AGENDA

Trust Board of Directors Meeting: held in Public

Date: Wednesday 25 May 2022	Location: Floor 12, The Spine
Start Time: 09:30	Finish Time: 12:30

Timings	Item No		Lead	Paper/Verbal
Opening Matters				
09:30	P1-86-22	Welcome & Apologies: Asutosh Yagnik, Non-Executive Director	KD	Verbal
	P1-87-22	Declarations of Committee Members' and other attendees' interests concerning agenda items:	KD	Verbal
	P1-88-22	Minutes of last meeting: 27 April 2022	KD	Paper
	P1-89-22	Matters Arising/Action Log	KD	Paper
09:40	P1-90-22	Chair's Report to the Board	KD	Verbal
Risk and Assurance				
09:50	P1-91-22	Extra-Ordinary Audit Committee Chair's Report	MT	Paper
10:05	P1-92-22	Charitable Funds Committee Chair's Report	EA	Paper
10:20	P1-93-22	Patient Story	JG	Paper
10:35	P1-94-22	Patient Experience Visits	JG	Paper
10:50	P1-95-22	Patient Experience Visits Process Review	JG	Paper
11:05	P1-96-22	Integrated Performance Report: Month 1	JSp/JSh	Paper
11:20	P1-97-22	Finance Report: Month 1	JT	Paper
11:30	P1-98-22	New Consultant Appointments	SK	Paper
11:35	P1-99-22	2022/23 Board Assurance Framework Update	GC	Paper
System Working				

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

AGENDA

11:40	**P1-100-22**	Cheshire & Merseyside Cancer Alliance Performance Report	**LB**	**Paper**
Closing Matters				
11:50	**P1-101-22**	Any Other Business	**ALL**	**Verbal**

Next Meeting:

Date: Wednesday 29 June 2022	Location: Floor 12, The Spine
Start Time 09.30	Finish Time: 12.30

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

Minutes of the Trust Board of Directors held in public

Held on: Wednesday 27 April 2022	Location: Floor 12, The Spine
Start time: 09:30	Finish time: 12:30

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
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:
Skye Thomson	Corporate Governance Administrator (minutes)
Katrina Bury (Item P1-83-22)	Head of Charity
Jane Wilkinson	Lead Governor
Laura Jane Brown	Staff Governor
Alun Evans	Staff Side Representative
Paula Pickford	Head of Business Intelligence
Jeni Bradshaw	Digital Programme Manager
Aaron Key	Business Intelligence Apprentice
Emer Scott	Associate Director of Communications

Item no.	Agenda item	Action
P1-72-22	**Welcome & Apologies: Elkan Abrahamson** The Chair welcomed the meeting and noted that this was the first hybrid (in person and online via Microsoft Teams) meeting of the Board. Apologies were noted from Non-Executive Director, Elkan Abrahamson (for the whole meeting) and Medical Director Sheena Khanduri, who left the meeting early after completing her items. The Chief Nurse updated those attending the meeting in person on the latest infection prevention and control measures regarding mask wearing.	

P1-73-22	**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	
P1-74-22	**Minutes of last meeting: 30 March 2022** The minutes of the Board meeting held on 23 February 2022 were approved subject to the following amendments: • Emer Scott to be added as 'In attendance' • Item P1-69-22, sixth bullet point, change 'explore a way to incorporate into risks, a revised score in the event of a risk having crystallised' to 'explore a way to highlight or distinguish if a risk had crystalised.'	
P1-75-22	**Matters Arising/Action Log** The Board noted that actions were either complete, on the Agenda or not yet due. With the following actions being confirmed as complete • P1-78-22: Complete, going through the system • P1-10-22 Complete, note to keep video format under review • P1-15-22 Complete • P1-061-22 Complete	
P1-76-22	**Chair's Report to the Board** The Chair updated the Board on the Integrated Care System (ICS) highlighting that Raj Jain had formally started as Chair of the ICS. Raj has previously been the Chief Executive for Liverpool Heart and Chest FT and the Northern Care Alliance and therefore has lots of relevant experience. The Chairs of the Trusts in the ICS had had one meeting with him and all are supportive of increased collaboration and establishing relationships. The work on collaboration is continuing, with talks continuing on one Liverpool. The Cheshire and Merseyside Acute and Specialist Trusts Group had a presentation on diagnostics by Clatterbridge's Chief Executive, Liz Bishop, along with presentations on elective recovery and clinical services from the relevant SROs. There are several ongoing programmes including, financial management, workforce and ICT. Each programme is to inform boards what they need to be doing. The North West Chairs and Chief Executives met the day before the Trust Board meeting, and discussed infection prevention control and finance. This is a large meeting which lends itself more to presentation than discussion.	
Risk and Assurance		
P1-77-22	**Audit Committee Chair's Report**	

Version: 1.0 Ref: FCGOMINS Review: May 2024

	Non-Executive Director and Chair of Audit Committee, Mark Tattersall introduced the Chair's reports, highlighting that the Audit Committee had two meetings in April, an extra-ordinary meeting on 1st April and the standard committee meeting on 14th April. **1st April:** The Extra-Ordinary Audit Committee meeting was scheduled to look at the accounting estimates, however it went wider than that and the committee took the opportunity to look at other issues including Improving cyber resilience. A letter to all audit committee Chairs from NHS England and NHS transformation highlighted immediate and urgent priorities around cyber security. The Trust needed to review any unsupported systems and Chairs were asked to review progress for immediate priorities. The Chief Information Officer brought a report to the audit committee and followed up on challenges after the meeting. The report was comprehensive and provided assurance to the Committee. The Audit Committee had reviewed the accounting estimates looking at the methodologies used. Four areas had been flagged up as needing further work, which were approved by the Committee. The Chair of Audit Committee highlighted the delayed income due to ERF (Elective Recovery Funding) which needed justification from auditors. Similar deferred income was received last year. The Director of Finance is working with the auditors on this. **14th April:** The Chair of Audit Committee highlighted the materiality figures in the report, noting the external auditors had informed the committee they needed to be lower on materiality as this is their first year as the external auditors with the Trust. Performance materiality has been introduced, which is new to the Trust, previously materiality would apply across the Trust not within specific directorates. The Board discussed how this could be applied and the Chair of Audit Committee confirmed they would update the Board when they knew more. The Internal Audit progress report was also highlighted, with seven reports finalised. At the meeting on 14th April the Director of Finance provided an update on medical devices (which had moderate assurance) and the Chief Nurse gave an update on Incident Management (which had limited assurance). These will now go to Quality Committee and the issues will be responded to in a timely manner. The Chair of Audit Committee highlighted that the committee received a declarations of interest register which required a few edits before publication. There is further work to be done on declarations of interest but progress is being made. **The Trust Board:** **Noted** the report	
P1-78-22	**Staff Story** The Head of Business Intelligence (BI) presented slides on the apprenticeship schemes within digital workforce. The Head of BI spoke passionately about the apprenticeship schemes and noted they are a great way to attract and retain staff. 2022 is the year of the Digital Profession and due to Covid a light has been shone on the digital team. The team has support for the apprenticeship schemes and 'graduates into health' internally through Steph Thomas the Head of learning and development. The schemes are a great opportunity to motivate and develop staff.	

	The Head of BI informed the board of the Level 3 to 7 digital Apprenticeship Standards and provided detail on each level's qualification and description. The Board heard form Aaron Key, Business Intelligence Apprentice, who was apprentice of the year in informatics and now uses his skills to enhance the Trust's performance reports. As well as Jeni Bradshaw, Digital Programme Manager, who is in the second year of her project management degree. Both members of staff spoke passionately about the work and opportunities their schemes had provided them with. The Director of Workforce confirmed that the apprenticeship schemes were paid for by a national levy and that there are over 50 apprenticeships across the Trust. **The Trust Board:** **Thanked** the staff for sharing their story	
P1-79-22	**Patient Experience Visits** The Chief Nurse introduced the report and noted that the process for the patient experience visits needed review. Previously, the head of patient experience managed the visits and the subsequent actions, however this role is currently vacant and not yet recruited to. The Deputy Director of Nursing will do a review of the process and a paper including the plan for the visits (when they will take place, if they will be face to face, how they will be conducted, scheduling), capturing actions and an overview of the process. This will be brought back to Board in May 2022. The report detailed the visit that took place on 17th March at the CANtreat chemotherapy clinic in Halton. The Chief nurse highlighted the positive patient perspective of the service and commented on the staff perspective which highlighted issues with morale and staffing. The Chief Nurse reassured the Board that conversations were happening regarding the issues raised. Both the Chief Operating Officer and the Chief Nurse have spoken to the staff members that were part of the visit about their concerns. Non-Executive Director, Geoff Broadhead, completed the April patient experience visit (the report for which will come to the Trust Board meeting in May). Geoff highlighted that on the visits, issues are often raised that he feels there are responses to, but he is not best placed to do so as a non-executive director who may not know the finer operational details. The Board discussed ways the visits could potentially be improved: • Inviting an Executive to the visit. This was discussed and the board decided against this as it may stifle conversation and stop the staff and patient voice truly shining through. • Inviting the ward manager or matron on the visit to provide responses to issues raised so that staff get a quick update on issues. • Getting a good process in place for picking up actions and feeding these back to the staff that raise them • Asking staff for three things they are proud of in the Trust and three things that are difficult to manage or could be improved • Keeping the staff feedback and the patient feedback separate • Non-Executive Directors having a particular area of the Trust they visit, to implement some continuity The Lead Governor highlighted the concerns around training and education from the report. The Director of Workforce informed her that there have been listening events happening on the back of the staff survey as well as informal walkabouts. There has been further	

	information regarding some of the issues raised in the report sent to staff. The Director of Workforce acknowledged that there is a piece of work to be done on staff responsibility and accountability. Non-Executive Director, Asutosh Yagnik, highlighted the issue on page 23 of the report regarding capacity and pharmacy. The Chief Operating Officer reassured that they are aware of the issues with pharmacy and have seen a big improvement from March to April with regards to missing drugs and the issues are now few and far between. The Chief Executive highlighted that staff were speaking up and noted that she is to visit Halton in May. Unfortunately, when visiting each site the Board are only able to see a small area. The Chief Executive noted that the support from the communications team meant that the Board were able to communicate digitally to staff through the intranet. Non-Executive Director, Mark Tattersall questioned the section of the report regarding the Aintree merger causing issues around service. The Chief Operating Officer was unsure about the impact this had on Halton and noted the transfer of activity from Aintree is planned and programmed and shouldn't be an issue. The Chief Operating Officer confirmed that the unit does have medical cover and this point in the report was a communication issue. **The Trust Board:** **Noted** the report **To receive** Patient Experience Visits Process Review at May 2022 meeting	JG
P1-80-22	**Integrated Performance Report: Month 12** The Chief Operating Officer introduced the report and noted that the next month's report would be the new version with the new KPI's (Key Performance Indicators). The Chief Operating Officer updated the Board on the access exception reports emphasising the actions taken to improve compliance. It was noted that proactive planning was taking place to manage the multiple bank holidays at this time of year. Further clarification was sought on radiotherapy being in a state of business continuity. The Chief Operating Officer confirmed this had been the case for 8 weeks and they were coming out of it now. However they are having difficulty accessing replacement parts which take a long time to come and on occasion the incorrect part has arrived. The Chair noted the 104 day target, and asked if there could be a failsafe in place. The Chief Operating Officer noted the Trust does a root cause analysis harm review on all 104 day breaches and the majority of the patients that breach have come to the Trust very late and the target is missed by 1 or 2 days. The team are looking at what can be done to manage pathways going forward. The Chief Operating Officer provided an update on efficiency and noted a report on Bed Utilisation - Future Plans and Potential Opportunities went to the Performance Committee in March. The Chief Nurse introduced the Quality section of the report and provided the Board with an overview of the Quality exception reports.	

	The Medical Director provided an update on the Research and Innovation exception reports noting that for 8 studies the Trust was awaiting Sponsor Greenlight. Non-Executive Director Mark Tattersall asked if anything could be done about this. The Medical Director confirmed the Trust is working closely with the Sponsors, however there are currently national and commercial pressures, in light of which the team are refreshing and revising plans. The Director of Workforce & OD provided an update on Workforce highlighting staff sickness absence, Mandatory Training and compliance with PADR (Performance Appraisal and Development Review). Non-Executive Director, Mark Tattersall, asked about the impact the Information Governance training compliance would have on the Data Security & Protection Toolkit. The Director of Finance reassured the Board the Information Governance manager is working with teams to find the best way to increase compliance. The Board highlighted the low compliance for mandatory training for the Networked Leadership Division. The Director of Workforce & OD, reassured that this had been picked up with the division. Non-Executive Director, Geoff Broadhead, noted that within staff turnover the information regarding the exit interview data was worrying. This showed it was evident that the leaving reasons of a few staff included more than just work-life balance, such as lack of management, He questioned if the staff were from one area. The Director of Workforce & OD noted that there were no particular themes identified from the staff exit interviews, where previously the workforce team have been able to identify issues, look at areas they can have 'itchy feet conversations' (staff that may be thinking of leaving) and provide additional support. The Director of Workforce & OD also noted that line management support scored highly on the staff survey and the staff turnover report is capturing a small number of staff. **The Trust Board:** **Noted** the report	
P1-81-22	**Finance Report: Month 12** The Director of Finance gave a brief overview of the Finance Report for month 12, Noting that the final numbers were still subject to audit. The Director of Finance highlighted that the integrated care system has work to get everyone to final position, therefore the Trust has returned some of its system funding back to the ICS. The Chair asked if this return was acknowledged. The Director of Finance confirmed that the ICS acknowledge it and it is shared amongst the Director of Finance community. The Trust has been able to return system funding due to its over performing and elective recovery funding. **The Trust Board:** **Noted** the report	
P1-82-22	**New Consultant Appointments** *-No new appointments*	
P1-83-22	**Extra-Ordinary Charitable Funds Chair's Report and Establishing independent charity status- Legal and Governance recommendations**	

	The Head of Charity introduced the report on Establishing independent charity status- Legal and Governance recommendations. She highlighted the next steps, to formulate articles of association and start the process of becoming independent. A representative from Hempsons Solicitors, specialising in charity law and governance, presented an overview of the pertinent legal and governance issues at the April Extra-Ordinary Charitable Funds Committee meeting and guided the corresponding decisions required to initiate the process of becoming an independent charity. Non-Executive Director, Mark Tattersall asked why it was decided being a separate legal entity was the best way. The Head of Charity informed the Board that this was best as it allows the Charity to grow and gives more flexibility with banking, so if for example they wanted to borrow money for property in the future they would be able to do so. Whereas, a CIO (Charitable Incorporated Organisation) is bound by the charity commission template. The Lead Governor asked if current staff working for the Charity would keep their pension benefits. The Head of Charity confirmed there would be no change to the current staff pensions and new staff would have different pensions. Non-Executive Director, Asutosh Yagnik enquired about voting rights for the Trust as a member. The Head of Charity confirmed that the Trust wouldn't have voting rights but decisions made by Trustees would need to be approved by the Trust. It was asked how the Trust did this without the right to vote, the Head of Charity acknowledged this was beyond their scope and she would follow this up post meeting. **POST MEETING NOTE**: After further clarification from Hempsons it was confirmed that the Trust would have class rights meaning the Trust would not have voting rights but its approval would be required if the new charity trustees ever decided to change the objects, name, dissolution or change articles. The reason a class right for the Trust is created, is to ensure that certain provisions in the Articles can't be changed without the Trust's consent. Hempsons noted, the Trust doesn't need voting rights, it is just written consent that will be required. The Chief Executive noted the absence of Non-Executive Director, Elkan Abrahamson, Chair of the Charitable Funds Committee and reassured the Board that he had ben thorough in his review of the recommendations. **The Trust Board:** **Approved** the recommendations made by the Charitable Funds to allow the first draft Memorandum and Articles of Association to be prepared, providing the clarification on the Trust's rights was given (See post meeting note) **Noted** the report	
P1-84-22	**Board & Committee Schedule** The Chief Nurse introduced the report on the new Board and Committee Schedule which had been agreed at the last meeting. The Risk and Quality Governance Committee had its first meeting in April which went well. The Chief Nurse noted the team had tried to disrupt calendars as little as possible by keeping meetings the same date when appropriate. The Chief Nurse thanked the PA to the Chief Nurse and the Director of Workforce & OD and the Corporate Governance Administrator for their work on the new schedule. .The Board highlighted a clash between Performance Committee and PropCare Board in November, This and any further clashes or problems with the schedule will be picked up by the Corporate Governance Administrator.	

	Members of the Board enquired if the committee meetings would be returning to face to face meetings. The Chief Nurse noted that the IPC (Infection Prevention and Control) guidelines must be followed and if some meetings are to go face to face, there needs to be good ventilation and where possible a hybrid approach. The Chair confirmed that the individual Chairs of the committees will have the authority to make decisions on the location of their meetings and to keep in mind their attendees, particularly clinicians and the room options available. Chairs could consider doing one meeting face to face a year and the rest online. The Chief Executive confirmed that the Spine room had been booked for the Board meetings and the upcoming Board away day. The Chair noted that further decisions were still to be made on the council of Governors meeting with the possibility of offering a hybrid meeting, IPC guidance allowing. **The Trust Board:** **Noted** the scheduled **Thanked** staff for their work	
System Working		
P1-85-22	**Cheshire & Merseyside Cancer Alliance Performance Report** The Chief Executive Introduced the report for April and noted it was similar to the March report with activity remaining high. The Chief Executive highlighted that there were 41% more patients in diagnostics than this time last year and that's where a lot of additional investment is going as a system. The Chief Executive highlighted the 62 day and 104 day cancer waiting time performance standards, noting the alliance can see which providers are challenged and where to do specific targeted work. There has been confirmed funding for the alliance and plans for that going forward. The Chief Executive noted that the bank holidays have impacted performance as there are challenges finding cover around this time. The Integrated Care Board is also starting to see data on each provider and can see the variations between them and put check and challenge in place for those not achieving performance targets. The patients that come to the Trust come from a variety of directions, the alliance is trying to get more traction on the front of the programme. The alliance is looking at doing work with GPs in primary care, to look at what diagnostics are provided in community. There is lots happening in primary care that's not looked at or mapped and GPs are pleased to be speaking about diagnostics for the first time. The Chief Executive noted this would be a good topic to take to the strategy away day. **The Trust Board:** **Noted** the report	
Strategy		
P1-86-22	**Board Development Feedback**	

	The Medical Director presented the formally noted the actions from the Clinical Horizon Scanning Board Development Session in March and noted any specific papers would come through the formal committee structure. **The Board:** **Thanked** colleagues for a good Board Development Session **Noted** the actions	
P1-87-22	**GGI Board Report & Action Plan** The Director of Strategy introduced the Good Governance Institute Well- Lead Review Report and the Trust's action plan. 18 substantive recommendations had been pulled out of the Well-Led review and put into a Trust action plan. The overall report was positive, with many issues known to the Trust already and work already occurring. The Action Plan will be used to monitor and manage the recommendations. Non-Executive Director, Mark Tattersall queried the deadline on Recommendation 18 of the end of June for the new quality strategy. The Director of Strategy confirmed that there was a current clinical quality strategy coming up for review and a paper on plans for the updated strategy would be pulled together by the end of June. **The Trust Board:** **Asked** for quarterly updates on the Well-Led review action plan **Noted** the report	
Closing Matters		
P1-88-22	**Any other business** The Lead Governor asked if there was anything further the Governors could do to support the Board. The Chair confirmed Governors are useful to Board in number of ways in their statuary and additional roles, appointment of non-executives, selection of auditors, work with patient experience inclusion and involvement (where the Governors have been patient champions) and work with membership. The Chair thanked the Governors for their work. The Chief Executive offered to have a further conversation with the Lead Governor regarding Governor involvement.	

Next meeting:

Date: Wednesday 25 May 2022	Location: Floor 12, 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**
P1-069-22	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	April 2022, structure went again to Board and was approved
P1-069-22	30-Mar-22	Board Committee Governance Structure 2022-2023	Formal Review of Board Committee Governance Structure	**JG**	Sep-22	
P1-79-22	27-Apr-22	Patient Experience Visits	The Chief Nurse to bring paper on Patient Experience visits - Process review	**JG**	May-22	Item P1-95-22

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 Audit Committee	Reporting to: Trust Board
Date of meeting: 11 May 2022	Parent Committee:
Chair: Mark Tattersall	Quorate: Yes

Agenda item	RAG	Key points	Actions required	Action lead	Expected date of completion
AUD-063-22 Review of External Audit Progress 2021-22		External Audit gave a verbal progress report. They were continuing to liaise with the Finance team and sign off is due 16 June 2022.	EY requested additional evidence for Value for Money to corroborate the Self-Assessment. EY will liaise with the Finance Team to clarify and confirm their outstanding requirements in relation to sampling A post-Audit review was requested.	Deputy Director of Finance Ernst & Young Ernst & Young	16 June 2022 May 2022 June 2022
AUD-064-22 Going Concern Management Assessment		The Committee received and considered the Going Concern Management Assessment.	The assessment was supported by the Audit Committee subject to further narrative being discussed and agreed with EY for inclusion in the relevant note in the Annual Accounts	Deputy Director of Finance	June 2022
AUD-065-22 Draft Annual Report & Accounts submission 2021-22		The Committee reviewed the Draft Annual Report and Accounts 2021-22 The Committee noted good progress had been made on the Annual Report and Accounts this year and thanked the team for their work.	The Committee requested some matters be considered for amendment and further analysis	Deputy Director of Finance	June 2022

Committee/Group 'Triple A'

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

Name of Committee/Group: Charitable Funds Committee	Reporting to: Trust Board
Date of meeting: 22nd 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-031-22 – Fundraising & Finance Report		The Charity were reporting a final year figure of £3.266m against a target of £3.035m representing 108% of target and an increase on the previous year of £1.035m. Expenditure to 31 March 2022 was £898,688 representing an efficiency of 72% and a cost to income ratio of 28%. After extracting costs and expenditure net income for 2021-22 was £1.22m. The Committee discussed and agreed the income and expenditure budget for 2022-23.		Head of Charity	
CHA-033-22 – Charitable Funding Requests Research & Innovation		The Committee approved charitable funding of £150k to support Research and £150k to support Innovation.		Head of Charity	

Version: 2.0 Ref: FTWOCHAIR Review: May 2024

REPORT COVER

Report to:	Trust Board
Date of meeting:	25 May 2022
Agenda item:	P1-93-22
Title:	Patient Story – Acute & Networked/Radiation Services
Report prepared by:	Julie Gray – Chief Nurse
Executive Lead:	Julie Gray – Chief Nurse
Status of the report: (please tick)	Public ☒ Private ☐

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

Purpose of the paper/key points for discussion:	The Patient story provides the Board with insight into an individual patient's experience. It is told from their own perspective, giving the Trust an opportunity to understand their experience of the care they have received, and what could be done to improve their experience, as detailed within the report under Actions Already Taken and Action Plan.

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

Next steps required:	As detailed within the Action Plan

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

☐ BE **INNOVATIVE**

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

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

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

Version 1.0 Ref: FCGOREPCOV Review: May 2024

Patient/Staff Story – Action Report

Julie Gray – Chief Nurse

Version: 1.0 Ref: FCGOREPO Review: May 2024

Patient/Staff Story Action Report

Story ID	Hannah	Committee	Board of Directors		
Date Presented	25/05/22	Patient Story	☒	Staff Story	☐
		In person	☐	Digital	☒
Date Consent Obtained	16/03/22	Consented by	Head of Patient Experience & Inclusion	Consent for:	Internal ☒ External ☒ Online ☒
Division/s involved	Acute & Networked Services –Haemato-oncology (Wards 1, 4 & 5)		External Organisation involved	LUHFT (Royal Liverpool)	
Formal Complaint	☐	Complaint closed	☐	Complaint Upheld	☐

1. Action Already Taken

No	Issue	Action taken	Action Lead
1	Awareness of issues experienced by the patient	Patient story shared with divisional teams at Patient Experience Inclusion Operational Group (PEIOG) & Patient Experience Inclusion Group (PEIG)	Deputy Director of Nursing / Chair of PEIG
2			
3			

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

No	Issue	Action required	Action Lead	Deadline Date	Expected Evidence of Completion
1	Inpatient meals - availability of healthy fruit and vegetable	1.Review of menu options and patient feedback from ISS	Tazeen Khatib, Kathryn Parr	July 2022	Review paper

	options & quality of the prepared meals	meal audits for wards 4 & 5 2.PLACE assessment results and review areas for improvement	& Danielle Roderick		
2	Phlebotomy waiting times on Level 1 Day ward	1.Review current pathways and identify areas for improvement	Liz Morgan	July 2022	Review Paper
3	Level 1 Day ward trolley stock management	1.Review current stock processes and identify areas for improvement	Liz Morgan	July 2022	Review Paper
4	Staff training on customer care and communication skills	1.Identify available education and training for inpatient & day ward	Clinical Education Lead Steph Wilson	June 2022	Training prospectus

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

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

REPORT COVER

Report to:	Trust Board
Date of meeting:	May 2022
Agenda item:	P1-94-22
Title:	Patient Experience Visit – April 2022
Report prepared by:	Geoff Broadhead, Non-Executive Director (NED)
In attendance at visit:	John Roberts, Public 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 14th April 2022 at the Radiotherapy and Diagnostic Imaging departments at Clatterbridge Cancer Centre – Wirral (CCCW).

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 CCCW • Note staff experience feedback • Note feedback shared with areas during visit • Note staff survey action plans are in development • Note action report progress and assurance monitored via Divisional Quality & Safety meeting and Patient Experience and Inclusion Committee • Request further updates as required

Version 1.0 Ref: FCGOREPCOV Review: May 2024

REPORT COVER

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

☐ 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.

Version 1.0 Ref: FCGOREPCOV Review: May 2024

Patient Experience Visits 14/04/2022

Geoff Broadhead, Non-executive Director
John Roberts, Public Governor
Claire Smith, Quality Improvement Manager

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

1. Summary

The Patient Experience 'round' was conducted on the 14th April 2022, visiting the Radiotherapy and Diagnostic Imaging department at Clatterbridge Cancer Centre – Wirral (CCCW). Due to Covid-19 restrictions across all CCC sites, Geoff Broadhead, Non-Executive Director and John Roberts, Public 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 – 4 patients were asked to share their experiences of being treated at CCCW.

- The first patient was at the centre with his daughter. He lives locally and was having his 13th of 20 scheduled treatments. He scored CCC 10/10 and described the staff to be very friendly, reassuring and efficient. He added that his appointments were hardly ever delayed. He knew CCCW because his wife had been treated here in the past, recalling that she had been treated well but she had sadly passed away. There was nothing he felt CCC could do to improve patient experience.

- The second patient was from Chester and was here to receive his third of ten treatments. So far his experience of CCC had been positive, and described staff as being very helpful and friendly. He mentioned that there had been some delay on the previous day but he was aware this was due to a problem with one of the machines, he didn't feel there was anything CCC could do to improve.

- The third patient had been waiting for three quarters of an hour in the diagnostic waiting area. She reported that she has been here several times and staff are always marvellous. She explained that she had travelled from Ellesmere Port for a scan, however she is receiving her monthly treatment (immunotherapy) at home which she described as impressive, and she had no complaints regarding the treatment she is receiving.

- The fourth patient attended with his wife and lived locally on the Wirral. They both agreed that he had received first class treatment at CCC and has been receiving treatment for 3 years. He explained that he has stage 4 cancer so it is not curative but that his cancer is currently under control. He had initially been given chemotherapy, followed by radiotherapy and was now on a new drug with his disease being monitored regularly. Both he and his wife stated that staff are very informative, supportive, empathetic, respectful and staff use language they can understand. When asked what CCC could do better he responded 'nothing'.

Any issues with appointments are always rectified and they appreciate the letter they receive after each visit to confirm what they had discussed. He described that he has his own specialist nurse he can contact if he has any problems and they always get back to him. Occasionally they reported that the car park can get very busy, in the early days of his treatment their car had been damaged but they voiced this was not the hospitals fault. They added that the facilities at Wirral are very good, the hospital is spotlessly clean when they visit and offered that "we won't get many complaints".

Staff experiences and comments

- Five staff members were able to share their experiences of working at CCCW (x1 therapy radiographer, x1 radiotherapy support worker x2 diagnostic radiographers and x1 admin staff). All staff talked about how patients always take priority and they were proud of their dedication to CCCW and the patients. Staff involved had been working at CCC for between one year and 30 years.

Staff support

- There were mixed reports about line management support with some feeling they had been listened to, and others less so. They described that they had good teamwork and could rely on their colleagues for support. They were aware of the wellbeing resources provided by the Trust but felt that training and education could be improved. A new member of staff felt unsure who to escalate issues to if their line manager was off.

- Change
  The staff who had worked for a longer period of time at CCCW described the impact of the changes to the site as a consequence of the opening of CCCL. They voiced concerns about emergency cover and an incident where a patient had waited a long period of time for an ambulance transfer. One member of staff reported that she missed the variety of work before CCCL was opened, but was pleased to be able to continue to work on the CCCW site as it was closer to home. Another expressed concern about the acute site feel of CCCL and concern for patients with mobility issues in relation to car parking. One member of staff felt that the Trust had neglected to maintain and develop relationships with unions and senior leaders and that clinical union representatives were finding it difficult to get to meetings to discuss issues.

- Work pressures
  Staff reported they were being required to work longer and at short notice as a consequence of being short staffed. There were issues with being able to book annual leave and they voiced concerns about the sustainability of the ongoing work pressures and staffing issues. One member of staff said the staffing levels had not been reviewed and that incentives and a longer term plan needed to be developed.

  One member of staff reported that systems and processes in the NHS felt overly complicated compared to their non NHS experience.

Staff ended the visit on a positive note and felt that the problems could be fixed and that working for CCC was not all bad.

3. Next Steps and Recommendations

- Discuss report findings at Trust Board
- Note content of report
- Feedback shared with areas during the visit including any factual innaccuracies
- Note staff survey action plans are in development
- Request further updates as required.

Patient/Staff Experience Walkabout – Action Report April 2022

Julie Massey – Divisional Director Radiation Services

Version: 1.0 Ref: FCGOREPO Review: May 2024

Patient/Staff Experience Walkabout Action Report

Walkabout	Radiation Services	Committee	Board of Directors		
Date Presented	May 2022	Patient Experience	☒	Staff Experience	☒
		In person	☐	Digital	☒
Division/s involved	Radiation Services		Non-Exec Director and Governor attended	Non-Executive Director – Geoff Broadhead Governor – John Roberts	

1. Action Already Taken

No	Issue	Action taken	Action Lead
1	Accurate log of shared experience by patients /staff	Draft report sent to Non-Executive and Governor for review.	Quality Improvement Manager
2	Coordinator / team awareness of issues experienced by patients/staff	Immediate feedback provided to team leader/team members	Quality Improvement Manager

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

No	Issue	Action required	Action Lead	Comments	Deadline Date
1	Actions required post patient interviews.	1. Review of patient experience element of report.	Divisional lead	Patients gave positive feedback regarding the services and the care they had received at CCC. No follow up actions identified.	Complete.
2	Emergency cover for Wirral.	1. Review of current pathway for escalation of emergency situations.	Divisional lead.	Medical cover has been increased until 18:30.	Complete.
				Additional ANP post approved and currently out to advert.	30/06/22

3	Internal Departmental escalation plans when line managers are off.	1. Review; current escalation plans and ensure robust communication to all staff.	Divisional lead	Review in progress. Communication via 8 listening events scheduled throughout May 2022 across all 3 sites. Managers will attend events from the 3 business units.	30/06/22
4.	Staff training	1.Review; available education & training and identify areas for improvement	Divisional lead Clinical Education Lead Psychological Medicine team	Review in progress. Expected feedback /discussion provided from planned listening events.	30/06/22
5.	Trust and union relations.	1. Review current situation, identify area/process where relationships could be strengthened.	Divisional Director HR lead Union representatives.	Review in progress. Expected feedback via planned listening events. Monthly meetings between staff side Chair and Vice Chair and the Director and Deputy Director of WOD Quarterly meetings between staff side Chair and Vice Chair and CEO Bi-monthly Strategic Partnership Forums in place Quarterly Joint Local Negotiation Committee (Medical Workforce)	30/06/22
6.	Recruitment and retention	1.Review staffing model post move to CCCL. Identify any gaps and proposed solution.	Divisional Director	Review in progress. Expected feedback/discussion via planned listening events.	30/06/22

3. Process for approval of walkabout report and monitoring of identified improvement/assurance actions

Following the patient/staff experience walkabout a draft report will be sent to the Non-Executive Director and Governor who attended the walk-around for comment and approval. At this time the report will not be shared outside of this process. The final draft report will be sent to the Divisional Senior Management Team for information and to support the production of the accompanying Action Report. The final reports will be sent to the Chief Nurse/Deputy Director of Nursing for sign off prior to Board submission.

All actions identified are monitored at Divisional level with assurance updates provided to the Patient Experience Inclusion Committee.

Agenda item P1-95-22

Board of Directors

25th May 2022

Report of	Chief Nurse			
Paper prepared by	Chief Nurse			
Subject/Title	Improving patient experience with Governor and Non-Executive Director Engagement Walk-rounds			
Background papers	Nil			
Purpose of paper	To propose a refreshed process for Governor and Non-Executive led patient experience visits for 2022/23			
Action required	To approve content/preferred option/recommendations			√
	To discuss and note content			
	To be assured of content and actions			
Link to risk:				
Link to: Trust's Strategic Direction Corporate Objectives	Be Outstanding	√	Be a great place to work	√
	Be Collaborative		Be Digital	
	Be Research Leaders		Be Innovative	

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

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

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

Board of Directors

25th May 2022

1. **Summary**
The purpose of this paper is to provide the Board of Directors with a refreshed process for the management of monthly Governor and Non-Executive Director (NED) lead patient and staff experience visits.

2. **Background**
For the last 10 to 15 years, walk-rounds have been widely used in healthcare organisations to improve both safety and experience for patients and staff. They gained traction following the public inquiry into poor care at the Mid Staffordshire NHS Foundation Trust and the subsequent publication of the Francis Report which questioned why the warning signs of serious failings were not recognised. Walk-rounds can identify early concerns when they are undertaken authentically and with the full commitment of the organisation. To be most meaningful walk-rounds should be approached with enquiry and support and must not became a form of surveillance or control. Conversations with patients and staff must not be restricted or orchestrated to avoid challenging topics. However, the role of the walk-round is more than enabling a safe environment for patients and staff to raise concerns, there must be a process to act on issues raised, provide timely feedback and monitor effectiveness.

3. **Introduction**
Governor and Non-executive lead walk-rounds have been in place at Clatterbridge Cancer Centre for many years and have proven to be a valuable method of hearing directly from patients and staff. Governor and Non-Executive Directors have a unique role in providing the eyes and ears of the outsider but with privileged access to the inside of the hospital. The walk rounds are arranged and supported by the Corporate Governance and Patient Experience teams. A brief report is produced for discussion at Board of Directors and whilst actions are noted there is no clear mechanism for the services to provide feedback on the issues raised or confirmation that the actions are logged and monitored to completion.

Due to Covid-19 restrictions over the last two years Governors and NEDs were unable to attend in person but where able to participate virtually using digital technology. Whilst it is widely acknowledged that this is not the preferred method it did ensure that throughout the pandemic the patient and staff voice continued to be heard. As the organisation transitions into the next phase of living with Covid-19 it is timely to refresh our walk-round process to ensure it remains meaningful and adds value to our quality agenda.

4. **Scheduling**
At the start of each financial year the revised schedule of walk round visits will be agreed at Board of Directors and subsequently shared with the divisional directors. The walk rounds will cover all divisions and sites of the organisation and where practicable all clinical services. Whilst it would be ideal to visit at different times of day and night and on different days of the week, it is noted that this may not be possible and in order to make best use of Governor and NED time walk-rounds may be scheduled to occur after monthly Board of Director meetings.

There are a number of options for how individuals are assigned to each walk-round, e.g. by division, by site, by speciality etc. However to minimise the administrative burden it would be prudent to adopt a simple process based on individual availability. Should Governors and NEDs wish to align themselves to a particular location they can do so by choosing to attend the corresponding dates.

The walk round schedule will be circulated and populated by the Corporate Governance Team in March each year in readiness for the new financial year. Appendix 1 – Current Schedule

5. Support and facilitation

Each visit will be supported by a member of the Patient Experience Team. They will meet the Governor and Non-Executive Director at the agreed location and escort them to the service/department at the agreed time. They will also provide an overview of the purpose of the visit and take notes of the discussion. Within the service the walk-round will be facilitated by senior lead i.e. Matron or service manager, they will provide an overview of the service, any current issues they may be addressing and identify any patients that may not be in a position to participate in a conversation. The facilitator will ensure that staff are released from their duties to speak with the team if they wish to do so. Whilst the person facilitating the visit will not be required to join the conversations they will be available at the end of the visit to receive verbal feedback on any immediate actions required and to communicate any positive feedback received from patients.

6. Process

It is often helpful to first take a few minutes to sit or stand to one side to quietly and unobtrusively, observe what is happening. Focussing on the welcome patients receive; whether they can see the name of the person dealing with them and whether and how staff introduce themselves. Review the written information that is available for patients, observe the quality of the physical environment and feel the atmosphere.

Whilst the walk-round itself needs to be organic and sufficiently flexible to accommodate an open and honest conversation it can be useful to have a broad structure. This could be an agreement on a specific aspect of the patient experience to focus on or a specific set of questions to ask. Often a more simple structure is to ask patients and staff to highlight 3 things they are happy with or proud of and 3 things they would like to change or improve. Or something as simple as identifying that one thing that, if changed, would improve their experience.

It is also helpful to note how much time there is allotted to the walk-round to enable patients and staff to focus their attention on the important issues. The Patient Experience Team member supporting the walk-round will be on hand to move the conversation along or draw to a close if needed.

It is often helpful to have an immediate debriefing, after the walk-round, with the team and the facilitator, to gain clarity where needed, agree the issues that must be taken away for action, quick fixes that can be resolved straight away and provide feedback or praise where good practices have been identified.

7. Follow-Up

Following the walk round the agreed template will be completed by the Patient Experience Team member and shared with the facilitator to ensure issues and realistic actions and timeframes have been captured correctly. The final agreed document will be shared with the Governor and Non-Executive Director for sign off one week before the papers are required for Board of Directors.

Findings from the walk round will be presented:

- At Board of Directors by the Non-Executive Director who undertook the visit
- At patient experience and inclusion committee by the patient experience team
- At team meetings and Divisional Board by the facilitator of the visit

8. Monitoring

The following quality measurements will be monitored annually via way of an annual report to evaluate whether or not the walk-rounds are providing value to the organisation and positive improvement on the experience of patients and staff.

- No less than 10 patient and staff experience walk-rounds will be undertaken during each financial year
- Each walk-round will include a Governor, a Non-Executive Director, a member of the Patient Experience Team (or delegated colleague) and a senior facilitator from the area visited.
- Walk-rounds will cover all sites of the organisation and all clinical divisions
- Where practicable 2 walk-rounds per year will include non-clinical services i.e. Workforce, Finance, Corporate Services
- Patient Experience and Inclusion Committee will be accountable for ensuring actions are monitored to completion or if required escalated to a more appropriate committee.
- There is a process in place to ensure patients and staff are alerted to changes made which are as a direct result of feedback during a walk-round.

9. Conclusion

An annual cycle of patient and staff experience walk-rounds undertaken by Governors and Non-Executive Directors demonstrates the organisations commitment to listening to patients and staff. If executed authentically the process nurtures a culture where problems in care are openly discussed and solutions identified, where hierarchies are flattened and all patients and staff feel that they can speak up and contribute to improving the services we provide.

10. Recommendations

The Board of Directors is asked to note the content of this paper and approve the process, report template and schedule for the 2022/23.

Appendix 1

Walk round Schedule 2022/23

Site	Division	Service	Date
CCC-W	Networked Services	Delamere	June
CCC-L	Acute	Ward 4 & 5	July
CCC-W	Networked Services	OPD, Cyclotron, Private Patient Unit	August
CCC-A	Radiation Services	Radiotherapy	September
CCC-L	Networked Services/Corporate	OPD, (M1), Cancer Information Centre, PALS (M2)	October
CCC-L	Radiation Services	Radiotherapy, Imaging, Pre-treatment	November
Aintree MD	Networked Services	Marina Dalglish	December
CCC-L	Acute/Radiation Services	Ward 1 –Day ward, Brachy, Papillion, Private Patient Unit, Clinical Intervention Service	**2023** January
CCC-L	Networked Services/Research/Acute	Chemotherapy Unit, Clinical Trials, Pharmacy, CPL	February
Halton	Networked Services	Halton unit	March
CCC-W	Radiation Services	Radiotherapy, Imaging, Pre-Treatment	April
CCC-L	Acute	Wards 2 & 3	May

Appendix 2

Governor and Non-Executive Director
Patient & Staff Experience Walk-round

Division	Choose an item.	Location		Date	
In attendance - Panel			In attendance – Patient & Staff		
Governor			Senior Manager facilitating the walk round		
Non Executive			Number of Patients		
Patient Experience Team			Number of Staff		

Patient Feedback: The patients were asked to describe their experience of care at CCC NB: *This is not a verbatim record but an overview of the key themes raised during the conversation.*	
Positive Comments:	
Areas where immediate action was taken on the day:	
Areas for improvement:	Service response: *Highlight in **Bold** outstanding actions to be added to PEIC action plan*

<table>
<tr><td colspan="2">Staff Feedback: Staff were asked to describe their experience of providing patient care at CCC

NB: This is not a verbatim record but an overview of the key themes raised during the conversation.</td></tr>
<tr><td colspan="2">Positive Comments:</td></tr>
<tr><td colspan="2">Areas where immediate action was taken on the day:</td></tr>
<tr><td>Areas for improvement:</td><td>Service response: Highlight in Bold outstanding actions to be added to Divisional action plan</td></tr>
</table>

REPORT COVER

Report to:	Board of Directors
Date of meeting:	Wednesday 25th May 2022
Agenda item:	P1-96-22
Title:	Integrated Performance Report M1 2022/2023
Report prepared by:	Hannah Gray: Head of Performance and Planning
Executive Lead:	Joan Spencer: Chief Operating Officer
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Performance Committee
Date & decision:	Wednesday 18th May 2022

Purpose of the paper/key points for discussion:	This report provides the Board of Directors with an update on performance for month 1 2022/23 (April 2022). This report provides an update on performance for April 2022, in the categories of access, efficiency, quality, workforce, research and innovation and finance. The scorecards have been revised to include statistical process control (SPC) charts and associated variation and assurance icons. Exception reports are then presented for 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 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.

Version 1.1 Ref: FCGOREPCOV Review: July 2024

Integrated Performance Report (Month 1 2022/23)

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

Introduction

This report provides an update on performance for April 2022, in the categories of access, efficiency, quality, workforce, research and innovation and finance.

The scorecards have been revised to include statistical process control (SPC) charts and associated variation and assurance icons. Further information is provided in the SPC Guidance section of this report. RAG rating shading for the last 12 months for all KPIs, is based upon 22/23 targets.

Exception reports are then presented for key performance indicators (KPIs) against which the Trust is not compliant.

The approach to exception reporting is under review; with SPC alerts requiring consideration alongside target non-compliance. The approach will be agreed at Performance Committee in July 2022. This will allow three months of 'SPC' reporting, which will provide intelligence on, and foster a collective understanding of the relationship between target non-compliance and SPC alerts.

The additional narrative, previously included in the version of the IPR presented at Performance and Quality Committee, will no longer be included in any version of the IPR. This is in line with the findings of the Trust's Well Led Review (2022), conducted by the Good Governance Institute, which recommended that the IPR be shortened. Instead, any aspects of performance for which Committee members require further information, will be presented as a separate, specific report.

SPC Guidance

Introduction of Statistical Process Control (SPC) Charts

The Integrated Performance Report for 2022/2023 has been revised to include Statistical Process Control Charts for all relevant metrics. This allows for the monitoring of variance in the metrics over time and is a method for recognising where a metric change is statistically significant. The NHS Improvement Making Data Count methodology for Statistical Process Control is implemented in this report.

Each metric displays the tabular data for the latest 12-month period RAG rated against target. Alongside a Statistical Process Control Chart which plots data for the latest 18 month period and an icon to help interpret the Variation (V) and Assurance (A) of the Chart.

If Statistical Process Control is not applicable for a metric, the metric is graphically represented by a bar chart and the icon removed.

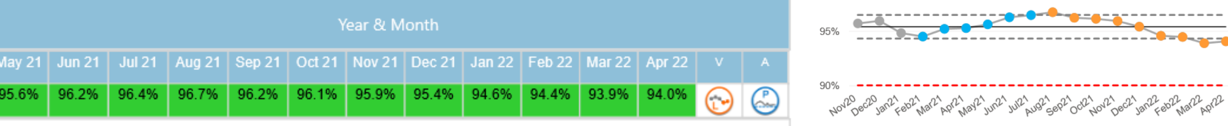
Interpretation of Statistical Process Control Charts

The following summary icons describe the Variation and Assurance displayed in the Chart:

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

The Variation is colour coded and any change to variation that indicates improvement is blue and indicates concern is orange. The Assurance icon is colour coded and explains how the data performs against the target. Interpreting the data using both of these icons allows monitoring of trends over time alongside the impact against target.

An Example:



Year & Month													
May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
95.6%	96.2%	96.4%	96.7%	96.2%	96.1%	95.9%	95.4%	94.6%	94.4%	93.9%	94.0%		

The Statistical Process Control chart displays the data plotted over time indicated by the solid line with large dots for each month. The mean (statistical average) is the solid straight grey line and the upper and lower control limits are the hashed straight grey lines. The target is the hashed straight red line. The target of 90% has been achieved for each of the 18 months.

The Variation icon and colour coding of the large dots indicates that the process has variation and this is a special cause for concern in the latest month. The Assurance icon confirms that the target has been consistently met. Although the target has been consistently achieved, the variation indicates a statistical decrease since August 2021 in the process.

Integrated Performance Report (May 21 - Apr 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Executive Director Lead: Chief Operating Officer

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
CW10	2 week wait from GP referral to 1st appointment	Green =93% Red <93%	Contractual / Statutory	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	92.9%	90.0%	100.0%	93.8%	84.6%		

Narrative: The target has not been achieved and an exception report is provided.
SPC: Performance is lower than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
CW00	28 day faster diagnosis - (Referral to diagnosis)	Green =75% Red <75%	Contractual / Statutory	83.3%	90.9%	91.7%	80.0%	60.0%	75.0%	91.7%	80.0%	57.1%	64.3%	58.8%	66.7%		

Narrative: The target has not been achieved and an exception report is provided.
SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
CW09	31 Day Firsts	Green =96% Red <96%	Contractual / Statutory	98.8%	99.2%	99.2%	100.0%	98.8%	100.0%	99.2%	98.7%	97.5%	99.5%	99.7%	99.6%		P

Narrative: The target has been achieved.
SPC: There is no significant change and the nature of variation indicates that the target is likely to be consistently achieved.

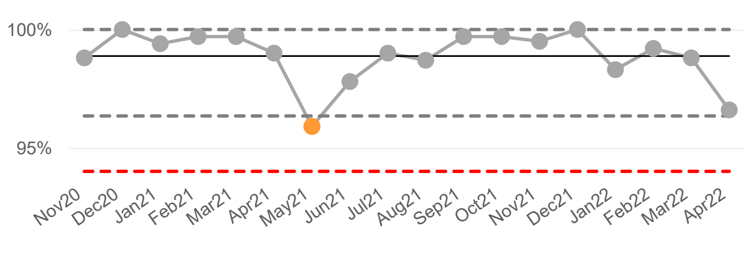
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
CW07	31 Day Subsequent Chemotherapy	Green =98% Red <98%	Contractual / Statutory	99.2%	98.8%	99.2%	99.6%	99.6%	100.0%	100.0%	99.2%	98.2%	99.2%	99.3%	99.6%		P

Narrative: The target has been achieved.
SPC: There is no significant change and the nature of variation indicates that the target is likely to be consistently achieved.

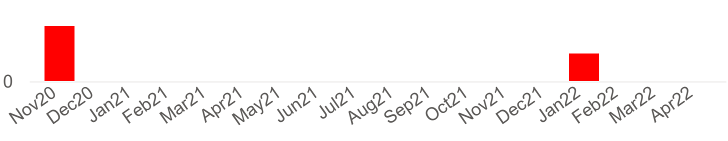
Integrated Performance Report (May 21 - Apr 22)

Access

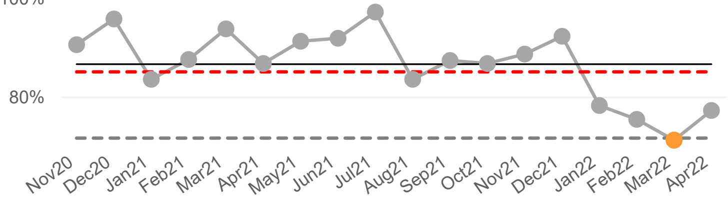
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
CW08	31 Day Subsequent Radiotherapy	Green =94% Red <94%	Contractual / Statutory	95.9%	97.8%	99.0%	98.7%	99.7%	99.7%	99.5%	100.0%	98.3%	99.2%	98.8%	96.6%		
			Narrative	The target has been achieved. SPC: There is no significant change and the nature of variation indicates that the target is likely to be consistently achieved.													



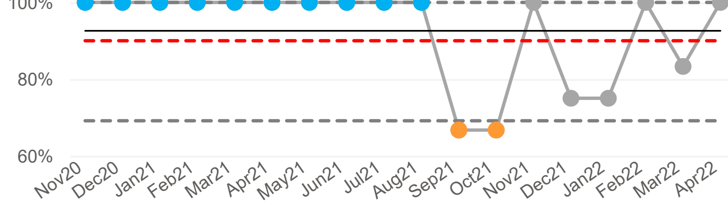
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
CW40	Number of 31 day patients treated => day 73	Green 0 Red >0	Contractual / Statutory	0	0	0	0	0	0	0	0	1	0	0	0		
			Narrative	The target has been achieved													



Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
CW03	62 Day Classic	Green =85% Red <85%	Contractual / Statutory	91.2%	91.8%	97.1%	83.5%	87.3%	86.7%	88.6%	92.2%	78.2%	75.4%	71.2%	77.2%		
			Narrative	The target has not been achieved and an exception report is provided. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
CW05	62 Day Screening	Green =90% Red <90%	Contractual / Statutory	100.0%	100.0%	100.0%	100.0%	66.7%	66.7%	100.0%	75.0%	75.0%	100.0%	83.3%	100.0%		
			Narrative	The target has been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Integrated Performance Report Month 1 2022/2023

Integrated Performance Report (May 21 - Apr 22)

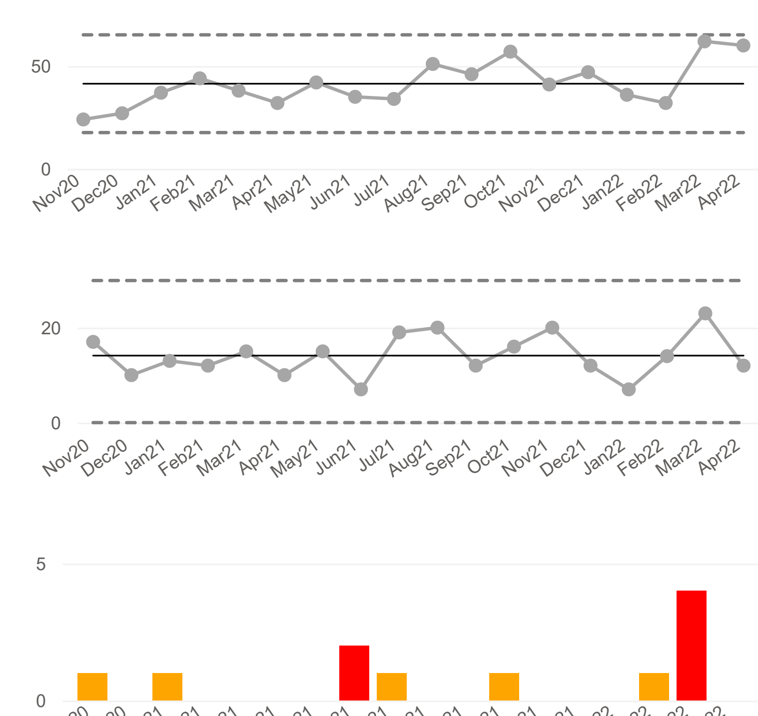
Access

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
CW41	Number of patients treated between 63 and 103 days (inclusive)	No Target	Covid-19 Recovery	42	35	34	51	46	57	41	47	36	32	62	60		
			Narrative	SPC: There is no significant change													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
CW42	Number of patients treated => 104 days	No Target	Contractual / Statutory	15	7	19	20	12	16	20	12	7	14	23	12		
			Narrative	SPC: There is no significant change													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
CW43	Number of avoidable breaches, treated => 104 days AND at CCC for over 24 days	Green 0 Amber 1 Red >1	Contractual / Statutory	0	2	1	0	0	1	0	0	0	1	4	0		
			Narrative	The target has been achieved													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
DI01	Diagnostic Imaging Waitlist - Within 6 Weeks	Green >=99% Red <99%	Contractual / Statutory	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
			Narrative	The target has been achieved. SPC: There is no significant change and the nature of variation indicates that the target is likely to be consistently achieved.													



Integrated Performance Report Month 1 2022/2023

Integrated Performance Report (May 21 - Apr 22)

Access

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
RT03	RTT Incomplete	Green >=92% Red <92%	Contractual / Statutory	98.7%	98.8%	99.1%	100.0%	98.0%	97.7%	98.0%	99.0%	99.1%	97.4%	98.4%	98.7%		P
			Narrative	The target has been achieved. SPC: There is no significant change and the nature of variation indicates that the target is likely to be consistently achieved.													

100%
95%
Nov20 Dec20 Jan21 Feb21 Mar21 Apr21 May21 Jun21 Jul21 Aug21 Sep21 Oct21 Nov21 Dec21 Jan22 Feb22 Mar22 Apr22

Integrated Performance Report Month 1 2022/2023

Access Exception Reports

2 week wait from GP referral to 1st appointment	Target	Apr-22
	G: ≥93%, R: <93%	84.6%

Reason for non-compliance

2 patients breached the target in April. Both breaches were unavoidable, due to medical reasons.

- Patient tested positive for COVID and re-arranged first appointment date
- Patient cancelled 1st appointment and was then admitted to secondary care with an unrelated condition.

Action taken to improve compliance

N/A

Expected Date of Compliance	May 2022
Escalation Route	Trust 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	Apr-22
	G: ≥75%, R: <75%	66.7%

Reason for non-compliance

4 patients breached the 28 FDS day target in April. All of the breaches were unavoidable, due to a complex pathway, medical and patient choice reasons and delay to diagnostic test at the referring Trust. Breach details:

- Patient did not attend follow up appointment for communication of ruling out of cancer
- Aintree on-boarding day 58, complex pathway at referring Trust and patient choice to delay follow up appointment
- Delay to diagnostic investigation at referring trust
- Patient cancelled diagnostic staging investigation appointment

Action taken to improve compliance

A review is underway to identify how The CCC's Imaging Department can support the staging aspect of the diagnostic pathway.

Expected Date of Compliance	May 2022
Escalation Route	Trust 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	Apr-22
	G: ≥85%, R: <85%	77.2%

Reason for non-compliance

15 patients breached the 62 day target in April. 1 breach was avoidable and 14 were unavoidable. The avoidable breach was due to slight delay to first appointment and the patient required a pre-treatment procedure prior to commencing treatment, however the results were not available for the treatment start date. The unavoidable breaches were due to complex pathway, delays to molecular test results at the referring Trust, medical and patient choice reasons.

Tumour group breach split:

- Lung: 7
- Urological: 3
- Head and Neck: 1
- HO: 2
- Upper GI: 1
- Lower GI: 1

Action taken to improve compliance

- Daily monitoring and escalating of appointment bookings remains in place to enable management and prioritisation for first appointments.
- Molecular test delays:
  - A further meeting is scheduled for 25/5/22, to include CCC, CMCA, LCL and GLH (Manchester lab).
  - LCL are procuring a next generation sequencing machine, which will expedite testing.
  - Cross organisational discussions are ongoing regarding amending the breach allocation for molecular tests to half each to CCC and the referring Trust, rather than CCC taking a full breach.
- The Trust Operational Group has revised its terms of reference, expanding the focus beyond the detailed management of breaches, to wider activity and service planning. This is already having an impact; fostering greater collaboration between Divisions in service planning, providing more robust processes for escalation of patients and promoting improved learning from breaches within SRGs.

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

Integrated Performance Report (May 21 - Apr 22)

Efficiency

Executive Director Lead: Chief Operating Officer

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP05-ST	Length of Stay Elective Care: Solid Tumour Wards (Average number of days on discharge)	Green =9 Amber 9.1-9.8 Red =9.9	Statutory	6	4	5	5	7	7	6	9	7	9	10	13		
			Narrative	The target has been reset for 22/23, based on 21/22 performance and taking account of service changes. The target has not been achieved. SPC: LoS is higher than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent. This is due to recent changes in flow, acuity and demand and the target therefore requires further adjustment to reflect this.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP06-ST	Length of Stay Emergency Care: Solid Tumour Wards (Average number of days on discharge)	Green =7 Amber 7.1-7.6 Red =7.7	Statutory	7	9	8	9	12	7	11	9	9	11	8	9		
			Narrative	The target has been reset for 22/23, based on 21/22 performance and taking account of service changes. The target has not been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. This is due to recent changes in flow, acuity and demand and the target therefore requires further adjustment to reflect this.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP05-4	Length of Stay Elective Care: HO Ward 4 (Average number of days on discharge)	Green =21 Amber 21.1-23 Red =23.1	Statutory	13	10	20	21	19	12	16	17	16	16	13	14		
			Narrative	The target has been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

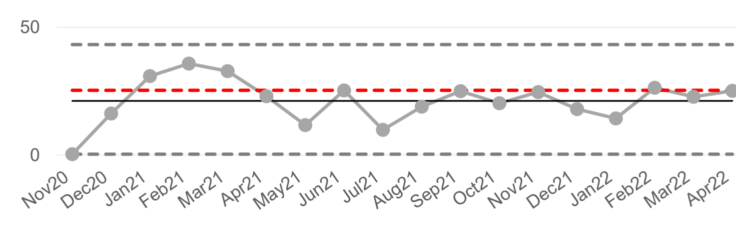
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP06-4	Length of Stay Emergency Care: HO Ward 4 (Average number of days on discharge)	Green =15 Amber 15.1-16.4 Red =16.5	Statutory	11	9	8	12	19	11	8	6	14	11	17	18		
			Narrative	The target has been reset for 22/23, based on 21/22 performance and taking account of service changes. The target has not been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. This is due to recent changes in flow, acuity and demand and the target therefore requires further adjustment to reflect this.													

Integrated Performance Report Month 1 2022/2023

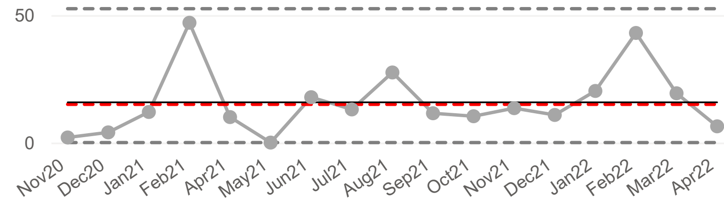
Integrated Performance Report (May 21 - Apr 22)

Efficiency

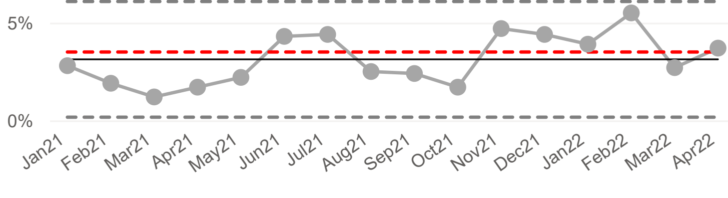
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP05-5	Length of Stay Elective Care: HO Ward 5 (Average number of days on discharge)	Green =25 Amber 25.1-27.4 Red =27.5	Statutory	11	25	10	19	25	20	24	18	14	26	22	25		
			Narrative	The target has been reset for 22/23, based on 21/22 performance and taking account of service changes. The target has been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



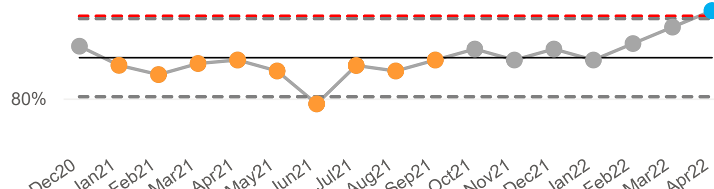
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP06-5	Length of Stay Emergency Care: HO Ward 5 (Average number of days on discharge)	Green =15 Amber 15.1-16.4 Red =16.5	Statutory	0	18	13	28	12	10	14	11	20	43	19	6		
			Narrative	The target has been reset for 22/23, based on 21/22 performance and taking account of service changes. The target has been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP22	Delayed Transfers of Care as % of occupied bed days	Green =3.5% Red >3.5%	Statutory	2.2%	4.3%	4.4%	2.5%	2.4%	1.7%	4.7%	4.4%	3.9%	5.5%	2.7%	3.7%		
			Narrative	The target has not been achieved and an exception report is provided. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP23	% of expected discharge dates completed	Green =>95% Amber 90% - 94.9% Red <90%	Contractual	85.0%	79.0%	86.0%	85.0%	87.0%	89.0%	87.0%	89.0%	87.0%	90.0%	93.0%	96.0%		
			Narrative	The target has been achieved. SPC: Performance is higher than expected, however the nature of variation indicates that failure to meet the target is more likely.													



Integrated Performance Report Month 1 2022/2023

Integrated Performance Report (May 21 - Apr 22)

Efficiency

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP20-4	Average Occupancy at 12 midday: Ward 4	Green =>85% Amber 81-84.9% Red <81%	Statutory	78.7%	86.5%	90.3%	89.8%	80.8%	88.2%	92.8%	83.7%	85.3%	91.1%	92.6%	95.2%		
			Narrative	The target has been achieved. SPC: Performance is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP21-4	Average Occupancy at Midnight: Ward 4	Green =>85% Amber 81-84.9% Red <81%	Statutory	81.6%	89.5%	91.0%	90.3%	81.2%	88.4%	93.5%	84.4%	85.8%	94.7%	93.1%	95.0%		
			Narrative	The target has been achieved. SPC: Performance is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP20-5	Average Occupancy at 12 midday: Ward 5	Green =>80% Amber 76%-79.9% Red <76%	Statutory	75.8%	69.9%	85.1%	86.0%	93.6%	89.0%	81.6%	71.4%	78.1%	88.1%	86.2%	83.9%		
			Narrative	The target has been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP21-5	Average Occupancy at Midnight: Ward 5	Green =>80% Amber 76%-79.9% Red <76%	Statutory	61.0%	72.7%	80.9%	83.9%	82.9%	78.1%	75.8%	66.2%	73.1%	83.8%	86.0%	83.8%		
			Narrative	The target has been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Integrated Performance Report Month 1 2022/2023

Integrated Performance Report (May 21 - Apr 22)

Efficiency

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP20-ST	Average Occupancy at 12 midday: ST Wards	Green =>85% Amber 81-84.9% Red <81%	Statutory	67.3%	72.1%	73.9%	79.3%	75.4%	61.5%	75.6%	71.7%	76.6%	82.3%	84.6%	83.0%		
			Narrative	The target has not been achieved and an exception report is provided. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP21-ST	Average Occupancy at Midnight: ST Wards	Green =>85% Amber 81-84.9% Red <81%	Statutory	72.4%	74.8%	67.2%	77.8%	73.5%	67.9%	73.9%	70.7%	75.2%	80.3%	83.3%	83.0%		
			Narrative	The target has not been achieved and an exception report is provided. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP24	% of elective procedures cancelled on or after the day of admission	Green 0% Red >0%	Contractual	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
			Narrative	The target has been achieved													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP25	% of cancelled elective procedures (on or after the day of admission) rebooked within 28 days of cancellation	Green 100% Red <100%	Contractual	-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	There is no data to display as there were no cancelled procedures to re book													

Integrated Performance Report Month 1 2022/2023

Integrated Performance Report (May 21 - Apr 22)

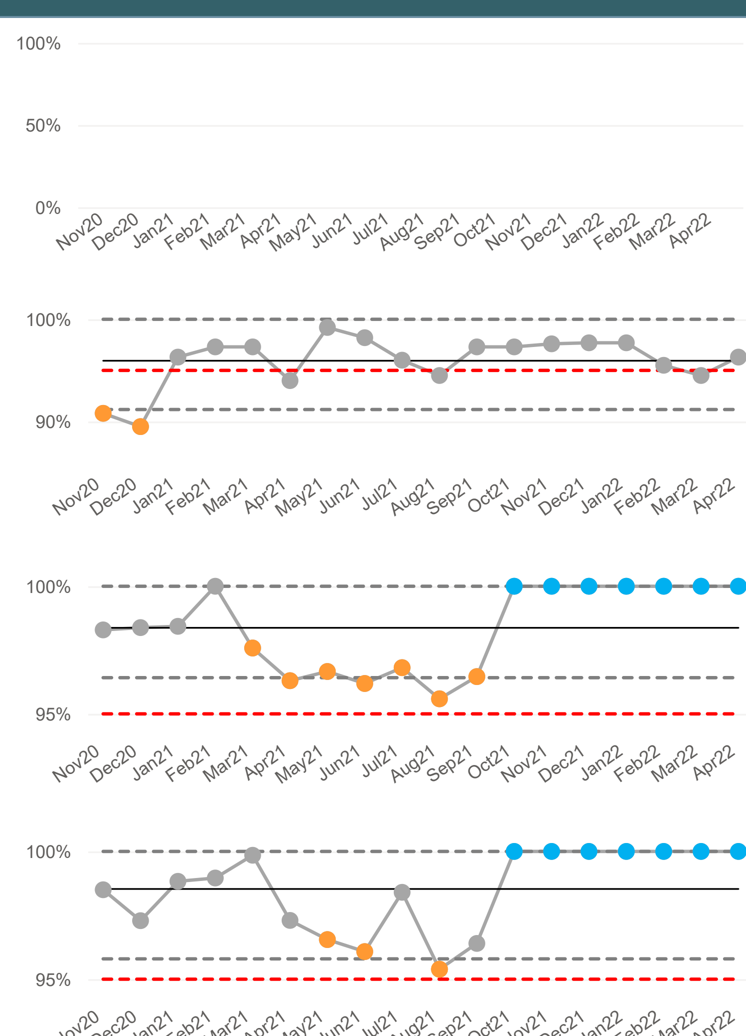
Efficiency

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
IP26	% of urgent operations cancelled for a second time	Green 0% Red >0%	Contractual	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
			Narrative	The target has been achieved													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
DQ01	Data Quality - % Ethnicity that is complete (or patient declined to answer)	Green =95% Amber 90-94.9% Red <90%	Covid-19 Recovery	99.2%	98.2%	96.0%	94.5%	97.3%	97.3%	97.6%	97.7%	97.7%	95.5%	94.5%	96.3%		
			Narrative	The target has been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
DQ02	Data Quality - % of outpatients with an outcome	Green =>95% Amber 90% - 94.9% Red <90%	Contractual	96.7%	96.2%	96.8%	95.6%	96.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
			Narrative	The target has been achieved. SPC: Performance is higher than expected and the nature of variation indicates that the target is likely to be consistently achieved.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
DQ03	Data Quality - % of outpatients with an attend status	Green =>95% Amber 90% - 94.9% Red <90%	Contractual	96.6%	96.1%	98.4%	95.4%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
			Narrative	The target has been achieved. SPC: Performance is higher than expected and the nature of variation indicates that the target is likely to be consistently achieved.													

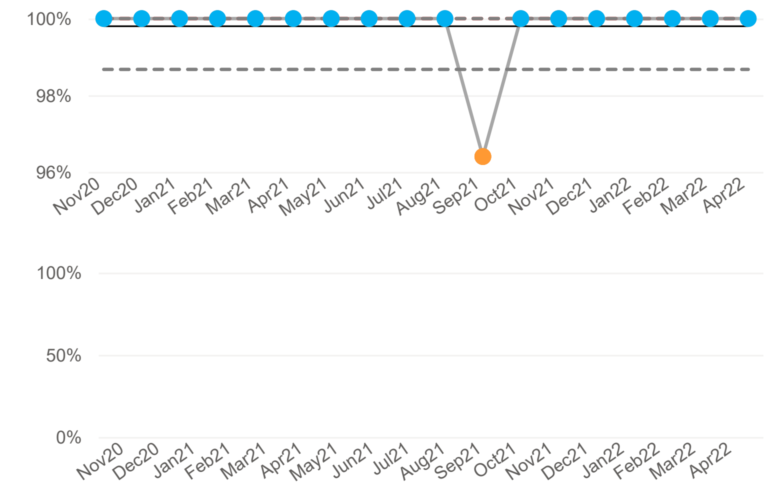


Integrated Performance Report (May 21 - Apr 22)

Efficiency

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
EF01	Percentage of Subject Access Requests responded to within 1 month	Green 100% Red <100%	Contractual	100.0%	100.0%	100.0%	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
			Narrative	The target has been achieved. SPC: Performance is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
EF02	% of overdue ISN (Information Standard Notices)	Green 0% Red >0%	Contractual	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
			Narrative	The target has been achieved.													



Efficiency Exception Reports

Delayed Transfers of Care as % of occupied bed days	Target	Apr-22
	G: ≤3.5%	3.7%

Reason for non-compliance

Delayed Transfers of Care (DTOC) as a % of occupied bed days for the month of April was above the Trust target of <= 3.5%, with 3.7% reported this month.

There were 11 DTOC in April, resulting in 93 extra bed days. The average length of DTOC was 8.45 days.

- 4 Patients awaited Fast Track Packages of care resulting in 12 extra bed days. Covid continues to affect community services; increasing the length of time to commission a package of care across all areas
- 2 Patient awaited Fast Track Nursing Home placement, resulting in 30 extra bed days.
- 5 Patients awaited Hospice placement resulting in 51 extra bed days. Some hospices have reduced day capacity due to Covid. One hospice is currently closed due to a covid outbreak.

Action taken to improve compliance

- Weekly 'Lengthened Length of Stay' meetings have continued with attendance of Matron and the Business Services Manager to ensure the flow of patients continues, and any concerns are escalated. The outcome of these meetings are forwarded to the General Manager for review.
- The Patient Flow Team continue to work with wider MDT to aid discharge planning during the COVID-19 pandemic, ensuring patients are discharged safely home or to a suitable care setting. Weekly complex discharge meetings occur with MDT
- Daily COW MDT meetings continue to allow discussion of all inpatients so there is a clear plan for each patient.

Expected Date of Compliance	May 2022
Escalation Route	Divisional Quality, Safety and Performance Group, Divisional Performance Review, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

Bed Occupancy	Target	Apr-22
	G: ≥85% A: 81-84.9% R: <81%	83%

Reason for non-compliance

Solid tumour ward bed occupancy continues to be below the Trust target of 85%, with midday occupancy at 83%, down 1.6% from last month.

These figures are calculated on a total bed base of 90 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 April. 4 Mutual aid patients have been transferred across to CCC from LUHFT in April 2022.
In April 2022, solid tumour wards have been at OPEL 3 level on 47 occasions.

The patient flow team 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 4% for April 2022 with shows good 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.
- A bed utilisation review was conducted, to understand any trends, however, it was identified that the increase was purely related to a general increase in referrals.

The Bed Utilisation 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	Quarter 2 2022/2023
Escalation Route	Trust Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Executive Lead	Joan Spencer, Chief Operating Officer

Integrated Performance Report (May 21 - Apr 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Executive Director Lead: Chief Nurse

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU17	Never Events	Green 0 Red >0	Contractual / Statutory	0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target has been achieved													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU04	Serious Untoward Incidents (SUIs)	Green =3 Red >3	Contractual / Statutory	2	0	0	1	0	0	0	0	0	0	0	0		
			Narrative	The target has been amended from 0 to <3 per year. This is a more realistic target than the previous target of 0. An SI is not always related to a lapse in care by a Trust. The target has been achieved.													

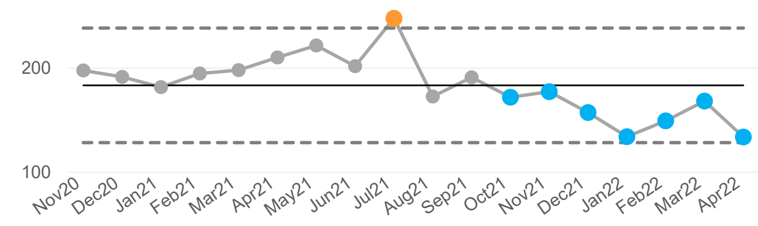
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU01	Serious Incidents: % submitted within 60 working days / agreed timescales	Green 100% Red <100%	Contractual / Statutory	-	-	100.0%	-	67.0%	-	-	-	-	-	-	-		
			Narrative	No SI reports were due to be submitted in April													

Integrated Performance Report Month 1 2022/2023

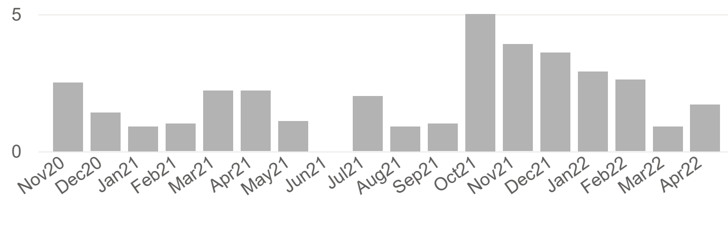
Integrated Performance Report (May 21 - Apr 22)

Quality

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU03	Incidents /1,000 Bed Days	No Target	Statutory	221	201	247	172	190	171	177	157	133	149	168	133		
			Narrative	SPC: Performance is lower than expected													



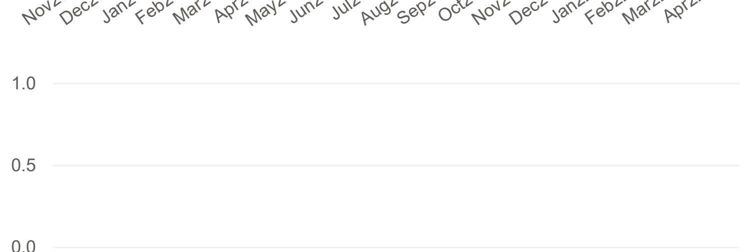
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU05	All incidents resulting in moderate harm and above /1,000 bed days	No Target	Local	1	0	2	1	1	5	4	4	3	3	1	2		
			Narrative	This KPI has been amended from all incidents, to those resulting in moderate harm or above, providing a more valuable indicator of the impact on patients.													



Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU06	Inpatient Falls resulting in harm due to lapse in care	Green 0 Red >0	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target has been achieved													

5
0
Nov20 Dec20 Jan21 Feb21 Mar21 Apr21 May21 Jun21 Jul21 Aug21 Sep21 Oct21 Nov21 Dec21 Jan22 Feb22 Mar22 Apr22

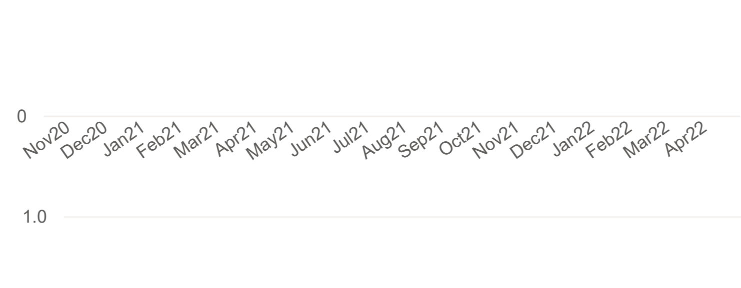
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU07	Inpatient falls resulting in harm due to lapse in care /1,000 bed days	Green 0 Red >0	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target has been achieved													



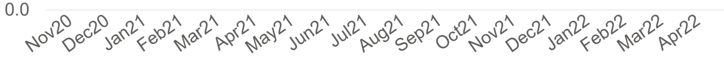
Integrated Performance Report (May 21 - Apr 22)

Quality

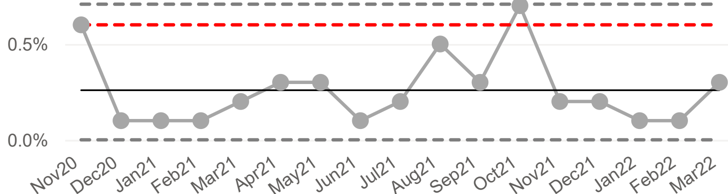
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU08	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care)	Green 0 Red >0	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target has been achieved													



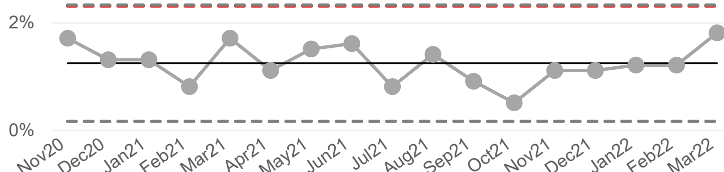
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU09	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care) /1,000 bed days	Green 0 Red >0	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target has been achieved													



Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU10	30 day mortality (Radical Chemotherapy)	Green =0.6% Amber 0.61% - 0.7% Red >0.7%	SOF	0.3%	0.1%	0.2%	0.5%	0.3%	0.7%	0.2%	0.2%	0.1%	0.1%	0.3%	-		
			Narrative	This KPI is newly included in the IPR for 22/23. This is in line with the SOF and reporting by our peers. It has always been reported at Divisional level. The target has been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU12	30 day mortality (Palliative Chemotherapy)	Green =2.3% Amber 2.31% - 2.5% Red >2.5%	SOF	1.5%	1.6%	0.8%	1.4%	0.9%	0.5%	1.1%	1.1%	1.2%	1.2%	1.8%	-		
			Narrative	This KPI is newly included in the IPR for 22/23. This is in line with the SOF and reporting by our peers. It has always been reported at Divisional level. The target has been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



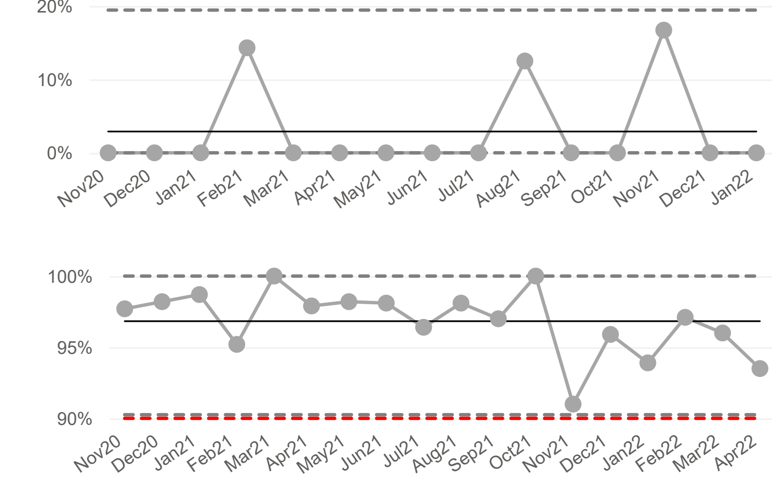
Integrated Performance Report Month 1 2022/2023

Integrated Performance Report (May 21 - Apr 22)

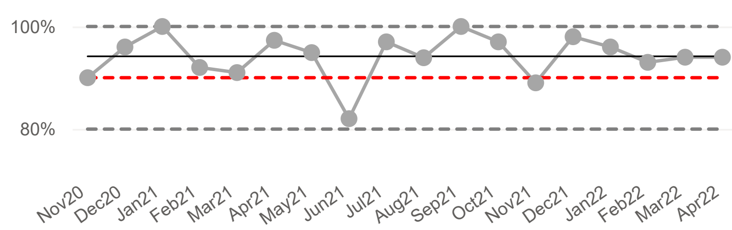
Quality

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU13	100 day mortality (Bone Marrow Transplant)	To Be Confirmed	SOF / NR	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	16.7%	0.0%	0.0%	-	-	-		
			Narrative	This KPI is newly included in the IPR for 22/23. This is in line with the SOF. It has previously been reported at Divisional level. The target is being developed. SPC: There is no significant change.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU62	Consultant review within 14 hours	Green =90% Red <90%	Contractual	98.2%	98.1%	96.4%	98.1%	97.0%	100.0%	91.0%	95.9%	93.9%	97.1%	96.0%	93.5%		
			Narrative	The target has been achieved. SPC: There is no significant change and the nature of variation indicates that the target is likely to be consistently achieved.													



Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU48	Sepsis IV antibiotics within an hour	Green =90% Red <90%	Contractual	94.9%	82.0%	97.0%	93.9%	100.0%	97.0%	89.0%	98.0%	96.0%	93.0%	94.0%	94.0%		
			Narrative	The target has been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Integrated Performance Report Month 1 2022/2023

Integrated Performance Report (May 21 - Apr 22)

Quality

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU31	Percentage of adult admissions with VTE Risk Assessment	Green =95% Red <95%	Contractual / Statutory	94.2%	93.2%	94.4%	97.0%	96.7%	97.0%	98.0%	95.0%	95.0%	98.0%	95.0%	97.0%		
			Narrative	The target has been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

100%
95%
Nov20 Dec20 Jan21 Feb21 Mar21 Apr21 May21 Jun21 Jul21 Aug21 Sep21 Oct21 Nov21 Dec21 Jan22 Feb22 Mar22 Apr22

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU14	Dementia: Percentage to whom case finding is applied	Green =90% Red <90%	Contractual	93.0%	100.0%	100.0%	100.0%	83.0%	100.0%	100.0%	100.0%	76.0%	80.0%	86.0%	94.0%		
			Narrative	The target has been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

100%
80%
Nov20 Dec20 Jan21 Feb21 Mar21 Apr21 May21 Jun21 Jul21 Aug21 Sep21 Oct21 Nov21 Dec21 Jan22 Feb22 Mar22 Apr22

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU15	Dementia: Percentage with a diagnostic assessment	Green =90% Red <90%	Contractual	-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	No patients required a diagnostic assessment													

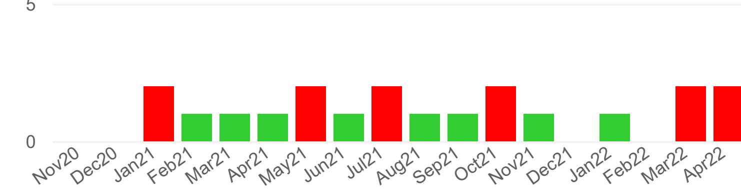
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU16	Dementia: Percentage of cases referred	Green =90% Red <90%	Contractual / Statutory	-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	No patients required referral													

Integrated Performance Report Month 1 2022/2023

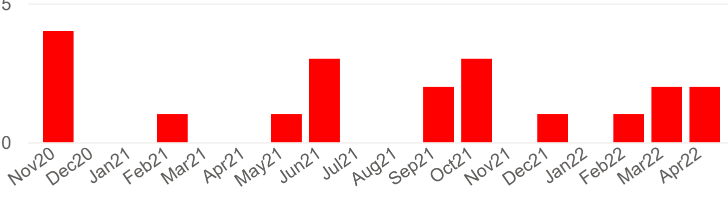
Integrated Performance Report (May 21 - Apr 22)

Quality

Metric ID	Metric Name	Target (Cumulative)	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU34	Clostridium difficile infections (HOHA and COHA)	Green <=17 per year Red >17 per year	Contractual / Statutory	2	1	2	1	1	2	1	0	1	0	2	2		
			Narrative	The nationally set targets for 22/23 have now been published and applied (an increase from 11 to 17). The target has not been achieved. An exception report is provided.													

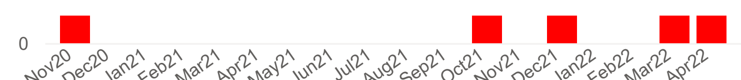


Metric ID	Metric Name	Target (Cumulative)	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU40	E. Coli bacteraemia (HOHA and COHA)	Green <=11 per year Red >11 per year	Contractual / Statutory	1	3	0	0	2	3	0	1	0	1	2	2		
			Narrative	The nationally set targets for 22/23 have now been published and applied (an increase from 6 to 11). The target has not been achieved. An exception report is provided.													



Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU36	MRSA infections (HOHA and COHA)	Green 0 Red >0	Contractual / Statutory	0	0	0	0	0	0	0	1	0	0	0	0		
			Narrative	The nationally set targets for 22/23 have now been published and applied; there is no change from 2021/22. The target has been achieved													

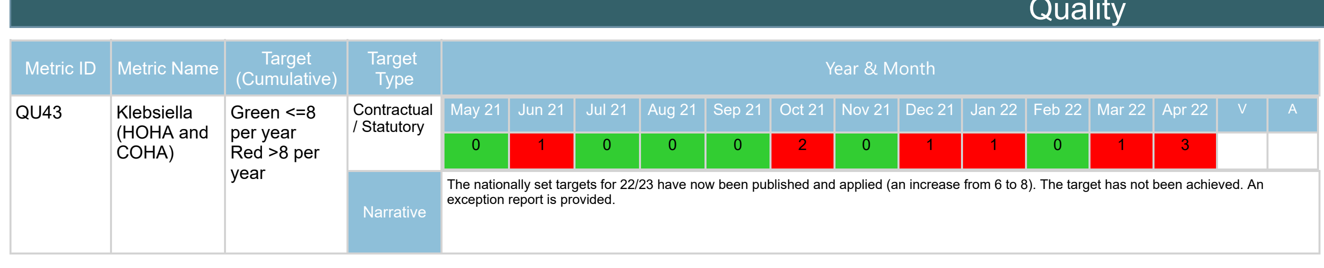
Metric ID	Metric Name	Target (Cumulative)	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU38	MSSA bacteraemia (HOHA and COHA)	Green <=4 per year Amber 4-5 per year Red >5 per year	Contractual / Statutory	0	0	0	0	0	1	0	1	0	0	1	1		
			Narrative	There is no national target for MSSA. The internal target has not been achieved. An exception report is provided.													



Integrated Performance Report Month 1 2022/2023

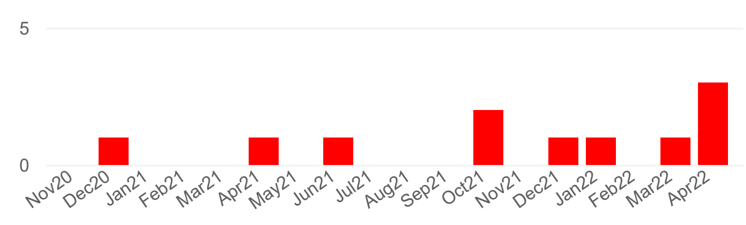
Integrated Performance Report (May 21 - Apr 22)

Quality



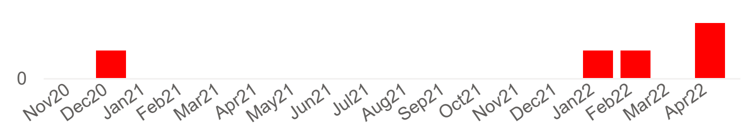
Metric ID	Metric Name	Target (Cumulative)	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU43	Klebsiella (HOHA and COHA)	Green <=8 per year Red >8 per year	Contractual / Statutory	0	1	0	0	0	2	0	1	1	0	1	3		

Narrative: The nationally set targets for 22/23 have now been published and applied (an increase from 6 to 8). The target has not been achieved. An exception report is provided.



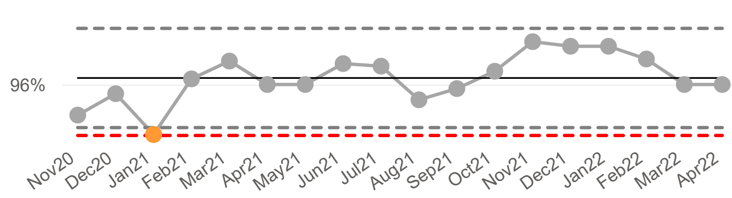
Metric ID	Metric Name	Target (Cumulative)	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU45	Pseudomonas (HOHA and COHA)	Green <=1 per year Red >1 per year	Contractual / Statutory	0	0	0	0	0	0	0	0	1	1	0	2		

Narrative: The nationally set targets for 22/23 have now been published and applied (a reduction from 10 to 1). The target has not been achieved and the annual target has been exceeded. An exception report is provided.



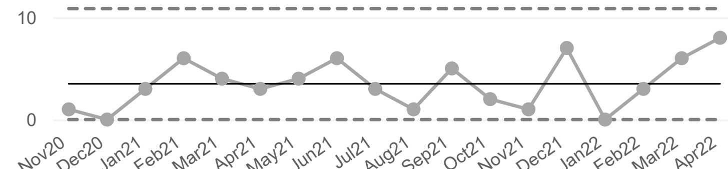
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU75	Patient FFT: Percentage of respondents who were either likely or extremely likely to recommend to friends and	Green =95% Amber 90% - 94.9% Red <90%	Contractual	96.0%	96.4%	96.4%	95.7%	95.9%	96.3%	96.8%	96.8%	96.8%	96.5%	96.0%	96.0%		

Narrative: The target has been achieved.
SPC: There is no significant change and the nature of variation indicates that the target is likely to be consistently achieved.



Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU11	Number of Complaints	No Target	Contractual	4	6	3	1	5	2	1	7	0	3	6	8		

Narrative: SPC: There is no significant change



Integrated Performance Report (May 21 - Apr 22)

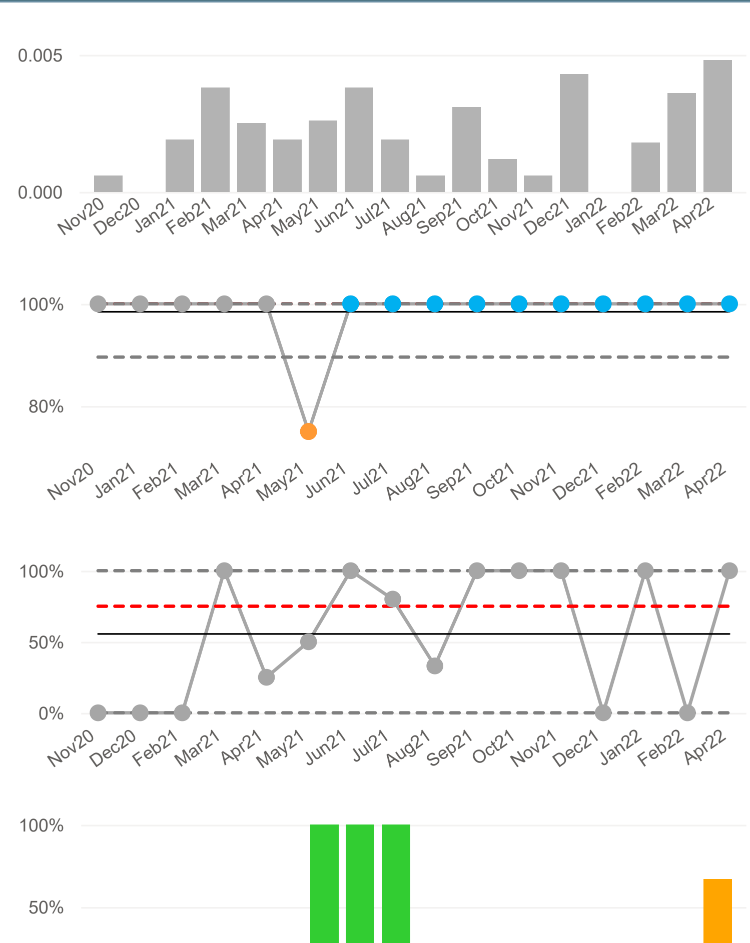
Quality

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU18	Number of complaints / count of WTE staff (ratio)	No Target	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU19	% of formal complaints acknowledged within 3 working days	Green 100 Red <100%	Contractual	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-	100.0%	100.0%	100.0%		
			Narrative	The target has been achieved. SPC: Performance is higher than expected however the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU20	% of routine complaints resolved within 25 working days	Green =>75% Amber 65% - 74.9% Red <65%	Local	50.0%	100.0%	80.0%	33.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	-	100.0%		
			Narrative	The target has been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU71	% of complex complaints resolved within 60 working days	Green =>75% Amber 65% - 74.9% Red <65%	Local	100.0%	100.0%	100.0%	-	0.0%	-	-	-	-	-	-	67.0%		
			Narrative	The target has not been achieved. An exception report is provided.													

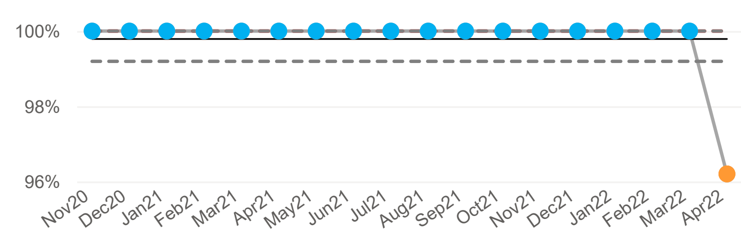


Integrated Performance Report (May 21 - Apr 22)

Quality

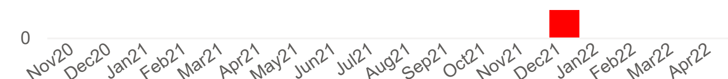
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU21	% of FOIs responded to within 20 days	Green 100% Red <100%	Contractual / Statutory	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%		

Narrative: The target has not been achieved. An exception report is provided.
SPC: Performance is lower than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.



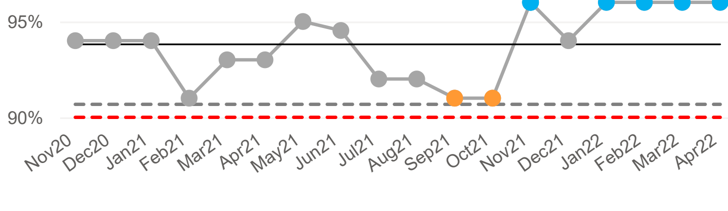
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU22	Number of IG incidents escalated to ICO	Green 0 Red >0	Contractual / Statutory	0	0	0	0	0	0	0	1	0	0	0	0		

Narrative: The target has been achieved



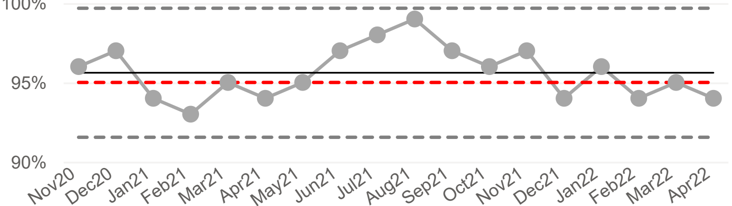
Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU60	NICE guidance compliance	Green =>90% Amber 85 - 89.9% Red <85%	Contractual	95.0%	94.5%	92.0%	92.0%	91.0%	91.0%	96.0%	94.0%	96.0%	96.0%	96.0%	96.0%		

Narrative: The target has been achieved.
SPC: Performance is higher than expected and the nature of variation indicates that the target is likely to be consistently achieved.



Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU23	% of policies in date	Green >=95% Amber 93.1 - 94.9% Red <93%	Contractual	95.0%	97.0%	98.0%	99.0%	97.0%	96.0%	97.0%	94.0%	96.0%	94.0%	95.0%	94.0%		

Narrative: The target has not been achieved and an exception report is provided.
SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.



Integrated Performance Report Month 1 2022/2023

Integrated Performance Report (May 21 - Apr 22)

Quality

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
QU24	NHS E/I Patient Safety Alerts: number not implemented within set timescale.	Green 0 Red >0	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target has been achieved													

5

0

Nov20 Dec20 Jan21 Feb21 Mar21 Apr21 May21 Jun21 Jul21 Aug21 Sep21 Oct21 Nov21 Dec21 Jan22 Feb22 Mar22 Apr22

Quality Exception Reports

E Coli (HOHA and COHA)	Target	Apr-22
	≤11 per year	2

Reason for non-compliance

2 HOHA E.coli bloodstream infections were identified in April 2022.

1 was a likely urinary source secondary to poor oral intake and fluid restrictions. No learning points were identified from this episode of infection.

- 1 remains unclear in source, possibly urinary. No learning points have been identified from this episode of infection.

Action taken to improve compliance

N/A

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

Klebsiella (HOHA and COHA)	Target	Apr-22
	≤8 per year	3

Reason for non-compliance

3 HOHA Klebsiella pneumoniae bloodstream infections were identified in April 2022.

Two infections are likely to be attributed to a GI source secondary to the patient's underlying condition. No learning points were identified from either episode of infection.

One infection is likely to be attributed to a urinary source. No learning points were identified from this episode of infection.

Action taken to improve compliance

N/A

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

MSSA bacteraemia (HOHA and COHA)	Target	Apr-22
	R: >5 per year A: 5 per year G: ≤4 per year	1

Reason for non-compliance

- 1 HOHA MSSA bloodstream infection was identified in April 2022. The source was attributed to an indwelling PICC line, which was removed upon identification of the infection.

Action taken to improve compliance

The clinical team are developing an action plan to address improved compliance with ANTT and documentation relating to indwelling devices.

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

Pseudomonas (HOHA and COHA)	Target	Apr-22
	≤1 per year	2

Reason for non-compliance

2 HOHA pseudomonas aeruginosa blood stream infections were identified in April 2022. The source in both cases is likely to be chest. The annual threshold of 1 has been exceeded.

No learning points were identified from either episode of infection.

Pseudomonas aeruginosa is an opportunistic pathogen that is often associated with water sources. As a precautionary measure, all outlets in patient room and in the sluice were tested. All were negative for any bacterial growth.

Action taken to improve compliance

N/A

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

Quality Exception Reports

Clostridioides difficile infections (HOHA and COHA)	Target	Apr-22
	≤17 per year	2

Reason for non-compliance

Two C.diff infections were identified in April, against an annual threshold of 17.

1 HOHA: The patient had presented with loose stools, however a sample was not obtained until day 3 of admission.

1 COHA: The patient was admitted with diarrhoea and has a recent history of C.diff. This is likely to be a recurring infection. Treatment was prescribed as advised by Microbiology. No learning points were identified from this episode of infection.

Definitions:

HOHA: Hospital-Onset Healthcare Associated, where days from admission to specimen date is equal to or greater than 3 days

COHA: Community-Onset Healthcare Associated, where days from admission to specimen date is equal to or less than 2 days, and patient has been discharged from the reporting trust within the last 28 days of this specimen date

Action taken to improve compliance

A task and finish group is being established, with the Matron, Ward and IPC staff involvement, to ensure timely sampling is embedded.

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

% of complex formal complaints resolved in month, which were resolved within 60 working days	Target	Apr-22
	R: <65% A: 65-74.9% G: 75%	67%

Reason for non-compliance

3 complex complaints were resolved in April; 2 of these were resolved within 60 working days.

Service pressures and staff absence in Q1 2021/22 created challenges to meeting the deadlines for complaints. There was also a delay due to the Christmas and New Year period.

The complainant was kept fully informed of the reasons for the delays and agreed to all renewed response dates.

Action taken to improve compliance

Ongoing complaints are discussed at the divisional quality and safety meetings to support the achievement of the targets.

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

% of FOIs responded to within 20 days	Target	Apr-22
	R: <100% G: 100%	96.2%

Reason for non-compliance

50 out of 52 FOI requests were responded to within 20 days.

This is the highest number of requests in any month in the last 2 years and significantly higher than in most months. The average per month was 30 in 2019/20 and 24 in 2020/21.

Prior to April, the target has been achieved for 23 consecutive months.

One of the requests taking over 20 days to respond to required responses from a number of teams, which created delay. Staff absence in the Information Governance Team has presented additional challenges to meeting the target.

Action taken to improve compliance

The Information Governance Team continue to work closely with staff across the Trust, to respond within 20 days.

Expected Date of Compliance	June 2022
Escalation Route	Information Governance Board, Risk and Quality Governance Committee, Quality Committee, Trust Board
Executive Lead	Julie Gray, Chief Nurse

% of Policies in Date	Target	Apr-22
	R: <93% A: 93-94.9% G: =>95%	94.7%

Reason for non-compliance

Out of a total of 266 policies, fourteen were out of date at the end of April, resulting in a compliance figure of 94.7%, marginally below the Trust target of 95%

5 policies are 1 month out of date. 5 are between 1 and 3 months out of date, 1 is between 3 and 6 months out of date and 3 are 6 or more months out of date.

Staff absence in the Information Governance Team has presented challenges to meeting the target.

Action taken to improve compliance

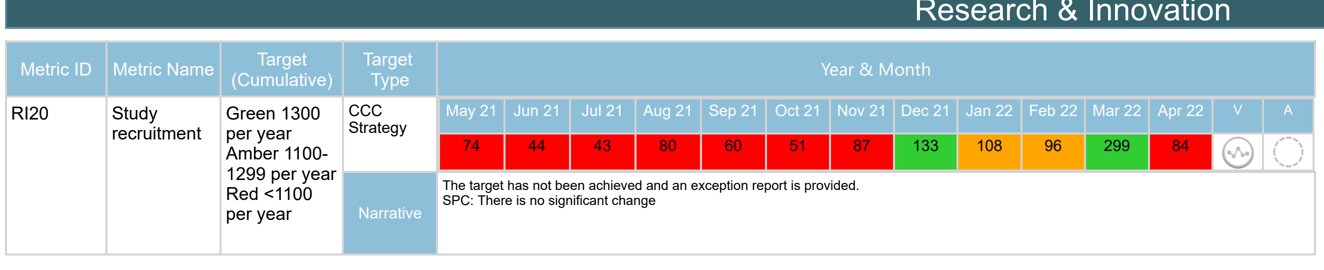
- Policy review reminders and instructions are sent to individual authors three months in advance of the review due, with further follow ups.
- Out of date policy information is reviewed at monthly Divisional meetings and Performance Reviews.
- Bi-monthly Document Control update reports are presented at the Information Governance Board
- Targeted meetings are held between Information Governance staff and Document Owners

Expected Date of Compliance	May 2022
Escalation Route	Information Governance Board, Divisional Performance Review, Risk and Quality Governance Committee, Quality Committee, Trust Board
Executive Lead	Liz Bishop, Chief Executive

Integrated Performance Report (May 21 - Apr 22)

Research & Innovation

Executive Director Lead: Medical Director

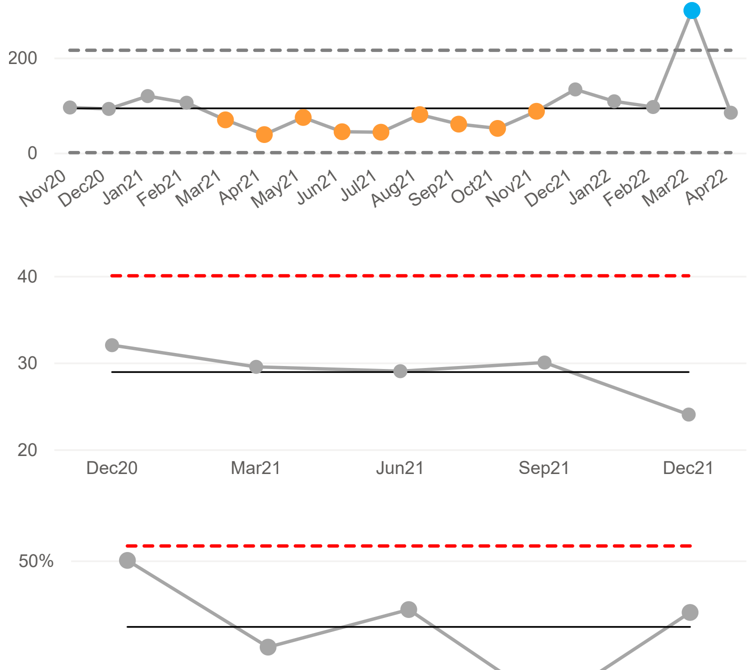


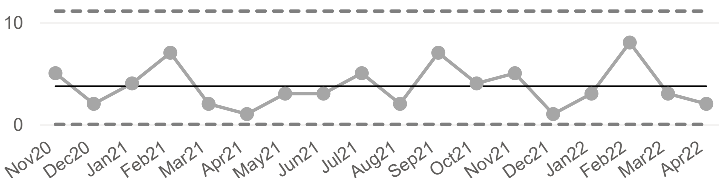
Metric ID	Metric Name	Target (Cumulative)	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
RI20	Study recruitment	Green 1300 per year Amber 1100-1299 per year Red <1100 per year	CCC Strategy	74	44	43	80	60	51	87	133	108	96	299	84		
			Narrative	The target has not been achieved and an exception report is provided. SPC: There is no significant change													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
RI03	Study set-up times in days	Green =40 days Red 0	National Reporting	-	29	-	-	30	-	-	24	-	-	-	-		
			Narrative	The latest performance has been reported in a previous IPR. This data is for the 12 month period up to the reported month i.e. Dec 2021 is 1/1/21 – 31/12/21													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
RI21	Recruitment to time and target	Green =55% Amber 45 - 54.9% Red <45%	National Reporting	-	33.0%	-	-	0.0%	-	-	32.0%	-	-	-	-		
			Narrative	The latest performance has been reported in a previous IPR. This data is for the 12 month period up to the reported month i.e. Dec 2021 is 1/1/21 – 31/12/21													

Metric ID	Metric Name	Target (Cumulative)	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
RI05	Number of new studies open to recruitment	Green =52 per year Amber 45 - 51 Red <45	CCC Strategy	3	3	5	2	7	4	5	1	3	8	3	2		
			Narrative	The target has not been achieved and an exception report is provided. SPC: There is no significant change													

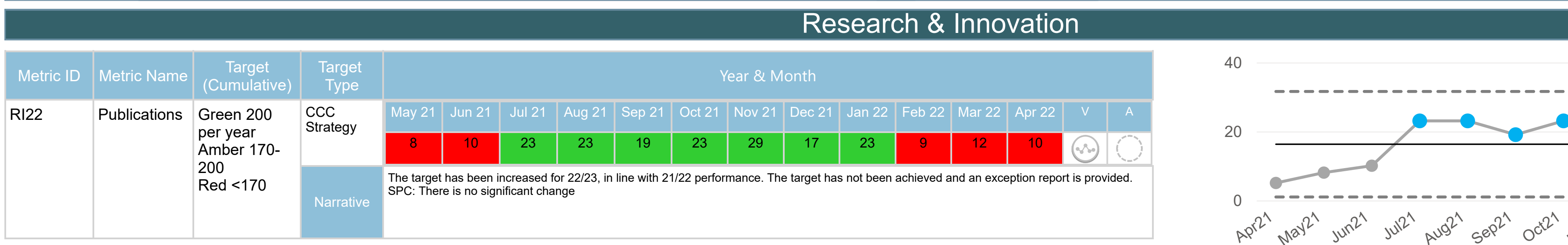




Integrated Performance Report Month 1 2022/2023

Integrated Performance Report (May 21 - Apr 22)

Research & Innovation



Metric ID	Metric Name	Target (Cumulative)	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
RI22	Publications	Green 200 per year Amber 170-200 Red <170	CCC Strategy	8	10	23	23	19	23	29	17	23	9	12	10		
			Narrative	The target has been increased for 22/23, in line with 21/22 performance. The target has not been achieved and an exception report is provided. SPC: There is no significant change													

Integrated Performance Report Month 1 2022/2023

Research & Innovation Exception Reports

Number of new studies open to recruitment	Target	Apr-22
	G: ≥5, A: 4-5, R: <4 (pr month)	2

Reason for non-compliance

- Two studies have opened to recruitment during April 2022 against an internal target of 4.3 in-month (47% of target) at the end of Month 1.
- Studies opened will ebb and flow throughout the year and in-month targets may not be met.
- Note: At the same time point last year we had opened one study.

CCC has issued local approval for capacity and capability (C&C) for seven additional studies. Due to sponsor requirements, Pharmacy has a second stage approval following C&C when the Site Initiation Visit (SIV) has been completed. This is to respond to any new information introduced by the Sponsor at the SIV. Currently six studies are awaiting second stage approval from Pharmacy and one study is awaiting activation by the Sponsor.

Action Taken to improve compliance

- Work with Chief Pharmacist and Lead Clinical Trials Pharmacist to open new drug studies.
- Work with the SRG Research Leads and the Network to optimise opportunities with observational studies.
- Work with Sponsors to greenlight study where all local approvals have been given.
- Work with Pharmacy to ensure second-stage approval following SIV is completed within 2-weeks.

Expected Date of Compliance	Q4 22/23
Escalation Route	SRG Research Leads, Committee for Research Strategy
Executive Lead	Sheena Khanduri, Medical Director

Publications	Target	Apr-22
	G: ≥17, A: 14-16, R: <14 (pr month)	10

Reason for non-compliance

Ten publications have been registered during April 2022, against an internal target of seventeen for the month (60% of target). There will be peaks and troughs with the number of publications throughout the year. This is dependent on journal review, journal publication and validation of outcome data. We would expect to see an increase around conference season.

Action Taken to improve compliance

- Work with the Library Services to ensure all publications are captured.
- Work with the SRG Research Leads and academics to ensure the list is accurate.
- Encourage staff to submit publications as part of the 'Achievements' request that is sent out each month.
- Note: at the same time point last year we had registered five publications.

Expected Date of Compliance	Q4 22/23
Escalation Route	SRG Research Leads, Committee for Research Strategy
Executive Lead	Sheena Khanduri, Medical Director

Study Recruitment	Target	Apr-22
	G: ≥108, A: 92 – 108, R: <92 (pr month)	84

Reason for non-compliance

84 patients have been recruited against an internal target of 108 (78% of target) at the end of Month 1. The main reasons at Month 1 for not achieving this target is:

- The Easter Bank Holiday period will have impacted on recruitment due to a reduction in capacity.
- Recruitment will ebb and flow throughout the year and in-month targets may not be met.
- Note: Recruitment in the month of April in 2022 is the highest it has been since reporting started in 2011.

Note: An additional 30 patients have been recruited compared to the same time point last year.

Action Taken to improve compliance

- Appointment of deputy Clinical Trial Pharmacist on 5th May 2022, awaiting start date.
- Recruitment to real world, psychosocial, radiotherapy and nursing research studies. Engaging with the PIs for these studies to maximise recruitment.
- Horizon scanning for potential new studies to open at CCC.
- Benchmarking studies at other sites to see if all potential studies we can open are open.
- Exploring collaboration opportunities within Cheshire & Merseyside region and other cancer centres.

Expected Date of Compliance	Q4 22/23
Escalation Route	SRG Research Leads, Committee for Research Strategy
Executive Lead	Sheena Khanduri, Medical Director

Integrated Performance Report (May 21 - Apr 22)

Workforce

Executive Director Lead: Director of Workforce and Organisational Development

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
WO01	Sickness absence	Green =4% Amber 4.1 - 4.9% Red =5%	Contractual / Statutory	4.2%	4.9%	4.7%	4.8%	4.7%	5.1%	5.5%	6.2%	7.0%	6.2%	5.6%	5.3%		
			Narrative	The target has not been achieved and an exception report is provided. SPC: Performance is higher than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
WO20	Sickness absence (short term)	Green =1% Amber 1.1 - 1.2% Red =1.2%	Contractual / Statutory	1.3%	1.4%	1.7%	1.8%	1.9%	2.1%	2.3%	3.1%	3.8%	2.2%	2.7%	3.0%		
			Narrative	This KPI has been introduced to the IPR for 22/23 in line with national reporting and other organisations. The target has not been achieved and an exception report (staff sickness) is provided. SPC: Performance is higher than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
WO21	Sickness absence (long term)	Green =3% Amber 3.1 - 3.5% Red =3.5%	Contractual / Statutory	3.0%	3.4%	3.4%	3.1%	3.1%	3.1%	3.4%	3.4%	3.2%	3.7%	3.0%	2.3%		
			Narrative	This KPI has been introduced to the IPR for 22/23 in line with national reporting and other organisations. The target has been achieved. SPC: Performance is lower than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
WO06	Staff Turnover (clinical staff): 12 month rolling	Green =14% Amber 14.1–14.9% Red =15%	Contractual / Statutory	15.9%	16.7%	17.7%	18.0%	18.1%	18.3%	17.8%	18.0%	18.4%	18.3%	17.9%	18.0%		
			Narrative	This KPI has been amended to include clinical staff only, in line with national reporting and other organisations. The target has not been achieved and an exception report is provided. An SPC chart will be included from M2 22/23.													

Integrated Performance Report Month 1 2022/2023

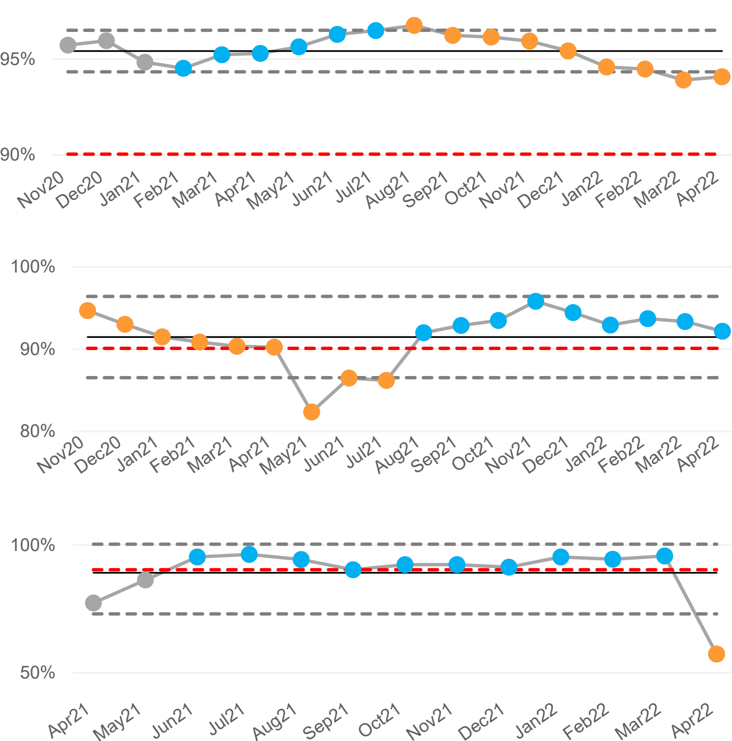
Integrated Performance Report (May 21 - Apr 22)

Workforce

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
WO07	Statutory Mandatory Training compliance	Green =90% Amber 75 - 89% Red =75%	Contractual / Statutory	95.6%	96.3%	96.5%	96.7%	96.2%	96.1%	95.9%	95.4%	94.6%	94.4%	93.9%	94.0%		
			Narrative	The target has been achieved. SPC: Performance is lower than expected, however the nature of variation indicates that the target is likely to be consistently achieved.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
WO22	Performance Development Reviews (PADR) snapshot month end	Green =90% Amber 75 - 89.9% Red =74%	Contractual	82.3%	86.4%	86.1%	91.9%	92.8%	93.4%	95.7%	94.4%	92.8%	93.6%	93.3%	92.1%		
			Narrative	The target has been amended from 95% to 90% for 22/23; this is in line with other organisations. The target has been achieved. SPC: Performance is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Target Type	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	V	A
WO23	Medical Appraisal	Green =90% Amber 75 - 89% Red =75%	Contractual / Statutory	86.0%	95.0%	96.0%	94.0%	90.0%	92.0%	92.0%	91.0%	95.0%	94.1%	95.4%	57.0%		
			Narrative	This KPI has been introduced to the IPR for 22/23 in line with other organisations. The target has not been achieved and an exception report is provided. SPC: Performance is lower than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Workforce Exception Reports

Medical Appraisal	Target	Apr-22
	G: ≥90% A: 75-89.9% R: ≤74%	57%

Reason for non-compliance

Four out of seven appraisals booked for April 2022 were completed, resulting in a compliance figure of 57% for April 2022.

The monthly percentage indicates how many were completed, of those booked each month, with the aim of completing all appraisals by 31st March each year. The compliance figure is therefore effectively cumulative for the year, with any not completed, re-booked for a later month. The cycle begins again on 1st April each year. Figures for 2021/22 show increasing compliance to above target within the first quarter and reflects the usual pattern of compliance each year. Compliance is therefore expected to improve within the next few months.

Staff absence has contributed to the low compliance in April 2022.

Action taken to improve compliance

The Trust is considering digital system options to support the management of medical appraisals, including the automatic alerting of appraisers and appraisees to due dates.

Expected Date of Compliance	June 2022
Escalation Route	Divisional Meetings, Workforce Transformation Committee, Quality Committee, Trust Board
Executive Lead	Sheena Khanduri, Medical Director

Staff Sickness Absence: Total and Short Term	Target	Apr-22
	G: ≤4% A: 4.01– 4.99% R: ≥ 5%	5.3%
	G: ≤1% A: 1.1 - 1.2% R: ≥1.3%	2.9%

Reason for non-compliance

The in-month figure for total staff sickness absence has decreased from 5.61% in March, to 5.28% in April 2022. This is a decrease for the second month; however, it is still above the Trust target of 4%.

The in-month figure for short term staff sickness absence has increased marginally from 2.74% in March, to 2.99% in April 2022, remaining above the target of 1%.

Chest and Respiratory problems remain the highest reason for absence with 109 episodes (92 Covid-19 related), unchanged from 109 Chest and Respiratory absences in March (75 Covid-19 related). We expect that this will begin to decrease as we enter the Spring and Summer months.

Anxiety, stress and depression is the second highest reason for absence and there has been an increase in episodes from 37 in March to 41 in April; this is an increase for the second month. The number of work-related absences has remained the same as last month at 3 episodes, showing that the increase in absences is due to personal reasons, with 38 episodes. There were 22 long-term absences, which is a decrease from 26 in the previous month, and 19 short-term episodes, which is an increase from 11.

Cold, cough and flu is now the third highest reason for absence and there has again been a decrease in the number of episodes from 46 in March to 32 in April.

Action taken to improve compliance

- The HRBP team continue to support managers in the monthly HR surgeries to ensure that all absences are reported accurately and closed in a timely manner.
- The HRBP team have begun to contact managers for information relating to the management of absences as part of the Attendance Management Policy audit. This is to provide assurance that absences are being managed appropriately and that the correct support is being provided.

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

Workforce Exception Reports

Staff Turnover: Clinical staff (12 month rolling)	Target	Apr-22
	G: ≤14% A: 14.1–14.9% R: ≥15%	18%

Reason for non-compliance

The rolling 12 month clinical staff turnover has increased marginally from 17.9% to 18%. This has been between 17.7% and 18.4% for the last 10 months, following a long period below 14% in the majority of 2020/21.

The number of leavers has increased from 22 in March, to 30 this month.

Relocation was the highest reason for leaving (7), with 2 moving back to other countries for personal reasons and 5 moving to a different location within the UK. In March, no staff left due to relocation.

Work Life Balance was the second highest reason for leaving (6), 1 of these moved to a GP practice for a promotion and another returned to Community Services. Only 2 remained within the NHS. In March, this was the highest reason for leaving, with 7.

Of the 30 leavers in April 2022, 10 completed an exit interview questionnaire (33.3%); an increase of 1 from last month.

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

- Following a period of sickness
- Career progression
- Less travel time and cost
- Lack of career opportunities

Action taken to improve compliance

- Following the success of the new approach to exit interviews, the HRBP team will continue to contact leavers directly and offer a face-to-face or MS Teams exit interview; this has increased uptake of exit interviews over the past few months.
- The HRBP team will start to collate data to identify any key themes to inform recommendations/ actions moving forwards.
- The HRBP team continue to support managers with Hybrid and Flexible Working both in HR surgeries and through training sessions to ensure this is applied consistently across the Trust.

Expected Date of Compliance	June 2022
Escalation Route	Divisional Meetings, Workforce Transformation Committee, Performance Review Meetings, Quality Committee, Trust
Executive Lead	Jayne Shaw, Director of Workforce and OD

Finance

Metric (£000)	In Mth 1 Actual	In Mth 1 Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	25	41	(16)	
CPL/Propcare Surplus/ (Deficit)	127	0	127	
Control Total Surplus/ (Deficit)	152	41	111	
Group Cash holding	62,911	51,858	11,053	
Capital Expenditure	71	0	(71)	
Agency Cap	49	95	46	

For 2022/23 the Cheshire & Merseyside ICS are managing the required financial position of each Trust through a whole system approach. The Trust has put a draft plan forward for a £291k surplus. The Trust position is reliant upon receiving Elective Recovery Funding (ERF) of £9m for activity over and above 104% of 2019.20.

The Trust financial position to the end of April is a £25k surplus, the group consolidated position is a £152k surplus. The Trust cash position is a closing balance of £62.9m, which is £11.1m above plan. Capital spend is £71k in month with the majority of planned spend being in the second half of the year.

REPORT COVER

Report to:	Trust Board	
Date of meeting:	25th May 2022	
Agenda item:	P1-97-22	
Title:	Finance Report - Month 1	
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 1 2022-23.

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

Next steps required:	N/A

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.	☒

☐ 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.

Finance Report

James Thomson - Director of Finance

Version: 1.0 Ref: FCGOREPO Review: May 2024

Contents

1.0 Introduction

2.0 Summary Financial Performance

3.0 Operational Financial Profile – Income and Expenditure

4.0 Cash and Capital

5.0 Balance Sheet Commentary

6.0 Recommendations

1. Introduction

1.1 This paper provides a summary of the Trust's financial performance for April 2022, the first month of the 2022/23 financial year.

Colleagues are asked to note the content of the report, and the associated risks.

2. Summary Financial Performance

2.1 For April the key financial headlines are:

Metric (£000)	In Mth 1 Actual	In Mth 1 Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	25	41	(16)	
CPL/Propcare Surplus/ (Deficit)	127	0	127	
Control Total Surplus/ (Deficit)	152	41	111	
Group Cash holding	62,911	51,858	11,053	
Capital Expenditure	71	0	(71)	
Agency Cap	49	95	46	

2.2 For 2022/23 the Cheshire & Merseyside ICS are managing the required financial position of each Trust through a whole system approach. The Trust has put a draft plan forward for a £291k surplus. The Trust position is reliant upon receiving Elective Recovery Funding (ERF) of £9m for activity over and above 104% of 2019.20.

3. Operational Financial Profile – Income and Expenditure

3.1 Overall Income and Expenditure Position

The Trust financial position to the end of April is a £25k surplus, the group consolidated position is a £152k surplus. The Trust cash position is a closing balance of £62.9m, which is £11.1m above plan. Capital spend is £71k in month with the majority of planned spend being in the second half of the year.

The Trust is under the agency cap by £46k in month.

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

Metric (£000)	Actual M1	Trust Plan M1	Variance	Draft Trust Annual Plan
Clinical Income	18,664	18,576	89	222,895
Other Income	1,973	2,456	(483)	21,535
Total Operating Income	**20,637**	**21,031**	**(394)**	**244,430**
Total Operating Expenditure	(20,275)	(20,644)	369	(239,979)
Operating Surplus	**362**	**388**	**(26)**	**4,451**
PPJV	31	67	(36)	804
Finance Costs	(368)	(414)	45	(4,964)
Trust Surplus/Deficit	**25**	**41**	**(16)**	**291**
Subsiduaries	127	0	127	**0**
Consolidated Surplus/Deficit	**152**	**41**	**111**	**291**

The table below summaries the consolidated financial position:

April 2023 (£000)	In Month Actual
Trust Surplus / (Deficit)	(57)
Donated Depreciation	82
Trust Retained Surplus / (Deficit)	**25**
CPL	49
Propcare	78
Consolidated Financial Position	**152**

3.3 **Expenditure Position**

3.3.1 The bridge below shows the key drivers between the £25k in month surplus and £41k surplus plan, which is a variance of £16k:

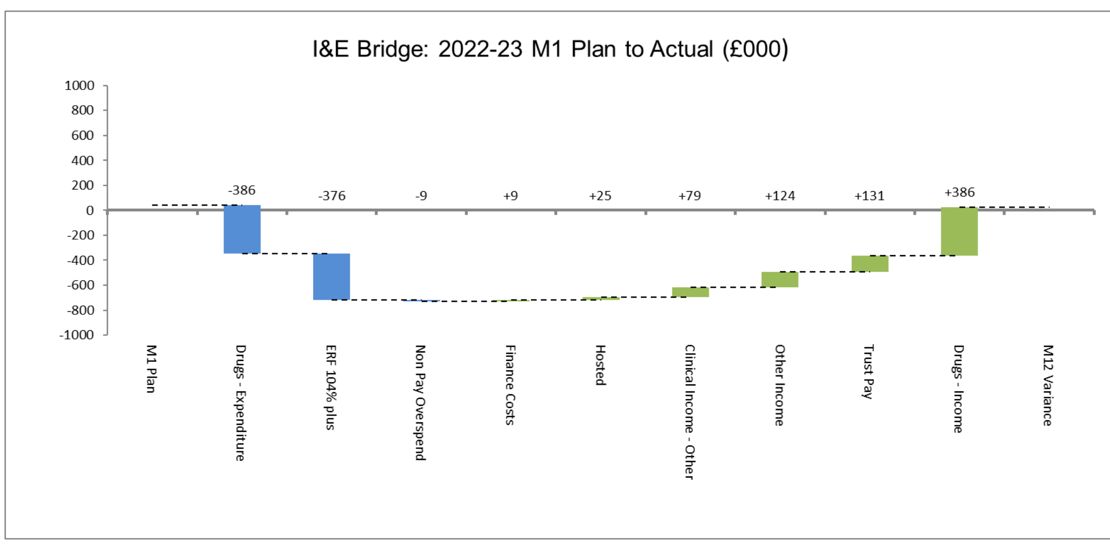
- Elective recovery (ERF) Income for activity over 104% of 2019.20 has been assumed at 50% of plan and so is showing a £375k under recovery against the income plan of £751k. The Trust is currently reviewing activity against the plans and awaiting feedback nationally for the calculation. This was a prudent approach due to current unknown elements within the calculation.

- Pay costs are underspent by £131k, this is expected due to a number of vacancies across Divisions, as well as slippage on investments. In terms of run rate Divisional pay spend is in line with the previous 2 months.

- Bank spend remains high at £120k however, this is a reduction compared to previous months, this is mainly due to sickness cover including covid.

- Drugs spend is over plan by £386k. This is offset by an increase in drugs income. As part of the 2022.23 funding agreement with commissioners high cost drugs remain on a pass-through basis.

- Non-Pay costs are showing an overspend of £9k.



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3.4 ERF Position

The CCG and NHSE Contracts include an element of block income block for Elective Recovery activity up to 104% of 2019.20 activity level. We will received £701k from CCGs and £3.1m from NHSE if the Trust achieve this level of activity.

For activity over and above 104% of 2019.20 the Trust will receive additional income at 75% of tariff. Based on predicted activity levels and assumptions around the calculation the Trust have assumed a further £9m expected ERF Income as part of the financial plan.

For month 1 reporting the Trust has assumed receipt of the ERF income up to 104% of activity. The plan for month 1 for ERF over 104% is £751k. The Trust has assumed 50% of this in the month 1 position while the activity data is reviewed nationally and the income figure generated.

3.5 Bank and Agency Reporting

Bank spend in April remains high at £120k, however, has shown a reduction since March. 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 £49k. The Trust is reporting £46k under the agency cap in month.

See Appendix F for further detail.

3.6 **Cost Improvement Programme (CIP)**

The Trust CIP requirement for 2022.23 is £6.765m.

This is broken down into 3% recurrent and 1.5% non-recurrent.

The £2.3m non-recurrent element will be met centrally by the Trust. Of the remaining £4.4m recurrent element, £1m will be met by reserves and the remaining £3.4m allocated to the Divisions.

Target		6,765,000
NR Contingency		2,300,000
Balance		**4,465,000**
Reserves		1,000,000
Divisional Allocation		3,465,000

As at month 1 against the expected year to date target of £536k target there is a shortfall of £245k.

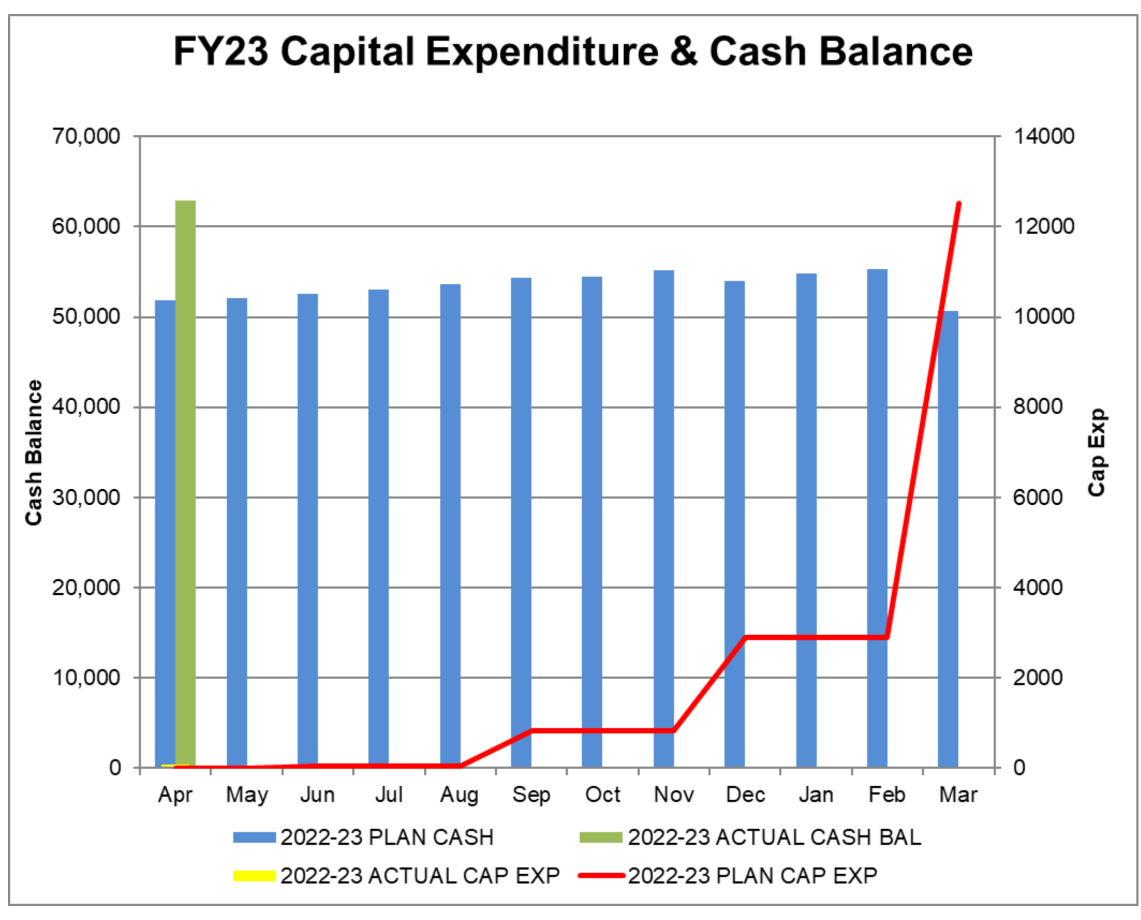
4. Cash and Capital

4.1 The original 2022/23 capital plan approved by the Board in March was £7.187m.

4.2 Capital expenditure of £71k has been incurred to the end of April. The majority of capital spend is profiled to be spent in the second half of the year. Capital Investment Group closely monitor the position to ensure any slippage risk is identified and mitigated.

4.3 The capital programme is supported by the organisation's cash position. The Trust has a current cash position of £62.9m, which is a positive variance of £11.1m to the cash-flow plan.

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 2022/23. It shows that for April the Trust has more cash than originally planned.

5. Balance Sheet Commentary

5.1 Current Assets

Cash and cash equivalents are £11m better than plan.

5.2 Current Liabilities

Payables (non-capital creditors) are showing a reduction of £7.58m against plan.

Deferred Income is £8.7m above plan. This relates to R&I income and Cancer Alliance with a number of multi-year schemes which are ongoing.

6. Recommendations

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

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

Appendix A – Statement of Comprehensive Income (SOCI)

(£000)	Month 1 Plan	Month 1 Actual	Month 1 Variance	%	2022/23 Annual Plan
Clinical Income	18,516	18,606	90		222,195
Other Income	667	791	124		7,895
Hosted Services	1,848	1,239	(608)		14,339
Total Operating Income	**21,031**	**20,637**	**(394)**	**2%**	**244,430**
Pay: Trust (excluding Hosted)	(6,144)	(6,014)	131		(73,852)
Pay: Hosted & R&I	(700)	(526)	173		(8,260)
Drugs expenditure	(7,695)	(8,081)	(386)		(92,340)
Other non-pay: Trust (excluding Hosted)	(4,913)	(4,922)	(9)		(58,906)
Non-pay: Hosted	(1,192)	(732)	460		(6,621)
Total Operating Expenditure	**(20,644)**	**(20,275)**	**369**	**2%**	**(239,979)**
Operating Surplus	**388**	**362**	**(26)**	**7%**	**4,451**
Profit /(Loss) from Joint Venture	67	31	(36)		804
Interest receivable (+)	386	415	30		4,626
Interest payable (-)	(434)	(429)	5		(5,213)
PDC Dividends payable (-)	(365)	(354)	11		(4,377)
Trust Retained surplus/(deficit)	**41**	**25**	**(16)**		**291**
CPL/Propcare	0	127	127		0
Consolidated Surplus/(deficit)	**41**	**152**	**111**		**291**

Appendix B – Balance Sheet

£'000	Unaudited 2022	Plan 2023	Year to date Month 1		
			YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	3,211	3,162	2,956	3,183	227
Property, plant & equipment	184,599	173,627	176,606	183,872	7,266
Investments in associates	977	800	800	1,008	208
Other financial assets	121,318	115,276	118,709	121,318	2,609
Trade & other receivables	449	434	433	643	210
Other assets	0	0	0	0	0
Total non-current assets	**310,554**	**293,298**	**299,504**	**310,025**	**10,521**
Current assets					
Inventories	3,504	3,000	2,092	2,513	421
Trade & other receivables					
NHS receivables	7,739	7,084	6,806	3,220	(3,586)
Non-NHS receivables	7,904	10,915	10,486	8,984	(1,502)
Cash and cash equivalents	76,701	50,708	51,858	62,911	11,053
Total current assets	**95,847**	**71,707**	**71,242**	**77,629**	**6,386**
Current liabilities					
Trade & other payables					
Non-capital creditors	37,170	32,207	32,880	25,300	(7,581)
Capital creditors	6,918	1,958	1,998	1,871	(128)
Borrowings					
Loans	1,730	1,730	1,730	1,730	0
Obligations under finance leases	0	0	0	0	0
Provisions	3,022	94	99	3,022	2,923
Other liabilities:-					
Deferred income	15,669	5,577	5,477	14,272	8,795
Other	0	0	0	0	0
Total current liabilities	**64,510**	**41,565**	**42,185**	**46,195**	**4,010**
Total assets less current liabilities	**341,892**	**323,440**	**328,562**	**341,459**	**12,897**
Non-current liabilities					
Trade & other payables					
Capital creditors	0	0	0	0	0
Borrowings				0	
Loans	32,090	30,360	32,090	32,090	0
Obligations under finance leases	0	0	0	0	0
Other liabilities:-				0	
Deferred income	1,064	1,018	1,064	1,064	(0)
Provisions	0	115	527	0	(527)
PropCare liability	122,540	113,436	116,869	122,540	5,670
Total non current liabilities	**155,693**	**144,929**	**150,550**	**155,693**	**5,143**
Total net assets employed	**186,198**	**178,511**	**178,011**	**185,766**	**7,754**
Financed by (taxpayers' equity)					
Public Dividend Capital	72,219	72,219	72,219	72,219	0
Revaluation reserve	4,558	2,699	2,699	4,558	1,859
Income and expenditure reserve	109,421	103,593	103,093	108,989	5,896
Total taxpayers equity	**186,198**	**178,511**	**178,011**	**185,766**	**7,754**

Version: 1.0 Ref: FCGOREPO Review: May 2024

Appendix C – Cash Flow

April (Month 1) 2022.23	FT	Group (exc Charity)	Group
Cash flows from operating activities:			
Operating surplus	(95)	72	797
Depreciation	4	4	4
Amortisation	764	764	764
Impairments			0
Movement in Trade Receivables	3,244	13,420	13,505
Movement in Other Assets	0	0	0
Movement in Inventories	991	857	857
Movement in Trade Payables	(11,917)	(18,618)	(18,630)
Movement in Other Liabilities	(529)	(1,243)	(1,046)
Movement in Provisions	(867)	(146)	(146)
CT paid	0	(35)	(35)
Net cash used in operating activities	**(8,406)**	**(4,925)**	**(3,931)**
Cash flows from investing activities			
Purchase of PPE	(4,325)	(4,325)	(4,325)
Purchase of Intangibles	(737)	(737)	(737)
Proceeds from sale of PPE	0	0	0
Interest received	415	32	48
Investment in associates	0	0	0
Net cash used in investing activities	**(4,647)**	**(5,030)**	**(5,014)**
Cash flows from financing activities			
Public dividend capital received	0	0	0
Public dividend capital repaid			
Loans received			
Movement in loans	47	47	54
Capital element of finance lease	0	0	0
Interest paid	(429)	(47)	(54)
Interest element of finance lease	0	0	0
PDC dividend paid	(354)	(354)	(354)
Finance lease - capital element repaid	0	0	0
Net cash used in financing activities	**(737)**	**(354)**	**(354)**
Net change in cash	**(13,790)**	**(10,309)**	**(9,299)**
Cash b/f	**76,701**	**80,726**	**82,815**
Cash c/f	**62,911**	**70,417**	**73,124**

Appendix D – Capital

Capital Programme 2022-23
Month 1

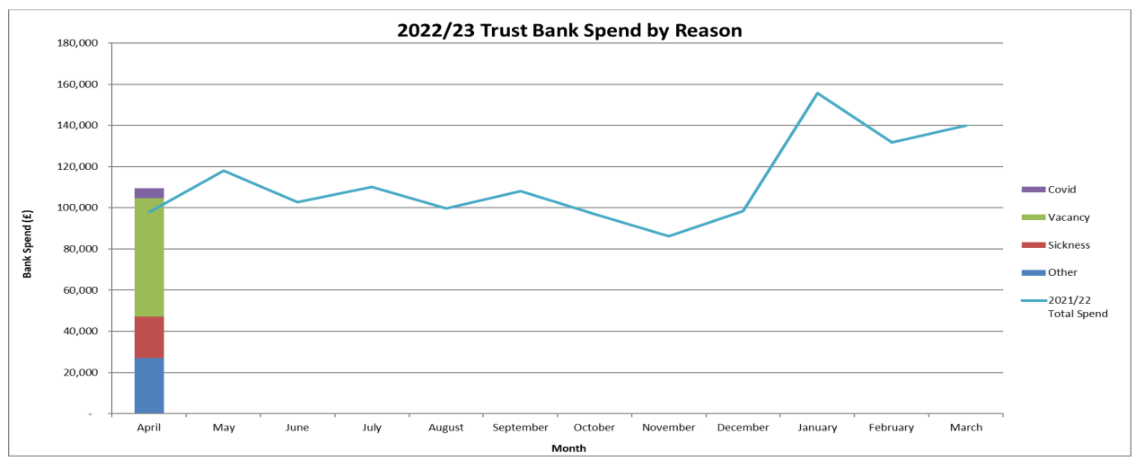
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

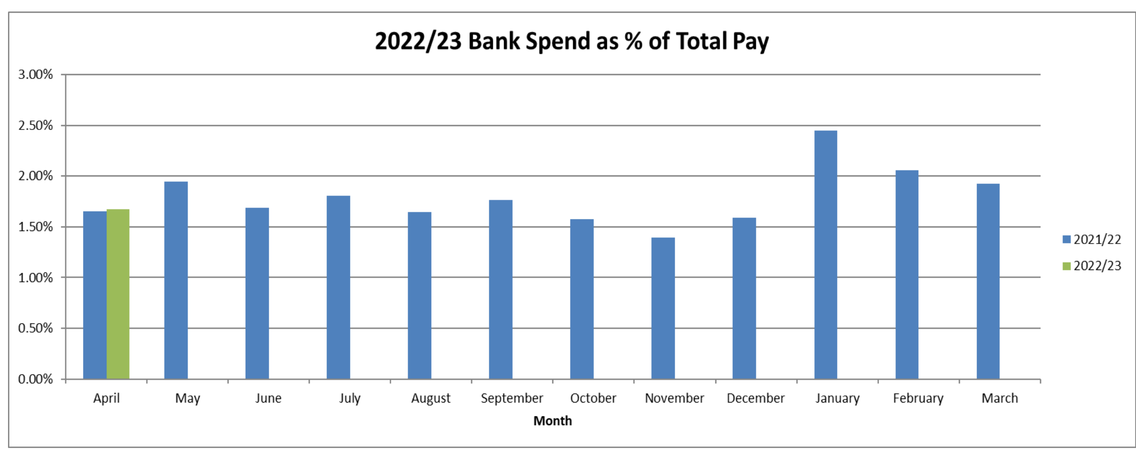
Code	Scheme	Lead	BUDGET (£'000) NHSI plan 22-23	Approved Adjustments	Budget 22-23	ACTUALS (£'000) Actuals @ Month 1	Variance to Budget	FORECAST (£'000) Forecast 22-23	Variance to Budget	Ordered?	Complete?	Comments
4142	***(21/22)*** TCC - Liverpool	Peter Crangle	0	0	0	0	(0)	0	(0)			
4142	***(21/22)*** TCC - Liverpool - Artwork	Sam Wade	0	0	0	(1)	1	(1)	1			
4142	***(21/22)*** TCC - Link Bridge installation	Peter Crangle	0	0	0	6	(6)	6	(6)			
4306	***(21/22)*** CCCL Ward 2 Sluice	Jeanette Russell	0	0	0	0	(0)	0	(0)			
4307	***(21/22)*** CCCL Ward 4/5 bathroom conv	Pris Hetherington	0	56	56	0	56	56	0	✕	✕	Charity funded
	CCC-A Cherry linac replacement		160	0	160	0	160	160	0	✕	✕	
	Major roofing works		500	0	500	0	500	500	0	✕	✕	
	6 Facet lifecycle		533	0	533	0	533	533	0	✕	✕	
	Contingency	*n/a*	200	0	200	0	200	195	5	-	-	
	Estates		**1,393**	**56**	**1,449**	**5**	**1,444**	**1,449**	**(0)**			
4180	***(19/20)*** CCCL HDR & Papillon tfr costs		0	0	0	11	(11)	11	(11)			
4192	***(19/20)*** Cyclotron	Carl Rowbottom	450	0	450	10	440	450	0			
4400	Hand Hygiene Scanner		0	0	0	12	(12)	12	(12)	✓	✓	Transferred from revenue
	CCC-A Cherry linac replacement		2,460	0	2,460	0	2,460	2,460	0	✕	✕	
	HDR Brachytherapy equip (Applicators)		110	0	110	0	110	110	0	✕	✕	
	Aria Software		500	0	500	0	500	500	0	✕	✕	
	Contingency	*n/a*	400	0	400	0	400	377	23	-	-	
	Medical Equipment		**3,920**	**0**	**3,920**	**33**	**3,887**	**3,920**	**0**			
4138	***(21/22)*** Infrastructure	James Crowther	0	0	0	34	(34)	34	(34)			
4317	***(21/22)*** Intelligent Automation (RPA)	James Crowther	0	0	0	(0)	0	(0)	0			
	VDI expansion		455	0	455	0	455	455	0	✕	✕	
	Core IT programme		785	0	785	0	785	752	33	✕	✕	
	Server/Citrix/Cyber upgrade		360	0	360	0	360	360	0	✕	✕	
	Website		100	0	100	0	100	100	0	✕	✕	
	IM&T		**1,700**	**0**	**1,700**	**33**	**1,667**	**1,700**	**(0)**			
	CDC National PDC		5,500	0	5,500	0	5,500	5,500	0	✕	✕	
	IFRS 16 - Chemo Cars		0	0	0	0	0	0	0	✕	✕	
	Other		**5,500**	**0**	**5,500**	**0**	**5,500**	**5,500**	**0**			
	TOTAL		**12,513**	**56**	**12,569**	**71**	**12,498**	**12,569**	**(0)**			

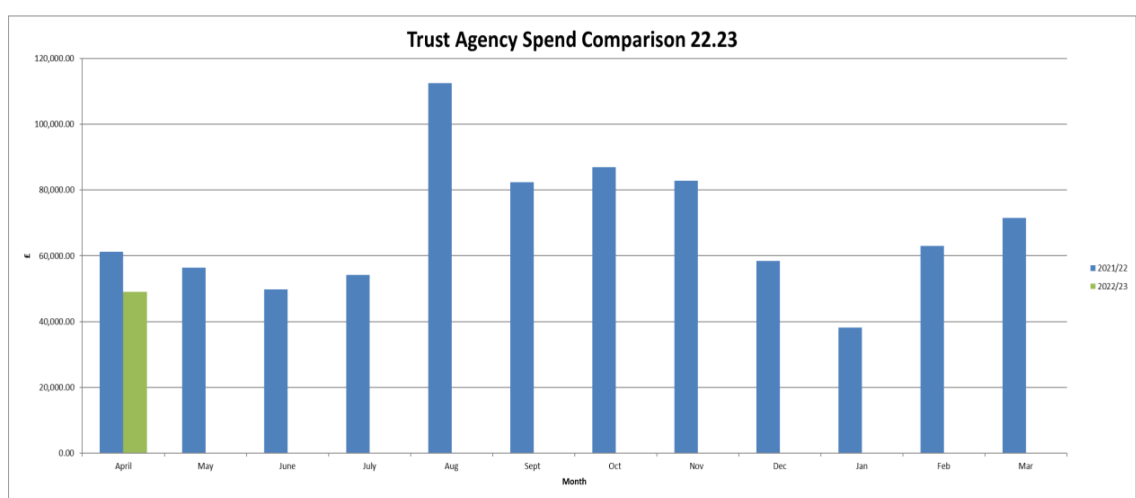
Appendix E – CIP

Detailed schemes to be updated from M2

Appendix F – Bank and Agency







Version: 1.0 Ref: FCGOREPO Review: May 2024

REPORT COVER

Report to:	Trust Board	
Date of meeting:	25 May 2022	
Agenda item:	P1-98-22	
Title:	Consultant Appointment	
Report prepared by:	Catherine Hignett-Jones	
Executive Lead:	Sheena Khanduri	
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	
Date & decision:	

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

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

Next steps required:	N/A

REPORT COVER

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

☒ BE **OUTSTANDING**

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

☐ BE **COLLABORATIVE**

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

☒ BE **RESEARCH LEADERS**

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

☒ BE **A GREAT PLACE TO WORK**

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

☐ BE **DIGITAL**

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

☐ BE **INNOVATIVE**

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

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

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

Version 1.0 Ref: FCGOREPCOV Review: May 2024

Introduction

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

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

Name	Dr Nils Elander
Job Title	Consultant Medical Oncologist –HPB
Qualifications	• Associate Professor - Linköping University • Medical Oncology Chief Physician qualification - Region Östergötland • Specialist in Oncology- National Board of Health and Welfare • PhD -Linköping University • University Medical Degree - Linköping University
Speciality	HPB
GMC number	GMC: 7474035
Membership/Appointments	
Details	Dr Elander was previously employed by Linköping University Hospital in Sweden as Chief Physician in the Department of Oncology. Here Dr Elander was the Head of the Division for gastrointestinal, urological and dermatological medical oncology. Dr Elander has a PhD degree on genetic variations in colorectal cancer and subsequently completed his post doc at the University of Liverpool (2014-2015), under Prof. Palmer and also working at The Clatterbridge Cancer Centre NHS Foundation Trust. He established a research team at Linkoping University and has published in total 25 papers in scientific peer-reviewed medical journals including real world evidence on palliative chemotherapy in advanced HPB cancers, and use of prognostic biomarkers.

REPORT COVER

Report to:	Board of Directors
Date of meeting:	25 May 2022
Agenda item:	P1-99-22
Title:	Board Assurance Framework 2022-23 Update
Report prepared by:	Gilly Conway, Managing Director, Conway Bloomfield Ltd
Executive Lead:	Liz Bishop, Chief Executive
Status of the report: (please tick)	Public ☒ Private ☐

Paper previously considered by:	Audit Committee
Date & decision:	14 April 2022 endorsed the refreshed strategic risks for Board approval; approved the proposal to improve the BAF

Purpose of the paper/key points for discussion:	Strategic risks for 2022-23 BAF are presented for Board approval. Provides a summary of outcomes from the Board strategic risk workshop in February and an outline plan to develop the BAF in two phases of work (for noting).

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

Next steps required:	A new style report of the full BAF will be presented to the Board 27 July 2022 Project to be scoped to transfer BAF to Datix by April 2023

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**

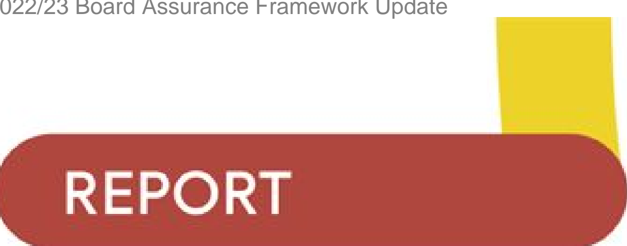
BAF Risk	
If we do not invest a clear vision, sufficient capacity and investment in our digital programme and teams there is a risk that the Trust will not achieve its digital ambition.	☐
If the Trust is hit by a Cyber/ransomware attack, there is a risk that all systems could be disabled resulting in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

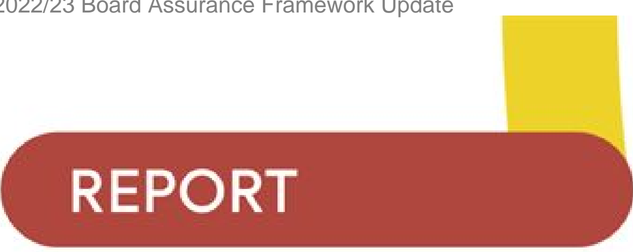
If YES to one or more of the above please add further detail and identify if a full impact assessment is required.



Board Assurance Framework 2022-23

Gilly Conway, Managing Director, Conway Bloomfield Ltd

Version: 1.0 Ref: FCGOREPO Review: May 2024



1.0 Executive Summary

Introduction

1.1 A recent internal audit review of the Trust's BAF confirmed that it meets the basic NHS requirements, however, it found limited evidence of engagement with the content of the BAF at Board or Committees. In addition, GGI's Well-led Review for the Trust found that the Trust could extract more value from the BAF than it does currently.

1.2 The Board participated in an externally facilitated workshop 23 February 2022 to refresh the Trust's strategic risks, and to discuss the existing BAF approach with reference to good practice.

1.3 This report provides a summary of the outcomes from the workshop, including a set of refreshed strategic risks, and an outline plan to develop the BAF in response to the Board's suggestions. This report was first presented to the Audit Committee 14 April 2022. The Committee agreed to recommend the proposed strategic risks for 2022-23 to the Board, and it approved the initial work to improve the BAF for this year.

Strategic risk refresh

1.4 Appendix 1 sets out the proposed risks for 2022-23 compared with the existing risks from the 2021-22 BAF. Each risk has an Executive lead and is assigned to either the Board or one of its Committees for oversight and scrutiny.

BAF development

1.5 A number of limitations and risks in relation to the current BAF approach have been identified and informed by external reviews. Taking into account suggestions made during the Board workshop in February, steps are being taken to improve the BAF during Q1 and a further phase of work will be scoped to incorporate the BAF into the Trust's risk management system, Datix Cloud IQ.

Recommendations

1.6 The Board is requested to:

- approve the revised set of strategic risks for 2022-23 and the lead Committees (Appendix 1);
- note the immediate steps being taken to improve the BAF ready for the Q1 report to the Board in July;
- note the direction of travel for incorporating the BAF into the Trust's risk management software by April 2023.

2.0 Introduction

2.1 Under the NHSI/CQC Well-Led Framework, NHS trusts need to ensure 'there is an effective and comprehensive process to identify, understand, monitor and address current and future risks'. This should include a Board Assurance Framework (BAF) that is assessed by the Board at least quarterly.

2.2 The BAF is an important component of the Trust's corporate governance and risk management framework. It is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives by ensuring it has appropriate oversight of the associated risks. It should aid transparency by mapping assurance evidence to key controls, and a properly used BAF will drive the forward work plans and agendas for the Board and its Committees.

2.3 A recent internal audit review of the Trust's BAF confirmed that it meets the basic NHS requirements, however, it found limited evidence of engagement with the content of the BAF at Board or Committees. In addition, GGI's Well-led Review for the Trust found that the Trust could extract more value from the BAF than it does currently and recommended that it should be used actively to shape the work of the Board, helping to rationalise congested agendas.

2.4 The Board participated in an externally facilitated workshop 23 February 2022 to refresh the strategic risks that form the basis of the BAF, and to discuss how the existing BAF approach compares with good practice.

2.5 This report provides a summary of the outcomes from the workshop, including a set of refreshed strategic risks, and an outline plan to develop the BAF in response to the Board's suggestions.

3.0 Strategic risk refresh

3.1 It is good practice to conduct an annual review of the strategic risks that are monitored and reported through the BAF to ensure they remain relevant in the context of strategic objectives and the Trust's operating environment.

3.2 The Board undertook a process of refreshing the strategic risks with external facilitation, involving a questionnaire for all Board members to provide their input, a Task & Finish Group workshop to discuss the findings, and further discussion during the full Board workshop 23 February.

3.3 Many of the existing risks remained broadly relevant, however, the articulation has been altered to ensure clearer distinction between a risk and its consequences in relation to strategic priorities. The resulting set of risks was circulated to the Executive team for review in March and their final amends have been incorporated.

3.4 Appendix 1 sets out the 15 proposed risks for 2022-23 compared with the 12 existing risks from the 2021-22 BAF. Each risk is assigned an Executive lead who will be accountable to the Board for the management of the risk. Each risk will also be assigned to either the Board or one of its Committees for oversight and scrutiny. The recent governance restructure that was approved by the Board 30 March 2022 presented an opportunity to review where each risk should be reported.

The Board should consider whether the stated lead assurance forum seems the most appropriate for each risk.

4.0 BAF development

4.1 The existing BAF is held as a document in Microsoft Word. It is updated quarterly through a series of meetings between the Associate Director of Corporate Governance and Executive risk owners. Historically, updating the BAF has predominantly relied on verbal information being provided during these meetings, and the changes since the last quarter are highlighted in yellow in the Board report.

4.2 The current BAF process presents a number of limitations and risks.

- Efficiency: gathering and maintaining the data inputs is labour-intensive.
- Insightfulness: the data cannot be manipulated and easily analysed in the current format.
- Ownership: the process built around one master document that requires central coordination precludes risk owners from having control or a ‘live’ view of their sections of the BAF.
- Accuracy: the manual steps in the process carry a high risk of error with limited audit trail.
- Currency: the BAF is a relatively static document rather than a dynamic tool that can provide an up-to-date view of key risk and assurance information at any time.
- Relevance: the BAF is a stand-alone document with no clear linkage to sources of evidence, Board and Committee agendas, or operational risk profiles.
- Engagement: the BAF is not user-friendly or insightful, which hinders the discussions at Board and Committees meetings, and limits its value as a governance tool.

4.3 At the Board workshop 23 February, the Board was reminded of the key principles that should underpin a useful BAF. These focused on:

- overarching purpose of the BAF;
- structure that demonstrates alignment between strategic objectives, risks, key controls, assurances, and actions to address control and assurance gaps;
- definitions of controls and assurances;
- quality of assurances, including the detail that is useful to include in the BAF;
- accountabilities and information flows.

4.4 The Board was shown examples from elsewhere and an overview of emerging best practice, which included use of software for the management and reporting of the BAF. This facilitates robust and efficient data management with a transparent audit trail, tailored analysis and reporting for different audiences, and greater control and ownership for risk owners.

4.5 Through discussion in groups during the workshop, it was acknowledged that the current BAF is a comprehensive document, provides a dashboard-style overview linked to strategic priorities, and indicates changes in risk scores since the last reporting period. A number of aspects identified for improvement are summarised in the table below.

Table 1: summary of suggested BAF improvements from Board workshop 23/02/22	
Format / presentation	• The alignment between risks, risk ratings, controls, assurances, gaps and actions could be clearer • It could be streamlined to improve the flow and make it more user-friendly • Summary analysis could be better presented and should focus on highlighting key changes and exceptions
Board and Committees' oversight	• BAF should inform agendas, currently the connection isn't clear and risk discussions take place without cross-reference to the BAF • Clarify the information flow through the governance structure and key responsibilities re BAF • Increase focus on the actions to address control and assurance gaps • Committees should ask themselves whether or not they are assured by the evidence presented
Content	• BAF should link/signpost to evidence-based assurances • Need for clearer and consistent definitions of controls and assurances • Controls and assurances need review/streamlining to ensure they are relevant and sufficiently strategic • Distinction between internal and external assurances should be included to indicate degree of independence • Introduce assurance ratings to indicate the level of assurance for key controls
BAF process	• Current format presents problems around version control and tracking of changes over time • It would be difficult to locate the source information for assurances in the current approach, which hinders scrutiny • A software solution could provide more efficient and insightful analysis • Support for the idea of risk owners and their senior teams being able to update information directly • Transition of the Trust's risk management system to Datix Cloud IQ presents an opportunity for systematising the BAF, which would also allow it to be incorporated in future plans for a data warehouse

5.0 Solutions

Phase 1

5.1 In response to the Board's comments and suggestions, there are aspects of the existing BAF that will be addressed ready for Q1 reporting (July 2022). In the short-term, the format and precision of the content can be improved, and the focus through the work of the Board and its Committees strengthened. In summary, this work involves:

- restructuring the lay-out of the BAF to provide clearer alignment (see new template, Appendix 2);
- designing a simple reporting template to highlight key analysis, exceptions, and next steps;

- population of the BAF detail with each Executive risk lead, including review of key controls and assurances, for the refreshed strategic risks;
- clarifying the definitions of controls and assurances and setting a consistent format for describing them in the BAF;
- introducing an assurance rating system to indicate the assessed strength of controls (Acceptable, Partial, or Low).

5.2 When the refreshed BAF detail has been fully populated and reviewed by the Board as part of the Q1 BAF update in July, the Board and Committee workplans will be cross-referenced with the BAF to ensure appropriate coverage of the key controls through the cycle of business. Reporting of individual risks to lead Committees is planned to commence after the Q1 update to the Board.

Phase 2

5.3 Aspects relating to managing the BAF process through the Trust's risk management system, Datix Cloud IQ, will be scoped with the software provider and necessitates a longer lead-time to ensure that Datix is configured to provide the desired functionality. It is anticipated that this transition would address many of the issues identified in this report concerning efficiency, insightfulness, ownership, accuracy, currency, and relevance (see para 3.2). The transition will facilitate links to be made with operational risks and improve the flow of risk information.

5.4 The phase 1 work being carried out to refine the BAF during 2022-23 will help establish improved usage of the BAF and will ensure that data to be transferred to Datix is of good quality.

5.4 The target timeline would be to have the BAF built and tested within the Datix system by April 2023. A proposal will be provided to the Audit Committee once the project has been scoped in more detail.

6.0 Recommendations

6.1 The Board is requested to:

- approve the revised set of strategic risks for 2022-23 and the lead Committees (Appendix 1);
- note the immediate steps being taken to improve the BAF ready for the Q1 report to the Board in July;
- note the direction of travel for incorporating the BAF into the Trust's risk management software by April 2023.

Appendix 1: proposed strategic risks 2022/23

Strategic aim	Existing BAF risk	Proposed for 2022/23	Executive lead	Oversight
Be Outstanding	B1. 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	BAF1. There is a risk that quality governance systems fail to drive improvements in patient safety and experience and the effectiveness of care, which would negatively affect the CQC's assessment of the Trust's services	Chief Nurse	Quality Committee
	B2. 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	BAF2. There is a risk of demand exceeding available resources, which could impact the quality and safety of services and patient outcomes	Chief Operating Officer	Quality Committee
	B3. Financial sustainability: Due to changes in funding, the Trust may exceed activity levels resulting in increased costs that exceed the current agreed block funding	BAF3. There is a risk of available funding being insufficient to deliver the Trust's strategic priorities	Director of Finance	Performance Committee
	N/A	BAF4. There is a risk that corporate and clinical governance arrangements do not provide comprehensive Board oversight and assurance, leading to inadequate visibility of critical issues and failure to meet regulatory expectations	Chief Executive	Board
	N/A	BAF5. If the Trust does not integrate environmental sustainability considerations into delivery of its strategic priorities, it will fail to realise the potential benefits and contribute to the NHS Net 0 target	Director of Strategy	Performance Committee
Be Collaborative	B4. 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	BAF6. There is a risk that the Trust fails to achieve sufficient strategic influence within the ICS to maximise collaboration around cancer prevention, early diagnosis, care and treatment	Chief Executive	Board
Be Research Leaders	B5. 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	BAF7. If the Trust is unable to increase the breadth and depth of research, it will not achieve its research ambitions as a specialist cancer centre	Medical Director	Performance Committee

Strategic aim	Existing BAF risk	Proposed for 2022/23	Executive lead	Oversight
	B6. 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	No longer a strategic risk		
	N/A	BAF8. Competition for talent and research sponsorship means that the research programme is at risk of being under-resourced, which would hinder the Trust's ambition to be research leaders	Medical Director	Performance Committee
Be a Great Place to Work	B7. 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	BAF9. There is a risk that leadership capacity and capability at the Trust is insufficient to drive the changes required to achieve its strategic ambitions	Director of Workforce & OD	People Committee
	B8. If we are unable to recruit and retain high calibre and diverse staff there is a risk of an adverse impact on the quality of care and reputation of the Trust	BAF10. There is a risk of being unable to attract and develop a diverse and highly skilled workforce, which could limit the Trust's capacity to deliver and develop further its specialist services	Director of Workforce & OD	People Committee
	N/A	BAF11. There is a risk of insufficient staffing levels in some areas of the Trust, which could result in disruption to services and jeopardise the quality of care	Director of Workforce & OD	People Committee
	B9. If we do not support and promote employee health and wellbeing, this will adversely impact on the stability of our workforce in terms of recruitment, retention and absence	BAF12. There is a risk of decline in the health and wellbeing of staff, which may result in increased absence and turnover, affect the Trust's ability to deliver services, and damage its reputation as an employer	Director of Workforce & OD	People Committee
Be Digital	B10. 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	BAF13. There is a risk of limited development and adoption of digitisation across the Trust, which would constrain service improvements and reduce the benefits for patients	Chief Information Officer	Quality Committee
	B11. 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	BAF14. There is a risk of major security breach arising from increasing digitisation and cyber threats, which could disable the Trust's systems, disrupt services and result in data loss	Chief Information Officer	Audit Committee
Be Innovative	B12. If we do not develop our Subsidiary Companies and Joint Venture we will not be able to re-invest back into the NHS	BAF15. There is a risk of inadequate governance of the Trust's Subsidiary Companies and Joint Venture, which would result in failure to maximise the potential commercial and efficiency benefits	Director of Finance	Performance Committee

BAF [risk ref + short title]

RISK APPETITE:

STRATEGIC OBJECTIVE: Be [insert]

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)*			Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions		Target risk score by 31/03/23 L x C
				Internal sources of assurance	External sources of assurance	Overall assurance level				Planned action	Progress update	
BAF[ref] [Risk description] **Executive Risk Lead:** [Name, job title] **Board Committee**: [insert lead assurance forum] **Last Update:** [Date]	**Causes** 1. 2. 3. **Consequences** 1. 2. 3.	***L x C = R*** ***Red/Amber/ Yellow/Green***	C1) [Brief description: what is in place, how does it address risk, date approved / currency] **Control Owner**: [Job title]	[What/where reported/when?]	[What/where reported/when?]	*Green-Acceptable* *Amber-Partial* *Red-Low*	***L x C = R*** ***R/A/Y/G*** ***Change since previous Q (↑/↓/→)***	*Y= green* *N= red*	G1) [Brief description: what needs improving or what additional assurance evidence required?]	[SMART action] **Action Owner**: [Job title] **Due date**:	[Brief status update for actions]	***L x C = R***
			C2) **Control Owner**:						G2)	**Action Owner**: **Due date**:		
			C3) **Control Owner**:						G3)	**Action Owner**: **Due date**:		
			C4) **Control Owner**:						G4)	**Action Owner**: **Due date**:		

Additional narrative

[E.g. rationale/evidence for risk score, key measures of the risk, where do you want to get to (rationale for target score)?
What are notable changes since last update? Future look: what are key milestones to be achieved? What is expected impact of future actions on risk?]

Performance Report

May 2022

Version 1

Contents

I. Summary
II. Restoration of cancer services – core metrics
III. 14 day standard and 28 Faster diagnosis standard
IV. 62 day standard

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*	111%
Cancer surgery activity*	113%
SACT (inc chemo) delivery**	126%

Measure	% of pre-Covid level
Radiotherapy planning**	113%
Radiotherapy treatment**	88%
Endoscopy activity♀	84%

- 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) reduced from the March 2022 high, and is now comparable to February 2022 level.
- Whilst Radiotherapy treatments are lower than in 2019/20, (due to a change in fractionation in early 2020/2021), compared to pre covid levels activity continues to be higher than in 2020/21, when the average was 74% of 2019/20.
- Endoscopy activity has recovered from the pandemic, with March 2022 activity (6,946 procedures) being the highest monthly activity since Jan 2020. **This represents 97% of the average pre-pandemic activity (April 19 to Feb 20)**, but 84% when comparing March 2022 with March 2019. Further capacity may be required in order to clear the backlog of patients on the endoscopy waiting list, which has stabilised. Trusts are being encouraged to increase patients booked on existing lists, as productivity analysis suggests achieving 120% of pre-pandemic activity (as required by the 2022-23 planning guidance) may be achievable if this is implemented. The Alliance has an established endoscopy network and an endoscopy operational recovery team (EORT) to oversee and co-ordinate restoration activities

*Data as of 16th May
** Solid tumour only (not inc. Haemato-oncology): reliable Haemato-oncology figures pre covid are unavailable – data as of April 2022
♀Assessment based on monthly DM01 endoscopy returns - latest update March 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 **March 2022**.

- The Alliance failed the **14 day standard** for urgent suspected cancer referrals, with eight trusts and all CCGs falling below the 93% threshold. The overall performance of the Alliance was 80.5%*, compared to 79.7%* last month. The England average was 80.6%. CMCA was the 14th 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 nine trusts and seven CCGs falling below the 75% threshold. The overall performance of the Alliance was 69.6%*, increasing from 69.3%* last month. The England average was 73.1%.

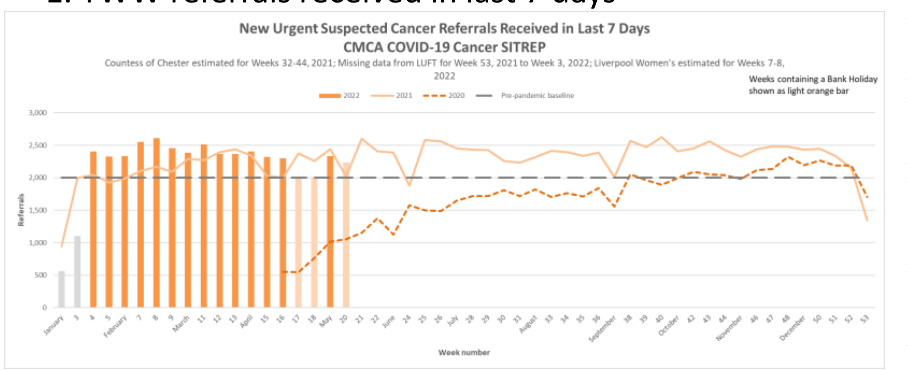
- The Alliance failed the **62 day standard**, achieving 68.5%* (increasing from 68.2%* last month) against a standard of 85% (England average was 67.4%). Nine trusts and all nine CCGs failed to meet the 62 day standard. Cheshire and Merseyside is the 13th best performing Alliance in England out of 21 against this standard.

- The number of urgent referral patients waiting **over 62 days** is significantly higher than pre-Covid levels. On 9th May 2022 there were 1,603 patients waiting more than 62 days for a diagnosis or treatment. This has increased from 1,357 reported last month (11th April). Of these, 417 have waited **over 104 days**. This is lower than the 455 patients reported last month.

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

Section II: Restoration of Cancer Services – Core Metrics

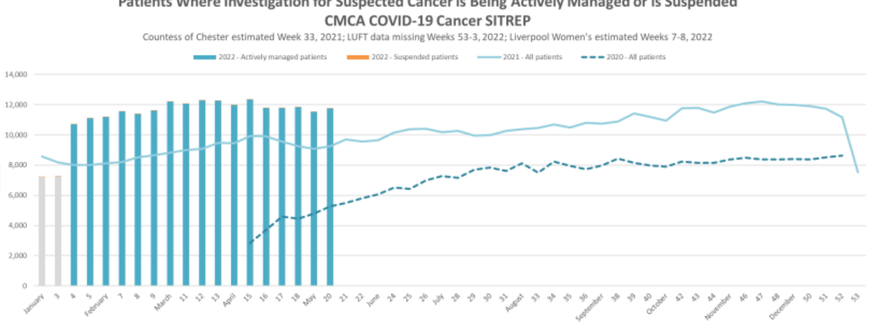
1. TWW referrals received in last 7 days



Referrals deceased with 2,233 patients referred this week (11% above pre-pandemic weekly average, 11% 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.

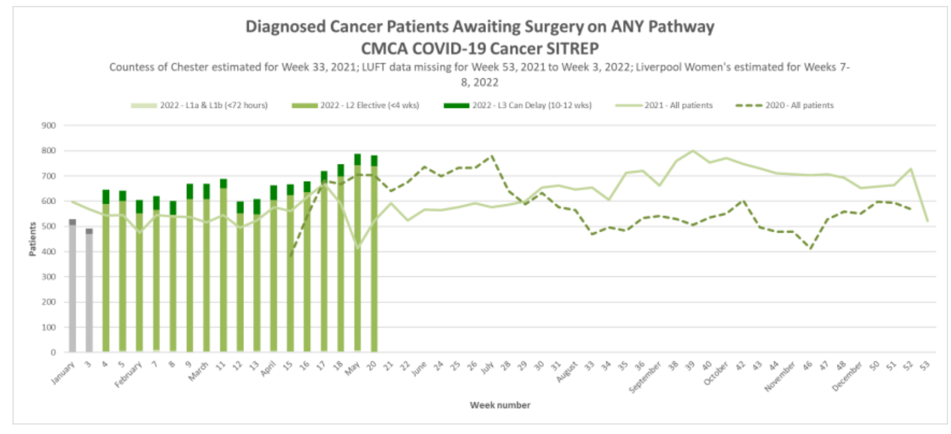
2. Diagnostic backlog (referrals without a DTT)



Currently 11,746 active patients, of which 8 suspended (27% 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.

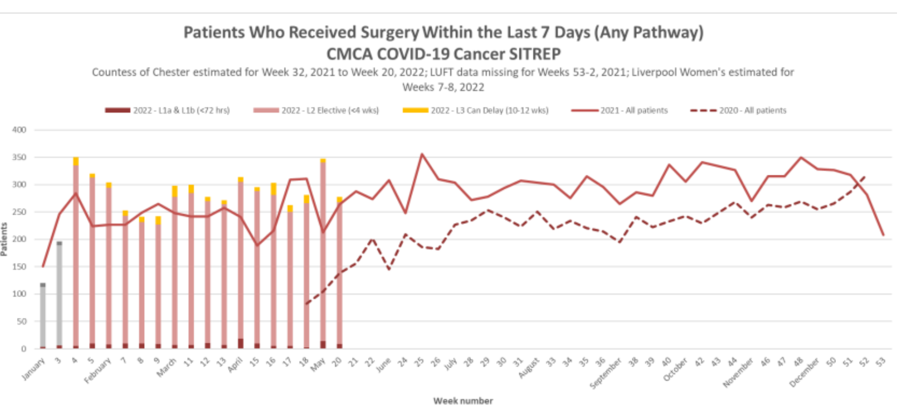
3. Cancer patients awaiting surgery



782 patients with a surgical DTT. 740 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

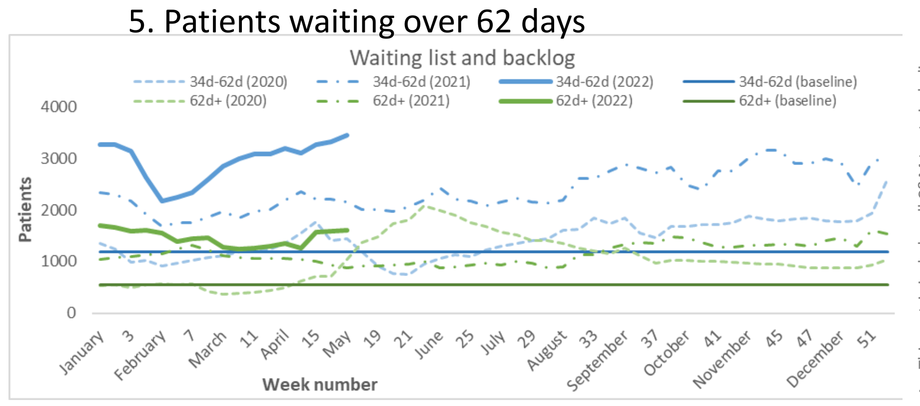


278 cancer operations performed last week.

Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. Countess of Chester data estimated for 02/08/21 to 09/05/22 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

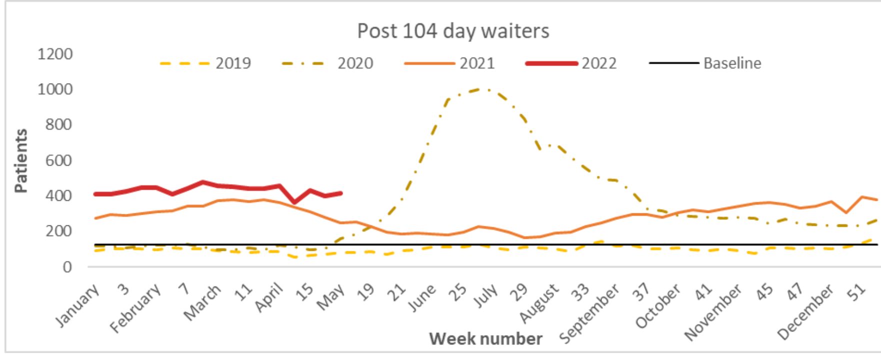


1,603 patients have waited over 62 days

- Higher than 1,596 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. Incorrect data submitted by Countess of Chester 10/04/22.

6. Patients waiting over 104 days

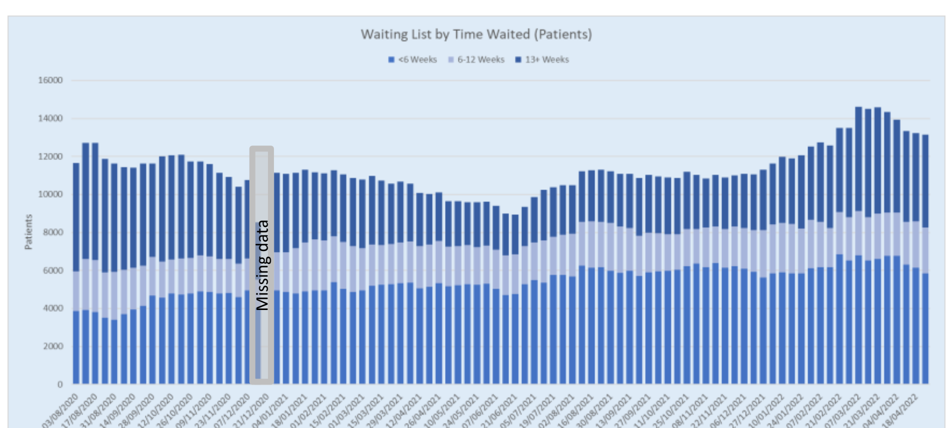


417 patients have waited over 104 days

- Higher than 400 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. Incorrect data submitted by Countess of Chester 10/04/22.

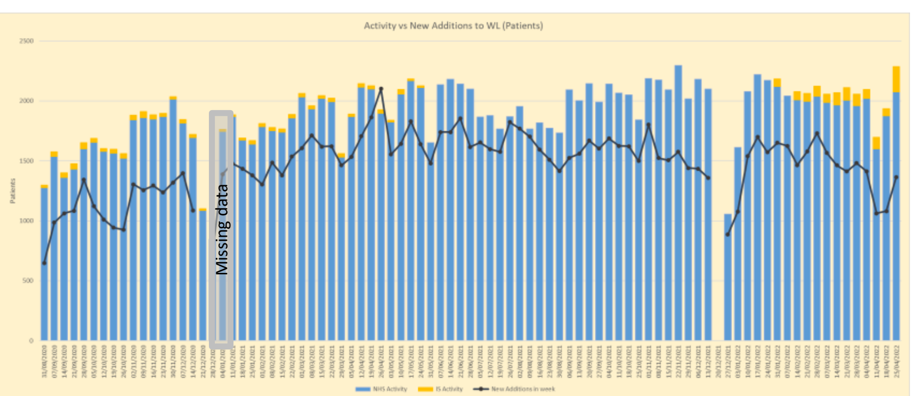
7. Endoscopy waiting list



Endoscopy waiting list decreased to 13,154 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, 21/03/22 and 11/04/22-18/04/22. Wirral estimated for 06/01/22.

8. Endoscopy activity



Activity increased with 2,287 patients seen.

New additions increased with 1,364 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 and 11/04/22-18/04/22, new additions estimated for 07/02/22 onwards.

9. Patients waiting between 63 and 103 days by provider

PTL data from W/E 24 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											5				5
Clatterbridge			5		5		5						9		38
Countess Of Chester			10		14	51					13	27	6		126
East Cheshire						33						7	9		59
Liverpool Foundation Trust		29			49	222	9					69	76		487
Liverpool Heart & Chest							6								6
Liverpool Women's			29												29
Mid Cheshire			7		6	52						9	6		86
Southport & Ormskirk			31			80					15	15	20		168
St Helens & Knowsley			9		10	40		6				10	15		96
Walton Centre															
Warrington & Halton													6		24
Wirral			7			25							28		68
Grand Total		**41**	**105**	**9**	**93**	**520**	**25**	**6**	**30**		**42**	**143**	**175**		**1192**

Tables from national Cancer PTL

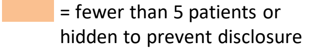
10. Patients waiting over 104 days by provider

PTL data from W/E 24 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							5								
Countess Of Chester					6	37						7			57
East Cheshire															17
Liverpool Foundation Trust					11	73						23	25		157
Liverpool Heart & Chest															
Liverpool Women's			13												13
Mid Cheshire															13
Southport & Ormskirk			26			58							8		102
St Helens & Knowsley						7									17
Walton Centre															
Warrington & Halton															
Wirral						13							11		29
Grand Total		**9**	**44**		**22**	**216**	**10**		**10**		**7**	**40**	**53**		**418**

From 29 November 2020, data source changed from CMCA SITREP to national weekly PTL

- Data no longer split out for acute leukaemia or testicular
- New data for non site specific symptoms referrals (not included in national totals in graphs 5 and 6)



= fewer than 5 patients or hidden to prevent disclosure

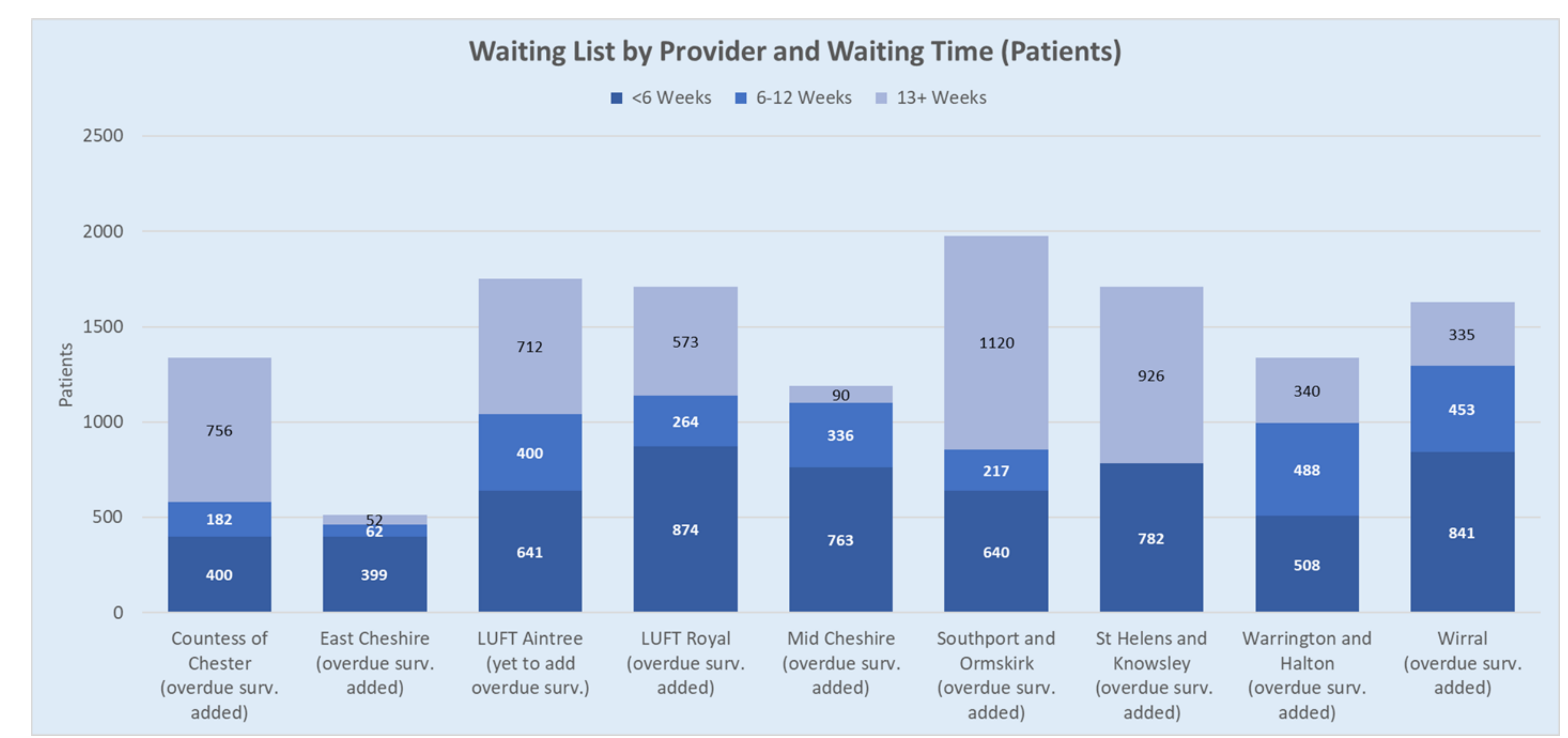
= No PTL submission this week

Restoration of Cancer Services – Core Metrics

Endoscopy (cancer and non-cancer pathways)

There are currently 13,158 patients waiting for an endoscopy. 6,923 have waited more than six weeks, and of these 4,482 have waited 13 or more weeks (36% of the total).

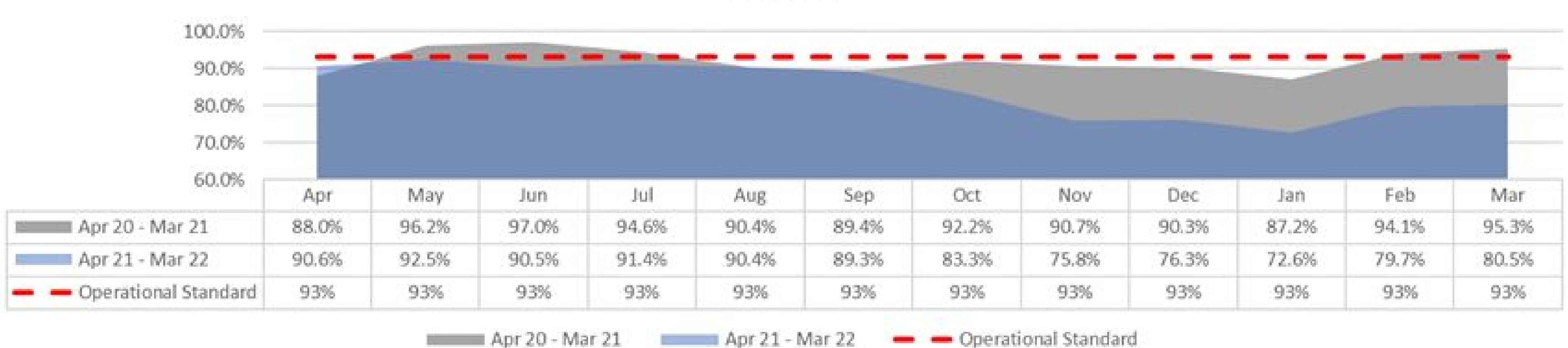
There is significant variation across units, with Southport and Ormskirk, St Helen's and Knowsley and CoCH having the greatest proportion of their waiting list made up of patients waiting 13 weeks or more (58%, 56%, 43% respectively).



Endoscopy data at 02 May 2022.

7

Section II: 14 day standard



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Apr 20 - Mar 21	88.0%	96.2%	97.0%	94.6%	90.4%	89.4%	92.2%	90.7%	90.3%	87.2%	94.1%	95.3%
Apr 21 - Mar 22	90.6%	92.5%	90.5%	91.4%	90.4%	89.3%	83.3%	75.8%	76.3%	72.6%	79.7%	80.5%
Operational Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

In March 2022, 80.5% of patients were seen within 2 weeks compared to 79.7% in the previous month. This is below the operational standard.

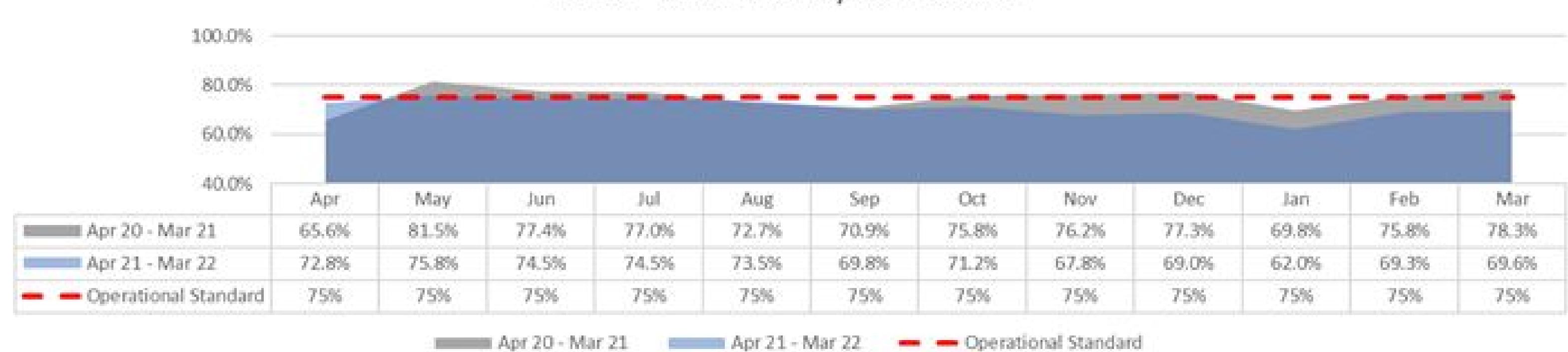
Providers not achieving the national operational standard were:

- Liverpool Women's 67.9% (98 breaches)
- Countess Of Chester Hospital 70.1% (362 breaches)
- Liverpool University Hospitals 72% (971 breaches)
- Wirral University Teaching Hospital 76.2% (481 breaches)
- Southport and Ormskirk Hospital 77.4% (281 breaches)
- St Helens and Knowsley Hospitals 84.3% (307 breaches)
- East Cheshire 90.5% (54 breaches)
- Warrington and Halton Teaching Hospitals 90.6% (120 breaches)

CCGs not achieving the national operational standard were:

- NHS Southport and Formby 67% (265 breaches)
- NHS South Sefton 73.4% (243 breaches)
- NHS Liverpool 75.6% (600 breaches)
- NHS Wirral 76% (466 breaches)
- NHS Knowsley 78.7% (197 breaches)
- NHS Cheshire 84.7% (545 breaches)
- NHS St Helens 86.1% (146 breaches)
- NHS Halton 89.2% (76 breaches)
- NHS Warrington 90.4% (116 breaches)

Section II: 28 day standard



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Apr 20 - Mar 21	65.6%	81.5%	77.4%	77.0%	72.7%	70.9%	75.8%	76.2%	77.3%	69.8%	75.8%	78.3%
Apr 21 - Mar 22	72.8%	75.8%	74.5%	74.5%	73.5%	69.8%	71.2%	67.8%	69.0%	62.0%	69.3%	69.6%
Operational Standard	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

The 28 day FDS standard is now live at 75%. In March 2022, 69.6% of patients were diagnosed or ruled out within 28 days compared to 69.3% in the previous month. This is below the operational standard.

Providers not achieving the expected standard were:

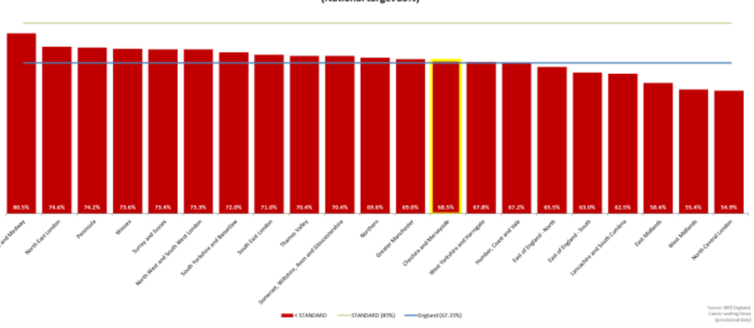
Liverpool Heart And Chest 45.5% (12 breaches)
Liverpool Womens 61.1% (116 breaches)
The Clatterbridge Cancer Centre 63.2% (7 breaches)
Southport and Ormskirk Hospital 67.2% (373 breaches)
Bridgewater Community Healthcare 73.8% (73 breaches)
East Cheshire 58.4% (284 breaches)
Liverpool University Hospitals 62.5% (1464 breaches)
Countess Of Chester Hospital 63.7% (431 breaches)
Warrington and Halton Teaching Hospitals 70.3% (385 breaches)

CCGs not achieving the expected standard were:

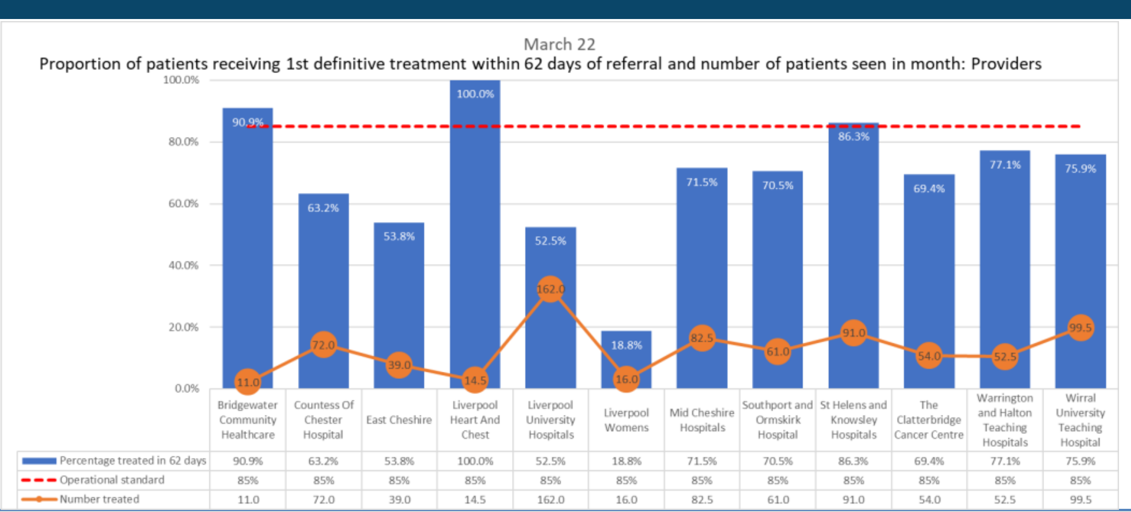
South Sefton 60.5% (367 breaches)
Southport And Formby 65.1% (278 breaches)
Warrington 70.6% (369 breaches)
Liverpool 64.4% (947 breaches)
Cheshire 68.6% (1084 breaches)
Knowsley 70.7% (271 breaches),Halton 73.6% (192 breaches)

Section III: 62 Day Standard

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



CMCA achieved 68.5% against a standard of 85%.
CMCA was the 13th best performer. The England average was 67.4%

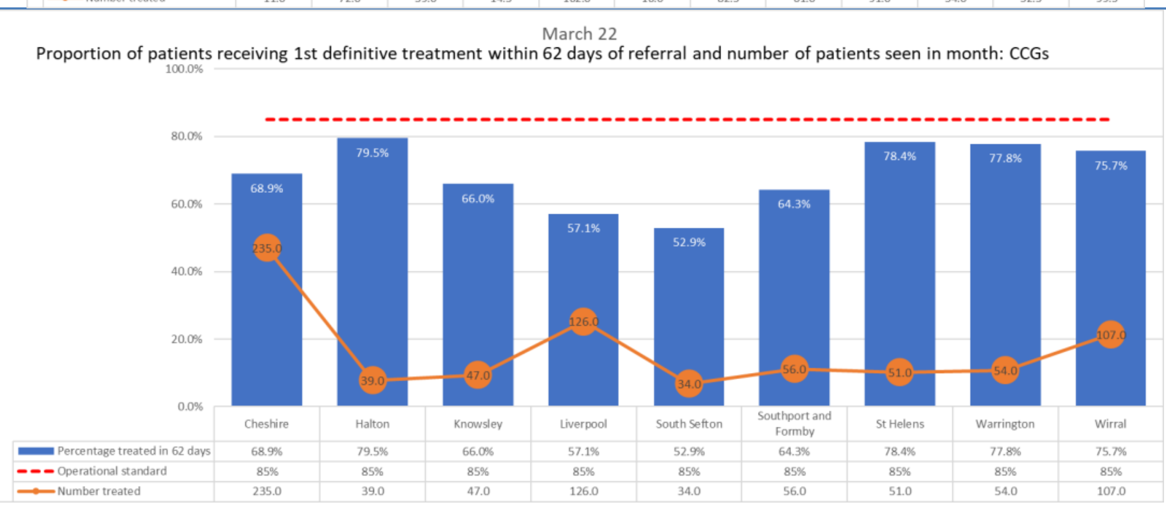


	Bridgewater Community Healthcare	Countess Of Chester Hospital	East Cheshire	Liverpool Heart And Chest	Liverpool University Hospitals	Liverpool Womens	Mid Cheshire Hospitals	Southport and Ormskirk Hospital	St Helens and Knowsley Hospitals	The Clatterbridge Cancer Centre	Warrington and Halton Teaching Hospitals	Wirral University Teaching Hospital
Percentage treated in 62 days	90.9%	63.2%	53.8%	100.0%	52.5%	18.8%	71.5%	70.5%	86.3%	69.4%	77.1%	75.9%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	11.0	72.0	39.0	14.5	162.0	16.0	82.5	61.0	91.0	54.0	52.5	99.5

Most Challenged Pathways (March 2022)

Cancer pathways not achieving the national objective were:

Lower Gastrointestinal 41.6% (45 breaches),
Gynaecological 42.4% (19 breaches),
Upper Gastrointestinal 46.4% (30 breaches),
Head & Neck 52.2% (22 breaches),
Sarcoma 60% (4 breaches),
Haematological (Excluding Acute Leukaemia) 61.3% (12 breaches),
Other 66.7% (1 breaches),
Lung 68% (24 breaches),
Urological (Excluding Testicular) 69.7% (40 breaches),
Breast 72.4% (35 breaches)"



	Cheshire	Halton	Knowsley	Liverpool	South Sefton	Southport and Formby	St Helens	Warrington	Wirral
Percentage treated in 62 days	68.9%	79.5%	66.0%	57.1%	52.9%	64.3%	78.4%	77.8%	75.7%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%
Number treated	235.0	39.0	47.0	126.0	34.0	56.0	51.0	54.0	107.0

Cheshire & Merseyside
Cancer Alliance

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

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

Jon Hayes
Managing Director
jon.hayes1@nhs.net

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

www.cmcanceralliance.nhs.uk

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