AGENDA

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Trust Board of Directors Meeting: held in Public

Date: Wednesday 27 April 2022	Location: Floor 13, The Spine
Start Time: 09:30	Finish Time: 12:30

Timings	Item No		Lead	Paper/Verbal
Opening Matters				
09:30	P1-72-22	Welcome & Apologies: Elkan Abrahamson	KD	Verbal
	P1-73-22	Declarations of Committee Members' and other attendees' interests concerning agenda items:	KD	Verbal
	P1-74-22	Minutes of last meeting: 30 March 2022	KD	Paper
	P1-75-22	Matters Arising/Action Log	KD	Paper
09:40	P1-76-22	Chair's Report to the Board	KD	Verbal
Risk and Assurance				
09:50	P1-77-22	Audit Committee Chair's Report	MT	Paper
10:05	P1-78-22	Staff Story	JSh	Verbal
10:20	P1-79-22	Patient Experience Visits	JG	Paper
10:35	P1-80-22	Integrated Performance Report: Month 12	JSp/JSh	Paper
10:50	P1-81-22	Finance Report: Month 12	JT	Paper
11:05	P1-82-22	New Consultant Appointments *-No new appointments*	SK	N/A
11:05	P1-83-22	Extra-Ordinary Charitable Funds Chair's Report Charity Independent status recommendations on legal and Governance	TJ KB	Paper
11:30	P1-84-22	Board & Committee Schedule	JG	Paper
System Working				

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11:45	**P1-85-22**	Cheshire & Merseyside Cancer Alliance Performance Report	**LB**	**Paper**
Strategy				
11:55	**P1-86-22**	Board Development Feedback	**SK**	**Paper**
12:10	**P1-87-22**	GGI Board Report & Action Plan	**TP**	**Paper**
Closing Matters				
12:25	**P1-88-22**	Any Other Business	**ALL**	**Verbal**

Next Meeting:

Date: Wednesday 25 May 2022	Location: Floor 13, The Spine
Start Time 09.00	Finish Time: 12.30

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Minutes of the Trust Board of Directors held in public

Held on: Wednesday 30th March 2022	Location: MS Teams
Start time: 10:15 (break 12:15- 14:00)	Finish time:

Present

Name:	Title:
Kathy Doran (KD)	Chair
Mark Tattersall (MT)	Non-Executive Director
Terry Jones (TJ)	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
Sarah Barr (SB)	Chief Information Officer
Julie Gray (JG)	Chief Nurse
Tom Pharaoh (TP)	Director of Strategy
Jayne Shaw (JSh)	Director of Workforce & OD
Joan Spencer (JSp)	Chief Operating Officer
Sheena Khanduri (SK)	Medical Director

In attendance

Name:	Title:
Margaret Saunders (MS)	Associate Director of Corporate Governance
Jane Wilkinson (JW)	Lead Governor
Michael Varey (MV)	Staff Side Chair

Item no.	Agenda item	Action
P1-050-22	**Welcome & Apologies:** The Chair welcomed the meeting. Apologies were noted from Non-Executive Director, Elkan Abrahamson	
P1-051-22	**Declarations of Committee 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	
P1-052-22	**Minutes of last meeting: 23 February 2022** The minutes of the Board meeting held on 23 February 2022 were approved subject to the following amendments: • Item P1-031-22 Matters Arising / Action Log: should state The Director of Strategy (TP) 'informed the Board P1-103-21, the 5 Year Strategy: Implementation Plan will be presented to the Board in March 2022' instead of Non-Executive Director (MT).	

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	• Item P1-038-22 Finance Report: Month 10: Reference to the 'NECIP differential' should instead be the 'CIP differential'. • Item P1-038-22 Finance Report: Month 10: where the minutes state 'AY commended the Trust on reclaiming £5.9 which would be received in February 2022', instead of £5.90 they should state £5.9 million in ERF funding. **The Trust Board:** **Approved** the minutes of the previous meeting subject to the above amendments. **Noted** the focus going forward will be for the minutes to be shorter and sharper, highlighting main discussion and resolutions.	
P1-053-22	**Matters Arising/Action Log** The Board noted that actions were either complete, on the Agenda or not yet due. In addition the following amendment was requested: P1-199-21 Mortality Dashboards: The Medical Director presented revised papers with SPC charts at Trust Board in February 2022 as noted in the minutes. The Trust Board approved action P1-199-21 as complete. **The Trust Board:** **Noted** the position in relation to the Action Log	
P1-054-22	**Chair's Report to the Board** The Chair provided an update on the collaborations the Trust is part of and the ongoing discussions being had, noting the following: • The Trust is awaiting notification on who the new Chair of the Integrated Care Board (ICB) will be. • The Cheshire and Merseyside Acute and Specialists Trusts Group have a number of workstreams they are working on going forward. - The Chairs of these Trusts met and the Trust's Chief Executive presented on the diagnostic workstream as the responsible officer for that workstream. - The group of Chairs will continue to review each of 5 workstreams. • There are ongoing discussions around one Liverpool and ongoing meetings with the Liverpool chairs and the interim ICB chair. • North West Chairs met with NHS England (NHSE). Main topics discussed were Covid infection rates and planning for next year. • NHS Providers (NHSP) held a session that highlighted similar issues and also noted a greater focus on equality and diversity. The Trust can expect to see NHSP produce more input in that area. In this context the new Equality and Diversity Lead for Clatterbridge, Walton and Alderhey is settling into her role. **The Trust Board:** **Noted** the report	
Risk and Assurance		
P1-055-22	**Quality Committee Chair's Report** Non-Executive Director, TJ introduced the report. In addition to the report, there are changes being made to the Quality Committee. TJ as Chair will work with the Chief Nurse to streamline the reporting through the integrated Governance Committee to ensure Quality Committee receives top line information to facilitate the Committee to move to a quarterly timetable. **The Trust Board:** **Noted** the report	

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P1-056-22	**Performance Committee Chair's Report** Non-Executive Director GB introduced the report from the meeting in March. The following areas were highlighted: • A revised version of the February 2022 meeting minutes will come to the committee in July 2022. • The Integrated Performance Report highlighted issues with life support training and delays in Covid testing leading to delays in treating patients. Actions for both were included in the report on the Board agenda. • The committee received a report on Bed Utilisation – Future plans and Potential opportunities from which an implementation plan will come to committee with quarterly updates. • The committee was pleased to see improved performance on pharmacy stock levels. • Further items on the report were included as agenda items for this Trust Board meeting. **The Trust Board:** **Noted** the report	
P1-057-22	**Patient Story** The Chief Nurse noted the patient story had been presented as a video and sent out prior to the meeting. Confirmation was received from the Board that they had received the video and had no technical issues with this mode of sharing the Patient Story. It was acknowledged the video of the patient story would be published on the Trust website. This Patient Story was Rachel's story of her diagnosis with breast cancer. The Chief Nurse highlighted the benefit of receiving Patient Stories digitally, as this format can allow patients to articulate an emotional story without the pressure of being directly in front of the board Rachel's Story demonstrated the impact a diagnosis can have on not only on patients but also on families. In light of Rachel's Story the Board discussed the Trust's Psychological services highlighting the following issues: • Receiving this type of treatment at Clatterbridge specifically is not necessarily appropriate for everyone. • The Trust has other linked services that patients can be sign posted to for example at: MerseyCare, LUFT psychology team, St Helens, Primary care. • Resources within the Psychological Services team will be reviewed to reflect demand. The possibility of recruiting nurses who are trained counselors, is being looked at. • Patient pathways need to be reviewed to help identify when patients may need information on referral to these services. When patients are referred to the Trust a Holistic Needs Assessment is completed (this was confirmed to have continued through Covid). The frequency and timing of this assessment needs to be reviewed. • The fact that those who are more articulate in their need for a referral may be more likely to get services needs to be taken into account. • A new Head of Patient Information Centre is in place. They will be a first point of contact for patients.	

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	Non-Executive Director AR raised an issue from the patient experience visit 'walkabout' she had attended in March 2022. A patient raised that they had researched a genetic cancer link through their ancestry. The Medical director confirmed that as part of the surgical breast work up questions are asked in relation to family history with the possibility of referral where appropriate to the genetics unit at Liverpool Women's Hospital. There is also guidance if women present below the age of screening for their relatives to be referred at a younger age onto the screening programme. **The Trust Board:** **Noted** the story and the insights it gave **Requested** feedback on the actions taken from this story be provided to the Patient Experience and Inclusion Group (PEIG) and for a summary of such actions to come to Trust Board in an annual report each year. **Thanked** Rachel for sharing her story and **asked** for a formal letter/card to be sent to Rachel on behalf of the Board	**JG** **JG**
P1-058-22	**Patient Experience Visits** The Chief Nurse introduced the report of the February Patient Experience visit that took place on Floor 1 of Clatterbridge Liverpool. The key discussions were: • The possibility of blood tests being closer to home: Community phlebotomy is being looked at across Cheshire and Merseyside. There have been challenges getting results quickly and to the right clinician when bloods are taken somewhere other than the Trust. As different Laboratories use different systems blood request forms are not universal, which can be challenging. The Trust has been working with GPs and commissioners on getting bloods taken locally to patients with a timescale for improvement of 12 months. The finance team are working with commissioners on joint assumptions to plan the financial impact of the service. • Appointment letters and how we communicate with patients: This is being picked up in the Patient Experience & Inclusion Strategy. • Comments from Staff on underutilising staff skills: There is a piece of work going on around Floor 1 and how it functions. Models and pathways are being looked at to reflect the way of working at Clatterbridge Liverpool. The Chief Operating Officer noted there will be changes to the service in the coming months. Staff are involved in the workstreams of the project and will be reminded to disseminate this information to colleagues. **The Trust Board:** **Thanked** those that attended or assisted with the Patient Experience Visit. **Noted** the report**.** **Requested** feedback on the actions taken from this visit be provided to the Patient Experience and Inclusion Group (PEIG) and come to Trust Board (with actions for other visits) in an annual report each year.	**JG**
P1-059-22	**Integrated Performance Exception Report: Month 11** The Chief Operating officer introduced the report and provided an update on performance for month 11 2021/22 (February 2022). The exception reports for the 24 day Referral to treatment target and 62 Day wait from GP referral to treatment target were highlighted. Access to molecular testing mainly regarding the lung pathway, had caused the breaches of these targets along with an increase of demand due to the high number of referrals seen. There are strategic and operational pieces of work	

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	going on to turn this around and short term support from Liverpool clinical laboratories is in place. The Chief Nurse gave an overview of the Quality section of the report and highlighted the c.difficile performance which was above target. The Trust have put changes in place. There was one complaint in February that did not meet the 25 day target by one day., The Chief Nurse noted the approval process has been re-communicated to Divisions to prevent future delays. The Medical Director noted that there were no exception reports for Research and Innovation in February and the revised annual target had been exceeded. Further recruitment will be taking place from March end and future targets will be more ambitious. The Director of Workforce & OD gave an overview of the Workforce section of the report noting sickness absence had decreased but was still above target. The report shows this is mainly due to chest and respiratory problems. The reduction in anxiety stress and depression as a reason for staff absence was highlighted as a positive. The Mandatory Training figures were highlighted and it was noted alternative approaches are being looked at to improve compliance. **The Trust board** **Noted** the contents of the report	
P1-060-22	**Finance Report: Month 11** The Director of Finance Introduced the report noting it had previously been to Performance Committee and highlighting the following: • The Trust is predicted to have a breakeven position or slightly better, this is supported by performance and ERF (Elective Recovery Funding). • There is volatility in the financial position of the Trust being managed through a whole system, however the Trust has sufficient contingency to at least break even. • As planned there has been an increase in recruitment costs and the agency and bank staff costs are stable. • There has been an Increase in drug costs which relates to an increase in activity. • There has been a cash increase as the ERF was paid and the Trust is holding cash for capital. The Cash and Capital position is closely managed and the Trust is expecting to spend money in March on medical equipment and digital software and hardware and expects to spend the full budget. In discussion the Director of finance confirmed that the £2.5million ERF mentioned in the report was in addition to the £5.9million ERF previously noted. **The Trust Board** **Noted** the contents of the report	
P1-061-22	**Annual Financial/Operating Planning Guidance** The Director of Finance Presented the Board with slides on the annual financial/operating planning guidance, noting they had previously been to Performance Committee. The key areas emphasised from the presentation were: **Shared Performance objectives:** **Start rationalisation of outpatient follow-up activity**- There are challenges with this objective as most of the Trust's treatment is classified as outpatient treatment so reduction to	

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	outpatient follow-up activity isn't appropriate in this context. The Trust is working with commissioners to determine which an appropriate target. **2022-23 growth at 11% across all activity-** The Trust is working to understand what 'growth' in activity means in order to ensure it is in line with the ICB (Integrated Care Board) view. **Draft Revenue plan 2022-23** **Assumed full ERF income above 104% activity** – This is the Trust's biggest risk factor. The Trust has included phlebotomy in its Elective Recovery Funding calculations as it is considered an outpatient service. This has been challenged by commissioners, and needs to be resolved. Cancer treatment is considered a follow up so is not currently included in ERF. The Trust is waiting on the financial guidance to be released for further information on this issue. **System fund allocations process and value to be confirmed** – the assumed system funding is being revisited **Inflation** – It has been noted there are inflationary pressures that hospitals are facing that haven't been taken into account in original calculations for tariff uplift. The Trust has a £2.5million energy budget pressure going into 2022. It is looking at how to manage this going forward. **Energy Contracts** The Board discussed the impact of the Russian/Ukraine crisis on the Trust. The Chief Executive confirmed that the Trust doesn't have any direct contracts with Gazprom. The Trust has SLAs (service level agreements) with two other Trusts that have contracts with Gazprom. These contacts end in 2023 and are owned and managed by the holders of the SLAs. The Director of Finance informed the Board that the Trust's energy contract comes up for renewal on 1st April 2022. The £2.5million increase estimate is based on a quote from the energy provider for the first month's payment which is fixed. Propcare will be advising on fixed versus floating contracts in light of the current volatile market and predictions going forward. **Next steps** The contract sign off deadline of 31st March won't be met by the system. Contracts are aimed to be signed off by end of April. As the plans were not ready to present to the Board, the Director of Finance proposed a sub-set of the Board reconvene prior to the next Trust Board meeting with delegated authority to review and submit the plans during the week of 18th April 2022 **The Trust Board:** **Noted** the progress that had been made and the ongoing work being done **Agreed** to hold another meeting the week of 18th April to sign off the final plan providing at least two Non-Executive Directors are in attendance.	**MS**
P1-062-22	**Gender Pay Gap** Director of Workforce & OD introduced the annual report, which shows the gender pay gap as of 31st March 2021. This is required to be published by the Trust. The following areas of the report were highlighted: • Gender pay gap indicators – this data was extracted from the national workforce system • .	

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	• Bonus payments – It was noted there has been a change to the medical staff clinical excellence awards. The payment previously required an application/ this is now not the case and is paid to all eligible staff. • How do we compare to other trusts – This was a new section of report and showed the Trust is behind, although it has improved this year. The Trust will make contact with those doing better to share actions and learn from each other. • Actions will be monitored by the Equality, Diversity & Inclusion Lead and work will be monitored through the new people committee The Director of Workforce & OD asked the Board for approval for the report to be published with final sign off from the Chief Executive. The Board discussed the report: • It was suggested the report should highlight, the positive actions the Trust has taken and acknowledge that improvements will be a slow process but one the Trust is committed to working on. • It was proposed there should be research into the pay gap of women of ethnic minorities. Although this was not a reporting requirement going forward it could be done alongside this report. • The Shadow Board which was a leadership learning opportunity and had predominately female participation will be included in next year's report. **Trust Board** **Approved** the report for publication with an amended introduction to reflect the ongoing work and the Trust's commitment to future improvement.	
P1-063-22	**5 Year Strategy Implementation Report** The Director of Strategy introduced the report. The first version of the report came to the Board in June 2021 where they asked for an update every 6 months. Due to pressures on the service in January 2022 and changes to committee agendas and timetables, the report was deferred until March 2022. This report had been to Performance Committee where it was discussed and noted that although it is a high level report it contains a lot of detail about the work going on; it gives a snapshot of the activity that contributes to the implementation of the 5 year strategic plan and is a useful report. Performance Committee had asked that going forward the report highlighted where new projects that hadn't been mentioned in the original plan, had been added. The Chair noted the 'highlights since last report' page was useful and welcome. **The Trust Board** **Noted** the report **Thanked** the Director of Strategy and his team for their work	
P1-064-22	**New Consultant Appointments** The Director of Workforce noted the appointed consultant had been interviewed prior to pandemic which had delayed him joining. He joined in March 2022 and has an extensive consultant background. The Trust will support him getting on the specialist register, as this is his first appointment in the UK. **The Trust Board** **Noted** the content of the report	
P1-065-22	**Guardian of Safe Working Report Q3** The Medical Director introduced the report for quarter 3, highlighting the 3 exception reports in this quarter which were submitted by GP trainees, managed appropriately and closed. The	

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	Trust relies on locums and had recently noted 3 resignations of clinical fellows, which are fixed term contracts. The Trust is reviewing the reasons for leaving. The Trust is also doing a piece of work to look at the middle grade tier, looking at training, fellowship programmes and developing skill mix. There is a new Guardian of Safe Working starting which means there might be more exception reporting going forward as they are likely to raise awareness of exception reporting with colleagues. The Director of Finance noted a budget for an increase in training numbers and clinical fellow posts is included in the financial plan. **The Trust Board** **Noted** the report	
P1-066-22	**4 Year Patient Experience Engagement Inclusion & Involvement (PEEII) Commitment** The Chief Nurse introduced the report noting that the Trust had worked with, patients, families, the public and staff to develop the PEEII Commitment with 4 key themes that align with trust values. Non-Executive Director AR noted that one of the themes was 'Give patients a leading voice: Inclusion and diversity' however the Commitment noted that an Equality Impact Assessment is not applicable. The Board agreed that if not already completed an equality impact assessment is needed for this strategy. The Chief Information Officer noted the Trust and wider network are looking at how they can include the potential digital exclusion of communities in the equality impact assessment **The Trust Board:** **Noted** the contents of the report. **Approved** the commitment/strategy subject to the equality impact assessment**.** **Approved** the 'visual minute'.	
P1-067-22	**Staff Survey Results** The Director of Workforce & OD introduced the staff Survey results for 2021. The results had been embargoed until the morning of the Trust Board and therefore the slides presented were not shared with the Board in advance. The Director of Workforce & OD gave background on the survey and highlighted the changes made from 2020. As the results had been embargoed it was not possible to compare them nationally at this point however after brief comparison they looked to be in line with the north west position. The presentation showed the Trust's position against the people 7 promise statements, staff engagement and morale. It was highlighted that for the following questions, the Trust's score had reduced and it was below average: • Care of patients is my organisation's top priority • I would recommend my organisation as a place to work • If a friend or relative needed treatment, I would be happy with the standard of care given my organisation Non-Executive Director, AR noted that on the recent patient experience walkabout they had heard an example of a staff member having the opportunity to progress within the	

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	organisation into a different area and noted that opportunity to use or develop different skills can impact morale. It was noted the Trust could do more to share similar stories of upskilling and progression and show these opportunities are available. The Director of Workforce & OD highlighted that after the move to the new hospital it had been expected that there would be a decline in staff survey results which hadn't been seen last year. It was noted that these results could show this delayed response, along with the impact that Covid has had on the system. It was highlighted that 78% of the questions showed no significant change and the Trust remained above average in a number of areas. The next steps will include looking at the national results to get more context. The presentation was requested to go out with the minutes of the meeting and the full 80+ page Staff Survey Results Report to go in the Board's online reading room. ***Post Meeting Note**: During the Private Board meeting on the afternoon of 30th March the Director of Workforce & OD informed the Board the national results had been published and the Trust compared favorably against others. A graph detailing this comparison is to be shared with colleagues*. **The Trust Board** **Noted** the content of the presentation. **Noted the** work program and **Remitted** further work to be managed by the people committee.	**MS** **JSh**
System Working		
P1-068-22	**Cheshire & Merseyside Cancer Alliance Performance Report** The Chief Executive introduced the report and highlighted that the levels of activity and referrals has stayed high but the diagnostic pathways, the 62 day and 104 day targets remain a challenge. However, the 62 and 104 day numbers had fallen a little. The aim is for the system to get the 62 day numbers down to pre-pandemic levels by end of March 2023. It was noted the Endoscopy waiting lists are growing as demand exceeds supply and non-cancer surveillance patients had been added. There was a requirement for all units to meet an increased efficiency target. However this was not met in the last few weeks due to Covid absences. The Chief Executive stated activity remains largely on track with increased focus on Trusts with more challenging issues. This report goes to all Trusts, ICBs and place leads as well as accountable officers of CCGs. As there are new Place leads appointed, the Chief Executive will ensure it also goes to them. **The Trust Board** **Noted** the report.	
Governance		

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P1-069-22	**Board Committee Governance Structure 2022-2023** The Chief Nurse introduced the report which covered the review of governance structure. The Board was asked to approve the recommendations as well as the new template for the coversheet and report. The report included a new committee membership structure and draft timetable. The Board discussed the recommendations and raised questions on the following topics: • Clarification on the recommendation for a 'single set of minutes' –For Committees that sit below Trust Executive Group in the Structure they will produce a single set of minutes rather than duplicating work by also producing a Chair's report. For Board committees there will be a set of minutes and a replacement of the 'Triple A' Chair's report that has a specific and separate purpose to the minutes. It was noted that having a separate summary to minutes can be helpful for attendees of multiple committees. This and the way minutes are written will be looked into. • It was noted that a change in culture would be required for the new structure, where Non-Executive Directors receive less information in reports with the ability to ask for additional information if not provided with assurance. • It was noted that the next Quality Committee was scheduled for June 2022 and that next year this meeting should be in July. • It was suggested the new coversheet should identify links to which BAF risks and strategic objectives • It was recommended in addition to recommendation 4 that minutes be written and approved within a target 48-72 hours of the meeting • It was recommended in addition to recommendation 8 that the Trust explore a way to incorporate into risks, a revised score in the event of a risk having crystallised • It was noted that the GGI (Good Governance Institute) Well-Led report given in the Part 2 Trust Board meeting gave insight into the current structure and need for development. The Non-executive directors recommended an 'away day' for the Board to discuss further. • The lack of branding in the coversheet was highlighted. The Chief Nurse agreed to follow up the discussion points as part of a continuous review of the structure. **The Trust Board** **Noted** the content of the report **Approved** the structure and recommendations provided there is continued monitoring and formal review in 6 months.	JG JG
P1-070-22	**Annual Review of Board Effectiveness 2021-2022** The Associate Director of Corporate Governance presented the questions for the Annual review of Board Effectiveness. **The Trust Board** **Approved** the questions	
Closing Matters		
P1-071-22	**Any Other Business** The Chief Nurse informed the Board that in early March 2022 there was a whistleblowing issue raised through the CQC (Care Quality Commission). This was investigated and the CQC were happy with the response and have closed the case.	

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Next meeting:

Date: Wednesday 27th April 2022	Location: Level 13, The Spine
Start time: 09:00	Finish time: 12:30

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

						P1-xxx-21
BOARD ACTION SHEET PART 1						
			KEY: BLUE = COMPLETE / GREEN = ON TRACK / AMBER = AT RISK / RED = LATE			
Item No.	**Date of Meeting**	**Item**	**Action(s)**	**Action by**	**Date to complete by**	**Date Completed / update**
P1-178-21	27-Oct-21	Finance Report - Month 6	Financial Impact Analysis report on APU to be presented to Performance Committee	**JT**	Q1 2022/23	Quality Committee received the APU DiaNovember gnostic Report 18th November QC-243-21 presented by JSp & TP, and presented at Board Part 2. Further financial impact report to be presented Q1 22/23
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/hear from patients in future.	**JG**	Q1 22/23	
P1-15-22	26-Jan-22	Nursing Safer Staffing Report	future reports to present information on actual staff numbers on given days rather than establishment only.	**JG**	Q4-2021/22	
P1-24-22	26-Jan-22	Constitution Amendments for Approval	Grammatical amendments required around the language used throughout the constitution and the inconsistency in the use of 'he/her' pronouns and 'they'. It was agreed this would be reviewed and amended prior to publishing.	**MS/AY**	Q4-2021/22	Ammendements made, Completed Feb-22
P1-061-22	30-Mar-22	Annual Financial/Operating Planning Guidance	To hold another meeting the week of 18th April to sign off the final plan providing at least two Non-Executive Directors are in attendance.	**MS/JT**	Apr-22	
P1-067-22	30-Mar-22	Staff Survey Results	The presentation was requested to go out with the minutes of the meeting and the full 80+ page Staff Survey Results Report to go in the Board's online reading room.	**MS**	Apr-22	Completed March 2022
P1-067-22	30-Mar-22	Staff Survey Results	To share graph detailing comparrison of staff survery results with national figures with the Board	**JSh**	Apr-22	Completed Apri 2022
P1-069-22	30-Mar-22	Board Committee Governance Structure 2022-2023	The Chief Nurse agreed to follow up the discussion points as part of a continuous review of the structure.	**JG**	Apr-22	
P1-069-22	30-Mar-22	Board Committee Governance Structure 2022-2023	Formal Review of Board Committee Governance Structure	**JG**	Sep-22	

CHAIR'S REPORT

NHS
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Committee/Group 'Triple A'

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

Name of Committee/Group: Audit Committee	Reporting to: Trust Board
Date of meeting: 1 April 2022	Parent Committee:
Chair: Mark Tattersall	Quorate: Yes

Agenda item	RAG	Key points	Actions required	Action lead	Expected date of completion
AUD-028-22 – 2021-22 Annual Accounts – Review of Accounting Policies		The Committee approved the changes		Deputy Director of Finance	1 April 2022 - Completed
AUD-029-22 – Accounting Estimates		The accounting estimates were considered by the Committee and there were a number of areas with work in progress	An update to 14 April 2022 Committee meeting	Deputy Director of Finance	14 April 2022
AUD-031-22 – Constitution Incorporating Standing Orders		Discussions were held around several areas which required clarity	An update to 14 April 2022 Committee meeting	Associate Director of Corporate Governance	Deferred due to Associate Director of Corporate Governance absence
AUD-033-22 – Improving Cyber Resilience		Substantial assurance was received on improving cyber resilience and on immediate priorities including unsupported services		Chief Information Officer	1 April 2022 - Completed

CHAIR'S REPORT

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Committee/Group 'Triple A'

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

Name of Committee/Group: Audit Committee	Reporting to: Trust Board
Date of meeting: 14 April 2022	Parent Committee:
Chair: Mark Tattersall	Quorate: Yes

Agenda item	RAG	Key points	Actions required	Action lead	Expected date of completion
AUD-041-22 – MIAA Internal Audit Progress Report April 2022		Seven reports finalised, ESR/Payroll – High assurance, R&I – Substantial assurance, Risk Management – Substantial assurance, Medical Devices – Moderate assurance, Complaints & PALS – Moderate assurance, Incident Management – Limited assurance, BAF – n/a. The plan is substantially complete with only two remaining pieces of work in progress, Data Security Toolkit & Finance procedures update.	Complete remaining outstanding work and progress recommended actions.	Internal Audit Manager Associate Director of Corporate Governance	May 2022
AUD-042-22 – MIAA Annual Report & HIAO 2021-22		MIAA presented the Annual report and confirmed that the Trust had received an overall assurance rating of substantial.	Noted, for inclusion in Trust Annual Report.	Corporate Governance team	April 2022
AUD-043-22 – MIAA Draft Internal Audit Plan 2022-232 for Approval		The Audit Committee approved the Draft Internal Audit Plan for 2022-23 subject to a minor amendment to include a Data Quality review in the plan.	Amendment to be made to include DQ review.	MIAA Internal Audit Manager	May 2022
AUD-045-22 – MIAA Anti-Fraud Plan 2022-23		The Audit Committee approved the 2022-23 Anti-Fraud Plan 2022-23	Approved	MIAA Anti-Fraud Specialist	
AUD-046-22 –		Ernst & Young presented the audit plan. Provisional Materiality limits have been	Confirm materiality limits for 2021-22 audit work.	Ernst & Young	May 2022

CHAIR'S REPORT

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Provisional Audit Planning Report 2021-22		calculated at £3.470m being 1.5% of group operating expenditure. A performance materiality has also been set at £1.735m being 50% of materiality. There was discussion around this materiality level as this is new to the Trust. EY explained that as new auditors they set a lower materiality in the first year. These limits will be reviewed and updated once they receive the draft 2021-22 Accounts at the end of April.			
AUD-048-22 – Key Financial Assurance Indicators		The Audit Committee noted the content of the report and the continued high BPPC performance, being greater than 95% in all areas. Continued low level of aged creditors and debtors with no debt write-offs in the month.	Maintain improvements delivered in all areas.	Deputy Director of Finance	On-going
AUD-051-22 – Audit Committee Terms of Reference V4		The Audit Committee agreed the Terms of Reference with minor amendments	To be signed off after amendments.	Corporate Governance team	July 2022
AUD-052-22 – Audit Committee Annual Work Plan		The Audit Committee agreed the annual work plan with minor amendments.	Agreed		
AUD-055-21 – Declarations of Interest Register		The Audit Committee reviewed the register of interests and discussed potential future improvements.	Improvements to be incorporated into future versions of the register.	Corporate Governance team	July 2022

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

Report to:	Trust Board	
Date of meeting:	27 April 2022	
Agenda item:	P1-000-22	
Title:	Patient Experience Visit – March 2022	
Report prepared by:	Cllr Anna Rothery, Non-executive Director	
In attendance at visit:	Myfanwy Borland, Governor	
	Claire Smith, Quality Improvement Manager	
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 17th March 2022 at CANtreat chemotherapy clinic Halton, 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

REPORT COVER

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NHS Foundation Trust

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

☐ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☒ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Patient Experience Visits 17/03/2022

Cllr Anna Rothery, Non-executive Director
Myfanwy Borland, Governor
Claire Smith, Quality Improvement Manager

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

1. Summary

The Patient Experience 'round' was conducted on the 17th March 2022, visiting the CANtreat chemotherapy clinic in Halton. Due to Covid-19 restrictions across all CCC sites, Anna Rothery, Non-executive Director and Myfanwy Borland, Governor were able to accompany Claire Smith, Quality Improvement Manager virtually on this occasion as scheduled.

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

2. Key Findings and Observations

Patient experiences and comments – 3 patients from the CANtreat chemotherapy clinic Halton were asked to share their experiences of being treated at CCC.

- The first patient shared that he had bowel, liver and lung cancer. He described the staff at the clinic as being 'great' stating he has 'lots of laughs' with them, he said they always help each other out and work together as a team. The day of the walkabout he said was unusually quiet as the clinic tends to be much busier. When asked if he minded not being able to bring a relative/friend in with him during his treatment, he responded that he didn't mind as the staff were lovely. The patient couldn't think of anything CCC could do better, although he recounted a negative experience at the start of his cancer journey when he had a CT scan performed at Halton hospital. He felt that there were delays in him receiving his results/feedback but never raised this as an issue at the time.

- The second patient shared the experience that she was currently working through her treatment as a community nurse in the NHS. Although she lived locally she was unaware that CCC had been delivering chemotherapy to patients at Halton for over 10 years. This service was a huge benefit to her as it was only a 5 minute journey from her home. Overall her experience had been very positive, all staff had been "fabulous and can't do enough for me". Although she found it difficult not being able to bring her husband in whilst she had treatment, she was grateful that her medical appointments had mainly been via telephone which meant he was able to be part of the conversations from their home. The hardest part of her journey so far was the wait for a treatment plan following diagnosis "everyday day matters as you fear it could be spreading"

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NHS
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NHS Foundation Trust

and although “chemotherapy is rubbish it is giving me a chance at life”. When asked what CCC could do better she said everything is so good, the only improvement she could suggest would be a short leaflet with the “little things” to expect; what will happen when you arrive at the clinic, informing patients how free car parking works, letting you know you will be offered free tea and coffee. The patient added that she felt cancer treatment was manageable as long as you know the plan.

- The third patient shared that they had been receiving cancer treatment since 2018, she had experienced care in different trusts but at the CANtreat clinic all staff had been “lovely, kind and nothing was too much”. A while ago she had an issue when her PICC line needing replacing, staff were able to sort this out the following day allowing her to continue with treatment. The patient was made aware by medical staff that her cancer diagnosis was related to her genes, she has since research her family tree and found a strong family history of cancers.The patient explained how grateful she is that she is able access modern cancer treatments unlike many of her relatives who have gone before her. The patient is a keen artist and would like to paint some pictures to hang in the waiting and treatment areas to give patients something positive to look at during their treatment.

Staff experiences and comments

- Five staff members were able to share their experiences of working at CANtreat at Halton (x3 healthcare assistants and x2 registered nurses). All staff talked about how lovely the patients were so it was a pleasure treating them and easy to go the extra mile for them whenever possible, they explained that it is often the positive patient feedback that keeps them going.

- Leadership - all staff expressed how they felt forgotten about in Halton, they all described how they rarely see the matron or other managers from the main sites. Staff revealed they would like to see more senior leaders coming to the clinic so they can see the issues for themselves. Although not present during the visit, staff reported that the ward manager showed great leadership. They were concerned that she was under a lot of pressure as she is the only hub manager not to have a deputy to share the managerial load. She often works clinically to bolster the nursing numbers in the clinic, however staff feel guilty that she frequently works late and in her own time.

- Capacity/pharmacy – Staff described issues with capacity at the clinic and delays due to pharmacy. It was reported that a patient had attended the clinic on the day of the visit, his chemotherapy was delayed by 2 hours 45 minutes

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and still hadn't arrived from CCCL. The patient had decided to leave and return the following day as his lift was waiting outside (he had travelled from Haydock). Staff felt frustrated that they were the ones having to give the news to patients face to face regarding chemotherapy delays, although mostly patients were understanding. Staff reported that they had seen an initial improvement with pharmacy issues until recently when CCC merged with Aintree Haemato-oncology, staff reported that they have witnessed a direct negative impact on the clinic. It was reported that it is common to have missing treatments most days, pharmacy frequently only send half a treatment and you need to wait for the rest to be delivered.

- Staffing pressures - staff reported how they had struggled as a small team over the past two years due to the number of staff on maternity leave, this was happening again this year and staff had some concerns about how those left behind are going to cope. As of April it was reported that 5 full time nurses will be on maternity leave. Staff also highlighted that the clinic does not have medical cover or access to a MET team. This week a patient had reacted to her chemotherapy and staff had been required to administered adrenaline, one nurse stated "you really need to be confident and trust in the team you are working with".

- Retention - some staff mentioned that they had looked for other jobs, one nurse stated that if staffing issues are still the same when she returns from maternity leave she will definelty be looking for another job. She was sad about this as she loves her job, the patients and the team. However the constant pressure of staffing and capacity was making it too stressful. Other staff who don't live locally cited the toll bridge and rising fuel costs as a reason for why they might be looking for other jobs.

- Training and education - One member of staff was new to CCC starting only 3 weeks ago, her second week was a planned training week at CCCL. The staff member described how a number of the sessons were cancelled so she had travelled to Liverpool unnecessarily, one session had been cancelled minutes before it was due to start, she described how another new member of staff from a different department had also travelled in for the training, she reported it had taken her 2 hours only to find the session was cancelled. One of the training sessions was critical to her role, no new dates had been sent so she was still unsure when the training would be delivered. However, she mentioned that she had witnessed this in other NHS trusts she had worked in, on a positive note she stated that so far CCC has been the best NHS trust. Training was also highlighted by other members of staff who were concered that without the necessary additional training, new healthcare assistants will be unable to

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The Clatterbridge Cancer Centre NHS Foundation Trust

support the trained staff at a time when they are needed the most. A staff member wanted to share that some of the experienced band 2 staff where training new starters who are band 3s which they didn't feel was fair.

- Communication - staff reported that patients generally don't know the clinic exists, CCC trust COMMs is focused around the new building and the other main sites. Staff felt it helps if the team live locally because they can advise about local services as this is not always advertised on the trust website.

- Staff progression - one healthcare assistant mentioned that recently the HCA numbers had increased so she was hoping to move to CCC Aintree as it is closer to home and would mean a promotion to a higher band if she was successful. This staff member described how she had been employed as a phlebotomist in a previous trust and had fought to move up from a housekeeper to healthcare assistant to be able to use her skills. Although she says this was difficult, she is now aware of other housekeepers in the turst who have made the same progression.

- One staff member mentioned that she had decided not to have her Covid 19 vaccine for personal reasons which she had dicussed with her manager. The NHS mandate to make the vaccine compulsary had not changed her mind and she was willing to leave the NHS. Although she felt supported by her immediate team and ward manager she didn't feel this extended to other trust members.

3. Next Steps and Recommendations

- Discuss report findings at Trust Board
- Note content of report
- Feedback shared with areas during the visit
- Acknowledge the need for further action required to share feedback received with relevant Divisional leaders and teams, by the Head of Patient Experience
- Request further updates as required.

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Board of Directors
Date of meeting:	Wednesday 27th April 2022
Agenda item:	
Title:	Integrated Performance Report M12 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:	
Date & decision:	

Purpose of the paper/key points for discussion:	This report provides the Board of Directors with an update on performance for month 12 2021/22 (March 2022). The access, efficiency, quality, research and innovation, workforce and finance (timing dependent) scorecards are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant. Points for discussion include under performance, developments and key actions for improvement.

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

Next steps required:	

REPORT COVER

The Clatterbridge Cancer Centre NHS Foundation Trust

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

☒ BE **OUTSTANDING**

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

☒ BE **COLLABORATIVE**

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

☒ BE **RESEARCH LEADERS**

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

☒ BE **A GREAT PLACE TO WORK**

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

☒ BE **DIGITAL**

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

☒ BE **INNOVATIVE**

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

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

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Integrated Performance Report (Month 12 2021/22)

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

Introduction

This report provides an update on performance for month twelve; March 2022. The access, efficiency, quality, workforce, research and innovation, and finance scorecards (depending on timing) are presented, each followed by exception reports of key performance indicators (KPIs) against which the Trust is not compliant.

Staff flu vaccine and Covid booster vaccine data is not included in this M12 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%), there are specific courses for which compliance is below target. Exception reports for those courses are included in this IPR.

From M1 2022/2023, a Covid-19 Recovery Activity Report will be included as an appendix to the IPR, presenting activity against national planning guidance targets and Trust forecasts.

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	Mar-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%	91.8%	92.7%	
C/S	**2 week wait** from GP referral to 1st appointment	⟷	93%	93.8%	97.1%	
L	**24 days** from referral to first treatment	↑	G: ≥85% A: 80-84.9% R: <80%	81.9%	86.1%	
C/S	**28 day** faster diagnosis - (Referral to diagnosis)	⟷	75% (formally monitored since Oct 2021)	58.8%	75.4%	
C/S	**28 day** faster diagnosis - (Screening)	-	75% (formally monitored since Oct 2021)	No patients	0%	There has only been 1 28 Day FDS Screening patient during this time
S	**31 day** wait from diagnosis to first treatment	⟷	96%	99.7%	99.2%	
C/S	**31 day** wait for subsequent treatment (Drugs)	⟷	98%	99.3%	99.3%	
C/S	**31 day** wait for subsequent treatment (Radiotherapy)	⟷	94%	98.8%	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%	71.2%	85.4%	
C/S	**62 Day** wait from screening to treatment	↓	90%	83.3%	85.7%	
L	Number of patients treated between **63 and 103 days** (inclusive)	↑	No Target	62	515	
S	Number of patients treated **≥ 104 days**	↑	No Target	23	175	
L	Number of patients treated **≥ 104 days AND at CCC for over 24 days (Avoidable)**	↑	G: 0 A: 1 R: >1	4	9	
C/S	Diagnostics: **6 Week Wait**	⟷	99%	100%	100%	
C/S	**18 weeks** from referral to treatment (RTT) Incomplete Pathways	⟷	92%	98.4%	98.5%	

Notes:

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

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

Cheshire and Merseyside Cancer Waiting Times Performance:

The February 2022 data has not yet been published Nationally

1.2 Efficiency

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

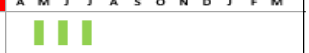
Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Mar-22	YTD 2021/22	Last 12 Months
Executive Director Lead: Joan Spencer, Chief Operating Officer						
S (SOF)	Diagnostic activity as % of the same month in 2019/2020	⟷	95% of 2019/20 levels	201%	181%	
S (SOF)	% of all (non-treatment) outpatient activity delivered remotely via telephone or video	⟷	25%	62%	67%	
L	Outpatient Appointments (including treatments) as % of the same month in 2019/2020	⟷	95% of 2019/20 levels	134%	128%	
S	Length of Stay: Elective (days): Solid Tumour	⟷	G: ≤6.5 A: 6.5-6.8 R: >6.8	6	6.4	
S	Length of Stay: Emergency (days): Solid Tumour	⟷	G: ≤8 A: 8.1-8.4 R: >8.4	5.4	7.8	
S	Length of Stay: Elective (days): HO Ward 4	⟷	G: ≤21 A: 21.1-22.1 R: >22.1	5.4	15.1	
S	Length of Stay: Emergency (days): HO Ward 4	-	G: ≤22 A: 22.1-23.1 R: >23.1	10	11.2	
S	Length of Stay: Elective (days): HO Ward 5	⟷	G: ≤32 A: 32.1-33.6 R: >33.6	6.7	18.1	
S	Length of Stay: Emergency (days): HO Ward 5	⟷	G: ≤46 A: 46.1-48.3 R: >48.3	5	11.3	
S	Delayed Transfers of Care as % of occupied bed days	↓	≤3.5%	2.7%	3.4%	
S	Bed Occupancy: Midnight (Ward 4: HO)	⟷	G: ≥85% A: 81-84.9% R: <81%	93.1%	87.8%	
S	Bed Occupancy: Midnight (Ward 5: HO)	⟷	G: ≥80% A: 76-79.9% R: <76%	86.0%	75.5%	
S	Bed Occupancy: Midday (Solid Tumour)	⟷	G: ≥85% A: 81-84.9% R: <81%	84.6%	73.8%	
S	Bed Occupancy: Midnight (Solid Tumour)	↑	G: ≥85% A: 81-84.9% R: <81%	83.3%	74.0%	
C	% of expected discharge dates completed	⟷	G: ≥95% A: 90-94.9% R: <90%	93.0%	87.0%	
C/S	% of elective procedures cancelled on or after the day of admission	⟷	0%	0%	0%	0% for all months
C/S	% of cancelled elective procedures (on or after the day of admission) rebooked within 28 days of cancellation	⟷	100%	None cancelled	N/A	No elective procedures have been cancelled on or after the day of admission
C/S	% of urgent operations cancelled for a second time	⟷	0%	0%	0%	0% for all months
L	Imaging Reporting: Inpatients (within 24hrs)	⟷	G: ≥90% A: 80-89.9% R: <80%	95.9%	96.4%	
L	Imaging Reporting: Outpatients (within 7 days)	⟷	G: ≥90% A: 80-89.9% R: <80%	82.3%	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%	94.5%	96.5%	
C	Data Quality - % of outpatients with an outcome	⟷	G: ≥95% A: 90-94.9% R: <90%	100.0%	99.8%	
C	Data Quality - % of outpatients with an attend status	⟷	G: ≥95% A: 90-94.9% R: <90%	100.0%	99.8%	
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	Mar-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	0 for all months
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	167.6	182.1	
L	Incidents resulting in harm /1,000 bed days	↓	No target	15	18	
C/S	Inpatient Falls resulting in harm due to lapse in care	⟷	0	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%	96.0%	97.0%	
C/S	% of Sepsis patients being given IV antibiotics within an hour*	⟷	90%	94.0%	95.0%	
C/S	VTE Risk Assessment	⟷	95%	95%	96%	
S	Dementia: Percentage to whom case finding is applied	⟷	90%	86%	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)	2	14	
C/S	E Coli (attributable)	⟷	≤6 (pr yr)	2	13	
C/S	MRSA infections (attributable)	⟷	0	0	1	
C/S	MSSA bacteraemia (attributable)	↑	G: ≤4, A: 5 R: >5 (pr yr)	1	3	
C	Klebsiella (attributable)	↑	≤6 (pr yr)	1	7	
C	Pseudomonas (attributable)	↓	≤10 (pr yr)	0	2	
C/S	FFT score: Patients (% positive)	⟷	G: ≥95% A: 90-94.9% R: <90%	96%	96%	

The Quality KPI scorecard continues on page 5

Directive	Key Performance Indicator	Change in RAG rating from previous month	Target	Mar-22	YTD 2021/22	Last 12 Months
Executive Director Lead: Julie Gray, Chief Nurse						
C	Number of formal complaints received	↑	No target	6	41	
S	Number of formal complaints / count of WTE staff (ratio)	↑	No target	0.0036	0.0021	
C	% of formal complaints acknowledged within 3 working days	↔	100%	100%	98%	
L	% of routine formal complaints resolved in month, which were resolved within 25 working days	-	G: ≥75% A: 65-74.9% R: <65%	None resolved	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	45	N/A	
L	% of policies in date	↑	G: ≥95% A: 93.1-94.9% R: <93%	95%	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.
*This data is subject to change following final validation.
** One Dec 2021 IG incident is under review (awaiting information from an external body), 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	Mar-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)	299	1113	
National	Study set up times (days)	↔	≤40 days	N/A	N/A	Latest reporting period is 1/1/21 – 31/12/21: 24 days
L (Strategy)	Recruitment to time and target	↔	G: ≥52% A: 45-54.9% R: <45%	N/A	N/A	Latest reporting period is 1/1/21 – 31/12/21: 32%
L (Strategy)	Studies Opened	↓	G: ≥5 A: 4-5 R: <4 (pr month)	3	45	
L (Strategy)	Publications	↑	G: ≥11 A: 10-9 R: <9 (pr month)	12	201	

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	Mar-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%	5.6%	5.2%	
S	Staff Turnover*	↑	G: ≤1.2% A: 1.21–1.24% R: ≥1.25%	1.21%	16.55%	
S	Statutory and Mandatory Training	↔	G: ≥90% A: 75-89% R: ≤75%	93.87%	N/A	
L	PADR rate	↔	G: ≥95% A: 75-94.9% R: ≤74%	93.26%	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 March 2022 financial data is not yet available.

2. Exception Reports

2.1 Access

24 days from referral to first treatment	Target	Mar-22	YTD	Last 12 Months
	G: ≥85% A: 80-84.9% R: <80%	81.9%	86.1%	

Reason for non-compliance

6 of the 27 breaches were treated within the 62 day target. These were all unavoidable; due to delay to molecular test result, patient choice and medical reasons.

21 of the 27 patients breached the 62 day target. Only 7 of these were avoidable; details are provided in the 62 Day exception report.

The unavoidable breaches were due to delays to molecular test results, delay with diagnostic tests at other trust, medical and patient choice reasons.

Action taken to improve compliance

Please see the 62 Day exception report for actions.

Expected Date of Compliance	30/4/22
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	Mar-22	YTD	Last 12 Months
	G: ≥ 75% R: <75%	58.8%	75.4%	

Reason for non-compliance

Only 2 of the 7 breaches were avoidable; due to delay to follow up appointments. The unavoidable breaches were due to delay at other trust/diagnostic test service, patient choice and medical reason.

- Patient 24 - Delay to follow up appointment
- Patient 28 - Delay to follow up appointment

Action taken to improve compliance

The Acute Care Division has identified a recent theme of increased time to follow up after diagnostic tests, partially related to the on boarding of HO patients (and Consultants) from Aintree. Consultant training is underway, to ensure pathways are aligned to the target.

Expected Date of Compliance	30/4/22
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	Mar-22	YTD	Last 12 Months
	G: ≥85% R: <85%	71.2%	85.4%	

Reason for non-compliance

21 patients breached the 62-day target in March. 7 of the breaches were avoidable and 14 were unavoidable. The unavoidable breaches were due to delays to molecular test results, delay to diagnostic tests at other trust, medical and patient choice reasons. The avoidable breach details are as follows:

- Delay to 1st appointment due to clinic capacity and delay to radiotherapy due to outlining capacity
- Delay to planning appointment due to machine break down and patient was category 1 (such patients have to start treatment on a Monday as they require 5 daily consecutive treatments).

• Patient had 1st appointment with medical oncology and then required an appointment with Clinical oncology. There was a delay to treatment due to planning machine breakdown. • Delay to radiotherapy due to consultant availability to outline treatment plan • Pathway delayed due to Pharmacy admin delay. The patient was treated on day 26. • Consultant admin delay. New consultant was unable to complete treatment action plan. • Pathway delayed as patient was category 1 (such patients have to start treatment on a Monday as they require 5 daily consecutive treatments). The patient was treated on day 25.	
Action taken to improve compliance • Daily monitoring and escalation of appointment bookings remains in place to enable management and prioritisation for first appointments • Waiting List Initiatives have been implemented for HPB, Breast, Head and Neck and LGI • Due to significant staffing and equipment issues, the Radiotherapy Department is in a state of business continuity; processes have been initiated to closely monitor and attempt to prevent breaches at this challenging time. • The TOG meeting terms of reference have been significantly revised, with the changes due to be implemented in April 2022. This will create stronger links between both Trust and system operational activity and cancer waiting times.	
Expected Date of Compliance	30/4/22
Escalation Route	CWT Target Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

62 Day wait from screening to treatment	**Target**	**Mar-22**	**YTD**	**Last 12 Months**
	G: ≥ 90% R: < 90%	**83.3%**	**85.7%**	
Reason for non-compliance 1 patient breached the 62-day Screening target in March. The breach was unavoidable due to patient choice of 1st oncology appointment date.				
Action taken to improve compliance N/A				
Expected Date of Compliance	30/4/22			

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

Number of patients treated ≥104 days AND at CCC for over 24 days (Avoidable breaches)	**Target**	**Mar-22**	**YTD**	**Last 12 Months**
	G: 0 A: 1 R: >1	4	9	

Reason for non-compliance

6 patients breached the 104-day target in March and were with CCC for more than 24 days. 4 of these were avoidable breaches. The avoidable breach details are as follows:

- Delay to 1st appointment due to clinic capacity and delay to radiotherapy due to outlining capacity
- Patient had 1st appointment with medical oncology and then required an appointment with Clinical oncology. There was a delay to treatment due to planning machine breakdown
- Delay to radiotherapy due to consultant availability to outline treatment plan
- Pathway delayed due to a Pharmacy admin delay. The patient was treated on day 26.

Action taken to improve compliance

Please see the 62 Day exception report for actions.

Expected Date of Compliance	30/4/22
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

Cheshire and Merseyside Cancer Waiting Times Performance:

The February 2022 data has not yet been published Nationally.

2.2 Efficiency

Bed Occupancy	Wards	Target	Mar-22	YTD	Last 12 Months
	Solid Tumour (Midday)	G: ≥85% A: 81-84.9% R: <81%	84.6%	**73.8%**	
	Solid Tumour (Midnight)	G: ≥85% A: 81-84.9% R: <81%	83.3%	**74%**	

Reason for non-compliance

Solid tumour ward bed occupancy has increased again this month and is now only 0.4% / 1.7% below the target for midday / midnight occupancy.

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 March. 8 Mutual aid patients have been transferred across to CCC from LUHFT in March 2022.

In March 2022, solid tumour wards have been at OPEL 3 level on 49 occasions and Haemato-oncology wards on 35 occasions. Trust wide, we have declared OPEL 3 on 12 occasions in March.

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.

The CUR non-qualifying rate was 3% for March 2022, which indicates appropriate utilisation of beds.

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.
- An initial proposal to improve bed utilisation was well received by the Performance Committee in March. This proposal will be developed into a more detailed plan for 2022/23 and implementation monitored via the Transformation and Innovation Committee.

Expected date of compliance	Q1 2022/2023
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	Mar-22	YTD	Last 12 Months
	G: ≥95% A: 90-94.9% R: <90%	93%	87%	

Reason for non-compliance

Compliance has improved and is now marginally below target at 93% in March.

This follows the re-launch of the Haemato-oncology (HO) admission documentation (which captures the expected discharge dates).

Action taken to improve compliance

- The Patient Flow Team are working with the Digital team on the 'virtual ward round' system, to ensure EDDs are regularly reviewed.
- 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	31/04/2022
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	Mar 22	YTD	Last 12 Months
	G: ≥90% A: 80-89.9% R: <80%	82.3%	82.5%	

Reason for non-compliance

The target has not been achieved; performance has fallen from 85.9% in February to 82.3% in March 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.
- Locum Radiologist planned to start in April has now declined the post.

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). • Bi-weekly report received by senior radiology team enabling continuous monitoring and prioritisation of outstanding reports. • Additional Radiologists / Clinical Imaging Fellow started in post in September 2021 and March 2022. • Business case developed to support an increase in CCC Radiologist workforce has now been approved and is being implemented; 3 additional permanent Radiologist posts are out to advert.	
Expected date of compliance	September 2022
Escalation route	Divisional Performance Review, Performance Committee, Trust Board.
Executive lead	Joan Spencer, Chief Operating Officer

Data Quality - % Ethnicity that is complete (or patient declined to answer)	**Target**	**Mar-22**	**YTD**	**Last 12 Months**
	G: ≥95% A: 90-94.9% R: <90%	94.5%	96.5%	
Reason for non-compliance Performance is marginally below the 95% target at 94.5% for March 2022. • Following the recent HO merge with Aintree, over 2000 patients transferred across and Ethnicity was not one of the data sets transferred for this group of patients. • An increase in referrals has also reduced the capacity of the Access team to obtain this information.				
Action taken to improve compliance • The Admin team are working with the Digital team to review the option of sending patients a questionnaire via Text message to capture this information. • The Trust has purchased Cancer Somerset Registry; this will help in capturing this information as it will come across from secondary care when captured in their data set. • Information from the National Spine records are to be automatically populated into Meditech, so if ethnicity exists on the spine it will populate the patient record. • Weekend and evening reception staff will be utilised to validate and update the ethnicity information.				
Expected date of compliance	April 2022			
Escalation route	Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board			
Executive lead	Joan Spencer, Chief Operating Officer			

2.3 Quality

Dementia: Percentage to whom case finding is applied	Target	Mar-22	YTD	Last 12 Months
	R: <90% G: 90%	86%	93%	

Reason for non-compliance

The dementia screening tool target of 90% was not achieved for the month of March 2022.

2 out of 14 patients were identified as not having an accurately completed dementia screening assessment tool on admission. Initial investigations highlighted that both patients had been incorrectly entered onto Meditech as a planned admission rather than an emergency admission. Further investigation revealed the involvement of one member of clerical staff in both cases, therefore the cause appears to have been human error. The same issue was identified in February 2022, with the same staff member. This was addressed with further training, however following this incident it was recognised that there are two separate data entry fields where the staff member required further training to support accurate data collection. This additional training is now complete.

Outcome:

- Patient 1; awaiting a hospice bed and would therefore not have been referred for further investigations despite outcomes of the screening tool.
- Patient 2; remains at CCC, alert and orientated. Therefore, does not require referral for further investigations.

Action taken to improve compliance

- Share results and lessons learned with inpatient ward managers and matrons for dissemination across teams.
- CDU manager to reinforce correct recording of type of admission with clerical staff.
- Quality Improvement Manager has delivered focused support to the member of staff, to ensure the correct procedure for admitting patients on Meditech is used.

Expected Date of Compliance	April 2022
Escalation Route	Divisional Quality, Safety and Performance Meetings, Divisional Performance Reviews, Patient Safety Committee, Risk and Quality Governance Committee, Trust Board
Executive Director Lead	Julie Gray, Chief Nurse

Clostridioides difficile infections (attributable)	Target	Mar-22	YTD	Last 12 Months
	≤11 per year	2	14	

Reason for non-compliance

2 healthcare associated CDI infections were identified in March 2022, taking the total for the year to 14.

- 1 case was identified as a result of delayed sampling; the patient was admitted with diarrhoea but a sample was not obtained until 72 hours after admission
- 1 case was identified promptly; the patient had received a multiple course of anti-microbials and is awaiting review by the Anti-Microbial Pharmacist to ascertain that all were prescribed within Trust Formulary

Action taken to improve compliance

- Continue with stool chart audits
- Implement IPC ward rounds to support identification and sampling of loose stools

Expected Date of Compliance	April 2022
Escalation Route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Director Lead	Julie Gray, Chief Nurse

E Coli (attributable)	**Target**	**Mar-22**	**YTD**	**Last 12 Months**
	≤6 per year	**2**	**13**	

Reason for non-compliance

2 attributable *E.coli* cases were identified in March 2022, taking the annual total to 13 attributable cases for the year.

The sources of infection was considered to be gastro-intestinal in one case, and hepatobiliary in the other. No lapses in care were identified in either case.

Action taken to improve compliance

N/A

Expected Date of Compliance	April 2022
Escalation Route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Director Lead	Julie Gray, Chief Nurse

Klebsiella sp. (attributable)	Target	Mar-22	YTD	Last 12 Months
	≤6 per year	1	7	

Reason for non-compliance

1 attributable *Klebsiella sp.* was identified in March 2022, taking the total to 7 attributable cases for the year.

The source of the infection was considered to be gastro-intestinal. No lapses in care were identified.

There is an additional *Klebsiella sp*. infection that was not reported at the time in the IPR due to operational pressures within the IPC Team. This occurred on the 31/1/22; the source of the infection was believed to be intra-abdominal and no lapses in care were identified during the PIR process.

Action taken to improve compliance

N/A

Expected Date of Compliance	April 2022
Escalation Route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Director Lead	Julie Gray, Chief Nurse

MSSA bacteraemia (attributable)	Target	Mar-22	YTD	Last 12 Months
	R: >5 per year A: 5 per year G: ≤4 per year	1	3	

Reason for non-compliance

1 MSSA bactereamia was identified in March 2022.

The infection was attributed to an indwelling intra-venous device due to lack of any other clear source. No lapses in the management of the device were identified.

Action taken to improve compliance

N/A

Expected Date of Compliance	April 2022

Escalation Route	Harm Free Care Meeting, Infection Prevention and Control Committee, Integrated Governance Committee, Divisional Performance Reviews, Quality Committee, Trust Board
Executive Director Lead	Julie Gray, Chief Nurse

2.4 Research and Innovation

Studies opening to recruitment	**Target**	**Mar-22**	**YTD**	**Last 12 Months**
	52	**3**	**45**	

Reason for non-compliance

Forty-five studies have opened to recruitment against an internal target of fifty-two at the end of Month 12 (85% of target).

CCC has issued local approval for eight additional studies, for which we are awaiting Sponsor Greenlight. If all studies had been greenlighted we would have opened 53 studies (102% of annual target at Month 12).

Action Taken to improve compliance

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

Expected date of compliance	The 2021/22 target has not been achieved. The key reason is due to the pauses to opening clinical trials to recruitment.
Escalation route	SRG Research Leads / Committee for Research Strategy
Executive Lead	Sheena Khanduri, Medical Director

Recruitment to Time & Target	Target	Q3 21/22	Last 12 months
	G: ≥52% A: 45-54.9% R: <45%	32%	For the previous reporting period of 1/10/20 – 30/09/21, compliance was 0%

Reason for non-compliance

- The target is an internal metric; no national metric is available.
- Improvement compared to last reporting period.
- Recruitment to Time & Target has shown a reduction at other NHS Trusts when compared to pre-pandemic data.
- Real time data now being monitored for all studies and compliance is 60%.

Action Taken to improve compliance

- Full review of current trial information to predict and manage Time and Target data completed.
- Data reviewed quarterly with SRGs at Portfolio Review meetings.

Expected date of compliance	The 2021/22 target has not been achieved. A national dip in data is evident due to the pandemic.
Escalation route	SRG Research Leads, Committee for Research Strategy
Executive Lead	Sheena Khanduri, Medical Director

2.5 Workforce

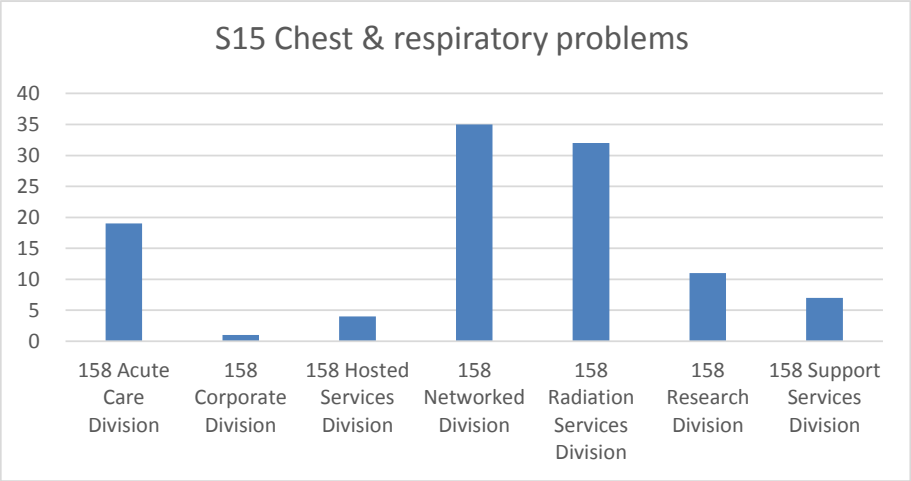
Staff Sickness Absence	Target	Mar-22	YTD	Last 12 Months (in month figures)
	G: ≤4% A: 4.01– 4.99% R: ≥ 5%	5.61%	5.30%	

Reason for non-compliance

- The in-month figure for absence has decreased from 6.24% to 5.61% in March 2022, however, it 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	109
S13 Cold, Cough, Flu - Influenza	46
S10 Anxiety/stress/depression/other psychiatric illnesses	37

- Chest and Respiratory Problems remains the highest reason for absence with 109 episodes across the Trust (75 Covid-19 related); this is an increase from 73 episodes (61 Covid-19 related) in the previous month. This was expected, due to the rise in cases locally.
- As shown in the graph below, the Networked Services Division had the highest number of absences due to Chest and Respiratory problems with 35, closely followed by Radiation Services with 32.
- Whilst Networked Services and Radiation Services had an increase from last month in the total absences due to Chest and Respiratory Problems, Acute Care actually saw a decrease from 26 episodes (21 Covid-19 related) to 19 episodes (10 Covid-19 related).



- Cold, cough and flu remains as the second highest reason for absence, however there has been an increase in the number of episodes from 34 in February to 46 in March. Networked Services accounted for over a third of the overall absences due to cold, cough and flu and within the division, CBU3 (mainly Stream 4 and 5) had the most absences for this reason.
- Anxiety, stress and depression remains as the third highest reason for absence and there has been an increase in episodes from 33 in February to 37 in March. The number of work-related stress absences has remained at 3. 1 absence was a mix of both work and personal stressors and the remaining 36 episodes were related to personal matters. Although we have seen a slight increase in the overall anxiety, stress and depression related absences, it is encouraging to see that the number of work-related stress absences has not increased. There were 26 long-term absences and 11 short-term absences and overall 16 episodes ended in March and 21 continue into April. CBU5 had the highest number of absences with 14, with all other business units having 5 episodes or less each.

Action taken to improve compliance

- The Attendance Management Policy audit is due to commence this 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. The audit will also provide assurance that all long-term sickness cases are being managed appropriately.

- The HR Business Partnering team are regularly checking in with managers to confirm that absence episodes are recorded correctly and that they are closed down in a timely manner; this is to ensure the most accurate absence data is provided in reports.
- On a monthly basis, the HRBP team confirm with managers whether absences relating to anxiety/ stress/ depression are work or personal related and update ESR accordingly. Again, this is to ensure that records are accurate and also to provide assurance that all these absences are managed appropriately and according to individual need.

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

Staff Turnover	**Target**	**Mar-22**	**YTD**	**Last 12 Months**
	G: ≤1.2% A: 1.21-1.24% R: ≥1.25%	1.21%	**16.55%**	

Reason for non-compliance

- The number of leavers this month has increased from 17 to 22. The highest reasons for leaving were 7 Work Life Balance, 6 Promotion and 3 Retirement age.

Reason for Leaving	Number of Leavers
Dismissal - Capability	1
Retirement Age	3
Voluntary Early Retirement – with Actuarial Reduction	1
Voluntary Resignation – Incompatible Working Relationships	1
Voluntary Resignation – Promotion	6
Voluntary Resignation - Relocation	2
Voluntary Resignation - To undertake further education or training	1
Voluntary Resignation – Work Life Balance	7
Grand Total	**22**

- Work Life Balance was the highest reason for leaving in March 2022 and of the 7 leavers, 4 of these were from Acute Care and 3 Networked Services. Only one of these leavers took up employment at another NHS Trust, whilst 2 went to no further employment, 1 to other public sector and 3 were unknown. 4 out of the 7 leavers had fewer than 7 months' service with the Trust. From exit interview data it is evident that the leaving reasons of a few of these staff included more than just work-life balance, such as lack of management support, workload pressures and team working relationships.

- The second highest reason for leaving was Promotion with 6 leavers and of these, 2 were from Acute Care, 2 Radiation Services, 1 Networked Services and 1 Research and Innovation. Of these 6 leavers, all but 1 employee had over 2 years' service with the Trust and 4 took up employment at other local NHS Trusts.

Division	Number of Leavers
158 Acute Care Division	**8**
Add Prof Scientific and Technic	3
Additional Clinical Services	1
Nursing and Midwifery Registered	3
Medical and Dental	1
158 Networked Division	**9**
Administrative and Clerical	6
Nursing and Midwifery Registered	2
Additional Clinical Services	1
158 Radiation Services Division	**3**
Additional Clinical Services	2
Allied Health Professionals	1
158 Research Division	**1**
Administrative and Clerical	1
158 Corporate Division	**1**
Administrative and Clerical	1
Grand Total	22

- As is evident from the table above, together Networked and Acute Care make up over 75% of the total leavers in March 2022.
- Half of the leavers from within Acute Care left due to work-life balance (4) and one of the leavers retired and returned to CCC, making this individual not a true leaver. Of the remaining 3 leavers, 2 were Promotion and 1 Relocation abroad.
- Of the 23 leavers in March 2022, 9 completed an exit interview questionnaire (39%); this was a significant increase from February where no questionnaires were returned and is also an improvement from January 2022 were 5 out of 25 leavers completed an exit interview (20%).
- From analysis of the exit interviews and questionnaires completed, in addition to their main reasons for leaving, the following reasons were cited as factors that also influenced their decision:
    - Staff shortages
    - Health reasons
    - Lack of opportunities
    - Move to Liverpool
    - Travel expenses and cost of parking
    - Lack of management support
    - Relocating abroad
    - Ward conditions
    - New post outside the NHS

Action taken to improve compliance

- The HRBP team have continued to contact leavers directly to ensure that the offer of an exit interview is given at the earliest opportunity, with both face-to-face interviews and MS Teams options being offered. So far, this has led to an increase in the number of interviews that are being accepted and undertaken and is allowing us to gather more valuable feedback of staff experience working at CCC.
- Following the implementation of the new approach to exit interviews, the HRBP team will start to collate data to identify any key themes to inform recommendations/ actions moving forwards.
- The HRBP team continue to run Hybrid and Flexible Working sessions for managers and there are 2 more dates scheduled for April 2022. Managers can book via ESR or alternatively, bespoke sessions can be provided to departments.
- Reminders have been set out to senior leaders and departmental managers to request the completion of the Hybrid Working Risk Assessment and Hybrid Working MS Form to ensure that we are able to accurately capture the uptake of Hybrid Working across the Trust.

Expected date of compliance	June 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**	**Mar-22**	**Last 12 Months**
	G: ≥95% A: 75% - 94.9% R: ≤74%	93.26%	

Reason for non-compliance

Overall, Trust compliance has decreased from 93.61% to 93.26% and remains below the KPI of 95%. 77 staff are currently non-compliant for an annual PADR.

Areas of underperformance are:

Org L4	Reviews Completed %
158 CBU1 - Day Care & Network	**93.08**
158 CBU3 - Admin Services	**94.61**
158 CBU5 - Inpatient Care	**85.03**
158 CBU7 - Radiology Services	**90.74**
158 CBU8 - Physics	**92.96**
158 Cancer Alliance	**86.67**
158 Executive Office	**83.33**
158 Finance	**92.86**
158 Networked Leadership	**90.00**
158 Project Management Office	**83.33**

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 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	01/05/2022
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	Target	Mar-22
	G: ≥95% A: 75% - 94.9% R: ≤74%	89.70%

Reason for non-compliance

150 staff are currently non-compliant and there has been a marginal in-month decline of 0.9% since February.

Current areas of underperformance are:

Org L4	Required	Achieved	Compliance %
158 CBU1 - Day Care & Network	174	153	87.93%
158 CBU4 - Pharmacy	74	66	89.19%
158 CBU5 - Inpatient Care	243	191	78.60%
158 CBU7 - Radiology Services	70	62	88.57%
158 Cancer Alliance	43	38	88.37%
158 Executive Office	17	15	88.24%
158 Project Management Office	8	7	87.50%
158 Quality	8	7	87.50%
158 Recharges	15	11	73.33%

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. • SME to add underperformance to the risk register.

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

Patient Handling	**Target**	**Mar-22**
	G: ≥90% A: 75% - 89.9% R: ≤74%	84.08%

Reason for non-compliance

There has been a gap in provision of patient handling training since February 2022 due to trainer retirement. From April 2022 until June 2022, an external provider has been secured to deliver this training whilst recruitment takes place.

There has been a further in month decline in compliance of 4.35%. 99 staff are currently non-compliant. Current areas of underperformance are:

Org L4	Required	Achieved	Compliance %
158 CBU1 - Day Care & Network	140	109	77.86%
158 CBU5 - Inpatient Care	194	155	79.90%
158 CBU7 - Radiology Services	57	46	80.70%
158 Networked Leadership	4	3	75.00%

Dates are now available for refresher training in May and June and provision for induction is in place for April, May and June. Based on the availability of training dates it is forecast that a further decline in compliance will be seen in April.

The gap in provision and decline in compliance is now recorded on the risk register.

Action taken to improve compliance

• External training provider commissioned to deliver training in April, May and June. • All non-compliant staff to be notified of available dates. • Manual Handling Trainer post to be re-advertised. • Manual Handling Link Trainers have been contacted with a request to provide support.	
Expected date of compliance	July 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 BLS	**Target**	**Mar-22**
	G: ≥90% A: 75% - 89.9% R: ≤74%	78.63%

Reason for non-compliance

There has been an in month increase of 1.4%, however compliance is still below the KPI of 90%. 125 staff are currently non-compliant and of the 97 due to become non-compliant within the next 90 days, only 38 of these are booked onto a further training date.

Current areas of underperformance are:

Org L4	Required	Achieved	Compliance %
158 CBU1 - Day Care & Network	72	56	77.78%
158 CBU2 - Outpatients & Clinical Support	72	62	86.11%
158 CBU3 - Admin Services	55	39	70.91%
158 CBU4 - Pharmacy	36	27	75.00%
158 CBU5 - Inpatient Care	170	132	77.65%
158 CBU6 - Radiotherapy	126	102	80.95%
158 CBU7 - Radiology Services	31	25	80.65%
158 Networked Leadership	3	1	33.33%
158 Research & Innovation	9	7	77.78%
158 Safeguarding	6	4	66.67%

36 DNAs occurred during March; 10 from Acute, 15 from Network and 11 from Radiation Services.

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.

There is sufficient training session capacity to achieve compliance.

Action taken to improve compliance

- All non-compliant staff have been emailed by L&OD requesting they book onto a training date as a matter of urgency.

• 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. • SME to add areas of underperformance to the risk register.	
Expected date of compliance	May 2022
Escalation route	Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Resuscitation Adult ILS	**Target**	**Mar-22**
	G: ≥90% A: 75% - 89.9% R: ≤74%	83.21%

Reason for non-compliance

There has been a small in-month decline of 0.26%. 44 staff are currently non-compliant. 33 of the 56 staff due to be non-compliant in the next 90 days are booked onto training in this period.

Urgent action is required to prevent any further decline in compliance; this has been escalated via the divisional workforce performance dashboards.

Current areas of underperformance are:

Org L4	Required	Achieved	Compliance %
158 CBU5 - Inpatient Care	55	45	81.82%
158 CBU6 - Radiotherapy	57	44	77.19%
158 CBU7 - Radiology Services	35	23	65.71%
158 Networked Leadership	1	0	0.00%

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

Sufficient availability of training dates to achieve compliance is available and additional dates have been made available to support previous DNAs.

Action taken to improve compliance

- All non-compliant staff to be emailed by the L&OD Team and requested to complete the training as a matter of urgency.
- Continue to provide managers with monthly compliance report to enable proactive management and planning of training by divisions.

• Continue to ensure a high level of scrutiny against divisional performance via PRGs, with relevant actions and improvement plans implemented. • SME to add underperformance to the risk register.	
Expected date of compliance	May 2022
Escalation route	Divisional Performance Review, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Safeguarding Adults Level 3	**Target**	**Mar-22**
	G: ≥90% A: 75% - 89.9% R: ≤74%	82.26%

Reason for non-compliance

There has been an in-month decline of 2.8%. 47 staff are currently non-compliant and a further 14 are due to become non-compliant within the next 90 days. 22 of these staff are booked onto training in April and May. Based on current data predictions, if no further action is taken, compliance within the next 90 days will increase to 85.28%.

Areas of current underperformance are:

Org L4	Required	Achieved	Compliance %
158 CBU1 - Day Care & Network	70	58	82.86%
158 CBU2 - Outpatients & Clinical Support	32	27	84.38%
158 CBU5 - Inpatient Care	62	40	64.52%
158 Networked Leadership	4	2	50.00%

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 have now completed 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

- All non-compliant staff to be emailed by the L&OD Team and requested to complete the training by 01 May 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.

• SME to add underperformance to be added to the risk register.	
Expected date of compliance	May 2022
Escalation route	Divisional Performance Review, Safeguarding Committee, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

Safeguarding Children Level 3	**Target**	**Mar-22**
	G: ≥90% A: 75% - 89.9% R: ≤74%	84.91%

Reason for non-compliance

There has been an in-month decline of 1.3% and there are currently 40 non-compliant staff.

Areas underperforming are:

Org L4	Required	Achieved	Compliance %
158 CBU1 - Day Care & Network	70	62	88.57%
158 CBU5 - Inpatient Care	62	42	67.74%
158 CBU6 - Radiotherapy	69	61	88.41%
158 Networked Leadership	4	2	50.00%

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

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

The L&OD Team have now completed enhancements to ESR to simplify the process for staff to identify the level of safeguarding training required for their role. The L&OD Team are also carrying out further investigation into the number of staff required to complete this training.

Action taken to improve compliance

- All non-compliant staff to be emailed by the L&OD Team and requested to complete the training by 01st May 2022.
- Review of training needs analysis to be complete by 30th April 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.

• SME to add areas of underperformance to the divisional risk register.	
Expected date of compliance	May 2022
Escalation route	Divisional Performance Review, Safeguarding Committee, Quality Committee, Trust Board
Executive lead	Jayne Shaw, Director of Workforce and OD

REPORT COVER

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Report to:	Trust Board	
Date of meeting:	27th April 2022	
Agenda item:	P1-81-22	
Title:	Finance Report - Month 12	
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 for Month 12 2021-22.

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

Next steps required:	N/A

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

☐ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

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Finance Report

James Thomson - Director of Finance

Version: 1.0 Ref: FCGOREPO Review: May 2024

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

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1. Introduction

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

Metric (£000)	In Mth 12 Actual	In Mth 12 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	264	43	221		266	0	266	
CPL/Propcare Surplus/ (Deficit)	153	0	153		886	0	886	
Control Total Surplus/ (Deficit)	417	43	374		1,152	0	1,152	
Group Cash holding	80,726	58,000	22,726		80,726	58,000	22,726	
Capital Expenditure	6,062	5,742	(320)		10,838	10,872	34	
Agency Cap	71	95	24		817	1,140	323	

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 has achieved a slight surplus.

3. Operational Financial Profile – Income and Expenditure

3.1 Overall Income and Expenditure Position

The Trust financial position to the end of March is a £266k surplus, the group consolidated position is a £1.152m surplus. The group cash position is a closing balance of £80.7m, which is £22.7m above plan and a £3m increase in month. Capital spend has increased by £6m and spend is £34k under plan.

The Trust is under the agency cap by £24k in month and £323k in the year to date.

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

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Metric (£000)	Actual M12	Trust Plan M12	Variance	Actual YTD	Trust Plan YTD	NHSI Variance	Draft Trust Annual Plan
Clinical Income	23,708	21,917	1,791	215,842	211,974	3,868	211,974
Other Income	7,692	1,861	5,831	26,106	22,695	3,411	22,695
Total Operating Income	**31,400**	**23,778**	**7,622**	**241,948**	**234,669**	**7,279**	**234,669**
Total Operating Expenditure	(31,567)	(23,414)	(8,153)	(238,394)	(230,810)	(7,584)	(230,810)
Operating Surplus	**(167)**	**364**	**(531)**	**3,554**	**3,859**	**(305)**	**3,859**
PPJV	663	67	596	1,496	804	692	804
Finance Costs	(232)	(389)	156	(4,784)	(4,663)	(121)	(4,663)
Trust Surplus/Deficit	**264**	**43**	**221**	**266**	**0**	**266**	**0**
Subsiduaries	153	0	153	886	0	886	**0**
Consolidated Surplus/Deficit	**417**	**43**	**374**	**1,152**		**1,152**	**0**

The table below summaries the consolidated financial position:

March 2022 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	464	(421)
Donated Depreciation	82	969
Donated Asset Income	(282)	(282)
Trust Retained Surplus / (Deficit)	**264**	**266**
CPL	(135)	151
Propcare	288	735
Consolidated Financial Position	**417**	**1,152**

3.3 Expenditure Position

3.3.1 The bridge below shows the key drivers between the £264k in month surplus against a £43k surplus plan, which is a positive variance of £221k:

- ERF Income is showing as above plan by £4.989m due to the Trust receiving more income than planned. This is offsetting additional costs, reduction in system monies and unmet CIP.

- The ICS have made an adjustment of £4.2m systems monies as part of managing the Cheshire & Mersey overall position.

- Pay costs are above plan in month. This is due to CEA Awards of £300k and backdated Consultant pay of £100k. The unmet pay CIP in M12 is £300k and this has been offset by the additional ERF Income.

- There is a notional expenditure adjustment included in pay of £3.2m for the element of pension paid by NHSE/I, this is offset by notional income.

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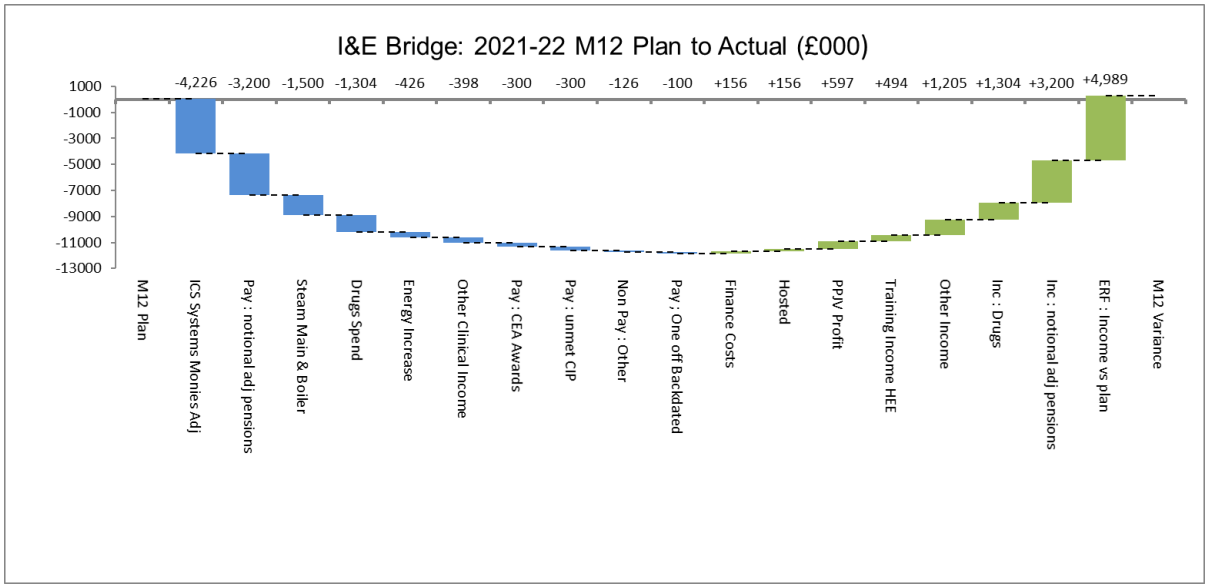
- Bank spend remains high at £156k in month 12, which is a £20k increase from month 11, this is mainly due to sickness cover including covid.

- Drugs spend is over plan by £1.3m. 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.

- The two keys items contributing towards the non-pay overspend of £1.9m are the payment for the contribution towards the steam main and boiler to LUFT of £1.5m and £427k increase in energy costs.

- PPJV is above plan by £596k due to an adjustment of £620k to correct previous years understated profit share.



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3.4 ERF Position

The Trust received £6.185m ERF in H1.

For H2 the Trust has been notified of final confirmed ERF figures for October to January of £8.168m. The Trust also been provided with provisional figures for February of £1.881m and March of £2.179m.

After discussions with a number of Trusts across C&M it is evident that activity in March is likely to be lower than previous months for a number of reasons. We have therefore recognised only 50% of the provisional figure for March as we believe this is a more realistic value.

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The total ERF recognised is £17.3m.

3.5 Bank and Agency Reporting

Bank spend in March remains high at £158k, an increase of £20k compared to February. The largest user of bank staff the Acute Division. The main reasons for bank spend is to cover vacancies and increased sickness including covid.

Agency spend in month is £71k, which is in line with previous months. The Trust is reporting £24k under cap in month and £323k in the year to date

See Appendix F for further detail.

3.6 Cost Improvement Programme (CIP)

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

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

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

As at month 12 of the required £1.9m Divisional target, a total of £1.326m of schemes have been identified, of which £724k are recurrent. The unmet Divisional CIP has been offset non-recurrently by additional ERF Income. 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 being made available the Trust has received confirmation of a number of bids. The revised annual plan is £10.872m.

4.2 Capital expenditure of £10.838m has been incurred to the end of March, this is slightly below the original planned spend profile for the year to date by £34k.

4.3 The capital programme is supported by the organisation's cash position. The Group has a current cash position of £80.7m, which is a positive variance of £22.7m to the cash-flow plan, and £3m compared to the previous month. The reason for the increase is due to the additional ERF received in month.

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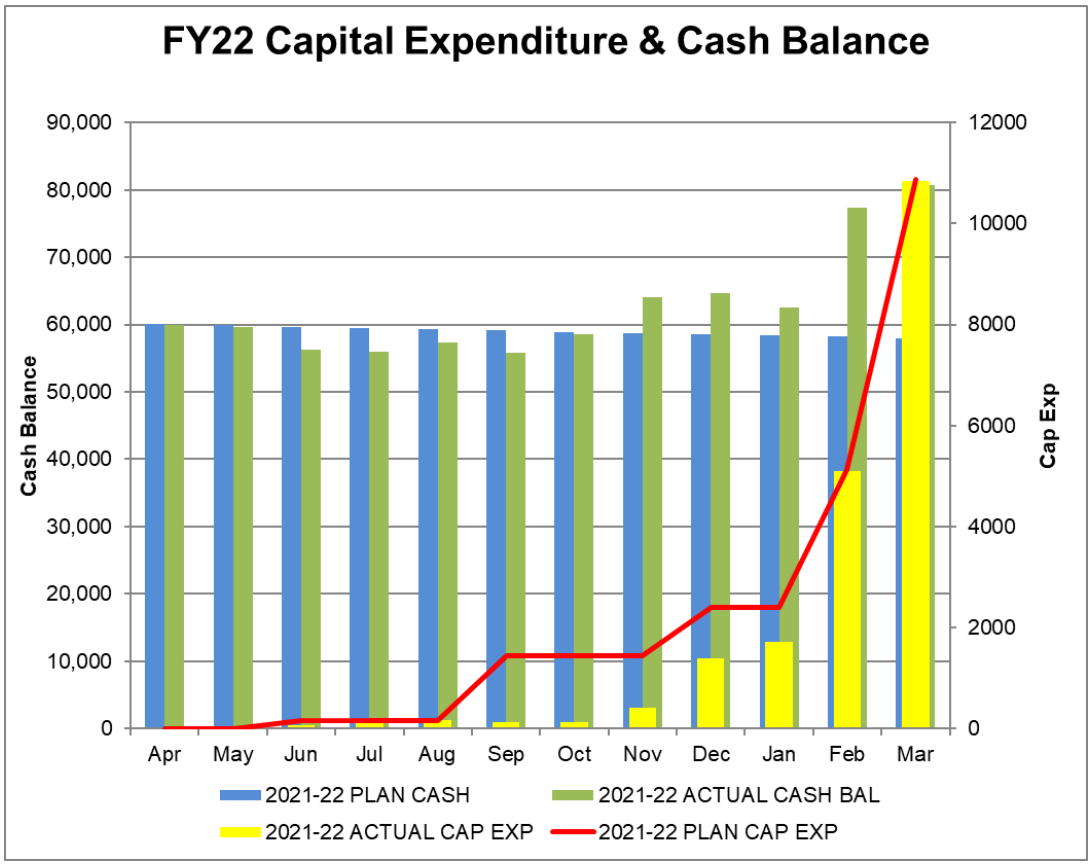
4.4 The Balance Sheet (Statement of Financial Position) is included in Appendix B and Cash flow in Appendix C.



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

5. Recommendations

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

- The reported surplus
- The updated ERF Income position
- The continuing strong liquidity position of the Trust

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Appendix A – Statement of Comprehensive Income (SOCI)

(£000)	Month 12			Cumulative YTD				2021/22
	Plan	Actual	Variance	Plan	Actual	Variance	%	Annual Plan
Clinical Income	17,199	18,868	1,669	205,196	208,839	3,643		205,196
Other Income	478	5,377	4,899	6,056	11,291	5,235		6,056
Hosted Services	6,101	7,155	1,054	23,417	21,819	(1,598)		23,417
Total Operating Income	**23,778**	**31,400**	**7,622**	**234,669**	**241,948**	**7,280**	**3%**	**234,669**
Pay: Trust (excluding Hosted)	(6,106)	(10,006)	(3,900)	(69,803)	(72,096)	(2,293)		(69,803)
Pay: Hosted & R&I	(927)	(766)	161	(8,110)	(6,263)	1,848		(8,110)
Drugs expenditure	(7,064)	(8,368)	(1,304)	(82,857)	(88,184)	(5,328)		(82,857)
Other non-pay: Trust (excluding Hosted)	(3,900)	(5,952)	(2,052)	(54,255)	(56,070)	(1,815)		(54,255)
Non-pay: Hosted	(5,417)	(6,476)	(1,059)	(15,784)	(15,782)	3		(15,784)
Total Operating Expenditure	**(23,414)**	**(31,567)**	**(8,153)**	**(230,809)**	**(238,395)**	**(7,586)**	**3%**	**(230,809)**
Operating Surplus	**365**	**(167)**	**(531)**	**3,859**	**3,553**	**(306)**	**-8%**	**3,859**
Profit /(Loss) from Joint Venture	67	663	596	804	1,497	693		804
Interest receivable (+)	401	453	52	4,809	4,767	(41)		4,809
Interest payable (-)	(439)	(438)	2	(5,272)	(5,272)	0		(5,272)
Loss on disposal of assets	0	(26)	(26)	0	(209)	(209)		0
Other Finance Costs	0	5	5	0	5	5		0
PDC Dividends payable (-)	(350)	(226)	124	(4,200)	(4,076)	124		(4,200)
Trust Retained surplus/(deficit)	**43**	**264**	**221**	**(0)**	**266**	**266**		**(0)**
CPL/Propcare	0	153	153	0	886	886		0
Consolidated Surplus/(deficit)	**43**	**417**	**374**	**(0)**	**1,152**	**1,152**		**(0)**

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Appendix B – Balance Sheet

£'000	Unaudited 2021	Plan 2022	Year to date Month 12		
			YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	2,488	2,100	2,424	3,211	787
Property, plant & equipment	177,180	174,267	175,680	185,029	9,349
Investments in associates	181	181	181	977	796
Other financial assets	1,364	0	0	0	0
Trade & other receivables	161	100	281	449	168
Other assets	0	0			0
Total non-current assets	**181,374**	**176,648**	**178,566**	**189,666**	**11,100**
Current assets					
Inventories	4,201	4,200	4,201	5,640	1,439
Trade & other receivables					
NHS receivables	4,621	4,500	4,621	7,749	3,128
Non-NHS receivables	4,484	4,500	7,779	6,278	(1,501)
Cash and cash equivalents	63,533	58,000	59,875	80,726	20,851
Total current assets	**76,839**	**71,200**	**76,476**	**100,393**	**23,917**
Current liabilities					
Trade & other payables					
Non-capital creditors	28,222	30,000	28,222	41,603	13,381
Capital creditors	3,544	2,000	2,000	1,863	(137)
Borrowings					
Loans	1,916	1,730	1,730	1,908	178
Obligations under finance leases	0	0	0	0	0
Provisions	2,160	1,535	2,160	4,213	2,053
Other liabilities:-					
Deferred income	5,974	4,000	5,974	15,669	9,695
Other	0	0	0	0	0
Total current liabilities	**41,816**	**39,265**	**40,086**	**65,255**	**25,170**
Total assets less current liabilities	**216,398**	**208,583**	**214,957**	**224,805**	**9,848**
Non-current liabilities					
Trade & other payables					
Capital creditors	970	0	970	120	(850)
Borrowings					
Loans	33,820	32,090	33,080	32,091	(990)
Obligations under finance leases	0	0	0	0	0
Other liabilities:-					
Deferred income	0	0	0	0	0
Provisions	1,270	110	1,270	197	(1,073)
Total non current liabilities	**36,060**	**32,200**	**35,320**	**32,407**	**(2,913)**
Total net assets employed	**180,338**	**176,383**	**179,637**	**192,399**	**12,762**
Financed by (taxpayers' equity)					
Public Dividend Capital	67,374	68,116	67,374	72,219	4,845
Revaluation reserve	2,700	2,600	2,700	4,988	2,288
Income and expenditure reserve	110,264	105,667	109,563	115,191	5,628
Total taxpayers equity	**180,338**	**176,383**	**179,637**	**192,399**	**12,761**

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix C – Cash Flow

March 2022 (M12) £'000	FT	Group	Group (exc Charity)
Cash flows from operating activities:			
Operating surplus	8,693	11,781	9,836
Depreciation	9,425	9,425	9,425
Amortisation	734	734	734
Impairments	(5,700)	(5,700)	(5,700)
Movement in Trade Receivables	(1,542)	(5,803)	(2,626)
Movement in Other Assets	2,376		0
Movement in Inventories	(1,490)	(1,439)	(1,439)
Movement in Trade Payables	11,705	12,180	12,176
Movement in Other Liabilities	9,581	9,694	9,694
Movement in Provisions	669	981	981
CT paid	0	(182)	(182)
Impairements /revaluations	2,405	2,405	2,405
Net cash used in operating activities	**36,857**	**34,076**	**35,304**
Cash flows from investing activities			
Purchase of PPE	(11,485)	(12,342)	(12,342)
Purchase of Intangibles	(1,459)	(1,459)	(1,459)
Proceeds from sale of PPE	(209)	(209)	(209)
Interest received	4,767	62	29
Investment in associates	700	700	700
Net cash used in investing activities	**(7,685)**	**(13,248)**	**(13,280)**
Cash flows from financing activities			
Public dividend capital received	4,845	4,845	4,845
Public dividend capital repaid			
Loans received			
Movement in loans	(1,739)	(1,739)	(1,739)
Capital element of finance lease	0	0	0
Interest paid	(5,267)	(578)	(578)
Interest element of finance lease			
PDC dividend paid	(4,076)	(4,076)	(4,076)
Finance lease - capital element repaid	0	0	0
Net cash used in financing activities	**(6,236)**	**(1,547)**	**(1,547)**
Net change in cash	**22,935**	**19,281**	**20,477**
Cash b/f	**53,765**	**63,533**	**60,248**
Cash c/f	**76,701**	**82,815**	**80,726**

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix D – Capital

Capital Programme 2021-22
Month 12

The Clatterbridge Cancer Centre NHS Foundation Trust

Code	Scheme	Lead	BUDGET (£'000) NHSI plan 21-22	Approved Adjustments	Budget 21-22	ACTUALS (£'000) Actuals @ Month 12	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	125	295	125	295	✓	✓	
4305	CCCW Linacc Bunker - Beech	Julie Massey	0	300	300	79	221	79	221	✓	✓	
4300	CCCW CT Simulator (Brilliance 2)	Louise Bunby	300	(191)	109	83	26	83	26	✓	✓	A Mooney confirmed no more spend
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	31	2	31	2	✓	✓	
4307	CCCL Ward 4 and 5 bathroom conversion	Pris Hetherington	0	0	0	0	0	0	0	✓	✗	Update 29/3, work not starting until 11th April
4312	Cyclotron Fire Works	Propcare	0	90	90	97	(7)	97	(7)	✓	✗	
4323	CCCL Ward 2 blood room conversion		0	0	0	11	(11)	11	(11)	✓	✓	
	Contingency	*n/a*	200	(552)	(352)	0	(352)	114	(466)	-	-	
	Estates		**920**	**(291)**	**629**	**457**	**172**	**571**	**58**			
4180	***(19/20)*** CCCL HDR & Papillon tfr costs		0	0	0	(12)	12	(12)	12	✓	✓	
4001	***(20/21)*** CCCL Pet CT		0	0	0	7	(7)	7	(7)	✓	✓	
4006	***(20/21)*** CCCL Linear Accelerator		0	0	0	4	(4)	4	(4)	✓	✓	
4010	***(20/21)*** CCCL Diagnostic CT		0	0	0	1	(1)	1	(1)	✓	✓	
4303	CCCA Linear Accelerator - Maple	Julie Massey	2,460	(155)	2,305	2,282	23	2,282	23	✓	✓	
4305	CCCW Linear Accelerator - Beech (PDC)	Julie Massey	0	2,305	2,305	2,174	131	2,174	131	✓	✓	
4318	CCCL Mobile Image Intensifier	Sam Wilde	138	0	138	108	30	108	30	✓	✓	
	MEME - Acute - Patient Monitor	Julie Massey	9	0	9	0	9	0	9	-	-	
4322	MEME - Acute - 2x Ultrasound	Julie Massey	25	0	25	40	(15)	40	(15)	✓	✓	
4314	MEME - Networked - Scalp Coolers	Julie Massey	97	0	97	184	(87)	184	(87)	✓	✗	
	MEME - Rad - Infinity Monitor M540	Julie Massey	9	0	9	0	9	0	9	-	-	
	MEME - Rad - 3x Patient Monitor C500	Julie Massey	33	0	33	0	33	0	33	-	-	
	MEME - Rad - 6x Patient Monitor M540	Julie Massey	54	0	54	0	54	0	54	-	-	
4192	Cyclotron	Carl Rowbottom	742	0	742	747	(5)	747	(5)	✓	✗	
4300	CCCW CT Simulator (Brilliance 2)	Louise Bunby	500	166	666	638	28	638	28	✓	✓	
4301	Stand Aids		0	0	0	14	(14)	14	(14)	✓	✓	
4304	CCCL Cardiac Monitors W4&5	Julie Massey	0	26	26	26	(0)	26	(0)	✓	✓	
4308	2x Rhinolaryngo Videoscopes	Richard Lacey	0	64	64	64	0	64	0	✓	✓	
4309	Linac Voltage Stabilisers	Martyn Gilmore	0	130	130	0	130	0	130	✗	✗	
4310	CCCA QA3 Dosimeter	Martyn Gilmore	0	12	12	9	3	9	3	✓	✓	
4311	Interventional Radiology Pressure Injector	Samantha Wilde	0	20	20	15	5	15	5	✓	✓	
4319	Omniboard mounting adaptors	Lesley Woods	0	47	47	38	8	38	8	✓	✓	
4321	MRI Acceleration	Sam Wilde	0	54	54	54	0	54	0	✓	✓	
4324	VT5 Birch Elbow Drive		0	0	0	28	(28)	28	(28)	✓	✓	
4325	Stryker Trolley	Sam Wilde	0	0	0	0	0	0	0	✗	✗	Dept failed to order
4326	L-Shield	Sam Wilde	0	0	0	0	0	0	0	✗	✗	Dept failed to order
4327	Workbooths		0	0	0	12	(12)	12	(12)			From revenue review
4328	Laserguard Scanner		0	0	0	12	(12)	12	(12)			From revenue review
4329	Shoulder Drive		0	0	0	5	(5)	5	(5)			From revenue review
4330	Linac UPS		0	0	0	6	(6)	6	(6)			From revenue review
4331	Donated Scalp Cooler - Wirral		0	11	11	11	0	11	0			Donated asset review
4332	Donated Scalp Cooler - Halton		0	11	11	11	0	11	0			Donated asset review
4333	Donated Xion EndoFlex System		0	40	40	40	0	40	0			Donated asset review
	Contingency	*n/a*	200	(519)	(319)	0	(319)	(80)	(239)	-	-	
	Medical Equipment		**4,267**	**2,211**	**6,478**	**6,519**	**(41)**	**6,439**	**39**			
4190	***(20/21)*** Digital Aspirant	James Crowther	0	0	0	49	(49)	49	(49)	✓	✓	
4138	Infrastructure	James Crowther	1,350	(400)	950	1,142	(192)	1,142	(192)	✓	✗	£400k pushed back to 22/23
4139	Other minor programmnes	James Crowther	250	0	250	98	152	98	152	✓	✗	
4315	CM Elective Fund - Remote Monitoring	James Crowther	0	300	300	300	0	300	0	✓	✗	New PDC funded scheme
4316	Digital Diagnostics Capability Programme	James Crowther	0	877	877	906	(29)	906	(29)	✓	✗	New PDC funded scheme
4317	Intelligent Automation (RPA)	James Crowther	0	311	311	358	(47)	358	(47)	✓	✗	50% PDC funded
4320	UTF Frontline Digitisation - Digital Infrastruc	James Crowther	0	790	790	793	(3)	793	(3)	✓	✗	New PDC funded scheme
	IM&T		**1,600**	**1,878**	**3,478**	**3,646**	**(168)**	**3,646**	**(168)**			
4142	Liverpool	Peter Crangle	0	0	0	(71)	71	(71)	71	✓	✓	
4142	Liverpool - Artwork	Sam Wade	0	66	66	43	23	43	23	✓	✗	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	24	(24)	24	(24)	✗	✗	
4313	CCCL Terraces	Peter Crangle	0	221	221	221	(0)	221	0	✓	✗	Charity Funded
	Building for the Future		**400**	**(113)**	**287**	**216**	**71**	**216**	**71**			
	TOTAL		**7,187**	**3,685**	**10,872**	**10,838**	**34**	**10,872**	**0**			

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

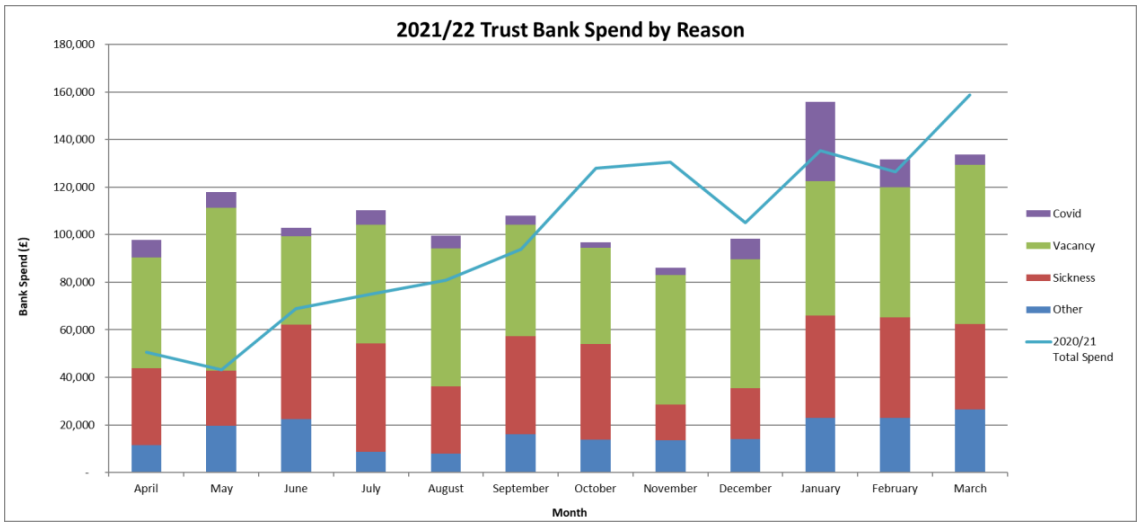
Appendix E – CIP

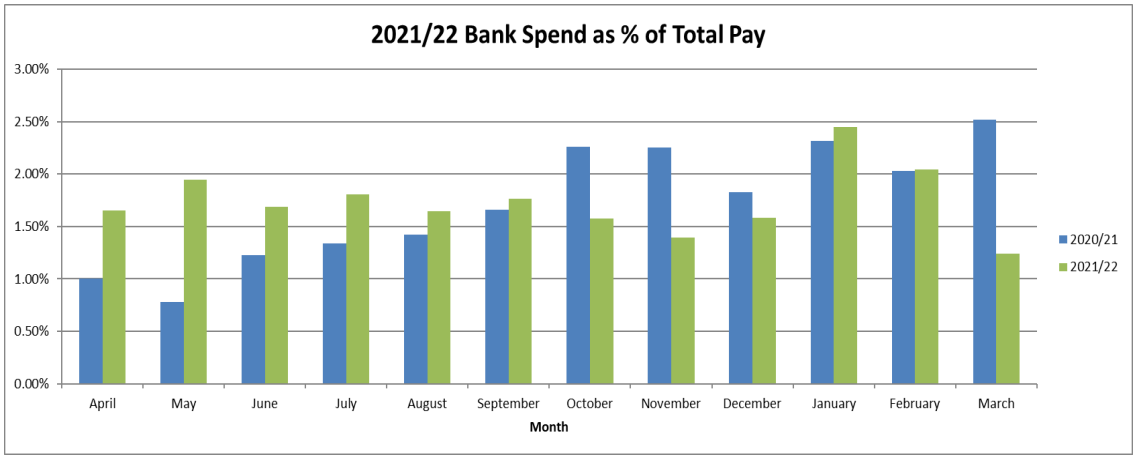
Directorate	Target	In Year 21.22	Full Year (Recurrent)	In Year Shortfall	Delivery % to date
ACUTE CARE	559,692	294,821	274,822	(264,871)	53%
CORPORATE	319,068	237,325	274,123	(81,744)	74%
NETWORKED SERVICES	547,860	543,239	78,150	(4,621)	99%
RADIATION SERVICES	453,380	250,301	96,709	(203,079)	55%
Divisional 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)**	

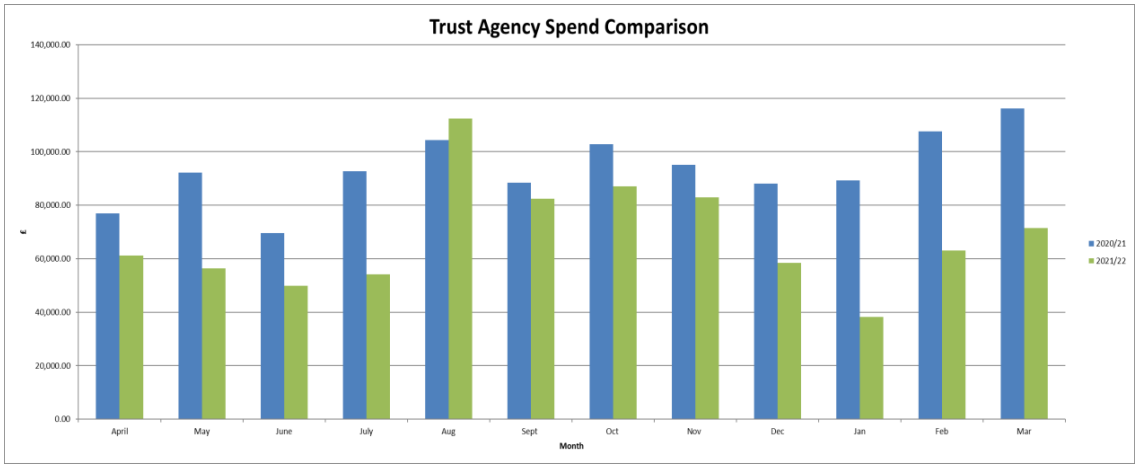
REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Appendix F – Bank and Agency







CHAIR'S REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Committee/Group 'Triple A'

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

Name of Committee/Group: Extraordinary Charitable Funds Committee	Reporting to: Trust Board
Date of meeting: 13th April 2022	Parent Committee: n/a
Chair: Elkan Abrahamson	Quorate: Yes

Agenda item	RAG	Key points	Actions required	Action lead	Expected date of completion
CHA-024-22 – Establishing an Independent Charity – Legal and Governance Issues for Consideration		Helen Hirst, Hempsons, attended the meeting. Nine items on the legal structure and governance of an independent Charity were put forward for discussion/decision. The Committee discussed and agreed these.	The nine recommendations on legal structure and governance to be presented for approval at Trust Board 27th April 2022.	KB	Ongoing

The Clatterbridge Cancer Charity

Report Cover

Report to:	Trust Board Part 1
Date of meeting:	27 April 2022
Agenda item:	P1-83-22
Title:	Establishing independent charity status- Legal and Governance recommendations.
Report prepared by:	Katrina Bury, Head of Charity
Executive Lead:	Liz Bishop, Chief Executive
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	
Date & decision:	

Purpose of the paper/key points for discussion:	In order to enable an application to be made to the Charity Commission to establish the Independent Charity, the first step is to prepare the Memorandum and Articles of Association. A representative from Hempsons Solicitors, specialising in charity law and governance, presented an overview of the pertinent legal and governance considerations and guided the corresponding decisions required to initiate this process. After discussion the following recommendations were agreed by the Charitable Funds Committee and are now presented to the Board as Corporate Trustee of the Charity for approval.

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

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

The Clatterbridge Cancer Charity

Report Cover

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

☐ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

The Clatterbridge Cancer Charity

Report

AGENDA ITEM Cxx/xx

Trust Board
27 April 2022

Establishing independent charity status- Legal and Governance recommendations.

Author: Katrina Bury, Head of Charity

Responsible Director: Liz Bishop, Chief Executive

For: Information

1. Introduction

The Charitable Funds Committee convened an extraordinary meeting on 13 April 2022, to consider legal and governance considerations relating to the formation of the new Independent Charity. In order to enable an application to be made to the Charity Commission to establish the Independent Charity, the first step is to prepare the Memorandum and Articles of Association. A representative from Hempsons Solicitors, specialising in charity law and governance, presented an overview of the pertinent legal and governance issues and guided the corresponding decisions required to initiate this process..

After discussion the following recommendations were agreed by the Committee and are now presented to the Board as Corporate Trustee of the Charity for approval.

2. Legal and governance structure recommendations

1. The charitable legal structure recommended for the new Charity is a Company Limited by Guarantee (CLG).
2. As a CLG the Independent Charity will require both members and trustees. The Committee recommend the Charity adopts a small membership with the option to create a wider membership at a later date. The trustees will also be members.

The Clatterbridge Cancer Charity

Report

AGENDA ITEM Cxx/xx

3. It is also recommended that the Trust will be a member with class rights.

4. The guidance specifies that the Trust may not have majority control of the Independent Charity, so the recommendation is that a minimum of 3 and a maximum of 11 trustees are appointed and that the majority trustees will be independent of the Trust.

5. The quorum for trustee meetings is recommended to be 3 trustees including one Trust appointed trustee.

6. The recommendation is that the objects of the Independent Charity remain the same as the existing Charity, although some small adjustments may be made for example to include the new name of the Trust Foundation.

7. The Independent Charity will retain the same name - The Clatterbridge Cancer Charity.

8. The Committee agreed there would be no requirement for the Independent Charity to hold an AGM. If members are to be the same as trustees there is no purpose in holding an AGM.

9. The Committee agreed that there will be committees of the independent Charity (the exact nature to be determined at a later date). It was agreed attendance at committees will require a minimum of 2 trustees, including 1 Trust appointed trustee.

Conclusion

Once the above recommendations are approved by the Corporate Trustee, Hempsons will proceed with preparing the draft Memorandum and Articles of Association for consideration and approval. It will be necessary to appoint independent trustees at this stage and the Charity has already initiated this process and is developing a rigorous and robust recruitment process to ensure the appointment of a diverse board of dynamic, skilled and committed trustees .

Recommendations:

The Board as Corporate trustee approves the above recommendations to allow the first draft Memorandum and Articles of Association to be prepared.

Agenda item P1-84-22

The Clatterbridge Cancer Centre NHS Foundation Trust

Board of Directors Committee

27 April 2022

Report of	Chief Nurse			
Paper prepared by	Chief Nurse			
Subject/Title	Board & Committee Schedule			
BAF risks reference				
Corporate risks reference				
Divisional risks reference				
Background papers	Board Committee Governance Structure 2022-2023 Report - March Good Governance Institute Review March 2022			
Purpose of paper	To share with the committee of the proposed revised meeting schedule			
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	√
You are reminded not to use acronyms or abbreviations wherever possible. However, if they appear in the attached paper, please list them in the adjacent box.				

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**		

The Clatterbridge Cancer Centre NHS Foundation Trust

Board of Directors

27 April 2022

1. Summary

The purpose of this paper is to provide the Board of Directors with sufficient information, to further support compliance with recommendation 1 from the Board Committee Governance Structure 2022-2023 Report which was presented to Board in March 2022. This recommendation was: Review and re-align the current committee structure to provide clear reporting processes focusing on assurance and triangulation of information. Specifically the key changes are:

- 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

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, findings were shared with the Board of Directors at March Board. In addition the paper presented to the Board of Directors in March provided a series of recommendations relating to the restructure of committees, committee effectiveness and process.

3. Schedule

Whilst it is best practice to make changes to structure at the start of a new reporting year April – March, it is acknowledged that there is no ideal time and the disruption this will cause is inevitable.

4. Conclusion

The Board is asked to accept the draft schedule.

Clatterbridge Board of Directors meetings for 2022-23

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	
Mon		2			1 TEG		3 TEG			2			Mon
Tues		3			2		4	1		3			Tues
Wed		4	1		3		5 CoG	2		4	1	1	Wed
Thurs		5	2		4	1	6	3	1	5	2	2	Thurs
Fri	1 Extra Audit Comm	6	3		5	2	7	4	2	6	3	3	Fri
Mon	4 TEG	9 TEG	6 TEG	4 TEG	8	5 TEG	10	7 TEG	5 TEG	9 TEG	6 TEG	6 TEG	Mon
Tues	5	10 Risk & Quality G	7	5	16 Risk & Quality Governan	6	11 Risk & Quality Gover	8 Risk & Quality Gov		10 Risk & Quality	7	7	Tues
Wed	6 Risk & Quality Go	11 Extra Audit Comm	8 People Committee	6 CoG	10	7. Propcare Board	12 Charitable Funds	9	7	11 CoG	8	8 People Committee	Wed
Thurs	7	12	9 Extra Audit Comm	7	11	8	13 Audit Committee	10	8	12 Audit Committee	9	9	Thurs
Fri	8	13	10	8 Charitable Funds	12	9	14	11	9	13	10	10	Fri
Mon	11	16	13	11	15	12 Clatterbridge Pharmacy Ltd	17 Clatterbridge Private	14	12	16	13	13	Mon
Tues	12	17	14 Risk & Quality Governa	12 Risk & Quality Governanc	16	13 Risk & Quality Governance	18	15	13 Risk & Quality Governa	17 Propcare Board	7 Risk & Quality Go	14 Risk & Quality Governar	Tues
Wed	13	17 Perforn Clatterbrid	15	13	17 Performance Committee	14 People Committee	19 Clatterbridge Private	16 Perforn Propcare	14 People Committee	18Clatterbringe Pha	15 Performance Con	15 Propcare Board	Wed
Thurs	14 Audit Committee	19	16	14 Audit Committee	18	15	20	17	15	19	16	16	Thurs
Fri	15	20 Propcare Board	17	15	19	16	21	18	16	20	17	17	Fri
Mon	18	23 Clatterbridge Priv	20	18 Clatterbridge Private Clin	22	19 Clatterbridge Private Clinic	24	21 Clatterbridge Priv	19	23	20 Clatterbridge Pha	20	Mon
Tues	19	24	21	19 Propcare Board	23	20	25 Capital Investment C	22	20	24	21	21	Tues
Wed	20 Clatterbridge Priv	25 BOD Board Dev	22 Clatterbridge Pharmac	20 Clatterbridge Pharmacy L	24	21	26 BOD	23 Clatterbridge Pha	21	25 BOD	22 BOD	22 Clatterbridge Pharmacy	Wed
Thurs	21	26	23 Quality Committee	21	25	22 Quallity Committee	27	24	22 Quality Ccommittee	26	23	23 Quality Committee	Thurs
Fri	22 Charitable Funds	27	24	22	26	23	28	25	23	27	24	24	Fri
Mon	25 Clatterbridge Priv	30	27	25	29	26	31	28	26	30	27	27	Mon
Tues	26 Capital investmer	31 Capital Investmer	28 Clatterbrid Capital Inve	26 Capital Investment Comn	30 Capital Investment Com	27 Capital Investment Committee		29 Capital Investmer	27	31 Capital Investmer	28 Capital Investmer	28 Capital Investment Com	Tues
Wed	27 BOD		29 BOD	27 BOD Board Developme	31	28 BOD Annual Members		30 BOD	28			29 BOD	Wed
Thurs	28		30	28		29			29			30	Thurs
Fri	29			29		30			30			31	Fri

KEY: Meetings

Board of Directors (Trust Board)	09:00 - 14:00
Audit Committee	varying times.
Quality Committee	09:30 - 12:30
Council of Governors (CoG)	17:00 - 19:00
Propcare Board	
Trust Executive Group	10:30 - 12:00
Clatterbridge Private Clinic	11.00 - 13.00
People Committee	10:00 -12:00
Risk & Quality Governance	10:00 - 12:00
Performance Committee	09:30 - 12:30
Board Development session	09:00 - 12:00
Capital Investment Committee	10:30 - 12:00
Charitable Funds Committee	10:00 - 12:00
Annual Members Meeting	
Clatterbridge Pharmacy Ltd	14:00 - 17:00 except Feb 23 09:00 -12:00
Remunerations & Nominations Committee	As & When
Bank holiday	

Cheshire & Merseyside Cancer Alliance

Performance Report

April 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*	115%
Cancer surgery activity*	124%
SACT (inc chemo) delivery**	123%

Measure	% of pre-Covid level
Radiotherapy planning**	147%
Radiotherapy treatment**	93%
Endoscopy activity♀	95%

- The sustained increase in SACT continues to present challenges to service delivery, however CCC continues to take action to meet demand, including detailed capacity and demand planning, enabling targeted WLI clinics. Additional SACT nurses are being recruited.
- Radiotherapy planning activity, compared to pre-covid, is at its highest % increase yet.
- Although rising, Radiotherapy treatments are lower than 2019/20, due to a change in fractionation in early 2020/2021, which equates to fewer treatments per patient in some tumour groups.
- Endoscopy activity had more than doubled between July 2020 (3,300 procedures) and March 2021 (6,600 procedures). Activity in February 2022 was the highest in 2021-22. Further capacity is required in order to clear the backlog of patients on the endoscopy waiting list, which has stabilised. The Alliance has established an endoscopy operational recovery team (EORT) to oversee and co-ordinate restoration activities

Cheshire & Merseyside Cancer Alliance

*Data as of 11th April
** 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 February 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 **February 2022**.

- The Alliance failed the **14 day standard** for urgent suspected cancer referrals, with nine trusts and all CCGs falling below the 93% threshold. The overall performance of the Alliance was 79.7%*, compared to 72.6%* last month. The England average was 80.7%. CMCA was the 12th 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 10 trusts and six CCGs falling below the 75% threshold. The overall performance of the Alliance was 69.3%*, increasing from 62.0%* last month. The England average was 74.1%.

- The Alliance failed the **62 day standard**, achieving 68.2%* (increasing from 67.9%* last month) against a standard of 85% (England average was 62.1%). 11 trusts and all nine CCGs failed to meet the 62 day standard. Cheshire and Merseyside is the 4th best performing Alliance in England out of 21 against this standard.

- The number of urgent referral patients waiting **over 62 days** is significantly higher than pre-Covid levels. On 11th April 2022 there were 1,357 patients waiting more than 62 days for a diagnosis or treatment. This has increased from 1,285 reported last month (14th March). Of these, 455 have waited **over 104 days**. This is equal to 455 patients reported last month, although not .

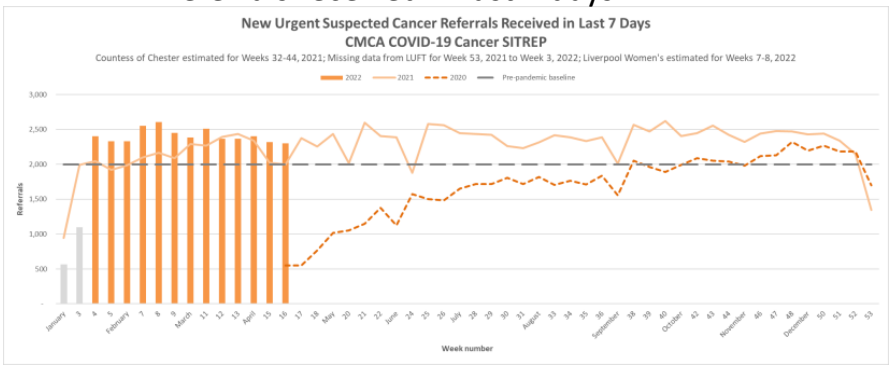
  The proportion of patients on urgent suspected cancer pathways who have already been on the pathway for over 62 days is slightly above, but broadly in line with the England average.

Cheshire & Merseyside Cancer Alliance

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

Section II: Restoration of Cancer Services – Core Metrics

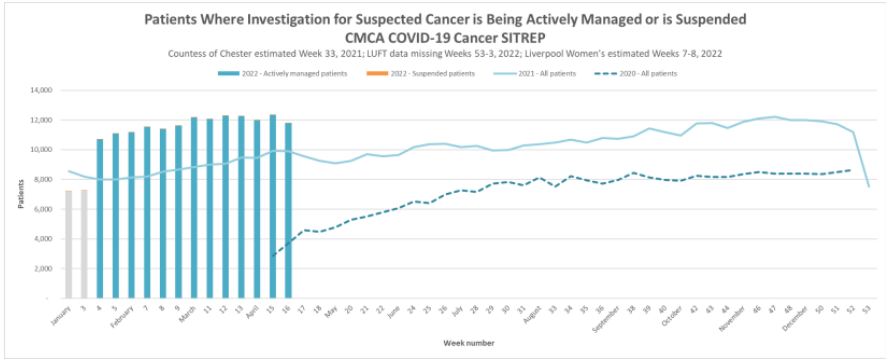
1. TWW referrals received in last 7 days



Referrals decreased with 2,300 patients referred this week (15% above pre-pandemic weekly average, 15% above same time last year).

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. Countess of Chester data estimated for all weeks 02/08/21 to 25/10/21 inclusive. Liverpool Women's Hospital estimated for 13/09/21, 20/09/21. Missing data from LUHFT for 26/12/21, 02/01/22 and 09/01/22. Liverpool Women's estimated for 07/02/22 & 14/02/22.

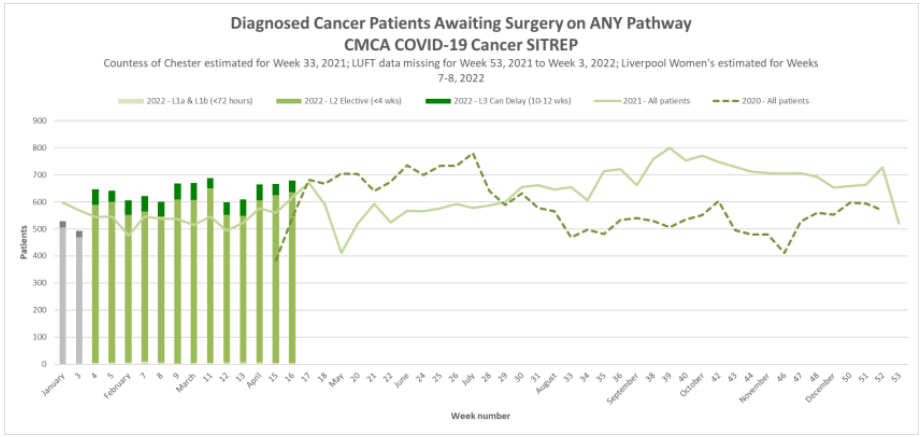
2. Diagnostic backlog (referrals without a DTT)



Currently 11,788 active patients, of which 14 suspended (19% 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.

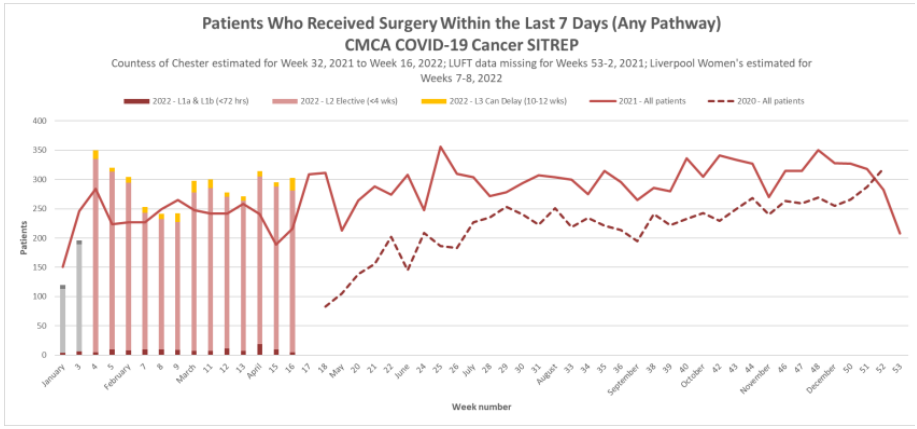
3. Cancer patients awaiting surgery



678 patients with a surgical DTT. 636 at L1&L2 and 42 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

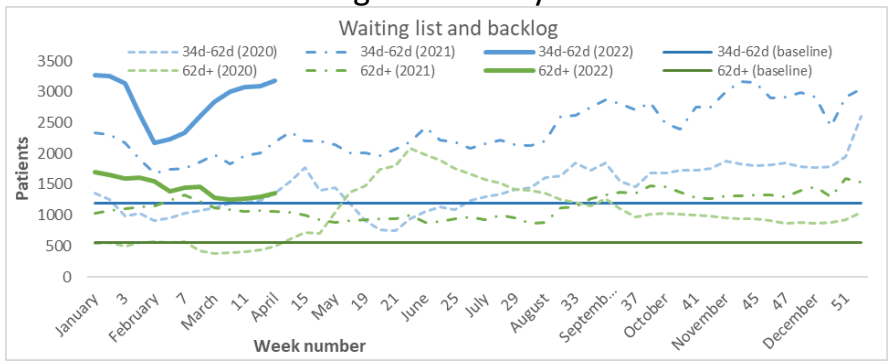


303 cancer operations performed last week.

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 11/04/22 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

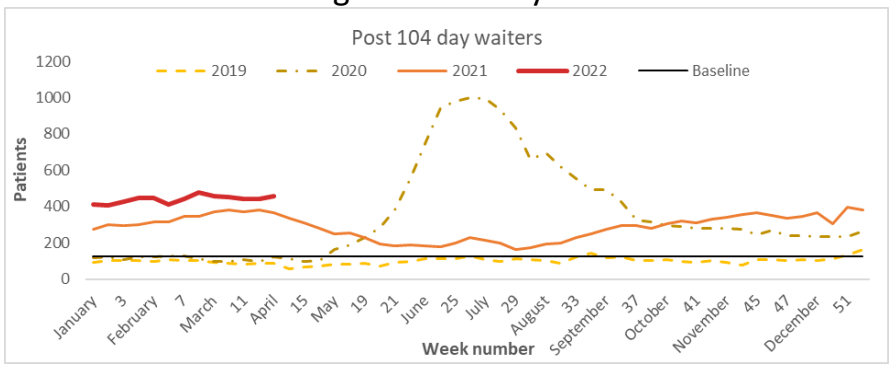


1,357 patients have waited over 62 days

- Higher than 1,296 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

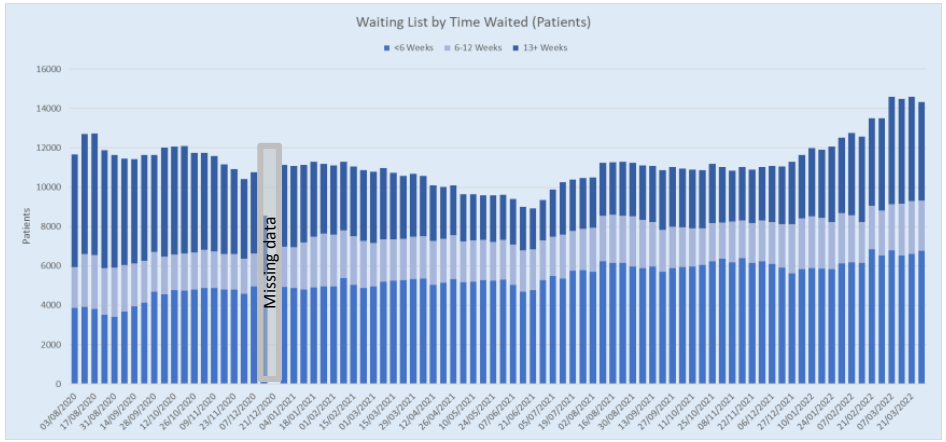


455 patients have waited over 104 days

- Higher than 443 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.

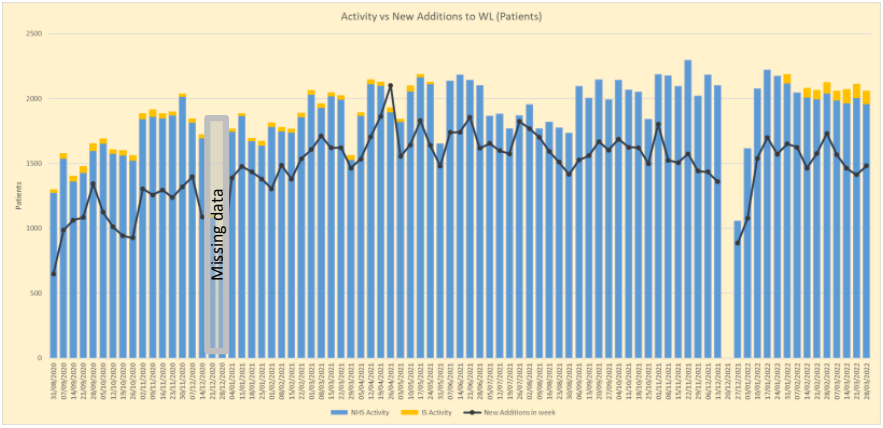
7. Endoscopy waiting list



Endoscopy waiting list decreased to 14,333 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 and 21/03/22. Wirral estimated for 06/01/22.

8. Endoscopy activity



Activity decreased with 2,056 patients seen.

New additions increased with 1,482 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 activity estimated for 07/03/22, new additions estimated for 07/02/22 onwards .

9. Patients waiting between 63 and 103 days by provider

PTL data from W/E 03 April

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						8	9					6	6		42
Countess Of Chester					8	55					11	19			102
East Cheshire		5				33									43
Liverpool Foundation Trust		19			22	125	8		16			46	43		283
Liverpool Heart & Chest															
Liverpool Women's			21												21
Mid Cheshire			6			40						9			68
Southport & Ormskirk			23			99					25	14	18		186
St Helens & Knowsley			8		11	37									70
Walton Centre															
Warrington & Halton						8									16
Wirral						26							26		60
Grand Total		**37**	**70**	**11**	**52**	**431**	**26**		**16**		**44**	**99**	**113**		**902**

Cheshire & Merseyside Cancer Alliance

Tables from national Cancer PTL

10. Patients waiting over 104 days by provider

PTL data from W/E 03 April

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													6		16
Countess Of Chester			5		6	62						7			88
East Cheshire															14
Liverpool Foundation Trust		5			6	77	6					26	22		150
Liverpool Heart & Chest															
Liverpool Women's			12												12
Mid Cheshire															14
Southport & Ormskirk			30			51					6	10	7		111
St Helens & Knowsley						8									16
Walton Centre															
Warrington & Halton															
Wirral						13							10		29
Grand Total		**10**	**51**	**9**	**18**	**238**	**11**				**11**	**49**	**54**		**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

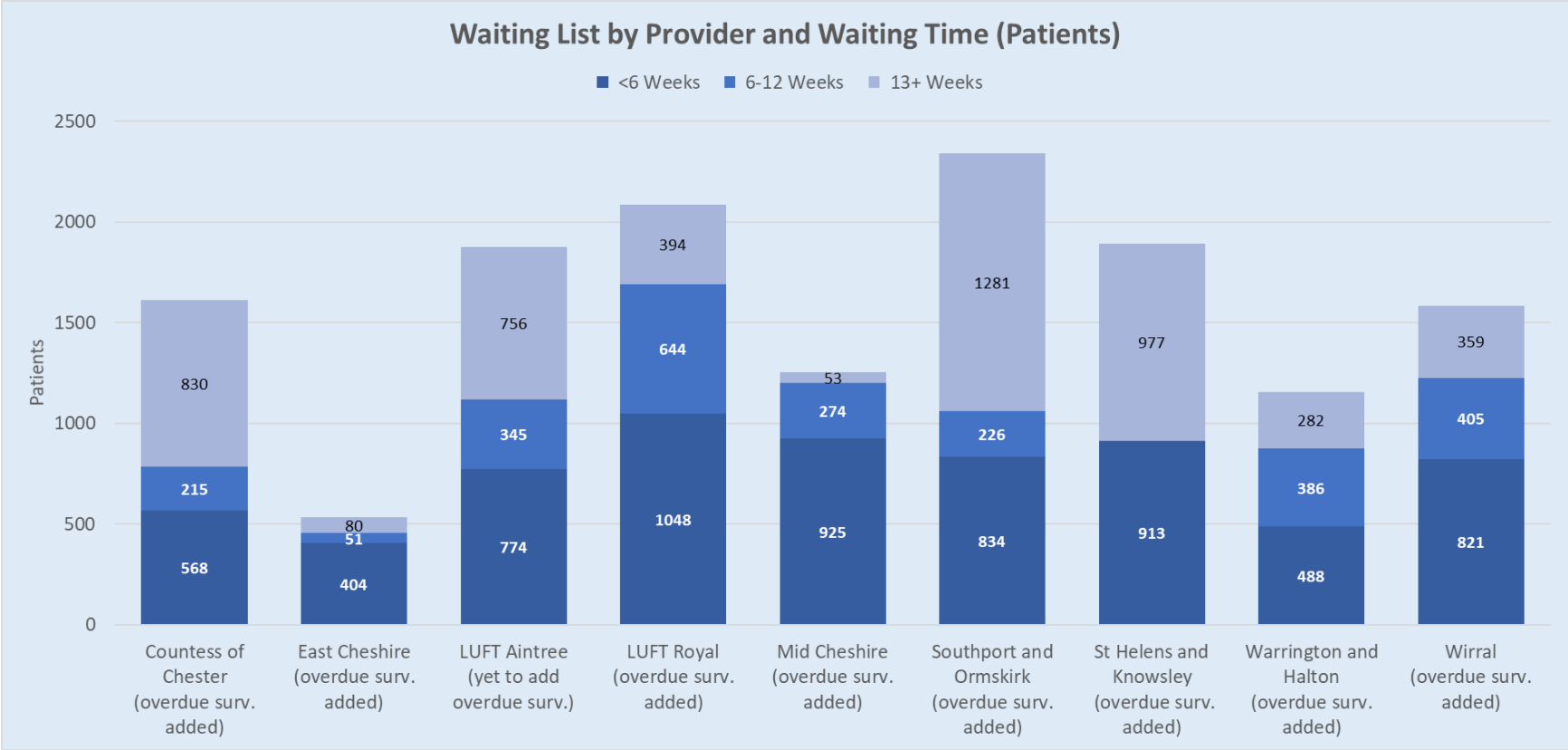
= No PTL submission this week,

Restoration of Cancer Services – Core Metrics

Endoscopy (cancer and non-cancer pathways)

There are currently 14,333 patients waiting for an endoscopy. 7,558 have waited more than six weeks, and of these 5,012 have waited 13 or more weeks (35% of the total).

There is significant variation across units, with Southport and Ormskirk, St Helen's and Knowsley and CoCH having the greatest proportion of their waiting list made up of patients waiting 13 weeks or more (55%, 52%, 51% respectively).



Endoscopy data at 04 April 2022.

Section II: 14 day standard

	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Mar 20 - Feb 21	96.1%	88.0%	96.2%	97.0%	94.6%	90.4%	89.4%	92.2%	90.7%	90.3%	87.2%	94.1%
Mar 21 - Feb 22	95.3%	90.6%	92.5%	90.5%	91.4%	90.4%	89.3%	83.3%	75.8%	76.3%	72.6%	79.7%
Operational Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

In February 2022, 79.7% of patients were seen within 2 weeks compared to 72.6% in the previous month. This is below the operational standard.

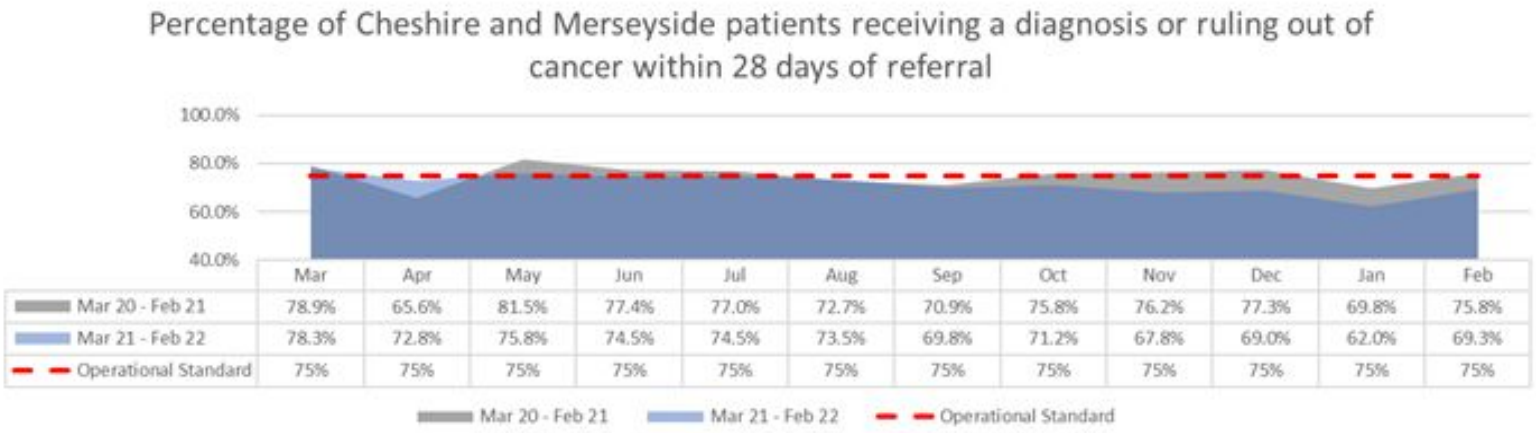
Providers not achieving the national operational standard were:

- Liverpool University Hospitals 71.6% (794 breaches)
- Southport and Ormskirk Hospital 77.1% (217 breaches)
- Wirral University Teaching Hospital 78% (339 breaches)
- St Helens and Knowsley Hospitals 79.1% (370 breaches)
- Countess Of Chester Hospital 81.9% (195 breaches)
- Liverpool Women's 81.9% (53 breaches)
- Warrington and Halton Teaching Hospitals 84.7% (168 breaches)
- Mid Cheshire Hospitals 85.4% (176 breaches)
- East Cheshire 90.2% (55 breaches)

CCGs not achieving the national operational standard were:

- NHS Southport and Formby 64.4% (226 breaches)
- NHS South Sefton 75.1% (171 breaches)
- NHS Liverpool 76% (486 breaches)
- NHS Knowsley 77.2% (178 breaches)
- NHS Wirral 77.7% (323 breaches)
- NHS St Helens 80.3% (182 breaches)
- NHS Halton 82.7% (115 breaches)
- NHS Cheshire 84.9% (470 breaches)
- NHS Warrington 86.1% (141 breaches)

Section II: 28 day standard



The 28 day FDS standard is now live at 75%. In February 2022, 69.3% of patients were diagnosed or ruled out within 28 days compared to 62.0% in the previous month. This is below the operational standard.

Providers not achieving the expected standard were:

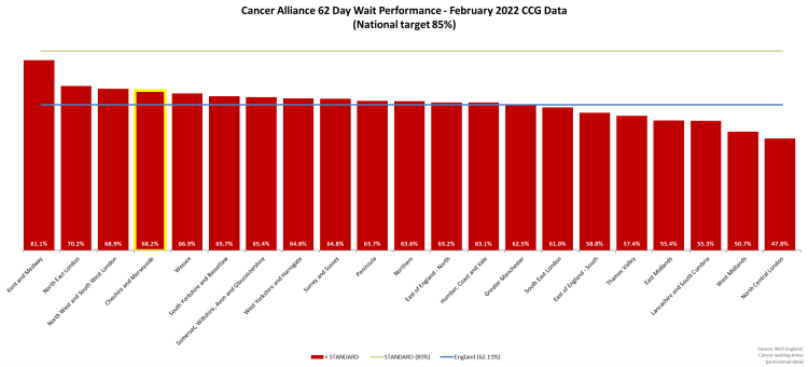
Liverpool Heart And Chest 41.7% (14 breaches)
Bridgewater Community Healthcare 60.2% (76 breaches)
Countess Of Chester Hospital 63.6% (393 breaches)
The Clatterbridge Cancer Centre 66.7% (5 breaches)
Mid Cheshire Hospitals 71.3% (354 breaches)
Liverpool Women's 57.9% (125 breaches)
Liverpool University Hospitals 61.9% (1240 breaches)
Southport and Ormskirk Hospital 66.4% (290 breaches)
Warrington and Halton Teaching Hospitals 68.7% (330 breaches)
East Cheshire 71.4% (154 breaches)

CCGs not achieving the expected standard were:

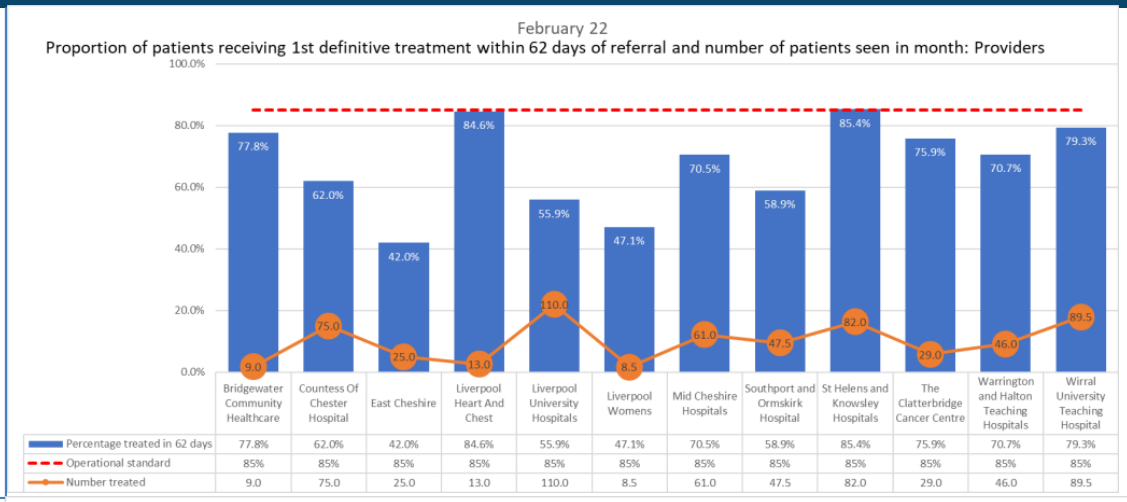
South Sefton 54.9% (369 breaches)
Southport And Formby 65.3% (210 breaches)
Cheshire 68.8% (960 breaches)
Liverpool 64.6% (763 breaches)
Warrington 65.4% (343 breaches)
Knowsley 68.9% (271 breaches)

Section III: 62 Day Standard

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



CMCA achieved 68.2% against a standard of 85%.
CMCA was the fourth best performer. The England average was 62.1%

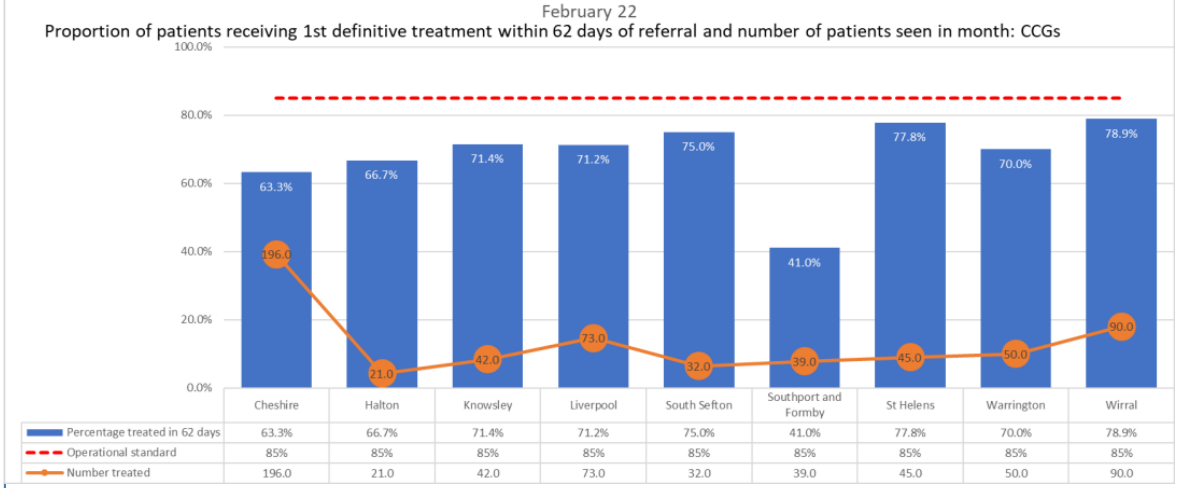


	Bridgewater Community Healthcare	Countess Of Chester Hospital	East Cheshire	Liverpool Heart And Chest	Liverpool University Hospitals	Liverpool Womens	Mid Cheshire Hospitals	Southport and Ormskirk Hospital	St Helens and Knowsley Hospitals	The Clatterbridge Cancer Centre	Warrington and Halton Teaching Hospitals	Wirral University Teaching Hospital
Percentage treated in 62 days	77.8%	62.0%	42.0%	84.6%	55.9%	47.1%	70.5%	58.9%	85.4%	75.9%	70.7%	79.3%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	9.0	75.0	25.0	13.0	110.0	8.5	61.0	47.5	82.0	29.0	46.0	89.5

Most Challenged Pathways (February 2022)

Cancer pathways not achieving the national objective were:

Lower Gastrointestinal 32.7% (35 breaches)
Other 33.3% (2 breaches)
Gynaecological 38.5% (24 breaches)
Head & Neck 51.6% (15 breaches)
Urological (Excluding Testicular) 61.5% (42 breaches)
Lung 63% (20 breaches)
Upper Gastrointestinal 70.6% (10 breaches)
Haematological (Excluding Acute Leukaemia) 73.9% (6 breaches)
Breast 74.1% (22 breaches)



	Cheshire	Halton	Knowsley	Liverpool	South Sefton	Southport and Formby	St Helens	Warrington	Wirral
Percentage treated in 62 days	63.3%	66.7%	71.4%	71.2%	75.0%	41.0%	77.8%	70.0%	78.9%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	196.0	21.0	42.0	73.0	32.0	39.0	45.0	50.0	90.0

Report prepared by Jenny Hampson
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Cheshire & Merseyside Cancer Alliance

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www.cmcanceralliance.nhs.uk

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

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board Part 1
Date of meeting:	30th March 2022
Agenda item:	
Title:	Clinical Horizon Scanning Board Development Session Report
Report prepared by:	Dr Sheena Khanduri
Executive Lead:	Dr Sheena Khanduri, Medical Director
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 note the actions from the Clinical Horizon Scanning Board Development Session held on Wednesday 30th March 2022

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

Next steps required:	

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

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

☒ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☐ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Clinical Horizon Scanning Board Development Session – 30th March 2022 Report

Sheena Khanduri
Medical Director

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

1.0 Introduction

The Board Development session regarding Clinical Horizon Scanning took place on Wednesday 30th October 2022.

The Board received presentations followed by discussion from Clinical Directors and National expert advice regarding developments including future NICE approved Systemic Anti-Cancer Treatments (SACT), CAR-T service development within the Haemato-oncology service and radiotherapy and imaging developments involving Artificial Intelligence and molecular radiology.

The action below was identified and will be monitored, as business as usual, via the Trust Executive Group

Action:

A process will be developed for clinical horizon scanning to be part of the cycle of business planning

Trust Executive Group: September 2022

2.0 Conclusion

The action identified above will be monitored as business as usual via the Trust Executive Group.

3.0 Recommendations

Board is recommended to note the report.

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Report to:	Trust Board	
Date of meeting:	27th April 2022	
Agenda item:	P1-87-22	
Title:	Well-led Review: Report from the Good Governance Institute (GGI) Plus associated Trust action plan	
Report prepared by:	Report: Good Governance institute Action plan: Tom Pharaoh, Director of Strategy	
Executive Lead:	Liz Bishop, CEO	
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	
Date & decision:	

Purpose of the paper/key points for discussion:	The report covers a developmental well-led review undertaken by GGI between November 2021 and February 2022. The review was based around the eight key lines of enquiry in NHS England's Well-led framework. For each of these the report outlines the characteristics of successful organisations, a summary and detailed findings, and recommendations for improvement. The GGI concluded that its findings should be seen as positive, reflecting the work of the trust's leadership and workforce in recent years but that nevertheless, some areas for development and improvement were identified. The report makes a number of recommendations, which are picked up in the associated Trust action plan, also presented here.

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

Next steps required:	Further develop and deliver action plan

REPORT COVER

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

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

☒ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☐ BE **RESEARCH LEADERS**

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

☒ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

EQUALITY & DIVERSITY IMPACT ASSESSMENT								
Are there concerns that the policy/service could have an adverse impact on:								
Age	Yes ☐	No ☒	**Disability**	Yes ☐	No ☒	**Gender**	Yes ☐	No ☒
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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.

Good Governance Institute

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Clatterbridge Cancer Centre NHS Foundation Trust
Well-led Review

Report from the Good Governance Institute (GGI)

March 2022

The Good Governance Institute exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat - in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

Report on Well-led Review at Clatterbridge Cancer Centre NHS Foundation Trust

Client:	Clatterbridge Cancer Centre NHS Foundation Trust
Project name:	Clatterbridge Cancer Centre NHS Foundation Trust Well-led Review
Document name:	Clatterbridge Cancer Centre NHS Foundation Trust Well-led Review – a report from the Good Governance Institute
Version:	Final Report
Date:	March 2022
Authors:	Janice Smith, Senior Consultant, GGI Joe Roberts, Consultant, GGI Mike Weaver, Consultant, GGI
Reviewed by:	Andrew Corbett Nolan, Chief Executive (Partner), GGI
Designed by:	Emiliano Rattin, Brand and Creative Manager, GGI

This document has been prepared by GGI Research and Development LLP. This report was commissioned by Clatterbridge Cancer Centre NHS Foundation Trust. The matters raised in this report are limited to those that came to our attention during this assignment and are not necessarily a comprehensive statement of all the opportunities or weaknesses that may exist, nor of all the improvements that may be required. GGI Development and Research LLP and Clatterbridge Cancer Centre NHS Foundation Trust has taken every care to ensure that the information provided in this report is as accurate as possible, based on the information provided and documentation reviewed. However, no complete guarantee or warranty can be given with regard to the advice and information contained herein. This work does not provide absolute assurance that material errors, loss or fraud do not exist.

This report is prepared solely for the use of Clatterbridge Cancer Centre NHS Foundation Trust. Details may be made available to specified external agencies, including external auditors, but otherwise the report should not be quoted or referred to in whole or in part without prior consent. No responsibility to any third party is accepted as the report has not been prepared and is not intended for any other purpose.

GGI Limited, Old Horsmans, Sedlescombe, near Battle, East Sussex TN33 0RL is the trading entity of the Good Governance Institute

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Contents

1. Introduction and context

This report covers a developmental well-led review undertaken by GGI between November 2021 and February 2022. The review was based around the eight key lines of enquiry in NHS England's Well-led framework. For each of these we have outlined the characteristics of successful organisations, a summary and detailed findings from our work, and recommendations for improvement. Based on this assessment, we also include some ideas to help the trust move forward to become a more significant player in the local system and nationally.

The trust was last inspected by the CQC in December 2018 and was rated as good overall, but requiring improvement for the well-led domain, largely due to ineffective processes for risk management, mandatory training and completion of the fit and proper persons test. The last time a developmental review of the well-led domain was completed at Clatterbridge was in 2016. The trust has experienced major change in the past five years, most notably the successful move to a new hospital in Liverpool; the appointment of a new chief executive, chair, and board; and the growth of its workforce by approximately 50%. All of this prompted us to look at the trust afresh rather than using previous report findings as our starting point.

2. Our approach

Our review followed a well-established methodology based on the triangulation of evidence from a variety of sources. This conforms with the standard for well-led reviews set in the NHSI and CQC guidance. In constructing this report, we used the extensive experience of our review team to assess the relevance and significance of the observations we made and data we collected.

We gathered information in the following ways:

- observation of key meetings (board of directors in public and private session, board assurance committees, council of governors)
- document review (based on agendas of meetings for the board and its committees held during the 2021 calendar year)
- interviews with board members, the lead governor, and other internal stakeholders
- four focus groups with staff at different levels of seniority
- one focus group with governors
- interviews with external stakeholders from the NHS and universities.

GGI's review team comprised: Professor Andrew Corbett-Nolan (Chief Executive), Janice Smith (Senior Consultant), Joe Roberts (Consultant), Mike Weaver (Consultant) and Lucie Middleton (Programme Manager).

The review is limited to the documentation provided to GGI during the period described and the information shared by those we interviewed, or observed at meetings . Most people selected for interview were able to make themselves available, although two external stakeholders were not.

The review team would like to thank everyone who gave their time to be interviewed, as well as those who provided us with project support and documentation, in particular the associate director of corporate governance and her team.

3. Summary of findings

Our findings should be seen as positive, reflecting the work of the trust's leadership and workforce in recent years. Nevertheless, we have identified some areas for development and improvement.

- **Leadership capacity and capability:** The chair and chief executive are both well-known and respected across the Cheshire and Merseyside system, and by the trust's staff. The executive team and board are cohesive and inclusive. The trust is developing both its current leaders and leaders of the future. This last point is important as the leadership bandwidth is seen as 'thin' by some stakeholders.
- **Strategy, vision and values:** There is a clear strategy that is ambitious but seen as attainable, and which was developed with meaningful input from staff. The board has a strategic focus, although its committees can sometimes become absorbed in operational detail. Some stakeholders would push the trust to be more ambitious still with its strategy, particularly around contributing to population health management, the research agenda and clinical leadership within the system.
- **Culture:** Employees told us that they work in a positive, open culture and feel comfortable raising queries or concerns with managers. The trust is taking positive action in relation to racial equality and disability. Employee wellbeing in the aftermath of the COVID-19 pandemic is seen as a priority by the board.
- **Roles, responsibilities and accountabilities:** There is open, constructive discussion and incisive questioning at the board and its committees, and non-executives are clearly very diligent in their duties. However, the agendas of board committees are sometimes congested and operationally focused. There is also a degree of frustration among managers about the number of meetings they are required to attend. The process for collection of declarations of interest has improved but needs time to bed in.
- **Managing risks and performance:** The trust's approach to risk management balances risk and opportunity, while remaining averse to any risks affecting the quality or safety of patient care. This approach has served it well but the systems and processes underpinning risk management could be improved. Management have been open and frank with the board when services or projects have not delivered the desired outcomes and the board has focused on learning from the experience.
- **Data and information:** The trust's digital maturity is improving, but there is more to do. The integrated performance report continues to evolve, and the work of the business intelligence team is recognised within the trust.

- **Stakeholder engagement:** The trust has a positive relationship with partners, who recognise its support for the system during COVID-19, its successful move to Liverpool and its increasingly outward focus. Foundation trust governors provide valued input on behalf of patients and the local community.

- **Learning, improvement and innovation:** Historically the trust was seen to punch below its weight in research and innovation but it is determined to become a major player and has a strategy and plan in place to do so. The picture in relation to clinical quality improvement is more mixed and the trust should review its strategy, and the skills, experience and resources that will be required to implement it.

For each key line of enquiry we have provided a series of headlines followed by a detailed narrative containing our findings below.

4. Detailed findings

KLOE 1 – Leadership capacity and capability

KLoE 1: Characteristics of good organisations

- Leaders have the experience, capacity and integrity to ensure that the strategy can be delivered and risks to performance addressed
- The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and takes action to address them
- Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, development, deployment and support processes and succession-planning
- Leaders at every level are visible and approachable

Headlines

- The CEO has **high visibility** and is well-respected, both inside the trust and beyond. Other leadership team members are less well known outside the trust.
- The chair's **inclusive style** is appreciated by directors and governors.
- The executive team, though still relatively new, is **cohesive and collegial**.
- Non-executives bring a **wide range of professional experience** from inside and outside the NHS.
- The **board development** programme is led by the executives themselves, with some external input, e.g. guest speakers. The programme is often informational in style, and not outcome or improvement orientated. It focusses only on the board as a group, not individual directors
- The shadow board programme **develops executive leaders of the future** and was well received by participants and the board alike.

Detailed findings

The CEO and executive team

The trust's executive team is still relatively new, with members having served in their current roles for between three months and four years. All but two are in their first board-level roles, but together they have formed a cohesive unit with a common sense of purpose. Executives themselves described the team as "collegial" and "constructive and collaborative", saying that the adversity of the pandemic had forged greater unity. This perception was shared by non-executive directors who saw the team as close-knit.

The chief executive is perceived positively by all those we interviewed, both within and outside the trust, with interviewees citing her strong vision and commitment to excellence. Peers in other NHS organisations in Cheshire and Merseyside see her very much as a team player, although were less familiar with some of the trust's other executives. Around half the stakeholders could not name one other board member and this played into a sense of the trust's position relied too much on the chief executive.

Participants in employee focus groups told us that the CEO is highly visible to staff in the organisation, despite the constraints of the pandemic, and the geographical spread of the trust's operations. As well as a regular blog, she uses more informal methods of communicating with staff, which can be as simple as chatting to employees during informal visits to services, and we were told that some other executives do likewise. The leadership style was very much seen as compassionate and empathetic.

The chair and non-executive directors

Since 2019 the board has been led by a chair with very extensive NHS experience, which includes having served as chief executive of a primary care trust and chaired a regional cancer network. Her business-like but inclusive and engaging style was widely praised, notably by a focus group of governors. We observed two meetings of the board – both public and private sessions – which confirmed this impression. A 'light touch' approach to chairmanship facilitated open and frank discussion and involved all participants, while keeping the meeting to time.

The non-executive directors, like the executive team, are a relatively new cohort, having joined the trust between 2018 and 2021. They bring to the boardroom a wide range of experience from their professional careers, which include medicine, accountancy, the law, science, management consultancy and local politics. Some are serving as NEDs for the first time, while others have been non-executives in other NHS organisations, in the social housing sector, or in private industry. Executive directors told us they respected the non-executives for their very thorough preparation for meetings and their probing scrutiny, which, in the words of one, "keeps us on our toes".

Employees are generally much less familiar with the non-executive directors. In our experience this is not uncommon in the NHS and has been worsened by the pandemic, which has largely prevented non-executives from visiting the premises and made it more difficult for them to see their trusts' services for themselves. Non-executives acknowledge that their profile has been reduced due to these circumstances. Virtual walkarounds, which also involve governors, are intended in part to address this.

Board development programme

The board has its own development programme, consisting of four sessions per year. Each session has a distinct theme and is facilitated by the lead executive for that topic, with input from guest speakers. The board has not been able to meet face-to-face, either in formal session or for board development, for almost two years and at least one director has not yet met any of the non-executives in person. The board is a cohesive and unified body despite this, but some members missed the more informal and free-flowing interaction of face-to-face meetings. The programme had neither overall improvement aims, nor had it been evaluated. It is built around sharing information and insight for the board as a group, and does not extend to include individual director personal development.

Developing leaders

The trust is developing the leaders of the future through its shadow board programme, which is intended for senior managers at deputy or associate director level who may aspire to a board-level position in the future. Through our focus groups we met people who had completed this programme, all of whom told us they found the programme highly worthwhile and were grateful for the trust's investment in their career development. We did not see any evaluation of how effective the programme is being.

Recommendations

R1. The trust should consider how it can use trust communications and engagement events to raise the profile of non-executive directors inside the organisation, and awareness of the important work they do.

KLOE 2 – Strategy, vision and values

KLoE 2: Characteristics of good organisations

- There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well-defined objectives that are achievable and relevant.
- The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population.
- Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.
- The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external planners.
- Progress against the delivery of the strategy and local plans is monitored and reviewed, and there is evidence of this. Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.

Headlines

- The five-year strategy is seen by staff as **straightforward and attainable**.
- Staff had **meaningful opportunities** to feed into development of the strategy and took advantage of them.
- The appraisal process is **linked to strategic objectives**, ensuring widespread awareness of the trust's strategy.
- External partners **support the direction of travel** but would have welcomed more opportunity to contribute to the strategy.
- Enabling strategies, e.g. **Our People Commitment**, are clear and focused.
- **Financial planning** is more difficult because of the changing national and local context.
- New trust values were **co-produced** with staff but have only recently been communicated into the organisation.
- Some stakeholders felt the strategy could be more comprehensive around the trust's potential role around service leadership in the system, the research agenda and population health management
- Stakeholders inferred rather than knew the trust's strategy

Detailed findings

Corporate strategy

At the time of our review, the trust had recently launched its corporate strategy, which covers the five years between 2021 and 2025. The strategy aims for the trust to be six things: outstanding, collaborative, a great place to work, research leaders, digital, and innovative. It is available in three forms: the 65-page full document, a summary version (20 pages), and a PowerPoint presentation with one slide for each of the six priorities. The strategy is clearly articulated and attractively presented. It makes clear how the trust will know if it has achieved its objectives.

There had been extensive internal consultation which shaped the development of the strategy. This took place principally through site reference groups – multi-disciplinary groups of doctors, nurses and managers for different types of cancers. Other groups, such as staff side representatives, were also consulted. Some managers who took part in one of our focus groups told us how they recognised from the content of the strategy how their own input had been considered. There is a balance to be struck when writing a strategy – buy-in from key stakeholders is essential, but very long consultation processes can delay strategy development and even make a new strategy outdated by the time it is launched. The trust appears to have managed this balance, although we noted that most of the consultation was internal to the trust – external partners we interviewed supported the direction of travel, but some would have appreciated more opportunities to comment.

Once the strategy was adopted, there was extensive communication to familiarise staff at all levels with the key principles – for example through CCC Live, an online question-and-answer session with the executive directors, and a video featuring the CEO. The annual appraisal process is referenced to the strategic priorities, which means that every employee should be made aware of the strategy, and how it applies to them, at least once a year. Those who attended the focus groups confirmed that it did. Furthermore, all business cases are required to make clear how the proposal contributes to the fulfilment of the strategy.

Recent and ongoing changes within the trust's context and local system provide important opportunities for the trust to maybe go further yet with the strategy, with stakeholders interested in whether the trust saw itself as exerting a greater leadership role to service development, around research and development and in terms of population health management.

Enabling strategies

Sitting below the corporate strategies are enabling strategies, which map out how the aspirations of the corporate strategy will be realised for specific priorities. An example is the 'Our People Commitment', which is effectively the trust's workforce strategy, approved in late 2021. This is based on five priorities: looking after our people, developing our people, workforce for the future, our digital workforce, and valuing our people. A clear ambition for each priority is captured in one or two sentences followed by a series of bullet point actions summarising how the trust will fulfil it. The priorities and actions were informed by intelligence from the national staff survey and other staff engagement activity. It is a clear, straightforward document and it was evident from our interviews with executive directors that it was owned corporately rather than just being seen as the domain of the Workforce department. We also reviewed the research strategy and have commented on this in detail under KLOE 8.

Formulating a financial strategy has been more difficult because of uncertainty around future funding allocations, changing payment mechanisms, and the need to work as part of an integrated care system with shared financial targets rather than in the previous unilateral relationship with commissioners. We understand that a medium-term financial plan is to be put before the board late in the current financial year.

Values

The trust has recently refreshed its values through widespread engagement with staff and patients that included huddles, 'big conversations', virtual engagement sessions, a survey, and attendance at corporate meetings. The values are to be kind, engaging, accountable and inclusive. At the time of our review these had only very recently been launched, so not all our focus group participants were fully familiar with them, but those who expressed an opinion described them as "simple and powerful".

Strategic approach

Our observation of the board and review of its agendas and minutes further shaped our impression of an organisation that is forward-looking and strategic, with wide-ranging discussion of topics such as health inequalities in the context of cancer, achieving net zero carbon emissions, and the future of the trust's charity. This was, however, not always the case in the agendas of the board's assurance committees, and this theme is explored further under KLOE 4. Another indicator of the board's strategic focus is the establishment of a separate director of strategy post, where previously there had been one executive post covering both operations and strategy.

Recommendations

R2. Communication of the new trust values to the entire workforce – and to patients and partners – should be a corporate priority in the coming months.

KLOE 3 - Culture

KloE 3: Characteristics of good organisations

- Leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services. Behaviour and performance inconsistent with the vision and values are acted on regardless of seniority.
- Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistle-blowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and prompt apology and are told about any actions being taken to prevent the same happening again.
- There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations.
- Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing.
- Equality and diversity are actively promoted, and the causes of any workforce inequality are identified, with action taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.
- There is a culture of collective responsibility between staff and teams, where conflicts are resolved quickly and constructively and responsibly is shared.

Headlines

- Moving from Wirral to central Liverpool is widely seen as representing a **change of culture and outlook, not just a change of location.**
- Staff told us the culture was **open and constructive** and they felt comfortable raising issues with managers.
- Services transferred in from other organisations may need to adapt to the Clatterbridge culture and way of working.
- **Diversity and inclusivity issues** did not always have a high profile in the past, but are now an area of focus, with a strong action plan in place.
- **Employee wellbeing** is seen as a priority by the board and is integrated into the appraisal process.

Detailed findings

A positive and changing culture

Our focus group interviews painted a positive picture of the trust's culture, which was described as friendly, open and supportive. Staff told us that managers and directors were approachable and that they felt comfortable asking questions and raising concerns. There is pride in the professionalism of colleagues who were working together in pursuit of a common aim. In fact, some participants said that this culture had been an important factor in attracting them to apply to work at Clatterbridge in the first place.

At a senior level, there is a sense that the move from a semi-rural setting in Wirral to the new building in central Liverpool represents not just a relocation to more modern premises, but a statement of intent – to play a leadership role both regionally and nationally, and to become a centre of research and innovation. Directors see this feeding into a change in culture and outlook, to become more dynamic and outward facing. This view is also shared by interviewees from outside the trust. It is acknowledged that some longer-serving employees found it more difficult to adjust, and that there has been some underlying dissatisfaction about practical issues such as car parking and longer journeys to work.

The trust is a growing organisation and now has approximately 1,600 staff, compared to fewer than 1,300 three years earlier. This increase is partly due to direct recruitment of staff, and partly to the transfer of services such as haemato-oncology into CCC from another trust. As with any such transfer, it will be important to integrate newcomers into Clatterbridge's culture and ways of working.

Diversity and inclusivity

The trust places a greater emphasis on diversity and inclusivity than was the case in the past and, with the Walton Centre and Alder Hey, has recently recruited to a shared post to lead on the equality agenda across all three organisations.

Its Workforce Race Equality Standard report shows a generally improving position, although the small size of the workforce in NHS terms – approximately 1,600 people, of whom 6% identify as BAME – makes it difficult to draw statistically valid conclusions from some performance indicators. There is a comprehensive action plan that includes initiatives such as increasing diversity in the membership of interview panels, a campaign against micro-aggressions, two-way mentoring, and setting up a diversity library. This plan supplements work that has already been done – for example, the trust also commissioned an external consultant to review its recruitment process against best practice in diversity and inclusivity, and the covering paper for all items presented to the board or its committees includes an equality impact assessment.

In terms of other protected characteristics, the results of the Workforce Disability Equality Standard in 2021 were generally encouraging, although fewer than 50 staff are recorded as disabled on the electronic staff record, which suggests a degree of under-recording, as has been found elsewhere in the NHS. There is a plan to establish a staff network in the trust for disabled staff, similar to those which already exist for BAME and LGBT+ employees. Thinking in terms of equality more generally, several directors raised the issue of socio-economic inequality, as the trust's catchment area on Merseyside includes some of the poorest neighbourhoods in the country, with all the challenges that presents in meeting communities' needs.

Raising concerns

There is clear evidence that employees feel empowered to raise any concerns they have at work. In the 2020 national staff survey, Clatterbridge was rated 16th out of 220 trusts based on the Freedom to Speak Up index, which aggregates the responses to five questions about organisational culture and raising concerns. The trust's freedom to speak up (FTSU) guardian is supported by three local guardians and 17 champions. There are also executive and non-executive leads for FTSU. During 2020/21, 12 concerns were raised with the guardian, 11 of which were resolved to the employee's satisfaction and one remained under investigation. Most of these concerns related to working relationships and behaviour, rather than failings in patient care. The consensus from our focus groups was that staff felt comfortable speaking up, and that they would normally approach their manager in the first instance. They were aware of the FTSU guardian role, although several thought that the service should be expanded and needed to be publicised more widely.

Employee wellbeing

The trust signed up to the NHS north west health and wellbeing pledge and its commitment to the wellbeing of its employees is evident in the range of staff support programmes in place. The trust commissions an employee assistance programme, which offers counselling support as well as practical advice about financial and (non-employment related) legal matters. It has also offered personal resilience training. CCC employees can also access the Resilience Hub, which is hosted by Mersey Care and is open to all health and social care workers in Cheshire and Merseyside. In line with national guidance, managers are expected to have individual 'wellbeing conversations' with their staff and this forms part of the employee's appraisal.

With so many initiatives underway, there is a risk that employees may not be aware of the full range of services available, or which service is most appropriate for their needs. Mindful of this risk, the Board discussed the organisational Health and Wellbeing Plan in January 2022. The plan includes a diagnostic exercise which will measure the impact of existing initiatives, identify unmet needs, and seek views from the workforce about what would make the difference to them.

Learning and development

A shared commitment to learning and development appears to be very much part of the culture at Clatterbridge. Participants in focus groups spoke positively about their experience of the appraisal process, both as appraiser and appraisee – they said that the appraisal was a structured and meaningful process for which both sides prepared thoroughly. The Workforce department completed an in-depth qualitative audit of appraisals in early 2021 which showed opportunities for further improvement including setting more SMART goals and having more coaching conversations. Through the focus groups we heard that staff appreciated the range of non-mandatory training and career development that is available. We do however consider that there is scope to provide a broader and deeper induction to new directors.

Recommendations

R3. The trust should consider how it can raise the profile of the freedom to speak up service among its workforce.

R4. Work on organisational development and culture should take account of the fact that staff who are new or who have transferred from other organisations may be accustomed to different cultures and ways of working.

R5. The trust should review the induction process for new directors, both executive and non-executive.

KLOE 4 – Roles, responsibilities and accountability

KLoE 4: Characteristics of good organisations

- Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.
- The board and other levels of governance in the organisation function effectively and interact with each other appropriately.
- Staff are clear on their roles and accountabilities.

Headlines

- Discussion in board and committees is **open and constructive**.
- Non-executives **prepare thoroughly and scrutinise** in great detail.
- There is a c**ommitment to openness**, evidenced by the balance between public and private board agendas.
- There is frustration among managers about the **length and frequency of meetings**.
- Committee papers sometimes include **a mass of operational detail** and should be more strategic / exception-based.
- Some **corporate policies** could be streamlined or made clearer.
- The process for collecting declarations of interest is being improved and needs to be embedded in the organisation. The register of interests should be included in the papers for every board meeting.
- The Trust is starting to pick up a role in holding other system partners to account

Detailed findings

Committee structure

The board has a committee structure that is fairly typical of NHS trusts; there are committees for finance and performance, quality, audit, and charitable funds. The quality committee's remit includes the workforce agenda, as there is no separate committee for workforce. Our work did not extend to the management committees that sit below the board assurance committees, although we note that during 2021 the trust reviewed and rationalised the structure of meetings which report into the quality committee for itself. These groups report to the committee through chair's reports in a 3A format (assure, advise, alert), which is good practice as recommended by GGI, although some of these reports are still written in a similar style to minutes and could be shortened.

Committee agendas

We reviewed the agendas and cycles of business of the committees in detail and observed one meeting of each committee. Our comments principally concern the quality committee. Its agenda is frequently congested, for example in January 2021 it included 21 reports. Furthermore, the papers often include a great deal of operational detail, of the sort we would normally expect to see at management meetings below board level, rather than at a board committee. For example, the risk management annual report listed the status of every national safety alert received during the year and a summary of each serious incident investigation. Further detail was added to some reports, such as the monthly medicines management report, at the request of the committee itself. Other reports were accompanied by extensive supporting documentation such as copies of regulatory standards or audit questionnaires, which can make agenda packs even larger – the agenda for June 2021 totalled 548 pages.

With so much detail in the papers, there is a risk that key messages are lost, and that discussion may centre on the specifics of the reports rather than identifying common themes and trends, or discussing future strategy. This risk is recognised. The chief nurse has signalled her intention to streamline some reports, such as the risk register report and the nurse staffing update, so they are more focused on exceptions, both positive and negative, and what is being done about them.

Regarding other committees, we found the agenda of the audit committee consistent with what we would expect to see in the public sector. The committee did ask for – and received – a detailed action plan for the 2020/21 external audit but we understand that this was in response to delays and performance issues in previous years' audits. The committee also attaches great importance to the completion of internal audit reports, which it monitors through a tracker, and considerable effort has gone into getting this right. The performance committee has a shorter and more standardised agenda based around the integrated performance report and the management accounts, although some meetings can be long – over three hours.

We also reviewed the agendas of the charitable funds committee, which meets less than other committees – usually four times per year. The agendas mixed standing items, such as the financial update and a regular report about the charity lottery, with reports about topical issues. The most significant issues discussed were the impact of COVID-19 on fundraising activities, and the proposal to make the charity independent of the trust. Other items included a business case for a digital fundraiser and a report about donations of artwork.

Conduct of meetings

Across all committees, it was clear from the questions asked that non-executives had studied the papers in detail. There was incisive questioning, constructive challenge and honest debate in an atmosphere of mutual respect. We noticed that questions came mostly from non-executives; executives did not usually question one another in committees.

We also observed some good triangulation between different sources of information, for example linking questions about patient safety indicators to other data about training and safe staffing levels.

Frequency and length of meetings

There is a widespread view – expressed most strongly by senior managers in two of our focus groups but echoed by some board members – that there are too many meetings in the trust, some of them last too long and they have too many people present. Some managers reported spending most of their working hours on video calls. It was not clear how much of this time was taken by formal meetings. Anecdotally, the number of one-to-one meetings has increased because informal catch-ups are not always possible with people working from home or at different sites. They also observed that the same report would often be presented to several different meetings, requiring the author to attend each one. There have been some efforts to reduce the number of meetings, for example a daily meeting to review incidents has been replaced with a weekly one.

Executive finance committee

As well as board assurance committees, we observed the executive finance committee. The meeting agenda included standing items and matters related to performance, investments and business cases, COVID recovery and sub-group reports. The meeting included a separate section to review and agree the trust's cost improvement programme (CIP). All points on the agenda were supported with relevant information and all items received positive and constructive discussion from all members of the meeting. The chair reported an excellent summary of discussion that included actions agreed and matters for escalation after each item on the agenda.

Council of Governors

We also observed a meeting of the council of governors. The meeting had a broad and informative agenda that included standing items such as updates from the chief executive and the lead governor, a presentation about clinical and financial performance, and reports from the chairs of board committees. In addition to routine business, the council also discussed a proposal to make the hospital charity independent of the trust, a constitutional amendment to create a seat for a governor from the Isle of Man, and the reappointment of a non-executive director. Members asked a range of constructive and relevant questions in relation to various agenda items, although we observed that only half of all governors were present, and of those attending, a small number accounted for much of the questioning and debate. Also, the chief executive and lead governors' reports were verbal only.

Corporate policies

Finally, we reviewed the following corporate policies: document control; acceptance and refusal of charitable donations, anti-fraud, bribery & corruption; processing charitable donations ; managing conflicts of interest; and duty of candour / being open. Some of the policies require further detail about the specific training needs for all staff groups to enable them to fulfil their responsibilities, and how the trust will monitor and report compliance with the policy. This is particularly important as an internal audit review of one of these (conflict of interest) found shortcomings in its implementation and graded the process as 'limited assurance'. We have also made some observations about points of detail in the policies that do not merit inclusion in this report but which we would be happy to share with the policy owners.

Conflicts of interest

The trust managing conflicts of interest policy was written to align with the national policy published in 2017. The policy is next scheduled for review in July 2022. The Internal Audit Managing Conflicts of Interest Review published in October 2021 only gave limited assurance and made nine recommendations of which two are rated as high. In response to the recommendations rated as high the trust has agreed that staff should be reminded of their role and responsibility to make a full declaration of gifts/other received. The trust will also investigate non-declared items to establish if a conflict of interest has occurred through a non-declaration. The trust will also ensure that all decision-making staff make a full declaration of interest, that is reviewed on an annual basis. Consultant doctors should make a full declaration of interest on the trust template form and provide an annual refresh. The trust has agreed that all declarations are subject to independent manager review, with a clear audit trail retained to evidence the process that has been followed. This is being actioned and the due date for completion is 31 March 2022. The trust is taking this seriously and is improving its processes around conflict of interest but it needs to ensure that the improvements continue.

The conflicts of interest register was not included in the meeting papers for the trust board meetings held in public on 24 November 2021 and 26 January 2022. The conflicts of interest register dated 2019/2020 published on the trust public website included declarations of interest for all existing voting members of the board except Anna Rothery, non-executive director (councillor), Dr Asutosh Yagnik, non-executive director and Julie Gray, Chief Nurse. For non-voting members there are no records of declaration for Sarah Barr, Chief Information Officer, Tom Pharaoh, Director of Strategy, and Jane Wilkinson, Lead Governor. The chair invited members and other attendees to declare interests concerning agenda items other than the usual conflicts declared. No interests were declared. We would recommend the trust ensures that it publishes its conflicts of interest register at all future meetings of the trust board held in public and ensures the register reflects the most current declarations of interest for all voting and non-voting members that attend the meeting. We would also advise the trust to ensure that, when it reviews its policy for managing conflicts of interest in July 2022, it identifies the team or individual with responsibility for providing advice training and support for staff on how interests should be managed.

Corporate governance support

The associate director of corporate governance and her team work hard to provide the necessary support for the board and its committees and the council of governors and many people praised them during this review. We understand that a lot of work has been done to improve the governance processes during the past few months and this was evident from the meetings we observed. However, this will need to continue to embed the processes fully in the trust. It is also important to provide sufficient resource for this function as it underpins the success of the corporate governance system.

Recommendations

R6. The agenda of the quality committee should be reviewed with the intention of condensing the agenda pack, and reporting for assurance, i.e. by highlighting positive and negative exceptions and planned actions, and summarising themes and trends, as opposed to detailed operational reporting.

R7. When corporate policies are next due for review, the policy owners should ensure that they make clearer how they will be monitored for compliance, and what training different groups of staff require.

R8. The trust should consider reviewing the structure of operational management committees which feed into board assurance committees, as it has already done for the groups which report to the quality committee. This will ensure that every group is serving its intended purpose and may allow some meetings to be eliminated or streamlined. GGI can recommend a way to do this.

R9. The trust should ensure that when it reviews its policy for managing conflicts of interest in July 2022, it identifies the team or individual with responsibility for providing advice training and support for staff on how interests should be managed.The policy should also say how the trust will audit compliance with its own policy and associated processes and procedures on an annual basis and subsequently in line with the review cycle of the policy.

R10. We recommend that the trust publishes a conflicts of interest register that reflects the current membership and attendance at the board. The conflicts of interest register should be included in meeting packs for all future meetings.

KLOE 5 – Managing risks and performance

KLoE 5: Characteristics of good organisations

- There is an effective and comprehensive process to identify, understand, monitor and address current and future risks.
- Financial pressures are managed so that they do not compromises the quality of care. Service developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood.
- The organisation has the processes to manage current and future performance.
- Performance issues are escalated to the appropriate committees and the board through clear structures and processes.
- Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve.

Headlines

- The trust has a **balanced risk appetite** – averse to risks affecting patients, but keen to take advantage of commercial and research opportunities.
- The board assurance framework is comprehensive, but it is **not obvious how it shapes the work of the board** and committees.
- The division between **risks and issues** on the risk register is not standard NHS practice and is confusing for some.
- Implementation of the **new risk management database** has been problematic and continues to cause some difficulties.
- Committees have commissioned **deep dives** in cases of poor performance or project failure – these have been methodical, candid and focused on learning.
- Financial performance and business strategy of **subsidiary companies** are monitored through the board and committee structure.
- There has traditionally been **little tension between finance and quality** considerations, and the financial environment may be more challenging and uncertain going forward.

Detailed findings

Risk management

Our overall impression of risk management is that the trust has a healthy and balanced approach to risk, and this has enabled it to succeed. A sign of its strong commitment to managing risk is that the risk management committee is chaired by the chief executive. However, some of the systems and reporting arrangements supporting the management of risk could be more effective.

The trust's risk appetite statement is clear: it is averse to risks affecting patient safety but is more open to financial and organisational risk in pursuit of innovation and growth. The stated risk appetite is consistent with how the trust actually operates and the decisions it makes. For example, its aversion to risks affecting patient safety is clear in the road map to recovery, which sets out its approach to re-opening sites. Meanwhile, the move to new premises in Liverpool, and the establishment of subsidiary companies that generate a financial dividend for the trust, show its ambition and willingness to take risks, provided that there are robust controls in place.

The risk management strategy is the policy governing risk in the trust. The process as described in the strategy is consistent with that found elsewhere in the NHS, although we did not find it a very user-friendly document – it is 60 pages long, half of which are appendices such as the terms of reference for committees. It also includes some outdated content, e.g. information about the discontinued NHS Sign Up to Safety programme.

The management of strategic risks is documented in the board assurance framework (BAF). This consists of 12 risks, most of which are broad and strategic in nature. It also includes some risks which are more operational, such as the delayed relocation of the aseptic pharmacy unit, and potential breaches in cybersecurity, but which are serious enough to jeopardise the achievement of strategic priorities. Interestingly, none of the risks explicitly refer to the impact of COVID-19, even though concern was expressed in interviews about the consequences of late diagnosis of cancer in people who delayed seeking medical attention during the pandemic. The risks are cross-referenced to the corporate strategy, and each is owned by an executive and a board assurance committee. Controls and assurances are listed for each risk, although the section which lists gaps in control and the actions to rectify them is combined, making it difficult to track some of the corrective actions.

In terms of how the BAF is used by the board, we observed – as have internal audit – that it is usually found towards the end of the agenda and not discussed in great detail. A major benefit of a board assurance framework is that, by identifying key risks and sources of assurance, it enables committees to structure their cycles of business and agendas around those risks and assurances. As such the BAF could help to rationalise the congested agendas of some committees that we previously mentioned. The trust could extract more value from its BAF than it currently does.

Operational risks are recorded in a risk and issues register. The distinction between risks and issues is unusual and is not mentioned in the risk management strategy. Risks are defined as foreseeable events that have not yet happened, while issues are risks that have already materialised and require corrective action. The split between risks and issues is not found elsewhere in the NHS and was confusing to some of our interviewees.

Each board committee receives a report about risks relevant to its remit. This includes the full detail of every open risk or issue scored 12 or above, any new risks, and any risks or issues which are overdue for review or action. For the quality committee, which has approximately 120 risks or issues allocated to it, this makes for a long report. The information is extracted from the trust's risk management database. This system was rolled out in 2020/21 and in common with other trusts where it is used, there have been difficulties in implementing it. One problem is that automated reports do not always capture changes to risk scores, requiring reports to be corrected before being presented to committees which can be significant extra work.

Managing performance

During the past 18 months the trust has experienced difficulties in performance or project management in some specific areas – complaints handling, the aseptic unit, and the clinical decisions unit. To the credit of executives, they have been very frank with the board about shortcomings in these services and have produced regular reports – monthly updates in the case of the aseptic unit – that provide assurance these services are being turned around. The aseptic unit in Liverpool finally re-opened for business in December 2021 and we see this as a good example of the board monitoring performance and driving improvement.

The trust has undertaken 'deep dives' into these issues with a focus on identifying causal factors and what can be learned. The reports have been shared with the relevant board committees. These have been very thorough exercises – for example, the complaints deep dive reviewed policies, previous audit reports, meeting minutes, examples of complaint response letters and database entries. There was also a survey of people involved in the complaints process. The review of the clinical decision unit involved audits, direct observation and staff feedback and resulted in an action plan including development of new pathways jointly with Liverpool University Hospitals, new referral criteria, a workforce review, and staff education. Finally, there was also a deep dive into the procurement and implementation of the new risk management database. This revealed important learning points around the governance process for approving business cases and seeking input from the digital team on technical specifications.

Oversight of commercial subsidiaries

The trust has two commercial subsidiaries – Clatterbridge Pharmacy Limited and PropCare – and holds a 49% stake in a joint venture company (Clatterbridge Private Clinic) formed with an independent sector provider. These businesses are commercially successful, although CPL recently experienced some difficulties due to the loss of key personnel and an incident involving accidental damage to inventory. The companies provide regular reports to the Performance Committee covering business strategy, risk, compliance and financial performance.

One non-executive director sits on the board of each subsidiary, which is appropriate for a wholly owned subsidiary, and CPL's board also includes a divisional director and the deputy director of finance from the trust.

Finance and quality

The trust has traditionally experienced little tension between finance and clinical quality considerations. There is a process for quality impact assessments of proposed efficiency savings which, as it was described to us, appears robust and requires sign-off by divisional triumvirates, subject to a review by the chief nurse and chief medical officer. However, in the near future, it faces a more challenging financial environment due to factors such as changes to the criteria for the Elective Recovery Fund, and the financial deficit across the Cheshire and Merseyside system – there is a common cost improvement programme target across the ICS. The trust has traditionally achieved financial balance, or a small surplus, and met its CIP target, although the external auditors point out that it has often relied on one-off savings, extra drug income, and profits from its commercial subsidiaries to do so. The performance committee has been well sighted on recent and future financial developments through a regular presentation by the director of finance and the chief operating officer.

Audit

There is an active clinical audit programme, consisting of approximately 50 audits in an average year. The audits are aligned to five themes: patient outcomes, patient experience, patient safety, quality of life, and staff experience. During 2020/21 there were seven audits relating specifically to COVID-19. There is a strong element of patient involvement through patient representatives on the clinical audit subcommittee. Patient and public involvement in audit is recognised as good practice but is not widespread in the NHS. The quality committee receives an informative annual report on the clinical audit programme, emphasising the learning and improvement resulting from audits. Unusually, the clinical effectiveness team, which facilitates clinical audits, sits within informatics alongside clinical coding, while in many other organisations clinical audit forms part of an integrated governance function.

The trust, like all NHS organisations, has an internal audit service, the remit of which extends beyond auditing financial systems to cover most corporate processes. This is outsourced to MIAA, a regional shared service provider that is accredited against the national Public Sector Audit Standards. It works to a risk-based annual plan and reports to the audit committee with a summary of the findings from reviews they have completed each quarter. In their head of internal audit opinion for 2020/21 they rated the trust as 'substantial assurance', indicating that internal control in the trust was robust.

In the past there had been issues with implementing some internal audit recommendations and the very critical internal review of the complaints process completed in 2021 recorded that MIAA had also found problems in 2018, when they rated complaints management as 'limited assurance'. The audit committee monitors outstanding and overdue recommendations as a standing agenda item and has sought update reports relating to specific audits such as medical devices. We understand that the audit tracker has been significantly improved and it was thoroughly examined at the audit committee we observed. At the time of our review, several actions relating to serious incidents, risk management and CQC compliance remained overdue.

Recommendations

R11. The risk management strategy should be reviewed and updated, in terms of content, style and format. The intention should be to make the document more succinct and visual and to remove outdated or unnecessary supporting information.

R12. The board assurance framework should differentiate more clearly between gaps in control or assurance, and the actions required to close those gaps.

R13. The board assurance framework should be used actively as a tool to shape the work of the board and ensure that the right information is going to the right places within the governance structure.

R14. The trust should consider adopting a more standardised definition of risk, in place of the current division between risks and issues on the risk register. Alternatively, it should ensure that the difference between risks and issues is clearly understood by all.

KLOE 6 – Data and Information

KLoE 6: Characteristics of good organisations

- Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary.
- Integrated reporting supports effective decision-making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people, with quality, operational and financial information.
- Performance information is used to hold management and staff to account.
- The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.
- Information technology systems are used effectively to monitor and improve the quality of care.
- Data or notifications are consistently submitted to external organisations as required.
- There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Headlines

- The trust is becoming more **digitally mature. Good progress is being made but, like other trusts, there is more to do.**
- There is **clinical engagement with the digital agenda** – with the chief medical officer as senior responsible officer for the digital transformation programme.
- The **business intelligence team** are seen as responsive and supporting service improvement.
- The integrated performance report **continues to evolve** with plans for revised indicators and statistical process control charts.
- The trust self-assessed compliance with all mandatory standards in the **data security toolkit**, which was validated by internal audit.

Detailed findings

Our overall impression – in common with those who we interviewed – is that the trust has matured in the way it produces and uses information, but that there is still more to do.

Performance reporting

The integrated performance report (IPR) is the centrepiece of board and committee agendas. This is a substantial report, 60-70 pages in length, making it one of the longer IPRs that we have seen in an NHS trust. The areas reported on include access, efficiency, COVID-19 recovery activity, quality, research and Innovation, workforce and finance. Information is presented first as a RAG-rated scorecard of compliance with statutory, contractual, and local targets, followed by an exception report and a detailed report. Of note are the exception reports, which summarise the reasons for non-compliance, action taken to improve compliance, expected date of compliance, the escalation route, and the executive lead for the performance indicator. The trust is planning to refresh the IPR for the next financial year in line with the changing performance framework nationally, and to include statistical process control charts, which are seen as good practice. It may also wish to consider condensing the document and presenting it in a more visual, landscape format.

Data quality

Our interviewees and focus group participants were generally confident in the quality of the data they received in reports, and some explained the work that goes on behind the scenes in areas such as clinical coding to assure data quality. We also observed from the audit committee papers that internal audit had tested a sample of performance indicators included in the IPR for accuracy and given a 'substantial assurance' rating. Producing performance reports still requires a lot of number crunching but the intention is to introduce more automated reporting over time. There has been a substantial investment in the business intelligence team in recent years and this team was spoken of favourably by several executives.

Another positive feature is the degree of clinical engagement with the digital agenda. The chief medical officer is the senior responsible officer for the digital transformation programme and the trust commissioned a company to undertake a staff engagement project which will inform the transformation programme.

Data security

The Well-led framework also requires NHS organisations to ensure the security and confidentiality of personal data. We did not assess this element of the framework as NHS trusts are required to self-certify their compliance with the NHS Data Security Toolkit every year and the self-assessment is validated by their internal auditors. In 2021 the trust met all 111 mandatory standards in the toolkit and 16 of the 38 voluntary standards. Over 95% of staff had completed their mandatory training on data protection. The audit committee receives regular reports about information governance and its minutes show that it takes an active interest in the subject.

Recommendations

R15. In the forthcoming refresh of the IPR, the trust should consider presenting the report in a more visual manner.

KLOE 7 – Stakeholder engagement

KLoE 7: Characteristics of good organisations

- A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture.
- The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture.
- The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.

Headlines

- External stakeholders respect the trust's leadership and its achievements but would like to see it show **even more ambition**.
- The chief executive plays a **leading role in Cheshire and Merseyside** as senior responsible officer of the Cancer Alliance and lead for diagnostics.
- **Mutual aid** provided by the trust during the pandemic was appreciated by local partners.
- The **new and uncertain world of integrated care systems** is a challenge for the trust, as for many NHS provider organisations, but is also seen as an opportunity.
- Foundation trust governors feel appreciated and involved, and **are proud of the trust.**

Detailed findings

External partners

In the course of our work, we interviewed senior personnel from the trust's partners in the NHS and in academia. The trust is perceived positively and the mutual aid it provided to other NHS trusts during the pandemic was greatly appreciated. The perception is that, while the trust rightly has ambitions of its own, it is very much a team player within the local system and is increasingly outward-looking. Those with longer experience of the NHS in Liverpool saw positive changes in this respect. It is open to new ways of working and new organisational structures, and willing to take informed risks to make changes happen locally.

The chief executive is personally well respected and is credited with driving forward improvements in the trust's profile and performance in recent years. She holds important cross-organisational leadership roles as senior responsible officer for the Cheshire and Merseyside Cancer Alliance and lead for diagnostics in the integrated care system. Some other executives, being newer in post, are not so well known within the system but the executive team is seen as effective, individually and collectively. The efforts of other executives are also recognised by some – for example, the director of finance's contribution to the community diagnostic centre programme.

Some external partners felt, as we have already stated, that, as is reasonable in a smaller organisation the bandwidth of the senior team may amount to a challenge in taking on more of a system leadership role. Many partners could not name any board member other than the chief executive, and so felt themselves unqualified to comment much on the desirable developmental potential of CCC.

Staff engagement

The trust engages well with its staff, and we saw evidence of it doing so in developing its strategy and values (see KLOE 2). The relationship between management and trade unions through Staff Side is seen as positive and constructive by both parties, and the chair of Staff Side is invited to attend part 1 of the board of directors' meeting.

Governors and membership

As a foundation trust, CCC has a council of governors comprising local people elected to represent their communities, employees chosen by their colleagues, and members nominated by external partner organisations such as local authorities and universities. The governors have a vital role in representing patients, public, staff and partner organisations in terms of how services are delivered, and important strategic decisions. The board recognises the vital importance of their role and there is close engagement with them. For example, the lead governor meets regularly with the chief executive, attends part 1 meetings of the board with the right to speak, and also participates in the audit committee. Some governors sit on a patient experience committee below board level and participate in virtual walk-arounds of clinical services alongside non-executive directors.

Governors told us that they were satisfied with the extent of their involvement and the information which they receive, and that they interact well with non-executive directors, although they had closer links with some than with others. They expressed great pride in being associated with Clatterbridge and the work it does. Among directors, the council of governors is seen to have become stronger and more effective in recent years. We did note that the foundation trust membership, from which most governors are chosen, has been static for several years. Governors have long been keen to grow the membership and to attract a broader cross-section of the population, for example more young people. The circumstances of the last two years have largely prevented progress from being made in this area, but the trust has a membership and engagement strategy in place.

Recommendations

R16. The trust should consider how it can grow, and involve, its foundation membership.

KLOE 8 – Learning, improvement and innovation

KLoE 8: Characteristics of good organisations

- There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.
- There is knowledge of improvement methods and the skills to use them at all levels of the organisation.
- The service makes effective use of internal and external reviews, and learning is shared effectively and used to make improvements.
- Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.
- There are organisational systems to support improvements and innovation work, including staff objectives, rewards, data systems and ways of sharing improvement work.

Headlines

- Research is now seen as **core business** but historically was not given such high priority.
- External partners are keen to see **even more focus** on research.
- Research programmes have been hindered by the pandemic and problems in the aseptic unit but have still made good progress.
- Responsibility for **clinical quality improvement programmes** is divided and there is no consistent methodology in use.
- Complaints handling was **acknowledged as a weakness** and action is being taken in response to the 'deep dive' review.
- The approach to **incident reporting and investigation** is changing in preparation for the new National Patient Safety Framework and to become more efficient.

Detailed findings

Research and innovation

Research is a growing area of focus for the trust, which acknowledges that its research portfolio had traditionally been small by the standards of a specialist tertiary centre. The trust's research strategy is ambitious, although some external stakeholders would like to see it become more ambitious still. The trust has committed itself to increasing patient participation in trials by 10% per year, doubling the number of consultants who do clinical research, establishing the Liverpool Cancer Research Institute, recruiting to new posts for clinical academics and research fellows, and to many other specific goals. Research is seen not as an end in itself, but primarily as a means of improving outcomes for patients. It is also a source of competitive advantage in recruiting the best talent to work for the trust. There is a detailed business plan that sits below the strategy and the performance committee receive regular updates on the progress of this plan. The integrated performance report also includes several indicators relating to research and innovation, prompting lively discussion at the quality committee and board; research is clearly close to the hearts of board members. The trust has appointed a new director of research, who was rated highly by our interviewees, to lead this agenda.

Much has already been done to expand the research programme, such as: restructuring the research and innovation department, establishing tumour site reference groups with a research lead in each, pump-priming projects with charitable funds, and applying Global Digital Exemplar funding. Despite the disruption caused by the pandemic, and the difficulties in transferring the aseptic pharmacy unit to Liverpool, the trust still managed to deliver 85% of its planned research activity during 2020/21, with over 900 patients taking part in 46 trials.

Clinical quality improvement

In terms of clinical quality improvement, the picture is mixed. There is a nursing quality inspection programme in place under the direction of the deputy chief nurse, using the Perfect Ward app. However, the quality strategy has expired, and there is no single agreed methodology for local quality improvement projects. Some staff have received quality improvement training from the Advancing Quality Alliance in the past, but not recently.

Incident management

We also enquired about how the trust learns lessons from incidents. The trust has made changes to its policy for investigating serious incidents and expects to make further changes after the new patient safety incident response framework is launched later this year by NHS England. It is delivering new training based on the national patient safety syllabus and has three accredited patient safety specialists. It is also working with Academic Health Sciences Network on patient safety improvement programmes. Within the trust we found agreement that there was a positive culture around incident reporting and were given examples of lessons learned and changes made after things had gone wrong. Some, however, felt that the learning from incidents was limited to the specialty or division where they occurred rather than being shared across the whole organisation . We understand that a new information resource for patient safety is being created within the trust's SharePoint system but the trust could do more here. Initiatives that have proven successful elsewhere include newsletters, email bulletins to all staff, lunchtime safety summits to discuss incidents, and even patient safety podcasts.

Complaints

The trust recognises that its management of complaints has not always met the standards to which it aspires. As mentioned previously, the quality committee commissioned a deep dive into complaints handling, which assessed the process as being only partially compliant with NHS complaint regulations. Issues concerned the tone and content of response letters, response times, communication with complainants, and organisational learning from complaints. Improving the management of complaints has been a personal priority for the chief executive, who signs all response letters herself, and decreed that it was no longer acceptable for timescales for responses to complaints to be extended. The most recent quarterly complaints report (November 2021) indicated that there is more work to do, as the key performance indicator of responding to complaints within 25 working days is not consistently being met.

Recommendations

R17. The trust should develop a new / revised quality strategy and ensure that the resources, methodology and training that are needed to implement it are in place.

R18. The clinical governance and communications teams should work together to find and implement new ways of spreading learning from patient safety incidents and complaints across the whole organisation.

5. Opportunities for the future

There are a number of themes from the review that have implications for the future development of the trust and its leadership, both in terms of individual and team development, and of how it works. Also, during the Well-led review, we had identified to us a number of opportunities that the Trust may be considering to deliver its strategy. These all have implications for the future application of the well-led framework and how the trust grow's it's leadership.

Role in systems and collaborative work

The local NHS system has been impressed by the role that the trust has taken in various activities over the pandemic such as Mutual Aid. They are very impressed with the chief executive's leadership, particularly in leading the Cancer Alliance and being SRO for diagnostics. She has become well known and respected by other organisations.

This also provides opportunities for others to build on and take a lead at systems level. We understand that this is already happening in some areas, but more work needs to be done to establish the trust as a true systems leader.

The current situation in Cheshire and Merseyside is such that the trust could decide to play a larger role in the system.

- **Potential contribution to population health**

The trust also needs to consider what part it can play in improving population health, maybe in the prevention of cancer as well as the treatment of it. We understand that some work is already in train to look at the role that deprivation plays in developing cancer and how some of the triggers might be avoided. The trust could find it beneficial to be more involved in this type of work, even though the benefits of doing so will only be derived in the longer term. This will also enhance the trust's reputation and make it a more significant systems player. This was felt important to do by a number of external stakeholders.

- **Delivery of clinical services**

The way that clinical services are delivered has changed over the past few years and the trust now delivers services in different settings and other trusts. This is beneficial to the trust's reputation but means that it is harder to maintain the quality of services.

We did not see a recent clinical strategy and there did not appear to be a quality improvement methodology that the trust adopts. We consider that this area should be prioritised coming out of the pandemic and that there are opportunities for the trust to lead the way.

- **Research**

The trust aspires to be a leader in research, which is appropriate for a specialist trust, and this is an area it has not been particularly involved with in the past. The trust has developed a research strategy and employed a director of research to help take it forward. This area will be helpful to the trust moving forward both for its clinical practice and reputation.

One specific area to consider is a joint research strategy with the University of Liverpool that would benefit the population as a whole. The trust has already made one joint appointment with them and more would be helpful.

Improving the trust's reputation for research will also reap other benefits such as attracting and retaining key staff with specialist skills.

Summarising these systems opportunities

In terms of specifics, through the developing ICS and the cancer alliance the Trust has the opportunity to take more of a lead in terms of system leadership. There are various ways this could manifest itself and much will depend on the character of the ICS as it develops. Cheshire and Merseyside ICS has had several false dawns in terms of its development but a chief executive is now in place and it can be hoped that a chair designate will be in place in the next few weeks. As the ICS develops options for growing excellence in cancer services are likely to include CCC in a leading role, be this through a lead provider role, or as the 'intel inside' part of a provider alliance. In either case more executive time will be needed to address system work, and the bandwidth issue will need to be addressed. The perception is that much of the external-facing work is reliant personally on the chief executive, and so increasingly the ability to work across networks with partners will be a key requirements for executive appointments to what is likely to need to be a larger team. Stakeholders felt that the trust could and should be a vanguard in this area and this could potentially be applicable to other specialist trusts.

Specifically around the role of the medical director, the role of a team of Associate Medical Directors, either on staff or implanted from the system, could be practical ways of the Trust working to address non-surgical cancer pathways through the local system, as well as pick up other challenges such as a greater contribution to population health management.

The executive team and the board have benefitted from a chief executive recognised as being hard-working, credible and insightful, and without diminishing this in any way the broader leadership needs to be seen as a broader team with these features recognised as 'Clatterbridge' rather than these contributions being individual.

The research and development agenda again provides a particular opportunity to the local system if galvanised and decisively lead, and CCC could and maybe should be taking the leading role for non-surgical cancer. There was an open jury as to whether the current leadership would be able to step into this role without recruitment in and significant development.

We have phrased these possible areas of growth as being rooted in the needs of the system, and CCC being uniquely placed to bring these to fruition. It will be early work for the board in working through the recommendations from this review to decide on how CCC will enact its strategy and in practical terms contribute to a system that is still very much in the making.

Areas of growth for the board and executive team

In terms of the next steps for the board, partly depending on appetite for stepping up the systems work, the board and leadership team need to settle on their own development. The board has come together well over the past three years with new executive and non-executive directors but there is more work to be done to turn it into a truly high-performing board.

The board needs to put in place a purposeful and ambitious board development programme, articulating the impact these should achieve over a reasonable period of time, perhaps 18 months to two years. This should be linked to the executive and clinical leadership development plans, and the existing personal development plans for all board members, both non-executive and executive. The board development plan should include seminar sessions and workshops, as well as interventions for individuals and pairings (sub-committee chairs and executive leads, for example) and have the aim of an end-point that is the system leadership team for non-surgical cancers as well as the Trust.

Specific issues to pick up would include much to do with the ordinary conduct of board governance as well as more strategic and systems issues. For example, the NEDs are strategic and challenge constructively at the board but can be too operational at committee level. While they do need the right information for each area, they also need to trust the executive team to undertake the operational work. To gain this trust, the executive team need to provide excellent papers that highlight potential risks so that the NEDs can have confidence that the correct controls are in place.

We suggest that some of the board development sessions are used to develop this style of working by taking a particular area and looking at it together bearing in mind the specific roles.

It is also important that the NEDs are enabled to become more visible across the trust as COVID restrictions are lifted. A schedule of visits and activities could be a way of addressing this.

6. Conclusion and way forward

There is much for the trust to be proud of in this report and it has undoubtedly made great strides in recent years, but of course there are also opportunities to improve further. We advise that the trust should consider the recommendations and develop an action plan to implement those it accepts. We believe that the trust will then continue to see improvements and be well placed for their next CQC Well-led review.

We have also included a number of opportunities that the trust may wish to consider moving forward to increase its role in systems leadership and to further strengthen the board itself. These will need to be considered carefully and implementation plans drafted for those it decides to pursue.

Appendix 1 - Recommendations

R1.	The trust should consider how it can use trust communications and engagement events to raise the profile of non-executive directors inside the organisation, and awareness of the important work they do.
R2.	Communication of the new trust values to the entire workforce – and to patients and partners – should be a corporate priority in the coming months.
R3.	The trust should consider how it can raise the profile of the freedom to speak up service among its workforce.
R4.	Work on organisational development and culture should take account of the fact that staff who are new or who have transferred from other organisations may be accustomed to different cultures and ways of working.
R5.	The trust should review the induction process for new directors, both executive and non-executive.
R6.	The agenda of the quality committee should be reviewed with the intention of condensing the agenda pack, and reporting for assurance, i.e. by highlighting positive and negative exceptions and planned actions, and summarising themes and trends, as opposed to detailed operational reporting.
R7.	When corporate policies are next due for review, the policy owners should ensure that they make clearer how they will be monitored for compliance, and what training different groups of staff require.
R8.	The trust should consider reviewing the structure of operational management committees which feed into board assurance committees, as it has already done for the groups which report to the quality committee. This will ensure that every group is serving its intended purpose and may allow some meetings to be eliminated or streamlined. GGI can recommend a way to do this.
R9.	The trust should ensure that when it reviews its policy for managing conflicts of interest in July 2022, it identifies the team or individual with responsibility for providing advice training and support for staff on how interests should be managed.The policy should also say how the trust will audit compliance with its own policy and associated processes and procedures on an annual basis and subsequently in line with the review cycle of the policy.
R10.	We recommend that the trust publishes a conflicts of interest register that reflects the current membership and attendance at the board. The conflicts of interest register should be included in meeting packs for all future meetings.
R11.	The risk management strategy should be reviewed and updated, in terms of content, style and format. The intention should be to make the document more succinct and visual and to remove outdated or unnecessary supporting information.
R12.	The board assurance framework should differentiate more clearly between gaps in control or assurance, and the actions required to close those gaps.
R13.	The board assurance framework should be used actively as a tool to shape the work of the board and ensure that the right information is going to the right places within the governance structure.
R14.	The trust should consider adopting a more standardised definition of risk, in place of the current division between risks and issues on the risk register. Alternatively, it should ensure that the difference between risks and issues is clearly understood by all.
R15.	In the forthcoming refresh of the IPR, the trust should consider presenting the report in a more visual manner.
R16.	The trust should consider how it can grow, and involve, its foundation membership.
R17.	The trust should develop a new / revised quality strategy and ensure that the resources, methodology and training that are needed to implement it are in place.
R18.	The clinical governance and communications teams should work together to find and implement new ways of spreading learning from patient safety incidents and complaints across the whole organisation.

Appendix 2

List of people interviewed

CCC interviewees

Elkan Abrahamson	Non-executive Director
Sarah Barr	Chief Information Officer
Dr Liz Bishop	Chief Executive
Geoff Broadhead	Non-executive Director and Chair of Performance Committee
Kathy Doran	Chair
Julie Gray	Chief Nurse
Professor Terry Jones	Non-executive Director and Chair of Quality Committee
Dr Sheena Khanduri	Chief Medical Officer
Chris Lube	Associate Director of Clinical Governance
Tom Pharaoh	Director of Strategy
Margaret Saunders	Associate Director of Corporate Governance
Jayne Shaw	Director of Workforce
Joan Spencer	Chief Operating Officer
Mark Tattersall	Non-executive Director and Chair of Audit Committee
James Thompson	Director of Finance
Jane Wilkinson	Lead Governor

External interviewees

Jon Hayes	Managing Director, Cheshire and Merseyside Cancer Alliance
Dr David Levy	Regional Medical Director, NHS England
Jan Ledward	Chief Officer, Liverpool Clinical Commissioning Group
Jane Tompkinson	Chief Executive, Liverpool Heart and Chest Hospital NHS Foundation Trust
Professor Tom Walley	Institute of Population Health, University of Liverpool

Meetings observed

Board of Directors	24th November 2021 and 26th January 2022
Charitable Funds Committee	10th February 2022
Council of Governors	12th January 2022
Performance Committee	19th January 2022
Audit Committee	20th January 2022
Quality Committee	20th January 2022

Appendix 3 - Clatterbridge documents reviewed by GGI

Board and Committee papers

All public and private board papers from January 2021 - January 2022

Audit Committee
- Meeting pack 21st January 2021
- Meeting pack 22nd April 2021
- Meeting pack 23rd June 2021
- Meeting pack 31th July 2021
- Papers October 2021
- Papers January 2022
- Terms of reference 22nd April 2021
- Planned Business 2021-2022
- Extra-ordinary committee May 2021
- Internal audit progress report October 2021

Charitable Funds Committee
- Meeting pack 10th March 2021
- Meeting pack 1st July 2021
- Meeting pack 1st September 2021
- Extra-ordinary meeting pack 1st September 2021
- Meeting pack 19th October 2021
- Terms of reference

Performance Committee
- Meeting pack 20th January 2020
- Meeting pack 24th March 2020
- Meeting pack 25th November 2020
- Meeting pack 19th May 2021
- Meeting pack 21st July 2021
- Meeting pack 22nd September 2021
- Meeting pack 17th November 2021
- Planned business 2021-2022

Quality Committee
- Terms of reference
- Meeting pack January 2021
- Meeting pack February 2021
- Meeting pack March 2021
- Planned business 2021-22

Other documents

Council of Governors
- Papers Jan 2021

Corporate Documents
- 2016 well-led report
- 2018 scheme of delegation
- 2018 standing financial instructions
- 2018 standing orders
- 2018 committee structure diagram
- 2020 risk management strategy
- 2020 equality, diversion and inclusion policy
- 2021 5 years strategic plan
- 2021 constitution
- 2021 board development sessions
- 2021 BAF
- 2021 divisional structure
- 2021 NHSE/I enhancing board oversight
- Open risks and issues
- Constitution

Conflicts of Interest
- Register of Interests
- Managing interests review - name properly.

Policies
- Performance, appraisal and development review
- Stress management policy
- Freedom to speak up policy
- Anti-fraud, bribery and corruption policy
- Data confidentiality
- Quality improvement and audit policy
- Processing charitable donations
- Confidentiality code of practice
- Acceptance and refusal of charitable donations policy
- Managing conflicts of interest
- Document control
- Quality policy
- Preventing bullying and harassment
- Health and safety policy
- Incident reporting policy
- Complaints and concerns policy
- Fit and proper person requirement
- Safeguarding adult policy
- Safeguarding children policy
- Duty of candour and being open policy
- Equality impact analysis

Strategies
- Research strategy
- 5-year plan
- Risk management strategy

All Executive Director CVs


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ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

DRAFT GGI well-led review action plan

Last updated: April 2022
Updated by: Tom Pharaoh

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

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
KLOE 1 – Leadership capacity and capability						
R1	The trust should consider how it can use trust communications and engagement events to raise the profile of non-executive directors inside the organisation, and awareness of the important work they do.	• Develop a post-covid NED profile raising programme	Corporate Governance/ Comms	By end May 22		
		• Restart on-site NED visits	Corporate Governance	By end May 22		
		• Deliver post-covid NED profile raising programme	Corporate Governance/ Comms	June & July 22		
KLOE 2 – Strategy, vision and values						
R2	Communication of the new trust values to the entire workforce – and to patients and partners – should be a corporate priority in the coming months.	• Stock-take of comprehensive ongoing trust values communication and engagement programme	WOD/Comms	By end May 22		
		• Ensure new values are fully incorporated into key trust processes: PADR, recruitment, induction, staff achievement awards, etc.	WOD	By end May 22		
		• Develop plan for further values awareness raising and review of impact	WOD	By end June 22		
KLOE 3 - Cultures						
R3	The trust should consider how it can raise the profile of the freedom to	• Stock-take of current awareness of freedom to speak up, ongoing	Clinical/ Corporate Governance	By end July 22		

ACTION PLAN

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
	speak up service among its workforce.	communications plans, and uptake of service				
		• Develop plan for further FTSU awareness raising and review of impact	Clinical/Corporate Governance	By end June 22		
R4	Work on organisational development and culture should take account of the fact that staff who are new or who have transferred from other organisations may be accustomed to different cultures and ways of working.	• Inform Learning & Organisational Development team of the recommendation and the relevant context in the GGI report	Jayne Shaw, Tom Pharaoh	By end June 22		
R5	The trust should review the induction process for new directors, both executive and non-executive.	• Develop and agree outline induction processes for new Executive and Non-Executive Directors (to inform detail induction packages to be developed as new Directors are appointed)	Execs/WOD	By end July 22		• Lower priority – no new directors expected imminently
KLOE 4 – Roles, responsibilities and accountability						
R6	The agenda of the quality committee should be reviewed with the intention of condensing the agenda pack, and reporting for assurance, i.e. by highlighting positive and negative exceptions and planned actions, and summarising themes and trends, as opposed to detailed operational reporting.	• Review Quality Committee agenda as part of wider review of governance and Board sub-committees	Julie Gray	By end Apr 22		• Complete

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
R7	When corporate policies are next due for review, the policy owners should ensure that they make clearer how they will be monitored for compliance, and what training different groups of staff require.	• Develop a checklist for future review of corporate policies – to include training and monitoring of compliance	Clinical/Corporate Governance	By end July 22		
R8	The trust should consider reviewing the structure of operational management committees which feed into board assurance committees, as it has already done for the groups which report to the quality committee. This will ensure that every group is serving its intended purpose and may allow some meetings to be eliminated or streamlined. GGI can recommend a way to do this.	• Review operational management committees	Joan Spencer	By end May 22		
R9	The trust should ensure that when it reviews its policy for managing conflicts of interest in July 2022, it identifies the team or individual with responsibility for providing advice training and support for staff on how interests should be managed. The policy should also say how the trust will audit compliance with its own policy and associated processes and procedures on an annual basis and subsequently in line with the review cycle of the policy.	• Review conflict of interests policy, taking into account the GGI feedback	Corporate Governance	By end July 22		

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
R10	We recommend that the trust publishes a conflicts of interest register that reflects the current membership and attendance at the board. The conflicts of interest register should be included in meeting packs for all future meetings.	• Update and republish conflicts of interest register	Corporate Governance	By end June 22		
		• Include conflicts of interest register at all future Trust Board meetings (and Board Committee meetings?)	Corporate Governance	By end June 22		
KLOE 5 – Managing risks and performance						
R11	The risk management strategy should be reviewed and updated, in terms of content, style and format. The intention should be to make the document more succinct and visual and to remove outdated or unnecessary supporting information.	• Review risk management strategy, taking into account the GGI feedback	Associate Director of Clinical Governance and Patient Safety	By end May 22		• Draft presented to April Risk and Quality Governance meeting
R12	The board assurance framework should differentiate more clearly between gaps in control or assurance, and the actions required to close those gaps.	• Review BAF in full as part of ongoing review of Board risks for 2022/23	Corporate Governance (supported by Gilly Conway)	By end July 22		• Review of BAF for 2022/23 ongoing
R13	The board assurance framework should be used actively as a tool to shape the work of the board and ensure that the right information is going to the right places within the governance structure.	• Develop plans for improvement of the use of the BAF in the Trust's governance structures	Execs	By end July 22		

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
R14	The trust should consider adopting a more standardised definition of risk, in place of the current division between risks and issues on the risk register. Alternatively, it should ensure that the difference between risks and issues is clearly understood by all.	• Adopt a standardised definition of risk	Julie Gray	By end April 22		• Taking place as part of review of risk management strategy
KLOE 6 – Data and information						
R15	In the forthcoming refresh of the IPR, the trust should consider presenting the report in a more visual manner.	• Take into account GGI feedback as part of ongoing IPR review	Hannah Gray	By end May 22		• Ongoing
KLOE 7 – Stakeholder engagement						
R16	The trust should consider how it can grow, and involve, its foundation membership	• Stock-take of membership position	Corporate Governance	By end May 22		• Membership strategy in development
		• Develop plans to grow and involve membership	Corporate Governance	By end May 22		• Membership strategy in development
KLOE 8 – Learning, improvement and innovation						
R17	The trust should develop a new / revised quality strategy and ensure that the resources, methodology and training that are needed to implement it are in place.	• Develop a new quality strategy	Julie Gray, Tom Pharaoh	By end June 22		

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
R18	The clinical governance and communications teams should work together to find and implement new ways of spreading learning from patient safety incidents and complaints across the whole organisation.	• Stock-take of current methods for spread of learning from incidents and complaints	Clinical Governance	By end May 22		
		• Develop plans to improve the spread of learning from incidents and complaints (as part of new quality strategy)	Clinical Governance, Comms	By end June 22		