The Clatterbridge Cancer Centre NHS Foundation Trust

Agenda: Trust Board Part 1
Date/Time of meeting: 26th October, 09:30

	Standard Business		Lead	Time
P1-173-22	Welcome, introduction, apologies and quoracy	v	**Chair**	09:30
P1-174-22	Declarations of interest	v	**Chair**	
P1-175-22	Minutes of the last meeting – 28 September 2022	p	**Chair**	
P1-176-22	Matters arising not covered on agenda –	v	**Chair**	
P1-177-22	Rolling programme/ Cycle of Business	p	**Chair**	
P1-178-22	Chair's report to the Board	v	**Chair**	09:40
	Reports and Action Plans			
P1-179-22	Board Assurance Framework	P	**BAF Advisor**	09:50
P1-180-22	Patient Story	P	**Chief Nurse**	10:00
P1-181-22	Quality Committee Chair's report	P	**NED-TJ**	10:10
P1-182-22	People Committee Chair's Report People Committee Terms of Reference Workforce Race Equality Standard Annual Report 2022 Workforce Disability Equality Standard Annual Report 2022	P	**Chair**	10:20
P1-183-22	Audit Committee Chair's Report	P	**NED-MT**	10:30
P1-184-22	Charitable Funds Committee Chair's Report	P	**NED-EA**	10:40
P1-185-22	Integrated Performance Report Month 6	P	**Exec Leads**	10:50
P1-186-22	Finance Report	P	**DoF**	11:00
P1-187-22	NHS England New Operating Framework & Annual Financial / Operational Planning Guidance	*	**DoF**	11:20
P1-188-22	NED and Governor Engagement Walk-Round	P	**Chair / Chief Nurse**	11:30
P1-189-22	New Consultant Appointments	P	**Medical Director**	11:40
P1-190-22	Good Governance Institute Well-Led review Action Plan Update	P	**Director of Strategy**	11:50
	For consultation/approval			
P1-191-22	Freedom to Speak Up Annual Report 2021/22	P	**Interim ADoCG**	12:00
	For information			
P1-192-22	Digital Board Development Session	P	**Chief Exec**	12:10
P1-193-22	R&I Annual Report	p	**Medical Director**	12:15
	System working			
P1-194-22	Cheshire and Merseyside Cancer Alliance Performance Report October 2022	P	**Chief Exec**	12:25
	Any other business			

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The Clatterbridge Cancer Centre NHS Foundation Trust

P1-195-22			**Chair**	
	Date and time of next meeting via MS Teams:			

p paper
***** presentation
v verbal report

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Minutes of: Trust Board Part 1
Date/Time of meeting: 28th September 2022 – 09.30am

Title / Department	Name	Initials	Present / apols	Attendance record	Deputy
Core member					
Chair	Kathy Doran	KD	P	5/5	☐
Non-Executive Director	Mark Tattersall	MT	P	5/5	☐
Non-Executive Director	Geoff Broadhead	GB	A	4/5	☐
Non-Executive Director	Elkan Abrahamson	EA	P	4/5	☐
Non-Executive Director	Terry Jones	TJ	P	4/5	☐
Non-Executive Director	Anna Rothery	AR	A	3/5	☐
Non-Executive Director	Asutosh Yagnik	AY	P	5/5	☐
Chief Executive	Liz Bishop	LB	P	5/5	☐
Director of Workforce & OD	Jayne Shaw	JSh	P	5/5	☐
Medical Director	Sheena Khanduri	SK	A	4/5	☒
Chief Nurse	Julie Gray	JG	P	5/5	☐
Chief Operating Officer	Joan Spencer	JSp	P	5/5	☐
Director of Finance	James Thomson	JT	P	5/5	☐
Chief Information Officer	Sarah Barr (NV)	SB	P	5/5	☐
Director of Strategy	Tom Pharaoh (NV)	TP	P	5/5	☐

Also in attendance		
Title	**Name**	**Initials**
Corporate Governance Manager (minutes)	Skye Thomson	ST
Associate Director of Communications	Emer Scott	ES
Staff Side Chair	Mike Varey	MV
Head of Patient Experience	Nikki Heazel	NH
Deputy Medical Director	Rosie Lord	RL
Innovation Manager	Drew Norwood-Green	DN

	Standard business
147	**Welcome, introduction & apologies:** The Chair welcomed the Board and noted apologies from Non-Executive Director: Geoff Broadhead, Non-Executive Director: Anna Rothery, Medical Director: Sheena Khanduri and Associate Director of Corporate Governance: Margaret Saunders, Lead Governor: Jane Wilkinson and Staff Governor: Laura Jane Brown

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	The Chair welcomed the Staff Side Chair, Head of Patient Experience and Deputy Medical Director to the meeting.
148	**Declarations of interest:**

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
James Thomson, Director of Finance	Non specific	Executive Lead for PropCare, Clatterbridge Pharmacy Limited, and Clatterbridge Private Clinic LLP – No action

149	**Minutes of previous meeting** The minutes of the meeting held on 27th July 2022 were approved as a correct record of the meeting with the following amendment • Finance Report page 6 paragraph 3 sentence 2 to be rephrased
150	**Matters Arising and Action Log** The Board agreed the action log items were with completed or on the agenda or on track.
151	**Rolling Programme/Cycle of Business** Noted
152	**Chair's Report to the Board** The Chair gave thanks to the staff who had worked on the additional bank holiday Monday given for Her Majesty the Queen's funeral. The Chair noted it was important that patients continued to have treatment. NHS England had also noted their thanks to all that worked that day The Chair noted she had taken part in a couple of successful consultant interviews. The Chair took part in the September NED and Governor Engagement Walk-rounds and visited Clatterbridge's Aintree site with Lead Governor Jane Wilkinson as well as a walkabout with Joan Spencer to the Marina Dalglish unit. The formal report from the NED and Governor Engagement walk-round will be presented to the Board in October, there were a few things to pick up however, both walk-rounds were pleasingly positive. The Chair noted the Integrated Care Board (ICB) had held a session for Non-Executive Directors in August. Unfortunately, no NEDs from Clatterbridge were able to attend, however, the Integrated Care System (ICS) had been discussed at the July Board Away Day and final versions of the papers reviewed then were on the agenda for approval. Over summer there had been continued discussions regarding the Liverpool clinical services review. The review is now at the stage where there are initial recommendations. The team are now looking at the next three months, and trying to agree with all partners the top areas to address.

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153	**Staff Story** The Director of Workforce and Organisational Development (WOD) introduced the Drew Norwood-Green the Innovation Manager to share the staff story on Bright ideas and Innovation. Drew gave an overview of the Bright ideas scheme and presented the following areas: • Charity established R&I innovation fund • What is meant by Bright ideas • Innovation vs improvement • Annual review • Who is submitting ideas • Percentage of ideas taken forward -19% • Example of ideas: tens machines, memory boxes, virtual reality, massage guns • Upcoming ideas: exercise machines, 3D virtual Tour, first patient-led innovation, MSCC Entertainment • Learning & Outcomes • Engagement – internally and externally • Innovation strategy The Director of WOD thanked DN, and questioned if the engagement numbers would likely continue of plateau. DN emphasised the need to continue engagement, there are innovation champions positioned locally to support this. When asked, DN confirmed that these innovations can be used as an opportunity for staff to be put forward for external awards. NED, AY, asked for clarification on the feedback loop for those with innovations that aren't taken forward, noting staff shouldn't feel reluctant or put off to submit bright ideas. DN noted that everyone unsuccessful gets a response with feedback. The answer isn't always 'no' it is often 'not now'. The idea needs to show a clear line to patient benefit if it needs funding. NED EA, noted that most ideas come in response to a perceived problem and some staff may know a problem but don't have solution. EA asked if there is a way for staff to voice areas that may need an innovative solution. DN noted that the Bright ideas team find these through group attendance. The Chief Executive noted when presenting at the monthly staff induction, she asks staff to highlight things that don't seem right or could be better. The Chief Executive suggested that slides she presents could be amended to include reference to the bright ideas scheme and responses could go there. ACTION: Chief Exec to pick up with Innovation Manager regarding incorporating Bright Ideas into Trust induction. The Director of WOD suggested DN link in with the Junior Doctors forum, if not already doing so. NED TJ, asked how the team judge success for an innovation and DN noted success was when something created benefited the patients, and we've been able to make the patient journey better. The Deputy Medical Director offered to discuss ideas for DN to engage with consultants on Bright ideas, for example through clinical forums, SRG meetings. The Board thanked DN for his presentation and attendance.
	Reports and Action Plans — **Action**
154	**Performance Committee Chair's Report**

	Non-Executive Director, MT, presented the Performance Committee Chair's report in the absence of Non-Executive Director and Chair of the Performance Committee, Geoff Broadhead. MT updated the Board on the items for concern, achievement and shared learning detailed in the report. MT noted the situation regarding the new Royal Hospital had moved on since the update at the committee. Pressing issues were identified and the committee members would expect to see an update from the Director of Strategy in the private Board meeting. MT noted further updates on the finance agency spend would be included in reports at this meeting. The committee had requested a deep dive into elective recovery funding and received an informative report, however there are still unknown factors. MT noted the committee received an update on the low energy proton beam and the amount of project work is immense The Board **noted** the report.	
155	**Integrated Performance Report Month 5 2022-2023** The Chief Operating Officer introduced the month 5 Integrated Performance report and noted the report continues to develop and work is still to be done on the SPC charts. Each Executive Lead picked out highlights in the SPC Charts and exception reporting for the following areas: Access, Efficiency, Quality, Research & Innovation and Workforce. There was further clarification/narrative and discussion given in the following areas: Efficiency The Chief Operating Officer noted there were still some pressures on length of stay. NED MT, enquired if delays in transfers was an area that the Integrated Care Board could help in. The Chief Executive responded that the Cheshire and Merseyside Acute and Speciality Trust Provider Collaborative (CMAST) are looking at delayed discharges across region which are significant, unfortunately there isn't the same data around domiciliary care and social care beds. The Chair noted there were finance discussions taking place for this area and Directors of Finance would hear more that week regarding fund allocation. The Deputy Medical director noted that the Trust has a new consultant on call model starting in January which should improve patient discharge, as well as a new radiology training programme which should help radiology reporting. Quality The Chief Nurse noted the volume of Freedom of Information (FOI) requests the Trust is receiving. NED MT enquired if there were themes to the requests, The Director of Finance noted the following themes procurement, digital contracts, workforce around Covid. Lots of the FOIs are blanket responses to questions that go to multiple organisations. There is a governance structure around sign off and opt outs. FOI replies are published on the website. NED MT, noted the missed target for the Friends and Family Test (FFT) respondents who had a positive experience. The report stated environment - signage and wayfinding	

	instructions in letters as a theme for reasons for dissatisfaction. MT sought further clarification. The Chief Nurse noted this theme was being highlighted in FFTs, complaints and walkabouts. The Head of patient experience, digital team and administrative services are involved in a piece of work to fix the needed elements of the letters. The teams will make sure everything going to patients is in its best and final version. Research and Innovation The Deputy Medical Director noted the lower level of recruitment as post Covid recovery improvement continues strategic choices have been made around which trials open. NED TJ, noted that the quality committee highlighted that on the face of it there is a discordance between the report and the BAF risks; the team need to keep an eye on them marrying up. Workforce The Director of WOD noted stress/ anxiety/ depression had reappeared in the top 3 reasons for sickness absence for the second month in a row. The teams are doing a piece of work to ensure this is recorded accurately as managers may be recording this as for personal reasons, however when staff go to occupational health it may be recorded differently. The Director of WOD noted the August compliance with PADRs and gave thanks to the divisions. The Board **noted** the report	
156	**Finance Report Month 5 2022-2023** The Director of Finance introduced the finance report for the Trust's financial performance for month 5 noting to the Board that the Trust is still on plan and seeing the positive effects of increased activity through Clatterbridge Pharmacy Limited. The Director of Finance acknowledged that there is financial pressure in the system, so even though there is a forecasted plan, the system hasn't been tested yet and it's uncertain how it will land the financial position at the end of the year. The Board discussed the external risks to the system and the uncertainty with forecasting. The Director of Finance confirmed there was a focus on risk management across the system. The Director of Finance noted there had been some progress around ERF with conversations taking place with ICB colleagues. However, the actual data hasn't matured. National conversations around ERF will be happening this week. The Board discussed the increase in referrals and noted the 20% increase from August 2020. Historically these statistics have gone up 7% a year. The Chief Executive noted the primary referrals seem steady. NED TJ asked if the Trust is seeing a climb in the number palliative patients. The Chief Executive had not seen the data. ACTION: team to take data on palliative patients in relation to referrals increase through to quality committee	JSp

	The Director of Finance highlighted the pay and agency spend. The Trust is taking weekly action to reduce agency spend, with nursing the biggest concern. The Board discussed the staffing challenges that are typically faced in winter with regards to agency spend. The Director of Finance highlighted the risk on energy spend after the gas and electricity contact was renewed and increased earlier in the year. The Director of Finance noted that the Wirral redevelopment will look at energy optimisation and PropCare are doing an analysis of current energy consumption. NED EA asked how positive statistics from the IPR will be shared with staff. The Chief Executive provides a video update for staff following each Board meeting and will include the information then. Information also goes to monthly Team Brief meetings and the Board papers are available on the Trust website. The Board **noted** the report.	
157	**NED and Governor Engagement Walk-rounds – July & August** The Chief Nurse introduced the reports for July and August and noted that the Chief Information Officer attended the July walk-round in place of a Non-Executive Director. The Chief Information Officer reported that the July walk-round had been really positive. The issue with car parking and patient drop off had been raised and PropCare together with Liverpool City Council are developing a plan to address the double parking issues outside of CCC Liverpool. There were no further comments with regards to the August walk-round. The Board discussed the different formatting of each report and agreed a mixture of narrative and short bullet points should be used going forward. The new Head of Patient Experience is looking at how to get the most out of the walk-rounds. The Board **noted** the report	
158	**New Consultant Appointments** The Deputy Medical Director noted the new appointment of Dr Shobha Silva and Dr Ruth Brown, two very positive appointments. The Chief Executive noted there is a robust process for pre-interviews including walk-abouts of the sites. The Board **noted** the report.	
159	**Guardian of Safe Working Report – April-June 2022** The Deputy Medical Director introduced the report and highlighted the appointment of Dr Ian Lampkin as Guardian of Safe Working Lead. The Deputy Medical Director noted the 9 exception reports which had all been reviewed and marked as complete; there were no fines in quarter 1. There is an expected increase in exception reports in the next quarter as haematology trainee reports will be included going forward. The Board **noted** the report	

160	**Formal Review of the Board Committee Governance Structure** The Chief Nurse noted that the changes to the Board committee governance structure had been made 6 months previously and the Board had requested the opportunity for a 6 month review. The biggest change was the frequency of some of the Board subcommittees, as Quality Committee changed from monthly to quarterly and Performance Committee changed from bi-monthly to quarterly. The Chief Nurse requested the NEDs feedback on this change. The NEDs noted that it was still early to take a view whether the new frequency fully worked, however there didn't seem to be issues. They noted the need for the timings to be tidied up with regards to feeding into Board, particularly for Quality Committee. The NEDs requested the minutes be distributed sooner and acknowledged the vacancies in the Corporate Governance Team. ACTION: The Board agreed to continue on this model and review again in 6 months. The Board **noted** the review	JG
161	**CQC Inspection – Clatterbridge Private Clinic** The Chief Nurse introduced the report and informed the Board of the unannounced inspection of The Clatterbridge Private Clinic on the 18th August 2022. There were no patients in on this day so the inspectors came back the following Tuesday to speak to patients. However they were able to speak to staff. The Chief Nurse noted there were no improvement actions at this point. There is an expectation of an unannounced inspection at Wirral site however the Chief Nurse was unsure if this would be before the CQC report was received as this is expected in the next few weeks. The Chief Nurse noted that CQC should inspect any new service within 12 months and despite being 2 years old, the Clatterbridge Liverpool site has not been inspected due to Covid The Board **noted** the report	
	For Consultation/Approval	
162	**Fit and Proper Person Requirement Policy and Annual Fit and Proper Person Compliance Audit September 2022** The Director of WOD introduced the policy and compliance audit for Fit and Proper Person requirements. The changes to the policy had been highlighted in the coversheet and the Board was asked to approve. The Board agreed to approve the updated fit and proper person policy. NED MT, highlighted that the DBS column on the compliance audit said 'none requested' for the Director of Strategy and the Chief Information Officer. The Director of WOD agreed to look into this and revise the compliance audit. NED MT highlighted that under section 8 in the policy there should be a 'web search of the individual and this column was not included in the compliance audit.	

	ACTION: The Board requested the Annual Fit and Proper Person Compliance Audit be reviewed and any additional information added. The paper will then go to the October Audit Committee for approval. The Board **approved** the policy and **noted** the audit	JSh
163	**Managing Conflicts of Interest Policy** The Director of Finance introduced the updated Managing Conflict of Interest Policy with changes done following an internal audit and review by anti-fraud. ACTION: NED MT requested the wording in section 8.1 be amended to include the need for line managers to approve and discuss actions for individuals with declarations. The Deputy Medical Director asked if the ABPI declarations were being monitored. The Director of Finance confirmed they were and this had been picked up in the audit. The Board approved the policy subject to the approval of the amended section 8.1 and the October Audit Committee. The Board **noted** the policy	JT
	For Information	
164	**Independent Charity Status – Memorandum & Articles of Association for the Charity Company Limited by Guarantee** The Head of the Charity joined the meeting for this item and introduced the Memorandum & Articles of Association and the letter in appendix 2. The Board approved Memorandum and Articles of Association for the new Charity and the letter to be dispatched to the Charity Commission, Department of Health and Social Care and NHS Charities Together informing them of the intention to move the Charity to independent status. The Head of Charity noted the appointment of a new Chair of the Trustees Brian Barwick OBE. The Charity continue to recruit other trustees. NED AY, noted that where he had had a previous discussion on clause 20 and 21, these comments have been picked up. The Board **noted** the report and **approved** the recommendations.	
165	**Emergency Preparedness Resilience and Response (EPRR) Annual Report and Core Standards** The Chief Operating Officer introduced the annual report and noted the quarterly report on EPRR goes to the Performance Committee. It was noted the Trust are preparing for the Covid enquiry and have made good progress. NED MT noted that the self-assessment wasn't seen at the August performance committee. The Chief Operating Officer confirmed that the core standards weren't published in time for the August meeting. This year there has been an increase in standards and going forward the Trust will be in a better position to monitor itself against the key standards. The Chief Information Officer noted in the risk management section a score of 10 needs changed.	

	ACTION: Chief Operating Officer to liaise with Chief Information Officer regarding score accuracy prior to paper publication. The Board noted that the online paper portal had cut off part of the self-assessment report which was included in the pdf version of the pack. The Board **noted** the annual report and core standards	JSp/SB
166	**2021-2022 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance** The Deputy Medical Director introduced the report and noted it had been seen and approved by the Quality Committee earlier in September. The Deputy medical Director summarised that despite the challenges of the pandemic the Trust has managed to maintain the revalidation and appraisal process for all doctors with connections to Clatterbridge Cancer Centre in line with national guidance. The Board **noted** and **approved** the annual submission	
167	**Safeguarding Annual Report 2021-2022** The Chief Nurse introduced the report and noted it had been seen and approved by the Quality Committee earlier in September. The Trust had maintained all regulatory and statutory guidance, apart from level 3. The team had been strengthened in year, and are currently reviewing the staffing budget. NED TJ, noted that it was highlighted at Quality Committee that for Appendix 4 the data was collected from a small subset of people. The Committee have asked for a report in 6 months to further understand this data. The Chief Nurse noted there had been 74 safeguarding concerns in year and she would expect more. The benchmarking data that comes to Quality Committee in 6 months will look at internal key performance indicators. The Board approved the report noting that additional information (including benchmarking) should be included in future reports. The Board **noted** the annual report.	
168	**Freedom to Speak Up Annual Report - deferred** The Director of Finance noted that the Freedom to Speak Up Annual report was deferred to the October Trust Board meeting, due to absence in the Corporate Governance Team. The Director of Finance highlighted that October is Freedom to Speak Up month and requested the Executives share this with their teams. The Board **noted** the update.	
169	**Board Away Day July 2022** The Chief Executive noted the Board had held an away in July and highlighted the importance that the Board take the time to understand the detail around the areas discussed. The Board **noted** the report.	
	System Working	
170	**CMAST Governance Update and Documentation** The Chief Executive introduced the papers and noted the Board had seen a previous version at the away day in July.	

	The Board **approved** the Committee in Common Terms of Reference and the CMAST joint working agreement.	
172	**Cheshire and Merseyside Cancer Alliance Performance Report** The Chief Executive introduced the report and noted the activity and referral levels which are being looked at through CMAST and the ICB. The Chief Executive highlighted that the alliance are not looking to meet the trajectory for March 2023. Improvements have been seen from one provider, but there are ups and downs elsewhere. Discussions will take place regionally next week to ensure Trusts don't settle into these figures as a 'new normal'. Jon Hayes and representative from the ICB are coming to the consultant away day which should help with this. The Chief Executive noted that significant funding had been approved for Community Diagnostic Centres (CDC) and diagnostic funding, and all 7 CDCs are now funded. All endoscopy suites can now be JAG accredited. The Chief Executive highlighted the work going on with workforce with the first international radiographers starting at the Trust. The Board **noted** the report.	
	Any other business	
173	The Director of WOD reminded the Board about the staff excellence award on the 14th October, which had 202 nominations for 7 awards. The Director of Workforce informed the Board that the Staff survey is currently out.	
	Date and time of next meeting via MS Teams/ hybrid : Wednesday 26th October 2022 at 9.30	

						P1-176-21
BOARD ACTION SHEET PART 1						
		KEY: BLUE = COMPLETE / GREEN = ON TRACK / AMBER = AT RISK / RED = LATE				
Item No.	**Date of Meeting**	**Item**	**Action(s)**	**Action by**	**Date to complete by**	**Date Completed / update**
P1-111-22	29th June 2022	People Committee Chair's Report	Final version of the People Committee Terms of Reference to go to October Trust Board for approval	**ST**	Oct-22	On October Agenda
P1-153-22	28th September 2022	Staff Story	Chief Exec to pick up with Innovation Manager regarding incorporating Bright Ideas into Trust induction.	**LB**	Oct-22	
P1-156-22	28th September 2022	Finance Report Month 5 2022-2023	Team to take data on palliative patients in relation to referrals increase through to quality committee	**JSp**	Oct-22	On cycle of business for Quality Committee in December
P1-160-22	28th September 2022	Formal Review of the Board Committee Governance Structure	The Board agreed to continue on this Committee governance model and review again in 6 months	**JG**	Mar-22	
P1-162-22	28th September 2022	Fit and Proper Person Requirement Policy and Annual Fit and Proper Person Compliance Audit September 2022	The Board requested the Annual Fit and Proper Person Compliance Audit be reviewed and any additional information added. The paper will then go to the October Audit Committee for approval.	**JSh**	Oct-22	Updated Annual Fit and Proper Person Compliance Audit taken to Audit Committee in October and approved
P1-163-22	28th September 2022	Managing Conflicts of Interest Policy	NED MT requested the wording in section 8.1 be amended to include the need for line managers to approve and discuss actions for individuals with declarations. The Board approved the policy subject to the approval of the amended section 8.1 and the October Audit Committee.	**JT**	Oct-22	Updated Managing Conflicts of Interest Policy taken to Audit Committee in October and approved
P1-165-22	28th September 2022	Emergency Preparedness Resilience and Response (EPRR) Annual Report and Core Standards	Chief Operating Officer to liaise with Chief Information Officer regarding score accuracy prior to paper publication.	**JSp/SB**	Oct-22	

Trust Board Annual Reporting Cycle 2022/23	Owner	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Strategy & Planning													
Progress against 5 Year Strategy	TP				√				√				√
Annual Financial/Operational Planning Guidance	JT							√			√	√ Draft	√ Submission
Bright Ideas Scheme	GH											√	
Green Plan Annual Report	TP												√
Assurance: Quality, Performance													
Quality Committee Chair Report	TJ	√			√			√			√		
Performance Committee Chair Report	GB		√				√		√			√	
Audit Committee Chair Report	MT	√	√	√	√			√			√		
Charitable Funds Committee Chair Report	EA	√			√			√			√		
People Committee Chairs report	JSh			√ inc. ToR				√ inc. ToR			√		√
Integrated Performance Report	Exec Leads	√	√	√	√		√	√	√		√	√	√
Finance Report	JB/JT	√	√	√	√		√	√	√		√	√	√
Safer Staffing Report	JG			√							√		
Gender Pay Gap (for review)	JSh												√
Workforce Race Equality Standard Data (for review)	JSh							√					
Workforce Disability Equality Standard Data (for review)	JSh							√					
Equality Diversity & Inclusion Annual Report (for review)	JSh										√		
Patient Story	JG		√		√			√			√		√
Staff Story	JSh	√		√			√		√			√	
Actions from Patient/Staff Survey Annual Report	JG												√
In-Patient Survey- embargoed	JG						√						
Patient Experience Visits / NED and Governor Engagement Walkround	JG	√	√	√	√		√	√	√		√	√	√
NED and Governor Engagement Walkround Annual Schedule	JG		√										√
Actions from NED and Governor Engagement Walk-rounds Annual Report	JG												√
New Consultant Appointments	SK	√	√	√	√		√	√	√		√	√	√
Caldicott Guardian Annual Report (For review)	SK										√		
5 year Patient Experience Engagement Inclusion & Involvement (PEEII) Commitment (For review)	JG												√
Staff Survey Results	JSh						√						√
Annual Risk Management Report	JG												√
Approval of Risk Management Strategy	JG												√
Quality strategy and Annual Report	JG												√
Board Governance													
Review of Constitution (ADHOC)	MS								√				
Board Assurance Framework Risk Appetite Statement	MS				√			√			√ Q3		
BAF Refresh (reporting on for year ahead)	MS	√											
Audit Committee Annual Report	MS				√								
Well-Led Review Action Plan Update	TP	√			√			√			√		
Annual Review of Board effectiveness	MS												√
Statutory Reporting/Compliance													

Annual Report & Accounts including the Annual Governance Statement	MS			√- extra ordinary										
External Audit Findings Report and Letter of Representation	MS			√ extra ordinary										
Self-Certification against the Provider Licence	MS			√ extra ordinary										
Regulation 5 Declarations (Fit and Proper)	MS				√ deferred		√							
Emergency Preparedness Resilience and Response (EPRR) Annual Report and core standards	JSp						√							
Learning From Deaths (Mortality Report) Quarterly	SK				√				Q1√			Q2√		
Mortality annual report	SK				√									
Revalidation Annual Report (for review)	SK						√							
Guardian of Safe Working Report (quarterly) (for review)	SK			√			√		√				√	
Guardian of safe working annual report (For review)	SK			√										
Infection Prevention and Control Annual Report (For review)	JG				√									
Freedom to Speak Up Annual Report	MS				√- deferred		√-deferred	√						
Health and Safety Annual Report (For review)	JSp						√							
R&I Annual Report	SK							√						
Safeguarding annual report (For review)	SK						√							
Collaboration														
CMCA Report	LB						√							
Board Development Sessions														
BDS: Research & Development	SK/GH	√									√			
BDS: Digital	SB						√							
Board Assurance Framework	MS		√											
Adhoc / Committee Requested														
Integrating specialised services within integrated care systems	JT			√										
Staff Walk-round Process Review	JG			√ - deferred	√									
Articles of association for the charity company limited by guarantee	KB						√							
Digital Annual report?														
Formal Review of the Board Committee Governance Structure	JG						√						√	
Mental health Services Letter (Speak to Julie)	JG								√					

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: **Board of Directors**
Date of meeting: **26 October 2022**

Report author	Gilly Conway, Managing Director, Conway Bloomfield Ltd				
Paper prepared by	Updates to strategic risks provided by the Executive Risk Leads				
Report subject/title	Board Assurance Framework (BAF) updates				
Purpose of paper	To provide an update on the sections of the BAF under direct oversight of the Board (strategic risks BAF4 and BAF6)				
Background papers	Q1 BAF report presented to July Board of Directors; BAF update reports to Performance Committee (August), Quality Committee (September), People Committee (September) and Audit Committee (October)				
Action required	Confirm level of assurance provided about key controls for BAF4 and BAF6. Note the current risk exposure across the set of strategic risks (Appendix 1).				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	x	Be a great place to work		
	Be Collaborative	x	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

The Clatterbridge Cancer Centre NHS Foundation Trust

1.0 Introduction

1.1 This report provides key updates about the Trust's strategic risks. It includes key highlights about strategic risks under direct oversight of the Board: BAF4 and BAF6 relating to Board governance and system working. 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 for reference.

1.2 Since the last update to the Board in July, Committees of the Board have received BAF reports as follows:

- BAF2, 3, 5, 8 and 15 reviewed by the Performance Committee 24 August;
- BAF1, 7 and 13 reviewed by the Quality Committee 22 September;
- BAF9, 10, 11 and 12 reviewed by the People Committee 29 September;
- BAF14 reviewed by the Audit Committee 13 October (see section 2 Key Highlights).

1.3 The Board should use the BAF as a tool to:

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

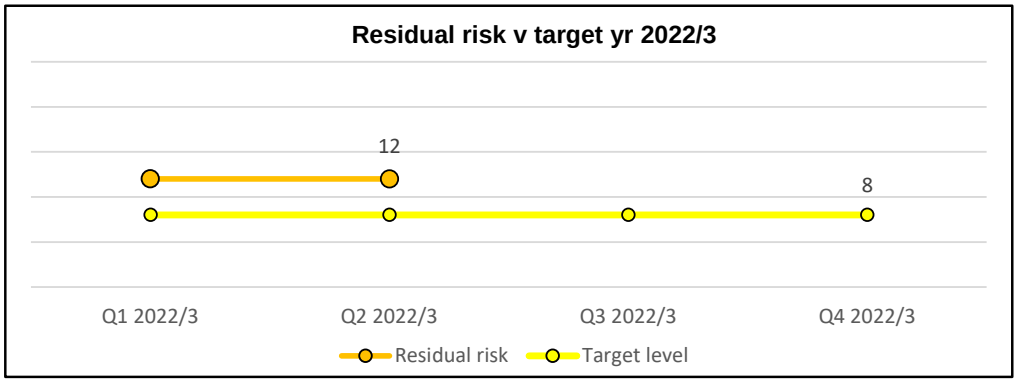
The Clatterbridge Cancer Centre NHS Foundation Trust

2.0 Key highlights

2.1 There has been one change to strategic risk scores since the Q1 report. The Audit Committee (13 October 2022) approved the reduction of the residual risk level for BAF14, cyber security, from 16 to 12 in light of work completed to strengthen controls.

2.2 The following tables provide summarised information about the two strategic risks under direct oversight of the Board of Directors, BAF4 and BAF6. The full detail can be found in Appendix 2.

Summary table: BAF4 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 5 controls (2 improved from partial since Q1) PARTIAL 2 controls	Completed Q2 - NED and CoG Walkarounds commenced - Revised BAF for 2022-23 in use by Board and Committees Reforecast - Review CCC corporate governance in light of latest NHSE guidance (revised from July 2022 to March 2023) Due Q3 None	**8**
Commentary Good progress has been made in terms of streamlining corporate governance processes and the Well Led Development Review was largely positive with an action plan in place to close any gaps. The 2022-3 BAF is in place with clearer description of assurances, controls, gaps and actions. All relevant Board Committees have received BAF reports during August to October. There is further work to be undertaken on the development of the Quality Strategy in 2022-3 but there has been significant improvement in the management of clinical risk. Corporate Governance support has been confirmed until the end of the financial year to improve capacity in that team.				



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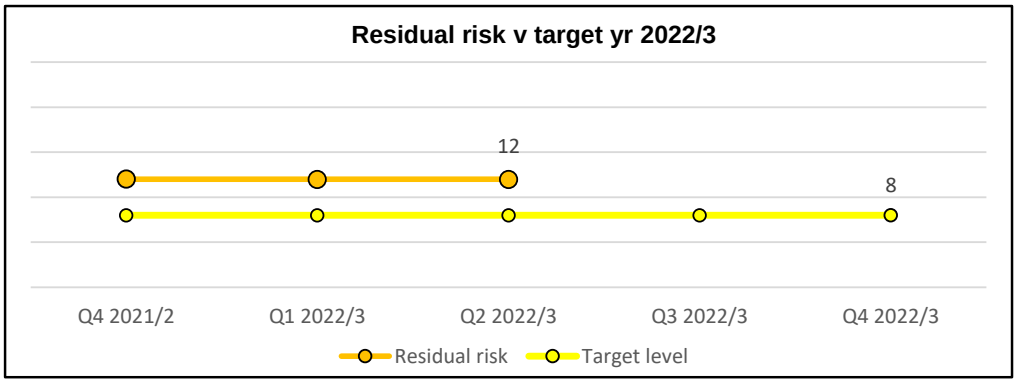
Ref: FCGOREPO
Review: July 2025
Version: 2.0

The Clatterbridge Cancer Centre NHS Foundation Trust

Summary table: BAF6 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 4 controls (1 improved from partial since Q1) PARTIAL 1 control	Completed Q2 - New arrangements in place for regional monitoring of cancer performance - Business cases for CDCs submitted to NHSE regional/national diagnostics team - Provider Collaborative workshop slides distributed to NEDs Due Q3 - Finance and HR Managers to be appointed for the Diagnostics programme (due date revised from July 2022)	**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 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. An additional control has been added to reflect CCC's involvement with the CMAST Provider Collaborative.



3.0 Recommendations

3.1 The Board is requested to interrogate BAF4 and BAF6 and confirm that members are satisfied with the information about key controls and assurances, and the remaining actions.

Appendix 1: Strategic risk heatmap showing initial, residual and target risk scores Q2 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?*	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
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:** 9 September 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 and Board Annual Clinical Audit Report, reviewed by Quality 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	Review of Risk Management Strategy underway. Awaiting publication of Patient Safety Straregy Framework national documentatin in order to align Incident Reporting Processes.	2 x 5 = 10
			C2) Patient Experience & Inclusion Strategy. Established Patient Experience & 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 to Quality Committee. Complaints, PALS & Claims reports, reviewed by Risk & Quality Governance 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	Complaints process review planned for Q3 Quarterly Quarter 1 - Patient Safety & Experience Report published	
			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. Review effectiveness of Harms Free Care Group **Action Owner**: Chief Nurse **Due date**: 31/03/23	Pressure Ulcer Collaborative supported by AQuA commenced 7/09/22 Falls/Manual Handling Lead appointed, due to start in post Q3	
			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	Integrated 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	Early scoping underway.	
			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 to Quality Committee	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	New Associate Director of Clinical Governance and Patient Safety post appointed - due to commence in post November 22. Patient Safety Committee refreshed - Consultant chair appointed. Patient Safety Incident Response Framework (PSIRF) initial implementation plan drafted.	
			C6) Single room occupancy so all patients are isolated. Antimicrobial prescribing 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	Discussion underway with commissioning quality team.	
			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 to Quality Committee and Board		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	Scoping underway, initial meeting planned 26/09/22	

Additional narrative

During 2022/23 existing governance stytems and processes are being reviewed and refreshed to ensure they meet the requirements to evidence a safe, caring, responsive, effective and Well-led organisation. Lack of knowledge, experience and requisit personnel within the clinical and corporate governance service has resulted in unclear and fragmented processes. The introduction of a new governance committee structure, clearer lines of responsibility and mechanisms to ensure accountability are embedding. Clinical engagement in key governance committees, the recruitment of new staff and development of a new aggregated patient safety and experience report wil all be key milestones through out this financial year.

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:** 9 October 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 monthly to Board and CCC CWT performance discussed at Trust Board via IPR	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 via weekly COOs meetings	
			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 demonstrated at Divisional Performance Review Groups (PRGs) and reported via COO's report to Performance Committee	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 now 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	1. Refer to C&M diagnostics delivery plan **Action Owner**: CCC CEO **Due date**: April 2023. 2. CCC to work with referring trusts with highest number of late referrals **Action Owner**: CCC COO **Due date**: April 2023	CCC CEO is the SRO for C&M Diagnostics recovery programme, clear improvement programme in place. Monitored at ICS and via national cancer Team. Meeting with LUHFT COO to agree improvement actions scheduled for the 7th Sept 2022	
			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			G5) Referral numbers continue to rise, highest on record in Sept 2022	SRGs monitoring activity, capacity challenges escalated to managers daily. Additional clinics in place across a number of tumour groups. **Action Owner:** CCC COO **(Complete)**	Daily escalation supporting early intervention.	
			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	IPR to Performance Committee quarterly and Board (monthly), Divisional PRGs		Acceptable						
			C9) Allocation of first appointments monitored by registrations team. Lack of capacity escalated to relevant senior manager **Control Owner:** COO	Capacity monitored via weekly TOG		Acceptable						
			C10) WLI clinic can be expanded to meet demand **Control Owner:** COO	Capacity monitored via weekly TOG		Acceptable						
			C11) CCC monitoring internal 24 day target **Control Owner**: COO	Weekly at TOG, monthly IPR to Trust Board and quarterly to Performance Committee, PRGs		Acceptable						
			C12) 62 day target to be performance managed alongside 78ww **Control Owner**: COO	Weekly TOG, Monthly IPR to Trust Board and quarterly to Performance Committee. 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. Divisonal BPs to be presented at Trust Performance Committee via a rolling programme.		Acceptable						

Additional narrative

Despite multiple mitigations, the risk score cannot currently be reduced below 12. Uncertainty regarding future waves of the Covid pandemic and the uncertain financial environment maintains the likelihood score as 4, however, there are sufficient controls in place to ensure that the predicted impact would be 'moderate' rather than 'catastrophic' as indicated by the inherent risk level.

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?*	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
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:** 4 October 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 and reported quarterly to Performance Committee. Budgets approved by lead managers	External Audit includes assessment of plan though VFM testing (reported to Audit Committee). National Financial Sustainability exercise by MIAA (HFMA checklist) - Q3 22/23.	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**: 31/03/23	Not applicable at this stage in the financial year. Trust submitted HFMA checklist - September 22.	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) and reported via Finance Report to Performance Committee and Board. 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. National Financial Sustainability exercise by MIAA (HFMA checklist) - Q3 22/23.	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. Trust submitted HFMA checklist September 22.	
			C4) Trust Board approved financial plan, and ICB approved target financial position **Control Owner**: DoF	Finance report quartelry to Performance Committee and monthly to 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 Financial Planning Reports to Performance Committee 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 participate in peer ICB networks. Trust working with partners in Liverpool health system to support, following Carnall Farrar report - October 22	
			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 escalate 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. Trust Capital Committee commenced future capital service need review - September 22	

Additional narrative

The financial system for 2022/23 is a transition period. This is because of structural change of ICB/system working and establishing financial income flows for the Trust. Key risks include securing sufficient funding through contractual mechanisms, including ERF, and delivering the efficiency programme.

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?*	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
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:** 30 September 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 2022 (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. Annual Risk Management Report to Quality Committee and Board	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 via Audit Committee Annual Report	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**: March 2023	Additional support for corporate governance confirmed until end of the financial year	
			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**: March 2023 (revised from 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 to Quality Committee and Board via IPR and quality reports to monthly Risk and Quality Governance Committee. Quality and Safety oversight at Divisional PRGs. NED and Governor Engagement Walk-rounds with action plans monitored through PEIG and oversight at Trust Board.	WLDR report to Board March 2022 with a number of reccommendations	**Acceptable (improved from partial)**			C5) NED and Governor quality & safety visits suspended during pandemic	Formal NED &COG Quality & Safety Walkarounds to commence. **Action owner:** CEO **Due date:** 31 July 2022 (**Complete**)	Complete	
			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	**Acceptable (improved from partial)**			C6) 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 (**Complete**)	Handover of ongoing management and reporting of the BAF from external support to Corporate Governance team from November.	
			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**						

Additional narrative

Significant change has been made to both the corporate and clinical governance processes and teams in recent months. Good progress has been made in terms of streamlining corporate governance processes and the Well Led Development Review was largely positive with an action plan in place to close any gaps. The 2022-3 BAF is complete with clearer description of assurances, controls, gaps and actions. There is further work to be undertaken on the development of the Quality Strategy in 2022-3 but there has been significant improvement in the management of clinical risk.

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)*			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	
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:** 9 August 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 and to Board March 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	**Control gap now addressed through completion of these actions.**	3 x 3 = 9
			C2) Multidisciplinary Sustainability Action Group formed to support delivery of the Green Plan action plan - supported by interim Sustainability Manager for 6 months. **Control Owner**: Director of Strategy	Programme reports reviewed quarterly		Partial			G2) Sustainability Action Group not yet fully functioning	1. Engage with current members to ensure engagement and participation 2. Review terms of reference including membership, accountabilities **Action Owner**: DoS **Due date**: revised to 5th September 2022 (from 14th July 2022)	Additional members invited. Existing members encouraged 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)		Partial			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	**Completed - PropCare Projects now in place.** High level redevelopment options in development.	

Additional narrative

The Trust has previously promoted sustainability in certain areas, for example cycle to work schemes and active travel facilities. The newly-approved Green Plan clarifies the Trust's overarching aims and states key targets to be achieved. The Green Plan also sets out the early, short-term priorities and the main initiatives that will be implemented in the longer term. The current risk score reflects the opening of the new, modern CCC-L building which marks a milestone in upgrading the Trust's estate.
A key part of future delivery depends on establishing effective programme management arrangements. Two unsuccessful attempts to appoint substantively to Sustainability Programme Manager role (12 months fixed term) has necessitated consideration of interim solution - interim sustainability manager now in post for 6 months from July to December 2022. PropCare projects division also formed - significant contribution to green agenda, including through progressing CCC-W redevelopment.

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)*			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	
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:** 30 September 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	Quarterly 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	Comms and Marketing Strategy in progress, to be completed by November 2022; preferred marketing provider engaged	**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 (**Complete**)	New arrangements in place for regional monitoring of cancer performance attended by MD of CMCA/CCC CEO and Tier 1/2 performance management in place and attended by MD CMCA	
			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**: 30 November 2022 (revised from July 2022)	Recruitment in progress to increase team establishment. Contracts to be held by CCC and risk sharing agreement in progress with ICB (led by ICB HRD)	
			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	**Acceptable (improved from 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 (**Complete**)	StHK and Salton CDC BC approved; 7 CDCs now funded	
			C5) Trust involvement with CMAST Provider Collaborative **Control Owner**: CEO	Update to CCC Board at Strategy Away Day 28 July 2022. Chair and CEO updates at monthly Board meetings. NED involvement and oversight at CMAST level. CEO and Chair attendance at CMAST Leadership Board		**Acceptable**			G5) No NED attendance at August Provider collaborative and ICS workshop	Session themes and slides to be passed on to NEDS **Action Owner**: Corporate Governance Manager **Due Date**: End August 2022 (**Complete**)	CMAST JWA and CiC ToR approved at October Board	

Additional narrative

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, although it is appreciated the diagnostics programme covers non cancer work.

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**: Quality **Last Update:** 7 October 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 **(Complete)**	Complete. Bid successfully submitted 30 June 2022	**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 Risk & 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 **(Complete)** 2. Recruitment of Early Phase Clinical Research Fellow **Action Owner**: Medical Director **Due date**: 31 March 2023	1. Policy approved at July 2022 TIC. 2. Funding identified for post, draft job description being prepared.	
			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 **(Complete)**	Deputy Clinical Trials Pharmacist appointed. Started in post July 2022. Advanced Pharmacist (0.4WTE) started August 2022.	
			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**: 14 October 2022 (original 31 August 2022) **(Complete)**	CRF meeting held between LUHFT and CCC CRFs June 2022. Governance structure agreed with LUHFT October 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 October 2022 (original 31 May 2022)	Outcome awaited. Outcome under embargo.	
			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	Appointment of aseptic pharmacy staff **Action Owner**: Medical Director **Due date**: 31 October 2022	Aseptic services staffing nearing fully established.	
			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**						

Additional narrative

Key controls will provide mitigation against the likelihood of adverse outcome to current bid renewal and consequences of any adverse outcome; the ability of CCC to continue to deliver high quality research will be strengthened, providing access to novel treatments and enhancing reputation through increased capacity and capability. Likelihood of future successful bids will be increased. Gaining Clinical Research Facilites status with a collaborative bid involving CCC and 2 other Trusts within the region secured £5.3m for local regional facilities. Outcome of BRC bid in May 2022 will, if successful demonstrate further research capability and ensure access to high quality research.

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:** 7 October 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**: March 2023 (revised from 31 December 2022)	Staffing gaps identified. Financial resource agreed. Recruitment process underway. Workforce plan agreed in-line with ECMC and Research Strategy funding.	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 **(Complete)**	**Bid submitted** within due date with CCC and UoL oversight; 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. Operational Oversight through new joint ECMC/CRF Operational meeting.		**Acceptable**			G4) CRF governance arrangements	Governance structure to be established for September **Action Owner**: Medical Director **Due date**: 14 October 2022 (Original 31 August 2022) **(Complete)**	CRF meeting between LUHFT and CCC CRFs June 2022; launch meeting scheduled September 2022 moved (national mourning) to November 2022. Governance structure agreed with LUHFT October 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 currently under embargo	
									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	

Additional narrative

The research strategy has a costed workplan wich is monitored at performance committee; the governance struture is aligned to ensure identification of bid developments, commercial funding opportunites and charitable funding to deliver the strategy.

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:** 16 September 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 in place for key staff groups (Medics/AHPs)	Develop competency framework **Action Owner**: Director of WOD **Due date**: 30/11/22 (original date 30/06/22)	Review undertaken focusing on medical leadership and a number of recommendations identified. Leadership programme for medics being developed following listening sessions with consultants. Head of OD developing	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 training needs analysis (TNA) for leadership roles for development of core leadership competencies **Action Owner**: Director of WOD **Due date**: 31/12/22 (original 30/06/22)	Dashboard developed to identify development needs identified as part of PADR process. Head of OD developing proposals leadership pathways for mid level managers/ leaders and senior leaders. Launching Leadership development programmes for Female Leaders in September 2022. Ledership masterclass schedule in place for 2022/23.	
			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**: 31/03/23 (original 30/04/22)	Working with external company to develop framework to support medical leadership development including coaching offer	
			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						

Additional narrative

Leadership development programmes and some associated workstreams have been impacted by the pandemic. The target date for completion reflects the work undertaken to date and the outsanding work to be completed.

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	Actions: 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:** 16 September 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	Complete. EDI lead joining the Trust in Dec 2022.	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**: 31/10/22 (original date 31/08/22)	Review underway, WRES/ WDES annual reports to be published in October 2022 which outlines plans for next 12 months	
			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**: 31/11/22 (original 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**: 30/10/22 (original date 30/09/22)	Recruitment Improvement Plan agreed at People Committee in June 2022. Proposal taken to RPA/ SharePoint operational group to identify areas of WOD transactional processes that can be digitised.	
			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						

Additional narrative

Recruitment challenges exist across the NHS and challenges are significant for some hard to recruit to posts. This risk is increased due to the additional recruitment underway by LUFT to support the opening of new Royal Hospital.

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:** 16 September 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 (to be revised)	Internal WOD scoping meeting taking place 27/09/2022. Timescale to be revised subsequently.	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) An E-Roster work plan is in place to support the achievement of NHSIE Levels of Attainment. Work is in progress but not complete	Detailed actions plans to be developed and implemented for each clinical are to address gaps/areas of focus **Action Owner**: Director of WOD **Due date**: 31/03/2023	Audit completed in Dec 2021 that identified number of key actions. Refreshed Trust-wide project plan agreed to support Level of Attainment. Divisional work groups identified to address specific gaps/areas of focus for each area.	
			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 **(Complete)**	Procurement process concluded Sept 2022. Workforce systems team developing implementation plans for the transition of systems. New system to go live January 2023. Backup of current system procured to support transition.	
			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		

Additional narrative

As with BAF 10, the opening of the new Royal Hospital may impact our ability to recruit.

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:** 16 September 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	Review of offer complete and to be monitored on an ongoing basis. Recruited H&WB co-ordinator role	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 (to be revised)	Commencement of this work delayed. New Engagement and Wellbeing coordinator to scope Wellbeing champion training offer and develop a proposal for recruitment.	
			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	Update provided to Workforce Advisory Group on progress of the regional projects in partnership with NW Trusts.	
			C4) Health & Wellbeing objectives for line managers and all staff **Control Owner**: Director of WOD	PADR compliance data monitored by Workforce Advisory Group and People Committee		Partial						
			C5) Resilience modules in Leadership Masterclass modules **Control Owner**: Director of WOD	Leadership Masterclass annual programme report to People Committee		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								

Additional narrative

Much has been progressed around health and wellbeing over the last 2 years but key to future success is ensuring that the offers available meet the needs of staff and are easily accessible for everyone.

BAF13. Development and adoption of digitisation

RISK APPETITE: Digital MODERATE (tolerance 8-12)

STRATEGIC OBJECTIVE: To 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
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:** 9 September 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 Committee **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. Digital Strategy Story Board completed 30/08/22. An initial Draft being reviewed internally as at 8/9/22. Full initial draft for sharing on target for 30/09/22	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 responsibilities 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 **(Complete)**	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. A full governance review has taken place and governance arrangements are in place for Clinical Systems optimisation with Executive oversight from Medical Director. Workstreams will have Executive Oversight from Chief Nurse and COO. Governance approach between programme and TIC signed off at Digital Board in August 22. Regular reviews of governance will continue.	
			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 **(Complete)**	Member of staff in post and inaugural Clinical System Optimisation Group took place on 1st September 2022	
			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 **(Workstream agreed)**	Chief Nursing Information Officer presented programme of work to Risk &Quality Committee June 2022. Work is underway and the programme fits into the overarching governance. Inaugural workstream meeting arranged for 26th September. CNIO having bi-weekly operational meetings with Nursing teams to start to review the nursing documentation.	
			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. Process mapping and inaugural workstream meeting being planned.	
									G4) Completion of National "What Good Looks Like Framework for Nursing" (WGLL) to be 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. Work has commenced with the WGLL Nursing Framework. CNIO is working with tools provided through NW region. Initial assessment will be reviewed at Digital Board October 22	
									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. A number of face to face demonstrations on Dashboards have taken place.	
									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. Key work required to be completed to enable level 6 is Closed Loop Prescribing for Non- Sact Medicines. This work will be managed within the Medicines workstream of the Clinical Systems Optimisation Programme. Date for assesment of HIMMs assessment is likely to change.	

Additional narrative:

The Organisation is developing it's levels of digital maturity through use of digital systems. It is essential that the addition of any new technologies is embedded for the right reasons and to support clinical and operational processes to its best effect. It is essential that process change and embedding of new ways of working is owned opertaionally. The inherent risk score is high as, if uncontrolled there is a risk the organisation could fall behind. There is considerable change management aspect of the work required in the development and adoption of digitisation which is cross-cutting and requires different parts of the organisation to own and lead alongside the Digital services team. Some initial actions have been completed and there will be a time period to understand the impact of those actions and time to embed. The key controls and current risk score will be reviewed once further actions have been completed.

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)*			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	
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:** 3 October 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 3 = 12 ⬇	Yes	G1) Heightened security threat due to war in Ukraine, use of Russian software.	Decommission Russian AV software **Action Owner**: CIO **Due date**: June 2022 (**Complete**)	Completed the migration from Kaspersky to Sophos. All Russian AV software fully decommissioned.	4 x 3 = 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 (**Complete**)	Corporate back-ups are now air Gapped. Status reported monthly through Data Security Committee.	
			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 (**Complete**)	Philips have applied patches to the PACS servers.	
			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. Exploring opportunities to adopt policies and practices to meet ISO27001 standards in the organisation. CE+ - All audit evidence submitted to Audit Portal. Awaiting feedback and next steps.	
			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	ICB awarded contract for SOC to prefered bidder. Initial contract meeting to commence October 22. 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 (**Complete**)	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 (**Complete** August 2022)	Policy in place (User Management Policy). Update report production from monthly to weekly. Gap in control identified via toolkit is now resolved.	

Additional narrative

Cyber is a risk that will always score high on a Trust Risk Register due to the fluctuating nature of this type of risk and new and emerging risks to Cyber Security happening at all times. There are a number of national approaches to control Cyber Risks which this Trust is fully immersed in.
Cyber Threats continue with an NHS supplier being recently targeted, causing large scale disruption to 111 services for a number of weeks. Whilst the Clatterbridge Cancer centre has a robust patching policy, recent national events have meant there has been an increase in Care Cert Alerts to all organisations which means the Digital team are continually responding to national requests from the National Data Security Centre. A number of actions to close control gaps have now been completed. Operational level cyber risks are being managed through monthly Data Security Commitee Meetings and Digital Board. With the closure of VPN gap and decommissioing of Russian software it is proposed that the residual (current) risk score be reduced to 12. The target risk score has also been reviewed but given the current climate should remain as a target score of 12. A further review of actions and gaps in control is currently being undertaken.

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)*			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	
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:** 4 October 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 relationship to complete before Trust financial plan for year.	Commence SLA discussion in Q3 22/23 **Action Owner:** DoF **Due date:** 31/12/22	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**: 30/11/22 (revised from 30/09/22)	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**: 30/11/22 (revised from 30/09/22)	Trust engaged with experienced governance lead for temporary contract. CPL SLA is still with KPMG - review period extended due to HMRC VAT issue.	
			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 3 (revised from Quarter 2). **Action Owner**: DoF **Due date**: 30/11/22 (revised from 31/09/22)	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. **Action Owner:** DoF **Due date:** 31/10/22	CPL Board Strategy session 13/06/22	

Additional narrative

The Trust recognises that the subsidiary companies and JV add commercial value to the Trust. They have separate management teams and there is a risk that if clear governance and strategy is not established the benefits of the Group will not be maximised - finanically, operationally - to the detriment of patient care.
The governance structures are routinely reviewed and arrangements are in place for performance monitoring. These have been strengthened recently due to input from new subsidiary/JV appointments.
Recent strategy developments (CPL/PropCare) and implementation will be reviewed through the Trust Board meetings.

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 26 October 2022

Report author	Emma Whitby, Head of Research Delivery			
Paper prepared by	Emma Whitby, Head of Research Delivery			
Report subject/title	R&I Patient Story – October Trust Board			
Purpose of paper	Action Plan to support Patient Story			
Background papers	Link to patient story			
Action required	Please see below			
Link to: Strategic Direction Corporate Objectives	Be Outstanding		Be a great place to work	x
	Be Collaborative		Be Digital	
	Be Research Leaders	x	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

Patient/Staff Story Action Report

Story ID		Committee	Board of Directors		
Date Presented		Patient Story	☒	Staff Story	☐
		In person	☐	Digital	☒
Date Consent Obtained		Consented by		Consent for:	Internal ☒External ☒Online ☒
Division/s involved	Research & Innovation		External Organisation involved	N/A	
Formal Complaint	☐	Complaint closed	☐	Complaint Upheld	☐

1. Action Already Taken

No	Issue	Action taken	Action Lead
1	Room Temperature and lack of access to “Fresh Air”. Air- con available in room, ward staff to escalate concerns to Propcare.	Roof Terrance is now open for patients to sit outside if safe to do so.	Prop Care

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

No	Issue	Action required	Action Lead	Deadline Date	Expected Evidence of Completion
1	Waiting time to see Doctor.	Funding secured for Research fellow.	Director of Clinical Research	Nov 2022	Appointment to post
2	Food Menu – Limited Choice.	Consider revision of menu choices.	Nutritional Steering Committee has an established working group looking at food quality. This action to be	Nov 2022	Improved menu choice for inpatients

			picked up via this group. Lead/Quality Lead Tazeen Khatib		
3	CT/MRI Radiology appointments can be more intense for patients on clinical trials and it is relatively common for patients to require multiple imaging such as a MRI & CT scan as part of screening or follow up. The Research Practitioner will request the scans as per protocol and will request that scans are booked on the same day.	To seek, where possible to ensure patients appointments are on the same day. Essential for patients that are out of area.	Imaging Simran Chander.	Nov 2022	Where possible to facilitate imaging on the same date for patients on clinical trials that require multiple scans.
4	Patient received a letter from the Interventional Team - Terminology confusing to patient.	Additional information to be included in patient letters to explain procedure.	Work stream for accessibility standards in existence. This action will be picked up via this group. Lead Lynne Benson.	Nov 2022	Updated Patient letter.

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

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

The Clatterbridge Cancer Centre
NHS Foundation Trust

WE ARE...
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The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1 – 26th October 2022

Chairs report for: Quality Committee

Date/Time of meeting: 22nd September – 09:30-12:30

			Yes/No
Chair	Terry Jones, Non-Executive Director	**Was the meeting Quorate?**	Y
Meeting format	MS Teams		
Was the committee assured by the quality of the papers (if not please provide details below)			Y
Was the committee assured by the evidence and discussion provided (if not please provide details below)			Y

Items of concern for escalation to the Board	**Safeguarding Annual Report 2021-2022** The Committee received the safeguarding annual report and noted concerning data regarding Performance against the Learning Disability Improvement Standards. • 57.9% of patients surveyed agreed that they were given a choice about their care. This is significantly lower than the national average of 83%. In contrast, 94% of staff agreed that they routinely involve patients in decision-making. •At time of data collection 36.8% of staff agreed that there is a clear policy in regards to DNACPR. This is comparable to the national average. The Trust has an up to date DNACPR, although this does not directly discuss patients with additional needs, it does make clear reference to the Mental Capacity Act and patients judged to lack capacity. It was acknowledged that these data are potentially skewed by a small, non-representative, responder group. The Safeguarding team are working to understand and improve this and the Committee requested a further update in 6 months.
Items of achievement for escalation to the Board	
Items for shared learning	**Research & Innovation** The Committee discussed BAF Risk 7 (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) and the R&I section of the Integrated Performance Report in detail. The Committee interrogated the data reported for study recruitment, new studies opening and publications. The Research & Innovation Operations Innovation provided further narrative for the data including the wider strategic agenda around the operational work of the R&I team including National funding bids and early phase trial units running the first in human trials. **2021-2022 Annual Submission to NHS England North West: Appraisal**

The Clatterbridge Cancer Centre NHS Foundation Trust

	and Revalidation and Medical Governance The Committee approved the submission in advance of final sign off going to Trust Board on 28th September 2022.

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1 – 26th October 2022

Chairs report for: People Committee
Date/Time of meeting: 29th September 2022

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

Items of concern for escalation to the Board	**Assurance Report from Workforce Advisory Group** The Committee discussed the 2022 pay award and its impact to the pension scheme for on staff bands 3, 5 and particularly 8a. They noted the issue and the support the Trust has put in place.
Items of achievement for escalation to the Board	**Assurance Report from Education Governance Committee and Terms of Reference and Integrated Performance Report** The Committee noted progress made against ILS and Manual handling training compliance, with further improvements underway. **Staff Story** The Committee heard from a representative from the LGBTQ+ network and noted the great work the network had been doing; discussing issues for staff and patients, creating rainbow badge pledges, doing presentations to teams in the Trust, raising awareness of pronouns in signature, attending Pride celebrations in Liverpool and more.
Items for shared learning	**Workforce Race Equality Standard Annual Report 2022** The Committee approved the publication of the report subject to minor amendments from the workforce team. The Committee discussed the figure of 0 for cluster 4 (Bands 8c-9 &VSM) in 2022. The report is included for noting – with emphasis on the action plan for 2022/23. **Workforce Disability Equality Standard Annual Report 2022** The Committee approved the publication of the report. The report is included for noting – with emphasis on the action plan for 2022/23. **Staff Well-being and Engagement Update** The Committee noted the launch of the staff survey for 2022.

TERMS OF REFERENCE

The Clatterbridge Cancer Centre NHS Foundation Trust

People Committee

ToR Reference	(To be provided by DCM)
Version	V.2~~1~~
Name and designation of ToR author(s)	Zoe Hatch (Deputy Director of Workforce and OD)
Approved by (committee, group, manager)	Trust Board of Directors
Approval evidence received (minutes of meeting, electronic approval)	(To be completed by DCM)
Date approved	(To be completed by DCM)
Review date	March~~December~~ 2023
Review type (annual, three yearly)	6 months, then Annually
Target audience	~~(To be provided by author)~~People Committee, Trust Board
Links to other strategies, policies, procedures	Trust Strategy (2021-2026) Our People Commitment (2021-2026) Education Strategy (TBC)
Protective Marking Classification	Internal
This document replaces	

Circulation/Dissemination

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

Version History

Date	Version	Author name and designation	Summary of main changes
June 2022	1	Zoe Hatch, Deputy Director of Workforce	Committee formed and document created ~~To be completed by author~~
Sept 2022	2	Zoe Hatch, Deputy Director of Workforce	Comments received from June 2022 Trust Board and minor amendments made

TERMS OF REFERENCE

The Clatterbridge Cancer Centre NHS Foundation Trust

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

TERMS OF REFERENCE

The Clatterbridge Cancer Centre NHS Foundation Trust

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

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The Clatterbridge Cancer Centre NHS Foundation Trust

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

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

TERMS OF REFERENCE

The Clatterbridge Cancer Centre NHS Foundation Trust

Membership	• The Committee will carry out an annual review of its effectiveness and provide an annual report to the Audit Committee on its work in discharging its responsibilities, delivering its objectives and complying with its Terms of Reference. The review of effectiveness will specifically comment on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks The Committee will be appointed by the Board and will consist of: • 3 x Non-Executive Directors • Chief Nurse • Medical Director • Director of Workforce and OD • Chief Operating Officer • Chief Information Officer • The Chief Executive may attend any meeting as required A Non-Executive Director shall be appointed Chair of the Committee with a second Non-Executive appointed as Deputy Chair The following will be in attendance: • Deputy Director of Workforce and OD • Head of Learning and Organisational Development • Head of Workforce Transformation • 1x Workforce Business Partner • Director of Pharmacy • Associate Director of Education • Associate Director of Communications • Head of Equality, Diversity and Inclusion • Associate Director of Corporate Governance • Staff Side Chair Members are required to attend at least 75% of the meetings in any one financial year. The Committee may invite other persons to attend the meeting from time to time to assist in discussions and the Chair will be notified in advance of attendees.

TERMS OF REFERENCE

The Clatterbridge Cancer Centre NHS Foundation Trust

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

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Workforce Race Equality Standard (WRES)

Annual Report 2022

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NHS Foundation Trust

Foreword

The Workforce Race Equality Standard was introduced in April 2015. Its aim is to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

NHS provider organisations are expected to show progress against a nine key indicators of workforce equality. This report contains the Trust's performance against these indicators using data from the Electronic Staff Records (ESR) system and relevant results from the 2020 National Staff Survey.

The data from the WRES report is important, as research demonstrates that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The data enables us to better understand the experiences of our BME staff so that we can target support and implement positive change thereby creating a more inclusive environment.

At The Clatterbridge Cancer Centre we are committed to ensuring:

- We treat everyone fairly, with dignity and respect
- Opportunities are open to all
- We provide a supportive and welcoming environment for everyone
- We reflect these values in everything we do, from strategic plans to everyday activities.

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We are also committed to delivering the NHS People Promise to be open and inclusive, that we do not tolerate any form of discrimination, bullying or violence, and that we make the NHS a place where we all feel we belong.

Equality, diversity and inclusion is the golden thread that runs through everything we do. We are committed to investing in a diverse workforce that enables us to deliver a more inclusive and improved patient care to the diverse communities that we serve

9 Key Indicators

1	Percentage of BME staff
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
7	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues
9	BME board membership

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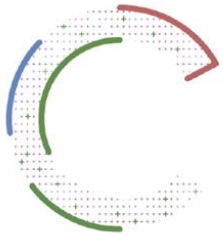

BE **OUTSTANDING**

Deliver safe, high-quality care and outstanding operational and financial performance

BE **COLLABORATIVE**

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

BE **A GREAT PLACE TO WORK**

Attract, develop and retain a highly-skilled, motivated and inclusive workforce to deliver the best care

Our strategic priorities

BE **RESEARCH LEADERS**

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

BE **DIGITAL**

Deliver digitally-transformed services, empowering patients and staff

BE **INNOVATIVE**

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

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We recognise that our people are our greatest asset. Their dedication, talent, knowledge and experience are at the heart of everything we do and have a big impact on the care that we provide.

In order to deliver our Five-Year Strategic Plan, we want to attract, retain and develop the brightest and best people locally, nationally and internationally, through our reputation for excellence in patient care, research and education, and our commitment to the health, wellbeing and experience of staff.

Our People Commitment outlines our plans for the next five years to build on our successes so far and to continue to build an inclusive and compassionate culture where all our staff can thrive.

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EQUALITY, DIVERSITY AND INCLUSION

Equality, Diversity and Inclusion is a golden thread that runs through everything that we do. We recognise the importance of ensuring our workforce is representative of our local population and celebrating diversity. Every one of us has a role to play in this.

Our Five-Year Strategic Plan outlines our commitment to creating an open, diverse and inclusive culture where everyone is treated with respect and dignity and our people are recognised and valued for the contributions they make.

We believe that by continuing to champion a culture of equality, diversity and inclusion, we will:

- **positively impact on the experience of our staff;**
- **nurture an environment where staff feel able to speak up and raise concerns; and**
- **ultimately improve the services we deliver to our patients.**

We are committed to promoting equality, diversity and inclusion and tackling all forms of discrimination and bullying to create an open and inclusive environment for all.

OUR VALUES

Our values were co-created by our people and form the foundation of our culture, our ethos and how we work every day. They define how we work to deliver the best care to our patients and how we make CCC the best place to work.

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The Clatterbridge Cancer Centre NHS Foundation Trust

Key Findings

Workforce Representation

As at 31 March 2022 6.8%% of staff were from a BME background, a slight increase from 6.0% in 2021.

There has been an increase of 1.5% of BME Staff in non-clinical roles but a 0.8% decrease across clinical roles

Shortlisting

White applicants were 1.31 times more likely to be appointed from shortlisting which is an increase from 1.06 last year

Capability

The likelihood of BME staff entering formal capability process has remained at 0 for 3 years.

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Key Findings

Training and CPD

2022 data shows that BME staff are as likely as white staff in accessing non-mandatory and CPD Training.

Harassment, bullying or abuse (from service users)

There has an increase in cases against BME staff from service users in 3 out of the 4 metrics. The trend is comparable to cases against Non-BME staff however the percentages are generally higher for BME staff.

Harassment, bullying or abuse (from staff)

Cases of bullying, harassment or abuse from staff have decreased from 20% to 16.3% and the comparable percentage for Non-BME staff is 16.8%

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WRES Metric 1- Workforce Representation

Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including executive board members) compared with the percentage of staff in the overall workforce.

1a) Non-clinical workforce (Data source: ESR)

	BME			Non-BME			Unknown/Null		
	2020	2021	2022	2020	2021	2022	2020	2021	2022
Cluster 1 (Bands 1 - 4)	8	9	17	277	291	311	6	2	3
Cluster 2 (Band 5 - 7)	3	3	3	131	124	158	5	2	4
Cluster 3 (Bands 8a - 8b)	2	3	4	40	37	43	1	1	1
Cluster 4 (Bands 8c – 9 & VSM)	1	3	0	21	23	18	0	0	0
Total	**14**	**16**	**24**	**469**	**475**	**530**	**12**	**5**	**8**

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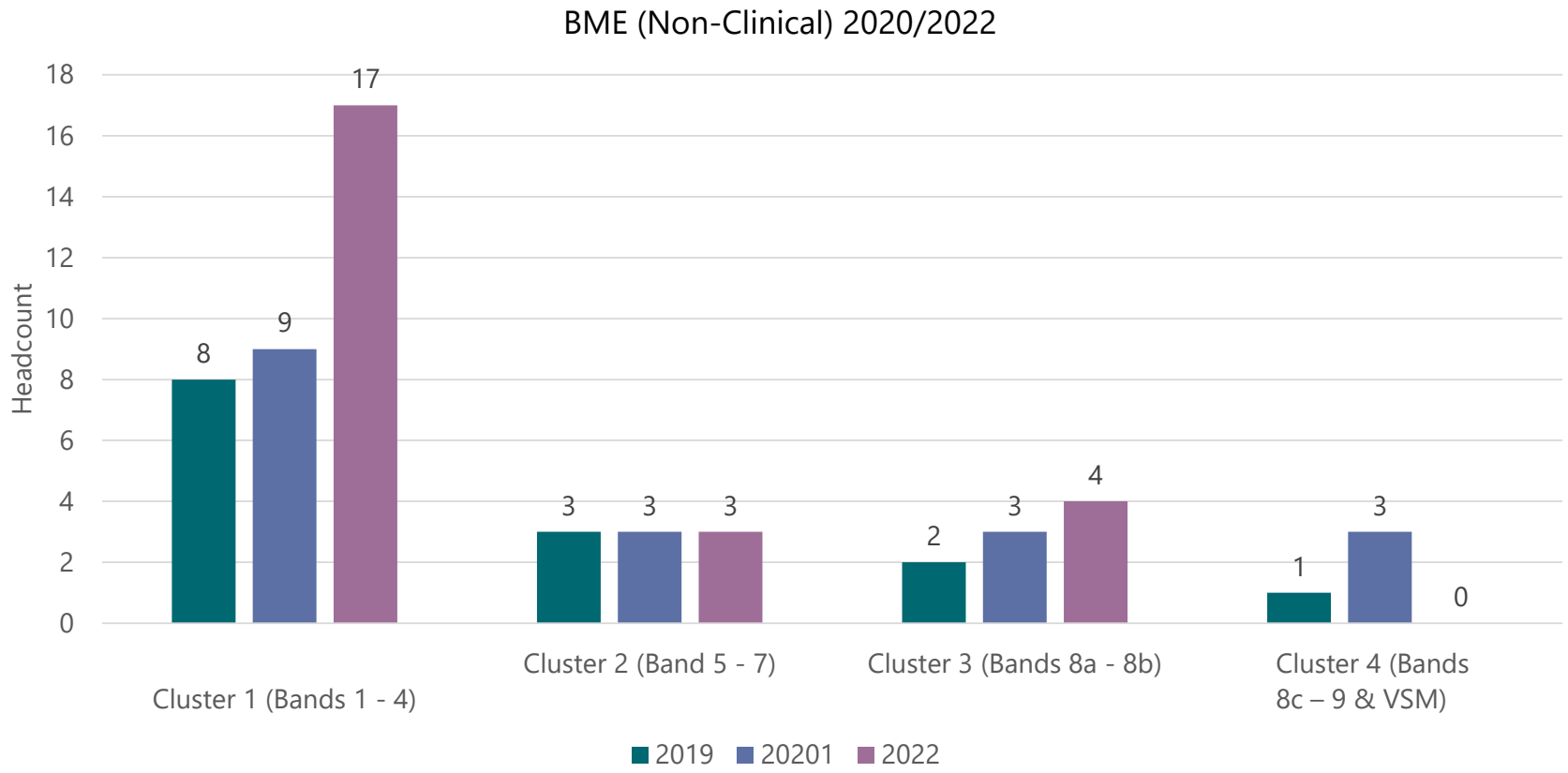

Breakdown of workforce by headcount per pay band

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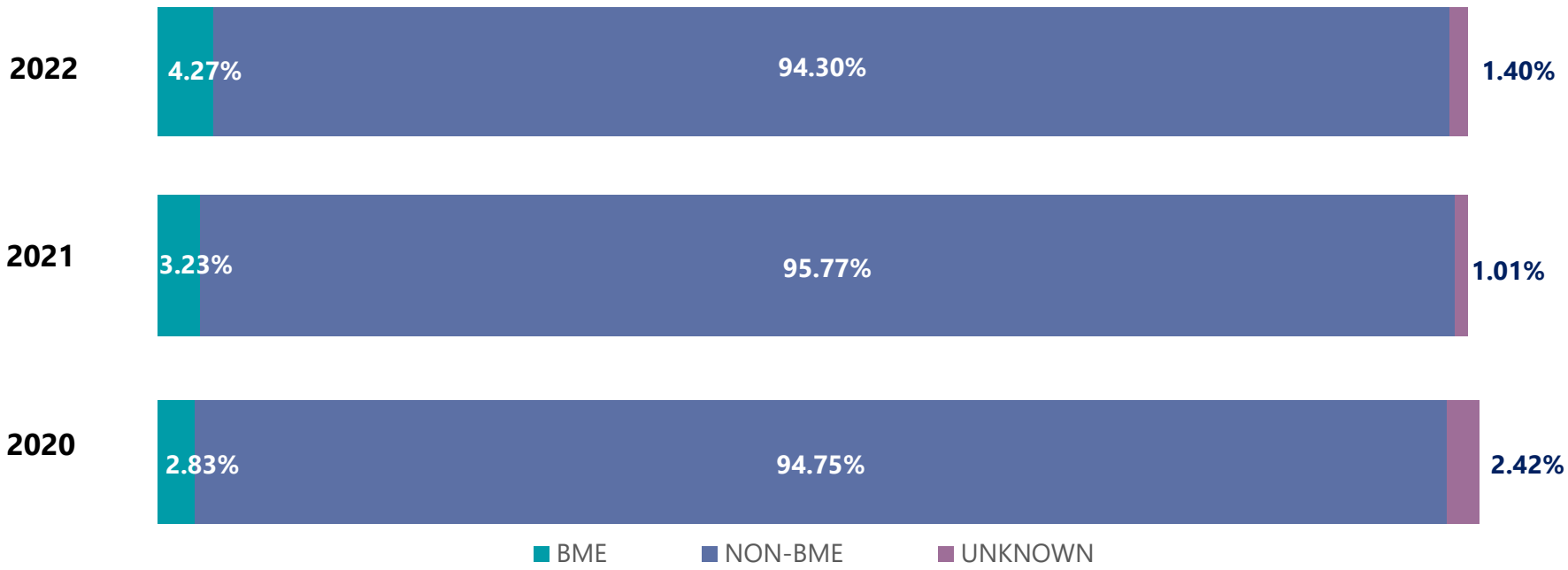

Breakdown of workforce by percentage of total workforce

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1b) Clinical workforce (Data source: ESR)

	BME			Non- BME			Unknown/Null		
	2020	2021	2022	2020	2021	2022	2020	in 2021	2022
Cluster 1 (Bands 1 - 4)	6	9	15	191	211	223	3	3	3
Cluster 2 (Band 5 - 7)	21	29	34	521	597	610	12	12	8
Cluster 3 (Bands 8a - 8b)	2	3	6	95	104	110	4	3	3
Cluster 4 (Bands 8c – 9 & VSM)	2	2	1	9	9	15	1	1	1
Cluster 5 (Medical and Dental staff, Consultants)	21	25	30	36	31	43	3	2	2
Cluster 6 (Medical and Dental staff, Non-consultant career grade)	4	7	6	4	4	10	0	1	0
Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades)	1	1	1	2	3	0	0	0	0
Total	**57**	**76**	**93**	**858**	**959**	**1011**	**23**	**22**	**17**

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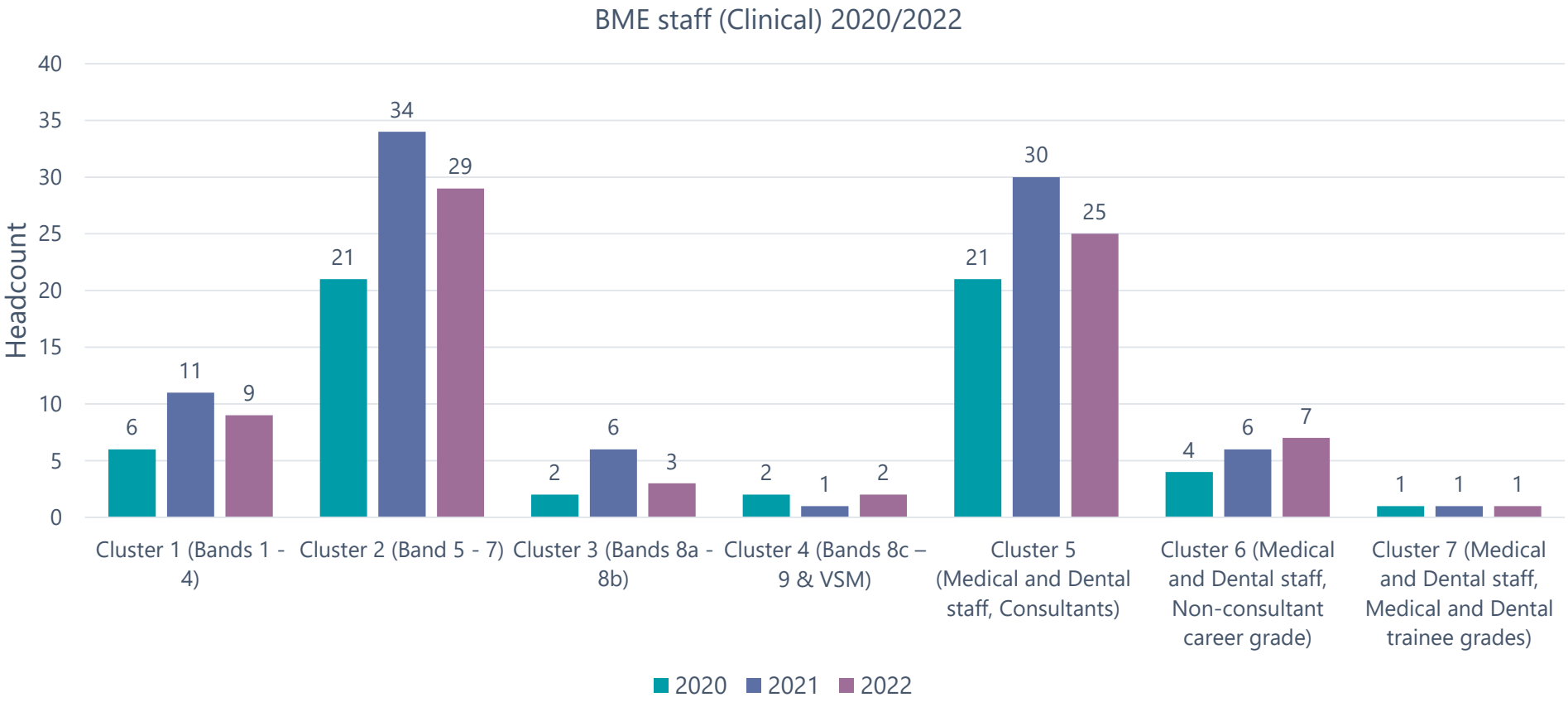

Breakdown of workforce by headcount per pay band

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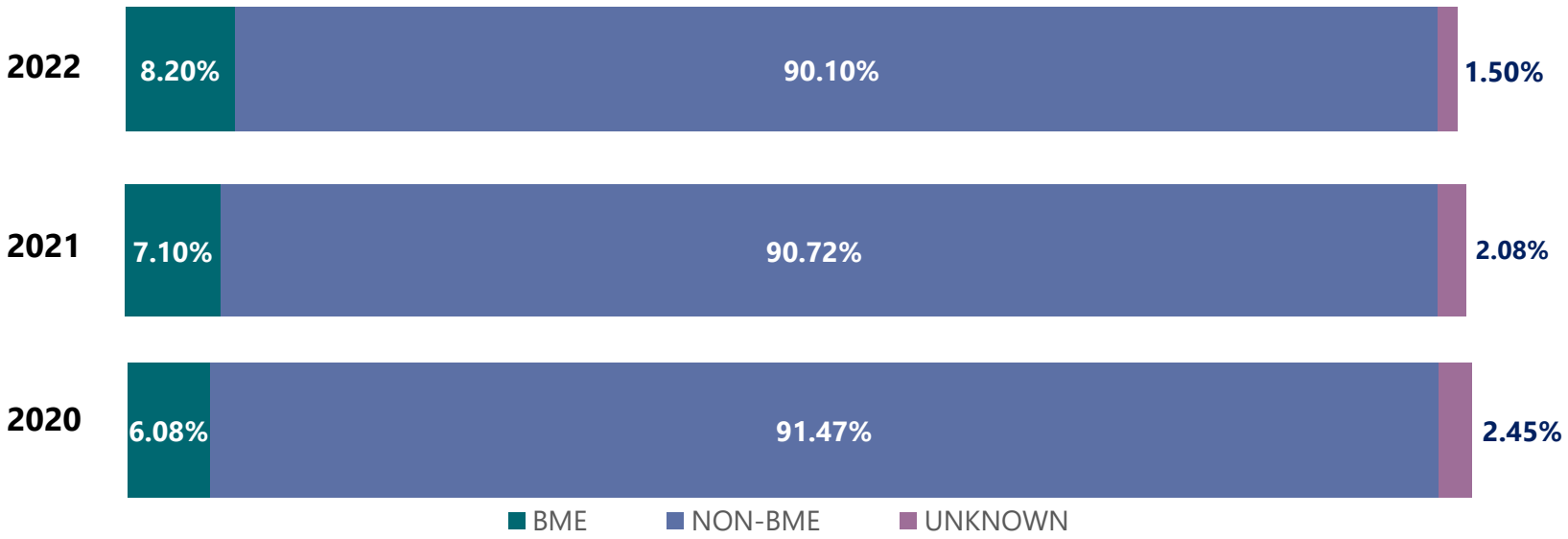

Breakdown of workforce by percentage of total workforce

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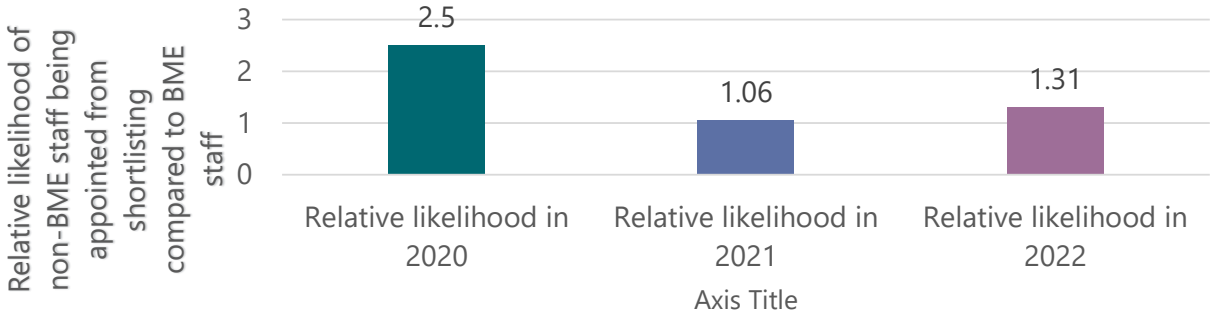
WRES Metric 2- Recruitment

This metric compares the data for BME and Non-BME applicants in regard to the relative likelihood of being appointed. The metric includes both internal and external recruitment

(Data source: Trust's Recruitment data)



i. A relative likelihood of 1 indicates that there is no difference

ii. A relative likelihood above 1 indicates that non- BME applicants are more likely to be appointed from shortlisting compared to BME applicants:

iii. A relative likelihood below 1 indicates that BME applicants are more likely to be appointed from shortlisting compared to non-BME applicants.

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WRES Metric 3- Capability

Relative likelihood of BME staff compared to non-BME staff entering the formal disciplinary process, as measured by entry into the formal disciplinary procedure.

(Data source: Trust's HR data)

	Relative likelihood in 2020	Relative likelihood in 2021	Relative likelihood in 2022
Relative likelihood of BME staff entering formal capability process compared to non-BME staff	0	0	0

Within the last three years we have not had any recorded BME staff that have entered a formal capability process.

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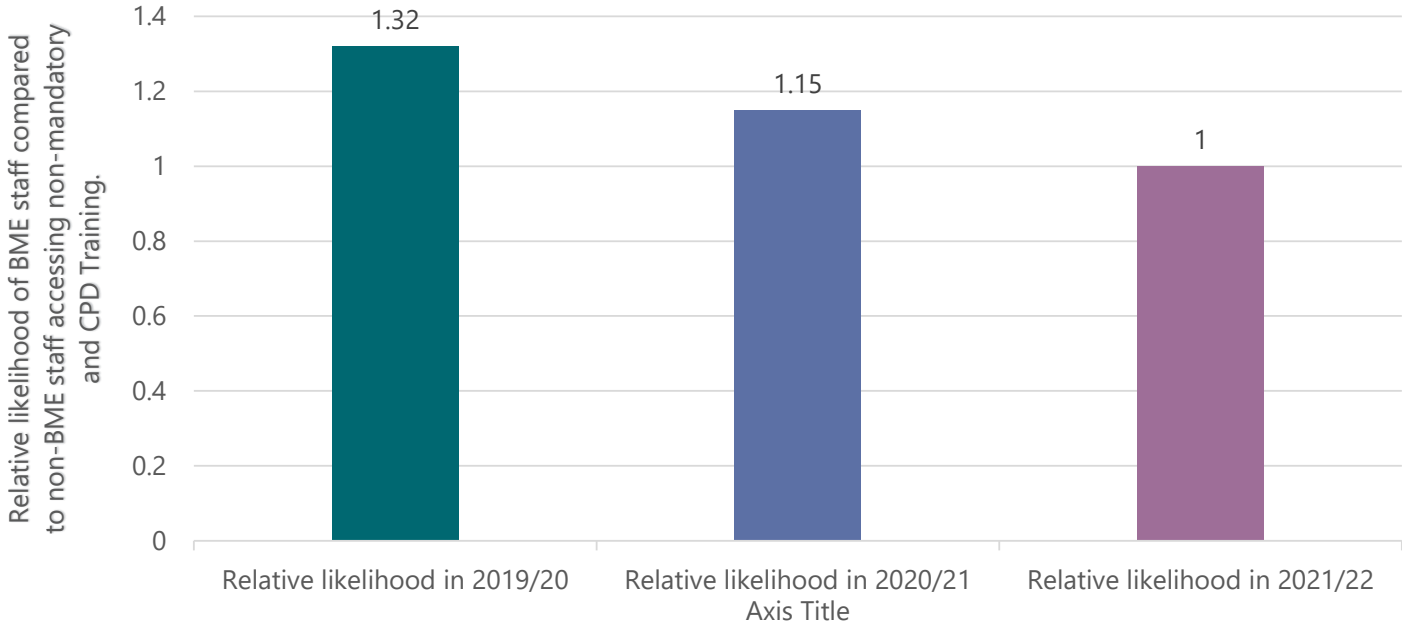
WRES Metric 4- Training and CPD

Relative likelihood of BME staff compared to non-BME staff accessing non-mandatory and CPD Training.

(Data source: Trust's HR data)



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WRES Metric 5-8- Harassment, bullying or abuse

Percentage of BME staff compared to non-BME staff experiencing harassment, bullying or abuse

(Data source: Question 13, NHS Staff Survey)

This metric is split into four parts:

1. Harassment, bullying or abuse from patients, service users or the public
2. Harassment, bullying or abuse from a line manager.
3. Harassment, bullying or abuse from other colleagues.
4. Percentage of staff who reported harassment, bullying or abuse the latest time it happened.

	Non-BME			BME		
	2019 NHS Staff Survey	2020 NHS Staff Survey	2021 NHS Staff Survey	2019 NHS Staff Survey	2020 NHS Staff Survey	2021 NHS Staff Survey
5. Staff experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months	14.10%	10.50%	13.10%	21.10%	12.50%	20.40%

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6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months	23.50%	15.40%	16.80%	18.40%	20.00%	16.30%
7. Staff believing that the organisation provides equal opportunities for career progression or promotion	57.30%	61.80%	61.40%	54.10%	45.00%	53.10%
8.Percentage of staff experiencing discrimination at work from managers / team leader or other colleagues in last 12 months	5.50%	4.00%	5.10%	5.60%	5.40%	12.20%

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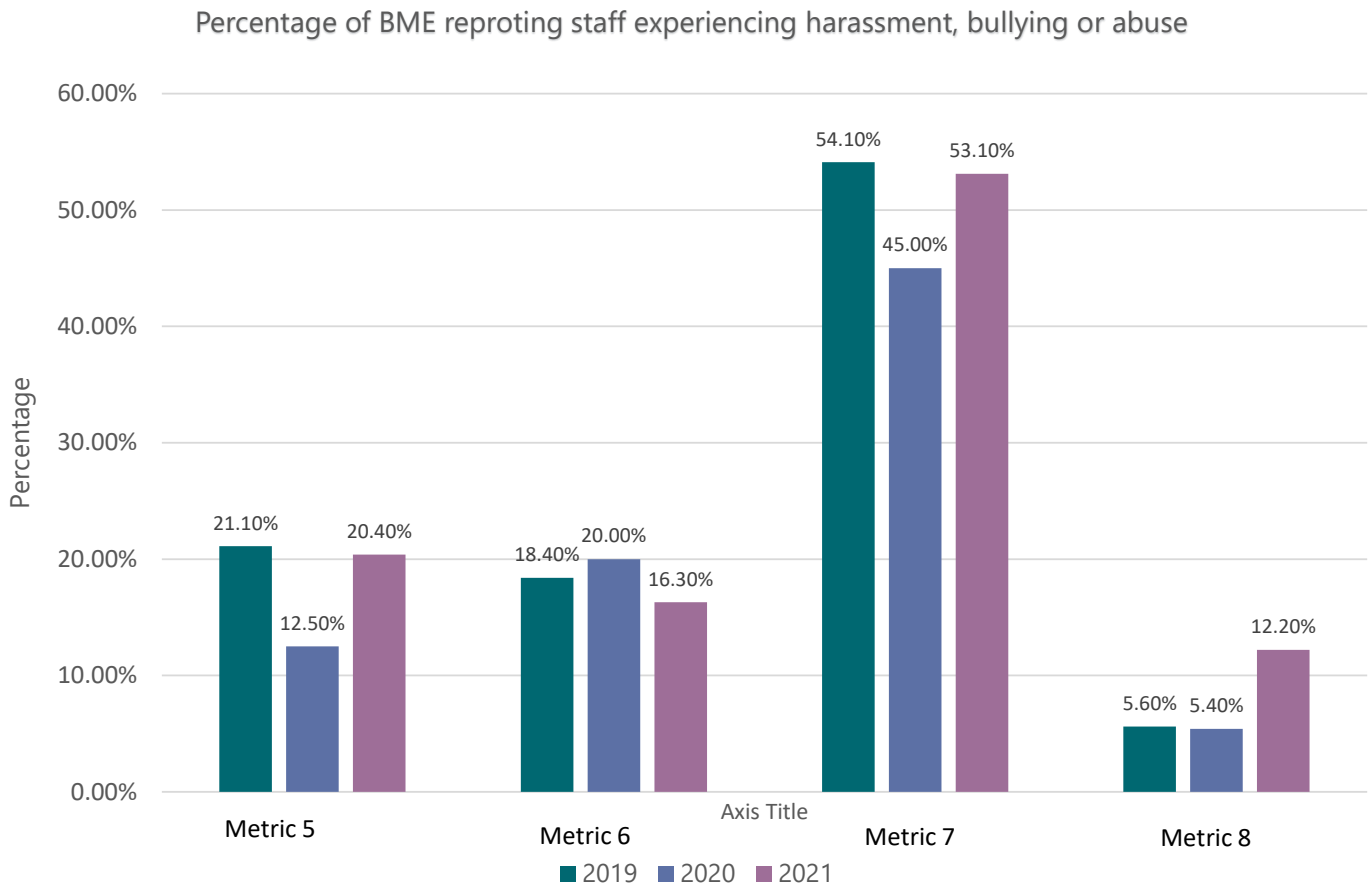

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WRES progress in 2021/22

During 2021/22 we have developed and implemented a number of initiatives to support and improve the experience of BME collegeues working at Clatterbridge Cancer Centre.

- Development of a shared EDI service with another specialist Trust, to share learning, best practise and enable collaboration
- The Ethnic Diversity Staff Network is in its second year, the Chair and Co-Chair have been active in supporting staff and improving engagement.
- The Chair of the Staff Network presented a proposal to the Trust's Executive Group regarding a CCC approach for a reverse mentoring scheme, this has now been approved and members of the senior leadership team will take part in the first cohort with relevant training planned.
- A proposal for key members of the Staff Network to have protected time to undertake work for the Networks is currently being drafted with the aim of this becoming live in 2023.
- A CCC Staff Network Group Arts Project has been set up to ensure that the artwork and arts activity at CCC represents the community it serves and to improve the health and wellbeing of staff, visitors and people undergoing cancer treatment at CCC using the arts. The Staff Network are currently sourcing artists from different ethnical backgrounds who will be involved in future arts activity.
- Micro aggression training has taken place in 2021/2022, this was rolled out by the University of Liverpool in conjunction with the Anthony Walker Foundation.

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- The Trust launched its first cohort of nurse international recruitment in 2021 in partnership with the system wide programme facilitated by Health Education England. The Trust is now in the process of welcoming its third cohort.
- In 2022 the Trust launched its new Trust Mission Statement and Values following a comprehensive staff engagement programme and subsequently a Civility & Respect Training programme has been rolled out.

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WRES Action Plan 2022/23

Objective	Action/s	Timescales	Lead/s
Increase representation of BME staff across all pay bands	• Build collaborative relationships with communities and professional organisations to help support attraction, recruitment & retention. • Support the Staff Network to have protected time to undertake initiatives	Mar 2023 Nov 2023	Recruitment Team EDI Lead Staff Networks
Ensure recruitment process is free from prejudices and bias	• Develop and embed a revised approach to recruitment a retention in line with NHSIE '6 Actions' • Develop a CCC plan for having an EDI representative on selective interview panels.	Mar 2023 Mar 2023	Recruitment Team EDI Lead
Ensure BME staff are able to progress within careers	• Update online performance appraisal system to capture ethnicity data in order to target appropriate staff for talent management opportunities		HR Business Partnering Team EDI Lead

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	• Promote and give priority to female BME staff on the Springboard Leadership Programme which is a critically acclaimed work and personal development programme for women. • Support the development and progression of disabled staff through education and leadership development opportunities		
Ensure all BME staff feel safe, supported and protected within the workplace	• Raise awareness for reporting and support mechanisms to ensure colleagues have confidence to speak up safely about issues regarding racism, behaviours, & prejudice • Relaunch FTSU Champions • Display positive messaging around the trust with regards anti discriminatory behaviour • Continue to embed new Trust Values	Jan 2023 Jan 2023 Dec 2022 Mar 2023	EDI Lead FTSU Guardian

The Clatterbridge Cancer Centre NHS Foundation Trust

Increase awareness amongst Senior Managers within the Trust regarding challenges faced by BME staff	Launch reverse mentoring programme	Jan 2023	EDI Lead Staff Network

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Workforce Disability Equality Standard (WDES)

Annual Report 2022

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The Clatterbridge Cancer Centre NHS Foundation Trust

Foreword

This Workforce Disability Equality Standard (WDES) annual report is our fourth since the national launch of the WDES in 2019 which aims to improve the workplace and career experiences of disabled colleagues in the NHS.

The WDES is a set of ten specific measures which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff using information drawn from the national electronic staff record (ESR) and the national staff survey results. We use the metrics to inform our workforce strategy and demonstrate progress.

The data from the WDES report is important as research shows us that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The data enables us to better understand the experiences of our disabled staff so that we can target support and implement positive change thereby creating a more inclusive environment.

At The Clatterbridge Cancer Centre we are committed to ensuring:

- We treat everyone fairly, with dignity and respect
- Opportunities are open to all
- We provide a supportive and welcoming environment for everyone
- We reflect these values in everything we do, from strategic plans to everyday activities.

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We are also committed to delivering the NHS People Promise to be open and inclusive, that we do not tolerate any form of discrimination, bullying or violence, and that we make the NHS a place where we all feel we belong.

Equality, diversity and inclusion is the golden thread that runs through everything we do. We are committed to investing in a diverse workforce that enables us to deliver a more inclusive and improved patient care to the diverse communities that we serve

Key Indicators

Table 1: WDES metrics based on ESR and HR/Recruitment databases

Metric	Description
1	Percentage of Disabled staff.
2	Relative likelihood of non-disabled staff applicants being appointed from shortlisting across all posts compared to Disabled staff.
3	Relative likelihood of Disabled staff entering the formal capability process (performance management rather than ill health) compared to non-disabled staff.
9b	Percentage of trusts that facilitate the voices of Disabled staff to be heard within the organisation.
10	Percentage of Disabled staff on Boards.

Table 2: WDES metrics based on NHS Staff Survey data

Metric	Description
4	Percentage of staff experiencing harassment, bullying or abuse in the last 12 months
5	Percentage of staff believing that trust provides equal opportunities for career progression or promotion
6	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7	Percentage of staff saying that they are satisfied with the extent to which their organisation values their work
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work
9a	Staff engagement score (a composite of nine questions)

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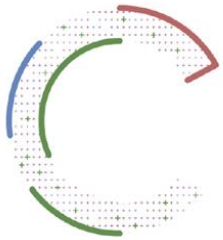

BE **OUTSTANDING**

Deliver safe, high-quality care and outstanding operational and financial performance

BE **COLLABORATIVE**

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

BE **A GREAT PLACE TO WORK**

Attract, develop and retain a highly-skilled, motivated and inclusive workforce to deliver the best care

Our strategic priorities

BE **RESEARCH LEADERS**

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

BE **DIGITAL**

Deliver digitally-transformed services, empowering patients and staff

BE **INNOVATIVE**

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

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OUR PEOPLE COMMITMENT 2021 2026

We recognise that our people are our greatest asset. Their dedication, talent, knowledge and experience are at the heart of everything we do and have a big impact on the care that we provide.

In order to deliver our Five-Year Strategic Plan, we want to attract, retain and develop the brightest and best people locally, nationally and internationally, through our reputation for excellence in patient care, research and education, and our commitment to the health, wellbeing and experience of staff.

Our People Commitment outlines our plans for the next five years to build on our successes so far and to continue to build an inclusive and compassionate culture where all our staff can thrive.

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EQUALITY, DIVERSITY AND INCLUSION

Equality, Diversity and Inclusion is a golden thread that runs through everything that we do. We recognise the importance of ensuring our workforce is representative of our local population and celebrating diversity. Every one of us has a role to play in this.

Our Five-Year Strategic Plan outlines our commitment to creating an open, diverse and inclusive culture where everyone is treated with respect and dignity and our people are recognised and valued for the contributions they make.

We believe that by continuing to champion a culture of equality, diversity and inclusion, we will:

- **positively impact on the experience of our staff;**
- **nurture an environment where staff feel able to speak up and raise concerns; and**
- **ultimately improve the services we deliver to our patients.**

We are committed to promoting equality, diversity and inclusion and tackling all forms of discrimination and bullying to create an open and inclusive environment for all.

OUR VALUES

Our values were co-created by our people and form the foundation of our culture, our ethos and how we work every day. They define how we work to deliver the best care to our patients and how we make CCC the best place to work.

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Key Findings

Workforce Representation

Increase of 1.7% of non-clinical staff declaring a disability and 0.6% for clinical staff (across Bands 1-9.)

Workforce information

The percentage of unknown/not specified percentage has fallen for the second year in the row from 7.24% in 2021 to 6.6% in 2022 for clinical staff.

Harassment, bullying or abuse

There has been an increase in disabled staff reporting experiencing abuse from patients, service users, relatives or patients by 2.2% and an equivalent increase of abuse from colleagues

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Key Findings

Health and Wellbeing

There has been an improvement of 5.2% in disabled staff not feeling pressure to come in to work when unwell (Metric 6)

Reasonable Adjustments

A consistent 71% of disabled colleagues said that the Trust has made adequate adjustment(s) to enable them to carry out their work.

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WDES Metric 1- Workforce Representation

Percentage of Disabled staff in each of the Agenda for Change (AfC) bands 1– 9, VSM (including executive board members), medical/dental and other staff, compared with the percentage of non-disabled staff in these categories

1a) Non-clinical workforce (Data source: ESR)

	Disabled			Non-Disabled			Unknown/ Null		
	2020	2021	2022	2020	2021	2022	2020	2021	2022
Cluster 1 (under Band 1, Bands 1-4	2.40%	3.00%	3.70%	92.80%	92.40%	91.40%	4.80%	4.60%	4.90%
Cluster 2 (Bands5-7)	4.30%	4.80%	6.10%	84.90%	85.00%	85.50%	10.80%	10.20%	8.50%
Cluster 3 (Bands 8a-8b)	2.30%	2.10%	2.10%	88.40%	91.70%	93.80%	9.30%	6.30%	4.20%
Cluster 4 (Bands 8c-9 & VSM)	0.00%	3.80%	0.00%	100.00%	96.20%	100.00%	0.00%	0.00%	0.00%

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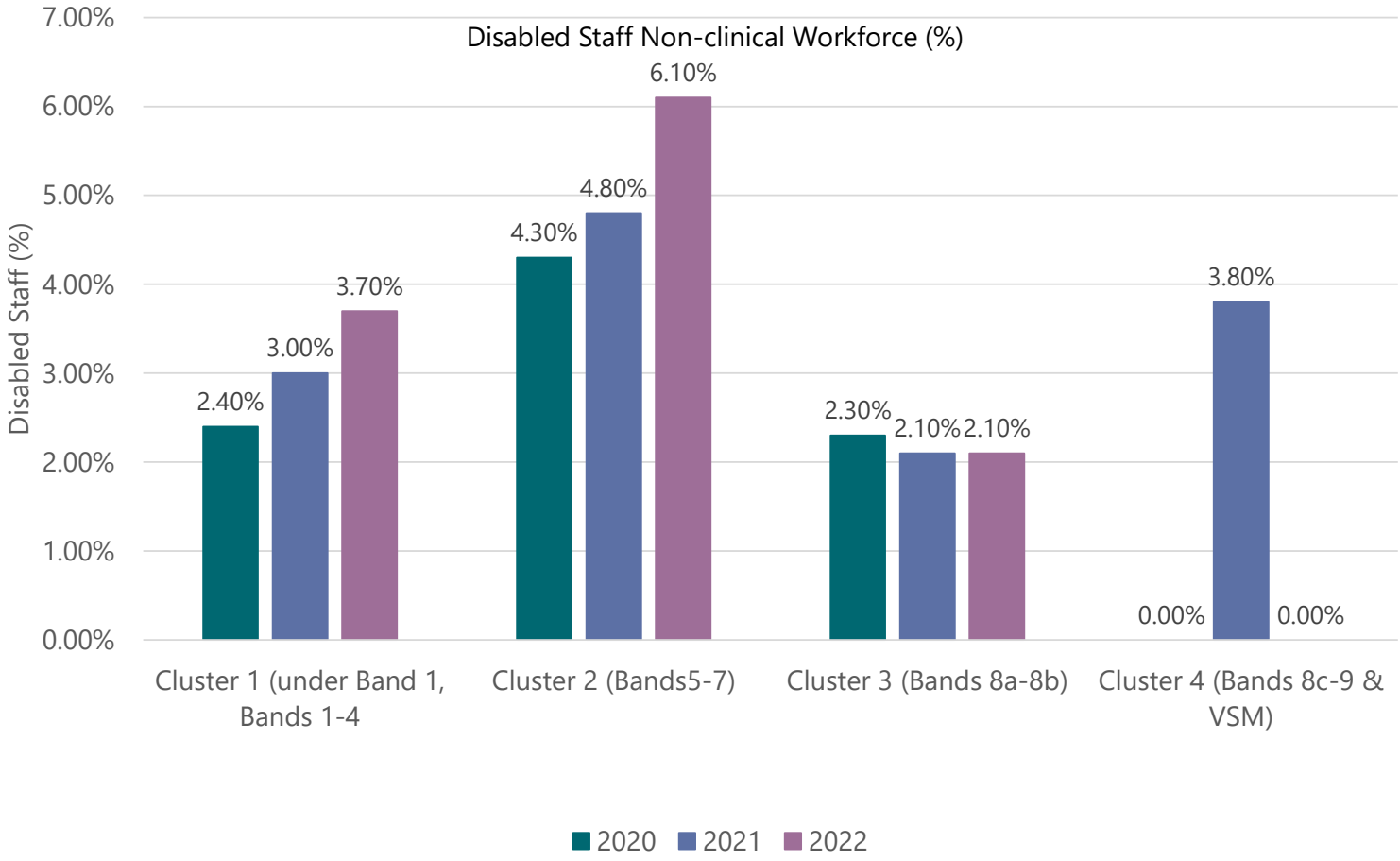

Breakdown of workforce by percentage of total workforce

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1b) Clinical workforce (Data source: ESR)

	Disabled			Non-Disabled			Unknown		
	2020	2021	2022	2020	2021	2022	2020	2021	2022
Cluster 1 (Bands 1 - 4)	2.00%	2.70%	3.30%	94.00%	93.70%	92.90%	4.00%	3.60%	3.70%
Cluster 2 (Band 5 - 7)	3.79%	4.00%	4.40%	87.73%	88.90%	89.40%	8.48%	7.10%	6.10%
Cluster 3 (Bands 8a - 8b)	0.00%	0.00%	1.70%	85.15%	83.50%	83.30%	14.85%	16.50%	15.00%
Cluster 4 (Bands 8c – 9 & VSM)	0.00%	0.00%	0.00%	75.00%	84.60%	87.50%	25.00%	15.40%	12.50%
Cluster 5 (Medical and Dental staff, Consultants)	0.00%	0.00%	0.00%	78.33%	85.48%	86.67%	21.67%	14.52%	13.33%
Cluster 6 (Medical and Dental staff, Non-consultant career grade)	0.00%	0.00%	0.00%	87.50%	91.67%	93.75%	12.50%	8.33%	6.25%
Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades)	0.00%	0.00%	0.00%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%

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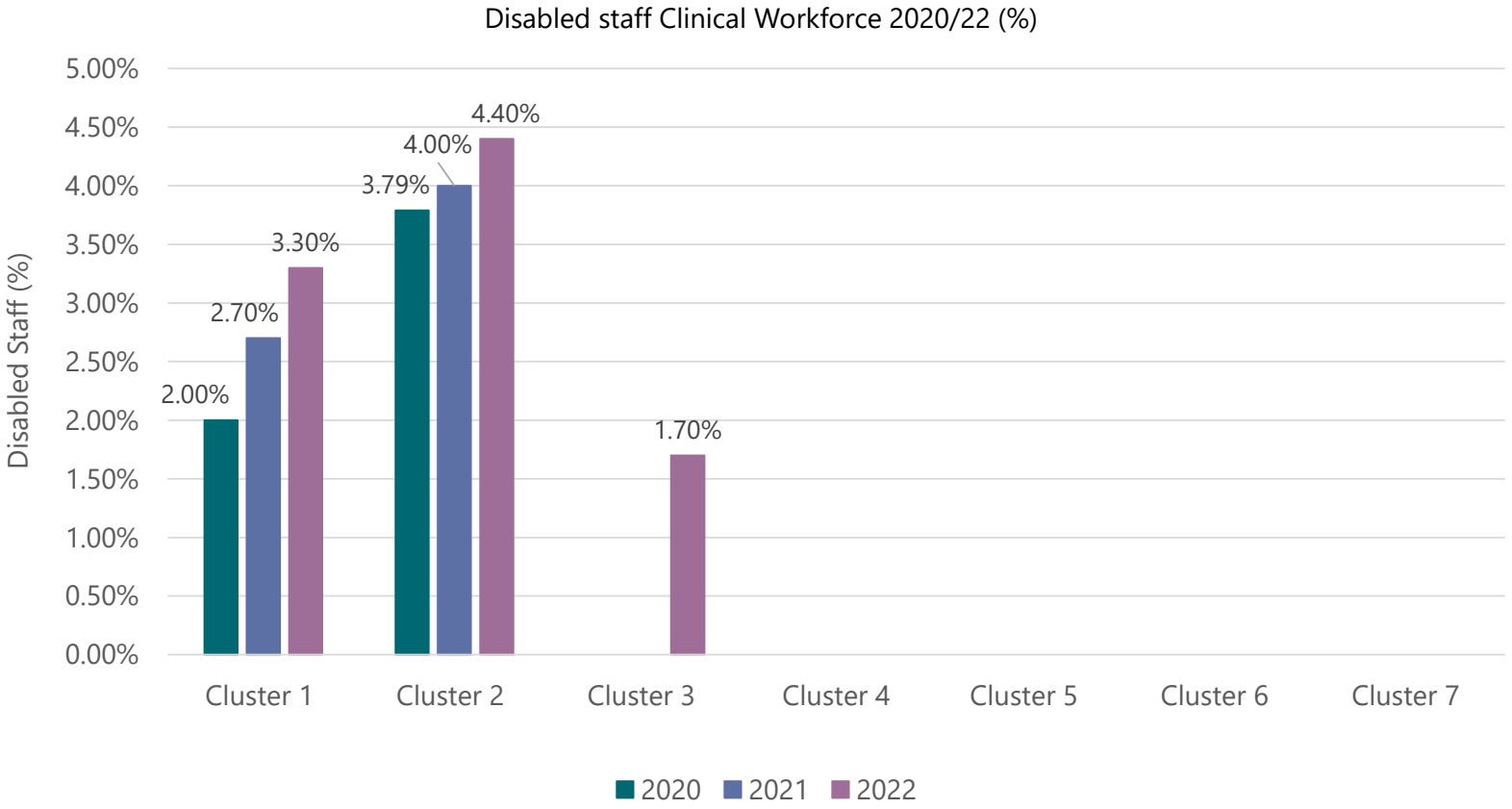

Breakdown of workforce by percentage of total workforce

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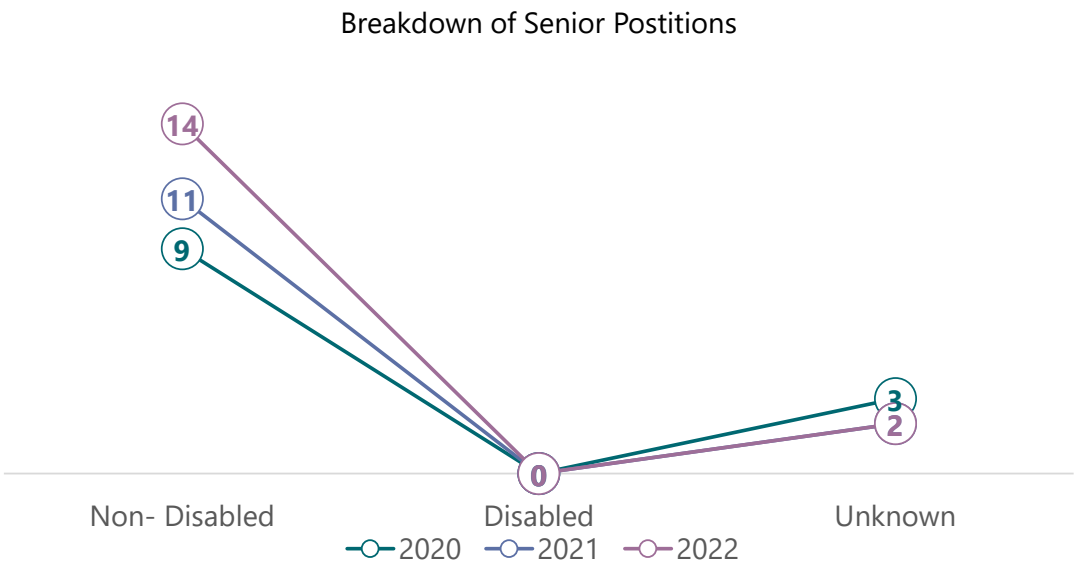
1c) Number of staff in senior positions (Clinical and Non-clinical roles at Band 8C and above) (Data source: ESR)

	Non- Disabled	Disabled	Unknown
2020	9	0	3
2021	11	0	2
2022	14	0	2



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WDES Metric 2- Recruitment

This metric compares the data for non-disabled and disabled staff in regard to the relative likelihood of being appointed. The metric includes both internal and external recruitment

(Data source: Trust's Recruitment data)

	Relative Likelihood
2020	2.14
2021	0.86
2022	1.51

i. A relative likelihood of 1 indicates that there is no difference: i.e. non-disabled applicants are equally as likely of being appointed from shortlisting as Disabled applicants.

ii. A relative likelihood above 1 indicates that non-disabled applicants are more likely to be appointed from shortlisting compared to Disabled applicants: e.g. a likelihood ratio of 2 indicates non-disabled applicants are twice as likely to be appointed from shortlisting compared to Disabled applicants.

iii. A relative likelihood below 1 indicates that non-disabled applicants are less likely to be appointed from shortlisting compared to Disabled applicants: e.g. a likelihood ratio of 0.5 indicates non-disabled applicants are half (0.5 times) as likely to be appointed from shortlisting as Disabled applicants.

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WDES Metric 3- Capability

Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process.

(Data source: Trust's HR data)

	Relative Likelihood
2020	0
2021	0
2022	0

Within the last three years we have not had any recorded disabled staff that have entered a formal capability process

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WDES Metric 4- Harassment, bullying or abuse

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months.

(Data source: Question 13, NHS Staff Survey)

This metric is split into four parts:

1. Harassment, bullying or abuse from patients, service users or the public
2. Harassment, bullying or abuse from a line manager.
3. Harassment, bullying or abuse from other colleagues.
4. Percentage of staff who reported harassment, bullying or abuse the latest time it happened.

	Disabled staff			Non-disabled staff		
	2019 NHS Staff Survey	2020 NHS Staff Survey	2021 NHS Staff Survey	2019 NHS Staff Survey	2020 NHS Staff Survey	2021 NHS Staff Survey
Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months	15.2%	14.3%	16.5%	14.4%	9.7%	13.0%

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Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months	17.4%	17.9%	16.7%	9.8%	5.4%	6.8%
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	27.4%	22.5%	24.7%	15.7%	9.8%	9.4%
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	45.6%	45.8%	42.6%	40.7%	48.2%	39.7%

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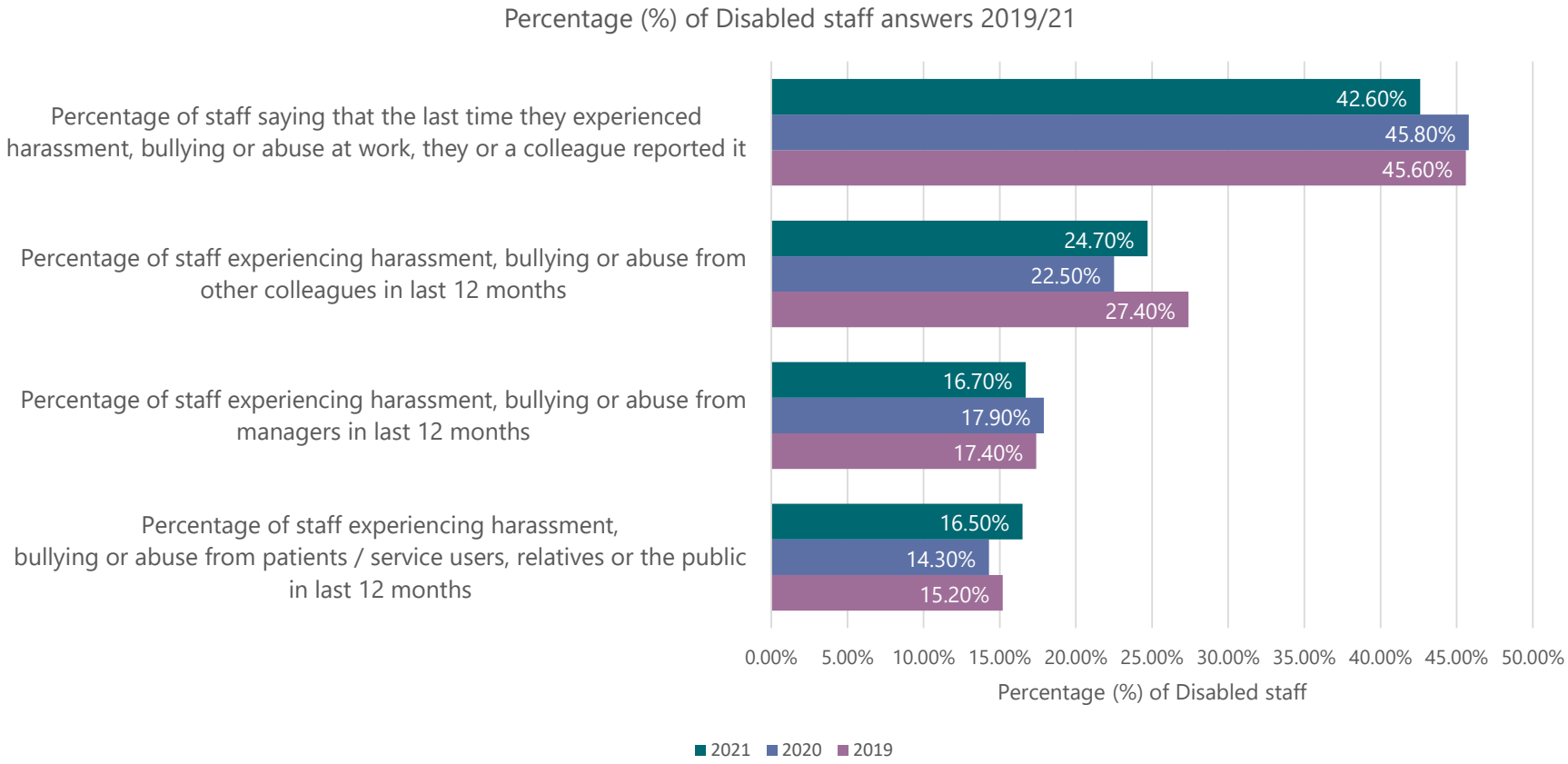

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WDES Metric 5-8- Support and Development

(Data source: Questions 14, 11, 5, 28b, NHS Staff Survey)

This metric is split into four parts:

5. Percentage of staff believing Trust provides equal opportunities for career progression or promotion
6. Percentage of staff feeling pressure from their manager to come to work, despite not feeling well enough to perform their duties
7. Percentage of staff satisfied with the extent to which their organisation values their work
8. Percentage of staff who believe Trust made adequate adjustment(s) to enable them to carry out their work.

	Disabled staff			Non-disabled staff		
	2019 NHS Staff Survey	2020 NHS Staff Survey	2021 NHS Staff Survey	2019 NHS Staff Survey	2020 NHS Staff Survey	2021 NHS Staff Survey
5. Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.	47.40%	54.70%	54.50%	59.30%	62.10%	62.40%

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6. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	39.30%	29.90%	25.80%	22.50%	19.80%	20.60%
7. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	38.80%	45.00%	43.00%	47.50%	55.20%	48.60%
8. Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	72.10%	71.60%	71.40%	N/A	N/A	N/A

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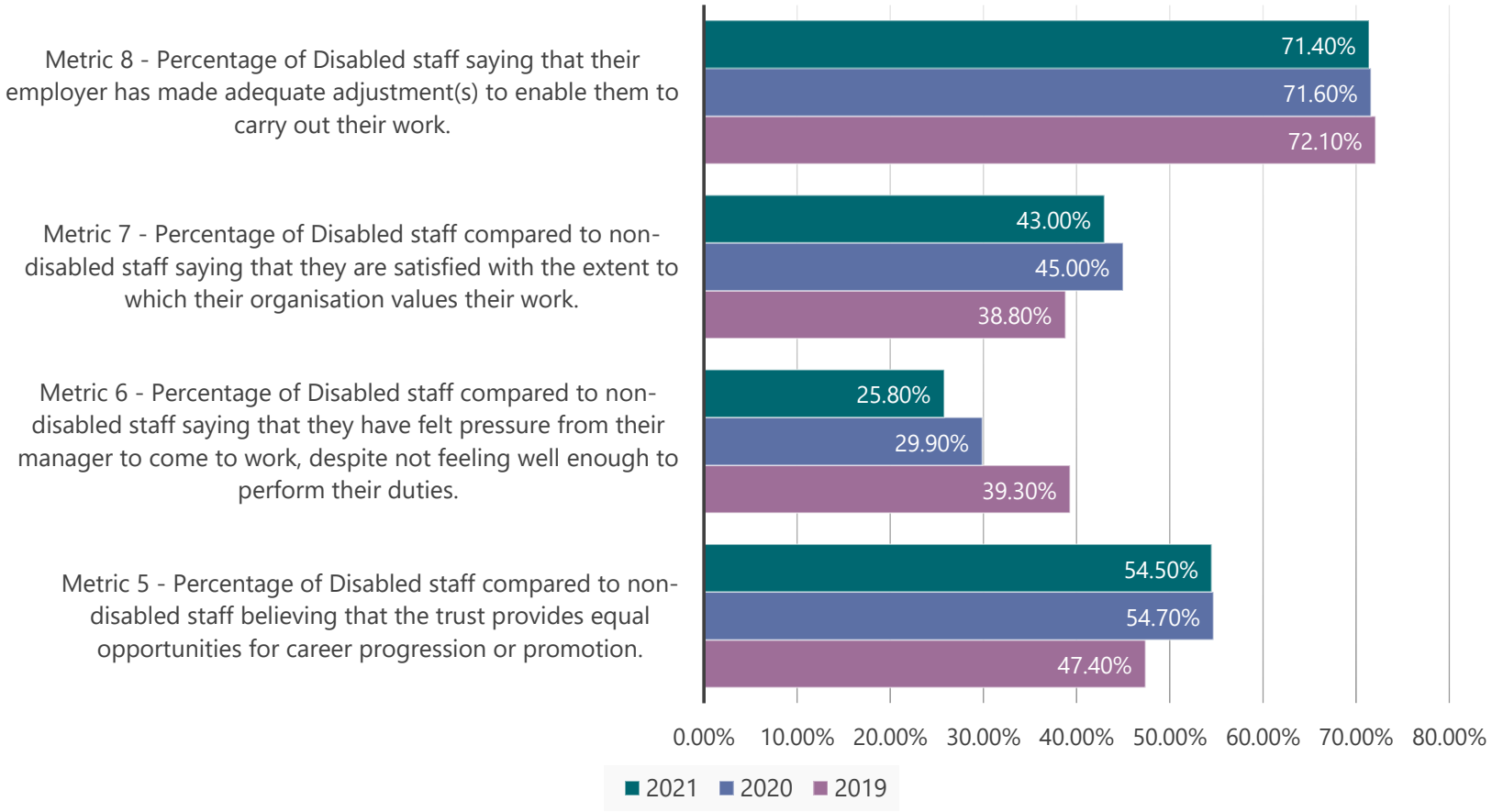
Percentage (%) of Disabled staff answers 2019/21



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WDES Metric 9- Staff Engagement

a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.
b) Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

The NHS Staff Survey has enabled disabled staff to feedback on what they think the Trust is doing well and areas of improvement. The Trust has also established a Disability and Long Term Health Conditions Staff Network which allows staff to have a voice and discuss shared experiences at CCC.

	Disabled staff			Non-disabled staff		
	2019 NHS Staff Survey	2020 NHS Staff Survey	2021 NHS Staff Survey	2019 NHS Staff Survey	2020 NHS Staff Survey	2021 NHS Staff Survey
Overall staff engagement score for Disabled staff, compared to non-disabled staff.	6.7	7	7	7.3	7.5	7.2

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WDES Metric 10- Board Representation

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- By voting and non-voting membership of the Board
- By Executive and Non-Executive membership of the Board
- Total Board membership

(Data source: NHS ESR and/or trust's local data)

	Voting	Non-Voting	Exec	Non-Exec	Totals
Disabled	7.69%	0.00%	0.00%	14.29%	6.67%
Non-disabled	92.31%	100.00%	100.00%	85.71%	93.33%
Unknown	0.00%	0.00%	0.00%	0.00%	0.00%

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WDES progress in 2021/22

A number of initiatives and work has been undertaken by the Trust over the last year which was captured in the WDES action plan for 2021/2022. A summary of these are as follows:

- The Trust has launched its Disability and Long Term Health Conditions Staff Network which is made up of staff members from different backgrounds and experiences. The group has started to raise awareness of various disabilities across the Trust and are have helped to improve our self-declarations in the Electronic Staff Records system.
- The Trust continued the work in line with the Disability Confident Level 2 status which was achieved in 2021.
- Recruitment training has been delivered to managers to ensure that anyone involved in recruitment is fully aware of their responsibilities under the Equality Act.
- The attendance management training programme for managers was reviewed and now includes a section in relation to disability to ensure disabled staff do not feel under pressure to attend work when unwell. The hybrid working training which commenced in 2021 includes the topic of presentism.
- The Trust has continued to promote the NHS Employers Health Passport and line manager guidance through monthly HR surgeries, New Starter Welcome Pack and access on the Staff Wellbeing Hub
- The Reasonable Adjustment Procedure introduced in 2021 continues to be embedded and is used to facilitate staff in returning and maintaining themselves in work
- Managers and HR continue to signpost staff to the Access to Work scheme for additional support when appropriate

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WDES Action Plan 2022/23

Objective	Action/s	Timescales	Lead/s
Ensure staff update their ESR records and declare disabilities	• Raise awareness of the importance of self-recording disability with particular focus on Bands 8 and above and medical workforce.	September 2022	Workforce Information Lead EDI lead Staff network group
Reduce inequality in recruitment process and community engagement	• Continue to ensure recruiting managers receive recruitment training • Undertake review of recruitment process to identify any improvements. • Work with local communities and networks to promote opportunities Disability/ Long Term Health Condition groups to encourage more diverse applicants to apply • Support the development and progression of disabled staff through education opportunities	2022-23 March 2023 December 2022	Recruitment Manager EDI Lead and Recruitment Manager EDI Lead Recruitment Team Staff Network
Reduce the number of disabled staff experiencing bullying, harassment and abuse.	• Raise awareness for reporting and support mechanisms to ensure colleagues have confidence to speak up safely about issues. • Relaunch "Freedom to Speak Up Champions"	January 2023 March 2023	EDI Lead FTSU Guardian Staff Network

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	• Display positive messaging around the trust with regards anti discriminatory behaviour • Continue to embed new Trust Values	December 2022	
Ensure staff feel supported in work	• Review training to ensure managers are trained to be able to provide appropriate support to staff through use of Trust policies. Processes and support mechanisms.	November 2022	HRBP Team Staff network
Improve staff engagement for disabled staff	• Continue to work closely with Disability and Long Term Health Conditions Staff Network to discuss ideas and make improvements for the Trust. • Introduce staff profiles and communications campaign supporting disabilities raising the awareness to staff • Continue to encourage disabled colleagues to participate and provide feedback in the NHS Staff Survey and the quarterly Staff Culture and Engagement Survey	2022-23 April 2023 January 2023	EDI Lead/ HR Business Partnering Team EDI Lead WOD Staff Network

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Trust Board Part 1 – 26th October 2022

Chair's report for: Audit Committee

Date/Time of meeting: 13 October 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 Committee reviewed BAF entry BAF 14 Cyber Security and considered a proposal to reduce the residual risk score. The Committee noted work carried out to implement effective mitigating actions to address a number of gaps in control and approved a reduction in the residual risk score from 16 to 12.
	• The Committee received a positive Internal Audit Progress Report and noted that recent Internal Audit reviews had resulted in outcomes as follows:
	  ○ Staff Appraisal / Mandatory Training – Substantial Assurance
	  ○ Cancer Waiting Times – Substantial Assurance
	• The Committee also received a report from Internal Audit which detailed outcomes of their Follow-Up on implementation of Audit recommendations and noted that good progress was being made with implementation. It was also noted that the Trust's management of the audit tracker will be enhanced through implementation of a Teammate+ system and work on a pilot exercise of this system will commence imminently. While good progress was noted, the Committee requested that future reports include details of the context and reasons where timescales for implementation of audit recommendations are revised.
	• The Committee considered a proposal from Health Procurement Liverpool (HPL) for the adoption of a revised standardised tender waiver across the Consortium's participating Trusts. The Committee noted the benefits of a standardised process and endorsed plans to jointly review relevant financial thresholds post-implementation of the standardised process. The Committee approved the Trust's adoption of the proposed HPL tender waiver process.

	• Board members will recall that the Board considered a revised Managing Conflicts of Interest Policy at its meeting held on 28 September 2022 and requested a number of changes to policy content. The Board delegated authority to the Audit Committee to approve the policy subject to confirmation that the relevant amendments had been made. The Committee considered a revised Managing Conflicts of Interest Policy document, satisfied itself that the relevant amendments had been incorporated and approved the revised policy document as presented.
Items of concern for escalation to the Board	• The Committee received a report from Ms G Conway which detailed the position with the BAF development project and, in particular, transition of the BAF to the Datix Cloud IQ system. The Committee endorsed use of a pilot approach to test and develop systems and processes but also noted factors resulting in a revised completion date of April 2024 (original planned date was April 2023). The Committee noted that one of the key factors in the delay related to the current functionality of the Datix system. Committee members held detailed discussion with management and audit representatives on this matter and concluded that, while the current approach should continue to be progressed, consideration should also be given as to whether transition to the Datix system remains the best solution for the Trust. Ms G Conway agreed to raise this matter with the Trust's project team. • The Director of Finance presented a report to support the Committee's understanding of the Trust's financial and governance risk profile by means of updates on progress against statutory duties and any emerging accounting and financial issues. The Committee noted in particular the Trust's participation in a Shared Business Services (SBS) Review, along with other provider trusts in Cheshire and Merseyside, which involves review of financial services processes and separately assessing procurement capabilities to assess the levels of maturity and effectiveness of current arrangements. The Director of Finance agreed to keep Committee members updated on progress and outcomes of the SBS review.
Items of achievement for escalation to the Board	• The Committee noted the good work of the Finance Team across a number of areas including positive outcomes against financial performance indicators and the establishment of an effective working relationship with the Trust's External Audit service providers, Ernst & Young LLP. The Committee noted in particular joint working with the Auditors to identify lessons learned from the recently completed external audit process and the agreed associated actions.

The Clatterbridge Cancer Centre NHS Foundation Trust

	• The Committee received and noted the Auditor's Annual Report, which included the Audit Completion Certificate, and marked the end of the 2021/22 audit process. The Auditor's Annual Report detailed a positive outcome to the year-end audit process including the review of the Value for Money requirements which now form a key part of the process. • The report from the Director of Finance referenced above also detailed positive outcomes for the Trust from a Productivity Analysis undertaken by NHS England which triangulates finance, activity and workforce data. The Committee noted that the Trust has a positive productivity position and is one of only seven organisations nationally to have improved its position when current performance is benchmarked against a 2019/20 baseline.
Items for shared learning	No items for shared learning were identified.

The Clatterbridge Cancer Centre NHS Foundation Trust

Charitable Funds Committee Chairs report for Trust Board
Date/Time of meeting: 12 October 22 – 10am

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

Items of concern for escalation to the Board	1. North West Cancer Research (NWCR) currently uses 'incorporating Clatterbridge Cancer Research' along with their name, which is causing confusion amongst donors. The Charity has requested they relinquish use of this name The Charity has applied to trademark its own name.
Items of achievement for escalation to the Board	CFC agreed two funding requests: 1. £150K to further support the successful NIHR Biomedical Research Centre (BRC) bid. To be fund by realignment of designated research funds. 2. £283K submitted by Prof. Christian Ottensmeier. To purchase an Akoya Phenocycler Fusion instrument to facilitate faster decisions on the type of immunotherapy to offer groups of patients and ultimately individual patients. To be funded from General fund.
Items for shared learning / information	1. Once the new independent charity is formed, the current Charity's investment portfolio will be transferred in specie. It is proposed that James Thomson and Elkan Abrahamson become authorised signatories to action this. It is proposed that they are nominated by Liz Bishop and Terry Jones with agreement from the Board. 2. The Charity will be applying for a full Gambling Commission licence in line with further growth in its Lottery.
Subject to ratification by the Board	As the meeting was not quorate the Committee requests ratification from the Board for the following decisions: • Approval of signatories for investment letter of authorisation • Approval of the recruitment of a Finance Manager and Direct Marketing Manager • Approval of the proposed movement of designated funds outlined above • Approval Prof. Christian Ottensmeier's funding request for an Akoya Phenocycler Fusion platform

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: **Trust Board**
Date of meeting: **26th October 2022**

Report author	Joan Spencer, Chief Operating Officer					
Paper prepared by	Hannah Gray, Head of Performance and Planning					
Report subject/title	Integrated Performance Report M6 2022 / 2023					
Purpose of paper	This report provides an update on performance for month 6 2022/23 (September 2022). This report provides an update on performance 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 presented below the relevant KPI against which the Trust is not compliant / alerting on SPC charts. 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 6 2022/23)

Hannah Gray: Head of Performance and Planning

Joan Spencer: Chief Operating Officer

Introduction

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

KPI data is presented with a RAG rating and statistical process control (SPC) charts and associated variation and assurance icons. Further information on SPC charts is provided in the SPC Guidance section of this report. Exception reports are presented for key performance indicators (KPIs) against which the Trust is not compliant.

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.

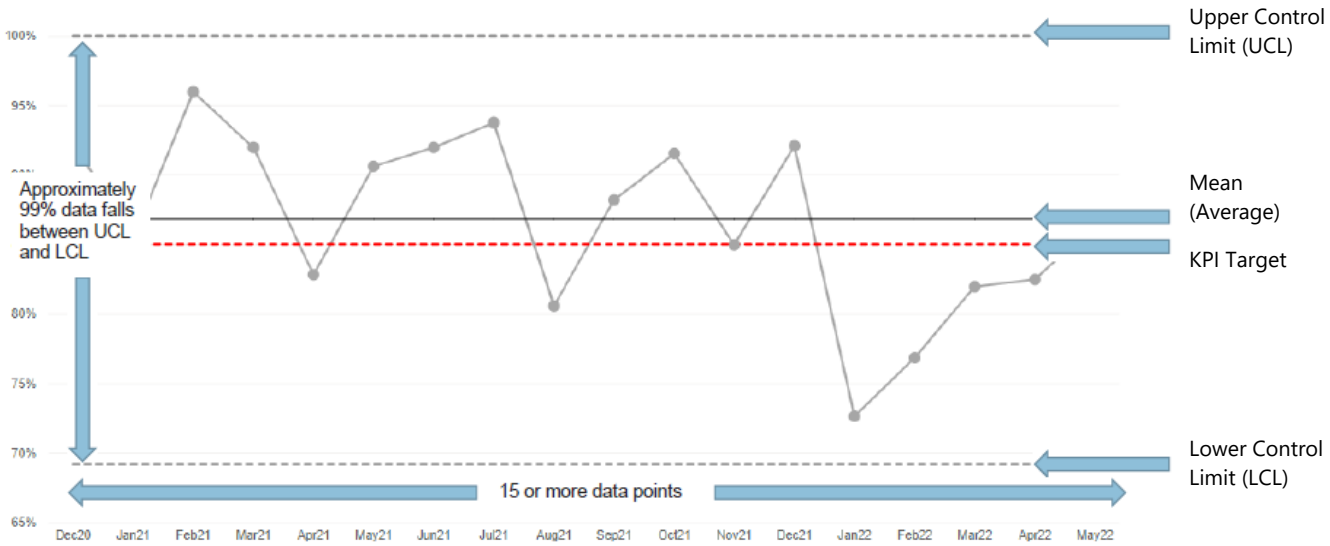
Are we improving, declining or staying the same? (Variation)			
Icon	**Variation**	Definition	Action
	Special Cause Improving Variation	Unexpected variation that results from unusual circumstances in a system or process i.e. assignable. (Blue = significant improvement/low pressure, H = high numbers,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

The Clatterbridge Cancer Centre NHS Foundation Trust

Anatomy of the SPC Chart

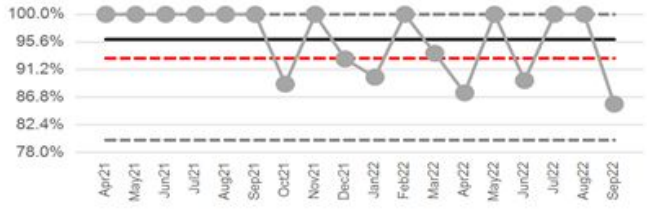


Integrated Performance Report (Oct 21 - Sept 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access

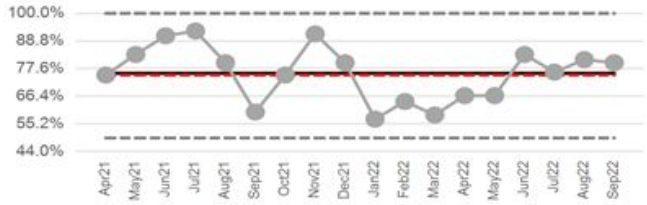
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
CW10	2 Week Wait From GP Referral to 1st Appointment	Green ≥93% Red <93%	Contractual / Statutory		88.9%	100.0%	92.9%	90.0%	100.0%	93.8%	87.5%	100.0%	89.5%	100.0%	100.0%	85.7%		
				Narrative	The target has not been achieved and an exception report is provided. 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 the 2 week wait target in September. One breach was unavoidable due to patient choice of 1st appointment date. The second breach was avoidable; the patient was contacted by letter, however this was received too late for the patient to attend.	The process has been reviewed and standardised Trust wide to ensure that patients in all tumour groups are contacted by telephone when short notice appointments are allocated.

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

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
CW00	28 Day Faster Diagnosis - (Referral to Diagnosis)	Green ≥75% Red <75%	Contractual / Statutory		75.0%	91.7%	80.0%	57.1%	64.3%	58.8%	66.7%	66.7%	83.3%	76.2%	81.3%	80.0%		
				Narrative	The target has been achieved. 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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 this month.													

Data Not Applicable for SPC

Integrated Performance Report (Oct 21 - Sept 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

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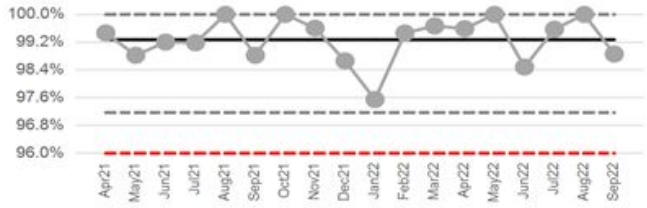
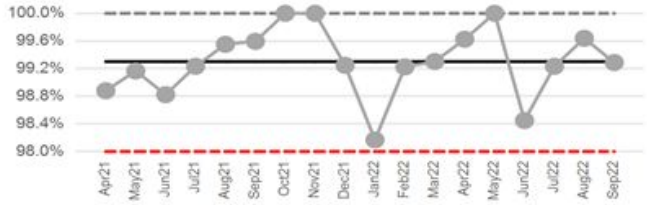
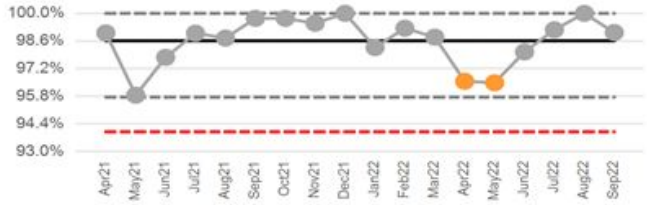
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
CW09	31 Day Firsts	Green ≥96% Red <96%	Contractual / Statutory		100.0%	99.6%	98.7%	97.5%	99.5%	99.7%	99.6%	100.0%	98.5%	99.6%	100.0%	98.9%		
			Narrative	The target has been achieved. 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
CW07	31 Day Subsequent Chemotherapy	Green ≥98% Red <98%	Contractual / Statutory		100.0%	100.0%	99.2%	98.2%	99.2%	99.3%	99.6%	100.0%	98.4%	99.2%	99.6%	99.3%		
			Narrative	The target has been achieved. 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
CW08	31 Day Subsequent Radiotherapy	Green ≥94% Red <94%	Contractual / Statutory		99.7%	99.5%	100.0%	98.3%	99.2%	98.8%	96.6%	96.5%	98.0%	99.2%	100.0%	99.0%		
			Narrative	The target has been achieved. 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
CW40	Number of 31 Day Patients Treated ≥ Day 73	Green 0 Red >0	Contractual / Statutory		0	0	0	1	0	0	0	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

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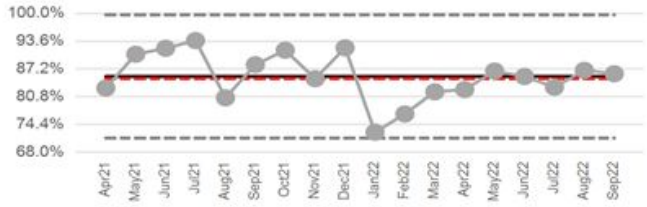
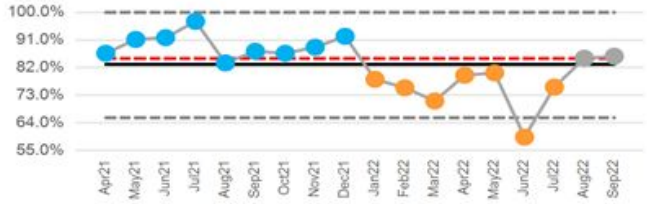
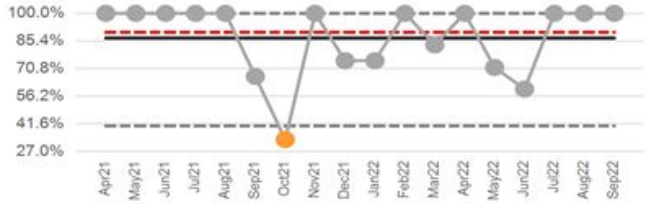
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
CW90	24 Day Wait Target - Referral Received to First Treatment (62 Day Classics Only)	Green >85% Amber 80-84.9% Red <80%			91.5%	85.0%	92.1%	72.6%	76.8%	81.9%	82.5%	86.7%	85.5%	83.0%	86.9%	86.1%		
			Narrative	The target has been achieved. 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
CW03	62 Day Classic	Green ≥85% Red <85%	Contractual / Statutory		86.7%	88.6%	92.2%	78.2%	75.4%	71.2%	79.5%	80.3%	59.4%	75.7%	85.1%	85.7%		
			Narrative	Following 7 months below target (largely due to the increased number of late referrals) the target has been achieved for the second consecutive month. Performance is as 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
CW05	62 Day Screening	Green ≥90% Red <90%	Contractual / Statutory		33.3%	100.0%	75.0%	75.0%	100.0%	83.3%	100.0%	71.4%	60.0%	100.0%	100.0%	100.0%		
			Narrative	The target has been achieved. 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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	0	1	4	0	1	1	3	0	1		
			Narrative	The target has not been achieved, with 1 such patient this month and an exception report is provided.														

Data Not Applicable for SPC

Integrated Performance Report (Oct 21 - Sept 22)

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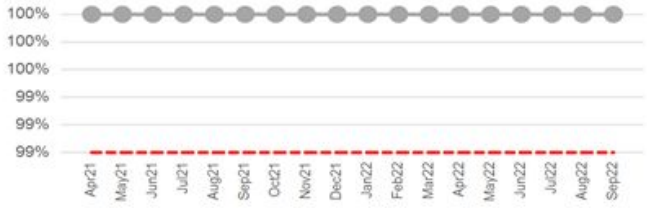
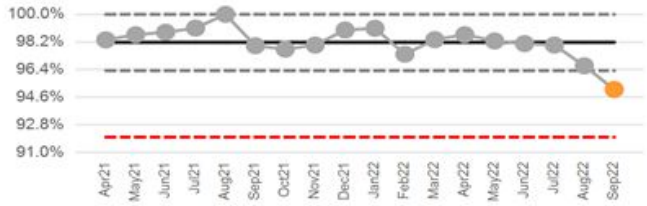
Reason for Non-Compliance	Action Taken to Improve Compliance
23 patients breached the 104 day target in September and 7 of the patients were with CCC for more than 24 days. 6 of these breaches were unavoidable, relating to complex pathways, patient choice, and patients requiring further tests / changes to treatment plan. The avoidable breach was due to treatment planning equipment breakdown and consultant availability to complete treatment plans.	Review of Gynae appointment scheduling to including pro-active tracking to enable pre-treatment appointments to be provisionally booked when first appointment allocated for patient.

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

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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. 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
RT03	RTT Incomplete	Green ≥92% Red <92%	Contractual / Statutory		97.7%	98.0%	99.0%	99.1%	97.4%	98.4%	98.7%	98.3%	98.1%	98.0%	96.6%	95.1%		
				Narrative	The target has been achieved. Performance is lower than expected, however the target is outside SPC limits and there remains assurance that this is likely to be achieved consistently.														



Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
CW44	2 Week Wait From GP Referral to 1st Appointment (Cheshire and Merseyside)	Green ≥93% Red <93%	Contractual / Statutory		82.2%	75.0%	75.7%	72.7%	79.4%	79.9%	77.0%	82.9%	77.0%	76.1%	-	-		
				Narrative	The August 2022 data is not yet available.													

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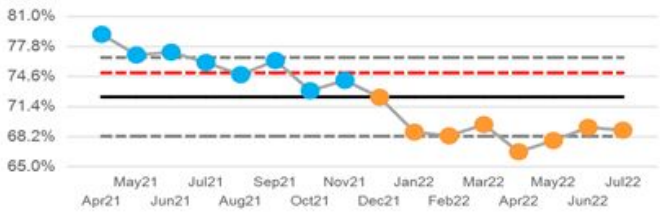
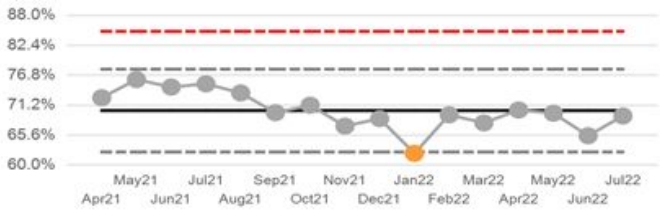
Access

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
CW45	28 Day Faster Diagnosis - (Referral to Diagnosis) (Cheshire and Merseyside)	Green ≥75% Red <75%	Contractual / Statutory		73.1%	74.2%	72.4%	68.7%	68.3%	69.5%	66.6%	67.8%	69.2%	68.9%	-	-		
			Narrative	The August 2022 data is not yet available.														



Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
CW46	62 Day Classic (Cheshire and Merseyside)	Green ≥85% Red <85%	Contractual / Statutory		71.2%	67.3%	68.7%	62.2%	69.4%	67.9%	70.3%	69.7%	65.5%	69.2%	-	-		
			Narrative	The August 2022 data is not yet available.														

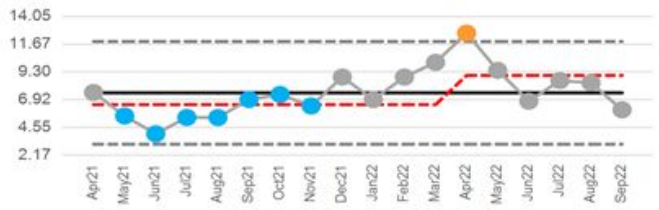


Integrated Performance Report (Oct 21 - Sept 22)

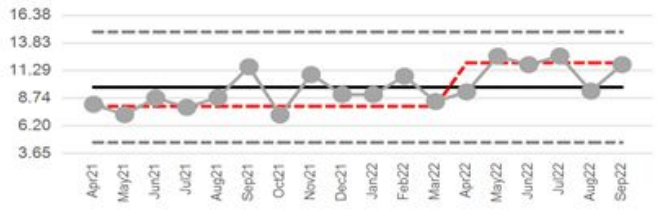
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

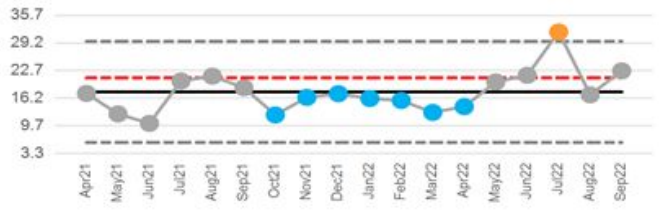
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
IP05-ST	Length of Stay Elective Care: Solid Tumour Wards (Average Number of Days On Discharge)	Green ≤9 Amber 9.1 -10.7 Red >10.7	Statutory		7.37	6.39	8.86	6.93	8.86	10.12	12.62	9.43	6.80	8.56	8.37	6.06		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



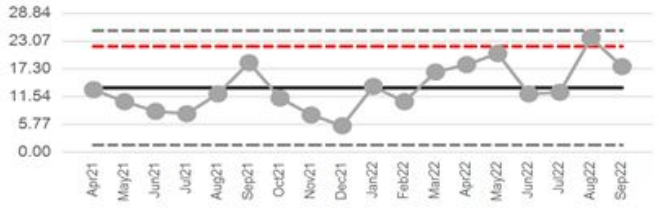
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
IP06-ST	Length of Stay Emergency Care: Solid Tumour Wards (Average Number of Days On Discharge)	Green ≤12 Amber 12.1-14.3 Red >14.3	Statutory		7.20	10.92	9.08	9.08	10.77	8.44	9.33	12.62	11.84	12.63	9.40	11.84		
			Narrative	The target has been achieved. 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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		12.3	16.4	17.3	16.2	15.7	12.9	14.3	20.0	21.6	31.8	17.0	22.6		
			Narrative	The target has not been achieved (1.6 days over). There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. As the target figure is internally created and the SPC indicates normal variation, an exception report is not provided.														



Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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		11.25	7.75	5.50	13.67	10.50	16.67	18.20	20.50	12.13	12.46	23.75	17.80		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



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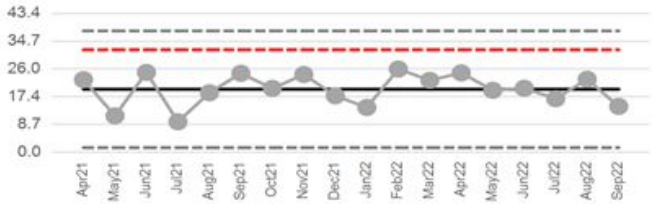
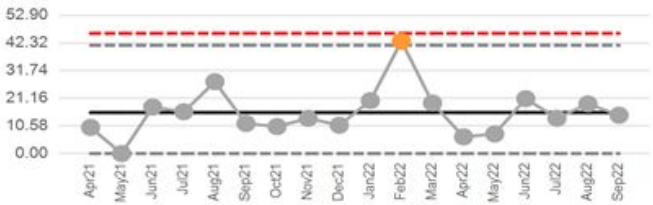
Efficiency

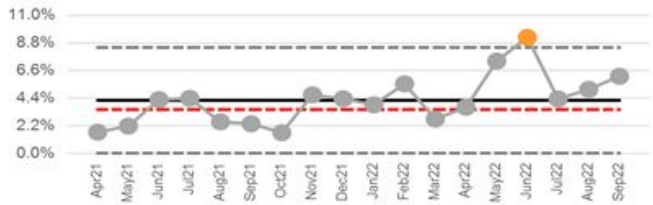
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
IP05-5	Length of Stay Elective Care: HO Ward 5 (Average Number of Days On Discharge)	Green ≤32 Amber 32.1-33.6 Red >33.6	Statutory		19.9	24.3	17.6	14.0	26.0	22.5	24.8	19.4	20.0	16.8	22.8	14.3		
				Narrative	The target has been achieved. 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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		10.33	13.50	10.83	20.25	43.00	19.33	6.38	7.50	21.00	13.50	19.00	14.67		
				Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that the target is likely to be consisently achieved.													



Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
IP22	Delayed Transfers of Care As % of Occupied Bed Days	Green ≤3.5% Red >3.5%	Statutory		1.7%	4.7%	4.4%	3.9%	5.5%	2.7%	3.7%	7.4%	9.2%	4.4%	5.1%	6.1%		
				Narrative	The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



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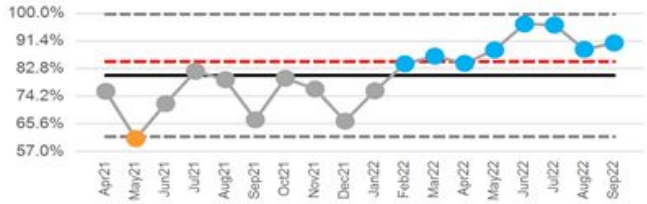
Efficiency

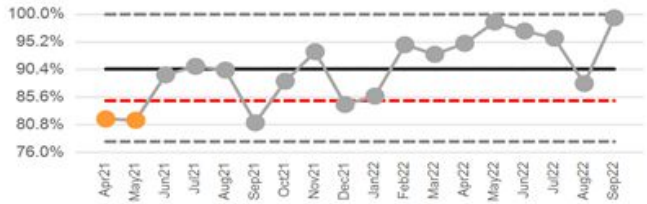
Reason for Non-Compliance	Action Taken to Improve Compliance
Delayed Transfers of Care (DTOCs) as a % of occupied bed days for the month of September was above the Trust target of <= 3.5%, with 6.1% reported this month. There were 14 DTOCs in September; an increase of 2 from last month. This equates to 158 extra bed days, 57 days more than last month. The average length of DTOC was 11 days, an increase of 3 days from last month. • 4 patients awaited Fast Track Packages of care resulting in 36 extra bed days. There remain delays across all areas in commissioning a package of care. • 2 patients awaited Fast Track Nursing Home placements, for a total of 11 extra bed days. • 3 patients awaited Intermediate Care Placements, for 69 extra bed days. 2 patients have remained in hospital for the whole of September due to complex nursing needs and lack of availability in their local area. CHC have been contacted daily for an updated about availability. • 2 patients awaited Hospice placement resulting in 9 extra bed days. Some hospices have reduced day capacity due to Covid-19. • 2 patients awaited Social Service Package of Care, resulting in 29 extra bed days. • 1 patient was awaiting suitable accommodation (DTOC for 3 days), however further chemotherapy was then required and the patient remains an inpatient.	• 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, ensuring patients are discharged safely home or to a suitable care setting. Weekly complex discharge meetings occur with the MDT. • Daily COW MDT meetings continue to allow discussion of all inpatients so that there is a clear plan for each patient. • CHC (NHS Continuing Healthcare) are being contacted daily for an update on the availability of beds.

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

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
IP20-4	Average Occupancy at 12 Midday: Ward 4	Green ≥85% Amber 81-84.9% Red <81%	Statutory		79.8%	76.4%	66.5%	75.9%	84.3%	86.7%	84.4%	88.6%	96.7%	96.4%	88.8%	90.8%		
			Narrative	The target has been achieved. Bed occupancy is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
IP21-4	Average Occupancy at Midnight: Ward 4	Green ≥85% Amber 81-84.9% Red <81%	Statutory		88.4%	93.5%	84.4%	85.8%	94.7%	93.1%	95.0%	98.7%	97.1%	95.9%	88.0%	99.4%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														

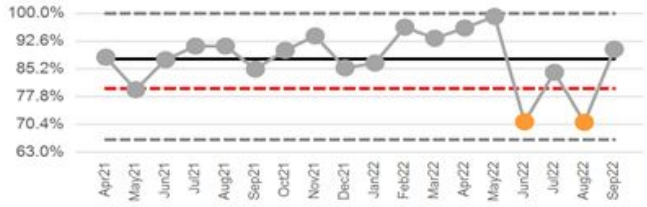


Integrated Performance Report (Oct 21 - Sept 22)

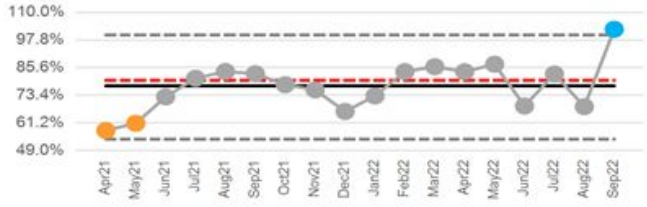
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

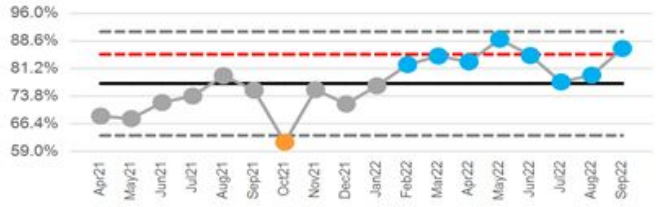
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
IP20-5	Average Occupancy at 12 Midday: Ward 5	Green ≥80% Amber 76%-79.9% Red <76%	Statutory		90.2%	94.0%	85.5%	86.8%	96.3%	93.4%	96.1%	99.2%	71.1%	84.3%	71.0%	90.4%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



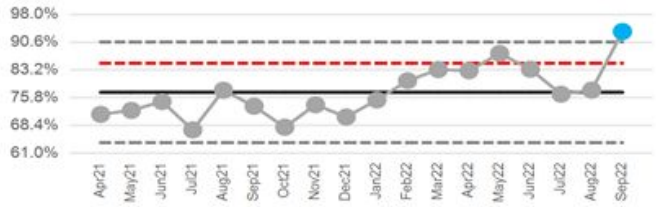
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
IP21-5	Average Occupancy at Midnight: Ward 5	Green ≥80% Amber 76%-79.9% Red <76%	Statutory		78.1%	75.8%	66.2%	73.1%	83.8%	86.0%	83.8%	87.1%	68.7%	82.8%	68.4%	102.5%		
			Narrative	The target has been achieved. Bed occupancy is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
IP20-ST	Average Occupancy at 12 Midday: ST Wards	Green ≥85% Amber 81-84.9% Red <81%	Statutory		61.5%	75.6%	71.7%	76.6%	82.3%	84.6%	83.0%	89.1%	84.7%	77.6%	79.5%	86.6%		
			Narrative	The target has been achieved. Bed occupancy is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
IP21-ST	Average Occupancy at Midnight: ST Wards	Green ≥85% Amber 81-84.9% Red <81%	Statutory		67.9%	73.9%	70.7%	75.2%	80.3%	83.3%	83.0%	87.6%	83.4%	76.7%	77.8%	93.4%		
			Narrative	The target has been achieved. Bed occupancy is higher than expected, however the nature of variation indicates that achievement of the target is likely to be inconsistent.														

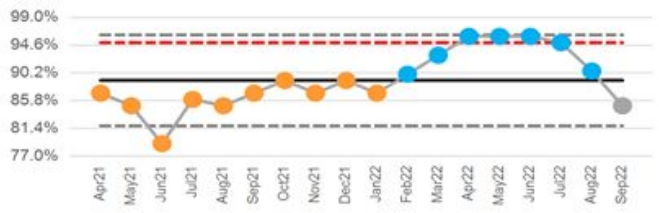


Integrated Performance Report (Oct 21 - Sept 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
IP23	% of Expected Discharge Dates Completed	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		89.0%	87.0%	89.0%	87.0%	90.0%	93.0%	96.0%	96.0%	96.0%	95.0%	90.5%	85.0%		
			Narrative	The target has not been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. As the target figure is internally created and performance is as expected, an exception report is not provided. This is reported real time within the Inpatient dashboard and monitored at the Acute Care Performance Review Group.															



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

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
IP25	% of Cancelled Elective Procedures (On or After The Day of Admission) Rebooked Within 28 Days of Cancellation	Green 100% Red <100%	Contractual		-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	There is no data to display, as no procedures were cancelled.														

Data Not Applicable for SPC

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

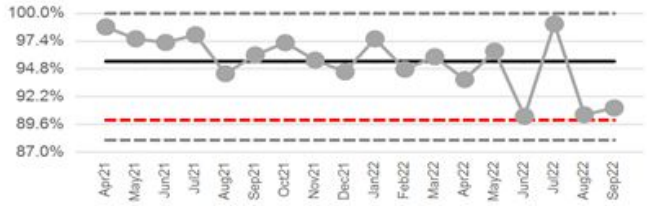
Data Not Applicable for SPC

Integrated Performance Report (Oct 21 - Sept 22)

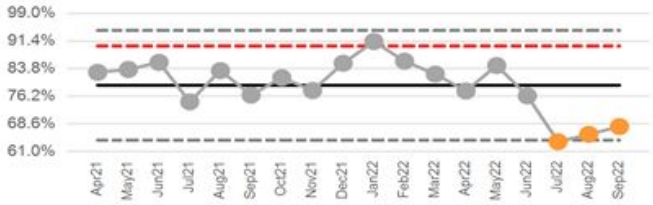
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
EF10	Imaging Reporting Turnaround (Inpatients)	Green >90% Amber 80-89.9% Red <80%			97.3%	95.6%	94.5%	97.6%	94.8%	95.9%	93.8%	96.5%	90.4%	99.0%	90.5%	91.1%		
			Narrative	The target continues to be achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



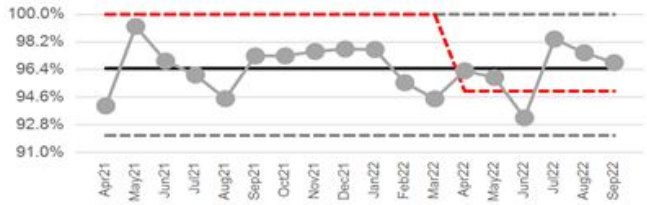
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
EF11	Imaging Reporting Turnaround (Outpatients)	Green >90% Amber 80-89.9% Red <80%			81.3%	77.8%	85.3%	91.3%	85.9%	82.3%	77.7%	84.7%	76.3%	63.7%	65.7%	67.9%		
			Narrative	The target has not been achieved. Performance is lower than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent. An exception report is therefore provided.														



Reason for Non-Compliance	Action Taken to Improve Compliance
• Radiology activity has increased since CCCL opened, placing increasing demands on the Radiologist team. More recently, activity has further increased by utilising extended days in MRI and weekend lists in both MRI and CT • CCC Radiologists are supporting additional MDT activity • Medica have been returning examinations unreported with increasing frequency as they have not had the capacity to report • Expected new radiologist (IR and reporting) withdrew shortly before September start date.	• On-going outsourcing of reporting activity to Medica and monitoring of Medica performance. Medica capacity has increased, with 10 new reporters approved in September, as well as the continuing use of overseas reporters. • All Radiologists who report for CCC have been offered additional hours to increase capacity. • Reporting delays have been recorded as a risk on the Radiology Risk Register (graded as 12) and associated actions monitored through both Operational and Quality and Safety Meetings. • The Registrar is now in post • The recruitment of 2 further Radiologists is planned for 2022/23. • IR post recruitment has begun again. • The daily report, received by the senior radiology team to enable continuous monitoring and prioritisation of outstanding reports enables prompt action to be taken if the backlog increases. The most recent report received 10.10.22 shows a significant reduction in the reporting backlog and in scans waiting over 2 weeks (3) and over 3 weeks (0).

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

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
DQ01	Data Quality - % Ethnicity That is Complete (or Patient Declined to Answer)	Green ≥95% Amber 90-94.9% Red <90%	Covid-19 Recovery		97.3%	97.6%	97.7%	97.7%	95.5%	94.5%	96.3%	95.9%	93.3%	98.4%	97.5%	96.9%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														

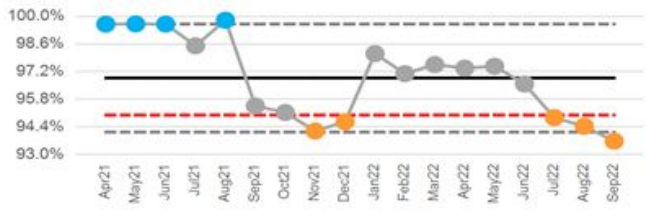


Integrated Performance Report (Oct 21 - Sept 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

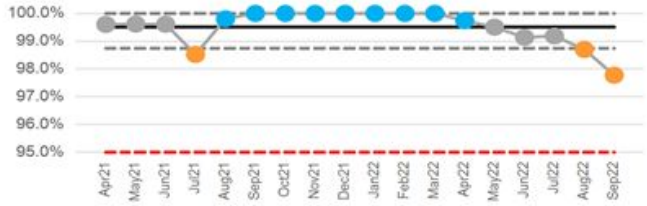
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
DQ02	Data Quality - % of Outpatients With an Outcome	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		95.1%	94.2%	94.7%	98.1%	97.1%	97.6%	97.4%	97.5%	96.6%	94.9%	94.4%	93.7%		
			Narrative	The target has not been achieved and an exception report is provided. Performance is lower than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



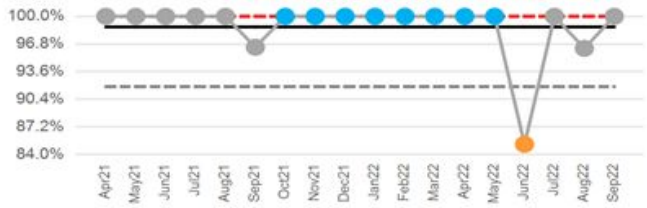
Reason for Non-Compliance	Action Taken to Improve Compliance
Performance is marginally below the 95% target and slightly improved since last month, at 93.7%. Whilst performance continues to be above target for consultant led clinic outpatient appointments, improvements are still required in the timely disposal of supportive appointments e.g. on-treatment reviews and cancer support worker appointment.	• Increased monitoring of the administration dashboard continues, with escalation of any undisposed appointments to the relevant managers. • A deep dive of both the 'outcome' and 'attend status' data is underway in collaboration with the BI team to enabled specific, targeted action.

Escalation Route & Expected Date of Compliance
Divisional Quality and Safety Meetings, Divisional Performance Reviews, Performance Committee, Trust Board October 2022

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
DQ03	Data Quality - % of Outpatients With an Attend Status	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	99.5%	99.1%	99.2%	98.7%	97.8%		
			Narrative	The target continues to be achieved. Although performance is lower than expected, the target remains outside SPC limits and is therefore likely to be achieved consistently. Based on this assurance, an exception report is not provided.														



Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
EF01	Percentage of Subject Access Requests Responded to Within 1 Month	Green 100% Red <100%	Contractual		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	85.2%	100.0%	96.3%	100.0%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Integrated Performance Report (Oct 21 - Sept 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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 (Oct 21 - Sept 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

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

Data Not Applicable for SPC

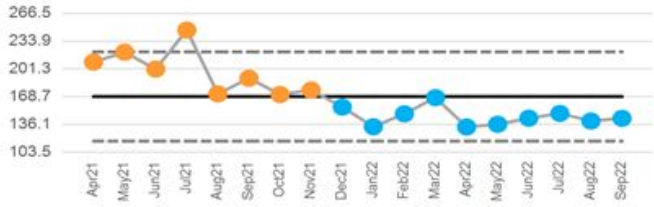
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU04	Serious Incidents (SIs)	No Target	Contractual / Statutory		0	0	0	0	0	0	0	0	0	2	0	1		
			Narrative	LUHFT have declared an SI. This relates to a patient referred by CCC. CCC staff will be fully involved in the investigation to ensure a robust and thorough review of the pathways and processes involved														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU01	Serious Incidents: % Submitted Within 60 Working Days / Agreed Timescales	Green 100% Red <100%	Contractual / Statutory		-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	No SI reports have been submitted this month.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU03	Incidents /1,000 Bed Days	No Target	Statutory		171.3	176.6	156.6	133.4	148.6	167.6	133.1	136.3	143.5	149.1	140.1	143.3		
			Narrative	Figures continue to be lower than expected. Incidents are reviewed at Divisional Quality and Safety meetings and Divisional Performance Review meetings. This focus promotes a good reporting culture and analysis of themes and trends to drive improvement.														



Integrated Performance Report (Oct 21 - Sept 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU05	All Incidents Resulting in Moderate Harm and Above /1,000 Bed Days	No Target	Local		5.038	3.935	3.593	2.911	2.616	0.857	1.735	0.779	0.872	1.293	0.904	2.794		
			Narrative	There were 7 such incidents this month; one severe harm and 6 moderate. Incidents are reviewed at Divisional Quality and Safety meetings 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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	1	0	0	0	0		
			Narrative	There were no falls resulting in harm due to a lapse in care. The harm review process has been amended and therefore figures may change retrospectively, following review.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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	0.390	0.000	0.000	0.000	0.000		
			Narrative	There were no falls resulting in harm due to a lapse in care. The harm review process has been amended and therefore figures may change retrospectively, following review.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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 this month. The harm review process has been amended and therefore figures may change retrospectively, following review.														

Data Not Applicable for SPC

Integrated Performance Report (Oct 21 - Sept 22)

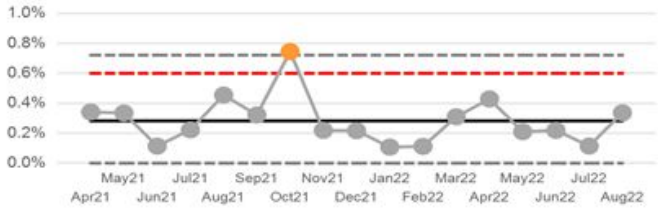
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

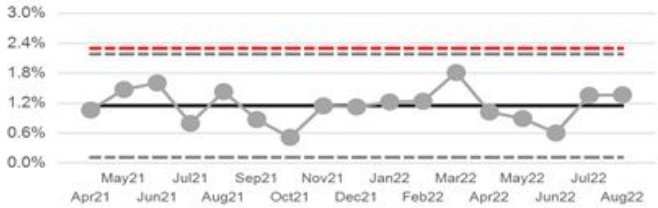
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU09	Pressure Ulcers (Hospital Acquired Grade 3/4, With a Lapse in Care) /1,000 Bed Days	Green 0 Red >0	Contractual		0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target continues to be achieved, with no such pressure ulcers this month. The harm review process has been amended and therefore figures may change retrospectively, following review.														

Data Not Applicable for SPC

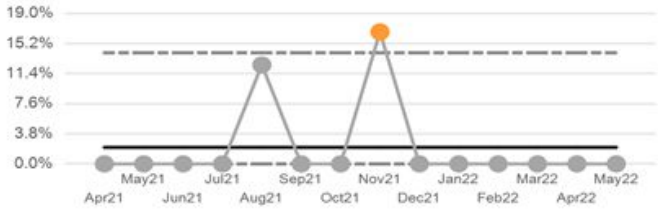
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU10	30 Day Mortality (Radical Chemotherapy)	Green ≤0.6% Amber 0.61% - 0.7% Red >0.7%	SOF		0.7%	0.2%	0.2%	0.1%	0.1%	0.3%	0.4%	0.2%	0.2%	0.1%	0.3%	-		
			Narrative	The target has been achieved. 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU12	30 Day Mortality (Palliative Chemotherapy)	Green ≤2.3% Amber 2.31% - 2.5% Red >2.5%	SOF		0.5%	1.1%	1.1%	1.2%	1.2%	1.8%	1.0%	0.9%	0.6%	1.4%	1.4%	-		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that the target is likely to be achieved.														



Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU13	100 Day Mortality (Bone Marrow Transplant)	To Be Confirmed	SOF / NR		0.0%	16.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-	-	-	-		
			Narrative	No patients who had a BMT transplant in May, have died within 100 days of transplant. A target is being developed for this KPI, using national benchmarking. No significant change is noted.														

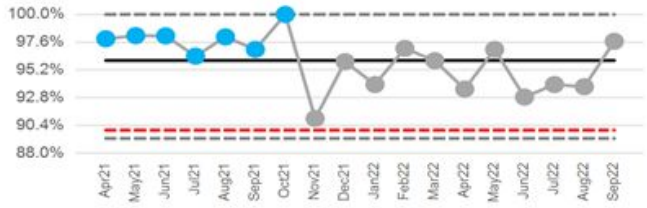


Integrated Performance Report (Oct 21 - Sept 22)

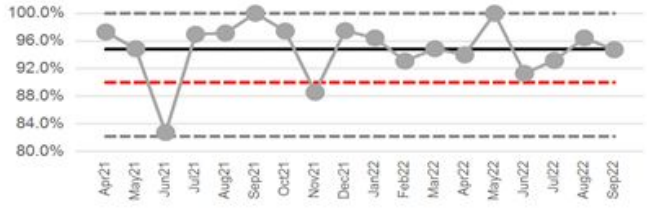
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

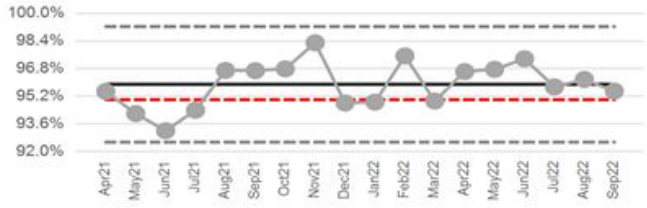
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU62	Consultant Review Within 14 Hours	Green ≥90% Red <90%	Contractual		100.0%	91.0%	95.9%	93.9%	97.1%	96.0%	93.5%	97.0%	92.9%	93.9%	93.8%	97.7%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



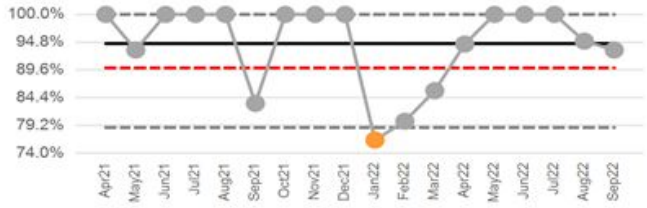
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU48	Sepsis IV Antibiotics Within an Hour	Green ≥90% Red <90%	Contractual		97.4%	88.6%	97.5%	96.4%	93.1%	94.9%	94.0%	100.0%	91.3%	93.2%	96.4%	94.7%		
			Narrative	The target has been achieved. 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU31	Percentage of Adult Admissions With VTE Risk Assessment	Green ≥95% Red <95%	Contractual / Statutory		96.8%	98.3%	94.8%	94.9%	97.5%	94.9%	96.6%	96.8%	97.4%	95.7%	96.2%	95.5%		
			Narrative	The target has been achieved. 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU14	Dementia: Percentage to Whom Case Finding is Applied	Green ≥90% Red <90%	Contractual		100.0%	100.0%	100.0%	76.5%	80.0%	85.7%	94.4%	100.0%	100.0%	100.0%	95.0%	93.3%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Integrated Performance Report (Oct 21 - Sept 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target	Target Type	Year & Month													
				Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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													
				Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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													
				Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU34	Clostridium Difficile Infections (HOHA and COHA)	Green ≤17 per year Red >17 per year	Contractual / Statutory	3	2	0	1	0	4	2	2	1	1	2	2		
			Narrative	The target has not been achieved, with 2 such infections this month and an exception report is provided.													

Data Not Applicable for SPC

Reason for Non-Compliance	Action Taken to Improve Compliance
One HOHA and one COHA C.diff infection were identified in September, taking the total YTD to 10 against an annual threshold of 17. HOHA: Whilst this did not contribute to the development of infection, there were missed opportunities to obtain the sample earlier COHA: The infection was treated appropriately, with no learning points identified.	The Division will revisit and revise the HCAI action plan to address this recurring issue.

Escalation Route & Expected Date of Compliance
Executive Review Group, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board October 2022

Integrated Performance Report (Oct 21 - Sept 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target (Cumulat	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU40	E. Coli Bacteraemia (HOHA and COHA)	Green ≤11 per year Red >11 per year	Contractual / Statutory		-	-	-	-	-	-	2	0	2	1	1	4		
			Narrative	The target has not been achieved, with 4 such infections this month and an exception report is provided.														

Data Not Applicable for SPC

Reason for Non-Compliance	Action Taken to Improve Compliance
4 HOHA E.coli bloodstream infections were identified in September 2022. This is higher than the CCC's typical monthly average, however 3 cases were related to the patients' underlying conditions and no learning points were identified. The remaining case is likely to be attributed to an indwelling IV line.	The clinical team are undertaking a programme of education and assessment related to ANTT practice.

Escalation Route & Expected Date of Compliance
Executive Review Group, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board October 2022

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU36	MRSA Infections (HOHA and COHA)	Green 0 Red >0	Contractual / Statutory		-	-	-	-	-	-	0	0	0	0	0	0		
			Narrative	The target has been achieved this month.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target (Cumulat	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU38	MSSA Bacteraemia (HOHA and COHA)	Green ≤4 per year Amber 5 Red >5 per year	Contractual / Statutory		-	-	-	-	-	-	1	0	0	1	0	3		
			Narrative	The target has not been achieved, with 3 such infections this month and an exception report is provided.														

Data Not Applicable for SPC

Reason for Non-Compliance	Action Taken to Improve Compliance
2 HOHA MSSA bloodstream infections were identified in September 2022. One source is likely to be infected cellulitis, the other was an unclear source. 1 COHA MSSA bloodstream infection was also identified, again of unclear source.	Not applicable

Escalation Route & Expected Date of Compliance
Executive Review Group, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board October 2022

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NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target (Cumulat	Target Type	Year & Month												V	A
				Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22		
QU43	Klebsiella (HOHA and COHA)	Green ≤8 per year Red >8 per year	Contractual / Statutory	-	-	-	-	-	-	3	1	0	1	1	1		
			Narrative	The target has not been achieved, with 1 such infection this month and an exception report is provided.													

Data Not Applicable for SPC

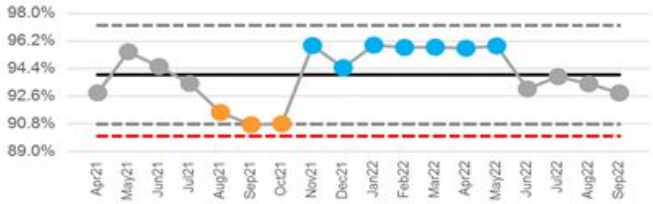
Reason for Non-Compliance	Action Taken to Improve Compliance
1 HOHA Klebsiella pneumoniae bloodstream infection was identified in September 2022. This is likely to be a line related infection.	The clinical team are undertaking a programme of education and assessment related to ANTT practice.

Escalation Route & Expected Date of Compliance
Executive Review Group, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board October 2022

Metric ID	Metric Name	Target (Cumulat	Target Type	Year & Month												V	A
				Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22		
QU45	Pseudomonas (HOHA and COHA)	Green ≤1 per year Red >1 per year	Contractual / Statutory	-	-	-	-	-	-	2	0	1	2	0	0		
			Narrative	The target has been achieved this month.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month												V	A
				Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22		
QU60	NICE Guidance Compliance	Green ≥90% Amber 85 - 89.9% Red <85%	Contractual	90.8%	95.9%	94.5%	95.9%	95.8%	95.8%	95.7%	95.9%	93.1%	93.9%	93.4%	92.8%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.													

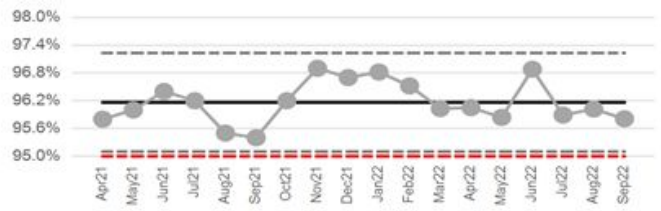


Integrated Performance Report (Oct 21 - Sept 22)

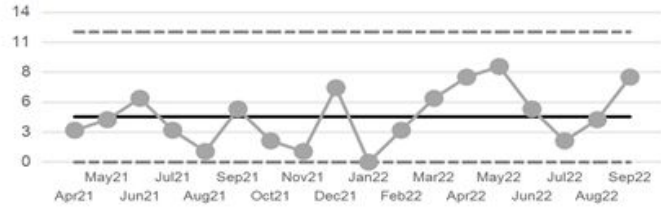
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU75	Patient FFT: % of Respondents Who Had a Positive Experience	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		96.2%	96.9%	96.7%	96.8%	96.5%	96.0%	96.1%	95.8%	96.9%	95.9%	96.0%	95.8%		
			Narrative	The target has been achieved. An issue has been identified with the calculation of this figure. This has now been resolved and the data refreshed. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



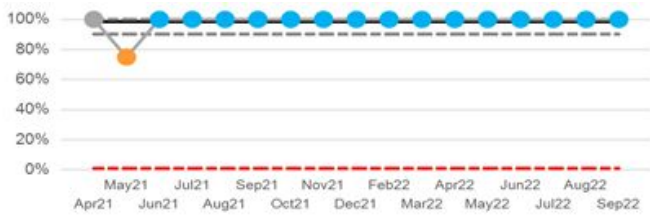
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU11	Number of Complaints	No Target	Contractual		2	1	7	0	3	6	8	9	5	2	4	8		
			Narrative	There were 8 complaints this month, with no significant change noted. Complaints are reviewed at Divisional Quality and Safety meetings, Divisional Performance Review meetings and RQGC. This promotes effective analysis of themes and trends to drive improvement.														



Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU18	Number of Complaints / Count of WTE Staff (Ratio)	No Target	Contractual		0.001	0.001	0.004	0.000	0.002	0.004	0.005	0.005	0.003	0.001	0.002	0.005		
			Narrative	There were 0.005 complaints per staff WTE this month (8 complaints). Complaints are reviewed at Divisional Quality and Safety meetings, Divisional Performance Review meetings and RQGC. 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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. There is no data for January as no complaints were received. Performance is higher than expected and the nature of variation indicates that the target is likely to be achieved.														



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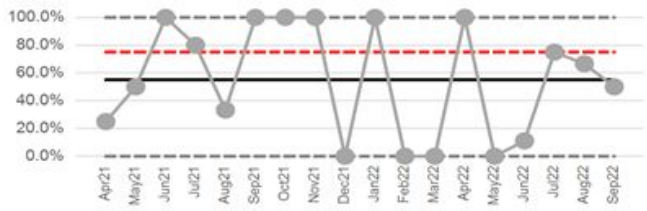
The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU20	% of Routine Complaints Resolved Within 25 Working Days	Green ≥75% Amber 65% - 74.9% Red <65%	Local		100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	11.1%	75.0%	66.7%	50.0%		
			Narrative	The target has not been achieved. Although this is an internally created target and there is no significant change, an exception report is provided as the upper and lower control limit range prevents any alerts. The control limits are therefore under review and likely to be adjusted for the 2023/24 IPR.														



Reason for Non-Compliance	Action Taken to Improve Compliance
Two routine complaints were completed in September 2022, one complaint did not meet the KPI of 25 working days. • Complaint received 04/08/22 with a response due date of 09/09/22 • Draft response letter required multiple amendments • Response letter was sent out on 15/09/22 – a delay of 4 working days • The complainant was kept informed of the reasons for the delay.	Ongoing complaints are discussed at the divisional quality and safety meetings to ensure timescales are being adhered to. Divisional teams have been reminded of the timescales involved in the complaint process 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 October 2022

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU71	% of Complex Complaints Resolved Within 60 Working Days	Green ≥75% Amber 65% - 74.9% Red <65%	Local		-	-	-	-	-	-	66.7%	-	100.0%	100.0%	100.0%	50.0%		
			Narrative	The target has not been achieved, with 1 out of 2 resolved, not being within the 60 days. An exception report is provided.														

Data Not Applicable for SPC

Reason for Non-Compliance	Action Taken to Improve Compliance
Two complex complaints were completed in September 2022, one complaint did not meet the KPI of 60 working days • Complaint received 20/04/22 with a response due date of 18/07/22 • Complainant confirmed they would like a response from primary care included in the Trust response • Long delay (3 months) in receiving information from primary care – complainant informed and would like to wait for full response • Response letter was sent out on 29/09/22	Ongoing complaints are discussed at the divisional quality and safety meetings to ensure timescales are being adhered to. Divisional teams have been reminded of the timescales involved in the complaint process 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 October 2022

Integrated Performance Report (Oct 21 - Sept 22)

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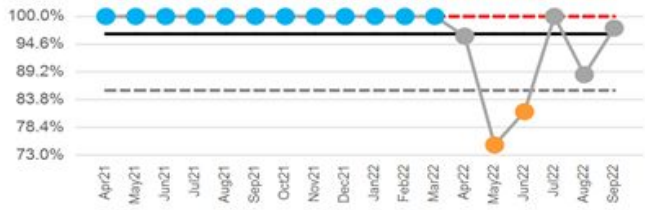
Quality

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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%	96.2%	75.0%	81.5%	100.0%	88.7%	97.7%		
			Narrative	The target has not been achieved and an exception report is provided. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent. An exception report is included as the 20 day limit is a national target.														



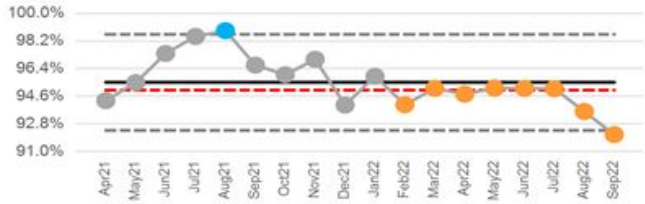
Reason for Non-Compliance	Action Taken to Improve Compliance
1 of the 43 FOI requests responded to in September was beyond the 20 working days, at 21 working days. The request was complex, regarding hospital initiated cancellations. Explanatory notes were required to explain the context behind the appointments cancelled due to patients being too unwell to begin planned radiotherapy treatment.	No further action could have been taken to improve compliance in relation to this complex query.

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

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU22	Number of IG Incidents Escalated to ICO	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 IGC incidents escalated to the ICO this month. Regarding the 1 reported in Dec 2021, the ICO have now confirmed that there was no evidence to show inappropriate disclosure of information and they have confirmed that the incident is no longer 'ICO reportable'.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
QU23	% of Policies in Date	Green ≥95% Amber 93.1 - 94.9% Red <93%	Contractual		96.0%	97.0%	94.0%	95.9%	94.1%	95.1%	94.7%	95.1%	95.1%	95.1%	93.6%	92.1%		
			Narrative	The target has not been achieved and an exception report is provided. Performance is lower than expected (triggering an exception report) and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Integrated Performance Report (Oct 21 - Sept 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Reason for Non-Compliance	Action Taken to Improve Compliance
The month of September has a significantly larger volume of policies that go out of date, than any other months. • 6 policies have been updated by the document owners and are scheduled to go to committees for approval • 9 policies are currently being updated by the document owners. • Document owners of the remaining 6 policies continue to be contacted for updates.	The Document Control Officer will continue to send regular reminders for overdue items. The Information Governance Team is currently in the process of setting up automatic reminders in QPulse. Any policies that continue to be out of date for long periods without communication to Document Control will be escalated to the Information Governance Manager.
Escalation Route & Expected Date of Compliance	
Divisional Quality, Safety and Performance meetings, Divisional Performance Reviews, Information Governance Board, Risk and Quality Governance Committee, Quality Committee, Trust Board October 2022	

Metric ID	Metric Name	Target	Target Type	Year & Month												
				Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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	1		
			Narrative	The target has not been achieved and an exception report is provided.													

Data Not Applicable for SPC

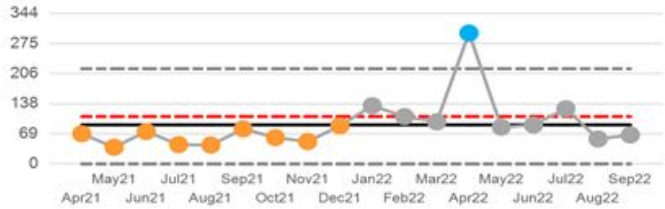
Reason for Non-Compliance	Action Taken to Improve Compliance
One safety alert is overdue for completion of required actions: • Alert issued on 03/08/22 with 7 actions to be completed by 10/08/2022 • CCC completed 6 actions relevant to the Trust by 10/08/22 • The last action requires input from LUHFT – information has been requested from LUHFT on a number of occasions but no reply has been received to date • The issue has been escalated to the Director of Pharmacy	CCC is fully compliant with all actions relevant to the Trust and this was completed within the set timescales required from the safety alert. Director of Pharmacy has escalated the issue to colleagues within LUHFT
Escalation Route & Expected Date of Compliance	
Risk and Quality Governance Committee, Quality Committee, Trust Board October 2022	

Integrated Performance Report (Oct 21 - Sept 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

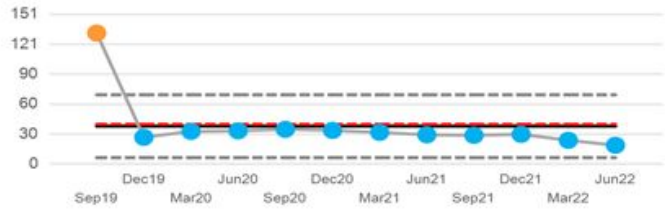
Metric ID	Metric Name	Target (Cumulat	Target Type	Year & Month													V	A
				Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22			
RI20	Study Recruitment	Green ≥1300 per year Amber 1100-1299 per year Red <1100 per	CCC Strategy	60	51	87	133	108	96	299	84	89	126	57	66			
			Narrative	The target has not been achieved. There is no significant change and target achievement is likely to be inconsistent. An exception report is provided as the LCL (0) prevents any negative variation alerts. The control limits are therefore under review and likely to be adjusted for the 2023/24 IPR.															



Reason for Non-Compliance	Action Taken to Improve Compliance
472 patients have been recruited against an internal target of 648 (73% of target) at the end of Month 6. The main reasons at Month 6 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. • 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. To note: 374 patients had been recruited at the same time point during 19/20 (pre-pandemic).	• Requested a refreshed study set-up list from each SRG by 12th October 2022 to revitalise the portfolio. • Continuing to work collaboratively with service departments and research-active staff to open all studies types in a timely way. • Full recovery plan for pharmacy presented at September 2022 R&I Directorate Board. Pharmacy greenlight for studies will be back to pre-pandemic levels by November 2022 with an increase in pharmacy greenlights anticipated from April 2023. • Reviewing all open studies to ensure optimised recruitment. Targets are reviewed quarterly at the Portfolio Review meetings. Portfolio Reviews are attended by the relevant consultants including the SRG Research Leads, research active clinicians, 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
R&I Directorate Board, Committee for Research Strategy, Performance Committee, Trust Board March 2023

Metric ID	Metric Name	Target	Target Type	Year & Month													V	A
				Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22			
RI03	Study Set-Up Times in Days	Green ≤40 days Red >40	National Reporting	-	-	30	-	-	24	-	-	19	-	-	-			
			Narrative	Data is for the 12 month period up to the reported month and is published every 3 months. The latest data was included in the M3 IPR. 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.														

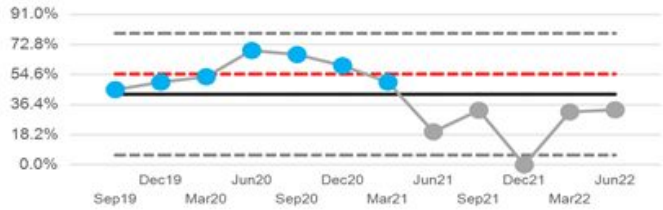


Integrated Performance Report (Oct 21 - Sept 22)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
RI21	Recruitment to Time and Target	Green ≥55% Amber 45 - 54.9% Red <45%	National Reporting		-	-	0.0%	-	-	32.0%	-	-	33.3%	-	-	-		
			Narrative	Data is for the 12 month period up to the reported month. This is published every 3 months. The latest data and exception report was included in the M3 IPR.														



Metric ID	Metric Name	Target (Cumulat	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
RI05	Number of New Studies Open to Recruitment	Green ≥52 per year Amber 45 - 51 Red <45	CCC Strategy		4	5	1	3	8	3	2	5	1	3	2	3		
			Narrative	The target has not been achieved. There is no significant change and target achievement is likely to be inconsistent. An exception report is provided as the LCL (0) prevents any negative variation alerts. The control limits are therefore under review and likely to be adjusted for the 2023/24 IPR.															

Reason for Non-Compliance	Action Taken to Improve Compliance
• 16 studies have opened to recruitment against an internal target of 26 (62% of target) at the end of Month 6. • Strategic decision taken in December 2021 to open Experimental Cancer Medicine Centre (ECMC) trials for 6-months which are complex and can take longer than non-ECMC studies to set-up. • Pharmacy team bedding in and will start to give pharmacy approval for studies to open at pre-pandemic levels from November 2022. • 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 five additional studies. Currently two studies are awaiting second stage approval from Pharmacy, three studies are awaiting Sponsor activation to open.	• Work with the Clinical Trial Pharmacy team to open new drug studies. • Work with the Director of Clinical Research and research active representatives to prioritise the opening of appropriate studies. • Work with the SRG Leads and the Network to optimise opportunities with observational studies. • Work with Sponsors and Pharmacy to greenlight studies where all local approvals have been given.

Escalation Route & Expected Date of Compliance
R&I Directorate Board, Committee for Research Strategy, Performance Committee, Trust Board March 2023

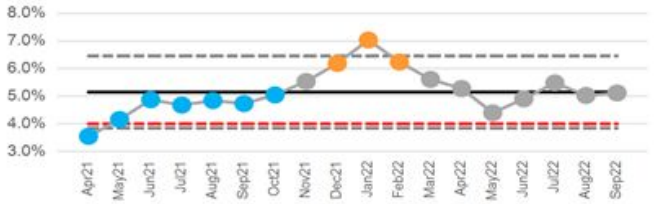
Metric ID	Metric Name	Target (Cumulat	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
RI22	Publications	Green >200 per year Amber 170-200 Red <170	CCC Strategy		23	29	17	23	9	12	10	15	16	15	16	18		
			Narrative	The target has been achieved. Performance is within normal variation and the nature of variation indicates that achievement of the target is likely to be inconsistent.														

Integrated Performance Report (Oct 21 - Sept 22)

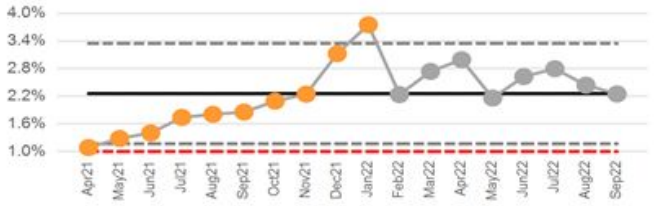
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
WO01	Sickness Absence	Green ≤4% Amber 4.1 - 4.9% Red ≥5%	Contractual / Statutory		5.1%	5.5%	6.2%	7.0%	6.2%	5.6%	5.3%	4.4%	4.9%	5.5%	5.0%	5.1%		
			Narrative	The target has not been achieved. Performance remains within the expected range (and therefore no exception report is provided against this internally created target figure), however the nature of variation indicates that achievement of the target is likely to be inconsistent.														



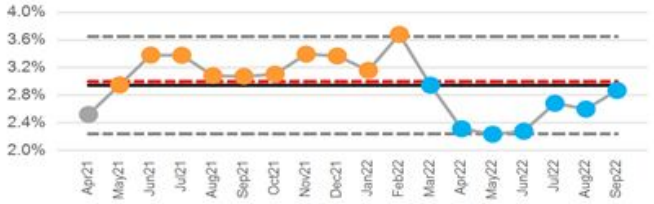
Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
WO20	Sickness Absence (Short Term)	Green ≤1% Amber 1.1 - 1.2% Red ≥1.3%	Contractual / Statutory		2.1%	2.2%	3.1%	3.8%	2.2%	2.7%	3.0%	2.2%	2.6%	2.8%	2.4%	2.3%		
			Narrative	The target has not been achieved. Although there is no significant change, the target is unlikely to be achieved without a significant change and an exception report is therefore provided.														



Reason for Non-Compliance	Action Taken to Improve Compliance
Following a decrease in the previous month, short term sickness has increased marginally from 2.25% in August to 2.3% in September 2022. There has been a total of 199 short term sickness absences across the Trust in September and the top three reasons for sickness are as followed; • Chest and Respiratory- 34 episodes of which 25 were Covid-19 related. A decrease from the August position. • Cold, cough and flu- 33 episodes in month and is likely to continue to increase as we move into winter. • Gastrointestinal problems- 30 episodes in month. Work is ongoing with teams and IPC to address any contributing factors to the high levels of gastrointestinal issues in the Trust	• HRBP team to continue to review any open sickness absences relating to Anxiety/Stress/Depression related absences across the divisions (as the month of September has seen a significant increase), to see if there are any trends/patterns. • HRBP team to continue to prompt line managers to record whether absences relating to Anxiety/stress/depression is work related or not, to provide further information for analysis as this information remains missing for majority of the absences. • HRBP team to remind line managers during HR surgeries/catch ups to encourage their staff to receive their flu vaccinations to try to prevent sickness absence relating to cough/cold/flu to try and prevent a continuous increase in these absences in the upcoming months. • HRBP team to review during HR surgeries whether the increase in short term sickness is in relation to vaccinations.

Escalation Route & Expected Date of Compliance
Divisional Meetings, Performance Review Meetings, Workforce Advisory Committee, People Committee, Trust Board January 2023

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
WO21	Sickness Absence (Long Term)	Green ≤3% Amber 3.1 - 3.5% Red ≥3.5%	Contractual / Statutory		3.1%	3.4%	3.4%	3.2%	3.7%	2.9%	2.3%	2.2%	2.3%	2.7%	2.6%	2.9%		
			Narrative	The target has been achieved. Performance is better than expected although the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Integrated Performance Report (Oct 21 - Sept 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

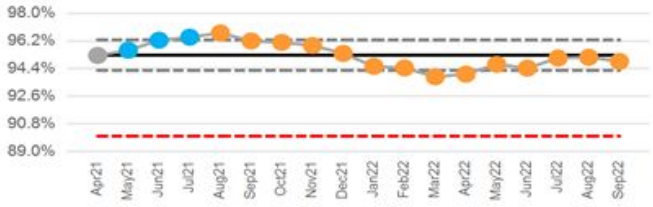
Workforce

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
WO02	% Turnover (Rolling 12 Months)	Green ≤15% Amber 14.1%-14.9% Red ≥14%			16.6%	16.9%	16.7%	16.9%	16.5%	16.6%	17.0%	17.0%	17.2%	16.9%	16.7%	16.3%		
			Narrative	The target has not been achieved and an exception report is provided. Although performance is now within expected ranges, the nature of variation indicates that the target is unlikely to be achieved without a significant change.														

Reason for Non-Compliance	Action Taken to Improve Compliance
Excluding end of fixed term contracts and retirement, our rolling 12 month turnover position is 14.2% which is only slightly above the Trust target The number of leavers for September 2022 was 23, with the majority being from Networked Services. 5 leavers left due to 'Voluntary resignation- Lack of opportunities'. Exit interview data suggests a lack of career progression and roles not fully meeting expectations. Of the 5 leavers, 3 staff have taken up positions in another NHS Trust (x1 Liverpool University Hospital, x1 Wirral University Teaching Hospital and x1 Bridgewater Community Healthcare). 5 leavers left due to 'Voluntary resignation- Promotion'. Out of the 5 leavers, x2 had a new position at Liverpool University Hospital, x1 Wirral Community Health & Care and x2 did not state the organisation. 3 individuals left the Trust due to retirement. 22% of all leavers took up the offer of an exit interview and data is being reviewed and fed back accordingly to relevant areas. 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: • Strained work relationships • Commute to CCC-L • Lack of support from senior management. • Relocation	• The HRBP Team will be reviewing and reporting turnover within the three clinical divisions on a quarterly basis to identify trends across staff groups, age groups etc. which will support with developing a feedback process and hopefully see an improvement in turnover going forward. • The HRBP to review whether there is a particular reason why staff feel there is a lack of career progression at CCC via conversations in HR surgeries and to see what other Trusts such as Liverpool University Hospitals NHS FT offer, in light of CCC staff moving there. • HRBP Team to work with line managers during HR Surgeries to ensure that they are recording the correct reason due to the most appropriate reason not being utilised when staff leave as this remains as an issue. Training for line managers may be required if this continues to be a concern.

Escalation Route & Expected Date of Compliance
Divisional Meetings, Performance Review Meetings, Workforce Advisory Committee, People Committee, Trust Board January 2023

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
WO07	Statutory Mandatory Training Compliance	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual / Statutory		96.1%	95.9%	95.4%	94.6%	94.4%	93.9%	94.0%	94.7%	94.4%	95.1%	95.1%	94.9%		
				Narrative	The target has been achieved. Although performance is lower than expected, the target remains outside SPC limits and is therefore likely to be achieved consistently. An exception report is therefore not provided, in light of this assurance. Course compliance is monitored at Divisional Performance Review Groups.														

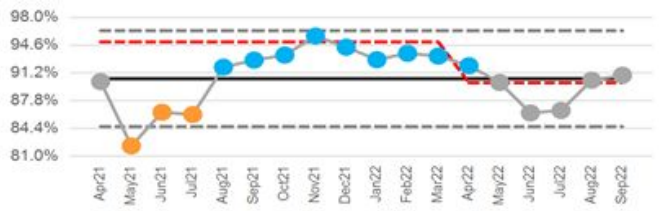


Integrated Performance Report (Oct 21 - Sept 22)

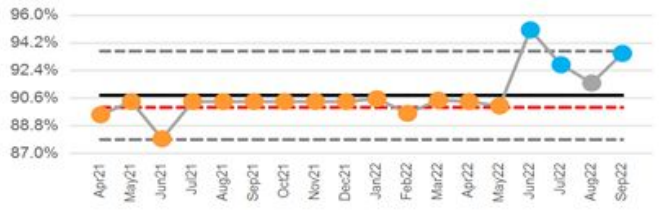
NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
WO22	Performance Development Reviews (PADR) Snapshot Month End	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual		93.4%	95.7%	94.4%	92.8%	93.6%	93.3%	92.1%	90.0%	86.3%	86.6%	90.3%	90.9%		
			Narrative	The target has been achieved. 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	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
WO23	Medical Appraisal	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual / Statutory		90.4%	90.4%	90.4%	90.6%	89.6%	90.5%	90.4%	90.1%	95.0%	92.8%	91.6%	93.5%		
			Narrative	The target has been achieved. Performance is better than expected although the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
WO24	Pulse Staff Survey: Employee Engagement Score	To Be Confirmed	Contractual		-	-	-	-	-	7.00	-	-	6.90	-	-	7.20		
			Narrative	CCC are performing better than the national average in this category. Targets are in development.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
WO25	Pulse Staff Survey: Advocacy Score	To Be Confirmed	Contractual		-	-	-	-	-	7.40	-	-	7.10	-	-	7.60		
			Narrative	CCC are performing better than the national average in this category. Targets are in development.														

Data Not Applicable for SPC

Integrated Performance Report (Oct 21 - Sept 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
WO26	Pulse Staff Survey: Involvement Score	To Be Confirmed	Contractual		-	-	-	-	-	6.80	-	-	6.80	-	-	6.90		
			Narrative	CCC are performing better than the national average in this category. Targets are in development.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Target Type	Year & Month	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	V	A
WO27	Pulse Staff Survey: Motivation Score	To Be Confirmed	Contractual		-	-	-	-	-	6.80	-	-	6.90	-	-	6.70		
			Narrative	CCC are performing better than the national average in this category. Targets are in development.														

Data Not Applicable for SPC

Integrated Performance Report (Oct 21 - Sept 22)

The Clatterbridge Cancer Centre NHS Foundation Trust

Finance

Metric (£000)	In Mth 6 Actual	In Mth 6 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	141	135	6		837	811	26	
CPL/Propcare Surplus/ (Deficit)	85	0	85		598	0	598	
Control Total Surplus/ (Deficit)	226	135	91		1,435	811	624	
Trust Cash holding	68,523	54,293	14,230		68,523	54,293	14,230	
Capital Expenditure	496	783	287		659	833	174	
Agency Cap	155	95	(60)		782	570	(212)	

For 2022/23 NHS Cheshire & Merseyside ICB are managing the required financial position of each Trust through a whole system approach. The Trust submitted a plan to NHSE/I showing a £1.621m surplus for 2022/23. The Trust position is reliant upon receiving Elective Recovery Funding (ERF) of £9m for activity over and above 104% of 2019/20 to achieve the plan.

The Trust financial position to the end of September is a £837k surplus, which is £26k above plan. The group position to the end of September is a £1.435m surplus. The Trust cash position is a closing balance of £68.5m, which is £14.2m above plan. Capital spend is currently reporting below plan with the majority of spend expected in the second half of the year.

The Trust is over the agency cap in September by £60k and £212k year to date. Further controls have been put in place by NHSE/I to monitor agency spend and the Divisions have provided exit strategies for all agency spend, these will be monitored regularly throughout the year. Further detail has been provided above.

Trust Board (P1-186-22)
26th October 2022

Report author	James Thomson, Director of Finance					
Paper prepared by	Jo Bowden, Deputy Director of Finance					
Report subject/title	Finance Report – Month 6 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		

1. Introduction

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

Metric (£000)	In Mth 6 Actual	In Mth 6 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	141	135	6		837	811	26	
CPL/Propcare Surplus/ (Deficit)	85	0	85		598	0	598	
Control Total Surplus/ (Deficit)	226	135	91		1,435	811	624	
Trust Cash holding	68,523	54,293	14,230		68,523	54,293	14,230	
Capital Expenditure	496	783	287		659	833	174	
Agency Cap	155	95	(60)		782	570	(212)	

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 a plan to NHSE/I showing a £1.621m surplus for 2022/23. The Trust position is reliant upon receiving Elective Recovery Funding (ERF) of £9m for activity over and above 104% of 2019/20 to achieve the plan.

3. Operational Financial Profile – Income and Expenditure

Overall Income and Expenditure Position

3.1 The Trust financial position to the end of September is a £837k surplus, which is £26k above plan. The group position to the end of September is a £1.435m surplus. The Trust cash position is a closing balance of £68.5m, which is £14.2m above plan. Capital spend is currently reporting below plan with the majority of spend expected in the second half of the year.

3.2 The Trust is over the agency cap in September by £60k and £212k year to date. Further controls have been put in place by NHSE/I to monitor agency spend and the Divisions have provided exit strategies for all agency spend, these will be monitored regularly throughout the year. Further detail has been provided below.

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

Metric (£000)	Actual M6	Trust Plan M6	Variance	Actual YTD	Trust Plan YTD	YTD Variance	Trust Annual Plan
Clinical Income	19,587	19,328	259	114,366	113,664	702	226,597
Other Income	1,811	2,210	(399)	11,343	12,981	(1,639)	24,561
Total Operating Income	**21,398**	**21,538**	**(140)**	**125,709**	**126,645**	**(936)**	**251,159**
Total Operating Expenditure	(21,011)	(21,056)	45	(123,174)	(123,754)	581	(245,378)
Operating Surplus	**387**	**482**	**(94)**	**2,535**	**2,891**	**(355)**	**5,781**
PPJV	65	67	(2)	383	402	(19)	804
Finance Costs	(311)	(414)	102	(2,081)	(2,482)	401	(4,964)
Trust Surplus/Deficit	**141**	**135**	**6**	**837**	**811**	**26**	**1,621**
Subsiduaries	85	0	85	598	0	598	**0**
Consolidated Surplus/Deficit	**226**	**135**	**91**	**1,435**	**811**	**624**	**1,621**

The table below summaries the consolidated financial position:

September 2023 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	59	346
Donated Depreciation	82	490
Trust Retained Surplus / (Deficit)	**141**	**837**
CPL	42	300
Propcare	43	298
Consolidated Financial Position	**226**	**1,435**

3.4 The bridge below shows the key drivers between the £141k in month surplus and £135k surplus plan, which is a variance of £6k:

- Elective Recovery Fund (ERF) income for activity over 104% of 2019/20 has been assumed at 25% of plan for month 6 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.

- Cost and Volume Drugs are overspent by £96k and are offset by an over recovery of income. As part of the 2022/23 funding agreement with commissioners high cost drugs remain on a pass-through basis. Block drugs are £122k under spend in month 6.

- Pay costs are underspent by £272k, however, £235k of this relates to the cumulative reprofiing of CIP targets between pay and non pay to ensure they align more appropriately with schemes. The remaining £37k underspend is consistent with previous months. While the Trust has a number of vacancies the gap is being covered with bank and agency spend.

- Month 6 pay costs includes the backdated pay award. The Trust was initially funded for an element of pay award as part of agreed plan, then received an additional 1.66% in September. The funding received was via a national calcuation with the expectation that it would fully cover the cost of the pay award. The Trust have costed the pay award and on the basis of current staff in post the funding is sufficient, however it does not fully fund all established posts, giving £170k annual pressure.

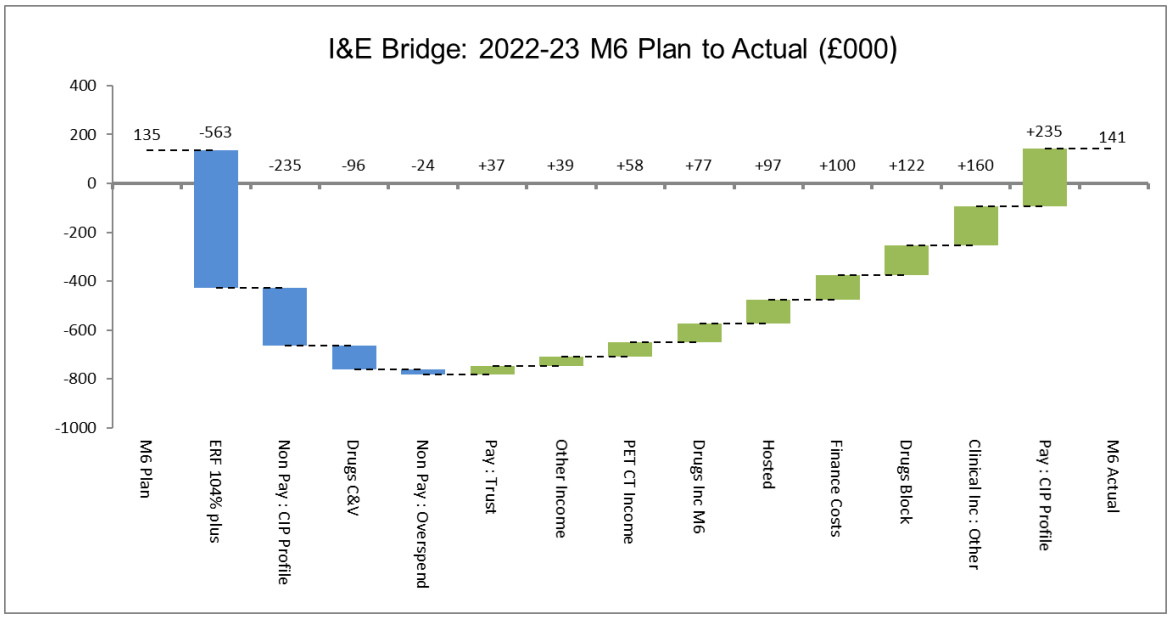
- Bank spend remains high at £140k, however, has shown a slight decrease from last month. Bank usage is mainly due to vacancies and sickness cover on the wards. There has a been a specific issue on ward 4 where 1 to 1 care has been required during both August and September.

- Agency spend is £154k in month. This is significantly above the £95k agency cap and is being monitored through the workforce establishment control panel and Finance Committee.

- Non pay is overspent by £37k. The Trust continue to make a risk provision for the LUFT SLA and energy, which is £148k in month. This is not causing a significant overspend in non pay due to the improvement in the non-pay CIP position

- Interest receivable is above plan by £86k in month, an element of this relates to increasing interest rates.

- Other income includes £58k for additional PET CT activity which is expected to continue.



3.5 Elective Recovery Fund Position

The CCG and NHSE Contracts include an element of block income block for Elective Recovery activity up to 104% of 2019/20 activity level. We will receive £701k from CCGs and £3.1m from NHSE if the Trust achieve this level of activity. For month 6 reporting the Trust has assumed receipt of the ERF income up to 104% of activity.

For activity over and above 104% of 2019/20 the Trust will receive additional income at 75% of tariff. Based on predicted activity levels and assumptions around the calculation the Trust have assumed a further £9m expected ERF Income as part of the financial plan. This is consistent with the annual activity assumptions.

The plan for the ERF over 104% is £751k per month. The Trust has assumed 25% of this in the month 6 position to achieve the planned year to date surplus. To date the Trust has included £1.1m of ERF income over 104%. The Trust is currently reviewing the ERF methodology and process with NHS England Specialised Commissioning to ensure that cancer pathway activity is appropriately recognised.

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

3.6 Bank and Agency Reporting

Bank spend in September remains high at £140k. The largest user of bank staff is the Acute Division. The main reasons for bank spend is to cover vacancies and increased sickness, there has also been a requirement for additional 1 to 1 care being required for two patients on the wards.

Agency spend is £154k in month. Whilst this is a slight reduction compared to previous months, the Trust is currently reporting above the 2019/20 agency cap of £95k per month by £60k in month 6 and £212k year to date.

Although the Trust is working to reduce its agency spend, it has at the same time opened 10 mutual aid beds to support LUHT's move into the new hospital given the reduced bed capacity in the new hospital and added an additional 5 ambulatory chairs. Agency staff which were originally planned to finish are being used to partly staff this additional bed base, in addition some pharmacy resource originally planned has been extended to support these additional beds. The increased spend relating to support is being highlighted to the ICS as part of the monthly reporting process.

Agency spend is split across 2 Divisions. Within Acute Care the areas of spend are Medical £35k, Healthcare Scientists £40k and Nursing £18k. Whilst the Directorates would usually use NHSP for Nursing, the Trust 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. Within Radiation Services spend is £61k, of which £15k relates to August and £46 September, this is due to PET CT locums for reporting due to increased activity and ultra-sonographer long term sickness.

See Appendix F for further detail.

3.7 **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

Against the full year CIP target of £6.7m, £5.8m of schemes have been identified (87%). £1.5m have been identified recurrently against the £4.4m recurrent target (34%).

Divisions are developing a number of recurrent opportunities that are currently being worked through and savings likely to be realised in future months. There are currently £0.5m of opportunities and plans in progress that are being worked up not included in the figures above.

4. Cash and Capital

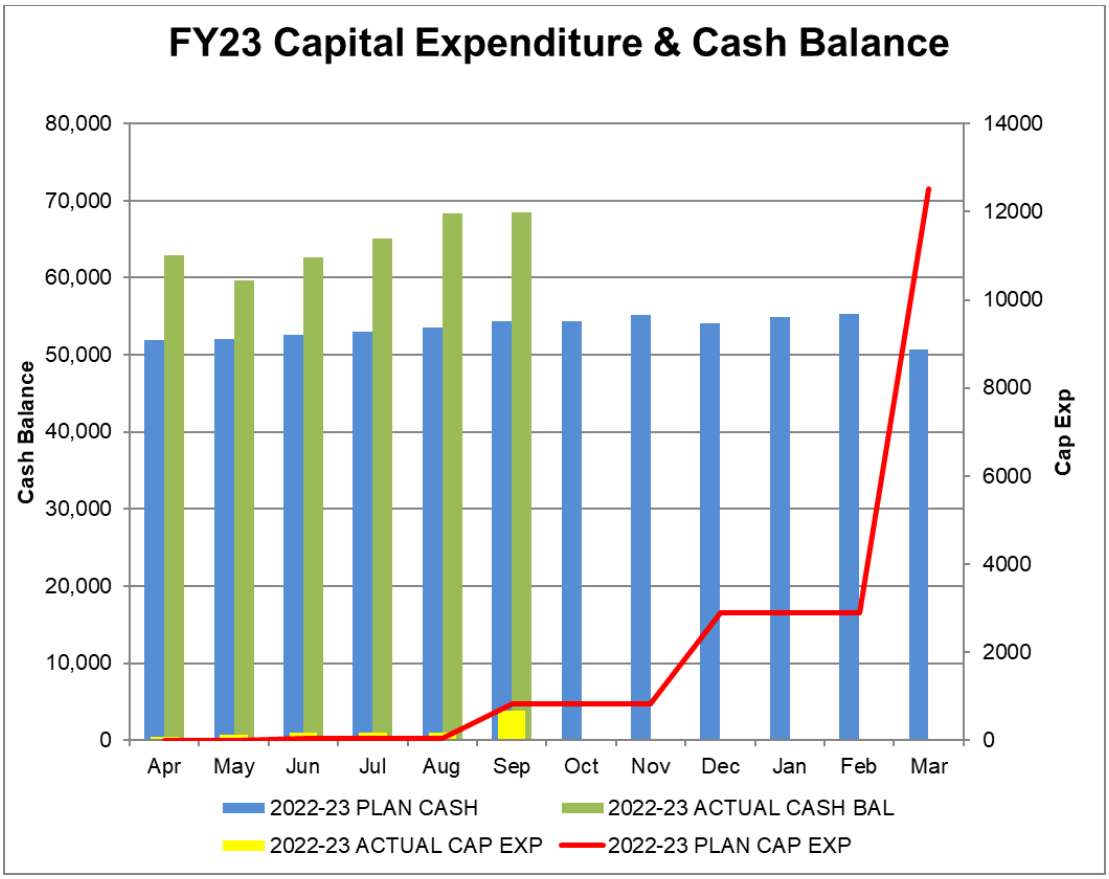
4.1 The 2022/23 capital plan approved by the Board in March was £7.013m. Since this national PDC funding of £5.5m have been approved to support the CDC facility. We have however agreed with Wirral University Teaching Hospital NHS FT that they will lead the CDC capital

programme and that the PDC will be transferred to them, this has not yet been transacted by the ICS.

4.2 Capital expenditure of £659k has been incurred to the end of September. 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 £68.5m, which is a positive variance of £14.2m 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.

5. Balance Sheet Commentary

5.1 Current Assets

The Trust's cash balance at the end of September is £68.5m, this is £14.2m above plan figure of £54.3m and is due to two main reasons. There is £8m in deferred income and around £7m for capital funds not yet spent.

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

5.2 Current Liabilities

Payables (non-capital creditors) are £1.0m below plan.

Deferred Income is £8.0m above plan. This relates in the main to R&I income and Cancer Alliance both of which have a number of multi-year schemes which are ongoing.

6. Recommendations

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

- The reported surplus position for September 2022
- The risk regarding ERF and the efficiency programme
- The increasing agency spend and the work being undertaken to manage this position
- The continuing strong liquidity position of the Trust

Appendix A – Statement of Comprehensive Income (SOCI)

(£000)	Month 6			Cumulative YTD			2022-2023	
	Plan	Actual	Variance	Plan	Actual	Variance	%	Annual Plan
Clinical Income	19,604	19,278	(326)	112,513	113,176	663		225,022
Other Income	782	879	**97**	4,386	5,109	724		8,846
Hosted Services	1,153	1,242	89	9,747	7,424	(2,323)		17,290
Total Operating Income	**21,538**	**21,398**	**(140)**	**126,645**	**125,709**	**(936)**	**1%**	**251,159**
Pay: Trust (excluding Hosted)	(7,482)	(7,210)	272	(38,810)	(38,058)	751		(77,919)
Pay: Hosted	(1,015)	(794)	221	(4,880)	(4,098)	781		(9,602)
Drugs expenditure	(7,694)	(7,669)	26	(46,165)	(47,259)	(1,094)		(92,330)
Other non-pay: Trust (excluding Hosted)	(4,540)	(4,799)	(259)	(28,706)	(30,342)	(1,636)		(57,180)
Non-pay: Hosted	(325)	(538)	(213)	(5,194)	(3,416)	1,778		(8,346)
Total Operating Expenditure	**(21,056)**	**(21,011)**	**45**	**(123,754)**	**(123,174)**	**580**	**0%**	**(245,378)**
Operating Surplus	**482**	**387**	**(94)**	**2,891**	**2,535**	**(356)**	**12%**	**5,781**
Profit /(Loss) from Joint Venture	67	65	(2)	402	383	(19)		804
Interest receivable (+)	386	472	86	2,313	2,620	307		4,626
Interest payable (-)	(434)	(429)	5	(2,607)	(2,577)	30		(5,213)
PDC Dividends payable (-)	(365)	(354)	11	(2,189)	(2,124)	65		(4,377)
Trust Retained surplus/(deficit)	**135**	**141**	**6**	**811**	**837**	**26**	**3%**	**1,621**
CPL/Propcare	0	85	85	0	598	598		0
Consolidated Surplus/(deficit)	**135**	**226**	**91**	**811**	**1,435**	**624**	**77%**	**1,621**

Appendix B – Balance Sheet

£'000	Audited 2022 (Group Ex Charity)	Plan 2023 (Trust only)	Year to date Month 6		
			YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	3,211	3,162	2,693	2,884	192
Property, plant & equipment	184,599	173,627	174,356	180,521	6,165
Investments in associates	977	800	800	1,360	560
Other financial assets	0	115,276	0	0	0
Trade & other receivables	449	434	433	567	134
Other assets	0	0	0	0	0
Total non-current assets	**189,236**	**293,298**	**296,990**	**185,332**	**(111,658)**
Current assets					
Inventories	5,640	3,000	2,459	3,711	1,253
Trade & other receivables					
NHS receivables	7,749	7,084	6,882	4,456	(2,427)
Non-NHS receivables	6,278	10,915	10,603	6,945	(3,658)
Cash and cash equivalents	80,726	50,708	53,041	77,071	24,030
Total current assets	**100,393**	**71,707**	**72,985**	**92,183**	**19,198**
Current liabilities					
Trade & other payables					
Non-capital creditors	6,918	32,207	32,697	31,646	(1,051)
Capital creditors	36,547	1,958	1,987	1,520	(467)
Borrowings					
Loans	1,908	1,730	1,730	1,905	175
Obligations under finance leases		0	0	0	0
Provisions	4,214	94	99	4,257	4,158
Other liabilities:-					
Deferred income	15,669	5,577	5,504	13,855	8,351
Other	0	0	0	0	0
Total current liabilities	**65,255**	**41,565**	**42,017**	**53,182**	**11,165**
Total assets less current liabilities	**224,374**	**323,440**	**327,958**	**224,333**	**(103,625)**
Non-current liabilities					
Trade & other payables					
Capital creditors	120	0	0	0	0
Borrowings					
Loans	32,090	30,360	31,350	31,225	(125)
Obligations under finance leases	0	0	0		0
Other liabilities:-					
Deferred income	0	1,018	(0)	0	0
Provisions	197	115	527	197	(330)
PropCare liability	(1)	113,436	(776)	(1)	775
Total non current liabilities	**32,406**	**144,929**	**149,810**	**31,421**	**319**
Total net assets employed	**191,968**	**178,511**	**178,148**	**192,913**	**14,765**
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	103,230	116,137	12,906
Total taxpayers equity	**191,968**	**178,511**	**178,148**	**192,913**	**14,765**

Appendix C – Cash Flow

September 2022 (M6) £'000	FT	Group	Group (exc Charity)
Cash flows from operating activities:			
Operating surplus	2,036	3,890	2,825
Depreciation	4,700	4,700	4,700
Amortisation	363	363	363
Impairments	0	0	0
Movement in Trade Receivables	2,478	2,648	2,508
Movement in Other Assets	1,701		
Movement in Inventories	1,818	1,929	1,929
Movement in Trade Payables	(10,410)	(5,217)	(5,062)
Movement in Other Liabilities	(1,814)	(1,814)	(1,814)
Movement in Provisions	0	43	43
CT paid	0	(35)	(35)
Net cash used in operating activities	**872**	**6,507**	**5,458**
Cash flows from investing activities			
Purchase of PPE	(6,073)	(6,140)	(6,140)
Purchase of Intangibles	(37)	(37)	(37)
Proceeds from sale of PPE	9	9	9
Interest received	2,620	343	326
Investment in associates	(0)	(0)	(0)
Net cash used in investing activities	**(3,481)**	**(5,825)**	**(5,842)**
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	(868)	(864)	(864)
Capital element of finance lease	0	0	0
Interest paid	(2,577)	(283)	(283)
Interest element of finance lease			
PDC dividend paid	(2,124)	(2,124)	(2,124)
Finance lease - capital element repaid	0	0	0
Net cash used in financing activities	**(5,569)**	**(3,271)**	**(3,271)**
Net change in cash	**(8,178)**	**(2,589)**	**(3,655)**
Cash b/f	**76,701**	**82,815**	**80,726**
Cash c/f	**68,523**	**80,225**	**77,071**

Appendix D – Capital

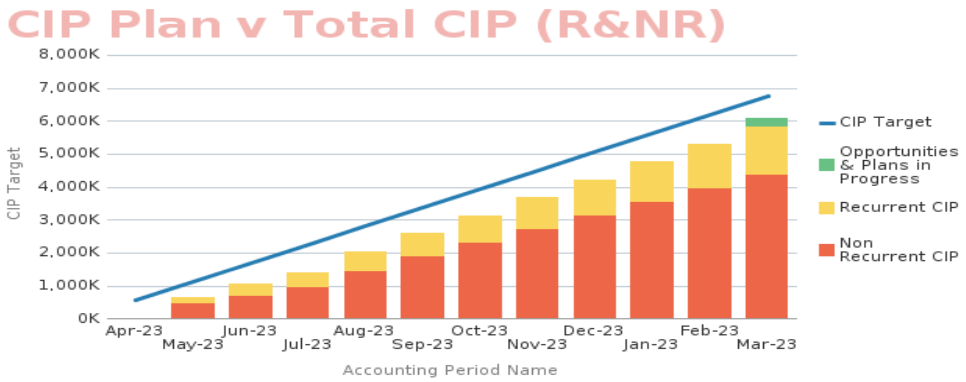
Capital Programme 2022-23
Month 6

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Code	Scheme	Lead	BUDGET (£'000) NHSI plan 22-23	Approved Adjustments	Budget 22-23	ACTUALS (£'000) Actuals @ Month 6	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	7	(7)	7	(7)			
4300	***(21/22)*** CCCW CT Simulator (Brilliance 2)	Louise Bunby	0	0	0	0	(0)	0	(0)			
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	67	(7)	69	(9)	✓	✗	£59,804 approved charity funding
4313	***(21/22)*** CCCL Terraces		0	0	0	15	(15)	15	(15)	✓	✓	Additional cost on prior year scheme
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
4407	CCC-A Cherry linac replacement		160	0	160	0	160	160	0	✗	✗	Awaiting revised forecast
	Major roofing works	Peter Crangle	500	0	500	0	500	500	0	✗	✗	Awaiting revised forecast
	6 Facet lifecycle	Peter Crangle	533	0	533	0	533	533	0	✗	✗	Awaiting revised forecast
	Contingency	*n/a*	200	(32)	168	0	168	133	35	-	-	
	Estates		**1,393**	**60**	**1,453**	**93**	**1,359**	**1,453**	**0**			
4180	***(19/20)*** CCCL HDR & Papillon tfr costs		0	0	0	11	(11)	11	(11)	✓	✓	Awaiting clarification
4189	***(19/20)*** Draeger IACS Monitoring C700		0	0	0	(2)	2	(2)	2	✓	✓	Refund received due to overcharge
4192	***(19/20)*** Cyclotron	Carl Rowbottom	450	0	450	111	339	450	0	✓	✗	
4303	***(20/21)*** CCCA Linear Accelerator - Maple		0	0	0	0	(0)	0	(0)	✓	✓	
4331	***(21/22)*** Donated Scalp Cooler - Wirral		0	(2)	(2)	(2)	0	(2)	0	✓	✓	VAT recovery on charitably funded asset
4332	***(21/22)*** Donated Scalp Cooler - Halton		0	(2)	(2)	(2)	0	(2)	0	✓	✓	VAT recovery on charitably funded asset
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	✗	✗	Likely to be delayed to 23/24
4404	HDR Brachytherapy equip (Applicators)	Chris Lee	110	24	134	134	0	134	0	✓	✗	Approved at CIG 26th July
	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
4402	Moving and Handling Training Equipment	Kate Greaves	0	29	29	14	15	29	0	✓	✗	Approved at Finance Committee 8th July
4406	CAMRIN Ultrasound (PDC funded) CCC-L	Julie Massey	0	80	80	0	80	80	0	✗	✗	Approved at CIG 26th July
	RFID Asset Tracking System	Julie Massey	0	200	200	0	200	200	0	✗	✗	Approved at TEG 3rd October
	Contingency	*n/a*	400	(313)	87	0	87	57	30	-	-	
	Medical Equipment		**3,920**	**76**	**3,996**	**276**	**3,720**	**3,996**	**0**			
4138	***(21/22)*** Infrastructure	James Crowther	0	0	0	70	(70)	70	(70)	✓	✓	
4190	***(20/21)*** Digital Aspirant Programme	James Crowther	0	0	0	16	(16)	16	(16)	✓	✓	
4316	***(21/22)*** Digital Diagnostics Capability Prg	James Crowther	0	0	0	(35)	35	(35)	35	✓	✓	VAT review on prior year invoices
4317	***(21/22)*** Intelligent Automation (RPA)	James Crowther	0	0	0	(0)	0	(0)	0	✓	✓	
4320	***(21/22)*** Digital Infrastructure	James Crowther	0	0	0	(129)	129	(129)	129	✓	✓	VAT review on prior year invoices
4403	Server/Citrix/Cyber upgrade	James Crowther	360	0	360	368	(8)	368	(8)	✓	✗	Revised IT plan approved Sept CIG
4408	Sharepoint	James Crowther	0	360	360	0	360	360	0	✗	✗	Revised IT plan approved Sept CIG
4409	VDI expansion	James Crowther	455	135	590	0	590	590	0	✗	✗	Revised IT plan approved Sept CIG
4410	Digital Transformation & Optimisation	James Crowther	0	175	175	0	175	175	0	✗	✗	Revised IT plan approved Sept CIG
4411	Windows Upgrade	James Crowther	0	49	49	0	49	49	0	✗	✗	Revised IT plan approved Sept CIG
4412	Security Hardening	James Crowther	0	170	170	0	170	170	0	✗	✗	Revised IT plan approved Sept CIG
4413	Structured Cabling	James Crowther	0	10	10	0	10	10	0	✗	✗	Revised IT plan approved Sept CIG
	Core IT programme	James Crowther	785	(785)	0	0	0	0	0	✗	✗	Revised IT plan approved Sept CIG
4405	Website	Emer Scott	100	0	100	0	100	100	0	✗	✗	Business case approved by TEG
	Contingency	*n/a*	0	(114)	(114)	0	(114)	(44)	(70)	-	-	
	IM&T		**1,700**	**0**	**1,700**	**290**	**1,410**	**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**	**185**	**12,698**	**659**	**12,039**	**12,698**	**0**			

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix E – CIP



Divisional CIP Against Full Year Plan

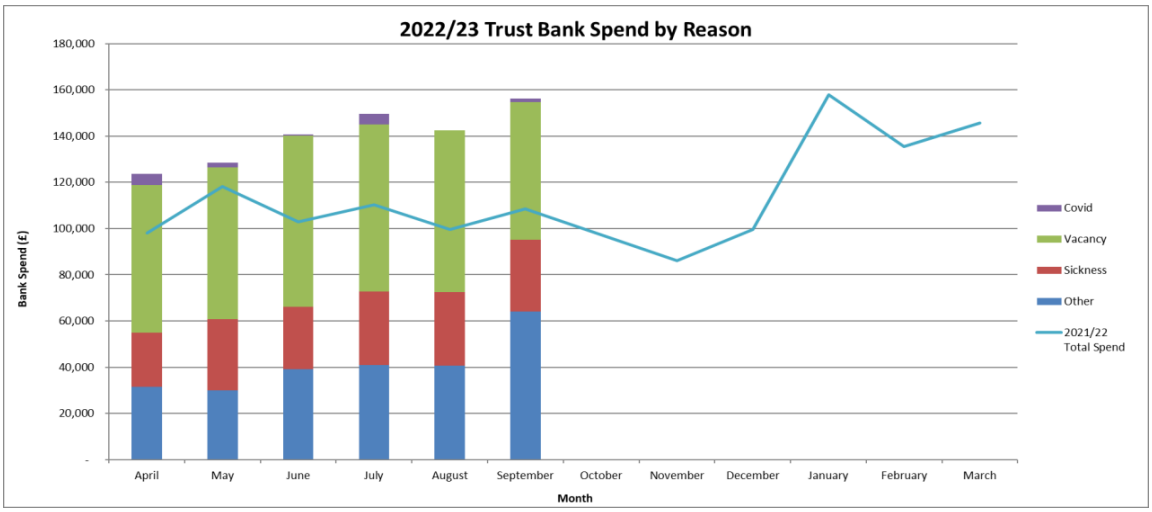
Division	Target	Total CIP	Recurrent CIP	Shortfall/Over Recovery	Delivery % to date
CENTRAL CIP	3,300,000	3,925,793	1,175,259	625,793	119%
NETWORKED SERVICES	1,096,368	767,041	109,536	(329,327)	70%
ACUTE CARE	877,743	625,376	34,376	(252,367)	71%
RADIATION SERVICES	880,168	378,425	88,718	(501,743)	43%
CORPORATE	610,721	129,538	72,564	(481,183)	21%
Total	**6,765,000**	**5,826,173**	**1,480,453**	**(938,827)**	

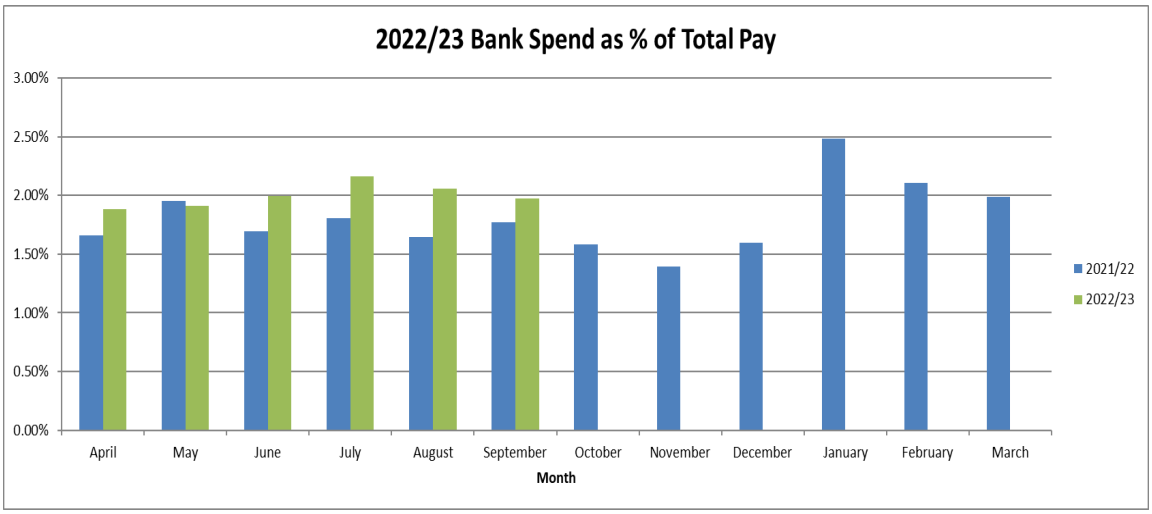
Full Year Plan (Recurrent & Non-Recurrent Split)

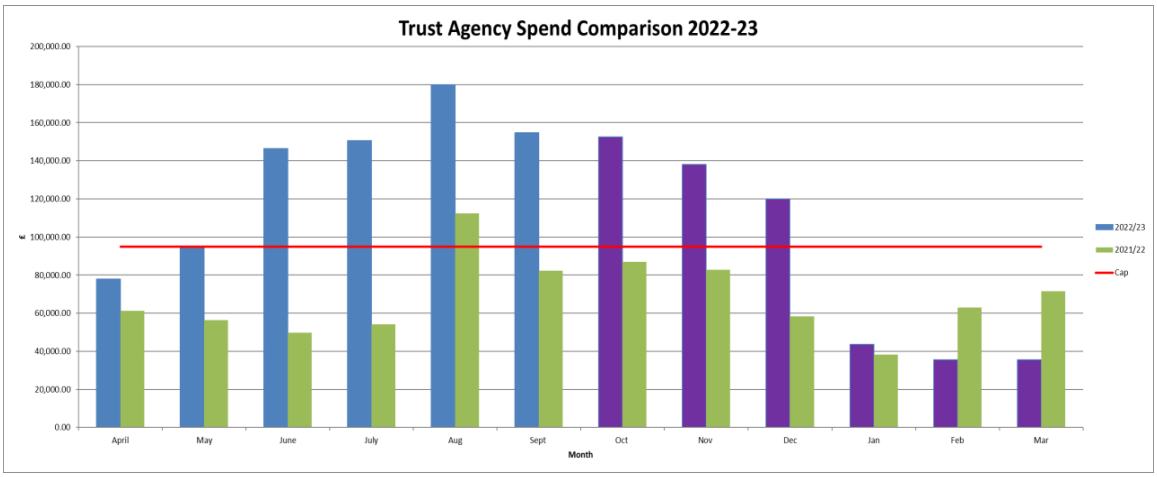
Recurrent	4,465,000	1,480,453	1,480,453	(2,984,547)	33%
Non-Recurrent	2,300,000	4,345,720	0	2,045,720	189%
Total	**6,765,000**	**5,826,173**	**1,480,453**	**(938,827)**	

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix F – Bank and Agency







*agency graph does not include forecast for escalation beds

The Clatterbridge Cancer Centre
NHS Foundation Trust

Operating Framework for NHS England

Trust Board Part 1

P1-187-22

26th October 2022

The Clatterbridge Cancer Centre NHS Foundation Trust

NHSE Operating Framework - Introduction

On 12th October, Mark Cubbon, Chief Delivery Officer for NHS England wrote to Chairs and Chief Executives to announce the new Operating Framework for NHS England.

The guidance sets out how the NHS will operate in the new structures created by the 2022 Health and Social Care Act.

The Act formally established ICSs on a statutory basis, enabling local systems to plan and deliver health and care services more effectively. The new operating framework sets out the roles that NHS England, ICSs and providers will now play in the new structure. It describes how we would like to work together and shows how accountabilities and responsibilities will work.

Document link: B2068-NHS-England-Operating-Framework.pdf

The Clatterbridge Cancer Centre NHS Foundation Trust

Operating Framework - Definition

"How we do things around here"

Four Core Foundations

1. Purpose
2. Areas of value
3. Leadership behaviours
4. Priorities and aims

Why do we need to change?

1. Work and behave differently following establishment of ICS in the new statutory framework
2. Proposals to bring together NHS England, Helath Education England and NHS Digital

The Clatterbridge Cancer Centre NHS Foundation Trust

Operating Framework - Purpose

"To lead the NHS in England to deliver high-quality services for all"

- Enabling local systems and providers to improve the health of their people and patients and reduce health inequalities
- Making the NHS a great place to work, where people can make a difference and achieve their potential
- Working collaboratively to ensure the healthcare workforce has the right knowledge, skills, values and behaviours to deliver accessible, compassionate care
- Optimising the use of digital technology, research and innovation, and delivering value for money

Operating Framework – Adding Value

NHSE will focus its activities around eight key areas where it is uniquely placed to add value

1. Setting direction
2. Allocating resources
3. Ensuring accountability
4. Supporting and developing people
5. Mobilising expert networks
6. Enabling improvement
7. Delivering services
8. Driving transformation

The Clatterbridge Cancer Centre NHS Foundation Trust

Operating Framework - Providers

NHS Providers will:

- Retain their statutory responsibilities for the delivery of safe, effective, efficient, high-quality services
- Continue to comply with the provider licence, Care Quality Commission (CQC) standards and NHS planning guidance requirements
- Contribute to effective system working via ICS strategies and plans
- Remain accountable to people, communities, services users, board of governors and ICS partners
- Be accountable to ICBs for 'business as usual' delivery of services and performance, and for their agreed contribution to the system strategy and plan
- Be accountable to NHSE as regulator by escalation/ exception or agreement with ICB
- Deliver some of these accountabilities with the support of provider collaboratives

The Clatterbridge Cancer Centre NHS Foundation Trust

Operating Framework – NHSE and ICB

Oversight responsibilities are:

ICB

- System leadership and delivery
- Commission and manage contracts
- Oversee system budgets
- Accountable to NHSE Regional Directors
- Oversee performance

NHSE

- Agree the mandate with HM Government
- Shape and set national policy for delivery
- Remain accountable to Parliament via the Secretary of State
- Oversee ICB delivery
- Lead on support for organisations in SOF 3 and 4

Title of meeting: Trust Board
Date of meeting: 26 October 2022

Report author	Claire Smith/Nikki Heazell				
Paper prepared by: In attendance at the visit	Claire Smith/Nikki Heazell Non-Executive Director – Kathy Doran Staff Governor – Jane Wilkinson Quality Improvement Manager – Claire Smith				
Report subject/title	NED and Governor Engagement Walk-round September 2022				
Purpose of paper	The purpose of this report is to provide Trust Board with oversight and a summary of the NED & Governor Patient Experience visit conducted on the 14th September 2022 at CCCA, Radiology Department.				
Background papers	n/a				
Action required	To approve content/preferred option/recommendations To discuss and note content To be assured of content and actions				 x
Link to: Strategic Direction Corporate Objectives	Be Outstanding	x	Be a great place to work	x	
	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		

Division	Radiation Services	Location	CCCA; Radiotherapy	Date	14/09/2022
In attendance - Panel			In attendance – Patient & Staff		
Governor	Jane Wilkinson		Senior Manager facilitating the walk round		Joanna Hughes Craig McGettrick
Non Executive	Kathy Doran		Number of Patients		3
Patient Experience Team	Nikki Heazell Claire Smith		Number of Staff		2

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:

Three patients were interviewed during the visit, all of whom stated how amazing the staff are at CCCA and praised their positive attitude and knowledge. The overall feedback from patients was that CCCA has an overall feeling of being well organised, calm and relaxed. Patients appreciated being able to utilise the garden space whilst waiting for treatment.

Areas where immediate action was taken on the day:

The only immediate action was to provide a hot drink for a patient who had arrived after the coffee shop had closed (2pm). It was highlighted by both patients and staff that there is a lack of access to refreshments at CCCA once the coffee shop has closed (and that it is only open on some days for restricted hours). There are no vending machines or self-service beverage bays as in other sites.

One patient mentioned he had chosen to cancel hospital transport because he felt vulnerable to infection travelling in a taxi with other patients, and because the transport times were long and inflexible The patient had taken the decision to drive himself to CCCA whilst he was still well enough despite the financial cost. He had already approached the MacMillan information centre and they are currently working with him to ascertain if he would be eligible for a grant. When asked if there was anything CCCA could improve he reply ‘’nothing as everything has been superb so far”.

Areas for improvement:	**Service response:** *Highlight in **Bold** outstanding actions to be added to PEIC action plan*
Improve refreshment facilities for patients at CCCA.	This piece of work will be addressed by the Nutritional Operational Group and Prop care to explore options in relation to refreshments.
Increase seating capacity in the waiting areas now that relatives are able to accompany patients to treatment.	CCCA manager undertook to respond to this on the day.
Staff reported that a patient had arrived at CCCA on the day of the visit following receipt of a text message from CCC. The patient was expected at CCCL; however,	A project is underway to review E-correspondence, part of the project is a task and finish group to include, patient letters, wayfinding and patient experience.

this was not clearly stated in the text message.	
A patient discussed feeling overwhelmed with the number of calls and contacts following the point of diagnosis and felt in hindsight that this could be streamlined for patients.	An area of work not just for Clatterbridge Cancer Centre but pan regionally to review patient pathways.
Improvements not for CCCA; A patient discussed having surgery earlier in the year for breast cancer, unfortunately the patient's wound became infected and she required a medical review over a weekend. The patient called CCC triage/hotline line and was advised to attend her local walk-in centre/A&E. The patient was fortunate that a surgical registrar was on call to review the wound, however if this had not been the case she was informed she would not have been seen until Monday. She felt isolated and unsupported.	The patient was given the correct information and directed to the most appropriate service.
Although not related to the care delivered at CCCA, a patient explained how she had waited 10 weeks for a wig ordered via the Lilac centre which caused distress, however she was able to have the same order delivered within 10 days from a third party. Head of Patient Experience contacted the General Manager for the Lilac Centre who informed that there are no particular issues relating to the supplier, from time to time there are delays, some stock comes from Germany and leaving the EU this has complicated things slightly. However generally things are fairly quick it is so rare to have the circumstance described relating to this service. The service holds a selection of stock, as do commercial providers, so sometimes a commercial site will have the wig a person asks for yet we don't and vice versa. Some products are ordered and are discontinued which can also cause delay's.	

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: The staff interviewed talked about working across all three sites on a rotational basis but preferring to work at CCCA. This was partly due to staff living closer to CCCA; however, they also discussed the friendly team at CCCA, having access to both an easily accessible staff room allowing team building and the garden space. Staff report being able to swap shifts when needed, maintaining a safe service but also allowing for a better work life balance. As patients come for the duration of their treatment to one of the two linacs at CCCA, staff are able to build up a good rapport with patients. One of the staff reported working at a number of other treatment centres both nationally and internationally, however they could see themselves working for CCC for the remainder of their career as they feel

safe and well supported within their role. Staff discussed feeling that their opinion and voice was heard and regular staff meetings made this possible.	
Areas where immediate action was taken on the day: Nothing during this visit.	
Areas for improvement:	**Service response:** *Highlight in **Bold** outstanding actions to be added to PEIC action plan*
n/a	

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting:

Report author	Nigel Howard, HR Business Partner – Medical Workforce			
Paper prepared by	Nigel Howard, HR Business Partner – Medical Workforce			
Report subject/title	P1-189-22 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 Jill Bishop
Job Title	Consultant Clinical Oncologist Breast
Start Date	1st October 2022
Qualifications	• MBChB – University of Sheffield • Post Graduate Certificate in Medical Education – University of Wales (Bangor) • Diploma in Palliative Medicine - University of Wales (Cardiff)
Speciality	Clinical Oncology
GMC number	GMC: 3334399
Membership/Appointments	• MRCP- Royal College of Physicians • FRCR - Royal College of Radiologists
Details	Prior to Dr Bishop's appointment with the Trust, she was employed by Betsi Cadwalader University Health Board in the role of Consultant Clinical Oncologist.

Name	Dr Ian Lampkin
Job Title	Consultant Clinical Oncologist Skin & Urology
Start Date	1st November 2022
Qualifications	• MBChB -Liverpool University • Medical Leadership Module – Edge Hill University • Teaching & Learning in the Medical Workplace Module – Edge Hill University
Speciality	Clinical Oncology
GMC number	GMC: 7148965
Membership/Appointments	• MRCP- Royal College of Physicians • FRCR - Royal College of Radiologists
Details	Prior to Dr Lampkin's appointment to the substantive role he has worked in the locum role since April 2022. Dr Lampkin is also the Trust's Guardian of Safe Working Hours. Dr Lampkin also trained at the Trust as Clinical Oncology Specialist Trainee since January 2017.

Name	Dr Stella Williams
Job Title	Consultant in Haemato-Oncology
Start Date	1st November 2022
Qualifications	• MBCHB -Liverpool University
Speciality	Palliative Medicine
GMC number	GMC: 7080667
Membership/Appointments	• MRCP - Royal College of Physicians • FRCP- Royal College of Physicians
Details	Prior to Dr Williams' appointment to the substantive role she has worked in the locum role since November 2021. Dr Williams also trained at the Trust as a Haematology Trainee since August 2014.

Name	Dr Richard Walshaw
Job Title	Consultant Clinical Oncologist Urology
Start Date	1st November 2022
Qualifications	• MBChB –University of Sheffield • PhD – University of Manchester
Speciality	Uro-oncology
GMC number	GMC: 7014687
Membership/Appointments	• MRCP - Royal College of Physicians • FRCP- Royal College of Physicians
Details	Prior to Dr Walshaw's appointment to the substantive role he has worked in the locum role since January 2022. Dr Walshaw also trained at the Trust as a Clinical Oncology Trainee since September 2012.

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: **Trust Board**
Date of meeting: **26th October 2022**

Report author	Tom Pharaoh, Director of Strategy				
Paper prepared by	-				
Report subject/title	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 2022. This report provides an update on progress against each of the agreed actions following the last Board update in July 2022.				
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		

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Ref: FCGOREPO
Review: July 2025
Version: 2.0

ACTION PLAN

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

GGI well-led review action plan

Last updated: October 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 (to be amended)		• Being done alongside Governor profile raising actions • Continues to be monitored by Membership Engagement and Communications Committee • Plans for 'Meet the NED' screensavers each month starting from November • Further action in development • Action target date to be amended
		• Restart on-site NED visits	Corporate Governance, Patient Experience Team	By end July 22		• Complete • First on-site visit took place in June
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

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
						• Promotional materials produced including screen savers, staff quotes, staff videos, lanyards
		• 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

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
KLOE 3 - Cultures						
R3	The trust should consider how it can raise the profile of the freedom to speak up service among its workforce.	• Stock-take of current awareness of freedom to speak up (FTSU), ongoing communications plans, and uptake of service	Corporate Governance	By end September 22		• Complete • Led by Interim Associate Director of Corporate Governance in conjunction with FTSU Guardians • Chief Nurse now FTSU executive lead
		• Develop plan for further FTSU awareness raising and review of impact	Corporate Governance	By end September 22		• Complete • Implementation of plan throughout FTSU month in October • Awareness raising through all comms channels: screensavers, Team Brief, intranet, CEO video message, etc. • FTSU NED Lead walkaround • FTSU pens distributed • FTSU policy and annual report to Trust Board 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

ACTION PLAN

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The Clatterbridge Cancer Centre
NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
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 • Board sub-committee arrangements to be reviewed again in quarter 4 of 2022/23
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 (to be amended)		• Document control process for policies and other key documents currently under review • Proposal to transfer ownership of all documents (1,000+) to committees rather than individuals and systematise review and quality control • Action target date to be amended to reflect extent of work involved in this proposal
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	• Review operational management committees	Chief Operating Officer	By September 22		• Complete • Session in September to ensure operational structures are aligned with clinical governance arrangements

ACTION PLAN

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
	some meetings to be eliminated or streamlined. GGI can recommend a way to do this.					
R9	The trust should ensure that when it reviews its policy for managing conflicts of interest in July 2022, it identifies the team or individual with responsibility for providing advice training and support for staff on how interests should be managed. The policy should also say how the trust will audit compliance with its own policy and associated processes and procedures on an annual basis and subsequently in line with the review cycle of the policy.	• Review conflict of interests policy, taking into account the GGI feedback	Corporate Governance	By end September 22		• Complete • Policy has been reviewed and is compliant with national guidance • Some minor changes to guidance and processes included • Policy outlines responsibilities for advice, training and support • Reviewed policy approved at all necessary committees and Trust Board in October
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		• Complete • Register currently publicly available on internet and members declare interests linked to agenda items • Inclusion of conflicts register with meeting packs considered but not pursued
KLOE 5 – Managing risks and performance						

ACTION PLAN

NHS
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Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
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 and Trust Board in July
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		• Complete • Relevant BAF risks reviewed at sub-committees of Trust Board and key Exec-led forums (TEG, Risk & Quality Governance Committee, Digital Board) • BAF review systematised by inclusion on committee rolling programmes
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 • Monthly Risk & Quality Governance Committee – chaired by CEO – reviews all 15+ risks
KLOE 6 – Data and information						

ACTION PLAN

The Clatterbridge Cancer Centre NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
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 and training that are needed to implement it are in place.	• Develop a new quality strategy	Chief Nurse, Director of Strategy	By end September 22 (to be amended)		• Development of meaningful clinical quality strategy will require broad engagement across the trust • Turnover and capacity currently within Clinical Governance team • Target date amended to quarter 4 of 2022/23 • New target date reflected in BAF
R18	The clinical governance and communications teams should work together to find and implement new ways of spreading learning from	• Stock-take of current methods for spread of learning from incidents and complaints	Clinical Governance	By end August 22		• Complete • Lessons learnt shared through general communications channels e.g. Team Brief

ACTION PLAN

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Ref	Recommendation	Action	Owner(s)	Dates	RAGB	Comments/progress
	patient safety incidents and complaints across the whole organisation.					• Capacity constraints in Clinical Governance team have hindered further development but new Associate Director of Clinical Governance starting in November
		• 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 (to be amended to align with quality strategy date)		• Proposals for 'Safety News Flash in development' • Capacity constraints in Clinical Governance team have hindered further development but new Associate Director of Clinical Governance starting in November • Target date amended to quarter 4 of 2022/23

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board
Date of meeting: 26 October 2022

Report author	Paul Buckingham, Interim Associate Director of Corporate Governance			
Paper prepared by	Madelaine Warburton, Interim Governance Advisor			
Report subject/title	Freedom to Speak Up Annual Report 2021/22			
Purpose of paper	To inform the Board of the current position in relation to the Trust's Freedom to Speak Up arrangements.			
Background papers	N/A			
Action required	The Trust Board is recommended to: • Receive the report and note the assurance provided • Endorse the 'Next Steps' detailed at s5 of the report.			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work	X
	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		

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Freedom to Speak Up Annual Report 2021/22

1. Introduction

Effective Freedom to Speak Up (FTSU) arrangements provide a mechanism to promote an open and honest culture and enable staff to raise concerns and feel supported in doing so. The Trust's arrangements for raising concerns in the workplace are set out in a Freedom to Speak Up Policy which was last reviewed and approved in June 2021. The FTSU Annual Report 2020/21 was considered by the Trust Board on 28 July 2021.

2. FTSU Activity in 2021/22

The Trust has a Lead Freedom to Speak Up Guardian, the Associate Director of Corporate Governance, who is supported by three Local Guardians based at each of the three hospital sites. During 2021/22 a total of five cases were raised with the FTSU local guardians, one of which related to a potential patient safety concern, compared with 12 cases in 2020/21. The Staff members who raised these concerns were supported and signposted to existing Trust processes to enable resolution. Detailed investigations were not required in any of the five cases.

3. Assurance

The Trust's FTSU arrangements were reviewed as part of the independent well-led review of the Trust's leadership and governance arrangements which was undertaken by the Good Governance Institute. The review was completed in March 2022 with outcomes reported to the Trust Board on 27 April 2022. The report confirmed that there was clear evidence that employees felt empowered to raise any concerns that they have at work. The consensus from the focus groups held during the review was that staff felt comfortable speaking up, and that they would normally approach their manager in the first instance.

While staff were aware of the FTSU Guardian role, several thought that the service should be expanded and needed to be publicised more widely. Work to address this was subsequently incorporated in the Well Led Review Action Plan. FTSU is inextricably linked to the Trust culture. The well led review found that the Trust has a positive culture, described as friendly, open and supportive. Staff told us that managers and directors were approachable and that they felt comfortable asking questions and raising concerns.

Up until 2021 the National Guardian's Office produced a Freedom to Speak Up (FTSU) Index to assist organisations in assessing their Speaking Up culture. The FTSU Index, which was based on responses to questions in the NHS Staff Survey, was last published in May 2021 (reflecting data from the 2020 Staff Survey) but is no longer produced as a result of changes to the staff survey questions. The Trust's 'index score' at that time was 84.1%, in 16th place nationally. While the FTSU Index is no longer produced, reference to responses to the relevant questions can provide Boards with an indication of trend data. Details of relevant responses from the 2021 NHS Survey questions are as follows:

	2017	2021
Q17a – I would feel secure raising concerns about unsafe clinical practice		
Best	79.7	82.2
Trust	**74.1**	**82.2**
Av	71.8	78.5
Worst	66	73.7
Q17b – I am confident that my organisation would address my concern		
Best	72.1	75.1
Trust	**66.4**	**70.3**
Av	63.2	66.8
Worst	54	62.7
Q21e - I feel safe to speak up about anything that concerns me in this organisation		
	2020	**2021**
Best	74.0	74.9
Trust	**72.8**	**68.8**
Average	69.3	68.3
Worst	64.1	60.5
Q21f - If I spoke up about something that concerned me I am confident my Trust would address my concern		
	N/A	**2021**
Best		67.4
Trust		**59.4**
Average		58.4
Worst		51.7

The data above is generally positive with the Trust recording above average scores against each of the four questions and was top ranked for Q17a – I would feel secure raising concerns about unsafe clinical practice. However, outcomes for the other three questions provide scope for improvement work to either address a deterioration in performance or progress towards the 'Best' rated marker.

Less positive has been the Trust's performance in submitting quarterly data to the National Guardian's Office. The Trust did not submit data for the Quarter 2 to Quarter 4 2021/22 and has yet to submit any data in 2022/23. This situation, together with little progress of improvement activity during 2021/22, which was aimed at raising the profile of FTSU arrangements, indicates a lack of coordination which, in part, will have resulted from the extended absence of the Lead Freedom to Speak Up Guardian. The Interim Associate Director of Corporate Governance will look to address this situation in conjunction with the Chief Nurse, who has recently taken over the role of the Freedom to Speak Up Executive lead.

4. National Guidance

NHS England issued a new Freedom to Speak Up Policy for the NHS in June 2022, which supersedes a national policy document originally issued in 2016. All NHS organisations are required to adopt this national policy as a minimum standard by January 2024. NHS England also issued a revised Freedom to Speak Up – Reflection & Planning Tool alongside the new policy document in June 2022. This is an improvement tool designed to identify strengths in lead post holders, the leadership team and the organisation and to identify any gaps that may need addressing.

Work has commenced on a review of the Trust's Freedom to Speak Up Policy to ensure that the content is consistent with requirements set out in the new national policy document. It is important that the revised policy accurately reflects local arrangements and therefore the intention is to complete the new Reflection & Planning Tool prior to finalising the policy document. This will both inform development of the new policy content and establish a baseline position to inform the content of future improvement / development plans. The Non-Executive lead for FTSU, the Executive lead for FTSU and the FTSU Guardian will have a role in populating the Reflection & Planning Tool prior to presentation of outcomes to the Trust Board for consideration and adoption.

5. Next Steps

October has been the national Speak Up Month 2022 and provided an opportunity to raise awareness of how much the Trust values Speaking Up. The theme for the month was 'Freedom to Speak Up for Everyone' and each week of the month had a specific focus as follows:

- Week 1 – Speak Up for Safety
- Week 2 – Speak Up for Civility
- Week 3 – Speak Up for Inclusion
- Week 4 – Freedom to Speak Up for Everyone

Further work to be progressed is summarised as follows:

- Re-establish an effective coordinating relationship between the Lead Freedom to Speak Up Guardian and the Trust's Local Freedom to Speak Up Guardians
- Ensure that appropriate arrangements are in place for the submission of data to the National Guardian's Office (including business continuity arrangements to mitigate post holder absences)
- Complete the Freedom to Speak Up - Reflection & Planning Tool for adoption of outcomes by Trust Board in January 2023
- Finalise review of the Trust's Freedom to Speak Up Policy for approval by the Trust Board in March 2023.

6. Conclusion

The relatively low number of referrals, together with outcomes from the independent well-led review of the Trust's leadership and governance arrangements and results of the NHS Staff

Survey provide evidence that the Trust has maintained an open culture and assurance that employees feel empowered to raise any concerns that they may have at work. However, there is a clear need for remedial action to address management and administrative gaps to ensure that the Trust has clear oversight in this key area and that effective and robust governance arrangements are in place.

7. Recommendation

The Trust Board is recommended to:

- Receive the report and note the assurance provided
- Endorse the 'Next Steps' detailed at s5 of the report.

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 26th October 2022

Report author	Liz Bishop, Chief Executive			
Paper prepared by	Sarah Barr, Chief Information Officer			
Report subject/title	P1-192-22 – Digital Board Development Session – September 2022			
Purpose of paper	The purpose of the paper is provide an overview of the digital board development session held on 28th September 2022 and to note the next steps.			
Background papers	N/A			
Action required	For Information / Noting			
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

Digital Board Development Session – 28th September 2022

1. Background

The Trust Board met for a Digital Board development session on Wednesday 28th September 2022. They received a presentation from the Digital Services Team, and the session focused on the wide ranging areas the digital service team provides. The session was led by the following staff:

Role	Name
Chief Information Officer	**Sarah Barr**
Clinical Leadership Team	**Dr Pete Robson**, Chief Clinical Information Officer **Emma Daley**, Chief Nursing Information Officer **Max Hughes**, Chief Medicines Information Officer
Chief Technology Officer	**James Crowther**
Head of Business Intelligence	**Paula Pickford**
Head of Digital Programmes	**Amanda Wilson**

2. Objective and format of the development session

The objective of the development session was to convey the strategic context locally, regionally and nationally. To share the breadth and depth of digital programmes within the Clatterbridge Cancer Centre and to discuss the emerging digital strategy. The development session was delivered face to face using a PowerPoint presentation which is attached within Appendix A.

The following topic areas were covered within the session:

- Digital transformation and optimisation
- Digital clinical leadership and engagement
- Digital infrastructure and cyber security
- Business Intelligence Journey
- Regional digital diagnostic and capability programme
- Regional CIPHA and Acute oncology data programmes

- Framework for the direction of the emerging Digital Strategy

The Board discussed each area in depth and thanked presenters for their contributions. The next steps on the digital strategy were highlighted.

3. Digital Strategy

The emerging Digital Strategy themes were described as follows:

- **Cancer Services Transformation**: Commitment to digitally transform services to support clinical outcomes
- **Empowering Staff**: Digital solutions designed with staff in mind
- **Empowering Cancer Patients**: Digital solutions co designed with patients providing them with the right tools to feel in control of their own care
- **Data Driven Innovation**: Harnessing data and building partnerships in order to digitally revolutionize support for cancer patients in our care.

The team described how a foundational partnership will be developed between the digital services team and staff to support a measure of success. It was noted that executive leads taking the role of Senior Responsible Owners (SROs) within the clinical systems transformation programme was successful and that a similar format for embedding the digital strategy is planned for.

4. Conclusion

The Trust Board members noted the depth and breadth of the work delivered by the digital services team. The Board agreed to the direction of the emerging digital strategy. The Digital services team noted that a full presentation of the digital strategy will be presented to the Digital Board in October 2022. A fully drafted document of the strategy will be available for circulation by the end of November 2022 and will go through the Trust governance processes with final sign off at Trust Board.

5. Next steps

The Board is asked to note the report.

Appendix 1

Digital Board development slides 28.09.22

Appendix 1

The Clatterbridge Cancer Centre NHS Foundation Trust

Digital Services-Board Development

Wednesday 28th September 2022

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Agenda

- Welcome and Introductions
- Digital Strategic Context
- Transformation and Optimisation
- Clinical Leadership & Engagement
- Infrastructure & Cyber
  - Digital Diagnostic & Capability Programme
- Business Intelligence Journey
  - CIPHA & Acute Oncology
- Digital Strategy
- Discussion
- Close

BE DIGITAL

What does Digital mean to you?

The Clatterbridge Cancer Centre NHS Foundation Trust

Definition of Digital: Applying the culture, processes, business models and technologies of the internet era to respond to people's raised expectations.

Tom Loosemore, Partner at Public Digital
28 Jun 2017

Digital Services

Working in collaboration with strong Clinical and Digital Leadership

Using Digital services to transform systems and processes

Digital Clinical Leadership

Pete Robson
CCIO

Steve Hawkins
Deputy CCIO

David Cobben
Deputy CCIO

Emma Daley
CNIO

Max Hughes
CMIO

Digital Infrastructure

James Crowther

- Cyber Security
- Network Team
- Desktop and Service desk
- Integration & DBA
- Electronic Patient Records
- Clinical Systems Training
- Digital Diagnostic Capabilities programme (DDCP)

Business Intelligence

Paula Pickford

- Data Analysts
- Data Scientist
- Clinical Effectiveness
- Business Intelligence
- Clinical Coding
- National & Regional returns

Digital Programmes

Amanda Wilson

- Clinical Systems Transformation programme
- Robotic Process Automation
- SharePoint
- Digital Programmes

High Level Strategic Context

The Wachter Report (2016) addressed the need for "**clinical informaticians**" and more generally the need to **raise levels of digital literacy** across all clinical professions.

The Topol Review (2018) highlighted the need for extensive education and training of the clinical workforce

NHS Long Term Plan (2019) Chapter 5 : Digitally enabled Care will go mainstream, also references *Wachter* and *5 year forward view (2017).* **LTP** key highlights also on *Genomics (personalised meds), Research, Cancer.*

NHS Architectural Principles (2021) Best practice guidance for designing digital health systems 10 principles including Cloud First, Interoperability, Ask the User First…

What Good Looks Like Framework (2021) sets out what good looks like at a system and organisation level – 7 measures of success: Well Led. Smart Foundations, Safe Practice, Empower Citizens, Improve care, Healthy Populations **Also Nursing WGLL Framework-** published March 2022

Goldacre Review (2022) Efficient and safe use of health data for research and analysis

Data Saves Lives (2022) Reshaping Health & Social care with data

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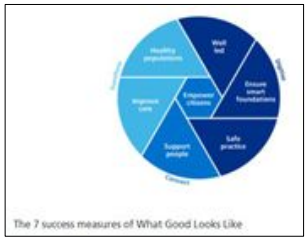

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Our Cultural Digital Journey

Digital Leadership and strengthening Clinical Leadership

Setting Secure & Robust Digital Foundations

Journey to Digital Maturity for success (HIMSS)

Journey to Data Intelligence

Digital Developments & Clinical Systems Optimisation

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NHS Foundation Trust

Transformation and Optimisation

Our Electronic Patient Record (EPR) Journey

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust went live with Meditech Electronic Patient Record (EPR) in 2016 – 8 years through a 10 year contract

First UK oncology customer for Meditech

Accredited to level 5 Healthcare Information Management Systems Society (HIMSS) for EPR maturity. (Minimum level required by all Trusts by 2025 (Plan for Health & Social Care)

Front Line Digitisation: "Levelling up" EPR One of 5 Trusts in C&M Group 3 –(Group 3 =EPR meets the Minimum Digital Foundations (MDF))

2021- Digital team **commissioned independent review** of Meditech

Over 400 staff interviewed
Process **highlighted number of areas** to focus on. Including processes and configuration

Review **optimisation of current features** available
Focus on **Medicines, Administration processes and Documentation.** Each with Executive oversight

The Clatterbridge Cancer Centre NHS Foundation Trust

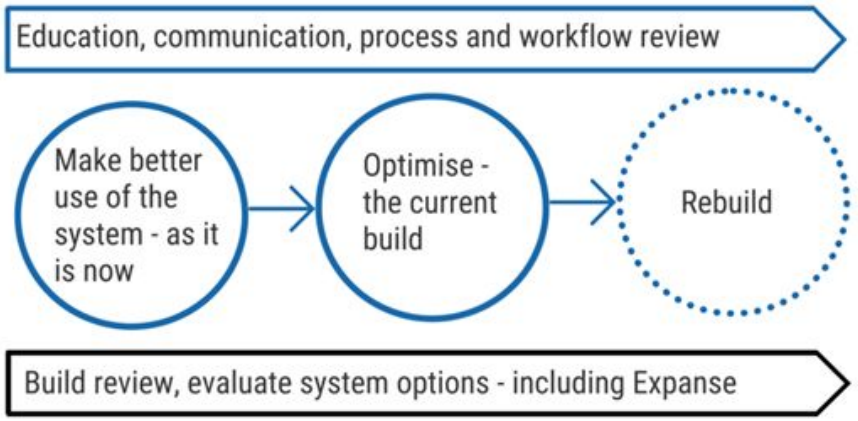
Optimisation into Next Generation EPR

Overall programme is managing optimisation and future planning for next generation EPR.

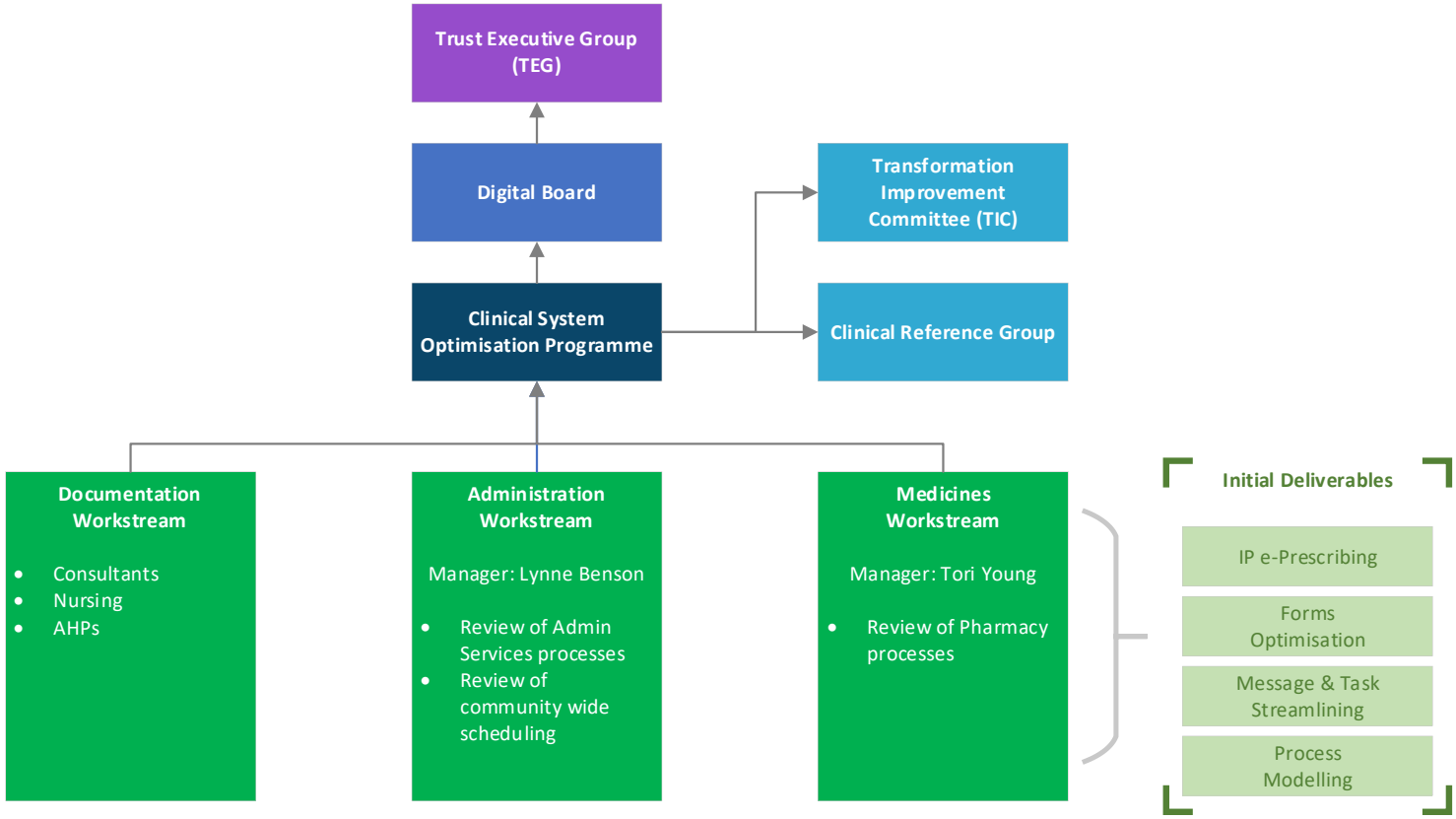
Includes requirements on optimisation, training and education plus required changes in processes.

Also funding and planning and any future convergence requirements in line with National constraints.

The big picture



Clinical System Optimisation Programme Governance



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Clinical Leadership and Engagement

Pete Robson CCIO,
Emma Daley CNIO
Max Hughes CMIO

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Clinical Healthcare Leaders In Digital

What does good look like.....

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Clinical Documentation Optimisation

Improving Clinical Workflows

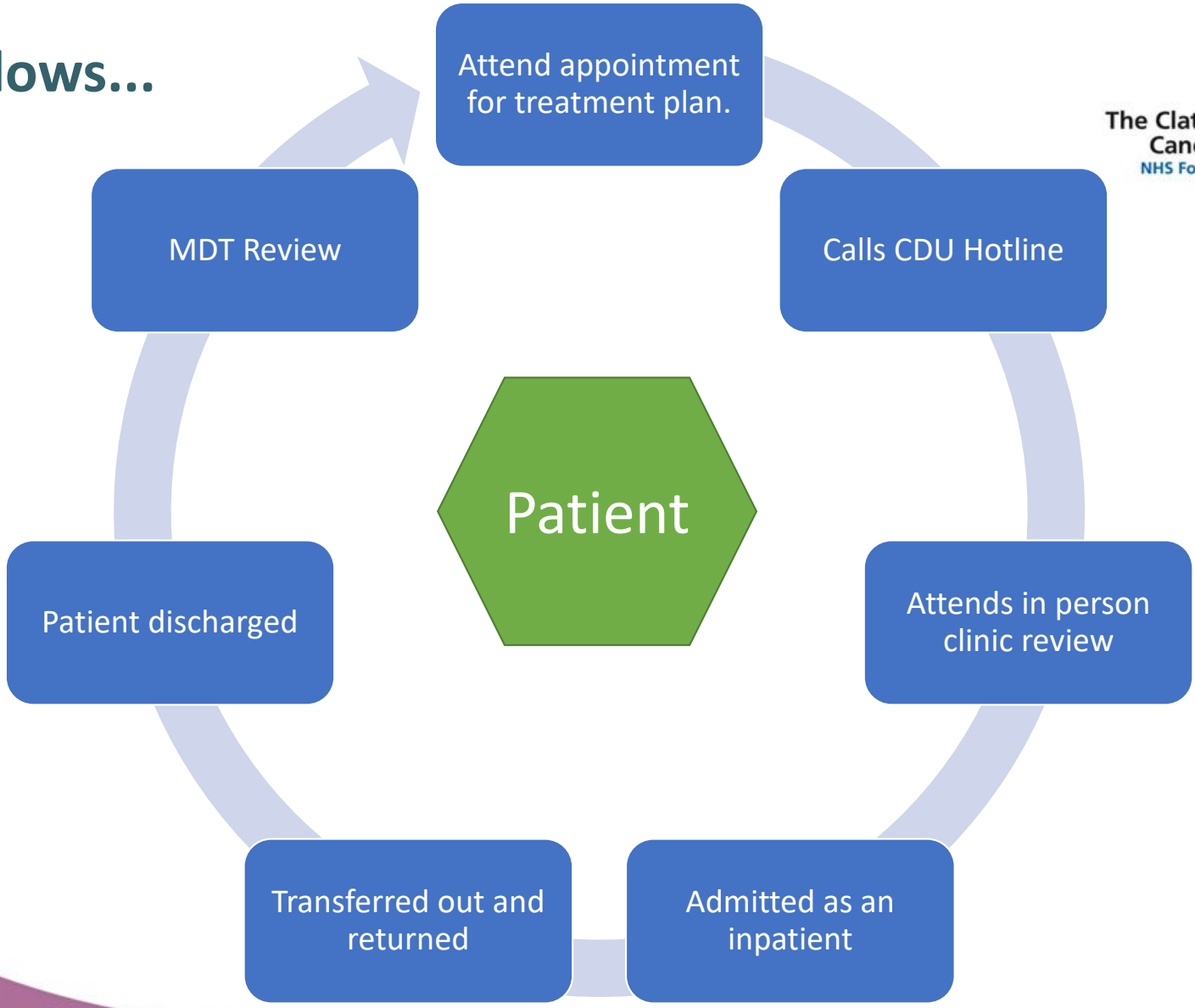
Engagement and inclusion from floor to board

Networking

Data input to output

Supporting Incident review process and Risk

Clinical Workflows...



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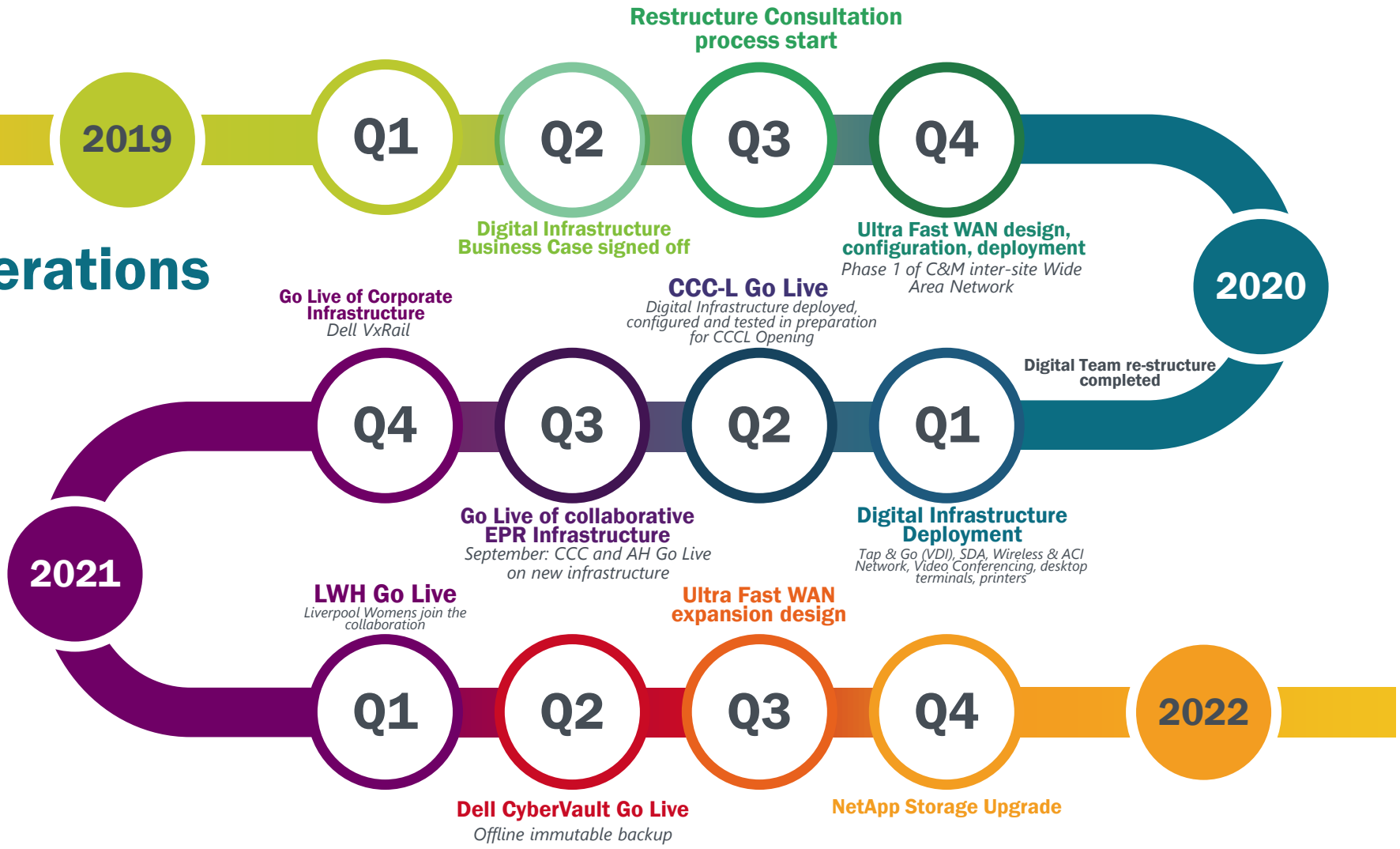
Infrastructure & Cyber Security

James Crowther

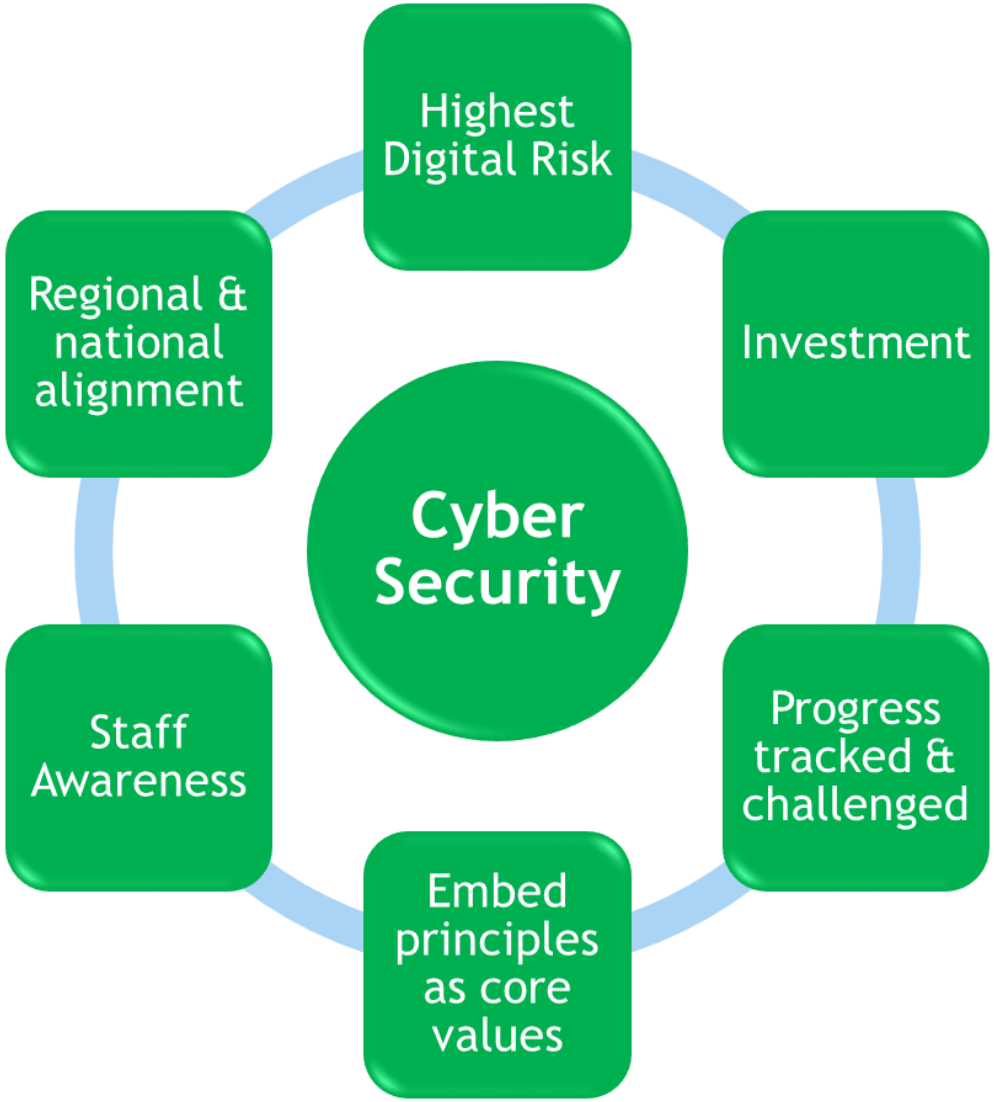
Digital Operations Journey

2019-2022

3 Year Plan



Cyber Controls



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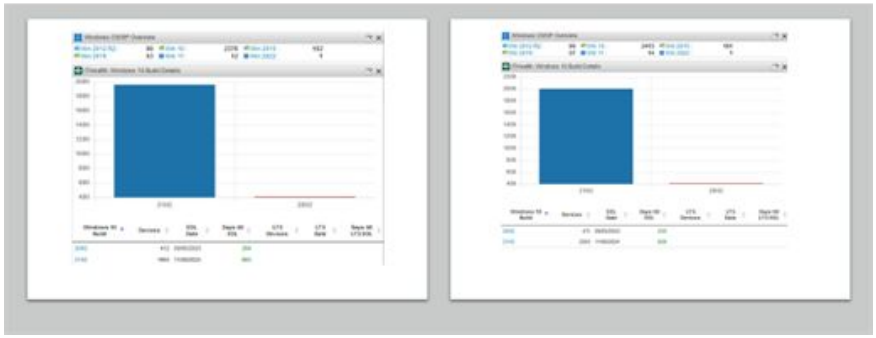
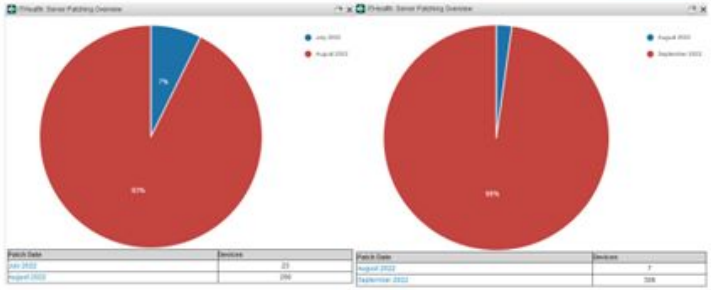
Digital Security Committee

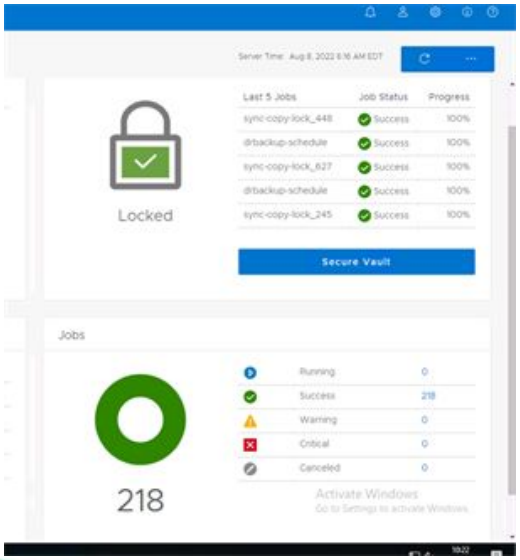
Windows Version Status

- Plan for VDI devices to be upgraded to 21H2 Has been discussed. 37 weeks of support remaining (20H2).
- All Desktops and laptops on latest release (21H2)
- All devices on fully supported operating systems



Windows Patching Status (Servers)

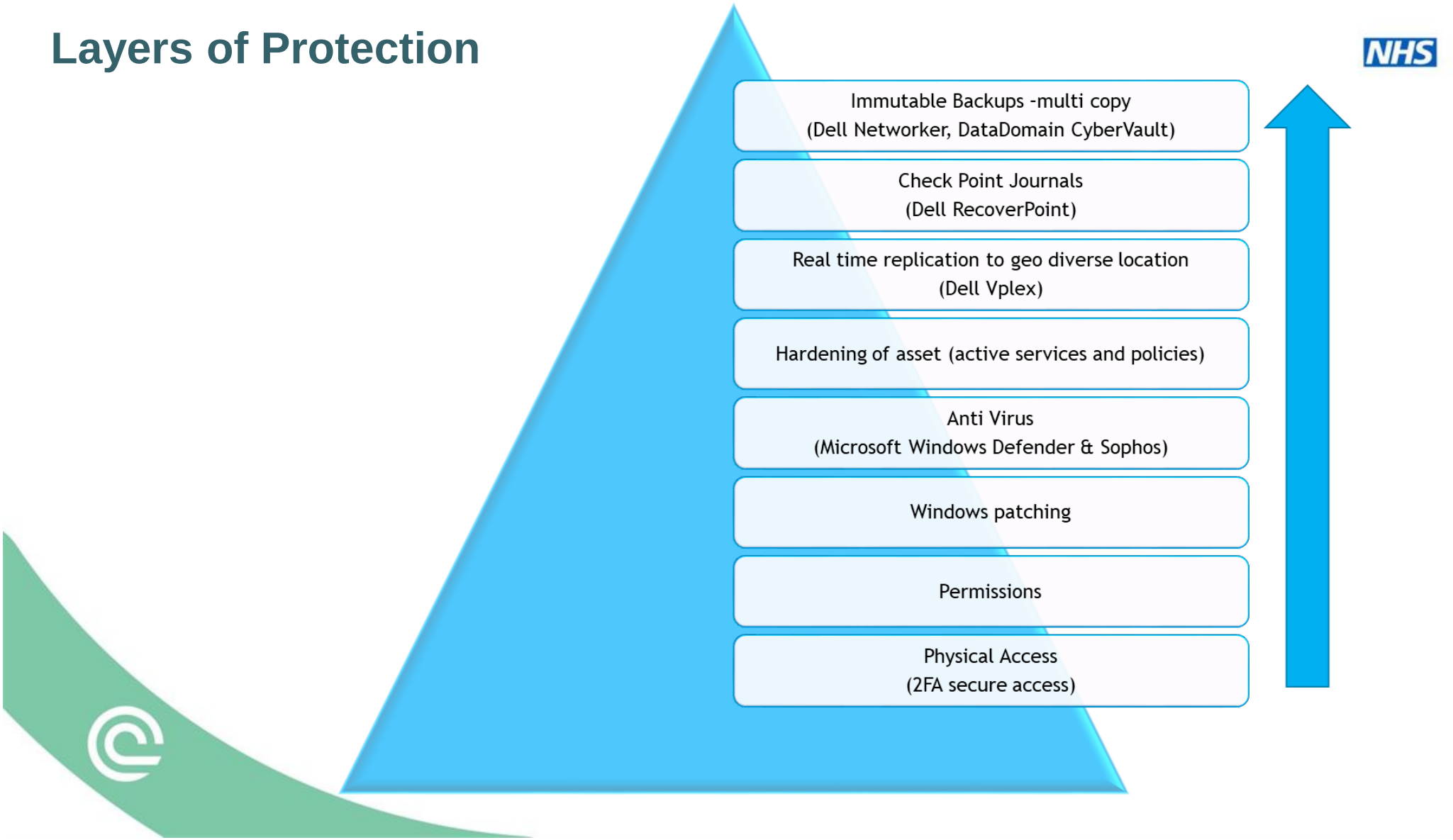




Microsoft Security Centre – Exposure Score

- Score varies due to current patching status and vulnerabilities. This month the score is higher due to the requirement to upgrade Chrome and Edge
- Actions to be reviewed to lower score by following best practice
- Exposure Score action plan has been drawn up and needs to be reviewed by all named staff and teams
- On 16th August exposure score dropped to 23

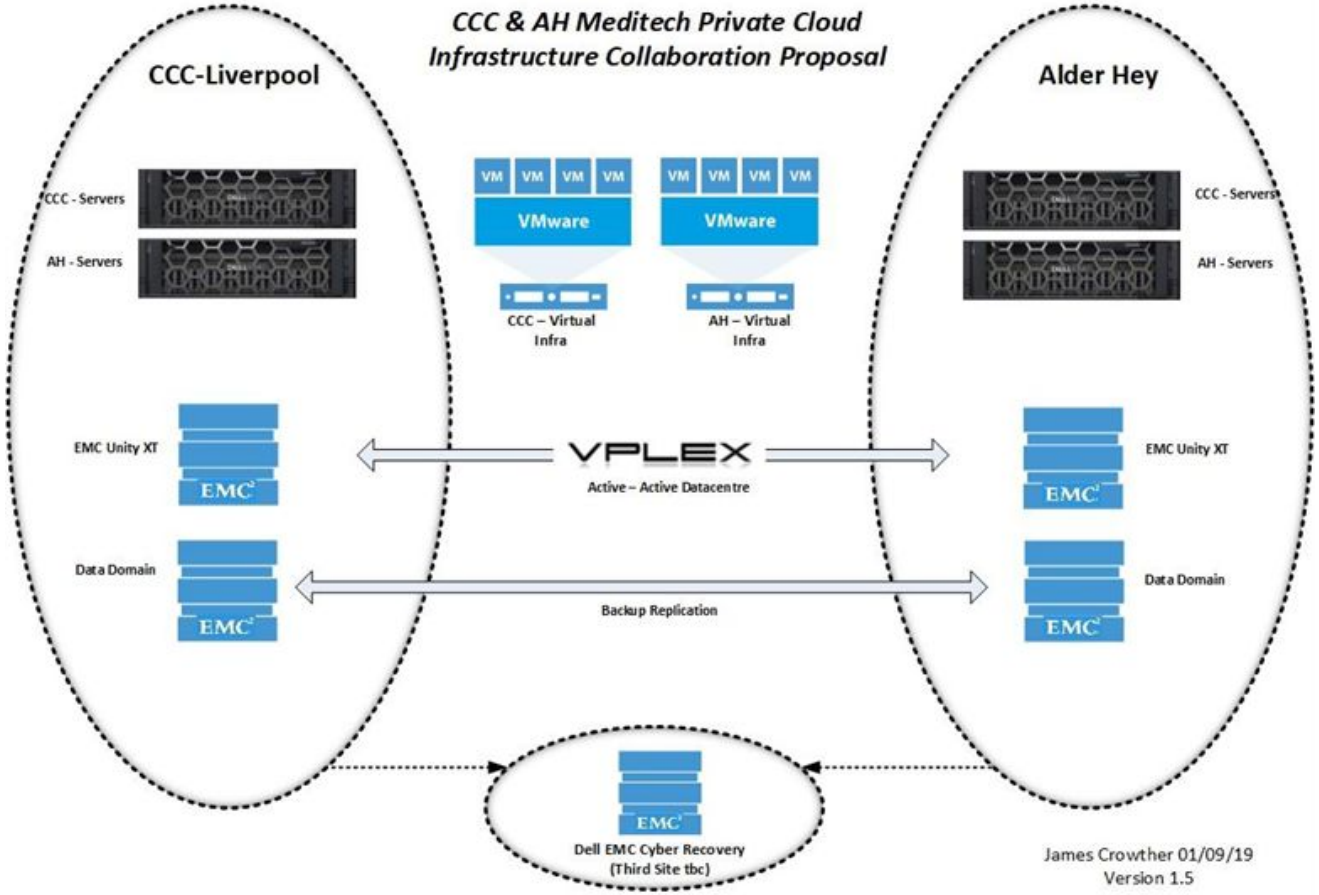
Layers of Protection



Infrastructure: Alignment with our partners & Design Overview

The Clatterbridge Cancer Centre NHS Foundation Trust

- Cost efficiencies
- Energy usage & overheads
- Building Relationships
- Cloud first approach within Strategy



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Digital Diagnostics Capabilities Programme (DDCP)

James Crowther, Chief Technology Officer

C&M DDP <> Networks Digital

Cheshire and Merseyside Health and Care Partnership | Digital Diagnostics Capability Programme

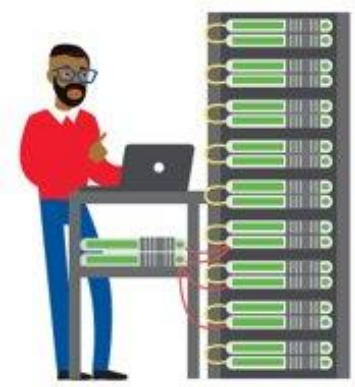
Diagnostics Networks IT & Clinical Groups
"Ownership of the Roadmap, articulation of Problem Statement"

Specification design - IT, clinical and operational recommendations

Supports the consortium

*The Networks are **closest** to the problems and the **clinical drivers** – Specialised digital teams (C&M DDP) can be pivoted to provide rapid deployments & solutions*

- Radiology
- Pathology
- CDCs
- Endoscopy
- Cardiorespiratory
- …and more



Collaborative working shouted about via the DDCP Protocol, with dedicated attention to good work in digital and keeping all informed

Collaborative and holistic approach to the patient journey, understanding how patients interact with multiple diagnostics services

Relevant to the Long Term Plan

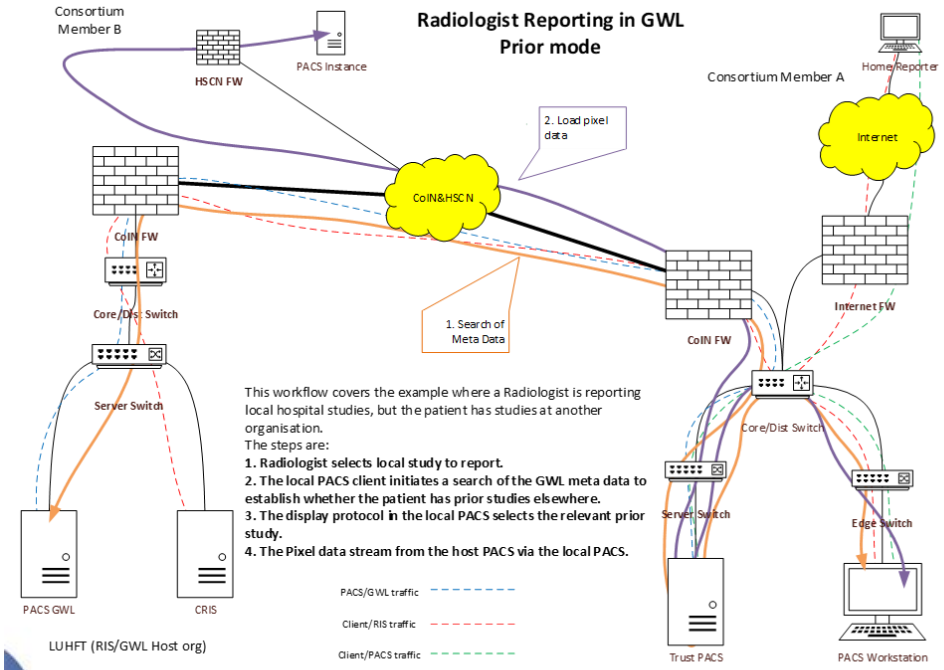
C&M DDP Team
"Problems in delivering Roadmap solved and managed"

Supports the Diagnostics Portfolio

Insights and lessons learnt are shared throughout the system to inform future joint working on technology procurements

A standardised approach to problem solving within the digital diagnostics portfolio, giving greater assurances to the consortium Trusts that solutions are relevant / necessary

Understanding the Problems



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- Topology diagnostics
- Workflow diagnostics
- Pain points & frustrations
- Problem management, patterns & analytics

Designing the solution, building the framework

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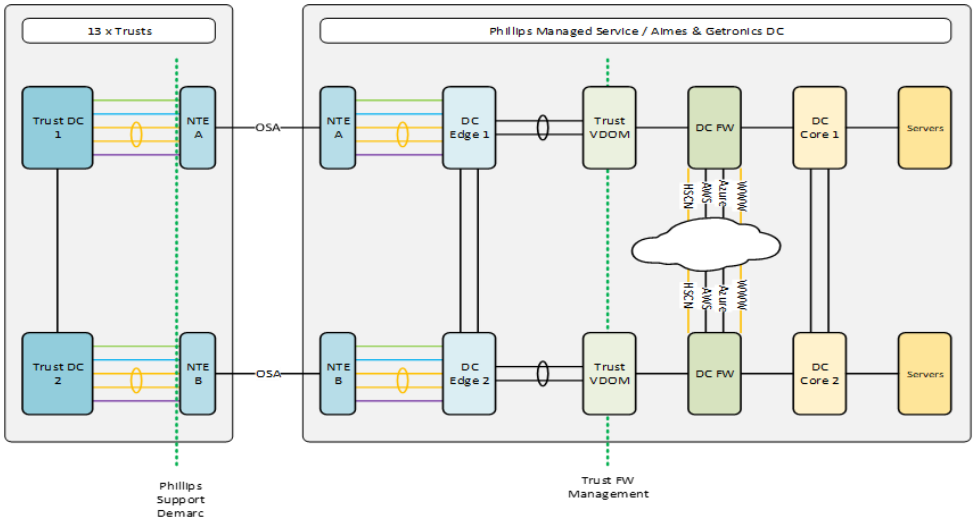
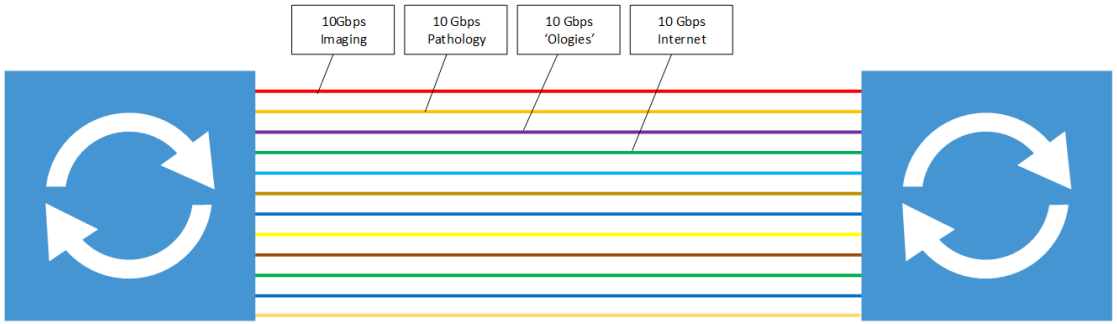
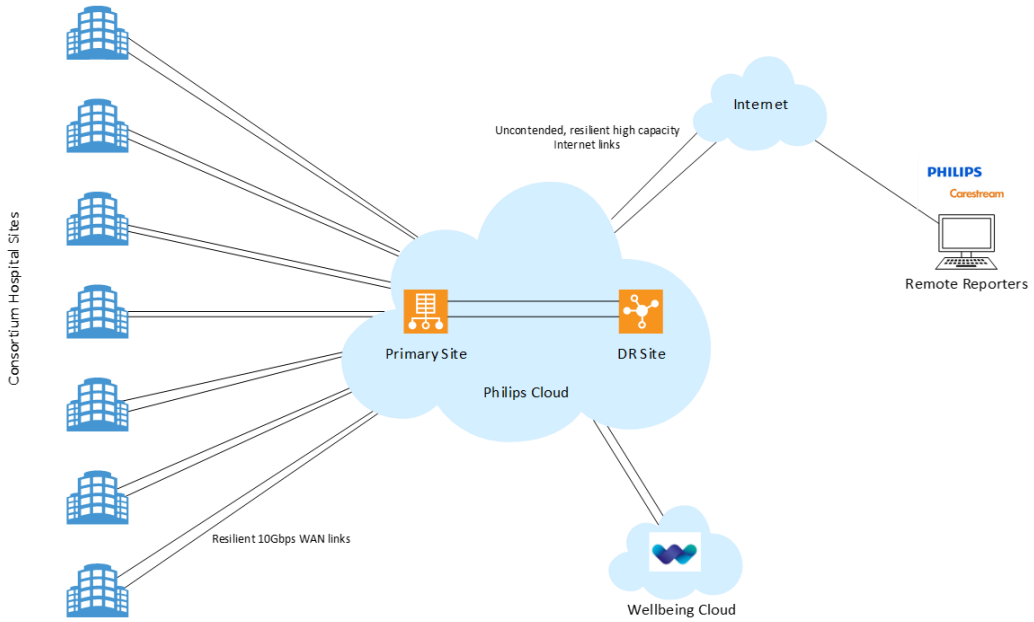


Network Capacity: Scalable Growth





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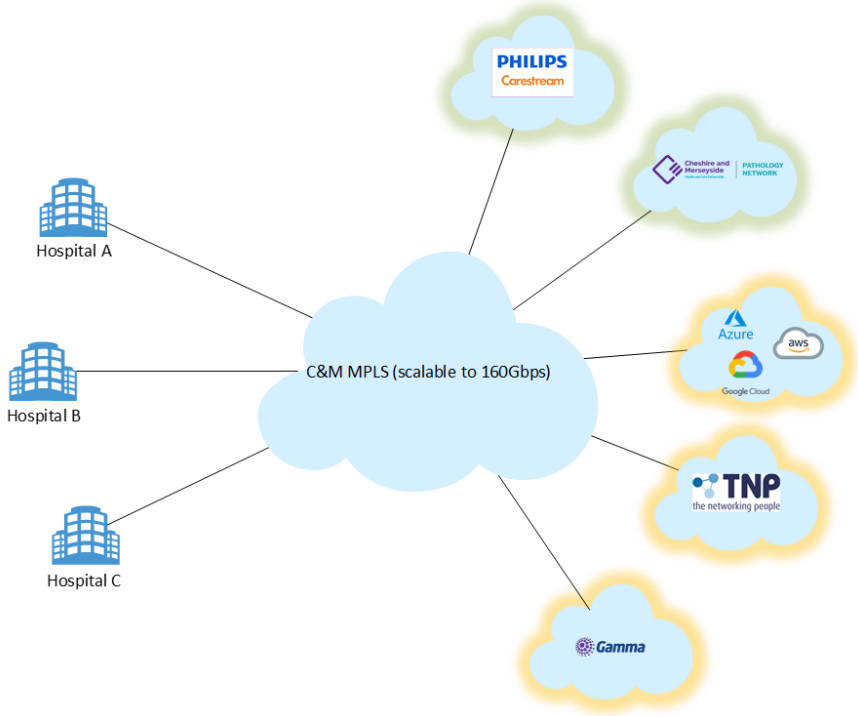
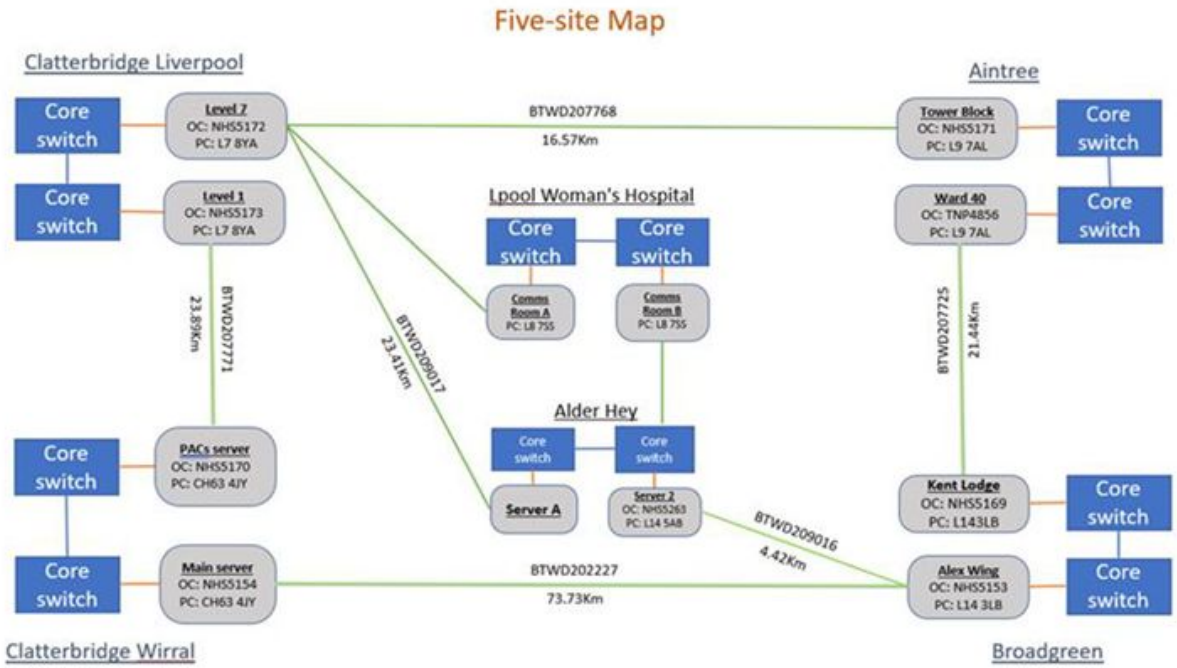


Wide Area Network Communications

The Clatterbridge Cancer Centre NHS Foundation Trust

- **Collaboration on inter site connectivity**
- Scalable to 160Gbps using OSA technology
- **Future use cases**
  - Ultra High Speed Internet (3Gbps+)
  - HSCN
  - SIP Telephony
  - PACS & Large image transfer
  - Better integration into regional partners



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NHS Foundation Trust

Business Intelligence - Data Analytics

Paula Pickford Head of Business Intelligence

Business Intelligence Journey

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Dec 2020

New BI Team all positions filled

2020-2022

Automation and streamlining of data foundations to enable analysis and BI Development

2022-2023

SRG specific dashboards tailored for clinical need. Analyst team strengthened to support key projects

Jan 2021

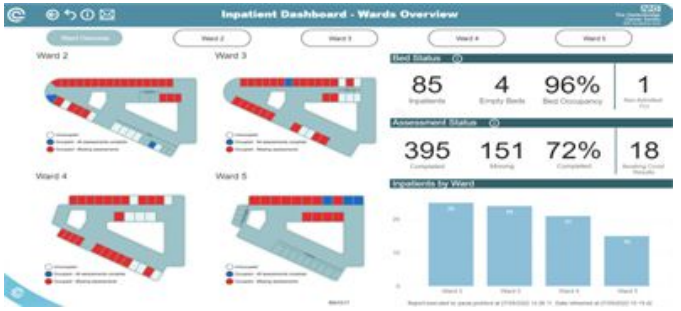
First Power BI dashboard released

Sep 2022

15 Power BI dashboards covering a wide variety of information to enable instant access to key insights

2023 +

Build on the solid foundations to provide analytics to support future Trust priorities



CIPHA Overview

What is CIPHA?

In 2020, the Cheshire and Merseyside region rapidly implemented a **population health management** system called CIPHA, to inform its response to the COVID-19 pandemic. CIPHA is an approach aimed at improving the health of an entire population.

CIPHA provides a steady flow of **real time data** feeds from **local NHS and Social Care** providers along with **national data** sets to deliver consistent, coherent and actionable dashboards for the ICS.

Population Health

- Comparing progress & performance to peers and between cohorts

Population Segmentation

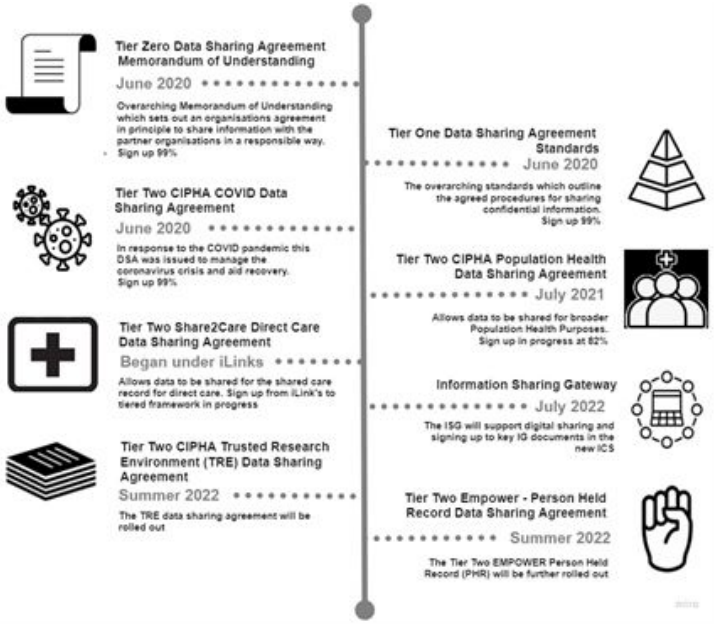
- Grouping of patient cohorts and understanding their characteristics such as age, ethnicity, deprivation and how health and care utilisation and outcomes differ for these populations

Population Health Management

- Risk stratification of individual cohorts to identify people who would benefit from proactive care

Research

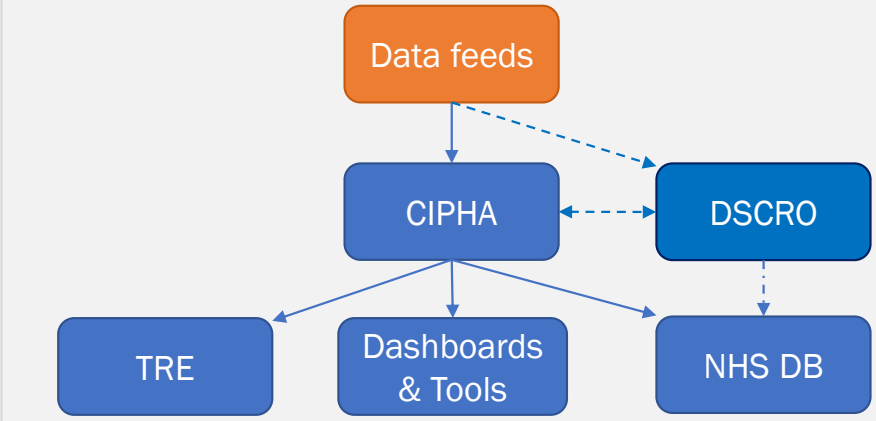
- Enable healthcare research on pseudonymised patient-level data across Cheshire & Merseyside ICS



CIPHA Data Landscape

How do I know what data is available?

Key Data Feeds
Primary Care
Social Care
SUS
ECDS
Waiting lists
Covid flows
Community
Mental health
Acute
Fingertips



Other reference and supporting data in CIPHA

- Master patient lists & demographics
- SITREP
- UK Health facts
- John Hopkins risk assessments
- Commissioning data
- Other PHE data
- Vaccinations

Data flows in the pipeline

- Enhanced 111/999 data
- Community data
- Cancer data
- BP & Vitals data
- Mortality data

Data to explore (no active use case)

- Pathology
- Radiology
- Screening
- Acute prescribing
- Education
- Drugs & Alcohol

CIPHA Projects – Use case Frailty and co-morbidity assessment in lung cancer

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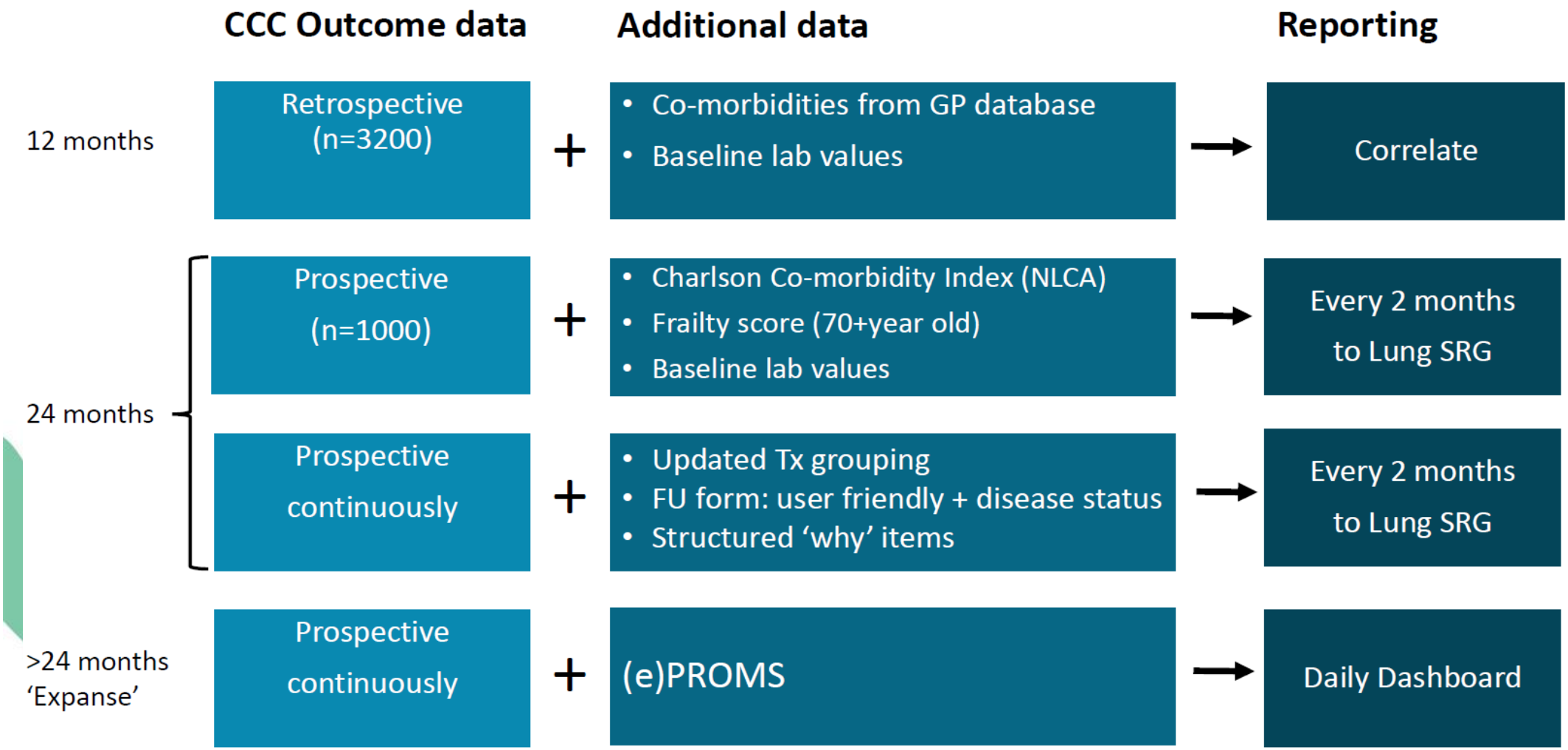

CIPHA Projects - Acute Oncology Dashboard

The Clatterbridge Cancer Centre NHS Foundation Trust

Phase 2 AO Dashboard Project

- ✓Regular project team meetings
- ✓All AO teams have now migrated to Somerset Cancer Registry for AO data collection
- ✓Working with Countess of Chester re potential proof of concept
- ✓Opportunity to review existing AO KPI's
- ✓Once KPI's agreed, dashboard design workshop to be held re look and feel of dashboard
- ✓Once COCH agree, technical extracts to be developed re live data feeds.

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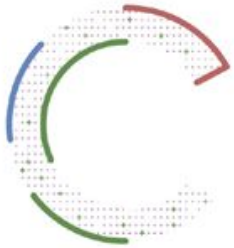
Digital Strategy



BE **OUTSTANDING**

Deliver safe, high-quality care and outstanding operational and financial performance

BE **COLLABORATIVE**

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

BE **A GREAT PLACE TO WORK**

Attract, develop and retain a highly-skilled, motivated and inclusive workforce to deliver the best care

Our strategic priorities & Our Digital Strategy

BE **RESEARCH LEADERS**

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

BE **DIGITAL**

Deliver digitally-transformed services, empowering patients and staff

BE **INNOVATIVE**

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

Digital Vision themes

CANCER SERVICES TRANSFORMATION

Commitment to transform services to deliver high quality care

We will use leading approaches for digital-transformation to develop and embed effective Clinical Systems in order to improve safety, quality and efficiencies.

STAFF CONFIDENCE

Digital solutions designed with staff in mind

User-friendly digital solutions will simplify workflow and will support staff in the provision of safe, high-quality care across sites and departments.

EMPOWERING CANCER PATIENTS

A world-class experience of care.

A digitally-empowered, holistic approach to cancer care will support patients alongside their journey. Digital solutions will provide patients with the right tools to feel in control of their own care.

DATA DRIVEN CANCER INNOVATION AND RESEARCH

Harnessing data and building partnerships in order to revolutionize care and treatment for cancer patients

Digital innovations and research will drive cutting-edge advances in cancer diagnostics, treatment and outcomes.

DIGITAL WILL…

STAFF WILL…

Our foundational partnership

How we will achieve the vision?

CANCER SERVICES TRANSFORMATION

- Process redesign
- Data quality/maturity
- EPR build and configuration
- New ways of working
- Business & Data Intelligence (BI) services

STAFF CONFIDENCE

- EPR
- Shared Care Records
- Digital diagnostics
- Digitally enabled staff
- Resilient technical infrastructure that promotes seamless digital experience
- Innovative training: Virtual Reality Gameification
- Online and video consultation

EMPOWERING CANCER PATIENTS

- Patient Held Records (PHR)
- Patient Choice
- Patient Empowerment Portal (PEP)
- Empowering choice
- Use of accredited patient facing apps
- Remote monitoring

DATA DRIVEN CANCER INNOVATION AND RESEARCH

- Single Trusted Research Environment (TRE) for Cheshire and Merseyside
- Data driven organisation
- Shift from data access to data analytics

A partnership to develop further with staff

The Clatterbridge Cancer Centre
NHS Foundation Trust

Next Steps & Discussion

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: **Trust Board**
Date of meeting: **26th October 2022**

Report author	Gillian Heap, Director of Research & Innovation Operations				
Paper prepared by	Gillian Heap, Director of Research & Innovation Operations				
Report subject/title	Research & Innovation Annual Report 2021 - 2022				
Purpose of paper	To review the activity, performance and advances in Research and Innovation during 2021 - 22.				
Background papers	None				
Action required	Discuss				X
	Information/Noting				X
Link to: Strategic Direction Corporate Objectives	Be Outstanding		Be a great place to work		
	Be Collaborative		Be Digital		
	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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The Clatterbridge Cancer Centre
NHS Foundation Trust

Research & Innovation Annual Report 2021-2022

Prepared by:
Dr Gillian Heap, Director of Research & Innovation Operations
Professor Christian Ottensmeier, Director of Clinical Research
Dr Seamus Coyle, Clinical Lead for Innovation
Dr Sheena Khanduri, Medical Director

R&I Team: Fiona Penk, Sally Jones, Dr Maria Maguire, Michelle Moffitt, Drew Norwood-Green, Paul Ogden, Jane Tinsley, Emma Whitby

The Clatterbridge Cancer Centre NHS Foundation Trust

Contents

1. Introduction

The Research and Innovation (R&I) Directorate of The Clatterbridge Cancer Centre NHS Foundation Trust (CCC) has had another great year during 2021/22. This report details the notable successes which have been achieved.

During the last 12 months, the R&I Directorate endeavoured to build a recovery programme after the COVID-19 pandemic. The year was not without challenge, with support given to aiding Pharmacy in the delivery of novel drug trials. Nonetheless, the focus of R&I turned to embedding the Directorate into Clatterbridge Cancer Centre – Liverpool (CCC-L), pictured below, with the benefits that gave us in developing novel research activity, both in terms of early phase trials and in CCC-led research.

CCC welcomed the Haemato-oncology Team who joined us from Aintree University Hospital NHS Foundation Trust, thereby linking a fully integrated service for our blood cancer patients and expanding our research into our Northern Hub.

We also continued to expand the diversification of the research portfolio in terms of translational, real world trials and qualitative studies, bringing a different dimension to the portfolio.

The appointment of new Innovation Manager, Drew Norwood-Green, and Clinical Lead for Innovation, Dr Seamus Coyle, bring another key element to the activity of R&I. These appointments and the refresh of the Bright Ideas initiative are already making a difference to our patients and we look forward to reporting on the benefits of the Innovation Strategy for the Trust that is being developed.

The new Clinical Director of Research, Professor Christian Ottensmeier was appointed and the implementation of the Trust Research Strategy started to be realised and notably the CCC Biobank was re-opened. Therefore, there has been a real step change in the opportunity afforded for our patients to access novel research and therapies.



2. Highlights of 2021-2022

The R&I Directorate has been responsible for a number of notable achievements during 2021/22.

These include:

- Key partner in the successful £5.3M NIHR Liverpool Clinical Research Facility (CRF) bid which is a partnership between CCC, Liverpool University Hospital NHS Foundation Trust and Liverpool Heart and Chest Hospital.
- 1113 new participants recruited into our research trials and studies.
- Opened 45 new research trials and studies to recruitment (53 given permission to open at CCC).

- Significantly increased the number of clinician-led studies for which CCC acts as sponsor with 10 trials and studies open, 7 in set-up and 4 reporting.
- 100% of clinical trials were unpaused as part of COVID-19 recovery, which exceeded the national recovery target.
- Issued first Patient and Public Involvement (PPI) Newsletter for research.
- Biobank renewal of research ethics secured for a further five years – maximum life cycle given.
- Significant Assurance achieved for a MIAA audit which reviewed R&I's financial and governance arrangements. This shows the systems and procedures that are in place are working well.
- Appointment of a new Director of Clinical Research and a Clinical Lead for Innovation.

3. Top Highlights by Month

April 2021

- Prof Christian Ottensmeier, pictured right, was appointed as the new Cancer Sub-speciality Lead for Immunotherapy for the NIHR CRN NW Coast.
- Dr David Cobben was appointed as the new Cancer Sub-speciality Lead in Radiotherapy for the NIHR CRN NW Coast.
- Dr Yngvar Floisand, Clinical Oncologist was appointed as the new Cancer sub-speciality Lead for HO for the NIHR CRN NW Coast.

May 2021

- CCC was the highest recruiter for the CCC Investigator-led TACE-3, trial which is a joint trial between CCC and Aintree (PI: Professor Palmer, Liver and Pancreatic, pictured left).
- Editors of Gynaecologic Oncology confirmed that a manuscript had been accepted for publication for which Clatterbridge consultant, Dr Rosie Lord, was the PI. This was for a national gynaecology, psychological intervention study linked with Clatterbridge Maggie's centre.

June 2021

- CCC remained top recruiter for the IMPACTOR study (PI: Prof Palmieri, Breast).
- The Proact team recruited their first patient into this study. It is the first cardiac study that CCC has participated in (PI: Prof Kalakonda, non-Hodgkins lymphoma), pictured right.
- CCC was the first site to open in the UK for the Brioche trial and received positive feedback from the sponsor (Dr Mehta, Brain).
- Prof Ottensmeier had a paper published in Nature Immunology, June 2021. Helping to understand why current checkpoint inhibitor treatment often does not work, how to use our drugs better and how to make better drugs to help immunotherapy work.
- The R&I team had an abstract accepted for the NCRI Conference 2021: 'Research, Response and Recovery: Clatterbridge Cancer Centre and the COVID-19 pandemic'. (See Appendix I).

- Dr Appleton presented a poster at the MASCC conference, 'Exploring the impact of COVID-19 on the psychological wellbeing of oncology healthcare professionals, see Appendix I.

July 2021

- Dr Jess Hale was awarded a £10,000 grant from the Pancreatic Society of Great Britain and Ireland to look at microbiome changes in pancreatic cancer.
- CCC was the highest recruiter for the Flaura 2 study. (PI: Dr Carles Escriu, Lung).
- Prof Palmieri, pictured right, was listed as a co-author and as one of the ISARIC-4C Investigators on a publication in the Lancet relating to Clinical Characterisation Protocol (CCP) Cancer-UK study – 'Characterisation of in-hospital complications associated with COVID-19 using the ISARIC WHO Clinical Characterisation Protocol UK: a prospective, multicentre cohort study'.

August 2021

- CCP Cancer-UK study opened to Clatterbridge patients looking at the impact of COVID-19 on people with cancer. This is an Experimental Cancer Medicine Centre (ECMC) study and CCC acts as sponsor. Data will be compared to non-cancer patients with COVID-19 so any differences can be identified. (PI: Prof Carlo Palmieri, COVID-19/Cancer).
- A CCC patient was one of first in UK to have a new ovarian cancer treatment after genomics testing. Dr Rosie Lord, pictured left, led on this treatment for patients whose disease is HRD positive. Published in Gynaecologic Oncology.

- Dr Mark Warren, of UoL, awarded a prestigious Fellowship after receiving seed funding from the CCC Research Development Fund 2019. Research is into radiotherapy side-effect reduction for lung cancer patients, testing how accurately MRI can describe tumour position and movement and, therefore, by improving its accuracy reduce the side effects of the radiation.
- Supported a national radiotherapy data study which is aiming to provide a better insight into what the impact of COVID-19 had on patient outcomes, treatment policy and prioritisation in radiotherapy and on the UK Radiotherapy Service. In total, CCC has collected data for 1964 patients. All data have been sorted, encrypted and sent to Public Health England.

September 2021

- Highest recruiter nationally for PIVOTALBoost for August and September. (PI: Dr Syndikus, Urology), pictured right.
- The Rhovac study treated its first patient. This is an exciting new vaccine study for patients with rising PSA markers following previous curative treatment (PI: Dr Malik, Urology).
- Sarah Watmough, Research Practitioner, presented at the 3rd NCRI AML ACADEMY conference in Birmingham. Her presentation, 'Holistic care for AML patients during COVID times', – discussed challenges and sharing best practice.

October 2021

- CCC was the highest recruiter for SCOPE 2 for the month with 19 patients recruited, and this was specifically mentioned in the SCOPE 2 newsletter. This study is a randomised Phase 2 trial to study radiotherapy dose escalation in patients with oesophageal cancer. (PI: Dr Eswar, Colorectal).
- The Ironman study recruited its first patient. It is an international registry to improve outcomes in men with advanced prostate cancer (PI: Dr Syndikus, Urology).
- CCC was the top recruiting site for the Finding My Way study, with 31 patients recruited. This study is determining the efficacy of an online CBT therapy intervention (PI: Emma Whitby, multiple disease sites, pictured right).

November 2021

- The Aphrodite study recruited its first patient. This study is looking at escalated dose of RT in rectal cancer patients. CCC also recruited the same patient to an observational study which runs alongside this called 'How do?' (PI: Dr Amir Montazeri, Colorectal, pictured left).
- CCC recruited its 150th patient to the HYST study against a recruitment target of 20 which has been a great response. HYST is a hypersensitivity study looking into drug and chemical induced hypersensitivity reactions in patients receiving treatment. (PI: Dr Anna Olsson-Brown)

- Skyscraper 07 screened its first patient. This study is looking at maintenance immunotherapy treatment in oesophageal cancer previously treated with chemoradiation that has not progressed. (PI: Dr Eswar Chinnamani, colorectal).
- 1st patient in the UK was recruited to the Brioche Trial. This study looks at patients with recurrent glioblastoma (PI: Dr Mehta, Brain), pictured right.

December 2021

- CCC was the highest recruiter this month for the COMICE trial recruiting nine patients. This meant the sponsor exceeded its goal of achieving 50% of its target by December 2021 (CI: Dr Lord, Gynae).
- The iLive study (Live well, die well) recruited their first patient and nominated relative. (PI: Dr Seamus Coyle, Palliative).
- The Compare trial recruited three patients in December 2021 and was referenced in the December newsletter from the sponsor. Compare is a Phase III randomised controlled trial comparing alternative regimens for escalating treatment of intermediate and high-risk oropharyngeal cancer. (PI: Dr Brammer/ Dr Ibrahim, both pictured above, Head & Neck).

- Checkpoint inhibition reduces the threshold for drug-specific T-Cell priming and increases the incidence of sulfasalazine hypersensitivity. Published: 29 November 2021, Toxicological Sciences, Oxford Academic, by Dr Olsson-Brown, pictured left.

January 2022

- The Transgene study treated the first patient in the UK. The study looks at vaccines tailored to each individual patient's cancer, to see if it reduces the risk of head and neck cancer returning. The Transgene trial will recruit around 30 people who have just

completed treatment for advanced, but still operable, HPV-negative squamous cell carcinoma of the head and neck. (PI: Professor Ottensmeier, Head and Neck).

- First patient has been recruited to the OXPLORED study. This is a study looking at pre-cancerous lymphoproliferative disorders and quality of life, clinical complications, and establishing guidance for monitoring and follow up. The study also has a translational element establishing markers for progression likelihood. (PI: Prof Pettitt, HO), pictured left.
- First patient has been recruited on to the Primrose study. This is an observational study for patients with breast cancer who also have brain metastases. (PI: Professor Palmieri, Breast).

February 2022

- CCC was the lead recruiter in the UK for the MK3476-867 study – SBRT with or without Pembrolizumab in Participants with Non-Small Cell Lung Cancer. (PI: Dr Haridass, Lung).
- The NIHR has awarded £5.3M to the Liverpool CRF which is a partnership between CCC, Liverpool University Hospital NHS Foundation Trust and Liverpool Heart and Chest Hospital to address the needs of the local population.
- Dr Coyle received £99,926 (with Prof Chris Probert at the University of Liverpool) from the University of Liverpool Enterprise Investment fund for his 'Proof of concept funding for predicting dying' study. (PI: Dr Coyle, Palliative).

- CCC was the highest recruiter in Europe for the Checkmate study. A Phase 3, Randomised, Open Label Study to Compare Nivolumab plus Concurrent Chemoradiotherapy (CCRT) Followed by Nivolumab plus Ipilimumab or Nivolumab plus CCRT followed by Nivolumab vs CCRT followed by Durvalumab in Previously Untreated, Locally Advanced Non-small Cell Lung Cancer (LA NSCLC).(PI: Dr Haridass pictured right, Lung).
- CCC was the highest recruiter in the UK for the Keynote 867 study. A Phase 3, Randomised, Placebo-Controlled Clinical Study to Evaluate the Safety and Efficacy of Stereotactic Body Radiotherapy (SBRT) with or without Pembrolizumab (MK-3475) in Participants with Unresected Stage I or II Non-Small Cell Lung Cancer (NSCLC). (PI: Dr Haridass, Lung).

March 2022

- CCC is one of the top recruiters nationally for the radiotherapy PACE-C trial. (PI: Dr Tolan, Urology), pictured left.
- The ATLANTA trial 'Additional Treatments to the Local tumour for metastatic prostate cancer: Assessment of Novel Treatment Algorithms' started treatment for its first patient on March 3rd, 2022. (PI: Dr Azman Ibrahim, Urology).
- CCC has achieved the 5,000 recruitment target for CCP-Cancer UK, which is a CCC sponsored trial (PI: Prof Carlo Palmieri, COVID-19).
- Dr Coyle presented at the national 'Palliative Care Congress'. The presentation title was 'Biochemical Markers in Death and Dying'.
- Louise Turtle, pictured right, Research & Development Expert Practitioner, presented at The BIR Annual Radiotherapy and Oncology meeting in London. The presentation title was 'Motion Management in the Abdomen'.
- Dr Coyle submitted his patent application in March 2022 in collaboration with The University of Liverpool for his 'Biology of Dying' research.

4. Early Phase Trials and Clinical Research Facility

This year focused on the further development of capacity to support early phase trials from First in Human, through Phase I to Phase II.

This capacity is a realised benefit of the opening of CCC-L, as without the new hospital, the Trust could not support such research.

As part of the benefits realisation of the move to Liverpool, CCC was able to be a collaborator on a successful national funding bid. The NIHR awarded £5.3m to the Liverpool CRF, which is a partnership between CCC, Liverpool University Hospital NHS Foundation Trust and Liverpool Heart and Chest Hospital, to address the needs of the local population. This means CCC now has national recognition for this research and a platform for collaboration over the forthcoming years.

CCC continues to be a collaborator with the University of Liverpool on the Liverpool Experimental Cancer Medicine Centre.

Last year's report described the implementation of an Early Phase Trials Unit. The R&I Directorate is delighted that it now has four bespoke in-patient rooms, on Ward 4 of CCC-L, to support such novel trials, offering Clatterbridge patients the opportunity to access state-of-the art, cutting edge therapies in cancer immunology.

This is an excellent example of novel research embedding in the Trust and has received support from the ward staff. Some of the staff who work in the Early Phase Clinical Trials Unit are pictured, above.

4.1 First-in-Human trials

To date the unit has supported the following first-in-human trials:

- Transgene: A randomised phase I trial in patients with newly diagnosed locoregionally advanced, HPV-negative, squamous cell carcinoma of the head and neck (SCCHN) evaluating a mutanome-directed immunotherapy initiated a completion of primary treatment at time of recurrence. (PI: Professor Ottensmeier)

- MOAT: A multicentre, open-label, non-randomized, phase Ib, neoadjuvant study of intravenous dosing of NG-641, an oncolytic adenoviral vector expressing a fibroblast activation protein-directed bi-specific T-cell activator antibody fragment (FAP-TAc) and an immune enhancer module (CXCL9/CXCL10/interferon alpha2), as monotherapy or in combination with pembrolizumab in patients with surgically resectable squamous cell carcinoma of the head and neck. CCC was the first UK site to open and also recruited the first UK patient. (PI: Professor Ottensmeier)

- Immunocore 103: A Phase 1/2 First In Human Study Of The Safety And Efficacy Of Imc-C103c As A Single Agen And In Combination With Atezolizumab In Hla-A*0201 Positive Patients With Advaced Mage-A4-Postive Cancer. (PI: Dr Sacco, pictured above-right).

There are a number of such trials in the pipeline and the facility is already well-used.

5. Clinical Trials Portfolio

The portfolio of clinical trials and research available to participants continues to evolve.

In particular, CCC supports not only those trials open at CCC, but is the regional centre for radiotherapy research supporting adjuvant and neo-adjuvant trials in collaboration with surgeons across the region.

We have once again worked to diversify the portfolio for patient access where 29 of the research studies opened this year were real world/observational/ translational.

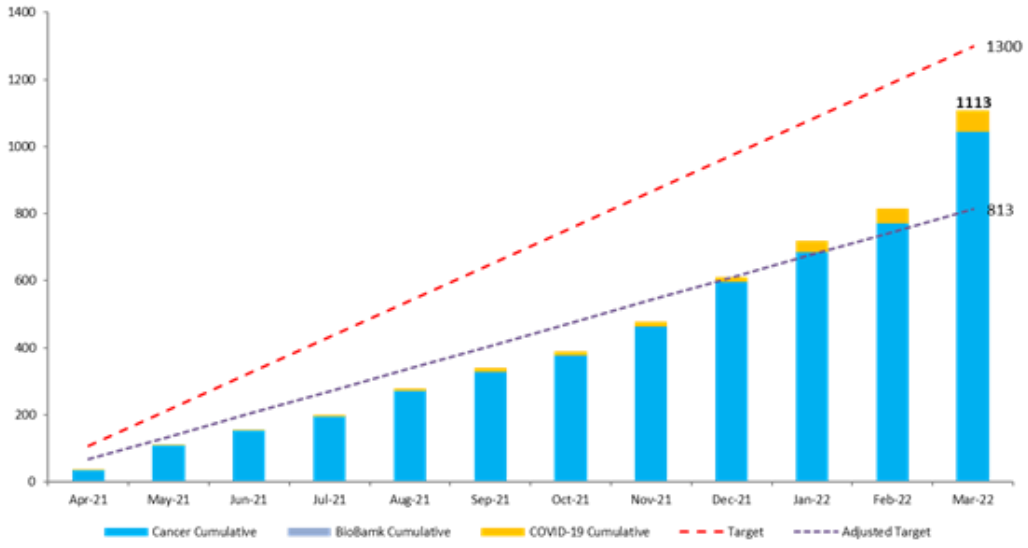
29

Real world/ observational/ translational studies opened this year

The R&I Team supporting those trials was also expanded and is led by a dedicated Research Practitioner. As we have come to expect, CCC achieved some notable 'firsts' and achievements again as detailed in Section 4.

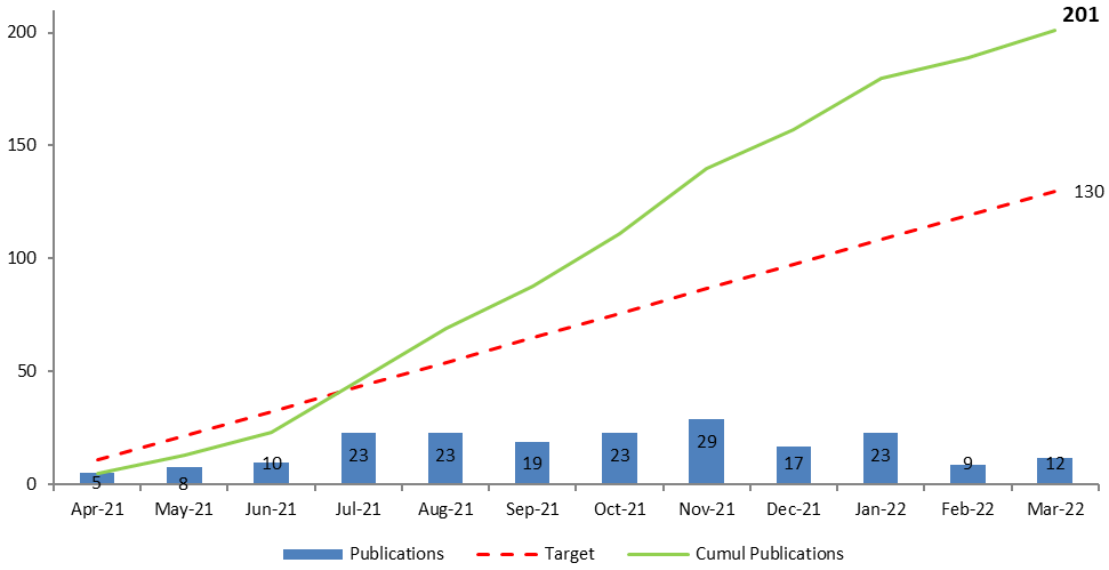
6. Research Performance

The R&I Directorate had a successful year for recruiting participants on to research trials and studies, see Graph 1. Due to COVID-19 and capacity issues within aseptics the Q4 forecast was revised resulting in a projected lower annual target. Despite that we successfully exceeded the revised target.



Graph 1. Recruitment against Time: Cumulative recruitment against internal target (n=800). Month on month split between Cancer (total Int&Obs), BioBank, COVID-19 (total UPH&Non-UPH) Cumulative stacked.

Two hundred and one publications have been recorded between April 2021 and March 2022. The target of 130 for 2021/22 was met. See Graph 2.



Graph 2 – New publications registered by month.

We continue to maintain study set-up times below the national target of 40 days. This metric has been consistently met since September 2019.

7. Systems Changes

During 2021/22 there have been a number of system changes that have led to increased productivity. Examples of these are shown below:

- Further configuration and development of CCC EDGE to support the Sponsorship Workstream. The system has been re-configured and streamlined for access to key documents and to map end-to-end processes from grant application through to study opening.
- R&I have also flexed the EDGE system to improve oversight of participating sites where CCC is Sponsor and is supporting in-house for non-CTIMP studies which is a major step-change in activity to go-live from September 2022.

- Improvement in transition of trials from set-up to delivery. In order to better align with the national Health Research Authority process, the current system was reviewed and improved. A new post, a Trial Facilitator, will provide a key link between the alignment of study set-up activity and trial opening. This will provide a seamless transition between Research Management & Governance and Delivery Teams within R&I, allow for improved screening times for potential participants, cross link with Sponsors and assure continued quality improvement metrics.

- R&I have worked with the CCC Digital team to create a paperless process for patient assessments. A digital worklist has been created on Meditech for each patient assessment opposed to having it on paper. This will support our staff and external auditor's when onsite. It will also support agile working.

8. CCC-led Trials and Studies

The CCC Sponsorship Group has gone from strength to strength again this year.

R&I has continued to review and update its processes for all activities where CCC acts as sponsor in order to support our portfolio of investigator-led research.

This year, R&I has again continued to build the portfolio with a diverse range of trials, with particular focus on translational research, observational/real world and COVID-related impact on cancer patients. All of these are fundamental in understanding mechanisms of cancer and also how cancer impacts on our patients to improve pathways and care.

R&I is pleased to report:

- 10 trials open and recruiting
- 7 trials in active set-up
- 4 trials closed to recruitment, which are in the analysis phase where outcomes can then be reported

The welcome expansion to CCC clinician-led trials and studies will further establish CCC as a research-focused hospital and enhance CCC's reputation nationally and internationally as a leader in oncology. A list of all current trials that are open and in set-up can be found in Appendix 2.

Appendix 3 provides details of all studies open or reporting during 2021/22.

9. Biobank

This year, R&I was delighted to report that it recruited a new Trials and Biobank Laboratory Manager, Jaime Young, pictured right. This is a key appointment as part of the Research Strategy.

In tandem, R&I successfully renewed its Research Ethics for the Biobank for the next five-year term. R&I took the opportunity to not only consolidate its work in CCC-L but expand the number and nature of the biological samples collected to support the ever-changing needs of the research landscape. Therefore, R&I looks forward to an increase in key collaborations, not only within Liverpool with its existing partners but also to extend its reach nationally with the new opportunities afforded.

The dedicated Laboratory Technical Team in the Biobank, pictured, support in all aspects of sample handling, storage and shipping to support the research portfolio.

The Trials Laboratory has continued to increase expertise and expanded to support the complex First-In Human and Early Phase Trials portfolio, which has shown a welcome increase in number.

10. Patient and Public Involvement in Research

The Research PPI Forum was established in November 2020. Members range from former patients, carers of former patients, Support Group chairs and lay persons with an interest in cancer.

Since its inception, members have contributed to an audit of patients' awareness of research, as well as commenting on a range of issues, such as research proposals and the process around withdrawal of consent for research studies.

- A CCC quarterly patient newsletter, Research Matters, pictured, is published for research which details the PPI Forum's activities as well as how to get involved with the group. The newsletter is available on the Trust website and members cascade within their own support groups.
- Several members are now involved with research projects, both at CCC and UCL.
- One member is on the Board of Governance for the CCC Biobank.
- Another member has served as a lay member of a team working with the Royal College of Radiologists to design a more consistent consent form for radiotherapy. The new form was piloted in breast and prostate before being rolled out to ten other cancers. The team won the BMJ Cancer Team of the Year 2021.
- The Committee also supported the ECMC renewal bid.

In addition to influencing strategy and policies, monthly meetings also welcome researchers to present their work to the Forum. These presentations are well received and generate dynamic Q&A sessions. This year has seen presentations from:

- Prof Christian Ottensmeier, who outlined his research to develop a vaccine for cancer.
- Charlotte Rawcliffe (University of Liverpool), who gave a presentation outlining the ECMC collaboration between CCC and the University of Liverpool.
- Dr Seamus Coyle, who described his research into methods to accurately predict when people are dying.

- Dr Maria Maguire (pictured right) who used the TACE study as an example of how an application for ethical approval operates after the Forum had requested some clarification around the governance and ethical approval processes.

- Jon Hayes, Managing Director of Cheshire & Merseyside Cancer Alliance, gave an overview of the work of the Alliance, explaining that it is an umbrella organisation comprising partners across Cheshire and Merseyside which is funded by NHS England and aims to improve cancer treatment and care. It is working to deliver the aims of Long Term Plan by identifying, diagnosing and treating cancer to achieve better patient outcomes.

- Dr Lynda Appleton, pictured left, outlined her study, the aim of which had been to determine the mental health and wellbeing needs of cancer staff throughout the pandemic.
- PPI leads from CCC, The Royal Marsden and The Christie have started quarterly meetings to share knowledge and experiences on supporting the PPI agenda.

11. External Partners

R&I continues to engage with Liverpool Health Partners (LHP) both strategically and operationally. Specifically, this results in:

- R&I having representatives from CCC at all LHP committees and works to drive the cancer agenda forward.
- The Research Management & Governance and Finance teams continue to be an active partner in the enablement and activity of SPARK.
- R&I continues to support in business intelligence via the EDGE system.
- R&I has taken a lead role in the streamlining of trial set-up activities and cross-collaboration between partner Trusts to ensure participant access to clinical trials.

The Clatterbridge Cancer Centre NHS Foundation Trust

12. Nurse-Led Research

The R&I Directorate continues to support Nurse-led research initiatives, which are flourishing.

- 185 patients and staff have been recruited on to trials over the last year by two qualified nurses, this equates to 16.6% of the total recruitment for the year.
- The R&I Directorate, through CCC's Research Strategy, is looking to engage other allied health professionals to do their own account research.

R&I nurses are leading on their own research and participating in national studies, such as:

12.1 Gynae Cancer Narratives Study

This project explores how patients experience radiotherapy for gynaecological cancer with the aim to increase understandings of how radiotherapy impacts on social, personal and sexual lives.

- The objective is to develop a range of resources for use by patients and practitioners in order to provide more support for cancer patients in the North West.
- Patients are invited to keep journals on their experiences of radiotherapy from consent to six months after treatment has finished.
- The study recruited 35 patients and has now closed.
- Findings have been written up for publication and the results were presented at the UKIO (UK Imaging and Oncology) Congress in July 2022.
- Chief Investigator: Dr Lynda Appleton.

12.2. CCC Staff Wellbeing Study

CCC-sponsored study, funding secured from The Clatterbridge Cancer Charity

Exploring the impact of COVID-19 on the psychological wellbeing of CCC oncology healthcare professionals

- The aim of the study is to understand how oncology healthcare professionals working at CCC have been managing their wellbeing during the COVID-19 pandemic, the coping strategies and support systems they use, and what, if anything, can be done to better support them.

- A total of 102 healthcare professionals were recruited from across five staff groups – medical staff, radiographers, nurses, allied health professionals (non-radiographers) and healthcare/cancer support workers.
- Staff were invited to keep diaries on their experiences for a period of up to four months. Fifty diaries were submitted.
- In addition, 35 interviews have been completed with staff.
- A final report was completed in November 2021 with the findings presented to staff groups at CCC and at a range of national and international conferences.
  - Royal College of Radiologists Learning Live 21 – October 2021
  - International Conference on Cancer Nursing – February 2022
  - MASCC/ISOO 2022 Annual Meeting (Multinational Association of Supportive Care in Cancer) – June 2022
  - ISQua (International Society for Quality in Healthcare) – October 2022
- Chief Investigator: Dr Lynda Appleton.

12.3 Nurse Wellbeing across Cheshire and Mersey during COVID-19

CCC-sponsored study, funding secured from The Burdett Trust For Nursing

Exploring the impact of the COVID-19 pandemic on the psychological wellbeing of nurses working in the cancer setting across Cheshire and Merseyside

- This study is exploring nurses' experiences of the psychological impact of COVID-19 on their day-to-day care and support of patients with a diagnosis of cancer.
- Questionnaire surveys will be used to investigate levels of resilience, anxiety, wellbeing and coping among registered nurses.
- 69 nurses have been recruited from 18 NHS Trusts in Cheshire and Merseyside.
- Data is currently being analysed.
- Chief Investigator: Dr Lynda Appleton.

12.4 REAP-CCC

CCC-sponsored study, funding secured from CCC Research Fund

Reducing Emergency Admissions for Patients with Cancer Complications and/or Co-morbidities

- The study aims to explore the reasons for the emergency department attendance and admission by patients with cancer (type 3 presentation), and the potential wider contextual influences, such as demographic, social and environmental factors leading to such occurrences.
- This will enable us to develop interventions and strategies to reduce unnecessary admissions among this group of cancer patients.
- The study has received ethical approval and is currently paused until the risks associated with the pandemic, and its impact at the Liverpool University Hospitals NHS Foundation Trust, have reduced.
- Chief Investigator: Dr Lynda Appleton.

12.5 Finding My Way

University of Chester-sponsored study

Funded by North West Cancer Research,

Online, self-help, coping programme

- This study offers information, suggestions, and support for people who have been diagnosed with cancer in the past six months.
- The programme offers six modules of information and interactive features, including worksheets, online activities, quizzes, relaxation/meditation and a personal note-taking feature relevant to their cancer diagnosis and treatment.

- Emma Whitby, Head of Research Delivery and a member of the R&I Senior Management Team, is acting as Principal Investigator. She is pictured, above, with the study team.
- To date, 126 patients have been recruited, which is the highest in the UK and more than half the national recruitment total.

13. Finance

During 2021/22, financial reporting transitioned from centralised to Site Reference Group (SRG). Reporting by SRG provides a greater insight into the portfolio's financial activities and enables greater financial management.

Grant income has increased from the previous year due to milestone payments of open studies being achieved and the opening of a new study.

In 2021/22, the impact of the pandemic and service department issues was still being felt resulting in Commercial Trial income being lower than the forecasted plan.

The R&I Directorate was successful in achieving a number of external funding awards:

- RCF (Research & Capability Funding) - for recruiting 500+ participants to Non-Commercial portfolio adopted trials.
- NWC Commercial Managed Recovery - to enable current portfolio Commercial Trial recovery.
- NWC Managed Recovery - to support the diversification of the portfolio of trials and to support the increase of CCC referrals.

The year also saw the successful transfer of the Haemato-Oncology trials from Aintree.

14. Communications

In light of the appointment of a research-specific Communications Manager (0.4WTE), Paul Ogden, through the Research Strategy, R&I has again had research stories highlighted in local, national and international media, as well as news items on national TV channels. This included widespread coverage of the Transgene trial, including filming by ITV News, pictured right. See Appendix 4 for key examples. There has also been internal communications involving R&I to increase exposure of R&I activities to the wider CCC workforce and highlight R&I's successes and the good work of individuals within the Directorate.

In addition to this coverage, we have received positive feedback from sponsors, patients and investigators, as shown in Appendix 5.

15. Innovation

15.1 Appointments

A new Clinical Lead for Innovation, Dr Séamus Coyle, pictured left, and a new Innovation Manager, Drew Norwood-Green, pictured right, were appointed in February 2022 and November 2021 respectively.

15.2 Bright Ideas Scheme

Launched in September 2021, the Bright Ideas Scheme uses £150,000 of CCC charitable funding – further approved for 2022-2023 – to take forward ideas from CCC staff for enhanced patient care and treatment.

Over 60 Bright Ideas were received during 2021-2022, with a notable examples being Bereavement Boxes to help young family members experiencing the loss of a loved one.

15.3 Patent – Biology of Dying

A patent for the Biology of Dying research being undertaken by Dr Séamus Coyle was submitted and contracting with the University of Liverpool is progressing to support this work.

15.4 Innovation Strategy

Innovation Strategy in development focusing in three key areas:

- Cultivating the Culture of Innovation: Identifying, developing and implementing initiatives aimed at encouraging and empowering staff across the organisation to seek opportunities for innovation whether these are new ideas or key challenges that if overcame would have a significant positive impact.
- Nurturing New Innovations: Collating ideas from across the organisation, providing support to fully realise concepts with potential. This support includes appropriate advice, funding, sourcing appropriate grants and identifying partners with whom to collaborate or co-create.
- Supporting Adoption of Innovation: Horizon scanning for the latest developments in technology, healthcare and beyond with the aim of accelerating access to these advancements to our patients.

16. Summary

The last year was spent in recovery from the pandemic and re-centering the Directorate's focus to support the best in cancer research, both as a participating site and as a sponsor of CCC clinician-led research.

The year has not been without challenge but, once again, there are notable successes to report with not only a fully diversified portfolio but also the step-change into fully supporting early phase research with the creation of the CCC Early Phase Trials Unit.

The Directorate has remained nationally and internationally competitive in recruitment to trials and remains committed to offering CCC patients the best in novel agents and therapies within the research portfolio.

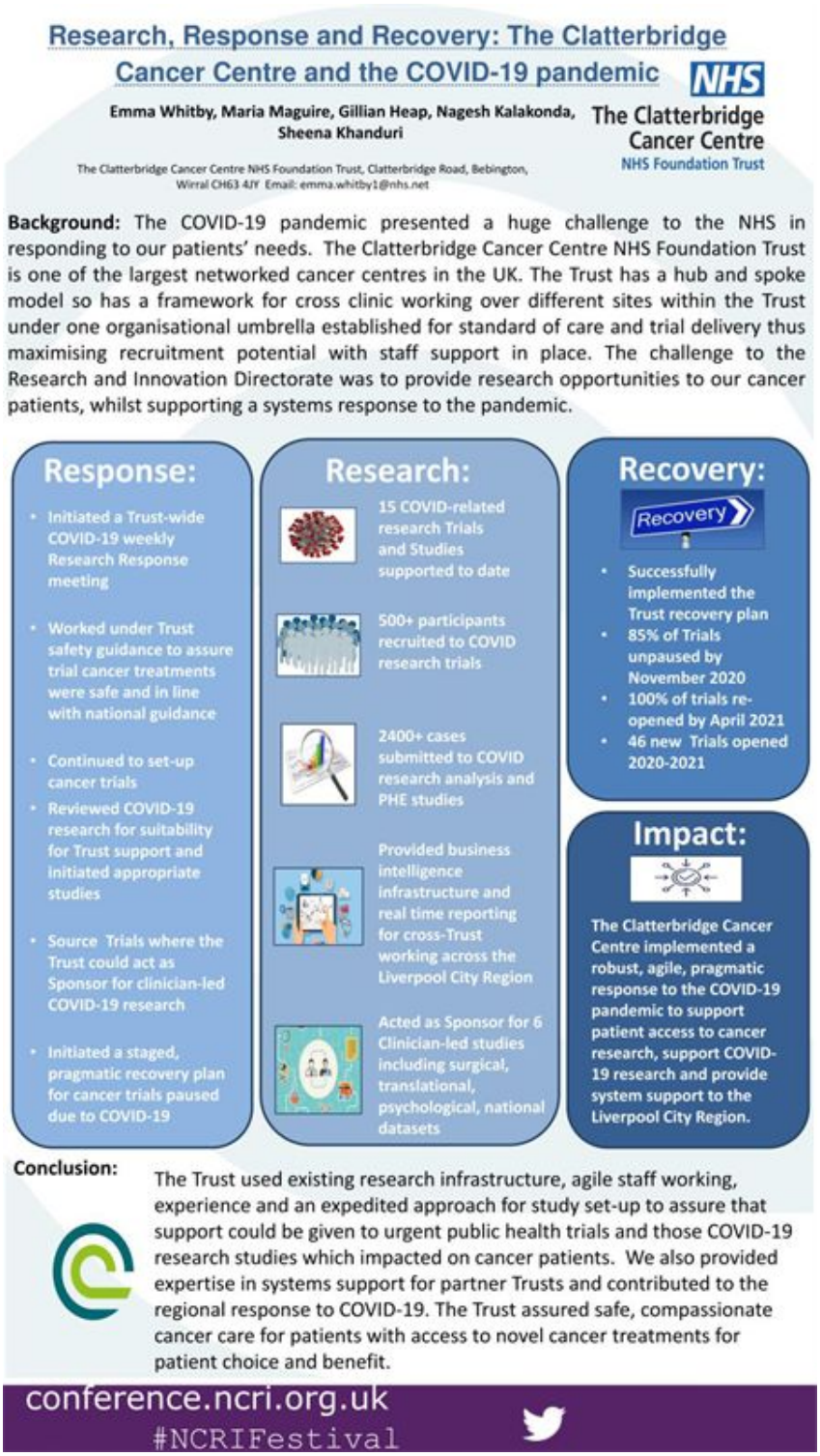
For innovation we have started building the infrastructure within the organisation with the establishment of the Innovation Team and developing a Trust-wide Innovation Strategy. This will allow us to build on existing work to drive innovation forward in a systematic and targeted approach which best aligns with our overall strategic objectives.






The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix 1: Example Conference posters



Research, Response and Recovery: The Clatterbridge Cancer Centre and the COVID-19 pandemic

Emma Whitby, Maria Maguire, Gillian Heap, Nagesh Kalakonda, Sheena Khanduri

The Clatterbridge Cancer Centre NHS Foundation Trust

The Clatterbridge Cancer Centre NHS Foundation Trust, Clatterbridge Road, Bebington, Wirral CH63 4JY Email: emma.whitby1@nhs.net

Background: The COVID-19 pandemic presented a huge challenge to the NHS in responding to our patients' needs. The Clatterbridge Cancer Centre NHS Foundation Trust is one of the largest networked cancer centres in the UK. The Trust has a hub and spoke model so has a framework for cross clinic working over different sites within the Trust under one organisational umbrella established for standard of care and trial delivery thus maximising recruitment potential with staff support in place. The challenge to the Research and Innovation Directorate was to provide research opportunities to our cancer patients, whilst supporting a systems response to the pandemic.

Response:

- Initiated a Trust-wide COVID-19 weekly Research Response meeting
- Worked under Trust safety guidance to assure trial cancer treatments were safe and in line with national guidance
- Continued to set-up cancer trials
- Reviewed COVID-19 research for suitability for Trust support and initiated appropriate studies
- Source Trials where the Trust could act as Sponsor for clinician-led COVID-19 research
- Initiated a staged, pragmatic recovery plan for cancer trials paused due to COVID-19

Research:

15 COVID-related research Trials and Studies supported to date

500+ participants recruited to COVID research trials

2400+ cases submitted to COVID research analysis and PHE studies

Provided business intelligence infrastructure and real time reporting for cross-Trust working across the Liverpool City Region

Acted as Sponsor for 6 Clinician-led studies including surgical, translational, psychological, national datasets

Recovery:

Recovery

- Successfully implemented the Trust recovery plan
- 85% of Trials unpaused by November 2020
- 100% of trials re-opened by April 2021
- 46 new Trials opened 2020-2021

Impact:

The Clatterbridge Cancer Centre implemented a robust, agile, pragmatic response to the COVID-19 pandemic to support patient access to cancer research, support COVID-19 research and provide system support to the Liverpool City Region.

Conclusion:

The Trust used existing research infrastructure, agile staff working, experience and an expedited approach for study set-up to assure that support could be given to urgent public health trials and those COVID-19 research studies which impacted on cancer patients. We also provided expertise in systems support for partner Trusts and contributed to the regional response to COVID-19. The Trust assured safe, compassionate cancer care for patients with access to novel cancer treatments for patient choice and benefit.

conference.ncri.org.uk
#NCRIFestival

The Clatterbridge Cancer Centre NHS Foundation Trust

Exploring the impact of COVID-19 on the psychological wellbeing of oncology health care professionals

Dr. Lynda Appleton., Prof. Helen Poole., Sarah Watmough., Andreia Ramos-Silva

Liverpool John Moores University

The Clatterbridge Cancer Centre NHS Foundation Trust

Introduction

- COVID-19 has had profound effects on the mental health and wellbeing of healthcare professionals (HCPs)[1]
- HCPs providing cancer care[2] have had to adjust to new ways of working as a result of the pandemic[3]
- Studies commonly use quantitative methods to investigate wellbeing[4,5]

Method

AIM

- Explore how oncology HCPs managed their psychological wellbeing Inc. The coping strategies and support systems used
- To inform the development of interventions to promote and sustain self-management of psychological wellbeing

DATA COLLECTION & ANALYSIS

- Diaries and semi-structured interviews between December 2020-April 2021 were analysed using Interpretative Phenomenological Analysis[6]

ETHICS

- HRA and LJMU approval

Table 1. Sample characteristics

	Diary only	Interview only	Diary & Interview	Total
Consultant	4	2	1	7
Radiographer	9	8	2	19
Nurses	10	4	12	26
Allied Health Professionals (non-radiographer)	5	1	2	8
Support workers	3	1	2	6
Total	**31**	**16**	**19**	**66**

Results (4 themes)

Self-management

Participants used different strategies to manage their wellbeing, such as concealing emotions and staying positive for colleagues.

"I did actually put a brave face on"

"I am generally optimistic & aim to keep others positive"

The monotony of managing everyday life through the pandemic and the relentless nature of COVID required resilience.

"Feels like can't see light at the end of the tunnel this week. Same old same old. Sleep, eat, work, repeat. Ground Hog day every day"

Managing employer-employee relationships

Participants were aware of the resources offered by the organisation, however, a lack of time was a reoccurring barrier to accessing resources.

"There's been stuff about mental health support and all like that on the emails but you don't have time to access that in work"

Communication was key to understanding well-being needs, as well as feeling valued and listened to.

"I don't really need a resilience workshop, I just want to feel like I'm being listened to"

It was acknowledged that the Trust were doing their best in a challenging situation

"I think the Trust probably has done everything they could do to be fair…we've just had to fumble our way along and learn as you go"

Delivery of patient care

A sense of wellbeing was achieved through the delivery of patient care. Patients were admired, linked to positive expressions of gratitude and appreciation.

"The patients I was in awe of – none of them complained at all or expressed concern – they clearly have a big battle of their own

"Patients were particularly grateful today… nice to be appreciated"

Usual communication methods were interrupted by the pandemic, as a result of mask wearing.

"Having delicate matters explained to them by half-faced health professionals trying to give comfort through their eyes"

Changes in patient numbers attending the Centre required active management.

"This sounds awful, oh I hate saying this out loud, we had to categorise patients"

Managing professional roles

Participants expressed anxiety about the potential for redeployment to other clinical areas.

"I did worry I would be redeployed and what would that mean, but I accepted that this could be something that would happen, luckily it didn't"

The normality associated with work routine and the solidarity experienced with colleagues provided a sense of positive wellbeing.

"So just the process of going to work actually does something for your mental health"

"It feels like the team is a family almost, but a family that really understands what you are going through"

Conclusions and recommendations

- The study identified the dynamic and evolving nature of mental health and wellbeing amongst oncology HCP's
- Wellbeing solutions should be co-produced by the organisation with staff, according to individual needs and preferences
- Access to Information on work-based wellbeing support should consider using a wide range of communication methods and routes
- Future research should consider the long-term health and wellbeing impact of COVID on HCPs e.g. fatigue and burnout, creating opportunities for socialisation, relaxation, reflection & supervision.

References

1. Department of Health (2020). COVID-19 mental health and wellbeing surveillance: report.
2. Macmillan (2020). The Forgotten 'C': The Impact of COVID-19 on Cancer Care.
3. Morgantini et al (2020). Factors contributing to healthcare professional burnout during the COVID-19 pandemic: A rapid turnaround global survey. https://doi.org/10.1371/journal.pone.0238217
4. Cai et al (2020). Psychological Impact and Coping Strategies of Frontline Medical Staff in Hunan Between January and March 2020 During the Outbreak of Coronavirus Disease 2019 (COVID-19) in Hubei, China. https://doi.org/10.12659/MSM.924171
5. Shechter et al (2020). Psychological distress, coping behaviors, and preferences for support among New York healthcare workers during the COVID-19 pandemic. https://doi.org/10.1016/j.genhosppsych.2020.06.007
6. Smith & Osborn (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. https://doi.org/10.1177/2049463714541642

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Appendix 2: CCC Clinician-led Research Where CCC Acts as Sponsor

Acronym	Title	Type	CCC Chief Investigator	Status
CHROME	Phase II study of the use of neoadjuvant cabazitaxel with hormonal treatment in patients with high risk operable prostate cancer, to assess the efficacy and toxicity of cabazitaxel, and, to explore potential predictive and prognostic markers of clinical outcome	CTIMP	Dr Zaf Malik	Open
COMICE	A randomized double blind placebo controlled Phase II clinical trial of Cediranib and Olaparib maintenance in advanced recurrent Cervical Cancer	CTIMP	Dr Rosie Lord	Open
TACE 3	A two-arm multi-stage (TAMS) seamless phase II/III randomised trial of nivolumab in combination with TACE/TAE for patients with intermediate stage HCC	CTIMP	Prof Daniel Palmer	Open
MRI Lung	MRI for lung radiotherapy; a prospective study	Radiotherapy	Dr Neeraj Bhalla	Open
TARGET Head and Neck	Tissue analysis for stratifying therapy in head and neck diseases	Translational	Prof Christian Ottensmeier	Open
CCP CANCER	Clinical Characterisation Protocol for Severe Emerging Infections in the UK– a prospective companion study for patients with Cancer and COVID-19	COVID-19	Prof Carlo Palmieri	Open
Cox-2 expression	Cox-2 expression and Checkpoint Inhibitor Therapy	Translational	Dr Olusola Faluyi	Open
MRI Imaging H&N	Assessing early response to Immunotherapy in Head & Neck Cancer	Translational	Mr Andrew Schache/ Dr Rachel Brooker	Open
UNCOVER	Understanding the impact of SARS-CoV-2 infection in patients with blood cancer	COVID-19	Prof Andrew Pettitt	Open
Burdett	Exploring the impact of the COVID-19 pandemic on the psychological well-being of nurses working in the cancer setting across Cheshire and Mersey	COVID-19	Dr Lynda Appleton	Open
Apollo	A Polatuzumab Vedotin containing Chemo-Immunotherapeutic regimen in patients with Diffuse Large B-Cell Lymphoma unsuitable for full dose R-CHOP Therapy	CTIMP	Prof Nagesh Kalakonda	In set-up

RATIO	Phase II randomised study of Durvalumab (MEDI4736) + Tremelimumab in combination with different radiotherapy modalities for advanced hepatocellular carcinoma	CTIMP	Prof Daniel Palmer	In set-up
Apollo +	A Prospective 'Real World Data' registry and sample collection study for patients with Diffuse Large B-cell Lymphoma	Real World	Prof Nagesh Kalakonda	In set-up
MPN Registry	The UK Myeloproliferative Neoplasm Registry	Registry	Dr Nauman Butt	In set-up
REAP	Reducing Emergency Admissions for Patients with Cancer Complications and/or Co-morbidities	Real World/ Observational	Dr Lynda Appleton	In set-up
Target CSI	Measurement of Immunocompetence in Cancer patients by use of Quantitative Experimental Contact Sensitisation	Translational	Prof Christian Ottensmeier	In set-up
Target Vaccination	Evaluation of response to routine vaccination to assess immunocompetence in patients with cancer	Translational	Prof Christian Ottensmeier	In set-up
Safe Surgery	Establishing the presence of SARS-CoV2 virus in the peritoneal cavity of patients undergoing abdominal surgery	COVID-19	Prof Christian Ottensmeier	Closed in analysis
COVID Staff	Exploring the impact of COVID-19 on the psychological well-being of oncology healthcare professionals	COVID-19	Dr Lynda Appleton	Closed in analysis
ACE	Analysis of an abdominal compression device to reduce respiratory motion of lower thorax and abdominal tumours	Radiotherapy	Dr Anoop Haridass	Closed in analysis
NICO	Neoadjuvant and adjuvant nivolumab as Immune Checkpoint inhibition in Oral cavity cancer	CTIMP	Dr Joe Sacco	Closed in analysis

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix 3: Open studies that CCC sponsor

The below four studies were opened during 2021/22:

Immunotherapy in the treatment of recurrent/metastatic head and neck squamous carcinoma (HNSCC) -Assessing early indicators of treatment response with diffusion weighted magnetic resonance imaging and the microbiome.

- We will assess if response to immunotherapy in HNSCC patients receiving immunotherapy as part of their standard treatment is detectable through a) changes seen in scans of patient and b) changes in the normal bacteria living in patients mouths and gut (oral/faecal microbiome).
- The research aims obtain comprehensive and holistic information addressing questions surrounding the complex interplay between tumour and host immune environment, microorganisms and imaging biomarkers.

Mr Andrew Schache

Dr Rachel Brooker

Exploring the impact of the COVID-19 pandemic on the psychological well-being of nurses working in the cancer setting across Cheshire and Mersey

This study will explore the evolving experiences of registered nurses working across community, primary, secondary and tertiary care sectors during the COVID pandemic, and its impact on the psychological well-being of individuals. The study will capture the experiences of a wide range of nurses – Nurse Consultants, Lead Nurses, Advanced Nurse Practitioners, Clinical Nurse Specialists, Nursing Directors, ward nurses, community nurses and district nurses – to provide a broad understanding of their needs and where support might be required.

Dr Lynda Appleton

Cox-2 expression and Checkpoint Inhibitor Therapy

- Treatment with certain drugs called checkpoint inhibitors (CKI) has emerged as an effective form of anti-cancer treatment over the past decade. However, not everyone with cancer benefits.
- This study is looking at whether levels of a protein called Cyclo-oxygenase-2 (Cox-2) which suppresses the body's immune reaction are higher in tumours which do not to respond to CKI therapy.
- Furthermore, what sort of immune differences occur in tumours with higher Cox-2.

Dr Olusola Faluyi

The Clatterbridge Cancer Centre NHS Foundation Trust

Un-CoV-er: Understanding the impact of SARS-CoV-2 infection in patients with blood cancer

- This is an important study looking at the effects of COVID-19 on patients with blood cancers:
- The first part of the study focusses on the incidence and severity of COVID-19 infection in patients with blood cancers, who are thought to be at higher risk than the general population. We will study whether this is the case using these 'real world' datasets and discover whether any other factors are able to predict poor outcome in this patient group.
- The second part of the study focusses on the impact of changes in practice during the COVID-19 pandemic on outcomes in blood cancer. In particular, to investigate any changes in rates of blood cancer diagnosis, cancer waiting times, deviations from pre-COVID standard of care, changes in treatment dosing or delays, and number and type of healthcare episodes.

Prof Andrew Pettitt

The below six studies have been active during 2021/22:

COMICE: A randomized double blind placebo controlled Phase II clinical trial of Cediranib and Olaparib maintenance in advanced recurrent Cervical Cancer

- We are looking to see if giving Cediranib and Olaparib together after patients have finished chemotherapy, can shrink or prevent the cancer from growing.
- This will be randomised against placebo and will be monitoring patients side effects, patient quality of life and patients potential life extension.

Dr Rosie Lord

MRI Lung Study

- Although MR imaging is well developed for the majority of tumour sites, it has rarely been used in the management of lung cancer, where tumour and normal tissue motion pose particular challenges.
- This research is testing the best way of getting the MRI images and the best way of seeing a moving tumour in the lung.

Louise Turtle

Dr Neeraj Bhalla

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

CHROME: Phase II study of the use of neoadjuvant cabazitaxel with hormonal treatment in patients with high risk operable cancer, to assess the efficacy and toxicity of cabazitaxel, and, to explore potential predictive and prognostic markers of clinical outcome

- This will help determine whether Cabazitaxel may be able to be used as a treatment for prostate cancer.
- This is a study where patients with high risk prostate cancer will be given an extra medication before they have their operation to remove the prostate cancer.
- We want to look at whether this drug may be successful as a treatment for prostate cancer in men who have high risk prostate cancer, and who are eligible for surgery .

Dr Zaf Malik

TACE-3: A two-arm multi-stage (TAMS) seamless phase II/III randomised trial of nivolumab in combination with TACE/TAE for patients with intermediate stage HCC

- This study is looking to see if adding the drug nivolumab to the current standard treatment will be better for treating patients with liver cancer.
- The current treatment TACE (Transcatheter Arterial Chemoembolisation) with drug eluting beads puts a large dose of chemotherapy drugs directly into the tumour. Current evidence suggests that adding an immunotherapy drug like Nivolumab at the same time as TACE may help increase the time taken until the tumour begins to grow/spread.

Prof Daniel Palmer

Target Head and Neck: Tissue analysis for understanding head and neck diseases

- The purpose of this project is to improve our knowledge of how the immune system works in head and neck and viral diseases.
- We will look at blood and tissue samples from patients with head and neck cancer and other non-cancer head and neck diseases. We will establish if these patients have had previous exposure to known viral infections to better understand how the immune system works.
- Our long term aim is that the results will guide us to developing better treatments for a range of diseases including viral infections and cancer.

Prof Christian Ottensmeier

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

CCP-Cancer UK: Clinical Characterisation Protocol for Severe Emerging Infections in the UK (CCP-UK) – a prospective companion study for patients with Cancer and COVID-19.

- Currently, there is extremely limited information regarding the risks posed by SARS-CoV-2 virus responsible for COVID19 to patients with cancer. This study aims to understand the presentation, management and outcomes of cancer patients with COVID19. The influence of cancer type and treatment will be explored as well as comparing cancer patients with non-cancer patients.
- This study will provide valuable information that would educate as well as help inform practice for future possible outbreaks. The information may also inform the development of guidelines with regard to the care and management of cancer patients with viruses such as COVID19 and similar infectious diseases.

Prof Carlo Palmieri

The below two studies have closed during 2021/22 and are now reporting:

COVID STAFF: Exploring the impact of COVID-19 on the psychological well-being of oncology healthcare professionals

This study will explore the evolving experiences of oncology healthcare professionals in the workplace during the COVID pandemic, and its impact on the psychological well-being of staff. The study will capture the experiences of a wide range of staff – medical, nursing, radiographers, support staff – to provide a broad understanding of their needs and where support might be required.

Dr Lynda Appleton

SAFE SURGERY: SARS-CoV2 viability in the Abdomen or Pelvis and the FEasibility of SURGERY

- The COVID-19 pandemic has raised concerns about the risk of viral transmission in a number of healthcare settings. These concerns mean that as we enter the recovery phase of this pandemic our ability to return to normal practice may still be affected.
- The overall aim of the study is to provide initial scientific data to help determine risk to the theatre team of SARS-CoV2 transmission via the peritoneal cavity in patients undergoing abdominal or pelvic surgery.

Prof Christian Ottensmeier

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Appendix 4: Key Communications throughout 2021/2022

During the year there have been articles on R&I in the press, on social media and on CCC's website and internal intranet, as well as featuring on national and regional TV News.

Below are some of the highlights:

Eric thanks clinical trials team for successful treatment
Liverpool Echo: *https://www.liverpoolecho.co.uk/news/liverpool-news/man-told-lung-cancer-after-20938913*

Clinical trial gives hope of new treatment for aggressive eye cancer
Liverpool World:
https://www.liverpoolworld.uk/news/clatterbridge-trial-makes-cancer-treatment-breakthrough-to-potentially-prolong-life-3434438

Important study into COVID and cancer opens to Clatterbridge patients
Technology Networks:
https://www.technologynetworks.com/cancer-research/news/uk-study-set-to-assess-the-impact-of-covid-19-on-people-with-cancer-339370

New technique helps clinical trial targeting hard to reach tumours
The Guide Liverpool: *https://theguideliverpool.com/this-new-technique-is-being-used-for-cancer-research-in-liverpool*

SIREN study is extended for another 12 months
Wirral Globe:
https://www.wirralglobe.co.uk/news/19566934.clatterbridge-staff-continue-stepping-covid-research/

Clatterbridge patient champions clinical research trials
Wirral Globe:
https://www.wirralglobe.co.uk/news/19248128.mum-takes-part-clatterbridge-cancer-trials/

Clinical researchers look for a test to pinpoint people with diabetes at a higher risk of cancer
Formby Bubble: *https://www.formbybubble.com/single-post/formby-resident-george-stacey-speaks-about-his-experience-during-pancreatic-cancer-awareness-month*

Clatterbridge charity grant helps radiotherapy researcher gain prized fellowship
University of Liverpool news:
https://news.liverpool.ac.uk/2021/08/04/nihr-fellowship-for-radiotheraphy-researcher


Clatterbridge trial makes cancer treatment breakthrough to potentially prolong life

Trial of a new drug to treat a form of cancer could "make a big impact on lengthening the survival time for patients".

By Dominic Raynor
Wednesday, 27th October 2021, 1:06 pm


WirralGlobe

News Sport Rovers What's On Events E-Edition Announcements

Mum takes part in Clatterbridge cancer trials

Clatterbridge is first site in UK to recruit patients for brain cancer clinical trial

CCC website: *https://www.clatterbridgecc.nhs.uk/news/clatterbridge-first-site-uk-recruit-patients-brain-cancer-clinical-trial*

Man who began smoking aged 10 joins pioneering cancer trial

Liverpool Echo:

https://www.liverpoolecho.co.uk/news/liverpool-news/man-who-began-smoking-aged-22959527

Woman completes treatment in pioneering cancer research trial

Liverpool Echo:

https://www.liverpoolecho.co.uk/news/liverpool-news/woman-knew-something-wrong-after-23227374

First UK patient to try bespoke cancer vaccine 'hopefully looking for a brighter future'

ITV News:

https://www.itv.com/news/2022-02-04/first-uk-patient-to-try-bespoke-cancer-vaccine-looking-for-a-brighter-future

Clatterbridge benefits from £5.3 million funding boost for Liverpool to explore new treatments

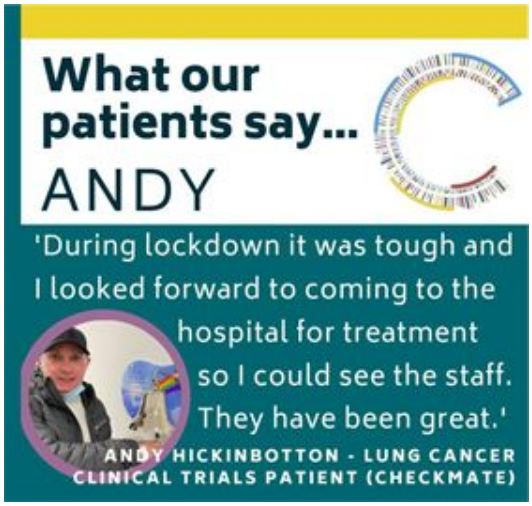
CCC website:

https://www.clatterbridgecc.nhs.uk/news/clatterbridge-benefits-53-million-funding-boost-liverpool-explore-new-treatments

Appendix 5: Positive Feedback from Sponsors and Patients

Sarah Feeney, R&I Advanced Research Practitioner, received the following feedback from a patient treated on the Inovate trial (PI: Dr Haridass, Head & Neck).

'On behalf of myself and my wife, I just wanted to say thank you for the care and compassion you have shown to me during my cycle of treatment. You've provided lots of useful advice and information but, perhaps more importantly, have shown me great kindness and understanding which I really appreciate. It has been a great pleasure for me to contribute to the trial in a very tiny way and we both hope that it will enable you and your colleagues to improve the quality of treatment you are able to offer in the future.'



Positive feedback received from the Sponsor of the Tulip study (PI: Professor Palmieri, Breast)

'*Thank you very much for your hard work and involvement in database cleaning for the Tulip study during last period. We are excited to notify you that we have successfully completed the database lock for the primary PFS analysis on Monday, 17 May 2021. After many weeks of entering and cleaning data, answering queries, and then signing the casebooks, we have achieved this goal. We understand that this was not an easy task as most sites were still experiencing COVID-19 related restrictions during these weeks, making it difficult to complete some tasks within the tight timelines of data cleaning. We cannot thank you enough for continuing to maintain close communication and collaboration with us to achieve this important milestone. Your hard work and dedication to this study made it all possible and we are so appreciative'.*

Positive feedback from the Sponsor of the Checkmate 73L trial (PI: Dr Haridass, Lung).

'The sponsor are really impressed with the number of participants you have been able to screen/ recruit despite what appears to be a challenging inclusion criteria and thanked you for your hard work. Other sites taking part have found it difficult to identify/ recruit patients into this study and would welcome any feedback around any ideas you might have to recruit?'

Positive feedback received from the sponsor /QA vendor about CCC Clinical trials Radiotherapy team from the Checkmate 73L study, acknowledging the hard work this team puts in for this study and others. (PI: Dr Haridass):

'It is truly a pleasure with you and those at your site.
We work with many sites and yours is top notch'

Positive feedback from the COPELIA study sponsor (PI: Dr Lord, Gynae):

'111 participants have been recruited into this study across all sites which has been a fantastic achievement. Thank you to all sites that have been involved in recruiting patients for this trial. Special mention to CCC who have randomised 2 patients in September 2021 – fantastic effort.'

Positive feedback from the CompARE study sponsor (PI: Dr Ibrahim, Head & Neck):

'Congratulations to the CCC team for recruiting 2 patients in September 2021. This trial is a phase 3 randomised controlled trial comparing alternative regimens for escalating treatment of intermediate and high-risk oropharyngeal cancer.'

Cheshire & Merseyside Cancer Alliance

Performance Report

October 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*	145%
Cancer treatment activity*	105%
SACT (inc chemo) delivery**	139%

Measure	% of pre-Covid level
Radiotherapy planning**	134%
Radiotherapy treatment**	91%
Endoscopy activity♀	99%

- 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, following a dip in July 2022, RT Planning figures and SACT activity have risen again to over 130%. Whilst Radiotherapy treatments reduced significantly in early 2020/2021 due to a change in fractionation, despite the continuation of this change, activity increased and has been between 88% and 99% of pre covid-19 levels since April 2022. The levels of activity reflect the significant rise in referrals into CCC since March 2022. In September 2022, referrals were 27% higher than September 2019's total; this is the highest monthly total CCC has received to date.

Cheshire & Merseyside Cancer Alliance

*Data as of 10th October – Cancer treatment activity taken from national PTL from August 2022 onwards – prior to this surgical activity was reported by Trusts
** Solid tumour only (not inc. Haemato-oncology): reliable Haemato-oncology figures pre covid are unavailable – data as of September 2022
♀Assessment based on monthly DM01 endoscopy returns - latest update August 2022. Activity is used as an indication of capacity.

Section I: Summary

- Endoscopy activity decreased slightly to 6,810 procedures (from 6,873 procedures in July). Whilst this is fewer procedures than August 2019 (7,344 procedures), changes to case-mix (more colonoscopies and fewer flexi sigmoidoscopies) mean it represents similar clinical activity (99% vs July 2019). Activity is usually lower in August than other months, but the decrease in 2022 was less than in other years.

- Endoscopy waiting list increased to 11,202 procedures (from 10,213 procedures in July). This increase was due to Liverpool University (Aintree site) adding their overdue surveillance patients. We know there is one trust still to add their overdue surveillance patients to the DM01 waiting list (St Helens and Knowsley). For other trusts, the endoscopy waiting list decreased to 7,767 procedures (from 7,925 procedures in July).

- Trusts are being encouraged to increase patients booked on existing lists, as productivity analysis suggests achieving 120% of pre-pandemic activity (as required by the 2022-23 planning guidance) may be achievable if this is implemented. The Alliance has an established endoscopy network and an endoscopy operational recovery team (EORT) to oversee and co-ordinate restoration activities.

Cheshire & Merseyside Cancer Alliance

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 **August 2022**.

The Alliance failed the **14 day standard** for urgent suspected cancer referrals, achieving 73.9%. This is lower than 76.1% the previous month.
The England average was 75.6%.
Eight trusts and nine historic CCGs failed to meet the 14 day standard of 93%.
Cheshire and Merseyside was the 13th best performing Alliance in England out of 21 against this standard.

The Alliance failed the **28 day standard** for all referral routes achieving 66.0%. This is lower than 68.9% the previous month.
The England average was 69.5%.
Seven trusts and eight historic 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 67.6%. This is lower than 69.2% the previous month.
The England average was 61.9%.
12 trusts and all nine historic CCGs failed to meet the 62 day standard of 85%.
Cheshire and Merseyside was the 3rd 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 10th October 2022 there were 1,992 patients waiting more than 62 days for a diagnosis or treatment. This has increased from 1,774 reported last month (5th September). Of these, 483 have waited **over 104 days**. This is higher than the 479 patients reported last month.

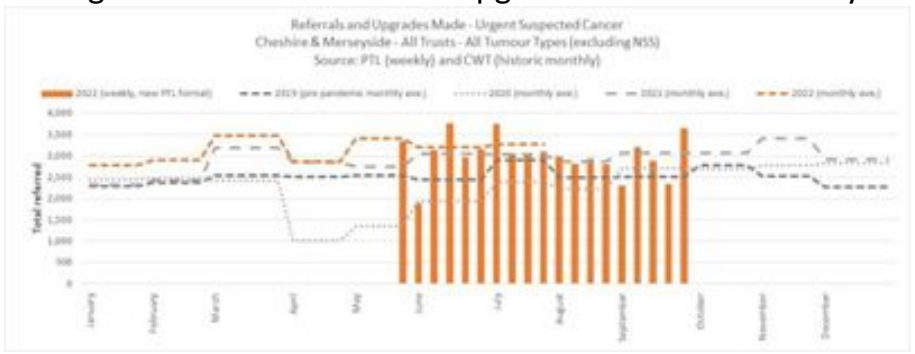
The Alliance failed the **31 day 1st treatment standard**, achieving 94.7%. This is lower than 96.3% the previous month.
The England average was 92.1%.
Six trusts and six historic CCGs failed to meet the 31 day 1st treatment standard of 96%.
Cheshire and Merseyside was the 4th best performing Alliance 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. Urgent cancer referrals and upgrades made in last 7 days



Referrals increased to 3,639 patients (previous week was Queen's funeral BH week).

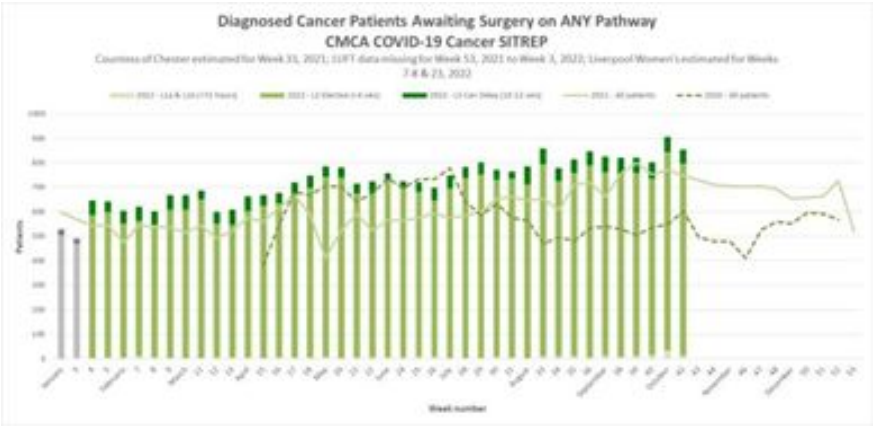
Data note: In Aug 2022, data source changed from weekly SITREP to national PTL. This metric covers all trusts. Missing data from Wirral week ending 24/07/22.

2. Urgent suspected cancer pathway PTL

Currently 15,922 patients on urgent suspected cancer waiting lists (24% above same time last year).

Data note: In Aug 2022, data source changed from weekly SITREP to national PTL. This metric covers all trusts. Missing data from Wirral week ending 24/07/22.

3. Cancer patients awaiting surgery



955 patients with a surgical DTT. 798 at L1&L2 and 57 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, 10/10/22. Liverpool Women's estimated for 07/02/22, 14/02/22, 23/05/22 & 18/07/22, 10/10/22. Bridgewater estimated for 29/08/22. Southport and Ormskirk estimated for 26/09/22, 03/10/22, 10/10/22.

4. Cancer treatments for urgent GP referrals in last 7 days

171 first treatments for patients with urgent GP referrals on 62 day pathway (4% above last year; 5% below pre-pandemic).

Data note: In Aug 2022, data source changed from weekly SITREP to national PTL. This metric covers all trusts but ONLY 62 day GP referrals (not all 62 day referrals or all first treatments. Missing data from Wirral week ending 24/07/22.

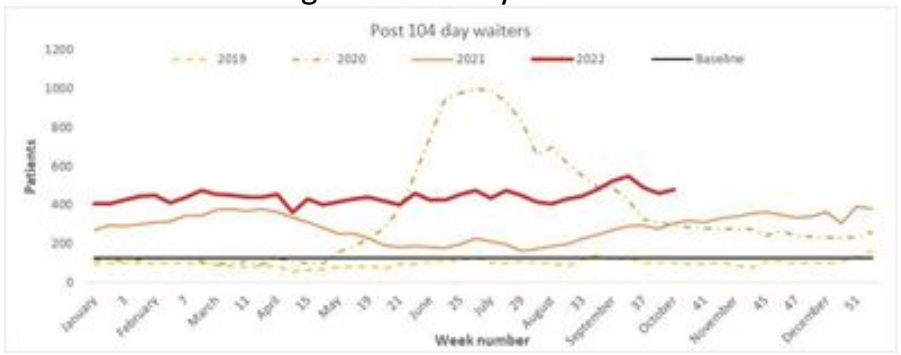
Section II: Restoration of Cancer Services – Core Metrics

5. Patients waiting over 62 days

1,992 patients have waited over 62 days
- Higher than 1,938 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; Countess of Chester 01/08/2021, 08/08/2021. No data for Warrington & Halton and Wirral 19/12/21, 17/07/22 (later data copied from previous week). Incorrect data submitted by Countess of Chester 10/04/22. No data for Mid Cheshire 25/07/2021.

6. Patients waiting over 104 days



483 patients have waited over 62 days
- Higher than 459 patients last week

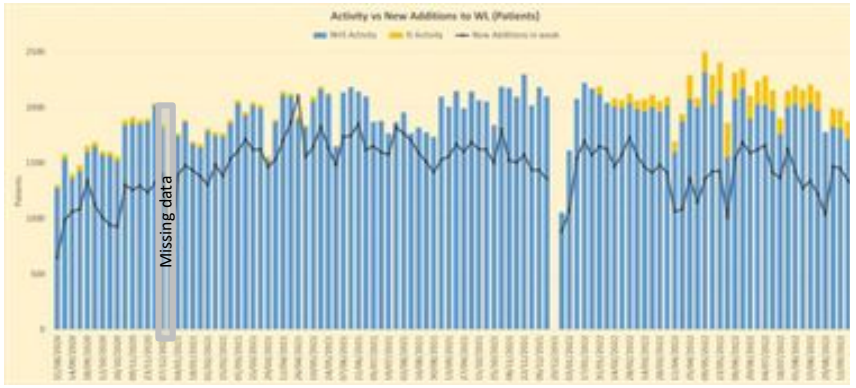
Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. Also, waiters with non-specific symptoms are not included in these national data. No data for Wirral 04/04/2021; Countess of Chester 01/08/2021, 08/08/2021. No data for Warrington & Halton and Wirral 19/12/21, 17/07/22 (later data copied from previous week). Incorrect data submitted by Countess of Chester 10/04/22. No data for Mid Cheshire 25/07/2021.

7. Endoscopy waiting list

Endoscopy waiting list decreased to 14,222 patients

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. No data from East Cheshire w/b 14/12/20; No collection 21/12/20. LUFT Aintree and LUFT Royal estimated for 24/05/21. Warrington and Halton estimated for 31/05/21. Southport and Ormskirk estimated for 05/07/21, 06/09/21, 16/05/22 and 06/06/22. Countess of Chester estimated for 26/07/21 to 31/01/22 inclusive, 21/03/22, 11/04/22 and 18/04/22. East Cheshire estimated for 26/05/22. LUFT Aintree estimated for 01/02/21, 03/05/21, 21/06/21, 08/08/22 to 22/08/22, 05/09/22. Wirral estimated for 03/01/22, 05/09/22 and 12/09/22. Mid Cheshire estimated for 26/09/22.

8. Endoscopy activity



Endoscopy activity increased to 2,053 patients

Data note: This metric includes all C&M trusts including East Cheshire and Mid Cheshire. No data from East Cheshire or Mid Cheshire w/b 14/12/20; No collection 21/12/20. LUFT Aintree and LUFT Royal estimated for 24/05/21. Warrington and Halton estimated for 31/05/21. Southport and Ormskirk estimated for 05/07/21, 06/09/21, 16/05/22 and 06/06/22. Countess of Chester estimated for 26/07/21 to 31/01/22 inclusive, 21/03/22, 11/04/22 and 18/04/22. East Cheshire estimated for 26/05/22. LUFT Aintree estimated for 01/02/21, 03/05/21, 21/06/21, 08/08/22 to 22/08/22, 05/09/22. Wirral estimated for 03/01/22, 05/09/22 and 12/09/22. Mid Cheshire estimated for 26/09/22.

9. Patients waiting between 63 and 103 days by provider

PTL data from week ending 03 October

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						7	7					5	10		40	
Countess Of Chester			14		9	101					10				146	18
East Cheshire		12				54									75	10
Liverpool Foundation Trust					46	244			27		31	82	46		491	-15
Liverpool Heart & Chest							6								6	
Liverpool Women's			97												97	10
Mid Cheshire						143					12	12	9		185	23
Southport & Ormskirk																
St Helens & Knowsley					11	59					15	8	14		116	-14
Walton Centre																
Warrington & Halton						12							10		27	9
Wirral			8		6	50							49		130	-21
Grand Total		**31**	**124**	**10**	**49**	**670**	**21**	**3**	**30**		**76**	**118**	**151**		**1,313**	NA

Cheshire & Merseyside Cancer Alliance

Tables from national Cancer PTL

10. Patients waiting over 104 days by provider

PTL data from week ending 03 October

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		22	
Countess Of Chester						17									28	
East Cheshire						8									14	
Liverpool Foundation Trust		5			8	111			27			40	37		234	24
Liverpool Heart & Chest																
Liverpool Women's			24												24	-4
Mid Cheshire						19						5			38	11
Southport & Ormskirk																
St Helens & Knowsley						16									32	-4
Walton Centre																
Warrington & Halton																
Wirral						22							34		57	8
Grand Total		**13**	**34**	**9**	**15**	**204**	**5**				**6**	**50**	**85**		**452**	NA

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)

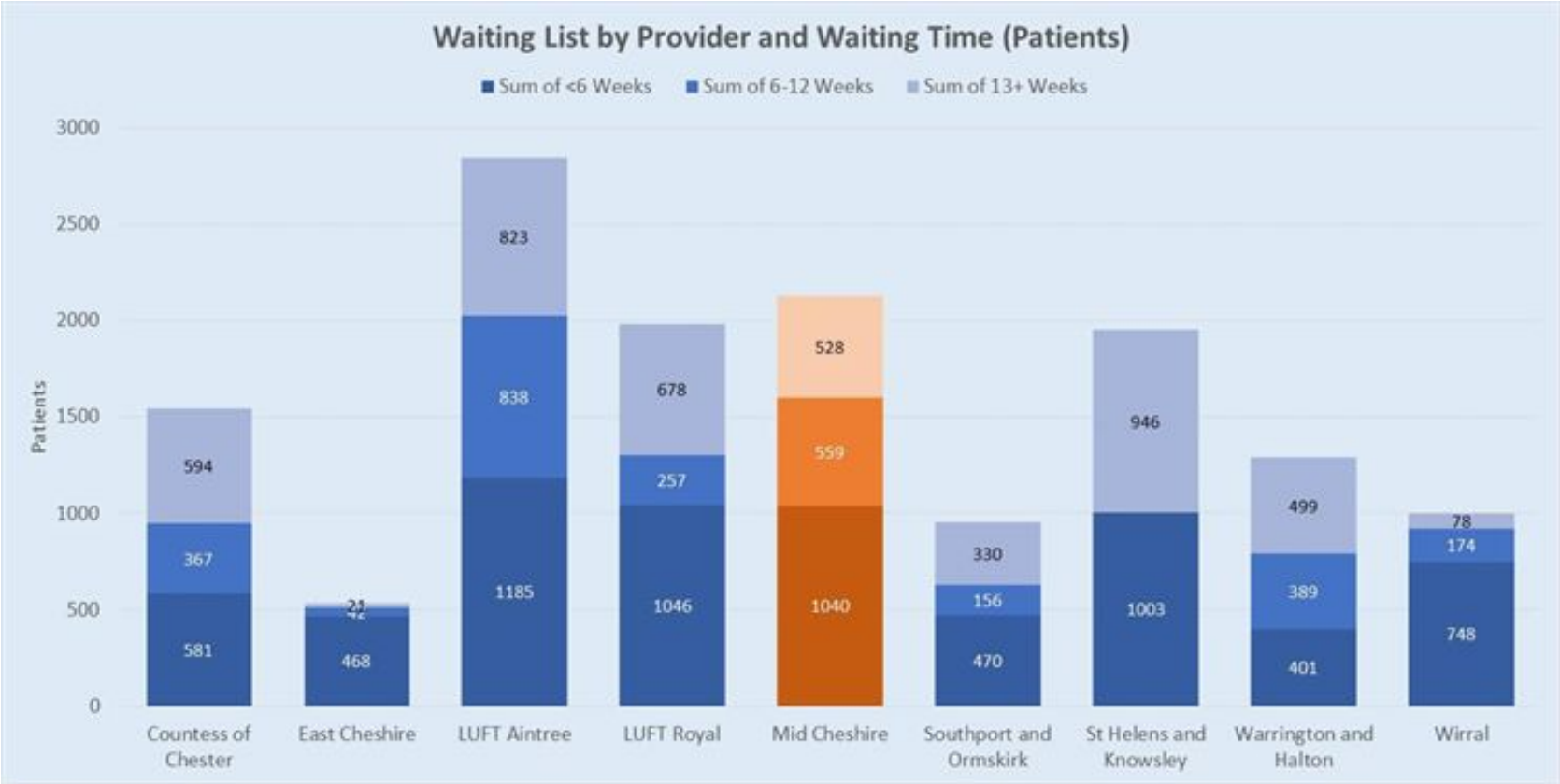
= No national PTL submission this week

Section II: Restoration of Cancer Services – Core Metrics

Endoscopy (cancer and non-cancer pathways)

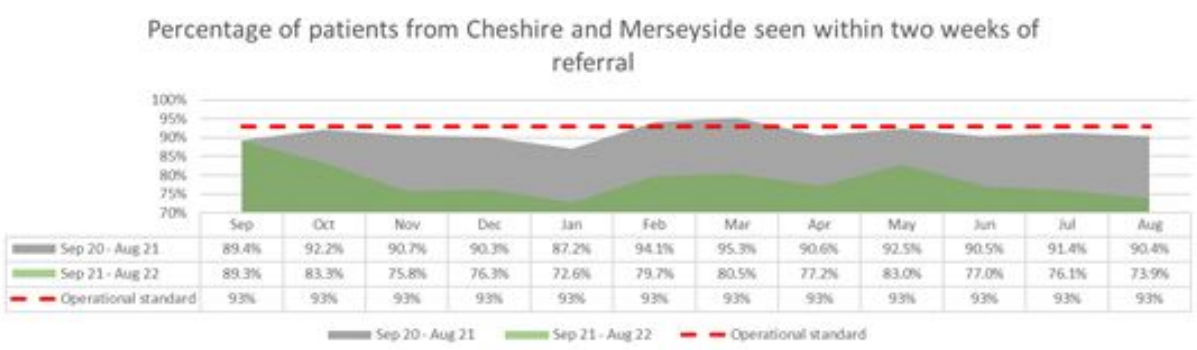
There are currently 14,222 patients waiting for an endoscopy. 7,280 have waited more than six weeks, and of these 4,497 have waited 13 or more weeks (32% of the total).

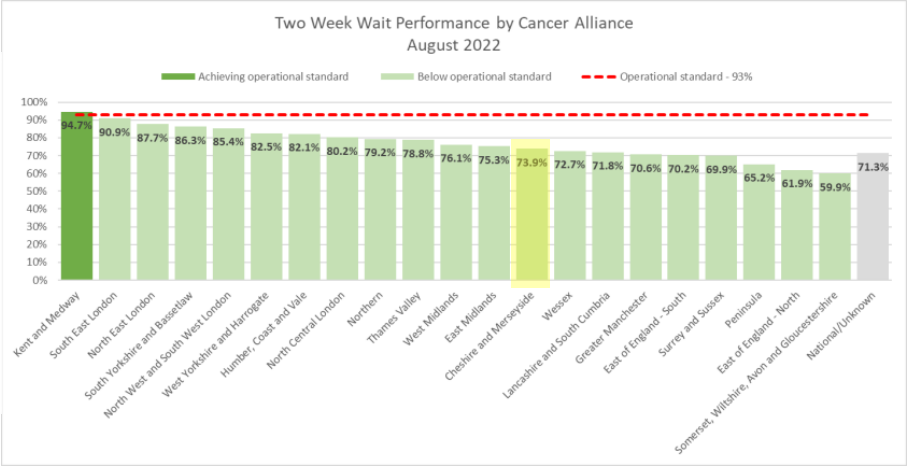
There is significant variation across units. In terms of patients waiting over 13 weeks the highest proportions are seen in St Helen's and Knowsley (49%), Warrington and Halton (39%), and CoCH (39%). Other units experiencing challenges are Southport and Ormskirk (35%), LUFT Royal (34%), and LUFT Aintree (29%).



Endoscopy data at 03 October 2022 – Mid Cheshire estimated

Section III: 14 day standard





In August 2022, 73.9% of patients were seen within 2 weeks compared to 76.1% in the previous month. This is below the operational standard.

In August 2022, Cheshire and Merseyside Cancer Alliance ranked 13 out of 21 for Two week wait performance (CCGs).

Providers not achieving the national operational standard were:

- Liverpool University Hospitals 50.6% (1482 breaches)
- Countess Of Chester Hospital 65.2% (497 breaches)
- St Helens and Knowsley Hospitals 68% (593 breaches)
- Southport and Ormskirk Hospital 78.3% (271 breaches)
- East Cheshire 78.9% (138 breaches)
- Warrington and Halton Teaching Hospitals 85.8% (166 breaches)
- Mid Cheshire Hospitals 86.4% (231 breaches)
- Wirral University Teaching Hospital 91.9% (156 breaches)

CCGs not achieving the national operational standard were:

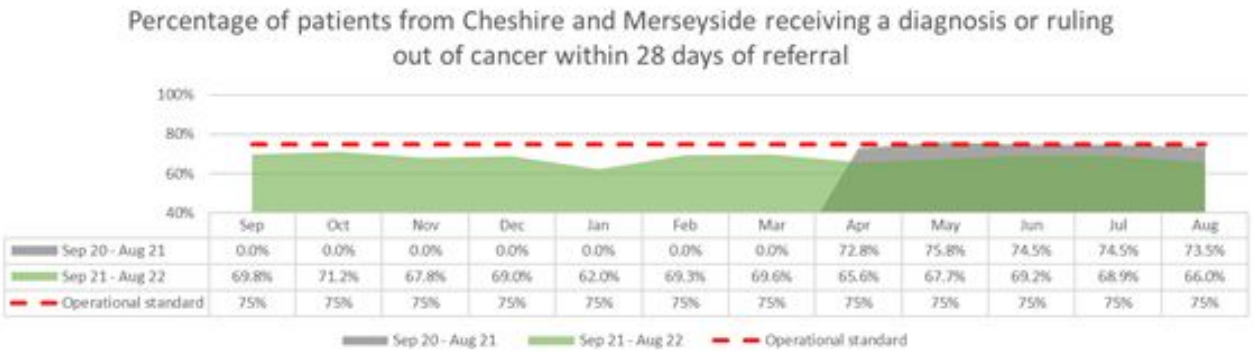
- NHS Liverpool 52.4% (1030 breaches)
- NHS Knowsley 65.5% (291 breaches)
- NHS St Helens 70% (302 breaches)
- NHS Southport and Formby 71.3% (212 breaches)
- NHS South Sefton 72.2% (230 breaches)
- NHS Halton 73.1% (200 breaches)
- NHS Cheshire 77.7% (864 breaches)
- NHS Warrington 87.8% (129 breaches)
- NHS Wirral 91.5% (156 breaches)

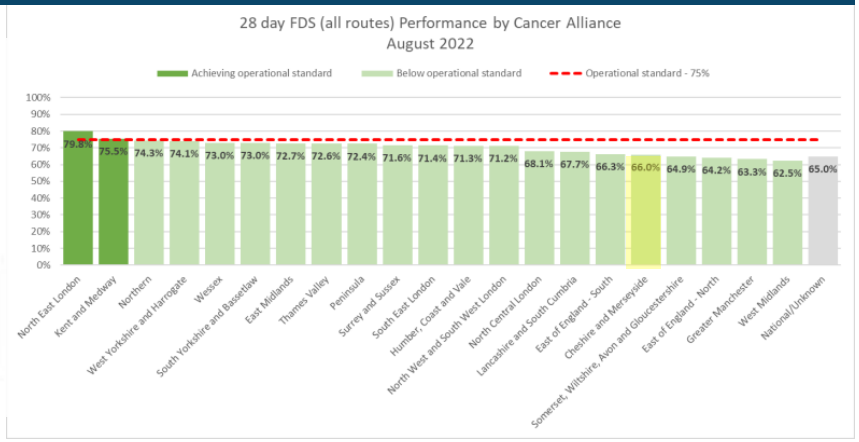
Cancer pathways* not achieving the national operational standard were:

- Suspected skin cancer 58.1% (1308 breaches)
- Suspected lower gastrointestinal cancer 70.6% (895 breaches)
- Suspected breast cancer 73.5% (542 breaches)
- Suspected upper gastrointestinal cancer 79.5% (230 breaches)
- Suspected gynaecological cancer 85.2% (190 breaches)
- Suspected head and neck cancer 86.8% (143 breaches)
- Suspected lung cancer 90.1% (19 breaches)
- Other suspected cancer (not listed) 90.6% (5 breaches)
- Suspected sarcoma 91.1% (4 breaches)
- Suspected testicular cancer 91.3% (4 breaches)
- Suspected urological malignancies (excluding testicular) 92.2% (71 breaches)
- Suspected children's cancer 92.7% (3 breaches)

*CCG based data – CADEAS source CCGs refer to the historic 2022 Clinical Commissioning Groups prior to the implementation of the Integrated Care Board (ICB)

Section III: 28 day standard





In August 2022, 66.0% of patients were diagnosed or ruled out within 28 days compared to 68.9% in the previous month. This is below the operational standard.

In August 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 31.3% (11 breaches)
- Countess Of Chester Hospital 51.1% (654 breaches)
- Liverpool University Hospitals 58.5% (1487 breaches)
- East Cheshire 59.8% (262 breaches)
- Liverpool Women's 61.1% (135 breaches)
- Southport and Ormskirk Hospital 63.1% (439 breaches)
- St Helens and Knowsley Hospitals 70.4% (567 breaches)

CCGs not achieving the national operational standard were:

- Liverpool 56.8% (1021 breaches)
- Southport And Formby 62.6% (286 breaches)
- South Sefton 62.7% (339 breaches)
- Cheshire 63.1% (1259 breaches)
- Knowsley 66.4% (306 breaches)
- St Helens 69.9% (320 breaches)
- Halton 73.2% (208 breaches)
- Warrington 74.8% (283 breaches)

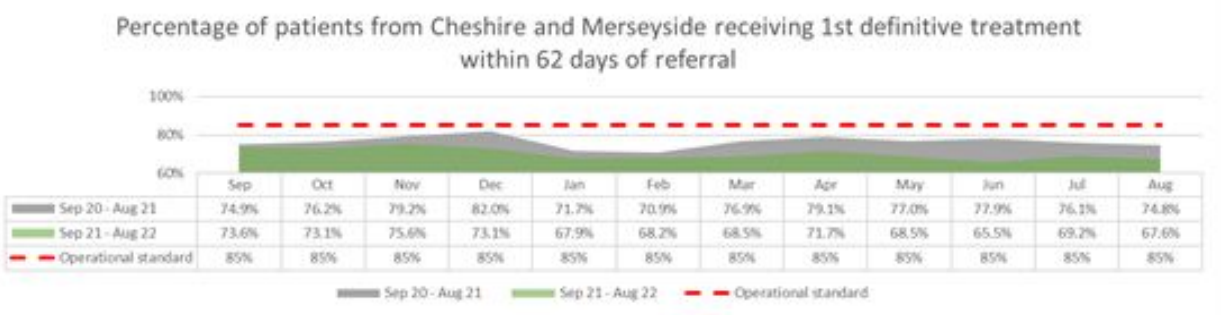
Cancer pathways* not achieving the national operational standard were:

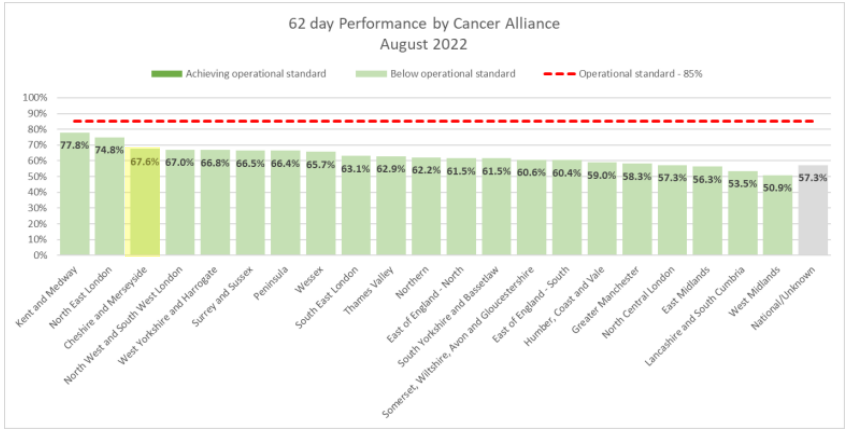
- Suspected haematological malignancies (excluding acute leukaemia) 40% (48 breaches)
- Suspected lower gastrointestinal cancer 43.2% (1598 breaches)
- Suspected urological malignancies (excluding testicular) 43.8% (453 breaches)
- Suspected upper gastrointestinal cancer 56.2% (445 breaches)
- Referral from a National Screening Programme: Unknown Cancer Report Category 58.4% (168 breaches)
- Suspected gynaecological cancer 63.8% (429 breaches)
- Suspected lung cancer 63.9% (73 breaches)
- Other suspected cancer (not listed) 69.2% (8 breaches)
- Suspected head and neck cancer 72.7% (292 breaches)

*CCG based data – CADEAS source

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

Section IV: 62 day standard





In August 2022, 67.6% of patients were treated within 62 days compared to 69.2% in the previous month. This is below the operational standard.

In August 2022, Cheshire and Merseyside Cancer Alliance ranked 3 out of 21 for 62 day performance (CCGs).

Providers not achieving the national operational standard were:

- Liverpool Women's 35.7% (9 breaches)
- East Cheshire 40.9% (19.5 breaches)
- Southport and Ormskirk Hospital 53.1% (22.5 breaches)
- Liverpool University Hospitals 53.2% (78 breaches)
- Countess Of Chester Hospital 68% (27.5 breaches)
- Warrington and Halton Teaching Hospitals 69.4% (15 breaches)
- Liverpool Heart And Chest 75% (2 breaches)
- Mid Cheshire Hospitals 75.1% (22 breaches)
- St Helens and Knowsley Hospitals 76% (23.5 breaches)
- Bridgewater Community Healthcare 77.8% (1 breaches)
- Wirral University Teaching Hospital 81.5% (21 breaches)
- The Clatterbridge Cancer Centre 84.6% (7 breaches)

CCGs not achieving the national operational standard were:

- Southport and Formby 51.4% (18 breaches)
- South Sefton 55.3% (21 breaches)
- Liverpool 56.4% (48 breaches)
- Knowsley 65.1% (15 breaches)
- Cheshire 68.3% (76 breaches)
- Warrington 72% (14 breaches)
- St Helens 76.1% (11 breaches)
- Halton 76.9% (9 breaches)
- Wirral 78.7% (26 breaches)

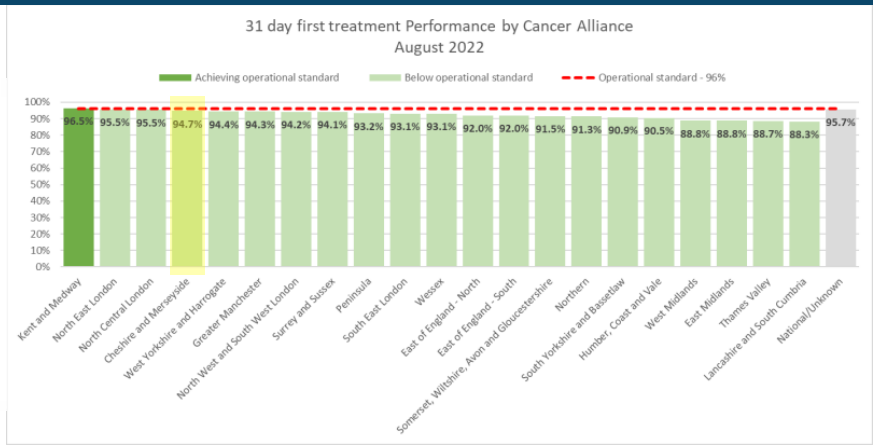
Cancer pathways* not achieving the national operational standard were:

- Sarcoma 33.3% (6 breaches)
- Gynaecological 37.8% (23 breaches)
- Lower Gastrointestinal 38.8% (41 breaches)
- Head & Neck 52.3% (21 breaches)
- Urological (Excluding Testicular) 56.8% (64 breaches)
- Upper Gastrointestinal 61.2% (19 breaches)
- Lung 62.3% (20 breaches)
- Haematological (Excluding Acute Leukaemia) 70.3% (11 breaches)

*CCG based data – CADEAS source

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

Section V: 31 day standard



In August 2022, 94.7% of patients were treated within 31 days compared to 96.3% in the previous month. This is below the operational standard.

In August 2022, Cheshire and Merseyside Cancer Alliance ranked 4 out of 21 for 31 day first treatment performance (CCGs).

Providers not achieving the national operational standard were:
- East Cheshire 77.3% (10 breaches)
- Liverpool Women's 87.5% (4 breaches)
- Mid Cheshire Hospitals 88.1% (14 breaches)
- Southport and Ormskirk Hospital 90.2% (5 breaches)
- Liverpool University Hospitals 91.5% (23 breaches)
- Wirral University Teaching Hospital 94.7% (10 breaches)

CCGs not achieving the national operational standard were:
- NHS Cheshire CCG 93% (30 breaches)
- NHS Knowsley CCG 93.6% (6 breaches)
- NHS Southport and Formby CCG 94% (4 breaches)
- NHS Wirral CCG 94.8% (12 breaches)
- NHS Liverpool CCG 94.9% (12 breaches)
- NHS St Helens CCG 95.4% (5 breaches)

Cancer pathways* not achieving the national operational standard were:
- Lower Gastrointestinal 86.1% (17 breaches)
- Gynaecological 92.4% (5 breaches)
- Skin 92.7% (21 breaches)
- Urological 93.2% (17 breaches)

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*CCG based data – CADEAS source

CCGs refer to the historic 2022 Clinical Commissioning Groups prior to the implementation 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.