The Clatterbridge Cancer Centre NHS Foundation Trust

Agenda: Trust Board Part 1
Date/Time of Meeting: 28 February 2024, 09:30am
Location: CCC-L Board room 3

	Preliminary Business		Purpose	Lead	Time
149-23/24	Welcome, Introduction, Apologies and Quoracy	v	Information	K Doran	09:30
150-23/24	Declarations of Interest	v	Information	K Doran	
151-23/24	Minutes of the Last Meeting – 29 Nov 2023	d	Decision	K Doran	
152-23/24	Matters Arising / Action Log	d	Information	K Doran	
153-23/24	Cycle of Business	d	Information	K Doran	
154-23/24	Chair and Chief Exec's Report to the Board	d	Information	K Doran / L Bishop	09:40
	Our Patients and Staff				
155-23/24	Patient Story	d	Information	J Gray	09:50
156-23/24	NED and Governor Engagement Walk-round Nov 2023 and January 2024	d	Assurance	K Doran / E Abrahamson	10:00
	Our Strategy and Performance				
157-23/24	Performance Committee Chair's Report	d	Assurance	M Tattersall	10:10
158-23/24	Quality Committee Chair's Report	d	Assurance	T Jones	10:20
159-23/24	People Committee Chair's Report	d	Assurance	A Rothery	10:30
160-23/24	Mortality Report Q2	d	Assurance	S Khanduri	10:40
161-23/24	Integrated Performance Report	d	Assurance	Exec Leads	10:50
162-23/24	Finance Report	d	Assurance	J Thomson	11:00
163-23/24	Green Plan Annual Report	d	Assurance	T Pharaoh	11.15
164-23/24	Cancer Alliance Q3 Performance Report	d	Assurance	L Bishop	11:25
	Our Governance				
165-23/24	Audit Committee Chair's Report	d	Assurance	M Tattersall	11:35
166-23/24	Charitable Funds Committee Chair's report	d	Assurance	E Abrahamson	11.45
167-23/24	Governance and Escalation Framework	d	Assurance	J Hindle	11:55
168-23/24	Board Assurance Framework	d	Assurance	L Bishop	12:05
169-23/24	Board Development Programme – January's Actions	d	Information	K Doran	12.15
170-23/24	Liverpool Joint Committee Assurance Report – December 2023	d	Information	K Doran	12.25
	Concluding Business				
171-23/24	Questions from Governors and members of the public	v		K Doran	12.35
172-23/24	Items for Inclusion on the Board Assurance Framework	v		K Doran	
173-23/24	Reflections on the Meeting	v		K Doran	
174-23/24	Any Other Business	v		K Doran	
	Date and time of next meeting: 27 March 2024, 09:30am				

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Ref: FCGOAGEND
Review: July 2025
Version: 2.0

The Clatterbridge Cancer Centre NHS Foundation Trust

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

The Clatterbridge Cancer Centre NHS Foundation Trust

DRAFT Minutes of Trust Board Part 1
25 November 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
Terry Jones	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
Anne Mason	Corporate Governance & Governor Engagement Officer
Laura Jane Brown	Staff Governor (Nurses)
Emer Scott	Associate Director of Communications
Gemma Sayer	System C

Item No.	Standard Business
128-23/24	**Welcome, Introduction, Apologies & Quoracy:** Kathy Doran welcomed the Board members, observing Governors, staff and Gemma Sayer from System C. Apologies were noted from: Jane Wilkinson, Lead Governor Kathy Doran confirmed the meeting was quorate.
129-23/24	**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

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The Clatterbridge Cancer Centre NHS Foundation Trust

130-23/24	**Minutes of Previous Meeting** The minutes of the meeting held on 27 September 2023 were approved as a true and accurate record subject to the following amendments: • Terry Jones was present at the meeting • Item 108-23/24 Quality Committee Chair's Report should include, Clarity was sought regarding Research and Innovation data within the Quality Committee Report and it was agreed to consider if oversight of this would be provide by the Performance Committee.
131-23/24	**Matters Arising / Action Log** There were no matters arising. The Board noted the following updates to the Action Log: **Item 109** is now completed. **Item 106** – Equality Impact Assessment - will be taken through the management structure via Trust Executive Group who will set the date to bring to Trust Board.
132-23/24	**Cycle of Business** Kathy Doran advised the Board that the Emergency Preparedness, Resilience and Response (EPRR) Annual Report and Core Standards were on the agenda. **The Board:** • **Noted the Cycle of Business.**
133-23/24	**Chair's and CEO's report** The Board received the Chair and Chief Executive Report. Liz Bishop advised the Board that the Cheshire and Merseyside Acute and Specialist Trusts (CMAST) gained national recognition after winning Provider Collaborative of the year at the HSJ Awards. The first round of the Big Conversation sessions, held across all sites, have been very successful. Once complete the themes will be shared with staff and action plans developed. Jayne Shaw commented that feedback will be taken to People Committee where three main themes will be chosen. Liz Bishop confirmed that industrial action has been suspended whilst pay negotiations are ongoing. Jayne Shaw added that the staff survey has now closed and achieved 66% of the 70% target, which is higher than previous surveys, and given the growth in staff members this equates to a further 100 staff completing the survey. **The Board:** • **Noted the contents of the report.**

The Clatterbridge Cancer Centre NHS Foundation Trust

	Our Patients
134-23/24	**Patient Story** Julie Gray presented the patient story from Rob who has bowel cancer and lung metastases. He talks about his perceptions of chemotherapy and how scared he was prior to treatment. However, following an induction explaining where he was going and what would happen to him, he felt reassured as to what to expect. He compliments the incredible nursing staff who help him through his treatment, and the comfortable atmosphere. Rob is also being treated locally at the CANtreat Service in Halton Hospital. Tom Pharaoh advised that the Halton site is undergoing a period of refurbishment and the team are being careful not to lose the atmosphere whilst making the improvements. Liz Bishhop added that some people like peace and quiet whilst receiving their treatment, which is being considered within the new design. Mark Tattersall asked if staff on the Halton site see the patient story and receive the feedback. Julie Gray confirmed that the video and any actions are shared with the staff across all sites. **The Board:** • **Noted the story**
135-23/24	**CQC Adult Inpatient Survey Results** Julie Gray presented the CQC Adult Inpatient Survey Results, highlighting that 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 the Trust was 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. Julie Gray added that 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-streams 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. Areas highlighted for improvement were: • Patients being able to take medication they bring into hospital when needed. • Having enough to drink. • Quality of food. • Privacy for examinations. Asutosh Yagnik asked which Trusts did consistently well and asked if the Trust could learn from them. Julie Gray advised that the Trust is benchmarked against other cancer centres but the team could review those at the top to make improvements. Geoff Broadhead queried the issue of patients not getting enough to drink. Julie Gray replied that this data is a snapshot in time from 2022 and that there are fridges in every room and hydration stations on every ward. Trust Volunteers also assist with providing patients with beverages. The Nutritional Steering Group have been also been doing a lot of work to improve the patient experience.

	Julie Gray added that the food has vastly improved since the survey took place and following the PLACE (Patient Led Assessment of the Care Environment) Assessment, the food scored 100%. **The Board:** • **Noted the contents of the Report.**
136-23/24	**Patient Experience Visit** Elkan Abrahamson presented the report noting the following: The report was produced following the Non-Executive Director and Governor Engagement Walk-Rounds of the Clinical Decisions Unit (CDU) and Ward 2 of The Clatterbridge Cancer Centre Wirral. Patients were full of praise for the hospital and staff. Only one item was highlighted, which was an issue with the food, although it was conceded that this may be due to the treatment having an effect on the patients' tastebuds. **CDU** – One patient called with a raised temperature and was really impressed with how well they were taken care of. Staff on the ward encourage their nurse colleagues to apply for vacancies within The Clatterbridge Cancer Centre. Staff also commented that they are lucky to have Advanced Nurse Practitioners as part of the team who bring knowledge and support. <u>Areas for Improvement</u> A proposal has been sent to the Space Committee to consider increasing the size of CDU to prevent patients waiting to be seen in the waiting area. Further information is required from the Ward Manager and CDU Operational Group to investigate the pathways and benefits this work would provide. **Ward 2** – One patient who stayed on the ward for one week due to a reaction to Immunotherapy treatment said they were very impressed they were with the **The Board:** • **Noted the contents of the Report**
137-23/2	**Q1 Mortality Review** Sheena Khanduri presented the mortality report and drew attention to the following: The mortality review process started in June 2012. Patients who fit the following criteria are included in the review: • 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 and are scored as follows: 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 84% (458/521) of cases had completed an independent peer review from July 2022 – June 2023 deaths. From this, 57 cases were selected for discussion out of which, 29 cases have been discussed (x8 inpatients and x21 Community/Other Hospital/Hospice). 14 of the Community/other Hospital/Hospice cases scored 6 and 9 of the inpatients scored 6. The remaining 28 will be discussed in Quarter 3, 2023/2024 and a further 8 are awaiting a date for discussion from the responsible consultant. Results showed the 3 monthly moving average mortality for solid tumour mortality were within tolerance. There were six lessons learned and in all six cases the outcome of death was unavoidable. Themes regarding completeness of documentation, communication with clinical teams and updating of Standard Operating Procedures (SOP's) and protocols were identified. Corrective action has been taken where appropriate. Kathy Doran commented that this is evidence of good practice to feedback the lessons learned to the teams. There were no overall themes identified and the team will continue to ensure the mortality review process is followed. **The Board:** • **Approved noted the contents of the Report.**
	Our Strategy and Performance
138-23/24	**Performance Committee Chairs Report** Geoff Broadhead presented the report highlighting the following items of concern: The Board Assurance Framework risks were reviewed and a revision to the risk score for BAF 3 was proposed. 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 will update the actions and assess the score. The Committee noted the delay in gaining £0.5m funding from the charity to support the funding of year 3 of the Research and Innovation Strategy. The Committee requested a revised plan to demonstrate funding flows from the Trust and Charity. 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. Future work is focused on reducing admissions, improving flow and reducing length of stay including implementation and full utilisation of the Ambulatory Care facility for myeloid, Stem Cell, Lymphoma & Sarcoma. **The Board:**

	• **Noted the contents of the Report**
139-23/24	**Five Year Strategy Update** Tom Pharaoh advised the Board that a six-monthly Implementation Report is now being produced to provide an update on the commitments set out in the Five-Year Strategic Plan. Highlights were as follows: • The programme to develop a cutting-edge CAR-T cell therapy service for Cheshire & Merseyside is progressing well, with a 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. • The new Quality Improvement & Learning Strategy 2023-25 has been developed through staff and public engagement and sets out the ambitions for learning for improvement. • A comprehensive maintenance and refurbishment programme is taking place at CCC-Wirral, with architects engaged to begin developing proposals for long-term redevelopment. Mark Tattersall highlighted the development of the eastern sector hub and advised the Board that a paper had been issued to NHS Cheshire and Merseyside outlining changes that have taken place since the original proposal including, Covid and recruitment. The paper proposes discontinuing the development plan. Once the final decision is made, Kathy Doran requested it be brought back to Board to conclude. **The Board:** • **Approved the format of the Report and noted the contents.**
140-23/24	**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</u> Joan Spencer reported good performance overall noting that challenges remain with the 24 and 62 day targets. There were 5 avoidable breaches with the 24 day target however the pathways for Category 1 patients has been reviewed which should resolve the issue. There were 5 avoidable breaches within the 62 day target. Following this, a skill mix review has taken place within the booking office and an additional two members of staff have been trained to book cyclotron appointments. The increase in staff will allow cover for planned and unplanned leave. <u>Efficiency</u> An increase in activity, unsuccessful radiologist recruitment and Sonographer sickness has impacted on efficiency. A bi-weekly meeting is in place to closely manage both the scanning and reporting backlog. The Sonographer capacity issue should resolve in December when all Sonographers are trained, which will release radiology capacity. Joan Spencer confirmed that the difficulty recruiting Radiologists and Interventional Radiologists is a national issue and Liz Bishop advised that the Trust has joined an international recruitment programme to try to alleviate this. Joan Spencer clarified that Interventional Radiologists use specific techniques which are therapeutic as well as diagnostic. Terry Jones confirmed that early phase clinical trials require Interventional Radiology which has added importance for the Trust.

Quality

Julie Gray advised the Board that 11 patients did not have their risk VTE assessments completed within 24 hours noting that 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, and no harm was 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, and no harm was caused.
- 2 patients were admitted following Interventional Radiology procedure, they were discharged the following day, prophylactic anticoagulation was not required, and no harm was caused.
- 1 patient had an unplanned stay following a medical emergency, prophylactic anticoagulation was not required, and no harm was 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) and outstanding VTE assessments to be identified in the 8pm evening handover to the night team.

Research and Innovation

Sheena Khanduri advised the Board that 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. The main reasons for not achieving the overall targets are due to a high number of complex early phase studies which are scientifically important but low recruiters. The Trust is supporting First-In-Human, true phase 1 and multi-cohort trials which is reputationally enhancing and offers patients different treatment options. A high number of observational studies have closed and a new observational study with higher recruitment has opened, however there will be an approximate 2-month lag before recruitment is realised.

Asutosh Yagnik queried Metric 120 which appears to be on track but is reported as below the target. Sheena Khanduri advised that the target is a stretched target which is currently not under review as some trials achieve high recruiting numbers which will compensate for low recruiting trials.

Asutosh Yagnik commented that the difference between the red and green rating is 0.1%, which seems a small number.

Terry Jones asked how many patients were offered the opportunity to access the trials. Liz Bishop replied that this is difficult to capture and has been discussed at Quality Committee previously. However, the Trust aim to benchmark against other organisations and will then agree what goes into the IPR to ensure the Trust is measuring the right data. Geoff Broadhead asked for a refresh of Research and Innovation for Performance Committee. Sheena Khanduri stated that the team are trying to achieve a measured view against the population and will take the comments back to the team and feedback.

Workforce

Jayne Shaw informed the Board that 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.

	Figures include those who have retired and those on fixed-term contracts and if these numbers were removed from the data set, the Trust would be at 13.51%, which is below target. There were 28 leavers in October and 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 number of leavers with 9 in total. The staff group with the highest number 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). Anna Rothery raised concern with those leaving due to work, life balance and suggested information from the Freedom to Speak Up Guardian could provide further information to address this issue. Geoff Broadhead queried if the target should include those on Fixed Term Contracts and those who have retired and suggested a review of the target if it is not achievable. Jayne Shaw added that the Trust does benchmark well against the model hospital data and the information does incorporate all leavers. Terry Jones added that the Statistical Process Control Chart highlights the changes over time. Liz Bishop commented that the optimal turnover of 15% is not specific to healthcare and advised that Jayne Shaw is reviewing this which may lead to a refresh of the Integrated Performance Report. **The Board:** • **Noted the contents of the Report.**
141-23/24	**Finance Report** James Thomson presented the report advising the Trust is on plan to reach the income and expenditure target. The year end target of £363k for the year 2023/24 remains the same. 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. 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. A request was received from the ICB to improve cost efficiencies. A figure of £1.9m has been agreed with the ICB and will form part of the recovery programme. 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. Month 7 CIP has been achieved and Month 8 CIP is on track to be achieved due to the cost benefits of work coming from North Wales and the Joint Venture.

	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. The Trust cash position is below plan by £0.3m which consists of payments from hosted services being outstanding, however it is hoped these payments will be recouped in December 2023. James Thomson confirmed that planning for next year's CIP will be carried out in December 2023 with a wider perspective and will align with budget setting. There are additional projects anticipated which will contribute toward CIP and will be reported on in Quarter 4. An update will be provided to the Board at the next Finance Committee in January 2024. **The Board:** • **Noted the contents of the Report.**
142-23/24	**Emergency Preparedness and Resilience and Response (EPRR) Annual Report and Core Standards Self-Assessment** Joan Spencer presented the report, noting that the NHS Core Standards for EPRR, set out the minimum requirements expected of providers of NHS funded services. All NHS organisations are assessed against these standards however following a pilot of a more stringent assessment in the Midlands in 2022, significant changes were made to the compliance for many Trusts. Fifty nine of the sixty-two revised standards applied to The Clatterbridge Cancer Centre with further adjustments to the standards taking place in August 2023. 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. The Trusts compliance position is as follows: • There are no areas of non-compliances. • Fully compliant against 10 core standards • Partially compliant against 49 core standards. The calculation applied to confirm an organisations over all position does not account for any partial compliances, consequently the Trust's over all compliance is rated at **17% - Non Complaint**. Consideration should be given to the lateness of the adjustments which are highlighted to the Board. The Trust will work with NHSE to ensure a better position next year. Joan Spencer added that a universal drop in ratings appears to have taken place across the region which is referred to in the NHSE Core Standards Overview for Boards.

	Mark Tattersall queried the EPRR resource challenge regarding the Trust having sufficient and appropriate resource to ensure it can fully discharge its EPRR duties. Joan Spencer explained that the standards are based on acute trusts and some are not applicable to specialist trusts. This standard relates to having a loggist on site 24 hours a day, 365 days of the year, which does not apply to The Clatterbridge Cancer Centre. Individual Trusts have their own protocols but are sharing experiences and learning from each other. This will be monitored through Performance Committee on a quarterly basis. **The Board:** • **Noted the contents of the Report and Self-Assessment.**
143-23/24	**Cancer Alliance Q2 Performance Report** Liz Bishop presented the report noting that activity remains high and continues to present challenges to service delivery however, the Trust continues to take action to meet the demand including continued capacity and demand, and workforce planning. The Trust compares well against other Trusts regarding the 62 day and 31 day treatment targets with faster diagnosis support. Liverpool University Hospital Foundation Trust (LUHFT) are improving standards which leads to the Trust being ahead on the 62 day plan which is expected to continue. Mark Tattersall commented that Mid-Cheshire appear to be an outlier. Liz Bishop explained that this may due to Endoscopy services however, there is a dedicated piece of work ongoing to bring the right suite of tests together. Liz Bishop added that the Trust is the second most improved within the alliance with well engaged Chief Operating Officers and Cancer Managers. Kathy Doran stated that Macmillan are shining a light on early diagnosis to ensure the focus is not lost. Liz Bishop noted that the Patient Tracking List (PTL) has doubled since pre-Covid-19 which accounts for the volume of patients. **The Board:** • **Noted the contents of the Report**
	Our Governance
144-23/24	**Audit Committee Chairs Report** Mark Tattersall presented the report highlighting the following: Following eight months of work, the Trust was awarded ISO27001 accreditation at the end of July. The certificate was issued in October, which coincided with Cyber Security Month. A separate meeting was convened to consider additional fees requested by the External Auditor which relate to both the 21/22 and the 22/23 audits. The request 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 further

	meeting involving the Chair of the Audit Committee, the Director of Finance, the Deputy Director of Finance and Ernst Young representatives was arranged and a compromise was reached. **The Board:** • **Noted the contents of the Report**
145-23/24	**Board Assurance Framework** Liz Bishop presented the report and explained that a discussion has taken place regarding the ambitious target of (2 x 3)6 for BAF 7, (Research Portfolio) as the risk still stands at (3 x 4)12 and it was agreed that the target of 6 may be too optimistic to achieve by March 2024. The Director of R&I, Medical Director and Corporate Governance Manager reviewed BAF 7 and proposed an amended target score of (3x3) 9, based on current progress. The Quality Committee Non-Executive Directors agreed the new proposed target. BAF 6 ICS (Integrated Care System) outlines the risk of the Trust not attaining sufficient influence within the ICS to maximize collaborative working around cancer preventions, early diagnosis, care and treatment. However, performance indicates that 90% of patients waiting for diagnostic testing will be seen within 6 weeks by the end of March 2024, this figure currently stands at 80%. **The Board:** • **Noted the contents of the Report**
146-23/24	**Freedom to Speak Up Reflection Tool Output Report** Julie Gray presented the report advising the Board that the National Guardians Office have designed a mandatory assessment tool which demonstrates the Trusts Freedom to Speak Up arrangements. 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 the Trust is compliant with best practice in 70 and 10 areas were identified for improvement. An action plan to address the 10 areas has been created and assessments will be carried out on a regular basis. Geoff Broadhead added that he felt confident after completing the tool that the Trust is on the right track. Kathy Doran stated that quarterly monitoring will be added into the Trust structure. Julie Gray stated that the aim is to highlight any themes and bring through the Committees however, the numbers are too low currently, which risks identifying individuals. **The Board:** • **Noted the report and endorsed the recommendations**
147-23/24	**Board of Directors Development Programme** The Board noted the next steps arising from the Board Development Session held in October regarding the Urgent Cancer Care within the Cheshire and Merseyside Region and the role of the Urgent Cancer Care Board. The next steps 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 December for the Urgent Cancer Care Programme Board to sit within the Alliance's mainstream portfolio **The Board:** • **Noted the report**
148-23/24	**Liverpool Joint Committee Assurance Report** Kathy Doran highlighted the update provided to meeting of the Liverpool Joint Committee held on 21st September in relation to medicines optimisation, radiology and emergency pathways. A review of the joint arrangements is underway, led by Chief Executives to understand whether the site specific work streams could be managed via a programme management approach, in order to successfully progress the recommendations from the Liverpool Clinical Services Review and other areas of collaboration identified. The next meeting will take place on 7 December 2023. **The Board:** • **Noted the content of the Report**
149-23/24	**Research and Innovation Annual Report** Sheena Khanduri presented the report. Some of the highlights for 2022-2023 were: • Associate partner in the successful £29.1m NIHR Biomedical Research bid with the Royal Marsden and Institute of Cancer Research • Retention of the CRUK Liverpool Experimental Medicine Centre with the University of Liverpool securing up to £1.5m • 1166 new participants recruited to CCC research trials • 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 income for CCC • Innovation Strategy was launched • Big Ideas Scheme was launched **The Board:** • **Noted the contents of the Report**
	Concluding Business
150-23/24	**Questions from Governors and members of the public** There were no questions from the Governors or members of the public.

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151-23/24	**Items for inclusion in the BAF** There are no further items for inclusion on the Board Assurance Framework.
152-23/24	**Reflections on meeting** Those attending via Teams noted that the meeting finished ahead of schedule which may be due to Performance Committee taking place a week prior where most matters on the agenda were discussed in detail. The Board agreed that the meeting went well.
153-23/24	**Any Other Business** Elkan Abrahamson noted the communication sent regarding the CPE (Carbapenemase Producing Enterobacterales) outbreak on Ward 5. Julie Gray replied that the team are raising awareness due to multiple strains and to minimise the risk of transmission. The Board were assured that the outbreak is being managed in the usual way.
	Date and time of next meeting: 28 February 2024 @ 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.	Julie Gray	Apr-24		Included on Cycle of Business
27/09/2023	106	Freedom to Speak Up Annual Report and Freedom to Speak Up Policy	FTSU Guardian and EDI Lead to review Equality Impact Assessment	Julie Gray	Nov-23		Impact assessment to be included in report to Trust Board in March

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								√				In CE&CR and BDD report	√ Submission
Progress against Innovation Strategy (Inc. Bright Ideas) Annual Report	Medical Director	Simon Bunting	Annually	For information/noting - This was incorporated in the Research Annual Report													
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			√									defer	√
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 March 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						√ deferred		√					
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 Report	Chief Nurse	Jo Wynne	Bi-Annually							√						Defer - go through PPC first	√
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														

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of Meeting: Trust Board Part 1
Date of Meeting: 28th February 2024

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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Chair's Update

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

1.1 I attended the Cheshire and Merseyside Acute and Specialist Trusts (CMAST) Chair's Meeting on 17th January where Chairs concluded that the forum would continue to meet bi-monthly to share information about collaborative working and to support the work of the CMAST programmes.

1.2 On 14 February I attended the Cheshire and Merseyside Trust Chairs meeting with the ICB Chair. The ICB Director of Finance outlined the approach to planning for 24/5 which we have discussed recently at our Board Development session. There will be further discussions at Performance Committee and at the Board on 28 February.

2.0 Liverpool Joint Committee

2.1 I attended a meeting of the Liverpool Joint Committee on 21st December with a continued focus on shared programmes of work between the trusts. We also received an update in relation to the Chair and Chief Executive arrangements for Liverpool Women's Hospital Foundation Trust.

2.2 I chaired the LUHFT and CCC Joint site Committee on 5th February 2024, where we reviewed progress against the joint work programmes, with an in depth review of the estates programme.

3.0 Consultant Appointments

3.1 Myself and Terry Jones have taken part in Consultant interviews since the last report and we have made a number of appointments:

Consultant Clinical Oncologist - Breast Cancers	Dr Jennifer Cotton
Consultant Medical Oncologist - Lung	Dr Nicola Hannaway
Consultant Medical Oncologist - Lung	Dr Niladri Ghosal
Locum Consultant Radiologist	Dr Mohammed Hussein
Locum Consultant Radiologist - Interventional	Professor Madhusudhan Kumble Seetharama
Consultant Medical Oncologist – Gynaecological and Immunotherapy	Dr Laura Cossar
Consultant Medical Oncologist in Melanoma and Lower GI (Colorectal)	Dr Naima Ikram

4.0 Remuneration Committee

4.1 The Remuneration Committee of the Board met on 29th of November to consider the Very Senior Manager's pay increase, succession planning and the terms of reference

for the Committee. In considering the current composition of the Board, the Committee reviewed the Board Skills Matrix (appendix a) and determined that the Board has the skills and knowledge to fulfil its duties. Further meetings took place on 18th December and 17th January 2024 to discuss the arrangements for the joint Chief Executive and Director of Finance roles.

5.0 Council of Governors - 31st January 2024

5.1 The Council of Governors meeting took place on 31st January 2024. On the 15th January 2024 the Council took part in a session on addressing health inequalities.

6.0 Consultant Away Day

6.1 On 30 November I attended the annual consultant awayday organised by Sheena Kandhuri. The event was lively and well attended with discussions ranging across a wide range of topics. It was a good opportunity to introduce the new Professor of Oncology {pl check I have got the right title!]from the University to our consultants.

7.0 Site Visit

7.1 On 8 December we welcomed Dame Angela Eagle MP to CCC-L. She welcomed the opportunity to see the hospital and met with a number of staff and patients.

8.0 Good Governance Webinar

8.1 On 26 January I attended a Good Governance webinar re People Committees. The session was very supportive of the role of People Committees – not all Boards on the call had established them. GGI are developing a matrix framework for People Committees which may be helpful for us in due course.

9.0 North West Systems Leaders Presentation

9.1 On 13 February, NW System Leaders received a presentation from Professor Oliver Stanley who lead a review of governance at Greater Manchester Mental Health Trust which has been recently published. The session was very thought provoking, outlining how despite best intentions, problems can be missed by Boards. I will circulate Professor Stanley's slides to Board members.

CEO Update

1.0 National Diagnostics Programme

1.1 Analysis published in early January 2024 shows that more people than ever before are getting tested for cancer with almost 3 million checks over the last 12 months

1.2 Almost 3 million people (2,980,258) were seen for urgent cancer checks over the last year (Nov 2022 to Oct 2023) – the highest year on record. Up by 147,960 on the same period last year, and up over a quarter (622,562) on the same period before the pandemic (2,357,696).

1.3 The new analysis also shows there has been a 133% increase in the number of people getting checked for cancer, over the last decade – with 1,275,231 urgent cancer referrals between Nov 2012 to Oct 2013.

1.4 This record year of checks has been delivered despite NHS staff managing one of the busiest winters ever in addition to unprecedented industrial action. The impact of Christmas and industrial action has affected C&M overall percentage of patients seen within 6 weeks (82.2% in Dec, 79.9% Jan) .However, with continued efforts, the C&M system can still achieve 90% of patients seen within 6 weeks by the end of March.

2.0 Planning Guidance 2024/25

2.1 In December 2023 NHS England wrote to trusts to advise them to commence planning for the 2024/25 financial year. The key requirements will be for systems to maintain the increase in core UEC capacity established in 2023/24, complete the agreed investment plans to increase diagnostic and elective activity and reduce waiting times for patients, and maximise the gain from the investment in primary care in improving access for patients, including the new pharmacy first service.

3.0 Cheshire and Merseyside Cancer Alliance Performance

3.1 The impact of junior doctor industrial action and the Christmas holiday period resulted in an increase in the number of patients waiting over 62 days and 104 days for treatment in Dec (62 days - 1,187 week ending 31st Dec compared to 1,112 week ending 10th Dec. 104 days- 325 w/e 31st December Vs 294 week ending 17th Dec). This rise is in line with the national trend and as the number of new referrals decreased during the same period it is expected our position will recover quickly.

4.0 Cheshire and Merseyside Acute and Specialist Trusts Update

4.1 The CMAST Leadership Board met on 2 February and explored a number of important issues, as follows:

4.2 The Leadership Board received an update from the ICB about the current, in year, financial priorities where it was indicated that contact would be made with a number of Trusts in the week ahead to ensure that support was in place to maximise delivery of this year's financial plan. The system's aim is to retain control of its own financial position and mitigations to financial risk, a view which was endorsed by the Leadership Board. Further discussions included current finance assumptions for 2024/5 with a priority being to secure a shared view on the delivery of recurrent CIP so as to address the system's underlying deficit. The Board endorsed a system focus

on the top 3 to 5 factors that had greatest potential to reduce cost, supporting transformation, while improving system flow.

4.2 The Leadership Board considered the current position with the system LIMS procurement and was informed that a revised investment profile would support a mixed revenue and capital investment. This meant that lead Trust Executives had been asked to brief their Board in February, moving toward Board decision in March. Such an expanded time horizon would align with the programme moving into an implementation phase.

4.3 The Board was provided with an update in the work of the CYP Alliance. This work provided an important focal point for the CYP agenda, supported existing CMAST work programmes such as in elective and diagnostics by providing a particular CYP focus and catalyses action with and through partners through its dual anchoring in the work of both C&M provider collaboratives. The Board reflected upon the impact of delayed access to CYP services including in dental, the need to prioritise the well-being of children and young people and the potential for this to act as prevention when it came to future demand for adult medicine. Wider health inequalities were also discussed which could now be seen presenting as problems in many of the region's young mothers. The Leadership Board was assured by the focus on this agenda at the recently established ICB CYP Committee.

4.4 Finally, a discussion took place on the impact of pressures in hospital ED departments, the impact on paramedic crews and vehicle's availability and response times and the need for action with relation to non-criteria to reside. A small group of CEOs agreed to discuss the best way to make progress on these interlinked issues within C&M.

5.0 Industrial Action

5.1 The latest round of junior doctors industrial action concluded on 9 January 2024 and there is little doubt that there will be further action unless a pay settlement is agreed. The BMA have formally put the government's pay offer to consultants to its members via a referendum that closes on 23 January 2024.

6.0 Appointment at LHCH – 1st Feb start

6.1 As part of our commitment to increase the visibility of the leadership team I am holding a number of informal question and answer sessions with staff during January.

7.0 Day in your shoes

7.1 I took part in a 'day in your shoes' with the Aintree Lung Team on 18th January 2024. It was great to see the amazing MDT teamwork (Consultant, ANP, Advanced Radiographer, CNS and ANP and CSW) working together as a team to serve the clinic both in person and remotely.

The Clatterbridge Cancer Centre NHS Foundation Trust

8.0 Monthly Star Awards

8.1 I had the pleasure of presenting the February star award to Hannah Monnaghan who was nominated by a colleague for showing kindness by doing all that she could to make sure a patient got home for Christmas with her family despite being on intravenous feed.

9.0 Trust Executive Group

9.1 The Trust Executive Group (TEG) met on 8th February and considered a number of matters including a Business Case for the Implementation of Surface Guided Radiotherapy and an update on the CART Business Case. The Group also received updates relating to Financial Planning, CCC Biobank, Pharmacy Workforce and a Progress Report on CCC Paddington.

9.2 In addition the following Chair's Reports were received: Performance Review Group, Risk and Quality Governance, Transformation and Innovation Committee.

9.3 The Trust Executive Group approved the Performance Management Framework.

9.4 There were no matters to escalate to the Trust Board.

10.0 Media Coverage

10.1 From the 1st December 2023 – 19th February 2024 there have been 30 news stories, radio appearances or video coverage about The Clatterbridge Cancer Centre, none of which have been negative. These include:

10.2 20th December 2023 Health and Social Care Journal reported on the CEO role to ` merge at CCC and LHCH.

10.3 30th and 31st December 2023 Liverpool Echo, Daily Mirror and Lancs Live reported on an Immunotherapy case study, noting the Clatterbridge Cancer Centre is the UK's first specialist immunotherapy toxicity service (SIOTS); a team of specialist nurses and doctors who identify and treat the side effects caused by immunotherapy.

10.4 On 1st February 2024 the BBC reported on the hand and foot cooling system being trialled at Clatterbridge to try reduce the painful side effects of chemotherapy.

11.0 Recommendations:

The Board is requested to:

- **Note the report**

Board Skills Matrix – November 2023 - Non- Executive Directors

	NAME						
	Kathy Doran Trust Chair	Mark Tattersall	Geoff Broadhead	Terry Jones	Asutosh Yagnik	Elkan Abrahamson	Anna Rothery
TENURE	2ND term Apr 22 to 31 Mar 25.	2ND term 1 Dec 21 to 30 Nov 24.	2ND term 1 Jul 22 to 30 Jun 25.	2ND term 1 Oct 22 to 30 Sep 25.	1ST term 1 Jan 21 to 31 Dec 23.	2ND term 1 Sep 22 to 31 Aug 25.	1st term 1 Jan 21 to 31 Dec 23.
Financial acumen		X	X	X	X		
Leadership of large complex organisations	X	X	X	X	X		X
Legal awareness			X	X	X	X	
Public policy	X		X	X		X	X
Risk Management	X	X	X	X	X	X	
Strategic Leadership	X	X	X	X	X	X	X
Transformation and change management	X	X	X	X	X	X	X
DESIRABLE							
Clinical Health Clinical Professional Registration/Qualifications Experience/e				X			
Commercial focus		X	X	X	X		
Corporate Communications and Media	X	X	X	X	X	X	X
Digital and IMT		X	X		X		
Ethics, Integrity and Accountability	X		X	X	X	X	X
Financial qualification		X	X				
Health Experience: Non Clinical	X	X	X				
Human Resource Management			X	X	X		X
Regulatory Knowledge and Experience	X	X		X			
Research and Development	X			X	X		X
Professional Registration/Qualifications		Fellow of the Chartered Institute of Management Accountants	Chartered Accountant	FRCS Edinburgh	MRSC	LLB from Hebrew University of Jerusalem LLM from London School of Economics	

Board Skills Matrix – November 2023 - Executive and Non-Voting Directors

	NAME							
	Liz Bishop	James Thomson	Joan Spencer	Julie Gray	Jayne Shaw	Sheena Khanduri	Tom Pharaoh	Sarah Barr
Financial acumen	X	X	X				X	
Leadership of large complex organisations	X	X	X	X		X		
Legal awareness					X	X		
Public policy	X	X	X	X		X	X	X
Risk Management	X	X	X	X	X	X	X	X
Strategic Leadership	X	X	X	X	X	X	X	X
Transformation and change management	X	X	X	X	X	X	X	X
Clinical Health Clinical Professional Registration/Qualifications Experience/e	X		X	X		X		
Commercial focus	X	X				X		
Corporate Communications and Media	X					X		
Digital and IMT						X		X
Ethics, Integrity and Accountability	X					X		
Financial qualification		X						
Health Experience: Non Clinical		X	X		X		X	
Human Resource Management	X	X	X	X	X	X	X	X
Regulatory Knowledge and Experience	X	X	X	X		X	X	X
Research and Development	X	X				X		
Professional Registration/Qualifications	Clinical Doctorate	Chartered Institute of Public Finance and Accountancy (CIPFA) 16877	NMC Registration 86K0511E	NMC Registration 90A1877E		GMC Registration 4368436		Member of the College of Healthcare Information Management (CHMIE)

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Board of Directors
Date of meeting: February 2024

Report of	Julie Gray – Chief Nurse			
Paper prepared by	Nicola Heazell Head of Patient Experience and Inclusion			
Report subject/title	Private Clinic Patient Narrative – Feb 2024 Trust Board			
Purpose of paper	Action Plan to support Patient Story			
Background papers				
Action required	Link to patient story: https://www.youtube.com/watch?v=cgjFRnLFUqY 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		

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Patient/Staff Story Action Report

Story ID	Feb 2024	Committee	Board of Directors		
Date Presented	TEG	Patient Story	☒	Staff Story	☐
		In person	☐	Digital	☒
Date Consent Obtained	6/11/23	Consented by	CH	Consent for:	☒ Internal ☒External ☒Online Anonymized
Division/s involved	Corporate Nursing		External Organisation involved	N/A	
Formal Complaint	☐	Complaint closed	☐	Complaint Upheld	☐

1. Action Already Taken

No	Issue	Action taken	Action Lead

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

No	Issue	Action required	Action Lead	Deadline Date	Expected Evidence of Completion
1.	Continued support of families	Continue to offer support to patient's family	Senior Chemotherapy Nurse	Ongoing	FFT and feedback forms, cards etc
2.	Continued positive feedback from patients'	Offer ways for patient's to provide feed back	Senior Chemotherapy Nurse	Ongoing	FFT and feedback forms, cards etc.

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

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

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board
Date of meeting: February 2024

Report of	Chief Nurse				
Paper prepared by: In attendance at the visit	Head of Patient Experience – Nikki Heazell Non-Executive Director – Kathy Doran Governor – Keith Lewis				
Report subject/title	Patient Experience Visit November 2023				
Purpose of paper	The purpose of this report is to provide Trust Board with a summary of the NED & Governor Patient Experience visit conducted on the 14th November 2023. The panel visited the Radiotherapy Department, CCCA.				
Background papers	n/a				
Action required	To approve content/preferred option/recommendations To discuss and note content To be assured of content and actions				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	x	Be a great place to work	x	
	Be Collaborative		Be Digital		
	Be Research Leaders		Be Innovative		

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

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Division	Radiation Services	Location	Radiotherapy Department, CCCA	Date	14th November 2023
In attendance – Panel			In attendance – Patient & Staff		
Governor	Keith Lewis		Senior Manager facilitating the walk round		Louise Corcoran
Non-Executive	Kathy Doran		Number of Patients		2
Patient Experience Team	Nicola Heazell		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 received 18 of 20 fractions at CCCW.

Positive Patient Comments:

- Perfect, receptionist is so kind to everybody.
- 16 days of treatment, everybody gets on well and has a laugh and joke including patients and staff.
- All staff are really lovely. Friend accompanied and noticed positive and friendly attitude of all the staff.
- Both patients, despite having challenging personal circumstances were overwhelmingly positive about the treatments and care received at CCCA.
- One patient made really lovely friends during treatment with other patients.
- Can't believe how well I have been looked after – staff are spot on.

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*
• Patient had a few issues with taking medication as hadn't read the leaflet or instructions on the box. Admits should have read the instruction, but was resolved at next appointment the following day when staff went through medication with the patient.	• If it is in relation to radiotherapy e.g a chemotherapy tablet or medication to take before radiotherapy the radiographers can advise even though they would not have been the professional who would have prescribed this. If the medication is not directly

	linked to their radiotherapy treatment we would always seek advice from a medic or OTR as generally radiographers would not prescribe medication If patients have a query about general medication we would of course signpost them accordingly.

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 Centre Manager gave a tour and overview of the CCCA site, explaining the history, overview of the site. There are 2 radiotherapy treatment machines in total, and on the whole this works well unless a treatment machine has some downtime which reduces capacity by 50%. This requires the whole radiotherapy team across all sites to manage workloads and schedules to ensure patients receive their treatments in a timely manner.

It was highlighted that plans are underway to relocate the phlebotomy area in CCCA to the old CT bunker, creating additional capacity for the provision of phlebotomy services, but in addition this will enable the current area to become a 'holding bay' for patients that unexpectedly become unwell whilst onsite. Due to the relatively recent relocation of medical oncology clinics from Aintree hospital, the acuity of patients attending the centre has changed and become more unpredictable, necessitating this change in usage. Patients that are awaiting transfer by ambulance to the acute Trust would now have a dedicated waiting area for the close monitoring of their condition whilst maintaining dignity and privacy.

As a consequence of the change in acuity of patients receiving treatment, this has provided the opportunity for both the learning and development of staff in respect of managing acutely unwell patients; developing wider multi-disciplinary relationships for all levels of staff with enhanced team working and support for the teams onsite.

Patients attending the CCCA site utilise the garden area frequently. Due to being a smaller treatment centre staff working in the area are aware of patients potentially wanting some space/quiet time whilst waiting for appointments. Therefore if patients would prefer to wait in the garden area rather than the waiting area staff assure patients that appointments would not be missed and are aware of patient location. It was observed that 3 colourful benches were in place within the garden in memory of staff members who had died in the last year. It was highlighted how patients engaged with these benches and their significance, for example one patient crocheted a sunflower for one of the benches.

Many patients receive between 4-6 weeks of radiotherapy treatment which allows staff to build up a strong rapport with patients. Staff do rotate sites, but work rotas are designed to maintain continuity of care for both patients and staff. The onsite Radiographers become the

<table>
<tr><td colspan="2">healthcare professional that patients see most frequently and therefore their role is often about signposting patients to the other healthcare professionals/services who can assist and support with their treatment pathway/care. Staff will often talk with patients in the waiting area and one patient devised a quiz for all patients to participate in, which was positively received by others.</td></tr>
<tr><td colspan="2">Positive Comments:
Staff are well supported.
All staff have a base, rotate sites and have access to regular training. This provides variety to the role as well as increasing skills.
Staff get to know patients very well, having ‘a laugh’ with them. Staff are proud to work at CCCA
Staff spoken to said they loved their jobs and working at CCCA. Real sense of team and team working, with a daily team meeting to provide cross support
The member of staff that spoke to the visiting team explained that they are empowered to make suggestions and influence change, providing an example of a mobile bell during the covid pandemic to ensure patients and families could still celebrate this milestone/achievement in a safe way. Staff take pride in the provision of personalised care ensuring that patients are not just a number, but have a positive experience as possible of their treatment and the treatment centre.</td></tr>
<tr><td colspan="2">Areas where immediate action was taken on the day: None</td></tr>
<tr><td>Areas for improvement:
Frustration at the ‘assumption’ that The Clatterbridge Cancer Centre refers to the Wirral site even though CCCA has been open since 2013.
Prior to covid a complementary therapy service was offered and run by volunteers.</td><td>Service response:
This is possibly due to CCCA not being involved in several Trust events previously however the team do feel that this is improving, particularly as members of the executive team are visiting CCCA more often and the staff find them very approachable.
The Macmillan office is staffed again now and providing face to face support and advice for patients throughout the week. The staff member usually joins the team huddle to remind staff of their support.
Plans are in place to extend the volunteering service to the CCCA site</td></tr>
</table>

• Lack of WRVS/Café facilities at the CCCA site since the withdrawal of the RVS.	from April 2024 to welcome and support patients to the site. • Small beverage bay located in CCCA reception currently. Discussions are underway to review the RVS site within CCCA and opportunities available, particularly whether a larger beverage bay can be included in the RVS space.
Observations on the day • The department was very calm and relaxed during the visit, with staff and patients overwhelmingly positive about their experiences.	

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board
Date of meeting: 28th February 2024

Report of	Chief Nurse				
Paper prepared by: In attendance at the visit	Quality Improvement Manager – Ruth Selvan Non-Executive Director – Elkan Abrahamson Governor – Councillor Tony Murphy				
Report subject/title	Patient Experience Visit January 2024				
Purpose of paper	The purpose of this report is to provide Trust Board with a summary of the NED & Governor Patient Experience visit conducted on the 10th January 2024. The panel visited the Marina Dalglish Unit at Aintree Hospital.				
Background papers	n/a				
Action required	To approve content/preferred option/recommendations				
	To discuss and note content				
	To be assured of content and actions				
Link to: Strategic Direction Corporate Objectives	Be Outstanding	X	Be a great place to work	x	
	Be Collaborative		Be Digital		
	Be Research Leaders		Be Innovative		

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

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOREPO
Review: July 2025
Version: 2.0

The Clatterbridge Cancer Centre NHS Foundation Trust

Division	Networked Services	Location	Marina Dalglish Unit	Date	10th January 2024
In attendance – Panel			In attendance – Patient & Staff		
Governor	Councillor Tony Murphy		Senior Manager facilitating the walk round		Claire Bennett Lucy Abbott
Non-Executive	Elkan Abrahamson		Number of Patients		2
Patient Experience Team	Ruth Selvan		Number of Staff		1

Patient Feedback:

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

Two patients were interviewed.

Patient 1. (& his wife) partway through treatment

Patient 2. 1st visit to unit

Positive Patient Comments:

- Fantastic experience, dealt with professionalism, sheer warmth, compassion and kindness, amazing people.
- Staff tell us everything we need to know and provide all information.
- "We love the sausage rolls!"
- Nice environment, very comfortable despite treatment being long.
- Lovely staff – I'm encouraged to get involved once treatment is complete as it's so supportive.
- Helps to have relatives here, it's a very pleasant experience and I've been able to eat today which I'm glad about!

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*
The patients that we chatted to at the time of the visit said that the only thing that could be improved would be to keep the staff! They had built up a good rapport with one nurse in	

particular who was leaving the trust to take up a post elsewhere. A Patient expressed that it would be good for them to receive feedback to know if their appreciation and comments had been received, they had submitted information via FFT but never get feedback to know it's received.	The ward team do display thank you cards and their patient experience award on the nursing station.

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 deputy ward sister gave an overview of the department at Marina Dalglish Unit and explained that the area treated a mixture of patients with solid tumours and Haemato-oncology disease with day case chemotherapy/rapid treatments/supportive treatments/blood transfusions.

Marina Dalglish Unit is a nurse led unit, and the team work collaboratively with pharmacists and ANP's to provide high quality care for patients.

There are generally 60-80 patients treated each day and additional patients can be added to the list as the day progresses.

There is a space that can be utilised for patients if they are upset and need some quiet time. This space is occupied by the Retreat team who run massage sessions mostly for patients with breast cancer.

The deputy ward manager felt that the team were well staffed and commented that they always get really good feedback from patients. Staff felt that it was good to get recognition and appreciation for patients particularly as they are not in the central hub. The team are very proud of their Patient Experience award.

The team have excellent senior support and work well together.

The team also provide cover for the unit at Ormskirk on a rotational basis.

Food and drink are provided for the patients who are having treatments via a service level agreement with Aintree. Warm food is provided and the patients always complement the sausage rolls.

The Clatterbridge Cancer Centre NHS Foundation Trust

Positive Comments:

- Very nice place to work, nice unit
- Good support from management
- Younger cohort of patients can relate to the young workforce in the unit and talk to them more easily.
- Staffing levels are good
- Huge benefit for patients to have treatment closer to home
- When the teams merged with Haematology-oncology staff embraced this, did extra training to undertake the Haematology-oncology component of their workload.
- Volunteers from Aintree Hospital support the MDU and are fully embedded within the team.

Areas where immediate action was taken on the day: None

Areas for improvement:	**Service response:**
• Some of the chairs are a bit tired and worn. A trust wide review has been undertaken and the team are hopeful that there will be some investment to replace some of the seating.	• Funding has been identified for a chair replacement scheme and ward manager is linking in with suppliers, IPC and Moving and Handling/Falls co-ordinator to identify the most suitable chairs for Marina Dalglish Unit
• Staff turnover is 10-14% it was felt that the team were losing staff to career progression. Work was underway to try and keep the staff within the trust	• Senior Managers have started discussions with the Research Team looking at a rotational plan to try and enable the expertise gained to be retained.
• Capacity- it is a very busy unit, the patient throughput is high and space is limited.	• The team are reviewing ways of working to better utilise the space/capacity. There are projects in progress to look at self-administration and more treatments at home.

The Clatterbridge Cancer Centre NHS Foundation Trust

Observations on the day:

- The department appeared organised and although busy there was a pleasant atmosphere during the visit.
- Space is at a premium – lots of patients in the main seating area with 1 family member per patient accompanying.

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board Part 1 – 28th February 2024

Chair's Report for: Performance Committee
Date/Time of meeting: 21st February 2024, 09:30

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

General items to note to the Board	**Risk Register** The Committee received the risk register report; There are 2 risks with risk scores of 15 and above assigned to the Committee HRMC challenge Medical Gases Assurance The Interventional Radiology Service infrastructure risk was reduced from 15 to 9 during the reporting period. The Committee noted work will be done to improve the presentation of the report. The next report to the Committee will report the up to date position rather than quarterly. The Committee acknowledged the progress that has been made to mitigate risks. **Integrated Performance Report (IPR)** 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 the pressures on access in December and January affected by holidays and industrial action. • There have been challenges around Imaging Capacity and there are interviews in place for reporting Radiologists. This is an area of challenge, however there has been more interest in Radiologist vacancies and the Trust has put trainee positions in place • The Trust is above target for Ecoli infections which is reflected nationally. No lapses in care have been found. **Integrated Performance Report (IPR) Annual Review** The Committee received the annual review of the IPR, which is conducted each year in quarter 4. The proposed approach for 24/25 was presented to Performance Committee and will be presented to Quality Committee and go to Trust Board for approval, ready to start reporting in M1.

	The Committee reviewed the drivers and subsequent proposed changes to the format, content and bank of KPIs for 2024/25. The Committee noted that some KPIs may be subject to change as key documents such as the National Planning Guidance and Trust Contract have not been finalised. The Committee reviewed the proposal to date and approved the approach. **Cancer Waiting Times Report** The report provided the Committee with evidence of the current challenges impacting on Cancer Waiting Times. The Committee discussed the challenges around molecular testing and the Trust's work with referring Trusts to ensure molecular testing is ordered earlier. **Community Diagnostic Hubs** The Committee received a presentation on Community Diagnostic Hubs, which reviewed the progress of the: • The Cheshire & Merseyside CDC Programme • Clatterbridge Diagnostics • Paddington CDC The Committee noted the positive results evident from the CDC roll-out and highlighted the benefits of the CDCs, collaborative system working and increased diagnostics. **Emergency Preparedness, Resilience and Response (EPRR) Quarterly Update** The Committee received the EPRR Quarter 3 report, which highlighted the progress against the work programme to improve the Trust's compliance with EPRR Core Standards. The Committee noted the report showed the Trust is is currently on track to achieve the 95% compliance against the Core Standards target, however there are factors which may make this hard to sustain. The Committee highlighted the resource implications of the planned work. **Research & Innovation Strategy Business Plan** The Committee received an update regarding the Research and Innovation Strategy Business Plan and noted the business case funding request will be presented for approval at the Charity Board meeting on the 22nd February. **Green Plan Annual Report** The Trust published its first Green Plan in January 2022. The Green Plan aims to drive sustainable change across the Trust over the next five years and prepare for the transition to delivering net zero carbon healthcare within two decades. The annual report outlined the progress and challenges of the second year of implementation of the Green Plan.

	The Committee discussed the challenges of measuring the impact of green initiatives and having standard processes for measuring across the region. The Committee discussed and acknowledged the positive progress made against the Green plan and the potential positive staff wellbeing and financial impacts as a result. **Finance Report** The Committee reviewed the Finance Report and noted the position at Month 10. The Trust financial position to the end of January is a £597k surplus, which is £294k above plan. The group is showing a £1,541k surplus to the end of January, which is £1,239k above plan. The Committee discussed the local variable API contract and ERF income risks, which could adversely impact the Trust's financial outturn. It was agreed that these risks should be discussed at the Trust Board. The Finance team reassured the Committee steps are being taken to address this and agreed to bring an updated assessment of the risks to the Board next week **Review Capital Investments** The Committee received the report, which showed progress on the delivery of the 2023/24 Capital Programme, highlighting progress on the key 2023/24 schemes. The Committee were reassured with the clarity given on the Capital Investments management process. However, the report demonstrated the challenges the Trust faces in prioritising which projects can be accommodated given the current constraints/limits on capital expenditure. The Committee thanked the Finance Team for the detail and clarity provided by the report. **ICB Planning Update and Liverpool Place Financial Strategy** The Committee received presentations on the ICB financial planning and the Liverpool Place financial strategy, including: • National Planning context • ICB Planning • Trust Planning • Liverpool Place planning • Next steps The Committee noted the ICB planning timetable including the final regional submission on the 20th March 2024. It was acknowledged by the Committee that this would be a major item for Board discussion next week. **Communications and Marketing Strategy** The Committee received an update on delivery of the Trust's Communications Strategy (2023-2025) and Marketing Strategy (developed Spring 2023). The Committee noted the positive work taking place. The Committee discussed the need to review and revise the Marketing Strategy and agreed it would be appropriate to do this alongside the development of the 5-year strategy to assess what the Trust needs to support the new strategy.

	CPL Performance Report The Committee noted the positive progress report from The Clatterbridge Pharmacy Limited and in particular the positive KPIs and financial performance. The Committee were also pleased to see that the CPL staff is nearly fully established. **Board Assurance Framework** The Committee reviewed the Board Assurance Framework risks within its remit and approved the reduction of the BAF 5 (Environmental Sustainability) score from (4 x 3) 12 to (3 x 3) 9, in light of the positive green plan progress. The Committee agreed BAF3 (Finance) should remain at 16 and requested the inclusion of a reference to the unfunded additional mutual aid beds in either BAF 2 or BAF 3, as appropriate. **Terms of Reference** The Committee reviewed its terms of reference and requested some amendments be made prior to going to Trust Board for approval.
Items of concern for escalation to the Board	None
Items for shared learning	No shared learning identified.

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board – 28th February 2024

Chair's Report for: Quality Committee

Date/Time of meeting: 20th December 2023, 13:30pm till 16:30pm

			Yes/No
Chair	Terry Jones	**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	<u>Patient Safety and Experience Quarterly Assurance Report</u> The Committee received the Patient Safety and Experience Quarterly Assurance Report, which informed the Committee on aspects of patient safety, patient experience and clinical effectiveness. A total number of 1089 incidents were reported and reviewed in quarter 2, with 880 reporting no harm. 92% of respondents to the Friends and Family test reported a positive experience in in-patient and day case areas and 97% reported a positive experience in the outpatient departments. Preparations for the transition to the new NHSE mandated Patient Safety Incident Response Framework (PSIRF) were ongoing in quarter 2 and the Trust went live with the new framework on the 1st October 2023. The Committee noted the challenges due to vacancies within the Quality, Experience and Standards Division and were reassured vacancies will be filled by April 2024. The Committee were assured by the contents of the report. <u>Mortality Report</u> The Committee received Mortality Report, which included the following papers: 1) Mortality summary report 2) Mortality Dashboards 3) Quarter 2 2023/24 Complaints, Claims, Inquests and Serious Untoward Incidents - Mortality Surveillance 4) Mortality lesson learnt 5) Model Health System Surveillance and Specialised Services: Haematopoietic Stem Cell Transplantation (Adult) The Committee noted there had been no avoidable deaths. Due to the small number of patients, some of the percentages in the report looked high. The Committee discussed the presentation of data and consistent narrative that small numbers skew the percentages. The Committee requested a Bone Marrow Transplant Mortality Rate update to come back to the Committee in March as a Ward to Board Presentation. The Committee noted the contents of the report. <u>Confidential Claims & Inquest Report</u> The Committee received the Confidential Claims & Inquest Report, which

	provided a full financial year overview of claims in 2022/2023. The Committee noted the contents of the report. Cost Improvement Programme Quality Impact Report The Committee received the Cost Improvement Programme Quality Impact Report, which provided assurance to the Committee on the Trust's CIP process. The Committee received the Quality Impact Assessment Form for CIP schemes and an overview of the Trust process for reviewing the impact on Quality. The Committee requested consideration to include any disproportional impact the scheme may have on any group with protected characteristics. The Committee also discussed how the impact of CIP schemes is reviewed post-implementation and were informed of further work to be done in 2024/25 to include post implementation reviews. The Committee requested a follow up report in 12 months. Integrated Performance and Quality The Committee received the Integrated Performance and Quality Report and reviewed the quality section including complaints, freedom of information requests, incidents and policies. The Committee noted the early resolution meetings being completed by the Patient Advice and Liaison Service to reduce the number of grievances, which reach the formal compliant stage. The targets for complaint responses and freedom of information responses were not met in month 5. The complaints response process is being reviewed and the freedom of information response delay was due to capacity in the Information Governance team. The Committee noted one incident was referred to the Information Commissioner's Office (ICO), which will be reviewed. The Committee noted the in-date policy target had been met for the second month in a row. Quality Account Update The Committee received the Quality Account Update, which provided an update on progress against the Trust's quality priorities for 2023/24 as set out in the Quality Accounts. The Trust was ahead of progress in quarter 1 and remains on track. In quarter 2, there had been lots of work on education and training on the wards. The Committee were assured by the contents. Patient Letters Ward to Board presentation The Committee received the Patient Letters Ward to Board presentation on the Admin Service Datix Review, which looked at appointment errors in quarter 2. There were 50 errors related to admin services, which accounted do 0.0002% of appointments booked. There were 4 themes identified and actions were presented to the Committee. The Committee were assured by the contents. Quality and Safety Walk-round Reports The Quality and Safety Walk-rounds involve an Executive Director and Senior Manager visiting a clinical or non-clinical area of the Trust each month to meet staff and look at their role in patient safety. The Committee received a verbal

	update that the September – December walk-rounds took place, however the reports had been deferred to the March 2024 meeting due to process delay. The Committee will review 6 months of Quality and Safety Walk-rounds in March 2024. Risk & Quality Governance Committee Assurance report The Committee received a verbal update regarding the Risk and Quality Governance Committee meeting, which took place the day prior. There were no items for escalation. The Committee will review the Risk and Quality Governance Committee assurance report in March 2024 Board Assurance Framework The Committee received the Board Assurance Framework (BAF) and discussed each of the BAF risks assigned to Quality Committee. The Committee were assured by the report and noted the connectivity with the rest of the agenda. Quality Risk Register The Committee received the Quality Risk Register for quarter 2, which detailed the 86 risks (5 of which score 15 or above) on Datix (the risk management system) that align to Quality Committee. The Committee discussed the risks and noted some of the risks had moved on since the end of quarter 2. Further discussions were had around Medical gases, storage at the Wirral and discharge cleaning in patient areas. The Committee were assured by the contents. Internal Audit Plan The Committee discussed the changes to the Internal Audit Plan to amend the planned Quality Spot Checks Audit to an audit of the discharge process following a serious incident, which came through the commissioners. The Final Report will be produced in quarter 4.
Items of concern for escalation to the Board	No items to escalate.
Items of achievement for escalation to the Board	The Committee were pleased with the items received.
Items for shared learning	No items for shared learning.

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board – 28th February 2024

Chairs report for: People Committee

Date/Time of meeting: 12 December 2023

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

Items of concern for escalation to the Board	**Guardian of Safe Working Report** A Haematology pathway has been established whereby the Liverpool University Hospital Foundation Trust (LUHFT) Guardian shares any relevant exception reports for systematic oversight to the Clatterbridge Cancer Centre (CCC) Guardian. At time of writing this report no information has been provided regarding Haematology trainees/junior doctors exemptions, and therefore it is assumed there are no exemptions at the time the report was written. However, an update has been requested from the LUHFT Guardian. **Workforce Growth Update** The plan demonstrates workforce growth against the workforce plan, which indicates that the Trust is an outlier having more staff than planned. However, the figures corresponded with the predicted numbers when the forecast was originally made. A forensic analysis has since been carried out and shared with the Integrated Care Board and Chief People Officer who have assurance around the Trust position. Additionally, during a Cheshire and Merseyside HR Directors meeting, it became apparent that Trusts are using different measures and data sources therefore, work will begin to develop one measure for all trusts to use. The purchase of Paddington Community Diagnostic Centre (CDC) has also affected staffing numbers however, going forward these figures will be reported separately from core business which will improve the figures.
Items of achievement for escalation to the Board	**Staff Story – Kerry Gibbons – On-Boarding Process** Kerry Gibbons joined the Trust in June 2023 and has worked for the NHS for 17 years in various organisations and commented that the most positive experience of the process has been here at the Trust. The process was very smooth and efficient and ESR and Mandatory training were all set up. Documentation throughout the On-Boarding process was easy to complete, and the team were helpful and friendly. The local induction was informative and interesting, and not too long. Kerry suggested adding information regarding the Trust Green Plan and having less printed materials.

The Clatterbridge Cancer Centre NHS Foundation Trust

	National Approach to Domestic Violence – patients and staff The Trust has signed up to the Sexual Safety in Healthcare Organisational Charter and will develop an action plan to meet the 10 principles, which be monitored through the Workforce advisory Group. The team will launch the Domestic Abuse and Sexual Violence Programme with Sheena Khanduri as Executive Lead. **Integrated Performance Report** Mandatory Training - The Trust has now achieved compliance for ILS, BLS and Safeguarding Training. Thanks was given to all those involved with achieving compliance. **Retention and Turnover Report** The Committee noted that the report demonstrates a reduction in staff turnover, however, remains above target in month. The report details reasons for leaving and information from leaving interviews which remain low in number despite encouragement from the team to complete the interviews. However, the Trust does compare favourably against other specialist organisations. **People Commitment Progress Report** The digital team will aim to support staff with digital literacy by discussing alternatives to online training such as the ECDL programme which is currently only offered to staff online. **Equality, Diversity and Inclusion Update** The Trust committed to joining up to the Northwest BAME Assembly Anti-Racist Framework to become an intentionally anti-racist organisation. One of key objectives for 2024-2025 will be to increase the number of staff who declare a disability. **Staff Wellbeing and Engagement** The Committee noted that 1779 (66%) of staff completed the staff survey against and ambitious target of 70% and local data results are expected in January 2024. Full national benchmarking data is expected in February 2024 and full national data will be received in March 2024. Results will be shared across the organisation once the embargo is lifted. **Apprenticeship Update** The Trust currently has a healthy cohort of staff on apprenticeship programmes; however, is not fully utilising the apprenticeship funding available which is a common theme across public sector organisations. The intention is to continue to educate managers and staff on understanding how apprenticeship training opportunities can assist patient safety, workforce planning, role transformation and promoting continuous professional development for its current staff members. Additionally, Trust levy funds have been transferred to 5 non-qualifying organisations in the last 12 months and the Learning and Organisational Team are working closely with the Liverpool Region Skills and Employability

	Team to identify opportunities for the Trust to support health and social care organisation across the Liverpool City Region via the levy transfer. **Board Assurance Framework (BAF)** Following a refresh that was undertaken in quarter 1, no changes have been made to the BAF scores for quarter 2. Further work will take place regarding BAF 10 to reduce the score by focussing on certain cohorts of staff, for example those who leave the Trust within 12 months of joining. **University Hospital Accreditation** The Trust has undertaken a self-assessment to establish whether it is feasible to achieve University Hospital status. A draft has been submitted to the University to consider collaborative working and an update will be brought back to the Committee in 2024 **People Committee Risk Report** The Committee noted there are two Risks on the Risk Register scoring over 12. One relates to lack of resource within the medical staffing team; however this risk has since closed due to recruiting a full team. The second risk relates to use of Agency constraints however this risk has now reduced due to new controls that have been put in place. **Workforce Advisory Group Assurance Report** Appraisals were showing as marginally underperforming for October however, data for November demonstrates that the Trust is now compliant.
Items for shared learning	No Shared Learning was identified

Title of meeting: Trust Board Part 1
Date of meeting: 28th February 2024

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 Q2			
Purpose of paper	To present Q2 23/24 Mortality report			
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: Oct 2022 – Sept 2023 for comparison to previous quarters

Year	2022/23		2023/24		Total
	Q3	Q4	Q1	Q2	
Total Patient Deaths	213	219	174	215	**806**
Number of Inpatient Deaths	50	53	37	52	**192**
Number of Outpatient Deaths	163	166	137	163	**614**
Outpatient (Requiring Review)	136	136	112	142	**526**
No. Cases Requiring Review	186	189	149	194	**718**
No. Cases Reviewed Phase 1	172	159	117	122	**570**
% Cases Reviewed Phase 1	92%	84%	79%	63%	**79%**
No. Cases Allocated for Phase 2	170	158	115	112	**555**
No. Cases Reviewed at Phase 2	164	152	103	56	**475**
% Cases Reviewed Phase 2	95%	96%	88%	46%	**83%**
No. Cases Selected Phase 3	21	17	12	9	**59**
No. Cases Discussed Phase 3	19	13	7	1	**40**
% Cases Discussed Phase 3	90%	76%	58%	11%	**68%**

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

- 83% (475/555) of cases had completed an independent peer review (Phase II) from October 2022 – September 2023 deaths. The process can take a minimum of 6 months to complete.
- From this, 59 cases have been selected for discussion out of which, 40 cases have been discussed (x12 inpatients and x28 Community/Other Hospital/Hospice).

  The scores for these cases are:

  - Inpatient SJR RCP Scores: x11 cases were scored 6. x1 case will be scored after Rapid Learning Review
  - Community/Other hospital inpatient RCP Scores: All x28 cases were scored 6.

  Of the remaining x19 cases awaiting discussion:

  - X7 are due to be discussed in Q3 23/24, x10 will be discussed in Q4 2023/24 and x1 is awaiting a date for discussion from the responsible consultant and the final case has gone back to the secondary reviewer for a final decision as to whether a phase 3 discussion is required
- 1 mortality case this quarter were subject to LeDeR review (Learning Disability) which was completed by the safeguard team. The case has been through the mortality review process and was not selected for a phase 3 discussion. The case has also been reviewed by the consultant mortality lead who assigned an avoidability score of 6.
- 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).

October 2022 – September 2023 treatment activities

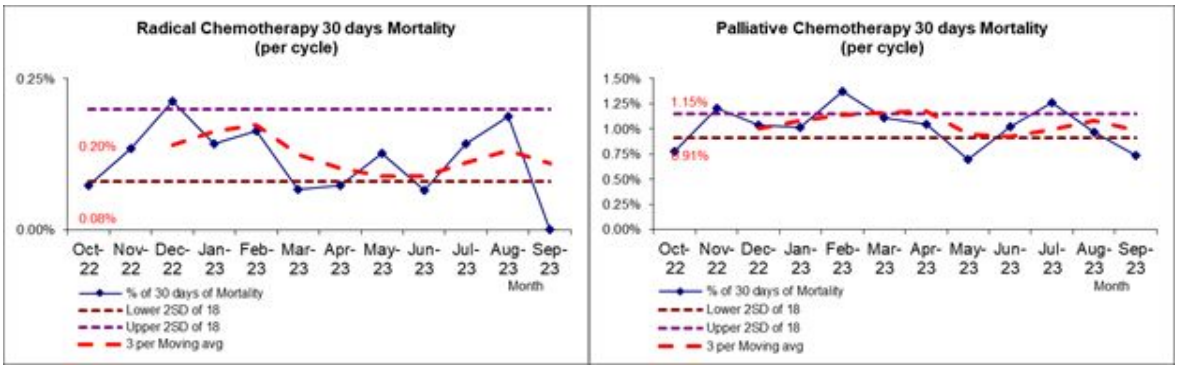
- Results showed the 3 monthly moving average mortality for solid tumour SACT & RT 30 day mortality were within tolerance, as well as RT 90-day mortality.
- Visually the HO patients treated with radical intent displayed peaks of high mortality due to the following points

1) improvement in data capture due to electronic prescribing in HO division
2) low in number of patients being treated with radical intent, 35 patients treated per month comparing to 240 patients per month in solid tumour
3) the control limits for HO analysis were adopted from solid tumour cohort which could be too sensitive, however this cannot be confirmed until HO data is more mature i.e. after a further 12 months of data collection

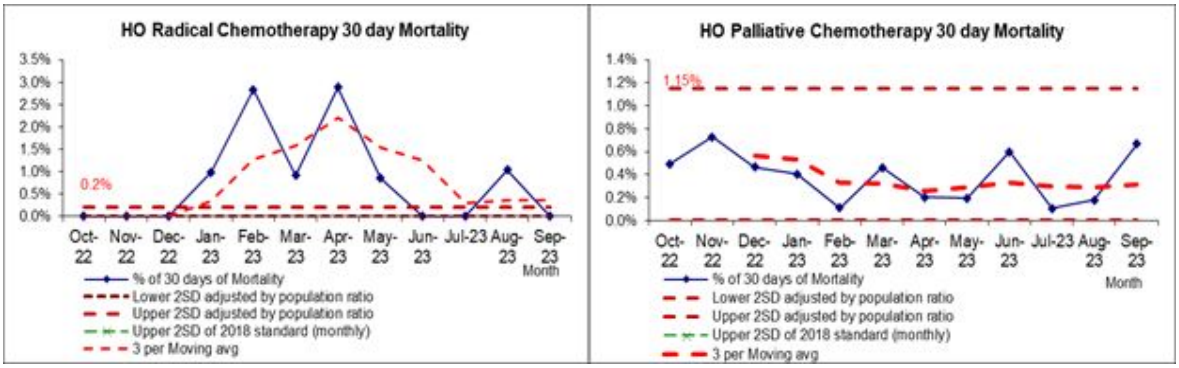
Furthermore, mortality rate for Acute lymphocytic leukemia (ALL), Acute myeloid leukemia (AML), Follicular lymphoma and Myeloma are comparable to available national benchmarking averages. If death rates exceed national benchmarking averages, then this will be highlighted and investigated.

A full mortality review process has been completed for 9 out of 10 radical deaths and no concerns were raised. A reminder has been sent out to the responsible clinician for the remaining case.

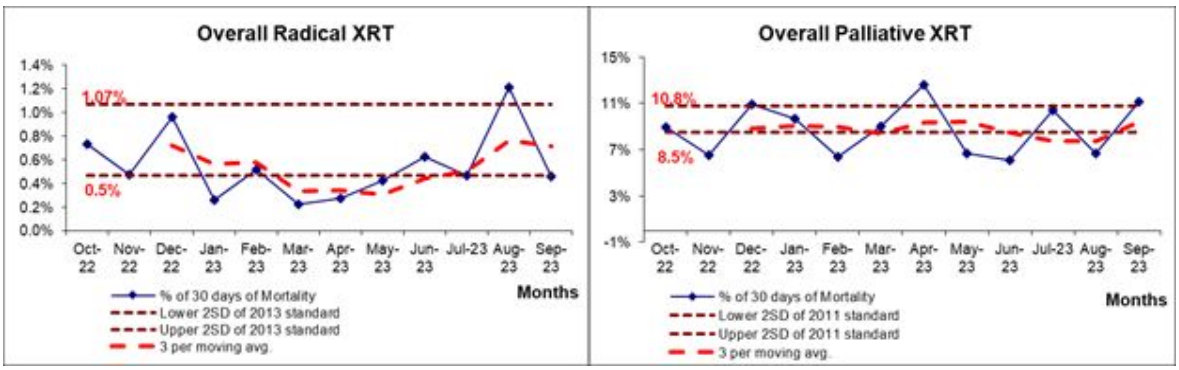
6.1 Chemotherapy 30 day mortality (Solid Tumour)



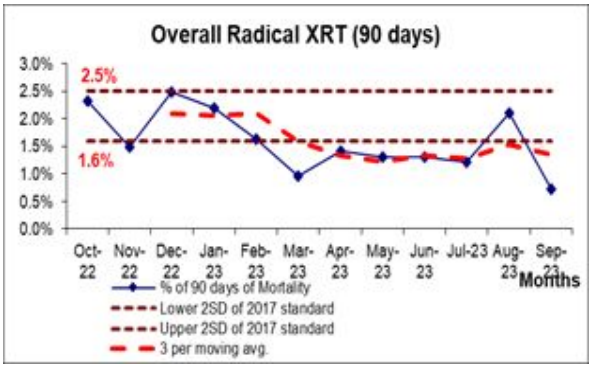
6.2 Chemotherapy 30 day mortality (Haemato-oncology)



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 Jul 2020 and Sep 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	378	343	239	70%	159	67%	21	8	38%
Q2	215	194	122	63%	56	46%	9	1	11%
Q1	163	149	117	79%	103	88%	12	7	58%
2022/23	795	687	623	91%	592	95%	59	52	88%
2021/22	657	567	505	89%	434	86%	47	47	100%
2020/21	501	437	408	93%	382	94%	53	53	100%
Total	2327	2034	1775	87%	1567	88%	180	160	89%

Total Number of Learning Disabilities in Scope

Year	No.	LeDaR Completed	Potentially Avoidable (Score <= 3)
2023/24	1	1	0
Q2	1	1	0
Q1	0	0	-
2022/23	1	1	0
2021/22	0	0	-
Total	2	2	0

Total Number of Children in Scope

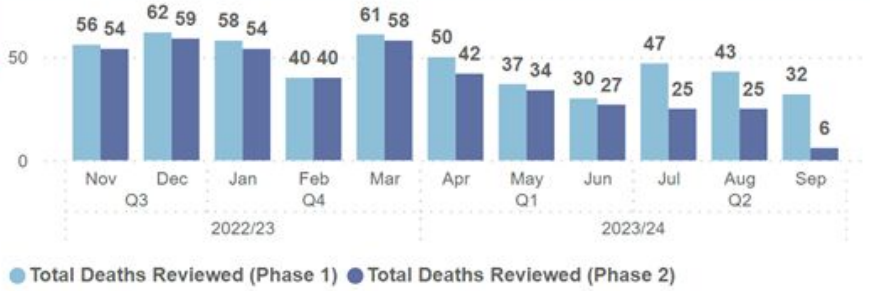
Year	No.	CDOP Completed	Potentially Avoidable (Score <= 3)
2023/24	0	0	-
Q2	0	0	-
Q1	0	0	-
2022/23	1	1	0
2021/22	0	0	-
Total	2	1	0

"-" 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	41
Q2	0	0	0	0	0	12
Q1	0	0	0	0	0	29
2022/23	0	0	0	0	0	171
2021/22	0	0	0	0	0	90
2020/21	0	0	0	1	1	77
Total	0	0	0	1	1	379

Number of cases reviewed at Phase 1 & Phase 2



ID	Year	QTR	Background	Action	CCC Lessons Learned	Closure Date
195	2023/24	Q2	A patient with a history of a haematological and solid tumour malignancy was admitted for issues relating to their solid tumour diagnosis on a haemato-oncology ward rather than solid tumour ward due to lack of appropriate set up of a separate Meditech account for his solid tumour diagnosis.	The process for arranging appropriate Meditech accounts for patients with new diagnoses to facilitate appropriate ongoing care was clarified and reinforced with the registrations team.	Registrations should be informed of new patients who attend with unrecorded malignancies as soon as possible so that new RCR accounts can be created, treating teams assigned and primary tumours and histology information recorded.	08/09/2023
196	2023/24	Q2	GMC guidelines explicitly state that prognosis including the no-treatment option should be documented in clinical correspondence. Ensuring complete and contemporaneous documentation is essential for good clinical care.	The group asked the consultant digital lead to establish a process on how to create pre set up text standard paragraphs in the Trust EPR Details and a request form have been sent to SRG Leads	Pre Set up text can be used to insert standardised text to improve the accuracy and speed of documenting mandatory fields in clinical correspondence.	23/08/2023
192	2023/24	Q2	There was an error relating to air being administered through the oxygen tubing which resulted in a never event. Whilst having no impact on the clinical outcome this was recognised and declared a never event.	Declared Never event Action plan from the never event investigation was disseminated through the divisional patient safety meeting and divisional board meeting	Connecting oxygen tubing to air is a never event. Air ports throughout the organisation have been disconnected where possible to prevent this happening again. Of the three air ports which remain in use, risk assessment have been conducted and mitigations are in place.	20/09/2023
124	2023/24	Q2	A scan contained a clinical alert. Documentation regarding acknowledgment and receipt and actions taken was incomplete. This does not change patient outcome.	A review of the process of informing of radiology scans with alerts was undertaken Clinical alerts on scans now follow a new process whereby they are emailed to consultants and followed up if no response by the diagnostic radiology team. There is a process to ensure that clinical oversight of all results are seen in a consultant's absence.	The process of alerting of abnormal scan findings has been strengthened through improving administrative and clinical oversight.	18/07/2023
171	2023/24	Q2	A request for a clinical review after cycle 1 (via msg/task) was not actioned resulting in a missed medical review. This does not change patient outcome.	Incident investigation has revealed the process for monitoring for patients becoming lost to follow up was not sufficiently robust and a system change required.	A system change has been enacted to ensure the automated system includes chemotherapy and medical follow up appointments. The team cancer support worker (CSW) tracks all patient undergoing chemotherapy and checks that they have the appropriate imaging and follow up required (based on instructions from the patient's consultant.) There is back up via the clinical nurse specialists.	02/07/2023
158	2023/24	Q2	Following a change in treating Consultant, the MRM raised concerns over lack of clarity as to which consultant was responsible for the care of the patient. There were no concerns about the care delivered.	A review of the process for changing attending consultants in the trust EPR was undertaken with the digital, administration and SRG teams.	A new, movers and leavers process has been implemented for when consultants change job roles or leave the organisation to allocate patient care to new named consultants without delay.	25/07/2023

Thematic Summary Q2 2023/24

All 6 cases which resulted in the above actions were scored as a 6 i.e. outcome of death was unavoidable. Themes regarding documentation, EPR usability and transfer of care between consultants and teams have been identified. Appropriate actions have been implemented

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: **Trust Board**
Date of meeting: **28th February 2024**

Report author	Joan Spencer, Chief Operating Officer and Deputy CEO					
Paper prepared by	Hannah Gray, Associate Director of Performance and Operational Improvement					
Report subject/title	Integrated Performance Report M10 2023 / 2024					
Purpose of paper	This report provides an update on performance for month 10 2023/24 (January 2024). 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		

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REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Integrated Performance Report (Month 10 2023/24)

Hannah Gray: Associate Director of Performance and Operational Improvement

Joan Spencer: Chief Operating Officer and Deputy CEO

Introduction

This report provides an update on performance for January 2024, 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.

A first draft of 2024/25 IPR KPI details will be presented at the February 2024 Performance Committee. This is subject to change, as the 2024 / 25 National Planning Guidance has not yet been published, or 2024 / 25 Contracts agreed.

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Interpretation of Statistical Process Control Charts

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

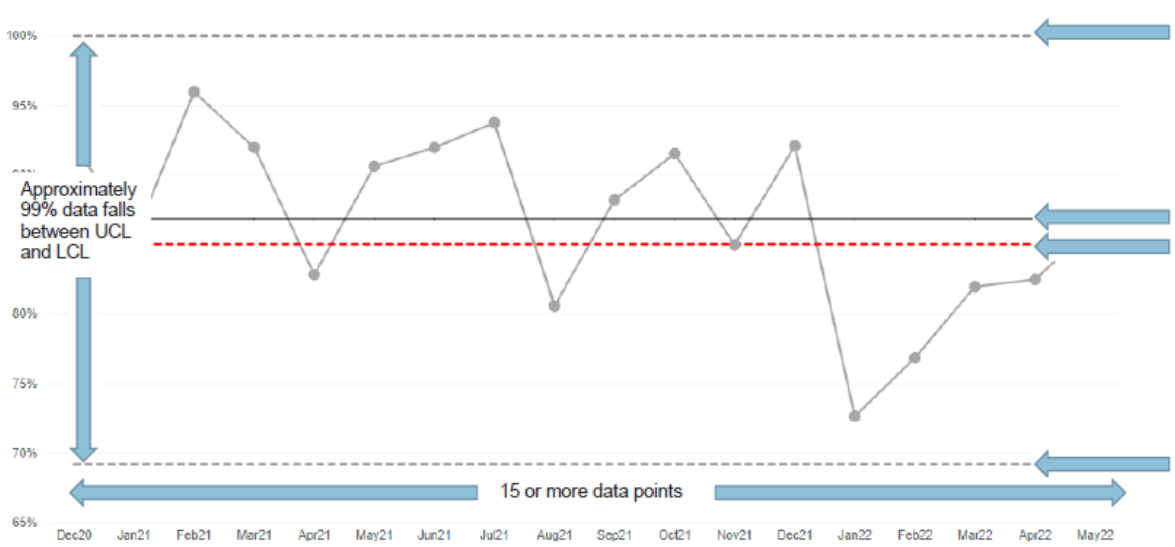
Are we improving, declining or staying the same? (Variation)			
Icon	**Variation**	Definition	Action
	Special Cause Improving Variation	Unexpected variation that results from unusual circumstances in a system or process i.e. assignable. (Blue = significant improvement/low pressure, H = high numbers,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

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

REPORT

The Clatterbridge Cancer Centre NHS Foundation Trust

Anatomy of the SPC Chart



Upper Control Limit (UCL)

Mean (Average)

KPI Target

Lower Control Limit (LCL)

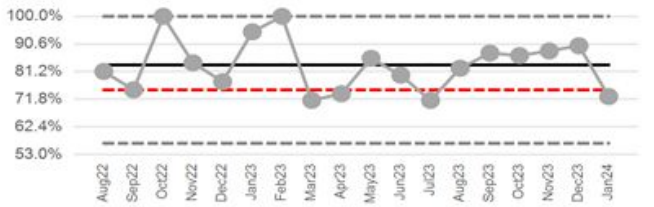
Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
CW00	28 Day Faster Diagnosis - (Referral to Diagnosis)	Green ≥75% Red <75%	Contractual / Statutory	100.0%	71.4%	73.7%	85.7%	80.0%	71.4%	82.4%	87.5%	86.7%	88.2%	90.0%	72.7%		
			Narrative	The nationally set target figure has not been achieved and an exception report is provided. There is no unexpected variation and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



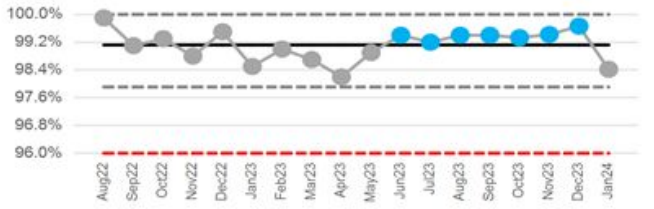
Reason for Non-Compliance	Action Taken to Improve Compliance
3 patients breached the 28 day FDS target in January. 2 of the breaches were unavoidable due to: - The patient required a repeat diagnostic test as the original was insufficient - The patient cancelled and rearranged the first offered appointment date 1 of the breaches was avoidable due to: Delay to diagnostic tests (Bone Marrow & PET CT) and delay to follow up appointment due to capacity.	Review and optimisation of the RDS triage service to ensure diagnostic tests are booked on triage.

Escalation Route & Expected Date of Compliance
Operational Performance Group, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board March 24

Metric ID	Metric Name	Target	Metric Type	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
CW31	31 Day Decision to Treat to Treatment Standard	Green ≥96% Red <96%	Contractual / Statutory	99.0%	98.7%	98.2%	98.9%	99.4%	99.2%	99.4%	99.4%	99.3%	99.4%	99.7%	98.4%		
			Narrative	The target has been achieved. Performance is higher than excepted and the target is outside SPC limits and is therefore likely to be achieved consistently.													



Integrated Performance Report (Feb 23 - Jan 24)

The Clatterbridge Cancer Centre NHS Foundation Trust

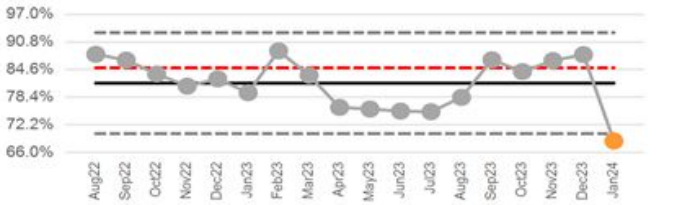
Access

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
CW40	Number of 31 Day Patients Treated ≥ Day 73	Green 0 Red >0	Contractual / Statutory		0	0	0	1	0	0	0	0	0	0	0	0		
			Narrative	This month, there were 0 x 31 day patients treated on or after day 73.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
CW24	24 Day Referral to CCC to Treatment (62 Day Patients)	Green >85% Amber 80-84.9% Red <80%	Contractual / Statutory		88.8%	83.3%	76.1%	75.8%	75.3%	75.2%	78.4%	86.8%	84.2%	86.6%	88.0%	68.6%		
			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 (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

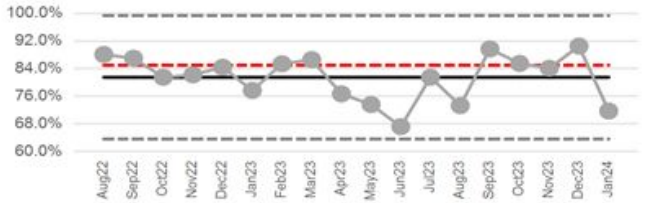
Access

Responsible Forum: Performance Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
60 of the 193 patients treated in January, breached the 24 day target. The longest wait was 45 days (the details of this interpreter related delay are under review) and the median wait was 24 days. This is the highest ever number of 62 Day patients treated in a month at CCC. 31 of these 60 patients breached 62 days; these breach details are provided in the 62 day exception report. Of the 29 patients for whom we breached 24 days but achieved the 62 day target, 13 breaches were unavoidable to CCC and 16 were avoidable. The breach reasons are as follows: Unavoidable breaches: Delay to 1st appointment awaiting molecular markers x 3 (Lung) Delay due to referring trust capacity for pre-treatment test x 1 (Breast) Delay to treatment start date due to clinic capacity at referring trust treatment hub x 1 (Breast) Patient referred to CCC for chemo, then required referral for palliative radiotherapy x 1 (Urology) Patient required further discussion at MDT pending PET CT and MRI x 1 (UGI) Biopsy result required prior to treatment x 1 (Lung) Treatment start date deferred awaiting DPYD. Sample was collected and sent from CCC x 1 (UGI) Change in treatment plan x 1 (LGI) Formal MDT review of PET-CT prior to treatment x 1 (Gynae) Interpreter pathway under review x 1 (Lung) Patient choice to defer treatment start date until after Christmas, folllowing inital acceptance of the appointment x 1 (Breast) Avoidable breaches: Radiotherapy related delays (including SABR), due to required service of treatment machine and Christmas and New Year related reduced capacity x 8 (4 x lung, 2 x H&N, 2 x LGI) 1st appointment delays due to Christmas and New Year related reduced capacity x 6 (Lung x 3, H&N x 1, UGI x 1 and Urology x 1) Cyclotron scheduling capacity / consultant availability x 2 (CNS)	The majority of avoidable delays were due to the bank holidays and annual leave over Christmas and New Year, which reduced capacity. The impact is particularly significant for SABR patients as there is already a tight turnaround on this pathway.

Escalation Route & Expected Date of Compliance
Operational Performance Group, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board February 24

Metric ID	Metric Name	Target	Metric Type	Year & Month													
				Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
CW62	62 Day Referral to Treatment Standard	Green ≥85% Red <85%	Contractual / Statutory	85.4%	86.6%	76.7%	73.6%	67.2%	81.5%	73.3%	89.7%	85.5%	84.1%	90.5%	71.7%		
			Narrative	The nationally set target figure has not been achieved and an exception report is provided. There is no unexpected variation and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Integrated Performance Report (Feb 23 - Jan 24)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access

Responsible Forum: Performance Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
31 patients breached the 62 day target in January. 26 of the breaches were unavoidable to CCC, due to: - Patient choice x 9 (Gynae x 1, Lung x 4 & Urology x 4) - Delay to 1st appointment awaiting molecular markers x 6 (Lung) - Medical x 4 (H&N, Lung & Urology x 2) - Patient referred to both CCC & LHCH - delay awaiting surgical appointment and then the patient was not for surgery x 1 (Lung) - Complex pathway – patient referred into Haematology and transferred to Sarcoma pathway x 1 (Haem) - Patient required discussion in MDT at another trust prior to commencing treatment, followed by delay to RT x 1 (Sarcoma) - Patient required further diagnostic test before commencing treatment x 1 (Urology) - Consultant required confirmation proposed treatment plan would not be detrimental to their other cancer diagnosis x 1 (Urology) - Patient required complete MRI staging/up to date CT after referral to CCC x 1 (Urology) - Patient required investigation for incidental finding prior to confirmation of treatment plan X 1 (Lung) The 5 avoidable breaches were due to: - Slight delay to planning and radiotherapy appointments x 1 (Gynae) - Delay to 1st app (18 days) due to clinic capacity: consultant planned leave and full clinics x 1 (Haem) - Delay to SABR Peer Review meeting due to Christmas / New Year bank holidays x 1 (Lung) - Delay to 1st app (20 days) due to capacity x 1 (Lung) - Delay to 1st app due to capacity - Christmas / New Year bank holidays x 1 (Sarcoma)	Gynae: Increased active monitoring of the planning pathway is now underway and since this breach, two further breaches have been saved as a result of this revised escalation process. Haem: Whilst planned leave of even 1 consultant in this small team creates capacity issues, the folllowing options are always explored: translating follow up appointments to new, delaying "non-urgent" follow ups, creating ad-hoc appointments or using waiting list initiatives. Lung: The weekly Tuesday SABR MDT fell on a BH and no provision was made between Christmas and New Year to review the patient's suitability for SABR. The team have recognised that on the rare occasion that Bank Holidays fall on a Tuesday, a virtual MDT should be initiated. Sarcoma: A Consultant was providing ward cover during Industrial Action. Additional support for consultant cover has been identified and is now in place.

Escalation Route & Expected Date of Compliance
Operational Performance Group, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board February 24

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
CW43	Number of Avoidable Breaches, Treated ≥ 104 Days and at CCC For Over 24 Days	Green 0 Amber 1 Red >1	Contractual / Statutory		2	1	2	1	3	2	1	1	0	0	0	3		
			Narrative	This month, there were 3 patients in this category. 30 patients were treated => day 104. For these patients, the median referral day was 96 days and the median time at CCC was 24 days.														

Data Not Applicable for SPC

Reason for Non-Compliance	Action Taken to Improve Compliance
4 Patients were treated +> 104+ days AND at CCC for over 24 days. 3 of the breaches were avoidable, due to: - Delay to 1st app (18 days) due to clinic capacity: consultant planned leave and full clinics x 1 (Haem) - Delay to 1st app (20 days) due to capacity x 1 (Lung) - Delay to 1st app due to capacity - Christmas / New Year bank holidays x 1 (Sarcoma)	These patients are 62 day patients, therefore the actions are stated in the 62 Day exception report.

Escalation Route & Expected Date of Compliance
Operational Performance Group, Divisional Meetings, Divisional Performance Reviews, Performance Committee, Trust Board February 24

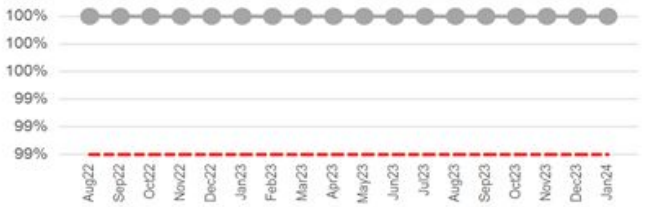
Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

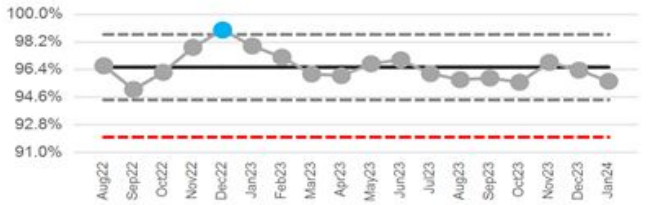
Access

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
DI01	Diagnostic Imaging Waitlist - Within 6 Weeks	Green ≥99% Red <99%	Contractual / Statutory		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
RT03	RTT Incomplete	Green ≥92% Red <92%	Contractual / Statutory		97.2%	96.1%	96.0%	96.8%	97.0%	96.1%	95.7%	95.9%	95.6%	96.9%	96.4%	95.6%		
			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.														



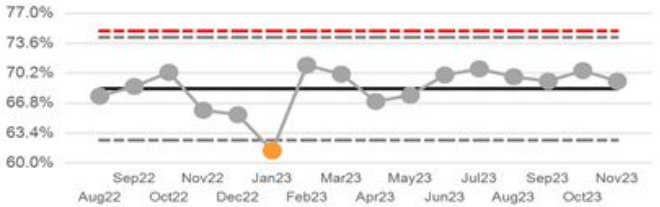
Integrated Performance Report (Feb 23 - Jan 24)

The Clatterbridge Cancer Centre NHS Foundation Trust

Access: Cheshire and Merseyside

Responsible Forum: Acute and Specialist Trust Provider Collaborative

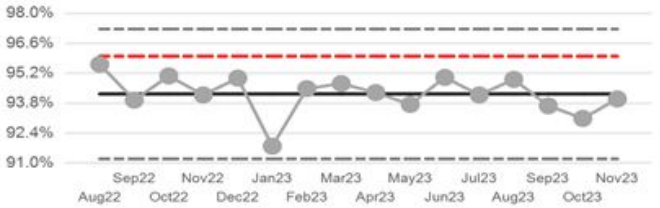
Metric ID	Metric Name	Target	Metric Type	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
CM28	28 Day Faster Diagnosis - (Referral to Diagnosis) (Cheshire and Merseyside)	Green ≥75% Red <75%	Contractual / Statutory	71.1%	70.1%	67.0%	67.7%	70.0%	70.7%	69.8%	69.3%	70.5%	69.3%	-	-		
			Narrative	The nationally set target figure has not been achieved and an exception report is provided. There is no unexpected variation and the target is unlikely to be achieved without significant change.													



Reason for Non-Compliance	Action Taken to Improve Compliance
Non-compliance with the 28 Day FDS was driven by underperformance in the following tumour groups: Suspected gynaecological cancer 44.5% (815 breaches), Suspected cancer - referral to non-specific symptom clinic 48.9% (69 breaches), Suspected lower gastrointestinal cancer 49.7% (1274 breaches), Suspected sarcoma 50% (15 breaches), Suspected urological malignancies (excluding testicular) 50.3% (550 breaches), Suspected haematological malignancies (excluding acute leukaemia) 52.6% (36 breaches), Other suspected cancer (not listed) 60% (2 breaches), Suspected lung cancer 68.3% (60 breaches), Suspected upper gastrointestinal cancer 73.3% (277 breaches) Providers not achieving the national standard were: Liverpool Womens 28% (309 breaches), Liverpool Heart And Chest 45.5% (6 breaches), Countess Of Chester Hospital 57.4% (598 breaches), Mersey and West Lancashire Teaching Hospitals 69.2% (1008 breaches), Wirral University Teaching Hospital 69.9% (643 breaches), Mid Cheshire Hospitals 71.5% (424 breaches), Liverpool University Hospitals 73.6% (949 breaches)	• 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	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
CM31	31 Day Decision to Treat to Treatment Standard (Cheshire and Merseyside)	Green ≥96% Red <96%	Contractual / Statutory	94.5%	94.7%	94.3%	93.7%	95.0%	94.2%	94.9%	93.7%	93.1%	94.0%	-	-		
			Narrative	The nationally set target figure has not been achieved and an exception report is provided. There is no unexpected variation and the nature of variation indicates that achievement of the target is likely to be inconsistent.													



Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

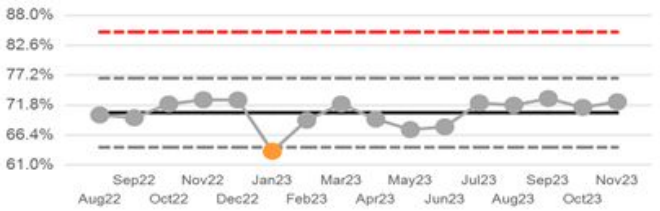
Access: Cheshire and Merseyside

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 88.8% (9 breaches), Lower Gastrointestinal 88.9% (31 breaches), Urological 91.4% (54 breaches), Skin 92.6% (46 breaches), Other 93.5% (2 breaches), Head & Neck 95% (6 breaches) Providers not achieving the national standard were: Liverpool Womens 66.7% (9 breaches), Mid Cheshire Hospitals 86% (22 breaches), Wirral University Teaching Hospital 86.7% (41 breaches), Liverpool University Hospitals 87.6% (52 breaches), Liverpool Heart And Chest 91% (8 breaches), Bridgewater Community Healthcare 92.9% (1 breaches), Mersey and West Lancashire Teaching Hospitals 93.8% (34 breaches)	Performance is marginally below target. The breach reason for over 50% of breaches is stated as 'Elective capacity inadequate for treatment in an admitted care setting'.

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	Year & Month												
				Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
CM62	62 Day Referral to Treatment Standard (Cheshire and Merseyside)	Green ≥85% Red <85%	Contractual / Statutory	69.1%	72.0%	69.3%	67.4%	67.9%	72.2%	71.8%	73.0%	71.4%	72.4%	-	-		
			Narrative	The nationally set target figure has not been achieved and an exception report is provided. There is no unexpected variation and the target is unlikely to be achieved without significant change.													



Integrated Performance Report (Feb 23 - Jan 24)

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 41.1% (26.5 breaches), Head & Neck 59.6% (23 breaches), Lower Gastrointestinal 62.7% (50.5 breaches), Lung 63.1% (53.5 breaches), Urological (Excluding Testicular) 64.4% (119 breaches), Haematological 68.6% (16.5 breaches), Other 70.2% (7 breaches), Upper Gastrointestinal 75.7% (24.5 breaches), Breast 80% (43.5 breaches) Providers not achieving the national standard were: Liverpool Womens 23.1% (15 breaches), Liverpool Heart And Chest 47.2% (14 breaches), Mid Cheshire Hospitals 57.7% (73 breaches), Liverpool University Hospitals 69.4% (91 breaches), East Cheshire 69.6% (22.5 breaches), Wirral University Teaching Hospital 70.4% (55 breaches), Bridgewater Community Healthcare 72.4% (4 breaches), Warrington and Halton Teaching Hospitals 73.4% (25.5 breaches), Mersey and West Lancashire Teaching Hospitals 81.1% (70 breaches), Countess Of Chester Hospital 82.2% (25 breaches), The Clatterbridge Cancer Centre 84.1% (12 breaches)	• 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	

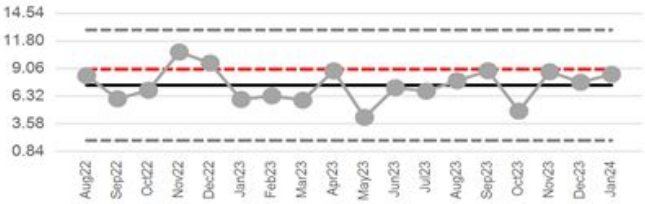
Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

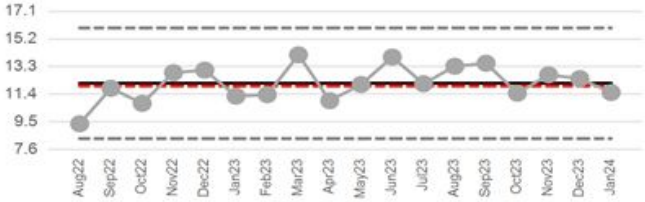
Efficiency

Responsible Forum: Performance Committee

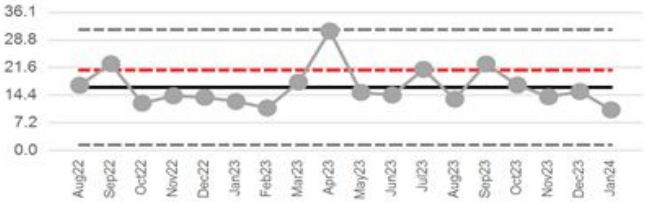
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
IP05-ST	Length of Stay Elective Care: Solid Tumour Wards (Average Number of Days On Discharge)	Green ≤9 Amber 9.1-10.7 Red >10.7	Statutory		6.36	5.93	8.84	4.22	7.17	6.82	7.86	8.85	4.85	8.75	7.70	8.49		
			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.														



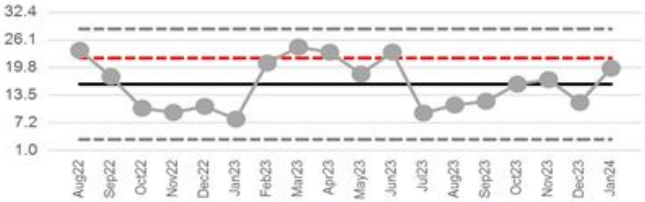
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
IP06-ST	Length of Stay Emergency Care: Solid Tumour Wards (Average Number of Days On Discharge)	Green ≤12 Amber 12.1-14.3 Red >14.3	Statutory		11.4	14.1	11.0	12.1	14.0	12.1	13.4	13.6	11.5	12.8	12.5	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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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		11.1	17.9	31.2	15.2	14.5	21.2	13.4	22.6	17.1	14.0	15.4	10.6		
			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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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		20.9	24.5	23.3	18.4	23.4	9.5	11.3	12.2	16.1	17.1	11.9	19.7		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



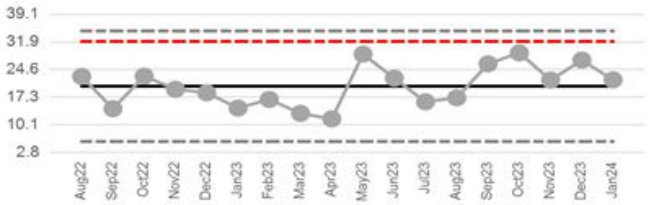
Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

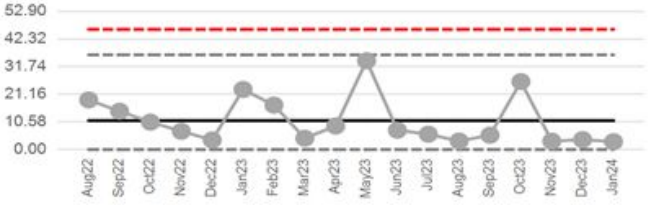
Efficiency

Responsible Forum: Performance Committee

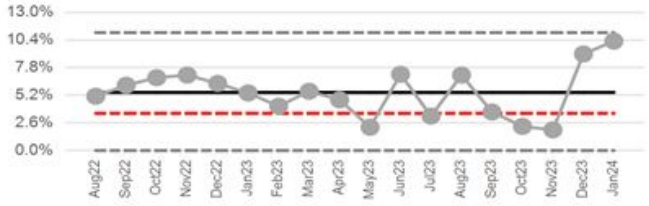
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
IP05-5	Length of Stay Elective Care: HO Ward 5 (Average Number of Days On Discharge)	Green ≤32 Amber 32.1-33.6 Red >33.6	Statutory		16.8	13.1	11.6	28.7	22.4	16.2	17.2	26.1	29.0	21.8	27.1	21.9		
			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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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		17.00	4.33	9.00	34.00	7.40	5.88	3.25	5.50	26.00	3.20	3.80	3.00		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that the target is likely to be consistently achieved.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
IP22	Delayed Transfers of Care As % of Occupied Bed Days	Green ≤3.5% Red >3.5%	Statutory		4.2%	5.6%	4.8%	2.2%	7.2%	3.2%	7.1%	3.6%	2.3%	1.9%	9.1%	10.3%		
			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	Action Taken to Improve Compliance
Delayed Transfers of Care (DTOC) as a % of occupied bed days was above the Trust target of <= 3.5%, by 6.8%. There were 262 extra bed days in January. There were 10 DTOC and the average length of DTOC was 26.2 days. 1 patient awaited Fast Track Package of care (1 extra bed day). 1 patient awaited Fast Track Nursing Home placement (12 extra bed days). 2 patients awaited hospice placement (10 extra bed days). 3 patients awaited a Nursing Home placement (193 extra bed days). 1 patient awaited Social Service POC (33 extra bed days). 2 patients awaited ICD (13 extra bed days)	The Patient Flow Transformation Project has commenced and will run from Jan 2024 to Jan 2025. The first Working Leads Group and Programme Board have now met.

Escalation Route & Expected Date of Compliance
Length of stay meeting, Divisional Meetings, Operational Performance Group, Divisional Performance Reviews, Performance Committee, Trust Board March 2024

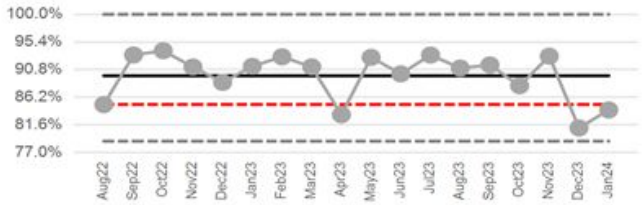
Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

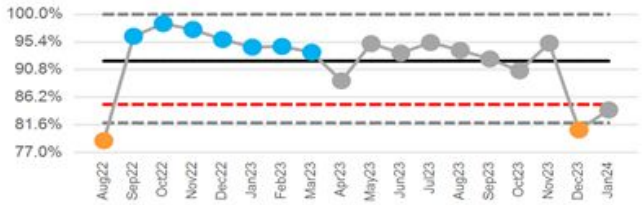
Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
IP20	Average Bed Occupancy - Midday	Green 85% - ≤92% Amber 81-84.9%, 92-94.9% Red <81% or >95%	Statutory		92.9%	91.3%	83.3%	92.8%	90.1%	93.2%	91.1%	91.6%	88.1%	93.0%	81.1%	84.1%		
			Narrative	Midday bed occupancy is below the nationally set ambition of 92% and also below the internally set minimum target of 85% 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.															



Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
IP21	Average Bed Occupancy - Midnight	Green 85% - ≤92% Amber 81-84.9%, 92-94.9% Red <81% or >95%	Statutory		94.7%	93.7%	88.9%	95.1%	93.6%	95.3%	94.0%	92.6%	90.6%	95.2%	80.8%	84.1%		
			Narrative	Midday bed occupancy is below the nationally set ambition of 92% and also below the internally set minimum target of 85% 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.															

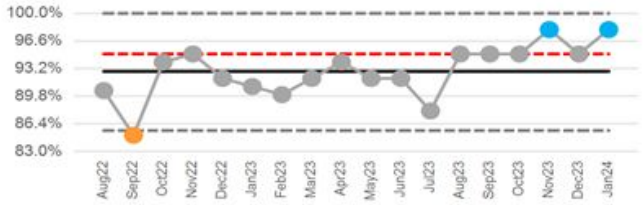


Reason for Non-Compliance	Action Taken to Improve Compliance
Whilst bed occupancy was below 92% and therefore within the national target range, it was marginally below the Trust minimum of 85%. In January we had a number of patients with complex nursing needs and their discharge was delayed whilst appropriate nursing home placements were secured.	Patient Flow team continue to work with the wider MDT to aid discharge planning. We continue to work with Acute Oncology teams to offer Mutual aid if required. Details of the CCC Patient Flow Transformation Project progress are provided in the DTOC exception report.

Escalation Route & Expected Date of Compliance

Length of stay meeting, Divisional Meetings, Operational Performance Group, Divisional Performance Reviews, Performance Committee, Trust Board
February 2024

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
IP23	% of Expected Discharge Dates Completed	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		90.0%	92.0%	94.0%	92.0%	92.0%	88.0%	95.0%	95.0%	95.0%	98.0%	95.0%	98.0%		
			Narrative	The target has been achieved and performance is higher than expected. The nature of variation indicates that achievement of the target is likely to be inconsistent.														



Integrated Performance Report (Feb 23 - Jan 24)

The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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

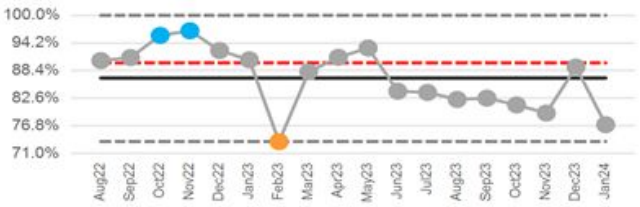
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
IP25	% of Cancelled Elective Procedures (On or After The Day of Admission) Rebooked Within 28 Days of Cancellation	Green 100% Red <100%	Contractual		-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	There is no data to display, as no procedures were cancelled.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
EF10	Imaging Reporting Turnaround (Inpatients)	Green >90% Amber 80-89.9% Red <80%			73.5%	88.1%	91.2%	93.1%	84.1%	83.8%	82.4%	82.6%	81.2%	79.5%	89.2%	77.1%		
			Narrative	Performance is below target 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.														



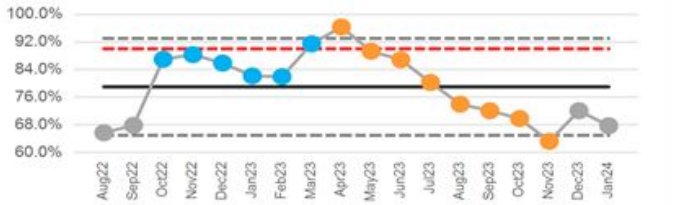
Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Efficiency

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
EF11	Imaging Reporting Turnaround (Outpatients)	Green >90% Amber 80-89.9% Red <80%			82.0%	91.5%	96.3%	89.3%	86.9%	80.3%	74.0%	72.1%	69.8%	63.2%	72.1%	67.8%		
			Narrative	Performance is below target 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.														

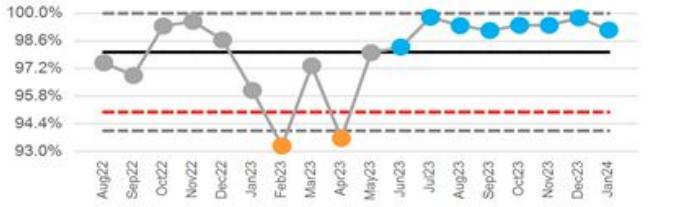


Reason for Non-Compliance	Action Taken to Improve Compliance
There has been a decrease in compliance for both inpatients and outpatients. There was an expectation of improvement for January following the Christmas period, however an increase in activity, maintenance of low waiting times for scans and vacancies and unplanned absence in the radiologist group has increased the turnaround times this month.	-The scanning wait remains at one week (except MRI at 3 weeks) and demand remains high. -Adherence to the revised SOP (detailing prioritisation of reporting) is being closely managed. -Radiology capacity has increased now that all Sonographers are in post and have completed their training. -Medica have agreed to an increased volume for the next few weeks at least. This continues to be closely managed by the clinical specialists and the PACS team. -Same day turnaround for reporting has been deployed and the clinical specialists are aware that this is now available for urgent reports . -The job plan of the reporting radiographer has been changed, to be able to provide cover across the week. Recruitment Progress: - 2 Radiographers started at CCC on 19th December. - The short term use of agency is being considered following unsuccesful Radiologist interviews in January. - The business case for 9 Radiologists in total was approved at the December 2023 Finance Committee. Alternative roles are also being considered. - The IR consultant commenced on 1st Feb, with reporting in their job plan.

Escalation Route & Expected Date of Compliance

Divisional Meetings, Divisional Performance Reviews, Operational Performance Group, Performance Committee, Trust Board
February 2024

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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		93.3%	97.3%	93.7%	98.0%	98.3%	99.8%	99.4%	99.1%	99.4%	99.4%	99.8%	99.2%		
			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.														



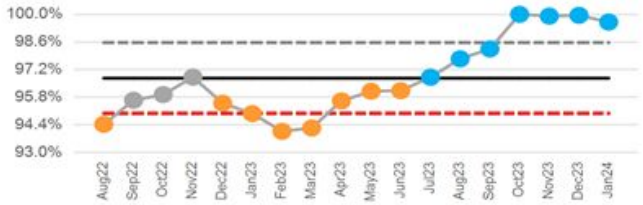
Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

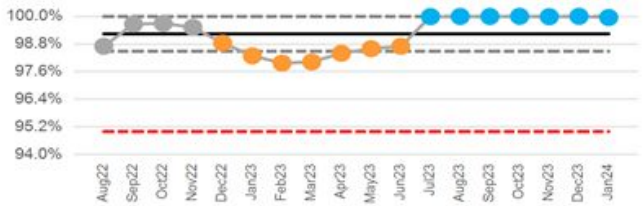
Efficiency

Responsible Forum: Performance Committee

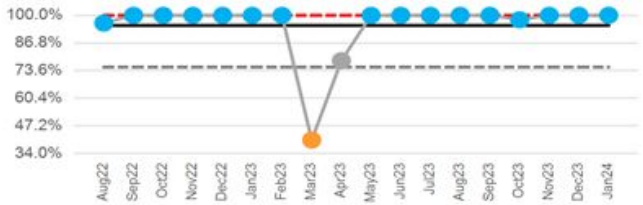
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
DQ02	Data Quality - % of Outpatients With an Outcome	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		94.1%	94.2%	95.6%	96.1%	96.1%	96.8%	97.7%	98.3%	100.0%	99.9%	99.9%	99.6%		
			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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
DQ03	Data Quality - % of Outpatients With an Attend Status	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		98.0%	98.0%	98.4%	98.6%	98.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%		
			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.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
EF01	Percentage of Subject Access Requests Responded to Within 1 Month	Green 100% Red <100%	Contractual		100.0%	40.4%	78.4%	100.0%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%	100.0%	100.0%		
			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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
EF02	% of Overdue ISN (Information Standard Notices)	Green 0% Red >0%	Contractual		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
			Narrative	The target continues to be achieved.														

Data Not Applicable for SPC

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Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU17	Never Events	Green 0 Red >0	Contractual / Statutory		0	0	0	1	0	0	0	0	0	0	0	0		
			Narrative	0 Never Events were reported this month.														

Data Not Applicable for SPC

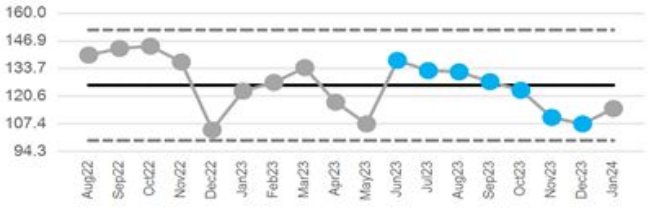
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU04	Serious Incidents (SIs)	No Target	Contractual / Statutory		0	0	1	0	1	0	0	0	0	0	1	0		
			Narrative	No SI s were recorded this month.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU01	Serious Incidents: % Submitted Within 60 Working Days / Agreed Timescales	Green 100% Red <100%	Contractual / Statutory		-	-	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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU03	Incidents /1,000 Bed Days	No Target	Statutory		127.1	134.2	117.8	107.4	137.6	132.8	132.2	127.5	123.4	110.5	107.4	114.7		
			Narrative	Incident numbers are lower than expected. Incidents are reviewed at Divisional Quality and Safety meetings and Divisional Performance Review meetings. This focus promotes a good reporting culture and analysis of themes and trends to drive improvement.														



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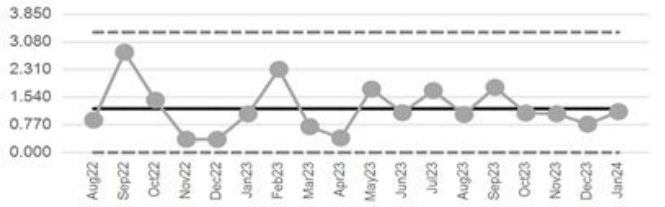
Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU05	All Incidents Resulting in Moderate Harm and Above /1,000 Bed Days	No Target	Local		2.318	0.719	0.405	1.767	1.110	1.724	1.060	1.816	1.098	1.080	0.790	1.139		
			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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU06	Inpatient Falls Resulting in Harm Due to Lapse in Care	Green 0 Red >0	Contractual		0	0	0	0	1	0	0	0	0	0	0	0		
			Narrative	There were no falls resulting in harm due to a lapse in care, however figures may change following harm review.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU07	Inpatient Falls Resulting in Harm Due to Lapse in Care /1,000 Bed Days	Green 0 Red >0	Contractual		0.000	0.000	0.000	0.000	0.370	0.000	0.000	0.000	0.000	0.000	0.000	0.000		
			Narrative	There were no falls resulting in harm due to a lapse in care. Figures may change retrospectively, following harm review.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU08	Pressure Ulcers (Hospital Acquired Grade 3/4, With a Lapse in Care)	Green 0 Red >0	Contractual		0	0	0	0	1	0	0	0	0	0	0	0		
			Narrative	The target continues to be achieved, with no such pressure ulcers this month. Figures may change retrospectively, following harm review.														

Data Not Applicable for SPC

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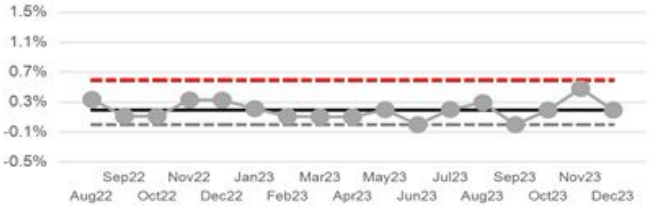
Quality

Responsible Forum: Quality Committee

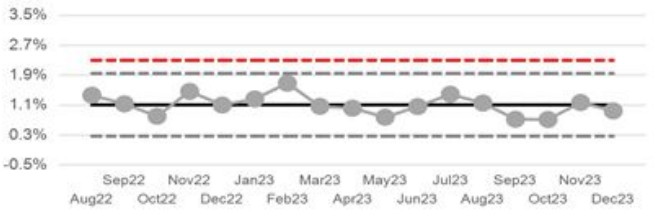
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU09	Pressure Ulcers (Hospital Acquired Grade 3/4, With a Lapse in Care) /1,000 Bed Days	Green 0 Red >0	Contractual		0.000	0.000	0.000	0.000	0.370	0.000	0.000	0.000	0.000	0.000	0.000	0.000		
			Narrative	The target continues to be achieved, with no such pressure ulcers this month. Figures may change retrospectively, following harm review.														

Data Not Applicable for SPC

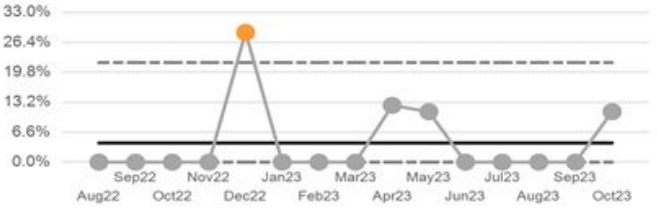
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU10	30 Day Mortality (Radical Chemotherapy)	Green ≤0.6% Amber 0.61% - 0.7% Red >0.7%	SOF		0.1%	0.1%	0.1%	0.2%	0.0%	0.2%	0.3%	0.0%	0.2%	0.5%	0.2%	-		
			Narrative	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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU12	30 Day Mortality (Palliative Chemotherapy)	Green ≤2.3% Amber 2.31% - 2.5% Red >2.5%	SOF		1.7%	1.1%	1.0%	0.8%	1.1%	1.4%	1.2%	0.7%	0.7%	1.2%	0.9%	-		
			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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU13	100 Day Mortality (Bone Marrow Transplant)	To Be Confirmed	SOF / NR		0.0%	0.0%	12.5%	11.1%	0.0%	0.0%	0.0%	0.0%	11.1%	-	-	-		
			Narrative	This month, there was 1 death within 100 days of transplant. This patient's care will be reviewed at the Mortality Review Group.														



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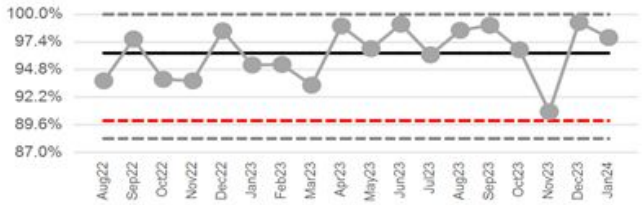
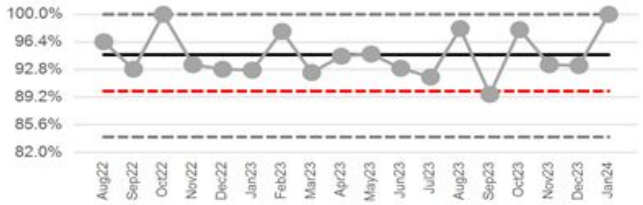
Quality

Responsible Forum: Quality Committee

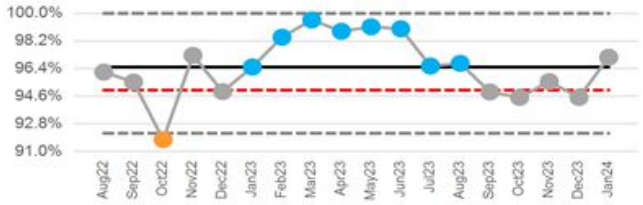
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU62	Consultant Review Within 14 Hours	Green ≥90% Red <90%	Contractual		95.3%	93.3%	98.9%	96.8%	99.1%	96.2%	98.5%	99.0%	96.7%	90.8%	99.2%	97.8%		
			Narrative	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.														



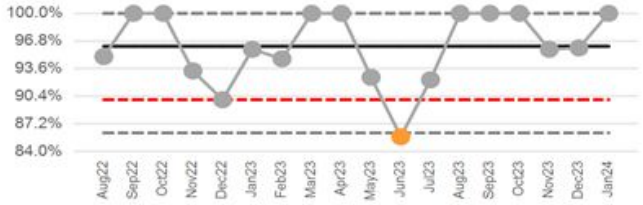
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU48	Sepsis IV Antibiotics Within an Hour	Green ≥90% Red <90%	Contractual		97.8%	92.4%	94.5%	94.8%	93.0%	91.8%	98.1%	89.6%	98.0%	93.4%	93.3%	100.0%		
			Narrative	The target has been achieved. There is no significant change and the nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU31	Percentage of Adult Admissions With VTE Risk Assessment	Green ≥95% Red <95%	Contractual / Statutory		98.4%	99.6%	98.8%	99.1%	99.0%	96.6%	96.7%	94.9%	94.5%	95.6%	94.5%	97.1%		
			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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU14	Dementia: Percentage to Whom Case Finding is Applied	Green ≥90% Red <90%	Contractual		94.7%	100.0%	100.0%	92.6%	85.7%	92.3%	100.0%	100.0%	100.0%	95.8%	96.0%	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.														



Integrated Performance Report (Feb 23 - Jan 24)

The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

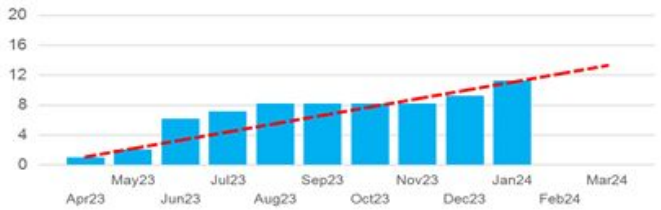
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU15	Dementia: Percentage With a Diagnostic Assessment	Green ≥90% Red <90%	Contractual		-	-	-	-	-	-	-	-	-	-	-	-		
			Narrative	No patients have required a diagnostic assessment.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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	Year & Month	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	0	1	2	-	-		
			Narrative	There were 2 such infections this month, however the YTD total remains below the threshold.														



Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	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	1	2	2	-	-		
			Narrative	There were 2 such infections this month. The annual threshold of 10 was exceeded in September. An exception report is provided.														

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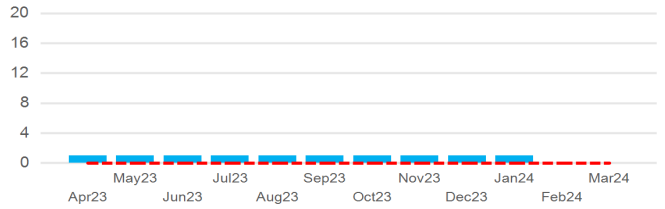
Reason for Non-Compliance	Action Taken to Improve Compliance
1 Hospital acquired Escherichia coli positive blood culture was identified in January 2024. IPC investigation concluded that the probable source of the bacteraemia was mouth ulcers (herpes simplex stomatitis). Superficial wound swabs of the ulcers also isolated Escherichia coli. Mouth care provided by nursing staff was well documented in the clinical notes. No areas of non–compliance were identified through IPC investigation. This infection was deemed as unavoidable. 1 Community acquired Escherichia coli positive blood culture was identified in January 2024. The patient attended the Marina Dalglish Centre for bloods. On assessment noted to be generally unwell. Blood cultures obtained and patient transferred to A&E. Treated as probable Urosepsis. This infection was deemed unavoidable.	N/A – No areas of non–compliance were identified

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 February 2024

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month													
				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	0	0	0	-	-		
			Narrative	There were no such infections this month.													



Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month													
				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	0	0	0	-	-		
			Narrative	There were no such infections this month.													

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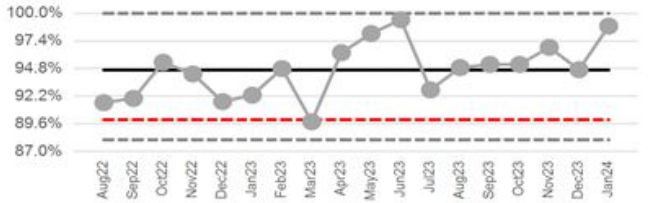
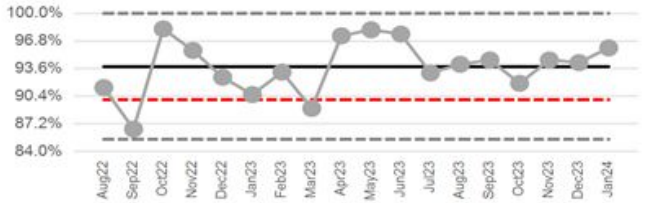
Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	V	A
QU43	Klebsiella (HOHA and COHA)	Green ≤ 8 per year Red >8 per year	Contractual / Statutory		2	0	0	0	1	0	3	0	0	0	-	-		
			Narrative	There were no such infections this month.														

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	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	1	1	0	-	-		
			Narrative	There were no such infections this month. The annual threshold of 1 was exceeded in September.														

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU66	Safer Staffing: Overall Fill-Rate	Green ≥90% Red <90%	Statutory		94.8%	89.8%	96.3%	98.1%	99.4%	92.8%	94.9%	95.2%	95.2%	96.8%	94.7%	98.8%		
			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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU61	Average Number of Registered Nurses Filled Shifts - Days	Green ≥90% Red <90%	Statutory		93.2%	89.0%	97.4%	98.1%	97.6%	93.1%	94.1%	94.6%	91.9%	94.6%	94.3%	96.0%		
			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.														



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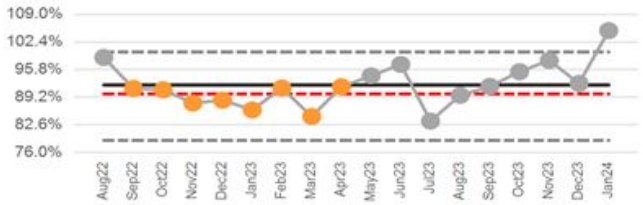
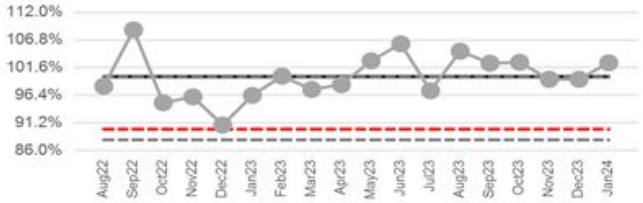
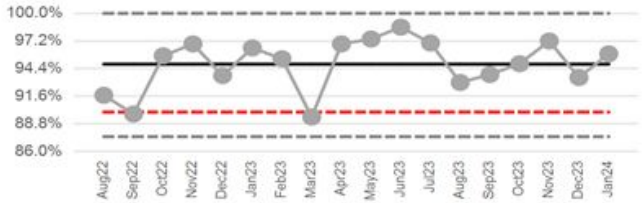
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU63	Average Number of Care Staff Filled Shifts - Days	Green ≥90% Red <90%	Statutory		91.4%	84.6%	91.7%	94.3%	97.0%	83.5%	89.7%	91.8%	95.3%	98.0%	92.5%	102.1%		
			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. The SPC chart point for January is incorrect and will be amended next month.														



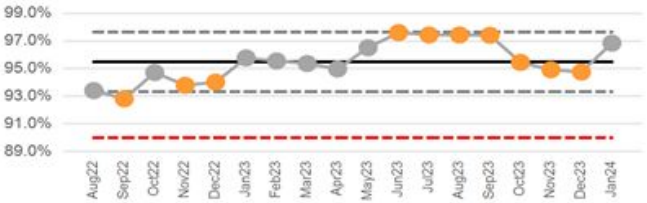
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU64	Average Number of Care Staff Filled Shifts - Nights	Green ≥90% Red <90%	Statutory		100.0%	97.5%	98.4%	102.9%	106.1%	97.3%	104.7%	102.4%	102.6%	99.4%	99.4%	102.5%		
			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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU65	Average Number of Registered Nurses Filled Shifts - Nights	Green ≥90% Red <90%	Statutory		95.4%	89.5%	96.9%	97.4%	98.6%	97.0%	93.0%	93.8%	94.9%	97.2%	93.5%	95.9%		
			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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU60	NICE Guidance Compliance	Green ≥90% Amber 85 - 89.9% Red <85%	Contractual		95.6%	95.4%	95.0%	96.5%	97.6%	97.4%	97.4%	97.4%	95.5%	94.9%	94.8%	96.8%		
			Narrative	The target has been achieved. Performance is lower than expected, however the target is outside SPC limits and is therefore likely to be achieved consistently.														

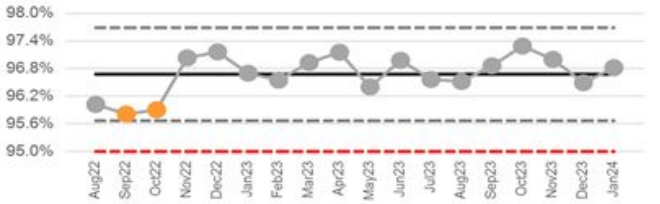


Integrated Performance Report (Feb 23 - Jan 24)

Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU75	Patient FFT: % of Respondents Who Had a Positive Experience	Green ≥95% Amber 90% - 94.9% Red <90%	Contractual		96.6%	96.9%	97.2%	96.4%	97.0%	96.6%	96.5%	96.9%	97.3%	97.0%	96.5%	96.8%		
			Narrative	The target has been achieved. There is no significant change and the target is outside SPC limits and is therefore likely to be achieved consistently.														

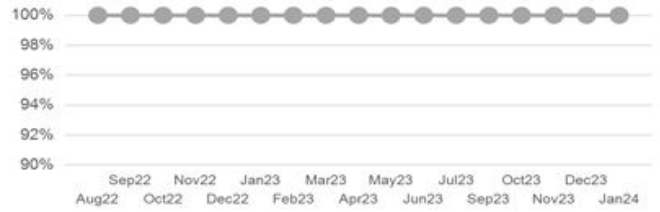


Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU11	Number of Complaints	No Target	Contractual		3	3	3	2	4	2	0	3	2	2	1	2		
			Narrative	There were 2 complaints this month and figures are now lower than expected. Complaints are reviewed at Divisional meetings, Divisional Performance Reviews and Risk and Quality Governance Committee. This promotes effective analysis of themes and trends to drive improvement.															

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU18	Number of Complaints / Count of WTE Staff (Ratio)	No Target	Contractual		0.002	0.002	0.002	0.001	0.002	0.001	0.000	0.002	0.001	0.001	0.001	0.001		
			Narrative	There were 0.001 complaints per staff WTE this month.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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.														



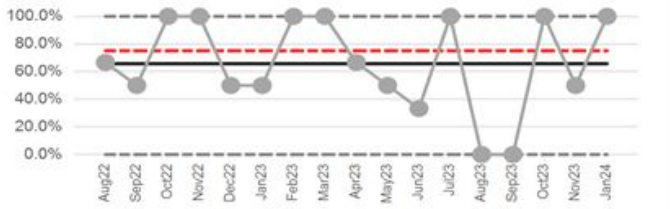
Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Quality

Responsible Forum: Quality Committee

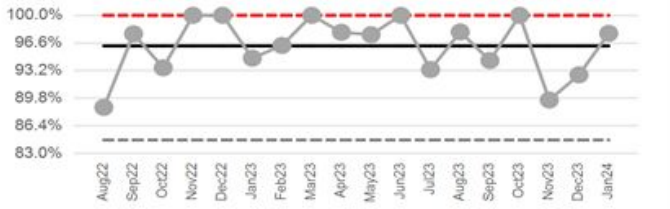
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU20	% of Routine Complaints Resolved Within 25 Working Days	Green ≥75% Amber 65% - 74.9% Red <65%	Local		100.0%	100.0%	66.7%	50.0%	33.3%	100.0%	0.0%	0.0%	100.0%	50.0%	-	100.0%		
			Narrative	The target has been achieved.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU71	% of Complex Complaints Resolved Within 60 Working Days	Green ≥75% Amber 65% - 74.9% Red <65%	Local		100%	50%	50%	50%	100%	100%	-	100%	50%	-	100%	-		
			Narrative	No complex complaints required resolution this month.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU21	% of FOIs Responded to Within 20 Days	Green 100% Red <100%	Contractual / Statutory		96.3%	100.0%	97.9%	97.6%	100.0%	93.3%	98.0%	94.4%	100.0%	89.6%	92.7%	97.8%		
			Narrative	This national 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
One FOI request, out of 45, was delayed by 2 days, due to absence within the Information Governance team needed to provide review and sign off.	Where possible, the Information Governance team try to receive sign off and send out requests in advance. If unplanned absence was prolonged, we would revert to the SIRO to review FOIs.

Escalation Route & Expected Date of Compliance
Information Governance Board, Risk and Quality Governance Committee, Quality Committee, Trust Board February 2024

Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

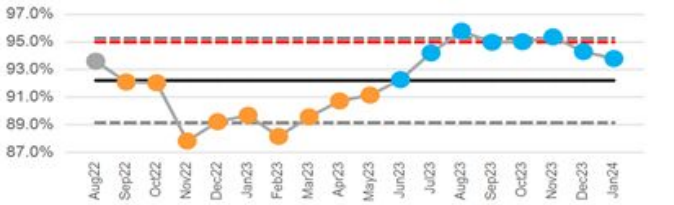
Quality

Responsible Forum: Quality Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU22	Number of IG Incidents Escalated to ICO	Green 0 Red >0	Contractual / Statutory		1	0	0	0	0	1	0	0	0	1	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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
QU23	% of Policies in Date	Green ≥95% Amber 90.1 - 94.9% Red <90%	Contractual		88.2%	89.6%	90.7%	91.2%	92.3%	94.2%	95.8%	95.0%	95.0%	95.4%	94.3%	93.8%		
			Narrative	Performance is marginally below the internal target, however performance remains higher than expected. The nature of variation indicates that achievement of the target is likely to be inconsistent.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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.														

Data Not Applicable for SPC

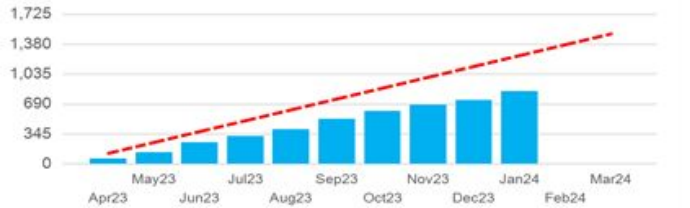
Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month													
				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	72	56	100	-	-		
			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
837 patients have been recruited between April 2023 and January 2024 against an internal target of 1250 at the end of Month 10 (67% of target). 198 interventional, 566 observational and 73 biobank recruited. The main reasons at Month 10 for not achieving the overall target are: • A high number of complex early phase studies have opened during the year. Early phase trials are scientifically important, highly complex, time intensive and low recruiters. The complexity and volume of the early phase trial work is reflected in the income received which is significantly higher that pre-pandemic levels and on plan to meet target. • A number of high recruiting observational studies have closed over recent months. • Low recruitment at periphery hubs into common cancer trials. To note: Currently 53 studies have opened in-year meeting the annual target of 52. At the same point last year 22/23 we had opened 28 studies and at the same point pre-pandemic 19/20 we had opened 43.	• Action plan in place to increase recruitment at periphery hubs. Meditech clinical trial referral tab communicated widely to consultants. Success evidenced through BNT122 cancer vaccine trial with referrals in from SHK, COCH, LUHFT and WUTH. Research Officer mobilised to Halton with first patient consented. Lung study, Latify, now consenting at Aintree. Laboratory space agreed at Aintree which will enable an increased number of trials to open. • Working with consultants to highlight the importance of a balanced portfolio such that we can open an increased number of trials to provide enhanced opportunities for our patients. Met with 8 SRGs in January 2024. Meetings with remaining SRG leads February 2024. Plan for clinical trial growth for each SRG requested by mid-March 2024. • Working with Allied Healthcare Professionals to become Principal Investigators (PI) on studies to increase the breadth of our research and to increase recruitment. • Potentially high recruiting study is at the protocol stage and then will be taken to Ethics. Anticipated opening March 2024. Second high recruiting study is bedding in and recruited 23 patients in January 2024. To note: • Seven new studies opened in-month. The trials cover a variety of portfolios, two new breast cancer trials have opened. The radiotherapy portfolio has received a welcome set of new trials including a nationally important radiotherapy trial in prostate cancer, a real world study using a new electronic platform for patient reported outcomes in colorectal cancer, and a real-world radiotherapy study opening at CCC which is Europe-wide and important in obtaining essential patient outcome data. A new phase III immunotherapy trial in lung cancer has opened with a multi arm design and the latest BioNtech trial has opened in the CCC pipeline which is across solid tumours and is a First in Human trial. • 400th Pivotal Boost patient recruited at CCC. Professor Isabel Syndikus is the National Chief Investigator. 2008 patients recruited over 41 sites against at target of 2229 since 2018.

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 Acknowledge changes to the portfolio with increased focus on early phase clinical trial recruitment. We expect to see trial recruitment increase year on year and intend to keep the 1500 target until this is met.

Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

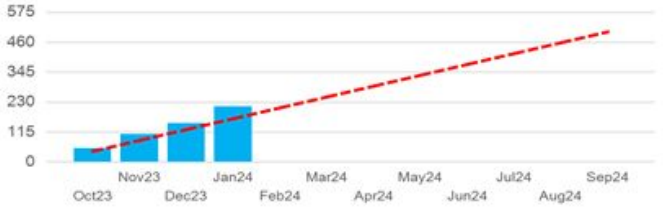
Research & Innovation

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	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	54	41	65	-	-	-	-	-	-	-	-		
			Narrative	Both the monthly and YTD targets have been achieved. The reporting period for this KPI is Oct - Sept rather than April - March.														



Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	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	5	3	7	-	-		
			Narrative	The monthly and YTD targets have been achieved.														

Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Research & Innovation

Responsible Forum: Performance Committee

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month													
				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	14	13	23	-	-		
			Narrative	The monthly and YTD targets have been achieved.													

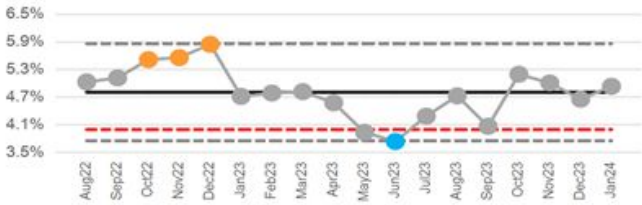
Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

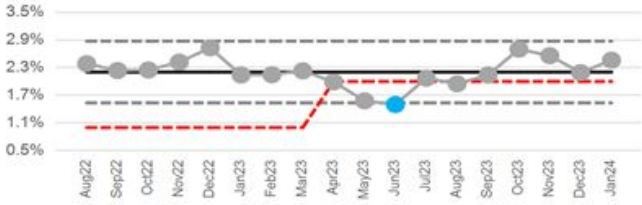
Workforce

Responsible Forum: People Committee

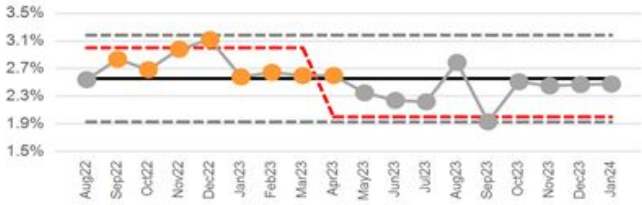
Metric ID	Metric Name	Target	Metric Type	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
WO01	Sickness Absence	Green ≤4% Amber 4.1 - 4.9% Red ≥5%	Contractual / Statutory	4.8%	4.8%	4.6%	3.9%	3.7%	4.3%	4.7%	4.1%	5.2%	5.0%	4.7%	4.9%		
			Narrative	Whilst sickness 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.													



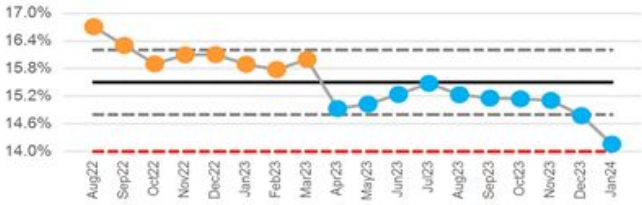
Metric ID	Metric Name	Target	Metric Type	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
WO20	Sickness Absence (Short Term)	Green ≤2% Amber 2.1-2.9% Red ≥3%	Contractual / Statutory	2.1%	2.2%	2.0%	1.6%	1.5%	2.1%	2.0%	2.1%	2.7%	2.6%	2.2%	2.5%		
			Narrative	Whilst 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	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
WO21	Sickness Absence (Long Term)	Green ≤2% Amber 2.1-2.9% Red ≥3%	Contractual / Statutory	2.6%	2.6%	2.6%	2.4%	2.2%	2.2%	2.8%	1.9%	2.5%	2.5%	2.5%	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	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
WO02	% Turnover (Rolling 12 Months)	Green ≤14% Amber 14.1%-14.9% Red ≥15%		15.8%	16.0%	14.9%	15.0%	15.2%	15.5%	15.2%	15.2%	15.1%	15.1%	14.8%	14.2%		
			Narrative	This month's figure is 0.2% above target and the lowest since February 2021. Whilst performance is lower than expected, the target is still unlikely to be achieved without significant change and an exception report is therefore provided.													



Integrated Performance Report (Feb 23 - Jan 24)

The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

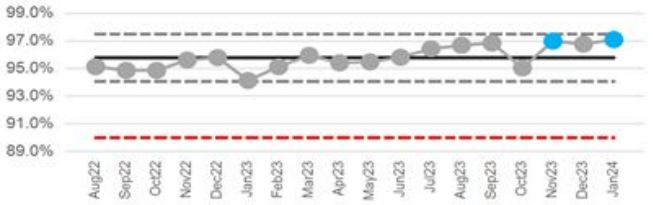
Responsible Forum: People Committee

Reason for Non-Compliance	Action Taken to Improve Compliance
The Trust turnover figure remains above Trust target however is only slightly above the target of 14% If leavers due to retirement, dismissal and end of fixed term contracts (FTC) were removed from the data set, the Trust would be at 12.5%, which is below target. There were 12 leavers in January 2024, a decrease of 8 from December 2023. The top reasons for leaving in October were; Voluntary resignation- Work life balance x3 Voluntary resignation- Promotion x3 Networked services had the highest amount of leavers with 6 in total followed by Quality, Experience and Standards Division with 2 leavers. The staff group with the highest amount of leavers was Administrative and Clerical and Additional Clinical Services with 4 leavers each followed by Nursing with 3 leavers.	The HRBP Team to 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 to work with managers to try to understand further the reasons that staff are leaving due to 'Promotion' and 'Work life balance' to see if staff are leaving to go to other NHS Trusts and what they potentially offer differently to CCC. A 12 month review has bene completed following 12 months of quarterly deep dives into turnover to develop a strategic action plan for the future. These actions will be shared at WAG and worked on throughout 2024 in order to try and improve the Trust's turnover.

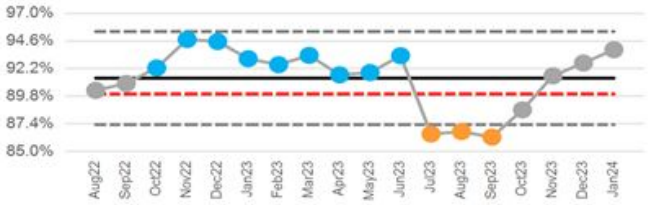
Escalation Route & Expected Date of Compliance

Divisional Meetings, Divisional Performance Reviews, Workforce Advisory Committee, People Committee, Trust Board
February 2024

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
WO07	Statutory Mandatory Training Compliance	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual / Statutory		95.1%	96.0%	95.4%	95.5%	95.8%	96.4%	96.7%	96.9%	95.1%	97.0%	96.8%	97.1%		
			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	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
WO22	Appraisal	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual		92.5%	93.4%	91.7%	91.9%	93.3%	86.5%	86.7%	86.3%	88.6%	91.6%	92.7%	93.8%		
			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.														



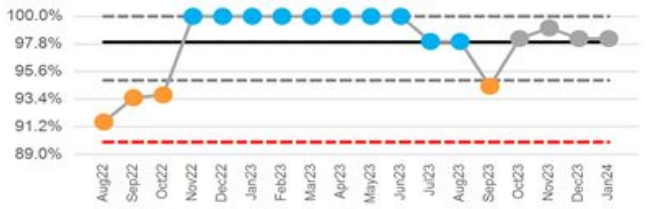
Integrated Performance Report (Feb 23 - Jan 24)

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Responsible Forum: People Committee

Metric ID	Metric Name	Target	Metric Type	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
WO23	Medical Appraisal	Green ≥90% Amber 76 - 89% Red ≤75%	Contractual / Statutory	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	98.0%	94.4%	98.2%	99.1%	98.2%	98.2%		
			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.													



Metric ID	Metric Name	Target	Metric Type	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	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 (Feb 23 - Jan 24)

The Clatterbridge Cancer Centre NHS Foundation Trust

Workforce

Responsible Forum: People Committee

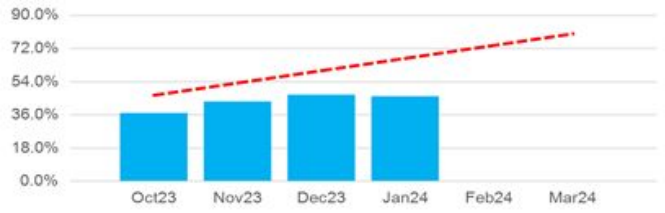
Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
WO27	Pulse Staff Survey: Motivation Score	Green text Amber text Red National Average	Contractual		-	6.80	-	-	6.90	-	-	7.10	-	-	-	-		
			Narrative	There was no quarterly pulse survey this month.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target	Metric Type	Year & Month	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	V	A
WO40	Bame Staff Representation	Green ≥8% Amber 6-7.9% Red ≤6%			8.2%	8.2%	8.2%	8.4%	8.3%	8.1%	8.2%	8.1%	8.5%	8.4%	8.8%	9.0%		
			Narrative	The target has been achieved.														

Data Not Applicable for SPC

Metric ID	Metric Name	Target Cumulative	Metric Type	Year & Month	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 2023	CQUIN		-	-	-	-	-	-	37.0%	43.3%	46.9%	45.9%	-	-		
			Narrative	The vaccination campaign has now ended and the target has not been achieved. This mirrors the low uptake nationally.														



Integrated Performance Report (Feb 23 - Jan 24)

Finance | Responsible Forum: Performance Committee

Metric (£000)	In Mth 10 Actual	In Mth 10 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG	Agreed FOT
Trust Surplus/ (Deficit)	72	30	42		597	303	294		729
CPL/Propcare Surplus/ (Deficit)	82	0	82		945	0	945		1,134
Control Total Surplus/ (Deficit)	154	30	124		1,541	303	1,239		1,863
Trust Cash holding	70,848	63,874	6,974		70,848	63,874	6,974		
Capital Expenditure	1,488	0	1,488		3,409	321	3,088		
Agency Cap	153	149	(4)		1,545	1,490	(55)		

The Trust financial position to month 10 (January 2024) is a surplus of £597k, which is £294k better than plan. The group position is a £1.54m surplus and is £1.24m better than plan and in line with the updated FOT agreed.

The Trust cash position is £70.8m, which is above plan by £6.97m. Capital spend is £3.41m 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 above the agency cap by £55k. This includes £184k of agency costs for Paddington CDC which weren't included in our plan

Trust Board
February 2024

Report author	James Thomson – Director of Finance					
Paper prepared by	Jo Bowden – Deputy Director of Finance					
Report subject/title	Finance Report – Month 10 2023/24 165-23/24					
Purpose of paper	To present the Trust's financial position at the end of January 2024.					
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 January 2024, the tenth 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 January, the key financial headlines are:

Metric (£000)	In Mth 10 Actual	In Mth 10 Plan	Variance	Risk RAG	YTD Actual	YTD Plan	Variance	Risk RAG	Agreed FOT
Trust Surplus/ (Deficit)	72	30	42		597	303	294		729
CPL/Propcare Surplus/ (Deficit)	82	0	82		945	0	945		1,134
Control Total Surplus/ (Deficit)	154	30	124		1,541	303	1,239		1,863
Trust Cash holding	70,848	63,874	6,974		70,848	63,874	6,974		
Capital Expenditure	1,488	0	1,488		3,409	321	3,088		
Agency Cap	153	149	(4)		1,545	1,490	(55)		

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. At the request of the ICB the Trust has reviewed the ability to increase its forecast outturn (FOT) and has agreed an improved position of £1.863m through non-recurrent means.

3. Operational Financial Profile – Income and Expenditure

Overall Income and Expenditure Position

3.1 The Trust financial position to the end of January is a £597k surplus, which is £294k above plan. The group is showing a £1,541k surplus to the end of January, which is £1,239k above plan. The position is in line with the updated FOT.

3.2 The Trust cash position is a closing balance of £70.8m, which is above plan by £6.97m. Capital spend is £3,409k 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 10 agency spend is above plan by £55k. This includes £184k for Paddington CDC which was not included in 2023/24 outturn.

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

	Actual M10	Trust Plan M10	Variance	Actual YTD	YTD Budget	Variance	Plan 23.24
Clinical Income	25,901	21,949	3,952	228,916	219,833	9,083	261,108
Other Income	377	1,913	(1,536)	17,439	19,443	(2,004)	23,226
Total Operating Income	**26,279**	**23,862**	**2,416**	**246,355**	**239,276**	**7,079**	**284,335**
Total Operating Expenditure	(26,183)	(23,697)	(2,487)	(245,399)	(237,879)	(7,520)	(282,606)
Operating Surplus	**96**	**166**	**(70)**	**956**	**1,397**	**(441)**	**1,728**
PPJV	75	75	0	1,012	750	262	900
Finance Costs	(98)	(210)	112	(1,372)	(1,845)	472	(2,265)
Trust Surplus/(Deficit)	**72**	**30**	**42**	**597**	**303**	**294**	**363**
Subsidiaries	82	0	82	945	0	945	**0**
Consolidated Surplus/Deficit	**154**	**30**	**124**	**1,541**	**303**	**1,239**	**363**

The table below summaries the consolidated financial position:

Jan 2024 (£000)	In Month Actual	YTD Actual
Trust Surplus / (Deficit)	(11)	(233)
Donated Depreciation	83	829
Trust Retained Surplus / (Deficit)	**72**	**597**
CPL	58	388
Propcare	24	557
Consolidated Financial Position	**154**	**1,541**

3.5 The bridge below shows the key drivers between the £72k in month Trust surplus and £30k surplus plan, which is a positive variance of £42k:

- As part of the financial plan the Trust had assumed an additional £1.6m of income for local variable activity above plan which includes Chemotherapy and Diagnostic Imaging. Based on M1-9 activity figures, while the Trust is showing as higher than the baseline plan, it is not as high as anticipated to achive the £1.6m. The Trust has therefore transacted a cumulative redution in month of £460k.

- ERF assumptions included in the month 10 position are based on the national data that has been published for months 1- 6.

- Cost and Volume drugs are overspent by £1.4m 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 £30k.

- Trust Pay is overspent by £208k. There is £157k unmet CIP within the pay position this month. While overall the CIP is overacheiving the profile between pay and non pay has been achieved differently to plan. In terms of run rate the pay position has increased since month 9 by £120k. There has been an overall increase on 14wte of which 9 are Registered Nurses and 4 AHP's. There has also been additional overtime paid to Radiographers of £27k which is due to Christmas cover.

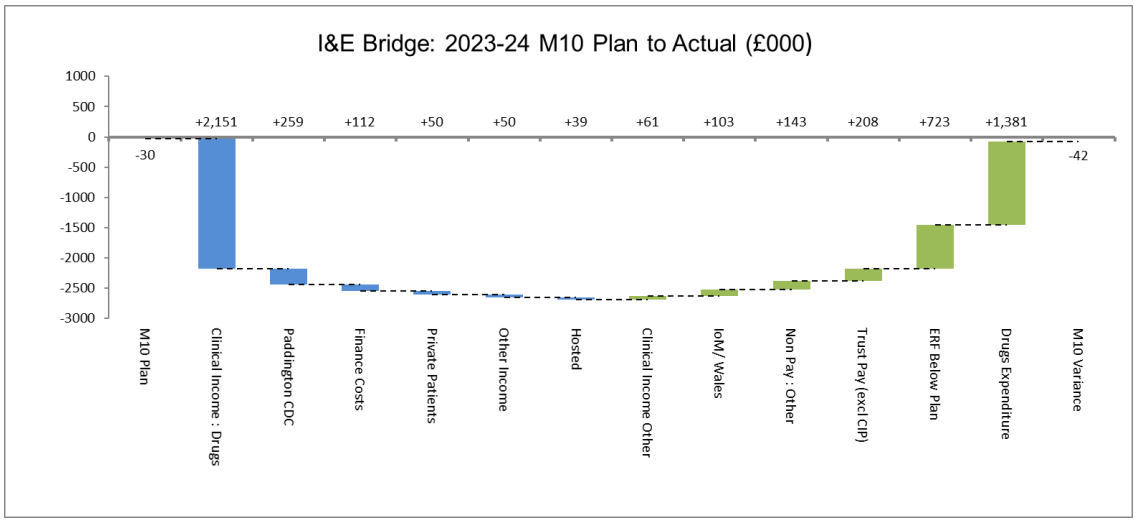
- Bank spend is £155k in month 10, which is a £54k reduction to month 9. The previous high sickness levels in Acute care, which cause a spike in spend in December, have come back in line and the previous positive work on reduction in bank spend is now showing in month 10.

- Agency spend is £153k in month, which is a reduction of £18k from month 9. While Trust spend is consistent to last month Paddington CDC has reduced by £14k. The Trust is being monitored against last years spend as a baseline and in month 10 is reporting above plan by £4k.

- Non pay is over spent by £143k. CIP in month is showing as over achieved for non-pay by £245k. The Trust has recognised overperformance in both the Mersey and West Lancshire NHS Trust and LUFT LCL SLA's, due to activity increases aginst baseline.

- The Paddington CDC income position has now been agreed for the year and reflected in the position year to date which has improved the position by £259k.

- Interest receivable is over plan by £95k in month 10, this relates to both the increasing level of interest rates and also the delay in paying supliers to maximise cash balances held.



3.6 Bank and Agency Reporting

Bank spend is £155k in month 10, which is a £54k reduction to month 9. The previous high sickness levels in Acute care, which cause a spike in spend in December, have come back in line and the previous positive work on reduction in bank spend is now showing in month 10.

Agency spend is £153k in month, which is a reduction of £18k from month 9. While Trust spend is consistent to last month Paddington CDC has reduced by £14k. The Trust is being monitored against last years spend as a baseline and is reporting above plan by £4k in month 10 and £55k year to date, it should be noted that the plan for agency was set based on last year's spend which excluded Paddington CDC and this accounts for £184k of agency spend.

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.

There has been £8.4m (102%) of the CIP target delivered by the end of January. £5.2m (63%) of these savings are recurrent.

The focus on the remainder of the year is recurrent schemes and a focus into 2024/25. There are currently 57 potential schemes in the pipeline for 2024/25. While most are still in the workup phase there are 7 schemes with a total value of £601k.

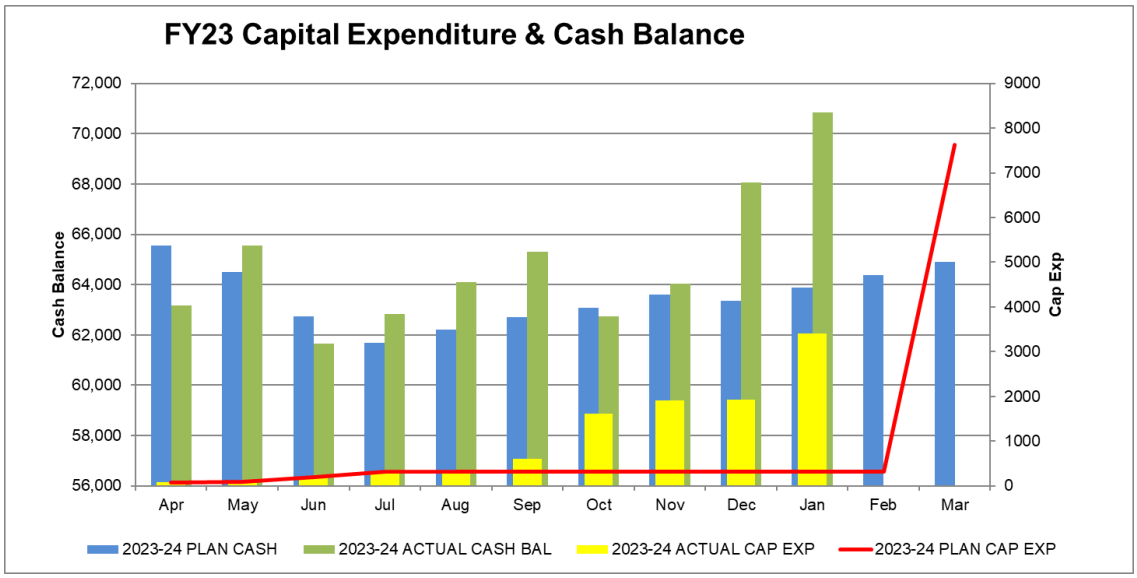
4. Cash and Capital

4.1 The 2023/24 capital plan approved by the Board in March was £7.407m. There was a further £291k of approved adjustments bringing the plan to £7.698m.

4.2 Capital expenditure of £3.4m has been incurred to the end of January. 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 £70.8m. The cash position is above plan by £6.97m. This is made up of the receipt of Cancer Alliance, Diagnostics funding and CDC from the ICB, better cash management by the move to paying suppliers later but within payment terms.

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 £70.8m, this is £6.97m above the plan figure of £63.8m.

NHS Receivables are higher than plan by £1.6m.

5.2 Current Liabilities

Payables (non-capital creditors) are above plan by £16.4m. 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 £6.6m above plan in month 10. This relates in the main to R&I income and Cancer Alliance both of which have a number of multi-year schemes which are ongoing.

Recommendations

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

- The January Trust and Group financial position
- The Local Variable API contract and ERF risk
- The continuing strong liquidity position of the Trust

Appendix A – Statement of Comprehensive Income (SOCI)

	Month 10			YTD			2023/24
	Plan	Actual	Variance	Plan	Actual	Variance	Annual Plan
Clinical Income	19,476	22,550	3,074	194,629	207,524	12,895	233,541
Other Income	1,417	(174)	(1,592)	12,718	9,879	(2,839)	15,510
Hosted Services	2,969	3,903	934	31,929	28,952	(2,977)	35,284
Total Operating Income	**23,862**	**26,279**	**2,416**	**239,276**	**246,355**	**7,079**	**284,335**
Pay: Trust (excluding Hosted)	(7,548)	(7,701)	(153)	(73,673)	(74,283)	(610)	(88,859)
Pay: Hosted & R&I	(882)	(958)	(76)	(10,411)	(8,964)	1,448	(12,175)
Drugs expenditure	(8,059)	(9,441)	(1,381)	(80,594)	(87,856)	(7,262)	(96,713)
Other non-pay: Trust (excluding Hosted)	(5,029)	(5,086)	(58)	(51,028)	(54,100)	(3,071)	(60,911)
Non-pay: Hosted	(2,179)	(2,998)	(819)	(22,172)	(20,197)	1,976	(23,949)
Total Operating Expenditure	**(23,697)**	**(26,183)**	**(2,487)**	**(237,879)**	**(245,399)**	**(7,520)**	**(282,606)**
Operating Surplus	**166**	**96**	**(70)**	**1,397**	**956**	**(441)**	**1,728**
Profit /(Loss) from Joint Venture	75	75	0	750	1,012	262	900
Interest receivable (+)	589	684	95	6,147	6,505	358	7,325
Interest payable (-)	(434)	(410)	25	(4,344)	(4,147)	197	(5,213)
PDC Dividends payable (-)	(365)	(365)	0	(3,648)	(3,648)	(1)	(4,377)
Interest - right of use	0	(8)	(8)	0	(82)	(82)	0
Trust Retained surplus/(deficit)	**30**	**72**	**42**	**303**	**597**	**294**	**363**
CPL/Propcare	0	82	82	0	945	945	0
Consolidated Surplus/(deficit)	**30**	**154**	**124**	**303**	**1,542**	**1,239**	**363**

Appendix B – Balance Sheet

£'000	Audited 2223 (Group Ex Charity)	Plan 2324 (Trust only)	Year to date Month 10		
			YTD Plan	Actual YTD	Variance
Non-current assets					
Intangible assets	6,741	3,486	3,486	5,593	2,106
Property, plant & equipment	201,605	189,187	189,187	195,718	6,531
Right of use assets	11,177	9,947	9,947	10,769	822
Investments in associates	1,304	455	455	912	457
Other financial assets	1,328	114,324	(0)	0	(114,324)
Trade & other receivables	448	2,382	482	755	(1,627)
Other assets	0	0	0	0	0
Total non-current assets	**222,603**	**319,782**	**203,558**	**213,747**	**10,190**
Current assets					
Inventories	4,175	2,000	4,585	5,786	3,786
Trade & other receivables	0	0	5	0	0
NHS receivables	18,989	5,642	6,362	7,260	1,618
Non-NHS receivables	0	9,299	8,637	9,599	300
Cash and cash equivalents	73,591	65,733	71,606	81,497	15,764
Total current assets	**96,754**	**82,675**	**91,196**	**104,143**	**12,946**
Current liabilities					
Trade & other payables	0	0	0	0	**0**
Non-capital creditors	0	23,211	23,331	39,654	16,444
Capital creditors	32,986	2,493	2,493	1,676	(818)
Borrowings	0	0	0	0	0
Loans	2,233	1,892	1,892	1,843	(50)
Lease liabilities	0	0	0	354	354
Provisions	2,533	761	1,804	1,195	434
Other liabilities:-		0	0	0	0
Deferred income	13,531	7,822	7,822	14,457	6,635
Other	0	0	0	0	0
Total current liabilities	**51,283**	**36,179**	**37,342**	**59,178**	**21,836**
Total assets less current liabilities	**268,074**	**366,278**	**257,412**	**258,712**	**(107,566)**
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	28,755	125
Lease liabilities	0	8,997	8,997	9,995	998
Other liabilities:-	0	0	0	0	0
Deferred income	1,110	972	0	0	(972)
Provisions	273	0	0	270	270
PropCare liability	0	115,633	0	(0)	(115,633)
Total non current liabilities	**44,286**	**154,233**	**38,111**	**39,020**	**(115,212)**
Total net assets employed	**223,788**	**212,046**	**219,301**	**219,692**	**7,646**
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	123,526	3,280
Total taxpayers equity	**223,788**	**212,046**	**219,301**	**219,692**	**7,646**

Appendix C – Cash Flow

	Plan 23/24	Actuals 2324 M10		
	FT	FT	Group	Group (exc Charity)
Cash flows from operating activities:				
Operating surplus	3,032	98	1,157	1,404
Depreciation	12,440	9,122	9,157	9,157
Amortisation	0	1,478	1,478	1,478
Impairments	0	0	0	0
Movement in Trade Receivables	0	1,585	1,438	1,508
Movement in Other Assets	0	1,764	1,340	(0)
Movement in Inventories	(120)	(867)	(1,611)	(1,611)
Movement in Trade Payables		9,619	11,253	11,264
Movement in Other Liabilities	0	(1,952)	(184)	(184)
Movement in Provisions	0	(1,242)	(1,342)	(1,342)
CT paid	(480)	0	(287)	(287)
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	(4,577)	0
Net cash used in operating activities	**14,872**	**19,606**	**17,823**	**21,388**
Cash flows from investing activities				
Purchase of PPE	(12,045)	(8,144)	(8,179)	(8,179)
Purchase of Intangibles	0	(333)	(333)	(333)
ROU Assets	0	460	407	407
Proceeds from sale of PPE	0	29	29	29
Interest received	5,626	6,505	2,934	2,926
Investment in associates	0	1,404	1,404	1,404
Cash movement from disposals of business	1,248	0	0	0
Net cash used in investing activities	**(5,171)**	**(79)**	**(3,738)**	**(3,745)**
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)	(1,662)	(1,662)	(1,662)
Capital element of finance lease	0	(386)	(340)	(340)
Interest paid	(5,213)	(4,147)	(447)	(447)
Interest element of finance lease- rou	0	(82)	(83)	(83)
PDC dividend paid	(4,377)	(3,648)	(3,648)	(3,648)
Finance lease - capital element repaid	(8)	0	0	0
Net cash used in financing activities	**(11,305)**	**(9,924)**	**(6,179)**	**(6,179)**
Net change in cash	**(1,604)**	**9,603**	**7,906**	**11,464**
Cash b/f	**67,150**	**61,246**	**73,591**	**70,033**
Cash c/f	**65,546**	**70,849**	**81,497**	**81,497**

Appendix D – Capital

Capital Programme 2023-24
Month 10

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 10	Variance to Budget	FORECAST (£'000) Forecast 23-24	Variance to Budget	Complete?	Comments
4142	TCC		0	0	0	(682)	682	(1,902)	1,902	✓	
4401	CCC-L Ward 3 bathroom conversion	Kathryn Williams	32	20	52	0	52	49	3	✗	Work starting 19 Feb
4433	CCC-A Estates Work and Rebranding	Emer Scott	0	0	0	17	(17)	13	(13)	✓	
4477	Wirral site redevelopment	Propcare	200	(40)	160	11	149	130	30	✗	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	0	0	0	0	0	0	-	
4472	- Building - internal	Propcare	0	73	73	40	33	73	0	✗	
4473	- M&E	Propcare	0	261	261	0	261	236	25	✗	Progressing, risk on vac plant delivery (£55k)
4474	- Physics building	Propcare	0	933	933	459	474	933	0	✗	Due for completion end of March
4475	- Fire compartmentation	Propcare	0	90	90	0	90	70	20	✗	
4476	- Tea bar / new staff lounge	Propcare	0	100	100	0	100	100	0	✗	Should be completed in March
	- Ground floor changing area	Propcare	0	0	0	0	0	0	0	-	Not to be progressed
4468	- Roofing	Propcare	0	1,581	1,581	1,605	(24)	1,605	(24)	✗	
4454	CCC-L Level 4 storage room conversion	Propcare	0	32	32	0	32	30	2	✗	Should be completed in March
4451	CCC-A Linac bunker	Louise Bunby	220	(118)	102	0	102	78	24	✗	In progress, should be completed in March
4471	CCC-L Winter Garden Refurb	Tom Pharaoh	0	33	33	16	17	33	0	✗	Charity funded, largely complete
4480	CCC-A LED Lights (PDC funded)	Propcare	0	78	78	0	78	78	0	✗	PDC funding approved
	Estates		**1,520**	**1,975**	**3,495**	**1,466**	**2,029**	**1,526**	**1,969**		
4192	Cyclotron	Carl Rowbottom	0	0	0	184	(184)	273	(273)	✗	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	19	6	✓	Tony confirmed arrived and configured
4451	CCC-A Linac	Louise Bunby	2,460	(82)	2,378	75	2,303	2,359	19	✗	Provisional delivery date 1 March 2024
4457	Vaginal CT/MR Multi Channel Applicator	Chris Lee	30	(2)	28	28	0	28	0	✓	
4470	Radionuclide calibrator	Louise Bunby	10	0	10	12	(2)	12	(2)	✓	
4469	2D array x2	Louise Bunby	80	0	80	45	35	45	35	✓	
4456	Concealement trolley	Mel Warwick	17	1	18	18	(0)	18	(0)	✓	
4448	BMT Sharepoint App	Priscilla Hetherington	0	11	11	9	2	9	2	✗	In development
4449	Whole body phantom	?	0	0	0	33	(33)	33	(33)	✓	
4450	Flojack flat lifting kits	Pauline Pilkington	0	35	35	34	1	34	1	✓	
4455	Cyclotron X-Ray panels	Stephen Elmer	0	0	0	26	(26)	26	(26)	✓	
4458	Ultrasound Phantom	Marc Rea	0	5	5	5	0	5	0	✓	
4459	CCC-L Document Scanner	Lynne Benson	0	29	29	29	0	29	0	✓	
4467	Cyclotron capacitors	Matt Temple	0	22	22	0	22	22	0	✗	Shipping due 13th Feb
4478	Anaesthetic Equipment	Louise Bagley	0	123	123	123	0	123	0	✗	Delivered 23rd Jan
4481	Cyclotron RF Amplifier Tubes	Peter Corlett	0	41	41	0	41	41	0	✗	Approved at CIG 30 Jan
	Medical Equipment		**2,597**	**207**	**2,804**	**640**	**2,164**	**3,076**	**(272)**		
4138	Infrastructure	James Crowther	0	0	0	(3)	3	(3)	3	✓	Minor correction on prior year scheme
4316	Digital Diagnostics Capability Programme		0	0	0	(49)	49	(49)	49	✓	VAT recovery on prior year scheme
4410	Digital Transformation & Optimisation		0	0	0	(2)	2	(2)	2	✓	Over accrual on prior year scheme
4422	DDCP 22-23	James Crowther	0	0	0	(36)	36	(36)	36	✓	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
4425	MS Teams Meeting Rooms	James Crowther	0	0	0	(0)	0	(0)	0	✓	Over accrual on prior year scheme
4427	Cyber Capital Access Management	James Crowther	0	0	0	0	0	0	0	✓	
4405	Website	Emer Scott	100	0	100	40	60	90	10	✗	
4452	Patient Flow, Digital Literacy and Capability	James Crowther	475	0	475	281	194	475	0	✗	
4461	PatientHealth	James Crowther	400	(400)	0	0	0	0	0	✗	Moved to revenue
4462	DigiFlow	James Crowther	190	0	190	132	58	132	58	✗	
4463	Patient Education Programme	James Crowther	250	0	250	0	250	307	(57)	✗	
4464	PoC Medical Device Integration	James Crowther	250	0	250	0	250	250	0	✗	
4465	HealthData	James Crowther	400	0	400	350	50	350	50	✗	
4466	EPMA Stock Control & Pharmacy RPA	James Crowther	419	181	600	0	600	370	230	✗	JAC costs only. Interface costs in 24/25
	DDCP (PDC Funded)	James Crowther	23	0	23	0	23	23	0	✗	
	Digital		**2,507**	**(219)**	**2,288**	**695**	**1,593**	**1,888**	**400**		
4421	Paddington CDC - costs (PDC funded)		0	175	175	175	0	175	0	✓	
4421	Paddington CDC - costs		0	0	0	90	(90)	90	(90)	✓	Excess over PDC funded costs
4435	Paddington CDC - CT Scanner		0	0	0	(32)	32	(25)	25	✓	Final enabling cost TBC, forecast u/spend
4479	Paddington CDC - MRI Hardware/Software	Marc Rea	0	120	120	0	120	120	0	✗	Expect installation end of February. PDC?
4453	Pharmacy - VHP commissioning	Tori Young	350	0	350	287	63	350	0	✗	
4460	Pharmacy - Automated Medicines Cabinets	Tori Young	300	(18)	282	0	282	272	10	✗	Delivery due 14th February
	Pharmacy - Prescriptions/medicines tracke	Tori Young	50	0	50	0	50	18	32	✗	
	IFRS16 - Pharmacy vehicles		28	0	28	28	0	28	0	✗	
	IFRS16 - Portakabins		55	5	60	60	0	60	0	✗	
	Other		**783**	**282**	**1,065**	**608**	**456**	**1,087**	**(23)**		
	Contingency		**0**	**(1,954)**	**(1,954)**		**(1,954)**	**121**	**(2,075)**		
	TOTAL		**7,407**	**291**	**7,698**	**3,409**	**4,289**	**7,698**	**0**		

The Clatterbridge Cancer Centre NHS Foundation Trust

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	5,166,491	1,268,491	133%	2,922,705	0	5,166,491
NETWORKED SERVICES	1,368,777	320,632	(1,048,145)	23%	192,784	0	320,632
ACUTE CARE	980,125	1,102,050	121,925	112%	696,863	0	1,102,050
RADIATION SERVICES	1,013,426	1,017,839	4,413	100%	579,365	0	1,017,839
CORPORATE	988,672	819,348	(169,324)	83%	771,873	0	819,348
Total	**8,249,000**	**8,426,360**	**177,360**	**102%**	**5,163,590**	**0**	**8,426,360**

Full Year Plan (Recurrent & Non-Recurrent Split)

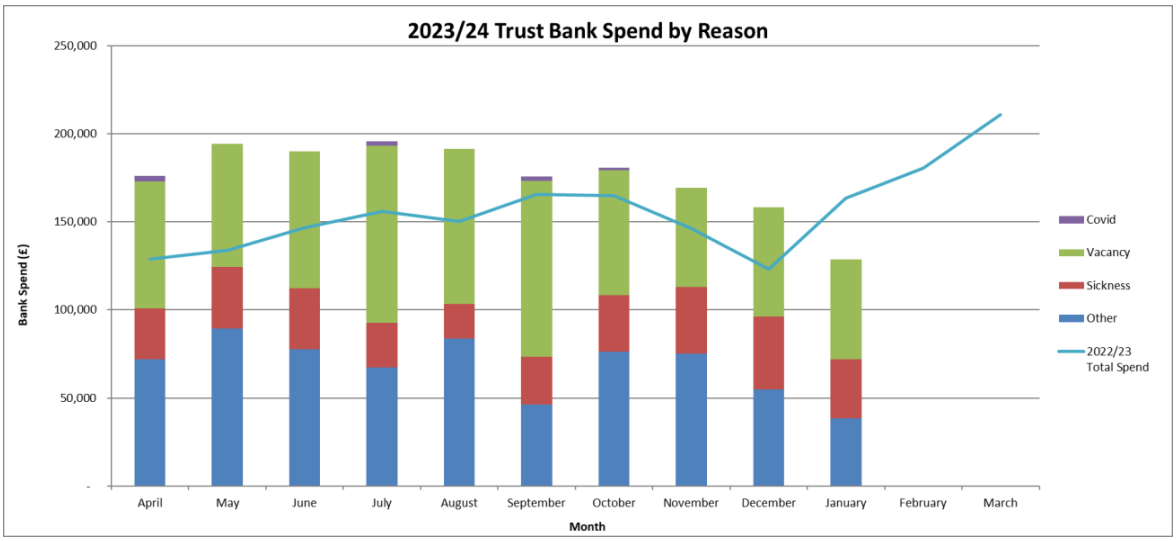
Recurrent	8,249,000	5,163,590	(3,085,410)	**63%**	5,163,590	0	5,163,590
Non-Recurrent	0	3,262,770	3,262,770		0	0	3,262,770
Total	**8,249,000**	**8,426,360**	**177,360**	**102%**	**5,163,590**	**0**	**8,426,360**

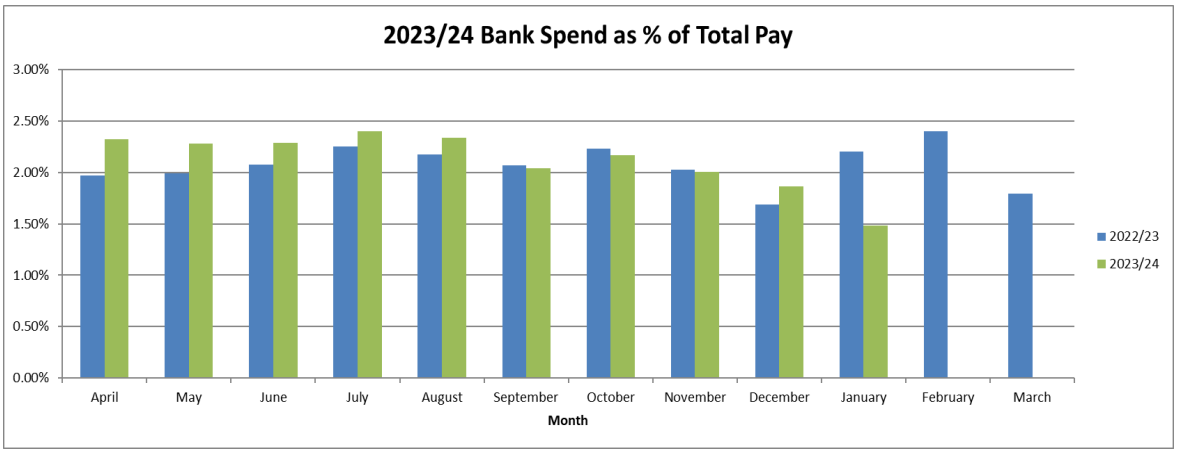
Delivery by CBU/Corporate Area

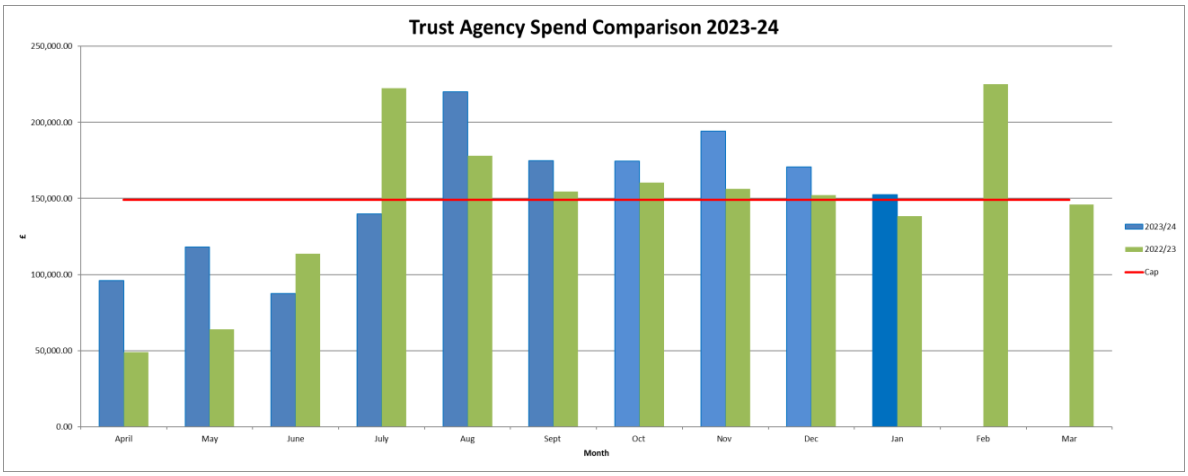
	23/24 CIP Target	Transacted (£)	Transacted (%)	Costed/Start Date (£)	Costed/Start Date (%)	Transacted/ Costed (%)	Idea (£)	Idea (%)	Transacted/ Costed/Idea (%)
CBU1 - DAY CARE & NETWORK	517,312	45,809	8.9%	-	0.0%	8.9%	-	0.0%	8.9%
CBU2 - OP & CLIN SUPPORT	550,843	247,091	44.9%	-	0.0%	44.9%	-	0.0%	44.9%
CBU3 - ADMIN SERVICES	300,622	27,732	9.2%	-	0.0%	9.2%	-	0.0%	9.2%
CBU4 - PHARMACY	106,114	544,956	513.6%	-	0.0%	513.6%	-	0.0%	513.6%
CBU5 - INPATIENT CARE	874,011	501,633	57.4%	-	0.0%	57.4%	-	0.0%	57.4%
CBU6 - RADIOTHERAPY	697,834	63,400	9.1%	-	0.0%	9.1%	-	0.0%	9.1%
CBU7 - RADIOLOGY SERVICES	222,750	901,614	404.8%	-	0.0%	404.8%	-	0.0%	404.8%
CBU8 - PHYSICS	92,842	52,825	56.9%	-	0.0%	56.9%	-	0.0%	56.9%
COMMUNICATIONS	5,524	5,500	99.6%	-	0.0%	99.6%	-	0.0%	99.6%
DIGITAL	129,781	129,781	100.0%	-	0.0%	100.0%	-	0.0%	100.0%
ESTATES	198,147	236,839	119.5%	-	0.0%	119.5%	-	0.0%	119.5%
EXECUTIVE OFFICE	156,107	30,875	19.8%	-	0.0%	19.8%	-	0.0%	19.8%
FINANCE	29,778	248,393	834.1%	-	0.0%	834.1%	-	0.0%	834.1%
LUFT SLA	197,569	20,000	10.1%	-	0.0%	10.1%	-	0.0%	10.1%
MEDICAL STAFFING	55,461	55,461	100.0%	-	0.0%	100.0%	-	0.0%	100.0%
PMO	8,755	10,000	114.2%	-	0.0%	114.2%	-	0.0%	114.2%
QUALITY (Governance)	64,463	25,496	39.6%	-	0.0%	39.6%	-	0.0%	39.6%
QUALITY (Education)	40,138	15,000	37.4%	-	0.0%	37.4%	-	0.0%	37.4%
WORKFORCE & OD	102,949	57,339	55.7%	-	0.0%	55.7%	-	0.0%	55.7%
CENTRAL - CPL	168,000	168,000	100.0%	-	0.0%	100.0%	-	0.0%	100.0%
CENTRAL - PROPCARE	730,000	737,547	101.0%	-	0.0%	101.0%	-	0.0%	101.0%
CENTRAL - OTHER	3,000,000	4,301,069	143.4%	-	0.0%	143.4%	-	0.0%	143.4%
	8,249,000	**8,426,360**	**102.2%**	**-**	**0.0%**	**102.2%**	**-**	**0.0%**	**102.2%**

The Clatterbridge Cancer Centre NHS Foundation Trust

Appendix F – Bank and Agency







The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: **Board of Directors**
Date of meeting: **28th February 2024**

Report author	Tom Pharaoh. Director of Strategy				
Paper prepared by	Kerry Gibbons, Sustainability Programme Manager				
Report subject/title	Creating a Greener CCC: Annual Report 2023				
Purpose of paper	The Trust published its first ever Green Plan in January 2022. Our Green Plan aims to drive sustainable change across the Trust over the next five years and prepare us for transition to delivering net zero carbon healthcare within two decades. The purpose of this report is to outline the progress and challenges of the second year of implementation of the Green Plan.				
Background papers	Creating a Greener CCC 2022-27: Our plan to achieve net zero carbon CCC Green Travel Plan 2023-25				
Action required	Trust Board of Directors is asked to note the contents 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		

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Creating a Greener CCC:

Our plan to achieve net zero carbon

Annual report

2023

Contents

Introduction

Climate change is a health emergency and is widely recognised as one of the greatest threats to public health globally, nationally and in our region. In June 2022, The Clatterbridge Cancer Centre NHS Foundation Trust (CCC) published its first ever Green Plan. This was done in response to the NHS setting the ambitious target of achieving net zero carbon emissions by 2040. The NHS itself is currently accountable for approximately 5% of the UK's carbon emissions.

In September 2023, as part of the wider green plan for the Trust, CCC produced its first ever Green Travel Plan, setting out the actions that will be taken over the coming years to support more sustainable travel across our organisation and helping to reduce the emissions associated with staff commuting and business travel.

The Green Plan – *Creating a Greener CCC* – sets clear objectives and targets to take us towards net zero carbon. It also includes an action plan explaining how we will achieve this. The purpose of this report is to outline the progress and challenges of the second year of implementation of *Creating a Greener CCC.*

The Green Plan is set out in ten broad sustainability themes:

- Corporate approach
- Care models
- Workforce
- Travel and transport
- Energy and utilities
- Waste
- Capital projects
- Green spaces
- Suppliers & partners
- Adaptation

This report contains a section on each of these themes. For each theme it sets out the activities that have taken place over the previous 12 months, and an overview of what is to come over the next 12 months. The penultimate section of this report includes an update on the role that we have as part of the wider anchor institution agenda, including an overview of how we have been working to capture the social value that we deliver as an NHS Foundation Trust within the Cheshire & Mersey region. The final section sets out some conclusions of the report.

1 Corporate approach

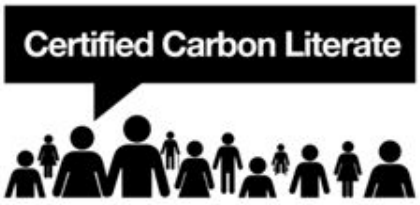
1.1 Background

In addition to having a **Board-level lead for sustainability** (the Directory of Strategy), forming a multidisciplinary **Sustainability Action Group**, and developing and launching the Trust's first ever **Green Plan**, CCC has now successfully appointed a permanent **Sustainability Programme Manager** to the Trust, who commenced in post in June 2023. The Sustainability Manager plays a leading role in building on last year's progress in establishing sustainability as a key part of the business of our organisation.

Sustainability continues to be included as one of the key corporate risks for the Trust – captured in our **Board Assurance Framework**. In addition to the annual reporting cycle, Board assurance on the sustainability programme is provided through quarterly update reports at **Performance Committee** meetings.

1.2 This year

A review of the Terms of Reference of the **Sustainability Action Group** took place earlier this year and regular meeting dates have now been arranged over the 12 months to come. There are a number of standing items now included within the agenda of this group, with the leads for each area taking more of a pivotal role in providing updates as part of this meeting. To further emphasise our commitment to sustainability as part of our wider corporate approach, it is now mandatory that all members of the Sustainability Action Group have completed the generic NHS **"Building a Net Zero NHS"** eLearning course.



Furthermore, a number of sub-groups have been formed from the Sustainability Action Group – including a Sustainable Waste Management Group (discussed in more detail under the "Waste" section of this report) and a group looking to improve our Green Spaces, specifically the **Wirral Woodland Glade** (discussed in more detail under the "Green spaces" section of this report).

As part of developing a corporate culture where impact on the environment is considered as part of everyday business we have **embedded sustainability in more of our key processes**, including:

- Amendment of the Trust **statement of case** document to ensure that sustainability is an early consideration for all proposals for investment
- The inclusion of our Green Plan within the key documents list as part of the **new vacancies** process
- Inclusion of sustainability and reference to the Green Plan and sustainable travel in our **induction** process when new members of staff join the Trust

Including sustainability and green travel as part of the new vacancies, recruitment and induction processes can have a positive impact in terms of employee **recruitment and retention**. It highlights to our staff, and prospective staff, that CCC is an organisation that cares about the climate crisis and is committed to reducing our own carbon emissions.

1.3 Next year

Over the previous few months, work has taken place to explore existing **methodologies for carbon reporting** in a bid to **measure and quantify** the impact of CCC's sustainability programme on our carbon footprint. This work has included market research for external consultancy providers, as well as engaging with other local NHS Trusts to see how this is currently managed at their organisations. Understanding how best to do this for our organisation continues to be a challenge. CCC's Sustainability Manager is now part of a wider ICB-led **Cheshire & Mersey Task and Finish Group,** which is currently looking to develop a bespoke carbon reporting tool to enable NHS Trusts in the region to report on their carbon emissions, in a way that is both consistent and cost-effective.

In addition to the above, over the coming 12 months we aim to explore opportunities for encouraging more of our staff members to complete the free **"Building a Net Zero NHS"** eLearning course. The Trust's Sustainability Manager will undertake a **carbon literacy "train the trainer"** session to support our goals of increasing the uptake of training with a sustainability focus across our organisation. An additional way of supporting this goal could be to introduce and establish a network of **Green Champions** across the Trust with the support of our Workforce & Organisational Development team, who have recently set up a network of **Health and Well-being Champions** (more information included in "Workforce" section below).

2 Care models

2.1 Background

CCC's unique **networked model of care** continues to see care delivered locally where possible and only delivered centrally where this is necessary. This model allows us to deliver services across multiple hospital sites in Cheshire and Merseyside for a population of 2.4 million while reducing to a significant degree the amount of travel required for patients. Furthermore, our clinical teams have sustained significant levels of the remote outpatient appointments that were made necessary during the Covid-19 pandemic, which further limits the need for patient travel.

Our **Clatterbridge in the Community (CIC)** service (delivering chemotherapy in a patient's home or workplace) continues to result in significantly lower volumes of car traffic than had this care been delivered in hospital premises. Giving patients the choice to receive their care closer to home also reducing the time

and expenses spent travelling to and from clinics and waiting for their treatment, improving patient experience and enhancing quality of life. The service has grown each year since it was first deployed in 2019, resulting in a 78% increase in the number of patients being treated by CIC. This has also resulted in a 122% increase in the delivery of drugs to patients in 2022 (compared to 2019).

Across the NHS, **anaesthetic and analgesic gases** are responsible for over 2% of all emissions. CCC is not a heavy user of anaesthetic gases as we are not a provider of surgical care. Nevertheless in order to minimise our environmental impact we have sought to understand our anaesthetic and analgesic use and achieved assurance that this is as environmentally sustainable as it could be.

2.2 This year

This year, the clinical team leading the Clatterbridge in the Community service is in the process of reviewing its options to **expand the service** even further and to develop a new hybrid model of community care, supporting care delivery closer to home and working across primary and secondary care boundaries to deliver a wide range of clinical treatments.

In addition to this service, over the past 12 months the Trust has continued to pilot **remote patient monitoring** where clinically appropriate. This model of remote monitoring enables appropriate lung cancer and immunotherapy patients to be supported to self-manage their care within their home environment. Evaluation data from the first 12 months of this pilot has been positive, with 75% of patients reporting that they felt more confident at managing their health at home as a result of taking part in this programme. Although not the main purpose of this pilot, the associated carbon reduction implications of reduced patient footfall to hospital sites is significant. The lung team is continuing to pilot this programme over the year to come to aid continuous learning, and the immune-oncology (IO) team is looking at how they can expand this care model to include SACT (systemic anti-cancer therapy) patients, as well as IO patients.

The past year has also seen the establishment of a Trust-wide **outpatient transformation programme**, which includes work streams directed at increasing the proportion of outpatient appointments conducted by video call and rolling out risk-based models of outpatient follow-up that reduced the need for patient travel in addition to other benefits for patients.

2.3 Next year

The outpatient transformation programme will begin to deliver results in the coming year that will continue to **reduce the need for patients to travel** for outpatient care when this is not clinically required.

The next 12 months will also present us with an exciting opportunity to start to further investigate the carbon emissions associated with our different services at CCC. The CCC team has recently started work as part of a wider national study which aims to assess the **carbon emissions associated with brachytherapy**. This study aims to explore and assess the level of carbon emissions associated with multiple elements of brachytherapy, including:

- Use of power during each element of the patient pathway
- Anaesthesia type
- Length of procedure
- Number of disposable and non-disposable consumables associated with the treatment
- Patient travel

Key area of focus: "Gloves-off" campaign

In the coming year we will explore options for launching a **"Gloves-off" campaign** across the Trust. Over 1 billion pairs of single-use plastic gloves are used across the NHS each year. Data from our colleagues at Health Procurement Liverpool (HPL) has revealed that we spend approximately £180,000 on single-use plastic gloves (and kits containing single use gloves) each year across our three sites at CCC.

Much of this glove use is unnecessary. There is clear guidance on when gloves are needed, which is when clinical staff are going to come in to contact with bodily fluid, non-intact skin, or mucous membrane. To combat this, a number of Trusts across the UK (including Great Ormond Street Hospital and our neighbours at LUHFT, Alder Hey and The Walton Centre) are on a mission to encourage healthcare professionals to reduce the unnecessary use of non-sterile gloves. Research has found that removing gloves when clinically appropriate can lead to improved hand hygiene practices. As well as improving patient safety/ clinical care, there are significant cost and carbon saving implications associated with rolling out this initiative across the Trust.

It is recognised by the sustainability team that wearing plastic gloves is an engrained behaviour, common to hospital staff. For this reason, the gloves off campaign would require a dedicated clinical lead and infection control lead to champion the project, with support from other colleagues across the Trust, including our communications team, procurement and workforce.

3 Workforce

3.1 Background

CCC employs approximately 1,850 members of staff across all of our sites. Our workforce are one of the greatest assets that we have at CCC with regards to bringing about sustainable change across the Trust. We have recently launched a comprehensive **staff awareness and engagement campaign**, raising the profile of

sustainability at CCC and highlighting the (often behind-the-scenes) work that is taking place to improve our organisation's carbon footprint. With the continued support of our communications team, the engagement campaign has sought to raise awareness among staff and pave the way for continued behaviour change through various methods including: the design of a "creating a greener CCC" banner, updates and information being shared via screensavers, staff surveys around travel and waste management practices and perceptions, CCC Live sessions, updates on the staff intranet and inclusion of sustainability as part of our staff-wide e-bulletins.

3.2 This year

This year, our staff awareness and engagement campaign has included the following:

- **Green tips of the month** – green tips and sustainable ideas are now shared on a monthly basis as part of the staff-wide e-bulletin in a bid to encourage more sustainable behaviour both inside and outside of work

- **In-person engagement events** - During November, the Trust's Sustainability Manager hosted a number of in-person engagement events at the main entrance to the CCC Aintree, Liverpool and Wirral sites – linking in with staff both to encourage participation in the survey and also to have more general conversations around our sustainability ambitions at CCC. Once again, this exercise revealed considerable enthusiasm and interest among our workforce for the green agenda

- **CCC Live events** – We have hosted a number of CCC Live events this year regarding green travel and updating on the progress of the development works that have been taking place at our Wirral site (including major roofing works, the renovation of our old physics building, and our plans for improving green spaces and increasing biodiversity on-site)

- **Green advent calendar** – in December 2023 we produced our first ever CCC Green Advent Calendar, containing handy tips for colleagues on how to combat your Christmas carbon both at work and at home

Carbon calculator Calculate your own carbon footprint using the WWF footprint calculator https://footprint.wwf.org.uk/ Set yourself the task of reducing your footprint score each year	**The gift of a better future** Animal adoption is a popular gift. The animal kingdom is under threat, with over 50% of species in danger. When you gift the adoption of an animal you help protect the species and their habitat	**Raise awareness** Have a conversation with a colleague about the environment	**Shop locally** Shopping locally can benefit the environment by reducing the distance that goods have to be transported, and can benefit the local economy – helping independent businesses to survive and thrive. Consider buying your fruit and veg from our very own market stall at the main entrance of CCC Aintree on Tuesday mornings	**Save energy** There are a number of ways you can do this over the Christmas period. Remember to turn off your lights and electronics, try reducing your home thermostat by one degree, or set yourself the challenge of unplugging your devices and leaving it overnight (for a week!)
Gift wrapping Why not give furoshiki a go?! Furoshiki is a traditional Japanese method of using wrapping cloth as an alternative to paper – a sustainable and creative way to gift wrap! Tutorials for the technique can be found online	**Sustainable food** Christmas is one of the worst periods for food waste. Search the web for inspiration on how to use leftovers and stick to a weekly shopping list/ menu	**Setting the table** Avoid single-use tablecloths and napkins. Invest in a quality tablecloth which will have a long life. Washing at lower temperatures will also help to reduce your environmental footprint	**Gift an experience** Give the gift of an experience to help reduce the demand for physical resources – a day out brings people together and is something to look forward to	**Dressing for party season** This year, choose the sustainable option and try to use clothing that you already own! If you can't find anything to wear, ask your friends or family. Or try looking around second-hand shops for your new Christmas party outfit
Think about materials Look at the materials gifts are made from and keep sustainability in mind. Ensure wood and paper gifts are made from recycled materials and avoid single use plastic items that can't be recycled	**Wrap it up** Look for cards and wrapping paper made from recycled paper. Avoid plastic ribbon and tape, glitter and foil-backed wrapping paper. Reuse this year's card as next year's gift tags. After Christmas, recycle all card wrapping and cards	**Anything!** Identify a change your team can make to reduce travel, waste, energy or water use	**Training** Complete the free "Building a Net Zero NHS" course on ESR	**Reduce waste and improve green space** Pick up litter in your area – exercise while helping the planet
Sustainable travel Going for a short drive? Try cycling or walking instead. Could you keep it up and remove one car journey per week?	**Don't forget the tree!** If buying a real tree, make sure it's Forest Stewardship Council certified. The more locally the tree is sourced the better. If buying an artificial Christmas tree, make sure that you're going to reuse it for at least 10 years	**Eat more plants** Poultry is in the top 10 most wasted foods in the UK and 100,000 tonnes of it ends up in the bin every year. Eating more plant based meals is good for both you and the planet	**Quality over quantity** Over 50% of adults say they have received a gift they don't want – think quality over quantity to reduce the chance of gifts going to waste	**Reduce waste** Commit to one week of waste-free lunches – swap cling film or foil for reusable packaging and ditch the crisps!
Green space The festive period is about spending quality time with friends and family. Try making one of your festive activities (or a work meeting!) a walk in the park	**Think about your lights** Use LED lights on your Christmas tree, they use less energy, last longer and look great! Also, switch off your lights at night - it's safer and won't cost the earth	**Green banking** Switch your bank to one that doesn't invest in fossil fuel expansion Find Ethical & Sustainable Banks In Your Area - Bank Green	**Make your own decorations** Save yourself some money by upcycling old decorations. Or make your own using spare materials around the house	**Reuse resources** Buying second-hand items saves on resources needed to make new products. Vintage clothes and home furnishings, and refurbished technology can make great sustainable gifts

8

Key area of focus: ECOSIA

In December 2023, we made Ecosia the default search engine on all CCC laptops and PCs. Ecosia is an eco-friendly search engine that uses 100% of its profits from advertising revenue to plant trees. Ecosia works just the same as any other search engine, but is greener. Ecosia has one of the largest and most diverse tree-planting portfolios in the world – planting in over 50,000 locations with over 70 partners across more than 35 countries – protecting not only the planet, but also benefiting local communities and allowing wildlife to thrive.

Making the switch to Ecosia as our default search engine was a simple, free and immediate way for our organisation to make a small change that can have a big impact. The Trust receive monthly tree reports from Ecosia, detailing how many trees our staff have been responsible for planting (approximately 50 searches results in one tree being planted).

Over the course of two months (December 2023 & January 2024) staff at CCC carried out over 175,000 searches through Ecosia, resulting in the planting of approximately 3,500 trees.

The change to Ecosia, and the reasons for doing so, was communicated widely across the Trust. However following the switch it emerged that a small number of colleagues had not been aware of the impending change and were therefore unable to make sure that they were prepared for it. We will learn the lessons of this to make sure that we plan as effectively as we can for the changes we make in the future to make CCC a more sustainable organisation.

3.3 Next year

The year to come provides us with exciting opportunities to build upon the engagement and awareness work that has happened over the last year. We will continue to refine and be guided by our **green communications plan** as the year progresses and will maintain our close working relationship with the communications team, who have played a pivotal role in supporting us to engage with our staff on the sustainability agenda within the Trust. We will work with our communications team to link in our plans and initiatives with themes and events that are happening nationally.

As sustainability and caring for our natural environment is intrinsically linked with health and wellbeing, we plan on joining forces with the recently established **Health and Wellbeing Champions** group to see how we can work together in the future. There are already plans in place for a "herbal walk" in spring 2024, which will include discussions around the impact that spending time in green and blue spaces can have on our health and wellbeing, and will also involve looking at the plants located at each of our sites and discussing their individual healing properties. With the support of the Workforce and Organisational Development team, we will explore the potential to introduce a similar **Green Champions** initiative within the Trust over the coming year, which would significantly increase our capacity for rolling out sustainability-focussed projects across our organisation.

4 Travel and transport

4.1 Background

The benefits of greener and more sustainable travel are well understood and are far reaching. They include:

- **Reducing carbon emissions –** benefiting both the health of the population and the health of the planet
- **Improving air quality –** Liverpool City Region Combined Authority says that poor air quality linked to traffic pollution is thought to be responsible for around 800 deaths every year in our region
- **Individual benefits –** regular activity is one of the most important things you can do for your physical and mental health and wellbeing
- **Making the roads safer –** having fewer vehicles on the roads makes roads safer for all
- **Financial benefits –** in the current financial climate, with the rising cost of living and decreased energy security, walking and cycling can be seen as comparatively low-cost travel options

When it comes to **travel and transport**, the Trust has been taking steps to encourage greener travel for some years:

- Our **networked model of care** and shift to virtual appointments had a significant impact in lessening the patient car miles associated with our care

- The Trust's **hybrid working guidelines** remain in place following the Covid-19 pandemic to support the continuation of some degree of home working where appropriate, resulting in a sustained reduction of staff commuting and levels of business travel

In order to supplement this, we have a number of schemes and incentives available to our staff to help them to make a greener commute at least some of the time, if not possible every day:

- We have **active travel facilities** across our sites, including showers, changing rooms, lockers and bike storage

- We have teamed up with NHS Fleet Solutions to launch a new salary sacrifice car lease scheme, making access to **ultra-low emission and zero-emission vehicles** easier for staff wishing to make this choice

- We have **EV charging** available at our CCC-Aintree and CCC-Liverpool sites (Paddington Village car park)

- We have a long-standing **cycle to work scheme** – run by our staff benefit providers Vivup, offering tax-free discounts on a wide range of bikes and cycling equipment

- We offer free **Dr Bike maintenance sessions** available to all staff

- Our **Arriva Travel Club** offers discounted bus fares for our staff – saving up to 25% per year on travel costs

- CCC-Liverpool staff have access to the Liverpool City Council **e-bike scheme** which has been launched as part of Liverpool City Council's VOI **e-scooter service**

- We have launched an **interest-free public transport season ticket loan**, allowing staff to benefit from more affordable public transport fares throughout the year

4.2 This year

Key area of focus: CCC's first Green Travel Plan

On World Car Free Day (22nd September 2023) we published the Trust's first ever **Green Travel Plan**. Given the nature of our patient population, the majority of this plan is focussed around staff commuting and business travel. With regards to staff commuting, the plan includes information regarding the **existing initiatives** that are in place to encourage and support staff to make greener choices (mentioned above). It also sets out the **future actions** that we will take to continue to support even more staff to consider making a switch where they can (such as upgrading our staff change facilities and bike store facilities on-site and working towards establishing an "Active Travel User Group"). Following the publication of the Green Travel Plan we hosted a CCC Live event to promote it and answer any questions that our colleagues had regarding its content.

Following the publication of our Green Travel Plan, in November 2023 we re-ran our **Staff Travel Survey** in order to further our understanding of the commuting practices of our colleagues, and to identify the barriers that are discouraging staff from making a greener commute, at least some of the time. This year we had 447 responses (almost twice the response rate from last year) giving us a more representative snapshot of the commuting practices across the Trust. Some significant findings include:

- Almost half of respondents had seen the recently published CCC Green Travel Plan
- 25% of participants said that they had made their commute greener within the last 12 months (including upgrading to an electric vehicle, using public transport more frequently, cycling to work more often, and car sharing)
- More of our staff now have access to a hybrid or electric vehicle

We plan to run this survey each year so that we can continue to measure trends and changes in commuting practices over the years to come.

In addition to our work regarding staff travel, improvements have been made to the travel and transport arrangements for some of our business services. For example, at the beginning of 2023 we introduced a formal hub delivery service managed by our pharmacy CPL vans to deliver medications to our patients. Many of the deliveries now undertaken by this **Patient Delivery Service** were previously done by taxi. CPL vans now run twice a day for both patient and hub deliveries, leading to a significant reduction in the

carbon emissions (and subsequently air pollution levels) associated with extensive taxi use, as well as a reduction in the cost associated with this service.

4.3 Next year

Following a review of our staff changing facilities this year, we are planning to work with our PropCare team to continue to make improvements for our colleagues in a bid to break down some of the barriers preventing staff from using public transport and active travel as part of their commute. This includes:

- Upgrading the staff changing facilities at our CCC-Wirral site (the former physics building – see section on capital projects)
- Exploring options for installing better bicycle parking at CCC-Wirral and CCC-Liverpool
- Installing ID badge swipe access to our bike stores

In addition to improving our on-site active travel facilities we aim to continue to work with our partner organisations (e.g. Knowledge Quarter Sustainability Network and our neighbouring NHS Trusts) to look in to the potential of rolling out a regional **car share scheme** available to staff across our organisations. We also aim to continue to work with our partners to influence the planning and investment in our local active travel infrastructure and to lobby for improvement to the cycle lanes and walking routes serving our sites.

Our other ambitions for the year to come are to:

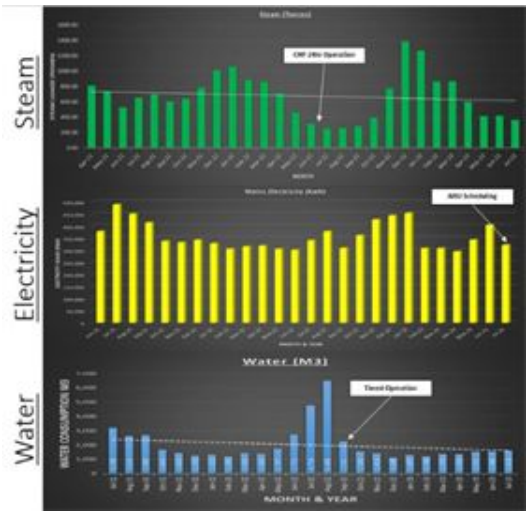
- Work with our partners at Wirral University Teaching Hospital (WUTH) to be able to offer free Dr Bike maintenance sessions to staff at our CCC-Wirral site
- Continue to work with our PropCare colleagues to look at how our issues with our electrical supply at CCC-Wirral can be overcome so that we can look to install EV charging on-site to allow us to electrify our fleet and offer EV charging to staff
- Work towards establishing an **Active Travel User Group** for people interested in walking, running, or cycling to work to link people with others in their area to share advice and encourage their colleagues. This could extend to arranging guided cycles led by external partners or more experienced CCC cyclists to help staff feel more secure in travelling to work by bike

5 Energy and utilities

5.1 Background

We have already taken a number of steps in previous years to moderate and reduce our energy consumption and our use of other utilities. Our **CCC-Liverpool** site has a comprehensive **building management system** (BMS) in place for increased energy efficiency and 30% of its electricity is generated on site by low and zero carbon systems, including photovoltaic panels on the roof.

5.2 This year



At CCC-Wirral, where our buildings are less modern, in addition to the work that we have previously undertaken to **insulate** and lag pipework to reduce energy consumption, we are now currently in the process of **refurbishing** our old physics building and **upgrading the roofing** in a number of areas on site, having a positive impact on the building's energy efficiency.

This year at CCC-Liverpool we have teamed up with colleagues from Vinci (our estates service provider for the site) and PropCare to use data from our BMS to feed in to an **energy dashboard**. This allows us to take a more targeted approach towards areas of high energy consumption across our CCC-Liverpool site. The energy dashboard utilises meters and sub-meters to provide live and historic energy usage within the hospital, on a floor-by-floor basis. This dashboard allows us to implement, manage and review energy saving and carbon reduction measures using real-time data, whilst ensuring that the patient environment is managed to its optimum.

Using the dashboard, several energy and cost saving initiatives have already been implemented, including:

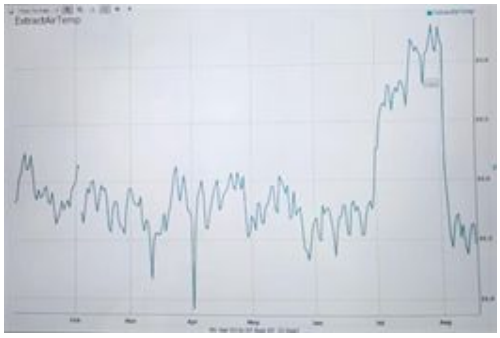
- Air handling units at CCC-Liverpool are now scheduled to switch off when not in use as part of a wider cost improvement scheme. This has resulted in an annual saving of 475,800 kw/hours at CCC-Liverpool (similar interventions have taken place at CCC-Wirral with an annual saving of 183,456 kw/hours)

- The settings for the atrium windows on level 2 (which are designed to open and close automatically to maintain optimum temperature ranges) have been upgraded in order to better control fluctuating temperatures, improving the thermal comfort of our patients, maximising natural ventilation and reducing energy consumption from heat loss

- The installation of additional software to ensure that all chilled beams (other than those at pharmacy) are to be switched off out of hours – producing energy savings whilst maintaining key

temperature parameters

- In July 2023 a 66% reduction in water usage (compared to July 2022) was achieved by amending the settings on the cold-water end of line valves – a saving equivalent to 3,149,000 Litres of water (approximately 1.3 Olympic size swimming pools)



- In August 2023, the energy dashboard recorded a significant number of locations on level M3 that had breached the 26 °C ambient temperature limit. After some investigating, it was discovered that the underfloor heating control located on M3 in the public toilet had been manually adjusted, causing temperatures to soar (M3 extract temperature graph to the right). To rectify this, the underfloor heating was manually disabled that same day and a cover has now been installed on the manual control to prevent future issues

In October 2023 the **water supply for CCC-Wirral** was transferred to a nearby borehole, a process that was managed by our neighbours at WUTH. This involves fresh water being sourced from a water table directly below the site from a narrow well. Boreholes are better from an environmental perspective as, although they don't play a part in reducing water consumption, 60% of mains water is recycled wastewater which requires treatment (using a significant amount of energy and chemicals). In comparison, water sourced directly from boreholes only requires limited treatment, resulting in energy savings and an improved carbon footprint for CCC-Wirral.

5.3 Next year

Next year, at CCC-Liverpool we will continue to work with Vinci to use the energy dashboard to improve the building's performance. We will work closely to identify more **energy-saving quick wins**. In addition to this, we will begin to assess our options for upgrading the building management system at our CCC-Wirral site.

At CCC-Wirral we will continue to invest in **refurbishments and improvements** that increase energy efficiency while also continuing to work on the longer term redevelopment of parts of the site. In addition to the major capital projects on site this will include a review of the taps across our site to identify those that do not have automatic and leak detection settings built in.

At CCC-Aintree, following a recent successful funding bid from the National Energy Efficiency Fund (NEFF), we will be upgrading all of our lighting to more energy efficient **LED lighting**, which will result in a monthly energy cost saving of approximately £1,500 and monthly carbon saving of approximately 3,000kg co2e.

In addition to the above, we are joining forces once more with our digital team to roll out a sustainability-focussed **printing initiative** across the Trust over the coming months. This will primarily include communications to improve the printing behaviour of our colleagues, however there are also plans in place

to default all of our printing to black and white and double sided. This will save up to 75% of the energy associated with printing as well as improving our use of resources and reducing waste.

6 Waste

6.1 Background

Staff engagement on the development of the Green Plan has shown us the importance to staff of **recycling**, with many staff asking for the installation of bins within our buildings to allow the separation of waste at source. We acknowledge, however, that development of our plans for how we deal with waste in the future needs to cover interventions to **reduce waste and reuse items** as well as increasing recycling.

6.2 This year

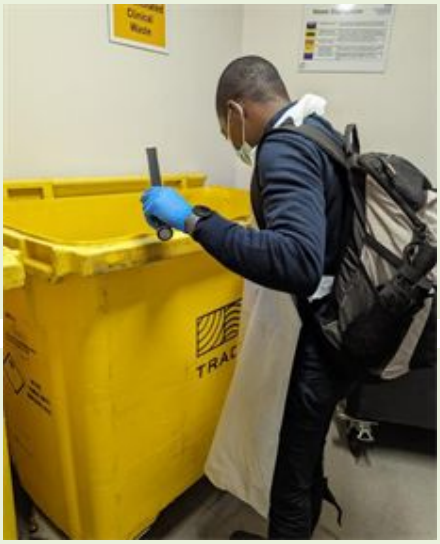
With regards to waste, over the last 12 months, we have:

- Engaged with our waste contractors at B&M (who have a **zero waste to landfill** policy in place) to obtain a better understanding of our waste arrangements across our sites
- Introduced **digital food ordering** at CCC-Liverpool to reduce food waste
- Worked with the PropCare team to ensure that any equipment or furniture that is not being **reused or reclaimed** from the old physics building redevelopment at CCC-Wirral is rehomed appropriately to prevent reusable equipment ending up in landfill
- Engaged with our digital colleagues as part of an **electrical equipment amnesty** following the Trust updating its mobile device contract (October 2023). This involved asking members of staff who have old Trust equipment/ electrical devices that are no longer needed to either bring them to the IT department or to arrange collection with our digital colleagues in order to minimise electrical equipment waste – having both a cost and carbon saving impact
- In addition to the above, this year we have been working with our colleagues at Health Procurement Liverpool and PropCare to explore a sustainable sharps waste disposal solutions. This **Bio Systems Sharps Management** solution consists of sharp bins that can be re-used up to 600 times after washing and disinfection, as opposed to the single use containers that are currently on use across the Trust, that are disposed of after just one use. This potentially exciting development could help us to cut the waste associated with our sharps disposal at CCC and discussions are expected to continue regarding this over the months to follow.

Key area of focus: Sustainable Waste Research Partnership

In addition to the above, we have worked in partnership with a Postdoctoral Research Fellow from Liverpool John Moores University, who is currently carrying out research on sustainable healthcare waste management within NHS Trusts. The aim of this project is to develop an assessment tool that can facilitate the implementation of sustainable healthcare waste management within NHS Trusts.

Following research interviews with CCC staff, and a visit to our three sites, it was discovered that there are a number of improvements that could be made with regards to waste management across our sites. As a result of these findings, we have set up a new **Sustainable Waste Management Group** to discuss the research findings and identify areas of improvement. This includes having better signage for what each bin bag is for, exploring opportunities for waste management training for staff, and looking in to the possibility of introducing separate bins for recycling on-site.



We will continue to work with the support of the researcher from LJMU to identify additional ways of improving how our waste is managed on-site (including the potential production of a **sustainable waste management plan** for the Trust).

6.3 Next year

Over the months to come, the newly formed Sustainable Waste Management group will work together to make improvements with regards to our **waste management** across our sites – with the continued support of our external waste contractors.

As part of this we are planning to work with our inpatient meals service providers, Apetito, to roll out an initiative that allows us to **recycle inpatient food trays** - a 100% closed loop recycling process. Investigations are currently underway to work through the challenges regarding kitchen space to store the used trays. Given the number of meals served each day to inpatients, this will make a significant difference to our sustainability across the catering service.

Our other plans for the year ahead include:

- Engaging with our catering team and B&M to pilot a project on **food waste and plastic packaging** reduction (more information included in "suppliers & partners" section of this report)
- Re-engage with our inpatient care team colleagues to look at their ideas for a **staff uniform reuse scheme**
- Understand how we deal with the disposal of **old medical equipment** that is no longer needed and look at improving our Waste Electrical and Electronic Equipment disposal practices / policies
- Working to decrease the overall amount of **printing** at the Trust and increase the use of recycled paper

7 Capital projects

7.1 Background

As previously noted, our major capital development recent years, CCC-Liverpool, was designed and built to a high standard, with features including photovoltaics panels on the roof and a combined heat and power unit. CCC-Aintree is a slightly older building but still relatively new compared to the majority of NHS estate. CCC-Wirral is where the Trust's oldest building stock is located and is therefore the site with the biggest opportunity for capital development to improve its environmental credentials.

7.2 This year

This year has seen significant investment in the **maintenance and refurbishment projects** at CCC-Wirral including:

- Major roof investments
- Improvements in some staff change facilities to support the green travel plan
- Improved insulation (increasing the building's energy efficiency)
- Installation of higher performance glazing (increasing the building's energy efficiency)
- New office accommodation in an upgraded older building

We have also launched a process to look at the **wider redevelopment** of the site beyond the immediate refurbishment programme. The competitive process to procure architectural support for this included a 15% weighting for sustainability and social value to ensure that this is considered as a key component of any proposals.

7.3 Next year

The coming 12 months will see further capital investment to improve the green credentials of the CCC-Wirral site, including:

- We will continue to invest in the **maintenance and refurbishment** of the CCC-Wirral estate in a way that contributes to a reduction of our environmental impact
- Investment in our **green spaces** (more information included under the "Green Spaces" section of this report)

In addition to the above, discussions have recently commenced with our partners and colleagues at Liverpool University Hospitals NHS Foundation Trust (LUHFT) with regards to the collective decarbonisation of our buildings in the Knowledge Quarter (which includes CCC-Liverpool). Discussions are expected to continue over the year to come.

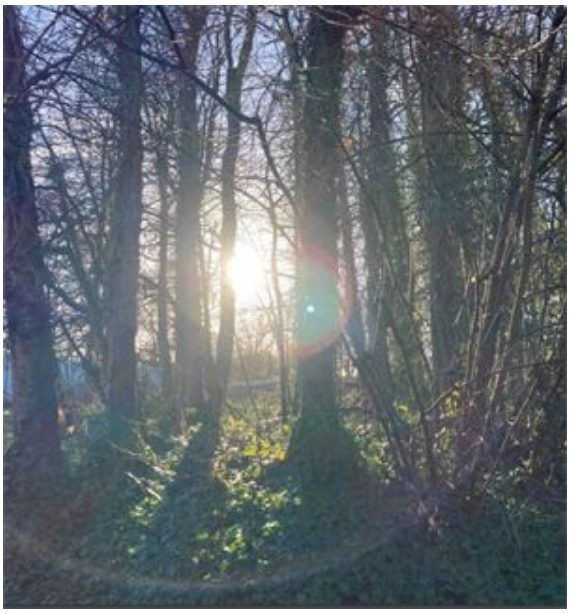
8 Green spaces

8.1 Background

When it comes to green space, **CCC-Wirral** is the jewel in CCC's crown. It sits in Wirral's green belt and on two sides the buildings look out over open fields. Over recent years we have maintained the site's green space to a good standard and responded to the changing nature of the site, for example by landscaping the areas left by the removal of temporary buildings following the expansion into CCC-Liverpool.

Our other main sites, **CCC-Aintree** and **CCC-Liverpool,** are in more urban locations and, therefore, do not benefit from the same level of surrounding green space. Nevertheless, CCC-Aintree is in close proximity to the award-winning Bluebell Woodland space and also benefits from the protected "no mow" areas on-site - both of which are managed by our LUHFT neighbours, with whom we share the site. At CCC-Liverpool we have the winter garden and five outdoor terrace areas serving the upper floors. Further work has been carried out since the opening of CCC-Liverpool with the support of the Clatterbridge Cancer Charity to enhance the terraces with furniture and planting.

8.2 This year



Following our recent green space audit (which aimed to bring together a record of the various green spaces on the site and undertake as assessment of their potential for improvement) we have begun working with partners to obtain advice and guidance as to what we can do to develop our plans to improve the outdoor space and **increase biodiversity** at our CCC-Wirral site.

Specifically, we are aiming to continue our work on the **Wirral Woodland Glade** – an area of relatively mature woodland at the rear of the site, beyond the radiotherapy bunkers. Previously, we have created paths in this area and improved the fencing to make it an accessible space for our staff, patients and visitors. We have also engaged the services of a landscape architect who has developed plans and proposals for us regarding landscape seating, sculptures, planting strategies of native plant species, upgrading the existing pond area and the installation of wayfinding and interpretation panels. This year we have successfully secured a grant from the Clatterbridge Cancer Charity to install a range of outdoor furniture in the Glade for the benefit of staff and patients. In addition to this, we have also re-engaged with NHS Forest this year to discuss obtaining free tree bundles to further enhance this space.

At CCC-Liverpool our focus for the last 12 months has been the improvement of the **winter garden** area to bring the space in line with the improvements to the terraces. We have worked with the necessary specialists to ensure that the appropriate planting, lighting and maintenance schemes are in place to make this a more inviting and useable space for staff and patients. Again, we were able to invest in this green space for the benefit of patients and staff thanks to the significant support of the Clatterbridge Cancer Charity.

8.3 Next year

We have big plans for the development of our green spaces this coming year, with a specific focus on the Wirral Glade. We have recently formed the Wirral Glade task and finish group and aim to look at the ways in which we can enhance this space further, not just for the benefit of our staff, patients and visitors but also for the benefit of our local wildlife. Our aims for the Glade for the year to come include:

- Installation of additional FSC-approved furniture (early spring 2024)
- Assess our options for planting additional trees and **improving the biodiversity of ground flora and fauna** by re-introducing native and pollen-rich plant species, perennials and bulbs of local

provenance in to the area

- Engaging with our neighbouring land owner to identify opportunities for **upgrading the pond** area
- Engage with our arts team to explore options for the installation of **artistic sculptures**
- Create a **wildflower meadow** and re-launch of our **"no mow"** initiative (both in the Glade and across the site) for the second year
- The installation of new, sustainably-sourced **wayfinding and interpretation panels** – explaining the plans and ecological strategies for the area, as well as offering descriptions of the trees, plants and wildlife that can be found on-site
- Liaising with **Mersey Forest** and **NHS Forest** to explore opportunities for collaboration
- Continuing to explore additional **funding opportunities** that would allow us to develop the area to its full potential in a quicker timeframe
- Engaging with **local woodworking colleges** to ask if they are able to use recycled/ reclaimed wood to make us items that can help with our biodiversity goals for the site (such as bird boxes, bug hotels, owl and bat boxes and decorative items/ wooden planters)

9 Suppliers and partners

9.1 Background

The activities and practices of our suppliers make up a large part of our **wider carbon footprint**. Only through engaging with our suppliers, and our many other partners, will we be able to fully address our impact on the environment. It is clear that our suppliers and partners are already on board with the green agenda, with various additional changes in legislation expected over the coming months.

We continue to work with our colleagues in **Health Procurement Liverpool (HPL)** who act as a shared procurement function for Clatterbridge and the other three specialist Trusts in our region (Alder Hey Children's Hospital, Liverpool Heart & Chest and The Walton Centre). We continue to look to HPL to implement the guidance from the wider NHS on incorporating considerations of environmental sustainability and wider social value into our procurement processes.

9.2 This year

This year, our colleagues from HPL have continued to be core members of the Sustainability Action Group. In September 2023, HPL published a strategy document outlining the organisation's strategic aims and ambitions over the next three years. **HPL include sustainability and social value** as part of their key strategic aims within this document. They state that HPL will work with their member Trusts to "promote and develop the sustainability and social value agenda and build all mandatory requirements into projects supported by and undertaken through procurement". Also in September 2023, HPL started working to add our suppliers to the Atamis system. The Atamis solution acts as a portal whereby all suppliers and contracts are listed, acting as a centralised database containing all the necessary information regarding our external partners.

In addition to this, a **new assessment tool** for suppliers known as the "Evergreen Assessment" (an Atamis-based tool) was rolled out earlier this year. The Evergreen Sustainable Supplier Assessment in an online self-reporting tool for suppliers to engage with the NHS on their sustainability journey and understand how to align with the NHS net zero and sustainability ambitions. The benefits of this tool are that it allows for an improved understanding of the supply chain, enables more transparent conversations between Trusts and suppliers, it can support contract management and, ultimately, can help NHS organisations to achieve their sustainability goals.

In addition to the above, over the last year the sustainability team has **continued to engage with partners and suppliers** across multiple areas within the Trust, including:

- Estates contractors with regard to the energy efficiency of our buildings (PropCare & Vinci)
- Waste contractors with regard to waste reduction and recycling (B&M)
- The sustainable travel teams in Local Authorities and the Liverpool City Region
- Catering partners to introduce both a digital meal ordering system and a reusable food trays for our inpatients (ISS & Apetito)
- Our NHS partners on our different sites with regard to wider sustainability issues
- Colleagues at NHS Forest & Mersey Forest
- Our independent fruit and veg provider for CCC-Wirral who sell their produce at the site's main entrance every Tuesday morning

9.3 Next year

With regards to our suppliers and partners, our plans over the year to come include:

- Maintain close links with the **sustainability teams** at our neighbouring NHS Trusts in a bid to align strategies, goals and projects where appropriate and share challenges, successes and best practice where possible
- Continuing our **work with HPL** to move us closer to achieving our next zero ambitions and create social value within our organisation
- Work more closely with our **waste contractors** and colleagues at JMU to improve how our waste is managed across our sites

In addition to the above we are keen to engage with our **catering partners** (ISS) and independent café providers over the year to come. We have lots of ideas for how we can engage with our catering teams to improve our sustainable practices including:

- Looking at increasing meat-free options on our menus
- Improving the contents of our vending machines (linking in with our wider prevention pledge goals)
- Obtaining locally-sourced and seasonal produce (reducing the transport associated with our food, and supporting local businesses)
- Working together to reduce plastic packaging / bottles
- Look to participate in a food waste trial with our B&M partners

10 Adaptation

As the NHS tackles climate change there is also a need to adapt to the immediate consequences it brings. Adaptation is the process of adjusting our systems and infrastructure to continue to **operate effectively** while the climate changes. We continue to have **business continuity plans** in place for all services which, while they may not explicitly mention climate change, set out plans for some of the impacts of a changing climate – like flooding and extreme heat events.

Adaptation has not been a priority for this year. Currently, a process to appoint a substantive EPRR Lead (Emergency Preparedness, Resilience and Response) at CCC is ongoing. In the coming year we will work with the EPRR Lead to identify a **nominated lead** for adaptation within the Trust and look to support them with the production of the Trust's first adaptation plan (with the support of our wider ICB colleagues).

11 CCC as an anchor institution

The reduction of our environmental impact is one of the ways that CCC can act as an anchor institution and positively contribute to our local area beyond the provision of healthcare.

As a Trust it is important that we understand and maximise our positive impact on the communities that we serve. There is also an expectation from NHS Cheshire & Merseyside that provider trusts in the integrated care system work to ensure that they are having this broader positive impact. As such we have continued to pursue a range of anchor institution work beyond the implementation of the Green Plan, including:

- Signing up to the Cheshire & Merseyside **Prevention Pledge** and setting out an ongoing range of actions in areas like improving staff health and wellbeing, undertaking preventive activity with patients, discouraging unhealthy behaviours, and providing access to healthy food and drinking water for staff and patients
- Adhering to the Cheshire & Merseyside **Anchor Institution Framework**
- Beginning to use the **Social Value Portal** to measure the value created by our interventions
- Achieving the Liverpool City Region **Fair Employment Charter**

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Prevention Pledge Summit – 26th September 2023 – Phase 3 Trusts receive plaques celebrating the adoption of the NHS Prevention Pledge

In the coming year we will formally establish a **Health Inequalities Steering Group** as part of our governance to oversee and coordinate all of our activities as a trust that have an impact on health inequalities, prevention and wellbeing, and the generation of social value.

12 Conclusion

The second year of the programme to implement the CCC Green Plan has continued to deliver positive progress. Our first two years have involved raising staff awareness and building the foundations for sustainable change. As we move in to our third year, we will begin to introduce and champion projects and initiatives across the Trust that bring about long-term change across our sites, reducing the carbon emissions associated with our organisation's activities.

The key challenges for the third year of this programme will be obtaining sustained engagement in the programme, as well as introducing projects that influence policy and bring about change across the Trust, as change can take time to adjust to. In the coming year we will also need to make meaningful progress on measuring and quantifying the impact that our programme is having on our environmental sustainability and carbon emissions. However, it is anticipated that, with the support of our staff and partners, we will continue to make significant steps towards playing in role in achieving the NHS's net zero ambitions over the year to come.

Cheshire and Merseyside Cancer Alliance

Performance Update

February 2024

Section i: Performance data

Cancer Wait Times data relate to December 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 December 2023

NHS

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

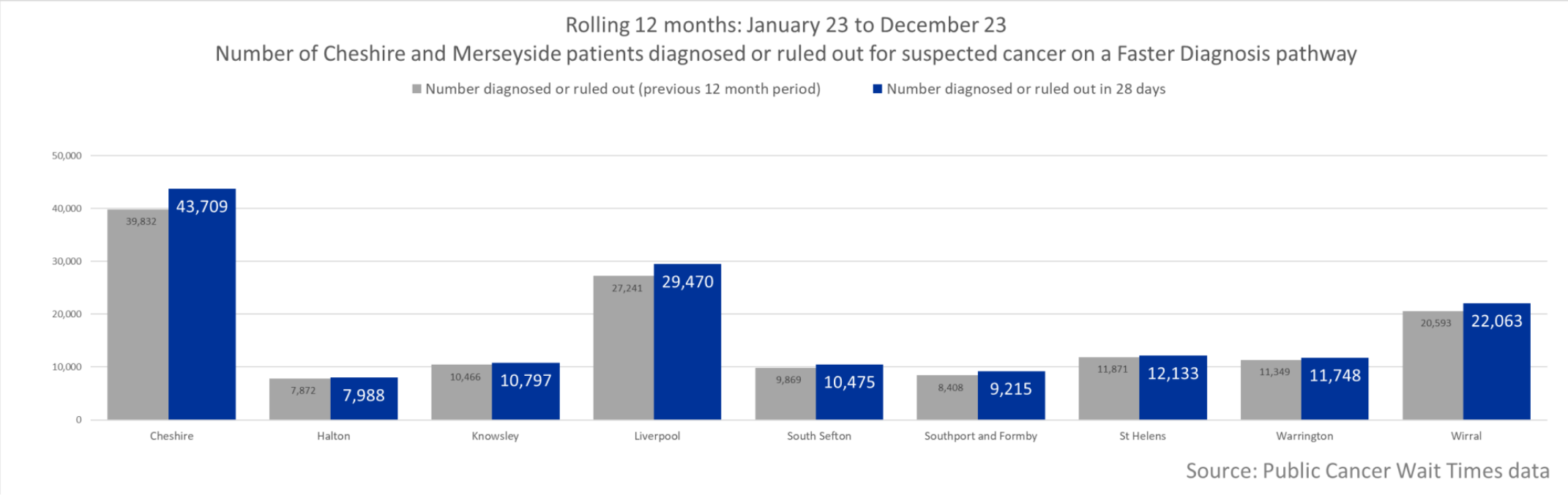
Measure	Value	Commentary
Volume of patients seen for the first time following an urgent GP referral for suspected cancer	105%	Data relate to patients registered with Cheshire and Merseyside GPs. Data are from Cancer Wait Times Dataset, most recent month December 23.
Cancer treatment activity: Volume of first definitive treatments for all diagnosed cancers	107%	
Cancer treatment activity: Volume of surgical treatments for all diagnosed cancers (all surgical treatments whether first or subsequent)	104%	
Systemic-Anti Cancer Therapies (SACT) (inc chemo) administrated at Clatterbridge Cancer Centre	109%	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. The data is Feb 23 - Jan 24 as a % of Feb 22 – Jan 23.
Radiotherapy (RT) planning volumes at Clatterbridge Cancer Centre	102%	

Patients diagnosed or ruled out for suspected cancer: Activity

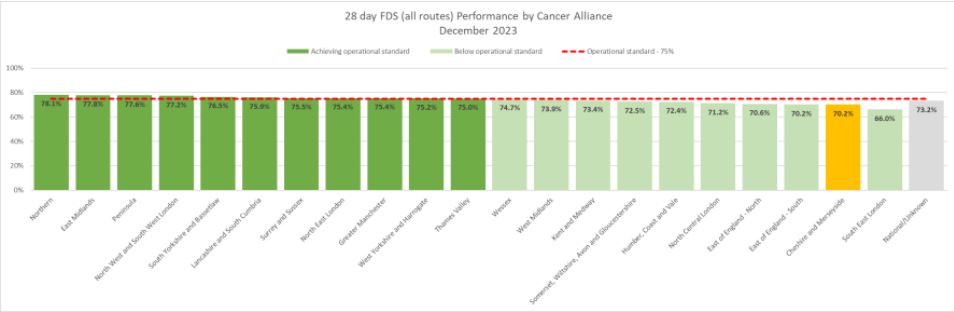
Patients registered with GP Practices in Cheshire and Merseyside:

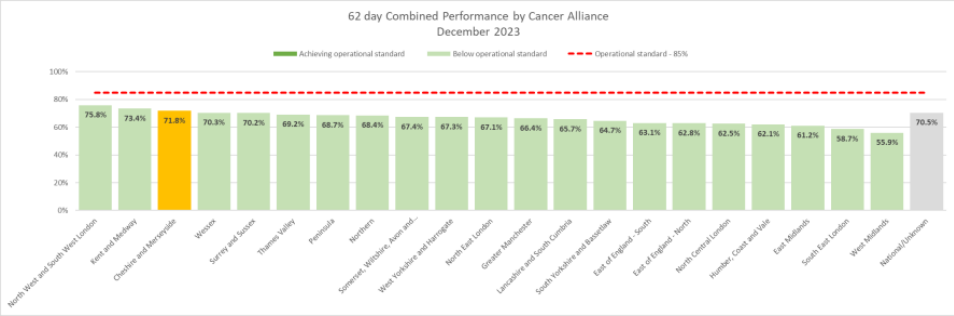
- Between Jan 23 - Dec 23 the overall number of patients diagnosed or ruled out on a 28 day FDS pathway was 157,598, compared to 147,501 in the previous 12 month period.

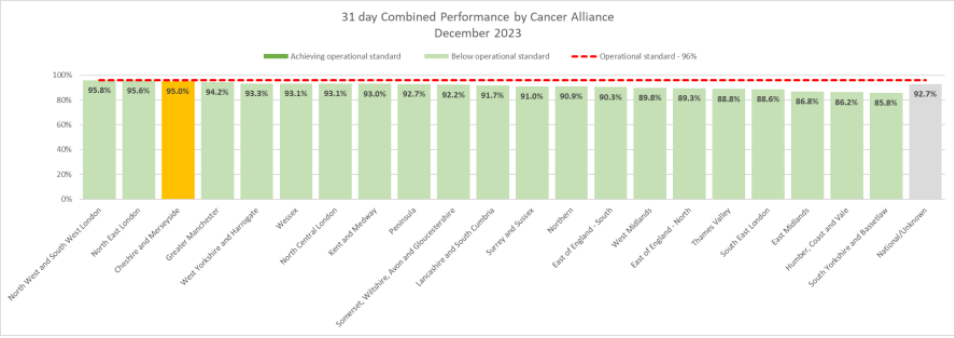
- On average this is **13,150** patients per month.



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 **20th** out of 21 (December 2023): **70.2%**
England average: 73.2% North West average: 73.5%

*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 first definitive treatment for cancer within 62 days of referral**.

CMCA ranks **3rd** out of 21 (December 2023): **71.8%**
England average: 70.5% North West average: 68.3%

**Referrals via urgent GP referral for suspected cancer, breast symptoms where cancer is not initially suspected, referral from a screening programme or consultant upgrade

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

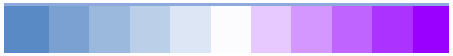
CMCA ranks **3rd** out of 21 (December 2023): **95.0%**
England average: 92.7% North West average: 93.9%

***Excludes subsequent treatments where the treatment plan is for Active Monitoring or Palliative Care

Source: Public Cancer Wait Times data

Place level vs operational standards: 12 months rolling
January 2023 to December 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%)	68.8%	65.8%	72.3%	68.5%	65.7%	69.3%	69.8%	68.4%	75.6%	73.8%
62 day combined standard (85%)	69.2%	67.9%	75.2%	72.3%	63.0%	61.7%	63.3%	79.3%	74.0%	73.3%
31 day combined standard treatment (96%)	94.2%	93.8%	94.6%	94.3%	93.6%	93.2%	92.4%	95.3%	95.5%	95.3%

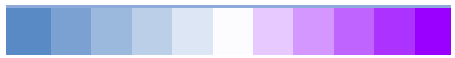
Highest  Lowest

Patients registered with GP Practices in Cheshire and Merseyside

Source: Public Cancer Wait Times data

Trust level vs operational standards: 12 months rolling
January 2023 to December 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%)	69.1%	84.1%	98.6%	85.0%	62.1%	69.7%	58.5%	68.8%	37.9%	67.8%	69.8%	100.0%	73.8%	74.7%
62 day combined standard (85%)	70.3%	80.9%	90.0%	79.5%	74.4%	63.0%	56.0%	61.9%	22.5%	66.9%	78.4%	75.0%	73.0%	72.6%
31 day combined standard (96%)	94.0%	99.1%	100.0%	94.2%	95.2%	95.2%	87.5%	86.8%	75.7%	87.2%	92.4%	99.2%	97.3%	92.4%

Highest  Lowest

Performance at The Walton Centre is 75%.
In NHS England data, 4.5 non-Brain / CNS patients have been mistakenly attributed to The Walton Centre 62 day performance. Including these patients, performance appears as 23.1%. The issue has been addressed, however the published data may not be amended due to processing deadlines. One Haematology patient was initially seen at TWC and subsequently treated at CCC (shared accountability).

Patients attending trusts in Cheshire and Merseyside

CCC: The Clatterbridge Cancer Centre
LWH: Liverpool Women's Hospital
WUTH: Wirral University Teaching Hospitals

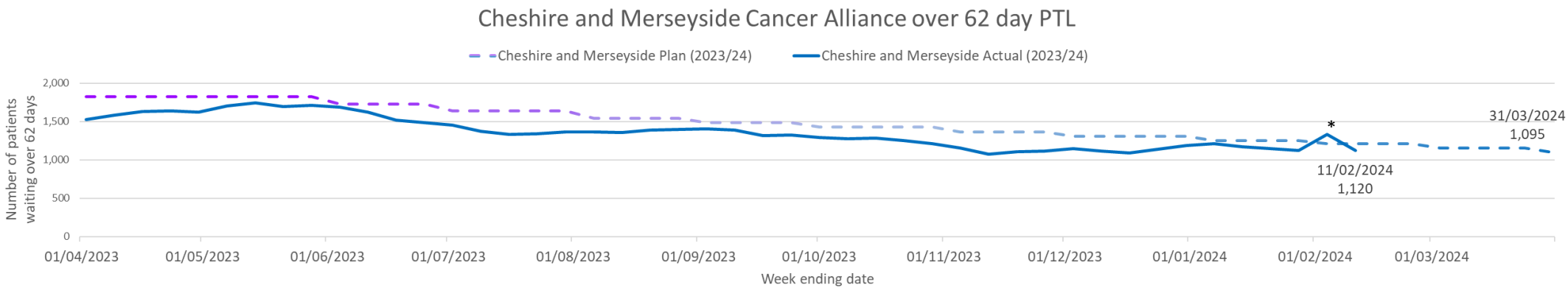
COCH: Countess of Chester Hospital
S&O: Southport and Ormskirk*

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.

Source: Public Cancer Wait Times data

Patients waiting over 62 days on the Cancer PTL



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: 11 Feb '24	1120	71	3	55	47	12	270	176	138	153	0	49	146
Distance from plan	-93	19	3	-49	-3	6	-54	101	-3	-97	0	-6	-10
Distance from end of March 2024 ambition	25	21	3	-47	0	7	6	111	10	-83	0	-6	3

Highest Lowest

Highest Lowest

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.

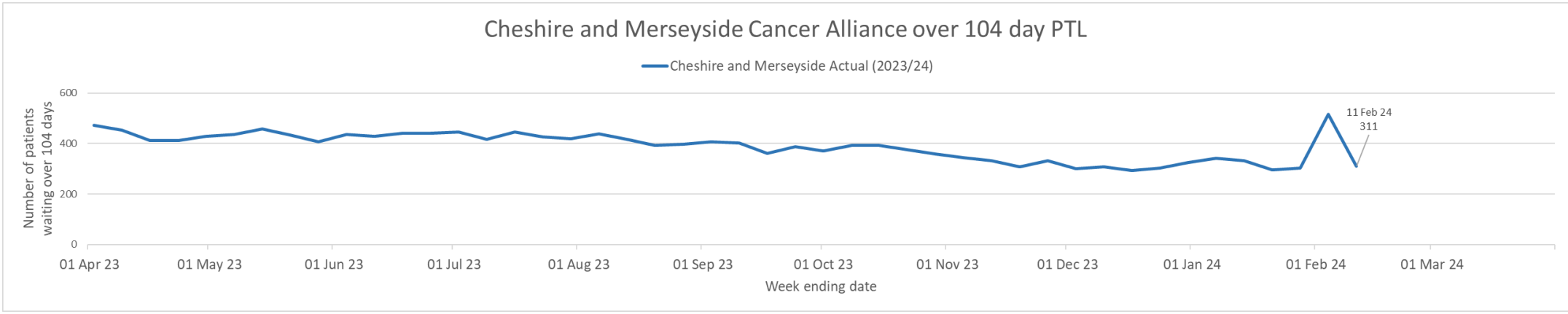
- Cheshire and Merseyside over 62 day PTL is **lower than** trajectory as of 11 February '24. The current number of patients waiting over 62 days is **92%** of the number planned for 11th February '24.
- As of 11th February '24 the current over 62 day PTL is **102% of the volume planned for the end of 2023/24.**

*On 4 February 24, a data error at a C&M trust led to a reported PTL volume of 1,336 rather than the correct volume of 1,114.

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



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: 11 Feb '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.
*On 4 February 24, a data error at a C&M trust led to a reported 104 day PTL volume of 516 rather than the correct volume of around 300.

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

Treatment Variation

In 2023/2024 Cancer Alliances were asked to undertake a new programme to implement the national priority recommendations from national clinical audit / Getting It Right First Time (GIRFT) reports to reduce unwarranted variation in treatment in four tumour sites - Lung, Prostate, Bowel (Rectal) and Breast cancers.
Work has progressed and the following are in place:

- Governance and clinical leadership agreed for each area.
- Tumour specific task and finish groups for audit and implementation work have been established with a range of stakeholders involved.
- Audit nurses have been appointed for each area.
- Data collection has started. This will be used to establish any variations in outcomes with actions then agreed through the appropriate Clinical Quality Group and clinical lead to reduce these.

Cancer Early Diagnosis Community Partnerships

This project aims to directly engage with high risks groups and communities identified as facing the most significant challenges to early diagnosis of cancer. It is doing this by working with all nine Council for Voluntary Services (CVS) organisations across Cheshire and Merseyside. Each CVS has been commissioned to provide community engagement roles, with allocated funding to support grass-roots organisations to raise awareness of early signs and symptoms and improve earlier presentation of cancer, including through screening uptake. During Q3 there were 112 engagement / education sessions reported across 19 different grass-roots organisations, with 3,728 individual interactions recorded as a result. There is also evidence of individuals participating in screening programmes and attending their GP with possible signs and symptoms of cancer, and a least one cancer diagnosed.

Challenges since last report

- Recruitment of clinical leads for the treatment variation programme has been a challenge, but all four areas now have a dedicated clinical lead.
- Data collection and quality from trusts for the treatment variation data has been difficult.
- Recruitment to the Primary Care team has proven difficult. However, new staff have been appointed and are now beginning to start in post.

Primary Care

The Primary Care programme has focused its revised delivery model on specific priority areas that support primary care teams with making improvements in the early diagnosis of cancer components of the Primary Care Network (PCN) Direct Enhanced Service (DES) contract and Quality Outcome Framework (QOF). These also align to the Cancer Alliance early diagnosis of cancer programme. With the appointment of a multi-skilled primary care Quality Improvement team, nine place based GP leads and additional project targeted clinical leadership the following has been achieved:

- Data dashboard – Through engagement with primary care and other partners key cancer diagnostic indicators, demographic and deprivation indices at PCN and practice level have been identified to form the foundation of a primary care dashboard. A dashboard developer has been recruited, a user group has been established and an early protype of the dashboard is expected end of Q1. This will support quality improvement initiatives for early diagnosis of cancer.
- Primary Care Education – In addition to the development of significant educational tools and resources being developed and collated on the Cancer Alliance's Cancer Academy platform two further areas have been prioritised:
    - GP Registrar education on cancer. Alongside the primary care team, a GP clinical lead has been appointed to shape a model of education focusing on cancer for GP Registrars in collaboration with Health Education Northwest. This work is now in progress.
    - Education on identifying and leading quality improvement has been commissioned for the place based GPs and wider primary care teams which has been identified as a gap in their knowledge.
- Cervical screening uptake (including downstream effects) across the region has been identified as a priority with early parts of the work plan identified in partnership with the Cancer Alliance Gynaecology programme and the Screening and Immunisations Team.
- All Urgent Suspected Cancer referral forms have been reviewed and are in line with the best practice timed pathways. They and are live and operational in seven of the nine places.

Key activities in the next six months

- Evaluation of the Early Diagnosis of Cancer Community Partnerships project.
- Treatment variation audits for each area will begin.
- Phase two of the Urgent Suspected Cancer referral project which includes referral guidance templates and safety netting will roll out in Q1.
- Prototype of the primary care cancer dashboard.

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 (Oct-Dec 2023).

- Breast: **89.2%** diagnosed / ruled out in 28 days (goal 92%)
- Lower GI: **51.2%** diagnosed / ruled out in 28 days (goal 62%)
- Skin: **78.3%** diagnosed / ruled out in 28 days (goal 85%)
- Urology: **48.0%** 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-October 2023, CM GP practices reported 56% of lower GI urgent GP cancer referrals with a FIT within 21 days before the TWW, compared with 64% in England. For CM this is an increase from 54% in April-September 2023. November data release was delayed at national level.
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

- Challenges in identifying clinical leadership for the breast cancer optimal pathway has delayed pathway finalisation and approval.
- Implementation of activities to further enhance the delivery of skin cancer optimal pathway have been delayed pending the recruitment of a project manager (now in post).
- Long term sustainability of NSS services and FIT remain a challenge pending the conclusion of commissioning discussions and receipt of confirmation of funding from the ICS for the latter.

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 February 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.
- 100% roll-out of NSS services across Cheshire and Merseyside is now complete, with the final service in Liverpool University Hospitals Aintree site opening on 5th February 2024.

Key activities in the next six months

- Establish a comprehensive lung cancer improvement programme under the guidance of the Lung CQG. A dedicated project manager is now in post to lead work on MDT Optimisation and pathway improvements, as well as overseeing projects as part of the wider CMCA programme.
- Finalise and mobilise the 2024/25 Faster Diagnosis and Early Diagnosis Pathways Programmes aligned to national and local priorities, with a focus upon improving operational performance.

Health Inequalities and Patient Experience: Highlights since last report

Demand for HIPE support across the system

We are in demand for training, advice, development of services, consultation and offering patient voice. Our Fresh approach has ensured we are very busy. The Planning Guidance has included a Health Inequality "golden thread" throughout the guidance. This is amazing progress, adding increased demand, but with significant impact..
We are reaching into research, offering advice on Non-responders, trial designs, into education, supporting the undergraduate programmes at Uni of Liverpool, Clinical trials with patients supporting trial design whilst remaining true to our regional health

123 Approach

The 123 approach will be introduced at board. This is our ambitious training approach regarding Health Inequalities that we would like to see delivered to every member of staff linked to cancer.

1. Training, both F2F and new e-learning, capturing patient voice and sharing both barriers, and actions from patients and staff to remove them. Powerful stuff!
2. Resources, we are designing a range of resources and capturing real life examples of tackling HI and sharing them across the system
3. Support, offering advice consultancy support and empowerment for our staff to take action to change one thing to tackle inequality.

Wider system

ECMC, most regional Trusts, CMAST, Diagnostics, Mental Health Services, SALT teams, Clatterbridge, Macmillan are a few of the wider system organisations we are supporting around Tackling Health Inequality

CMCA roadshows 2024

Venue planning has commenced and all documentation ready to go. September and October will be Roadshow months in 2024. Roadshow 2023 Evaluation to be presented at Board.

Patient Engagement

There are currently 46 patient representatives, 70% of which are actively contributing to CMCA projects alongside collaborative work with other trusts. The patient representative group has seen a slight decrease in numbers over recent months, mainly due to changes to personal circumstances and ill health. 24/25 planning has begun, ensuring that increasing engagement with our diverse population is a main priority, working to recruit additional patient representatives from all walks of life.
Storytelling work is ongoing and a library of stories is now available to all CMCA staff, ensuring patient involvement in CMCA projects, meetings and education. The readers panel profile has significantly increased and they have reviewed 12 documents from CMCA and other trusts so far this year with requests continuing to be made. The Patient Engagement Team have co-designed a patient experience survey with 14 patient representatives and LCNs which will be rolled out in all trusts in Summer 2024.
The team are continuing to raise awareness of the importance of patient engagement within CMCA, presenting at team meetings, the Health Inequalities staff network and HIPE Champion meetings.

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. The wider system wants HIPE support for patient engagement, service design, evaluation, approaches to care and more training.

Key activities in the next six months

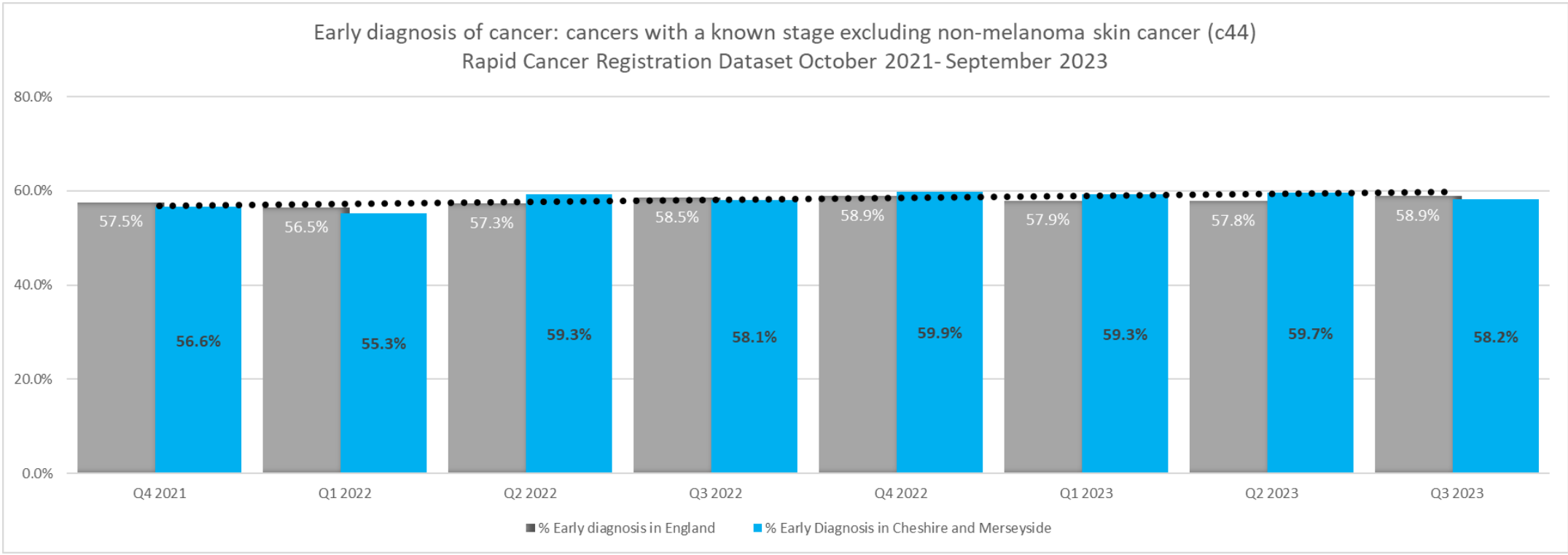
Section iii:

Early diagnosis of cancer

Cheshire and Merseyside Cancer Alliance

NHS

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



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, **58.3%** of Cheshire and Merseyside cancers were diagnosed at an early stage in the last two years, this is **statistically similar to England** (57.9%)
- Early diagnosis in Cheshire and Merseyside has increased from 56.6% in Q4 2021 to 58.2% in Q3 2023.

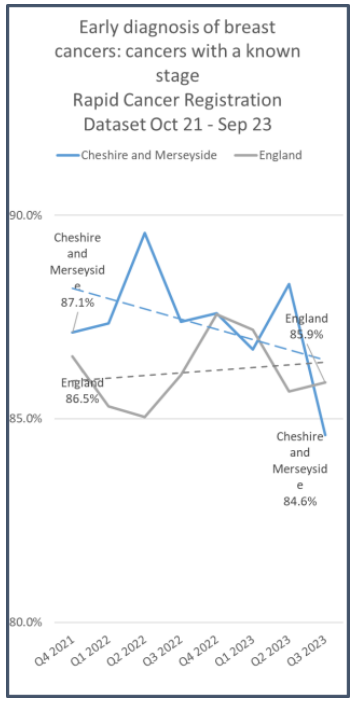
Source: Rapid Cancer Registration Dataset, CancerStats2

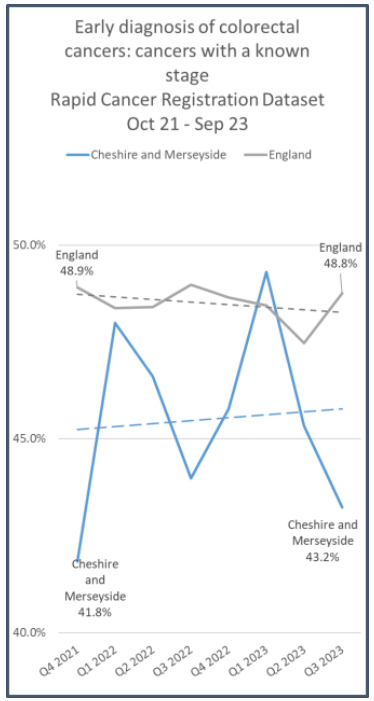
Cancer stage at diagnosis: Rapid Cancer Registration Database (RCRD)

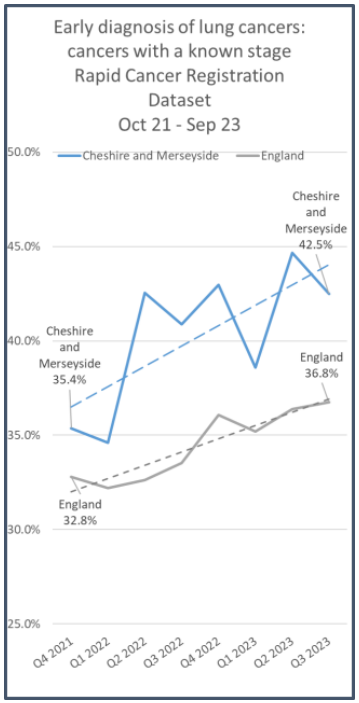
Average percentage early diagnosis: Oct 21 – Sep 23

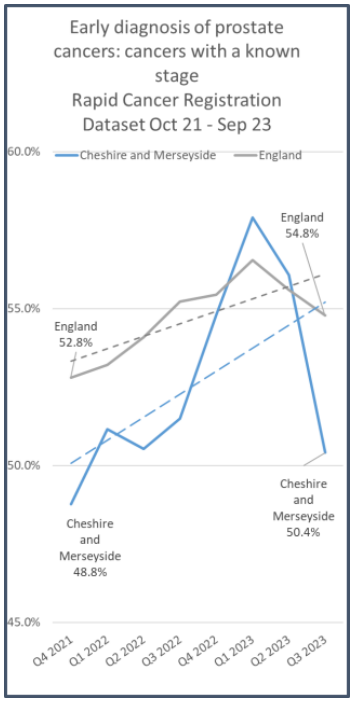
Area	Breast	Colorectal	Lung	Prostate	Other
Cheshire and Merseyside	87.4%	45.5%	40.3%	52.9%	62.4%
England	86.1%	48.5%	34.4%	54.8%	61.2%

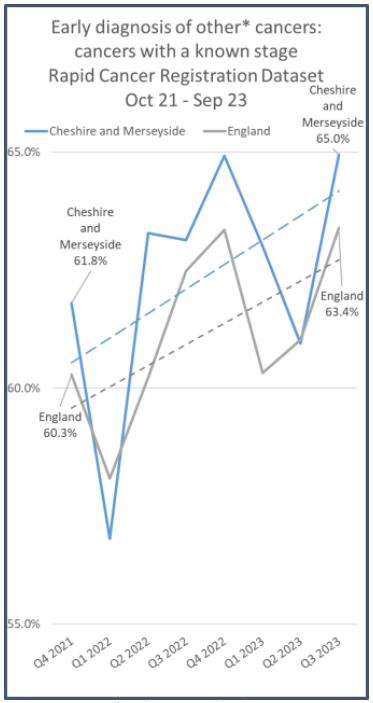
The most recent data from RCRD is up to September 2023. Over the past two years (24 months), early diagnosis rates in Cheshire and Merseyside have been above the England average for breast, lung and other* cancers. Colorectal and prostate cancer rates were below the England average,(prostate cancer early diagnosis rates were above the England average in Q1 and Q2 2023).











Source: Rapid Cancer Registration Dataset, CancerStats2

*Other excluding non-melanoma skin cancer

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board – 28th February 2024

Chair's Report for: Audit Committee

Date/Time of meeting: 18 January 2024

			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	**Internal Audit Report** The Committee received the Internal Audit Progress Report which provided details of the following audits and outcomes: Key Finance Systems – received Substantial Assurance and confirmed that there is a good system of internal control designed to meet the system objectives. Threat and Vulnerability Management – received Substantial Assurance and highlighted good evidence of internal controls including evidence that cyber security awareness training is taking place. **Director of Finance Report** The Trust is forecasting that it will deliver its revised financial target position for 2023/24. During November, Cheshire and Merseyside ICB requested that organisations improve their financial positions if possible. The Trust increased its plan from £343k surplus to £1,860k surplus. This was discussed and agreed at an Extra-ordinary Trust Board in November, and is based on an improved financial run-rate from across the Clatterbridge Group. **Ant-Fraud Progress Report** The Committee received an update on the progress of the work of the Trust's Anti-Fraud Specialist (AFS), against the Anti-Fraud Plan. It was reported that the NHS Counter Fraud Agency planned to visit the Trust on 25th January to review the Trust's use of the case management national database. Three referrals were received during quarter 3 and these related to: a member of staff working whilst off sick from their role in another trust, an

alleged theft by a service manager and an alleged patient fraudulent letter. All three referrals have been added to the national database.

Financial KPI's

- The Committee reviewed the key financial assurance indicators and noted the positive position across the range of indicators:

Better Payment Practice Code

NHS

- Performance remains high, significantly above the required 95% of invoices paid in 30 days for all months except September. In September one invoice for £98k was paid on day 33. The Trust is looking into the reason for late payment which appears to be due to a systems/processing issue with the purchase ledger. This meant we failed the required 95% by value, but not volume as the issue related to a single invoice.

Non-NHS

- Performance remains high above the required 95% for all months except October. There had been a large number of unaccounted invoices with a Research and Innovation transport supplier. The issues with this supplier were resolved and they were all paid in October but were paid later than the 30 days target.

Aged Debtors

- The level of NHS debt outstanding for over 90 days has reduced, with 26 invoices totalling £144k, the majority of which relate to one provider and will be picked up as part of discussions to review the Service Level Agreement between the parties.

- The level of Non-NHS debt over 90 days at the end of November was £707k (99 invoices), £211k of this relates to charges linked to the Clatterbridge private clinic and the majority of the remaining balance relates to commercial trials activities. The Finance Team are actively working to resolve these.

Aged Creditors

- Both the NHS and Non-NHS position is positive which continues to support the high Better Payment Practice achievement.

NHS

- There are 3 invoices totalling £349k over 90 days.

- *Non-NHS*
  - There are only 7 invoices outstanding over 90 days totalling £8k.

Accounting Timetable 2023/24

NHS England have not yet formally published the key submission dates for the 2023/24 Annual Report and Accounts. However, the Trust has formulated a draft plan for the year-end using the 2023 timetable as a guide. The Audit Committee will review the draft reports at its meetings in April and May 2024.

Tender Waivers

- The Committee noted the Tender Waiver Register which provided details of waivers approved in Q3 23/24. A total of eleven waivers totalling £1.948m were signed off in Q3 23/24 where the value of the contract exceeded £50k (inc. VAT) and included ten retrospective tender waivers. Five quotation waivers were also signed off in Q3, totalling £156k (including VAT). The most common reason for the waivers related to the specialist character of the goods or services required meaning it is not possible or desirable to obtain competitive quotations.

Cyber and Information Governance Quarterly Update

- The Committee received the quarterly update on Cyber Security and Data Security Assurance that outlined the work completed in the reporting period. The Trust has received its formal certification for ISO27001 accreditation for all sites. This is a huge accolade for the Trust and demonstrates our commitment to data security to our stakeholders.

- **Microsoft Defender Endpoint (MDE) status -** Microsoft MDE is a tool that measures the Trust's security posture in real time and is closely monitored by NHS England. A monthly report is delivered outlining the security position for all Trusts in England. In November 2023 the trust remained at the top of the posture table for Cheshire and Merseyside.

- The national data also shows the Trust's position as the most secure for the virtual desktop estate, and in the top 25 for desktops and laptops.

- The Committee reviewed the Board Assurance Framework risk BAF14 that relates to Cyber Security. The Committee noted and approved the residual risk score of 12, which remains unchanged due to the dynamic nature of the risk.

The Clatterbridge Cancer Centre NHS Foundation Trust

	Code of Governance Checklist • The Committee noted the progress against the compliance requirements set out in the revised Code of Governance for NHS Provider Trusts. Good progress has been made across the majority of the principles where non-compliance gaps were previously identified due to work progressed in relation to the composition of the Council of Governors and the role of the Remuneration Committee. Work will continue on the outstanding non-compliance areas over the coming quarter to enable compliance by the end of the financial year.
Items of concern for escalation to the Board	None

Items of achievement for escalation to the Board	• The Committee noted positive assurance in relation to the follow-up actions from three audits for which the Committee had asked for specific progress reports to be produced. James Crowther, Head of IT, Joan Spencer, Chief Operating Officer and Owen Smith, Managing Director of PropCare attended the meeting to provide detailed updates in relation to a number of technical matters for the audits:
	
	  • Critical Apps (estates) 2022/23
	  • Medical Devices year 2021/22
	  • IT Service Continuity and Resilience 2020/21
	
	• The Committee noted that the Trust has delivered its Cost Improvement Programme for 2023/24 and achieved the annual efficiency target. This significant achievement has resulted in year-to-date savings of £8,300k, against the annual target of £8,249k.

Items for shared learning	There were no items for shared learning.

The Clatterbridge Cancer Centre NHS Foundation Trust

Trust Board 28th February 2024

Chairs report for: Charitable Funds Committee

Date/Time of meeting: 20 December 2023

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

Items of concern for escalation to the Board	**Audit findings**
Items of achievement for escalation to the Board	The Committee received and approved the final part year accounts of the Charity for year ending 31st March 2023 prior to submission to the Charity Commission on 31st January 2024. The covering Annual Report reflected the utilisation of the charitable funds to fund life-saving research & technology, enhancing the patient environment and enabling innovations in care for all of our patients. The Committee reviewed the Report of the Auditor which concluded that the financial statements gave a true and fair view of the state of the charity's affairs as at 31 March 2023 and of its incoming resources and application of resources. It confirmed that for the year then ended the financial statements have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and had been prepared in accordance with the requirements of the Charities Act 2011. The Committee noted an unadjusted misstatement of £10,873 as an error on post year end payment test due to the request for a certain donation to be refunded In terms of the going concern basis for the accounts, the auditor concluded that the trustees' use of the going concern basis of accounting in the preparation of the financial statements was appropriate and there were no matters to report in respect of exceptions identified within the Charities Accounts ad Reports Regulations 2008. The Committee confirmed that they were happy for the Chair of the Trust to sign the Letter of Representation.

The Clatterbridge Cancer Centre NHS Foundation Trust

Items for shared learning	No Shared Learning was identified

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Public Trust Board
Date of meeting: 28th February 2024

Report lead	Jane Hindle, Associate Director of Corporate Governance				
Paper prepared by	Jane Hindle, Associate Director of Corporate Governance				
Report subject/title	Governance and Escalation Framework				
Purpose of paper	In response to a letter from NHS England in August 2023 NHS trusts were required to provide assurances in relation to their governance arrangements and to ensure that matters in relation to patient safety have a clear route for escalation and receive independent challenge by exception. A high-level summary of the Trust's arrangements was presented in September 2023 and it was agreed that a more detailed document would be developed and reported at a future date. The attached framework draws on the sources of information and processes within the Trust that enable a "ward to Board" view. It describes the responsibility and accountability for the Trust's governance structure and systems through which the Board receives assurance or escalated concerns/ risks related to quality of services, performance targets, service delivery and achievement of strategic objectives				
Background papers	Assessment of the Trust's governance arrangements September 2023				
Action required	For discussion and approval				
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 – Not applicable						
The content of this paper could have an adverse impact on:	Age	No	Disability	No	Sexual Orientation	No
	Race	No	Pregnancy/Maternity	No	Gender Reassignment	No
	Gender	No	Religious Belief	No		

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOREPO
Review: July 2025
Version: 2.0

Governance and Escalation Framework

Author:	Associate Director Corporate Governance
Date:	February 2024
Review Date:	February 2025

1. INTRODUCTION

1.1 The Clatterbridge Cancer Centre Foundation Trust has developed a range of policies, systems and processes, which, when drawn together, comprise a robust framework for the assurance of quality and escalation of risk within the Trust.

1.2 This document describes the risk escalation and assurance framework and demonstrates how the Trust's risk systems and learning from events is monitored by an effective committee structure. It also illustrates how this process links to the Care Quality Commission's requirements for registration and the NHS Oversight Framework.

1.3 A robust governance framework is essential as it provides assurance to the Chief Executive, the Trust Board, the Council of Governors, senior managers and clinicians that the essential standards of quality and safety are being met by the organisation. It also provides assurance that the processes for the governance are embedded throughout the organisation.

2. PURPOSE

2.1 This framework describes the responsibility and accountability for the Trust's governance structure and systems through which the Board receives assurance. It addresses under-performance, the process for the escalation of concerns or risks related to quality of services, performance targets, service delivery and achievement of strategic objectives and ensures that potential performance problems are identified early and rectified.

2.2 The framework sets out or signposts the Trust's policies, systems and processes and should be read in conjunction with the Trust's:

- Scheme of Delegation and Reservation
- Terms of Reference for Board Committees and relevant executive level assurance committees
- Risk Management Strategy
- Quality and Learning Strategy
- Board Assurance Framework
- Performance Management Framework
- Non-Executive Director Walk-rounds Process
- Reportable Issues Log

2.3 This Framework is intended to be a dynamic process that will be reviewed on an annual basis in order to reflect any changes in governance, assurance and escalation processes.

3.DEFINITION OF QUALITY

3.1 The Trust's Quality Improvement and Learning Strategy references the common and enduring definition of quality care is that of Darzi (2008) who stated that; *"High quality care should be as **safe** and **effective** as possible, with patients treated with **compassion**, **dignity** and **respect**.*

*As well as clinical quality and safety, quality means care that is **personal** to each individual."*

4. CULTURE

4.1 The Quality Improvement and Learning Strategy is written within the context of this definition whilst also acknowledging the national guidance 'Developing People, Improving Care' published by NHS Improvement in 2016 which urged NHS organisations to nurture compassionate and inclusive leadership and to invest at scale in improvement skills across the workforce as a whole.

4.2 The Trust has an open, honest and learning culture, which is described in its "*Freedom to Speak Up (Raising Concerns)*" policy. The Trust encourages the reporting of all adverse incidents by its staff and the reporting of complaints and concerns by patients, their carers and relatives.

5. RECEIVING ASSURANCE AND IDENTIFYING CONCERNS

5.1 The Trust has a number of systems and processes that support the delivery of high quality care and ensure good governance. These processes enable those responsible for delivering, monitoring and receiving care to provide assurance to the Trust Board and also identify and raise concerns.

5.2 Staff Involvement

The Trust has a number of policies and mechanisms that encourage staff at all levels to be involved in performance monitoring and to raise concerns about any risk issues. These include:

- Freedom to Speak Up (Raising Concerns in the Workplace) Policy
- Duty of Candour and Being Open Policy
- Risk Management Policy
- Complaints and Concerns Policy
- Incident Reporting Policy
- Reporting and Management of Serious Incidents Policy
- Safeguarding policies and procedures
- Staff Induction
- National staff surveys
- Quarterly Pulse Surveys
- Travel Survey
- Staff Partnership Forum/ Monthly meetings with staff side organisations
- Staff Networks LBGT+, Ethnic Diversity, Menopause and Disability and Long Term Conditions
- Various staff communications including monthly Team Brief and weekly bulletin
- Staff stories to committees and Trust Board
- My Appraisal – Appraisal/Personal Development Process
- "In your shoes" – executive job shadowing

- Operational Performance meetings (weekly)
- Quarterly Performance Review meeting for Divisions and corporate functions
- Health & Safety Committee
- Care Quality Commission compliance with registration reports

5.3 Patients/Relatives/Carers/Public Involvement

The Trust has a Public Involvement and Engagement Strategy (including associated implementation plans) that direct the development of its engagement and involvement with patients and carers. The Trust encourages patients, carers and the public to make comments and/or raise concerns both formally and informally via a number of mechanisms, such as:

- Patient Advice and Liaison and Complaints Team
- Compliments
- Complaints – both formal and informal
- Patient experience surveys
- Patient Stories presented to committees and at Trust Board
- Health Watch
- NED and Governors walk rounds
- Local Authorities – Health Overview and Scrutiny Committees
- Patient focus groups
- Patient Led Assessments of the Care Environment (PLACE)
- Patient Facing Staff
- Patient representatives in a range of Trust activities

5.4 Internal and External Sources of Assessment and Assurance

In addition to the processes and sources of assurance identified above, the Trust Board typically gains assurance from numerous internal and external sources. Each committee manages these assurances through the terms of reference and cycle of business. This includes:

Internal

- Board Committee Chair's Assurance Reports
- Integrated Performance Report
- Reportable Issues Log
- Chairs Report/Minutes (of key meetings)
- The Annual Quality Account
- Internal Audit Reports
- Local Counter Fraud Report
- Incident Report
- Complaints & Concerns Report
- Patient Experience Report
- Practice Improvement & Lessons Learnt Report
- Patient Led Assessments of the Care Environment (PLACE) inspections
- Patient Safety Investigation Framework

- Clinical Audit Reports
- Equality Delivery System 2 assessment
- Workforce Race Equality Standard and Workforce Disability Standard Assessment
- Equality
- Research Audit Reports
- Green Plan Quarterly Reporting
- Equality Impact Assessments
- Annual Governance Statement
- Data Security and Protection Toolkit
- Cost Improvement Programmes / Quality Impact Assessments
- Evaluation and Review of documents relating to the Board Committees
- Exception Reports (ie. Mortality, IPC)

External assessments, reviews and benchmarking

- National Staff Survey
- External visits/inspection reports
- National Audits reports
- Independent Reviews (eg. Ombudsman Reports)
- National Inpatient Survey
- Annual Audit Letter
- External Audit reports
- National Patient Satisfaction Surveys (Friends & Family Test)
- PLACE Inspection reports
- JACIE accreditation
- ISO 9001:2015 Radiation Services
- Quality Standard Imaging (UKAS)
- ISO: 27001, Cyber Security Standards
- Digital Maturity Assessment
- Healthwatch reports

The Trust also commissions additional external reviews of activities, services and events where a need for independent assessment and assurance has been identified.

5.5 Commissioners & Regulators

In addition to the internal routes for raising concerns and escalating risk, there are formal mechanisms which can be used by key stakeholders eg. Commissioners and regulators to raise concerns:

- CQC Relationship management meetings
- Contract and performance review meetings with ICB and Specialist Commissioners

- Specialist commissioning meetings
- Liverpool Joint Committee meetings Exec to Exec
- Cheshire and Merseyside Acute and Specialist Trusts (CMAST) meetings
- NHS England's formal response to Trust quarterly submissions
- Learning from Patient Safety Events (LFPSE previously NRLS)
- Escalation to the MHRA or Research Ethics Committee if required and as per the clinical trials contract
- North West Pharmaceutical Quality Assurance and Procurement Team

5.6 Monitoring Compliance with Care Quality Commission (CQC) Essential Standards

The Trust has a Quality, Experience and Standards Division that acts as a central compliance team to ensure the Trust has effective assurance processes in place. To enhance current processes the Team are working to produce a meaningful accreditation framework to enable the inpatient ward teams to evidence the quality of care they are providing, with a clear structure to celebrate success and recognition.

The framework will incorporate fundamentals of care with the measures relating to CQC standards. The framework will be co-produced by a cross-section of ward staff and multi-professional colleagues

5.7 Clinical Audit

At the start of the financial year the Quality Committee reviews an annual clinical audit forward plan of priority clinical audit activity for the Trust. This takes account of national, regional and local requirements. The National Healthcare Quality Improvement Partnership Clinical Audit Programme Guidance tool (HQIP, 2009) is used to prioritise audits.

The tool consists of four levels:

- Priority level one – External 'must do' audits
- Priority level two – Internal 'must do' audits
- Priority level three – Divisional priorities
- Priority level four – Clinician interest

The Medical Director in conjunction with the Chief Nurse will provide clarity regarding the priority levels of audits when required.

The clinical audit forward plan consists of priority level one and two audits and a number of standard items i.e consent to treatment. It is considered by senior leadership teams prior to submission to the Quality Committee for approval.

The Clinical Audit Plan is triangulated against the risk register during the year to ensure congruency of risk entries and completeness of assurances arising from clinical audits.

5.8 **Research Audits**

The Research and Innovation Directorate has an internal audit programme as per Good Clinical Practice requirements for the conduct of research. This is led by the Research Quality Manager and reported through the R&I Directorate Board.

5.9 **Internal Audit**

Developed at the start of each financial year the internal audit plan seeks to ensure the strategic risks identified within the Trust are subject to adequate testing and review.

The Internal Audit forward plan is predicated on the strategic risks identified within the Board Assurance Framework, has input from Board Directors, and is reviewed in detail by the Audit Committee.

Executive Directors flag-up additional concerns, issues and emerging risks throughout the lifecycle of the plan. Where appropriate these are incorporated into the internal audit plan.

6. TRUST INTERNAL SYSTEMS FOR MONITORING QUALITY, PERFORMANCE, DECISION MAKING AND ESCALATION

The Trust operates a process of 'distributed leadership' through each of the divisions. A 'Ward to Board' structure showing the relationship between clinical teams and the Board is included as Appendix x. Each Clinical Division has its own structures for governing quality from clinical teams to directorates/localities to support the corporate structures and processes.

Processes for monitoring performance, managing risk, receiving assurance and escalating concerns are outlined below. These processes commence at team level and managers and Executive Directors provide assurance or escalate concerns through the organisations structures.

6.1 Board Level Oversight

The Trust has a number of fora where performance is discussed, Performance Committee, People Committee, Quality Committee, Trust Executive Group, Performance Review Group Meetings for each division and corporate services, Transformation and Innovation Committee and weekly Operational Performance Group.

6.2 The Board receives an Integrated Performance Report at each meeting. It details a range of indicators with the most recent month's performance against target on a RAG rated basis. The content of the report covers those areas of performance and quality that have been reported through the escalation process and/or which are subject to scrutiny by commissioners.

Any areas of adverse performance are reported to the Board via exception reports contained within the Integrated Performance Report. Each Board Committee also reviews the relevant elements of the report.

6.3 The **Quality Committee** receives information and intelligence relating to all aspects of quality, safety, risk and regulation, and patient experience. Reporting is on an exception basis and any significant risks or issues are reported through to the Trust Board either via the Committee Chair's Report or the Board Assurance Framework which is submitted quarterly to the Board.

6.4 The **Performance Committee** receives exception reports on key performance targets and national core standards. The exception reports also provide assurance against the steps being taken to ensure compliance is achieved. Any significant risks or issues are reported through to the Trust Board either via the Committee's Assurance Report or the Board Assurance Framework which is submitted quarterly to the Board.

6.5 The **People Committee** provides oversight delivery and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust.The Committee reviews the KPI's within the Integrated Performance Report relevant to its remit and reports by exception to the Trust Board.

6.6 The **Trust Executive Group,** chaired by the Chief Executive provides oversight of all areas of the Trust's Strategy supported by a number of management groups. Areas of significant concern relating to safety and risk are discussed at the Risk and Quality Governance Committee and escalated, as appropriate, to the Trust Executive Group. The Group is supported by a number of other groups – see appendix A.

6.7 The **Transformation and Improvement Committee -** is established to provide information and assurances to the Trust Executive Group that all matters relating to transformation and operational improvement are being managed

6.8 The **Operational Performance Group** meets on a weekly basis and reviews the Access and Efficiency KPI's within the Integrated Performance Report (IPR) by exception and also monitors activity data for each SRG to understand operational challenges and appropriate mitigations for referrals, OP capacity, diagnostic imaging capacity and inpatient capacity and flow. Any issues are escalated to the Transformation and Improvement Committee.

6.9 **Divisional Assurance Boards**

Performance is managed at a local level through monthly operational performance meetings which are chaired by the Divisional Director. Each division considers its performance against key performance targets and reviews the performance of individual teams within the division against these indicators. Where performance issues are identified, outlying teams are identified and actions plans developed and implemented to address the issues. The flow of information from individual wards through this structure and up to the Committees of the Board can be seen at appendix B.

6.10 The **Performance Review Group** (PRG's) quarterly meetings are chaired by the Chief Operating Officer and attended by other Executives. These are 'Board to Board' style sessions with each division to ensure that they are held to account, challenged and

supported by the Executive Team. The PRGs form a key part of a system of escalation and oversight used to monitor and improve performance. This process is described in the Performance Management Framework. The outcomes from the PRGs are reported monthly to the Trust Executive Group (TEG) via a chair's report, for information and assurance; to ensure risks are captured and actions are appropriate.

6.11 **Cost Improvement Plans -** The Trust has in place a process for the development and monitoring of Cost Improvement Plans (CIP) via the submission of a completed template for each individual CIP scheme including a Quality Impact Assessment (QIA).

Each proposing manager completes a form that sets out the detail of the CIP and includes an assessment of risk to the quality of services by implementing the scheme.

Stage 1: QIA completed by the Scheme Owner, proposing the CIP and submitted for review and initial assessment by the Divisional Director/Corporate Director, Divisional Nurse and Senior Finance Business Partner. The assigns a risk score based on the individual risks to:

i. Patient Safety
ii. Clinical Effectiveness
iii. Patient Experience
iv. Workforce

Stage 2: QIA reviewed, assessed and signed off by the Medical Director and Chief Nurse..

Stage 3: QIA reviewed and approved by the above process is added to the CIP tracker and discussed at the Finance Committee ensuring a robust clinical and financial challenge independent from the proposing manager.

Any risks identified during implementation are reported via the process defined within the Risk Management Policy.

6.12 **Data Quality -** Data is processed by the Business Intelligence Team, and is reviewed prior to inclusion in reports to ensure it is accurate. Data is produced in line with the NHS Data Dictionary that provides guidance on data collection and relevant returns to assist in standardisation across providers

The **Integrated Performance Report** contains a range of data across quality, safety, research and innovation, performance, workforce and finance.

The data is validated via various operational fora and it is tested by the relevant Performance Review Group meetings on a quarterly basis, which are attended by the senior leadership team of each Division to review delivery against the key performance indicators/metrics identified by the Board, our commissioners, and our regulators.

The Data Management Group oversees the implementation of the Data Quality Policy within the Trust. Through regular reports, it ensures compliance with statutory requirements and

guidance issued in respect of records management and data quality including information Quality Assurance Standards. It also provides an opportunity to Identify and mitigate any risks associated with health records and data quality.

6.13 **Executive and Non-Executive Director Walk-rounds**

Executive and Non-Executive Directors conduct a programme of visits to clinical areas and corporate areas. Whilst those conducted by Non-Executives and governors focus on patients the Executive visits have a focus on quality and safety from the perspective of staff. These visits are conducted using the principles of the NHS Institute's '15 Steps Challenge. The visits enable staff and patients to provide direct feedback to Board members.

There are a number of aims for these visits, including:

- Experience the initial welcome and gaining overall impression on entering premises;
- Providing an opportunity for frontline staff to talk about their services;
- Meeting patients and carers to gain an insight into their experience of care
- Understanding Quality and Safety from the perspective of staff
- Observing compliance with Trust policy and procedures;
- Observing clinical and non-clinical premises;
- Identifying any areas for improvement and working with staff to continuously improve the quality of care provided, addressing both patient and staff concerns;
- Noting the effectiveness of overall communications within the organisation;
- Raise the profile of the Board, its role in leading the organisation and delivering key messages in person.

The visiting board member is required to complete a feedback form after each visit, the outcome of which is recorded and presented to the Quality Committee, and the Trust Board.

Any significant concerns are escalated within a specified timescale to the relevant manager. Feedback focuses on good practice to share, and areas for improvement. The visits by board members are repeated on a regular basis, to cover all clinical areas and to ensure that improvements are being progressed. An analysis report summarising the main emerging themes is provided to the Quality and Committee and the Trust Board at each meeting.

6.12 **Quality Improvement and Learning Strategy**

The Trust has in place a Quality, Improvement and Learning Strategy 2023-25, directed at achieving the best quality care and outcomes for our patients. The strategy outlines the plans, focused around 4 key priorities for improving quality linked directly to the Trust's strategic objectives. It also contains key milestones to enable us to make the best use of digital resource, research evidence, national policy and our dedicated staff to drive continuous improvement.

Staff are involved in setting the quality priorities through the annual business planning process, via the governance committee structure and the Bright ideas scheme.

Progress of implementation of the strategy is overseen by the Quality Committee.

6.13 **The Trust's annual Quality Account**

The Quality Account provides a report to the public about the quality of the services the Trust provides and the progress against its strategic and annual quality objectives. It provides an opportunity for scrutiny on how the Trust performs in relation to quality and sets out the focused areas for quality improvement for the forthcoming year. Assurance is obtained on the Trust's Quality Account from commissioners and Healthwatch.

6.14 **Compliance with Regulators**

Care Quality Commission

The Trust has systems in place to ensure adherence to CQC registration. Overall compliance to registration requirements is monitored through the governance process and reported to the Quality Committee. .

The Quality Committee receives exception reports on any areas of non- compliance or with compliance concerns. The exception reports also provide assurance against the steps being taken to ensure compliance is achieved.

6.15 **Risk Escalation Framework**

Risks are assessed using the methodology described in the Trust's Risk Management Policy.Risk assessments are entered onto the Datix Risk Management System to inform the organisation's risk registers. All staff with responsibility for risk assessment have access to the register relating to their areas of responsibility and the Risk team provide scrutiny to the register to ensure consistency.

The Trust has three levels of operational risk registers - the Local Risk Register, the Divisional Risk Register and the Corporate Risk Register. Further details relating to the risk registers can be found in the Risk Management Strategy and the Risk Policy, both documents are held on the intranet.

6.16 **Board Assurance Framework (BAF)**

The Board Assurance Framework underpins the delivery of its strategic objectives and incorporates the highest risks faced by the organisation. It, therefore, aligns the Trust's principal risks with key controls and assurances for each of the Trust's strategic objectives. Where gaps in assurance are identified, mitigating actions are developed to reduce the risk of non-delivery of these key objectives.

The BAF is reviewed on a quarterly basis by the Trust Board. The Board Committees also receive the BAF to monitor any significant changes and consider this in the context of their cycle of business. The formation and development of the BAF is the responsibility of the Associate Director Corporate Governance (Board Secretary). Strategic risks are identified by the Board and reviewed quarterly on receipt of the BAF and annually against the Trust's strategic objectives.

The Board Assurance Framework provides a vehicle for the Trust Board to receive assurance that the systems, policies and people in place are operating in a way that is effective and focused on the key risks that might prevent the achievement of the Trust's objectives.

The BAF is updated by the Executive Leads on a quarterly basis and reviewed by each of the committees of the Board in advance of submission to the Trust Board.

6.17 **Escalation of Risks through the Reportable Issues Log**

Reportable Issues relate to information which has identified significant issues with quality, safety or organisational reputation. These issues, which are reported outside of the Trust, will be fed into the governance structure, as appropriate. The reportable issues alert informs all Board members of new (ie. since the last Board meeting) issues. They include, but are not limited to:

- Never Events
- Incidents related to death or severe harm
- Care Quality Commission notifications
- NHS England notification
- Regulation 28
- High profile inquests
- Claims
- Complaints – e.g vexatious complainants
- Reporting of incidents/risks to external bodies (eg. Information Commissioner's Office)
- Employment tribunals
- Notifications from professional bodies
- Notifications from local commissioners

This alert is compiled on a monthly basis and considered during the closed session of the formal Board meetings.

In addition to the above mechanisms, any issue identified through the course of the Trust's daily business that pose a significant threat to the Trust and its ability to deliver services is considered by the Chief Executive and Chair of the Trust. The Chief Executive, or nominated Director, will ensure the Associate Director Corporate Governance informs all Directors and Non-Executive Directors immediately of the issue and the risks posed to the Trust.

6.18 **Assuring Board Effectiveness**

There are a number of ways in which the Trust Board assures itself that it is fulfilling its duties effectively. These include:

- Committee and Board effectiveness reviews
- External effectiveness reviews e.g Well-Led
- Annual assessment against the NHS Provider Licence
- Annual governance statement and corporate governance statement within the

Annual Report
- Board Development Sessions
- Scrutiny of Board of Director minutes
- Robust monitoring and follow up of the Board's Action Log
- Board director induction and appraisals
- Monitoring of relevant action plans and sharing of lessons learnt

7. OUTPUTS FROM THE GOVERNANCE AND ESCALATION FRAMEWORK

Using the Information flows defined within the Governance and Escalation Framework supports the Board of Director, both in terms of the development of, and evidence for the following:

- Quality Account
- Annual Governance Statement
- NHS England Provider Licence Compliance Statements
- NHS England Oversight Framework Targets
- CQC Compliance

7.1 Learning Lessons

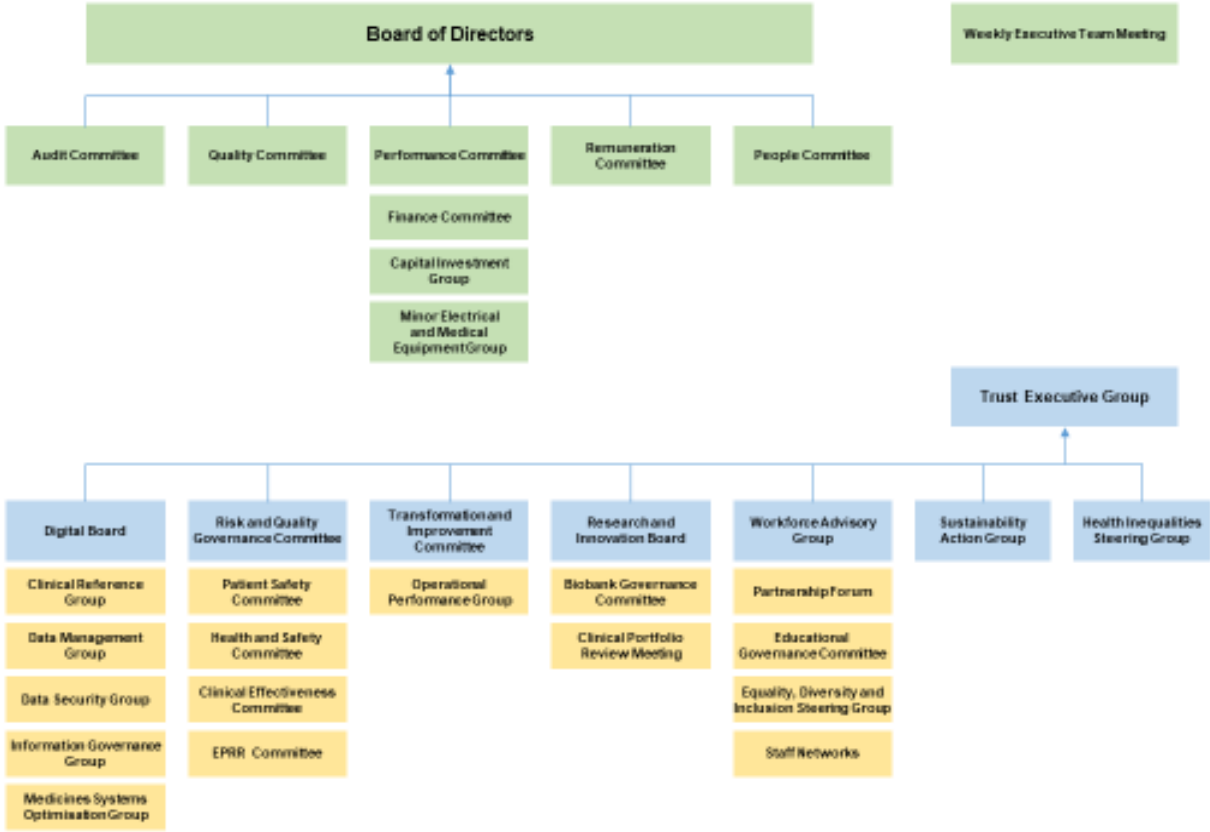
The Trust is committed to learning lessons in an open and transparent way. It does this through the examination of complaints, incidents, serious untoward incidents, staff feedback, patient feedback, internal reports, external reviews, assessments and inspections and the review of national reports and reviews. The themes and learning are then examined via a number of mechanisms and communicated in a number of ways

- Divisional Governance / Assurance Groups
- Trust Board effectiveness reviews
- Team Brief and Trust Communications
- Triangulated complaints, incidents and Serious Incident reports to consider themes and trends
- Freedom to Speak Up reports and themes
- Committee evaluation and review of performance
- Executive Team weekly meetings
- External Visits quarterly report
- Review of SI reports by Commissioners and Regulators and cascade of feedback to clinical teams
- Senior Leadership meetings (including Trust Executive Group)
- Targeted training and development
- Professional Leadership fora
- Operational Management Team meetings

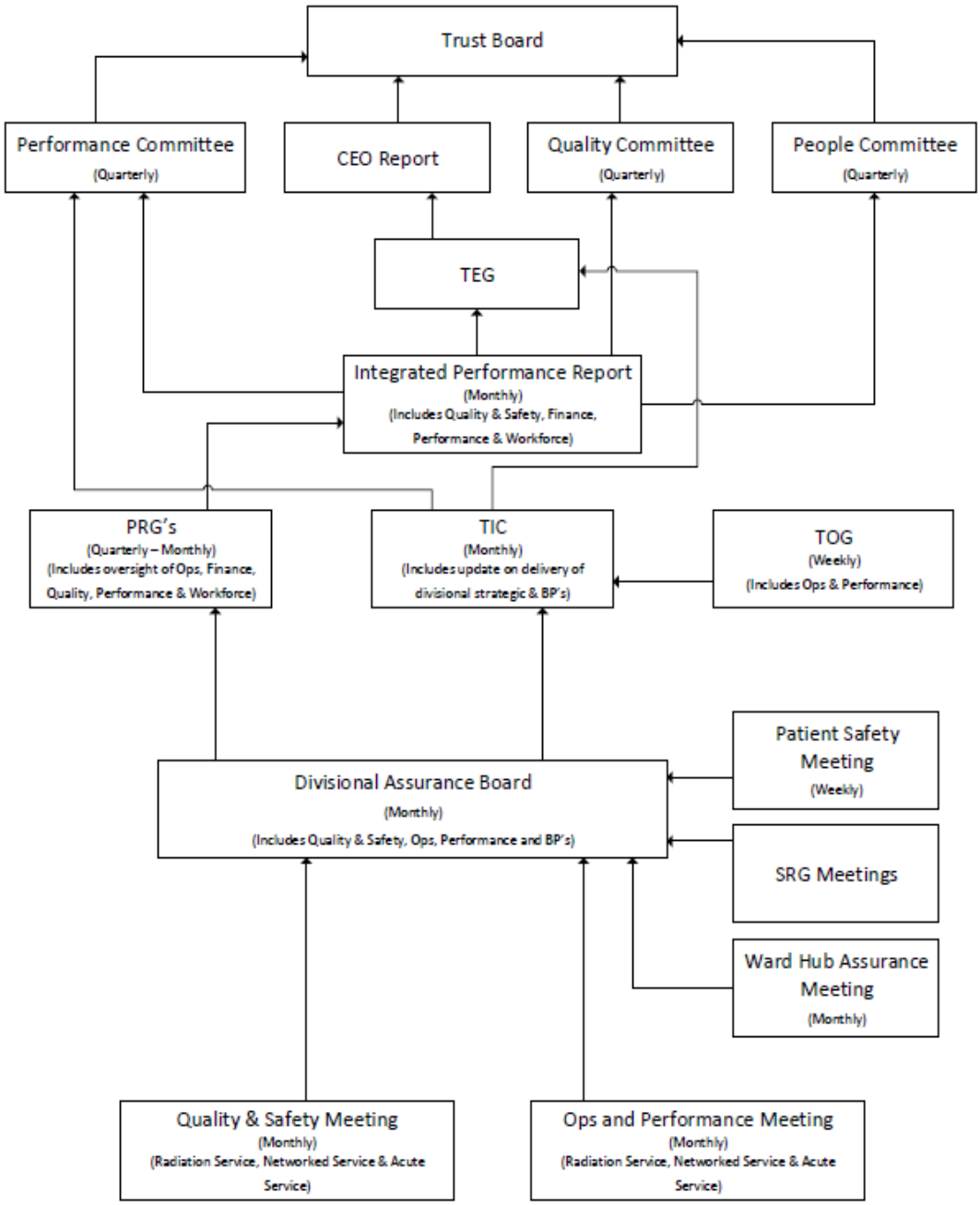
8.0 Conclusion

The Board Governance and Escalation Framework will be reviewed on an annual basis by the Trust Board. To ensure it is effectively utilised, the Board Committees will retain oversight of its implementation through their forward plans, review of issues escalated to them and, specifically, through the review of risk registers by each committee. The Audit Committee will also ensure the framework remains fit for purpose by reviewing, as appropriate, the systems and processes contained within it.

Appendix A


Board of Directors
Weekly Executive Team Meeting
Audit Committee
Quality Committee
Performance Committee
Remuneration Committee
People Committee
Finance Committee
Capital Investment Group
Minor Electrical and Medical Equipment Group
Trust Executive Group
Digital Board
Clinical Reference Group
Data Management Group
Data Security Group
Information Governance Group
Medicines Systems Optimisation Group
Risk and Quality Governance Committee
Patient Safety Committee
Health and Safety Committee
Clinical Effectiveness Committee
EPRR Committee
Transformation and Improvement Committee
Operational Performance Group
Research and Innovation Board
Biobank Governance Committee
Clinical Portfolio Review Meeting
Workforce Advisory Group
Partnership Forum
Educational Governance Committee
Equality, Diversity and Inclusion Steering Group
Staff Networks
Sustainability Action Group
Health Inequalities Steering Group

Appendix B Operational Divisional Structure - Ward to Board



APPENDIX C

RISK MATRIX

Risk Grading = Likelihood x Consequence (impact) (L x C)

		Likelihood				
Consequence score		**1**	**2**	**3**	**4**	**5**
		Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5	**Catastrophic**	5	10	15	20	25
4	**Major**	4	8	12	16	20
3	**Moderate**	3	6	9	12	15
2	**Minor**	2	4	6	8	10
1	**Negligible**	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows (Adapted from NPSA Risk Matrix 2008)

Score	**Level of Risk**	**Level of action**	**Monitoring**
1 - 3	Low risk	Risks subject to aggregated review Use for trend analysis	Risks monitored and managed at Divisional Level and relevant SRG / team / project meetings
4 - 8	Moderate risk	Action planned within one month to reduce risk Commenced within 3 months Review at least quarterly.	Place on the appropriate Divisional Level and relevant SRG / team / project and monitor manage as appropriate.
9 - 12	High risk	Action required immediately Risk must be reviewed monthly.	Divisional review of risk Add to Divisional Risk Register
15 - 25	Extreme risk	Immediate attention required. Risk must be reviewed weekly by Exec Team.	Corporate review of risk through Quality Committee, Performance Committee and People Committee. Add to Trust Risk Register

APPENDIX D

REPORTABLE ISSUES LOG

RISK CATEGORY	Ref	DESCRIPTION	LEAD DIRECTOR	ACTION/UPDATE/ CONCLUSION
Serious Incidents				
Never Events				
Incidents related to death or severe harm				
Regulation 28				
High profile inquests				
High profile claims				
Parliamentary Health Service Ombudsman (PHSO)				
Significant Complaints				
Employment Tribunals				
Notifications relating to professional bodies				
Notifications relating to local commissioners				
Media Interest				
CQC notifications				
NHSE notification				

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Board of Directors
Date of meeting: 28 February 2024

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) updates			
Purpose of paper	To provide an update on the sections of the BAF under direct oversight of the Board (BAF6)			
Background papers	BAF report presented to November Board of Directors; BAF update reports to Performance Committee (February), Quality Committee (December), People Committee (December) and Audit Committee (January)			
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		

WE ARE... KIND EMPOWERED RESPONSIBLE INCLUSIVE

Ref: FCGOREPO
Review: July 2025
Version: 2.0

The Clatterbridge Cancer Centre NHS Foundation Trust

1.0 Introduction

1.1 This report provides key updates about the Trust's strategic risks. It includes key highlights about 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 November, Committees of the Board have received BAF reports as follows:

- BAF2, 3, 5, 8 and 15 reviewed by the Performance Committee 21 February,
- BAF10 and 12 reviewed by the People Committee 12 December,
- BAF1, 7 and 13 reviewed by the Quality Committee 20 December,
- BAF14 reviewed by the Audit Committee 18 January.

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**

At the time of this report, the meeting on the 21st February has not taken place. The Committee will review a proposed score change for BAF 5 (Environmental Sustainability) from (4 x 3)12 to (3 x3) 9.The Committee's response can be found in the Chair's report to Trust Board.

2.1.**2 People Committee**

On the 12th December, the People Committee noted there were no changes to the BAF scores from quarter 2. The Committee agreed, BAF10 (one of the highest scoring BAF risks at a score of 16) should remain at 16, as shown through the retention report received by the Committee.

2.1.3 **Quality Committee**

On the 20th December, the Committee noted there were no changes to the BAF scores from quarter 2. The Committee confirmed they were satisfied with the assurance provided.

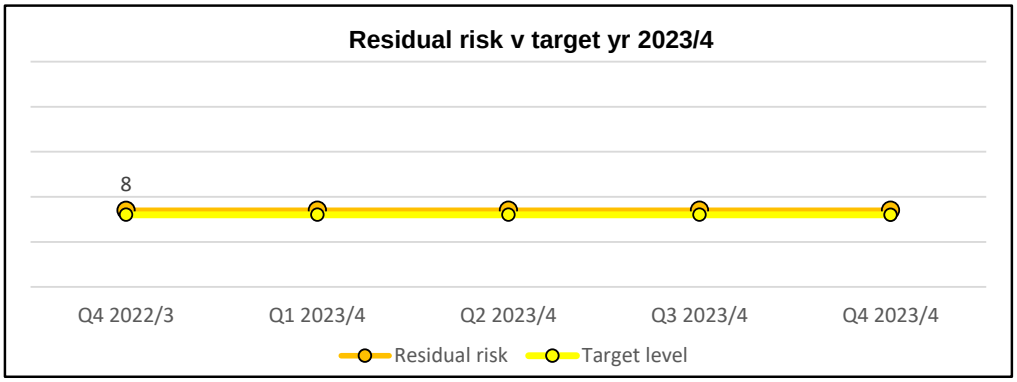
2.1.4 **Audit Committee**

The Clatterbridge Cancer Centre NHS Foundation Trust

On the 18th January, 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.

2.2 The following tables provide summarised information about the two strategic risks 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 Chief Executive **Last Updated:** 15 February 2024	**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% 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	Due Q4 -Complete risk sharing agreement with ICB (March 24)	**8**
Commentary This risk is largely mitigated through the CCC hosting of the Cheshire & Merseyside Cancer Alliance, to enable CCC to influence prevention, early diagnosis and cancer surgery. The recent leadership role and hosting of the Cheshire & Merseyside Diagnostics Programme on behalf of the ICB, gives greater influence over cancer diagnostics, 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. There have been no changes to the risk since the last report.				

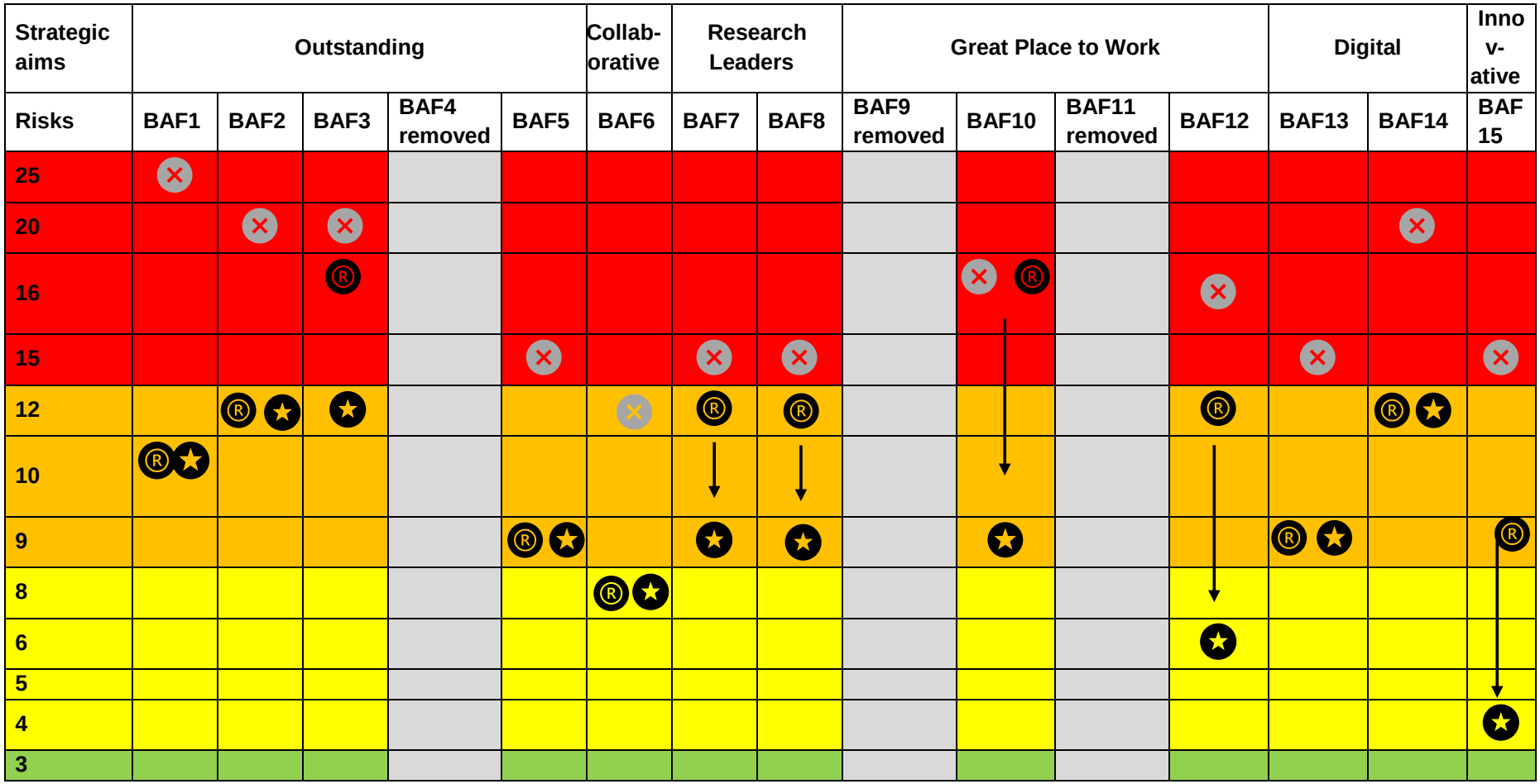


3.0 Recommendations

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.
- Note the full Board Assurance Framework

Appendix 1: Strategic risk heatmap showing initial, residual and target risk scores Q3-4 2023-24



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

BAF1 Quality governance	**BAF6** Strategic influence within ICS	**BAF11** Staffing levels
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	**BAF9** Leadership capacity and capability	**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:13 December 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)) **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	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 and a further 13% reduction from Q1 to Q2. 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	Trust wide compliance with Fall Prevention training remains above 90% The average monthly fall risk assessment compliance remains above 90%. Number of inpatient falls reduced by 29% from Q4 to Q1. And falls with harm remains low. Number of hospital acquired pressure ulcers reduced by 31% from Q4 to Q1, with a slight increase in Q2. 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	
			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:** March 2024 (revised from 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	PSIRF policy and plan signed off at Board September 2023. Patient Safety Lead vacancy	
			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. Pilot of the new acuity tool underway December 2023.	

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?*	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
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:** 05 February 2024	**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/Deputy CEO	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/Deputy CEO Due date: Ongoing Ongoing discussions with COO/Deputy CEOs across C&M via weekly COO/Deputy CEOs meetings **Action Owner:** COO/Deputy CEO **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/Deputy CEO	Oversight & utilisation of escalation processes demonstrated at weekly Patient Tracking List Meeting, weekly Operational Performance Group, quarterly Divisional Performance Review Groups (PRGs) reported via Chair's report to Trust Executive Group	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/Deputy CEO	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 Operational Performance Group. SRG reviews presented to Transformation and Improvement Committee.	Trust activity plans monitored by ICS, monthly reporting back to Trust via hospital cell.			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/Deputy CEO	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/Deputy CEO	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/Deputy CEO	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/Deputy CEO **Due Date:** all reviews completed by 31.03.24	Output of capacity & demand work will be shared at Dec 2023 TIC - Action COMPLETE.	
			C7) Planning, monitoring and recovery meetings for Industrial Action established Control Owner COO/Deputy CEO	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/Deputy CEO Due Date: 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/Deputy CEO	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/Deputy CEO **Due Date:** Complete	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/Deputy CEO	Capacity monitored via weekly Operational Performance Group, Utilisation monitored via ECP Bi weekly					Wait List Initiative spend included in SRG reviews **Action Owner:** COO/Deputy CEO **Due Date:** March 2024	WLI spend is included in the decision making rearding investments.Ongoing March 24	

			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/Deputy CEO	Work programmes to improve service delivery (detailed in Business plans) are reviewed at Trust Transformation and Improvement committee.Updates presented at Trust Executive Group	Activity and service issues reviewed at Contracts meetings with Commissioners monthly			G10) Expansion of workforce is limited by the availability of staff & budget	Prioritisation process in place and funding allocated to areas with pressure. Any WF gaps are risk assessed and mitigation pans are in place **Action Owner:** COO/Deputy CEO **Due Date:**March 2024 (revised from Dec 2023)	SRG reviews commenced Dec 23 - will continue until March 24. This will inform the investment process.	

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)*		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	
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:** 12 February 2024	**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.	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**: **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. Data sets comparison of SUS to SLAM in place with BI.	Commissioner (NHSE/ICB) review of contract performance - quality and financial. NHSE produce ERF calculations and ICB supporting Trusts to verify performance. Latest ERF performance data shared in January 24 and relates to M6 data.			G2) Impact of 23/25 API funding methodology and contracting round to be finally determined. NHSE ERF data upto M6, indicates that the Trust has underperformed compared to plan, which may present income risk. Given the historic nature of The Trust is aware that the ICB and NHSE are seeking to confirm an approach for 23/24 outturn ERF.	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. The Trust is validating its contract activity information to ensure all relevant activity is captured. There is a weekly Task and Finish group that is auditing elective data flow. **Action Owner:** DoF/COO **Due Date:** 29/02/24 (revised from Dec 2023)	Trust has established methodology to understand variable elements of the contract contract performance. The Trust has verified current contract data with NHSE, and an agreed overperformance value has been identified for the Trust (M6). Current levels of performance and contract income are reflected in the Trust's financial position. The Trust is actively planning its activity/income position for 24/25.	
			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. Final recurrent CIP achievement to be identified. 2. Productivity position shared with Trust Board, at January Board Development session. 3. Productivity measures are being considered for inclusion in the Trust's IPR. This will be informed by planning guidance requirements for 24/25. **Action Owner:** DoF/COO **Due Date:** 31/03/24 (revised from february 2024)	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, and in line with ICB expectations. (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	In November, the Trust improved its 23/24 financial plan to support the ICB's risk position. It is on target to deliver the increased surplus target. 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: 31/3/24	Trust is fully expecting to deliver its financial target for 23/24.	
	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:** 31/3/24 (revised from November 2023)	The Trust is not in financial deficit and is not part of the ICB expenditure control regime for 23/24. The ICB is not currently in financial recovery and is aiming to deliver its break-even plan. Should the ICB submit a deficit plan for 24/25, NHSE could require special review measures to be imoplemented. The impact on the Trust is unknown at this point. However, if the Trust submits a deficit plan it will be included in the expenditure control regime for 24/25.	
			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.	Capital demand for 24/25 has been reviewed and included in Trust planning for 24/25 through Capital Committee. This aligns to the Trust's notified capital envelop for 24/25. **Action Owner:** DoF **Due Date:** 31/3/24	24/25 is the final year of current capital process. Howeverr, major changes to establishing capital budgets are not likely.	

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 Risk Score has been increased to 16 (4x4). The probability reflects that the finance plan includes a historic high level of efficiency requirement and uncertasinty on the Trust's contractual perfromance position regarding ERF in Q4.

BAF5 Environmental Sustainability										
RISK APPETITE: Regulatory compliance LOW (tolerance 4-8)										
STRATEGIC OBJECTIVE:	**Be Outstanding**									
Risk description & information	**Causes & consequences**	**Initial (inherent) risk score L x C**	**Key controls** *(what is in place to manage the risk?)*	**Board Assurance** *(evidence that controls are working)*		**Residual (current) risk score L x C**	**Within risk tolerance?**	**Gaps in Control / Assurance**	**Actions**		**Target risk score by 31/03/24 L x C**
				Internal assurance *What/where reported/when?*	**External assurance** *What/where reported/when?*				**Planned action**	**Progress update**	
BAF5 If the **Trust does not integrate environmental sustainability considerations into delivery of its strategic priorities**, it will fail to realise the potential benefits and contribute to the NHS Net 0 target **Executive Risk Lead:** Tom Pharaoh, Director of Strategy **Board Committee**: Performance **Last Update:** 12th February 2024	**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 **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	**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	Programme plan in place. Quarterly assurance reporting to TEG and Performance Committee (based on selected Green Plan themes at each meeting). Regular SAG meeting Chair's report to Trust Executive Group 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.	**3 x 3 = 9**	**Yes**	G1) Delivery mechanisms for some key Green Plan work streams not yet developed	1. Develop and deliver sustainability staff engagement programme **Action Owner**: Sustainability Programme Manager **Due Date**: 31st March 2024	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.	**3 x 9 = 9**
			C2) Substantive Green Plan programme management arrangements in place **Control Owner**: Sustainability Programme Manager						2. 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.	
			C3) Delivery mechanisms for key Green Plan work streams developed: Green Travel Plan, communications plan. **Control Owner**: Sustainability Programme Manager						3. 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.	
			C4) Multidisciplinary Sustainability Action Group fully-functioning to support delivery of the Green Plan action plan **Control Owner**: Director of Strategy								
			C5) 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.				G2) Quality of the Trust's building stock: CCC-W requires improvement and long term redevelopment	1. 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.	
			C6) Quality of the Trust's building stock: programme of significant investment in CCC-W has commenced with architects engaged to develop longer term plans for redevelopment. **Control Owner**: PropCare Head of Capital and Projects	Reporting on investment programme via capital plan to monthly Capital Investment Group. Outputs of redevelopment design process to be reported to Trust Executive Group.					2. Develop 2024/25 capital plan to include further investment in the maintenance and refurbishment of the CCC-W site to increase sustainability profile of buildings **Action Owner**: PropCare Head of Capital and Projects **Due Date**: 31st March 2024	On track. Outline 2024/25 capital plan developed and agreed through Capital Investment Group.	
									3. Work with 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	Contract awarded to Ryder Architecture following comprehensive process. Work underway.	

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: 8a 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:** 8 December 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 (for year 4) and March 2025 (for year 5)		**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:** March 2024 (revised from June 2023 and September 2023)	Capacity increased from June 2023. No further capacity released at December 2023. Currently reviewing staffing capacity and space in Pharmacy. To be reviewed 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 and TEG. Increased capacity now available for research. Current trials need provided.	
			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 completed 3. Planning engagement event to highlight training/ research opportunities for AHPs.	
			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/Action Plan 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 and TEG with exceptions only escalated to Quality Committee				G5) Gaps identified via Clinical Research Gap Analysis paper. Links to G2.			
			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).				G6) Appointment of additional research active staff	1. Appoint Chair in Oncology 2. Appoint two Clinical Research Fellows via BRC 3. Appoint Senior Lecturer 4. Appoint Clinical Research Fellow via Research Strategy 5. Appoint two Early Phase Clinical Research Fellows. **Action Owner: Medical Director** **Due date: March 2024**	1. In post, complete 2. Business cases prepared for approval at January 2024 CCC Research Strategy Committee. 3. Job description written. Awaiting approval to go to advert. 4. Awaiting outcome of Charitable Funds Committee, January 2024. 5. In post, complete	
			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).				G7) Appropriate infrastructure available at periphery sites.	Action Plan developed to increase research activity at periphery hubs. **Action Owner: Medical Director** **Due date: March 2024**		

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:** 07 February 2024	**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**	**No**	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. Job descriptions for two BRC Clinical Research Fellows written.	**3 x 3 = 9**
			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:** February 2024 (revised from Januray 2024, November 2023)	Business case approved at October 2023 TEG. The Research Business Case was approved at January 2024 Charitable Spending Committee. Scheduled for February 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:** Complete	Trust Charity Application SOP approved Charity Business Case template developed.	
			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:** February 2024 (revised from Januray 2024, 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 February 2024.	
	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										

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 business case submission to the Clatterbrige cancer Charity in February ~~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. Risk reviewed and increased to a 9 to better reflect progress made.

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

RISK APPETITE: Workforce MINIMAL (tolerance 4-8)

Risk Trend / Movement: As 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	Planned action	Actions: Progress update	Target risk score by 31/03/24
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:** 4th December 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 September 2023 highlighting Q2 achievements and a further update to be presented in December 2023 highlighting Q3 achievements and challenges. Progress report presented at WAG in November 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:** 31st December 2023 (revised from 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 developed and an update on progress reported to WAG in November 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 Workforce **Date due:** 30th December 2023	Report to People Committee in September 2023 highlighting Q2 achievements Progress report presented at WAG in November 23 detailing achievements and mitigations	
			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 staff side. 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 K	Implement sickness and retention divisional reviews to support achievement of KPIs **Owner:** HRBPs **Date due:** 30th March 2024	Update on progress reporting to WAG November 2023 Policy review in partnership with Trade Unions being undertaken	
									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 Head of Medical Workforce joined Trust 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 completed 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 developed and an update on progress reported to WAG in November 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 plan 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 **(COMPLETED)**	Wellbeing and engagement champions recruited. Staff Health MOTs have taken place across all sites during November New Health, Wellbeing and Engagement intranet site launched	
			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 NHSIE 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 APH workforce development Lead **Owner:** DDWOD **Date due:** 30th Aug 2023 **(completed)**	N/A	
			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 First in-house Foundations of Leadership Programme delivered Cohort 2 of Shadow Board programme to commence January 2024	
									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 and 3 candidates identified	
								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**: DDW&OD/HRBP **Date due:** 01st March 2024	Workforce planning round for 2024/25 to commence January 2024 Assurance reports to be provided to WAG and People Committee on Workforce Plan progress	
									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:** 4th December 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:** December 2023 (revised from 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:** December 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:** January 2024 (original date - September 2023, November 2023)	DDWOD returned from Maternity leave November 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	Wellbeing and engagement champions recruited. MHFA aider training options being explored	
			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 not available 2023/24. Funding for L&OD and Staff Wellbeing a challenge	
								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. Ten Big conversations - A Great Place to work taken place with key actions identified . Increased score reported in Q2 Culture and Engagement Pulse results. 2023 Staff Excellence Award took place on 06th October 2023. Staff Survey 2023 closed 24/11/2023 with 66% response rate	
										You said we did communications developed. 2023 Staff Survey 2023 closed 24/11/2023 with 66% response rate	
								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. Further dependencies and ownership are being managed through Transformation & Improvement Committee	
			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 programmes Trust wide with digital dependency supporting Trust strategic objectives. Robust process in place with appropriate digital, clinical and operational subject matter experts to manage the project lifecycle	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. A project lifecycle approach is currently in pilot phases to ensure all of the key stakeholders across clinical, relevant digital subject matter expert and operational stakeholders are engaged in an agile approach to launching any new digital products across the organisation.	
			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) Chief Pharmacy Information Officer (CPIO) **Control Owner**: Medical Director	N/A				C5) Strong clinical Leadership required to embed and deliver Digital Strategy themes . Requirement for further clinical champions/digital fellows	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. Engagement is in place through digital strategy work and EPR optimisation and discovery work for a next generation EPR.	
			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 and prioritise operational change	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. Engagement on clinical system optimisation and transformation has been taken through TIC in November 23 with progress updates through Digital Boarding December 23.	
			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 c9) Strategy aligned with ICB and national objectives for digital and data			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** February 2024 (revised from 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. TEG update provided. Update PIEG in January/February 2024	
								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 January 2024 (revised from 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. Digital maturity presented at TEG themes will go to Workforce advisory committee in January 24 in line with the people Commitment	
			C9) Trust wide Digital Strategy in place **Control Owner:**CIO	Strategy endorsed by Trust Board				C9) Trust wide understanding and ownership of Digital Strategy requirements	Communications plan in place internally with Executive Sponsorship and examples of progress and delivery for each theme **Action Owner**: CIO **Due Date**: March 2024	Internal communication in December for Digital strategy themes spanning 6 week period. Engagement taken place with Transformation & Improvement Committee in November and ongoing engagement to embed digital partnership themes.	

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 and cultural 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 KPIs 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. Development of foundational partnership working has commenced and will be operationally managed via the Transformation & Improvement Committee. Regular intranet updates and leadership from Executive directors with differing portfolios will continue to endorse the requirement of cultural change to support the delivery of a Trust wide Digital strategy

BAF14. Cyber security

RISK APPETITE: Digital MODERATE (tolerance 8-12)

STP Aspiration: Be Digital 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:** 02 January 2024	**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 & ISO27001 **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 **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	Following successful accreditation of ISO27001 against 2022 standards, working is in progress against the new 2023 standards for the annual reaccreditation. Paddington will be included in the re-assessment	
								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	Most work is complete against Cyber Essentials plus re accreditation. Results of recent Penetration Testing are pending and any remedial actions will be completed before final submission for reaccreditation at the end of 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 **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)	ICS 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 Strategy to be shared with ICB Board in January/February 24 . Some national funding became available which will be used to support this development.	
								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. MFA compliance forms part of the Toolkit and evidence will be provided as part of the baseline submission of the DSPT in February 24 SOP has been developed for domain administration.	

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 + (CE+) certification in December 2022 and working on CE+ reaccreditation by January 2023.. 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 is now underway with reaccreditation against the 2023 version of ISO27001. 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 (MFA) remains a national priority and is seen as a basic cyber security control. MFA compliance will form part of the interim compliance check of Data Security Protection Toolkit (DSPT) due by the end of February.

BAF15 Subsidiary Companies and Joint Venture											
RISK APPETITE: Commercial and partnership working, financial MODERATE (9-12)											
STRATEGIC OBJECTIVE:	Be Innovative										
Risk description & information	**Causes & consequences**	**Initial (inherent) risk score L x C**	**Key controls** *(what is in place to manage the risk?)*	**Board Assurance** *(evidence that controls are working)*		**Residual (current) risk score L x C**	**Within risk tolerance?**	**Gaps in Control / Assurance**	**Actions**		**Target risk score by 31/03/23 L x C**
				Internal assurance *What/where reported/when?*	**External assurance** *What/where reported/when?*				**Planned action**	**Progress update**	
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:** 13 Febraury 2024	**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 **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	**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 23/24, with reference to strategic developments, ie clinic location (Paddington). **Action Owner:** DoF **Due Date:** 31/3/24	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**: 31/3/24	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.	
			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 updates on PropCare plan periodically through governance structure (PRG, Performance Committee) PropCare and Trust Strategy Group is embedded. **Action Owner**: DoF **Due Date**: 31/3/24 (revised from Nov 2023)	PropCare have produced a strategy, and are pursuing opportunities within the Trust and with other NHS organisations. PropCare are working with professional advisers to scope potential changes to their contract position with the Trust, to capture gains for the group.	
			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:** 31/3/24	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.

The Clatterbridge Cancer Centre NHS Foundation Trust

Title of meeting: Trust Board Part 1
Date of meeting: 28 February 2024

Report lead	Kathy Doran, Chair				
Paper prepared by	Jane Hindle, Associate Director of Corporate Governance				
Report subject/title	Board of Directors Development Session –				
Purpose of paper	The purpose of the paper is provide an overview of the development session held on 31st January 2024 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						
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

Board Development Session

31st January 2024

1.0 Background

The 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 31st January 2024 was delivered by:

- James Thomson, Chief Finance Officer
- Frankie Morris, Deputy Director of Finance, Cheshire and Merseyside ICB
- Rachael Sullivan, Radiotherapy Expert Practitioner
- Jo Bowden, Deputy Director of Finance, Hannah Gray, Associate Director of Performance and Operational Improvement, Zoe Hatch, Deputy Director of Workforce and Organisational Development,
-

The session was designed to provide the Board with a comprehensive understanding of Corporate Planning for 2024/25 with a focus on understanding clinical and operational planning at SRG level and corporate planning with a focus on activity, workforce, finance and productivity.

The governance and oversight of plans at SRG level were highlighted including the benefits of an annual away day to create the opportunity to review the final position and identify areas of focus and known demand for the coming year.

The Board received an overview of the planning process including the predicted changes in demand, the key assumptions including workforce planning assumptions, the national ambitions and the prioritisation of investments.

The Board received an overview of the planning process and expectations from the ICB and a number of risk scenarios were discussed.

An update regarding draft plans would be submitted to the Performance Committee in February.

4.0 Recommendation

The Board is requested to:

- **note the report.**

Board Committee Assurance Report

Report to	Board of Directors
Date	28th February 2024
Committee Name	Liverpool Trusts Joint Committee
Date of Committee Meeting	21 December 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-committees as follows:

1. **The Walton Centre NHS Foundation Trust/Liverpool University Hospitals NHS Foundation Trust Joint Committee Update**
   The North Mersey Stroke Centre was rated the best for patient outcomes in the country in the last quarter, with significant progress seen in the last year. It was noted that patients were able to receive a CT scan, directly from an ambulance, within two minutes and that the Centre was the only one in the country to achieve this. It was acknowledged that Thrombectomy delivery would be the focus of ongoing work which would be reported back during Q4.

2. **Liverpool Heart & Chest/Liverpool University Hospitals NHS Foundation Trust Joint Committee Update**
   The change to Ward 6 is anticipated to displace LUHFT administration staff and options which include the use of NHS estate across Liverpool are being explored by all trusts.

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**
   - a Programme Board, chaired by James Sumner, has been established to oversee the work to improve the quality and safety of care provided to women and babies requiring acute services in the city.
   - a workshop was held to determine the short term (12 months), medium term (one to three years) and long term (over three years) risks identified for action.
   - the outcome of the workshop would be presented to the Cheshire & Merseyside Integrated Care Board in January 2024, as well as the LTJC.

5. **Liverpool Women's Health & Alder Hey Partnership Board**

A requirement to strengthen governance to enable better understanding of data was acknowledged, with a meeting for clinicians planned for mid-January. A report following that meeting would come back to the LTJC.

PLACE and Merseycare

A verbal update on work being progressed through PLACE and Merseycare was provided:

- Face to Face mental health outreach to homeless people was seeing an increase in demand; this was helpful in terms of understanding the scale of support required.
- addiction services had achieved nil service users within the drug community with Hepatitis C, the only service in the country to do so.
- an additional 600 highly frail people in the community had been identified in the last 6 months, with the community lifting service response rate between 10 mins and 31 mins. This has resulted in a greater number of people remaining at home.

CMAST Workplan

Clatterbridge Cancer Centre had been working with clinical leaders in diagnostics, who had highlighted the Clinical Reliability Groups (CRGs) would benefit from input from CMAST. This would encourage system thinking and focus.

A review to understand whether the budget given to provider collaboratives across the Northwest were proportionate to their size and whether Liverpool was receiving sufficient resource versus others was requested.

Electronic Patient Record (EPR)

With LUHFT's ongoing work on their business case submitted to the National Team for approval, the opportunity to consider an enterprise system across provider trusts was discussed. This it was recognised would address t recommendations within the Liverpool Clinical Services Review (LCSR) for greater collaboration to deliver the best care for patients in Liverpool and beyond.

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 December 2023.