Trust Board Part 1
29th June 2022 at 09:30
Floor 12, The Spine
A G E N D A

	Standard Business		**Lead**	**Time**
P1-102-22	Welcome & Introduction	v	Chair	09:30
P1-103-22	Apologies for absence	v	Chair	
P1-104-22	Declarations of interest	v	Chair	
P1-105-22	Minutes of the last meeting – 25th May 2022	*	Chair	
P1-106-22	Matters arising not covered on agenda - None	v	Chair	
P1-107-22	Action Log	*	Chair	
P1-108-22	Chair's Report to the Board	v	Chair	09:40
	Reports and Action Plans			
P1-109-22	Performance Committee Chair's Report	*	GB	09:50
P1-110-22	Extra-Ordinary Audit Committee Chair's Report	*	MT	10:00
P1-111-22	People Committee Chair's Report and Terms of Reference	*	GB/AR	10:05
P1-112-22	Integrated Performance and Quality Report	*	Exec Leads	10:20
P1-113-22	Finance Report	*	JT	10:35
P1-114-22	Safer Staffing Report	*		10:45
P1-115-22	Staff Story	v	JSh	10:55
P1-116-22	NED and Governor Engagement Walk-round: May	*	MT/JG	11:10
P1-117-22	*Deferred - Staff Walk-round Process Review*	*	JG	11:20
P1-118-22	New Consultant Appointments - none		SK	11:30
P1-119-22	Guardian of Safe Working Report	*	SK	11:35
	System Working			
P1-120-22	*Deferred- The alignment of the ICB and CCC Corporate Governance*	*	ST	11:45
P1-121-22	ICB Transfer Letter	*	JT	11:55
P1-122-22	Integrating specialised services within integrated care systems	*	JT	12:05
P1-123-22	Cheshire and Merseyside Cancer Alliance Performance Report	*	LB	12:15
P1-124-22	**Any other business**	v	Chair	12:25
	Date and time of next meeting: 27th July 2022 at 09:30		Chair	

* paper
p presentation
v verbal report

Trust Board Part 1
25th May 2022, 09:30 via MS Teams
Minutes

Title / Department	Name	Initials	Attendance Record	
			April	May
Chair	Kathy Doran	KD	1	1
Non-Executive Director	Mark Tattersall	MT	1	1
Non-Executive Director	Geoff Broadhead	GB	1	1
Non-Executive Director	Elkan Abrahamson	EA	1	1
Non-Executive Director	Terry Jones	TJ	1	1
Non-Executive Director	Anna Rothery	AR	0	1
Non-Executive Director	Asutosh Yagnik	AY	1	A
Chief Executive	Liz Bishop	LB	1	1
Director of Workforce & OD	Jayne Shaw	JSh	1	1
Medical Director	Sheena Khanduri	SK	1	1
Chief Nurse	Julie Gray	JG	1	1
Chief Operating Officer	Joan Spencer	JSp	1	1
Director of Finance	James Thomson	JT	1	1
Chief Information Officer	Sarah Barr	SB	1	1
Director of Strategy	Thomas Pharaoh	TP	1	1

Title/Department	Name	Agenda Item	Initials	May
Corporate Governance Manager	Skye Thomson	All (minutes)	ST	1
Staff Governor	Laura Jane Brown	All	LJB	1
Communications Manager	Susan King	All (to create staff video)	SK	1
Consultant for BAF Development	Gilly Conway	P1-99-22	GC	1

<table>
<tr><th></th><th>Standard business</th><th>Action</th></tr>
<tr><td>P1-86-22</td><td>Apologies: Asutosh Yagnik, Non-Executive Director</td><td></td></tr>
<tr><td>P1-87-22</td><td>Declarations of Interest
In relation to any item on the agenda of the meeting, members are reminded of the need to declare:
(i) Any interests which are relevant or material to the Trust.
(ii) Any changes in interest previously declared; or
(iii) Any pecuniary interest (direct or indirect) on any item on the agenda
Any declaration of interest should be brought to the attention of the Chair in advance of the meeting or as soon as they become apparent in the meeting. For any interest declared the minutes of the meeting must record:
(iv) The name of the person declaring the interest
(v) The agenda number to which the interest relates
(vi) The nature of the interest and action taken
(vii) Be declared under this section and at the top of the agenda item which it relates to
<table>
<tr><td>Name</td><td>Agenda No.</td><td>Nature of Interest / Action Taken</td></tr>
<tr><td>Geoff Broadhead, Non-Executive Director</td><td>P1-93-22 Patient Story</td><td>GB knows the family of the patient that the story is about. The Board noted this.</td></tr>
<tr><td>Mark Tattersall, Non-Executive Director</td><td>Non specific</td><td>Nominated Non-Executive Director for PropCare – No action</td></tr>
<tr><td>Terry Jones, Non-Executive Director</td><td>Non specific</td><td>Director of Liverpool Head and Neck Centre and Director of Research and Innovation, Liverpool University Hospital NHS Foundation Trust – No action</td></tr>
<tr><td>Geoff Broadhead, Non-Executive Director</td><td>Non specific</td><td>Nominated Non-Executive Director for Clatterbridge Pharmacy Limited – No action</td></tr>
<tr><td>James Thomson, Director of Finance</td><td>Non specific</td><td>Executive Lead for PropCare, Clatterbridge Pharmacy Limited, and Clatterbridge Private Clinic LLP – No action</td></tr>
<tr><td>Sheena Khanduri, Medical Director</td><td>Non specific</td><td>Executive Director on PPJV Board for CLATTERBRIDGE Private Clinic and Member of Cancer Alliance Board- CCC/ oncology representative – No action</td></tr>
</table></td><td></td></tr>
<tr><td>P1-88-22</td><td>Minutes of Previous Meeting
The minutes of the meeting held on 27 April 2022 were <u>approved</u> subject to the following amendments:

Page 5 third paragraph: The sentence stating there was similar deferred income last year is incorrect and to be removed
Page 9 second paragraph: MT asked about the Charity being a separate legal company entity by guarantee rather than Charitable Incorporated Organisation
Page 7 IPR: Refers to the 104 day target missed by one or two days, this should be the 24 day target
Page 6 Staff story: To change the section on the apprentice of the year award to ‘The Board heard from Aaron Key, Business Intelligence Apprentice, who was awarded Apprentice of the year from the Informatics Skills Development
</td><td></td></tr>
</table>

	Network (ISDN) and…'	
P1-89-22	**Matters Arising / Action Log** The Board noted that actions were either complete, on the Agenda or not yet due.	
P1-90-22	**Chair's Report** The Chair updated the Board on the Cheshire and Merseyside Acute and Specialists Trust Provider Collaborative. The Chairs and CEs had met for an away day and the collaborative is going well. A lot of work is going on in the programmes of work that have been agreed across the Trusts including diagnostics, elective recovery and clinical services. The away day was facilitated by Mike Farrar and Hill Dickinson LLP, and the group was looking at potential governance models for the provider collaborative. The discussion was to be taken away and brought back to the next meeting. The Chair also informed the Board the article in the Health Service Journal (HSJ) the week of the Board meeting. The article was regarding the NHS England sponsored review of hospitals in Liverpool. The Chair noted that the Trust will be part of the review and is waiting for the reviewer to be identified. The Chair noted the Medical Oncology candidate had been appointed. The Chair informed the Board that the appraisals for the Non-Executive Directors had begun and would be completed by the end of June to go to the Council of Governors in July.	
P1-91-22	**Extra-Ordinary Audit Committee Chair's Report** Non-Executive Director and Chair of Audit Committee, MT, presented the Extra-Ordinary Audit Committee Chair's Report and noted high volumes of audit samples were required by the external auditors and the finance team were providing the information as requested. The Committee had received and considered the Going Concern Management Assessment looking at cash flow, future plans, etc. The Trust is in a strong cash position and the external auditors requested further narrative. The Committee reviewed the draft annual report and accounts and suggested a few amendments. The annual governance statement had been seen by committee 4 times and still had amendments. The Audit Committee will meet for another extra-ordinary meeting on the 16th June to approve the annual report and accounts. **The Board noted** the Chair's report	
P1-92-22	**Charitable Funds Committee Chair's Report** Non-Executive Director and Chair of Charitable Funds Committee, EA, presented the Charitable Funds Committee Chair's report and noted the Committee had discussed and agreed the income and expenditure budget for 2022-23. EA noted there was no further update on the Charity becoming an independent body. **The Board noted** the Chair's report	
P1-93-22	**Patient Story** *Declaration of Interest: Non-Executive Director, GB, knows the family of the patient the story is about.* The Chief Nurse noted the Board had received the video of the patient story prior to the meeting. This month the Board reviewed Hannah's Story. The Chief Nurse noted that Hannah's story highlighted areas for the Trust to improve on which were outlined in the accompanying action plan. In addition to the actions detailed in the report, the Trust is working with the estates team to look at food provision and having a food tasting next week. The Medical Director and Chief Nurse are looking at the themes around communication and looking into communication training.	

	The Trust still has a vacancy for the Head of Patient Experience, so this role is being covered by the quality team. Once the post is filled the new Head of Patient Experience will review how the team complete the action plans for patient stories and monitor them, to focus on creating action rather than reviewing process. The Board discussed the Patient Story with the following areas raised and challenged by Non-Executive Directors: Inpatient Meals • TJ noted that there is a difference between long-term and short-stay patients and they may have varying food needs and responses. This patient had spent 3 blocks of at least 4 weeks in hospital and the Trust needs to ensure that the food offered meets their needs. • MT highlighted that the food was also raised on the patient experience walk-round he did in May. It was also raised at the May PropCare Board meeting. • KD agreed that the food needed to work for all lengths of stay and patient conditions. • The Chief Nurse noted the need for a review and the nutrition team will pick this up. • The Chief Executive noted that part of the review should be looking at the rules around what patients can bring in, as patients often want to eat their own food. Communication • MT informed the Board that they spoke to a patient on the May walk-round that had been passed from one area of the Trust to another, and their details hadn't been passed on and asked for confirmation that this should not occur. • The Medical Director noted there had been education on the functionality of the Meditech record system for staff. A dashboard had now been created to make getting patient information easier. Clinicians had previously been emailed when their patient was admitted, which was challenging for them to check. There is continued awareness raising of this new dashboard. • EA noted that this may not have been a functionality issue and could be doctors asking for a patient to 'tell their story' to start the conversation. • GB restated his declaration of interest as he knows Hannah's family, and highlighted that when you are ill for a long-time the frustrations can come from an accumulation of small things that build up. Rather than there had been a big issue, there may be little areas that need some work. The Chair noted that the Board receiving the story by video in advance allowed for good discussion in the meeting. The Chief Nurse noted the discussion and that the action plan will be updated to capture it. The Chief Nurse will discuss capturing the actions with thenCorporate Governance Manager. **The Board thanked** Hannah for sharing her story and **noted** the report.	JG
P1-94-22	**Patient Experience Visits** The Chief Nurse introduced the report for the patient experience visit that took place in April, visiting the Radiotherapy and Diagnostic Imaging department. She noted the response from patients was very positive and the staff had raised some challenges. Non-Executive Director, GB, had been the NED on the visit and informed the Board that he hadn't been able to answer the challenges the staff had raised and that the visits needed a member of staff there to be able to respond to staff questions on the day. This was addressed in P1-95-22 Patient Experience Visits Process Review. GB also noted that the visits will be better once back in person The Chief Nurse informed the Board that the new Head of Patient Experience will look at the action format from the patient experience visits. The recruitment position for the post is ongoing.	

	Non-Executive Director, AR, noted the concerns with staff cover raised at the March 2022 patient experience visit to Halton. The Chief Operating Officer confirmed this had been a communication issue, a plan for back fill had been in place but staff hadn't been informed. AR noted the staff had good suggestions and asked how these were being captured. The Director of Workforce and Organisational Development informed the Board that in response to the staff survey the Trust were holding over 50 listening events with executive team representation. The events have been going down really well, and have had good engagement from the staff. The Workforce team will review the process for the listening events and take a paper to the Trust Executive Group meeting and the People Committee. **The Board noted** the report	
P1-95-22	**Patient Experience Visits Process Review** The Chief Nurse introduced the report on the Patient Experience Process Review and noted the value that the visits bring and the need for them to continue with a focus on the aim which is to hear directly from patients. At the start of the financial year a schedule with the department for each walk-round will be created and brought to the Board meeting. The Governors and Non-Executive Directors will self-roster and if they wish to stick to a particular site or area can do so by choosing those dates. The walk-rounds will have a senior member on staff on site to advise and answer any questions. They might not want to be in the room when staff/patients are talking. The priority for the Governor and Non-Executive Director Engagement walk-rounds is hearing from patients. Once appointed the new Head of patient experience will write the report and actions, the template for which was included in the paper. The Chief Nurse will bring a paper on the staff walk-rounds to the June Trust Board meeting. Non-Executive Director, EA, questioned if there was a process for feedback to be provided to the patients, following the report and action log. The Chief Nurse informed him that part of the role of the senior member of staff that attended the walk-round is for them to go back and speak to the patients. The Director of Workforce and Organisational Development noted that the report mentions doing a walk-round in corporate services which were not included in the schedule. The Chief Nurse informed her that the June paper will look at staff walk-rounds. The Chief Executive highlighted that non-clinical services should include ISS. The Chair asked if walk-rounds could now take place in person. The Chief Nurse agreed with the exclusion of the occasional area when not appropriate to attend in person, for example haematology and bone marrow transplant. Non-Executive Director, MT, noted the schedule had Clatterbridge Liverpool Ward 5 on for July and this had been done in June. The Chief Nurse and Corporate Governance Manager will review the schedule before distributing. **POST MEETING NOTE:** July 2022 walk-round will take place in Ward 2 & 3 at CCC-L and May 2023 will be Ward 4 & 5 CCC-L. MT also raised that the physical areas outlined are very large and the NEDs and Governors may be unable to go to all areas listed due to time. The Chief Nurse noted the services have been grouped together based on the floor and the walk-rounds will be continually reviewed. **The Board noted** the report.	 JG
P1-96-22	**Integrated Performance Report: Month 1** The Chief Operating Officer introduced the Integrated Performance Report in its new	

	format. The IPR had been to performance committee the week before, the new format was well received and work will continue to refine the report further. **Access** 62 day wait from GP referral to treatment exception report. The Chief Operating Officer explained that the lung pathway breaches should drop off because of an increase in capacity for molecular testing at Liverpool labs, which will reduce delays past breaches have experienced. The number of patients treated between 63-103 days metric has been higher in the last few months due to referrals being late into the organisation. The Chief Operating Officer recommended that the 24 day from referral to CCC to first treatment target be added back into the IPR next month as it gives a better indication of the Trust's performance. The Chair questioned what happened when the Trust doesn't meet the target and the Chief Operating Officer informed her that for every breach a root cause analysis (RCA) is completed and fed back through the Cheshire and Merseyside Cancer Alliance (CMCA). It is anticipated that there will be a high volume of late referrals in the next 12 months. It is important to see the 24 day target as the 62 day target doesn't reflect the work the team is doing. The Chief Executive agreed the 24 day from referral to CCC to first treatment target was needed to measure Clatterbridge's performance. **The Board agreed** for this to be included in the IPR going forward. Non-executive Director, TJ, questioned which patient group the 28 day faster diagnosis target referred to. The Chief Operating Officer confirmed this target only applied to Haemato-oncology patients and the focus should be on avoidable breaches. The Chief Operating Officer noted there will be changes to the cancer wait times in Autumn.	
	The Chief Executive suggested the at the Board away day, the Board spend an hour looking at activities around improving the pathways, and get the team to talk about the current activity and the implications of the cancer wait time appropriate clinical changes.	ST
	Quality The Chief Nurse noted that in the infections exception reports there were no lapses in care and there is ongoing increased monitoring. An annual report will go to quality committee in June. The Chief Nurse informed the Board that the missed timings in complaints and FOI's were due to temporary staffing challenges, and the non-compliance will be resolved imminently. **Research and Innovation** The Medical Director noted the improvements on study recruitment from last month. Non-Executive Director, MT, asked if there were difficulties recruiting to the Pharmacy trial. The Medical Director confirmed there had been. The Chair asked if the Trust is at pre-pandemic levels of research and innovation. The Medical Director noted that the Trust is still recovering but is more sighted on where the issues are. The Medical Director noted the Experimental Cancer Medicine Centre (ECMC) applications are ongoing and due to be submitted July, with a decision made at the end of the year. **Workforce** The Director of Workforce and Organisational Development noted the inclusion of the new Key Performance Indicators (KPIs) and highlighted that the red medical appraisal figure for April was a calculation error. The Medical Director provided an accurate statistic for the medical appraisals, stating 92% compliance as 13/14 have been completed. The one outstanding was due to issues with annual leave and is being picked up.	

	Sickness absence for the Trust has reduced and continues to reduce which is to be expected during summer. Turnover has increased; after seeing a reduction during Covid people arennow starting to make career decisions. The workforce team anticipate an increase in staff leaving in light of the end of the travel protection. A report on nurse recruitment and retention will go to the People Committee. Non-Executive Director, EA, referenced an article on the clawback of funding for overseas nurses who leave early and asked if there had been an impact on Clatterbridge. The Director of Workforce and Organisational Development noted she would look to see if this had affected Clatterbridge's international nurses. **The Board noted** the report	
P1-97-22	**Finance Report: Month 1** The Director of Finance introduced the finance report for the Trust's financial performance for April 2022, informing the Board the Trust is on plan for revenue, capital and cash performance. The main risks for the Trust are the Cost Improvement Programme (CIP) and Elective Recovery Funding (ERF) performance. Final ERF guidance has yet to be published. However, NHSE has informed the Trust that certain radiotherapy and chemotherapy activity will be included in the ERF calculation. The Trust has not yet received any information from NHSE to assess ERF income in April. Therefore, there is a risk that income may not be recovered as planned. The Chair enquired about the level of planned activity. Trust information shows that current levels of elective activity are above the 2019/20 baseline. The Director of Finance noted the pay costs are consistent with previous months' expenditure. Trusts are under scrutiny from NHSE and the ICS regarding staffing costs, with a renewed focus on bank and agency staff. The Trust is spending less on premium bank and agency, compared to the historic target. However, this may change with activity increases. The Chair noted the ICS workforce scheme is looking at this issue, and trying to standardise where possible. Non-Executive Director, MT, noted the Board's ERF position and asked when the cash would be seen for it. The Director of Finance confirmed this would likely be August. **The Board noted** the contents of the report	
P1-98-22	**New Consultant Appointment** The Medical Director provided an update to the Board on newly appointed consultant Dr Nils Elander. **The Board noted** the report	
P1-99-22	**2022/23 Board Assurance Framework Update** The Chief Executive Introduced the report on the 2022/23 Board Assurance Framework (BAF) Update. After the Good Governance Institute well-led report, and feedback from consultant Gilly Conway (GC) the Board have been working to update the BAF. The Board met in April to review the old risks and develop the new BAF which has been presented in a new template. GC noted the 2 parts to the paper, the first to gain the Board's approval of the refreshed strategic risks, and the second to update the Board on development. Appendix 1 set out the risks with comparisons to last year's BAF. Each one has an exec lead and an oversight committee. GC had the first set of meetings with the exec leads and mapped out the controls and assurances. GC noted BAF risk 2 in the report should sit with Performance Committee not Quality Committee as written.	

	GC asked the Board to approve the risks and the appointed committees. Non-Executive Director, MT, noted the report had been approved at Audit Committee. The Chief Information Officer highlighted she had discussed BAF risk 10 with GC and this will go to the Audit Committee. The Chief Information Officer as a non-member of the committee will attend the appropriate meeting to introduce it and attend subsequent meetings when requested. **The Board approved** annex 1 the proposed strategic risks 2022/23. GC presented the new BAF template, appendix 2, and informed the Board that the Exec Leads have been asked to review and amend their individual risks. The full new BAF will be presented to the Board in July, which marks the completion of Phase 1. Phase 2 is to scope the project to take move the BAF onto the Datix platform. The Board discussed the full BAF going to the next Audit Committee as a one off and concluded that if the BAF was ready by the 7th July for the distribution of the papers prior to the Audit Committee on the 14th July then it would go. The Chief Information Officer raised that on reviewing the newly formulated BAF the risk appetite for Digital was very low, between 4 and 8, however the risks are unlikely to be below that score. The Chair suggested the Chief Information Officer review the risk appetite for digital when reviewing the BAF and suggest a new scoring that could be discussed in July GC thanked the Board for their positive strong engagement with the BAF refresh. The Chair thanked GC for her support and for pulling the new BAF together. **The Board noted** the next steps and the report.	 SB
P1-100-22	**Cheshire & Merseyside Cancer Alliance Performance Report** The Chief Executive introduced the Cheshire and Merseyside Cancer Alliance (CMCA) Performance Report and noted there had been a slip in performance which reflected the pressure in the system. The CMCA 62 day cancer waiting time had still not come down like last year. The endoscopy waiting list had come down. The CMCA had focused endoscopy workshops and there are clear action plans. The CMCA are expecting a 40% increase in referrals for GI (Gastrointestinal endoscopy) which will impact performance. The Chief Executive is keen to give more detail about what the CMCA is doing about performance and has asked for the report to be expanded. The Chief Executive also suggested that the Board have an hour on system activity at the Board away day. The Chief Executive highlighted the 22 head and neck breaches in the 'Most Challenged Pathways (March 2022)' section of the report, informing the Board that the rapid diagnostic clinic had started at Aintree which should help this pathway. Since October 2021 the CMCA have been reviewing the gynaecology pathway. There were 100 attendees at a workshop the previous week, which brought out 42 recommendations. These recommendations will be turned into specific actions to improve this pathway. Non-Executive Director, TJ, enquired about the link between the CMCA and the ICB (Integrated Care Board). The Chief Executive informed him that the CMCA is the cancer arm of the ICB and they are working well together. The Chair questioned if there was representation from the ICB in the CMCA or vice versa. The Chief Executive and Director of Finance explained there is not direct representation however, the CMCA is part of the landscape and the two are linked through the Cheshire and Merseyside Acute and Specialist Trusts Prover	 ST

	Collaborative (CMAST). When questioned about the expected increase in endoscopy referrals, the Chief Executive informed the Board that the teams were rising to the challenge and endoscopy workshops are taking place. The '40% increase' figure refers to the increase in people coming forward to their GP with symptoms, a small percentage of which would have cancer. GPs are looking at campaigns for hard to reach groups regarding coming forward with symptoms. More details regarding these will be brought to the Board Away day in July. **The Board noted** the report	
P1-101-22	**Any other business** The Director of Finance referenced the letter from Julian Kelly (NHS England CFO) regarding additional funding which will be brought to the private Trust Board meeting for discussion.	
	Date and time of next meeting: 29th June 09:30-12:30, Floor 12, The Spine	

						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	Formal Review of Board Committee Governance Structure	**JG**	Sep-22	
P1-095-22	25-May-22	Patient Experience Visits Process Review	The Chief Nurse will bring a paper on staff walk-rounds to the June Trust Board meeting	**JG**	Jun-22	Deferred on June agenda

Chairs report for: Performance Committee
Date/Time of meeting: 18th May 2022, 09:30

			Yes/No
Chair	Geoff Broadhead	**Was the meeting Quorate?**	Y
Meeting format	Microsoft Teams		
Was the committee assured by the quality of the papers (if not please provide details below)			Y
Was the committee assured by the evidence and discussion provided (if not please provide details below)			Y

Items of concern for escalation to the Board	• IPR – infection rates • Change in Acuity of patients & challenges around genomic/molecular testing turnaround times • Finance - Notification that system plan was not accepted and therefore a, potential risk to CCC • Presentation on Link bridges and Royal opening to go to Board in June 2022
Items of achievement for escalation to the Board	• Usefulness of Apollo 2 Exercise • Propcare Performance Report • R&I Business plan
Items for shared learning	• Nursing Deep dive, detail to be picked up at People Committee • The Committee asked for an update on link bridges to go to Board (*Update: the link bridge is on track and the LUHFT consultation has now come out and the team will respond and bring back any concerns to Board in July*)

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Extraordinary Audit Committee
16 June 2022

Chairs Report

Chair	Mark Tattersall	Was the meeting Quorate?	Yes
Meeting format	MS Teams		Yes
Was the committee assured by the quality of the papers (if not please provide details below)			Yes
Was the committee assured by the evidence and discussion provided (if not please provide details below)			Yes

General items to note to the Board	• The Committee considered the updated Annual Report and Accounts 2021-2022 and approved subject to the review and final sign off of the outstanding audit items by Ernst & Young • Supported the updated Going Concern Assessment subject to some commentary changes • Considered in detail the External Auditors' Findings Report and approved the unadjusted items as presented by the External Auditors. • The Committee approved the Management Letter of Representation subject to additional narrative being included at paragraph A5. The additional narrative to be included to address Ernst & Young's requirement to document the rationale for not adjusting the differences identified during the year end audit and which were highlighted in section 4 of the External Auditors' Findings Report. • Approved the Provider Licence Conditions
Items of concern for escalation to the Board	
Items of achievement for escalation to the Board	
Items for shared learning	

Page 1 of 1

Chairs report for: People Committee
Date/Time of meeting: 8th June 2022 at 10am

			Yes/No
Chair	Anna Rothery/ Geoff Broadhead	**Was the meeting Quorate?**	Y (after amendment to ToR)
Meeting format	Microsoft Teams		
Was the committee assured by the quality of the papers (if not please provide details below)			Y
Was the committee assured by the evidence and discussion provided (if not please provide details below)			Y

Items of concern for escalation to the Board	• Concern raised regarding ongoing non-compliance of Mandatory Training despite additional courses being offered. To address this, role essential training is being reviewed to assess if training can be delivered via another route to allow time for Mandatory Training to be completed
Items of achievement for escalation to the Board	• Successful staff listening events taking place with subsequent action plan to provide assurance to the Board on progress • First Staff Awards Ceremony taking place in November 2022 at the Winter Ball, to thank staff for their contributions during Covid.
Items for shared learning	

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TERMS OF REFERENCE

People Committee

ToR Reference	(To be provided by DCM)
Version	V.1
Name and designation of ToR author(s)	Zoe Hatch (Deputy Director of Workforce and OD)
Approved by (committee, group, manager)	Trust Board of Directors
Approval evidence received (minutes of meeting, electronic approval)	(To be completed by DCM)
Date approved	(To be completed by DCM)
Review date	December 2022
Review type (annual, three yearly)	6 months, then Annually
Target audience	(To be provided by author)
Links to other strategies, policies, procedures	Trust Strategy (2021-2026) Our People Commitment (2021-2026) Education Strategy (TBC)
Protective Marking Classification	Internal
This document replaces	

Circulation/Dissemination

Date added into Q-Pulse	For completion by DCM
Date document posted on the Intranet	For completion by DCM

Version History

Date	Version	Author name and designation	Summary of main changes
			To be completed by author

Issue Date:	Page 3 of 9	Reference:	Issue No:
Author:	Authorised by:		Copy No:

TERMS OF REFERENCE

Title	People Committee
Authority	1. The Committee is constituted as a standing committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings. 2. The Committee is authorised by the Trust Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee. 3. The Committee is authorised by the Trust Board of Directors to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions. 4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
Aim	The purpose of the Committee is to provide assurance to the Trust Board of Directors on the quality, delivery and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust. This includes but is not limited to • employee health and wellbeing • organisational culture • equality diversity and inclusion • employee engagement • leadership • organisational values and behaviours • education and training • learning and development • organisational development • workforce development • workforce planning • recruitment and retention

TERMS OF REFERENCE

	The Committee will assure the Trust Board of Directors of the achievement of the objectives set out in the Trust's 5-year strategy, Our People Commitment and NHS People Promise
Purpose	• The People Committee is responsible for providing assurance to the Trust Board of Directors in relation to the delivery of the Trust's People Committee to People Committee, ensuring the cultural identity, values and behaviours framework is aligned to the delivery of corporate objectives and compliance with legislation. The Committee will ensure that the Trust's workforce has the capacity and capability to deliver the Trust's objectives through effective leadership and development, workforce planning and organisation development. • The Committee will ensure that risks relevant to the Committee's purpose are minimised through the application of the Trust's risk management system. This will include, but not be restricted to the consideration of significant risks to the delivery of the Trust's strategic objectives, through review and scrutiny of the relevant risks from the Board Assurance Framework (BAF) and the divisional/corporate risk registers requiring consideration in accordance with the risk management policy.
Specific Areas of Work	• Review and recommend to Trust Board of Directors workforce key performance indicators and targets • Monitor and review performance against key performance indicators and any action plans to deliver improved performance • To receive assurance that the Trust people policies and procedures are in accordance with legislation, NHS Guidelines and requirements and are operating within the Trust's overall assurance framework.

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Author:	Authorised by:		Copy No:

TERMS OF REFERENCE

- Receive assurance that all staff are receiving an effective annual appraisal and that robust succession plans and talent management processes are in place
- To receive and consider the National Staff Survey and Culture and Engagement survey results for the Trust and oversee the implementation and effectiveness of improvement plans on staff experience and engagement.
- Receive assurance that the Trust has adequate staff with the necessary skills and competencies to meet the current and future needs of patients and service users
- Monitor and evaluate compliance with public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics (i.e. Workforce Race Equality Standards, Workforce Disability Equality Standards and Gender Pay Gap reporting)
- Monitor the effectiveness of staff engagement processes
- Monitor and review the effectiveness of the Freedom to Speak Up service in the Trust
- Oversee the development and delivery of a workforce education and development plan
- Oversee the development of leadership skills and capacity across all levels of the Trust.
- Oversee the development and implementation of new roles and career pathways that support the sustainable provision of services within the Trust
- Ensure the Trust fosters an open, transparent and high-performing culture, where staff feel valued and recognised and feel empowered to raise concern

TERMS OF REFERENCE

Reporting arrangements	• Oversee the development of the cultural identity, values and behaviours of the Trust, seeking assurance on the alignment with the delivery of workforce improvements. • To review progress being made to establish the Trust as an anchor institution in terms of workforce and education. • To oversee, review and ensure all aspects of staff health and wellbeing • Monitor and oversee other relevant items as identified on the Committee's Forward Plan (agreed annually by the Committee). • Monitor and oversee the embedding of digital workforce solutions and technology to support our people to become digitally enabled and connected • The minutes of all meetings of the People Committee shall be formally recorded by a member of the Corporate Governance Office or their nominee; • The Committee will report to the Trust Board of Directors following each meeting and the Chair of the Committee will bring to the attention of the Board any items that the Committee feels that the Board should be aware of in addition to any issues that require disclosure to external bodies or authorities; • The following sub-committees shall provide assurance and performance management reports which have been agreed with, and are required by, the Committee; and any report or briefing requested by the Committee: o Education Governance Committee o Workforce Advisory Group

Issue Date:	Page 7 of 9	Reference:	Issue No:
Author:	Authorised by:		Copy No:

TERMS OF REFERENCE

<table>
<tr>
<td>Membership</td>
<td>

The Committee will carry out an annual review of its effectiveness and provide an annual report to the Audit Committee on its work in discharging its responsibilities, delivering its objectives and complying with its Terms of Reference. The review of effectiveness will specifically comment on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks

The Committee will be appointed by the Board and will consist of:

3 x Non-Executive Directors
Chief Nurse
Medical Director
Director of Workforce and OD
Chief Operating Officer
Chief Information Officer
The Chief Executive may attend any meeting as required

A Non-Executive Director shall be appointed Chair of the Committee with a second Non-Executive appointed as Deputy Chair

The following will be in attendance:

Deputy Director of Workforce and OD
Head of Learning and Organisational Development
Head of Workforce Transformation
1x Workforce Business Partner
Director of Pharmacy
Associate Director of Education
Associate Director of Communications
Head of Equality, Diversity and Inclusion
Associate Director of Corporate Governance
Staff Side Chair

Members are required to attend at least 75% of the meetings in any one financial year.

The Committee may invite other persons to attend the meeting from time to time to assist in discussions and the Chair will be notified in advance of attendees.
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TERMS OF REFERENCE

	Membership of the Committee will include at least one common Non-Executive member of the Audit Committee. This member will act as a conduit of information and assurance across the two Committees in support of the Trust's Integrated Governance approach
Quorate	The Committee will be deemed quorate to the extent that the following members are present: • Two Non-Executive Directors, one of whom shall Chair the Committee • The Director of Workforce and OD • One other Executive Director
Notice of meetings	An agenda of items to be discussed and supporting papers will be forwarded to each member of the Committee and any other attendees no later than 4 working days before the date of the meeting
Standard items	Standard Agenda items will fall under the following headings: 1. Workforce Performance and Risk 2. Reports and Presentations 3. Annual Reports 4. Delegations from the Trust Board 5. Approvals 6. Committee Report to the Trust Board of Directors 7. Any other business The business of the People Committee will take into account the relevant risks on the Board Assurance Framework
Frequency	The committee will meet Quarterly

REPORT COVER

Report to:	Board of Directors
Date of meeting:	Wednesday 29th June 2022
Agenda item:	
Title:	Integrated Performance Report M2 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:	Quality Committee
Date & decision:	Thursday 23rd June 2022

Purpose of the paper/key points for discussion:	This report provides the Board of Directors with an update on performance for month 2 2022/23 (May 2022). This report provides an update on performance for May 2022, in the categories of access, efficiency, quality, workforce, research and innovation and finance. RAG rated data and statistical process control (SPC) charts (with associated variation and assurance icons) are presented for each KPI. 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:	

Version 1.1 Ref: FCGOREPCOV Review: July 2024

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 2 2022/23)

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

Introduction

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

From M1 2022/2023, the scorecards 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 August 2022. This will allow four months of 'SPC' reporting, which will provide intelligence on, and foster a collective understanding of the relationship between target non-compliance and SPC alerts.

It was agreed at the May 2022 Committees and Trust Board to re introduce the following targets to the IPR:
- 24 days from referral to first treatment (62 Day Classics only)
- Imaging Reporting: Inpatients (within 24hrs) and Imaging Reporting: Outpatients (within 7 days)
and start to report on the following targets:
- Pulse survey scores by category

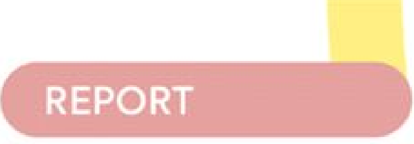
The Trust is collaborating with peer Trusts to review the length of stay targets, ensuring we are benchmarking with other organisations where possible.

Interpretation of Statistical Process Control Charts

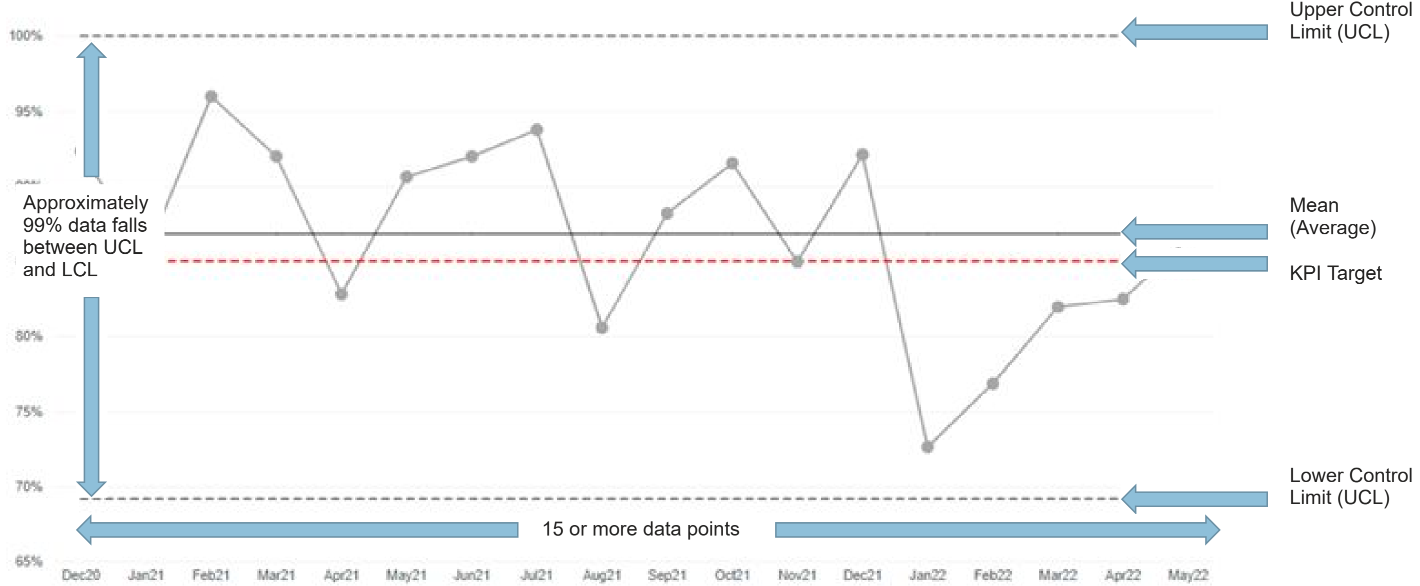
The following summary icons describe the Variation and Assurance displayed in the Chart.

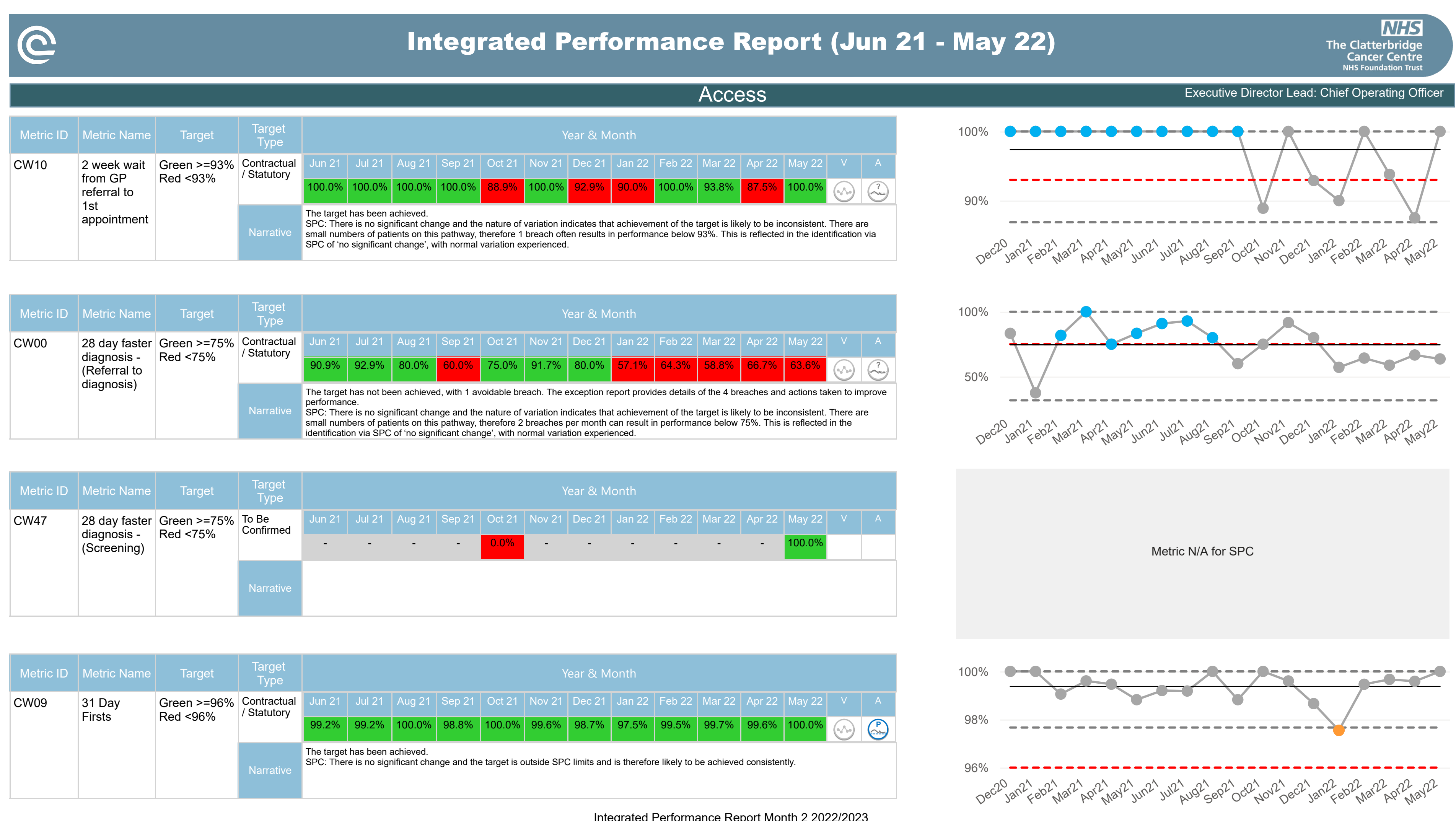
Are we improving, declining or staying the same? (Variation)			
Icon	Variation	Definition	Action
	Special Cause Improving Variation	Unexpected variation that results from unusual circumstances in a system or process i.e. assignable. (Blue = significant improvement/low pressure, H = high numbers, L = low numbers).	External cause should be identified and understood. Analyse whether change is attributable to service redesign or not.
	Special Cause Concerning Variation	Unexpected variation that results from unusual circumstances in a system or process i.e. assignable. (Orange = significant concern/high pressure, H = high numbers, L = low numbers).	Process is unstable and unpredictable. External cause should be identified and tackled. Develop contingency plans.
	Common Cause Variation	A natural or expected variation in a system or process i.e. random. (Grey = no significant change)	Process is stable and predictable. If the current performance is acceptable, do nothing. If it is not acceptable, redesign your processes.

Can we reliably hit the target? (Assurance)			
Icon	Assurance	Definition	Action
	Consistently hitting target	The current target is outside the process or control limits in the direction to improvement. (Blue = will reliably hit target)	Be assured that without significant change, the system would be expected to continue to hit the target, regardless of natural variation.
	Consistently failing target	The current target is outside the process/control limits in the opposite direction to improvement. (Orange = system change required to hit target)	Be aware that without significant change, the system would be expected to consistently miss the target, regardless of natural variation.
	Hitting and missing target	The current target is in between the process/control limits. (Grey = subject to random)	Without significant change, the system would be expected to inconsistently hit the target in future. The difference between success and failure may be down to the natural variation of the system and may have no underlying significance.



Anatomy of the SPC Chart





Integrated Performance Report (Jun 21 - May 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Executive Director Lead: Chief Operating Officer

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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%	88.9%	100.0%	92.9%	90.0%	100.0%	93.8%	87.5%	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. There are small numbers of patients on this pathway, therefore 1 breach often results in performance below 93%. This is reflected in the identification via SPC of 'no significant change', with normal variation experienced.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
CW00	28 day faster diagnosis - (Referral to diagnosis)	Green >=75% Red <75%	Contractual / Statutory	90.9%	92.9%	80.0%	60.0%	75.0%	91.7%	80.0%	57.1%	64.3%	58.8%	66.7%	63.6%		

Narrative: The target has not been achieved, with 1 avoidable breach. The exception report provides details of the 4 breaches and actions taken to improve performance.
SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. There are small numbers of patients on this pathway, therefore 2 breaches per month can result in performance below 75%. This is reflected in the identification via SPC of 'no significant change', with normal variation experienced.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
CW47	28 day faster diagnosis - (Screening)	Green >=75% Red <75%	To Be Confirmed	-	-	-	-	0.0%	-	-	-	-	-	-	100.0%		

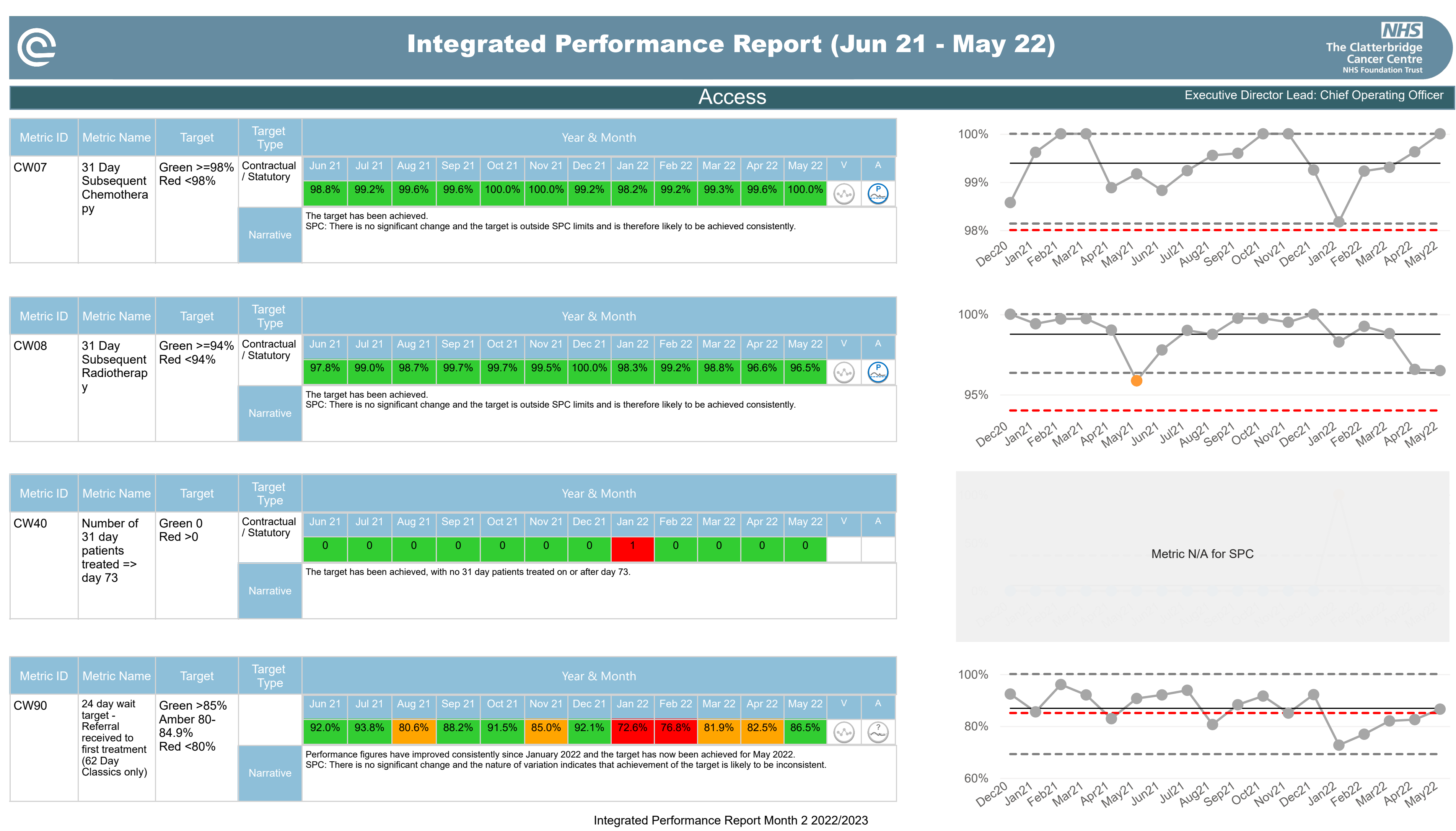
Narrative:

Metric N/A for SPC

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

Narrative: The target has been achieved.
SPC: There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Executive Director Lead: Chief Operating Officer

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

Narrative: The target has been achieved.
SPC: There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
CW08	31 Day Subsequent Radiotherapy	Green >=94% Red <94%	Contractual / Statutory	97.8%	99.0%	98.7%	99.7%	99.7%	99.5%	100.0%	98.3%	99.2%	98.8%	96.6%	96.5%		

Narrative: The target has been achieved.
SPC: There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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	1	0	0	0	0		

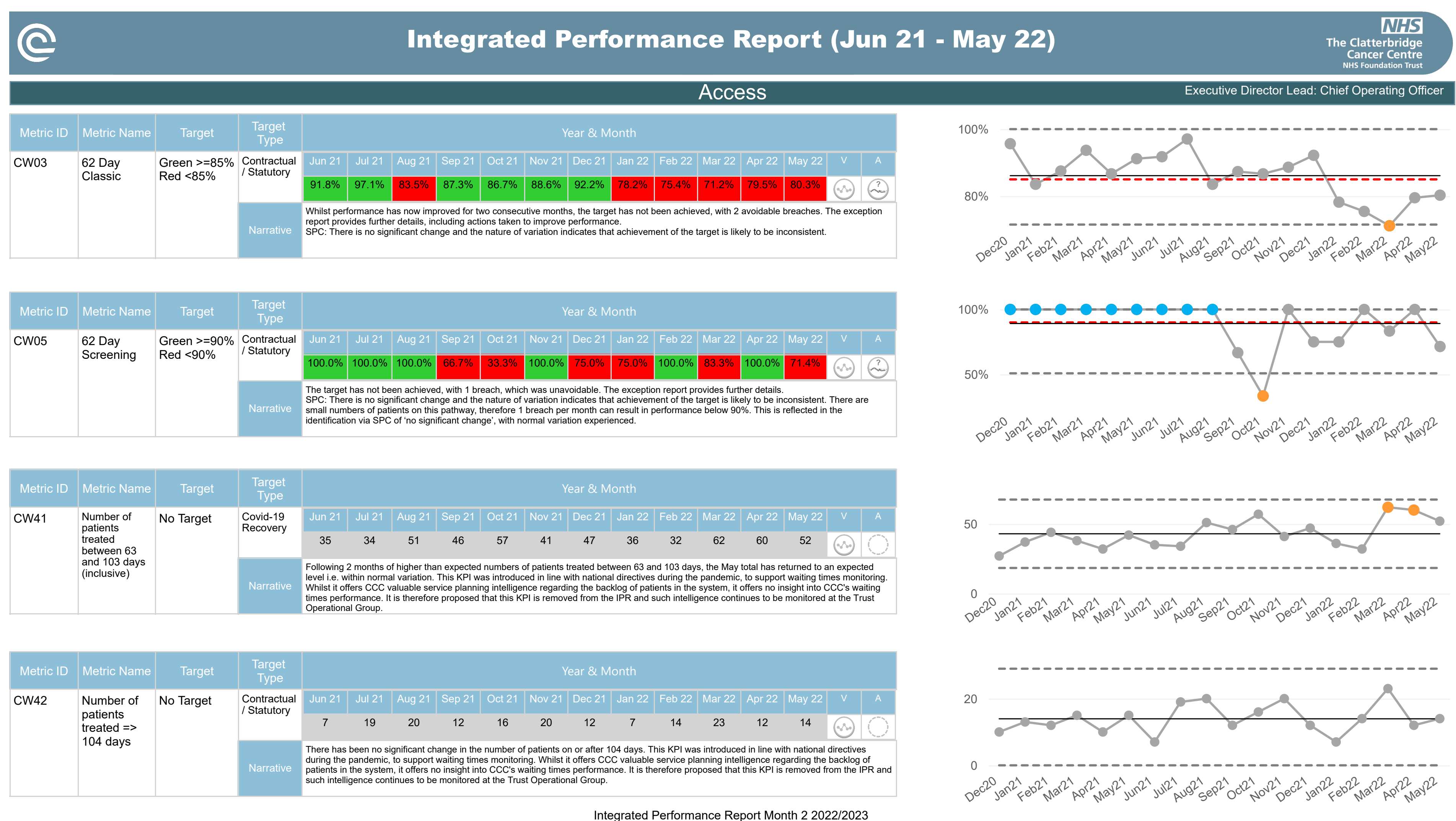
Narrative: The target has been achieved, with no 31 day patients treated on or after day 73.

Metric N/A for SPC

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
CW90	24 day wait target - Referral received to first treatment (62 Day Classics only)	Green >85% Amber 80-84.9% Red <80%		92.0%	93.8%	80.6%	88.2%	91.5%	85.0%	92.1%	72.6%	76.8%	81.9%	82.5%	86.5%		

Narrative: Performance figures have improved consistently since January 2022 and the target has now been achieved for May 2022.
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 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Executive Director Lead: Chief Operating Officer

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
CW03	62 Day Classic	Green >=85% Red <85%	Contractual / Statutory	91.8%	97.1%	83.5%	87.3%	86.7%	88.6%	92.2%	78.2%	75.4%	71.2%	79.5%	80.3%		

Narrative: Whilst performance has now improved for two consecutive months, the target has not been achieved, with 2 avoidable breaches. The exception report provides further details, including actions taken to improve performance.
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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
CW05	62 Day Screening	Green >=90% Red <90%	Contractual / Statutory	100.0%	100.0%	100.0%	66.7%	33.3%	100.0%	75.0%	75.0%	100.0%	83.3%	100.0%	71.4%		

Narrative: The target has not been achieved, with 1 breach, which was unavoidable. The exception report provides further details.
SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. There are small numbers of patients on this pathway, therefore 1 breach per month can result in performance below 90%. This is reflected in the identification via SPC of 'no significant change', with normal variation experienced.

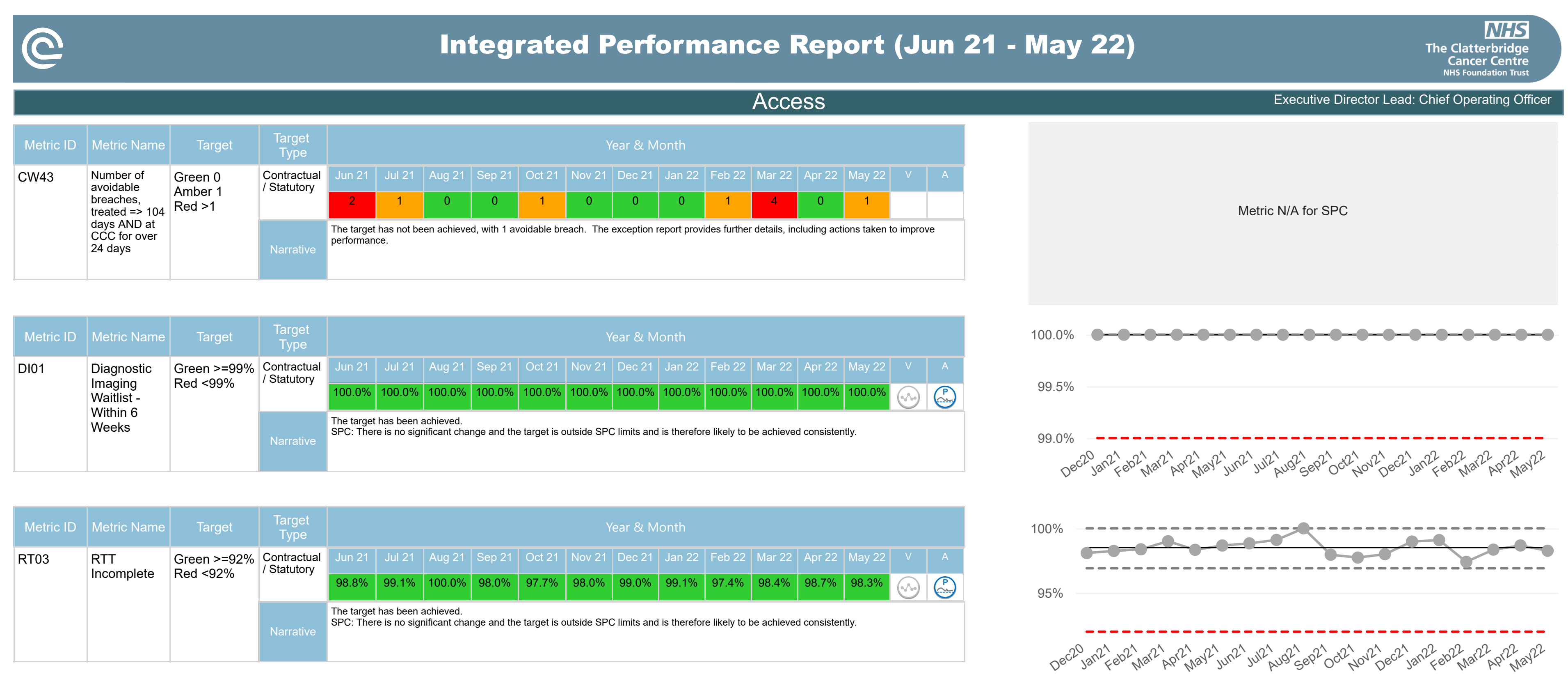
Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
CW41	Number of patients treated between 63 and 103 days (inclusive)	No Target	Covid-19 Recovery	35	34	51	46	57	41	47	36	32	62	60	52		

Narrative: Following 2 months of higher than expected numbers of patients treated between 63 and 103 days, the May total has returned to an expected level i.e. within normal variation. This KPI was introduced in line with national directives during the pandemic, to support waiting times monitoring. Whilst it offers CCC valuable service planning intelligence regarding the backlog of patients in the system, it offers no insight into CCC's waiting times performance. It is therefore proposed that this KPI is removed from the IPR and such intelligence continues to be monitored at the Trust Operational Group.

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

Narrative: There has been no significant change in the number of patients on or after 104 days. This KPI was introduced in line with national directives during the pandemic, to support waiting times monitoring. Whilst it offers CCC valuable service planning intelligence regarding the backlog of patients in the system, it offers no insight into CCC's waiting times performance. It is therefore proposed that this KPI is removed from the IPR and such intelligence continues to be monitored at the Trust Operational Group.

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Executive Director Lead: Chief Operating Officer

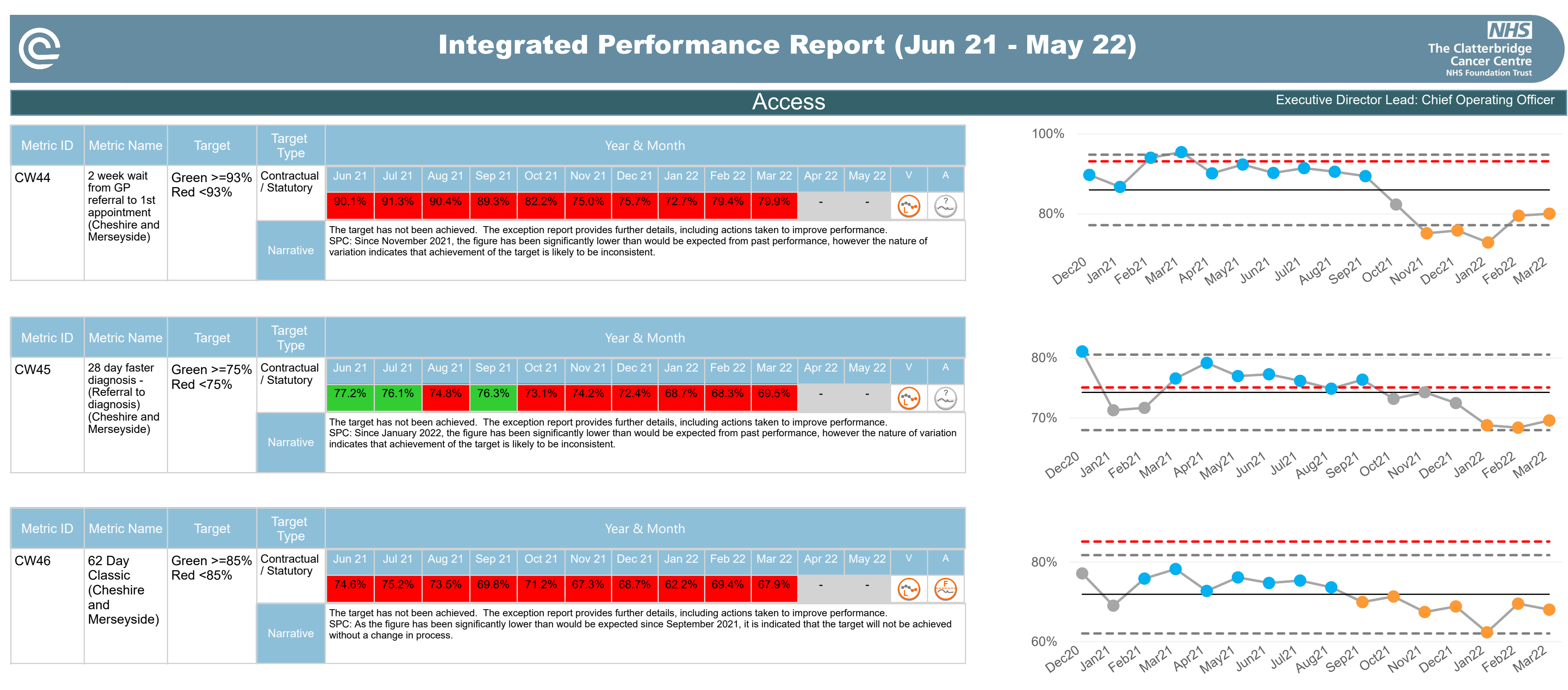
Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
CW43	Number of avoidable breaches, treated => 104 days AND at CCC for over 24 days	Green 0 Amber 1 Red >1	Contractual / Statutory	2	1	0	0	1	0	0	0	1	4	0	1		
			Narrative	The target has not been achieved, with 1 avoidable breach. The exception report provides further details, including actions taken to improve performance.													

Metric N/A for SPC

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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 target is outside SPC limits and is therefore likely to be achieved consistently.													

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
RT03	RTT Incomplete	Green >=92% Red <92%	Contractual / Statutory	98.8%	99.1%	100.0%	98.0%	97.7%	98.0%	99.0%	99.1%	97.4%	98.4%	98.7%	98.3%		
			Narrative	The target has been achieved. SPC: There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.													

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Executive Director Lead: Chief Operating Officer

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
CW44	2 week wait from GP referral to 1st appointment (Cheshire and Merseyside)	Green >=93% Red <93%	Contractual / Statutory	90.1%	91.3%	90.4%	89.3%	82.2%	75.0%	75.7%	72.7%	79.4%	79.9%	-	-		

Narrative: The target has not been achieved. The exception report provides further details, including actions taken to improve performance.
SPC: Since November 2021, the figure has been significantly lower than would be expected from past performance, however the nature of variation indicates that achievement of the target is likely to be inconsistent.

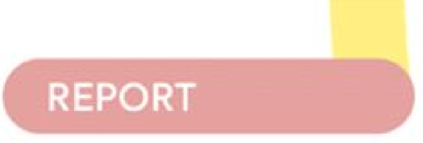
Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
CW45	28 day faster diagnosis - (Referral to diagnosis) (Cheshire and Merseyside)	Green >=75% Red <75%	Contractual / Statutory	77.2%	76.1%	74.8%	76.3%	73.1%	74.2%	72.4%	68.7%	68.3%	69.5%	-	-		

Narrative: The target has not been achieved. The exception report provides further details, including actions taken to improve performance.
SPC: Since January 2022, the figure has been significantly lower than would be expected from past performance, however the nature of variation indicates that achievement of the target is likely to be inconsistent.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
CW46	62 Day Classic (Cheshire and Merseyside)	Green >=85% Red <85%	Contractual / Statutory	74.6%	75.2%	73.5%	69.8%	71.2%	67.3%	68.7%	62.2%	69.4%	67.9%	-	-		

Narrative: The target has not been achieved. The exception report provides further details, including actions taken to improve performance.
SPC: As the figure has been significantly lower than would be expected since September 2021, it is indicated that the target will not be achieved without a change in process.

Integrated Performance Report Month 2 2022/2023



Access Exception Reports

28 day faster diagnosis - (Referral to diagnosis)	Target	May 22
	Green >=75% Red <75%	63.6%
Reason for Non-Compliance		
4 of the 11 patients on this pathway breached the target in May. Three of the breaches were unavoidable, due to medical reasons and patient choice. The avoidable breach was due to a delay to receiving diagnostic test results from another Trust.		
Action Taken to Improve Compliance		
Following the transfer of the Aintree HO service to CCC, the target has not been achieved. This is a result of the Aintree HO service offering a support and guidance service to GPs to minimise the number of patients requiring a 2 week rule appointment. Consequently this reduces the denominator and therefore makes the target difficult to achieve. The Aintree process has now been revised and this activity will now be included in the denominator, resulting in improved performance figures. The CBU Manager at CCC has collaborated with her counterpart at LUHFT to develop a formal escalation process, which has now been implemented. This is enacted whenever there are delays with diagnostics.		
Expected Date of Compliance	July 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 Classic	Target	May 22
	Green >=85% Red <85%	80.3%
Reason for Non-Compliance		
Although performance has improved marginally and is now above 80%, achieving the target remains challenging due to the increased number of late referrals. The Trust received the highest number of referrals ever in May 2022, with 1106 in month and a weekly high of 302 for the week commencing 23rd May. In May, a total of 111 patients were treated at CCC on a 62 day classic pathway. 79 of the 111 came in late to CCC. However, CCC treated 96 of the 111 within 24 days, which equates to 86.5%. Despite CCC treating 86.5% of patients within 24 days, a proportion of these (treated within 24 days but exceeding 62 days due to the late referral) are not included in the calculation of the 62 day figure and therefore do not positively contribute to our performance. CCC do however incur half a breach for late referred, breaching patients who we do not treat within 24 days. The increasing demand for non-surgical oncology treatment at CCC as well as the number of patients referred in late is creating challenges to consistent delivery of the target. The Teams continue to escalate individual patients and only 2 of the 12 breaches were avoidable. These were both due to delays to radiotherapy. The unavoidable breaches were due to a complex pathway, awaiting molecular test results, medical reasons and patient choice. Tumour group breach split: • Lung: 6 • Urological: 2 • Head and Neck: 2 • HO: 1 • Gynae: 1		
Action Taken to Improve Compliance		
• Daily monitoring and escalating of appointment bookings remains in place to enable management and prioritisation for first appointments. A communication issue regarding escalation in Radiotherapy has been identified. Corrective action has been taken and the escalation process re-iterated and agreed with staff. • Molecular test delays: o GLH are procuring a next generation sequencing machine, which will expedite testing. o Discussions have taken place with Manchester Labs who currently process our genomics tests and it has been agreed that all EGFR tests will now be completed at LCL for a period of 6 months, whilst Manchester install new equipment to process the tests more quickly. • Further valuable developments have been made to the Cancer Waiting Times Dashboard, providing additional intelligence to clinical teams to support patient tracking and identification of areas for improvement in pathways.		
Expected Date of Compliance	July 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	

Access Exception Reports

62 Day Screening	Target	May 22
	Green >=90% Red <90%	71.4%
Reason for Non-Compliance		
Of the 9 62 day screening patients treated in May, 1 patient breached the target. The breach was unavoidable due to a complex pathway. The patient was referred to CCC from Breast Screening at another trust on day 37 and then required further investigation to confirm/exclude disease progression prior to confirming the treatment plan.		
Action Taken to Improve Compliance		
Expected Date of Compliance	June 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	

Number of avoidable breaches, treated => 104 days AND at CCC for over 24 days	Target	May 22
	Green 0 Amber 1 Red >1	1
Reason for Non-Compliance		
4 of the 13 patients who breached the 104 day target in May were not treated at CCC within 24 days. 1 of the 4 breaches was avoidable; due to a delay to radiotherapy. The 3 unavoidable breaches were due to a complex pathway and medical reasons.		
Action Taken to Improve Compliance		
A communication issue regarding escalation in Radiotherapy has been identified. Corrective action has been taken and the escalation process re-iterated and agreed with staff.		
Expected Date of Compliance	June 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	

Access Exception Reports

2 week wait from GP referral to 1st appointment (Cheshire and Merseyside)	Target	Mar 22
	Green >=93% Red <93%	79.9%
Reason for Non-Compliance		
Non-compliance with the 14 day standard was largely driven by underperformance in the following tumour groups: Suspected breast cancer 49.4% (1330 breaches), Suspected gynaecological cancer 82.7% (229 breaches), Suspected upper gastrointestinal cancer 83.1% (223 breaches), Suspected lower gastrointestinal cancer 84% (458 breaches), Suspected skin cancer 89.8% (297 breaches), Suspected head and neck cancer 90.1% (127 breaches), Other suspected cancer (not listed) 90.6% (3 breaches), Suspected urological malignancies (excluding testicular) 90.9% (96 breaches), Suspected lung cancer 91.5% (19 breaches) Providers not achieving the national standard were: Liverpool Womens 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) Outpatient capacity issues were recorded as the most frequent breach reason (74%), followed by patient choice (18%).		
Action Taken to Improve Compliance		
· Business case for additional mammography machine at CoCH - approved · Additional consultant recruitment at CoCH (breast) · The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group to identify areas of service pressure. · £600,000 investment to support full implementation of symptomatic faecal immunochemical testing (sFIT) in primary care. This builds on the existing secondary care sFIT model. Implementation will reduce demand for endoscopy services. · Patient and public communications to improve patient confidence to attend for appointments. · 2ww referrals are now above pre-pandemic levels		
Expected Date of Compliance	July 2022	
Escalation Route	NHS England, North West CCC Performance Committee, Trust Board	
Executive Lead	Liz Bishop, CMCA SRO	

28 day faster diagnosis - (Referral to diagnosis) (Cheshire and Merseyside)	Target	Mar 22
	Green >=75% Red <75%	69.5%
Reason for Non-Compliance		
Non-compliance with the 28 day FDS was driven by underperformance in the following tumour groups: Suspected lower gastrointestinal cancer 48.3% (1436 breaches), Suspected urological malignancies (excluding testicular) 50.2% (410 breaches), Suspected haematological malignancies (excluding acute leukaemia) 50.5% (49 breaches), Referral from a National Screening Programme: Unknown Cancer Report Category 59.4% (167 breaches), Suspected upper gastrointestinal cancer 59.6% (517 breaches), Suspected gynaecological cancer 61.9% (488 breaches), Suspected testicular cancer 62.2% (14 breaches), Suspected lung cancer 70.8% (62 breaches), Other suspected cancer (not listed) 73.7% (5 breaches) Providers not achieving the national standard were: Liverpool Heart And Chest 45.5% (12 breaches), East Cheshire 58.4% (284 breaches), Liverpool Womens 61.1% (116 breaches), Liverpool University Hospitals 62.5% (1464 breaches), The Clatterbridge Cancer Centre 63.2% (7 breaches), Countess Of Chester Hospital 63.7% (431 breaches), Southport and Ormskirk Hospital 67.2% (373 breaches), Warrington and Halton Teaching Hospitals 70.3% (385 breaches), Bridgewater Community Healthcare 73.8% (73 breaches) The main reasons for breaches were outpatient capacity (28%), administrative delay (15%) and 'other' (16%).		
Action Taken to Improve Compliance		
· Continuation of surgical and diagnostics hubs as part of CMCA's response to Covid-19. · The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group. · The endoscopy operational recovery team, in collaboration with the C&M Hospital Cell has produced a clear, prioritised plan to increase capacity. · The Alliance has secured £5.4m capital investment to increase endoscopy capacity and improve productivity. · £600,000 investment to support full implementation of symptomatic faecal immunochemical testing (sFIT) in primary care. This builds on the existing secondary care sFIT model. Implementation will reduce demand for endoscopy services. · Further £400k invested in using FIT to validate and risk stratify LGI endoscopy waiting lists and surveillance lists. · Patient and public communications to improve patient confidence to attend for appointments. · Additional £1m secured to accelerate recovery especially in lower GI pathways		
Expected Date of Compliance	July 2022	
Escalation Route	NHS England, North West CCC Performance Committee, Trust Board	
Executive Lead	Liz Bishop, CMCA SRO	

Access Exception Reports

62 Day Classic (Cheshire and Merseyside)	Target	Mar 22
	Green >=85% Red <85%	67.9%

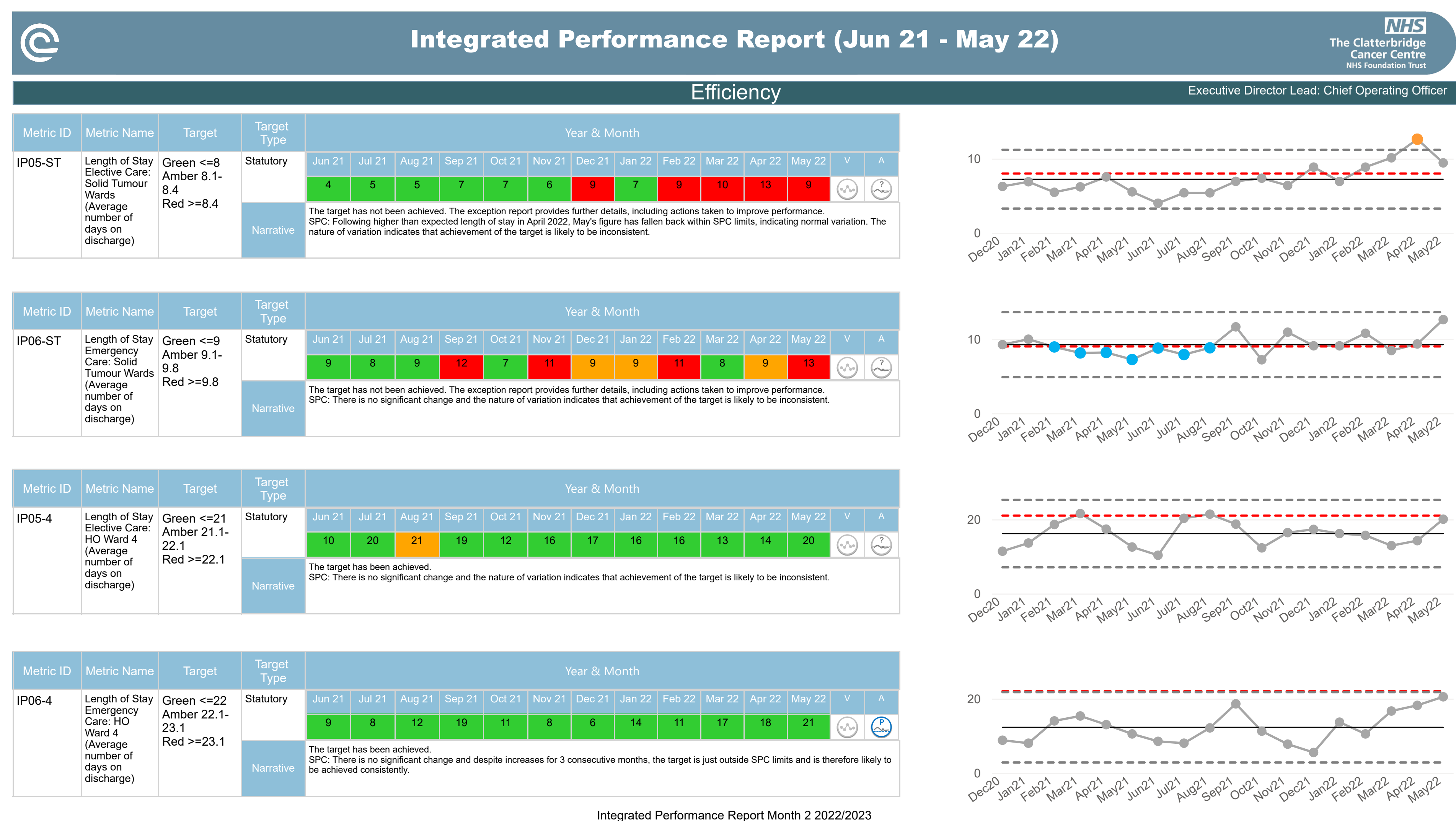
Reason for Non-Compliance

Non-compliance with the 62 day standard was driven by underperformance in the following tumour groups:
Gynaecological 32.4% (24 breaches), Lower Gastrointestinal 40.3% (47.5 breaches), Upper Gastrointestinal 47.3% (29 breaches), Sarcoma 52.9% (4 breaches), Head & Neck 54.2% (22 breaches), Haematological (Excluding Acute Leukaemia) 63.3% (11 breaches), Lung 66.2% (25 breaches), Other 66.7% (1 breaches), Urological (Excluding Testicular) 68.8% (40.5 breaches), Breast 73.2% (33.5 breaches)
Providers not achieving the national standard were:
Liverpool Womens 18.8% (13 breaches), Liverpool University Hospitals 52.5% (77 breaches), East Cheshire 53.8% (18 breaches), Countess Of Chester Hospital 63.2% (26.5 breaches), The Clatterbridge Cancer Centre 69.4% (16.5 breaches), Southport and Ormskirk Hospital 70.5% (18 breaches), Mid Cheshire Hospitals 71.5% (23.5 breaches), Wirral University Teaching Hospital 75.9% (24 breaches), Warrington and Halton Teaching Hospitals 77.1% (12 breaches)
The main reasons for breaches were complex diagnostic pathways (23%), healthcare provider initiated delay to diagnostic test or treatment planning (14%) and 'other' (36%).

Action Taken to Improve Compliance

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

Expected Date of Compliance	April 2023
Escalation Route	NHS England, North West CCC Performance Committee, Trust Board
Executive Lead	Liz Bishop, CMCA SRO



Integrated Performance Report (Jun 21 - May 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Executive Director Lead: Chief Operating Officer

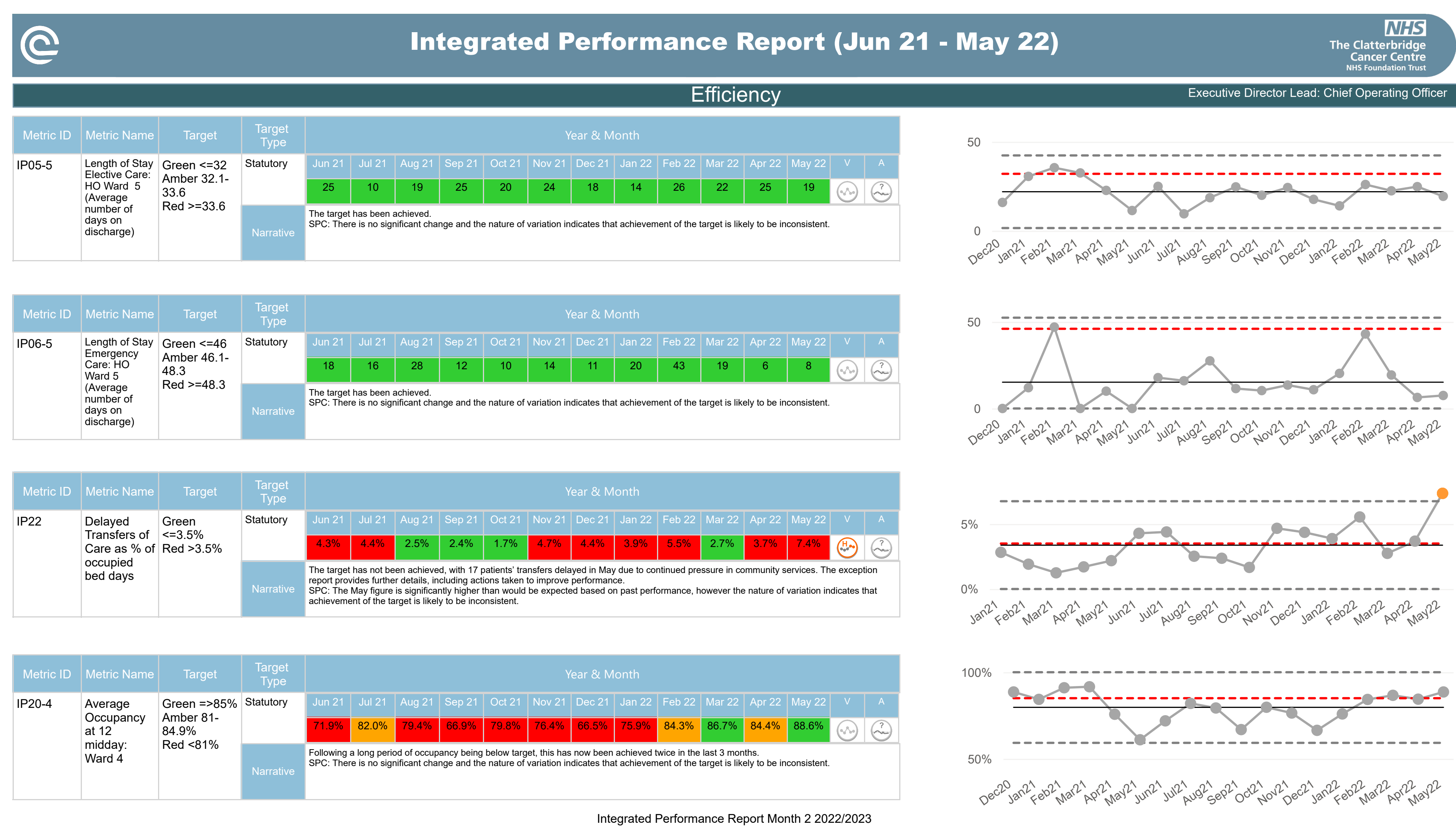
Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP05-ST	Length of Stay Elective Care: Solid Tumour Wards (Average number of days on discharge)	Green <=8 Amber 8.1-8.4 Red >=8.4	Statutory	4	5	5	7	7	6	9	7	9	10	13	9		
			Narrative	The target has not been achieved. The exception report provides further details, including actions taken to improve performance. SPC: Following higher than expected length of stay in April 2022, May's figure has fallen back within SPC limits, indicating normal variation. The nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP06-ST	Length of Stay Emergency Care: Solid Tumour Wards (Average number of days on discharge)	Green <=9 Amber 9.1-9.8 Red >=9.8	Statutory	9	8	9	12	7	11	9	9	11	8	9	13		
			Narrative	The target has not been achieved. The exception report provides further details, including actions taken to improve performance. 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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP05-4	Length of Stay Elective Care: HO Ward 4 (Average number of days on discharge)	Green <=21 Amber 21.1-22.1 Red >=22.1	Statutory	10	20	21	19	12	16	17	16	16	13	14	20		
			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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP06-4	Length of Stay Emergency Care: HO Ward 4 (Average number of days on discharge)	Green <=22 Amber 22.1-23.1 Red >=23.1	Statutory	9	8	12	19	11	8	6	14	11	17	18	21		
			Narrative	The target has been achieved. SPC: There is no significant change and despite increases for 3 consecutive months, the target is just outside SPC limits and is therefore likely to be achieved consistently.													

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Executive Director Lead: Chief Operating Officer

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP05-5	Length of Stay Elective Care: HO Ward 5 (Average number of days on discharge)	Green <=32 Amber 32.1-33.6 Red >=33.6	Statutory	25	10	19	25	20	24	18	14	26	22	25	19		

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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP06-5	Length of Stay Emergency Care: HO Ward 5 (Average number of days on discharge)	Green <=46 Amber 46.1-48.3 Red >=48.3	Statutory	18	16	28	12	10	14	11	20	43	19	6	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.

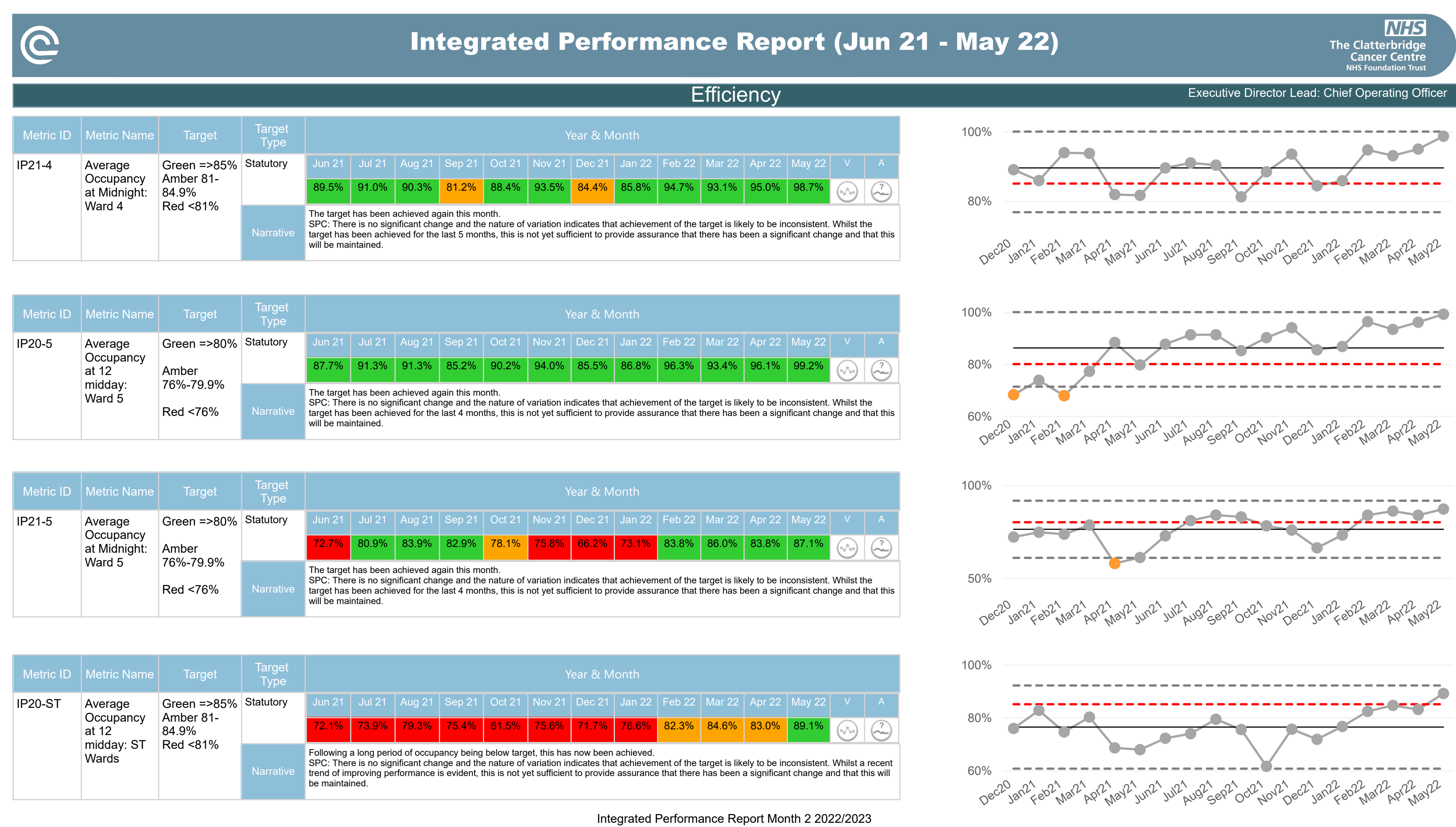
Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP22	Delayed Transfers of Care as % of occupied bed days	Green <=3.5% Red >3.5%	Statutory	4.3%	4.4%	2.5%	2.4%	1.7%	4.7%	4.4%	3.9%	5.5%	2.7%	3.7%	7.4%		

Narrative: The target has not been achieved, with 17 patients' transfers delayed in May due to continued pressure in community services. The exception report provides further details, including actions taken to improve performance.
SPC: The May figure is significantly higher than would be expected based on past performance, however the nature of variation indicates that achievement of the target is likely to be inconsistent.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP20-4	Average Occupancy at 12 midday: Ward 4	Green =>85% Amber 81-84.9% Red <81%	Statutory	71.9%	82.0%	79.4%	66.9%	79.8%	76.4%	66.5%	75.9%	84.3%	86.7%	84.4%	88.6%		

Narrative: Following a long period of occupancy being below target, this has now been achieved twice in the last 3 months.
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 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Executive Director Lead: Chief Operating Officer

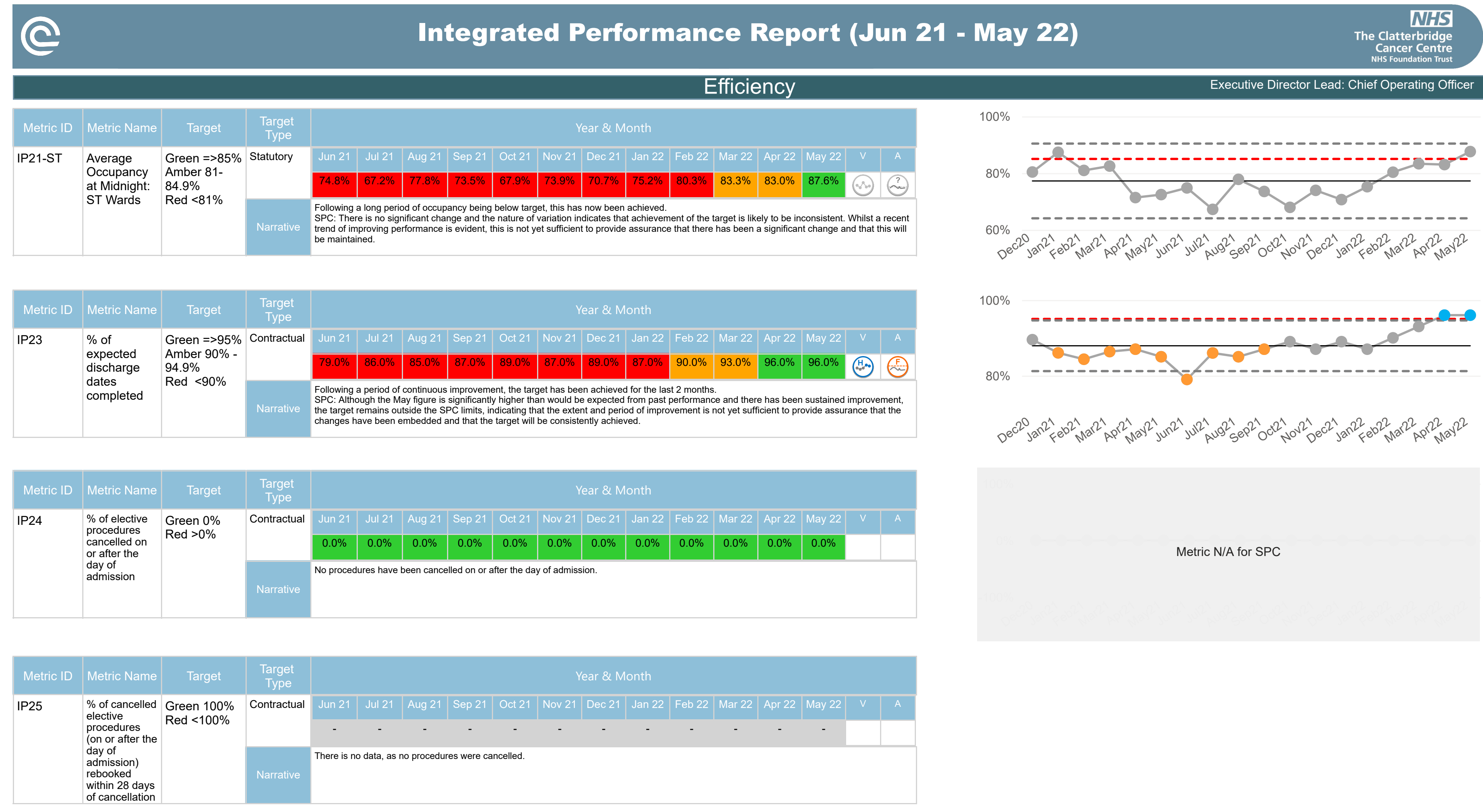
Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP21-4	Average Occupancy at Midnight: Ward 4	Green =>85% Amber 81-84.9% Red <81%	Statutory	89.5%	91.0%	90.3%	81.2%	88.4%	93.5%	84.4%	85.8%	94.7%	93.1%	95.0%	98.7%		
			Narrative	The target has been achieved again this month. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. Whilst the target has been achieved for the last 5 months, this is not yet sufficient to provide assurance that there has been a significant change and that this will be maintained.													

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP20-5	Average Occupancy at 12 midday: Ward 5	Green =>80% Amber 76%-79.9% Red <76%	Statutory	87.7%	91.3%	91.3%	85.2%	90.2%	94.0%	85.5%	86.8%	96.3%	93.4%	96.1%	99.2%		
			Narrative	The target has been achieved again this month. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. Whilst the target has been achieved for the last 4 months, this is not yet sufficient to provide assurance that there has been a significant change and that this will be maintained.													

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP21-5	Average Occupancy at Midnight: Ward 5	Green =>80% Amber 76%-79.9% Red <76%	Statutory	72.7%	80.9%	83.9%	82.9%	78.1%	75.8%	66.2%	73.1%	83.8%	86.0%	83.8%	87.1%		
			Narrative	The target has been achieved again this month. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. Whilst the target has been achieved for the last 4 months, this is not yet sufficient to provide assurance that there has been a significant change and that this will be maintained.													

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP20-ST	Average Occupancy at 12 midday: ST Wards	Green =>85% Amber 81-84.9% Red <81%	Statutory	72.1%	73.9%	79.3%	75.4%	61.5%	75.6%	71.7%	76.6%	82.3%	84.6%	83.0%	89.1%		
			Narrative	Following a long period of occupancy being below target, this has now been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. Whilst a recent trend of improving performance is evident, this is not yet sufficient to provide assurance that there has been a significant change and that this will be maintained.													

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Executive Director Lead: Chief Operating Officer

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP21-ST	Average Occupancy at Midnight: ST Wards	Green =>85% Amber 81-84.9% Red <81%	Statutory	74.8%	67.2%	77.8%	73.5%	67.9%	73.9%	70.7%	75.2%	80.3%	83.3%	83.0%	87.6%		

Narrative: Following a long period of occupancy being below target, this has now been achieved.
SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. Whilst a recent trend of improving performance is evident, this is not yet sufficient to provide assurance that there has been a significant change and that this will be maintained.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP23	% of expected discharge dates completed	Green =>95% Amber 90% - 94.9% Red <90%	Contractual	79.0%	86.0%	85.0%	87.0%	89.0%	87.0%	89.0%	87.0%	90.0%	93.0%	96.0%	96.0%		

Narrative: Following a period of continuous improvement, the target has been achieved for the last 2 months.
SPC: Although the May figure is significantly higher than would be expected from past performance and there has been sustained improvement, the target remains outside the SPC limits, indicating that the extent and period of improvement is not yet sufficient to provide assurance that the changes have been embedded and that the target will be consistently achieved.

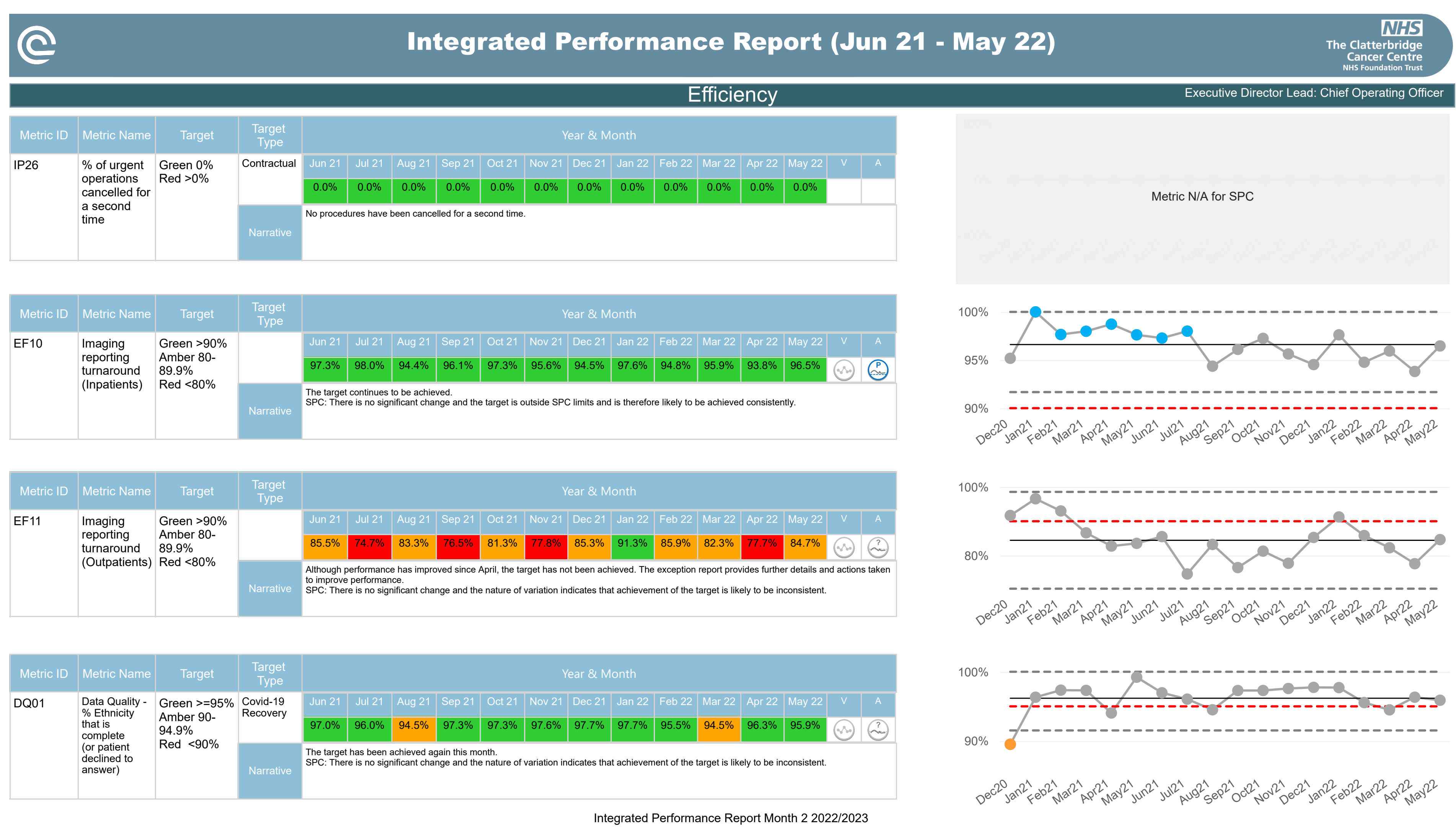
Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
IP24	% of elective procedures cancelled on or after the day of admission	Green 0% Red >0%	Contractual	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		

Narrative: No procedures have been cancelled on or after the day of admission.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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, as no procedures were cancelled.

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Executive Director Lead: Chief Operating Officer

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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	No procedures have been cancelled for a second time.													

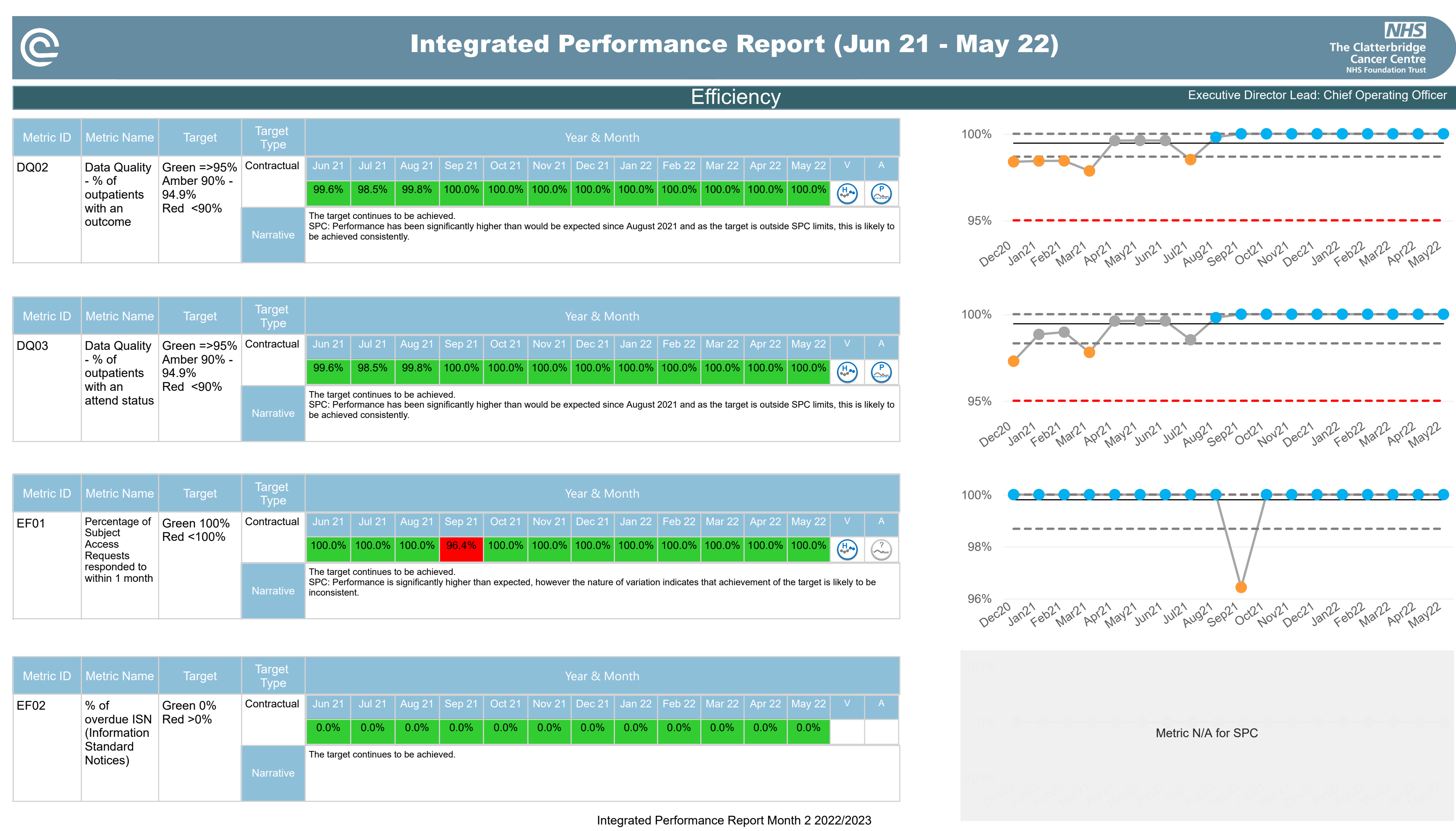
Metric N/A for SPC

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
EF10	Imaging reporting turnaround (Inpatients)	Green >90% Amber 80-89.9% Red <80%		97.3%	98.0%	94.4%	96.1%	97.3%	95.6%	94.5%	97.6%	94.8%	95.9%	93.8%	96.5%		
			Narrative	The target continues to be achieved. SPC: There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.													

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
EF11	Imaging reporting turnaround (Outpatients)	Green >90% Amber 80-89.9% Red <80%		85.5%	74.7%	83.3%	76.5%	81.3%	77.8%	85.3%	91.3%	85.9%	82.3%	77.7%	84.7%		
			Narrative	Although performance has improved since April, the target has not been achieved. The exception report provides further details and actions taken to improve performance. 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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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	97.0%	96.0%	94.5%	97.3%	97.3%	97.6%	97.7%	97.7%	95.5%	94.5%	96.3%	95.9%		
			Narrative	The target has been achieved again this month. 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 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Executive Director Lead: Chief Operating Officer

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
DQ02	Data Quality - % of outpatients with an outcome	Green =>95% Amber 90% - 94.9% Red <90%	Contractual	99.6%	98.5%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		

Narrative: The target continues to be achieved.
SPC: Performance has been significantly higher than would be expected since August 2021 and as the target is outside SPC limits, this is likely to be achieved consistently.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
DQ03	Data Quality - % of outpatients with an attend status	Green =>95% Amber 90% - 94.9% Red <90%	Contractual	99.6%	98.5%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		

Narrative: The target continues to be achieved.
SPC: Performance has been significantly higher than would be expected since August 2021 and as the target is outside SPC limits, this is likely to be achieved consistently.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		

Narrative: The target continues to be achieved.
SPC: Performance is significantly 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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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 continues to be achieved.

Integrated Performance Report Month 2 2022/2023

Efficiency Exception Reports

	Target	May 22
Length of Stay: Elective (days): Solid Tumour	Green <= 8 Amber 8.1-8.4 Red > 8.4	9
Length of Stay: Emergency (days): Solid Tumour	Green <= 9 Amber 9.1 - 9.8 Red >9.9	2.2%

Reason for Non-Compliance

The LOS for elective admissions on ST Wards was 1 day over the target of 8 days. The LOS for non-elective admissions on ST Wards was 4 days over the target of 9 days. In May, there has been an increase in the number of patients admitted for fractionated radiotherapy due to Spinal Cord Compression, with rehabilitation required. There has also been an increase in patients admitted with Immunotherapy toxicities. Due to community staffing issues and the number of referrals, it continues to take much longer to commission Packages of Care (POC), with delays of months rather than weeks. Further details of transfer delays are provided in the DTOC exception report. The CUR non-qualifying rate for May is 5%, which provides some assurance that there was a low incidence of inappropriate utilisation of beds, however this figure has risen in recent months, mirroring the discharge challenges.

Action Taken to Improve Compliance

The Patient Flow Team continue to work alongside the MDT to start discharge planning at the point of admission to prevent delays once patients are medically fit and ready for discharge.

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

	Target	May 22
Delayed Transfers of Care as % of occupied bed days	Green <=3.5% Red >3.5%	7.4%

Reason for Non-Compliance

Delayed transfers of care (DTOC) as a % of occupied bed days for the month of May was above the Trust target of ≤3.5%, at 7.4%. There were 17 DTOC in May, equating to 183 extra bed days. The average length of DTOC was 10.7 days. 8 patients awaited fast track packages of care (POC), resulting in 96 extra bed days. Covid continues to impact community services; increasing the length of time to commission a POC across all areas. 3 patients awaited fast track nursing home placement (a total of 39 extra bed days), with 1 of the 3 patients remaining in hospital for the whole of May due to complex nursing needs. 6 patients awaited hospice placement, resulting in 46 extra bed days. Some hospices have reduced day capacity due to Covid.

Action Taken to Improve Compliance

- Weekly 'Lengthened Length of Stay' meetings have continued with attendance of Matron and the Business Services Manager to ensure the flow of patients continues, and any concerns can be escalated. The outcome of these meetings are 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 that there is a clear plan for each patient.
- CHC (NHS Continuing Healthcare) are being contacted daily for an update on availability.

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

	Target	May 22
Imaging reporting turnaround (Outpatients)	Green >90% Amber 80-89.9% Red <80%	84.7%

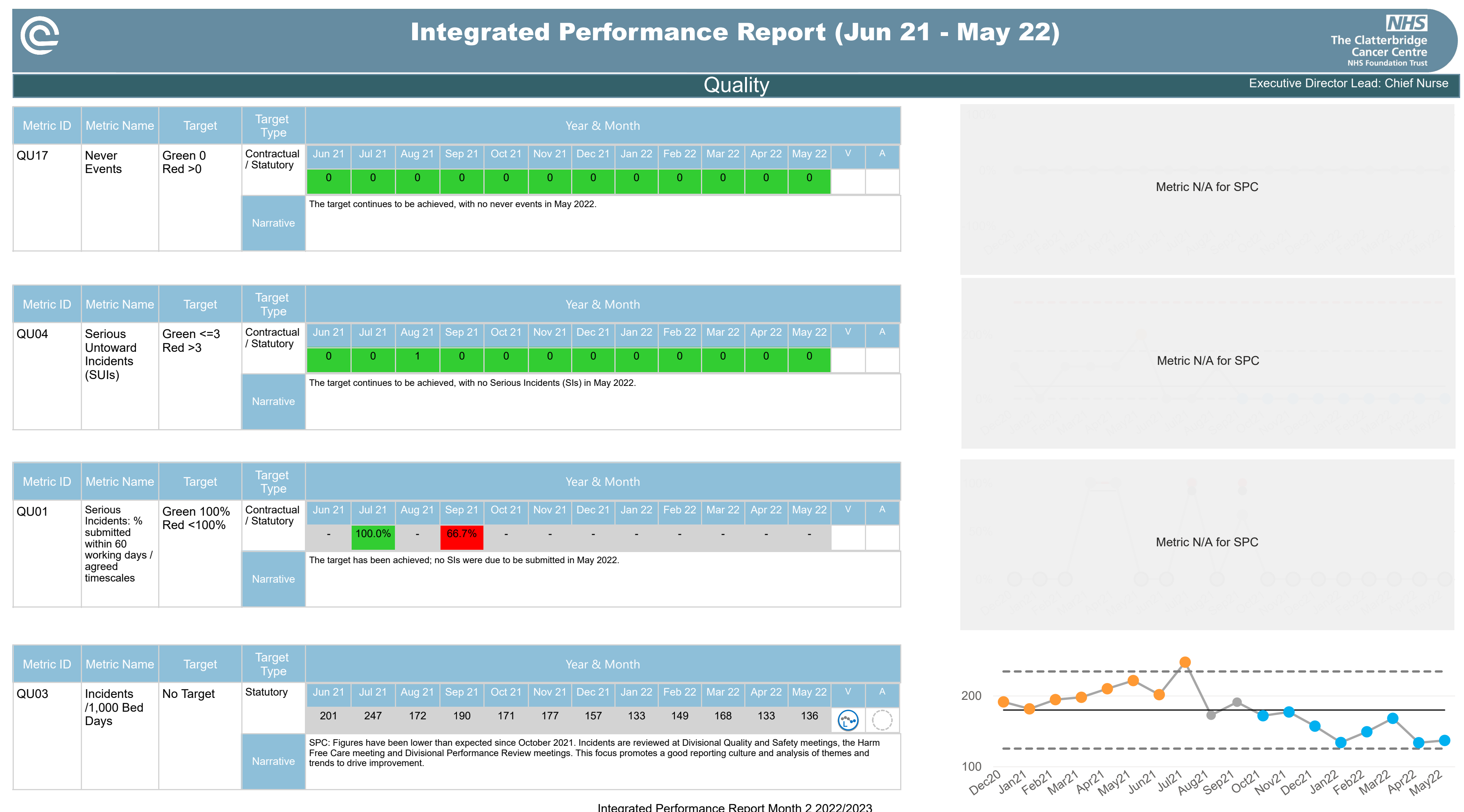
Reason for Non-Compliance

Although the target has not been achieved, performance has improved from 77.7% in April to 84.7% in May against a target of 90%. Reasons for non-compliance include: • Radiology activity has increased since CCCL opened, placing increasing demands on the Radiologist team • Loss of reporting capacity due to Radiologists supporting clinical services; Interventional Radiology and Ultrasound • Radiologist planned and unplanned absence • CCC Radiologists supporting additional MDT activity • Locum Radiologist planned to start in April declined post • Medica turnaround time targets not being met. The inpatient reporting target has been achieved over the last 12 months.

Action Taken to Improve Compliance

- On-going outsourcing of reporting activity to Medica
- On-going monitoring of Medica performance
- Clinical Imaging Fellow started in September 2021 and appointed to Consultant role, to start September 2022
- 1 interventional radiologist recruited – start date and job plan to be confirmed
- Radiologist started 3rd March 2022
- Interviews for additional Radiologists are scheduled for 30th May 2022.
- Weekly report received by senior radiology team enabling continuous monitoring and prioritisation of outstanding reports.

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



Integrated Performance Report (Jun 21 - May 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Executive Director Lead: Chief Nurse

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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 continues to be achieved, with no never events in May 2022.

Metric N/A for SPC

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU04	Serious Untoward Incidents (SUIs)	Green <=3 Red >3	Contractual / Statutory	0	0	1	0	0	0	0	0	0	0	0	0		

Narrative: The target continues to be achieved, with no Serious Incidents (SIs) in May 2022.

Metric N/A for SPC

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU01	Serious Incidents: % submitted within 60 working days / agreed timescales	Green 100% Red <100%	Contractual / Statutory	-	100.0%	-	66.7%	-	-	-	-	-	-	-	-		

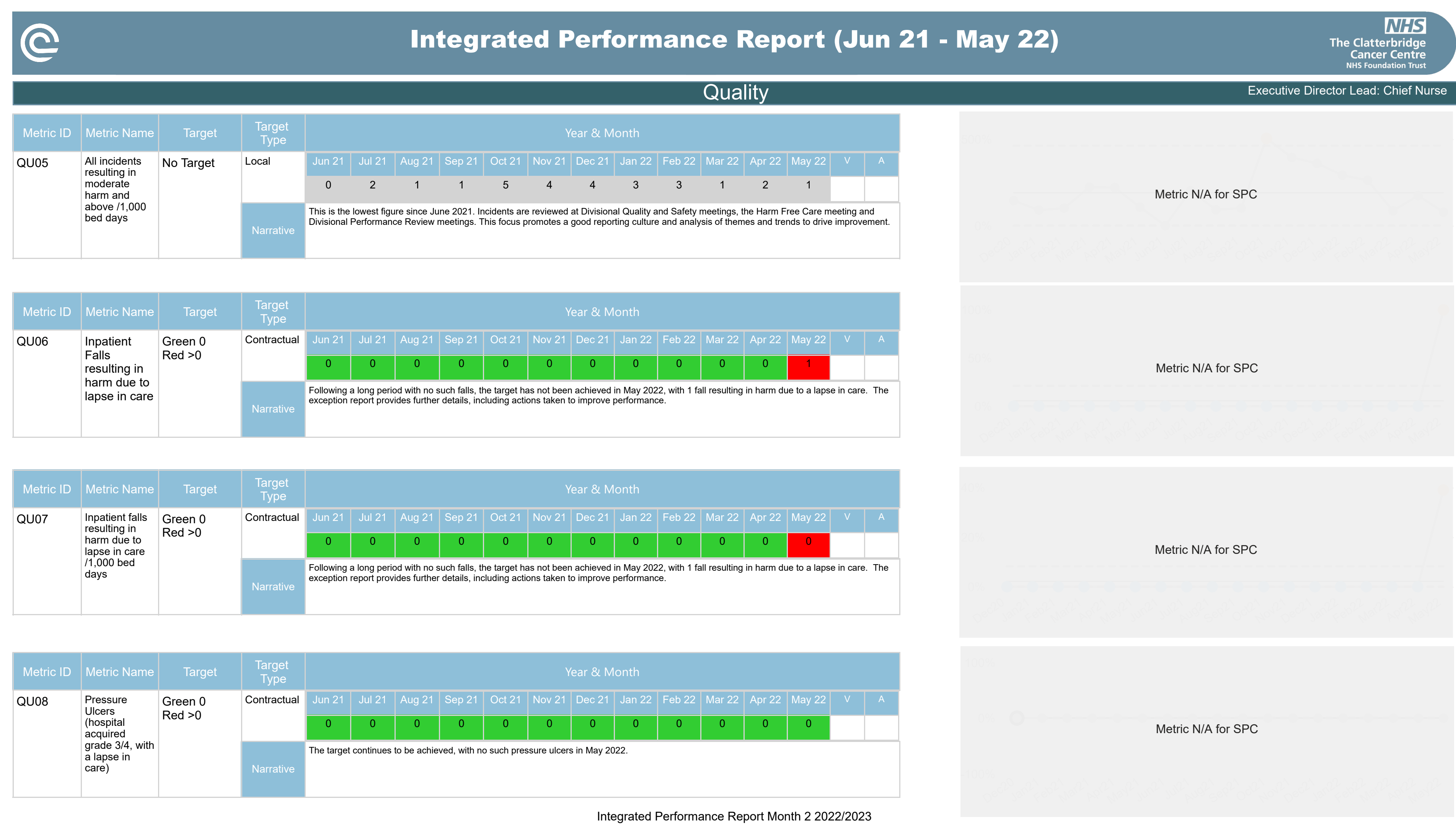
Narrative: The target has been achieved; no SIs were due to be submitted in May 2022.

Metric N/A for SPC

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU03	Incidents /1,000 Bed Days	No Target	Statutory	201	247	172	190	171	177	157	133	149	168	133	136		

Narrative: SPC: Figures have been lower than expected since October 2021. Incidents are reviewed at Divisional Quality and Safety meetings, the Harm Free Care meeting and Divisional Performance Review meetings. This focus promotes a good reporting culture and analysis of themes and trends to drive improvement.

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Executive Director Lead: Chief Nurse

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU05	All incidents resulting in moderate harm and above /1,000 bed days	No Target	Local	0	2	1	1	5	4	4	3	3	1	2	1		

Narrative: This is the lowest figure since June 2021. Incidents are reviewed at Divisional Quality and Safety meetings, the Harm Free Care meeting and Divisional Performance Review meetings. This focus promotes a good reporting culture and analysis of themes and trends to drive improvement.

Metric N/A for SPC

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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	1		

Narrative: Following a long period with no such falls, the target has not been achieved in May 2022, with 1 fall resulting in harm due to a lapse in care. The exception report provides further details, including actions taken to improve performance.

Metric N/A for SPC

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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: Following a long period with no such falls, the target has not been achieved in May 2022, with 1 fall resulting in harm due to a lapse in care. The exception report provides further details, including actions taken to improve performance.

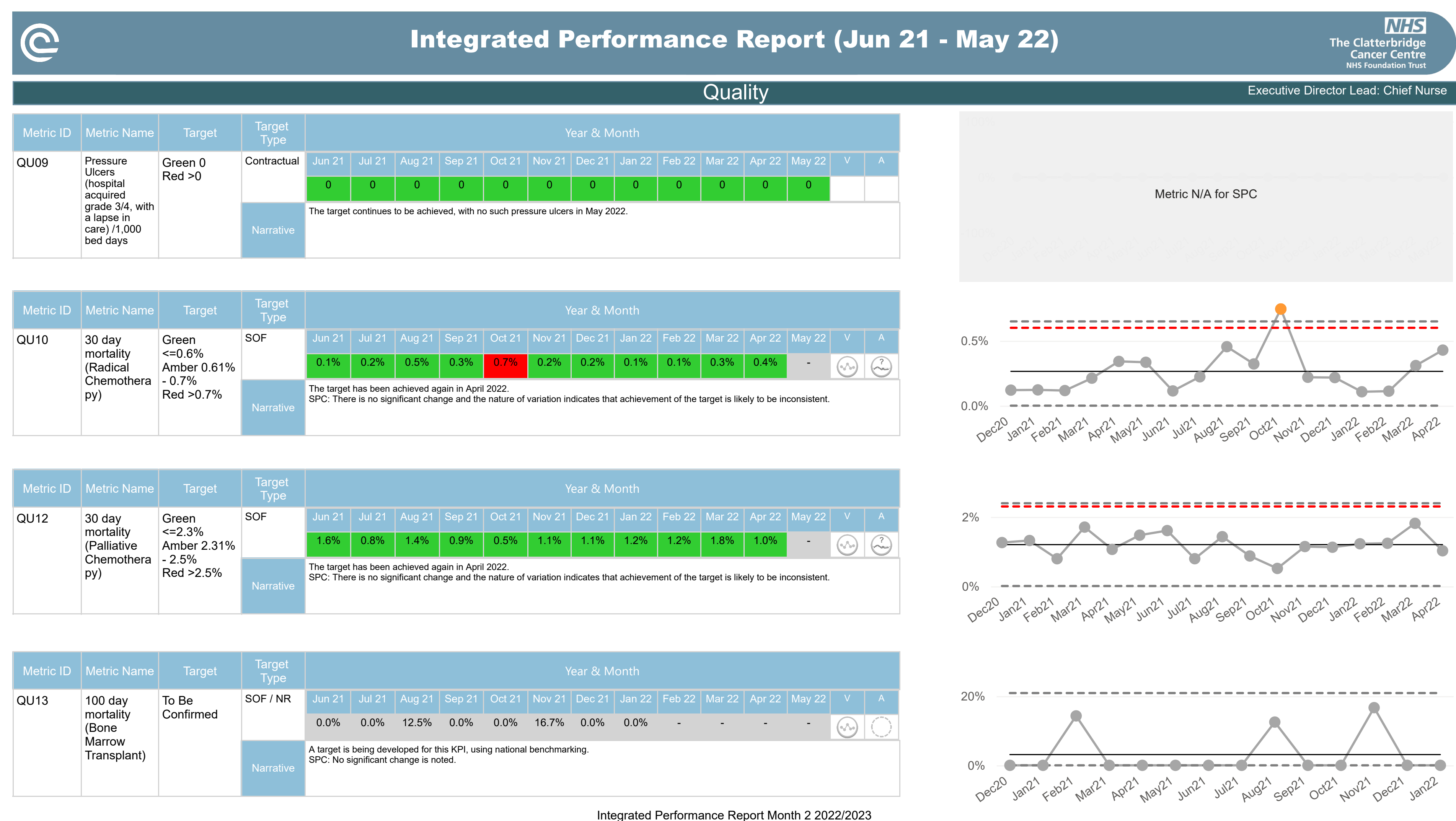
Metric N/A for SPC

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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 continues to be achieved, with no such pressure ulcers in May 2022.

Metric N/A for SPC

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Executive Director Lead: Chief Nurse

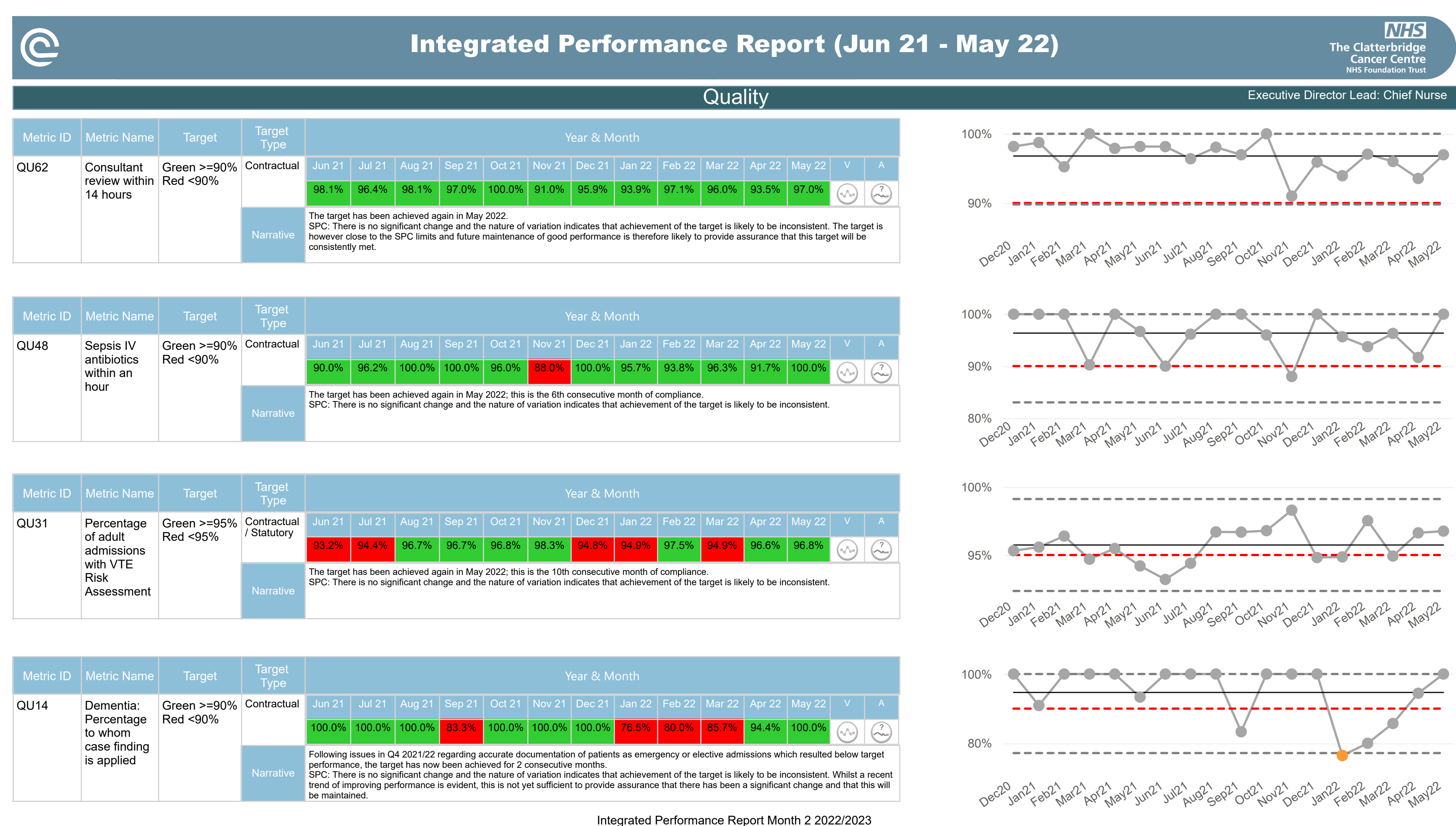
Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU09	Pressure Ulcers (hospital acquired grade 3/4, with a lapse in care) /1,000 bed days	Green 0 Red >0	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target continues to be achieved, with no such pressure ulcers in May 2022.													

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU10	30 day mortality (Radical Chemotherapy)	Green <=0.6% Amber 0.61% - 0.7% Red >0.7%	SOF	0.1%	0.2%	0.5%	0.3%	0.7%	0.2%	0.2%	0.1%	0.1%	0.3%	0.4%	-		
			Narrative	The target has been achieved again in April 2022. 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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU12	30 day mortality (Palliative Chemotherapy)	Green <=2.3% Amber 2.31% - 2.5% Red >2.5%	SOF	1.6%	0.8%	1.4%	0.9%	0.5%	1.1%	1.1%	1.2%	1.2%	1.8%	1.0%	-		
			Narrative	The target has been achieved again in April 2022. 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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU13	100 day mortality (Bone Marrow Transplant)	To Be Confirmed	SOF / NR	0.0%	0.0%	12.5%	0.0%	0.0%	16.7%	0.0%	0.0%	-	-	-	-		
			Narrative	A target is being developed for this KPI, using national benchmarking. SPC: No significant change is noted.													

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Executive Director Lead: Chief Nurse

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU62	Consultant review within 14 hours	Green >=90% Red <90%	Contractual	98.1%	96.4%	98.1%	97.0%	100.0%	91.0%	95.9%	93.9%	97.1%	96.0%	93.5%	97.0%		

Narrative: The target has been achieved again in May 2022.
SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. The target is however close to the SPC limits and future maintenance of good performance is therefore likely to provide assurance that this target will be consistently met.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU48	Sepsis IV antibiotics within an hour	Green >=90% Red <90%	Contractual	90.0%	96.2%	100.0%	100.0%	96.0%	88.0%	100.0%	95.7%	93.8%	96.3%	91.7%	100.0%		

Narrative: The target has been achieved again in May 2022; this is the 6th consecutive month of compliance.
SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.

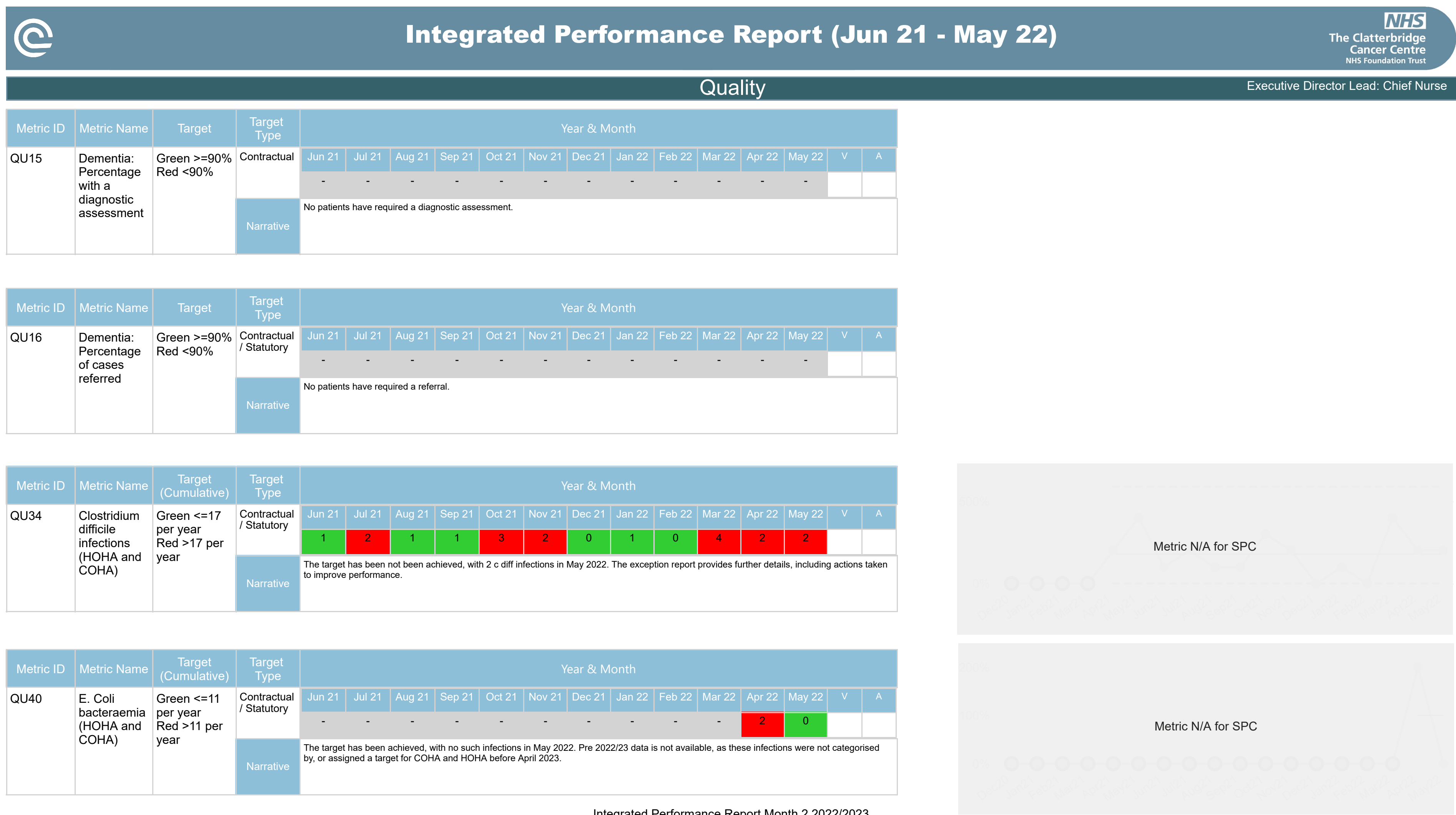
Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU31	Percentage of adult admissions with VTE Risk Assessment	Green >=95% Red <95%	Contractual / Statutory	93.2%	94.4%	96.7%	96.7%	96.8%	98.3%	94.8%	94.9%	97.5%	94.9%	96.6%	96.8%		

Narrative: The target has been achieved again in May 2022; this is the 10th consecutive month of compliance.
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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU14	Dementia: Percentage to whom case finding is applied	Green >=90% Red <90%	Contractual	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	100.0%	76.5%	80.0%	85.7%	94.4%	100.0%		

Narrative: Following issues in Q4 2021/22 regarding accurate documentation of patients as emergency or elective admissions which resulted below target performance, the target has now been achieved for 2 consecutive months.
SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. Whilst a recent trend of improving performance is evident, this is not yet sufficient to provide assurance that there has been a significant change and that this will be maintained.

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Executive Director Lead: Chief Nurse

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

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

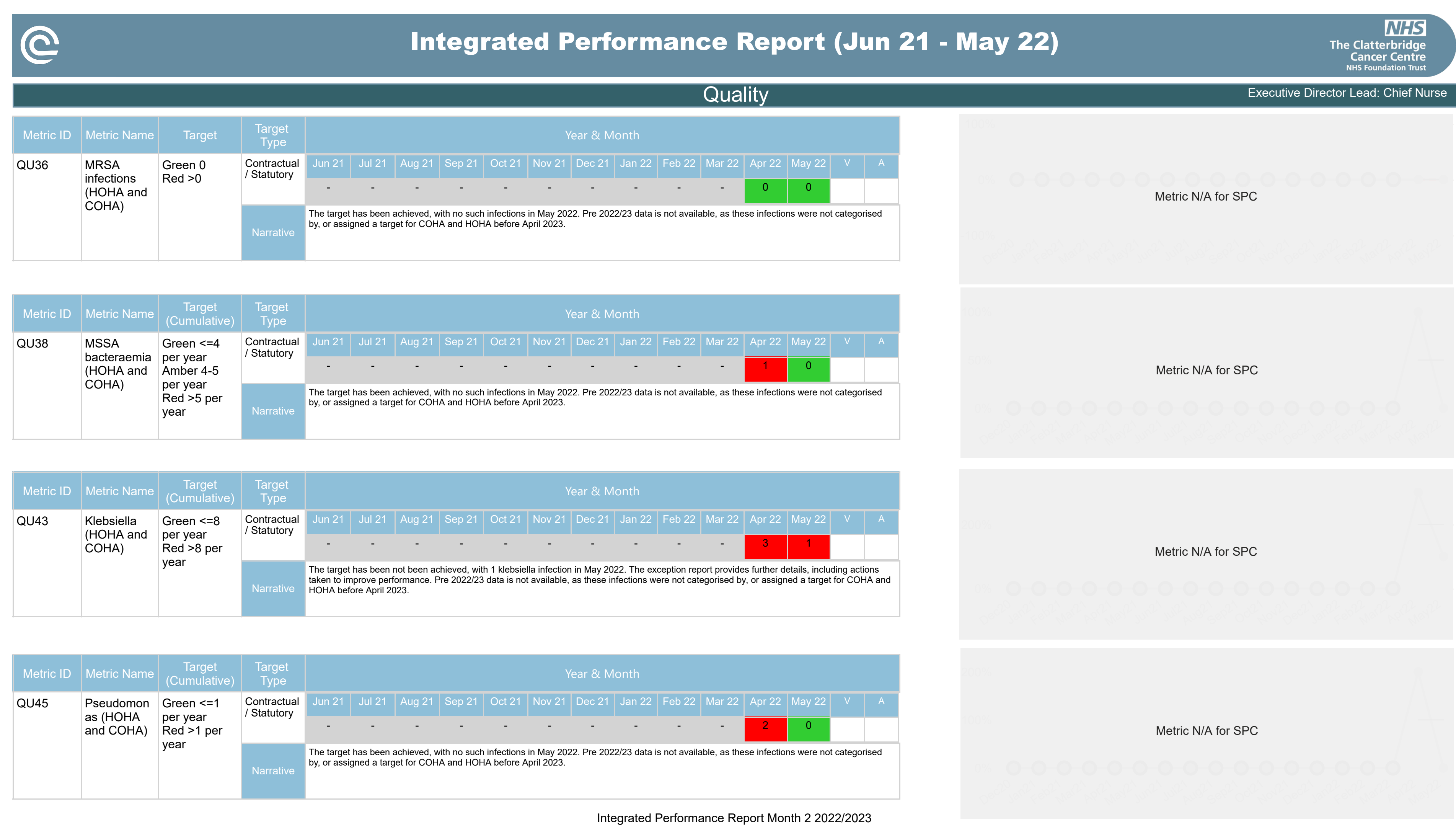
Metric ID	Metric Name	Target (Cumulative)	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU34	Clostridium difficile infections (HOHA and COHA)	Green <=17 per year Red >17 per year	Contractual / Statutory	1	2	1	1	3	2	0	1	0	4	2	2		
			Narrative	The target has been not been achieved, with 2 c diff infections in May 2022. The exception report provides further details, including actions taken to improve performance.													

Metric N/A for SPC

Metric ID	Metric Name	Target (Cumulative)	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU40	E. Coli bacteraemia (HOHA and COHA)	Green <=11 per year Red >11 per year	Contractual / Statutory	-	-	-	-	-	-	-	-	-	-	2	0		
			Narrative	The target has been achieved, with no such infections in May 2022. Pre 2022/23 data is not available, as these infections were not categorised by, or assigned a target for COHA and HOHA before April 2023.													

Metric N/A for SPC

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Executive Director Lead: Chief Nurse

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU36	MRSA infections (HOHA and COHA)	Green 0 Red >0	Contractual / Statutory	-	-	-	-	-	-	-	-	-	-	0	0		
			Narrative	The target has been achieved, with no such infections in May 2022. Pre 2022/23 data is not available, as these infections were not categorised by, or assigned a target for COHA and HOHA before April 2023.													

Metric N/A for SPC

Metric ID	Metric Name	Target (Cumulative)	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU38	MSSA bacteraemia (HOHA and COHA)	Green <=4 per year Amber 4-5 per year Red >5 per year	Contractual / Statutory	-	-	-	-	-	-	-	-	-	-	1	0		
			Narrative	The target has been achieved, with no such infections in May 2022. Pre 2022/23 data is not available, as these infections were not categorised by, or assigned a target for COHA and HOHA before April 2023.													

Metric N/A for SPC

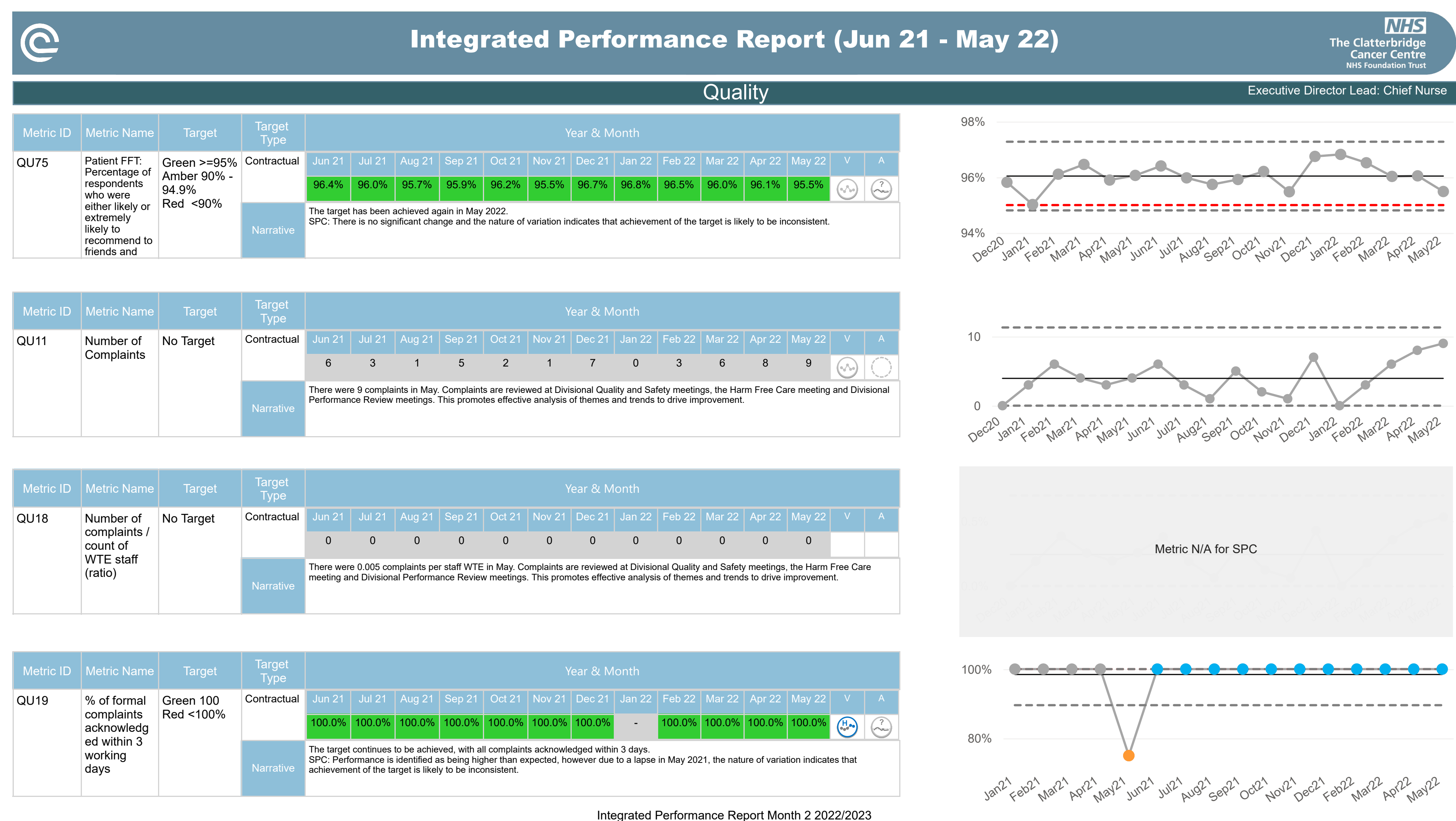
Metric ID	Metric Name	Target (Cumulative)	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU43	Klebsiella (HOHA and COHA)	Green <=8 per year Red >8 per year	Contractual / Statutory	-	-	-	-	-	-	-	-	-	-	3	1		
			Narrative	The target has been not been achieved, with 1 klebsiella infection in May 2022. The exception report provides further details, including actions taken to improve performance. Pre 2022/23 data is not available, as these infections were not categorised by, or assigned a target for COHA and HOHA before April 2023.													

Metric N/A for SPC

Metric ID	Metric Name	Target (Cumulative)	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU45	Pseudomonas (HOHA and COHA)	Green <=1 per year Red >1 per year	Contractual / Statutory	-	-	-	-	-	-	-	-	-	-	2	0		
			Narrative	The target has been achieved, with no such infections in May 2022. Pre 2022/23 data is not available, as these infections were not categorised by, or assigned a target for COHA and HOHA before April 2023.													

Metric N/A for SPC

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Executive Director Lead: Chief Nurse

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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	96.4%	96.0%	95.7%	95.9%	96.2%	95.5%	96.7%	96.8%	96.5%	96.0%	96.1%	95.5%		

Narrative: The target has been achieved again in May 2022.
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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU11	Number of Complaints	No Target	Contractual	6	3	1	5	2	1	7	0	3	6	8	9		

Narrative: There were 9 complaints in May. Complaints are reviewed at Divisional Quality and Safety meetings, the Harm Free Care meeting and Divisional Performance Review meetings. This promotes effective analysis of themes and trends to drive improvement.

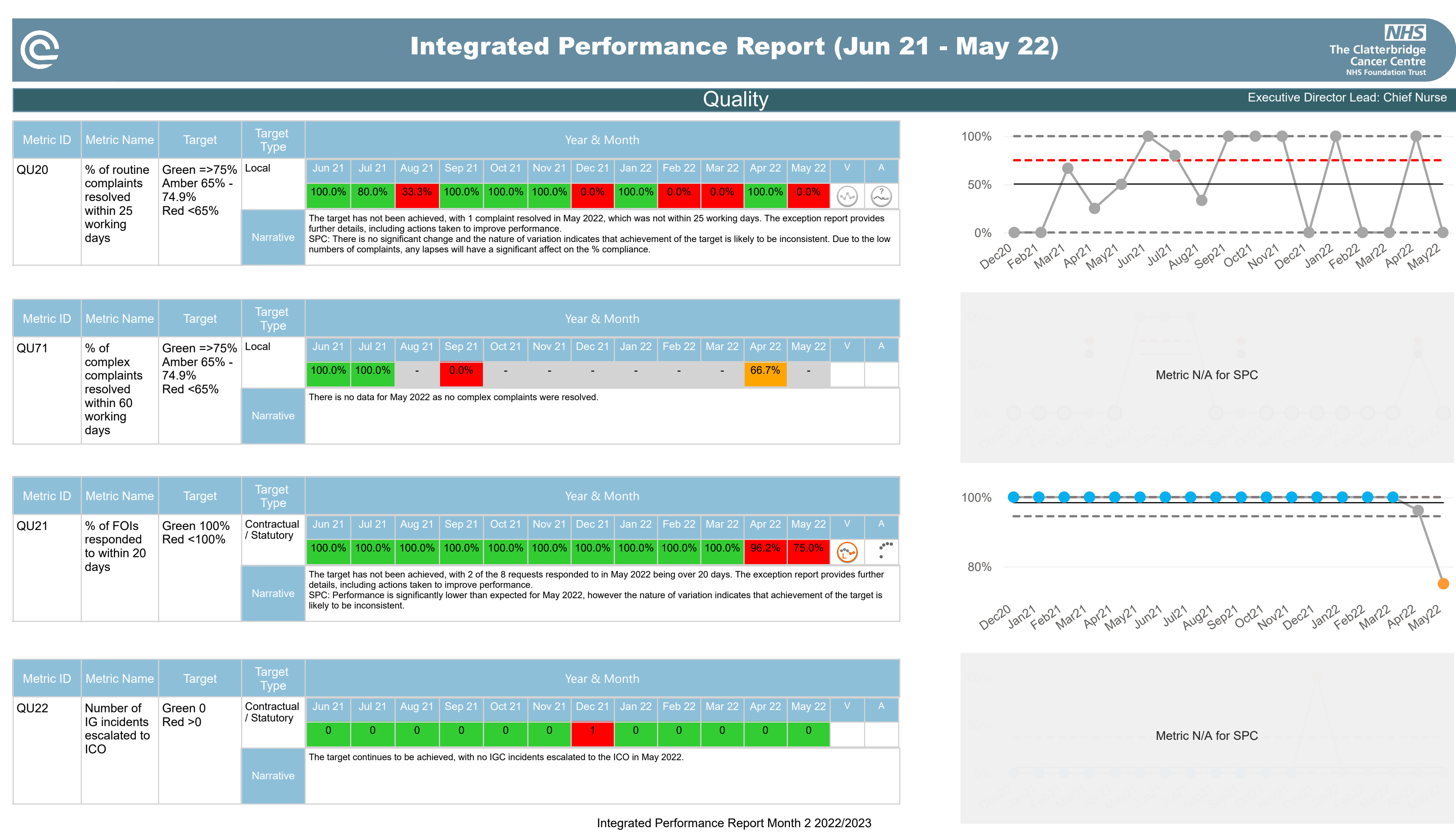
Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU18	Number of complaints / count of WTE staff (ratio)	No Target	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		

Narrative: There were 0.005 complaints per staff WTE in May. Complaints are reviewed at Divisional Quality and Safety meetings, the Harm Free Care meeting and Divisional Performance Review meetings. This promotes effective analysis of themes and trends to drive improvement.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU19	% of formal complaints acknowledged within 3 working days	Green 100 Red <100%	Contractual	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 continues to be achieved, with all complaints acknowledged within 3 days.
SPC: Performance is identified as being higher than expected, however due to a lapse in May 2021, the nature of variation indicates that achievement of the target is likely to be inconsistent.

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Executive Director Lead: Chief Nurse

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU20	% of routine complaints resolved within 25 working days	Green =>75% Amber 65% - 74.9% Red <65%	Local	100.0%	80.0%	33.3%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%		

Narrative: The target has not been achieved, with 1 complaint resolved in May 2022, which was not within 25 working days. The exception report provides further details, including actions taken to improve performance.
SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. Due to the low numbers of complaints, any lapses will have a significant affect on the % compliance.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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%	-	0.0%	-	-	-	-	-	-	66.7%	-		

Narrative: There is no data for May 2022 as no complex complaints were resolved.

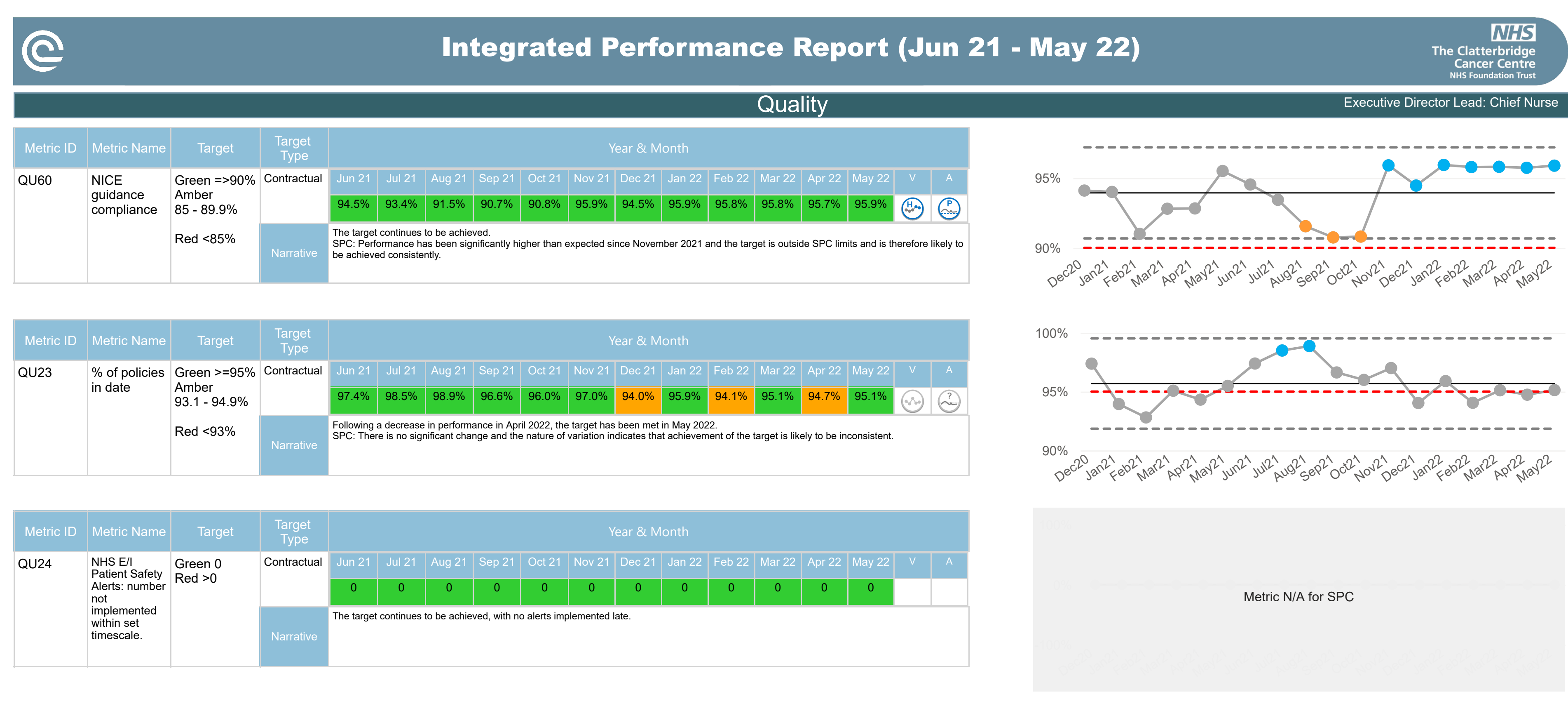
Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU21	% of FOIs responded to within 20 days	Green 100% Red <100%	Contractual / Statutory	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	75.0%		

Narrative: The target has not been achieved, with 2 of the 8 requests responded to in May 2022 being over 20 days. The exception report provides further details, including actions taken to improve performance.
SPC: Performance is significantly lower than expected for May 2022, however the nature of variation indicates that achievement of the target is likely to be inconsistent.

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

Narrative: The target continues to be achieved, with no IGC incidents escalated to the ICO in May 2022.

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Executive Director Lead: Chief Nurse

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU60	NICE guidance compliance	Green =>90% Amber 85 - 89.9% Red <85%	Contractual	94.5%	93.4%	91.5%	90.7%	90.8%	95.9%	94.5%	95.9%	95.8%	95.8%	95.7%	95.9%		

Narrative: The target continues to be achieved.
SPC: Performance has been significantly higher than expected since November 2021 and the target is outside SPC limits and is therefore likely to be achieved consistently.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
QU23	% of policies in date	Green >=95% Amber 93.1 - 94.9% Red <93%	Contractual	97.4%	98.5%	98.9%	96.6%	96.0%	97.0%	94.0%	95.9%	94.1%	95.1%	94.7%	95.1%		

Narrative: Following a decrease in performance in April 2022, the target has been met in May 2022.
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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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 continues to be achieved, with no alerts implemented late.

Integrated Performance Report Month 2 2022/2023

Inpatient Falls resulting in harm due to lapse in care	Target	May 22
	Green 0 Red >0	1
Reason for Non-Compliance		
Following immunotherapy treatment, later the same evening the patient fell whilst mobilising to the bathroom; the fall was witnessed by a member of staff. A full investigation has been carried out and a report is scheduled to be taken to Patient Safety Committee for wider learning.		
Action Taken to Improve Compliance		
Ward Manager contacted the Immunotherapy team to request further education and face to face training for ward staff Immunotherapy workbook on ESR to be refreshed as noted to be complicated and errors noted Clinical Practice Facilitator post to be recruited into.		
Expected Date of Compliance	July 2022	
Escalation Route	Harm Free Care Meeting, 'Divisional Quality, Safety and Performance Meeting', Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board	
Executive Lead	Julie Gray, Chief Nurse	

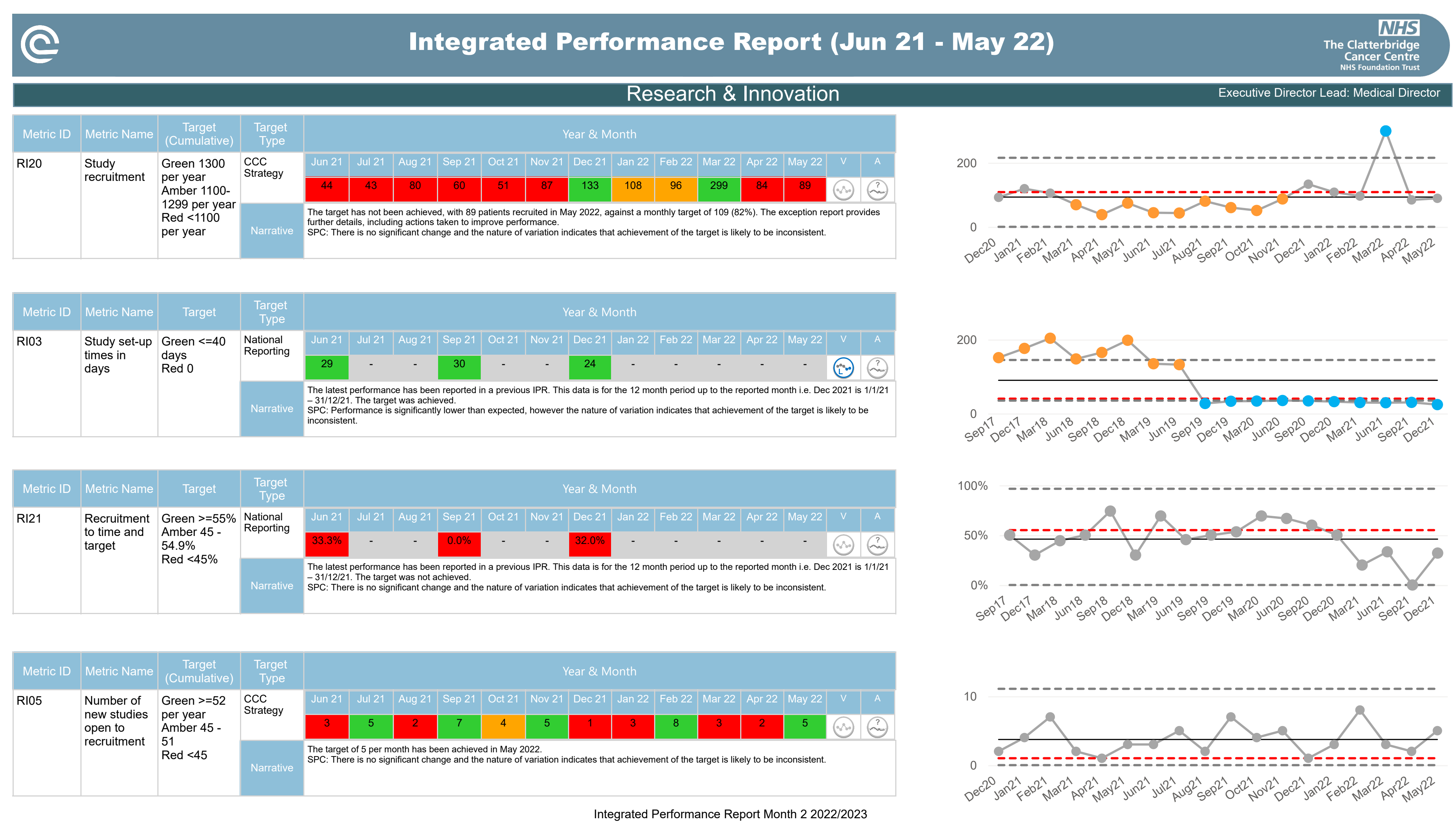
Clostridium difficile infections (HOHA and COHA)	Target	May 22
	Green <=17 per year Red >17 per year	2
Reason for Non-Compliance		
Two C.diff infections were identified in May, against an annual threshold of 17. 2 X HOHA: One patient developed loose stools 7 days after admission and was sampled promptly. No learning points were identified from this episode of infection. Gaps were identified in the documentation of the second patient, it is therefore unclear when loose stools developed and if samples could have been obtained sooner. Definitions: HOHA: Hospital-Onset Healthcare Associated, where days from admission to specimen date is equal to or greater than 3 days		
Action Taken to Improve Compliance		
A task and finish group is being established, with the Matron, Ward and IPC staff involvement, to ensure accurate documentation and 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	

Klebsiella (HOHA and COHA)	Target	May 22
	Green <=8 per year Red >8 per year	1
Reason for Non-Compliance		
1 HOHA Klebsiella pneumoniae bloodstream infection was identified in April 2022. Source was likely to be a wound adjacent to a leaking stoma. Patient was under the care of the Tissue Viability Nurse. There is potential for the referral to Tissue Viability to have been made earlier, but it is not clear if that would have affected the outcome in this case. Patient was also referred to the stoma team at LUHFT, however this was not picked up by the team at LUHFT and the current referral pathway is unclear on how to follow up on delayed/missed referrals		
Action Taken to Improve Compliance		
· Newly appointed TVN to commence in post next month – this will enable patient referrals to be identified at an earlier stage. · A robust referral pathway is required to the stoma team at LUHFT – this will be supported by the TVN		
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	

Quality Exception Reports

% of routine complaints resolved within 25 working days	Target	May 22
	Green =>75% Amber 65% - 74.9% Red <65%	0.0%
Reason for Non-Compliance		
The 1 complaint that was resolved in May 2022 was not resolved within 25 working days. The complaint was received from a patient's relative and the patient died soon after. It was then agreed with the relative that the complaint process would be paused, with a meeting scheduled for an agreed date. Following the meeting, during a follow up conversation, the relative confirmed that they had no further questions and was satisfied with the resolution.		
Action Taken to Improve Compliance		
Ongoing complaints are discussed at the divisional quality and safety meeting to ensure timescales are being adhered to.		
Expected Date of Compliance	June 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	May 22
	Green 100% Red <100%	75.0%
Reason for Non-Compliance		
Two of eight FOI responses exceeded the 20 working day turn around period. For one FOI request on transport services, there were multiple points of contact for the required information. It was unclear with whom certain contracts sat, hence a delay in obtaining all requested information. Ongoing staff absences in the team throughout May affected capacity to undertake FOI workload. This also lead to a significantly lower number of requests being responded to during the month of May.		
Action Taken to Improve Compliance		
FOI Administrator now in full time, supported by Information Governance Manager. It is however likely that the impact of the absence will bleed into the June data.		
Expected Date of Compliance	July 2022	
Escalation Route	Information Governance Board, Risk and Quality Governance Committee, Quality Committee, Trust Board	
Executive Lead	Julie Gray, Chief Nurse	



Integrated Performance Report (Jun 21 - May 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

Executive Director Lead: Medical Director

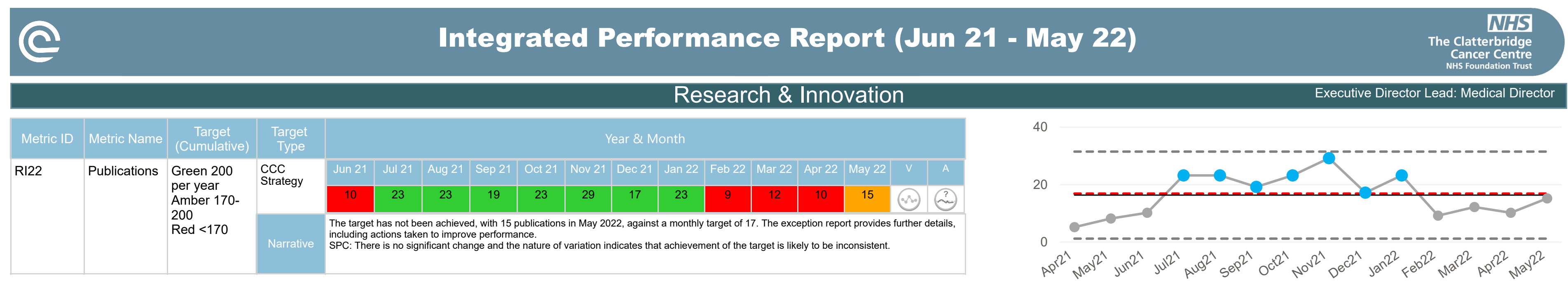
Metric ID	Metric Name	Target (Cumulative)	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
RI20	Study recruitment	Green 1300 per year Amber 1100-1299 per year Red <1100 per year	CCC Strategy	44	43	80	60	51	87	133	108	96	299	84	89		
			Narrative	The target has not been achieved, with 89 patients recruited in May 2022, against a monthly target of 109 (82%). The exception report provides further details, including actions taken to improve performance. 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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 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. The target was achieved. SPC: Performance is significantly 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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
RI21	Recruitment to time and target	Green >=55% Amber 45 - 54.9% Red <45%	National Reporting	33.3%	-	-	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. The target was not 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 (Cumulative)	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
RI05	Number of new studies open to recruitment	Green >=52 per year Amber 45 - 51 Red <45	CCC Strategy	3	5	2	7	4	5	1	3	8	3	2	5		
			Narrative	The target of 5 per month has been achieved in May 2022. 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 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

Executive Director Lead: Medical Director

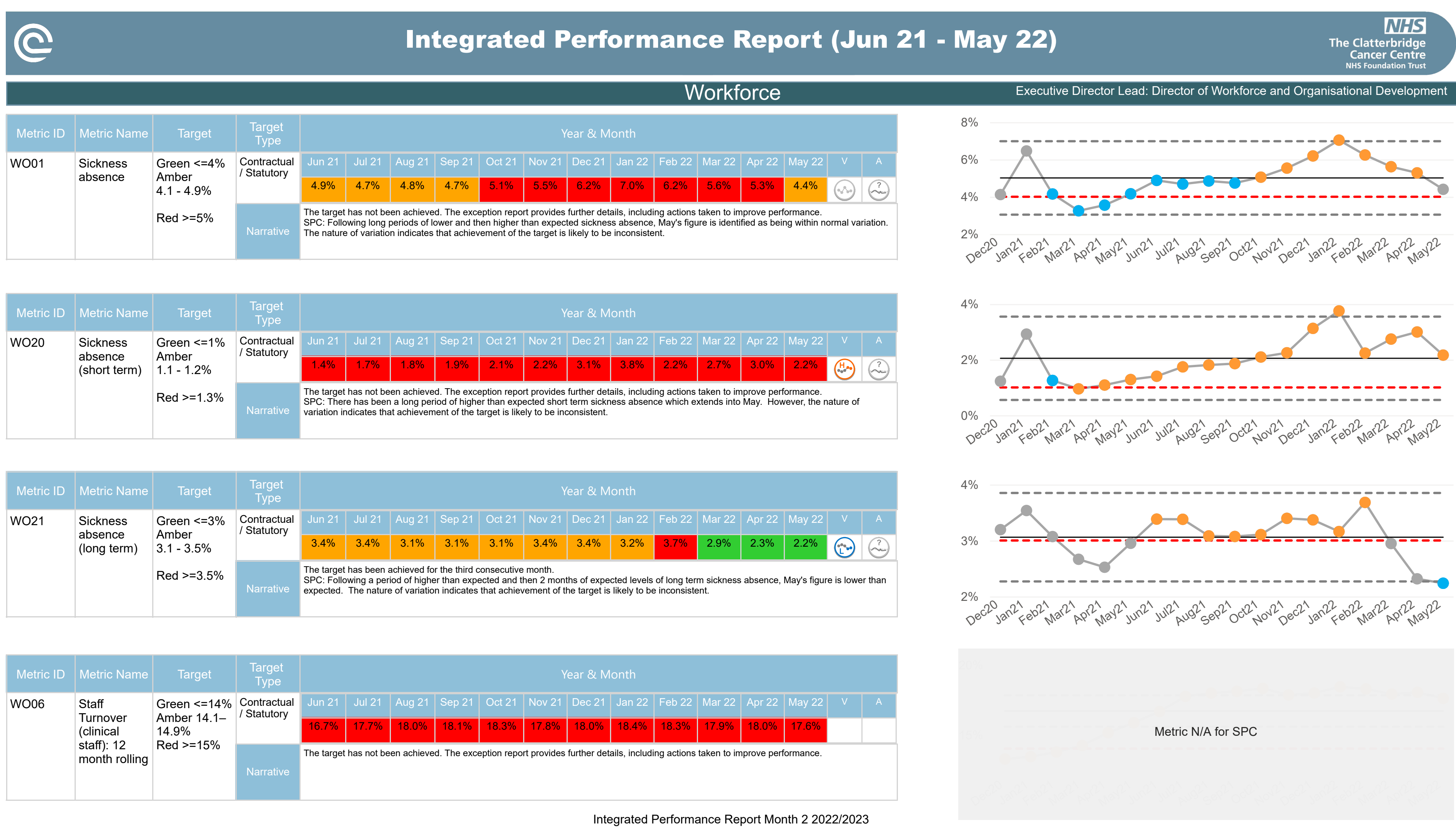
Metric ID	Metric Name	Target (Cumulative)	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
RI22	Publications	Green 200 per year Amber 170-200 Red <170	CCC Strategy	10	23	23	19	23	29	17	23	9	12	10	15		
			Narrative	The target has not been achieved, with 15 publications in May 2022, against a monthly target of 17. The exception report provides further details, including actions taken to improve performance. 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 2 2022/2023

Research & Innovation Exception Reports

Study recruitment	Target	May 22
	Green 1300 per year Amber 1100-1299 per year Red <1100 per year	89
Reason for Non-Compliance		
173 patients have been recruited against an internal target of 216 (80% of target) at the end of Month 2. The main reasons at Month 2 for not achieving this target is: • Recruitment will ebb and flow throughout the year and in-month targets may not be met. • Note: Recruitment in the month of May in 2022 is the highest it has been since reporting started in 2011. • Note: An additional 39 patients have been recruited compared to the same time point last year. • Note: Currently highest recruiter in the UK for a number of studies including the Finding my way Study. 124 patients recruited against a target of 125, 193 recruited in total nationally so CCC is the highest recruiter by far.		
Action Taken to Improve Compliance		
• New deputy Clinical Trial Pharmacist now in post to support the opening of increased drug trials. • Recruitment to real world, psychosocial, radiotherapy and nursing research studies fast tracked. 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	April 2023	
Escalation Route	SRG Research Leads, Committee for Research Strategy, Performance Committee, Trust Board	
Executive Lead	Sheena Khanduri, Medical Director	

Publications	Target	May 22
	Green 200 per year Amber 170-200 Red <170	15
Reason for Non-Compliance		
• Twenty-five research publications have been registered during April and May 2022, against an internal target of thirty-three at the end of Month 2 (75% 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. • Note: at the same time point last year we had registered thirteen publications.		
Action Taken to Improve Compliance		
• Work with the Library Services to ensure all publications are captured. • Work with the Director of Clinical Research to ensure the list is accurate. • Encourage staff to submit publications as part of the 'Achievements' request that is sent out each month to cross reference.		
Expected Date of Compliance	April 2023	
Escalation Route	SRG Research Leads, Committee for Research Strategy, Performance Committee, Trust Board	
Executive Lead	Sheena Khanduri, Medical Director	



Integrated Performance Report (Jun 21 - May 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Executive Director Lead: Director of Workforce and Organisational Development

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
WO01	Sickness absence	Green <=4% Amber 4.1 - 4.9% Red >=5%	Contractual / Statutory	4.9%	4.7%	4.8%	4.7%	5.1%	5.5%	6.2%	7.0%	6.2%	5.6%	5.3%	4.4%		

Narrative: The target has not been achieved. The exception report provides further details, including actions taken to improve performance.
SPC: Following long periods of lower and then higher than expected sickness absence, May's figure is identified as being within normal variation.
The nature of variation indicates that achievement of the target is likely to be inconsistent.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
WO20	Sickness absence (short term)	Green <=1% Amber 1.1 - 1.2% Red >=1.3%	Contractual / Statutory	1.4%	1.7%	1.8%	1.9%	2.1%	2.2%	3.1%	3.8%	2.2%	2.7%	3.0%	2.2%		

Narrative: The target has not been achieved. The exception report provides further details, including actions taken to improve performance.
SPC: There has been a long period of higher than expected short term sickness absence which extends into May. However, the nature of variation indicates that achievement of the target is likely to be inconsistent.

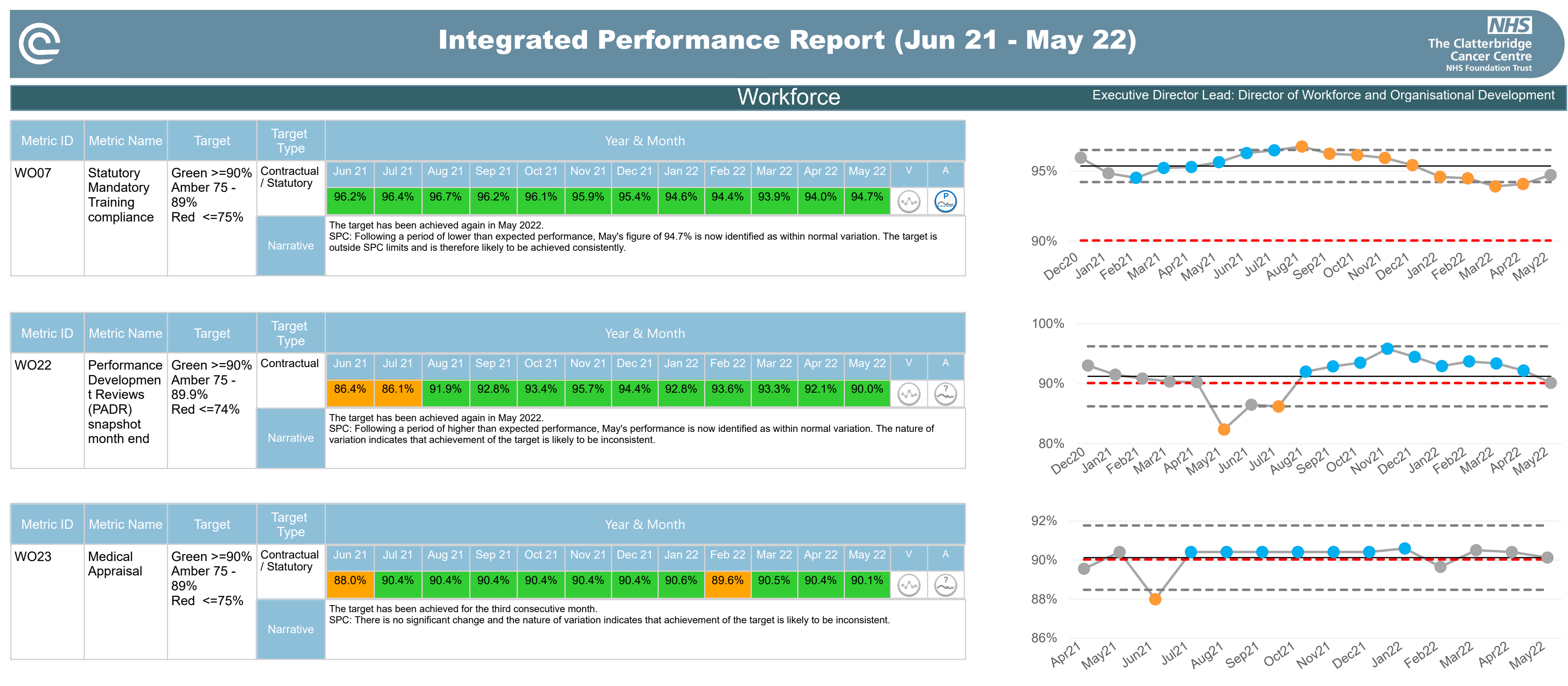
Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
WO21	Sickness absence (long term)	Green <=3% Amber 3.1 - 3.5% Red >=3.5%	Contractual / Statutory	3.4%	3.4%	3.1%	3.1%	3.1%	3.4%	3.4%	3.2%	3.7%	2.9%	2.3%	2.2%		

Narrative: The target has been achieved for the third consecutive month.
SPC: Following a period of higher than expected and then 2 months of expected levels of long term sickness absence, May's figure is lower than expected. The nature of variation indicates that achievement of the target is likely to be inconsistent.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
WO06	Staff Turnover (clinical staff): 12 month rolling	Green <=14% Amber 14.1– 14.9% Red >=15%	Contractual / Statutory	16.7%	17.7%	18.0%	18.1%	18.3%	17.8%	18.0%	18.4%	18.3%	17.9%	18.0%	17.6%		

Narrative: The target has not been achieved. The exception report provides further details, including actions taken to improve performance.

Integrated Performance Report Month 2 2022/2023



Integrated Performance Report (Jun 21 - May 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Executive Director Lead: Director of Workforce and Organisational Development

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
WO07	Statutory Mandatory Training compliance	Green >=90% Amber 75 - 89% Red <=75%	Contractual / Statutory	96.2%	96.4%	96.7%	96.2%	96.1%	95.9%	95.4%	94.6%	94.4%	93.9%	94.0%	94.7%

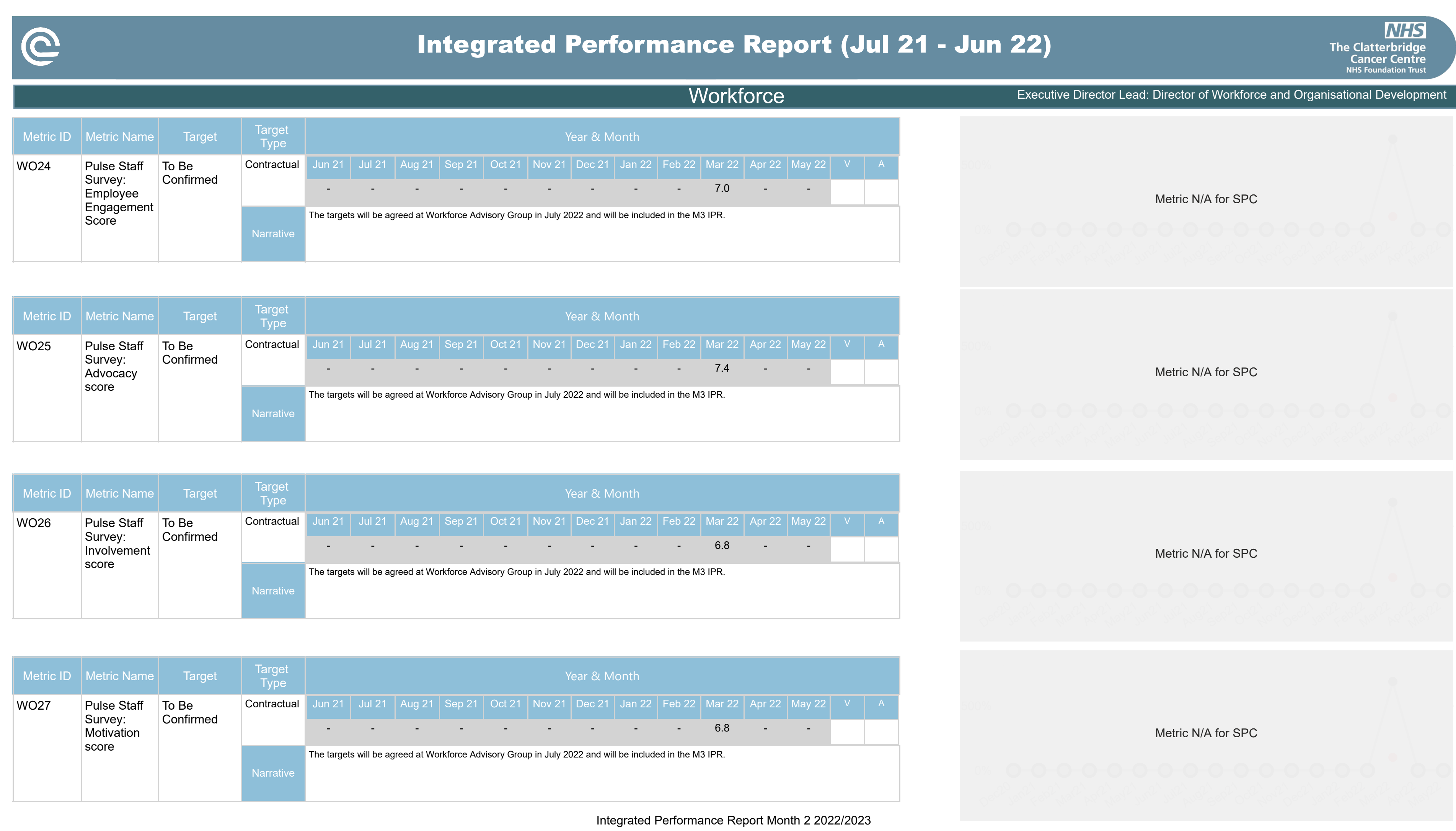
Narrative: The target has been achieved again in May 2022.
SPC: Following a period of lower than expected performance, May's figure of 94.7% is now identified as within normal variation. The target is outside SPC limits and is therefore likely to be achieved consistently.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
WO22	Performance Developmen t Reviews (PADR) snapshot month end	Green >=90% Amber 75 - 89.9% Red <=74%	Contractual	86.4%	86.1%	91.9%	92.8%	93.4%	95.7%	94.4%	92.8%	93.6%	93.3%	92.1%	90.0%

Narrative: The target has been achieved again in May 2022.
SPC: Following a period of higher than expected performance, May's performance is now identified as within normal variation. The nature of variation indicates that achievement of the target is likely to be inconsistent.

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
WO23	Medical Appraisal	Green >=90% Amber 75 - 89% Red <=75%	Contractual / Statutory	88.0%	90.4%	90.4%	90.4%	90.4%	90.4%	90.4%	90.6%	89.6%	90.5%	90.4%	90.1%

Narrative: The target has been achieved for the third consecutive month.
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 (Jul 21 - Jun 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Executive Director Lead: Director of Workforce and Organisational Development

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
WO24	Pulse Staff Survey: Employee Engagement Score	To Be Confirmed	Contractual	-	-	-	-	-	-	-	-	-	7.0	-	-		

Narrative: The targets will be agreed at Workforce Advisory Group in July 2022 and will be included in the M3 IPR.

Metric N/A for SPC

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
WO25	Pulse Staff Survey: Advocacy score	To Be Confirmed	Contractual	-	-	-	-	-	-	-	-	-	7.4	-	-		

Narrative: The targets will be agreed at Workforce Advisory Group in July 2022 and will be included in the M3 IPR.

Metric N/A for SPC

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
WO26	Pulse Staff Survey: Involvement score	To Be Confirmed	Contractual	-	-	-	-	-	-	-	-	-	6.8	-	-		

Narrative: The targets will be agreed at Workforce Advisory Group in July 2022 and will be included in the M3 IPR.

Metric N/A for SPC

Metric ID	Metric Name	Target	Target Type	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	V	A
WO27	Pulse Staff Survey: Motivation score	To Be Confirmed	Contractual	-	-	-	-	-	-	-	-	-	6.8	-	-		

Narrative: The targets will be agreed at Workforce Advisory Group in July 2022 and will be included in the M3 IPR.

Metric N/A for SPC

Integrated Performance Report Month 2 2022/2023

Workforce Exception Reports

	Target	May 22
Sickness Absence	Green <= 4% Amber 4.1% - 4.9% Red >= 5%	4.4%
Sickness Absence (short term)	Green <= 1% Amber 1.1% - 1.2% Red >= 1.3%	2.2%

Reason for Non-Compliance

Although still slightly above the Trust target of 4%, sickness absence decreased from 5.28% to 4.4% in May 2022. This table (Top right) summarises the absence position for each Division.

The 3 main causes of absence are summarised in the bottom right table.

Absences due to Gastrointestinal problems has increased consistently since February 2022, with an additional 9 episodes recorded in May 2022.

Chest and Respiratory problems remains within the top three reasons for absence, however there has been a significant decrease since April from 91 episodes (74 Covid-19 related) to 39 episodes (21 Covid-19 related) in May. This is a decrease for the second consecutive month and we would expect this to continue to decrease as we enter the Spring and Summer months.

Anxiety, stress and depression remain the third highest reason for absence and there has been a decrease in episodes from 41 in April to 35 episodes in May 2022. There are a total of 3 absences due to work related issues. 20 absences are long-term, which is a decrease from the previous month. Of the total 35 episodes, 11 ended in May whilst 24 continue into June.

Action Taken to Improve Compliance

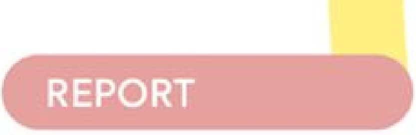
Action taken to improve compliance

- HRBP team to discuss with relevant managers to the potential reasons to why we have had a sudden increase of gastrointestinal absences among staff and identify any patterns/trends in teams where it is particularly high.
- HRBP to work closely with divisions to understand the reasons for Anxiety/stress/depression absences being high and offer the correct support.
- In addition to the actions above, 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.

Expected Date of Compliance	September 2022
Escalation Route	Divisional Meetings, Performance Review Meetings, Workforce Advisory Committee, People Committee, Trust Board
Executive Lead	Jayne Shaw, Director of Workforce and OD

Org L3	06/21	07/21	08/27	09/21	10/21	11/21	12/21	01/22	02/22	03/22	04/22	05/22
Acute Care Division	5.41%	7.35%	6.96%	6.50%	7.37%	6.99%	8.97%	10.11%	8.72%	6.68%	4.14%	4.01%
Corporate Division	3.52%	4.00%	2.28%	2.44%	9.42%	7.04%	4.67%	2.90%	1.00%	2.02%	3.94%	6.77%
Hosted Services Division	1.84%	3.56%	3.73%	3.95%	4.03%	0.30%	1.84%	3.24%	4.16%	4.29%	5.21%	1.39%
Networked Division	7.14%	5.61%	5.48%	6.08%	6.20%	7.64%	7.81%	8.12%	7.09%	6.79%	7.02%	5.40%
Radiation Services Division	3.74%	4.47%	3.54%	3.75%	3.82%	4.77%	6.09%	6.17%	4.59%	5.15%	4.55%	4.73%
Research Division	2.70%	3.02%	1.55%	1.08%	3.26%	3.44%	4.10%	3.69%	4.93%	6.23%	5.08%	3.76%
Support Services Division	0.90%	2.04%	3.85%	3.33%	1.75%	1.95%	1.84%	2.17%	1.47%	2.46%	3.41%	2.58%

Absence Reason	Number of Episodes
S25 Gastrointestinal problems	44
S15 Chest and Respiratory Problems	39
S10 Anxiety/stress/depression/other psychiatric illnesses	35



Workforce Exception Reports

Staff Turnover (clinical staff): 12 month rolling	Target	May 22
	Green <=14% Amber 14.1– 14.9% Red >=15%	17.6%

Reason for Non-Compliance

The number of leavers for May 2022 has decreased from 30 to 20. The reasons are shown in the table on the top right.

Promotion was the highest reason for leaving; 3 staff moved to other NHS Trusts (1 to The Christie and 2 Wirral Community Health & Care Trust). The remaining 4 staff did not state their new employer. Retirement age was the second highest reason for leaving with 5 leavers; 3 were from Networked Division, 1 from Support Services and 1 from Radiation Services.

This table on the bottom right shows leavers by area and staff group.

The Acute Care and Networked Services divisions had the highest number of leavers in May. Within Acute Care the majority of leavers (5) were from CBU5 –Inpatient Care, with reasons stated as promotion, work life balance and lack of opportunities. Two leavers had been with the Trust less than 12 months. In Networked Services the highest reason for leaving was Retirement Age.
Of the 20 leavers in May 2022, 2 completed an exit interview questionnaire (10%).

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.
The HRBP team continue to support managers (in HR surgeries and through training sessions), to manage Hybrid and Flexible Working, ensuring this is applied consistently across the Trust.
The HRBP Team continue to support managers and staff with the Retirement process as there has been an increase in staff retiring in the past month.

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

Leaving Reason	Leavers
End of Fixed Term Contract - Other	1
Retirement Age	5
Voluntary Resignation - Lack of Opportunities	2
Voluntary Resignation - Promotion	7
Voluntary Resignation- Other/Not known	1
Voluntary Resignation - Relocation	3
Voluntary Resignation - Work Life Balance	1
Grand Total	20

Division	Number of Leavers
Acute Care Division	6
Add Prof Scientific and Technical	1
Additional Clinical Services	2
Nursing and Midwifery Registered	2
Medical and Dental	1
Networked Division	6
Administrative and Clerical	4
Nursing and Midwifery Registered	2
Radiation Services Division	4
Allied Health Professionals	2
Healthcare Scientists	2
Research Division	1
Administrative and Clerical	1
Corporate Division	2
Administrative and Clerical	1
Nursing and Midwifery	1
Support Services	2
Administrative and Clerical	2
Hosted Services	1
Administrative and Clerical	1
Grand Total	**20**

Finance

Metric (£000)	In Mth 2 Actual	In Mth 2 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	27	24	3		54	49	5	
CPL/Propcare Surplus/ (Deficit)	85	0	85		212	0	212	
Control Total Surplus/ (Deficit)	112	24	88		266	49	217	
Trust Cash holding	59,625	52,080	7,545		59,625	52,080	7,545	
Capital Expenditure	42	0	(42)		113	0	(113)	
Agency Cap	64	95	31		113	190	77	

For 2022/23 the Cheshire & Merseyside ICS are managing the required financial position of each Trust through a whole system approach. The Trust submitted a draft plan in April 2022 showing a £291k surplus. At this point the overall ICS was in deficit, further work is being undertaken across the ICS, with a further submission due on 20th June. 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 May is a £49k surplus, which is in line with plan. The group position to the end of May is a £266k surplus. The Trust cash position is a closing balance of £59.6m, which is £7.5m above plan. Capital spend is £42k in month with capital spend YTD being low in line with plan.

REPORT COVER

Report to:	Trust Board
Date of meeting:	29th June 2022
Agenda item:	P1-113-22
Title:	Finance Report - Month 2
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 2 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.

Version 1.0 Ref: FCGOREPCOV Review: May 2024

Finance Report

James Thomson - Director of Finance

Version: 1.0   Ref: FCGOREPO   Review: May 2024

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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

Version: 1.0 Ref: FCGOREPO Review: May 2024

1. Introduction

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

Metric (£000)	In Mth 2 Actual	In Mth 2 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	27	7	20		52	48	4	
CPL/Propcare Surplus/ (Deficit)	85	0	85		212	0	212	
Control Total Surplus/ (Deficit)	112	7	105		264	48	216	
Trust Cash holding	59,625	52,080	7,545		59,625	52,080	7,545	
Capital Expenditure	42	0	(42)		113	0	(113)	
Agency Cap	64	95	31		113	190	77	

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 submitted a draft plan in April 2022 showing a £291k surplus. At this point the overall ICS was in deficit, further work was undertaken across the ICS, with a further submission being made on 20th June. 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 May is a £52k surplus, the group consolidated position is a £264k surplus. The Trust cash position is a closing balance of £59.6m, which is £7.5m above plan. Capital spend is £42k in month with capital spend being low YTD in line with plan.

The Trust is under the agency cap by £31k in month.

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

Metric (£000)	Actual M2	Trust Plan M2	Variance	Actual YTD	Trust Plan YTD	YTD Variance	Draft Trust Annual Plan
Clinical Income	18,444	18,607	(162)	37,109	37,182	(74)	223,051
Other Income	1,570	2,007	(437)	3,542	4,463	(920)	21,716
Total Operating Income	**20,014**	**20,614**	**(600)**	**40,651**	**41,645**	**(994)**	**244,767**
Total Operating Expenditure	(19,692)	(20,260)	568	(39,967)	(40,904)	938	(240,316)
Operating Surplus	**322**	**354**	**(32)**	**684**	**741**	**(57)**	**4,451**
PPJV	67	67	0	98	134	(36)	804
Finance Costs	(362)	(414)	52	(730)	(827)	97	(4,964)
Trust Surplus/Deficit	**27**	**7**	**20**	**52**	**48**	**4**	**291**
Subsidiaries	85	0	85	212	0	212	0
Consolidated Surplus/Deficit	**112**	**7**	**105**	**264**	**48**	**216**	**291**

The table below summaries the consolidated financial position:

May 2023 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	(55)	(112)
Donated Depreciation	82	163
Trust Retained Surplus / (Deficit)	**27**	**52**
CPL	50	99
Propcare	35	113
Consolidated Financial Position	**112**	**264**

3.3 Expenditure Position

3.3.1 The bridge below shows the key drivers between the £27k in month surplus and £7k surplus plan, which is a variance of £20k:

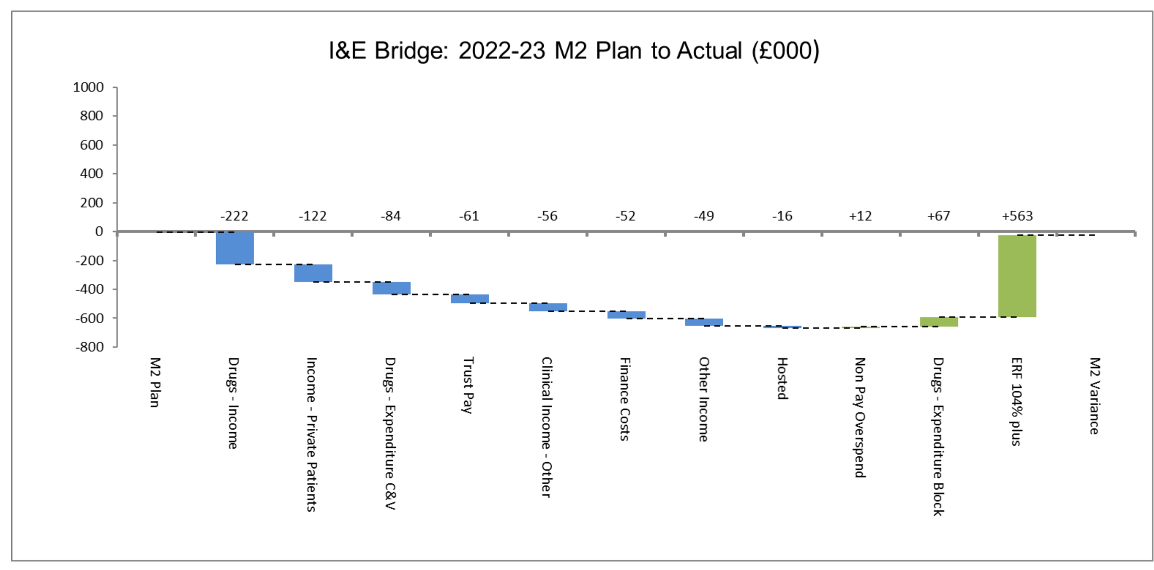
- Elective recovery (ERF) Income for activity over 104% of 2019.20 has been assumed at 25% of plan for month 2 and so is showing a £563k under recovery against the income plan of £751k. The Trust is currently reviewing activity against the plans and awaiting feedback nationally for the calculation. This was a prudent approach due to current unknown elements within the calculation.

- Pay costs are underspent by £61k, in terms of run rate Divisional pay spend has increased by £110k compared to month 1.

- Bank spend remains high at £129k which is a slight increase compared to previous months, this is mainly due to sickness cover including covid.

- Block drugs are overspent by £67k in month, this is a pressure for the Trust and a more detailed review is being undertaken. High cost drugs are underspent by £84k, this is offset by a reduction 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 £28k.



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 2 reporting the Trust has assumed receipt of the ERF income up to 104% of activity. The plan for month 1 and 2 for ERF over 104% is £751k per month. The Trust has assumed 25% of this in both the month 1 and 2 position while the activity data is reviewed nationally and the income figure generated.

3.5 Bank and Agency Reporting

Bank spend in May remains high at £129k, which is an increase compared to previous months. The largest user of bank staff the Acute Division. The main reasons for bank spend is to cover vacancies and increased sickness including covid.

Agency spend in month is £64k. The Trust is reporting £31k 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 2 against the expected year to date target of £1.127m target there is a shortfall of £486k.

Against the full year CIP target of £6.7m there has been £3.8m schemes identified which is 56%. Of which £1.2m have been identified recurrently.

The majority of the CIP that has been identified has been identified through central schemes. The Divisions have identified a number of opportunities that are currently being worked through and savings likely to be realised in future months.

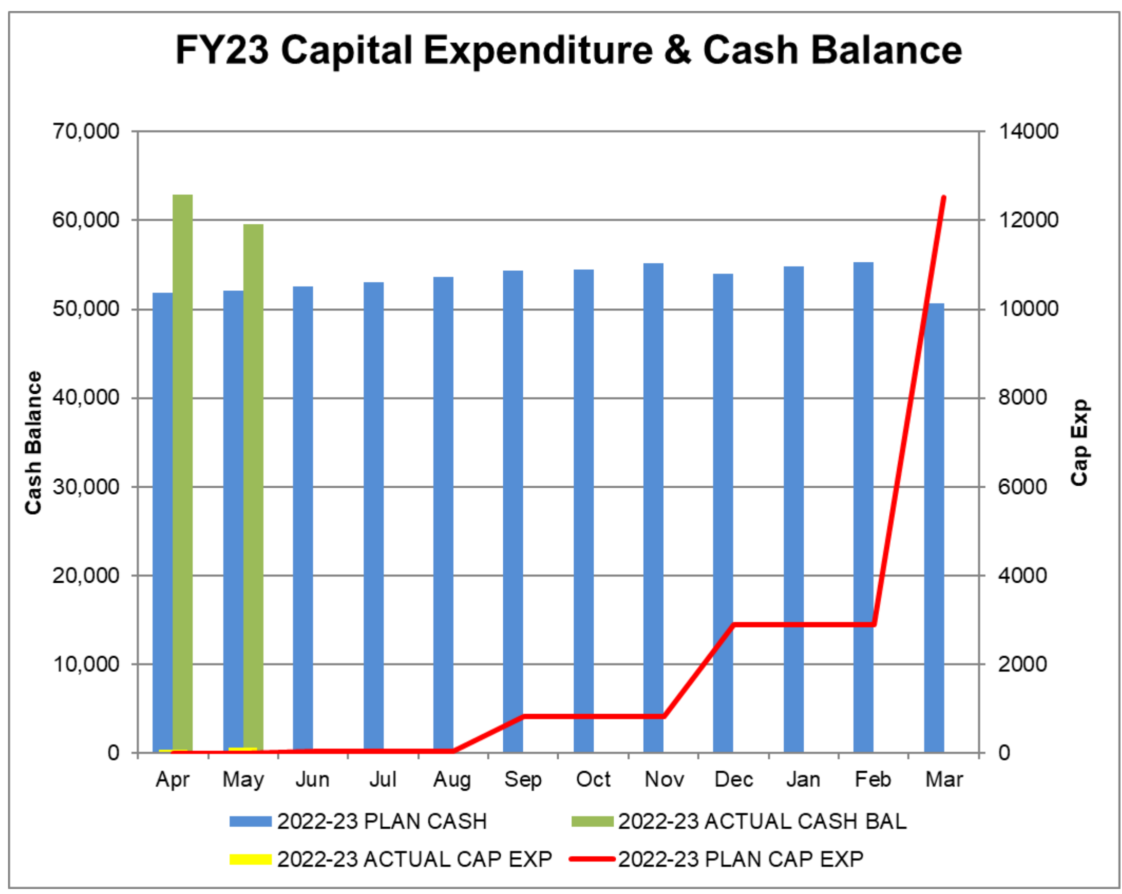
4. Cash and Capital

4.1 The 2022/23 capital plan approved by the Board in March was £7.013m. Since this national PDC funding of £5.5m have been approved to support the CDC facility.

4.2 Capital expenditure of £113k has been incurred to the end of May. 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 £59.6m, which is a positive variance of £7.5m 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

The Trust's cash balance at the end of May is £59.6m, this is £7m above plan figure of £52m and is due to two main reasons. Firstly, some 2021/22 capital invoices have not yet been received. Secondly, income from 2021/22 was deferred due to delays in recovery activity during omicron not originally include in our cash planning

Receivables are below plan which is positive as demonstrates that debt is being collected promptly.

5.2 Current Liabilities

Payables (non-capital creditors) are £7.58m below plan. This is positive and demonstrates that creditors are being paid promptly.

Deferred Income is £9.4m above plan. This relates in the main to R&I income and Cancer Alliance both of which have 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 2			YTD			%	2022/23 Annual Plan
	Plan	Actual	Variance	Plan	Actual	Variance		
Clinical Income	18,541	18,378	(163)	37,057	36,984	(73)		222,344
Other Income	681	729	49	1,348	1,521	172		7,793
Hosted Services	1,392	907	(485)	3,240	2,146	(1,094)		14,629
Total Operating Income	**20,614**	**20,014**	**(600)**	**41,645**	**40,651**	**(994)**	**3%**	**244,767**
Pay: Trust (excluding Hosted)	(6,187)	(6,125)	61	(12,331)	(12,139)	192		(73,950)
Pay: Hosted & R&I	(702)	(599)	103	(1,401)	(1,125)	276		(8,309)
Drugs expenditure	(7,695)	(7,678)	17	(15,390)	(15,758)	(368)		(92,340)
Other non-pay: Trust (excluding Hosted)	(4,942)	(4,954)	(12)	(9,855)	(9,876)	(20)		(58,855)
Non-pay: Hosted	(735)	(337)	398	(1,927)	(1,069)	858		(6,862)
Total Operating Expenditure	**(20,260)**	**(19,692)**	**568**	**(40,904)**	**(39,967)**	**938**	**3%**	**(240,316)**
Operating Surplus	**354**	**322**	**(31)**	**741**	**684**	**(57)**	**15%**	**4,451**
Profit /(Loss) from Joint Venture	67	67	0	134	98	(36)		804
Interest receivable (+)	386	421	36	771	836	65		4,626
Interest payable (-)	(434)	(429)	5	(869)	(859)	10		(5,213)
PDC Dividends payable (-)	(365)	(354)	11	(730)	(708)	22		(4,377)
Trust Retained surplus/(deficit)	**7**	**27**	**20**	**48**	**52**	**4**	**13%**	**291**
CPL/Propcare	0	85	85	0	212	212		0
Consolidated Surplus/(deficit)	**7**	**112**	**105**	**48**	**264**	**216**	**94%**	**291**

Version: 1.0 Ref: FCGOREPO Review: May 2024

Appendix B – Balance Sheet

£'000	Unaudited 2022	Plan 2023	Year to date Month 2		
			YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	3,211	3,162	2,870	3,120	250
Property, plant & equipment	184,599	173,627	175,874	183,152	7,278
Investments in associates	977	800	800	1,075	275
Other financial assets	0	115,276	118,709	0	(118,709)
Trade & other receivables	449	434	433	2,367	1,934
Other assets	0	0	0	0	0
Total non-current assets	**189,236**	**293,298**	**298,686**	**189,714**	**(108,972)**
Current assets					
Inventories	5,640	3,000	1,874	4,241	2,367
Trade & other receivables					
NHS receivables	7,749	7,084	6,832	5,977	(855)
Non-NHS receivables	6,278	10,915	10,525	4,826	(5,699)
Cash and cash equivalents	80,726	50,708	52,079	67,069	14,990
Total current assets	**100,393**	**71,707**	**71,310**	**82,113**	**10,803**
Current liabilities					
Trade & other payables					
Non-capital creditors	36,547	32,207	32,819	25,747	(7,072)
Capital creditors	6,918	1,958	1,995	1,837	(158)
Borrowings					
Loans	1,908	1,730	1,730	1,764	34
Obligations under finance leases	0	0	0	0	0
Provisions	4,214	94	99	4,075	3,976
Other liabilities:-					
Deferred income	15,669	5,577	5,486	14,868	9,382
Other	0	0	0	0	0
Total current liabilities	**65,255**	**41,565**	**42,129**	**48,291**	**6,162**
Total assets less current liabilities	**224,374**	**323,440**	**327,867**	**223,536**	**(104,331)**
Non-current liabilities					
Trade & other payables					
Capital creditors	120	0	0	120	120
Borrowings					
Loans	32,090	30,360	31,350	31,350	0
Obligations under finance leases	0	0	0	0	0
Other liabilities:-					
Deferred income	0	1,018	1,064	0	(1,064)
Provisions	197	115	527	0	(527)
PropCare liability	(1)	113,436	116,869	(1)	(116,870)
Total non current liabilities	**32,406**	**144,929**	**149,810**	**31,469**	**(118,342)**
Total net assets employed	**191,968**	**178,511**	**178,057**	**192,068**	**14,011**
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	115,191	103,593	103,139	115,291	12,152
Total taxpayers equity	**191,968**	**178,511**	**178,057**	**192,068**	**14,011**

Appendix C – Cash Flow

May 2022 (M2) £'000	FT	Group	Group (exc Charity)
Cash flows from operating activities:			
Operating surplus	512	795	913
Depreciation	1,529	1,529	1,529
Amortisation	121	121	121
Impairments			0
Movement in Trade Receivables	382	1,306	1,486
Movement in Other Assets	0	0	0
Movement in Inventories	1,492	1,399	1,399
Movement in Trade Payables	(13,161)	(10,837)	(10,840)
Movement in Other Liabilities	(1,150)	(800)	(800)
Movement in Provisions	0	(336)	(336)
CT paid	0	(35)	(35)
Net cash used in operating activities	**(10,276)**	**(6,859)**	**(6,563)**
Cash flows from investing activities			
Purchase of PPE	(5,163)	(5,163)	(5,163)
Purchase of Intangibles	(31)	(31)	(31)
Proceeds from sale of PPE	9	9	9
Interest received	836	71	77
Investment in associates	(0)	(0)	(0)
Net cash used in investing activities	**(4,349)**	**(5,114)**	**(5,108)**
Cash flows from financing activities			
Public dividend capital received	0	0	0
Public dividend capital repaid	0	0	0
Loans received	0	0	0
Movement in loans	(884)	(884)	(877)
Capital element of finance lease	0	0	0
Interest paid	(859)	(93)	(100)
Interest element of finance lease	0	0	0
PDC dividend paid	(708)	(708)	(708)
Finance lease - capital element repaid	0	0	0
Net cash used in financing activities	**(2,451)**	**(1,685)**	**(1,685)**
Net change in cash	**(17,075)**	**(13,657)**	**(13,356)**
Cash b/f	**76,701**	**80,726**	**82,815**
Cash c/f	**59,625**	**67,069**	**69,457**

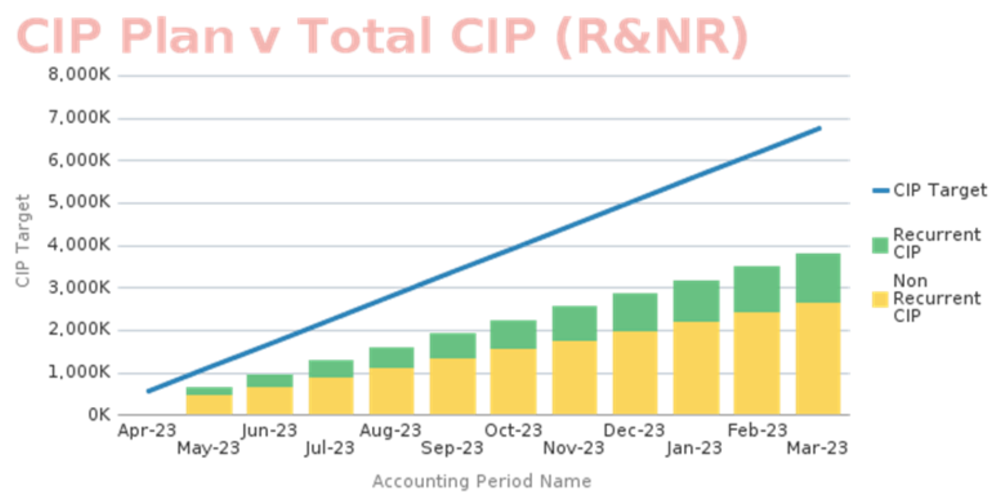
Appendix D – Capital

Capital Programme 2022-23
Month 2

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 2	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
4401	CCC-L Ward 3 bathroom conversion	Kathryn Williams	0	32	32	0	32	32	0	✗	✗	Approved by Feb Finance Committee
	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	(32)	168	0	168	163	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	38	412	450	0			
4309	Voltage Stabilisers	Martyn Gilmore	0	60	60	0	60	70	(10)	✓	✗	
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	(60)	340	0	340	307	33	-	-	
	Medical Equipment		**3,920**	**0**	**3,920**	**61**	**3,859**	**3,920**	**0**			
4138	***(21/22)*** Infrastructure	James Crowther	0	0	0	31	(31)	31	(31)			
4190	***(20/21)*** Digital Aspirant Programme	James Crowther	0	0	0	16	(16)	16	(16)			
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	738	47	✗	✗	
	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**	**47**	**1,653**	**1,700**	**(0)**			
	CDC National PDC		5,500	0	5,500	0	5,500	5,500	0	✗	✗	
	IFRS 16 - Chemo Cars		0	49	49	0	49	49	0	✗	✗	
	Other		**5,500**	**49**	**5,549**	**0**	**5,549**	**5,549**	**0**			
	TOTAL		**12,513**	**105**	**12,618**	**113**	**12,506**	**12,618**	**(0)**			

Appendix E – CIP



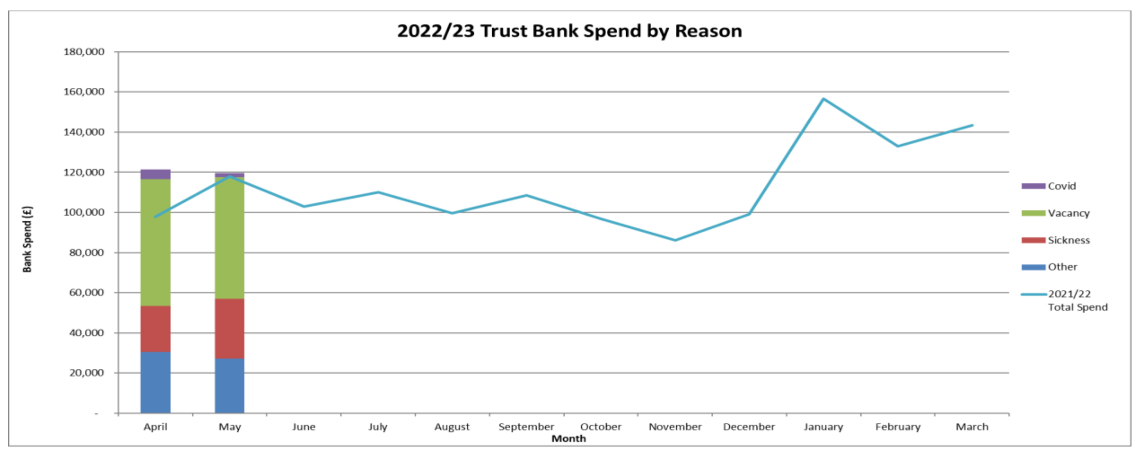
Divisional CIP Against Full Year Plan

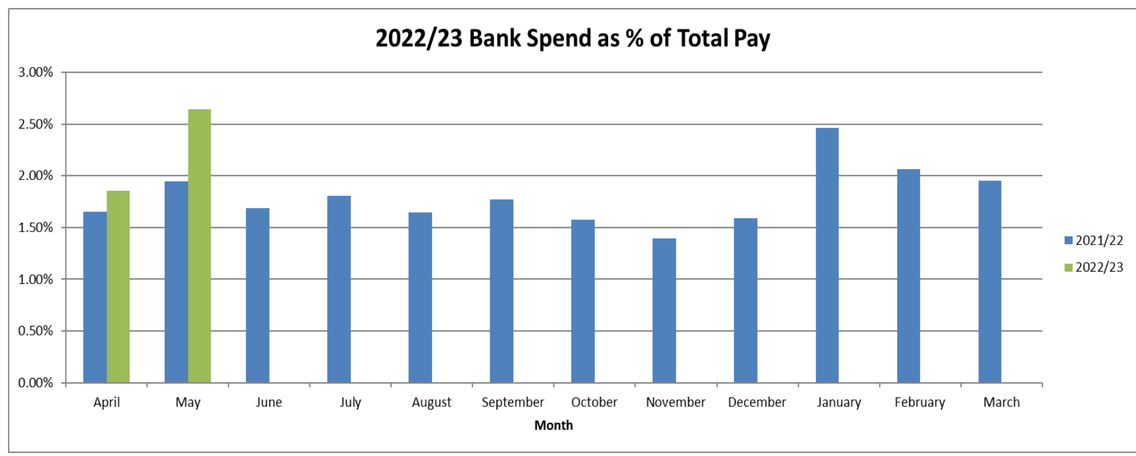
Division	Target	Total CIP	Recurrent CIP	In Year Shortfall/Over Recovery	Delivery % to date
CENTRAL CIP	3,300,000	3,552,793	952,259	252,793	108%
NETWORKED SERVICES	1,096,368	109,536	109,536	(986,832)	10%
ACUTE CARE	877,743	22,376	22,376	(855,367)	3%
RADIATION SERVICES	880,168	62,706	54,206	(817,462)	7%
CORPORATE	610,721	57,063	57,063	(553,658)	9%
Total	**6,765,000**	**3,804,474**	**1,195,440**	**(2,960,526)**	

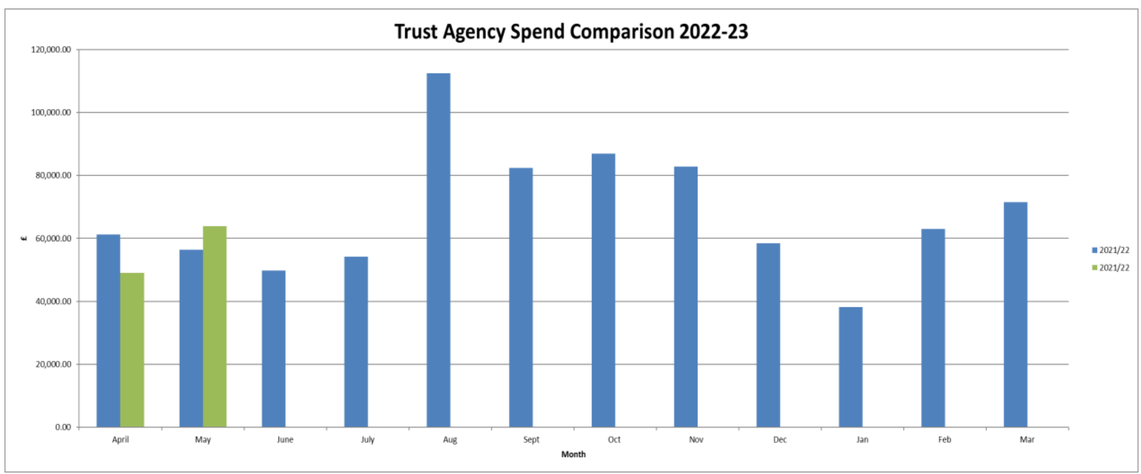
Full Year Plan (Recurrent & Non-Recurrent Split)

Recurrent	4,465,000	1,195,440	1,195,440	(3,269,560)	0
Non-Recurrent	2,300,000	2,609,034	0	309,034	113%
Total	**6,765,000**	**3,804,474**	**1,195,440**	**(2,960,526)**	

Appendix F – Bank and Agency







Version: 1.0 Ref: FCGOREPO Review: May 2024

Meeting of the Board of Directors
29th June 2022

Report of	Chief Nurse
Paper prepared by	Deputy Director of Nursing
Subject/Title	Safer Staffing Report: To review and approve the nurse staffing levels as assessed using the Safer Nursing Care Tool in line with recommendations within NICE Guidance.
Purpose of paper	To endorse the findings and conclusion of this six monthly nursing establishment review and approve the nurse staffing levels.
Background papers	NHSEI Winter 2021 Preparedness: Nursing and Midwifery Safer Staffing (Nov 2021) National Quality Board (Jan 2019): Safe sustainable & productive staffing. NHS Improvement (June 2018) Care Hours per Patient Day (CHPPD) Guidance for Acute and Acute Specialist Trusts NICE Safe staffing guideline [SG1]; NHS England November 2014: Safer Staffing, a guide to care contact time National Quality Board (July 2016): Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time

Action required		
	To approve content/preferred option/recommendations	√
	To discuss and note content	
	To be assured of content and actions	

Link to: Strategic Direction Corporate Objectives				
	Be Outstanding	√	Be a great place to work	√
	Be Collaborative		Be Digital	
	Be Research Leaders		Be Innovative	

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

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

Equality & Diversity Impact Assessment

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

Meeting of the Board of Directors
29th June 2022
Six Monthly Compliance with NICE Safe Staffing Guidelines

1. Background

The Trust has carried out a bi-annual audit of patient acuity and dependency for a number of years using the Safer Nursing Care Tool© (SNCT). The SNCT is embedded within the e-rostering system and calculates the baseline nursing establishment required to meet patient care need and has been used successfully to inform and support workforce planning over this period.

In the wake of the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry published in February 2013 and the Government's commitment to safe staffing requirements outlined in a succession of publications, NICE Safe Staffing Guidelines were published in July 2014 and updated by NHS Improvement in January 2018.

The NICE guidance on safe staffing addresses five overarching elements which need to be met:

- Organisational strategy;
- Principles for determining nursing staff requirements;
- Setting the ward nursing establishment;
- Assessing availability of nursing staff on the day to meet patient need;
- Monitoring and evaluation of nursing staff establishments.

The Trust continues to meet the expectations of the National Quality Board relating to nursing, midwifery and care staffing capacity and capability, which were published in 2013. It is also compliant with the NICE guidance and publishes this data publically including the care hours per day on a monthly basis on The Model Hospital website via returns to the Strategic Data Collection Service (SDCS).

The Chief Nursing Officer's paper Safer Staffing: A Guide to Care Contact Time published in November 2014, sets out the expectations of commissioners and providers to optimise nursing, midwifery and care staffing capacity and capability so that they can deliver high quality care and the best possible outcomes for their patients. The Trust meets this expectation.

In February 2018 NHS Improvement updated their guidance on agency staffing rules, these rules set a ceiling on total agency spending by each trust.

As a requirement of the guidance, the Board of Directors has monthly review of the details and summary of planned and actual staffing on a ward-by-ward basis through the integrated performance and quality report. Due to the pandemic this requirement was paused but will be re-instated here at CCC by Quarter two of this financial year. Furthermore, the guidance requires that organisational responsibility and accountability for budgeted nurse staffing establishments sits with the Board of Directors and must encompass a formal board level review. This responsibility is currently executed via Quality Committee and reported to Board of Directors via the Chairs report. This paper provides the board with the information required for it to discharge this duty.

The Care Quality Commission recognises that services have faced tremendous challenges over the past two years as a result of the COVID 19 pandemic and that the nursing workforce experienced these pressures particularly acutely. The CQC acknowledged that Trust Boards were required to make staffing decisions with a focus on managing patient safety and risk by using available resources effectively and responsibly, in line with national guidance – and that where staffing shortages were

identified, use of temporary solutions including a multidisciplinary approach to manage immediate risks may have been implemented.

2. Introduction

Following the last review in September 2021 The Clatterbridge Cancer Centre and the wider NHS has remained focussed on delivering safe and effective services whilst also beginning to recover from the COVID-19 global pandemic. For the 6 months covered by this paper, nurse staffing levels, have been managed as part of the national alert level 3 and trust escalation level 2/3.

This review routinely considers a range of data including the nursing care requirement of patients determined by acuity and dependency data (SNCT data). It also includes consideration of all the other factors that can influence the nursing staff requirement including patient flow, the care environment, staff turnover, sickness rates, patient harm and patient experience data.

For the purposes of this review a new element was introduced which provides the ward managers and matrons the opportunity to share directly with the chief nurse their professional view of their ward nursing establishment, any pressures they are managing and what developments they have planned. This is a new process within CCC and will evolve in time to ensure the ward managers are empowered to lead and advocate on behalf of their teams and their patients.

As a result, this paper will describe how nurse staffing has been monitored throughout this 6 month period, together with the ward managers overall professional judgement of staffing during that time and any recommendations they wish to make. It will also offer recommendations to further refine the internal safe staffing process and the associated data within this report.

3. Nurse Staffing during the Pandemic

During the phases of the pandemic there has been ongoing adjustments to the way in which services delivery care and treatment to patients. To accommodate these changes and ensure essential services could continue to function some of our nurses were retrained and redeployed to support clinical areas where additional staffing was required. In addition, in June 2020 the organisation opened its new site in Liverpool where the in-patient wards are located. The new centre provides single room occupancy for patients, ensuring privacy, space and an overall improved experience for patients. However, a single room occupancy model provides different challenges for the nursing team in order to provide visible and safe care. There is limited data on the impact of single occupancy rooms on staffing ratios and required skill mix. Pre-pandemic the nationally accepted ratio for registered nurse to patient was 1-8, however, it was accepted that in most hospitals this target was unachievable during acute phases of the pandemic. In some areas of CCC, due the specialist nature of the service the nurse to patient ratio aims to be 1-5.

4. Ensuring the correct staff with the correct skills

The daily nurse staffing meeting continued to take place with the divisional nurse directors, ward managers, matrons and patient flow, and when required a second meeting would take place in the afternoon. In addition a daily sitrep/incident control room meeting led by the Chief Operating Officer and Executive on Call was established. This meeting is a multi-professional operational meeting focused on the daily management of the organisation. Ward level staffing, patient acuity, required skill mix and any other clinical concerns were reviewed and immediate actions put into place.

Overall summary

- CCC Inpatient Wards achieved safe staffing over the last 6 months in relation to having sufficient staff to care for the number of inpatients.
- All ward managers reported that there have been daily challenges ensuring sufficient numbers of registered nurses were available to meet safe staffing requirements. However, the ward managers, matrons and divisional nurse directors have worked together and flexibly to ensure all shifts were safely staffed.
- The equivalent of 23 whole time equivalent registered NHS Professional (NHSP) nurses' and 29 health care support workers were required during this time period to support safe staffing requirements.
- The ward managers and matrons confirm that whilst their funded establishments during this time period were sufficient the challenge has been to fill permanent vacancies and ad-hoc shifts.
- Ward 2 & 3 faced particular challenges with staffing numbers, morale and the capacity to provide the standard of patient care that they were able to provide pre-pandemic on the Wirral site.
- A new Matron has been appointed into the Acute Division who is working with the ward managers to review skill mix and introduce new ways of working in order to reduce inefficiencies and release time for direct patient care. The impact of this appointment is already being felt by the wards 2 & 3 and improvements are evident.
- Our first cohort of internationally recruited nurses also joined the organisation.

5. Individual ward/area key aspects

The following tables provide the Board with feedback from the ward managers, in order to hear about their services from their perspective.

Ward 2
Achievements
Despite the challenges of nursing patients during the pandemic the team continue to adapt to new ways of working with a professional can do attitude. The team have tirelessly swapped shift at short notice and undertaken additional NHSP shifts to ensure the ward is adequately covered to provide safe and effective care and the service provided has remained at a high standard. Positive feedback from patients supports this view. The ward is a popular student placement area with excellent feedback and recruitment opportunities evidenced by feedback from practice educators. Students stated how welcome the staff made them feel and how much they enjoyed their placement. Several students signed up for NHSP and undertake HCSW shifts on the ward during their training. As part of the in house preceptorship programme the SACT passport has now been adopted to allow ward nurses to gain competency in the administration of SACT and work flexibly across other areas and departments to support with SACT administration.
Challenges
The clinical environment on Ward 2 continues to be a challenge particularly the single en-suite accommodation and footprint design. The ward cares for patients at risk of falls who require high levels of care and close supervision or 1:1 nursing by the dedicated team of HCSW's to prevent/minimise harm. It is challenging to observe patients who are a falls risk at times due to design challenges however at risk patients are placed in rooms directly opposite

staff bases and ramble-guard monitors are used to support these patients and alert staff if the patient moves.

Ward staff care for end of life patients and provide psychological support to family members and holistic care to patients. Nursing staff frequently have to deal on many occasions with very complex discharges due to poor prognosis, which is emotionally draining especially when there is a sense of fatigue and anxiety due to the ongoing challenges of the global pandemic.

There is a variety of patient acuity on the ward due to the number of different specialities, reason for admission and treatment required. The current registered nurse to patient ratio is 1:5 however due to the high number of vacancies on ward 2 there is a reliance on staff covering NHSP/agency shifts which at times has a negative impact on staff morale.   There is a very junior workforce on the ward which can impact skill mix and many applicants for jobs are student nurses. The ward leadership team continues to work in collaboration with HR workforce department, planning recruitment events to attract more senior nurses. Registered Nurse recruitment and retention is a national issue. A rolling advert is in place supported by a flexible interview process.

Professional Judgement

WARD MANAGER VIEW; The current staffing budget is sufficient however due to ongoing vacancies it is challenging to ensure safe staffing is achieved due to the increased patient acuity, the change is nursing model and the majority staff recruited being newly Registered Nurses.

Ward 3

Achievements

Despite the challenges nursing patients during the pandemic the team continue to adapt to new ways of working and have responded effectively. During the pandemic the ward hosted the red zone where Covid positive patients (regardless of tumour group) and those symptomatic and awaiting confirmation of results were nursed. The staff had to change their practice, sometimes at short notice to care for this patient cohort as well as their solid tumour group.

The team have tirelessly swapped shift at short notice and undertaken additional NHSP shifts to ensure the ward is adequately covered to provide safe and effective care and the service provided has remained at a high standard. They continue to "step up" with a positive attitude and professional manner. Positive feedback from patients supports this view.

The ward is a popular student placement area with excellent feedback and recruitment opportunities, with 2 of the band 6 staff acting as link nurses. Assessors and Supervisors are allocated prior to the student commencing their placement with local induction and learning outcomes set in the students first week on the ward. A student nurse on her last placement has recently been recruited into a vacant Band 5 position. Students feedback stated " *by far the best placement I have ever had, I would honestly recommend this placement to any learner who strives for a good quality learning experience".*

As part of the in house preceptorship programme the SACT passport has now been adopted to allow ward nurses to gain competency in the administration of SACT and work flexibly across other areas and departments to support with SACT administration. Staff have recently

undertaken further expansion of the SACT treatment regimens administered to accommodate haematology patients who also have an altered airway.

Due to a high number of Covid related absence and isolation of staff, the wards have supported each other to address staffing shortfalls which has resulted in an increase in the number of staff movements between areas. This has been undertaken in a professional and supportive manner to ensure high standards of care are maintained across all inpatient areas.

Challenges

The challenges when adhering to COVID guidance has meant that we have had to adapt and change our methods of working to ensure that staff are supported to maintain their attendance at work as much as possible and this has included changing working patterns, shift days and times, facilitating working from home, removing staff from a patient facing role and in some cases transferring staff to an area considered less at risk of COVID exposure (early pregnancy/COVID assessed-high risk) and initiating pre maternity isolation. Working collaboratively with all ward areas has been fundamental in facilitating this safely across all areas to ensure safe staffing levels.

Changes in senior leadership including absence of substantive ward manager due to maternity leave has had an effect on staff morale and the seamless working of the ward.

Nursing staff frequently deal with very complex discharges due to poor prognosis and care for patients in the final days of life which can be emotionally draining especially when there is a sense of fatigue and anxiety due to the ongoing challenges of the global pandemic.

There are a number of Band 6 deputy ward managers within the nursing team however clarity regarding responsibility/accountability within this role requires improvement.

Due to the number of students/newly qualified nurses/International nurses and changes in practice that require additional training and support including the facilitation of role essential training, it would be beneficial to have a Clinical Education Facilitator based on the ward. Their role would have a significant impact on timely teaching and support available to staff and support effective staff retention.

There is no dedicated staff break room on the ward however the social space (available due to Covid restrictions including no visitors unless exceptional circumstances) has been used to support staff during the pandemic. A room has now been identified to provide this resource going forward.

Professional Judgement

WARD MANAGER VIEW; The nursing model has changed significantly following the move to CCCL. Following review of the ward 3 establishment the staffing budget is sufficient, however due to ongoing current vacancies it is challenging to safely staff the ward due to layout, size, design and the increase in patient acuity.

Ward 4

Achievements

Following the challenges faced by staff over the last 6 months (and since the pandemic began) recognition has to be given to the teams ongoing determination, commitment and hard work. The team continues to adapt to new ways of working with professionalism and a can do attitude and the staff swapped shifts at short notice/worked additional NHSP shifts to ensure the ward provided safe, effective care and a high quality service.

In December 2021 a new ward manager was appointed and significant positive changes have been made eg the introduction of a monthly newsletter and employee of the month nomination and reward which has given the team an opportunity to give/receive praise/feedback to each other.

Strengthened working with the LUHFT ICU outreach team has been fostered with very positive feedback received regarding the level of skills and expertise the nurses have attained.

The ward has a successful in-house education programme led by clinical educators with sessions delivered bi-weekly to HO and stem cell transplantation. Nursing staff are encouraged to identify topics to be undertaken or delivered by themselves. These sessions have received very positive feedback and met JACIE standards to ensure nurse training is complaint with the accreditation process.

Challenges

In February 2022 official integration with North Mersey HO took place which has led to a significant increase in the number of lymphoma inpatients treated, particularly CNS Lymphoma patients. This patient cohort are often under deprivation of liberty safeguards, often lacking capacity and/or confused with complex/intensive treatment regimens which has had an impact on the number of enhanced support shifts required to ensure patient safety.

The ward takes post-transplant readmissions if there is no capacity on ward 5. These patients experience severe side effects and are often highly dependent on full nursing care with level 2 acuity in the acute illness phase.

PADR's and essential training compliance remains steady but there is room for improvement. As vacancies are filled and staffing numbers increase staff will be supported with time to complete outstanding training. During the last 2 years it has not been possible to undertake any "away days" to enable collaboration/leadership and service development engagement for all staff however, this is to be addressed over the next 12 months.

Professional Judgement

Following a recent nursing workforce review I feel that the 1:5 staffing ratio/current ward establishment is safe, the budget is set correctly and the team provides effective high quality care. Maintaining the nurse:patient ratio is important to continue to deliver a quality service and ensure that continuous improvement is achieved. Within the next 12 months we aim to sustain the motivation to drive the service forward together with further development for our staff offering improved learning opportunities to the team.

Ward 5

Achievements

High quality support for learners and all staff has been maintained during the pandemic with support from the Clinical Skills Facilitator in addition to leadership and guidance from the band 6 team on a daily basis which is complimented by regular input from and access to the Ward Manager and Matron.

Safety Huddles take place on each ward every morning to proactively enable the team to focus on patient safety, highlight concerns, share information/lessons learned and facilitate effective communication between staff. In response to patient feedback regarding experience at meal times, the ward establishment has been reviewed and slippage monies used to support an additional housekeeper to the team who will support the hostess at meal times and ensure mid-morning and afternoon snacks are offered to all patients. Preparation for the JACIE accreditation inspection has progressed well and due to the pandemic this will be undertaken remotely. Successful accreditation is valid for 2 years however a full on-site inspection is planned during the next 2 years which will then result in the award of a 4 year accreditation certificate.
Challenges
The introduction of a CAR-T programme later this year will pose additional training and competency requirements for nursing staff resulting in the need for additional clinical facilitator support and the introduction of a practice educator role within BMT and HO The post-transplant phase of care required is consistent with "single organ failure" where patients require 1:2 or 1:1 nursing prior to transfer to ICU. Variables in patient acuity are common and it is expected that acuity levels increase further 10-14 days post stem cell transplant infusion and it is vital that flexible staffing numbers are available to respond safely and effectively Since the onset of Covid-19 all donor cells whether received from overseas or locally are now frozen prior to patient administration to mitigate the risk of unsuccessful cell delivery which has resulted in a significant increase in nursing time to administer the cells and remain at the patient's bedside due to the increased risk of side effects. There is a need to support staffing shortages across the trust however the recognition to limit staff movement from ward 5 due to the patient group has been achieved.
Professional judgment
The nursing establishment for ward 5 has been reviewed and I feel the ward is safe. We have achieved safe staffing across the last 6 months and provided safe, effective care to our patients. The agreed nurse:patient ratio was maintained and this ensured high quality care and experience was delivered to our patients. Two areas highlighted for improvement are enabling and supporting staff to attend and present at study days and conferences on a national and international level and facilitate dedicated hostess and cleaners to be part of the ward team to provide care continuity and maintenance of high standards.

6. Conclusion

The in-patient senior nurses have supported staff throughout the 6 months covered within this report, they have demonstrated exemplary team work when coordinating nurse to patient ratios across the trust to keep patients safe. Staff have continued to adapt accordingly with a positive professional attitude, with kindness, resilience and care and compassion for our patients.

This review confirms that whilst the budgeted nursing establishments set for the trust's in-patient wards align with the current care needs of patients in the context of other workload sensitive factors, it is evident that filling vacancies, managing sickness and appropriate skill mix continues to be a daily challenge. Therefore as the country moves into COVID recovery and as the organisation has settled within its new location and ward layout, it is timely to undertake a more detailed review of ward establishment.

The Board of Directors is asked to support the findings and recommendations of this six monthly nursing establishment review.

7. Recommendations

- Re-introduce monthly safe staffing data into the integrated performance and quality report.
- Acute Division Matrons with the support of Workforce and Corporate nursing will review establishments based on maximum number of bed availability. This will include skill mix to take into consideration the added complexity of the new layout and the additional fundamental care needs of patients that can be safely addressed by health care support workers.
- The established recruitment and retention steering group will continue to identify opportunities to maximise the nursing pipeline and make CCC a great place to work in line with our 5 year strategic plan.
- We will collaborate and engage with any new and emerging system wide and national reviews of nursing requirements for single occupancy room model organisations, in order to inform best practice and lead change.
- In collaboration with ward managers, matrons, workforce and corporate nursing evolve the bi-annual staff staffing review to ensure accurate and meaningful quantitative data is included to support the qualitative professional nursing judgement narrative.

8. References

NICE: Safe staffing for nursing in adult inpatient wards in acute hospitals – July 2014
https://www.nice.org.uk/guidance/sg1

NHS England: Safer Staffing: A Guide to Care Contact Time – November 2014
https://www.england.nhs.uk/wp-content/uploads/2014/11/safer-staffing-guide-care-contact-time.pdf

NHS Improvement; Safe staffing for adult inpatients - January 2018
https://improvement.nhs.uk/resources/safe-staffing-improvement-resources-adult-inpatient-acute-care/

NHS Improvement; Safe staffing for adult inpatients - November 2016 (Updated February 2020)
https://improvement.nhs.uk/resources/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps/

NHS England: National Quality Board guidance on Safe Staffing
https://www.england.nhs.uk/publication/national-quality-board-guidance-on-safe-staffing/

NHS Improvement: Safe, sustainable and productive staffing improvement resource for the deployment of nursing associates in secondary care – January 2019
https://improvement.nhs.uk/resources/safe-sustainable-and-productive-staffing-nursing-associates/

NHSEI Winter 2021 Preparedness: Nursing and Midwifery Safer Staffing (Nov 2021)

REPORT COVER

Report to:	Trust Board	
Date of meeting:		
Agenda item:	Patient Experience Visit	
Title:	Patient Experience Visit – May 2022	
Report prepared by:	Mark Tattersall, Non-executive Director	
In attendance at visit:	Laura Jane Brown, Staff Governor Claire Smith, Quality Improvement Manager	
Executive Lead:	Julie Gray, Chief Nurse	
Status of the report: (please tick)	Public ☒	Private ☐

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

Purpose of the paper/key points for discussion:	The purpose of this report is to provide Trust Board with oversight and a summary of the NED & Governor Patient Experience visit conducted on the 10th May 2022 on Ward 5, within Acute Care Services at CCCL.

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

Next steps required:	Trust Board are requested to; • Note the visit undertaken and patient voice accounts of their experience of care at CCC • Request further updates as required

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 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.

Version 1.0 Ref: FCGOREPCOV Review: May 2024

Patient Experience Visits 10/05/2022

Mark Tattersall, Non-executive Director
Laura Jane Brown, Staff Governor
Claire Smith, Quality Improvement Manager

Report: May 2022: Version 2: Author: Patient Experience

1. Summary

The Patient Experience 'round' was conducted on the 10th of May 2022, visiting Ward 5, within Acute Care Services at the Clatterbridge Cancer Centre- Liverpool (CCC-L). The walkaround was conducted virtually with Mark Tattersall, Non-executive Director, Laura Jane Brown, Staff Governor and Claire Smith, Quality Improvement Manager.

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

2. Key Findings and Observations

Patient experiences and comments – 2 patients were asked to share their experiences of being treated at CCCL Ward 5.

The first patient had been an inpatient for two weeks following a stem cell transplant; he stated that he now feels well and is looking forward to going home, what is expected to be in about 10 days' time. He advised that he could contact his family and doesn't mind not having any visitors as he is able to speak to them every day on the phone. He expressed that the hospital is "brilliant" and that everything had gone to plan; he could not fault any of the staff. When asked what CCC does well, he mentioned his specialist nurses who are always there for him and never fail to respond when he contacts them. When asked what CCC could do better he focused on two areas:

1. He spoke about his experience, upon a previous admission, when he was an inpatient on Ward 2 receiving chemotherapy. He mentioned that there appears to be a shortage of chemotherapy trained nurses, which resulted in a nurse being called from Ward 5 to come and administer the chemotherapy, however, because the Ward 5 nurse had other patients, he received his treatment very late that night.

2. He felt that CCC could improve the food. He said "it isn't the greatest food" and felt that there wasn't much variety with the menu, because of his chemotherapy treatment he often feels sick and 'goes off stuff' so with the menu being unvaried he feels fortunate enough to live locally, as his family were able to bring in most of the food he was eating. He finished by saying he was looking forward to watching the football in his room that evening.

The second patient had been an inpatient on Ward 5 for approximately 10 days for a stem cell transplant, she expected to be an inpatient for another 2-3 weeks. She said that the staff at CCC were excellent and cannot do enough for her; this ranged from the support staff through to the doctors. She advised that she had had many forms of technology such as phone, iPad, kindle and was also able to stay in contact with family and friends using her devices. When asked what CCC do well she answered that she has received the very best of treatment. She mentioned that she had not experienced any issues with communication from CCC

and had been contacted in a variety of ways, text, phone, letters and occasionally email, all of which she had been happy with. When asked what CCC could do better she discussed a few areas:

1. She mentioned that there had been issues and delays in her diagnosis. She went to her GP in Dec-20 who advised that it looked probable myeloma and was referred for a biopsy. In Jan-21 the biopsy was reported inconclusive and was asked in June to have another. When she went for results in June the doctor advised the results were inconclusive but then rang her later to say the wrong report had been read and she needed a scan. 3 months later she had still not had the scan and had to contact the secretary multiple times to chase. After she finally got her scan her treatment for myeloma was commenced 2 weeks later and CCC have been amazing. ***(This element of the patient pathway was within another Trust)***
2. The patient mentioned she had her bloods done at CCC as part of the stem cell plan. 8 days later she received a call from CCC to say that her potassium was lower than expected and to go to her GP or the Countess of Chester for repeat blood test. However, as it was bank holiday, she was unable to get an appointment, she rang CCC who asked her to come to CCCL for bloods; the results were within normal range.
3. The patient said that the temperature in the bedrooms are too warm; she had occasionally felt claustrophic in the room but understood the reason why she needed to stay in the room. She discussed that she had experienced a very dry throat and mouth during her treatment and craved cold drinks. Although she acknowledged that the rooms had a fridge, she felt it was too small, and she had asked frequently for ice to be added to her jug of water, but it still didn't stay cool for long and she missed access to chilled water.
4. She went on to talk about the meals which she said were 'ok as they were edible', however, she went on to add that the although the menu looked lovely, it didn't always reflect the meal she received. She described the food as 'uninspiring'. She had tried a chicken arrabiata, but when it arrived it was very dry with hardly any sauce; another day she had ordered a chicken salad that she described as uninspiring with no dressing, she offered that the lettuce could have been fresher as it was turning brown at the edges. Over the past week she said she had barely eaten because of nausea, but she was now eating rice crispies as advised by her inpatient doctor. She did mention that the 'Sunday Lunch' was lovely.

Staff experiences and comments

Two staff members were able to share their experiences of working on Ward 5 CCCL, both staff involved had been working on the Stem Cell unit for a considerable number of years both at LUHFT and CCC

One staff member described how she has always loved her role, but the past year has been the most challenging and she admitted that she had found the transition to CCC a testing time. The staff member expressed that she was grateful for the opportunity to talk to the panel and share her experiences. She discussed her passion in delivering high quality care that CCC patients deserve. The main themes identified from the interview with both staff members are described below:

1. **Patient Experience**

The staff commented that the patients love the bedrooms and the building is great. Staff expressed concerns in relation to food standards and portering service which has impacted on patient experience and staff on duty.

It was highlighted the great work that the porters do but that there isn't enough of them and often there are waits for them to attend. This is particularly challenging out of hours services, especially when blood products might need collecting form the lab in LUHFT

2. **Safer staffing and Education And Training**

During the past two years turnover of staff, in particular skilled nurses had been unusually high and it has not been easy to recruit experienced staff. This had resulted in challenges of working with an increasing junior team and the skill mix and this has impacted on the more senior staff on duty. The integration of TYA patients on the ward had been challenging, it was a new cohort of patients with very complex needs, new treatment regimes and different ways of administration.

3. **Communication**

Staff acknowledged the need to continue to build on realtionships with other teams and colleagues both within CCC and speciality services from LUHFT and the need for improved operational and medical communication. Some issues were highlighted were staff desribed at times that they felt isolated and vulnerable.

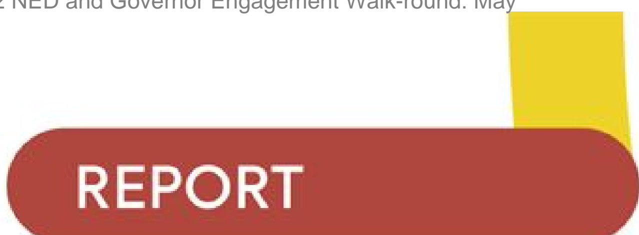
Staff also stated managers had not been visible however were well supported by the Matron and Ward Manager

4. **Aseptics**

The ward has experienced some pharmacy related issues with timely production of chemotherapy which has had an impact on the patient experience, patient treatments and impacted on the smooth running of the ward.

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 inaccuracies
- Note staff survey action plans are in development
- Request further updates as required.



Divisional Response

The last two years have the been the most challenging years for Ward 5 due to the move to a new hospital, adopting and adapting to new ways of working both in a new Trust and within the Stem Cell Transplant programme itself with the appointment of a new clinical lead and the pandemic. The staff cannot be praised enough for the way they rose to the challenges they faced particularly during the heights of the pandemic. They isolated and dedicated themselves solely to the care of the patients that did not have an option to defer treatment and had to continue with their transplant.

In order to protect the patients as much as possible the staff on ward 5 did not mix or socialise with any other wards in the trust and stopped working anywhere else, other staff unless directly involved in the care of the patients on ward 5 were also restricted from entering the ward. The staff have complied with strict infection control guidelines and screening regime. Whilst this has meant that to date ward 5 has not had a positive COVID patient, it has isolated the staff on ward 5 significantly, we are continuously working with the infection and prevention and control team to review our guidelines and relax our measures. We are supporting our staff as we transition to more 'normal' ways of working and encouraging them to do so however, staff are fearful mindful of the extremely vulnerable patients in their care and changes will take time.

The workforce model for portering has recently been reviewed and additional funding has been provided to increase the number of porters out of hours.

In April 2021 ward 5 opened three rooms for TYA in-patients. This had always been the plan for the new hospital and during 2019 in preparation for the joint BMT/TYA ward (Ward 5) staff received training in TYA protocols. Due to the pandemic the integration of the the TYA patients was delayed until April 2021 and training did not take place during the pandemic in the same way, by April 2021 some staff that had received training had left and the whole integration process proved more challenging for the staff. However the Matron together with the TYA CNS team provided ongoing support and education to the team.

Due to the pandemic acute services in the Royal Liverpol University Hospital (RLUH) were undertaking virtual reviews rather than on-site reviews for a number of reasons, firstly due to the challenges that acute trust were put under and secondly to protect vulnerable cancer patients. Whilst staff understood this to be the case, nevertheless the change to virtual reviews/telephone advice added to the feeling of isolation and led to the staff feeling vulnerable at times. It is important to note that whilst virtual/telephone reviews were carried out by most acute services in RLUH, despite their own challenges the critical care team continued to provide outstanding support to the BMT programme and provided face-to-face reviews, this was and continues to be much appreciated.

At the end of 2019 the BMT programme director left to take up a post in another trust, this coupled with the above was a further challenge especially given what followed in early 2020. The team has to be hugely commended for the way in which it maintained the service led by the acting programme director who worked tirelessly to lead the team and ensure that the patients continued to receive the same outstanding care. In

April 2021 a new programme director commenced in post, he has worked exceptionally hard alongside the team to strengthen the programme which has enabled us to submit our application and evidence for JACIE re-accreditation and embark on CAR -T therapy. This is a hugely excting opportunity for the region.

Following advice from Infection Prevention and Control the Acute Senior Leadership team, the Executives have now restarted their walkabout program across all wards including ward 5. The first face to face visit to ward 5 was undertaken in May 2022. This visit was undertaken with the Medical Director together with the Acute Care General Manager.

ACTION PLAN

Patient Experience Visit Action plan

Work plan developed: 10th May 2022: Liz Furmedge & Pris Hetherington

Last updated:

Updated by:

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

Ref	Action	Measure	Owner	Start date	End date	RAGB	Comments/progress
Theme: **Education and Training** ***Supports safe patient care, safer staffing, right staff with the right skills, supporting new starters and on the floor clinical training***							
	All staff to have an PADR discussion to reflect on key achievements during 2021/22 ; agree priorities/objectives; personal development needs and health & wellbeing support	➢ 95% of staff have received a PADR	Divisional / CBU managers and Matrons	May 2022	July 2022		*These actions form part of the Listening to you Staff Survey action plan work stream and will be monitored to completion at both the Divisional Assurance meetings and at Executive led PRG*
	Recruit x2 PEF posts to support Ward Education and Clinical skills training	Workforce flexibility and skill development	Matrons	March 2022	May 2022		

ACTION PLAN

		Newly qualified and International Nurse Educational support					
	To undertake a TNA of each ward / dept area	TNA completed	LR	June 2022	August 2022		
	Development of a CBU training plan	Training plan completed & A suite of training and development opportunities available and accessible to all staff that can be built upon as we move forwards into next year.	PD/ JMC	August 2022	August 2022		*These actions form part of the Listening to you Staff survey action plan work stream and will be monitored to completion at both the Divisional Assurance meetings and at Executive led PRG*
	Together with WOD review nurse induction program including key clinical skills required ie SACT	Induction Program reviewed with key action & recommendations Workforce flexibility and skill development	Matrons	April 2022	August 2022		

ACTION PLAN

NHS
The Clatterbridge Cancer Centre
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2.0 Safer Staffing: ***Supports safe patient care, safer staffing, staff morale, health & wellbeing***							
	Review of OOH hospital at night team roles and responsibilities and escalation procedures (ANPS& Junior Drs)	Clear roles, responsibilities and escalation framework of OOH Hospital at Night Team	AOB/ SJ	June 2022	July 2022		
	X 2 daily staffing reviews and monitoring of patient safety	To ensure safer staffing levels and skills mix are maintained.	Matrons	April 2022	May 2022		Completed New proforma developed and live in TEAMS
3.0 Theme: Communication (floor to board) ***Supports safe patient care, communications to and within teams, staff feeling supported, valued and listened to***							
	Review of the nurse safety huddle system and processes to ensure appropriately SACT training nurses are on shift	Review complete and new process in place	Matrons	May 2022	June 2022		*These actions form part of the Listening to you Staff Survey action plan work stream and will be monitored to completion at both the Divisional Assurance meetings and at Executive led PRG*
	Continue the Divisional Safe space conversation forums through the Divisional Staff Experience group for staff to share experiences and ideas on initiatives to address issues and feedback	Feedback and ideas from staff about what matters to them Visible and Inclusive Leadership	PD/ VY	Ongoing quarterly meetings			
	Development of a back to the floor program		LF/ VY	April 2022	April 2022		Completed
	Bi weekly Manager Back to the floor program		Senior Leadership Team	April 2022	May 2022		Program in place and commenced

ACTION PLAN

	TYA, ANP manager and HO Matron task and finish group to review issues raised in relation to staff report	Visible and Inclusive Leadership Early identification of issues and action planning	PD	June 2022	June 2022		*These actions form part of the Listening to you staff survey action plan work stream and will be monitored to completion at both the Divisional Assurance meetings and at Executive led PRG*
	Monthly TYA CNS meeting with ward 5 Senior Sisters	Early identification of issues and action planning	LE	June 2022	June 2022		
	Development of a joint LUHFT & CCC Operational Group	Pathway development Early identification of issues and joint action planning Improved Operational and Medical Communication	MW/LF	May 2022	July 2022		This will be monitored through the CCC / LUHFT Joint Executive Group
4.0 Environmental & and Food ***Supports patient experience and quality of patient care***							
	Introduction of a formal framework for weekly matron ward rounds	Early identification and rectifying of environmental, food & nutritional issues	LF & Matrons	June 2022	June 2022		*These actions will be monitored to completion at Acute Care Divisional Assurance meetings*
	Weekly Propcare Matrons meetings to review key standards and review of		Matrons	June 2022	June 2022		

ACTION PLAN

	actions required by ISS/ propcare	Improved patient experience					
	Immediate escalation to ISS / Propcare of food standard issues/ concerns		Matrons	Ongoing			
	Acute Care Representatives at ISS patient food tasting session		JG	May 2022	May 2022		Completed
	Procurement of additional portering services from 5am – 7am to support blood collection from LUHFT	Full overnight shift ward portering support	LF	May 2022	July 2022		
5.0 Aseptic Services : Support responsive patient care and treatment							
	Review of Melphelan (BMT Condition chemotherapy regime) Production	No delays in	PH/VY	April 2022	April 2022		Noted incident in relation to a one day delay to patient transplant Immediate action by Chief Pharmacist Plan now in place – now further delays experienced

Regarding late delivery of chemotherapy to the wards there is an established work-stream with a comprehensive action plan for Aseptic Services that is being monitored to completion via the Executive led PRG.

REPORT COVER

Report to:	Trust Board	
Date of meeting:	25 May 2022	
Agenda item:	P1-119-22	
Title:	Guardian of Safe Working Hours – Q4 Report January – March 2022	
Report prepared by:	Dr Ian Lampkin	
Executive Lead:	Dr Sheena Khanduri	
Status of the report: (please tick)	Public ☒	Private ☐

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

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

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

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

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 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

Guardian of Safe Working Hours – Q4 Report January - March 2022

Ian Lampkin, Guardian of Safe Working

1.0 Introduction

This report covers the period January - March 2022.

On 1st April 2022, Dr Ian Lampkin was appointed to the Guardian of Safe Working role, succeeding Dr Madhuchanda Chatterjee.

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

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

Since August 2021, Haematology doctors in training come under The Clatterbridge Cancer Centre NHS Trust when in placement at the Trust. We liaise with this group of trainees around attendance at Junior Doctors Forum and issues related to Exception Reports are raised at each Trust. Dr Gillian Brearton, Haematology Training Programme Director, advised the Haematology exception reports are submitted to the relevant Education Supervisor whether at the Royal or Clatterbridge but oversight remains with the GOSW at Liverpool University Foundation Hospitals NHS Trust (LUFHT). Dr Lampkin will liaise with the Guardian of Safe Working at LUFHT and the Haematology team in order to be notified of any relevant exception reports for future reference.

1. High level data

Number of doctors/dentists in training (total): 32

Number of doctors/dentists in training on 2016 TCS (total): 32

Amount of time available in job plan for guardian to do the role: 0.5 PA (2 hours per week)

Admin support provided to the guardian (if any): As required by Medical Workforce

Amount of job-planned time for educational supervisors: 0.25 PA per trainee

Exception Reports (with regard to working hours)

There were 13 Exception Reports submitted during the period January – March 2022. These reports were submitted by GP and IMT trainees covering our wards and who fall under General Medicine. The nature of the reports cited variances in hours of work due to the wards not being sufficiently staffed and 3 reports were highlighted as 'Immediate Safety Concern' (ISC) relating to staffing levels.

Of the 13 Exception Reports, all have been have been reviewed and marked as complete.

Dr Lampkin has escalated the ISC's to relevant departmental managers. A number of the ISC's and recent exception reports have been around out of hours cover for our

Wirral site and work is ongoing to address this. Please see “Action Plan Summary” for further details.

It is expected based upon the Terms and Conditions of the 2016 Junior Doctor Contract that Exception Reports are initially acted upon by Supervisors within 7 to 14 days based on the nature of the report made.

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A number of Exception Reports have breached the 7 to 14 day window for initial action and consequently Dr Lampkin directly intervened to complete these reports and further education around completion of exception reports is being implemented. Work is underway to employ more Clinical Fellows to improve ward numbers. Current workforce numbers have meant taking Time in Lieu (TOIL) from exception reports more difficult to so the current recommended position for the next few months would be payment for working additional hours, subject to the trainees agreement. Though recognising that the long term outcome would be TOIL. The Exception Report/Work Schedule policy will be updated to reflect this and agreed at Joint Local Negotiating Committee. BMA guidance has been sought in developing this.

After recent discussions, the Trust would like to further demonstrate its commitment to junior doctor safe working by extending the ability to exception report for additional hours to the Clinical Fellow group of doctors, on the same Allocate system as Doctors in Training, where they have not been able to exception report before.

Junior doctors who have not been appointed to a training programme, and are undertaking a fixed term Trust doctor post at the Trust (starting on or after 2nd August 2021) are eligible to exception report additional hours or missed breaks. This provides them with the same protection as doctors in training, and ensures their working patterns are acceptable, and they are sufficiently rested to provide safe care for our patients.

Additional hours should be remunerated with TOIL or payment as per the guidance for trainee’s exception reports. However, additional work by Trust doctors cannot incur fines.

As Trust posts are for service and experience rather than training, Trust doctors are not able to exception report for educational opportunities but the Trust actively encourages educational opportunities for these doctors where possible.

Educational exception reports submitted by Trust doctors may be discussed at regular supervision meetings, but the Trust is not committed to provide alternative experiences and the report should be closed as non-valid.

Dr Lampkin and Dr Olsson-Brown will provide the oversight for the exception reporting process for Clinical Fellows.

Work Schedule reviews

There has been one request from a trainee supervisor for a work schedule review related to Junior trainee rotas/staffing issues. The Work Schedule is directly related to low staffing levels for junior ward trainees as opposed to direct serious breaches. The actions taken for the Work Schedule review are as outlined in the attached Action Plan Summary.

Medical Workforce are in the process of reviewing the ST3+rota as a redesign is required to better accommodate our Less Than Full Time trainees and reduce the number of known gaps due to non-working days.

Locum bookings

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

Specialty	Shifts worked by bank doctors	Shifts worked by agency doctors	Patchwork shifts
Clinical Oncology / Medical Oncology	0	0	28
General Medicine	4	62	19
Haemato Oncology	16	0	0

Vacancies

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

The 1 in 13 junior rota currently has 3 full time vacancies with 2 posts being covered by agency locums, 1 vacant and we also have 1 doctor working at 80%. The rota is made up of 2.8 Trust Junior Clinical Fellows, 6.8 full time equivalent Doctors in Training and 2 agency locums. This makes the full time equivalent of 11.6 but with 2 of those full time posts being covered by agency locums. We have received 4 resignations from Junior Clinical Fellows since January 2022 so we have advertised for replacements via agency for the interim period whilst we are recruiting via NHS Jobs and TRAC. Extending contracts for current locum agency doctors will be considered to help maintain ward junior trainee numbers in the interim to August 2022.

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

Significant work has been undertaken done to recruit more Clinical Fellows, and following recent interviews, the Trust has recruited 8 new Clinical Fellows to commence employment between May and August 2022. Confirmation has been received that funding has been identified and allocated to maintain the number of Clinical Fellows employed.

Dr Lampkin will engage with workforce, junior doctor leads and tTust management with regarding to foreseen lower levels of junior ward doctors in the next few months due to Clinical Fellows leaving in /not starting until August 2022.

NHS
The Clatterbridge Cancer Centre
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Fines

There were no fines incurred in this quarter (January-March 2022).

All Trainees who require access to Exception Reporting, have been reissued with login details. On this issue and trainee interaction with the exception reporting system Dr Lampkin has undertaken a questionnaire survey with the junior trainees and will report on this in the Annual GOSW report

Actions taken to resolve issues – See Action Plan Summary attached

Conclusion

The information in this report confirms for this quarter, the working hours of Ward - based doctors in training IMT/CMT, GP trainees and Oncology trainee doctors remain compliant with the 2016 contract.

Locums were used appropriately to cover on-call shifts during this time period to ensure all critical out of hours shifts were covered.

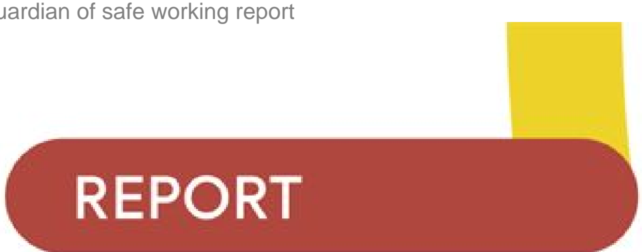
There has been an increase in the number of exception reports in this quarter in line with lower staffing levels, out of hours issues at the Wirral site and active encouragement from new Guardian of Safe Working for trainees and supervisors to interact with the exception reporting process.

I am confident that Trust management, workforce and junior doctor leads are addressing and acting on the current issues appropriately.

Within this organisation, working hours for doctors in training are considered safe at the current time based upon rotas and rostered hours.

Dr Ian Lampkin

Guardian of Safe Working



Version: 1.0 Ref: FCGOREPO Review: May 2024

ACTION PLAN

Guardian of Safe Working (GOSW) Report

Last updated: 18/05/2022

Updated by: Dr Lampkin GOSW / Medical Workforce

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

Ref	Action	Measure	Owner	Start date	Due date	RAGB	Comments/progress
GOSW-1	Junior trainee rota/Clinical Fellow Recruitment		AOB/PD/ CT	March 2022	August 2022		To date 8 Clinical Fellows have been recruited to commence work at Clatterbridge by August 2022 to improve ward trainee numbers.
GOSW-2	Wirral Out of Hours		AOB/PD/ CT	March 2022	August 2022		Following exceptions for Wirral site cover the Acute Care Division to implement new policy regarding patient transfer with stratification plan, changes to escalation policy and additional support requirements
GOSW-3	Escalation of Exception Reports		IL/CT	April 2022	Ongoing/August 2022		Relevant exception reports and immediate patient safety concerns in reports will be escalated to relevant directorate/executive management whilst encouraging trainees to also use DATIX system
GOSW-4	Junior Doctor Forum/Trainee engagement		IL	April 2022	Ongoing/ Dec 2022		GOSW to attend JDFs, trainee inductions and to give a teaching session to trainees to encourage engagement with GOSW/Exception reporting. Trainee survey done (reported on in Annual report) and to repeat survey end of 2022
GOSW-5	Improving Exception Report processing delays		IL	May 2022	10th June 2022		To give training session to Educational Supervisors on Exception reporting/Work Schedules on 10th June
GOSW-6	Exception Reporting/Work Schedule Policy		IL/CT	June 2022	Oct/Nov 2022		To write a new trust policy for Exception Reporting/Work Schedule

GOSW-7	Clinical Fellows using same Exception system as Trainees		IL	April 2022	May 2022		Trust grade Clinical Fellows are now on and can use the same Exception reporting system in parity with fellow Junior Trainees.
GOSW-8	Haematology trainee engagement		IL/CT	April 2022	Dec 2022		Improve interaction and awareness of Haematology trainees exception reports that go to Royal Liverpool GOSW

Key:

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

REPORT COVER

Report to:	Trust Board	
Date of meeting:	25 May 2022	
Agenda item:	P1-21-22	
Title:	ICB Transfer Letter	
Report prepared by:	James Thomson	
Executive Lead:		
Status of the report: (please tick)	Public ☒	Private ☐

Paper previously considered by:	
Date & decision:	

Purpose of the paper/key points for discussion:	For Information: Notice of NHS Liverpool CCG (and on behalf of all co-commissioners) intent to transfer contract to Cheshire and Merseyside Integrated Care Board

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

Next steps required:	The committee is asked to note the content of the letter.

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 1.0 Ref: FCGOREPCOV Review: May 2024

Ref: Contract Transfer

NHS Liverpool Clinical Commissioning Group
The Department
2 Renshaw Street
Liverpool
L1 2SA

Tel: 0151 247 6439
Email: alison.picton@liverpoolccg.nhs.uk

Clatterbridge Cancer Centre NHS FT

Via Email Only to: **sally.garner2@nhs.net**

31st May 2022

Dear Sally,

Re: Notice of NHS Liverpool CCG (and on behalf of all co-commissioners) intent to transfer contract to Cheshire and Merseyside Integrated Care Board

We are writing to you following the Health and Care Bill receiving Royal Assent on 28 April 2022 to become the Health and Care Act 2022. The new Act will change the landscape of current commissioning arrangements and the intent is that NHS Clinical Commissioning Groups will cease to exist in statutory form from 30th June 2022. In addition, from the 1st July 2022, there will be a formalisation of the Integrated Care Systems into a new statutory body, which will be an Integrated Care Board (ICB).

Therefore, we wish to outline to you, the plans for the establishment of the Cheshire and Merseyside ICB which will assume the responsibility of NHS Liverpool CCG. As such, we are writing to all our providers of healthcare services to notify them of them of the planned changes and to confirm our intentions regarding the services delivered under our existing contracts or grants.

The expectation is that all NHS Clinical Commissioning Group (CCG) functions and duties will transfer to an ICB when they are established, along with all CCG assets and liabilities, including their commissioning responsibilities and contractual agreements.

Collectively, CCGs across Cheshire and Merseyside have sought to establish a consistent approach that will be adopted in respect of all existing healthcare agreements, in preparation for the establishment of a single body that will become responsible for commissioning services for the population of Cheshire and Merseyside.

The Integrated Care Board and contracting with providers

The ICB NHS body will be a statutory organisation responsible for specific functions that enable it to deliver against four core purposes:

- improve outcomes in population health and healthcare

- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

One of the functions for which the ICB will be responsible, is arranging for the provision of health services in line with the allocated resources across the Integrated Care System (ICS), through a range of activities that include putting in place contracts and agreements with providers to secure delivery of its plan to meet the needs of the population within their area. These may be contracts and agreements with individual providers or lead providers within a place-based partnership or provider collaboratives and will reflect the resource allocations, priorities and specifications developed across the whole system and at place level.

Contracts will be awarded by the ICB with all payments also made by the ICB as the legal entity and are expected to be strategic, long-term and based on outcomes, with providers responsible for designing services and interventions to meet agreed system objectives.

Financial framework and funding flows

NHS England and NHS Improvement will make financial allocations to each ICB NHS body for the performance of its functions. Funding will continue to be linked to population need and allocations will be based on longstanding principles of supporting equal opportunity of access for equal needs and contributing to the reduction of health inequalities.

Decisions about spending will be devolved to ICB NHS bodies and will include budgets for: acute, community and mental health services (currently CCG commissioned), primary medical care (general practice) services (currently delegated to CCGs). The ICB NHS body will agree how the allocation will be distributed to perform its internal functions and how funding will flow from the ICB NHS body to providers largely through contracts for services/outcomes, which may be managed by place-based partnerships or provider collaboratives.

Continuity of Service Provision

As it has now been confirmed that the ICB will be established on 1st July 2022 and the CCG will cease to exist from 30th June 2022 your contract will automatically 'Transfer' to the Cheshire and Merseyside ICB as the new statutory commissioning body. As this change is brought about due to the implementation of the new Act, the handover of assets, including contractual agreements will be undertaken via a 'Transfer Scheme' rather than the more traditional 'Novation' process. This means that there is no new documentation to sign, and your existing contractual agreement will continue with the ICB.

Next Steps

You will be contacted in due course separately, with a letter from the NHS Liverpool CCG finance team regarding future billing arrangements, new invoice address details and to confirm any change in process. If you do not receive this letter in the coming weeks, please contact us via contracts@liverpoolccg.nhs.uk.

Please note you may receive similar letters from other local CCGs as we are all required to advise our providers of the proposed changes.

We would also wish to highlight that in future, as contracts come to their natural expiry, we may wish to review historic contractual terms and conditions and where these are not on NHS standard formats, consider moving these over to the standard published contract versions.

Finally, may we take the opportunity to thank you for the commitment that Clatterbridge Cancer Centre (CCC) has continued to show day to day in response to the evolving pressures and challenges that have impacted every part of healthcare during and following the COVID pandemic. Your support in maintaining high quality services for the population of Liverpool and the wider area during the transfer period and beyond, and the flexibility you have demonstrated in the face of the most challenging period the NHS has ever experienced, is very much appreciated.

We thank you in advance for your patience and co-operation as we undertake this process.

Yours sincerely

p.p.

Mark Bakewell

Chief Finance and Contracting Officer

Cc. Alison Picton, Head of Contracts, LCCG

REPORT COVER

Report to:	Trust Board
Date of meeting:	29th May 2022
Agenda item:	P1-122-22
Title:	Integrating Specialised Services Within Integrated Cate Systems
Report prepared by:	James Thomson, 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:	This paper outlines NHS England's proposed roadmap for integrating specialised services into integrated care systems. The paper discuss the key areas of the guidance, and will: • Identify the aims of devolving specialised commissioning • Highlight Trust services that that will be affected • Outline the transition process to the new arrangements and associated funding methodology Trust Board is asked to note the information and discuss the content of the paper.

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

Next steps required:	N/A

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 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.

Version 1.0 Ref: FCGOREPCOV Review: May 2024

Integrating specialised services within integrated care systems

James Thomson - Director of Finance

Contents

1.0 Introduction

2.0 Proposed Commissioning Changes

3.0 Process and Timeline

4.0 Proposed Finance Changes

5.0 Recommendation

1. Introduction

1.1 This paper provides a summary of the recent guidance from NHS England, "Roadmap for integrating services within Integrated Care Systems". This was published on 31st May 2020[1], after several years development, and started a period of consultation. The guidance sets out how prescribed specialised services will be commissioned, in response to the Health and Social Care Act 2022, linking previously nationally commissioned services with management at the Integrated Care Board level.

1.2 NHS England are also consulting on amending the funding approach for specialised services.[2] This has been developed by NHSE/I and the Advisory Committee on Resource Allocation (ACRA). The aim of the proposal is to amend service funding methodology, so that ICBs receive funding for specialised services on a population basis, rather than historic cost base. The consultation closes on 30th June 2022.

1.3 Both the guidance and the proposed funding changes will have an impact on the services provided by the Trust and its relationships with commissioners. Currently, NHSE Specialist Commissioning contracts for 80% of the Trust's service income.

2. Proposed Commissioning Changes

2.1 The "Roadmap" outlines how specialised commissioning will evolve over the coming years. Effectively, this will aim to integrate commissioning into ICB structures, with the benefit of improving the ability to improve care pathways and outcomes. ICBs "will be the commissioner for the primary, community, secondary and tertiary elements of pathways for their population". A summary of the desired benefits of the change is included at Appendix A.

2.2 Although NHSE remain formally accountable for the provision of 154 specialised services, commissioning for certain services will be delegated for management at system level. NHSE have reviewed the specialised service portfolio and have placed services into three categories, in terms of suitability and readiness. The following table outlines the categories and the relevant services provided by the Trust.

1. Services identified as not suitable for delegated commissioning	2. Services identified as suitable for delegated commissioning, but deferred as not ready	3. Services identified as not suitable and ready for delegation
• Proton beam therapy services	• Blood and marrow transplants • PET imaging • Soft tissue sarcoma • Penile cancer • Genomic testing • Molecular diagnostics	• Radiotherapy • Specialist cancer services • Chemotherapy • Teenage and young adult cancer • Clinical genomic services

[1] https://www.england.nhs.uk/wp-content/uploads/2022/05/PAR1440-specialised-commissioning-roadmap-addendum-may-2022.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2022/05/B1201-acra-prescribed-specialised-services-needs-based-allocations-methodology.pdf

2.3 Since its inception in 2013, there have been recognised benefits to national commissioning. These include national clinical standards, service specifications and clinical access policies. The guidance states that some of these features will be retained, including:

- All services will continue to have prescribed specialised service status
- NHSE/I retain accountability for the entire portfolio
- All services will be subject to national service specifications, with supporting clinical policies that ensure consistent access
- Clinical Reference Groups will continue and be strengthened
- NHSE/I will ensure continued involvement of patients and communities
- NHE/I will maintain national and regional commissioning expertise, whilst supporting transition

3. Process and Timeline

3.1 The transition to the new arrangements will occur in a phased approach. 2022/23 is considered a transition year. Formal statutory commissioning will not be delated during the year and NHSE will continue to hold the budget for services. However, it is expected that ICBs will have increasing involvement in specialised services in the year, such that governance structures can be developed and strengthened, in advance of full delegation.

3.2 The guidance outlines that delegation could happen from 2023/24. To ensure that ICBs are sufficiently developed to take the responsibility, NHSE will make a readiness assessment of each system, using a nationally consistent pre-delegation assessment framework (PDAF).

3.3 The PDAF assessment criteria include the following domain areas;

Domain	Principle
Transformation	ICB demonstrates understanding of benefits of delegation
Governance	Sufficient specialist clinical expertise to scrutinise services
Finance	Risk factors understood and track record of balanced budgets
Workforce	Risk factors understood and mitigated
Data, analytics	Clear understanding of digital maturity required
Health and care geography	Meaningful geographc footprint, taking into account patient flows

3.4 For ICBs that are not assessed as ‘ready’ a joint commissioning arrangement will take place for 2023/24, via a statutory joint committee.

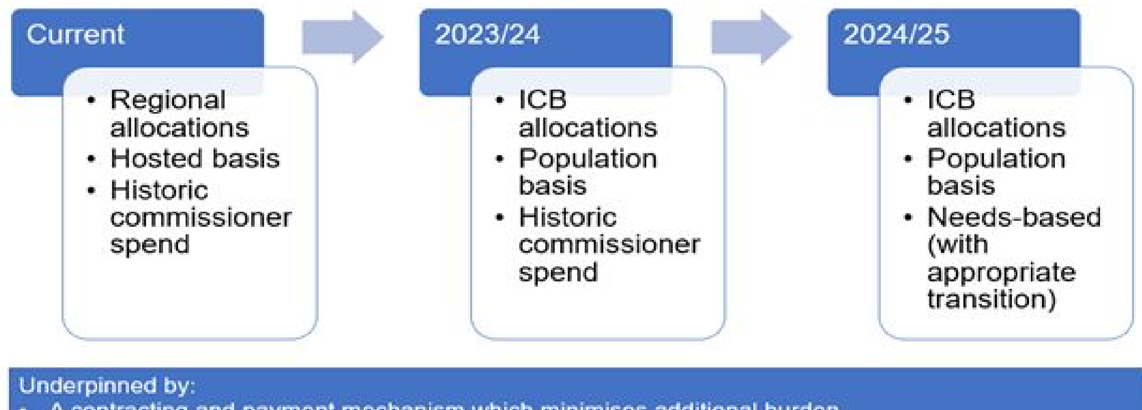
NHSE North West will lead the assessment process for Cheshire and Merseyside, with final recommendations made to the national NHSE/I Board in February 2023.

3.5 The guidance mentions that clinical networks will be critical to the success of delegating commissioning. Specifically, it states that “Cancer Alliances will support ICB arrangements by providing advice and planning support to deliver the NHS Long Term Plan commitments for cancer, and joining up whole care pathways for cancer services.”

4. Proposed Finance Arrangements

4.1 During the transition year, 2022/23, funding arrangements will continue on a historic cost basis and remain the responsibility of NHSE. Non-core allocations will be allocated to ICBs, as part of the process of devolving budgets. To ensure that financial stability is maintained, NHSE and Trusts will complete a baseline exercise, so that activity and funding flows can be mapped across system boundaries. There is a risk for some Trust that provide specialised services to multiple ICBs that funding could be mis-aligned in the move to system commissioning and this would adversely impact financial stability.

4.2 The proposed finance changes will be phased over 2023/24 and 2024/25, and are summarised as follows:



4.3 The population basis proposal is supported by the ACRA methodology that aims to identify a needs based funding allocation for each ICS. This will include deprivation and demographic factors. The engagement exercise demonstrates that this is a highly technical piece of work, which involves multiple data feeds and reference sources. The financial impact to the Trust will be calculated later in the year, when the methodology process has concluded, and shared when available.

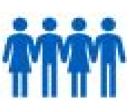
4.4 At this stage, high cost drugs are excluded from the movement to population based funding, and will continue on a pass-through basis.

5. Recommendation

5.1 The Trust Board is asked to note the contents of the report, and raise any points for clarity or further discussion.

Appendix A – NHSE Commissisoning Delegation Improvements

Integrating commissioning of specialised services with ICSs will support our triple aim of improving…



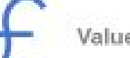
What should this mean for our patients, populations and their communities?

Quality of patient care

- Patients will receive more **joined up care** – better communication and sharing of information between professionals and services.
- More of a **holistic, multi-disciplinary approach** to care. A range of professionals can be involved in planning a patient's care.
- Increase focus and investment on **prevention**.
- Patients will receive the **right care at the right time in the right place**.
- Better **step-down care** to support patients who are ready to leave specialised care.

Equity of access

- Population based budgets means decisions on spend are based on the **needs of a local population** – the demographics, health behaviours etc rather than on activity in hospitals.
- Specialised clinical expertise will have a role in managing population health and to **challenge underlying drivers of health inequalities**.
- Providers and professionals working collaboratively, free from organisational constraints and commissioning boundaries, will help improve **quality of care and tackle unwarranted variation**.
- Opportunity to **level up access across the country**



Value

- Investment in preventative care could **reduce demand** for specialised services.
- Providers and professionals can **better manage patient demand**, even when one part of the system becomes stretched. Patients can be re-directed or transferred so they have faster and better access to treatment.
- A whole system approach creates opportunities **to protect and build 'workforce resilience'**, as shown during the pandemic.
- Pooled/delegated budgets allow **underspends to be shared or reinvested** and avoids commissioning pressures on any one organisation.

Accessible care

Tailored care

Seamless care

Effective care

Preventative care

Performance Report

June 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
V. 31 day 1st treatment 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*	133%
Cancer surgery activity*	123%
SACT (inc chemo) delivery**	122%

Measure	% of pre-Covid level
Radiotherapy planning**	127%
Radiotherapy treatment**	88%
Endoscopy activity♀	85%

- 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 continue to be recruited.
- Radiotherapy planning activity (compared to pre-covid) is one of the highest experienced to date. This reflects the increasing numbers of referrals into CCC.
- 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 remains consistently higher than in 2020/21, when the average was 74% of 2019/20.
- Endoscopy activity continues to recover from the pandemic, with April 2022 activity (6,085 procedures) being similar to April 2021 activity (6,198 procedures). The endoscopy waiting list fell slightly, from 11,658 procedures in March 2022 to 10,956 procedures in April 2022. Further capacity may be required in order to clear the backlog of patients on the endoscopy waiting list. 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.

Cheshire & Merseyside Cancer Alliance

*Data as of 13th June
** Solid tumour only (not inc. Haemato-oncology): reliable Haemato-oncology figures pre covid are unavailable – data as of May 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, 62 day and 31 day 1st treatment cancer waiting times performance data relate to **April 2022**.

The Alliance failed the **14 day standard** for urgent suspected cancer referrals, achieving 72.2%. This is lower than 80.5% the previous month.
The England average was 79.1%.
Ten trusts and all CCGs failed to meet the 14 day standard of 93%.
Cheshire and Merseyside was the 16th best performing Alliance in England out of 21 against this standard (providers).

The Alliance failed the **28 day standard** for urgent suspected cancer referrals achieving 65.6%. This is lower than 69.6% the previous month.
The England average was 70.8%.
11 trusts and eight CCGs failed to meet the 28 day standard of 75%.
Cheshire and Merseyside was the 18th best performing Alliance in England out of 21 against this standard (providers).
This new standard came into force from October 2021.

The Alliance failed the **62 day standard**, achieving 71.7%. This is higher than 68.5% the previous month.
The England average was 65.2%.
Nine trusts and eight CCGs failed to meet the 62 day standard of 85%.
Cheshire and Merseyside was the 7th best performing Alliance in England out of 21 against this standard (providers).

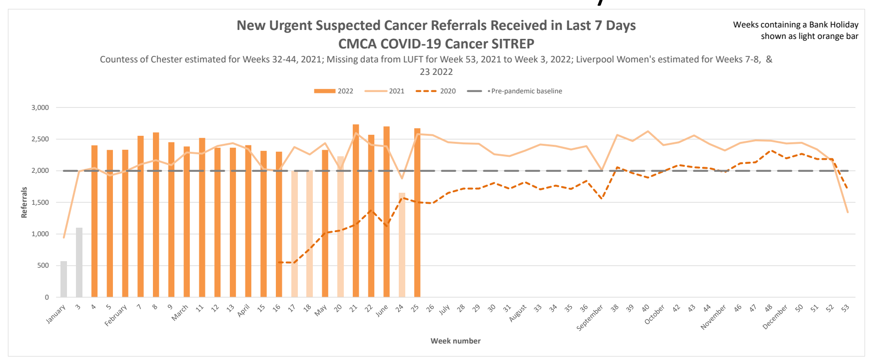
The number of urgent referral patients waiting **over 62 days** is significantly higher than pre-Covid levels. On 13th June 2022 there were 1,692 patients waiting more than 62 days for a diagnosis or treatment. This has increased from 1,603 reported last month (9th May). Of these, 459 have waited **over 104 days**. This is higher than the 417 patients reported last month.

The Alliance failed the **31 day 1st treatment standard**, achieving 95.2%. This is slightly lower than 95.6% the previous month.
The England average was 92.8%.
Six trusts and three CCGs failed to meet the 31 day 1st treatment standard of 96%.
Cheshire and Merseyside was the 5th best performing Alliance in England out of 21 against this standard (providers).

* 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 increased with 2,428 patients referred this week (33% above pre-pandemic weekly average, 4% 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 & 23/05/22

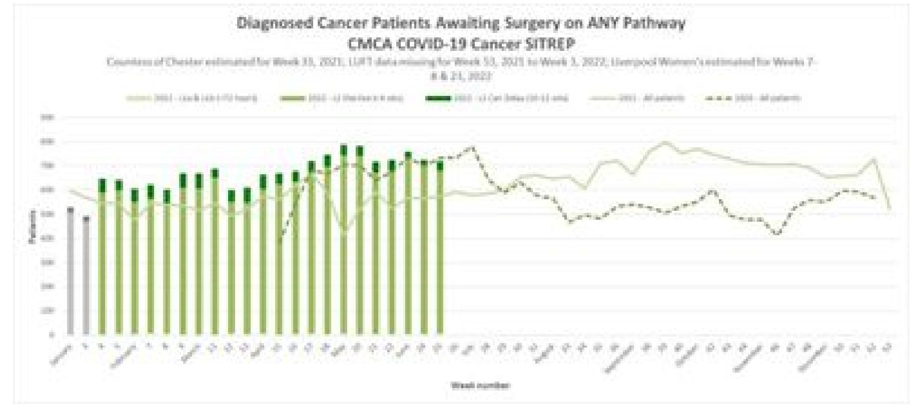
2. Diagnostic backlog (referrals without a DTT)

Patients Where Investigation for Suspected Cancer is Being Actively Managed or is Suspended
CMCA COVID-19 Cancer SITREP
Countess of Chester estimated Week 33, 2021; LUFT data missing Weeks 53-3, 2022; Liverpool Women's estimated Weeks 7-8 & 23, 2022
2022 - Actively managed patients
2022 - Suspended patients
2021 - All patients
2020 - All patients
Patients
Week number

Currently 12,421 active patients, of which less than 5 suspended (20% 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 & 23/05/22

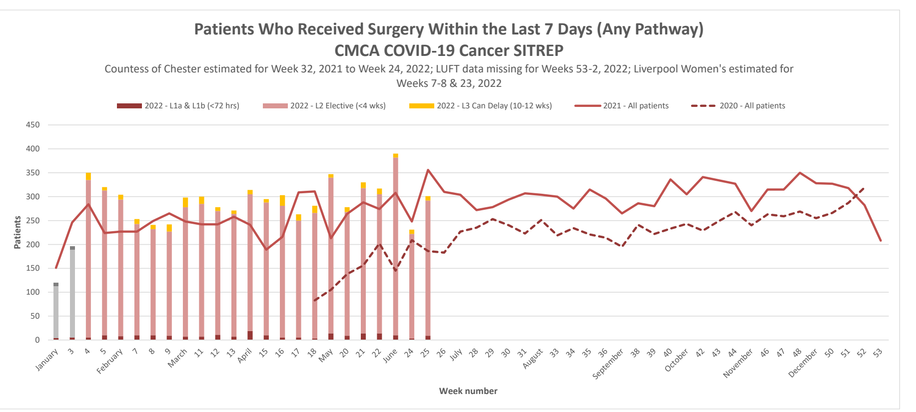
3. Cancer patients awaiting surgery



719 patients with a surgical DTT. 681 at L1&L2 and 38 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 & 23/05/22.

4. Cancer surgery performed in last 7 days

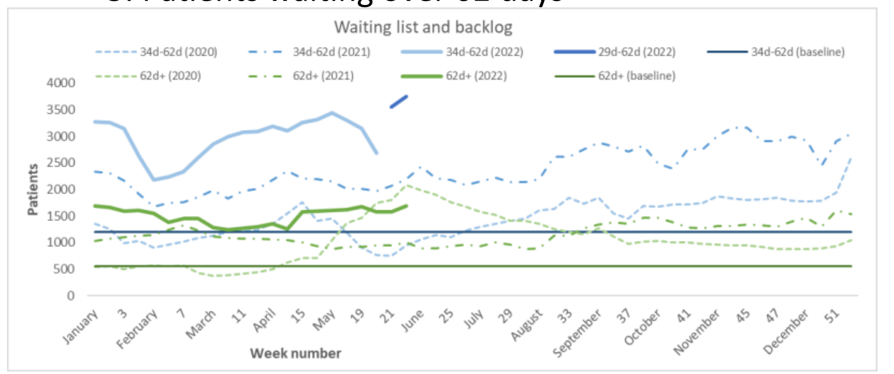


301 cancer operations performed last week.

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 estimated for 02/08/21 to 06/06/22 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 & 23/05/22.

Section II: Restoration of Cancer Services – Core Metrics

5. Patients waiting over 62 days

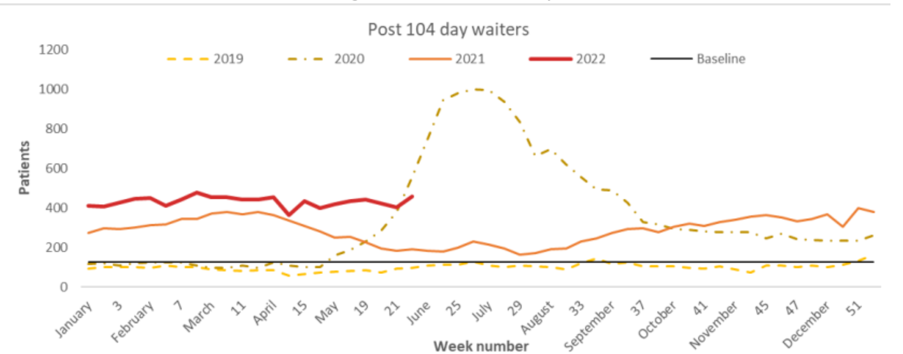


1,692 patients have waited over 62 days

- Higher than 1,582 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

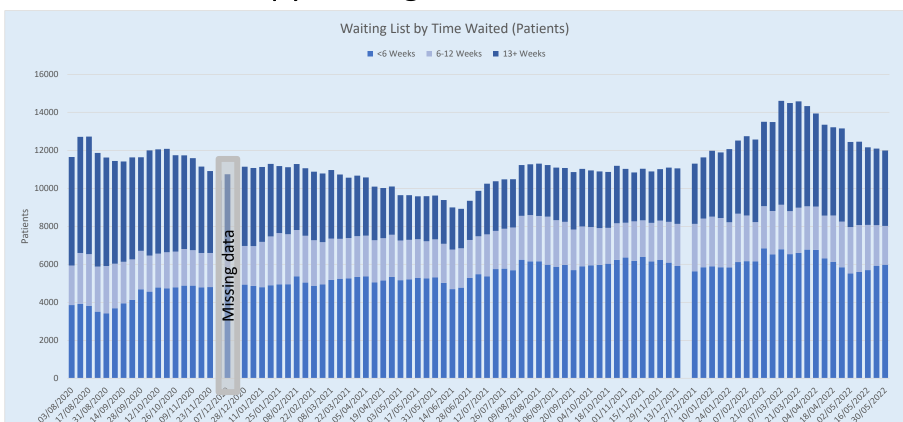


459 patients have waited over 104 days

- Higher than 403 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.

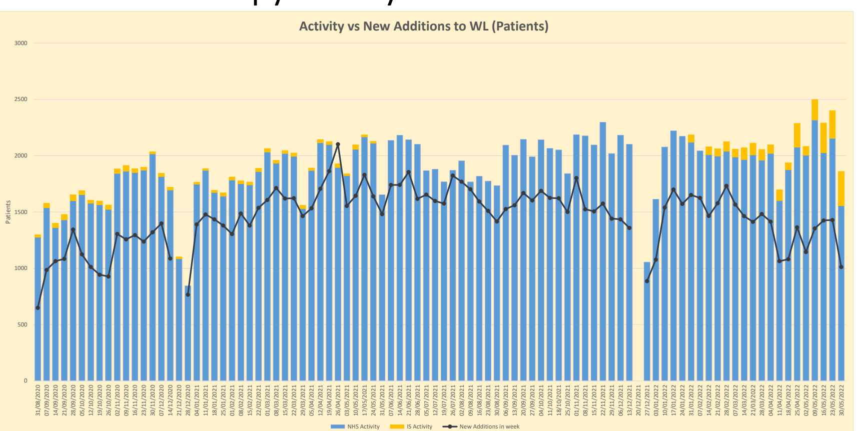
7. Endoscopy waiting list



Endoscopy waiting list lower than last week at 11,996 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. East Cheshire estimated for 26/05/22 Countess of Chester and Southport & Ormskirk estimated for 6/6/22.

8. Endoscopy activity



Activity decreased with 1,860 patients seen (cover BH week)

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. Southport & Ormskirk activity estimated for 26/05/22. East Cheshire estimated for 26/05/22. Countess of Chester and Southport & Ormskirk estimated for 6/6/22.

9. Patients waiting between 63 and 103 days by provider

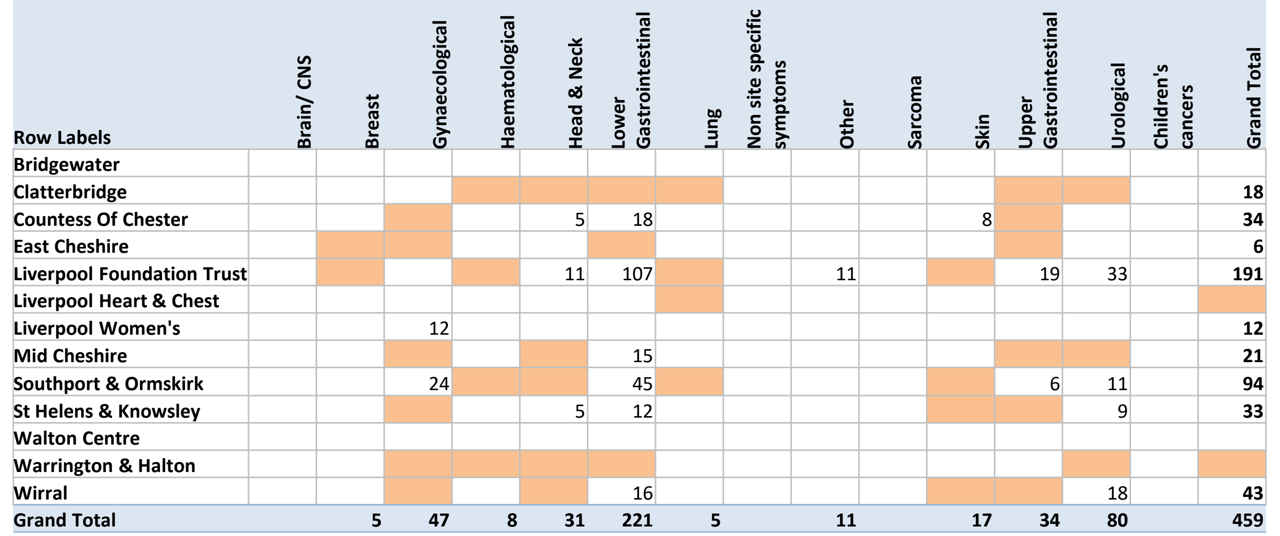
PTL data from W/E 05 June

Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total
Bridgewater															
Clatterbridge		6					16						16		66
Countess Of Chester			14		5	50					14	8			102
East Cheshire		6				17							7		34
Liverpool Foundation Trust		26			34	199			20		21	111	82		501
Liverpool Heart & Chest															
Liverpool Women's			43												43
Mid Cheshire			12		7	44						10			91
Southport & Ormskirk			46			32	6				30	14	30		166
St Helens & Knowsley			16		8	55					13	7	16		124
Walton Centre															
Warrington & Halton													10		18
Wirral			12		5	28						6	30		85
Grand Total		47	150	17	68	440	38		20		84	163	201		1237

Tables from national Cancer PTL

10. Patients waiting over 104 days by provider

PTL data from W/E 05 June

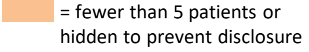


Row Labels	Brain/ CNS	Breast	Gynaecological	Haematological	Head & Neck	Lower Gastrointestinal	Lung	Non site specific symptoms	Other	Sarcoma	Skin	Upper Gastrointestinal	Urological	Children's cancers	Grand Total
Bridgewater															
Clatterbridge															18
Countess Of Chester					5	18					8				34
East Cheshire															6
Liverpool Foundation Trust					11	107			11			19	33		191
Liverpool Heart & Chest															
Liverpool Women's			12												12
Mid Cheshire						15									21
Southport & Ormskirk			24			45						6	11		94
St Helens & Knowsley					5	12							9		33
Walton Centre															
Warrington & Halton															
Wirral						16							18		43
Grand Total		5	47	8	31	221	5		11		17	34	80		459

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



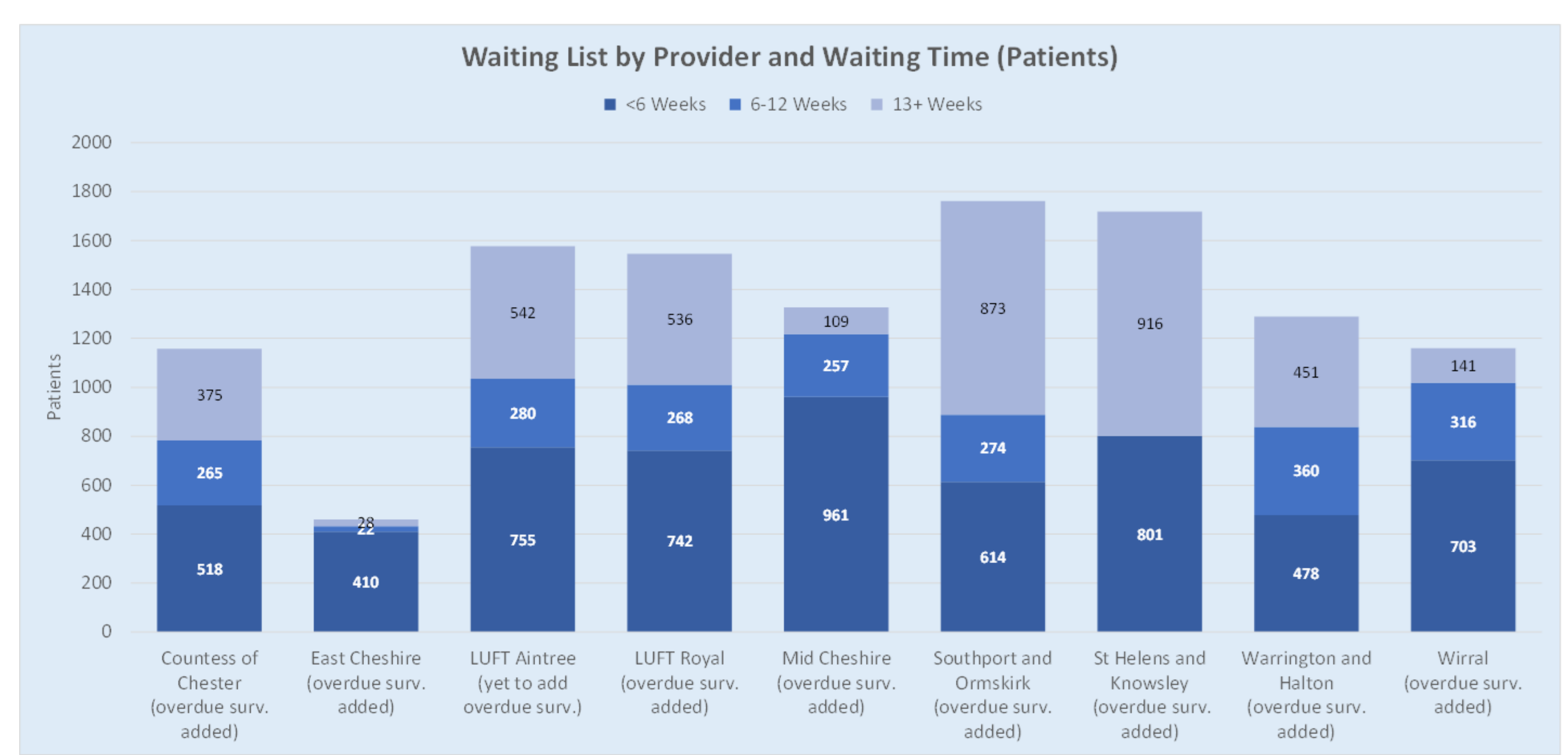
= No PTL submission this week

Section II: Restoration of Cancer Services – Core Metrics

Endoscopy (cancer and non-cancer pathways)

There are currently 11,996 patients waiting for an endoscopy. 6,014 have waited more than six weeks, and of these 3,971 have waited 13 or more weeks (33% of the total).

There is significant variation across units. In terms of patients waiting over 13 weeks the highest proportions are seen in Southport and Ormskirk (50%) and St Helen's and Knowsley (53%).
Other units experiencing challenges are Warrington and Halton (35%), LUFT Royal (35%), LUFT Aintree (34%) and CoCH (32%).



Endoscopy data at 06 June 2022.

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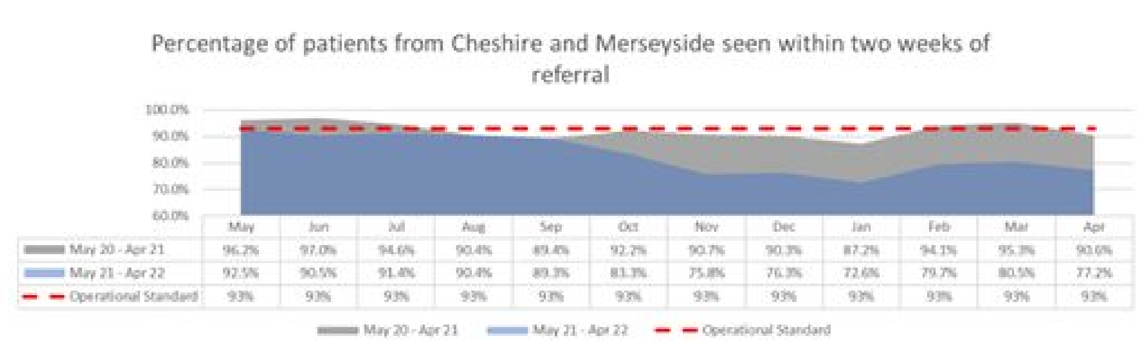
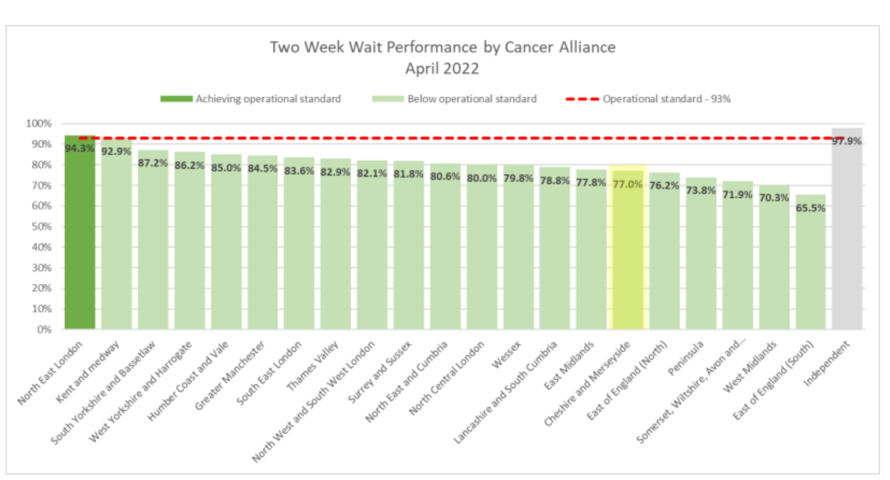
Section III: 14 day standard





In April 2022, 77.2% of patients were seen within 2 weeks compared to 80.5% in the previous month. This is below the operational standard.

In April 2022, Cheshire and Merseyside Cancer Alliance ranked 16 out of 21 for Two week wait performance (Providers**).

Providers not achieving the national operational standard were:

- Liverpool Womens 11.9% (259 breaches)
- Liverpool University Hospitals 64.8% (963 breaches)
- Countess Of Chester Hospital 65.7% (373 breaches)
- St Helens and Knowsley Hospitals 82.5% (280 breaches)
- Warrington and Halton Teaching Hospitals 82.9% (181 breaches)
- The Clatterbridge Cancer Centre 85.7% (2 breaches)
- Wirral University Teaching Hospital 85.8% (238 breaches)
- Southport and Ormskirk Hospital 86.1% (146 breaches)
- East Cheshire 88.9% (57 breaches)
- Mid Cheshire Hospitals 89.5% (124 breaches)

CCGs not achieving the national operational standard were:

- NHS Liverpool 60.2% (784 breaches)
- NHS South Sefton 68.8% (238 breaches)
- NHS Knowsley 74.2% (198 breaches)
- NHS Southport and Formby 77.4% (140 breaches)
- NHS Halton 80.3% (120 breaches)
- NHS Cheshire 81.7% (551 breaches)
- NHS St Helens 83.2% (140 breaches)
- NHS Wirral 85.5% (228 breaches)
- NHS Warrington 86% (131 breaches)

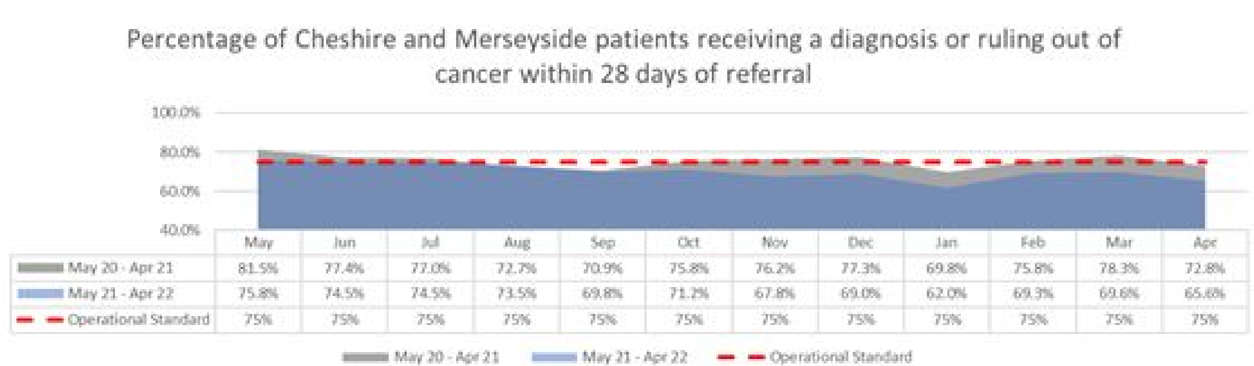
Cancer pathways* not achieving the national operational standard were:

- Suspected breast cancer 56.7% (865 breaches)
- Suspected gynaecological cancer 58.6% (445 breaches)
- Suspected head and neck cancer 75.4% (232 breaches)
- Suspected lower gastrointestinal cancer 83.3% (384 breaches)
- Suspected children's cancer 84.4% (5 breaches)
- Suspected upper gastrointestinal cancer 86.1% (139 breaches)
- Suspected skin cancer 86.1% (353 breaches)
- Suspected urological malignancies (excluding testicular) 89.8% (87 breaches)
- Suspected sarcoma 91.8% (5 breaches)

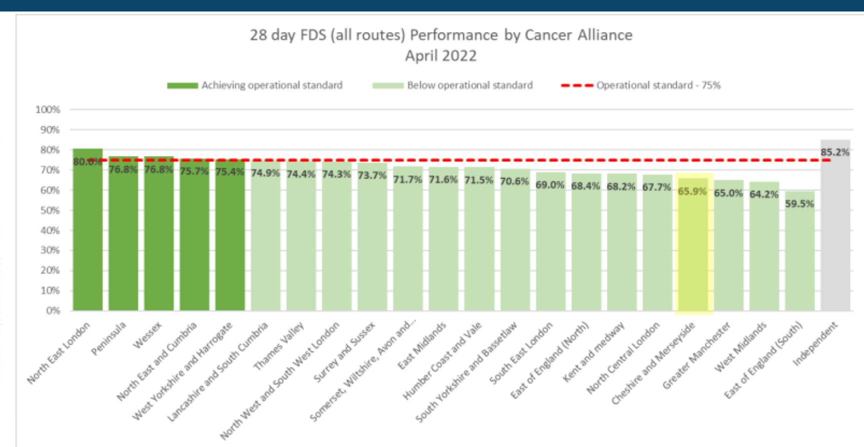
*CCG based data

**For June's report rankings are based on provider performance – from July onwards rankings will be CCG based in line with other data within this report

Section III: 28 day standard



	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
May 20 - Apr 21	81.5%	77.4%	77.0%	72.7%	70.9%	75.8%	76.2%	77.3%	69.8%	75.8%	78.3%	72.8%
May 21 - Apr 22	75.8%	74.5%	74.5%	73.5%	69.8%	71.2%	67.8%	69.0%	62.0%	69.3%	69.6%	65.6%
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 April 2022, 65.6% of patients were diagnosed or ruled out within 28 days compared to 69.6% in the previous month. This is below the operational standard.

In April 2022, Cheshire and Merseyside Cancer Alliance ranked 18 out of 21 for 28 day FDS (all routes) performance (Providers).

Providers not achieving the national operational standard were:

- Warrington and Halton Teaching Hospitals 43.8% (9 breaches)
- Liverpool Heart And Chest 45.2% (17 breaches)
- Liverpool Women's 54.3% (133 breaches)
- Countess Of Chester Hospital 55.5% (459 breaches)
- Liverpool University Hospitals 58.1% (1233 breaches)
- East Cheshire 65.2% (206 breaches)
- Southport and Ormskirk Hospital 66% (339 breaches)
- Bridgewater Community Healthcare 66.5% (69 breaches)
- The Clatterbridge Cancer Centre 66.7% (5 breaches)
- Mid Cheshire Hospitals 70% (337 breaches)
- St Helens and Knowsley Hospitals 74.5% (445 breaches)

CCGs not achieving the national operational standard were:

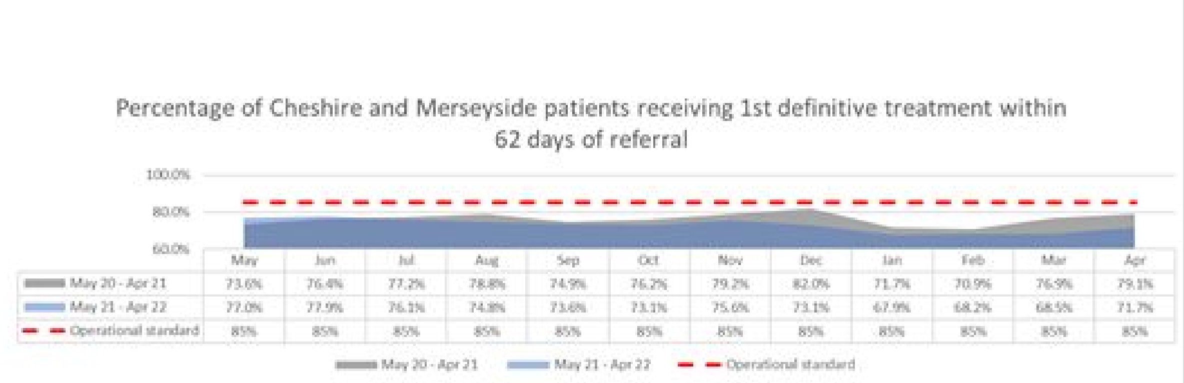
- Southport And Formby 57.7% (281 breaches)
- South Sefton 58.6% (306 breaches)
- Liverpool 61% (788 breaches)
- Cheshire 63.3% (1075 breaches)
- Warrington 65.5% (101 breaches)
- Knowsley 65.6% (283 breaches)
- Halton 71.6% (103 breaches)
- St Helens 74.4% (229 breaches)

Cancer pathways* not achieving the national operational standard were:

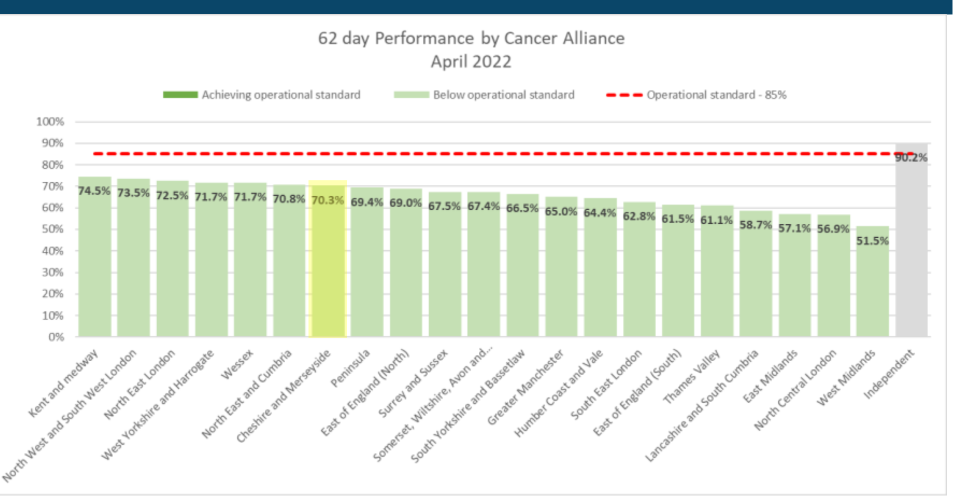
- Suspected urological malignancies (excluding testicular) 43.8% (352 breaches)
- Suspected lower gastrointestinal cancer 45.9% (1075 breaches)
- Referral from a National Screening Programme: Unknown Cancer Report Category 46.2% (176 breaches)
- Suspected haematological malignancies (excluding acute leukaemia) 48.5% (35 breaches)
- Other suspected cancer (not listed) 55% (9 breaches)
- Suspected gynaecological cancer 56.2% (383 breaches)
- Suspected upper gastrointestinal cancer 57.2% (323 breaches)
- Exhibited (non-cancer) breast symptoms - cancer not initially suspected 64.7% (160 breaches)
- Suspected lung cancer 68.9% (46 breaches)
- Suspected head and neck cancer 74.6% (207 breaches)

*CCG based data **For June's report rankings are based on provider performance – from July onwards rankings will be CCG based in line with other data within this report

Section IV: 62 day standard



	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
May 20 - Apr 21	73.6%	76.4%	77.2%	78.8%	74.9%	76.2%	79.2%	82.0%	71.7%	70.9%	76.9%	79.1%
May 21 - Apr 22	77.0%	77.9%	76.1%	74.8%	73.6%	73.1%	75.6%	73.1%	67.9%	68.2%	68.5%	71.7%
Operational standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



In April 2022, 71.7% of patients were treated within 62 days compared to 68.5% in the previous month. This is below the operational standard.
In April 2022, Cheshire and Merseyside Cancer Alliance ranked 7 out of 21 for 62 day performance (Providers).

Providers not achieving the national operational standard were:

- Liverpool Women's 26.9% (9.5 breaches)
- Southport and Ormskirk Hospital 48.3% (22.5 breaches)
- East Cheshire 49.2% (15.5 breaches)
- Liverpool University Hospitals 53.7% (56.5 breaches)
- Mid Cheshire Hospitals 69.6% (20.5 breaches)
- Countess Of Chester Hospital 72.2% (23.5 breaches)
- Warrington and Halton Teaching Hospitals 76.7% (10 breaches)
- Wirral University Teaching Hospital 79.2% (17.5 breaches)
- The Clatterbridge Cancer Centre 79.5% (8.5 breaches)

CCGs not achieving the national operational standard were:

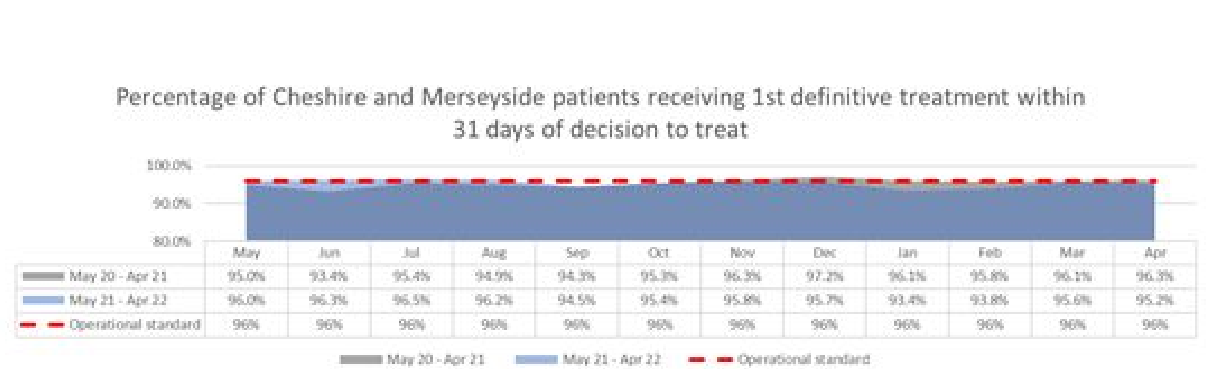
- South Sefton 41.7% (14 breaches)
- Southport and Formby 60.5% (15 breaches)
- Liverpool 63% (40 breaches)
- Knowsley 68.6% (11 breaches)
- Cheshire 70.5% (67 breaches)
- Wirral 78.8% (18 breaches)
- Warrington 79.2% (11 breaches)
- Halton 80% (7 breaches)

Cancer pathways* not achieving the national operational standard were:

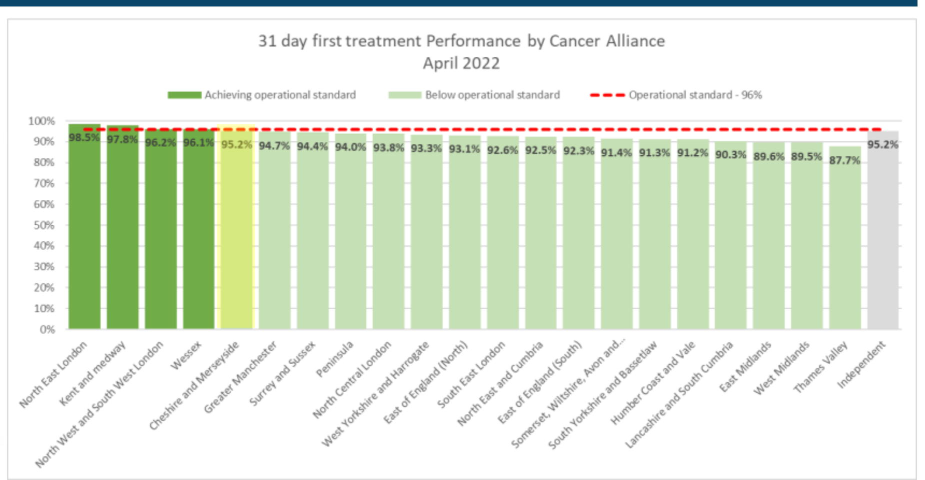
- Gynaecological 34.3% (23 breaches)
- Lower Gastrointestinal 42.9% (40 breaches)
- Lower Gastrointestinal 42.9% (40 breaches)
- Head & Neck 50% (11 breaches)
- Haematological (Excluding Acute Leukaemia) 52% (12 breaches)
- Upper Gastrointestinal 60% (16 breaches)
- Lung 66.7% (17 breaches)
- Urological (Excluding Testicular) 68.8% (40 breaches)
- Other 75% (1 breaches)
- Breast 82.7% (18 breaches)

*CCG based data **For June's report rankings are based on provider performance – from July onwards rankings will be CCG based in line with other data within this report

Section V: 31 day standard



	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
May 20 - Apr 21	95.0%	93.4%	95.4%	94.9%	94.3%	95.3%	96.3%	97.2%	96.1%	95.8%	96.1%	96.3%
May 21 - Apr 22	96.0%	96.3%	96.5%	96.2%	94.5%	95.4%	95.8%	95.7%	93.4%	93.8%	95.6%	95.2%
Operational standard	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%



In April 2022, 95.2% of patients were treated within 31 days compared to 95.6% in the previous month. This is below the operational standard.
In April 2022, Cheshire and Merseyside Cancer Alliance ranked 5 out of 21 for 31 day first treatment performance (Providers).

Providers not achieving the national operational standard were:

- East Cheshire 75.6% (11 breaches)
- Liverpool Women's 85.7% (3 breaches)
- Wirral University Teaching Hospital 91.2% (12 breaches)
- Southport and Ormskirk Hospital 91.3% (4 breaches)
- Liverpool University Hospitals 93.3% (15 breaches)
- Countess Of Chester Hospital 93.4% (8 breaches)

CCGs not achieving the national operational standard were:

- NHS Cheshire CCG 92.6% (29 breaches)
- NHS Liverpool CCG 94.9% (12 breaches)
- NHS Wirral CCG 95.3% (8 breaches)

Cancer pathways* not achieving the national operational standard were:

- Lower Gastrointestinal 90.9% (11 breaches)
- Urological 92.2% (16 breaches)
- Head & Neck 93% (3 breaches)
- Gynaecological 93.1% (4 breaches)
- Upper Gastrointestinal 94.3% (5 breaches)
- Other 95.2% (1 breaches)
- Breast 95.3% (10 breaches)

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*CCG based data **For June's report rankings are based on provider performance – from July onwards rankings will be CCG based in line with other data within this report

Cheshire & Merseyside
Cancer Alliance

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