The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1
Date/Time of meeting: 27th July 2022, 09:30

	Standard Business		Lead	Time
P1-125-22	Welcome, introduction, apologies and quoracy	v	Chair	09:30
P1-126-22	Declarations of interest	v	Chair	
P1-127-22	Minutes of the last meeting – 29 June 2022	p	Chair	
P1-128-22	Matters arising not covered on agenda • AY to pass comments on to Director of Workforce & OD regarding People Committee Terms of Reference. • AR to meet with Director of Workforce & OD to discuss the Committee and the Terms of Reference.	v	Chair	
P1-129-22	Rolling programme	p	Chair	
P1-130-22	Chair's report to the Board	v	Chair	09:40
	Reports and Action Plans			
P1-131-22	Patient Story	P	Chief Nurse	09:50
P1-132-22	Board Assurance Framework	P	Chief Exec / GC	10:00
P1-133-22	Quality Committee Chair's Report	P	NED- TJ	10:10
P1-134-22	Audit Committee Chair's Report	P	NED- MT	10:20
P1-135-22	Audit Committee Annual Report	P	NED- MT	10:30
P1-136-22	Charitable Funds Committee Chair's Report	P	NED- EA	10:40
P1-137-22	Integrated Performance Report	P	Exec Leads	10:50
P1-138-22	Finance Report	P	DoF	11:05
P1-139-22	NED and Governor Engagement Walk-round	P	Chief Nurse / NED-EA	11:15
P1-140-22	Quality and Safety Leadership Walk-rounds	P	Chief Nurse	11:25
P1-141-22	New Consultant Appointments	P	Medical Director	11:35
P1-142-22	Quarterly Mortality Report	P	Medical Director	11:40
P1-143-22	Mortality Annual Report	P	Medical Director	11:50
P1-144-22	Good Governance Institute Well-Led Review Action Plan Update	p	DoS	12:00
P1-145-22	Cheshire and Merseyside Cancer Alliance Performance Report	p	Chief Executive	12:10
P1-146-22	**Any other business**			

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Ref: FCGOAGEND
Review: July 2025
Version: 2.0

The Clatterbridge Cancer Centre NHS Foundation Trust

	Board Development Session – 28th September Pay Award	 v	Chair DoF and Director of W&OD	 12:20
	Date and time of next meeting via MS Teams: 28th September 2022, 09:30			

p paper
***** presentation
v verbal report

The Clatterbridge Cancer Centre NHS Foundation Trust

Draft Minutes of: Trust Board Part 1
Date/Time of meeting: 29th June 2022

Title / Department	Name	Initials	Present / apols	Attendance record	Deputy
Core member					
Chair	Kathy Doran	KD	P	3/3	☐
Non-Executive Director	Mark Tattersall	MT	P	3/3	☐
Non-Executive Director	Geoff Broadhead	GB	P	3/3	☐
Non-Executive Director	Elkan Abrahamson	EA	P	2/3	☐
Non-Executive Director	Terry Jones	TJ	A	2/3	☐
Non-Executive Director	Anna Rothery	AR	P	2/3	☐
Non-Executive Director	Asutosh Yagnik	AY	P	3/3	☐
Chief Executive	Liz Bishop	LB	P	3/3	☐
Director of Workforce & OD	Jayne Shaw	JSh	P	3/3	☐
Medical Director	Sheena Khanduri	SK	P	3/3	☐
Chief Nurse	Julie Gray	JG	P	3/3	☐
Chief Operating Officer	Joan Spencer	JSp	P	3/3	☐
Director of Finance	James Thomson	JT	P	3/3	☐
Chief Information Officer	Sarah Barr	SB	P	3/3	☐

Also in attendance		
Title	**Name**	**Initials**
Corporate Governance Manager (minutes)	Skye Thomson	ST
Staff Governor	Laura Jane Brown	LJB
Associate Director of Communications	Emer Scott	ES
International Nurse Recruit	Raga-Prabanjani George	RPG
Matron	Ruth Selvan	RS
Practice Education Facilitator	Charlotte Emerson	CE

	Standard business
102& 103	**Welcome, introduction & apologies:** The Chair welcomed the Board and noted apologies from Non-Executive Director: Terry Jones, Lead Governor: Jane Wilkinson, Staff Side representative: Alun Evans and Associate Director of Corporate Governance: Margaret Saunders
104	**Declarations of interest:** *In relation to any item on the agenda of the meeting, members are reminded of the need to declare:*

The Clatterbridge Cancer Centre NHS Foundation Trust

Any interests which are relevant or material to the Trust.
Any changes in interest previously declared; or
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:
The name of the person declaring the interest
The agenda number to which the interest relates
The nature of the interest and action taken

Be declared under this section and at the top of the agenda item which it relates to:

Name	Agenda No.	Nature of Interest / Action Taken
Mark Tattersall, Non-Executive Director	Non specific	Nominated Non-Executive Director for PropCare – No action
Terry Jones, Non-Executive Director	Non specific	Director of Liverpool Head and Neck Centre and Director of Research and Innovation, Liverpool University Hospital NHS Foundation Trust – No action
Geoff Broadhead, Non-Executive Director	Non specific	Nominated Non-Executive Director for Clatterbridge Pharmacy Limited – No action
James Thomson, Director of Finance	Non specific	Executive Lead for PropCare, Clatterbridge Pharmacy Limited, and Clatterbridge Private Clinic LLP – No action
Sheena Khanduri, Medical Director	Non specific	Executive Director on PPJV Board for CLATTERBRIDGE Private Clinic and Member of Cancer Alliance Board- CCC/ oncology representative – No action

105 **Minutes of previous meeting**
The minutes of the meeting held on 25th May 2022 were approved as a correct record of the meeting

106 **Matters arising / outstanding actions**
None

107 **Action Log**
The Board noted the following actions:
Item P1-069-22 is on track
Item P1-095-22 was deferred from June to July agenda

	Reports and Action Plans	**Action**
108	**Chair's Report to the Board** The Chair updated the Board on the Cheshire and Merseyside Acute and Specialists Trust (CMAST) Provider Collaborative noting it had been a busy month. Progress was being made on all CMAST sponsored collaborative programmes.	

	CMAST have organised a Non-Executive Director Development day in August, the Chair noted NED and Vice Chair MT would be attending in her place. The Liverpool Chairs continue to discuss the Clinical Service Review. The Chair attended a session of the North West Chairs with the Good Governance Institute (GGI) where the draft guidance on governance in the Integrated Care Systems (ICS) was noted. The Chair advised the Board pick this up at their away day on 18th July 2022. The Board held an extra-ordinary Trust Board meeting in June prior to the final submission on the operational and financial plan budget and an update will be provided by the Director of Finance later in the meeting. The Chair noted the recruitment of two radiologists. The Chair noted NHS Chief Executive Amanda Pritchard visited Liverpool for the NHS Confederation conference and had a positive and successful visit to the Clatterbridge Cancer Centre- Liverpool. The Charity held the summer ball which was very successful raising over £160,000. The Governors' Nominations Committee held a meeting in June to agree the NED and Chair appraisals and approve the recommendation of the re-appointment of Non-Executive Directors, TJ and EA.	
109	**Performance Committee Chair's Report** Non-Executive Director and Chair of Performance Committee, GB, presented the Performance Committee Chair's Report from the 18th May and noted changes in length of stay and testing turnaround, due to significant increase in acuity and delays with transfers of care particularly to community services and nursing homes. Further details provided in the integrated performance review (IPR). GB noted the finance report informed the committee in May that the system plan was not accepted and therefore a, potential risk to the Trust. The plan has since been approved. The Committee received a presentation on link bridges with the new Liverpool Royal Hospital, noting link bridge one will be in situ before the hospital opens in September 2022. The other two are to be completed by March 2023. The Committee requested a further update at the next meeting in August. The Chief Executive noted that the link bridge is on track for opening and the LUHFT service consultation has now come out. The team will respond and bring back any concerns to the Board in July. GB highlighted the completion of the Apollo 2 exercise which was a business continuity emergency planning exercise that tested the BCPs in the event of a Meditech downtime. The Committee noted the achievements from the PropCare performance report and Research & Innovation Business Plan. The Committee noted the Nursing deep dive, GB informed the Board the newly established People Committee will pick up the detail going forward	

	The Board noted the Chair's report.	
110	**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 the following: • 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 three 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 The Director of Finance provided an update on the annual report and accounts highlighting that the amount of testing of the accounts had largely increased this year. The External Auditors' (Ernst Young) technical team have challenged the Trust's relationship with PropCare. The Trust sees Propcare as a limited company and Ernst Young consider it to be public. This makes the accounts different. Should Ernst Young's view be correct this would mean a fundamental change, and the Trust would need to talk to NHSE. The timing of the challenge isn't good as the annual report and accounts was unable to be submitted on time. The Trust is pushing to get to a definitive position and is challenging the external auditors' view. The external audit team have had their own challenges with recent staff sickness and leave. However, the information was provided to Ernst Young in December 2021. NHSE are kept informed regarding the late submission and the ongoing discussions. The Director of Finance confirmed that the Annual report and going concern are all clear and ready to be submitted once the final accounts are agreed. This is very much a technical issue and an extra-ordinary Trust Board will be scheduled as soon as possible to sign off the annual report and accounts. Non-Executive Director, EA, asked if there is a risk of having to reopen previous years accounts. The Director of Finance has asked Ernst Young what they would expect to see happen if they are correct and if there are any provisions. Non-Executive Director, MT noted that advisors KPMG supported the Trust in this model, which is based on their advice. It has also been audited previously by Grant Thornton who came to the conclusion that it was sound. **The Board noted** the Chair's report and the updated position on the annual report and accounts and **thanked** colleagues for their hard work.	
111	**People Committee Chair's Report** Non-Executive Director and Chair of People Committee, AR, apologised and informed that Board that due to technical difficulties she had been in and out of the first People Committee meeting and been unable to Chair. AR noted the Terms of Reference were	

	bulky and the Committee is still finding its feet, however the first meeting went well. AR noted the need for a guardian for equality, someone to look at it from a staff position. Non-Executive Director, GB, chaired the meeting on AR's behalf and noted there had been a lot of papers, which could have been consolidated. GB highlighted non-compliance of some aspects of Mandatory training, the successful staff listening events and the staff award ceremony, all noted in the report. Director of Workforce noted the attendance of the Equality Diversity and Inclusion Lead in the membership of the committee. Non-Executive Director, AY, questioned the difference between aim and purpose in the Terms of Reference. The Director of Workforce & OD noted the template set the headings but was under review. AY noted the wording of the section on monitoring and overseeing digital solutions in the Terms of Reference, which needs to be looked at. ACTION: AY to pass comments on to Director of Workforce & OD regarding People Committee Terms of Reference. ACTION: AR to meet with Director of Workforce & OD to discuss the Committee and the Terms of Reference. **The Board noted** the report and the Terms of Reference. ACTION: Final version of the People Committee Terms of Reference to go to October Trust Board for approval.	AY AR/JSh ST
112	**Integrated Performance Report (IPR): Month 2** **Access** The Chief Operating Officer introduced the Integrated Performance Report and noted the changes made in response to the Board's comments (additional radiology report and 24 day faster diagnosis target). The Chief Operating Officer reported on the figures in the IPR. Non-Executive Director, MT, highlighted page 32 of the papers and sought clarification on the comment regarding the transfer to Aintree service in the 28 day faster diagnosis exception report. The Chief Operating Officer clarified that this is regarding haemato-oncology at Aintree, patients having a remote assessment and then being referred back to the GP. These patients were originally not counted in the data but will be going forward. **Efficiency** The Chief Operating Officer informed the Board of ongoing work on the length of stay target and noted the acuity target needs adjusting accordingly which should be done for next month's report. Bed occupancy is now above target, showing really good work from the teams. The Chief Operating Officer confirmed there were about 20 beds not opened. The Director of Finance noted there is ongoing work in the Cheshire and Merseyside system regarding beds. The Chief Executive noted there is some additional revenue funding available which the Trust has bid for. There is work going on to prioritise funding which is not yet complete.	

The Chief Operating Officer noted an error on the report on page 42 of the papers for Length of Stay: Emergency (days): Solid Tumour it says 2.2% for May 2022, this should say 13%.

Quality
The Chief Nurse highlighted the exception reports:

Falls: provided the narrative around the fall in the report declared as a lapse in care and on the surface the fall did not appear to be a lapse in care, however after a deep dive, the team found that during the patient's treatment regime there was an opportunity to give IV fluids that was not taken. As the Trust deviated from protocol, something could have been done differently, meaning it could have been a lapse in care. This case demonstrates the detail that goes into each investigation. The Trust is reviewing the process of sharing learning.

Clostridium difficile infections: The Chief Nurse informed the Board she had met with the regional infection control lead, who noted a number of trigger points for infections. There has been a national increase in cdifficile cases. The regional lead was happy with the Trust's process. There is a task and finish group with the IPC team and matron to review the timeliness of sampling, they are confident things will start to improve. A post infection review is done for all cdifficile cases.

Klebsiella: information from the report noted

Complaints: Information from the report noted.
Non-Executive Director, AY, asked if the Trust can 'pause the clock' for complaints like this. The Chief Nurse noted the target is the Trust's own and it is possible to 'pause the clock', and may have been appropriate to do so in this case. The Trust is cautious about this as it's important to deliver responses in a timely manner. The team are bringing a member of staff from a different team over to work on the complaints process.

Freedom of Information (FOI) Requests: There has been an increase in FOI's, the Information Governance Manager is looking at publishing information on the website to combat this.

Research & Innovation
The Medical Director updated the Board on study recruitment which ebbs and flows, with May 2022 higher than this time last year. The Medical Director noted the action taken to improve compliance.

The Medical Director noted that the Quality Committee had picked up on a limitation on the data within the SPC charts. The team are reviewing going forward.

Workforce
The Director of Workforce & OD noted that sickness absence had reduced in month from 5.3% to 4.4%. The Trust has seen an increase in gastrointestinal issues, the team are completing a deep dive which will go through the Workforce Advisory Group.

The Trust has seen a reduction in staff turnover in month. The Director of W&OD informed the Board that the travel protection arrangements come to an end at end of

	June. The public transport arrangements have been extended for 6 months. Turnover may increase. The Chair asked how many staff were on the travel protection scheme. The Director of W&OD didn't have exact numbers to hand, and noted that the team were supporting staff, there had been an increase in the car park capacity and flexibility on eligibility criteria. Non-Executive Director, GB, raised the concern that sickness could be miscategorised, with gastrointestinal sickness actually being a result of long Covid in some cases. The Director of W&OD noted that the gastro sicknesses tend to last one or two days. Sick pay arrangements have been different for long Covid, however that is coming to an end. Non-Executive Director, AY< asked how the Trust was managing the risk of staff leaving en masse at the end of the travel protection scheme. The Director of W&OD informed the Board that the Trust are looking to put support in place for travel (travel loans/passes with options to payback gradually over a period) The team are communicating with staff. Non-Executive Director, AY, asked if the Trust was prepared if it needs to do mass recruitment. The Director of W&OD noted the Trust over recruit in some areas. Whilst the end of the protection will be an issue, it is likely that staff that were moved to Liverpool and have had issues will have already left in the last 2 years. The Board discussed the impact of the recent train strikes and noted that the Trust hadn't seen any operational impact. The Director of Strategy noted that travel was part of the Trust's Green Plan and a new staff member is starting (two days a week) to manage the implementation of the Green plan. The Medical Director noted that the statutory mandatory training compliance is green on the IPR, but was to be escalated to People Committee and questioned if reporting was right. The Director of W&OD noted that overall the Trust is at 90% but the People Committee will be looking at the figures in detail. NED, MT, expressed that it was raised at Performance Committee, CQC have previously highlighted that the Trust hit the headline number but not some key training numbers in particular areas. The Board **noted** the Integrated Performance report	
113	**Finance Report: Month 2** The Director of Finance introduced the finance report for the Trust's financial performance for May 2022, informing the Board the Trust is on plan for revenue, capital and cash performance The Director of Finance highlighted elective recovery funding and noted it was still early in the year. Activity performance supports the view that the Trust will meet the 104% target, however the target doesn't take into account some of the Trust's activity. Three cancer specialist hospitals are putting together a paper in July, for making the 104% target more fit for purpose for NHS cancer trusts. The actual performance will not be clear until the Trust has gone through this process. Lots of organisations are hovering around the 104% mark, across the north west. The Director of Finance will take a deep dive on elective recovery funding to Performance Committee in August and bring it to the Board in September. The Board discussed the conditions of the Elective Recovery Funding.	

	Non-Executive Director, AY, noted the Trust is behind on the Cost Improvement Programme (CIP), and asked how this would be made up. The Director of Finance highlighted that this is the second biggest financial risk (behind ERF). This year the target is higher and therefore more challenging. The finance team are going through the target with Divisions, to ensure clarity and help identification of CIP areas. Lots of organisations manage CIP non-recurrently, however NHSE want it managed recurrently. The Chief Executive noted that the NHSE Segmentation ratings came out this week for every provider and ICB. NHS England allocates Trusts and ICBs to one of four 'segments'. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). As predicted the Trust is segment 2 and the ICS is segment in 3. The segmentations are linking with performance management and reviews. The Chair asked if having the system in segment 3 put it under more scrutiny. The Director of Finance noted this meant increased reporting and support but it is not special measures. The Board **noted** the report.	
114	**Safer Staffing Report** The Chief Nurse introduced the Safer Staffing Report and outlined the requirement to submit a 6 monthly report to board to ensure that the Trust's establishment was correct. The Chief Nurse explained that a new process had been introduced with the views of the ward managers being sought on the staffing establishment. She outlined that the views were that the establishment was correct however due to vacancies/recruitment timeframes there had been some pressures during the past 6 months. During the next 6 months the skill mix would be looked at by the matrons/ward managers to ensure that the configuration was correct for the single room occupancy. The last report focused on the data, this one focuses on the narrative, going forward the report will contain a mix of both. The Board discussed the paper and the Chief Nurse noted that it was written collectively by the matrons and ward managers. The team had identified that the establishment was correct but there weren't the 'boots on the ground'. This needs to be conveyed to staff and will be part of seeking to achieve a mind shift. Doing the review in this way will enable the Matrons to look at how they measure acuity. The team have the resource and need to get recruitment and turnover streamlined. The Board **noted** the report and **approved** the recommendations	
115	**Staff Story** *RPG, CE and RS joined the meeting* for this item. *The Staff Story agenda item was taken earlier in the meeting.* The Director of Workforce and Organisational Development (OD) introduced the nursing staff in attendance to tell and support the staff story. Raga-Prabanjani George, international nurse recruit presented to the Board supported by Matron Ruth Selvan & Practice Education Facilitator Charlotte Emerson. • RPG was a cardiology nurse in Chennai, India before joining the Trust six months ago as one of CCC's first international nurses.	

	• She is now a Band 5 in Outpatients and told Board about her experience so far at CCC. • It had been a huge change with lots to learn – a new specialty, different equipment, new culture – but the team had been very supportive. • RPG highlighted the challenges with the OSCE Programme and the variation between machine quality at different sites for the exam. • RPG had planned to go to the US but got delayed by COVID. Now she loves CCC and wants to stay here. The Director of Workforce & OD informed the Board that there were 6 international recruits initially and the Trust are keen to learn what's gone well and what can be done better. The team will continue to talk to RPG, thanked her for coming and sharing. The Non-Executive Directors asked RPG how long it took her to adjust and settle in both inside and outside of work. RPG responded that after 2 months had felt well adjusted, noting it took a month to get to know the wards. RPG has suggested timing improvements to the Practice Education Facilitator around time to prepare for training. Outside of work, the international nurses stayed in student accommodation for 3 months, and afterwards found housesRPG noted the Practice Education Facilitator and Ward Matron had helped her and the other nurses find homes. The Chief Executive asked if the issues with the training site had been fedback, the Practice Education Facilitator confirmed it had, and a letter will be sent with further feedback soon. The Trust are exploring the option of using other newly opened sites for the second cohort. The Chief Executive thanked RPG for sharing her story and the staff for attending the meeting. *RPG, CE and RS left the meeting.* The Director of Workforce & OD responded to Non-Executive Director, EA's question from the May Trust Board meeting and noted that there was no 'claw back' for the Trust's international nurses'. The Director of Finance suggested it would be good to hear back from RPG in 6 months-12 months' time to hear more about how she is getting on long term. Non-Executive Director, AR, asked if the international nurses are given the opportunity to link into the Equality, Diversity and Inclusion (EDI) network. The Director of Workforce & OD confirmed this and highlighted the Ward Manager is from South India and has supported the international recruits. The Chief Executive highlighted the system is doing its first round of international radiographer recruitment. She noted that international nursing recruitment had been around for a while, but radiographer recruitment is new. The Director of Workforce & OD confirmed the Trust has 2 international radiographers starting. **The Board thanked** the staff for attending and **noted** the story	
116	**NED and Governor Engagement Walk-round** The Chief Nurse introduced the report for the NED and Governor Engagement Walk-round that took place in May visiting ward 5 within Acute Care Services at the	

	Clatterbridge Cancer Centre- Liverpool (CCC-L). The Chief Nurse noted steps were being taken to ensure that the patients and staff spoken to understand the reporting process for the walk-rounds going forward. The feedback from patients was very positive. The quality of the food was raised and a tasting session is planned for 30th August 2022. Non-Executive Director, MT, attended the May Walk-round and described the feedback from the staff on the day of the site visit and a discussion followed. MT noted that the staff were very appreciative of having the opportunity to speak to the NED and Governor. MT noted the items that were raised and have been addressed in the report (food, out of hours support, porters etc.). The Board discussed additional feedback given at the walk-round. Staff Governor, LJB, noted the importance of communicating and understanding how staff feel. The Chief Executive highlighted the need for an authentic staff voice to be heard at the Board. The Board **noted** the report	
117	**Deferred- Staff Walk-round process review** Item deferred until July 2022	
118	**New Consultant Appointments** No items	
119	**Guardian of Safeworking Report** The Medical Director introduced the report and noted that an earlier version had been submitted and the most up to date version would be published on the Board papers site and the website. *Post meeting note: paper updated on the Board Paper site and CCC Website* The Medical Director noted that the Trust had remained compliant in quarter 4 and locums were used appropriately when required. The Trust has a new guardian of safeworking, who is very engaged and will be looking at the fuller picture. There had been some issues around lower staffing, however these were identified and the report shows the mitigations put in place. The Board **noted** the report	
120	**Deferred- The alignment of the ICB and CCC Corporate Governance** Item deferred until September 2022	
121	**ICB Transfer letter** The Director of Finance presented the Integrated Care Board Transfer Letter marking the transfer of commissioning services from the CCG to the ICB on the 1st July 2022. Non-Executive Director, EA, sought clarification on the first paragraph on the final page, '*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.'* The Director of Finance confirmed this is standard wording. The Chair noted the whole system is being reviewed. The Board **noted** the letter	
122	**Integrated specialised services with integrated care systems**	

	The Director of Finance presented a paper on NHS England's proposed roadmap for integrating specialised services within Integrated Cate Systems which was published on 31st May 2022. The Director of Finance highlighted the proposed commissioning changes, the process and timeline, the proposed financial arrangements and the risk factors for specialist Trusts. The Chief Executive noted the word 'not' on section 2.2 column 3 of the report, should be removed. The Board discussed the report and the involvement of the Trust and the Cancer Alliance. The Chief Executive noted that the Trust is engaged in the ICS through multiple routes. The Board **noted** the report	
123	**Cheshire and Merseyside Cancer Alliance Performance Report** The Chief Executive noted this month's report was similar to previous, with no particular change in trends. More detail regarding the Cancer Alliance will go to the Board Away Day on 28th July. The Chief Executive highlighted the CMCA's performance against the targets. Non-Executive Director, AY, noted the wait times target and asked when this might come through. The Chief Executive noted that if the CMCA had kept the trend this would have been hit at the end of June. A new trajectory is in the process of being set. Non-Executive Director, MT, asked if performance as a region slips where this is reported to. The Chief Executive noted that the CMCA hold Trusts to account fortnightly for performance. The CMCA reports to, the ICB, the Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative, as well as regional and national reporting. The CMCA have requested for reporting to be streamlined, focusing on actions and delivery, and where needed, national or regional support to make changes. All 3 Cancer Alliances had same request to regional and national team and are awaiting response. A request has been made for a cancer voice at the ICB. The Chair and Chief Executive are due to meet Raj Jain Chair of the ICB to discuss. The Director of Finance noted that there needs to be clear governance stating, who sits where, what are terms of reference are, etc. The Board **noted** the report.	
124	**Any other business**	
	None	
	Date and time of next meeting via MS Teams:	
	Wednesday 27th July 2022 at 09:30	

The Clatterbridge Cancer Centre NHS Foundation Trust

Action Rolling Programme

Committee name: Trust Board Part 1
Items in addition to planned cycle of business

Month	Previous Agenda No:	Item	Responsible	Action
July	Requested in P1-095-22	Quality and Safety Leadership Walk-rounds	JG	For approval
Sept	P1-069-22	Formal Review of the Board Committee Governance Structure	JG	For noting
Sept	N/A	The alignment of ICB and CCC Corporate Governance (deferred from June)	ST	For information
Sept	N/A	CMAST Governance Update and documentation	LB	For information
Oct	P1-111-22	People Committee Terms of Reference – Final Version	AR/JSh	For approval

Trust Board Part 1
27th July 2022

Report of	Chief Nurse				
Paper prepared by	Laura Elder - Teenage and Young Adult Lead Nurse				
Subject/Title	P1-131-22 Patient Story Action Report				
Background papers	Patient Story Video TEG-090-22 Patient Story Action Report				
Purpose of paper	To share patient experience of care and improvement actions				
Action required	To approve content/preferred option/recommendations				
	To discuss and note content	√			
	To be assured of content and actions				
Link to risk:					
Link to: Trust's Strategic Direction Corporate Objectives	Be Outstanding	√	Be a great place to work	√	
	Be Collaborative	√	Be Digital	√	
	Be Research Leaders	√	Be Innovative	√	

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

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

Equality & Diversity Impact Assessment

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

Story ID	ERJ	**Committee**	Board of Directors		
Date Presented	27/07/22	**Patient Story**	☒	**Staff Story**	☐
		In person	☐	**Digital**	☒
Date Consent Obtained	23/05/22	**Consented by**	Laura Elder TYA Lead Nurse	**Consent for:**	Internal ☒External ☒Online ☒
Division/s involved	Acute Care Teenage and Young Adult (TYA) Service		**External Organisation involved**	Anonymous	
Formal Complaint	☐	**Complaint closed**	☐	**Complaint Upheld**	☐

1. Action Already Taken

No	Issue	Action taken	Action Lead
1			

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

No	Issue	Action required	Action Lead	Deadline Date	Expected Evidence of Completion
1	Increase awareness of the unique needs of TYA patients around the Trust	Patient story to be shared with divisional teams Patient story to be shared with nursing team responsible for the care of TYA patients and potential improvement ideas identified and actioned Secure a place on the Aqua improvement programme for shared decision making for TYA patients	TYA Lead Nurse	Nov 22 July 2022	Noted in minutes of Patient Experience and Inclusion Group Rare Cancer Specialist Reference Group TYA CQG Divisional assurance board Progress noted in minutes of Transformation and Innovation Committee minutes

2	The impact of breaking bad news in a shared space.	Review the protocol for breaking bad news to ensure a safe space is available.	TYA Lead Nurse	Nov 22	Updated protocol
3	TYA education & training provision to all health care professionals involved in TYA cancer care	Increase education opportunities for health care staff TYA patient handbook to be available on all TYA areas TYA Nurses to visit all inpatient areas daily to support care delivery for TYA patients Ensure access to University TYA module for staff	TYA Team TYA Lead Nurse TYA Lead Nurse TYA Lead Nurse	Nov 22 Nov 22 Nov 22	Agenda for the TYA Study Day Blueprint of care by TCT to be provided to nurses Feedback on effectiveness shared at divisional quality meeting and noted in minutes.
4	Increase understanding of TYA lived experience of cancer care at CCC	Patient experience data to be gathered to deepen understanding of current care in form of surveys To include current day case and inpatient stays from both TYAs and loved ones.	TYA CNS	Nov 22	Capture of TYA patient experience bi annually as directed by TYA Quality Surveillance Programme Present to Patient Experience and Inclusion Group
5	Feeling of social isolation by TYA patients	Increase opportunities for interaction with peers Clear guidance for staff and patients re mobility of patients around ward and hospital Secure funding for additional TYA nurse resource to support patients& families in diagnostic phase of the care pathway	Youth support coordinator Acute Care Divisional Director	Nov 22 Aug 22	Social events calendar TYA policy Employment control Panel. Acute care PRG
6	Network/ local hospital experience and referral process to CCC	Utilise the TYA Operational Delivery Network (ODN) to share learning to ensure referral pathways to CCC are well known Acute Care Division to ensure CCC TYA service	TYA Lead Nurse/ Acute Care Divisional Director	Nov 22 Dec 22	Minutes of discussion at ODN meeting Compliance report presented at Acute

		meets new TYA service specification Work with the Cancer Alliance to support a CCC TYA Rapid Diagnostic Services pilot project proposal	Divisional Director – Acute Care	Sept 22	Services Divisional Board Project proposal submission

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

All actions identified during the collation of patient and staff experience stories will follow the process set out in the Patient and Staff Experience Story Process Standard Operating Procedure. Updates will be presented to PEIOG with assurance provided to PEIG on progress. Where significant service transformation is required, that is beyond the remit of the Head of Patient Experience & Inclusion, the management of the change process will be handed over to the Transformation and Improvement Committee. An annual report summarising any themes, learning and changes in practice will be collated by the Head of Patient Experience & Inclusion.

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 27th July 2022

Report author	Gilly Conway, Managing Director, Conway Bloomfield Ltd				
Paper prepared by	Gilly Conway, Managing Director, Conway Bloomfield Ltd				
Report subject/title	P1-132-22 Board Assurance Framework 2022-23				
Purpose of paper	Fully populated BAF for 2022-23 using new format is presented to the Board as the main method for monitoring the Trust's strategic risks. BAF4 and BAF6 highlighted for the Board's attention. Remaining strategic risks are assigned to Committees for oversight. Recommended that BAF7 be assigned to Quality Committee (initially assigned to Performance Committee). Recommended that Digital risk appetite be increased from Low to Moderate.				
Background papers	Audit Committeee:14 July 2022 endorsed the populated BAF as a tool for Board and Committees to monitor strategic risks; approved the proposal to increase risk appetite level for Digital from Low to Moderate				
Action required	For Board discussion Next steps: BAF reporting to Committees during Q2				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	x	Be a great place to work		
	Be Collaborative		Be Digital		
	Be Research Leaders		Be Innovative		

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

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REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Board Assurance Framework 2022-23

Gilly Conway, Managing Director, Conway Bloomfield Ltd
8 July 2022

REPORT

NHS
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NHS Foundation Trust

1.0 Introduction

1.1 The Board agreed 23 February 2022 that the Board Assurance Framework (BAF) format, content, process and usage could be improved to maximise its value as a governance tool. A short-term solution was proposed, including a revised format to provide clearer alignment of the key information about risks to strategic objectives, controls, assurances and action plans. A longer-term solution is being explored to transfer the BAF content to Datix Cloud IQ, the Trust's risk management system, by April 2023. 25 May 2022, the Board approved a refreshed set of strategic risks for 2022-23 that will be monitored through the BAF.

1.2 This report provides an overview of the process undertaken to develop the detailed content of the BAF. A one-page summary of risk levels aligned to the Trust's strategic priorities is provided in Appendix 1, and the full BAF detailing risks, controls, assurances and actions is provided in Appendix 2.

1.3 Strategic risks BAF4 and BAF6, relating to Board Governance and the Integrated Care System (ICS) respectively, are assigned to the Board for direct oversight, therefore members should interrogate the detail for those risks to ensure it provides sufficient overview of the activities to control them. Key highlights are summarised in Section 5 below. The other strategic risks are assigned to Committees as agreed by the Board in May, and will be reported to them at the earliest opportunity during Q2.

2.0 Development of the BAF detail

2.1 During May and June, the respective executive risk leads worked with Conway Bloomfield to develop the detailed content of the BAF using the new format. This consisted of:

- articulating causes and consequences of the risks;
- reviewing risk ratings (initial, residual and target);
- mapping controls, associated assurances and assurance ratings;
- identifying control and assurance gaps, and the actions planned to address them;
- providing brief narrative to contextualise each risk.

REPORT

NHS
The Clatterbridge Cancer Centre
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3.0 Usage by the Board and Committees

3.1 As agreed by the Board, either the Board or one of its Committees has been assigned as the lead forum for oversight of each risk and will receive quarterly reports highlighting key changes.

3.2 The Board should note that the Performance Committee was initially assigned as lead Committee for both the research risks, BAF7 and BAF8 (Research Portfolio and Research Resourcing). After mapping the controls and assurances, it is clear that the majority of the assurances for BAF7 are reported to the Quality Committee. The Medical Director proposes that the lead Committee should therefore be Quality for BAF7, and BAF8 remain with the Performance Committee. Working with the lead executives, Corporate Governance will facilitate communication of relevant issues between the Committees within the quarterly BAF reports.

3.3 The Board and its Committees should use the BAF as a tool:

- to keep updated about the strategic risks and where the Trust is operating outside of the Board's risk appetite;
- to gain an overview of the effectiveness of risk controls through the assurance information provided; and
- to track progress towards target risk levels as planned actions are completed.

3.4 To aid the Board and Committees establish a clear understanding of the correlation between the controls listed in the BAF and the substantive items in their workplans, a mapping exercise will be undertaken during August by Corporate Governance supported by Conway Bloomfield. Any resulting recommendations for alterations to workplans will first be discussed with individual chairs and lead executives.

4.0 Digital risk appetite

4.1 The refresh of the strategic risks has prompted the Chief Information Officer to reconsider the Board's risk appetite for Digital, which has previously been set as 'low'. One of the Trust's strategic priorities is to deliver digitally transformed services for the benefit of patients and staff; this requires an openness to change, innovation and a degree of considered risk-taking given the level of investment. The increasing universal reliance on digital technologies means that risks to information assets, data security and the stability of digital infrastructure are going to be ever-present, and achieving a low level of risk is unrealistic for most organisations. These factors underpin a proposal to increase the risk appetite for Digital to 'moderate', which was discussed and supported by the Audit Committee 14 July 2022.

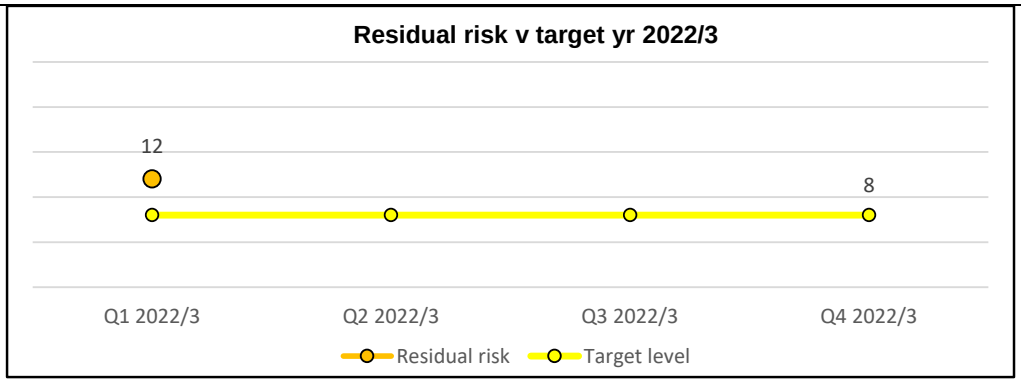
REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

5.0 BAF4 (Board Governance) and BAF6 (ICS)

5.1 Strategic risk BAF4 is a new addition to the BAF for 2022-23. The table below provides a summary of key information and the full detail can be found in Appendix 2.

Summary table: BAF 4 Board Governance				
Risk appetite: low (EXCEEDED)				
Risk title	**Residual risk**	**Assurance ratings**	**Actions**	**Target 31/03/23**
There is a risk that **corporate and clinical governance arrangements** do not provide comprehensive **Board oversight and assurance**, leading to inadequate visibility of critical issues and failure to meet regulatory expectations **Executive Risk Lead**: Liz Bishop Chief Executive	**12**	ACCEPTABLE 3 controls PARTIAL 4 controls	Completed Q1 - Additional interim support for corporate governance confirmed Due Q2 - Review CCC corporate governance to align with new NHSE guidance on Good Governance and Collaboration - Revised BAF to be reported through Committee structure and mapped to workplans	**8**
Commentary A concerted focus on both corporate and clinical governance in recent months has resulted in a number of changes to the governance structure and processes, as well as staffing within the respective teams. The GGI Well Led Development Review provided additional recommendations that are being acted on, and there is a need to ensure that CCC's governance aligns with national guidance for collaborative arrangements. Two key strategies require focus this year: the Risk Management Strategy and the Quality Strategy.				

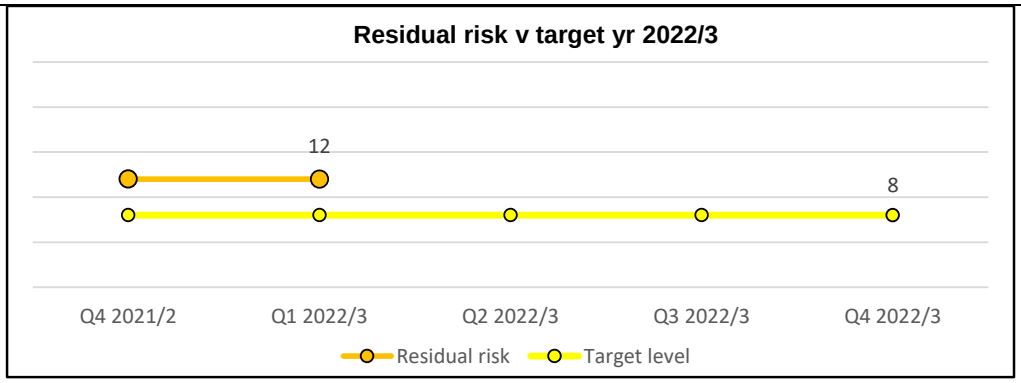


REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

5.2 The risk relating to strategic collaboration from the 2021/22 BAF has been rearticulated to reference the ICS context. The residual risk and target risk levels remain unchanged at 12 and 8 respectively. The table below provides a summary of key information for BAF6 and the full detail can be found in Appendix 2.

Summary table: BAF 6 ICS				
Risk appetite: moderate				
Risk title	**Residual risk**	**Assurance ratings**	**Actions**	**Target 31/03/23**
There is a risk that the Trust fails to achieve sufficient **strategic influence within the ICS** to maximise collaboration around cancer prevention, early diagnosis, care and treatment **Executive Risk Lead**: Liz Bishop Chief Executive	**12**	ACCEPTABLE 2 controls PARTIAL 2 controls	Due Q2 - Confirm with ICB governance, performance and delivery reporting mechanisms - Finance and HR Managers to be appointed for the Diagnostics programme - Business cases for CDCs to be submitted to NHSE regional/national diagnostics team	**8**
Commentary This risk is largely mitigated through the CCC hosting of the Cheshire & Merseyside Cancer Alliance, to enable CCC to influence prevention, early diagnosis and cancer surgery. The recent leadership role and hosting of the Cheshire & Merseyside Diagnostics Programme on behalf of the ICB, gives greater influence over cancer diagnostics. There is work planned through the year to broaden executive directors' stakeholder engagement, and raise the profile of CCC's brand and senior leaders.				



REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

6.0 Recommendations

6.1 The Board is requested to:

- note the process undertaken for refreshing the BAF content, and the expectation for its use by the Board and Committees through the year;
- agree Quality Committee as lead oversight for BAF7;
- approve the increased risk appetite for Digital from low to moderate;
- interrogate the information about BAF risks 4 and 6 to ensure the Board is satisfied with the assessment and approach to managing the risks.

Appendix 1: Strategic risk heatmap showing initial, residual and target risk scores Q1 2022-23

Strategic aims	Outstanding					Collab-orative	Research Leaders		Great Place to Work				Digital		Innov-ative
Risks	**BAF1**	**BAF2**	**BAF3**	**BAF4**	**BAF5**	**BAF6**	**BAF7**	**BAF8**	**BAF9**	**BAF10**	**BAF11**	**BAF12**	**BAF13**	**BAF14**	**BAF15**
25	✕														
20		✕	✕											✕	
16			Ⓡ	✕					✕	✕	✕ Ⓡ	✕		Ⓡ	
15	Ⓡ				✕		✕	✕					✕		✕
12		Ⓡ		Ⓡ	Ⓡ	✕ Ⓡ	Ⓡ	Ⓡ	Ⓡ	Ⓡ			Ⓡ	★	Ⓡ
10	★														
9					★				★	★	★	Ⓡ	★		
8				★		★	★	★							
6		★										★			
5															
4			★												★
3															

Key

✕	Initial (inherent)
Ⓡ	Residual (current)
★	Target
→	Distance to target

BAF1 Quality governance	**BAF6** Strategic influence within ICS	**BAF11** Staffing levels
BAF2 Demand exceeds capacity	**BAF7** Research portfolio	**BAF12** Staff health and wellbeing
BAF3 Insufficient funding	**BAF8** Research resourcing	**BAF13** Development and adoption of digitisation
BAF4 Board governance	**BAF9** Leadership capacity and capability	**BAF14** Cyber security
BAF5 Environmental sustainability	**BAF10** Skilled and diverse workforce	**BAF15** Subsidiaries companies and Joint Venture

BAF1. Quality governance systems

RISK APPETITE: Patient safety & experience - Regulatory compliance LOW (tolerance 4-8)

STRATEGIC OBJECTIVE: Be Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)* Internal assurance *What/where reported/when?*	External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF1 There is a risk that **quality governance systems fail to drive improvements in patient safety and experience and the effectiveness of care**, which would negatively affect the CQC's assessment of the Trust's services **Executive Risk Lead:** Julie Gray, Chief Nurse **Board Committee**: Quality **Last Update:** 4 July 2022	**Causes** 1. Insufficient and ineffective clinical governance processes 2. Failure to learn from patient feedback 3. Exceeding thresholds for harm free care indicators (falls, pressure ulcers, health care associated infections (HCAIs)) 4. Lack of coherent and sustained focus on Quality 5. National Patient Safety new ways of working 6. Nosocomial outbreaks 7. Increased patient dependency and acuity **Consequences** 1. Increased levels of patient harm 2. Negative impact on patient experience 3. Quality standards not met 4. Poorer outcomes for patients 5. Lower CQC rating 6. Reputational damage	5 x 5 = 25	C1) Risk Management Strategy 2022 Incident reporting and investigation policies. Dedicated Clinical Governance and Safety Team. **Control Owner**: Chief Nurse	Risk management strategy annual update report - Quality Committee Annual Clinical Audit Report, reviewed by Audit Committee.	Audited Quality Account, reviewed by Quality Committee, June 22 MIAA audits of key systems: Risk Management, Substantial Assurance March 22; Incident reporting, Limited Assurance April 22; Claims, Substantial Assurance, 2021/22	Partial	3 x 5 = 15	No	G1) Requirement for further development of clinical audit programme. MIAA recommendations for incident reporting and risk management process.	1. Develop the clinical audit programme and align to clinical governance structures and processes 2. MIAA audit improvement plan 3. Review risk management strategy **Action Owner**: Chief Nurse **Due date**: 31/03/23		2 x 5 = 10
			C2) Patient Experience & Inclusion Strategy. Established Patient Experince & Inclusion Committee and dedicated Head of Patient Experience Role. Action plans developed and monitored from national surveys. Complaints and PALs procedures in place. **Control Owner**: Chief Nurse	Patient Experience and Inclusion Annual Report. Complaints, PALS & Claims reports, reviewed by Risk & Quality Assurance Committee monthly and quarterly by Quality Committee.	National Cancer Patient Experience Survey results, reviewed by Quality Committee, September 22 showed Trust in top decile. MIAA Sustantial Assurance for Patient Experience, 2020/21 MIAA Moderate Assurance for Complaints March 2022.	Partial			G2) Number of complaints and PALs contacts exceeds tolerance level	1. Review and restructure of complaints process 2. Quarterly (Aggregated) Patient Safety and Experience Report **Action Owner**: Chief Nurse **Due date**: 31/03/23		
			C3) All falls, Pressure Ulcers and HCAIs are reviewed via Harm Free Care group. Call don't fall initiative & falling leaf symbol in place. Ramble guard TAB system in place. Waterlow system for assessment of risk used. NHSI criteria for assessment & expectations around pressure ulcers - internal review undertaken. Maintain low rates of catheter associated UTI's and maintain 95%+ VTE assessments. **Control Owner**: Chief Nurse	Harms Free Care Committee Data reported to Board of Directors via Integrated Performance and Quality Report	Model Hospital Data	Partial			G3) Training data, appropriateness of Waterlow Risk assessment for Oncology patients. Risk of a single room facility not adequately understood. No tangible impact for learning for improvement evident from Harms Free Care Group	Collaborative improvement projects for Falls reduction and Pressure Ulcers. Identify/gather 12 months of baseline data in order to set improvement targets. Reveiw effectiveness of Harms Free Care Group **Action Owner**: Chief Nurse **Due date**: 31/03/23		
			C4) Investment - Access to AQuA Expertise in PMO. Data expertise in BI/Digital/CNIO 'Bright Ideas' and Innovation Centre to capture areas for improvement. Dedicated Quality Improvement Nurse and investment in Tentable - formerly Perfect Ward **Control Owner**: Chief Nurse	Intergrated performance and quality report	Care Quality Commission (CQC) rating. Specialist commissioners oversight. Good Governance Institute Review 2022.	Partial			G4) Lack of up to date Quality Strategy. No clear system to demonstrate and celebrate quality improvement activity	Trustwide engagement and development of a Quality Improvement Strategy, including agreed prefered methodology and improvement programme **Action Owner**: Chief Nurse **Due date**: 31/03/23		
			C5) Dedicated role - Associate Director of Clinical Governance and Patient Safety. Patient Safety champions. Newly established Executive Review Group and Patient Safety Committee with Consutant leadership. Learning from incidents internal wepage. Incident investigation training in line with the Patient Safety Syllabus published May 2021 **Control Owner**: Chief Nurse	Improvement actions from incident investigations report to Risk and Quality Governance committee monthly. Quarterly patient safety and experience report - new	MIAA Quality spot checks to start Q2	Low			G5) Patient Safety Strategy due a refresh. Newly introduced and not yet embeded incident reporting system. Limited accurate safety data to inform trends and targeted improvements. Variable levels of demonstrable risk and patient safety knowledge across the Trust	Undertake trust-wide safety culture survey and associated action plans. Foster clinical leadership in patient safety initiatives. **Action Owner**: Chief Nurse **Due date**:31/03/23		
			C6) Single room occupancy so all patients are isolated. Antimicrobial presecribing polcy and lead pharmacist. Post infection review (PIR) undertaken for each known case. **Control Owner:** Chief Nurse	Established IPC Team Weekly data reported via Silver Command meeting Monthly IPC Committee Established PIR process in place with expert microbiology/virology support Antimicrobial pharmacist	Quality Accounts. ICNet benchmarking data. Monthly C&M and NW nosocomial benchmarking report with oversight from regional IPC team. Collaboration/peer scrutiny with other specialist oncology centres	Acceptable			G6) Monthly scrutiny panel with specialist commissioner input	Establish monthly Nosocomial Infection Performance Review meeting **Action Owner**: Chief Nurse **Due date**: 30/09/22		
			C7) Twice daily patient flow meetings. Utilisation of the safer Nursing Care assessment Tool. Bi-annual Safer Staffing Report to Board of Directors. Visible leadership at ward level from Matrons. **Control Owner**: Chief Nurse	Patient Flow Report Bi-annual safer staffing report		Partial			G7) Variable levels of demonstrable patient accuity assessment knowledge across the Trust	Targeted training for inpatient service staff on the use of safer nursing care tool **Action Owner**: Chief Nurse **Due date**: 31/03/23		

BAF2. Demand exceeds resources

RISK APPETITE: Contractual and regulatory compliance, patient experience LOW (tolerance 4-8)

STRATEGIC OBJECTIVE: Be Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)* Internal assurance *What/where reported/when?*	Board Assurance External assurance *What/where reported/when?*	Board Assurance Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions Planned action	Actions Progress update	Target risk score by 31/03/23 L x C
BAF2 There is a risk of **demand exceeding available resources**, that could impact the quality and safety of services and patient outcomes **Executive Risk Lead:** Joan Spencer, Chief Operating Officer **Board Committee**: Performance **Last Update:** 12 July 2022	**Causes** 1. Changing patterns of demand 2. Workforce gaps 3. Covid threat alters the operating environment indefinitely 4. Waiting list backlogs at referring Trusts 5. Population health needs change due to long-term effects of Covid **Consequences** 1. Ineffective restoration of services 2. Detrimental impact on patient care and experience 3. Poorer outcomes for patients 4. Regulatory and reputational impact	**4 x 5 = 20**	C1) Planning process based on Cheshire & Merseyside Cancer Alliance weekly cancer waiting time reports **Control Owner**: COO	C&MCA waiting time report and CCC CWT performance discussed at Trust Board	MIAA programme includes review of cancer waiting times systems and processes	Acceptable	**4 x 3 = 12**	**No**	G1) CCC has no control over the impact of the pandemic on activity flows from referring Trusts	Capacity & Demand monitored daily. Weekly monitoring of CMCA data **Action Owner**: COO **Due date**: 31 March 2023	Currently delivering capacity to meet demand. Weekly monitoring of activity	**2 x 3 = 6**
			C2) C&MCA activity plan cascaded to all senior managers to aid planning **Control Owner:** COO	C&MCA waiting time report is a standing agenda itemat Trust Operational Group		Acceptable			G2) Referring Trusts may increase their recovery activity without understanding impact on CCC	Request to COOs at referring Trust for updates on planned increases/ changes to recovery plans **Action Owner: COO** Due date: 31 March 2022	Action complete, ongoing discussions with COOs across C&M	
			C3) Cancer Waiting Times Dashboard updated daily, CWT team alert senior managers to any issues with flow of referrals **Control Owner:** COO	Oversight & utilisation of escalation processes clearly demonstrated at performance review groups	C&MCA activity plans monitored by ICS, monthly reporting back to Trusts across C&M via hospital cell	Acceptable			G3) Further waves of increases in Covid incidence may affect workforce and therefore reduce capacity to deliver the Trust recovery plan	Monitor Trust recovery plan via Trust Operational Group **Action Owner**: COO **Due date**: Commenced 30th June 2022	Trust recovery Plan to be monitored via TOG from 1.7.22	
			C4) Recovery and escalation plan to meet NHS System Oversight Framework Metrics **Control Owner**: COO	Progress reported monthly via Trust Board and quarterly to Peformance Committee	Trust activity plans monitored by ICS, monthly reporting back to Trust via hospital cell	Acceptable			G4) High number of late referrals to CCC due to delays in diagnostic capacity, this is creating challenge to delivery of the 62 day target for C&M	Refer to C&M diagnostics delivery plan		
			C5) Live dashboard of new referrals & SACT activity available to Divisional Teams **Control Owner**: COO	Divisional Performance Review meetings held monthly and/ or quarterly with outcomes reported to Performance Committee	Trust performance and activity against CWTs monitored by CMCA	Acceptable						
			C6) Daily & weekly flow monitoring via registrations team and Trust Operational Group **Control Owner**: COO	Reported and monitored via weekly TOG	MIAA review cancer waiting times	Acceptable						
			C7) Flexible Consultant job plans that enable additional Waiting List Initiative clinics to be held at short notice **Control Owner**: COO	Job plans are agreed and signed off by Divisional Teams		Acceptable						
			C8) Weekly activity monitoring and escalation via Trust Operational Group and PTL meetings **Control Owner**: COO			N/A						
			C9) Allocation of first appointments monitored by registrations team. Lack of capacity escalated to relevant senior manager **Control Owner:** COO			N/A						
			C10) WLI clinic can be expanded to meet demand **Control Owner:** COO			N/A						
			C11) CCC monitoring internal 24 day target **Control Owner**: COO	Weekly at TOG, monthly IPR to Trust Board, PRGs		Acceptable						
			C12) 62 day target to be performance managed alongside 78ww **Control Owner**: COO	Weekly TOG, Monthly IPR to Trust Board. CCC CEO is SRO for diagnostics for C&M	Weekly Monitoring via C&MCA, ICS & National Cancer Team	Partial						
			C13) Divisional business plans detailing response to increased demand via expansion of the workforce & changes to operational hours across a number of services **Control Owner**: COO	Work programmes to improve service delivery (detailed in Business plans) are reviewed at Trust Transformation and Improvement committee		Acceptable						

BAF3. Insufficient funding

RISK APPETITE: Financial LOW (4-8)

STRATEGIC OBJECTIVE: Be Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)* Internal assurance *What/where reported/when?*	Board Assurance External assurance *What/where reported/when?*	Board Assurance Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions Planned action	Actions Progress update	Target risk score by 31/03/23 L x C
BAF3 There is a risk of **available funding being insufficient** to deliver the Trust's strategic priorities **Executive Risk Lead:** James Thomson, Director of Finance **Board Committee**: Performance **Last Update:** 7 July 2022	**Causes** 1. Changes to the commissioning regime and funding process 2. Inability to meet patient demand without further investment 3. Inability to deliver further efficiencies 4. Inflationary pressure 5. Management of the ICB financial position (deficit) might negatively impact funding position or efficeincy requirement **Consequences** 1. Re-evaluate cost base and resource levels 2. Review strategic ambitions if additional resource required 3. Increased performance management from NHSE/I and ICB 4. Reduced Trust board risk appetite 5. Reduced ability to invest in capital infrastructure and staff	**4 x 5 = 20**	C1) Divisional and departmental budget setting process **Control Owner**: DoF	Planning process managed through Finance Committee. Budgets approved by lead managers	External Audit includes assessment of plan though VFM testing	Acceptable	**4 x 4 = 16**	**No**	G1) None identified at this stage.	Start budget setting cycle in Q3 2022/23 - in line with national financial guidance publication. Take complete budget plan to Trust Board by March 2023. **Action Owner**: DoF **Due Date**: 31/3/23	Not applicable at this stage in the financial year.	**2 x 2 = 4**
			C2) Contract position agreed and managed with commissioners **Control Owner**: DoF	Monthly formal contract meetings with commissioners. Annual planning process, with rebasing exercise.	Commisioner (NHSE/ICB) review of contract perfromance - quality and commercial	Acceptable			G2) Need to verify NHSE's calculation of 22/23 Elective Recovery Fund	Trust to review NHSE contract data and process when available **Action Owner:** DoF **Due Date:** 30/09/2022	Trust requested ERF activity data from ICB and commissioners. Trust working with RMH and The Christie on options for ERF and approach for cancer pathways	
			C3) Efficieny (CIP) and productivity plan in place - with clear cash releasing schemes **Control Owner**: DoF	Performance managed through Finance Committee (total) and Pefromance Review Groups (PRGs). Dedicated finance lead. Process for MD and CNO review	External Audit includes assessment of plan though VFM testing. Efficiency programme monitored monthly by NHSE/I	Acceptable			G3) Assurance on recurrent CIP delivery pipeline to be confirmed. Productivity analysis of core services to be complete	1. Escalate CIP non-delivery as required through Performance Committee. 2. Produce productivity analysis for Performance Committee. **Action Owner:** DoF **Due date:** 31/03/23	CIP profiles agreed with operational divisions and departments. Quantum of CIP included in ICB planning	
			C4) Trust Board approved financial plan, and ICB approved target financial position **Control Owner**: DoF	Monthly Finance report to Performance Committee and Trust Board	Audited accounts annually. Financial performance managed by ICB and NHSE/I. ICB receives governance score through Strategic Outcomes Framework rating.	Acceptable			G4) Impact of system financial position and risk management approach to be established	Trust to monitor system financial position monthly. **Action Owner:** DoF **Due date:** 31/12/22	Trust has visiblity of 2022/23 financial system plans and plans of other Trusts..	
			C5) Trust included in emerging system financial planning **Control Owner:** DoF	DoF updates through sub-committees and Trust Board. Chair and Executives included in ICB peer networks	ICB receives governance score through Strategic Outcomes Framework rating.	Partial			G5) ICB financial governance and programme structures in development.	Trust participating in finance system governance development - through DoF and senior finance teams interactions with peers. **Action Owner:** DoF **Due date:** 31/12/22	Executives particpate in peer ICB networks.	
			C6) Trust 5 year capital plan identifies capital and cash requirement **Control Owner:** DoF	Capital plan managed through Capital Committee. Input from divisions and departments	Audited accounts annually. Financial performance managed by ICB and NHSE/I	Acceptable			G6) Capital decision making governance for C&M ICB not established	Trust toreview multi-year capital rogramme quaterly, and esclate to ICB capital governance systemas required. **Action Owner:** DoF **Due date:** 31/03/23	Trust capital plan for 2022/23 agreed with ICB. 5 year capital plan submitted as part of ICB planning exercise.	

BAF4. Board governance

RISK APPETITE: Regulatory compliance LOW (tolerance 4-8)

STRATEGIC OBJECTIVE: Be Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)* Internal assurance *What/where reported/when?*	Board Assurance External assurance *What/where reported/when?*	Board Assurance Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions Planned action	Actions Progress update	Target risk score by 31/03/23 L x C
BAF4 There is a risk that **corporate and clinical governance arrangements** do not provide comprehensive **Board oversight and assurance**, leading to inadequate visibility of critical issues and failure to meet regulatory expectations **Executive Risk Lead:** Liz Bishop, Chief Executive **Board Committee**: Board **Last Update:** 20 June 2022	**Causes** 1. Development areas identified in WLDR 2. Increased complexity in operating environment and system context 3. Governance models including risk management need to take account of ICS developments **Consequences** 1. Poor decision making 2. Failure to manage key risks 3. Failure to improve CQC well-led rating	4 x 4 = 16	C1) Risk management strategy (RMS) and risk registers **Control Owner**: Chief Nurse	Risks monitored through monthly Risk and Quality Governance Committee; operational risk reports to Board Committees with escalation route to Board via Chairs' reports	MIAA audits 2022 and actions approved at audit committee (Risk Register-substantial assurance; Complaints-moderate assurance; SI's-Limited assurance)	Partial	3 x 4 = 12	No	G1) MIAA recommendations; RMS overdue review	MIAA audit action plans to be completed. Complaints process refresh. Learning from interests dissemination process to be developed. RMS to be refreshed. **Action Owner**: Chief Nurse **Due date**: March 2023	Action plans in place for all MIAA audits	2 x 4 = 8
			C2) Revised governance structure approved by Board April 2022; Board and Committees keep their workplans under regular review **Control Owner**: Ass Dir of Corp Gov	Committee effectiveness evaluations reported to Board annually	New structure aligns with the reccomendations made in the Well Led Development Review (WLDR)	Acceptable			G2) Capacity constraints in clinical and corporate governance teams	Interim plans to cover governance gaps **Action Owner**: CEO **Due date**: 30 June 2022	Additional support for corporate governance confirmed	
			C3) Corporate Governance framework **Control Owner**: Ass Dir of Corp Gov	Annual Governance Statement approved by the Board	Well Led Development Review report to Board March 2022 with a number of reccommendations	Partial			G3) NHSE draft Guidance on Good Governance and Collaboration (May 2022) sets out expectations for Trusts under the Provider Licence to reflect 5 key characteristics in their governance arrangements	Review CCC corporate governance in light of new guidance **Action Owner**: CEO **Due date**: 31 July 2022		
			C4) Trust Strategy implementation plans **Control Owner:** Director of Strategy	Progress updates 6 monthly to Board	WLDR report highlighted the robustness of strategic planning and strength of engagement with plans	Acceptable			G4) Outdated Quality Strategy	Update Quality Strategy for approval by Quality Committee **Action owner:** Chief Nurse **Due date:** March 2023		
			C5) Quality Strategy **Control Owner:** Chief Nurse	Quality reporting via IPR and quality reports to monthly Risk and Quality Governance Committee	WLDR report to Board March 2022 with a number of reccommendations	Partial			C5) BAF improvements	Revised BAF 2022-23 to be drafted and embedded to direct the agendas and work programmes for Board and Sub-Committees **Action owner:** CEO **Due date:** 31 July 2022	In progress with external support	
			C6) Board Assurance Framework (BAF) - strategic risks assigned to Board/Committees for oversight **Control Owner:** Ass Dir of Corp Gov	Quarterly reporting cycle at Committees and Board	MIAA annual review of BAF, small number of recommendations; WLDR review highlighted improvements to be made	Partial						
			C7) Performance management arrangements - IPR refresh completed May 2022 to include SPC charts **Control Owner:** Chief Nurse	Oversight at Performance Committee and Board	MIAA IPR audit 2021 gave substantial assurance	Acceptable						

BAF5. Environmental sustainability

RISK APPETITE: Regulatory compliance LOW (tolerance 4-8)

STRATEGIC OBJECTIVE: Be Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)* Internal assurance *What/where reported/when?*	External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF5 If the **Trust does not integrate environmental sustainability considerations into delivery of its strategic priorities**, it will fail to realise the potential benefits and contribute to the NHS Net 0 target **Executive Risk Lead:** Tom Pharaoh, Director of Strategy **Board Committee**: Performance **Last Update:** 25 June 2022	**Causes** 1. Lack of environmental sustainability strategy/plan 2. Environmental considerations not embedded in policy and decision-making processes 3. Limited understanding of the potential benefits 4. Up-front investment required **Consequences** 1. Failure to reduce waste and realise efficiencies 2. Failure to contribute toward improving local environment, e.g. air quality 3. Failure to meet public, staff and regulatory expectations as a responsible healthcare provider	5 x 3 = 15	C1) Green Plan approved by Board and summary version published. Board-level sustainability lead identified. **Control Owner**: Director of Strategy	First annual report on Green Plan delivery due to be presented to Performance Committee February 2023	Quarterly national 'Greener NHS' NHS England data collection exercise	Partial	4 x 3 = 12	No	G1) Green Plan programme management arrangements not yet in place	1. Source interim Sustainability Programme Manager resource **Action Owner**: DoS **Due date**: 14th July 2022 2. Develop short-term action plan with programme manager to deliver early priorities **Action Owner**: DoS **Due date**: 31st July 2022	Programme management proposal sought from sustainability consultants who supported development of the Green Plan. Outline action plan in place - to be further developed when resource in place.	3 x 3 = 9
			C2) Multidisciplinary Sustainability Action Group formed to support delivery of the Green Plan action plan. **Control Owner**: Director of Strategy	Programme reports reviewed quarterly					G2) Sustainability Action Group not yet fully functioning	1. Engage with current members to ensure engagement and participation **Action Owner**: DoS **Due date**: 14th July 2022 2. Review terms of reference including membership, accountabilities **Action Owner**: DoS **Due date**: 14th July 2022	Additional members invited. Existing members encourage to prioritise and engage in delivery of the action plan. Terms of reference under review.	
			C3) Build specification of CCC-L supports Trust's environmental sustainability commitments, with potential to improve further. **Control Owner**: PropCare Managing Director	Monitoring of CCC-L building management system (BMS)					G3) Development of the delivery mechanisms for key workstreams identified in the Green Plan	1. Develop green travel plan **Action Owner**: DoS **Due date**: 31st October 2022 2. Develop and deliver sustainability staff engagement programme **Action Owner**: DoS **Due date**: 31st October 2022 3. Develop waste management proposals to include waste segregation facilities to support recycling **Action Owner**: DoS **Due date**: 31st October 2022	Initial discussions in all areas - programme manager role vital to drive delivery of actions.	
									G4) CCC-W redevelopment plans not yet developed	1. Creation of new projects division in PropCare **Action Owner**: PropCare MD **Due date**: 31st July 2022 2. Development of proposals for redvelopment of CCC-W to include sustainability considerations **Action Owner**: DoS/PropCare MD **Due date**: 31st Dec 2022	Appointments made to PropCare Projects division - awaiting start dates. High level redevelopment options in development.	

BAF6. Strategic influence within ICS

RISK APPETITE: Partnership working MODERATE (tolerance 9-12)

STRATEGIC OBJECTIVE: Be Collaborative

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)* Internal assurance *What/where reported/when?*	External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF6 There is a risk that **the Trust fails to achieve sufficient strategic influence within the ICS** to maximise collaboration around cancer prevention, early diagnosis, care and treatment **Executive Risk Lead:** Liz Bishop, Chief Executive **Board Committee**: Board **Last Update:** 20 June 2022	**Causes** 1. Organisational politics 2. Senior capacity and relevant experience 3. Shared goals and plans still in development 4. Lack of single data sources across the system 5. Immature ICS **Consequences** 1. Failure to improve population health and cancer outcomes 2. Disjointed care pathways 3. Failure to realise efficiencies 4. Failure to innovate at scale 5. Reduced CQC rating 6. Reputational damage	**3 x 4 = 12**	C1) Trust hosting the Cheshire and Merseyside Cancer Alliance (CMCA) with CEO as SRO **Control Owner**: CCC CEO	Progress reports on WLDR Action Plan to Trust Executive Group (16 May 2022) and May Board		Acceptable	**3 x 4 = 12**	**Yes**	G1) WLDR report highlighted need to increase senior capacity and visibility in ICS to take on greater leadership role	1. Broaden executive directors' stakeholder engagement in ICS 2. Develop marketing plan to strengthen CCC brand and raise profile of senior leaders **Action Owner**: Dir of Strategy **Due date**: April 2023	Work commenced, in progress, monitored quarterly through Trust Executive Group	**2 x 4 = 8**
			C2) CMCA Business Plan 2022-23 submitted and approved by National Cancer Team; funding confirmed **Control Owner**: Managing Director, CMCA	CMCA performance reports to Board monthly	Monthly CMCA performance reports are circulated to acute/ST providers CEO,COOs and Place Leads	Acceptable			G2) Lack of clarity about cancer reporting to ICB	Confirm with ICB governance and performance and delivery reporting mechanisms **Action Owner**: CEO **Due date**: 31 July 2022		
			C3) Trust CEO is ICS System Lead for all diagnostics; governance and management arrangements established and delivered via bi-monthly Diagnostic Delivery Board **Control Owner**: CEO	Update to CCC Board at Strategy Away Day 28 July 2022	CEO and Programme Director report monthly to CMAST SRO Group chaired by CMAST Lead	Partial			G3) Diagnostics Programme Team not complete	Finance Manager and HR manager to be appointed for the Diagnostic Programme **Action Owner**: CEO **Due date**: July 2022	Agreed with ICB DoW and DoF; awaiting the completion of CCGs into ICS	
			C4) Funding to 2024 to deliver CDCs and C&M Diagnostics Recovery Plan **Control Owner**: CEO	Update to CCC Board at Strategy Away Day 28 July 2022	Financial approval through CDC Delivery Board and ICB scrutiny via FARG	Partial			G4) Business cases for CDCs	Business cases for CDCs to be submitted to NHSE regional/national diagnositcs team summer 2022 **Action Owner**: CEO **Due date**: June and August 2022	BCs being developed by Diagnostics Programme Director	

BAF7. Research portfolio

RISK APPETITE: Clinical innovation MODERATE (tolerance 9-12)

STRATEGIC OBJECTIVE: Be Research Leaders

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)* Internal assurance *What/where reported/when?*	External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF7 If the **Trust is unable to increase the breadth and depth of research**, it will not achieve its research ambitions as a specialist cancer centre **Executive Risk Lead:** Sheena Khanduri, Medical Director **Board Committee**: Propose Quality as lead Committee rather than Performance **Last Update:** 27 June 2022	**Causes** 1. Reliance on partners to maintain Experimental Cancer Medicine Center (ECMC) status 2. Liverpool unsuccessful for BRC and CRUK 3. Service pressures impact upon research capacity **Consequences** 1. Failure to achieve status as a leading cancer research centre 2. Insufficient future funding to sustain planned research programmes 3. Failure to develop new treatments for patients 4. Reputational damage	**3 x 5 = 15**	C1) Research Strategy 2021-2026, approved by Trust Board **Control Owner**: Medical Director	Research Strategy Business Plan updates reported quarterly to Performance Committee		Acceptable	**3 x 4 = 12**	**Yes**	G1) ECMC status requires renewal from April 2023	Development and submission of ECMC application **Action Owner**: Medical Director **Due date**: 30 June 2022	Bid progressing with submission expected within due date	**2 x 4 = 8**
			C2) Dedicated Early Phase Trials Unit at CCC operational from 5 April 2022 **Control Owner**: Medical Director	Occupancy is reported monthly through R&I Directorate Board and to Research & Quality Governance Committee		Acceptable			G2) Early Phase Trials Unit Operational Policy required and recruitment of support staff	1. Policy to be developed and approved by TIC 2. Recruitment of Early Phase Clinical Research Fellow **Action Owner**: Medical Director **Due date**: 30 June 2022	Draft policy written Funding identified for post	
			C3) ECMC clinical trials open **Control Owner**: Medical Director	Quarterly ECMC updates to Research Strategy Committee reporting to Quality Committee		Acceptable			G3) Clinical trial pharmacy staffing capacity	Appointment of Deputy Clinical Trials Pharmacist **Action Owner**: Medical Director **Due date**: 30 June 2022	Deputy Clinical Trials Pharmacist appointed. Awaiting start date	
			C4) Successful collaborative bid securing funding as an NIHR Clinical Research Facility 2022 for 5 years **Control Owner: Medical Director**	Quarterly CRF updates to Research Strategy Committee reporting to Quality Committee		Acceptable			G4) CRF governance arrangements	Governance structure to be established for September Action Owner: Medical Director Due date: 31 August 2022	CRF meeting between LUHFT and CCC CRFs June 2022	
			C5) Collaboration with major cancer centre for Biomedical Research Centre bid 2022 **Control Owner**: Medical Director	Quarterly BRC updates to Research Strategy Committee reporting to Quality Committee		Partial			G5) BRC bid outcome awaited May 2022	Report outcome to Research Strategy Committee when received **Action Owner**: Medical Director **Due date**: 31 May 2022	Outcome awaited	
			C6) Research Activity Policies **Control Owner**: Medical Director	Internal audit plan monitored at monthly R&I Directorate Board through to Risk and Quality Governance	Regulatory compliance evidenced external audit MIAA	Acceptable			G6) Aseptic Unit recovery reliant on Pharmacy staffing	See G3		
			C7) Pharmacy Aseptic Unit recovery plan in place since 30 August 2021 **Control Owner**: Medical Director	Monitored monthly by Performance Review Group with exceptions only escalated to Quality Committee		Partial			G7) Study opening reliance on pharmacy staffing plan	See G3		
			C8) Study Prioritisation Committee meets monthly **Control Owner**: Medical Director	Monthly updates to R&I Directorate Board; studies opening in month included in Trust Board IPR with exception report		Partial						

BAF8. Research resourcing

RISK APPETITE: Clinical innovation, financial MODERATE (tolerance 9-12)

STRATEGIC OBJECTIVE: Be Research Leaders

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)*			Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions		Target risk score by 31/03/23 L x C
				Internal assurance *What/where reported/when?*	External assurance *What/where reported/when?*	Overall assurance level				Planned action	Progress update	
BAF8 Competition for talent and research sponsorship means that **the research programme is at risk of being under-resourced**, which would hinder the Trust's ambition to be research leaders **Executive Risk Lead:** Sheena Khanduri, Medical Director **Board Committee**: Performance **Last Update:** 27 June 2022	**Causes** 1. International competition for specialist research skills 2. Reliance on partners to secure major sources of funding 3. Current vacancies 4. Funding shortfall following the Covid pandemic **Consequences** 1. Failure to develop new treatments for patients 2. Failure to achieve status as a leading cancer research centre 3. Loss of status and influence 4.Inability to deliver planned research programmes	3 x 5 = 15	C1) Research Strategy Funding ringfenced to support Early Phase Clinical Trial Infrastructure and future growth in capacity **Control Owner**: Medical Director	Quarterly report to Performance Committee		Partial	3 x 4 = 12	Yes	G1) Early Phase staffing capacity	Recruitment of Early Phase staff **Action Owner**: Director of Clinical Research **Due date**: 31 December 2022	Staffing gaps identified	2 x 4 = 8
			C2) Monitoring of use of funding **Control Owner:** Medical Director	Monthly reporting to R&I Directorate Board; Quarterly report to Performance Committee	MIAA R&I Audit of finance and governance arrangements 2022 - substantial assurance received	Acceptable			G2) ECMC funding until March 2023	ECMC bid submission 2023-27 **Action Owner**: Medical Director **Due date**: 30 June 2022	Bid progressing with submission expected within due date; funding contribution from CCC identified from R&I envelope	
			C3) Required research establishment is set out in Board approved Research Strategy **Control Owner**: Medical Director	Quarterly updates to Research Strategy Committee and Trust Executive Group; Quarterly report to Performance Committee		Partial			G3) Recruitment required to reach full establishment in line with approved Research Strategy	Identify funding sources to recruit academic posts in line with Research Strategy **Action Owner**: Medical Director **Due date**: 31 March 2023	On plan in line with Research Strategy 2022/3	
			C4) Successful collaborative bid securing funding as an NIHR Clinical Research Facility 2022 for 5 years **Control Owner:** Medical Director	Quarterly monitoring of use of funding via Research Strategy Committee		Acceptable			G4) CRF governance arrangements	Governance structure to be established for September Action Owner: Medical Director Due date: 31 August 2022	CRF meeting between LUHFT and CCC CRFs June 2022	
			C5) Major bid development - Biomedical Research Centre **Control Owner:** Medical Director	Bid development monitored via Research Strategy Committee		Partial			G5) BRC bid outcome awaited May 2022	Report outcome to Research Strategy Committee when received Action Owner: Medical Director Due date: 31 May 2022	Outcome awaited	
									G6) Contribution from Clatterbridge Cancer Charity in line with the Research Strategy	Delivery of 1st year fundraising activity Action Owner: Medical Director Due date: 31 March 2023	Annual activity plan in place	

BAF9. Leadership capacity and capability

RISK APPETITE: Workforce LOW (tolerance 4-8)

STRATEGIC OBJECTIVE: Be a Great Place to Work

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)* Internal assurance *What/where reported/when?*	External assurance *What/where reported/when?*	Overall assurance level	Residual risk (current) score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF9 There is a risk that **leadership capacity and capability at the Trust is insufficient** to drive the changes required to achieve its strategic ambitions **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee**: People **Last Update:** 3 July 2022	**Causes** 1. Leadership development required to adapt to system reforms and strategic ambitions 2. Multiple changes in the operating environment divert leadership capacity **Consequences** 1. Inability to adapt quickly enough to keep pace with system changes 2. Inability to manage competing priorities 3. Ineffective decision-making 4. Insufficient leadership visibility to drive change and right culture 5. Reduced health, wellbeing and morale for senior staff 6. Reputational damage	4 x 4 = 16	C1) Leadership passport programme **Control Owner**: Director of WOD	People Committee annual Learning and Development Report		Partial	3 x 4 = 12	No	G1) No competency framework for AHP's	Develop competency framework for AHPs **Action Owner**: Director of WOD **Due date**: 30/06/22	Review undertaken focusing on medical leadership and a number of recommendations identified. Head of OD developing proposals leadership pathways for mid level managers/ leaders and senior leaders.	3 x 3 = 9
			C2) Leadership programme for Divisional Triumvirates - Team at the Top **Control Owner**: Director of WOD	People Committee annual Learning and Development Report		Partial			G2) Lack of consistent approach to succession planning	1. Development of succession plans for critical posts across all staff groups 2. Develop a TNA for leadership roles for development of core leadership competencies **Action Owner**: Director of WOD **Due date**: 30/06/22	Dashboard developed to identify development needs identified as part of PADR process	
			C3) Coaching programme (all levels) **Control Owner**: Head of Learning and OD	People Committee annual Learning and Development Report		Low			G3) Lack of leadership development approach specific to medical staff	Develop medical leadership framework **Action Owner**: Director of WOD **Due date**: 30/04/22	Working with external company to develop framework to support medical leadership development	
			C4) Competency framework (nursing) **Control Owner**: Chief Nurse	People Committee annual Clinical Education Report		Acceptable			G4) No framework to support talent management cosistently within organisation	Trust to work with system level stakeholders including HEE to support the development of a robust approach to Talent management **Action Owne**r: Director of WOD **Due date:** 31/03/2023	Working in partnership with HEE on Scope for Growth and Talent Management programmes. HEE evaluating current offers, engaged in feedback mechanisms.	
			C5) Medical Leadership development programme of work **Control Owner**: Director of WOD									
			C6) Shadow Board programme to develop future leaders Control Owner: Director of WOD	People Committee annual Learning and Development Report								
			C7) People Commitment outlines our plans for the next five years to build an inclusive and compassionate culture and enhance our leadership skills and capacity **Control Owner**: Director of WOD	People Committee quarterly updates		Partial						

BAF10. Skilled and diverse workforce												
RISK APPETITE: Workforce LOW (tolerance 4-8)												
STRATEGIC OBJECTIVE: Be a Great Place to Work												
Risk description & information	**Causes & consequences**	**Initial (inherent) risk score L x C**	**Key controls** *(what is in place to manage the risk?)*	**Board Assurance** *(evidence that controls are working)* **Internal assurance** *What/where reported/when?*	**External assurance** *What/where reported/when?*	**Overall assurance level**	**Residual risk (current) score L x C**	**Within risk tolerance?**	**Gaps in Control / Assurance**	**Actions** **Planned action**	**Progress update**	**Target risk score by 31/03/23 L x C**
BAF10 There is a risk of being **unable to attract and develop a diverse and highly skilled workforce**, which could limit the Trust's capacity to deliver and develop further its specialist services **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee**: People **Last Update:** 3 July 2022	**Causes** 1. Different expectations of younger people entering the workforce 2. Perceived or real cultural barriers for BAME staff 3. Poor perception of NHS as a place to work 4. Competition within NHS and from private sector **Consequences** 1. Failure to improve services 2. Widening vacancy gaps 3. Inability to plan capacity effectively 4. Reduced workforce morale 5. Damage to reputation as an employer 6. Failure to maintain CQC ratings	**4 x 4 = 16**	C1) Equality, Diversity an Inclusion action plans (WRES/WDES/ EDS2) **Control Owner**: Director of WOD	Action plan updates through EDI group and People Committee	WRES & WDES Annual Reports incl external benchmarking data, reviewed at Trust Board in October 2021 and showed improvements	Acceptable	**3 x 4 = 12**	**No**	G1) No dedicated lead for EDI for the Trust	EDI lead to be appointed and service agreement to be developed **Action Owner**: Director of WOD **Due date**: 30/04/22	A new EDI lead is being progressed. If unsuccessfule the post will be re-advertised	**3 x 3 = 9**
			C2) Inclusive Recruitment processes (NHSIE framework) **Control Owner**: Director of WOD	Managed through EDI group and assurance reported quarterly though People Committee	WRES & WDES Annual Reports incl external benchmarking data, reviewed at Trust Board in October 2021 and showed improvements	Acceptable			G2) Revised Recruitment policy	Full scale review of policy underway to support the NHSIE 6 Actions for Inclusive recrutiment **Action Owner**: Director of WOD **Due date**: 31/08/22		
			C3) Retention plans of critical staff groups **Control Owner**: Director of WOD	Turnover KPIs monitored month through IPR and through Trust sub-committee structure		Partial			G3) Robust clinical skills/ development programme for clinical staff	Review of clinical skills offer and ensure clinical staff have access to relevent training and development oppourtunities **Action Owner**: Chief Nurse **Due date**: 31/07/22	Task and finish group established to review all role essential and clinical skills training	
			C4) Revised Values Framework launched February 2022 **Control Owner**: Director of WOD	Annual staff survey results, to be reviewed by People Committee annually		Acceptable			G4) Values based recruitment framework	Embed a model of values based recruitment **Action Owner**: Director of WOD **Due date**: 31/12/22		
			C5) Recruitment Development and Improvement Plan **Control Owner**: Director of WOD	Update to Workforce Assurance Group bi-monthly					G5) Digitally streamlined recruitment and on boarding processes	Streamline transactional processes for recruitment to ensure we adopt digital solutions **Action Owner**: Director of WOD **Due date**: 30/09/22	Recruitment Improvement Plan agreed at People Committee in June 2022	
			C6) Participation in ICS international recruitment campaigns for Nursing and AHP's **Control Owner**: Chief Nurse	Update to Workforce Assurance Group bi-monthly		Partial			G6) Clinical Education Strategy requires updating for 2022 onwards	New strategy to be developed in partnership with key stakeholders **Action Owner**: Chief Nurse **Due date**: 30/09/22		
			C7) Clinical Education strategy **Control Owner**: Chief Nurse	Monitored through People Committee quarterly								
			C9) Appraisal and personal development process **Control Owner**: Director of WOD	PADR completion report to be reviewed monthly though IPR	MIAA Staff Appraisals & Mandatory Training audit planned Q1 2022/23	Partial						

BAF11. Staffing levels

RISK APPETITE: Workforce, patient safety LOW (tolerance 4-8)

STRATEGIC OBJECTIVE: Be a Great Place to Work

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)*			Residual risk (current) score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions		Target risk score by 31/03/23 (L x C)
				Internal assurance *What/where reported/when?*	External assurance *What/where reported/when?*	Overall assurance level				Planned action	Progress update	
BAF11 There is a risk of **insufficient staffing levels in some areas of the Trust**, which could result in disruption to services and jeopardise the quality of care **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee**: People **Last Update:** 27 June 2022	**Causes** 1. Short-term and long-term staff absences 2. Vacancies 3. Misalignment of workforce planning, activity and finance 4. Lack of accurate and up-to-date workforce information and data **Consequences** 1. Inability to plan capacity effectively 2. Disruption to service delivery 3. Poorer patient care and experience 4. Failure to maintain CQC ratings 5. Reputational damage	4 x 4 = 16	C1) Targeted recruitment campaigns for hard to recruit roles (Nurses/ Radiographers) **Control Owner**: Director of WOD	Reported quarterly through people committee and monitored through recruitment and retention focus group		Acceptable	4 x 4 = 16	No	G1) Dedicated lead for recruitment for Nursing and AHP	Establish Recruitment and Retention focus group with key stakeholders **Action Owner**: Director of WOD **Due date**: 30/06/2022		3 x 3 = 9
			C2) E-roster implemented in all clinical areas in line with NHSIE Levels of Attainment **Control Owner**: Director of WOD	Reported bi-monthly through Workforce Assurance Group and monitored monthly through Systems Utilisation Group	MIAA E-Roster audit 2021/22, substantial assurance	Acceptable			G2) A work plan is in place but work is in progress and not complete	Deep dives into each clinical area to identify any gaps/ areas of focus **Action Owner**: Director of WOD **Due date**: 30/09/2022	Audit completed in Dec 2021 that identified number of key actions. Refreshed project plan agreed with Divisional leads.	
			C3) Implementation of E-job planning for medics and advance practice roles **Control Owner**: Director of WOD	Reported bi-monthly through Workforce Assurance Group and monitored monthly through Systems Utilisation Group	MIAA Medical Job Planning audit planned Q3 2022/23	Acceptable			G3) Procurement of new E-job planning system	Procure new system to support e-job planning **Action Owner:** Director of WOD **Due date**: 30/06/2022	Procurement process underway. Two providers shortlisted. Final phase on process to commence July 2022	
			C4) Bank framework to support temporary gaps in the workforce **Control Owner**: Director of WOD	Reported bi-monthly through Workforce Assurance Group and Divisional Performance reports		Acceptable			G4) Implementation workforce planning model and tools for the Trust	Development and implementation of workforce planning tools **Action Owner**: Director of WOD **Due date**: 31/03/2023		
			C5) Robust workforce plans for all clinical areas **Control owner:** Director of WOD	Reported quarterly through People Committee		Acceptable			G5) Automation of ESR reporting	1. Joint working between WOD and BI to automate current reporting processes 2. Validation of data 3. Build of WOD metrics and PowerBI dashboard **Action Owner**: CIO and Director of WOD **Due date**: 31/03/2023	Member of WOD team working with BI to support automation of ESR reporting 1 day a week. ESR data is data warehouse-validation in progress.	
			C6) Real time reporting of workforce metrics including turnover and sickness **Control Owner**: Chief Information Officer	Reported bi-monthly through Workforce Assurance Group and monitored monthly through Systems Utilisation Group		Low			G6) Utilisation of Safe Care as the tool for reporting safe staffing levels at ward level	Joint working between WOD/ Digital/ Nursing teams to embed systems and ensure fit for purpose **Action Owner**: Chief nurse and Director of WOD **Due date**: 31/03/2023		

BAF12. Staff health and wellbeing

RISK APPETITE: Workforce LOW (tolerance 4-8)

STRATEGIC OBJECTIVE: Be a Great Place to Work

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)* Internal assurance *What/where reported/when?*	External assurance *What/where reported/when?*	Overall assurance level	Residual risk (current) score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF12 There is a risk of **decline in the health and wellbeing of staff**, which may result in increased absence and turnover, affect the Trust's ability to deliver services, and damage its reputation as an employer **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee**: People **Last Update:** 27 June 2022	**Causes** 1. Increase in mental health issues in the wake of the initial waves of Covid 2. Staff with 'long Covid' 3. Staff burn-out 4. Covid part of long-term operating environment **Consequences** 1. Loss of goodwill and staff engagement 2. Fluctuating capacity 3. Increase in long-term sickness 4. Increased staff turnover 5. Disruption to services 6. Reputational damage	4 x 4 = 16	C1) Occupational Health Service for staff **Control Owner**: Director of WOD	OH contract performance monitored quarterly and reported to Workforce Advisory Group annually		Acceptable	3 x 3 = 9	No	G1) Staff survey results state that only 55% of staff believe we take positive action on H&WB as a Trust	Review H&WB offer to staff **Action Owner**: Director of WOD **Due date**: 30/06/22	Recruitment underway for a H&WB coordinator role. Developing role profile for a H&WB lead.	2 x 3 = 6
			C2) Employee Assistance Programme, including counselling, available for all staff **Control Owner**: Director of WOD	OH contract performance monitored quarterly and reported to Workforce Advisory Group annually Staff Survey results reported annually to People Committee		Acceptable			G2) MHFA are not embedded into the organisation/ routinely accesses for support	Implement Wellbeing Champions and a H&WB Champions group **Action Owner**: Director of WOD **Due date**: 30/09/22		
			C3) Mental Health First Aiders **Control Owner**: Director of WOD	Heath and Wellbeing Guardian meetings quarterly and annual report to People Committee					G3) Plan required to fulfil the Board's commitment to the NW Wellbeing Pledge	Develop NW Wellbeing Pledge Action Plan **Action Owner**: Director of WOD **Due date**: 30/09/22		
			C4) Health & Wellbeing objectives for line managers and all staff **Control Owner**: Director of WOD	PADR process		Partial						
			C5) Resilience modules in Leadership Masterclass modules **Control Owner**: Director of WOD	Leadership Masterclass annual programme		Acceptable						
			C6) Culture and Engagement Groups in each Division and for Corporate Services **Control Owner**: Director of WOD	Staff Culture and Engagement Pulse results, reviewed quarterly by People Committee		Partial						
			C7) Health and Wellbeing activities and interventions in place for 2022 **Control Owner**: Director of WOD	Quarterly Guardian meetings and reported annually through People Committee		Partial						
			C8) Non-Executive Health & Wellbeing Guardian to hold Trust to account on ensuring H&WB is an organisational priority **Control Owner**: Director of WOD	Quarterly Guardian meetings and reported annually through People Committee								

BAF13. Development and adoption of digitisation

RISK APPETITE: Digital MODERATE (tolerance 8-12)

STRATEGIC OBJECTIVE: Be Digital

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)* Internal assurance *What/where reported/when?*	Board Assurance External assurance *What/where reported/when?*	Board Assurance Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF13 There is a risk of **limited development and adoption of digitisation across the Trust**, which would constrain service improvements and reduce the benefits for patients **Executive Risk Lead:** Sarah Barr, Chief Information Officer **Board Committee**: Quality **Last Update:** 27 June 2022	**Causes** 1. Lack of local published Digital Strategy. 2. Unknown national funding arrangements for Digital. 3.Lack of operational and clinical workforce digital capabability. 4.Emerging Integrated care System (ICS) and Places across Cheshire & Merseyside and developing Digital and Data strategies. 5. Inconsistent and unreliable data recording at source. **Consequences** 1. Inability to achieve intended benefits for patient care and safety 2. Inability to ensure data-driven decision making 3. Lost opportunity to modernise 4. Inefficient use of resources 5. Unsustainable operating costs 6. Reputational damage	**4 x 4 = 16**	C1) Digital Board established with Medical Director as Senior Responsible Owner(SRO). Digital Board is the single governance for Trust wide Digital assurance **Control Owner**: CIO	Digital Board ensures the Trust's strategic and operational plans are supported by Digital Technology. The Digital Board is accountable to Quality Committee		Acceptable	**4 x 3 = 12**	**YES**	G1) Digital Strategy required to set long term direction of travel	Digital Strategy to be developed and approved by Trust Board. Iterative approach planned with content to be completed by end of September 2022. Establishing a reporting cycle into Quality Commitee **Action Owner**: CIO **Due date**: 30th September 2022	Framework approach for Digital Strategy shared and approved with Digital Board. Approach shared with ICS and Liverpool Place to support their emerging Digital and Data strategies. Facilitated sessions have commenced.	**3 x 3 = 9**
			C2) Clinical System Transformation Programme to ensure clinical systems are operationalised and embedded to improve quality and safety **Control Owner**: CIO	Digital Board signed off the workstream approach and proposed Governance to take forward the findings from the review of clinical systems optimisation	CCC nationally ranked within group 3 for Electronic Patient Record (EPR) Capability Levels as part of the work undertaken by National Frontline Digitisation Team. Group 3 classifies as an EPR that "already meets the national core capabilities"	Partial			G2) Operational ownership for embedding technical change within clinical divisions	Agreement of roles and responsibilies of Governance between Digital Board and Transformation Improvement Committee.Additional Key Performance Indicators to be monitored via divisional performance review Groups **Action Owner**: COO **Due date**: 30 July 2022	CIO and COO working collaboratively to ensure any technical change in systems and processes is clear and ownership is managed within the clinical divisions and exceptions managed through Performance Review Group by division.	
			C3) Digital Programme plan **Control Owner**: CIO	Full Digital Programme plan is monitored monthly through Digital Board. Monitoring a broad range of projects across all disciplines within the Digital Services function.	Number of work streams in line with national initiatives and reported to Integrated care System or NHS Transformation Team.	Acceptable			G3) Full overview of all digital programmes ensuring capture of new and emerging programmes	Review of Digital Programme reporting dashboard to be undertaken by the Head of Digital programmes **Action Owner**: CIO **Due date**: 31 October 2022	A full review of digital programme reporting is currently underway to ensure regular reporting of new and emerging projects such as Robotic Process Automation (RPA), Remote Monitoring and Clinical Transformation programme work streams are captured within the monthly reporting cycle.	
			C4) Data Warehouse and Interactive Power Bi Dashboards in place **Control Owner**: CIO	Data Management Group chaired by the Director of Finance monitors progress and feeds into Digital Board		Acceptable			G3.1) Resource and capacity to deliver the clinical systems transformation programme of work	Recruitment of Project Manger **Action Owner**: CIO **Due date**: 04 July 2022	Recruitment process completed and new project manager to oversee all digital workstreams within the programme will commence 04/07/22	
			C5) Strong Clinical Leadership and Engagement **Control Owner**: Medical Director	Formal roles in place for Clinical Digital Leadership with Chief Clinical Information Officer (CCIO) and Chief Nursing Information Officer (CNIO)	Roles in line with objectives of the Digital section of the Long Term Plan	Acceptable			G3.2) Clinical Documentation work stream programme	Clinical Documentation work stream to be launched with Chief Nurse as Clinical Lead **Action Owner**: Chief Nurse **Due date**: 30 June 2022	Chief Nursing Information Officer presented programme of work to Risk &Quality Committee June 2022	
			C6) Progress against Digital Maturity Model using the Internationally recognised tool Healthcare Information and Management Systems Society (HIMSS) approach **Control Owner**: CIO	HIMSS assessment report taken through Digital Board	HIMSS level 5 achieved (externally verified via an onsite assessment by the Regional Director HIMSS-Europe) - findings report reviewed by Digital board and NHS Digital. Level 5 was a requirement of the GDE programme.	Acceptable			G3.3) Pharmacy Digital work stream	Digital Pharmacy work stream led by Chief Medicines Information Officer (CMIO) with Chief Operating Officer (COO) as Operational Lead **Action Owner**: COO **Due date**: 31 August 2022	Work commenced, full progress scope to be completed and reported through Transformation Improvement Committee (TIC) for operational embedding.	
									G4) Completion of National "What Good Looks Like Framework for Nursing" (WGLL) to be undertaken by CNIO and a baseline assessment undertaken	National "What Good Looks Like Framework for Nursing" (WGLL) to be undertaken by CNIO and a baseline assessment undertaken **Action Owner**: Chief Nurse **Due date**: 31 October 2022	The general national "What Good Looks Like" (WGLL) framework assessment completed with a wide range of stakeholders across the Trust November 21 and submitted to ICS. Action plan to be monitored through Digital Board.	
									G5) Education in use of BI Dashboards and monitoring of usage through Divisional Performance Review Groups (PRGs)	Further 1-1 training planned on request. Head of Performance and Planning to include within performance reviews with divisional and operational teams **Action Owner**: COO **Due date**: 30th September 2022	Training video been created and shared with clinical divisions and available on intranet. Face to face sessions held at divisional cabinet meetings.	
									G6) HIMMS level 6 gaps identified	Plan in place to review and close level 6 gaps is being led by the Head of Digital Programmes. **Action Owner**: CIO **Due Date**: December 2022	Nationally, Level 5 HIMSS is the standardised requirement for Digital Maturity. A level 6 assessment has been undertaken and a plan to close gaps is in progress. All levels of stand 6 need to be met before moving to level 7. Level 7 status is the highest level an organisation can reach.	

BAF14. Cyber security

RISK APPETITE: Digital MODERATE (tolerance 8-12)

STRATEGIC OBJECTIVE: Be Digital

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)* Internal assurance *What/where reported/when?*	External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF14 There is a risk of **major security breach** arising from increasing digitisation and cyber threats, which could disable the Trust's systems, disrupt services and result in data loss **Executive Risk Lead:** Sarah Barr, Chief Information Officer **Board Committee**: Audit **Last Update:** 27th June 2022	**Causes** 1. Increasing sophistication and variety of malicious attacks 2. Integration of networks across the ICS 3. Increased reliance on digitised processes 4. Legacy infrastructure requiring modernization 5. Heightened national threat from Russia **Consequences** 1. Disruption to services 2. Loss of data 3. ICO fines (Highest maximum amount is £17.5m or 4% of the annual turnover in preceeding year-whichever is highest) 4. Fraud/theft 5. Reputational damage	4 x 5 = 20	C1) Anti-virus software up to date across server and PC estate, regularly monitored and maintained **Control Owner**: CIO	Anti-virus posture reported monthly to Digital Security Committee (DSC). Forms part of the Triple A Chairs report to Digital Board. Ad Hoc papers are written and shared with Audit Committee - for example: Improving Cyber rescilence Report in March 2022 in response to National request.	NHS Digital receive real-time telemetry from Windows devices, which feeds national dashboards and triggers alerting.	Acceptable	4 x 4 = 16	No	G1) Heightened security threat due to war in Ukraine, use of Russian software.	Decommission Russian AV software **Action Owner**: CIO **Due date**: June 2022	Completed the migration from Kaspersky to Sophos	3 x 4 = 12
			C2) Enterprise Backup Solution **Control Owner**: CIO	Backups checked daily. Reported monthly to Digital Security Committee. Restores tested on a quarterly basis. All backups are immutable and can not be altered.	MIAA , substantial assurance for Cyber Security Audit. (12th March 2022) NHSD/MTI - Full backup review performed in Feb 2021. All recommendations now in place.	Acceptable			G2) Corporate backups are yet to be air-gapped.	Digital Team reviewing cloud backup options **Action Owner**: CIO **Due date**: December 2022	Evaluating options to expand Cyber Vault/stage to cloud	
			C3) Windows Advanced Threat Protection (ATP). **Control Owner**: CIO	ATP deployed to all applicable assets.	All CCC devices have Windows ATP and are continuously monitored by NHSD Security Operations Centre (SoC)	Acceptable			G3) Global Log4j vulnerability - High Severity Alert issued by NHS Digital December 2021	All assets patch for Log4j where available, or work around applied. **Action Owner**: CIO **Due date**: December 2022	Awaiting Phillips to patch remaining PACS machine. A Phillips Project Manager has been assigned to Log4j issue.	
			C4) Adherence to Cyber Essentials standard **Control Owner**: CIO	CE & CE+ accreditations and compliance progress tracked via Digital Security Committee	Trust is engaged with Cyber Essentials Direct and Fortis to achieve compliance for CE+. Engaged with Greater Manchester Shared Services for ISO27001 compliance.	Partial			G4) Adoption of enhanced standards via Cyber Essentials Plus and ISO27001	Plan in place for progress towards Cyber Essentials Plus and ISO27001 implementation **Action Owner**: CIO **Due date**: March 2023	ISO27001 - All stakeholders identified and monthly meetings being held. Actions plan given to all parties. All standards and policies being developed. CE+ - Awaiting full audit to commence in July	
			C5) Network vulnerability Monitoring **Control Owner**: CIO	Security posture dashboards presented to Digital Security Committee on a monthly basis.	External audits take place to provide independent assurance on posture. Annual external Pentration Testing is undertaken by PH Consulting (16/6/22). Plans to move to Quartely Pen Testing	Acceptable			G5) Cyber incident response in-house skills - details SOC 24/7 monitoring not available	Digital Security Team taking Cyber Incident Response exams Cheshire& Merseyside Regional 24/7 Security Operations Centre (SOC) being developed. CCC Leading on this. **Action Owner**: CIO **Due date**: November 2022	Initial demonstrations and meetings have taken place with 3 other Trusts to form part of a Proof of Concept with Cynet (managed service). In house SOC will be developed later.	
			C6) Patch Management process is in place to ensure any software or operating Systems (OS) updates that are released by System Vendors is managed in a robust and timely manner **Control Owner**: CIO	ITHealth Assurance Dashboard reported at monthly Data Security Committee. 98% of endpoint devices patched up to date. 100% of servers patched up to date. 100% of windows devices on fully supported operating systems	NHS Digital National Dashboard	Acceptable			G7) 2% of devices not up to date due to not logging on to the Trust Virtual Private Network (VPN)	Non VPN devices will be captured over the internet **Action Owner**: CIO **Due date**: July 2022	Solution has been deployed to 10 laptops and approval will be sought at the next Change Control Board (CAB) for deployment to all laptop devices	
			C7) Data Security Protection Toolkit **Control Owner**: CIO	Annual Assesment undertaken by Mersey Internal Audit.	External Reporting to NHS England.	Acceptable			G8) Process for Joiners Movers and Leavers (JML)	Procees for leavers and movers on a weekly basis **Action Owner**: Director of WOD **Due date**: July 2022	Policy in place (User Management Policy). Update report production from monthly to weekly	

BAF15. Subsidiary Companies and Joint Venture

RISK APPETITE: Commercial and partnership working, financial MODERATE (9-12)

STRATEGIC OBJECTIVE: Be Innovative

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)* Internal assurance *What/where reported/when?*	External assurance *What/where reported/when?*	Overall assurance level	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/23 L x C
BAF15 There is a risk of **inadequate governance of the Trust's Subsidiary Companies and Joint Venture**, which would result in failure to maximise the potential commercial and efficiency benefits **Executive Risk Lead:** James Thomson, Director of Finance **Board Committee**: Performance **Last Update:** 7 July 2022	**Causes** 1. Lack of clear strategy for subsidiaries 2. Lack of governance and assurance interfaces with Trust 3. Lack of signed SLA/contract agreements **Consequences** 1. Failure to realise efficiencies 2. Failure to maximise commercial income 3. Subsidiaries and JV do not invest in business and reduce growth/market share	**5 x 3 = 15**	C1) Limited Liability Partnership agreement with the Mater Private Healthcare. Renewed by both parties 2020. **Control Owner: DoF**	Contract format and agreement reviewed by Trust Board. Also managed through joint venture Board.	Legal advice taken on initial structuring and renewal agreement.	Acceptable	**4 x 3 = 12**	**Yes**	G1) Annual review of budgets to support SLA relationashp to complete before Trust financial plan for year.	Commence SLA discussion in Q3 22/23 **Action Owner:** DoF **Due date:** 31/12/23	Agreed SLA postion for 2022/23. Budget for JV approved by JV Board in June 2022.	**2 x 2 = 4**
			C2) Financial plan set by The Mater and approved by Trust **Control Owner: DoF**	JV performance reports and finance results reported to Performance Committee - twice per year.	External audit required annually	Partial			G2) Revised multi-year marketing and growth plan to be developed and approved.	JV producing revised multi-year strategy for growth. **Action Owner:** DoF **Due date**: 30/9/22	Standing item on JV Board. Separate strategy session planned July 2022. Budget approved by JV Board in June 2022. Marketing and engagement plan revised and being implemented by JV Manager.	
			C3) Separate governance and Board arrangements for CPL and PropCare **Control Owner: DoF**	Internal SLA and financial reporting process managed through Finance Committee and Divisional Boards (monthly).	Governance arrangements included in MIAA audit plan Both subsidiaries subject to external audit, and for CPL professional regulatory licensing.	Acceptable			G3) Governance process impacted by absence of Company Secretary. Final revised SLA with CPL, not signed.	Temporary Company Secretary to be engaged Trust/CPL to sign SLA following review. **Action Owner:** CEO **Due date:** 30/9/22	Trust engaged with experienced govenrnace lead for temporary contract. CPL SLA is due for aproval, following external review (KPMG) in June 2022.	
			C4) PropCare approved business strategy and medium term plans March 2022 **Control Owner**: **DoF**	PropCare performance reports to Performance Committee and Trust Board - bi-annually. Trust Board Non Executive Directors named as Directors of subsidiaries.	PropCare subject to external audit.	Partial			G4) PropCare have developed strategy (March 2022) and required to translate into full business plan.	Trust to receive full business plan Quarter 2. **Action Owner**: DoF **Due date**: 31/9/22	PropCare have started to implement the strategy, making key appointments as planned.	
			C5) CPL approved business strategy and medium term plans March 2022 **Control Owner**: DoF	CPL performance reports to Performance Committee and Trust Board - bi-annually. Trust Board Non Executive Directors named as Directors of subsidiaries.	Subsidiaries subject to external audit. CPL corprate tax structure advised by KPMG.	Partial			G5) CPL to develop and present 5 year strategy to Trust Board for approval.	CPL to finalise 5 year strategy at CPL July Board. To present to Trust Board at next update [September] **Action Owner:** DoF **Due date:** 31/10/22	CPL Board Strategy session 13/6/22	

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1
27th July 2022

P1-133-22 Quality Committee Chairs Report: 23rd June 2022

Chair	Terry Jones	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

Items of concern for escalation to the Board	<u>Papillon Service</u> Ongoing issues with commissioning the new installation services suspended and patient being offered alternative centre or treatment (commissioners aware) <u>Safer Staffing Report</u> Additional assurance about safe staffing for single room delivery mode. The new report include the ward manager judgement statement on safe staffing levels.
Items of achievement for escalation to the Board	<u>Pharmacy</u> Positive report from pharmacy on Quality improvement and staff culture <u>IPC Report</u> Comprehensive IPC support provided additional assurance to wards
Items for shared learning	<u>ECMC Submission</u> Due end of June and on track. University of Liverpool leading the submission ad supporting with bid writers.

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1
27th July 2022

P1-134-22
Chair's report for: Audit Committee
Date/Time of meeting: 14 July 2022 – 09.30-12.30

			Yes/No
Chair	Mark Tattersall	**Was the meeting Quorate?**	Yes
Meeting format	MS Teams		
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 Data Protection Security Toolkit self-assessment has been uploaded and we have declared standards met. The MIAA audit of our compliance with the National Standards delivered a moderate rating. The rating was based on the risk posed by the Joiners-Movers-Leavers Policy/process which resulted in a moderate assurance rating for the relevant standard. All other standards achieved a substantial assurance rating. • The Committee considered the Anti-Fraud Annual Report 2021-22 containing the work carried out during 2021/22 which had been reviewed against the Function Standard Requirements relating to fraud, bribery and corruption and Service Condition 24 of the NHS Standard Contract. • The Committee approved the Health Procurement Liverpool Governance arrangements • The Committee received and reviewed the Quality Committee and Performance Committee Annual Reports for 2021-22. The Audit Committee acknowledged that both Committees have clearly evidenced they have met the requirements of their Terms of Reference and the scope of the work undertaken by each Committee delivered substantial assurance. • The Committee received and discussed the revised BAF for 22/23. The Committee welcomed the enhancements to the BAF and noted that additional development is being progressed over the next few months to create a clear link between the BAF and Trust Board and Committee Work Plans. The Audit Committee approved the revised BAF and

The Clatterbridge Cancer Centre NHS Foundation Trust

	agreed to recommend it to the Trust Board. The Audit Committee also reviewed BAF 14 relating to Cyber Security for which the Committee has oversight responsibility. Following a detailed discussion the Audit Committee accepted the revised moderate risk appetite rating for BAF 14 and going forward requested further narrative as the identified control/assurance actions are progressed and/or revised. • The Audit Committee received and considered the results of the Committee's self-assessment of its effectiveness for 2021-22. The Committee agreed an action plan for improvement including: addressing the delays in Committee papers being circulated to Members, enhancing the quality/content of minutes and circulating draft minutes within a reasonable timescale following a meeting.
Items of concern for escalation to the Board	The Committee received the Audit Tracker and acknowledged the significant efforts of the Corporate Governance team in co-ordinating the production of the document. However, it was agreed that further development is required to deliver a Tracker which provides assurance regarding the timely completion of agreed actions and in particular relating to limited assurance reviews and high level control risks.
Items of achievement for escalation to the Board	
Items for shared learning	

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1
Date of meeting: 27th July 2022

Report author	Mark Tattersall – Non-Executive Director and Chair of Audit Committee				
Paper prepared by	Skye Thomson – Corporate Governance Manager				
Report subject/title	P1-135-22 Audit Committee Annual Report 2021-22				
Purpose of paper	In accordance with its current Terms of Reference, the Audit Committee is required to present an Annual Report to the Trust Board providing assurance that the Committee has fulfilled its duties in accordance with the Terms of Reference. The following Annual Report provides assurance to the Trust Board that the functions and requirements of the Audit Committee have been met for 2021-22.				
Background papers	Quality Committee Annual Report 2021-22 Performance Committee Annual Report 2021-22				
Action required	The Board is asked to discuss and note the contents to the report				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	x	Be a great place to work	x	
	Be Collaborative	x	Be Digital	x	
	Be Research Leaders	x	Be Innovative	x	

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

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Ref: FCGOREPO
Review: July 2025
Version: 2.0

The Clatterbridge Cancer Centre NHS Foundation Trust

Audit Committee Annual Report 2021-22

Contents

1. Introduction

1.1 The requirement for the Trust to have an Audit Committee is set out in Monitor's Code of Governance[1]. The Audit Committee provides an independent and objective review of the Trust's internal controls and has a key role in ensuring the adequacy and effectiveness of systems, governance (corporate and clinical), risk management and internal control (both financial and non-financial), all of which support the Trust's Strategic Priorities. In carrying out its function the Audit Committee predominantly utilises the work of Internal and External Audit functions.

1.2 In accordance with the approved Terms of Reference (section 9.2), the audit committee will review relevant assurances from other Board Committees, working groups and senior managers within the Trust to provide assurance relevant to the Committee's own scope of work. The Audit Committee will report annually to the Board in respect of the fulfilment of its function within the Terms of Reference (section 10.3). The following report illustrates the work of the Audit Committee during the period 2021-22.

2. Terms of Reference

2.1 The purpose of the Audit Committee is clearly set out within its approved Terms of Reference. In summary, the Audit Committee is a fully constituted standing committee of the Trust Board tasked with providing support and in-year assurance to the Board by carrying out a critical review of the governance and assurance processes that the Board relies upon.

2.2 The Audit Committee has specific work areas with which it is responsible for namely:

a) Integrated Governance, Risk Management and Internal Control.

[1] Monitor (2014) The NHS Foundation Trust Code of Governance

b) Internal Audit: ensure there is an effective Internal Audit function established by management in addition to reviewing and approving the Internal Audit Plan. In the event the Internal Audit function carry out any non-audit work, the Audit Committee has responsibility for ensuring that their independence is maintained.

c) External Audit: responsibility for making recommendations to the Council of Governors in respect of the appointment, re-appointment and removal of the Trust's External Auditors. In addition, the Audit Committee reviews all external audit reports

d) Monitor the integrity of the financial statements and Annual Statutory Accounts prior to presentation at the Trust Board.

e) Review of the Annual Report and Annual Governance Statement and recommend approval to the Trust Board.

f) Review the content and the operation of the Trust's Standing Orders and Standing Financial Instructions and the associated registers.

g) Cyber Security: the Audit Committee provides assurance to the Trust Board that the Trust is properly managing cyber risk.

2.3 The Audit Committee reviewed its Terms of Reference in April 2022 and a final amended version will be approved in July 2022.

3. Membership of the Audit Committee

3.1 The Audit Committee membership comprises three Non-Executive Directors, and two of those Non-Executive Directors have recent relevant financial experience. The Committee is Chaired by Non-Executive Director Mark Tattersall. The additional Non-Executive Directors are Geoff Broadhead and Asutosh Yagnik. Asutosh Yagnik joined the committee in January 2022 replacing Non-Executive Director Anna Rothery, who was a member of the committee from January 2021-October 2021.

3.2 Representation from Internal Audit and Anti-Fraud is provided by MIAA and representation from External Audit was provided by Grant Thornton until October 2021 and has since been provided by Ernst Young.

3.3 In addition to the above, the following are in attendance at the Audit Committee; Director of Finance, Chief Nurse, and Associate Director of Corporate Governance, Representatives from Internal Audit, Representatives from External Audit Representatives from Counter Fraud. The Audit Committee has the authority within its Terms of Reference to request the attendance of any member of staff or persons to assist with any discussions.

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4. Meetings and Quoracy

4.1 The last financial year brought challenges as a result of the Covid-19 Pandemic, however this has not impacted on the ability of the Audit Committee to fulfil its functions.

4.2 In accordance with its Terms of Reference, the Audit Committee meets for a minimum of four scheduled meetings a year. During the last financial year, the Audit Committee met a total of six times with two of those meetings being an extra-ordinary meeting to first review and then approve the Annual Accounts and Annual Report under delegated authority from the Trust Board.

4.3 For the Audit Committee to be quorate, two of the three Non-Executive Directors are required to attend Committee meetings. The Audit Committee held one additional extra-ordinary meeting in June 2021 which was not quorate, a replacement extra-ordinary meeting took place shortly after in June to ensure quoracy. The 6 meetings of the Audit Committee were quorate.

5. Audit Committee Business 2021-22

5.1 During the period reviewed, the Audit Committee Chair and members of the Audit Committee confirm that the Audit Committee has reviewed the following matters:

a) Internal Audit:

- Reviewed the Head of Internal Audit Annual Report and Head of Internal Audit Opinion 2021-22
- Approved the Internal Audit Plan for 2021-22
- Reviewed the findings from individual reviews carried out by MIAA

b) Anti-Fraud:

- Received the Anti-Fraud Annual Report
- Approved the Anti-Fraud Work Plan for 2021-22 and monitored and reviewed progress on plan delivery throughout the year.

c) Engaged with new External Auditors and recommended that the Council of Governors appoint Ernst Young.

d) Under delegated authority from the Trust Board, approved the Annual Accounts and Annual Report (including Annual Governance Statement) for 2020-21 and submissions in relation to compliance with the Provider Licence.

e) Reviewed the ongoing development of the Board Assurance Framework, acknowledging that whilst this was work in progress, the Audit Committee agreed that the visibility of risks within the Trust had been enhanced during the last year.

f) Monitored responses by management to the recommendations made by Internal Audit through associated reviews.

g) Received assurance around the Trust's Clinical Audit function.

h) Received assurance in relation to the Trust's processes for managing litigation and inquests in addition to progressing any actions arising from litigation.

i) Maintained oversight of the Trust's schedule of losses and compensations.

j) Maintained oversight and scrutiny of the Trust's Tender Waiver Register.

k) Received and considered the implications of ISA 540: accounting estimates and the potential implications for Audit Committee members and the Trust Board.

l) Reviewed the lessons learned and action plan that resulted from the challenges experienced during the External Audit and year-end process for 2020-21.

m) Monitored the delivery of the data security and protection toolkit submission

n) Reviewed the Corporate Governance Manual

o) Received Director of Finance reports highlighting changes in financial system governance

p) Monitored key finance assurance indicators including performance in relation to the better payment practice code

6. Reports to the Trust Board

6.1 The Chair of the Audit Committee provides a Chair's Report to Trust Board following every meeting. During the period reviewed, the Audit Committee alerted the Trust Board to the following issues/challenges:

a) External Audit Findings Report, Annual Report and Accounts submission

b) Delays incurred in the completion of the External Audit work

c) Managing Conflicts of Interest Limited Assurance MIAA Audit Report, Anti-fraud Component 12 (Conflicts of Interest) marked as amber.

d) Anti-Fraud Component 3 Fraud Bribery and Corruption risk assessment marked as amber.

6.2 The Audit Committee also provided assurance via the Chair's Report to Board in relation to the following:

a) Head of Internal Audit Opinion

b) Progress against the Audit Tacker

c) Progress against the Board Assurance Framework

d) Anti-Fraud Annual Report and the content thereof

e) Data Security and Protection Toolkit Review and assessment of National Data Guardian Standards

6.3 In addition, the Audit Committee has received annual reports from the Performance Committee and Quality Committee and was assured that both Committees have fulfilled their respective Terms of Reference during 2021-22.

7. Conclusion

7.1 As the predominant governance committee of the Trust Board, the Audit Committee maintained its independence from operational management throughout the period of review by not including management within the membership with voting rights.

7.2 The Audit Committee has maintained an open and professional relationship with both Internal and External Audit and the Anti-Fraud Service.

7.3 The Chair of the Audit Committee concludes that the Committee has fulfilled its role in accordance with its approved Terms of Reference and alerted the Board to matters requiring escalation in addition to providing assurance where necessary and relevant.

7.4 The Audit Committee members would like to thank all those who have contributed to the work of the Audit Committee throughout the year.

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1
27th July 2022

P1-136-22 Charitable Funds Committee Chairs Report: 6th July 2022

Chair	Elkan Abrahamson	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 Midsummer Ball was very successful raising over £170k. • The Committee discussed the Memorandum and Articles of Association which will now go to the Charity's Accountants for review. The Committee agreed the Memorandum and Articles of Association go to the September Trust Board for approval. • The Committee agreed the changes to the Charitable Funds Committee Scheme of Delegation. • The Committee approved the setting up of a Charitable Spending Committee and Staff Wellbeing Fund to be administered by HR. • The Committee approved the Policies: Complaints and On-Site Activity by other Charities.
Items of concern for escalation to the Board	There is an ongoing issue with NWCR over who is entitled to various legacies. Katrina Bury will prepare a report for the next Committee meeting.
Items of achievement for escalation to the Board	The Arts in Health Programme Annual Report 2021-22
Items for shared learning	None

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board
Date of meeting: 27th July 2022

Report author	Joan Spencer, Chief Operating Officer				
Paper prepared by	Hannah Gray, Head of Performance and Planning				
Report subject/title	P1-137-22 Integrated Performance Report M3 2022 / 2023				
Purpose of paper	This report provides the Board of Directors with an update on performance for month 3 2022/23 (June 2022). This report provides an update on performance for June 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 now presented below the relevant KPI / group of KPIs against which the Trust is not compliant. Points for discussion include under performance, developments and key actions for improvement.				
Background papers					
Action required	For discussion and approval				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	Y	Be a great place to work	Y	
	Be Collaborative	Y	Be Digital	Y	
	Be Research Leaders	Y	Be Innovative	Y	

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		

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Ref: FCGOREPO
Review: July 2025
Version: 2.0

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Integrated Performance Report
(Month 3 2022/23)

Hannah Gray: Head of Performance and Planning

Joan Spencer: Chief Operating Officer

Introduction

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

The scorecards include statistical process control (SPC) charts, with associated variation and assurance icons. Further information is provided in the SPC Guidance section of this report.

Exception reports, for key performance indicators (KPIs) against which the Trust is not compliant, are now included below the relevant KPI or group of KPIs.

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.

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Interpretation of Statistical Process Control Charts

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

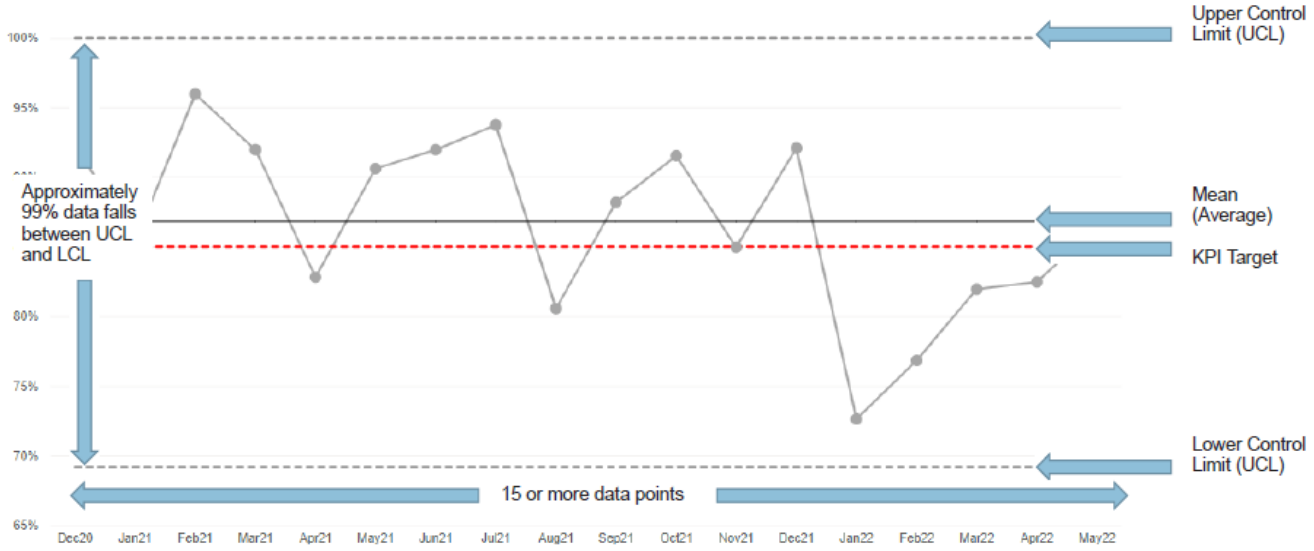
Are we improving, declining or staying the same? (Variation)			
Icon	**Variation**	Definition	Action
	Special Cause Improving Variation	Unexpected variation that results from unusual circumstances in a system or process i.e. assignable. (Blue = significant improvement/low pressure, H = high numbers, 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.

REPORT

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Anatomy of the SPC Chart

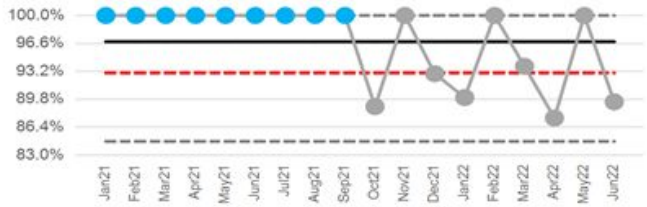


Integrated Performance Report (Jul 21 - Jun 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 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%	88.9%	100.0%	92.9%	90.0%	100.0%	93.8%	87.5%	100.0%	89.5%		
			Narrative	The target has not been achieved, with 2 unavoidable breaches. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														

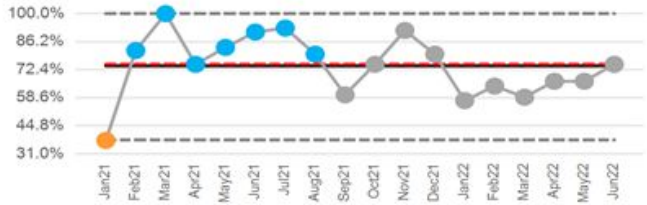


Reason for Non-Compliance	Action Taken to Improve Compliance
2 patients breached this target in June. Both breaches were unavoidable to CCC and were due to patient choice of first appointment date.	N/A

Escalation Route & Expected Date of Compliance

Trust Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Expected Date of Compliance July 2022

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
CW00	28 day faster diagnosis - (Referral to diagnosis)	Green >=75% Red <75%	Contractual / Statutory		92.9%	80.0%	60.0%	75.0%	91.7%	80.0%	57.1%	64.3%	58.8%	66.7%	66.7%	75.0%		
			Narrative	Following 5 consecutive months of non-compliance, the target has been achieved this month. 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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
CW47	28 day faster diagnosis - (Screening)	Green >=75% Red <75%	To Be Confirmed		-	-	-	0%	-	-	-	-	-	-	100%	-		
			Narrative	There were no 28 day faster diagnosis screening patients in June.														

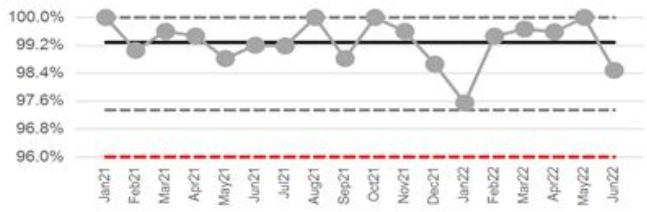
Data Not Applicable for SPC

Integrated Performance Report (Jul 21 - Jun 22)

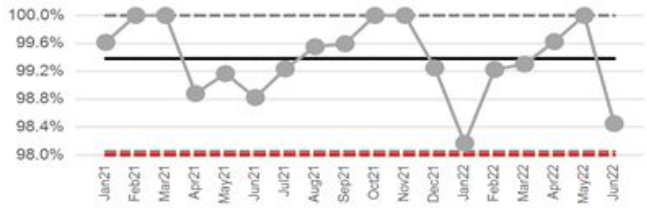
The Clatterbridge Cancer Centre NHS Foundation Trust

Access

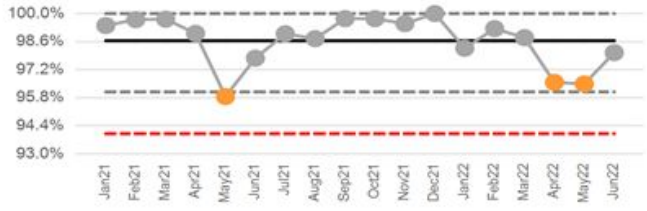
Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
CW09	31 Day Firsts	Green >=96% Red <96%	Contractual / Statutory		99.2%	100.0%	98.8%	100.0%	99.6%	98.7%	97.5%	99.5%	99.7%	99.6%	100.0%	98.5%		
			Narrative	The 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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
CW07	31 Day Subsequent Chemotherapy	Green >=98% Red <98%	Contractual / Statutory		99.2%	99.6%	99.6%	100.0%	100.0%	99.2%	98.2%	99.2%	99.3%	99.6%	100.0%	98.4%		
			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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
CW08	31 Day Subsequent Radiotherapy	Green >=94% Red <94%	Contractual / Statutory		99.0%	98.7%	99.7%	99.7%	99.5%	100.0%	98.3%	99.2%	98.8%	96.6%	96.5%	98.0%		
			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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
CW40	Number of 31 day patients treated => day 73	Green 0 Red >0	Contractual / Statutory		0	0	0	0	0	0	1	0	0	0	0	0		
			Narrative	The target has been achieved, with no 31 day patients treated on or after day 73.														

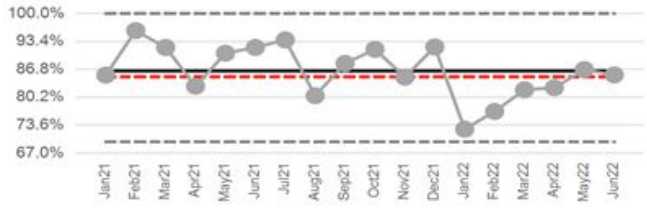
Data Not Applicable for SPC

Integrated Performance Report (Jul 21 - Jun 22)

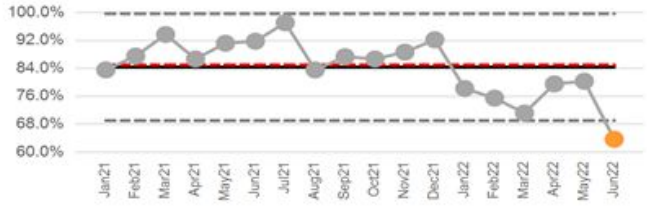
The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 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%			93.8%	80.6%	88.2%	91.5%	85.0%	92.1%	72.6%	76.8%	81.9%	82.5%	86.7%	85.5%		
			Narrative	Performance figures have improved consistently since January 2022 and the target has now been achieved for May and June 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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
CW03	62 Day Classic	Green >=85% Red <85%	Contractual / Statutory		97.1%	83.5%	87.3%	86.7%	88.6%	92.2%	78.2%	75.4%	71.2%	79.5%	80.3%	63.6%		
			Narrative	The target has not been achieved, with 3 avoidable breaches. The exception report provides further details, including actions taken to improve performance. SPC: Performance is significantly lower than expected in June. The nature of variation indicates that achievement of the target is likely to be inconsistent.															



Reason for Non-Compliance	Action Taken to Improve Compliance
17 patients breached the 62 day target in June; 14 were unavoidable to CCC and 3 were avoidable. The unavoidable breach reasons include: complex pathway, delays waiting for molecular testing (9 patients), medical reasons, trial related (patient ultimately ineligible) and patient choice. The avoidable breach reasons were as follows: • Delay to diagnostics • Delay of 3 days for 1st appointment and then awaiting the next SABR MDT • Delay to patient being prescribed Immunotherapy (Prembrolizumab), due to awaiting funding confirmation. Tumour group breach split: Lung (12), Haematology (5) and Head and Neck (1) 24 Day performance was 85% for June; of the 117 patients treated at CCC on the 62 Day classic pathway, 100 patients were treated within 24 days. NB: There was 1 62 Day rare cancer (testicular) breach for June which was unavoidable due to being a complex pathway.	• Meeting held with Operational lead at LCL who confirmed that patient's molecular test results are now being turned around in 7 days. Training will be arranged for secretaries to ensure they can access the results timely. • Investigations will be ordered at the point of triage, to avoid any delays. The new Pathway Navigator (for lymphoma RDS) is working closely with the Cancer Waits Team to ensure that the patients are tracked efficiently through diagnostics and any delays are appropriately escalated. • Review options for increasing the visibility of a target patient's status within the electronic patient record. Developing the functionality of the CWT online Dashboard to support more real time tracking. These developments will support all departments involved in the patients' pathway to prevent breaches, rather than relying solely on CWT Team tracking and monitoring of escalation status.

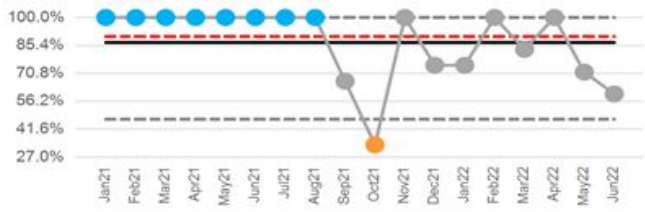
Escalation Route & Expected Date of Compliance
Trust Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board Expected Date of Compliance August 2022

Integrated Performance Report (Jul 21 - Jun 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
CW05	62 Day Screening	Green >=90% Red <90%	Contractual / Statutory		100.0%	100.0%	66.7%	33.3%	100.0%	75.0%	75.0%	100.0%	83.3%	100.0%	71.4%	60.0%		
			Narrative	The target has not been achieved, with 1 avoidable breach. 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. Due to small numbers of patients, 1 breach can result in target failure.															



Reason for Non-Compliance	Action Taken to Improve Compliance
1 of the 5 June 62 day screening patients breached the target. The breach was avoidable as the patient was not registered as a screening patient on receipt of referral.	The SOP has been re circulated and refresher training carried out for new staff.

Escalation Route & Expected Date of Compliance

Trust Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Expected Date of Compliance July 2022

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 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		1	0	0	1	0	0	0	1	4	0	1	1		
			Narrative	The target has not been achieved, with 1 avoidable breach. The exception report provides further details, including actions taken to improve performance.														

Data Not Applicable for SPC

Reason for Non-Compliance	Action Taken to Improve Compliance
4 patients breached the 104 day target in June and were with CCC for more than 24 days. 3 of the breaches were unavoidable to CCC, due to a complex pathways and patient choice. The 1 avoidable breach was administration related, with information received after registration not reviewed and managed in accordance with protocol. A clinical harm review will be undertaken for the complex pathway related breach. Clinical harm reviews are coordinated by the Trust who the patient was with for the longest period during the full pathway. CCC will coordinate this review as the patient was with CCC for longer than the referring Trust. CCC contributes information to reviews conducted by other organisations.	The team have now been trained to ensure that any information received after the patient is registered is reviewed separately, systems are updated accordingly and this is signed off.

Escalation Route & Expected Date of Compliance

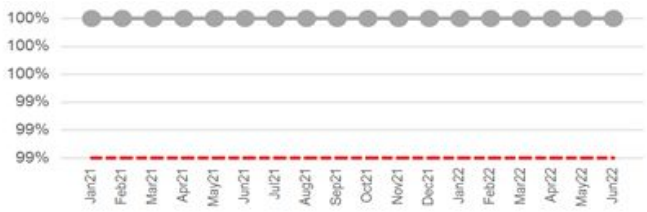
Trust Operational Group, Divisional Quality, Safety and Performance Meeting, Divisional Performance Reviews, Performance Committee, Trust Board
Expected Date of Compliance July 2022

Integrated Performance Report (Jul 21 - Jun 22)

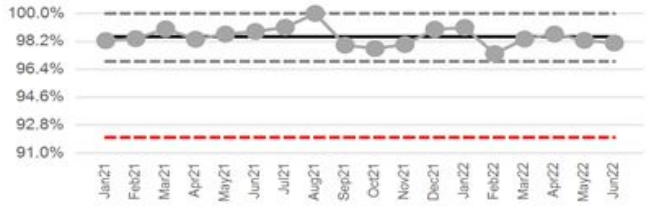
The Clatterbridge Cancer Centre NHS Foundation Trust

Access

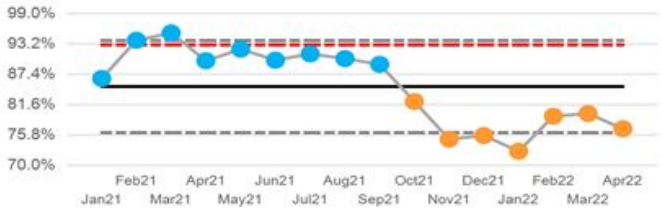
Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
DI01	Diagnostic Imaging Waitlist - Within 6 Weeks	Green >=99% Red <99%	Contractual / Statutory		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
			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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
RT03	RTT Incomplete	Green >=92% Red <92%	Contractual / Statutory		99.1%	100.0%	98.0%	97.7%	98.0%	99.0%	99.1%	97.4%	98.4%	98.7%	98.3%	98.1%		
			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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
CW44	2 week wait from GP referral to 1st appointment (Cheshire and Merseyside)	Green >=93% Red <93%	Contractual / Statutory		91.3%	90.4%	89.3%	82.2%	75.0%	75.7%	72.7%	79.4%	79.9%	77.0%	-	-		
			Narrative	The target has not been achieved. The exception report provides further details, including actions taken to improve performance. SPC: Performance is lower than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Integrated Performance Report (Jul 21 - Jun 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Reason for Non-Compliance	Action Taken to Improve Compliance
Non-compliance with the 14 day standard was largely driven by underperformance in the following tumour groups: Suspected breast cancer 57.7% (887 breaches), Suspected gynaecological cancer 59.8% (455 breaches), Suspected head and neck cancer 77.4% (215 breaches), Suspected lower gastrointestinal cancer 81.8% (432 breaches), Suspected children's cancer 85% (6 breaches), Suspected upper gastrointestinal cancer 85.3% (151 breaches), Suspected skin cancer 85.3% (375 breaches), Suspected urological malignancies (excluding testicular) 89.8% (92 breaches), Suspected sarcoma 90.2% (6 breaches) Providers not achieving the national 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) Outpatient capacity issues were recorded as the most frequent breach reason (72%), followed by patient choice (19%).	• 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

Escalation Route & Expected Date of Compliance
NHS England, North West CCC Performance Committee, Trust Board Expected Date of Compliance September 2022

Metric ID	Metric Name	Target	Target Type	Year & Month													
				Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
CW45	28 day faster diagnosis - (Referral to diagnosis) (Cheshire and Merseyside)	Green >=75% Red <75%	Contractual / Statutory	76.1%	74.8%	76.3%	73.1%	74.2%	72.4%	68.7%	68.3%	69.5%	66.6%	-	-		
			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 lower than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Integrated Performance Report (Jul 21 - Jun 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Reason for Non-Compliance	Action Taken to Improve Compliance
Non-compliance with the 28 day FDS was driven by underperformance in the following tumour groups: Suspected urological malignancies (excluding testicular) 43.9% (365 breaches), Suspected lower gastrointestinal cancer 45.9% (1106 breaches), Suspected haematological malignancies (excluding acute leukaemia) 47% (35 breaches), Referral from a National Screening Programme: Unknown Cancer Report Category 49.4% (182 breaches), Suspected gynaecological cancer 54.8% (421 breaches), Other suspected cancer (not listed) 56.5% (10 breaches), Suspected upper gastrointestinal cancer 57.9% (329 breaches), Exhibited (non-cancer) breast symptoms - cancer not initially suspected 66.6% (153 breaches), Suspected lung cancer 70.3% (44 breaches) Providers not achieving the national standard were: Warrington and Halton Teaching Hospitals 43.8% (9 breaches), Liverpool Heart And Chest 45.2% (17 breaches), Liverpool Womens 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) The main reasons for breaches were outpatient capacity (32%), healthcare provider initiated delay to diagnostic test (13%) and 'other' (17%).	• 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

Escalation Route & Expected Date of Compliance
NHS England, North West CCC Performance Committee, Trust Board Expected Date of Compliance September 2022

Metric ID	Metric Name	Target	Target Type	Year & Month													
				Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
CW46	62 Day Classic (Cheshire and Merseyside)	Green >=85% Red <85%	Contractual / Statutory	75.2%	73.5%	69.8%	71.2%	67.3%	68.7%	62.2%	69.4%	67.9%	70.3%	-	-		
			Narrative	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.													

Integrated Performance Report (Jul 21 - Jun 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access

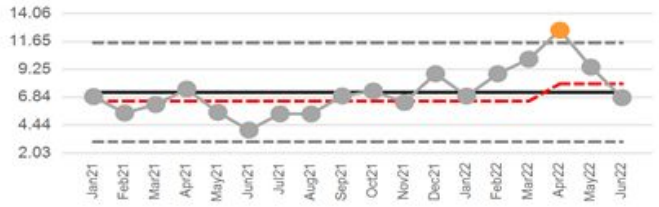
Reason for Non-Compliance	Action Taken to Improve Compliance
Non-compliance with the 62 day standard was driven by underperformance in the following tumour groups: Sarcoma 33.3% (4 breaches), Gynaecological 34.3% (22 breaches), Lower Gastrointestinal 42% (41.5 breaches), Head & Neck 48.8% (10.5 breaches), Haematological (Excluding Acute Leukaemia) 57.1% (10.5 breaches), Upper Gastrointestinal 58.9% (15 breaches), Other 60% (2 breaches), Lung 61.2% (19 breaches), Urological (Excluding Testicular) 65% (46 breaches), Breast 80.6% (20 breaches) Providers not achieving the national standard were: Liverpool Womens 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) The main reasons for breaches were complex diagnostic pathways (22%), healthcare provider initiated delay to diagnostic test or treatment planning (18%) and 'other' (37%).	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
Escalation Route & Expected Date of Compliance	
NHS England, North West, CCC Performance Committee, Trust Board Expected Date of Compliance March 2023	

Integrated Performance Report (Jul 21 - Jun 22)

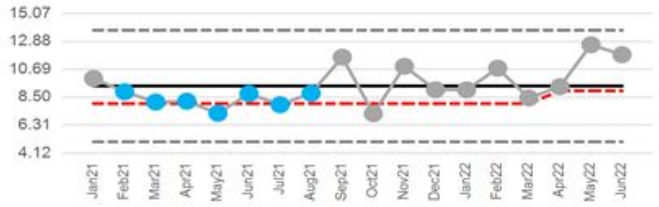
The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

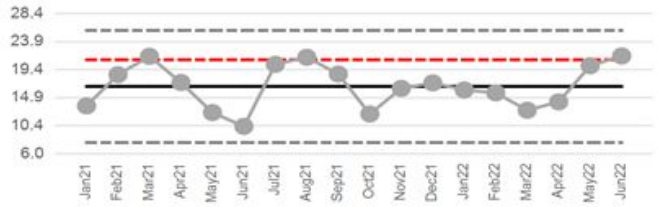
Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
IP05-ST	Length of Stay Elective Care: Solid Tumour Wards (Average number of days on discharge)	Green <=8 Amber 8.1 -8.4 Red >8.4	Statutory		5.40	5.40	6.95	7.37	6.39	8.86	6.93	8.86	10.12	12.62	9.43	6.80		
			Narrative	The target has been achieved.SPC: Following significantly higher than expected length of stay in April, May and June's figures have fallen back within SPC limits, indicating normal variation. The nature of variation indicates that achievement of the target is likely to be inconsistent.														



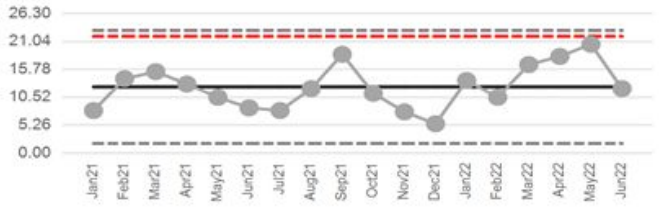
Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
IP06-ST	Length of Stay Emergency Care: Solid Tumour Wards (Average number of days on discharge)	Green <=9 Amber 9.1 -9.8 Red >9.8	Statutory		7.90	8.81	11.64	7.20	10.92	9.08	9.08	10.77	8.44	9.33	12.62	11.84		
			Narrative	The target has not been achieved. The LoS exception report can be found below the final LoS KPI presented. This 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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 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		20.3	21.4	18.7	12.3	16.4	17.3	16.2	15.7	12.9	14.3	20.0	21.6		
			Narrative	LoS for June is marginally above target. The exception report can be found below the final LoS KPI. This 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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 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		8.00	12.13	18.60	11.25	7.75	5.50	13.67	10.50	16.67	18.20	20.50	12.13		
			Narrative	The target has been achieved. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														

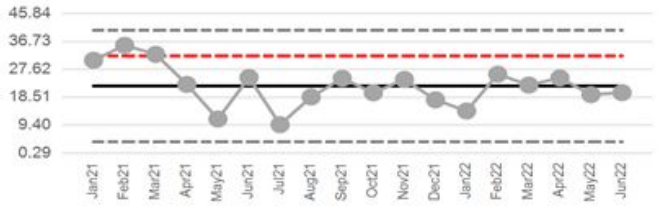


Integrated Performance Report (Jul 21 - Jun 22)

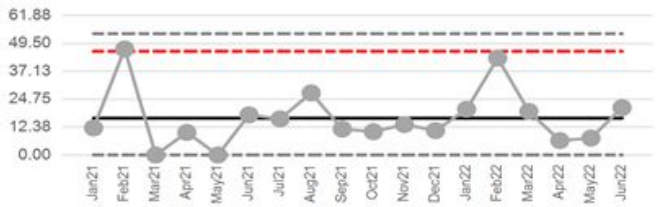
The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 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		9.53	18.59	24.67	19.94	24.29	17.64	14.00	26.00	22.46	24.80	19.35	20.00		
			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.														



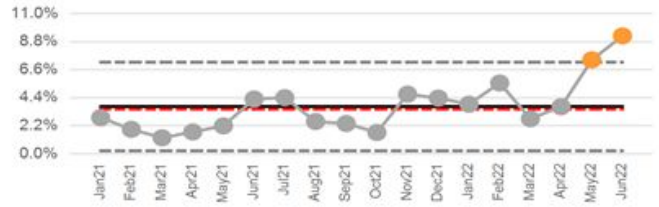
Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
IP06-5	Length of Stay Emergency Care: HO Ward 5 (Average number of days on discharge)	Green <=46 Amber 46.1-48.3 Red >48.3	Statutory		16.00	27.50	11.50	10.33	13.50	10.83	20.25	43.00	19.33	6.38	7.50	21.00		
			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.														



Reason for Non-Compliance	Action Taken to Improve Compliance
Length of stay exception report: ST Wards (non-elective) and Ward 4 (elective). There has been an increase in patients admitted on an unplanned pathway for fractionated radiotherapy due to Spinal Cord Compression. These patients often have complex therapy needs, which can delay discharge. There has also been an increase in patients admitted on an unplanned pathway 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 now rather than weeks. Currently, 2 of the 3 Wirral Intermediate Care Bed Hubs are closed due to Covid-19. On Ward 4, there has been an increase in the number of patients with a prolonged LOS due to the complex nature of their cancer treatment. One patient waited for the whole of June for a Nursing Home placement due to their nursing needs. The CUR non-qualifying rate for June is 7%, which provides some assurance that there was a low incidence of inappropriate utilisation of beds, however this figure has risen again this month, mirroring the continuing discharge challenges.	The Patient Flow Team continue to work alongside the MDT to start discharge planning earlier with patients to prevent the delays once patients are medically fit and ready for discharge. Daily Consultant lead board rounds take place on in patient wards.

Escalation Route & Expected Date of Compliance
Divisional Quality, Safety and Performance Group', Divisional Performance Review, Quality Committee, Trust Board Expected Date of Compliance September 2022

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
IP22	Delayed Transfers of Care as % of occupied bed days	Green <=3.5% Red >3.5%	Statutory		4.4%	2.5%	2.4%	1.7%	4.7%	4.4%	3.9%	5.5%	2.7%	3.7%	7.4%	9.2%		
			Narrative	The target has not been achieved in June. The exception report provides further details, including actions taken to improve performance. SPC: Figures are again higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Integrated Performance Report (Jul 21 - Jun 22)

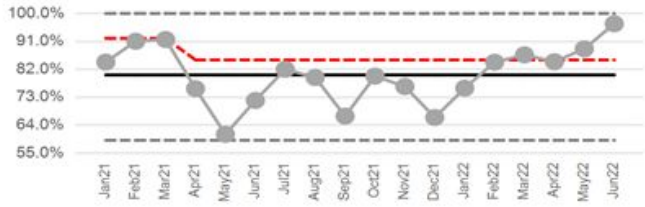
The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

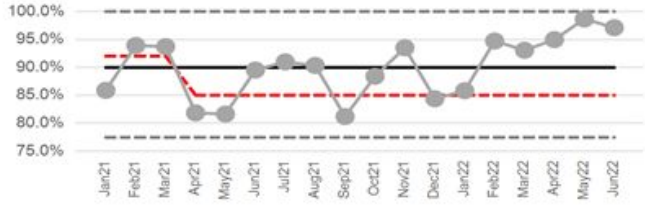
Reason for Non-Compliance	Action Taken to Improve Compliance
There were 16 DTOC in June, equating to 212 extra bed days. The average length of DTOC was 13.25 days. 7 patients awaited fast track packages of care (POC), resulting in 37 extra bed days. Covid-19 continues to impact community services; increasing the length of time to commission a POC across all areas. 5 patients awaited fast track nursing home placement (138 extra bed days), with 3 of the 5 patients remaining in hospital for the whole of June due to complex nursing needs. 4 patients awaited hospice placement, resulting in 35 extra bed days. Some hospices have reduced day capacity due to Covid-19.	• 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.

Escalation Route & Expected Date of Compliance
Divisional Quality, Safety and Performance Group', Divisional Performance Review, Performance Committee, Trust Board Expected Date of Compliance September 2022

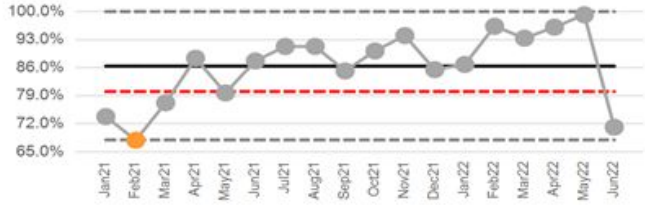
Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
IP20-4	Average Occupancy at 12 midday: Ward 4	Green =>85% Amber 81-84.9% Red <81%	Statutory		82.0%	79.4%	66.9%	79.8%	76.4%	66.5%	75.9%	84.3%	86.7%	84.4%	88.6%	96.7%		
			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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
IP21-4	Average Occupancy at Midnight: Ward 4	Green =>85% Amber 81-84.9% Red <81%	Statutory		91.0%	90.3%	81.2%	88.4%	93.5%	84.4%	85.8%	94.7%	93.1%	95.0%	98.7%	97.1%		
			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.														



Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
IP20-5	Average Occupancy at 12 midday: Ward 5	Green =>80% Amber 76%-79.9% Red <76%	Statutory		91.3%	91.3%	85.2%	90.2%	94.0%	85.5%	86.8%	96.3%	93.4%	96.1%	99.2%	71.1%		
			Narrative	The target has not been achieved. The exception report can be found below the final bed occupancy KPI presented. SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														

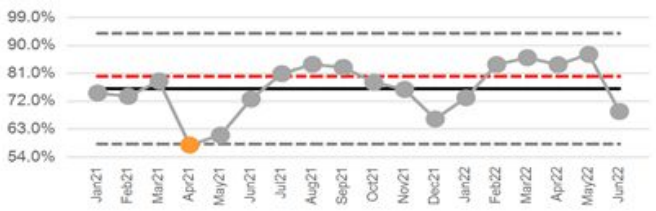


Integrated Performance Report (Jul 21 - Jun 22)

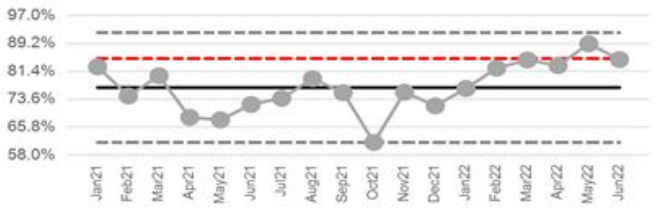
The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

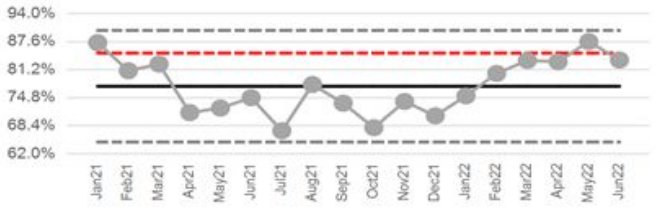
Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
IP21-5	Average Occupancy at Midnight: Ward 5	Green =>80% Amber 76%-79.9% Red <76%	Statutory		80.9%	83.9%	82.9%	78.1%	75.8%	66.2%	73.1%	83.8%	86.0%	83.8%	87.1%	68.7%		
				Narrative	The target has not been achieved. The exception report can be found below the final bed occupancy KPI presented. 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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
IP20-ST	Average Occupancy at 12 midday: ST Wards	Green =>85% Amber 81-84.9% Red <81%	Statutory		73.9%	79.3%	75.4%	61.5%	75.6%	71.7%	76.6%	82.3%	84.6%	83.0%	89.1%	84.7%		
				Narrative	ST ward bed occupancy is marginally below target this month. The exception report can be found below the final bed occupancy KPI presented. 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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
IP21-ST	Average Occupancy at Midnight: ST Wards	Green =>85% Amber 81-84.9% Red <81%	Statutory		67.2%	77.8%	73.5%	67.9%	73.9%	70.7%	75.2%	80.3%	83.3%	83.0%	87.6%	83.4%		
				Narrative	ST ward bed occupancy is marginally below target this month. The exception report can be found below the final bed occupancy KPI presented. 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)

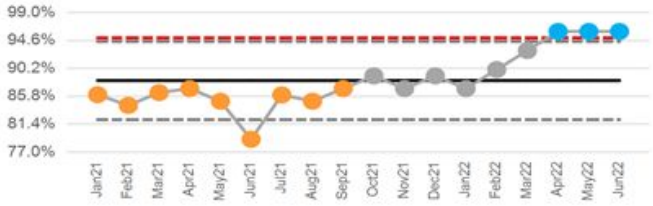
The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Reason for Non-Compliance	Action Taken to Improve Compliance
Bed Occupancy exception report: ST Wards and Ward 5. Following a month of occupancy above target, June solid tumour ward occupancy has fallen slightly and is marginally below the 85% target. Following 4 months above target, ward 5 occupancy has fallen significantly in June. This is because of a reduction in the numbers of transplant patients in May and June. TYA activity has also fallen in the same period. These figures are calculated on a total bed base of 90 beds. An additional 4 beds on Ward 3 have been designated as 'escalation beds' to help the trust and wider system with Winter/Covid pressures. These beds have not been used in June. Service changes have been made whereby mutual aid provision during Covid-19 has now appropriately become routine practice and will no longer be reported as such in this report. The PFT and the wider MDT continue to proactively discharge plan to ensure that patients are in the safest place for them during the Covid pandemic. The CUR non-qualifying rate for June is 7%, which provides some assurance that there was a low incidence of inappropriate utilisation of beds, however this figure has risen again this month, mirroring the continuing discharge challenges.	The CDU Nurse Consultant liaises with LUHFT AO on a daily basis to identify patients who are appropriate for transfer to CCC.

Escalation Route & Expected Date of Compliance
Divisional Quality, Safety and Performance Group', Divisional Performance Review, Performance Committee, Trust Board Expected Date of Compliance September 2022

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
IP23	% of expected discharge dates completed	Green =>95% Amber 90% - 94.9% Red <90%	Contractual		86.0%	85.0%	87.0%	89.0%	87.0%	89.0%	87.0%	90.0%	93.0%	96.0%	96.0%	96.0%		
			Narrative	Following a period of continuous improvement, the target has been achieved for the last 3 months.SPC: Although performance is higher than expected and there has been sustained improvement, there has not yet been sufficient improvement to provide assurance that the target will be consistently achieved.														



Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 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%		
			Narrative	No procedures have been cancelled on or after the day of admission.														

Data Not Applicable for SPC

Integrated Performance Report (Jul 21 - Jun 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

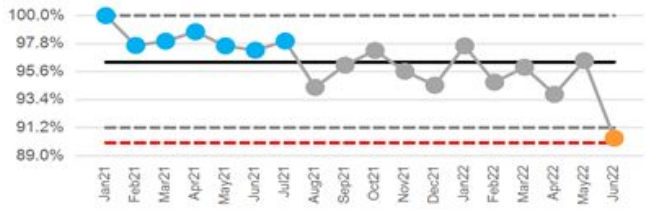
Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
IP25	% of cancelled elective procedures (on or after the day of admission) rebooked within 28 days of cancellation	Green 100% Red <100%	Contractual		-	-	-	-	-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

Data Not Applicable for SPC

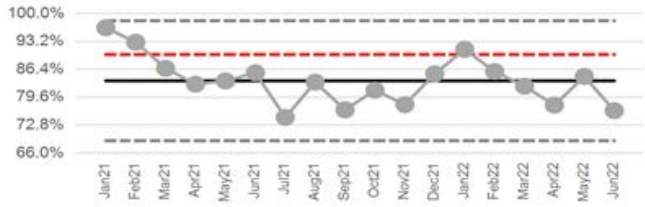
Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
IP26	% of urgent operations cancelled for a second time	Green 0% Red >0%	Contractual		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
			Narrative	No procedures have been cancelled for a second time.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
EF10	Imaging reporting turnaround (Inpatients)	Green >90% Amber 80-89.9% Red <80%			98.0%	94.4%	96.1%	97.3%	95.6%	94.5%	97.6%	94.8%	95.9%	93.8%	96.5%	90.4%		
			Narrative	The target continues to be achieved. SPC: Whilst June's performance is significantly lower than expected, the target remains outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
EF11	Imaging reporting turnaround (Outpatients)	Green >90% Amber 80-89.9% Red <80%			74.7%	83.3%	76.5%	81.3%	77.8%	85.3%	91.3%	85.9%	82.3%	77.7%	84.7%	76.3%		
			Narrative	The target has not been achieved in June. 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 (Jul 21 - Jun 22)

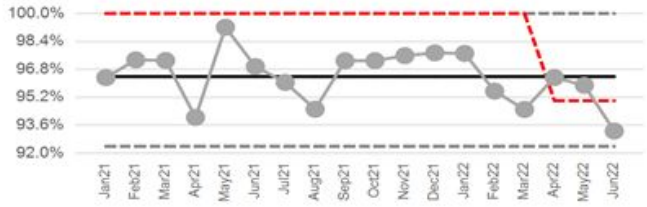
The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Reason for Non-Compliance	Action Taken to Improve Compliance
• Radiology activity has increased since CCCL opened, placing increasing demands on the Radiologist team • Loss of reporting capacity due to Radiologists supporting clinical services; Interventional Radiology and Ultrasound • CCC Radiologists are supporting additional MDT activity • Medica turnaround time targets are not being met.	• On-going outsourcing of reporting activity to Medica • On-going monitoring of Medica performance, with regular contract review meetings being held • Clinical Imaging Fellow started in September 2021 and then appointed to Consultant role, to start September 2022 • 1 interventional radiologist recruited and due to start in September 2022 • The recruitment of 2 further Radiologists and a Registrar post is planned for 2022/23 • Weekly report received by senior radiology team, enabling continuous monitoring and prioritisation of outstanding reports.

Escalation Route & Expected Date of Compliance
Divisional Quality, Safety and Performance Group', Divisional Performance Review, Performance Committee, Trust Board Expected Date of Compliance January 2023

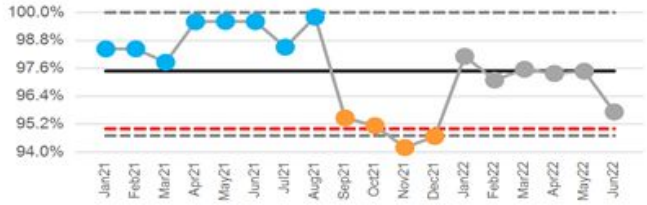
Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
DQ01	Data Quality - % Ethnicity that is complete (or patient declined to answer)	Green >=95% Amber 90-94.9% Red <90%	Covid-19 Recovery		96.0%	94.5%	97.3%	97.3%	97.6%	97.7%	97.7%	95.5%	94.5%	96.3%	95.9%	93.3%		
			Narrative	The target has not been achieved. The exception report provides further details, including actions taken to improve performance. SPC: There is however no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Reason for Non-Compliance	Action Taken to Improve Compliance
Due to staff unplanned leave, the text messages sent to patients requesting this information were delayed for 1 week in June. These 300 messages have now been sent, however the responses were not recorded on the patient records before the end of June.	The process has been amended, with text messages now sent daily rather than weekly and meditech is updated the following day. A member of the administration team has now been assigned to conduct closer weekly monitoring of the process.

Escalation Route & Expected Date of Compliance
Divisional Quality, Safety and Performance Meeting', Divisional Performance Reviews, Performance Committee, Trust Board Expected Date of Compliance July 2022

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
DQ02	Data Quality - % of outpatients with an outcome	Green =>95% Amber 90% - 94.9% Red <90%	Contractual		98.5%	99.8%	95.5%	95.1%	94.2%	94.7%	98.1%	97.1%	97.6%	97.4%	97.5%	95.7%		
			Narrative	The target continues to be achieved. SPC: There is however no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.The methodology for this KPI has been reviewed and data amended accordingly.														

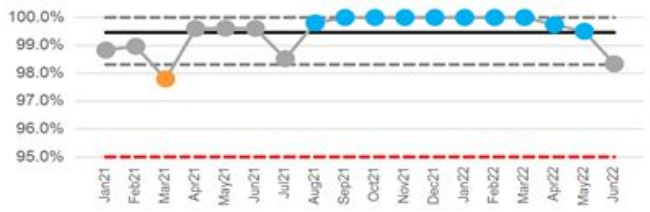


Integrated Performance Report (Jul 21 - Jun 22)

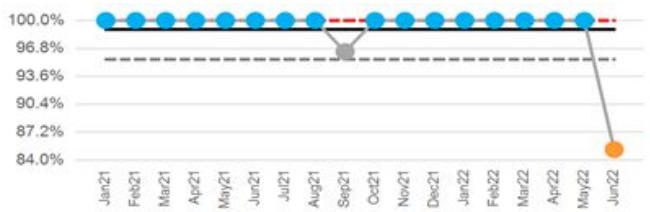
The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
DQ03	Data Quality - % of outpatients with an attend status	Green =>95% Amber 90% - 94.9% Red <90%	Contractual		98.5%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	99.5%	98.3%		
			Narrative	The target continues to be achieved. SPC: Although the June figure is significantly lower than expected based on past performance, the target remains outside SPC limits and is therefore likely to be achieved consistently. The methodology for this KPI has been reviewed and data amended accordingly.															



Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
EF01	Percentage of Subject Access Requests responded to within 1 month	Green 100% Red <100%	Contractual		100.0%	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	85.2%		
			Narrative	The target has not been achieved, following 8 consecutive months of compliance. The exception report provides further details, including actions taken to improve performance. SPC: Performance is lower than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Reason for Non-Compliance	Action Taken to Improve Compliance
During June, the administration team have experienced delays in obtaining this information due to reduced capacity (covid related sickness and vacancies) within the administration team and a rise in the number of requests. There were 23% more requests in Q1 2022/23 than in Q1 2021/22.	The administration team have developed a SOP (including an escalation process) which will be signed off by administration and clinical teams across the Trust.

Escalation Route & Expected Date of Compliance
Divisional Performance Reviews, Performance Committee, Trust Board Expected Date of Compliance July 2022

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 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%		
			Narrative	The target continues to be achieved.														

Data Not Applicable for SPC

Integrated Performance Report (Jul 21 - Jun 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 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 June.														

Data Not Applicable for SPC

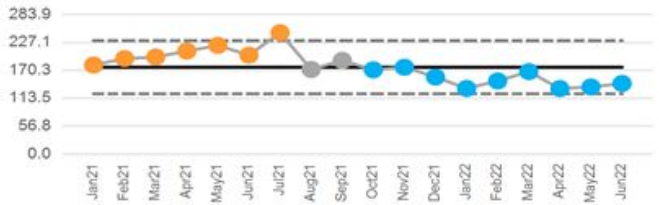
Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU04	Serious Incidents (SIs)	No Target	Contractual / Statutory		0	1	0	0	0	0	0	0	0	0	0	0		
				Narrative	The target continues to be achieved, with no Serious Incidents (SIs) this month. The target has been removed, at the request of our Commissioners.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU01	Serious Incidents: % submitted within 60 working days / agreed timescales	Green 100% Red <100%	Contractual / Statutory		100.0%	-	66.7%	-	-	-	-	-	-	-	-	-		
				Narrative	No SIs were due to be submitted in June 2022.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU03	Incidents /1,000 Bed Days	No Target	Statutory		247.0	172.0	190.4	171.3	176.6	156.6	133.4	148.6	167.6	133.1	136.3	143.5		
				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 (Jul 21 - Jun 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU05	All incidents resulting in moderate harm and above /1,000 bed days	No Target	Local		2.020	0.917	1.008	5.038	3.935	3.593	2.911	2.616	0.857	1.735	0.779	0.872		
			Narrative	There has been minimal change since May 2022. 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.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 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	1	0		
			Narrative	There were no falls resulting in harm due to a lapse in care in June.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU07	Inpatient falls resulting in harm due to lapse in care /1,000 bed days	Green 0 Red >0	Contractual		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.390	0.000		
			Narrative	There were no falls resulting in harm due to a lapse in care in June.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 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 June.														

Data Not Applicable for SPC

Integrated Performance Report (Jul 21 - Jun 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

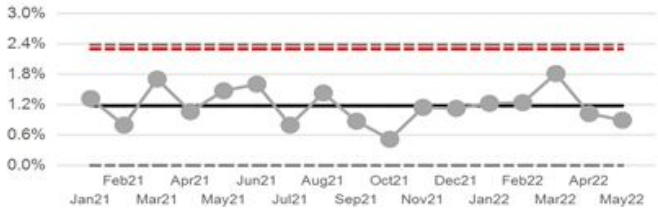
Quality

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 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 June.														

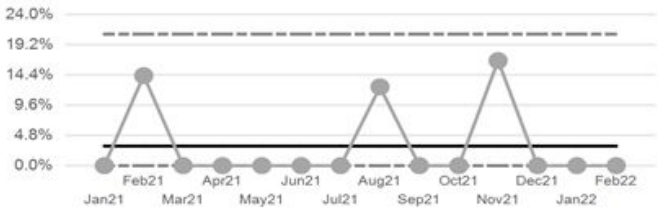
Data Not Applicable for SPC

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

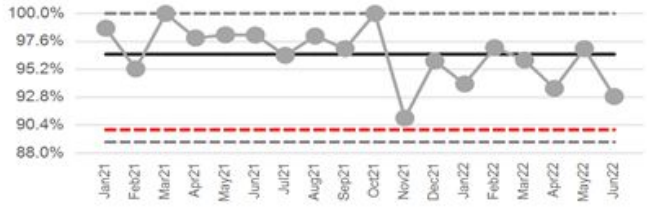


Integrated Performance Report (Jul 21 - Jun 22)

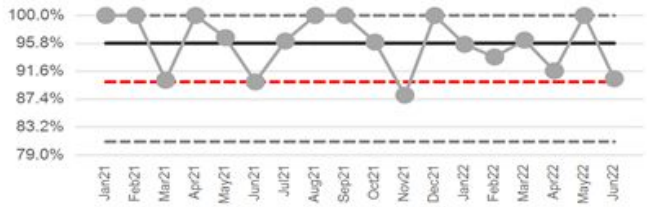
The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

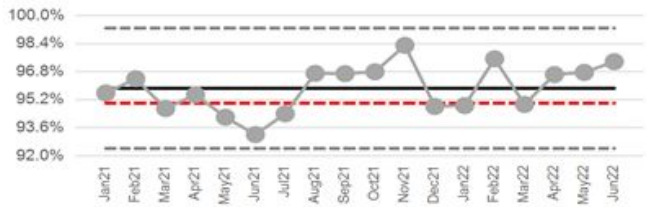
Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU62	Consultant review within 14 hours	Green >=90% Red <90%	Contractual		96.4%	98.1%	97.0%	100.0%	91.0%	95.9%	93.9%	97.1%	96.0%	93.5%	97.0%	92.9%		
			Narrative	The target has been achieved again in June.SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



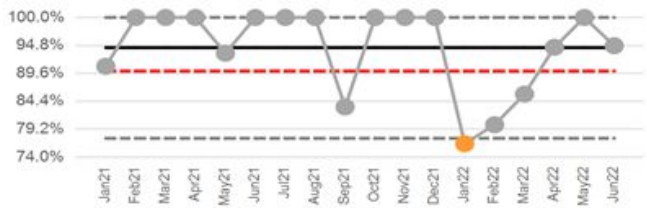
Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU48	Sepsis IV antibiotics within an hour	Green >=90% Red <90%	Contractual		96.2%	100.0%	100.0%	96.0%	88.0%	100.0%	95.7%	93.8%	96.3%	91.7%	100.0%	90.5%		
			Narrative	The target has been achieved again in June 2022; this is the 7th 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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU31	Percentage of adult admissions with VTE Risk Assessment	Green >=95% Red <95%	Contractual / Statutory		94.4%	96.7%	96.7%	96.8%	98.3%	94.8%	94.9%	97.5%	94.9%	96.6%	96.8%	97.4%		
			Narrative	The target has been achieved in June.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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU14	Dementia: Percentage to whom case finding is applied	Green >=90% Red <90%	Contractual		100.0%	100.0%	83.3%	100.0%	100.0%	100.0%	76.5%	80.0%	85.7%	94.4%	100.0%	94.7%		
			Narrative	The target has been achieved in June.SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. Whilst performance has improved, this is not yet sufficient to provide assurance that this will be maintained.														



Integrated Performance Report (Jul 21 - Jun 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

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

Data Not Applicable for SPC

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

Data Not Applicable for SPC

Metric ID	Metric Name	Target (Cumulat	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU34	Clostridium difficile infections (HOHA and COHA)	Green <=17 per year Red >17 per year	Contractual / Statutory		2	1	1	3	2	0	1	0	4	2	2	1		
			Narrative	The target has been achieved in June. There have now been 5 YTD against a threshold of 17 or fewer per year.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target (Cumulat	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU40	E. Coli bacteraemia (HOHA and COHA)	Green <=11 per year Red >11 per year	Contractual / Statutory		-	-	-	-	-	-	-	-	-	2	0	2		
			Narrative	The target has not been achieved, with 2 such infections in June. 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 2022.														

Data Not Applicable for SPC

Integrated Performance Report (Jul 21 - Jun 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Reason for Non-Compliance	Action Taken to Improve Compliance
2 HOHA E.coli bloodstream infections were identified in June 2022. Both were from a urinary source. One patient had a urinary catheter in situ on transfer from another Trust. There is no documentation relating to the length of time the catheter had been in situ or whether it was a long or short term catheter.	PIR findings discussed with Ward Manager and Matron. If patients are transferred from other healthcare providers with urinary catheters in situ, staff should contact the provider to establish when and why catheter was inserted. If this information is not available, the catheter should be changed.

Escalation Route & Expected Date of Compliance
Harm Free Care Meeting, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board Expected Date of Compliance August 2022

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

Data Not Applicable for SPC

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

Data Not Applicable for SPC

Metric ID	Metric Name	Target (Cumulat	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU43	Klebsiella (HOHA and COHA)	Green <=8 per year Red >8 per year	Contractual / Statutory		-	-	-	-	-	-	-	-	-	3	1	0		
			Narrative	The target has been achieved, with no such infections in June. Pre 2022/23 data is not available, as these infections were not categorised by, or assigned a target for COHA and HOHA before April 2022.														

Data Not Applicable for SPC

Integrated Performance Report (Jul 21 - Jun 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target (Cumulat	Target Type	Year & Month												
				Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU45	Pseudomonas (HOHA and COHA)	Green <=1 per year Red >1 per year	Contractual / Statutory	-	-	-	-	-	-	-	-	-	2	0	1		
			Narrative	The target has not been achieved, with 1 such infection in June. 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 2022.													

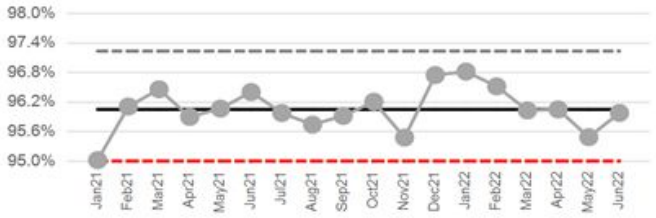
Data Not Applicable for SPC

Reason for Non-Compliance	Action Taken to Improve Compliance
1 HOHA P.aeruginosa bloodstream infection was identified in June 2022. This was initially treated as chest sepsis, however following IPC MDT it is apparent that P.aeruginosa has only been identified from line cultures, and is therefore indicative of a line infection.	Additional ANTT Peer Reviewers have been identified on the ward who will undertake refresher training in relation to ANTT with all staff

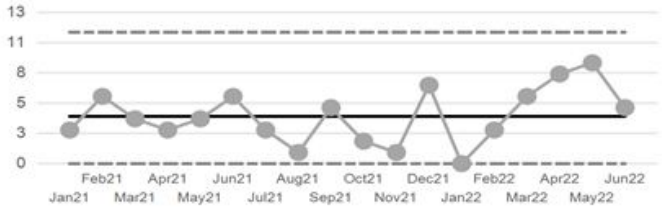
Escalation Route & Expected Date of Compliance

Harm Free Care Meeting, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board
Expected Date of Compliance August 2022

Metric ID	Metric Name	Target	Target Type	Year & Month												
				Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU75	Patient FFT: Percentage of respondents who were either likely or extremely likely to recommend to friends and family.	Green >=95% Amber 90% - 94.9% Red <90%	Contractual	96.0%	95.7%	95.9%	96.2%	95.5%	96.7%	96.8%	96.5%	96.0%	96.1%	95.5%	96.0%		
			Narrative	The target has been achieved again in June.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	Year & Month												
				Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU11	Number of Complaints	No Target	Contractual	3	1	5	2	1	7	0	3	6	8	9	5		
			Narrative	There were 5 complaints in June. 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.													



Integrated Performance Report (Jul 21 - Jun 22)

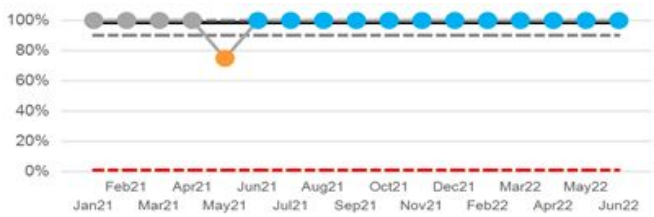
The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

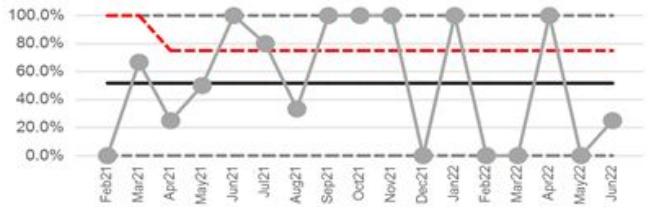
Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU18	Number of complaints / count of WTE staff (ratio)	No Target	Contractual		0.002	0.001	0.003	0.001	0.001	0.004	0.000	0.002	0.004	0.005	0.005	0.003		
			Narrative	There were 0.003 complaints per staff WTE in June. 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.															

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU19	% of formal complaints acknowledged within 3 working days	Green 1 Red <100%	Contractual		100%	100%	100%	100%	100%	100%	-	100%	100%	100%	100%	100%		
			Narrative	The target continues to be achieved, with all complaints acknowledged within 3 days. No complaints were received in January.SPC: Performance is identified as being higher than expected and the nature of variation indicates that the target is likely to be achieved.															



Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU20	% of routine complaints resolved within 25 working days	Green =>75% Amber 65% - 74.9% Red <65%	Local		80.0%	33.3%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	25.0%		
			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.															



Reason for Non-Compliance	Action Taken to Improve Compliance
3 out of 4 routine complaints responded to in June were resolved after the 25 working day target. Reasons for delays include staffing issues and inaccurate contact details provided by the complainant. 4 complex complaints were also resolved in June; these were all within the 60 working day target.	Ongoing complaints are discussed at the divisional quality and safety meetings to support timely response. Divisional teams have been reminded of the timescales involved in the complaint process, including for quality assurance and final Executive approval, to ensure all KPIs are met.

Escalation Route & Expected Date of Compliance
Divisional Quality, Safety and Performance meetings, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board Expected Date of Compliance Juy 2022

Integrated Performance Report (Jul 21 - Jun 22)

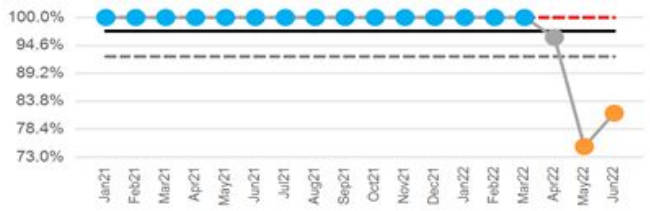
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU71	% of complex complaints resolved within 60 working days	Green =>75% Amber 65% - 74.9% Red <65%	Local		100.0%	-	0.0%	-	-	-	-	-	-	66.7%	-	100.0%		
				Narrative	The target has been achieved, with 4 complex complaints resolved within the 60 day target.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 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%	96.2%	75.0%	81.5%		
				Narrative	The target has not been achieved. The exception report provides further details, including actions taken to improve performance. SPC: Performance is significantly lower than expected for June, however the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Reason for Non-Compliance	Action Taken to Improve Compliance
Whilst 10 FOI responses exceeded the 20 working day turn around period in June, the number completed has increased significantly from 8 in May to 54 in June. Staff absences in the team throughout May continue to negatively impact capacity to undertake the increased FOI workload.	FOI Administrator now in full time, supported by the Information Governance Manager. However as predicted, the staffing issues have affected compliance for a second month.

Escalation Route & Expected Date of Compliance
Information Governance Board, Risk and Quality Governance Committee, Quality Committee, Trust Board Expected Date of Compliance July 2022

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU22	Number of IG incidents escalated to ICO	Green 0 Red >0	Contractual / Statutory		0	0	0	0	0	1	0	0	0	0	0	0		
				Narrative	The target continues to be achieved, with no IGC incidents escalated to the ICO in June.													

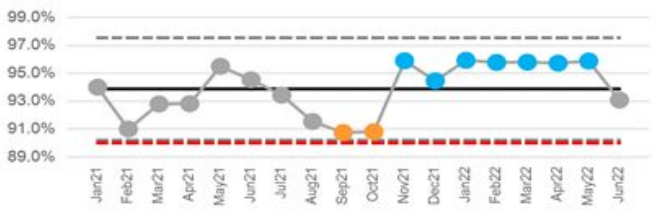
Data Not Applicable for SPC

Integrated Performance Report (Jul 21 - Jun 22)

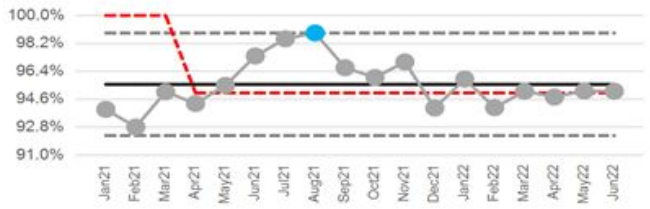
The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU60	NICE guidance compliance	Green =>90% Amber 85 - 89.9% Red <85%	Contractual		93.4%	91.5%	90.7%	90.8%	95.9%	94.5%	95.9%	95.8%	95.8%	95.7%	95.9%	93.1%		
			Narrative	The target continues to be achieved. SPC: Following a period of higher than expected performance, this is just below average for June. Despite this, the target remains outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
QU23	% of policies in date	Green >=95% Amber 93.1 - 94.9% Red <93%	Contractual		98.5%	98.9%	96.6%	96.0%	97.0%	94.0%	95.9%	94.1%	95.1%	94.7%	95.1%	95.1%		
			Narrative	Following a decrease in performance in April 2022, the target has been achieved in May and June. 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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 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.														

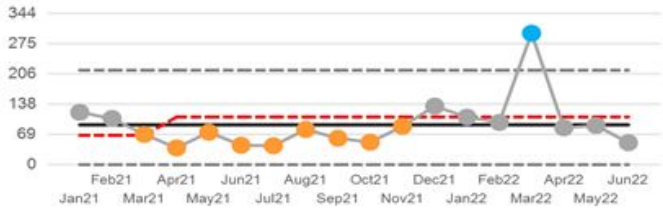
Data Not Applicable for SPC

Integrated Performance Report (Jul 21 - Jun 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

Metric ID	Metric Name	Target (Cumulat	Target Type	Year & Month												V	A
				Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22		
RI20	Study recruitment	Green >=1300 per year Amber 1100-1299 per year Red <1100 per	CCC Strategy	43	80	60	51	87	133	108	96	299	84	89	50		
			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.													



Reason for Non-Compliance	Action Taken to Improve Compliance
223 patients have been recruited against an internal target of 324 (69% of target) at the end of Month 3. The main reasons at Month 3 for not achieving this target are: • A strategic, clinically-led decision was made in December 2021 to prioritise the set-up and opening of ECMC studies to recruitment. ECMC studies are scientifically relevant but by nature recruit lower patient numbers. • Two key studies which are high recruiters are currently paused to recruitment by the Sponsor. • Due to limited drug studies opening during 21/22 the pipeline of studies opening has been affected. The pipeline is gradually starting to recover. • Recruitment will ebb and flow throughout the year and in-month targets may not be met. • Networked funded Clinical Research Fellow (CRF) who recruited high numbers onto Observational studies has come to the end of their fixed-term contract. This post will be replaced by an Early Phase CRF who will support recruitment to ECMC/Early phase studies which are low recruiters. • Two Research Officers are currently out to interview meaning observational recruitment is down. • Two key studies which were anticipated to be high recruiters have not recruited as expected. One study closed early due to low recruitment, this was a COVID-19 health and wellbeing study (only 64 staff recruited from an anticipated 300) and the pathway for a second study, involving end of life care was not working and is currently being reviewed (only 5 patients recruited out of an anticipated 50). • COVID-19 recruitment has slowed significantly, with no recruitment to COVID-19 studies this year. NB: two first-in-human patients were treated this during June 2022: - IMC-C103C (PI: Dr Sacco, Various (Melanoma)). - MOAT (CI: Professor Ottensmeier, Head & Neck).	• Continuing to work collaboratively with service departments and research-active staff to open all studies types in a timely way. • Full recovery plan requested from Pharmacy now that the Clinical Trials Team will be at full complement from 1st August 2022. • Reviewing all open studies to ensure optimised recruitment. A dashboard has been prepared which details all studies types and if they are on track with regards to the agreed target. Targets are reviewed quarterly at the Portfolio Review meetings. Portfolio Reviews are attended by the relevant consultants including the SRG Research Leads, the Lead Research Practitioner and key service support staff. There may be occasions, for example a short recruitment window, where the target is reviewed more frequently • Ensuring observational studies are fast tracked to opening and recruitment started as quickly as possible. • 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.
Escalation Route & Expected Date of Compliance	
SRG Research Leads, Committee for Research Strategy, Performance Committee, Trust Board Expected Date of Compliance March 2023	

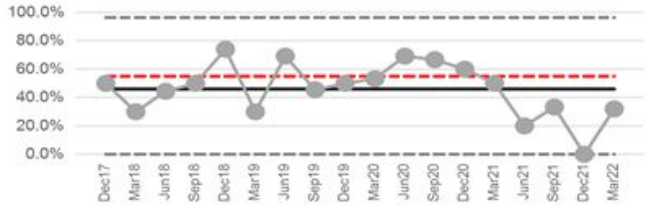
Metric ID	Metric Name	Target	Target Type	Year & Month												V	A
				Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22		
RI03	Study set-up times in days	Green <=40 days Red >40	National Reporting	-	-	29	-	-	30	-	-	24	-	-	-		
			Narrative	This data is for the 12 month period up to the reported month. The figure for the period ending in March 2022 has recently been published and meets the target. SPC: Performance is better than expected and the target has been achieved since Dec 2019, which provides assurance that the target will continue to be met.													

Integrated Performance Report (Jul 21 - Jun 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

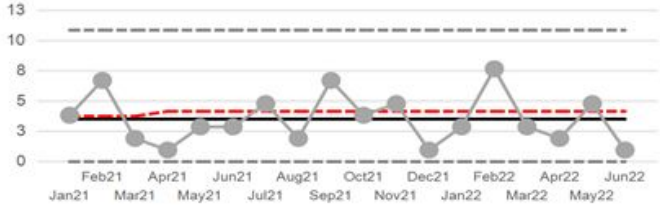
Metric ID	Metric Name	Target	Target Type	Year & Month												V	A
				Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22		
RI21	Recruitment to time and target	Green >=55% Amber 45 - 54.9% Red <45%	National Reporting	-	-	33.3%	-	-	0.0%	-	-	32.0%	-	-	-		
			Narrative	Data is for the 12 month period up to the reported month. The figure for the period ending in March 22 has recently been published and does not meet the target - exception report below.SPC: There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Reason for Non-Compliance	Action Taken to Improve Compliance
• CCC data are skewed due to the low number of studies submitted (n=3). • The target is an internal metric; no national metric is available.	• Continuous review of current trial information to predict and manage Time and Target data in real time via Portfolio Review meetings. • A dashboard has been prepared which details all studies types and if they are on track with regards to the agreed target. Targets are reviewed quarterly at the Portfolio Review meetings. Portfolio Reviews are attended by the relevant consultants including the SRG Research Leads, the Lead Research Practitioner and key service support staff. There may be occasions, for example a short recruitment window, where the target is reviewed more frequently.

Escalation Route & Expected Date of Compliance
SRG Research Leads, Committee for Research Strategy, Performance Committee, Trust Board Expected Date of Compliance March 2023

Metric ID	Metric Name	Target (Cumulat	Target Type	Year & Month												V	A
				Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22		
RI05	Number of new studies open to recruitment	Green >=52 per year Amber 45 - 51 Red <45	CCC Strategy	5	2	7	4	5	1	3	8	3	2	5	1		
			Narrative	The target of 5 per month was not achieved in June. 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.													



Reason for Non-Compliance	Action Taken to Improve Compliance
• Eight studies have opened to recruitment against an internal target of 13 (62% of target) at the end of Month 3. At the same time point last year we had opened seven studies. • One study opened in month. This is due to the next tranche of drug trials, as prioritised by the Study Prioritisation Committee, moving through the set-up process whilst the non-CTIMP studies are under contract review. This therefore forms a lead time on studies opening to recruitment in month. • Studies opened will ebb and flow throughout the year and in-month targets may not be met. • CCC has issued local approval for capacity and capability (C&C) for six additional studies. Due to sponsor requirements, Pharmacy has a second stage approval following C&C when the Site Initiation Visit (SIV) has been completed. This is to respond to any new information introduced by the Sponsor at the SIV. Currently four studies are awaiting second stage approval from Pharmacy and two studies are awaiting activation by the Sponsor.	• Work with the Clinical Trial Pharmacy team to open new drug studies. • Work with the Director of Clinical Research to prioritise the opening of appropriate studies. • Work with the SRG Research Leads and the Network to optimise opportunities with observational studies. • Work with Sponsors to greenlight study where all local approvals have been given. • Work with Pharmacy to ensure second-stage approval following SIV is completed within 2-weeks.

Escalation Route & Expected Date of Compliance
SRG Research Leads, Committee for Research Strategy, Performance Committee, Trust Board Expected Date of Compliance March 2023

Integrated Performance Report (Jul 21 - Jun 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

Metric ID	Metric Name	Target (Cumulat	Target Type	Year & Month												
				Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
RI22	Publications	Green >200 per year Amber 170-200 Red <170	CCC Strategy	23	23	19	23	29	17	23	9	12	10	15	16		
			Narrative	Performance is marginally below target. 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.													

Reason for Non-Compliance	Action Taken to Improve Compliance
• Forty-one research publications have been registered from April to June 2022, against an internal target of fifty at the end of Month 3 (82% 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. At the same time point last year we had registered twenty-three publications.	• Work with the Library Services to ensure all publications are captured. • Work with the Director of Clinical Research each month 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.

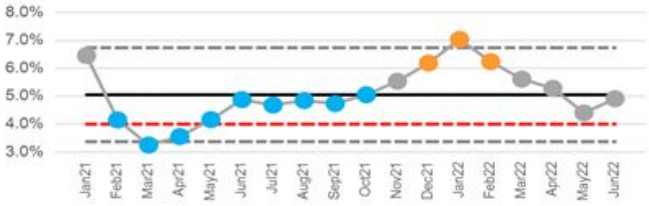
Escalation Route & Expected Date of Compliance
SRG Research Leads, Committee for Research Strategy, Performance Committee, Trust Board Expected Date of Compliance March 2023

Integrated Performance Report (Jul 21 - Jun 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

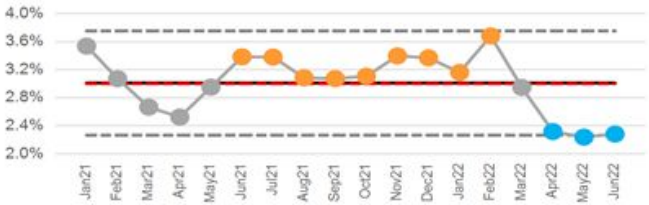
Workforce

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
WO01	Sickness absence	Green <=4% Amber 4.1 - 4.9% Red >=5%	Contractual / Statutory		4.7%	4.8%	4.7%	5.1%	5.5%	6.2%	7.0%	6.2%	5.6%	5.3%	4.4%	4.9%		
			Narrative	The target has not been achieved. The exception report is located at the end of the sickness absence KPIs. SPC: June'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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
WO20	Sickness absence (short term)	Green <=1% Amber 1.1 - 1.2% Red >=1.3%	Contractual / Statutory		1.7%	1.8%	1.9%	2.1%	2.2%	3.1%	3.8%	2.2%	2.7%	3.0%	2.2%	2.6%		
			Narrative	The target has not been achieved. The exception report is located at the end of the sickness absence KPIs. SPC: June's figure is higher than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.														

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
WO21	Sickness absence (long term)	Green <=3% Amber 3.1 - 3.5% Red >=3.5%	Contractual / Statutory		3.4%	3.1%	3.1%	3.1%	3.4%	3.4%	3.2%	3.7%	2.9%	2.3%	2.2%	2.3%		
			Narrative	The target has been achieved for the fourth consecutive month.SPC: Following a period of higher than expected levels of long term sickness absence, this has been lower than expected since April 2022. The nature of variation indicates that achievement of the target is likely to be inconsistent.														



Integrated Performance Report (Jul 21 - Jun 22)

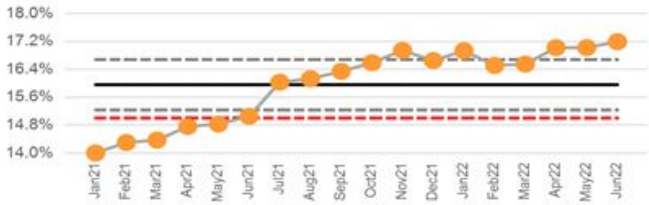
The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Reason for Non-Compliance	Action Taken to Improve Compliance
Sickness Absence exception report: Total and short term sickness absence. Sickness absence has increased for the first time in 3 months; from 4.4% in May 2022 to 4.91% in June 2022. The 3 main absence reasons in June were Chest and Respiratory (90 episodes), Gastrointestinal problems (52) and Cold, Cough Flu – Influenza (35). Trust Covid-19 absences have increased in line with community prevalence. Of the 90 episodes of Chest and Respiratory, 65 episodes have been recorded as Covid-19 related. Networked Services had the highest number of Chest and Respiratory episodes in June, with 39. Radiation Services had 31 and Acute Care 14. Gastrointestinal problems remains a main reason for absence and has increased in month (52 episodes). Acute Care had the highest number of such episodes in June, with 18. Networked Services had 17 and Radiation Services had 10. In June, Stress/ Anxiety/ Depression was not in the top 3 absence reasons for the first time since January. There has been an increase in Cold, Cough and Flu (not COVID related). Short term sickness has increased from 2.16% in May to 2.63% in June. The highest reason for short term sickness absence was Chest and Respiratory with 80 episodes (64 recorded as Covid-19). The division with the highest level of short term sickness is Networked Services with 97 episodes in total.	• HRBP team to continue to discuss with relevant managers the reasons for the sudden increase in gastrointestinal absences and identify any patterns/trends in teams where it is particularly high. • HRBP to work closely with Networked Services to understand the reasons for absences being high across the division and offer necessary support and ensure adherence to the Attendance Management Policy. • 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. • HRBP team to continue to monitor Anxiety/Stress/Depression related absences across the divisions and ensure staff are aware of support available in a timely manner to avoid this resulting in sickness absence where possible. • HRBP team will liaise with infection control in relation to the rise of gastrointestinal absences across the Trust to consider any seasonal impact and any further support required.

Escalation Route & Expected Date of Compliance
Divisional Meetings, Performance Review Meetings, Workforce Advisory Committee, People Committee, Trust Board Expected Date of Compliance November 2022

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
WO02	% Turnover (Rolling 12 months)	Green >=15% Amber 14.1%-14.9% Red <=14%			16.0%	16.1%	16.3%	16.6%	16.9%	16.7%	16.9%	16.5%	16.6%	17.0%	17.0%	17.2%		
			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 turnover and the nature of variation indicates that the target is unlikely to be achieved without a significant change.														



Integrated Performance Report (Jul 21 - Jun 22)

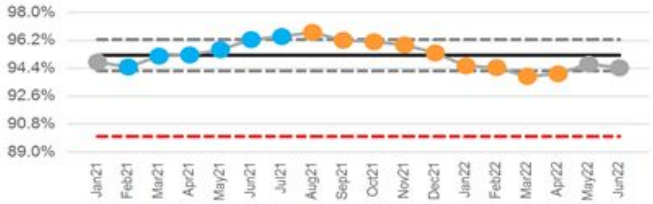
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

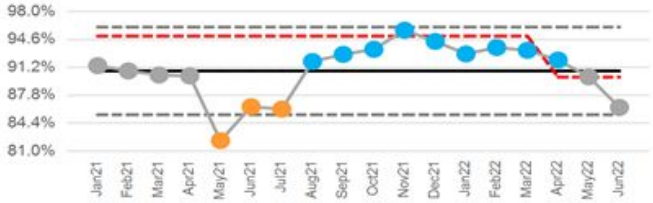
Reason for Non-Compliance	Action Taken to Improve Compliance
The number of leavers for June 2022 has remained the same as in May at 20. The highest number of leavers in June were from the three clinical divisions, with 5 each. 'Voluntary Resignation - Relocation' and 'Voluntary Resignation - Work life balance' were the joint highest reasons for leaving in June, with 4 in each category. Of the staff who declared they were leaving due to work life balance, 3 moved to Public/Private Sector and 1 secured a position at LUHFT. Of the staff who left due to work life balance (and provided detail), 1 desired more home working (flexibility with shift patterns was however offered); 1 had on going personal issues and felt a new job role would be more appropriate and 1 expressed dissatisfaction with travel and car parking. For those who voluntarily resigned for relocation reasons, 2 leavers have relocated abroad and 2 have moved to other Public Sector organisations. 'Other/Not known' was the second highest reason for leaving with 3 leavers. As part of our focus on retention, the HRBP team are reviewing exit information that states Other/ Unknown and following this up with managers. 7 of the 20 leavers completed an exit interview questionnaire (35%); this is an increase of 6 from last month. From analysis of the exit interviews, in addition to their main reasons for leaving, the following reasons were cited as factors that also influenced their decision: • End of Fixed Term Contract • Lack of development/career progression • New post within the NHS • Workload pressure	• The HRBP Team will continue to drive towards holding face to face exit interviews with leavers to ensure we continue to review and identify trends across staff groups, divisions, age groups etc which will support with developing a feedback process. • The HRBP Team to offer/capture exit interviews for internal movements as this feedback is also important. • The HRBP team continue to support managers with Hybrid and Flexible Working requests both in HR surgeries and through training sessions to ensure this is applied consistently across the Trust. • The HRBP Team to continue to review reasons for leaving stating incompatible work relationships and work life balance to make sure staff are supported/retaining where possible. • HRBP Team to ensure that staff and line managers are recording leaving reason as the most appropriate and discourage the use of Other/Not known via an educational piece.

Escalation Route & Expected Date of Compliance
Divisional Meetings, Performance Review Meetings, Workforce Advisory Committee, People Committee, Trust Board Expected Date of Compliance November 2022

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
WO07	Statutory Mandatory Training compliance	Green >=90% Amber 76 - 89% Red <=75%	Contractual / Statutory		96.4%	96.7%	96.2%	96.1%	95.9%	95.4%	94.6%	94.4%	93.9%	94.0%	94.7%	94.4%		
			Narrative	The target has been achieved again in June 2022.SPC: Following a period of higher (to July 2021) and then lower than expected performance, May and June's figures are 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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
WO22	Performance Development Reviews (PADR) snapshot month end	Green >=90% Amber 76 - 89% Red <=75%	Contractual		86.1%	91.9%	92.8%	93.4%	95.7%	94.4%	92.8%	93.6%	93.3%	92.1%	90.0%	86.3%		
			Narrative	The target has not been achieved in June. The exception report provides further details, including actions taken to improve performance. SPC: May and June's performance is now identified as within normal variation. The nature of variation indicates that achievement of the target is likely to be inconsistent.														



Integrated Performance Report (Jul 21 - Jun 22)

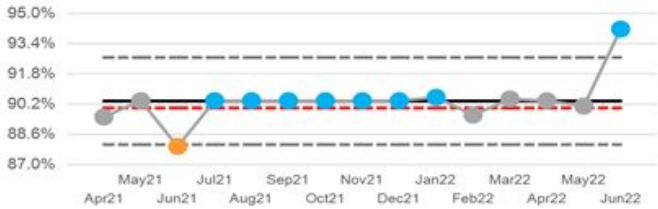
The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Reason for Non-Compliance	Action Taken to Improve Compliance
Overall, Trust compliance has decreased from 90% to 86%, with 159 staff non-compliant with PADR. On reviewing compliance data with divisions, a number of managers have indicated that PADRs have been completed, however they had not updated ESR to reflect this.	• Escalation via Workforce Advisory Group with a target set for divisional achievement of PADR compliance by 31st August 2022. • Additional communications to managers on the importance of updating ESR in a timely manner on completion of a PADR • A review of the PADR system is currently underway to identify any areas of enhancement • Audit linked to pay progression underway • Divisions underperforming against the KPI to record this as a divisional risk • The L&OD Team will continue to work with divisions to support them in achieving compliance, but more importantly to ensure that all staff have a meaningful and purposeful annual appraisal conversations • PADR training for both staff and managers continues to be available • Automated ESR notifications continue to be sent to managers and staff member, 4, 3, 2 and 1 month before the PADR is due, alongside monthly reports from the L&OD Team

Escalation Route & Expected Date of Compliance
Divisional Meetings, Performance Review Groups, Workforce Advisory Committee, People Committee, Trust Board Expected Date of Compliance September 2022

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
WO23	Medical Appraisal	Green >=90% Amber 76 - 89% Red <=75%	Contractual / Statutory		90.4%	90.4%	90.4%	90.4%	90.4%	90.4%	90.6%	89.6%	90.5%	90.4%	90.1%	94.2%		
			Narrative	The target has been achieved for the third consecutive month.SPC: June's 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	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
WO24	Pulse Staff Survey: Employee Engagement Score	To Be Confirmed	Contractual		-	-	-	-	-	-	-	-	7.00	-	-	6.90		
			Narrative	The targets will be agreed at Workforce Advisory Group in July 2022 and will be included in the M4 IPR.														

Data Not Applicable for SPC

Integrated Performance Report (Jul 21 - Jun 22)

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
WO25	Pulse Staff Survey: Advocacy score	To Be Confirmed	Contractual		-	-	-	-	-	-	-	-	7.40	-	-	7.10		
			Narrative	The targets will be agreed at Workforce Advisory Group in July 2022 and will be included in the M4 IPR.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
WO26	Pulse Staff Survey: Involvement score	To Be Confirmed	Contractual		-	-	-	-	-	-	-	-	6.80	-	-	6.80		
			Narrative	The targets will be agreed at Workforce Advisory Group in July 2022 and will be included in the M4 IPR.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	V	A
WO27	Pulse Staff Survey: Motivation score	To Be Confirmed	Contractual		-	-	-	-	-	-	-	-	6.80	-	-	6.90		
			Narrative	The targets will be agreed at Workforce Advisory Group in July 2022 and will be included in the M4 IPR.														

Data Not Applicable for SPC

Integrated Performance Report (Jul 21 - Jun 22)

Finance

Metric (£000)	In Mth 3 Actual	In Mth 3 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	367	357	10		418	405	13	
CPL/Propcare Surplus/ (Deficit)	(21)	0	(21)		191	0	191	
Control Total Surplus/ (Deficit)	346	357	(11)		609	405	204	
Trust Cash holding	62,692	52,610	10,082		62,692	52,610	10,082	
Capital Expenditure	49	50	1		162	50	(112)	
Agency Cap	116	95	(21)		229	285	56	

For 2022/23 the Cheshire & Merseyside ICS are managing the required financial position of each Trust through a whole system approach. The Trust submitted an updated plan on 20th June 2022 showing a £1.621m surplus. This £1.3m increase to the plan was due to additional inflation of 0.7% applied to NHSE and CCG contracts of £0.8m and £0.5m brokerage. 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 June is a £418k surplus, which is £13k above plan. The group position to the end of May is a £609k surplus. The Trust cash position is a closing balance of £62.7m, which is £10m above plan. Capital spend is £49k in month with capital spend YTD being low in line with plan.

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1
27th July 2022

Report author	Joanne Bowden, Deputy Director of Finance				
Paper prepared by	James Thomson, Director of Finance				
Report subject/title	P1-138-22 Finance Report – Month 3 2022/23				
Purpose of paper	Present the Trust's financial position				
Background papers	N/a				
Action required	To note the contents of the report				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work		
	Be Collaborative		Be Digital		
	Be Research Leaders		Be Innovative		

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

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOREPO
Review: July 2025
Version: 2.0

The Clatterbridge Cancer Centre NHS Foundation Trust

1. Introduction

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

Metric (£000)	In Mth 3 Actual	In Mth 3 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	367	357	10		418	405	13	
CPL/Propcare Surplus/ (Deficit)	(21)	0	(21)		191	0	191	
Control Total Surplus/ (Deficit)	346	357	(11)		609	405	204	
Trust Cash holding	62,692	52,610	10,082		62,692	52,610	10,082	
Capital Expenditure	49	50	1		162	50	(112)	
Agency Cap	116	95	(21)		229	285	56	

2.2 For 2022/23 NHS Cheshire & Merseyside ICB are managing the required financial position of each Trust through a whole system approach. The Trust submitted an updated plan to NHSE/I on 20th June 2022 showing a £1.621m surplus. This £1.3m increase to the plan is due to additional inflation funding of 0.7%, applied to commissioning contracts of £0.8m and £0.5m brokerage. 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 The Trust financial position to the end of June is a £418k surplus, which is £13k above plan. The group position to the end of May is a £609k surplus. The Trust cash position is a closing balance of £62.7m, which is £10m above plan.

The Trust is over the agency cap in June by £21k. Although the cumulative position is showing a £56k positive variance, it will need to be monitored closely over the financial year. Further detail has been provided below.

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

The Clatterbridge Cancer Centre NHS Foundation Trust

Metric (£000)	Actual M3	Trust Plan M3	Variance	Actual YTD	Trust Plan YTD	YTD Variance	Trust Annual Plan
Clinical Income	18,471	18,844	(374)	55,579	56,027	(448)	224,004
Other Income	1,998	2,167	(169)	5,540	6,629	(1,089)	23,384
Total Operating Income	**20,469**	**21,011**	**(542)**	**61,120**	**62,656**	**(1,537)**	**247,388**
Total Operating Expenditure	(19,761)	(20,308)	547	(59,728)	(61,211)	1,483	(241,607)
Operating Surplus	**708**	**703**	**4**	**1,392**	**1,445**	**(53)**	**5,781**
PPJV	12	67	(55)	110	201	(91)	804
Finance Costs	(353)	(414)	61	(1,083)	(1,241)	158	(4,964)
Trust Surplus/Deficit	**367**	**357**	**10**	**418**	**405**	**13**	**1,621**
Subsiduaries	(21)	0	(21)	191	0	191	**0**
Consolidated Surplus/Deficit	**346**	**357**	**(11)**	**609**	**405**	**204**	**1,621**

The table below summaries the consolidated financial position:

June 2023 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	285	173
Donated Depreciation	82	245
Trust Retained Surplus / (Deficit)	**367**	**418**
CPL	38	137
Propcare	(59)	54
Consolidated Financial Position	**346**	**609**

3.3 The bridge below shows the key drivers between the £367k in month surplus and £357k surplus plan, which is a variance of £10k:

- Elective Recovery Fund (ERF) income for activity over 104% of 2019/20 has been assumed at 25% of plan for month 3 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.

- Block drugs are under spent by £33k in month. High cost drugs are underspent by £129k, this is offset by a reduction in clinical income. As part of the 2022/23 funding agreement with commissioners high cost drugs remain on a pass-through basis.

- A prudent view of the drugs income over and above plan for months 1 and 2 was taken, while contracting data was under review. This has now been confirmed via freeze and an additional £311k has been included in the position at month 3.

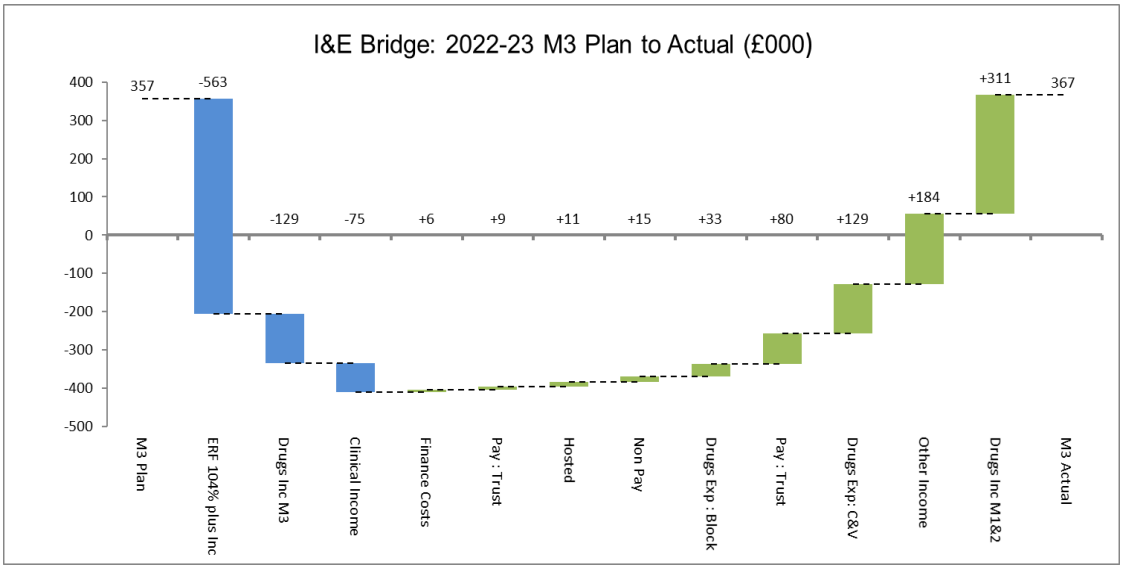
- Pay costs are underspent by £9k, in terms of run rate Divisional pay spend has increased by £165k compared to month 2.

- Bank spend remains high at £129k which is in line with to previous months, this is mainly due to vacancies and sickness cover.

- Agency has increased significantly to £116k which takes the Trust over the agency cap in month.

- Non-Pay costs are showing an under spend of £16k. This takes into account the efficiency programme.

- Other income includes £80k for additional PET CT activity which is expected to continue.



3.4 Elective Recovery Fund Position

3.4.1 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 receive £701k from CCGs and £3.1m from NHSE if the Trust achieve this level of activity. For month 3 reporting the Trust has assumed receipt of the ERF income up to 104% of activity.

3.4.2 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. This is consistent with the annual activity assumptions.

3.4.3 The plan for the ERF over 104% is £751k per month. The Trust has assumed 25% of this in the month 3 position to hold to a planned outturn position. The Trust is currently reviewing the ERF methodology and process with NHS England Specialised Commissioning to ensure that cancer pathway activity is appropriately recognised. It is expected that this will be resolved in Q2.

In gross activity terms, the Trust has significantly over performed against the 2019/20 ERF baseline.

3.5 Bank and Agency Reporting

Bank spend in June remains high at £124k, which is in line with the previous two months. The largest user of bank staff is the Acute Division. The main reasons for bank spend is to cover vacancies and increased sickness.

Agency spend in month is £116k, this has increased significantly since last month. The Trust is reporting £21k over the agency cap in month. Whilst cumulatively the Trust is still under the agency cap this will need to be monitored.

The agency spend is split across three main areas – Medical £55k, Healthcare Scientists £23k and Nursing £34k, all falling within Acute Care. Whilst the Directorates would usually use NHSP for Nursing, we only have our own permanent staff registered on NHSP and they have already worked their maximum hours allowable. To ensure safer staffing it has been agreed agency can be used on an interim basis whilst the Division have a large number of vacancies.

See Appendix F for further detail.

3.6 Cost Improvement Programme (CIP)

The Trust CIP requirement for 2022/23 is £6.765m, representing 4.5% of turnover.

This is broken down into £4.4m recurrent and £2.3m 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 3 against the expected year to date target of £1.7m there is a shortfall of £638k. Against the full year CIP target of £6.7m, £4.2m of schemes have been identified (62%). £1.4m have been identified recurrently (33%).

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

The Clatterbridge Cancer Centre NHS Foundation Trust

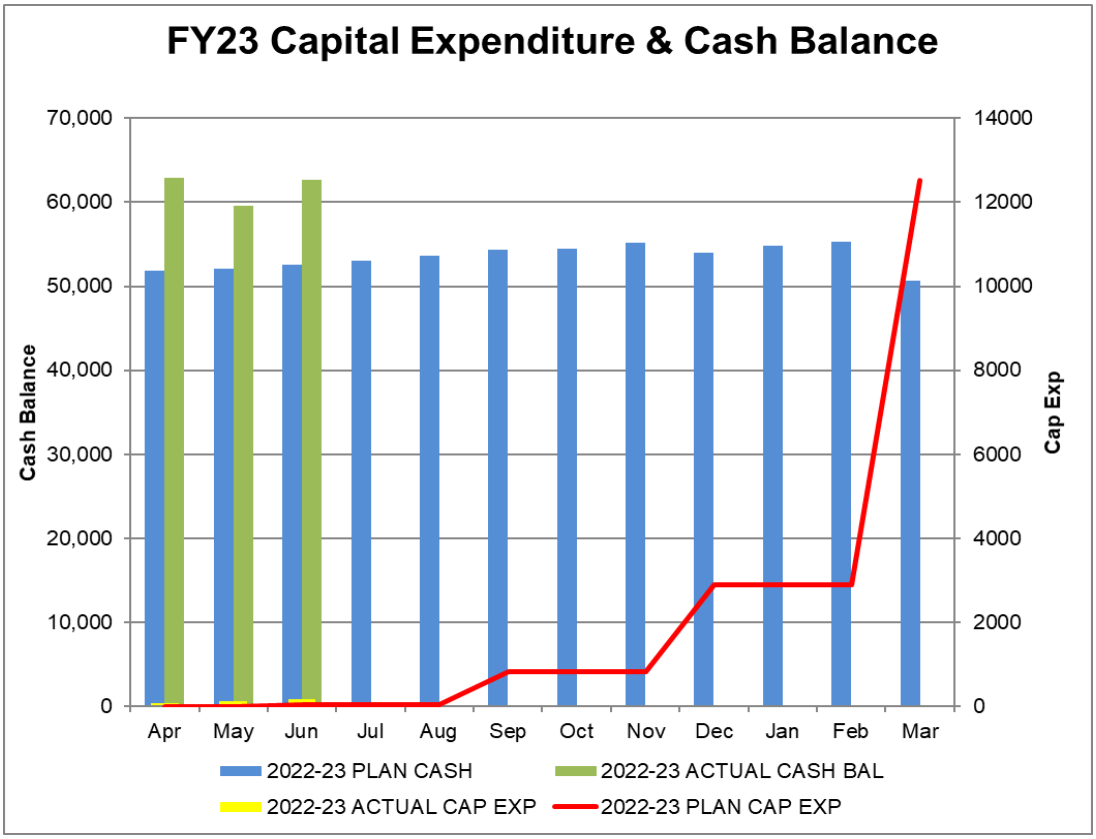
4. Cash and Capital

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. We have however agreed with Wirral University Teaching Hospital NHS FT that they will lead the CDC capital programme and that the PDC will be transferred to them.

4.2 Capital expenditure of £162k has been incurred to the end of June. The majority of capital spend is profiled to be spent in the second half of the year. Capital Investment Group closely monitor the position to ensure any slippage risk is identified and mitigated.

4.3 The capital programme is supported by the organisation's cash position. The Trust has a current cash position of £62.6m, which is a positive variance of £10m 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.

The Clatterbridge Cancer Centre NHS Foundation Trust

5. Balance Sheet Commentary

5.1 Current Assets

The Trust's cash balance at the end of June is £62.6m, this is £10m above plan figure of £52.6m and is due to two main reasons. There are still £3m capital creditors from 2021/22 to be paid. Also, due to the ICBs faster reporting requirement the Trust closed down accounts payable two days earlier than usual. This is a one-off benefit with an impact of £3.7m. Accruals have been made to compensate for the change in process.

Receivables are below plan, demonstrating that debt is being collected promptly.

5.2 Current Liabilities

Payables (non-capital creditors) are £3.6m below plan. This is positive and demonstrates that creditors are being paid promptly.

Deferred Income is £8.4m 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

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

- The reported surplus position for July 2022
- The risk regarding ERF and the efficiency programme
- The continuing strong liquidity position of the Trust

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix A – Statement of Comprehensive Income (SOCI)

(£000)	Month 3			YTD				2022/23
	Plan	Actual	Variance	Plan	Actual	Variance	%	Annual Plan
Clinical Income	18,723	18,267	(456)	55,780	55,251	(529)		223,121
Other Income	1,044	1,144	100	2,392	2,665	272		9,347
Hosted Services	1,244	1,058	(186)	4,484	3,204	(1,280)		14,920
Total Operating Income	**21,011**	**20,469**	**(542)**	**62,656**	**61,120**	**(1,537)**	**2%**	**247,388**
Pay: Trust (excluding Hosted)	(6,534)	(6,291)	243	(18,865)	(18,430)	435		(75,536)
Pay: Hosted & R&I	(723)	(765)	(41)	(2,125)	(1,890)	235		(8,375)
Drugs expenditure	(7,692)	(7,532)	161	(23,082)	(23,290)	(207)		(92,330)
Other non-pay: Trust (excluding Hosted)	(4,843)	(4,897)	(54)	(14,697)	(14,772)	(75)		(58,482)
Non-pay: Hosted	(515)	(277)	238	(2,442)	(1,345)	1,096		(6,884)
Total Operating Expenditure	**(20,308)**	**(19,761)**	**547**	**(61,211)**	**(59,728)**	**1,483**	**2%**	**(241,607)**
			0			0		
Operating Surplus	**703**	**708**	**4**	**1,445**	**1,392**	**(53)**	**4%**	**5,781**
Profit /(Loss) from Joint Venture	67	12	(55)	201	110	(91)		804
Interest receivable (+)	386	430	44	1,157	1,266	109		4,626
Interest payable (-)	(434)	(429)	6	(1,303)	(1,287)	16		(5,213)
PDC Dividends payable (-)	(365)	(354)	11	(1,094)	(1,062)	32		(4,377)
Trust Retained surplus/(deficit)	**357**	**367**	**10**	**405**	**418**	**13**	**3%**	**1,621**
CPL/Propcare	0	(21)	(21)	0	191	191		0
Consolidated Surplus/(deficit)	**357**	**346**	**(11)**	**405**	**609**	**204**	**50%**	**1,621**

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix B – Balance Sheet

£'000	Unaudited 2022	Plan 2023	Year to date Month 3 YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	3,211	3,162	2,784	3,060	276
Property, plant & equipment	184,599	173,627	175,141	182,436	7,295
Investments in associates	977	800	800	1,087	287
Other financial assets	0	115,276	118,709	0	(118,709)
Trade & other receivables	449	434	433	2,533	2,100
Other assets	0	0	0	0	0
Total non-current assets	**189,236**	**293,298**	**297,867**	**189,116**	**(108,751)**
Current assets					
Inventories	5,640	3,000	2,087	3,947	1,860
Trade & other receivables					
NHS receivables	7,749	7,084	6,857	5,695	(1,162)
Non-NHS receivables	6,278	10,915	10,564	6,506	(4,058)
Cash and cash equivalents	80,726	50,708	52,610	69,510	16,900
Total current assets	**100,393**	**71,707**	**72,118**	**85,658**	**13,540**
Current liabilities					
Trade & other payables					
Non-capital creditors	36,547	32,207	32,758	29,480	(3,278)
Capital creditors	6,918	1,958	1,991	1,625	(366)
Borrowings					
Loans	1,908	1,730	1,730	1,810	80
Obligations under finance leases	0	0	0	0	0
Provisions	4,214	94	99	4,082	3,983
Other liabilities:-					
Deferred income	15,669	5,577	5,495	13,977	8,482
Other	0	0	0	0	0
Total current liabilities	**65,255**	**41,565**	**42,073**	**50,972**	**8,899**
Total assets less current liabilities	**224,374**	**323,440**	**327,912**	**223,802**	**(104,110)**
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**	**178,102**	**192,333**	**14,231**
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	103,184	115,556	12,372
Total taxpayers equity	**191,968**	**178,511**	**178,102**	**192,333**	**14,231**

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix C – Cash Flow

June 2022 (M3) £'000	FT	Group	Group (exc Charity)
Cash flows from operating activities:			
Operating surplus	1,138	1,407	1,647
Depreciation	2,293	2,293	2,293
Amortisation	181	181	181
Impairments			0
Movement in Trade Receivables	(1,058)	(257)	(179)
Movement in Other Assets	0	0	0
Movement in Inventories	1,717	1,693	1,693
Movement in Trade Payables	(8,871)	(7,111)	(7,337)
Movement in Other Liabilities	(2,042)	(1,692)	(1,692)
Movement in Provisions	0	(329)	(329)
CT paid	0	(35)	(35)
Net cash used in operating activities	**(6,640)**	**(3,850)**	**(3,758)**
Cash flows from investing activities			
Purchase of PPE	(5,424)	(5,424)	(5,424)
Purchase of Intangibles	(31)	(31)	(31)
Proceeds from sale of PPE	9	9	9
Interest received	1,266	119	128
Investment in associates	(0)	(0)	(0)
Net cash used in investing activities	**(4,181)**	**(5,328)**	**(5,319)**
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	(838)	(838)	(831)
Capital element of finance lease	0	0	0
Interest paid	(1,287)	(139)	(146)
Interest element of finance lease	0	0	0
PDC dividend paid	(1,062)	(1,062)	(1,062)
Finance lease - capital element repaid	0	0	0
Net cash used in financing activities	**(3,188)**	**(2,039)**	**(2,039)**
Net change in cash	**(14,008)**	**(11,217)**	**(11,115)**
Cash b/f	**76,701**	**80,726**	**82,815**
Cash c/f	**62,692**	**69,510**	**71,700**

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix D – Capital

Capital Programme 2022-23
Month 3

The Clatterbridge Cancer Centre NHS Foundation Trust

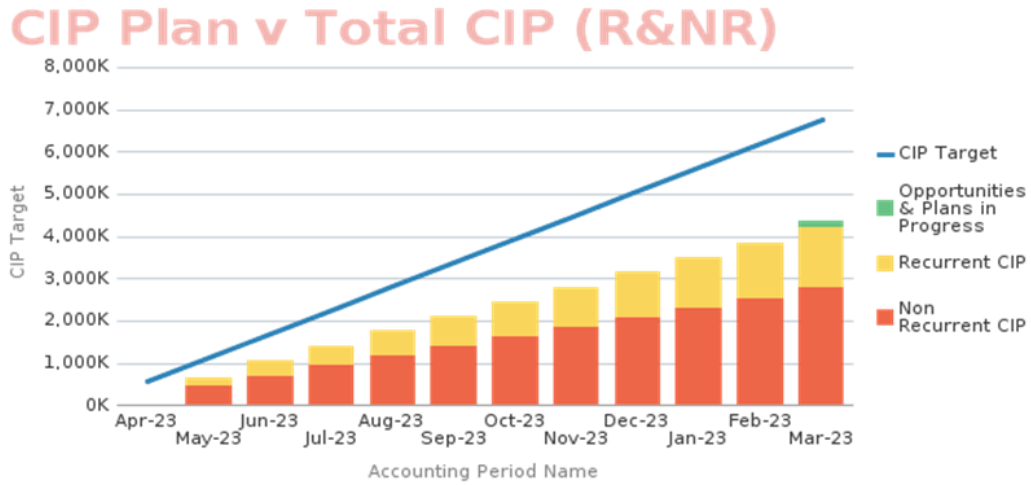
Code	Scheme	Lead	BUDGET (£'000) NHSI plan 22-23	Approved Adjustments	Budget 22-23	ACTUALS (£'000) Actuals @ Month 3	Variance to Budget	FORECAST (£'000) Forecast 22-23	Variance to Budget	Ordered?	Complete?	Comments
4142	***(21/22)*** TCC - Liverpool	Peter Crangle	0	0	0	0	(0)	0	(0)			
4142	***(21/22)*** 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	60	60	34	26	65	(6)	✓	✗	£59,804 approved charity funding
4323	***(21/22)*** CCCL Ward 2 blood room conv		0	0	0	3	(3)	3	(3)	✓	✓	Additional cost on prior year scheme
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	Peter Crangle	500	0	500	0	500	500	0	✗	✗	
	6 Facet lifecycle	Peter Crangle	533	0	533	0	533	533	0	✗	✗	
	Contingency	*n/a*	200	(32)	168	0	168	154	14	-	-	
	Estates		**1,393**	**60**	**1,453**	**43**	**1,410**	**1,453**	**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	49	401	450	0	✓	✗	
4303	***(20/21)*** CCCA Linear Accelerator - Maple		0	0	0	0	(0)	0	(0)	✓	✓	
4309	Voltage Stabilisers	Martyn Gilmore	0	60	60	0	60	70	(10)	✓	✗	Delivery and installation due in October
	CCC-A Cherry linac replacement		2,460	0	2,460	0	2,460	2,460	0	✗	✗	Potential to replace an alternative linac
	HDR Brachytherapy equip (Applicators)		110	0	110	0	110	110	0	✗	✗	
	Aria Software	Carl Rowbottom	500	0	500	0	500	500	0	✗	✗	
4400	Hand Hygiene Scanner		0	0	0	12	(12)	12	(12)	✓	✓	Transferred from revenue
	Contingency	*n/a*	400	(60)	340	0	340	307	33	-	-	
	Medical Equipment		**3,920**	**0**	**3,920**	**72**	**3,848**	**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	James Crowther	455	0	455	0	455	455	0	✗	✗	
	Core IT programme	James Crowther	785	0	785	0	785	738	47	✗	✗	
	Server/Citrix/Cyber upgrade	James Crowther	360	0	360	0	360	360	0	✗	✗	
	Website	Emer Scott	100	0	100	0	100	100	0	✗	✗	Business case to Finance Committee 08/07
	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**	**109**	**12,622**	**162**	**12,460**	**12,622**	**(0)**			

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOREPO
Review: July 2025
Version: 2.0

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix E – CIP



Divisional CIP Against Full Year Plan

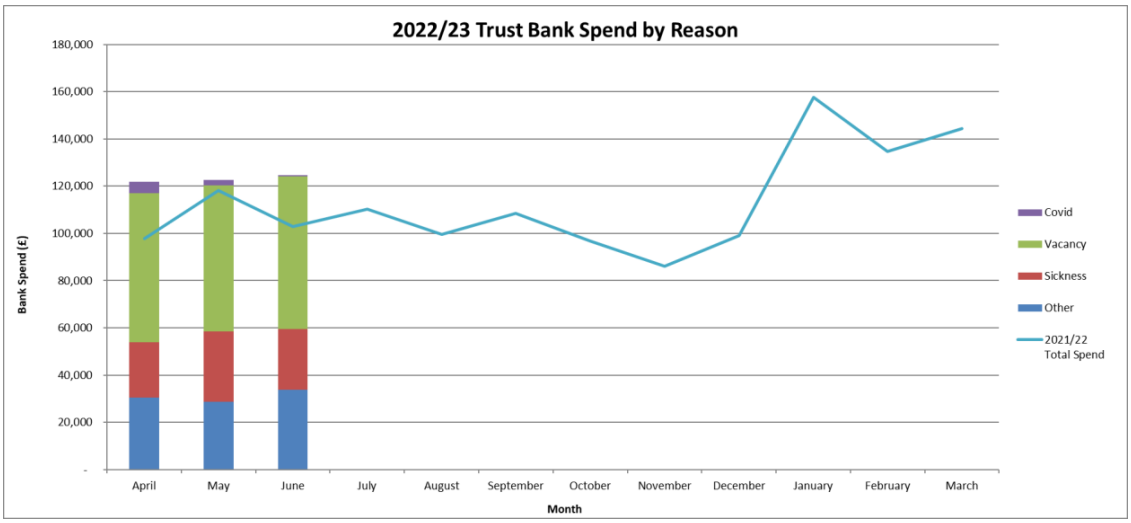
Division	Target	Total CIP	Recurrent CIP	Shortfall/Over Recovery	Delivery % to date
CENTRAL CIP	3,300,000	3,925,793	1,175,259	625,793	119%
NETWORKED SERVICES	1,096,368	109,536	109,536	(986,832)	10%
ACUTE CARE	877,743	32,376	32,376	(845,367)	4%
RADIATION SERVICES	880,168	62,706	54,206	(817,462)	7%
CORPORATE	610,721	57,063	57,063	(553,658)	9%
Total	**6,765,000**	**4,187,474**	**1,428,440**	**(2,577,526)**	

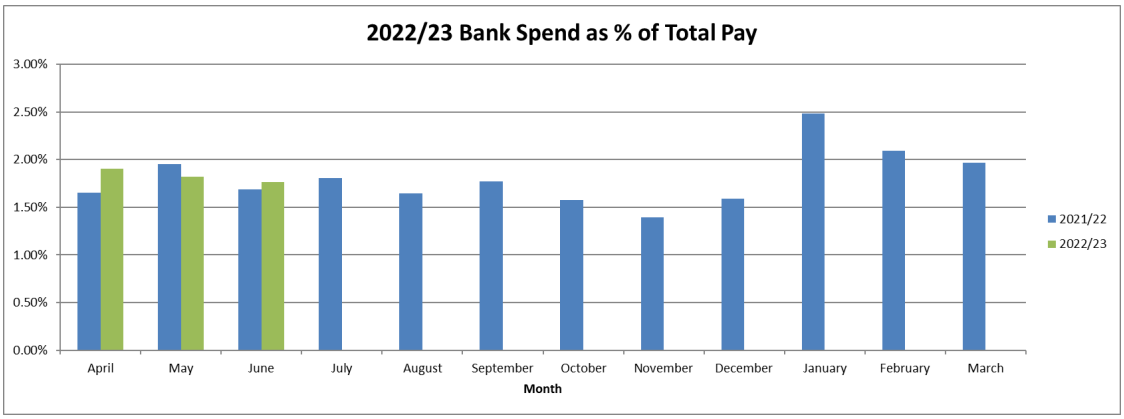
Full Year Plan (Recurrent & Non-Recurrent Split)

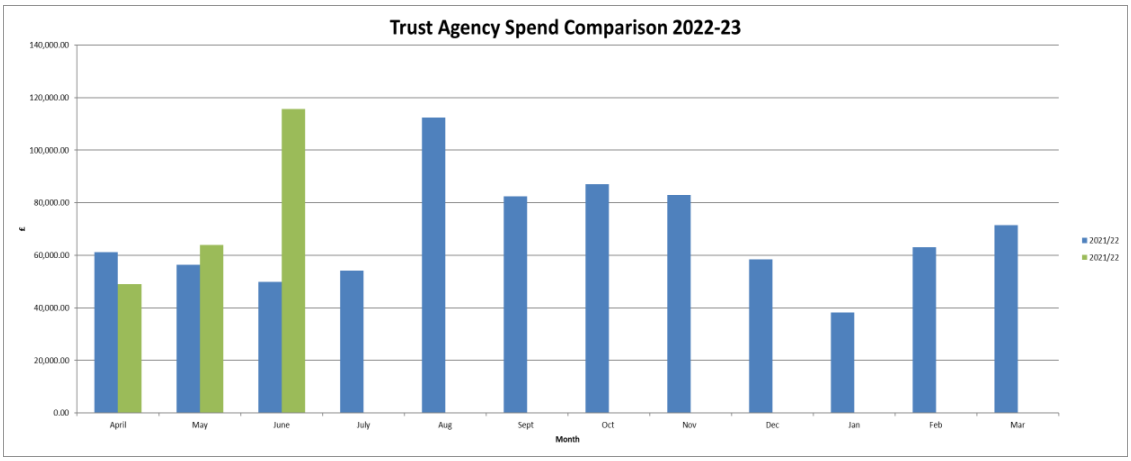
Recurrent	4,465,000	1,428,440	1,428,440	(3,036,560)	32%
Non-Recurrent	2,300,000	2,759,034	0	459,034	120%
Total	**6,765,000**	**4,187,474**	**1,428,440**	**(2,577,526)**	

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix F – Bank and Agency







The Clatterbridge Cancer Centre NHS Foundation Trust

Report of	Non-Executive Directors and Governors				
Paper prepared by	Quality Improvement Nurse Divisional Nurse Director – Networked Services				
Subject/Title	P1-139-22 Non-Executive Director and Governor Engagement Walk-round				
Background papers	N/A				
Purpose of paper	To share the findings from the June Patient & Staff Experience Walk-round				
Action required	To approve content/preferred option/recommendations				
	To discuss and note content	√			
	To be assured of content and actions				
Link to risk:					
Link to: Trust's Strategic Direction Corporate Objectives	Be Outstanding	√	Be a great place to work	√	
	Be Collaborative		Be Digital		
	Be Research Leaders		Be Innovative		

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

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

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

Non-Executive Director and Governor Engagement Walk-round

Division	Networked Services	Location	Delamere Ward	Date	17/06/2022
In attendance - Panel			In attendance – Patient & Staff		
Governor	None		Senior Manager facilitating the walk round		Liz Morgan Sarah Mullis
Non Executive	Elkan Abrahamson		Number of Patients		4
Patient Experience Team	Claire Smith		Number of Staff		4 (plus the Ward Manager and DND)

Patient Feedback: The patients were asked to describe their experience of care at CCC

NB: *This is not a verbatim record but an overview of the key themes raised during the conversation.*

Positive Comments:

Two patients were interviewed whilst receiving chemotherapy in the treatment bays;

One patient was using the cold cap, she was pleased that it had worked well and she had managed to maintain some of her hair.

One patient had contacted the Triage line which she had found to be extremely helpful, she was appreciative that a nurse had followed her up via a telephone call.

One patient mentioned that despite receiving cancer treatment, coming to Delamere ward was a lovely day out.

Two patients in the rapid chairs were interviewed;

Both patients explained how the rapid chairs had been very efficient, worked well and prevented unnecessary delays.

All four patients said that the staff were wonderful and friendly, the chemotherapy unit was lovely and well run.

Patients reported how they had felt staff had adapted well and responded quickly to the changes caused by the pandemic.

One patient praised the knowledge of staff and added that CCC is a centre of excellence.

Areas where immediate action was taken on the day:

Nothing to action.

Areas for improvement:	Service response: *Highlight in **Bold** outstanding actions to be added to PEIC action plan*

Communication; One patient had contacted triage due to neuropathic pain following cycle 10 of 16, she was told her consultant would be informed of her symptoms but this never happened.	**Acute Division GM/Matron Response**- To review process to inform consultants of any required actions following a patient call to Hotline and communicate process to staff via safety huddles 30/6/22- 30/8/22
One patient would have preferred more contact with her consultant, she had 1 zoom call with them and a further 2 telephone calls from a registrar. She would also have liked an option to have face to face consultations. Another patient also expressed that they had never met their oncologist, although the consultant had been amazing they had not been offered zoom consultations and they had communicated by telephone only.	**Networked Response** We understand the impact of COVID on patients and accessing F2F appointments. The guidance has now changed with F2F appointment being offered where appropriate. Remote clinics will still be offered and many patients welcome this option.
During a telephone consultation a patient was asked to attend CCCL. It was not clear where she was meant to attend and therefore arrived at the wrong hospital.	**Networked Response**: Administration staff contacting patients via the phone to change appointments have been reminded to clearly state which hospital to attend and how to access car park options. In addition, a facility to access appointments details digitally is being introduced.
Admin errors were highlighted; one patient explained she had experienced last minute changes to her appointments including the venue.	**Networked Response**: Delamere ward manager has set up weekly meetings with the scheduling team to discuss and review any issues/concerns in patient appointment booking

Patients mentioned that pre-assessment is overwhelming with the amount of information they receive. It would be useful to receive a leaflet when attending pre-assessment listing things patients need to bring in to hospital with them e.g devices, snacks, headband. Staff mentioned that leaflets might have been withdrawn due to the pandemic as they were available pre-Covid.	**Networked Response**: The Macmillan information centre to explore availability of resources on offer to patients both digital and in paper format. Hub SACT nursing team to create a leaflet for patients with handy hints & tips for attending SACT treatment. SACT Lead Nurse creating a leaflet to support patients attending for cool cap treatment. 30/6/22- 15/9/22
Scheduling/Pharmacy An issue involving both pharmacy and scheduling showed that a patient was booked in for an 11am appointment. However, the treatment they were waiting for was coming from Bath via CCCL before travelling to CCCW. At the time of the visit the patient had been waiting for 1 hour, pharmacy were unable to give an expected time of delivery.	**Networked Response**: This will be managed via the weekly meeting with the ward manager and scheduling manager to ensure treatment times booked appropriately. Robust process to communicate any delays in treatments to waiting area.

Staff Feedback: Staff were asked to describe their experience of providing patient care at CCC NB: *This is not a verbatim record but an overview of the key themes raised during the conversation.*
Positive Comments: All staff interviewed during the visit reported that Delamere ward was a lovely place to work; the management team were supportive and did come and help if needed. Staff said that during the pandemic they felt that they had noticed improved relationships with patients, due to the reduced numbers of visitors they had been able to get to know their patients better. Staff talked about feeling like their voices are heard by the senior team, they felt that action is taken if issues are highlighted.

<table>
<tr><td colspan="2">One staff member talked about being rostered in the pre-assessment clinic/rapid chairs a lot when she first started. She found this isolating, however once she had discussed this with the ward manager it was rectified with staff now being rotated.</td></tr>
<tr><td colspan="2">Areas where immediate action was taken on the day:

Nothing to action.</td></tr>
<tr><td>Areas for improvement:

Staffing

Staff reported that there had been some issues with staffing levels, however mostly they felt that this was improving and they were aware of future plans for recruitment. The senior managers informed the visit that they are planning to ‘over recruit’ to cushion against future staffing pressures.

Although staff appreciated that they were not alone, they sometimes felt so busy that they struggled to give patients the extra time they may need.

Scheduling

Staff mentioned that occasionally the scheduling could be better, longer treatments must be booked in earlier in the day to prevent patients being delayed until the following day.

Pharmacy

Staff said they send patients to either the coffee shop/Maggies whilst waiting for pharmacy deliveries.</td><td>Service response: Highlight in Bold outstanding actions to be added to Divisional action plan

The leadership team review staffing levels on an ongoing basis on order to manage activity. Investment in the service has enabled the recruitment of 3 nurses.

Discussed in patient actions.</td></tr>
</table>

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1

27th July 2022

Report of	Chief Nurse				
Paper prepared by	Chief Nurse				
Subject/Title	Quality and Safety Leadership Walk-rounds				
Background papers	P1-140-22 Patient Safety Leadership Walk-Rounds™ 2004 Institute for Healthcare Improvement (IHI)				
Purpose of paper	To propose the introduction of Executive Patient Safety Leadership Walk-rounds				
Action required	To approve content/preferred option/recommendations				√
	To discuss and note content				
	To be assured of content and actions				
Link to risk:					
Link to: Trust's Strategic Direction Corporate Objectives	Be Outstanding	√	Be a great place to work		√
	Be Collaborative		Be Digital		
	Be Research Leaders		Be Innovative		

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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**		

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Board of Directors

July 2022

1. Summary

The purpose of this paper is to propose to the Board of Directors the introduction of quality and safety leadership walk-rounds based on the methodology developed by the Institute for Healthcare Improvement. There is perhaps no other action a senior leader can take that carries as much symbolism as regularly spending time with staff talking about the quality and safety issues that concern them and then following up to address those issues of concern.

2. Background

In May 2000 The Institute for Healthcare Improvement formed the Idealised Design of the Medication System (IDMS) Group. A multi-professional group established an aim to design a medication system that was safer by a factor of 10 and more cost effective than other systems in use at that time. An important element of the system was the strong commitment of senior leadership to a culture that encouraged safety. The walk-rounds were introduced as a tool to connect senior leaders with people working on the front line as a way both to educate senior leadership about quality and safety issues and to signal to front-line workers the senior leaders' commitment to creating a culture of quality and safety. Over the last 20 years the model of leadership walk-rounds has been adopted across the UK in most NHS organisations, including here at CCC.

3. Introduction

The concept of leadership walk-rounds is well established at CCC. Formal Governor and Non-executive director walk-rounds take place monthly with a written report presented at Board of Directors. Executive Directors regularly undertake informal walk-rounds and have a visible presence across the various sites and departments of the organisation. The proposed introduction of walk-rounds focused on quality and safety are not intended to replace any of the existing systems merely to enhance staff engagement with a more targeted focus on quality and safety issues. The purpose being to:

- Demonstrate a commitment to quality and safety
- Fuel a culture for change pertaining to quality and safety
- Provide opportunities for senior executives to learn about quality and safety issues
- Identify opportunities for improving quality and safety
- Establish lines of communication about quality and safety among clinical and non-clinical staff, executives and managers
- Establish a plan for the rapid testing of quality and safety based improvements

4. Aims and success measures

- Staff will feel confident to share their experience of quality and safety issues (outcome measure)
- Spontaneous reporting of quality and safety incidents will increase by 5 percent – CCC is already defined as a high reporting low harm organisation (outcome measure)
- Evidence of quality and safety based improvements will be shared across the Trust (outcome measure)
- Each Executive Director will participate in at least 2 walk rounds per year (process measure)

5. Who should participate

It is recommended that participants should be at Director level and be independent from the service they are visiting.

- Medical Director

- Chief Operating Officer
- Chief Nurse
- Chief Finance Officer
- Chief Information Officer
- Director of Workforce and Organisational Development
- Director of Strategy

Each senior leader should commit to conducting at least 2 walk rounds each year, with no cancellations. (Circumstances may demand postponement from an originally scheduled date, but the walk-round should still occur within the scheduled month.)

6. Where to visit

- All patient facing services
- All corporate and supportive services
- All joint venture partnership services

It is acknowledged that 12 walk-rounds per year will not capture all services in year 1, however this is a long term commitment which will ultimately see all areas of the organisation visited by the senior team. The directors reserve the right to add in additional safety and quality walk-rounds or prioritise a particular area should an emerging concern arise.

7. Format

The walk rounds can follow a number of formats depending on the preferred style of the senior leader and the nature of the service visited. Ultimately, the aim is an open conversation between the senior leader and between three to five staff members of varying roles and bands. The conversation can be structured in various ways, including:

- Corridor conversations
- Individual conversations in succession
- Conversations with staff together in a safe space
- Conversations in the same location each month – drop in style

However, regardless of the format, it is important to achieve a balanced view of areas of good practice, which could be replicated in other services and areas where improvements may be required to improve quality and safety.

Opening statements may include:

“The purpose of this visit is for us to have an open conversation around your views on quality and safety, the aim being to make your work environment safer for you and your patients”

“We are interested in focusing on the system and not individuals (no names are necessary)”

“The discussion we’re interested in having with you is confidential — purely for patient safety and improvement; the specific detail of what we talk about won’t go beyond this small group if you don’t want it to, however the themes may be shared if significant risks to patient safety are identified”

“The questions are very general, to help you think of areas to which the questions might apply consider medication errors, miscommunication between individuals (including arguments), distractions, inefficiencies, invasive treatments, falls, protocols not followed, etc.”

Example questions

“Can you think of any events in the past few days that have resulted in prolonged hospitalisation for a patient?”
“Have there been any near misses that almost caused patient harm but didn’t?”
“Have there been any incidents lately that you can think of where a patient was harmed?

"What aspects of the environment are likely to lead to the next patient harm?"

"Is there anything that could be done to prevent the next safety incident?"
"Can you think of a way in which the system or your environment fails you on a consistent basis?"
"What specific intervention from leadership would make the work you do safer for patients?"
"Do you feel we promote a just culture?
"Can you summarise 2 or 3 things that if addressed would impact on quality and safety and 2 or 3 things that you are most proud of?"

Closing statements may include:
"Thank you for taking the time to speak with me today and for being so open and honest"

"You shared some really interesting examples of the great care/service you provide and you are clearly and rightly proud of the work you do. In terms of the areas for improvement I will take this information away and see how we can work on these issues"

"The key points will be anonymised, drafted into a brief report and shared with the executive team, I will also let you know if the improvements are possible and how they will be implemented"

8. Support and facilitation

Each visit will be supported by a member of the Clinical Governance and Safety Team.
They will be responsible for:

- Drafting and agreeing the walk-round schedule
- Agreeing the dates and times with the senior leader and the service lead
- Communicating with the service lead via a standard email template the purpose and format of the walk-round
- Meeting the senior leader at an agreed location and taking notes of the discussion
- Drafting the brief headline report in a timely manner and sharing with the senior leader and the service lead
- Liaising with the divisional teams to ensure improvement actions are addressed and evidenced

The Service lead will be requested to ensure:

- 3 – 5 staff are available and free to have a conversation at the agreed time (numbers will be dependent on the size of the service and work commitments on the day)
- A suitable space is available to hold the conversation
- Staff are briefed and have time to consider what they might wish to share
- Staff are encouraged to be open, honest and proportionate

9. Follow-Up

Any immediate high risk quality and safety issues will be escalated to the divisional director to be managed via established governance processes.
Where immediate improvement actions can be addressed this will be shared with the divisional director. Where any longer term improvements are already in progress i.e. via Transformation and Improvement Committee (TIC) or Patient Safety Committee (PSC) this will be reported back to the service. Improvements not currently in progress will be feasibility assessed within the division and feedback will be provided to the service by the divisional director.

10. Monitoring

The following quality measurements will be monitored by way of an annual report, to Quality Committee, to evaluate whether the walk-rounds are providing value to and having a positive impact on the quality and safety culture within the organisation.

- No less than 12 quality and safety walk-rounds will be undertaken during each financial year
- Walk-rounds cover all sites of the organisation and include a split of clinical and non clinical divisions on a rolling basis
- There is a process in place to ensure staff are alerted to changes made which are as a direct result of feedback during a walk-round.

11. Conclusion

The Board is a critical driver in moving the organisation to higher levels of quality, safety and effectiveness. Whilst improving quality and safety is everyone's job, senior leaders play a critical role in creating systems that support staff to have open conversations, share their concerns and focus on improvement. The formal adoption of the leadership walk-rounds demonstrates our commitment to building a culture of quality and safety.

12. Recommendations

The Board of Directors is asked to note the content of this paper and approve the introduction of the senior leadership quality and safety walk-rounds.

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 27th July 2022

Report author	Catherine Hignett-Jones, Resourcing Manager			
Paper prepared by	Catherine Hignett-Jones, Resourcing Manager			
Report subject/title	P1-141-22 New Consultant Appointments			
Purpose of paper	To inform of New Substantive Appointments			
Background papers				
Action required	The Board to note			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	Y	Be a great place to work	Y
	Be Collaborative		Be Digital	
	Be Research Leaders		Be Innovative	

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

Introduction

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

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

Name	Dr Alexandra McDougall
Job Title	Consultant in Palliative Medicine
Qualifications	• MbCHB -Keele University • MRCP- Royal College of Physicians • SCE Palliative Care- Royal College of Physicians
Speciality	Palliative Medicine
GMC number	GMC: 7266349
Membership/Appointments	
Details	Dr McDougall has been working in the role of Palliative Medicine Registrar at Aintree Hospital, and was responsible for chairing the daily hospital MDT meetings and reviewing complex palliative care patients. Dr McDougall has previously worked at CCC as a rotational post with Lead Employer covering CCC and the Woodlands Hospice.

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 27th July 2022

Report author	Helen Wong, Quality Manager (Audit & Statistics)				
Paper prepared by	Helen Wong, Quality Manager (Audit & Statistics)				
Report subject/title	P1-142-22 Mortality Dashboards 2021-2022 Q4				
Purpose of paper	This supplementary report supports the public dashboard, explains the background behind the figures and filling in the gap that the public dashboard does not cover (community death SJR scores). Dashboards and summary report were presented to the Risk and Quality Governance Committee.				
Background papers					
Action required	The Trust board is asked to note the mortality dashboards and summary report.				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work		
	Be Collaborative		Be Digital		
	Be Research Leaders		Be Innovative		

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		

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

The Clatterbridge Cancer Centre NHS Foundation Trust

1.0 Background

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

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

2.0 Mortality Review Inclusion Criteria

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

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

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

3.0 Case Review and Selection Process

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

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

The Clatterbridge Cancer Centre NHS Foundation Trust

4.0 Dashboard Interpretation

Data coverage: April 2021 – March 2022 for comparison to previous quarters

	Apr – Jun 21	Jul – Sept 21	Oct – Dec 21	Jan – Mar 22*
No. of inpatient death *(all inpatient deaths are reviewed)*	29	31	34	38
No. of outpatient death post treatment	126	120	133	145
No. of outpatient cases requiring review	116	107	107	123
Total cases requiring review	145	138	141	161
No. of cases reviewed (Phase I)	117/145 (81%)	109/138 (79%)	96/141 (68%)	62/161 (39%)
No. of cases peer reviewed (Phase II)	93/117 (79%)	95/109 (87%)	72/96 (75%)	37/62 (60%)
No. of case(s) selected for discussion (Phase III)	6	12	9	5
No. of case(s) discussed (Phase III)	6/6 (100%)	9/12 (75%)	7/9 (78%)	1/5 (20%)

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

- A total of 297 cases have completed an independent peer review (Phase II) from April 2021 – March 2022 deaths.
- From this, 32 cases have been selected for discussion out of which, 23 cases were discussed (x7 inpatients and x15 Community/Other Hospital). out of which:

  Inpatient SJR Scores.
  All x7 were scored an RCP score of 6.
  Community/Other hospital inpatient RCP Scores
  All x16 were scored an RCP score of 6.
  The remaining x9 cases are scheduled for discussion at a future date.
- 0 cases required a LeDar (Learning Disability) submission
- 0 mortality case was subject to a Child Death Overview Panel (CDOP) form (required for in scope patients <=18).

5.0 Inpatient SJR Score (avoidability score <6) case description

There were no new Inpatient SJR scores <6 reported during the period

The Clatterbridge Cancer Centre NHS Foundation Trust

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

There were no new community/other hospital inpatient RCP scores <6 reported during the period

5.2 Historic cases RCP Score (avoidability score <6) case description

Community/Other hospital inpatient RCP Scored 4 (id20**23)

This patient with a metastatic Small Cell Lung Cancer (SCLC) became symptomatic after 1 cycle of immuno-chemotherapy (chemo IO). There were concerns the patient's cancer was progressing, however imaging taken a month later showed a good response to both chest and brain.

Patient was well and existing symptoms had resolved, cycle 2 was administered. Patient became unwell again and attended Clinical Decision Unit. On review, it was noted that although patient had a slightly swollen leg this was not felt clinically significant and there were complex clinical issues. Patient was not admitted to CCC and therefore did not formally undergo VTE assessment. Patient was booked to undergo investigations and outpatient review the following week. However patient died shortly afterward.

The cause of death was originally cited as lung cancer; however, the treating consultant felt a post mortem (PM) should be undertaken to rule out a rare/unknown chemo IO toxicity, as this was the first SCLC chemo IO patient.

A PM confirmed the cause of death as 1a) Pulmonary embolism 1b) Deep vein thrombosis 2) Ischaemic heart disease and coronary artery atherosclerosis.

The Immunotherapy team have amended the pneumonitis protocol (serendipity) to consider pneumonitis and PE as differentials. The lead registrar and nurse consultant agreed that this case had been a subtle presentation and that it was beneficial to share with their teams for educational reasons.

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

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

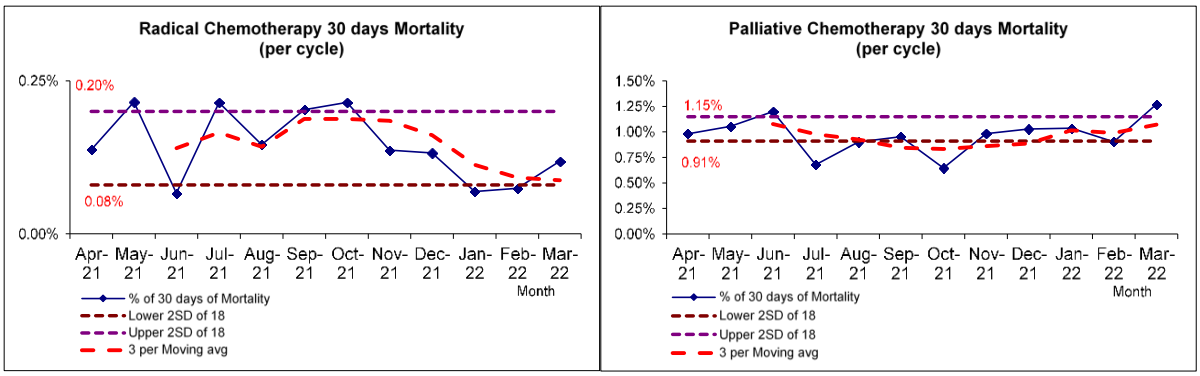
The control limits (lower & upper 2 standard deviation – brown dash line on chart) are reviewed annually and are set by the best performing annual figures from 2009 onward. All data points fallen inside the control limits are deemed to be within tolerance.

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

April 2021 – March 2022 treatment activities

- Results showed the 3 monthly moving average mortality for each of the areas were within tolerance.
- The increasing trend for Haemato-oncology palliative SACT mortality between September 21 to January 2022 had been reversed in the next 2 months. No reason has been identified.

6.1 Chemotherapy 30 day mortality (Solid Tumour)



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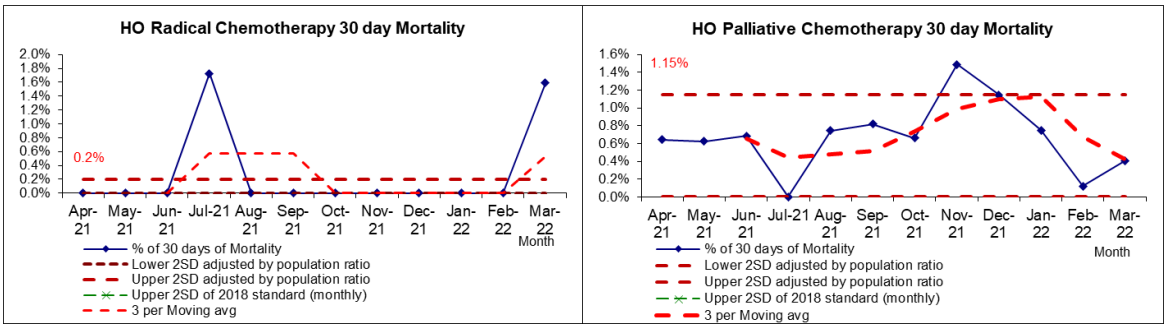
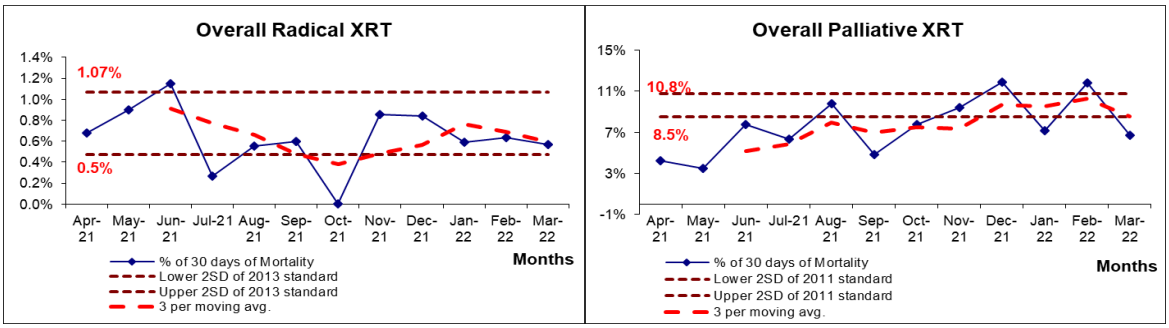
6.2 Chemotherapy 30 day mortality (Haemato-oncology)

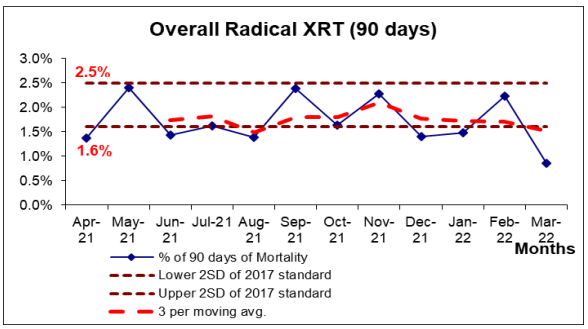


**Due to small number of patients in the radical chemotherapy group, the 2 peaks were related to a single death of that particular month.*

6.3 Radiotherapy 30 day mortality



6.4 Radical radiotherapy 90 day mortality



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Ref: FCGOREPO
Review: July 2025
Version: 2.0

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

NHS
The Clatterbridge Cancer Centre
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Summary of total number of inpatient, 30 day SACT, 30 day RT, 90 day radical RT & BMT deaths	Date Range for data	01 April 21	-	31 March 22

Trust Mortality Programme QTR 1 - QTR 4

Total Number of Deaths in Scope	No.
QTR 1	155
QTR 2	151
QTR 3	167
QTR 4	183
YTD	656

Total Deaths Requiring Phase 1 Review (excluding not applicable eg bone mets, MSCC)	No.
QTR 1	145
QTR 2	138
QTR 3	141
QTR 4	161
YTD	585

Total Deaths Reviewed (Phase 1) *Target = 100% completion*	No.	%
QTR 1	117	*81%*
QTR 2	109	*79%*
QTR 3	96	*68%*
QTR 4	62	*39%*
YTD	384	*66%*

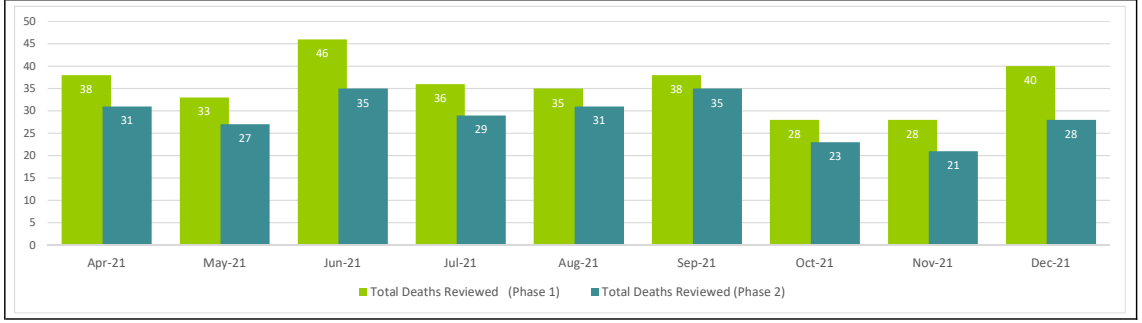
Total Structured Judgement Reviews completed and avoidability scored against RCP Methodology (Conducted for inpatient deaths only)

	Score 1 - Definitely avoidable	Score 2 - Strong evidence of avoidability	Score 3 - Probably avoidable (more than 50:50)	Score 4 - Probably avoidable but not very likely	Score 5 - Slight evidence of avoidability	Score 6 - Definitely not avoidable
QTR 1	0	0	0	0	0	18
QTR 2	0	0	0	0	0	27
QTR 3	0	0	0	0	0	20
QTR 4	0	0	0	0	0	15
YTD	0	0	0	0	0	80

Total Deaths Reviewed (Phase II) *nb. Total deaths reviewed out of those deaths reviewed at Phase 1* *Target = 100% completion*	No.	%
QTR 1	93	79%
QTR 2	95	87%
QTR 3	72	75%
QTR 4	38	61%
YTD	298	*78%*

Total Deaths Selected for Review (Phase III) *nb. Total deaths reviewed out of those deaths selected at Phase 2* *Target = No Target CCC share best practice alongside learning*	No. Reviewed	/	No. Selected	%
QTR 1	6	/	6	100%
QTR 2	9	/	12	75%
QTR 3	7	/	9	78%
QTR 4	1	/	5	20%
YTD	23	/	32	72%

Number of cases reviewed at Phase 1 & Phase 2



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

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

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

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

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable: Children

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

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

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

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

The Clatterbridge Cancer Centre NHS Foundation Trust

Haemopoietic Stem Cell Transplants Dashboard
QTR 3 2021-22

Date Range	October 20	-	December 21

These results indicate that successful engraftment in our BMT patient is well above average. Deaths within 100 days of allogeneic stem cell transplantation remains well below national average showing excellent results for the centre for all quarters. Survival data for allogeneic stem cell transplant (number of patients alive at one year) also remains above average for our patients for all quarters. For autologous stem cell transplantation, percentage of patients dying within first 100 days is just below national average but not statistically significant (last quarter CCCL value 2.2 , national value 1.7 which is a similar trend for all quarters). Overall there are no negative indicators, 6 positive indicators and 3 neutral indicators.

Summary: Outcome of patients receiving stem cell transplantation in Liverpool shows well above average outcomes for allogeneic transplant and well within average (2SD) outcome for autologous transplantation despite COVID pandemic. There are no concerns in these data.

It is also worth noting that since 25th March 2020 submission of data to the dashboard has been voluntary and it is not known how many centres have continued to submit data, this may impact national figures and averages.

- Dr Muhammed Saif

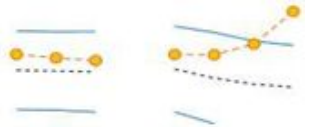
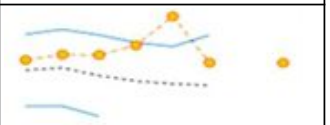
Proportion of patients with successful engraftment

BMT02a-A - Relating to Autograft Stem Cell Transplant Patients
• Numerator Description - Number of patients where engraftment was successful (successful defined as neutrophil count of > 0.5 * 10^9 per litre for three consecutive days by day plus 28)
• Denominator Description - Total number of patients transplanted in the first 6 months of the previous 7 month reporting period
• Value – CCC SCT Programme
• Interpretation Guidance - Higher is better

QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
QTR 4 2020.21	Oct 20 - Mar 21	41	41	100	98.1		
QTR 1 2021.22	Jan 21 - June 21	30	30	100	97.3		
QTR 2 2021.22	Apr 21 - Sep 21	30	30	100	97.8		
QTR 3 2021.22	**Jul 21 - Dec 21**	43	44	97.7	97		

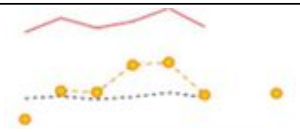
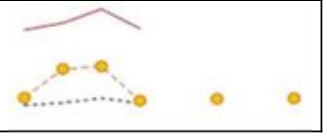
Percentage of transplant patients registered in research trials

BMT06-A – Relates to ALL both Autograft and Allogeneic where applicable
• Numerator Description - Number of patients having a bone marrow transplant as part of a trial protocol registered with UK CRN database, EU or clinicaltrials.gov
• Denominator Description - Total number of transplants
To include interventional trials and include all trials where there is a transplant arm / option (eg AML18, 19 and UKALL14) and not just transplant-only trials
• Value – CCC SCT Programme
• Interpretation Guidance – Non-discriminatory indicator

QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
QTR 4 2020.21	Apr 20 - Mar 21	21	57	36.8	12.4		
QTR 1 2021.22	Jan 21 - June 21	6	30	20	11.8		
QTR 2 2021.22	Oct 20 - Sep 21	14	70	20	10.6		
QTR 3 2021.22	Jan 21 - Dec 21	20	74	27	10.6		

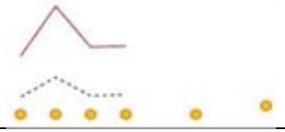
Percentage of patients dying within 100 days of transplant

BMT08a-A – Relates to Autograft Stem Cell Transplant Patients
• Numerator Description – Number of patients in denominator who dies within 100 days of transplant
• Denominator Description – total number of autologous transplants in the first 365 days of the previous 465 day reporting period
• Value – CCC SCT Programme
Interpretation Guidance – Lower is better

QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
QTR 4 2020.21	Apr 20 - Mar 21	*	*	4.7	2.2		
QTR 1 2021.22	Jan 21 - June 21	*	*	2	1.8		
QTR 2 2021.22	Oct 20 - Sep 21	*	*	2.1	1.7		
QTR 3 2021.22	Jan 21 - Dec 21	*	*	2.2	1.7		

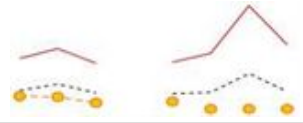
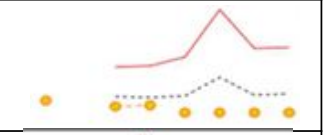
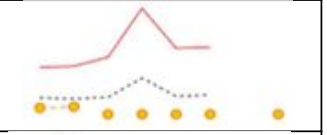
Percentage of patients alive at 1 year post transplant

BMT09a-A – Relates to Allogeneic Stem Cell Transplant Patients
• Numerator Description – Number of patients in denominator alive 1 year after transplant
• Denominator Description – Total number of autologous transplants in the first 12 months of the previous 24 month reporting period
• Value – CCC SCT Programme
Interpretation Guidance – Higher is better

QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
QTR 4 2020.21	Apr 20 - Mar 21	50	53	94.3	92.8		
QTR 1 2021.22	Jan 21 - June 21	43	450	95.6	92.8		
QTR 2 2021.22	Oct 20 - Sep 21	29	30	96.7	93.9		
QTR 3 2021.22	**Jan 21 - Dec 21**	*	*	4.2	8.6		

Percentage of patients dying within 100 days of transplant

BMT13-A – Relates to Allogeneic Stem Cell Transplant Patients
o Numerator Description – Number of patients in denominator who died within 100 days of allogenic transplant
o Denominator Description – Total number of allogenic transplants in the first 365 days of the previous 465 day reporting period
o Value – CCC SCT Programme
Interpretation Guidance – Lower is better

QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
QTR 4 2020.21	Apr 20 - Mar 21	0	14	0	8.8		
QTR 1 2021.22	Jan 21 - June 21	0	15	0	9.5		
QTR 2 2021.22	Oct 20 - Sep 21	0	18	0	8.3		
QTR 3 2021.22	**Jan 21 - Dec 21**	*	*	4.2	8.6		

Haemopoietic Stem Cell Transplant Positive Alerts

QTR	Detail
QTR 4 2020.21	• For Quarter 4 2020.21 the Haematopoietic Stem Cell Transplant Programme had 0 Negative alerts, 2 Positive alerts, 1 neutral alerts Last AA Outcome (AA 2019/2020): Routine surveillance Last SD Score (SD 2019/2020): 100.0 Latest SSQD Alerts (SSQD Q4 2020/2021): Positive Alerts: 2, Negative Alerts: 0, Neutral Alerts: 1 Submission Audit Log Negative Alerts 0 Positive Alerts 2 Neutral Alerts 1
QTR 1 2021.22	• For Quarter 1 2021.22 the Haematopoietic Stem Cell Transplant Programme had 0 Negative alerts, 2 Positive alerts, 0 neutral alerts SSQD description: SSQD Q1 2021/2022 Last AA Outcome (AA 2019/2020): Routine surveillance Last SD Score (SD 2019/2020): 100.0 Latest SSQD Alerts (SSQD Q1 2021/2022): Positive Alerts: 2, Negative Alerts: 0, Neutral Alerts: 0 Submission Audit Log Negative Alerts 0 Positive Alerts 2 Neutral Alerts 0
QTR 2 2021.22	• For Quarter 2 2021.22 the Haematopoietic Stem Cell Transplant Programme had 0 Negative alerts, 2 Positive alerts, 1 neutral alert SSQD description: SSQD Q2 2021/2022 Last AA Outcome (AA 2019/2020): Routine surveillance Last SD Score (SD 2019/2020): 100.0 Latest SSQD Alerts (SSQD Q2 2021/2022): Positive Alerts: 2, Negative Alerts: 0, Neutral Alerts: 1 Submission Audit Log Negative Alerts 0 Positive Alerts 2 Neutral Alerts 1
QTR 3 2021.22	• For Quarter 3 2021.22 the Haematopoietic Stem Cell Transplant Programme had 0 Negative alerts, 0 Positive alerts, 1 neutral alert Submission Audit Log Negative Alerts 0 Positive Alerts 0 Neutral Alerts 1

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

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Trust wide summary of total number of inpatient, 30 day SACT, 30 day RT, 90 day radical RT & BMT deaths	Date Range	April 21	-	March 22

Lessons Learnt from Mortality Review Quarter 4 2021-22
Page 1

	QTR	No.	Background	Actions Taken	CCC Lessons Learned	Action closed	MSG
New	QTR 4	MRM 133	Patient was admitted to a local network Trust on a 5FU bottle; this was not discontinued until the following morning as the admission team felt this could only authorised by the acute oncology team. It is quite possible that the 5FU contributed to cardiac arrhythmias / ischaemic pain.	This case was flagged to the local Trust mortality team who discussed this case at their local Mortality Review meeting and cascaded learning to their acute admissions team.	Patients admitted to DGHs acutely unwell with 5FU bottles in situ should have these discontinued.	17/01/2022	07/06/2022
New	QTR 4	MRM 142	An inpatient received a combination of different formulations of insulin used at differing doses with their blood sugars fluctuating from high 20s to 2. There was no clear documented advice sought from the diabetic specialist team. MET calls were needed to manage hypoglycaemic episodes.	CCC have adopted LUHFT diabetic protocols to standardise best practice and have established clear referral processes for diabetic advice from LUHFT.	Inpatient management of diabetes should follow LUHFT guidelines and referral pathway is in place to obtain advice when needed.	01/02/2022	07/06/2022
New	QTR 4	MRM 145	An inpatient with renal cell carcinoma required a MRI Scan at the Liverpool University Hospital Foundation Trust (LUHFT) to rule out metastatic spinal cord compression (MSCC) urgently over a weekend. Once transferred patient sadly deteriorated and died from a retroperitoneal heamatoma despite appropriate management. The receiving team did not feel they had sufficient handover that the patient had been medically unstable prior to transfer adversely affected patient care although did not on balance contribute to the outcome.	Incident investigation launched in collaboration with LUHFT to review the referral and communication process of acutely unwell patients including out of hours.	Patients requiring urgent scans at CCC should be able to access these at CCC- these are now available 24/7 at CCCL. In the event of needing to transfer patients to LUHFT, transfers should be accompanied by digital transfer template which has been co-designed between the 2 trusts.	27/01/2022	07/06/2022
New	QTR 4	MRM 146 a,b,c MRM 149	A patient attended CDU unwell with suspected IO pneumonitis where it was noted that they had a swollen leg. This was documented and felt not to be significant as part o the overall clinical picture. The patient later died and a post-mortem examination revealed the cause of death to be 1a) Pulmonary embolism 1b) Deep vein thrombosis 2) Ischaemic heart disease and coronary artery atherosclerosis.	The Immunotherapy team have amended the pneumonitis protocol (serendipity) to consider pneumonitis and PE as differentials. Ward manager included this case in morning safety huddles and feedback was also provided to the ANP/Medical team.	DVT/ PE is an important differential to consider in patients presenting with clinical features of IO pneumonitis and now consideration of this differential forms part of the diagnostic protocol.	16/03/2022	07/06/2022
New	QTR 4	MRM 151a & b	DNACPR was appropriately put in place on admission for a patient but without the required communication and without documentation to support this. This was felt to be due to lack of documentation by junior medical colleagues documenting a consultant's ward round rather than the conversation not occurring.	Requirements for specific discussion points and documentation requirements are present in the resuscitation document on meditech. This has been fed back to consultants and has been included in junior doctor induction. A further training day has been set up to educate MDT colleagues on best practice in complex discussions and legal requirements of documentation.	It is essential that DNACPR decisions are discussed with patients who have mental capacity unless it is clearly documented that those patients would be harmed by such discussions. Discussions should also include relatives and carers if the patient gives consent.	18/01/2022	07/06/2022

Lessons Learnt from Mortality Review Quarter 3 2021-22
Page 2

QTR	No.	Background	Actions Taken	CCC Lessons Learned	Action closed	MSG
QTR 3	MRM 146a / MRM 146c	Post cycle two a patient attended CDU. On review it was documented the patient had a slightly swollen leg but this was not deemed relevant. Patient was not admitted to CCC, therefore no VTE assessment was undertaken as VTE was not expected as a diagnosis. Patient was discharge with a plan for outpatient review and investigations the following week. Later the cause of death was originally deemed as lung cancer; however, the treating consultant felt strongly that CCC needed to look into this and learn from this case, as this was the first SCLC chemo IO patient. Treating consultant asked for a PM to be undertaken.	Post mortem report obtained. The PM confirmed that the cause of death as 1a) Pulmonary embolism 1b) Deep vein thrombosis 2) Ischaemic heart disease and coronary artery atherosclerosis. The Immunotherapy team amended the pneumonitis protocol (serendipity) to consider pneumonitis and PE as differentials.	It is important to share these rare and complex clinical cases to increase education amongst junior colleagues and encourage professional curiosity. It is also important to continuously amend protocols to reflect rare real-world toxicities. The lead registrar and nurse consultant agreed that this case had been a subtle presentation and that it was beneficial to share with their teams for educational reasons	17/12/2021	15/03/2022
QTR 3	MRM70	A patient had an Ascitic Drain left in-situ for 5 days.	An action was made to review the Ascitic drain policy and ensure that it covered siting and duration to be left in-situ. The ascitic drain policy states clearly to remove the drain by 24 hours to minimise risk of infection.	Ascitic drains should be removed within 24 hours of insertion unless there is a clinical reason in which cause it should be clearly documented. CET have shared this information with all SRGs	26/10/2021	15/03/2022
QTR 3	MRM101	There have been 2 cases of Capecitabine doses taken wrongly by patients despite advice being given.	Actions undertaken by the Medicines Safety Advisory Committee: 1. Correct dosage now properly explained to the patient and Capecitabine diary is given. 2. Capecitabine stopped for remainder of the cycle and bloods reviewed by on-call registrar 3. Reassurance and education given around how and when to take Capecitabine.	Patients require additional information and support when taking capecitabine in order to take this medication correctly. This additional support is now provided.	09/11/2021	15/03/2022
QTR 3	MRM123	Patient started to progress while receiving Rucaparib treatment so treatment was stopped. A side effect of Rucaparib treatment is myelosuppression and reduced platelet counts however the patients platelet counts did not improve with discontinuation of treatment so it was felt these were secondary to marrow infiltration and disease progression. The option of best supportive care or platinum based chemotherapy (BRCA positive) were discussed with the decision being made to go ahead with dose reduced Carboplatin under close supervision. 10 days post cycle 1 the patient had a large PR bleed and despite blood transfusion support he experienced a further episode of bleeding and died 3 days later	The Urology SRG now hold a weekly peer review MDT discussion in cases where risks and benefits are finely balanced to peer review treatment decisions and ensure patients are treated as safely as possible.	Clinical decisions where risks and benefits are finely balanced with associated risks to treatment should be peer reviewed and this peer discussion documented within meditech.	23/11/2021	15/03/2022
QTR 3	MRM129	Dabrafenib + Trametinib was commenced in a frail melanoma patient with a PS 4. The patient's PS measured 4 as he was on strict bed rest and was in a lot of pain. At the time of the decision to treat it was felt this was appropriate as this regime has a high response rate with a likelihood of improving the patient's symptoms quickly (70-80%).	Melanoma team to undertook an audit of this regimen in terms of survival compared to published literature. All palliative deaths occurred as a result of progressive malignancy that either illustrated primary resistance (n=1) or secondary resistance (n=7). In the case of adjuvant deaths 1 case was related to treatment toxicity and appropriate steps were taken and 1 case was unrelated to malignancy or toxicity	Given the indication for dabrafenib and trametinib treatment and the activity of metastatic disease on secondary progression following response as experienced by the majority of patients in this cohort the deaths the mortality observed do not raise concerns following evaluation. Learning points from this review are the need for clear documentation as to the events pertaining to patients on the isle of man (IOM), the need for annotation within the patients records as to the cause of death certificated as well as the date of death and ongoing awareness of the toxicities of D&T treatment to ensure all patients have their treatment discontinued if showing evidence of toxicity (as did happen in the case of the patient within this cohort).	12/10/2021	15/03/2022

Lessons Learnt from Mortality Review Quarter 3 2021-22
Page 3

QTR	No.	Background	Actions Taken	CCC Lessons Learned	Action closed	MSG
QTR 3	MRM136	This patient developed a COVID infection either during her last week of admission in CCCL or in transit back to the IOM. Due to the IOM 14-day COVID isolation rule no family or healthcare professionals were allowed to visit the patient at home prior to her emergency admission to Nobles hospital where she passed away.	Treating consultant reviewed the discharge policy for patients from IOM who needs safety net care of support outside CCC	All discharges to the Isle of Man in which the patient flor team have been involved require a check the day after discharge to ensure local support is in place and the patient is receiving the right support.	09/11/2021	15/03/2022
QTR 3	MRM137		Treating consultant liaised with nursing manager to cascade lessons learnt of this case. Policy amended to account for patients being discharged to IOM. The patient flow team now undertake a day after discharge telephone call with all level 2 discharges. A Level 2 discharge is anything the patient flow time have been involved in.		28/10/2021	15/03/2022
QTR 3	MRM144	A patient with symptom issues and a changing prognosis spanning an 8 month period was reviewed by a physician's associate 5 times and no letters were communicated to the GP. They were also reviewed by the medical team during this period and on three occasions letters were also not issued.	HBP team to reviewed frequency of letters from consultation. E-Mail distributed to all SRG members stating it is imperative that appropriate communication is provided to the GP and extended healthcare team.	If SRG teams would like their PAs to write letters, then the clinical team should oversee and supervise this or a member of the team dictate on their behalf. Regular communication with primary care about changes in patient's clinical condition is essential.	23/11/2021	15/03/2022
QTR 3	MRM113	The reason for this case being discussed at MRM is due to it being an inpatient child death which we have a requirement to discuss and feedback to the Child Death Overview Panel (CDOP). This was a tragic case of an aggressive cancer that responded poorly to treatment. The treating team were asked whether they had the opportunity to debrief after these deaths. The team replied that there was not a formal process but it is done informally. The CCC Palliative care team replied that support locally can be provided and that there is national peer support available.	MRM asked the treating team to consider the use of the CCC local debriefing tool. There is a new family support practitioner in post at CCC who now delivers ward debriefs as needed. The trust debrief tool 'AFFECTS' is also available to all colleagues via the intranet and on the wards.	Teams in need of debrief following complex deaths can access team support from the psychological medicine team, palliative care team and family support practitioner.	12/10/2021	15/03/2022

Lessons Learnt from Mortality Review Quarter 2 2021-22
Page 4

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

Lessons Learnt from Mortality Review Quarter 1 2021-22
Page 5

QTR	No.	Background	Actions Taken	CCC Lessons Learned	Action closed	MSG
QTR 1	MRM91	A patient had nausea and vomiting throughout their admission but no palliative care medical review was undertaken	Palliative care team to review this case in terms of escalation process within palliative care team	Cases where symptoms are difficult to manage despite initial interventions should be raised for medical SPCT review and this has been disseminated to the team. The weekly MDT also includes detailed review of symptoms to ensure patients needing medial review are picked up.	01/04/2021	21/09/2021
QTR 1	MRM121	During an infusion of a 3rd cycle of Paclitaxel a patient reported lower back pain, treatment was stopped immediately and the patient was treated timely for an infusion related allergic reaction as per the CCC hypersensitivity guidelines. A MET call was logged but unfortunately the patient then suffered a cardiac arrest from which the patient died. Cause of death was cited as 1a Anaphylactic drug reaction, 1b Paclitaxel Chemotherapy and 1c Metastatic Breast Adenocarcinoma	Local audit of hypersensivity reactions with paclitaxel undertaken.	Rates of reaction for CCC patients were reported to be 0.6% for mild to moderate hypersensitivity (compared to 10-30% in literature), 0.5% for severe hypersensitivity (compared to 1% in literature) and 0.07% for anaphylactic reactions (compared to 0.1% in literature). Assurance given that CCC hypersensitivity reaction rates are below other published rates.	18/05/2021	21/09/2021
QTR 1	MRM92	Cyclizine and Metoclopramide are mutually antagonistic yet they are frequently prescribed together	Pharmacy to provide a digital warning on meditech to prevent co-prescription if attempted.	Pharmacy have linked these two drugs in the Meditech EPR system and this now can create a message to the prescriber to state why they are prescribing the medication together and will request a reason for doing so. This will mandate the prescriber to pause and reconsider the prescription.	06/04/2021	21/09/2021
QTR 1	MRM120	A consultant raised that some trusts have the option of "I've discussed the option of no treatment" on consent forms and asked if CCC could we discuss having this on our consent forms with PWR	Copy of case was forwarded to PWR with consideration of inclusion of "discussed no treatment" in consent forms going forwards to evidence base conversations more robustly	The consent forms used at CCC already have a section for highlighting that the option of no treatment has been discussed- this has been cascaded to consultants	25/05/2021	21/09/2021
QTR 1	MRM33	Borderline metastatic lung cancer patient with multiple co-morbidities. Treating consltant and the patient discussed at length the pros and cons of supportive care vs. high risk immunotherapy. The patient opted for the latter and unfortunately died 10 days after cycle 1	Feedback the results of the Pembro audit to the MSG once available	A local audit established that Pembrolizumab in our patient group is overall well tolerated. Over the first three months, grade 3-4 toxicity is rare and correlates with poor prognosis when it starts within the first 3 weeks. Fast responses are also rare. Most problems within the first three months tend to be cancer-related, due to progression. Our toxicity incidence is consistent with that seen in the published prospective studies, but our mortality is better, probably thanks to our protocols and IO-team support"	07/06/2021	21/09/2021
QTR 1	MRM114	Patient was seen early November "breathless and fatigued" when recovering from COVID. A decision was made to proceed with cycle three at 80% dose. The patient subsequently died on day 20 of cycle three of 'acute myocardial insufficiency'. A CT undertaken midway through cycle three had shown some disease progression and also residual COVID changes in the lungs. It was felt that this could have indicated that the patient's death may have been related to the prior COVID infection from which he had not fully recovered.	Upper GI/HPB SRG reviewed this case at the request of the MRM and were asked to consdier mechanisms to prevent treating too early in patients recovering from COVID-19.	This patient's chemotherapy should have been delayed and further review before consideration of treatment. A peer review group has been set up which meets fortnightly to discuss chemotherapy options for complex Oesophegeal and HPB patients which will peer review further treatment decisions in this patient group	07/06/2021	21/09/2021
QTR 1	MRM117	Treatment was continued despite evidence of progression on CT from Nov 2019 and April 2020. The group advised as two scans had shown signs of progression on SACT and that the treatment should have been stopped, or at least the decision to treat peer reviewed to double check the clinical rationale.	Upper GI/HPB SRG reviewed this case at the request of the MRM and were asked to consdier mechanisms to prevent treatment being continued despite evidence of disease progression	A peer review group has been set up which meets fortnightly to discuss chemotherapy options for complex Oesophegeal and HPB patients which will peer review further treatment decisions in this patient group	07/06/2021	21/09/2021
QTR 1	MRM119	It was noted that a consent form for second line chemotherapy could not be located in Evolve	Further investigation was undertaken into the location of the form which was later located in the wrong section of Evolve. Confirmation of the correct process and location of consent forms was disseminated.	All paper documents should be scanned into the consent form section in Evolve - this has been communicated to the scanning bureau team via their line manager	16/06/2021	21/09/2021

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 27th July 2022

Report author	Dr Sheena Khanduri, Medical Director			
Paper prepared by	Helen Wong, Quality Manager (Audit & Statistics)			
Report subject/title	P1-143-22 Mortality Annual Report 2021-2022			
Purpose of paper	The Mortality Annual Report 2021-2022 were approved by the Mortality Surveillance Group.			
Background papers				
Action required	The committee is asked to note the Annual Report and published onto the Trust internet.			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work	
	Be Collaborative		Be Digital	
	Be Research Leaders		Be Innovative	

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		

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOREPO
Review: July 2025
Version: 2.0

The Clatterbridge Cancer Centre NHS Foundation Trust

Mortality Surveillance Group Annual Report 2021-2022

Prepared by: Dr. Sheena Khanduri (Medical Director & Chair of Mortality Surveillance Group)

Dr. Dan Monnery (Consultant Palliative Care)

Dr. Zaf Malik (Consultant Clinical Oncologist & Consultant Mortality Lead)

Helen Wong (Quality Manager –Audit & Statistics)

Marie McKay (Clinical Audit and Information Specialist)

Andrea Law (Clinical Audit and Information Specialist)

on behalf of Mortality Surveillance Group

Members: Elkan Abrahamson (Non-Executive Director), Vikram Singh (Consultant Haemato-Oncologist & Consultant Mortality Lead), Safeguarding representative, Legal & Governance Manager and Associate Director of Clinical Governance and Patient Safety.

Table of Contents

Mortality Surveillance Group Annual Report 2021-2022

Executive Summary

Putting People first

- Families and carers actively involved in shaping our care following deaths by undertaking The National Care of the Dying Evaluation Round 3 which contained a carer reported measure to seek the views of bereaved relatives and friends about their experience, and the quality of care that was provided for someone close to them during their last hours or days of life

Achieving Excellence

- The Trust results of the 2020/21 round of NACEL were positive overall with significant improvements made in many areas and CCC compares favourably with end of life care delivered throughout England.
- Continued compliance against all National Requirements as set out by the National Quality Boards guidance on "National Guidance on Learning from Deaths"
- Outcomes for patients measuring the Quality Surveillance Specialist Service Dashboard for Haematopoietic Stem Cell Transplantation (Adult) demonstrated that in Liverpool CCC is well above the average outcomes for allogeneic transplant and well within average (2SD) outcome for autologous transplantation despite the COVID pandemic.
- National Systemic Anti Cancer treatment body published 30 day mortality benchmarking for a number of tumour groups, the Trust is compariable or better than the national average figure for majority of tumour groups
- The CCC Palliative Care Team were awarded the Specialist Service Redesign Inititative Award for the joint Enhanced Supportive Care (ESC) Pilot.
- The CCC Palliative Care Team submitted 8 abtracts to the European Association of Palliative Care

Passionate about what we do

- The Trust reported on findings of the quarterly deep dive analysis to the mortality surveillance group for 1 local audit from actions arising from the Mortality Review Process, with a further 3 in progress.

Always improving our care

- Continued evolution of the 16 year Trust Mortality Review programme
- Datix Mortality Module was built and rolled out on 16th May 2022 along with bespoke training videos. The digitisation of the proforma enables a more efficient system for clinicians to complete and the system sends automated reminders on a daily basis.

Progress against previous year's annual report 'looking to the future' objectives

Looking to the future 20/21 - We Said, We Did

Completed during 2021-2022

- Participating in NACEL Round 3
  - All data was uploaded on 8th September 2021 within the agreed timescale
  - Bespoke dashboard received in March 2022
  - Trust individual action plan has been developed

- Continue to digitise the mortality review process by embedding a Datix system to support the data collection and reporting process
  - Datix Mortality Module went "live" on 16th May 2022 for deaths from 1st April 2022 onwards
  - Datix training video was launched on 16th May 2022

Developments continuing during 2021-2022

- Mortality Reduction Strategy is in development
  - Measures have been identified to support the strategy

Virtual Conferences / Events Attended - HSJ Patient Safety Awards 2021

Winner of the Specialist Service Redesign Initiative Award for the joint Enhanced Supportive Care (ESC) pilot

ESC helps people living with advanced cancer to stay healthier for longer and have a better quality of life by providing personalised advice and support, including nutrition, wellbeing and managing pain.

Patients receiving ESC have lived longer and enjoyed a better quality of life during their treatment. They also remain healthier while being cared for so the service – which is being extended nationally – saves money for the NHS.

Dr Dan Monnery, Consultant in Palliative Care at The Clatterbridge Cancer Centre NHS Foundation Trust, led the initiative. He said: "We were delighted to have been singled out for a nomination, but to win the award is overwhelming. "ESC is one of The Clatterbridge Cancer Centre's biggest successes of recent times in palliative care and is now being rolled out across the country. This project highlights the huge contribution it is making to patient outcomes while at the same time reducing demand on services."

"The fabulous ESC team here are pioneers in this important area of care and we are all extremely proud have won this award."

Virtual Conferences / Events Attended – European Association of Palliative Care 2021

The Clatterbridge Cancer Centre Palliative Care Team submitted 8 abstracts to the European Association of Palliative Care

Enhanced Supportive Care Impact for Patients and Healthcare System

- **Conclusion:** The delivery of our ESC service improved patients' quality of life with significant reductions in symptom burden. There were fewer unplanned admissions and no deaths within 30 days of chemotherapy. These outcomes impacted the wider healthcare economy.

Assessment and Management of Fatigue in Patients with Cancer: A Multi-centre Regional Audit

- **Conclusion:** The majority surveyed did not use an assessment tool. Most clinicians considered corticosteroids. However, around half did not consider referral for educational or exercise interventions. Psychostimulants were not prescribed. Respondents would consider referral for acupuncture/acupressure but this was not widely available.

Assessing the Relative Impact of Enhanced Supportive Care on Patients' Quality of Lives between Primary Tumour Diagnoses

- **Conclusion**: ESC benefits were not equivalent across primary tumour groups after a first appointment. Patients with breast, lower GI and upper GI cancers benefitted most, whilst patients with head and neck cancer benefitted least. Further work is needed to describe the cause of this variation.

Continuous Subcutaneous Infusions in Palliative Care - A Literature Review

- **Conclusion**: While the use of CSCIs is common place in the palliative care setting for symptom management when the oral route is no longer available, there is a lack of evidence that supports anticipatory prescribing of medication delivered via this route. It was also highlighted that there remains negative connotations associated with the use of CSCIs. Further work is required in both areas.

Development, Delivery and Evaluation of Spirituality and Palliative Care Mandatory Training Programme

- **Conclusion:** This evaluation indicates that delivery of spirituality and Palliative care training increases professionals understanding of spiritual care needsnfidence in delivering such care within a palliative care patient cohort.

Using IPOS to Measure Longitudinal Effect of Enhanced Supportive Care - What Interval Is Ideal?

- **Conclusion:** Whilst clinically important reductions in IPOS score are seen after 1 appointment with ESC, the peak effect is later than initially suspected. This finding informs national discussions about when to measure impact of ESC using IPOS.

The Impact of Enhanced Supportive Care on the Nature of Non-elective Admissions for Patients with Hepatobiliary Cancer

- **Conclusion:** For 101 patients with HPB cancer who attended ESC, 97 unplanned admissions in the last year of life were avoided and average length of stay reduction totaled 534 days. The financial impact of this using commissioner reference costs is a saving of £668,576.30.

Does the AMBER Care Bundle Have a Role in a Regional Cancer Centre?

- **Conclusion:** The ACB has a role within our centre in guiding discussions when patients deteriorate acutely and recovery is uncertain. Whilst willingness to communicate with patients and families about uncertain recovery is generally good, the content of that discussion requires some structure and guidance, facilitated by the ACB, to enable patients' wishes to be respected if they do not recover.

National Mortality Benchmarking

There are 2 indicators available for Trusts to measure whether their mortality performance is higher or lower than expected, Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indictor (SHMI). The statistical calculations behind these 2 indicators are different; both have their strengths and weaknesses, complementing each other.

The Trust is not subscribed to these 2 indicators for the following reasons:

HSMR – focuses on in-hospital deaths. The majority of CCC activities are out-patient based, resulting in the majority of records being excluded.
– focuses on 56 diagnoses (85% of death), excluding rare cancers.
– CCC in-hospital mortality measure is not comparable with peers, as peers hospitals carry out diagnostic and surgical procedures.

SHMI – Specialist trusts, mental health trusts, community trusts and independent sector providers are excluded from the SHMI because there are important differences in the case-mix of patients treated there compared to non-specialist acute trusts and the SHMI has not been designed for these types of trusts. Integrated trusts which provide both acute and community services are included in the SHMI

Evolution of the Trust's Mortality Review Programme

The Trust's internal mortality review programme has gone from strength to strength over the last 17 years commencing with a local interest audit on 30 day mortality in lung cancer patients, to the introduction of the multi-disciplinary mortality review meeting in 2012. 2017 saw the introduction of a trust wide mortality review policy and the inception of a new mortality surveillance group. A Structured Judgement Review form based on documentation from the Royal College of Physicians was introduced in March 2018 for all inpatient deaths, allowing a thorough and structured investigation of specific phases of inpatient care delivered within the trust.

April 2018 saw the introduction of the Trust Mortality Dashboard for CCC Wirral to aid in headline discussions and give executive oversight of the Trust Mortality programme. In December 2018 HO data was added to the dashboard in a new section along with compliance to newly introduced reporting on Learning Disabilities Mortality Review Programme (LeDeR) & Child death overview panels (CDOP).

During 2019, further dissemination of Trust-wide shared learning was emphasised with actions and learning from mortality cases in each directorate data pack for discussion at each Directorate Quality and Safety Meeting as well as the Trust Shared Learning Newsletter.

Roadmap of Trust's Mortality Review Programme

2005

Lung cancer 30 day Systemic Anti-Cancer Therapy mortality audit

2008

NCEPOD "Systemic Anti-Cancer Therapy: For better, for worse?"

2009

Statistical Analysis of 30 day treatment mortality

2010

Global Trigger Tool Introduced

2012

Mortality Review Meeting Established

2017

- Mortality Surveillance Group
- Established & Mortality Policy Introduced

2018

- Structured Judgement Review introduced
- Mortality Dashboard Developed
- HO join Mortality Dashboard, having own section
- LeDeR & CDOP
- compliance added

2019

Inclusion of Mortality Review actions in each Directorate data pack

Learning from mortality included in Trust wide shared learning newsletter

HO and CCC-W data combined forming new Trust wide Mortality Dashboard

2020

2021

Following COVID19 lockdown, the Mortality review programme was digitised with MRM & MSG meetings being hosted on Microsoft teams and paperwork being completed electronically.

2022

Datix®

Continued to develop Datix Mortality software for managing MRM programme digitally

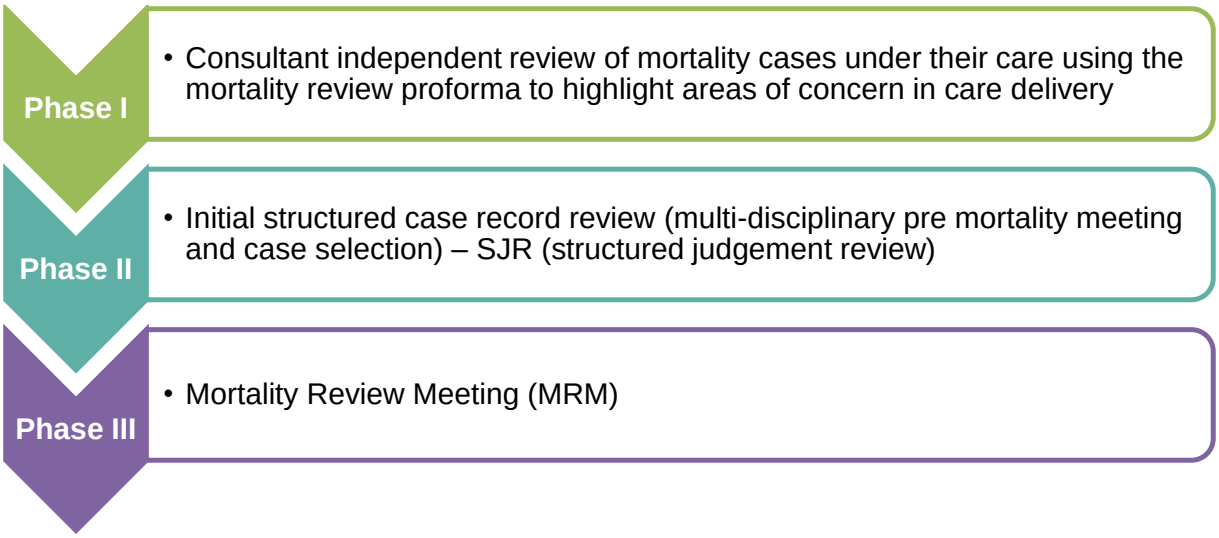
Mortality Review Scrutiny 2021/2022

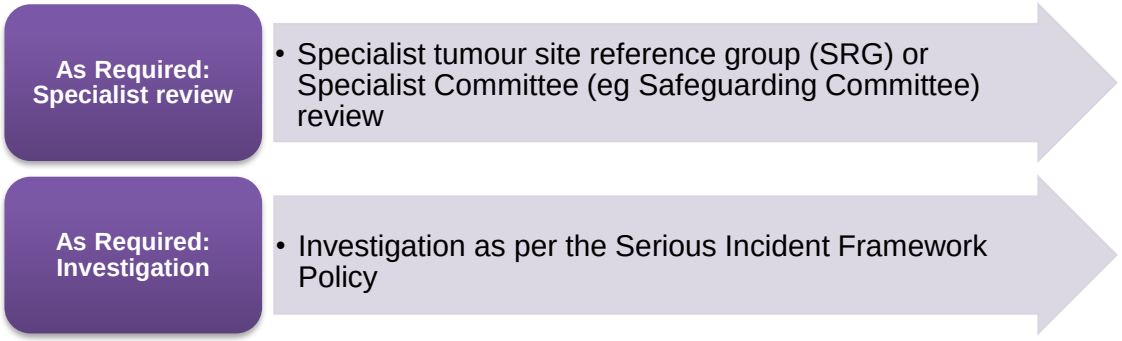
The Mortality Review Meetings are a forum for both improving practice as well as celebrating best practice. They form part of the existing Trust wide mortality review process and underpin the Trust's strategic goal to prioritise patient safety, prevent avoidable deaths and improve patient care.

This is a multidisciplinary review meeting looking at

- 30 day post treatment mortality
- 90 day post radical radiotherapy mortality
- All inpatient deaths
- Formal incident related deaths
- Concerns raised from the Global Trigger Tool extracted deaths
- Any other concerns raised by individual Consultants

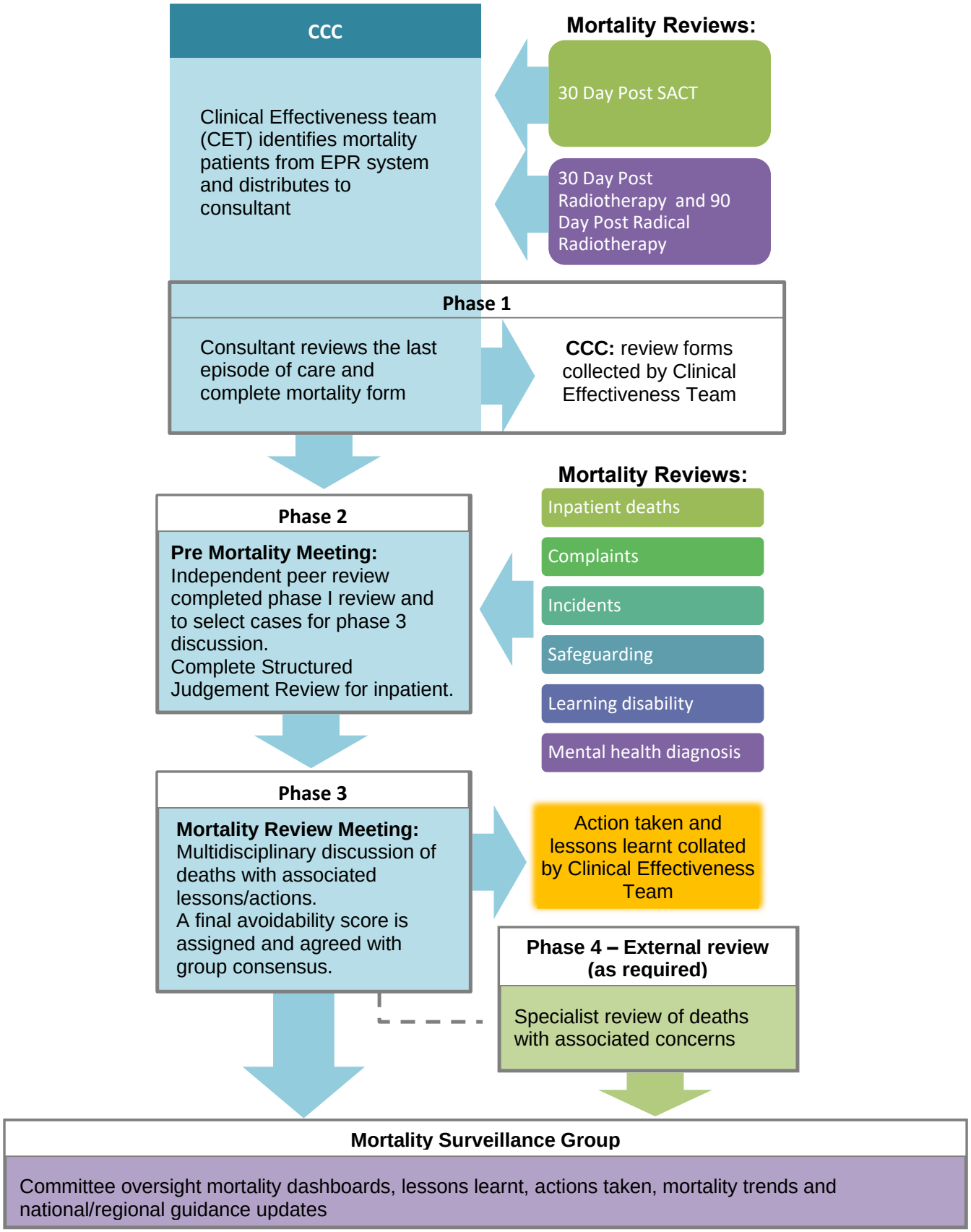
One or more of five levels of scrutiny for identified cases:





Detailed Mortality Review Process for CCC

As from December 2020, the Haemato-oncology mortality review process has been merged with the solid tumour process. Now the Trust has a single process to review mortality cases to ensure consistency and robustness.



Compliance against National Guidance on Learning from Deaths 2021/2022

Mortality governance is a key priority for the CCC Trust board. Executives and nonexecutive directors have the capability and capacity to understand the issues affecting mortality in our Trust. CCC continues to remain compliant with the following key requirements from the National Guidance on learning from deaths issued by The NHS Quality Board published in March 2017 and updated in February 2018:

Medical Examiner

A new medical examiner system has been rolled-out across England and Wales to provide greater scrutiny of deaths. In February 2021, the government published Working together to improve health and social care for all, the white paper which includes provisions for medical examiners to be put on a statutory footing. During 2021/22, the role of these offices is being extended to include all non-coronial deaths, wherever they occur.

The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data

The Clatterbridge cancer centre medical examiner service is provided by the Royal Liverpool and Broadgreen University Hospitals due to the small number of deaths which occur in the Trust.

To support the new medical examiner initiative, the Trust reviewed and streamlined the documentation for deceased patients within the electronic patient record (EPR). The medical examiners have direct read-only access to the EPR in order to review documentation.

The new process commenced in October 2021, with all deaths occurring on the Trust's inpatient wards (aside from those being directly referred to the coroner) being reported to the medical examiner office. The patient's cause of death was agreed with the next of kin/informant and any concerns with care prior to the patient's death can be discussed.

The Trust also integrated the medical examiner feedback into the Trust structured judgement review which strengthened the process further.

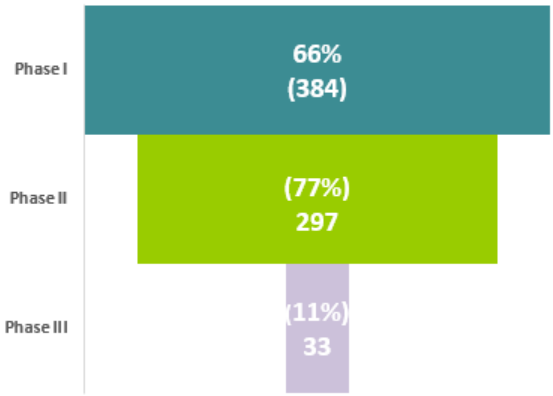
Structured Judgement Review

The Structured Judgement Review (SJR) process introduced in March 2018 has been strengthened by the introduction of dedicated time allocated within the Consultant in Palliative Medicine's job plan. CCC have always strived to review all inpatient deaths utilising structured judgement review rather than a sample. SJRs take place once a phase 1 review is completed by the treating/admitting consultant.

There were 132 inpatient deaths during 2021-22 out of which 80 have had a phase 1 review (61%). Out of the 80 which have had a phase 1 review, we have conducted 80 SJR's (100%).

Engagement with the Trust Mortality Process

Out of the 585 cases identified as requiring review at Phase I, the graph on the left demonstrates that 384 were reviewed at Phase I which equates to 66%. Of the 384 forms completed, 297 were reviewed at Phase II equating to 77%.



Out of the 297 reviewed at the pre-meeting 33 were selected for further discussion at the Multidisciplinary Mortality Review Meeting (Phase III) which equates to 11% of cases.

<u>Attendance at the Trust Mortality Review Meetings</u>

During 2021-22 we held 11 Mortality Review Meetings. 22 out of 74 (30%) consultants achieved the target of 30% attendance at the mortality meeting.

The Importance of the Phase 2 Process

Out of a snapshot audit of cases selected for Phase III discussion during 20 21-22, highlighted that (60%) of cases were selected via the independent mortality peer review (phase II) process. The remaining 40% were selected by the treating clinician during phase I.

Lessons Learnt from Mortality Review Process

Learning from case reviews and investigations conducted in relation to deaths (inpatient and outpatient deaths) along with description of actions taken in the reporting period

Background	Action	CCC Lesson Learned
Patient was admitted to a local network Trust on a 5FU bottle; this was not discontinued until the following morning as the admission team felt this could only authorised by the acute oncology team. It is quite possible that the 5FU contributed to cardiac arrhythmias / ischaemic pain.	This case was flagged to the local Trust mortality team who discussed this case at their local Mortality Review meeting and cascaded learning to their acute admissions team.	Patients admitted to DGHs acutely unwell with 5FU bottles in situ should have these discontinued.
An inpatient received a combination of different formulations of insulin used at differing doses with their blood sugars fluctuating from high 20s to 2. There was no clear documented advice sought from the diabetic specialist team. MET calls were needed to manage hypoglycaemic episodes.	CCC have adopted LUHFT diabetic protocols to standardise best practice and have established clear referral processes for diabetic advice from LUHFT.	Inpatient management of diabetes should follow LUHFT guidelines and referral pathway is in place to obtain advice when needed.
DNACPR was appropriately put in place on admission for a patient but without the required communication and without documentation to support this. This was felt to be due to lack of documentation by junior medical colleagues documenting a consultant's ward round rather than the conversation not occurring.	Requirements for specific discussion points and documentation requirements are present in the resuscitation document on meditech. This has been fed back to consultants and has been included in junior doctor induction. A further training day has been set up to educate MDT colleagues on best practice in complex discussions and legal requirements of documentation.	It is essential that DNACPR decisions are discussed with patients who have mental capacity unless it is clearly documented that those patients would be harmed by such discussions. Discussions should also include relatives and carers if the patient gives consent.

Background	Action	CCC Lesson Learned
An inpatient with renal cell carcinoma required a MRI Scan at the Liverpool University Hospital Foundation Trust (LUHFT) to rule out metastatic spinal cord compression (MSCC) urgently over a weekend. Once transferred patient sadly deteriorated and died from a retroperitoneal heamatoma despite appropriate management. The receiving team did not feel they had sufficient handover that the patient had been medically unstable prior to transfer adversely affected patient care although did not on balance contribute to the outcome.	Incident investigation launched in collaboration with LUHFT to review the referral and communication process of acutely unwell patients including out of hours.	Patients requiring urgent scans at CCC should be able to access these at CCC- these are now available 24/7 at CCCL. In the event of needing to transfer patients to LUHFT, transfers should be accompanied by digital transfer template which has been co-designed between the 2 trusts.
A patient had an Ascitic Drain left in-situ for 5 days.	An action was made to review the Ascitic drain policy and ensure that it covered siting and duration to be left in-situ. The ascitic drain policy states clearly to remove the drain by 24 hours to minimise risk of infection.	Ascitic drains should be removed within 24 hours of insertion unless there is a clinical reason in which cause it should be clearly documented. CET have shared this information with all SRGs

Background	Action	CCC Lesson Learned
Post cycle two a patient attended CDU. On review it was documented the patient had a slightly swollen leg but this was not deemed relevant. Patient was not admitted to CCC, therefore no VTE assessment was undertaken as VTE was not expected as a diagnosis. Patient was discharge with a plan for outpatient review and investigations the following week. Later the cause of death was originally deemed as lung cancer; however, the treating consultant felt strongly that CCC needed to look into this and learn from this case, as this was the first SCLC chemo IO patient. Treating consultant asked for a PM to be undertaken. Post-mortem examination revealed the cause of death to be 1a) Pulmonary embolism 1b) Deep vein thrombosis 2) Ischaemic heart disease and coronary artery atherosclerosis.	Post mortem report obtained. The PM confirmed that the cause of death as 1a) Pulmonary embolism 1b) Deep vein thrombosis 2) Ischaemic heart disease and coronary artery atherosclerosis. The Immunotherapy team amended the pneumonitis protocol (serendipity) to consider pneumonitis and PE as differentials.	It is important to share these rare and complex clinical cases to increase education amongst junior colleagues and encourage professional curiosity. It is also important to continuously amend protocols to reflect rare real-world toxicities. The lead registrar and nurse consultant agreed that this case had been a subtle presentation and that it was beneficial to share with their teams for educational reasons
Dabrafenib + Trametinib was commenced in a frail melanoma patient with a PS 4. The patient's PS measured 4 as he was on strict bed rest and was in a lot of pain. At the time of the decision to treat it was felt this was appropriate as this regime has a high response rate with a likelihood of improving the patient's symptoms quickly (70-80%).	Melanoma team to undertook an audit of this regimen in terms of survival compared to published literature. All palliative deaths occurred as a result of progressive malignancy that either illustrated primary resistance (n=1) or secondary resistance (n=7). In the case of adjuvant deaths 1 case was related to treatment toxicity and appropriate steps were taken and 1 case was unrelated to malignancy or toxicity	Given the indication for dabrafenib and trametinib treatment and the activity of metastatic disease on secondary progression following response as experienced by the majority of patients in this cohort the deaths the mortality observed do not raise concerns following evaluation. Learning points from this review are the need for clear documentation as to the events pertaining to patients on the isle of man (IOM), the need for annotation within the patients records as to the cause of death certificated as well as the date of death and ongoing awareness of the toxicities of D&T treatment to ensure all patients have their treatment

Background	Action	CCC Lesson Learned
		discontinued if showing evidence of toxicity (as did happen in the case of the patient within this cohort).
Patient started to progress while receiving Rucaparib treatment so treatment was stopped. A side effect of Rucaparib treatment is myelosuppression and reduced platelet counts however the patients platelet counts did not improve with discontinuation of treatment so it was felt these were secondary to marrow infiltration and disease progression. The option of best supportive care or platinum based chemotherapy (BRCA positive) were discussed with the decision being made to go ahead with dose reduced Carboplatin under close supervision. 10 days post cycle 1 the patient had a large PR bleed and despite blood transfusion support he experienced a further episode of bleeding and died 3 days later	The Urology SRG now hold a weekly peer review MDT discussion in cases where risks and benefits are finely balanced to peer review treatment decisions and ensure patients are treated as safely as possible.	Clinical decisions where risks and benefits are finely balanced with associated risks to treatment should be peer reviewed and this peer discussion documented within meditech.
There have been 2 cases of Capecitabine doses taken wrongly by patients despite advice being given.	Actions undertaken by the Medicines Safety Advisory Committee: 1. Correct dosage now properly explained to the patient and Capecitabine diary is given. 2. Capecitabine stopped for remainder of the cycle and bloods reviewed by on-call registrar 3. Reassurance and education given	Patients require additional information and support when taking capecitabine in order to take this medication correctly. This additional support is now provided.

Background	Action	CCC Lesson Learned
	around how and when to take Capecitabine.	
Cyclizine and Metoclopramide are mutually antagonistic yet they are frequently prescribed together	Pharmacy to provide a digital warning on meditech to prevent co-prescription if attempted.	Pharmacy have linked these two drugs in the Meditech EPR system and this now can create a message to the prescriber to state why they are prescribing the medication together and will request a reason for doing so. This will mandate the prescriber to pause and reconsider the prescription.
During an infusion of a 3rd cycle of Paclitaxel a patient reported lower back pain, treatment was stopped immediately and the patient was treated timely for an infusion related allergic reaction as per the CCC hypersensitivity guidelines. A MET call was logged but unfortunately the patient then suffered a cardiac arrest from which the patient died. Cause of death was cited as 1a Anaphylactic drug reaction, 1b Paclitaxel Chemotherapy and 1c Metastatic Breast Adenocarcinoma	Local audit of hypersensivity reactions with paclitaxel undertaken.	Rates of reaction for CCC patients were reported to be 0.6% for mild to moderate hypersensitivity (compared to 10-30% in literature), 0.5% for severe hypersensitivity (compared to 1% in literature) and 0.07% for anaphylactic reactions (compared to 0.1% in literature). Assurance given that CCC hypersensitivity reaction rates are below other published rates.
A patient had nausea and vomiting throughout their admission but no palliative care medical review was undertaken	Palliative care team to review this case in terms of escalation process within palliative care team	Cases where symptoms are difficult to manage despite initial interventions should be raised for medical SPCT review and this has been disseminated to the team. The weekly MDT also includes detailed review of symptoms to ensure patients needing medial review are picked up.
A consultant raised that some trusts have the option of “I’ve discussed the option of no	Copy of case was forwarded to PWR with consideration of inclusion of	The consent forms used at CCC already have a section for highlighting that the option of no

Background	Action	CCC Lesson Learned
treatment" on consent forms and asked if CCC could we discuss having this on our consent forms with PWR	"discussed no treatment" in consent forms going forwards to evidence base conversations more robustly	treatment has been discussed- this has been cascaded to consultants
A patient with symptom issues and a changing prognosis spanning an 8 month period was reviewed by a physician's associate 5 times and no letters were communicated to the GP. They were also reviewed by the medical team during this period and on three occasions letters were also not issued.	HBP team to reviewed frequency of letters from consultation. E-Mail distributed to all SRG members stating it is imperative that appropriate communication is provided to the GP and extended healthcare team.	If SRG teams would like their PAs to write letters, then the clinical team should oversee and supervise this or a member of the team dictate on their behalf. Regular communication with primary care about changes in patient's clinical condition is essential.
The reason for this case being discussed at MRM is due to it being an inpatient child death which we have a requirement to discuss and feedback to the Child Death Overview Panel (CDOP). This was a tragic case of an aggressive cancer that responded poorly to treatment. The treating team were asked whether they had the opportunity to debrief after these deaths. The team replied that there was not a formal process but it is done informally. The CCC Palliative care team replied that support locally can be provided and that there is national peer support available.	MRM asked the treating team to consider the use of the CCC local debriefing tool. There is a new family support practitioner in post at CCC who now delivers ward debriefs as needed. The trust debrief tool 'AFFECTS' is also available to all colleagues via the intranet and on the wards.	Teams in need of debrief following complex deaths can access team support from the psychological medicine team, palliative care team and family support practitioner.

Background	Action	CCC Lesson Learned
Treatment was continued despite evidence of progression on CT from Nov 2019 and April 2020. The group advised as two scans had shown signs of progression on SACT and that the treatment should have been stopped, or at least the decision to treat peer reviewed to double check the clinical rationale.	Upper GI/HPB SRG reviewed this case at the request of the MRM and were asked to consider mechanisms to prevent treatment being continued despite evidence of disease progression	A peer review group has been set up which meets fortnightly to discuss chemotherapy options for complex Oesophegeal and HPB patients which will peer review further treatment decisions in this patient group
A patient with a stomach adenocarcinoma died of neutropenic sepsis after cycle 1 of his 4th line chemotherapy. No prophylactic GCSF was given, however chemotherapy was dose reduced by 20%.	An update was circulated to consultants about the protocol for use of prophylaxis of GCSF in palliative treatments with high risk of neutropenia.	GCSF prophylaxis can be offered for palliative chemotherapy regimens with moderate/high risk of febrile neutropenia at the discretion of the consultant.
Borderline metastatic lung cancer patient with multiple co-morbidities. Treating consultant and the patient discussed at length the pros and cons of supportive care vs. high risk immunotherapy. The patient opted for the latter and unfortunately died 10 days after cycle 1.	Feedback the results of the Pembro audit to the MSG once available	A local audit established that Pembrolizumab in our patient group is overall well tolerated. Over the first three months, grade 3-4 toxicity is rare and correlates with poor prognosis when it starts within the first 3 weeks. Fast responses are also rare. Most problems within the first three months tend to be cancer-related, due to progression. Our toxicity incidence is consistent with that seen in the published prospective studies, but our mortality is better, probably thanks to our protocols and IO-team support"
It was noted that a consent form for second line chemotherapy could not be located in Evolve	Further investigation was undertaken into the location of the form which was later located in the wrong section of Evolve. Confirmation of the correct process and location of consent forms was disseminated.	All paper documents should be scanned into the consent form section in Evolve - this has been communicated to the scanning bureau team via their line manager

Background	Action	CCC Lesson Learned
A patient had failed to attend several appointments due to ongoing illness. The patient was contacted by treating nurses, the care navigator and finally the police. There was no next of kin and the patient was socially isolated.	This case received a formal investigation as well as mortality review. A new system has been set up for triage to be contacted when a patient cancels an appointment in order to undertake a UKONS assessment and provide the most appropriate safety netting and follow up advice.	Patients who call up to cancel appointments should receive a UKONS assessment from the triage team. This change in the care pathway has been communicated to all stakeholders
Patient was seen early November “breathless and fatigued” when recovering from COVID. A decision was made to proceed with cycle three at 80% dose. The patient subsequently died on day 20 of cycle three of ‘acute myocardial insufficiency’. A CT undertaken midway through cycle three had shown some disease progression and also residual COVID changes in the lungs. It was felt that this could have indicated that the patient’s death may have been related to the prior COVID infection from which he had not fully recovered.	Upper GI/HPB SRG reviewed this case at the request of the MRM and were asked to consider mechanisms to prevent treating too early in patients recovering from COVID-19.	This patient's chemotherapy should have been delayed and further review before consideration of treatment. A peer review group has been set up which meets fortnightly to discuss chemotherapy options for complex Oesophegeal and HPB patients which will peer review further treatment decisions in this patient group
A patient who was treated with Carboplatin had an 8kg weigh loss reported during chemotherapy along with a deteriorating kidney function. The question was raised if the correct dose of Carboplatin was given.	Investigation by pharmacy revealed that the correct dose of chemotherapy was given but that different laboratories supporting CCC patients use different Wright formulae. The head and neck team are auditing this to determine if this alters chemotherapy prescription dosing.	All SRGs informed of the variation in laboratory protocol. Whilst this does not appear to alter chemotherapy dosing banding, SRGs are advised to ask for eGFR clearance for patients when borderline.

Background	Action	CCC Lesson Learned
	The medicines safety pharmacist and associate medical director investigated if the appropriate formula was used for the laboratory in this case. It was found that neither formula would have affected the dosage prescription with dose banding in place for this case.	
This patient developed a COVID infection either during her last week of admission in CCCL or in transit back to the IOM. Due to the IOM 14-day COVID isolation rule no family or healthcare professionals were allowed to visit the patient at home prior to her emergency admission to Nobles hospital where she passed away.	Treating consultant reviewed the discharge policy for patients from IOM who needs safety net care of support outside CCC Treating consultant liaised with nursing manager to cascade lessons learnt of this case. Policy amended to account for patients being discharged to IOM. The patient flow team now undertake a day after discharge telephone call with all level 2 discharges. A Level 2 discharge is anything the patient flow time have been involved in.	All discharges to the Isle of Man in which the patient flor team have been involved require a check the day after discharge to ensure local support is in place and the patient is receiving the right support.

National Audit of Care at the End of Life (NACEL) – Round 3

NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission before death in acute, community hospitals and mental health inpatient providers in England, Wales and Northern Ireland.

NACEL was commissioned by HQIP on behalf of NHS England and the Welsh Government in October 2017 and commissioned separately by Northern Ireland Public Health Agency in July 2018. The commission was for four rounds of data collection, with the 2021 audit being round three.

The aim of the audit is to improve the quality of care at the end of their life. NACEL covers NHS funded inpatient care provided to adults (18+).

The audit objectives for the third round of NACEL encompassed the following:

To refine the tools for assessing compliance with national guidance on care at the end of life – One Chance To Get It Right (2014), NICE guidelines (NG31) and the NICE Quality Standards for end of life care (QS13 and QS144).

To measure the experience of care at the end of life for dying people and those important to them

To provide outputs which enable stakeholders to identify areas for service improvement.

To provide a strategic overview of progress with the provision of high-quality care at the end of life in England, Wales and Northern Ireland.

NACEL Round 3

Data was collected in May 2021 and the full report was published in March 2022. Overall the Trust results of the 2020/21 round of NACEL are positive with significant improvements made in many areas and compare favourably with end of life care delivered throughout England. There are however always areas to develop and a comprehensive action plan has been drawn up and implementation of the action plan has commenced.

Audit elements

Organisational Level Audit

- Comprises of the trust/HB overview and the hospital/site overview
- Trust/HB overview: Policies and guidelines
- Hospital/site overview: Activity, workforce, training, quality and outcomes

Case Note Review (CNR)

- Completed by acute and community providers
- Patient demographics, final admission details, recognition of imminent death, communication, involvement in decision-making and individualised EoL care planning

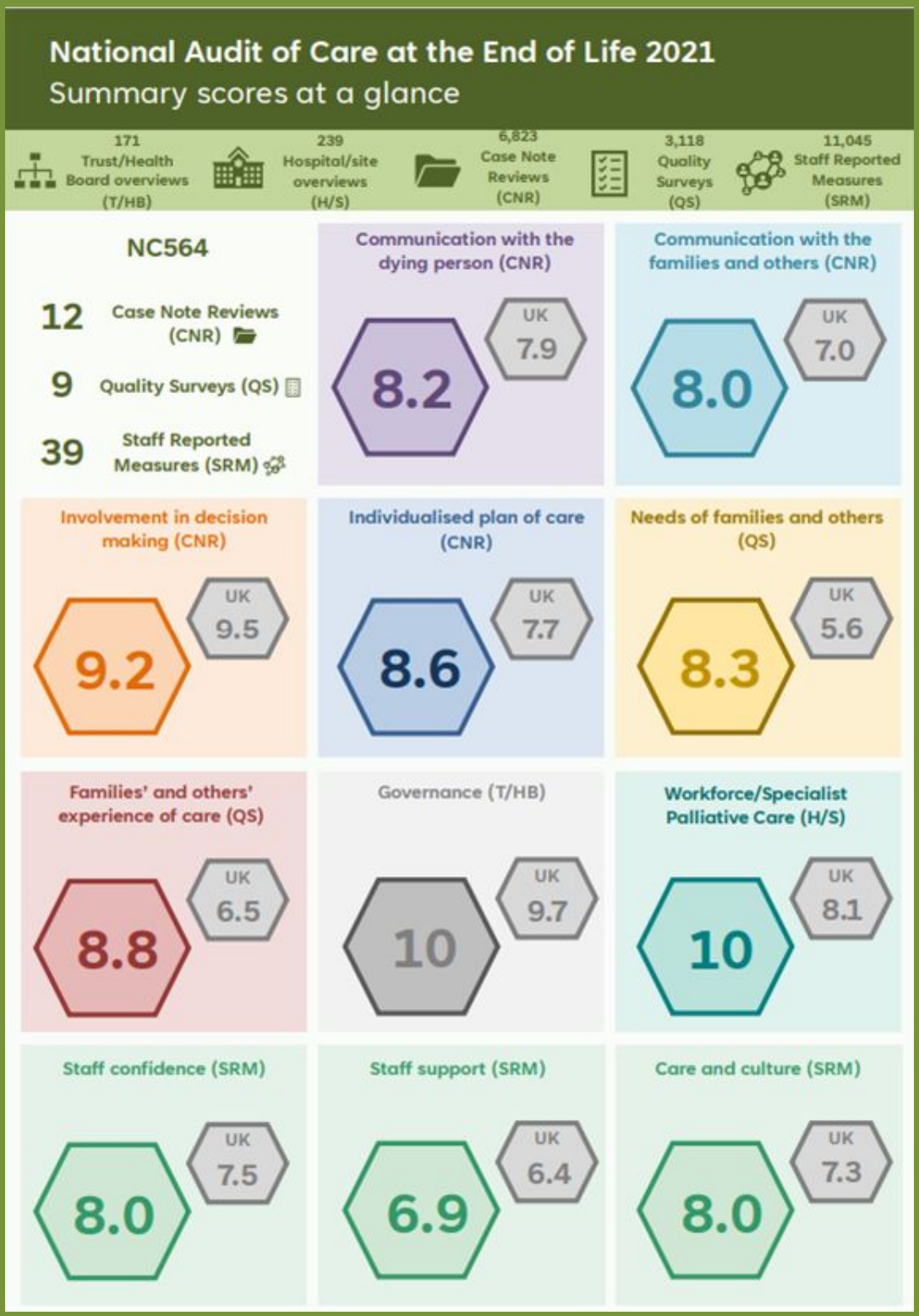
Quality Survey (QS)

- Developed with the assistance of the Patients Association
- Online survey completed by bereaved carers with the option to complete over the telephone

NEW Staff Reported Measure (SRM)

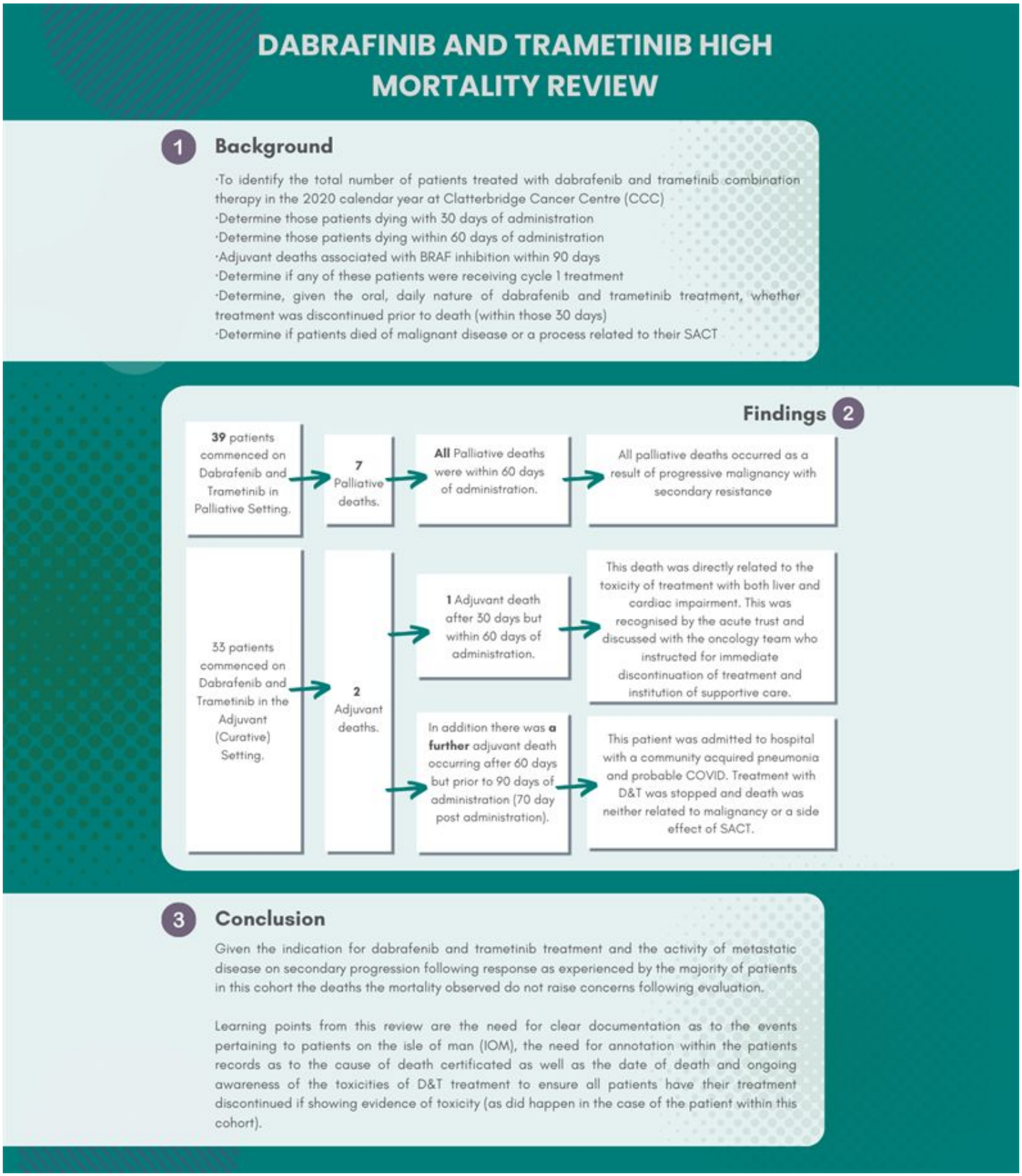
- Staff who are most likely to come into contact with dying patients and those important to them
- Staff confidence and experience in delivering care at the end of life


National Audit of Care at the End of Life 2021
Key findings at a glance
NC564 - The Clatterbridge Cancer Centre NHS Foundation Trust
(CNR – Cat 1)
83%
UK 87%
Case notes recorded that the patient might die within hours or days
(CNR– Cat 1)
100%
UK 95%
Case notes, with an individualised plan of care, recorded a discussion (or reason why not) with the patient regarding the plan of care
(CNR – Cat 1)
100%
UK 98%
Case notes recorded a discussion (or reason why not) with families/carers regarding the possibility the patient may die
(CNR – Cat 1)
80%
UK 86%
Case notes recorded extent patient wished to be involved in care decisions, or a reason why not
(CNR – Cat 1)
100%
UK 73%
Case notes recorded an individualised plan of care
(QS)
89%
UK 57%
Families/carers were asked about their needs
(QS)
89%
UK 74%
Families/carers felt the quality of care provided to the patient was good, excellent or outstanding
(T/HB)
Yes
UK 99%
Trusts/Health Boards have guidelines on how to respond to/learn from deaths of patients
(H/S)
Yes
UK 60%
Hospitals have face-to-face specialist palliative care service available 8 hours a day, 7 days a week
(SRM)
90%
UK 85%
Staff feel confident they can recognise when a patient might be dying imminently
82%
UK 77%
Staff feel supported by their specialist palliative care team
83%
UK 80%
Staff feel they work in a culture that prioritises care, compassion, respect and dignity


National Audit of Care at the End of Life 2021
Summary scores at a glance
171 Trust/Health Board overviews (T/HB)
239 Hospital/site overviews (H/S)
6,823 Case Note Reviews (CNR)
3,118 Quality Surveys (QS)
11,045 Staff Reported Measures (SRM)
NC564
12 Case Note Reviews (CNR)
9 Quality Surveys (QS)
39 Staff Reported Measures (SRM)
Communication with the dying person (CNR)
8.2
UK 7.9
Communication with the families and others (CNR)
8.0
UK 7.0
Involvement in decision making (CNR)
9.2
UK 9.5
Individualised plan of care (CNR)
8.6
UK 7.7
Needs of families and others (QS)
8.3
UK 5.6
Families' and others' experience of care (QS)
8.8
UK 6.5
Governance (T/HB)
10
UK 9.7
Workforce/Specialist Palliative Care (H/S)
10
UK 8.1
Staff confidence (SRM)
8.0
UK 7.5
Staff support (SRM)
6.9
UK 6.4
Care and culture (SRM)
8.0
UK 7.3

Audits arising from Mortality Review Process

The following audits arose from discussions at either the Mortality Review meeting or the Mortality Surveillance Group.



Quality Surveillance and Specialised Services

What is Quality Surveillance?

The Quality Surveillance Team (QST), formerly National Peer Review Programme, lead an Integrated Quality Assurance Programme for the NHS and is part of the National Specialised Commissioning Directorates, Quality Assurance and Improvement Framework (QAIF).
The role of the QST is to improve the quality and outcomes of clinical services by delivering a sustainable and embedded quality assurance framework for all cancer services and specialised commissioned services within NHS England.

These results indicate that successful engraftment in our BMT patient is well above average. Deaths within 100 days of allogeneic stem cell transplantation remains well below national average showing excellent results for the centre for all quarters. Survival data for allogeneic stem cell transplant (number of patients alive at one year) also remains above average for our patients for all quarters. For autologous stem cell transplantation, percentage of patients dying within first 100 days is just below national average but not statistically significant (last quarter CCCL value 2.2 , national value 1.7 which is a similar trend for all quarters). Overall there are no negative indicators, 6 positive indicators and 3 neutral indicators.

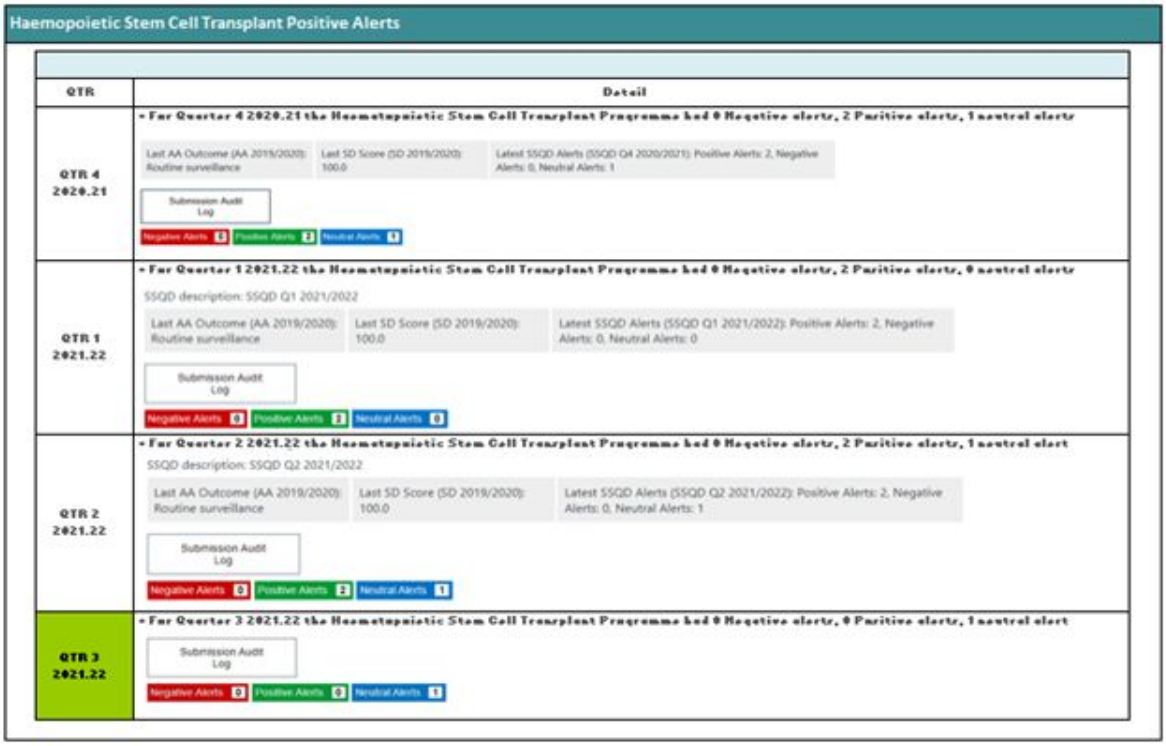
Summary: Outcome of patients receiving stem cell transplantation in Liverpool shows well above average outcomes for allogeneic transplant and well within average (2SD) outcome for autologous transplantation despite COVID pandemic. There are no concerns in these data.

It is also worth noting that since 25th March 2020 submission of data to the dashboard has been voluntary and it is not known how many centres have continued to submit data, this may impact national figures and averages.

- Dr Muhammed Saif
  Director of BMT and Cellular Therapy
  Consultant Haematologist

Haemopoietic Stem Cell Transplant Positive Alerts

For Q4 (2020-21) and Q2-Q3 (2021-22) the Haemopoietic Stem Cell Transplant Programme had 0 Negative alerts, 6 Positive alerts, 3 neutral alerts



Haemopoietic Stem Cell Transplants full Dashboard

Proportion of patients with successful engraftment

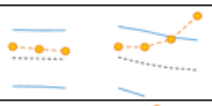
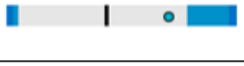
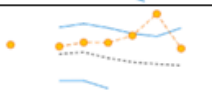
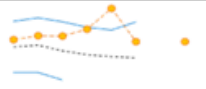
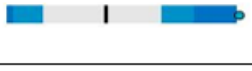
BMT02a-A - Relating to Autograft Stem Cell Transplant Patients
- Numerator Description - Number of patients where engraftment was successful (successful defined as neutrophil count of > 0.5 * 10^9 per litre for three consecutive days by day plus 28)
- Denominator Description - Total number of patients transplanted in the first 6 months of the previous 7 month reporting period
- Value – CCC SCT Programme
- Interpretation Guidance - Higher is better

QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
QTR 4 2020.21	Oct 20 - Mar 21	41	41	100	98.1		
QTR 1 2021.22	Jan 21 - June 21	30	30	100	97.3		
QTR 2 2021.22	Apr 21 - Sep 21	30	30	100	97.8		
QTR 3 2021.22	Jul 21 - Dec 21	43	44	97.7	97		

Percentage of transplant patients registered in research trials

BMT06-A – Relates to ALL both Autograft and Allogeneic where applicable
- Numerator Description - Number of patients having a bone marrow transplant as part of a trial protocol registered with UK CRN database, EU or clinicaltrials.gov
- Denominator Description - Total number of transplants

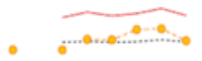
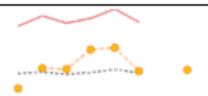
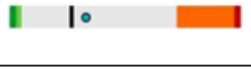
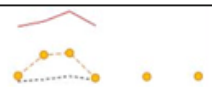
To include interventional trials and include all trials where there is a transplant arm / option (eg AML18, 19 and UKALL14) and not just transplant-only trials
- Value – CCC SCT Programme
- Interpretation Guidance – Non-discriminatory indicator

QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
QTR 4 2020.21	Apr 20 - Mar 21	21	57	36.8	12.4		
QTR 1 2021.22	Jan 21 - June 21	6	30	20	11.8		
QTR 2 2021.22	Oct 20 - Sep 21	14	70	20	10.6		
QTR 3 2021.22	Jan 21 - Dec 21	20	74	27	10.6		

Percentage of patients dying within 100 days of transplant

BMT08a-A – Relates to Autograft Stem Cell Transplant Patients
- Numerator Description – Number of patients in denominator who dies within 100 days of transplant
- Denominator Description – total number of autologous transplants in the first 365 days of the previous 465 day reporting period
- Value – CCC SCT Programme

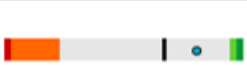
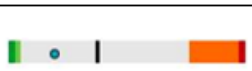
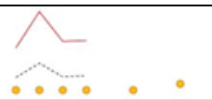
Interpretation Guidance – Lower is better

QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
QTR 4 2020.21	Apr 20 - Mar 21	-	-	4.7	2.2		
QTR 1 2021.22	Jan 21 - June 21	-	-	2	1.8		
QTR 2 2021.22	Oct 20 - Sep 21	-	-	2.1	1.7		
QTR 3 2021.22	Jan 21 - Dec 21	-	-	2.2	1.7		

Percentage of patients alive at 1 year post transplant

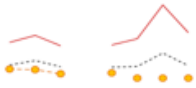
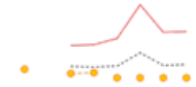
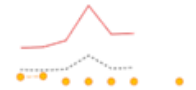
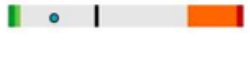
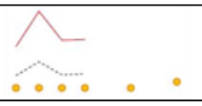
BMT09a-A – Relates to Allogeneic Stem Cell Transplant Patients
- Numerator Description – Number of patients in denominator alive 1 year after transplant
- Denominator Description – Total number of autologous transplants in the first 12 months of the previous 24 month reporting period
- Value – CCC SCT Programme

Interpretation Guidance – Higher is better

QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
QTR 4 2020.21	Apr 20 - Mar 21	50	53	94.3	92.8		
QTR 1 2021.22	Jan 21 - June 21	43	450	95.6	92.8		
QTR 2 2021.22	Oct 20 - Sep 21	29	30	96.7	93.9		
QTR 3 2021.22	Jan 21 - Dec 21	-	-	4.2	8.6		

Percentage of patients dying within 100 days of transplant

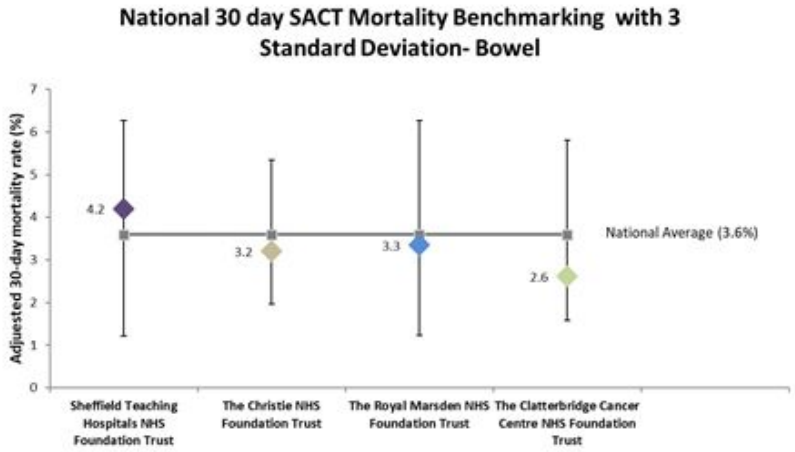
BMT13-A – Relates to Allogeneic Stem Cell Transplant Patients
o Numerator Description – Number of patients in denominator who died within 100 days of allogenic transplant
o Denominator Description – Total number of allogenic transplants in the first 365 days of the previous 465 day reporting period
o Value – CCC SCT Programme
Interpretation Guidance – Lower is better

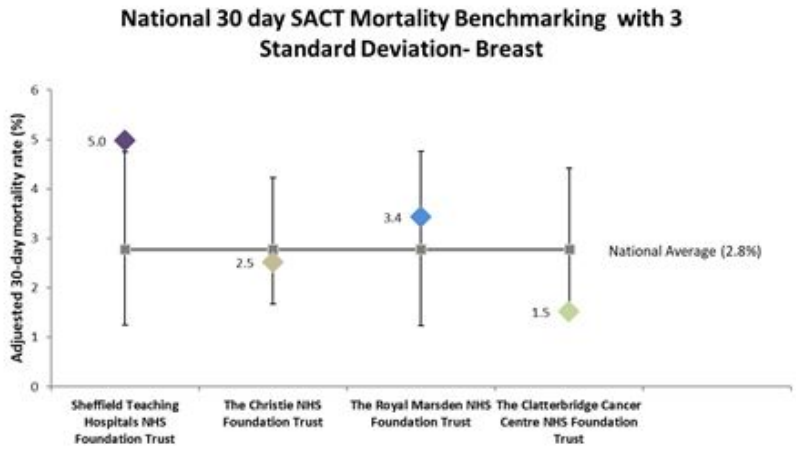
QTR	Period	Num	Denom	Value	Nat Avg	Chart	Trend
QTR 4 2020.21	Apr 20 - Mar 21	0	14	0	8.8		
QTR 1 2021.22	Jan 21 - June 21	0	15	0	9.5		
QTR 2 2021.22	Oct 20 - Sep 21	0	18	0	8.3		
QTR 3 2021.22	Jan 21 - Dec 21	-	-	4.2	8.6		

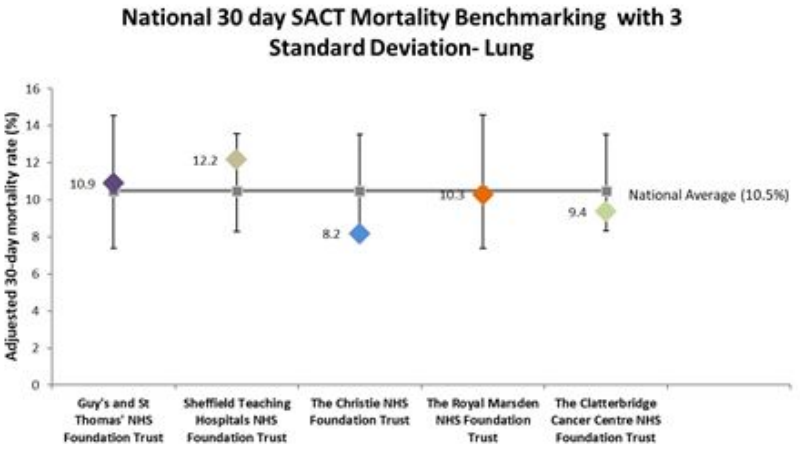
30 Day SACT Treatment Mortality Benchmark

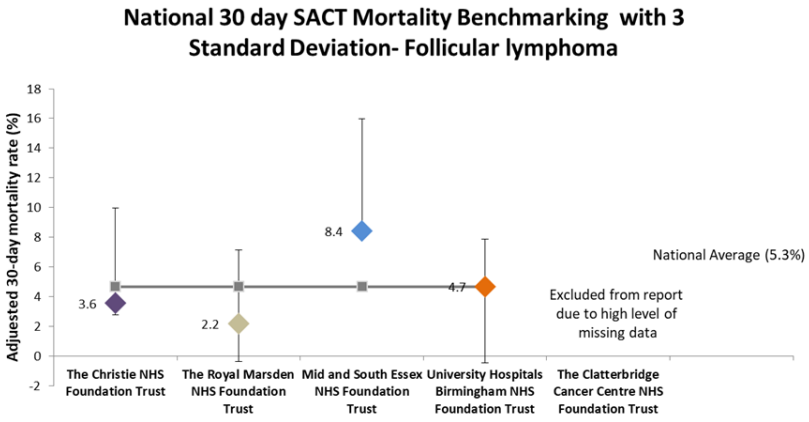
During April 2021 – March 2022, National Systematic Anti-Cancer Treatment (SACT) body published 30 day SACT 30 day mortality benchmarking by treating NHS hospitals for Bowel, Breast, Lung and Follicular lymphoma cancer, utilising data submitted between 2017 - 2020.

Trust performance is comparable to peer hospitals and below national average for Bowel, Breast and Lung cancer. However, the Trust was excluded from Follicular lymphoma national comparison due to high level of missing data. As from December 2019, the collection of Haemato-oncology SACT data for the Trust has been consolidated by electronic prescribing of Meditech system and also handed over to the designated team of experts who has been collecting solid tumour SACT since 2003. The Haemato-oncology SACT data collection has been since improved in terms of completeness and consistency.






National 30 day SACT Mortality Benchmarking with 3 Standard Deviation- Lung
Adjusted 30-day mortality rate (%)
16
14
12
10
8
6
4
2
0
10.9
12.2
8.2
10.3
9.4
National Average (10.5%)
Guy's and St Thomas' NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
The Christie NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
The Clatterbridge Cancer Centre NHS Foundation Trust


National 30 day SACT Mortality Benchmarking with 3 Standard Deviation- Follicular lymphoma
Adjusted 30-day mortality rate (%)
18
16
14
12
10
8
6
4
2
0
-2
3.6
2.2
8.4
4.7
National Average (5.3%)
Excluded from report due to high level of missing data
The Christie NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
Mid and South Essex NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
The Clatterbridge Cancer Centre NHS Foundation Trust

In House 30 Day Treatment Mortality Analysis - 2021 data

Methodology
Treatment mortality analysis is presented in a Statistical Process Control (SPC) chart and split by intent; Radical and Palliative. A set of acceptable limits (upper and lower limits) is derived from historic data since 2009 (purple dotted lines). Monthly actual Trust mortality performance is presented as a blue line, averages of every 3 data points (moving averages) are also employed to gauge the direction of the current trend (red dotted line). HO is excluded from this analysis as control limits are based on CCC solid tumour historic data.

Chemotherapy
Treatment mortality performance reported to the Trust Board as part of the Quality Report. At year end, an individualised performance report was distributed to all consultants, presented in the format of control charts.

Solid Tumour Chemotherapy Mortality Analysis

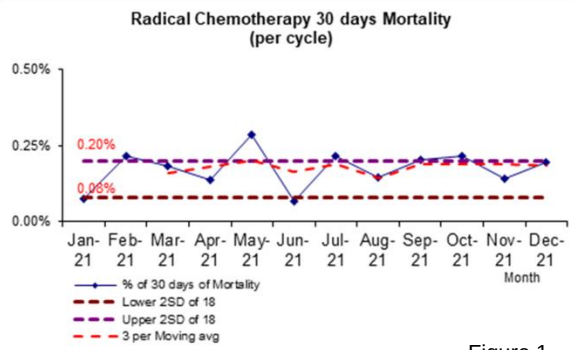


Figure 1

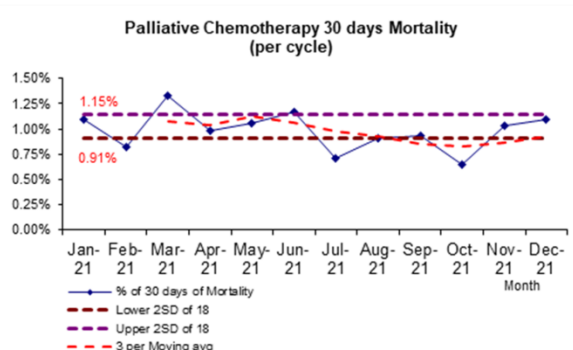


Figure 2

Radical Chemotherapy

- The overall 30 day mortality rate for patients treated with radical chemotherapy in 2021 was 0.7% which was a reduction from patients treated during 2020 (0.97%), however, this is not statistically significant.
- Figure 1 shows the monthly 30 day mortality percentages utilising a 3 month moving average and set control limits. Results demonstrated two mortality data points above the upper limit, however the 3 month moving averages were within control limits, therefore there was no concern raised.

Palliative Chemotherapy

- The overall 30 day mortality rate for patients treated with palliative chemotherapy during 2021 was 5.2% which was a statistically significant reduction from patient treated during 2020 (7.1%).
- Figure 2 demonstrated two mortality data points above the upper limit however the 3 month moving averages were within the control limits, therefore there was no concern raised.

Trends Identified

From the in-depth mortality analysis, 26 chemotherapy regimens were identified as having a high mortality rate, and were added to the CCC monitoring list, of which 22 required no further action. The remaining four were flagged as requiring audits to be undertaken by the corresponding Tumour Specific Site Reference Group. At time of publication, one audit has reported findings and three are ongoing.

Overall 2021 results demonstrated a reduction in mortality rate, despite SACT a 50% increase in activity compared to 2020.

Haemato-oncology Chemotherapy Mortality Analysis

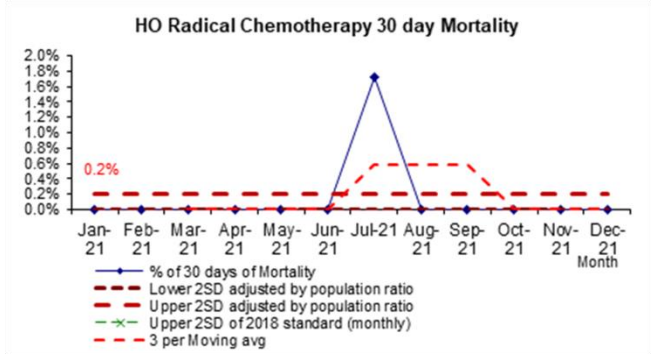


Figure 3

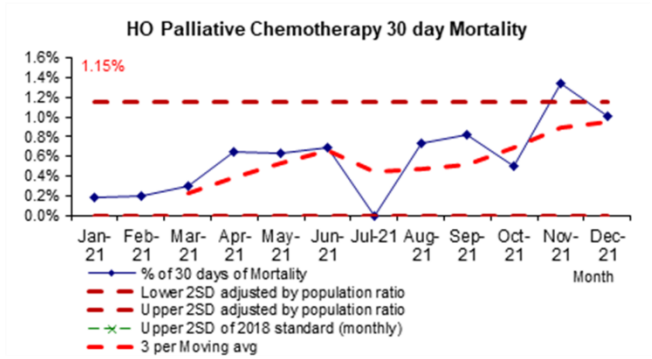


Figure 4

Radical HO Chemotherapy

- The overall 30 day mortality rate for patients treated with radical chemotherapy during 2021 was 0.6% (1/171), demonstrating a reduction from the 2020 mortality rate of 4.9% (4/101 patients), however this was not statistically significant due to small numbers.
- Figure 3 demonstrated that one mortality data point was above the upper limit, this was in relation to a single patient, therefore there were no concerns raised.

Palliative HO Chemotherapy

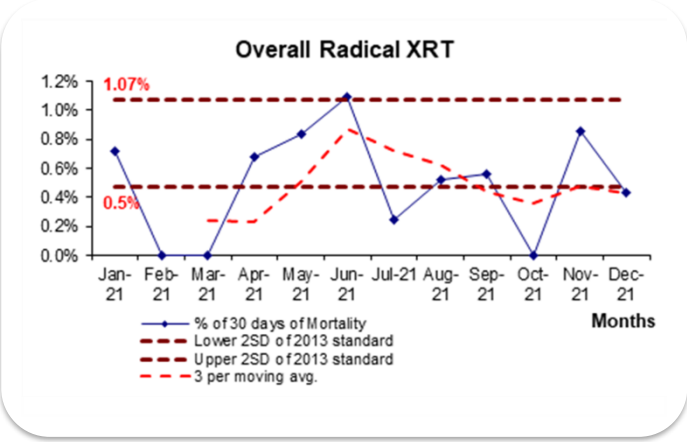
- The overall 30 day mortality rate for patients treated with palliative chemotherapy during 2021 was 4.0% compared to 4.6% for patients who were treated in 2020, which is not statistically significant.
- Figure 4 demonstrates the monthly mortality rate is below the control limits, however there is an indication of increasing mortality from September 2021 onwards.

Trends Identified

There is a suggestion that mortality for palliative HO chemotherapy had initially increased from September 2021 onwards, however further analysis undertaken during QTR 4 of 2021-2022 demonstrated that this has now returned to within limits.

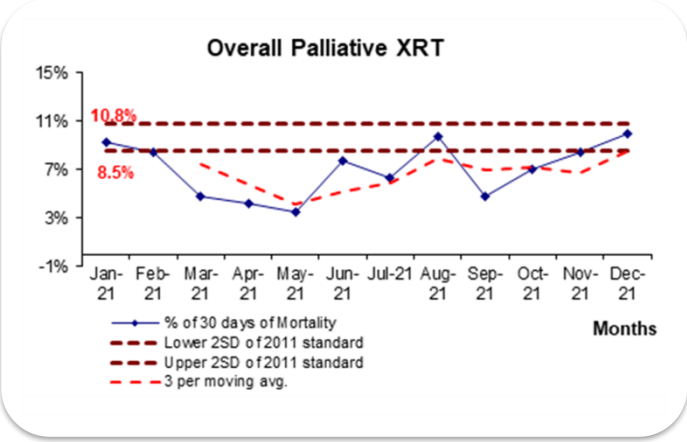
Radiotherapy

There was no significant difference in mortality performance observed in 2020 radiotherapy data compared to the previous year's performance. The overall CCC performance for Radiotherapy 30 day mortality is as follows:



Radical Radiotherapy

- The overall 30 day mortality rate for patients treated with radical radiotherapy during 2021 was 0.56%, a reduction for 2 consecutive years.

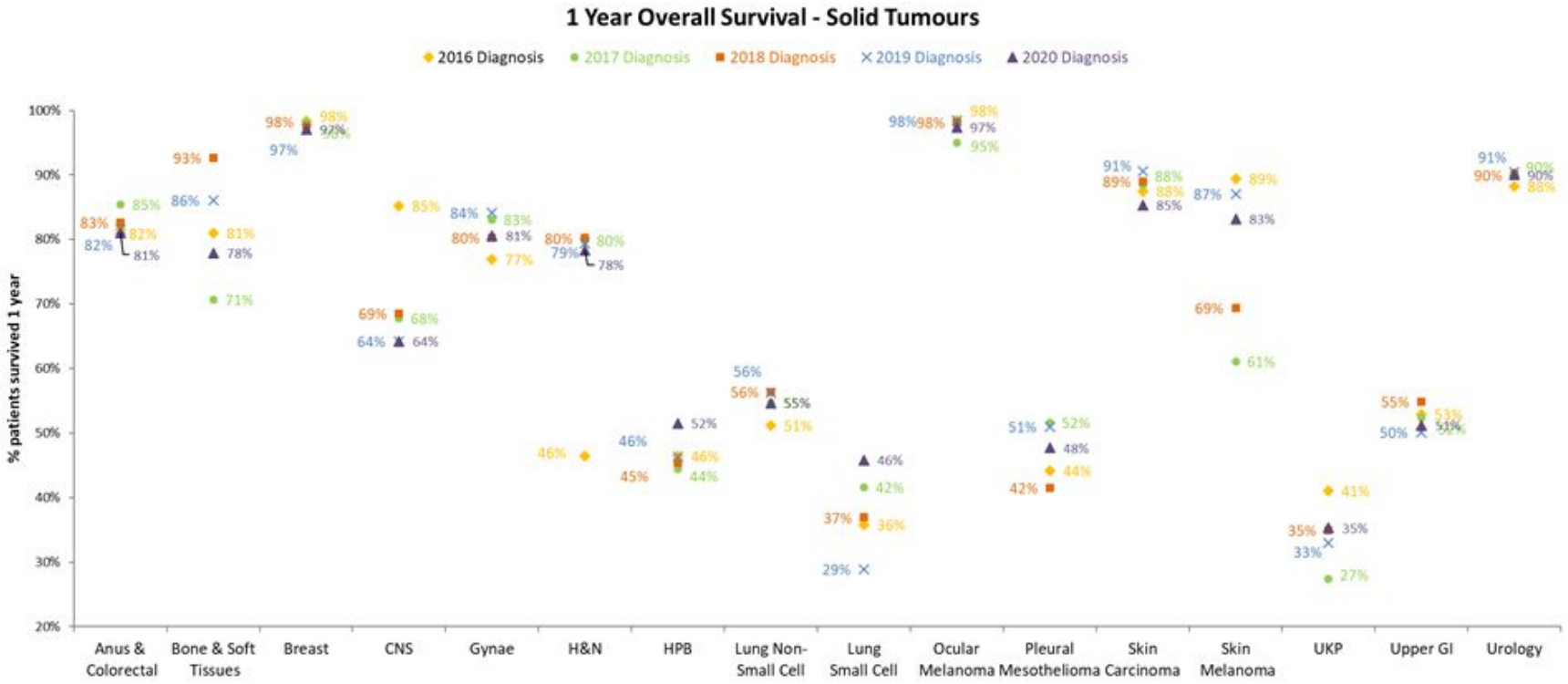


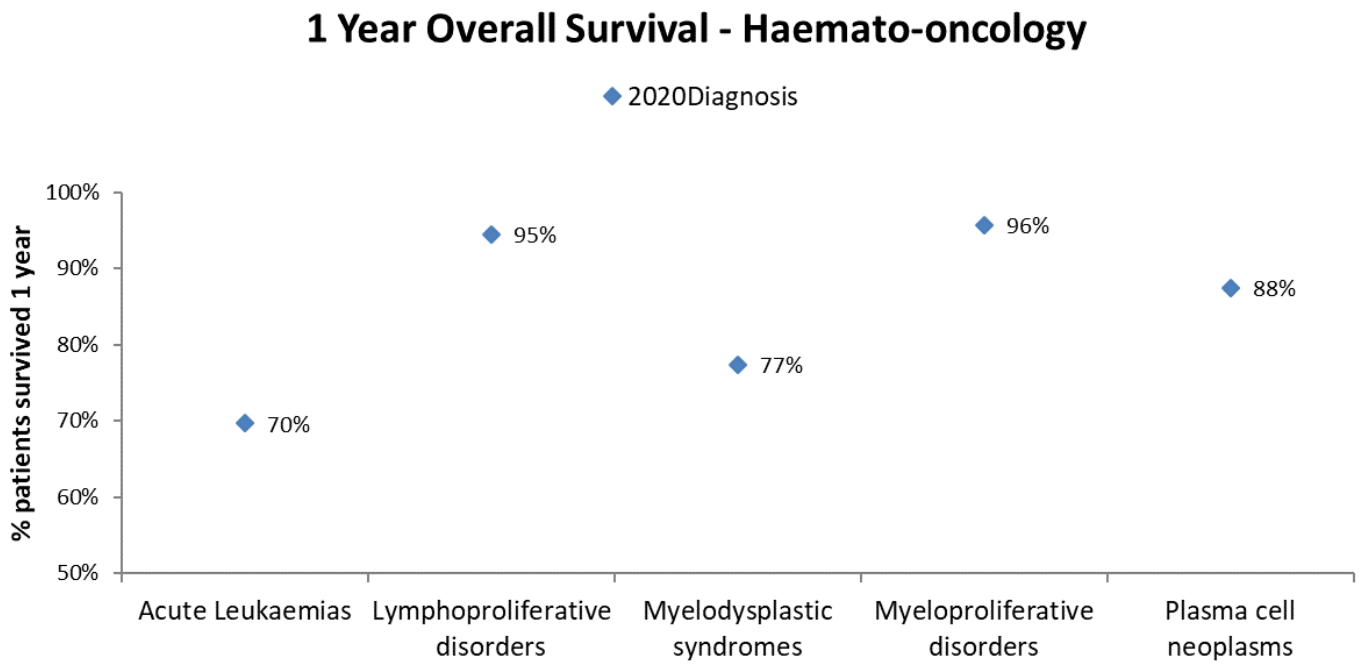
Palliative Radiotherapy

- The overall 30 day mortality rate for patients treated with palliative radiotherapy during 2021 was 8.8%, a reduction for 2 consecutive years.

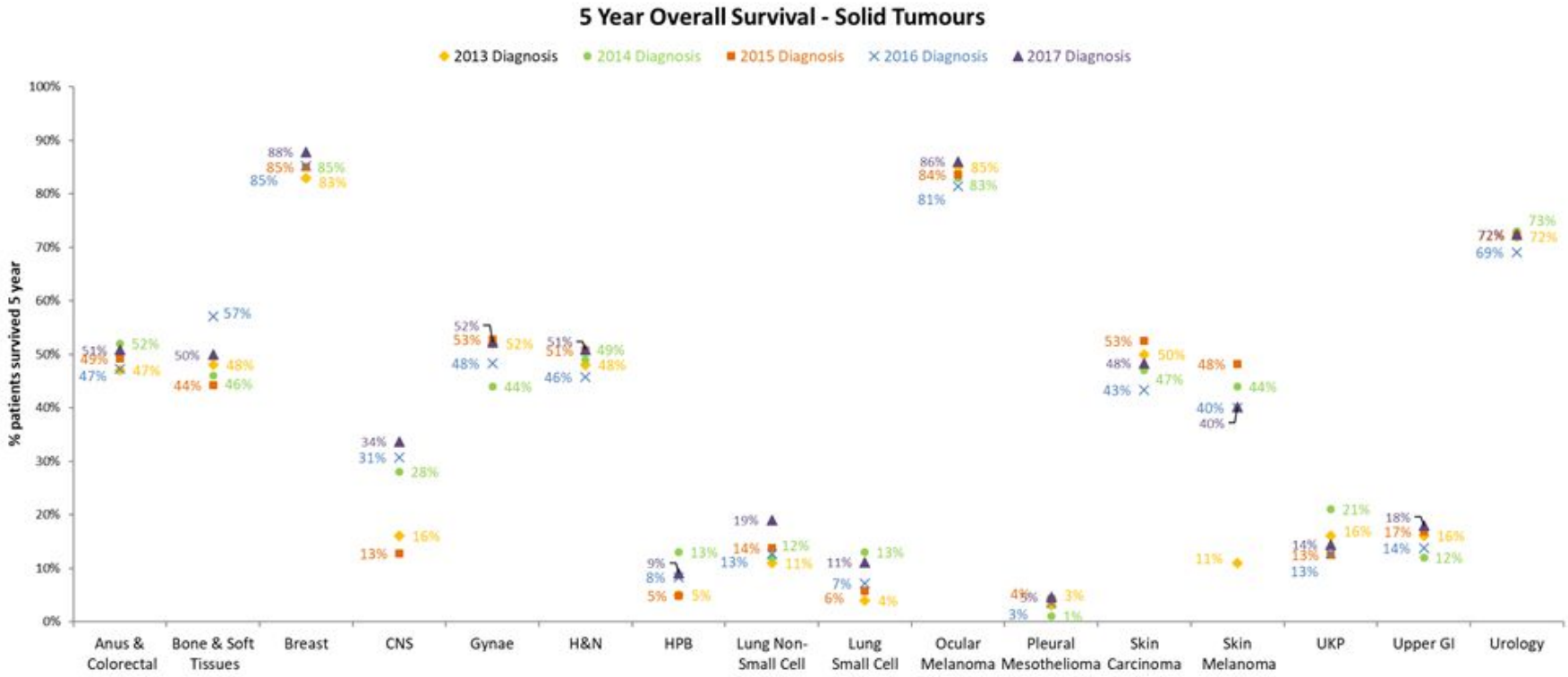
CCC Cancer patient survival rate by Specific Tumour Group

Graphs below showed percentage of patient survived 1 year and 5 years. One year survival is based on patient diagnosed in 2016 - 2020 (2020 only for Haemato-oncology due to regrouping of disease groups, leads to comparison with previously calculated survival figures not comparable) to show short term outcome, whilst 5 year survival is based on patient diagnosed in 2013 - 2017 to show long term outcome. Majority of figures are comparable with some showing improvement and some showing reduced survival. Understanding the differences requires an in-depth analysis which is included in the SRG dashboard development and will be discussed in SRG meetings.




1 Year Overall Survival - Haemato-oncology
2020Diagnosis
% patients survived 1 year
100%
90%
80%
70%
60%
50%
95%
96%
88%
77%
70%
Acute Leukaemias
Lymphoproliferative disorders
Myelodysplastic syndromes
Myeloproliferative disorders
Plasma cell neoplasms

*


5 Year Overall Survival - Solid Tumours
2013 Diagnosis
2014 Diagnosis
2015 Diagnosis
2016 Diagnosis
2017 Diagnosis
% patients survived 5 year
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Anus & Colorectal
Bone & Soft Tissues
Breast
CNS
Gynae
H&N
HPB
Lung Non-Small Cell
Lung Small Cell
Ocular Melanoma
Pleural Mesothelioma
Skin Carcinoma
Skin Melanoma
UKP
Upper GI
Urology

Looking to the future [22/23]

- Participate in NACEL round 4
- Continue to develop a Mortality Reduction Strategy
- Continue to digitise the mortality review process by embedding a Datix system to support the data collection and reporting process for go live May 2022
- Continue to strengthen integration of the medical examiner role into CCC processes
- Digitalise the Mortality Review Dashboard
- Investigate means of cascading lessons learned Trustwide
- Tumour Specific Site Reference Group Outcome measures/benchmarking to be initiated

Glossary

Abbreviation	Description
2SD	Two standard deviation
ACB	Amber care bundle
CCC	The Clatterbridge Cancer Centre
CCC-W	The Clatterbridge Cancer Centre - Wirral
CDOP	Child death overview panels
CDOP	Child Death Overview Panel
CDU	Clinical Descision Unit
CET	Clinical Effectiveness Team
CNR	Case note review
CSCI	Continuous Subcutaneous Infusion
CT	Computerized Tomography
D & T	Dabrafenib + Trametinib
Datix	Software company
DGH	District General Hospital
DNACPR	Do not attempt cardiopulmonary resuscitation
EAPC	Europeam Association of Palliative Care
eGFR	Estimated glomerular filtration rate
EPR	Electronic Patient Record
ESC	Enhanced supportive care
Evolve	Sofware for scanning information into the patient record
GCSF	Granulocyte colony stimulating factor
GI	Gastrointestinal
GP	General Practitioner
HO	Haemato-Oncology
HPB	Hepatobiliary
HPB	Hospital Board
HQIP	Healthcare Quality Improvement Partnership
HSJ	Health Service Journal
HSMR	Hospital Standardised Mortality Ratio
IO	Immuno-oncology
IOM	Isle of Man
IPOS	Integrated palliative care outcome scale
LeDeR	Learning Disabilities Mortality Review
LUHFT	Liverpool University Hospital Foundation Trust
MDT	Multidisciplinary teams
Meditech	Electronic Patient Record system
MET	Medical Emergency Team
MRM	Mortality Review Meeting
MSCC	Metastatic spinal cord compression
MSG	Mortality Surveillance Group
NACEL	National Audit of Care at the End of Life
NCEPOD	National Confidential Enquiry into Patient Outcomes and

	Death
NICE	The National Institure for Health and Care Excellence
PA	Physician associate
PE	Pulmonary Embolism
PM	Post mortem
PR	Rectal bleeding
PS	Performance Status
QAIF	Quality Assurance and Improvement Framework
QS	Quality Survey
QST	Quality Surveillance Team
RCP	Royal College of Physicians
SACT	Systemic Anti-Cancer Therapy
SCLC	Small cell lung cancer
SHMI	Summary Hospital-Level Mortality Indictor
SJR	Structured Judgement Review
SPC	Statistical Process Control
SPCT	Specialist Palliative Care Team
SRG	Site Reference Group
SRM	Staff Reported Measure
UKONS	UK Oncology Nurses Society
VTE	Venous thromboembolism

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 27th July 2022

Report author	Tom Pharaoh, Director of Strategy				
Paper prepared by	Tom Pharaoh, Director of Strategy				
Report subject/title	P1-144-22 Update report on the Good Governance Institute (GGI) well-led review action plan				
Purpose of paper	The report from the developmental well-led review undertaken by GGI between November 2021 and February 2022 was presented to the Trust Board at its meeting in April 2022. The GGI concluded that its findings should be seen as positive, reflecting the work of the trust's leadership and workforce in recent years but that nevertheless, some areas for development and improvement were identified. The report made a number of recommendations and these were picked out an associated draft action plan, also presented to the Trust Board in April. This report presents the final action plan, updated and refined following the Board's April meeting, and provides an update on progress against each of the agreed actions.				
Background papers	Well-led Review: Report from the Good Governance Institute (GGI)				
Action required	The Trust Board is asked to note the progress made with the majority of actions as well as the challenges faced in other areas. It is proposed that a further update report on progress is presented to the Trust Board in three months.				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	✓	Be a great place to work		
	Be Collaborative		Be Digital		
	Be Research Leaders		Be Innovative		

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		

WE ARE...
KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOREPO
Review: July 2025
Version: 2.0

ACTION PLAN

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GGI well-led review action plan

Last updated: July 2022
Updated by: Tom Pharaoh

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

Ref	Recommendation	Action	Owner(s)	Dates*	RAGB	Comments/progress
KLOE 1 – Leadership capacity and capability						
R1	The trust should consider how it can use trust communications and engagement events to raise the profile of non-executive directors inside the organisation, and awareness of the important work they do.	• Develop and deliver a post-covid NED profile raising programme	Corporate Governance, Communications	By end September 22		• Will be done alongside Governor profile raising actions (currently being managed by the Membership Engagement and Communications Committee)
		• Restart on-site NED visits	Corporate Governance, Patient Experience Team	By end July 22		• First on-site visit took place in June – plans for visits to be in person going forward (following appropriate assessment of clinical risk)
KLOE 2 – Strategy, vision and values						
R2	Communication of the new trust values to the entire workforce – and to patients and partners – should be a corporate priority in the coming months.	• Stock-take of comprehensive ongoing trust values communication and engagement programme	Workforce & OD, Communications	By end May 22		• Complete • Values communicated through divisional listening events, team meetings, staff groups and engagement events • Walkabouts at all sites to raise awareness of values and associated behaviours • Promotional materials produced including screen savers, staff quotes, staff videos, lanyards

* Some dates refined from draft version presented in April/May 2022

ACTION PLAN

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NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates*	RAGB	Comments/progress
		• Ensure new values are fully incorporated into key trust processes: PADR, recruitment, induction, staff achievement awards, etc.	Workforce & OD	By end July 22		• Trust induction, new starter welcome pack, PADR and monthly awards have all been updated to incorporate the new values • Job adverts, on-boarding and other recruitment documentation has been updated • Learning and OD programmes have been updated to reflect the values • The new values will also form part of the criteria for the Trust Annual Staff Awards, due to take place on 14/10/22
		• Develop plan for further values awareness raising and review of impact	Workforce & OD	2023		• Values will feature in the new manager induction programme launching later this year • Introduction of values based recruitment is included in the People Commitment and will be implemented in 2023 • Ongoing work to embed the values into everything we do (green agenda, education, staff networks, EDI, celebration event, innovation) • More staff videos about the values e.g. Ethnic Diversity Staff Network on being Inclusive
KLOE 3 - Cultures						
R3	The trust should consider how it can raise the profile of the freedom to	• Stock-take of current awareness of freedom to speak up (FTSU),	Corporate Governance	By end September 22		• Being led by Interim Associate Director of Corporate Governance in conjunction with FTSU Guardians

ACTION PLAN

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

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

ACTION PLAN

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Ref	Recommendation	Action	Owner(s)	Dates*	RAGB	Comments/progress
R7	When corporate policies are next due for review, the policy owners should ensure that they make clearer how they will be monitored for compliance, and what training different groups of staff require.	• Develop a checklist for future review of corporate policies – to include training and monitoring of compliance	Information Governance Team	By end September 22		
R8	The trust should consider reviewing the structure of operational management committees which feed into board assurance committees, as it has already done for the groups which report to the quality committee. This will ensure that every group is serving its intended purpose and may allow some meetings to be eliminated or streamlined. GGI can recommend a way to do this.	• Review operational management committees	Chief Operating Officer	By September 22		• Operational committees have been streamlined • Session arranged in September to ensure operational structures are aligned with clinical governance arrangements
R9	The trust should ensure that when it reviews its policy for managing conflicts of interest in July 2022, it identifies the team or individual with responsibility for providing advice training and support for staff on how interests should be managed. The policy should also say how the trust will audit compliance with its own policy and associated processes and procedures on an annual basis and subsequently in	• Review conflict of interests policy, taking into account the GGI feedback	Corporate Governance	By end September 22		• Policy has been reviewed and is compliant with national guidance • Some minor changes to guidance and processes to be included in policy for approval in September 2022 • Policy will outline responsibilities for advice, training and support

ACTION PLAN

NHS
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NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates*	RAGB	Comments/progress
	line with the review cycle of the policy.					
R10	We recommend that the trust publishes a conflicts of interest register that reflects the current membership and attendance at the board. The conflicts of interest register should be included in meeting packs for all future meetings.	• Update and republish conflicts of interest register	Corporate Governance	By end June 22		• Complete – published on CCC website
		• Consider inclusion of conflicts of interest register at all future Trust Board meetings (and Board Committee meetings)	Corporate Governance	By end September 22		• Register currently available on internet – consider usefulness of also supplying with meeting packs
KLOE 5 – Managing risks and performance						
R11	The risk management strategy should be reviewed and updated, in terms of content, style and format. The intention should be to make the document more succinct and visual and to remove outdated or unnecessary supporting information.	• Review risk management strategy, taking into account the GGI feedback	Associate Director of Clinical Governance and Patient Safety	By end May 22		• Complete • Reviewed strategy approved at April Risk and Quality Governance Committee • Strategy scheduled for further review and broad engagement in 12 months
R12	The board assurance framework should differentiate more clearly between gaps in control or assurance, and the actions required to close those gaps.	• Review BAF in full as part of ongoing review of Board risks for 2022/23	Corporate Governance (supported by Conway Bloomfield Ltd)	By end July 22		• Review complete • Approved at Audit Committee 14/07/22 • On agenda at Trust Board 27/07/22
R13	The board assurance framework should be used actively as a tool to shape the work of the board and ensure that the right information is going to the right places within the governance structure.	• Develop plans for improvement of the use of the BAF in the Trust's governance structures	Executive Team	By end September 22		• To take place following approval of reviewed BAF

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates*	RAGB	Comments/progress
R14	The trust should consider adopting a more standardised definition of risk, in place of the current division between risks and issues on the risk register. Alternatively, it should ensure that the difference between risks and issues is clearly understood by all.	• Adopt a standardised definition of risk	Chief Nurse	By end April 22		• Complete • All issues on risk register converted to risks or closed • Additional risk management training ran in April/May
KLOE 6 – Data and information						
R15	In the forthcoming refresh of the IPR, the trust should consider presenting the report in a more visual manner.	• Take into account GGI feedback as part of ongoing IPR review	Head of Performance & Planning, Head of Business Intelligence	By end May 22		• Complete • A reviewed more visual IPR was presented during April/May for comment and refinement • IPR will continue to develop
KLOE 7 – Stakeholder engagement						
R16	The trust should consider how it can grow, and involve, its foundation membership	• Stock-take of membership position	Corporate Governance	By end May 22		• Complete
		• Develop plans to grow and involve membership	Corporate Governance	By end May 22		• Complete • Membership strategy approved by Membership Engagement and Communications Committee • Membership position monitored quarterly through membership engagement and communications committee I would say this is complete
KLOE 8 – Learning, improvement and innovation						
R17	The trust should develop a new / revised quality strategy and ensure that the resources, methodology	• Develop a new quality strategy	Chief Nurse, Director of Strategy	By end September 22		• Development of meaningful clinical quality strategy will require broad engagement across the trust

ACTION PLAN

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates*	RAGB	Comments/progress
	and training that are needed to implement it are in place.					• Turnover and capacity currently within Clinical Governance team
R18	The clinical governance and communications teams should work together to find and implement new ways of spreading learning from patient safety incidents and complaints across the whole organisation.	• Stock-take of current methods for spread of learning from incidents and complaints	Clinical Governance	By end August 22		• Capacity constraints in Clinical Governance team • Lessons learnt shared through general communications channels e.g. Team Brief
		• Develop plans to improve the spread of learning from incidents and complaints (as part of new quality strategy)	Clinical Governance, Communications	By end October 22		• Capacity constraints in Clinical Governance team • Proposals for 'Safety News Flash in development'

Cheshire & Merseyside Cancer Alliance

Performance Report

July 2022

Version 1

Contents

Section I: Summary

Restoration of cancer services

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

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

Measure	% of pre-Covid level
2WW referrals*	122%
Cancer surgery activity*	141%
SACT (inc chemo) delivery**	144%

Measure	% of pre-Covid level
Radiotherapy planning**	126%
Radiotherapy treatment**	99%
Endoscopy activity♀	101%

- 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 when required. Additional SACT nurses continue to be recruited.
- As a % of 2019/20 figures, June 2022 radiotherapy planning activity is similar to May 2022. Whilst Radiotherapy treatments had reduced significantly in early 2020/2021 due to a change in fractionation, despite the continuation of this change, activity has continued to rise and is now almost at pre covid-19 levels in June 2022. The levels of activity reflect the significant rise in referrals into CCC since March 2022.
- Endoscopy activity rose in May to 7,003 procedures (from 6,085 procedures in April). Whilst this is fewer procedures than May 2019 (7,521 procedures), changes to casemix (more colonoscopies and fewer flexi sigmoidoscopies) mean it represents more clinical activity (101% vs May 2019).
  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

*Data as of 13th June
** Solid tumour only (not inc. Haemato-oncology): reliable Haemato-oncology figures pre covid are unavailable – data as of June 2022
♀Assessment based on monthly DM01 endoscopy returns - latest update May 2022. Activity is used as an indication of capacity.

Section I: Summary

Tiered approach to 78 week elective and >62 day cancer backlog recovery

- As part of the second phase of the national elective recovery plan, all providers have been assessed based on confidence of delivering against the targets of reducing the cancer 62 day backlog back to pre-pandemic levels by March 2023, and reducing the number of 78 week elective long waiters to zero by April 2023.

- Those providers at the highest risk have been included in a tier 1 grouping. This means additional national support and oversight, which may include on-site expertise and ongoing conversation between ministers and CEOs. There are 20 providers in tier 1, of which 12 are included given concern across both cancer 62d and elective 78w, five are included only on the basis of concerns with cancer, and three are included on the basis of only concerns with 78w.

- A second tier 2 grouping has been identified and includes providers who are less challenged but still indicate material risk of 62d and/or 78ww breaches in April 2023. For this cohort the relevant Region will lead and develop delivery plans. There are 24 providers in tier 2.

- Provider performance will be monitored on a weekly basis to assess the appropriateness of the current tier, and there may be moves up or down between tiers 1 and 2 based on monthly review points. Consequently, providers not currently in either grouping may be moved directly into either tier.

- In Cheshire and Merseyside there are currently three providers in tiers 1 and 2. Liverpool University Hospital is in tier 1 for both cancer and electives, Southport and Ormskirk is in tier 2 for both cancer and electives, and the Countess of Chester is in tier 2 for electives only.

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 **May 2022**.

The Alliance failed the **14 day standard** for urgent suspected cancer referrals, achieving 83.0%. This is higher than 77.2% the previous month.
The England average was 83.2%.
Eight trusts and eight historic CCGs failed to meet the 14 day standard of 93%.
Cheshire and Merseyside was the 12th best performing Alliance in England out of 21 against this standard.

The Alliance failed the **28 day standard** for urgent suspected cancer referrals achieving 67.7%. This is higher than 65.6% the previous month.
The England average was 70.8%.
10 trusts and eight CCGs failed to meet the 28 day standard of 75%.
Cheshire and Merseyside was the 17th best performing Alliance in England out of 21 against this standard.
This new standard came into force from October 2021.

The Alliance failed the **62 day standard**, achieving 68.5%. This is higher than 71.7% the previous month.
The England average was 61.5%.
11 trusts and eight CCGs failed to meet the 62 day standard of 85%.
Cheshire and Merseyside was the 5th best performing Alliance in England out of 21 against this standard.

The number of urgent referral patients waiting **over 62 days** is significantly higher than pre-Covid levels. On 11th July 2022 there were 1,628 patients waiting more than 62 days for a diagnosis or treatment. This has decreased from 1,692 reported last month (13th June). Of these, 477 have waited **over 104 days**. This is higher than the 459 patients reported last month.

The Alliance failed the **31 day 1st treatment standard**, achieving 95.8%. This is slightly higher than 95.2% the previous month.
The England average was 91.8%.
Five trusts and two CCGs failed to meet the 31 day 1st treatment standard of 96%.
Cheshire and Merseyside was the 3rd best performing Alliance in England out of 21 against this standard.

Cheshire & Merseyside Cancer Alliance

* Overall figures are based on commissioners within Cheshire and Merseyside.
CCGs refer to the historic 2022 Clinical Commissioning Groups prior to the implementation of the Integrated Care Board (ICB)

Section II: Restoration of Cancer Services – Core Metrics

1. TWW referrals received in last 7 days

Referrals decreased with 2,451 patients referred this week (22% above pre-pandemic weekly average, 1% above same time last year).

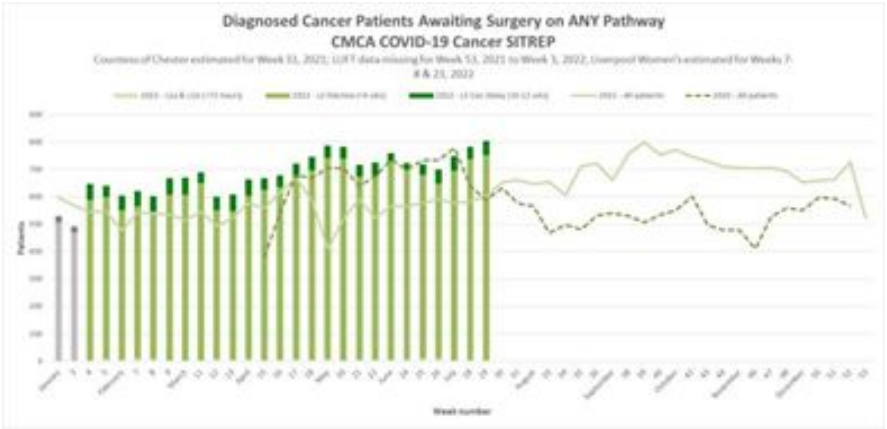
Data note: This metric does not include East Cheshire and only includes head and neck for Mid Cheshire as they feed into Greater Manchester's SITREP. Countess of Chester data estimated for all weeks 02/08/21 to 25/10/21 inclusive. Liverpool Women's Hospital estimated for 13/09/21, 20/09/21. Missing data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

Currently 12,207 active patients, of which less than 5 are suspended (22% 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



803 patients with a surgical DTT. 753 at L1&L2 and 50 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.

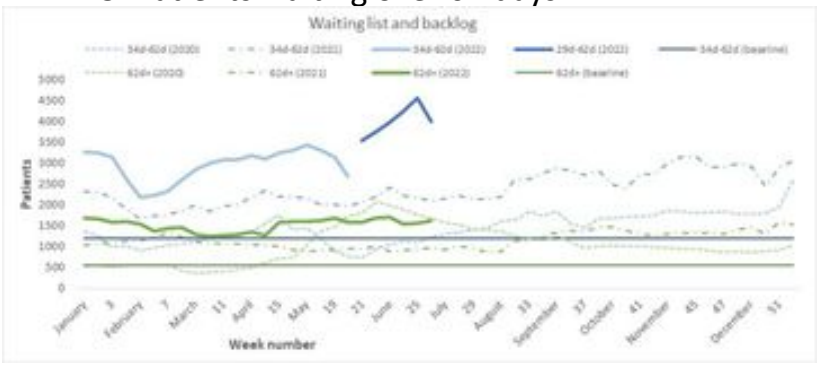
4. Cancer surgery performed in last 7 days

346 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 27/06/22 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

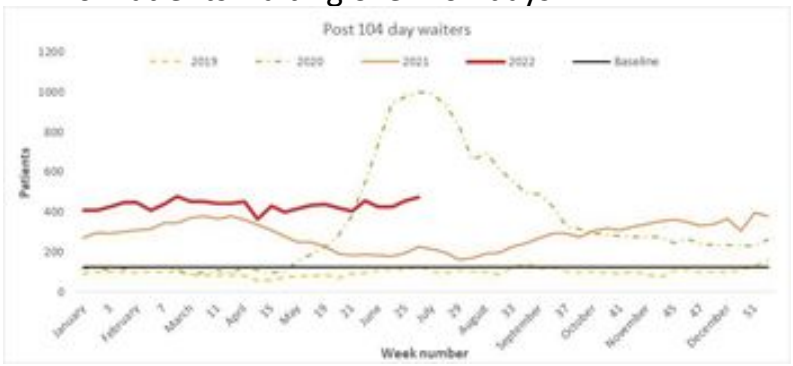


1,628 patients have waited over 62 days

- Higher than 1,569 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



477 patients have waited over 104 days

- Higher than 458 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.

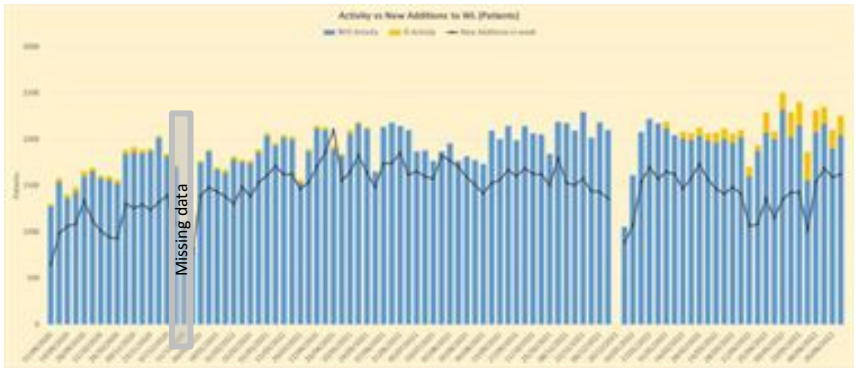
7. Endoscopy waiting list

Endoscopy waiting list lower than last week at 13,274 patients.

Over last 2 weeks, LUTH Aintree added over 800 overdue surveillance 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, 11/10/21 and 27/06/22. 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 increased with 2,251 patients seen.

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, 11/10/21 and 27/06/22. 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 03 July

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	Change from last week
Bridgewater																
Clatterbridge				5		5	6					8	5		**37**	-6
Countess Of Chester			7		7	33					5	10	6		**71**	-18
East Cheshire						19							8		**31**	
Liverpool Foundation Trust		11			48	193			14		10	131	72		**484**	13
Liverpool Heart & Chest							5								**5**	
Liverpool Women's			48												**48**	
Mid Cheshire			5		7	52						12	6		**90**	23
Southport & Ormskirk			37	7		47					50	6	15		**166**	20
St Helens & Knowsley			17		8	37					17	7	6		**98**	7
Walton Centre																
Warrington & Halton						7							14		**25**	
Wirral			11		5	29							41		**98**	4
Grand Total		**25**	**129**	**21**	**81**	**422**	**17**		**14**	**5**	**86**	**177**	**171**		**1153**	40

Cheshire & Merseyside Cancer Alliance

Tables from national Cancer PTL

10. Patients waiting over 104 days by provider

PTL data from W/E 03 July

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	Change from last week
Bridgewater																0
Clatterbridge													9		**21**	7
Countess Of Chester						14									**26**	
East Cheshire						7									**11**	3
Liverpool Foundation Trust					7	98			20			36	41		**210**	9
Liverpool Heart & Chest																
Liverpool Women's			20												**20**	4
Mid Cheshire						13									**16**	
Southport & Ormskirk			22			29							10		**75**	-6
St Helens & Knowsley						16							9		**38**	
Walton Centre																
Warrington & Halton																0
Wirral						23							29		**59**	
Grand Total		**6**	**49**	**11**	**18**	**202**	**10**		**20**		**10**	**47**	**102**		**479**	18

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 (fewer than 3 for change from last week)

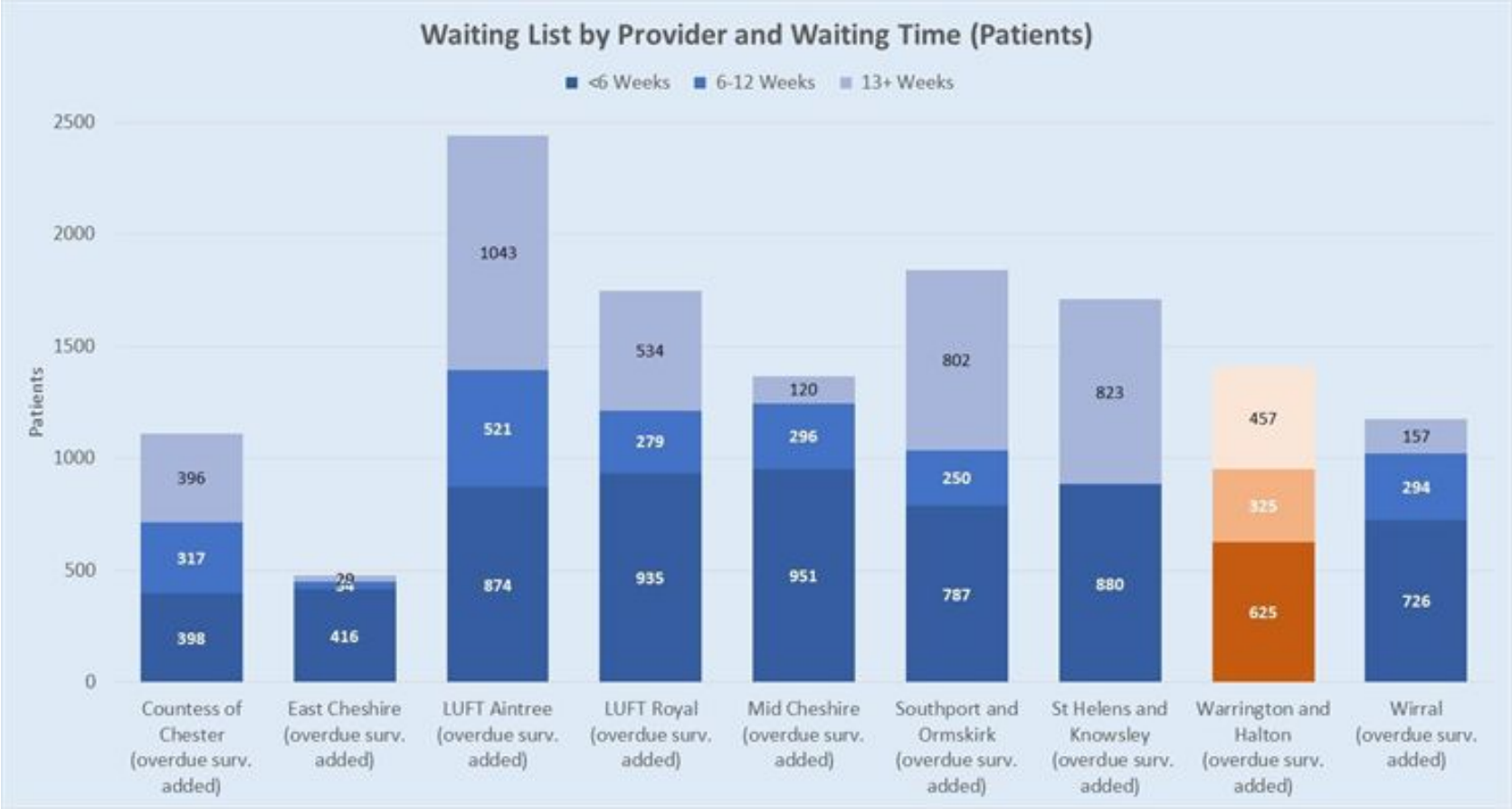
= No PTL submission this week

Section II: Restoration of Cancer Services – Core Metrics

Endoscopy (cancer and non-cancer pathways)

There are currently 13,274 patients waiting for an endoscopy. 6,682 have waited more than six weeks, and of these 4,361 have waited 13 or more weeks (33% of the total).

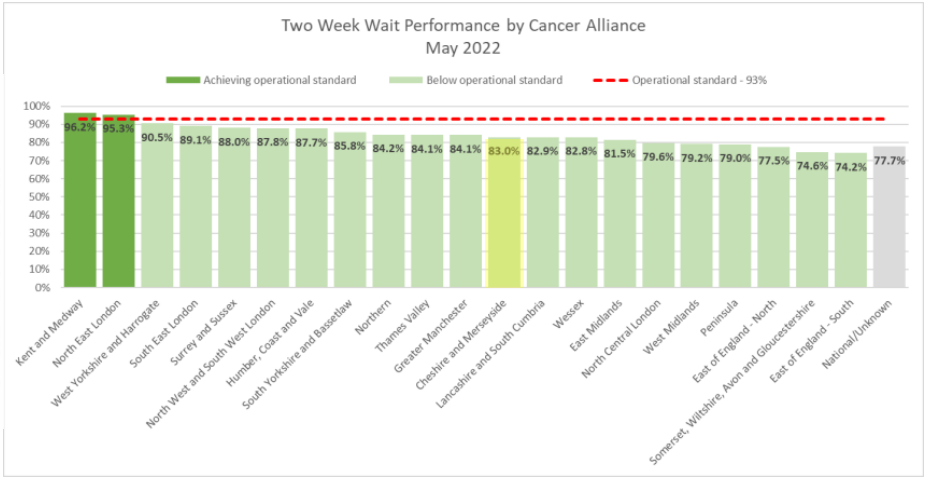
There is significant variation across units. In terms of patients waiting over 13 weeks the highest proportions are seen in Southport and Ormskirk (44%), St Helen's and Knowsley (48%), and LUFT Aintree (43%).
Other units experiencing challenges are Warrington and Halton (32%), LUFT Royal (31%), and CoCH (36%).



Endoscopy data at 04 July 2022.

Section III: 14 day standard

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Jun 20 - May 21	97.0%	94.6%	90.5%	89.4%	92.2%	90.7%	90.3%	87.1%	94.1%	95.3%	90.6%	92.5%
Jun 21 - May 22	90.5%	91.4%	90.4%	89.3%	83.3%	75.8%	76.3%	72.6%	79.7%	80.5%	77.2%	83.0%
Operational standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%



In May 2022, 83% of patients were seen within 2 weeks compared to 77.2% in the previous month. This is below the operational standard.

In May 2022, Cheshire and Merseyside Cancer Alliance ranked 12 out of 21 for Two week wait performance (CCGs).

Providers not achieving the national operational standard were:

- Liverpool Women's 52.7% (201 breaches)
- Liverpool University Hospitals 69.6% (999 breaches)
- Countess Of Chester Hospital 76% (346 breaches)
- Southport And Ormskirk Hospital 84.2% (197 breaches)
- Warrington And Halton Hospitals 88% (132 breaches)
- St Helens And Knowsley Hospitals 88.3% (216 breaches)
- East Cheshire 89.4% (72 breaches)
- Liverpool Heart And Chest 92.3% (1 breaches)

CCGs not achieving the national operational standard were:

- NHS Liverpool 70.3% (707 breaches)
- NHS Southport and Formby 70.9% (209 breaches)
- NHS South Sefton 73.7% (246 breaches)
- NHS Knowsley 78.3% (189 breaches)
- NHS Cheshire 86.3% (504 breaches)
- NHS Halton 87.5% (86 breaches)
- NHS St Helens 89% (110 breaches)
- NHS Warrington 89.7% (106 breaches)

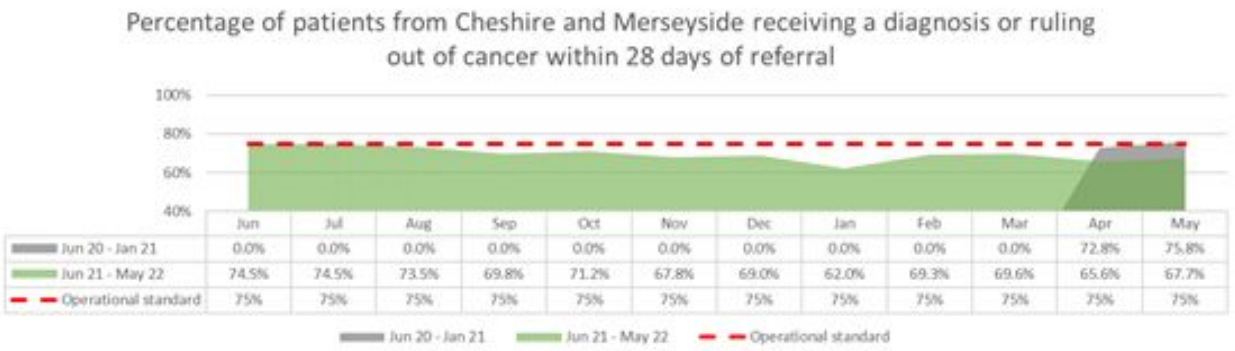
Cancer pathways* not achieving the national operational standard were:

- Suspected breast cancer 67.2% (693 breaches)
- Suspected gynaecological cancer 72.1% (372 breaches)
- Suspected children's cancer 82.7% (9 breaches)
- Suspected upper gastrointestinal cancer 85.1% (178 breaches)
- Suspected lower gastrointestinal cancer 85.4% (393 breaches)
- Suspected head and neck cancer 87.2% (157 breaches)
- Suspected skin cancer 89.4% (328 breaches)
- Suspected urological malignancies (excluding testicular) 92% (71 breaches)"

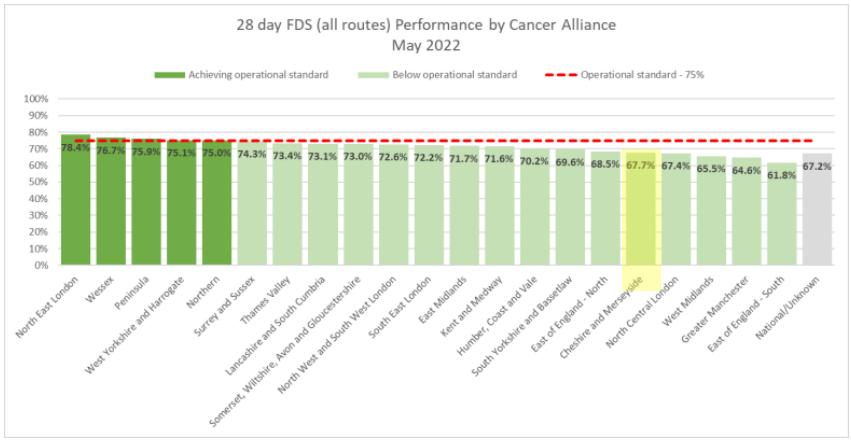
*CCG based data – CADEAS source

CCGs refer to the historic 2022 Clinical Commissioning Groups prior to the establishement of the Integrated Care Board (ICB)

Section III: 28 day standard



	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Jun 20 - Jan 21	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	72.8%	75.8%
Jun 21 - May 22	74.5%	74.5%	73.5%	69.8%	71.2%	67.8%	69.0%	62.0%	69.3%	69.6%	65.6%	67.7%
Operational standard	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%



In May 2022, 67.7% of patients were diagnosed or ruled out within 28 days compared to 65.6% in the previous month. This is below the operational standard.

In May 2022, Cheshire and Merseyside Cancer Alliance ranked 17 out of 21 for 28 day FDS (all routes) performance (CCGs).

Providers not achieving the national operational standard were:

- Liverpool Heart And Chest 33.3% (14 breaches)
- Liverpool Women's 60.1% (131 breaches)
- Liverpool University Hospitals 60.6% (1395 breaches)
- Countess Of Chester Hospital 61.1% (550 breaches)
- East Cheshire 63.2% (235 breaches)
- Southport And Ormskirk Hospital 66% (384 breaches)
- The Clatterbridge Cancer Centre 66.7% (4 breaches)
- Bridgewater Community Healthcare 71.9% (73 breaches)
- Mid Cheshire Hospitals 72.6% (372 breaches)
- Warrington And Halton Hospitals 74.7% (273 breaches)

CCGs not achieving the national operational standard were:

- Southport And Formby 57.7% (298 breaches)
- South Sefton 59.4% (355 breaches)
- Liverpool 64.6% (846 breaches)
- Cheshire 65.9% (1177 breaches)
- Knowsley 67% (292 breaches)
- Warrington 72.7% (283 breaches)
- St Helens 73.4% (278 breaches)
- Wirral 74.6% (439 breaches)

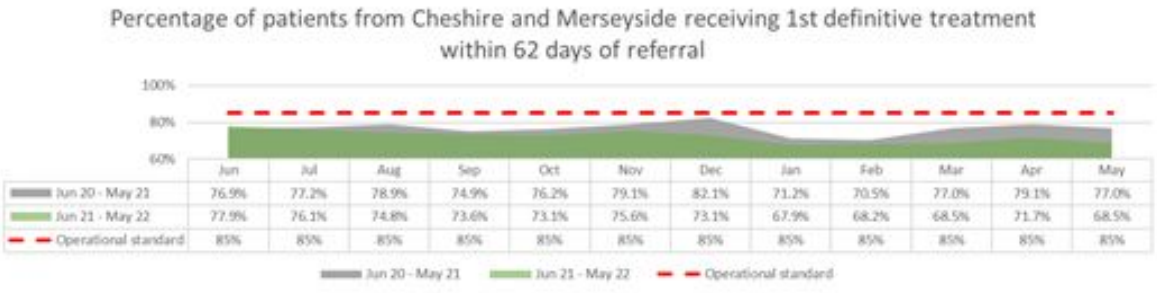
Cancer pathways* not achieving the national operational standard were:

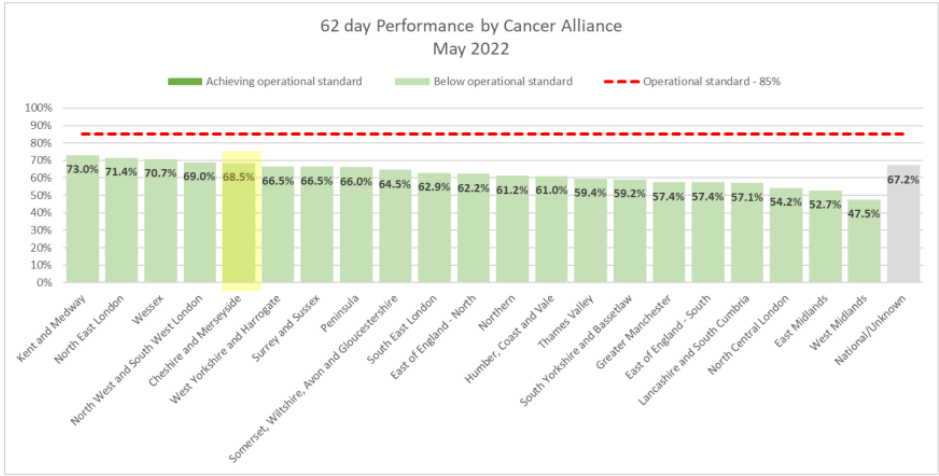
- Suspected urological malignancies (excluding testicular) 40.4% (522 breaches)
- Referral from a National Screening Programme: Unknown Cancer Report Category 45% (216 breaches)
- Suspected lower gastrointestinal cancer 46.6% (1384 breaches)
- Suspected haematological malignancies (excluding acute leukaemia) 49.2% (33 breaches)
- Suspected upper gastrointestinal cancer 57.9% (433 breaches)
- Other suspected cancer (not listed) 60% (8 breaches)
- Suspected lung cancer 62.4% (74 breaches)
- Suspected gynaecological cancer 63.2% (420 breaches)
- Suspected testicular cancer 72.5% (11 breaches)
- Exhibited (non-cancer) breast symptoms - cancer not initially suspected 74.9% (120 breaches)

*CCG based data – CADEAS source

CCGs refer to the historic 2022 Clinical Commissioning Groups prior to the establishment of the Integrated Care Board (ICB)

Section IV: 62 day standard





In May 2022, 68.5% of patients were treated within 62 days compared to 71.7% in the previous month. This is below the operational standard.

In May 2022, Cheshire and Merseyside Cancer Alliance ranked 5 out of 21 for 62 day performance (CCGs).

Providers not achieving the national operational standard were:

- Liverpool Women's 22.7% (8.5 breaches)
- Liverpool University Hospitals 45.3% (70.5 breaches)
- East Cheshire 50.8% (16 breaches)
- Southport And Ormskirk Hospital 67.5% (20 breaches)
- Countess Of Chester Hospital 67.9% (26 breaches)
- Liverpool Heart And Chest 76.5% (4 breaches)
- Mid Cheshire Hospitals 76.8% (19.5 breaches)
- Wirral University Teaching Hospital 79.6% (24 breaches)
- The Clatterbridge Cancer Centre 80% (7 breaches)
- St Helens And Knowsley Hospitals 83.2% (17.5 breaches)
- Warrington And Halton Hospitals 83.3% (7.5 breaches)

CCGs not achieving the national operational standard were:

- South Sefton 47.1% (18 breaches)
- Cheshire 62.6% (88 breaches)
- Liverpool 62.6% (37 breaches)
- Knowsley 64.9% (13 breaches)
- Southport and Formby 70.8% (14 breaches)
- St Helens 75% (10 breaches)
- Wirral 77.1% (27 breaches)
- Halton 81% (8 breaches)

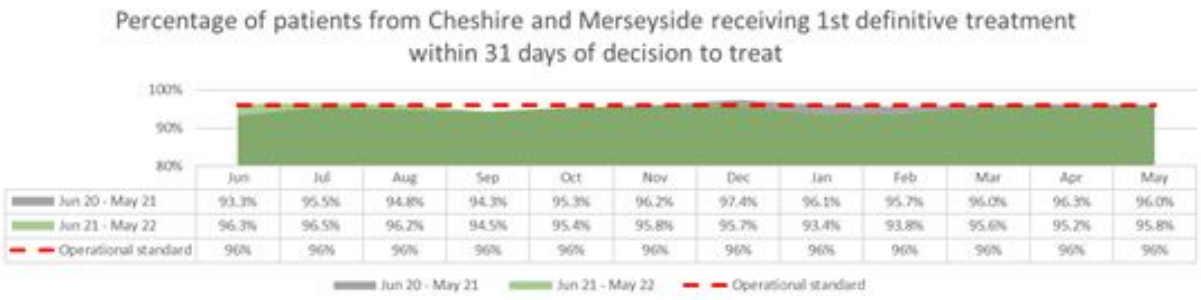
Cancer pathways* not achieving the national operational standard were:

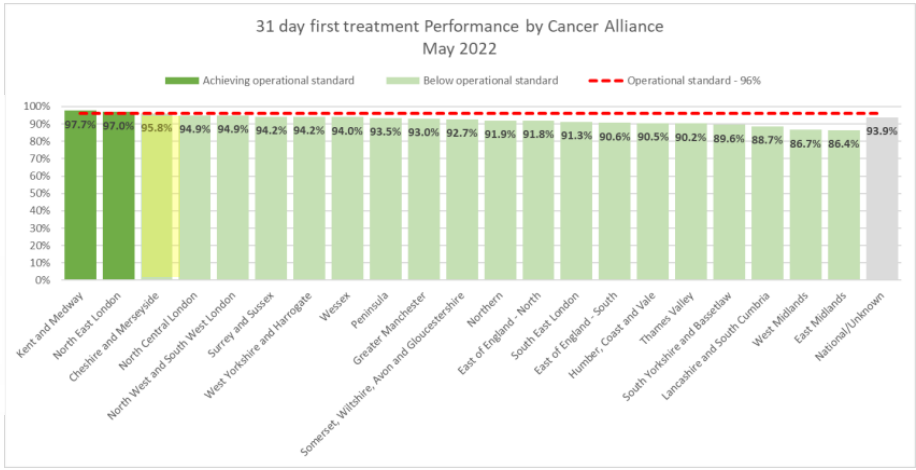
- Head & Neck 20% (32 breaches)
- Gynaecological 40.6% (19 breaches)
- Sarcoma 44.4% (5 breaches)
- Lower Gastrointestinal 47.7% (34 breaches)
- Other 50% (2 breaches)
- Lung 61.7% (23 breaches)
- Haematological (Excluding Acute Leukaemia) 69.2% (8 breaches)
- Urological (Excluding Testicular) 70.3% (46 breaches)
- Upper Gastrointestinal 73.3% (12 breaches)
- Breast 76% (24 breaches)

*CCG based data – CADEAS source

CCGs refer to the historic 2022 Clinical Commissioning Groups prior to the establishment of the Integrated Care Board (ICB)

Section V: 31 day standard





In May 2022, 95.8% of patients were treated within 31 days compared to 95.2% in the previous month. This is just below the operational standard.
In May 2022, Cheshire and Merseyside Cancer Alliance ranked 3 out of 21 for 31 day first treatment performance (CCGs).

Providers not achieving the national operational standard were:
- Bridgewater Community Healthcare 80% (3 breaches)
- Liverpool Women's 83.3% (4 breaches)
- East Cheshire 84.2% (9 breaches)
- Liverpool University Hospitals 91.3% (19 breaches)
- Countess Of Chester Hospital 94.2% (6 breaches)

CCGs not achieving the national operational standard were:
- NHS Cheshire CCG 93.8% (26 breaches)
- NHS Liverpool CCG 94.5% (11 breaches)

Cancer pathways* not achieving the national operational standard were:
- Gynaecological 88.2% (8 breaches)
- Sarcoma 91.7% (1 breaches)
- Lower Gastrointestinal 93.9% (9 breaches)
- Breast 94.9% (11 breaches)
- Upper Gastrointestinal 95% (5 breaches)
- Urological 95.4% (11 breaches)
- Skin 95.6% (12 breaches)

*CCG based data – CADEAS source

CCGs refer to the historic 2022 Clinical Commissioning Groups prior to the establishment of the Integrated Care Board (ICB)

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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.