AGENDA

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Trust Board of Directors Meeting: held in Public

Date: Wednesday 30 March 2022	Location: via **MS Teams**
Start Time: 10:15	Finish Time: 12:15

Timings	Item No		Lead	Paper/Verbal
Opening Matters				
10:15	P1-50-22	Welcome & Apologies:	KD	Verbal
	P1-51-22	Declarations of Committee Members' and other attendees' interests concerning agenda items:	KD	Verbal
	P1-52-22	Minutes of last meeting: 23 February 2022	KD	Paper
	P1-53-22	Matters Arising/Action Log	KD	Paper
	P1-54-22	Chair's Report to the Board	KD	Verbal
Risk and Assurance				
10.20	**P1-55-22**	Quality Committee Chair's Report	**TJ**	**Paper**
10.25	**P1-56-22**	Performance Committee Chair's Report	**GB**	**Paper**
10.30	**P1-57-22**	Patient Story	**JG**	**Verbal**
10.40	**P1-58-22**	Patient Experience Visits	**JG**	**Paper**
10.45	**P1-59-22**	Integrated Performance Exception Report: Month 11	**JSp/JSh**	**Paper**
10.55	**P1-60-22**	Finance Report: Month 11	**JT**	**Paper**
11.05	**P1-61-22**	Annual Financial/Operating Planning Guidance	**JT**	**Presentation**
11.15	**P1-62-22**	Gender Pay Gap	**JSh**	**Paper**
11.20	**P1-63-22**	5 Year Strategy Implementation Report	**TP**	**Paper**
11.30	**P1-64-22**	New Consultant Appointments	**SK**	**Paper**

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11.35	**P1-65-22**	Guardian of Safe Working Report Q3	**SK**	**Paper**
11.40	**P1-66-22**	4 Year Patient Experience Engagement Inclusion & Involvement (PEEII) Commitment	**JG**	**Paper**
11.45	**P1-67-22**	Staff Survey Results	**JSh**	**Presentation**
System Working				
11.50	**P1-68-22**	Cheshire & Merseyside Cancer Alliance Performance Report	**LB**	**Paper**
Governance				
12.00	**P1-69-22**	Board Committee Governance Structure 2022-2023	**JG**	**Paper**
12.10	**P1-70-22**	Annual Review of Board Effectiveness 2021-2022	**MS**	**Paper**
Closing Matters				
	P1-71-22	Any Other Business	**ALL**	**Verbal**

Next Meeting:

Date: Wednesday 27 April 2022	Location: MS Teams
Start Time 09.00	Finish Time: 12.00

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Minutes of the Trust Board of Directors held in Public

Held on: Wednesday 23 February 2022	Location: **MS Teams**
Start time: 9:00am	Finish time: 12.30

Present

Kathy Doran (KD)	Chair
Mark Tattersall (MT)	Non-Executive Director
Terry Jones (TJ)	Non-Executive Director
Elkan Abrahamson (EA)	Non-Executive Director
Asutosh Yagnik (AY)	Non-Executive Director
Geoff Broadhead (GB)	Non-Executive Director
Anna Rothery (AR)	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
Lesley Campbell (LC)	Interim Governance Manager
Alun Evans (AE)	Staff Side Representative
Zoe Hatch (ZH)	Deputy Director of Workforce & OD
Emer Scott(ES)	Associate Director of Communications
Jane Wilkinson (JW)	Lead Governor

Item no.	Agenda item	Action
P1-028-22	**Chair Welcome and Note of Apologies** The Chair welcomed all to the meeting, no apologies were noted.	
P1-029-22	**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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P1-030-22	**Minutes of Previous Board Meeting: 26 January 2022** • The minutes of the Board meeting held on 26th January 2022 were approved subject to the following amendments • MT requested QC-13-22, paragraph 3 be amended to read, SK introduced the Research section of the report, highlighting the following key points: • Geoff Broadhead attended Part 1 & 2 of the Trust Board meeting on the 26th January 2022 and to be reinstated on all previous minutes. • AY requested the Board add a reference in **P1-24-22 that the** constitutional amendments also concerned the Senior Independent Director and the use of the term Deputy Executive. **The Trust Board:** **Approved** Minutes of meeting on 26th January 2022 were approved subject to corrected amendments.	
P1-031-22	**Matters Arising/Action Log** • The Board noted that actions were either complete, on the Agenda or not yet due. In addition the following amendments were requested: • MT informed the Board P1-103-21, the 5 Year Strategy: Implementation Plan will be presented to the Board in March 2022. • JSh informed the Board ISS were not included in the gender pay gap reports. The Trust does not have access to information regarding pay and conditions for subsidiaries. • JSh confirmed there had been an historic intention to undertake a review of subsidiaries in relation to pay and conditions which perhaps was no longer required and would be discussed off-line. • Extension of staff surveys to contracted ISS staff to be closed as an action. **Action:** The Board agreed that action **P1-148-21** be closed and presented at a later date as a new item. **The Trust Board:** **Noted** the position in relation to the action log.	
P1-032-22	**Chair's Report to the Board** • KD informed the Board that the main focus in recent Chairs' meetings was regarding the future ICS arrangements for collaboration. Discussions are ongoing and will be reported back to the Trust Board in due course. • Business as usual discussions focused on vaccinations and related Covid issues.	

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	• Formal implementation of the ICS will take place on 1st of July 2022, Arrangements were in place for CCGs to continue for the first 3 months of the financial year. **The Trust Board:** **Noted** the Report	
	Risk and Assurance	
P1-033-22	**Quality Committee Chair Report** TJ introduced the report, explaining the one amber rating was regarding the JACIE Accreditation preparedness. An Inspection is likely to take place in April 2022. LB explained that the Department would have a mock inspection in readiness for the Trust regulatory inspection. **The Trust Board:** **Discussed and noted** the content of the report.	
P1-034-22	**Charitable Funds Committee Chair's Report** The Board noted the report as the main report will be presented at agenda **P1-43-22**. **The Trust Board:** **Noted** the content of the report	
P1-035-22	**Staff Story – Shadow Board** ZH introduced the report updated the Board on reflections from the Shadow Board and highlighted the following points: This was a three month programme that commenced in September 2021 as part of the national leadership development programme, and focused on developing colleagues' understanding of being a member of a Board and how Boards operate. The topics focused on Corporate Governance, Finance and Culture and Engagement, along with practical experiences of presenting papers and mock board scenarios. 1. 10 people participated in the programme and took away key pieces of learning, demystifying what it means to be part of a Board. People stated their confidence in presenting and their understanding of producing Board papers for the Board had improved. 2. A significant learning point was understanding that Executives' and Board Members' responsibility was across all areas and not just their own specialist areas. 3. Personal stories of executive team members were shared. These provided an understanding of individuals' professional journeys. 4. Programme members were challenged by presenting papers with subject matters from an area outwith their area of expertise. 5. There was appreciation of the value of constructive challenge and deeper questioning by the Board leading to better outcomes for the organization.	

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6. Participation had informed understanding regarding the production of papers for the Board, and how they were presented with a greater appreciation of the volume of papers the Board members read.

ES explained people's perceptions about of Board had changed. Individuals also learnt valuable personal experiences during the Programme, which gave people the opportunity to look at their current roles and future while working with the Trust.

ZH informed the Board that the Shadow Board had been a welcome opportunity which benefited people personally and professionally. The Trust would also benefit from staff working at sub level gaining an enhanced understanding of issues the Trust Board were experiencing in Finance, CIP's and how services can be delivered in the future.

ZH thanked the Board for participating in the Shadow Board Programme.

EA welcomed the introduction of the Programme at the Trust and the benefits it provided which was demonstrated by the quality of the presentation.

JSh thought the timing for Staff Story was ideal with the opportunity to hear directly from individuals who were part of program. It was good to see a group of keen and committed individuals working well together. Phase 2 of the Programme was continuing and updates would be provided to Board.

JT raised the issue of collaborative and system working and how the inclusion of these elements into the Programme would be beneficial.

MT confirmed the issues of collaboration and system working were raised by the Shadow Board. Participants had views on enhancing collaboration with other organizations and it would be valuable to the Trust and individuals to become involved in some of these projects.

TJ enquired how participants were selected for scheme to ensure diversity. JSh explained this was a nationally formulated program, designed for second in line officers. However, a couple of individuals who could have been part of the program, were unable to commit to the dates of Shadow boards. They will be included in phase 2. In addition, another individual had completed Phase 1 of the program in another organization, and will be going through to Phase 2 of the Shadow Board Programme at the Trust.

JSh explained that in addition to this Programme there are associated Leadership Academy Programmes which staff can access. Plus there is wrap around support for staff including coaching and shadowing opportunities.

AR enquired regarding the feedback mechanisms to the Trust Board from the Shadow Board. KD explained a Non- Executive Director (NED) would Chair the Shadow Board. The forthcoming review of NED roles would consider how best this could be managed. It might be helpful to have one NED Chair the Shadow Board for a consistent period of time rather than on a rotating basis as had been previously discussed to ensure consistent feedback.

AR suggested that in terms of diversity the Trust should ensure the organization reflects the community and society at large and the organization might consider conversations around this area.

The Trust Board:
Discussed and noted the content of the report.

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P1-036-22	**Patient Experience Visits** JG provided an overview of the report informing the Board that the Patient Experience 'rounds' were conducted in early January 2022 on Ward 2. JG highlighted the following key points taken from the visit: • Patient feedback was positive although there were issues regarding car parking which hopefully will be resolved shortly • The issue on food related to one patient. The Trust was looking at the quality of food and different sources of food for patients. The PLACE Assessment covers these issues. • The Staff Experience and Comments section reported the impact of staff fatigue and morale which the Trust is aware of. JG suggested a number of reasons for staff fatigue including the move from the Wirral site into a completely different working environment within the new hospital, e.g. providing nursing in single side rooms and staff who initially transferred now seeking alternative opportunities due to additional journey time to work. Work is taking place with Workforce & OD colleagues to accelerate recruitment. During this period senior ward staff, Bands 7 & 8 are being supported. A positive from the visit was as a small Trust the Board is aware of these issues and practical actions can be implemented to support staff. GB commented it would be helpful to have a better understanding of the underlying causes for staff fatigue. JG suggested it was a combination of issues, more acutely unwell patients, the changed working environment, a different way of working with colleagues, no visitors and providing services during a pandemic. Work is taking place regarding a flexible staffing model, patient to staff ratio and working practices, e.g. ensuring shift patterns are the best fit and maintain safety and quality care. EA re-iterated the points regarding the extended working day for staff due to travelling from the Wirral and the issues with the current car park in terms of perceptions of staff safety. Staff had also expressed the importance of patients maintaining contact with families through phone and tablets and the queried the potential for volunteers to support patients. SB confirmed devices were made available at the start of the pandemic with support from volunteers JG concluded by confirming, as the Executive Lead for Schwartz rounds, that she had recently met with the Schwartz Round Team. A Schwartz round would be arranged shortly for the Matrons. AE provided an update regarding car parking arrangements for staff with the opening of the Paddington Village car park. **The Trust Board:** **Discussed and noted** the content of the report	
P1-037-22	**Integrated Performance Exception Report: Month 10** JSp introduced the report which provided an update on performance for month 10 2021/22 (January 2022). The following points were highlighted from the exception section of the report:	

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Patients often defer treatment from December into January.

As evidenced from the scorecard the nine day and 24 day internal targets are designed to ensure the 62 day standard is achieved. The nine day target was not met however only one patient breached the 24 day target. In relation to the 24 day target there were 22 breaches with four of those avoidable.

JSp continued citing contributory factors to breaches being staff sickness with admin staff deployed to different roles not always being familiar with systems and processes. There was also delays with the genetic and molecular testing with the laboratories and work is being undertaken to better understand the issues. Plus high rates of sickness of clinical staff there reduced capacity.

There had been a difficult start to February 2022 however additional clinics were operating to ensure targets would be met.

MT queried the 28 day diagnosis target and sought assurance that the Trust could manage demand.

JSp re-iterated the challenges posed by sickness absence, delays with testing and overall capacity issues. A paper will be presented to Performance Committee in March 2022 to provide an update.

EA suggested the key elements for strategic development were morale, capacity and recruitment. JSp confirmed the business planning process was addressing these issues.

JSp presented the Efficiency Score Card section of the report and stated the Performance Committee would receive a Bed Utilization report in March 2022.

JSp confirmed there had been improvements in out-patient reporting times. MT congratulated JSp and the Teams for achieving out- patient targets.

JT commented that although the delayed transfers of care as a percentage of bed days was red it was understood this was higher in other organizations. JT suggested the Trust planning and efficiency processes do enable patients to progress through the system safely and appropriately which is welcomed. JSp concurred and commended the work of the Patient Flow Team.

JG presented the **Quality** section of the report, and highlighted the following exceptions:

1. There were no complaints received in January 2022.

2. There were two infection exception reports. The Post Infection Reviews were complete and confirmed the infections occurred during a period of increased C-difficile infection. In response to the reports additional equipment has been ordered to reduce sharing. The ICP Team will undertake additional surveillance and audits at ward level to support staff.

3. One patient was diagnosed with a Pseudomonas infection on admission. As this was unavoidable there was no learning for the Trust on this occasion.

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SK presented the **Research & Innovation** section of the report.

It was noted there was improved recruitment to studies over the last two months reported. However given the pressures on trial recruitment the annual target has been revised for Q4 with the intention to continue to make progress.

SK continuing citing the pandemic and aseptic pharmacy issues as underlying reasons impacting on trial recruitment. There were an additional 6 studies which were awaiting sponsorship which was outwith the control of the Trust which would have increased the success rate to 93%.

A new Director of Research commenced in post in January 2022 and a new Chief Pharmacist in February 2022. Overall it was considered good progress was being made against the strategic objectives.

KD suggested input from the new Director of Research to Board would be valuable at some point in the future.

JSh presented the **Workforce Scorecard.**

There were three main exception reports with individual exception reports for those non-compliant mandatory training competencies as requested by Performance Committee.

Sickness absence is reducing albeit slowly. The figure in January 2022 was 7% it is now 6.5%. However if Covid related absences were disaggregated it is approximately 4%, almost in line with target. Stress related absence has seen a significant reduction in month. The Trust is aware of the details associated with seven work related absences for anxiety, stress & depression. The individuals concerned are receiving appropriate assessments and support.

Staff turnover is above target with the two main reasons being promotion and work-life balance which includes shift patterns, travel time and car parking. It is predominately non-clinical staff moving for promotion however there are increased resignations of clinical staff. In response to this, face to face exit interviews will be conducted with clinical staff to understand the issues and if there are opportunities to retain individuals. A Recruitment Programme has been developed and is proving successful with good response rates.

PADRs are below target which is being addressed with monthly reports provided to all divisions and departments detailing which individuals are non-compliant and those approaching non-compliance. Divisions and Departments are encouraged to prioritize on the basis on having breached or on the point of breach. The Learning & OD Team is working with Teams to enable correct use of the reports to support achieving an improved position.

Covid and flu figures are not included in this report however the flu vaccination programme has re-commenced and will be reported next month.

TJ queried the impact the imminent changes to Covid reporting would have. JSh confirmed guidance currently remains unchanged for health service staff with further guidance awaited.

JW sought further information regarding the promotion opportunities in Network Services as the most common reason for leaving was promotion. JSh confirmed there was a piece of work being undertaken regarding career structures for nursing across the Trust to introduce development pathways or competency frameworks for Bands 5 and 6.

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	EA queried the potential to offer rotational opportunities to staff via the ICS. JSh confirmed this was discussed with ICS colleagues at a recent Retention Workshop. EA would also welcome receiving a monthly representation of unfilled vacancies and the length of time taken to fill these vacancies. JSh responded it would be possible to provide information regarding vacancies albeit it would be slightly more problematic regarding duration but this would be explored. There was an extensive discussion regarding recruitment and retention including the impact of the hospital moving into a city environment with the local alternative opportunities that presents and the recruitment of staff by LUHFT for its new hospital. As the universities encouraged movement across organizations to enhance skill sets and experiences it would be beneficial for the Trust to become a 'training site' to grow staff and partake in a rotational scheme within Cheshire and Merseyside across a range of specialties. TJ raised the potential of working with local schools of nursing to attract candidates at an early stage. JG confirmed this was taking place with Higher Educations Institutions (HEI) and as restrictions ease the Trust could hold an open day to encourage working on the bank to enable people to familiarize themselves with the environment. The key factor would be to give learners the best experience. SK said that in relation to the medical workforce the aim was to make the Trust an attractive as option as possible given the national shortage of medics. It was also acknowledged more is being asked of the workforce which impacts on numbers and existing and new models of care, e.g. investment in interventional radiology AE concurred with the comments above explaining AHPs were subject to rotation and provided the example of diagnostic radiographers staying for a period of time and then moving on. The suggestion of an open day was welcomed as an inducement to bring people in and explore opportunities. JG supported the approach along with taking a diverse approach to the language of recruitment and staff roles. LB confirmed the region is pursuing the recruitment of international radiographers which is also a positive step. **The Trust Board:** **Action**: Director of Research to be invited to Board. **Discussed and noted** the content of the Exception report	
P1-038-22	**Finance Report: Month 10** JT introduced the report which provided a summary of the Trust financial performance for January 2022, Month 10 of the 2021/22 financial year. The following key points were highlighted from the report. All the Trust KPI headlines were on plan or slightly above plan due to the change in the Elective Recovery Fund (ERF) variable income position in month 10. Previously the position has been under plan due to a level of unrecoverable income resulting from the system being unable to meet its activity target. Following further analysis and work by partner organizations to improve individual performance the system as a whole benefits, with the Trust now able to recover levels of activity relative to the ERF process. The Trust will receive £6.4 million for Q3 which was approximately the amount originally planned and consequently can report a break even position.	

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	Going forward and in order to avoid a repeat, Cheshire and Merseyside has agreed the system as a whole will break even and individual organizations may be supported to achieve this. This is a unique ICS approach and is supported by Chief Executives, Chairs and Directors of Finance. There is a level of risk in Q4. However due to this change of approach it is anticipated the Trust will achieve more EFR and meet the breakeven duty. The key task of the system will be to ensure all organizations individually reach this position. CIP recovery continues and the extra additional income allows the Trust to offset the NECIP differential. The salient point in this regard is the importance of aligning capacity and income in order to reflect the efficient use of capacity with receipt of income for additional work. The pay bill has increased slightly with use of Bank Staff due to Covid pressures. Agency costs remain low and usually relate to medical staffing. It is currently forecast that the capital budget will meet the planned spend by year end. Close monitoring is taking place to ensure purchases are made (i.e. linear accelerators, digital equipment, diagnostic kits and software) and are delivered and receipted within Q4. Following a query from MT regarding receipt of ERF cash JT confirmed those figures were not included in the Report and would be reported for February in March 2022. MT confirmed Capital Spend would be a Performance Committee agenda item to ensure the planned amount is spent. JW queried the amounts in the capital program for repairs or replacement at CCC-L given it is a new build. JT explained that following staff feedback a number of changes were made to facilities which were not being used as originally intended, e.g. bathrooms due to patient rooms being en-suite which were converted into staff facilities to enable staff to stay on the wards during breaks. AY commended the Trust on reclaiming £5.9 which would be received in February 2022. JT explained the principle of ERF in H2 rewards 'clock stops' and meeting RTT requirements; if a Trust removes patients from the waiting lists and reaches 95% or above pre-Covid activity level an extra payment can be received. In essence it is a mechanism to incentivize behavior to reduce waiting lists with payment attached. **The Trust Board:** **Discussed and noted** the content of the Finance report.	
P1-39-22	**Annual Financial / Operational Planning Submission** JT introduced the presentation. The first high level draft of the Plan had been submitted acknowledging there is a high level of variability as not all guidance is available and financial flows are not fully understood. At this stage there is an established approach to planning and risk management with a unified timetable. Risks are being assessed with an appetite to ensure consistency and appropriate management throughout the system. Trust Plans are based on current expected volumes of patient demand for 2022/2023. This is currently being discussed with Commissioners and will contributes to the overall system performance. JT emphasized this was an iterative process with a second submission regarding activity submitted on 22 February 2022 with a second Finance submission due today. This information will be assimilated and aggregated following which the Trust will receive feedback prior to the conclusion of the process in April.	

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	In relation to Operational Planning the performance objective is to eliminate 104 or 52 week waits, deliver cancer performance and rationalize outpatient follow up activity contributing towards productivity requirements and increased Patient Initiated Follow Ups (PIFU) to meet the target. There are a range of performance targets and it is intended to achieve a baseline of 104% of 2019/2020 costed activity multiplied by price. The target for RTT is 110% and diagnostic activity 120%. This Trust has been consistently achieving these levels of performance and the plans support this level of over performance. The activity profile from September to December 2021 is being used to inform the Plan as it is the best historic data for planning purposes. An 11% activity increase has been assumed and the Cheshire & Merseyside ICS is currently planning for 11% increase in cancer referrals from primary care which would filter through to secondary/tertiary care, the detail of which is being discussed with the Cancer Alliance. JT added the Trust was producing a high level growth assumption which would be refined over the next couple of submission. Following the transfer of the Haemo-Oncology Service from Aintree, estimates have been revised for bone marrow transplants by the clinical team as this is a high value activity which was significantly impacted by Covid with planning taking place to return to pre-Covid levels. Planning continues to retain a bed occupancy rate of 85%. Feedback from the system focuses on challenging planning with regard to reductions in follow-ups, plans for 11% growth and service developments. **Finances** JT explained Finance Guidance was still be produced with Elective Recovery Planning Guidance only received the previous day. The Directors of Finance across the system meet weekly and have agreed 13 System Financial Principles for 2022/2023. The key elements are; Trusts are in agreement to commit to financial balance across the system, each organization would remain accountable for its own performance and work with partners to develop their risk and reward sharing arrangements. JT confirmed all Trusts are now using the same System Financial Planning Assumptions. The starting point for contract values for income for each organization will be matched by Commissioners and the assumption of the level of growth and how that will be applied. The red line on income system fund allocation processes and values is still subject to confirmation. There are certain monies which have been received into the Cheshire and Merseyside system which were not included in the H2 x 2 number which are awaiting agreement and is a significant sum. The Trust is therefore unable reach a definitive position until the process was completed. JT explained the efficiency target was 2% which was a 1.1% national target and was embedded into the growth number and convergence target as Cheshire & Merseyside currently had a larger budget than considered necessary and applying this target would reduce costs in the system from a central stance. A 3% pay award and National Insurance contribution would be funded centrally. There will be a non-pay inflation 2.7%. It is anticipated Covid costs are reducing in line with guidance which is a limited risk for the Trust as there were minimal costs when compared to other organizations.	

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	Local pressures should be funded internally. The principle being if a decision is made locally the responsibility is at local level and should be funded either through CIP, via transformation projects or via income gained by the organization. This is to maintain the accountability principle and ensure organizations are not cross subsidizing each other as part of the system risk share. JT continued the Trust should be aware costs must triangulate with activity plans so if an organization has planned high local pressures or business case investments then that should be backed up through its activity portfolio and its activity plan. The Trust is currently going through that process. It includes workforce which submitted its first plan this week. The key element being triangulation of resource to activity to finance. The Trust is aware drugs costs have increased by 5.5 million based on current activity however that is net neutral. This income matches costs for the high cost drug element and the block element which is consistent with the Trust cost base. JT further advised the Board utility prices have increased. The Trust energy and gas deal was due to end in March 2022. The Trust were receiving weekly market quotes to monitor the markets. The Trust received a recent quoted of £2.5m increased cost pressure. LUHFT is in a similar position as its contract expired and has a bigger value than the Trust £2.5m proportionately. This is causing a cost pressure across the system which has been highlighted to the ICS. Depreciation has increased as the Trust has significant assets including digital assets which depreciate rapidly which has impacted the deprecations forecast. Finance charges have also increased due to the mechanism of repaying loans. The Board was informed the Trust had a full year business case. It was anticipated the decisions made in 2021/2022 would cover costs for the full year 2022/2023. The Trust is currently planning a 2% CIP which equates to £4.5 million. Internally financial planning rounds are currently taking place with the Divisions to consider cost pressures in conjunction with resource capacity planning and activity. JT confirmed the timeline with submissions having already been made followed by feedback and further iterations, with key dates of 11 March for the Trust and 4 April for final plans submission including balance sheet, cash flow and income and expenditure The final position will be shared with the Finance Committee on the 11th of March for approval. This will be followed by presentation to Performance Committee on 23 March and for approval to Trust Board on the 30th of March 2022. There is also the contact sign off on 31 March 2022 with Commissioners which will be the CCGs and NHSE pending the commencement of the ICB from 1 July 2022. EA sought clarification regarding the view that Cheshire and Merseyside had larger budgets than considered necessary. JT explained historically allocations for Commissioners were set on a formula based on population etc. which provided a target for CCGs which was the theoretical spend values that Cheshire & Merseyside should spend according to the Department of Health. Cheshire and Merseyside has historically spent more than the theoretical amount. The purpose of the convergence target is to reduce spend over a three year transition period to target spend.	

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	There is a debate questioning if the formula itself is correct given the Cheshire & Merseyside level of Covid recovery, deprivation and inequality. This is a historic position for the whole of the North West. **The Trust Board:** **Noted** the content of the report.	
P1-40-22	**Learning from Deaths – Mortality Report – Quarter 2** SK introduced the Report presented in a standard format with Section 5 providing additional information regarding the processes used to provide additional assurance as noted in the Action Log. There is a comprehensive system which collates SPC charts by consultant, by regime by modality and by intent, which is an extensive Report. This is reviewed in depth by SK, Trust Mortality Lead, Patient Safety Lead, Palliative Care Consultant and Quality Manager. Any exceptions or points of interest are noted prior to submission to the Mortality Surveillance Group chaired by SK and attended by EA. The Report provides details of matters which are considered and the process utilized for that purpose. The Statistical Process Control (SPC) charts have a running rate across the bottom. In terms of the control limits these are not automatically adjusted in response to peaks or troughs rather a three month rolling review is undertaken which would prompt a further review to ascertain a changed position if necessary. The Learning from Deaths dashboards with the lessons learnt and completed were reported in Q2. Processes in care for potentially vulnerable patients who live alone or who have been difficult to make contact with have been strengthened. Work has also been undertaken regarding carboplatin dosage JW sought further information regarding the means of contacting elderly vulnerable patients citing the example within the Report of the patient who lived alone and having failed to attend the hospital appointment was contacted by Treating nurses, the Care Navigation Team and finally the Police. SK confirmed the process with patients contacted by the telephone number landline/mobile logged on the system. A letter would be sent confirming an appointment however many appointments have a quick turnaround plus an identified next-of-kin would be contacted if possible which in the case quoted was not an option. GB queried whether the Trust shared lessons learnt with other organizations and do other organizations share with the Trust. SK explained currently there is no systematic consistent process other than all organizations are required to present to Trust Boards. If there was a significant issue across pathways that would be brought to the attention of the Cancer Alliance or the respective Trust involved. EA confirmed that following an Inquest the Coroner can issue a Prevent Future Deaths Reports which are shared nationally through the NHS system. **The Trust Board:** **Noted** the content of the report.	
P1-41-22	**Guardian of Safe Working Report – Quarter 2**	

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	SK introduced the report and informed the Board there were no Exception Reports during Q2. There was continued reliance on agency staff to fill shifts however work was underway regarding the recruitment of middle grade doctors in order to gain a greater understanding of staffing requirements. No fines were incurred during this period. **The Trust Board:** **Noted** the content of the report	
P1-42-22	**Bright Ideas Scheme – Progress and Outputs** SK introduced the Report. The initiative was developed as a collaboration between the Trust and the Cancer Charity. The infrastructure includes a dedicated panel which review any submissions, based on ways to improve or grow and transform services and helps the patients and staff experience that is out with NHS funding. It is also open to subsidiary staff. Four initiatives have been funded to date with a key highlight being the awarding of £1,000 for Children's Memory Boxes which subsequently led to £10,000 being raised by the charity. There are risks in terms of future funding and reputational organizational risks which are noted. In relation to the next steps a Clinical Lead for Innovation and Innovation Manager have been appointed who will review the scheme going forward and already have suggestions regarding future developments. KD noted the Report was self-explanatory and very welcome from a staff perspective to have an avenue to follow because in an era of CIPs and ward and department constraints it can be difficult to achieve funding for initiatives. AE was a member of the panel and commented on the excellent ideas which were presented including a submission from the Palliative Team which was successful. AE considered every Trust should have a Scheme as it enables different people from all areas of the hospital to join the Panel and agree on how the monies should be spent to benefit patients. KD thanked AE for his role in the Scheme. EA commented that as the Scheme is so successful and given that it requires that idea submitted for consideration provide a direct clear patient benefit can the Scheme be extended to include ideas that provide an indirect patient benefit by benefiting staff. TP confirmed the initial starting point for the Scheme was innovation funding from the charity which is specifically in relation to benefit for patients. The Scheme is designed to enable the submission of as broad a range of ideas as possible with those appropriate for alternative funding transferred for consideration elsewhere in the Trust, e.g. sustainability suggestions moved to the Sustainability Group. TP confirmed a rolling log of suggestions was maintained to update the Panel on progress at every meeting and was confident further information could be shared in future reports AY commended the Trust on the Scheme. It was also suggested to consider the importance of acknowledging the interdependencies of culture and innovation in ensuring a safe environment to maximize the number of ideas coming from the grassroots level. **Action**: Future Reports to include updates of all ideas submitted for consideration.	

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	The Trust Board: **Noted** the content of the report	
P1-43-22	**Conversion of the Clatterbridge Cancer Charity to Independent Status** KB introduced the report and requested the Board acting as the corporate trustee of the Charity to approve in principle the conversion of the existing charity to a new charity with independent status which is a multiple staged process which takes between 12 to 18 months. Currently the Charity is a NHS charity regulated by the DHSC and the Charity Commission. Independent charities are only regulated by the Charity Commission KB highlighted the following key points: 1. The Charity is in the top 30% of NHS Charities 2. The Proposal was presented to the Council of Governors on the 12th of January 2022 with no objections 3. The new Charity would have a dedicated board of trustees which are voluntary positions 4. The new Charity would be in a position to make decisions independently of the Trust 5. The Trust would no longer be responsible for the Charity however would maintain a close relationship generally between the CEOs of both organisations 6. The Charity Commission recommends there are two NEDs from the Trust on the Charity Board 7. Initially there would be no changes in the Charity's objects although this position could change at a later date with Trust NEDs on the Board party to that decision making process. 8. The Charity's funds would be accounted for separately from the Trust accounts 9. The Charity would be independent from NHS regulation which would enable an agile flexible innovative approach 10. Future Recruitment would not be subject to Agenda for Change requirements. The main driver for the conversion is to ensure the long term growth of the charitable income and the safeguarding of funds. Income growth would not be overnight at it would take time to build relationships in the community utilizing the Trustee Board to open networks, improve reach and influence the corporate sector and make introductions to major donors. The largest impact on the Charity's income would be from major donors and corporate income both of which are underdeveloped at the moment due to the structural constraints of the Charity operating without a dedicated Trustee Board. From the Charity's perspective independence status would be more advantageous. 1. A Five Year income plan was presented using historical data and market research. Past forecasting accuracy has been approximately 4% in the short term with longer term 3 – 5 year more problematic to predict. KB stressed a cautious approach was taken. 2. The top line assumes the Charity becomes independent from April 2023. 3. There had been fluctuations in income due to the pandemic with a fall in income in 2021. The 2021/2022 figures had increased leading to a recovery phase which it is anticipated will take two years.	

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4. It is envisaged the momentum of recovery would continue into 2023/2024 at the time of independence however there may be a slight divergence due to a backlog of legacies which amounts to approximately 20% growth per year and would be unsustainable without a different approach.

5. It is assumed the Board of Trustees would be appointed well in advance of April 2023 to support the Charity with the potential for an uplift in Charitable income of £320,000 in 2024/2025, £540,000 in 2025/2026, and 2026/2027 £865,000, cumulatively overtime becoming £1.7m difference and by 2026/2027 reach a 70% uplift in income.

6. The impact of the costs for independence are less than a £200,000 year increase and overtime the impact decreases to become closer to the cost to income ratio of 30%.

7. In relation to net income comparison, at the point of independence from April 2023 there will be increased costs. However from 2024/2025 income is predicted to increase to 11% in 2025/2026 and 16% in 2026/2027. A staffing and resource plan is included in the figures.

KB continued the charity is currently recharged for all its salary, pension costs, legal, audit, finance, IT and fund raising costs and therefore independent status would not incur substantial additional costs.

Accommodation for the Charity is not currently funded and therefore not included in the figures. It is anticipated the Charity would negotiate this element with the Trust. Plus there would an estimated one off conversion cost of approximately £100,000 including legal costs.

In summary it is estimated there would be an additional £160,000 per annum for the Charity however this would be outweighed by the growth of the charity as it moves forward and the impact reduce as the Charity's income grows.

The Trust Board was asked to approve in principle to pursuance of the Charity to independent status. This is a lengthy, approximately 12 – 18 month, multi-stage process which does provide opportunities to review. The Charitable Funds Committee approved the submission, and the Trust Board reviewed the advantages and disadvantages in September 21.

KD sought clarity regarding the governance of the proposal and queried at the stage at which there would be a requirement for a final decision by the Trust Board.

KB confirmed a final decision would be required at the point of application by the Charity to the Charity Commission to become independent and form a new charity, in approximately 3 – 4 months. The Trust Board would be required to make decisions regarding the legal structure of the charity and name and objective of the charity which would require a number of submissions to Board. KB also confirmed there was a Working Group established to progress this potential change.

MT queried whether £160,000 included increased staff costs. KB confirmed all pay, non - pay and the fund raising costs and corporate services costs are included in the costs.

TJ queried the risk associated with the Charity remaining with the Trust in relation to the ICS and resources. JT confirmed it is a risk which is problematic to asses within the wider financial context. However by becoming an independent charity with the charity's

MEETING NOTES

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	funds accounted for independently from the Trust accounts this does enable a clear financial demarcation of the two entities. TJ sought information regarding the options available if the forecast did not materialize. KB confirmed the approach would be as currently which reviews market pressures and opportunities and take an innovative approach. AY queried the specific issues in relation the NHS charity status which were limiting. KB confirmed the most important contributors will be the voluntary members of the Trustee Board. Volunteer members are committed to the Charity and their influence in opening doors and improving the reach of the charity to secure major donors and corporate income will be instrumental in generating the funds with the forecast. JT commented this approach was similar to that of the subsidiaries which operate with independent, subject matter leadership which brings a different focus and works well. AY requested further details of the risks associated with not pursuing the proposal. KB concluded the most significant risk would be the lack of opportunity to grow income at a higher rate. KD recommended future reports provided explicit detail of the risks associated with both remaining with the status quo and conversion. EA commented that one of the risks of conversion was the Trust would lose control over the objects of the charity as the new trustees can alter the objects. The Hempsons Report confirms the charity must be independent in order to be allowed to register as a charity. There are also two classes of membership, the trustees would have full voting rights as members, and the trust itself could have a separate class of membership that would not confer voting powers, but would require its approval if the members ever resolved to change the object name, dissolution clause or other specified provision. This would imply the Trust has a veto over changing the objects which mitigates a potential risk. However what was unclear was how this correlates with the requirement that the Trust does not control the charity. KD confirmed this was an important issue to raise and requested the Working Group undertake further work and report back to Board. EA also queried if the increase in the number of excess deaths, approximately 14%, over the last couple of years which may lead to an increase in legacies had been taken into account in determining the projections. KB confirmed this was not something incorporated into the forecast as the legacy situation is difficult to match as it is problematic to trace legacies and determine the number which have been received. However she acknowledged this would be considered for inclusion going forward. AR queried if there would be issues when transferring existing funds from Trust legacy to independent status. KB explained at the period of transition there was an agreement with the Trust to transfer all their assets over to the charity. KB continued by explaining the issue is probably more with regard to future legacies rather than existing legacies. Legacies usually state the name of the Charity and Charity number. However if a charity is superseded by another charity, the legacy would still be automatically be allocated to the Charity. The new charity would also explain any change of name and change of number on the Charity Commission website. JW queried if Charity staff were currently members of a separate pension scheme or the NHS pension scheme and was this transferable to the new Charity. KB explained Trust staff would be moved via TUPE into the new Charity with the same terms and conditions.	

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	New staff would not be eligible for NHS a pension and would be enrolled in a separate scheme. A further query from JW was in relation to the inclusion in the costings of different pension contributions for new staff in the future. KB confirmed the calculations were based on the NHS system pending further guidance regarding structure, salary bands and pension contributions which may result in lower costs for new staff. **Action**: A detailed risk analysis of the Conversion of the Clatterbridge Cancer Charity to Independent Status to be presented to a future Trust Board Meeting. **Action**: AR expressed her interest to become a member of the Working Group. **The Trust Board:** **Approved in principle** the Conversion of the Clatterbridge Cancer Charity to Independent status subject to the proposal being presented to Board prior to the application to the Charity Commission.	
P1-44-22	**Cheshire & Merseyside Cancer Alliance Performance Report** LB introduced the report and highlighted the following summary. Cancer surgery levels are above pre-pandemic levels. In terms of the two week referrals which drive demand and activity the Cheshire & Merseyside Alliance is one of only three in the country to have fully recovered the referral rate and is currently the highest in the country. The lower GI Pathway continues to be a challenge with a significant focus regarding endoscopy recovery. The endoscopy waiting list has increased as every Trust has been requested to add surveillance patients to non-cancer work in order to understand the scale of the activity to be managed. However it would appear activity is increasing which requires managing within the system of recovery in conjunction with cancer patients are being prioritizing. Endoscopy is one of the seven diagnostic areas which is required to reach a 20% target above pre-pandemic levels with increased capacity generated via the Community Diagnostic Centres, five of which come on-stream at the end of March 2022, albeit not all provide a endoscopy service. The Alliance is also considering the productivity of the12 endoscopy providers as there has been a degree of variation in the past. The final two sites are now included in the 'Thrive' productivity tool with further analysis underway in order to achieve an activity rate of 119% of pre pandemic levels; currently it is 112% of due to the increased complexity of procedures which require delivery. LB concluded confirming the Alliance is required to submit plans detailing the timescale for recovering the 62 day and 104 day backlogs. It is anticipated the Trust will return to the pre pandemic baseline by the end of March 2023. MT commented on the analysis which evidenced three trusts which continued to experience challenges regarding meeting the 62 and 104 day target LB, on behalf of the Alliance, confirmed a targeted approach was taken with additional funding and resource to support the different issues in the different trusts. There is a significant focus regarding the endoscopy service at LUHFT. Plus a deep dive exercise has been conducted at the Countess of Chester Hospital to gain a better understanding of the local cancer pathways. This has been shared with the Executives following which	

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	remedial plans will be developed. The approach is to target the allocation of funds rather than take a broad brush approach. MT concurred with the approach taken by the Alliance. JT confirmed Trusts in the system only receive ERF funding if plans are submitted which achieve the 104% target over the course of the year. The data suggest Trusts are not achieving the level and which is being addressed at system level. KD sought clarification the Cancer Alliance was contributing to the operational planning process. LB confirmed a draft plan has been submitted and will be presented to the NHSE regional team shortly. The Alliance is fully engaged in the process and the Elective Recovery Programme and the wider diagnostics workstreams. EA commented that if an organization is being poorly managed it may be of more benefit to provide services rather than funds. LB confirmed the approach of the Alliance was to take a supportive facilitative approach by funding diagnostic initiatives to determine the problems hindering increasing activity with the respective Executive Teams to enable ownership, e.g. hosting rapid recovery workshops. Individual Trusts develop solutions working with the Alliance to create joint actions plans. The Alliance is also proactive, e.g. a gynaecological review is in progress across the region the outcomes of which will be shared in due course. It is also intended to replicate the process for lower GI services. JT commented that the Elective Recovery Program funded by the ICS, which reports into the Chief Executives Group, is seeking an informed understanding of all elective work in order to manage it appropriately. For organizations which may experience challenges support is offered either directly through management capacity or through actual physical infrastructure including the location of clinical hubs. An example of this the project underway on the Broad Green site to add extra capacity to become a high volume low complexity hub which will support LUHFT's position in terms of those cohorts of patients which should allow for the more specialized cancer work to place within current capacity. **The Trust Board:** **Noted** the content of the report and the Chair thanked Cancer Alliance for their work	
P1-46-22	**Board Meeting Review** The Chair confirmed the Board had covered all strategic items on the agenda, received updates on Operational Planning and received good engagement from staff. KD thanked the Board and attendees for their participation.	
P1-47-22	**Any Other Business** KD confirmed from Wednesday 27 April 2022 Trust Board meetings would be held in person with MS Teams facilities available. Board Committee meetings would remain as virtual meetings pending review later in the year. KD confirmed Patient Experience Visits would commence in person when safe to do so. The Governors meeting in March 2022 would be virtual and reviewed for the next meeting to meet in person.	

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Next meeting:

Date: Wednesday 27th April 2022	Location: **MS Teams**
Start time: 09:30	Finish time:
Signature: Chair	Date: (Insert date when minutes are signed)

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board

Last updated: 28 March 2022

Updated by: Margaret Saunders

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	RA GB	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**	Mar-22		Item deferred. Added to the 30 March 22 Trust Board agenda, P1-063-22 following presentation to the Performance Committee 23 Mach 2022
P1-147-21	29-Sep-21	Gender Pay Gap	Consideration of analysis of pay arrangements across the Trust subsidiaries.	**JSh**	April-22		For discussion off-line.
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**	April-22		Closed
P1-150-21	29-Sep-21	Culture and Engagement Update - Staff Survey Results	Results of the Staff Survey to be presented to the Board	**JSh**	Mar-22		Presented to Trust Board in March 2022, Agenda Item P1-067-22.
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 Diagnostic Report 18th November QC-243-

ACTION PLAN

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							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		Received February 2022 Agenda P1-42-22. Future Reports to include updates of all ideas submitted for consideration.
P1-180-21	27-Oct-21	Guardian of Safe Working	Future reports to include content regarding the nature of exceptions and how they were managed	**SK**	Q3 2021/22		March 2022 Agenda Item P1-65-22
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. Draft Report to be presented to Audit Committee 14 April 2022
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		SK to provide an update. Q2 Report summited to Board February 2022, P1-040-22.
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		JG to provide update.
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		JG to provide update
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		Amendments made and revised Constitution published on website March 2022.
P1-43-22	23-Feb-22	Conversion of the CCC to independent status	A detailed risk analysis of the Conversion of the Clatterbridge Cancer Charity to Independent Status to be presented to a	**KB**	Q1-2022/23		

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

			future Trust Board Meeting.				
P1-43-22	23 –Feb-22	Conversion of the CCC to independent status Working Group	AR to become a member of the Working Group	**KB/AR**	Q4-2021/22		

CHAIR'S REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Committee/Group 'Triple A'

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

Name of Committee/Group: Quality Committee	Reporting to: Trust Board
Date of meeting: 24 March 2022	Parent Committee:
Chair: Terry Jones	Quorate: Yes

Agenda item	RAG	Key points	Actions required	Action lead	Expected date of completion
QC-047-22 Quality Committee Minutes 17th February 2022		The Committee received the minutes of the 17th February 2022. Requested minutes to be reviewed and amended	The minutes of the 17th February 2022 to be amended and presented to the next meeting of the Quality Committee.	MS	June 2022
QC-049-22 Risk and Issues Summary Report		The Committee received the report and was provided with an update.	Transition to the production of a single risk register.	JG/CL	June 2022
QC-053- Update Communications Incident Deep Dive		The Committee received the report and noted the issues raised: 1. Importance of correctly classifying communication complaints 2. Enabling and supporting improved communication between wards and imaging services 3. The value of system wide communication as patients receive multi centre care 4. Ability of processes to capture low level concerns	Provide an updated Report on Non-Complaint communication issues.	JG/CL	Oct 2022
QC—060-063-22 Annual Review of Committee Effectiveness Draft QC Annual Report 2021-2022		The Committee received the papers and agreed with the approach to review for adoption for 2022/2023	1. Documents to be circulated to members of the Committee individually. 2. TJ/JG/MS to meet to draft Annual Report, ToRs and Cycle of Business.	TJ/JG/MS	June 2022

CHAIR'S REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Annual Review of Committee ToRs Annual Review of Committee Cycle of Business					

CHAIR'S REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Committee/Group 'Triple A'

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

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

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

Name of Committee/Group: Performance Committee	Reporting to: Trust Board
Date of meeting: 23 March 2022	Parent Committee:
Chair: Mark Tattersall	Quorate: Yes

Agenda item	RAG	Key points	Actions required	Action lead	Expected date of completion
PC-022-22 Performance Committee Minutes 16th February 2022		The Committee received the minutes of the 16th February 2022. Requested minutes to be reviewed and amended	The minutes of the 16th February 2022 to be amended and presented to the next meeting of the Performance Committee.	MS	July 2022
PC-026-22 Integrated Performance Report – Month 11		The Committee received and discussed the report focussing on the non-compliance training rates with specific reference to BLS, ILF and Cyber Security training. Committee noted issues regarding testing detailed below and will continue to monitor closely due to impact on waiting times: 1. Turnaround times for PDL1 and Estimated glomerular filtration rate (EGFR) testing remain challenging. 2. Challenges were being experienced with the PDL1 molecular test within the lung pathway. 3. Lack of availability of PDL1 test results at time of appointment for patients on lung pathway.	Committee will continue to monitor via IPR Report. Operational group established to resolve. Senior leaders are meeting with the Genomics Lab to review the strategic approach to streamline the pathways. Emergency pathway in place and continue to work collaboratively with the Genomics Lab to resolve.	Executives JSp	July 2022 July 2022

CHAIR'S REPORT

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PC-028-22 Bed Utilisation - Future Plans and Potential Opportunities		The Committee received and discussed the report noting: The Trust plan to improve utilisation included a number of service changes that would be implemented over an 18 month period and an anticipated 11% growth in activity as the system recovers from the pandemic. Bed occupancy rates have remained below the national target of 85% with an average occupancy of 76%. In preparation for the predicted increase in referrals, the Trust has developed a recovery plan that commits to a bed occupancy rate of 89%.	Implementation of Plan to continue with quarterly updates to continue to the Committee.	JSp	July 2022
PC-029-22 5 Year Strategy Implementation - Progress Report		The Committee welcomed the Report and focussed on the issues below: Continued impact of Covid-19 and elective recovery on management capacity to support delivery Requirement of clinical and operational teams to focus on high priority projects – aseptic pharmacy and Aintree H-O integration Impact of programme management office (PMO) transition on central capacity to support projects	Agree divisional business plans and setting priorities for divisional and PMO support through the new Transformation and Improvement sub-Committee. Establish a programme to prepare the Trust for the upcoming opening of the new Royal Liverpool University Hospital Establish an electronic patient record (EPR) optimisation programme following the recommendations of the external review and report progress to Committee. Share the estates masterplan for the Clatterbridge Health Campus and develop a medium-term development plan for CCC-Wirral.	TP	July 2022

			On completion Digital Strategy to be submitted to Committee with recommendation for Board to approve.		
PC-030-22 Finance Report – Month 11		All the indicators are currently rated as green with the break-even target achieved with a surplus including subsidiary companies. Cash is actually above plan and spending less on agency than CAP. Due to level of activity and the ERF calculation in the second half of this year significant additional revenue has been generated and being utilised to manage risks and offsetting CIP requirement and overachieve on financial position and actually have a surplus. Anticipated to spend capital forecast which will reduce cash position.	Monitoring position as uncertain of ERF amounts for months 11 and 12. Continue to manage Trust risks and with any surplus return to the system to contribute to the overall system balance position. Cash position overall buoyed by the ERF cash, charity monies and additional Public Dividend Capital (PDC) received but not yet expended.	JT	July 22
PC-034-22 CPL Report / Strategy Implementation, Risk Assurance, - Regulatory Compliance, Financial Performance		The Committee received and discussed the report noting: CPL still awaiting regulatory visits for new premises. Received positive feedback from the Home Office inspection relating to the organisations management of controlled drugs, and do not expect any kind of formal report from inspection. All outpatient survey results continued to be good, 100% of patients were either extremely satisfied or satisfied with services surveyed across the Wirral and Liverpool sites.	Committee commended the work to reduce the Stock position below £2,000,000 To continue to report to the Committee 3 times a year.	JM	July 2022

		98% of patients received their medication within 30 minutes. Stock position below £2,000,000			
PC-035-22 Improving Cyber Resilience		Committee welcomed the verbal update following receipt of correspondence from the national Chief Information Security Officer for Health and Social Care to SIROs sent on 1 March 2022 with instructions to improve cyber resilience Key areas requiring assurance to be submitted including patching, access control, monitoring, backups, instant response and business continuity planning and cyber awareness in the DSPT submission of 4 March 2022. NHS England wrote to Chairs and Audit Chairs of Trusts on 9 March. Guidance stated NHS England would use NIS regulations to intervene where trusts have 10% or more of devices on unsupported versions of Microsoft Windows.	SB to report to Audit Committee on the 1 April 2022	SB	1 April 22

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	30 March 2022
Agenda item:	P1-057-22
Title:	Patient Story – Networked Services (Psychological Medicine)
Report prepared by:	Julie Gray – Chief Nurse
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 Patient story provides the Board with insight into an individual patient's experience. It is told from their own perspective, giving the Trust an opportunity to understand their experience of the care they have received, and what could be done to improve their experience, as detailed within the report under Actions Already Taken and Action Plan.

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

Next steps required:	As detailed within the Action Report.

REPORT COVER

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

☒ BE **OUTSTANDING**

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

☒ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Patient/Staff Story – Action Report

Julie Gray – Chief Nurse

Version: 1.0 Ref: FCGOREPO Review: May 2024

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Patient/Staff Story Action Report

Story ID	Rachel	Committee	Board of Directors		
Date Presented	30/03/22	Patient Story	☒	Staff Story	☐
		In person	☐	Digital	☒
Date Consent Obtained	01/03/22	Consented by	Head of Patient Experience & Inclusion	Consent for:	Internal ☒ External ☒ Online ☒
Division/s involved	Networked Services – Psychological Medicine		External Organisation involved	The Countess of Chester Ursula Keyes Unit	
Formal Complaint	☐	Complaint closed	☐	Complaint Upheld	☐

1. Action Already Taken

No	Issue	Action taken	Action Lead
1	Awareness of issues experienced by the patient	Patient story shared with divisional teams	Head of Patient Experience & Inclusion

2. Action Plan *(for outstanding actions not covered above)*

No	Issue	Action required	Action Lead	Deadline Date	Expected Evidence of Completion
1	Impact of MDT outcome letters on patients and follow up process	1.Review of current process to identify areas for improvement	Administrative Service Lead	April 2022	Review paper
2	Awareness of mental health options to best support and	1.Review of current communications	Psychological Medicine team	April 2022	Communication tools

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	signpost patients to access/referral. Recognition of the importance of the psychological medicine team's work for other patients to be directed to their care	information available & update as required 2.Patient Story shared with patients/public via social media channels and Trust website	Communications team Communications Lead	April 2022	
3	Psychological education & training provision to all health care professionals involved in cancer care	1.Review available education and training and identify areas for improvement	Clinical Education Lead Psychological Medicine team	May 2022	Training prospectus
4	Expansion of the Psychological Medicine service	1. Review current pathway and identify areas for improvement. 2.Business case developed to explore opportunities to expand service and support to patients	Divisional Director	June 2022	Review paper and business case

3. Process for monitoring completion of identified improvement/assurance actions

All actions identified during the collation of patient and staff experience stories will follow the process set out in the Patient and Staff Experience Story Process Standard Operating Procedure. Actions will be assigned to the appropriate subject matter committee for action and evidence of resolution. Where significant service transformation is required, that is beyond the remit of the Head of Patient Experience & Inclusion, the management of the change process will be handed over to the Transformation and Improvement Committee. An

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annual report summarising any themes, learning and changes in practice will be collated by the Head of Patient Experience & Inclusion.

REPORT COVER

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Report to:	Trust Board	
Date of meeting:	30 March 2022	
Agenda item:	P1-058-22	
Title:	Patient Experience Visit – February 2022	
Report prepared by:	Asutosh Yagnik, Non-executive Director	
In attendance at visit:	Jane Wilkinson, Governor Kirsteen Scowcroft, Head of Patient Experience	
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 8th February 2022 at CCC Liverpool, Level 1 Day ward & CIT, Networked 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

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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

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Patient Experience Visits 08/02/2022

Asutosh T. Yagnik, Non-executive Director
Jane Wilkinson, Governor
Kirsteen Scowcroft, Head of Patient Experience

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

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1. Summary

The Patient Experience 'round' was conducted on the 8th February 2022, visiting Level 1 CCCL Day Ward and Clinical Interventions Team (CIT), Networked Services. Due to Covid-19 restrictions across all CCC sites Jane Wilkinson, Governor, and Asutosh Yagnik, Non-executive Director, were able to accompany Kirsteen Scowcroft, Head of Patient Experience virtually on this occasion as scheduled.

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

2. Key Findings and Observations

Patient experiences and comments – 3 patients from day ward on Level 1, CCCL were asked to share their experiences of being a patient at CCC.

- The first patient shared that she had been attending CCCL for six months and couldn't think of anything that could be improved on, as everyone had been wonderful in a lovely new environment with free beverages and sandwiches if chemotherapy infusions ran over lunchtime.

- The second patient shared the experience that he had attended CCCL over 20 times in the past year. Travelling from Chorley, on a 3 hour round trip with his wife, which they made a positive out of, by enjoying days out in Liverpool sightseeing and watching the cruise ships come in on the River Mersey to dock. The patient discussed how he brings his own coffee in a thermal flask, as he didn't like the free coffee on offer, but that was personal preference. The patient mentioned he had to come to CCCL since he felt his local hospital would quite likely lose his blood sample if it were taken there.

- The third patient informed us that he had previously received treatment and care at the Royal Liverpool hospital and now CCCL and wouldn't change a thing about the care and support he had received over the years from all the nurses who have looked after him. He was also thankful for the much nicer environment and surroundings in the new building. One thing he mentioned was about using a combination of SMS text messages and letters for appointments since sometimes the letters arrive after the appointment.

- **What does CCC do well?**

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Patients interviewed all felt they had received excellent care, treatment and a positive experience. Staff were compassionate and kind throughout their visits and they enjoyed being cared for in a beautiful new environment.

- **What can CCC do better?**
  Patients highlighted two things they felt CCC could do better to improve on their experience that may also benefit other patients.

  Phlebotomy/Bloods – Options for better access to closer to home phlebotomy and blood test results. Having made more than 20 x 3 hour round trips for a 10 minute phlebotomy appointment to take bloods to check levels before chemotherapy appointments has been tiring at times.

  Appointment letters – Provide more patient choice to also receive a text and/or email copy of their appointment letter. This would be easier and quicker to find, when needed and no longer have to store so many paper letters at home. The patient shared a particular experience, where the paper appointment letter arrived in the post the day after the appointment had taken place.

Staff experiences and comments

- Two staff members were able to share their experiences of working at CCCL. Both staff commented that overall they enjoyed caring for patients, although staff reported becoming increasingly frustrated on the patients behalf. This was described as being due to scheduling time constraints/delays with Haemato-oncology (HO) pharmacy chemotherapy, poor layout & flow on Level 1, staffing challenges & working overtime and the breadth of treatment/procedures planned for the patients without sufficient daily capacity, as well as not sufficiently using staff skills which could free up doctors' time. Staff were worried that this is having a direct impact on patient experience and staff morale (experience) as well as potentially not fully recognising a potential cost saving..

- **What can CCC do better for you?**
  Conisder a service review where appropriate to address the key points raised below;

  Haemato-oncology Chemotherapy/Pharmacy – At the moment HO chemotherapy is made up for CCC patients at the Royal Liverpool and transported across to CCCL, which causes delays for a patient, for example this means for a 30 minute injection, a 2 hour wait. There is only so many times staff can apologise and provide cups of tea when all the patients wish to be at home as soon as possible. Having HO chemotherapy made up on the CCCL site and

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moving all HO chemotherapy to Level 6 as initially planned with the move to CCCL, would reduce delays and the negative impact on patients and staff.

Capacity and Demand – Staff report that the occupancy capacity of 20 bays does not match the daily treatment demand and provided an example of a typical day where 59 patients were scheduled for treatment using 20 bays.

Level 1 building layout – Being in the new hospital compared to previously at the Royal Liverpool is much better, the flow of the environment from working was voiced to be not well thought through with the grass roots staff working on a daily basis, prior to moving. Listening to staff concerns and reviewing the work flow in the area would be a good start.

Staff overtime – broached the issue of a knock on impact from capacity and demand issues of having a detrimental affect on staff health and wellbeing when staff are working longer and later extensions of their shifts, that run over the 6pm closing time, more frequently for a variety of reasons.

Communication – Concerns are raised on a daily basis to line managers, however those who raise concerns don't know that any action is taking place by the senior leadership team and no updates are fed back to those who raised the concerns to inform the team and improve communication.

Embracing Innovation (CIT) – The staff feel they have the right skills and training to truly be a service of excellence to benefit patients and organisations. Specifically, several staff feel they have been trained to insert many types of lines and were recruited on that basis, however these are not being utilised to their full potential. Utilising those skills, with adequate risk assessment, could potentially free up 6 hours per week of an interventional radiologist (IR) consultants time. Then with further investment in training competencies and working closely with the IR consultants, further medical time would be freed to care and further develop the nursing workforce.

- **What can CCC do to improve patient experience?**
  Reviewing capacity & demand and improving internal processes & flow, would make the biggest impact to patients, reducing waiting times caused by unnecessary delays.
  In addition reviewing what services were planned to be in Level 1 vs other Levels (e.g. Level 6) and what has actually happened vs plan. There is a sense that a number of different services were planned to be in different Levels but this has not been fully implemented as yet.

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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

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Board of Directors	
Date of meeting:	30th March 2022	
Agenda item:	P1-059-22	
Title:	Integrated Performance Report M11 2021/2022	
Report prepared by:	Hannah Gray: Head of Performance and Planning	
Executive Lead:	Joan Spencer: Chief Operating Officer	
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	Performance Committee and Quality Committee
Date & decision:	Wednesday 23rd March and Thursday 24th March 2022

Purpose of the paper/key points for discussion:	This report provides the Board of Directors with an update on performance for month 11 2021/22 (February 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:	

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

☒ BE **OUTSTANDING**

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

☒ BE **COLLABORATIVE**

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

☒ BE **RESEARCH LEADERS**

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

☒ BE **A GREAT PLACE TO WORK**

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

☒ BE **DIGITAL**

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

☒ BE **INNOVATIVE**

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

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

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

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Integrated Performance Report (Month 11 2021/22)

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

Introduction

This report provides an update on performance for month eleven; February 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 6th December 2021; The Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers Phase 1: Planning and Preparation (V1). Regulations revoking vaccination as a condition of deployment came into force on 15th March 2022. This means that it will not become a requirement for people to have received a COVID-19 vaccine in order to deliver face to face CQC-regulated activities in wider social care settings.

Staff flu vaccine and Covid booster vaccine data is not included in this M11 report. Trusts use the National Immunisation Management Service (NIMS) dashboard to produce the figures and this system remains unavailable to access.

Whilst the Trust is compliant with the Statutory and Mandatory training target overall (94.4%), 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	Feb-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%	96.2%	92.8%	
C/S	**2 week wait** from GP referral to 1st appointment	↑	93%	100.0%	97.6%	
L	**24 days** from referral to first treatment	↔	G: ≥85% A: 80-84.9% R: <80%	75.9%	86.6%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	↔	75% (formally monitored since Oct 2021)	64.3%	77.8%	
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%	99.4%	99.2%	
C/S	**31 day** wait for subsequent treatment (Drugs)	↔	98%	99.2%	99.2%	
C/S	**31 day** wait for subsequent treatment (Radiotherapy)	↔	94%	99.2%	98.8%	
S	Number of **31 day** patients treated **≥ day 73**	↓	0	0	1	
C/S	**62 Day** wait from GP referral to treatment	↔	85%	75.4%	87.2%	
C/S	**62 Day** wait from screening to treatment	↑	90%	100.0%	86.0%	
L	Number of patients treated between **63 and 103 days** (inclusive)	↓	No Target	32	453	
S	Number of patients treated **≥ 104 days**	↑	No Target	14	152	
L	Number of patients treated **≥ 104 days AND at CCC for over 24 days (Avoidable)**	↑	G: 0 A: 1 R: >1	1	5	
C/S	Diagnostics: **6 Week Wait**	↔	99%	100%	100%	
C/S	**18 weeks** from referral to treatment (RTT) Incomplete Pathways	↔	92%	97.4%	99%	

Notes:

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

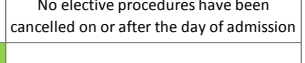
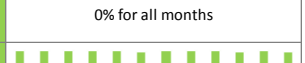
This border indicates that the figure has not yet been validated and is therefore subject to change.
This is because national CWT reporting deadlines are later than the CCC reporting timescales.

Cheshire and Merseyside Cancer Waiting Times Performance:

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Jan-22	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%	72.7%	85.2%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	↔	75% (formally monitored since Oct 2021)	62.2%	70.9%	
C/S	**62 Day** wait from GP referral to treatment	↔	85%	68.7%	74.8%	

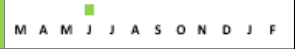
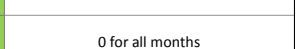
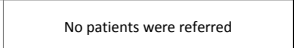
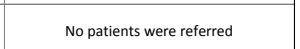
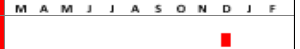
1.2 Efficiency

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

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Feb-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	182%	179%	
S (SOF)	% of all (non-treatment) outpatient activity delivered remotely via telephone or video	⟷	25%	53%	67%	
L	Outpatient Appointments (including treatments) as % of the same month in 2019/2020	⟷	95% of 2019/20 levels	121%	127%	
S	Length of Stay: Elective (days): Solid Tumour	⟷	G: ≤6.5 A: 6.5-6.8 R: >6.8	5.8	6.4	
S	Length of Stay: Emergency (days): Solid Tumour	⟷	G: ≤8 A: 8.1-8.4 R: >8.4	4.9	7.9	
S	Length of Stay: Elective (days): HO Ward 4	⟷	G: ≤21 A: 21.1-22.1 R: >22.1	6.5	15.6	
S	Length of Stay: Emergency (days): HO Ward 4	-	G: ≤22 A: 22.1-23.1 R: >23.1	No Discharge s	11.3	
S	Length of Stay: Elective (days): HO Ward 5	⟷	G: ≤32 A: 32.1-33.6 R: >33.6	10.6	18.3	
S	Length of Stay: Emergency (days): HO Ward 5	⟷	G: ≤46 A: 46.1-48.3 R: >48.3	9.5	11.7	
S	Delayed Transfers of Care as % of occupied bed days	⟷	≤3.5%	5.5%	3.4%	
S	Bed Occupancy: Midnight (Ward 4: HO)	⟷	G: ≥85% A: 81-84.9% R: <81%	94.7%	87.3%	
S	Bed Occupancy: Midnight (Ward 5: HO)	↑	G: ≥80% A: 76-79.9% R: <76%	83.8%	74.5%	
S	Bed Occupancy: Midday (Solid Tumour)	↑	G: ≥85% A: 81-84.9% R: <81%	82.3%	72.9%	
S	Bed Occupancy: Midnight (Solid Tumour)	⟷	G: ≥85% A: 81-84.9% R: <81%	80.3%	73.1%	
C	% of expected discharge dates completed	↑	G: ≥95% A: 90-94.9% R: <90%	90.0%	86.5%	
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%	94.8%	96.5%	
L	Imaging Reporting: Outpatients (within 7 days)	↓	G: ≥90% A: 80-89.9% R: <80%	85.9%	82.5%	
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%	95.5%	96.7%	
C	Data Quality - % of outpatients with an outcome	⟷	G: ≥95% A: 90-94.9% R: <90%	100.0%	99.73%	
C	Data Quality - % of outpatients with an attend status	⟷	G: ≥95% A: 90-94.9% R: <90%	100.0%	99.73%	
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	Feb-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	80.0%	
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	148.6	183.7	
L	Incidents resulting in harm /1,000 bed days	↑	No target	23	19	
C/S	Inpatient Falls resulting in harm due to lapse in care	⟷	0	0	0	0 for all months
S	Inpatient falls resulting in harm due to lapse in care /1,000 bed days	⟷	0	0	0	0 for all months
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care)	⟷	0	0	0	0 for all months
C/S	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care) /1,000 bed days	⟷	0	0	0	0 for all months
S	Consultant Review within 14 hours (emergency admissions)*	⟷	90%	97.1%	97.1%	
C/S	% of Sepsis patients being given IV antibiotics within an hour*	⟷	90%	93.0%	95.1%	
C/S	VTE Risk Assessment	⟷	95%	98%	96%	
S	Dementia: Percentage to whom case finding is applied	⟷	90%	80%	93%	
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)	0	12	
C/S	E Coli (attributable)	↑	≤6 (pr yr)	1	11	
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	2	
C/S	FFT score: Patients (% positive)	⟷	G: ≥95% A: 90-94.9% R: <90%	97%	96%	

The Quality KPI scorecard continues on page 5

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Feb-22	YTD 2021/22	Last 12 Months
Executive Director Lead: Julie Gray, Chief Nurse						
C	Number of formal complaints received	↑	No target	3	35	
S	Number of formal complaints / count of WTE staff (ratio)	↑	No target	0.0018	0.0020	
C	% of formal complaints acknowledged within 3 working days	-	100%	100%	97%	
L	% of routine formal complaints resolved in month, which were resolved within 25 working days	↓	G: ≥75% A: 65-74.9% R: <65%	0%	65%	
L	% of complex formal complaints resolved in month, which were resolved within 60 working days	↔	G: ≥75% A: 65-74.9% R: <65%	None to resolve	N/A	
C/S	% of FOIs responded to within 20 days	↔	100%	100%	100%	
C/S	Number of IG incidents escalated to ICO**	↔	0	0	1	
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	41	N/A	
L	% of policies in date	↓	G: ≥95% A: 93.1-94.9% R: <93%	94%	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	Feb-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)	96	814	
National	Study set up times (days)	-	≤40 days		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	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)	8	42	
L (Strategy)	Publications	↓	G: ≥11 A: 10-9 R: <9 (pr month)	9	189	

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

1.5 Workforce

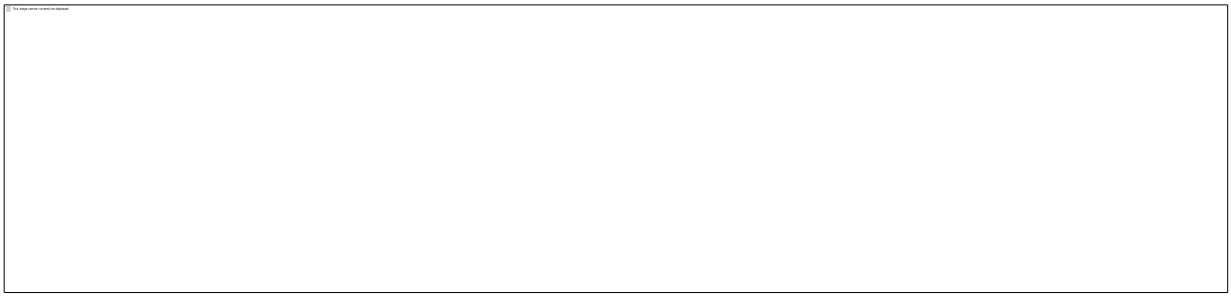
Scorecard Directive Key: S = Statutory | C = Contractual | L = Local

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Feb-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%	6.2%	5.2%	
S	Staff Turnover*	↓	G: ≤1.2% A: 1.21–1.24% R: ≥1.25%	0.82%	16.50%	
S	Statutory and Mandatory Training	⟷	G: ≥90% A: 75-89% R: ≤75%	94.44%	N/A	
L	PADR rate	⟷	G: ≥95% A: 75-94.9% R: ≤74%	93.61%	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

The key financial headlines for February are:



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 11 the Trust has been notified of £8.8m ERF income in relation to month 7 to 10, an element of which has been deferred into future months to offset potential future risks and to support the overall ICS aggregate position.

The Trust financial position to the end of February is a £3k surplus, the group consolidated position is a £736k surplus. The group cash position is a closing balance of £77.4m, which is £19.2m above plan and a £15m increase in month. Capital spend has increased by £4.7m in month with the remainder of spend being profiled in month 12.

The Trust is under the agency cap by £32k in month and £299k in the year to date.

2. Exception Reports

2.1 Access

24 days from referral to first treatment	Target	Feb-22	YTD	Last 12 Months
	G: ≥85% A: 80-84.9% R: <80%	75.9%	86.6%	

Reason for non-compliance

19 patients breached the 24-day target in February. 7 of the 19 patients were treated within the 62-day target and were deemed unavoidable breaches due to delays to molecular test result and medical reasons. 12 of the 19 patients breached the 62 day target, with 3 of these deemed to be avoidable.

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	31/03/22
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	Feb-22	YTD	Last 12 Months
	G: ≥ 75% R: <75%	64.3%	78.8%	

Reason for non-compliance

5 patients breached the 28 FDS day target in February. All of the breaches were deemed unavoidable; 1 due to patient choice of diagnostic scan appointment date and 4 due to Aintree on-boarding, with the latter group transferred to CCC approaching or beyond day 28.

Action taken to improve compliance

N/A

Expected Date of Compliance	31/03/22

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**	**Feb-22**	**YTD**	**Last 12 Months**
	G: ≥85% R: <85%	**75.4%**	87.2%	

Reason for non-compliance

12 patients breached the 62-day target in February. The unavoidable breaches were due to delays to molecular test results, medical and patient choice reasons. Only 3 of the breaches were avoidable; as described below.

- Slight delay to 1st appointment due to clinic capacity. Patient breached 24 day target by 1 day
- Patient referred from Sarcoma pathway to HO. Delay to pre-treatment test appointment
- Delay to 1st appointment due to Consultant capacity (13 days). Patient then required review with Geriatrician to assess suitability for treatment. Radiotherapy was deferred 3 days due to machine breakdown.

Action taken to improve compliance

- Daily monitoring and escalating of appointment bookings remains in place to enable management and prioritisation for first appointments
- An operational group is now in place to support the turnaround times for PDL1 and EGFR Testing
- Review of HO optimal pathways now on boarding has been completed
- Waiting List Initiatives have been implemented for Lung, HPB, UGI and LGI
- Following several instances of Linac breakdowns, a root cause analysis is being conducted.

Expected Date of Compliance	April 2022
Escalation Route	CWT Target Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

Number of patients treated ≥104 days AND at CCC for over 24 days (Avoidable breaches)	Target	Feb-22	YTD	Last 12 Months
	G: 0 A: 1 R: >1	1	7	

Reason for non-compliance

14 patients breached the 104+ day target in February; referred in between day 61 and 190 to CCC. 4 of the patients were at CCC for more than 24 days between referral and treatment. 1 of the breaches was deemed to be an avoidable breach to CCC, as one of the reasons for delay was due to a delay to 1st appointment. Full details are as follows:

- Delay to 1st appointment due to Consultant capacity (13 days). Patient then required review with Geriatrician to assess suitability for treatment. Radiotherapy was deferred 3 days due to machine breakdown.

Action taken to improve compliance

- Daily monitoring and escalating of appointment bookings remains in place to enable management and prioritisation for first appointments.

Expected Date of Compliance	April 2022
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

Cheshire and Merseyside Cancer Waiting Times Performance:

14 Day Cancer Standard (Alliance-level)	Target	Jan-22	YTD	Last 12 Months (to Jan 22)
	93%	72.6%	85.2%	

Reason for non-compliance

Non-compliance with the 14 day standard in January 2022 was largely driven by underperformance in the following tumour groups:

Suspected breast cancer 30.6% (1595 breaches),
Suspected lower gastrointestinal cancer 72.7% (672 breaches),
Suspected upper gastrointestinal cancer 77.9% (243 breaches),
Suspected gynaecological cancer 81.5% (188 breaches),
Suspected head and neck cancer 89.3% (94 breaches),
Suspected urological malignancies (excluding testicular) 89.4% (84 breaches),
Suspected children's cancer 92.5% (3 breaches)

Providers not achieving the national standard were:

Countess Of Chester Hospital 63.3% (399 breaches),
Liverpool University Hospitals 65.5% (1037 breaches),
Warrington and Halton Teaching Hospitals 68.6% (298 breaches),
St Helens and Knowsley Hospitals 73.5% (394 breaches),
Wirral University Teaching Hospital 76.2% (356 breaches),
Liverpool Womens 76.7% (60 breaches),
East Cheshire 80.5% (102 breaches),
Mid Cheshire Hospitals 80.9% (209 breaches),
Southport and Ormskirk Hospital 82.4% (172 breaches),
The Clatterbridge Cancer Centre 90% (1 breaches)

Outpatient capacity issues were recorded as the most frequent breach reason (64%), followed by patient choice (22%).

Action Taken to improve compliance

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

Expected date of compliance	Compliance with the 14 day standard is expected to return by the end of Q1 2022/23
Escalation route	NHS England, North West CCC Performance Committee, Trust Board
Executive Lead	Liz Bishop, CMCA SRO

28 Day Cancer Standard (Alliance-level)	**Target**	**Jan-22**	**YTD**	**Last 12 Months** (to Jan 22)
	75%	**62.0%**	**71.0%**	

Reason for non-compliance

Non-compliance with the 28 day FDS in January 2022 was driven by underperformance in the following tumour groups:

Suspected lower gastrointestinal cancer 34.4% (1521 breaches),
Suspected urological malignancies (excluding testicular) 38.8% (446 breaches),
Referral from a National Screening Programme: Unknown Cancer Report Category 42.4% (272 breaches),

Other suspected cancer (not listed) 43.3% (17 breaches),
Suspected testicular cancer 46.9% (17 breaches),
Suspected haematological malignancies (excluding acute leukaemia) 47.4% (41 breaches),
Suspected upper gastrointestinal cancer 48.5% (537 breaches),
Suspected gynaecological cancer 58.4% (433 breaches),
Suspected lung cancer 70.6% (57 breaches)

Providers not achieving the national standard were:

Liverpool Heart And Chest 40.9% (13 breaches),
Countess Of Chester Hospital 53.9% (578 breaches),
Liverpool Womens 54.1% (140 breaches),
Bridgewater Community Healthcare 54.6% (94 breaches),
The Clatterbridge Cancer Centre 57.1% (6 breaches),
Liverpool University Hospitals 57.8% (1276 breaches),
East Cheshire 60.3% (236 breaches),
Warrington and Halton Teaching Hospitals 61% (349 breaches),
Southport and Ormskirk Hospital 62.6% (329 breaches),
Mid Cheshire Hospitals 64.8% (419 breaches),
Wirral University Teaching Hospital 70.5% (458 breaches),
St Helens and Knowsley Hospitals 70.7% (449 breaches)

The main reasons for breaches were outpatient capacity (29%), administrative delay (12%) and 'other' (18%).

Action Taken to improve compliance

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

Expected date of compliance	Compliance with the 28 day standard is expected in Q1 2022/23
Escalation route	NHS England, North West CCC Performance Committee, Trust Board
Executive Lead	Liz Bishop, CMCA SRO

62 Cancer Standard (Alliance-level)	Target	Jan-22	YTD	Last 12 Months (to Jan 22)
	85%	67.9%	74.7%	

Reason for non-compliance

Non-compliance with the 62 day standard in January 2022 was driven by underperformance in the following tumour groups:

Lower Gastrointestinal 36.4% (42 breaches),
Gynaecological 39.6% (16 breaches),
Upper Gastrointestinal 50% (17.5 breaches),
Head & Neck 52.7% (13 breaches),
Breast 63.5% (29 breaches),
Urological (Excluding Testicular) 66.5% (40 breaches),
Sarcoma 66.7% (1.5 breaches),
Lung 68.9% (20.5 breaches)

Providers not achieving the national standard were:

East Cheshire 31% (20 breaches),
Liverpool Womens 34.8% (7.5 breaches),
Liverpool University Hospitals 56.4% (51.5 breaches),
Countess Of Chester Hospital 60.9% (21.5 breaches),
Southport and Ormskirk Hospital 67.7% (16 breaches),
Mid Cheshire Hospitals 67.7% (20 breaches),
Warrington and Halton Teaching Hospitals 74.1% (10.5 breaches),
The Clatterbridge Cancer Centre 78.2% (8.5 breaches),
Wirral University Teaching Hospital 79.6% (16 breaches),
St Helens and Knowsley Hospitals 83.4% (17 breaches),
Bridgewater Community Healthcare 84.6% (2 breaches)

The main reasons for breaches were complex diagnostic pathways (18%), healthcare provider initiated delay to diagnostic test or treatment planning (21%) and 'other' (34%).

Action Taken to improve compliance

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

Expected date of compliance	Compliance is expected in Q4 2022/23

Escalation route	NHS England, North West, CCC Performance Committee, Trust Board
Executive Lead	Liz Bishop, CMCA SRO

2.2 Efficiency

Delayed Transfers of Care as % of occupied bed days	**Target**	**Feb-22**	**YTD**	**Last 12 Months**
	G: ≤3.5%	**5.5%**	3.4%	

Reason for non-compliance

Delayed Transfers of Care (DTOCs) as a % of occupied bed days for the month of February was above the Trust target of ≤3.5%, at 5.5% this month.

There were 11 DTOCs in February:

- 5 Patients awaited Fast Track Packages of care, resulting in 27 extra bed days. Covid continues to have an impact on community services, with an increased length of time to commission a POC across all areas.
- 1 Patient awaited an Intermediate Care Bed for 9 days.
- 3 Patient awaited Fast Track Nursing Home placement for a total of 48 extra bed days, with 2 of the patients remaining in hospital due to complex nursing needs. CHC have been contacted daily for an update on availability.
- 2 Patients awaited Hospice placement resulting in 10 extra bed days. Some hospices have reduced day capacity due to Covid.

There were 94 extra bed days in February. The average length of DTOC was 8.5 days.

Action taken to improve compliance

- Weekly 'Lengthened Length of Stay' meetings have continued with attendance of Matron and the Business Services Manager to ensure the flow of patients continues, and any concerns can be escalated. The outcome of these meetings are sent on to General Manager for review.
- The Patient Flow Team 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 continue to allow discussion of all inpatients so there is a clear plan for each patient.

Expected date of compliance	May 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**	**Feb-22**	**YTD**	**Last 12 Months**
	Solid Tumour (Midday)	G: ≥85% A: 81-84.9% R: <81%	82.3%	**72.9%**	
	Solid Tumour (Midnight)	G: ≥85% A: 81-84.9% R: <81%	**80.3%**	**73.1%**	

Reason for non-compliance

Solid tumour ward bed occupancy continues to be below the Trust target of 85%, however occupancy has increased by 5% from January to February and midday occupancy is marginally below target at 82.3%. This is the highest occupancy since January 2021.

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 wider system with Winter/Covid pressures. These beds have not been used in February. 5 Mutual aid patients have been transferred across to CCC from LUHFT in February 2022.

In February 2022, solid tumour wards have been at OPEL 3 level on 26 occasions and Haemato-oncology wards on 19 occasions.

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

Action taken to improve compliance

- The CDU Nurse Consultant liaises with LUHFT AO on a daily basis to identify patients who are appropriate for transfer to CCC.
- A proposal to improve bed utilisation will be presented at the March Performance Committee.

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

Reason for non-compliance

Following a review of compliance, the Haemato-oncology (HO) admission documentation, which captures the expected discharge dates (EDD) has been re launched. Compliance has improved from 87% in January to 90% in February.

Action taken to improve compliance

- 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.

Expected date of compliance	March 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

Imaging Reporting: Outpatients (within 7 days)	Target	Feb-22	YTD	Last 12 Months
	G: ≥90% A: 80-89.9% R: <80%	85.9%	82.5%	

Reason for non-compliance

Although performance improved in January, the target has not been achieved in February, at 85.9%, against a target of 90%.

Reasons for non-compliance include:

- Radiology activity has increased since CCCL opened, placing increasing demands on the Radiologist team.
- Loss of reporting capacity due to Radiologists supporting clinical services; Interventional Radiology and Ultrasound.
- CCC Radiologists supporting additional MDT activity.
- Radiologist planned and unplanned absence.

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

Action taken to improve compliance

- On-going outsourcing of reporting activity to Medica (100 scans (CT/ MRI) per week).
- 1 additional Radiologist started on 18th September 2021.
- A Clinical Imaging Fellow started on 1st September 2021.
- A Radiologist recruited in December 2019 started on the 3rd March 2022.
- An additional locum Radiologist is due to start in April 2022.
- 3 additional permanent Radiologist posts are to be advertised following approval of the business case.
- Bi-weekly report received by senior radiology team enabling continuous monitoring and prioritisation of outstanding reports.

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

2.3 Quality

Dementia screening: % to whom case finding is applied	Target	Feb-22	YTD	Last 12 Months
	90%	80%	93%	

Reason for non-compliance

The target of 90% was not achieved for the month of February 2022, with compliance at 80%.

Non-compliance related to 3 out of 15 patients being identified as not having an accurately completed dementia screening assessment tool on admission. Initial investigations highlighted that all three patients had been incorrectly entered onto Meditech as a planned admission rather than an emergency admission. A training issue has been identified and now addressed.

Patient details:

- Patient discharged to hospice for end of life care. Therefore, would not have been referred for further investigations despite outcomes of the screening tool.
- Patient remains at CCC, alert and orientated. Therefore, does not require referral for further investigations.
- Patient has since been discharged home where patient lives with family. Recorded as being alert and orientated throughout admission, therefore does not require referral for further investigations.

Action Taken to improve compliance

- Share results with inpatient ward managers, matrons and the named nurse for safeguarding.
- CDU manager to reinforce correct recording of type of admission.
- Ward manager to highlight incident with the staff member involved to share the learning.

Expected date of compliance	March 2022
Escalation route	Divisional Quality and Safety Meeting, Divisional Performance Review, Quality Committee, Trust Board
Executive Lead	Julie Gray, Chief Nurse

***E.coli* infections (attributable)**	**Target**	**Feb-22**	**YTD**	**Last 12 Months**
	< 9 per yr	1	11	

Reason for non-compliance

There was 1 CCC attributable case of *E.coli* in February, taking the total to 11 YTD against a target of <9 per year.

Likely urinary source as *E.coli* also identified in urine cultures. No lapses in care were identified.

There are 2 E coli infections which were not reported at the time in the IPR. One was in June 2021 on Ward 5. This wasn't reported to us at the time due to technical issues at the lab. Reporting was only possible once we had requested the national database be unlocked to enable retrospective reporting. The other was in October 2021 on Ward 2. No lapses in care were identified during the reviews.

Action taken to improve compliance

- No learning points identified

Expected date of compliance	February 2022
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

***Pseudomonas aeruginosa* infections (attributable)**	**Target**	**Feb-22**	**YTD**	**Last 12 Months**
	≤ 10 per year	1	2	

Reason for non-compliance

There was 1 CCC attributable case of *Pseudomonas aeruginosa* in February, taking the total to 2 YTD against a target of 10 or fewer for the year.

This case was likely to be a line related infection. No lapses in care were identified during the review.

Action taken to improve compliance

- No learning points identified

Expected date of compliance	February 2022
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

% of routine formal complaints resolved in month, which were resolved within 25 working days	Target	Feb-22	YTD	Last 12 Months
	R: <65% A: 65-74.9% G: 75%	0%	65%	

Reason for non-compliance

One complaint was resolved in February 2022; this did not meet the 25 day target, at 31 days.

- Complaint received 17/12/2021 with a response due date of 25/01/2022
- Review of care completed and draft response letter sent for approval on 21/01/2022
- Further information was then required and the final letter was sent to the complainant on 03/02/2022.

The complainant was kept fully informed of the reason for the delay and had agreed the renewed response date.

Action taken to improve compliance

- Ongoing complaints are discussed at the divisional quality and safety meeting to support the achievement of targets.
- The approval process has been re communicated to Divisions to prevent future delays.

Expected Date of Compliance	March 2022
Escalation Route	Divisional Quality, Safety and Performance meetings, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Director Lead	Julie Gray, Chief Nurse

% of Policies in Date	Target	Feb-22	YTD	Last 12 Months
	R: <93% A: 93-94.9% G: ≥95%	94%	96%	

Reason for non-compliance

Out of a total of 269 policies, sixteen were out of date at the end of February, resulting in a compliance figure of 94.42%

All sixteen policies are between one and ten months out of date. A summary of the status of the policy reviews is as follows:

- Five polices became out of date on 1st February 2022.
- Seven policies have gone to various meetings/groups for approval.
- Four policies are awaiting update by the document owners.

Action taken to improve compliance • Policy review reminders and instructions are sent to individual authors three months in advance of the review due. Further follow ups then on a weekly basis. • Out of date policy information is provided for review at monthly Divisional meetings and Performance Reviews. • Bi-monthly Document Control update reports are presented at the Information Governance Board. • Promotion of policy self-management with Document Owners – ongoing. • Targeted meetings being held between Information Governance staff and Document Owners – under review.	
Expected Date of Compliance	March 2022
Escalation Route	Associate Director of Corporate Governance, Information Governance Board, Integrated Governance Committee, Divisional Performance Review, Quality Committee, Trust Board
Executive Director Lead	Liz Bishop, Chief Executive

2.4 Research and Innovation

There are no exception reports for Research and Innovation this month. Although the monthly target for publications is marginally below target, the annual target has been surpassed.

2.5 Workforce

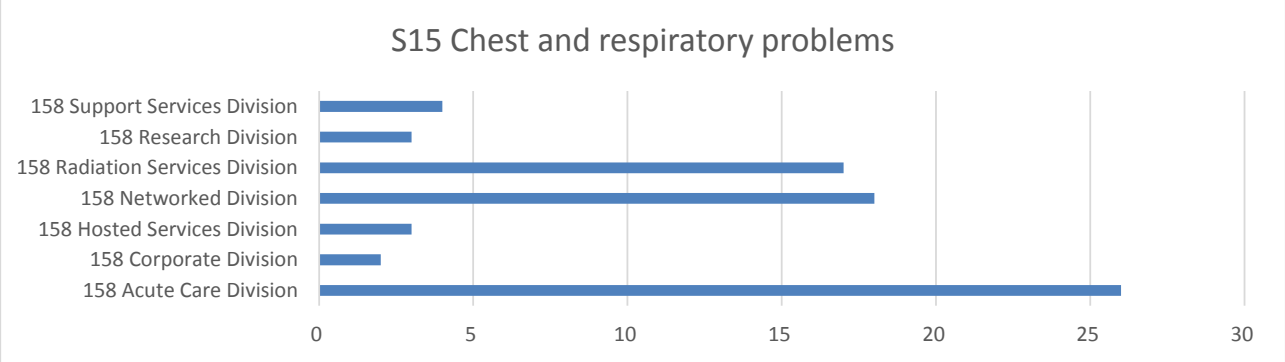
Staff Sickness Absence	Target	Feb-22	YTD	Last 12 Months
	G: ≤4% A: 4.01– 4.99% R: ≥ 5%	6.24%	5.31%	

Reason for non-compliance

The in-month figure for absence has decreased from 7.04% to 6.24% in February 2022, however this is still above the Trust target of 4%. The highest reasons for absence are summarised in the table below:

Absence Reason	Number of Episodes
S15 Chest and Respiratory problems	73
S13 Cold, Cough, Flu - Influenza	34
S25 Gastrointestinal problems	34
S10 Anxiety/stress/depression/other psychiatric illnesses	33

The highest reason for absence across the Trust remains as Chest & Respiratory Problems, with 73 episodes in February (61 recorded as Covid-19 related) but encouragingly there has been a significant reduction from the previous month when there were 183 episodes.



The Acute Care Division had the highest number of absences due to Chest & Respiratory problems with 26 episodes (21 Covid-19 related) which accounts for over a third of the total Chest and Respiratory absences across the division and over half of these occurred on Wards 3 and 4, with 7 and 8 episodes respectively.

There has been a change from the previous 2 months when the Networked Services Division had the highest number of absences due to Chest and Respiratory problems, whereas this month they had the second highest number of episodes with 18, closely followed by Radiation Services with 17.

Cold, cough and flu remains as the second highest reason for absence although there has been a decrease in the number of episodes, for the second month, from 52 in January to 34 in February. The Acute Care division had the highest number of absences with 11, closely followed by Networked Services with 10 and Radiation Services with 9. Within Networked Services, CBU3 made up 7 of the 10 absences relating to cold, cough and flu whereas CBU1 only had 2 episodes and CBU2 had 1 episode. In addition to this the absences only came from Stream 4 & 5 within Admin Services and not the other streams.

Gastrointestinal problems have entered into the top 3 reasons for absence this month; this used to be something we saw on a monthly basis, however it has not appeared in the top 3 reasons since October 2021. The Networked Services Division had 12 episodes, Acute Care 10 episodes and Radiation Services 9 episodes.

Anxiety, stress and depression was the third highest reason for absence but there has been another reduction in the number of episodes from 39 in January to 33 in February. This is really encouraging to see as we have seen a reduction of almost half the number of episodes from 52 in December and we are also noticing a reduction in the number of work-related stress episodes. Of the 33 episodes in February, 3 were work-related, 29 were personal related and 1 was a mix of both work and personal stressors; this is a reduction of 3 work-related episodes from last month. The number of work-related stress absences has remained static around 7 episodes for the last 2 months, and previous to this there were 10 episodes in November 2021, so it is encouraging to see this reducing. Overall, there were 21 long-term episodes and 12 short-term and of the total absences 11 ended in February whilst the remaining 22 continue into March. CBU5 had the highest number of absences with 11, followed by CBU1 with 6, CBU3 and CBU7 both with 4 episodes.

Action taken to improve compliance

- Upon reviewing the monthly absence data, it has been evident that a number of Covid-19 sicknesses are showing as ongoing when the individuals have returned to work. The HRBP team have picked these up with individual managers and have amended the ESR records accordingly; the team will continue to review this on a monthly basis at HR surgeries to ensure absences are closed down in a timely manner and therefore ensuring the most accurate data is reported.
- Given the positive reduction in the number of work-related stress absences, the HRBP team continue to ensure early intervention in these cases and the completion of stress risk assessments where appropriate. This is to ensure meaningful action plans are put in place to address areas of concern as this has shown to have a positive impact on reducing work-related stress.
- The Attendance Management Policy audit is due to commence in the next month and this will allow us to provide further assurance that the policy requirements are being met and that staff are being provided with the appropriate support where necessary.

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

PADR	Target	Feb-22	Last 12 Months
	G: ≥95% A: 75% - 94.9% R: ≤74%	93.61%	

Reason for non-compliance

Overall trust compliance has increased from 92.83% to 93.61% however remains marginally below the KPI of 95%.

Areas performing below the KPI are as follows:

Org L4	Assignmen	Reviews	Reviews Completed %
158 CBU1 - Day Care & Network	131	123	93.89
158 CBU3 - Admin Services	166	157	94.58
158 CBU4 - Pharmacy	57	54	94.74
158 CBU5 - Inpatient Care	177	154	87.01
158 CBU7 - Radiology Services	51	46	90.20
158 CBU8 - Physics	69	65	94.20
158 Cancer Alliance	30	27	90.00
158 Executive Office	11	10	90.91
158 Networked Leadership	9	8	88.89
158 Project Management Office	4	3	75.00
158 Research & Innovation	49	46	93.88
158 Safeguarding	10	9	90.00
Grand Total	**1,126**	**1,054**	**93.61**

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	30 April 2022
Escalation route	Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Statutory and Mandatory Course Compliance:

Information Governance Training	Target	Feb-22
	G: ≥95% A: 75% - 94.9% R: ≤74%	90.60%

Reason for non-compliance

IG compliance is currently below the nationally set KPI of 95% and has seen an in-month decline of 2.09%.

Areas of underperformance are:

Competence Name	Org L4	Required	Achieved	Compliance %
NHS|CSTF|Information Governance and Data Security - 1 Year|	158 CBU1 - Day Care & Network	172	150	87.21%
NHS|CSTF|Information Governance and Data Security - 1 Year|	158 CBU4 - Pharmacy	76	66	86.84%
NHS|CSTF|Information Governance and Data Security - 1 Year|	158 CBU5 - Inpatient Care	235	183	77.87%
NHS|CSTF|Information Governance and Data Security - 1 Year|	158 Cancer Alliance	43	38	88.37%
NHS|CSTF|Information Governance and Data Security - 1 Year|	158 Communications	4	3	75.00%
NHS|CSTF|Information Governance and Data Security - 1 Year|	158 Project Management Office	6	4	66.67%
NHS|CSTF|Information Governance and Data Security - 1 Year|	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.
- 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.
- Areas of underperformance to be added to the risk register

Expected date of compliance	31st March 2022
Escalation route	Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Patient Handling Training	Target	Feb-22
	G: ≥90% A: 75% - 89.9% R: ≤74%	88.43%

Reason for non-compliance

There are 70 staff currently out of compliance with patient handling training, with a further 22 staff coming out of compliance during March 2022.

Org L4	Required	Achieved	Compliance %
158 CBU1 - Day Care & Network	139	114	**82.01%**
158 CBU2 - Outpatients & Clinical Support	48	47	**97.92%**
158 CBU5 - Inpatient Care	188	162	**86.17%**
158 CBU6 - Radiotherapy	146	139	**95.21%**
158 CBU7 - Radiology Services	54	45	**83.33%**
158 Networked Leadership	3	3	**100.00%**
158 Research & Innovation	26	24	**92.31%**
158 Safeguarding	1	1	**100.00%**

The Manual Handling Trainer retired in January 2022 which is impacting on the ability to deliver the required number of training sessions to achieve compliance.

The two sessions planned in April and May are already fully booked, so it is likely a further decline in compliance will be seen, if additional dates cannot be made available. This has been added to the Trust risk register.

Action taken to improve compliance

- A previous manual handling trainer post holder has joined NHSP and has booked induction training sessions during February. Unfortunately, due to a unexpected leave, sessions including induction which were planned for March, have been cancelled
- Manual Handling Trainer post has been advertised
- Contact was made with the MH team at WUTH, however they are unable to provide support at this time
- Discussions are ongoing with the MH team at LUHFT regarding their ability to provide support and refresher training for our ward/department-based MH link trainers
- Contact made with other agencies regarding temporary recruitment into the role

Expected date of compliance	June 2022
Escalation route	Divisional Performance Review, Health and Safety Committee, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Resuscitation Adult ILS Training	Target	Feb-22
	G: ≥90% A: 75% - 89.9% R: ≤74%	83.47%

Reason for non-compliance

Compliance for ILS has seen a further in-month decline of 3.33%.

Underperformance is detailed below;

Competence Name	Org L4	Required	Achieved	Compliance %	Expiring Soon	Predicted %	Future Enrolments	Predicted % (inc. Enrolments
NHS|CSTF|Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year|	158 CBU5 - Inpatient Care	55	47	85.45%	13	61.82%	11	81.82%
NHS|CSTF|Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year|	158 CBU6 - Radiotherapy	44	36	81.82%	11	56.82%	12	84.09%
NHS|CSTF|Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year|	158 CBU7 - Radiology Services	33	16	48.48%	2	42.42%	2	48.48%

It should be noted that due to trainer absence, 1 ILS session was cancelled in February affecting 5 staff. These staff have all been allocated a new date to attend training in March.

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.

Sufficient availability of training dates to achieve compliance is available.

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. Names of staff not yet booked into a session to be escalated to divisional leads.
- 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.
- Areas of underperformance to be added to the risk register

Expected date of compliance	31 March 2022
Escalation route	Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Resuscitation Adult BLS Training	Target	Feb-22
	G: ≥90% A: 75% - 89.9% R: ≤74%	77.23%

Reason for non-compliance

Compliance for BLS has seen an in-month decline of 2.8%; this is the fourth consecutive month of decline in compliance.

Areas of non-compliance are as follows;

Competence Name	Org L4	Required	Achieved	Compliance %
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	158 CBU1 - Day Care & Network	70	52	74.29%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	158 CBU2 - Outpatients & Clinical Support	65	56	86.15%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	158 CBU3 - Admin Services	55	38	69.09%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	158 CBU4 - Pharmacy	38	25	65.79%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	158 CBU5 - Inpatient Care	164	128	78.05%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	158 CBU6 - Radiotherapy	139	111	79.86%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	158 CBU7 - Radiology Services	30	22	73.33%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	158 Networked Leadership	2	1	50.00%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	158 Research & Innovation	9	8	88.89%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	158 Safeguarding	6	4	66.67%

Due to trainer absence in February, one day's training was cancelled, which affected 21 bookings. A further 26 DNAs occurred in February.

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.

Sufficient availability of training dates to achieve compliance is available.

Action taken to improve compliance

- All non-compliant staff have been emailed by L&OD requesting they book onto a training session by 1st March and complete the training by 31st March. Names of staff who have still not booked onto training, to be escalated to divisional leads.
- 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.
- Areas of underperformance to be added to the risk register

Expected date of compliance	31st March 2022
Escalation route	Education Governance, Divisional Performance Reviews, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Safeguarding Children Level 3 Training	Target	Feb-22
	G: ≥90% A: 75% - 89.9% R: ≤74%	86.21%

Reason for non-compliance

Compliance for Safeguarding Children Level 3 training has seen an in month increase of 1.82%, but remains underperforming against the KPI of 90%.

Areas underperforming are:

Competence Name	Org L4	Required	Achieved	Compliance %
NHS|CSTF|Safeguarding Children - Level 3 - 3 Years|	158 CBU1 - Day Care & Network	72	62	86.11%
NHS|CSTF|Safeguarding Children - Level 3 - 3 Years|	158 CBU5 - Inpatient Care	60	45	75.00%
NHS|CSTF|Safeguarding Children - Level 3 - 3 Years|	158 CBU6 - Radiotherapy	69	62	89.86%
NHS|CSTF|Safeguarding Children - Level 3 - 3 Years|	158 Research & Innovation	22	18	81.82%

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

Non-compliant staff were emailed in February requesting they complete the training by 1st March, names of staff who have not actioned this requested to be escalated to the divisional leads.

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 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.
- Areas of underperformance to be added to the risk register

Expected date of compliance	31st March 2022
Escalation route	Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Safeguarding Adults Level 3 Training	Target	Feb-22
	G: ≥90% A: 75% - 89.9% R: ≤74%	85.06%

Reason for non-compliance

Level 3 Safeguarding Adults training compliance has seen an in month increase of 1.42%, but is still performing below the KPI of 90%.

Competence Name	Org L4	Required	Achieved	Compliance %
Safeguarding Adults Level 3 - 3 Years|	158 CBU1 Day Care & Network	72	57	**79.17%**
Safeguarding Adults Level 3 - 3 Years|	158 CBU2 - Outpatients & Clinical Support	29	25	**86.21%**
Safeguarding Adults Level 3 - 3 Years|	158 CBU5 Inpatient Care	60	46	**76.67%**

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.
- Areas of underperformance to be added to the risk register

Expected date of compliance	31st March 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:	30th March 2022	
Agenda item:	P1-60-22	
Title:	Finance Report - Month 11	
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 11) 2021-22.

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

Next steps required:	N/A

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

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

☐ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

REPORT

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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The Clatterbridge Cancer Centre
NHS Foundation Trust

1. Introduction

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

Metric (£000)	In Mth 11 Actual	In Mth 11 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	4	(20)	24		3	(43)	46	
CPL/Propcare Surplus/ (Deficit)	128	0	128		733	0	733	
Control Total Surplus/ (Deficit)	132	(20)	152		736	(43)	779	
Group Cash holding	77,415	58,192	19,223		77,415	58,192	19,223	
Capital Expenditure	4,776	5,130	354		5,099	5,130	31	
Agency Cap	63	95	32		746	1,045	299	

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 11 the Trust has been notified of £8.8m ERF income in relation to month 7 to 10, an element of which has been deferred into future months to offset potential future risks and to support the overall ICS aggregate position.

3. Operational Financial Profile – Income and Expenditure

3.1 Overall Income and Expenditure Position

The Trust financial position to the end of February is a £3k surplus, the group consolidated position is a £736k surplus. The group cash position is a closing balance of £77.4m, which is £19.2m above plan and a £15m increase in month. Capital spend has increased by £4.7m in month with the remainder of spend being profiled in month 12.

The Trust is under the agency cap by £32k in month and £299k in the year to date.

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

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Metric (£000)	Actual M11	Trust Plan M11	Variance	Actual YTD	Trust Plan YTD	NHSI Variance	Draft Trust Annual Plan
Clinical Income	17,793	18,788	(995)	192,134	190,057	2,077	207,440
Other Income	2,161	2,470	(309)	18,414	20,834	(2,420)	22,706
Total Operating Income	**19,954**	**21,258**	**(1,304)**	**210,548**	**210,891**	**(343)**	**230,146**
Total Operating Expenditure	(19,673)	(20,956)	1,283	(206,826)	(207,396)	570	(226,287)
Operating Surplus	**281**	**302**	**(21)**	**3,722**	**3,495**	**227**	**3,859**
PPJV	110	67	43	833	737	96	804
Finance Costs	(387)	(389)	2	(4,552)	(4,275)	(277)	(4,663)
Trust Surplus/Deficit	**4**	**(20)**	**24**	**3**	**(43)**	**46**	**(0)**
Subsidiaries	128	0	128	733	0	733	**0**
Consolidated Surplus/Deficit	**132**	**(20)**	**152**	**736**	**(43)**	**779**	**(0)**

The table below summaries the consolidated financial position:

February 2022 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	(77)	(883)
Donated Depreciation	81	886
Trust Retained Surplus / (Deficit)	**4**	**3**
CPL	32	286
Propcare	96	447
Consolidated Financial Position	**132**	**736**

3.3 Expenditure Position

3.3.1 The bridge below shows the key drivers between the £4k in month surplus and £20k deficit plan, which is a positive variance of £24k:

- In month 11 the Trust has been notified of an additional £2.5m ERF income relating to month 10 and an additional £237k in relation to Q3 freeze. The Trust had previously received £6.1m for M7-9. 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 covered the ERF risk up to month 11 as well as offsetting unidentified CIP non-recurrently. £6m has been deferred into future periods to offset potential further risk of not receiving ERF for month 12 and to support the overall ICS aggregate position. This is reporting into the monthly position as showing ERF income over-recovered in month by £297k. In addition the Trust has incurred lower than planned restoration costs, both pay and non-pay.

- 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 £127k overspend in month in the Divisions.

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

- Bank spend remains high at £136k in month 11, which is similar to M10, this is mainly due to sickness cover including covid.

- Drugs spend is over plan by £297k. This is offset by an increase in drugs income. As part of the 2021-22 funding agreement with commissioners high cost drugs remain on a pass-through basis.

- Non-Pay costs are showing an overspend of £58k. Unmet CIP has been mitigated by lower than plan planned restoration costs on a non recurrnet basis.

- The Trust overall position appears to be showing an under recovery of income and underspend against expenditure in month. However, this relates to our hosted Cancer Alliance service, which nets through to a £32k difference.

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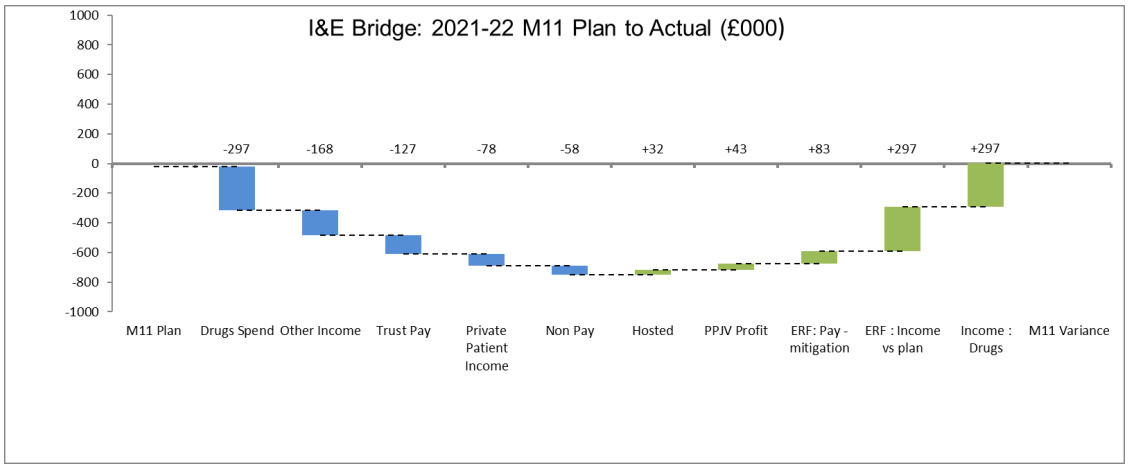

3.4 ERF Position

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 the Trust received £6.1m in relation to Q3 in Month 10.

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In month 11 the Trust has been notified of a further £2.5m of ERF income in relation to month 10 and an increase of £237k for Q3 freeze, bringing the total received to £8.8m. The Trust has used this additional income to offset the ERF risk to month 11 and additional restoration costs of £83k, as well as covering £1.1m unmet CIP non-recurrently. The remainder of the income (£6m) has been deferred into future months to offset potential future risks support the overall ICS aggregate position. It is not yet confirmed if any further ERF income will be received in relation to months 11 and 12.

3.5 Bank and Agency Reporting

Bank spend in February remains high at £136k, similar to January's spend. This is a significant increase compared to previous months where spend has been around £80k. The Acute Services Division is the largest user of bank staff. The main reasons for bank spend is to cover vacancies and increased sickness including covid.

Agency spend in month is £63k, which is in line with previous months. The Trust is reporting £32k under cap in month and £299k 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 11, of the required £1.9m Divisional target a total of £1.326m of schemes have been identified, of which £724k 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.

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 have been made available and the Trust has received additional resources. 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.

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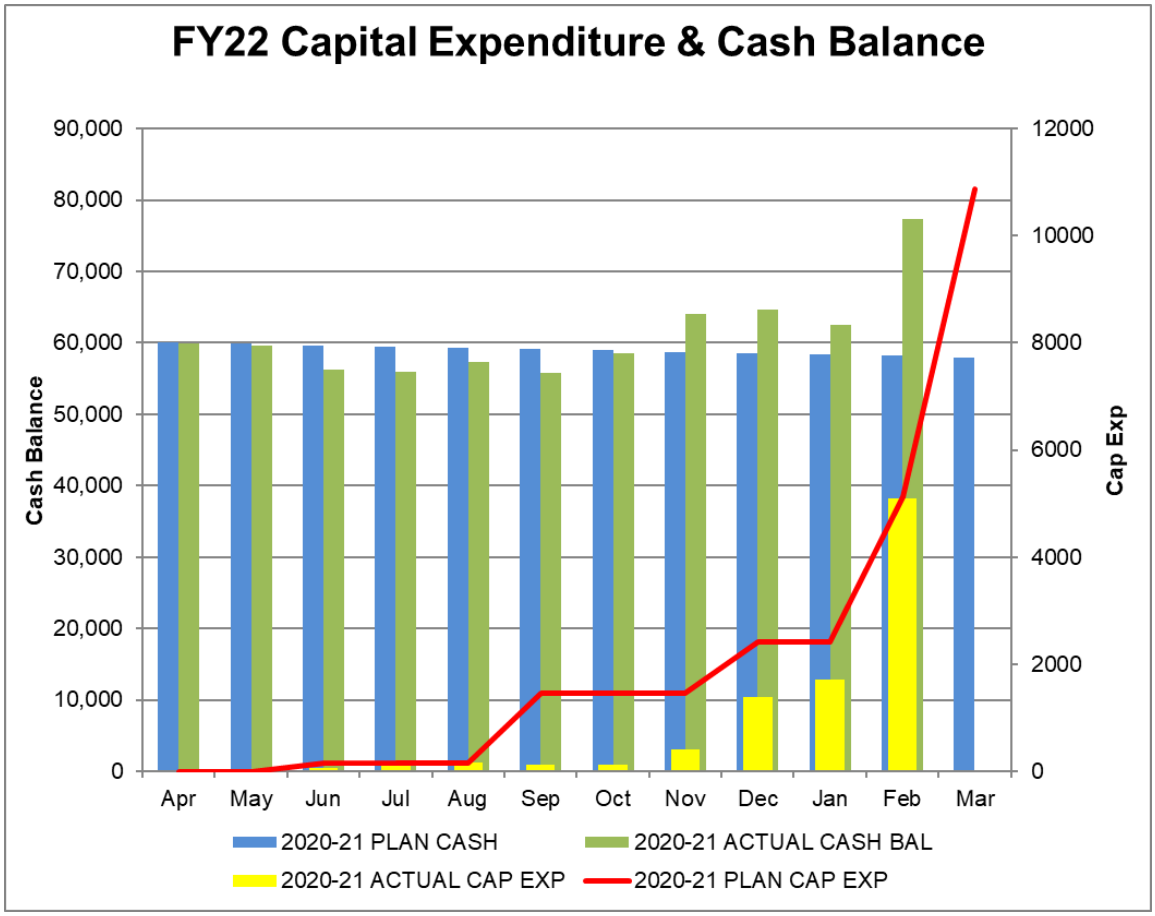
4.2 Capital expenditure of £5.1m has been incurred to the end of February, this is below the original planned spend profile for the year to date. The remainder of the Trust expenditure is expected to occur in March, a large number of orders have now been placed and receipted in March. Capital Investment 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 £77.4m, which is a positive variance of £19.2m to the cash-flow plan, and £15m compared to the previous month. The reason for the increase is due to the additional £5.9m ERF received in month, the drawdown of cash to support the additional national PDC capital schemes of £4.8m and £3m received from the charity which is the balance for the new hospital.

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



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

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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 11			Cumulative YTD				2021/22
	Plan	Actual	Variance	Plan	Actual	Variance	%	Annual Plan
Clinical Income	17,364	17,510	146	187,996	189,970	1,974		205,324
Other Income	570	770	200	5,578	5,914	337		6,073
Hosted Services	3,323	1,674	(1,649)	17,316	14,664	(2,652)		18,748
Total Operating Income	**21,257**	**19,954**	**(1,303)**	**210,890**	**210,548**	**(342)**	**0%**	**230,146**
Pay: Trust (excluding Hosted)	(5,842)	(5,885)	(44)	(63,697)	(62,090)	1,606		(69,347)
Pay: Hosted & R&I	(695)	(535)	160	(7,183)	(5,497)	1,686		(7,868)
Drugs expenditure	(7,064)	(7,361)	(297)	(75,793)	(79,816)	(4,023)		(82,857)
Other non-pay: Trust (excluding Hosted)	(4,676)	(4,734)	(58)	(50,355)	(50,118)	238		(55,085)
Non-pay: Hosted	(2,680)	(1,158)	1,522	(10,368)	(9,306)	1,062		(11,130)
Total Operating Expenditure	**(20,956)**	**(19,674)**	**1,283**	**(207,396)**	**(206,827)**	**569**	**0%**	**(226,286)**
Operating Surplus	**301**	**280**	**(21)**	**3,495**	**3,722**	**227**	**6%**	**3,859**
Profit /(Loss) from Joint Venture	67	110	43	737	833	96		804
Interest receivable (+)	401	396	(5)	4,408	4,315	(93)		4,809
Interest payable (-)	(439)	(432)	7	(4,833)	(4,834)	(1)		(5,272)
Loss on disposal of assets	0	0	0	0	(182)	(182)		
PDC Dividends payable (-)	(350)	(350)	0	(3,850)	(3,850)	0		(4,200)
Trust Retained surplus/(deficit)	**(20)**	**4**	**24**	**(43)**	**3**	**46**	**107%**	**(0)**
CPL/Propcare	0	132	0	0	733	733		0
Consolidated Surplus/(deficit)	**(20)**	**4**	**24**	**(43)**	**736**	**779**	**1815%**	**(0)**

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Appendix B – Balance Sheet

£'000	Unaudited 2021	Plan 2022	Year to date Month 11 YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	2,488	2,100	2,424	2,539	115
Property, plant & equipment	177,180	174,267	175,680	172,893	(2,787)
Investments in associates	181	181	181	314	133
Other financial assets	1,364	0	0	0	0
Trade & other receivables	161	100	281	418	137
Other assets	0	0			0
Total non-current assets	**181,374**	**176,648**	**178,566**	**176,164**	**(2,402)**
Current assets					
Inventories	4,201	4,200	4,201	4,897	696
Trade & other receivables					
NHS receivables	4,621	4,500	4,621	6,796	2,175
Non-NHS receivables	4,484	4,500	7,779	2,815	(4,964)
Cash and cash equivalents	63,533	58,000	59,875	77,415	17,540
Total current assets	**76,839**	**71,200**	**76,476**	**91,923**	**15,447**
Current liabilities					
Trade & other payables					
Non-capital creditors	28,222	30,000	28,222	33,768	5,546
Capital creditors	3,544	2,000	2,000	1,947	(53)
Borrowings					
Loans	1,916	1,730	1,730	1,905	175
Obligations under finance leases	0	0	0	0	0
Provisions	2,160	1,535	2,160	2,433	273
Other liabilities:-					
Deferred income	5,974	4,000	5,974	15,725	9,751
Other	0	0	0	0	0
Total current liabilities	**41,816**	**39,265**	**40,086**	**55,778**	**15,692**
Total assets less current liabilities	**216,398**	**208,583**	**214,957**	**212,310**	**(2,647)**
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**	**178,705**	**(932)**
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	108,632	(931)
Total taxpayers equity	**180,338**	**176,383**	**179,637**	**178,705**	**(932)**

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Appendix C – Cash Flow

February 2022 (M11) £'000	FT	Group	Group (exc Charity)
Cash flows from operating activities:			
Operating surplus	2,835	5,387	3,821
Depreciation	8,456	8,456	8,456
Amortisation	693	693	693
Impairments			
Movement in Trade Receivables	800	1,892	1,821
Movement in Other Assets	1,658		0
Movement in Inventories	(946)	(696)	(696)
Movement in Trade Payables	6,275	2,195	5,454
Movement in Other Liabilities	9,685	9,660	9,660
Movement in Provisions	49	364	364
CT paid	0	(170)	(170)
Net cash used in operating activities	**29,505**	**27,779**	**29,401**
Cash flows from investing activities			
Purchase of PPE	(3,996)	(4,852)	(4,852)
Purchase of Intangibles	(746)	(746)	(746)
Proceeds from sale of PPE	(182)	(182)	(182)
Interest received	4,315	41	12
Investment in associates	700	700	700
Net cash used in investing activities	**90**	**(5,040)**	**(5,069)**
Cash flows from financing activities			
Public dividend capital received	0	0	0
Public dividend capital repaid			
Loans received			
Movement in loans	(2,782)	(2,782)	(2,782)
Capital element of finance lease	0	0	0
Interest paid	(4,834)	(533)	(533)
Interest element of finance lease	0	0	0
PDC dividend paid	(3,850)	(3,850)	(3,850)
Finance lease - capital element repaid	0	0	0
Net cash used in financing activities	**(11,466)**	**(7,165)**	**(7,165)**
Net change in cash	**18,129**	**15,574**	**17,167**
Cash b/f	**53,765**	**63,533**	**60,248**
Cash c/f	**71,894**	**79,106**	**77,415**

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Appendix D – Capital

Capital Programme 2021-22
Month 11

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Code	Scheme	Lead	BUDGET (£'000) NHSI plan 21-22	Approved Adjustments	Budget 21-22	ACTUALS (£'000) Actuals @ Month 11	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	129	291	129	291	✓	✗	In progress
4305	CCCW Linacc Bunker - Beech	Julie Massey	0	300	300	23	277	95	205	✓	✗	In progress
4300	CCCW CT Simulator (Brilliance 2)	Louise Bunby	300	(191)	109	84	25	87	23	✓	✓	Delivered and in use, await final costs
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	✓	✗	Expected completion 25th Feb
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
4323	CCCL Ward 2 blood room conversion		0	0	0	11	(11)	11	(11)	✓	✓	Initially within revenue
	Contingency	*n/a*	200	(552)	(352)	0	(352)	92	(443)	-	-	
	Estates		**920**	**(226)**	**694**	**280**	**414**	**633**	**62**			
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	2,258	47	2,278	27	✓	✗	Delivered in Feb, Phantom due in March
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 Image Intensifier	Sam Wilde	138	0	138	0	138	108	30	✓	✗	Ordered 18th February
	MEME - Acute - Patient Monitor	Julie Massey	9	0	9	0	9	0	9	-	-	Not required
4322	MEME - Acute - 2x Ultrasound	Julie Massey	25	0	25	0	25	40	(15)	✓	✗	Ordered 18th February
4314	MEME - Networked - Scalp Coolers	Julie Massey	97	0	97	97	(0)	184	(87)	✓	✗	9 delivered Jan. Further 8 ordered 11/03
	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	618	48	638	28	✓	✗	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	✓	✗	Receipted and invoiced early March
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	60	70	✗	✗	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	✓	✗	Confirmed delivered in March
4319	Omniboard mounting adaptors	Lesley Woods	0	47	47	38	8	38	8	✓	✓	Delivered in February
4321	MRI Acceleration	Sam Wilde	0	54	54	0	54	54	0	✓	✗	Ordered 3rd Mar. PDC Funded.
4324	VT5 Birch Elbow Drive		0	0	0	28	(28)	28	(28)	✓	✓	Moved from revenue
	Contingency	*n/a*	200	(519)	(319)	0	(319)	72	(391)	-	-	
	Medical Equipment		**4,267**	**2,149**	**6,416**	**3,177**	**3,239**	**6,546**	**(129)**			
4190	***(20/21)*** Digital Aspirant	James Crowther	0	0	0	20	(20)	20	(20)	✓	✓	
	Infrastructure	James Crowther	1,350	(400)	950	575	375	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	37	840	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 Infrastru	James Crowther	0	790	790	775	15	790	0	✓	✗	New PDC funded scheme
	IM&T		**1,600**	**1,878**	**3,478**	**1,506**	**1,972**	**3,478**	**(0)**			
4142	Liverpool	Peter Crangle	0	0	0	(67)	67	(67)	67	✓	✓	
4142	Liverpool - Artwork	Sam Wade	0	66	66	0	66	43	24	✓	✗	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	23	(23)	23	(23)	✗	✗	
4313	CCCL Terraces	Peter Crangle	0	221	221	180	41	221	0	✓	✗	Charity Funded
	Building for the Future		**400**	**(113)**	**287**	**136**	**151**	**219**	**67**			
	TOTAL		**7,187**	**3,689**	**10,876**	**5,099**	**5,777**	**10,876**	**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	294,821	274,822	(264,871)	53%
CORPORATE	319,068	237,325	274,123	(81,744)	74%
NETWORKED SERVICES	547,860	543,239	78,150	(4,621)	99%
RADIATION SERVICES	453,380	250,301	96,709	(203,079)	55%
Divisional Total	**1,880,000**	**1,325,686**	**723,804**	**(554,314)**	
H1 Central	485,000	485,000	0	0	
H2 Central	1,776,000	1,776,000	0	0	
Central Total	**2,261,000**	**2,261,000**	**0**	**0**	
Overall Trust Total	**4,141,000**	**3,586,686**	**723,804**	**(554,314)**	

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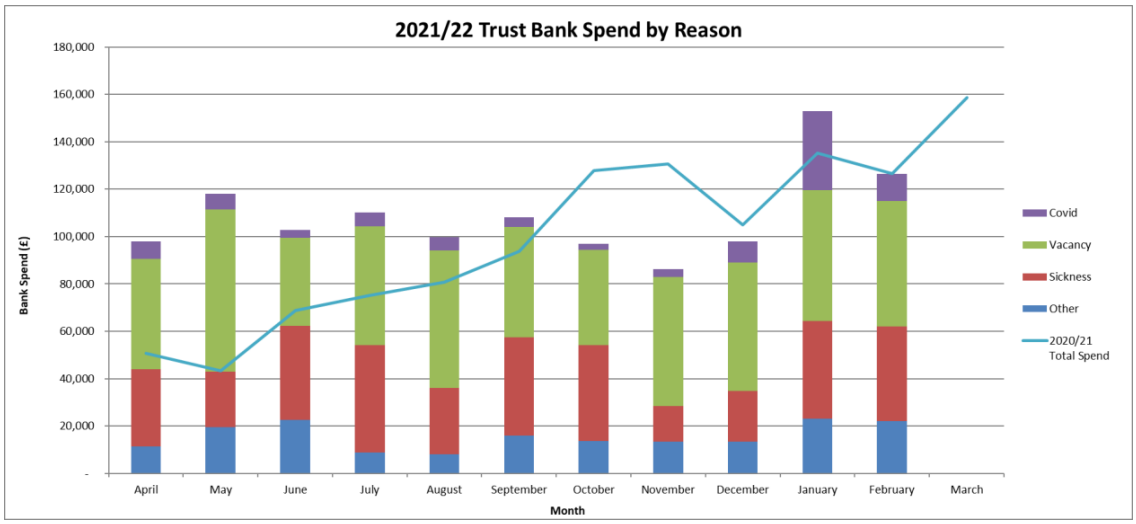
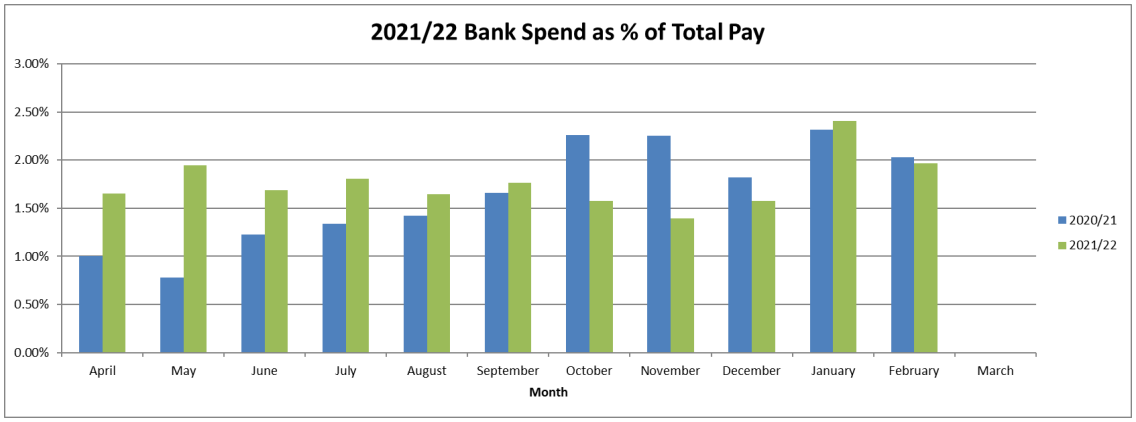
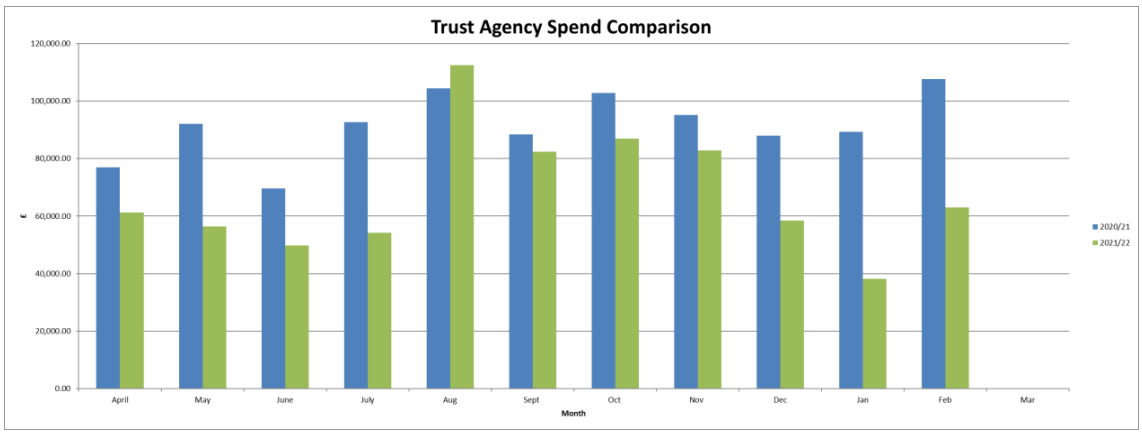
Appendix F – Bank and Agency







REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	30 March 2022
Agenda item:	P1-062-22
Title:	Gender Pay Gap
Report prepared by:	Zoë Hatch, Deputy Director of Workforce and OD
Executive Lead:	Jayne Shaw, Director of Workforce and OD
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	
Date & decision:	

Purpose of the paper/key points for discussion:	This report provides details of our gender pay gap in line with the statutory requirements set out in the Equality Act 2010 (Specific Duties) Regulations (2017). As of 31st March 2021 our average gender pay gap for hourly pay was 23.1% and our median gender pay gap for hourly pay was 19.2% indicating that we have a significant gender pay gap within the organisation. The report provides a number of metrics and provides analysis and context to support understand of our findings. A number of key recommendations have also been identified which aim to support with the reduction in the Trust's gender pay gap.

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

Next steps required:	Undertake further analysis to see how we compare to peers organisations for 2020/21 Incorporate recommendations to implementation plan for the Trust People Commitment

REPORT COVER

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

☐ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☒ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Gender Pay Gap Report

31 March 2021

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

1. Introduction

The Equality Act 2010 (Specific Duties) Regulations 2017 require public bodies with 250 or more employees to publish information on their gender pay gap on a yearly basis. The data produced in the report is a snapshot position as at 31st March of each year and each organisation is duty bound to publish this information on publically on their website. This report includes the statutory requirements and also provides context to help understand our findings and identifies a number of recommendations to reduce our gender pay gap.

2. What is the gender pay gap?

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

2.1. The Gender Pay Gap Indicators

The legislation requires an employer to publish six calculations:

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

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

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

2.2. What employees count?

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

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

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

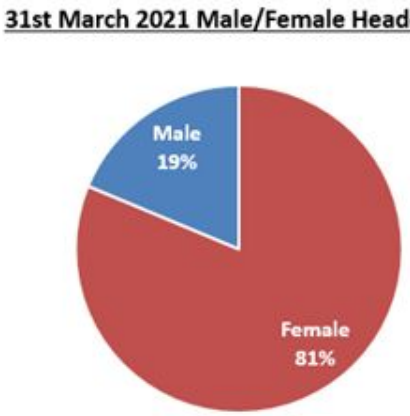
3. Our Gender Pay Gap data

3.1. Total Number of Trust Employees as at 31st March 2021

The Clatterbridge Cancer Centre NHS Foundation Trust is reflective of the position across NHS Trusts in that it employs a higher number of females than males in its workforce as depicted in Table 1.

Headcount	Female	Male	Total
	1203	277	1480

Table 1- Headcount by Gender



Graph 1- Percentage of headcount by Gender

There was a headcount growth of 41 from 2020 to 2021. The ratio of male to female staff however remains mostly reflective of the 2020 position with a marginal increase of 1% for males (Graph 1)

REPORT

NHS
The Clatterbridge Cancer Centre
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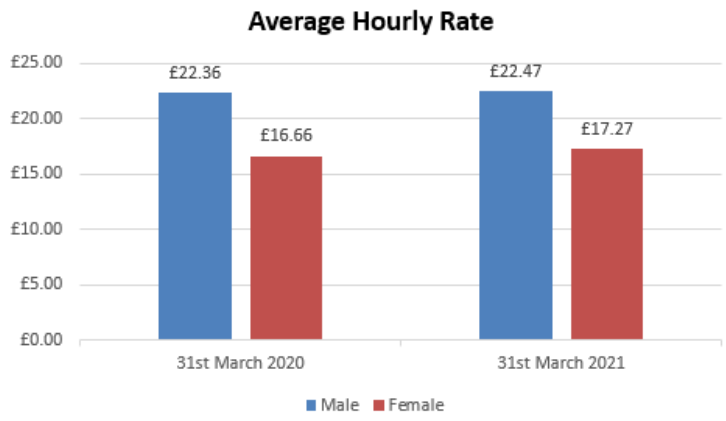
3.2. Mean (average) pay for male and female staff:

Table 2 and Graph 2 show the mean hourly pay by Gender. The average pay for males is £5.20 per hour higher than that for females, resulting in a gender pay gap of 23.10%.

Gender	Average Hourly Rate	
	31 March 2021	31 March 2020
Male	£22.47	£22.36
Female	£17.27	£16.66
Difference	£5.19	£5.69
Pay Gap %	**23.10%**	**25.48%**

Table 2- Mean pay for male and female staff 2020/2021 comparison

The mean pay has increased slightly for both men and women across the Trust, however women have seen a marginally higher increase of £0.61 per hour compared with £0.11 for men. The pay gap percentage has decreased slightly from 25.48% to 23.10%. The comparison between the 2020 and 2021 years is depicted in Graph 2



Graph 2- Mean pay for male and female staff 2020/2021 comparison

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

The median hourly rate for both males and females has increased in 2021 (Table 3). However, the median hourly rate for males is £3.72 higher than females. This equates to a gender pay gap of 19.20%. This position remains static from the 2020 report.

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NHS
The Clatterbridge Cancer Centre
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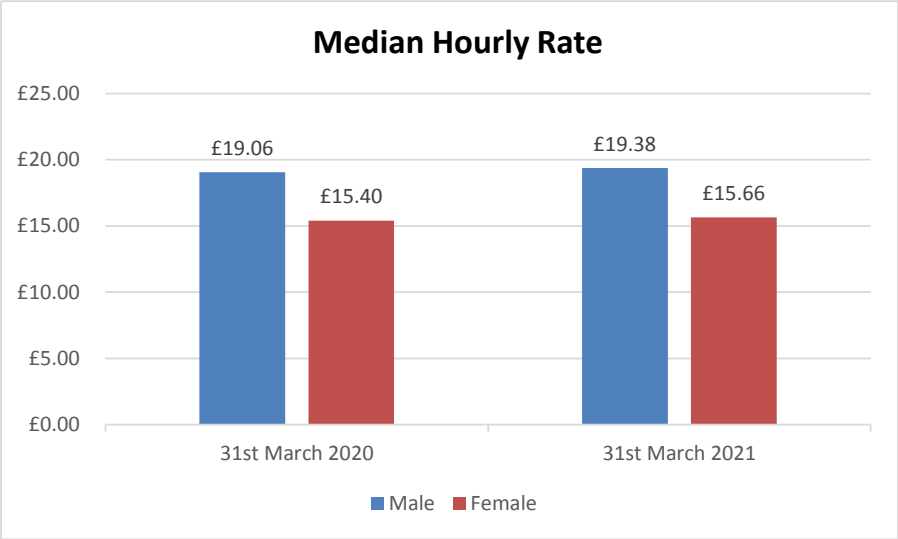
Gender	Median Hourly Rate	
	31 March 2021	31 March 2020
Male	£19.38	£19.06
Female	£15.66	£15.40
Difference	£3.72	£3.66
Pay Gap %	**19.20%**	**19.20%**

Table 3- Median pay for male and female staff 2020/2021 comparison



Graph 3- Median pay for male and female staff 2020/2021 comparison

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

Tables 4 shows the workforce divided into four equal parts (quartiles) based on pay. Each quartile represents an increase in level of pay with quartile 1 representing the workforce with the lowest pay and quartile 4 is the highest earners. Table 4 shows the proportion of males and females in each quartile for 2020 and 2021.

	2021		2020	
Quartile	Female	Male	Female	Male
1	321 (87%)	49 (13%)	298 (87%)	45 (13%)
2	319 (88%)	44 (12%)	308 (89%)	39 (11%)
3	302 (80%)	75 (20%)	277 (79%)	72 (21%)
4	261 (71%)	109 (29%)	244 (70%)	104 (30%)

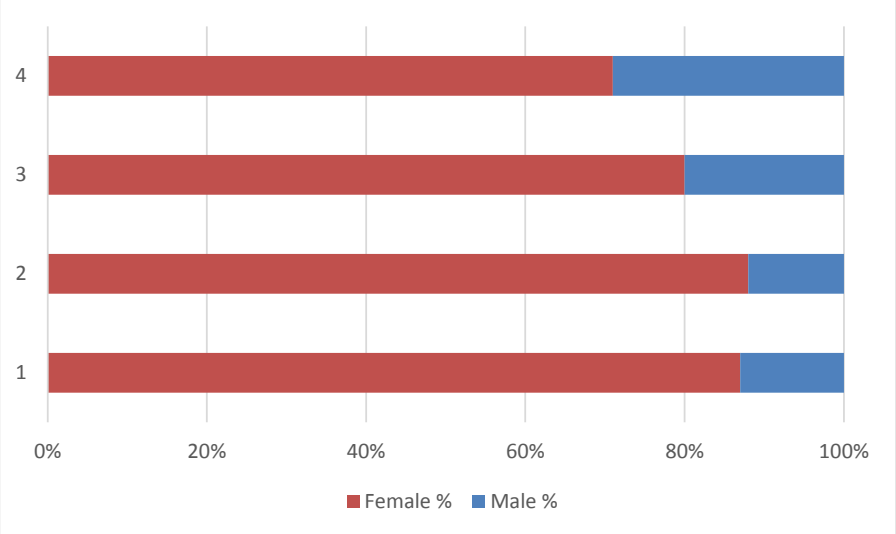
Table 4- Percentage of male and female per pay quartile 2020/21 comparison

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Table 4 demonstrate a higher percentage of female staff in each of the pay quartiles that is to be expected given the higher percentage of females employed. In quartile 4, the percentage of male staff proportionately increases suggesting that men tend to be amongst the highest earners despite only equating for 19% of the total workforce.

The above quartile analysis for 2021 is also depicted Graph 4.



Graph 4- Percentage of male and female per pay quartile (2021 data)

4. What does the data tell us?

The median pay gap position is provides a more representative position of the gender pay gap across the workforce in comparison to the mean position. However, the median figure does not take into account any anomalies that could be skewing the data. The Trust's data indicates a bigger gender pay gap in the mean pay, which suggests that there is a proportionately higher number of males earning higher salaries. This is supported by table 4 and Graph 4, which show a higher proportion of men in the higher pay quartiles.

5. Further Analysis per Staff Groups

5.1. Percentage of male and female in each staff group

An analysis of male and female ratios within the current workforce professions is summarised in the Graph 5. The data shows a higher proportion of females all staff groups, with the exception of medical and dental, and healthcare scientists staff groups.

REPORT

NHS
The Clatterbridge Cancer Centre
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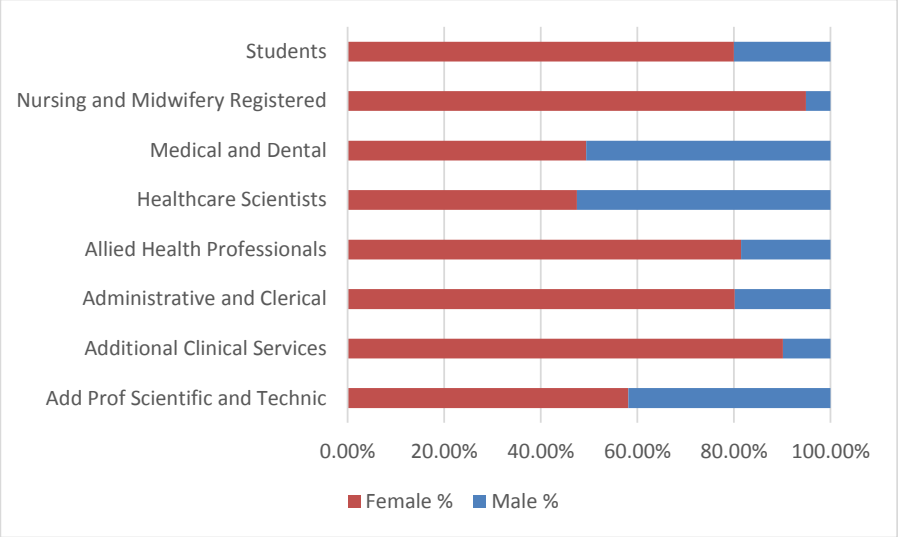
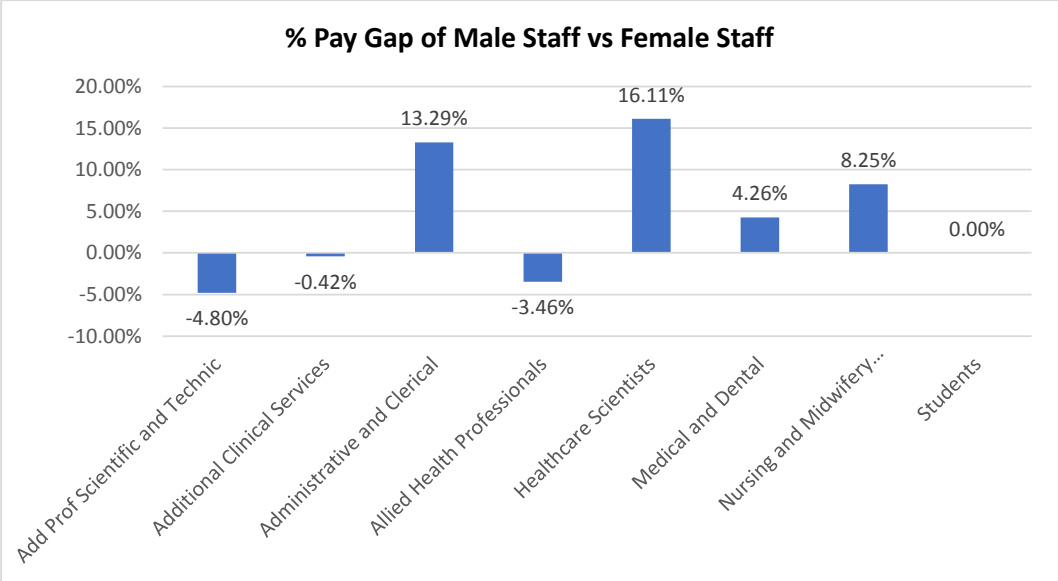


Graph 5- Percentage split of male and female staff by ESR Staff Group

Graph 6 shows the gender pay gap for each of the staff groups, a negative value indicates a pay gap that favours female staff.



Graph 6- Gender pay gap by ESR Staff Group

The gender pay gap for Administrative and Clerical, and Healthcare Scientists staff groups has increased between 2020 and 2021. For Administrative and Clerical the gap has increased from 12.21% in 2020 to 13.29% in 2021 and Healthcare Scientists, it has increased 14.15% to 16.11% in 2021. The pay gap for Medical and Dental has significantly reduced from 10.87% in 2020 to 4.26% in 2021. This reduction in part can

be accounted for by changes made to Local Clinical Excellence Awards (LCEA). During the COVID-19 pandemic NHS Employers released guidance that stipulated the LCEA funds should be equally distributed to all eligible consultants and therefore all eligible consultants regardless of years' experience received equivalent award payments. The Nursing & Midwifery staff group has also seen a reduction in pay whereas Additional Professional Scientific and Technical staff group analysis demonstrates an increase in favour of women from -1.1% to -4.80%.

The Nursing & Midwifery staff group presents an anomaly as although 95% of the workforce within this staff group is female there is an 8.25% gender pay gap in favour of male. Further analysis has identified that 50% of the total male staff within in this group are Band 7 and above whereas only 36.7% of total females with the staff group are employed at Band 7 and above.

Similarly, 80% of the Administrative & Clerical staff group workforce is female but the data presents a 13% pay gap. Analysis of the data demonstrates that the females within this staff group are predominately in Band 2- 5 roles whereas there is a higher proportion of males within higher banded roles, mainly within Digital and Physics.

6. Bonus payments

The only bonuses paid in the timeframe by the Trust were to Local Clinical Excellence Awards to Medical Consultants in line with the National Medical & Dental Terms and Conditions, which was paid equally to all eligible consultants.

6.1. Mean bonus pay of male and female staff

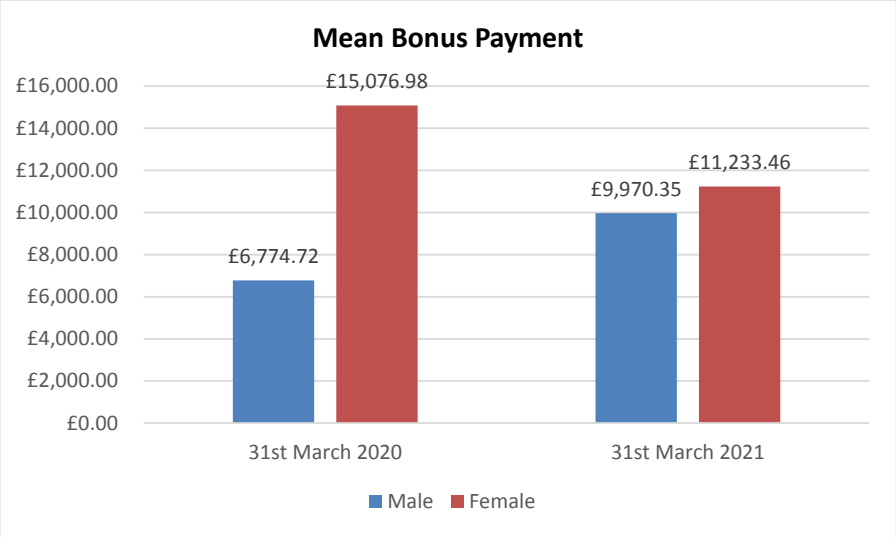
Table 5 and Graph 7 shows the average bonus pay for male and female consultants for 2021 compared to 2020. A negative pay gap percentage demonstrates a pay gap that favours women.

Gender	Mean Bonus	
	31 March 2021	31 March 2020
Male	£9,970.35	£6,774.72
Female	£11,233.46	£15,076.98
Difference	**-£1,263.11**	**-£8,302.26**
Pay Gap %	**-12.76%**	**-122.55%**

Table 5- Mean bonus pay by gender 2020-2021 comparison

The bonus payments made to the eligible Consultant staff group would indicate that the mean bonus paid to our female staff is slightly higher than male staff, however the difference has significantly reduced compared to the 2020 position. The average

bonus payment for males has increased by £3,195.63 whilst for females this has decreased by £3,843.52. One reason attributed to the reduction in the mean (average)



Graph 7- Mean bonus pay by gender 2020-2021 comparison

bonus pay for females is retirement.

6.2. Median bonus pay of male and female staff

Table 6 and Graph 8 shows the median bonus pay for male and female staff in 2021 compared to 2020. The most noticeable difference that the median bonus pay has significantly improved in favour of men in 2021.

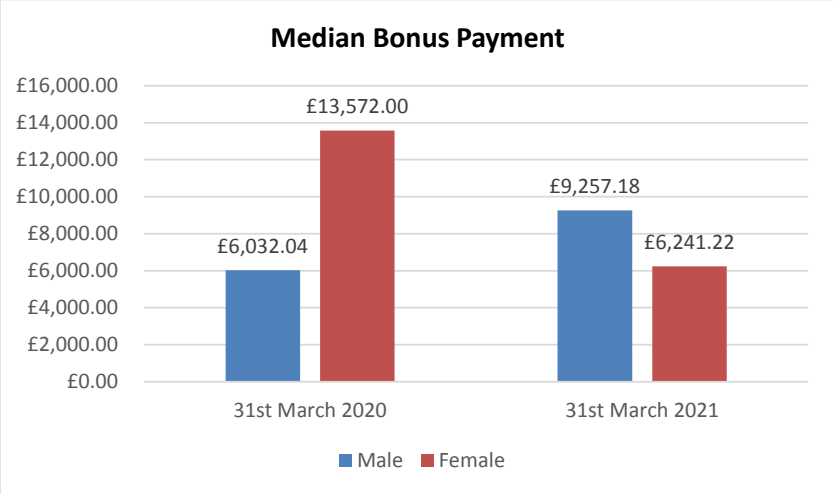
The median payment for females has decreased by 54% from 2020 to 2021 to the value of £7,330.78, whereas the median payment for males has increased by 52% (£3,225.14). This difference is due to an increase in the number of females receiving a bonus in 2021 compared to 2020.

Gender	Median Bonus Pay %	
	31 March 2021	31 March 2020
Male	£9,257.18	£6,032.04
Female	£6,241.22	£13,572.00
Difference	**£3,015.96**	**-£7,539.96**
Pay Gap %	**32.58%**	**-125.00%**

Table 6- Median bonus pay by gender 2020-2021 comparison

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust



Graph 8- Median bonus pay by gender 2020-2021 comparison

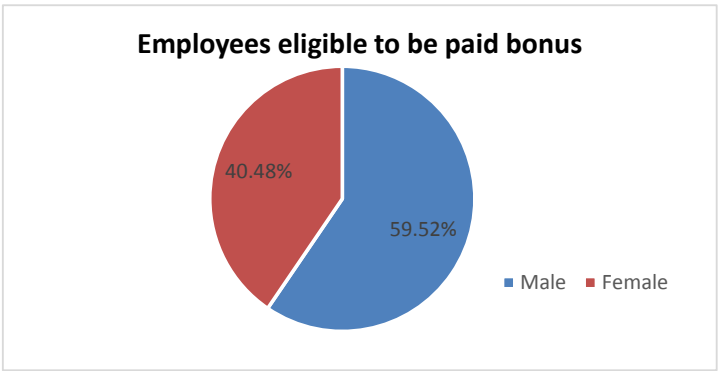
6.3. The proportion of male and female staff, who receive bonus pay

Gender	Employees Paid Bonus	Total Eligible Employees
Female	17 (100%)	17
Male	25 (100%)	25

Table 7- Breakdown of eligible staff by gender (Bonus pay)

Table 7 demonstrates the number of eligible employees for a bonus and those that received payment. Due to the changes to the processes for how LCEAs were awarded, all eligible employees (both male and female) received a bonus payment in 2021.

Graph 9 shows the percentage split by male and female of staff eligible for a bonus. There was a higher percentage of males eligible for a bonus, which is reflective of the gender split for the staff group



Graph 9- Breakdown of eligible staff by gender (Bonus pay)

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

7. How do we compare to other Trusts (2019/2020)?

Model Hospital enables us to compare our performance in a number of key People metrics against peer organisations including our gender pay gap position. The current data is reflective of the 2019/2020 submissions and we will complete further analysis for 2020/2021 data once this is available in May 2022.

In comparison to our peers across Cheshire and Merseyside when looking at the gender pay gap for average hourly pay, we fall within quartile 3, which is the Mid-High 25% range. Similarly, when we compare ourselves to our Cancer Specialist Trust peers we fall within the mid-high range.

When comparing our gender pay gap for median hourly pay we fall within quartile 4 with one of the highest gender pay gaps for this metric. The median pay gap across our peers within across Cheshire and Merseyside is 9.2% and for Cancer Specialist Trusts is 6.2%.

We have however seen improvements in our position from previous years and when compared to peers. For both our average and median gender pay gap we are within the best performing 25% of Trusts, with reductions of -3.1% and -3.7% respectively for each metric

Although the data from Model Hospital demonstrates the necessity to make significant improvements in regards to our gender pay gap compared to our peers, it also highlights that we have made some positive improvements that we need to build upon. Further analysis is required to understand why we differentiate so significantly compared to our peers, in particular for our median pay gap position.

8. What have we done to date?

Since the 2020 gender pay gap report the impact of COVID-19 has been evident and therefore the Trust has not been able to make significant progress with the previous actions identified. We have however been able to implement the following:

- The Trust has developed Hybrid Working Guidance to support staff in working flexibly in roles that allow this. The experience of working during the pandemic has illustrated that we can work differently and more flexibly whilst still providing high quality services
- The Trust has held briefing sessions on Hybrid Working and Flexible Working for managers in order to engage and educate on the importance of flexibility within the workforce and the benefits this has on staff morale, engagement and wellbeing
- In July 2021, an additional analysis report was undertaken and presented to Board to further understand the gender pay gap data. This analysis looked at the data by paybands, staff groups and removed outliers

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The Clatterbridge Cancer Centre NHS Foundation Trust

- A new Head of EDI has been appointed to work across Alder Hey, The Walton Centre and CCC. This appointment will allow us to work in in collaboration, share best practice and learning across the three specialist Trusts.

9. Conclusion

In real terms, there remains a significant gender pay gap within the Trust of 23.10% in terms of average hourly pay and 19.20% in terms of median pay. When compared to our peers we perform negatively which could potentially influence our ability to attract and retain high calibre females. Whilst some of the reasons for these differences are described in detail, this report focuses on one data set and does not include qualitative information about the experiences of our female workforce and the access to opportunities and development. This data therefore needs to be considered in conjunction with findings from the staff survey and feedback from the culture and engagement groups to ensure that improvement plans are truly reflective of staff experiences.

The data and the analysis clearly demonstrates that we need to implement and sustain long-term improvements in reduce the gender pay gap. We need to understand the differences compared to our peers and continuously review our recommendations to ensure we have robust plans to reduce our gender pay gap. The recommendations from this report will form part of our People Commitment, which will be monitored through the People Committee and Trust Board and Directions. In addition, they will also form part of our work in partnership with the Walton centre and Alder Hey Children's Hospital as part of our collaboration on Equality, Diversity and Inclusion.

10. Recommendations

- To triangulate data with staff survey findings and work in partnership with culture and engagement groups to develop a qualitative understanding of the experiences of the female workforce
- Develop a programme for identifying and nurturing talent which provides opportunities for development, celebrates success and supports individual aspirations whilst ensuring equality of opportunity.
- Continue to produce recruitment reports on a bi-annual basis to identify any gender trends across roles, paybands and stages of recruitment.
- Work in partnership with C&M workforce network to further enhance our Leadership Development offer
- Review implementation of the Hybrid working guidelines as well as data in relation to flexible working across the Trust.
- Launch of Level 3 and Level 5 Women in Leadership apprenticeship programmes

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The Clatterbridge Cancer Centre NHS Foundation Trust

- Launch of the Springboard Development Programme for Women

11. Approval

The Trust Board of Directors is asked to approve the content of this report and support the recommendations above.

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	30 March 2022
Agenda item:	P1-063-22
Title:	Five-year strategic plan – strategy implementation report
Report prepared by:	Tom Pharaoh, Director of Strategy
Executive Lead:	-
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Trust Executive Group; Performance Committee
Date & decision:	TEG 7th March – Noted; PC 23rd March – tbc

Purpose of the paper/key points for discussion:	This report provides a high-level update on progress in the implementation if the five-year strategic plan. The contents of the report have been provided by leads from across the Trust. The report draws out the commitments made in the strategy against the six strategic themes and provides an update on each of them. The report is intended to be a working document, to be developed throughout the life of the strategic plan. The first iteration of this report was developed in June 2021. At that time the Trust Board requested 6-monthly updates on the implementation of the strategy. The update scheduled in January 2022 was delayed because of the Covid-19 pressures in the Trust at the time. This iteration of the report includes a new summary page. The format and usefulness of this report will be kept under review. The Trust Board is asked to: • Note the contents of the report • Suggest improvements, amendments or developments for future iterations of the report

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

Next steps required:	

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

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

☒ BE **OUTSTANDING**

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

☒ BE **COLLABORATIVE**

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

☒ BE **RESEARCH LEADERS**

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

☒ BE **A GREAT PLACE TO WORK**

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

☒ BE **DIGITAL**

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

☒ BE **INNOVATIVE**

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

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

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

Five-year strategic plan 2021-2025

Implementation report

March 2022

The Clatterbridge Cancer Centre NHS Foundation Trust

Contents

Introduction

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

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

This report is intended to be a working document that provides a high-level update on the progress and challenges with the implementation of the strategic plan.

The first iteration of this report was developed in June 2021. At that time the Trust Board requested 6-monthly updates on the implementation of the strategy.

The update scheduled in January 2022 was delayed because of the Covid-19 pressures in the Trust at the

A note on the report

Some of the commitments outlined in this report have been updated to ensure that they accurately reflects a change in position from the wording used in the strategic plan. Where commitments have been reworded they are marked **. In addition, some commitments have been added since the publication of the strategy as key new areas of work have emerged. These additional commitments are marked ◊◊.

Highlights since last report

Be outstanding

- Production began in CCC-Liverpool aseptic pharmacy unit on 6th December 2021
- Successful transfer of the Aintree University Hospital haemato-oncology service into CCC on 1st February 2022

Be research leaders

- New Director of Clinical Research appointed in January 2022
- Clinical Research Facility (CRF) bid successful in partnership with Liverpool University Hospitals and Liverpool Heart and Chest - £5.3m awarded

Be collaborative

- Community Diagnostic Centre (CDC) on Clatterbridge Health Campus site in partnership with Wirral University Hospital opened in July 2021
- CEO now senior responsible officer for C&M diagnostic programme and Diagnostic Delivery Board established

Be digital

- Electronic patient record upgrade successfully deployed 2021
- Successful bid for funding to enhance the use of the hotline and provide remote monitoring of symptoms and side effects for patients
- Multiple business intelligence dashboards rolled out

Be a great place to work

- Leadership development through Team at the Top programme for Divisional leadership teams and Shadow Board programme
- Refresh of trust values through staff engagement complete and communicated across Trust

Be innovative

- Clinical Lead for Innovation and Innovation Manager appointed and in post
- Bright Ideas scheme launched: 40+ ideas submitted and reviewed to-date – first projects awarded funding from charity

Challenges since last report

- Continued impact of Covid-19 and elective recovery on management capacity to support delivery of the commitments in the strategic plan
- Requirement of clinical and operational teams to focus on high priority projects – aseptic pharmacy and H-O integration
- Impact of PMO transition on central capacity to support projects to deliver the commitments of the strategic plan

Key activities in next 6 months

- Agreement of divisional business plans and setting priorities for divisional and PMO support through the new Transformation and Improvement sub-Committee
- Develop and deliver an action plan to address the recommendations of the GGI developmental well-led review
- Establish a programme to prepare the Trust for the upcoming opening of the new Royal Liverpool University Hospital

- The Good Governance Institute (GGI) developmental well-led review, while largely positive, has highlighted areas for continued action and further development
- Establish an electronic patient record (EPR) optimisation programme following the recommendations of the Health Care International (HCI) review
- Share the estates masterplan for the Clatterbridge Health Campus and develop a medium-term development plan for CCC-Wirral

Be outstanding | deliver safe high quality care and outstanding operational and financial performance

Theme		Commitment	June 2021	March 2022	Next
Quality and safety	Clinical quality strategy	Implement clinical quality strategy	> Current clinical quality strategy expires 2021	> New strategy to be developed > Initial priority of New Chief Nurse to review governance and committee structures	> Clinical Strategy to be developed in Quarter 1 2022/23 linking in with National Patient Safety Strategy
Quality and safety	Patient safety	Empower staff to report near misses and incidents	> Following a review of the Trust's clinical governance structures a Patient Safety Group will be formed and led by new Associate Director of Clinical Governance > Group will lead the delivery of the national patient safety agenda in the Trust and report to Integrated Governance Committee	> Patient Safety Group has been established and is currently being embedded > Work has been completed to establish a Patient Safety staff intranet page which is managed by the governance team	> A review of the gap analysis of the National Patient Safety Strategy has been undertaken > This will assist in developing a plan - this is also linked into the clinical governance business plan
Quality and safety	Patient experience and involvement	Implement our dementia and learning disability strategies	> Implementation of the dementia strategy (2019-2021) remains on track as it enters its third year > The Trust has over 45 Dementia/Learning Disability and Autism Champions who support the delivery of the strategy ensuring robust provision and monitoring of work plans	> Implementation of the dementia and learning disability and autism strategy remains on track > Reduction in the number of Dementia/Learning Disability and Autism Champions due to the effects of Covid-19 > Departure of Trust Lead for Dementia/Learning Disability and Autism in November 2021 > NHS Improvement report on NHS Learning Disability Improvement Standards not received by the Trust	> Revision of both strategies to be undertaken by April 2022 > Await receipt of report on NHS Learning Disability Improvement Standards to inform the revision of the strategy > Recruitment of a new Practitioner for Additional Needs is underway > Once the new practitioner in post, a review of the champions will be undertaken and recruitment of new champions as part of the work plans

Theme		Commitment	June 2021	March 2022	Next
Quality and safety	Patient experience and involvement	Implement our patient involvement and engagement strategy	> The Trust is engaged in the NHS Improvement Learning Disability Standards to measure the quality of service provision to those with a Learning Disability and/or autism > We also contribute to the LeDeR programme and have a Safeguarding Practitioner who is the Lead for this work plan	> Trust has continued to work with national, regional and local peers, stakeholders and networks to complete delivery of the Patient and Public Involvement and Engagement Strategy 2019–21 > All eight pledges and associated action plans tracked, actioned and implemented via the Patient Experience and Inclusion Group (PEIG) > In early 2021 work commenced at CCC to implement the NHS England & Improvement Patient Experience Improvement Framework > Co-production of new Patient Experience, Engagement, Inclusion and Involvement (PEEII) 'Commitment' by Q4 2021/22	> 2021-2026 Patient Experience, Engagement, Inclusion & Involvement Commitment to be presented to Board in Q4 2021/22 and launched in March 2022 > Work with L&OD and partners on a staff educational/training package in improving for patient experience > Establish reportable metrics in the form of a PREMs dashboard (including FFT, national surveys) for staff to access
Quality and safety	Quality improvement	Review and refresh our quality improvement methodology	> Work undertaken with Advancing Quality Alliance (AQuA) to refresh our approach to quality improvement and build a culture and system for improvement	> No further work in this period – pending commencement in post of Chief Nurse	> Review external support for quality improvement > Development of a quality improvement approach and strategy
		Provide training for staff in quality improvement skills to equip staff to lead change and improvement	> Work with AQuA also includes the building of QI capacity across the Trust, initially through the development of a programme of masterclasses to take place during the rest of 2021/22	> Masterclasses have taken place, others to come > Review of programme to take place once complete	> Establish a structured training programme once quality improvement methodology is agreed and strategy in place

Theme		Commitment	June 2021	March 2022	Next
Quality and safety	Clinical governance	Embed new clinical governance structure	> Staff turnover in clinical governance leadership positions has prompted a further review of the Trust's clinical governance structures	> New Chief Nurse and Associate Director of Clinical Governance and Patient Safety > Ongoing review of governance structures > New governance managers have been appointed and commenced in 2022	> Implementation and embedding of reviewed governance structures, roles and responsibilities
Quality and safety	Regulation and accreditation	Maintain good CQC rating while striving for outstanding	> CQC now using 'transitional monitoring approach' (TMA) that sees inspection targeted when monitoring of risks and key lines of enquiry raises concerns	> CQC has developed a new strategy for monitoring trusts over next five years > As part of this new standards of care are being developed which will be launched in spring 2022 > Developmental well-led review by Good Governance Institute (GGI) largely positive with some recommendations for action	> Once new standards released a review will be completed to establish Trust base line position and any improvement required > New process for internal monitoring of standard and KLOEs to be established to provide assurance to the Board > Develop and implement action plan from GGI review, to include review of Board Assurance Framework and how it is used
		Maintain key clinical accreditations and compliance with regulatory standards	> Register of regulatory and advisory relationships developed following recent clinical governance review > Includes dates of upcoming visits, inspections, accreditations and submissions > Also details who lead contacts are and current status of relationships	> Role of Governance Managers to ensure all regulatory visits and inspections are registered and reported on > Monthly reporting of regulatory register to Integrated Governance Committee	> Ongoing maintenance of and reporting on regulatory register > Focus on renewal of key accreditations, e.g. JACIE accreditation for stem cell transplant

Theme		Commitment	June 2021	March 2022	Next
Quality and safety	Supporting quality of care	Work with the charity to develop a quality of care grant to continue to fund services that are over and above those commissioned by the NHS	> General plans in development to align fundraising plans with the implementation of the five-year strategy	> Ongoing work with Charity to align fundraising plans with Trust strategy > Charity continues to fund elements of care beyond NHS standard	> Continue to align charity and Trust strategies > Review relevance of commitment to develop 'quality of care grant' and reword in future reports as necessary
Operational performance	Clinical structure	Reorganise clinical divisions to underpin SRG model	> Reorganisation undertaken and now complete > New clinical structure in place and communicated across the Trust	> New clinical structure now embedded	
Operational performance	Maximising the benefits of CCC-Liverpool	Fully integrate services for haemato-oncology and solid tumour patients in the chemotherapy unit and non-chemotherapy day case area	> Project group forming to progress > Work to be based on an assessment of activity following move plus changes to patient pathways	> Oversight group and work streams established > Prioritisation of work streams identified > Brachytherapy work stream complete	> Blood transfusion and phlebotomy pathway reviews underway > Some elements of strategy for day case area are dependent on other developments
Operational performance	Maximising the benefits of CCC-Liverpool	Further integrate our haemato-oncology services with those in the North Mersey area	> Programme underway to integrate Aintree University Hospital haemato-oncology service into CCC > Steering group in place with representation of CCC, LUHFT, commissioners > Business case drafted > Comprehensive program of public engagement led by CCC	> Public engagement successfully concluded > Business case finalised and agreed at Trust Board 15.12.21 > Financial model agreed with a plan to mitigate stranded costs > Formal TUPE consultation commenced 16.12.21 > Due diligence process completed > Service transfer took place successfully on 1st February 2022	> Agree service specifications > Lessons learnt review to be undertaken

Theme		Commitment	June 2021	March 2022	Next
		Manage the comprehensive service level agreement	> Regular oversight group in place between LUHFT and CCC > Suggested changes to clinical services in SLA to be developed through Clinical and Operational Group and Trust Executive Group before discussion at joint oversight group with LUHFT	> Following the Joint Oversight Group meeting held in June, it was agreed that this would be re-purposed to an operational group for the ongoing review and management of the SLA and operational issues > A further meeting date has yet to be arranged due to operational pressures and a management restructure at LUHFT	> Discussions underway with the LUHFT Senior Management & Divisional Management teams to set regular meeting dates in 2022
		Report on delivery of benefits of CCC-L	> Work not yet begun	> Work to be scheduled into PMO programme for Q2 of 2022/23	
Operational performance	Developing our services	Fully open our teenage and young adult (TYA) unit in CCC-L	> The TYA day case unit opened in February 2021 providing chemotherapy and other supportive cancer care in a dedicated day case facility > The TYA in-patient unit opened in April 2021 with four beds staffed with a mix of Haemato-oncology and Solid Tumour nursing staff trained in the delivery of SACT	> Fluctuation in demand has led to challenges in staffing TYA inpatient unit > TYA inpatients now accommodated on Ward 5 bed base > Review of inpatient capacity and demand underway	> Conclude review of inpatient capacity and demand > Gap analysis against national TYA service specification
Operational performance	Developing our services	Develop an interventional radiology service	> Project group formed to lead the development of the service in CCC-L > Service will support service delivery and research > Joint working needed with interventional radiology service at Royal Liverpool	> Business case for additional equipment (pump injector) approved > Review of current activity and forecast of future growth complete > Meetings regarding nursing support and recovery underway > Regular progress updates submitted to TEG	> SRG Chairs Forum to be approached (Jan 22) to identify IR procedures clinicians want to be undertaken at CCC > Develop optimal model of procedures to be offered at CCC-L vs provided in LUHFT > Ongoing discussions regarding nursing support and recovery

Theme		Commitment	June 2021	March 2022	Next
Operational performance	Developing our services	Upgrade the National Centre for Eye Proton Therapy	> Contract with external contractor agreed to upgrade safety critical control system > Commercial treatment planning system procured > Engineering programme manager recruited and in post	> Upgrade to safety critical control system with external contractor progressing well > Additional revenue costs agreed with NHS England specialised commissioning team > CCC proton upgrade committee established to provide oversight and documentation of internal component upgrades > First group of upgrades approved	> Evaluation of commercial quality assurance devices for low energy proton use > Implementation of first group of component level upgrades > Development of second group of component upgrades > Recruitment of additional engineer to support internal component upgrades
Operational performance	Developing our services	Develop a sustainable and high quality model of care for referrals from the Isle of Man	> CCC clinicians formerly provided an element of service on island > Covid-19 expedited an ongoing review of the service > New service model developed of remote care with face-to-face consultation on mainland > Supported by digital team and electronic prescribing	> Regular joint operational and strategic meetings developed to continue collaboration and integration	> Mitigate IT operational issues for efficient remote telehealth consultations (escalated to CEO Manx Care Nov 21) > Integrate IOM MDTs (Breast/CRC) into merged LUFHT MDTs (Q1 2022/23)

Theme		Commitment	June 2021	March 2022	Next
Operational performance	Developing our services	Fully open aseptic pharmacy production unit in CCC-L◊◊	> Preparations for opening unit continue > New Aseptic Pharmacy Move Programme Board created with executive leadership to oversee and scrutinise preparations > Plans in place or in development for both facility readiness (including estate readiness and unit cleanliness) and service mobilisation (transition plan and workforce/training plans)	> NWPQA completed audit of Aseptic Unit on 29.11.21 – no concerns highlighted > Aseptic Pharmacy Move Programme Board approved move on 30.11.21 > Production started on 06.12.21	> Plans in development for increasing activity on South side at CCCL, starting process validation on north side and development of batch production > These will facilitate the transfer of HO products from LUHFT and repatriation of outsourced products > Aseptic Pharmacy Board will continue to maintain oversight of activity – working with new Director of Pharmacy > Gain MHRA licence for CCC-L unit > Deliver recommendations from national aseptics implementation board
Operational performance	Embedding our clinical model	Continue to work with our partners on the development of the CCC eastern sector hub	> Progress delayed by covid-19 pandemic > Ongoing engagement with commissioners > Recent positive correspondence received	> Exec Team representatives joined commissioners at 4 Local Authority Health Overviews and Scrutiny Committees (OSCs) in late 2021 > Al 4 OSCs (Knowsley, St Helens, Warrington, Halton) concluded that the proposals constituted a 'significant variation' to services and that a joint OSC should be formed to scrutinise further	> Knowsley CCG continue to lead process and liaise with Local Authorities to arrange joint OSC > CCC team to be closely involved in preparations for joint OSC to ensure clinical case is clear and limited impact on populations is understood

Theme		Commitment	June 2021	March 2022	Next
Operational performance	Improving urgent and unplanned care	Develop a comprehensive and coordinated approach to urgent cancer care	> Programme Board developed by CCC with partners from across the system > Clinical, executive and programme leadership for programme board come from CCC > Aim of board is to draw together relatively disparate activity into coherent programme	> Urgent cancer care programme continues with excellent engagement and support from across the system > Specific work underway (with dedicated funding) on acute Oncology and same day emergency care > Further funding proposal submitted to CMCA to continue work for the next 2 years and support CCC hotline infrastructure to deliver more efficient coordination of emergency cancer care across C&M	> Confirm the urgent cancer care programme work programme for 2022/23 and associated funding stream/s > Review of consultant of the week/consultant of the day and exploration of new medical model
Operational performance	Improving urgent and unplanned care	Support coordinated expansion of acute oncology services across the region	> Project manager in place and funded by Cheshire and Merseyside Cancer Alliance > Recent extension of project manager term	> Acute oncology project is now in the implementation phase with roll out of a number of initiatives including the AO/urgent care dashboard across 3 trust sites in C&M	> Work plan developed for 2022 with clear milestones for delivery
Operational performance	Improving urgent and unplanned care	Consider whether the operating hours of CDU should be extended to cover the weekend	> Reviews of Hotline service and CDU in early 2021 resulted in service improvements and further action plans > Consideration of extended hours now in context of wider service review and entire urgent cancer care system	> Following the move into CCCL, further work is required within CDU to ensure efficient pathways both in and out of the department > Proposal for a specific programme of work relating to CDU is in development with a view to commencing in early 2022 > Further work will be required to agree pathways with LUHFT and other ambulatory units	> To finalise the proposal for CDU and develop a work plan for 2022 > Focus on virtual wards and remote monitoring > Provide dedicated project support from March 2022

Theme	Commitment	June 2021	March 2022	Next
High quality environments	Redevelop the CCC-Wirral site	> First phase of refurbishment and consolidation of office accommodation to allow removal of portakabins now complete > Joint estates masterplanning process underway with WUTH for Clatterbridge campus	> Joint estates masterplanning process concluded and output presented to Board > Joint expression of interest submitted to new hospitals programme for investment > High volume of competing bids for limited pot > R&I Building (leased from WUTH) vacated and staff accommodated elsewhere on site > Initial discussions between Trust and new PropCare Managing Director regarding development of plans for CCC-W in short, medium and long term	> Await final outcome of new hospital programme expression of interest > Develop plan for further short to medium term site redevelopment with PropCare > Develop clear communications with staff on short/medium term plans, masterplanning outcome, and longer term vision for the site
High quality environments	Work with the charity to develop a plan for the upgrade if priority patient environments across our sites	> General plans in development to align fundraising plans with the implementation of the five-year strategy	> Ongoing development of aligned plans > Initial discussions regarding potential to fundraise for refurbishment of Halton unit	> Continue to develop and refine plans through Trust Executive Group > Further site visit to Halton unit to understand future clinical flows and potential principles for refurbishment
High quality environments	Move relevant staff into The Spine and develop the our relationship with RCP	> Spine opened in 05/2021 > Corporate departments, charity team and divisional management now located in building > Meet and greet with senior RCP team in May 2021 > Site visits have taken place for key staff to RCP event and education floors	> Review of use of accommodation has taken place > Proposals developed to adapt space to increase utilisation and bring corporate teams together	> Variation request to be submitted to PropCare for necessary changes > Communication of proposed changes to affected teams and others accommodated in Spine

Theme	Commitment	June 2021	March 2022	Next
Financial performance	Deliver a productivity improvement programme	> Cost improvement programme launched in May 2021 with a focus on recurrent savings to support critical investments	> Monitoring of development and delivery of cost improvement programme schemes through Finance Committee	> Ongoing monitoring
Financial performance	Deliver an effective capital programme	> Five-year capital programme in place > Business case process to ensure investment in the areas that deliver sustainable services and the latest care for patients	> Ongoing process delivered through TEG, Finance Committee and Capital Committee > In the process of replacing a linac in Aintree, planning CT at Wirral and planning for a linac replacement at Wirral early 2022	> Ongoing process delivered through TEG, Finance Committee and Capital Committee
Financial performance	Deliver our partner programme, increasing charitable income and continuing to grow the private clinic	> Building charitable programme to recover following impact of Covid > Linking fundraising plan with strategy implementation > Strong focus on research & innovation and patient environments > Private clinic growth focused on new services (like interventional radiology) and new markets (Liverpool following the move to CCC0L, and haemato-oncology	> Continuing to build charitable programme and develop new opportunities > Exploring potential benefits of charity independence from Trust > New PropCare Managing Director and new lead for private patient joint venture to lead future plans and growth	> Continue to explore charity independence and conclude with a clear recommendation > New leads to develop future plans in PropCare and PPJV
Sustainability	Develop plans to continue to create social value in our local communities and reduce our waste, water consumption and carbon footprint in line with the ambitions set out in the NHS Long Term Plan	> Sustainability group in formation to lead the development of a Green Plan for the Trust > Led by Director of Strategy with representatives from PropCare, Workforce, Procurement and Communications initially	> External expertise engaged to support development of Green Plan by January 2022 and submission to HCP > Staff communication and engagement around Green Plan development > Board approval of Green Plan	> Development of detailed action plan to support Green Plan delivery > Delivery will be through Sustainability Action Group > Explore recruitment of dedicated Sustainability Programme Manager to drive implementation

Theme	Commitment	June 2021	March 2022	Next
			> Sustainability Group has continued to progress interim work plan while longer term Green Plan in development	

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

Theme	Commitment	June 2021	March 2022	Next
Cheshire & Merseyside Cancer Alliance	Play a full part in the work of the Cancer Prevention Steering Group	> Cancer alliance prevention steering group has been affected by covid-19 pandemic - due to restart in summer 2021	> Director of Strategy now represents Trust on cancer alliance prevention steering group > Work underway with HCP team to sign up to C&M prevention pledge	> Continue developing the Trust's action plan for the C&M prevention pledge
	Work through the alliance to explore whether any of our services could develop the rapid diagnostic service (RDS) model to support the delivery of the 28-Faster Diagnosis Standard**	> Cancer alliance programme focuses on Rapid Diagnostic Services (rather than 'Centres') to emphasise pathways rather than buildings > CCC teams currently involved in development of two RDSs - one for primary liver cancer patients (with LUHFT colleagues) and one for haemato-oncology patients	> Development of H-O Rapid Diagnostic Service for Lymphoma has been driven by CCC > First section of this pathway piloted at AUH site (in service that has now transferred to CCC) > CCC team also involved in liver RDS with LUHFT and cancer alliance team – optimal liver timed pathway developed	> Confirmation of funding from CMCA to implement the whole of this pathway expected > Includes a collaborative working between CCC & LUHFT to deliver a partial "same day" diagnostic service for suspected lymphoma patients, followed by additional "rapid access" to CT and core biopsy
Cheshire & Merseyside Health & Care Partnership	Play a full and active role in the partnership	> CCC CEO is SRO for Cancer Alliance (the cancer vehicle for the HCP) and endoscopy network > CEO has also led the development of the Community Diagnostic Hub (CDH) programme for Cheshire and Merseyside with input from others at CCC	> Continued active role in Health & Care Partnership and with Provider Collaborative (CMAST) > CEO continues to lead Community Diagnostic Centre (CDC) programme - CCC successful in bid to be added to procurement framework as prime provider for CDCs in C&M > CEO now also SRO for wider HCP diagnostic programme > HCP Diagnostic Delivery Board established in January 2022	> Continue to develop role within the HCP > Continue to lead CDC programme and develop prime provider role

Theme	Commitment	June 2021	March 2022	Next
Cheshire & Merseyside Health & Care Partnership	Work with WUTH to develop a Community Diagnostic Centre on the Clatterbridge Health Campus ◊◊	> Clatterbridge health campus (which includes CCC-W) has been agreed as an early adopter CDH site > Trust teams now working with WUTH to implement CDH by July	> CDC on Clatterbridge Health Campus site ("Clatterbridge Diagnostics") opened in July 2021 in partnership with WUTH > Makes use of CCC imaging capacity and previously vacant estate (Papillon Suite)	> Continue to work in partnership with WUTH to further develop Clatterbridge Diagnostics service
Cheshire & Merseyside Health & Care Partnership	Work collaboratively with our partners in C&M and offer mutual aid where appropriate	> Trust has undertaken significant amounts of mutual aid in imaging for partners in the system during Covid pandemic (WUTH and LUHFT)	> Continuation of imaging mutual aid > Trust has accepted appropriate inpatient transfers from acute providers across C&M during pandemic > Wirral Community Trust has operated intermediate care facility in wards on the CCC-Wirral site since January 2021	> Continue to collaborate and offer mutual aid to system partners as appropriate > Transition into a sustainable part of the C&M radiology network
Operational Delivery Networks	Play a full and active role in the North West Radiotherapy ODN **	> CCC CEO is chair of the ODN and members of the team are actively involved in its work programme > Work to date has focused on clinical sustainability of low volume services > CCC has been allocated 3 stereotactic ablative radiotherapy (SABR) centres to mentor	> Ongoing work on low volume services, including service change for sarcoma and transfer of CCC paediatric radiotherapy to Manchester > Mutual aid has been provided to one of the centres in the ODN in gynae and this will continue > Ongoing work to mentor 3 allocated stereotactic ablative radiotherapy (SABR) centres	> Continue to actively participate in ODN and its work programme > Work through ODN to complete proposed service changes for low volume services

Theme	Commitment	June 2021	March 2022	Next
Operational Delivery Networks	Play a full and active role in the North West Teenage and Young Adult ODN ◊◊	-	> NW TYA ODN formed with Christie as other primary treatment centre > ODN hosted by Christie and chaired by CCC Chief Operating Officer > Programme Manager recruited and outline work programme agreed	> Programme Manager in post > Regular ODN Board meetings scheduled > Work programme to be formalised and delivered with support of Programme Manager
Genomics	Ensure molecular diagnostic testing is available and access to molecular testing is embedded into pathways	> Ongoing engagement with nascent North West Genomic Medicine Service Alliance hosted in Manchester > Creation of Genomics Steering Group to lead the genomics agenda within the Trust > Also liaison with cancer alliance as whole system approach necessary	> Genomics Steering Group continues to meet and deliver work plan > Genomics Operational Group now formed to map detail of current genomic testing pathways and opportunities for improvement > Bids submitted with cancer alliance for regional genomic funding through Genomic Medicine Service Alliance	> Operational group to map priority pathways and identify potential to improve, including through digitisation > Await outcome of regional funding bids and develop project structures to deliver as appropriate
Other partnerships	Explore where there will be benefits to working together with specialist trusts in areas like estates, innovation and research	> Ongoing collaborative working with Liverpool's other specialist trusts	> CEO now also vice chair of the national Federation of Specialist Hospitals (FoSH) > Continued collaborative working through Liverpool Specialist Provider Alliance > Early discussions about increased collaboration across all Liverpool provider trusts	> Continue to engage in the work of FoSH > Continue to work with Liverpool specialist trusts > Engage with future discussions around collaboration across Liverpool

Be a great place to work | Attract, develop and retain a highly skilled, motivated and inclusive workforce to deliver the best care

Theme	Commitment	June 2021	March 2022	Next
Leadership	Enhance leadership skills and capacity across all levels of the trust, with an increased focus on supporting middle managers and developing a pipeline of talent	> Launch of the Trust Leadership and management passport and coaching framework > Leadership and management apprentice programmes	> Team at the Top programme launched in November 2021 for Divisional leadership teams > Shadow Board Development programme was completed from September 2021 – December 2021 > Prospectus of in-house Leadership and Management courses for 2022 developed > Talent mapping report developed from PADRs and used to support effective engagement onto 2022 leadership and coaching programmes > Identified as a pilot trust for the NHS Scope for Growth Talent Model	> Development of peer support for Shadow Board members and coaching support for all participants > Launch leadership and management course in January 2022 > Implement of Leaders induction programme by April 2022 > Implement Scope for Growth Model (awaiting timescales from NHSE/I > Work with C&M specialist trusts to explore the possibility of developing a collaborative leadership/talent management programme
Leadership	Reorganise the directorate structures to ensure the SRGs are embedded	> Reorganisation complete > Implementation of new structure onto all workforce systems	> Increased engagement/OD work with divisions to strengthen and support team integration and ways of working	> Continue to support divisions with bespoke OD interventions, including the further roll out of the Core Strength Team Development Programme
Leadership	Develop an AHP strategy to harness the potential and enhance the value of AHPs	> Linda Williams (Lead AHP) leading on development > Draft developed and engagement with AHP staff taking place	> On hold – Joint Nursing and AHP strategy to be developed > Three AHP OD events have taken place to support identify key APH priorities > Engaged and supporting the HEE AHP Workforce Priorities project	> Support with future engagement/ OD work in developing the joint Nursing and AHP strategy

Theme	Commitment	June 2021	March 2022	Next
Recruitment	Promote a compelling employer proposition placing emphasis on the harder to recruit groups		> Recruitment offer being reviewed and development of corporate recruitment branding framework for all roles	> Overhaul of the recruitment strategy in line with the national People Plan and EDI agenda > Hold regular recruitment fairs for all professional groups
Recruitment	Focus on the recruitment of a research workforce for the future, including academic clinicians and clinician scientists		> Research Strategy development and approved in November 2021	> Implementation of Research strategy
Recruitment	Work with schools, colleges, universities and community groups to improve access routes for local people into Trust jobs	> Links developed across Liverpool city region with schools, colleges and employability programmes to support Together for Children (TfC) agenda > Work paused due to Covid	> Work continues to be paused due to COVID-19 > Plans being developed to participate in school career events from February 2022 and to launch a Step into Health Programme in Feb / March > Working in partnership with Liverpool City Region to promote roles and opportunities to local community groups – including new LCR site for advertising jobs > Partnership developed with Liverpool Compact	> Developing Work Experience coordinator role as part of the L&OD team to support access to opportunities to local schools and colleges > New Work Placement policy in development > Working in partnership with Liverpool City Region Employment and Skills Team to promote roles and opportunities to local community groups
Workforce transformation	Continue to develop our innovative approach to workforce planning, creating new roles and new career pathways		> Report to Workforce Transformation Committee in November, highlighted opportunities to increase engagement with apprenticeships, especially clinical pathways > Commitment for divisions to feature apprenticeships in next round of business planning	> Increase manager awareness of the apprenticeship opportunities available for both new roles and as a means of developing current staff

Theme	Commitment	June 2021	March 2022	Next
Workforce transformation	Sustain agile ways of working in support of our multi-site clinical model beyond Covid-19		> Development and launch of Hybrid Working guidance in December 2021	> Delivery of Hybrid Working sessions for managers
Retention	Provide a comprehensive reward and recognition package	> Trust will be gifting all staff with a 'wellbeing pass' and a £25 gift voucher in recognition of hard work and support during the pandemic	> Review of reward and recognition offer across the Trust including staff benefits and recognition programmes	> Host staff awards ceremony to recognise the achievements of individuals across the organisation
Retention	Continue and refine the e-PADR process	> Health and Wellbeing conversation aligned to 2021/22 PADR (in line with People Plan) > Draft specification sent to Informatics Merseyside for enhancements to talent management process and reporting	> Significant enhancements made to the system which included: > Health and Wellbeing section developed and implemented > New Trust objectives added to the system > New starter pathway developed and implementation > A set of trust wide objectives at an individual and manager level developed and implemented > Talent Report developed and shared with HRBP Team bi-annually to support succession planning	> Continue to refine e-PADR process including utilisation of the new ESR platform > E-PADR data to be used to inform Learning a Development and Leadership Development plan over the next 12 months > Develop reporting capabilities around wellbeing conversation data

Theme	Commitment	June 2021	March 2022	Next
Culture and engagement	Foster an open, transparent and high performing culture, where staff feel valued and recognised, actively participate and feel empowered to raise concerns	> Divisional Culture and Engagements Groups implemented to support increased staff engagement > AQuA QI programme delivery scoped for September 21-March 22 > Review of values and behaviours work commencing in June	> Culture and Engagement groups embedded into Divisional structures > Values refresh completed and signed off by Board > New in-house quarterly Culture and Engagement Pulse survey developed and implement in July 2021	> Relaunch Freedom to Speak Up (FTSU) to support staff to raise concerns > Launch new values and staff charter, which has a focus on staff been empowered to raise concerns > Quarterly Culture and Engagement Pulse survey
Culture and engagement	Develop an inclusive and healthy environment where everyone is treated with respect and dignity		> Values refresh completed and signed off by Board > Recruitment of EDI lead in collaboration with Specialist Trusts across C&M > Appointment of Health and Wellbeing Guardian role	> Health and Wellbeing Group to be established chaired by Health and Wellbeing Guardian > Implement/recruitment Health and Wellbeing Champions from across all divisions - January / February 2021 > Launch new values and staff charter > Develop action plan from the 2021 staff survey (results expected March 2021)
Culture and engagement	Actively engage with and involve our diverse communities, ensuring that seldom-heard groups are included from a patient and staff perspective	> Staff network implemented	> EDI lead recruited and LGBT+ and Disability Networks established	> EDI KPIs to be established and refresh of workforce EDI strategy and support plan
Culture and engagement	Work proactively to increase the diversity of our workforce		> EDI lead recruited	> Overhaul of the recruitment strategy in line with the national People Plan and EDI agenda > Refresh of EDI strategy to support

Theme	Commitment	June 2021	March 2022	Next
Culture and engagement	Review our trust values	> Review taking place during June and July > This will include open staff sessions, SmartSurvey, targeted engagement sessions and floor walking	> Values refresh completed and signed off by Board > Draft Staff Charter developed > Values implementation group established and implementation plan developed	> Sign off of Staff Charter > Delivery of actions within the values implementation plan
Health and wellbeing	Implement our health and wellbeing plan	> Work continues on embedding and enhancing our health and wellbeing support for staff > Significant improvement in the theme of health and wellbeing was seen in 2020 national staff survey	> Appointment of Health and Wellbeing Guardian role > Health and wellbeing continues to be discussed as part of Culture and Engagement Groups > Northwest Wellbeing Pledge signed > Findings from COVID Wellbeing Research Study presented > Draft wellbeing plan produced, but awaiting the publication of the national NHS Wellbeing Framework to ensure alignment	> Health and Wellbeing Group to be established chaired by Health and Wellbeing Guardian > Implement/recruitment Health and Wellbeing Champions from across all divisions - January / February 2021 > Manager wellbeing conversation training to be rolled out – February > Continue developing the trusts action plan for the C&M Prevention Pledge > Wellbeing Plan and Staff offer for 2022 to be launched – April
Education and training	Achieve teaching hospital status	> Initial working group formed to complete self-assessment against teaching hospital criteria > Assessment revealed that requirements are largely met > The further developments required in research (some dependent on University of Liverpool) will be addressed through the implementation of the new research strategy	> New Library and Knowledge Service SLA in place with LUHFT > No further work towards Teaching Hospital status in last period	> Options for future applications for Teaching Hospital status to be set out in 2022/23, to include possible interim status while research strategy is delivered

Theme	Commitment	June 2021	March 2022	Next
Education and training	Implement our education strategy	> Delivery of the implementation plan led by Associate Director of Clinical Education on behalf of the Trust	> Education Governance Committee continues to have oversight of delivery of the Education Strategy implementation plan > All associated actions are now completed, with exception of finalising review and standardisation of CNS/ANP job descriptions and job plans > Completion date for this action revised due to pause as a result of clinical pressures due to Covid-19 > Work now being progressed to completion by newly created Advanced Nurse Project Group	> Current CCC Education Strategy ends in 2022 > New multi-professional Education Strategy to be developed by Q3 2022, led by Associate Director of Clinical Education, reflecting Trust, national and regional strategic priorities

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

Theme	Commitment	June 2021	March 2022	Next
Research strategy	Implement our research strategy	> Strategy endorsed by Trust Board 10/2020 > Associated operational Business Plan approved 01/2021 > Research Strategy started 04/2021	> Research strategy designed and uploaded onto CCC website 12/2021 > New Director of Clinical Research, Prof Christian Ottensmeier, appointed in 01/2022	> Operationalise research strategy via research strategy business plan and update quarterly at Performance Committee
Clinical trials delivery and infrastructure	Strengthen key aspects of the research and innovation staffing infrastructure and the core team, such as additional research nurses and biobanking staff	> Appointed: > 1 x Senior Research Practitioner > 2 x Research Practitioner > 1 x R&I Communications Lead > Contributed to: > 1 x Chair post > Maintained: > 14 x SRG Research Leads posts	> In addition to the posts recruited at the 06/2021 update, the following posts have been appointed to: > Clinical Research Fellow > 3 x Clinical Trials Assistants > Research Educator > Research Radiotherapy Practitioner > Observational Research Lead > Research Commercial Costing post > Innovation Manager > These posts have either started or we are awaiting a start date	> Research governance posts are in progress
Clinical trials delivery and infrastructure	Develop clinical job plans with protected time for research activities and recruit research active clinicians	> 8 x Research PAs available during 2021/22	> Research PA allocation discussed at the Consultants Away Day, November 2021 > Working Group to be established to progress	> Update on next steps requested at March 2021 Clatterbridge Committee for Research Strategy

Theme	Commitment	June 2021	March 2022	Next
Clinical trials delivery and infrastructure	Submit our renewal bid for the ECMC in 2022	> Clinical Director of ECMC provided assurance at May 2021 Clatterbridge Committee for Research Strategy (CCRS) that the renewal is on track	> Research Study Prioritisation Committee formed and prioritised ECMC studies for opening > Monthly ECMC metrics meetings taking place to ensure on track > Renewal bid writing group set-up with clinical representation from CCC	> Support ECMC renewal bid
Clinical trials delivery and infrastructure	Support the Liverpool Clinical Research Facility bid as a collaborator in 2021 ◊◊	-	> Application successfully submitted 29th September 2021 > LUHFT is the lead applicant and CCC co-applicant with Liverpool Heart and Chest Hospital > Bid successful - £5.3M awarded to Liverpool CRF	> Meeting with LUHFT, CCC and LHCH is being arranged to discuss successful bid and ways of working going forward as a partnership
Academic research	Increase the number of academic staff within the trust with the aim of securing a future BRC and CRUK Centre status	> 1 x Senior Lecturer to be appointed 09/2021	> Scoping exercise carried out to determine strengths and opportunities for development of radiotherapy at CCC - clear need for academic leadership > BRC bid was submitted in October 2021 - CCC listed as a collaborator on five work streams	> Discussions between senior CCC and the UoL colleagues taking place > Invite to interview on 4th April 2022 received. Mock interviews taking place 17th and 30th March 2022. > Final decision expected in May 2022
Academic research	Support and foster an environment for growth in academic oncology	> Research Rounds' fortnightly seminars by CCC researchers, and University scientists to foster and re-invigorate a research community at CCC	> 12-month anniversary of Research Rounds in 12/2021	> Clatterbridge Research Funding Scheme 2021/22 to be launched postponed until mid-2022 > Research@Clatterbridge day postponed in light of new COVID-19 restrictions
Academic research	Expand the clinical research fellow programme	> 1 x Clinical Research Fellow to be appointed 09/2021	> Clinical Research Fellow appointed and started in post 11/2021	> Second Clinical Research Fellow post to be appointed 11/2022

Theme	Commitment	June 2021	March 2022	Next
Academic research	Increase research in advanced radiotherapy techniques	> Radiotherapy research strategy under development	> Scoping exercise carried out to determine strengths and opportunities for development of radiotherapy at CCC > Clear need for academic leadership	> Discussions between senior CCC and UoL colleagues taking place
Academic research	Explore and develop research collaborations ◊◊	> LCRI endorsed by Trust Board October 2021 > Continue to support LCRI activities through representation on the LCRI Partnership Board and Leadership Committee > Supporting the development of the Liverpool Health Partners (LHP) cancer programme	> LCRI Symposium held 11/2021 - CCC representatives presented at the event and attended > Discussions have taken place with The Crick Institute regarding potential opportunities for collaboration > Scoping meetings have taken place with Crick to determine areas of mutual benefit	> Continuing support for the development and refresh of the LHP cancer programme > Follow-up Crick meeting scheduled for early 2022
Allied health professional research	Expand medical physics based research in line with development in imaging and radiotherapy techniques	> Increased trials using imaging and radiotherapy	> Increased trials using imaging and radiotherapy	> Initiate discussions through the Clatterbridge Committee for Research Strategy
Allied health professional research	Invest to promote research awareness and participation within other non-medical areas such as pharmacy, nursing, AHPs and IM&T	> Research Rounds' fortnightly seminars by CCC researchers, and University scientists to foster and re-invigorate a research community at CCC	> 12-month anniversary of Research Rounds in 12/2021	> Clatterbridge Research Funding Scheme 2021/22 postponed until mid-2022 > Research@Clatterbridge day postponed in light of new COVID-19 restrictions

Be digital | Deliver digitally transformed services, empowering patients and staff

Theme	Commitment	June 2021	March 2022	Next
Digital strategy	Develop our digital strategy	> Be Digital sessions facilitated by Cube Creative November and December 2020 > "Day in your Life" sessions with Health Care International (HCI) with staff around systems and processes > HCI Group have spoken to over a hundred staff in the Trust covering clinical and administration roles in Meditech	> Health Care International review complete and an extensive findings document has been received > Digital Team, CCIO and CNIO to review the HCI recommendations > Findings and recommendations presented to Digital Board in December 21, highlighting a focus on six key areas within the Electronic Patient record > Executive Leads workshop held to understand the scale of the programme within the Trust > Work has commenced around ambitions within the 5 year plan, namely Robotic Process Automation (RPA) and Remote Monitoring work > Drafting of full strategy underway	> Review and agree programme of work developing a resource plan and supporting business case > Transformation programme of work to be established to support the HCI findings and EPR Optimisation > Pilots on RPA and Remote monitoring are underway > Full strategy to be presented
Digital strategy	Achieve HIMSS level 7 status	> Work commenced with HIMSS for self-assessment of level 7 requirements > The Digital Team have engaged with the Electronic Medical Record Adoption Model (ERAM) Team to undertake at level 6 and 7 HIMSS gap analysis	> To achieve HIMMS 6 & 7 the Trust was dependant on the latest software upgrade to its EPR, Priority Pack 42 (PP42) - PP42 was successfully deployed in December 2021 > Work continues in preparation with HIMMS self-assessment along with preparatory discussions with the external HIMMS assessment assessors	> Complete self-assessment for level 6

Theme	Commitment	June 2021	March 2022	Next
Delivering digital for patients	Engage with our patients to design solutions through co-production	> Co-production pre Covid taken place with our patients around Patient Held Records (PHR) to co-design solutions	> NHSX launched What Good Looks Like Framework 31/8/21, updated in October 21 > Framework builds on progress through the pandemic and ensures strong foundation in digital practice - one of the 7 success measures is around empowering citizens > Framework presented to Digital Board in September 21 > Self-assessment completed in November 21 with a wide range of key stakeholders in the Trust > Digital Team working with patient engagement lead and PIEG around ensuring patient engagement is aligned with national digital ambition > Self-assessment shared with Liverpool Place for alignment with ICS strategy > Work continues with Patient Held Records (PHR) testing within the live PHR environment commenced December 21	> Set an action plan for the Trust on the seven factors of success within the "What Good Looks like Framework" > Pilot started in January 2022 with Teenage and Young Adult cohort. Successful pilot with patients receiving an email to inform them to log onto PHR and review clinical correspondence within the digital platform. The process of not reviewing the letters within the agreed timeframe was also tested and a paper copy was sent as planned.

Theme	Commitment	June 2021	March 2022	Next
Delivering digital for patients	Expand use of telehealth and other new technologies to keep individuals connected with health professionals and support the delivery of care closer to home	> Attend Anywhere is fully rolled out and training complete with all clinicians and administration staff > Patient feedback in review along with clinician feedback - CCC early adaptor of Patient Held Record	> Attend Anywhere still being used > Successful bid made to the elective recovery fund to enhance the use of the hotline services and provide remote monitoring to support the tracking of symptoms and side effects > Planning work underway to review remote monitoring technologies already in use within C&M including virtual wards > Current available technologies for remote monitoring reviewed and evaluated for pilot	> Commence pilot March 22 and Q1 2022 > Work with divisions to review use of Attend Anywhere and increase usage where relevant

Theme	Commitment	June 2021	March 2022	Next
Delivering digital for patients	Work with other to develop a single digital access point for patients across Cheshire and Merseyside that gives patients access to their electronic records	> The Trust is feeding data into e-xchange, also known as share2Care, which contains patient level data for Trusts across Cheshire & Merseyside > CCC has been an early adopter of this platform > The Trust is also feeding data into CIPHA (Combined Intelligence for Public Health Action) > The Trust is also an early adopter of system wide Patient Held Record (PHR) initiative that will, in the future, utilise the data that is currently within Share2Care > The PHR will be accessed via a single NHS login, enabling patients to access their own health records, correspondence and appointments > It will also include an ecosystem of apps- so that the patient has one place to go to access all of the health care records	> Trust continues to work with colleagues across C&M and are utilising Patient held Record (Amity), Combined intelligence for Public Health Action (CIPHA) and eXchange > This now falls within the new ACE platform as part of the C&M Strategy which is moving to Full Business Case stage > The Patient Held Record has been tested in December 21 Pilot started in January 2022 with Teenage and Young Adult cohort. Successful pilot with patients receiving an email to inform them to log onto PHR and review clinical correspondence within the digital platform. The process of not reviewing the letters within the agreed timeframe was also tested and a paper copy was sent as planned.	> Continue to work on clinical use case within CIPHA for CCC > Continue to share data sets with CIPHA and eXchange > Continue to work with Regional team on PHR developments to roll the service out further
Delivering digital for patients	Give patients access to assistive technology, including remote monitoring	> CCC patients are linked into early adopter of the Patient Held Record (PHR) solution, giving patients access, through a single NHS log in, to an ecosystem of apps	> Successful bid for remote monitoring pilot > Current available technologies reviewed and evaluated with clinical teams	> Implement remote monitoring pilot

Theme	Commitment	June 2021	March 2022	Next
Delivering digital for our people	Empower and equip our workforce with digital skills to become fully agile and digitally connected to the wider health and social care environment	> Trust wide digital champions identified departmentally for MS Teams > Training plan with workforce and OD around Meditech in development ensuring clinical skills is aligning to clinical systems > Workforce & OD offer of digital skills passport to support basic generic competencies	> Full review underway with Digital and Organisational Development - programme of work managed through Digital Board > Digital skills literacy programme to be launched by HR & OD colleagues > "Support People" within the nationally launched "What Good Looks Like Framework" sets out standards around digital literacy	> Continue with Training review > Develop Action Plan for What Good Looks Like framework to be monitored through Digital Board > Ensuring the "Supporting People" element is developed across the Trust > Successful Health Education England bid in March 2022 for upskilling clinical workforce Fund. Enabling technologies successfully bid for. Procurement in progress
Delivering digital for our people	Enable our people to make intelligence-driven decisions and have access to the right digital tools	> Roll out of BI Tools/Dashboards in progress	> Dashboards rolled out and continue to be developed - dedicated awareness programme in development	> Awareness programme to be delivered > Statistical Process Control (SPC) to be embedded into Trust IPR in May (April Data)
Delivering digital for our people	Embed strong clinical digital leadership	> The Digital Team works closely with the Trusts Chief Clinical Information Officer (CCIO) and has recently recruited to a new post of Chief Nursing Information Officer (CNIO) role who will join the team in July 2021 > The team hosts a Digital Pharmacy team that is led by the Chief Medicines Information Officer	> Associate Chief Clinical Information Officer now in place to support CCIO role > Clinical Digital Leadership now comprises of CCIO, Associate CCIO, Chief Nursing Information Officer (CNIO), Clinical Safety Officer and Chief Medicines Information Officer (CMIO)	> Strong Digital Clinical Leadership in place supporting CIO and Digital team - continuous review
Be driven by intelligence	Establish a true business intelligence function	> The Business Intelligence (BI) function has now been created and all positions have been filled > Engagement is taking place to embed BI into all working day practices	> Work continues to integrate CET into BI function	> Review roles and responsibilities of CET with Quality function

Theme	Commitment	June 2021	March 2022	Next
Be driven by intelligence	Deliver a new data warehouse and a single set of data visualisation tools	> Single Data Warehouse delivered which currently includes data from ESR, Datix-Web, Meditech, IPM and CUR Systems > Power BI and SSRS are the chosen visualisation tool in place > The roll out and awareness and engagement of dashboards is in progress	> Work continues with development of dashboards and programme of work is managed through Digital Board > Further data sources continue to be added to the data warehouse which include PADR and Perfect ward data	> Work continues with awareness raising around use of data and utilisation of dashboards to inform decision making > Review of IPR work is underway including incorporation of statistical process control (SPC)
Be driven by intelligence	Share data across Cheshire & Merseyside as part of the CIPHA programme	> Feeds are going into CIPHA which include real time HL7 messages for Demographics, Inpatient ADT and Outpatient appointments > Vaccine workforce data also being included for vaccination programme	> Pilot for Clinical Use case for CCC has been agreed by the CIPHA programme Board > The new Associate CCIO along with Head of BI are leading this work	> Continue to share CIPHA data sets and progress the clinical use case for predictive analytics
Secure and robust digital infrastructure	Work with partners to deliver a 'cloud first' approach to our digital infrastructure	> A private cloud has been developed with Alder Hey and Liverpool Women's, is now live and serving the Meditech environment	> Continuing to migrate corporate assets to the hybrid cloud solution > Simultaneously working with 3rd party to build Azure landing platform for next phase of cloud adoption > This will enable the future alignment into public cloud for Clatterbridge assets	> Complete the migration into the hybrid cloud solution in a safe and coordinated way > Complete the build of the Azure landing platform, and begin transition planning for 23/24 > Train the technical team in the use of Azure services, to support the organisations assets
Secure and robust digital infrastructure	Achieve Cyber Essentials Plus status	> The Trust has renewed its cyber highway subscription and the Cyber team are undertaking a gap analysis of steps to achieve Cyber Essentials Plus (CE+) accreditation	> Preliminary gap analysis has been performed on ISO27001 > The team is currently evaluating this report to build a programme of works to facilitate IS27001 adoption and compliance > CE+ will be absorbed as part of this programme	> Agree programme of works, resourcing and funding to achieve IS027001

Theme	Commitment	June 2021	March 2022	Next
Secure and robust digital infrastructure	Embed collaboration tools to support better communication and collaboration across our sites	> Microsoft Teams deployed to all workstations in the organisation > CCC are leaders in the use of Microsoft Teams > All meeting rooms are now furnished with collaboration technology	> Clatterbridge leverage Microsoft teams heavily as standard processes since 2020 > This is now fully embedded within the organisation	> Collaborate with MDT coordinators to ensure they have Cloud Video Interoperability (CVI) enabled on their accounts, to enable other organisations who may not be harnessing Microsoft Teams to be able to connect into teams hosted MDTs > CCC Digital will working closely with CAMRIN to drive this forward

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

Theme	Commitment	June 2021	March 2022	Next
Build the capacity, capability and culture to support innovation	Develop an innovation strategy to encapsulate how we will build the capacity, capability and culture to support innovation	> Funding secured through the Research Strategy for an Innovation Manager and Clinical Director of Innovation > Intellectual Property Policy approved at May 2021 TEG	> Innovation Manager appointed 11/2021 > Clinical Lead for Innovation appointed 02/2022	> Scope out areas of innovation already taking place > Develop relationships with external innovation agencies and peers > Develop Innovation Strategy for the Trust
Build the capacity, capability and culture to support innovation	Establish an Innovation Fund	> £150k secured through The Clatterbridge Cancer Charity	> Bright Ideas scheme launched 09/2021 ~ 50 ideas submitted and reviewed to date > Funding awarded to first projects > A communication is prepared monthly on a bright idea submitted	> Continue to review bright ideas monthly > Review process for bright ideas that may need significant resource
Improving patient care through innovation	Expand the Clatterbridge in the Community programme	> Expanding from 5wte up to 10wte nurses this year and opening additional hub at CCC-A	> Service has expanded beyond 10 WTE treating nurses > Currently nearly 60% of all eligible treatments approved for CIC use > Service promoted with SRG leads and interest shown from a range of other patient groups, including gynae and head and neck patients > Starting to treat HO patients at home in the near future > Aintree hub delayed due to issues with the delivery of our new lease cars	> Continue to expand range of service to other patient groups > Open Aintree hub once delivery taken of new lease cars

Theme	Commitment	June 2021	March 2022	Next
Improving patient care through innovation	Introduce model of stratified outpatient follow-up	> Patient-initiated follow-up based on risk stratification > Stratified outpatient follow-up in place for breast cancer – now extended to prostate	> Stratified outpatient follow-up in place for breast cancer Central, North, South, prospective not retrospective for East (400+ stratified) > Now extended to include prostate Central, South, North, East (800+ on tracker) > Extended stratified follow-up to haemato-oncology (150 patients stratified)	> Work with partners to translate broad national guidance and targets into appropriate clinical pathways for CCC patients > Identify further SRGs for PIFU as per CMCA guidance > Ensure that PIFU is in place for major outpatient specialties
Improving patient care through innovation	Sustain and embed the use of telemedicine in outpatient care beyond Covid-19	> SRG recovery plans produced outlining return to activity and the proportion that will remain virtual	> SRGs have embedded a mixed model of telemedicine and face to face as required > Consistently achieve the target of 75%/25% remote telehealth target	> SRG Annual Reports to monitor KPIs including telemedicine
Improving patient care through innovation	Explore concept an 'innovation bunker' on the CCC-Liverpool site **	> Work yet to begin	> Work yet to begin	> Review relevance of commitment to explore this idea and reword in future reports as necessary
Subsidiaries and joint venture	Develop and grow our subsidiaries and joint venture	> PropCare is developing a 3-5 year business plan to include succession planning and further explore opportunities to support partner trusts > CPL currently supported by project manager with scope to review internal processes and consider opportunities to optimise logistics and productivity	> New PropCare Managing Director in post > New lead for private patient joint venture (PPJV) appointed > Findings of CPL review presented to Trust and implementation of recommendations underway	> Plans to be developed by new leads for PropCare and PPJV > Continue implementation of recommendations from CPL review

Theme	Commitment	June 2021	March 2022	Next
Explore opportunities	Explore commercial opportunities or opportunities to enhance and strengthen patient care or our national and international reputation and brand	> Ongoing process	> Approval received from NHS England for development of a CAR-T therapy service at CCC-L > Initial meetings with CAR-T partners underway > Initial discussions held with clinical team at STHK regarding possible collaboration in skin service for keloid scarring	> Establish project structure and governance for CAR-T therapy service development > Continue to work with STHK skin team on keloid development

List of acronyms used

AHP	Allied Health Professional
ANP	Advanced nurse practitioner
AO	Acute oncology
AQuA	Advancing Quality Alliance
BI	Business intelligence
BRC	Biomedical Research Centre
C&M	Cheshire and Merseyside
CAMRIN	Cheshire and Merseyside Radiology and Imaging Network
CAR-T	Chimeric antigen receptor T-cell
CCG	Clinical commissioning group
CCIO	Chief Clinical Information Officer
CCRS	Clatterbridge Committee for Research Strategy
CDC	Community diagnostic centre (was community diagnostic hub - CDH)
CDU	Clinical Decisions Unit
CE+	Cyber essentials plus
CEO	Chief Executive Officer
CET	Clinical effectiveness team
CIC	Clatterbridge in the Community
CIPHA	Combined Intelligence for Public Health Action
CIO	Chief Information Officer
CMAST	Cheshire & Merseyside Acute and Specialist Trust Provider Collaborative
CMCA	Cheshire and Merseyside Cancer Alliance
CMIO	Chief Medicines Information Officer
CNIO	Chief Nursing Information Officer
CNS	Clinical nurse specialist
CPL	Clatterbridge Pharmacy Limited
CQC	Care Quality Commission
EDI	Equality, diversity and inclusion
EPR	Electronic patient record
ESR	Electronic staff record
FoSH	Federation of Specialist Hospitals
FFT	Friend and family test
FTSU	Freedom to speak up
HCI	Health Care International
HCP	(Cheshire & Merseyside) Health and Care Partnership
HEE	Health Education England
HIMSS	Healthcare Information and Management Systems Society
HO	Haemato-oncology
IM&T	Information management and technology
IoM	Isle of Man
IR	interventional radiology
JACIE	Joint Accreditation Committee of the International Society for Cellular Therapy (ISCT) and the European Group for Blood and Marrow Transplantation (EBMT)
KLOE	Key line of enquiry
KPI	Key performance indicator
L&OD	Learning and organisational development
LCR	Liverpool city region
LCRI	Liverpool Cancer Research Institute
LeDeR	A service improvement programme for people with a learning disability and autistic people
LHCH	Liverpool Heart and Chest Hospital NHS Foundation Trust
LHP	Liverpool Health Partners
LUHFT	Liverpool University Hospitals NHS Foundation Trust
MDT	Multidisciplinary team
NHSE/I	NHS England/Improvement
NWPQA	North West Pharmaceutical Quality Assurance
OD	Organisational development
ODN	Operational delivery network
OSC	Overview and scrutiny committee
PADR	Performance appraisal and development review
PEIG	Patient Experience and Inclusion Group
PHR	Patient held record
PIFU	Patient initiated follow-up
PMO	Programme Management Office
PPJV	Private patient joint venture
PREMs	Patient reported experience measures
QI	Quality improvement
RCP	Royal College of Physicians
RDS	Rapid diagnostic service (was rapid diagnostic centre – RDC)
R&I	Research and innovation
RPA	Robotic process automation
SABR	Stereotactic ablative radiotherapy
SACT	Systemic anti-cancer therapy
SLA	Service level agreement
SPC	Statistical process control
SRG	Site reference group
SRO	Senior responsible officer
STHK	St Helens and Knowsley Teaching Hospitals NHS Trust

TEG	Trust Executive Group
TfC	Together for Children
TMA	Transitional monitoring approach
TUPE	Transfer of Undertakings (Protection of Employment)
TYA	Teenage and young adult
UoL	University of Liverpool
WTE	Whole time equivalent
WUTH	Wirral University Teaching Hospital NHS Foundation Trust

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board	
Date of meeting:	30th March 2022	
Agenda item:	P1-64-22	
Title:	New Consultant Appointment	
Report prepared by:	Catherine Hignett-Jones	
Executive Lead:	Sheena Khanduri	
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	
Date & decision:	

Purpose of the paper/key points for discussion:	Information on appointment of new consultants

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 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.

Introduction

This paper provides an update to the Trust Board on consultant appointments in post February 2022

A short biography and account of achievements for the Consultant appointment is provided as follows:

Name	Dr Abhishek Mahajan
Job Title	Consultant Radiologist
Qualifications	FRCR 2021 MBBS Kasturba Medical College, India MD Radiodiagnosis Kasturba College, India Fellowship in Cancer Imaging, Tata Memorial Centre, India
Speciality	Radiology
GMC number	GMC: 7908052
Membership/Appointments	
Details	This is Dr Mahajan's first appointment in the UK and was previously employed as Consultant Radiologist at the Tata Memorial Hospital in Mumbai, specialising in Head and Neck & Neuro-oncology.

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

2

Report to:	Trust Board
Date of meeting:	30 March 2022
Agenda item:	P1-065-22
Title:	Guardian of Safe Working Hours – Q3 Report October-December 2021
Report prepared by:	Dr Madhuchanda Chatterjee
Executive Lead:	Dr Sheena Khanduri
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

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.

The Clatterbridge Cancer Centre NHS Foundation Trust

Guardian of Safe Working Hours – Q3 Report October-December 2021

Madhuchanda Chatterjee, Guardian of Safe Working

1.0 Introduction

This report covers the period October-December 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):	39
Number of doctors/dentists in training on 2016 TCS (total):	39
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 3 Exception Reports submitted during this period, October – December 2021. These reports were submitted by GP trainees covering our wards whom fall under General Medicine. The nature of the reports cited variances in hours of work due to the wards not being sufficiently staffed. The reports were reviewed by their Supervisors and an outcome of TOIL was agreed, this was then added to their entitlement on Allocate. The Exception reports were then subsequently closed off and marked as completed.

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	39
General Medicine	0	94	11
Haemato Oncology	12	69	2

Vacancies

The Trust operates a 1 in 13 junior doctor ward rota and a 1 in 20 senior (registrar) rota, which both feature out of hours work in CDU. The 1 in 20 senior rota does not have any vacancies. Acute Care are advertising for a Senior Clinical Fellow in Immuno-Oncology which would be an additional worker on this rota.

The 1 in 13 junior rota currently has 2 full time vacancies with 1 post being covered by an agency locum, 1 vacant and we also have 1 doctor working at 80%. The rota is made up of 5 Trust Junior Clinical Fellows, 5.8 full time equivalent Doctors in Training and 1 agency locum. This makes the full time equivalent of 11.8 but with one of those full time time posts being covered by agency locum. We have received 3 resignations from Junior Clinical Fellows since January 2022 so have gone out to advert for replacements and agency for the interim period whilst we are recruiting via NHS Jobs and TRAC.

We have a training post gap for our April 2022 changeover as one GPST is not being replaced. This vacancy is included in the recruitment process mentioned above. The Trust will place adverts for August 2022 vacancies in May 2022 and we hope to interview suitable candidates from the current advert who will be ready to take up posts in August so we have offers ready as-and-when we learn of the HEE training posts in June 2022.

The Trust introduced a new long day duty on the 1 in 13 junior rota on 02/02/2022.

Fines

There were no fines incurred in this quarter (October-December 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.

The Clatterbridge Cancer Centre NHS Foundation Trust

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

The Clatterbridge Cancer Centre NHS Foundation Trust

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REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

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Report to:	Trust Board
Date of meeting:	30th March 2022
Agenda item:	P1-066-22
Title:	Patient Experience, Engagement, Inclusion & Involvement Commitment 2022-2025
Report prepared by:	Kirsteen Scowcroft, Head of Patient Experience Karen Kay, Deputy Director of Nursing
Executive Lead:	Julie Gray, Chief Nurse
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Quality Committee
Date & decision:	17th February 2022 - Approved

Purpose of the paper/key points for discussion:	Provide Trust Board members with the opportunity to discuss/comment prior to publication on The Clatterbridge Cancer Centre (CCC) NHS Foundation Trust Patient Experience, Engagement, Inclusion & Involvement Commitment 2022-2025 previously approved at Quality Committee. Trust Board are requested to also approve the "visual minute" element of the Commitment to be displayed across all CCC sites. This will support strengthened communication with our patients, carers, families and staff regarding continued improvements to the patient experience across the Trust. Please Note: 2 graphics contained in the report will be replaced with (high quality professional diagrams) by the communications team prior to publication.

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

Next steps required:	Trust Board are requested to; • Note content of the patient experience Commitment. • Deliver comment/feedback as required

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

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	• Approve the display of the 'visual minute' across all CCC sites.

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.	☐

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

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

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

STRATEGY

The Clatterbridge Cancer Centre NHS Foundation Trust

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Trust/Corporate Strategy

Patient Experience, Engagement, Inclusion & Involvement Commitment 2022-2025

Strategy Reference	(To be provided by DCM)
Version	1.1
Summary/Opening Statement	Welcome to the Clatterbridge Cancer Centre's patient experience, engagement, inclusion and involvement commitment, which was developed and co-produced by patients, families, carers, members of the public and staff.
Name and designation of Strategy author(s)	Kirsteen Scowcroft, Head of Patient Experience & Inclusion Karen Kay, Deputy Director of Nursing
Approved by (committee, group, manager)	Agreed Quality Committee 17th February 2022
Approval evidence received (minutes of meeting, electronic approval)	(To be provided by DCM)
Date approved	(To be provided by DCM)
Review date	March 2025
Review type (annual, three yearly)	Three Yearly
Target audience	Patients, Families, Carers, Public and Staff
Links to other strategies, policies, procedures	
Protective Marking Classification	
This document supersedes	Patient Experience & Inclusion Strategy 2019-2021

STRATEGY

The Clatterbridge Cancer Centre NHS Foundation Trust

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CONSULTATION

	Authorised by	Date authorised	Comments
Equality Impact Assessment	N/A	N/A	N/A
Fraud Department	N/A	N/A	N/A

CIRCULATION/DISSEMINATION

Date added into Q-Pulse	To be completed by DCM
Date document posted on the intranet	To be completed by DCM

VERSION HISTORY

Date	Version	Author name and designation	Summary of main changes
01/07/21	1.0	**Kirsteen Scowcroft, Head of Patient Experience & Inclusion.** **Karen Kay, Deputy Director of Nursing**	New Strategy

STRATEGY

The Clatterbridge Cancer Centre NHS Foundation Trust

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1.0 INTRODUCTION

What is 'patient experience'?

Welcome to The Clatterbridge Cancer Centre's patient experience, engagement, inclusion and involvement Commitment, aimed at patients and staff alike and which was developed & co-produced by patients, families, carers, members of the public and staff. Working together, we can realise our mission, as a leading cancer centre to: 'Drive improved outcomes and experience through our unique network of specialist cancer care across Cheshire & Merseyside'.

Patient experience refers to what the process of receiving care feels like for the patient, their family and carers. A positive patient experience is defined by the Department of Health and Social Care as 'getting good treatment in a comfortable, caring and safe environment, delivered in a calm and reassuring way, having information to make choices, to feel confident and in control, being talked to and listened to as an equal and being treated with honesty, respect and dignity'.

The patient experience Commitment is in line with our mission, the core themes of our overall Five-Year Strategic Plan (2021-2025) and, importantly, our Trust values (see diagram 1).

The National Health Service (NHS) Constitution (2015) requires all services to be tailored to the needs and preferences of patients, their families and carers, and for the services to be guided by the feedback from patients, families, staff and the public. At The Clatterbridge Cancer Centre (CCC) we aim to achieve the NHS's primary goal to continuously improve care quality, helping to create the safest, highest quality health and care service. People deserve consistently high quality healthcare that is personal, effective and safe, that respects their dignity and that is delivered with compassion.

This document shows you how we will keep to our commitment of providing patients with safe, harm-free care in a clean and pleasant environment. We understand that it is important to you that our systems work well, but also that we are welcoming and that you have confidence in us. We want the care you receive during each visit to be focused on you as an individual, meeting your specific needs.

These needs may include being provided with timely clear, jargon-free information or tasty nutritious food. Your thoughts and feedback are vital to us. We currently receive comments in various formats and from a variety of local and national sources (see diagram 2) but we are continually working on new ways to improve and streamline these processes. We want to involve you, work in partnership with you and ensure you have a 'strong voice' in everything we do.

Your care is provided by staff who work together in multi-professional teams and they will be respectful and kind to you at all times. We recognise that it is important to provide the right kind of support to all staff to enable a high quality staff experience to be achieved, as there is a strong link between happy staff and the provision of a high quality patient experience.
On behalf of the Leadership Team and all our staff, here is our patient experience Commitment which we hope you will enjoy reading.

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The Clatterbridge Cancer Centre NHS Foundation Trust

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2.0 How our Commitment was developed

What matters to you matters to us! Patients, families, carers, members of the public and staff helped us to develop this patient experience Commitment?

Between February and October 2021, the Trust hosted a number of workshops for patients, carers and staff. Those patients and carers were from different age groups and ethnic backgrounds, and had experience of various types of cancer. The outcomes of the workshops, along with local and national information collected about our services, were discussed with the Trust Patient Experience & Inclusion Group (PEIG) in July and September 2021.

In producing this patient experience commitment we also took account of a 'sentiment analysis', the process of identifying opinions expressed by a patient, in order to determine whether the individuals attitude towards a particular topic, is positive, negative, or neutral. This has been carried out during patient experience 'rounds' and walkabouts with Non-Executive Directors & Governors between January and September 2021. This looked at comments and shared lived experiences about The Clatterbridge Cancer Centre.

Following this process we have developed the following shared aim;
Patient experience being everyone's business which drives improved experiences through delivering care together in an empathetic manner.'

Diagram 1 This diagram shows the core themes of our overall Five-Year Strategic Plan (2022‑2025) and our Trust values. (Communication Team to develop a high quality pictorial of the pyramid in corporate colours below, with values to be added when this document is being designed for publication)

STRATEGY

The Clatterbridge Cancer Centre NHS Foundation Trust

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As well as our shared aim, the workshops also highlighted five key themes captured in the pictorial format seen below which will be displayed across all CCC sites.

Key themes

- **Give patients a leading voice: Inclusion and diversity** - give all patients & carers who represent the communities we serve, including those 'underserved groups, opportunities to give feedback and be involved.
- **Listen and Learn: communication & clarity of information** - provide clear, understandable information at all times. Learn from each other and those with lived experiences to make things better.
- **Confidence and trust** - people will feel confident under the care we provide, feel heard and that what we hear is used to inform developments and make shared decisions.
- **Access: simplicity and efficiency** Processes for involving patients will be simple, accessible and efficient.
- **Effectiveness: impact and value** - publicise the actions we have taken following patient feedback and involvement, and this information will be in formats accessible to everyone.

Examples of feedback received following the workshop;

"This simple illustration is in a patient friendly visual format that is easy to understand and captures the workshop discussions really well".

"This looks fab, looking forward to seeing the next stage".

"I love this, it is amazing! Well done to everyone involved for getting it to this point. CCC absolutely amazing work".

"Well done. It looks great and well captured".

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The Clatterbridge Cancer Centre NHS Foundation Trust

3.0 Our aim and vision

Involving patients, carers, members of the public and staff when developing our patient experience, engagement, inclusion and involvement commitment has created a shared mission and vision to guide us through the next four years.

Our mission
'Drive improved outcomes and experience through our unique network of specialist cancer care across Cheshire and Merseyside.'

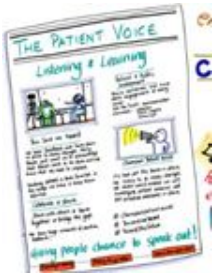
To support this shared mission, staff at The Clatterbridge Cancer Centre plan to deliver the patient experience Commitment over the next four years together with excellent, person-centred cancer care.

We will do this in partnership with our patients, their families and friends, carers and our colleagues, as cancer does not affect anyone in isolation.

Our vision to provide improved outcomes and patient experience alongside the best cancer treatment and care is supported by the following four promises that make up the Trust commitment to you.

- 'We will listen, hear, learn and act'
- 'We will communicate clearly in ways you can understand and demonstrate that hearing is happening'
- 'We will act upon your feedback, involvement and engagement demonstrating; 'what matters to you, matters to us'
- 'We will give patients a leading voice and support each other to develop innovative ways to obtain feedback, involve and engage with you'

4.0 We will listen, hear, learn and act



We want to make sure you feel confident and safe under our care. We aim to offer clear and simple ways for everyone to give feedback and to be involved when they want to be.

- **Collecting your feedback**

We will continue to collect your feedback in different ways.

- **Reporting your feedback**

We will work with patient and carer representatives to streamline our committees, in line with feedback we receive.

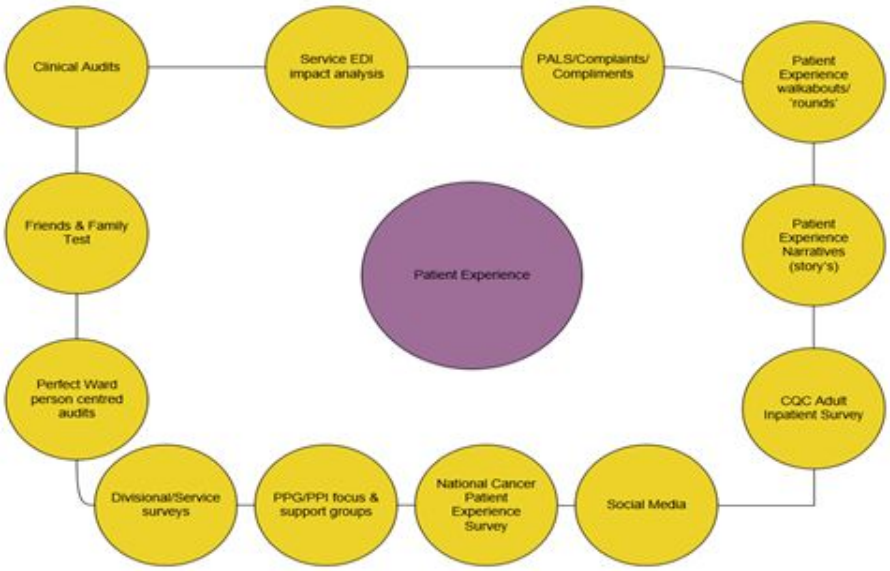
- **Acting on your feedback**

We will publish regular reports and action plans. And we will use 'You said we heard' displays on the department TV screens and noticeboards to keep you informed of local issues.

- **Personalising your feedback**

We will provide individually tailored support for everyone who has concerns

Diagram 2 This diagram shows current methods of collecting feedback. Communication Team to insert high quality bubble diagram below in corporate colours)



5.0 We will communicate clearly in ways you can understand & demonstrate that hearing is happening

We will do the following:

- Communicate with everyone in clear language in a way that is appropriate to that individual.
- Minimise the use of medical terms, jargon and abbreviations.
- Use a range of communication methods, including electronic methods such as email and through social media.
- Always learn lessons from your feedback and share best practice.
- Use your experiences to guide our decision‐making committees.
- Share reports and action plans in a range of ways to make them easily accessible.
- Make sure information about patient experience is available immediately.
- Make sure patient experience is discussed by healthcare professionals and departments every day.
- Monitor the responses and action plans developed by healthcare professionals and departments.
- Improve partnership/co production working between healthcare professionals, patients and carers on all service, research developments and digital changes.

STRATEGY

The Clatterbridge Cancer Centre NHS Foundation Trust

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6.0 We will act upon your feedback, involvement and engagement demonstrating that what matters to you matters to us

We will do the following:

- Simplify access to all our systems and processes to make it easier for you to get involved.
- Review the role volunteers' play and aim to increase the number of volunteers.
- Increase the involvement of a broad range of people, representing the communities that we serve.
- Provide support and training for people interested in helping us to shape our services, research, commitment and governance.
- Give everyone a say and allow them to play an active role in developing our aims and visions for the future.

7.0 We will give patients a leading voice and continue to lead as equal partners together on the development of innovative ways to improve, involve and engage with you.

We will do the following:

- Make sure patient involvement is central to the culture at The Clatterbridge Cancer Centre.
- Identify and develop new ways to learn from the feedback we are given.
- Lead the way in providing support and training for patient feedback and involvement - for example, improvement toolkits, mentoring, coaching, seminars and workshops.
- Monitor and maintain the effectiveness of all patient feedback and involvement.

Conclusion

Thank you for reading this patient experience Commitment. We hope we have made it clear that what matters to you really does matter to all of us at Clatterbridge Cancer Centre. Together we will improve the experience of all our patients and strengthen their involvement. We want to be an outstanding cancer centre providing outstanding patient experience and the best cancer treatment, and we can only do that by listening to you, communicating with you, involving you and by leading developments on your behalf.

Thank you to all the patients, carers, members of the public and staff who helped us to develop this important document. We also thank the following people for their support;

Our patients, their families and carers
Our Patient Participation Group members
Our Patient Experience & Inclusion Group (PEIG) members

Healthwatch Liverpool and Healthwatch Wirral

Our Chief Nurse
Our Deputy Director of Nursing & Chair of PEIG
Our Head of Patient Experience
Our Patient Experience Clinical Lead Partners
Our staff

8.0 References

4Pi standards for involvement 'No decision about me, without me' https://www.nationalvoices.org.uk/sites/default/files/public/4pinationalinvolvementstandardsfullreport20152.pdf

NHS England & Improvement 'A Co-production Model: Five values and seven steps to make this happen in reality' https://www.england.nhs.uk/get-involved/resources/co-production-resources/

Cheshire & Merseyside Cancer Alliance

Performance Report

March 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*	117%
Cancer surgery activity*	113%
SACT (inc chemo) delivery**	118%

Measure	% of pre-Covid level
Radiotherapy planning**	112%
Radiotherapy treatment**	85%
Endoscopy activity♀	77%

- 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.
- Radiotherapy planning activity has been on average 105% higher than pre covid levels in 2021/22 to date.
- Radiotherapy treatments are lower than 2019/20 (at 85% in 2021/22 to date), due to a change in fractionation in early 2020/2021, which equates to fewer treatments per patient in some tumour groups.
- Endoscopy activity in January 2022 was 11% higher than in January 2021, but still lower than before COVID-19 (5,900 in January 2022 compared with over 7,500 in pre-pandemic Januarys). 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 14th March
** Solid tumour only (not inc. Haemato-oncology): reliable Haemato-oncology figures pre covid are unavailable – data as of February 2022
♀Assessment based on monthly DM01 endoscopy returns - latest update January 2022. 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 **January 2022**.

- The Alliance failed the **14 day standard** for urgent suspected cancer referrals, with ten trusts and all CCGs falling below the 93% threshold. The overall performance of the Alliance was 72.6%*, compared to 76.3%* last month. The England average was 75.0%. 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 (the new standard came into force from October 2021), with 12 trusts and all CCGs falling below the 75% threshold. The overall performance of the Alliance was 62.0%*, reducing from 69.0%* last month. The England average was 63.8%. CMCA was the 17th best performing Alliance in England out of 21 against this standard.

- The Alliance failed the **62 day standard**, achieving 67.9%* (decreasing from 73.1%* last month) against a standard of 85% (England average was 61.8%). 11 trusts and all nine CCGs failed to meet the 62 day standard. Cheshire and Merseyside is the 6th 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 14th March 2022 there were 1,285 patients waiting more than 62 days for a diagnosis or treatment. This has decreased from 1,609 reported last month (7th February). Of these, 455 have waited **over 104 days**. This is higher than the 409 patients reported last month.

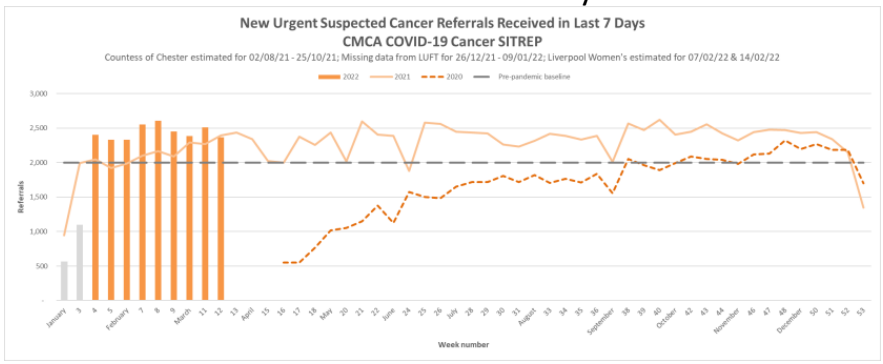
  The proportion of patients on urgent suspected cancer pathways who have already been on the pathway for over 62 days is slightly above, but broadly in line with the England average (9.6% vs 8.5% nationally).

Cheshire & Merseyside Cancer Alliance

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

Section II: Restoration of Cancer Services – Core Metrics

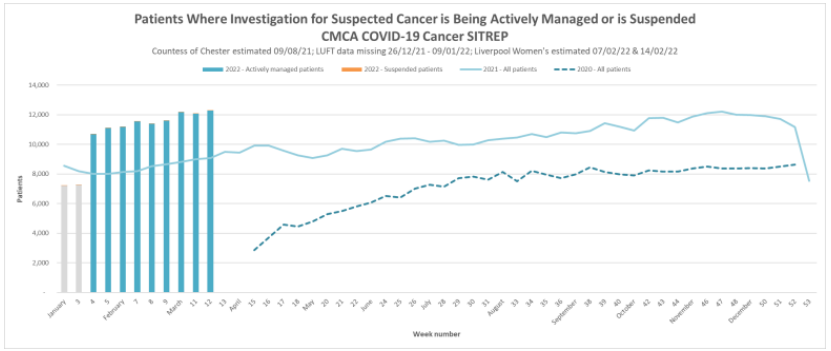
1. TWW referrals received in last 7 days



Referrals decreased with 2,365 patients referred this week (17% above pre-pandemic weekly average, 1% below 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 & 14/02/22.

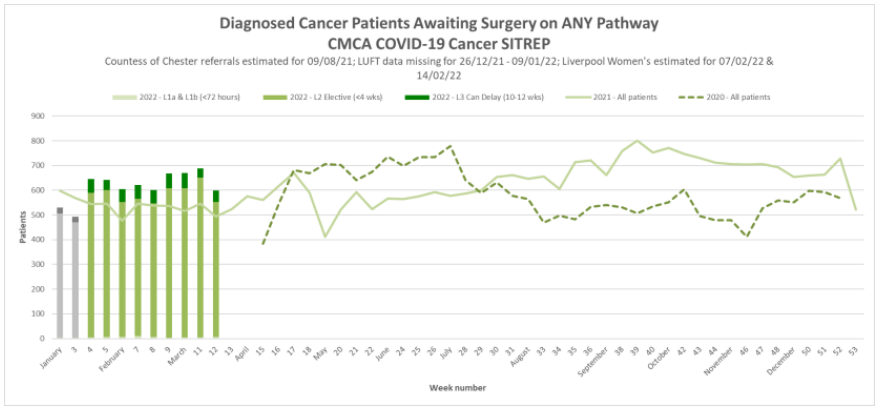
2. Diagnostic backlog (referrals without a DTT)



Currently 12,294 active patients, of which less than 5 suspended (35% 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 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 & 14/02/22.

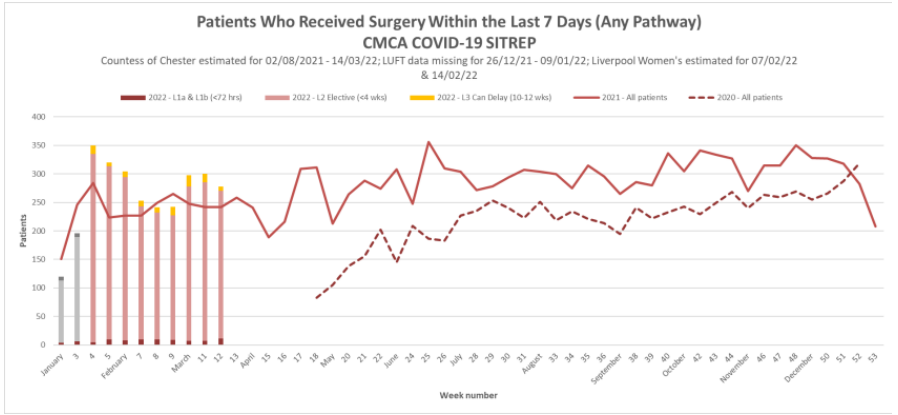
3. Cancer patients awaiting surgery



599 patients with a surgical DTT. 552 at L1&L2 and 47 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 & 14/02/22.

4. Cancer surgery performed in last 7 days

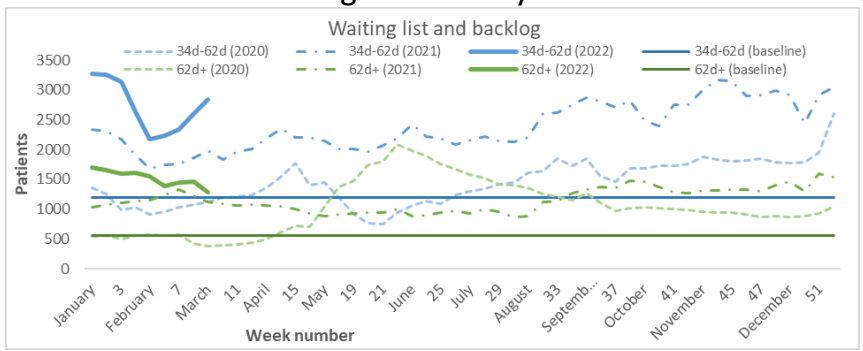


278 cancer operations performed last week.

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 14/03/22 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 & 14/02/22.

Restoration of Cancer Services – Core Metrics

5. Patients waiting over 62 days

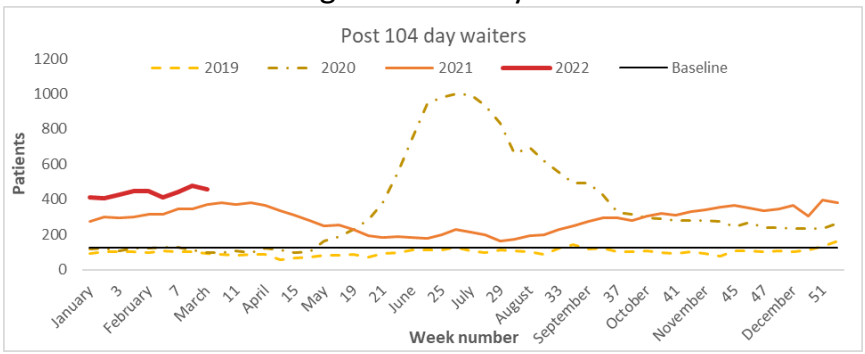


1,286 patients have waited over 62 days

- Lower than 1,459 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

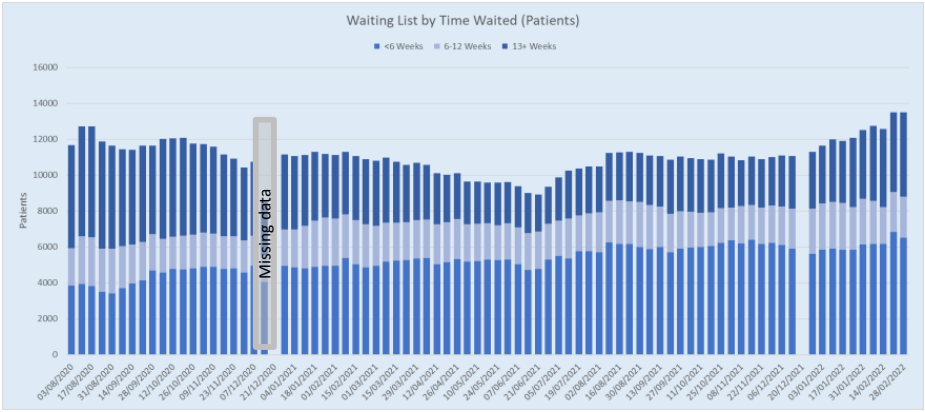


455 patients have waited over 104 days

- Lower than 478 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.

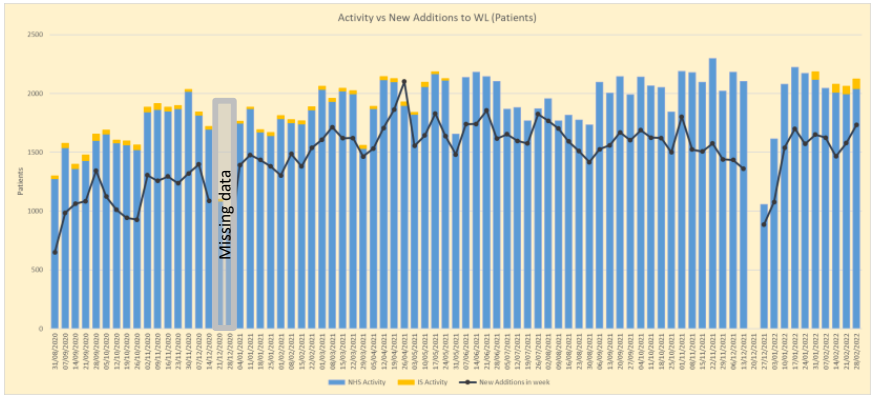
7. Endoscopy waiting list



Endoscopy waiting list similar to previous week at 13,490 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 31/01/22 inclusive. Wirral estimated for 06/01/22.

8. Endoscopy activity



Activity increased with 2,124 patients seen.
New additions increased with 1,732 new 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 31/01/22 inclusive. Wirral estimated for 06/01/22. Countess of Chester new additions estimated for 07/02/22 onwards.

9. Patients waiting between 63 and 103 days by provider

PTL data from W/E 06 March

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			8	7					10	8		**44**
Countess Of Chester		7	5		15	58						11	15		**118**
East Cheshire		6				22						9			**41**
Liverpool Foundation Trust		14			37	107						57	38		**264**
Liverpool Heart & Chest							6								**6**
Liverpool Women's			15												**15**
Mid Cheshire				5		42						17			**72**
Southport & Ormskirk			22			83						14	20		**150**
St Helens & Knowsley					10	21						5	7		**50**
Walton Centre															
Warrington & Halton						5							7		**18**
Wirral						24							20		**51**
Grand Total		**32**	**56**	**17**	**71**	**370**	**19**				**13**	**126**	**119**		**829**

Cheshire & Merseyside Cancer Alliance

Tables from national Cancer PTL

10. Patients waiting over 104 days by provider

PTL data from W/E 06 March

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															**22**
Countess Of Chester			7		10	50						8			**82**
East Cheshire															**15**
Liverpool Foundation Trust		9			9	85						34	17		**164**
Liverpool Heart & Chest															
Liverpool Women's			9												**9**
Mid Cheshire						15									**19**
Southport & Ormskirk			30			45						5	7		**94**
St Helens & Knowsley						10					7				**24**
Walton Centre															
Warrington & Halton															
Wirral						11							8		**24**
Grand Total		**13**	**53**	**11**	**25**	**233**	**10**				**14**	**53**	**41**		**457**

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

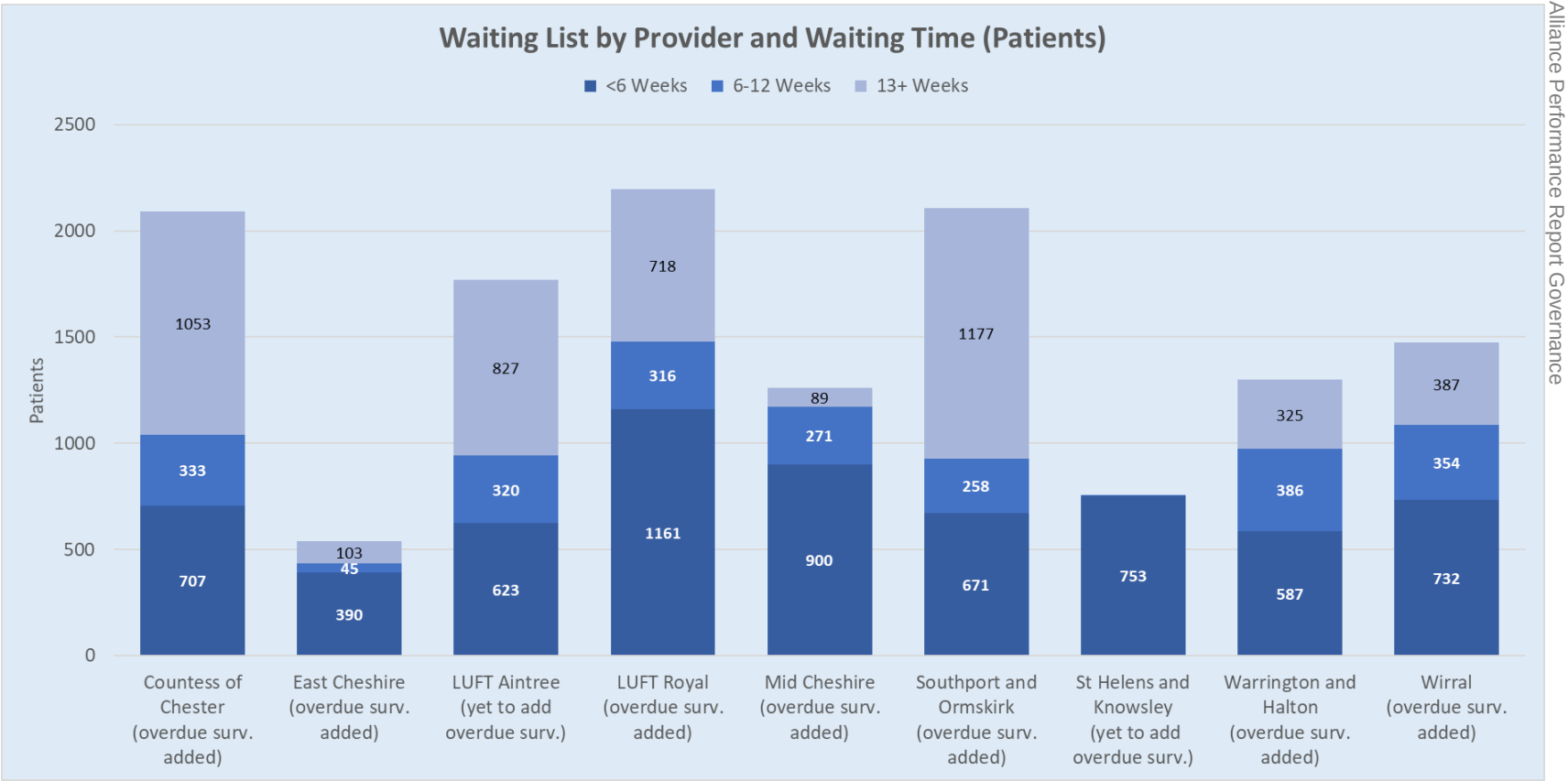
= No PTL submission this week,

Restoration of Cancer Services – Core Metrics

Endoscopy (cancer and non-cancer pathways)

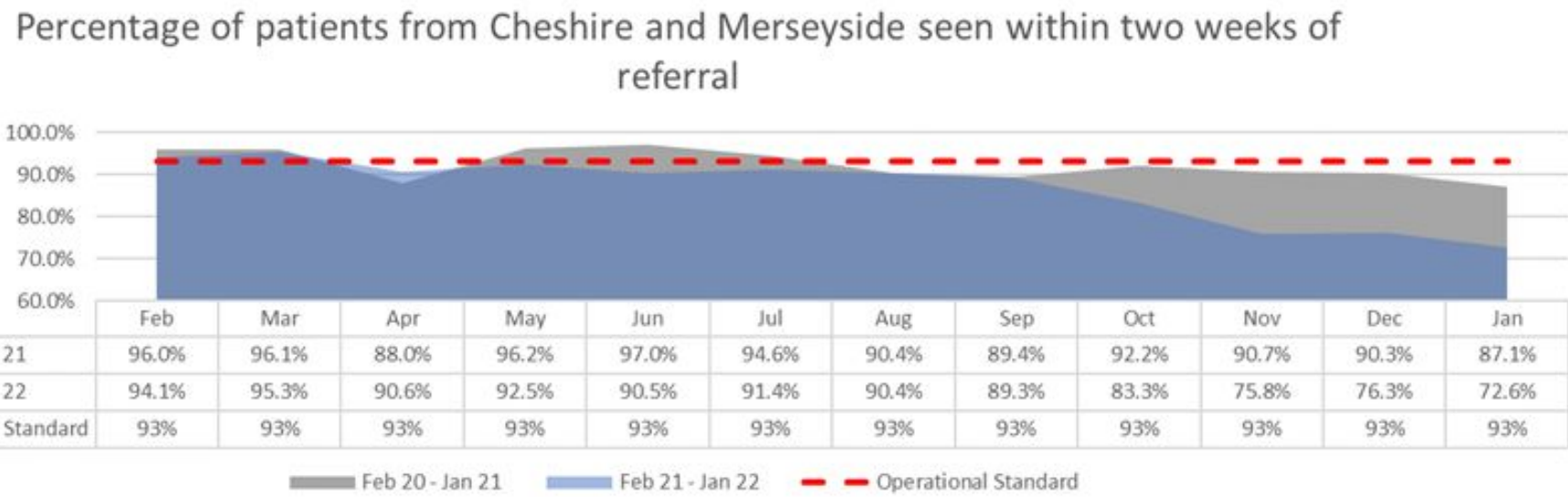
There are currently 13,490 patients waiting for an endoscopy. 6,234 have waited more than six weeks, and of these 4,679 have waited 13 or more weeks (35% of the total).

There is significant variation across units, with Southport and Ormskirk, CoCH and LUFT having the greatest proportion of their waiting list made up of patients waiting 13 weeks or more (56%, 50%, 39% respectively).



Endoscopy data at 28 February 2022.

Section II: 14 day standard



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Feb 20 - Jan 21	96.0%	96.1%	88.0%	96.2%	97.0%	94.6%	90.4%	89.4%	92.2%	90.7%	90.3%	87.1%
Feb 21 - Jan 22	94.1%	95.3%	90.6%	92.5%	90.5%	91.4%	90.4%	89.3%	83.3%	75.8%	76.3%	72.6%
Operational Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

In January 2022, 72.6% of patients were seen within 2 weeks compared to 76.3% in the previous month. This is below the operational standard.

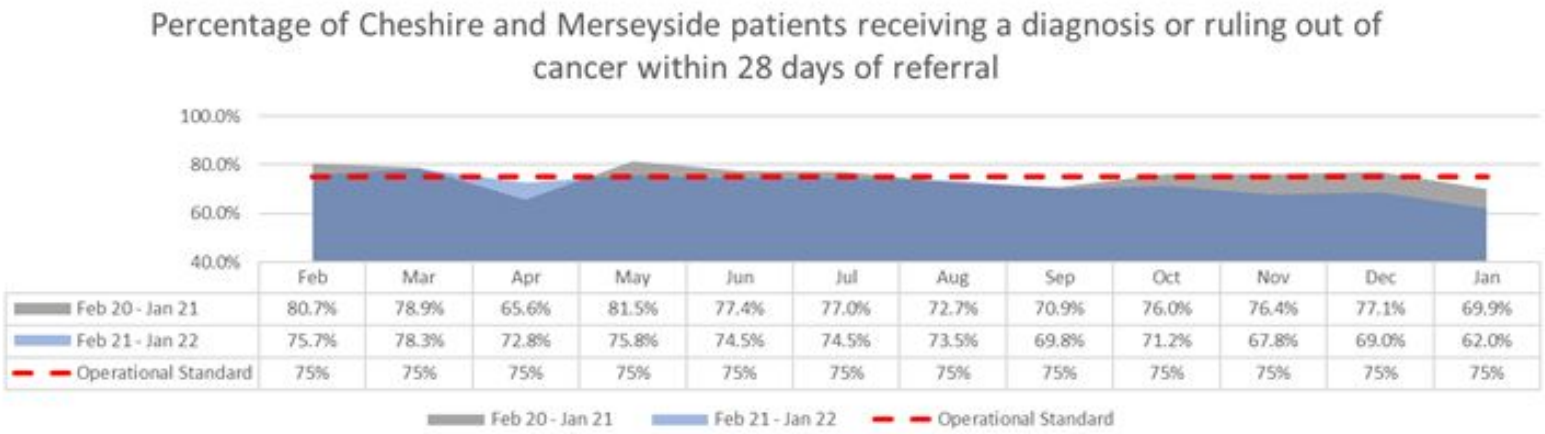
Providers not achieving the national operational standard were:

- Countess Of Chester Hospital 63.3% (399 breaches)
- Liverpool University Hospitals 65.5% (1037 breaches)
- Warrington and Halton Teaching Hospitals 68.6% (298 breaches)
- St Helens and Knowsley Hospitals 73.5% (394 breaches)
- Wirral University Teaching Hospital 76.2% (356 breaches)
- Liverpool Womens 76.7% (60 breaches)
- East Cheshire 80.5% (102 breaches)
- Mid Cheshire Hospitals 80.9% (209 breaches)
- Southport and Ormskirk Hospital 82.4% (172 breaches)
- The Clatterbridge Cancer Centre 90% (1 breaches)

CCGs not achieving the national operational standard were:

- NHS South Sefton 69.4% (232 breaches)
- NHS Liverpool 69.9% (649 breaches)
- NHS Southport and Formby 70% (189 breaches)
- NHS St Helens 71.1% (233 breaches)
- NHS Halton 73.1% (144 breaches)
- NHS Knowsley 73.6% (195 breaches)
- NHS Cheshire 73.7% (761 breaches)
- NHS Warrington 75.1% (205 breaches)
- NHS Wirral 76.1% (338 breaches)

Section II: 28 day standard



The 28 day FDS standard is now live at 75%. In January 2022, 62% of patients were diagnosed or ruled out within 28 days compared to 69% in the previous month. This is below the operational standard.

Providers not achieving the expected standard were:

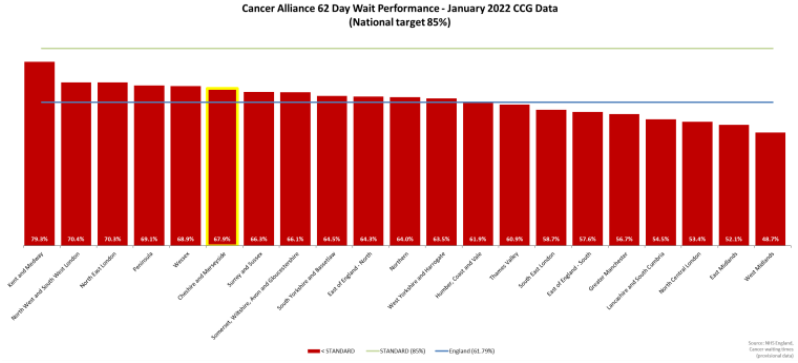
Liverpool Heart And Chest 40.9% (13 breaches)
Liverpool Women's 54.1% (140 breaches)
The Clatterbridge Cancer Centre 57.1% (6 breaches)
East Cheshire 60.3% (236 breaches)
Southport and Ormskirk Hospital 62.6% (329 breaches)
Wirral University Teaching Hospital 70.5% (458 breaches)
Countess Of Chester Hospital 53.9% (578 breaches)
Bridgewater Community Healthcare 54.6% (94 breaches)
Liverpool University Hospitals 57.8% (1276 breaches)
Warrington and Halton Teaching Hospitals 61% (349 breaches)
Mid Cheshire Hospitals 64.8% (419 breaches)
St Helens and Knowsley Hospitals 70.7% (449 breaches)

CCGs not achieving the expected standard were:

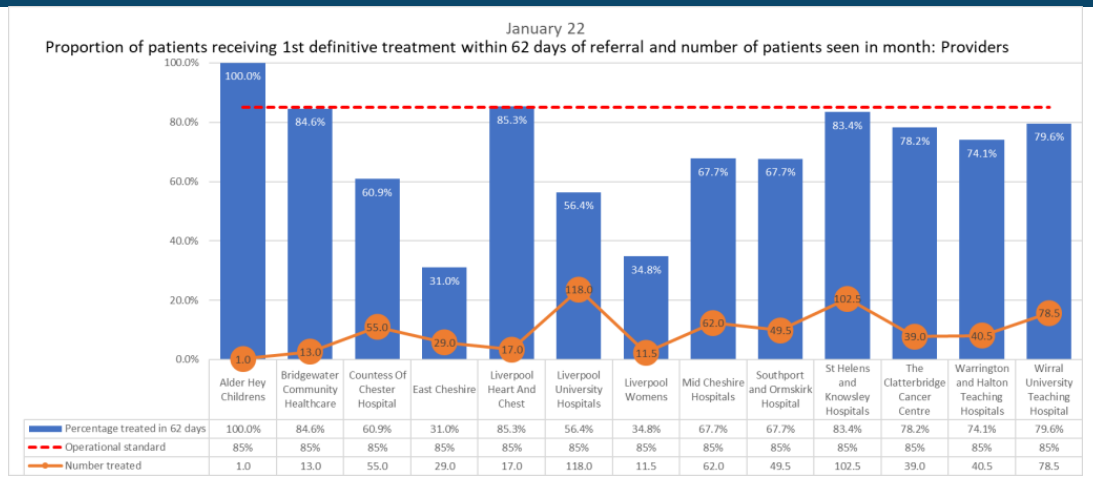
South Sefton 56% (344 breaches)
Cheshire 58.4% (1319 breaches)
Knowsley 61% (298 breaches)
Halton 67.5% (176 breaches)
Wirral 70.9% (430 breaches)
Warrington 57% (369 breaches)
Liverpool 60.7% (812 breaches)
Southport And Formby 64.2% (209 breaches)
St Helens 69.7% (261 breaches)

Section III: 62 Day Standard

62 Day Performance by Cancer Alliance – CCG based (January 2022)



CMCA achieved 67.9% against a standard of 85%.
CMCA was the sixth best performer. The England average was 61.8%

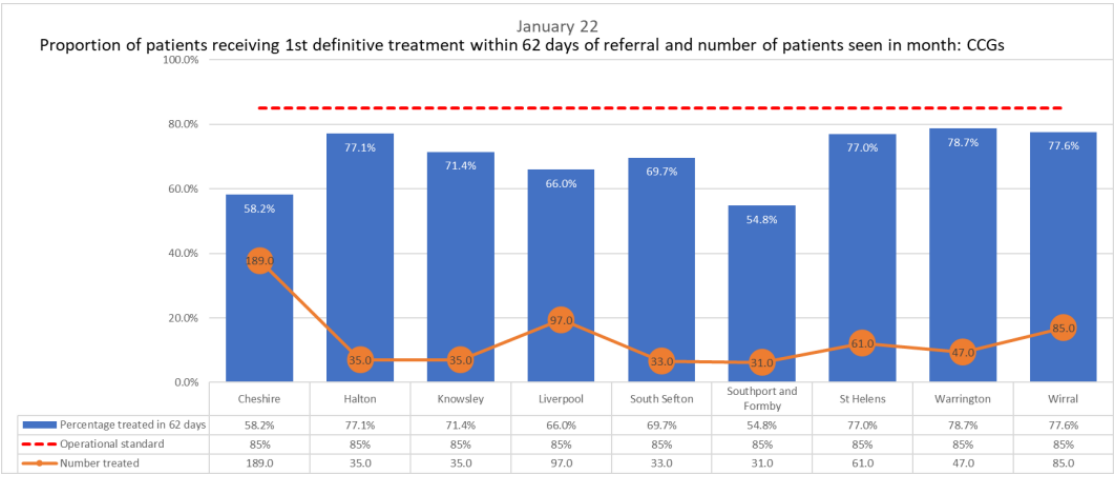


	Alder Hey Childrens	Bridgewater Community Healthcare	Countess Of Chester Hospital	East Cheshire	Liverpool Heart And Chest	Liverpool University Hospitals	Liverpool Womens	Mid Cheshire Hospitals	Southport and Ormskirk Hospital	St Helens and Knowsley Hospitals	The Clatterbridge Cancer Centre	Warrington and Halton Teaching Hospitals	Wirral University Teaching Hospital
Percentage treated in 62 days	100.0%	84.6%	60.9%	31.0%	85.3%	56.4%	34.8%	67.7%	67.7%	83.4%	78.2%	74.1%	79.6%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	1.0	13.0	55.0	29.0	17.0	118.0	11.5	62.0	49.5	102.5	39.0	40.5	78.5

Most Challenged Pathways (January 2022)

Cancer pathways not achieving the national objective were:

Lower Gastrointestinal 37.3% (42 breaches)
Gynaecological 44% (14 breaches)
Upper Gastrointestinal 48.6% (19 breaches)
Head & Neck 58.1% (13 breaches)
Sarcoma 60% (2 breaches)
Breast 64.2% (29 breaches)
Lung 65.7% (24 breaches)
Urological (Excluding Testicular) 66.4% (39 breaches)



	Cheshire	Halton	Knowsley	Liverpool	South Sefton	Southport and Formby	St Helens	Warrington	Wirral
Percentage treated in 62 days	58.2%	77.1%	71.4%	66.0%	69.7%	54.8%	77.0%	78.7%	77.6%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	189.0	35.0	35.0	97.0	33.0	31.0	61.0	47.0	85.0

Report prepared by Jenny Hampson
Performance Information Analyst
jenny.hampson@nhs.net

Cheshire & Merseyside
Cancer Alliance

Dr Liz Bishop
Senior Responsible Officer
liz.bishop1@nhs.net

Jon Hayes
Managing Director
jon.hayes1@nhs.net

General enquiries: ccf-tr.admin.cmca@nhs.net

www.cmcanceralliance.nhs.uk

Cheshire and Merseyside Cancer Alliance is an NHS organisation that brings together NHS providers, commissioners, patients, cancer research institutions and voluntary & charitable sector partners to improve cancer outcomes for our local population.

The Clatterbridge Cancer Centre NHS Foundation Trust

Meeting of the Board of Directors
30th March 2022

Agenda item P1-069-22

4

Report of	Chief Nurse			
Paper prepared by	Chief Nurse Associate Director of Corporate Governance PA to the Chief Nurse			
Subject/Title	Proposed Terms of Reference			
BAF risks reference	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.			
Corporate risks reference				
Divisional risks reference				
Background papers	Good Governance Institute Review March 2022			
Purpose of paper	To advise the committee of the proposed Term of Reference			
Action required	To approve content/preferred option/recommendations			√
	To discuss and note content			
	To be assured of content and actions			
Link to: Trust's Strategic Direction Corporate Objectives	Be Outstanding	√	Be a great place to work	√
	Be Collaborative	√	Be Digital	√
	Be Research Leaders	√	Be Innovative	√

The use of abbreviations within this paper is kept to a minimum, however, where they are used the following recognised convention is followed:

Full name written in the first instance and follow immediately by the abbreviated version in brackets.

Equality & Diversity Impact Assessment

The content of this paper could have an adverse impact on:	Age	Yes/**No**	Disability	Yes/**No**	Sexual Orientation	Yes/**No**
	Race	Yes/**No**	Pregnancy/Maternity	Yes/**No**	Gender Reassignment	Yes/**No**
	Gender	Yes/**No**	Religious Belief	Yes/**No**		

Meeting of the Board of Directors
30th March 2022

1. Introduction

At The Clatterbridge Cancer Centre NHS Foundation Trust we want quality and safety to be our core philosophy and to be at the heart of every decision that we make. Our expertise, reputation and network places us in a unique position to lead the way in delivering excellence in care through our networked, acute and specialist oncology services.

In order to do this we must ensure that our clinical and corporate governance framework supports continuous improvement in the quality and safety of the delivery of care and treatment to our patients. This includes having a positive culture of risk management where everyone understands their role in reporting and managing risks. Each area must hold its own risk register which feeds into the corporate risk register and then into the board assurance framework, thereby identifying the biggest risks to the organisational strategy. This allows the board to examine the risks and scrutinise the mitigations.

We must also have policies and procedures to safeguard patient care, be committed to learning from where things go wrong and promote a culture of robust investigation of incidents with open transparency through duty of candour. It is also of upmost importance that we promote an organisational culture that encourages patients, visitors and staff to report any concerns they may have or make suggestions for improvement. We must demonstrate that concerns, comments or suggestions are investigated and that remedial action is put into place where needed.

2. Background

As an organisation we have established systems of internal control that have been effective and tested internally and externally by the regulators. In 2019 the Care Quality Commission rated the organisation as Good overall, with Requires Improvement within the Well-led domain, suggesting areas of improvement which have been considered and where possible implemented.

However, the COVID 19 pandemic has resulted in significant interruption and as an organisation we have had to adapt our services, our systems and the new risks it presented. As we transition into the recovery phase of the pandemic it is an opportunity to take stock of our governance structure to ensure we have the right framework in place to support our recovery and embed a culture of continuous improvement which focuses on patient safety, experience and outcomes. To support this process the Good Governance Institute (GGI) were commissioned to undertake a review of the Trusts position in relation to the Care Quality Commissions (CQC) Well Led requirements. This took place in quarter 4 of the reporting year 2021/22, draft findings were shared with the Board of Directors at February Board and a full report will be issued in due course.

The recommendations in this paper are based on the findings from the GGI report, feedback from senior managers and internal stakeholders and modelled on systems and process in place at NHS Trusts rated Outstanding by the CQC, i.e. The Royal Papworth NHS Foundation Trust.

3.0 Committee Process

3.1 Governance Committee Structure

This is a robust committee structure to ensure that the Trust has systems and processes in place, which are monitored, safe and effective. This process ensures transparency from ward/department operational practice through monitoring, oversight and assurance to Board of Directors, with check and challenge from our Non-executives and governors.

Current position
The committee structure has been reviewed and enhanced over the previous 12 months in order to ensure closer scrutiny of strategic and operational risks. The current structure, whilst providing close oversight, is protracted and time consuming. There is potential for this system to become overly complex and in turn introduce risk into the organisation. For example Integrated Governance Committee comprises of an average 35 written papers per monthly meeting, 8 of which are received past the submission date. On average 40 separate items are discussed per meeting.

Recommendation 1
Review and re-align the current committee structure to provide clear reporting processes focusing on assurance and triangulation of information. **Appendix 1** Proposed committee structure.

Key changes:

- Non Executive Director led assurance committees to be held quarterly. **Appendix 2** Committee membership
- Introduce a new Non Executive led assurance committee known as 'People committee' in response to the NHS People plan and in alignment with Quality, Performance and Audit committee
- Merge Integrated Governance committee and Risk Management committee into Risk & Quality Governance Committee chaired by CEO to be held monthly
- Elevate the status of Patient Safety Group to an Assurance committee held monthly

3.2 Committee chairs and administration support
The role of the Chairperson is to ensure that the Committee functions properly, that there is full participation during meetings that all relevant matters are discussed and that effective decisions are made and carried out. The Chairperson of the committee has an operational role in quality assuring the content of the agenda and papers. The key to a highly functioning committee is having the appropriate support system in place.

Current position
The operational assurance committees are chaired by senior leaders and includes multi-disciplinary representation by other key members of Trust staff, however there is often repetition with the same people attending multiple meetings and due to clinical commitments there is minimal medical representation. Each meeting has a set of minutes (often recorded verbatim from a MS Teams recording), a Triple A (Assure, Advise, Alert)/Chairs report and an action log. The action log details every closed and open action and therefore by month 12 is quite sizable.

Recommendation 2
Review and re-align membership to ensure equity and appropriateness of attendance and improve medical representation by encouraging medical chairs of the operational assurance committees.

Recommendation 3
Introduce the role of lead officer for the sub committees to be the guardian of the meeting. They are the person who liaises with the chairperson and administrator to make the arrangements for the meetings, including terms of reference, agenda items, decisions made and the content of the minutes of the meeting.

Recommendation 4
Lean the administrative burden by producing 1 set of minutes per meeting which includes a section for 'items for escalation' (this can be either one of or a combination of Assure, Advice, Alert) which are items that the chair of the committee is unable to manage without the support of the parent committee. Capture actions within the minutes to be reviewed at the following meeting. Refine the action list to an action rolling programme which details the forward work plan. Merge the report front page into the report template and lean the content.

Recommendation 5
Provide support and guidance to committee chairs, lead officers and administrators.

3.3 Committee effectiveness
It is good practice to evaluate the effectiveness of the committees on an annual basis.

Current position
There is no current process to evaluate committee effectiveness for operational assurance committees

Recommendation 6
Introduce an annual audit of committee effectiveness to align with the annual review of the terms of reference in order for any issues to be managed collectively.

4.0 Risk Management
Risk is inherent in everything that we do and it is incumbent on the Board of Directors and Divisional teams to ensure that decisions made on behalf of the organisation are taken with consideration to effectively manage risk. The organisational structure is supported by the Risk Management Framework which provides a systematic process for identifying risks attached to new and current business activities.

4.1 Risk Register
The risk register is the central repository where risks that may be a threat (or opportunity) to the achievement of objectives are recorded. The Trust has in place registers for teams, divisions, corporate operational and strategic risks. Each committee is also assigned its own risk register which includes risk and issues pertaining to the business of the committee.

4.2 Levels of Risk
- Board Assurance Framework (BAF) details the strategic risks that affect the Trust's ability to deliver the strategy or function as an organisation as a whole.
- Corporate Operational Risks are risks that affect the delivery of the business plan or common team risks that require a corporate response.
- Divisional risks are risks that are related to the delivery of departmental operations and objectives. Programmes and their project outcomes have associated risks, usually, time limited activities and medium- to long-term delivery of benefits.

Current position
The Trust utilises the Datix risk management system which is commonly used across the NHS. Approximately 24 months ago the Trust became an early adopter site for the latest version of the system known as Datix Cloud IQ. The transition onto this version has been challenging for multiple internal and external reasons but the team have worked in collaboration with the company to make the required adjustments. It is acknowledged that there continues to be a period of transition before the system is truly embedded and its full functionality is utilised.

In parallel with the move to Datix IQ the Quality Committee agreed on 20th May 2021 to move from a single risk register being the central repository for all organisational risks to a two tier system of risks and issues. This process has been in place and tested for 10 months but has not shown to offer any additional assurance and there is potential for this system to become overly complex and in turn introduce risk into the organisation. The Good Governance Institute noted that the division between risks and issues in the risk register is not standard NHS practice.

Recommendation 7
Continue as a test site for Datix IQ with the aim of fully embedding the system and becoming an exemplar site for other organisations.

Recommendation 8
Revert to a recognised risk register methodology for the management and monitoring of all organisational risks

5. Incident reporting, investigation and management
Open, honest and timely reporting of incidents with fair and thorough investigation and evidence of improvement actions taken demonstrates a mature and transparent organisation. As an organisation we aim to have a high reporting low harm culture.

Current position
The Trust utilises Datix cloud IQ for the reporting and management of incidents. Prior to January 2022 an incident meeting took place daily at 10am where staff reviewed incidents from the previous day and decided on perceived levels of harm. Whilst this quickly shared issues there was no robust process in place for following up on actions taken and system wide changes required. Reports presented at committees were focussed on activity/numbers and compliance rather than patient experience and continuous improvement and learning. The daily incident meeting was stopped at the end of December 2021 and replaced with a weekly Executive Review Group (ERG) chaired by the Chief Nurse where moderate incidents, complaints, PALs, claims and harms are triaged and full investigation analysis is discussed with the clinical teams. Actions from these reviews are monitored to completion by the clinical governance team.

Recommendation 9
Continue to refine the executive review group process and develop an overarching monthly report for discussion and action.

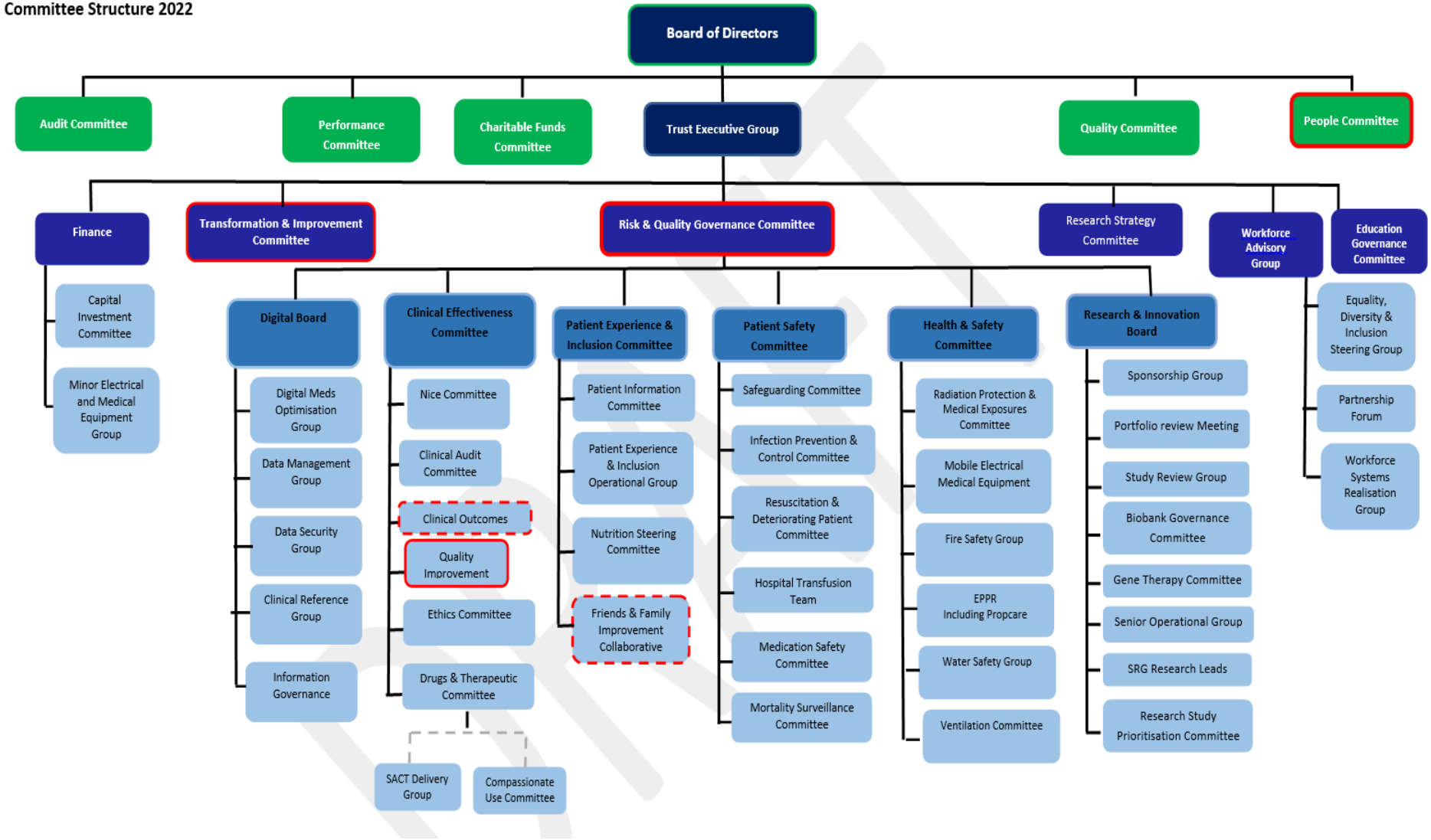
Recommendation 10
Provide education and training on incident scoring, investigation and report writing

5. Conclusion
There is no immediate risk identified with the current governance systems and processes. The structures in place are functioning to keep the organisation safe. However, there are areas where improvements could be made to bring the Trust in line with recognised NHS practice and where efficiencies and effectiveness can be realised with a more streamlined process, as noted by the Good Governance Institute.

Members of the Committee are asked to consider and approve the following:
- 10 recommended areas for improvement detailed within the report.
- 2022/23 committee structure in Appendix 1
- Timeline for implementation 12 months with quarterly review following a plan, do, study, act (PDSA) methodolgy of continuous quality improvement.

Appendix 1

Committee Structure 2022



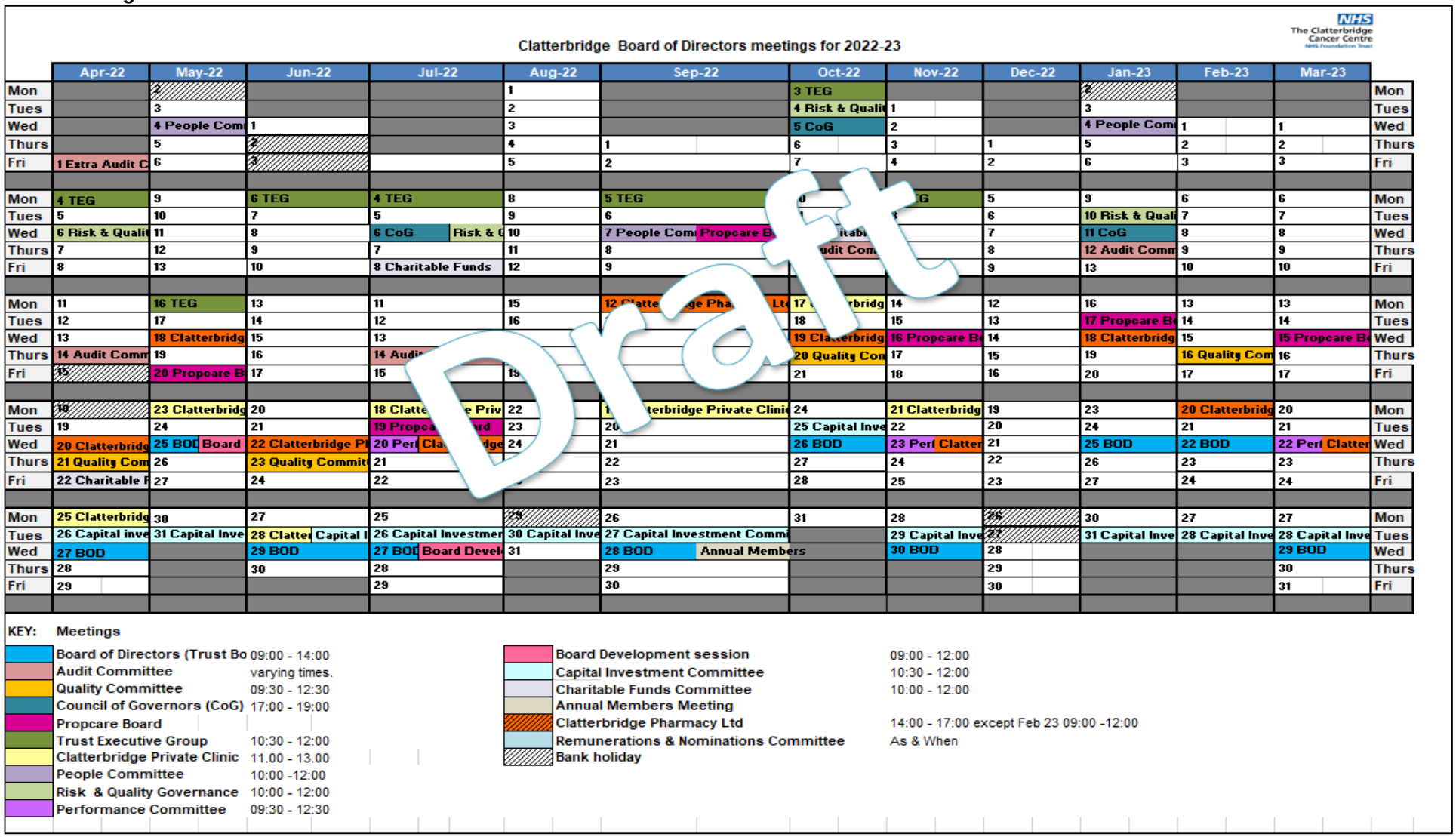
Appendix 2

Proposed Non executive director membership

Committee	Membership
Audit committee	Mark Tattersall Geoff Broadhead Asutosh Yagnik
Quality Committee	Terry Jones Elkan Abrahamson Asutosh Yagnik
Performance Committee	Geoff Broadhead Mark Tattersall Elkan Abrahamson
Charitable Funds	Elkan Abrahamson Anna Rothery Terry Jones
People Committee	Anna Rothery Geoff Broadhead Asutosh Yagnik

Appendix 3

Draft Meeting Schedule



REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	30 March 2022
Agenda item:	P1-070-22
Title:	Annual Review of Board Effectiveness 2021-2022
Report prepared by:	Margaret Saunders, Associate Director of Corporate Governance
Executive Lead:	Liz Bishop, Chief Executive
Status of the report: (please tick)	Public ☐ Private ☒

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

Purpose of the paper/key points for discussion:	NHS Improvement Guidance (2017) requires all Board Committees and Trust Board to undertake an annual self-assessment to assess performance and effectiveness and report to the Audit Committee. Appendix 1, based upon the Self-Assessment Checklist within the hfma NHS Audit Handbook provides details of the digital Self-Assessment Checklist which will be circulated electronically for completion via a Microsoft Form, following the March/April 2022 Committee and Board Meetings. The results will be presented to Committee to inform the Trust Annual Report and develop the Board Cycle of Business for 2022-2023.

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

Next steps required:	Members are requested to complete the digital Committee Effectiveness Review Form.

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.

Appendix 1 - Self-Assessment Checklist

Statements		Assessment					Comments
		1	2	3	4	5	
1	The membership of the Committee reflects its remit						
2	The action log is monitored by the Committee and used effectively to manage the business in conjunction with the Cycle of Business						
3	Conflicts of interest are disclosed and managed appropriately						
4	Reports provide the Committee with robust information on assurance strength						
5	There is clarity in reporting to enable the Committee to focus on the key issues and challenge effectively and appropriately						
6	Committee members and regular attendees understand the Committee's role & duties						
8	All Committee members are thoughtful participants in debates and respectful of each other's opinions						
9	All Committee members add value through their skills and expertise and through providing relevant challenge						
10	Committee members and regular attendees come to the meetings well prepared						
11.	The Committee chair is an effective leader						
12	Committee members and others in attendance challenge each other appropriately						
13	The Committee receives robust assurance on the operational risks & issues aligned to the committee						

Appendix 1 - Self-Assessment Checklist

Statements		Assessment					Comments
		1	2	3	4	5	
14	The committee considers and understands the Board Assurance Framework Risks aligned to the Committee and are able to discuss and agree on appropriate scoring.						
15	Papers for committee meetings are received at least 5 working days prior to committee meetings						
16	The committee minutes are a true reflection of the discussion and challenge within committee meetings.						

Strongly Agree	5
Agree	4
Neither Agree nor Disagree	3
Disagree	2
Strongly Disagree	1