AGENDA

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Trust Board of Directors Meeting held in Public

Date: Wednesday 24 November 2021	Location: via **MS Teams**
Start Time: 09:00	Finish Time: 12:00

Timings	Item No		Lead	Paper/Verbal
Opening Matters				
09:15	P1-186-21	Welcome & Apologies:	KD	Verbal
	P1-187-21	Declarations of Committee Members' and other attendees' interests concerning agenda items:	KD	Verbal
	P1-188-21	Minutes of last meeting: 27 October 2021	KD	Paper
	P1-189-21	Matters Arising/Action Log	KD	Paper
	P1-190-21	Chair's Report to the Board	KD	Verbal
Risk and Assurance				
9:30	P1-191-21	Quality Committee Chair's Report	TJ	Paper
9:40	P1-192-21	Performance Committee Chair's Report	GB	Paper
09:50	P1-193-21	Charitable Funds Committee Chair's Repot	EA	Paper
10:00	P1-194-21	Staff Story – Experiences from the Ethnic Diversity Network	JSh/WA	Verbal
10:20	P1-195-21	Patient Experience Visits	JSp	Paper
10:30	P1-196-21	New Consultant Appointments	SK	Paper
10:40	P1-197-21	Integrated Performance Exception Report: Month 07	JSp/JSh	Paper
11:00	P1-198-21	Finance Report: Month 07	JT	Paper
11:10	P1-199-21	Learning from Deaths – Mortality Dashboards	SK	Paper
System Working				

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11:20	**P1-200-21**	Cheshire & Merseyside Cancer Alliance Performance Report	**LB**	**Paper**
11:30	**P1-201-21**	North West Region Health & Wellbeing Pledge	**JSh**	**Paper**
Closing Matters				
11:40	**P1-202-21**	Board Meeting Review	**ALL**	**Verbal**
11:50	**P1-203-21**	Any Other Business	**ALL**	**Verbal**

Next Meeting:

Date: Wednesday 26 January 2022	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 27 October 2021	Location: **MS Teams**
Start time: 9:00am	Finish time:

Present

Kathy Doran (KD)	Chair
Mark Tattersall (MT)	Non-Executive Director
Terry Jones (TJ)	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

Margaret Saunders (MS)	Associate Director of Corporate Governance
Emily Kelso (EK)	Corporate Governance Manager **(minutes)**
Jane Wilkinson (JW)	Lead Governor
Alun Evans (AE)	Staff Side Representative

Observer
None

Item no.	Agenda item	Action
P1-166-21	**Chair Welcome and Note of Apologies** The Chair welcomed all to the meeting, the following apologies were noted: Julie Gray – Chief Nurse, Anna Rothery – Non-Executive Director & Geoff Broadhead – Non-Executive Director	
P1-167-21	**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 • James Thomson – Executive Lead for PropCare and CPL	

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P1-168-21	**Minutes of Previous Board Meeting: 29 September 2021** The minutes of the Board meeting held on 29 September 2021 were approved subject to some minor grammatical amendments: SB further advised the Board that following the discussions at September Board meeting around patient loneliness and the possibility of introducing a patient radio station, work had been undertaken to ensure "Clatterbridge Radio" was now available on SPARK and televisions, it was noted that there was a facility to take requests. JW suggested that Governors might wish to support the radio., it was agreed this could be explored further. **The Trust Board:** **Approved** the minutes of the previous meeting subject to the minor amendments.	**SB**
P1-169-21	**Matters Arising/Action Log** The Board noted that actions were either complete, on the Agenda or not yet due. In addition the following updates were provided: P1-140-21 – The lifting of Covid-19 restrictions impact on visiting patients. JSp confirmed the Trust was currently still at amber with no plans to reduce because of local prevalence. It was further noted some adjustments were being made to the tiers, which would be communicated appropriately to patients and staff. It was agreed that the action could be marked as complete on the Action Log. P1-139-21 - SB provided an update on the work being undertaken with the Immunotherapy - Oncology Team and IT to optimise the use of digital technology. A session had been arranged for 17th November to identify ways to improve. It was agreed that the action could be marked as complete on the Action Log. **The Trust Board:** **Noted** the position in relation to the Action Log.	
P1-170-21	**Chair's Report to the Board** KD expressed condolences on behalf of the Trust at the unexpected passing of Shaun Jackson, CCC Governor and respected Head and Neck Surgeon at LUHFT, sympathies had been sent on behalf of the Trust. KD further informed the Board that there had been no appointment made to the ICS Chair position and that David Flory had agreed to continue in the position in the interim. Plans were in place to go out to advert for the position again in the new year. Interviews for the Chief Executive role were taking place during the current week. A letter had been received from Amanda Doyle North West Regional Director NHSE regarding the System Oversight Framework Segmentation Assessment, the process for ranking organisations according to level of risk, with 4 possible rankings 1 being low risk and 4 being high. CCC was ranked at 2. It was further noted that Ms Doyle would be meeting with KD & LB for a visit to the CCCL site, which was planned for 5th November.	

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	KD further noted the Trust's results from the national patient survey. CCC were one of six hospitals nationally to get a 'better than expected rating', a great endorsement of the wiork of our staff. **The Trust Board:** **Noted** the Report	
	Risk and Assurance	
P1-171-21	**Quality Committee Chair Report** EA provided an overview of the report, alerting the Board to progress relating to the Aseptic Pharmacy Unit. It was noted that positive progress had continued against the projected move date – 6th December. Assurance was received on the action plan and mitigations of risks which could contribute to any further delays. EA further informed the Board of the committee discussion on the format of the Risk & Issues summary report and the benefits of separating of risks from issues. It was agreed that the Chief Nurse would lead on further development of risk assurance reporting into Board committees. **The Trust Board:** **Discussed and noted** the content of the report.	
P1-172-21	**Audit Committee Chair Report** MT provided an overview of the report advising the Board of the ongoing work with internal auditors MIAA to roll out TeamMate, a digital programme that would enable more effective tracking of internal audit recommendations. The Board were further advised the limited assurance received on Managing Conflicts of Interests, in response the Committee requested a further progress report against actions to be presented in January. A financial update had been provided emphasising the increased risk to the Trust of the proposed ICS system changes. It was noted that the Value for Money report had been received from current auditors Grant Thornton, which was positive with only a few recommendations made. MT confirmed the Trust was looking forward to working with the newly appointed auditors Ernst Young for the 2021/22 financial year. **The Trust Board:** **Discussed and noted** the content of the report.	
P1-173-21	**Patient Story** KD informed the Board that the patient story video had been shared via email link to all Board members, and once edited would be made available on the Trust website. The Board reflected on the video, the following key points were taken from the discussion that followed • The compliments had been noted on all staff throughout the patients' treatment.	**ES**

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	• The appointment system - specifically the opportunity for appointment notifications to be digitalised, using email or outlook calendars for those patients who wished. SB confirmed options were being explored to both reduce paper usage and enable digital management of appointments for patients via 'patient held records', it was agreed this required a system wide approach driven by the ICS and that the Trust had been involved in some early piloting of digital platforms. • The importance of taking the lessons learned through the patient's story further afield, particularly those related to the early stages of the journey which were typically managed at GP level and not by the Trust by working more systematically to improve the patient journey. LB confirmed that lessons learned from the patient story would be addressed through the Patient Experience & Inclusion Group. • The Board supported production of patient videos to share experiences and enable new patients to learn from the familiarity of others, as opposed to leaflets which were often less engaging. • The role of a patient pathway coordinator was discussed, to work across the system on integrated pathways for patients, to ensure a consistent point of contact throughout a patient's treatment, particularly during highly emotive times i.e. when awaiting results. • The support offered by Maggie's and the importance of signposting patients to the locations and support available. It was further noted that work was ongoing to decide on locations for additional Maggie's centres based on patient access requirements and feedback. • The 28-day faster diagnosis standard was discussed, it was noted that this can feel very long for those patients waiting, however the activity taking place behind the scenes to ensure the best plan for patients was quite complex. Reporting on delivery of the 28-day standard regionally would continue through the Cancer Alliance. **The Trust Board:** **Discussed and acknowledged** the content of the narrative provided to Board	
P1-174-21	**Patient Experience Visits** JSp provided an overview of the report informing the Board that the visit took place on the 17th August 2021 at CCC Aintree and Marina Dalglish Chemotherapy Unit. Due to Covid restrictions, the visits were conducted virtually. The key highlights from the paper and the board discussion, were as follows: • The benefit of having a named nurse on the treatment unit to build up a relationship with someone who could guide patients through their treatment, rather than being treated by a different nurse at each attendance. JSp commented that the position of pathway coordinator as discussed under item P1-173-21, would help alleviate this frustration. • One patient explained their journey as a cancer patient in 2003 compared to again in 2021 and the improvement in treatments, service and facilities, particularly improved access to the community nurse who was available to support and answer their queries. • Covid visitor restrictions had affected patient experience. Suggested improvements were providing carers/visitors with a comfortable area to sit, make refreshments and chat with other families going through similar journeys. • It was noted that at the time of the visit the Patient Experience team did not have their own budget to buy necessary items, such as volunteer uniforms, art materials for inpatient art packs and leaflets/posters etc. It was noted that	

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	since the visit, this issue had been resolved, with the team being allocated a separate budget. **The Trust Board:** **Discussed and noted** the content of the report	
	Patient Safety Specialist (PSS) Programme JSp introduced the presentation providing the Trust Board with details of the new role of a Patient Safety Specialist to ensure full engagement by the Trust. It was highlighted that for the role to be effective, patient safety specialists would need to develop a strong working relationship with the Board and ensure the Board had a good understanding of their role in supporting the programme. The Board were informed of the background to the programme, which had been relaunched in February 2021. It was noted that since then Trust had appointed three patient safety specialist leads (Deputy Director of Clinical Governance, a Lead Clinician, Director of Physics Drug Use) the Executive Lead for the programme was the Chief Nurse and the NED lead was Terry Jones Chair of the Quality Committee. The presentation went on to outline the key highlights of the programme, including: • A description of the Patients Safety Specialist role • Key deliverables and the time scales for their delivery • Early Milestones • Short and Medium Term priorities and details of those which had been completed by the Trust • Executive PSS support requirement • Next Steps	
P1-175-21	EA sought clarity on the divisional structure and whether and updated organogram could be shared with NEDs showing where the patient safety specialist roles fitted in. JSp agreed the updated structure could be shared with NEDs. MT sought some clarity of the appointment of specialists, recognising that each had a different set of expertise and highlighting the importance of identifying patient safety specialist champions, this had been an item discussed in detail at the Shadow Board Meeting 26th October i.e. AHPs and nurses to sit underneath and promote the programme amongst peers. JSp assured that champions would be identified as part of the programme action plan. MT sought further assurance on mandatory training for the programme and the impact additional training requirements would have on staff time and performance against mandatory training KPIs which was raised in the Shadow Board Meeting. JSp confirmed it was the intention to embed the training into existing mandatory training modules to ensure patient safety Level 1 was completed by all staff and in addition higher-level role specific training where required. Performance against PSS deliverables was to be embedded into the existing Quality and Safety agenda and reported through the Integrated Governance Committee with assurance provided up to Quality Committee. This would ensure reporting on KPIs followed a robust governance process. **The Trust Board:** **Discussed and Noted** the contents of the presentation and the role within CCC.	**JSp** **JSp**

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P1-176-21	**New Consultant Appointments** KD acknowledged that no new Consultants had commenced at the Trust in month.	
P1-177-21	**Integrated Performance Report: Month 06** JSp provided an overview of the report highlighting that both the Performance Committee and Quality Committee had reviewed it in detail. Following agreement of NHS System Oversight Framework (SOF) metric reporting arrangements at the September 2021 Performance Committee, the following activity data were now included: • Elective activity levels • Diagnostic activity levels • % of all Outpatient activity delivered remotely via telephone or video consultation It was further noted that the KPI 'percentage of patients requiring sepsis screening, who have been screened' was due to be included from M6. However, reporting had been delayed and would be included for November 2021. Assurance was provided that effective screening was taking place and patients at risk of sepsis were being managed appropriately. In addition Flu vaccine and Covid booster vaccine data was to be included in the M7 report, as the programme had only just started and data was not yet available. **Access** Overall the Trust was performing well, the following exceptions were highlighted: 28 Day Faster Diagnosis - Two patients breached the 28-day FDS target in September. One of the breaches was deemed avoidable, due to a delay to diagnostic test and awaiting results. 62 Day wait from screening to Treatment - One patient breached the 62 Day Screening target in September; the breach was deemed to be unavoidable as the patient required a cardio review to assess fitness prior to commencing treatment. YTD was still sitting at 95.7%. **Efficiency** Elective activity was reporting below target, discussions were taking place with the national team around the possibility of adjusting the Trust's position for H2. It was explained that some day case activity had shifted to outpatient procedures; which required some further work around coding classification. Bed occupancy whilst still below target was expected to increase over the winter months, in line with the winter plan to pull oncology patients from other acute Trusts to support the system. Imaging reporting was still below target, however the clinical prioritisation plan was now in place and two new members of staff had been appointed in September a consultant and clinical fellow, which would help to improve the position. The Board discussed the ongoing concerns around radiology and diagnostics. It was noted that this was an issue across Cheshire and Merseyside with a large backlog of patients and ever-increasing demand. It was noted the Trust was supporting community diagnostics hubs, and problems around workforce shortages were being experienced	**JSp**

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	nationally. A business plan has been approved and recruitment had begun. The C&M system was involved in a programme for international recruitment. It was agreed that the performance committee would receive a recovery programme plan report to inform of the Trust's position in the system wide Cheshire and Merseyside recovery plans. It was further noted that the operational issues related to IT networks were external to CCC. The radiology team were collaborating with the Digital Team to resolve. A task and finish group had been established to investigate and resolve some of these issues. **Quality** There had been an Increase in attributable C.Diff and E.coli cases. A deep dive into the root causes was being undertaken and was to be presented to the Quality Committee in November. **Workforce** JSh introduced the workforce section of the report highlighting the following: Sickness had seen a slight decrease in month with anxiety, stress and depression the main reasons reported; a theme of work related stress had been recorded in pharmacy. It was highlighted that discussions with managers were being undertaken to understand what further support staff could have been offered at the time of their absence. It was noted that the Trust continues to benchmark well nationally and regionally. Turnover had reported an increase in month; the main reasons recorded as further education, work/life balance and promotion. Seven registered nurses had left, however with no themes identified. The Board were informed of the diagnostic work being undertaken around turnover, results of which would be reported through the Workforce and Transformation Committee in November with assurance provided into Quality Committee. It was further noted that a Medical Workforce Deep Dive was to be presented to the Performance Committee in November. The Board discussed the continued underperformance against target for PADRs and the possibility of the target being unrealistic. It was confirmed that when benchmarked across the region the Trust was one of only two organisations with a target of 95% and whilst ambitious this was a reflection of the Trust's commitment to supporting staff. It was agreed that targets would be discussed in more detail at performance committee. The Board further discussed performance on ILS & BLS safeguarding training. JSh confirmed the BLS target had been achieved and that the ILS position had improved. It was recognised that the position had improved significantly since 2020/21and work would continue to support and encourage staff to undertake the mandatory training. **The Trust Board:** **Discussed and noted** the content of the report.	**JSp** **JSp** **JSh** **JSh** **JSh**
P1-178-21	**Finance Report: Month 06** JT provided an overview of the financial position for month 6, highlighting an overall break-even position in line with the plan.	

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	The Trust was operating with less ERF than planned and reporting an overall H1 value of £6.159m against the original plan of £9.441m, a shortfall of £3.282m. The Trust had been able to mitigate the ERF risk non-recurrently to month 6. JT further highlighted that divisional pay budgets were underspent in month. It was explained that workforce budgets were set to reflect fully established staffing levels and the pay award had been applied to all posts. Final confirmation had not yet be received from commissioners that their contract offers for H2 would fully fund the cost of the pay award. It was noted that the majority of CIP targets were being met non-recurrently mainly through pay savings, details on which would be presented to the performnce committee in November. It was further noted that the drugs overspend had been offset by an increase in drugs income as part of the 2021-22 funding agreement with commissioners on high cost drugs. MT sought clarity on the financial position on the joint ventures, and whether more detail could be included in future reporting. It was agreed details would be reported through the performance committee. AY sought clarity on the diagnostic review being undertaken to understand the actual and projected costs incurred because of the issues within the Aseptic Pharmacy Unit. It was confirmed a business case had been approved, which gave details of the investment incurred to re-establish the APU and the underlying position. It was further noted that a diagnostic report would be presented to the Quality Committee including lessons learned and would be bought through to Trust Board (Part 2) in November. It was further noted that the comprehensive report detailing the financial impact analysis would take longer; with an expected completion date for presentation to Board Committees February/March 2022. **The Trust Board:** **Discussed and approved** the financial position of the Trust	**JT** **JT** **JT** **TP** **JT**
P1-179-21	**Research & Innovation Annual Report** GH introduced the report acknowledging that the past year had been challenging for the NHS, the Trust and the R&I Directorate. The key challenges highlighted were the Covid-19 pandemic and the move to the new CCCL site. It was highlighted that the report covered the 2020/21 financial year and within this time R&I had not been impacted by the issues within the Aseptic Pharmacy Unit. The Trust had been able to manage the research portfolio, providing system support through the city region, acting both as sponsor and participating site for COVID-19 studies notably the SIREN study to which 250 staff members were recruited. It was further highlighted that the Trust had continued to open critically important cancer trials throughout the year. MT queried the process for promoting research at all levels across the Trust and encouraging Nurse and AHP involvement which had been raised at Shadow Board. GH confirmed this was a focus for 2021/22 with specific emphasis on the chief investigator and principal investigator building further enthusiasm around research opportunities and the benefits to patient outcomes.	

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	GH informed the Board that the Innovation Manager post had been appointed to and would start with the Trust 29th November, which would ensure innovation was high on the agenda throughout the Trust. The Board discussed the 'Bright Ideas' scheme which had been introduced as a way of encouraging innovation from Trust staff. GH explained the format of submissions via an online form and receipt each submission would go through an assessment process involving a panel of individuals from different disciplines across the Trust. It was noted that all submissions were followed up with a response on outcomes. LB added that the scheme to date was proving to be successful with 25 submissions received in the initial round and a second round to take place in the coming weeks. The Communications and R&I teams were both thanked for their commitment to developing promoting the scheme which had resulted in positive engagement from staff at all levels. KD asked that a future item be scheduled on the Board cycle of business to receive more detail on the scheme and the outcomes to date. **The Trust Board:** • **Discussed** the content of the reports and • **Approved** for publication.	**MS/GH**
P1-180-21	**Guardian of Safe Working Report** SK introduced the report providing the Board with assurance on the Trust's compliance with the Junior Doctors' 2016 Terms and Conditions and to assure the Board where exception reports had been raised. It was explained the process was in place to safeguard the working hours for doctors in training. One exception had been reported which had been dealt with appropriately with the individual and the Trust had not incurred any penalties. EA sought assurance on the level of confidence in reporting following the move from monitoring hours to exception reporting. SK confirmed her confidence that trainees were familiar with the exception reporting system which had been in place for some time and that it had been embedded appropriately throughout the Trust. MT asked that future reports include some content around the nature of the exceptions and how they were managed. SK agreed this would be provided for future reports. **The Trust Board:** **Noted** Annual Report.	**SK**
P1-181-21	**Workforce & OD Strategy** JSh introduced the presentation on the Workforce & OD Strategy 'Our People Commitment' and plans for the next five years. It was highlighted that the aim of the revised strategy was to be clear, concise, measurable and also support delivery of the strategic objectives. The Board were advised of the five key commitments, which had been developed, based on feedback from staff and keeping in line with national and local Workforce	

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	context, specifically the NHS People Promise. Each commitment was supported by an ambition statement and details of how each ambition would be delivered. 1. Looking after our people 2. Developing our people 3. Workforce for the future 4. Our digital workforce 5. Valuing our people It was confirmed that a focus on EDI was incorporated into each of the commitments rather than being a standalone objective. It was noted that the next steps would involve development of communication plans & operational delivery plans to support the strategy. Progress would be reported through Quality Committee. **The Trust Board:** **Approved** the Strategy	
P1-182-21	**Trust Values & Behaviours Update** JSh introduced the report detailing the programme of work to review and develop the Trust Values. It was noted that the current Values had been in place since 2006 and in May 2021 a review was commissioned to develop new Values that aligned with the Trusts 5-Year Strategy. It was explained that it was the intention to engage with as many staff as possible and to start engagement in 2021. However due to the Covid-19 restrictions in place engagement had been limited. The Trust adapted engagement techniques in order to keep in line with restrictions and mitigate any further delays. Examples were given of Big Conversations, Walkabouts, surveys, graffiti board, attendance at team meetings, and patients group floor walking. The result of which was that 400 staff directly contributed to the development of the four refreshed values: 1. We are Kind 2. We are empowered 3. We are responsible 4. We are inclusive The Board took assurance that the next steps would include development of the marketing and communication plan, development of Staff Charter to support values, along with launching activities to embed across Trust sites. It was confirmed that the intended time to launch the values was January 2022. MT commented that the item had been discussed in length at Shadow Board with all participants supporting the work and the involvement of staff in its development, he further highlighted the “we are responsible value” that had replaced “we are accountable”, which was welcomes by all shadow Board participants. MT sought further assurance as raised in Shadow Board on the importance of embedding the values into all areas of the Trust, specifically PADRs and Medical appraisals. JSh confirmed this would be addressed as part of the embedding programme. **The Trust Board:**	**JSh**

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	Approved the report subject to the addition of the vaccination data.	
System Working		
P1-183-21	**Cheshire & Merseyside Cancer Alliance Performance Report** LB provided an overview of the report highlighting that restoration of cancer services continues to be under pressure across the system and nationally as a result of increased activity. It was explained that Endoscopy activity had reported a reduction, which had been impacted by underreporting from two Trusts. Further capacity was required in order to clear the backlog of patients on waiting lists. The Alliance had established an Endoscopy Operational Recovery Team (EORT) to oversee and co-ordinate restoration activities. KD queried whether other organisations within the CMCA were placing the targets as high on their agendas as the CCC. LB confirmed that the system was benchmarking reasonably well, however within CMCA there were two providers who were struggling more than others. The system was supporting them through a number of interventions and additional funding. SK added that although recovery was a system responsibility and cancer surgery activity burden was shared across region, for SACT and radiotherapy, CCC were the sole principal provider. It was highlighted that a focus was required on supporting staff to deliver the recovery plan given the impact of increased activity on the Trust. LB added that the surgical hub met weekly to prioritise mitigate the risks associated with patients awaiting surgery, with particular focus on skin surgery and lower GI. Work was ongoing with surgical clinical leaders to find sustainable solutions. The Board discussed the ongoing capacity issues around diagnostics and the anticipated additional NHS funding to be announced by the PM and how that could be used to reduce the backlog. JT confirmed that the additional capital funding had been confirmed and the focus would be on using the funding to aid sustainability. It was recognised that whist capital funding was welcomed many of the pressures in diagnostics were around staffing capacity as discussed under **item P1-177-21** which was a national issue. LB further highlighted the Trust's commitment to improving diagnostics and highlighted the work on the delivery of two early adopter community diagnostics hubs in the CMCA. Activity reporting on the two sites had begun, recognising that not all diagnostic work being carried out was cancer related. Details on performance would be shared with the Performance Committee, within scheduled CDU update reports. **The Trust Board:** **Discussed and noted** the content of the report.	
Corporate Governance		

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P1-184-21	**Board Assurance Framework** MS introduced the report providing the Board with latest information relating to the Trust's strategic risks alongside an update on Controls and Mitigation, Assurance/Evidence and Gaps in Controls/Assurances to reflect the current position of each of the 12 BAF risks and their associated scoring. It was further noted that the report had been received by the Audit Committee, 14th October. It was confirmed that the scoring for the majority of the 12 BAF risks remained static since Quarter 1, with two exceptions: B1 – Which has reduced scoring from 12 to 9 B6 - Which has reduced scoring from 15 to 9 JT provided a further update on BAF 3 confirming the risk scoring had increased from 12 to 15, given the Trust's position resulting from the changes to funding specifically the ERF. The Board discussed the BAF report agreeing that some further work was required on the formatting and the reporting process. MS agreed that whilst the report showed some improvements a further review was to take place to ensure the BAF served its purpose as a monitoring tool for the Board to assess the performance against strategic objectives and to provide appropriate oversight of the Trust's risk profile and risk management arrangements. Updates would be provided to the Board on progress of the BAF review. **The Trust Board** **Approved** the Board development programme.	**MS**
Closing Matters		
P1-185-21	**Board Meeting Review** KD reflected on the meeting together with Board members and the following key points were highlighted: • The patient story was well received, providing the Board valuable insight into the patient journey from diagnosis through to recovery. It had also highlighted areas that could be improved and lessons learned. The Patient Experience & Inclusion Group (PEIG) would pick this up. • There had been some gaps in paper coversheets particularly in selecting appropriate BAF Risks, which was to be a focus for authors going forward and reflected in November Board and Board Committee Papers. • EA informed the Board of his involvement as NED representative in the Patient Experience & Inclusion Group and asked if he could bring one item selected by the group to be highlighted to the Board at future meetings. The Board supported this approach.	

Next meeting:

Date: Wednesday 24 November 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: 11 November 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
P1-103-21	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**	Jan-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		
P1-147-21	29-Sep-21	Gender Pay Gap	To provide assurance on the gender pay gap amongst sub-contacted staff. An analysis of pay arrangements across the Trust's subsidiaries was planned.	**JSh/MS**	Jan-22		
P1-148-21	29-Sep-21	Workforce Race Equality Standard (WRES)	To extend Staff Surveys to contracted ISS staff Governance Review of the reporting processes and frequency of WRES & WRDS, it was agreed quarterly reporting thorough Quality Committee should be taken forward Staff member from the BAME network to be invited to present at Board Navajo project to be considered for involvement by the Trust once the new EDI lead was in post	**JSh** **JSh** **JSh** **AR/EDI Lead/JSh**	Jan-22		

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

P1-150-21	29-Sep-21	Staff Survey – Culture and Engagement Update	Results of the new Staff Survey to be presented to the Board	**JSh**	Feb-22		
Any Other Business	29-Sep-21	Any Other Business	Shadow Board participants to be invited to share their story with the Board on completion of the programme	**JSh**	Jan-22		
P1-168-21	27-Oct-21	Minutes of the Pervious Meeting	Governor involvement in "Clatterbridge Radio" options to be explored	**SB/JW**	Jan-22		
P1-175-21	27-Oct-21	Patient Safety Specialist Programme	Updated organogram to be circulated to NEDs, detailing where Patient Safety Specialist report though within the Trusts Governance Structure Patient Safety Specialist Champions to be identified	**JSp**	Jan-22		
P1-177-21	27-Oct-21	Integrated Performance Report: Month 06	Covid and Flu Immunisation Data to be included in Month 7 Report to Board and Board Committees Diagnostics Recovery Programme Report to be received by the Performance Committee C.Diff and E.coli Deep Dive to be received by the Quality Committee	**JSp**	Nov-21		On the November Performance Committee Agenda PC-099-21 On the November Quality Committee Agenda QC-232-21
P1-177-21	27-Oct-21	Integrated Performance Report: Month 06	Medical Workforce Deep Dive to be presented to the Performance Committee in November	**JSh**	Nov-21		Deferred Jan 2022
P1-178-21	27-Oct-21	Finance Report - Month 6	Financial Position of Joint Ventures to be reported through Performance Committee Diagnostic Report to be received on the Aseptic Pharmacy Unit by the Quality Committee Financial Impact Analysis report on APU to be presented to Performance Committee Details of CIPs to be presented through the Performance Committee	**JT** **JSp/TP** **JT**	01/11/2021 Nov-21 March-22		Performance Committee revived a JV Report presented by JT Item PC-108-21 Quality Committee revived the APU Diagnostic Report 18th November QC-243-21 presented by JSp & TP, and presented at Board Part 2 Report to be presented to Performance Committee Q4
P!-184-21	27-Oct-21	Board Assurance Framework	A further review of the Trust BAF to take place	**MS**	Feb-21		

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

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

The Clatterbridge Cancer Centre NHS Foundation Trust

Committee/Group 'Triple A' Chair's Report

Name of Committee/Group	Quality Committee	Reporting to:	Trust Board
Date of the meeting:	18 November 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: • Positive progress had continued against the revised planned move date of the 6th December. Assurance was received on the Quality Assurance action plan and mitigation of any risks, which could contribute to any further delays. • The committee noted that there were still some issues around staffing, however assurance was received that recruitment plans were progressing and sufficient establishment was in place for the effective functioning of the CCCL unit, required for the move.	Monthly progress reports will continue to be provided to the Quality Committee.	KF	Ongoing
Risk & Issues Summary Report		The committee discussed in detail the transition to the new Datix Cloud IQ system. It was noted that the manual move of information from the previous system had posed some challenges but continued to progress well. A training programme was being rolled out across divisions.	The committee requested an interactive presentation of the new digital Datix Cloud IQ platform to gain a further understanding of the reporting process. The committee requested some further analysis of risk/issue scoring and actions some of which were out of date.	SB/JSp CL	January 2022
Integrated Performance Report – Month 7		The Committee received the report providing an update on performance. The committee discussed in detail the under performance against KPI targets within Research and Innovation.	It was agreed the recovery trajectory would be monitored through more detailed exception reporting in to the committee.	GH	January

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Medicines Management Report		The committee received the paper providing an update on the revised reporting framework and oversight of actions taken in response to all drug/medication incidences. The committee discussed the report and agreed sufficient assurance had been received that incidents were being monitored and managed effectively across the Trust and that the level of indents being reported was in line with expected rates.	The Quality Committee to receive quarterly assurance reports going forward	KF/JSp	February

	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:	17 November 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 discussed in detail: • The Trust was planning for a similar level of activity in H2 • It was possible the Trust may receive ERF but there was a greater level of risk compared to H1, as the ERF methodology had changed and the financial income value was subject to overall CM system performance • The CM ICS and its constituent Trusts were expected to achieve break-even positions for H2 • The financial and operational risks associated with improving the Trusts draft financial H2 plan The Committee were advised of the ongoing work with LUHFT and commissioners on the transfer on the Haematology-Oncology service to CCCL, around agreed income. It was expected this would be resolved in the coming months.	Updates would continue to be shared with the committee the Board would be informed of any developments. An update to be provided to the committee detailing the conclusion of the project	JT JT	Ongoing Q4

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
Finance Report – Month 7		The Performance Committee received and discussed the report noting the requirement for the Trust for the first six months of the year (H1) was to achieve a break-even position. The H2 draft plan had been submitted to the ICS on 11th November, identifying a planned deficit. The ICS was expected to undertake a final re-allocation of systems monies, which would impact the Trust's final H2 plan. **Cost Improvement Programme (CIP)** The committee discussed the challenges around the CIP for H2, including additional requirement following the H2 planning process and contribution to the system planning gap.	Bi-monthly updates to the Committee and monthly reports on progress to be presented at Board. Final plans would be submitted to NHSE on 18th November. The Committee requested a further analysis of the schemes included in the programme to be included in monthly finance reporting	JT JT JT	Ongoing 18 November 21 ongoing
Outpatient Recovery Programme		The committee received a report on the outpatient Radiology reporting turnaround Trust target, outlining the challenges in meeting the KPI and actions taken to improve the reporting turnaround. A business case to support an increase in Radiographers and support staff to expand capacity in MRI and CT had been approved. A separate business case to support reporting capacity was to be presented at Finance Committee in November 2021.	It was noted that next steps would include the development pf a 3 year radiology plan in order to sustain performance once improved,	JSp	Q4
Medical Staffing Deep Dive		The report was deferred due to some further diagnostic work taking place which was essential to the robustness of the report.	It was agreed, the report would be received by the committee in January 2022.	JSh	Jan-22
Integrated Performance Report – Month 7		The committee received the IPR and discussed in detail the exceptions as acknowledged within the report. The committee sought further assurance on the work being undertaken to improve bed occupancy. It was noted that additional beds had been opened to support the system throughout winter pressures however, and that some further work was to be carried out in regards to mutual aid.	A detailed review on bed occupancy/capacity was to be carried out and reported back to the committee in Q4.	JSp	March-22
Green Plan		The committee received the presentation which outlined the progress on the development of a Green Plan for CCC. It was noted that *WRM Sustainability* had been commissioned to work with the Trust in the development of the plan. It was noted that the draft plan was to be reviewed by the Sustainability Group and Executive Team in December 2021;	The committee to receive a further progress report in Q4	TP	Q4

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Expected Date for Completion
		the final plan would be approved by the Trust Board. The submission date to the ICSs was 14th January 2022. Each ICS would then develop a consolidated system-wide Green Plan by 31st March 2022			
PropCare Report		The committee received the report providing information to the Trust as PropCare's shareholder on; Strategy Implementation, Risk Assurance, Regulatory Compliance and Financial Performance. The report assured the committee on the performance of the subsidiary company. It was highlighted that the audit report had been received identifying no concerns and only minor recommendations which was a credit to the subsidiaries finance team.	6 monthly performance reports to the Committee, which would include progress on the development of the Strategy and Board Assurance Framework.	PropCare MD	Ongoing

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

CHAIR'S REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Committee/Group 'Triple A'

ALERT the Committee on areas of non-compliance or matters that need addressing urgently

ADVISE the Committee on any on-going monitoring where an update has been provided to the sub-committee and any new developments that will need to be communicated or included in operational delivery

ASSURE the Committee on any areas of assurance that the Committee/Group has received

Name of Committee/Group: Charitable Funds Committee	Reporting to: Trust Board
Date of meeting: 29th October 2021	Parent Committee: n/a
Chair: Elkan Abrahamson	Quorate: Yes

Agenda item	RAG	Key points	Actions required	Action lead	Expected date of completion
CHA-037-21 – Fundraising & Finance Report		There is a shortfall in funds which could carry cross as a risk item if income didn't increase	The risk to be fed into the risk framework if the need arose	JT	Ongoing
CHA-041-21 – Assessment of Charity Artwork Donations		There was a query as to who owned and insured the Trust's artwork	An asset register to be set up of the Trust's artwork. The Trust's insurance will then be checked to ensure it was sufficient. To be done annually and after the Charity becomes independent.	KB/MS	21.01.22

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	24 November 2021
Agenda item:	P1-195-21
Title:	Patient Experience Visits 16.11.2021
Report prepared by:	Kirsteen Scowcroft, Head of Patient Experience
In attendance at visit:	Glen Crisp, Governor, Professor Terry Jones, Non-Executive Director, Angela Ditchfield, Interim EDI lead and Kirsteen Scowcroft, Head of Patient Experience
Executive Lead:	Joan Spencer, Director of Operations Julie Gray, Chief Nurse
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 16th November 2021 at CCC Aintree and Marina Dalglish chemotherapy unit.

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

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

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

☐ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☒ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Patient Experience Visits 16.11.2021

Glen Crisp, Governor
Prof. Terry Jones, Non-Executive Director
Kirsteen Scowcroft, Head of Patient Experience
Angela Ditchfield, Interim EDI lead

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

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

1. Summary

Patient Experience 'rounds' were conducted on the 16th November 2021, visiting radiation and chemotherapy services at CCC Aintree and Marina Daglish sites. Due to Covid-19 restrictions across all CCC sites Glen Crisp, Governor and Terry Jones, Non-Executive Director were able to accompany Kirsteen Scowcroft, Head of Patient Experience and Angela Ditchfield interim EDI lead virtually on this occasion as scheduled.

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

2. Key Findings and Observations

- Patient experiences and comments -Nine patients in the waiting area receiving radiotherapy at CCC Aintree were asked to share their experiences with four patients sharing that it was a very relaxing and calm environment, that didn't feel like a hospital, where they still felt safe and all the staff are fantastic. One patient was on their fifth treatment and visit to CCCA, which was scary at first, but now feels at ease. The staff are really caring and let you go at a pace that you are comfortable with and don't feel rushed, particularly if you suffer from dizziness when lying down. Another patient commented that it was good to be able to sit in the waiting area and talk to other patients going through the same experiences, stating that it was a great support. It was good to not have to travel too far from home and the patient transport service was always on time and a great help.

- Patient experiences and comments – Three patients at the Marina Daglish chemotherapy unit based at Aintree University Hospital shared that they felt very well cared for by the staff, that the unit was lovely to have and easy to find for those living in the North Mersey area (Ormskirk, Southport), plenty more room compared to Ormskirk, extremely busy, but the staff always did a fantastic job with a smile on their face. One patient shared that if they had been in a weaker state, they would have found it challenging to walk from the multi-storey car park on their own to the unit on foot and unaided without a wheelchair available.

- Staff experiences and comments

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Staff shared their experiences of working at CCC Aintree and Marina Daglish unit. One recently joined the Trust in the summer and is enjoying the role now fully completed training and assessed competent to perform the role. Car parking is much easier and available on the CCC Aintree site compared to CCC Liverpool where they also work. Also comments and discussion about medical workforce cover & safety and being able to see medical colleagues in outpatient settings again who are seeing patients face to face (dependent often on consultant preference also) and that one size does not and should not fit all. Whilst acknowledging that digital technologies are available at the Trust to use and are useful in those circumstances were clinically appropriate and the patient chooses to opt for those.

- What does CCC do well?
  Patients come first and make patients feel at ease during a difficult time
  Staff work hard and as a team, during extremely busy and challenging times and smile. Even when wearing PPE masks, a smile shines through in the eyes!
  Radiotherapy and Chemotherapy care is very good for patients at the CCC Aintree site and Marina Daglish unit

- What can CCC do better?
  Review accessibility and support of property sites, particular for those people weakened by treatments who attend appointments without a visitor/family member/carer, who may need to walk a distance from car parks to the treatment location

3. Next Steps and Recommendations

- Discuss report findings at Trust Board
- Note content of report
- 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:	Board of Directors
Date of meeting:	Wednesday 24th November
Agenda item:	P1-197-21
Title:	Integrated Performance Exception Report M7 2021/2022
Report prepared by:	Hannah Gray: Head of Performance and Planning
Executive Lead:	Joan Spencer: Chief Operating Officer
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Performance Committee and Quality Committee
Date & decision:	Wednesday 17th and Thursday 18th November 2021

Purpose of the paper/key points for discussion:	This exception report provides the Board of Directors with an update on performance for month 7 2021/22 (October 2021). The access, efficiency, quality, research and innovation, workforce and finance scorecards are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant. Points for discussion include under performance, developments and key actions for improvement.

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

Next steps required:	

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

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

☒ BE **OUTSTANDING**

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

☒ BE **COLLABORATIVE**

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

☒ BE **RESEARCH LEADERS**

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

☒ BE **A GREAT PLACE TO WORK**

BAF Risk	
If we do not invest in effective, inclusive leadership, there is a risk this will adversely impact on the Trust's ability to deliver the Trust's five year Strategy.	☒
If we are unable to recruit and retain high calibre staff there is a risk of an adverse impact on the quality of care and reputation of the Trust.	☒
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 7 2021/22)

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

Introduction

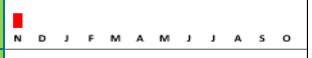
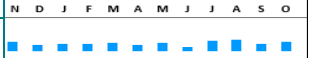
This report provides an update on performance for month seven; October 2021. The access, efficiency, quality, workforce, research and innovation, and finance scorecards are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant.

Staff flu vaccine and Covid booster vaccine data is included in this M7 report.

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	Oct-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer						
L	**9 days** from referral to first appointment	⟷	G: ≥90% A: 85-89.9% R: <85%	96.8%	93.6%	
C/S	**2 week wait** from GP referral to 1st appointment	↓	93%	88.9%	99%	
L	**24 days** from referral to first treatment	⟷	G: ≥85% A: 80-84.9% R: <80%	91.5%	88.7%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	⟷	75%	75.0%	82.3%	
	28 day faster diagnosis - (Screening)	-	75%	0%	0%	There has only been 1 28 Day FDS Screening patient during this time
S	**31 day** wait from diagnosis to first treatment	⟷	96%	100.0%	99.4%	
C/S	**31 day** wait for subsequent treatment (Drugs)	⟷	98%	100.0%	99.3%	
C/S	**31 day** wait for subsequent treatment (Radiotherapy)	⟷	94%	99.7%	98.5%	
S	Number of **31 day** patients treated **≥ day 73**	⟷	0	0	0	
C/S	**62 Day** wait from GP referral to treatment	⟷	85%	85.2%	88.8%	
C/S	**62 Day** wait from screening to treatment	⟷	90%	66.7%	92.3%	
L	Number of patients treated between **63 and 103 days** (inclusive)	↑	No Target	57	297	
S	Number of patients treated => **104 days**	↑	No Target	16	99	
L	Number of patients treated => **104 days AND at CCC for over 24 days (Avoidable)**	↑	G: 0 A: 1 R: >1	1	4	
C/S	Diagnostics: **6 Week Wait**	⟷	99%	100%	100%	
C/S	**18 weeks** from referral to treatment (RTT) Incomplete Pathways	⟷	92%	97.7%	98.7%	

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	Sep-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Liz Bishop, CMCA SRO						
C/S	**2 week wait** from GP referral to 1st appointment	⟷	93%	89.3%	90.5%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	↓	75% (shadow monitoring)	69.8%	73.5%	
C/S	**62 Day** wait from GP referral to treatment	⟷	85%	76.3%	76.4%	

Notes:

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

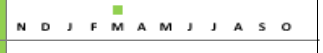
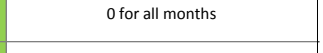
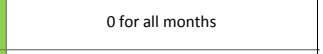
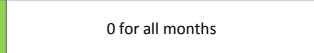
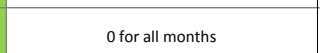
1.2 Efficiency

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Oct-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer						
S (SOF)	Elective activity (inpatient admissions and day case) as % of the same month in 2019/2020	⟷	95% of 2019/20 levels	57%	66%	
S (SOF)	Diagnostic activity as % of the same month in 2019/2020	⟷	95% of 2019/20 levels	175%	181%	
S (SOF)	% of all (non-treatment) outpatient activity delivered remotely via telephone or video	⟷	25%	67%	70%	
L	Outpatient Appointments (including treatments) as % of the same month in 2019/2020	⟷	95% of 2019/20 levels	113%	129%	
S	Length of Stay: Elective (days): Solid Tumour	⟷	G: ≤6.5 A: 6.5-6.8 R: >6.8	7.4	6.3	
S	Length of Stay: Emergency (days): Solid Tumour	↓	G: ≤8 A: 8.1-8.4 R: >8.4	6.9	7.9	
S	Length of Stay: Elective (days): HO Ward 4	⟷	G: ≤21 A: 21.1-22.1 R: >22.1	12.3	16.1	
S	Length of Stay: Emergency (days): HO Ward 4	⟷	G: ≤22 A: 22.1-23.1 R: >23.1	11.3	12	
S	Length of Stay: Elective (days): HO Ward 5	⟷	G: ≤32 A: 32.1-33.6 R: >33.6	19.9	18.7	
S	Length of Stay: Emergency (days): HO Ward 5	⟷	G: ≤46 A: 46.1-48.3 R: >48.3	10.3	12.9	
S	Delayed Transfers of Care as % of occupied bed days	⟷	≤3.5%	1.7%	2.7%	
S	Bed Occupancy: Midnight (Ward 4: HO)	↑	G: ≥85% A: 81-84.9% R: <81%	88.4%	86.3%	
S	Bed Occupancy: Midnight (Ward 5: HO)	↓	G: ≥80% A: 76-79.9% R: <76%	78.1%	74.5%	
S	Bed Occupancy: Midday (Solid Tumour)	⟷	G: ≥85% A: 81-84.9% R: <81%	61.5%	70.9%	
S	Bed Occupancy: Midnight (Solid Tumour)	⟷	G: ≥85% A: 81-84.9% R: <81%	67.9%	72.1%	
C	% of expected discharge dates completed	⟷	G: ≥95% A: 90-94.9% R: <90%	89.0%	85.0%	
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	N/A	No elective procedures have been cancelled on or after the day of admission
C/S	% of urgent operations cancelled for a second time	⟷	0%	0%	0%	0% for all months
L	Imaging Reporting: Inpatients (within 24hrs)	⟷	G: ≥90% A: 80-89.9% R: <80%	97.3%	97.0%	
L	Imaging Reporting: Outpatients (within 7 days)	↑	G: ≥90% A: 80-89.9% R: <80%	81.3%	81.0%	
C/Phase 3 Covid-19 Guidance	Data Quality - % Ethnicity that is complete (or patient declined to answer)	⟷	G: ≥95% A: 90-94.9% R: <90%	97.3%	96.5%	
C	Data Quality - % of outpatients with an outcome	⟷	G: ≥95% A: 90-94.9% R: <90%	100.0%	99.6%	
C	Data Quality - % of outpatients with an attend status	⟷	G: ≥95% A: 90-94.9% R: <90%	100.0%	99.6%	
Executive Direct	Executive Director Lead: James Thomson, Director of Finance					
S	Percentage of Subject Access Requests responded to within 1 month	↑	100%	100%	99%	
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	Oct-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Julie Gray, Chief Nurse						
C/S	Never Events	⟷	0	0	0	0 for all months
C/S	Serious Untoward Incidents (month reported to STEIS)	⟷	0	0	4	
C/S	Serious Untoward Incidents: % submitted within 60 working days / agreed timescales	-	100%	0 requiring submission	80%	
S	RIDDOR - number of reportable incidents	↑	0	1	2	
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	171.3	201.07	
L	Incidents resulting in harm /1,000 bed days	↓	No target	19	19	
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%	100.0%	98.0%	
C/S	% of Sepsis patients being given IV antibiotics within an hour*	-	90%	Data not yet validated	Data not yet validated	
C/S	VTE Risk Assessment	⟷	95%	97.0%	95.4%	
S	Dementia: Percentage to whom case finding is applied	↑	90%	100.0%	98.0%	
S	Dementia: Percentage with a diagnostic assessment	-	90%	No patients	N/A	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)	2	10	
C/S	E Coli (attributable)	⟷	≤6 (pr yr)	2	7	
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)	1	1	
C	Klebsiella (attributable)	↑	≤6 (pr yr)	2	4	
C	Pseudomonas (attributable)	⟷	≤10 (pr yr)	0	0	
C/S	FFT score: Patients (% positive)	⟷	G: ≥95% A: 90-94.9% R: <90%	96%	95%	

The Quality KPI scorecard continues on page 5

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Oct-21	YTD 2021/22	Last 12 Months
Executive Director Lead: Julie Gray, Chief Nurse						
C	Number of formal complaints received	↓	No target	2	24	
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%	96%	
L	% of routine formal complaints resolved in month, which were resolved within 25 working days	↔	G: ≥75% A: 65-74.9% R: <65%	100%	65%	
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	75%	100% or None to be resolved in all months, except 0% in March 2021 and Sept 2021
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%	91%	93%	
L	Number of policies due to go out of date in 3 months	↑	No target	24	N/A	
L	% of policies in date	↔	G: ≥95% A: 93.1-94.9% R: <93%	96%	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	Oct-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)	51	390	
National	Study set up times (days)	↔	≤40 days	N/A	N/A	Latest reporting period is 1/7/20 – 30/6/21: 29 days
L (Strategy)	Recruitment to time and target	↔	G: ≥55% A: 45-54.9% R: <45%	N/A	N/A	Latest reporting period is 1/7/20 – 30/6/21: 33%
L (Strategy)	Studies Opened	↓	G: ≥5 A: 4-5 R: <4 (pr month)	4	25	
L (Strategy)	Publications	↔	G: ≥11 A: 10-9 R: <9 (pr month)	23	111	

An amber, rather than red RAG rating is now applied to YTD figures that do not breach the annual target.

1.5 Workforce

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Oct-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%	5.1%	4.6%	
S	Staff Turnover*	↓	G: ≤1.2% A: 1.21–1.24% R: ≥1.25%	1.17%	10.5%	
S	Statutory and Mandatory Training	↔	G: ≥90% A: 75-89% R: ≤75%	96.11%	N/A	
L	PADR rate	↔	G: ≥95% A: 75-94.9% R: ≤74%	93.39%	N/A	
C	% of 'Frontline' Staff Flu Vaccinated (at month end)	-	85% by campaign end	49%	N/A	Flu vaccinations began in October 2021
L	% of Staff (who have had the first and second vaccine) who have also had the Covid-19 booster vaccination (at month end)	-	No national target	19%	N/A	Covid 19 Booster vaccinations began in October 2021

*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 October the key financial headlines are:

Metric (£000)	In Mth 7 Actual	In Mth 7 Plan*	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit)	(484)	(806)	322		(468)	(806)	337	
CPL/Propcare Surplus/ (Deficit)	(41)	0	(41)		379	0	379	
Control Total Surplus/ (Deficit)	(525)	(806)	281		(89)	(806)	716	
Group Cash holding	58,534	58,940	(406)		58,534	58,940	(406)	
Capital Expenditure	(5)	0	5		119	1,451	1,332	
Agency Cap	87	95	8		504	665	161	

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) was to achieve a break-even position. The Trust submitted a draft plan to the ICS for the second six months of the year (H2) on 11th November, this identified a planned deficit of £6.167m. The planning process is still on-going with final plans due to NHSE/I on 18th November. The ICS is expected to undertake a final re-allocation of systems monies before this date.

2. Exception Reports

2.1 Access

2 week wait from GP referral to 1st appointment	Target	Oct-21	YTD	Last 12 months
	G: ≥93% R: <93%	88.9%	99%	

Reason for non-compliance

1 patient breached the 2 week wait target in October due to patient choice of appointment date. This breach was deemed unavoidable.

Patient choice of first appointment date, patient re-arranged the first appointment date that was offered.

Action taken to improve compliance

N/A

Expected Date of Compliance	31/12/21
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

28 day faster diagnosis (Screening)	Target	Oct-21	YTD	Last 12 Months
	G: ≥ 75% R: <75%	0%	0%	There has only been 1, 28 Day FDS Screening patient during this time

Reason for non-compliance

1 patient breached the 28 day FDS Screening target in October. The patent was referred from another trust on day 36 of the Screening pathway and required further diagnostic tests after referral, to confirm a no cancer diagnosis. The breach was deemed unavoidable to CCC.

Patient did not attend a diagnostic scan appointment at CCC and the appointment was rescheduled.

Action taken to improve compliance

N/A

Expected Date of Compliance	30/11/21
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

62 Day wait from screening to treatment	**Target**	**Oct-21**	**YTD**	**Last 12 Months**
	G: ≥ 90% R: < 90%	66.7%	92.3%	

Reason for non-compliance

1 patient breached the 62-day Screening target in October due to a medical reason. This breach was deemed unavoidable.

Medical reason as treatment was booked to start within target date but was deferred as patient needed further assessment for unrelated medical condition prior to commencing treatment.

Action taken to improve compliance

N/A

Expected Date of Compliance	31/12/21
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

Number of patients treated ≥104 days AND at CCC for over 24 days (Avoidable breaches)	**Target**	**Oct-21**	**YTD**	**Last 12 Months**
	G: 0 A: 1 R: >1	1	4	

Reason for non-compliance

16 patients breached the 104+ day target in October; referred in between day 73 and 200 to CCC.

4 of the 16 patients were at CCC for more than 24 days between referral and treatment. 1 of these patients was an avoidable accountable breach to CCC.

This was an admin error; the patient was not registered as a target patient and therefore not tracked on a 62 day pathway.	
Action taken to improve compliance Training plans for the registration team have been reviewed. All staff are following a rigorous training plan and the Service Lead and Waiting Times Manager have worked closely to develop this plan to ensure the training incorporates all targets.	
Expected Date of Compliance	31/12/21
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

2 week wait from GP referral to 1st appointment (Alliance-level)	**Target**	**Sept-21**	**YTD**	**Last 12 Months** (to Sept)
	93%	**89.3%**	**90.1%**	

Reason for non-compliance

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

Suspected lower gastrointestinal cancer 78.3% (572 breaches),
Suspected upper gastrointestinal cancer 85.9% (164 breaches),
Suspected gynaecological cancer 88.5% (132 breaches),
Suspected breast cancer 90.7% (206 breaches),
Exhibited (non-cancer) breast symptoms - cancer not initially suspected 90.7% (41 breaches),
Other suspected cancer (not listed) 90.9% (2 breaches),
Suspected head and neck cancer 91.8% (82 breaches),
Suspected haematological malignancies (excluding acute leukaemia) 92.6% (6 breaches)

Providers not achieving the national standard were:

Countess of Chester Hospital 52.2% (506 breaches),
Southport and Ormskirk Hospital 78.5% (243 breaches),
St Helens and Knowsley Hospitals 89.4% (194 breaches),
East Cheshire 91.7% (49 breaches),
Liverpool University Hospitals 92.7% (249 breaches)

Outpatient capacity issues were recorded as the most frequent breach reason (56%), followed by patient choice (31%).

TWW referral rates were exceptionally high in September, 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	Compliance with the 14 day standard is expected in to return by the 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**	**Sept-21**	**YTD**	**12 month trend** (to Sept)
	85%	**73.6%**	**76.4%**	

Reason for non-compliance

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

Brain/Central Nervous System 0% (0.5 breaches),
Gynaecological 26.7% (33 breaches),
Other 33.3% (6 breaches),
Lower Gastrointestinal 36.9% (44.5 breaches),
Head & Neck 56.3% (14 breaches),
Upper Gastrointestinal 59.4% (13 breaches),
Haematological (Excluding Acute Leukaemia) 64.3% (10 breaches),
Lung 68.7% (15.5 breaches),
Urological (Excluding Testicular) 72.1% (31 breaches)

Providers not achieving the national standard were:

Liverpool Womens 6.1% (15.5 breaches),
Southport and Ormskirk Hospital 54.2% (24.5 breaches),
Warrington and Halton Teaching Hospitals 64.2% (21.5 breaches),
Liverpool University Hospitals 67.1% (52 breaches),
East Cheshire 68.2% (10.5 breaches),
Countess Of Chester Hospital 71.6% (25 breaches),
Bridgewater Community Healthcare 72.7% (1.5 breaches),
Mid Cheshire Hospitals 84.4% (11.5 breaches),
Wirral University Teaching Hospital 84.4% (13 breaches)

The main reasons for breaches were complex diagnostic pathways (15%), healthcare provider initiated delay to diagnostic test or treatment planning (22%) and 'other' (44%).

Action Taken to improve compliance

- Continuation of surgical and diagnostics hubs as part of CMCA's response to Covid-19.
- The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group.
- The endoscopy operational recovery team, in collaboration with the C&M Hospital Cell has produced a clear, prioritised plan to increase capacity.
- The Alliance has secured £5.4m capital investment to increase endoscopy capacity and improve productivity.
- £600,000 investment to support full implementation of symptomatic faecal immunochemical testing (sFIT) in primary care. This builds on the existing secondary care sFIT model. Implementation will reduce demand for endoscopy services.
- Further £400k invested in using FIT to validate and risk stratify LGI endoscopy waiting lists and surveillance lists.
- Patient and public communications to improve patient confidence to attend for appointments.
- Additional £1m secured to accelerate recovery especially in lower GI pathways

Expected date of compliance	Compliance with the 62 day standard is expected in Q4 2021/2022.
Escalation route	NHS England, North West CCC Performance Committee, Trust Board
Executive Lead	Liz Bishop, CMCA SRO

2.2 Efficiency

Length of Stay: Elective (days) Solid Tumour	**Target**	**Oct-21**	**YTD**	**Last 12 Months**
	G: ≤6.5 A: 6.5-6.8 R: >6.8	7.4	6.3	

Reason for non-compliance

The LOS for elective admissions on ST wards was 0.9 days over target at 7.4 days**.**

Several patients were admitted for planned Chemotherapy but were septic on admission, leading to a longer length of stay**.**

There has been an increased demand for ambulance services (to transfer patients to other hospitals and hospices) resulting in delays in arrival; on average an end of life ambulance is taking up to 8 hours. Due to these delays, we have lost beds in other hospitals when patients require repatriation.

Due to community staffing issues, it is continuing to take much longer to commission Packages of Care (POC) for both social and fast track POC; taking on average 3 weeks to commission. This

has led to increased length of stay at CCC and is also having a knock on effect on hospices, leading to longer waits to transfer patients to hospices.

The CUR non-qualifying rate for October is 3%, which provides assurance that there was a low incidence of inappropriate utilisation of beds.

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	December 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

Bed Occupancy	**Wards**	**Target**	**Oct-21**	**YTD**	**Last 12 Months**
	Solid Tumour (Midday)	G: ≥85% A: 81-84.9% R: <81%	61.5%	70.9%	
	Solid Tumour (Midnight)	G: ≥85% A: 81-84.9% R: <81%	67.9%	72.1%	
	Ward 5 (HO) (Midnight)	G: ≥80% A: 76-79.9% R: <76%	78.1%	74.5%	

Reason for non-compliance

Solid tumour ward bed occupancy continues to be below the Trust's target of 85% and has fallen 10% since September.

Ward 5 (HO) occupancy has fallen 5% since September, to 78%, which is marginally (1.9%) below the target.

These 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 October. No mutual aid patients have transferred across to CCC Liverpool from LUHFT in October 2021.

The Trust has been predominantly on OPEL 1(Green) during October 2021, however OPEL 3 has been recorded for the solid tumour wards on 4 occasion and Haemato-oncology on 10 occasions.

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 • PFT continue to work with wider MDT to aid discharge planning during the COVID-19 pandemic, and also liaise with Acute Oncology so that we are offering oncology beds to our patients when they are required • 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

% of expected discharge dates completed	**Target**	**Oct-21**	**YTD**	**Last 12 Months**
	G: ≥95% A: 90-94.9% R: <90%	89%	85%	

Reason for non-compliance Although this target for recording expected discharge dates on Meditech has not been achieved, this has improved and is now 6% below target for October 2021, at 89%. Following review of compliance, it has been identified that the Haemato-oncology (HO) admission documentation requires amendments to improve the capture of expected discharge dates (EDD) information.	
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	31st December 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

Imaging Reporting: Outpatients (within 7 days)	**Target**	**Oct-21**	**YTD**	**Last 12 Months**
	G: ≥90% A: 80-89.9% R: <80%	81.3%	81%	

Reason for non-compliance

Although the target has not been achieved, performance improved from 76.5% in September to 81.3% in October, against a target of 90%.

Reasons for non-compliance include:

- Radiology activity has doubled since CCCL opened, placing increasing demands on the Radiologist team.
- Loss of reporting capacity due to Radiologists supporting clinical services; Interventional Radiology and Ultrasound, whilst recruitment is underway.
- Implementation of the recruitment plan is being hindered by a lack of available workforce and competing rates of pay locally and nationally.
- CCC Radiologists supporting additional MDT activity.
- Operational issues with CRIS and PACS across Cheshire and Merseyside continue to be reported, which is creating a delay in the ability to report scans in a timely way. An alternative network path is being tested on 10th November as part of the on-going work to resolve these issues.

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 (100 CT/ 20 MRI per week), however this increase is having a negative effect on Medica's response times.
- 1 additional Radiologist started on 18th September 2021.
- Clinical Imaging Fellow started on 1st September 2021.
- Radiologist recruited in December 2019 was delayed by COVID in their country of residence; recent progress has been made, with an estimated start date early 2022.
- Bi-weekly report received by senior Radiology team enabling continuous monitoring and prioritisation of outstanding reports.
- Business case developed to support an increase in CCC Radiologist workforce to be presented at Finance Committee on 12th November.
- A recovery plan is being developed.

Expected date of compliance	September 2022
Escalation route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Performance Committee, Trust Board
Executive lead	Joan Spencer, Chief Operating Officer

2.3 Quality

RIDDOR – number of reportable incidents	Target	Oct-21	YTD	Last 12 Months
	R: >0 G: 0	1	2	

Reason for non-compliance

There was 1 RIDDOR reportable incident in October 2021.

A member of staff slipped indoors (close to an entrance) at CCCW, during wet weather. The member of staff continued to work until they attended A&E 5 days later and an x-ray confirmed a closed fracture of the fibula.

Action taken to improve compliance

The incident was investigated to ascertain the cause of the fall. There were no witnesses to the fall and CCTV was reviewed, however the incident was not captured. The cause of the fall cannot be confirmed.

This incident happened during a period of wet weather. The following mitigating features were in place at the time and remain so:

- The entrance used to access the main corridor has an absorbent fitted mat to remove any excess water from footwear.
- Umbrella bags are also available for staff to place wet umbrellas in to prevent dripping onto surfaces.

Expected Date of Compliance	November 2021
Escalation Route	Divisional Quality, Safety and Performance Meetings, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Director Lead	Julie Gray, Chief Nurse

Clostridiodes difficile infections (attributable)	Target	Oct-21	YTD	Last 12 Months
	≤11 per year	2	10	

Reason for non-compliance

There were 2 CCC attributable cases of CDI in October, taking the total to 10 YTD against a target of 11 or fewer for the year.

Both patients developed loose stools after admission and were sampled appropriately. No learning points were identified in the first case, the second case may have been acquired during a recent previous admission to CCC; this is being further investigated. Learning points and actions required in response to the recent increase in infection rates have been shared at Quality Committee and an implementation plan is underway.

Action taken to improve compliance

- Root Cause Analysis has been completed, this will be taken to an Executive Review Panel on 23.11.21
- Improve hand hygiene compliance – encourage use of soap and water for enteric pathogens, explore new technologies available to improve compliance
- Support patients with hand hygiene after using commode/bed pans and patients who cannot access the hand wash basin to be given packs of wipes
- Reinforce hand hygiene methods for patients with use of placemats and updated leaflets
- Improve cleaning of shared equipment – pilot smaller packs of wipes on BP monitors
- Improved collaboration and communication with ISS colleagues – regular meetings and updates
- Improve discharge process – facilitate discharges earlier in the day

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	Julie Gray, Chief Nurse

E.coli infections (attributable)	Target	Oct-21	YTD	Last 12 Months
	≤6 Per year	2	7	

Reason for non-compliance

There were 2 CCC attributable cases of E.coli in October, taking the total to 7 YTD, which is beyond the target of 6 or fewer for the year.

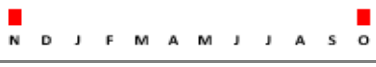
1 case was as a result of gut translocation. 1 case was hepatobiliary in origin. Both also identified *klebsiella* in the same set of cultures. Mixed bactereamia such as this are typically associated with gut or hepatobiliary sources. Both patients were HO patients who developed mucositis after treatment.

Action taken to improve compliance

No learning points were identified from this case. Due to the recent rise in cases however, the following actions have been identified:

- Immediate implementation of new Catheter Care Plan
- Immediate communication regarding referral process to both medical and nursing teams
- Raise awareness of the care plan and process at daily safe huddles
- Ensure care plans are available on the ward for staff to use
- Support staff with any training/education relating to the care plan including via the Clinical Skills Educators
- Upload the IPC Catheter Care Presentation to MS Teams for all staff to access.
- Identify catheter champions in the ward areas

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	Julie Gray, Chief Nurse

Meticillin Sensitive staphylococcus aureus (MSSA) infections (attributable)	Target	Oct-21	YTD	Last 12 Months
	G: ≤4, A: 5 R: >5 Per year	1	1	

Reason for non-compliance

There was one MSSA blood stream infection in October 2021 from a treatment site reaction (cellulitis) on patient's neck reported to have been sloughy. The patient also had a *Staphylococcus aureus* positive wound swab obtained in October. Skin / soft tissue seems the most likely source in this case.

Action taken to improve compliance The wound was a radiation burn, this is an accepted risk of radiotherapy treatment.	
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	Julie Gray, Chief Nurse

Klebsiella infections (attributable)	**Target**	**Oct-21**	**YTD**	**Last 12 Months**
	≤ 6 Per year	2	4	
Reason for non-compliance There were 2 CCC attributable cases of Klebsiella in October, taking the total to 4 YTD against a target of 6 or fewer for the year. 1 case was as a result of gut translocation. 1 case was hepatobiliary in origin. Both also identified *E.coli* in the same set of cultures. Mixed bactereamia such as this are typically associated with gut or hepatobiliary sources. Both patients were HO patients who developed mucositis after treatment.				
Action taken to improve compliance No learning points were identified.				
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	Julie Gray, Chief Nurse			

2.4 Research and Innovation

Study Recruitment	Target	Oct-21	YTD	Last 12 months
	G: ≥1300, A: 1100-1299, R: <1100 per year	51	390	

Reason for non-compliance

390 patients have been recruited against an internal target of 758 (51% of target) at the end of Month 7. The main reasons at Month 7 for not achieving this target are:

- Only three new studies that use the Aseptic Service have been greenlighted to recruitment since 5th March 2021. Two out of the three studies have now been closed early by Sponsor with three patients in total recruited.
- New studies that are opening are taking time to bed-in before recruitment increases are evident; increases are seen after approximately two months, depending on the trial type and target.
- It has also been noted during this current round of Portfolio Reviews that some portfolios are getting smaller as the clinical trial pipeline is not flowing through as it has done in the past. This is due to studies opening being affected by the pandemic and more recently pharmacy issues.
- Currently the rate limiting factor for opening new studies to recruitment is clinical trials pharmacy staffing capacity.

Action taken to improve compliance

- 0.5 WTE Interim Lead Clinical Trials Pharmacist in post. Substantive full-time post appointed to and due to start in January 2022. Deputy Lead Clinical Trials Pharmacist back out to advert.
- Agreed priority list with SRGs and with Interim Chief Pharmacist to progress studies requiring green light.
- Research Study Prioritisation Committee is currently being set-up, this will be clinician-led and will have representation from ECMC/Early Phase, Medical Oncology, Clinical Oncology, Heamato-Oncology, Pharmacy, Associate Medical Director for Network Services, Research Delivery and Research Governance. Aiming for first meeting w/c 15th November 2021.
- Engaging with the PIs on observational studies through the Portfolio Review meetings to maximise recruitment.

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

2.5 Workforce

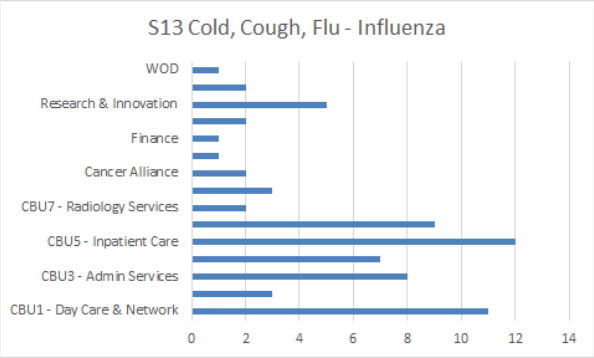
Staff Sickness	Target	Oct-21	YTD	Last 12 Months
	G: ≤4%, A: 4.01– 4.99% R: ≥ 5%	5.05%	4.69%	

Reason for non-compliance

The in-month figure for absence has increased from 4.73% to 5.05% in October 2021, the 12-month figure has also increased marginally from 4.61% to 4.69%. The highest reasons for absence are summarised in the table below:

Absence Reason	Number of Episodes
S13 Cold, Cough, Flu - Influenza	69
S10 Anxiety/stress/depression/other psychiatric illnesses	40
S25 Gastrointestinal problems	32

Cold, cough and flu was the highest reason for absence and the number of episodes has increased significantly from 38 episodes in September to 69 episodes in October. CBU5 had the highest number of episodes, followed closely by CBU1 and CBU6.



Anxiety, stress and depression was the second highest reason for absence and the total number of episodes has decreased from 44 in September to 40 in October. Of the 40 episodes, 8 were work related and 32 were personal related; this is a decrease of 4 work related stress absences from the previous month. Of the total stress related absences, 26 are long-term, which is a decrease of 4 from last month and another 8 of these episodes ended in October whilst 18 continue into November. There were 14 short-term absences and 8 continue into November.

Gastrointestinal problems remains the third highest reason for absence, however the number of episodes have decreased from 35 episodes in September to 32 in October.

Action taken to improve compliance

- As anxiety/ stress/ depression is consistently in the top 3 reasons for absence and the number of work-related stress absences was increasing, the HRBP team have created a page on the intranet dedicated to supporting managers with stress management.

- 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.
- Following completion of the annual stress audit, the HR Business Partnering team are currently in the process of contacting members of staff who have been absent recently due to anxiety/stress/depression to ask them to provide feedback on their experience and the support that they were provided in order to identify if improvement of the management of stress absences is required going forward and whether this can reduce the number of absences and the absence lengths due to anxiety/stress/depression.
- As gastrointestinal problems are consistently a high reason for absence, the HR Business Partnering team are raising awareness at HR surgeries of the Infection, Prevention and Control guidance to wash hands with soap and water where norovirus is present as this is more effective than hand gel.

Expected date of compliance	February 2022
Escalation route	Divisional Meetings, Workforce Transformation Committee, Performance Review Meetings, Quality Committee, Trust
Executive lead	Jayne Shaw, Director of Workforce and OD

PADR	**Target**	**Oct-21**	**Last 12 Months**
	G: ≥95% A: 75% - 94.9% R: ≤74%	93.39%	

Reason for non-compliance

The overall Trust's in month compliance for PADRs is 93.39% which remains below the target of 95% but continues to show a positive increase from previous months.

As part of Performance Review Group (PRG) meetings, a target date of achieving and maintaining compliance by the end of September was agreed but compliance still remains below the target.

Areas underperforming against the target are detailed below;

Org L4	Assignment Count	Reviews Completed	Reviews Completed %
158 CBU1 - Day Care & Network	130	118	**90.77**
158 CBU4 - Pharmacy	47	43	**91.49**
158 CBU5 - Inpatient Care	194	177	**91.24**
158 CBU6 - Radiotherapy	166	157	**94.58**
158 CBU7 - Radiology Services	55	50	**90.91**
158 Communications	4	3	**75.00**
158 Executive Office	12	11	**91.67**
158 Informatics & IT	65	61	**93.85**
158 Project Management Office	6	2	**33.33**

158 Recharges	14	12	**85.71**
158 Research & Innovation	43	40	**93.02**
158 Safeguarding	8	7	**87.50**

All divisions have been issued with detailed reports to support the proactive management of PADR compliance.

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 conversations.

Action taken to improve compliance

- Underperforming departments to achieve compliance by the revised date of the end of November 2021
- 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	Revised date of December 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
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Report to:	Trust Board	
Date of meeting:	24th November 2021	
Agenda item:	P1-198-21	
Title:	Finance Report - Month 7	
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 October (Month 7) 2021-22.

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

Next steps required:	N/A

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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.

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Finance Report

Jo Bowden - Deputy Director of Finance

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The Clatterbridge Cancer Centre NHS Foundation Trust

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1. Introduction

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

Metric (£000)	In Mth 7 Actual	In Mth 7 Plan*	Variance	Risk RAG	YTD Actual	YTD Plan*	Variance	Risk RAG
Trust Surplus/ (Deficit)	(484)	(806)	322		(468)	(806)	337	
CPL/Propcare Surplus/ (Deficit)	(41)	0	(41)		379	0	379	
Control Total Surplus/ (Deficit)	(525)	(806)	281		(89)	(806)	716	
Group Cash holding	58,534	58,940	(406)		58,534	58,940	(406)	
Capital Expenditure	(5)	0	5		119	1,451	1,332	
Agency Cap	87	95	8		504	665	161	

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) was to achieve a break-even position. The Trust submitted a draft plan to the ICS for the second six months of the year (H2) on 11th November, this identified a planned deficit of £6.167m. The planning process is still on-going with final plans due to NHSE/I on 18th November. The ICS is expected to undertake a final re-allocation of systems monies before this date.

3. Operational Financial Profile – Income and Expenditure

3.1 Overall Income and Expenditure Position

The Trust financial position to the end of October is a £468k deficit against an £806k deficit plan, the group consolidated position is a £89k deficit. The group cash position is a closing balance of £58.5m, which is £0.4m below plan. Capital spend has reduced by £5k in month due to some old purchase orders being closed following review.

As previously reported the agency cap has been re-introduced as a metric in this financial year. As at month 7 we are slightly under the cap in month by £8k and £161k under year to date.

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

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Metric (£000)	Actual M7	Trust Plan M7	Variance	Actual YTD	Trust Plan YTD	NHSI Variance	Draft Trust Annual Plan
Clinical Income	16,974	16,063	911	118,052	116,254	**1,798**	195,687
Other Income	2,131	2,559	(428)	12,834	13,356	**(522)**	22,989
Total Operating Income	**19,105**	**18,622**	**483**	**130,886**	**129,610**	**1,276**	**218,676**
Total Operating Expenditure	(19,112)	(19,106)	(6)	(128,887)	(128,165)	**(722)**	(220,984)
Operating Surplus	**(7)**	**(484)**	**477**	**1,999**	**1,445**	**554**	**(2,308)**
PPJV	105	67	38	507	469	**38**	804
Finance Costs	(582)	(389)	(193)	(2,975)	(2,721)	**(254)**	(4,663)
Trust Surplus/Deficit	**(484)**	**(806)**	**322**	**(468)**	**(806)**	**338**	**(6,167)**
Subsiduaries	(41)	0	(41)	379	0	**379**	**0**
Consolidated Surplus/Deficit	**(525)**	**(806)**	**281**	**(89)**	**(806)**	**717**	**(6,167)**

The table below summaries the consolidated financial position:

October 2021 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	(565)	(1,032)
Donated Depreciation	81	564
Trust Retained Surplus / (Deficit)	**(484)**	**(468)**
CPL	35	146
Propcare	(76)	233
Consolidated Financial Position	**(525)**	**(89)**

3.3 Expenditure Position

3.3.1 The bridge below shows the key drivers between the £484k in month deficit and £806k deficit plan, which is a positive variance of £322k:

- Pay is under spent by £27k. While the run rate has only incrased by £26k compared to previous months avergae, the CIP requirement has increased in pay by c£100k per month reducing the overall variance.
- Drugs spend is over plan by £417k. 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.
- There has been a one off non-recurrent benefit in month of £464k. This is due to the freeze drugs payments for months 5 and 6 being higher than originally notified.
- Non-Pay costs are showing an overspend of £267k – this is predomiantly driven by un-met CIP of £189k.
- There is a one-off charge in month £182k relating to the loss on disposal of assets, this relates to beds purchased as part of the new hospital no longer been required and giften to another NHS organisation.
- The PPJV position is showing a £38k profit in month. This relates to the uncreased expected dividend position at the end of month 6.

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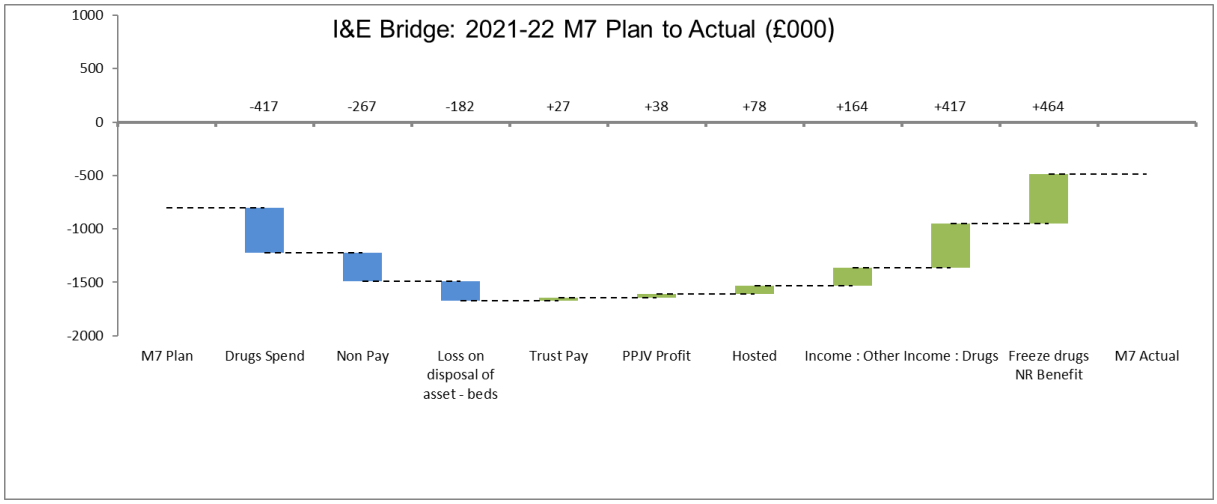
- Following joint review of the Propcare reoprted position we have adjusted the group position to reflect requirement for a minor works provision of £140k.



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

The pay position shows that divisions are largely operating below plan. Drugs spend is showing an overall overspend of £417k, the increase relates to pass-through drugs so is offset by an over recovery of income. In terms of other non-pay costs the Divisions are in the main showing slight overspends. As CIP is being met non-recurrently through the pay underspend, with the target sat in non-pay there is a misalignment.

The Cancer Alliance position is balanced overall by income.

October 2021 (M7) £(000)	Pay			Non-Pay			Total Expenditure
	Budget	Actual	Variance	Budget	Actual	Variance	Variance
Acute Care	1,687	1,640	47	694	731	(37)	10
Corporate	996	848	148	2,820	2,931	(111)	37
Networked	1,675	1,538	137	519	607	(88)	50
Radiation Services	1,574	1,580	(6)	353	484	(131)	(137)
Research	432	282	150	46	86	(40)	110
Drugs	0	0	0	7,064	7,481	(417)	(417)
Sub-Total Operating	**6,365**	**5,889**	**476**	**11,496**	**12,320**	**(824)**	**(348)**
Hosted - Cancer Alliance	266	251	15	1,348	834	515	529
Finance Costs	0	0	0	322	294	27	27
TOTAL	**6,631**	**6,140**	**491**	**13,166**	**13,449**	**(283)**	**208**

**please note there have been no changes to direct Divisional budgets as a result of the new plan as it has not yet been confirmed. The above is based on the current ledger plan excluding drugs and not updated to reflect the draft plan submitted to the ICS.*

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OCT 2021 (M7) WTE	Pay Budget	Pay Actual	Pay Variance	M6 Actual
Acute Care	395	374	(21)	379
Corporate	249	214	(35)	211
Networked	478	432	(46)	445
Radiation Services	326	327	1	312
Research	106	75	(30)	72
Hosted - Cancer Alliance	53	50	(3)	50
TOTAL	**1,607**	**1,472**	**(135)**	**1,469**
Of which substantive	1,607	1,443	(164)	1,433
Of which temporary	0	29	29	36
TOTAL	**1,607**	**1,472**	**(135)**	**1,469**

3.4 Bank and Agency Reporting

Bank spend in October is £89k, which is in line with previous months. The largest user of bank staff the Acute Division whose spend in month is £67k. The main reasons for bank spend is to cover vacancies and sickness in ward areas.

Agency spend in month is £86k, similar to last month but still higher than average for the year. We are reporting £8k below the agency cap in month and £161k cumulatively.

See Appendix F for further detail.

3.5 Cost Improvement Programme (CIP)

The Trust CIP requirement was £1.423m for the first six months of the year (H1).

In the latest plan submission on 11th November 2021 the assumed CIP requirement for the second 6 months of the year (H2) is £2.716m, 2.5% of plan.

CIP targets allocated to the Divisions remains at 2.0% which equates to £1.9m (excluding drugs and hosted services). The remainder of the CIP target will be managed centrally.

As at month 7 of the required £1.9m, a total of 807k of schemes have been identified by the Divisions, of which £608k 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 original 2021/22 capital plan approved by the Board in March was £7.187m. Subsequently, due to additional national capital funding sources being made available the Trust has received confirmation of a successful bid of £1.9m towards a Linear Accelerator and £300k TIF funding for a remote patient monitoring system. The revised annual plan is £9.233m. Due to the Cheshire & Merseyside overall capital position all organisations have been asked to review their positions and identify slippage and unrequired contingency. The Trust have identified £150k and offered a further £350k to support system pressures.

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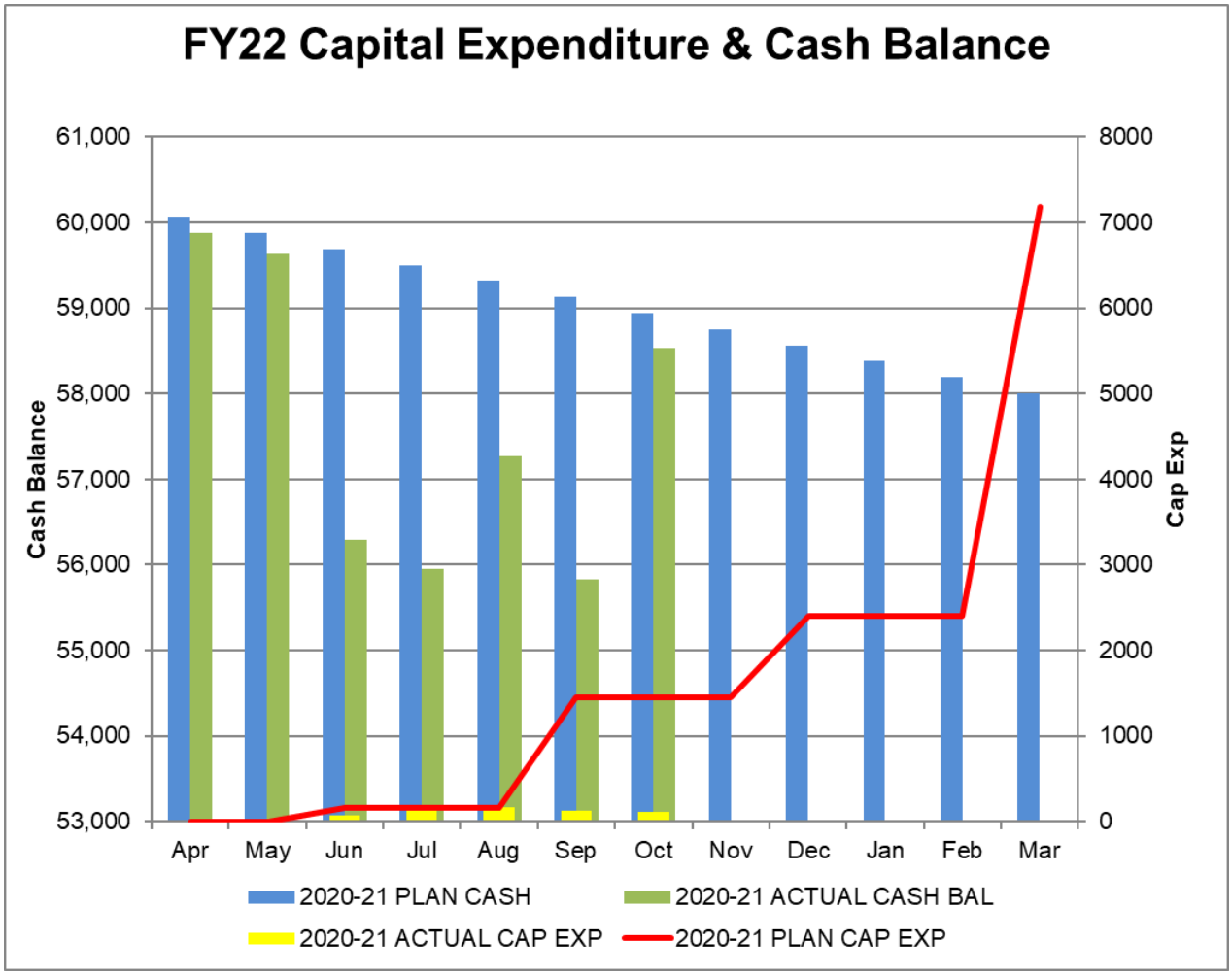
4.2 Capital expenditure of £119k has been incurred to the end of October, this is below the original planned spend profile for the year to date. The majority of the Trust expenditure is expected to occur towards the end of the year, and a large number of orders have now been placed. Capital Investment Group are closely monitoring the position to ensure any slippage risk is identified and mitigated.

4.3 The capital programme is supported by the organisation's cash position. The Group has a current cash position of £58.5m, which is a negative variance of £0.4m to the cash-flow plan. Cash is slightly below plan, however, there has been a £2.7m increase since last month which is largely due to receiving the remainder of elective recovery funding payment for H1.

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



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This chart shows monthly planned and actual Cash Balances and Planned Capital Expenditure for 2021/22. It shows that for October the Trust slightly less cash than planned, however, a significant increase since September.

5. Balance Sheet Commentary

5.1 Current Assets

Non-NHS receivables are £2,884k above plan, this is due to an increase in accrued income.

5.2 Current Liabilities

Payables (non-capital creditors) are showing a reduction of £2,651k against plan. This reduction is due to the exercise undertaken to review and clear old creditor balances.
Deferred Income is £4,486k above plan. This relates to R&I income, cancer alliance funding and HEE income.

6. Recommendations

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

- The reported deficit position for the month and cumulatively.
- The plan for H2 still being in draft and not due to be finalised until 18th November.
- The continuing strong liquidity position of the Trust

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Appendix A – Statement of Comprehensive Income (SOCI)

(£000)	Month 7			Cumulative YTD				2021/22
	Plan	Actual	Variance	Plan	Actual	Variance	%	Annual Plan
Clinical Income	16,012	16,958	946	115,888	118,697	2,809		195,065
Other Income	570	669	99	3,990	4,685	694		6,851
Hosted Services	2,040	1,479	(561)	9,733	7,504	(2,229)		16,760
Total Operating Income	**18,622**	**19,106**	**484**	**129,611**	**130,886**	**1,275**	**1%**	**218,676**
Pay: Trust (excluding Hosted)	(5,626)	(5,599)	27	(40,522)	(39,037)	1,485		(67,517)
Pay: Hosted & R&I	(698)	(533)	165	(4,423)	(3,400)	1,023		(7,850)
Drugs expenditure	(7,064)	(7,481)	(417)	(47,537)	(51,081)	(3,544)		(83,531)
Other non-pay: Trust (excluding Hosted)	(4,324)	(4,579)	(255)	(30,339)	(31,382)	(1,043)		(52,927)
Non-pay: Hosted	(1,394)	(920)	474	(5,346)	(3,986)	1,360		(9,159)
Total Operating Expenditure	**(19,106)**	**(19,112)**	**(6)**	**(128,166)**	**(128,886)**	**(720)**	**1%**	**(220,984)**
Operating Surplus	**(484)**	**(7)**	**477**	**1,445**	**2,000**	**555**	**38%**	**(2,308)**
Profit /(Loss) from Joint Venture	67	105	38	469	507	38		804
Interest receivable (+)	401	388	(12)	2,805	2,750	(55)		4,809
Interest payable (-)	(439)	(438)	2	(3,075)	(3,092)	(17)		(5,272)
Loss on disposal of assets	0	(182)	(182)	0	(182)	(182)		
PDC Dividends payable (-)	(350)	(350)	0	(2,450)	(2,450)	0		(4,200)
Trust Retained surplus/(deficit)	**(806)**	**(484)**	**322**	**(806)**	**(468)**	**338**	**42%**	**(6,167)**
CPL/Propcare	0	(41)	(41)	0	379	379		0
Consolidated Surplus/(deficit)	**(806)**	**(525)**	**281**	**(806)**	**(89)**	**717**	**89%**	**(6,167)**

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The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix B – Balance Sheet

£'000	Unaudited 2021	Plan 2022	Year to date Month 7		
			YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	2,488	2,100	2,424	2,305	(119)
Property, plant & equipment	177,180	174,267	175,680	171,848	(3,832)
Investments in associates	181	181	181	95	(86)
Other financial assets	1,364	0	0	0	0
Trade & other receivables	161	100	281	470	189
Other assets	0	0	0	0	0
Total non-current assets	**181,374**	**176,648**	**178,566**	**174,717**	**(3,849)**
Current assets					
Inventories	4,201	4,200	4,201	5,416	1,215
Trade & other receivables					
NHS receivables	4,621	4,500	4,621	6,057	1,436
Non-NHS receivables	4,484	4,500	7,779	10,663	2,884
Cash and cash equivalents	63,533	58,000	59,875	58,534	(1,341)
Total current assets	**76,839**	**71,200**	**76,476**	**80,670**	**4,194**
Current liabilities					
Trade & other payables					
Non-capital creditors	28,222	30,000	28,222	25,571	(2,651)
Capital creditors	3,544	2,000	2,000	1,730	(270)
Borrowings					
Loans	1,916	1,730	1,730	1,963	233
Obligations under finance leases	0	0	0	0	0
Provisions	2,160	1,535	2,160	2,266	106
Other liabilities:-					
Deferred income	5,974	4,000	5,974	10,460	4,486
Other	0	0	0	0	0
Total current liabilities	**41,816**	**39,265**	**40,086**	**41,990**	**(1,904)**
Total assets less current liabilities	**216,398**	**208,583**	**214,957**	**213,397**	**(1,559)**
Non-current liabilities					
Trade & other payables					
Capital creditors	970	0	970	970	0
Borrowings					
Loans	33,820	32,090	33,080	32,955	(125)
Obligations under finance leases	0	0	0	0	0
Other liabilities:-					
Deferred income	0	0	0	0	0
Provisions	1,270	110	1,270	1,270	0
Total non current liabilities	**36,060**	**32,200**	**35,320**	**35,195**	**(125)**
Total net assets employed	**180,338**	**176,383**	**179,637**	**178,204**	**(1,433)**
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	(0)
Income and expenditure reserve	110,264	105,667	109,563	108,130	(1,433)
Total taxpayers equity	**180,338**	**176,383**	**179,637**	**178,204**	**(1,433)**

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Appendix C – Cash Flow

October 2021 (M7) £'000	FT	Group	Group (exc Charity)
Cash flows from operating activities:			
Operating surplus	1,435	2,219	1,998
Depreciation	5,267	5,267	5,267
Amortisation	181	181	181
Impairments			
Movement in Trade Receivables	(5,443)	(2,214)	(5,340)
Movement in Other Assets	1,658		0
Movement in Inventories	(1,463)	(1,215)	(1,215)
Movement in Trade Payables	(1,651)	(5,922)	(2,618)
Movement in Other Liabilities	4,509	4,395	4,395
Movement in Provisions	49	197	197
CT paid	0	(26)	(26)
Net cash used in operating activities	**4,542**	**2,883**	**2,839**
Cash flows from investing activities			
Purchase of PPE	22	15	15
Purchase of Intangibles	0	0	0
Proceeds from sale of PPE	(182)	(182)	(182)
Interest received	2,750	21	0
Investment in associates	593	593	593
Net cash used in investing activities	**3,183**	**447**	**426**
Cash flows from financing activities			
Public dividend capital received	0	0	0
Public dividend capital repaid			
Loans received			
Movement in loans	(2,185)	(2,185)	(2,185)
Capital element of finance lease	0	0	0
Interest paid	(3,092)	(344)	(344)
Interest element of finance lease	0	0	0
PDC dividend paid	(2,450)	(2,450)	(2,450)
Finance lease - capital element repaid	0	0	0
Net cash used in financing activities	**(7,728)**	**(4,980)**	**(4,980)**
Net change in cash	**(3)**	**(1,650)**	**(1,714)**
Cash b/f	**53,765**	**63,533**	**60,248**
Cash c/f	**53,762**	**61,883**	**58,534**

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Appendix D – Capital

Capital Programme 2021-22
Month 7

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 7	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 Linacc Bunker - Maple	Julie Massey	420	0	420	0	420	100	320	✓	✗	Commences 1st November
4305	CCCW Linacc Bunker - Beech	Julie Massey	0	300	300	0	300	300	0	✗	✗	At planning stage with Propcare
4300	CCCW CT Simulator (Brilliance 2)	Louise Bunby	300	(191)	109	0	109	109	0	✓	✗	Commences 15th November
4302	CCCL Air Handling Unit Upgrade	Mel Warwick	0	28	28	31	(3)	31	(3)	✓	✓	
4306	CCCL Ward 2 Sluice	Jeanette Russell	0	33	33	2	31	33	0	✗	✗	Progress update required
4307	CCCL Ward 4 and 5 bathroom conversion	Pris Hetherington	0	56	56	0	56	56	0	✗	✗	Progress update required
	Contingency	*n/a*	200	(318)	(118)	0	(118)	256	(375)	-	-	
	Estates		**920**	**(91)**	**829**	**34**	**795**	**887**	**(58)**			
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	✓	✗	Delivery due 5th February
4305	CCCW Linear Accelerator - Beech (PDC)	Julie Massey	0	2,305	2,305	0	2,305	2,305	0	✓	✗	Delivery due 12th March
	CCCL Mobile Imagine Intensifier	Sam Wilde	138	0	138	0	138	138	0	✗	✗	Business case drafted
	MEME - Acute - Patient Monitor	Julie Massey	9	0	9	0	9	11	(2)	✗	✗	Business case expected at MEME 11/11
	MEME - Acute - 2x Ultrasound	Julie Massey	25	0	25	0	25	30	(5)	✗	✗	Business case expected at MEME 11/11
	MEME - Networked - 3x Scalp Cooler (I)	Julie Massey	28	0	28	0	28	34	(6)	✗	✗	Business case to Finance Committee 12/11
	MEME - Networked - 6x Scalp Cooler (II)	Julie Massey	69	0	69	0	69	83	(14)	✗	✗	Business case to Finance Committee 12/11
	MEME - Rad - Infinity Monitor M540	Julie Massey	9	0	9	0	9	0	9	✗	✗	Postponed to 23/24
	MEME - Rad - 3x Patient Monitor C500	Julie Massey	33	0	33	0	33	0	33	✗	✗	Postponed to 23/24
	MEME - Rad - 6x Patient Monitor M540	Julie Massey	54	0	54	0	54	0	54	✗	✗	Postponed to 23/24
4192	Cyclotron	Carl Rowbottom	742	0	742	45	697	742	0	✓	✗	PDC Funded
4300	CCCW CT Simulator (Brilliance 2)	Louise Bunby	500	166	666	0	666	666	0	✓	✗	Delivery due 5th December
4301	Stand Aids		0	0	0	14	(14)	14	(14)	✓	✓	
4304	CCCL Cardiac Monitors W4&5	Julie Massey	0	26	26	0	26	26	0	✗	✗	Progress update required
4308	2x Rhinolaryngo Videoscopes	Richard Lacey	0	64	64	0	64	64	0	✗	✗	App TEG 01/11. Requisition placed 08/11
	Contingency	*n/a*	200	(185)	15	0	15	70	(55)	-	-	
	Medical Equipment		**4,267**	**2,221**	**6,488**	**59**	**6,429**	**6,488**	**0**			
4190	***(20/21)*** Digital Aspirant	James Crowther	0	0	0	(14)	14	(14)	14	✓	✓	
	Infrastructure	James Crowther	1,350	(400)	950	(0)	950	964	(14)	✗	✗	£400k pushed back to 22/23
	Other minor programmes	James Crowther	250	0	250	97	153	250	0	✗	✗	
	CM Elective Fund - Remote Monitoring	James Crowther	0	300	300	0	300	300	0	✗	✗	New PDC funded scheme
	IM&T		**1,600**	**(100)**	**1,500**	**83**	**1,417**	**1,500**	**(0)**			
4142	Liverpool	Peter Crangle	0	0	0	(74)	74	(74)	74	✓	✓	
4142	Liverpool - Artwork	Sam Wade	0	66	66	0	66	66	0	✗	✗	Balance of original £250k allocation
4142	Wirral	Peter Crangle	400	(400)	0	0	0	0	0	✗	✗	Not expected to happen in 2021-22
4142	CCCL Link Bridge installation	Peter Crangle	0	0	0	16	(16)	16	(16)	✗	✗	
	Building for the Future		**400**	**(334)**	**66**	**(58)**	**124**	**8**	**58**			
	TOTAL		**7,187**	**1,696**	**8,883**	**119**	**8,764**	**8,883**	**0**			

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Appendix E – CIP

Directorate	Target	In Year 21.22	Full Year (Recurrent)	In Year Shortfall
ACUTE CARE	559,692	251,298	251,298	(308,394)
CORPORATE	319,068	137,116	97,931	(181,953)
NETWORKED SERVICES	547,860	66,817	78,150	(481,043)
RADIATION SERVICES	453,380	352,139	180,709	(101,241)
Divisional Total	**1,880,000**	**807,369**	**608,088**	**(1,072,631)**
H1 Central	485,000	485,000	0	0
H2 Central	1,776,000	0	0	(1,776,000)
Central Total	**2,261,000**	**485,000**	**0**	**(1,776,000)**
Overall Trust Total	**4,141,000**	**1,292,369**	**608,088**	**(2,848,631)**

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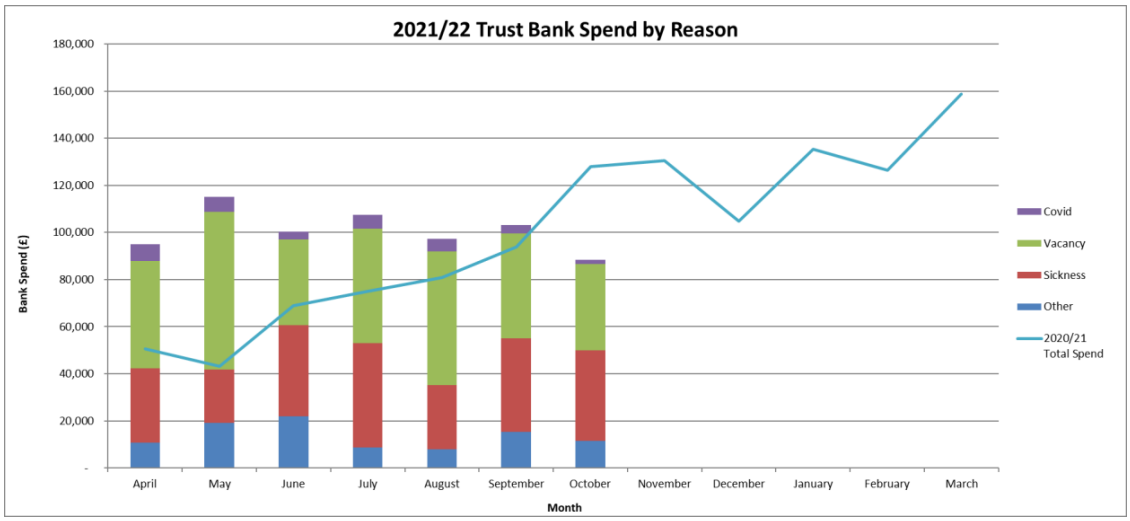
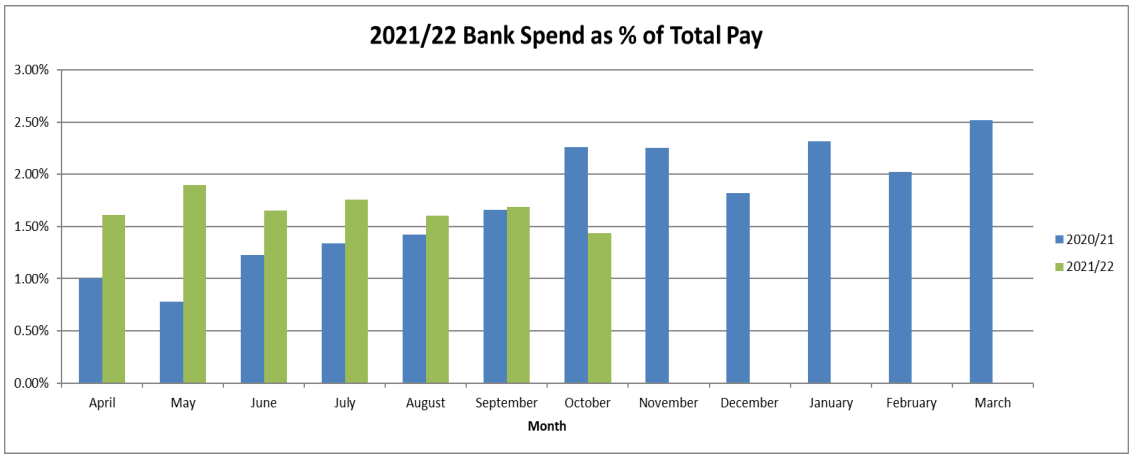
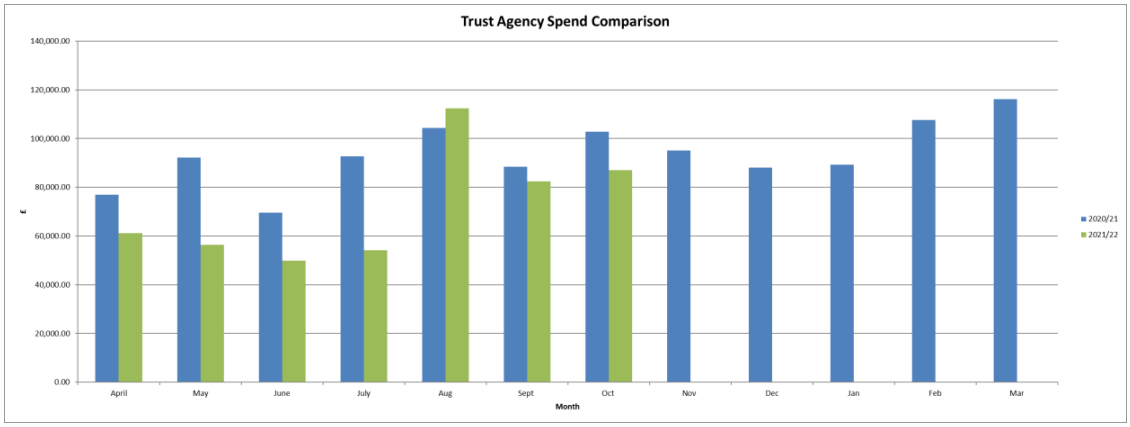
Appendix F – Bank and Agency







REPORT COVER

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Report to:	Trust Board
Date of meeting:	P1-199-21
Agenda item:	Learning from Deaths – Mortality Dashboards
Title:	Mortality dashboard & Lesson Learnt
Report prepared by:	Helen Wong, Quality Manager (Audit & Statistics)
Executive Lead:	Dr. Sheena Khanduri, Medical Director
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	The Integrated Governance Committee
Date & decision:	5th October 2021

Purpose of the paper/key points for discussion:	The public mortality dashboard and Mortality Lesson learnt 2021-2022 Q1 were approved by the Mortality Surveillance Group. The committee is asked to note the dashboard & lessons learnt and forward to the Board.

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

Next steps required:	The Board meeting

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.

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Q1 2021/2022 Mortality Dashboard Executive Summary

Helen Wong
Quality Manager (Audit & Statistics)

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1.0 Backgrpund

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

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

2.0 Mortality Review Inclusion Criteria

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

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

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

3.0 Case Review and Selection Process

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

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

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3.0 Dashboard Interpretation

Data coverage: July 2020 – June 2021 for comparison to previous quarters

	July – Sept 20	Oct – Dec 20	Jan – Mar 21	Apr – Jun 21
No. of inpatient death	21	28	31	28
No. of outpatient death post treatment	123	167	131	126
No. of cases requiring review	121	176	140	144
No. of cases reviewed (Phase I)	103(85%)	154 (88%)	112 (80%)	86 (60%)
No. of cases peer reviewed (Phase II)	94 (78%)	129 (73%)	96 (69%)	44 (31%)
No. of case(s) selected for discussion (Phase III)	12	22	15	3

**Process takes a minimum of 3 months to complete*

- A total of 218 cases were in process from July 2020 – June 2021 deaths.
- From the 51 cases selected for discussion, 38 cases were discussed, of which 33 cases were scored a RCP score of 6, 3 were scored 5 and 1 was scored 4.
- 0 cases required a LeDar (Learning Disability) submission
- 0 mortality case was subject to a Child Death Overview Panel (CDOP) form (required for in scope patients <=18).

4.0 RCP Score (avoidability score <6) case description

Scored 4 case.

A patient with liver cancer had been admitted to CCC with COVID infection after their second cycle of chemotherapy. They were reviewed and noted still recovering from COVID. A decision was made to proceed with cycle three at 80% dose.

The patient died shortly after cycle three, cause of death was cited as ‘acute myocardial insufficiency’. A CT undertaken midway through cycle three had shown some disease progression and also residual COVID changes in the lungs. The question for the MRM was did chemotherapy restart too soon after his COVID infection, considering patient’s comorbidities included type 2 diabetes and myocardial insufficiency.

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The group noted patient's performance status and co morbidities, and agreed the outcome would not be radically different; but noted that treatment could have contributed to an earlier death. The group concluded that the patient's treatment could have been deferred and the patient reviewed prior to consideration of further treatment.

The group requested that the SRG review this case, recommendations and share learnings with the extended team. The group assigned an avoidability score of 4 for this case.

Update from Lung SRG discussion to be followed at next report

Scored 5 case 1.

This patient successfully underwent 9 cycles of combination of immunotherapy/chemotherapy before developing a grade 1 pneumonitis in March 2021. Patient informed the clinician that they had COVID in January 2021 and not hospitalised. Their shortness of breath had improved since. CT scan undertaken before cycle 9 showed that the tumour response. It also showed bilateral inflammatory changes in both lungs. It was felt this was related to the patient's previous COVID infection.

The patient was subsequently admitted to A&E with a new onset of breathlessness. IV Methylprednisolone and antibiotics were advised for pneumonitis which was subsequently confirmed by CT imaging during admission (grade 3 pneumonitis) and unfortunately, the patient did not respond to steroid treatment and passed away.

An action from this case was for clinicians to consider early CT in patients with grade 1 pneumonitis and for the Lung SRG chair to discuss this case in their SRG meeting with IO and interstitial lung team. Following this input, to implement any changes to the treatment policy if necessary. The group scored the avoidability of death as a 5 i.e. Slight evidence of avoidability.

Scored 5 case 2.

It was queried as to whether this CCC inpatient COVID-19 death was nosocomial. COVID19 swab was negative on admission and on day 3, but a positive result was returned on day 11.

The CCC infection control team had reviewed this case and suggested it is possible that the virus was not at detectable levels on the initial swabs. This may have been due to swabbing technique, but equally may have been due to undetectable levels of viral RNA in the nose and throat.

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The group agreed that the case should be scored as 5 given the uncertainty as to whether the patient had potentially acquired COVID19 at CCC.

Infection & Prevention Team confirmed there is no lapse in care has been identified. They undertook swabbing of all other patients and did not identify any other positive cases. There were no staff with symptoms or positive results on the ward at that time.

Scored 5 case 3.

This case was referred for review and investigation by the Royal Liverpool University Teaching Hospital following a transfer from CCC. Full review is still ongoing.

A patient with known bone metastases was suspected to have developed spinal cord compression following deterioration during inpatient admission. An out of hours MRI scan was requested from LUFT.

The transfer call was in morning but the patient was not transferred until later the same day. Upon transfer, the patient's condition had worsened. An urgent CT was undertaken and patient found to have a retroperitoneal haematoma, Despite attempted embolization, the patient died.

The group concluded that this patient experienced a rare event and that this was not an avoidable death. The group collectively scored this case as a 5 i.e. Slight evidence of avoidability.

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust wide summary of total number of inpatient, 30 day SACT, 30 day RT, 90 day radical RT & BMT deaths

Date Range April 21 - June 21

Lessons Learnt from Mortality Review Quarter 1 2021-22

QTR	No.	Background	Actions Taken	CCC Lessons Learned	Action closed
QTR 1	MRM121	During an infusion of a 3rd cycle of Paclitaxel a patient reported lower back pain, treatment was stopped immediately and the patient was treated timely for an infusion related allergic reaction as per the CCC hypersensitivity guidelines. A MET call was logged but unfortunately the patient then suffered a cardiac arrest from which the patient died. Cause of death was cited as 1a Anaphylactic drug reaction, 1b Paclitaxel Chemotherapy and 1c Metastatic Breast Adenocarcinoma	Local audit of hypersensivity reactions with paclitaxel undertaken.	Rates of reaction for CCC patients were reported to be 0.6% for mild to moderate hypersensitivity (compared to 10-30% in literature), 0.5% for severe hypersensitivity (compared to 1% in literature) and 0.07% for anaphylactic reactions (compared to 0.1% in literature). Assurance given that CCC hypersensitivity reaction rates are below other published rates.	18/05/2021
QTR 1	MRM91	A patient had nausea and vomiting throughout their admission but no palliative care medical review was undertaken	Palliative care team to review this case in terms of escalation process within palliative care team	Cases where symptoms are difficult to manage despite initial interventions should be raised for medical SPCT review and this has been disseminated to the team. The weekly MDT also includes detailed review of symptoms to ensure patients needing medial review are picked up.	01/04/2021
QTR 1	MRM92	Cyclizine and Metoclopramide are mutually antagonistic yet they are frequently prescribed together	Pharmacy to provide a digital warning on meditech to prevent co-prescription if attempted.	Pharmacy have linked these two drugs in the Meditech EPR system and this now can create a message to the prescriber to state why they are prescribing the medication together and will request a reason for doing so. This will mandate the prescriber to pause and reconsider the prescription.	06/04/2021
QTR 1	MRM120	A consultant raised that some trusts have the option of "I've discussed the option of no treatment" on consent forms and asked if CCC could we discuss having this on our consent forms with PWR	Copy of case was forwarded to PWR with consideration of inclusion of "discussed no treatment" in consent forms going forwards to evidence base conversations more robustly	The consent forms used at CCC already have a section for highlighting that the option of no treatment has been discussed- this has been cascaded to consultants	25/05/2021
QTR 1	MRM33	Borderline metastatic lung cancer patient with multiple co-morbidities. Treating consltant and the patient discussed at length the pros and cons of supportive care vs. high risk immunotherapy. The patient opted for the latter and unfortunately died 10 days after cycle 1	Feedback the results of the Pembro audit to the MSG once available	A local audit established that Pembrolizumab in our patient group is overall well tolerated. Over the first three months, grade 3-4 toxicity is rare and correlates with poor prognosis when it starts within the first 3 weeks. Fast responses are also rare. Most problems within the first three months tend to be cancer-related, due to progression. Our toxicity incidence is consistent with that seen in the published prospective studies, but our mortality is better, probably thanks to our protocols and IO-team support"	07/06/2021
QTR 1	MRM114	Patient was seen early November "breathless and fatigued" when recovering from COVID. A decision was made to proceed with cycle three at 80% dose. The patient subsequently died on day 20 of cycle three of 'acute myocardial insufficiency'. A CT undertaken midway through cycle three had shown some disease progression and also residual COVID changes in the lungs. It was felt that this could have indicated that the patient's death may have been related to the prior COVID infection from which he had not fully recovered.	Upper GI/HPB SRG reviewed this case at the request of the MRM and were asked to consdier mechanisms to prevent treating too early in patients recovering from COVID-19.	This patient's chemotherapy should have been delayed and further review before consideration of treatment. A peer review group has been set up which meets fortnightly to discuss chemotherapy options for complex Oesophegeal and HPB patients which will peer review further treatment decisions in this patient group	07/06/2021
QTR 1	MRM117	Treatment was continued despite evidence of progression on CT from Nov 2019 and April 2020. The group advised as two scans had shown signs of progression on SACT and that the treatment should have been stopped, or at least the decision to treat peer reviewed to double check the clinical rationale.	Upper GI/HPB SRG reviewed this case at the request of the MRM and were asked to consdier mechanisms to prevent treatment being continued despite evidence of disease progression	A peer review group has been set up which meets fortnightly to discuss chemotherapy options for complex Oesophegeal and HPB patients which will peer review further treatment decisions in this patient group	07/06/2021
QTR 1	MRM119	It was noted that a consent form for second line chemotherapy could not be located in Evolve	Further investigation was undertaken into the location of the form which was later located in the wrong section of Evolve. Confirmation of the correct process and location of consent forms was disseminated.	All paper documents should be scanned into the consent form section in Evolve - this has been communicated to the scanning bureau team via their line manager	16/06/2021

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

The Clatterbridge Cancer Centre NHS Foundation Trust

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

Trust Mortality Programme QTR 1 - QTR 4

Total Number of Deaths in Scope	No.
QTR 1	154
QTR 2	
QTR 3	
QTR 4	
YTD	154

Total Deaths Requiring Phase 1 Review (excluding not applicable eg bone mets, MSCC)	No.
QTR 1	144
QTR 2	
QTR 3	
QTR 4	
YTD	144

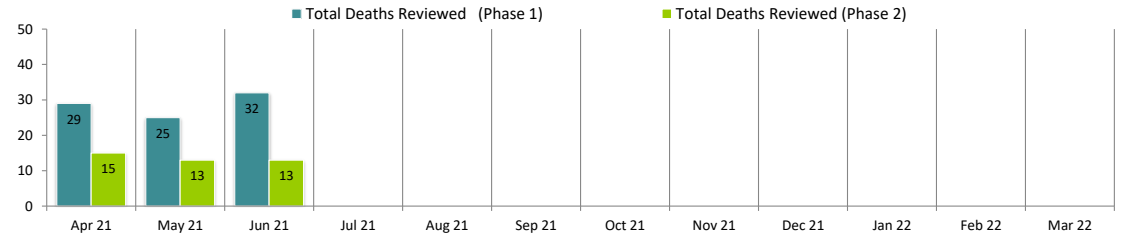
Total Deaths Reviewed (Phase 1)	No.	%
QTR 1	86	*60%*
QTR 2		
QTR 3		
QTR 4		
YTD	86	*60%*

Total Structured Judgement Reviews completed and avoidability scored against RCP Methodology (Conducted for inpatient deaths only)	Score 1 - Definitely avoidable	Score 2 - Strong evidence of avoidability	Score 3 - Probably avoidable (more than 50:50)	Score 4 - Probably avoidable but not very likely	Score 5 - Slight evidence of avoidability	Score 6 - Definitely not avoidable
QTR 1	0	0	0	0	0	4
QTR 2						
QTR 3						
QTR 4						
YTD	0	0	0	0	0	4

Total Deaths Reviewed (Phase II)	No.	%
QTR 1	41	48%
QTR 2		
QTR 3		
QTR 4		
YTD	41	*48%*

Total Deaths Selected for Review (Phase III)	No.	%
QTR 1	3	3%
QTR 2		
QTR 3		
QTR 4		
YTD	3	7%

Percentage of cases reviewed at Phase 1 & Phase 2



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

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

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

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

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

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

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

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

Cheshire & Merseyside Cancer Alliance

Performance Report

November 2021

Version 1

Contents

Section I: Summary

Restoration of cancer services

The Cheshire and Merseyside Cancer Alliance is providing system leadership and operational oversight for the restoration of cancer services. The restoration is focusing on three objectives, namely:

- To create sufficient **capacity** to ensure that patients who have had their care pathways disrupted are delayed no further, and ensure that all newly referred patients are diagnosed and treated promptly;
- To ensure **equity of access** across the system so that patients are not disadvantaged because of local capacity constraints;
- To build **patient confidence** – patients need to be reassured that their diagnosis and treatment will take place in an environment and manner that is safe.

Measure	% of pre-Covid level
2WW referrals*	121%
Cancer surgery activity*	129%
SACT (inc chemo) delivery**	106%

Measure	% of pre-Covid level
Radiotherapy planning**	85%
Radiotherapy treatment**	74%
Endoscopy activity♀	89%

- The sustained increase in SACT continues to present challenges to service delivery, however CCC is taking a number of steps to ensure that demand continues to be met. This includes detailed capacity and demand planning enabling targeted WLI clinics. SACT administration levels in Oct 2019 were especially high; 16% above the previous month (Sept 2019) and 11% above the following month (Nov 2019).
- Until Oct 2021, Radiotherapy planning activity had been comparable to pre covid levels, with between 94 and 110% (no rising or falling trend) of 2019/20 activity since April 2021. This fell to 85% in Oct 2021, however Oct 2019 activity was especially high; 16% higher than in Sept 2019. This fell 14% from Oct 2019 to Nov 2019. Oct 2021 activity was also the lowest since April 2021.
- Radiotherapy treatments are lower than 2019/20 and are likely to remain so, due to a change in fractionation in early 2020/2021, which equates to fewer treatments per patient in some tumour groups. Whilst Oct 21 activity was slightly higher than Sept 2021, Oct 2019 activity was unusually high, with an 11% increase on Sept 2019.
- Endoscopy activity had more than doubled between July 2020 (3.300 procedures) and March 2021 (6,600 procedures). Activity remained at around 6,000 procedures per month until June 21. Activity reductions in July and August are in line with previous seasonal trends, but are also influenced by under-reporting at the Countess of Chester Hospital (CoCH). It is estimated that if the under-reported data were captured; activity would be around 95% of pre-Covid levels. Further capacity is required in order to clear the backlog of patients on the endoscopy waiting list, which has stablised. The Alliance has established an endoscopy operational recovery team (EORT) to oversee and co-ordinate restoration activities.

Cheshire & Merseyside Cancer Alliance

*Data as of 18th October
** Solid tumour only (not inc. Haemato-oncology): reliable Haemato-oncology figures pre covid are unavailable
♀Assessment based on monthly DM01 endoscopy returns - latest update August 2021. activity dropped in July, against a 2019 baseline that rose. Activity is used as an indication of capacity.

Summary

Cancer waiting times performance

The latest published 14 day, 28 day and 62 day cancer waiting times performance data relate to **September 2021**.

- The Alliance failed the **14 day standard** for urgent suspected cancer referrals in September, with five trusts and six CCGs falling below the 93% threshold. The overall performance of the Alliance was 89.3%*, reducing from 90.4%* last month. The England average was 84.1%. CMCA was the 8th best performing Alliance in England out of 19 against this standard.

- The Alliance failed the **28 day standard** for urgent suspected cancer referrals in September (shadow monitored – the new standard comes into force from October 2021), with seven trusts and seven CCGs falling below the 75% threshold. The overall performance of the Alliance was 69.8%*, reducing from 73.5%* last month. The England average was 71.7%.

- The Alliance failed the **62 day standard**, achieving 73.6%* (reducing from 74.8%* last month) against a standard of 85% (England average was 68.0%). Nine trusts and nine CCGs failed to meet the 62 day standard. Cheshire and Merseyside is the 5th 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 8th November 2021 there were 1,308 patients waiting more than 62 days for a diagnosis or treatment. This has decreased slightly from 1,378 reported last month (18th October). Of these, 341 have waited **over 104 days**. This is higher than the 321 patients reported last month.

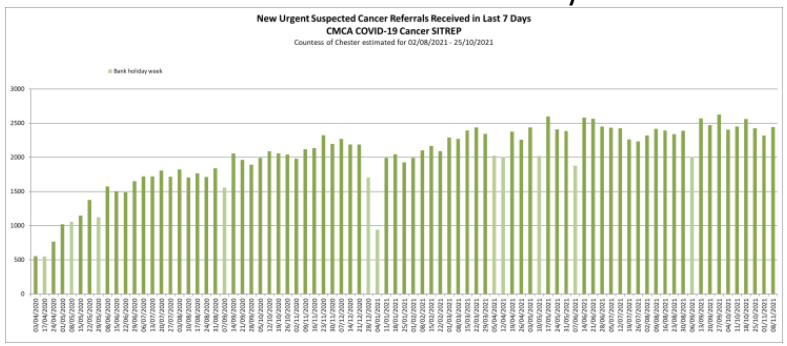
  The proportion of patients on urgent suspected cancer pathways who have already been on the pathway for over 62 days is in line with the England average.

Cheshire & Merseyside Cancer Alliance

* Overall figures are based on commissioners within Cheshire and Merseyside.

Section II: Restoration of Cancer Services – Core Metrics

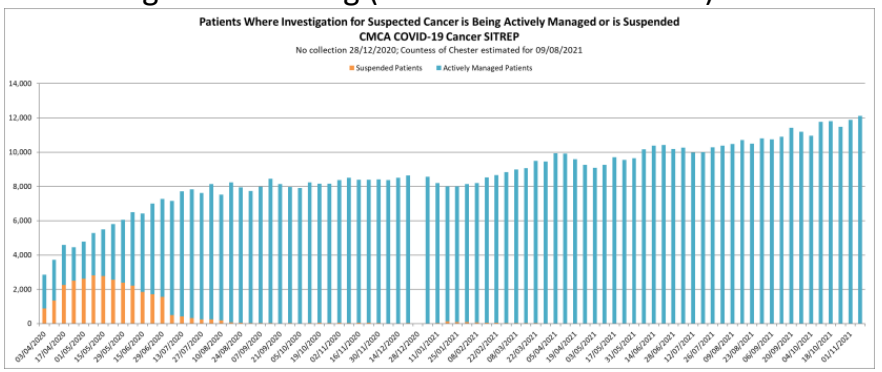
1. TWW referrals received in last 7 days



Referrals were high with 2,440 patients referred (21% 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 all weeks 02/08/21 to 25/10/21 inclusive. Liverpool Women's Hospital estimated for 13/09/21, 20/09/21.

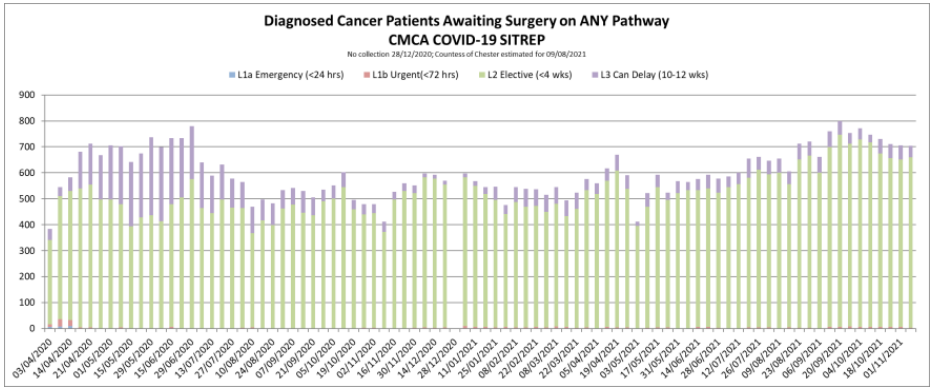
2. Diagnostic backlog (referrals without a DTT)



Currently 12,114 active patients, of which 7 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. Liverpool Women's Hospital estimated for 13/09/21, 20/09/21.

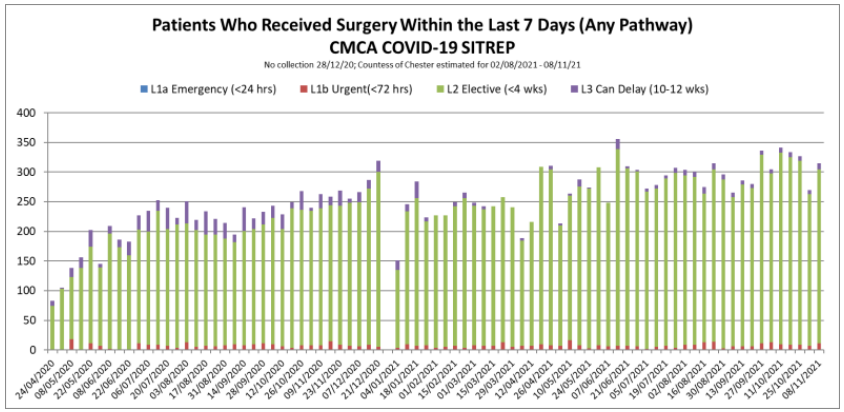
3. Cancer patients awaiting surgery



704 patients with a surgical DTT. 660 at L1&L2 and 44 at L3.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. Countess of Chester data estimated for 09/08/21. Liverpool Women's Hospital estimated for 13/09/21, 20/09/21.

4. Cancer surgery performed in last 7 days



315 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 to 08/11/21 inclusive. Liverpool Women's Hospital estimated for 13/09/21, 20/09/21.

Restoration of Cancer Services – Core Metrics

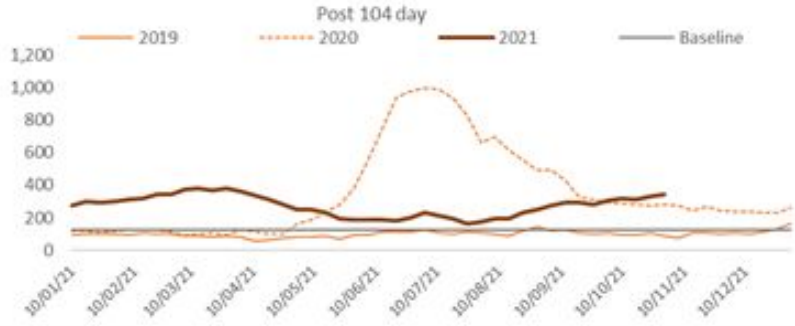
5. Patients waiting over 62 days

1,308 patients have waited over 62 days

- Higher than 1,272 patients last week.

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. Also, waiters with non-specific symptoms are not included in these national data. No data for Wirral 04/04/2021; Mid Cheshire 25/07/2021, Countess of Chester 01/08/2021 and 08/08/2021.

6. Patients waiting over 104 days

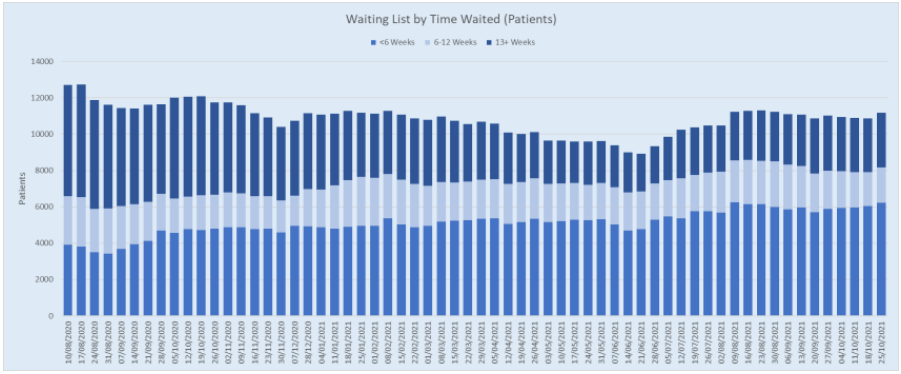


341 patients have waited over 104 days

- Higher than 329 patients last week.

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. Also, waiters with non-specific symptoms are not included in these national data. No data for Wirral 04/04/2021; Mid Cheshire 25/07/2021, Countess of Chester 01/08/2021 and 08/08/2021.

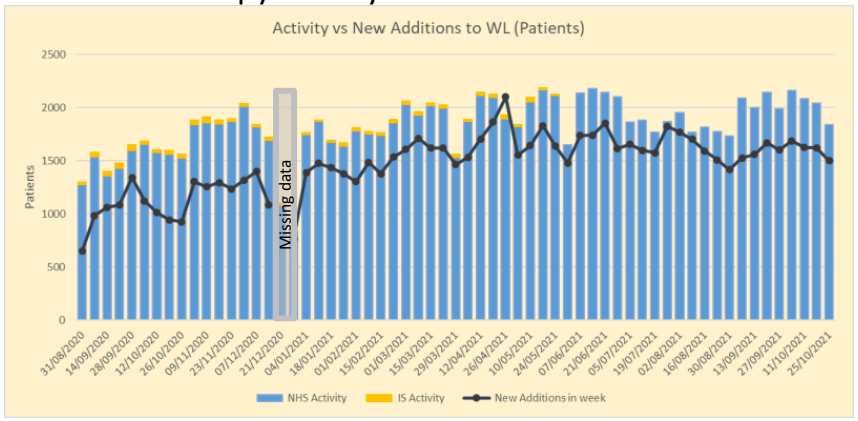
7. Endoscopy waiting list



Endoscopy waiting list increased to 11,190 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 and 11/10/21. Southport and Ormskirk estimated for 05/07/21 and 06/09/21. Countess of Chester estimated for 26/07/21 to 08/11/21 inclusive.

8. Endoscopy activity



Activity lower than recent weeks, with 1,840 patients seen.
New additions decreased with 1,500 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 and 11/10/21. Southport and Ormskirk estimated for 05/07/21 and 06/09/21. Countess of Chester estimated for 26/07/21 to 08/11/21 inclusive.

9. Patients waiting between 63 and 103 days by provider

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total
Bridgewater															
Clatterbridge						7	5					9			**35**
Countess Of Chester			27	5	15	121					27	21	12		**233**
East Cheshire						29									**39**
Liverpool Foundation Trust		12			13	127						110	34		**314**
Liverpool Heart & Chest															
Liverpool Women's			15												**15**
Mid Cheshire						44					6	13			**70**
Southport & Ormskirk			24			20					8	7	12		**77**
St Helens & Knowsley					9	54					14	15			**107**
Walton Centre															
Warrington & Halton						10							9		**27**
Wirral						18							19		**41**
Grand Total		**23**	**79**	**15**	**45**	**430**	**11**				**77**	**182**	**99**		**968**

Cheshire & Merseyside Cancer Alliance

Tables from national Cancer PTL

Up to 31 October 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											15				**15**
Clatterbridge						5							7		**20**
Countess Of Chester			17		6	36						9			**77**
East Cheshire															
Liverpool Foundation Trust						92						26	10		**136**
Liverpool Heart & Chest															
Liverpool Women's			15												**15**
Mid Cheshire															
Southport & Ormskirk						8							7		**35**
St Helens & Knowsley											5				**18**
Walton Centre															
Warrington & Halton															**6**
Wirral						7							7		**14**
Grand Total			**46**	**9**	**12**	**156**	**5**				**27**	**40**	**42**		**341**

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

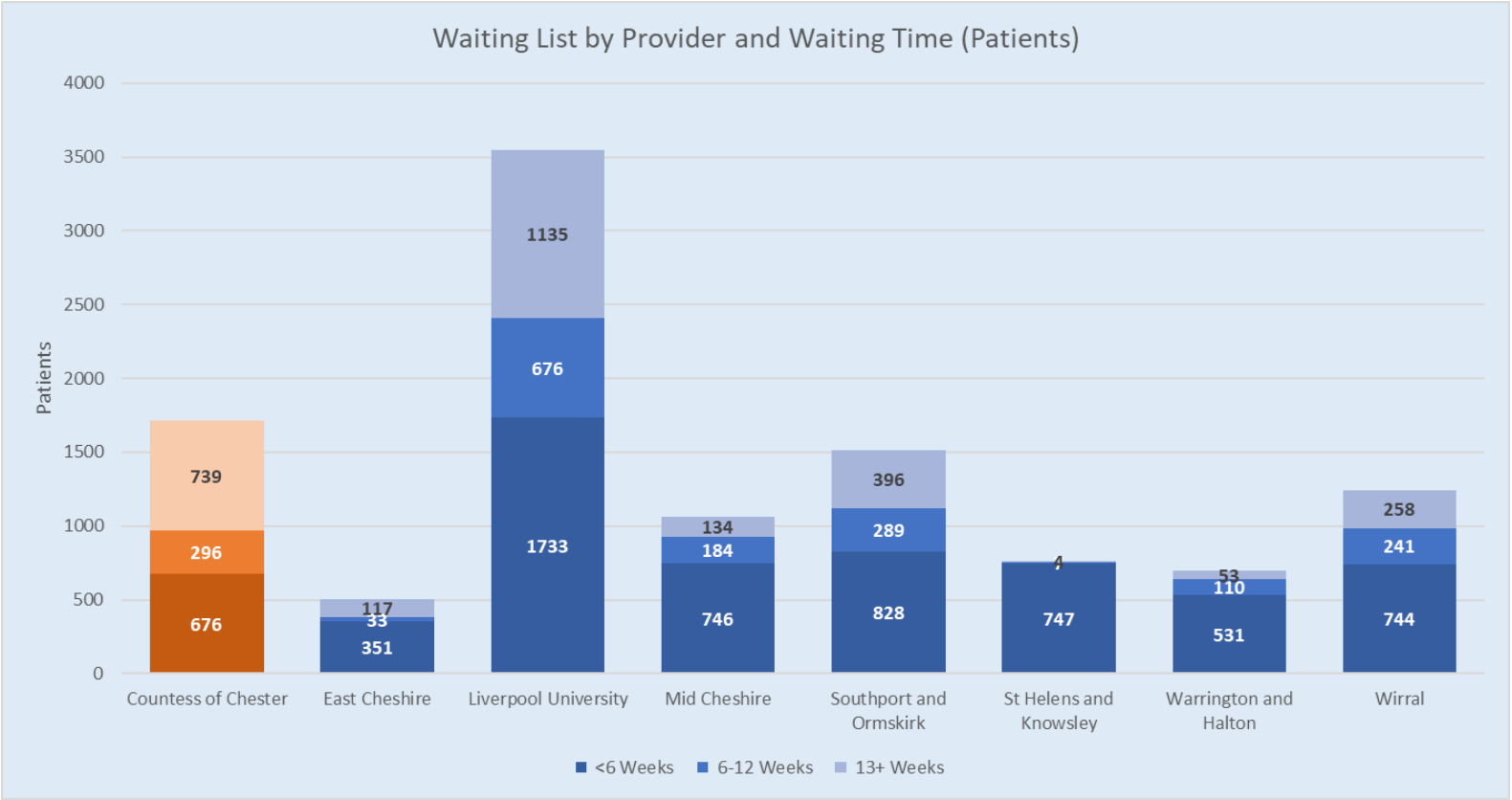
Restoration of Cancer Services – Core Metrics

There are currently 11,028 patients waiting for an endoscopy. 4,672 have waited more than six weeks, and of these 2,836 have waited 13 or more weeks (26% of the total).

There is significant variation across units, with CoCH (estimated), LUFT, Southport and Orskirk, and East Cheshire having the greatest proportion of their waiting list made up of patients waiting 13 weeks or more (43%, 32%, 26% and 23% respectively).

Endoscopy (cancer and non-cancer pathways)

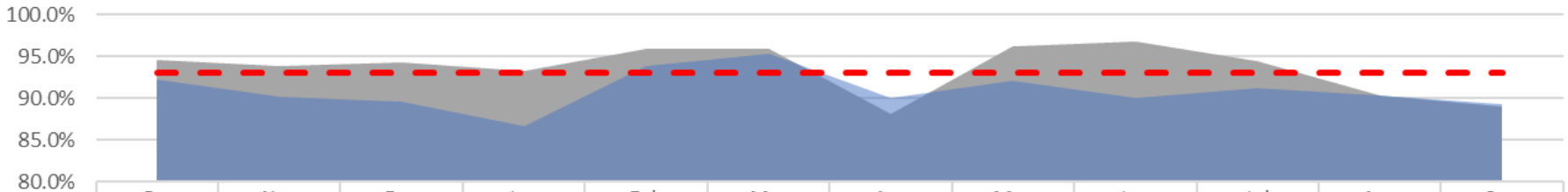
Countess of Chester estimated from 19 July 2021.



Endoscopy data at 1 November 2021

Section II: 14 day standard

Percentage of patients from Cheshire and Merseyside seen within two weeks of referral



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Oct 19 - Sep 20	94.6%	93.9%	94.3%	93.2%	95.9%	96.0%	88.1%	96.2%	96.9%	94.4%	90.3%	89.0%
Oct 20 - Sep 21	92.2%	90.1%	89.6%	86.6%	93.9%	95.3%	90.0%	92.2%	90.1%	91.3%	90.4%	89.3%
Operational Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

In September 2021, 89.3% of patients were seen within 2 weeks compared to 90.4% in the previous month. This is below the national target.

Providers not achieving the national operational standard were:

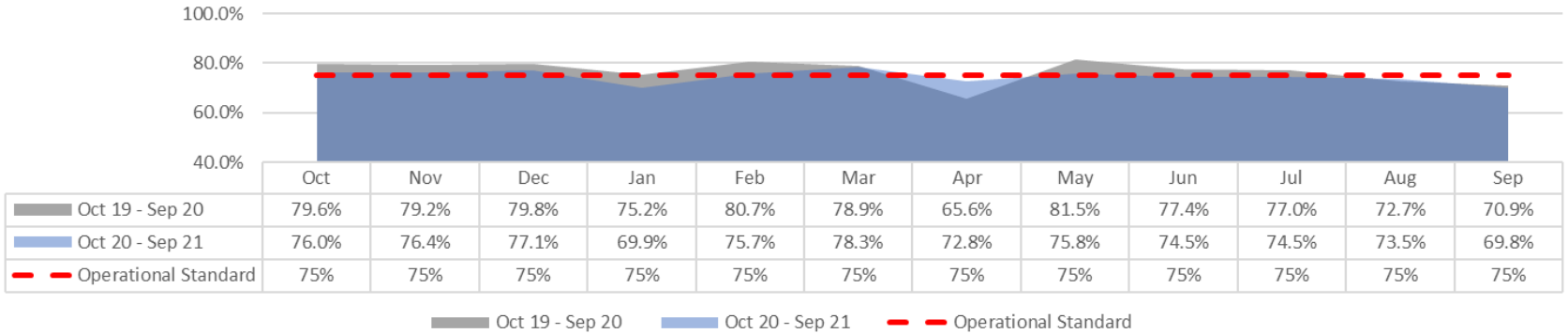
- Countess Of Chester Hospital 52.2% (506 breaches),
- Southport and Ormskirk Hospital 78.5% (243 breaches),
- St Helens and Knowsley Hospitals 89.4% (194 breaches),
- East Cheshire 91.7% (49 breaches),
- Liverpool University Hospitals 92.7% (249 breaches)

CCGs not achieving the national operational standard were:

- Southport and Formby 80.5% (143 breaches),
- Cheshire 81.4% (620 breaches),
- Knowsley 90.4% (80 breaches),
- South Sefton 90.7% (81 breaches),
- St Helens 90.9% (90 breaches),
- Halton 91% (56 breaches)

Section II: 28 day standard

Percentage of Cheshire and Merseyside patients receiving a diagnosis or ruling out of cancer within 28 days of referral



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Oct 19 - Sep 20	79.6%	79.2%	79.8%	75.2%	80.7%	78.9%	65.6%	81.5%	77.4%	77.0%	72.7%	70.9%
Oct 20 - Sep 21	76.0%	76.4%	77.1%	69.9%	75.7%	78.3%	72.8%	75.8%	74.5%	74.5%	73.5%	69.8%
Operational Standard	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 September 2021, 69.8% of patients were diagnosed or ruled out within 28 days compared to 73.5% in the previous month. This is below the national target.

Providers not achieving the expected standard were:

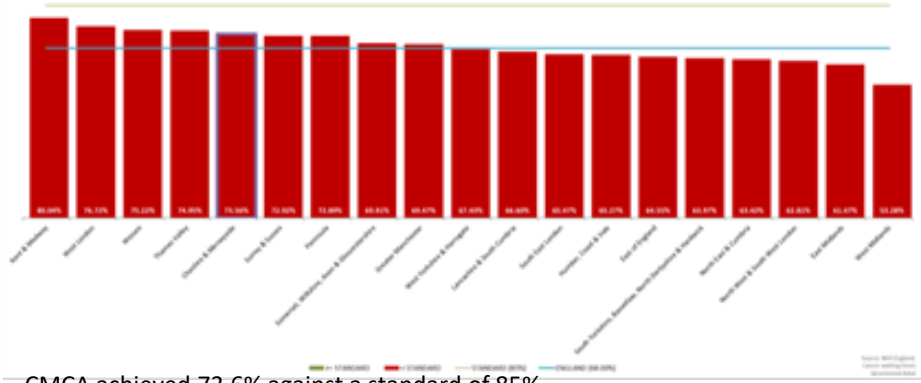
Liverpool Heart And Chest 31.3% (11 breaches),
Countess Of Chester Hospital 53.9% (430 breaches),
The Clatterbridge Cancer Centre 60% (2 breaches),
Southport and Ormskirk Hospital 66.9% (345 breaches),
St Helens and Knowsley Hospitals 73.7% (440 breaches),
Liverpool Women's 49.1% (202 breaches),
Bridgewater Community Healthcare 58.3% (101 breaches),
East Cheshire 61.2% (230 breaches),
Liverpool University Hospitals 71.1% (876 breaches),
Mid Cheshire Hospitals 74.2% (321 breaches)

CCGs not achieving the expected standard were:

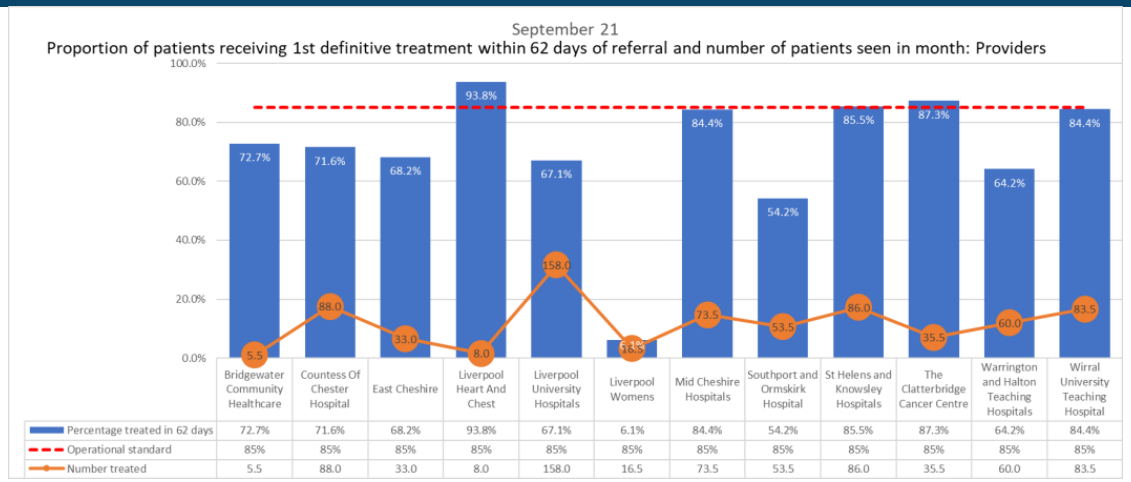
South Sefton 64% (301 breaches),
Southport And Formby 66.3% (235 breaches),
Warrington 70.3% (251 breaches),
St Helens 71.9% (267 breaches)
Cheshire 64.4% (1079 breaches),
Knowsley 69.1% (232 breaches),
Liverpool 71.9% (584 breaches),

Section III: 62 Day Standard

62 Day Performance by Cancer Alliance – CCG based (September 2021)



CMCA achieved 73.6% against a standard of 85%.
CMCA was the fifth best performer. The England average was 68.0%

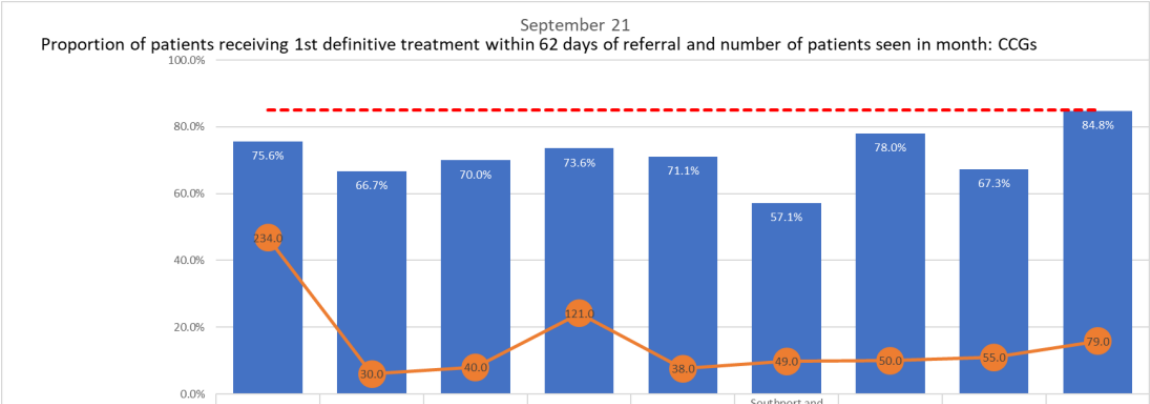


	Bridgewater Community Healthcare	Countess Of Chester Hospital	East Cheshire	Liverpool Heart And Chest	Liverpool University Hospitals	Liverpool Womens	Mid Cheshire Hospitals	Southport and Ormskirk Hospital	St Helens and Knowsley Hospitals	The Clatterbridge Cancer Centre	Warrington and Halton Teaching Hospitals	Wirral University Teaching Hospital
Percentage treated in 62 days	72.7%	71.6%	68.2%	93.8%	67.1%	6.1%	84.4%	54.2%	85.5%	87.3%	64.2%	84.4%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	5.5	88.0	33.0	8.0	158.0	16.5	73.5	53.5	86.0	35.5	60.0	83.5

Most Challenged Pathways (September 2021)

Cancer pathways not achieving the national objective were:

Gynaecological 27.3% (32 breaches),
Lower Gastrointestinal 38.6% (43 breaches),
Other 42.9% (4 breaches),
Head & Neck 54.3% (16 breaches),
Upper Gastrointestinal 55.9% (15 breaches),
Haematological (Excluding Acute Leukaemia) 70.4% (8 breaches),
Lung 71.2% (15 breaches),
Urological (Excluding Testicular) 74.1% (28 breaches)



	Cheshire	Halton	Knowsley	Liverpool	South Sefton	Southport and Formby	St Helens	Warrington	Wirral
Percentage treated in 62 days	75.6%	66.7%	70.0%	73.6%	71.1%	57.1%	78.0%	67.3%	84.8%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	234.0	30.0	40.0	121.0	38.0	49.0	50.0	55.0	79.0

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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

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Report to:	Trust Board	
Date of meeting:	24th November 2021	
Agenda item:	P1-201-21	
Title:	North West Health and Wellbeing Pledge	
Report prepared by:	Zoe Hatch – Deputy Director of Workforce & OD	
Executive Lead:	Jayne Shaw – Director of Workforce & OD	
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	
Date & decision:	

Purpose of the paper/key points for discussion:	Our ambition, as set out in Our People Commitment, is to create an environment where everyone feels supported and empowered to lead healthy lives and make informed choices about their wellbeing. This report updates on the current regional position for sickness and outlines the proposals around the North West Wellbeing Pledge. Board, are asked, in principle, to support the North West approach to shifting the focus towards supporting a culture of wellbeing.

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

Next steps required:	Implementation of nine board level principles for wellbeing Review and refresh our wellbeing offer to ensure we are supporting a person centred approach Develop and implement our wellbeing plan for the next 12-18 months

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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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North West Health and Wellbeing Pledge

Zoe Hatch
Deputy Director of Workforce and OD

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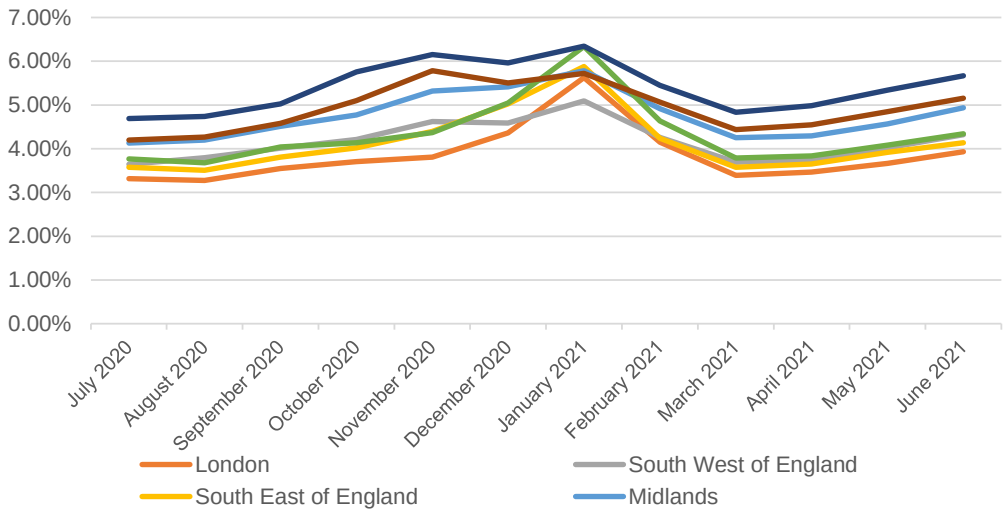
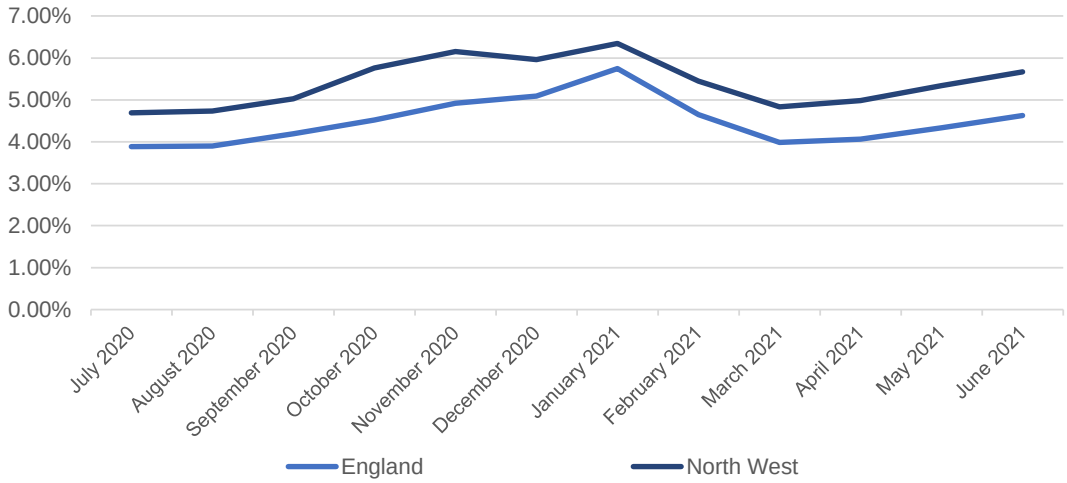
1.0 Introduction

It is well documented that the North West Region has the highest rates of sickness absence in England. This was exacerbated during the pandemic and the data released by NHS Digital for the period July 2020 to August 2021 demonstrates that, as a region absence rates are consistently higher than other areas of the country (Graph 1) and above the national average (Graph 2).



Graph 1- National absence position by region (*Data source- NHS Digital*)



Graph 2- North West Comparison against National average (*Data source- NHS Digital*)

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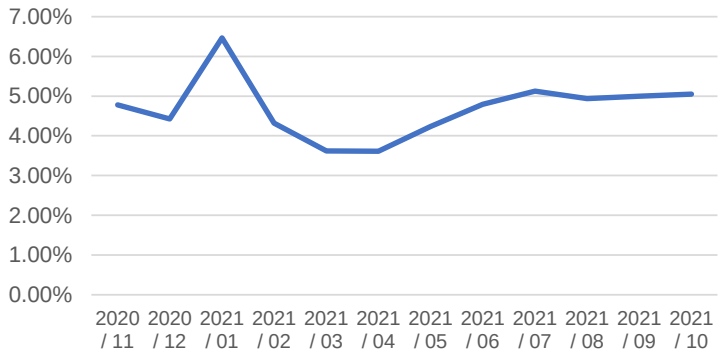
In response to this the North West HR Directors Network hosted a Wellbeing workshop in September 2021, for Chief Executives, Chairs, Wellbeing Guardians and staff side chairs. The event was attended by members of the NW Regional Team including Dr. Amanda Doyle.

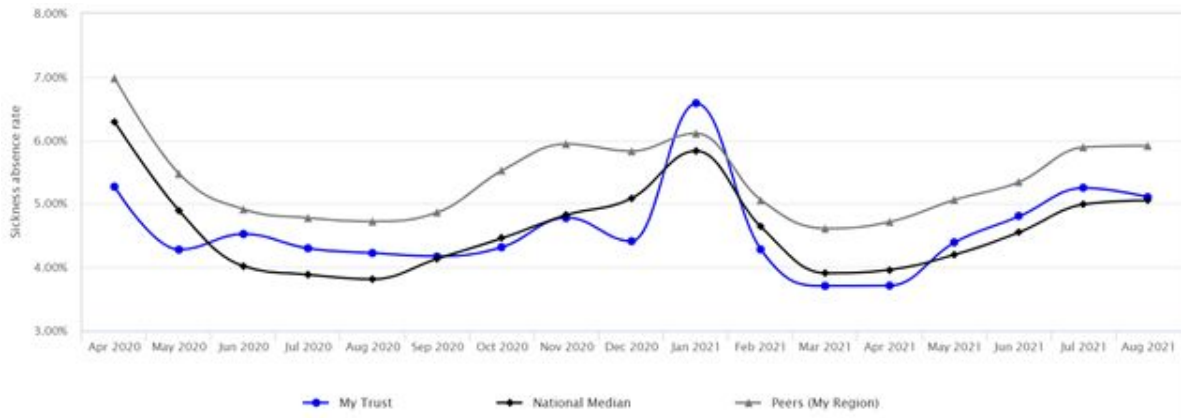
Sickness absence and health and wellbeing data was presented by Rand Europe, commissioned by NHS Employers, to highlight that focusing on sickness absence was missing the real opportunity to improve health and wellbeing more generally and that this would, in turn, deliver improvements in productivity.

2.0 Our current position

The Trust sickness absence position as at 31st October 2021 was 5.05% This equates to 2,303 WTE working days lost in month (Graph 3). Our sickness position has been on an upward trajectory since April 2021, when our absence position was at 3.61%. However, in comparison to the rest of the North West region, the Trust's sickness absence rates are consistently below the regional average (Graph 4).



Graph 3- CCC 12 month absence Trend (*Data source- ESR*)



Graph 4- CCC absence Trend compared to Regional and National Average *(Data source- Model Hospital*)

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Given that research articulates clearly that an individual's ability to perform and be productive is strongly linked to their health and wellbeing, we should note that in the 2020 staff survey 32.4% of staff who responded said that they believe the Trust takes positive action on health and wellbeing. This highlights that we have still have improvements to make.

3.0 The North West Health and Wellbeing pledge

As an output from the workshop, organisations were asked to sign up to *Our Pledge for the Wellbeing of our NHS People* to support improvements in wellbeing of staff and the aim of fostering a workforce that is healthy and engaged. The pledge is formed of three main areas of focus;

3.1. Preparing our Board for the change:

- Having equal focus on addressing presenteeism as well as sickness absence
- Reframing our policy to focus on holistic well-being through a person centred & flexible approach
- Considerations for ethics, equality, diversity and inclusion - moving away from treating everyone 'equally' to supporting the individual
- Develop approach as part of embedding a just and fair learning culture

3.2. Evidencing that well-being is a priority at our Trust Board by:

- Understanding the well-being of our people and how we are meeting their needs and giving staff a safe voice
- Showing how a well-being lens is applied to all decisions
- Understanding our organisation's culture, including taking positive action to address the issues and support our People

3.3. Committing to the three NW themes of enabling work:

- Well-being services that support the 100%
- A new person-centred well-being and attendance management policy framework
- Leadership development that supports managers in our new approach

4.0 Conclusion and recommendations

Our ambition, as set out in Our People Commitment, is to create an environment where everyone feels supported and empowered to lead healthy lives and make informed choices about their wellbeing. The work we have planned over the next 12- 18 months includes, but is not limited to, a review and refresh of our health and wellbeing support

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for staff, including a review of our offer through Vivvup and occupational health. The national Wellbeing Guardian implementation plan outlines nine Board level principles that support the North West approach and our priority is to ensure we implement these and embed a culture of wellbeing where everyone can thrive. All of this work aligns with the NHS Wellbeing Pledge and the Board are asked, in principle, to support the North West approach to shifting the focus towards supporting a culture of wellbeing. That said, it is recommended that any decision around a new attendance management policy framework should be considered separately. In any event, any new Policy would need to be approved through the Trust's usual governance processes. Progress will be monitored through the Quality Committee and Board as part of the Our People Commitment updates which are scheduled quarterly.

5.0 Next steps

The below outlines the key deliverables over the next 6 months for supporting the health and wellbeing of our people.

- **November 2021** - Pledges discussed and agreed with Board
- **January 2022** - Agree health and wellbeing action plan with Board and launch Our People Commitment
- **April 2022**- report to Board on progress to date