Agenda: Trust Board Part 1
Date/Time of Meeting: 29th November 2023, 09:30am
Location: CCC-L Board room

	Preliminary Business		**Purpose**	**Lead**	**Time**
128-23/24	Welcome, Introduction, Apologies and Quoracy	v	**Information**	**K Doran**	09:30
129-23/24	Declarations of Interest	v	**Information**	**K Doran**	
130-23/24	Minutes of the Last Meeting – 27 Sep 2023	d	**Decision**	**K Doran**	
131-23/24	Matters Arising / Action Log	d	**Information**	**K Doran**	
132-23/24	Cycle of Business	d	**Information**	**K Doran**	
133-23/24	Chair and Chief Exec's Report to the Board	d	**Information**	**K Doran / L Bishop**	09:40
	Our Patients				
134-23/24	Patient Story	p	**Information**	**J Gray**	09:50
135-23/24	CQC Adult Inpatient Survey Results	d	**Assurance**	**J Gray**	10:00
136-23/24	Patient Experience Visit Sept 2023	d	**Assurance**	**E Abrahamson**	10:10
137-23/24	Q1 Mortality Report	d	**Assurance**	**S Khanduri**	10.20
	Our Strategy and Performance				
138-23/24	Performance Committee Chair's Report		**Assurance**	**G Broadhead**	
139-23/24	Five Year Strategy Update	d	**Assurance**	**T Pharaoh**	10.30
140-23/24	Integrated Performance Report	d	**Assurance**	**Exec Leads**	10:45
141-23/24	Finance Report	d	**Assurance**	**J Thomson**	11.05
142-23/24	Emergency Preparedness Resilience and Response (EPRR) Annual Report and Core Standards Self-Assessment	d	**Assurance**	**J Spencer**	11.15
143-23/24	Cancer Alliance Q2 Performance Report	d	**Assurance**	**L Bishop**	
	Our Governance				
144-23/24	Audit Committee Chair's Report	d	**Assurance**	**M Tattersall**	11.30
145-23/24	Board Assurance Framework	d	**Assurance**	**L Bishop**	11.40
146-23/24	Freedom to Speak Self Reflection Tool Output Report	d	**Assurance**	**J Gray**	
147-23/24	Board Development Programme	d	**Information**	**K Doran**	
148-23/24	Liverpool Joint Committee Assurance Report	d	**Information**	**K Doran**	11.50

Items for Information
These items are provided for Information. Members are asked to read the papers prior to the meeting and, unless the Chair / Trust Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items will be noted without debate at the meeting and the minutes will reflect that the matter was noted.

149-23/24	Research and Innovation Annual Report		**Information**	S Khanduri	12.10
	Concluding Business				
150-23/24	Questions from Governors and members of the public	v		**K Doran**	12.35

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Review: July 2025
Version: 2.0

151-23/24	Items for Inclusion on the Board Assurance Framework	v		**K Doran**	
152-23/24	Reflections on the Meeting	v		**K Doran**	
153-23/24	Any Other Business	v		**K Doran**	12.40
	Date and time of next meeting: 28 February 2024, 09:30am				

Resolution: *"To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".*

	Close

D document
P presentation
V verbal

DRAFT Minutes of Trust Board Part 1
27th September 2023 at 9.30am

Kathy Doran	Chair
Mark Tattersall	Non-Executive Director
Geoff Broadhead	Non-Executive Director
Asutosh Yagnik	Non-Executive Director
Anna Rothery	Non-Executive Director
Elkan Abrahamson	Non-Executive Director
Liz Bishop	Chief Executive
Jayne Shaw	Director of Workforce & Organisational Development
Sheena Khanduri	Medical Director
Julie Gray	Chief Nurse
Joan Spencer	Chief Operating Officer
James Thomson	Director of Finance
Tom Pharaoh	Director of Strategy (non-voting)
Sarah Barr	Chief Information Officer (non-voting)

In attendance:

Jane Hindle	Associate Director of Corporate Governance
Skye Thomson	Corporate Governance Manager
Laura Jane Brown	Staff Governor (Nurses)
Emer Scott	Associate Director of Communications
Joanna Wynne	Freedom to Speak Up Guardian
Emily Daly	Staff Side Representative
Alex Gilbertson	AHP Clinical Supervision (item 100-23/24)
Jill Tozer	Interim Head of Patient Safety (Item 109-23/24)

Item No.	Standard Business
94-23/24	**Welcome, Introduction, Apologies & Quoracy:** Kathy Doran welcomed the Board members, observing Governors, and staff. Apologies were noted from: Jane Wilkinson, Lead Governor Mike Varey, Staff Side Alun Evans, Staff Side Kathy Doran confirmed the meeting was quorate.
95-23/24	**Declarations of Interest** There were no declarations made in relation to any of the agenda items. The Board's register of interests is published on the Trust website: https://www.clatterbridgecc.nhs.uk/application/files/2316/8233/2399/The_Clatterbridge_Cancer_Centre_Register_of_Interests_2022-23.pdf

96-23/24	**Minutes of Previous Meeting** The minutes of the meeting held on 26th July 2023 were approved as a true and accurate record subject to the following amendments: • Elkan Abrahamson should be marked present • The title of the minutes say 27th July and should say 26th July • Item 80: Finance Report, paragraph 3, the second sentence needs rewording • Item 83: CMCA Presentation, typo needs correcting for 'hotspots' • Item 85: Board Assurance Framework, the fourth paragraph should say that the Community Diagnostic Centres will be centrally funded until 2025.
97-23/24	**Matters Arising / Action Log** There were no matters arising. The Board noted that all the actions were complete.
98-23/24	**Cycle of Business** Due to the reduction of the number of Trust Board meetings, a revised cycle of business was presented. Jane Hindle encouraged Board members to check the reporting against external deadlines. The Board noted the Emergency Preparedness, Resilience and Response (EPRR) Annual Report and Core Standards had been deferred until November to fit with submission timings. The Board **noted** the Cycle of Business.
99-23/24	**Chair's and CEO's report** The Board received the Chair and Chief Executive Report. Kathy Doran highlighted the webinar she attended delivered by NHS England in relation to the strengthened requirements for the Fit and Proper Persons Test. The Liverpool Trusts' Joint Committee met with national and regional representatives of the NHS England on 7th August to update them on the work of the Committee; NHSE were pleased with the work going on. The local meeting on the 21st September was also positive. Kathy Doran attended the CMAST Chairs meeting on Wednesday 20 September. The main discussion covered opportunities for collaborative working in the HR function across Cheshire and Merseyside. The Integrated Care Board (ICB) is working with HR Directors to consider opportunities for working at scale. The Council of Governors have met for two sessions, which have been well received. Liz Bishop highlighted that the industrial action has gone as smoothly as possible, with all patients managed through the EPRR process. There has been a significant amount of time and hard work into planning for the industrial actions and Liz thanked the teams involved. Details regarding the financial impact of industrial action will be taken through the Performance Committee. The Trust's Standing Orders contain provision for the powers retained by the Board in emergency, to be exercised by the Chief Executive and the Chair, after having consulted with at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the board in public session for ratification. The Trust was required to submit a self-certification regarding Protecting and expanding elective capacity to the NHS England regional team by 14th September. The Board **ratified** the use of emergency powers for the submission of the self-certification.

	With regards to the requirement to check for Reinforced aerated autoclaved concrete (RAAC), the team have confirmed that the Wirral site is the only part of the estate where RAAC may have been present. However following an intrusive review of the concrete roofing structure there is no RAAC on site to the best of our knowledge. The Board discussed the engagement with the Liverpool Trusts' Joint Committee. Kathy Doran noted it had been recognised that there were some challenges with engagement from LUHFT and the last meeting had identified an action for the Chief Executives to go away and look at the number of meetings. When the structure was originally formed and individual NED-led joint committees for LUHFT and each specialist Trust were set up, the Liverpool Trusts' Joint Committee wasn't in place. Liz Bishop noted that there have been discussions about doing more than just establishing workstreams with the Royal, and collaborating across the wider sector. The Board **noted** the contents of the report.
	Our People
100-23/24	**Staff Story** Alex Gilbertson joined the meeting and presented the staff story informing the Board of her new role in AHP Clinical Supervision at CCC. She had had previously presented to the Board on the AHP supply strategy, which had identified the need for a review of clinical supervision. Clinical Supervision helps develop skills and knowledge throughout a registrant's career and supports continuing fitness to practise. The benefits of effective Clinical Supervision are: • Job satisfaction and staff retention • Reduced stress and anxiety • Better working environment • Increased quality of care delivery Alex Gilbertson highlighted the standards of proficiency, the Trust's current position, barriers and enablers. Pilot supervision sessions have taken place and Alex shared positive staff feedback. The project task and finish group has representatives from all staff groups and there are 47 staff trained so far. Alex shared the proposed CCC Clinical Supervision Model and noted this is an opportunity for staff to be part of a trail blazing service development. The Board were pleased to see the work going on and the benefits to staff and were happy to see it was a mixed group of staff taking part, as it creates a space for more shared learning and understanding. The project will be reviewed through the People Committee. The Board discussed the limitations of the term 'supervisor' and Alex agreed to look into if the term was bound or could be changed. The Board **noted** the story and thanked Alex for attending. *Alex Gilbertson left the meeting.*
101-23/24	**People Committee Chair's Report** Anna Rothery introduced the report from the People Committee meeting held on 19th September 2023. The Committee received and commended a staff story on the role of the Professional Nurse Advocate (PNA), which focuses on nurturing staff through restorative supervision to support the health and wellbeing of colleagues and nursing teams. Many of the items on the People Committee agenda were on the Trust Board agenda.

	Anna Rothery noted the overlap between the WRES report and the NW BAME Anti-Racist Framework and highlighted the importance of not looking at these in isolation. Jayne Shaw noted that the Head of Equality Diversity and Inclusion is pulling together one action plan that brings together the requirements of both to avoid duplication and ensure there is a clear plan. The risk around Bank and Agency was highlighted and it was noted the workforce team are making sure systems around bank and agency are robust and signed off and that the proper process is used to cover shifts. James Thomson noted there will be an internal audit review on Bank and Agency. The Board **noted** the report.
102-23/24	**Workforce Race Equality Standard (WRES) Data** Jayne Shaw presented the 2022-23 WRES report. The Workforce Race Equality Standard (WRES) is a requirement for all NHS organisations to publish data and action plans against 9 indicators of workforce race equality. 2023 is its eighth year. It aims to facilitate an inclusive, supportive and fair culture in organisations to ensure that every member of the NHS's diverse workforce has a sense of belonging and a positive working experience. The report presents the Trust's latest workforce race equality data (as of 31st March 2023) and identifies where improvements have been made and where data has remained static and/or deteriorated. The 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. Four of the indicators link to staffing data, four come from the staff survey results and one is on Board composition. Jayne Shaw noted the report needs a couple of amendments prior to publication, notably the second indicator. Jayne Shaw noted the results were disappointing, as the Trust has done a lot of work around WRES. The most concerning is indicator 6 'Percentage of staff experiencing harassment, bullying or abuse from staff' where there has been an increase. The Trust do not see staff reporting cases; however, they have been reported through the survey. The BAME network are doing a piece of work to try to address this. There is an action plan at the end of the report. Actions from within the body of the narrative will be pulled out and included in the action plan. Progress against the action plan will be reported to People Committee. The report has been reviewed by the People Committee Kathy Doran noted the links between indicator 6 and the Freedom to Speak Up function and the importance of creating an environment where staff feel safe to speak up. Asutosh Yagnik noted the report uses 'BME' and 'BAME' interchangeably and questioned if there was a reason for this. Jayne Shaw noted the language cannot always be dictated by the Trust as it is used in the staff survey, by CQC and in national reporting. The Board discussed being consistent when possible and potentially doing a self-definition exercise. Asutosh Yagnik queried what the target was in relation to Indicator 1 'Percentage of staff in each AfC Bands 1 to 9 and VSM compared with the percentage of Black, Asian, and Minority Ethnic staff in overall workforce/. Jayne Shaw informed the Board the target will be set as part of the antiracist work target setting. The Trust needs to be clear about what actions will support the journey to the target.

	Asutosh Yagnik noted that the wording of indicator 9 is confusing as on the surface it looks like the make-up of the board has changed, but it is actually the organisation data that has changed, and therefore the comparison of the two is different. Jayne Shaw agreed to feed this back. The Board discussed indicator 6. Elkan Abrahamson noted that the Trust values are 'Be Kind and Be Inclusive' and there may need to be a campaign around this with staff. Jayne Shaw noted that the national position had seen a decrease in this indicator however, CCC had increased. The work the staff network are doing could lead to a campaign. Jayne Shaw noted that the Freedom to Speak Up Lead has attended the staff network meetings to promote the function and her role and to provide assurance on the process. Mark Tattersall noted that indicator 8 'Percentage of staff personally experiencing discrimination at work from their manager/team leader or colleagues' was concerning and queried how 14.3% for BAME staff in 2022 compares with the national picture. Jayne Shaw informed the Board it is lower than the national average and not where the Trust wants to be. The team have started to provide support for managers managing staff with protected characteristics. Anna Rothery questioned for indicator 4 'Relative likelihood of staff accessing non-mandatory training and CPD' how the Trust encourage staff with protected characteristics to come forward for leadership programmes. The Board discussed the programmes available and the importance of encouraging staff to develop. Kathy Doran queried if the quarterly pulse survey could also monitor these areas. Jayne Shaw noted that the pulse survey is promoted as a shorter version of the annual staff survey, however they could look at doing something in quarter one to sense check where the organisation is. Kathy Doran noted it would be good to see a trend over time and frequent monitoring. The Board **approved** the publication of the report and **noted** its contents.
103-23/24	**Workforce Disability Equality Standard Data** Jayne Shaw introduced the WDES report. The Workforce Disability Equality Standard (WDES) was introduced in 2019 and is a requirement for all NHS organisations to publish data and action plans set against the ten specific measures 'Metrics' of workforce disability equality. Each of these metrics compares the experiences of disabled and non-disabled staff in the NHS. The report provides information relating to staff at Clatterbridge Cancer Centre in 2022/23. The data provided which is taken from the national electronic staff record ESR) and the national staff survey, will help the Trust to better understand the experiences of our disabled staff so that we can support the development of an action plan to demonstrate progress against the metrics to improve equality and inclusion for disabled staff. The intention of the WDES data is to help improve the experiences of disabled staff working in the NHS. Jayne Shaw noted that indicator 3 'Relative likelihood of entering formal capability process' looks like big increase, however it is a small number and the data is disproportional. Jayne Shaw highlighted concerns with indicator 4.1 ' Harassment, bullying or abuse in the last 12 months from patients/service users, their relatives or other members of the public' The data is in line with the national increase, which NHSE have attributed to the return of face to face appointments. Jayne Shaw noted the Staff network have found their feet and been very engaging. The new Chair is very positive in taking it forward.

	Anna Rothery highlighted indicator 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’ which had improved but was still an issue that needed looked at. Jayne Shaw agreed and commented that it forms part of the training for managers. Jayne Shaw noted there will be minor amendments to the report prior to publication and the presentation of the data will be reviewed going forwards. The Board **approved** the publication of the report and noted its contents.
104-23/24	**Assessment against NHS NW BAME Assembly Anti-Racist Framework** Jayne Shaw introduced the report which provided a high-level overview of the progress the Trust is making in regard to becoming an anti-racist organisation, applying the guidance and support from the North West BAME Assembly Anti-Racist Framework. The recommended framework is organised into three levels of achievement: Bronze, Silver and Gold. Each level builds on the next, assisting organisations to make incremental changes and take consistent actions towards eliminating racial discrimination. The Trust has completed the suggested self-assessment tool developed by the North West BAME Assembly to identify gaps in our current performance. These gaps will allow us to formulate a robust action plan, prioritising activities that will help us achieve a bronze status in the next 12 months. Once we achieve the bronze status, we will continue to measure our actions, helping us to progress to silver status. Progress will be monitored through the People Committee. Asutosh Yagnik highlighted the positive reverse mentoring scheme and Jayne Shaw noted there would be a staff story for the Board on reverse mentoring. Mark Tattersall noted the stretch target of April 2024 for ‘The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members’. Jayne Shaw informed the Board the work towards this has started and the team are satisfied there are processes in place to support the target. The assessment will be validated externally. The Board discussed the Trust position in comparison to other NHS organisations. Jayne Shaw noted anecdotally that the EDI Lead suggested the Trust was around the middle of the patch. The Board **noted** the report.
105-23/24	**Guardian of Safe work Report** Sheena Khanduri introduced the quarter one Guardian of Safe Working Report, which was presented at the September People Committee meeting where the Committee were assured by its contents. Sheena Khanduri highlighted there had been seven exception reports in quarter one. There was one immediate patient safety issue, which was confirmed to have the necessary levels of staffing and no fines have been incurred. There was one additional payment in the reporting period and the rest were taken as time in lieu. The Board **noted** the report.
106-23/24	**Freedom to Speak Up Annual Report and Freedom to Speak Up Policy** Joanna Wynne introduced the report showing the current position in relation to the Trust’s

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	Freedom to Speak Up arrangements. Joanna highlighted the importance of having an open and honest learning culture and a safe place for staff to raise concerns, where they are welcomed, listened to and concerns investigated and acted on. Joanna Wynne started as Freedom to Speak Up Guardian for the Trust in June 2023 and provided the annual report for 2022/23. During 2022/23 two local champions/guardians supported the Freedom to Speak Up function, as well as Julie Gray (Executive Lead) and Geoff Broadhead (Non-Executive Lead). There were 11 cases raised in 2022/23, 4 of which required a detailed investigation. This is an increase on the year before and comparable with 2020/21. None of the cases were raised anonymously and no disadvantageous / demeaning treatment was indicated as a result of speaking up. The results of the 2021/22 staff survey were generally positive for speaking up culture, especially when compared to other Cancer Trusts. All NHS trusts in England are required, by the National Guardian's Office (NGO), to submit high level, anonymised data quarterly from FTSU cases. The NGO reports annually to the boards of the CQC and NHS E/I on the work of the NGO. Unfortunately, no data was submitted by the Trust to the NGO during 2022/23. It was noted that the data reporting for 2023/24 is now underway with the appointment of the new FTSU Guardian with Q1 submitted. Joanna Wynne highlighted the next steps section of the report and proposed an interim secondary Freedom to Speak Up report to Trust Board for a shorter focused update at the 6 month mark due to the current ongoing work, the appointment of a new guardian and the re-promotion of the service which may invite a greater volume of users. The Board **agreed** to receive a 6 monthly update. **ACTION:** 6 month FTSU report to be included on the Cycle of Business. Mark Tattersall queried if there had been any challenge from the National Guardian's office with regards to not completing the quarterly reporting in 2022/23. Jo Wynne confirmed there had not been any feedback. Joanna Wynne confirmed that the Trust is already seeing an increase in speaking up and this is likely to ebb and flow. There is confidence being built in staff the more listening and feedback is done. Part of the re-promotion is making the process for speaking up clearer for staff, as there are many ways they can speak up. The Board discussed the progress made and the importance of having an open culture, which fosters continuous improvement. Joanna Wynne noted that a lot of speaking up happens in management systems and there is a need to support middle managers to help them address speaking up issues. NHS England issued a new Freedom to Speak Up Policy for the NHS in June 2022 with all Trusts required to update their existing policy by January 2024 to accurately reflect it. Joanna Wynne presented the revised Freedom to Speak Up Policy for Board approval. James Thomson noted that on page 99 of the pack the equality impact assessment for 'how relevant is the policy to each Equality category?' is down as 'low' and suggested that this needed to be reviewed. **ACTION:** FTSU Guardian and EDI Lead to review Equality Impact Assessment

	The Board **approved** the Freedom to Speak Up Policy.
107-23/24	**NED and Governor Engagement Walk round - July & August** Kathy Doran introduced the report for the walk-round, which took place in the Lymphedema Service and the Delamere Day Ward at CCCW with Governor Laura Jane Brown. Lymphedema Service The staff were really passionate and very positive, no patients were seen as there were none scheduled in for that day. The team noted the vulnerability of the service due to long-term sickness, however this is being supported by the lead nurse. The team also highlighted queries with regards to the cardiac arrest trolley. Julie Gray confirmed the trolley location has been discussed with the resuscitation lead. For patient safety the resuscitation trolley will need to remain in the current location. Delamere Day Ward The patients in the ward gave positive feedback. One patient raised that phlebotomy appointments could not be pre-booked. The staff try to accommodate patient preference where possible however, pre-booking appointments can be problematic, should the treatment need to be moved or deferred. The walk-round team spoke with a member of staff who had begun her career at CCC as a receptionist, then moved into a position as a healthcare assistant before undertaking her nurse training. Once qualified, she worked in CCCL on the ward as a staff nurse before coming across to Delamere to continue her nursing career. Kathy Doran noted it was incredibly positive to hear about her development journey and the support she had received. Geoff Broadhead introduced the walk-round, which took place in the Radiotherapy Department at CCCL with Governor Jane Wilkinson. Radiotherapy Department The walk-round team met one patient who felt privileged to be part of the first wave of patients to be receiving treatment via a new protocol for her cancer following a clinical trial. The team also met a member of staff who was working in the department as a support worker to gain experience before applying to university to train as a therapeutic radiographer. Mark Tattersall raised the comment in the report made by staff regarding an issue in the main waiting area when it is raining, 'the ceiling from the internal atrium has large windows that are meant close automatically' and checked Vinci/Propcare had addressed the issue. Geoff Broadhead commented that staff believed it had been resolved, Joan Spencer agreed. The Board discussed the differences in electronic communication at CCCW and CCCL. Sarah Barr noted there had been extensive work with the Business Intelligence Team and kiosks at all sites about getting patients to receive letters/information online. This is up and running at the Wirral site, however there is a lot of work taking place to optimise the process. This is part of the national work and reflected in the digital strategy. The Board **noted** the walk-round reports.
108-23/24	**Quality Committee Chairs Report** Terry Jones introduce the Chair's report from the Quality Committee meeting on the 20th September 2023. The Committee received and were satisfied with the revalidation annual report, which is on the Trust Board agenda. This report will go to the People Committee going forward.

	The Committee had discussions at the last two meetings regarding presenting data that is not nationally mandated and it has been agreed this will be monitored by TEG and Performance Committee. The Committee received the Board Assurance Framework and discussed each of the BAF risks. The Committee agreed the proposed decrease in BAF 1 (Quality) from (3 x 5)15 to (2 x 5)10. The Committee noted the target for March 2024 is (2 x 5)10 and agreed to keep this, acknowledging this was an annual target, the measures need to be maintained and if the Trust achieves further actions to lower the score towards the low risk appetite, the target does not prevent this. The Committee discussed the ambitious target of (2 x 3)6 for BAF 7,(Research Portfolio) as the risk still stands at (3 x 4)12 and agreed that the target of 6 may be too ambitious to achieve by March 2024. The Director of R&I, Medical Director and Corporate Governance Manager will review BAF 7 and propose a revised target to the Board as part of the November paper. The Committee were satisfied with the narrative around BAF 13 (Development and adoption of digitalisation). The quarter 2 Board Assurance Framework will be included on the November 2023 Trust Board agenda. The Board **noted** the report.
109-23/24	**Patient Safety Incident Response Framework (PSIRF) Plan and Policy** Jillian Tozer, Interim Head of Patient Safety, joined the meeting and introduced the Patient Safety Incident Response Plan (PSIRP). This describes how Clatterbridge Cancer Centre NHS Foundation Trust intends to respond to patient safety incidents reported by staff and patients, their families and carers as part of work to continually improve the quality and safety of care following implementation of the Patient Safety Incident Response Framework from 30th September 2023. The PSIRF plan and policy are mandated as part of the PSIRF standards and every Trust is required to have both documents published on their website. The Integrated Care Board and specialist commissioner have signed off the Trust's PSIRF plan and policy. The plan is a living document, which will be constantly evaluated and evolved over 12 months. The framework facilitates a learning focused findings and outcomes process, immediately allowing the Trust to identify opportunities for patient safety improvements. The framework looks at the holistic system with human factors. Mark Tattersall informed the Board he found the documents difficult to read, as some of the language used was quite hard to understand. He also noted on page 137 of the pack it says 'This will be achieved through reporting processes as well as receiving assurance via the RQC and the Audit Committee' and questioned how the audit committee would receive assurance. Jill Tozer informed the Board that whilst there needs to be an awareness of PSIRF across the organisation, the policy and plan are not intended for every colleague to understand. There will be appropriate training on patient safety for those expected to understand in detail and they will translate to their colleagues at ward level. There is a specific NHS England mandated template for the policy and plan and feedback regarding the wording has been given. Jill noted that feedback on audit and evaluation will go through Clinical Audit and Effectiveness Committee and Patient Safety Committee. The Board will receive a quarterly assurance paper providing information on the Trust's position in the transition to PSIRF where at with transition. The ICB and Specialised Commissioning will monitor this every month.

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	The Board agreed Audit Committee's role was unclear in this and requested confirmation on their requirements. **ACTION:** Jill Tozer to confirm the role of the Audit Committee in the PSIRF Policy and determine if instead it should say Quality Committee. The Board discussed the accessibility of the document and Jill Tozer highlighted the glossary of terms and noted this is a huge language shift. There is an education piece running alongside the policy, which is on trajectory with divisional quality groups and manager groups. The Board discussed the new process under PSIRF and Julie Gray noted along with terminology changes the 'Executive Review Group' could change name and new templates are being piloted to ensure a more streamlined process that is intuitive to the end user. The Board **approved** the PSIRF Plan and Policy *Jill Tozer left the meeting.*
110-23/24	**Medical Revalidation Annual Report** Sheena Khanduri introduced the report, which provides assurance that the Trust is compliant with the medical professional regulations as a designated body. The Quality Committee have reviewed the report and were satisfied with the contents. It is a requirement to bring the report through Trust Board. Kathy Doran asked if peer review with other orgs was common. Sheena Khanduri noted it is recommended as good practice, but hasn't recently happened. Going forward it would be good practice to link in with another specialist cancer Trust like the Christie. The Board **approved** the Medical Revalidation Annual Report.
111-23/24	**Cheshire and Merseyside Cancer Alliance Quarter 1 report** Liz Bishop introduced the report and noted that since the last Board the report style had been through the system, including to the provider Chief Executives' meeting and there were no further amendments requested. The report is circulated to all relevant Chief Executives and Chairs to take through all Boards and subcommittees. Liz Bishop highlighted the following key points: • Activity remains high in terms of treatment • Faster diagnosis standard remains similar to the previous report. • Cheshire and Merseyside over 62 day patient tracking list is lower than trajectory as of 13 August 23. The current number of patients waiting over 62 days is 88% of the number planned for 13 August 23 • There has been a data query from the Walton Centre • A letter from the national cancer team showed LUHFT have been removed for tier 1 cancer banding to tier 2 , which is a positive improvement • LWH and Mid-Cheshire continue to be in in tier 2. There are no longer any Cheshire & Merseyside Trusts in tier 1 • Transformation work and health inequalities work continues and there is focus on the gynae pathway. Anna Rothery informed the board she met with Jo Trask from the Cancer Alliance to discuss the work she is doing on tackling health inequalities. Tom Pharaoh commented that he and Jo, along with other colleagues are part of the Trust's health inequalities steering group. The Board discussed the data in the report in correlation with socio-economically deprived areas. Liz Bishop noted there is an NHSE led conversation regarding making sure waiting lists are equitable, with a focus on engaging with communities, ensuring patients are aware of symptoms

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	and get through the door to treatment. Liz Bishop noted that the Cancer Alliance can't manage all of the work and information needs to be delegated into PLACE. Asutosh Yagnik queried if the report is viewed through an ICB lens. Liz Bishop noted that the Medical Director of the ICB receives the reports. The Board **noted** the report.
112-23/24	**Performance Committee Chair's Report** Geoff Broadhead introduced the Chair's report from the Performance Committee meeting on the 23rd August 2023 and highlighted the following items. The Committee received the Emergency Preparedness, Resilience and Response report and noted the Trust is working towards the submission deadline on the 30th September 2023. The Committee received the community diagnostic hubs update, which provided an update on Clatterbridge's involvement in the Cheshire and Merseyside community diagnostic centre (CDC) programme. The Committee received the green plan quarterly assurance report, which provided an update on energy & utilities, capital projects and suppliers & partners. The Committee received a positive Clatterbridge Pharmacy Ltd. Subsidiary performance report. The Committee had a thorough discussion on the board assurance framework (BAF) risks aligned to the Committee. The Committee noted the requirement for the narrative of each risk to be updated following the discussions held at the meeting, particularly in relation to the impacts of industrial action, changes in business and system working. BAF 2 (Demand Exceeds Resources) The Committee received in depth reports, such as the IPR report and Capacity and Demand Deep Dive, which highlighted the pressures on capacity and the cost of extended hours. BAF 3 – (Insufficient funding) The Committee received the finance report and noted the of the 5 associated key performance indicators 4 targets are not being met. Geoff Broadhead noted this was identified as a concern and the Performance Committee will continue to monitor it. BAF 8 (Research resourcing) The Committee received the research and innovation progress report, which highlighted the challenge of securing the additional £500k funding. A business case will be presented at October 2023' Charity Funding Committee and November 2023' Trust Board, but it was noted the probability of the Trust being able to support the additional funding is low. It was proposed the business plan may need to be reviewed, as it may no longer be fit for purpose for the next 5 years. The Board discussed the £500k assumed charitable fund contribution to the R&I business plan. Sheena Khanduri noted that when the business plan was approved all the objectives were linked with a cost, totalling a level of funding required to deliver the R&I business plan. If there is a change to the funding there will need to be revisions made to year 4 and 5 of the strategy. The Board noted that research is linked to quality; the plan may need evaluated to ensure it is fit for purpose and achievable in a post-covid world.

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	Asutosh Yagnik noted that the overall appetite and the annual target for BAF 8 don't match up. In Quality Committee BAF 7 was discussed and will be reviewed to see if the current target is appropriate or too ambitious. Asutosh Yagnik, suggested BAF 8 be reviewed as well. Mark Tattersall noted there has previously been a shortfall on charity income and the Trust has had the capacity to absorb this cost. However current financial planning cannot guarantee this. Sheena Khanduri agreed to look over BAF 7 and 8 and review the current position and pressures. The Board discussed the disparity between risk appetite, tolerance and the annual target and sought clarification on scoring in the next report. The Board **noted** the report.
113-23/24	**Integrated Performance Report** Joan Spencer introduced the month 5 Integrated Performance Report, which highlights exceptions in Access, Efficiency, Quality, Research & Innovation, Workforce and Finance. <u>Access and efficiency</u> Joan Spencer noted the challenges with the 24 day and 62 day targets and highlighted the avoidable breaches. There were data validation issues in month, which impacted the imaging waiting times. Mark Tattersall highlighted the delay transfers of care target and queried if this was beyond the Trust's control. Joan Spencer noted the patient flow team continue to work with a wider multi-disciplinary team to aid discharge planning Joan Spencer highlighted that the expected date of discharge target was achieved in month. One key area of focus is imaging turnaround where the demand for all imaging modalities continues to increase. A business case is being developed with staff consultation for extending the service by an hour. The Board discussed the challenges recruiting radiology workforce. <u>Quality</u> Julie Gray noted the infection prevention and control targets are just under trajectory and the numbers month on month had come down. The reds on the safer staffing target link to short term sickness, however there was no impact from a patient care perspective. One 25-day complaint didn't hit the deadline in month. The divisional team have been reminded of the timescales involved in routine complaints and to escalate all delayed responses to the Complaints Manager. The target for the percentage of policies in date is green this month and there is a plan to make the system for updating more robust. The Board was pleased to see this target green. <u>Research & Innovation</u> Sheena Khanduri highlighted the one exception report for trial recruitment and noted the report provided a detailed reason for not meeting the target. The Board noted a discussion regarding internal reporting of the paused targets had been held and these will be included in reporting to TEG and Performance Committee. <u>Workforce</u>

	Jayne Shaw highlighted long-term sickness absence was above target in amber in month, although there had been a decrease in stress, anxiety and depression. Short term sickness was just within target, although the Trust is seeing an increase in the number of covid cases. Turnover continues to be above target, although is below once fixed contracts are removed. Turnover is reported in more detail to the People Committee and the Trust is benchmarked against the model hospital data. Admin and Clerical are the largest group for turnover. The appraisal target hasn't been met for the second month. The team have reviewed this and found that managers aren't completing the final step in confirming the appraisal is complete and therefore the data is not imputed to the electronic staff record. The team have distributed additional guidance and flow chart for managers. The Board discussed turnover and noted that the reason for leaving is not always accurate; work life balance is often put as a default. The Workforce team ring round leavers where they haven't taken up a workforce exit interview. Mark Tattersall noted that the number of leavers for Admin and Clerical was high. Jayne Shaw noted this included leaves from multiple areas including finance and Workforce and Organisational Development. The Board **agreed** the Integrate Performance Report.
114-23/24	**Cancer Waiting Times Targets: National changes and implications for the Trust** Joan Spencer updated the Board on the new cancer waiting time standards NHS England has published to speed up diagnosis and treatment for patients, which will come into effect from 1st October 2023. The NHS has until now had ten performance standards for cancer, but following a rigorous consultation and with the support of leading cancer charities and clinicians, the Government has agreed these targets will be simplified and consolidated into three key standards. These are: 28 Day Faster Diagnostic Standard 62 day referral to treatment standard 31 day decision to treat standard Joan Spencer highlighted the implications for the Trust's performance section of the report. For the 28 day target the existing target is 75% and this will become 80% from 1st April 2025. The interim target for 2024/25 (to be confirmed in the 2024/25 planning guidance) is estimated to be between 75% and 80%. As the Trust only diagnoses in the HO service; this standard applies to low numbers of our patients and % compliance therefore changes significantly with just 1 breach. Based on current data there may be challenges achieving the 80% target. With regards to the 31 day target, Joan Spencer didn't highlight any challenges achieving this as the Trust has consistently been achieving the targets for the 31 day standard. The Trust achieved the 62 Day 'classic' standard in 5 of the last 12 months. Against the new single 62 Day standard, we would have achieved the 85% target in 2 of the last 12 months. In the other 3 months in which the 62 Day 'classic' standard only was achieved, performance against the new standard was 83%, 84% and 84%, narrowly missing the 85% target. In relation to the national ambition of 70% by March 2024, we exceeded this in 11 of the last 12 months. It is not possible to predict what CCC's individual provider trajectory will be in 2024/25. As organisations are not required to monitor this as tightly, the number of late referrals could go up.

	Joan Spencer highlighted the mitigations included in the report for the risk around the 28 day and 62 day targets including the genomics steering group work. The Board of Directors **noted** the amendments to the targets, the implications for CCC's performance and **agreed** the internal monitoring and reporting processes from 1st October.
115-23/24	**Finance Report** James Thomson introduced the Month 5 finance report. The Trust financial position to the end of August is a £292k deficit, which is £443k below plan. The group is showing a £207k surplus to the end of August, which is £56k above plan. The Trust cash position is a closing balance of £64m, which is above plan by £1.9m. Capital spend is £322k for the year to date, with the majority of spend profiled in future months As part of the financial plan the Trust has assumed an additional £1.6m of income for activity over and above 2023/24 activity levels. As part of month 5 the Trust has made an assumption that the income will be received as so has included income of £133k.The position has not been verified and transacted. Agency spend is £220k in month, which is an increase from last month, mainly due to reclassification of costs from bank and consultancy to agency of £80k. Year to date agency spend is lower than plan by £83k. However, in month we are above plan by £71k. There is continued focus on the reduction of agency usage across the Trust and this is reported and monitored through both the Trusts Establishment Control Panel and Finance Committee. The Trust CIP requirement for 2023/24 is £8.249m, representing 5% of turnover. Both NHSE and C&M ICB are expecting this to be achieved recurrently. The report shows there has been £5.1m (62%) of the CIP target delivered by the end of August. £2.1m of these savings are recurrent. James Thomson informed the Board that as of the 26th September CIP is just under 100% for delivered schemes and schemes undergoing quality impact assessments. There is still a portion of this which is non-recurrent. Mark Tattersall queried the Trust's confidence around the assumed income. James Thomson informed the Board that he had discussed it with specialised commissioning the day before and they are aware of the Trust's over performance on its contract and the variation in data sets used for 'fixed' activity. An early planning phase for 2024/25 is starting and the ICB are viewing the consolidated position, as they are still reporting they will achieve a breakeven position by the end of the year. However this is currently at risk, and there have been additional pressures due to industrial action. The Board discussed ICB funding and noted they would receive some funding to cover for emerging risks during the winter. This will go through their prioritisation processes. The Board **noted** the report
116-23/24	**Assessment of the Trust's governance and escalation arrangements** Julie Gray introduced the True for Us report following the verdict in the trial of Lucy Letby. The report was to provide evidence of assurance and identify any areas in the Trust where improvement might be required. On 18th August 2023 Amanda Pritchard - NHS Chief Executive, Sir David Sloman - Chief Operating Officer NHS England, Dame Ruth May - Chief Nursing Officer, England and Professor Sir Stephen Powis - National Medical Director wrote to all NHS organisations via their Chief Executives. They requested that Boards reflect on these appalling crimes and take

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	action to ensure that all reasonable safeguards are in place within their own organisations. In particular Boards were asked to review, governance frameworks, Freedom to speak up arrangements and fit and proper persons processes to identify any immediate issues requiring action. The report provided a review of these areas and the current position, evidence and assurance from external bodies. On behalf of the Trust, Julie Gray noted our thoughts are with all the families affected, who have suffered indescribable pain and loss. The Board noted whilst we cannot completely mitigate against the risk of a determined individual we can ensure that as an organisation we have employed sufficient safeguards to identify concerns, listen to our staff and protect those who speak up. This True for Us review concluded that the organisation has suitable systems and controls in place to support staff to raise concerns safely and without recrimination. No immediate issues requiring action have been identified but some future actions to further enhance the physiological safety of our staff and continue organisational vigilance have been suggested. Mark Tattersall noted the Board is familiar with the areas in the report and has regular oversight of the mortality report. He highlighted there were other areas of assurance not highlighted in the report. Julie Gray informed the Board that the teams will pull together an escalation framework to demonstrate the process for how information regarding what is happening at ward level is communicated to the Board. This will be brought to the Trust Board meeting in November. The Board discussed the freedom to speak up process and the multiple routes for speaking up available including through, Champion, NED Lead, Executive Lead, Managers, Chief Executive, CQC etc. The Board **noted** the report.
117-23/24	**Board of Directors Development Session – Quality Improvement** The paper provided presented an overview of the Quality Improvement Board development session held on 26th July 2023. The Board noted the date on the cover sheet was an error. The Board **noted** the report.
118-23/24	**Safeguarding Annual Report** The item was noted as part of the consent agenda
119-23/24	**Health & Safety Annual Report** The item was noted as part of the consent agenda
120-23/24	**Questions from Governors and members of the public** There were no questions from the Governors or members of the public
121-23/24	**Items for inclusion in the BAF** There are no further items for inclusion on the Board Assurance Framework.
122-23/24	**Reflections on meeting** Those attending via Teams noted there were occasionally challenges with picking up the sound in the meeting room, however they were still able to follow the meeting and felt it went well. The Board agreed there had been a good level of discussion and debate.
123-23/24	**Any Other Business** There was no other business to note
	Date and time of next meeting: 29th November 2023 @ 09:30

Trust Board Part 1 Action Log

KEY	
	Complete
	On Track
	At Risk
	Late

Date of Meeting	Item No.	Agenda Item	Action(s)	Action By	Date to Complete By	RAGB	Status Update/Assurance
27/09/2023	**106**	**Freedom to Speak Up Annual Report and Freedom to Speak Up Policy**	6 month FTSU report to be included on the Cycle of Business.	**Joanna Wynne**	**Apr-24**		
	106	**Freedom to Speak Up Annual Report and Freedom to Speak Up Policy**	FTSU Guardian and EDI Lead to review Equality Impact Assessment	**Joanna Wynne**			
	109	**PSIRF Policy and Plan**	Jill Tozer to confirm the role of the Audit Committee in the PSIRF Policy and determine if instead it should say Quality Committee.	**Jill Tozer**	**Sep-23**		**The policy has been ammended to say 'This will be achieved through reporting processes as well as receiving assurance via the RQC and the Quality Committee'**

Trust Board Cycle of Business 2023/24

Item	Lead	Author	Frequency	Item For	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	2024	Jan-24	Feb-24	Mar-24
Standard Items																	
Welcome, Introductions, Apologies and Quoracy	Chair	NA	Monthly	Standard Business	√	√	√	√		√		√				√	√
Declarations of Interest	Chair	NA	Monthly	Standard Business	√	√	√	√		√		√				√	√
Matters Arising / Action Log	Chair	NA	Monthly	Standard Business	√	√	√	√		√		√				√	√
Cycle of Business	Chair	NA	Monthly	Standard Business	√	√	√	√		√		√				√	√
Chair and Chief Executive Update	Chair / Chief Exec	Kathy Doran Liz Bishop	Monthly	Standard Business	NA	√	√	√		√		√				√	√
Strategy & Planning																	
Progress against 5 Year Strategy	Director of Strategy	Tom Pharaoh	6 monthly	For information/noting		√						√					
Annual Financial/Operational Planning Guidance	Director of Finance	James Thomson	Q3 and Q4	For information/noting								√				√ Draft	√ Submission
Progress against Innovation Strategy (Inc. Bright Ideas) Annual Report	Medical Director	Drew Norwood-Green	Annually	For information/noting												√	
Progress against Research Strategy Annual Report	Medical Director	Gillian Heap	Annually	For information/noting								√					
Progress against Green Plan Annual Report	Director of Strategy	Tom Pharaoh	Annually	For information/noting												√	
Digital Strategy	Chief Information Officer	Sarah Barr	Annually	For approval	√ (deferred)	√											
Quality Strategy	Chief Nurse	Julie Gray	Annually	For approval				√									
Risk Management Strategy	Chief Nurse	Julie Gray	Annually	For approval	√												
Assurance: Quality & Performance																	
Patient Story	Chief Nurse	Depends on area of patient story	Every other meeting	For information/noting		√		√				√					√
Staff Story	Director of WOD	Stephanie Thomas	Every other meeting	For information/noting	√		√			√						√	
Quality Committee Chair Report	NED TJ	Skye Thomson	Quarterly	For information/noting	√		√			√						√	√
Performance Committee Chair Report	NED GB	Abby Ashcroft	Quarterly	For information/noting		√				√		√				√	
Audit Committee Chair Report	NED MT	Jane Hindle	6 times a year	For information/noting	√	√		√				√				√	
People Committee Chairs Report	NED AR	Anne Mason	Quarterly	For information/noting	√ (inc ToR - deferred from		√			√						√	√
Integrated Performance Report	Exec Leads	Hannah Gray	Monthly	For discussion	√	√	√	√		√		√				√	√
Finance Report	Director of Finance	Jo Bowden/Lucy Blackhurst	Monthly	For information/noting	√	√	√	√		√		√				√	√
Safer Staffing Report	Chief Nurse	Julie Gray	6 monthly	For approval			√									√	
Gender Pay Gap	Director of WOD	Angela Ditchfield	Annually	For discussion For approval													√
Workforce Race Equality Standard Data	Director of WOD	Angela Ditchfield	Annually	For information/noting						√							
Workforce Disability Equality Standard Data	Director of WOD	Angela Ditchfield	Annually	For information/noting						√							
Equality Diversity & Inclusion Annual Report	Director of WOD	Angela Ditchfield	Annually	For approval				√ (moved to Feb in line with publishing schedule)								√	
In-Patient Survey	Chief Nurse	Julie Gray	Annually	For information/noting				√ (deferred to Oct)				√					
NED and Governor Engagement Walk round	NED attended	Claire Smith	Monthly	For information/noting	√	√	√	√		√		√				√	√
Actions from NED and Governor Engagement Walk-rounds Annual Report	Chief Nurse	Nikki Heazell	Annually	For information/noting	√												
Caldicott/SIRO Annual Report	Medical Director / Director of I	Peter Case-Upton, MIAA James Thomson	Annually	For information						√							
Staff Survey Results	Director of Workforce	Stephanie Thomas	Annually	For information/noting													√
Statutory Reporting / Compliance																	
Self-Certification against the Provider Licence	Associate Director of Corporate Governance	Jane Hindle	Annually	For approval		√ (deferred)		√ (went in June)									
Regulation 5 Declarations (Fit and Proper)	Associate Director of Corporate Governance	Jane Hindle	Annually	For approval				√									
Risk Management Strategy (including Risk Appetite Statement)	Chief Nurse	Julie Gray	Annually	For approval													√
Emergency Preparedness Resilience and Response (EPRR) Annual Report and Core Standards	Chief Operating Officer	Julie Gray	Annually	For approval						√							
Mortality Report (Learning from Deaths)	Medical Director	Helen Wong	Quarterly	For information/noting	√			√				√				√	
Mortality Annual report	Medical Director	Helen Wong	Annually					√									
Revalidation Annual Report	Medical Director	Chris Thompson	Annually	For approval						√							
Guardian of Safe Working Report	Medical Director	Chris Thompson Ian Lampkin	Quarterly	For information/noting						√		√					√
Guardian of Safe Working Annual Report	Medical Director	Chris Thompson Ian Lampkin	Annually	For approval			√										
Infection Prevention and Control Annual Report	Chief Nurse	Julie Gray	Annually					√									
Freedom to Speak Up Annual Report	Chief Nurse	Jo Wynne	Annually							√							
Health and Safety Annual Report	Chief Operating Officer	Derry Sinclair	Annually							√							
Safeguarding Annual report	Chief Nurse	Julie Gray	Annually							√							
Collaboration																	
CMCA Report	Chief Executive	Liz Bishop	Quarterly	For information/noting			√	√		√		√				√	
Liverpool Trust's Joint Committee Report	Chair	Skye Thomson	Bi-monthly	For information/noting		√	√					√				√	
Board Governance																	
Review of Constitution (ADHOC)	Associate Director of Corporate Governance	Jane Hindle	Adhoc	For approval													
Board Assurance Framework	Associate Director of Corporate Governance	Skye Thomson	Quarterly	For information/noting For approval	√			√				√				√	

Board Assurance Framework Refresh	Associate Director of Corporate Governance	Skye Thomson	Annually	For approval	√												
Audit Committee Annual Report and Annual Review of Board Effectiveness	Associate Director of Corporate Governance	Jane Hindle	Annually	For discussion For information/noting				√									
Trust Board Annual Cycle of Business	Associate Director of Corporate Governance	Skye Thomson	Annually	For discussion For approval													√
NED Independence & Board Register of Interest	Associate Director of Corporate Governance	Jane Hindle	Annually	For information/noting													√
Scheme of Reservation and Delegtation/Standing Financial Instructions	Associate Director of Corporate Governance	Jane Hindle/Jo Bowden	Annually	For approval													
Use of Trust Seal Report	Associate Director of Corporate Governance	Jane Hindle	Annually	For information/noting	√												
Adhoc / Committee Requested																	
Formal Review of the Board Committee Governance Structure	Associate Director of Corporate Governance	Jane Hindle	Adhoc	For discussion				√									√
Freedom to Speak Up Reflections and Planning Tool	Chief Nurse	Jo Wynne	Adhoc	For information/noting						√							
Freedom to Speak Up Policy	Chief Nurse	Jo Wynne	Adhoc	For approval						√							
Palliative Care End of Life Strategy	Chief Nurse	Daniel Monnery	One-off	For information/noting				√									
NHS BAME antiracist framework Action Plan Quarterly Update	Director of WOD	Angie Ditchfield	Quarterly	For information/noting						√						√	
PSIRF Quarterly Assurance Report	Chief Nurse		Quarterly	For information/noting													

Title of Meeting: Trust Board Part 1
Date of Meeting: 29th November 2023

Report lead	Kathy Doran Chair, Liz Bishop CEO			
Paper prepared by	Jane Hindle, Associate Director of Corporate Governance			
Report subject/title	Chair and Chief Executive report to Trust Board			
Purpose of paper	This is a combined Chair's and Chief Executive's report containing an update on items of national, regional and local significance.			
Background papers	N/A			
Action required	The Board is requested to: • Note the report			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work	X
	Be Collaborative	X	Be Digital	X
	Be Research Leaders	X	Be Innovative	

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

Chair's Update

1.0 **North West Providers North West Regional Meeting**

1.1 On 7th November I attended the North West Providers Regional Meeting. Julian Hartley CE of NHSP provided a helpful strategic overview of the current national context in health policy given the anticipated General Election in the next year or so.

2.0 Cheshire and Merseyside Acute and Specialist Trusts Chair's Meeting

2.1 I attended the Cheshire and Merseyside Acute and Specialist Trusts (CMAST) Chair's Meeting on 15th November. It focussed on managing the 2023/24 Financial Position following NHS England's announcement regarding the impact of industrial action.

3.1 Consultant Appointments

3.1 I took part in interviews for a Consultant Radiologist on 13th November and was delighted that we appointed Professor Madhusudhan Kumble Seetharama, who is anticipated to join us early next year.

4.0 Clatterbridge Cancer Charity Board Meeting

4.1 I attended a meeting of the Clatterbridge Cancer Charity Board on 13th November where we received a presentation from the Trust, in relation to the an overview of future potential charitable funding projects to the Charity Board.

5.0 Visits to services

5.1 During November I completed a visit to the Radiotherapy Service at Aintree accompanied by Keith Lewis, public governor.

6.0 Governor Forum

6.1 Governors had the opportunity to attend an informal session held on 13th November regarding the Board Assurance Framework and strategic risks.

CEO Update

1.0 Cheshire & Merseyside Acute and Specialist Trusts (CMAST) Provider Collaborative Update

1.1 CMAST Leadership Board met on 6th October including Chairs. The purpose of the meeting was twofold: to provide an update to the Board on progress in delivery against CMAST Programme's workplan commitments; and to reflect on the potential for system learning and approaches to assurance in response to incidents.

1.2 Diagnostics Programme

2023/4 delivery headlines:

Against a backdrop of an overall increase in activity, there has been a reduction in waiting times across specialities, including 100% reduction in patients waiting 79 wks+ and 74% reduction in patients waiting 26 wks+

Increased productivity has been achieved through the introduction of single guidelines and productivity tools meaning performance can be monitored more accurately across C&M.

System first thinking is enabling innovation across C&M through increased:

- capital investment
- screening opportunities
- cost avoidance through efficiency

A number of key decisions on significant direction of travel issues have been taken in the first part of the year to further the following workstreams within the diagnostics programme:

- Pathology target operating model
- Pathology LIMS (Laboratory Information System)
- Endoscopy transformation

Anticipated 2023/4 next steps and delivery milestones:

- Enhanced mutual aid offer to harmonise waiting times
- Continued development of shared digital systems
- Workforce – interventional radiology, workforce growth and development
- Development and testing of risk and gain share mechanisms
- Increased use of AI deployment across diagnostics

1.3 Elective Recovery

2023/4 delivery headlines:

Waiting lists and PTL management:

- C&M were one of the only ICBs in the country to eliminate 104 week waits in line with deadlines
- C&M ERF performance has tracked 2% higher than the England average since May

Reducing variation in care:

- Mutual aid for over 6500 patients from 8 different trusts throughout C&M has been facilitated

- System resources:

- C&M theatre utilisation performance started in the 2nd quartile a year ago, and rose to 4th best in the country during August
- Over 2,600 patients have been treated in the shared elective hub

Anticipated 2023/4 delivery milestones:

- Waiting lists and PTL management
  - C&M are on track to eliminate 65 week waits by the end of March 2024
  - Over 110,000 patients have been cleared from the potential breach cohort since April
- System resources:
  - The second cohort of attendees will be starting Theatre Academy to ensure the spread of best practice techniques throughout C&M

1.4 Clinical Pathway

2023/4 delivery headlines:

- The CPP Programme continues to follow its established methodology while continuing to follow identified road maps for orthopaedics, dermatology and ENT
- A current state assessment has been undertaken for gynaecology with the first workshop held over the summer

Anticipated 2023/4 next steps and delivery milestones:

- Orthopaedics - C2Ai risk stratification project currently ongoing in all Trusts that deliver orthopaedic services will conclude and further pathway standardisation will be progressed
- Dermatology – Continued focus on exploring the potential use of technology within the specialty, through establishment of pilots and stocktaking existing projects
- ENT – Further development of the collaborative alliance with key focus on workforce with support from the workforce programme
- Gynaecology – Prioritisation and evaluation of opportunities to agree an improvement roadmap
- Connecting with other workstreams to maintain connection when identifying and scoping of further specialties for inclusion in the programme

1.5 Finance, Efficiency & Value – Efficiency at Scale

2023/4 delivery headlines:

- Programme Director is in place and funding for the programme has been secured for 2023/4 and 2024/5
- Principles and a workplan for 2023/24 have been established for efficiency at scale. The workplan is aligned to the National Corporate Services Transformation Programme
- Highlights from workstreams include:
  - Funding for the medicines optimisation workstream has been secured for 2023/4 and 2024/5, a single governance structure is now in place for medicines to support this

- A full procurement governance structure is in place and ICB Chief Procurement Officer commenced in September
- An additional indemnity insurances review has been completed and £2.1m identified for review across C&M
- A business case in under development for a single financial ledger and is supported by all trusts in C&M

Anticipated 2023/4 key targets include system delivery and contribution to:

- Medicines management will deliver an estimated £10m of savings in 2023/4, subject to continuation of ICB investment in infrastructure
- Procurement initiatives will deliver a £5m full year effect although the full value will not be realised until 2024/5
- Planning to support finance and legal workstreams to potentially release up to £1m in savings in 2024/25

1.5 Workforce

2023/4 delivery headlines:

- A detailed analytical review of workforce and benchmarking exercise has been completed with all C&M providers in conjunction with the ICB and the efficiency at scale programme
- AHP Faculty has been established with a robust system wide workplan
- Clear priorities and strategic workforce plan have been developed and aligned to support focus areas for the elective recovery and clinical pathway programmes
- A number of pilot sites have been identified to facilitate testing of a career pathway aimed at Band 6 ward nurses to support retainment and career progression
- After undertaking scoping exercises and in conjunction with system partners it has been agreed not to pursue projects at this time around developing a HCA collaborative bank or midwifery trainee nursing associate role

Anticipated 2023/4 delivery milestones will support delivery of objectives by:

- Ongoing funding will not be provided for the workforce programme in 2024/5
- A refocusing of the programme to identify commitments moving beyond 2023/4 has commenced

A planned discussion on the ICS Digital Strategy has had to be rescheduled due to an unforeseen cancellation.

2.0 Clatterbridge Centre Staff Excellence Awards 2023

2.1 The second staff excellence awards were held on 6 October 2023 at The Crowne Plaza in Liverpool.

2.2 Over 400 staff attended the event which organised by the Learning and Organisational Development Team and recognised staff achievements across 12 categories with the winners for each listed below:

- Excellence in Quality Improvement and Innovation Award – Metastatic Spinal Cord Compression Team
- Learner of the Year Award – Emily Marsden – Communications Team
- Excellence in Research Award – Cup COMP Trial Team
- Clinical Unsung Hero of the Year Award – Dr Alia Alchawaf
- Non-Clinical Unsung Hero of the Year Award – Danielle Cartright , Radiation Services
- Equity, Diversity and Inclusion Award, Anastasia Sinclair, Research and Innovation
- People's Choice Award – Cantreat Halton Team
- Spirit of Clatterbridge Award – Kate Greaves
- CCC Star of the Year Award – Anumkol Chandredath, Network Services
- Non-Clinical Team of the Year Award – Paddington CDC Programme Team
- Clinical Team of the Year Award – Radiotherapy Team
- Lifetime Achievement Award – Kate Greaves, Associate Director of Clinical Education

2.3 We also celebrated staff who had achieved a long service milestone in the previous 12 months.

2.4 The evening was a huge success and feedback confirms it was much appreciated and enjoyed by staff.

3.0 Monthly Star Awards

3.1 I had the pleasure of presenting the October Monthly star awards to Letitia Corner, Speech and Language Therapist who was nominated by her colleague who said Tish went above and beyond by providing a truly holistic approach to patient centred care to a patient who experienced some extremely challenging circumstances.

4.0 Private Clinic opening evening

4.1 Along with other executives I attended an open evening for the private clinic which was arranged by Duncan Armfield to raise the profile of the Clinic. The evening was well attended by GPs, secondary care consultants and other representatives from CCC.

5.0 Reverse mentoring programme

5.1 The matching process for mentors and mentees is now complete and myself, along with other Executives, will meet with our mentors shortly. Updates will be provided to People Committee including an evaluation of the programme prior to a wider roll out.

6.0 Reception at Buckingham Palace

6.1 Vidya Jyothi, one of our international nurses on ward 4 has been nominated by the Trust to attend a reception, hosted by his Majesty the King, at Buckingham Palace to celebrate the contribution of international nurses and midwives in the health and social care sector.

7.0 A Big Conversation sessions

7.1 The first round of Executive led sessions has commenced. The theme is, Being a great place to work and sessions are being held across all sites with representatives across all staff groups and departments. Once complete the themes will be shared with staff and action plans will be developed.

8.0 Industrial action

8.1 BMA - Ballots for further industrial action close on 18 December 2023.

SoR – No further update at this point

9.0 Media Coverage

The Clatterbridge Cancer Centre recently featured on ITV national news, as our pioneering research into cancer vaccines continue to make headlines. The feature focuses on the Replimune study - where a cancerous tumour is injected directly with an altered virus to trigger the body's immune system to fight the cancerous cells.

10. Recommendations:

The Board is requested to:

- **Note the report**

Title of meeting: TEG
Date of meeting: October 2023

Report author	Nicola Heazell Head of Patient Experience			
Paper prepared by	Laura Selby - Chemotherapy unit manager Nicola Heazell Head of Patient Experience			
Report subject/title	Patient Story - Halton CANtreat Service			
Purpose of paper	Action Plan to support Patient Story			
Background papers	N/A			
Action required	Link to patient story: https://youtu.be/PA2sh3yyNE4 See attached Action Report			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	x	Be a great place to work	x
	Be Collaborative	x	Be Digital	X
	Be Research Leaders	x	Be Innovative	x

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

Ref: FCGOREPO
Review: July 2025
Version: 2.0

Patient/Staff Story Action Report

Story ID	Oct 2023	Committee	Board of Directors		
Date Presented	TEG	Patient Story	☒	Staff Story	☐
		In person	☐	Digital	☒
Date Consent Obtained	28/08/2023	Consented by	Laura Selby	Consent for:	☒ Internal ☒External ☒Online Anonymized
Division/s involved	Networked Services		External Organisation involved	N/A	
Formal Complaint	☐	Complaint closed	☐	Complaint Upheld	☐

1. Action Already Taken

No	Issue	Action taken	Action Lead

There were no immediate actions required.

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

No	Issue	Action required	Action Lead	Deadline Date	Expected Evidence of Completion
1.	Reducing stereotype of Chemotherapy between diagnosis and pre-assessment appointments	Creation of digital Welcome videos for treatment units (once refurbishment completed for Halton Unit) for patients to watch at home; As part of the outpatient transformation work is currently being looked at to potentially digitalise part of the pre assessment appointment.	Laura Selby and Comms Team	June 2024	Completed video on internet.
2.	Share best practice with other	Share patient narrative with other Chemo Units/CBUs	Laura Selby	Nov 2023	Narrative shared

	Chemotherapy Units				

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.

Title of meeting: Board of Directors
Date of meeting: 29 November 2023

Report of	Julie Gray – Chief Nurse
Paper prepared by	Nicola Heazell - Head of Patient Experience and Inclusion
Report subject/title	CQC Adult Inpatient Survey 2022 Report
Purpose of paper	To provide an overview of relevant key messages, findings and recommendations from the publication of the Adult Inpatient Survey 2022 and any subsequent actions to be undertaken by Clatterbridge Cancer Centre NHS Foundation Trust (CCC).
Background papers	None

Action required	Discuss	✓
	Approve	
	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		

CQC Adult Inpatient Survey 2022 Report

1. Introduction

The Care Quality Committee (CQC) Adult Inpatient Survey 2022 has rated The Clatterbridge Cancer Centre NHS Foundation Trust as one of the best hospitals in England for inpatient care for the third year running. We are one of just nine hospital trusts nationally to achieve the top overall rating of 'Much better than expected'. There were no areas that scored worse than expected.

This paper will provide an overview of key findings and recommendations from the publication and any subsequent actions to be undertaken.

2. Background

The Care Quality Committee (CQC) Adult Inpatient Survey looks at the experiences of adults that have been an inpatient at an NHS hospital. The survey has been running since 2002 and is published annually. All eligible organisations in England are required to participate in the survey. Nationally a total of 133 NHS trusts in England took part in the Adult Inpatient Survey. 63,224 patients who were in hospital in November 2022 responded to the survey resulting in a national response rate of 40%.

The Care Quality Commission will use the results from the survey in their regulation, monitoring and inspection of NHS trusts in England. Survey data will be used in CQC's monitoring tools, which provide inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be used to support CQC inspections. NHS England and Improvement will use the results to check progress and improvement against the objectives set out in the NHS mandate, with the Department of Health and Social Care holding organisations to account for the outcomes they achieve.

3. Adult Inpatient Experience Survey 2022 Key Summary

The Clatterbridge Cancer Centre achieved the best scores in the country on 10 of the questions:

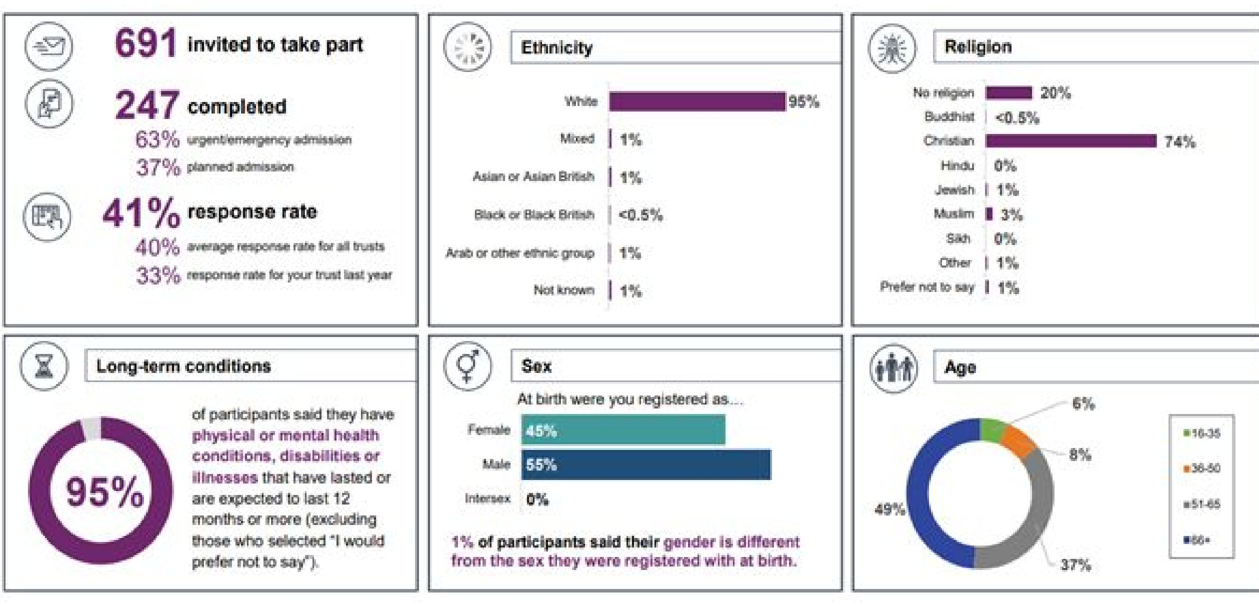
- Time spent on a waiting list before admission
- Receiving information from hospital staff about your condition/treatment
- Being able to discuss your condition/treatment without being overheard
- Having enough privacy when being examined/treated
- The hospital doing enough to control your pain
- Hospital staff explaining how you might feel after treatment
- Getting enough information about what to do or not do after discharge
- Knowing before you left hospital what would happen next with your care
- The hospital doing enough to arrange social/community care
- Overall being treated with respect and dignity

Other areas of strength included patients feeling involved in decisions about their care, understanding the answers they got to any questions, feeling they could open up and speak to staff if they had any worries, and being able to have a peaceful night's sleep.

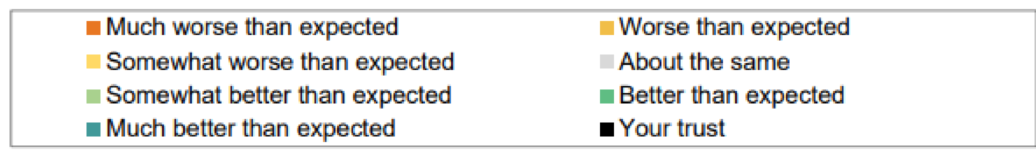
In total, we scored 'much better than expected' on 21 of the survey questions, 'better than expected' on 15 questions and 'somewhat better than expected' on 2 questions. There were no areas where we performed worse than expected.

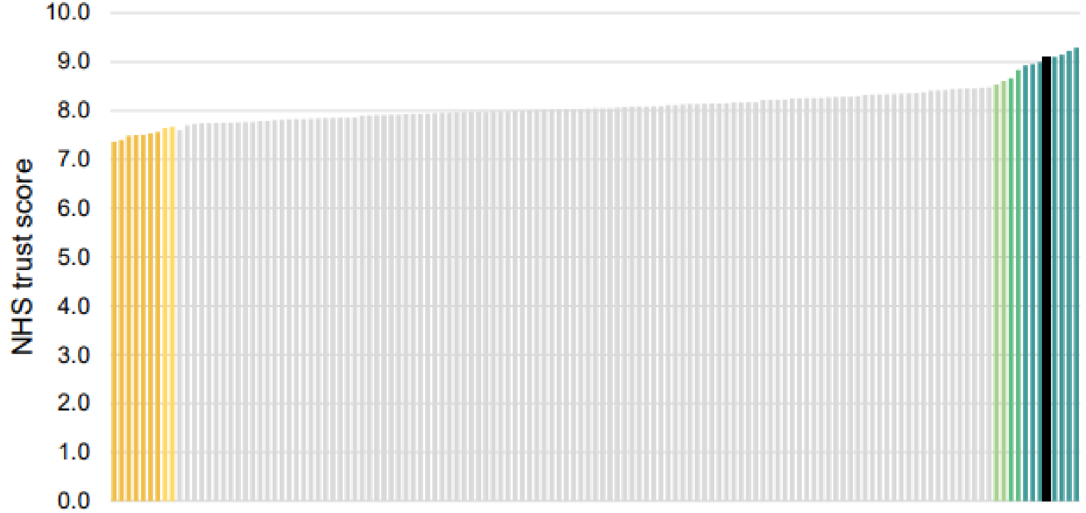
4. Local Context

691 patients were invited to complete the survey, of these 247 patients completed the survey which is a response rate of 41%. This is slightly higher than the average response rates for similar trusts and significantly higher in comparison to our response rate for 2021.



The table below shows Clatterbridge Cancer Centre benchmarked score for patient's overall experience as: **9.1 (Much better than expected).**



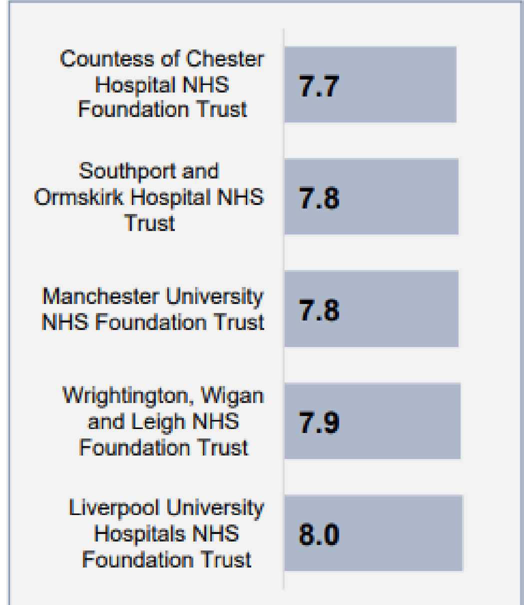


Comparison with other trusts within your region

Trusts with the highest scores

Trust	Score
Liverpool Heart and Chest Hospital NHS Foundation Trust	9.2
The Clatterbridge Cancer Centre NHS Foundation Trust	9.1
The Christie NHS Foundation Trust	9.0
The Walton Centre NHS Foundation Trust	8.9
St Helens and Knowsley Teaching Hospitals NHS Trust	8.5

Trusts with the lowest scores



Where patient experience is best

- ✓ Noise from other patients: patients not being bothered by noise at night from other patients
- ✓ Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital
- ✓ Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital
- ✓ Waiting to get to a bed: patients feeling that they waited the right amount of time to get to a bed on a ward after they arrived at the hospital
- ✓ Information about medicines to take at home: patients being given information about medicines they were to take at home

Where patient experience could improve

- Taking medication: patients being able to take medication they brought to hospital when needed
- Having enough to drink: patients getting enough to drink whilst in hospital
- Quality of food: patients describing the hospital food as good
- Feedback on care: patients being asked to give their views on the quality of their care
- Privacy for examinations: patients being given enough privacy when being examined or treated

NB. Quality of food was also a theme for improvement in the 2022 PLACE inspection and in the Non-Executive Director and Governor Walk-rounds – in June 2023 the food provider was changed and feedback to date has been overwhelmingly positive.

The full publications is available at: www.cqc.org.uk/inpatientsurvey

5. Conclusion

For the 3rd consecutive year the Care Quality Committee (CQC) Adult Inpatient Survey has rated The Clatterbridge Cancer Centre NHS Foundation Trust as one of the best hospitals in England. This year we were one of just nine hospital trusts nationally to achieve the top overall rating of 'Much better than expected', and notably there were no areas that scored worse than expected. This achievement is testament to the care and compassion provided to our patients by our staff and volunteers.

In the areas where patient experience could be improved work-stream are already established and improvements being implemented. These areas form the basis of the 2023/2024 Patient Experience and Inclusion improvement plan, overseen by the Patient Experience and Inclusion Committee.

7. Recommendations

The Board of Directors is asked to note the excellent results in the Adult Inpatient Survey 2022.

Title of meeting: Trust Board
Date of meeting: October 2023

<table>
<tr><td>Report of</td><td colspan="4">Chief Nurse</td></tr>
<tr><td>Paper prepared by:

In attendance at the visit</td><td colspan="4">Quality Improvement Manager – Claire Smith
Non-Executive Director – Elkan Abrahamson
Governor – Anne Olsson</td></tr>
<tr><td>Report subject/title</td><td colspan="4">Patient Experience Visit September 2023</td></tr>
<tr><td>Purpose of paper</td><td colspan="4">The purpose of this report is to provide Trust Board with a summary of the NED & Governor Patient Experience visit conducted on the 7th September 2023. The panel visited the Clinical Decisions Unit (CDU) and Ward 2, Level 2 CCCW.</td></tr>
<tr><td>Background papers</td><td colspan="4">n/a</td></tr>
<tr><td rowspan="3">Action required</td><td colspan="3">To approve content/preferred option/recommendations</td><td></td></tr>
<tr><td colspan="3">To discuss and note content</td><td></td></tr>
<tr><td colspan="3">To be assured of content and actions</td><td></td></tr>
<tr><td rowspan="3">Link to:
Strategic Direction
Corporate Objectives</td><td>Be Outstanding</td><td>x</td><td>Be a great place to work</td><td>x</td></tr>
<tr><td>Be Collaborative</td><td></td><td>Be Digital</td><td></td></tr>
<tr><td>Be Research Leaders</td><td></td><td>Be Innovative</td><td></td></tr>
<tr><td colspan="5">Equality & Diversity Impact Assessment</td></tr>
</table>

<table>
<tr><td rowspan="3">The content of this paper could have an adverse impact on:</td><td>Age</td><td>Yes/No</td><td>Disability</td><td>Yes/No</td><td>Sexual Orientation</td><td>Yes/No</td></tr>
<tr><td>Race</td><td>Yes/No</td><td>Pregnancy/Maternity</td><td>Yes/No</td><td>Gender Reassignment</td><td>Yes/No</td></tr>
<tr><td>Gender</td><td>Yes/No</td><td>Religious Belief</td><td>Yes/No</td><td colspan="2"></td></tr>
</table>

Division	Acute Services	Location	Clinical Decision Unit (CDU) Level 2 CCCL	Date	7th September 2023
In attendance – Panel			In attendance – Patient & Staff		
Governor	Anne Olsson		Senior Manager facilitating the walk round		Jackie Dillon Theresa Gimson
Non-Executive	Elkan Abrahamson		Number of Patients		1
Patient Experience Team	Claire Smith		Number of Staff		1

Patient Feedback:

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

One patient was interviewed who had called triage with a raised temperature and had been asked to come to CCCL for assessment.

Positive Patient Comments:

- Can't say enough I love CCC, Hotline is a great service, and I am very well taken care of.
- Called Triage due to a raised temperature, on arrival to CDU waited 3 minutes in reception, then called straight through and treated.
- Food wise – chicken sandwich from the ward was lovely and hot food from the café is tasty too.

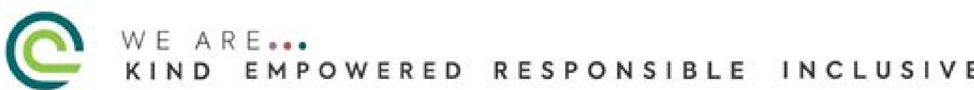
Areas where immediate action was taken on the day: Nil

Areas for improvement:	Service response: *Highlight in **Bold** actions to be added to PEIC action plan*
No improvement needed, I don't need anything else.	N/A

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.*

The matron explained the pathway processes and how CDU prioritises patients depending on clinical need. The visit was informed that Hotline had undergone some changes to



<table>
<tr><td colspan="2">reduce patient waiting times; the unit had been involved in benchmarking with both The Christie and The Royal Marsden, with CCC waiting times being very competitive.

The Matron explained the role of the Practice Education Facilitator based on the inpatient wards, supporting new staff, enabling them to be skilled members of the team.</td></tr>
<tr><td colspan="2">Positive Comments:

• CCC have supported me to complete the chemotherapy course and through my first Master’s module, I hope to be able to continue onto a Master’s programme.

• I have worked at a few different hubs across CCC and gained lots of experience as well as being given many opportunities. I have encouraged a number of my nurse friends to apply for jobs at CCC.

• Staff are aware of and feel able to speak up with regard to identifying Bright Ideas.

• Although complimentary, patients often have the expectation that CCC can do anything. Many patients will refuse the advice to attend their local A+E and attend CCCL instead, sometimes it isn’t the most appropriate place for them to attend.

• Staff reported one patient had recently fed back that they were amazed that he had been assessed and treated so quickly on a bank holiday, which was lovely to hear.

• The CDU team are so lucky to have the Advanced Nurse Practitioners as part of the team, they are amazing, their knowledge is immense and they are so supportive to less experienced staff.</td></tr>
<tr><td colspan="2">Areas where immediate action was taken on the day: None</td></tr>
<tr><td>Areas for improvement:

• It feels like CDU now needs to be made bigger to prevent patients waiting to be seen in the waiting area.</td><td>Service response:

• Proposal sent to space committee for consideration, additional information was required to make decision.

• Action- CDU ward manager to discuss at CDU operation group the potential pathway and benefit that this work would provide.</td></tr>
<tr><td colspan="2">Observations on the day

• Very calm and relaxed atmosphere.

• All staff appeared happy, smiling and in control of the department.</td></tr>
</table>

Division	Acute Services	Location	Ward 2, Level 2 CCCL.	Date	7th September 2023
In attendance – Panel			In attendance – Patient & Staff		
Governor	Anne Olsson		Senior Manager facilitating the walk round		Jackie Dillon
Non-Executive	Elkan Abrahamson		Number of Patients		1
Patient Experience Team	Claire Smith		Number of Staff		3

Patient Feedback: NB: *This is not a verbatim record but an overview of the key themes raised during the conversation.* One patient was interviewed who had been an inpatient on the ward for one week following a reaction to his immunotherapy treatment.	
Positive Patient Comments: • The patient reported that he has been very impressed with the excellent care he has received at CCC. • Can't fault the care given, even the telephone consultations have been great. • CCC is a fantastic hospital.	• The Hotline service is wonderful, patient called the line, came into CDU and treatment started all within a couple of hours. Patient reported having occasionally attended his local A+E, only to leave hospital after a number of hours with nothing happening.
Areas where immediate action was taken on the day: • N/A	
Areas for improvement: • The patient had an inpatient stay at CCC a number of months ago; he thought that the food was much better at that time. Although there is lots of choice the patient and his wife reported that, they felt the quality of the food was not as good as his stay at Christmas time. However, he did acknowledge that this was his personal preference and that his treatment had changed his appetite, he asked if we included patients in tasting new menus.	Service response: *Highlight in **Bold** actions to be added to PEIC action plan* CCC has recently changed food provider to Apetito based on previous feedback from patients. Initial feedback from patients has been positive. Trust board were invited to do taste testing. The ward team and prop care will continue to monitor feedback and action accordingly.

Ref: FCGOREPO
Review: July 2025
Version: 2.0

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

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

The visit met with 3 staff with different roles/grades on the inpatient ward. Staff talked about a meeting at 09.30 each day, at this meeting safe staffing and any issues are raised; staff felt this is a positive meeting and allows teams to raise issues and request support from other wards if needed.

One of the staff interviewed had recently had a change in role which meant they had been able to view the patient's pathway from a different perspective. This has enabled the staff member to understand the potential issues that may affect the shift running smoothly, they have gained a greater appreciation of other departments and their barriers.</td></tr>
<tr><td>Positive Comments:

• Although initially it felt like the 4 wards worked separately, there is more movement between them now which is really positive and noticeably staff are working together.

• One member of staff had been a HCA at CCC for a number of years and was now being funded to train as a Nursing Associate; she is hoping to be able to continue her training and top up to a registered nurse in the future.</td><td>• Staff agreed CCC is a lovely place to work and there are plenty of opportunities to move roles and progress.

• The social space is a great place for patients to spend time with relatives or build relationships with other patients.

• One member of staff was grateful for the flexible working policy; she was able to work a different pattern for a short time to facilitate her partner having essential surgery.</td></tr>
<tr><td colspan="2">Areas where immediate action was taken on the day: None</td></tr>
<tr><td>Areas for improvement:

• Staff discussed staffing levels; one of the staff had recent experience at LUHFT where they had provided an incentive for staff who picked up a number of the week day shifts as extras. Staff questioned if this might support staffing levels at CCC as most NHSP members prefer to pick up weekend shifts due to shift enhancements.

• Since moving to 100% single side rooms, staff discussed feeling guilty that</td><td>Service response:

• DND and workforce are in discussion with NHSP to consider options around incentives to support winter planning. This will require executive approval and an outcome will be communicated when decision has been made.

• The trust are reviewing volunteer involvement to support inpatient areas. Safer nursing care tool is due</td></tr>
</table>

they don't always have the time to talk to patients who are sometimes lonely. • Some staff working shifts highlighted that they sometimes felt unsafe walking to their car alone after work, especially during the winter months. Staff raised the possibility of the shuttle bus hours being extended? • Staff discussed the provision of food for staff during out of hours shifts. The café is closed at weekends, they reported the vending machine only stocks snacks and is frequently empty.	in October to review the nursing establishment. • DND has escalated to the executive team and is currently being considered and costed, a response will be provided within 10 days. Staff can access safety devices from health and safety. • DND has escalated to Propcare to consider alternative vending machines. Staff can access facilities at LUHFT.
Observations on the day: • Cleary a busy day, although staff were very pleasant and the ward felt well-led, under control and calm.	

Title of meeting: Trust Board
Date of meeting:

Report author	Helen Wong, Quality Manager (Audit & Statistics)			
Paper prepared by	Helen Wong, Quality Manager (Audit & Statistics)			
Report subject/title	Mortality Dashboards & Summary Report 2023-2024 Q1			
Purpose of paper	To present Q1 23/24 Mortality dashboard and reports including: 1) Mortality review dashboard 2) Mortality summary report 3) Mortality lesson learnt			
Background papers				
Action required	For noting			
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work	
	Be Collaborative		Be Digital	
	Be Research Leaders		Be Innovative	

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

1.0 Background

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

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

2.0 Mortality Review Inclusion Criteria

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

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

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

3.0 Case Review and Selection Process

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

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

4.0 Dashboard Interpretation

Data coverage: July 2022 – June 2023 for comparison to previous quarters

Year			2022/23	2023/24	Total
	Q2	Q3	Q4	Q1	
Total Patient Deaths	197	213	219	174	**803**
Number of Inpatient Deaths	47	50	53	37	**187**
Number of Outpatient Deaths	150	163	166	137	**616**
Outpatient (Requiring Review)	123	136	136	112	**507**
No. Cases Requiring Review	170	186	189	149	**694**
No. Cases Reviewed Phase 1	145	167	146	85	**543**
% Cases Reviewed Phase 1	85%	90%	77%	57%	**78%**
No. Cases Allocated for Phase 2	145	166	142	68	**521**
No. Cases Reviewed at Phase 2	133	148	131	46	**458**
% Cases Reviewed Phase 2	92%	89%	90%	54%	**84%**
No. Cases Selected Phase 3	14	21	15	7	**57**
No. Cases Discussed Phase 3	10	15	4	0	**29**
% Cases Discussed Phase 3	71%	71%	27%	0%	**51%**

N.B Process takes a minimum of 6 months to complete

- 84% (458/521) of cases had completed an independent peer review (Phase II) from July 2022 – June 2023 deaths. The process can take a minimum of 6 months to complete.
- From this, 57 cases have been selected for discussion out of which, 29 cases have been discussed (x8 inpatients and x21 Community/Other Hospital/Hospice).

  The scores for these cases are:

  - Inpatient SJR RCP Scores: All x9 cases were scored 6.
  - Community/Other hospital inpatient RCP Scores: All x14 cases were scored 6.

  Of the remaining x28 cases awaiting discussion:

  - X16 are due to be discussed in Q2 23/24, x4 will be discussed in Q3 2023/24 and the remaining x8 are awaiting a date for discussion from the responsible consultant
- 0 mortality cases this quarter were subject to LeDeR review (Learning Disability)
- 0 mortality cases this quarter were subject to a Child Death Overview Panel review (CDOP

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

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

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

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

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

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

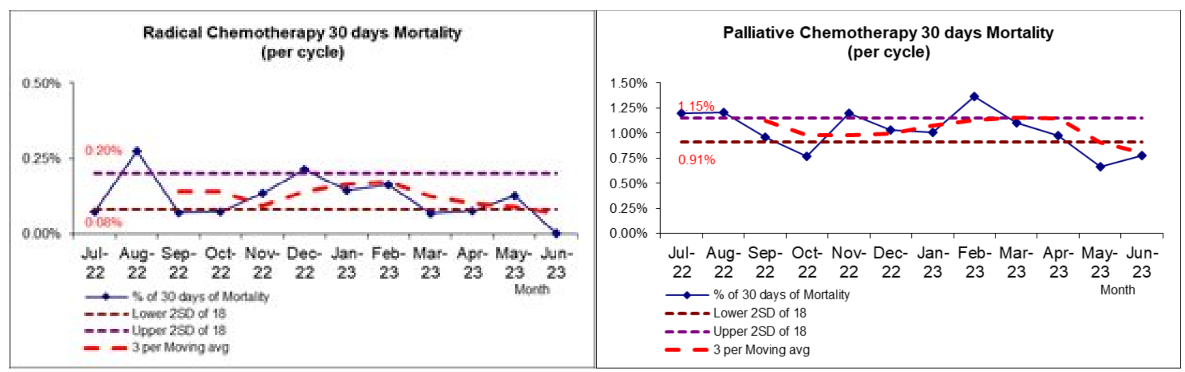
The control limits (lower & upper 2 standard deviation – brown dash line on chart) are reviewed annually and are set by the best performing annual figures from 2009 onward. All data points fallen inside the control limits are deemed to be within tolerance.

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

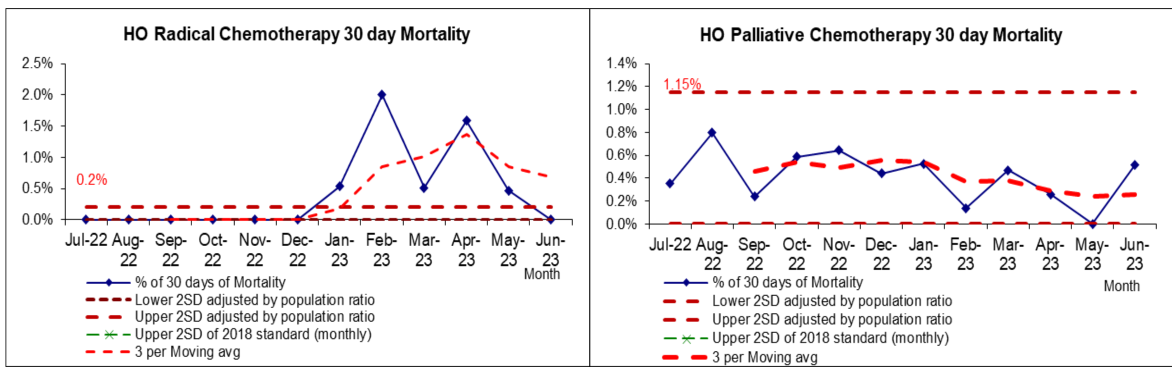
July 2022 – June 2023 treatment activities

- Results showed the 3 monthly moving average mortality for solid tumour SACT & RT 30 day mortality were within tolerance, as well as RT 90-day mortality.
- There were nine deaths in the radical HO SACT treatment in 2023. Although there is no particular regimen was identified as high mortality at this point, the Team will ensure mortality review process is followed.

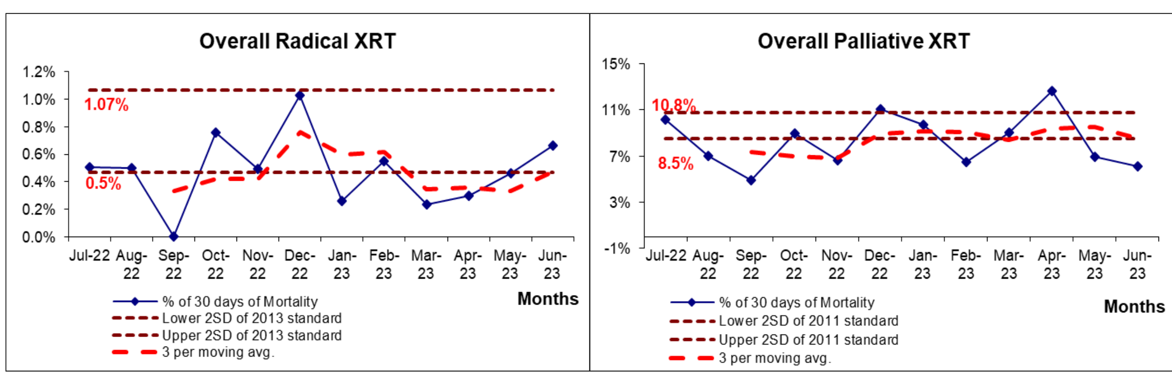
6.1 Chemotherapy 30 day mortality (Solid Tumour)



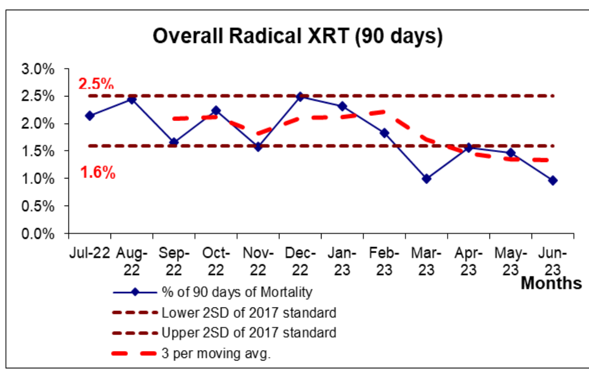
6.2 Chemotherapy 30 day mortality (Haemato-oncology)



6.3 Radiotherapy 30 day mortality



6.4 Radical radiotherapy 90 day mortality



Total Number of Inpatient, 30 day SACT, 30 day RT and 90 day Radical RT Deaths

The Clatterbridge Cancer Centre NHS Foundation Trust

Number of Deaths in Scope and Phase 1, 2 & 3 Reviews between Apr 2023 and Jun 2023

Year	Number of Deaths in Scope	Total Deaths Requiring Phase 1 Review	Total Deaths Reviewed (Phase 1)	% Deaths Reviewed (Phase 1)	Total Deaths Reviewed (Phase 2)	% Phase 1 Reviews Reviewed (Phase 2)	Total Deaths Selected for Review (Phase 3)	Total Deaths Discussed (Phase 3)	% Discussed (Phase 3)
2023/24	174	149	85	57%	46	54%	7	0	0%
Q1	174	149	85	57%	46	54%	7	0	0%
Total	163	149	85	57%	46	54%	7	0	0%

Total Number of Learning Disabilities in Scope

Year	No.	LeDaR Completed	Potentially Avoidable (Score <= 3)
2023/24	0	0	-
Q1	0	0	-
Total	0	0	-

Total Number of Children in Scope

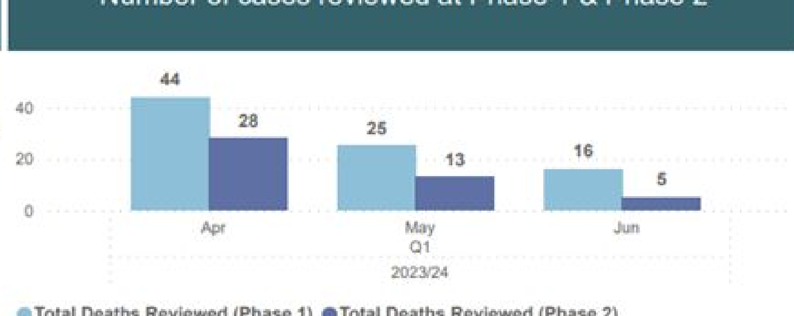
Year	No.	CDOP Completed	Potentially Avoidable (Score <= 3)
2023/24	0	0	-
Q1	0	0	-
Total	0	0	-

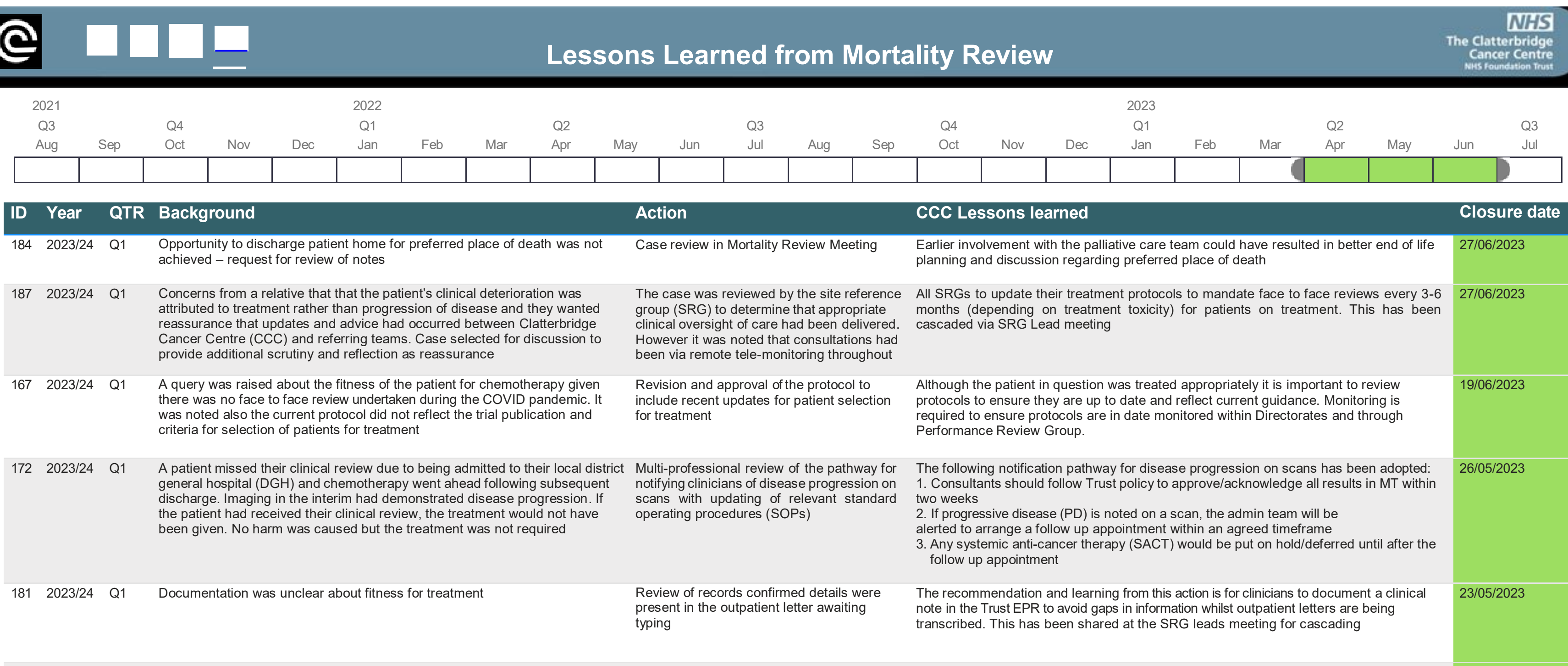
"-" occurs when the quarter/ case score is yet to be finalised

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

Year	Score 1 - Definitely Avoidable	Score 2 - Strong Evidence of Avoidability	Score 3 - Probably Avoidable (more than 50:50)	Score 4 - Probably Avoidable but not very likely	Score 5 - Slight evidence of avoidability	Score 6 - Definitely Not Avoidable
2023/24	0	0	0	0	0	19
Q1	0	0	0	0	0	19
Total	0	0	0	0	0	19

Number of cases reviewed at Phase 1 & Phase 2





ID	Year	QTR	Background	Action	CCC Lessons learned	Closure date
184	2023/24	Q1	Opportunity to discharge patient home for preferred place of death was not achieved – request for review of notes	Case review in Mortality Review Meeting	Earlier involvement with the palliative care team could have resulted in better end of life planning and discussion regarding preferred place of death	27/06/2023
187	2023/24	Q1	Concerns from a relative that that the patient's clinical deterioration was attributed to treatment rather than progression of disease and they wanted reassurance that updates and advice had occurred between Clatterbridge Cancer Centre (CCC) and referring teams. Case selected for discussion to provide additional scrutiny and reflection as reassurance	The case was reviewed by the site reference group (SRG) to determine that appropriate clinical oversight of care had been delivered. However it was noted that consultations had been via remote tele-monitoring throughout	All SRGs to update their treatment protocols to mandate face to face reviews every 3-6 months (depending on treatment toxicity) for patients on treatment. This has been cascaded via SRG Lead meeting	27/06/2023
167	2023/24	Q1	A query was raised about the fitness of the patient for chemotherapy given there was no face to face review undertaken during the COVID pandemic. It was noted also the current protocol did not reflect the trial publication and criteria for selection of patients for treatment	Revision and approval of the protocol to include recent updates for patient selection for treatment	Although the patient in question was treated appropriately it is important to review protocols to ensure they are up to date and reflect current guidance. Monitoring is required to ensure protocols are in date monitored within Directorates and through Performance Review Group.	19/06/2023
172	2023/24	Q1	A patient missed their clinical review due to being admitted to their local district general hospital (DGH) and chemotherapy went ahead following subsequent discharge. Imaging in the interim had demonstrated disease progression. If the patient had received their clinical review, the treatment would not have been given. No harm was caused but the treatment was not required	Multi-professional review of the pathway for notifying clinicians of disease progression on scans with updating of relevant standard operating procedures (SOPs)	The following notification pathway for disease progression on scans has been adopted: 1. Consultants should follow Trust policy to approve/acknowledge all results in MT within two weeks 2. If progressive disease (PD) is noted on a scan, the admin team will be alerted to arrange a follow up appointment within an agreed timeframe 3. Any systemic anti-cancer therapy (SACT) would be put on hold/deferred until after the follow up appointment	26/05/2023
181	2023/24	Q1	Documentation was unclear about fitness for treatment	Review of records confirmed details were present in the outpatient letter awaiting typing	The recommendation and learning from this action is for clinicians to document a clinical note in the Trust EPR to avoid gaps in information whilst outpatient letters are being transcribed. This has been shared at the SRG leads meeting for cascading	23/05/2023
180	2023/24	Q1	Documentation surrounding the communication with a patient regarding the decision to proceed with treatment was inadequate and did not include details discussed with the patient by another clinician regarding prognosis	The mortality review group disseminated the lesson from this case regarding clear documentation to the wider SRG Leads meeting and Education Leads	A full range of discussion with the patient should be captured in the notes/letter including information communicated by another clinician during the consultation and especially if performance status and co-morbidity is a factor in the treatment recommendation. This should be included in training programs	23/05/2023

Summary

All six cases which resulted in the above actions were scored as a 6 i.e. outcome of death was unavoidable. Themes regarding completeness of documentation, communication with clinical teams and updating of SOP's and protocols were identified. Corrective action has been taken where appropriate.

Trust Board Part 1 – 29th September 2023

Chair's Report for: Performance Committee
Date/Time of meeting: 22nd November 2023, 09:30am

			Yes/No
Chair	Geoff Broadhead	**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

<table>
<tr>
<td>General items to note to the Board</td>
<td>
Risk Register
The Committee received the risk register report;

There are 3 risks with risk scores of 15 and above assigned to the Committee

HRMC challenge
Medical Gases Assurance
Interventional Radiology Service infrastructure – this risk has now been reduced in score following discussion at Risk and Quality Committee.

Progress has been made to mitigate risks with a score of 12 and below and 4 risks were closed during the reporting period.

Integrated Performance Report
The Committee received the integrated performance report (IPR) which provided an update on performance in the categories of access, efficiency, quality, workforce, research and innovation and finance.

The Committee noted there have been challenges in achieving the 24-day and 62-day targets.89% with 14 avoidable breaches occurring.
Some challenges were noted regarding category 1 patients but a plan to commence treatment on alternate day has recently been agreed and is expected to deliver improvements.
Appraisals have seen an improvement in month, as at the date of the meeting the position was above 90%.

Inpatient Capacity Management Report
The Committee received a report regarding management of inpatient capacity including the revised governance arrangements underpinned by the development of activity dashboards which have supported improved productivity. In addition the work around the Urgent Care Pathway and the benefit to the system was highlighted. . Future work is focused on reducing admissions, improving flow and reducing length of stay including Implementation and full utilisation of our Ambulatory Care facility for myeloid, Stem Cell, Lymphoma & Sarcoma.
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	Cancer Waiting Times Report The report provided the Committee with evidence of the current challenges impacting on Cancer Waiting Times. **62 day performance** - Molecular testing delays at Manchester Genomic Laboratory Hub (MGLH), Radiographer industrial action and late referrals have impacted performance. Actions take to reduce avoidable breaches include the launch of an E-Referral system, which will include up to date test results and improve the quality of referrals. The importance of working closely with the Cancer Alliance and other Trusts around this was noted. In addition, the ongoing development of a Cancer Wait Times (CWT) Dashboard to provide greater intelligence to track patients and expedite pathways will support improvement. **Finance Report** The Committee reviewed the Finance Report and noted the positive position at Month 7. The Trust financial position to the end of October is a £308k surplus, which is £96k above plan. The group is showing a £741k surplus to the end of October, which is £529k above plan. Trust Pay is overspent by £68k, within this is £159k unmet CIP. While the CIP programme is overachieving overall the Trust is achieving more in non-pay areas and less in pay areas. The Trust's cash position is in line with plan. with Capital expenditure of £996k has been incurred to the end of October. **Research & Innovation Strategy Business Plan** The Committee received an update regarding the Research and Innovation Strategy Business Plan and noted that there had been a delay in gaining approval for £0.5m funding from the charity, to support the funding of year 3 of the strategy. It was noted that due to two vacant posts the current position is outside of plan however recruitment initiatives are on-going to secure suitable candidates. It was noted that the recent job planning cycle has included the allocation of research sessions which will enable consultants to carry out additional research activity. In terms of performance against agreed indicators currently academic commercial income and grant income are behind plan. The Committee requested a revision of the plan to demonstrate the funding flows from the Trust and Charity. **Green Plan Assurance Report** The Committee reviewed progress against the Green plan which detailed corporate approach, workforce, care models and adaptation. Highlights

	included the appointment of a permanent Sustainability Programme Manager, the inclusion of sustainability work as part of the recruitment process, and corporate induction. Clinical teams have sustained significant levels of virtual outpatient appointments, and a model of remote monitoring for lung cancer immunotherapy patients is being piloted. The Annual Sustainability Report will bring together the key achievements over the past 12 months and will be presented to the next meeting of the Committee. **Five Year Strategy Progress Report** The progress and achievements during the reporting period were noted by the Committee. **PropCare Performance Report** The Committee received an update on performance from the Managing Director of PropCare with highlights including the operationalisation of Paddington CDC, and positive delivery on a number of capital projects. The Committee noted that PropCare are supporting the wider NHSE requirement for collaboration at scale through a number of initiatives which have the potential to benefit both CCC and the wider Cheshire and Merseyside Trusts. **Clatterbridge Private Clinic JV** The Committee received a performance update that provided assurance regarding operational and financial performance. The new manager is working through the previous issues. In terms of activity, there has been an increase in demand for both Chemotherapy and Radiotherapy treatments and overall activity is expected to perform in line with plan. The financial position is positive with year to date profit above budget and a continued strong liquidity position. **Annual Insurance Report** The Committee reviewed the Trust's Annual Insurance Report which demonstrated the current insurance provision in place in addition to the Clinical Negligence Scheme. The Committee noted that there is a piece of work underway nationally to determine if there is an opportunity to simplify and strengthen the market in order to reduce costs. **ICB Planning Update** The Committee received an update regarding the operational planning timeline for 2024/25, with the annual planning guidance expected in December. Preparations are underway to launch system wide planning across all areas – quality, workforce, activity and finance. Following receipt of the guidance the Board Development Session scheduled for January 2024 will focus on the draft 2024/25plan and the five year outlook which will help inform the Trust's strategy for the next five years.

	Board Assurance Framework The Committee reviewed the Board Assurance Framework risks within its remit and noted the proposed revision to the risk score for BAF risk 3. The Committee challenged the scoring given the system position and the need to consider the articulation of the control gaps in order to reflect the financial pressures. The Committee requested that the ongoing work to mitigate risks be reflected in the dates within the BAF where actions will continue through to year-end.
Items of concern for escalation to the Board	**Forecast Out-turn position 2023/24** The Committee reviewed the revised position following recent discussions with the ICB and noted the risks around ERF funding and depreciation. **Emergency Preparedness Resilience & Response and Core Standards Report** The Committee received an update regarding the activity completed during quarter 2, including the review and updating all relevant policies, completion of a Training Needs Analysis and delivery of Strategic and Tactical Health Commander training to managers. During the reporting period 7 episodes of industrial action were managed, the Trust was on standby for a major incident (M53) and 4 business continuity incidents were managed. During the latter part of quarter 2 there has been a robust focus on completing the Core Standards Submission including collation of the supporting evidence. The feedback from the submission has led to the identification of a number of additional risks which will be monitored via the Committee. The Committee noted the deterioration in the Trust's position in relation to revised EPRR Core Standards. Following a Check and Challenge process by NHS England NW the findings show the Trust's position as **fully compliant** with 10 standards and **partially compliant** with 49 standards. It was noted that an action plan to improve compliance will be brought back to the Committee on a quarterly basis.
Items for shared learning	No shared learning identified.

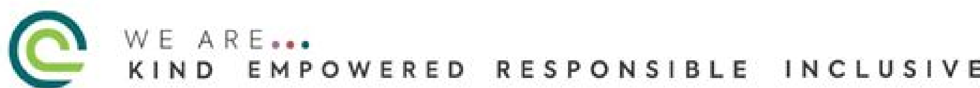
Title of meeting: **Trust Board of Directors**
Date of meeting: **29th November 2023**

Report author	Tom Pharaoh, Director of Strategy
Paper prepared by	Tom Pharaoh, Director of Strategy
Report subject/title	Five-year strategic plan 2021-2025: Implementation report – November 2023
Purpose of paper	This report provides a high-level update on progress in the implementation if the five-year strategic plan. The contents of the report have been provided by leads from across the Trust. Since the publication of the five-year strategic plan in 2021, a six-monthly implementation report has been collated to provide an update on the commitments set out in the plan. This is the first iteration of a new and shorter strategy implementation report that is more appropriate and relevant for the later stages of the lifespan of the strategic plan. As with the previous version of the report, key highlights from the last six months are provided against each of the six strategic priorities. This version then provides much higher level updates on the specific commitments for each of the strategic priorities.
Background papers	Five-year Strategic Plan 2021-2025
Action required	The Board of Directors is asked to: • Note the contents of the report • Suggest improvements, amendments or developments for future iterations of the report

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		



Ref: FCGOREPO
Review: July 2025
Version: 2.0

Five-year strategic plan 2021-2025

Implementation report

November 2023

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Introduction

Our five-year strategic plan (2021-2025) sets out our aims and ambitions years against six strategic themes. The strategic plan sets out a number of commitments for each theme.

As part of our commitment to deliver the strategic plan we have provided a strategy implementation report – giving an update against each of these commitments – every six months since June 2021.

This report was intended to provide a high-level update on the progress and challenges with the implementation of the strategic plan. As we have progressed through the lifespan of the five-year strategic plan this implementation report has become less useful for a number of reasons:

- Many of the commitments have now been delivered and the work on others is part of a continuous process that will not have a clear date of completion.
- It has been necessary to change our position on, or approach to, some of the original commitments meaning that it was necessary to reword them in the report.
- New work streams and initiatives (not mentioned in the five-year strategic plan) have now become priorities for the Trust.
- A number of supporting strategies have now been developed. These outline the ongoing work to deliver specific elements of the five-year strategic plan and there is now separate reporting in place on the delivery of these supporting strategies.

As such, a new and shorter strategy implementation report will be prepared for the remainder of the lifespan of the current five-year strategic plan. This is the first version of this new report.

This report

This report contains a section on each of the six themes in the five-year strategic plan. Each section outlines:

- The key highlights for the theme in the latest reporting period
- The supporting strategies that are now in place to support the theme and where the Trust Board of Directors receives assurance on the delivery of these strategies
- A brief summary of the status of the main work areas outlined in the five-year strategic plan, outlining for each whether they are original commitments, have been reworded, or are additional commitments
- A brief narrative update for each commitment, and
- A description of the status of the commitment, with each being identified as being either:
  i) Complete
  ii) In progress
  iii) Continuous, or
  iv) Under review

Summary of highlights

Be outstanding

- Development of CAR-T cell therapy service progressing well, positive JACIE inspection of clinical programme and target date of spring 24
- New Quality Improvement & Learning Strategy 2023-25 developed through engagement
- Comprehensive maintenance/refurbishment programme at CCC-Wirral and architects engaged on long term redevelopment

Be research leaders

- Additional research PAs have been allocated to clinical staff and will demonstrate enhanced support for research within the Divisions
- Two new Early Phase Clinical Research Fellows started in August 2023
- Chair of Oncology jointly appointed with the University of Liverpool and started in November 2023

Be collaborative

- The Paddington CDC in CCC-Paddington opened in July 2023 following a rapid mobilisation programme
- CCC continues to engage with Joint Committee of Liverpool providers and site sub-committee
- Health Inequalities Steering Group now formed to coordinate CCC's 'anchor institution' work

Be digital

- Our new Digital Strategy 2023-2025 launched in June 2023
- Self-assessment made against the national Digital Maturity Assessment highlighting existing maturity and areas for improvement
- New Outpatient Transformation Programme will drive increased telehealth consultations

Be a great place to work

- Second annual Staff Excellence Awards took place in October 2023 celebrating the dedication of colleagues across the Trust
- Significant staff engagement through 'Big Conversation' events, 'A Day in Your Shoes' programme and 'Pop-up Sessions' with CEO
- Network of Wellbeing and Engagement Champions from across Trust in development

Be innovative

- Options appraisal in development for second phase of development of CCC-Paddington site now that Paddington CDC is operational
- Outpatient Transformation Programme established to increase telemedicine and innovative patient-initiated follow-up (PIFU)
- New Innovation Manager starting in early 2024 and Innovation Committee to be formed

Key strategic activities in the next 6 months

- Initial delivery of a cutting edge CAR-T cell therapy service for the people of Cheshire and Merseyside
- Continue to deliver Outpatient Transformation Programme
- Proposals for the further use of CCC-Paddington following the exploration of the further opportunities that the acquisition provides
- Deliver further proposals for refurbishment & development of CCC-Wirral and Halton sites
- Continue to work with partner provider trusts to increase opportunities for improvements and efficiencies through collaboration

Be outstanding

Deliver safe high quality care and outstanding operational and financial performance

A. HIGHLIGHTS IN THE LATEST REPORTING PERIOD

- The programme to develop a cutting edge CAR-T cell therapy service for Cheshire & Merseyside is progressing well, with positive JACIE inspection of the clinical programme and a revised target date of spring 2024 to allow completion of the stem cell lab (LCL) JACIE action plan
- Our new Quality Improvement & Learning Strategy 2023-25 has been developed through staff and public engagement and sets out our ambitions for learning for improvement
- Comprehensive maintenance and refurbishment programme taking place at CCC-Wirral, with architects engaged to begin developing proposals for long term redevelopment

B. SUPPORTING STRATEGIES

There are various supporting strategies in place with relevance to this strategy priority:

- Quality Improvement & Learning Strategy 2023-25
- Patient Experience Commitment 2022-2025
- Creating a Greener CCC 2022-2027

The Trust Board of Directors gains assurance on the delivery of these supporting strategies through Quality, People and Performance Committees.

C. SUMMARY OF COMMITMENTS IN STRATEGIC PLAN

The commitments set out in the five-year strategic plan are against four broad themes:

- Operational performance
- Quality, standards and experience
- High quality environments
- Financial and environmental sustainability

Operational performance			
Commitment	**Type**	**Status**	**Update**
Reorganise clinical divisions to underpin SRG model	Original	Complete	Completed in year one of five-year strategic plan
Further integrate our haemato-oncology services with those in the North Mersey area	Original	Complete	Service transfer took place successfully on 1st February 2022
Support the opening of the New Royal	Additional	Complete	New Royal open and link bridges in place
Develop a sustainable and high quality model of care for referrals from the Isle of Man	Original	Complete	Service model in place with ongoing work to optimise MDT working
Report on delivery of benefits of CCC-L	Original	In progress	Work underway, data collection ongoing, draft report target Jan 24

Upgrade the National Centre for Eye Proton Therapy	Original	In progress	Full replacement programme will be delivered by the end of 2023/24
Fully open aseptic pharmacy production unit in CCC-L	Additional	In progress	Awaiting date for MHRA inspection – ongoing work to develop service and commission VHP isolators
Develop a CAR-T cell therapy service for Cheshire & Merseyside	Additional	In progress	Positive JACIE inspection of clinical programme. JACIE action plan developed for LCL stem cell lab. Target start date revised to spring 24.
Develop the working relationship with LUHFT, including the review and management of the SLA for services between RLUH and CCC-L	Reworded	Continuous	SLA review and development one of key work stream of Joint CCC/LUHFT Partnership Group.
Fully open our teenage and young adult (TYA) unit in CCC-L	Original	In progress	CAR-T cell therapy business case includes changes to Ward 5 allowing the opening of the TYA unit.
Develop an interventional radiology service	Original	In progress	Ongoing work with partners in C&M on a coordinated approach to interventional radiology
Continue to work with our partners on the development of the CCC eastern sector hub	Original	Under review	Proposal under review following submission of CCC paper to NHS C&M outlining changes since eastern hub originally proposed
Develop a comprehensive and coordinated approach to urgent cancer care	Original	Continuous	Urgent Cancer Care Programme Board in place bringing together partners from the region under CCC leadership

Quality, standards and experience

Commitment	Type	Status	Update
Develop new clinical quality strategy	Reworded	Complete	Quality Improvement & Learning Strategy 2023-2025 developed and launched July 2023
Review and refresh our quality improvement methodology	Original	Complete	As above
Implement our dementia and learning disability strategies	Original	In progress	New Dementia Strategy 2022-2026 in place. New Learning Disability and Autism Strategy 2023-2025 in place.
Implement our patient involvement and engagement strategy	Original	In progress	Our Commitment: Patient experience, engagement, inclusion & involvement 2022-2025
Empower staff to report near misses and incidents	Original	Continuous	Ongoing work to achieve this outlined in Quality Improvement & Learning Strategy
Maintain good CQC rating while striving for outstanding	Original	Continuous	Deliver work programme to ensure ongoing readiness of the organisation for CQC inspection
Maintain key clinical accreditations and compliance with regulatory standards - ongoing	Original	Continuous	Managed through Risk and Quality Governance Committee

High quality environments			
Commitment	**Type**	**Status**	**Update**
Optimise our accommodation in The Spine to increase utilisation and bring corporate teams together	Reworded	Complete	Work complete
Redevelop the CCC-Wirral site	Original	In progress	Full maintenance and refurbishment programme for 2023/24. Architect-led process work up redevelopment plans will commence Nov 23.
Work with the charity to develop plans for refurbishing the Halton unit	Reworded	In progress	Architect plans drawn up with division and Halton team. Plans to be finalised in Nov 23 to allow engagement with Charity on fundraising

Financial performance and sustainability			
Commitment	**Type**	**Status**	**Update**
Deliver a productivity improvement programme	Original	Continuous	Challenging cost improvement programme for 2023/24 is on track. 2024/25 programme in development
Deliver an effective capital programme	Original	Continuous	2023/24 capital programme on track with planning underway for 2024/25
Deliver our partner programme, increasing charitable income and continuing to grow the private clinic	Original	Continuous	Charity now independent to seek to maximise income. Strategies in place to grow private joint venture and wholly-owned subsidiaries.
Develop plans to continue to create social value in our local communities and reduce our waste, water consumption and carbon footprint in line with the ambitions set out in the NHS Long Term Plan	Original	Continuous	Green plan in place sin Jan 2022. Sustainability Manager in place with governance and reporting, including annual report.

Be collaborative

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

A. HIGHLIGHTS IN THE LATEST REPORTING PERIOD

- The Paddington Community Diagnostic Centre in CCC-Paddington opened in July 2023 following a rapid mobilisation programme after the acquisition of the former Rutherford Cancer Centre: North West earlier in the year
- CCC continues to engage with Joint Committee of Liverpool providers and site-specific sub-committee focused on joint working between CCC-Liverpool and the Royal Liverpool Hospital
- Health Inequalities Steering Group now formed to coordinate CCC's contribution as an 'anchor institution', including through initiative aimed at preventing ill health and lessening health inequalities

B. SUPPORTING STRATEGIES

- There are no dedicated supporting strategies for this strategic objective

C. SUMMARY OF COMMITMENTS IN STRATEGIC PLAN

The commitments to further this strategic objective were set out in four areas:

- NHS Cheshire & Merseyside
- Cheshire & Merseyside Cancer Alliance
- Operational Delivery Networks
- Other partnerships

NHS Cheshire & Merseyside			
Commitment	**Type**	**Status**	**Update**
Work with WUTH to develop a Community Diagnostic Centre on the Clatterbridge Health Campus	Additional	Complete	Clatterbridge Diagnostics opened in July 2021 with some services operating out of CCC-W
Work with partners to develop Paddington Community Diagnostic Centre within CCC-Paddington	Additional	Complete	Opened in July 2023 following a rapid mobilisation programme involving multiple work streams
Play a full and active role in the partnership	Original	Continuous	CEO continues to lead Community CDC programme and wider diagnostic programme
Further develop CCC's credentials as an 'anchor institution' that positively contributes to our local areas in ways beyond providing healthcare	Additional	Continuous	Health Inequalities Steering Group now formed to understand CCC's existing contribution and oversee development of new initiatives

Cheshire & Merseyside Cancer Alliance			
Commitment	**Type**	**Status**	**Update**
Work through the alliance to explore whether any of our services could develop the rapid diagnostic service (RDS) model to support the delivery of the 28-Faster Diagnosis Standard	Reworded	Complete	Lymphoma RDS piloted successfully and implemented with improvements seen in waiting times
Work with the Cancer Alliance, Macmillan and Health Education England to develop an integrated specialist cancer speech and language therapy service for C&M	Additional	In progress	Service model in place and development underway. Discussions with key partners on ongoing project funding concluded.
Work with cancer alliance colleagues on the delivery of our comprehensive and coordinated approach to urgent cancer care	Original	Continuous	Urgent Cancer Care Programme Board in place bringing together partners across the region with strong Cancer Alliance involvement

Operational Delivery Networks (ODNs)			
Commitment	**Type**	**Status**	**Update**
Play a full and active role in the North West Radiotherapy ODN	Reworded	Continuous	CCC CEO chairs Radiotherapy ODN with engagement from clinical team
Play a full and active role in the North West Teenage and Young Adult ODN	Additional	Continuous	CCC COO chairs TYA ODN with engagement from clinical team

Other partnerships			
Commitment	**Type**	**Status**	**Update**
Work together with Liverpool provider trusts to increase opportunities for improvements and efficiencies through collaboration	Additional	Continuous	CCC playing active role in work put in place following Liverpool Clinical Services Review. Other collaboration taking place through CMAST.
Ensure molecular diagnostic testing is available and access to molecular testing is embedded into pathways	Original	Continuous	Internal work underway to streamline processes for receiving and recording genomic results. External engagement taking place with partners on turnaround times and impact on cancer waits.

Be a great place to work

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

A. HIGHLIGHTS IN THE LATEST REPORTING PERIOD

- Second annual Staff Excellence Awards took place in October 2023 to celebrate the outstanding commitment, dedication and achievement of colleagues across the Trust. A total of 220 nominations were received in the 12 award categories.
- Significant staff engagement activity through 'Big Conversation' events, 'A Day in Your Shoes' programme and 'Pop-up Sessions' with the CEO
- Network of Wellbeing and Engagement Champions in development, drawn from teams across the Trust

B. SUPPORTING STRATEGIES

Work towards this strategic aim is set out in **Our People Commitment 2021-2026**. The Trust Board of Directors gains assurance on the delivery of this work through People Committee.

C. SUMMARY OF COMMITMENTS IN STRATEGIC PLAN

The commitments to further support this strategic objective were set out in seven areas in the five-year strategic plan. These areas have been reviewed and updated, especially through the launch of the People Commitment, to five key themes:

- Developing our People
- Workforce for the Future
- Valuing our People Recruitment
- Looking after our People
- Education and Training

Developing our People			
Commitment	**Type**	**Status**	**Update**
Reorganise the directorate structures to ensure the SRGs are embedded	Original	Complete	Reorganisation took place in year one of the strategic plan
Enhance leadership skills and capacity across all levels of the trust, with an increased focus on supporting middle managers and developing a pipeline of talent	Original	Continuous	Leadership and Management Skills Passport in place. Leadership training offer continually developing. New 3 day leadership programme and 2 day management programme launched.
Identify and develop talent and leaders of the future to maximise the potential of all staff and develop the Trusts approach to succession planning	New	Continuous	Funding secured for new Shadow Board Cohort. Work underway to define and educate leaders on succession planning and links to workforce planning. New BI dashboard developed to enable reporting of career conversations from My Appraisal System.
Continue and refine the e-PADR process	Original	Complete	My Appraisal system rolled out to replace e-PADR and processes in place to record and report on appraisals

Develop an allied health professional (AHP) strategy to harness the potential and enhance the value of AHPs	Original	Under review	Joint Nursing and AHP strategy to be developed

Workforce of the Future			
Commitment	**Type**	**Status**	**Update**
Further develop our employer brand to attract and retain the best talent and promote CCC as an employer of choice	Reworded	Continuous	Review of website recruitment pages underway. Refreshed recruitment training and values-based recruitment toolkit in development.
Focus on the recruitment of a research workforce for the future, including academic clinicians and clinician scientists	Original	Continuous	Ongoing in support of the Research Strategy
Work with schools, colleges, universities and community groups to improve access routes for local people into Trust jobs	Original	Continuous	Work with the Princes Trust to run a step in Health programme. Continue to develop and roll out career insight days to raise the profile of working within the NHS.
Continue to develop our innovative approach to workforce planning, creating new roles and new career pathways	Original	Continuous	Ongoing work linked to ICB workforce planning and workforce growth. New AHP and Nursing Lead reviewing carer pathways and career conversations.
Sustain agile ways of working in support of our multi-site clinical model beyond Covid-19	Original	Continuous	Hybrid and flexible working policies and guidance in place to support managers and staff. Recording of flexible working in ESR in development, alongside the development of reportable metric for flexible working.
Embed digital workforce solutions that will enable our people to work to their full potential through the automation of systems and processes	New	Continuous	Completed establishment control project to enhance reporting. Robotic process automation (RPA) process launched for appraisal and inter-authority transfer process. RPA implemented for ongoing work to digitalise key HR forms and workforce data.
Implement systems and process to enable the expansion of the Undergraduate Placement Programme	New	Continuous	Positive feedback received in Annual Medical Student Report. Increased student capacity from September 23. New collaboration with Edge Hill in place for medical students.

Valuing our People			
Commitment	**Type**	**Status**	**Update**
Review our trust values	Original	Complete	New Trust Values co-produced with staff and launched in 2022 alongside People Commitment
Provide a comprehensive reward and recognition package	Original	Continuous	2nd Staff Excellence Awards took place in Oct 2023. Recognition toolkit in development. Planning for CCC Festival in June 24 underway.

Foster an open, transparent and high performing culture, where staff feel valued and recognised, actively participate and feel empowered to raise concerns	Original	Continuous	Freedom to Speak Up Guardian in post and awareness raising launched. Series of 'Big Conversation' events held across our sites in autumn 2023. 'A Day in your Shoes' programme launched. Pop up sessions with CEO.
Develop systems and process to enable regular opportunities for staff to share their views and experiences and future develop the trusts culture	New	Continuous	Q2 culture and engagement pulse survey completed, with the Trust highest ever response rate achieved. Improvements seen in 8 out of the 9 questions with 1 question remaining the same. 2023/24 Staff survey launched in September 23, with a closing date of 24th November.
Develop an inclusive and healthy environment where everyone is treated with respect and dignity	Original	Continuous	EDI strategy in development. Range of staff networks in place. Range of leadership and development programmes launched to support developing a compassionate and inclusive culture.
Actively engage with and involve our diverse communities, ensuring that seldom-heard groups are included from a patient and staff perspective	Original	Continuous	As above plus Trust involvement in Pride events and reverse mentoring programme to begin.

Looking after our People

Commitment	Type	Status	Update
Continue to provide a targeted action on improving the health, wellbeing and engagement of our staff by ensuring staff have access to services and support that will help them manage their physical, mental and financial wellbeing.	Reworded	In progress	Establishing network of engagement and wellbeing champions. Development of Wellbeing and Engagement Trust Forum. Wellbeing and Engagement plan approved at People committee. New Intranet pages in place against the 4 pillars of Wellbeing and Engagement. Variety of wellbeing and engagement activities taking place including free Health MOTs for staff.

Education and training

Commitment	Type	Status	Update
Achieve teaching hospital status	Original	In progress	Association of University Hospitals has issued new guidance. Trust reviewing new criteria with a view to achieving status.
Implement our education strategy	Original	Continuous	New combined education strategy in development

Be research leaders

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

A. HIGHLIGHTS IN THE LATEST REPORTING PERIOD

- Significant work relating to research PA allocation is now complete. Additional research PAs have been allocated to clinical staff and will demonstrate enhanced support for research infrastructure within the Divisions.
- Two new Early Phase Clinical Research Fellows started in August 2023 and are embedded in the ECMC team.
- Chair of Oncology jointly appointed with the University of Liverpool and started in November 2023. This post will be a strategic leader for cancer research across the region.

B. SUPPORTING STRATEGIES

Work towards this strategic aim set out in our **Research Strategy 2021-2026**. The Trust Board of Directors gains assurance on the delivery of this work through Performance and Quality Committees.

C. SUMMARY OF COMMITMENTS IN STRATEGIC PLAN

The commitments to further this strategic objective set out in the five-year strategic plan are against four broad themes:

- Research strategy
- Clinical trials delivery and infrastructure
- Academic research
- Research awareness and education

Research strategy			
Commitment	**Type**	**Status**	**Update**
Implement our research strategy	Original	Continuous	Operationalising the research strategy continues via the Research Strategy Business Plan and quarterly updates to Performance Committee

Clinical trials delivery and infrastructure			
Commitment	**Type**	**Status**	**Update**
Submit our renewal bid for the ECMC in 2022	Original	Complete	Completed – successful ECMC bid announced 01/2023
Support the Liverpool Clinical Research Facility (CRF) bid as a collaborator in 2021	Additional	Complete	Completed – successful CRF bid with LUHFT and LHCH announced in 2022
Develop clinical job plans with protected time for research activities and recruit research active clinicians	Original	Complete	Research PAs allocated. To be awarded for 3-years to start December 2023 with annual review.

Strengthen key aspects of the research and innovation staffing infrastructure and the core team	Original	Continuous	Strengthening has taken place as part of implementation of Research Strategy. Further additions planned, e.g. National Funding Bid Manager, Research Industry Manager.

Academic research

Commitment	**Type**	**Status**	**Update**
Increase the number of academic staff within the trust with the aim of securing a future BRC and CRUK Centre status	Original	Continuous/ complete	BRC bid with the Royal Marsden Hospital successful, announced October 2022. Work to further increase academic staff ongoing.
Expand the clinical research fellow programme	Original	In progress	Clinical Research Fellows appointed in 2021 and 2022 to support medical oncology and haemato-oncology respectively. Two Early Phase Clinical Research Fellows appointed and started in post in 2023 to support the academic team. Further expansion planned.

Research awareness and education

Commitment	**Type**	**Status**	**Update**
Invest to promote research awareness and participation within other non-medical areas	Reworded	Continuous	Work to promote research awareness ongoing through regular scheduled Research Rounds, for example

Be digital

Deliver transformed services,
empowering patients and staff

A. HIGHLIGHTS IN THE LATEST REPORTING PERIOD

- Our new Digital Strategy 2023-2025 launched in June 2023
- Work continues on remote monitoring pilot. New Outpatient Transformation Programme will drive increased telehealth and video consultations.
- Self-assessment made against the national Digital Maturity Assessment highlighting existing maturity and areas for improvement

B. SUPPORTING STRATEGIES

Work towards this strategic aim set out in our **Digital Strategy 2023-2025**. The Trust Board of Directors gains assurance on the delivery of this work through Quality and Audit Committees.

C. SUMMARY OF COMMITMENTS IN STRATEGIC PLAN

The commitments to further this strategic objective set out in the five-year strategic plan are against four broad themes:

- Digital strategy
- Delivering digital for patients
- Delivering digital for our people
- Be driven by intelligence
- Secure and robust digital infrastructure

Digital strategy

Commitment	Type	Status	Update
Develop our digital strategy	Original	Complete	Digital strategy 2023-2025 launched in June 2023
Achieve HIMSS level 7 status	Original	In progress	Work to improve digital maturity ongoing. New national digital maturity assessment (DMA) process now in place and year 1 self-assessment completed. Digital Board tracking improvements for year 2.

Delivering digital for patients

Commitment	Type	Status	Update
Engage with our patients to design solutions through co-production	Original	Continuous	Chief Information Officer is chair of the C&M Digital Inclusion Forum. "Empower Citizens" is a pillar of digital maturity assessment. Empowering cancer patients and carers is a key theme of the Digital Strategy.

Expand use of telehealth and other new technologies to keep individuals connected with health professionals and support the delivery of care closer to home	Original	Continuous	Work continues on remote monitoring pilot. New Outpatient Transformation Programme will drive increased telehealth and video consultations. This forms part of the national, regional and digital strategies to support patients to take control of their own health and is a key element of demonstrating increased organisational digital maturity.
Work with others to develop a single digital access point for patients across Cheshire and Merseyside that gives patients access to their electronic records	Original	In progress	Plans are in place to increase the scope of current systems to provide patient portal functionality for CCC patients via NHS app. Digital letters now in place for patients with further development planned.
Give patients access to assistive technology, including remote monitoring	Original	Continuous	Work continues on remote monitoring pilot working with Mersey Care's Clinical Telehealth Hub and access to Cheshire and Merseyside's "Share2Care" shared record platform

Delivering digital for our people

Commitment	Type	Status	Update
Embed strong clinical digital leadership	Original	Continuous	Strong medical, nursing and pharmacist digital leadership now in place
Empower and equip our workforce with digital skills to become fully agile and digitally connected to the wider health and social care environment	Original	Continuous	Ongoing work looking at use of virtual reality in training and education. Also development of 'Attensi' gamification platform to support EPR optimisation and wider training needs.

Be driven by intelligence

Commitment	Type	Status	Update
Establish a true business intelligence function	Original	Complete	BI team is fully embedded and continues to develop with the opportunity of collaborations to support artificial intelligence (AI) and data science
Deliver a new data warehouse and a single set of data visualisation tools	Original	Complete	Fully embedded Data Management Group reports into Digital Board
Share data across Cheshire & Merseyside as part of the CIPHA programme	Original	Continuous	Continue to engage with CIPHA work stream. Progress and opportunities shared with Data Management Group.

Secure and robust digital infrastructure

Commitment	Type	Status	Update
Achieve Cyber Essentials Plus status	Original	Complete	Cyber Essentials Plus achieved in December 2022. Annual

			reaccreditation in progress for Cyber Essentials and Cyber Essentials Plus.
Work with partners to deliver a 'cloud first' approach to our digital infrastructure	Original	In progress	Cloud first strategy continues within Digital Strategy and current work programmes
Embed collaboration tools to support better communication and collaboration across our sites	Original	Continuous	Continued development of collaboration tools through new national Microsoft deal. Work with Isle of Man to align PACs image sharing systems.

Be innovative

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

A. HIGHLIGHTS IN THE LATEST REPORTING PERIOD

- Options appraisal in development for second phase of development of CCC-Paddington site now Paddington CDC has been established: opportunities include CDC expansion, an MR-linac research programme, services for private patients, and additional outpatient capacity
- Outpatient Transformation Programme established with clear remit including increased used of telemedicine to relieve pressure on clinic room capacity and provide innovative models of patient-initiated follow-up (PIFU) where appropriate
- New Innovation Manager starting in early 2024 and new Innovation Committee to be formed

B. SUPPORTING STRATEGIES

Much of the work towards this strategic aim is set out in the Innovation Strategy 2023-2025. The Trust Board of Directors gains assurance on the delivery of this work through Quality Committee.

C. SUMMARY OF COMMITMENTS IN STRATEGIC PLAN

The commitments to further this strategic objective set out in the five-year strategic plan are against four broad themes:

- Build the capacity, capability and culture to support innovation
- Improving patient care through innovation
- Ventures and opportunities

Build the capacity, capability and culture to support innovation

Commitment	Type	Status	Update
Develop an innovation strategy	Original	Complete	Innovation Strategy 2023-2025 published in Feb 2023. New Innovation Manager starting in early 2024. Innovation Committee to be formed.
Establish an innovation fund	Original	Complete	Charity innovation funding channelled through Bright Ideas and Big Ideas programmes

Improving patient care through innovation

Commitment	Type	Status	Update
Introduce model of stratified outpatient follow-up	Original	Continuous	Work to establish patient-initiated follow-up ongoing through the newly-established Outpatient Transformation Programme
Expand the Clatterbridge in the Community programme	Original	Continuous	Second service hub opened in Aintree in March 2022 to give equity of service patients in North Merseyside. Continue to expand treatments offered.

Sustain and embed the use of telemedicine in outpatient care beyond Covid-19	Original	Continuous	Key work streams of newly-established Outpatient Transformation Programme

Ventures and opportunities			
Commitment	**Type**	**Status**	**Update**
Explore commercial opportunities or opportunities to enhance and strengthen patient care or our national and international reputation and brand	Original	Continuous	Current focus is developing phase 2 options appraisal use of CCC-Paddington following successful opening of CDC (phase 1)
Develop and grow subsidiaries and joint venture	Original	Continuous	Ongoing – strategies in place for development/growth

List of acronyms used

AHP	Allied Health Professional
BI	Business intelligence
BRC	Biomedical Research Centre
C&M	Cheshire and Merseyside
CAR-T	Chimeric antigen receptor T-cell
CDC	Community diagnostic centre
CEO	Chief Executive Officer
CIC	Clatterbridge in the Community
CIPHA	Combined Intelligence for Public Health Action
CMAST	Cheshire & Merseyside Acute and Specialist Trust Provider Collaborative
CMCA	Cheshire and Merseyside Cancer Alliance
COO	Chief Operating Officer
CPL	Clatterbridge Pharmacy Limited
CQC	Care Quality Commission
CRF	Clinical Research Facility
ECMC	Experimental Cancer Research Centre
EDI	Equality, diversity and inclusion
EPR	Electronic patient record
ESR	Electronic staff record
FTSU	Freedom to speak up
HCP	(Cheshire & Merseyside) Health and Care Partnership
HIMSS	Healthcare Information and Management Systems Society
HO	Haemato-oncology
ICS	Integrated Care System
ICB	Integrated Care Board
IoM	Isle of Man
IR	interventional radiology
JACIE	Joint Accreditation Committee of the International Society for Cellular Therapy (ISCT) and the European Group for Blood and Marrow Transplantation (EBMT)
KPI	Key performance indicator
L&OD	Learning and organisational development
LHCH	Liverpool Heart and Chest Hospital NHS Foundation Trust
LUHFT	Liverpool University Hospitals NHS Foundation Trust
MDT	Multidisciplinary team
NHSE/I	NHS England/Improvement
NIHR	National Institute for Health and Care Research
ODN	Operational delivery network
PA	Programmed activity (a block of time in a consultant job plan)
PADR	Performance appraisal and development review
PEIG	Patient Experience and Inclusion Group
PHR	Patient held record
PIFU	Patient initiated follow-up
PMO	Programme Management Office
PPJV	Private patient joint venture
PSIRF	Patient Safety Incident Response Framework
QI	Quality improvement
RDS	Rapid diagnostic service
RPA	Robotic process automation
R&I	Research and innovation
SACT	Systemic anti-cancer therapy
SLA	Service level agreement
SRG	Site reference group
TYA	Teenage and young adult
UoL	University of Liverpool
WUTH	Wirral University Teaching Hospital NHS Foundation Trust

Title of meeting: **Trust Board**
Date of meeting: **22nd November 2023**

Report author	Joan Spencer, Chief Operating Officer
Paper prepared by	Hannah Gray, Associate Director of Performance and Operational Improvement
Report subject/title	Integrated Performance Report M7 2023 / 2024
Purpose of paper	This report provides an update on performance for month 7 2023/24 (October 2023). 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.
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		

Ref: FCGOREPO
Review: July 2025
Version: 2.0

Integrated Performance Report
(Month 7 2023/24)

Hannah Gray: Associate Director of Performance and Operational Improvement

Joan Spencer: Chief Operating Officer

Introduction

This report provides an update on performance for October 2023, in the categories of access, efficiency, quality, workforce, research and innovation and finance.

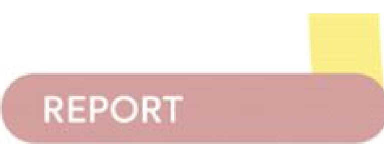
KPI data is presented with RAG ratings and statistical process control (SPC) charts, with associated variation and assurance icons. Further information on SPC charts is provided in the SPC Guidance section of this report. Exception reports are presented for key performance indicators (KPIs) against which the Trust is not compliant with the target / is negatively alerting on the SPC alert. The criteria for inclusion of an exception report is determined by whether the target figure is nationally defined, in conjunction with the nature of SPC assurance and variation.

For KPIs with annual targets, the monthly data is accompanied by charts which present the cumulative total against the YTD target each month. For these KPIs, exception reports are provided when both the monthly and YTD figures are below the respective targets.

The National changes to Cancer Waiting times targets came into affect on 1st October 2023 and are now reflected in this report. Data pre October 2023 is also as per the new standards to show trends over time.

Although August 2023 data is the latest available for Cheshire and Merseyside, the 62 Day figures shown are now for the new merged standard. The Cheshire and Merseyside figures for the new 31 day standard will be published nationally from next month and included in the M8 report.

The Staff Flu vaccine campaign has begun and figures are included in this report.



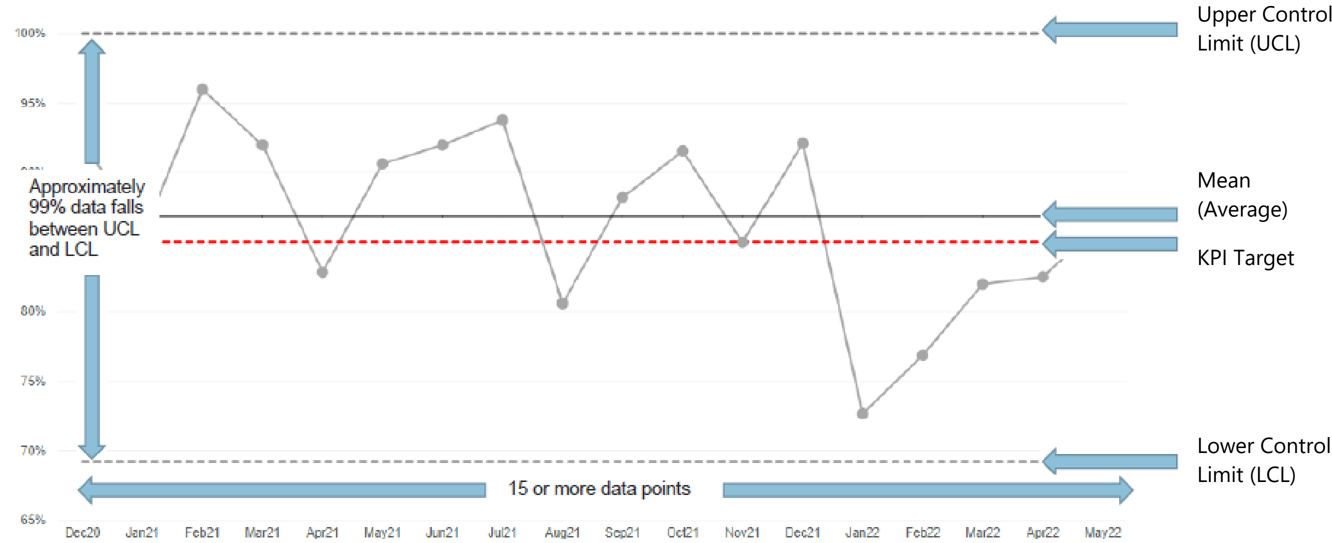
Interpretation of Statistical Process Control Charts

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

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

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

Anatomy of the SPC Chart



Integrated Performance Report (Oct 22 - Sept 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
CW00	28 Day Faster Diagnosis - (Referral to Diagnosis)	Green ≥75% Red <75%	Contractual / Statutory	88.2%	77.8%	94.7%	94.7%	71.4%	78.9%	92.3%	80.0%	72.7%	85.7%	86.7%	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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
CW47	28 Day Faster Diagnosis - (Screening)	Green ≥75% Red <75%	To Be Confirmed	-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	There were no 28 day faster diagnosis screening patients this month.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
CW31	31 Day Decision to Treat to Treatment Standard	Green ≥96% Red <96%	Contractual / Statutory	98.8%	99.5%	98.5%	99.0%	98.7%	98.2%	98.9%	99.4%	99.2%	99.4%	99.4%	99.3%		P
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
CW40	Number of 31 Day Patients Treated ≥ Day 73	Green 0 Red >0	Contractual / Statutory	1	0	0	0	0	0	1	0	0	0	0	0		
			Narrative	This month, there were 0 x 31 day patient treated on or after day 73.													

Data Not Applicable for SPC

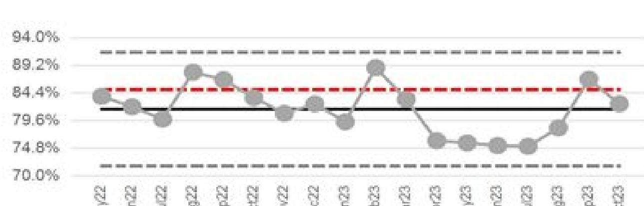
Integrated Performance Report (Oct 22 - Sept 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
CW24	24 Day Referral to CCC to Treatment (62 Day Patients)	Green >85% Amber 80-84.9% Red <80%	Contractual / Statutory	80.9%	82.5%	79.4%	88.8%	83.3%	76.1%	75.8%	75.3%	75.2%	78.4%	86.8%	82.5%		
			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.													

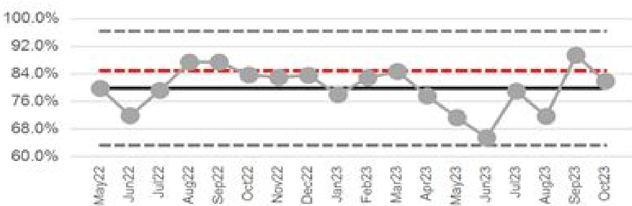


Reason for Non-Compliance	Action Taken to Improve Compliance
36 of the 189 x 62 day patients treated in October breached 24 days from referral to CCC to treatment. 21 of the 36 patients breached 62 days (and details are provided in the 62 Day exception report) and 15 were treated within 62 days. The mean number of days for all 24 day breaches was 33 days and the median was 31. Of the 15 patients who did not breach 62 days: There were 10 breaches which were unavoidable to CCC: - Delay to 1st appointment awaiting molecular markers x 4 (Lung) - Patient choice x 3 (1 x Urology and 2 x Lung) - Patient required admission to another trust with tumour related condition (Lung) - Delay to 1st appointment as patient required RT to other primary (Left Lung) before being seen for Right Lung (Lung) - Patient required face to face follow up prior to treatment (UGI) The 5 avoidable breaches were due to: - Cyclotron treatment deferred due machine maintenance x 2 (Brain/Central Nervous System, both 33 days) - Patients were Category 1, x 2 (1 x UGI 27 days and 1 x Lung 25 days) - Delay to 1st app due to capacity (UGI 26 days)	The pathway for Category 1 patients has been reviewed and all patients who can, are now starting treatment on alternative days of the week.

Escalation Route & Expected Date of Compliance

Trust Operational Group, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board
November 2023

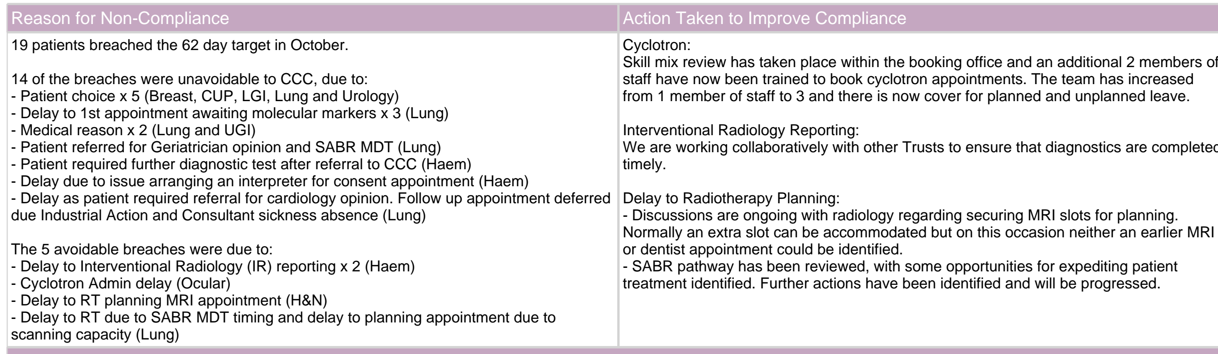
Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
CW62	62 Day Referral to Treatment Standard	Green ≥85% Red <85%	Contractual / Statutory	83.0%	83.6%	78.0%	82.9%	84.7%	77.6%	71.3%	65.5%	79.0%	71.7%	89.4%	81.9%		
			Narrative	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.													



Integrated Performance Report (Oct 22 - Sept 23)

Access

Responsible Forum: Performance Committee

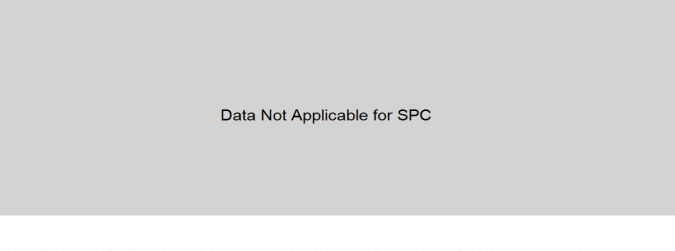


Reason for Non-Compliance	Action Taken to Improve Compliance
19 patients breached the 62 day target in October. 14 of the breaches were unavoidable to CCC, due to: - Patient choice x 5 (Breast, CUP, LGI, Lung and Urology) - Delay to 1st appointment awaiting molecular markers x 3 (Lung) - Medical reason x 2 (Lung and UGI) - Patient referred for Geriatrician opinion and SABR MDT (Lung) - Patient required further diagnostic test after referral to CCC (Haem) - Delay due to issue arranging an interpreter for consent appointment (Haem) - Delay as patient required referral for cardiology opinion. Follow up appointment deferred due Industrial Action and Consultant sickness absence (Lung) The 5 avoidable breaches were due to: - Delay to Interventional Radiology (IR) reporting x 2 (Haem) - Cyclotron Admin delay (Ocular) - Delay to RT planning MRI appointment (H&N) - Delay to RT due to SABR MDT timing and delay to planning appointment due to scanning capacity (Lung)	Cyclotron: Skill mix review has taken place within the booking office and an additional 2 members of staff have now been trained to book cyclotron appointments. The team has increased from 1 member of staff to 3 and there is now cover for planned and unplanned leave. Interventional Radiology Reporting: We are working collaboratively with other Trusts to ensure that diagnostics are completed timely. Delay to Radiotherapy Planning: - Discussions are ongoing with radiology regarding securing MRI slots for planning. Normally an extra slot can be accommodated but on this occasion neither an earlier MRI or dentist appointment could be identified. - SABR pathway has been reviewed, with some opportunities for expediting patient treatment identified. Further actions have been identified and will be progressed.

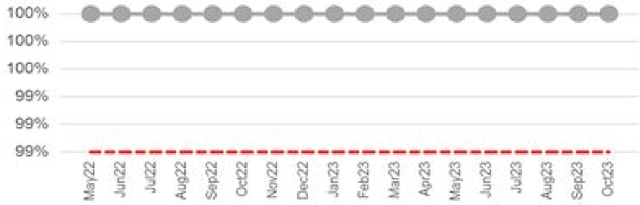
Escalation Route & Expected Date of Compliance

Trust Operational Group, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board
November 2023

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
CW43	Number of Avoidable Breaches, Treated ≥ 104 Days and at CCC For Over 24 Days	Green 0 Amber 1 Red >1	Contractual / Statutory	0	1	5	2	1	2	1	3	2	1	1	0		
			Narrative	This month, there were 0 patients in this category. 36 patients were treated => day 104. For these patients, the median referral day was 105 days and the median time at CCC was 31 days.													



Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	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%		P
			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.													

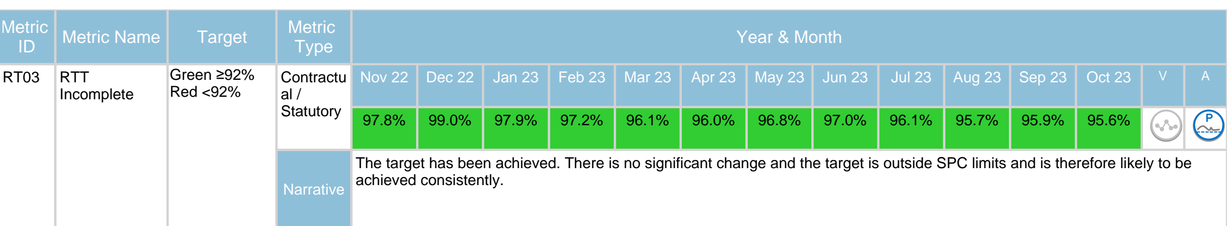


Integrated Performance Report (Oct 22 - Sept 23)

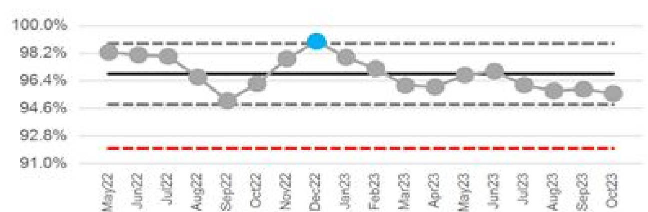
The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Responsible Forum: Performance Committee



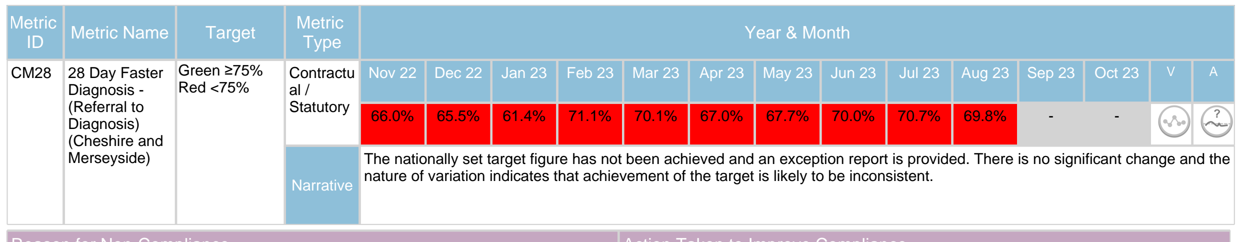
Metric ID	Metric Name	Target	Metric Type	Year & Month													
RT03	RTT Incomplete	Green ≥92% Red <92%	Contractual / Statutory	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
				97.8%	99.0%	97.9%	97.2%	96.1%	96.0%	96.8%	97.0%	96.1%	95.7%	95.9%	95.6%		P
			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.													



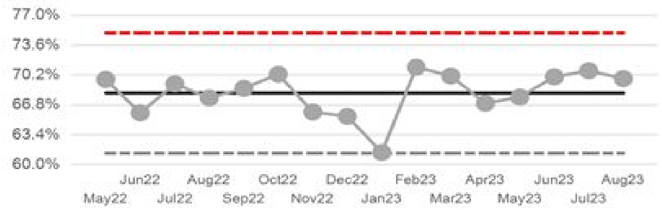
Integrated Performance Report (Oct 22 - Sept 23)

Access: Cheshire and Merseyside

Responsible Forum: Acute and Specialist Trust Provider Collaborative



Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
CM28	28 Day Faster Diagnosis - (Referral to Diagnosis) (Cheshire and Merseyside)	Green ≥75% Red <75%	Contractual / Statutory	66.0%	65.5%	61.4%	71.1%	70.1%	67.0%	67.7%	70.0%	70.7%	69.8%	-	-		
			Narrative	The nationally set target figure 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

Non-compliance with the 28 Day FDS was driven by underperformance in the following tumour groups:
Suspected cancer - referral to non-specific symptom clinic 44.1% (57 breaches),
Suspected lower gastrointestinal cancer 46.6% (1502 breaches),
Other suspected cancer (not listed) 46.7% (8 breaches),
Suspected urological malignancies (excluding testicular) 49.5% (430 breaches),
Suspected haematological malignancies (excluding acute leukaemia) 50% (35 breaches),
Suspected gynaecological cancer 52.4% (599 breaches),
Suspected testicular cancer 65.7% (12 breaches),
Suspected upper gastrointestinal cancer 67.2% (377 breaches),
Suspected lung cancer 69% (53 breaches)

Providers not achieving the national standard were:
Liverpool Womens 33.9% (187 breaches),
Countess Of Chester Hospital 53.5% (655 breaches),
Mid Cheshire Hospitals 68.7% (582 breaches),
Liverpool Heart And Chest 70% (3 breaches),
Mersey and West Lancashire Teaching Hospitals 70.3% (969 breaches),
Liverpool University Hospitals 73% (1031 breaches),
Wirral University Teaching Hospital 73.4% (528 breaches)

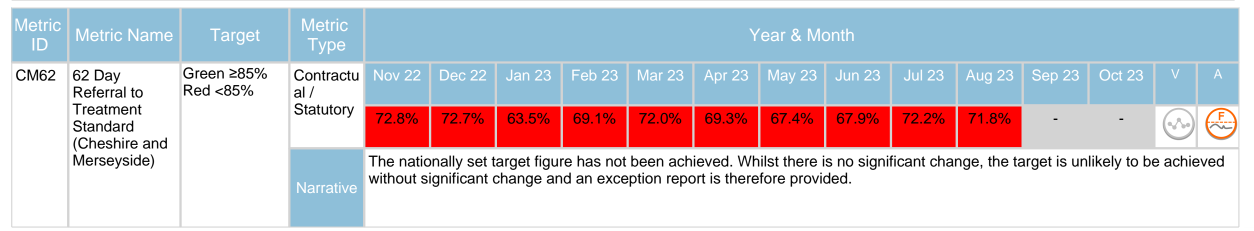
The main reasons for breaches were outpatient capacity (29%), 'other' (17%), administrative delay (13%) and healthcare provider initiated delay to diagnostic test or treatment planning (12%).

Action Taken to Improve Compliance

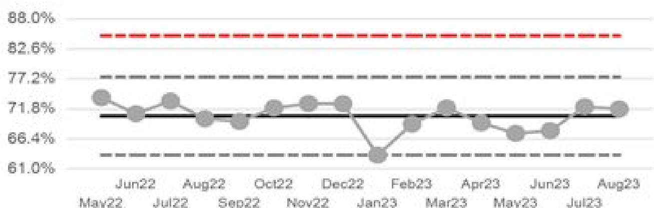
- Continuation of surgical and diagnostics hubs as part of CMCA's response to Covid-19.
- The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group.
- Alignment with the C&M diagnostic programme with a clear, prioritised plan to increase capacity.
- CMCA primary care programme – improvement team established including investment in GP clinical leadership for each of the nine places in Cheshire and Merseyside.
- Increased use of appropriate filter tests in primary care including FIT.
- Productivity gains have increased capacity to see new patients by 25%.

Escalation Route & Expected Date of Compliance

NHS England, North West, CMAST
CCC Performance Committee, Trust Board
March 2024



Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
CM62	62 Day Referral to Treatment Standard (Cheshire and Merseyside)	Green ≥85% Red <85%	Contractual / Statutory	72.8%	72.7%	63.5%	69.1%	72.0%	69.3%	67.4%	67.9%	72.2%	71.8%	-	-		
			Narrative	The nationally set target figure has not been achieved. Whilst there is no significant change, the target is unlikely to be achieved without significant change and an exception report is therefore provided.													



Integrated Performance Report (Oct 22 - Sept 23)

Access: Cheshire and Merseyside | Responsible Forum: Acute and Specialist Trust Provider Collaborative

Reason for Non-Compliance	Action Taken to Improve Compliance
Non-compliance with the 62 day standard was driven by underperformance in the following tumour groups: Gynaecological 34.7% (31 breaches), Lower Gastrointestinal 37.6% (51.5 breaches), Other 47.6% (5.5 breaches), Head & Neck 50% (23 breaches), Haematological (Excluding Acute Leukaemia) 52.4% (10 breaches), Lung 54.9% (20.5 breaches), Urological (Excluding Testicular) 63.7% (60.5 breaches), Upper Gastrointestinal 68.2% (14 breaches), Sarcoma 75% (2 breaches), Breast 78.2% (29 breaches) Providers not achieving the national standard were: Liverpool Womens 20% (14 breaches), Liverpool Heart And Chest 54.5% (5 breaches), Liverpool University Hospitals 60.2% (65.5 breaches), East Cheshire 67.2% (11 breaches), Bridgewater Community Healthcare 68.4% (3 breaches), Warrington and Halton Teaching Hospitals 70.5% (18 breaches), Countess Of Chester Hospital 70.7% (18 breaches), Mid Cheshire Hospitals 71.1% (36 breaches), Mersey and West Lancashire Teaching Hospitals 71.4% (47 breaches), Wirral University Teaching Hospital 71.6% (40 breaches), The Clatterbridge Cancer Centre 74.7% (11 breaches) The main reasons for breaches were complex diagnostic pathways (17%), elective capacity inadequate (8%), healthcare provider initiated delay to diagnostic test or treatment planning (15%) and 'other' (39%).	• Continuation of surgical and diagnostics hubs as part of CMCA's response to Covid-19. • The single patient tracking list (PTL) across Cheshire and Merseyside continues to be vetted each week through the CMCA clinical prioritisation group. • Alignment with the C&M diagnostic programme with a clear, prioritised plan to increase capacity. • CMCA primary care programme – improvement team established including investment in GP clinical leadership for each of the nine places in Cheshire and Merseyside. • Increased use of appropriate filter tests in primary care including FIT. • Patient and public communications to improve patient confidence to attend for appointments.

Escalation Route & Expected Date of Compliance
NHS England, North West, CMAST CCC Performance Committee, Trust Board March 2024

Integrated Performance Report (Oct 22 - Sept 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	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	10.70	9.61	6.00	6.36	5.93	8.84	4.22	7.17	6.82	7.86	8.85	4.85		
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	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	12.9	13.1	11.3	11.4	14.1	11.0	12.1	14.0	12.1	13.4	13.6	11.5		
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	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	14.3	13.9	12.8	11.1	17.9	31.2	15.2	14.5	21.2	13.4	22.6	17.1		
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
IP06-4	Length of Stay Emergency Care: HO Ward 4 (Average Number of Days On Discharge)	Green ≤22 Amber 22.1-23.1 Red >23.1	Statutory	9.62	11.00	8.10	20.86	24.50	23.31	18.36	23.36	9.50	11.31	12.17	16.07		
			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 22 - Sept 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	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	19.4	18.5	14.5	16.8	13.1	11.6	28.7	22.4	16.2	17.2	26.1	29.0		?
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	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	7.00	3.67	23.00	17.00	4.33	9.00	34.00	7.40	5.88	3.25	5.50	26.00		P
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
IP22	Delayed Transfers of Care As % of Occupied Bed Days	Green ≤3.5% Red >3.5%	Statutory	7.1%	6.3%	5.4%	4.2%	5.6%	4.8%	2.2%	7.2%	3.2%	7.1%	3.6%	2.3%		?
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
IP20	Average Bed Occupancy - Midday	Green 85% - ≤92% Amber 81-84.9%, 92-94.9% Red <81% or >95%	Statutory	91.2%	88.7%	91.4%	92.9%	91.3%	83.3%	92.8%	90.1%	93.2%	91.1%	91.6%	88.1%		?
			Narrative	The nationally set ambition of 92% 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 22 - Sept 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
IP21	Average Bed Occupancy - Midnight	Green 85% - ≤92% Amber 81-84.9%, 92-94.9% Red <81% or >95%	Statutory	97.5%	95.8%	94.5%	94.7%	93.7%	88.9%	95.1%	93.6%	95.3%	94.0%	92.6%	90.6%		
			Narrative	The nationally set ambition of 92% 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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
IP23	% of Expected Discharge Dates Completed	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual	95.0%	92.0%	91.0%	90.0%	92.0%	94.0%	92.0%	92.0%	88.0%	95.0%	95.0%	95.0%		
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	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

Integrated Performance Report (Oct 22 - Sept 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
IP26	% of Urgent Operations Cancelled For a Second Time	Green 0% Red >0%	Contractual	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
			Narrative	No procedures have been cancelled for a second time.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
EF10	Imaging Reporting Turnaround (Inpatients)	Green >90% Amber 80-89.9% Red <80%		96.8%	92.6%	90.7%	73.5%	88.1%	91.2%	93.1%	84.1%	83.8%	82.4%	82.6%	81.2%		
			Narrative	The target has not been achieved and an exception report is provided (at the end of the imaging reporting turnaround KPIs). 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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
EF11	Imaging Reporting Turnaround (Outpatients)	Green >90% Amber 80-89.9% Red <80%		88.3%	85.9%	82.2%	82.0%	91.5%	96.3%	89.3%	86.9%	80.3%	74.0%	72.1%	69.8%		
			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.													

Integrated Performance Report (Oct 22 - Sept 23)

Efficiency

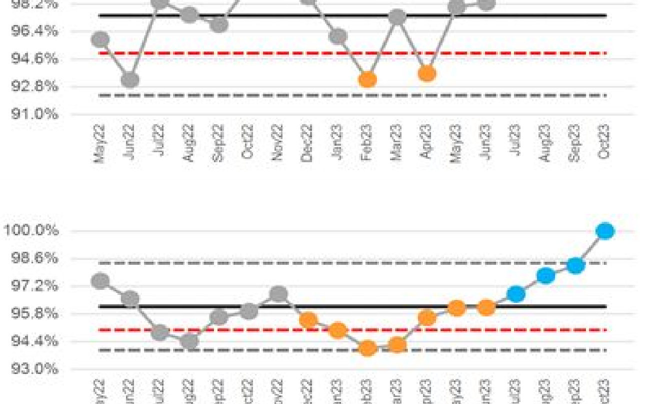
Responsible Forum: Performance Committee

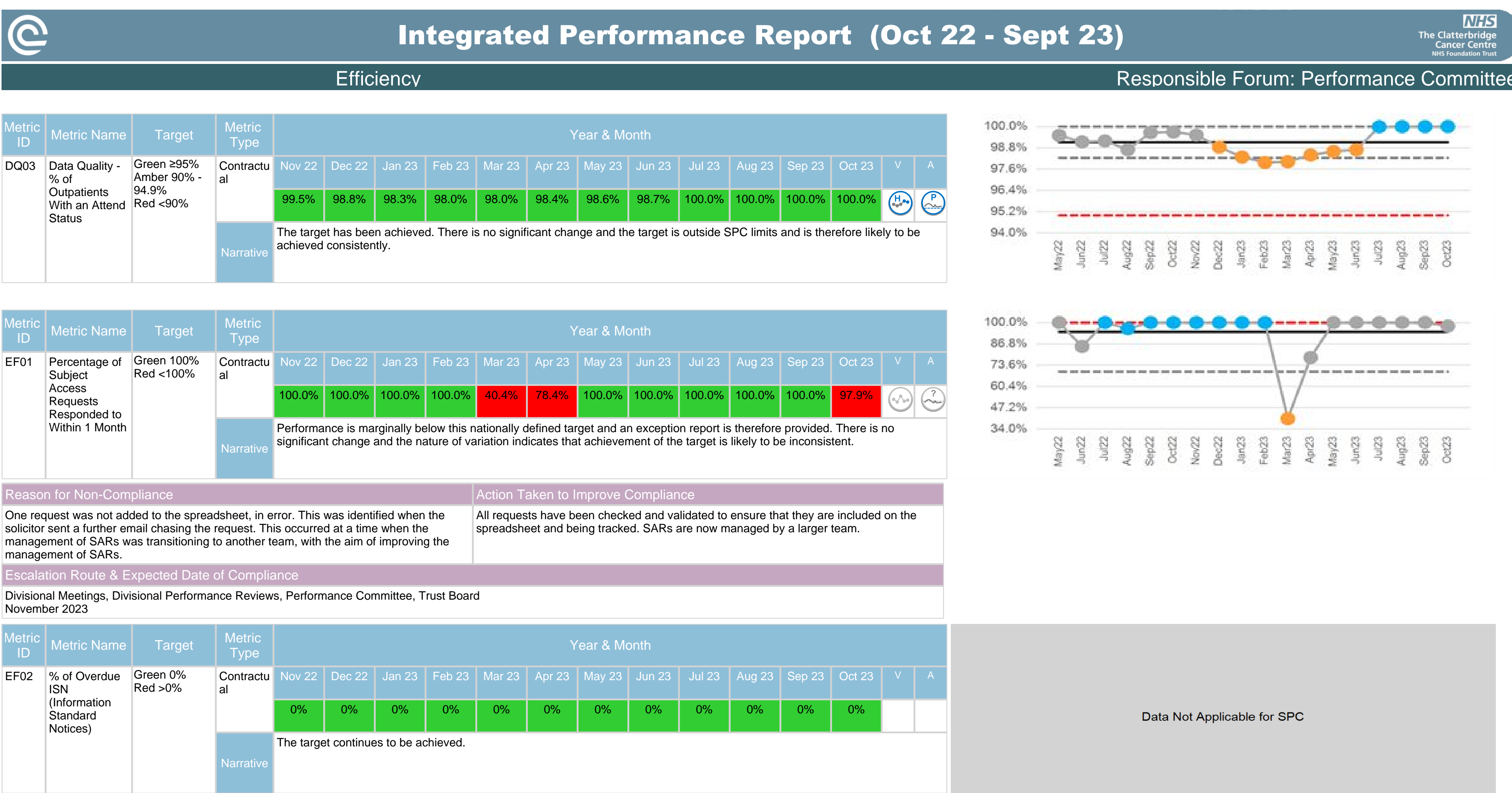
Reason for Non-Compliance	Action Taken to Improve Compliance
Increase in activity across all modalities. Unsuccessful recruitment to radiologist vacancies and Sonographer sickness/ training needs. Reporting prioritisation processes require formalisation.	A bi-weekly meeting is in place, to closely manage both the scanning waiting list and the reporting backlog. The scanning wait has been reduced to one week wait which is really positive, however this then has a knock on effect on the reporting. The importance of reporting urgent cases first and then in chronological order has been reiterated to Radiologists. Emails are being sent daily to closely manage this prioritisation. A new SOP is being developed to formalise this process. We have not yet recruited to radiologist vacancies, however the reporting radiographer has returned from leave. The Sonographer capacity issues should be resolved by December, when all sonographers are trained. This will then release radiology capacity. We are asking Medica on a weekly basis for extra reporting numbers and this is being managed on a daily basis by the clinical specialists and the PACS team. An improvement is expected in M8.

Escalation Route & Expected Date of Compliance
Divisional Meetings, Divisional Performance Reviews, Trust Operational Group, Performance Committee, Trust Board December 2023

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
DQ01	Data Quality - % Ethnicity That is Complete (or Patient Declined to Answer)	Green ≥95% Amber 90-94.9% Red <90%	Covid-19 Recovery	99.6%	98.7%	96.1%	93.3%	97.3%	93.7%	98.0%	98.3%	99.8%	99.4%	99.1%	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.													

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
DQ02	Data Quality - % of Outpatients With an Outcome	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual	96.8%	95.5%	95.0%	94.1%	94.2%	95.6%	96.1%	96.1%	96.8%	97.7%	98.3%	100.0%		
			Narrative	The target has been achieved, with significant positive change. The nature of variation indicates that achievement of the target is likely to be inconsistent.													





Integrated Performance Report (Oct 22 - Sept 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
DQ03	Data Quality - % of Outpatients With an Attend Status	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual	99.5%	98.8%	98.3%	98.0%	98.0%	98.4%	98.6%	98.7%	100.0%	100.0%	100.0%	100.0%		
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	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%	40.4%	78.4%	100.0%	100.0%	100.0%	100.0%	100.0%	97.9%		
			Narrative	Performance is marginally below this nationally defined target and an exception report is therefore 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
One request was not added to the spreadsheet, in error. This was identified when the solicitor sent a further email chasing the request. This occurred at a time when the management of SARs was transitioning to another team, with the aim of improving the management of SARs.	All requests have been checked and validated to ensure that they are included on the spreadsheet and being tracked. SARs are now managed by a larger team.

Escalation Route & Expected Date of Compliance
Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board November 2023

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	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.													

Integrated Performance Report (Oct 22 - Sept 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU17	Never Events	Green 0 Red >0	Contractual / Statutory	0	0	0	0	0	0	1	0	0	0	0	0		
			Narrative	0 Never Events were reported this month.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU04	Serious Incidents (SIs)	No Target	Contractual / Statutory	0	0	1	0	0	1	0	1	0	0	0	0		
			Narrative	No SIs were reported to STEIS this month.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU01	Serious Incidents: % Submitted Within 60 Working Days / Agreed Timescales	Green 100% Red <100%	Contractual / Statutory	100%	-	-	-	-	100%	-	-	100%	-	-	-		
			Narrative	No SIs reports were due to be submitted this month.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU03	Incidents /1,000 Bed Days	No Target	Statutory	136.9	104.6	123.0	127.1	134.2	117.8	107.4	137.6	123.4	132.2	127.5	124.9		
			Narrative	Incident numbers are as 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.													

167.8
153.6
139.3
125.0
110.8
96.5
May22 Jun22 Jul22 Aug22 Sep22 Oct22 Nov22 Dec22 Jan23 Feb23 Mar23 Apr23 May23 Jun23 Jul23 Aug23 Sep23 Oct23

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Integrated Performance Report Month 7 2023/2024

Integrated Performance Report (Oct 22 - Sept 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU05	All Incidents Resulting in Moderate Harm and Above /1,000 Bed Days	No Target	Local	0.370	0.367	1.076	2.318	0.719	0.405	1.767	1.110	1.724	1.060	1.816	1.098		
			Narrative	Numbers of incidents of this severity are as 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.													

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU06	Inpatient Falls Resulting in Harm Due to Lapse in Care	Green 0 Red >0	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU07	Inpatient Falls Resulting in Harm Due to Lapse in Care /1,000 Bed Days	Green 0 Red >0	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	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 22 - Sept 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU10	30 Day Mortality (Radical Chemotherapy)	Green ≤0.6% Amber 0.61% - 0.7% Red >0.7%	SOF	0.3%	0.3%	0.2%	0.1%	0.1%	0.1%	0.2%	0.0%	0.2%	0.3%	0.0%	-		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and therefore likely to be achieved consistently.													

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU12	30 Day Mortality (Palliative Chemotherapy)	Green ≤2.3% Amber 2.31% - 2.5% Red >2.5%	SOF	1.5%	1.1%	1.3%	1.7%	1.1%	1.0%	0.8%	1.1%	1.4%	1.2%	0.7%	-		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and therefore likely to be achieved consistently.													

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU13	100 Day Mortality (Bone Marrow Transplant)	To Be Confirmed	SOF / NR	0.0%	28.6%	0.0%	0.0%	0.0%	12.5%	11.1%	0.0%	0.0%	-	-	-		
			Narrative	This month, there were 0 deaths within 100 days of transplant.													

Integrated Performance Report (Oct 22 - Sept 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU62	Consultant Review Within 14 Hours	Green ≥90% Red <90%	Contractual	93.8%	98.4%	95.2%	95.3%	93.3%	98.9%	96.8%	99.1%	96.2%	98.5%	99.0%	96.7%		
			Narrative	The target has been achieved. Performance is now higher than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU48	Sepsis IV Antibiotics Within an Hour	Green ≥90% Red <90%	Contractual	93.4%	92.9%	92.7%	97.8%	92.4%	94.5%	94.8%	93.0%	91.8%	98.1%	89.6%	98.0%		
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU31	Percentage of Adult Admissions With VTE Risk Assessment	Green ≥95% Red <95%	Contractual / Statutory	90.4%	94.9%	96.5%	99.5%	99.6%	98.8%	99.1%	99.0%	96.6%	96.7%	94.9%	94.5%		
			Narrative	Performance is 0.5% below the nationally set target figure 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.													

Integrated Performance Report (Oct 22 - Sept 23)

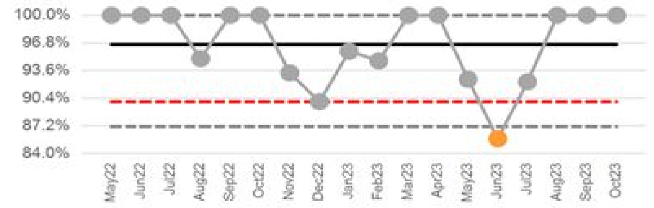
Quality

Responsible Forum: Quality Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
11 patients did not have their risk assessment completed within 24 hours. 5 of the 11 patients were admitted during the Doctor's strike between the 2nd - 5th October (45.4%). 3 assessments were completed within 48 hours and received the appropriate anticoagulation - none harm caused. 2 assessments were completed after 48 hours of admission, 1 patient missed 2 days of prophylactic anticoagulation - no harm caused. 3 patients were part of a clinical trial protocol, they were discharged the following day, prophylactic anticoagulation was not required - no harm caused. 2 patients were admitted following Interventional Radiology procedure, they were discharged the following day, prophylactic anticoagulation was not required - no harm caused. 1 patient had an unplanned stay following a medical emergency, prophylactic anticoagulation was not required - no harm caused.	Missed assessments are reported to the relevant medical teams, Divisional lead, matrons, and ward managers. Details are discussed in the VTE committee meeting (next meeting 24th November) Outstanding VTE assessments to be identified in the 8pm evening handover to the night team.

Escalation Route & Expected Date of Compliance
Divisional Meetings, Divisional Performance Reviews, Patient Safety Committee, Quality Committee, Trust Board November 2023

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU14	Dementia: Percentage to Whom Case Finding is Applied	Green ≥90% Red <90%	Contractual	93.3%	90.0%	95.8%	94.7%	100.0%	100.0%	92.6%	85.7%	92.3%	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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	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

Integrated Performance Report (Oct 22 - Sept 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality | Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	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 Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU34	Clostridium Difficile Infections (HOHA and COHA)	Green ≤ 13 per year Red >13 per year	Contractual / Statutory	1	1	4	1	1	0	0	-	-	-	-	-		
			Narrative	There were no such infections this month.													

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU40	E. Coli Bacteraemia (HOHA and COHA)	Green ≤ 10 per year Red >10 per year	Contractual / Statutory	1	5	2	0	1	4	2	-	-	-	-	-		
			Narrative	There were 2 such infections this month. The annual threshold of 10 was exceeded in September. An exception report is provided.													

Reason for Non-Compliance	Action Taken to Improve Compliance
Two COHA E.coli bloodstream infections were identified in October 2023. 1. Source unknown. No learning points identified. 2. Source urinary. No learning points identified. COHA = Community Onset – Hospital Acquired, where patient has been discharged within 28 days prior to presenting with infection.	N/A

Escalation Route & Expected Date of Compliance
Harm Free Care Meeting, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board November 2023

Integrated Performance Report (Oct 22 - Sept 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality | Responsible Forum: Quality Committee

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU36	MRSA Infections (HOHA and COHA)	Green 0 per year Red >0 per year	Contractual / Statutory	1	0	0	0	0	0	0	-	-	-	-	-		
			Narrative	There were no such infections this month.													

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU38	MSSA Bacteraemia (HOHA and COHA)	Green ≤ 4 per year Amber 5 Red >5 per year	Contractual / Statutory	0	3	0	2	1	1	1	-	-	-	-	-		
			Narrative	There was 1 such infection this month. The annual threshold of 5 was exceeded in August. An exception report is provided.													

Reason for Non-Compliance	Action Taken to Improve Compliance
1 HOHA Staphylococcus aureus bloodstream infection was identified in October 2023. Source of infection is likely to be gut. No learning points identified from this episode of infection.	N/A

Escalation Route & Expected Date of Compliance

Harm Free Care Meeting, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board
November 2023

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU43	Klebsiella (HOHA and COHA)	Green ≤ 8 per year Red >8 per year	Contractual / Statutory	2	0	0	0	1	0	3	-	-	-	-	-		
			Narrative	There were 3 such infections this month and the YTD target has been exceeded. The annual threshold of 8 has not been breached, with 6 YTD. An exception report is provided.													

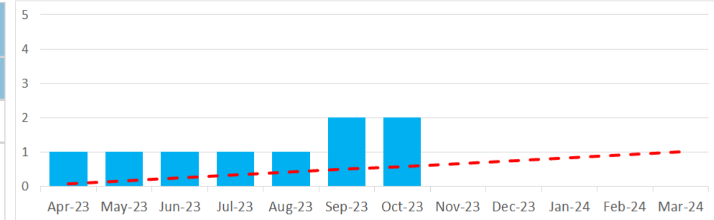
Integrated Performance Report (Oct 22 - Sept 23)

Quality | Responsible Forum: Quality Committee

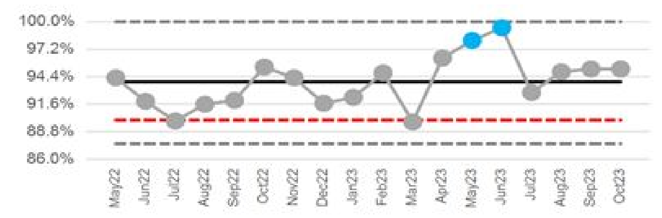
Reason for Non-Compliance	Action Taken to Improve Compliance
2 HOHA Klebsiella pneumoniae bloodstream infections were identified in October 2023. 1. Likely gut source, no learning points identified 2. Likely urinary source. Paired line and peripheral cultures were not obtained upon suspicion of sepsis. Although this did not contribute to this episode of infection, it is a learning point.	The clinical team have produced an action plan detailing how feedback from this episode of infection will be cascaded to both nursing and medical teams to reiterate the need for paired culture collection.

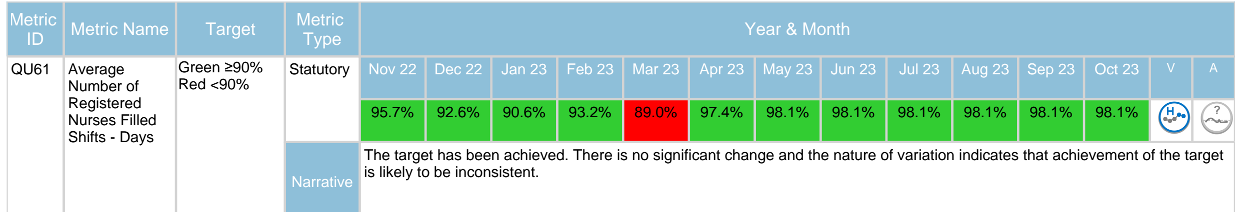
Escalation Route & Expected Date of Compliance
Harm Free Care Meeting, Infection Prevention and Control Committee, Divisional Performance Reviews, Risk and Quality Governance Committee, Quality Committee, Trust Board November 2023

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU45	Pseudomonas (HOHA and COHA)	Green ≤ 1 per year Red >1 per year	Contractual / Statutory	1	0	0	0	0	1	0	-	-	-	-	-		
			Narrative	There were no such infections this month.													



Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU66	Safer Staffing: Overall Fill-Rate	Green ≥90% Red <90%	Statutory	94.3%	91.7%	92.3%	94.8%	89.8%	96.3%	98.1%	99.4%	92.8%	94.9%	95.2%	95.2%		
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU61	Average Number of Registered Nurses Filled Shifts - Days	Green ≥90% Red <90%	Statutory	95.7%	92.6%	90.6%	93.2%	89.0%	97.4%	98.1%	98.1%	98.1%	98.1%	98.1%	98.1%		
			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.													

Integrated Performance Report (Oct 22 - Sept 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU63	Average Number of Care Staff Filled Shifts - Days	Green ≥90% Red <90%	Statutory	87.8%	88.5%	86.2%	91.4%	84.6%	91.7%	94.3%	97.0%	83.5%	89.7%	91.8%	95.3%		
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU64	Average Number of Care Staff Filled Shifts - Nights	Green ≥90% Red <90%	Statutory	96.1%	90.8%	96.4%	100.0%	97.5%	98.4%	102.9%	106.1%	97.3%	104.7%	102.4%	102.6%		
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU65	Average Number of Registered Nurses Filled Shifts - Nights	Green ≥90% Red <90%	Statutory	96.9%	93.7%	96.5%	95.4%	89.5%	96.9%	97.4%	98.6%	97.0%	93.0%	93.8%	94.9%		
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU60	NICE Guidance Compliance	Green ≥90% Amber 85 - 89.9% Red <85%	Contractual	93.8%	94.0%	95.8%	95.6%	95.4%	95.0%	96.5%	97.6%	97.4%	97.4%	97.4%	95.5%		
			Narrative	The target has been achieved. Performance is higher than expected and the target is outside SPC limits and is therefore likely to be achieved consistently.													

Integrated Performance Report (Oct 22 - Sept 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

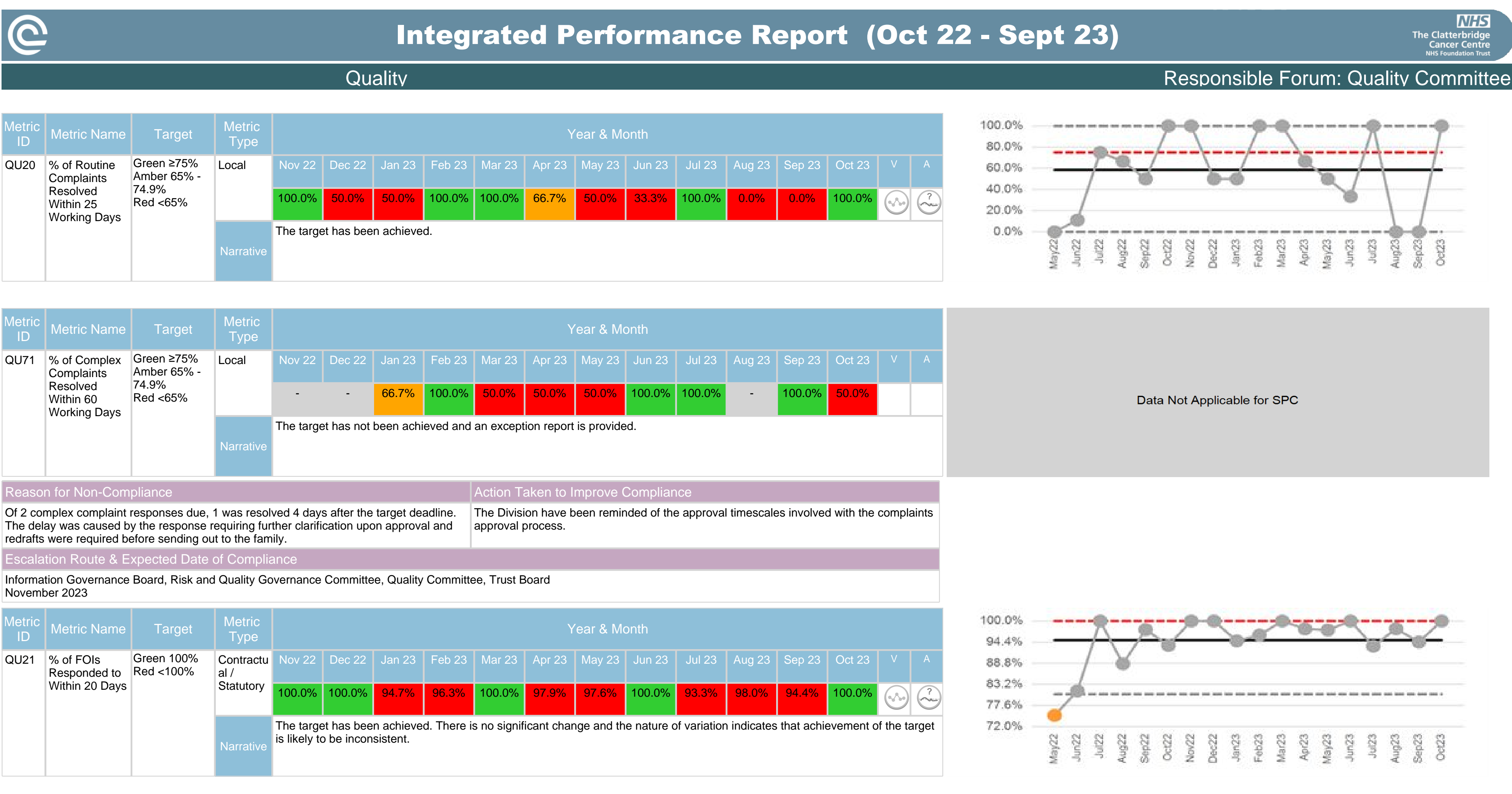
Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU75	Patient FFT: % of Respondents Who Had a Positive Experience	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual	97.0%	97.2%	96.7%	96.6%	96.9%	97.2%	96.4%	97.0%	96.6%	96.5%	96.9%	97.3%		
			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	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU11	Number of Complaints	No Target	Contractual	6	4	6	3	3	3	2	4	2	0	3	2		
			Narrative	There were 2 complaints this month, which remains lower than expected. Complaints are reviewed at Divisional meetings, Divisional Performance Reviews and RQGC. This promotes effective analysis of themes and trends to drive improvement.													

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU18	Number of Complaints / Count of WTE Staff (Ratio)	No Target	Contractual	0.003	0.002	0.003	0.002	0.002	0.002	0.001	0.002	0.001	0.000	0.002	0.001		
			Narrative	There were 0.001 complaints per staff WTE this month. Complaints are reviewed at Divisional meetings, Divisional Performance Reviews and RQGC. This promotes effective analysis of themes and trends to drive improvement.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU19	% of Formal Complaints Acknowledged Within 3 Working Days	Green 100% Red <100%	Contractual	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.													



Integrated Performance Report (Oct 22 - Sept 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU20	% of Routine Complaints Resolved Within 25 Working Days	Green ≥75% Amber 65% - 74.9% Red <65%	Local	100.0%	50.0%	50.0%	100.0%	100.0%	66.7%	50.0%	33.3%	100.0%	0.0%	0.0%	100.0%		
			Narrative	The target has been achieved.													

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU71	% of Complex Complaints Resolved Within 60 Working Days	Green ≥75% Amber 65% - 74.9% Red <65%	Local	-	-	66.7%	100.0%	50.0%	50.0%	50.0%	100.0%	100.0%	-	100.0%	50.0%		
			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
Of 2 complex complaint responses due, 1 was resolved 4 days after the target deadline. The delay was caused by the response requiring further clarification upon approval and redrafts were required before sending out to the family.	The Division have been reminded of the approval timescales involved with the complaints approval process.

Escalation Route & Expected Date of Compliance

Information Governance Board, Risk and Quality Governance Committee, Quality Committee, Trust Board
November 2023

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU21	% of FOIs Responded to Within 20 Days	Green 100% Red <100%	Contractual / Statutory	100.0%	100.0%	94.7%	96.3%	100.0%	97.9%	97.6%	100.0%	93.3%	98.0%	94.4%	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 22 - Sept 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU22	Number of IG Incidents Escalated to ICO	Green 0 Red >0	Contractual / Statutory	0	0	0	1	0	0	0	0	1	0	0	0		
			Narrative	0 IG incidents have been escalated to the ICO this month.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU23	% of Policies in Date	Green ≥95% Amber 90.1 - 94.9% Red <90%	Contractual	87.8%	89.2%	89.7%	88.2%	89.6%	90.7%	91.2%	92.3%	94.2%	95.8%	95.0%	95.0%		
			Narrative	The target has been achieved. Performance is higher than expected and the nature of variation indicates that achievement of the target is likely to be inconsistent.													

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
QU24	NHS E/I Patient Safety Alerts: Number Not Implemented Within Set Timescale.	Green 0 Red >0	Contractual	0	0	0	0	0	0	0	0	0	0	0	0		
			Narrative	The target has been achieved this month.													

Data Not Applicable for SPC

Integrated Performance Report (Oct 22 - Sept 23)

Research & Innovation

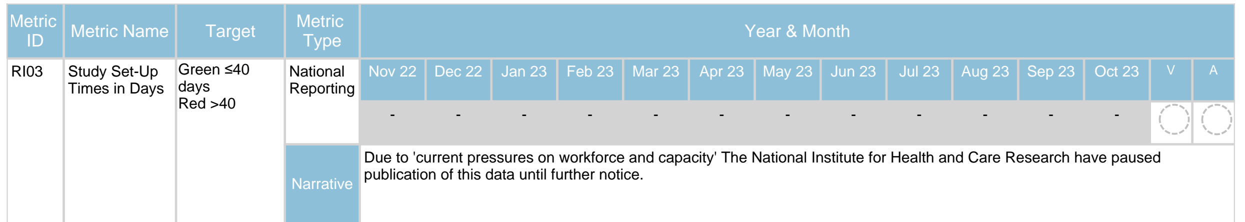
Responsible Forum: Performance Committee

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
RI20	Study Recruitment	Green ≥1500 per year Amber 1275-1499 per year Red <1275 per year	CCC Strategy	62	69	116	71	81	119	91	-	-	-	-	-		
			Narrative	The internally set monthly target has not been achieved and YTD performance remains below the target. An exception report is provided.													

Reason for Non-Compliance	Action Taken to Improve Compliance
609 patients have been recruited between April and October 2023 against an internal target of 875 (70% of target) at the end of Month 7. 135 interventional, 401 observational and 79 biobank recruited. The main reasons at Month 7 for not achieving the overall target are: • A high number of complex early phase studies have opened since December 2021 (when the Study Prioritisation Committee started). Currently 22% of our portfolio is made up of early phase studies. These studies are scientifically important but low recruiters. A key point to note in the ECMC and early phase portfolio is the nature and complexity of the trials opened which has been made possible due to the move to Liverpool. We are supporting First-in-Human and true phase I and multi-cohort trials. This is reputationally enhancing and offers patients different treatment options. • A number of high recruiting observational studies have closed. A new observational study with higher recruitment has opened now but there will be approximately a 2-month lag before recruitment is realised. • One potentially higher recruiting study is not recruiting as expected due to patient choice. Target recruitment for this study is being reviewed.	• Clinical Research Gap Analysis paper monitored monthly at R&I Directorate Board and via TEG every 4 months. Actions plan is on track. Significant piece of work relating to Research PA allocation is now complete. Additional Research PAs have been allocated to clinical staff and will demonstrate enhanced support for research infrastructure within the Divisions which will see increased outputs. • Research Study Prioritisation Committee had a complete refresh of the studies taken through in September 2023. • Potentially high recruiting study is at the protocol stage and then will be taken to Ethics. Anticipated opening from January 2024. To note: 3 studies opened expanding the observational portfolio: Adapt-P important for men with prostate cancer, in documenting the biochemical effectiveness, as determined by the PSA and impact of apaluatmide on health related quality of life. IMPACT, important in palliative care, mapping illness trajectories for people with advanced cancer receiving immunotherapy treatment to identify palliative care need and ACTION which is Feasibility and Acceptability of a Physical Activity Intervention for Young People During Cancer Treatment.

Escalation Route & Expected Date of Compliance

R&I Directorate Board, Committee for Research Strategy, Performance Committee, Trust Board
March 2024



Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
RI03	Study Set-Up Times in Days	Green ≤40 days Red >40	National Reporting	-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	Due to 'current pressures on workforce and capacity' The National Institute for Health and Care Research have paused publication of this data until further notice.													

Integrated Performance Report (Oct 22 - Sept 23)

Research & Innovation

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target Cumulative	Metric Type	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	V	A
RI10	Number of Patients Recruited (Non-Commercial, Portfolio Studies)	Green ≥500 per year Amber 425-499 Red <425		53	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	Both the monthly and YTD targets have been achieved. The reporting period for this KPI is Oct - Sept rather than April - March and the target remains the same for this new 12 month period.													

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
RI21	Recruitment to Time and Target	Green ≥55% Amber 45 - 54.9% Red <45%	National Reporting	-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	Due to 'current pressures on workforce and capacity' The National Institute for Health and Care Research have paused publication of this data until further notice.													

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
RI05	Number of New Studies Open to Recruitment	Green ≥52 per year Amber 45 - 51 Red <45	CCC Strategy	3	5	6	6	8	7	3	-	-	-	-	-		
			Narrative	Whilst the monthly target has not been achieved, the YTD performance remains above the YTD target.													

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
RI22	Publications	Green >200 per year Amber 170-200 Red <170	CCC Strategy	11	17	31	20	14	26	29	-	-	-	-	-		
			Narrative	The monthly and YTD targets have been achieved.													

Integrated Performance Report (Oct 22 - Sept 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce | Responsible Forum: People Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
WO01	Sickness Absence	Green ≤4% Amber 4.1 - 4.9% Red ≥5%	Contractual / Statutory	5.6%	5.9%	4.7%	4.8%	4.8%	4.6%	3.9%	3.7%	4.3%	4.7%	4.1%	5.2%		

Narrative: Whilst sickness absence is above the CCC defined target, there is no significant change. The nature of variation indicates that achievement of the target is likely to be inconsistent.

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
WO20	Sickness Absence (Short Term)	Green ≤2% Amber 2.1-2.9% Red ≥3%	Contractual / Statutory	2.4%	2.7%	2.1%	2.1%	2.2%	2.0%	1.6%	1.5%	2.1%	2.0%	2.1%	2.7%		

Narrative: Whilst short term sickness absence is marginally above the CCC defined target, there is no significant change. The nature of variation indicates that achievement of the target is likely to be inconsistent.

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
WO21	Sickness Absence (Long Term)	Green ≤2% Amber 2.1-2.9% Red ≥3%	Contractual / Statutory	3.0%	3.1%	2.6%	2.6%	2.6%	2.6%	2.4%	2.2%	2.2%	2.8%	1.9%	2.5%		

Narrative: Whilst long term sickness absence is marginally above the CCC defined target, there is no significant change. The nature of variation indicates that achievement of the target is likely to be inconsistent.

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
WO02	% Turnover (Rolling 12 Months)	Green ≤14% Amber 14.1%-14.9% Red ≥15%		16.1%	16.1%	15.9%	15.8%	16.0%	14.9%	15.0%	15.2%	15.5%	15.2%	15.2%	15.1%		F

Narrative: The target has not been achieved. Whilst performance is lower than expected, the target is unlikely to be achieved without significant change and an exception report is therefore provided.

Integrated Performance Report (Oct 22 - Sept 23)

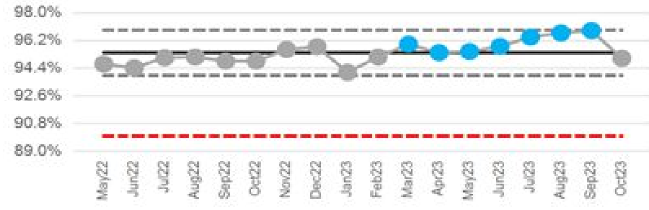
Workforce

Responsible Forum: People Committee

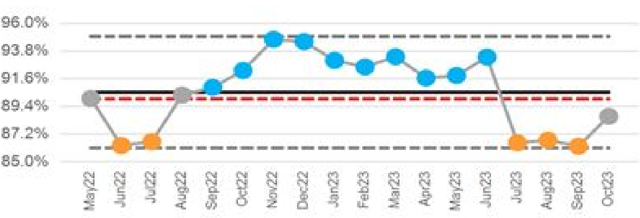
Reason for Non-Compliance	Action Taken to Improve Compliance
The Trust turnover has decreased for the second month in a row from 15.16% to 15.14% in October. However, it remains above the Trust target. However if leavers due to retirement and end of fixed term contracts (FTC) were removed from the data set, the Trust would be at 13.51%, which is below target. There were 28 leavers in October. The top reasons for leaving were; Voluntary resignation - Health x5 Voluntary resignation - Promotion x7 Voluntary resignation - Work life balance x7 Network services had the highest amount of leavers with 9 in total. The staff group with the highest amount of leavers was Administrative and Clerical with 9 in total. The reasons for leaving within this staff group were Promotion (5), Health (1), Lack of opportunities (1), Mutually agreed resignation (1) and Work life balance (1).	The HRBP Team continue to push for exit interviews to be completed to ensure that we are receiving useful information which can drive improvements and reduce turnover. These are shared and discussed with managers where necessary in order to identify improvements. The HRBP Team have recently submitted a Retention Review Paper to Workforce Advisory Committee to highlight areas of action for Divisional leads and will continue to provide support. The HRBP team to work with managers to try to understand further the reasons that staff are leaving due to 'health' (as this has increased) and to ensure that it is being used as the appropriate reason.

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

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
WO07	Statutory Mandatory Training Compliance	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual / Statutory	95.6%	95.8%	94.1%	95.1%	96.0%	95.4%	95.5%	95.8%	96.4%	96.7%	96.9%	95.1%		
			Narrative	The target has been achieved. Performance is higher than expected and the target is likely to be achieved consistently. NB: Compliance against specific courses is closely monitored at People Committee and in Divisional and Corporate Service PRGs, with actions identified to improve compliance.													



Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
WO22	Appraisal	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual	94.7%	94.6%	93.1%	92.5%	93.4%	91.7%	91.9%	93.3%	86.5%	86.7%	86.3%	88.6%		
			Narrative	This internally defined target has not been achieved, however with a rise in October, performance is no longer lower than expected. The nature of variation indicates that achievement of the target is likely to be inconsistent.													



Integrated Performance Report (Oct 22 - Sept 23)

The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Responsible Forum: People Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
WO23	Medical Appraisal	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual / Statutory	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	98.0%	94.4%	98.2%		P
			Narrative	The target has been achieved. Performance is as expected and the nature of variation indicates that achievement of the target is likely to be consistent.													

100.0%
97.8%
95.6%
93.4%
91.2%
89.0%
May22 Jun22 Jul22 Aug22 Sep22 Oct22 Nov22 Dec22 Jan23 Feb23 Mar23 Apr23 May23 Jun23 Jul23 Aug23 Sep23 Oct23

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
WO24	Pulse Staff Survey: Employee Engagement Score	Green text Amber text Red National Average	Contractual	-	-	-	-	7.10	-	-	7.20	-	-	7.40	-		
			Narrative	There was no quarterly pulse survey this month.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
WO25	Pulse Staff Survey: Advocacy Score	Green text Amber text Red National Average	Contractual	-	-	-	-	7.40	-	-	7.80	-	-	8.00	-		
			Narrative	There was no quarterly pulse survey this month.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
WO26	Pulse Staff Survey: Involvement Score	Green text Amber text Red National Average	Contractual	-	-	-	-	7.00	-	-	7.00	-	-	7.10	-		
			Narrative	There was no quarterly pulse survey this month.													

Data Not Applicable for SPC

Integrated Performance Report (Oct 22 - Sept 23)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Responsible Forum: People Committee

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
WO27	Pulse Staff Survey: Motivation Score	Green text Amber text Red National Average	Contractual	-	-	-	-	6.80	-	-	6.90	-	-	7.10	-		
			Narrative	There was no quarterly pulse survey this month.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	V	A
WO40	Bame Staff Representation	Green ≥8% Amber 6-7.9% Red ≤6%		8.1%	8.2%	8.1%	8.2%	8.2%	8.2%	8.4%	8.3%	8.1%	8.2%	8.1%	8.5%		
			Narrative	The target has been achieved.													

Data Not Applicable for SPC

Metric ID	Metric Name	Target Cumulative	Metric Type	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
WO33	Staff Flu Vaccination: % of Frontline Staff Who Have Been Vaccinated	Green ≥80% Red <80% Ending Feb 2024	CQUIN	-	-	-	-	-	-	37.0%	-	-	-	-	-		
			Narrative	Whilst a monthly target trajectory is shown on the chart, this is purely shown as a monitoring aid; there are no set monthly targets, only the 80% by the end of February 2024. Staff continue to be encouraged to have the vaccine.													

90.0%
72.0%
54.0%
36.0%
18.0%
0.0%
Oct23 Nov23 Dec23 Jan24 Feb24 Mar24

Integrated Performance Report (Oct 22 - Sept 23)

Finance | Responsible Forum: Performance Committee

Metric (£000)	In Mth 7 Actual	In Mth 7 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	149	30	119		308	212	96	
CPL/Propcare Surplus/ (Deficit)	26	0	26		433	0	433	
Control Total Surplus/ (Deficit)	175	30	145		741	212	529	
Trust Cash holding	62,737	63,085	(348)		62,737	63,085	(348)	
Capital Expenditure	996	996	0		1,608	1,608	0	
Agency Cap	176	149	(27)		1,027	1,043	16	

For 2023/24 NHS Cheshire and Mersey ICB are managing the required financial position of each Trust through a whole system approach. The Trust submitted a plan to NHSE/I on 4th May 2023 showing a £363k surplus for 2023/24.

The Trust financial position to month 7 (October 2023) is a surplus of £308k, which is £96k better than plan. The group position is a £741k surplus and is £529k better than plan.

The Trust cash position is £63m, which is slightly below plan by £348k. Capital spend is £1,608k in the year to date, with the majority of capital spend profiled later in the year.

The agency cap has been re-set based on prior year spend and for the year to date the Trust is reporting below the agency cap by £16k.

Trust Board
November 2023

Report author	James Thomson – Director of Finance
Paper prepared by	Jo Bowden – Deputy Director of Finance
Report subject/title	Finance Report – Month 7 2023/24 141-23/24
Purpose of paper	To present the Trust's financial position at the end of October 2023.
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 October 2023, the seventh month of the 2023/24 financial year.

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

2. Summary Financial Performance:

2.1 For October, the key financial headlines are:

Metric (£000)	In Mth 7 Actual	In Mth 7 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG
Trust Surplus/ (Deficit)	149	30	119		308	212	96	
CPL/Propcare Surplus/ (Deficit)	26	0	26		433	0	433	
Control Total Surplus/ (Deficit)	175	30	145		741	212	529	
Trust Cash holding	62,737	63,085	(348)		62,737	63,085	(348)	
Capital Expenditure	996	996	0		1,608	1,608	0	
Agency Cap	176	149	(27)		1,027	1,043	16	

2.2 For 2023/24 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 on 4th May 2023 showing a £363k surplus for 2023/24.

3. Operational Financial Profile – Income and Expenditure

Overall Income and Expenditure Position

3.1 The Trust financial position to the end of October is a £308k surplus, which is £96k above plan. The group is showing a £741k surplus to the end of October, which is £529k above plan.

3.2 The Trust cash position is a closing balance of £62.7m, which is below plan by £0.3m. Capital spend is £996k for the year to date, with the majority of spend profiled in future months.

3.3 The Trust put an agency plan forward as part of the planning submission based on previous year spend, which it will be monitored against for the 2023/24 financial year. To month 7 agency spend is below plan by £16k.

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

	Actual M7	Trust Plan M7	Variance	Actual YTD	YTD Budget	Variance	Plan 23.24
Clinical Income	23,303	22,117	1,186	158,038	154,096	3,942	254,194
Other Income	1,598	2,404	(806)	11,517	12,619	(1,102)	17,600
Total Operating Income	**24,901**	**24,520**	**380**	**169,556**	**166,716**	**2,840**	**271,795**
Total Operating Expenditure	(24,721)	(24,355)	(366)	(168,829)	(165,815)	(3,014)	(269,808)
Operating Surplus	**180**	**166**	**14**	**726**	**900**	**(174)**	**1,987**
PPJV	126	75	51	612	525	87	900
Finance Costs	(157)	(210)	53	(1,030)	(1,213)	183	(2,524)
Trust Surplus/(Deficit)	**149**	**30**	**119**	**308**	**212**	**96**	**363**
Subsidiaries	26	0	26	433	0	433	**0**
Consolidated Surplus/Deficit	**175**	**30**	**145**	**741**	**212**	**529**	**363**

The table below summaries the consolidated financial position:

Nov 2023 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	232	888
Donated Depreciation	(83)	(580)
Trust Retained Surplus / (Deficit)	**149**	**308**
CPL	18	261
Propcare	8	171
Consolidated Financial Position	**175**	**741**

3.5 The bridge below shows the key drivers between the £149k in month Trust surplus and £30k surplus plan, which is a positive variance of £119k:

- As part of the financial plan the Trust has assumed an additional £1.6m of income for activity over and above 2023/24 activity levels. As part of month 7 the Trust has made an assumption that the income will be received as so has included income of £133k.

- Cost and Volume drugs are overspent by £923k and are offset by an increase to income. As part of the 2023/24 funding agreement with commissioners high cost drugs remain on a pass-through basis. Block drugs are overspent by £83k.

- Trust Pay is overspent by £68k, within this is £159k unmet CIP. While the CIP programme is overacheiving overall the Trust is achiving more in non-pay areas and less in pay areas. In terms of run rate the pay position is consistent with previous months and there has been an overall increase of 5.6wte.

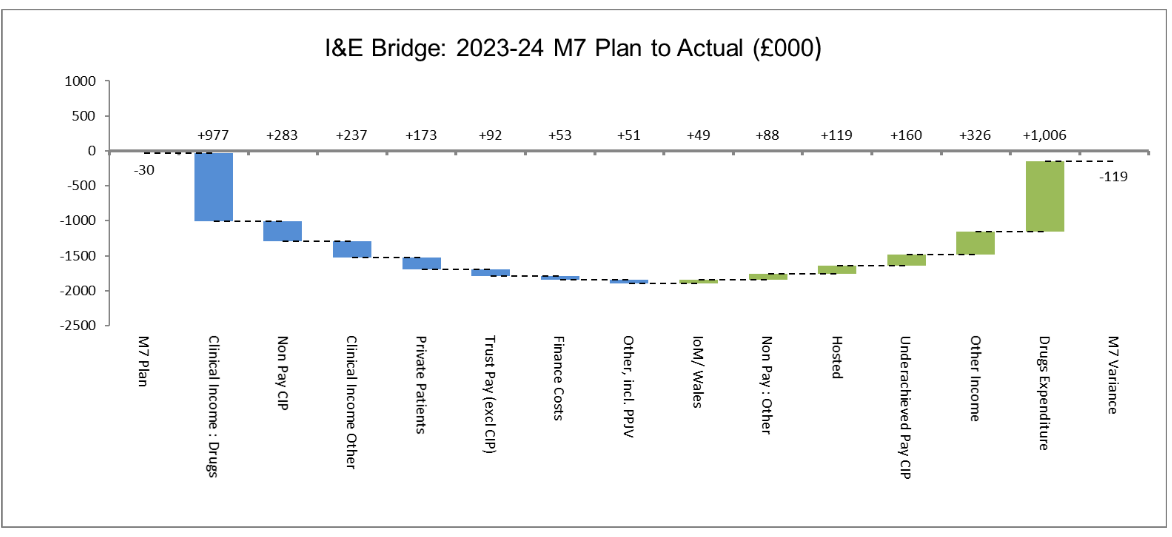
- Bank spend is £182k in month 7, which is £6k higher than month 6. Agency spend is £174k in month, which is consistent with M6. Further details are included in section 3.6 below.

- Non-pay is underspent by £195k. CIP in month is showing as over achieved for non-pay by £283k. The Trust has recognised overperformance in both the Mersey and West Lancshire NHS Trust and LUFT SLA's, due to activity increases aginst baseline. This has not yet been agreed and is under review.

- There has been an increase in income through the private clinic in relation to Welsh patients of £71k in month 7. This is a non-recurrent benefit as related to a specific cohort of patients.

- Interest receivable is over plan by £49k in month 7, this relates to both the increasing level of interest rates and also the delay in paying supliers to maximise cash balances held.

- PPJV profit in month is £51k above plan.



3.6 Bank and Agency Reporting

Bank spend is £182k in month 7, which is £6k higher than month 6. There has been a slight reduction in Acute care, the majority of the increase is within Radiation Services and relates to the new Paddington CDC, these costs are offset with additional income.

Agency spend is £174k in month, which is consistent with M6. There has been a significant reduction in agency use in the Acute Care Division. The Workforce team has also seen a reduction due to the substantive appointment of a Medical Staffing lead. There has been an increase in Radiation Services, of which £58k relates to Paddington CDC, which is offset by additional income. Overall the underlying Trust position has decreased. The Trust is being monitored against last years spend as a baseline and as at month 7 is reporting below plan by £16k.

See Appendix F for further detail.

3.7 Cost Improvement Programme (CIP)

The Trust CIP requirement for 2023/24 is £8.249m, representing 5% of turnover.

Both NHSE and C&M ICB are expecting this to be achieved recurrently.

CIP has been allocated as below:

CIP Target 2023/24	Value £000
Central	3,000
Propcare	730
CPL	168
Unmet Recurrent CIP 22/23	2,558
Divsional	1,793
Total CIP Target	**8,249**

£3m will be met by central corporate schemes, £0.86 has been allocated to the Trust subsidiaries and £4.4m has been allocated to the operational Divisions. Of the £4.4m allocated to Divisions £2.6m is carry forward of unmet recurrent CIP, the new allocation if £1.8m represents 1.3% of budgets.

There has been £7.9m (96%) of the CIP target delivered by the end of October. £4.9m (59%) of these savings are recurrent. This is a significant There are also a further £216k (3%) of schemes with submitted forms and so reporting as amber or green, once approved this will bring the CIP achievement to 99%.

There are a 54 potential schemes at the initial idea stage, while not all have been fully quantified, there is potential of £861k that is currently being worked through to achieve sign off. The Trust is forecasting to achieve the full CIP target, although an element will be through non-recurrent means.

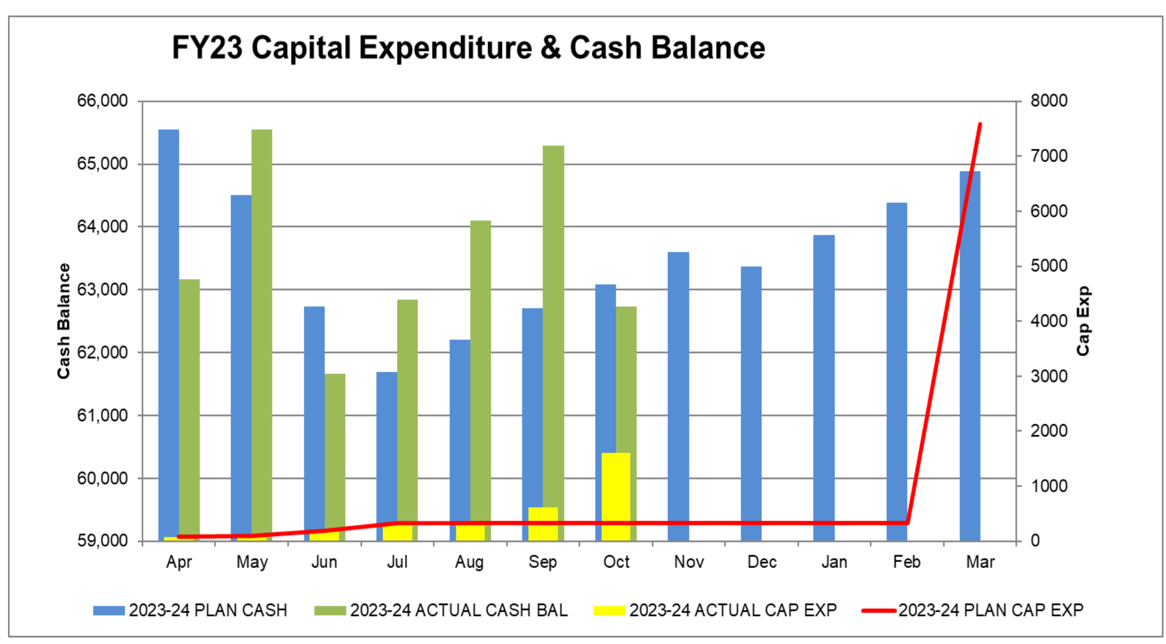
4. Cash and Capital

4.1 The 2023/24 capital plan approved by the Board in March was £7.407m. There was a further £175k of approved adjustments bringing the plan to £7.582m.

4.2 Capital expenditure of £996k has been incurred to the end of October. With the majority of capital spend profiled for future months.

4.1 The capital programme is supported by the organisation's cash position. The Trust has a current cash position of £62.7m. The cash position is below plan by £0.3m. This is made up of the non-receipt of Cancer Alliance and Diagnostics funding from the ICB since April totalling £7m, better cash management by the move to paying suppliers later but within payment terms and lower than expected invoicing from LUFT resulting in accrued expenditure of £4.1m.

4.2 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 2023/24.

5. Balance Sheet Commentary

5.1 Current Assets

The Trust's cash balance at the end of October is £62.7m, this is £0.3m below the plan figure of £63m.
NHS Receivables are £7.2m above plan. This relates predominantly to the income due from the ICB for both the Cancer Alliance and C&M Diagnostics hosted services.

5.2 Current Liabilities

Payables (non-capital creditors) are above plan by £17.6m. The majority of the increase is due to our change in the working capital policy, in order to maximise interest earned on cash balances in the bank.

Deferred Income is £7.9m above plan in month 7. This relates to two main areas, R&I income Cancer Alliance, both of which have a number of multi-year schemes which are ongoing.

Recommendations

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

- The improved Trust and Group financial position.
- The continuing strong liquidity position of the Trust.
- The high level of CIP achieved to date.

Appendix A – Statement of Comprehensive Income (SOCI)

	Month 7			YTD			2023/24 Annual Plan
	Plan	Actual	Variance	Plan	Actual	Variance	
Clinical Income	19,618	21,235	1,617	136,702	144,340	7,638	233,309
Other Income	1,840	1,236	(605)	7,555	6,752	(803)	9,661
Hosted Services	3,062	2,430	(632)	22,459	18,464	(3,995)	28,824
Total Operating Income	**24,520**	**24,901**	**380**	**166,716**	**169,556**	**2,840**	**271,794**
Pay: Trust (excluding Hosted)	(7,433)	(7,501)	(68)	(51,052)	(51,486)	(433)	(84,682)
Pay: Hosted & R&I	(1,322)	(871)	451	(7,467)	(6,220)	1,247	(11,691)
Drugs expenditure	(8,031)	(9,037)	(1,006)	(56,445)	(61,348)	(4,903)	(96,828)
Other non-pay: Trust (excluding Hosted)	(5,738)	(5,543)	195	(35,480)	(37,265)	(1,785)	(58,650)
Non-pay: Hosted	(1,831)	(1,770)	61	(15,371)	(12,511)	2,860	(17,957)
Total Operating Expenditure	**(24,355)**	**(24,721)**	**(366)**	**(165,815)**	**(168,829)**	**(3,014)**	**(269,808)**
Operating Surplus	**166**	**180**	**14**	**900**	**726**	**(174)**	**1,986**
Profit /(Loss) from Joint Venture	75	126	51	525	612	87	900
Interest receivable (+)	589	638	49	4,381	4,501	120	7,066
Interest payable (-)	(434)	(431)	4	(3,041)	(2,978)	63	(5,213)
PDC Dividends payable (-)	(365)	(365)	0	(2,553)	(2,554)	(1)	(4,377)
Trust Retained surplus/(deficit)	**30**	**149**	**119**	**212**	**308**	**96**	**363**
CPL/Propcare	0	26	26	0	433	433	0
Consolidated Surplus/(deficit)	**30**	**175**	**145**	**212**	**741**	**529**	**363**

Appendix B – Balance Sheet

£'000	Audited 2223 (Group Ex Charity)	Plan 2324 (Trust only)	Year to date Month 7		
			YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	6,741	3,486	3,486	6,245	2,759
Property, plant & equipment	201,605	189,187	189,187	196,922	7,734
Right of use assets	11,177	9,947	9,947	11,069	1,122
Investments in associates	1,304	455	455	1,166	711
Other financial assets	1,328	114,324	(0)	0	(114,324)
Trade & other receivables	448	2,382	482	778	(1,604)
Other assets	0	0	0	0	0
Total non-current assets	**222,603**	**319,782**	**203,558**	**216,180**	**12,622**
Current assets					
Inventories	4,175	2,000	4,585	5,681	3,681
Trade & other receivables	0	0	5	0	0
NHS receivables	18,989	5,642	6,362	12,834	7,192
Non-NHS receivables	0	9,299	8,637	11,956	2,657
Cash and cash equivalents	73,591	65,733	71,606	75,859	10,126
Total current assets	**96,754**	**82,675**	**91,196**	**106,331**	**15,134**
Current liabilities					
Trade & other payables	0	0	0	0	**0**
Non-capital creditors	0	23,211	23,331	40,807	17,597
Capital creditors	32,986	2,493	2,493	2,656	162
Borrowings	0	0	0	0	0
Loans	2,233	1,892	1,892	1,941	49
Lease liabilities	0	0	0	357	357
Provisions	2,533	761	1,804	803	43
Other liabilities:-		0	0	0	0
Deferred income	13,531	7,822	7,822	15,791	7,969
Other	0	0	0	0	0
Total current liabilities	**51,283**	**36,179**	**37,342**	**62,355**	**25,013**
Total assets less current liabilities	**268,074**	**366,278**	**257,412**	**260,156**	**(106,123)**
Non-current liabilities					
Trade & other payables	2,189	0	484	0	0
Capital creditors	0	0	0	0	0
Borrowings	0	0	0	0	0
Loans	40,714	28,630	28,630	29,495	865
Lease liabilities	0	8,997	8,997	10,297	1,300
Other liabilities:-	0	0	0	0	0
Deferred income	1,110	972	0	0	(972)
Provisions	273	0	0	1,224	1,224
PropCare liability	0	115,633	0	0	(115,633)
Total non current liabilities	**44,286**	**154,233**	**38,111**	**41,016**	**(113,216)**
Total net assets employed	**223,788**	**212,046**	**219,301**	**219,140**	**7,095**
Financed by (taxpayers' equity)					
Public Dividend Capital	88,793	87,242	87,242	88,793	1,552
Revaluation reserve	7,374	4,558	4,558	7,373	2,815
Income and expenditure reserve	127,621	120,246	127,501	122,974	2,728
Total taxpayers equity	**223,788**	**212,046**	**219,301**	**219,140**	**7,095**

Appendix C – Cash Flow

October 2023-24 (M7) £'000	Plan	Actuals		
	FT	FT	Group	Group (exc Charity)
Cash flows from operating activities:				
Operating surplus	3,032	126	1,094	747
Depreciation	12,440	5,952	5,973	5,973
Amortisation	0	918	918	918
Impairments	0	0	0	0
Movement in Trade Receivables	0	(4,277)	(6,355)	(6,446)
Movement in Other Assets	0	1,764	(0)	(0)
Movement in Inventories	(120)	(1,454)	(1,506)	(1,506)
Movement in Trade Payables	0	6,550	12,345	12,345
Movement in Other Liabilities	0	(613)	1,150	1,150
Movement in Provisions	0	(855)	(779)	(779)
CT paid	(480)	0	(0)	(0)
Impairements /revaluations Annual	0	0	0	0
All other movements in operating cash flows (including working capital movements)	0	0	0	0
Charity funds	0	0	0	0
Net cash used in operating activities	**14,872**	**8,112**	**12,840**	**12,402**
Cash flows from investing activities				
Purchase of PPE	(12,045)	(5,198)	(5,219)	(5,219)
Purchase of Intangibles	0	(426)	(426)	(426)
ROU Assets	0	175	108	108
Proceeds from sale of PPE	0	20	20	20
Interest received	5,626	4,501	1,986	1,981
Investment in associates	0	750	750	750
Cash movement from disposals of business units and s	1,248	0	0	0
Net cash used in investing activities	**(5,171)**	**(178)**	**(2,782)**	**(2,786)**
Cash flows from financing activities				
Public dividend capital received	23	0	0	0
Public dividend capital repaid	0	0	0	0
Loans received	0	0	0	0
Movement in loans	(1,730)	(823)	(823)	(823)
Capital element of finance lease	0	(88)	(35)	(35)
Interest paid	(5,213)	(2,919)	(310)	(310)
Interest element of finance lease- rou	0	(59)	(68)	(68)
PDC dividend paid	(4,377)	(2,554)	(2,554)	(2,554)
Finance lease - capital element repaid	(8)	0	0	0
Net cash used in financing activities	**(11,305)**	**(6,443)**	**(3,790)**	**(3,790)**
Net change in cash	**(1,604)**	**1,491**	**6,269**	**5,825**
Cash b/f	**67,150**	**61,246**	**73,591**	**70,033**
Cash c/f	**65,546**	**62,737**	**79,860**	**75,859**

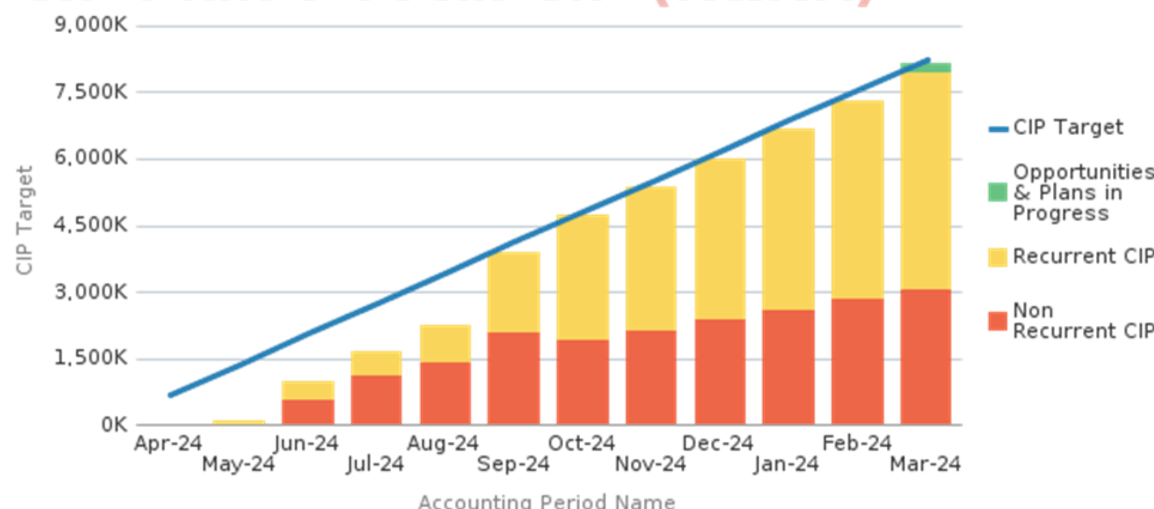
Appendix D – Capital

Capital Programme 2023-24
Month 7

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Code	Scheme	Lead	BUDGET (£'000) NHSI plan 23-24	Approved Adjustments	Budget 23-24	ACTUALS (£'000) Actuals @ Month 7	Variance to Budget	FORECAST (£'000) Forecast 23-24	Variance to Budget	Complete?	Comments
4142	TCC		0	0	0	0	0	(1,902)	1,902	✓	
4401	CCC-L Ward 3 bathroom conversion	Kathryn Williams	32	0	32	0	32	46	(14)	✗	Latest estimate £52k.
4433	CCC-A Estates Work and Rebranding	Emer Scott	0	0	0	17	(17)	17	(17)	✗	
	Wirral site redevelopment	Propcare	200	0	200	0	200	150	50	✗	Consultancy/Design works
	Electric vehicle charging points	Propcare	100	(100)	0	0	0	0	0	✗	CIG Sept - agreed to postpone to 24/25
	CCC-W Propcare Plan:	Propcare	968	(968)	0	0	0	0	0	-	Plan figure now allocated to below schemes
	- Building - external fabric	Propcare	0	24	24	0	24	24	0	✗	
	- Building - internal	Propcare	0	129	129	0	129	129	0	✗	
	- M&E	Propcare	0	261	261	0	261	261	0	✗	
	- Physics building	Propcare	0	800	800	0	800	800	0	✗	Quote received c£860k
	- Fire compartmentation	Propcare	0	100	100	0	100	100	0	✗	Significant unknowns - surveys in progress
	- Tea bar	Propcare	0	40	40	0	40	40	0	✗	
	- Ground floor changing area	Propcare	0	52	52	0	52	52	0	✗	
4468	- Roofing	Propcare	0	1,430	1,430	690	740	1,430	0	✗	Work commenced in August, 20 week plan
4454	CCC-L Level 4 storage room conversion	Propcare	0	16	16	0	16	16	0	✗	
	CCC-A Linac bunker	Louise Bunby	220	0	220	0	220	102	118	✗	Awaiting updated costs from Propcare
4471	CCC-L Winter Garden Refurb	Tom Pharaoh	0	33	33	0	33	33	0	✗	Charity funding approved
	Estates		**1,520**	**1,816**	**3,336**	**708**	**2,628**	**1,297**	**2,039**		
4192	Cyclotron	Carl Rowbottom	0	0	0	0	(0)	280	(280)	✗	Ongoing scheme
4309	Voltage Stabilisers	Martyn Gilmore	0	0	0	0	0	0	0	✗	Installation delayed, in progress
4415	RFID Asset Tracking System	Tony Marsland	0	25	25	19	6	25	0	✗	Tony confirmed arrived and configured
4451	CCC-A Linac	Louise Bunby	2,460	(82)	2,378	0	2,378	2,378	0	✗	Provisional delivery date 1 March 2024
4457	Vaginal CT/MR Multi Channel Applicator	Chris Lee	30	(2)	28	28	0	28	0	✗	Requisition submitted 7th August
4470	Radionuclide calibrator	Louise Bunby	10	0	10	0	10	10	0	✗	Business case approved CIG 31/10
4469	2D array x2	Louise Bunby	80	0	80	0	80	45	35	✗	Bus' case approved CIG 31/10. Req 3/11.
4456	Concealement trolley	Mel Warwick	17	1	18	18	(0)	18	(0)	✗	Receipted in July, awaiting invoice
4448	BMT Sharepoint App	Priscilla Hetherington	0	11	11	9	2	11	0	✗	In development
4449	Whole body phantom	?	0	0	0	33	(33)	33	(33)	✓	Moved from revenue
4450	Flojack flat lifting kits	Pauline Pilkington	0	35	35	34	1	34	1	✓	Receipted and invoiced
4455	Cyclotron X-Ray panels	Stephen Elmer	0	0	0	26	(26)	26	(26)	✓	Moved from revenue
4458	Ultrasound Phantom	Marc Rea	0	5	5	5	0	5	0	✗	Urgent replacement part, order 15 August
4459	CCC-L Document Scanner	Lynne Benson	0	29	29	24	5	29	0	✗	Requsition 27 September
4467	Cyclotron capacitors	Matt Temple	0	22	22	0	22	22	0	✗	Urgent replacement parts
	Medical Equipment		**2,597**	**43**	**2,640**	**197**	**2,443**	**2,944**	**(304)**		
4138	Infrastructure	James Crowther	0	0	0	(2)	2	(2)	2	✓	Minor correction on prior year scheme
4422	DDCP 22-23	James Crowther	0	0	0	(11)	11	(11)	11	✓	VAT recovery on prior year scheme
4423	Rapid7 Vulnerability Manager	James Crowther	0	0	0	(19)	19	(19)	19	✓	VAT recovery on prior year scheme
4427	Cyber Capital Access Management	James Crowther	0	0	0	0	0	0	0	✗	New PDC funded scheme
4405	Website	Emer Scott	100	0	100	20	80	100	0	✗	
4452	Patient Flow, Digital Literacy and Capability	James Crowther	475	0	475	96	379	475	0	✗	
4461	PatientHealth	James Crowther	400	0	400	330	70	400	0	✗	
4462	DigiFlow	James Crowther	190	0	190	0	190	190	0	✗	
4463	Patient Education Programme	James Crowther	250	0	250	0	250	250	0	✗	
4464	PoC Medical Device Integration	James Crowther	250	0	250	0	250	250	0	✗	
4465	HealthData	James Crowther	400	0	400	0	400	400	0	✗	
4466	EPMA Stock Control & Pharmacy RPA	James Crowther	419	181	600	0	600	600	0	✗	
	DDCP (PDC Funded)	James Crowther	23	0	23	0	23	23	0	✗	
	Digital		**2,507**	**181**	**2,688**	**415**	**2,273**	**2,656**	**32**		
4421	Paddington CDC - costs (PDC funded)		0	175	175	175	0	175	0	✗	
4421	Paddington CDC - costs		0	0	0	9	(9)	45	(45)	✗	Forecast excess over PDC funded costs
4435	Paddington CDC - CT Scanner		0	0	0	(25)	25	(25)	25	✗	Final enabling cost TBC, forecast u/spend
4453	Pharmacy - VHP commissioning	Tori Young	350	0	350	42	308	350	0	✗	Work to commence around Sept-Nov
4460	Pharmacy - Automated Medicines Cabinets	Tori Young	300	(18)	282	0	282	282	0	✗	Requsition 27 September
	Pharmacy - Prescriptions/medicines tracker	Tori Young	50	0	50	0	50	50	0	✗	
	IFRS16 - Pharmacy vehicles		28	0	28	28	0	28	0	✗	
	IFRS16 - Portakabins		55	5	60	60	0	60	0	✗	
	Other		**783**	**162**	**945**	**289**	**656**	**965**	**(20)**		
	Contingency		**0**	**(1,988)**	**(1,988)**		**(1,988)**	**(242)**	**(1,746)**		
	TOTAL		**7,407**	**213**	**7,620**	**1,608**	**6,011**	**7,620**	**0**		

Appendix E – Cost Improvement Programme



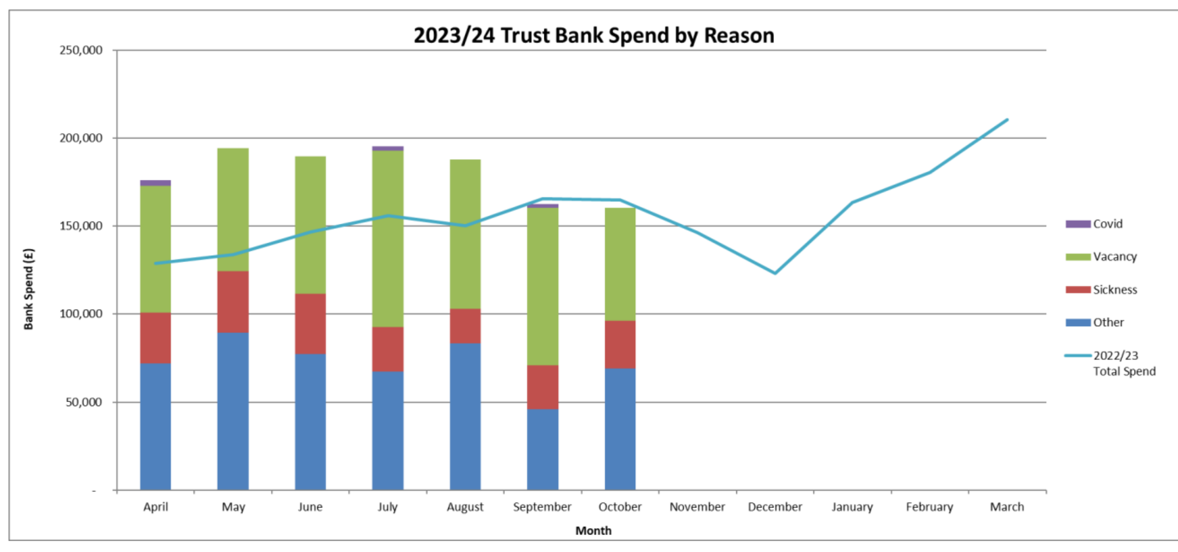
Divisional CIP Against Full Year Plan

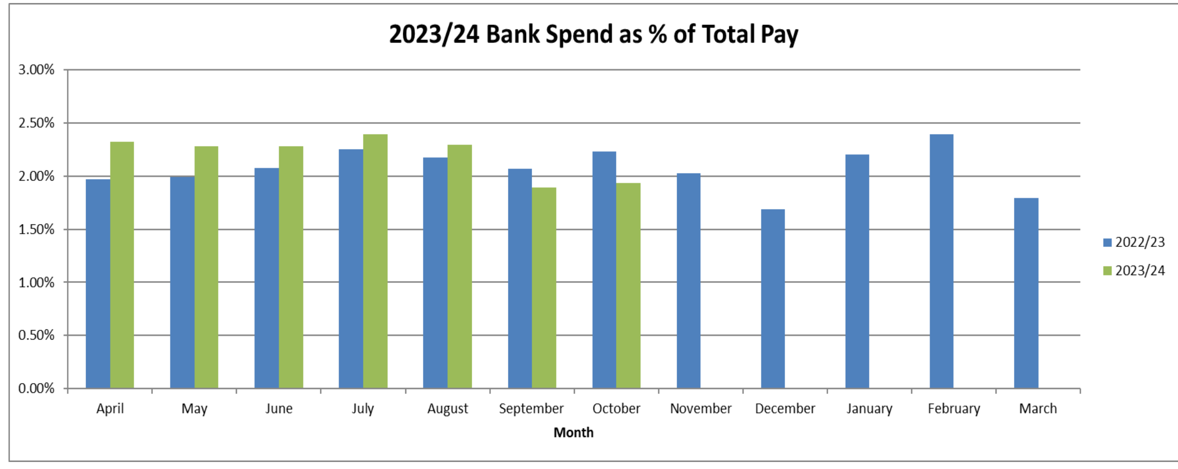
Division	Target	Total CIP Delivered	Variance	Delivery % to date	Recurrent CIP Delivered	Opportunities & Plans in Progress	Total Forecast CIP
CENTRAL CIP	3,898,000	4,870,482	972,482	125%	2,693,296	40,125	4,910,607
NETWORKED SERVICES	1,368,777	320,632	(1,048,145)	23%	192,784	97,000	417,632
ACUTE CARE	980,125	986,589	6,464	101%	686,863	60,000	1,046,589
RADIATION SERVICES	1,013,426	1,017,839	4,413	100%	579,365	0	1,017,839
CORPORATE	988,672	743,082	(245,590)	75%	735,732	19,491	762,573
Total	**8,249,000**	**7,938,624**	**(310,376)**	**96%**	**4,888,040**	**216,616**	**8,155,240**

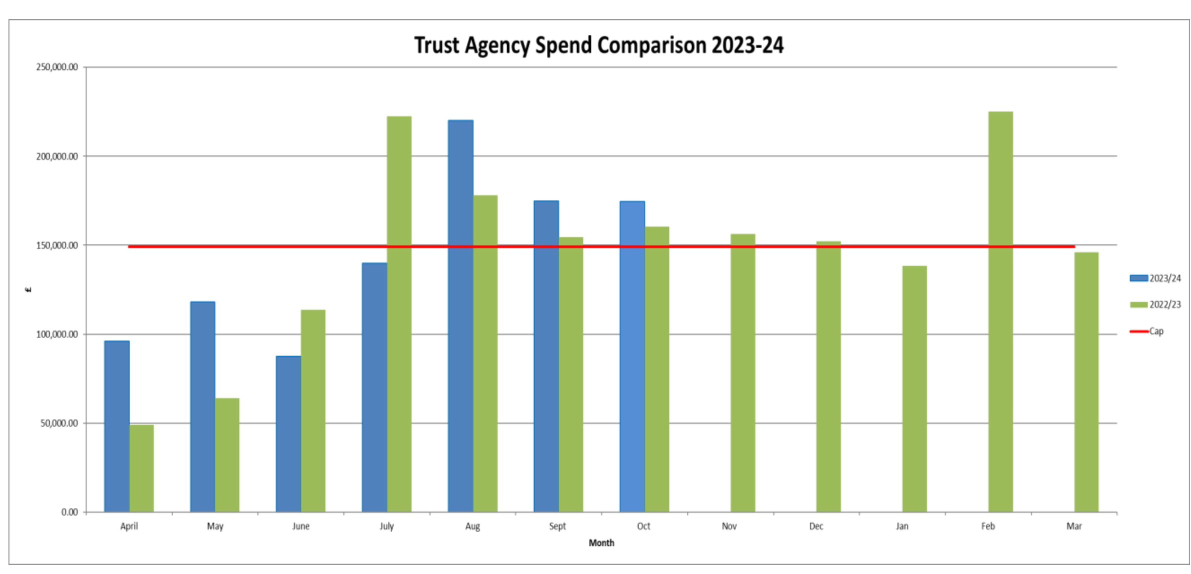
Full Year Plan (Recurrent & Non-Recurrent Split)

	Target	Total CIP Delivered	Variance	Delivery % to date	Recurrent CIP Delivered	Opportunities & Plans in Progress	Total Forecast CIP
Recurrent	8,249,000	4,888,040	(3,360,960)	**59%**	4,888,040	126,491	5,014,531
Non-Recurrent	0	3,050,584	3,050,584		0	90,125	3,140,709
Total	**8,249,000**	**7,938,624**	**(310,376)**	**59%**	**4,888,040**	**216,616**	**8,155,240**

Appendix F – Bank and Agency







Title of meeting: Trust Board

Date of meeting: 29nd November 2023

Report author	Joan Spencer			
Paper prepared by	Joan Spencer / Ken Jones			
Report subject/title	Emergency Preparedness Resilience Response (EPRR) Annual Assurance Process Outcome 2023			
Purpose of paper	To update on the outcomes of the EPRR Annual Assurance Process for 2023; to put findings into context and to outline the way forward to improve compliance.			
Background papers	Not applicable			
Action required	To note key activities and changes to the assessment process, accept the new compliance position and sign off the statement of compliance to enable submission to NHSE before 31st Dec 2023.			
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	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		

Ref: FCGOREPO
Review: July 2025
Version: 2.0

EPRR Annual Assurance Process Outcomes 2023

Introduction

The NHS Core Standards for Emergency Preparedness Resilience and Response (EPRR) set out the minimum requirements expected of providers of NHS funded services in respect of EPRR. All NHS organisations are assessed against these standards on an annual basis.

During 2022 NHSE piloted a new and more stringent approach to the assessment process in the Midlands region and this resulted in a significant change in compliance for many Trusts.

On the 27th July 2023 NHSE announced that the new process would be applied to Trusts across Cheshire and Merseyside for the 2023 submission. Further adjustments were also made to the standards on the 1st August 2023. The new compliance requirements stated for each standard were markedly more detailed and amounted to an increase in the compliance threshold.

Results and Analysis

Fifty Nine of the sixty two revised core standards were applicable to The Clatterbridge Cancer Centre.

As a direct consequence of the late introduction of the new assessment process the Trust was limited in its ability to make the adjustments required to maintain compliance. It is also important to note that given the significance of the changes it is not helpful to compare this year's compliance rating with the last.

Following a highly intensive effort and a number of communications with the NHSE EPRR Team it concluded in an agreement that the Trusts compliance position is as follows;

- There are **no** non-compliances
- Fully compliant against 10 core standards
- Partially compliant against 49 core standards.

Full details of compliance against each standard can be found in Appendix 1.

NHSE categorise compliance against the following scoring system

Overall EPRR assurance rating: Fully- The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards

Overall EPRR assurance rating: Substantial - The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards

Overall EPRR assurance rating: Partial - The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards

Overall EPRR assurance rating: Non-compliant- The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

The calculation applied to confirm an organisations over all position does not account for any partial compliances, consequently the Trusts over all compliance is rated at **17% - Non Complaint**.

The table below provides an analysis of compliance against the ten sub categories of the Core Standards

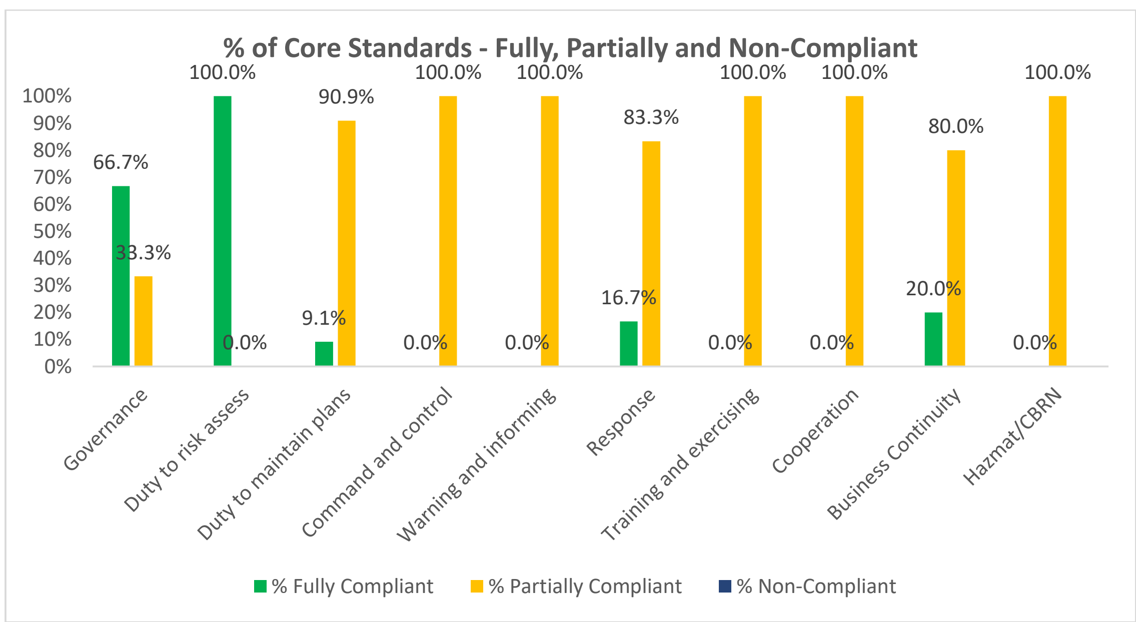


Figure 1: Compliance Analysis

By way of context for these findings:

- A universal drop in rating appears to have taken place across the region. This is referred to in the NHSE Core Standards Overview for Boards (Appendix 2).

Ref: FCGOREPO
Review: July 2025
Version: 2.0

- The Clatterbridge Cancer Centre's rating is not, as we understand, at the lower end of the revised ratings
- We were commended by NHSE for our EPRR governance system.

Moreover, Trust preparedness is not completely correlated with findings in that:

- Lack of full compliance can be due to administrative detail (noting that the EPRR & Business Continuity Management is progressively addressing such points)
- Compliance does not fully assure incident mitigation, preparedness and response given a general requirement cannot apply to the individual circumstances of each Trust.

Conclusions/Concerns

The EPRR function recognises that there is scope for improvement across the domain. As such, the benefits of a more rigorous standard and compliance assessment approach is welcomed and was recognised in correspondence between the Accountable Emergency Officer (AEO) for the Trust and NHS England.

However, the correspondence and CCCs contribution to the development of the overview for boards has highlighted a number of concerns:

- Firstly, recognition that given a different standard, a different score does not mean our preparedness and response capability has suddenly dropped. This is evidenced by an excellent recent track record in incident response during the pandemic, industrial action, the provision of mutual aid and local power and technology outages

- EPRR Core Standards construction, the assessment process and compliance guidelines are still undergoing changes and are therefore not optimal and clear.

- The NHSE improvement and engagement strategy to support organisations with compliance is to be confirmed.

- There are budgetary implications for compliance against the revised standards.

Road Map and Work Plan - Next Steps

To deliver an enhanced compliance position and improve the Trusts EPRR and Business Continuity plans the Trusts EPRR function has developed a road map/work plan (illustrated at Figure 2 and provided in greater detail at Appendix 3 to this document). The plan will enable;

- Implementation of a best practice, combined EPRR and Business Continuity Management system
- Use of the management system to enable improvement in policy, incident response plans and their enabling training, exercising and asset management capabilities
- Concise feedback on progress quarterly to the Performance Committee via the EPRR Quarterly Report.

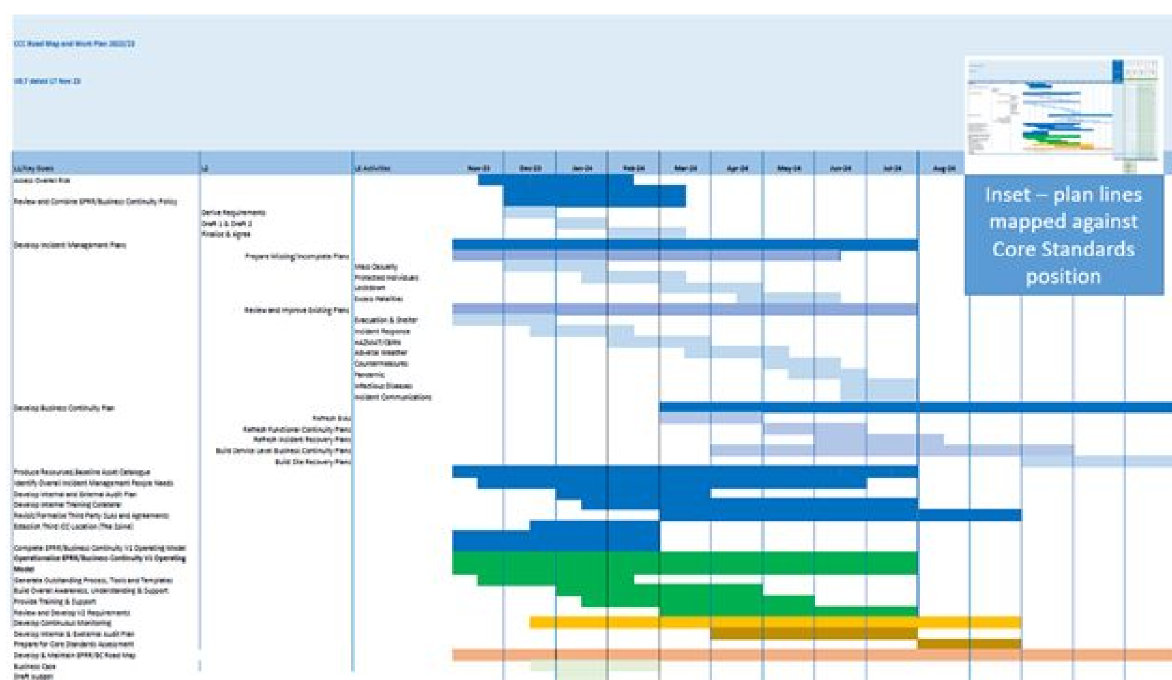


Figure 2: Road Map/Work Plan for 2023/24

Recommendations

It is recommended that the Trust Board;

- Accepts the outcomes of the 2023 Assurance Process and signs off the statement of compliance to enable submission to NHSE before 31st Dec 2023.
- Recognises that the changed standard does not mean our preparedness and response position is worsened.
- Recognises the progress made so far as evidenced by verbal statements on the strength of our EPRR governance.
- Notes the Trusts track record of managing incidents and business continuity issues.
- Endorses the proposed approach and progress reporting arrangements.

To:
Joan Spencer
Accountable Emergency Officer (AEO)
The Clatterbridge Centre

Date: 7th November 2023

Dear Joan,

As you will be aware NHS England is responsible for gaining assurance on the preparedness of the NHS to respond to incidents and emergencies, whilst maintaining the ability to remain resilient and continue to deliver critical services.

This is achieved through the EPRR Annual Assurance process, and for 2023/24 we described how we would further enhance our assurance arrangements using the EPRR Core Standards, by introducing an evidence-based check and challenge process, whereby organisations would be required to submit evidence which supported their self-assessment.

Check & Challenge findings.

For the 2023/24 period, your organisation submitted a provisional self-assessment of –

Self-Assessment assurance rating	Partially	Percentage compliance	86%
Core standard position after organisation self-assessment			
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
59	51	8	0

Colleagues from the North West have now completed a full review of evidence submitted through both primary and supplementary submission periods.

Following completion of the check and challenge process, and review of any supplementary evidence we have identified the following proposed assurance position –

Core standard position recommendation after check and challenge process			
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
59	10	49	0

The final findings of the check and challenge review, along with the rationale and specifics of any challenges raised, are detailed within this letter, and subsequently

confirms whether the check and challenge team "accept" or "challenges" your organisations provisional self-assessment.

Final Assurance position

Upon receipt of this letter, Accountable Emergency Officers are requested to re-assess their self-assessment scoring based on feedback and any residual challenges. A copy of their final self-assessment and statement of compliance should be returned to your ICB and copied to the regional team (england.eprrnw@nhs.net) within 10 days of receipt of this letter.

For your organisation this means that your final submission self-assessment and annual statement of compliance should be received by close of play on 16th November 2023.

Governance via Local Health Resilience Partnerships

Once your final self-assessment and statement of compliance has been completed, these are required to be signed off by your Board by 31st December 2023.

Your ICB will liaise with you to agree a schedule for Local Health Resilience Partnership (LHRP) meetings, where the normal schedule of confirm and challenge sessions will take place.

At these sessions each organisation will be required to outline their overall compliance level and an action plan for any partially or non-compliant standards.

Where an agreement has not been reached in support of an assurance rating, or where an organisation chooses to submit a higher level of assurance than has been identified through the check and challenge review, a strong rationale must be discussed with peers and their lead ICB as part of the LHRP session, and ahead of a final assurance discussion at the Regional Health Resilience Partnership (RHRP).

Continuous Improvement Cycle - Governance

As with previous years, organisations will be required to provide updates against their EPRR Assurance action plans through their LHRP. The schedule for these updates is linked to the final level of compliance reported by the organisation and in line with our revised approach, the ongoing governance for continuous improvement will require ICBs to review evidence submitted against the organisation's assurance action plan as part of this process –

- Fully compliant – formal updates annually, with any changes or reduction in compliance reported 6 monthly.
- Substantially compliant – formal updates against action plan every 6 months.
- Partially compliant – formal updates against action plan every 3 months.

- Non-compliant - formal updates against action plan every 3 months, and monthly progress discussions to take place between the provider and their lead ICB.

Continuous Improvement Cycle – Collaborative Working

We recognise and understand the significance of undertaking the evidence-based review process this year, and the demands and challenges this has placed across the system.

We will be looking to schedule debrief sessions for AEO's and EP leads following completion of the assurance process in order to –

- Identify what elements worked well and could be used in future assurance processes or as part of continuous improvement throughout the year.
- Identify what elements need improvement and require further review and amendment ahead of next year's assurance cycle.
- Identify areas of good practice which can be shared across the system in order to improve our collective resilience and
- Identify where there are consistent themes and trends across domains and services to explore opportunities for collaborative work to enhance collective resilience and reduce burdens on individual agencies.

We hope that colleagues have found the process a useful opportunity to reflect on areas which would further enhance their organisations own preparedness, as well as opportunities to work collaboratively with partners to address common areas of concern.

Finally, we want to again take the opportunity to thank you, and your EPRR lead(s), not only for your engagement in the amended assurance process, but in your support through another challenging year in the world of resilience, and amidst a backdrop of a number of concurrent issues and incidents, not least the prolonged planning and response to the ongoing industrial action.

Kind Regards

Paul Dickens
Regional Head of EPRR for the North East & Yorkshire and North West Regions
NHS England

Cc Anthony Middleton, AEO, Cheshire & Merseyside Integrated Care Board
Beth Warburton, Head of EPRR, Cheshire & Merseyside Integrated Care Board
Ken Jones, EPRR Lead, The Clatterbridge Centre

Appendix 1 – Organisations summary sheet

Organisation name	The Clatterbridge Centre	2022/23 Assurance Rating (and % compliance)	Partially – 77%
Initial self-assessment rating (2023/24)	Partially	If the organisations accept the challenges identified in the check & challenge process their compliance rating would be -	Non-Complaint
Initial self-assessment percentage compliance	86%	Check & challenge percentage compliance	17% — Variance (-) – 69%

CS	Domain	Standard	Detail of standard	Self-assessment rating	Check & Challenges rating	Accepted or challenged	Comments
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	G	G	Accepted	
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	G	A	Challenged	
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	G	G	Accepted	

4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	G	A	Challenged	Work programme finished in June 2023 plans described include challenges as not being compliant with national guidance which need to be picked up as part of review cycle
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	G	G	Challenged	Resource not in place
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	G	G	Accepted	
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	G	G	Accepted	
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	G	G	Accepted	
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	G	G	Accepted	
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	G	A	Challenged	

11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	G	A	Challenged	
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	G	A	Challenged	
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	G	A	Challenged	
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	G	A	Challenged	
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	G	A	Challenged	Evidence provided is for mass fatalities - casualties will be distributed to ensure optimum clinical outcomes for which the trust has provided no evidence
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	G	A	Challenged	
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	G	A	Challenged	Evidence provided shows a checklist for the ICC
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	A	A	Accepted	

19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	G	A	Challenged	
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	G	A	Challenged	Plan needs to be updated
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	G	A	Challenged	TNA does not set out the training burden in terms of how many staff are required to be trained
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	G	A	Challenged	TNA does not set out the training burden in terms of how many staff are required to be trained
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	G	A	Challenged	Evidence shows a process however does not provide documentation of any post exercise reports, evidence of attendance of staff or aims and objectives clearly set out that link back to defined risks
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	G	A	Challenged	(Evidence reviewed from Standard 25 folder) Evidence appears to demonstrate system which is in place that will evidence training however no actual evidence of personal portfolios in line with MOS and NOS
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	G	A	Challenged	Same evidence applied as per 24 (assumed mis uploaded into wrong folder as no evidence stating 25)

26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	G	A	Challenged	Plan provided which was updated in September 2023 is out of date - incident levels are describing an old operating model, NHS England Area Teams still referred to (2017 model)
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	G	A	Challenged	
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	G	A	Challenged	Evidence provided is a ? draft plan framework and not evidenced that is signed off in line with governance
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	G	A	Challenged	The evidence provided does not address the challenges set out in the primary evidence review

30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	G	A	Challenged	Evidence provides a SitRep template however does not address specific elements raised at primary review. The plan also has incorrect information regarding MACA - this should be early engagement with NHS England Regional team - AL NHS MACA requests need to be signed off by the Regional EPRR lead or delegated Deputy in their absence.
31	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	G	G	Accepted	Accepted - the lack of clarity regard **OR** has been flagged to national colleagues however this is clearly set out as a requirement in CC27 as **BOTH** electronically and local copies
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	A	A	Accepted	
34	**Warning and informing**	**Incident Communicati on Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	G	A	Challenged	Access to 24/7 appears to be on a 'best endeavours' basis rather than a service which provides 24/7 365 on call - no evidence of any rotas
35	**Warning and informing**	**Communicati on with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	G	A	Challenged	As per 34 - note The EPRR Comms Strategy states POLICY in line with ISO 22301 Policies should have an annual review date not 3 yearly
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	G	A	Challenged	
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	G	A	Challenged	Evidence needs to be clear that deputies for the AEO must be director level with delegated authority. Evidence does not provide 75% compliance attendance at LHRP
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	G	A	Challenged	

39	Cooperation	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	G	A	Challenged	
43	Cooperation	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	G	A	Challenged	
44	Business Continuity	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	G	A	Challenged	No evidence of policy being signed off by board.
45	Business Continuity	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	A	A	Accepted	
46	Business Continuity	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	G	A	Challenged	
47	Business Continuity	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises	G	A	Challenged	

			• suppliers and contractors • IT and infrastructure				
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	G	A	Challenged	
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	G	G	Accepted	
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	G	G	Accepted	
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	G	A	Challenged	
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	G	A	Challenged	Evidence provided is a JD not evidence of process
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	G	A	Challenged	
55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning	A	A	Accepted	

			- Training - Equipment checks and maintenance Which should be clearly documented				
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	G	A	Challenged	
57	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	G	A	Challenged	Evidence provide clarifies and has required details however this appears to be a DRAFT plan it contains no approval, review date. Classification is not in line with HMG classification requirements: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1166697/Procurement_Policy_Note_-_Government_Security_Classifications_Policy.pdf Document still makes reference to PHE even with a version date of 26/09/23
58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	A	A	Accepted	
60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx	G	A	Challenged	

			• Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf				
61	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	G	A	Challenged	
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	A	A	Accepted	

64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	A	A	Accepted	
65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safety undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	G	A	Challenged	
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	A	A	Accepted	

Classification: Official-Sensitive

NHS England EPRR Core Standards Overview for Boards

Applicable to – NHS organisations in the North East & Yorkshire and North West regions

Content – Overview of changes to the NHS England EPRR Core Standards assurance process in the North East & Yorkshire and North West for the 2023/24 assurance cycle

Version – 1.0 FINAL November 2023

Contact – england.eprrney@nhs.net or england.eprrnw@nhs.net

Publication reference: NEY&NWEPRRAssurance2023

The rationale for change

Over recent years the Emergency Preparedness Resilience & Response (EPRR) world has seen both significant disruption and major change – from our exit from the European Union to the COVID-19 pandemic, Manchester Arena attack, and the recent series of industrial action. The demands on Accountable Emergency Officers, EPRR professionals and Boards in ensuring robust, resilient systems for patients and communities, has never been greater.

In the wake of lessons identified from recent incidents and a number of public inquiries (Manchester Arena, Grenfell & the ongoing COVID-19 inquiry – as well as the recent verdict in the Letby trial and the announcement of the Thirlwall Inquiry), it is clear that the standard which organisations must achieve, and the burden of proof in regard to robust governance, proactive planning and tried & tested plans is one which requires a dedicated assurance framework which can ensure our collective system resilience

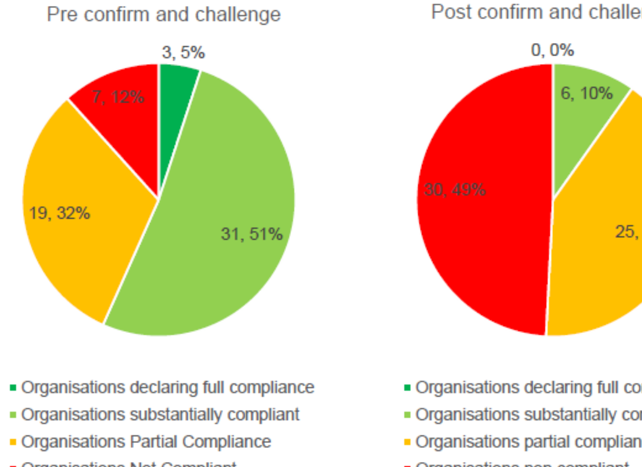
The 2023/24 EPRR Assurance model

In 2022, colleagues in the Midlands Region undertook an amended EPRR assurance process. This pilot, involved a new and detailed analysis of compliance evidence against each core standard, alongside the organisations self-assessment.

This model required commissioners and providers of NHS commissioned care to submit evidence, which went through a formal review and subsequent check and challenge, whereby they were given the opportunity to submit supplementary evidence against any challenges before finalising their assurance position.

The Midlands results, as detailed in the diagrams below, clearly demonstrated that despite the efforts of organisations in delivering their EPRR responsibilities, there were substantial differences between the self-assessment results and the evidential review of the organisations documentation.

Levels pre and post confirm and challenge



The position before and after the confirm and challenge shows the value in this step of the process in assuring the wider NHS of the positions being self reported.

NHS England recognises several organisations were already very open with the positions they had with 5 organisations not moving in position.

The highlighting of issues assists the whole of the system manage and improve.

The maximum of accepted challenges to an organisational assessment was 30 standards.

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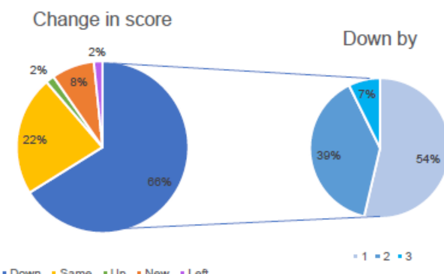
Change from 2021/22

Breaking down the change into positive or reduced positions.

- 8% of organisations had a first assessment
- 2% increased in position
- 22% remained in the same assessment position
- 66% decreased on the previous assessment, of these:
    - 7% dropped three compliance levels (full to non compliance)
    - 39% dropped two compliance levels (full to partial or Sub to non)
    - 54% dropped one compliance level (Full to Sub, Sub to partial or Partial to Non)



The changes in assurance levels indicated that there were areas of collective and individual action which would improve resilience at both an organisational and system level for patients and communities. This enabled Midlands colleagues to identify areas for collaborative working in delivering key actions associated with their resilience.

Implementation of the same model within the North East & Yorkshire and North West regions was agreed with the intention to undertake an open, honest and transparent, review of evidence associated with the core standards in order to assess evidential compliance with the objective of improving our collective resilience for patients and communities.

NHS England worked with ICB colleagues through the summer to provide guidance and clarity on the assessment requirements and highlighted that it was likely we may see the same compliance shift that Midlands colleagues had seen in 2022.

Introducing this model in the regions was about establishing a baseline compliance level – a hard reset of our readiness following protracted periods of response and in order to identify greater opportunities for collaboration and system improvement.

The way forward

Following completion of the evidence reviews, provider organisations will undertake a check & challenge via their Local Health Resilience Partnership (LHRP), this will give an opportunity for peer discussion and for ICBs to seek assurance ahead of their own system level check & challenge via the Regional Health Resilience Partnership (RHRP).

Organisations will be required to participate in ongoing assurance against their action plans, this will follow pre-existing arrangements that are well established across both regions –

- **Fully compliant** – formal updates annually, with any changes or reduction in compliance reported 6 monthly.
- **Substantially compliant** – formal updates against action plans every 6 months.
- **Partially compliant** – formal updates against action plan every 3 months.
- **Non-compliant** - formal updates against action plan every 3 months, and monthly progress discussions to take place between the provider and their lead ICB.

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The intention of the revised process is absolutely intended to be constructive, and to allow organisations to reflect on the robustness of the plans they have in place, what more they could or should be doing to improve their resilience, and to demonstrate that position to their Boards.

The collective focus over the coming months, will be to identify common themes and the NHS England EPRR teams will continue to proactively support opportunities to collaboratively address areas for improvement in order to enhance system preparedness, patient outcomes, and opportunities to share best and notable practice. This will deliver greater resilience at provider level, for place based systems and across the regions, with greater interoperability and opportunities to undertake collective planning.

It is recognised that the change in process has come at a very difficult time for EPRR professionals across organisations given the competing pressures, and that Boards may be concerned by the reduction in compliance ratings. However, it is important to note that this does not signal a material change or deterioration in preparedness but should be considered as a revised and more rigorous baseline in which to improve plans for preparedness, response and recovery.

Following completion of this years process, it is important to take time to come together and reflect on the lessons identified through this process. This will enable opportunities to collectively provide greater guidance to colleagues where questions have been raised (e.g. annual review of plans and policies), ensure that areas which have worked well in this process are embedded in future years, and to identify improvements in the assurance process ahead of next year’s assurance cycle.

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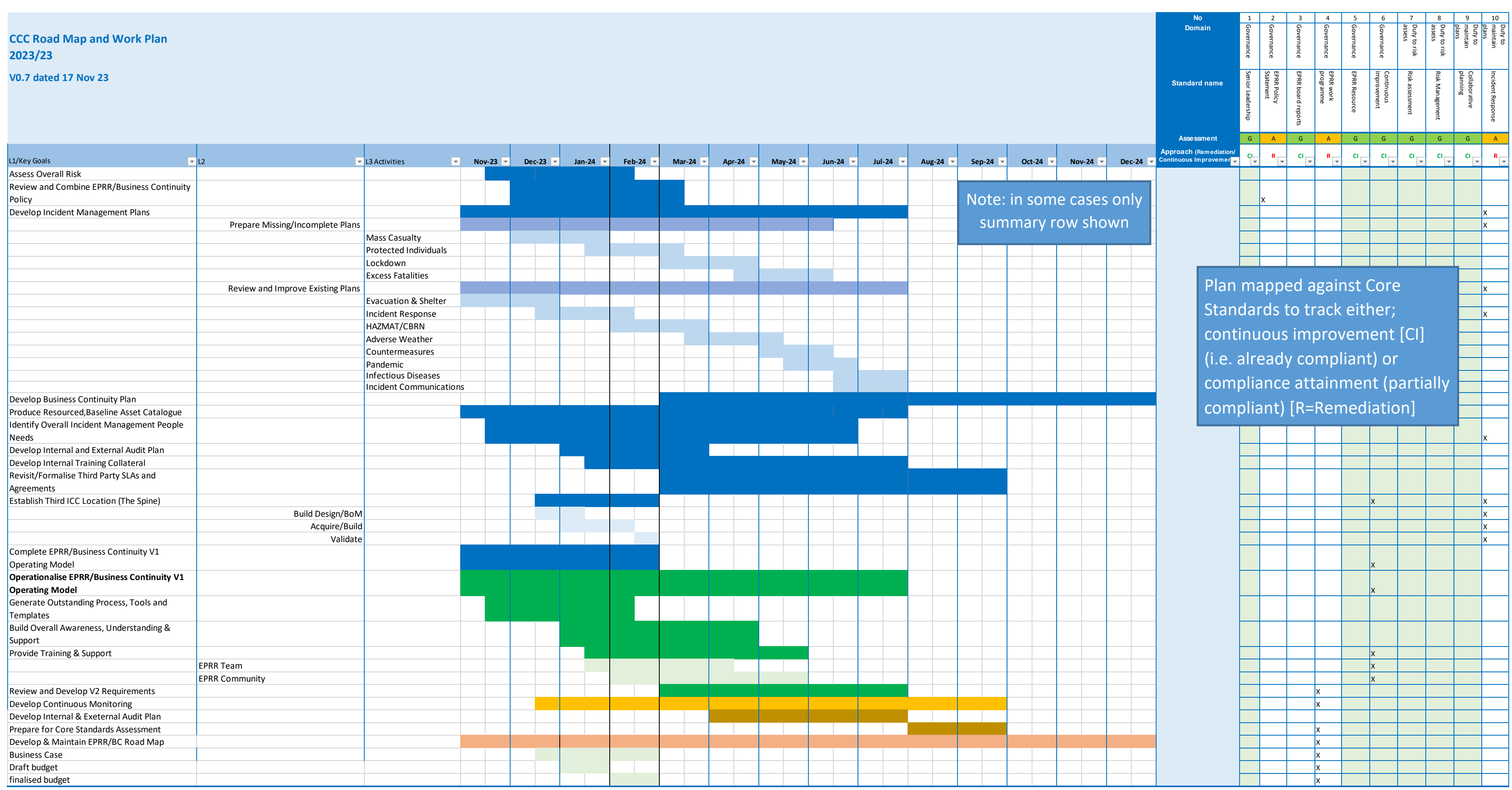
APPENDIX 3 TO
SUPPORT PAPER EPRR CORE STANDARDS ASSESSMENT
DATED 23 NOV 23

EPRR ROAD MAP SUMMARY 2023/24



Title of meeting: Trust Board
Date of meeting: 29th November 2023

Report Lead	Joan Spencer, Chief Operating Officer			
Paper prepared by	Ken Jones Interim EPRR Manager			
Report subject/title	Emergency Preparedness, Resilience & Response (EPRR) Annual Report April 2022 – March 2023			
Purpose of paper	This report details the work of the Trust EPRR Team from April 2022 to March 2023 to ensure the Trust is able to meet its statutory obligations as an NHS Category 1 responder.			
Background papers	Not Applicable			
Action required	To note key activities and approve recommendations for 23-24			
Link to:	Be Outstanding	X	Be a great place to work	
Strategic Direction	Be Collaborative		Be Digital	
Corporate Objectives	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		

The Clatterbridge Cancer Centre NHS Foundation Trust

Annual Report for Emergency Preparedness, Resilience & Response (EPRR) 2022-23

Ken Jones, EPRR Manager (Interim)

May 2023

1. Introduction

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a terrorist attack.

The Civil Contingencies Act 2004 (CCA 2004) specifies that responders to such incidents must be classified as either Category 1 - (Primary Responders) or Category 2 (Responders Supporting Agencies). The Clatterbridge Cancer Centre is a Category 1 Responder and has a statutory and moral obligation to be prepared to respond to major incidents and have appropriate plans in place.

In addition, the Health & Social Care Act places a duty on Category 1 organisations to have in place a Director of Emergency Preparedness, Resilience & Response (EPRR) who is known as the Accountable Emergency Officer (AEO). At The Clatterbridge Cancer Centre (CCC) this role is fulfilled by the Chief Operating Officer.

Support to this role is provided by the Emergency Planning Officer (EPO) who operates at practitioner level and attends meetings of the Practitioners Sub-Group in Cheshire or Merseyside, subject to operational requirements. At The Clatterbridge Cancer Centre this role was fulfilled by the Health & Safety Adviser/EPO until July 2022 and details of the change in role can be found in section 3.

The Trust must also have an identified location for an Incident Coordination Centre (ICC) and a backup ICC location. At The Clatterbridge Cancer Centre locations have been identified on both the Liverpool and Wirral sites.

2. Annual Work Plan

The Trust has in place an EPRR Annual Work Plan that is monitored through the EPRR Committee. The plan details key review dates and tasks for the upcoming year. In Q2 2022-23, the Annual Work Plan was updated to align with the reporting year April to March and is closely link to the Annual EPRR Core Standards. Compliance against these standards has been reported in the EPRR quarterly reports.
A copy of the 2022-23 Annual Work Plan can be viewed in Appendix 1.

3. Key Activities

- The H&S Advisor/EPO post became vacant in July 2022; immediate cover for the role was provided by the Head of Risk & Compliance whilst a recruitment campaign took place. Recruitment did not result in an appropriate or suitable candidate, consequently a review of the job description was undertaken, and a decision made to create two new posts; H&S Advisor and EPO, to provide clarity and appropriate focus. An interim EPRR Manager was appointed in April 2023 and recruitment to the substantive post is currently underway.

- In Q2 2022-23, the Annual Work Plan was updated to align with the reporting year – April to March and is closely linked to the Annual EPRR Core Standards.

Compliance against these standards has been reported in the quarterly reports and a focused piece of work is underway to develop a structured compliance methodology to ensure an improved position for the peer review process, planned for September 2023.

- The Trust continues to be represented at the LHRP meetings (at Strategic level), by the Chief Operating Officer, who is the Trust's Accountable Emergency Officer (AEO), and at Practitioners' meetings by the Emergency Planning Officer (EPO) and/or the Governance Officer.

- In Q2 (July 2022) NHSE produced the Minimum Occupational Standards for EPRR. The standards set out the requirements for health commanders, managers and staff responding to incidents as part of an incident management team that must be achieved to be competent and effectively undertake their roles. Compliance against this standard can be seen in section 10.2

- In Q2, following publication of the Annual Core Standards, all EPRR policies were reviewed and updated where required. The completed policies were presented and approved at the December EPRR Committee. The Chemical Biological Radiological and Nuclear policy (CBRN) remains under review and will be updated by the new Interim EPRR Manager in preparation for the June 2023 EPRR Committee.

- The Trust continues to have a Strategic, Tactical & Operational On-Call Rota which is fit for purpose and consistent across all Trust sites. Duty Site Managers (during core hours) and a 24/7 Tactical and Strategic On-Call structure (out of hours), provides greater resilience and clear lines of escalation.

- During Q3 and Q4, planned industrial action (IA) led by the Royal College of Nursing (RCN) and the British Medical Association (BMA) significantly affected the availability of staff who provided clinical care for our patients. To minimise any risk to patient care, the AEO led the Trust response, working proactively and in partnership with workforce, clinical, operational teams and Union representatives to agree a plan that allowed staff to express their right to take IA whilst safe patient services were maintained. Further details can be found in section **12.5** of this report.

- The Trust EPRR Team were also fully engaged with the National Operations Centre and System Operations Centre (ICB) to ensure effective communication and timely submission of SitReps.

- The Trust continues to receive Counter Terrorism Bulletins from the Local Resilience Forum (LRF) and the Local Health Resilience Partnerships (LHRP); these have been distributed as appropriate and are now a standing agenda item on the Trust EPRR Committee.

- In Q2, the national response to the COVID-19 National Major Incident moved towards business as usual and Strategic Command made the decision to close

the formal Incident Coordination Centre (ICC), with the response continuing to be managed by the EPRR Team during working hours (9-5pm) and the Trust Tactical On Call out of hours.

- In Q3 (November 2022), Sir John Saunders published Volume 2 of his report into the deaths of the 22 victims of the Manchester Arena attack in May 2017. The Trust EPRR Team reviewed the recommendations and will share the learning at the EPRR Committee in June 2023. All actions relevant to the Trust will be added to the EPRR work plan. Some key themes were:
  - Importance of regular testing of EPRR plans.
  - Identification and tracking of lessons learned to ensure implementation.
  - The value of action cards to support response participants.
  - Essential need for a positive organisational culture

4. NHSE Annual Core Standards Assurance

The NHS core standards for EPRR constitute the minimum requirements expected of providers of NHS Funded services. Their purpose is to:

- Enable health agencies to share a common approach to EPRR,
- Allow co-ordination of EPRR activities given organization size/scope,
- Provide a consistent and cohesive framework for EPRR activities,
- Inform the organisation's annual EPRR work programme.

Following the self-assessment against the NHSE Annual Core Standards in which the Trust reported 91% compliance, a peer review and validation exercise led by the ICB in Q3 adjusted the compliance percentage to 77% - partially complaint. The revision was due to the reduction in exercises and testing of emergency procedures (including the deferral of the full hospital evacuation exercise led by the ICB) owing to the COVID-19 response, a change to the CBRN standards nationally and the availability of documentation relating to lessons learnt.

The Integrated Care System (ICB) EPRR Team also acknowledged that the change in compliance ratings across the system was directly related to changes and developments they were implementing whilst preparing for the publication of the Manchester Arena Inquiry Volume 2: Emergency Response report.

The peer review process will recommence in September 2023 and the Trust Interim EPRR Manager is already working on a structured compliance methodology derived from the measures implied in the Core Standards self-assessment Tool. Following implementation, an improvement in the Trust’s compliance rating is anticipated.

In Q2 our compliance rate was summarised as per table 1 below.

Table 1.**Domain**	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	10	1	0	0
Command and control	2	2	0	0	0
Training and exercising	4	3	1	0	0
Response	6	5	1	0	1
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	0	3
Business continuity	10	5	5	0	1
CBRN	7	2	5	0	7
Total	**56**	**43**	**13**	**0**	**12**

By following the annual work plan and taking appropriate action, current compliance with the core standards following self-assessment has improved, however it is recognised that a programme of work to improve compliance relating to CBRN is required.

Table 2.

Table 1.**Domain**	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	10	1	0	0
Command and control	2	2	0	0	0
Training and exercising	4	3	1	0	0
Response	6	6	0	0	1
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	0	3
Business continuity	10	10	0	0	1
CBRN	7	5	4	0	7
Total	**56**	**50**	**6**	**0**	**12**

5. EPRR Key Performance Indicators

In December 2022, new key performance indicators to improve compliance were agreed at the EPRR Committee meeting and are now documented in the updated EPRR policy. Work to achieve these KPI`s has been delayed during Q4 but is a priority for 2023-24 and is already underway.

Key Performance Indicators – Preparedness

Description	Compliance Evidence
All Trust Services/Departments have a BIA for their area.	EPRR log of BIA documents, with annual review dates.
All Trust Services/Departments have a BCP for their area.	EPRR log of BCP documents, with annual review dates.
All Trust Services/Departments have carried out an annual BCP test/exercise.	EPRR log of exercises.
The Trust has appropriate resources and equipment in place to respond to an incident.	Fully compliant with ICC Audits
The Trust has undertaken all required exercises detailed in the EPRR Policy.	EPRR Exercises Log and Post-Exercise Reports demonstrating compliance with time-frames.

Key Performance Indicators – Response

Description	Compliance Evidence
The Trust has appropriate arrangements in place to be rapidly alerted to potential incidents.	All Tactical On-Call Managers and Strategic Executives On-Call have Resilience Direct accounts.
The Trust has in place plans to respond to Business Continuity, Critical and Major Incidents.	All EPRR Plans and Policies up-to-date with an annual review scheduled.
The Trust has in place trained and competent staff to lead an incident response.	All Operational, Tactical and Strategic Commander CPD portfolios up-to-date with relevant evidence.

Reports on these and the outcome of any exercises, and status of any corrective action will be reported to the board via the EPRR Annual Report.

6. EPRR Committee

The delivery of the EPRR agenda is the responsibility of the EPRR Committee. It is chaired by the AEO and is held quarterly. Following the publication of the new EPRR Core Standards, a review of the committee took place. The agenda is now structured around the core standards to aid focus and improved compliance. A further review is underway in preparation for the new reporting year.

In addition to the EPRR Committee there is an On-Call Review Meeting that convenes as frequently as necessary (weekly at the height of the pandemic to monthly in Q3).

The On Call Review meeting assesses risk, provides consultation and approval of new and reviewed EPRR plans and policies and supports annual EPRR training and exercise schedules. Members also share on call experiences and learning from events with peers. It is important to note that due to a gap in the recruitment of a substantive EPRR Manager, IA and some long term sickness the EPRR Committee and On Call Review Meeting did not meet in Q4. However, the debrief process and sharing of lessons learnt post incidents has been maintained. The EPRR committee will meet on the 6th June 2023.

7. Intranet Page Review

The EPRR intranet page has been developed and contains links to useful, trusted sources of information related to weather updates, anti-terrorism resources and coronavirus. The page is reviewed regularly to ensure the information available remains accurate.

8. EPRR Risk Management

The NHSE Core Standards for EPRR require organisations to have an overarching policy in place for building resilience in order that EPRR and business continuity issues are mainstreamed in processes, strategies and action plans across the Trust. To support the delivery of this, the Trust is guided by the following suite of policies, plans and Standard Operating Processes (SOPs);

8.1. Policies, Plans and SOPs

The EPRR Committee is responsible for the following policies, plans and Standard Operating Processes.

Policy	Next Review Date	Comments
EPRR Business Continuity Management Policy	December 2023	Updated policy was approved at December's EPRR Committee
EPRR Emergency Response & Recovery Policy	December 2023	Updated policy was approved at December's EPRR Committee.
CBRN Policy	September 2022	Review ongoing, update will be completed by June 23
Manager On-Call Policy	December 2023	Updated policy was approved at December's EPRR Committee.
EPRR Fuel Shortage Plan	June 2025	N/A
EPRR Full Hospital Wide Evacuation Plan	June 2025	N/A
EPRR Pandemic Outbreak Plan	June 2025	N/A

EPRR Incident Response Plan	December 2023	
EPRR Adverse Weather Plan	June 2025	N/A
EPRR Communications Plan	June 2025	N/A
EPRR Manager On-Call SOP	December 2023	
EPRR Incident Management Team & Incident Coordination Centre SOP	December 23	

The PREVENT Policy was also reviewed and approved in partnership with the Safeguarding Team at the EPRR Committee meeting in Q3.

8.2. EPRR Open Risks

The EPRR Committee is responsible for the monitoring and management of specific EPRR risks within the Trust. Should any risk score 15 or above it will be escalated to the Trust wide Risk & Quality Governance Committee for review.

The following are the current open EPRR related risks:

Risk ID	Risk Title	Current Rating	Comments
14	Emergency Preparedness	12	Risk score increased due to vacancy and sickness absence amongst the EPRR Team
15	Climate Change Risk	8 Low	Tolerated risk
24	Severe Weather Risk	8 Low	Tolerated risk
34	Threat from terrorism	10 Moderate	Risk assessment has been requested by an external specialist company to review necessary mitigation to be put in place outside CCCL to reduce the risk of an attack by a hostile vehicle - Report awaited

During the Royal Collage of Nursing Industrial Action days in December 2022 a further risk assessment related to the maintenance of safe services was completed and added to the Trust wide risk register.

9. Trust On-Call Arrangements

The Trust has a Strategic, Tactical & Operational On-Call Rota which is fit for purpose and consistent across all Trust sites. Duty Site Managers during core hours, and a 24/7 Tactical and Strategic On-Call structure out of hours, provides greater resilience and clear lines of escalation.

9.1 On-Call Managers' Resources

The On-Call Managers now have access to resources via MS Teams to support their on-call responsibilities. These include Major Incident and Operational Action Cards, an On-Call Pocket logbook and On-Call Managers' Handbook.

Feedback for all these resources remains positive, in particular the information available in the On-Call Handbook which includes contact numbers, an index of the action cards available and clear roles and responsibilities for the levels of on-call.

The production of the action cards has been welcomed by staff and has also been highlighted as good practice in the Manchester Arena Inquiry Volume 2: Emergency Response report. The EPRR Team will continue to develop the action cards in the coming year.

10. Training

Trust compliance for preventing radicalisation remains above the 90% target.

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Preventing Radicalisation - Basic Prevent Awareness - 3 Years|	1316	1316	1287	97.80%
NHS|CSTF|Preventing Radicalisation - Prevent Awareness - 3 Years|	321	321	315	98.13%

10.1 Incident Response Training

The training plan for On-Call Managers was re-written in Q4 2021-22 to accompany the new on-call arrangements. This continues to take place on an ongoing basis via MS Teams 'Bite size Sessions'. Bite size Training sessions are organised by the EPRR Team, but led by subject matter experts. The training is a 30 minute MS Teams meeting, consisting of a presentation or run through of the action card followed by questions from the on-call managers in attendance. The sessions are recorded to enable managers to watch when they are available. On-Call Managers are encouraged to record the sessions they attend in their Personal Development Portfolios. Feedback regarding the new training programme has been extremely positive.

10.2 NHSE Strategic & Tactical Health Commander Training

During Q2 (July 2022) NHSE produced the Minimum Occupational Standards for EPRR. The standards clearly state that health commanders, managers and staff who participate in incident management must be competent to effectively undertake their roles.

Although there are no set time scales for compliance described within the document, it is anticipated that compliance will be explored during the peer review process.

Consequently, a series of training events to deliver Health Commander Training for senior leaders commenced by NHSE. The Trust Executive Team booked their training

places, however the second training event was suspended due to the period of mourning and NHSE North West EPRR is yet to release any further dates.

Q2	NHSE Strategic Health Commander Training	8	3	37.50%	Training suspended due to a period of mourning
Q2	NHSE Tactical Health Commander Training	10	0	0.00%	Dates awaited

As part of our commitment to develop the training for on call participants, the Trust also ran a training day for Strategic Commanders entitled "Strategic Leadership in a Crisis", led by an external trainer. This took place in Q3 and was well attended by the Executive Team. Feedback was very positive regarding the clarity around the roles and responsibilities of a strategic leader.

11. EPRR Exercises

In response to the feedback from the ICB Peer Review Process the Trust has conducted a number of training exercise to ensure response plans are tested and effective. Exercises included a collaboration with Wirral Community Trust (WCT) and participation in a desk top exercise led by the ICB to explore the health response to multiple, concurrent operational and winter pressures in England.

11.1 Business Continuity Exercise – KIKO

In November 2022, and in conjunction with the digital team, Exercise KIKO was carried out. The aim of the exercise was to test the Trust ability to communicate, without using personal or work mobile devices, should the main telephone system fail. Communication would be by the RED Phone System.

Feedback was given by all representatives at the end of the exercise and an action plan was developed which was due for completion in Q4.Outstanding actions will be reviewed at the June 2023 EPRR Committee.

11.2 Fire Evacuation Exercise – Fuego

On 22 November 2022 the Trust participated in exercise Fuego. The aim was to raise awareness and exercise the arrangements within a neighboring Trust (WCT) to test their evacuation plan and possible scenarios against key elements.

A debrief event took place and the outcome was shared at the December EPRR Committee. The Trust continues to work in partnership with colleagues across the ICB.

11.3 Winter Planning Exercise – Arctic Willow

On 29 November 2023 the Trust participated in exercise 'Arctic Willow'. The aim of the exercise was to explore the health response to multiple, concurrent operational and winter pressures in England and the interdependencies within the Local

Resilience Forum (LRF) partners in responding to these pressures. The Trust was issued with several workbooks to be completed in preparation for the exercise – these covered a range of scenarios. The workbooks were completed over a two week period, the content of which was shared with the forum on the day of the exercise. As a result of the exercise, the Trust identified a number of additional business continuity plan considerations that were added to the EPRR work programme.

11.4 Industrial Action

As the IA on the 15th and 20th of December 2022 was the first time the Trust had experienced IA by the nursing profession the Trust EPRR Team managed the two days as a major incident, this enabled testing of our incident room set up, communications plan and testing of roles within the emergency planning command structure. This exercise was very well received by staff who participate on the on call rota and it identified some minor IT change that were addressed on the first day of IA.

12 EPRR Incidents

12.1 Major Incidents

Healthcare Definition - Any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

Figure 1: NHSE Incident Levels

Incident level	
Level 1	An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners.
Level 2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office.
Level 3	An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.
Level 4	An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.

The Trust did not declare any major incidents in the last year, however the national response to the Covid Pandemic remained at Level 4 (major incident) until Q2.The current National Incident Response Level remains at Level 3.

The CCC Incident Coordination Centre for COVID-19 remains closed with clear instruction to escalate the level of response should it be required.

The Trust continues to receive and disseminate correspondence from NHS England National Team, North West Regional Operations Centre (NWROC), and the Regional Vaccination Hub (SVOC). Trust response is expected seven days per week, with EPRR responding Monday-Friday and the Tactical On-Call monitoring correspondence out of hours and weekends.

The daily COVID-19 Bed Occupancy and Ready for Discharge SitReps continue to be submitted by the Business Intelligence Team using the Trust Inpatient Dashboard.

12.2 COVID-19 Public Inquiry

Preliminary hearings for the national inquiry's first three investigations took place in February and March 2023. The Inquiry held its first preliminary hearing for its third investigation, looking at the impact of the pandemic on healthcare, on Tuesday 28 February 2023.The Trust has no further update to date.

12.3 Critical Incidents

Healthcare Definition - Disruption results in the temporary or permanent loss of critical service delivery. Patients may have been harmed or the environment is not safe requiring special measures and support from other agencies. These incidents will usually develop over a period of time (rising tide) and will go through the Operational Pressure Escalation Levels (OPEL) escalation levels before being declared as a critical incident.

The Trust was involved in a serious business continuity incident in Q2, however due to proactive management by the IM&T team this did not escalate to a critical incident. The event occurred on Friday 9 September 2022 at the CCC-Aintree site.

12.4 Business Continuity Incident

This was caused by a severe power outage at the Clatterbridge Wirral Site on Thursday evening (8 September 2022) and communications to CCC-A were lost.

The power outage at CCC-Wirral was caused by a National Grid issue off site and affected all services at CCC-A resulting in no access to patient information systems for approximately 24 hours (Thursday night through to Friday evening). The Trust enacted its business continuity plans and services at the Marina Dalglish Unit (MDU), Outpatients and Phlebotomy were able to continue. The Trust was unable to recover the radiotherapy service at CCC-A as any further intervention with the network may have compromised services at the other sites. All Patients were offered repatriation to

Liverpool and Wirral for treatment and services were fully functioning in time for patients booked for treatment on Monday 12th Sept 2022.

A detailed incident report and action plan was shared at the December 2022 EPRR Committee.

12.5 Royal College of Nursing (RCN) & British Medical Association (BMA) Industrial Action

During Q3 and Q4 the Trust managed a series of planned industrial action days;
(15th and 20th December, 6th – 7th February. 1st March to 3rd March - RCN.
13th -15th March - BMA Junior Doctors)

The preparation for each if the IA days to minimize impact on service was highly challenging.

Preparations included the submission of written requests for derogations for key services, Daily meetings with the RCN Strike Committee. Daily planning meetings with strategic, tactical and operational teams supported by senior medical colleagues, the Communications Team and Workforce and Organisational Development Teams to minimise the risk to patient safety.

Daily SitRep meeting were held to review availability of the workforce and rescheduled activity. Risk assessments were conducted to determine impact of deferred activity and activity plans were adjusted accordingly. SitReps were submitted as requested to the Regional and National Operational Control Centres.

The commitment and engagement of staff and the effectiveness of the Trusts business continuity planning were key factor in the Trusts ability to deliver services during each period of industrial action.

13. Conclusions

The impact of the Covid Pandemic has highlighted the need for Trusts to have excellent EPRR systems and processes in place at all times. The revision of the EPRR Core Standards, introduction of the ICB Peer Review process and launch of the Minimum Occupational Standards for EPRR clearly indicate NHSE's intention to improve the EPRR capability within the health and social care system.

These standards provide clear metrics to measure performance and CCC will meet these requirements via the implementation of a new assessment methodology explicitly based on the Core Standards.

The Trust has demonstrated a positive and collaborative culture towards improving its EPRR expertise and this has played a significant role in the successful outcomes noted following IA and the power outage at CCCA.

Although significant improvements have been made, the impact of long term sickness absence, vacancy and IA during Q4 has affected the delivery of the work programme.

Consequently, the recruitment of a substantive EPRR manager is a key priority for the coming year.

In the meantime, the interim EPRR Manager will continue to work on improving compliance against the EPRR Core Standards, particularly in regards to the CBRN agenda.

The development of a new work programme for 2033-24 is underway and this will be shared at the next Performance committee.

14. Recommendations

The following recommendations will be added to the 2023-24 work programme

No	Recommendation
1	Policies, plans and SOP documents should be refined and categorised to: • Support compliance attainment • Enable better use in an emergency or from day to day
2	A structured compliance methodology should be implemented and all possible contributions to compliance must be clearly recorded to optimize compliance score and reduce the probability of post-peer review adjustment
3	Implementation of any KPIs should be considered in line with the assessment methodology that is explicitly based on the Core Standards. The EPRR policy should be updated accordingly
4	The Annual Work Programme should include development or enhancement of EPRR capabilities that reinforce the fundamental lessons offered by the Manchester Arena Inquiry Volume 2
5	To support compliance with the new Minimum Occupational Standards a training needs analysis needs to be developed and records of compliance need to maintained centrally.

Appendix 1 – Annual Work Plan (Q4 Update)

EPRR Annual Work Plan 2022-23

Month	Weeks (w/c)
Apr-22	04, 11, 18, 25
May-22	02, 09, 16, 23, 30
Jun-22	06, 13, 20, 27
Jul-22	04, 11, 18, 25
Aug-22	01, 08, 15, 22, 29
Sep-22	05, 12, 19, 26
Oct-22	03, 10, 17, 24, 31
Nov-22	07, 14, 21, 28
Dec-22	05, 12, 19, 26
Jan-23	02, 09, 16, 23, 30
Feb-23	06, 13, 20, 27
Mar-23	06, 13, 20, 27

No.	Task	Lead
Governance		**Lead**
1	Confirm Trust have a nominated AEO	EPO
2	Review EPRR Resource – ensure sufficient and appropriate	EPO
3	Review Annual EPRR Work Plan	EPO
4	Trust Emergency Preparedness, Resilience and Response (EPRR) Committee	Quality Administration
5	EPRR Committee Terms of Reference Review	EPO
6	Quarterly EPRR Report	EPO
7	Annual EPRR Trust Board Report	EPO
8	Quarterly On-Call Review Meetings	Quality Administration
9	Completion of NHSE Annual Assurance Core Standards for EPRR	EPO
10	External Audit or validation of plans at least three yearly	EPO
Duty to risk assess		
11	Review EPRR Risk Register	EPO
12	Ensure LHRP risks are on the Trust Risk Register	EPO
13	Submit Risk Management update to EPRR Committee via Quarterly Report	EPO
Duty to Maintain Plans		
14	Audit and review EPRR Response & Recovery Policy	EPO
15	Audit and review Adverse Weather Policy	EPO
17	Audit and review Fuel Shortage Plan	EPO
18	Audit and review Pandemic Flu Plan	EPO &IPC
19	Audit and review EPRR Communications Strategy	EPO & Communications
20	Audit and review Evacuation Plan	EPO & H&S
21	Audit and review Manager On-Call Policy	EPO
23	Audit and review Mass Vaccination Plan	EPO & IPC
24	Audit and review Lockdown Policy	EPO & H&S
24	Lead exercise to test lockdown plan	EPO & H&S
Command and control		
25	Access Codes/Keys/Swipes	EPO & PropCare
26	Review EPRROnCall email distribution list	EPO
27	Review annual On-Call Managers training programme to meet core standards	EPO
Training and exercising		
28	Strategic On Call Training (1/2 Day, Mandatory)	EPO
29	Tactical On Call Manager Training (1/2 Day, Mandatory)	EPO
30	Duty Site Manager Training (1/2 Day, Mandatory)	EPO
31	On-Call Incident Response Bitesize Training Sessions	EPO
32	EPRR training for all at induction reviewed	EPO
33	Quarterly Business Continuity Exercise	EPO & Divisional Directors
34	Monthly RED Phone Test	General Managers
35	Six-Monthly Communications Test/Exercise	EPO & IM&T
36	Annual Table Top Exercise	EPO
37	Review Trust ACT Training Compliance	EPO & H&S - L&D
38	Review Trust PREVENT Training Compliance	EPO & H&S - L&D
39	Live Exercise (Three Yearly)	EPO
40	Command Post Exercise (Three Yearly)	EPO
41	Review On-Call Managers Personal Development Portfolios	EPO

Response		
42	Incident Co-ordination Centre (ICC)	EPO
43	Review designated ICC and backup ICC, including audit of ICC Red Cases.	EPO
44	Review Major Incident Action Cards	EPO
45	Review Critical Incident Action Cards	EPO
46	Review Business Continuity Action Cards	EPO
47	Ensure sufficient availability of Trust Loggists	EPO
48	Provide annual Loggist refresher training	EPO
Warning and Informing		
49	Intranet Content Review & Update	EPO
50	Review On-Call Activity Logs on MS Teams	EPO
Cooperation		
51	AEO to attend Strategic LHRP meetings (Cheshire or Mersey)	AEO
52	EPO to attend Practitioners LHRP Meetings (Cheshire or Mersey)	EPO
53	Review documented mutual aid arrangements	EPO
54	Review information sharing policy	EPO & IG Officer
55	NWAS to invite trusts to Safety Advisory Groups	EPO
Business Continuity		
56	Audit and review Emergency, Contingency & Business Continuity Planning Policy	EPO
57	Annual review of Business Continuity Management Systems (BCMS)	EPO & Divisional Directors
58	Annual audit and review of Trust critical function using Business Impact Assessment (BIA)	Divisional Directors
59	Annual review of Trust Business Continuity Plans (BCP)	Divisional Directors
60	BCP Testing and Exercises	EPO & Divisional Directors
61	Certify compliance with the Data Protection and Security Toolkit	IM&T
62	Assurance of commissioned providers / suppliers BCPs	Procurement & Finance
63	Check EPRR Portacabin stock - dates and quantities	EPO
CBRN		
64	Confirm arrangements for telephony advice for CBRN exposure	EPO & Head of Physics
65	Review CBRN Policy	EPO & Head of Physics
66	Review HAZMAT / CBRN Risk Assessments	EPO & Head of Physics
67	Complete equipment and supplies inventory	EPO & Head of Physics
68	Review training programme content and compliance - PPE & decontamination	EPO & Head of Physics
69	Review FFP3 compliance and access	EPO & IPC

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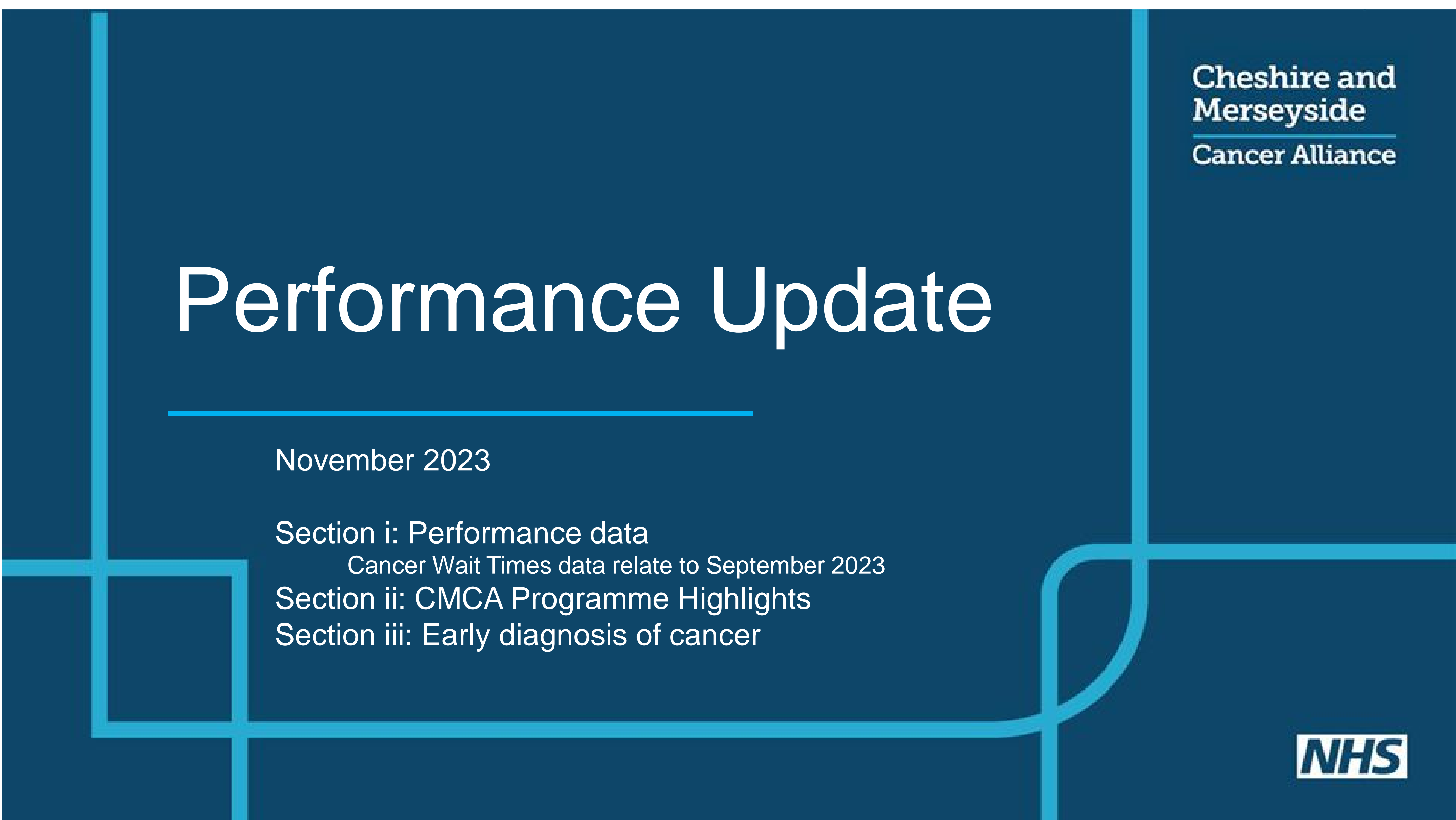
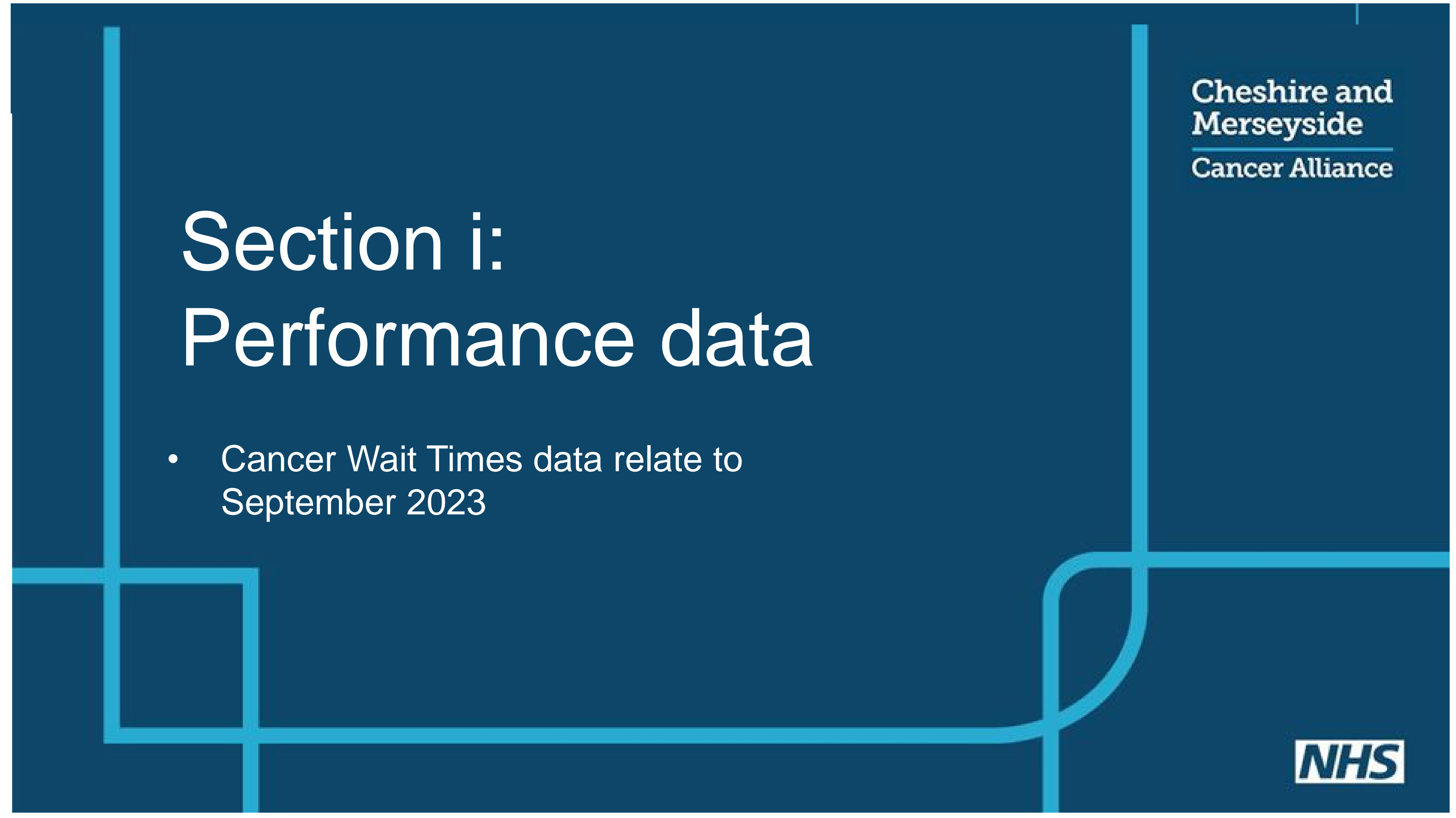
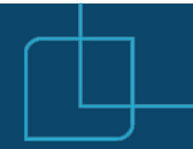

Cheshire and
Merseyside
Cancer Alliance
Performance Update
November 2023
Section i: Performance data
Cancer Wait Times data relate to September 2023
Section ii: CMCA Programme Highlights
Section iii: Early diagnosis of cancer
NHS

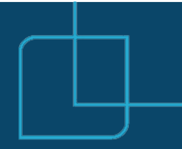

Cheshire and
Merseyside
Cancer Alliance
Section i:
Performance data
• Cancer Wait Times data relate to September 2023
NHS

Summary measures:
Most recent 12 months vs previous 12 months (%)



Measure	Value	Commentary
Volume of patients seen for the first time following an urgent GP referral for suspected cancer	105%	Data relate to patients registered with Cheshire and Merseyside GPs. Data are from Cancer Wait Times Dataset, most recent month September 23.
Cancer treatment activity: Volume of first definitive treatments for all diagnosed cancers	106%	
Cancer treatment activity: Volume of surgical treatments for all diagnosed cancers (all surgical treatments whether first or subsequent)	101%	
Systemic-Anti Cancer Therapies (SACT) (inc chemo) administrated at Clatterbridge Cancer Centre	110%	The sustained increase in activity continues to present challenges to service delivery, however CCC continues to take action to meet demand, including detailed capacity, demand and workforce planning. SACT and RT data refer to November 22 – October 23 as a % of November 21 – October 22.
Radiotherapy (RT) planning volumes at Clatterbridge Cancer Centre	130%	

Urgent GP referrals for suspected cancer: Activity



Patients registered with GP Practices in Cheshire and Merseyside:

- Between Oct 22 - Sep 23 155,414 patients were seen for the first time, following an Urgent GP Referral for Suspected Cancer, compared to 147,389 in the previous 12-month period.
- On average this is **12,950** patients per month.

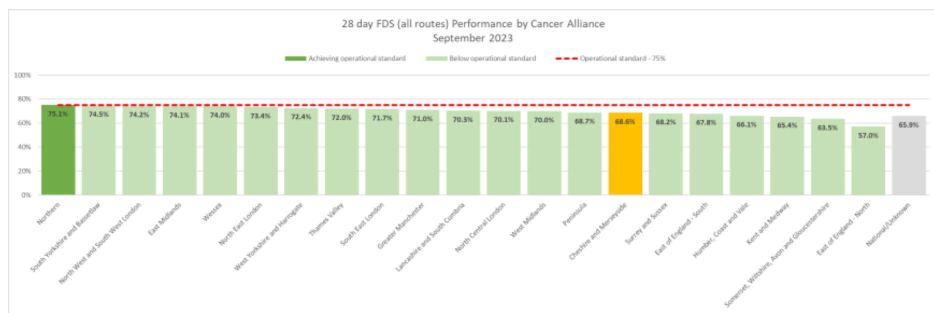
Rolling 12 months: October 22 to September 23

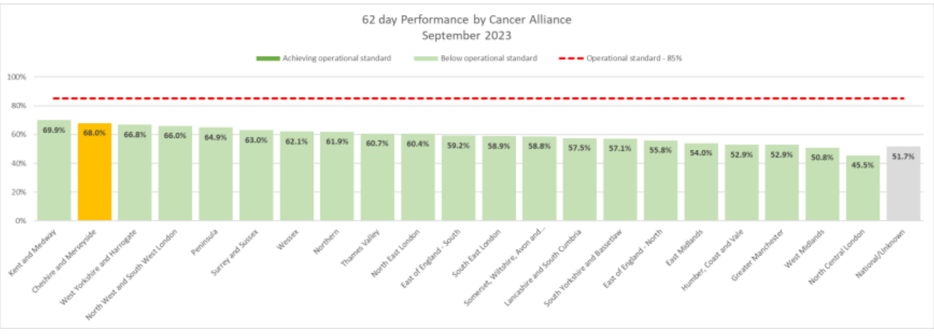
Number of Cheshire and Merseyside patients seen for the first time following an urgent GP referral for suspected cancer

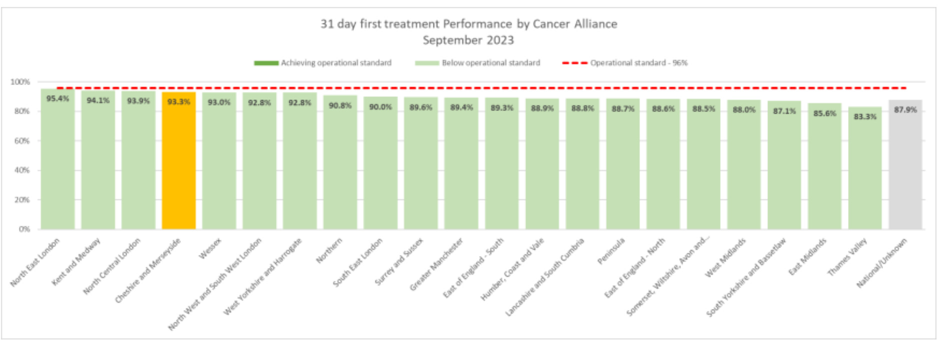
	Number seen (previous 12 month period)	Number seen Rolling 12 months: October 22 to September 23
Cheshire	40,839	44,130
Halton	7,830	8,012
Knowsley	10,035	10,389
Liverpool	26,724	28,016
South Sefton	9,863	10,198
Southport and Formby	8,341	9,616
St Helens	11,558	11,399
Warrington	11,875	12,276
Wirral	20,324	21,378

Source: NHS England Cancer Wait Times data

National comparisons: Operational Standards







Data refer to patients registered in Cheshire and Merseyside

75% of patients should have a diagnosis or ruling out of cancer communicated within 28 days of referral*

CMCA ranks **15th** out of 21 (September 2023): **68.6%**
England average: 69.7% North West average: 70.0%

*Referral may be via urgent GP referral for suspected cancer, breast symptoms where cancer is not initially suspected or referral from a screening programme.

85% of patients should receive their first definitive treatment for cancer within 62 days of an urgent referral from a GP for suspected cancer.

CMCA ranks **2nd** out of 21 (September 2023): **68.0%**
England average: 59.3% North West average: 60.5%

96% of patients should receive their first definitive treatment for cancer within 31 days of a decision to treat.

CMCA ranks **4th** out of 21 (September 2023): **93.3%**
England average: 88.7% North West average: 90.9%

Source: NHS England Cancer Wait Times data

Place level vs operational standards: 12 months rolling
October 2022 to September 2023

Operational standard	Cheshire and Merseyside	Cheshire	Halton	Knowsley	Liverpool	South Sefton	Southport and Formby	St Helens	Warrington	Wirral
28 day diagnosis / ruling out of cancer (75%)	67.8%	65.1%	71.8%	66.7%	63.5%	66.9%	68.2%	67.9%	74.4%	74.8%
62 day first definitive treatment (85%)	65.6%	65.3%	68.6%	65.5%	57.6%	57.2%	61.7%	75.7%	65.3%	72.7%
31 day first definitive treatment (96%)	93.7%	92.4%	93.9%	94.3%	92.5%	92.3%	91.0%	96.3%	95.7%	96.0%

Highest – Lowest

Patients registered with GP Practices in Cheshire and Merseyside

Source: NHS England Cancer Wait Times data

Trust level vs operational standards: 12 months rolling
October 2022 to September 2023

Operational standard	Cheshire and Merseyside Trusts	CCC	Alder Hey	Bridgewater	COCH	East Cheshire	Liverpool Heart and Chest	LUHFT	LWH	Mid Cheshire	Mersey and West Lancashire	The Walton Centre	Warrington And Halton Hospitals	WUTH
28 day diagnosis / ruling out of cancer (75%)	68.1%	84.0%	100.0%	83.2%	62.0%	68.0%	53.2%	65.8%	44.2%	66.9%	68.7%	99.3%	72.6%	75.7%
62 day first definitive treatment (85%)	65.7%	79.3%	100.0%	79.3%	68.6%	54.1%	65.2%	54.9%	15.0%	69.4%	71.1%	100.0%	62.7%	72.1%
31 day first definitive treatment (96%)	93.7%	99.2%	100.0%	96.2%	96.4%	88.7%	89.9%	89.0%	75.2%	89.1%	95.2%	98.9%	97.2%	95.3%

Highest Lowest

Brain /CNS 62 day performance at The Walton Centre is 100%.
In NHS England data, five non-Brain / CNS patients have been mistakenly attributed to The Walton Centre 62 day performance. Including these patients, performance appears as 16.74%. The issue has been addressed, however the published data may not be amended due to processing deadlines.

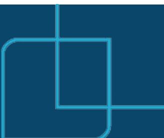
Patients attending trusts in Cheshire and Merseyside

CCC: The Clatterbridge Cancer Centre
LWH: Liverpool Women's Hospital
WUTH: Wirral University Teaching Hospitals
COCH: Countess of Chester Hospital
S&O: Southport and Ormskirk*
LUHFT: Liverpool University Hospitals NHS Foundation Trust
StHK: St Helens and Knowsley*

*Southport and Ormskirk, and St Helens and Knowsley trusts merged in July 23 to form Mersey and West Lancashire Teaching Hospitals NHS Trust. Data from June still refer to original trusts.

Source: NHS England Cancer Wait Times data

Patients waiting over 62 days on the Cancer PTL



Cheshire and Merseyside Cancer Alliance over 62 day PTL

Cheshire and Merseyside Plan (2023/24) | Cheshire and Merseyside Actual (2023/24)

Number of patients waiting over 62 days: 0, 500, 1,000, 1,500, 2,000

Week ending date: 01/04/2023, 01/05/2023, 01/06/2023, 01/07/2023, 01/08/2023, 01/09/2023, 01/10/2023, 01/11/2023, 01/12/2023, 01/01/2024, 01/02/2024, 01/03/2024

12/11/2023 1,072

31/03/2024 1,095

Over 62 day PTL	Cheshire and Merseyside trusts	CCC	Bridgewater	COCH	East Cheshire	Liverpool Heart and Chest	LUHFT	LWH	Mid Cheshire	Mersey and West Lancashire	The Walton Centre	Warrington And Halton Hospitals	WUTH
End of March 2024 ambition	1095	50	0	102	47	5	264	65	128	236	0	55	143
Latest Week: 12 Nov '23	1072	61	0	72	35	14	208	130	175	189	0	51	137
Distance from plan	-296	7	0	-33	-18	8	-206	40	22	-73	0	-4	-39
Distance from end of March 2024 ambition	-23	11	0	-30	-12	9	-56	65	47	-47	0	-4	-6

Highest Lowest (Latest Week colour scale) — Highest Lowest (distance colour scale)

Patients on Cheshire and Merseyside Trust PTL lists, waiting over 62 days

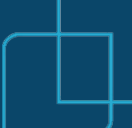
Trusts have agreed Patient Tracking List (PTL) trajectories, to reduce the number of patients waiting over 62 days by the end of 2023/24. The number of patients waiting over 62 days is planned to reduce gradually during 2023/24.

- Cheshire and Merseyside over 62 day PTL is **lower than** trajectory as of 12 November 23. The current number of patients waiting over 62 days is **78%** of the number planned for 12th November 23.
- As of 12th November 23 the current over 62 day PTL is **98% of the volume planned for the end of 2023/24.**

Source: Cancer 62 Day Patient Tracking List (PTL)

Southport and Ormskirk, and St Helens and Knowsley Trusts merged in July 23 to form Mersey and West Lancashire Teaching Hospitals NHS Trust.

Patients waiting over 104 days on the Cancer PTL



Cheshire and Merseyside Cancer Alliance over 104 day PTL

Cheshire and Merseyside Actual (2023)

Number of patients waiting over 104 days

800 600 400 200 0

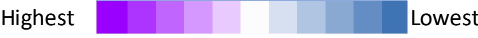
01 Jan 23 642

12 Nov 23 333

01 Jan 23 | 01 Feb 23 | 01 Mar 23 | 01 Apr 23 | 01 May 23 | 01 Jun 23 | 01 Jul 23 | 01 Aug 23 | 01 Sep 23 | 01 Oct 23 | 01 Nov 23 | 01 Dec 23

Week ending date

Over 104 day PTL	Cheshire and Merseyside trusts	CCC	Bridgewater	COCH	East Cheshire	Liverpool Heart and Chest	LUHFT	LWH	Mid Cheshire	Mersey and West Lancashire	The Walton Centre	Warrington And Halton Hospitals	WUTH
Latest Week: 12 Nov '23	333	28	0	17	9	3	53	46	66	53	0	13	45

Highest  Lowest

Patients on Cheshire and Merseyside Trust PTL lists, waiting over 104 days

This is a subset of the total number of patients on the PTL over 62 days as presented on the previous page.
Other than the overarching plan for reducing the over 62 day PTL, there is no specific planning trajectory for 104 days.

Source: Cancer 62 Day Patient Tracking List (PTL)

Southport and Ormskirk, and St Helens and Knowsley Trusts merged in July '23 to form Mersey and West Lancashire Teaching Hospitals NHS Trust.

Section ii:
CMCA Programme Highlights
Cheshire and Merseyside
Cancer Alliance
NHS

Transformation and Partnerships: Highlights since last report

Psychosocial Support

In 2022/2023 Cancer Alliances undertook a psychosocial gap analysis and created an associated development plan for delivery in 2023/2024.

The psychosocial gap analysis identified themes for those living with and beyond cancer:

- Inequity of psychology service provision for patients across Cheshire and Merseyside.
- Inconsistent offer of level two psychological training and supervision for staff in trusts.
- Variation in provision to assess psychosocial needs of all cancer patients.
- Limited NHS talking therapies long term condition pathways specific to cancer or include cancer. This includes knowledge of services, service offer, access and waiting lists.

Progress to date includes:

- Governance and clinical leadership agreed.
- Multi-professional psychosocial task and finish group established with a clear implementation and delivery development plan.
- Partnership with NHS Talking Therapies across Cheshire and Merseyside who have prioritised cancer in their development plan.
- Baseline information on psychological training and supervision complete.

IMPACTT: Improving Molecular Pathways and Cancer Turnaround Times

In partnership with Northwest GMSA this project focuses on the colorectal, breast, gynaecology, and teenage/young adult molecular pathways. It will map, audit and assess variances in turnaround times aiming to identify and make improvements. Progress to date:

- Audit data received from all Trusts bar one, with analysis work well underway.
- Gynaecology and colorectal pathway mapping complete; Breast is underway.
- Data visualisation tool developed to share this highly complex information.
- System-wide stakeholders engaged ensuring data is interrogated, analysed and communicated to pathology, clinicians, and the wider system.
- Full reporting to commence next quarter to initiate pathway improvements.

Challenges since last report

Psychosocial Support: Progress has been slow due to system pressures and capacity within the CMCA team. Realignment of staffing and resources is taking place to increase capacity. Incidental findings from the TLHC programme are causing an increase in workload for Primary Care impacting on some places engagement with the programme. The CMCA TLHC team are working with ICB colleagues and the national team to find ways to ameliorate this.

Targeted Lung Health Checks (TLHC)

The TLHC programme invites people aged 55 to 75 identified on GP registers as current or ex-smokers for a lung health check and if appropriate, refers them onwards for a low dose CT-scan. The programme aims to achieve a stage shift in the early detection of lung cancer. The national trial programmes have been judged to be a success and in June 2023, the national screening committee recommended that the trial programmes transition to a national targeted lung cancer screening programme, achieving 100% coverage by March 2030.

Cheshire and Merseyside has participated in all phases of the national trial programme: Knowsley, Halton and Liverpool (Phases 1 & 2) have been in the programme since July 2021 with St Helens and South Sefton (Phase 3) joining in December 2022. CMCA have been working with the ICB to procure Phase 4 which brings Wirral, Warrington and North Sefton into the programme. Liverpool Heart and Chest Hospital Foundation Trust have now been awarded delivery of phase 4 in addition to phases 1 to 3. Contracts are being drawn up with the target date of March 2024 for Phase 4 invitations to begin. Planning is underway to confirm procurement processes for Phase 5 which will expand the programme to Cheshire achieving 100% population coverage. In October 2023 the National Team requested all Cancer Alliances to provide indicative plans by January 2024 to achieve 100% population coverage by April 2027, transitioning all existing projects to a full screening programme with a 2 year round length and ensuring cohorts who have aged or moved in, or who had a close risk score in previous years are now invited. This is a substantial change in scope for the programme for CMCA. As of 9th October 2023, 118,220 patients had been invited to a lunch health check (over 10% of the total invitees nationally) resulting in 49,349 Health Checks (41.7% uptake), resulting in 33,829 low dose CT scans. So far across Cheshire and Merseyside, 277 new lung cancers have been identified. Of those 277 lung cancers, 221 (80%) have been diagnosed at Stage 1 or 2. (approx 30% of lung cancers diagnosed through general routes are found at an early stage). This is a making a significant contribution to the overall improved stage shift being seen across Cheshire and Merseyside from 32.5% in 2021 Q2 to 38.6% in 2022 Q4.

Key activities in the next six months

- Commence pathway improvements identified within the IMPACTT project
- Psychosocial Support – Develop improvement plans for access and wait for Talking Therapies and psychological training and supervision.
- Mobilisation of Phase 4 TLHC sites (Warrington, Wirral and North Sefton) and the generation of plans to transition the programme to a full screening programme with 100% population coverage in place by April 2027.

Faster Diagnosis: Highlights since last report

Faster Diagnosis Standard (FDS)

Overall, 75% of patients should receive a diagnosis or ruling out of cancer within 28 days of referral, however some cancer pathways consistently achieve above 75% (e.g. skin and breast), whilst other, more complex pathways consistently achieve below 75% (e.g. urology and lower GI).
NHS England has suggested some tumour specific goals for FDS performance for these four main cancer types. Performance against these goals is shown below for the most recent full financial quarter (Jul-Sep 2023).

- Breast: **91.5%** diagnosed / ruled out in 28 days (goal 92%)
- Lower GI: **46.1%** diagnosed / ruled out in 28 days (goal 62%)
- Skin: **79.8%** diagnosed / ruled out in 28 days (goal 85%)
- Urology: **49.0%** diagnosed / ruled out in 28 days (goal 63%)

Faecal immunochemical test (FIT)

FIT is a home test which checks faeces for tiny amounts of blood, a strong indicator for colorectal cancer. If FITs accompany urgent GP referrals for suspected colorectal cancer (lower GI), endoscopies can be avoided and patients can be ruled out for cancer sooner.
All main trusts in Cheshire and Merseyside have live FIT pathways.
The FIT metric in 2023/24 measures the percentage of lower GI urgent GP cancer referrals accompanied by a FIT result, with the result recorded in the 21 days leading up to the referral. In April-Sept 2023, CM GP practices reported 54% of lower GI urgent GP cancer referrals with a FIT within 21 days before the TWW, compared with 62% in England. For CM this is an increase from 47% in April-June 2023.
Work continues locally to improve data recording within GP practices. Local KPI data from trusts indicate this figure is well above the England average in most trusts.

Challenges since last report

- Achievement of BPTP targets for lower GI and prostate remain challenging and there is a risk they will not be achieved by year-end.
- Long term sustainability of NSS service and individual site-specific transformation funding remains a challenge. Significant work is in progress locally to develop Place-level NSS options appraisals to support sustainability and commissioning discussions in Q3.

Best Practice Timed Pathways (BPTP)

- Best practice timed pathways support the ongoing improvement effort to shorten diagnosis pathways and meet the 28 day Faster Diagnosis Standard. In 2023/24 CMCA is monitoring BPTP steps for six pathways: prostate, colorectal, lung, oesophageal, gynae and head and neck. NHSE only require monitoring of prostate and lower GI.
- Since May all trusts who are submitting BPTP data are now submitting data for all relevant pathways with the exception of WUTH which has not yet submitted any BPTP data as of November 2023.

Non Specific Service (NSS)

- NSS pathways are for patients who do not fit into a single ‘urgent cancer’ referral pathway, as defined by NICE guidance NG12, but who are, nonetheless, at risk of being diagnosed with cancer. Symptoms include unexplained weight loss, fatigue, abdominal pain or nausea; and / or GP ‘gut feeling’ about cancer. Numbers of NSS patients first seen in trusts on a 28 day pathway are compared against planned numbers from ICS level trajectories.
- In the last three months (July 23-September 23), 513 referrals were received. This is higher than the 430 referrals planned in the ICS trajectory*. From July 2023 NSS patients are included in the Faster Diagnosis Standard and Cancer Wait Times data.

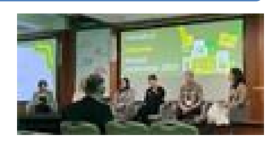
*Higher than planned is good

Key activities in the next six months

- Complete the transition of the FIT programme into a wider lower GI improvement programme. A new lower GI project manager has commenced in post at the end of Q2. A scoping exercise has been undertaken to identify current pathway performance challenges, with focused proposals/projects in development with five trusts.
- NSS – Complete options appraisal exercise which will provide a comparison, assessment, and evaluation of a range of long term options for NSS services. Work with ICB colleagues to agree a sustainable approach for the full and recurrent commissioning of this service.

Health Inequalities and Patient Experience: Highlights since last report

Showcasing CMCA's work around HIPE



HIPE Programme Manager attended the HI Conference in Manchester and Kings Fund Annual Conference, accompanied by a CMCA patient representative, to present on the HIPE team's approach to tackling cancer inequalities.

In addition to continuing to deliver the 'no more tickboxes' training, the HIPE Programme Manager also delivered a keynote speech at the Psychology Education Event & Psychology CQG.

HIPE Champions and Staff Network

A HIPE Champions Away Day took place in September, with lots of exciting updates and actions to come away with. Sessions on communication / engagement and the 2021 census data were also delivered.

Monthly meetings with the HI Staff Network continue to take place. The Network has seen a 26% increase in membership over the last 3 months, with representation from across C&M.

Patient Experience

HIPE Officer has become the data manager for the cancer QoL survey and CPES/U16 CPES for C&M. A comms plan to promote the Cancer QoL survey has been developed and will be delivered over the coming months. The 2022 CPES results have been reported on and shared. A comms plan to promote uptake of the 2023 survey is being delivered during the sampling period (Nov 23 – Feb 24). The surveys were discussed at the LCN/CMAG event.

CMCA roadshows 2023

All 8 roadshows have now taken place, visiting a variety of different places including Bootle Car Boot, Cheshire show, Wallasey, and IOM. The Roadshows involved staff across CMCA who engaged with the public, discussed barriers in accessing cancer screening, raised awareness of cancer and recruited patient reps from diverse backgrounds. The roadshow evaluation is currently underway and will identify key themes on public views around cancer and screening.

Patient Engagement

The patient representative group has seen a significant increase of 26% over the last 6 months. There are currently 53 patient reps with additional recruitment ongoing. Two staff are working to increase engagement with diverse patient reps from all walks of life. 74% of patient reps are actively contributing to CMCA projects alongside collaborative work with other trusts.

Patient reps are being encouraged to utilise the new Patient Involvement Expenses Policy to remove a potential barrier in not being able to engage with CMCA activities.

Storytelling work has begun with the first patient rep story being recorded and shared. Patient reps have also been involved in CMCA's first co-designed project with the LCN's patient experience survey. The patient rep forum has been developed in collaboration with The Cancer Academy to enable patient reps to comment on topics of discussion and access documents including the expenses policy easily.

The team have been raising awareness of the importance of patient engagement within CMCA, with a spotlight on patient engagement at the Health Inequalities Staff Network.

Challenges

Demand exceeds capacity.

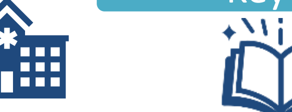
The quality and unique approach of the HIPE team work ensures regular demand to share at national level, deliver workshops and share.

Key activities in the next six months

Training

Recruitment

Reach more Trusts

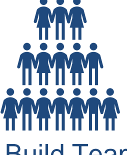


Patient Stories

Increase Reach

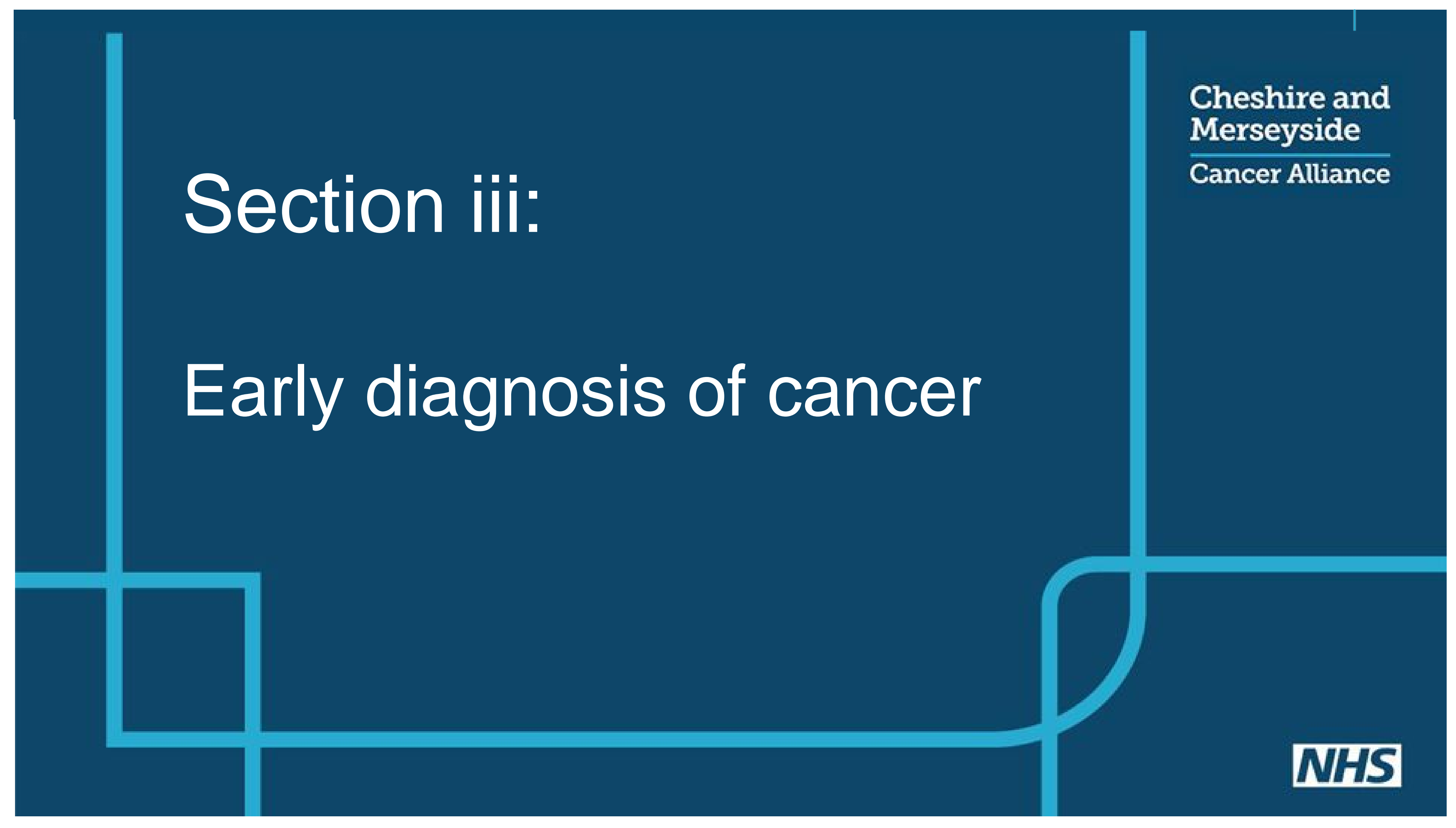
Improve Surveys

Create E-learning

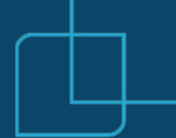


Build Team

Develop networks


Section iii:
Early diagnosis of cancer
Cheshire and Merseyside
Cancer Alliance
NHS

Cancer stage at diagnosis: Rapid Cancer Registration Database (RCRD)



Early diagnosis of cancer: cancers with a known stage excluding non-melanoma skin cancer (c44)
Rapid Cancer Registration Dataset July 2021-June 2023

Quarter	% Early diagnosis in England	% Early Diagnosis in Cheshire and Merseyside
Q3 2021	56.8%	56.3%
Q4 2021	57.5%	56.6%
Q1 2022	56.5%	55.3%
Q2 2022	57.3%	59.3%
Q3 2022	58.5%	58.1%
Q4 2022	58.9%	59.9%
Q1 2023	57.9%	59.3%
Q2 2023	57.8%	59.7%

The NHS Long Term Plan (LTP) sets an ambition that by 2028, 75% of people with cancer will be diagnosed at an early stage (stage one or two).

- Quarterly early diagnosis proportions have increased overall in the past two years.
- Overall, **58.0%** of Cheshire and Merseyside cancers were diagnosed at an early stage in the last two years, this is **statistically similar to England** (57.6%)
- Early diagnosis in Cheshire and Merseyside has increased from 56.3% in Q3 2021 to 59.7% in Q2 2023.

Source: Rapid Cancer Registration Dataset, CancerStats2

Cancer stage at diagnosis: Rapid Cancer Registration Database (RCRD)

Average percentage early diagnosis: Jul 21 – Jun 23

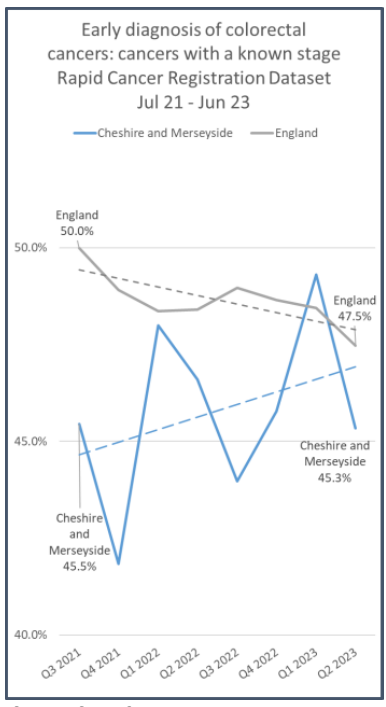
Area	Breast	Colorectal	Lung	Prostate	Other
Cheshire and Merseyside	87.6%	45.7%	39.1%	52.6%	61.9%
England	86.1%	48.7%	33.6%	54.5%	60.8%

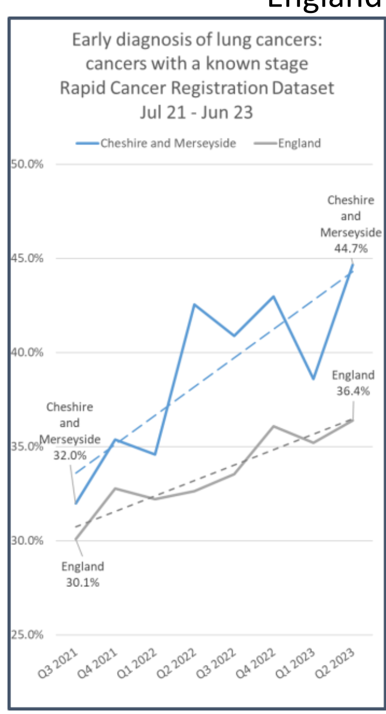
The most recent data from RCRD is up to June 2022. Over the past two years (24 months), early diagnosis rates in Cheshire and Merseyside have been above the England average for breast, lung and other* cancers, (other cancers were equal to England in the most recent quarter). Colorectal and prostate cancers rates were below the England average,(prostate cancer early diagnosis rates were above the England average in the last two quarters).

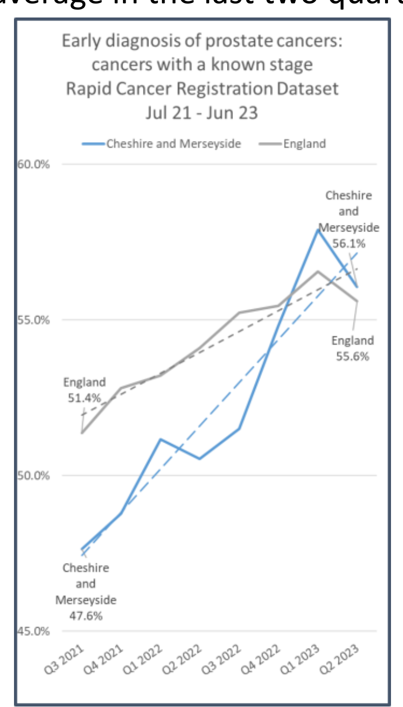
Early diagnosis of breast cancers: cancers with a known stage
Rapid Cancer Registration Dataset
Jul 21 - Jun 23

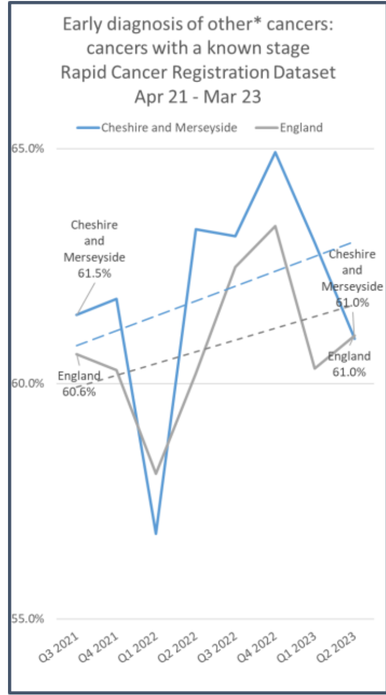
Cheshire and Merseyside — England

Cheshire and Merseyside 87.0%; Cheshire and Merseyside 88.3%; England 85.9%; England 85.7%









Source: Rapid Cancer Registration Dataset, CancerStats2

*Other excluding non-melanoma skin cancer

Council of Governors – 25th October 2023

Chair's Report for: Audit Committee

Date/Time of meeting: 12th October 2023, 09.30pm till 12:30pm

			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 received the Internal Audit Progress Report which provided details of the following audits: • Cost Improvement Plan Audit – Substantial Assurance • The review identified that controls were satisfactorily designed and generally operated effectively. The identification of more recurrent/transformational schemes requires more attention as the CIP target becomes more challenging to meet. Furthermore, action is needed to ensure robust quality impact assessments are completed to evaluate scheme impact on service quality and patient safety indicators. • The Committee received an update on the progress of the work of the Trust's Anti-Fraud Specialist (AFS), against the Anti-Fraud Plan, which detailed the work undertaken in quarter 2 2023/24. It was reported that Fraud Prevention Checks continue to be issued in response to increasing numbers of phishing attacks. None of the phishing attacks were successful against the Trust. Work is under way to revise the Trust's Anti-Fraud Policy to align it to the NHS Counter Fraud Authority's (NHSCFA) new Strategy 2023-26. • The Committee reviewed the key financial assurance indicators and noted the positive position across the range of indicators: • **Better Payment Practice Code** performance remains high at 100% for both volume and value for NHS and 99% for non-NHS value and 97.7% for volume. The national standard requires that the NHS pays at least 95% of all invoices in line with contract terms, typically 30 days. This KPI is closely monitored both nationally and by the Cheshire and Merseyside ICB. The Trust received a second letter of congratulations from NHS England's Chief Finance Officer, Julian Kelly in September. • **Aged Debtors** – There has been a slight increase in the level of NHS debt >90 days with 31 invoices totalling £235k outstanding, 16 of which relate to one NHS provider and discussions are on-going to agree a resolution.

Ref: FTWOCHAIR
Review: July 2025
Version: 3.0

	• For *Non-NHS* the level of debt over 90 days at the end of March was £364k (83 invoices). There was a balance of £133k outstanding with the Clatterbridge private clinic, of which £65k was paid during September. The balance relates to dispensing activity where the Trust increased the dispensing fee in April 23 to reflect current costs. • **Aged Creditors** Both the NHS and Non-NHS position is really positive which supports the high BPPC achievement. *NHS* There are 4 invoices totalling <£1k over 90 days. *Non-NHS* There are only 8 over 90 days totalling £4k. • The Committee noted the Tender Waiver Register which provided details of waivers approved in Q2 23/24. Three tender waivers were signed off in Q2 23/24 where the value of the contract exceeded £50k (inc. VAT) and there was a total of two retrospective tender waivers totalling £178,992.00. • The Committee received the Annual Auditors Report from the External Auditor following the completion of the audit of the 2022/23 audit. The auditor issued an unqualified opinion on the financial statements and did not identify any risks of significant weaknesses in the Trust's Value For Money arrangements for 2022/23. This led to the conclusion that The Trust had in place the arrangements we would expect to see in 2022/23 to enable it to plan and manage its resources to ensure that it can continue to deliver its services. Hassan Rohimun from Ernst Young is scheduled to present the report at the Annual Members meeting on the 26th of October. • In a separate meeting of Audit Committee members a single item was considered in relation to additional fees requested by the External Auditor which relate to both the 21/22 and the 22/23 audits. The request if agreed would result in significantly higher fees than the original contract. The Audit Committee concluded that the majority of the additional fees could not be agreed based on the information provided to support the request. A meeting involving the Chair of the Audit Committee, the Director of Finance, the Deputy Director of Finance and Ernst Young representatives has been arranged to discuss the additional fees and to enable the Trust to understand the basis for the request.

	• The Committee received the quarterly update on Cyber Security and Data Security Assurance that outlined the work completed in the reporting period. Following eight months of work the Trust was awarded ISO27001 accreditation at the end of July. The certificate will be issued by the end of October, coinciding with Cyber Security Month. • The Trust recently achieved the highest rating in the region for Microsoft Defender Endpoint (MDE) status. This monthly data published by NHS England, highlights the Trust's position as the most secure for the virtual desktop estate, and in the top 20 NHS Trust's in England for desktops and laptops. • The Committee reviewed the Digital Maturity Assessment (DMA) that has recently been submitted to NHS England. The assessment has also received peer review via partners within the NHS. The Tool covers the 7 "What Good Looks Like" domains. The average score for CCC across all 7 domains was 3.7, on a scale of 1 – 5. IS027001 accreditation is recognised as maximum maturity within the national Digital Maturity Assessment (DMA) tool and would therefore support an improved rating for the "how mature is your cyber and network security" within the "Safe Practice Domain" next year. • The Committee reviewed the Board Assurance Framework risk BAF14 that relates to Cyber Security. The Committee confirmed that they remain satisfied with the key controls and assurances provided, recognising that the IS027001 accreditation for all sites provided additional assurance and endorsed the residual risk score of 12 and noted due to the dynamic external environment the target risk also remains at 12. • The Committee reviewed the proposed amendments to the Scheme of Reservation and Delegation and Standing Financial Instructions following the establishment of the independent charity and agreed to recommend the items for approval by the Board. • The Committee reviewed the Code of Governance checklist and noted that good progress had been made against the majority of actions. Further action is required in relation to the work of the Remuneration Committee and reviewing the effectiveness of the Council of Governors.
Items of concern for escalation to the Board	The Report from the Director of Finance highlighted the following • The Trust is forecasting that it will deliver its financial target position for 2023/24 - £0.363m surplus.

	Overall the Trust's financial position is in line with plan. However, this is supported by the surpluses currently delivered by the Trust's subsidiaries. The Trust only operational position is a deficit. The Trust is expecting to improve its operational position over the remainder of the year, through CIP implementation cost benefits and reduced temporary staffing costs. • The Trust has transacted the majority of the £8.2m CIP target and continues to remain focussed on additional schemes as part of the planning for 2024/25 which has commenced. The five year financial plan is being developed to support the Trust's strategy and it is expected that it will be shared with the Trust Board in November. • The Committee received an update regarding Specialised Commissioning Devolution and those services that will be delegated to the Integrated Care Board from 1st April 2024 which will include Chemotherapy. However, the Committee noted that High-Cost Drugs will continue to be nationally funded. Members discussed the potential implications for the Trust if the devolved funding was not ring-fenced for cancer services and what the potential impact of moving to population based funding could mean. The Director of Finance sits on a working group of the ICB that is currently looking at how financial risk is managed across the system and the implications of devolution should be picked up in future discussions and system planning.
Items of achievement for escalation to the Board	• The Committee noted positive progress in relation to the follow-up actions from previous audits. The pilot of Team Mate, an online tracking system provided a single source of evidence and enabled reporting of an accurate position of the outstanding recommendations. 20 recommendations have been partially implemented or superseded and 19 recommendations are not yet due. • The Committee endorsed the proposal to procure the Trust's Internal Audit Service via a Cheshire and Merseyside system approach. This proposal will be presented to a future Trust Board meeting for approval.
Items for shared learning	There were no items for shared learning.

Title of meeting: Board of Directors
Date of meeting: 29 November 2023

Report lead	Liz Bishop, Chief Executive
Paper prepared by	Updates to strategic risks provided by the Executive Risk Leads
Report subject/title	Board Assurance Framework (BAF) update
Purpose of paper	To provide an update on the sections of the BAF under direct oversight of the Board (BAF6)
Background papers	Q1 BAF report presented to April Board of Directors; BAF update reports to Performance Committee (August and November), Quality Committee (September), People Committee (September) and Audit Committee (October)
Action required	Confirm level of assurance provided about key controls for 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		

Ref: FCGOREPO
Review: July 2025
Version: 2.0

1.0 Introduction

1.1 This report provides key updates about the Trust's strategic risks. It includes key highlights about the strategic risk under direct oversight of the Board: BAF6 relating to 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 23 August and 22 November;
- BAF10 and 12 reviewed by the People Committee 19 September;
- BAF1, 7 and 13 reviewed by the Quality Committee 20 September;
- BAF14 reviewed by the Audit Committee 12 October.

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.

2.0 Key highlights

2.1 Highlights from committees

2.1.1 **Performance Committee**

On the 23rd August the Committee agreed that the narrative for each BAF risk needed to be updated to reflect the meeting discussions e.g. industrial action, unfunded escalation beds, changes in business and system working. No scores have been changed since the May report.

At the time of this report, the meeting on the 22nd November has not taken place. The Committee will review a proposed score change for BAF 3 (Insufficient Funding) from (4 x 4)16 to (3 x4) 12.The Committee's response can be found in the Chair's report to Trust Board.

2.1.**2 People Committee**

On the 19th September, the People Committee noted there were no changes to the BAF scores that were reviewed in quarter 1 and approved in July. The Committee agreed, BAF10 is on track to achieve the target score of 9 by March 2024, which includes time to allow the actions to embed.

2.1.3 **Quality Committee**

On the 20th September the Committee agreed the proposed decrease in the risk score for BAF 1 (Quality) from (3 x 5)15 to (2 x 5)10. The Committee noted the target for March 2024 is (2 x 5)10 and agreed to keep this, acknowledging this was an annual target, the measures need to be maintained and if the Trust achieves further actions to lower the score towards the low risk appetite, the target does not prevent this.

The Committee discussed the ambitious target of (2 x 3)6 for BAF 7, (Research Portfolio) as the risk still stands at (3 x 4)12 and agreed that the target of 6 may be too ambitious to achieve by March 2024. The Director of R&I, Medical Director and Corporate Governance Manager reviewed BAF 7 following the meeting and proposed an amended target score of (3x3) 9, based on current progress. The Committee Non-Executive Directors agreed the new proposed target outside of the meeting.

The Committee were satisfied with the narrative around BAF 13 (Development and adoption of digitalisation) and actions to mitigate the risk.

2.1.4 **Audit Committee**

On the 12th October, the Committee reviewed the Board Assurance Framework risk BAF14 that relates to Cyber Security. The Committee confirmed that they remain satisfied with the key controls and assurances provided, recognising that the IS027001 accreditation for all sites provided additional assurance and endorsed the residual risk score of 12 and noted due to the dynamic external environment the target risk also remains at 12.

2.2 The following tables provide summarised information about the strategic risk, BAF 6 under direct oversight of the Board of Directors, BAF6. The full detail can be found in Appendix 2.

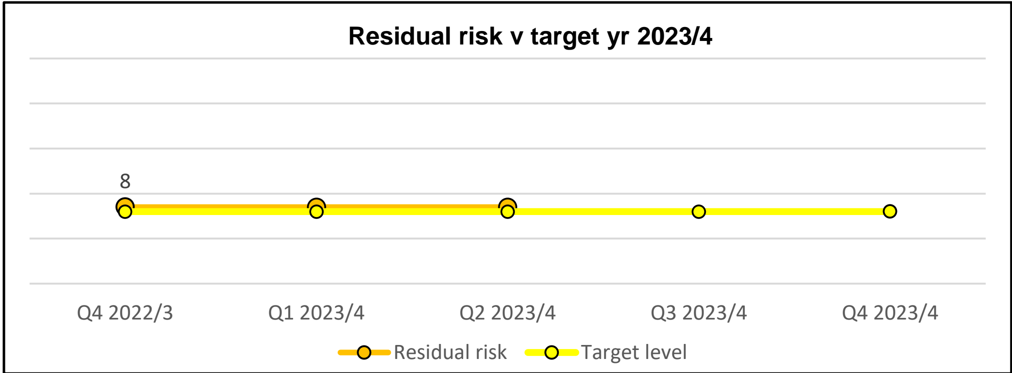
Summary table: BAF6 ICS				
Risk appetite: moderate				
Risk title	**Residual risk**	**Measure**	**Actions**	**Target 31/03/24**
There is a risk that the Trust fails to achieve sufficient **strategic influence within the ICS** to maximise collaboration around cancer prevention, early diagnosis, care and treatment **Executive Risk Lead**: Liz Bishop	**8**	1. Early cancer diagnosis improvement data as per quarterly Board report 2. Achieve Faster diagnosis standard 75% by March 2024 3. Have no more than 1,095 patients on cancer pathways beyond day 62 by the end of March 2024 4. 31-day performance standard 96%	Revised Deadline -Complete risk sharing agreement with ICB (March 24)	**8**

Ref: FCGOREPO
Review: July 2025
Version: 2.0

Chief Executive **Last Updated:** 16 November 2023		5. Diagnostic dashboard reported through CMAST performance: 90% of patients waiting for a diagnostic test will be seen within 6 weeks by the end of March 2024 6. Cheshire and Merseyside Diagnostics will be in the top 10 performing ICBs		

Commentary

This risk is largely mitigated through the CCC hosting of the Cheshire & Merseyside Cancer Alliance, to enable CCC to influence prevention, early diagnosis and cancer surgery. The recent leadership role and hosting of the Cheshire & Merseyside Diagnostics Programme on behalf of the ICB, gives greater influence over cancer diagnostics, although it is appreciated the diagnostics programme covers non cancer work. Formal channels through the CMAST/ICB governance and reporting arrangements are established. On 8 November NHSE issued a letter to address the significant financial challenges 2023-24 calling for action by ICB/Trusts. *At the time of updating the BAF, the cancer and diagnostic programmes are being reviewed to assess if a proportion of 23/24 funds can be released.



3.0 Recommendations

3.1 The Board is requested to:

- Interrogate BAF6 (ICS) and confirm that members are satisfied with the information about key controls and assurances, and the remaining actions.
- Approve the amended target score of (3x3)9 by 31/03/24 for BAF 7 (Research Portfolio)
- Note the full Board Assurance Framework

Appendix 1: Strategic risk heat map showing initial, residual and target risk scores Q1 2023-24

Strategic aims	Outstanding				Collaborative	Research Leaders		Great Place to Work		Digital		Innovative
Risks	**BAF1**	**BAF2**	**BAF3**	**BAF5**	**BAF6**	**BAF7**	**BAF8**	**BAF10**	**BAF12**	**BAF13**	**BAF14**	**BAF 15**
25	✕											
20		✕	✕								✕	
16								✕ Ⓡ	✕			
15				✕		✕	✕			✕		✕
12		Ⓡ ★	Ⓡ ★	Ⓡ	✕	Ⓡ	Ⓡ		Ⓡ		Ⓡ ★	
10	Ⓡ ★											
9				★		★		★	★	Ⓡ ★		Ⓡ
8					Ⓡ ★							
6							★					
5												
4												★
3												

Symbol	Meaning
✕	Initial (inherent)
Ⓡ	Residual (current)
★	Target (31.03.24)
→	Distance to target

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

Board Assurance Framework (BAF) Key

Risk Appetite Level	Definition
NONE (1-3)	Avoidance of risk and uncertainty is a key organisational objective
MINIMAL (4-8)	As little as reasonably possible (ALARP). Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
CAUTIOUS (9-12)	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
OPEN (12-15)	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward and Value for Money (VfM)
SEEK (16-20)	Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk
SIGNIFICANT (25)	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Term	**Definition**
RISK APPETITE	The level of risk that the Trust is prepared to accept in relation to an event/situation, after balancing the potential opportunities and threats that situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings
INHERENT RISK SCORE	An 'inherent' risk is one that is unmitigated or changed by any risk management action we might decide to take.
RESIDUAL (CURRENT) RISK SCORE	A 'residual' risk is the risk that remains once the inherent risk has been subjected to risk mitigation or management.
TARGET RISK SCORE	The risk score the Trust aims to achieve by the end of the financial year.
CONTROL	Process, plan, policy, practice, tool or mechanism that is used to manage a risk. For the BAF risks, the key organisational controls are identified, which are the main tools that provide direction, define expected activity/behaviours, and that drive compliance/performance
ASSURANCE	Evidence that conveys information about the effectiveness of controls. In the context of the BAF, this would ordinarily be some form of written report providing, for example, compliance data, performance information, progress updates, audit results, evaluation findings etc.
RISK TOLERANCE	The range of risk score which the Trust is prepared to accept, temporarily or permanently within the risk appetite category, eg 4-8.

BAF1. Quality

RISK APPETITE: Patient safety & experience - Regulatory compliance MINIMAL(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: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24 L x C
BAF1 There is a risk that a **lack of organisational focus on patient safety and quality of care** will lead to an increased incidence of avoidable harm, higher than expected mortality, and significant reduction in patient satisfaction. **Executive Risk Lead:** **Julie Gray, Chief Nurse** **Board Committee:** **Quality** **Last Update:** **29 August 2023**	**Causes** 1. Insufficient and ineffective clinical governance processes 2. Failure to learn from patient feedback 3. Lack of coherent and sustained focus on Quality 4. Failure to implement National Patient Safety Incident Response Framework 5. Increased patient dependency and acuity 6. Unsafe staffing levels and skill mix **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 7. Exceeding thresholds for harm free care indicators (falls, pressure ulcers, nosocomial outbreaks, health care associated infections (HCAIs))	5 x 5 = 25	C1) Risk Management Strategy 2023-26. Incident reporting and investigation policies. Dedicated Clinical Governance and Safety Team. **Control Owner**: Chief Nurse	Risk management strategy annual update report - Trust Board (April) Quarterly aggregated patient safety and experience report to Quality Committee	Audited Quality Account, reviewed by Quality Committee, June 23 MIAA audits of key systems: Risk Management, Substantial Assurance March 22; Incident reporting, Limited Assurance April 22; Claims, Substantial Assurance, 2021/22	**2 x 5 = 10** ↓	**No**	G1) Implementation of year one Risk Management Strategy objectives	Complete Risk Management Strategy year one objectives **Action Owner:** Chief Nurse **Due Date:** 31/03/24	Patient Safety Syllabus training needs assessment developed & rolled out to priority groups. Mechanisms for dissemination of learning from incidents to ensure the right messages reach the right people captured within the new Quality improvement and Learning Strategy	**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. Annual Complaints, PALs and Claims Report to Quality Committee Quarterly aggregated data patient safety and experience report to Quality Committee. Overview of complaints process reported to quality committee	National Cancer Patient Experience Survey results, reviewed by Quality Committee, September 22 showed Trust in top decile. MIAA Substantial Assurance for Patient Experience, 2020/21 MIAA Moderate Assurance for Complaints March 2022.			G2) Current PALs service delivered remotely	Increase responsive face to face PALs service at CCC-L **Action Owner**: Chief Nurse **Due date**: 31/03/24	38% reduction in complaints from Q4 2022/23 - Q1 2023/24 PALs officer onsite part of the week at CCC-L.	
			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. Maintain low rates of catheter associated UTI's and maintain 95%+ VTE assessments. Dedicated falls prevention Lead and Tissue Viability Nurse. **Control Owner**: Chief Nurse	Harms Free Care Committee Data reported to Board of Directors via Integrated Performance and Quality Report	Quality metrics reviewed at Commissioners Quality meetings quarterly.			G3) Minimal impact of learning for improvement evident from Harms Free Care Group	Collaborative improvement projects for Falls reduction and Pressure Ulcers supported by Aqua. Deliver falls reduction and skin damage quality priorities identified within quality accounts. **Action Owner:** Chief Nurse **Due date:** 31/03/24	96.22% trust wide compliance with Fall Prevention training Q1. The average monthly fall risk assessment compliance for Q1 was 91.49%, an increase on 80.27% during Q4.Number of inpatient falls has reduced by 29% from Q4 to Q1. Number of hospital acquired pressure ulcers has reduced by 31% from Q4 to Q1. New investigation templates developed for pressure ulcers and falls in PSIRF requirements	
									Relaunch Harms Free Care scrutiny process under the leadership of the Deputy chief nurse **Action Owner:** Chief Nurse **Due date:** 31/03/24	New investigation template launched in line with PSIRF requirements September	
	Measure 1. Thresholds for: - Avoidable hospital acquired c. dificile - Falls with moderate harm - Avoidable hospital acquired skin damage - Avoidable VTE 2. Safe staffing levels 3. Implementation of Risk Management Strategy annual objectives 4. Implementation of the Quality Strategy annual objectives 5. Performance in NCPES		C4) Investment - Access to AQuA Data expertise in BI/Digital/CNIO 'Bright Ideas' and Innovation Centre to capture areas for improvement. Dedicated Quality Improvement Nurse and investment in Tendable - formerly Perfect Ward **Control Owner**: Chief Nurse	Integrated performance and quality report reported to QC and TB Bright Ideas report to Board of Directors.	Care Quality Commission (CQC) rating. Specialist commissioners oversight.			G4.1) Lack of up to date Quality Strategy. No clear system to demonstrate and celebrate quality improvement activity	Draft Quality Strategy to Quality Committee **Action Owner**: Chief Nurse **Due date**: 21/06/23 Complete	Quality improvement and Learning Strategy approved at Board July 2023. Board development session on Quality improvement methodologies July 2023.	
								G4.2) CQC preparedness	Recruit a governance lead for inspection preparedness **Action Owner:** Chief Nurse **Due date:** July 2023	No funding identified for a preparedness lead, tasks lead by key individuals. Organisational preparedness in progress.	
			C5) Dedicated role - Associate Director of Clinical Governance and Patient Safety. Established Executive Review Group and Patient Safety Committee with Consultant leadership. **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 and updates provided to Quality Committee			G5) Patient Safety Incident Response Framework (PSIRF) work stream	Secure funding to recruit dedicated patient safety lead **Action Owner**: Chief Nurse **Due date**: 31/05/23 Complete	New Patient Safety Lead appointed August 23 - on target for PSIRF sign off at Board September 2023	
			C6) Single room occupancy so all patients are isolated. Antimicrobial prescribing policy and lead pharmacist. Post infection review (PIR) undertaken for each known case. **Control Owner:** Chief Nurse	Quarterly 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			G6) Monthly scrutiny panel with specialist commissioner input	Establish monthly Nosocomial Infection Performance Review meeting **Action Owner**: Chief Nurse **Due date**: 30/09/23 Complete	Weekly IPC escalation meeting in place for any avoidable infection. Monthly scrutiny panel established with spec comm - commenced July 2023	
			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	Bi-annual safer staffing report to Trust Board				G7) Variable levels of demonstrable patient acuity assessment knowledge across the Trust due to newly recruited staff	Ward Managers and DNDs attending NHSEI education event. **Action Owner**: Chief Nurse **Due date**: 30/06/23 Complete	Targeted training for inpatient service staff on the use of safer nursing care tool completed June 2023. Deputy Chief Nurse to complete Safer Staffing Diploma 2023/24	

Additional narrative

During 2023/24 recruitment will take place to support key roles, this will provide the additional resource, knowledge and experience required to drive the systems and processes needed to ensure the requirements to evidence a safe, caring, responsive, effective and Well-led organisation are met. The governance committee structure, clearer lines of responsibility and mechanisms to ensure accountability are embedding. The implementation of the year 1 objectives of the Risk Management Strategy, the publication of the Quality Improvement and Learning Strategy and the roll out of the Patient Safety Incident Response Framework will all be key milestones throughout this financial year. The target risk score for the financial year 2023/24 stands at 10, which exceeds the low tolerance range of 4-8 for this risk. In order to mitigate this risk and ensure greater assurance, long-term strategies have been established, the risk management strategy, patient experience and inclusion strategy, patient safety incident response framework, and quality improvement and learning strategy. These strategies incorporate specific actions aimed at enhancing risk controls and offering supplementary assurance, thereby gradually reducing the risk score and aligning it more closely with the desired tolerance level. It should be noted that the implementation and integration of these actions will require a considerable amount of time.

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?*	External assurance *What/where reported/when?*	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Progress update	Target risk score by 31/03/24 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:** 27 October 2023	**Causes** 1. Changing pattern in demand as referring Trusts recover post Covid 2. Workforce gaps 3. Population health needs change due to long-term effects of Covid 4. Ongoing industrial action 5. Trust has opened additional unfunded in patient escalation beds to support system. **Consequences** 1. Detrimental impact on patient care and experience 2. Poorer outcomes for patients 3. Regulatory and reputational impact 4. Pressure on workforce to support unfunded in patient beds	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 via IPR and Trust Operational Group. CCC CWT performance discussed at Trust Board via IPR.	MIAA programme includes review of cancer waiting times systems and processes (Substantial Assurance Q3 2022)	4 x 3 = 12	No	G1) CCC has no control over referring Trust recovery plans and therefore the volume of referrals for CCC	Capacity & Demand monitored daily. Weekly monitoring of CMCA data. Deep dive into managemnt of activity & capacity to meet CWT presented at Performance committee 16th Aug 2023 **Action Owner**: COO **Due date**: Ongoing Ongoing discussions with COOs across C&M via weekly COOs meetings **Action Owner:** COO **Date Due:** Ongoing	Currently delivering capacity to meet demand. Weekly monitoring of activity. Late referral data shared with referring trust on a monthly basis	4 x 3 = 12
			C2) Trust monitoring Cancer Waiting Times (CWT) through Dashboard updated daily, CWT team alert senior managers to any capacity issues with flow of referrals **Control Owner:** COO	Oversight & utilisation of escalation processes demonstrated at weekly Patient Tracking List Meeting, weekly Trust Operational Group, quarterly Divisional Performance Review Groups (PRGs) reported via Chair's report to Performance Committee	C&MCA activity plans monitored by ICS, monthly reporting back to Trusts across C&M via hospital cell Cancer Performance reviewed by CMCA and ICB						
			C3) Recovery and escalation plan meets NHS System Oversight Framework Metrics **Control Owner**: COO	Progress reported monthly via Finance and activity update at Trust Board and quarterly to Performance Committee. Activity monitored via PRGs. Trust recovery plan monitored via Trust Operational Group	Trust activity plans monitored by ICS, monthly reporting back to Trust via hospital cell. Elective recovery plan activity reports indicate CCC is delivering according to plan.			G3), G4), G5) High number of late referrals to CCC due to delays in diagnostic capacity, this impacts the delivery of the 62 day target for CCC and C&M	1. Refer to C&M diagnostics delivery plan **Action Owner**: CEO **Due Date**: April 2024.	CCC CEO is the SRO for C&M Diagnostics recovery programme, clear improvement programme in place. Monitored at ICS and via national cancer Team.CDC at CCCP opened 24th July 2023	
	Measure 1. 62 day standard >85% 2. Faster Diagnosis Standard >75% 3. 31 Day Access to Treatment Standard		C4) CCC additional monitoring of CWT performance via internal 24 day target and 62 day target 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						
			C5) CCC working with referring trusts with highest number of late referrals **Control owner:** COO	Late referral activity data shared with all referring trusts monthly (when, where)							
			C6) CCC monitoring referrals daily & weekly patient flow for in patient and out patient care monitored via dashboard.Live oversight of new referrals, Radiotherapy & SACT activity and allocation of first appointments within Trust's internal targets **Control Owner**: COO	Divisional Performance Review meetings held monthly and/or quarterly with outcomes reported to Performance Committee Daily & weekly flow Reported and monitored via weekly Trust Operational Group (TOG) Allocation of first appointments monitored by registrations team. Lack of capacity escalated to relevant senior manager Capacity monitored via weekly TOG. Bed utilisation and length of stay monitored daily . Escalation process in place to manage pressures on capacity	Trust performance and activity against CWTs monitored by CMCA, activity plans monitored via ICB MIAA review cancer waiting times (substantial assurance 2023)			G6) Referral numbers continue to rise, highest on record in March 2023. Presure on system results in increased demand for urgent cancer care beds at CCC	Site Reference Groups (SRGs)& supporting services monitoring activity, capacity challenges escalated to managers daily. Additional clinics in place across a number of tumour groups. Starting work to review SRG membership and structure to improve productivity. Capacity and demand work underway in Radiology, Inpatient wards. ICB aware of unfunded beds, discussions in progress to seek a solution **Action Owner:** COO **Due Date:** all reviews completed by 31.03.24	Started membership review Q1, time needed to review across the Board. Output of capacity & demand work will be shared at Dec 2023 TIC	
			C7) Planning, monitoring and recovery meetings for Industrial Action established **Control Owner COO**	SitReps provided at every IA meeting detailing impact of IA on all services. Recovery & Communication plans monitored.Escalations raised at IA meetings and within Divisions	Impact of IA monitored with ICB via SitReps			G7) Impact of IA may differ on each occasion.	1.Planning commences as soon as IA dates announced 2. Mangers working closely with clinical teams to minimise impact on patients 3.Every patient is risk assessed to minimise any impact on patient care and outcome **Action Owner**: COO **Due Date:** Review March 2024	Impact of IA had minimal impact on patient care. However distruption to patient appointments may affect patient experience. Review March 2024	
			C8) 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				G8) Clinicians not always able to accommodate additional activity	SRGs working as one to offer patients an appointment with alternative clinician who may have capacity within the specialist area. Outpatient transformation programme with key focus on patient initiated follow up - starting to be rolled out **Action Owner:** COO **Due Date:** 31.03.2024	Transformation programme started to roll out with several work streams. Focus on breast SRG and aim to see impact by end of Q2	
			C9) Wait List Initiative clinics to be utilised to meet demand **Control Owner:** COO	Capacity monitored via weekly TOG Utilisation monitored via ECP Bi weekly							
			C10) 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.BP presented at Finance Committee and Trust Executive Group Divisional BPs to be presented at Trust Performance Committee via a rolling programme.				G10) Expansion of workforce is limited by the availability of staff & budget	Prioritisation process in place and funding allocated to areas with pressure. To do a benefits relation process. **Action Owner**: COO **Due Date:** 31.12.2023		

Additional Narrative:
Despite multiple mitigations and a low risk appetite, the risk score cannot currently be reduced below 12. Uncertainty regarding the 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. The BAF has been updated to include key performance indicators which can reviewed in line with the BAF risk.

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?*	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Progress update	Target risk score by 31/03/24 L x C
BAF3 There is a risk that the Trust does not deliver its finanical target because it has either insuffucent income to cover costs, and/or it does not achieve the required level of recurrent efficiency savings. **Executive Risk Lead:** James Thomson, Director of Finance **Board Committee**: Performance **Last Update:** 15 November 2023	**Causes** 1. Changes to the commissioning regime and funding process 2. Inability to meet patient demand without further investment or productivity gains 3. Inability to recurrently identify and deliver the cost improvement programme (CIP) 4. Inflationary pressures 5. Management of the system financial position (deficit) might negatively impact funding position or efficiency requirement **Consequences** 1. Identify drivers of financial risk - review cost base, resource and productivity levels 2. Increased CIP requirement in future years if target not recurrently achieved 3. Review strategic ambitions if additional resource required 4. Reduced ability to invest in operational capital infrastructure and staff 5. Reduction in liquidity position 6. Increased performance management from NHSE/I and ICB - and associated regulatory action 7. Reduced Trust board risk appetite	4 x 5 = 20	C1) Divisional and departmental budget management process **Control Owner**: DoF	Budget setting process managed through Finance Committee (monthly) and reported to Performance Committee (quarterly). Budgets approved by lead managers. Monthly budgetary performance in place through Performance Review Groups and Finance Committee to ensure cost control.	External Audit includes assessment of plan though VFM testing (reported to Audit Committee). National Financial Sustainability exercise by MIAA (HFMA checklist) - Q3 22/23. Reference Cost Index position reported to Performance Committee - Q4 23/24.	4 x 4 = 16	No	G1) Timing of budgeting process 23/24 determined by ICS timetable, and approvals not in place before 1st April 2023.	Ensure that Trust Board is informed throughout the financial planning process, such that overall plan was approved per the NHSE timetable. The Trust management has also been kept informed of the planning and budgetary process through Finance Committee. Final budgets approved by budget holders May 2023. **Action Owner**: DoF **Due Date**: 31/05/23 - Complete for 23/24	Finance Committee, 12th May, finalised all elements of the budget plan for 2023/24 - including pressures and developments. Budgetary performance reviewed monthly as part of Trust management process. Changes to budgets are managed through financial governance routes.	3 x 4 = 12
			C2) Contract position agreed and managed with commissioners. Elective Recovery Fund (ERF) income baseline and in year performance monitored. **Control Owner**: DoF	Monthly formal contract meetings with commissioners. Annual planning process, with rebasing exercise undertaken for 2023/25 to reflect new contracting methodology (API). ERF methodology verified by BI and Finance Teams.	Commissioner (NHSE/ICB) review of contract performance - quality and financial. NHSE produce ERF calculations and ICB supporting Trusts to verify performance.			G2) Impact of 23/25 API funding methodology and contracting round to be finally determined. The ERF process is not mature. Information is historic (M4 at M7) and baselines have changed to reflect industrial action.	Trust reviewing its contract performance position monthly, and aligning to 2023/5 NHSE guidance. Any risks to the contract and income position, will be monitored through Finance Committee and Performance Committee. The ERF position is under review, and performance is being analysed, with issues raised to NHSE ERF leads. Trust will query baseline/data where not consistent with local analysis. **Action Owner:** DoF **Due Date:** 31/12/23	Trust has established methodology to understand contract performance, this will be tested through Q1 and issues raised. The Trust has verified current contract data with NHSE, and an agreed overperformance value has been identified for the Trust (M6). ERF position presents risk to the Trust, regarding performance against revised baselines. Trust actively reviewing ERF activity data through Task and Finish Group.	
			C3) Efficiency (CIP) and productivity plan in place - with clear cash releasing schemes **Control Owner**: DoF	Performance managed through Finance Committee (total) and Performance Review Groups (PRGs) and reported via Finance Report to Performance Committee and Board. Process for MD and CNO review and approval.	CIP process is included on internal audit review plan for 2023/24 - to take place Q3. ICB financial programme includes review of CIP plans.			G3) Assurance on recurrent CIP delivery pipeline to be confirmed. Productivity analysis of core services to be complete and benchmarked against peers.	1. Escalate CIP risk approach through Performance Committee. 2. Produce productivity process for Performance Committee. 3. Additional finance support for CIP programme **Action Owner** DoF **Due Date:** 21/02/24 - Performance Committee	For 23/24 CIP target has been met. And in line with expectations. Actions remain to increase level of recurrent CIP and improve pipeline for 24/25. Trust working to refine CIP target process for 24/25. Trust planning assumption of 5% CIP target, per 23/24. (Tariff efficecny factor 1.1%).	
			C4) Trust Board approved financial plan, and ICB approved target financial position **Control Owner**: DoF	Finance report quarterly 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.			G4) Impact of system financial position and risk management approach to be established	Trust is developing its financial plan for 2023/5. It is in active discussions with partners in the ICS to identify approach to organisational finance risk for 2023/5. **Action Owner:** DoF **Due Date:** 31/09/23	ICB is developing a financial programme approach to recovery. This will be approved by the ICB Board with input from DoFs. DoF meetings every fortnight to progress actions from programme. Trust to feedback through Performance Committee (May 2023 onwards).	
	Key Performance Indicators 1. Trust financial performance to target (monthly) 2. Trust CIP performance to target (monthly) 3. Trust activity/income performance to target (monthly) 4. Trust paybill to target (monthly)		C5) Trust included in emerging system financial planning **Control Owner:** DoF	DoF updates through Financial Planning Reports to Performance Committee, Audit Committee and Trust Board. Chair and Executives included in ICB peer networks.	ICB receives governance score through Strategic Outcomes Framework rating. NHSE approach to regulation for deficit ICS is to be determined.			G5) ICB financial governance and programme structures in development. Increased ICB financial risk process implemented November 23, in line with national requirements. Improved financial forecast mandated by NHSE.	Trust participating in finance system governance development - through DoF and senior finance team. Trust reviewing its financial forecast and likely to increase its surplus target, to support ICB position. **Action Owner: DoF** **Due Date: 29/11/23**	Executives participate in peer ICB networks. Trust working with partners in Liverpool health system to support, following Carnal Farrar report. Trust in discussion with ICB to increase forecast surplus position. Extra-ordinary Board to discuss increased surplus 16/11/23	
			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			G6) Capital decision making governance for C&M ICB not embedded. Impact of medium term capital allocation on asset base to be identified.	Trust to review multi-year capital programme quarterly. Lifecycle and asset replacement programme to be reviewed and included in Trust planning for 24/25 through Capital Committee. **Action Owner:** DoF **Due Date:** 31/12/23	Trust capital plan for 2023/24 agreed with Trust Board and ICB. 5 year capital plan submitted as part of ICB planning exercise. Capital prioritisation process for 24/25 commenced, through Capital Investment Group.	

Additional Narrative:
The financial system for 2023/24 is based on a new funding methodology - Elective Recovery Fund income and contract performance through the Aligned Payment Incentive model. This holds for 2023/24 and 2024/25, and establishes fixed and variable elements of commissioner contracts (ICB/NHSE).
Key risks for the Trust include securing sufficient funding through contractual mechanisms, including variable elements of commissioning contracts, and recurrently delivering the efficiency programme.
Given the risks, at this stage of the financial year, the Target Risk Score has been maintained at 12 (3x4). The probability reflects that the finance plan includes a historic high level of efficiency requirement.

BAF5 Environmental Sustainability

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

STRATEGIC OBJECTIVE: Be Outstanding

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls *(what is in place to manage the risk?)*	Board Assurance *(evidence that controls are working)* Internal assurance *What/where reported/when?*	Board Assurance External assurance *What/where reported/when?*	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24 L x C
BAF5 If the **Trust does not integrate environmental sustainability considerations into delivery of its strategic priorities**, it will fail to realise the potential benefits and contribute to the NHS Net 0 target **Executive Risk Lead:** Tom Pharaoh, Director of Strategy **Board Committee**: Performance **Last Update:** 9th November 2023	**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 (Jan/Feb 2022) and summary version published. Board-level sustainability lead identified. **Control Owner**: Director of Strategy	Quarterly assurance reporting to TEG and Performance Committee (based on selected Green Plan themes at each meeting). Annual report on whole programme of Green Plan delivery to TEG, Performance Committee and Trust Board in February each year.	Quarterly national 'Greener NHS' NHS England data collection exercise. Green plan annual report shared with ICB sustainability team.	4 x 3 = 12	No	G1) Delivery mechanisms for key Green Plan work streams not yet developed	1. Develop and publish green travel plan **Action Owner**: DoS/Sustainability Programme Manager **Due Date**: 30th September 2023 **(Complete)**	Green travel plan drafted by interim sustainability manager following successful green travel survey with staff. Refined by DoS for launch in 2023. Action delayed due to limited capacity within sustainability team and summer period - date changed to September 2023	3 x 3 = 9
									2. Develop and deliver sustainability staff engagement programme **Action Owner**: Sustainability Programme Manager **Due Date**: 31st March 2024 (date revised)	Proposal made for staff engagement programme to be deferred to link with staff health and wellbeing engagement programme in 2023. Proposal to be reviewed in 2024 as may not deliver outcomes required. Standalone Green Champions programme to be considered. To be delivered by substantive programme manager. Due date revised to reflect.	
			C2) Substantive Green Plan programme management arrangements in place	Programme plan in place. Quarterly internal programme reporting from Sustainability Action Group as set out above (put in place following first annual report in February 2023). Annual Green Plan report as above					3. Develop full communications plan to communicate with staff and stakeholders on key sustainability issues - incl. energy efficiency, waste management arrangements and rates of recycling - using comms to outline further plans and seek staff behaviour change **Action Owner**: Sustainability Programme Manager **Due Date**: 30th September 2023 **(Complete)**	Comms plan in place and key channels developed (e.g. staff intranet site). Sustainability manager to work with comms team to build on existing work to develop schedule thematic updates throughout the year as part of regularised programme. For example current waste management processes reviewed by Sustainability Action Group. Positive current situation and steps to improve to be communicated to staff as part of wider comms plan.	
	Key Performance Indicators 1. The Green Plan sets the following targets in line with the national NHS targets: - 20% reduction in air pollution from business mileage and fleet by March 2025 - Waste - zero to landfill policy by March 2026 - 90% of our fleet will be low or zero emission vehicles by 2029 - We will achieve a 100% reduction of direct carbon dioxide equivalent (CO2e) emissions by 2040. An 80% reduction will be achieved by 2032 at the latest - We will achieve a 100% reduction of indirect CO2e emissions by 2045. An 80% reduction will be achieved by 2039 at the latest. 2. The Green Plan sets out our baseline carbon footprint and we will repeat the carbon baselining two years following the Green Plan's publication 3. As part of the development and delivery of the sustainability programme, the substantive sustainability manager will propose additional targets, measures and milestones to the Sustainability Action Group for agreement								4. Develop a comprehensive, accessible and replicable approach to carbon accounting to ensure that the Trust is measuring the impact of its sustainability interventions **Action Owner:** DoS/Sustainability Programme Manager **Due Date:** 31st March 2024	Market research of external carbon accounting services has been undertaken. Discussions with NHS partners in C&M and the ICB sustainability team with regard to a potential standardised approach to accounting.	
									5. Develop a clear timeline for installation of electric vehicle charging at CCC-Wirral to allow eventual transition of chemotherapy car fleet to zero emission vehicles **Action Owner:** PropCare MD/Sustainability Programme Manager **Due Date:** 31st March 2024	Funding identified in 2023/24 capital plan for EV charging at CCC-W. Issues with electrical capacity to site prevented installation as planned. Timeline to identify earliest possible date to rectify issues and install charging points.	
			C3) Multidisciplinary Sustainability Action Group formed to support delivery of the Green Plan action plan **Control Owner**: Director of Strategy	Quarterly internal programme reporting from Sustainability Action Group as set out above (put in place following first annual report in February 2023). Annual Green Plan report as above.				G2) Sustainability Action Group does not have programme management support to fully function	1. Engage with current members to ensure engagement and participation **Action Owner**: DoS **Due Date**: 5th September 2022 **(Complete)**	Control gap partially addressed through completion of actions 1 and 2. Additional members invited. Existing members encouraged to prioritise and engage in delivery of the action plan. Group now functioning well with good engagement and work progressing.	
									2. Establish substantive Sustainability Programme Manager as lead officer for the Sustainability Action Group **Action Owner**: DoS **Due Date:** 30th June 2023 **(Complete)**	Further review of terms of reference has been drafted by substantive programme management for discussion and approval at November meeting. Due date revised to reflect. To be moved to controls once complete.	
									3. Further review of Sustainability Action Group terms of reference in context of substantive programme management, including membership, accountabilities **Action Owner**: Sustainability Programme Manager **Due Date**: 30th November 2023 (date revised)		
			C4) Quality of the Trust's building stock: build specification of CCC-L supports Trust's environmental sustainability commitments, with potential to improve further. **Control Owner**: PropCare Managing Director	Internal monitoring of CCC-L building management system (BMS) and PropCare performance reporting.				G3) Quality of the Trust's building stock: CCC-W requires improvement and long term redevelopment	1. Creation of new projects division in PropCare **Action Owner**: PropCare MD **Due Date**: 31st July 2022 **(Complete)**	Control gap partially addressed by completion of action. PropCare projects division now in place.	
									2. Form CCC-Wirral Development Group to oversee progress on refurbishment, improvement and redevelopment of CCC-Wirral site. **Action Owner**: DoS **Due Date**: 31st January 2023 **(Complete)**	Control gap partially addressed by completion of action. CCC-W development group formed and functioning.	
									3. Develop 2023/24 capital plan to include significant investment in the maintenance and refurbishment of the CCC-W site to increase sustainability profile of buildings **Action Owner**: PropCare Senior Projects Manager **Due Date**: 30th April 2023 **(Complete)**	Control gap partially addressed by completion of action. Capital plan agreed.	
									4. Deliver CCC-W improvements and maintenance set out in 2023/24 capital plan **Action Owner**: PropCare Head of Capital and Projects **Due Date**: 31st March 2024	Concerted effort required to deliver ambitious range of capital projects at CCC-W in year. Programme currently on track with capital plan for 2024/25 in development.	
									5. Launch a procurement process (with sustainability as a key scoring component) to engage architectural services to begin development of longer term plans for CCC-W site redevelopment **Action Owner**: DoS/Head of Capital and Projects **Due Date**: 31st May 2023 **(Complete)**	Procurement process to develop next stage of proposal has been concluded.	
									6. Work with appointed architects to develop proposals for the redevelopment of the CCC-Wirral site up to RIBA stage 2 and beyond **Action Owner:** DoS/Head of Capital and Projects **Due Date:** 31st March 2024 (revised from December 2023)	Contract awarded to Ryder Architecture following comprehensive process. Initial work to take place in November. Slight delays during procurement and contract award processes mean revision of due date necessary.	

Additional Narrative:
The Trust has previously promoted sustainability in certain areas, for example cycle to work schemes and active travel facilities. The Board-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.
A key part of delivery depended on establishing effective programme management arrangements. Two unsuccessful attempts to appoint substantively to Sustainability Programme Manager role (12 months fixed term) necessitated the consideration of an interim solution. The interim sustainability manager (part time) was in post for 6 months from July to December 2022. Following a further unsuccessful attempt to recruit to the post on a fixed term basis it was advertised as a permanent role in January 2023. Substantive sustainability manager started on 20th June 2023. The post holder is a dedicated resource to drive the delivery of the programme, working with the Director of Strategy, and operates as lead officer for the Sustainability Action Group.
The quality of the Trust's building stock is a key component of our sustainability position. The current risk score reflects the opening of the new, modern CCC-L building which marks a milestone in upgrading the Trust's estate. PropCare has formed a projects division to support its significant contribution to the green agenda, including through making capital improvements to CCC-Wirral estate and supporting the longer term work to redevelop the site. Fully addressing the gap in control caused by condition of CCC-Wirral is a long term objective, as clearly is the general move towards net zero. This is reflected in the target score.

BAF6. Strategic influence within ICS

RISK APPETITE: Partnership working CAUTIOUS (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: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24 L x C
BAF6 There is a risk that **the Trust fails to achieve sufficient strategic influence within the ICS** to maximise collaboration around cancer prevention, early diagnosis, care and treatment **Executive Risk Lead:** Liz Bishop, Chief Executive **Board Committee**: Board **Last Update:** 16 November 2023	**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	Board oversight of CMCA employee contracts becoming substantive (last reported to Board June 2022) Overview of business plans approval for 23/24 by National Cancer Team and NHS England included in Chief Executive report to Trust Board (April 2023) Business Plan approved at CMCA Board (March 2023)		**2 x 4 = 8**	**Yes**				**2 x 4 = 8**
			C2) CMCA Business Plan 2022-23 submitted and approved December 2022 by National Cancer Team; funding confirmed for 2023-25 **Control Owner**: Managing Director, CMCA	CMCA performance reports to CCC Board quarterly and distributed to CMAST members and ICB quarterly. Overview of business plans approval for 23/24 by National Cancer Team and NHS England included in Chief Executive report to Trust Board (April 2023)	Weekly sit reps produced by CMCA for COOs. Quarterly CMCA performance reports are circulated to acute/ST providers CEO,COOs and Place Leads and reported fortnightly to CMAST						
			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. CMAST reports incorporates into Chair and CEO report to Trust Board monthly.	Diagnostic Delivery Board established and diagnostic performance reports into CMAST (fortnightly) and ICB Integrated Performance Report (monthly)			G3) Risk sharing agreement with ICB not in place	Complete risk sharing agreement with ICB **Action Owner**: CEO **Due date**: 31 March 2024 (revised from, 1 April 2023, November 2022, July 2022, Aug 2023)	Proceeded to recruit to Fixed Term Contract as agreed at September Board Risk sharing agreement in draft, with ICB DoW. Has been reviewed by CCC DoW	
	Measure 1. Early cancer diagnosis improvement data as per quarterly Board report 2. Achieve Faster diagnosis standard 75% by March 2024 3. Have no more than 1,095 patients on cancer pathways beyond day 62 by the end of March 2024 4. 31-day performance standard 96% 5. Diagnostic dashboard reported through CMAST performance: 90% of patients waiting for a diagnostic test will be seen within 6 weeks by the end of March 2024 6. Cheshire and Merseyside Diagnostics will be in the top 10 peforming ICBs		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	Diagnostic Delivery Board established and diagnostic performance reports into CMAST (fortnightly) and ICB Integrated Performance Report (monthly)			G4)(closed) No confirmation for funding of diagnostic programmes other than CDCs, but will be overseen by Diagnostic Delivery Board.	Business plan being developed in order to bid to both national and ICB teams **Action Owner**: CEO **Due date**: 31 March 2023 **(complete)**	ICB and diagnostic transformation funding approved. Additional NHSE funding secured*. By November 2023 10 CDCs will be opened. Funding now being drawn down and overseen by CCC DoF	
			C5) Trust involvement with CMAST Provider Collaborative and ICS **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 via quarterly NED CMAST events. CEO and Chair attendance at CMAST Leadership Board				G5) (closed) WLDR report highlighted need to increase senior capacity and visibility in ICS to take on greater leadership role	Broaden executive directors' stakeholder engagement in ICS **(complete)** **Action Owner:** Dir of Strategy **Due date:** April 2023 **(Complete)**	Executive directors attending respective C&M leadership fora **July:** Director of Strategy and COO attend CCC LUHFT Joint Committee Sub Committee, chaired by CCC Chair	
									2. Develop marketing plan to strengthen CCC brand and raise profile of senior leaders **Action Owner:** Dir of Strategy **Due date**: April 2023 **(Complete)**	In progress, preferred marketing provider engaged Communications Strategy approved at TEG. Marketing strategy complete and implementation commenced e.g.. Podcast series in development **July**:Comms and Marketing Strategy in place and implementation underway	

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. Formal channels through the CMAST/ICB governance and reporting arrangements are established. On 8 November NHSE issued a letter to address the significant financial challenges 2023-24 calling for action by ICB/Trusts. *At the time of updating the BAF, the cancer and diagnostic programmes are being reviewed to assess if a proportion of 23/24 funds can be released.

BAF7 Research Portfolio

RISK APPETITE: Clinical innovation CAUTIOUS (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: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24 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:** 31 August 2023	**Causes** 1. Reliance on partners to maintain National funding bids 2. Liverpool unsuccessful for BRC and CRUK Centre status 3. Service pressures impact upon research capacity 4. Adequate research active workforce 5. Adequate clinical trial access across sites. **Consequences** 1. Failure to develop new treatments for patients 2. Failure to achieve status as a leading cancer research centre 3. Insufficient future funding to sustain planned research programmes 4. Reputational damage	**3 x 4 = 12**	C1) Research Strategy 2021-2026, approved by Trust Board **Control Owner**: Medical Director	Research Strategy Business Plan updates reported quarterly to Performance Committee. Annual Research Strategy Updates to Trust Board.		**3 x 4 = 12**	**Yes**	G1) Research Strategy and Business Plan requires refresh for years 4 and 5.	Research Strategy and Business Plan to be refreshed for Years 4 and 5. **Due date: March 2024**		**3 x 3 = 9** ⬆
			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. Research updates reported to TEG and metrics reported in Integrated Performance Report at Quality Committee (quarterly) and Trust Board (monthly).				G2) Study opening reliance on service support departments	1. Increase number of trials clinical trial pharmacy can open. **Action owner:** Medical Director **Due date:** September 2023 (revised from June 2023)	1. Capacity increased from June 2023. To be reviewed again in 3 months time.	
									2.Develop Research vision for the CCC IR Service to remove dependence on third party providers. Action owner: Medical Director Due date: February 2024	2. Radiology Business Case approved at Finance Committee 12th May 2023 to be reviewed at TEG June 2023. Business case approved by TEG.	
			C3) Strategic Partnership Groups for National funding bids established. **Control Owner**: Medical Director	Quarterly ECMC, BRC, CRF updates to Research Strategy Committee. Research updates reported to TEG and metrics reported in Integrated Performance Report at Quality Committee (quarterly) and Trust Board (monthly).				G3) Additional staff required to develop, deliver and support research trials.	1. Full review of R&I senior leadership team infrastructure. 2. Review NHS consultant job plans for appropriate research time allocation 3. Wider engagement with medical, nursing and AHP staff. **Action owner:** Medical Director **Due date:** March 2024	1. Full review completed and funding available. 2. Research PA allocation under review with AMDs.	
			C4) 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 - January 2022			G4) Current processes/staffing need to be aligned to periphery sites.	Resource mapping from R&I and service support departments across all sites. **Action Owner:** Medical Director **Due date**: March 2024	Current position paper to be presented to R&I Directorate Board October 2023.	
	Measure 1. Yearly study recruitment target (>1300) met 2. Number of new studies open target (>52 per year) met 3. Interventional Radiology Service implemented (due February 2024 - enabling more early phase trials to open and more biopsies to be completed.) 4.Research infrastructure in place (G3) 5. Patients being recruited at periphery sites (G4) 6. Funding will reduce likelihood and staffing/infrastructure, grant awards will reduce the consequence (link to BAF 8 Research Funding)		C5) Clinical trial service support departments fit for purpose. **Control Owner**: Medical Director	Monitored monthly by Performance Review Group with exceptions only escalated to Quality Committee							
			C6) Appointment of research active staff. **Control Owner: Medical Director**	Monthly updates to R&I Directorate Board and quarterly updates to Research Strategy Committee. Research updates reported to TEG and metrics reported in Integrated Performance Report at Quality Committee (quarterly) and Trust Board (monthly).							
			C7) Access to clinical trials for patients across all sites. **Control Owner: Medical Director**	Monthly updates to R&I Directorate Board and quarterly updates to Research Strategy Committee. Research updates reported to TEG and metrics reported in Integrated Performance Report at Quality Committee (quarterly) and Trust Board (monthly).							

Additional Narrative:

ECMC bid renewal was successful and will be renewed in April 2023 for a further 5 years ; 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 Facilities status with a collaborative bid involving CCC and 2 other Trusts within the region secured £5.3m for local regional facilities. The successful outcome of the BRC bid will help demonstrate further research capability and ensure access to high quality research. The risk score is 12 as the Trust is ambitious in its targets for increasing the breadth and depth of research there are gaps in infrastructure and resource mapping across sites which will be addressed in year.

BAF8 Research Resourcing

RISK APPETITE: Clinical innovation, financial CAUTIOUS (tolerance 6-8

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 31/03/24 L x C
				Internal assurance What/where reported/when?	External assurance What/where reported/when?				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:** 13 November 2023	**Causes** 1. International competition for specialist research and academic skills 2. Reliance on partners to secure major sources of funding 3. Current vacancies relating to the Research Strategy 4. Funding shortfall from National Funding bids **Consequences** 1. Failure to develop new treatments for patients 2.Inability to deliver planned research programmes 3. Failure to achieve status as a leading cancer research centre 4. Loss of status and influence	3 x 4 = 12	C1) Research Strategy Funding ring-fenced to support Infrastructure and future growth in capacity **Control Owner**: Medical Director	Research Strategy Business Plan update reported quarterly to Performance Committee from January 2021		3 x 4 = 12	Yes	G1) Research staffing capacity. Reliance on external partners for academic recruitment.	Recruitment of Research staff. CCC/UoL joint working via recruitment company to appoint academic staff. Action Owner: Medical Director Due Date: March 2024	Staffing gaps identified. Financial resource agreed for Early Phase Clinical Research Fellow posts. Recruitment process underway and appointed, start date August 2023. Chair in Oncology appointed and started in post November 2023. Clinical Senior Lecturer pre-advert stage. Finances to be agreed with Charity for these posts.	2 x 3 = 6
			C2) Monitoring of use of funding (£0.5M allocated to the Research Strategy for year 3, additional £0.5M needed.) **Control Owner:** Medical Director	Monthly reporting to R&I Directorate Board; Business Plan update quarterly report to Performance Committee	MIAA R&I Audit of finance and governance arrangements 2022 - substantial assurance received			G2) £0.5M secured from the Clatterbridge Cancer Charity, £0.5M still to secure for Year 3.	Prepare Business Case to request the outstanding finances from the Charity for Year 3. **Action Owner**: Medical director **Due Date:**January 2024 (revised from: November 2023)	Business case approved at October 2023 TEG. The Research Business Case review is scheduled for January 2024 Charity Board meeting.	
			C3) Contribution from Clatterbridge Cancer Charity to support research opportunities.	Reporting through R&I Directorate Board through to Performance Committee.				G3) No process to apply for Charity funding via Research. Communication plan with Charity.	Developing a SOP for the Research application to the Charity Develop a Communication Plan. **Action Owner:** Medical Director **Due date:**November 2023 (revised from: September 2023)	Trust Charity Application SOP reviewed at October 2023 TIC meeting. Awaiting approval.	
	Measure 1. When funding to covered the funding gap is reduced. 2. When staffing to meet the requirements as outlined in the Research Strategy are recruited 3. Funding will reduce likelihood and staffing/infrastructure, grant awards will reduce the consequence		C4) Successful collaborative bids securing funding for National funding bids 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 and BRC operational meetings.				G4) Process to acquire full funding	Review alternative income streams. **Action Owner:** Medical Director **Due date:** January 2024(revised from:December 2023)	£150k secured via the Charity for the BRC. Additional funding for the ECMC/CRF is being requested through the Research Business Case going to Charity Board in January 2024.	

Additional Narrative:
The Research Strategy has a fully costed Business Plan (Research Strategy Business Plan 2021-2026) which is monitored at Performance Committee; the Business Plan outlines bid developments, commercial funding opportunities and charitable funding to deliver the strategy. The target risk being achieved is subject to the outcome of buisness case submission to the Clatterbrige cancer Charity in January 2024 for funding. If successfull this will ensure no shortfall between planned vs actual funding for National Funding bids. Recruitment of research infrastructure in-line with Research Strategy is dependent on securing additional funding . At the end of 22/23 we had achieved or were well on the way to achieving all our planned actions hence the full review in Q1 2023/24. This included securing or retaining national funding bids (ECMC, BRC, CRF). As BAF 8 is still relevant, and we are now looking to deliver on the national funding bids, we added extra causes and associated controls, assurances, gaps in control and planned actions to be completed during 23/24. This increased the residual risk up to 12. The target risk reduced from 8 to 6 to highlight we want to be more ambitious with the risk reduction as detailed within the BAF. The target risk will be reviewed in January 2024.

BAF10. Ability to ensure provision of sufficient workforce capacity and capability

RISK APPETITE: Workforce MINIMAL (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: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Residual risk (current) score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24 L x C
BAF10 If the Trust is unable to recruit, train and retain staff sufficiently then there is a risk that workforce capacity and capability will not meet demand resulting in undue pressure on staff and adverse impacts on patient safety, effectiveness of care and patient and staff experience **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee:** People **Last Update:** 7th September 23	**Causes** 1. Retention of staff who are in post. 2. Ability to recruit sufficient numbers and skill mix of staff, including impact of Brexit 3. Misalignment of workforce planning, activity and finance 4. Lack of accurate and up-to-date workforce information and data 5. Poor perception of NHS as a place to work 6. 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 7. Reputational damage 8. Reduced staff wellbeing and morale	4 x 4 =16	C1) People commitment 2023/24 implementation plan developed, with key deliverables identified against the 5 workforce pillars **Control owner:** Director of Workforce	2023/24 People Commitment implementation plan approved at People Committee (April 2023), with bi monthly progress updates reported to WAG and quarterly assurance reports reported to People Committee and Workforce key performance indicators monitored quarterly at People Committee	National NHS Staff Survey results 2022 – Increase in 7 out of 9 People Promise scores. Full report reported to Board and People Committee in April 2023	4 x 4 = 16	No	G1.1) Full implementation of strategy	Delivery of the 2023/24 People Committee Implementation Plan **Owner:** DDWOD **Date due:** 31st March 24	Report to People Committee in June 23 highlighting Q1 achievements and challenges. Progress report presented at WAG in Sept 23 detailing achievements and mitigations were actions have not been achieved.	3 x 3 = 9
								G1.2) Delay in publication of the national NHS People Plan leading to uncertainty around national priorities	Continue delivering priorities in People Commitment whilst awaiting publication. Once published complete full review of People Committee to ensure priorities align **Owner:** DDWOD **Date due:** 30th November 2023	NHS People Plan published in July 2023. A gap analysis is underway to ensure the Trusts People Commitments is aligned to the national plan	
			C2) Base line assessments in place to support full implementation of e-roster **Control owner:** Director of Workforce	E- roster optimisation reported to WAG (May 23 and July 23).	MIAA audit - E-Roster 2021/22, substantial assurance received			G2) Gaps in the roll out of e-roster across all clinical areas / achievement of e-roster KPI	Fully optimise e-rostering systems to improve productivity and make significant savings through better management of the substantive and temporary workforces **Owner:** Head of Workforce Transformation **Date Due:** 30th January 2024 (previous date 30th December 2023)	e-roster divisional trajectories in development and to be reported to WAG in June 2023 Trajectories embedded into monthly divisional data packs and performance against plans now monitored via PRG	
			C3)New job planning system implemented in April 2023 **Control owner:** Director of Workforce	Job planning compliance reported monthly via the Workforce dashboards	MIAA audit - Medical Job Planning 2022/23, substantial assurance received			G3) Effective use of system to support job planning	Full role out of system training and compliance with job planning to support service requirements. Owner: Head of Medical Education **Date due:** 30th December 2023	L2PJob planning system launched – April 2023. System training delivered and supporting documentation developed	
			C4)Engagement and collaborative working with trade union colleagues, via monthly meetings and bi monthly Strategic Partnership Forum **Control owner:** Director of Workforce	Monthly meeting with Director of Workforce/Deputy Director of Workforce and Chair of staffside. Bi monthly SPF meetings and reports							
			C5)Divisional & Trust Workforce Dashboards provided to support the proactive management of workforce data. **Control owner:** Director of Workforce	Monthly workforce dashboards provided to divisions detailing workforce KPI performance. Data reported in monthly dashboards. Workforce key performance indicators monitored monthly to Board Trust via the IPR, quarterly to People Committee and bi monthly at WAG.				G5) Achievement of workforce KPIS	Implement sickness and retention divisional reviews to support achievement of KPIs **Owner:** HRBPs **Date due:** 30th March 2024	Finding from sickness and retention deep dives reported to WAG in September 23	
									Alignment of ESR with other key trust systems (e.g. finance, e-roster) to enable a comprehensive and accurate representation of the Trust workforce **Owner: Head of Workforce Transformation** **Date Due:** 30th December 2023	Alignment of ESR and the financial ledger completed and data included in divisional dashboards from July 2023. ESR optimisation report received at WAG in Sept 2023. Positive progress been made around the use of IPA to automatic workforce processes	
									Development of robust KPIs for medical workforce **Owner:** Head of Medical Workforce **Date due:** 30th December 2023 (previous date 30th Aug 2023)	KPI data for junior doctors now in place. A revised target date for completed of reminding KPI has been implemented due to a vacancy and the new Head of Medical Workforce not joining until October 2023	
	Measures 1. Turnover greater than 14% 2. Statutory Mandatory Training Compliance over 90%		C6)Vacancy management process (ECP) in place to manage, monitor and control vacancies **Control owner:** Director of Workforce	Bi weekly ECP meetings and Workforce Plan update reported bi annual to People Committee (September 23)				G6) Controls to monitor agency uses / spend	Full review of bank and agency processes and spend **Owner:** Director of Workforce and OD **Date Due:** 30th December 2023	Divisional bank and agency plans presented at ECP in August 23 Review of system and controls underway to ensure compliance with national requirements, and to support the uses of bank/agency spend	
			C7) Implementation of e-roster **Control owner:** Director of Workforce / Chief Nurse	E- roster optimisation reported to WAG (May 23 and July 23).	MIAA audit - E-Roster 2021/22, substantial assurance received			G7) Gaps in the roll out of e-roster across all clinical areas / achievement of e-roster KPI	Fully optimise e-rostering systems to improve productivity and make significant savings through better management of the substantive and temporary workforces **Owner:** Head of Workforce Transformation **Date Due:** 30th January 2024 (Original date 30th December 2023)	e-roster divisional trajectories in development and to be reported to WAG in June 2023 Trajectories embedded into monthly divisional data packs and performance against plans now monitored via PRG	
			C8)Health and wellbeing support including OH services to support staff absence and wellbeing **Control owner:** Director of Workforce	Quarter updates reports to People Committee (June and Sept 2023). Bi- monthly reports to WAG (July 2023)	Pulse results reported and Q2 on Model Hospital.				Provide a targeted action on improving the Health, Wellbeing and Engagement of all staff by ensuring staff have access to services and support that will help them manage their physical, mental and financial wellbeing **Owner:** Head of L&OD **Date Due:** September 2023	Wellbeing and engagement champions recruited. New intranet site in development to support effective signposting to services.	
			C9) Appraisal system in place to support career development, training and wellbeing conversations **Control owner:** Director of Workforce	Annual Review of Appraisal reported to WAG. Appraisal compliance reported in IPR and via monthly workforce dashboards	MIAA audit – Mandatory Training and Appraisal June 2022, substantial assurance received			G9) Ability to define critical roles within the Trust with associated succession plans	Provide support to the divisions in ensuring effective succession plans are in place for critical roles and develop effective mechanisms for identifying and managing talent **Owner:** HRBPs **Date due:** 1st March 2024	New appraisal system launched in June 2023 to support managing performance, supporting wellbeing conversations and managing career progression and development needs. BI appraisal dashboards implemented	
			C10) retention plans workforce intelligence **Control owner:** Director of Workforce	Quarterly retention report to WAG (Sept 23) and reported bi annually to People Committee (Sept 23)	HEE Nursing Retention tool submitted and positive assurance received			G10.1) Clear and consistence recruitment branding to promoting the trust as an employer of choice	Further develop our employer brand to attract the best talent and promote CCC. **Owner:** DDWOD **Date due:** December 2023	New processes implemented for proactively supporting work experience and careers events Review of recruitment pages on Trust website underway	
								G10.2) Full scale review of policy underway to support the NHSE 6 Actions for inclusive recruitment	Development of EDI work plan, including review of recruitment processes and practice support to ensure we provide inclusive recruitment opportunities. **Owner:** Head of EDI **Date Due:** 30th December 2024 (Original date 30th Aug 2023)	EDI work plan in place.	
								G10.3) Bespoke recruitment and retention plan for nursing and AHP workforce	Recruitment of Nursing and AHP workforce development Lead **Owner:** DDWOD **Date due:** 30th Aug 2023 **(completed)**	Nursing and AHP Development Lead post out to advert Nursing and AHP Development Lead recruited with a start date of 02nd October 2023	
			C11)Robust suite of leadership, personal development and clinical education and training programmes available to staff **Control owner:** Director of Workforce	Bi Annual Learning and OD Report to WAG (Sept 23) and People Committee (April 23 and Sept 23)	MIAA audit – Mandatory Training and Appraisal June 2022, substantial assurance received			G11) Reduced funding for Learning and OD activities with could lead to a reduction in staff training and support	Delivery of learning and OD programmes outlined in the 2023 prospectus and the commissioning of a bespoke leadership programme of staff in band 8b and above **Owner:** Head of L&OD **Date due:** 31 March 2024	2023 Leadership and Personal Development offer launched and approved at People Committee in April 2023 Bi Annual review of Learning and OD reported to WAG in Sept 23	
									Funding bid to be submitted via charitable funds Owner: Head of L&OD Date Due: September 2023 **(Completed)**	Additional funding to support L&OD programmes secured	
			C12)NHSI Workforce Plan developed **Control owner:** Director of Workforce	Approved at Trust Board, reported to WAG (July 23) and People Committee (Sept 23)				G12.1) Effective use of apprenticeship levy to supporting workforce transformation / workforce planning	Increase in engagement in apprenticeships as a means for supporting workforce / role transformation and attracting candidates into the Trust **Owner:** Head of L&OD **Date due:** March 2024	Pilot AHP apprenticeship approved	
								G12.2) Trust wide understanding of work planning to support workforce transformation to meet service needs	Provide support to the divisions in ensuring understanding of workforce planning and work planning data **Owner:** DDWOD/HRBP **Date due:** 31st March 2024		
									Increase number of postgraduate placements **Owner:** DDWOD **Date due:** 30 March 2024	Increased placements from September 2023. New partnership with Edge Hill implemented	

Additional Narrative

BAF 12 Ability to promote and embed a positive, inclusive and healthy workplace culture.

RISK APPETITE: Workforce MINIMAL (tolerance 4-8)

STRATEGIC OBJECTIVE: Be a Great Place to Work

Risk description & information	Causes & consequences	Initial (inherent) risk score	Key controls *(what is in place to manage the risk?)*	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Residual risk (current) score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24
BAF12 If the Trust is unable to provide a positive, supportive and inclusive culture, where individuals wellbeing needs are met and individuals feel valued and rewarded for their contributions there is a risk that this will result in an adverse impact on staff performance, wellbeing, engagement, retention, trust reputation, and the ability to deliver services and patient care **Executive Risk Lead:** Jayne Shaw, Director of Workforce & OD **Board Committee:** People **Last Update:** 7th September 23	**Causes** 1. Staff burn out 2. Increased pressure on staff due to high turnover / sickness 3. Lack of inclusivity 4. Staff not feeling a sense of belonging to the trust 5. Lack of reward and recognition 6. Lack of investment in staff development and wellbeing Consequences 1. Loss of goodwill and staff engagement 2. Increased sickness 3. Increased turnover 4. Reputational damage **Measure** 1. Sickness Absence greater than 4% 2. Turnover greater than 14% 3. Pulse Staff Survey Employee Engagement Score 4. BAME Staff representation	4 x 4 = 16	C1) Occupational Health Service for staff **Control owner:** Director of Workforce	Performance monitored quarterly and reported to WAG annually	Staff Survey Results 2022 – Increase in 7 out of 9 People Promise scores. Increases in all wellbeing scores. Full report reported to Board and PC in April 2023	3 X 4 = 12	No	G1, G2)Gaps in the provision of wellbeing workforce metrics / KPI	Develop KPI and metrics for wellbeing and engagement to support with the triangulation of workforce intelligence **Owner:** DDWOD / HRBPs **Date due:** November 2023	Gap analysis against NHS Wellbeing framework completed. Review of NHS people plan underway to identify any national targets required	2 x 3 = 6
			C2) Employee Assistance Programme, including counselling and virtual resources **Control owner:** Director of Workforce								
			C3)Non-Executive Health & Wellbeing Guardian to hold Trust to account on ensuring H&WB is an organisational priority **Control owner**: Director of Workforce	Quarterly Wellbeing and Engagement reports to People Committee							
			C4)Divisional Culture and Engagement Improvement Plans **Control owner**: Director of Workforce	Annual to WAG (July 2023) and via divisional PRGS				G4)Gaps in the provision of wellbeing and engagement workforce metrics / KPI	Develop KPI and metrics for wellbeing and engagement to support with the triangulation of workforce intelligence **Owner:** DDWOD / HRBPs **Date due:** November 2023	Gap analysis against NHS Wellbeing framework completed. Review of NHS people plan underway to identify any national targets required	
			C5)OD interventions to support developing team culture Divisional Culture and Engagement Groups **Control owner:** Director of Workforce	Bi Annual Learning and OD Report to WAG (Sept 23) and People Committee (April 23 and Sept 23)				G5.1)Reduction in funding for leadership and staff development	Funding bid to be submitted via charitable funds Owner: Head of L&OD Date Due: September 2023 **(Completed)**	Additional funding to support L&OD programmes secured	
								G5.2)Structured process, engagement and reporting for Freedom to Speak up	Full review of Freedom to Speak up processes and relaunch across the organisation. Quarterly reporting into People Committee **Owner:** FTSU Lead **Due date:** December 2023	New Freedom to Speak up Guardian recruited. Relaunch of FTSU process at CCC. National Freedom to Speak Up training assigned to all staff (level 1) and Managers (level 2)	
								G5.3)No formal trust wide wellbeing and engagement group	Implement a Trust wide wellbeing and engagement group chaired by the Deputy Director of Workforce and feeding into Workforce Advisory Group **Owner:** DDWOD **Due date:** 30th November 2023 (original date - September 2023)		
			C6)Mental Health First Aiders **Control owner:** Director of Workforce					G6)MHFA are not embedded into the organisation/ routinely accesses for support	Allocate trust lead for MHFA, re-engage with trained mental health first aiders and introduce formal reporting of activities into Wellbeing and Engagement Group **Owner:** Head of L&OD **Due date:** December 2023		
			C7)Live Well, Work Well Health and Wellbeing programme **Control owner**: Director of Workforce	Approved at People Committee April 2023. Quarterly Wellbeing and Engagement reports to People Committee				G7.1) Lack of invest in wellbeing & engagement, including physical environment	Explore opportunities for external funding to support wellbeing and engagement activities **Owner:** Head of L&OD **Due date**: December 2023	Charitable funds bid for 2022/23 successful achieved. Charitable funds bid developed for 23/24	
								G7.2)Wellbeing champions role to be implemented	Develop a role description and recruit staff Wellbeing Champions across the organisation **Owner**: Head of L&OD **Due date**: July 2023 (completed)	15 staff wellbeing and engagement champions rec	
			C8)Staff networks ensuring an inclusive staff voice is heard **Control owner:** Director of Workforce	Bi Monthly at WAG	WRES & WDES Annual Reports incl external benchmarking data reviewed at Trust Board (April) and PC (April)			G8)Engagement in and outputs of staff networks	Celebrate diversity and promote an environment of openness and inclusion free from discrimination and bullying **Owner**: Head of EDI **Due date:** January 2024	Positive engagement in Liverpool Pride in Aug 2023. Plans developed for inclusion week in September 2023	
			C9)Trust values embedded into annual appraisal process **Control owner:** Director of Workforce	Annual Review of Appraisal reported to WAG. Appraisal compliance reported in IPR and via monthly workforce dashboards					Develop systems and processes that enable high quality appraisal conversations with their manager that supports performance, wellbeing and career development **Owner:** Head of L&OD **Due date**: November 2023**(complete)**	New appraisal system launched in June 2023 to support managing performance, supporting wellbeing conversations and managing career progression and development needs	
			C10)Quarterly Pulse surveys providing a temperature check for organisational culture & engagement levels **Control owner:** Director of Workforce	Pulse survey results reported to PRGs, WAG, People Committee and in IPR	Model hospital data report via IPR. National staff survey data			G10.1)Decline across some areas for staff feeling valued and recognised	Implementation of Trust staff survey priorities to support improvements in culture, engagement and wellbeing **Owner**: Head of L&OD **Due date:** December 2023	Day in your Shoes Programme launched. Big conversations - A Great Place to work, planned for September 2023, new face to face with Chief Executive introduced. Increased score reported in Q2 Culture and Engagement Pulse results. 2023 Staff Excellence Award planned for 06th October 2023.	
										You said we did communications developed. 2023 Staff Survey launching 11th September 2023	
								G10.2)Lower quartile in staff survey for staff recommending the Trust as a place to work in compared to C&M Trusts		Divisional culture and engagement plans received and reported to Julys WAG	
										Q1 pulse survey completed, with an increase in completion rate and improvements seen in 7 out of the 9 questions, including recommending the Trust as a place to work. Q2 pulse survey completed, and increased score seen across 8 out of the 9 questions, including staff recommending the trust as a place to work.	

Additional Narrative

BAF13. Development and adoption of digitisation

RISK APPETITE: Digital CAUTIOUS (tolerance 8-12)

STRATEGIC OBJECTIVE: Be Digital

Risk description & information	Causes & consequences	Initial (inherent) risk score	Key controls (*what is in place to manage the risk?*)	Board Assurance: Internal assurance *What/where reported/when?*	Board Assurance: External assurance *What/where reported/when?*	Residual (current) risk score	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24
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:** 6 September 2023	**Causes** 1. Unknown national funding arrangements for Digital. 2.Lack of operational and clinical workforce digital capability. 3. 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. Digital Board ensures the Trust's strategic and operational plans are supported by Digital Technology. **Control Owner**: CIO	The Digital Board reports monthly to Trust executive Group (TEG) with 6 monthly strategy updates to Quality Committee and quarterly Cyber reports to Audit Committee Committee.		3x 3 = 9	Yes				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 work stream approach and proposed Governance to take forward the findings from the review of clinical systems optimisation - July 22	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"			G2) Operational ownership for transformational change prior to digitisation	Progress of operational transformational programmes will be monitored via Transformation Improvement Committee (TIC) and digital dependencies will be managed via Digital Board **Action Owner**: COO **Due date**: 31st March 2024	Alignment of roles and responsibilities is ongoing with The Outpatient Transformation Programme (TOTP) , ensuring operational change is planned for before digital solutions and resource are introduced. This will be managed via TOTP programme Board and Digital Board.	
			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.			G3) Full overview of all digital programmes needed to ensure capture of new and emerging programmes and is fully aligned to Digital Strategy	Review of existing and new digital programmes and alignment to Digital strategy themes. **Action Owner**: CIO **Due date**: 30th July 2023. Complete	All programmes and projects currently aligned and to be reviewed at programme Board in June 23. All existing digital programmes of work are now fully mapped against the new Digital Strategy. This will be reviewed on an ongoing basis in line with any new and emerging regional/national strategies. Complete	
			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							
	Measure 1. The National Digital Maturity Assessment sets levels of digital maturity scores between 0-5 (5 being the highest) against the 7 domains of the What Good looks like Framework. We will report on progress of all 52 questions where scores fall below 5. Progress update December 23 2. Key KPIs will be aligned to the new Digital Strategy as part of its implementation plan and additional measures will be developed and added to BAF 13 KPIs		C5) Strong Clinical Leadership and Engagement through Chief Clinical Information Officer (CCIO) and Chief Nursing Information Officer (CNIO) **Control Owner**: Medical Director	N/A				C5) Strong clinical Leadership required to embed and deliver Digital Strategy themes	Continued clinical leadership in digital optimisation programmes and clinical involvement for key deliverables within the strategy. To be monitored via digital board. **Action Owner**: Medical Director **Due date**: 31st March 2024	Clinical leaders in place to support clinical systems optimisation work streams, presenting at Digital Board. The work with clinical and digital leadership continues through all programmes of work and exceptions flagged at Digital Board and Digital Performance Review Group.	
			C6) Trust Digital Strategy in place to set organisation strategic direction. **Control Owner: CIO**	Digital Strategy endorsed by Digital Board and Quality Committee and approved at Trust Board on 31 May 2023				C6) Strong operational Leadership required to embed and deliver Digital Strategy themes	Continued alignment of programmes and dependencies through Transformation Improvement Committee and Digital Board. TIC leading on process change. **Action Owner**: COO **Due Date**: 31st March 2024	The Outpatient Transformation Programme (TOTP) has updated TIC and Digital Board and progress will be monitored by both meetings. TIC for process optimisation and Digital Board for digitisation. A new TIC Terms of reference was approved at Trust Executive Group in September ensuring digital involvement is maintained . All key projects supporting the Trust's Digital strategy will have appropriate clinical, operational and digital leadership.	
			C7) C&M Digital & Data Strategy in place to support ICB digital direction **Control Owner: CIO**	CCC Clinical and digital involvement in development of C&M digital and Data strategy through a series of interactive and formation workshops, Summer 23.							
			C8) National Digital Maturity Assessment completed, establishing a digital maturity baseline for 23/24 for all seven domains of the What Good Looks like Framework (WGLL) Well Led, Ensure Smart Foundations, Safe Practice, Support People, Empower Citizens, Improve care and Health Populations. **Control Owner: CIO**	National Self assessment completed collaborative and assured via digital Board	National baseline expected Summer 2023 to measure improvements			C8.1) Trust wide ownership and engagement with the What good Looks like framework to support improvements in Digital maturity, particularly in "Empowering Citizens"	Present "Empower Citizens" Digital maturity Scores to Patient Inclusion and Engagement Group developing a co-produced action plan for any areas of improvement **Action owner**: Chief Nurse **Due date** 31st December 2023	C&M Digital Inclusion Lead scheduled to present best practice and tools for digital inclusion in July2023. Chief Nursing Information Officer to present Digital maturity scores and develop action plan with Head of Patient Experience . Overall progress to be monitored by Digital Board. Position statement of scores for Full Digital Maturity assessment, scores and areas for improvement will be shared with Trust Executive Group in October 23. Improvements required will require Trust wide leadership and commitment.	
								C8.2) Trust wide ownership of the What good Looks like framework to support improvements in Digital maturity, particularly "Support People"	"Support People" digital maturity scores to be presented to Workforce Advisory Group (WAG) and a joint plan developed for any areas of improvement **Action Owner** : HRD **Due date** 31st December 2023	Digital maturity scores for "Supporting People to be presented to Workforce Advisory group (WAG) with a joint plan developed to increase levels of Digital maturity. Overall progress of all domains to be monitored via Digital board. Supporting people section to be presented to WAG following presentation at TEG	

Additional narrative

The Organisation is developing it's levels of digital maturity through better use of digital systems and data. 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 clinically and operationally. 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. The Digital Strategy for the organisation has been approved by Trust Board in June 2023 . Along with implementation plans of the Strategy, further KPs will be added to measure BAF 13. There are a number of actions to complete within year , which will add to our controls .. A number of the actions are dependant on transformational change and it is expected that the risk will maintain a score of 9 throughout the year.

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: Internal assurance (What/where reported/when?)	Board Assurance: External assurance (What/where reported/when?)	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score by 31/03/24 L x C
BAF14 There is a risk of **major security breach** arising from increasing digitisation and cyber threats, which could disable the Trust's systems, disrupt services and result in data loss **Executive Risk Lead:** Sarah Barr, Chief Information Officer **Board Committee**: Audit **Last Update:** 03 October 2023	**Causes** 1. Increasing sophistication and variety of malicious attacks 2. Integration of networks across the ICB 3. Increased reliance on digitised processes 4. Legacy infrastructure requiring modernization 5. Heightened national and international threat **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 preceding year- whichever is highest) 4. Fraud/theft 5. Reputational damage **Key Performance Indicators**: 1. The National Digital Maturity Assessment sets levels of digital maturity scores between 0-5 (5 being the highest) against the 7 domains of the What Good looks like Framework. We will report on progress of specific Cyber related questions within Safe Practice domain. 2. Data Security and Protection Toolkit scores (annual) 3. Microsoft Defender endpoint scores (Monthly) ISO27001 (annually)	**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 Chairs report to Digital Board. Regular quarterly report to Audit Committee including security posture	NHS Digital receive real-time telemetry from Windows devices, which feeds national dashboards and triggers alerting.	**4 x 3 = 12**	**Yes**				**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.						
			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)						
			C4) Adherence to Cyber Essentials standards & IS027001 **Control Owner**: CIO	CE & CE+ accreditations and compliance progress tracked via Digital Security Committee. Quarterly reporting to Audit Committee	Cyber Essentials Plus certification awarded December 2022. External audit process underway to support ISO27001 compliance.			G4) Adoption of enhanced standards via ISO27001	Plan in place for progress towards 2022 ISO27001 implementation **Action Owner**: CIO **Due date**: July 2023 (revised from March 2023 **Complete**	ISO27001 - Gained accreditation for the International Standard for Information Security ISO27001. British Standards Institution (BSI) Group performed audits at CCCW, CCCA and CCCL during June and July 2023. Their recommendation was to approve accreditation for the Trust Cyber Essentials Plus certification action complete. Certification awarded in December 2022. Reaccreditation due in Dec 23	
								G4) Adoption of enhanced standards via ISO27001	Plan in place for progress towards "2023" ISO27001 accreditation **Action Owner**: CIO **Due date**: July 2024		
								G4) Adoption of enhanced standards via re-accreditation of Cyber essentials Plus	Plan in place for re accreditation of Cyber Essentials Plus Accreditation **Action Owner**: CIO **Due date**: January 2024		
			C5) Network vulnerability Monitoring **Control Owner**: CIO	Security posture dashboards presented to Digital Security Committee on a monthly basis. Quarterly reporting to Audit Committee	External audits take place to provide independent assurance on posture. Annual external Penetration Testing is undertaken by an external body.			G5.1) Cyber incident response in-house skills	Digital Security Team taking Cyber Incident Response exams **Action Owner**: CIO **Due date**: Complete	Digital Security Team have undertaken Cyber Incident response courses.	
								G5.2) SOC 24/7 monitoring not available	Cheshire& Merseyside Regional 24/7 Security Operations Centre (SOC) being developed. CCC Leading on this **Action Owner:** CIO **Due date**: March 2024 (revised from November 2022)	CS working with external supplier and NHS England to develop a regional Cyber Security Strategy and a Regional Security Operations Centre (SOC) Roadmap for C&M. It is anticipated this will include an underpinning Blueprint to support the procurement of a SOC during 23/24- subject to regional funding	
								G5.3) Multi-factor Authentication	Roll out of Multi Factor Authentication remains a national priority. Full compliance is expected by June 2024. Plan in place to achieve compliance will be monitored through Digital Security Committee and Digital Board. **Action Owner**: CIO **Due date**: June 2024	Plan in place to monitor progress of MFA roll out monitored via Digital Security Committee. Digital Team regularly attend the national town hall events for latest news and developments related to national MFA roll out.	

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. The Trust has been awarded Cyber Essentials + certification in December 2022. This is a significant achievement for the organisation. The Trust has gained accreditation for ISO 27001 for all sites (CCCW CCCL and CCCA. This is a continuous process and work will now commence on getting ready for 2023 version of ISO27001. As with Cyber accreditation ongoing work is required for the organisation to maintain its accreditation annually . Operational level cyber risks continue to be managed through monthly Data Security Committee Meetings and IG Board. The 2023 submission of the Data Security and Protection Toolkit (DSPT) has received substantial assurance. Work has now commenced around collection of evidence for next years submission. Multi Factor Authentication remains a national priority and is seen as a basic cyber security control. MFA compliance will form part of the interim compliance check of DSPT.

BAF15 Subsidiary Companies and Joint Venture

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

STRATEGIC OBJECTIVE: Be Innovative

Risk description & information	Causes & consequences	Initial (inherent) risk score L x C	Key controls (*what is in place to manage the risk?*)	Board Assurance (*evidence that controls are working*) — Internal assurance *What/where reported/when?*	Board Assurance — External assurance *What/where reported/when?*	Residual (current) risk score L x C	Within risk tolerance?	Gaps in Control / Assurance	Actions — Planned action	Actions — Progress update	Target risk score by 31/03/23 L x C
BAF15 There is a risk of **inadequate management and governance of the Trust's Subsidiary Companies and Joint Venture**, which would result in failure to maximise the potential commercial and efficiency benefits for the Trust. **Executive Risk Lead:** James Thomson, Director of Finance **Board Committee**: Performance **Last Update:** 15 May 2023	**Causes** 1. Lack of clear strategy for subsidiaries 2. Lack of sufficient governance and assurance interfaces with Trust 3. Lack of signed SLA/contract agreements 4. Insufficient management capability/capacity **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. Internal audit review of governance arrangements complete May 2023 - substantial assurance received.	3 x 3 = 9	Yes	G1) Annual review of budgets to support SLA relationship to complete before Trust financial plan for year.	Review SLA discussion in Q4 22/23, with reference to strategic developments, ie clinic location (Paddington). **Action Owner:** DoF **Due Date:** 31/12/23	Agreed SLA position for 2022/23. Location option appraisal to be included in Phase 2 of Paddington development.	2 x 2 = 4
			C2) Strategy and 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. JV reports to Trust Board - twice per year (Part 2)	External audit required annually.			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**: 30/06/23 Complete	Marketing and engagement plan revised and being implemented by JV Manager. New JV Manager started April 23.	
			C3) Separate governance and Board arrangements for CPL and PropCare **Control Owner: DoF**	Internal SLA and financial reporting process managed through Finance Committee and Performance Committee. Also, operational performance managed through subsidiary specific Performance Review Groups.	Internal audit review of PropCare governance arrangements complete May 2023 - substantial assurance received. Both subsidiaries subject to external audit, and for CPL professional regulatory licensing.			G3) Final revised SLA for corporate services provided by the Trust to CPL, not approved between the parties.	CPL DoF has established a work stream to finalise Trust to CPL SLA for services. Trust/CPL to sign SLA following review. **Action Owner:** CPL Executive **Due Date**: 31/12/23	CPL DoF has established a work stream to finalise Trust to CPL SLA for services. Revised CPL SLA signed January 2023 for dispensary and procurement services.	
	Key Performance Indicators 1. Subsidiary financial performance updates to Trust Board (Part 2) 2. JV financial performance updates to Trust Board (Part 2) 3. Risk ratings above 15 to have mitigations in place		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.			G4) PropCare business development plan to be embedded	Trust to receive full business development plan Quarter 2, through Performance Committee. **Action Owner**: DoF **Due Date**: 22/09/23	PropCare have produced a strategy, and are pursuing opportunities within the Trust and with other NHS organisations.	
			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 corporate tax structure advised by KPMG.			G5) CPL to develop and present 5 year strategy to Trust Board for approval.	CPL to present strategy to Trust Board at next update. **Action Owner:** CPL Executive **Due Date:** 31/12/23	CPL has completed its draft strategy. Final version taken to CPL Board session June 2023.	

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, 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 Trust Board meetings.

Title of meeting: Trust Board
Date of meeting: 29th November 2023

Report author	Johanna Wynne FTSU Guardian			
Paper prepared by	Johanna Wynne FTSU Guardian			
Report subject/title	FTSU Board Self Reflection Tool Outputs November 2023			
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:			x
	Receive the report and note the assurance provided.			x
	Endorse the next steps detailed.			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	No	Disability	No	Sexual Orientation	No
	Race	No	Pregnancy/Maternity	No	Gender Reassignment	No
	Gender	No	Religious Belief	No		

Freedom to Speak Up Board Self Reflection Tool

Introduction

The National Guardian's Office and NHSE in partnership have produced two documents to allow organisations to assess their FTSU arrangements:-

A Guide for Leaders in the NHS and organisations delivering NHS services

And

FTSU: A reflection and planning Tool

These two documents are designed to be used together to asses FTSU arrangements.

The Reflection and Planning Tool Assessment

The guidance for assessment given by the NGO/NHSE is as follows:-

"The improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements."

"All NHS trusts and foundation trust boards have been asked to update their local policy to reflect the new national template by the end of January 2024. By this time, they should have also seen the outputs from using the self-reflection tool and provided at least one progress update"

The improvement tool with accompanying guide was completed on the 6th of November 2023 by Julie Gray and Geoff Broadhead, Exec and Non-Exec leads for FTSU supported by Johanna Wynne FTSU Guardian.

The Outcome

The tool helps identify gaps in the service provision and allows for the recording of high level development actions to be taken for improvement within the Trust over the next 6-24 months. Out of 80 questions our answers identified that we were compliant with best practice in 70 and 10 identifying areas for improvement. The areas for improvement are detailed below:-

We will develop our communication in relation to not accepting detriment for speaking up by adding information about this in to our FTSU policy. We will add information about identifying detriment into our FTSU Feedback Questionnaire	March 2024 Completed November 2023
We will develop the quarterly reporting of themes and trends by our guardian for inclusion within the current Trust reporting and monitoring structure to enable the triangulation of FTSU with other Trust data.	March 2024
We will use our FTSU intelligence to support workforce intelligence and OD interventions via data triangulation.	March 2024
We will consider an amendment to our FTSU Policy to sign post individuals to our guardian if they have not received a positive experience when speaking up directly within teams or directorates.	March 2024
Our guardian works closely with our patient safety and EDI lead to understand who isn't speaking and why. We will learn more about this by triangulating data.	March 2024
An investigation will be undertaken into any case of detriment – we will amend our FTSU Policy to clarify this.	March 2024
We will investigate the appropriate implementation of timescales for the timely progression of FTSU cases by reviewing the actual timescales achieved within the cases brought to the guardian at the point of the next FTSU Trust Board report due March 2024 when the guardian has been in post for 10 months and we have a suitable number of cases to make a meaningful assessment.	May 2024
We will undertake work to capture and share good practice and learning from concerns raised, with the key aim of fostering openness and transparency using an organizational wide learning platform to share lessons learnt and good practice in conjunction with PSIRF.	September 2024
We will research using Temperature check methodologies to help us to measure the effectiveness of our FTSU communications strategy.	September 2024

Conclusion

The Board is asked to note and approve the development actions and implementation timescales relating to the FTSU provision within the Trust. An update on the improvement actions will be provided in the March 2024 Board Report.

It is recommended that the Reflection and planning tool is refreshed every two years to ensure that the Trust FTSU provision is kept up to date with the next tool to be completed on or before November 2025.

Title of meeting: Trust Board Part 1
Date of meeting: 29 November 2023

Report lead	Kathy Doran, Chair			
Paper prepared by	Jane Hindle, Associate Director of Corporate Governance			
Report subject/title	Board of Directors Development Session – Developing Regional Expertise and Leadership to improve Urgent Cancer Care.			
Purpose of paper	The purpose of the paper is provide an overview of the development session held on 25th October 2023, and 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

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	Race	No	Pregnancy/Maternity	No	Gender Reassignment	No
	Gender	No	Religious Belief	No		

Ref: FCGOREPO
Review: July 2025
Version: 2.0

Board Development Session

25th October 2023

1.0 Background

Board Development Programme is designed to enhance the knowledge and awareness of Board Members and ensure the effectiveness of the Board collectively and individually.

Whilst individuals focus on their own learning identified within their annual appraisal the programme of Board Development Sessions provides opportunities for in-depth learning and discussion on key topics, e.g. system working and decision making, and reflect on how these will shape the future strategy of the Trust.

2.0 Objective and format of the development session

The development session held on 25th October was delivered by:

- Joan Spencer, Senior Responsible Officer and Chair of the Cheshire and Merseyside Urgent Cancer Care Programme Board,
- Dr Ernie Marshall, Deputy Chair of the UCCPB, Mel Warwick, Head of Transformation CCC,
- Laura Jane Brown - Senior Project Manager CCC
- Sarah Griffiths, Senior Project Manager Cheshire and Merseyside Cancer Alliance (CMCA).

The session was designed to provide the Board with an understanding of the work underway to improve Urgent Cancer Care within the Cheshire and Merseyside Region. Including:

- The role of the Urgent Cancer Care Programme Board and governance arrangements
- The work streams within the programme and the funding arrangements
- The improved outcomes for patients since the establishment of the Programme

3.0 Next Steps

The next steps for the Programme are to:

- Complete a benefits realisation for each work stream
- Utilise the data to accurately measure impact and refine service specifications (reduction in demand / attendance at Emergency Department, hotline data analysis, patient experience)
- Develop a proposal for the expansion of the CCC Hotline service (NHS 111)
- Present a proposal for the future model to the Cheshire and Mersey Cancer Alliance board in Dec – for the Urgent Cancer Care Programme Board to sit within the Alliance's mainstream portfolio

4.0 Recommendation

The Board is requested to:

- note the report.

Board Committee Assurance Report

Report to	Board of Directors
Date	
Committee Name	Liverpool Trusts Joint Committee
Date of Committee Meeting	21 September 2023
Chair's Name & Title	David Flory, Chair Liverpool University Hospitals NHS Foundation Trust

Matters for Escalation

There are no matters for escalation.

Key Discussions

The Committee received an update on the activities from the following sub-committee as follows:

1. **The Walton Centre NHS Foundation Trust/Liverpool University Hospitals NHS Foundation Trust Joint Committee Update**

   Progress on the three priorities of work was provided which detailed progress within imaging pathway, emergency care pathway and estates and digital pathway.

   It was noted that the thrombectomy pathway has been identified as a priority following changes in clinical guidelines. The utilisation of the exiting pathway and a demand and capacity review aligned to the new clinical guidelines is being undertaken.

2. **Liverpool Heart & Chest/Liverpool University Hospitals NHS Foundation Trust Joint Committee Update**

   Progress on the four priorities of work was provided which detailed progress within diagnostics, ward development pharmacy and critical care. Work ongoing within the Liverpool Cardiology Partnership was also noted.

3. **Clatterbridge Cancer Centre NHS FT/Liverpool University Hospitals NHS FT Joint Committee Update**

   A reminder of the three priorities of work was provided which detailed progress within medicines optimisation, radiology and emergency pathways.

4. **Liverpool Women's Health NHS FT/Liverpool University Hospitals NHS FT Partnership Group Update**

   - Health Sub-Committee of the Cheshire & Merseyside Integrated Care Board
   - Interim Joint Chief Executive Officer Recruitment Update
   - Liverpool Womens Health & Alder Hey NHS Foundation Trust Partnership Board
   - Progress on the development of the Liverpool Joint Risk Register

The Joint Risk Register between LUHFT & LWH was presented following a review undertaken between the trusts.

An update on the PLACE work updates was also presented detailing Alder Hey, Merseyside and Liverpool University Hospitals NHS FT which covered key updates. The Committee also received an update on progress on the move the Merseycare Walk-In Centre to the Linda McCartney Building at LUHFT was successful.

Programme Management Arrangements
Members agreed to progress a review by Trust Chief Executive Officers in order to meet the need to identify a programme management methodology for the Committee and reporting sub-group joint committees in order to successfully progress the recommendations from the Liverpool Clinical Services Review and other areas of collaboration identified.

LUHFT Improvement Journey
The Committee received an overview of the Liverpool University Hospitals NHS Foundation Trust Improvement Plan, alongside governance arrangements with the System Improvement Board as a Trust in Segmentation 4 of the Strategic Oversight Framework (SOF4).

Efficiency at Scale Opportunities
An update on the Efficiency at Scale Opportunities Programme being undertaken at a system level was presented. The aim in the programme was to identify and reduce unwarranted variation across corporate services, increasing service resilience and improving value for money.

Decisions Made

No decisions were made at the meeting.

Recommendation

The Board of Directors is asked to note the Liverpool Trusts Joint Committee Assurance Report pertaining to the meeting of 21 September 2023.

Title of meeting: Trust Board
Date of meeting: 29 November 2023

Report author	Gillian Heap, Director of Research and Innovation Operations
Paper prepared by	Gillian Heap, Director of Research and Innovation Operations
Report subject/title	Research & Innovation Annual Report 2022 - 2023
Purpose of paper	To review the activity, performance and advances in Research and Innovation during 2022 - 23.
Background papers	None
Action required	For discussion For information/ noting

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

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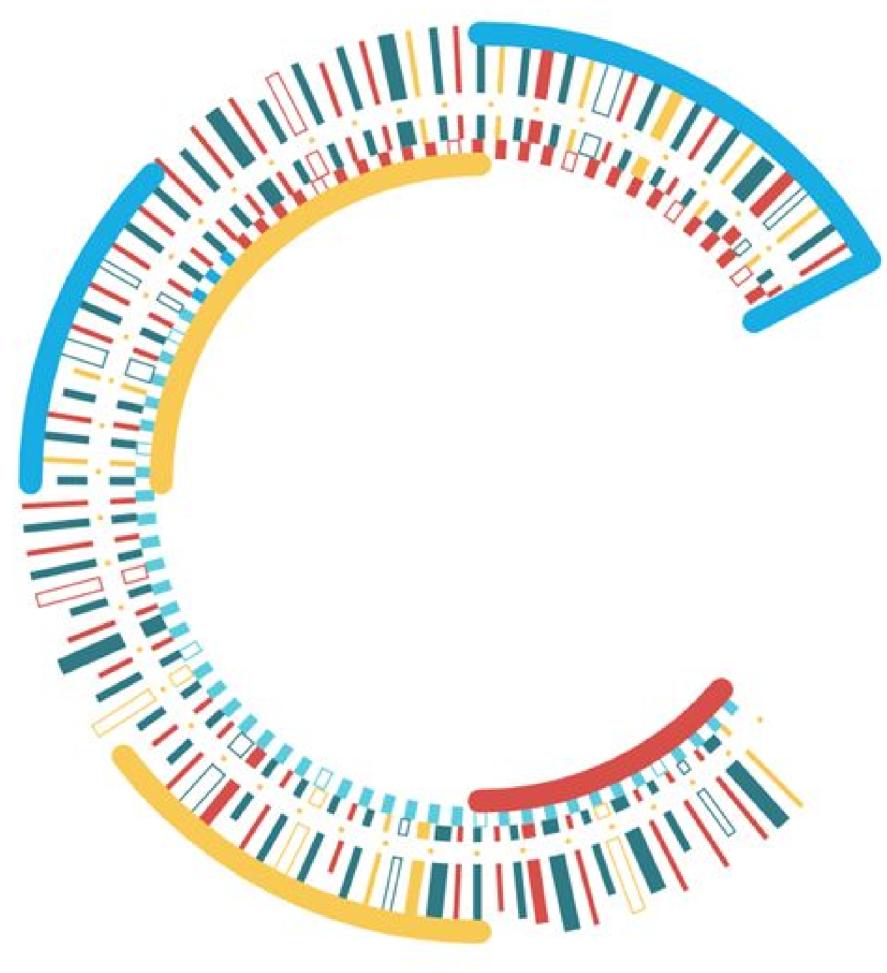
	Race	No	Pregnancy/Maternity	No	Gender Reassignment	No
	Gender	No	Religious Belief	No		

Ref: FCGOREPO
Review: July 2025
Version: 2.0



Research & Innovation Annual Report 2022-2023

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: Dr Maria Maguire, Emma Whitby, Fiona Penk, Drew Norwood-Green, Paul Ogden, Sally Jones

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1. Introduction

Research and Innovation (R&I) at The Clatterbridge Cancer Centre NHS Foundation Trust (CCC) has had another great year during 2022/23. This report details the notable successes which have been achieved.

R&I has recovered well after the national pause in cancer research in an NHS setting due to the COVID-19 pandemic. We are continuing to implement the key aims of the Trust's Research Strategy (2021-26) and are making great strides in achieving its vision to strengthen links and collaborations through our flagship hospital in Liverpool – within the city's Knowledge Quarter – and academic partners, including the University of Liverpool, other NHS organisations and stakeholders, which will ultimately improve the treatment and care of cancer patients.

In furthering this vision we are delighted to report that CCC is now an associate partner with the Royal Marsden in gaining Biomedical Research Centre (BRC) status and we also retained CRUK Experimental Cancer Medicine Centre (ECMC) status for the next five years.

These two national funding awards, in combination with our collaboration with the Liverpool Clinical Research Facility (CRF), are remarkable achievements as this is the first time that CCC has held such prestigious awards, and it is especially encouraging as they were gained within a highly competitive environment nationally.

These collaborations mean that CCC can now expand its early phase trials portfolio, bringing novel therapeutics to our patients and establishing CCC on a national platform as leaders in the key themes within the BRC and ECMC, notably in the cancer vaccine field.

As one of the most important centres nationally for cancer vaccine research, we have expanded our clinical trials in this pioneering treatment during 2022/23, with a number of important UK-first studies opening here and being led by researchers at CCC.

We have also continued to expand the diversification of the research portfolio in terms of translational, real world trials and qualitative studies – including opening our first international investigator-led research study – bringing a different dimension to the scope of the studies we carry out at CCC.

Our focus and reputation for always enhancing services for the benefit of patients is another key driver within the Trust's Research Strategy and we continue to improve choices, care, experience and outcomes for patients through cutting-edge research.

In striving to achieve this, we have embedded our new Early Phase Clinical Trials Unit at Clatterbridge Cancer Centre – Liverpool into the clinical research environment, with the support of the hospital's wider clinical teams. The unit has allowed us to open more important early phase clinical trials at Clatterbridge and given our patients an enhanced experience while they participate in them.

Our Biobank has also seen a rapid strengthening in its ability to collect and store important material to enhance our own clinical research trials and to provide a valuable biobanking service to other institutions and research teams across the sub-region.

In the area of innovation, CCC's Innovation Strategy (2023-25) was launched, giving strategic direction to our aim of solidifying a culture of enterprise within the Trust's workforce. The Strategy aims to generate fresh ideas, novel solutions and new ways of working which will drive the ultimate aim of R&I – better outcomes for patients.

Dr Gillian Heap, Director of R&I Operations
Dr Sheena Khanduri, Medical Director

Dr Gillian Heap

Dr Sheena Khanduri

2. Highlights of 2022/23

The R&I Directorate has been responsible for a number of notable achievements during 2022/23.

These include:

- Associate partner in the successful £29.1M NIHR Biomedical Research Centre bid with the Royal Marsden and Institute of Cancer Research.
- Retention of the CRUK Liverpool Experimental Cancer Medicine Centre with the University of Liverpool securing up to £1.5M.

£29.1M

Bid for NIHR Biomedical Research Centre status is successful. CCC is an Associate Partner

- 1166 new participants recruited into our research trials and studies.

1166
New participants on research trials and studies

37
New research trials and studies opened to recruitment

- Opened 37 new research trials and studies to recruitment (45 given permission to open at CCC).
- Exceeded national target of 500 participants into non-commercial NIHR portfolio studies securing additional funding for research at CCC.
- The Innovation Strategy was launched February 2023 focusing on three key areas: Cultivating the Culture of Innovation, Nurturing New Innovations and Supporting Adoption of Innovation.
- Big Ideas Scheme was launched in January 2023 with two successful applications funded by the Clatterbridge Cancer Charity.

BE **INNOVATIVE**

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

- The CCC Biobank continues to expand with a recruitment drive this year to collect age-matched samples from healthy volunteers.
- Diversification of the research portfolio to include not only interventional studies but also real world, observational, quality of life and translational studies. CCC also supported nationally important COVID-related trials, including non-cancer.

3. Top Highlights by Month

April 2022

- The MPN Registry (The Myeloproliferative Neoplasm Registry) went live. CCC is the sponsor for this HO database which is the first of its kind for this disease.
  CI: Dr Nauman Butt, pictured, Haematology
- The myeloma team were awarded the Myeloma UK CSEP (Clinical Service Excellence Programme) award for the second time. The award recognises best practice in myeloma care. This included being assessed within different areas. The team scored 100% in the 'Research and Clinical Trials' category.
- Dr Azman Ibrahim was a co-author on an article, 'A definitive prognostication system for patients with thoracic malignancies diagnosed with COVID-19', published in the Journal of Thoracic Oncology.

May 2022

- The first patient was randomised onto the ATNEC trial. ATNEC is a randomised trial investigating whether axillary treatment can be avoided in patients with no residual cancer in the lymph glands after chemotherapy for breast cancer. Patients are randomised to either radiotherapy to the axilla or no treatment to the axilla.
  PI: Dr Shaveta Mehta, Breast, (pictured right)
- CUP-COMP observational study reached its target recruitment of 5 patients within 7 weeks of opening. A comparison across tissue and liquid biomarkers.
  PI: Dr Elyaz Ahmed, Cancer of unknown primary (CUP)
- ANNAR study hit target recruitment. This is a biomarker study looking to identify bladder cancer patients who have a mutation in their FGFR gene. The patients identified can then potentially be recruited to other clinical trials investigating the effectiveness of the Erdafitinib drug which specifically targets the FGFR proteins.
  PI: Prof Isabel Syndikus, Urology

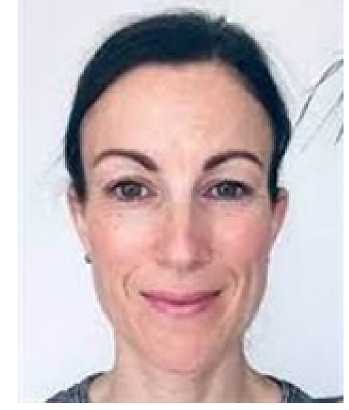
June 2022

- The first patient was treated on the Immunicore103 study in our Early Phase Trials Unit on Ward 4 at the end of June 2022. This is a first-in-human study. The patient was well after treatment and the team collected all of the required PK samples. Immunicore103 uses an experimental drug developed to help the body's own immune system to fight tumours.
  PI: Dr Joe Sacco, Various
- The Finding My Way study recruited 196 patients against a target of 128 which remained the highest in the UK.
  PI: Emma Whitby, Observational

- It was Red4Research Day on 17th June 2022, when R&I staff wore red to highlight the fantastic research in healthcare and beyond and to thank our Clatterbridge patients who participate in research and clinical trials.

July 2022

- First patient recruited nationally onto the MOAT study, a multicentre, non-randomised, phase Ib, neoadjuvant study of intravenous dosing in patients with surgically resectable squamous cell carcinoma of the head and neck.
  PI: Prof Christian Ottensmeier, Head and Neck
- The ICI Genetics study achieved its target recruitment. The study is looking to identify genetic factors that may lead to toxicities from immune checkpoint inhibitors.
  PI: Prof Isabel Syndikus, Urology
- Louise Turtle, Research and Development Expert Practitioner, pictured, presented 'Abdominal Motion Management' at the July UKIO Congress in Liverpool.



- The 300th patient was randomised to the Pivotal Boost study since it opened in 2018. This is a phase III randomised controlled trial of prostate and pelvis versus prostate alone radiotherapy with or without prostate boost.
  PI: Prof Isabel Syndikus, Urology

- The Rad-IO study was opened 21st July 2022, the first patient was referred on 22nd July 2022 and randomised on 26th July 2022. This study is a multi-stage randomised trial with chemoradiotherapy in patients with muscle-invasive bladder cancer.
  PI: Dr Joachim Chan, Urology

- The ManCan study looks to help men who suffer with hot flushes and night sweats due to hormone therapy given for prostate cancer by the use of self-directed CBT. The ManCan2 Study had its first national face-to-face CBT workshop meeting for patients and recruited their first patient.
  PI: Emma Whitby, Observational

- CCC was highest UK recruiter during July 2022 for the Atlanta study. Atlanta is a study for men with cancer which has spread from the prostate and is hoping to target the cancer with hormone therapy and other treatments.
  PI: Dr Azman Ibrahim, Urology

August 2022

- A story was shared on local media following a male CCC patient on the Ironman study. Ironman, which is sponsored by men's health charity the Movember Foundation, is aiming to enrol 5,000 men across 16 countries, including in Australia, Brazil, Kenya and the United States.
  PI: Prof Isabel Syndikus, Prostate

- Dr Rachel Brooker, pictured, passed her PhD viva following her successful CCC Clinical Research Fellow placement. Dr Brooker's thesis is titled 'Stratified Management of Oral Cavity Cancer – Reducing Side Effects and Improving Outcomes'.

- TACE-3, an immunotherapy trial designed to help a patient's own immune system fight the disease for patients with liver cancer. TACE-3 has opened as a site in a French hospital in collaboration with CCC. This is CCC's first investigator-led research study to open internationally.
  PI: Prof Dan Palmer, HPB

September 2022

- BNT-113 in combination with Pembrolizumab is a cancer vaccine clinical trial for patients with HPV16+ squamous cell carcinoma of the head and neck, first opened in May 2022 and Dr Ehab Ibrahim recruited the first patient
  PI: Prof Christian Ottensmeier, Head and Neck, pictured.

- The PEARLS trial was second joint highest recruiter behind the sponsor site, which was a great achievement from the team. This study is a phase II/III trial of Primary radiothErapy for Androgen sensitive pRostate cancer patients with Lymph nodeS.
  PI: Prof Isabel Syndikus, Urology

October 2022

- Dr Tony Pope was co-author on an article published in The Lancet on 14th October 2022, ‘Combination lurbinectedin and doxorubicin versus physician's choice of chemotherapy in patients with relapsed small-cell lung cancer (ATLANTIS): a multicentre, randomised, open-label, phase 3 trial’.

- 100th patient consented on to the RAPPER trial. The purpose of this study is to understand why some patients who receive radiotherapy are more likely to experience side effects than others.
  PI: Dr Zafar Malik, Multiple, pictured

- CCC is consistently highest recruiter nationally each month for the Pivatol Boost trial averaging 5-10 patients monthly. A phase III randomised controlled trial of prostate and pelvis versus prostate alone radiotherapy with or without prostate boost.
  PI: Prof Isabel Syndikus, Urology

- CCC consistently second highest recruiter in the UK for the Rampart study. An international investigator-led phase III multi-arm, multi-stage randomised controlled platform trial of adjuvant therapy in patients with resected primary renal cell carcinoma (RCC) at high or intermediate risk of relapse.
  PI: Dr Richard Griffiths, Urology, pictured

November 2022

- Prof Isabel Syndikus, pictured, was awarded an Honorary Professorship by the University of Liverpool after working in medicine for more than 35 years and more recently teaching students at the University of Liverpool.

- The first two patients for the RADAR trial for newly diagnosed myeloma patients started treatment. This is a national study for newly diagnosed transplant eligible myeloma patients. It is looking at precision medicine using two risk platforms – one based on genetics at diagnosis and the second based on depth of response (MRD response) following induction and stem cell transplant.
  PI: Dr Stephen Hawkins, HO

- Tagrisso is a prospective study looking at long-term survival and other outcomes after first-line Osimertinib. Recruitment target has been exceeded to date.
  PI: Dr Carles Escriu, Lung

- CCC was the second highest recruiter in the UK for the ACTICCA trial, only two recruits behind the lead recruiter. ACTICCA study is looking at adjuvant chemotherapy with gemcitabine and cisplatin compared to standard of care (capecitabine) after curative intent resection of cholangiocarcinoma and muscle invasive gallbladder carcinoma. This is because survival rates are low following curative treatment due to high rates of disease recurrence, and, therefore, evaluation of adjuvant treatment in biliary tract cholangiocarcinoma is needed.
  PI: Prof Dan Palmer, HPB

- ‘Clinical and molecular response to tebentafusp in previously treated patients with metastatic uveal melanoma: a phase 2 trial’ published in October’s Nature Medicine co-authored by Dr Joe Sacco. Together with previous publications in NEJM and JCO, this provides evidence for the efficacy of tebentafusp in metastatic uveal melanoma and provides really important data relating to the use of ctDNA to monitor benefit.

December 2022

- CCC was highest recruiting site for the Spruce study. Spruce is a study within a trial of electronic versus paper based Patient Reported oUtocmes CollEction health questionnaire completion.
  PI: Dr Isabel Syndikus. Urology

- CCC was highest recruiter for The Validation/Cancer Immunotherapies study 'Patient perceptions of outcomes and burdens of receiving immunotherapies for cancer'. This study is looking at side effects of Immunotherapy treatment via QOLs.
  PI: Dr Anna Olsson-Brown, pictured, basket study across all tumour groups

- The Hunter study has achieved target recruitment of 10 patients. The purpose of the study is examining why some people respond to treatments and some people do not in patients with hepatocellular carcinoma (HCC).
  PI: Prof Dan Palmer, HPB

- CCC was highest recruiter for the MOAT cancer vaccine study, receiving positive feedback.
  PI: Prof Christian Ottensmeier, Head and Neck

- Dr Raj Sripadam, pictured, co-authored an article in the Lancet. Immediate surgery compared with short-course neoadjuvant gemcitabine plus capecitabine, FOLFIRINOX, or chem-radiotherapy in patients with borderline resectable pancreatic cancer (ESPAC5): a four-arm multicentre randomised phase 2 trial.

January 2023

- CCC in collaboration with the University of Liverpool renewed its ECMC status for the next five years. The renewal is part of a network of 17 ECMCs across the UK funded by Cancer Research UK. This has achieved a funding investment of up to £1.5m over next five years, which is fantastic news for clinical research, in particular early phase trials of novel treatments.

- First patient recruited onto the Stamina study. Stamina is a supported exercise training for men with prostate cancer on Androgen deprivation therapy.
  PI: Michelle Cain, Urology

- Prof Dan Palmer was a contributing author in The Lancet – Gastroenterology & Hepatology, February 2023. 'Immediate surgery compared with short-course neoadjuvant gemcitabine plus capecitabine, FOLFIRINOX, or chemoradiotherapy in patients with borderline resectable pancreatic cancer (ESPAC5): a four-arm, multicentre, randomised, phase 2 trial'.

- Dr Maria Maguire, pictured, Sharon McGinn and Louise Turtle were contributing authors on 'Barriers and facilitators to conducting radiotherapy clinical trials: Findings from a UK survey'.

February 2023

- CCC was highest recruiter on the 'How do patients make decisions about rectal cancer treatment?' study. This is the DCE study – sub study from Aphrodite (PI: Dr Amir Montazeri, Colorectal and Lung, pictured).
- CCC achieved the recruitment target for the Vinehealth study. This study is an observational study, patients get randomised to a digital app or standard of care (PI: Dr Amir Montazeri, Breast, Colorectal and Lung).
- Through the Bright Ideas scheme, patients with Metastatic Spinal Cord Compression (MSCC) are now able to use a Levo screen holder which has been adapted for use in clinical environments, so patients having to lie flat and immobile for long periods while being diagnosed can still use a tablet device for entertainment, communication or to manage their care.

March 2023

- Prof Andy Pettitt received a grant award £278,968.87 from Blood Cancer UK. The importance of this grant is in terms of Liverpool's position in the health data research in blood cancer. This was awarded following a collaborative study that CCC sponsored.

- CCC was the highest recruiter in March for the Paradigm study. The study is trying to find out if a new blood test can provide information about which current treatments for prostate cancer will work best for future patients with this disease.
  PI: Prof Isabel Syndikus, Urology

- Dr Umair Khan, a Research Fellow and one of the leads for the UNCOVER Study gained his PhD which was excellent news and very well deserved. The PhD was awarded with no corrections which is very unusual and speaks to the high quality of his work.

4. Successful National Funding Bids

4.1 Clinical Research Facility and Early Phase Trials Unit

The NIHR Liverpool CRF is a collaboration between CCC, Liverpool University Hospital NHS Foundation Trust (LUHFT) and Liverpool Heart and Chest Hospital (LHCH). The collaboration was launched formally in November 2022.

CCC has identified our first new study that will run out of the CCC-CRF called Attainment, 'a modular, multi-arm, first-in-human trial to evaluate the safety and tolerability of MDX-124 alone and in combination with anti-cancer treatments, in participants with locally advanced, unresectable or metastatic solid malignancies' (PI: Prof Dan Palmer). Strategic and Operational CRF meetings now take place regularly between the three sites to ensure aligned strategic direction and operational efficiency.

The Liverpool CRF collaboration has opened up shared training opportunities for the nursing and medical staff involved in early phase research and we look forward to developing this further in 2023/24. To enable cross-site working, the teams have ensured they have the necessary honorary contracts to work across sites. The CRF PPI strategy is drafted with content included from all sites. Professor Dan Palmer is the academic lead.

Investment in staff to support the complexity of the early phase work has led to the introduction of a number of new and exciting roles to support the delivery of the early phase portfolio. Two Clinical Research Fellows have been appointed to join the medical team and within he nursing team, pictured, we have introduced a new trainee Advanced Nurse Practitioner an exciting role taking on advanced nursing skills such as physical examination and prescribing.

The Early Phase Clinical Trials Unit continues to support the following first-in-human trials:

- Transgene: A randomised phase I trial in patients with newly diagnosed loco-regionally 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: Prof Christian 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: Prof Christian Ottensmeier

- Immunocore 103: A phase 1/2 first in human study of the safety and efficacy of Imc-C103c as a single agent and in combination with Atezolizumab in Hla-A*0201 positive patients with advanced Mage-A4-Postive cancer.
  PI: Dr Joe Sacco, pictured

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

4.2 Experimental Cancer Medicine Centre

It was confirmed at the end of January 2023 that we successfully retained Liverpool's ECMC status. The Liverpool ECMC is a collaboration between Clatterbridge, Liverpool Clinical Trials Centre and scientists and researchers at The University of Liverpool. It is part of a network of 17 ECMCs across the UK, funded by Cancer Research UK, which deliver clinical trials of promising new treatments. Prof Dan Palmer (pictured overleaf) is the academic lead.

The bid successfully secured up to £1.5M for Liverpool. This additional core ECMC funding will support new posts in research nursing, research governance and trial administration at CCC. CCC will continue to support ECMC research nursing and research administration posts. Two new Early Phase Clinical Research Fellows, additional pharmacy support and further research governance support will be provided by CCC.

The research team has revisited and strengthened its governance arrangements in light of the successful CRF and ECMC bids and have introduced a new early phase operational meeting chaired by Emma Whitby, Head of Research Delivery.

4.3 Biomedical Research Centre

During 2022/23 we successfully became an associate partner in a NIHR Biomedical Research Centre 2022-27. This is a collaboration with The Royal Marsden/Institute of Cancer Research. The successful bid included eight cancer research themes and CCC will collaborate on the five themes, as shown below. Prof Nagesh Kalakonda, pictured, is the academic lead.

Theme	CCC Lead
Immunotherapeutics	Christian Ottensmeier
Precision Diagnostics and Cancer Evolution	Carlo Palmieri
Advanced Technologies for Cure	Isabel Syndikus
Precision Therapeutics	Nagesh Kalakonda
Cancer Treatment Effects and Survivorship	Anna Olsson-Brown

5. Clinical Trials Portfolio

The focus this year was on the early phase trials portfolio as part of the strategy to successfully retain ECMC status and to continue to build our reputation and skill set in such complex drug trials.

The early phase clinic and use of our CCC-CRF has facilitated this step-change in capacity. We have opened the third Replimune trial using an oncolytic virus to infect and kill cancer cells, and became a pipeline site for the series of trials using novel vaccines to combat cancers. The MOAT and NEBULA trials recruited the first national participants to the studies

and TebeMRD recruited the first patient on study at CCC, a key trial in the melanoma portfolio.

There is strength in depth in the support given by radiotherapy as the regional centre supporting the ATNEC trial, continuing as national lead recruiter to the PivotalBoost trial and Brioche trials. The portfolio continues to diversify with the welcome opening of the prehabilitation study SIPSMART. CCC hosted the first face-to-face CBT workshop nationally for the MANCAN2 prostate cancer study.

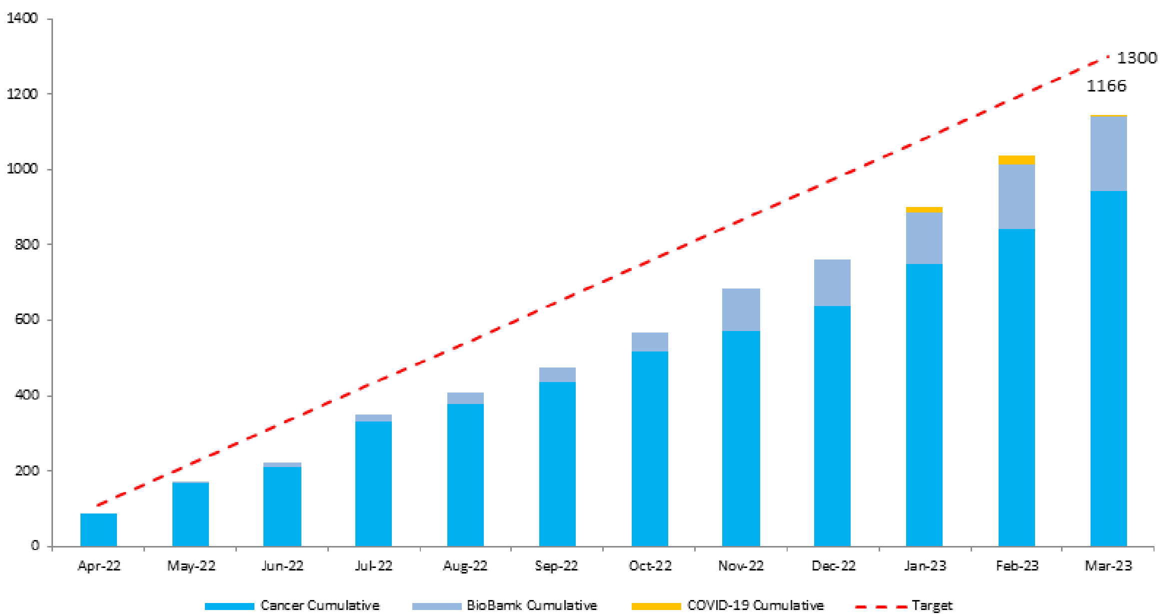
The Trust also supported the RAPID PROTECTION trial for immunosuppressed patients highly vulnerable to infection with SARS-CoV-2 virus. This extended our research reach nationally and we could also support non-cancer patients as part of this trial. The R&I team supporting those trials was also expanded 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

6.1 Patient Recruitment

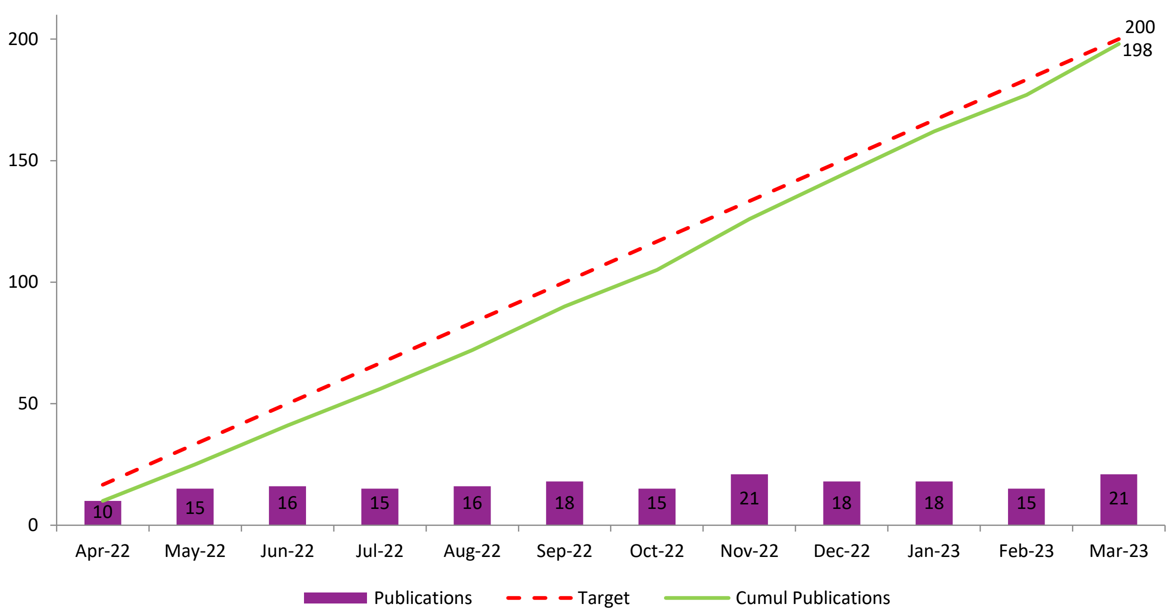
The R&I Directorate had a successful year for recruiting participants on to research trials and studies, see Graph 1. Retaining our ECMC status was key this year and a clinically-led, strategic decision was taken to increase the opening of ECMC studies as renewal approached. Although ECMC studies are scientifically relevant they are low recruiters which impacted on our overall result. Despite that we successfully recruited 1,166 patients, which is 90% of our original target.



Graph 1. Recruitment against Time: Cumulative recruitment against internal target (n=1300). Month on month split between Cancer (total Int&Obs), BioBank, COVID-19 (total UPH&Non-UPH) Cumulative stacked.

6.2 Publications

There were 198 publications recorded between April 2022 and March 2023, achieving 99% of the original target set, see Graph 2.



Graph 2 – New publications registered by month.

Impact factors for each publication were sourced and the information is summarised below. The impact factor relates to the journal and not the article itself. High impact journals are defined as over 15.

As can be seen in Table 1, the impact factor range for all 198 journals is 0.15-102.6 with a median of 5. The impact factor range where we are first or last author is 0.15-69.5 with a median of 5. We were either first or last author for over 30% of our publications.

	Publication Number	Impact Factor Range	Impact Factor Median
Total	198	0.15-102.6	5
First or Last author	61	0.15-69.5	5

Table 1: Summary of Clatterbridge publications for 2022/23

Breaking down the impact factors further, it can be seen that the highest percentage of our publications have impact factors of between 0-4.9 at 51.5%. Publications with an impact factor of over 15 makes up 20.2% of our publications.

Grouped Impact Factor	Number of Articles	%
0 to 4.9	102	51.5
5 to 9.9	35	17.7
10 to 14.9	21	10.6
over 15	40	20.2

Table 2: Total Clatterbridge publications for 2022/23 broken down by grouped Impact Factors

7. Systems Changes

During 2022/23, there have been a number of system changes that have led to increased productivity. Examples of these are shown below:

- Recruited a new Research Quality Manager. This is a key appointment for R&I as this post facilitates a step change in the quality improvement workstream within R&I. A new Quality and Governance Committee has already been implemented providing increased assurance on clinical trials process and procedures.
- R&I recruited two new administrative assistants to support trials processes in particular around Investigator Site File set-up and amendments to trials.

- Revised the process for review and implementation of amendments to clinical trials. The process was mapped, streamlined and tightened to assure timely implementation and feedback to Sponsor.
- The CCC Edge system continues to be developed to adapt to changing research needs. This year, we focussed on widening access to the Edge system to our CCC Chief and Principal Investigators. This allows rapid access to the trial documentation, including the protocols and to see where the trial is up to in set-up and recruitment status.
- We developed new reporting processes through Edge for internal and external metrics reporting. The RM&G team is working with IM&T to develop at a glance dashboards for BI for all aspects of trial set-up and conduct.

8. CCC-led trials and studies

This has been a year of consolidation and analysis for our CCC-led research. We have 11 studies currently open, with 2 in set-up and 5 in the analysis stage.

11	2
CCC-led studies open	CCC-led studies in set-up

We are delighted to report that the Uncover trial, led by Prof Andy Pettitt and funded by the Clatterbridge Cancer Charity, has been awarded a further grant from Blood Cancer UK of £278,968.87 to extend the current research.

This will centre CCC as the UK lead to understand how the treatment of blood cancer has changed during the pandemic. It will also look at the pros and cons of different blood cancer treatments to see which of them work best in different situations.

The research will involve a network of collaborators from across the UK, including not only senior blood cancer doctors but also patients and early career researchers.

We opened the MPN (Myeloproliferative Neoplasm) Registry, led by Dr Nauman Butt. This is the first national registry of its kind in this disease area and is expanding in the number of participating sites across the UK.

The TACE-3 trial, led by Prof Dan Palmer, opened to recruitment of patients in France. This is the first time CCC has led and recruited participants into an international trial.

Our nationally important COMICE trial in cervical cancer, led by Dr Rosie Lord, pictured, has closed to recruitment and entered analysis phase with an exciting linked translational research study underway.

Two of our COVID-19 trials are in analysis. These are The Burdett Study, led by Dr Lynda Appleton, looking at the COVID-19 pandemic on the psychological wellbeing of nurses working in cancer; and the CCP Cancer study: Clinical Characterisation Protocol for Severe Emerging Infections in the UK – a prospective companion study for patients with Cancer and COVID-19, led by Prof Carlo Palmieri, pictured.

Notably, the Safe Surgery study, led by Prof Christian Ottensmeier, has now been published in the British Journal of Surgery. The study confirms the absence of SARS-CoV2 in the peritoneal cavity of positive patients. It represents one of the largest studies of its kind and hopefully reassures the surgical community that open/minimally invasive surgery is safe.

A list of all current CCC-led trials that are open and in set-up can be found in Appendix 1.

9. Biobank

A total of 195 participants donated samples to the CCC Biobank this year, with huge support from CCC staff following a recruitment drive to collect age-matched samples from healthy volunteers.

We developed a collaboration to support the national Teenage and Young Adult cancer biobank and also a key collaboration to support novel research in drug induced cardiotoxicity, thus extending the nature and number of samples biobanked for novel research.

The Biobank, pictured, continues to prospectively collect samples from our patients to support high quality cancer research. This year we were supported by the brilliant CCC Trust staff in a sample recruitment drive to collect samples from healthy volunteers to provide crucial age matched control samples. This adds significant depth and range to our sample collection for researchers.

We also increased our collaborations this year, supporting sample collection in:

- Breast cancer prospective sample collection pre- and post-radiotherapy and chemotherapy treatments led by Dr Sheena Khanduri.
- Uveal Melanoma sample collection study: Do inherent differences in circulating immune cell populations predict for outcome to tebentafusp in metastatic uveal melanoma? Led by Dr Joe Sacco.
- Translational insights into Anthracycline cardiotoxicity, led by Dr David Gent, this is an important inter-Trust collaboration with the Liverpool Heart and Chest NHS Foundation Trust.

The trials laboratory staff worked across a range of clinical trials supporting sample collection, processing, storage and shipping in internationally important research, including complex ECMC and early phase trials.

10. Patient and Public Involvement in Research

The Clatterbridge Cancer Centre Research PPIE 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.

In December 2022, David Price, Research Governance and Quality Manager, took over as PPI Group Chair. The group discussed how they should look moving forward and how the group feel they can best be utilised.

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:

- Dr Michelle Lawton, University of Liverpool, gave a presentation on her Head and Neck study asking the PPI group for their review.
- Jamie Young, CCC Biobank and Clinical Trials Manger outlined his background in research and the expansion of the biobank. He believes that every patient should have the opportunity to donate to the biobank and he has engaged with clinicians and academics to assess their need for samples.
- Charlotte Rawcliffe and Sara Martin, ECMC Operational Director and ECMC Manager, informed the group of re-accreditation process for ECMC status and highlighted the work of the Adult and Paediatric Centres and their collaboration with the University of Liverpool in early phase and translational studies. Their work at present centres around pancreatic, haematological, hepatic and head and neck cancers.
- Dr Heulwen Sheldrick, Principal Speech and Language Therapist, informed the group of the research being done by the speech and language therapists (SaLTs) at CCC. Her particular research interests centre on clinical decision-making and she has been doing some national work with Prof Jo Patterson regarding laryngeal tumours.
- Paul Ogden, CCC Communications Manager, gave a presentation to the group on a communications plan for a ‘Be Research Ready’ campaign to raise awareness of research across the Trust, seeking the Forum’s feedback and comments.
- David Price gave the group a presentation on CCC sponsored research, informing the group of the sponsorship process including costing, legal requirements and the current sponsor portfolio of studies.

As well as hosting our own successful PPIE group, Emma Whitby, Head of Research Delivery, is leading on the CCC collaboration with the NIHR Liverpool CRF. The group is newly formed and is focused on developing the PPIE agenda with a special emphasis placed upon early phase research. To date the group has attended several meetings and have created a PPIE strategy.

11. External partners

11.1 Liverpool Health 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.

11.2 Clinical Research Network, North West Coast

In 2022/23, the Clinical Research Network, North West Coast (CRN NWC) provided over £830,000 of direct funding to CCC to support National Institute of Health Research portfolio activities.

In June 2022, CRN NWC appointed CCC's Dr Shaveta Mehta as an Associate Research Lead for Cancer covering the Cheshire and Merseyside area to work closely with the CRN NWC leadership team.

12. Nurse-Led Research

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

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 the following examples.

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 Gynae Cancer Narratives Project was a collaboration between Lancaster University and CCC, running between 2019 and 2022 and funded by North West Cancer Research.

A dissemination event was held for CCC staff on 28th November 2022 in CCC-L, to launch a book for patients and staff, published from the results of the study findings. The book, entitled 'We Need to Talk… about radiotherapy for gynaecological cancer', is intended to support professional-patient conversations about women's experiences of radiotherapy and its impact on their everyday life.

CI: Dr Lynda Appleton

12.2 CCC Staff Wellbeing Study

A CCC-sponsored study, with 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 managed their wellbeing during the COVID-19 pandemic, the coping strategies and support systems they used, and what, if anything, can be done to better support them. This year the study has been published in the Journal of Advanced Nursing.

CI: 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.

Recruitment has been completed: 69 nurses recruited from 18 NHS Trusts in Cheshire and Merseyside. 69 completed the survey, 7 attended focus groups, including 5 providers of wellbeing services.

A final report was completed January 2023 with positive feedback from the Burdett Trust. Study findings will be presented at two international conferences: the Royal College of

Nursing International Research Conference, in Manchester, and the International Conference on Cancer Nursing, in Glasgow.

CI: Dr Lynda Appleton

12.4 REAP-CCC

A CCC-sponsored study, Reducing Emergency Admissions for Patients with Cancer Complications and/or Co-morbidities, with funding secured from CCC Research Fund.

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. The study has received green light to begin recruitment of patients and their informal carers.

CI: Dr Lynda Appleton

12.5 Finding My Way

A University of Chester-sponsored study, funded by North West Cancer Research. An 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.

This work has been published in BMC Cancer and presented at two national conferences.

PI Emma Whitby, pictured.

12.6 Mancan2 Study

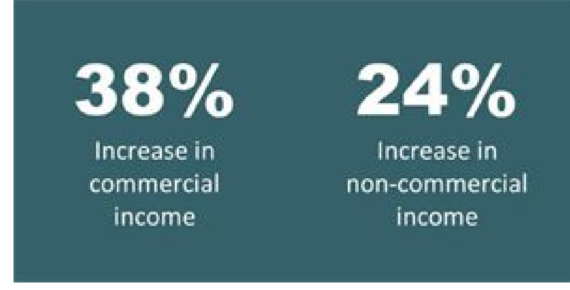
University of Chester-sponsored study, funded by North West Cancer Research, into virtual self-help cognitive behavioural therapy.

This study is a multicentre, randomised controlled trial of virtual self-help cognitive behavioural therapy to MANage the impact of hot flush and night sweat symptoms in patients with prostate CANcer undergoing androgen deprivation therapy (MANCAN2). A total of 23 patients are currently recruited.

PI: Emma Whitby

13. Finance

During 2022/23, financial recovery was on going with commercial income being below planned expenditure. However, commercial income grew by 38%, which was due to an increase in commercial studies opening in year.



Non-commercial income increased by 24% from the previous year. This is due to more non-commercial studies opening which have funding attached to them.

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

- RCF (Research and Capability Funding) – for recruiting 500+ participants to non-commercial portfolio adopted trials
- NIHR CRF joint bid with LUHFT and LHCH
- Royal Marsden BRC collaboration
- Renewal of ECMC status
- National Blood Cancer Grant awarded to CCC.

14. Communications

Over the past year, R&I has had high-profile promotion in the national, regional and local press and national and regional TV and radio, as well as being given regular exposure on the Trust's own channels: website, Facebook, Instagram, Twitter, Linkedin and YouTube.

Communications are carried out by Communications Manager (0.4 WTE), Paul Ogden pictured, who is a member of the Trust's communications team.

This media exposure has included widespread coverage of the Transgene trial, including filming by Sky News, pictured overleaf. *Please see Appendix 2 for other key examples.*

A communications campaign to promote the work of the biobank internally, with a request that staff donate samples, was a success, with over 60 patients coming forward to support this work.

There has also been internal communications involving R&I with the aim of increasing exposure of research and innovation activities to the wider CCC workforce – including celebrating International Clinical Trials Day, pictured below – and highlighting R&I's successes and the good work of individuals within the Directorate.

In addition to media coverage, R&I received positive feedback from sponsors, patients and investigators, as shown in Appendix 3.

Happy International Clinical Trials Day!

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Many thanks to everyone involved in clinical trials at CCC – you are leading the way in cancer research!

15. Innovation

15.1 Innovation Strategy

The Innovation Strategy was launched February 2023, with focus 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.

15.2 Bright Ideas Scheme

The Bright Ideas Scheme progresses innovations and ideas originated by staff and patients. The number of submissions the scheme received during 2022/23 increased to 98 from the previous year's 65. Notable examples of the projects supported by the scheme are:

- Pilot of Novel Bone Marrow Biopsy Technique – this is using the battery-powered OnControl system aiming to provide faster and better quality sampling and expected to cause less pain than existing manual techniques
- Pilot of Biozoon Seneopro, a flavoured foam which will enhance the patient experience for those that are aphagic or nil by mouth.

- Virtual tours of CCC-L have been explored and multiple suppliers considered. This is expected to form part of upcoming work, which seeks to address issues around wayfinding in the Trust.
- A patient-led innovation to develop clothing that can be easily added or removed without dislodging IV lines during chemotherapy (pictured left).
- Support has been provided to procure the e-Forms module for Healthcare Communications so that e-PROMS (electronic patient reported outcomes measures) can be trialled at CCC. This is aimed at facilitating personalised stratified follow-up so that there is less disruption to our patients' lives whilst providing enhanced care and support to those patients that require it.
- Collaboration with industry and University of Liverpool to enhance the patient experience for those diagnosed with metastatic spinal cord compression (MSCC) through change to a screen reader stand. This has been through an initial pilot with the original company (Serious Brands) developing adaptations to their product as a result, (pictured right).

15.3 Big Ideas Scheme

In an effort to promote larger scale project ideas, the Big Ideas Scheme was developed. The inaugural funding call launched in January 2023 and decisions were finalised March 2023. Two projects have been supported in this round, with a second call planned for later in the year:

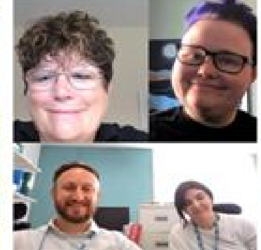
- Dr Ernie Marshall is developing a risk stratification tool by analysing the data across the region of our patients' unplanned attendances and admissions to emergency departments.

- Digital Home-Based Physical Activity – Dr Jess Hale, pictured, will be launching an 8-month pilot for our immunotherapy patients, using the MOTIVATE platform developed by Liverpool John Moores University.

16. Summary

Research and Innovation has remained nationally competitive in recruitment to trials and remains committed to offering CCC patients the best in novel agents and therapies within the research portfolio, in our ultimate goal in securing better outcomes for our patients and also making a significant contribution to the worldwide growth in knowledge and understanding of cancer.

In terms of innovation, we have started to build the infrastructure within the organisation to grow our culture of enterprise, 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.



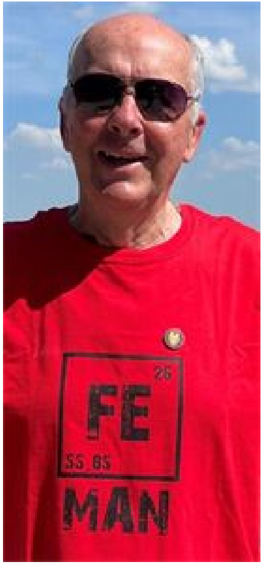
Appendix 1: CCC-led Research Where CCC Acts As Sponsor

Acronym	Title	Type	CCC Chief Investigator	Status
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
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
MPN Registry	The UK Myeloproliferative Neoplasm Registry	Registry	Dr Nauman Butt	Open
IMPULSE	IMmune-checkPoint inhibitors (ICI) in non-small cell lUng carcinoma	Translational	Dr Carles Escriu	Open
Target Vaccination	Evaluation of response to routine vaccination to assess immunocompetence in patients with cancer	Translational	Prof Christian Ottensmeier	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
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 under re-design
COMICE	A randomized double blind placebo controlled Phase II clinical trial of Cediranib and	CTIMP	Dr Rosie Lord	Closed in analysis

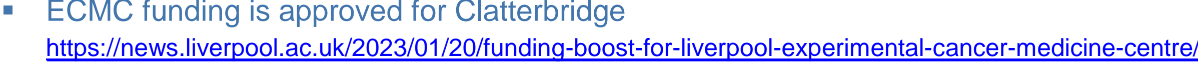
	Olaparib maintenance in advanced recurrent Cervical Cancer			
CCP CANCER	Clinical Characterisation Protocol for Severe Emerging Infections in the UK– a prospective companion study for patients with Cancer and COVID-19	COVID-19	Prof Carlo Palmieri	Closed in analysis
Burdett	Exploring the impact of the COVID-19 pandemic on the psychological well-being of nurses working in the cancer setting across Cheshire and Mersey	COVID-19	Dr Lynda Appleton	Closed in analysis
Safe Surgery	Establishing the presence of SARS-CoV2 virus in the peritoneal cavity of patients undergoing abdominal surgery	COVID-19	Prof Christian Ottensmeier	Published
COVID Staff	Exploring the impact of COVID-19 on the psychological well-being of oncology healthcare professionals	COVID-19	Dr Lynda Appleton	Closed in write up phase
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
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	Closed

Appendix 2: Key Communications

- Transgene vaccine clinical trial
  https://news.sky.com/story/personalised-cancer-vaccine-trials-produce-really-hopeful-results-12645491
  https://www.youtube.com/watch?v=0KO94fomo5Q
- Bowel cancer patient interviewed on TV about being part of a clinical research trial
  Clatterbridge bowel cancer patient talks on TV about being part of a clinical research trial (clatterbridgecc.nhs.uk)
- Prostate cancer patient promotes the Ironman study (pictured)
  https://www.mirror.co.uk/news/uk-news/dad-handed-silent-killer-diagnosis-27902206
  https://www.chesterstandard.co.uk/news/22385822.chester-ironman-grandad-jim-pleased-join-prostate-cancer-research-trial/



- Leukaemia patient talks about taking part in research
  https://www.liverpoolworld.uk/news/wirral-cancer-survivor-urges-people-to-consider-clinical-trials-3873476
- Clinical trial team tops league table for recruits
  https://www.wirralglobe.co.uk/news/20212765.clatterbridge-research-team-tops-table-study-recruits/
- Launch of Innovation Strategy
  Major cancer centre launches new Innovation Strategy | UK Healthcare News (nationalhealthexecutive.com)
- ECMC funding is approved for Clatterbridge
  https://news.liverpool.ac.uk/2023/01/20/funding-boost-for-liverpool-experimental-cancer-medicine-centre/
- Skin Cancer research patient – Viral oncology clinical trial
  https://www.liverpoolecho.co.uk/news/health/john-lewis-worker-injected-herpes-25563829



  https://www.wirralglobe.co.uk/news/23140622.mum-given-ground-breaking-cancer-treatment-clatterbridge/
- Clatterbridge in leukaemia research breakthrough
  https://www.wirralglobe.co.uk/news/23107309.clatterbridge-cancer-research-breakthrough-leukaemia/
- Prof Carlo Palmieri's breast cancer prevalence research
  https://www.dailymail.co.uk/wires/pa/article-11566693/More-women-living-secondary-breast-cancer-new-research-reveals.html
  https://www.independent.co.uk/news/uk/england-breast-cancer-now-university-of-liverpool-nhs-australia-b2250108.html
- Nurse's innovation goes national
  https://www.nursingtimes.net/news/cancer/liverpool-cancer-nurses-innovation-goes-global-03-11-2022/

- TV and press coverage of MOAT clinical trial (pictured)
  https://www.itv.com/news/granada/2023-01-27/mum-amongst-first-in-the-world-to-receive-pioneering-cancer-therapy
  https://www.mirror.co.uk/news/uk-news/mum-floored-given-5050-chance-29081064
  https://www.liverpoolecho.co.uk/news/liverpool-news/healthy-mum-given-5050-chance-26103331
  https://theguideliverpool.com/merseyside-mum-has-world-first-cancer-treatment-at-clatterbridge-cancer-centre/

- RAPID PROTECTION clinical trial
  https://www.liverpoolecho.co.uk/news/health/new-treatment-people-risk-covid-26150916
  https://theguideliverpool.com/liverpool-kidney-transplant-patient-joins-research-into-covid-19-treatment-for-people-with-poor-immune-systems/
- Dr Seamus Coyle's Biology of Dying research
  https://www.liverpoolecho.co.uk/news/health/liverpool-doctor-who-can-predict-26164721
  https://www.mirror.co.uk/news/uk-news/meet-doctor-who-can-predict-29203720
  https://www.dailystar.co.uk/news/weird-news/doctor-predicts-death-new-invention-29205901
- New hi-tech fitness project to help cancer patients
  https://theguideliverpool.com/a-new-hi-tech-fitness-project-to-help-clatterbridge-cancer-patients/
  https://www.youtube.com/watch?v=XqjVj7JHNNI&t
  https://www.nationalhealthexecutive.com/articles/digital-pilot-helping-cancer-patients-through-immunotherapy
- Patient raises awareness of clinical research trials
  https://www.youtube.com/watch?v=pvIoo8pYaBg
- Retired nurse given lifeline with new MODIfy research study
  https://www.liverpoolecho.co.uk/news/health/mum-news-never-expected-after-26852352
  https://theguideliverpool.com/clatterbridge-cancer-centre-clinical-research-trial-offers-a-lifeline/
- Grant success for blood cancer research
  https://www.wirralglobe.co.uk/news/23420731.boost-clatterbridge-cancer-centre-study-covid-19/

Appendix 3: Positive Feedback from Sponsors and Patients

Patient feedback from the daughter of a patient:

"To Justine, and the whole team for Dad's care, Thank you will never be enough, because of yourselves Dad was simply not scared of the cancer he had and he trusted you all without doubt. He talked about you all like you had been with him for years and he strived to have positive results with the treatment so the trial would be a success.

Every meeting, phone call or appointment he had with you he would retell me word for word, particularly when his blood work showed positive signs. Despite all this, I still feared he wasn't completely truthful of the pain he was in but he always said his team of Drs had everything in hand and were looking after him.

You did wonders for him and I'm only sorry he's not here to tell you himself. I really appreciate how you all made him feel – even when he was trying to get rid of Covid.

He said you had been in touch. I know he was just one patient in the NHS but to me he was my whole world and you're all never far from my thoughts and prayers for the care, confidence and positivity you gave Dad, so thank you.

Dad thought so highly of you all & I only hope you knew that from him. Thanks again x"

Sponsor positive feedback – for Atlanta Team, pictured (PI: Dr Azman Ibrahim, Urology):

Atlanta is a study for men with cancer which has spread from the prostate and is hoping to target the cancer with hormone therapy and other treatments. Highest recruiter in the UK during July 2022.

"Dear Azman, Lucy, Linda, and Sharon, I just wanted to personally thank you for your fantastic efforts in recruiting to IP2-ATLANTA. The team and myself are immensely grateful for everything you do in this study and this confidence has really helped when it came to convincing the funder and sponsor to continue to support it with an unprecedented 4-5 year extension so we can complete it.

Please do pass on my thanks to other colleagues involved in the local success of this study."

Sponsor positive feedback – for the R&I team:

"Dear RAGNAR team, I just wanted to say a big thank you for your hospitality and cooperation over the past couple of days for the RAGNAR audit, especially for all of the hard work that went into the preparation.

… overall Sarah had nothing but praise for the team at your site, particularly for all of the opportunities that you have given patients to participate in the study during the pandemic which is quite remarkable.

- *Nic and Katie had done a great job with the files and there were no findings there*
- *Praise for the level of study training compliance (again thanks Nic and Katie!)*
- *No findings at Pharmacy*
- *Praise for the Nursing Team in terms of their documentation of study visits*
- *No issues with patient safety*
- *No major issues with protocol compliance (other than the minor P(rotocol) D(eviations)s that have been documented)*
- *No issues with SDV (fix for documentation of AEs seems to have done the trick)"*

Patient feedback from a Lower GI patient on the ATICCA trial (PI: Prof Dan Palmer, HPB):

"I can never thank you enough for your parts in giving me precious time I would otherwise probably never have had xx".

Sponsor positive feedback – for Ironman team (PI: Prof Isabel Syndikus, Urology). The Ironman study (Prostate Cancer Outcomes: An International Registry to Improve Outcomes in Men with Advanced Prostate Cancer) has reached target. Positive feedback received from sponsor.

"Thank you for confirming you are continuing recruitment – as one the UKs fastest recruiters - we are really keen for you to keep going!"

Positive feedback from MANCAN2 sponsor, (PI: Emma Whitby, Urology):

"Thank you to all sites for identifying, inviting, and consenting your men for COHORT 1/ 2. A special thanks to Clatterbridge Cancer Centre for sharing their Top Tips for workshop delivery. Well done for leading the way and being our first site to deliver workshop 1 and 2, to your first group of men with plenty more recruits coming through for cohort 2!"

Positive feedback from MOAT sponsor, (PI: Prof Christian Ottensmeier, Head & Neck). MOAT is A multicentre, open-label, non-randomized, phase Ib, neoadjuvant study in patients with surgically resectable squamous cell carcinoma of the head and neck.

"You and your team are absolutely amazing! Thank you ever so much for being so proactive."

Positive feedback from Prof Chester who covered Prof Ottensmeier's clinic w/c 24th October 2022 working on the Modi-1 clinical trial to the ECMC team:

'I've always been a believer in the all-conquering powers of team-work, and Christian clearly has a marvelous trials team. It's a real pleasure to work with you all.'

Positive feedback from the Validation/Cancer Immunotherapies sponsor (PI: Dr Anna Olsson-Brown, SRG – basket study across all tumour groups). Validation/Cancer Immunotherapies looks at patient perceptions of outcomes and burdens of receiving immunotherapies for cancer. This study is looking at side effects of Immunotherapy treatment via QOLs.

'You have been absolutely incredible with getting these (questionairres) out, I am so grateful but also so impressed with your efficiency. When I've finished my PhD I'm picking up the CRUK centre nurse role and I'm going to persuade them (if you'll have me) to let me come up and learn a bit more about how your teams operate. We have quite a lot of learning to do'.

Patient feedback from a Nebula patient:

'Hello Lauren, thanks again for a pleasant treatment experience today – as always everyone is so nice and that makes a difference when you're spending so much of your time in hospital!'

Feedback for Dr Lynda Appleton from Senior Grants Manager, Burdett Trust for Nursing:

'Congratulations for driving this work forward through such challenging times. It is clearly evident that getting nurses to be able to have time to participate in research like this has been an enormous challenge for everyone. It is great that by going through this process you were able to identify such specific recommendations and that you have noted wide-ranging dissemination plans. We look forward to hearing how they go"