AGENDA

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Trust Board of Directors Meeting held in Public

Date: Wednesday 23 February 2022	Location: via **MS Teams**
Start Time: 09:00	Finish Time: 12:00

Timings	Item No		Lead	Paper/Verbal
Opening Matters				
09:00	P1-28-22	Welcome & Apologies:	KD	Verbal
	P1-29-22	Declarations of Interest	KD	Verbal
	P1-30-22	Minutes of last meeting: 26 January 2021	KD	Paper
	P1-31-22	Matters Arising/Action Log	KD	Paper
	P1-32-22	Chair's Report to the Board	KD	Verbal
Risk and Assurance				
9:10	P1-33-22	Quality Committee Chair's Report	TJ	Paper
9:20	P1-34-22	Charitable Funds Committee Chair's Report	EA	Paper
9:30	P1-35-22	Staff Story – Shadow Board	JSh	Verbal
10:50	P1-36-22	Patient Experience Visits	JG	Paper
10:00	P1-37-22	Integrated Performance Exception Report: Month 10	JSp/JSh	Paper
10:20	P1-38-22	Finance Report: Month 10	JT	Paper
10:35	P1-39-22	Annual Financial/Operational Planning Guidance	JT	Presentation
10:45	P1-40-22	Learning from Deaths – Mortality Report – Quarter 2	SK	Paper
11:00	P1-41-22	Guardian of Safe Working Report – Quarter 2	SK	Paper
11:10	P1-42-22	Bright Ideas Scheme – Progress and Outputs	SK	Paper

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11:25	**P1-43-22**	Conversion of the Clatterbridge Cancer Charity to Independent Status	**KB**	**Paper**
System Working				
11:45	**P1-44-22**	Cheshire & Merseyside Cancer Alliance Performance Report	**LB**	**Paper**
Closing Matters				
12:00	**P1-45-22**	Board Meeting Review	**ALL**	**Verbal**
12:05	**P1-46-22**	Any Other Business	**ALL**	**Verbal**

Next Meeting:

Date: Wednesday 30 March 2022	Location: MS Teams
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 26 January 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
Geoff Broadhead (GB)	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
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
Julie Gray (JG)	Chief Nurse

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

Janice Smith (JS)	Good Governance Institute
Joe Roberts (JR)	Good Governance Institute
Deborah Matier	Healthcare Solutions Manager - AMGEN
Owen Smith	Managing Director of PropCare

Item no.	Agenda item	Action
P1-01-22	**Chair Welcome and Note of Apologies** The Chair welcomed all to the meeting, no apologies were noted.	
P1-02-22	**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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P1-03-22	**Minutes of Previous Board Meeting: 24 November 2021** The minutes of the Board meeting held on 27 October 2021 were approved subject to the following minor amendments: • Geoff Broadhead to be marked as present in the meeting • JSP asked that QC-197-21, paragraph 3 be amended to read outpatient radiology reporting recovery programme **The Trust Board:** **Approved** the minutes of the previous meeting subject to the above amendment.	
P1-04-22	**Matters Arising/Action Log** The Board noted that actions were either complete, on the agenda or not yet due. In addition the following update was provided. P1-168-22 – SB informed the Board that discussions had taken place with Clatterbridge Radio station facilitators who agreed they would welcome involvement from volunteers and Governors particularly in visiting wards and taking requests/playlists from patients to be played over the radio. It was agreed that once Covid-19 restrictions had eased this option could be explored further with Governors. JW welcomed the update confirming Governors' support. **The Trust Board:** **Noted** the position in relation to the Action Log.	
P1-05-22	**Chair's Report to the Board** KD informed the Board of the positive Council of Governors meeting that had taken place Wednesday 12th January. It was noted that the Council had agreed to recommend the amendments to the Constitution for approval by the Board, which would be covered under agenda item P1-24-22. In addition, the Council had approved the reappointment of Non-Executive Director Geoff Broadhead for a second 3-year term following successful review and recommendation by the Council's Nominations Committee. It was noted that some Governors would be taking part in a focus group session as part of the Well Led review by the Good Governance Institute. The Council had requested to pass on their thanks to all staff for their efforts and continued commitment throughout the most recent wave of the Covid-19 pandemic. The Chair informed the Board of the Vaccination as a Condition of Deployment (VCoD) discussion that had been taking place during regional Chairs' meetings and developments would be discussed further by the Board in Part 2 of the meeting. Finally the Board were asked to note that the legislation on Integrated Care Systems (ICS) had been delayed, meaning that the Cheshire and Merseyside ICS would not be in place until July, revised from the original plan of April. The CCGs would work with the ICS to cover the first three months of the new financial year. **The Trust Board:**	

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	Noted the Report	
	Risk and Assurance	
P1-06-22	**Quality Committee Chair Report** TJ introduced the report, explaining that reports received were followed by effective challenge and discussion by committee members, resulting in a high level of assurance on agenda items. The Board were asked to note: I. The ongoing work around risk reporting particularly timely data extraction. Work was taking place with system developers to improve. II. The committee had discussed the risks around Medical Staffing and confirmed a paper on workforce business planning would be presented to the committee in March 2022. III. Compassionate Funding - The committee discussed in detail the Trust's provision of an additional funding route for cohorts of patients who fell outside of NHSE funding criteria and the associated financial and ethical risks to the Trust. It was agreed the risk required adding to the Trust risk register, and assurance reporting would follow through the approved governance route and assurance on progress would be provided to the committee. **The Trust Board:** **Discussed and noted** the content of the report.	
P1-07-22	**Performance Committee Chair's Report** GB introduced the report informing the Board of the two financial alerts around finances and financial and operational planning particularly, the duty for the Trust to achieve a breakeven position for 2022/23 and the risks in achieving this, including inflation uplift/costs, efficiency targets and non-receipt of activity based funding. The committee had discussed CIP challenges and received details around divisional CIP schemes. The Board were informed of the assurance report received in regards to Medical Staffing, the committee requested an expansion of the report to look at Nursing and AHPs staffing also, in order for the committee to receive appropriate assurance on gaps in establishment and the planning in place to mitigate risk. The committee had received and discussed the R&I business plan. It was recognised that 20/21 had been a challenging year for the Trust in relation to R&I and that recovery against KPIs was starting to show some promising trajectories. The committee would continue to receive updates on performance, 4 monthly. The Green Plan was received by the committee who discussed and agreed to recommend it to Trust Board for approval under item P1-17-22. **The Trust Board:** **Discussed and noted** the content of the report	
P1-08-22	**Audit Committee Chair's Report** MT introduced the report highlighting the following key points:	

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	I. The Anti-Fraud Progress report had been mostly positive however flagged as an advise as there was some further work required around implementing recommendations following the MIAA conflicts of interest review. Hence, conflicts of interest was marked as an Alert on the report until appropriate assurance was received and compliance achieved. Compliance was expected for April. II. Finance Assurance Indicators – It was noted that this had been the first month that performance in respect of paying creditors-BPPC was greater than 95% in all areas, which was a credit to the hard work of the Trust's finance team. **The Trust Board:** **Noted** the report	
P1-09-22	**Transition of Aseptic Pharmacy Production to CCC-L: Summary Report** JSp introduced the report which provided the Board with an update on the transition of aseptic pharmacy production to CCC-Liverpool. Assurance was given that the preparations and governance put in place to support the transition of aseptic pharmacy production to CCC-L on the 6 December 2021, had been effective and the unit continued to function well. A full audit by North West Pharmaceutical Quality Assurance (NWPQA) had taken place 20th January and positive feedback had been received, with a full report expected within 28 days. It was highlighted that the Aseptic Pharmacy Move Programme Board had been introduced to support the proposed transition of production to CCC-L on behalf of the Trust and would continue to provide regular progress reports to the Trust Executive Group until full-scale production was achieved. MT sought clarity on the governance around the receipt of the NWPQA Audit report. JSp confirmed the report would follow the revised Governance structure which was designed to ensure no single point of failure. AY sought clarity on the communication between the Trust and MHRA. JSp confirmed that conversations were taking place with MHRA and a site visit would take place any time between January – June 2022. It was noted that MHRA had been fully engaged throughout the planning and kept informed of the successful move. EA sought assurance on the communications with staff around the problems experienced in January, the project to Transition the Aseptic Pharmacy Production to back to CCC-L, and the success of the move. JSp acknowledged the difficult time for pharmacy staff resulting in some staff turnover, which had since settled. Recruitment was progressing well and there had been a successful staff engagement programme, supported by HR. Engagement sessions continued following the successful move and overall staff morale had improved considerably. TJ queried whether the Aseptic Pharmacy Production Unit at CCC-L with its exceptional facilities was having a positive effect on recruitment. JSp confirmed that interest in positions and quality of applications indicated that CCC-L was seen as a desirable place to work. A focus on building the reputation of the Aseptic Pharmacy Unit would help to further attract highly skilled candidates. **The Trust Board:** **Discussed and noted** the content of the report	

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P1-10-22	**Patient Story** JG introduced the report , explaining the revised format which was to be used for patient stories going forward which identified; actions required by the Trust to improve the patient experience, identifying owners and deadlines in order to effectively monitor progress. The Board discussed the individual patient's story which had been circulated to Board members as a recording and viewed prior to the meeting. MT sought clarity around the timing issues experienced by the patient particularly in relation to blood and scan results and whether this was a common issue. JG responded that the patient had a complex pathway and her residing on the Isle of Mann made the pathway considerably more complex. However, lessons had been learned and the action plan developed to take forward. AY queried the level of patient involvement in developing action plans and the communication following completed actions and improvements. JG confirmed that patients were fully involved in the process from start to finish and that communications were scheduled and adapted to meet patients' needs/preferences. TJ queried whether Isle on Mann patient feedback and outcomes data had been reviewed overall, to identify trends and opportunities for improvement. JG explained that she did not have the data to hand, however it would useful to review, and would be looked into. The Board discussed the potential gap in the process of receiving the patient report and video, rather than meeting with patients in person to discuss their experience. JG confirmed this action would be taken forward and that the Board would have the opportunity to meet with patients in future when Covid restrictions permitted. **The Trust Board:** **Noted** the patient story	**JG**
P1-11-22	**Patient Experience Visits** JSp gave an overview of the report providing the Board with oversight of the NED & Governor Patient Experience visit conducted on the 9th December 2021 at CCC Wirral Outpatients, Radiotherapy and Delamere Chemotherapy Unit. Key highlights from the report were as follows: I. explore the establishment of a beverage and biscuit provision at Radiotherapy department on the CCC Wirral site, particularly as the CCC Liverpool Radiotherapy department have a beverage bay forpatients whilst they are waiting for their treatment. II. Patients felt well supported and cared for and put at ease during a difficult time, especially where visitors restrictions continue. III. It was acknowledged that further actions were required to share feedback received with relevant Divisional leaders and teams, by the Head of Patient Experience IV. Patient interest in finding out more about the role of the Governor was a common theme throughout the visit, it was noted that this might be a potential avenue to promote the role and recruit FT members. **The Trust Board:** **Discussed and noted** the content of the report	
P1-12-22	**New Consultant Appointments**	

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	SK introduced the report informing the Board of one new Consultant appointment in month, Dr Matthew Howell whose specialty was lung and Acute Oncology. **The Trust Board:** **Noted** the content of the report	
P1-13-22	**Integrated Performance Report: Month 09** JSp introduced the report and informed the Board that the Performance Committee were to receive a detailed report around bed occupancy & capacity in Q4. The following key points were highlighted from the **Access** and **Efficiency** section of the report: I. The exceptions were attributable to medical issues and delayed discharge as detailed within the report. JG introduced the **Quality** section of the report, highlighting the following exceptions: i. Complaints - it was explained that the 0% compliance was due to one complaint resolved in month on day 26, against the 25 working day target. It was noted that the complaint response required an additional review by the Director of Nursing prior to sending. Assurance was given that response timeframes were to be monitored by the Associate Director of Clinical Governance and Patient Safety on a weekly basis in order to mitigate delays. ii. Rates of E.coli Infections were reporting 8 YTD against a <6 threshold. Some work was to take place on reporting and appropriately recording attributable as opposed to non-attributable cases. MT sought assurance on the validation of exceptions for reporting as Sepsis was not included and given the target had not been achieved in November and no data was included for December, this required some explanation. JSp confirmed that this was a timing issue and Sepsis data had not met the IPR reporting deadline, however yesterday data had been validated and the Trust had met the Sepsis target for December GH introduced the **Research** section of the report, highlighting the following key points: I. Publications had shown considerable improvement in trajectory since July 2021, with the target for the year being reached II. December had been a slow month for new studies opening however, the Trust had issued local approval for seven additional studies, which were awaiting greenlight. It was noted that the the new trials pharmacist had started with the Trust in January, which would increase capacity to support new aseptic trials. JSh introduced the **Workforce** section of the report, highlighting the following exceptions: I. The in-month figure for absence had increased from 5.54% to 6.19% in December 2021. It was further noted that at its peak sickness absence had reached 11% and that the rise in the Omicron variant had affected staff absence considerably more than previous waves. II. ILS and BLS training was under target, however there had been an increase in uptake of training opportunities which would translate into improved performance against indicators in March 2022. III. Performance on PADRs had seen some decline due to operational pressures	

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	IV. The flu vaccination programme was below target. Following a pause, plans were being developed to restart in order to improve the position. **The Trust Board:** **Discussed and noted** the content of the report.	
P1-14-22	**Finance Report: Month 09** JT introduced the report which provided a summary of the Trust financial performance for October 2021, the ninth month of the 2021/22 financial year. The following key points were highlighted from the report: I. Overall the month 9 position had worsened slightly reporting a £516k deficit, and a group consolidated position of £2k deficit. II. In Month 9 no ERF income was included. Although the Trust had delivered activity levels above its target it is not able to recover income because the Cheshire and Merseyside system had not achieved its planned level of activity in aggregate III. The Trust's planned breakeven position for H2 was reliant upon receiving Elective Recovery Funding (ERF). The system was also planning for a breakeven position IV. Bank and agency spend was increasing the main reasons were; to cover vacancies and increased sickness due to Covid-19. V. Capital spend had increased by £994k in month, however, this was still under plan year to date with the majority of spend being profiled in the last quarter. VI. CIP – the requirement for H2 was, 2.5% of plan and CIP targets remained at 2.0%. The remainder of the CIP target would be managed centrally. The Board were informed that capital planning was to be managed at system level, which excluded extra funding for digital and diagnostics, acknowledging that this came with some risk to the Trust. Work was being undertaken with partners to understand spending and dividing up the capital budget appropriately, based on the 3 year allocation. **The Trust Board:** **Discussed and noted** the content of the report.	
P1-15-22	**Nursing Safer Staffing Report** JG introduced the report which provided assurance that despite the subsequent waves of the Covid-19 pandemic and the challenges such as staff redeployment, staff shielding and staff self-isolation, safer nurse staffing had been maintained across the Trust in line with national and professional obligations. The Board were informed that the report was to undergo a review as discussed in the Quality Committee meeting and that future versions would be more succinct to provide high level assurance to the board and allow for benchmarking against comparable organisations. MT queried whether future reports could present information on actual staff numbers on given days rather than establishment only. JG agreed this could be reviewed. The Board discussed the association between mandatory training compliance and levels of pressure ulcers and falls reported. It was noted that regular staff mandatory training was built into training schedules and that along with training presence the tissue viability nurse and matrons doing quality checks will encourage improved quality assurance on wards. It was	**JG**

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	noted that there was some work planned on setting improvement trajectorIES for falls and pressure ulcers **The Trust Board** **Noted** the Report	
P1-16-22	**Caldecott Guardian Annual Report** SK introduced the report informing the Board that the report covered two years, as reporting had been stepped down throughout the pandemic. The Board were informed that there had been only one reportable breach that required forwarding to the Information Commissioners Office ICO, which was not patient but staff related, which had been resolved, with no further action against the Trust. MT queried the process for ICO breach reporting through to Trust Board. SK confirmed all breaches were recorded as serious incidents, which are reported through the robust governance reporting process, into Quality and Audit Committees, and were also recorded in the Annual Report. **The Trust Board** **Noted** the Report	
P1-17-22	**The CCC Green Plan: 2022-2027** TP introduced the paper which set out the Sustainability Strategy for the Trust for the next five years. The plan had been received by the Performance Committee 19th January where it was agreed to recommend to Trust Board for approval and following that it would be submitted to the ICS by the deadline of January 2022. The Board were informed the Sustainable Action Plan would undergo further development as the sustainability programme emerged. The Board discussed the plan agreeing that is was important for the Trust to include sustainability goals into decision making processes and business cases, and to ensure staff received the training so that they were equipped to incorporate sustainability into their day-to-day work. Discussion also took place around a focus on people and staff retention as an important factor in organisational sustainability. MT highlighted the risks around energy price increases and the Board discussed the importance of as well as long term goals. Looking at short term efficiency targets that could produce some cost savings for the Trust including optimising the efficiency capabilities of the current estates particularly CCC-L. **The Trust Board** **Approved** the CCC Green Plan 2022-27	
P1-18-22	**Our People Commitment- Implementation Plan Update** JSh introduced the report, providing the Board with an update on the implementation plan and priorities against the 5-key commitments, which had been identified based on feedback from staff and the national and local workforce context. The Board were informed that progress had been discussed in detail at the Quality Committee and that the committee would continue to receive quarterly assurance reports on progress. **The Trust Board**	

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	Noted the Report	
P1-19-22	**Health & Wellbeing at CCC** JSh introduced the report which provided an overview of the national and regional health and wellbeing initiatives and provided an update on the Trust's Health and Wellbeing Action plan. The Board discussed in detail the Trust's approach to agile and flexible working, it was noted that the Trust had revised the flexible working policy to adopt a sensible and pragmatic approach. The policy was to be reviewed in 6 months' time. It was agreed the Trust should look further afield at companies that had seen success in their approach to agile and flexible working to see what lessons could be leant. The Board further discussed the importance of a united approach incorporating Health and Wellbeing of staff into the Trust Values and Behaviours, the People Commitment, the 5-Year Strategy and also the Sustainability Plan to ensure staff were informed of and encouraged to take advantage of the support available. KD summarised the Board discussion confirming this was an important focus for the Trust going forward to support and retain staff in line with the strategic priority to Be a Great Place to Work which would continue to be monitored closely by the Board. **The Trust Board** **Noted** the Report	
P1-20-22	**Shadow Board Development Programme** JSh introduced the paper which provided an overview of the Shadow Board programme, a national leadership development programme for aspirant board members and senior management in health and social care. The Board discussed the paper agreeing the program was of significant value to the Trust in developing its senior leaders. It was agreed that NED involvement required some review possibly to give all NEDs an opportunity to participate in the programme by taking on the role of Chair, it was noted that this would be picked up as part of the ongoing NED roles and responsibilities review. MT summarised his experience in the programme as being very positive and that participants had shown a significant amount of dedication to the programme in both their meeting behaviors and preparation, he congratulated them for their commitment and performance. **The Trust Board** **Noted** the Report	
	System Working	
P1-21-22	**Cheshire & Merseyside Cancer Alliance (CMCA) Performance Report** LB provided an overview of the system wide performance report highlighting that restoration of cancer services continued with a focus on creating sufficient capacity, to ensure equity of access across the system and to build patient confidence. The following key points were highlighted from the report: I. In regards to restoration of services First Treatments the Trust was performing well when benchmarked II. There was a gap in endoscopy recovery, lower and upper GI pathways. The Endoscopy focus group had continued to work throughout the pandemic and during Omicron the surgical hub arrangement had been stepped up. CMCA Managing	

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	Director Jon Hayes and LB met with surgeons weekly to plan and support recognising the system pressures. III. Cancer surgeries had been prioritised in the system and maintained across providers – lessons had been learnt and improvements made with each new wave of the pandemic. IV. Cancer waiting time standards had not been met as detailed within the report, with benchmarking details provided. It was noted that the first Diagnostics Delivery Board meeting was to take place 28th January, where broader diagnostics issues would be looked at in more detail. **The Trust Board:** **Noted** the content of the report.	
P1-22-22	**Inequalities of Access to Services** LB introduced the report which followed the first edition of the report on the impact of COVID-19 on cancer health inequalities received by the Board in July 2021. However the data then was not yet mature enough to make robust comparisons. JH was introduced as co-presenter. LB summarised that the report showed that there had been a significant increase in inequities particularly in relation to a reduction in referrals from the most deprived neighbourhoods and amongst the elderly. First treatments showed no significant inequity in terms of age, deprivation, gender or ethnicity. It was further noted that there was currently no evidence of a statistically significant shift in the stage of disease at diagnosis. The report also set out in more detail the Alliance's approach to tackling health inequalities in cancer, including those inequalities that existed before the impact of COVID-19. It was noted that a team of two, jointly funded by Macmillan and CMCA had been appointed to develop the health inequalities strategy and monitor its implementation. The 9 pillars of the strategy were briefly explained with more detail provided within the report. TJ sought clarity on political awareness and involvement in the Marmot Community (as detailed within the report). KD confirmed that she had attended a session organised by the Cheshire & Merseyside Public Health Network where Professor Sir Michael Marmot had presented, which had been well attended by local politicians. It was noted that the aim was to circulate the report widely following the meeting. **The Trust Board:** **Noted** the content of the report.	
Corporate Governance		
P1-23-22	**Board Assurance Framework - Quarter 3 Report** MS introduced the paper which detailed the Board Assurance Framework, providing an update on Controls and Mitigations, Assurance/Evidence and Gaps in Controls/Assurances to reflect the Quarter 3 position of each of the risks and their associated scoring. The Board noted that the scoring for the majority of the BAF Risks remained static since Quarter 2, with four exceptions: I. BAF Risk 3 had increased to 16, given the continued uncertainty around the ERF	

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	II. BAF Risk 5 had reduced to 12, given the assurance on the controls in place to mitigate impact and also the continued progress against the research strategy. III. BAF Risk 8 had increased to 12, due to the upcoming workforce challenges IV. BAF Risk 11 had increased to 16, following the global vulnerability known as Apache Foundation Log4j 2 vulnerability (CVE-2021-44228), identified in December 2021. **The Trust Board:** **Noted** the content of the report	
P1-24-22	**Constitution Amendments for Approval** MS introduced the report which outlined the proposed changes to the Constitution. The Board were informed that the revised Constitution was presented to the Council of Governors at its meeting 12th January 2022, where it was agreed to recommend to the Trust Board for approval. The amendments were explained as • The addition of an appointed governor from Department of Health & Social Care – Isle of Man. Increasing the number of appointed Governors from 8 to 9, and increasing the total number of Governors to 30 from 20. AY highlighted several grammatical amendments required around the language used throughout the constitution and the inconsistency in the use of 'he/her' pronouns and 'they'. It was agreed this would be reviewed and amended prior to publishing. **The Trust Board:** **Approved** the amendments to the Constitution	**AY/MS**
Closing Matters		
P1-25-22	**Board Meeting Review** KD reflected on the meeting together with Board members, it was agreed that the meeting had been effective with constructive challenge and conversation on key topics.	
P1-26-22	**Any Other Business** No further business was raised.	

Next meeting:

Date: Wednesday 23 February 2022	Location: **MS Teams**
Start time: 09:00 hours	Finish time: 12:30
Signature:	Date:
Chair	(Insert date when minutes are signed)

ACTION PLAN

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Trust Board

Last updated: 14 February 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-22		Item had been deferred and added to the 30 March 22 Trust Board agenda, in line with its presentation to the Performance Committee
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	**JSh/MS**	Jan-22		JSh to provide and update the Board on progress.
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 & WRES, it was agreed quarterly reporting thorough Quality Committee should be taken forward Navajo project to be considered for involvement by the Trust once the new EDI lead was in post	**JSh** **JSh** **AR/EDI Lead/JSh**	Jan-22		JSh to update the Board on progress.
P1-150-21	29-Sep-21	Culture and Engagement Update - Staff Survey Results	Results of the new Staff Survey to be presented to the Board	**JSh**	Mar-22		To be presented to Quality Committee and Trust Board in March
P1-178-21	27-Oct-21	Finance Report - Month 6	Financial Impact Analysis report on APU to be presented to Performance Committee	**JT**			Performance Committee revived a JV Report presented by JT Item PC-108-21 Quality Committee received the APU

ACTION PLAN

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							Diagnostic Report 18th November QC-243-21 presented by JSp & TP, and presented at Board Part 2
P1-179-21	27-Oct-21	Research & Innovation Annual Report	Bright Ideas Scheme progress Update and Outcomes to be presented to the Board	**GH**	Feb-22		On the February Agenda P1-44 -22
P1-180-21	27-Oct-21	Guardian of Safe Working	Future reports to include content around the nature of exceptions and how they were managed	**SK**	Q3 2021/22		
P1-184-21	27-Oct-21	Board Assurance Framework	A further review of the Trust BAF to take place	**MS**	Feb-22		Board Risk Workshop and BAF Refresh 2022/2023 scheduled for 23rd February 2-4pm
P1-199-21	24-Nov-21	Mortality Dashboards	Further work to be carried out on presentation of Mortality processes to Board and Board Committees in order to provide assurance.	**SK**	Q4-2021/22		
P1-10-22	26-Jan-22	Patient Story	Potential gap in the process of receiving the patient report and video, rather than meeting with patients in person to discuss their experience. Trust Board would have the opportunity to meet/discuss with patients in person in the future when Covid restrictions are no longer in force.	**JG**	Q1 22/23		
P1-15-22	26-Jan-22	Nursing Safer Staffing Report	Future reports to present information on actual staff numbers on given days rather than establishment only.	**JG**	Q4-2021/22		
P1-24-22	26-Jan-22	Constitution Amendments for Approval	Grammatical amendments required around the language used throughout the constitution and the inconsistency in the use of ‘he/her’ pronouns and ‘they’. It was agreed this would be reviewed and amended prior to publishing.	**MS/AY**	Q4-2021/22		

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:	17 February 2022	Parent Committee:	
Chair:	Elkan Abrahamson	Quorate (Y/N)	Y

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Date for Completion/Review
JACIE Accreditation Preparedness		The committee received the scheduled quarterly progress report, providing assurance to the Committee on the progress on the forthcoming JACIE Accreditation. The committee acknowledged the significant amount of work being undertaken and the robust systems and processes in place to achieve compliance. Assurance was provided on the identified risks and associated mitigations in place.	Inspection to take place in approximately 3 months' time.	JSp	May 2022
Patient Experience, Engagement, Inclusion & Involvement Commitment 2021-2024 (Strategy)		The committee received and approved the Strategy, which had been developed & co-produced by patients, families, carers, members of the public and staff. With an aim to provide patients with safe, harm-free care in a clean and pleasant environment.	The Strategy was approved by the Committee. Assurance on progress would be reported into the Committee following the Trusts reporting/ governance framework.	JG	September 2022
Patient Experience and Inclusion Annual Report 2020 - 2021		The Committee received and approved the Annual Report. The report provided a summary of patient experience key highlights for 2020.2021. It was noted that the Trust was rated one of the top six hospitals in England who took part in the National Inpatient Survey 2020.	The report was approved by the committee for publication. No further actions	JG	Complete
Patient Experience Improvement Framework 2021/22		The committee received the report and noted the work undertaken to utilise and implement the Framework, to enable the Trust to achieve an Outstanding status regarding patient experience.	The committee noted the recommendations and subsequent actions required. Framework to be reviewed annually.	JG	February 2023

Agenda Item:	RAG	Key Points	Actions Required	Action Lead	Date for Completion/Review
		Lesley Goodburn - NHS England and Improvement, Experience of Care Lead, presented a set of slides informing the Committee of the National Quality Improvement Initiative.			

	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

NHS
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: 10th February 2022	Parent Committee: n/a
Chair: Elkan Abrahamson	Quorate: Yes

Agenda item	RAG	Key points	Actions required	Action lead	Expected date of completion
CHA-011-22 – Fundraising and Finance Report		The Charity were reporting an income of over £2.5m for the first 10 months of the financial year and will hit, or exceed, their year target. The Glow Green night walk 04.02.22 had been very successful attracting 650 participants and raising over £100k. Glow Green will become an annual event.		KB KB	Ongoing
CHA-012-22 – Report from Hempsons Solicitors - Next Steps to Establishing Independence and Draft 5 Year Business Plan		Hempsons were unable to attend the meeting. The Committee therefore referred the paper to the Board for approval. The Charity's Draft 5 Year business plan covered expenditure for the Charity to become independent, and how this would impact on net income going forward. The continuing commitment to research culminating in a £5m contribution and how/whether this would be achieved.		KB KB	Ongoing Ongoing

CHAIR'S REPORT

NHS
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CH-014-22 – 2022-23 Arts Programme Charitable Funding Request		An application for 2022/23 funding of £84k had been made.	The Committee approved the application for funding and confirmed its ongoing commitment to the Arts for Health Programme for patients and staff. Sam Wade, Arts Coordinator, to produce an Annual Report.	KB KB/SW	Completed 22.04.22

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	23rd February 2022
Agenda item:	P1-35-22
Title:	Staff Story: Shadow Board
Report prepared by:	Zoe Hatch (Deputy Director of Workforce & OD) and Emer Scott (Associate Director of Communications)
Executive Lead:	Jayne Shaw (Director of Workforce & OD)
Status of the report: (please tick)	Public ☒ Private ☐

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

Purpose of the paper/key points for discussion:	The Trust has invested in a Shadow Board Development Programme, a national leadership development programme for aspirant board members and senior management in health and social care. It includes experiential (practice) and modular (theory) learning, which supports participants in developing the right level of knowledge and understanding of working at Board-level. The Trust Board has received regular feedback from Shadow Board meetings, informing discussion and debate by the Board. A paper evaluating the first cohort and recommending next steps was discussed at the January 2022 Board meeting. Board members were keen to hear directly from participants in the first cohort. Shadow Board members are presenting their own reflections on the programme and their feedback and recommendations as this month's staff story for the Trust Board.

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

Next steps required:	N/A

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.

The Clatterbridge Cancer Centre NHS Foundation Trust

Reflections from Shadow Board

Trust Board, 23rd February 2022

Fran Ashley, Divisional Director, Networked Services
James Crowther, Head of IT Operations
Liz Furmedge, Divisional Director, Acute Care
Zoe Hatch, Deputy Director of Workforce & OD
Gillian Heap, Director of Research & Innovation Operations
Karen Kay, Deputy Director of Nursing
Rosie Lord, Deputy Medical Director
Julie Massey, Divisional Director, Radiation Services
Emer Scott, Associate Director of Communications
Mel Warwick, Head of Transformation

Key learning we gained

The Clatterbridge Cancer Centre NHS Foundation Trust

Board

- “Better understanding of Board – demystifying it”
- “Importance of unified Board approach”
- “Exposure to Board-level discussion and input from Board NED”

Personal

- “Time out from the day-to-day to reflect on the bigger strategic issues facing the Trust and our role in tackling them”
- “Learning more about colleagues and the huge breadth of knowledge, insight and ideas that they had about issues that weren't part of the day job. Peer support and confidence-building"
- “Build my confidence in presenting in meetings and contributing”

“That I don't need to stay in my own lane”

Biggest surprises

Board

- “Understanding that executives have a responsibility across all areas and not just own specialist area”
- “Importance of discussion and collaboration and working beyond area of expertise”
- “The difference between the role of a 'Deputy' and the role of an 'Executive'”
- “How accessible Trust Board is and ability to shadow and observe”

Personal

- “Enjoyed developing a greater understanding of finance”
- “The value of sharing personal stories – in particular, learning about Executives personal journeys to Board-level roles”
- “Enjoyed pushing myself to understand and analyse things that don't sit within my comfort zone (finance)”

“As deputies and corporate leads, we can work quite silo-ed. This showed the importance of wider collaboration”

Perceptions of Board

Board

- “Better understanding of Board and how it works – demystifying it”
- “The big challenge execs have – writing/reading papers, preparing for meeting and challenging/contribution on discussion”
- “Understanding the role of Board in the management, governance and oversight of the organisation”

Personal

- “I now observe Executives' approaches in meetings and committees and reflect on their approaches”
- “It informed how I approach preparing and writing papers and built my confidence in presenting”

“Helped to understand the importance and benefits of scrutiny, challenge and deeper questioning”

The Clatterbridge Cancer Centre NHS Foundation Trust

Perceptions of self

- “Understand our corporate responsibility and a greater appreciation of how we support the bigger picture and the roles of our teams”
- “Reflected that I spent a lot of time on day-to-day operational matters and the role I can play in supporting the Trust's wider strategic objectives”
- “Understanding that I can input, question and challenge beyond my own area of expertise”
- “The role of an executive isn't for me”
- “Previously did not consider becoming an executive as part of my progression – this has now changed”
- “Importance of delegation to a strong senior team to support an Exec”

“Improved my confidence, especially in presenting and participating in discussions”

“Reflected on my own role in the organisation and the value I bring (and can bring) as part of the senior management team”

The Clatterbridge Cancer Centre NHS Foundation Trust

What next for Shadow Board

- “Shadow Board to continue as a sub-group to feed back and contribute to the discussions at Trust Board”
- “Utilise Shadow Board to deliver specific projects and agendas”
- “Continue to get exposure to Board-level discussions and priorities with support from NED colleagues”
- “Ability to contribute and be involved in Trust-wide projects and initiatives and work as a group to support achievement of objectives”
- “Continued professional development”

“Dedicated time to have meaningful discussions and be able to contribute our perspectives into Trust Board”

Final thoughts

- “Shadow board was worthwhile and enjoyable, even if uncomfortable at times”
- “Enjoyable, insightful opportunity”
- “Hugely rewarding and beneficial, both professionally and personally”
- “Really enjoyed the challenge and experience”
- “Shadow Board is a group that have ambition, interest and are willing to be involved in driving things forward and would benefit from having dedicated space to focus on big issues and work collaboratively”
- “Thank you for investing in us and believing in us”

“Grateful for the opportunity and all members of Board for giving the time to support us”

“Shadow Board is a group with ambition, interest and willing to be involved in driving things forward”

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board	
Date of meeting:	23/02/2022	
Agenda item:	P1-36-22	
Title:	Patient Experience Visit – January 2022	
Report prepared by:	Claire Smith, Quality Improvement Manager	
In attendance at visit:	Elkan Abrahamson, Non-executive Director Andrew Waller, Governor	
Executive Lead:	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 NED & Governor Patient Experience visit conducted on the 13th January 2022 at CCC Liverpool, Ward 2, Acute Care Services.

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

The Clatterbridge Cancer Centre NHS Foundation Trust

Patient Experience Visits 13/01/2022

Elkan Abrahamson, Non-executive Director
Andy Waller, Governor
Claire Smith, Quality Improvement Manager

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

1. Summary

The Patient Experience 'round' was conducted on the 13th January 2022, visiting Ward 2 CCCL, Acute Care Services. Due to Covid-19 restrictions across all CCC sites Andy Waller, Governor and Elkan Abrahamson, Non-executive Director were able to accompany Claire Smith, Quality Improvement Manager 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 – 2 patients from ward 2 were asked to share their experiences of being an inpatient at CCC.

- The first patient reported that the staff are extremely caring, helpful and nothing is too much trouble for them. The patient expressed how grateful he is to the NHS for the treatment he has received. The patient shared the experience that he had attended radiotherapy daily for five weeks. Travelling from Ormskirk, West Lancashire each day, parking at Mount Pleasant and taking the shuttle bus to CCCL which was very tiring, especially when given early appointment slots. The patient discussed using the hotline service due to feeling unwell, this resulted in this inpatient episode of care. He was impressed with the free use of the guest Wifi which enabled him to keep in contact with his family via his mobile phone. The patient also mentioned that his daughters had been able to contact the ward directly for regular updates from nursing/medical staff.

- The second patient also reported feeling very well looked after, the only negative comment was regarding the food, which she felt was "tasteless" and lacked flavour although she wasn't sure if this was due to her condition. The patient was pleased to be able to have the use of a free TV that could pass away the hours. Again this patient was using her mobile phone to stay in contact with relatives, both using audio and video calling. Having been a previous patient at the Royal Liverpool, she was pleased to have a single room and commented that the new CCC building was beautiful.

- **What does CCC do well?**

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Patients interviewed both felt they had received excellent care and a positive experience. Staff were professional throughout their stay and they enjoyed being cared for in a beautiful building and single room accomodation.

- **What can CCC do better?**
  Neither patient could highlight anything they felt CCC could do better to improve on their inpatient stay.

Staff experiences and comments

- Three staff members were able to share their experiences of working at CCCL. All staff commented that overall they enjoy their work and caring for patients, although staff reported not being able to spend as much time with patients as they did on the Wirral site. This was described as being due to time restraints, larger wards, staffing challenges and the acuteness of the patients, staff were worried that this could have a direct impact on patient experience. Staff recounted that sometimes when patients die on the ward there is no time to stop and reflect, it is straight back onto the next patient which can be difficult if staff have built up a rapor with the patient.

  Staff reported being physically and emotionally drained at the end of shifts, although they found support and encouragement from their peers and colleagues. Two staff members who had both started at the Trust within the last two years voiced issues with aspects of training, adding that this was due to Covid 19 restrictions reducing the availability of face to face training. All staff expressed their concerns that restricted visiting is impacting on patient experience, although they understand the reasons they are in place. Staff talked about assisting patients with making both voice and audio calls home in order to stay in contact with loved ones. Staff discussed the benefits that family volunteers and “chatter buddies” are having on the wards as they are able to spend quality time with patients.

- **What can CCC do better for you?**
  Conisder a blended training approach where appropriate – one member of staff is about to embark on her chemotherapy training, this will not be face to face as she had hoped.

  Recruitment - Staff report that a number of staff have left the ward in recent months, but they don’t appear to have been replaced, however recruitment is ongoing. One staff member suggested that a trust wide recruitment drive might assist with filling staff vacancies. The ward is reported to be expecting to have 10 x band 5 vacancies by March 2022.

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Car parking - One staff member has moved to CCC from another NHS trust where she had free, allocated parking. Due to the cost and being worried about walking alone to the mount pleasant car park at night, she has opted to use public transport although frequently misses the bus when she is unable to leave on time.

Breaks - another staff member broached the issue of having longer breaks, she stated that staff receive a total of 45 minutes during a 12 and a half hour shift?

- **What can CCC do to improve patient experience?**
  Reviewing visitor restrictions would make the biggest impact to patients, increasing family and carer contact, however this needs to be in line with biosecurity measures to maintain patient safety.

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 the Head of Patient Experience
- Request further updates as required

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Board of Directors
Date of meeting:	Wednesday 23rd February 2022
Agenda item:	P1-37-22
Title:	Integrated Performance Report M10 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:	Quality Committee
Date & decision:	Thursday 17th February 2022

Purpose of the paper/key points for discussion:	This report provides the Board of Directors with an update on performance for month 10 2021/22 (January 2022). 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
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Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding.	☒

☒ BE **COLLABORATIVE**

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

☒ BE **RESEARCH LEADERS**

BAF Risk	Please select
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 10 2021/22)

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

Introduction

This report provides an update on performance for month ten; January 2022. 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.

The following document was published on 6 December 2021; The Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers Phase 1: Planning and Preparation (V1). On 31st January it was announced that the regulations would be revoked, subject to public consultation and parliamentary approval. CCC continues to monitor the situation.

Staff flu vaccine and Covid booster vaccine data is not included in this M10 report. Trusts use the National Immunisation Management Service (NIMS) dashboard to produce the figures and this is currently not available to access. This should come back online soon.

Whilst the Trust is compliant with the Statutory and Mandatory training target overall (94.6%), there are specific courses for which compliance is below target. Exception reports for those courses are included in this IPR.

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	Jan-22	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%	83.5%	92.3%	
C/S	**2 week wait** from GP referral to 1st appointment	↔	93%	90.0%	97.2%	
L	**24 days** from referral to first treatment	↓	G: ≥85% A: 80-84.9% R: <80%	72.6%	87.3%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	↓	75% (formally monitored since Oct 2021)	61.5%	80.4%	
C/S	**28 day** faster diagnosis - (Screening)	-	75% (formally monitored since Oct 2021)	No patients	0%	There has only been 1 28 Day FDS Screening patient during this time
S	**31 day** wait from diagnosis to first treatment	↔	96%	97.5%	99.2%	
C/S	**31 day** wait for subsequent treatment (Drugs)	↔	98%	98.1%	99.2%	
C/S	**31 day** wait for subsequent treatment (Radiotherapy)	↔	94%	98.3%	98.8%	
S	Number of **31 day** patients treated **≥ day 73**	↑	0	1	1	
C/S	**62 Day** wait from GP referral to treatment	↓	85%	77.3%	88.2%	
C/S	**62 Day** wait from screening to treatment	↔	90%	75.0%	85.7%	
L	Number of patients treated between **63 and 103 days** (inclusive)	↓	No Target	36	421	
S	Number of patients treated => **104 days**	↓	No Target	8	139	
L	Number of patients treated => **104 days AND at CCC for over 24 days (Avoidable)**	↔	G: 0 A: 1 R: >1	0	4	
C/S	Diagnostics: **6 Week Wait**	↔	99%	100%	100%	
C/S	**18 weeks** from referral to treatment (RTT) Incomplete Pathways	↔	92%	99.1%	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.

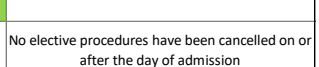
Cheshire and Merseyside Cancer Waiting Times Performance:

The December 2021 data has not yet been published nationally.

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Nov-21	Dec-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%	74.1%	Data not yet available	87.1%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	↔	75% (formally monitored since Oct 2021)	67.8%	Data not yet available	72.3%	
C/S	**62 Day** wait from GP referral to treatment	↔	85%	75.6%	Data not yet available	75.9%	

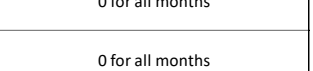
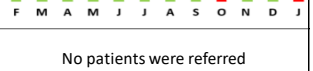
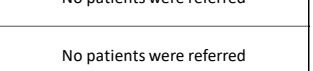
1.2 Efficiency

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Jan-22	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer						
S (SOF)	Diagnostic activity as % of the same month in 2019/2020	⟷	95% of 2019/20 levels	159%	179%	
S (SOF)	% of all (non-treatment) outpatient activity delivered remotely via telephone or video	⟷	25%	66%	69%	
L	Outpatient Appointments (including treatments) as % of the same month in 2019/2020	⟷	95% of 2019/20 levels	115%	127%	
S	Length of Stay: Elective (days): Solid Tumour	↓	G: ≤6.5 A: 6.5-6.8 R: >6.8	3.7	6.5	
S	Length of Stay: Emergency (days): Solid Tumour	↓	G: ≤8 A: 8.1-8.4 R: >8.4	5.7	8	
S	Length of Stay: Elective (days): HO Ward 4	⟷	G: ≤21 A: 21.1-22.1 R: >22.1	6.4	15.8	
S	Length of Stay: Emergency (days): HO Ward 4	⟷	G: ≤22 A: 22.1-23.1 R: >23.1	5	11.3	
S	Length of Stay: Elective (days): HO Ward 5	⟷	G: ≤32 A: 32.1-33.6 R: >33.6	5.6	18.6	
S	Length of Stay: Emergency (days): HO Ward 5	⟷	G: ≤46 A: 46.1-48.3 R: >48.3	1	11.8	
S	Delayed Transfers of Care as % of occupied bed days	⟷	≤3.5%	3.9%	3.2%	
S	Bed Occupancy: Midnight (Ward 4: HO)	↑	G: ≥85% A: 81-84.9% R: <81%	85.8%	86.7%	
S	Bed Occupancy: Midnight (Ward 5: HO)	⟷	G: ≥80% A: 76-79.9% R: <76%	73.1%	73.6%	
S	Bed Occupancy: Midday (Solid Tumour)	⟷	G: ≥85% A: 81-84.9% R: <81%	76.6%	72.0%	
S	Bed Occupancy: Midnight (Solid Tumour)	⟷	G: ≥85% A: 81-84.9% R: <81%	75.2%	72.5%	
C	% of expected discharge dates completed	⟷	G: ≥95% A: 90-94.9% R: <90%	87.0%	86.0%	
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%	97.6%	96.6%	
L	Imaging Reporting: Outpatients (within 7 days)	↑	G: ≥90% A: 80-89.9% R: <80%	91.3%	82.2%	
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%	97.7%	96.9%	
C	Data Quality - % of outpatients with an outcome	⟷	G: ≥95% A: 90-94.9% R: <90%	100.0%	99.7%	
C	Data Quality - % of outpatients with an attend status	⟷	G: ≥95% A: 90-94.9% R: <90%	100.0%	99.7%	
Executive Director Lead: James Thomson, Director of Finance						
S	Percentage of Subject Access Requests responded to within 1 month	⟷	100%	100%	99.6%	
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	Jan-22	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	0	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	133.4	187.1	
L	Incidents resulting in harm /1,000 bed days	↑	No target	15	18	
C/S	Inpatient Falls resulting in harm due to lapse in care	-	0	1 under review	TBC	0 for all months. Jan 2022 TBC
S	Inpatient falls resulting in harm due to lapse in care /1,000 bed days	-	0	1 under review	TBC	0 for all months. Jan 2022 TBC
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%	94%	97%	
C/S	% of Sepsis patients being given IV antibiotics within an hour*	⟷	90%	96%	95%	
C/S	VTE Risk Assessment	⟷	95%	95%	96%	
S	Dementia: Percentage to whom case finding is applied	↓	90%	76%	95%	
S	Dementia: Percentage with a diagnostic assessment	-	90%	No patients	N/A	No patients were referred
S	Dementia: Percentage of cases referred	-	90%	No patients	N/A	No patients were referred
C/S	Clostridiodes difficile infections (attributable)	↑	≤11 (pr yr)	1	12	
C/S	E Coli (attributable)	↓	≤6 (pr yr)	0	8	
C/S	MRSA infections (attributable)	↓	0	0	1	
C/S	MSSA bacteraemia (attributable)	↓	G: ≤4, A: 5 R: >5 (pr yr)	0	2	
C	Klebsiella (attributable)	↓	≤6 (pr yr)	0	5	
C	Pseudomonas (attributable)	↑	≤10 (pr yr)	1	1	
C/S	FFT score: Patients (% positive)	⟷	G: ≥95% A: 90-94.9% R: <90%	97%	97%	

The Quality KPI scorecard continues on page 5

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Jan-22	YTD 2021/22	Last 12 Months
Executive Director Lead: Julie Gray, Chief Nurse						
C	Number of formal complaints received	↓	No target	0	32	
S	Number of formal complaints / count of WTE staff (ratio)	↓	No target	0.000	0.002	
C	% of formal complaints acknowledged within 3 working days	-	100%	None received	97%	
L	% of routine formal complaints resolved in month, which were resolved within 25 working days	↑	G: ≥75% A: 65-74.9% R: <65%	100%	68%	
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	N/A	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	1 Dec 2021 incident under review as at 14/1/22
C	NICE Guidance: % of guidance compliant	↔	G: ≥90% A: 85-89.9% R: <85%	96%	94%	
L	Number of policies due to go out of date in 3 months	↑	No target	28	N/A	
L	% of policies in date	↑	G: ≥95% A: 93.1-94.9% R: <93%	96%	96%	
C/S	NHS E/I Patient Safety Alerts: number not implemented within set timescale.	↔	0	0	0	0 for all months

NB: blue arrows are included for KPIs with no target and show the movement from last month's figure.
HCAI targets have been amended in line with National Guidance. An amber, rather than red RAG rating is now applied to YTD figures that do not breach the annual target.
*This data is subject to change following final validation
** One Dec 2021 IG incident is under review, to determine whether this requires reporting to the ICO.
"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	Jan-22	YTD 2021/22	Last 12 Months
Executive Director Lead: Sheena Khanduri, Medical Director						
L (Strategy)	Study recruitment	↔	G: ≥68 A: 58-68 R: <58 (pr month)	108	718	
National	Study set up times (days)	↔	≤40 days	N/A	N/A	Latest reporting period is 1/10/20 – 30/09/21: 30 days
L (Strategy)	Recruitment to time and target	↔	G: ≥52% A: 45-54.9% R: <45%	N/A	N/A	Latest reporting period is 1/10/20 – 30/09/21: 0 days
L (Strategy)	Studies Opened	↔	G: ≥5 A: 4-5 R: <4 (pr month)	3	34	
L (Strategy)	Publications	↔	G: ≥11 A: 10-9 R: <9 (pr month)	23	180	

An amber, rather than red RAG rating is now applied to YTD figures that do not breach the annual target.
For Study Recruitment, the target from April to December 2021 remains 1300 (per year) but for the remainder of the year, from January 2022 to March 2022 the target is 813 per year, which equates to 68 per month.

1.5 Workforce

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Jan-22	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%	7.0%	5.1%	
S	Staff Turnover*	↑	G: ≤1.2% A: 1.21–1.24% R: ≥1.25%	1.54%	14.3%	
S	Statutory and Mandatory Training	⟷	G: ≥90% A: 75-89% R: ≤75%	94.55%	N/A	
L	PADR rate	⟷	G: ≥95% A: 75-94.9% R: ≤74%	92.83%	N/A	

*The YTD figure is cumulative; this enables monitoring of the annual target of 14%.

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 January 2022 the key financial headlines are:

Metric (£000)	In Mth 10 Actual	In Mth 10 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	516	(124)	640		0	23	(23)	
CPL/Propcare Surplus/ (Deficit)	91	0	91		605	0	605	
Control Total Surplus/ (Deficit)	607	(124)	731		605	23	582	
Group Cash holding	64,719	58,566	6,153		64,719	58,566	6,153	
Capital Expenditure	323	0	(323)		1,720	2,408	688	
Agency Cap	58	95	37		645	855	210	

The Trust is reporting a break even position year to date, which is in line with the Trust plan. Once this is consolidated with the subsidiaries it shows a £605k surplus year to date. Previously the Trust had been showing a deficit position due to the Trust not receiving the planned amount of elective recovery funding. In January a number of Trusts across Cheshire & Merseyside (C&M) ICS reviewed their baseline plans which resulted in increase in ERF across Trusts in C&M that are achieving the increased activity plans. This resulted in the Trust receiving £6.1m additional income for Elective recovery – this has been used to offset the previously reported deficit and an element deferred into future periods to offset any risk for future ERF.

The requirement for the Trust for the second six months of the year (H2) is to achieve a break-even.

2. Exception Reports

2.1 Access

9 days from referral to first appointment	Target	Jan-22	YTD	Last 12 Months
	G: ≥90% A: 85-89.9% R: <85%	83.5%	92.3%	

Reason for non-compliance

15 patients breached the 9 day target in January. This was as a result of high referrals and limited capacity due to the bank holidays. The proactive offer of treatment over the bank holiday period resulted in only 1 of these patients breaching the 24 day target.

The breaches were from the Breast, Gynae, LGI, Lung, UGI and Urology Tumour groups.

Action taken to improve compliance

- Waiting List clinics were held to manage the increased demand and maintain performance. There are a number of planned WLI clinic over the next 2 months.
- The Business Managers are working closely with SRG Leads to manage capacity.

Expected Date of Compliance	28/2/22
Escalation Route	CWT Target Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

CWT figures are subject to change as validation continues until the national submission deadline, which is around six weeks after the month end. The 2 week wait performance for December 2021 has changed since the last IPR was produced and is now below target. Details are provided in this exception report.

2 week wait from GP referral to 1st appointment	Target	Dec-21	YTD	Last 12 months
	G: ≥93% R: <93%	92.5%	97.8%	

Reason for non-compliance

1 patient breached the 2 week wait target in December 2021 as they were unable to attend the appointment for medical reasons. This breach was deemed unavoidable, as the patient cancelled the first offered appointment date as they were too ill to attend.

Action taken to improve compliance • N/A	
Expected Date of Compliance	28/2/22
Escalation Route	CWT Target Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

2 week wait from GP referral to 1st appointment	**Target**	**Jan-22**	**YTD**	**Last 12 months**
	G: ≥93% R: <93%	**90%**	97.2%	

Reason for non-compliance 1 patient breached the 2 week wait target in January due to patient choice of appointment date. This breach was deemed unavoidable as the patient did not attend the two first appointments booked and then requested a later date to attend the appointment.	
Action taken to improve compliance • N/A	
Expected Date of Compliance	28/2/22
Escalation Route	CWT Target Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

24 days from referral to first treatment	**Target**	**Jan-22**	**YTD**	**Last 12 Months**
	G: ≥85% A: 80-84.9% R: <80%	**72.6%**	87.3%	

Reason for non-compliance There were 22 breaches of the 24 day target in January (13 chemotherapy patients and 9 radiotherapy patients). Of the 22 breaches, only 4 were avoidable and 11 of them achieved the 62 day target. Further details are provided in the 62 Day exception report.

Action taken to improve compliance Please see the 62 Day exception report for actions.	
Expected Date of Compliance	28/2/22
Escalation Route	CWT Target Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

28 day faster diagnosis (Referral to diagnosis)	**Target**	**Jan-22**	**YTD**	**Last 12 Months**
	G: ≥ 75% R: <75%	**61.5%**	80.4%	

Reason for non-compliance

5 patients breached the 28 day FDS target in January. 2 of the breaches were avoidable and 3 were unavoidable. The unavoidable breaches were due to patient initiated delays to the pathways. The reasons for the avoidable breaches are as follows:

- Delay due to diagnostic delays (awaiting GP arranged tests) and out-patient capacity (day 33).
- Delay due to diagnostic delays (14 days to PET scan), clinic booking administration error and out-patient capacity (day 32).

Action taken to improve compliance

- Escalation to LUHFT and exploration of alternative pathways underway.
- Development of the Interventional Radiology service at CCC.
- The administration error is being reviewed and training will be implemented as required.

Expected Date of Compliance	28/2/22
Escalation Route	CWT Target Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

Number of 31 day patients treated ≥ day 73	**Target**	**Jan-22**	**YTD**	**Last 12 Months**
	G: 0 R: <0	**1**	**1**	

Reason for non-compliance

1 patient breached this target in January. The breach was deemed to be avoidable due to an administration delay; the 'message and task' to book treatment was not actioned timely by the booking office staff.

Action taken to improve compliance	
• Patient had a follow-up appointment in the EPR system therefore the treatment appointment did not appear in the lost to follow up report. The report has now been adjusted to ensure it picks up any patients on treatment but without a further treatment appointment in the system. • All administration staff are undergoing refresher training.	
Expected Date of Compliance	28/2/22
Escalation Route	CWT Target Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

62 Day wait from GP referral to treatment	**Target**	**Jan-22**	**YTD**	**Last 12 Months**
	G: ≥85% R: <85%	**77.3%**	88.2%	

Reason for non-compliance

11 patients breached the 62 day target in January. 4 of the breaches were deemed avoidable and 7 were unavoidable. The unavoidable breach reasons include patient choice and medical fitness. The reasons for the avoidable breaches are as follows:

- Administration delay to the initial booking of the pre-treatment appointment and waiting for treatment appointments to be made
- Administration delay as the referral was incomplete on receipt at CCC, which was not picked up by a new member of the team.
- Delay to first appointment and DPYD test not available
- Delay to the radiotherapy treatment plan due to capacity for treatment planning staging scan.

Action taken to improve compliance

- Daily monitoring of appointment bookings to enable closer management and prioritisation to prevent target breaches. A review of the skill mix of radiotherapy booking office has been undertaken and additional resource to be recruited to the team
- Further checking mechanisms have been put in place, as well as the delivery of additional training and cancer waiting times standards awareness sessions
- The radiotherapy treatment plan delay is an isolated incident related to staff sickness, however this is being monitored closely.

Expected Date of Compliance	28/2/22

Escalation Route	CWT Target Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

62 Day wait from screening to treatment	**Target**	**Jan-22**	**YTD**	**Last 12 Months**
	G: ≥ 90% R: < 90%	**75%**	**85.7%**	

Reason for non-compliance

1 patient breached the target in January. This breach was unavoidable as the patient was undecided on their treatment plan and requested a further surgical appointment at the referring Trust prior to treatment.

Action taken to improve compliance

- N/A

Expected Date of Compliance	28/2/22
Escalation Route	CWT Target Operational Group, Divisional Quality Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

2.2 Efficiency

Delayed Transfers of Care as % of occupied bed days	Target	Jan-22	YTD	Last 12 Months
	G: ≤3.5%	3.9 %	3.2%	

Reason for non-compliance

Delayed transfers of care were at 3.9% in January 2022, against a target of 3.5%.

The number of patients affected by DTOC has stayed the same as the previous month, with 14 patients affected in January. The number of DTOC days decreased from 83 days in December to 80 days in January. The average length of DTOC was 5.7 days; a slight reduction from 5.9 days in December. Delays involved both Solid Tumour and HO patients.

The delays were due to:

- 7 Patients awaited Fast Track Packages of Care at Home.
- 3 Patient awaited Social Packages of Care at Home
- 3 Patients awaited hospice placement
- 1 Patient awaited ICB placement

There remains an increase in the length of time from CHC/Fast track funding agreement to commissioning packages of care, due to covid related reduced staffing.

Action taken to improve compliance

- Weekly 'Lengthened Length of Stay' meetings are held to ensure the flow of patients continues and any concerns can be escalated.
- The Patient Flow Team (PFT) continue to work with the wider MDT to aid discharge planning during the COVID-19 pandemic, ensuring patients are discharged safely home or to a suitable care setting. Weekly complex discharge meetings occur with the MDT.
- Daily COW MDT meetings include a discussion of all inpatients, ensuring that there is a clear plan for each patient.

Expected date of compliance	April 2022
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	Jan-22	YTD	Last 12 Months
	Solid Tumour (Midday)	G: ≥85% A: 81-84.9% R: <81%	**76.6%**	**72.0%**	
	Solid Tumour (Midnight)	G: ≥85% A: 81-84.9% R: <81%	**75.2%**	**72.5%**	
	Ward 4 (HO) (Midnight)	G: ≥85% A: 81-84.9% R: <81%	85.8%	86.7%	
	Ward 5 (HO) (Midnight)	G: ≥80% A: 76-79.9% R: <76%	**73.1%**	**73.6%**	

Reason for non-compliance

Solid tumour ward bed occupancy continues to be below the Trust's target of 85%, however midday occupancy increased by 5.1% December to January to 76.6 %. This is 8.3 % below trust target.

Ward 5 (HO) occupancy has increased by 6.9% December to January to 73.1%, which is 6.8% below Trust target.

Increased occupancy is expected in January, following a reduction over the Christmas and New Year period.

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 in January. 9 mutual aid patients have transferred across to CCC Liverpool from LUHFT in January 2022.

In January, solid tumour wards have been at OPEL 3 level on 7 occasions and Haemato-oncology wards on 6 occasions.

The Patient Flow Team (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 new CDU Nurse Consultant liaises with LUHFT AO on a daily basis; identifying patients who are appropriate for transfer from LUHFT to CCC.
- The Ward 1 day case model remains under review. This may result in an increase in demand for inpatient beds.
- A report on bed utilisation is due to be presented at the Performance Committee in Q4 2021/22.

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	Jan-22	YTD	Last 12 Months
	G: ≥95% A: 90-94.9% R: <90%	87%	86%	

Reason for non-compliance

Following a 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. A trial of revised documentation is now underway.
- The Patient Flow Team will monitor data to ensure that all EDDs are completed within 24 hours of admission. The new Inpatient dashboard highlights patients for whom there is no EDD recorded.
- 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	31/3/22
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

2.3 Quality

The November figures for this sepsis KPI were not reported in the M9 IPR due to delays in validating the data over the Christmas and New Year period. Details of the performance and reasons for non-achievement of the target are provided in this exception report.

% of Sepsis patients being given IV antibiotics within an hour	Target	Nov-21	YTD (end Jan 22)	Last 12 Months
	R: <90% G: 90%	89%	95%	

Reason for non-compliance:

The target was underachieved by 1% in November 2021, with 4 patients not being given IV antibiotics within 4 hours (Solid Tumour 26/29, HO 19/20). 2 of the 4 patients breached the hour target by fewer than 14 minutes. 1 of these 2 patients was off the ward having a chest x-ray at the time and had the antibiotics immediately on their return to the ward. There was no harm to the 4 patients as a result of these delays.

The target was achieved in December and January.

Action taken to improve compliance:

- Sepsis task and finish group re-established with a particular focus on embedding a standardised digital documentation and reporting process.
- New rotation of medical trainees to be made aware of the sepsis process at CCC on induction.
- Wards reminded that ready-made Tazocin is available to all areas to reduce administration times to ensure timely care. Notices are also in place in each clinical area.

Expected Date of Compliance	28/2/22
Escalation Route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Integrated Governance Committee, Quality Committee, Trust Board
Executive Director Lead	Julie Gray: Chief Nurse

Dementia screening	Target	Jan-22	YTD	Last 12 Months
	100%	76%	95.3%	

Reason for non-compliance

The 100% target for completion of the dementia screening tool target was not achieved in January.

4 out of 17 patients, were identified as not having an accurately completed dementia screening assessment tool on admission. On further investigation the admitting nurses had commenced the assessment appropriately, however had incorrectly entered that the patient was a planned rather than an emergency admission. This meant that the screening tool was concluded in error at this stage.

A review of the 4 patients concludes that they were either alert and orientated during their inpatient stay or had a poor prognosis and therefore would not have been referred for further investigations despite the outcomes of the screening tool.

Action Taken to improve compliance

- Share results with inpatient ward managers and matrons to prevent further instances of the above.
- Ward managers and matrons to reinforce correct completion of the screening tool with ward staff.
- Ward manager to highlight incident with the staff member involved to ensure learning.

Expected date of compliance	28/2/22
Escalation route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Integrated Governance Committee, Quality Committee, Trust Board
Executive Lead	Julie Gray: Chief Nurse.

Clostridiodes difficile infections (attributable)	Target	Jan-22	YTD	Last 12 Months
	≤11 per yr	1	12	

Reason for non-compliance

There was 1 CCC attributable case of CDI in January, taking the total to 12 YTD against a target of 11 or fewer for the year.

This case is subject to an ongoing post infection review.

Action taken to improve compliance

- Actions are dependent on the outcome of the review
- There is an ongoing investigation into this Period of Increased Incidence

Expected date of compliance	28/2/22
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/DIPC

***Pseudomonas aeruginosa* infections (attributable)**	**Target**	**Jan-22**	**YTD**	**Last 12 Months**
	≤ 10 per yr	**1**	1	

Reason for non-compliance

There was 1 CCC attributable case of *Pseudomonas aeruginosa* in January, taking the total to 1 YTD against a target of 10 or fewer for the year.

The source is likely chest, with the same pathogen identified in the patient's sputum. This case is subject to an ongoing post infection review.

Action taken to improve compliance

- No learning points have yet been identified, however actions are dependent on the final outcome of the review

Expected date of compliance	28/2/22
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/DIPC

2.4 Research and Innovation

Studies opening to recruitment	Target	Jan-22	YTD	Last 12 months
	52	3	34	

Reason for non-compliance

Thirty-four studies have opened to recruitment against an internal target of forty-three at the end of Month 10 (79% of target).

- A key reason we have not met the target relates to two separate pauses to opening trials to recruitment. The first due to the pandemic and the second due to aseptic pharmacy issues.
- CCC has issued local approval for six additional studies, for which we are awaiting Sponsor Greenlight. If all studies had been greenlighted we would have opened forty studies (93% of target at Month 10).

Action Taken to improve compliance

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

Expected date of compliance	21/22 target will not be achieved. The key reason is due to the pauses to opening clinical trials to recruitment.
Escalation route	SRG Research Leads / Committee for Research Strategy
Executive Lead	Sheena Khanduri, Medical Director

2.5 Workforce

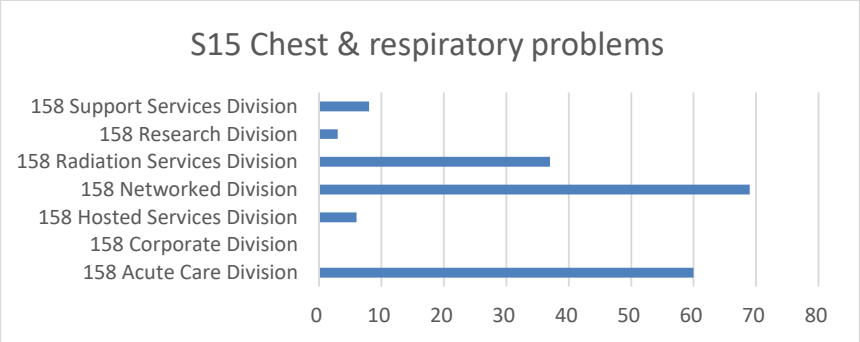
Staff Sickness Absence	Target	Jan-22	YTD	Last 12 months
	G: ≤4% A: 4.01– 4.99% R: ≥ 5%	7.04%	5.09%	

Reason for non-compliance

The in-month figure for absence has increased from 6.19% to 7.04% in January 2022, the 12-month figure has also increased from 4.94% to 5.02% and the YTD is 5.09%. The highest reasons for absence are summarised in the table below:

Absence Reason	Number of Episodes
S15 Chest and Respiratory problems	183
S13 Cold, Cough, Flu - Influenza	52
S10 Anxiety/stress/depression/other psychiatric illnesses	39

Chest and Respiratory problems has been the highest reason for absence across the Trust since November 2021; this is reflective of the significant increase in the number of COVID-19 cases seen across the community.



Networked Services and Acute Care Divisions had the highest level of chest and respiratory related absences, with 62 and 47 directly attributed to COVID-19 respectively. The absence position is monitored daily through the Divisional teams and daily situation reporting.

Cold, cough and flu remains the second highest reason for absence although there has been a slight decrease in the number of episodes from 55 in December to 52 in January. Acute Care had the highest number of absences with 19, followed by Networked Services with 14 and Radiation Services with 13.

Anxiety, stress and depression was the third highest reason for absence but there has been a significant decrease in the number of episodes, from 52 in December to 39 in January, which is a positive improvement. Of the 39 episodes, 7 were work-related and 32 were personal related; the number of work-related stress absences remains the same as last month. Overall, there were 25 long-term absences and 15 short-term absences and of the total number of absences, 23 ended in January whilst 17 continue into February.

Action taken to improve compliance

- Whilst reviewing the absences recorded with a related reason of Covid-19, it has become evident that some records are incorrectly recorded i.e. with a related reason of Covid-19 Household Member Symptoms. This would mean that the absence is an isolation rather than a sickness and therefore needs to be recorded as such. Individual cases have been addressed with line managers and the HRBP team will continue to review Covid-19 related absences at HR surgeries to ensure that all are recorded correctly.
- Given the high number of absences due to Covid-19, the HRBP team continue to support with the Test to Return and Asymptomatic testing for staff to ensure we help reduce staff pressures and absence rates where possible. Testing no longer runs daily but will be supported on an ad-hoc basis when required.

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

Staff Turnover	**Target**	**Jan-22**	**YTD**	**Last 12 months**
	G: ≥1.2% A: 1.21 – 1.24% R: ≤1.25%	**1.54%**	**14.3%**	

Reason for non-compliance

The number of leavers this month has increased from 19 to 25. The highest reasons for leaving were 8 Promotion, 7 Work Life Balance and 6 Relocation.

Reason for Leaving	Number of Leavers
Voluntary Resignation – Child Dependants	1
Voluntary Resignation – Other/ Not Known	1
Voluntary Resignation - Promotion	8
Voluntary Resignation - Work Life Balance	7
Voluntary Resignation - Relocation	6
Voluntary Resignation - To undertake further education or training	2
Grand Total	**25**

Promotion was the highest reason for leaving in January 2022 and of the 8 leavers, all but one took up employment at other local NHS Trusts, 3 of which went to LUHFT. 6 of these leavers had more than 2 years' service with the Trust showing that they were experienced staff members that unfortunately left for promotion.

The second highest reason for leaving was relocation and all of these were true relocations out of area. 4 of these individuals took up employment at other NHS Trusts but not in the Cheshire and Merseyside area.

Division	Number of Leavers
158 Acute Care Division	**5**
Add Prof Scientific and Technic	1
Additional Clinical Services	1
Nursing and Midwifery Registered	3
158 Networked Division	**8**
Administrative and Clerical	5
Medical and Dental	1
Nursing and Midwifery Registered	2
158 Radiation Services Division	**5**
Additional Clinical Services	2
Allied Health Professionals	3
158 Research Division	**3**
Additional Clinical Services	1
Nursing and Midwifery Registered	2
158 Support Services Division	**4**
Administrative and Clerical	3
Nursing and Midwifery Registered	1
Grand Total	25

Networked Services continue to be the division with the highest number of leavers with 8, which is an increase of 2 from the previous month. The most common reason for leaving this division was promotion.

Both Acute Care and Radiation Services had the second highest number of leavers with 5 each. In Acute Care, the most common reason for leaving was relocation. Within Radiation Services, the most common reason for leaving was work-life balance.

Of the total number of leavers in January, 5 had worked in the Trust for under 1 year and amongst these 5, the highest reason for leaving was work-life balance.

Of the 25 leavers, 5 completed an exit interview questionnaire, this remains the same as the previous month.

From analysis of the exit interview questionnaires, in addition to their main reason for leaving, the following reasons were cited as factors that also influenced their decision:

- Further development opportunities/ progression for CPD
- Support from senior managers
- Emigrating
- Better parking/ travel

Action taken to improve compliance

- The HRBP team have launched the Hybrid Working Guidance and to support this we are running briefing sessions for managers (the roll out of these sessions had previously been paused due to Covid-19 pressures) throughout February 2022. Managers can book via ESR or alternatively, we can also offer bespoke sessions to departments if requested.
- The HRBP team will continue to ensure that staff who are leaving the Trust are sent the exit interview questionnaire link at the earliest opportunity to encourage completion.

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

Statutory and Mandatory Course Compliance:

Information Governance	Target	Jan-22
	G: ≥95% A: 75% - 94.9% R: ≤74%	92.69%

Reason for non-compliance

IG training compliance is currently below the nationally target of 95% and has seen an in-month decline of 0.82%. 106 staff are currently non-compliant.

Areas of underperformance are:

Team	Required	Achieved	Compliance
158 CBU1 - Day Care & Network	173	157	90.75%
158 CBU4 - Pharmacy	73	67	91.78%
158 CBU5 - Inpatient Care	249	213	85.54%
158 CBU6 - Radiotherapy	198	185	93.43%
158 Executive Office	18	17	94.44%
158 Informatics & IT	80	72	90.00%
158 Project Management Office	8	6	75.00%
158 Recharges	15	13	86.67%

IG training is available via e-learning.

The L&OD Team continue to contact staff who are non-compliant and those staff due to become non-compliant, and provide managers with detailed monthly compliance reports.

Action taken to improve compliance

- All non-compliant staff to be emailed by the L&OD Team and requested to complete the training by 1st March 2022

- Continue to provide managers with monthly compliance reports to enable proactive management and planning of training
- Continue to ensure a high level of scrutiny against divisional performance via PRGs, with relevant actions and improvement plans implemented.

Expected date of compliance	01/03/22
Escalation route	Education Governance Committee, Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Resuscitation Adult BLS	**Target**	**Jan-22**
	G: ≥90% A: 75% - 89.9% R: ≤74%	80.03%

Reason for non-compliance

Compliance for BLS has seen an in-month decline of 2.51%, with 119 staff currently non-compliant.

Areas of non-compliance are as follows:

Team	Required	Achieved	Compliance
158 CBU1 - Day Care & Network	70	49	**70.00%**
158 CBU2 - Outpatients & Clinical Support	69	62	**89.86%**
158 CBU3 - Admin Services	56	38	**67.86%**
158 CBU4 - Pharmacy	36	28	**77.78%**
158 CBU5 - Inpatient Care	173	140	**80.92%**
158 CBU6 - Radiotherapy	141	119	**84.40%**
158 CBU7 - Radiology Services	30	24	**80.00%**
158 Networked Leadership	2	1	**50.00%**
158 Research & Innovation	9	8	**88.89%**
158 Safeguarding	6	4	**66.67%**

It should be noted that to support operational staffing pressures, 4 BLS courses were cancelled in January. Additional dates have been made available in February and March to accommodate the 22 staff this affected. In addition to the 4 courses cancelled, a further 18 DNAs occurred in January.

The L&OD Team continue to contact staff who are non-compliant and those staff due to become non-compliant and provide managers with detailed monthly compliance reports.

Action taken to improve compliance

- All non-compliant staff to be emailed by the L&OD Team and requested to complete the training by 1st March 2022
- Continue to provide managers with monthly compliance report to enable proactive management and planning of training
- Continue to ensure a high level of scrutiny against divisional performance via PRGs, with relevant actions and improvement plans implemented.

Expected date of compliance	01/3/22
Escalation route	Education Governance Committee, Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Resuscitation Adult ILS	**Target**	**Jan-22**
	G: ≥90% A: 75% - 89.9% R: ≤74%	86.90%

Reason for non-compliance

Compliance for ILS has seen an in-month decline of 2.57%, with 33 staff currently non-compliant.

Current performance is detailed below:

Team	Required	Achieved	Compliance
158 CBU1 - Day Care & Network	92	86	**93.48%**
158 CBU2 - Outpatients & Clinical Support	4	4	**100.00%**
158 CBU5 - Inpatient Care	59	54	**91.53%**
158 CBU6 - Radiotherapy	43	38	**88.37%**
158 CBU7 - Radiology Services	33	17	**51.52%**
158 Networked Leadership	1	1	**100.00%**
158 Research & Innovation	20	19	**95.00%**

The L&OD Team continue to contact staff who are non-compliant and those staff due to become non-compliant and provide managers with detailed monthly compliance reports.

Action taken to improve compliance

- All non-compliant staff to be emailed by the L&OD Team and requested to complete the training by 31st March 2022
- Continue to provide managers with monthly compliance report to enable proactive management and planning of training
- Continue to ensure a high level of scrutiny against divisional performance via PRGs, with relevant actions and improvement plans implemented

Expected date of compliance	31/03/22
Escalation route	Education Governance Committee, Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Safeguarding Adults Level 3	**Target**	**Jan-22**
	G: ≥90% A: 75% - 89.9% R: ≤74%	83.64%

Reason for non-compliance

Level 3 Safeguarding Adults compliance has fallen from 86.62% to 83.64%, with 44 staff currently non-compliant.

Areas underperforming against the 90% target are:

Team	Required	Achieved	Compliance
158 CBU1 - Day Care & Network	74	56	75.68%
158 CBU2 - Outpatients & Clinical Support	31	25	80.65%
158 CBU5 - Inpatient Care	62	46	74.19%

Training dates are available to enable staff to achieve compliance.

The L&OD Team continue to contact staff who are non-compliant and those staff due to become non-compliant, and provide managers with detailed monthly compliance reports.

The L&OD Team are undertaking enhancements to ESR to simplify the process for staff to identify the level of safeguarding training required for their role.

Action taken to improve compliance

- Undertake enhancements to ESR by 31st March 2022
- All non-compliant staff to be emailed by the L&OD Team and requested to complete the training by 1st March 2022
- Continue to provide managers with monthly compliance report to enable proactive management and planning of training
- Continue to ensure a high level of scrutiny against divisional performance via PRGs, with relevant actions and improvement plans implemented.

Expected date of compliance	01/03/22
Escalation route	Education Governance Committee, Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Safeguarding Children Level 3	Target	Jan-22
	G: ≥90% A: 75% - 89.9% R: ≤74%	84.39%

Reason for non-compliance

Compliance for Safeguarding Children Level 3 has seen a small in-month decline, with 42 staff currently non-compliant.

Areas of underperformance are:

Team	Required	Achieved	Compliance
158 CBU1 - Day Care & Network	74	60	**81.08%**
158 CBU5 - Inpatient Care	62	47	**75.81%**
158 Research & Innovation	24	18	**75.00%**

This training is available via e-learning, with optional face to face sessions available throughout the year.

The L&OD Team continue to contact staff who are non-compliant and those staff due to become non-compliant, and provide managers with detailed monthly compliance reports.

The L&OD Team are undertaking enhancements to ESR to simplify the process for staff to identify the level of safeguarding training required for their role.

Action taken to improve compliance

- Undertake enhancements to ESR by 31st March 2022
- All non-compliant staff to be emailed by the L&OD Team and requested to complete the training by 1st March 2022
- Continue to provide managers with monthly compliance report to enable proactive management and planning of training
- Continue to ensure a high level of scrutiny against divisional performance via PRGs, with relevant actions and improvement plans implemented

Expected date of compliance	01/03/22
Escalation route	Educational Governance Committee, Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

PADR	Target	Jan-22	Last 12 months
	G: ≥95% A: 75% - 94.9% R: ≤74%	92.83%	F M A M J J A S O N D J

Reason for non-compliance

Overall Trust compliance has dropped from 94.35% to 92.83%, which is below the target of 95%. 82 staff are currently non-compliant.

Areas performing below the KPI are as follows:

Org L4	Org L7	Assignment Count	Reviews Completed	Reviews Completed %
158 CBU1 - Day Care & Network	158 Aintree Hub Team 903008	16	15	93.75
158 CBU1 - Day Care & Network	158 MSCC Team 906055	4	3	75.00
158 CBU1 - Day Care & Network	158 PPJV Wirral Team 903003	4	3	75.00
158 CBU1 - Day Care & Network	158 Ward 1 Team 960031	14	11	78.57
158 CBU1 - Day Care & Network	158 Wirral Hub Team 903005	32	29	90.63
158 CBU2 - Outpatients & Clinical Support	158 AHP Team 906056	19	18	94.74
158 CBU2 - Outpatients & Clinical Support	158 CBU2 SRG's Nursing Team 906047	8	7	87.50
158 CBU2 - Outpatients & Clinical Support	158 Outpatients CCCL Team 906041	10	9	90.00
158 CBU3 - Admin Services	158 Stream 4 Team 905018	50	46	92.00
158 CBU3 - Admin Services	158 Stream 5 Team 905019	35	33	94.29
158 CBU4 - Pharmacy	158 Pharmacy Team 903015	52	48	92.31
158 CBU5 - Inpatient Care	158 Advanced Nursing Team 906031	18	17	94.44
158 CBU5 - Inpatient Care	158 CDU/Hotline Team 906030	17	14	82.35
158 CBU5 - Inpatient Care	158 Haemato-oncology Admin Team 961684	5	3	60.00
158 CBU5 - Inpatient Care	158 Haemato-oncology Nurse Clinicians & SPN's Team 960032	14	11	78.57
158 CBU5 - Inpatient Care	158 Matron Services Team 906046	6	5	83.33
158 CBU5 - Inpatient Care	158 Ward 2 Team 906025	24	21	87.50
158 CBU5 - Inpatient Care	158 Ward 3 Team 906020	34	27	79.41
158 CBU5 - Inpatient Care	158 Ward 4 Team 960030	28	23	82.14
158 CBU5 - Inpatient Care	158 Ward 5 Team 960533	30	27	90.00
158 CBU6 - Radiotherapy	158 Radiation Services SRGs Team 906006	21	17	80.95
158 CBU7 - Radiology Services	158 Diagnostic Imaging Team 906110	53	49	92.45
158 CBU8 - Physics	158 Physics / Technical Services Team 902020	68	63	92.65
158 Cancer Alliance	158 Cancer Alliance - Core Team 906017	6	5	83.33
158 Cancer Alliance	158 Cancer Alliance - PED & Personalised Care 906017	6	5	83.33
158 Cancer Alliance	158 Cancer Alliance - RDS/FIT Programme 906017	7	5	71.43
158 Executive Office	158 Executive Team 905085	11	10	90.91
158 Networked Leadership	158 Networked Leadership Team 906052	9	8	88.89
158 Project Management Office	158 Project Management Office Team 906016	6	5	83.33
158 Research & Innovation	158 R&D North West Coast Team 905150	5	2	40.00
158 Workforce & Organisational Development	158 Workforce & OD Business Units Team 905055	13	12	92.31
158 Workforce & Organisational Development	158 Workforce & OD Resourcing & Information Team 905057	6	5	83.33

The L&OD continue to provide data to support managers in proactively managing compliance.

Action taken to improve compliance

- All divisions continue to be issued with detailed reports to support the proactive management of PADR compliance

• Continue to ensure a high level of scrutiny against divisional performance via PRGs, with relevant actions and improvement plans implemented • 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 • Appraisal training for both staff and managers continues to be available. • Automated ESR notifications continue to be sent to the manager and staff member; 4, 3, 2 and 1 month before the appraisal is due.	
Expected date of compliance	April 2022
Escalation route	Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board	
Date of meeting:	23rd February 2022	
Agenda item:	P1-38-22	
Title:	Finance Report - Month 10	
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 December (Month 10) 2021-22.

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

Next steps required:	N/A

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

Finance Report

Jo Bowden - Deputy Director of Finance

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

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REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

1. Introduction

1.1 This paper provides a summary of the Trust's financial performance for January 2022, the tenth 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 January the key financial headlines are:

Metric (£000)	In Mth 10 Actual	In Mth 10 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	516	(124)	640		0	(22)	22	
CPL/Propcare Surplus/ (Deficit)	91	0	91		605	0	605	
Control Total Surplus/ (Deficit)	607	(124)	731		605	(22)	627	
Group Cash holding	62,580	58,379	4,201		62,580	58,379	4,201	
Capital Expenditure	323	0	(323)		1,720	2,408	688	
Agency Cap	38	95	57		683	950	267	

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 second six months of the year (H2) was to achieve a break-even position. The Trust position for H2 is reliant upon receiving Elective Recovery Funding (ERF) of £6.4m. The Trust included recovery costs of £4.8m against this, leaving a residual risk of £1.6m if no ERF was to be received. To month 10 the Trust has been notified of £6.1m ERF income in relation to month 7 to 9, an element of which has been deferred into future months to offset potential future risks.

3. Operational Financial Profile – Income and Expenditure

3.1 Overall Income and Expenditure Position

The Trust financial position to the end of January is breakeven, the group consolidated position is a £605k surplus. The group cash position is a closing balance of £62.5m, which is £4.2m above plan. Capital spend has increased by £323k in month, however, this is still under plan by £688k year to date, the majority of spend being profiled in the last two months of the year.

The Trust is under the agency cap by £57k in month and £267k in the 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 M10	Trust Plan M10	Variance	Actual YTD	Trust Plan YTD	NHSI Variance	Draft Trust Annual Plan
Clinical Income	19,116	17,376	1,740	174,341	171,269	3,072	206,029
Other Income	(907)	1,868	(2,775)	16,253	18,364	(2,111)	22,081
Total Operating Income	**18,209**	**19,244**	**(1,035)**	**190,594**	**189,633**	**961**	**228,110**
Total Operating Expenditure	(17,359)	(19,046)	1,687	(187,152)	(186,439)	(713)	(224,251)
Operating Surplus	**850**	**198**	**652**	**3,442**	**3,194**	**248**	**3,859**
PPJV	61	67	(6)	723	670	53	804
Finance Costs	(395)	(389)	(6)	(4,165)	(3,886)	(279)	(4,663)
Trust Surplus/Deficit	**516**	**(124)**	**640**	**0**	**(22)**	**22**	**(0)**
Subsiduaries	91	0	91	605	0	605	**0**
Consolidated Surplus/Deficit	**607**	**(124)**	**731**	**605**	**(22)**	**627**	**(0)**

The table below summaries the consolidated financial position:

January 2022 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	435	(806)
Donated Depreciation	81	806
Trust Retained Surplus / (Deficit)	**516**	**0**
CPL	54	254
Propcare	37	351
Consolidated Financial Position	**607**	**605**

3.3 Expenditure Position

3.3.1 The bridge below shows the key drivers between the £516k in month surplus and £124k deficit plan, which is a positive variance of £640k:

- In month 10 we received £5.9m ERF income relating to months 7 to 9. We had previously received £187k.

  This increase in income is due to other Trusts in Cheshire & Merseyside having their activity baselines corrected by NHSE/I, this led to a higher level of ERF being earned across the ICS. The Trust have used this additional income to offset the previously reported deficit, as well as covering the lack of likely ERF income earned in month 10. £4.7m has been deferred into future periods to offset potential further risk of not receiving ERF for months 11 & 12.

  This is reporting into the monthly position as showing ERF income over-recovered in month by £189k, however in line with plan cumulatively. In addition the Trust has incurred lower than planned restoration costs, both pay and non-pay.

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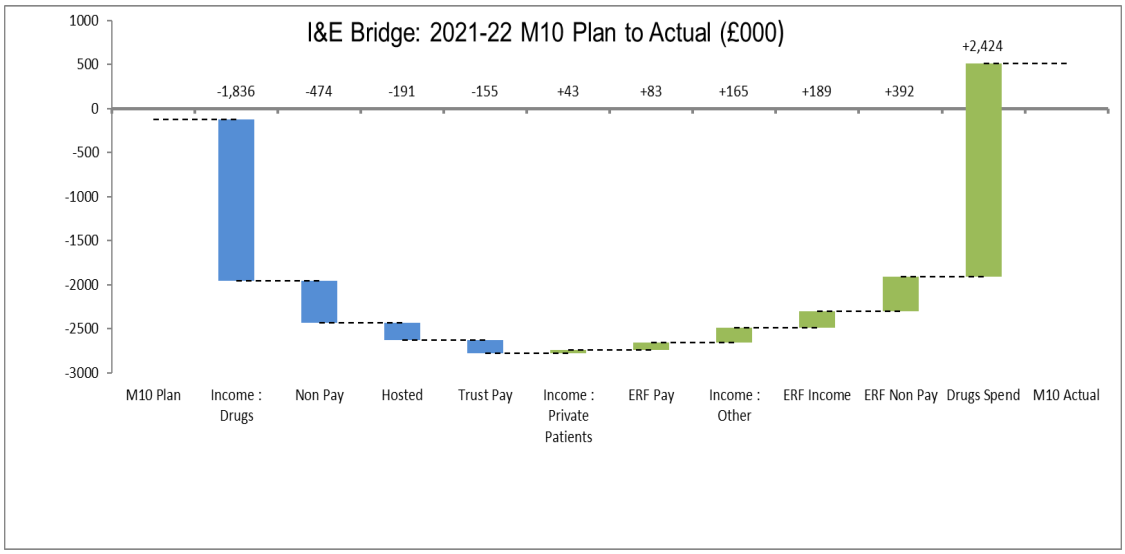
- Pay costs have increased in month, and have been increasing at a rate of between £50-£100k in H2 per month compared to H1. The Trust is showing a £155k overspend in month in the Divisions. Bank spend has increased significantly from an average of £80k per month previously to £143k in month, this is mainly due to covid sickness cover.
- Drugs spend is under plan by £2.4m. This is a £2.6m retrospective correction back to April 21. This position is revenue neutral for the Trust and CPL.
- Non-Pay costs are showing an overspend of £474k.
- The Clinical Diagnotic Centre is showing an overspend against both pay of £24k and non-pay of £47k in month. This is fully offset by income.



3.4 ERF Position

The Trust planned position for H2 was reliant upon receiving Elective Recovery Funding (ERF) of £6.4m. The Trust included recovery costs of £4.8m against this, leaving a residual risk of £1.6m if no ERF was to be received, and assuming no increases in costs. Spread across H2 this gives a £262k per month risk per the table below:

ERF Budget for H2 (£000)	Mth 7	Mth 8	Mth 9	Mth 10	Mth 11	Mth 12	Total
Planned Expenditure - Pay	83	83	84	83	83	84	500
Planned expenditure - non pay	725	725	724	725	725	725	4,349
Total planned expenditure	**808**	**808**	**808**	**808**	**808**	**809**	**4,849**
Planned Income	1,070	1,070	1,070	1,070	1,070	1,070	6,419
Risk	**262**	**262**	**262**	**262**	**262**	**261**	**1,570**

As previously mentioned, in month 9 the Trust received £187k relating to months 7 and 8. This gave an under-recover to month 9 of £596k, driving the Trust's reported deficit position.

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In month 10 the Trust has been notified of a further £5.9m of ERF income in relation to month 7 to 9, bringing the total received to £6.1m. The Trust has used this additional income to offset the deficit to month 9. A further element has been used to cover the lack of any likely ERF income in month 10 and additional restoration costs of £333k. The remainder of the income (£4.67m) has been deferred into future months to offset potential future risks. It is not yet confirmed if any further ERF income will be received in relation to months 10 to 12.

Based on a total planned risk of £1.57m for H2, the risk to month 10 was £1.046m. As per the table below the Trust have used ERF income to offset this fully.

ERF Actuals for H2 (£000)	Mth 7	Mth 8	Mth 9	Mth 10	Total
Pay expenditure	0	0	0	0	0
Non-pay expenditure	0	0	0	333	333
Total expenditure	**0**	**0**	**0**	**333**	**333**
Total income	0	0	187	1,259	1,446
Total	**0**	**0**	**187**	**926**	**1,113**

3.5 Bank and Agency Reporting

Bank spend in December is £143k, which is a significant increase compared to previous months. The largest user of bank staff the Acute Division. The main reasons for bank spend is to cover vacancies and increased sickness due to Covid.

Agency spend in month is £37k, which is a reduction to previous months. We are reporting £57k under cap in month and £267k in the year to date

See Appendix F for further detail.

3.6 Cost Improvement Programme (CIP)

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

As previously reported CIP requirement for the second 6 months of the year (H2) is £2.716m, 2.5% of plan. This gives an annual CIP requirement of £4.1m.

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 10 of the required £1.9m Divisional target, a total of £1.194m of schemes have been identified, of which £698k are recurrent. The central CIP has been met for H1 through the achievement of a break-even position and is being met non-recurrently in H2 through slippage. See breakdown at Appendix E.

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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 number of bids. The revised annual plan is £10.966m. There is pressure in the overall Cheshire and Merseyside plan to stay within the required CDEL on the basis of this the Trust have agreed to underspend by £700k in year to support this position. It has been agreed in principal that this underspend will be returned to the Trust in 2022/23.

4.2 Capital expenditure of £1.7m has been incurred to the end of January, 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 £62.6m, which is a positive variance of £4.2m to the cash-flow plan. This is mainly due to the profiling of the original cash plan, the majority of capital spend cash is still being held in the bank.

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

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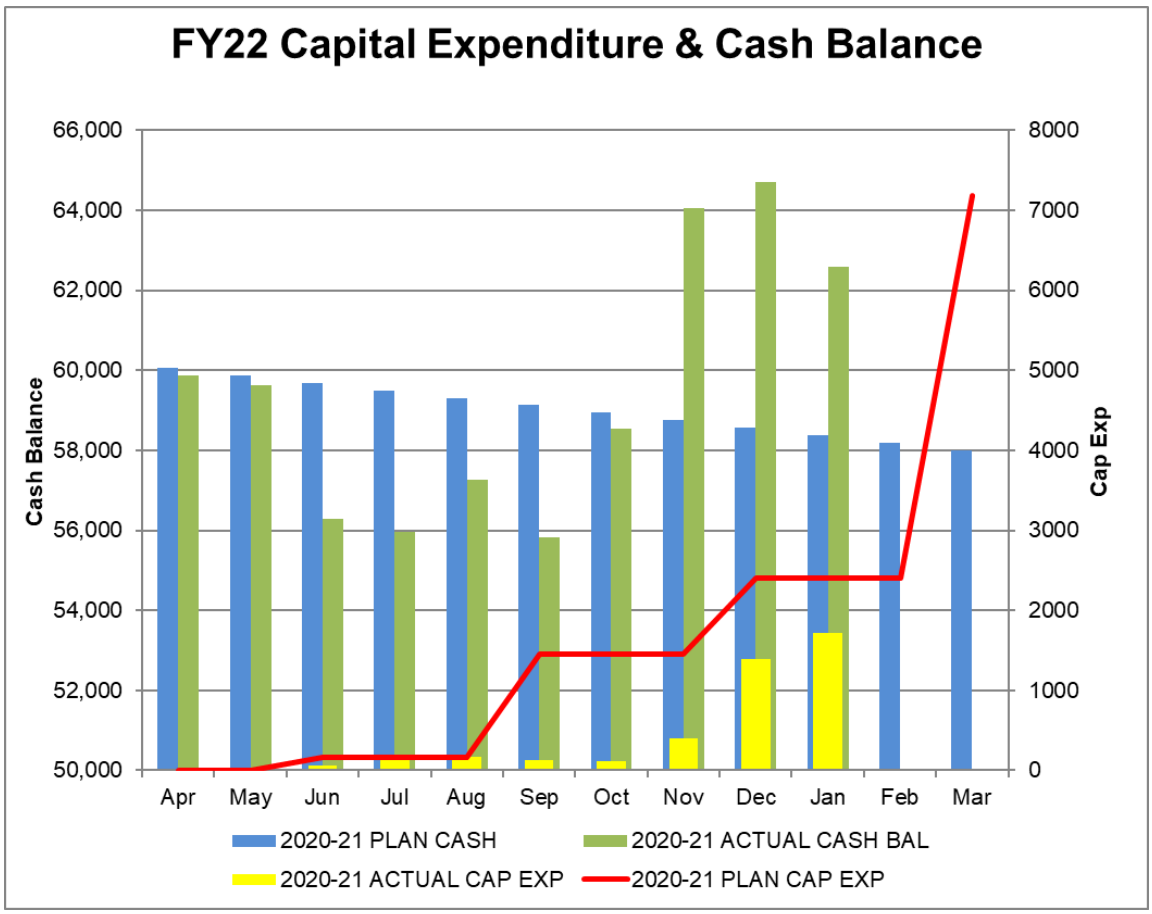
The Clatterbridge Cancer Centre NHS Foundation Trust



This chart shows monthly planned and actual Cash Balances and Planned Capital Expenditure for 2021/22. It shows that for January the Trust has more cash than originally planned.

5. Recommendations

6.1 The Performance Committee is asked to note the contents of the report, with reference to:

- The reported breakeven position
- The revised ERF Income position
- The continuing strong liquidity position of the Trust

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Appendix A – Statement of Comprehensive Income (SOCI)

(£000)	Month 10			Cumulative YTD				2021/22
	Plan	Actual	Variance	Plan	Actual	Variance	%	Annual Plan
Clinical Income	17,328	18,459	1,131	170,632	172,460	1,828		205,289
Other Income	511	(2,059)	(2,570)	5,008	5,144	136		5,999
Hosted Services	1,405	1,810	404	13,993	12,990	(1,003)		16,822
Total Operating Income	**19,244**	**18,209**	**(1,035)**	**189,633**	**190,595**	**961**	**1%**	**228,110**
Pay: Trust (excluding Hosted)	(5,740)	(5,812)	(72)	(57,855)	(56,519)	1,336		(69,575)
Pay: Hosted & R&I	(709)	(536)	173	(6,488)	(4,961)	1,526		(7,859)
Drugs expenditure	(7,064)	(4,640)	2,424	(68,729)	(72,455)	(3,727)		(82,857)
Other non-pay: Trust (excluding Hosted)	(4,786)	(4,856)	(70)	(45,680)	(45,069)	610		(54,748)
Non-pay: Hosted	(748)	(1,516)	(768)	(7,688)	(8,148)	(460)		(9,213)
Total Operating Expenditure	**(19,047)**	**(17,360)**	**1,687**	**(186,439)**	**(187,153)**	**(714)**	**0%**	**(224,251)**
Operating Surplus	**198**	**849**	**651**	**3,194**	**3,442**	**248**	**8%**	**3,859**
Profit /(Loss) from Joint Venture	67	61	(6)	670	723	53		804
Interest receivable (+)	401	392	(9)	4,007	3,919	(88)		4,809
Interest payable (-)	(439)	(437)	3	(4,393)	(4,402)	(8)		(5,272)
Loss on disposal of assets	0	0	0	0	(182)	(182)		
PDC Dividends payable (-)	(350)	(350)	0	(3,500)	(3,500)	0		(4,200)
Trust Retained surplus/(deficit)	**(124)**	**516**	**639**	**(22)**	**(0)**	**22**	**98%**	**(0)**
CPL/Propcare	0	91	91	0	605	605		0
Consolidated Surplus/(deficit)	**(124)**	**607**	**730**	**(22)**	**605**	**627**	**2824%**	**(0)**

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The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix B – Balance Sheet

£'000	Unaudited 2021	Plan 2022	Year to date Month 10 YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	2,488	2,100	2,424	2,253	(171)
Property, plant & equipment	177,180	174,267	175,680	170,603	(5,077)
Investments in associates	181	181	181	204	23
Other financial assets	1,364	0	0	0	0
Trade & other receivables	161	100	281	432	151
Other assets	0	0			0
Total non-current assets	**181,374**	**176,648**	**178,566**	**173,492**	**(5,074)**
Current assets					
Inventories	4,201	4,200	4,201	4,368	167
Trade & other receivables					
NHS receivables	4,621	4,500	4,621	6,781	2,160
Non-NHS receivables	4,484	4,500	7,779	5,658	(2,121)
Cash and cash equivalents	63,533	58,000	59,875	62,580	2,705
Total current assets	**76,839**	**71,200**	**76,476**	**79,388**	**2,912**
Current liabilities					
Trade & other payables					
Non-capital creditors	28,222	30,000	28,222	25,455	(2,766)
Capital creditors	3,544	2,000	2,000	1,995	(5)
Borrowings					
Loans	1,916	1,730	1,730	1,861	131
Obligations under finance leases	0	0	0	0	0
Provisions	2,160	1,535	2,160	2,426	266
Other liabilities:-					
Deferred income	5,974	4,000	5,974	8,884	2,910
Other	0	0	0	0	0
Total current liabilities	**41,816**	**39,265**	**40,086**	**40,621**	**536**
Total assets less current liabilities	**216,398**	**208,583**	**214,957**	**212,259**	**(2,698)**
Non-current liabilities					
Trade & other payables					
Capital creditors	970	0	970	120	(850)
Borrowings					
Loans	33,820	32,090	33,080	32,216	(865)
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**	**33,605**	**(1,714)**
Total net assets employed	**180,338**	**176,383**	**179,637**	**178,655**	**(982)**
Financed by (taxpayers' equity)					
Public Dividend Capital	67,374	68,116	67,374	67,374	(0)
Revaluation reserve	2,700	2,600	2,700	2,699	(1)
Income and expenditure reserve	110,264	105,667	109,563	108,582	(982)
Total taxpayers equity	**180,338**	**176,383**	**179,637**	**178,655**	**(982)**

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Appendix C – Cash Flow

January 2022 (M10) £'000	FT	Group	Group (exc Charity)
Cash flows from operating activities:			
Operating surplus	2,636	4,933	3,467
Depreciation	7,696	7,696	7,696
Amortisation	650	650	650
Impairments			
Movement in Trade Receivables	(1,454)	2,223	(1,022)
Movement in Other Assets	1,658		0
Movement in Inventories	(499)	(167)	(167)
Movement in Trade Payables	(490)	(6,101)	(2,832)
Movement in Other Liabilities	2,844	2,819	2,819
Movement in Provisions	49	357	357
CT paid	0	(170)	(170)
Net cash used in operating activities	**13,090**	**12,239**	**10,797**
Cash flows from investing activities			
Purchase of PPE	(897)	(1,754)	(1,754)
Purchase of Intangibles	(418)	(418)	(418)
Proceeds from sale of PPE	(182)	(182)	(182)
Interest received	3,919	31	4
Investment in associates	700	700	700
Net cash used in investing activities	**3,122**	**(1,622)**	**(1,649)**
Cash flows from financing activities			
Public dividend capital received	0	0	0
Public dividend capital repaid			
Loans received			
Movement in loans	(2,826)	(2,826)	(2,826)
Capital element of finance lease	0	0	0
Interest paid	(4,402)	(489)	(489)
Interest element of finance lease	0	0	0
PDC dividend paid	(3,500)	(3,500)	(3,500)
Finance lease - capital element repaid	0	0	0
Net cash used in financing activities	**(10,728)**	**(6,815)**	**(6,815)**
Net change in cash	**5,484**	**3,801**	**2,332**
Cash b/f	**53,765**	**63,533**	**60,248**
Cash c/f	**59,249**	**67,334**	**62,580**

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Appendix D – Capital

Capital Programme 2021-22
Month 10

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 10	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	66	354	177	243	✓	✗	In progress
4305	CCCW Linacc Bunker - Beech	Julie Massey	0	300	300	0	300	95	205	✗	✗	At planning stage
4300	CCCW CT Simulator (Brilliance 2)	Louise Bunby	300	(191)	109	68	42	77	33	✓	✓	Delivered and in use, await final invoices
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	✓	✗	Expect to start in Jan and take circa 4 wks
4307	CCCL Ward 4 and 5 bathroom conversion	Pris Hetherington	0	65	65	0	65	65	0	✓	✗	Charity funded, may now drop into 2022/23
4312	Cyclotron Fire Works	Propcare	0	90	90	0	90	90	0	✓	✗	Need to confirm forecast costs/timescales
	Contingency	*n/a*	200	(352)	(152)	0	(152)	243	(395)	-	-	
	Estates		**920**	**(26)**	**894**	**167**	**727**	**812**	**83**			
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	2,278	27	✓	✗	Delivery due 5th February
4305	CCCW Linear Accelerator - Beech (PDC)	Julie Massey	0	2,305	2,305	0	2,305	2,174	131	✓	✗	Delivery due 12th March
4318	CCCL Mobile Imagine Intensifier	Sam Wilde	138	0	138	0	138	138	0	✗	✗	Business case approved 10th Dec
	MEME - Acute - Patient Monitor	Julie Massey	9	0	9	0	9	0	9	-	-	Not required
	MEME - Acute - 2x Ultrasound	Julie Massey	25	0	25	0	25	40	(15)	✗	✗	Business case to Feb Finance Committee
4314	MEME - Networked - Scalp Coolers	Julie Massey	97	0	97	97	(0)	97	(0)	✓	✓	Delivered in January
	MEME - Rad - Infinity Monitor M540	Julie Massey	9	0	9	0	9	0	9	-	-	Postponed to 2023/24
	MEME - Rad - 3x Patient Monitor C500	Julie Massey	33	0	33	0	33	0	33	-	-	Postponed to 2023/24
	MEME - Rad - 6x Patient Monitor M540	Julie Massey	54	0	54	0	54	0	54	-	-	Postponed to 2023/24
4192	Cyclotron	Carl Rowbottom	742	0	742	50	692	742	0	✓	✗	PDC Funded
4300	CCCW CT Simulator (Brilliance 2)	Louise Bunby	500	166	666	631	35	652	15	✓	✗	Delivered, in use, Gating Phantom outs'ding
4301	Stand Aids		0	0	0	14	(14)	14	(14)	✓	✓	Delivered in May
4304	CCCL Cardiac Monitors W4&5	Julie Massey	0	26	26	0	26	26	0	✓	✗	Ordered 8th Dec
4308	2x Rhinolaryngo Videoscopes	Richard Lacey	0	64	64	64	0	64	0	✓	✓	Delivered in January
4309	Linac Voltage Stabilisers	Martyn Gilmore	0	130	130	0	130	70	60	✗	✗	May not now be deliverable in year
4310	CCCA QA3 Dosimeter	Martyn Gilmore	0	12	12	9	3	9	3	✓	✓	Delivered in January
4311	Interventional Radiology Pressure Injector	Samantha Wilde	0	20	20	0	20	15	5	✓	✗	Ordered 5th Jan
4319	Omniboard mounting adaptors	Lesley Woods	0	47	47	0	47	47	0	✓	✗	Ordered 11th Jan
	Contingency	*n/a*	200	(549)	(349)	0	(349)	95	(444)	-	-	
	Medical Equipment		**4,267**	**2,066**	**6,333**	**867**	**5,466**	**6,462**	**(129)**			
4190	***(20/21)*** Digital Aspirant	James Crowther	0	0	0	20	(20)	20	(20)	✓	✓	
	Infrastructure	James Crowther	1,350	(400)	950	434	516	930	20	✗	✗	£400k pushed back to 22/23
	Other minor programmes	James Crowther	250	0	250	98	152	250	0	✗	✗	
4315	CM Elective Fund - Remote Monitoring	James Crowther	0	300	300	0	300	300	0	✗	✗	New PDC funded scheme
4316	Digital Diagnostics Capability Programme	James Crowther	0	877	877	0	877	877	0	✗	✗	New PDC funded scheme
4317	Intelligent Automation (RPA)	James Crowther	0	311	311	0	311	311	0	✗	✗	50% PDC funded
4320	UTF Frontline Digitisation - Digital Infrastruc	James Crowther	0	790	790	0	790	790	0	✗	✗	New PDC funded scheme
	IM&T		**1,600**	**1,878**	**3,478**	**552**	**2,926**	**3,478**	**(0)**			
4142	Liverpool	Peter Crangle	0	0	0	(67)	67	(67)	67	✓	✓	
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	21	(21)	21	(21)	✗	✗	
4313	CCCL Terraces	Peter Crangle	0	195	195	180	15	195	0	✓	✗	Charity Funded
	Building for the Future		**400**	**(139)**	**261**	**134**	**128**	**215**	**47**			
	TOTAL		**7,187**	**3,779**	**10,966**	**1,720**	**9,246**	**10,966**	**0**			

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Appendix E – CIP

Directorate	Target	In Year 21.22	Full Year (Recurrent)	In Year Shortfall	Delivery % to date
ACUTE CARE	559,692	240,278	220,278	(319,414)	43%
CORPORATE	319,068	237,101	302,931	(81,968)	74%
NETWORKED SERVICES	547,860	466,817	78,150	(81,043)	85%
RADIATION SERVICES	453,380	250,301	96,709	(203,079)	55%
Divisional Total	**1,880,000**	**1,194,496**	**698,068**	**(685,504)**	
H1 Central	485,000	485,000	0	0	
H2 Central	1,776,000	1,184,000	0	(592,000)	
Central Total	**2,261,000**	**1,669,000**	**0**	**(592,000)**	
Overall Trust Total	**4,141,000**	**2,863,496**	**698,068**	**(1,277,504)**	

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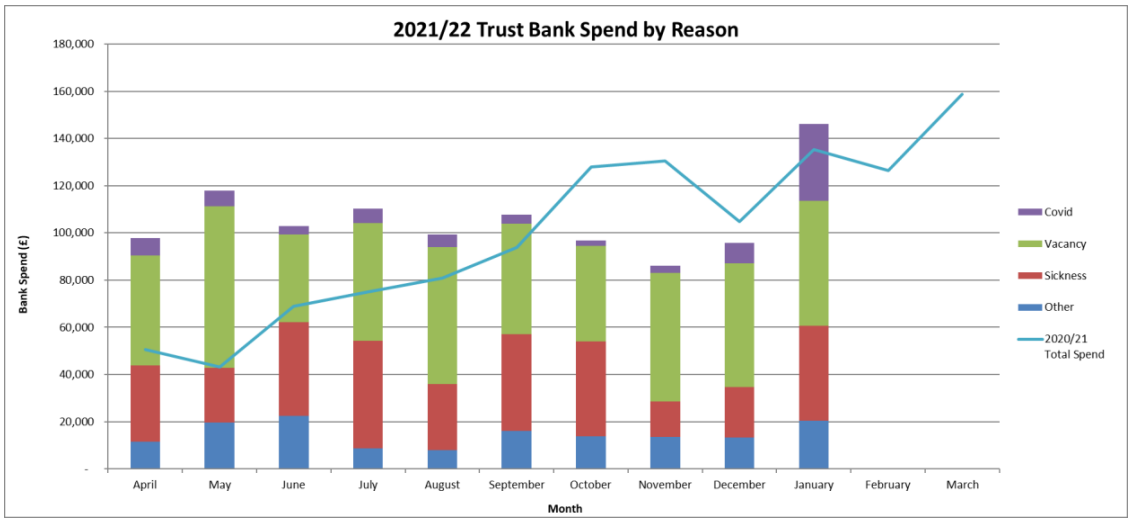
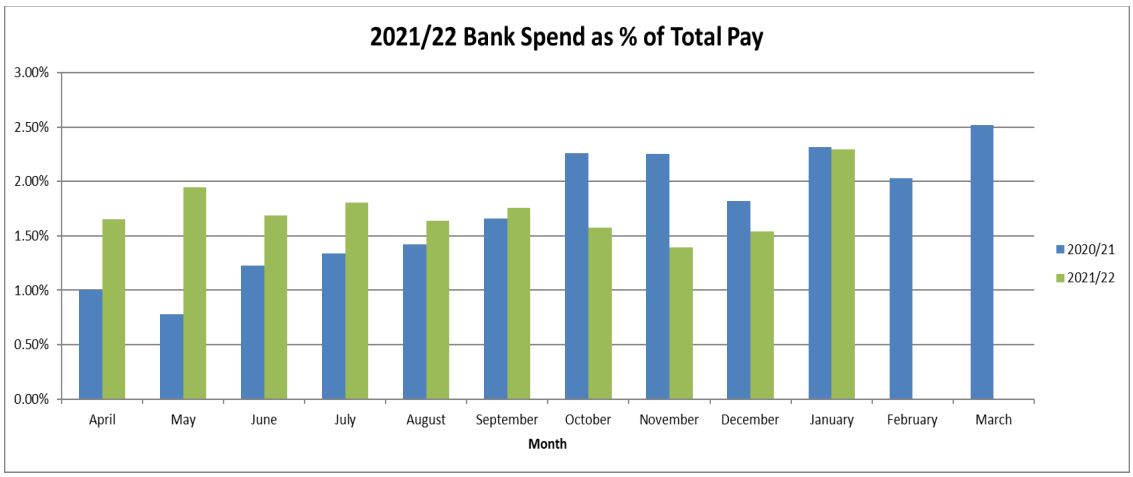
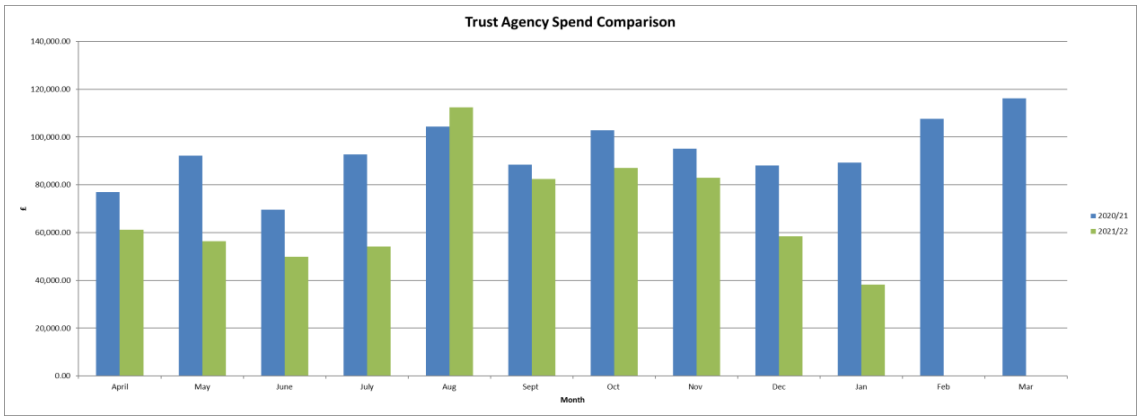
Appendix F – Bank and Agency







REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	The Trust Board
Date of meeting:	23rd February 2022
Agenda item:	P1-40-22
Title:	Learning from Death Mortality Dashboard Q2
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 Quality Committee
Date & decision:	17th February 2022

Purpose of the paper/key points for discussion:	The public mortality dashboard and Mortality Lesson learnt 2021-2022 Q2 were approved by the Mortality Surveillance Group. .

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

Next steps required:	

REPORT COVER

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

☐ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Q2 2021/2022 Mortality Dashboard Executive Summary

Helen Wong
Quality Manager (Audit & Statistics)

Version: 1.0 Ref: FCGOREPO Review: May 2024

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

1.0 Background

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

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

2.0 Mortality Review Inclusion Criteria

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

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

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

3.0 Case Review and Selection Process

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

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

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

3.0 Dashboard Interpretation

Data coverage: October 2020 – September 2021 for comparison to previous quarters

	Oct – Dec 20	Jan – Mar 21	Apr – Jun 21	Jul – Sept 21
No. of inpatient death ***(all inpatient deaths are reviewed)***	35	31	29	31
No. of outpatient death post treatment	160	131	126	120
No. of outpatient cases requiring review	141	109	116	107
Total cases requiring review	176	140	145	138
No. of cases reviewed (Phase I)	154/176 (88%)	113/140 (81%)	98/145 (68%)	80/138 (58%)
No. of cases peer reviewed (Phase II)	132/154 (86%)	101/113 (89%)	68/98 (69%)	31/80 (39%)
No. of case(s) selected for discussion (Phase III)	23	15	5	5
No. of case(s) discussed (Phase III)	21/23 (91%)	9/15 (60%)	2/5 (40%)	1/5 (20%)

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

- A total of 332 cases have completed an independent peer review (Phase II) from October 2020 – September 2021 deaths.
- From this, 48 cases have been selected for discussion out of which, 33 cases were discussed, out of which x1 has been given a provisional score (to be finalised after external Trust investigation), x2 cases were scored an RCP score of 4, x3 were scored an RCP score 5 and x27 were scored an RCP score of 6. The remaining cases are scheduled for discussion at a future date.
- 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 Inpatient SJR Score (avoidability score <6) case description

There were no new Inpatient SJR scores reported during the period

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

4.1 Community/Other hospital inpatient RCP Score (avoidability score <6) case description

Community/Other hospital inpatient RCP Scored 4.

An Isle of Man (IOM) patient returned to IOM for a 14-day COVID isolation rule after completed a course of radical (SABR) radiotherapy treatment at CCC as an inpatient. COVID test was negative and usual infection control measure were undertaken when discharged from CCC. Patient deteriorated at home over 10 days since returned from CCC, hence admitted to their local acute hospital and passed away due to COVID 19 pneumonia.

An incident review was undertaken. The following actions resulted from mortality review meeting discussions:

- The Clinical Director (CD) for acute care immediately initiated an interim discharge risk assessment for IOM patients and cascaded this to the acute care management team. The consultant of the week communicated to the ward team immediately.
- The patient flow team has been informed of the incident and as from the 1st November 2021, the team undertakes a “day after discharge” telephone call with all level 2 discharges to ensure patients have the support/equipment they need. Level 2 discharge is anything the patient flow team have been involved in e.g. ordered equipment, District Nurse referral etc. The patient flow manager will review the discharge policy after the level 2 discharge process has been fully embedded.
- The circumstances were reviewed at the MRM and no other issue was raised and agreed treatment was appropriated. CCC treating consultant personally wrote to the family to clarify the rationale of the decision to treat and the family accepted this response.

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

5.0 Statistical Deep Dive Analysis of Chemotherapy (30 day) and Radiotherapy (30 day / 90 day) mortality

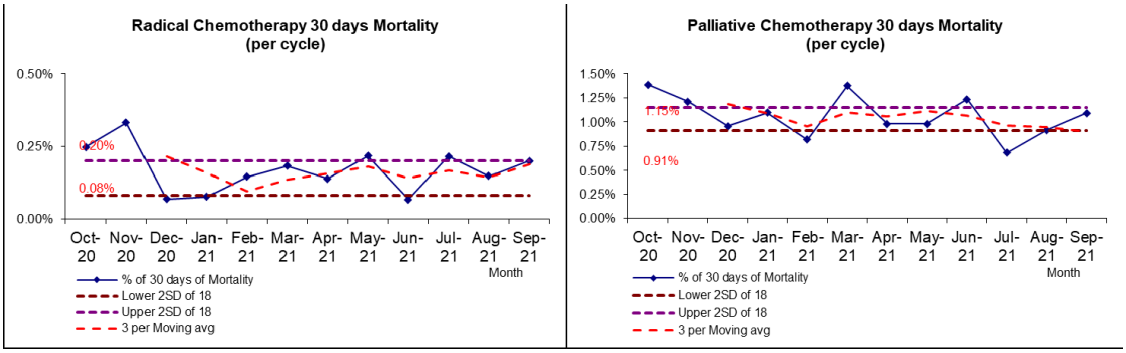
In addition to the mortality review of individual cases, the Trust has been performing a deep dive analysis on chemotherapy mortality drilled down by intent and consultant in the form of Statistical Process Control (SPC) charts since 2009.

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

The trend is displayed by the three months moving average (red dash line on chart). If increasing trend is identified on the chart, these are audited by the Site Reference Group (SRG).

The following are the results of October 2020 – September 2021 treatment activities. The moving average mortality for each of the areas are within tolerance.

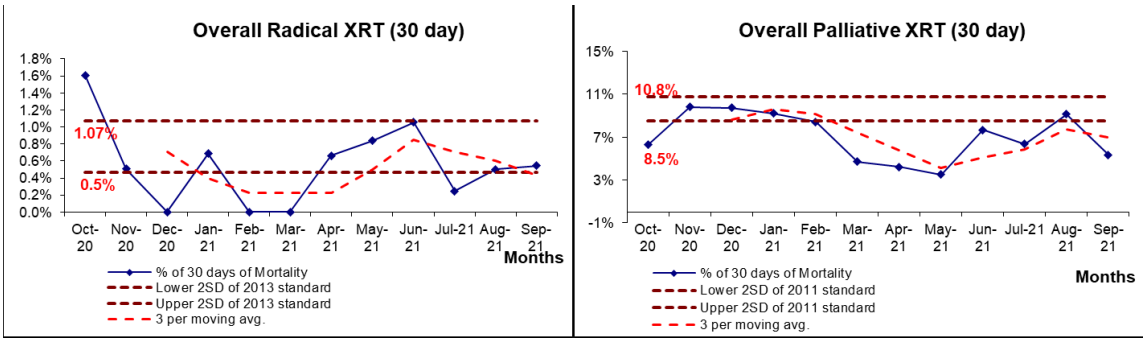
5.1 Chemotherapy 30 day mortality



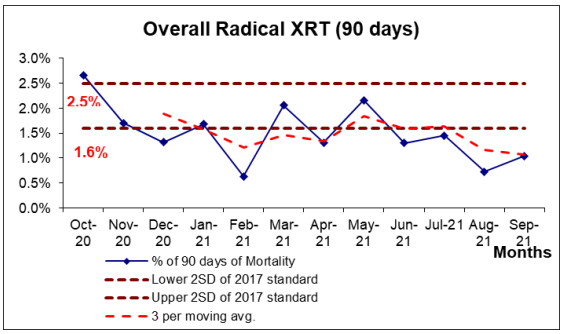
REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

5.2 Radiotherapy 30 day mortality



5.3 Radical radiotherapy 90 day mortality



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

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 - September 21

Lessons Learnt from Mortality Review Quarter 2 2021-22

	QTR	No.	Background	Actions Taken	CCC Lessons Learned	Action closed	MSG
New	QTR 2	MRM110	A patient had failed to attend several appointments due to ongoing illness. The patient was contacted by treating nurses, the care navigator and finally the police . There was no next of kin and the patient was socially isolated.	This case received a formal investigation as well as mortality review. A new system has been set up for triage to be contacted when a patient cancels an appointment in order to undertake a UKONS assessment and provide the most appropriate safety netting and follow up advice.	Patients who call up to cancel appointments should receive a UKONS assessment from the triage team. This change in the care pathway has been communicated to all stakeholders	24/08/2021	07/12/2021
New	QTR 2	MRM127	A patient who was treated with Carboplatin had an 8kg weigh loss reported during chemotherapy along with a deteriorating kidney function. The question was raised if the correct dose of Carboplatin was given.	Investigation by pharmacy revealed that the correct dose of chemotherapy was given but that different laboratories supporting CCC patients use different Wright formulae. The head and neck team are auditing this to determine if this alters chemotherapy prescription dosing.	All SRGs informed of the variation in laboratory protocol. Whilst this does not appear to alter chemotherapy dosing banding, SRGs are advised to ask for eGFR clearance for patients when borderline.	15/07/2021	07/12/2021
New	QTR 2	MRM128		The medicines safety pharmacist and associate medical director investigated if the appropriate formula was used for the laboratory in this case. It was found that neither formula would have affected the dosage prescription with dose banding in place for this case.			
New	QTR 2	MRM132	A patient with a stomach adenocarcinoma died of neutropenic sepsis after cycle 1 of his 4th line chemotherapy. No prophylactic GCSF was given, however chemotherapy was dose reduced by 20%.	An update was circulated to consultants about the protocol for use of prophylaxis of GCSF in palliative treatments with high risk of neutropenia.	GCSF prophylaxis can be offered for palliative chemotherapy regimens with moderate/high risk of febrile neutropenia at the discretion of the consultant	19/08/2021	07/12/2021

Lessons Learnt from Mortality Review Quarter 1 2021-22

QTR	No.	Background	Actions Taken	CCC Lessons Learned	Action closed	MSG
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	21/09/2021
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	21/09/2021
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	21/09/2021
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	21/09/2021
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	21/09/2021
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	21/09/2021
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	21/09/2021
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	21/09/2021

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	01 April 21 - 30 September 21

Trust Mortality Programme QTR 1 - QTR 4

Total Number of Deaths in Scope	No.
QTR 1	155
QTR 2	151
QTR 3	
QTR 4	
YTD	306

Total Deaths Requiring Phase 1 Review (excluding not applicable eg bone mets, MSCC)	No.
QTR 1	145
QTR 2	138
QTR 3	
QTR 4	
YTD	283

Total Deaths Reviewed (Phase 1) *Target = 100% completion*	No.	%
QTR 1	98	*68%*
QTR 2	80	*58%*
QTR 3		
QTR 4		
YTD	178	*63%*

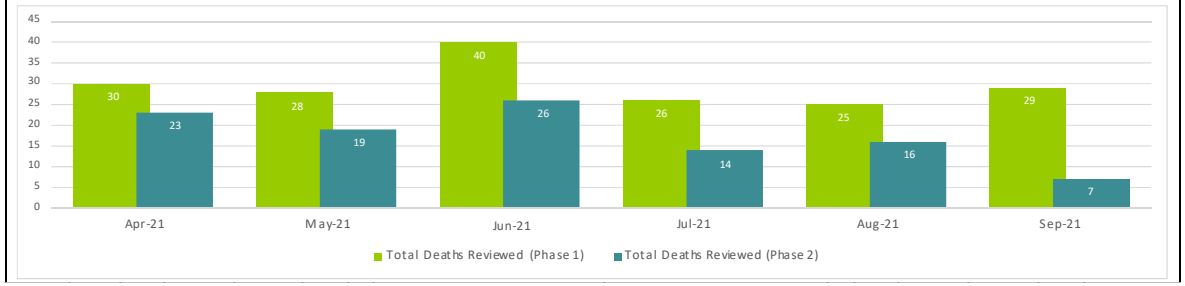
Total Structured Judgement Reviews completed and avoidability scored against RCP Methodology (Conducted for inpatient deaths only)

	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	15
QTR 2	0	0	0	0	0	4
QTR 3						
QTR 4						
YTD	0	0	0	0	0	19

Total Deaths Reviewed (Phase II) *nb. Total deaths reviewed out of those deaths reviewed at Phase 1* *Target = 100% completion*	No.	%
QTR 1	68	69%
QTR 2	37	46%
QTR 3		
QTR 4		
YTD	105	*59%*

Total Deaths Selected for Review (Phase III) *nb. Total deaths reviewed out of those deaths reviewed at Phase 2* *Target = No Target CCC share best practice alongside learning*	No.	%
QTR 1	5	7%
QTR 2	5	14%
QTR 3		
QTR 4		
YTD	10	10%

Number of cases reviewed at Phase 1 & Phase 2



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

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

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

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

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

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

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	23rd February 2022
Agenda item:	P1-41-22
Title:	Guardian of Safe Working Hours – Q2 Report July-September 2021
Report prepared by:	Dr Madhuchanda Chatterjee
Executive Lead:	Dr Sheena Khanduri – Medical Director
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Workforce and Organisational Development Committee
Date & decision:	

Purpose of the paper/key points for discussion:	To brief the Board and provide assurance the Trust maintains compliance with the Junior Doctor's 2016 Terms and Conditions. To assure the Board where Exception Reports have been raised, the Trust has taken the correct steps to rectify the issues.

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

Next steps required:	The committee is asked to discuss and note the content of the report.

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

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

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

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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.	☐

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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.

Guardian of Safe Working Hours – Q2 Report July-September 2021

Madhuchanda Chatterjee, Guardian of Safe Working

1.0 Introduction

This report covers the period July-September 2021.

The 2016 Contract for doctors in training ('Junior Doctors') sets out terms and conditions regarding Working Hours (Schedule 03), Work Scheduling (Schedule 04) and Exception Reporting and Work Schedule Reviews (Schedule 05). These are a system of checks and balances to ensure doctors in training work fixed numbers of hours in a 24 hour period, fixed numbers of consecutive days of work and have designated break times in a work period, to try to ensure they are never so fatigued from work as to be a risk to patient safety, which is of paramount importance. The contract also has schedules outlining the training opportunities the junior doctors should be receiving to ensure appropriate development of skills and knowledge.

With effect from December 2019, all doctors in training transferred to the 2016 Terms and Conditions of service. Eight current ST3+ trainees have their previous pay and banding protected on their existing salaries. Significant breaches on working hours can incur financial penalties.

Since August 2021, Haematology doctors in training officially come under ourselves as opposed to Liverpool University Hospitals. We liaise with this group of trainees around attendance at Junior Doctors Forum and issues related to Exception Reports raised at each Trust. The Clatterbridge Cancer Centre will manage this group of trainees Exception Reporting moving forward, liaising with Liverpool University Hospitals for any issues that relate to their service or education aspects. If Exception Reports like this are raised by Haematology trainees whilst at our Trust, we will report them but also include which Trust it relates to.

1. High level data

Number of doctors/dentists in training (total):	42
Number of doctors/dentists in training on 2016 TCS (total):	42
Amount of time available in job plan for guardian to do the role:	0.5 PA (2 hours per week)
Admin support provided to the guardian (if any):	As required by Medical Workforce
Amount of job-planned time for educational supervisors:	0.25 PA per trainee

Exception reports (with regard to working hours)

There were no Exception Reports submitted during this period, July-September 2021.

This is a recurring topic at the Junior Doctor Forum to ensure that the trainees know their rights to exception report. It is also discussed and highlighted at the 2 main trainee inductions each year.

Hours Monitoring

Because all doctors in training are on the 2016 Terms and Conditions of service, monitoring of hours is no longer undertaken and has been replaced by Exception Reporting which offers trainees the ability to raise concerns as-and-when they occur.

Work schedule reviews

There have not been any requests from trainees for work schedule reviews. Medical Workforce are in the process of reviewing the ST3+rota as a redesign is required to better accommodate our Less Than Full Time trainees and reduce the number of known gaps due to non-working days.

Locum bookings

All 'Patchwork' shifts are the additional locum duties worked by our doctors in training. These are a result of known gaps in the rota plus last minute cover due to absences.

Specialty	Shifts worked by bank doctors	Shifts worked by agency doctors	Patchwork shifts
Clinical Oncology / Medical Oncology	0	0	59
General Medicine	3	164	8
Haemato Oncology	0	100	0

Vacancies

The Trust currently has 2 x Junior Clinical Fellow vacancies, 1 of which has been offered and pending a start date and the 2nd vacancy is currently at shortlisting stage. These posts feature on a 1 in 13 pattern which covers out of hours work within CDU.

There are currently 3 x agency locum doctors supporting the junior Ward Doctor rota, The rota is 1 in 13 so has 13 slots. The trust only has 11 whole time equivalent doctors made up of doctors in training and Clinical Fellows, therefore 2 posts remain vacant (which are the vacancies referenced above). 2 of the locums are filling the gaps but the division approved an extra doctor to cover 9am-5pm only hence the overstaffing by 1.

We have been asked by the Acute Care Services Division to review the current rota with the aim to improve the Haematology ward cover from 5pm-9pm, Monday-Friday, so discussions are taking place with the relevant parties with the aim to implement the new duty in time for February 2022.

The Trust also advertised a Senior Clinical Fellow in Immuno-Oncology to participate in the Registrar rota. This post being vacant is not having a negative impact on the Registrar rota as we received new training posts in August 2021 that have increased the overall number.

Fines

There were no fines incurred in this quarter (July - September 2021).

All Trainees who require access to Exception Reporting, have passwords and log in details for exception reporting have been reissued.

Actions taken to resolve issues

- Carry on encouraging Trainees to record their exception reports when necessary.

The information in this report confirms for this quarter, the working hours of Ward - based doctors in training IMT/CMT, GP trainees and Oncology trainee doctors remain compliant with the 2016 contract. Locums were used appropriately to cover on-call shifts during this time period to ensure all critical out of hours shifts were covered.

Within this organisation, working hours for doctors in training are considered safe at the current time. The information collected and documented in this report provides assurance for this.

Dr Madhuchanda Chatterjee

Guardian of Safe Working

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	23rd February 2022
Agenda item:	P1-42-22
Title:	Bright Ideas Scheme – Progress and Outputs
Report prepared by:	Gillian Heap, Drew Norwood-Green
Executive Lead:	Sheena Khanduri
Status of the report: (please tick)	Public ☒ Private ☐

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

Purpose of the paper/key points for discussion:	To provide an update on the Bright Ideas Scheme since it started on 31st August 2021. To highlight some background to the scheme, infrastructure available, strategic focus, key highlights to date, risks and next steps.

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

Next steps required:	The Board is asked to note the content of the paper.

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 investment6 in our digital programme and teams there is a risk that the Trust will not achieve its digital ambition.	☐
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in potential loss of data and delayed care.	☐

☐ BE **INNOVATIVE**

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

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

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Bright Ideas Scheme – Progress and Outputs

Drew Norwood-Green, Innovation Manager
Gillian Heap, Director of Research & Innovation Operations
Seamus Coyle, Clinical Lead for Innovation
Sheena Khanduri, Medical Director

February 2022

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

1. Background

The Bright Ideas Scheme was developed as a collaboration between The Clatterbridge Cancer Centre and The Clatterbridge Cancer Charity. The scheme launched 31st August 2021 in alignment with the 'Be Innovative' theme of the Trust Strategy, and in response to the Staff Survey 2020 which highlighted a need for an established route for staff to submit their ideas with a mechanism for receiving feedback. The Charity has pledged £150,000 annually to support ideas which have a direct, clear patient benefit. The Bright Ideas panel convenes monthly to review ideas that have been submitted and consider their feasibility and where appropriate, potential ways to be adopted by the Trust.

2. Infrastructure

Innovation Infrastructure	Bright Ideas Panel
Sheena Khanduri, *Medical Director*	Drew Norwood-Green, *Innovation Manager*
Seamus Coyle, *Clinical Lead for Innovation*	Gillian Heap, *Director of R&I Operations*
Gillian Heap, *Director of R&I Operations*	Seamus Coyle, *Clinical Lead for Innovation*
Drew Norwood-Green, *Innovation Manager*	James Thomson, *Executive Director of Finance*
	Thomas Pharaoh, *Director of Strategy*
	Emer Scott, *Associate Director of Communications*
	Katrina Bury, *Head of Charity - Clatterbridge Cancer Charity*
	Kirsteen Scowcroft, *Head of Patient Experience & Inclusion*
	James Crowther, *Head of IT Operations*
	Paul Ogden, *Communications Manager – R&I*
	Stephanie Thomas, *Head of Learning & OD*
	Alun Evans, *Advanced Practitioner and Staff Side*

3. Strategic Focus

- Providing a single point of contact for all staff to submit their ideas for ways to improve, grow or transform our services to enhance patient and staff experience.
- In addition to this, Bright Ideas provides a route for greener solutions to improve our sustainability and become more eco-friendly.
- Whilst the Bright Ideas fund provided by The Clatterbridge Charity is solely for initiatives where the primary benefit is for patients, staff are encouraged to submit all ideas as alternative funding streams may be identified once we are aware of the idea.
- Bright Ideas is open to all CCC, PropCare, PharmaC, Vinci, ISS and voluntary staff.
- Increasing staff engagement, ensuring that idea submitted receives a direct and personal response from the panel on the outcome of their submission.

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

4. Progress to Date – Key Highlights 2021/22

54 Bright Ideas have been submitted as of February 2022 which have been assessed against the following criteria: benefit to the patient, cost, fundraising potential, existing processes or resources available, existing or planned works to address the same or similar issue.

40 of 54 Bright Ideas have now been closed, with the following outcomes: awareness of existing process/resources available (6), implemented (4), incorporated into existing/planned works (10) and re-directed to relevant area (20).
There are currently 7 being investigated further with 7 new ideas pending review.

Four initiatives have been funded to date:

- **Children's memory boxes to support children losing a family member**, including a children's book on grief, stress-relief toys, personal items of their loved one to act as a 'touchstone to memory' (submitted by Michelle Williams, Family Support Practitioner). £1,000 was awarded from the scheme, this initiative has subsequently led to £10,000 being raised for the Charity.
- **Massage guns purchased for personal use by patients to provide temporary pain relief** (submitted by Dr Seamus Coyle, Consultant and Clinical Research Lead in Palliative Medicine). £480 was awarded from the scheme.
- **Virtual reality headsets for long-term inpatients unable to leave their room**, the headsets provide an escape from the four walls of their room to improve wellbeing (submitted by David Croft, Digital Projects Team Leader). Funding approved in principle, VR Headset prototype had already been procured by Digital and currently being tested as a proof of concept.
- **Water bottles with volume measurements to help patients adequately hydrate prior to receiving radiotherapy treatment**, 50 bottles to be retained on the unit have been funded (submitted by Kate Shrewsbury-Gee, Therapy Radiographer). £310 was awarded from the scheme.

5. Risks

- Financial - longevity of scheme if Clatterbridge Cancer Charity does not approve future funding.
- Reputational - ensuring all approved Bright Ideas which use charitable funds are primarily for patient benefit.
- Organisational - ensuring Bright Ideas do not conflict with existing or planned work projects - both a duplication of effort and potential waste of resource.

6. Next Steps

- Continue to raise awareness of the Bright Ideas Scheme across the workforce.
- Develop and launch the Innovation Champions programme to establish localised points of contact within departments to promote innovation and bright ideas.

The Clatterbridge Cancer Charity

Report Cover

Report to:	Trust Board	
Date of meeting:	Wednesday 23 February 2022	
Agenda item:	P1-43-22	
Title:	Conversion of the Clatterbridge Cancer Charity to Independent Status	
Report prepared by:	Katrina Bury, Head of Charity	
Executive Lead:	Liz Bishop, Chief Executive	
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	
Date & decision:	

Purpose of the paper/key points for discussion:	The recommendation of Charitable Funds Committee is for the Corporate Trustee to consider approving in principle the conversion of the existing Charity to a new independent charity and to progress the process for the existing Charity to become established as an independent charity. This is a staged process with multiple points for review and opportunities to revise the decision to convert. The proposal has been reviewed by the council of Governors in Jan 2022 with no objections.

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

Next steps required:	Approval in principle to start the process to independence. Next steps decisions on key points of independent governance structure.

The Clatterbridge Cancer Charity

Report Cover

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

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The Clatterbridge Cancer Charity

Report Cover

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

The Clatterbridge Cancer Centre NHS Foundation Trust

Proposed Charity conversion to Independent status

Trust Board 23 February 2022

The Clatterbridge Cancer Charity

The Clatterbridge Cancer Centre NHS Foundation Trust

About hospital charities

Hospital charities can take 2 forms:

NHS Charity

A restricted type of charity:

- Accountable to Department of Health & Social Care
- Bound by NHS laws as well as Charity Commission
- Limited freedom to act/innovate

Good for hospitals with small charities & limited fundraising activity

‘Independent’ Charity

Still fundraising for the hospital but:

- Independent of Department of Health & Social Care
- Bound by Charity Commission
- Greater freedom to act/innovate
- Freedom to appoint external trustees who can mobilise major donations

Popular with larger hospital charities keen to continue growing

The Clatterbridge Cancer Charity

Proposal

Proposal to change The Clatterbridge Cancer Charity's status:

- Current status – NHS Charity (more common in hospitals with small charities)
- Proposed status – 'Independent' charity (Charity Commission recognised model for all non NHS charities)

Importantly, there would be no change to the Charity's objects which are:

"for any charitable purpose or purposes relating to the National Health Service, wholly or mainly for the service provided by the Clatterbridge Cancer Centre for Oncology NHS Foundation Trust or its successors"

Proposal presented to Council of Governors 12 Jan 2022 with no objections

Independent status

Many of the biggest hospital charities have already taken advantage of the opportunity to convert to independent status, including:

- Alder Hey Charity
- Barts and the London Charity
- Birmingham Children's Hospital Charity
- Great Ormond Street Hospital Charity
- King's College Hospital Charity
- The Royal Marsden Charity

Charities retain the same commitment to raising funds that benefit their hospital – their core purpose doesn't change.

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Factors to consider

Independent charities have more freedom to act:

- Dedicated Board of trustees – (voluntary positions no remuneration)
- Funds not incorporated into NHS foundation trust
- Free from rules designed for NHS bodies not charities

This means they can:

- Safeguard charitable funds
- Increase transparency
- Be more innovative / flexible
- Demonstrate independent decision-making & therefore improve donor confidence
- Freedom to recruit staff and attract talent on competitive industry-driven terms (not AfC)
- Potential to increase income through above opportunities

Mitigating any risks

- Important to maintain strong relationships to NHS foundation trust.
- Two NEDs on the Board. Secure Trustees that will share the same Trust values.
- May see a short term drop in income but aim to secure high-calibre trustees who can mobilise major donations in the future.
- Achieve best value for any transition costs & future estates, staffing, services.
- The Trust Board and the Charity will establish the objectives together but there is a risk that the plans can change at a later date. This will be mitigated by the above.

The Clatterbridge Cancer Charity

Considerations

- Main drivers are long term growth of charitable income source for the Trust and safeguarding of funds.
- Existing structure limits development of the Charity
- Lack of dedicated Charity Trustee Board limits fundraising potential
- Our ambitions for the Charity seem better served by converting to independent status
- Advantages & risks to both options
- Independent status has greater advantages than NHS Charity status
- Risk of independent status but will be mitigated through the set up
- Further work & due diligence required

Income projections 2023/27

The Clatterbridge Cancer Centre NHS Foundation Trust

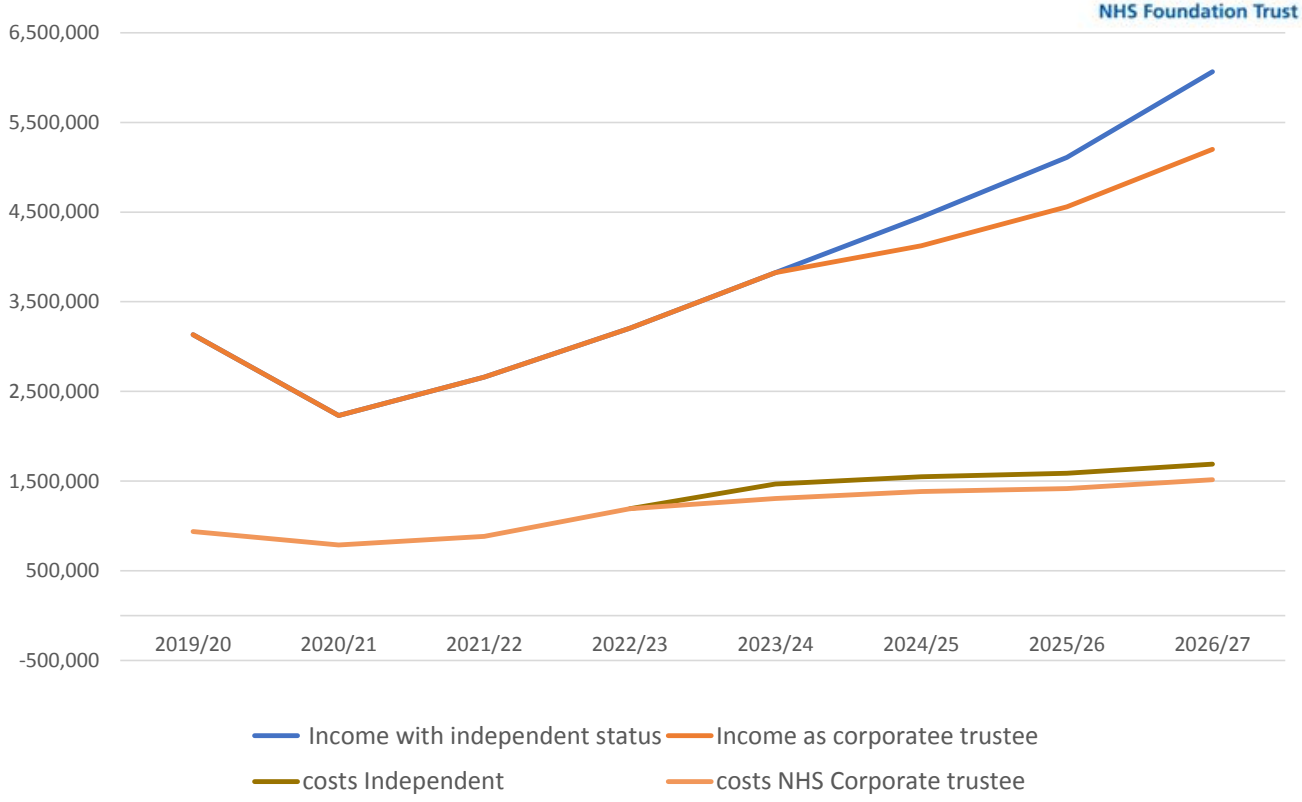
2022/23 NHSCT income regains increase at pre-pandemic rate

2023 independent income starts to increase and diverge due to influence from Charity Board - extending network, reach & engagement with major donors and corporates.

2026/27 income forecast 17% higher than NHS CT.

2023-27 £1.73m (8%) cumulative uplift in income for independence and % difference widening.

2026/27 Costs become proportionally smaller- close to 30% cost to income ratio target.



The Clatterbridge Cancer Charity

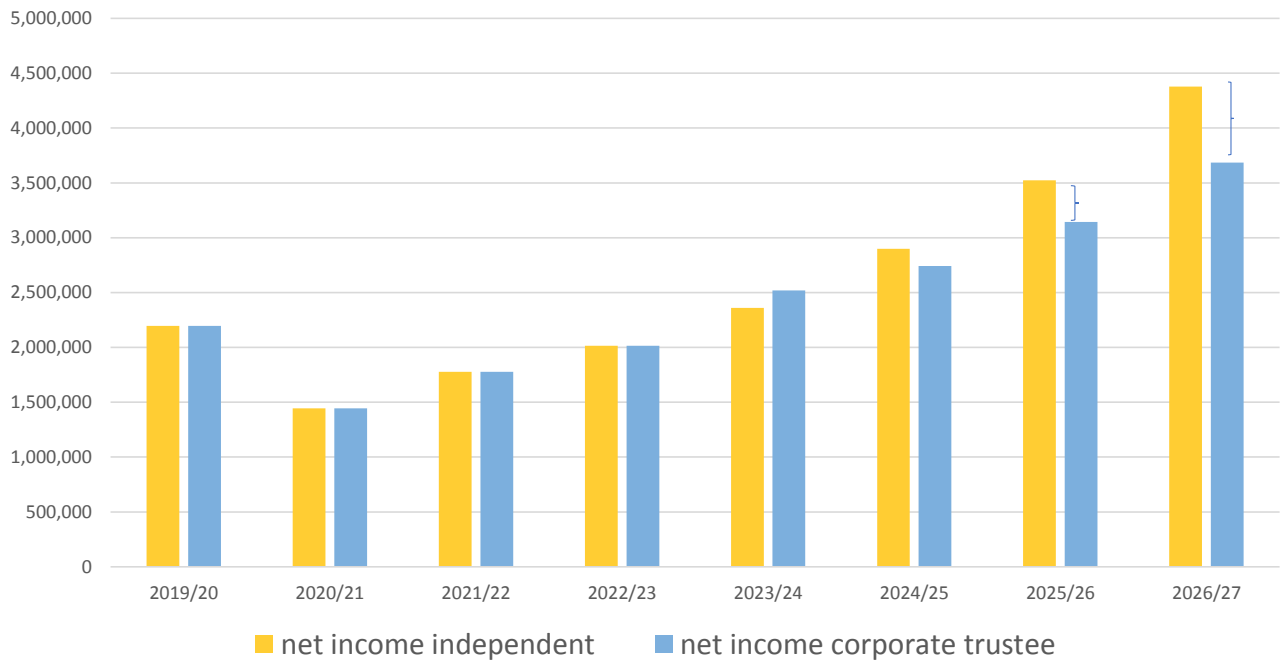
Net Income comparison

2023/24 increased costs impact net independent income

2024/25 independent income increase overtakes cost impact

2025/26 net income 11% higher

2026/27 net independent income 16% higher



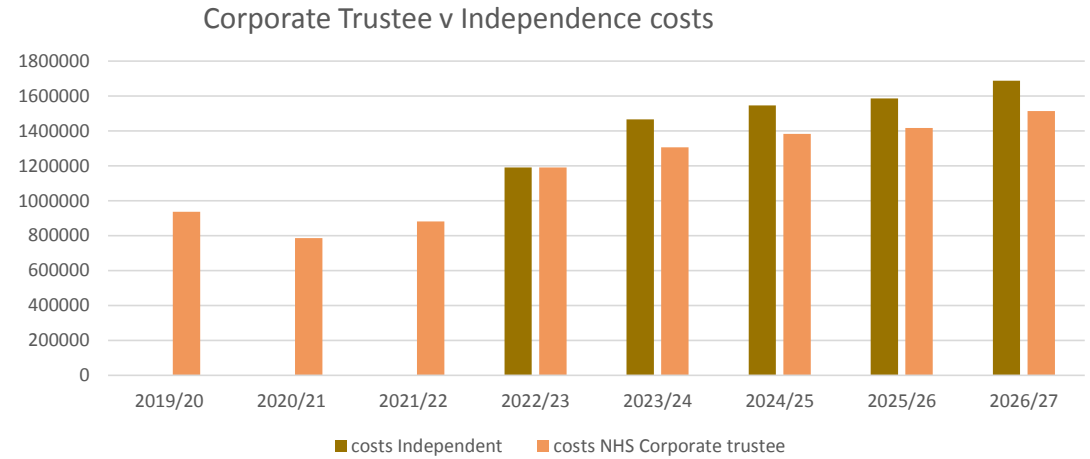
Income assumptions

5 year income projections

- Cautious assessment of income growth.
- Review of other independent NHS charities income profiles show no pattern, highly variable.
- Assumes proactive Charity Trustees from 2023
- Based on historical and market data (historically 4% forecast accuracy)
- Long term projections susceptible to economic fluctuations, unforeseen events (Covid)
- Assumes Trustee Board approve resource investment

Transition costs

- The Charity is already recharged for all salary/ pension, legal, audit & finance, IT, fundraising costs so independent status would not incur substantial additional costs
- One off Conversion cost estimated £100K (including legal costs)
- Additional ongoing costs for new Charity corporate support services estimated £160K p.a. (excluding accommodation costs - to be negotiated with Trust)



Next steps

- **Trust Board approves in principle whether or not to pursue independent status (23 Feb)**
- Council of Governors reviewed in January 2022 with no objections
- Charitable Funds Committee approved submission of proposal to Trust Board in February 2022
- Trust Board reviewed advantages & disadvantages September 2021
- **Conversion to independent status will take 12-18 months – this is a staged process, with multiple points for review and opportunities to revise the decision to conve**rt.

If approved in principle, there would be further work before any final decision:

- Lawyers would draft MOU & articles of association & governance arrangements (Hempson's identified)
- Trust to decide on objects, number of trustees, Charity name.
- Recruitment of Charity Trustees
- Consultation with Charity staff
- Board & external body approval of the transition

Cheshire & Merseyside Cancer Alliance

Performance Report

February 2022

Version 1

Contents

Section I: Summary

Restoration of cancer services

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

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

Measure	% of pre-Covid level
2WW referrals*	127%
Cancer surgery activity*	103%
SACT (inc chemo) delivery**	112%

Measure	% of pre-Covid level
Radiotherapy planning**	106%
Radiotherapy treatment**	78%
Endoscopy activity♀	83%

- The sustained increase in SACT continues to present challenges to service delivery, however CCC continues to take the following steps to ensure that demand continues to be met. This includes detailed capacity and demand planning, enabling targeted WLI clinics. Additional SACT nurses are being recruited, however this impact is unlikely to be made for several months due to recruitment and training.

- Radiotherapy planning activity has been on average 105% higher than pre covid levels in 2021/22.
- Radiotherapy treatments are lower than 2019/20 and will remain so, due to a change in fractionation in early 2020/2021, which equates to fewer treatments per patient in some tumour groups.

- Endoscopy activity more than doubled between July 2020 (3,300 procedures) and March 2021 (6,600 procedures). Endoscopy activity decreased in December (due to bank holidays), but in 2021 fell by more than other years (likely due to Omicron). The DM01 waiting list has risen sharply - Countess of Chester were able to submit data for November and December but with substantial data quality issues. A more accurate submission is expected for January. The weekly SITREP suggests the endoscopy waiting list is rising slightly, primarily due to trusts adding overdue surveillance patients to their active waiting lists. Further capacity is required in order to clear the backlog of patients on the endoscopy waiting list. The Alliance has established an endoscopy operational recovery team (EORT) to oversee and co-ordinate restoration activities.

Cheshire & Merseyside Cancer Alliance

*Data as of 18th October
** Solid tumour only (not inc. Haemato-oncology): reliable Haemato-oncology figures pre covid are unavailable – data as of December 2021
♀Assessment based on monthly DM01 endoscopy returns - latest update December 2021. 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 **December 2021**.

- The Alliance failed the **14 day standard** for urgent suspected cancer referrals in December, with seven trusts and all CCGs falling below the 93% threshold. The overall performance of the Alliance was 76.3%*, improving from 75.8%* last month. The England average was 78.6%. CMCA was the 13th best performing Alliance in England out of 21 against this standard.

- The Alliance failed the **28 day standard** for urgent suspected cancer referrals in December (the new standard has now come into force from October 2021), with eight trusts and seven CCGs falling below the 75% threshold. The overall performance of the Alliance was 69.0%*, increasing from 67.8%* last month. The England average was 70.5%. CMCA was the 16th best performing Alliance in England out of 21 against this standard.

- The Alliance failed the **62 day standard**, achieving 73.1%* (decreasing from 75.6%* last month) against a standard of 85% (England average was 67.0%). Ten trusts and all nine CCGs failed to meet the 62 day standard. Cheshire and Merseyside is the 4th best performing Alliance in England out of 21 against this standard.

- The number of urgent referral patients waiting **over 62 days** is significantly higher than pre-Covid levels. On 7th February 2022 there were 1,609 patients waiting more than 62 days for a diagnosis or treatment. This has decreased slightly from 1,692 reported last month (17th January). Of these, 409 have waited **over 104 days**. This is higher than the 343 patients reported last month.

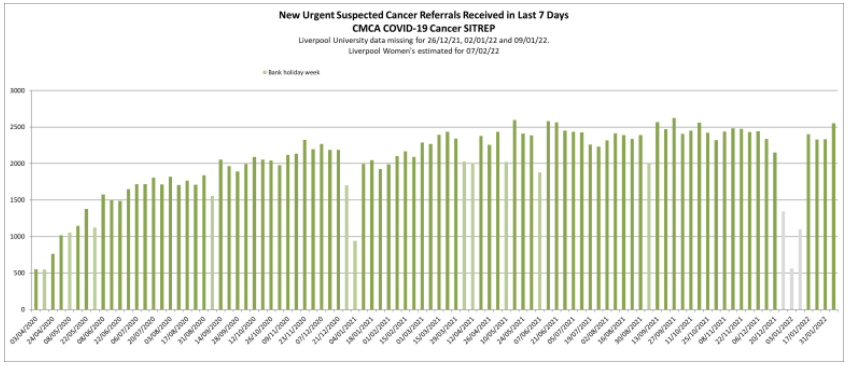
  The proportion of patients on urgent suspected cancer pathways who have already been on the pathway for over 62 days is in line with the England average.

Cheshire & Merseyside Cancer Alliance

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

Section II: Restoration of Cancer Services – Core Metrics

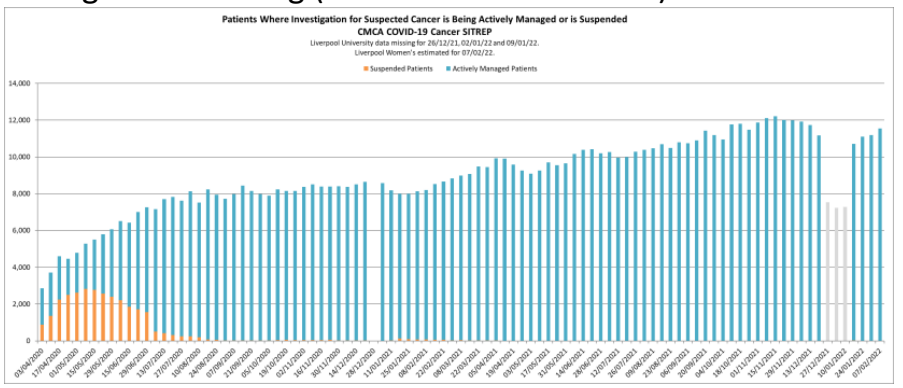
1. TWW referrals received in last 7 days



Referrals high with 2,553 patients referred this week (27% above pre-pandemic weekly average, 41% above same time last year).

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. 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. Missing data from LUHFT for 26/12/21, 02/01/22 and 09/01/22. Liverpool Women's estimated for 07/02/22.

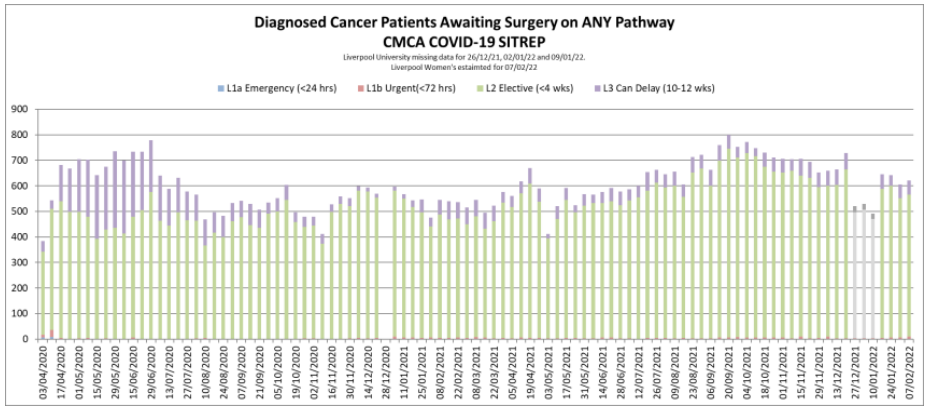
2. Diagnostic backlog (referrals without a DTT)



Currently 11,552 active patients (of which 5 are suspended).

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. Countess of Chester data estimated for 9/08/21. LWH estimated for 13/09/21, 20/09/21. Missing data from LUHFT for 26/12/21, 02/01/22 and 09/01/22. Liverpool Women's estimated for 07/02/22.

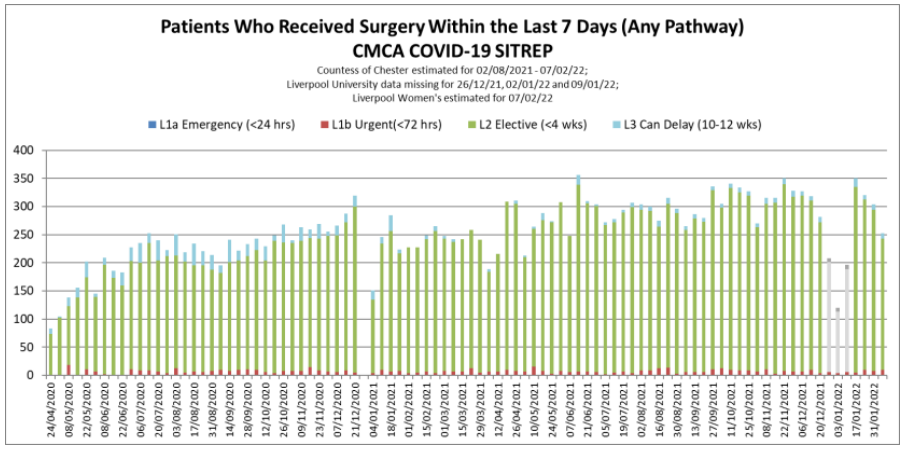
3. Cancer patients awaiting surgery



621 patients with a surgical DTT. 565 at L1&L2 and 56 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. Missing data from LUHFT for 26/12/21, 02/01/22 and 09/01/22. Liverpool Women's estimated for 07/02/22.

4. Cancer surgery performed in last 7 days

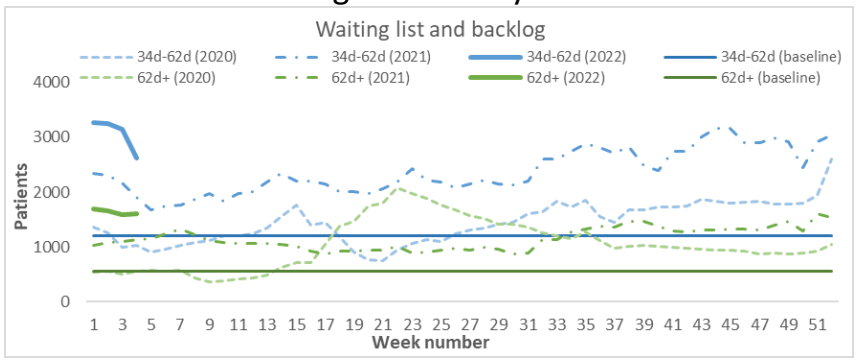


253 cancer operations performed last week.

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 07/02/22 inclusive. LWH estimated for 13/09/21, 20/09/21. Missing data from LUHFT for 26/12/21, 02/01/22 and 09/01/22. Liverpool Women's estimated for 07/02/22.

Restoration of Cancer Services – Core Metrics

5. Patients waiting over 62 days

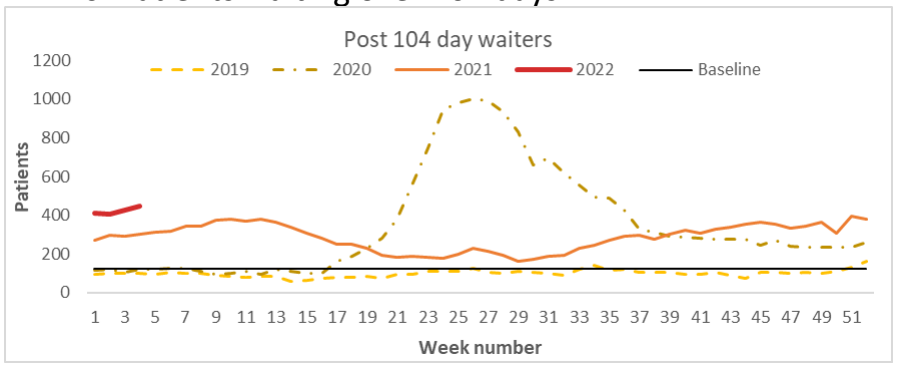


1,609 patients have waited over 62 days

- Higher than 1,588 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. No data for Warrington & Halton and Wirral 19/12/21.

6. Patients waiting over 104 days

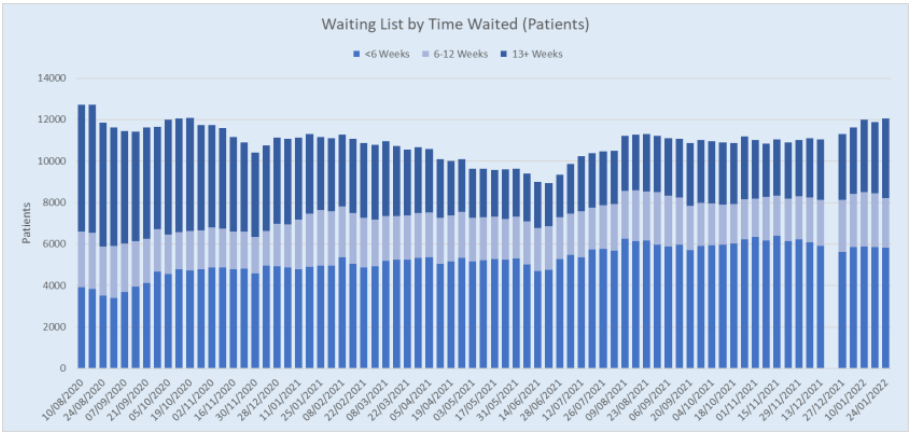


447 patients have waited over 104 days

- Higher than 426 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. No data for Warrington & Halton and Wirral 19/12/21.

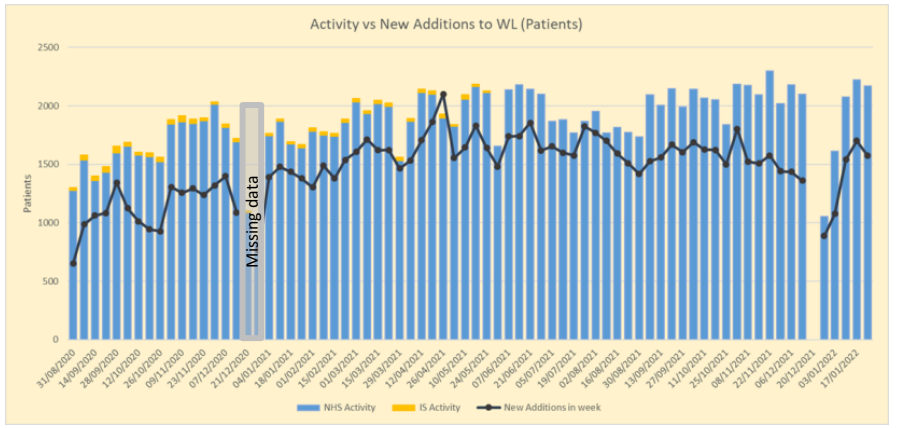
7. Endoscopy waiting list



Endoscopy waiting list increased to 12,068 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 17/01/22 inclusive. Warrington & Halton estimated for 20/12/21. Wirral estimated for 06/01/22.

8. Endoscopy activity



Activity decreased with 2,172 patients seen.

New additions decreased with 1,572 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 16/01/22 inclusive. Warrington & Halton estimated for 20/12/21. Wirral estimated for 06/01/22.

9. Patients waiting between 63 and 103 days by provider

PTL data from W/E 31 January

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total
Bridgewater															
Clatterbridge			5				10					7	7		**42**
Countess Of Chester		9	7		15	121					26	21	15		**217**
East Cheshire		12				45									**64**
Liverpool Foundation Trust		19			45	226					9	80	30		**420**
Liverpool Heart & Chest															
Liverpool Women's			27												**27**
Mid Cheshire						58						8			**79**
Southport & Ormskirk			33			67					7	15	15		**141**
St Helens & Knowsley					13	37					10	6	16		**89**
Walton Centre															
Warrington & Halton													5		**24**
Wirral						20							18		**51**
Grand Total		**48**	**83**	**10**	**83**	**592**	**17**		**5**	**5**	**63**	**143**	**113**		**1162**

Cheshire & Merseyside Cancer Alliance

Tables from national Cancer PTL

10. Patients waiting over 104 days by provider

PTL data from W/E 31 January

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total
Bridgewater															
Clatterbridge															**9**
Countess Of Chester					5	69						6			**93**
East Cheshire															**12**
Liverpool Foundation Trust		7				115						27	8		**170**
Liverpool Heart & Chest															
Liverpool Women's			13												**13**
Mid Cheshire															**18**
Southport & Ormskirk			31			42							6		**86**
St Helens & Knowsley						6							8		**25**
Walton Centre															
Warrington & Halton															
Wirral						11									**19**
Grand Total		**11**	**54**		**15**	**266**	**9**				**11**	**40**	**34**		**448**

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

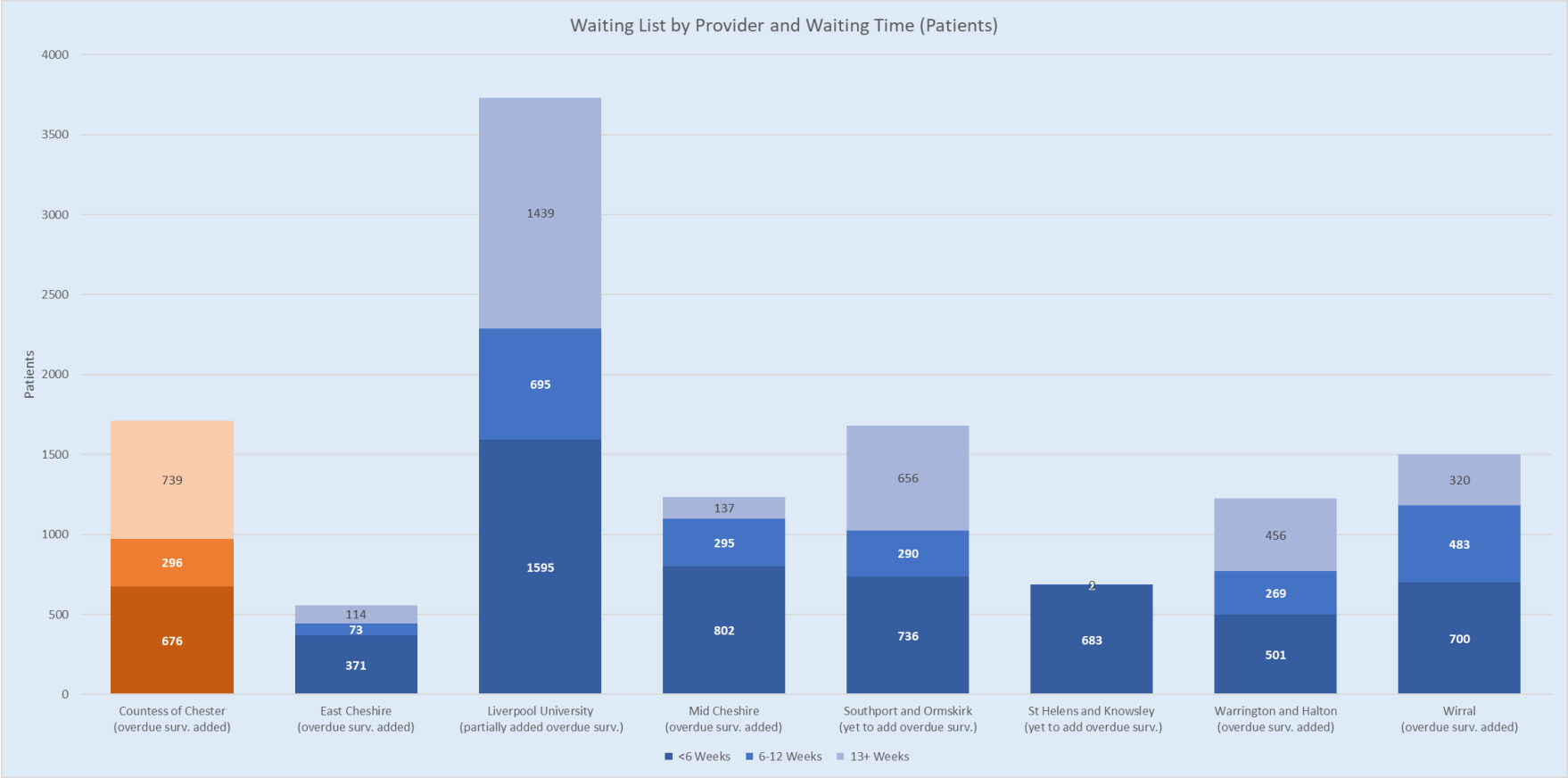
= No PTL submission this week,

Restoration of Cancer Services – Core Metrics

Endoscopy (cancer and non-cancer pathways)

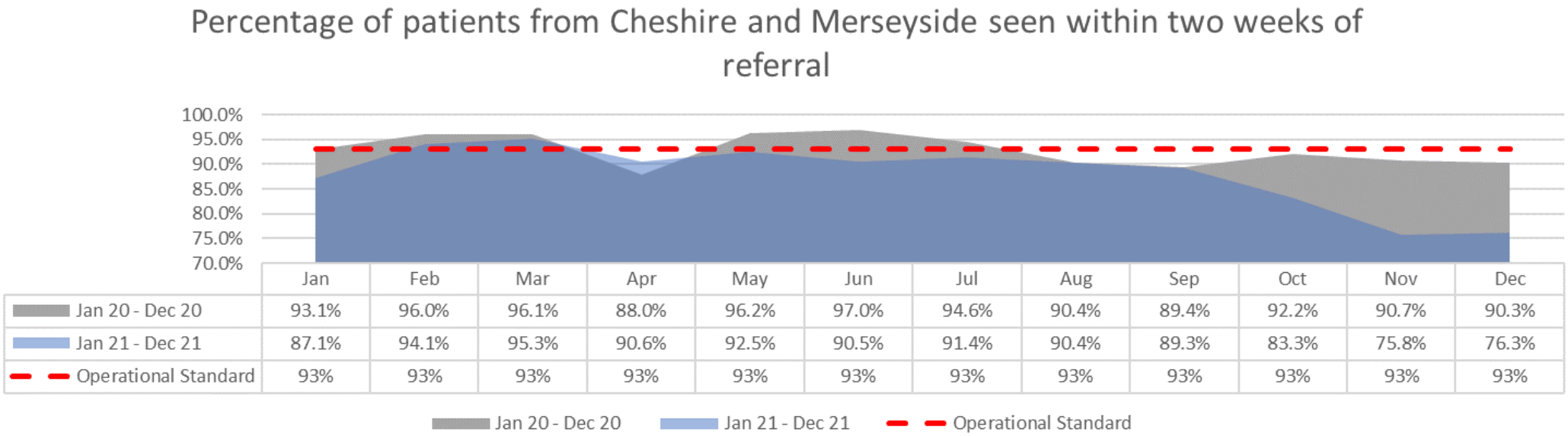
There are currently 12,328 patients waiting for an endoscopy. 6,234 have waited more than six weeks, and of these 3,861 have waited 13 or more weeks (28% of the total).

There is significant variation across units, with CoCH, LUFT & Southport and Ormskirk, having the greatest proportion of their waiting list made up of patients waiting 13 weeks or more (43%, 39%, 39% respectively).



Endoscopy data at 31 January 2022. CoCH data not available so estimate based on previous submission.

Section II: 14 day standard



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Jan 20 - Dec 20	93.1%	96.0%	96.1%	88.0%	96.2%	97.0%	94.6%	90.4%	89.4%	92.2%	90.7%	90.3%
Jan 21 - Dec 21	87.1%	94.1%	95.3%	90.6%	92.5%	90.5%	91.4%	90.4%	89.3%	83.3%	75.8%	76.3%
Operational Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

In December 2021, 76.3% of patients were seen within 2 weeks compared to 75.8% in the previous month. This is below the operational standard.

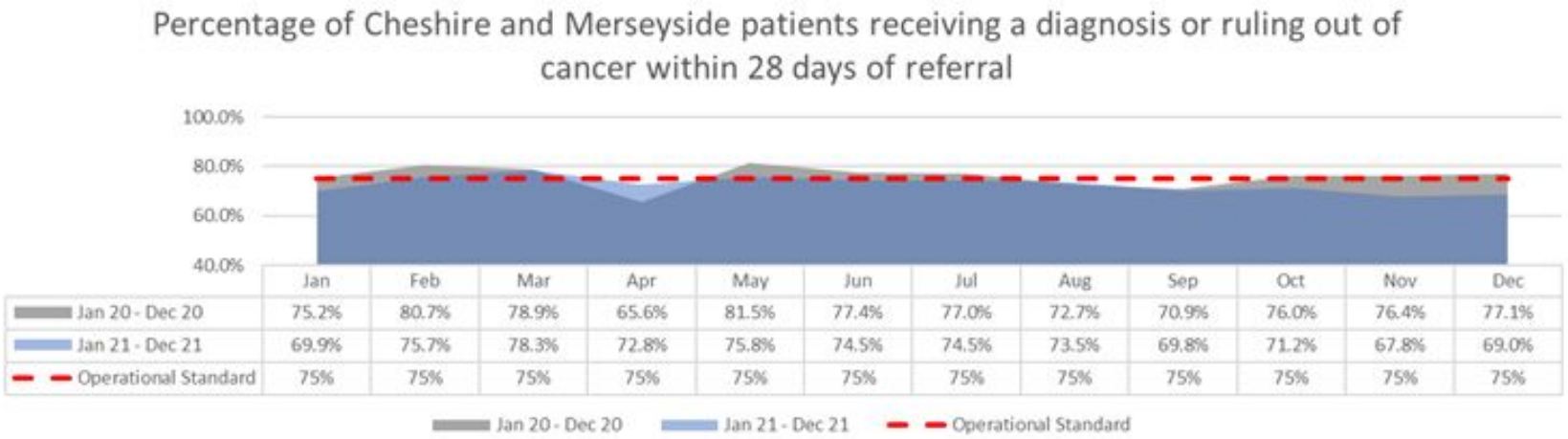
Providers not achieving the national operational standard were:

- Countess Of Chester Hospital 60.4% (441 breaches)
- Liverpool University Hospitals 64.1% (1082 breaches)
- East Cheshire 67.3% (183 breaches)
- Warrington and Halton Teaching Hospitals 67.6% (309 breaches)
- Southport and Ormskirk Hospital 77.2% (215 breaches)
- St Helens and Knowsley Hospitals 78.5% (357 breaches)
- Wirral University Teaching Hospital 91.4% (146 breaches)
- Mid Cheshire Hospitals 92.3% (93 breaches)
- The Clatterbridge Cancer Centre 92.9% (1 breaches)

CCGs not achieving the national operational standard were:

- NHS Southport and Formby 64% (217 breaches)
- NHS Liverpool 67.8% (709 breaches)
- NHS Warrington 73.7% (229 breaches)
- NHS Halton 73.9% (145 breaches)
- NHS South Sefton 74.8% (191 breaches)
- NHS Cheshire 77.4% (718 breaches)
- NHS Knowsley 77.5% (172 breaches)
- NHS St Helens 79% (189 breaches)
- NHS Wirral 91.4% (137 breaches)

Section II: 28 day standard



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Jan 20 - Dec 20	75.2%	80.7%	78.9%	65.6%	81.5%	77.4%	77.0%	72.7%	70.9%	76.0%	76.4%	77.1%
Jan 21 - Dec 21	69.9%	75.7%	78.3%	72.8%	75.8%	74.5%	74.5%	73.5%	69.8%	71.2%	67.8%	69.0%
Operational Standard	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

The 28 day FDS standard is now live at 75%. In December 2021, 69% of patients were diagnosed or ruled out within 28 days compared to 67.8% in the previous month. This is below the operational standard.

Providers not achieving the expected standard were:

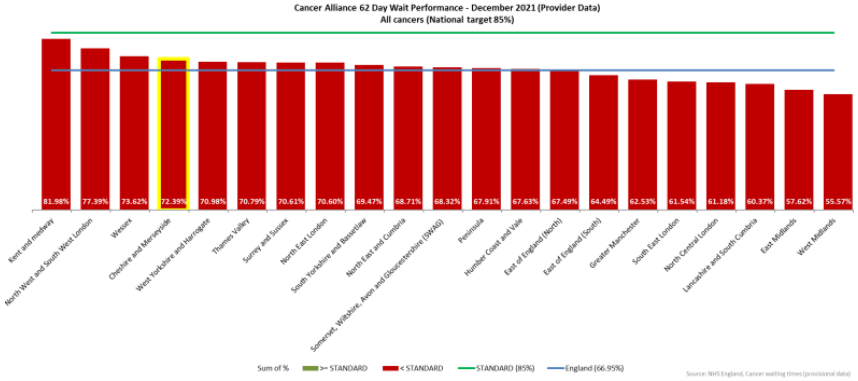
Bridgewater Community Healthcare 52.3% (82 breaches)
Liverpool Women's 59.8% (115 breaches)
Liverpool University Hospitals 64.8% (1188 breaches)
Warrington and Halton Teaching Hospitals 71.4% (266 breaches)
Countess Of Chester Hospital 52.5% (564 breaches)
East Cheshire 63.2% (224 breaches)
Southport and Ormskirk Hospital 66.5% (281 breaches)
Mid Cheshire Hospitals 71.8% (369 breaches)

CCGs not achieving the expected standard were:

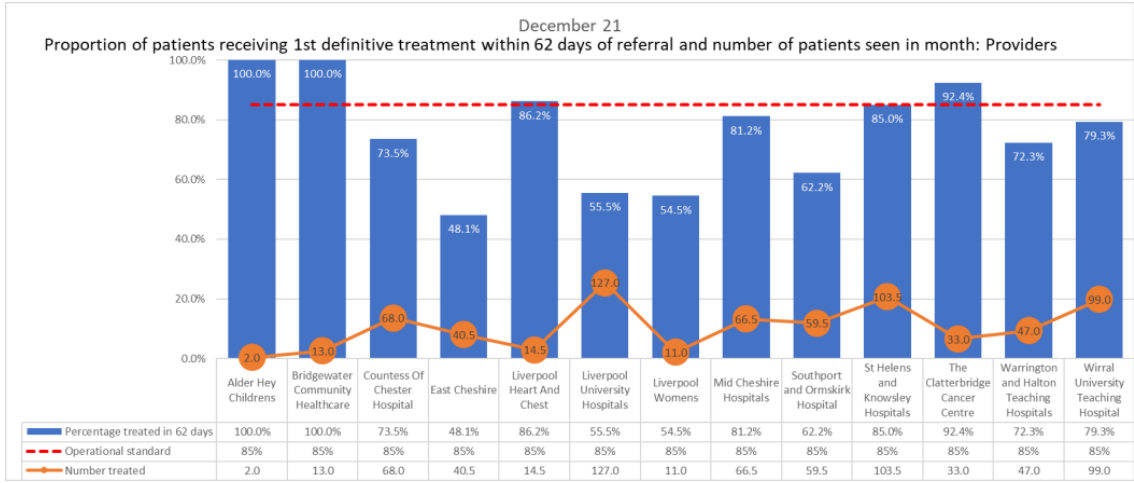
South Sefton 64.2% (302 breaches)
Liverpool 65.4% (808 breaches)
Warrington 66% (291 breaches)
Halton 73% (162 breaches)
Cheshire 64.8% (1159 breaches)
Southport And Formby 65.6% (202 breaches)
Knowsley 72.9% (213 breaches)

Section III: 62 Day Standard

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



CMCA achieved 72.39% against a standard of 85%.
CMCA was the fourth best performer. The England average was 67.5%

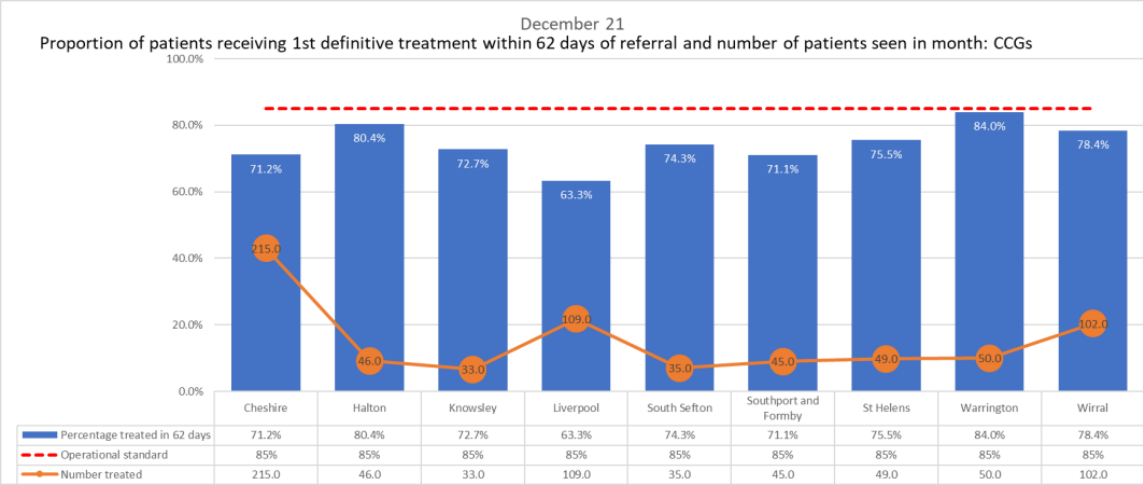


	Alder Hey Childrens	Bridgewater Community Healthcare	Countess Of Chester Hospital	East Cheshire	Liverpool Heart And Chest	Liverpool University Hospitals	Liverpool Womens	Mid Cheshire Hospitals	Southport and Ormskirk Hospital	St Helens and Knowsley Hospitals	The Clatterbridge Cancer Centre	Warrington and Halton Teaching Hospitals	Wirral University Teaching Hospital
Percentage treated in 62 days	100.0%	100.0%	73.5%	48.1%	86.2%	55.5%	54.5%	81.2%	62.2%	85.0%	92.4%	72.3%	79.3%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	2.0	13.0	68.0	40.5	14.5	127.0	11.0	66.5	59.5	103.5	33.0	47.0	99.0

Most Challenged Pathways (December 2021)

Cancer pathways not achieving the national objective were:

Lower Gastrointestinal 40.5% (50 breaches)
Head & Neck 46.7% (16 breaches)
Gynaecological 50% (21 breaches)
Upper Gastrointestinal 56.1% (18 breaches)
Other 60% (2 breaches)
Sarcoma 66.7% (1 breaches)
Urological (Excluding Testicular) 75.2% (29 breaches)
Haematological (Excluding Acute Leukaemia) 76% (6 breaches)
Lung 78.6% (12 breaches)
Breast 84.1% (17 breaches)



	Cheshire	Halton	Knowsley	Liverpool	South Sefton	Southport and Formby	St Helens	Warrington	Wirral
Percentage treated in 62 days	71.2%	80.4%	72.7%	63.3%	74.3%	71.1%	75.5%	84.0%	78.4%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	215.0	46.0	33.0	109.0	35.0	45.0	49.0	50.0	102.0

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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.