay gap of 19.2%, which is a decrease from 22.9%.

There was a request by the Board to look at options that could be implemented to reduce the pay gap further and in order to do this there is a need to better understand the data in order to be able to focus on appropriate actions.

2. Further Analysis

2.1. Hourly pay

Appendix 2 provides a detailed analysis of our Gender Pay Gap position as of 30th March 2020. When comparing average pay between male and female staff (Table 1) the overall average pay for

Table 1- Average Hourly rate	
Male	£22.34
Female	£16.65
Difference	£5.69
Pay Gap %	**25.47%**

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male employees is £5.69 higher when compared to females (25.5%).

Table 2- Average Hourly Rate (excluding VSM & Medics)	
Male	£17.45
Female	£15.69
Difference	£1.76
Pay Gap %	**10.09%**

When we break the data down further and exclude Very Senior Managers (VSM) and Medical staff (Table 2) the pay gap is significantly reduced to £1.76 (10.09%). This is also reflected when we review the median pay gap. When comparing all staff the Trust Median pay gap is 19.2% (Appendix 2, Table 4), this reduces to 11.97% when VSM and Medical staff are excluded (Appendix 2, Table 5). This indicates that male staff average pay is higher than the female staff in VSM and medical roles.

A similar result was seen by removing the 5% highest and lowest paid staff which aims to remove the distortion to the overall Trust. The resultant pay gap for average pay is 10.72% (Appendix 2, Table 3) and the median pay gap is 8.77% (Appendix 2, Table 6).

2.2. Pay bands

A comparison of average hourly pay was also reviewed for staff employed in Bands 2-8. This analysis indicated that average hourly pay was higher for women in all pay bands with the exception of Band 3 and 8 (Table 3). However when we review the median pay, there is no median pay gap for staff employed pay bands 3 and 8 (Table 4) suggesting parity of pay between men and women across these pay bands (Band 3 and 8).

Table 3- Average Hourly rate (Bands 2-8)							
	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8
Male	£9.40	10.56	10.69	13.45	16.37	20.51	27.5
Female	£9.79	10.04	11.21	14.14	17.32	20.65	27.34
Difference	-£0.39	£0.52	-£0.52	-£0.69	-£0.95	-£0.14	£0.16
Pay Gap %	**-4.15%**	**4.92%**	**-4.86%**	**-5.13%**	**-5.80%**	**-0.68%**	**0.58%**

Table 4- Median for Hourly rate (Bands 2-8)							
	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8
Male	£9.20	£9.62	£10.79	£12.38	£15.79	£20.12	£25.99
Female	£9.73	£9.62	£10.88	£13.94	£16.63	£20.33	£25.99
Difference	-£0.53	£0.00	-£0.09	-£1.56	-£0.85	-£0.22	£0.00

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Pay Gap %	**-5.77%**	**0.00%**	**-0.85%**	**-12.58%**	**-5.36%**	**-1.07%**	**0.00%**

2.3. Data by Staff Groups

When analysing the data by staff group we accounted for outliers in the data by excluding those at the very top and bottom of pay bands from the data set. When comparing hourly pay by staff group the data demonstrates a positive gender pay gap in favour of women in the Allied Health Professional Staff Group of 6.37% for average hourly pay (Table 5) and a median pay gap of 14.76% (Table 6).

The biggest average hourly pay gap was demonstrated within the Admin and Clerical Staff Group at 14.87% (Table 5) and a median pay gap of 30.22% (Table 6)

Table 5- Average for Hourly rate by staff group							
	Add Prof & Tech	**Add Clinical Services**	**Admin & Clerical**	**AHP**	**Healthcare Scientists**	**Medical**	**Nursing**
Male	£19.10	£10.45	£15.53	£17.58	£24.66	£48.58	£19.99
Female	£18.71	£10.16	£13.22	£18.71	£23.24	£42.90	£17.71
Difference	£0.39	£0.29	£2.31	-£1.12	£1.42	£5.68	£2.28
Pay Gap %	**2.03%**	**2.78%**	**14.87%**	**-6.37%**	**5.78%**	**11.70%**	**11.40%**

Table 6- Average for Hourly rate (-5%)							
	Add Prof & Tech	**Add Clinical Services**	**Admin & Clerical**	**AHP**	**Healthcare Scientists**	**Medical**	**Nursing**
Male	£19.14	£9.62	£15.55	£16.61	£22.45	£49.94	£21.22
Female	£18.81	£9.73	£10.85	£19.06	£22.15	£43.73	£17.18
Difference	£0.33	-£0.11	£4.70	-£2.45	£0.29	£6.21	£4.04
Pay Gap %	**1.70%**	**-1.09%**	**30.22%**	**-14.76%**	**1.30%**	**12.44%**	**19.04%**

Further analysis of this data has identified that within the Nursing Staff Group, male staff are either the highest or the lowest paid within this staff group (Appendix 2, Table 12).

3. Conclusion

Whilst the further analysis provides us with more insight, it also raises more questions.

We now have a better understanding on where some of the pay differences lie within the Trust. Detailed analysis of the data has enabled us to identify that as a Trust our

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most significant pay gaps lay predominately at the top and bottom of the pay bands. In addition when reviewing the Trusts overall position it was identified that our pay gap considerably decreases when Very Senior Managers and Medical staff are excluded.

As an organisation the majority of our workforce are within Bands 1-8, the data demonstrates that the pay gap is positive for female staff compared to male staff in terms of average pay for the majority of pay bands. When comparing median pay, the pay gap is again positive towards female staff for the majority of bands, with the exception of bands 3 and 8 where pay is equal.

The data in terms of staff groups paints a more mixed picture with Admin & Clerical and Medical & Dental staff having the biggest pay gaps.

4. Progress to date

- In collaboration with The Walton Centre and Alder Hey Children's Hospital we have appointed an Equality, diversity and Inclusion Lead. This role will enables learning and the sharing of best practice across organisations and identify opportunities for collaboration and improvement. .
- As part of our Learning and Development priorities we will continue to build on the foundations of our Talen Management programme to support the development of staff and facilitate the opportunities for female staff in more senior roles
- In September 2021 we launched our Shadow Board programme with a cohort of 9 individuals beginning the development journey, of which 8 were female
- Development and growth of our coaching and mentoring pool
- Launched the CCC Leadership & Management Skills Passport, which is aimed at first-line managers looking to develop within the role. The Passport incorporates a range of programmes including leadership fundamentals through to corporate governance and budget management

5. Recommendations and Next Steps

- Undertake the next Gender Pay Gap reporting for year ending 31st March 2021 in Quarter 3 2021/22. This will enable us to get an updated position on the pay

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of staff and identify any variation in trends. This data will be used to further improve the measures been taken to improve the gender pay

- Scope out the potential for the development of a Female Leaders Forum as part of our EDI collaboration to facilitate the sharing of learning and provide opportunities for developing networks
- Participate in the development of the national Scope for Growth programme and incorporate learning and best practice into local processes

The Clatterbridge Cancer Centre NHS Foundation Trust

31st March 2020

Gender Pay Gap Report

1.0 Introduction:

The Equality Act 2010 (Specific Duties) Regulations 2017 require public bodies with 250 or more employees to publish information on their gender pay gap on a yearly basis. This is based on a snapshot from 31st March of each year and each organisation is duty bound to publish this information on their website.

2.1 What is the gender pay gap?

The gender pay gap is a defined term in the Regulations and means the difference between the average hourly earnings of men and those of women. This is not the same as equal pay, which is concerned with men and women earning equal pay for the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because of gender. The gender pay gap highlights any imbalances of average pay across an organization.

2.2 The Gender Pay Gap Indicators:

The legislation requires an employer to publish six calculations:

- The difference between the average (mean) hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees ('the mean gender pay gap');
- The difference between the median rate of pay of male full-pay relevant employees and that of female full-pay relevant employees ('the median gender pay gap');
- The difference between the average (mean) bonus pay paid to male relevant employees and that of female relevant employees ('the mean gender bonus gap');
- The difference between the median bonus pay paid to male relevant employees and that of female relevant employees ('the median gender bonus gap')
- The proportions of male and female relevant employees paid bonus pay ('the proportions of men and women getting a bonus'); and
- The proportions of male and female relevant employees in the lower, lower middle, upper middle and upper quartile pay band ('the proportion of men and women in each of four pay quartiles').

The information contained in this report has been extracted from the national Electronic Staff Record system using standard reports which have been produced to ensure that NHS organisations are able to meet their gender pay gap reporting requirements.

2.3 What employees count?

For the purposes of gender pay reporting, the definition of who counts as an employee is defined in the Equality Act 2010. This is known as an 'extended' definition which includes:

- employees (those with a contract of employment)
- workers and agency workers (those with a contract to do work or provide services)
- some self- employed people (where they have to personally perform the work)

For the purpose of the gender pay gap reporting, Agency workers will form part of the headcount of the agency that provides them, and not the employer they are on assignment to.

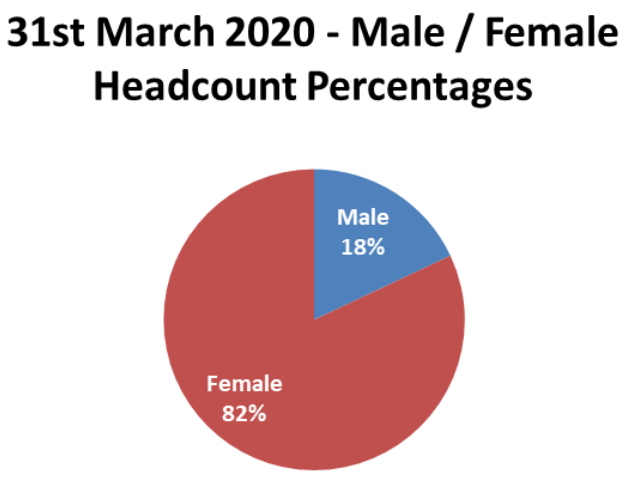
3.0 Our Gender Pay Gap data:

3.1 Total Number of Trust Employees as at 31st March 2020:

The Clatterbridge Cancer Centre NHS Foundation Trust is typical of NHS Trusts in that it has a higher number of females than males in its workforce as depicted below:

Headcount	Female	Male	Total
	1178	261	1,439

Despite a headcount growth of 174 staff the percentage ratio of male to female staff remained unchanged from 2019.

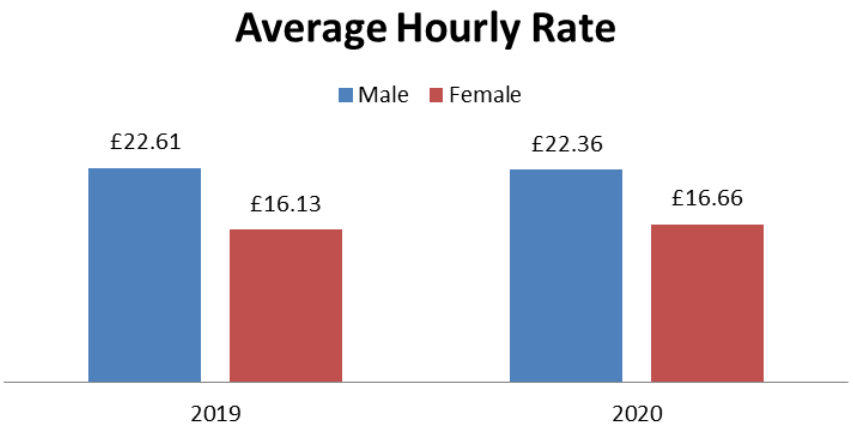


3.2 Average (mean) pay of male and female staff:

The next table and graph shows that the average hourly pay for males is £5.69 per hour higher than that for females, a gender pay gap of 25.48%.

Gender	Average Hourly Rate	
	31 March 2020	31 March 2019
Male	£22.36	£22.61
Female	£16.66	£16.14
Difference	£5.69	£6.47
Pay Gap %	25.48%	28.6%

The average pay has decreased slightly for men and increased for women across the Trust; however, the pay of male staff remains higher than that of women. The pay gap percentage has decreased since 2019 from 28.6% to 25.48%. The following graph depicts the changes over the last 2 years.

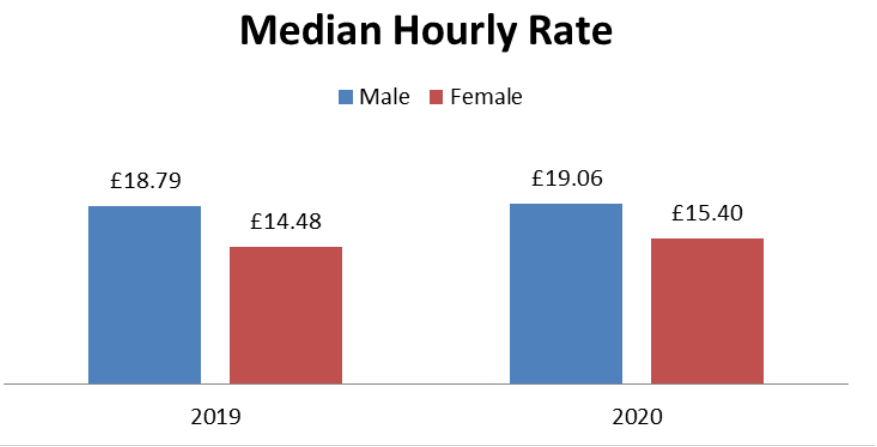


3.3 Median pay of full-pay male and female staff:

The median hourly rate is £3.66 higher for males than females which is a pay gap of 19.20%.

Gender	Median Hourly Rate	
	31 March 2020	31 March 2019
Male	£19.06	£18.79
Female	£15.40	£14.48
Difference	£3.66	£4.31
Pay Gap %	19.20%	22.9%

The median pay has increased slightly for both men and women across the Trust between 31 March 2019 and 31 March 2020. The median pay gap percentage reduced from last year. The information is also presented in the following graph:



3.4 The proportion of full-pay male and female staff in each of the four quartile pay bands:

The data below divides the workforce into four equal parts (quartiles) and shows the proportion of males and females in each quartile (increasing in pay with quartile 1 being the lowest pay and 4 being the highest).

31 March 2020:

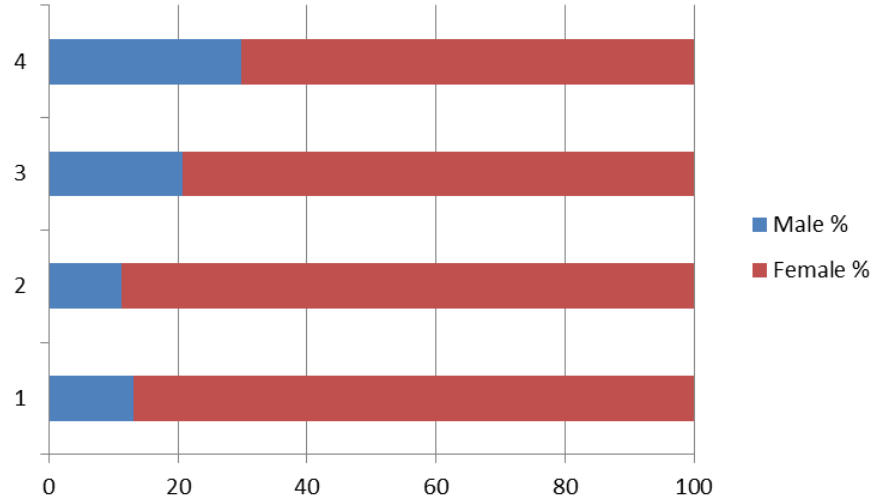
Quartile	Female	Male
1	298 (87%)	45 (13%)
2	308 (89%)	39 (11%)
3	277 (79%)	72 (21%)
4	244 (70%)	104 (30%)

31 March 2019:

Quartile	Female	Male
1	276 (87%)	40 (13%)
2	275 (87%)	41 (13%)
3	268 (85%)	48 (15%)
4	215 (68%)	102 (32%)

There is a fairly even split between female staff in each of the quartiles however the figure does fall in quartile 4 (the highest paid staff) with only a 2% increase in this area since 2019. In comparison, the quartile 4 for male staff the numbers of men proportionately increases in quartile 4 suggesting that men tend to be paid more even though there are less male staff across the Trust.

The above quartile analysis for 2020 is depicted in the following graph:



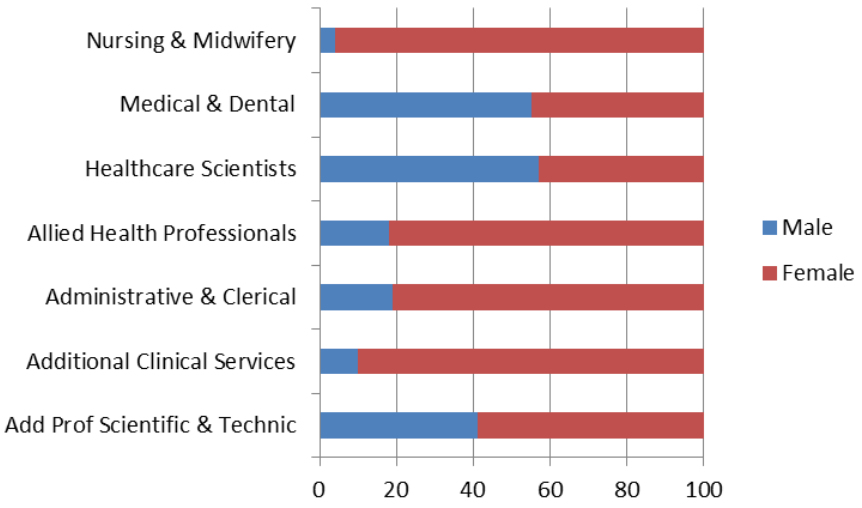
3.5 What does this indicate?

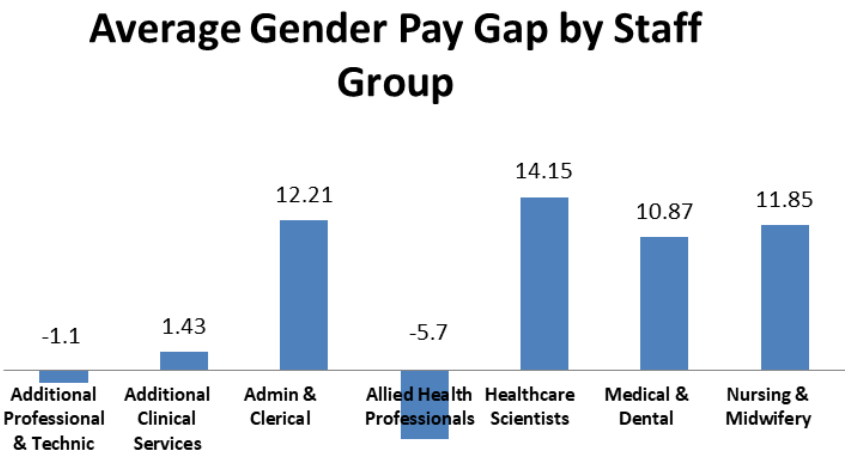
The figure for the median pay gap is usually considered to be more representative of gender pay gap across the workforce; however, it does not take account of small numbers of higher paid employees that could be skewing the data of the mean (or average). The Trust's data would seem to indicate a bigger pay gap in the average pay data which suggests that there are a disproportionate number of males that are paid higher salaries. This is also supported by the quartiles analysis where the proportion of men increases in the higher quartiles.

3.6 Further Analysis per Staff Groups

Percentage of male and female in each staff group:

Historically, certain professions within the NHS have been predominately female orientated whilst others are more male orientated the analysis of male and female ratios within the current workforce is summarised in the graph below:





* negative values indicate that the pay gap favours females

The gender pay gap analysis for staff groups would indicate that the highest gender pay gaps remain consistent with previous years and exist within the Medical, Healthcare Scientists, Administrative & Clerical and Nursing & Midwifery. Female staff are paid more than their male counterparts in the Allied Health Professionals and marginally higher within the Additional Professional and Technical staff group.

Overall the differences in the gender pay gaps by staff group have reduced over the last 12 months, with the exception of the gap for male medical staff which increased by 0.57% and gap for female staff within Additional Professional & Technical which increased by 0.90%.

The Nursing & Midwifery staff group would indicate a significant anomaly since even though 96% of this staff group is female there is a 11.85% pay gap, although improved from last year (15.9%), further analysis shows the small numbers of males within this staff group is skewing the data since 9 of the 13 male staff captured in this group are Band 7 and above, 102 women (out of 308 within this staff group) are employed at Band 7 and above.

The Administrative & Clerical group is also predominantly female due to the lower banded clerical and secretarial roles however this staff group includes Information Technology roles and Project Management roles which have a high proportion of senior banded males.

3.7 Bonus payments:

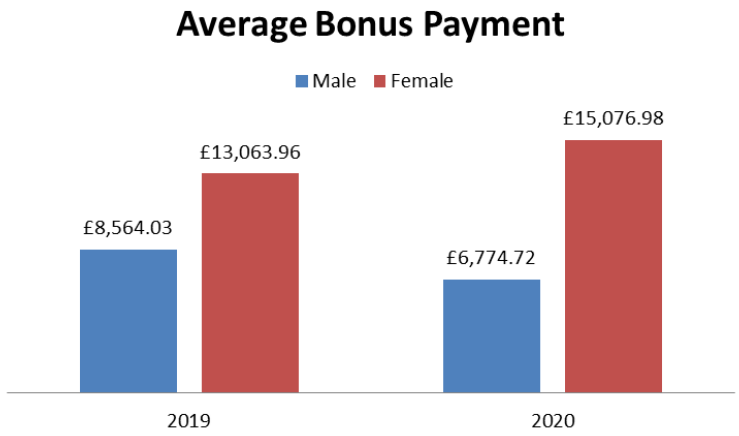
The only bonuses paid in the timeframe by the Trust were to Medical Consultants. Under the National Medical & Dental Terms and Conditions, Consultants are eligible to apply for Clinical Excellence Awards (CEA). These recognise and reward individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role, with a commitment to

the continuous improvement of the NHS. An analysis of these bonus payments follows:

3.7.1 Average (mean) bonus pay of male and female staff:

Gender	Mean Bonus	
	31 March 2020	31 March 2019
Male	£6,774.72	£8,564.03
Female	£15,076.98	£13,063.96
Difference	-£8,302.26*	£-4,499.93*
Pay Gap %	-122.55%*	-52.54%*

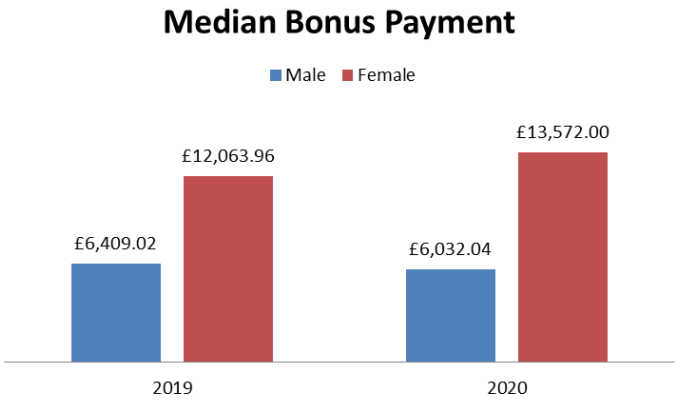
* negative values indicate that the pay gap favours females



The bonus payments made to the eligible Consultant staff group would indicate that the mean bonus paid to our female staff is higher than what is paid to the male staff and that this difference has increased between 31 March 2019 and 31 March 2020. Similarly the same is true for the median payment as indicated below.

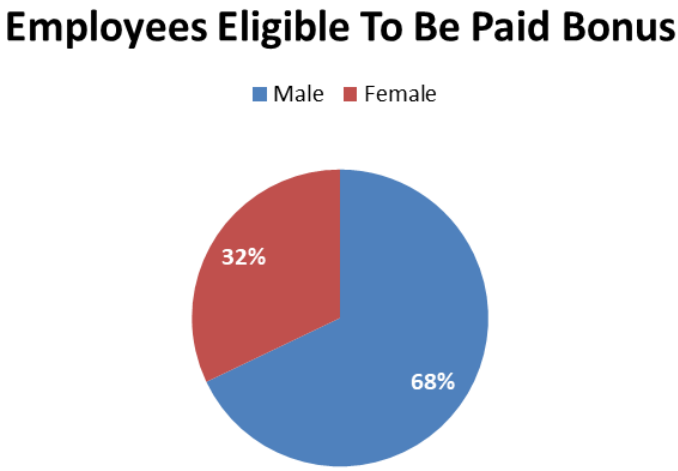
3.7.2 Median bonus pay of male and female staff, expressed as a percentage:

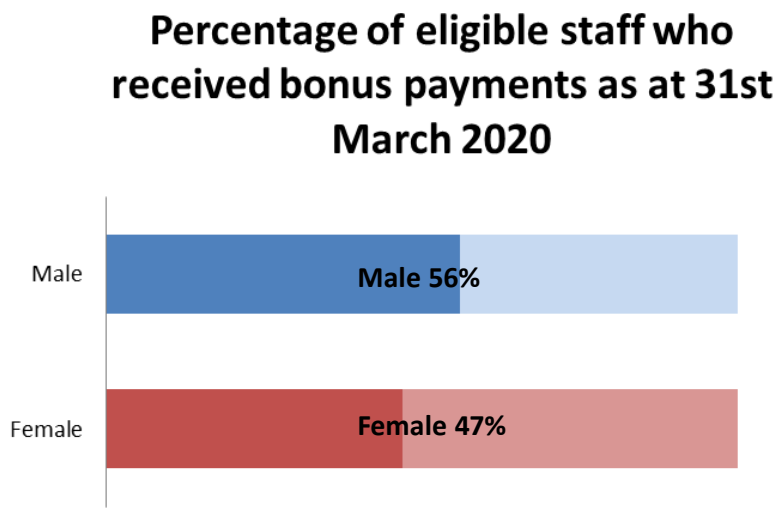
Gender	Median Bonus Pay %	
	31 March 2020	31 March 2019
Male	£6,032.04	£6409.02
Female	£13,572.00	£12,063.96
Difference	-£7,539.96*	£-5,654.94*
Pay Gap %	-125.00*	-88.23%*



3.7.3 The proportion of male and female staff, who receive bonus pay:

Gender	Employees Paid Bonus	Total Eligible Employees	Employees Paid Bonus	Total Eligible Employees
	31 March 2020		31 March 2019	
Female	8 (47%)	17	10 (67%)	18
Male	20 (56%)	36	20 (57%)	35





The percentage of eligible female staff in receipt of a bonus payment has decreased from 67% to 47% in 2020. The actual numbers of female staff receiving a bonus has decreased by 2 whilst the number of female staff eligible to received a bonus has also decreased by 1.

There has been no change in the overall number of male staff receiving bonuses (20) the decrease in the total percentage (57% to 56%) is due to an increase of 1 additional male member of staff being eligble for a bonus payment within the qualifying timeframe. The Trust's data in relation to bonus payments and gender is a positive one and reflects the current cohort of senior female oncologists and the cumulative nature of the awards to date.

4.0 What have we done to date?

Due to the COVID-19 pandemic and the consequent pressures on the workforce, the Trust has not made significant progress with the actions identified in last year's report. We have however been able to further developed the Trust's family friendly workforce policies which are used in our recruitment documentation to attract new staff and and also to support existing staff. We have also been running webinars for line managers on flexible and remote working during the pandemic and are in the process of gathering feedback from staff about flexible and home working to ascertain what learnings we can take into the future.

5.0 Conclusion

In real terms there remains a significant gender pay gap difference within the Trust of 25.5%, in terms of average hourly pay however there has been a positive indication that this has decreased this year (from 28.6%). In March 2019 the overall NHS gender pay gap was 23% as per the www.gov.uk website, the Trust therefore has a slightly higher gender pay gap than the average NHS rate.

There has also been a positive reduction in the median pay gap from 22.9% last year to 19.2% this year. Whilst some of the reasons for these differences are described in detail above, there is still a need for further analysis across paybands to better understand the reasons for these differences and ensure that there is parity of

opportunities for female staff across staff groups and pay bands. The Trust does however, continue to have a positive gender pay difference in relation to bonuses paid to medical staff through Clinical Excellence Awards.

6.0 Next steps:

To update the Gender Pay Gap Action Plan to include the following actions:

- To further analyse pay differences according to pay bands to provide wider intelligence regarding the gender pay gap
- To produce a report and analyse take up of leadership and development programmes by males and females across the Trust to identify any under representation in specific areas
- Continue to produce recruitment reports on a bi-annual basis to identify any gender trends across roles and paybands

7.0 Recommendations

The Trust Board of Directors is asked to confirm their understanding of the above report and support the recommended actions.

Signed on Behalf of the Trust Board: _____

Dr Liz Bishop
Chief Executive Officer

Date: 23.3.21

REPORT

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Appendix 2

Gender Pay Gap Report- Further analysis of data

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

1.0 All Staff Results - Average Hourly Rate

Table 1

Average Hourly rate	
Male	£22.34
Female	£16.65
Difference	£5.69
Pay Gap %	25.47%

Graph 1

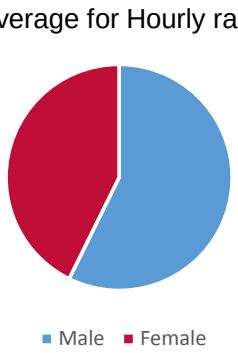


Table 2

Average Hourly Rate Minus Very Senior Managers (VSM)	
Male	£17.45
Female	£15.69
Difference	£1.76
Pay Gap %	10.09%

Graph 2

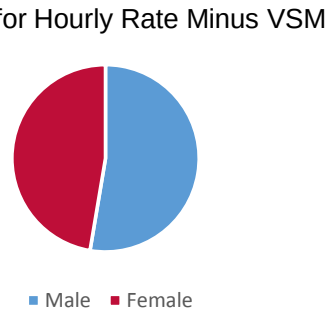
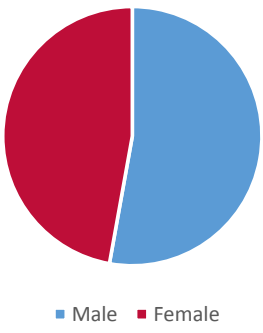


Table 3

*Average Hourly Rate Minus 5%	
Male	£18.00
Female	£16.07
Difference	£1.93
Pay Gap %	10.72%

*There are 85 VSM which is 5.7% of our workforce. 70 people = 5% so took 70 off the highest and lowest hourly rate pay.

Graph 3



REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

2.0 All Staff- Median Hourly Rate

Table 4

Median Hourly rate	
Male	£19.06
Female	£15.40
Difference	£3.66
Pay Gap %	19.20%

Graph 4

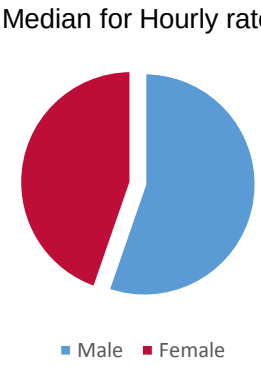


Table 5

Median Hourly Rate Minus Very Senior Managers (VSM)	
Male	£16.63
Female	£14.64
Difference	£1.99
Pay Gap %	11.97%

Graph 5

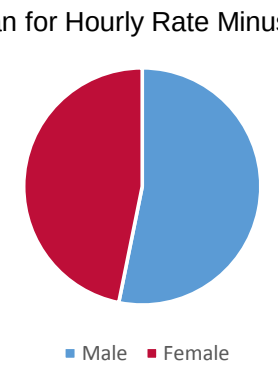
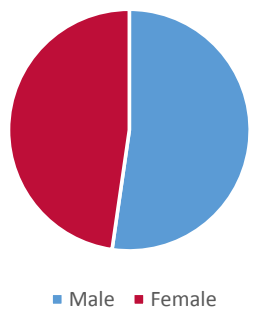


Table 6

*Median Hourly Rate Minus 5%	
Male	£16.88
Female	£15.40
Difference	£1.48
Pay Gap %	8.77%

*There are 85 VSM which is 5.7% of our workforce. 70 people = 5% so took 70 off the highest and lowest hourly rate pay.

Graph 6



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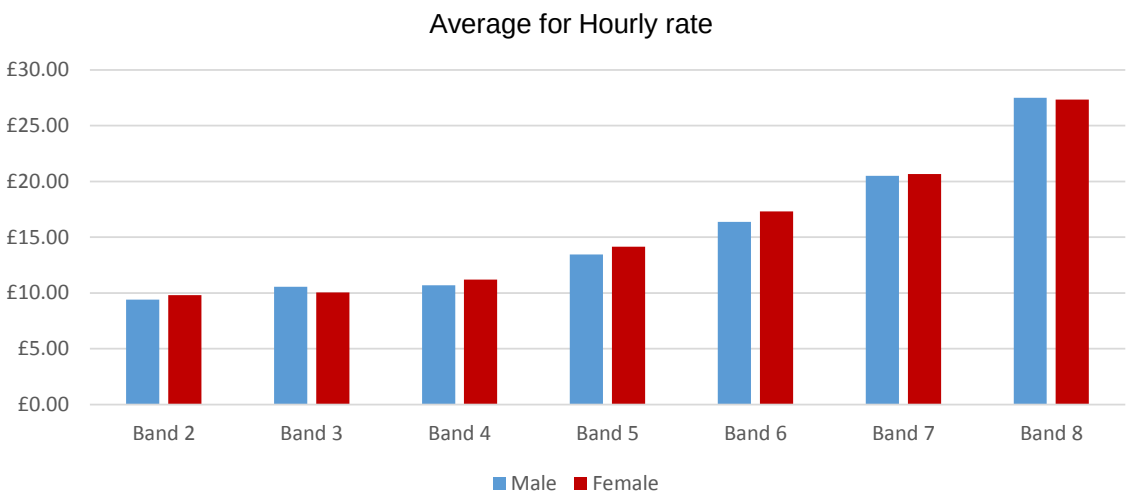
3.0 Average Hourly Rate – Pay Bands

Table 7

Average Hourly rate							
	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8
Male	£9.40	10.56	10.69	13.45	16.37	20.51	27.5
Female	£9.79	10.04	11.21	14.14	17.32	20.65	27.34
Difference	-£0.39	£0.52	-£0.52	-£0.69	-£0.95	-£0.14	£0.16
Pay Gap %	-4.15%	4.92%	-4.86%	-5.13%	-5.80%	-0.68%	0.58%

Graph 7



4.0 Median Hourly Rate- Pay bands

Table 8

Median for Hourly rate							
	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8
Male	£9.20	£9.62	£10.79	£12.38	£15.79	£20.12	£25.99
Female	£9.73	£9.62	£10.88	£13.94	£16.63	£20.33	£25.99
Difference	-£0.53	£0.00	-£0.09	-£1.56	-£0.85	-£0.22	£0.00
Pay Gap %	-5.77%	0.00%	-0.85%	-12.58%	-5.36%	-1.07%	0.00%

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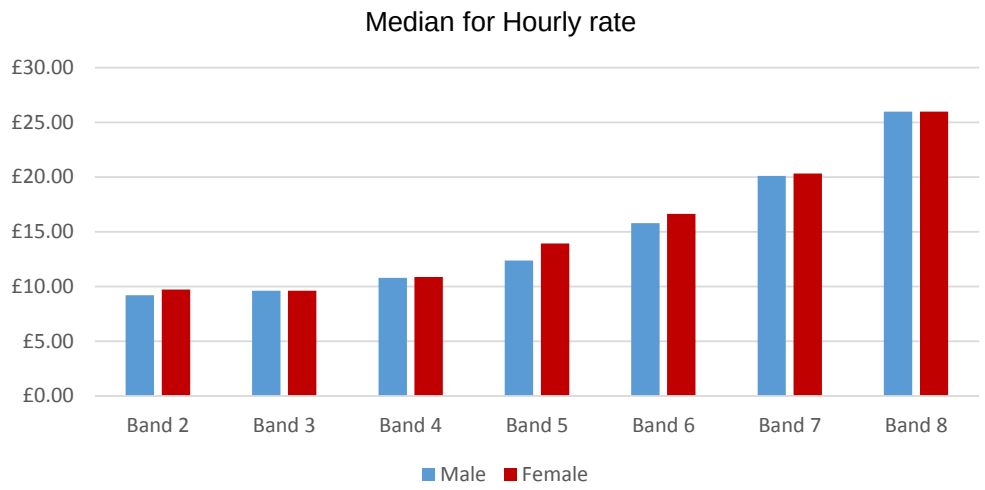
Graph 8



5.0 Pay Gap by staff Groups (removing top and bottom 5% & 10% of outliers)

Table 9

No. people to percentage taken from each group							
	Additional Professional &Technic	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Healthcare Scientists	Medical & Dental	Nursing & Midwifery
5%	4	9	25	11	2	4	16
10%	8	18	50	21	4	7	32

6.0 Average Hourly Rate (Minus 5% of Highest and Lowest Hourly Pay)

Table 10

Average for Hourly rate (-5%)							
	Additional Professional &Technic	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Healthcare Scientists	Medical & Dental	Nursing & Midwifery
Male	£19.10	£10.45	£15.53	£17.58	£24.66	£48.58	£19.99
Female	£18.71	£10.16	£13.22	£18.71	£23.24	£42.90	£17.71
Difference	£0.39	£0.29	£2.31	-£1.12	£1.42	£5.68	£2.28
Pay Gap %	2.03%	2.78%	14.87%	-6.37%	5.78%	11.70%	11.40%

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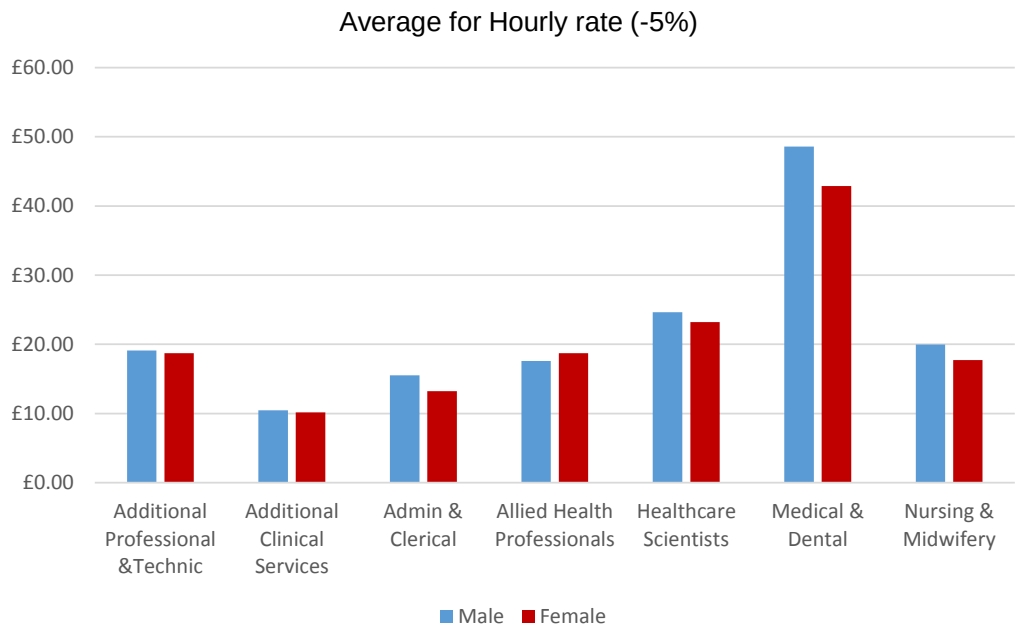
Graph 10



7.0 Median Hourly Rate Minus 5% of Highest and Lowest Hourly Pay Rate

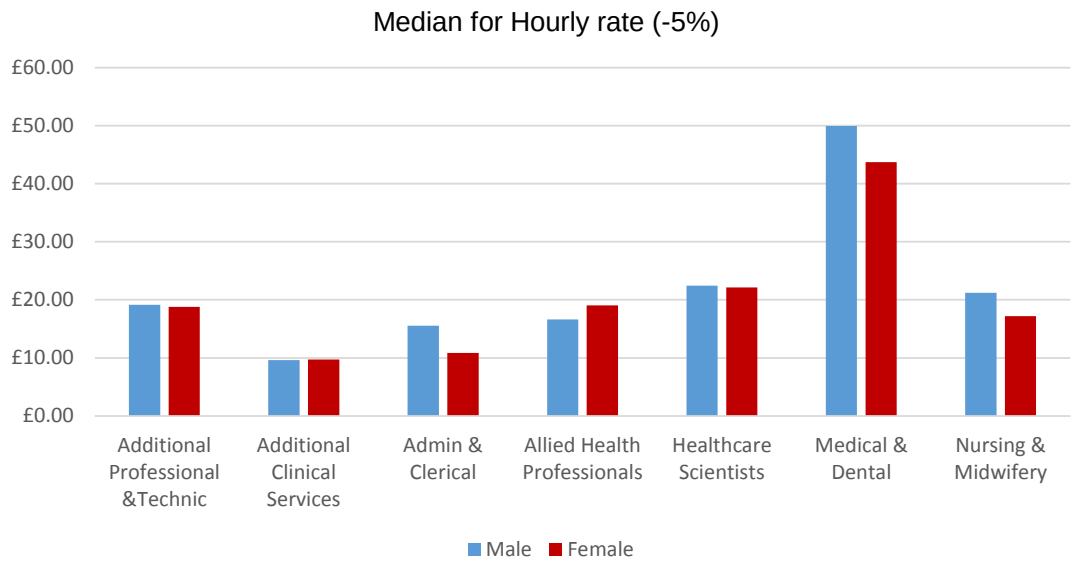
Table 11

Median Hourly rate (-5%)							
	Additional Professional &Technic	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Healthcare Scientists	Medical & Dental	Nursing & Midwifery
Male	£19.14	£9.62	£15.55	£16.61	£22.45	£49.94	£21.22
Female	£18.81	£9.73	£10.85	£19.06	£22.15	£43.73	£17.18
Difference	£0.33	-£0.11	£4.70	-£2.45	£0.29	£6.21	£4.04
Pay Gap %	1.70%	-1.09%	30.22%	-14.76%	1.30%	12.44%	19.04%

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Graph 11



8.0 Average Hourly Rate Minus 10% of Highest and Lowest Hourly Pay Rate

* Please note that when 10% was taken from highest and lowest of Nursing & Midwifery all of the workforce in this grouping was female.*

Table 12

Average for Hourly Rate (-10%)						
	Additional Professional &Technic	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Healthcare Scientists	Medical & Dental
Male	£19.10	£9.95	£15.05	£17.58	£22.99	£48.41
Female	£18.67	£10.10	£12.74	£18.64	£23.98	£44.04
Difference	£0.43	-£0.15	£2.31	-£1.06	-£1.00	£4.37
Pay Gap %	2.27%	-1.55%	15.33%	-6.02%	-4.33%	9.03%

REPORT

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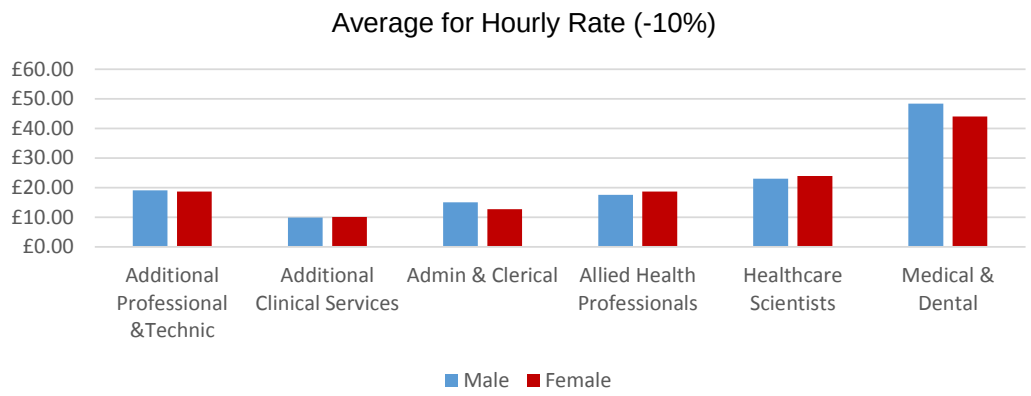
NHS Foundation Trust

Graph 12

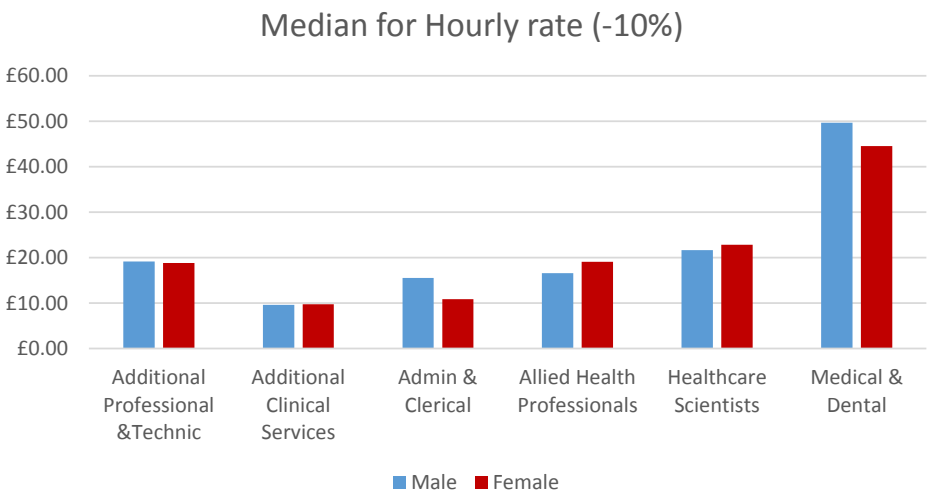


9.0 Median Hourly Rate Minus 10% of Highest and Lowest Hourly Pay Rate

Table 13

Median for Hourly rate (-10%)						
	Additional Professional &Technic	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Healthcare Scientists	Medical & Dental
Male	£19.14	£9.62	£15.55	£16.61	£21.68	£49.67
Female	£18.81	£9.75	£10.85	£19.06	£22.81	£44.59
Difference	£0.33	-£0.13	£4.70	-£2.45	-£1.13	£5.08
Pay Gap %	1.70%	-1.36%	30.22%	-14.76%	-5.22%	10.23%

Graph 13



REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	21st September 2021
Agenda item:	P1-148-21
Title:	Workforce Race Equality Standard (WRES)
Report prepared by:	Catrin Wilde
Executive Lead:	Jayne Shaw
Status of the report: (please tick)	Public ☐ Private ☒

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

Purpose of the paper/key points for discussion:	The Workforce Race Equality Standard (WRES) is an annual regulatory requirement. Employee data as of 31 March 2021 is drawn from the Electronic Staff Records (ESR) system and also the relevant results from the 2020 National Staff Survey is submitted by 31 August 2021 and this is followed by a requirement to publish the data along with an action plan on the Trust website by 31 October 2021. The Trust has grown in overall staff numbers from 1332 in March 2020 to 1560 in March 2021 and the percentage of BAME staff employed by the Trust has increased from 5.0% to 6.0% between these years. The number of unknown or undisclosed data has fallen slightly from 2.4% to 1.7%. The feedback from BAME staff in the staff survey provides some positives but also identifies areas where staff feel less supported in comparison to last year. The action plan has been shared with the Ethnic Diversity Staff Network. Through the appointment of a new Head of EDI and the collaborative partnership working with The Walton Centre & Alder Hey Children's NHS Trusts we hope to be able to further raise the profile of our BAME staff and improve their work experiences.

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

Next steps required:	Report to be published on Trust website by 31 October 2021.

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

	There is a request to approve a more reader friendly version with infographics if possible

REPORT COVER

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.	☒
If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	☒

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

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The Clatterbridge Cancer Centre NHS Foundation Trust

NHS Workforce Race Equality Standard (WRES)

Annual Report 2021

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1.0 Introduction

The Workforce Race Equality Standard was mandated in April 2015 through the NHS contract starting in 2015/2016 with the requirement to publish the data on external websites. The aim is to ensure employees from black and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BAME board members across the organization.

This report contains the Trust's employee data drawn from the Electronic Staff Records (ESR) system and also the relevant results from the 2020 National Staff Survey.

At The Clatterbridge Cancer Centre, we believe everyone has the right to be respected and valued as an individual. We care about empowering people and having a culture that promotes equality, inclusivity and human rights. We are determined to do all we can for all people at all times to meet their individual needs and provide the very best experience.

2.0 Executive Summary

The Trust opened its new hospital in Liverpool in June 2020, moving its main site from a rural site on the Wirral to a more culturally diverse city centre location. The Trust has grown in overall staff numbers from 1332 in March 2020 to 1560 in March 2021 and the percentage of BAME staff employed by the Trust has increased from 5.0% (72 staff) to 6.0% (94 staff) between these years. The number of individuals with unknown or undisclosed data has also reduced from 2.4% to 1.7%.

The percentage of non-clinical BAME staff has increased from 2.8% (14 staff) to 3.6% (18 staff). Similarly we have seen an increase in BAME colleagues in clinical roles from 6.1% of the total workforce in 2020 to 7.3% (77 staff) in 2021.

The percentage of unknown/non disclosed is fairly low but has decreased from 2.4% to 1.7% for non-clinical staff and from 2.4% to 2.1% for clinical staff.

When reviewing opportunities for BAME colleagues the data suggests that the number of White colleagues being appointed from shortlisting compared to BAME staff has decreased from 2.5 in 2020 to 1.31 in 2021. Although an improvement it indicates that White staff are 1.31 times more likely to be appointed than BAME staff and that there is further work to be undertaken to address this disparity.

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In the NHS People Plan 2020/2021 part of the focus was to tackle the disciplinary gap across the NHS. A 'Fair Experience for All' outlined aspirational aims and support for organisations to ensure that all staff are treated fairly. Over the past 3 years the Trust has had no BAME staff managed under formal disciplinary or capability procedures and therefore there is a nil return for the measure in relation to the likelihood of BME staff entering formal process compared to non-BAME staff.

The relative likelihood of non BAME staff accessing non-mandatory and CPD Training compared to BAME staff has decreased demonstrating an improvement and that as a Trust we provide equal access to training and development.

Our non-executive BAME representation at Board has increased from 14.3% in 2020 to 50% in 2021 with an associated increase as a result of the Board members with voting rights increasing from 27.3% in 2020 to 41.7% in 2021.

From our Staff Survey Results in 2020 we have the following information from staff feedback;

- There has been a decrease in BAME staff reporting experiencing harassment, bullying or abuse from patients, relatives or the public (from 21.1% to 12.5%). There was also a decrease in white staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months compared to 2019 (from 14.1% to 10.5%).
- There had been an increase in the number BAME staff reporting that they had experienced harassment, bullying or abuse from staff in comparison to 2019 (from 18.4% to 20%)
- Whilst there was a significant increase in BAME staff believing that the trust provides equal opportunities for career progression or promotion from 2018 to 2019, this has fallen from 90.9% to 81.8% in 2020 whilst White staff believing the trust provides equal opportunities for career progression or promotion has increased from 85.1% to 91.3%.
- The Trust has continued to see a decrease again this year of BAME staff (5.4% down from 5.6%) and White staff (4.0% down from 5.5%) personally experiencing discrimination at work from manager/team leader or other colleagues.

3.0 WRES Progress in 2020/21

A number of initiatives and work has been undertaken by the Trust over the last year. This includes;

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- Established an Ethnic Diversity Staff Network Group that has met regularly since November 2020.
- We have reviewed and enhanced our Performance Appraisal system and further developed training material to ensure managers are aware of the importance of wellbeing and career conversations.
- In 2020 we implemented a new quarterly staff culture and engagement pulse survey to further understand the views of staff and ensuring all staff have a voice. We have also developed Culture and Engagement Group across all divisions to enable more direct change and improvements at a local level.
- The number of Board members from a black and ethnic minority background has increase from 3 to 5 during the last year improving representation at the very senior level of the Trust. This increase is also evident in our senior leadership positions (Band 8a and above).
- In Dec 2021 an EDI audit was undertaken by an external EDI consultant on the Trust's recruitment policy and processes in order to identify any improvements that could be made to ensure inclusiveness at each stage.
- The Trust undertook an audit of all incidents of racist abuse from patients towards our staff over a 2 year period in order to identify any learning or improvements that could be made to support our staff.
- The Trust's Equality Impact Analysis policy was updated and reviewed by an external EDI Consultant, training will be rolled out in 2021.
- An engagement piece of work to review the Trust's values and behaviours has taken place and a relaunch of the values and a new staff charter will be launched in early 2022.
- New Freedom to Speak Up Champions have been recruited and trained in order to provide better access for staff to seek the advice for any concerns or issues they might have.
- In November 2019 the Trust promoted the national Anti-Bullying week and raised awareness of support available to staff.
- The offer of coaching opportunities for all staff were enhanced during 2019/2020 in order to support staff with career development discussions.
- Identified by NHSI/E as a Trust achieving under the national disparity ratio target. This is the comparison between the progression ratios for white and BAME staff and reflects the probability of white staff versus BAME staff being promoted within the organisation.

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4.0 Recommendations

The data for the Trust in respect of BAME staff continues to show small but positive improvements in relation to the number of staff employed who are from diverse backgrounds. The establishment of an Ethnic Diverse Staff Network is a positive step in providing staff with a voice and a forum to discuss issues arising and to help promote and suggest improvements.

Following the opening of our new hospital in Liverpool we also aim to actively engage with local stakeholders and community groups to widen our candidate pool. 13.8% of Liverpool's population are Black and Minority Ethnic, similar to the proportion of the BAME population in the UK which stands at 13%. We also plan to make links with several community and professional diverse organisations who we plan to work collaboratively with building relationships in order to gain insights and advice. These organisations will act as our critical friends guiding us and offering advise recommendations with regards to 'Attraction, Recruitment, Retention planning.

The Trust is also planning to introduce a reciprocal mentoring program and BAME staff will be encouraged to become core members, offering leadership development and mentoring from senior leadership team members. A series of listening groups with staff will be undertaken to engage and understand perceived or real experiences of discrimination so we can plan initiatives that work towards eradicating discriminatory behaviors/language and start to build a culture of inclusion.

During the next 12 months we hope to see a big improvement in our Equality, Diversity, and Inclusion (EDI) activity, continuing the work we have started, we will introduce new initiatives and continue developing our EDI Plan. The past year has been challenging for all departments, services and society as a whole but with the appointment of a new EDI lead and the collaborative partnership working with The Walton Centre & Alder Hey Children's NHS Trusts we aim to see a significant transformation in the behavior, culture and experiences of our workforce and our service users.

Appendix 1 WRES metrics report

Detailed below is the organisation's WRES data as at 31 March 2021

Metric 1 - Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including executive board members) compared with the percentage of staff in the overall workforce.

(Data source: ESR)

1a. Non-clinical workforce

	BAME staff in 2020	BAME staff in 2021	BAME staff in 2020/2021	Non-BAME staff in 2020	Non-BAME staff in 2021	Non-BAME staff in 2020/2021	Unknown/ null staff in 2020	Unknown/ null staff in 2021	Unknown/ null staff in 2020/2021
	Number	Number	Difference	Number	Number	Difference	Number	Number	Difference
Cluster 1 (Bands 1 - 4)	8	9	+1	277	291	+14	6	2	-4
Cluster 2 (Band 5 - 7)	3	3	0	131	124	-7	5	2	-3
Cluster 3 (Bands 8a - 8b)	2	3	+1	40	37	-3	1	1	0
Cluster 4 (Bands 8c – 9 & VSM)	1	3	+2	21	23	+2	0	0	0
Total	14	18	4	469	475	6	12	5	-7

1b. Clinical workforce

	BAME staff in 2020	BAME staff in 2021	BAME staff in 2020/2021	Non-BAME staff in 2020	Non-BAME staff in 2021	Non-BAME staff in 2020/2021	Unknown/ null staff in 2020	Unknown/ null staff in 2021	Unknown/ null staff in 2020/2021
	Number	Number	Difference	Number	Number	Difference	Number	Number	Difference
Cluster 1 (Bands 1 - 4)	6	9	+3	191	211	+20	3	3	0
Cluster 2 (Band 5 - 7)	21	29	+8	521	597	+76	12	12	0
Cluster 3 (Bands 8a - 8b)	2	3	+1	95	104	+9	4	3	-1
Cluster 4 (Bands 8c – 9 & VSM)	2	2	0	9	9	0	1	1	0
Cluster 5 (Medical and Dental staff, Consultants)	21	25	+4	36	31	-5	3	2	-1
Cluster 6 (Medical and Dental staff, Non-consultant career grade)	4	7	+3	4	4	0	0	1	+1
Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades)	1	1	0	2	3	+1	0	0	0
Total	57	76	19	858	959	101	23	22	-1

Metric 2 – Relative likelihood of BAME staff compared to non-BAME staff being appointed from shortlisting across all posts

(Data source: Trust's recruitment data)

	Relative likelihood in 2020	Relative likelihood in 2021	Relative likelihood difference (+-)
Relative likelihood of non-BAME staff being appointed from shortlisting compared to BAME staff	**2.5**	**1.31**	**-1.19**

Metric 3 – Relative likelihood of BAME staff compared to non-BAME staff entering the formal disciplinary process, as measured by entry into the formal disciplinary procedure

(Data source: Trust's HR data)

	Relative likelihood in 2019/20	Relative likelihood in 2020/21	Relative likelihood difference (+-)
Relative likelihood of BAME staff entering formal capability process compared to non-BAME staff	**0**	**0**	**0**

Metric 4 – Relative likelihood of BAME staff compared to non-BAME staff accessing non-mandatory and CPD Training

(Data source: ESR)

	Relative likelihood in 2019/20	Relative likelihood in 2020/21	Relative likelihood difference (+-)
Relative likelihood of non BAME staff accessing non-mandatory and CPD Training compared to BAME staff	**1.32**	**1**	**-0.32**

Metrics 5-8 – Percentage of BAME staff compared to non-BAME staff experiencing harassment, bullying or abuse

(Data source: NHS Staff Survey)

	BAME staff responses to 2019 NHS Staff Survey	Non-BAME staff responses to 2019 NHS Staff Survey	% points difference (+/-) between BAME staff and non-BAME staff responses 2019	BAME staff responses to 2020 NHS Staff Survey	Non-BAME staff responses to 2020 NHS Staff Survey	% points difference (+/-) between BAME staff and non-BAME staff responses 2020
	Percentage (%)	Percentage (%)	Difference	Percentage (%)	Percentage (%)	Difference
5. Staff experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months	21.1%	14.1%	7.0%	12.5%	10.5%	2.0%
6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months	18.4%	23.5%	-5.1%	20.0%	15.4%	4.6%
7. Staff believing that the organisation provides equal opportunities for career progression or promotion	90.9%	85.1%	5.8%	81.8%	91.3%	-9.5%
8. Staff experienced harassment, bullying or abuse at work from manager/team leader or other colleagues in the last 12 months	5.6%	5.5%	0.1%	5.4%	4.0%	1.4%

Metric 9 – Percentage difference between the organisation's board voting membership and its organisation's overall workforce

(Data source: NHS ESR and/or trust's local data)

	BAME Board members in 2020	Non-BAME Board members in 2020	Board members with BAME status unknown in 2020	% points difference (+/-) between BAME Board members and BAME staff in overall workforce	BAME Board members in 2021	Non-BAME Board members in 2021	Board members with BAME status unknown in 2021	% points difference (+/-) Between BAME and non-BAME Board members in 2021
	Percentage (%)	**Percentage (%)**	**Percentage (%)**	**Difference**	**Percentage (%)**	**Percentage (%)**	**Percentage (%)**	**Difference**
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by Exec/non-exec and Voting/non-voting.	Exec = 33.3% Non-exec = 14.3% Voting = 27.3% Non-voting = 0%	Exec = 66.7% Non-exec = 85.7% Voting = 72.7% Non-voting = 100%	Exec = 0% Non-exec = 0% Voting = 0% Non-voting = 0%	Total Board = 23.10% Overall workforce = 5% Difference = 18.1%	Exec = 22.2 Non-exec = 50% Voting = 41.7% Non-voting = 0%	Exec = 77.8% Non-exec = 50% Voting = 58.3% Non-voting = 100%	Exec = 0% Non-exec = 0% Voting = 0% Non-voting = 0%	Total Board = 33.3% Overall workforce = 6.0% Difference = 27.3%

ACTION PLAN

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The Clatterbridge Cancer Centre
NHS Foundation Trust

Appendix 2 - WRES action plan 2020/21

Last updated: 15th September 2021

Updated by: Catrin Wilde and Angela Ditchfield

Metric	Objective	Action/s	Timescales	Lead/s	Why
1. Percentage of staff in each of the AfC 1-9 OR Medical and Dental sub groups and Very Senior Managers (VSM) (including Executive Board members) compared with the percentage of staff in the overall workforce.	Increase representation of BAME staff across all paybands	• Review options in relation to targeted job opportunities and positive action initiatives • Review process of encouraging application from volunteers • Building collaborative relationships with community and professional organisations to help support 'Attraction, Recruitment & Retention' such as BIMA, British Sikh Nurses • Ensure BAME staff can access training and CPD and are encouraged to do so • Introduce Inclusive behaviour training	February 2022 March 2022 Dec 2021 March 2022 March 2022 Dec 2021	Recruitment Team EDI Lead Staff Networks Comms Director/Deputy Director Workforce	To diversify our current workforce so that it representative of the patient population who access our services. Diversifying our workforce will bring benefits to our organisation in which we can celebrate difference, learn from each other, gain new ideas, insights & perspectives beginning to creating a culture of inclusion.

		• Utilise our existing staff, with their agreement, to showcase job roles, working for the trust, developing videos, staff profiles, webinars, staff experience talks • Develop a Diversity & Inclusion library which all staff can access, providing resources which educate staff about Diversity & Inclusion workforce	October 2021		
2. Relative likelihood of staff being appointed from shortlisting across all posts	Ensure recruitment process is free from prejudice and bias whether conscious or unconscious	• Staff networks support and offer representative on selective interview panels • Host open days to promote the directorates and the current job roles, applicants can come and find out all about the trust, job roles etc • Applicant support, development of a resource offering advice around completion of application, interview masterclass etc • Collaborative working with professional and community organisations to promote job roles for both nurses	December 2021 March 2022 June 2022 Dec 2021	Recruitment Team Staff Networks EDI Lead Comms Director/Deputy Director of Workforce	To improve experiences/employment opportunities of BAME staff, diversifying our current workforce and building a culture of inclusivity

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		and medical staff, BIMA, British Sikh Nurses etc			
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	To ensure BAME staff do not suffer discrimination in becoming more likely to enter formal capability process.	• Due to no cases over last 2 years, continue to review and record cases. • Review the incident reporting processes	March 2022	HR Business Partnering Team EDI Lead	To ensure there is no unfair treatment of BAME staff.
4. Relative likelihood of staff accessing non-mandatory and CPD Training	To ensure BAME staff are able to progress within careers and up the salary scale	• Introduce reciprocal mentoring programme encouraging BME staff to be core members • Ensure all staff have access to non-mandatory development opportunities & Identify any barriers to staff accessing training & CPD	March 2022 Dec 2021	EDI Lead Learning & Development team Staff Network	To improve career progression opportunities of BAME staff, improving their experiences, making them feel valued
5. Percentage of staff experiencing harassment, bullying or	To ensure all BAME staff feel safe, supported and protected	• Increase awareness of all staff regarding reporting and support mechanisms • Promote new FTSU Champions	January 2022 Dec 2021	H&S Officer ED Lead Comms Learning & development	To ensure all staff are treated with dignity and respect

abuse from patients, relatives or the public in last 12 months	within the workplace	• Work closely with Staff network to ensure colleagues have confidence to speak up safely about issues regarding racism, behaviours, & prejudice • Display positive messaging around the trust with regards anti discriminatory behaviour	Dec 2021 Oct 2021	Staff Network	Demonstrate to patients, carers and service users that the trust does not tolerate discriminatory behaviour/language and has a zero tolerance approach Promoting an inclusive culture
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	To have zero tolerance for all forms of harassment, bullying and abuse and create a culture of civility and respect	• Launch refreshed Trust values and behaviours • Introduction of an Inclusive Behaviours program • Review of incident reporting • Work with Staff network to support colleagues to speak up safely on issue related to anti discriminatory behaviour • Collaborate with other NHS trusts to learn and share best practice	Jan 2022 May 2022 Dec 2021 March 2022 Oct 2021	Learning & Organisation Development Team EDI Lead Director/Deputy Director of Workforce Staff Network Comms	To ensure all staff are treated with dignity and respect, feel valued and enjoy coming to work at CCC. Build a culture of inclusion, enhancing the reputation of the organisation.
7. Percentage of staff believing that the Trust provides	To ensure BAME staff are able to progress within careers and up the salary scale	• Introduce career conversation for all staff with particular attention to BAME staff	April 2022 March 2022 Dec 2021	Learning & Organisation Development Team Trust FTSU Lead	To improve career progression opportunities for BAME staff, improving their experiences and making them feel valued and part of CCC. Building an

equal opportunities for career progression and promotion		• Introduce reciprocal mentoring programme for BAME staff • Interview questions will include a question regarding Equality, Diversity & Inclusion as mandatory • Once all networks have been established members will be asked to support interviews to improve panel diversity • Career development plan to be developed with Learning & Development • Collaboration with professional and community organisations to attract a diverse workforce and gain insight into the needs of BAME groups • Introduction of staff profiles which will be shared on appropriate platforms reaching out to BAME groups, showcasing CCC as a 'Great place to work'	March 2022 March 2022 June 2022 Dec 2022	EDI Lead Comms BAME Network Director/Deputy Director Workforce	inclusive culture, promoting CCC as a great place to work, enhancing the reputation of CCC

8. In the last 12 months have you personally experienced discrimination at work from any of the following? Management, team leader or other colleagues.	To ensure all staff are treated with dignity and respect and don not experience discrimination in the workplace.	• Launch refreshed Trust values and behaviours • Promote new Freedom to Speak Up Champions • Work towards recruiting and developing inclusive leaders • Work with BAME network to support and encourage colleague to have the confidence to speak out • Launch micro-aggressions campaign to ensure staff are aware of micro-aggressions, including training on micro-aggressions and the impact this has on individuals • Awareness raising and skills development with line managers across the trust regarding understanding and recognising all forms of racism, and developing cultural knowledge	Jan. 2022 Dec 2021 Dec 2022 March 2022 Dec 2021 March 2022	Learning & Organisation Development Team Trust FTSU Lead HR Team Learning & Development team BAME Network EDI Lead Director/Deputy Director Workforce Comms	To ensure all staff are treated with dignity and respect and that everyone recognises that CCC take a zero-tolerance approach, building a culture of inclusivity, enforcing the trust values
9. Percentage difference between the organisations' Board voting	To ensure there is appropriate BAME representation at Board level with voting rights.	• Review the approach to executive succession planning, with support from North West Leadership Academy	July 2022	EDI Lead Learning & Development Team	To ensure that senior BAME staff are represented at Board level and are part of the decision making at a strategic level within the Trust. Encouraging staff to

membership and its overall workforce **NOTE: Only voting members of the Board are included in this indicator**					professionally progress and develop

REPORT COVER

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Report to:	Trust Board
Date of meeting:	23rd September 2021
Agenda item:	P1-149-21
Title:	Workforce Disability Equality Standard (WDES)
Report prepared by:	Emma Dunroe
Executive Lead:	Jayne Shaw
Status of the report: (please tick)	Public ☐ Private ☒

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

Purpose of the paper/key points for discussion:	The Workforce Disability Equality Standard (WDES) is an annual regulatory requirement. Employee data as of 31 March 2021 is drawn from the Electronic Staff Records (ESR) system and also the relevant results from the 2020 National Staff Survey is submitted by 31 August 2021 and this is followed by a requirement to publish the data along with an action plan on the Trust website by 31 October 2021. The Trust has achieved Disability Confident Employer level 2 during the last year. It has also launched a Reasonable Adjustment SOP and Health Passport, however other work such as setting up a staff network and improving declaration of disabilities has been delayed although this is planned to be launched in Q3. Further joint working across The Walton Centre and Alder Hey is expected that will enable us to raise awareness, share staff stories and improve disclosure by staff of their disabilities.

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

Next steps required:	Report to be published by 31 October 2021. There is a request to approve a more reader friendly version with infographics if possible.

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

☒ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

NHS Workforce Disability Equality Standard (WDES)

Annual Report 2021

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1.0 Introduction

The Workforce Disability Equality Standard (WDES) was launched in 2019 and aims to improve the workplace and career experiences of disabled colleagues in the NHS. This report contains the Trust's employee data drawn from the Electronic Staff Records (ESR) system and also the relevant results from the 2019 National Staff Survey.

The WDES is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. NHS Trust's to use the metrics to develop and publish an action plan. Year on year comparison enables Trust's to demonstrate progress against the indicators of disability equality.

The WDES is important, as research shows us that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The WDES enables us to better understand the experiences of our Disabled staff and support and implement positive change for our people by creating a more inclusive environment.

At The Clatterbridge Cancer Centre we are committed to ensuring:

- We treat everyone fairly, with dignity and respect
- Opportunities are open to all
- We provide a supportive and welcoming environment for everyone
- We reflect these values in everything we do, from strategic plans to everyday activities.

We are also committed to delivering the NHS People Promise to be open and inclusive, that we do not tolerate any form of discrimination, bullying or violence, and that we make the NHS a place where we all feel we belong.

2.0 Executive summary

Clatterbridge Cancer Centre is one of the largest NHS providers of non-surgical cancer treatment. In 2020 we opened our new hospital in the heart of Liverpool city centre, and embedded our networked model of care providing care to our patients at multiple sites across Cheshire and Merseyside. The Trust has grown over the last 12 months employing 1560 individuals in March 2021 compared to 1332 in March 2020.

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The percentage of our total workforce with a declared disability as of 31 March 2021 was 3.14%, a total of 49 members of staff in total.

The percentage of non-clinical staff who have declared a disability increased from 2.6% in 2020 (14 members of staff) to 3.4% in 2021 (18 members of staff). The percentage of staff whose status is unknown or not specified decreased from 8.3% to 6.1% of overall staff however the actual numbers of staff this equates to remained unchanged

Similarly, the percentage of clinical staff who have declared a disability has increased from 3% in 2020 (25 members of staff) to 3.2% in 2021 (31 members of staff)) across Bands 1-7. For Bands 8a and above there are no declared disabilities for any clinical staff, including the medical workforce, which identifies there is further work to be done to ensure we are supporting our whole workforce. The percentage of unknown/not specified percentage has fallen significantly from 14.5% in 2020 to 7.24% in 2021 for clinical staff.

The data regarding the relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff has improved significantly from a ratio of 2.14 in 2020 to 0.86 in 2021.

In the 2020 Staff Survey results the percentage disabled staff reporting that they felt satisfied with the extent the Trust values their work has increased from 38.8% (in 2020) to 45.0% in 2021 which is a positive indication.

The percentage of disabled staff believing that the trust provides equal opportunities for career progression or promotion has also increased from 79.3% to 83.5%.

The proportion of disabled staff reporting that they felt pressured to attend work when feeling unwell has decreased to from 39.3% in 2020 to 29.9% in 2021 and the percentage of disabled staff believing that adequate reasonable adjustments were made to enable them to carry out their work has remained at 71.6%.

The overall staff engagement score remains slightly lower for disabled staff in comparison to non-disabled staff at 7.0 compared to 7.5.

3.0 WDES progress in 2020/21

A number of initiatives and work has been undertaken by the Trust over the last year which was captured in the WDES action plan for 2020/2021. A summary of these are as follows:

- The Trust achieved the Disability Confident Level 2 status.

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- An EDI audit was undertaken by an external EDI consultant on the Trust's recruitment policy and processes in order to identify any improvements that could be made to ensure inclusiveness at each stage.
- Recruitment training for staff has also been reviewed to ensure that anyone involved in recruitment is fully aware of their responsibilities under the Equality Act.
- Bullying & Harassment training for managers was revised to include a focus on appropriate values and behaviours and to highlight that any form of discriminatory behaviour or language is unacceptable.
- The Trust has worked collaboratively with the Cheshire & Merseyside Equality Group and consequently launched a Reasonable Adjustment Process for Managers which can be accessed via the Intranet page.
- The Attendance Management Training was reviewed in relation to disability to ensure disabled staff do not feel under pressure to attend work when unwell.
- The Trust has launched the NHS Employers Health Passport and line manager guidance to allow staff to store any information regarding a disability, long term health condition, mental health issue or learning disability/difficulty.
- A new quarterly Staff Culture and Engagement Pulse Survey has been implemented to further understand the views of staff and ensuring all staff have a voice.
- Culture and Engagement Groups across all divisions have been created in order to enable more direct change and improvements at a local level.
- The Trust's Equality Impact Analysis policy was updated and reviewed by an external EDI Consultant, training will be rolled out in 2021.

4.0 Conclusion and next steps

Whilst a recruitment audit has been undertaken to try to ensure that our policies and recruitment materials are inclusive, free from bias and promote equality, the Trust has committed through the Disability Confident Level 2 action plan to ensure that we continue to improve employment, career opportunities and experiences for disabled staff. It is clear that there is under reporting for staff in senior roles and further work is required to encourage staff to update their personal records in relation to disability.

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Our focus this year will be to establish a Disability and Long Term Health Conditions Staff Network Group either for CCC solely or with co-located Trusts in Liverpool and help to raise awareness and improve engagement with disabled staff. The development of the staff network will raise the profile of disabilities and will give staff a voice to make changes within the organisation.

The past year has been challenging but through the appointment of a Head of EDI working across CCC, The Walton Centre and Alder Hey Children's Hospital we aim to have a more strategic, cohesive approach, learning from each other and in turn improving the working lives of our disabled staff and increasing opportunities for future employees.

Appendix 1 WDES metrics report

Detailed below is the organisation's WDES data as at 31 March 2021

Metric 1- Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including executive board members) compared with the percentage of staff in the overall workforce.

(Data source: ESR).

1a. Non-clinical workforce

	Disabled staff in 2020	Disabled Staff in 2021	Disabled staff in 2020/2021	Non-disabled staff in 2020	Non-disabled staff in 2021	Non-disabled staff in 2019/2020	Unknown/null staff in 2020	Unknown/null staff in 2021	Unknown/null staff in 2020/2021
	Percentage (%)	Percentage (%)	% points difference (+/-)	Percentage (%)	Percentage (%)	% points difference (+/-)	Percentage (%)	Percentage (%)	% points difference (+/-)
Cluster 1 (Bands 1 - 4)	2%	3%	+1%	93%	92%	-1%	5%	5%	0%
Cluster 2 (Band 5 - 7)	4%	5%	+1%	85%	85%	0%	11%	10%	-1%
Cluster 3 (Bands 8a - 8b)	2%	2%	0%	88%	92%	+4%	9%	7%	-2%
Cluster 4 (Bands 8c – 9 & VSM)	0%	0%	0%	100%	100%	0%	0%	0%	0%
Total									

1b. Clinical workforce

	Disabled staff in 2020	Disabled staff in 2021	Disabled staff in 2020/2021	Non-disabled staff in 2020	Non-disabled staff in 2021	Non-disabled staff in 2020/2021	Unknown/null staff in 2020	Unknown/ null staff in 2021	Unknown/null staff in 2020/2021
	Percentage (%)	Percentage (%)	% points difference (+/-)	Percentage (%)	Percentage (%)	% points difference (+/-)	Percentage (%)	Percentage (%)	% points difference (+/-)
Cluster 1 (Bands 1 - 4)	2%	3%	+1%	94%	94%	0%	4%	4%	0%
Cluster 2 (Band 5 - 7)	4%	4%	0%	88%	89%	+1%	8%	4%	-4%
Cluster 3 (Bands 8a - 8b)	0%	0%	0%	85%	83%	-2%	15%	17%	+2%
Cluster 4 (Bands 8c – 9 & VSM)	0%	0%	0%	75%	82%	+7%	25%	18%	-7%
Cluster 5 (Medical and Dental staff, Consultants)	0%	0%	0%	78%	86%	+8%	22%	15%	-7%
Cluster 6 (Medical and Dental staff, Non-consultant career grade)	0%	0%	0%	88%	92%	+4%	13%	8%	-5%
Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades)	0%	0%	0%	100%	100%	0%	0%	0%	0%
Total									

Metric 2 – Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts

(Data source: Trust's recruitment data)

	Relative likelihood in 2019	Relative likelihood in 2020	Relative Likelihood in 2021	Relative likelihood difference (+-)
Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff	**2.01**	**2.14**	**0.86**	**-1.28**

A figure below 1:0 indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting

Metric 3 – Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

(Data source: Trust's HR data)

	Relative likelihood in 2019/20	Relative likelihood in 2020/2021	Relative likelihood difference (+-)
Relative likelihood of Disabled staff entering formal capability process compared to non-disabled staff	**0.00**	**0.00**	**0.00**

Within the last two years we have not had any recorded disabled staff that have entered a formal capability process

Metric 4 – Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse.

(Data source: Question 13, NHS Staff Survey)

	Disabled staff responses to 2019 NHS Staff Survey	Non-disabled staff responses to 2019 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-disabled staff responses 2019	Disabled staff responses to 2020 NHS Staff Survey	Non-disabled staff responses to 2020 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-disabled staff responses 2020
	Percentage (%)	Percentage (%)		Percentage (%)	Percentage (%)	
4a) Staff experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months	**15.2%**	**14.4%**	**0.8%**	**14.3%**	**9.7%**	**+4.6%**
4b) Staff experiencing harassment, bullying or abuse from managers in the last 12 months	**17.4%**	**9.8%**	**7.6%**	**17.9%**	**5.4%**	**+12.5%**
4c) Staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	**27.4%**	**15.7%**	**11.7%**	**22.5%**	**9.8%**	**+12.7%**

4d) Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	**45.6%**	**40.7%**	**5.0%**	**45.8%**	**48.2%**	**+2.4%**

Metrics 5 – 8

(Data source: Questions 14, 11, 5, 28b, NHS Staff Survey)

	Disabled staff responses to 2019 NHS Staff Survey	Non-disabled staff responses to 2019 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-disabled staff responses 2019	Disabled staff responses to 2020 NHS Staff Survey	Non-disabled staff responses to 2020 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-disabled staff responses 2020
	Percentage (%)	Percentage (%)		Percentage (%)	Percentage (%)	
Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.	**79.3%**	**86.7%**	**-7.4%**	**83.5%**	**92.5%**	**-9%**
Metric 6 - Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	**39.3%**	**22.5%**	**16.8%**	**29.9%**	**19.8%**	**-10.1%**
Metric 7 - Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	**38.8%**	**47.5%**	**-8.7%**	**45.0%**	**55.2%**	**-10.2%**
Metric 8 - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	**72.1%**	**N/A**	**N/A**	**71.6%**	**N/A**	**N/A**

Metric 9 – Disabled staff engagement

(Data source: NHS Staff Survey)

	Disabled staff engagement score for 2019 NHS Staff Survey	Non-disabled staff engagement score for 2019 NHS Staff Survey	Difference (+/-) between Disabled staff and non-disabled staff engagement scores 2019	Disabled staff engagement score for 2020 NHS Staff Survey	Non-disabled staff engagement score for 2020 NHS Staff Survey	Difference (+/-) between disabled staff and non-disabled staff engagement scores 2020
a) The staff engagement score for Disabled staff, compared to non-disabled staff.	**6.7**	**7.3**	**-0.6**	**7.0**	**7.5**	**+0.5**

b) Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?
The NHS Staff Survey has enabled disabled staff to feedback on what they think the Trust is doing well and areas of improvement.

Metric 10 – Percentage difference between the organisation's board voting membership and its organisation's overall workforce

(Data source: NHS ESR and/or trust's local data)

	Disabled Board members in 2020	Non-disabled Board members in 2020	Board members with disability status unknown in 2020	% points difference (+/-) Between Disabled and non-disabled Board members in 2020	Disabled Board members in 2021	Non-disabled Board members in 2021	Board members with disability status unknown in 2021	% points difference (+/-) Between Disabled and non-disabled Board members in 2021
	Percentage (%)	Percentage (%)	Percentage (%)		Percentage (%)	Percentage (%)	Percentage (%)	
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by Exec/non-exec and Voting/non-voting.	**Exec = 0%** **Non-exec = 14%** **Voting = 9%** **Non-voting =0%**	**Exec = 100%** **Non-exec = 86%** **Voting = 91%** **Non-voting = 100%**	**Exec = 0%** **Non-exec = 0%** **Voting = 0%** **Non-voting = 0%**	**Total Board = 8%** **Overall workforce = 3%** **Difference = 5%**	**Exec= 0%** **Non-exec= 13%** **Voting= 0%** **Non-voting= 0%**	**Exec= 100%** **Non-exec= 87%** **Voting= 100%** **Non- voting= 100%**	**Exec = 0%** **Non-exec= 0%** **Voting= 0%** **Non-voting= 100%**	**Total Board = 7%** **Overall workforce= 1%** **Difference = 6%**

ACTION PLAN

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Appendix 2 - WRES action plan 2020/21

Last updated: 15th September 2021

Updated by: Catrin Wilde and Emma Dunroe

Metric	Objective	Action/s	Timescales	Lead/s	Why	Comments
Metric 1- Percentage of staff in AfC pay bands OR Medical and Dental sub groups and Very Senior Managers (VSM) (including Executive Board members) compared with the percentage of staff in the overall workforce.	Ensure staff update their ESR records and declare disabilities	Develop appropriate communication to raise awareness of the importance of self-recording disability and the Trusts legal obligation in reporting mandatory information. Provide particular focus on Bands 8 and above and medical workforce.	December 2021	Workforce Information Lead/Head of Medical Workforce Communication Team	To improve data quality To understand the needs of our staff	Communication piece developed and just needs to be shared.
Metric 2 – Relative likelihood of Disabled staff	Reduce inequality in recruitment process	Continue to ensure training is offered to recruiting managers	All 2021-22	Recruitment Manager	To improve employment and career	Actions have been completed during 2020-21 but to continue

compared to non-disabled staff being appointed from shortlisting across all posts		Undertake review of recruitment activity on a six monthly basis. Complete the action plan in relation to Disability Confident Employer level 2.	January and July 2022 All 2021-22	Recruitment Manager EDI Lead	opportunities of disabled staff	with into 2021-22.
Metric 3 – Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	Reduce inequality in capability procedures	Continue to review data and present bi-annually	January and July 2022	HR Business Partnering Team	To ensure fairness in application of performance management policy	Action has been completed during 2020-21 but to continue with into 2021-22.
Metric 4 – Percentage of Disabled staff compared to non-disabled staff experiencing	Reduce the number of disabled staff experiencing bullying, harassment and abuse.	Following the recruitment of additional Freedom to Speak Up (FTSU) Champions promote their role in providing	January 2021	FTSU Guardian	To ensure Trust has inclusive culture with zero tolerance towards	There have been more FTSU champions recruited but to develop a way to promote these.

harassment, bullying or abuse.		confidential sign posting advice. Work closely with the disability staff network, supporting staff to share experiences, giving them a voice to speak up			bullying & harassment.	
Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.	Improve staff survey response in relation to number of staff believing staff provide equal opportunities for career progression	Work closely with the staff network to identify areas for development to enhance staff experiences	November 2021	Learning & Organisational Development Team Staff network	To ensure disabled staff feel valued and able to progress within their careers. To build a culture of openness and inclusivity.	
Metric 8 - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them	To ensure managers are able to put suitable adjustments in place for disable staff	To continue to promote the use of the recently launched Reasonable Adjustments SOP for managers.	December 2021 February 2021	HR Business Partnering Team Learning & Organisational	To ensure managers have the appropriate guidance to give proper consideration to reasonable adjustments for disabled staff	We have a wellbeing champion Staff network preparation has started and the aim is to launch this in line with

to carry out their work.		Continue to promote awareness and understanding of unconscious bias through our managers passport and launch the Trusts role essential unconscious bias training		Development Team		National Disability History month.
Metric 9 – Disabled staff engagement	Improve staff engagement scores for disabled staff from….	Launch Disability and Long Term Health Conditions Staff Network Group. Provide training sessions for staff via webinar regarding disabilities Introduce staff profiles and communications campaign supporting disabilities raising the awareness to staff Continue to encourage disabled colleagues to participate and	January 2022 November/December 2021 January 2021	EDI Lead Communications team Learning & Organisational Development Team	To increase the focus and provide support for disabled staff	We currently have a Wellbeing Champion Staff network preparation has started and the aim is to launch this in line with National Disability History month. Make staff more aware of unseen disabilities. Provide them with information

		provide feedback in the NHS Staff Survey and the quarterly Staff Culture and Engagement Survey, feedback results into the newly developed Divisional Culture and Engagement Groups				regarding staff experiences.
Metric 10 – Percentage difference between the organisation's board voting membership and its organisation's overall workforce	Reduce the gap between Board representation and overall representation of disabled staff in the workforce.	Review recruitment processes for non-executive directors to ensure we attract diverse applicants. Review learning from reciprocal mentoring scheme for BAME staff due to be introduced to the Trust and explore the application of the scheme for disabled staff.	March 2021 June 2021	Recruitment Manager EDI Lead	To demonstrate visible leadership at senior levels.	

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	29 September 2021
Agenda item:	P1-150-21
Title:	Staff Survey & Culture and Engagement Update
Report prepared by:	Stephanie Thomas, Head of Learning and OD
Executive Lead:	Jayne Shaw, Director of Workforce and Organisational Development
Status of the report: (please tick)	Public ☒ Private ☐

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

Purpose of the paper/key points for discussion:	Staff are the trusts key resource; the engagement, satisfaction and health and well-being of the workforce is of critical importance to optimal performance and enabling achievement of the strategic objectives. This reports provides the Board of Directors with an update on process since the 2020 national NHS Staff Survey, along with an update on the new quarterly NHSE/I requirement to undertake a quarterly Culture and Engagement Survey. The report also provides an overview of the national changes to the 2021 NHS Staff Survey.

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

Next steps required:	The Board of Directors is asked to; • Note the contents of this report and the work undertaken to date • Note the introduction of the quarterly Culture and Engagement Pulse • Note the results from the July 2021 Culture and Engagement Pulse • Note the changes to the NHS Staff Survey for 2021 • Request a future report detailing the key findings from the 2021 Staff Survey

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.	☒
If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	☒

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

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Staff Survey & Culture and Engagement Update

Stephanie Thomas
Head of Learning and Organisational Development

Version: 1.0 Ref: FCGOREPO Review: May 2024

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1. Introduction

The annual NHS Staff Survey is the largest annual workforce survey in the world and is one of the most widely used methods for measuring staff engagement within the NHS. The survey is a mandated requirement for all NHS provider organisations, with results published nationally and forming part of the CQC framework.

In addition to the annual survey, the trust also undertakes the quarterly staff friends and family survey to act as a temperature check in relation to staff recommending the trust as a place to work and as a place to receive care. In June 2021 this survey was revised by NHSE/I to focus on the nine questions that make up the staff engagement score from the annual Staff Survey.

Both surveys provide the trust with a valuable source of insight in understanding the perspectives and concerns of staff, and whether progress is been made as part of the trusts People strategy.

This reports provides the Board of Directors with an update on process since the 2020 national NHS Staff Survey, along with an update on the new quarterly NHSE/I requirement to undertake a quarterly Culture and Engagement Survey.

The report also provides an overview of the national changes to the 2021 NHS Staff Survey.

2. 2020 Staff Survey Results

As previously reported the 2020 Staff Survey took place during September 2020 - November 2020, not only was this in the midst of the pandemic, but also during the transition period of opening CCC-L.

The trusts response rate for the 2020 survey was 58%, which although was a decline of 8% from the previous year, it was above the sector average of 56%. It should be noted that due to the challenging circumstances in which the 2020 Staff Survey was completed during, a national decline in response rates was seen.

In 2020 the trust improved in 9 out of the 10 themes, with two themes, Health and Wellbeing and Staff Environment – Bullying and Harassment seeing significant improvements. The trust was also top performing specialist acute trust in 4 out of the 10 themes. See appendix 1 for further details.

Whilst the trust was delighted to see the improvements in the survey, it remains committed to ensuring it continues to create an environment and culture that enables the trust to be a great place to work and to receive care.

3. Staff Friends and Family Test / Staff Culture and Engagement Survey

In addition to the national Staff Survey the trust also conducts a quarterly Staff Friends and Family Test (SFFT), in line with NHSE/I provider requirements.

SFFT is a feedback tool which enables NHS staff to give regular feedback about their organisation as a place of work and to receive care or treatment.

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During the pandemic, there was no formal requirement by NHSE/I to undertaken the survey, however the trust continued to conduct the survey as a means of gathering intelligence from the workforce, until the survey was withdrawn nationally in April 2021.

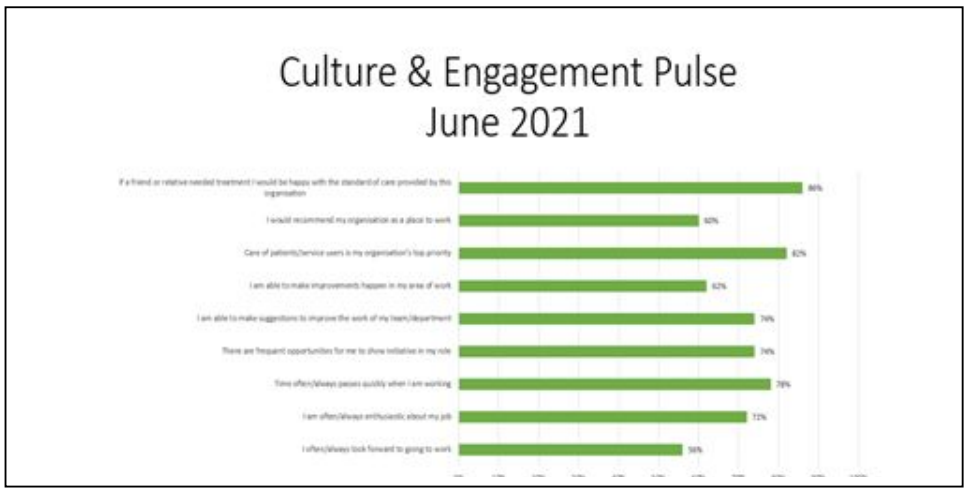
In June 2021 NHSE/I announced a new requirement for all NHS provider organisations to undertaken a quarterly Staff Survey that asks the nine engagement theme questions from the annual Staff Survey, during the months of July, January and April (no survey is undertaken October due to the annual Staff Survey)

These questions are;

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

The survey has been introduced following a parliamentary request for greater and more regular national reporting on the experiences of NHS staff and to further embed the NHS People Promise. The new quarterly survey will provide this consistency and a standardised approach nationally.

The trust undertook its first Culture and Engagement Pulse in July 2021 and received the following results;



Results at a divisional level have been shared with the divisions and feed into divisional culture and engagement improvement plans.

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As this was the first time the trust had undertaken the survey, it was not possible to complete any further analgise of performance against comparable month's data, however moving forward this will be provided in line with the quarterly survey reporting schedule at both a trust and divisional level.

It is also anticipated that a new engagement index will be included on the new single oversight framework, to enable greater regional and national benchmarking.

4. Process and deliverables

Following the results of the 2021 Staff Survey a key focus has been on supporting the implementation of divisional culture and engagement groups and the development of local action plans to drive and embed improvements at a more local team level.

The culture and engagement groups have developed local improvement plans, based on their Staff Survey results and other workforce intelligence, ensuring the focus is on things that really matter to staff within these areas. Process against these plans are reviewed and monitored during the divisional performance review meetings.

Eight culture and engagement groups are now in place, covering all divisions across the trust. These groups not only focus on improvements within their area, but are also support wider trust communications and disseminating key messages and activities across all areas of the organisation. They also provide vital staff intelligence around issues, concerns and/or areas for celebration and best practice.

The trust has also contained to focus on health and wellbeing, staff morale and staff engagement as key corporate priorities.

Key deliverables include;

- Set up the Bright Ideas Scheme so we can hear colleague's views on how we can further improve patient and staff experience.
- 38 staff engagement sessions have been held as part of the review of the trusts values to gain the thoughts and opinions of staff in refreshing the values.
- Introduced e-cards as a way to send a compliment to a colleague or team in recognition of their support
- Revamped the monthly staff awards scheme
- The Trust gifted staff a 3.5 hours wellbeing pass and a £25 gift voucher in recognition of hard work and support during the pandemic
- Provided a series of training courses and masterclasses to support staff to improve their mental health and wellbeing
- Further development of the ePADR process to include a health and wellbeing discussion and strengthens the process for identify talent
- Promoted various health and wellbeing events and initiatives with prizes and incentives to raise awareness and to encourage positive action e.g. Step Challenge, Stress Awareness 30 day challenge, Nutrition and Hydration Week, Coffee Roulettes and Cycle Challenge

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- Invested in our Mental Health First Aiders. Two of our MHFA's undertook the Instructor course and they trained a further 10 staff members to become MHFAs
- Launched regular blogs from senior staff, to keep you up-to-date with what is happening across the Trust

Further details can be viewed in the 'You said…..We did' document available here .

5. Staff Survey 2021

2021 will see the most significant changes made to the survey to date, with the survey being designed to align with the NHS People Promise.

From this year the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of our NHS people, the things that would most improve staff working experience. The People Promise is made up of seven elements;

To improve inclusion, belonging and encourage increased participation all trusts will be required to undertaken a full census, this is something CCC implemented a new of years ago, to ensure all staff views could be heard.

Eligibility criteria has be extended this year to provide the opportunity for staff on long term sickness absence of more than 90 days and staff employed by an NHS organisation working on secondment within another NHS organisation for more than 12 months to complete the Staff Survey.

The 2021 Staff Survey opened on 14th September and will close on 26th November 2021 and will be an on-line survey sent to staff via their NHS email address, with the exception of staff on long term sickness or maternity leave, who will be sent a paper copy of the survey with an option to complete on-line via a QA code.

The L&OD team will provide weekly communications on the Staff Survey, including team completion rates and will also be out and about across the staff supporting and encouraging staff to complete the survey.

As with previous years a number of individual and team incentives will be offered as a means of encouraging staff to participate in the survey and to share their views and experiences.

The trust has set a target completion rate of 60%.

NHSE/I are yet to confirm the date for publication of the national results, although this is accepted to be towards the end of January 2022.

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6. Conclusions

Staff are the trusts key resource; the engagement, satisfaction and health and well-being of the workforce is of critical importance to optimal performance and enabling achievement of the strategic objectives.

The trust is committed to ensuring it creates an environment and culture that enables staff to be at their best and to deliver the best care of patients.

7. The Board of Directors is asked to;

- Note the contents of this report and the work undertaken to date
- Note the introduction of the quarterly Culture and Engagement Pulse
- Note the results from the July 2021 Culture and Engagement Pulse
- Note the changes to the NHS Staff Survey for 2021
- Request a future report detailing the key findings from the 2021 Staff Survey

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Appendix 1 – 2020 Staff Survey Results Summary

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	29th September 2021
Agenda item:	P1-151-21
Title:	Appraisal and Revalidation- Annual Board Report and Statement of Compliance
Report prepared by:	Medical Education Team
Executive Lead:	Sheena Khanduri – Medical Director
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Workforce Transformation Committee
Date & decision:	21st September 2021

Purpose of the paper/key points for discussion:	This paper provides the Board with assurance that as a Trust we are meeting the mandatory requirements in relation to medical appraisal and revalidation. The paper outlines the Trust responses to a number of compliance metrics, provides an update on previously identified actions and details our priorities for improving performance moving forward .

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

Next steps required:	Development of communication plans to share our People Commitment with the organisation Development of operational delivery plans to support the 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.	☒
If we do no support and promote employee health and wellbeing this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence.	☒

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

1 | Annex D – annual board report and statement of compliance

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess

their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) Help the designated body in its pursuit of quality improvement.

b) Provide the necessary assurance to the higher-level Responsible Officer and

c) Act as evidence for CQC inspections.

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Designated Body Annual Board Report

Section 1 – General:

The Clatterbridge Cancer Centre NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N/A **Comments:** Dr Sheena Khanduri, Medical Director is the nominated Responsible Officer. **Action for next year:** Continue to maintain nominated Responsible Officer.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes **Action from last year**: None **Comment**s: No issues reported. **Action for next year:** None.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: N/A **Comments:** A regularly updated list is maintained by the Medical Education Team on GMC Connect. This is cross referenced with list of joiners and leavers. An area of potential risk has been identified where newly appointed practitioners may not update connections with GMC in a timely manner. The prescribed list is kept up to date as doctors join or leave the Trust or the Head of Medical Workforce (HoMW). All policies in place to support medical revalidation are actively monitored and regularly reviewed. **Action for next year:** For HoMW to ensure that all newly appointed practitioners have up to date connection between GMC and CCC.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: N/A **Comments:** The Appraisal Lead and Head of Medical Workforce regularly monitor and review policies to support medical revalidation. This includes guidance issued during Covid pandemic. In addition, we have developed a specific CCC medical appraisal checklist based on the Responsible Officer and Appraisal Network document "Simplifying Appraisal Preparation for Doctors". This has been devised to ensure appraises and their appraisers are aware of the minimum requirements for appraisal documentation. The Head of Medical Workforce or Appraisal Lead quality assure all completed appraisals against this checklist. The appraisal policy is subject to 3 yearly review and document control. **Action for next year:** Appraisal Lead and Head of Medical Workforce to actively monitor and review appraisal policy.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: An Internal Audit of Medical Appraisal and Revalidation was undertaken by MIAA between August and November 2019. The audit concluded that there is an adequate system of internal control and concluded there was moderate assurance around our systems and processes. The audit identified a 6 actions to improve our assurances around appraisals and revalidation; 1. The Trust needs to ensure the policy requirements are complied with 2. The Trust undertakes 6 monthly audits reconciling the tracking spreadsheet to the GMC Connect database to ensure all appropriate staff feature on it and this is reported as part of quarterly update to Quality Committee. 3. Interface between CRMS database and other Trust databases e.g. Datix for incidents should be progressed to enable a smoother information gathering process for appraisal preparation. 4. All sections of the quarterly report are completed and a future policy review include the requirement for a quality assurance mechanism to assure the completeness of the performance report are defined. 5. An Appraiser Support Group should meet regularly to highlight common areas of concern and improvements for appraisal process

6. Formal agreement and sign off of the Medical Appraisal and Revalidation policy by the Quality Committee at earliest opportunity

All of these recommendations have been implemented.

Comments:

A review of medical appraisals and validation was conducted at the Trust in accordance with the requirements of the 2019/20 Internal Audit Plan, as approved by the Audit Committee. The overall objective was to review the Trust's systems and processes in place for the delivery and monitoring of medical staff appraisals and monitoring of compliance with GMC Registration revalidation requirements. There were 6 recommendations identified which were reviewed and steps put in place to address the issues identified.

A Higher level Responsible Officer Quality Review (HLROQR) was previously undertaken in December 2018, reporting May 2019 and action plan included as part of Statement of Compliance report to Trust Board.

The quality of appraisals is reviewed annually by the Appraisal Lead. Results of the review for 2019-20 appraisal year were very positive. There was an increase in the quality of appraisals overall, the score using the externally validated "Excellence" tool increased to a mean scare of 18/20, compared to 16/20 in 2018-19.

Internal review of appraisal evaluation is undertaken and reviewed by the appraisal lead. There was excellent feedback on the appraisal evaluations which are completed by all appraises post appraisal. For example, the mean score on 1.1 to the statement "The appraiser was skilled in conducting my appraisal", where 1 is "strongly agree" and 5 is "strongly disagree". Similarly, there was a mean score of 1.5 to the statement "my appraisal was worthwhile".

There were also a number of excellent comments, including "My appraiser managed to make the appraisal process, previously regarded as a 'waste of time' into a painless and meaningful process" and "My appraisal was a very thorough look at all that I have done and not done this year and a sensible and pragmatic look ahead at what I might set myself as goals and how to work towards them this year".

Action for next year: Repeat review cycle to ensure standards are maintained.

To review the Trusts medical workforce systems (CRMS) and identify if there are any digital solutions to further improve the systems and processes in place for the delivery and monitoring of medical staff appraisals and GMC Registration revalidation requirements

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: N/A

Comments: Training grade doctors with a National Training Number under placement at CCC are appraised by HENW. Locum doctors are appraised in the same way as substantive post. Agency locum doctors are the responsibility of the agency/individual doctor.

Action for next year: Ensure connection made for CCC when joining Trust. Maintain communication with Medical Staffing for new doctors details including if they are a Trust doctor/NHS locum or agency.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: N/A

Comments: The 2020 appraisal model was adopted in this Trust from April 2021. Feedback has generally been positive, although there is a significant increase in work for appraisers; verbal reflection, discussion of the impact of Covid on individuals and reduction in the amount of submitted information increase the time taken for the meetings and for writing the appraisal summary.

In this Trust, not all doctors have completed the new proforma with some still opting to complete the usual electronic format. A challenge has been that completion of 360 degree assessment. Obtaining patient feedback using the paper based system is hampered by the lack of face to face consultations for some practitioners and the absence of a digital solution from our 360 assessment provider (PremIT).

The Trust successfully developed a local solution using Cancer Support Workers to identify patients and collate feedback forms which are then sent to PremIT.

Action for next year:

1) Review use of 2020 template, await guidance for continuation.
2) Review appraisal reminder email to include revalidation date and last 360 degree assessment date.
3) Encourage 360 assessment 2 years before revalidation due.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A.

Comments: See above.

Action for next year: See above.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: N/A.

Comments: A policy is in place and is regularly reviewed by the Appraisal Lead and HoMW. The Medical Appraisal policy used this year was in line with national Covid guidelines.

Action for next year: Trust policy will be updated to reflect this and will be approved by the Education Governance Committee.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: 1 new appraiser.

Comments: 2 further new appraisers approached. Training pending. Currently there are 13 appraisers for 86 connections. This will shortly increase to 15 reducing the average number of appraisal meetings per year to 5-6 sessions. A further 4 appraisers are needed to reduce the ratio to the recommended 4-5 appraisees to 1 appraiser.

Action for next year: Recruit more appraisers. Reduce burden on appraisers with >8 appraisees as a priority.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

The new simplified and supportive appraisal will continue to be for the first 6 months of the new appraisal year, from April 2021 at least until the end of September 2021 and is likely to be longer term, given the very positive feedback which has been received from any quarters.

Action for next year: Repeat review cycle and arrange virtual refresher training.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: The significant improvements seen since the implementation of the Action Plan in 2018/19 has continued this year.

Comments: The Trust is monitored through the Annual Organisational Audit process which is administered by the Regional Offices of the NHS England who collect a standard data set. The Trust participates in this audit and a quarterly return is submitted on appraisal and revalidation which is also captured by NHS England. The Trust is due to complete and submit the Annual Organisational Audit for 2020-21 by the 24 September 2021. Findings are reported to the Trust Board.

Number of appraisals undertaken per quarter is reported to Workforce Committee.

The quality of appraisals is reviewed annually by the Appraisal Lead. Results of the review for 2019-20 appraisal year were very positive. There was an increase in the quality of appraisals overall, the score using the “Excellence” tool increased to a mean score of 18/20 compared to 16/20 in 2018-19.

Action for next year: Continue to review appraisal process, engagement policy to maintain current standard.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: *Clatterbridge Cancer Centre NHS Foundations Trust*	
Total number of doctors with a prescribed connection as at 31 March 2021	**79**
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	**35**
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	**44**
Total number of agreed exceptions	**44**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Revalidations were suspended as per the guidance during the Covid pandemic.

Comments: Any doctor wishing to revalidate during this time, with completed paperwork was able to do so. 8 recommendations were submitted during that time period with no delays and no deferrals.

Action for next year: Appraisal and revalidation have now resumed as normal. Continue quarterly appraisal and revalidation meeting to identify doctors approaching submission date.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: N/A

Comments: Following revalidation recommendation, an email is sent to the doctor. For deferral and non-engagement this is the Head of Medical Workforce follow up by written communication and a meeting between the Responsible Officer and doctor.

Action for next year: Continue the current process.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

> **Action from last year:** Clinical Governance leads are in post for each directorate to oversee patient safety, guidance on complaints, incidents and attendance at relevant incident panels.
>
> **Comments:** The posts are currently under review following a restructuring of directorates and in response to feedback of the increased and unforeseen workload pressures for some of the leads.
>
> Site Reference Groups (SRGs) for each cancer tumour site meet regularly to review treatment protocols and updates. Changes to protocols must be approved by the SRG and Drug and Therapeutics Committee (in the case of systemic treatments) prior to usage.
>
> Treatment outside of the approved protocols requires approval by the SRG before going ahead.
>
> **Action for next year:** Directorate leads to review posts and governance structure. Continue effective SRG and DTC system.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

> **Action from last year:** N/A
>
> **Comments:** The Trust has in place policy documents relating to management and investigation of incidents with the Just Culture built into the policies. In relation to concerns around a doctor's practice, the Trust would follow the policy for Responding to Concerns (Maintaining High Professional Standards) which is in line with National guidance. Where there are concerns around a doctor's practice, the Trust is required to consider the involvement of Practitioner Performance Advice (formerly the National Clinical Assessment Service (NCAS) in order to obtain an independent and fair view of the case particularly where exclusion is being considered. Individual Consultant activity data is received and uploaded by the Medical Education Team to the CRMS system. Data on complaints and Serious Untoward Incidents (SUIs) is provided for inclusion in doctor's appraisal portfolio. These should be reflected on during the appraisal process.
>
> **Action for next year:** Continue current process.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved

responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: N/A.

Comments: In relation to concerns around a doctor's practice, the Trust would follow the policy for Responding to Concerns (Maintaining High Professional Standards) which is in line with National guidance. Where there are concerns around a doctor's practice, the Trust is required to consider the involvement of Practitioner Performance Advice (formerly the National Clinical Assessment Service (NCAS) in order to obtain an independent and fair view of the case particularly where exclusion is being considered.

Action for next year: Continue current processes.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: N/A.

Comments: The Trust has a MHPS policy in which the process for management concerns is reported through Workforce Committee.

Action for next year: Continue to monitor and update policy.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: N/A

Comments: HoMW will collate information for the Responsible Officer to approve transferring information around the concerns quickly and effectively using a standard template according to the MHPS policy.

Action for next year: Continue current processes.

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None.

Comments: The Trust has in place policy documents relating to management and investigation of incidents with the Just Culture built into the policies. In relation to concerns around a doctor's practice, the Trust would follow the policy for Responding to Concerns (Maintaining High Professional Standards) which is in line with National guidance. Where there are concerns around a doctor's practice, the Trust is required to consider the involvement of Practitioner Performance Advice (formerly the National Clinical Assessment Service (NCAS) in order to obtain an independent and fair view of the case particularly where exclusion is being considered.

Action for next year: Keep signposting staff to where the relevant guidance is located and be aware of any changes to processes.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: N/A.

Comments: All employees at the Trust are processed via our Recruitment Team in line with NHS Checking standards. This includes honorary contracts. External agency, short term cover is arranged via an approved framework who adhere to the same principles.

Action for next year: Continue to operate to same standard with recruitment checks and processes.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report:** Implementation of new appraisal form during Covid-19 pandemic has been successful and well received. Two new appraisers have been trained and have begun to conduct appraisals.
- **Actions still outstanding:** None
- **Current Issues:** Recruitment of additional appraisers.
- **New Actions:**
    - To collate responses to new template, continue to recruit appraisers.
    - Review and maintain documents/policies as required under the document control process and/or in response to new guidance.
    - Consider peer review when appropriate.

Overall conclusion: Despite the challenges of the pandemic the Trust has managed to maintain the revalidation and appraisal process for all doctors with connections to Clatterbridge Cancer Centre in line with National guidance.

Section 7 – Statement of Compliance:

The Executive Management Team of Clatterbridge Cancer Centre NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

Chief Executive

Official name of designated body:

Clatterbridge Cancer Centre NHS Foundation Trust.

Name: **Liz Bishop** Signed:

Role: **Chief Executive**

Date: **September 2021**

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

Cheshire & Merseyside Cancer Alliance

Performance Report

September 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*	127%
Cancer surgery activity*	117%
SACT (inc chemo) delivery**	119%

Measure	% of pre-Covid level
Radiotherapy planning**	99%
Radiotherapy treatment**	82%
Endoscopy capacity♀	68%

- The sustained increase in SACT continues to present challenges to service delivery, however The Clatterbridge Cancer Centre is taking a number of steps to ensure that demand continues to be met. Radiotherapy activity has been comparable to pre covid levels; this % comparison has fallen in August 2021 which is due to an unusually high level of activity in August 2019.
- 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, which is increasing. The Alliance has established an endoscopy operational recovery team (EORT) to oversee and co-ordinate restoration activities.

Cheshire & Merseyside Cancer Alliance

*Data as of 13th September
** Solid tumour only (not inc. Haemato-oncology): reliable Haemato-oncology figures pre covid are unavailable
♀Assessment based on monthly DM01 endoscopy returns - latest update July 2021. activity dropped in July, whereas against a 2019 baseline that rose

Summary

Cancer waiting times performance

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

- The Alliance failed the **14 day standard** for urgent suspected cancer referrals in July, with five trusts and six CCGs falling below the 93% threshold. The overall performance of the Alliance was 90.6%*, improving from 89.58%* last month. The England average was 85.6%. CMCA was the 3rd best performing Alliance in England out of 19 against this standard.

- The Alliance failed the **62 day standard**, achieving 75.7%* (reducing from 77.2%* last month) against a standard of 85% (England average was 72.1%). Eight trusts and seven CCGs failed to meet the 62 day standard. Cheshire and Merseyside is the 7th best performing Alliance in England out of 19 against this standard.

- The number of urgent referral patients waiting **over 62 days** is significantly higher than pre-Covid levels. On 6th September 2021 there were 1,336 patients waiting more than 62 days for a diagnosis or treatment. This has increased from 988 reported last month (16th August). Of these, 273 have waited **over 104 days**. This has increased from 204 reported last month.

  The proportion of patients on urgent suspected cancer pathways who have already been on the pathway for over 62 days is in line with the England average.

Cheshire & Merseyside Cancer Alliance

* Overall figures are based on providers within Cheshire and Merseyside.

Section II: Restoration of Cancer Services – Core Metrics

1. TWW referrals received in last 7 days

Referrals were high and similar to post May and Spring bank holidays, with 2,567 patients referred (27% above pre-pandemic weekly average).

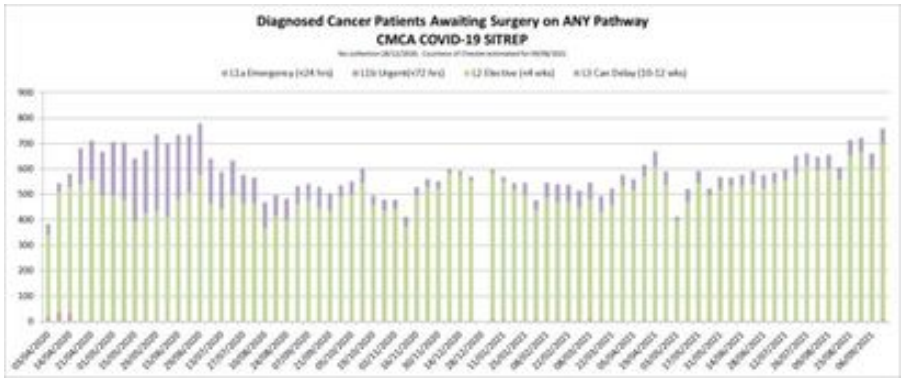
Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. Countess of Chester data estimated for 02/08/21, 09/08/2021, 16/08/21, 23/08/21, 30/08/21 and 06/09/21.

2. Diagnostic backlog (referrals without a DTT)

Currently 10,900 active patients, of which fewer than 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. Countess of Chester data estimated for 9/08/21

3. Cancer patients awaiting surgery



759 patients with a surgical DTT. 699 at L1&L2 and 60 at L3.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. Countess of Chester data estimated for 09/08/21.

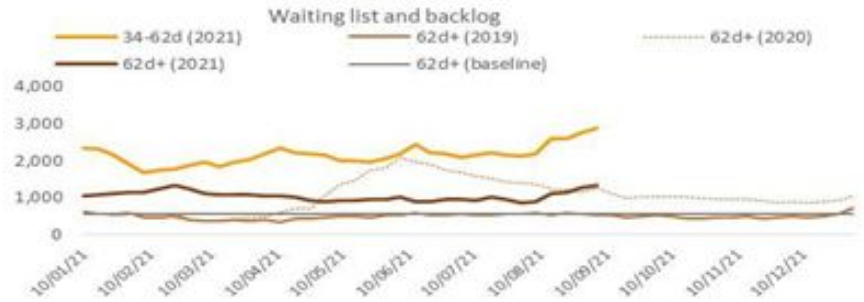
4. Cancer surgery performed in last 7 days

286 cancer operations performed

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. Countess of Chester data estimated for 02/08/21, 09/08/21, 16/08/21, 23/08/21, 30/08/21 and 06/09/21.

Restoration of Cancer Services – Core Metrics

5. Patients waiting over 62 days

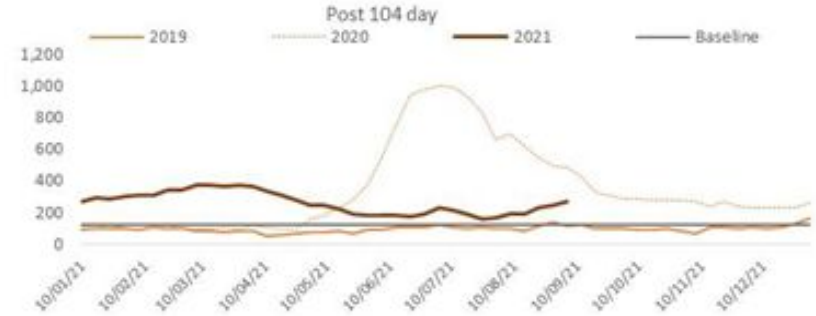


1,335 patients have waited over 62 days

- Higher than 1,269 last week.

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. Also, waiters with non-specific symptoms are not included in these national data. No data for Wirral 04/04/2021; Mid Cheshire 25/07/2021, Countess of Chester 01/08/2021 and 08/08/2021.

6. Patients waiting over 104 days



273 patients have waited over 104 days

- Higher than 247 last week.

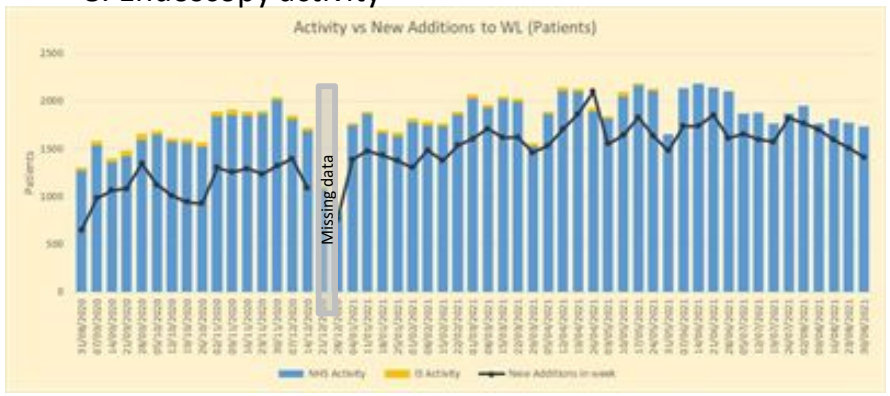
Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. Also, waiters with non-specific symptoms are not included in these national data. No data for Wirral 04/04/2021; Mid Cheshire 25/07/2021, Countess of Chester 01/08/2021 and 08/08/2021.

7. Endoscopy waiting list

Endoscopy waiting list decreased slightly to 11,230 patients.

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 21/12/20. Aintree estimated for 01/02/21, 03/05/21, 21/06/21. Aintree and Royal estimated for 24/05/21. Warrington and Halton estimated for 31/05/21. Southport and Ormskirk estimated for 05/07/21. Countess of Chester estimated for 26/07/21, 02/08/21, 09/08/21, 16/08/21, 23/08/21 and 30/08/21.

8. Endoscopy activity



Activity fell slightly (bank holiday), with 1,734 patients seen.
New additions fell with 1,416 patients added.

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 21/12/20. Aintree estimated for 01/02/21, 03/05/21, 21/06/21. Aintree and Royal estimated for 24/05/21. Warrington and Halton estimated for 31/05/21. Southport and Ormskirk estimated for 05/07/21. Countess of Chester estimated for 26/07/21, 02/08/21, 09/08/21, 16/08/21, 23/08/21 and 30/08/21.

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											16				16
Clatterbridge			6				6					9	10		44
Countess Of Chester		8	46	5	14	102					15	19	11		220
East Cheshire						19									
Liverpool Foundation Trust		7		5	20	256					11	102	17		422
Liverpool Heart & Chest															
Liverpool Women's			22												22
Mid Cheshire						35					5	8			54
Southport & Ormskirk			28	7		17					8	8	7		78
St Helens & Knowsley			11		15	30	5					12	12		97
Walton Centre															
Warrington & Halton			9			17							8		39
Wirral													17		39
Grand Total		**21**	**130**	**25**	**56**	**494**	**16**				**64**	**164**	**86**		**1,063**

Cheshire & Merseyside Cancer Alliance

Tables from national Cancer PTL

Up to 06 September 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						7									12
Countess Of Chester			9			25									46
East Cheshire															
Liverpool Foundation Trust						83						21	14		128
Liverpool Heart & Chest															
Liverpool Women's			16												16
Mid Cheshire															
Southport & Ormskirk			8										5		14
St Helens & Knowsley						7									20
Walton Centre															
Warrington & Halton															9
Wirral													7		13
Grand Total			**36**	**7**	**11**	**134**	**5**				**10**	**29**	**35**		**273**

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

- Data no longer split out for acute leukaemia or testicular
- New data for non site specific symptoms referrals (not included in national totals in graphs 5 and 6)

= fewer than 5 patients or hidden to prevent disclosure

= No PTL submission this week

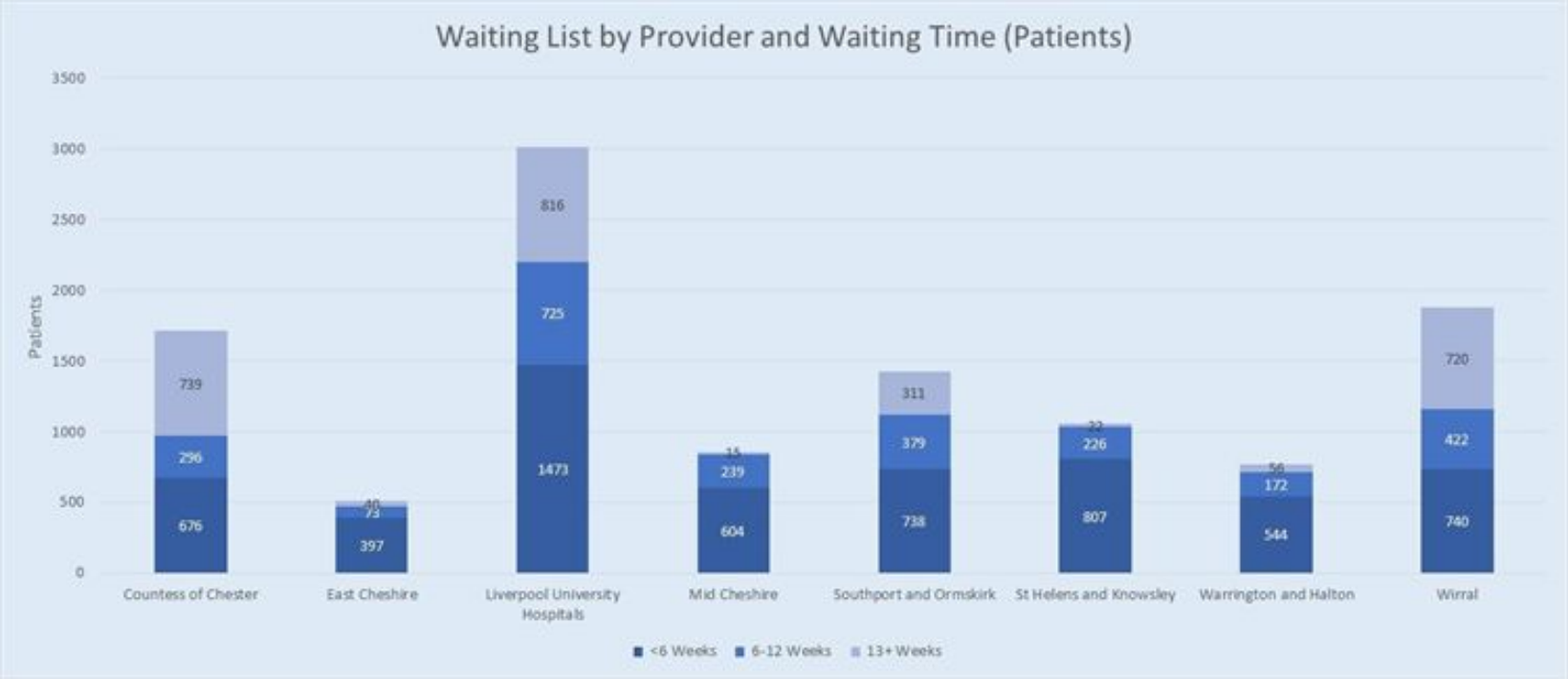
Restoration of Cancer Services – Core Metrics

There are currently 11,230 patients waiting for an endoscopy. 5,251 have waited more than six weeks, and of these 2,719 have waited 13 or more weeks (24% of the total).

There is significant variation across units, with CoCH (estimated), LUFT Aintree and Wirral having the greatest proportion of their waiting list made up of patients waiting 13 weeks or more (43%, 34% and 34% respectively).

Endoscopy (cancer and non-cancer pathways)

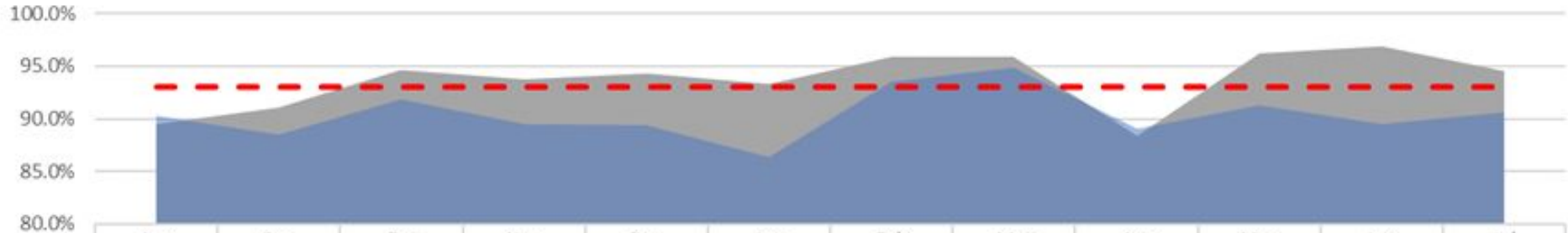
Countess of Chester estimated



Endoscopy data at 06 September 2021

Section II: 14 day standard

Percentage of patients seen within two weeks of referral in Cheshire and Merseyside



	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Aug 19 - Jul 20	89.5%	91.1%	94.7%	93.8%	94.3%	93.3%	95.9%	95.9%	88.4%	96.2%	96.8%	94.5%
Aug 20 - Jul 21	90.3%	88.5%	91.9%	89.5%	89.4%	86.3%	93.5%	94.9%	89.1%	91.2%	89.5%	90.6%
Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

Aug 19 - Jul 20 Aug 20 - Jul 21 Target

In July 2021, 90.6% of patients were seen within 2 weeks compared to 89.5% in the previous month. This is below the national target.

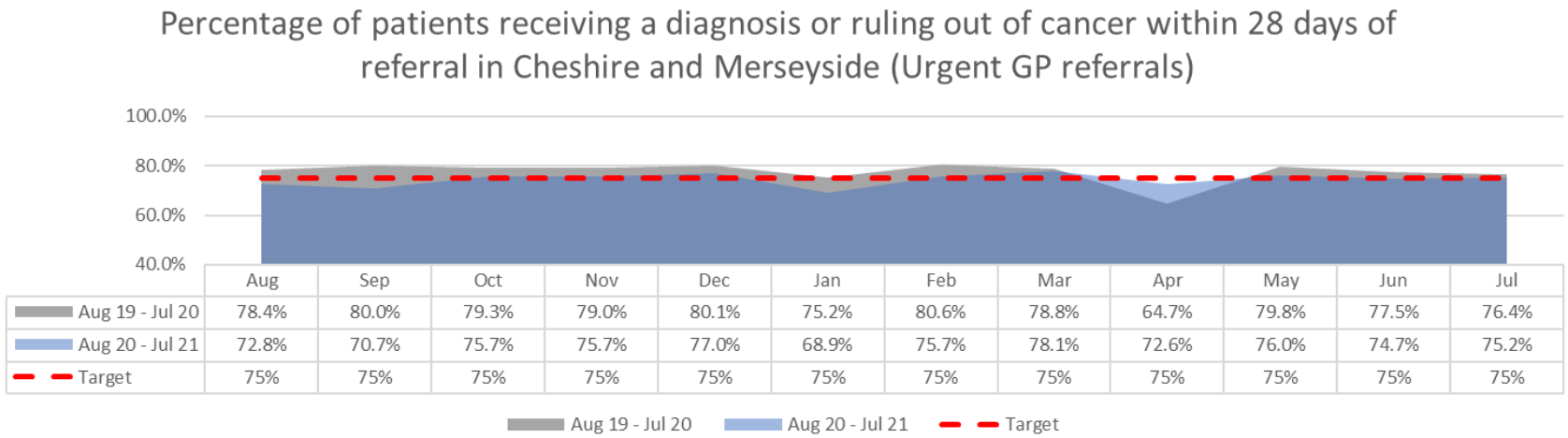
Providers not achieving the national operational standard were:

- East Cheshire 70.7% (184 breaches)
- Southport and Ormskirk Hospital 82.5% (204 breaches)
- Countess Of Chester Hospital 84% (185 breaches)
- St Helens and Knowsley Hospitals 91.1% (170 breaches)
- Warrington and Halton Teaching Hospitals 91.3% (91 breaches)

CCGs not achieving the national operational standard were:

- NHS Southport and Formby 81.7% (137 breaches)
- NHS Cheshire 88% (392 breaches)
- NHS Halton 90.4% (61 breaches)
- NHS Knowsley 92% (67 breaches)
- NHS St Helens 92.1% (80 breaches)
- NHS Warrington 92.9% (73 breaches)

Section II: 28 day standard



	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Aug 19 - Jul 20	78.4%	80.0%	79.3%	79.0%	80.1%	75.2%	80.6%	78.8%	64.7%	79.8%	77.5%	76.4%
Aug 20 - Jul 21	72.8%	70.7%	75.7%	75.7%	77.0%	68.9%	75.7%	78.1%	72.6%	76.0%	74.7%	75.2%
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 will be 75% from October 2021.
In July 2021, 75.2% of urgent GP referral patients were diagnosed or ruled out within 28 days compared to 74.7% in the previous month. This is above the national target.

Providers not achieving the expected standard were:

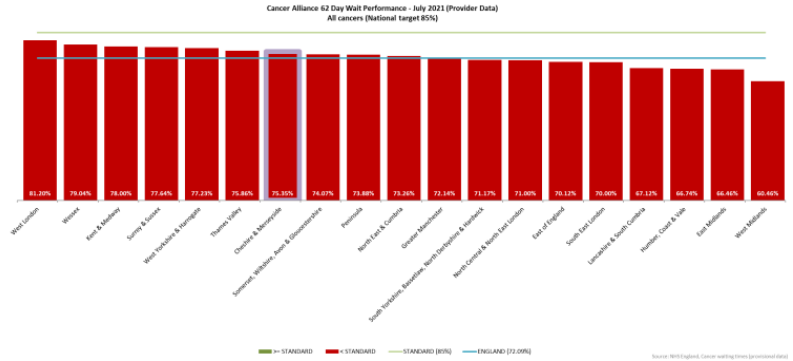
Southport and Ormskirk Hospital NHS Trust 31.8% (15 breaches)
Bridgewater Community Healthcare NHS Foundation Trust 60.1% (59 breaches)
Liverpool Heart And Chest NHS Foundation Trust 68.8% (5 breaches)
Warrington and Halton Teaching Hospitals NHS Foundation Trust 73.2% (220 breaches)
Liverpool Womens NHS Foundation Trust 59.5% (109 breaches),
Countess Of Chester Hospital NHS Foundation Trust 65.6% (341 breaches)
East Cheshire NHS Trust 68.8% (154 breaches),

CCGs not achieving the expected standard were:

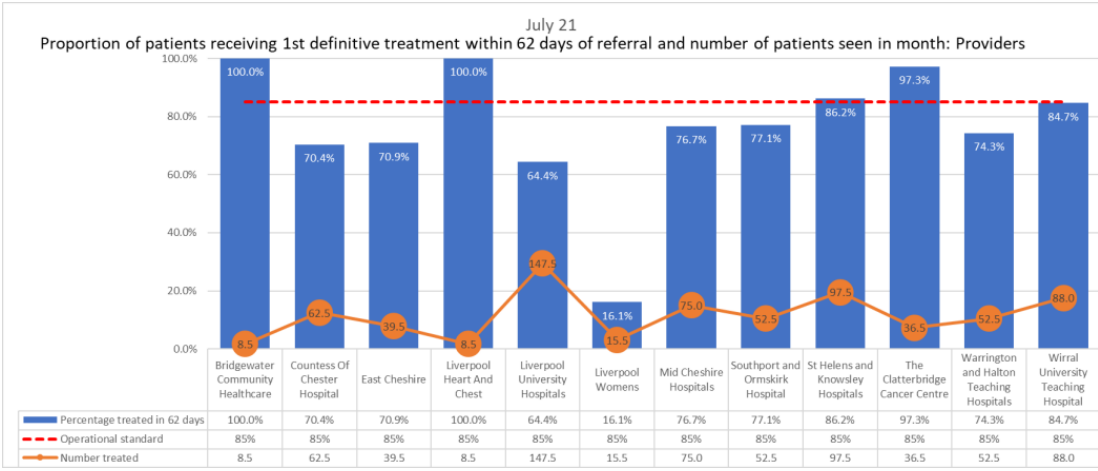
Warrington 68.9% (227 breaches)
Cheshire 72.7% (727 breaches)
South Sefton 70.6% (178 breaches),
Southport And Formby 73.8% (28 breaches)

Section III: 62 Day Standard

62 Day Performance by Cancer Alliance (July 2021)



CMCA achieved 75.7% against a standard of 85%.
CMCA was the seventh best performer. The England average was 72.1%

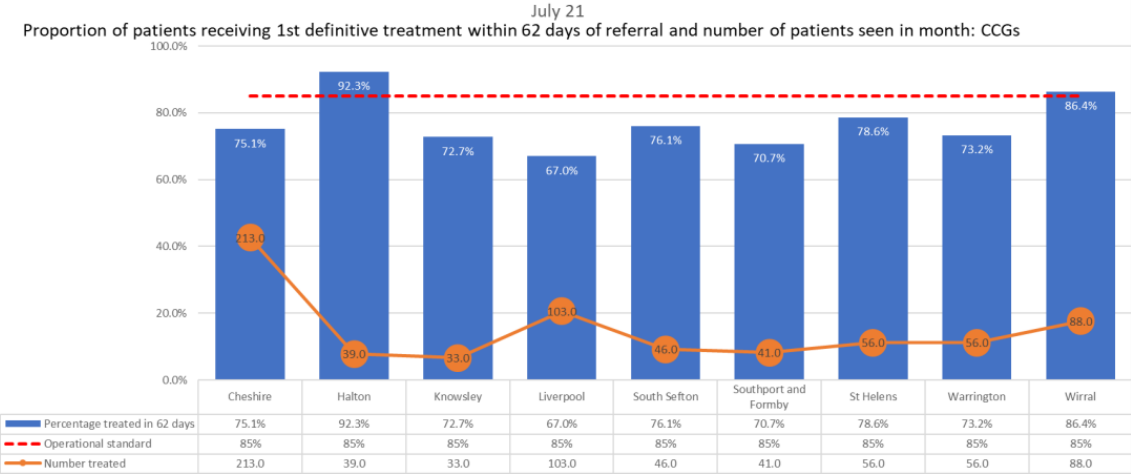


	Bridgewater Community Healthcare	Countess Of Chester Hospital	East Cheshire	Liverpool Heart And Chest	Liverpool University Hospitals	Liverpool Womens	Mid Cheshire Hospitals	Southport and Ormskirk Hospital	St Helens and Knowsley Hospitals	The Clatterbridge Cancer Centre	Warrington and Halton Teaching Hospitals	Wirral University Teaching Hospital
Percentage treated in 62 days	100.0%	70.4%	70.9%	100.0%	64.4%	16.1%	76.7%	77.1%	86.2%	97.3%	74.3%	84.7%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	8.5	62.5	39.5	8.5	147.5	15.5	75.0	52.5	97.5	36.5	52.5	88.0

Most Challenged Pathways (July 2021)

Cancer pathways not achieving the national objective were:

Other 25% (3 breaches),
Gynaecological 35% (26 breaches),
Lower Gastrointestinal 44.1% (35.5 breaches),
Haematological (Excluding Acute Leukaemia) 54% (14.5 breaches),
Head & Neck 59% (12.5 breaches),
Urological (Excluding Testicular) 70.9% (34 breaches),
Upper Gastrointestinal 72.1% (14.5 breaches),
Sarcoma 75% (1 breaches),
Lung 79.5% (11.5 breaches).



	Cheshire	Halton	Knowsley	Liverpool	South Sefton	Southport and Formby	St Helens	Warrington	Wirral
Percentage treated in 62 days	75.1%	92.3%	72.7%	67.0%	76.1%	70.7%	78.6%	73.2%	86.4%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	213.0	39.0	33.0	103.0	46.0	41.0	56.0	56.0	88.0

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

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	29 September 2021
Agenda item:	P1-153-21
Title:	Constitution: For Final Approval
Report prepared by:	Emily Kelso – Corporate Governance Manager
Executive Lead:	Margaret Saunders – Associate Director of Corporate Governance Manager
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Not applicable
Date & decision:	

Purpose of the paper/key points for discussion:	The Trust is required to review its Constitution every 3 years. The last review and update was carried out in 2018, therefore the Trust is required to review, update if necessary. As per the current and revised Trust Constitution: **45. Amendment of the constitution** 45.1 The Trust may make amendments of its Constitution only if: 45.1.1 More than half of the members of the Council of Governors of the Trust voting approve the notices, and 45.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments. The revised Constitution was presented to the Council of Governors at its meeting 7th July. A number of minor formatting/grammatical errors were noted and actioned following the meeting. On 4th August 2021, a revised version was emailed to the Council of Governors, who were asked to respond with any further amendments by 27th August via email. No further amendments were received. The attached revised constitution has been, approved by the Council of Governors, reflecting the following; a) the Constitution is now aligned to the model NHS Constitution and therefore the order has been amended. b) the composition of each Constituency is set out in Annex 1-3 c) the inclusion of paragraph 9- Automatic Membership of Staff. d) the inclusion of Annex 7 – Standing Orders for the Council of Governors. e) the Dispute Resolution section has been refined and expanded and added as an Annex to the Constitution (Annex 8) f) the current Constitution used the terminology of ‘nominated’ and ‘appointed’ governors referring to the same class of constituent. The revised version consistently uses ‘Appointed’ Governor’

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

	g) the change of name of Appointing organisation, Manx Cancer help to MCH Psychological Services h) The Cancer Steering Group as an Appointing organisation has ceased to exist and has been replaced with the Cancer Alliance i) the approval of Liverpool Council as an additional Appointing Organisation.

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

Next steps required:	The Trust Board is asked to approve the revised version.

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 Constitution

CONSTITUTION OF

THE CLATTERBRIDGE CANCER CENTRE

NHS FOUNDATION TRUST

(A PUBLIC BENEFIT ORGANISATION)

Version 12
July 2021

The Clatterbridge Cancer Centre NHS Foundation Trust Constitution

TABLE OF CONTENTS

1. Interpretation and Definitions

1.1 Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012

1.2 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

1.3 In this Constitution:

Accounting Officer	means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.
Appointed Governor	means those Governors appointed by the appointing organisation
Appointing Organisations	means those organisations named in this Constitution who are entitled to appoint Governors
Areas of the Trust	means the areas of the Public Constituencies in Annex 1
Authorisation	means an authorisation given by NHS Improvement (NHSI)
Board of Directors	means the Board of Directors as constituted in accordance with this Constitution and the 2006 Act
Chairman	means the Chair of the organisation
Company Secretary	means the Secretary of the Trust or any other person appointed to perform the duties of the Company Secretary including a joint, assistant of deputy Secretary or such other person as may be appointed by the Trust to perform the functions of the Company Secretary under this Constitution
Council of Governors	means the Council of Governors as constituted in accordance with this Constitution which shall have the same meaning as the Council of Governors in the 2006 Act
Dispute Resolution Procedure	means the dispute resolution procedure as set out in Annex 8

Elected Governors means those Governors elected by the public constituencies and staff constituencies

Financial Year means any period of 12 months beginning on 1 April

Lead Governor means the Governor elected by the Council of Governors as the main link between the Governors and the Chair of the Trust

Monitor means the body corporate known as Monitor (as provided by Section 61 of the 2012 Act) and incorporated into NHSI, the statutory entity that remains the regulator of NHS foundation trusts

Nominations Committee means a Committee of the Council of Governors established in accordance with Paragraph 26

Senior Independent means a Non-Executive Director appointed by the Board of Directors in consultation with the Governors, supports the Chair and serves as an intermediary for other directors.
Director

Significant Transaction as defined in Paragraph 45

2. Name

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

3. Principal Purpose

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

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

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

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

3.3.2 the promotion and protection of public health.

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

[1] The principal purpose is as set out in sub-section 43(1) of the 2006 Act and must be included in the constitution by virtue of paragraph 2(2). The paragraphs which follow reflect other provisions in section 43

4. Powers

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

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

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

5. Membership and Constituencies

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

5.1 a public constituency

5.2 a staff constituency

5.3 appointed constituency

6. Application for Membership

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

7. Public Constituency

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

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

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

8. Staff Constituency

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

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

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

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

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

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

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

9. Automatic membership by default – staff

9.1 An individual who is:

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

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

10. Restriction on Membership

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

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

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

10.4 A member shall cease to be a member if:

10.4.1 they resign by notice to the Company Secretary
10.4.2 they die
10.4.3 they are expelled from membership under this Constitution
10.4.4 they cease to be entitled under this Constitution to be a member of the public or any classes of the staff constituencies.

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

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

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

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

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

11. Annual Members' Meeting

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

11.2 Members meetings are open to all Members of the Trust, Governors, Directors and representatives of the Trust External Auditors.

11.3 All Annual members' meetings shall be convened by the Company Secretary.

11.4 At the Annual Members' meeting:

11.4.1 The Board of Directors shall present to the members:
11.4.2 the annual accounts
11.4.3 any report of the Trust's External Auditor
11.4.4 the annual report

11.5 The Council of Governors shall present to the members:

11.5.1 a report on steps taken to secure that (taken as a whole) the actual membership of its public constituencies and of the classes of staff constituencies is representative of those eligible for such membership.
11.5.2 the progress of the membership strategy
11.5.3 any proposed changes to the composition of the Council of Governors and of Non-Executive Directors.
11.5.4 the results of the election and appointment of Governors and the appointment of any Non-Executive Directors will be announced.

11.6 Notice of a members' meeting is to be given:

11.6.1 by notice prominently displayed a the Trust Headquarters and at all of the Trust's places of business; and
11.6.2 by notice on the Trust website

At least 14 clear days before the date of the meeting. The notice must:

11.6.3 be given to the Council of Governors and the Board of Directors and to the External Auditor;
11.6.4 state whether the meeting is an annual or a special members meeting;
11.6.5 give the time, date and place of the meeting; and
11.6.6 indicate the business to be dealt with at the meeting**.**

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

12. Council of Governors – Composition

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

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

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

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

13. Council of Governors – Election of Governors

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

13.2 The Model Election Rules as published from time to time by the Department of Health, form part of this constitution. The Model Election Rules current at the date of the trust's Authorisation are attached at Annex 5.

13.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of Paragraph 44 of the constitution (amendment of the constitution).

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

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

14. Council of Governors - Tenure

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

14.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected

14.3 An elected governor shall be eligible for re-election at the end of his term and be allowed to serve a maximum of 9 years (3 consecutive terms if so elected).

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

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

14.4.2 Where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty to either, call an election within three months to fill the seat for the remainder of the term; or invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office.

14.5 An appointed governor may hold office for a period of up to 9 years.

14.6 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

14.7 An appointed governor shall be eligible for re-appointment at the end of his term.

15. Council of Governors – Disqualification and Removal

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

15.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
15.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;
15.1.3 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
15.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

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

16. Council of Governors – Duties of Governors

16.1 The general duties of the Council of Governors are:

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

16.1.2 to represent the interests of the members of the trust as a whole and the interests of the public.

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

17. Council of Governors – Meetings of Governors

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

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

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

18. Council of Governors – Standing Orders

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

19. Council of Governors – Referral to the Panel

19.1 In this paragraph, the "Panel" means a panel of persons appointed by NHSI to which a Governor of an NHS Foundation Trust may refer a question as to whether the Trust has failed or is failing:

19.1.1 to act in accordance with its constitution, or

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

19.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Council of Governors - Conflicts of Interest of Governors

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

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

21. Council of Governors – Travel Expenses

The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

22. Lead Governor

22.1 Any Governor who, immediately after the Annual Members meeting, and having at least one year of his term remaining may nominate himself for the office of Lead Governor by giving notice to the Chairman at least ten working days before the Annual Members meeting.

22.2 The Council of Governors shall vote on the nomination of the Lead Governor.

22.3 If more than one nomination has been received, the Council of Governors shall choose the Lead Governor by paper ballot. If there is equality of votes, the tied nominees shall be subject to a second vote by paper ballot.

22.4 The Lead Governor's duties shall include:

- 22.4.1 facilitating communication between Governors and members of the Board of Directors
- 22.4.2 contributing to the appraisal of the Chairman in such manner and to such extent as the person conducting the appraisal may see fit
- 22.4.3 initiating proceedings to remove a Governor where circumstances set out in this Constitution for removal have arisen.
- 22.4.4 Liaising, as appropriate with Council of Governors for other NHS Foundation Trusts.

23. Council of Governors – Further Provisions

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

24. Board of Directors – Composition

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

24.1 The Board of Directors is to comprise:

24.1.1 a Non-Executive Chairman
24.1.2 up to 6 other Non-Executive Directors; and
24.1.3 up to 6 Executive Directors.
24.1.4 a Director of Strategy (non-voting)
24.1.5 a Chief Information Officer (non-voting)

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

24.3 The Chief Executive shall be the Accounting Officer.

24.4 One of the Executive Directors shall be the Finance Director

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

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

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

25. Board of Directors – General Duty

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

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

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

26.1 he is a member of a Public Constituency, and

26.2 he is not disqualified by virtue of Paragraph 30 below.

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

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

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

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

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

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

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

27.7 Removal of the Chairman or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors. Written reasons for the proposal to remove shall be provided to the Non-Executive Director in question, who shall be given the opportunity to respond to such reasons.

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

28. Board of Directors – Appointment of a Vice Chair

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

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

29.1 Non-Executive Directors shall appoint or remove the Chief Executive.

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

30. Board of Directors – Disqualification

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

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

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

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

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

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

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

31. Board of Directors – Meetings

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

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

32. Board of Directors – Standing Orders

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

33. Board of Directors - Conflicts of Interest of Directors

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

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

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

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

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

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

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

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

33.4.1 The Trust, or

33.4.2 A person acting on its behalf.

33.5 If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

33.6 If a declaration under this paragraph proves to be, or becomes inaccurate or incomplete, a further declaration must be made.

33.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

33.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

33.9 A Director need not declare an interest –

33.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

33.9.2 If, or to the extent that, the Directors are already aware of it;

33.9.3 If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

33.9.3.1 By a meeting of the Board of Directors, or
33.9.3.2 By a committee of the Directors appointed for the purpose under the Constitution.

34. Board of Directors – Remuneration and Terms of Office

34.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other Non-Executive Directors.

34.2 The Chairman and the Non-Executive Directors shall be eligible for appointment for three, three year terms of office, and in exceptional circumstances a further term of one year subject to a satisfactory appraisal. The Chairman or the Non-Executive Directors shall not be appointed to that office for a total period which exceeds ten years in aggregate.

34.3 The Trust shall establish a Committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

35. Registers

The Trust shall have:

35.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

35.2 a register of members of the Council of Governors;

35.3 a register of interests of governors;

35.4 a register of directors; and

35.5 a register of interests of the directors.

36. Admission to and Removal from the Registers

36.1 The Company Secretary shall add to the confidential register of members the name of any member who is accepted under the provisions of this Constitution.

37. Registers – Inspection and Copies

37.1 The Trust shall make the registers specified in Paragraph 35 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

37.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

37.3 So far as the registers are required to be made available:

37.3.1 they are to be available for inspection free of charge at all reasonable times; and

37.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract

37.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

38. Documents Available for Public Inspection

38.1 The trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

38.1.1 a copy of the current Constitution

38.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

38.1.3 a copy of the latest annual report.

38.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

38.2.1 a copy of any order made under Section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act.

38.2.2 a copy of any report laid under Section 65D (appointment of Trust special administrator) of the 2006 Act.

38.2.3 a copy of any information published under Section 65D (appointment of Trust special administrator) of the 2006 Act.

38.2.4 a copy of any draft report published under Section 65F (administrator's draft report) of the 2006 Act.

38.2.5 a copy of any statement provided under Section 65F (administrator's draft report) of the 2006 Act.

38.2.6 a copy of any notice published under Section 65F (administrator's draft report), 65G (consultation plan); 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision); 65KB (Secretary of State's response to Monitor's decision); 65KC (action following Secretary of State's rejection of the final report or, 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

38.2.7 a copy of any statement published or provided under Section 65G (consultation plan) of the 2006 Act.

38.2.8 a copy of any final report published under Section 65I (administrator's final report).

38.2.9 a copy of any statement published under Section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of the final report) of the 2006 Act.

38.2.10 a copy of any information published under Section 65M (replacement of Trust special administrator) of the 2006 Act.

38.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

38.4 If the person requesting a copy or extract is not a member of the Trust, the trust may impose a reasonable charge for doing so.

39. Auditor

39.1 The Trust shall have an auditor.

39.2 The Council of Governors shall appoint or remove the auditor at a general meeting or extraordinary meeting of the Council of Governors.

39.3 The Auditor is to carry out his duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by NHS Improvement (NHSI) the organisation that incorporates Monitor, the statutory entity that remains the regulator of NHS Foundation Trusts.

40. Audit committee

The Trust shall establish a Committee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

41. Accounts

41.1 The Trust must keep proper accounts and proper records in relation to the accounts.

41.2 NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

41.3 The accounts are to be audited by the Trust's auditor.

41.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS Improvement, the organisation that incorporates Monitor may with the approval of the Secretary of State direct.

41.5 The functions of the Trust with respect to the preparation of the Annual Accounts shall be delegated to the Accounting Officer.

42. Annual Report, Forward Plans and Non-NHS Work

42.1 The Trust shall prepare an Annual Report and send it to NHS Improvement.

42.2 The Trust shall give information as to its forward planning in respect of each financial year to NHS Improvement, the organisation that incorporated Monitor, the statutory entity that remains the regulator of NHS Foundation Trusts. The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.

42.3 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

42.4 Each forward plan must include information about:

42.4.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

42.4.2 the income it expects to receive from doing so.

42.5 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 42.4.1 the Council of Governors must:

42.5.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the trust of its principal purpose or the performance of its other functions, and

42.5.2 notify the Directors of the Trust of its determination.

42.6 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the council of governors of the Trust voting approve its implementation.

43. Presentation of the Annual Accounts and Reports to the Governors and Members

43.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

43.1.1 the Annual Accounts

43.1.2 any report of the auditor on them

43.1.3 the Annual Report.

43.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

43.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1 with the Annual Members' Meeting.

44. Instruments

44.1 The Trust shall have a seal.

44.2 The seal shall not be affixed except under the authority of the Board of Directors.

45. Amendment of the constitution

45.1 The Trust may make amendments of its Constitution only if:

45.1.1 More than half of the members of the Council of Governors of the Trust voting approve the notices, and

45.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

45.2 Amendments made under Paragraph 45.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

45.3 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

45.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

45.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

45.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

45.5 Amendments by the Trust of its Constitution are to be notified to NHS Improvement. For the avoidance of doubt, NHS Improvement's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

46. Mergers etc. and Significant Transactions

46.1 The Trust may only apply for a merger, acquisition, separation or dissolution (in accordance with the provisions of the 2006 Act) with the approval of more than half of the members of the Council of Governors.

46.2 The trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

46.3 "Significant transaction" means a transaction that equates to:

46.3.1 the value equates to 25% of either the Trust's Gross Assets, Income or Gross Capital (inclusive of the transaction), calculated with reference to the Trust's opening Balance Sheet for the Financial Year in which approval is being sought.

47. ANNEX 1 – THE PUBLIC CONSTITUENCIES

Name of Areas within the Constituency	Number of Governors
Liverpool	3
St Helen's and Knowsley	2
Sefton	2
Cheshire West and Chester	2
Warrington and Halton	2
Wirral and the Rest of England	3
Wales	1
Total	**15**

48. ANNEX 2 – THE STAFF CONSTITUENCY

Name of Constituency	Class of Staff Membership	Number of Governors
Staff	Doctor	1
	Non-Clinical	1
	Nurse	1
	Other Clinical	1
	Radiographer	1
	Volunteers, Service Providers, Contracted Staff	1
	Total	**6**

49. ANNEX 3 – THE APPOINTED CONSTITUENCY

NAME OF APPOINTED CONSTITUENCY	NUMBER OF APPOINTED GOVERNORS
Liverpool University	1
Macmillan Cancer Support	1
MCH Psychological Services	1
Liverpool University Hospital NHS Foundation Trust	1
Cancer Alliance	1
NHS England: Cheshire and Merseyside sub regional team	1
Liverpool Council	1
Wirral Council	1
Total	**8**

50. ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

29 Governors in Total

Elected Governors

Public Constituency	Number of Governors
Liverpool	3
St Helen's and Knowsley	2
Sefton	2
Cheshire West and Chester	2
Warrington and Halton	2
Wirral and the Rest of England	3
Wales	1
Total	**15**

Appointed Governors

Appointing Organisation	Number of Governors
Liverpool University	1
Macmillan Cancer Support	1
MCH Psychological Services	1
Liverpool University Hospital NHS Foundation Trust	1
Cancer Alliance	1
NHS England: Cheshire and Merseyside sub regional team	1
Wirral Council	1
Liverpool Council	1
Total	**8**

Staff Governors

Name of Constituency	Class of Staff Membership	Number of Governors
Staff	Doctor	1
	Non-Clinical	1
	Nurse	1
	Other Clinical	1
	Radiographer	1
	Volunteers, Service Providers, Contracted Staff	1
Total		**6**

51. ANNEX 5 –THE MODEL ELECTION RULES

MODEL ELECTION RULES 2014

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
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PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

PART 10: ELECTION EXPENSES AND PUBLICITY

Expenses

Publicity

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

PART 12: MISCELLANEOUS

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for

return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) the paper does not include a declaration of eligibility as required by rule 12, or

(e) the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of

candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[2]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

[2] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as “disqualified” all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV49.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are

deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of

vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with “rejected in part”,

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

52. ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

Eligibility to be a Member of the Council of Governors

1. Council of Governors – Further Provisions on Disqualification and Removal:

Further to the provisions set out in Paragraph 15 the following may not become or continue as a Governor of the Council of Governors if they are:

1.1 In the case of a Staff Governor, Public Governor or Appointed governor, he ceases to be a Member of the Constituency or the Class of a Membership Constituency by which he was elected, or appointed.

1.2 NHS Improvement (incorporating Monitor) has exercised its powers to remove that person as a Governor or has suspended him from office or has disqualified him from holding office as a Governor for a specified period.

1.3 A person who has within the preceding five years been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS Body.

1.4 A person whose tenure of office as the Chair, Non-Executive Director or as a Governor of an NHS body has previously been terminated on the grounds that his appointment is not in the interests of the NHS for non-attendance at meetings or for non-disclosure of a pecuniary interest.

1.5 A person who is a vexatious complainant of the Trust

1.6 A person who has had his name removed from a relevant list of medical practitioners pursuant to Paragraph 10 of the National Health Service (Performers Lists) Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere), and has not subsequently had his name included in such a list.

1.7 A person who is currently a member of an independent scrutiny body whose role includes or will include independent scrutiny of The Clatterbridge Cancer Centre NHS Foundation trust.

1.8 A person who is under 16 years of age.

1.9 A person who on the basis of disclosures obtained through an application to the Disclosure and Barring Scheme is not considered suitable by the Trust.

1.10 A person who is a spouse, partner, parent or child of a Director or the Chair of the Trust.

1.11 A person who is incapable by reason of a mental disorder, illness of injury, of managing and administering his property and affairs.

1.12 A person has failed to, and continues to refuse to make the required Declarations.

1.13 A person who makes a false declaration for any purpose under this Constitution or the 2006 Act.

1.14 A person whose conduct has caused, or is likely to cause, material prejudice to the best interests of the Trust or the proper conduct of the Council of Governors or otherwise in a manner inconsistent with continued membership of the Council of Governors.

2. Termination of Tenure

In addition to Paragraph 14, the following will apply:

2.1 A Governor may resign from that office at any time during the term of that office by giving notice in writing to the Company Secretary.

2.2 If a Governor fails to attend 3 consecutive meetings of the Council of Governors his tenure of office shall be terminated immediately unless, on application by that Governor to the Council of Governors, the Council of Governors resolves that:

2.2.1 the absence was due to reasonable cause; and

2.2.2 the Governor will be able to start attending meetings of the Council of Governors within such a specified period as the Council of Governors considers reasonable.

2.3 The Council of Governors may, at a Council of Governors, by a Resolution approved by not less than 75% of the remaining Governors present terminate a Governor's tenure of office if for reasonable cause it considers that:

2.3.1 he is disqualified from becoming or continuing as a Member under this Constitution; or
2.3.2 he has knowingly or recklessly made a false declaration for any purpose provided under this Constitution or in the 2006 Act; or
2.3.3 his continuing as a Governor would or would be likely to:

2.3.3.1.1 prejudice the ability of the Trust to fulfil its principal purpose or other of its purposes under this Constitution or otherwise to discharge its duties and functions; or
2.3.3.1.2 harm the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provisions of goods and services; or
2.3.3.2 adversely affect public confidence in the goods or services provided by the Trust; or
2.3.3.3 otherwise bring the Trust into disrepute.

2.4 Upon a Governor resigning or, upon the Council of Governors resolving to terminate a Governor's tenure of office, that Governor shall cease to be a Governor and his name shall be forthwith removed from the Register of Governors notwithstanding any reference to the Dispute Resolution Procedure.

2.5 Any decision of the Council of Governors to terminate a Governor's tenure of office may be referred by that Governor to the Dispute Resolution Procedure (as set out in Annex 8) within 28 calendar days of the date upon which notice in writing of the Council of Governor's decision is given to the Governor.

2.6 A Governor whose tenure of office is terminated under this Paragraph 2 shall not be eligible for re-election.

53. ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

The following Standing Orders form part of the Constitution of The Clatterbridge Cancer Centre NHS Foundation Trust

1. Interpretation

1.1 The Chairman shall be the final authority on the interpretation of these Standing Orders.

1.2 Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

2. The Trust

2.1 All business shall be conducted in the name of the Trust

3. Meetings of the Council of Governors

3.1 Admission of the Public and Press – the public and representatives of the press shall be afforded facilities to attend all meetings of the Council of Governors but shall be required to withdraw upon the Council of Governors resolving as follows:

"That the representatives of the Press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted publicity on which would be prejudicial to the public interest."

3.2 The right of attendance referred to above carries no right to ask questions or otherwise participate in the meeting.

3.3 The Chairman (or other person presiding under the provision of Standing Order [ ]) shall give such directions as he thinks fit in regards to the arrangements for meetings and accommodation of the public and representatives of the press to ensure that the business of the meeting shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public and press will be required to withdraw upon the Council of Governors resolving as follows:

"*That in the interests of public order the meeting adjourn for (the period to be specified) to enable the completion of business without the presence of the public and press."*

Nothing in these Standing Orders shall require the Council of Governors to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings r via social media as they take place without the prior agreement of the Council of Governors.

3.4 Calling Meetings – The Council of Governors is to meet at least four times in each

financial year. Save in the case of emergencies or the need to conduct urgent business, the Company Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors to all Governors. The notice will be placed on the Trust website.

3.5 Extraordinary meetings may be called by the Chair at short notice.

3.6 Meetings of the Council of Governors may be called by six Governors (including at least two Elected and two Appointed Governors) who give written notice to the Company Secretary specifying the business to be carried out. The Company Secretary shall send a written notice to all Governors as soon as practically possible following receipt of such a request.

3.7 Prior to each meeting of the Council of Governors, a public notice of the time and place of the meeting and the public agenda shall be displayed on the Trust website at least three working days prior to the meeting.

3.8 The Annual Members' Meeting of the Council of Governors will consider the Annual Accounts, any report of the Auditor on these Accounts and the Annual Report.

4. Agenda and Supporting Papers

4.1 The Agenda will be provided to the Governors not less than 3 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda.

4.2 A Governor desiring a matter to be included on an agenda shall make his request in writing to the Chairman at least 10 working days before the meeting. Requests made less than 10 working days before a meeting may be included on the agenda at the discretion of the Chairman.

5. Chairman of the Meeting

5.1 The Chairman shall preside at meetings of the Council of Governors and shall be entitled to exercise a casting vote where the number of votes for and against a motion is equal.

5.2 If the Chairman is absent from a meeting of the Council of Governors, the Vice Chair shall preside over that meeting and he shall exercise all the rights and obligations of the Chairman including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

5.3 If any matter for consideration at a meeting of the Council of Governors relates to the conduct or interests of the Chairman or of the Non-Executive Director as a class, neither the Chairman nor any of the Non-Executive Directors shall preside over the period of the meeting during which the matter is under discussion. In these circumstances the period of the meeting shall be chaired by the Lead Governor, or in his absence, by another Governor chosen by the Governors. This person shall exercise all the rights and obligations of the Chairman including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

6. Notice of, Amending or Withdrawing Motions and Notice to Rescind a Resolution

6.1 A Governor desiring to move or amend a motion shall send a written notice thereof at least 10 working days before the meeting to the Chairman, who shall insert in the

agenda of the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This does not prevent a motion being moved during a meeting without notice on any business mentioned on the agenda.

6.2 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

6.3 Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governor who gives it and also the signature of ten other Governors. When any such motion has been disposed of by the Council of Governors, it cannot be proposed again tot eh same effect within the next six calendar months unless the Chairman deems it to be appropriate.

6.4 The proposer of the motion shall have the right of reply at the close of any discussions on the motion or any proposed amendments.

6.5 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

6.5.1 An amendment to the motion;
6.5.2 The adjournment of the discussion or the meeting;
6.5.3 That the meeting proceed to the next business;
6.5.4 The appointment of an ad hoc committee to deal with a specific item of business
6.5.5 That the motion be now put.

6.6 No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

7. Voting

7.1 If, in the opinion of the Chairman, a vote should be required on a question at a meeting of the Council of Governors, the result shall be determined by a majority of the votes of the Governors present and voting on the question.

7.2 All questions put to the vote shall, at the discretion of the Chairman of the meeting be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

7.3 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

8. Minutes

8.1 Minutes of the proceedings of a meeting shall be drawn up and submitted for approval at the next meeting where they will be signed by the Chairman of that meeting.

8.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

8.3 Minutes of the meeting shall record the names of those present.

8.4 Minutes of the meetings shall be made available to the public except for those

minutes relating to business conducted when members of the public or press are excluded under the terms of Paragraph 3.3 of these Standing Orders.

9. Quorum

9.1 No business shall be transacted at a meeting of the Council of Governors unless at least five Public Governors, one Staff Governor and one Appointed Governor are present at the meeting.

9.2 If a Governor has been disqualified from participating in the discussion on any matter and/or from voting or any resolution by reason of the declaration of a conflict of interest he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

9.3 The Council of Governors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

10. Nominations Committee

10.1 The Council of Governors shall create a duly authorised Nominations Committee who shall seek the views of the Board of Directors as to their recommended criteria and process for the selection of candidates, and having regards to those views, shall then seek, shortlist and interview such candidates as the Nominations Committee considers appropriate and shall make recommendations to the Council of Governors as to potential appointments as Non-Executive Directors and shall advise the Board of Directors of those recommendations.

10.2 The Company Secretary shall attend the Nominations Committee and take minutes of any proceedings.

10.3 The Nominations Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Council of Governors). Such terms of reference shall have effect as if incorporated into the Standing Orders.

10.4 The Council of Governors shall approve the appointments to the Nominations Committee. The Chairman of the Nominations Committee shall be the Trust Chairman.

10.5 Confidentiality – A member of the Nominations Committee shall not disclose a matter dealt with, or brought before the Nominations Committee without its permission until the Nominations Committee have reported to the Council of Governors or shall otherwise have concluded the matter.

11. Declarations of Interest and Register of Interests

11.1 Interests which should be regarded as ‘relevant and material’ and which, for the avoidance of doubt should be included in the register are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs.

b) Ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) A position of authority in a charity or voluntary organisation in the field of health and social care.

d) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.

e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.

f) Membership of clubs, societies or organisations whose purpose may include furthering the business or personal interests of their members by undeclared or informal means. Such organisations include Masonic lodges and religious societies whose membership consists of professional and business people.

g) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement wi the NHS

54. ANNEX 8 – DISPUTE RESOLUTION PROCEDURE

1. In the event of a dispute with:

a) A member or prospective Member in relation to eligibility or disqualification; or

b) A Governor or prospective governor in relation to matters of eligibility, disqualification or termination of tenure;

The individual concerned shall be invite to an informal meeting with Company Secretary or with one or more of the Directors. If not resolved, the dispute shall be referred to a panel comprising the Chairman, at least one Elected Governor, and wither the Company Secretary or one of the Directors. The decision of the panel shall be final.

2. A dispute arising between the Council of Governors and the Board of Directors shall be referred to a panel comprising the Chairman, the Chief Executive and two governors who have been nominated by the Council of Governors. The panel shall use all reasonable endeavours to facilitate the resolution of the dispute.
3. In the event resolution is not reached under Paragraph 2 above, the panel shall consult the Council of Governors and the Board of Directors to determine whether the matter should be referred to mediation. In the event the decision is to refer to mediation, an external mediator shall be appointed by the Centre for Dispute Resolution or such other organisation as the panel shall agree.