NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Annual Report and Accounts

From 1st April 2018 to 31st March 2019

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Presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006

Contents

Introduction from the Chair and Chief Executive

We are proud to be one of the country's leading cancer centres.

The past 12 months have been another defining year for The Clatterbridge Cancer Centre.

Innovation, progression and collaboration have all been key to us continuing to provide exceptional care and treatment.

Fantastic progress has been made on our new hospital in Liverpool city centre due to open next year. The external works have now been completed and attention has turned to the internal fit out. This landmark building will place us in the heart of a community of medical and scientific innovation as part of Liverpool's Knowledge Quarter. The 11-storey state of the art specialist hospital is part of a £162million investment, expanding the care given to people with cancer in the region.

Seeing the building take shape is hugely motivating and we are sure it will exemplify the culture we are so proud of. Together with our sites in Wirral and Aintree, and our chemotherapy clinics across the region, this building is taking treatment closer to a vast proportion of the population we serve.

Being co-located with the University of Liverpool will also give us the opportunity to expand our research portfolio which is crucial to developing new treatments.

This year we launched our new research strategy for the next three years which sets out our intention as an organisation to improve patient care through world-class research. As a result, 846 patients took part in clinical trials in the last 12 months, expanding the Trust's portfolio and improving clinical excellence. This is more people than ever before.

Collaboration continues to be vital to The Clatterbridge Cancer Centre and we are a pivotal part of the Cheshire and Merseyside Cancer Alliance. We support the Alliance and the healthcare system in improving and delivering on waiting times targets and helping to diagnose cancer earlier, to improve outcomes.

By aligning and unifying our efforts, we can create a future service model that drives improvements in both clinical outcomes and the experience that patients have.

We have continued to receive extremely positive patient feedback this last year about our services and the colleagues who have been at the centre of the care being given including results published in the Care Quality Commission's Adult Inpatient Survey for 2017, which saw the centre once again ranked as one of the top five hospitals for Overall Experience.

Throughout the year we also promoted and entered a number of external awards and were delighted that the team behind our pioneering Papillon treatment was honoured with a prestigious British Medical Journal award as winner of 2018 Cancer Care Team of the year.

So much of what The Clatterbridge Cancer Centre is able to deliver would not be possible without our charity. Thanks to the support of our generous donors over the last 12 months we now only have £5million left to raise to make the new hospital the best it can be.

Our thanks must finally go to the dedication and efforts shown by our strong and committed workforce, our governors, Members and team of volunteers. They work tirelessly, day in and day out to provide the very best care for our patients. None of the achievements outlined in this report would be possible without their skill, dedication and compassion.

We will now look towards 2020 and the opening of our new hospital with pride and positivity. It is a beautiful building which we hope will give confidence to our patients and be a pleasure for our staff to work in.

Kathy Doran, Chair

Dr Liz Bishop, Chief Executive

Overview of Performance

The overview section of our Annual Report is to provide a short summary of the Trust, our history, purpose, in addition to the key risks to the achievement of our objectives and our performance during the last year.

Chief Executive's Statement

I am delighted to introduce my first Annual Report and Accounts for 2018/19. I was immensely proud to take over as Chief Executive in November 2018. One of the key things I have noticed is that our staff always do everything they can to help our patients, from providing the best outstanding care to carrying out ground breaking research into new treatments.

The Clatterbridge Cancer Centre (CCC) is one of the UK's leading cancer centres and I am very excited to join at a pivotal time in our history as we move forward to delivering on Liverpool's first Cancer Hospital due to open in summer 2020.

In December 2018 and January 2019, we welcomed the Care Quality Commission (CQC) into the Trust, during which time they spent several days with us inspecting our medical and outpatient services in addition to carrying out their planned Well Led review. Whilst they rated the Trust as outstanding for Care, our overall rating dropped one rating to Good. This was disappointing for our patients and staff however, we have already made significant improvements in our systems and processes in response to the CQC report.

The Trust has experienced a challenging year with a number of changes to the leadership team and despite this, our teams have continued to deliver high quality care in conjunction with a positive patient experience; 96% of those who responded to our Friends and Family test for both inpatients and out patients concluded that they would recommend our services.

During the course of last year, we developed a range of highly ambitious priorities which resulted in the development of our Strategy for 2018-2022. The Strategy, developed in conjunction with our staff and partners very clearly places the needs of the patients at the very heart of the organisation. The Trust has focused on strengthening a number of partnerships and alliances with the Trust hosting the Cheshire and Merseyside Cancer Alliance thus providing Executive and clinical leadership. The Clatterbridge Cancer Charity has seen further growth this year, raising another £2,805,050 during the last year and we are immensely grateful to all our supporters who have helped to raise this incredible amount.

Last year was a defining year for our Research and Innovation Directorate with the approval of a new Research Strategy which is underpinned by £1.8 million investment over three years thereby enabling a refreshed positioning of research within the Trust. This has resulted in a strong foundation to re-invigorate research within the Trust thus ensuring we make every patient's experience count, increase patient access to research in addition to increased partnership working. We have made significant progress in 2018/19 with the implementation of our Research Strategy and we have increased the number of patients recruited to clinical trials to 846 in 2018/19 with the aim to increase this next year.

We have consistently achieved the 18 week target for both admitted and non-admitted episodes. In addition, the Trust achieved all but two of the Cancer Waiting Time targets for 2018/19 and we continue to work with our partners to ensure referrals are received in a timely manner.

We have experienced another successful year from a financial perspective whereby we have exceeded all of our key financial targets. Our ongoing concern remains that we ensure that the Trust makes the most effective use of the public monies it receives.

None of the above could have been achieved without the dedication of staff, Governors, volunteers and partners and I thank them all for their commitment and continued support to ensure we can continue to provide the very best care for our patients.

Although the last year has been challenging, we now have a complete and stable leadership team and we look forward to working with our patients and staff in the years to come to continue to deliver excellence in cancer care, treatment and research.

A Brief History and Statutory Background

In 1862, Mr James Seaton Smythe, a prominent surgeon, set up the Liverpool Hospital for Cancer and Diseases of the Skin. Seven years later he bequeathed the hospital £10,000; this was the first of many legacies which support our work in caring for cancer patients and helping to pioneer research into the disease, searching for both the cause and the cure. Developments have continued since 1958 and in 2006, The Clatterbridge Cancer Centre became a Foundation Trust under the Health and Social Care (Community Health and Social Care) Act 2003. The Clatterbridge Cancer Centre, currently based on the Wirral is now one of the largest NHS specialist cancer treatment facilities in the UK; our core business being radiotherapy and chemotherapy treatments. We are the only cancer centre in the United Kingdom to offer proton therapy for treatment of eye cancers.

Dr Liz Bishop, Chief Executive

Purpose and Principal Activities of the Trust

The Trust has developed and grown in scale since the early days of the hospital in 1958. Today, The Clatterbridge Cancer Centre has over 1,200 dedicated staff providing services for our patients and their families with volunteers providing additional support and services.

Combining world-class clinical services, research and academic excellence, The Clatterbridge Cancer Centre is one of the UK's leading cancer hospitals operating across 18 sites for the people of Merseyside, Cheshire and the Isle of Man where we continually provide the highest quality, specialist, non-surgical oncology treatment.

Services are provided in a number of different locations with the Trust's Wirral-based facility supported by a £17million radiotherapy satellite facility in Aintree with Liverpool and specialist chemotherapy clinics in eight other Merseyside hospitals. This enables the Trust treatments for rare eye cancers). The services we provide comprise:

Chemotherapy services – The Chemotherapy Services Directorate provides systemic anti-cancer therapy (SACT), supportive therapies and outpatient services for patients across Cheshire and Merseyside and the Isle of Man. The Directorate has close links with all external key providers within the Cancer Alliance (North West Coast Strategic Clinical Network) in both strategic and operational capacities.

•The Directorate provides four core services

Day case SACT clinics
(including phase 1,2 and 3 clinical trials) on the main site and at 7 District General Hospitals across the Merseyside and Cheshire region

Acute Oncology services across the main site and 7 acute trusts within the Merseyside and Cheshire region

Chemotherapy at home which is currently being rolled out across Merseyside and Cheshire

Pharmacy – prescription verification, preparation and dispensing of SACT and supportive therapies. Trust wide responsibility for medicines management, information and advice. Parenteral cancer treatment manufacturing and dispensing through Medicines and Healthcare Regulatory Authority (MHRA) licensed production facilities. Pharmacy dispensing provision through the Clatterbridge Pharmacy Ltd.

•The Chemotherapy Service delivery model is based on providing safe and effective cancer care and treatment close to the patient's home. Over 90% of treatments are delivered in the outpatient setting with 70% of patients receiving their treatment at a clinic close to their home.

Radiation Services

Radiation Services provide an external beam radiotherapy service, brachytherapy, Papillon, low energy proton service and imaging services for the Trust.

External beam radiotherapy
Provision for patients across Merseyside and Cheshire, Isle of Man and parts of North Wales. The service at The Clatterbridge Cancer Centre is one of the largest in England with over 90,000 attendances delivered annually. The service is provided from two locations, CCC Wirral, which delivers the majority of treatment attendances and currently all planning attendances and CCC Aintree delivering external beam treatments and Stereotactic Radiation services. From 2018/19 planning will also be delivered at CCC Aintree.

Brachytherapy
Provision for patients across Merseyside and Cheshire, Isle of Man and North Wales provided from the CCC Wirral site. The specialist skin brachytherapy service also takes referrals from across England due to many other providers having little experience in this area.

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Papillon Contact Radiotherapy

At present, Papillon is only offered in 4 centres in England and as we have the most well established service we receive significant referrals from across the UK.

National Centre for Eye Proton Therapy

Provision for patients of a low energy proton service across the UK, however 5-10% of referrals annually originate outside of the UK as Eye Proton services are rare across the world; we treat around 200 patients per year.

Imaging

The Diagnostic Imaging provides a range of services, mostly for cancer patients across Merseyside and Cheshire although Nuclear Medicine is provided on behalf of Wirral University Teaching Hospitals. All services are provided from CCC Wirral and include:

- CT
- PET/CT
- MR
- Nuclear Medicine (gamma camera)
- X-ray
- Ultrasound

Integrated Care

The Integrated Care Directorate is a Clinical Directorate that works closely with the other Clinical Directorates to provide the clinical support required for patients receiving their specialist cancer treatment.

It comprises a broad range of clinical and non-clinical services that collectively support each individual patient's journey:

- Three wards comprising 64 beds, including a dedicated four bed Teenage and Young Adult (TYA) unit, and two step up beds for patients requiring more intense monitoring
- A patient hotline and Clinical Decisions Unit
- Nurse led intervention service (PICCs and PORTs)
- Nurse led lymphoedema service
- Advanced Nursing team with Clinical Nurse Specialists and Advanced Nurse Practitioners across all tumour groups.
- A 7-day Palliative Care service
- Allied health professionals comprising physiotherapy, occupational therapy, speech and language therapy an dietetics
- Associated health professionals in social work and additional needs
- Psychological support service
- Patient services, supporting front of house and other duties
- MacMillan advice and support service, including benefits advice

Haemato-Oncology Service

With a strong reputation for innovative care of patients, the Haemato-Oncology Service is the major tertiary referral centre and the largest provider of specialist level 4 clinical Haemato-oncology service for adults, teenagers and young adults in Cheshire, Merseyside and the Isle of Man. The service is hosted within the Royal Liverpool University Hospital with access to acute and emergency care including accident and emergency and intensive care services.

The service provides a wide range of Haemato-oncology consultant-led care that can be broadly split into four sub specialities:

- Myeloid (Leukaemia and Myeloproliferative Disorders)
- Lymphoid (lymphoma and Lymphoid conditions)
- Myeloma
- Stem Cell transplantation (Allogenic and Autologous)
- Bone Marrow Transplants

Research and Development is a core function of the service with particular focus on the development of novel therapies and innovative conditioning regimens and immunotherapeutic strategies within all specialities.

Key achievements/developments in 2018/19

Chemotherapy Services

- We exceeded the predicted growth of 5% in Systemic Anti-Cancer Treatment
- Chemotherapy Nursing teams are based at four sector hubs which has enabled the delivery of more complex treatments closer to home which in turn improves equity of access to research trials
- The 'Chemotherapy at Home' project has been rolled out across the network receiving outstanding feedback from patients. This innovative service will be rolled out to support our Haemato-Oncology service in 2019/2020
- The 'Chemotherapy at Work' programme has been introduced (for eligible regimens) to enable those patients who have cancer and want to remain in work can do so
- The Trust is the first in the country to offer an adjuvant Bisphosphonate service to patients with breast cancer which won an international award for partnership working and innovation

Radiotherapy Services

- The appointment of 4 new Consultant Radiographers to support our Breast, prostate and Palliative Radiotherapy Services has been a significant success by bridging some of the gaps in the Consultant workforce in addition to developing a 4 tier model in Radiotherapy in addition to raising the profile of CCC with many of our peers who have been seeking our support in securing these roles within their own organisations
- Installations and commissioning of a Varian True Beam linear accelerator (Linac) as a replacement thus continuing our commitment to provide high quality technical radiotherapy
- Improvement in the efficiency of staff training and safety by standardisation of radiotherapy planning from being split across three planning systems to using a single system
- Moving to a paperless working for the majority of external beam radiotherapy treatment has improved efficacy with very few cancer waiting time breaches being linked to delays in planning
- Development of ultrasound guided biopsy has increased access to Clinical Trials

Integrated Care

- The adoption of a new Metastatic Spinal Cord Compression pathway led by CCC has brought together professionals across multiple Trusts to deliver rapid acute responses and treatment delivery
- Introduction of the Enhanced Supportive Care Programme has delivered a reduction in hospital admissions for some patients in addition to improving the quality of life for others
- The Clinical Utilisation Review, an approach which ensures that patients receive the right level of care, in the right place, at the right time according to their needs against international clinical best practice is a system that captures real time delays, interruptions, gaps and barriers in and to patient care, supporting effective patient flow management. We have seen a reduction in length of stays and a significant reduction in excess bed days as a result of this initiative
- The development of the Clinical Decisions Unit at the Wirral site has significantly improved the management of patients that become unwell during treatment. Patients are assessed and prescribed a treatment plan within a single facility staffed by a multidisciplinary team. This service has seen a reduction in the number of overnight admissions and offers urgent treatments such as blood transfusions as a short stay procedure on the same day as the unplanned care assessment

Haemato-Oncology Service

- All outpatient treatment regimens are now prescribed and delivered via CCC's E-prescribing system and has improved multidisciplinary working; we are planning to extend this to in patient regimens in June 2019
- An extended research portfolio has ensured we can offer more patients access to clinical trials
- We have introduced a new one stop clinic for patients with myeloma which has reduced waiting times in the outpatient department and subsequently improved patient flow. It has also significantly reduced the number of patients having multiple hospital attendances for diagnostics and treatment
- We tested, through a pilot the use of an ambulatory backpack for patients with acute leukaemia which dramatically reduced the length of stay for the patients involved in addition to helping those patients maintain some independence and quality of life during their treatment. We will be rolling the pilot out to other eligible patients in early 2019-2020.
- During the last year we have provided significant investment in the workforce including;
  - ► An additional medical consultant specialising in Myeloid Leukaemia and Bone Marrow Transplant who will support growth in activity and contribute to the reconfiguration of the consultant workforce in preparation of the move to our new hospital
  - ► A nurse consultant to manage the Haemato-oncology outliers within the Royal Liverpool Hospital bed base has been hugely successful in maintaining and coordinating individualised specialist Haemato-oncology care for patients who are outliers
  - ► A nurse clinician who is pivotal in the delivery of the multidisciplinary team care for all patients across each subspecialty within the Haemato-oncology service.
  - ► A clinical fellow who supports the delivery of a safe junior Dr rota
  - ► Additional administrative support for the JACIE Accreditation process

Overview of the Trust's Strategy

During 2018/19, we worked together with our staff and partners to shape a highly ambitious range of priorities which culminated in our Strategy focusing on four main priorities for 2018-2022. These are deliverable within an overall environment of maintaining our excellent quality, operational and financial performance which also allows us to be more enterprising.

Our strategy makes it clear what we want to achieve over the next five years with our partners, placing the needs of the patients at the very heart of the organisation to ensure that we can continue to provide the best possible care and outcomes for cancer patients long into the future. The Strategy is presented in two phases, the main focus being on our strategic priorities to 2022. Such priorities are built around but not limited to delivering our new model of cancer care in Liverpool. This will have a fundamental impact on everything we do, allowing us to provide high-quality, sustainable services into the future, move care and treatment closer to our patients and their families and bring together care with pioneering research.

Additionally, our other priority objectives and programmes involve working across the system, being enterprising, investing in research and innovation, maintaining excellent quality, financial and operational performance in addition to developing our people have been designed to complement and support our transformation.

Our Mission

To improve health and wellbeing through compassionate, safe and effective cancer care

Our Vision

To provide the best cancer care to the people we serve

Our mission, vision and values will help in providing organisational strategic direction during a pivotal time in our history as we move towards fulfilling our commitment of transforming cancer care through the development of the new centre in Liverpool.

Our Values

Putting people first
Achieving excellence
Passionate about what we do
Always improving our care
Looking to the future

System Leadership and Stakeholder Relations

We recognise that continued collaboration between organisations will be essential in tackling the challenges facing the NHS in the future. The Clatterbridge Cancer Centre has focused on the further development of a number of partnerships and alliances during the last financial year:

Building for the Future – our new Cancer Centre in Liverpool

Our new Cancer Hospital situated in the centre of Liverpool will open in 2020 as a result of £162 million investment that will also see improvements to our Wirral site. Significant progress has been made in the development and the building is currently on track to be handed over to the Trust in the spring of 2020. However, delays to the changes taking place affecting the Liverpool Royal Hospital will have an impact on some of the works relating to our new hospital. The respective project teams from both Trusts are currently working to fully understand the impact and to ensure plans are in place to manage any consequences of this on the new development.

Cheshire and Merseyside Cancer Alliance

The Trust hosts the core team of the Cheshire and Merseyside Cancer Alliance which was established in 2016 to lead the delivery of the national cancer strategy, Achieving World Class Cancer Outcomes: A Strategy for England 2015-2020. The Cancer Alliance covers a population of 2.4 million and is the cancer delivery arm of the Cheshire and Merseyside Health and Care Partnership. The aim of the Cancer Alliance is to radically improve cancer outcomes and to ensure that patients can benefit from high quality, modern services. The major themes within the Cancer Alliance Programme include preventing avoidable cancer, earlier and better diagnosis, high quality, modern services and living with and beyond cancer. The Trust continues to host the core team in addition to providing Executive and clinical leadership.

The Clatterbridge Cancer Charity

The Clatterbridge Cancer Charity has continued to grow, raising another £2,806,050 during 2018/19. The Charity has carried out a number of fundraising events during the last year and remains focused on supporting our new Cancer Hospital in Liverpool.

We remain incredibly grateful to all our supporters who help make these things possible by giving their time, money or services to the Charity year on year.

For further information about our Charity, including a list of what has been made possible at Clatterbridge, can be found at www.clatterbridgecc.org.uk

Outpatient Pharmacy Dispensing Subsidiary Company

The Clatterbridge Pharmacy Ltd (CPL, trading as PharmaC) was established in October 2013 as a registered company and is wholly owned by the Trust. Since being established, the company has gone on to provide drug top-up services at a number of Trust locations in addition to supporting the delivery of chemotherapy at home and more recently, chemotherapy at work. Any financial contribution from the Company to the Trust is reinvested in supporting us in delivering high quality of pharmaceutical care to all.

PropCare

The Trust established a wholly owned subsidiary, Clatterbridge PropCare Services Ltd (PropCare) in 2016. PropCare has responsibility for the management of the Trust's existing sites at Clatterbridge and Aintree. PropCare took over responsibility for the existing estate in May 2017 and continues to work with the construction team on the delivery of the new Cancer Hospital in Liverpool.

PropCare continues to provide a dedicated focus on the management of the estate and facilities function thus allowing the Trust to concentrate on the delivery of clinical services.

Private Patient Facility

The Clatterbridge Private Clinic offers patients access to specialist, integrated cancer services in dedicated private surroundings. The Clinic is a Limited Liability Partnership and was launched in 2013. It operates as a joint venture partnership between The Clatterbridge Cancer Centre NHS Foundation Trust and the Mater Private Healthcare and is committed to the delivery of exceptional cancer care, which is consultant-led and tailored to meet the needs of the patients.

Maggie's Centre

The Trust continues to have a close relationship with Maggie's. Our patients have access to a Maggie's Centre at CCC-Wirral which enables patients to have access to and benefit from a range of practical, emotional and social support.

Macmillan Cancer Support

The Trust has continued to work in close partnership with Macmillan cancer support, to the benefit of our patients. This ensures that our patients have access to additional cancer information resources, benefits advice, several specialist clinical posts and the delivery of the Living With and Beyond Cancer Programme.

Research and Innovation

The Research and Innovation (R&I) Directorate at CCC comprise the Research Management and Governance Team, the Clinical Delivery Team (supported by Data Managers, Healthcare Assistants and Laboratory Technicians) and Academic Oncology. The core functions are robust governance and research study delivery in line with legislation and Trust policies and procedures; sponsorship of CCC-clinician led studies is supported by R&I.

Developments in 2018/19

This year has delivered a step-change for research at the Clatterbridge Cancer Centre NHS Foundation Trust. The new Research Strategy was approved by the Board in July 2018 which was underpinned by an investment of £1.8 million over three years. This has enabled a refreshed positioning of research within the Trust and a strategy which focuses on making each patient's experience count, increasing patient access to research for tangible patient benefit and increased partnership working and leading system change within the region.

The current research strategy, although still nascent has already delivered at pace and provided a strong platform to initiate CCC as a research active hospital, delivering the highest level of research participants attributable to CCC with 846 participants in research studies, 644 of which relate to NIHR portfolio studies. We have successfully diversified the research portfolio increasing recruitment to qualitative, observational and translational studies whilst retaining strength in the complex systemic anti-cancer therapies, supporting the ECMC agenda and offering participants novel therapies. We have widened CCC reach with CCC clinician-led studies and provided infrastructure and support for clinicians and service departments in delivery of research.

CCC has worked to engage our stakeholders and partners; this includes leading in the implementation of the Liverpool Health Partners Joint Research Service (JRS), systems change in bespoke service level agreements, opening the Eastern sector Trusts to CCC research studies and enhanced working with the University of Liverpool, Liverpool John Moores University, the AHSN, ARC and industry partners. We continue to be a national exemplar in the use of the Edge systems for research which has provided a strong Business Intelligence base in support of the JRS.

R&I continues to support the Transforming Cancer Care Programme, looking to flex our research portfolio and research teams to ensure equitable access to clinical trials and research wherever the locality. We are working to develop IT systems so that opportunities to take part in research are identified for our patients as they attend a CCC clinic. This will enable smart working and an enabler for capturing activity and intelligence on patient access and uptake and support the development of a forward facing research active workforce. We recognise the value and contribution from our patients and are working to establish a new PPIE group for research and are actively engaging in a visibility and communications project for the Trust and wider reach.

We have made a strong foundation to re-invigorate CCC and provide opportunity for research to progress. The implementation of the current strategy as a proof of principle of change leading to successful gains can now be used as a lever to take CCC research forward through to a five year plan and refreshed strategy for our patient population.

Performance Analysis

Measuring Performance

The Board maintains a focus on Trust performance with the aim to improve the quality of care and enhance productivity. The Trust's Planning and Performance Improvement Framework outlines how performance is managed and assurance is obtained, from Ward to Board.

At each Board meeting the Trust Board reviews the Integrated Performance Report which includes its key performance measures including quality, workforce, operational and finance. The indicators include:

- Referral to treatment times
- A range of safety and effectiveness indicators
- Patient experience including Friends and Family Test
- Finance and activity
- People management

Trust Board, Committees and Sub-Committees review in detail, aspects of performance within the scope of their terms of reference. Meeting reports are generated and presented at the forum into which each meeting reports; this is one method of escalating any issues, concerns and risks.

Monthly Trust Executive Group meetings were introduced early 2019 and provides a forum for the Executive Team to challenge each Clinical and Corporate Senior Management Team on progress against annual Business Plans and a range of performance measures, as well as reviewing risks and opportunities. Monthly Performance Review meetings are held with each Clinical Directorate to provide challenge and support in meeting performance requirements.

The Trust aims to deliver real time, online dashboards by Q3 2019/2020 to support the work of committees, the performance review process and senior teams' day to day management requirements.

Performance against key healthcare targets 2018/19
18 weeks performance

The Trust has consistently achieved the 18 weeks target for both admitted and non-admitted episodes.

Performance Indicator	Target/Threshold	2017/18 Trust Performance	2018/19 Trust Performance
Referral to treatment for admitted patients seen within 18 weeks from the initial GP referral to treatment	90%	99.93%	97.1%
Referral to treatment for non-admitted patients seen within 18 weeks from initial GP referral to treatment	95%	97.62%	97.7%
Number of incomplete pathways	92%	96.33%	98%

Cancer Waiting Times Performance

The Trust has achieved all but two of the Cancer Waiting Time targets for 2018/19*:

Performance Indicator	Target/Threshold	2017/18 Trust Performance	2018/19 Trust Performance
Patients treated within 62 days from the date of urgent GP referral (pre application of the breach reallocation policy within Merseyside and Cheshire)	85%	79%	58%
Patients treated within 62 days from the date of urgent GP referral (post application of the breach reallocation policy within Merseyside and Cheshire)	85%	Not measured	86%
Screening patients (post allocation) treated within 62 days from the date of recall (9 patients breached in this period, CCC responsible for one, and partly responsible for 8)	90%	93.3%	64.5%
Patients treated within 31 days form the time of decision to treat to first treatments	96%	97.18%	98.7%
Patients treated within 31 days from the time of decision to treat for chemotherapy subsequent treatments	98%	98.7%	99.2%
Patients treated within 31 days form the time of decision to treat for radiotherapy subsequent treatments	94%	98.28%	98.2%
Patients who had their first appointment within 14 days from the date of urgent GP referral	93%	Not measured	95%

*The 62 day pre allocation standard will be superseded by the post allocation standard in 2019/20. In addition, the Trust will also be monitoring against the new 28 Day target in 2019/2020.

Additional Quality Indicators:

- No patients waited longer than 6 weeks for Imaging (CT and MRI at CCC)
- We have had 0 'Never Events' (our target is 0)
- We have had 0 incidence of an MRSA bacteraemia (our target is 0)
- We have had 2 cases of Clostridium Difficile attributed to CCC, against a target of no more than 4. Both cases have been reviewed with no lapses in care identified by the Trust
- We have achieved 94% year to date (95% target) for VTE risk assessments. Performance is improving and the ongoing implementation of a robust action plan will ensure compliance in 2019 / 2020

Financial Performance Analysis

Key Financial Risks

The Trust is currently investing £162 million to build a new cancer centre in Liverpool. The Trust has a guaranteed maximum price (GMP) with Laing O'Rourke for the construction costs, but there is a risk that with the delay in completion of the new Royal Liverpool University Hospital (due to the insolvency of Carillion), further delays could have a financial impact on our project. The CCC project team continue to work with our contractors Laing O'Rourke to address any consequences of the delay to the new Royal.

The majority (88%) of the Trust's income is received for the provision of non-surgical cancer treatments to the residents of Cheshire, Merseyside and parts of Lancashire, North Wales and the Isle of Man. In 2018/19 approximately 20% of the Trust's clinical income was funded by Payment by Results (PbR) national tariffs, with the remainder from locally determined prices. Both PbR and the local tariff arrangements are usually based on the principle that the Trust is reimbursed for activity performed. Therefore a reduction in activity would represent a financial risk to the Trust. However the Trust is able to mitigate against this risk by:

Where possible, employing contract tolerances to reduce in year income volatility, such as fixed value contract agreements. In 2018/19 we agreed a block contract with our main commissioner for the year.

Agreeing local tariffs with commissioners for 80% of clinical income that are not, therefore, subject to the same degree of price volatility as the nationally determined tariffs within Payment by Results.

Continuing to agree funding for cancer drug developments based on actual drug usage.

As in previous years, a key concern for the forthcoming financial years will be to ensure that the Trust makes most effective use of the public monies it receives. The Trust is working with commissioners and other stakeholders across the health economies to ensure quality cancer services can be maintained whilst increasing productivity and efficiency. The Trust will be required to deliver its own challenging organisational cost improvement programme (CIP) and improvements in operational efficiency. Non-delivery of this target represents a key financial risk to the Trust. However, this risk is reduced to the extent that the savings target was achieved in 2018/19 and the majority of the 2019/20 programme has been identified.

The Trust's risk and control framework is described within the Annual Governance Statement

Financial Summary

The Trust has again had a successful year and has achieved or exceeded all of its key financial targets. The Trust's financial position is detailed in the accounts included as part of this report, however the table below summarises performance in the key areas.

Financial Targets	Outcome
Planned income & expenditure surplus of 1.787m	Achieved actual surplus of £6.007m
Planned operating surplus of £5.418m	Achieved actual operating surplus of £9.259m
I&E surplus margin of 1.23%	Achieved margin of 3.67%
Operating surplus margin of 3.85%	Achieved margin of 5.66%
Overall Financial Risk Rating determined by NHSI (NHS Improvement) for:	
Capital Service Cover – plan rating of 2	Achieved Financial Risk Rating of 1
Liquidity Capital – plan rating of 1	Achieved Financial Risk Rating of 1
I&E margin – plan rating of 1	Achieved Financial Risk Rating of 1
I&E margin variance – plan rating of 1	Achieved Financial Risk Rating of 1
Agency spend – plan rating of 1	Achieved Financial Risk Rating of 2
OVERALL RATING – plan rating of 1	Achieved Financial Risk Rating of 1

NHSI financial risk ratings comprise of 5 metrics, each with an equal weighting (a rating of 1 being the best and a rating of 4 being the worst). They are; Capital Service Cover, Liquidity, I&E Margin, I&E Margin Variance and Agency spend.

Activity

The majority of the Trust's income is derived from providing non-surgical cancer treatments and support (such as radiotherapy, chemotherapy, bone marrow transplants, palliative care, diagnostic imaging, psychiatric and other support). During 2018/19 the Trust experienced growth for some of its services such as Chemotherapy, Outpatient procedures, and Outpatient consultations. Ocular Proton therapy activity was also significantly above plan for the year. This is a national service as the Trust is the only UK provider. It treats circa 225 patients per annum and activity is quite volatile year on year. A number of services experienced activity levels below plan, these included Radiotherapy, Bone Marrow Transplants, and the number of patients admitted to the hospital sites (Wirral and Liverpool) as in-patients. The main Trust contracts have been rebased for 2019/20 to reflect these activity levels.

Activity	2018/19 Actual	2018/19 Plan	% Variance	Growth Forecast 2019/20
Chemotherapy Attends	63,005	57,548	9.5%	5.0%
Radiotherapy Attends	86,762	94,070	-7.8%	1.0%
Bone Marrow Transplants	82	108	-24.6%	7.0%
Proton Therapy Treatments	1,366	1,001	36.4%	1.0%
Admitted Patient Care: In-patients	2,997	3,283	-8.7%	1.5%
Admitted Patient Care: Day Cases	4,693	4,835	-2.9%	1.5%
Out-patient consultations	152,015	143,833	5.7%	1.6%
Out-patient procedures	19,575	19,409	0.9%	1.6%

Forecast growth is related to the increase in estimated numbers of our relevant catchment population, historic growth patterns and is based on the same assumptions that underpin the Trust's 3 year Financial Plan.

Other Income and Non-healthcare Activities

As noted above, the majority of the Trust's income is derived from providing clinical cancer services. In addition, the remaining 12% of income is derived from:

- Undertaking research & development
- Education and training
- Hosting non-clinical services, such as the Cancer Alliance. In CCC's accounts income for these services matches expenditure and therefore there is no impact on the Trust's EBITDA and overall I&E surplus
- Support from charities and recharges to other NHS and non-NHS bodies

Investment Activity

The Trust invested £73.562 million in capital expenditure on buildings and replacement of capital equipment in 2018/19.

The main schemes were:

- £64.701 million on Building for the Future (the new Cancer Hospital in Liverpool).
- £4.120 million for state of the art Radiotherapy treatment and planning equipment.
- £3.892 million investing in IT systems (as a Global Digital Exemplar Fast Follower).
- £0.849 million on other equipment and minor upgrades to the Trust estate.

The Trust is planning capital expenditure in 2019/20 of £54.6 million. The main schemes include completion of the new Cancer Hospital in Liverpool, and the continuation of the on-going equipment enhancement and replacement programme. A total of £88 million of capital expenditure is planned over the next 5 years which includes the completion and equipping of the new cancer hospital and redevelopment of the Trust's Wirral site.

Investment in Associates

The Clatterbridge Private Clinic is a specialist cancer clinic for private patients, operated as a joint venture partnership between The Clatterbridge Cancer Centre and Mater Private Healthcare.

The Clinic was opened in 2013 and offers a wide range of treatments across cancer types and delivers personalised care of an exceptional quality, which is tailored to the needs of patients.

The financial contribution from the Clinic to the Trust is reinvested in supporting us to deliver a high quality of patient care to all our patients.

Subsidiaries

The Clatterbridge Pharmacy Ltd was established in October 2013 as a registered company (trading as PharmaC) to provide pharmacy dispensing services. The company is 100% owned by the Clatterbridge Cancer Centre. The key objectives of the company are:

Putting patients first: improved patient experience through improved access to dispensing services.

Drive efficiencies and strive to improve services: reduce patient waiting times and develop a more customer focussed service.

Financial efficiencies: benefit from the tax and other efficiencies that are open to similar high street pharmacies.

Again, the financial contribution from the company to the Trust is reinvested in supporting us deliver a high quality of patient care to all our patients.

Clatterbridge Prop Care Services Ltd was established in 2016 as a registered company and is overseeing construction of the new hospital in Liverpool and redesign of the Wirral site, and going forward will manage the Trust's property, estates and facilities on its behalf.

Charitable Funding

The Board of The Clatterbridge Cancer Centre are also the Corporate Trustee of The Clatterbridge Cancer Centre Charitable Funds. During 2018/19 £155k has been spent by the Charity in support of the Foundation Trust. The main areas of expenditure were:

Improving patients welfare: £ 16k
Improving staff welfare: £ 4k
Research & Development: £135k

In addition, the Trust received £280k of income to support clinical activity across the Trust.

Accounting Policies

Accounting policies comply with International Financial Reporting Standards (IFRS) and a full list of these policies is included as part of the Annual Accounts.

Group Accounts

The annual accounts reflect not only the outcome of the Trust, but of the financial performance of the group which consists of:

- The Clatterbridge Cancer Centre NHS Foundation Trust
- The Clatterbridge Cancer Charity
- The Clatterbridge Pharmacy Limited (a wholly owned subsidiary)
- Clatterbridge Prop Care Services Ltd (a wholly owned subsidiary)

The surplus of The Clatterbridge Cancer Centre Group Accounts is summarised below:

The Clatterbridge Cancer Centre Group Position	£m
The Clatterbridge Cancer Centre NHS Foundation Trust	6.007
The Clatterbridge Cancer Charity	1.464
The Clatterbridge Pharmacy Limited	0.423
Clatterbridge PropCare Services Ltd	0.442
Total Clatterbridge Group	8.336

Environmental Matters

The Clatterbridge Cancer Centre recognises the need to minimise its impact on the environment and is committed to reducing energy usage and waste in order to meet its social and community responsibilities.

Energy

The table below illustrates the energy consumption and cost for the Trust during the last financial year.

	KWhr			
	WUTH	Cyclotron	Aintree	Total
Electric	4,098,000	879,000	780,000	5,757,000
Gas	2,814,000	-	22,000	2,836,000
Heat	1,606,000	-	-	1,606,000
	8,518,000	879,000	802,000	10,199,000

The main factor that influences our high electric consumption is the demand generated by the use of the Trusts' major medical equipment. However, this year, we have been successful in securing funding for the Trust to replace internal lighting on the Wirral site with LED lighting which is projected to save 865,000 KWhr's of electricity annually; these are programmed for installation during 2019/20.

Sustainability

The Trust has extended its property footprint and the new hospital currently under construction in Liverpool is subject to a British Research Establishment Environmental Assessment Methodology (BREEAM). The building is assessed at various stages of design and construction and we continue to be on target to receive a BREEAM rating of 'excellent' for the new build.

Our management of waste is sub-contracted to Wirral Teaching Hospitals (WUTH) and we continue to work closely with our service providers at WUTH to deliver a more efficient service. Currently our waste is aggregated with that of the rest of the site at WUTH and therefore we are not able to provide any analysis of our individual waste; we have investigated the segregation of our waste, however, the additional costs that would be incurred have made this not viable.

The Trust recognises that further work is required to establish data relating to procurement and travel and future work will enable the Trust to improve monitoring against the Sustainable Development Management Plan.

Social, Community, anti-bribery and human rights issues

The Trust is committed to maintaining a culture of integrity, openness and honesty. It is therefore also committed to the elimination of any fraud within the Trust and to the rigorous investigation of any such cases. Where necessary we work with Local NHS Counter Fraud Specialists to review policies and procedures. The Trust's Anti-Fraud, Bribery & Corruption Policy, outlines the definition of fraud and provides guidance for employees who have suspicions of fraud.

The Trust's Audit Committee receives and agrees the annual Local NHS Counter Fraud Specialist work plan in addition to receiving regular reports on progress against delivery of the work plan.

Modern Slavery Act 2015

The Trust Board is committed to ensuring that the Trust follows best practice and takes reasonable steps to ensure there is no modern slavery or human trafficking in any aspect of our business or through our supply chains to ensure compliance with the Modern Slavery Act 2015.

This statement is made pursuant to Section 54(1) of the Modern Slavery act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2019. Our statement can be found on our website at www.clatterbridgecc.nhs.uk

The Clatterbridge Cancer Centre cares for more than 30,000 patients per year, with an excess of 323,000 patient contacts for treatment/appointments. The Centre registers more than 11,000 new patients each year.

More than 1,000 staff are employed at the centre, with volunteers providing additional support and services. The Trust spends approximately £154million per year on all aspects of cancer treatment, diagnosis and care.

During 2018/19, our procurement and management of the supply chain has been through a service level agreement with Wirral University Teaching Hospital.

All members of the Trust have a responsibility for the prevention of slavery and human trafficking. Modern slavery is included in our Safeguarding Adults and Children Policy which aims to support front line staff to be able to identify and report any concerns. We will continue to ensure we meet the provisions of the Act.

As we build our new Cancer Hospital in Liverpool, we will continue to work closely with Laing O'Rourke to ensure that their Global Code of Conduct is enforced during the construction of the new hospital.
We will continue to receive assurance through our subsidiary company, PropCare Ltd that any suppliers and contractors that we directly contract with understand their obligations under the Act.

Contracts will not be awarded to suppliers who do not demonstrate their commitment to ensuring that slavery and human trafficking are not taking place in their own business or supply chains.

We will be reviewing and refreshing our Modern Slavery Statement during 2019/20.

Important events since the end of the financial year affecting the Trust

There are no events since the end of the financial year affecting the Trust.

Overseas Operations

The Trust does not have any overseas operations.

Going Concern

The Clatterbridge Cancer Centre NHS Foundation Trust Annual Report and accounts have been prepared on a going concern basis.

After making reasonable enquiries, the Directors have a reasonable expectation that The Clatterbridge Cancer Centre NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Performance Report signed by the Chief Executive in the capacity as accounting officer

Dr Liz Bishop
Chief Executive

Date: 23 May 2019

Accountability Report

Directors' Report

Board of Directors

The Board of Directors has overall responsibility for defining the Trust's strategy, strategic priorities, vision and values in addition to the overall management and performance of the Trust.

The Board of Directors is led by the Chair and comprises four other Non-Executive Directors and one Associate Non-Executive Director and five Executive Directors, including the Chief Executive.

The Trust is satisfied that the Board of Directors and it associated committees have the necessary skills, experience and knowledge to enable them to discharge their duties and responsibilities effectively. The Trust is confident that the all the Non-Executive Directors are independent and has appointed Alison Hastings as the Senior Independent Director.

During the course of the year there have been significant changes to the Board of Directors, which are reflected in this report. This includes acting up arrangements to cover the absence of substantive Executive Directors. At the end of the financial year, the Trust had a vacancy for one Non-Executive Director.

Phil Edgington – Chair (from 1 January 2018-31 December 2018)

Phil was appointed as Trust Chair from 1 January 2018 until 31 December 2018. Phil had over 20 years of Board-level experience in the Private, Public and Not for Profit sectors. He was Vice President in the UK for a large US Energy Company and prior to that held a number of Chief Executive roles including leadership of the Central Regional Health Authority in New Zealand.

One of Phil's last executive roles was CEO of Community Integrated Care (CIC) a large not-for-profit provider of health and social care services. He has also held a number of Non-executive Director roles both in the UK and New Zealand and until March 2018 was on the Board on Your Housing Group.

Alison Hastings – Non-Executive Director, Vice Chair (and Senior Independent Director), Interim Chair (from 1 January 2019 – 31 March 2019)

Alison trained as a journalist in 1983 and was Head of Training and Staff Development for Thomson Newspapers before becoming Editor of the Evening Chronicle in Newcastle in 1996.

Alison is the Vice President of the British Board of Film Classification, a Board member of Durham University, an advisory Board member at Pagefield Communications, a Commissioner of the Gambling Commission, a specialist partner at Alder Media and a Non-Executive Director at the media company Archant.

Alison stepped into the role of Interim Chair from 1 January 2019 until 31 March 2019. Alison is Chair of the Charitable Funds Committee.

Gil Black – Non-Executive Director (until 15 January 2019)

Gil is a qualified Chartered Accountant with 20 years' experience at Deloitte and was a partner in the audit practice. He has spent a number of years in the international financial sector in various Director roles including Chair and Non-Executive Director roles. He has sat on numerous audit committees at different times both in an Executive and Non-Executive capacity. He has also worked in finance, sales and other operational roles.

Gil is a specialist in change management, major company reorganisations, risk management and mergers and acquisitions. He has worked with a number of not for profit organisations and is currently Chair of the Manchester based Charity POPS

David Teale – Non-Executive Director (1st term of office, 3 years) until January 2020

David joined the Trust Board in February 2017 and Chairs the Performance Committee (formally the Finance and Business Development Committee). David has significant experience of leading transformational change having worked at Board level with the Manchester Airports Group, and has Chaired facilities management companies and housing associations. He has also worked with the NHS as a Non-Executive Director in the NHS Business Services Authority.

Professor Mark Baker – Non-Executive Director (1st term of office, 3 years) until October 2019

Mark started his three year term of office in November 2016. He is currently the Director of the Centre for Guidelines at The National Institute for Health and Care Excellence (NICE) and is responsible for designing and operating methods and systems to produce clinical guidelines for the NHS. Mark is Chair of the Quality Committee.

In 2008, together with Roger Cannon, he produced the Baker Cannon Report into the provision of cancer services in Merseyside and Cheshire. Its recommendations included the building of a new cancer hospital in Liverpool city centre.

Debbie Francis – Non-Executive Director (1st term of office, 3 years until January 2020) left March 2019.

Debbie is a qualified accountant with 20 years' experience in senior management including executive and board roles and has operated both in the UK and overseas. She is currently Managing Director of Direct Rail Services Limited which is a rail freight operator owned by the Nuclear Decommissioning Authority (NDA) as a consequence of its core activities related to the transportation of nuclear waste. Prior to this, Debbie held a number of Finance Director roles that regularly incorporated commercial within their remit.

Debbie has held a number of Non-Executive Director and governor roles in relation to schools.

Mark Tattersall – Non-Executive Director (1st term of office, 3 years until December 2021)

Mark was appointed as a Non-Executive Director on 1 December 2018. He has significant Board level experience as both an Executive and Non-Executive Director across the NHS, private and public sectors.

Mark, as Chair of the Audit Committee, brings a wealth of experience to this role, having held five previous positions as Audit Chair and extensive knowledge and proficiency in governance, internal control and risk management frameworks.

Alongside his role as Audit Chair, Mark is also a member of the Performance Committee and the nominated Non-Executive Director for the Clatterbridge PropCare Ltd Board.

Geoff Broadhead – Associate Non-Executive Director (1st term of office, 1 year until December 2019)

Geoff was appointed as an Associate Non-Executive Director on 1 December 2018. Geoff has over 30 years' experience in senior finance roles within the public and private sectors with 20 years at Executive Board level.

Geoff has a strong corporate services background having managed finance, IT, HR and facilities services at Board level. He has strong change management and systems implementation experience. Geoff is additionally a non-executive director for Magenta Living and a member of the Merseyside Fund Pension Board.

Geoff is a member of the Trust Audit and Quality Committees.

Liz Bishop – Chief Executive (from November 2018)

Liz joined the Trust as Chief Executive in November 2018. Liz has significant experience within the NHS, completing her BSc in Nursing in Scotland in 1986 and her MSc and Doctorate at Surrey University in 2004 and 2009 respectively. She has worked in a number of clinical settings from surgery to haemato-oncology in several acute London Trusts. Liz was latterly at The Royal Marsden from January 2010 where she was appointed Deputy Chief Executive in July 2016.

Barney Schofield – Director of Operations and Transformation, Acting Chief Executive from 5 March – 2 April 2018, Deputy Chief Executive/Director of Operations and Transformation from 3 April 2018 – November 2018; Director of Operations and Transformation until April 2019

Barney has worked in the NHS since 1994 after graduating in History from the University of Sheffield. He joined the Trust in November 2015 and his responsibilities included oversight of the delivery of the organisation's clinical services and also leadership of the Transforming Cancer Care Programme.

A past participant of the King's fund Top Managers Programme, Barney has previously served leading NHS teaching hospitals in Birmingham, London and Staffordshire in a variety of senior operational and strategic management roles, including significant responsibilities for developing and delivering cancer services. Barney's areas of specialist expertise include the integration of clinical services between hospitals, the development of new models of acute and elective care and developing significant strategic partnerships.

His professional interests include managerial and medical leadership development and he is a past associate of the University of Warwick Medical School.

Sheena Khanduri – Medical Director

Sheena trained in Clinical Oncology at West Midlands and Yorkshire Deaneries and was appointed Consultant at Shrewsbury and Telford Hospitals NHS Trust in 2007. During that time, Sheena worked as Radiotherapy then Departmental Lead and served on the Heads of Service Committee for the Royal College of Radiologists (RCR). In 2016, Sheena was appointed as Lead Clinician for Cancer Services and became Medical Director at The Clatterbridge Cancer Centre in December 2017. Sheena is an elected member on the Board of Faculty, RCR and Joint Collegiate Council for Oncology. Sheena has a post graduate qualification in strategic leadership from the University of Warwick and completed the Senior Clinical Leadership Programme, Kings Fund in 2019. She is also the Responsible Officer, Caldicott Guardian and Executive lead for Research.

Sheila Lloyd – Director of Nursing and Quality

Sheila Lloyd joined the Trust in April 2018 following two previous roles as Executive Director of Nursing at NHS Trusts.

Sheila has been in the NHS for over 30 years and has substantial clinical and nursing leadership experience together with a proven track record in the development, management and improvement of governance and performance.

Sheila's role within the Trust includes corporate responsibility for the delivery of quality, safe and effective patient care and experience and is the designated Director of Infection Prevention and Control.

Sheila is also the Executive lead for the Care Quality Commission

James Thomson – Director of Finance (from February 2019)

James Thomson joined the Trust on 1 February 2019, having held a previous role as Deputy Director of Finance at the Christie NHS Foundation Trust. Prior to this, he held a number of senior finance positions within the healthcare sector.

James has a strong background in financial delivery, commercial development and is committed to supporting excellent patient care through sustainable financial planning and decision making.

James is also the Executive Director Trust representative for one of our subsidiary companies - Clatterbridge PropCare Ltd.

Jayne Shaw – Director of Workforce and OD (from December 2018)

Jayne joined the Trust on 10 December 2018, having previously held Executive Director roles in Workforce and OD within the NHS for the last 15 years.

Jayne has experience of working in a range of NHS organisations including specialist, mental health and acute services and has significant experience of successful workforce development and organisational change to improve patient care and staff performance.

Alongside her Director role, Jayne is also the Executive lead for the effective transformation and transition of the workforce for the Transforming Cancer Care Programme.

John Andrews – Acting Director of Finance (from 5 March 2018- 31 January 2019)

John has worked within the Trust's Finance Department at a senior level since 1996. He is an IPFA qualified accountant who has spent his entire career to date in the NHS. He is also an Executive Director of one of our wholly owned subsidiary companies, Clatterbridge Pharmacy Ltd.

Heather Bebbington – Acting Director of Workforce & Organisational Development (from 5 March 2018 – 31 October 2018)

Heather commenced her career in NHS Wales in 2002; the majority of her career has been in HR providing expert advice on employee relations, employment law and workforce policy implementation. Heather worked for the Trust until October 2018 where her primary focus had been to ensure the effective transformation and transition of the workforce as part of the Transforming Cancer Care programme.

Ann Farrar - Interim Chief Executive between 03 April 2018 and 30 November 2018

Ann joined the Trust in April 2018 bringing with her a wealth of experience in the NHS. Ann was the Chief Executive at North Cumbria University Hospital for 7 years where she led a significant transformation of culture and clinical services. During her time at The Clatterbridge Cancer Centre she led on the development and subsequent approval of the Trust's Strategic Direction 2018-2022, engaging key stakeholders across Cheshire and Merseyside. Ann retired from the NHS in December 2018.

Andrew Cannell left the Board as Chief Executive on 22 May 2018

Yvonne Bottomley left the Board as Director of Finance / Deputy Chief Executive on 24 May 2018

Division of Responsibilities

There is a clear division of responsibility between the Chair and the Chief Executive. The Chair ensures that the Trust has a strategy which delivers and meets the needs of the population we serve, in addition to ensuring the Trust has an Executive team with the ability to deliver on the strategy. The Chair also facilitates the contribution of the Non-Executive Directors and their ongoing constructive relationships with the Executive Directors.

The Chief Executive is responsible for the leadership of the Executive team and for implementing the strategy in addition to the delivery of our overall objectives.

The Chair and Chief Executive take into account the required skills, qualifications, experience and diversity of the composition of the Board as part of the recruitment process to the Board of The Clatterbridge Cancer Centre. It is the role of the Nominations Committee to oversee the recruitment of Non-Executive Directors in addition to oversight of the appraisal of the Chair and other Non-Executive Directors. Although the Nominations Committee does not have decision making powers, it will make recommendations for approval at the Council of Governors.

The Board has, in consultation with the Council of Governors reviewed the Trust's Strategy and further developed an understanding of the views of the Governors through recent regular attendance at meetings of the Council of Governors.

Independence of Directors

The Non-Executive Directors at the Trust bring a strong, independent oversight to the Board and currently all Non-Executive Directors are considered to be independent. The Trust is committed to ensuring that the Board is made up of a majority of independent Non-Executive Directors who can objectively challenge management and hold to account.

The Non-Executive Directors utilise their expertise, independence and experience to scrutinise the performance of management by monitoring performance in addition to satisfying themselves as to the integrity of clinical and financial information presented to Board.

Declarations of Interest

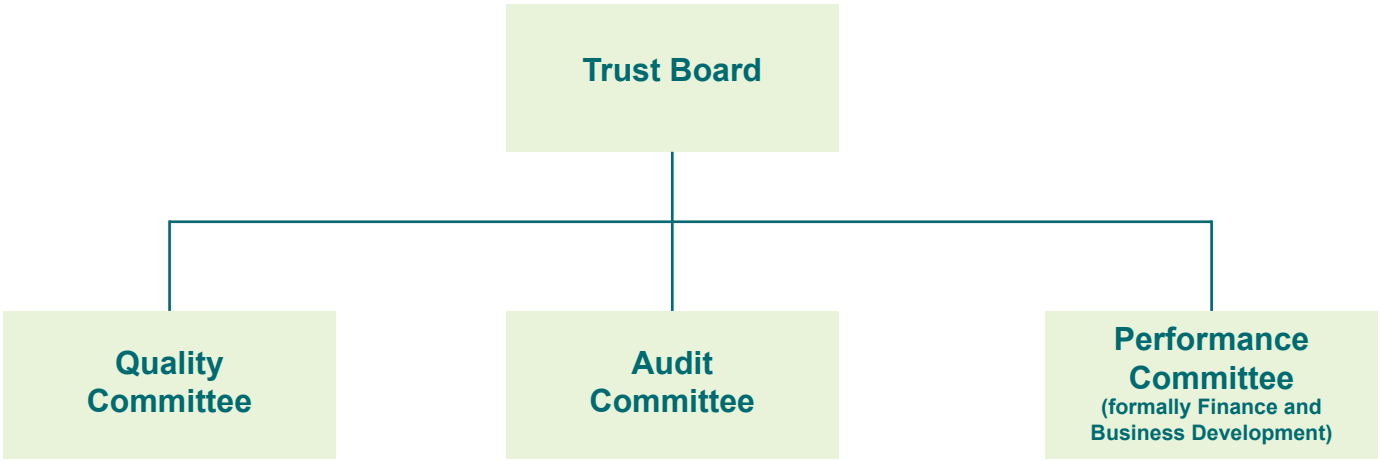
The Trust maintains a Register of Interests which contains details of company directorships and other significant interests held by directors or governors which may conflict with their management responsibilities. The Register was last updated and published in April 2018. Further work is being carried out to align the Trust policy and register to the national template and plans are underway to publish a wider register containing Declaration of Interests from any member of staff.

A copy of the Register of Interests is available via the Trust website https://www.clatterbridgecc.nhs.uk/about-centre/corporate-matters/public-documents/register-of-interests.

Alternatively you can contact the Associate Director of Corporate Governance, on 0151 556 5331 to request a copy.

Committees of the Board

Following a review of the governance structure, the Board now meets monthly with the exception of August and December. In order to discharge its duties, the Board has met in public with the exception of times when matters of a confidential or commercially sensitive nature have been discussed where the Board has met in private.



Audit Committee

The Audit Committee is a formally constituted Committee of the Board and comprises three independent Non-Executive Directors and is chaired by a Non-Executive Director who has recent and relevant financial experience. The Chair of the Audit Committee, Gil Black retired on 15 January 2019 and one of the new Non-Executive Directors, Mark Tattersall was appointed Chair from that point forward.

The Audit Committee provides the Board with an independent and objective review of the effectiveness of system of internal control (both financial and non-financial) in addition to the underlying processes around how the Trust manages risk.

The Audit Committee met six times last year in order to discharge its responsibilities and sought assurances that appropriate and adequate audit processes were in place.

Representatives from Internal and External Audit were in attendance at each meeting and the Audit Committee considered the following key issues:

- Agreed the Annual Plan and associated fees relating to External Audit
- Received quarterly reports from Counter Fraud in addition to approving the annual Counter Fraud work plan
- Recommended the 2017/18 Annual Accounts and Annual Report, including the Quality Report for approval
- Recommended the Annual Governance Statement for approval
- Reviewed the schedule of losses and compensations, outstanding debts and financial procedures updates
- A review of the Corporate Risk Register and Board Assurance Framework took place. The Audit Committee noted the work that had already been completed, recognising that further work is required in order for the Audit Committee to gain assurance that supporting risk management and escalation systems and processes were working effectively. A broader review of governance was initiated, reporting back to the Audit Committee in July 2019
- The Audit Tracker was a standing agenda item for review and consideration by the Audit Committee and significant work during Quarter 4 was conducted in conjunction with Internal Audit to present a clearer position, delivering enhanced assurance to the Audit Committee around process

- Substantial assurance was provided to the Audit Committee for Sickness Absence Management, Financial Systems, and Critical Application Systems with robust good practice in place for Cyber Security. Counter fraud reported no activity requiring intervention or corrective action

- Improvements were identified in relation to processes and procedures in some areas including Complaints and the Programme Management Office. Action plans have been developed and will be monitored via the updated Audit tracker

- Due to a number of changes in the Executive and Corporate Governance leadership, the Audit Committee agreed to defer a review of the Committee Effectiveness until 2019/2020, providing time for the new governance arrangements to embed within the Trust

- The Audit Committee reviewed the risks around the new ledger implementation in year as this was a risk identified in the Audit Plan.

- The Audit Committee made a recommendation to the Council of Governors for a one year extension to the External Auditor contract to 30 September 2019. This was approved in October 2018 and a full tender process will be initiated during the next financial year.

Quality Committee

The Quality Committee supports the Board in obtaining assurance that high standards of care and governance are provided by the Trust and, in particular that adequate and appropriate controls are in place throughout the Trust.

The Quality Committee is chaired by a Non-Executive Director and its core membership includes two further Non-Executive Directors in addition to the Chief Executive, Director of Nursing and Quality, Medical Director, Director of Operations and the Director of Workforce and OD.

Following a review of the wider governance agenda, the Quality Committee commenced monthly meetings from January 2019.

The Quality Committee in particular considered and provided oversight in relation to the following matters:

- Development and approval of a number of key strategies including Patient and Public Involvement and Engagement, Palliative and End of life care, Research, Organisation Development, Workforce and Medicines Optimisation. Delivery of the aforementioned strategies will be monitored during future financial years

- Received regular reports in relation to Safeguarding, safer staffing, Serious Incidents and Clinical Governance issues

- Compliance against Regulatory requirements

- Progress against the plans to transition to Digital requirements

Finance and Business Development Committee

The Finance and Business Development Committee was established to provide the Board with in-year assurance in relation to the operational and financial performance of the Trust against its Business and Strategic Plans. The Finance and Business Development Committee met five times during the last year and following a review of the wider Governance agenda, was re-constituted as the Performance Committee and commenced monthly meetings from February 2019.

The Performance Committee is chaired by a Non-Executive Director and considered the following matters:

- Overall operational and financial performance
- Transforming Cancer Care Programme, including financial performance
- Approval of key strategies and developments for the new hospital, including the Patient Access Strategy, procurement approach for Energy Supplies and budgetary items
- Consideration of business cases as appropriate
- Agreement of the 3 year Operational Plan (2019/2022) prior to approval at Trust Board
- Consideration of the main risks considered by the Committee related to the delay in completion of the new Royal Liverpool Hospital and any associated impact for the Trust

Nominations and Remuneration Committee

The Council of Governors is responsible for the appointment and re-appointment of Non-Executive Directors, receiving recommendations from the Nominations Committee. During the reporting year, the Nominations Committee (comprising the Chair, or Interim Chair for the appointment of the new Chair), and elected Governors met and provided recommendations to the Council of Governors on the appointment of the following:

Chair
One Non-Executive Director
One Associate Non-Executive Director

The Remuneration Committee is responsible for reviewing and making decisions on the remuneration and conditions of service for the Chief Executive, Executive Directors and where applicable, other senior managers.
During the reporting year, the Remuneration Committee met to discuss and approve the remuneration and conditions of service for the following:

Chief Executive
Director of Workforce and OD
Director of Finance

The Trust used the services of an external recruitment consultant for the above positions.

Arrangements in Place to ensure the Trust's services are Well-Led

The Board carried out a review of progress against the Well-Led self- assessment action plan during September 2018 in conjunction with AQuA.

Further review of our governance arrangements took place in December 2018 which cumulated in a revised committee structure and focus on a revision of the Board Assurance Framework; this work has begun to take shape and will continue to be embedded in the next financial year. This was further supported by our recent CQC findings where our Well-Led domain was rated 'Requires Improvement'.

Terms of Office and Attendance at Meetings of the Board of Directors and Sub-Committees 2018/19.

Name	Role	Meetings attended as at 31 March 2019	Term of office	End of current term
Board of Directors				
Phil Edgington	Chair	3/4	2 Terms	Resigned – 31 Dec 2018
Alison Hastings	Non-Executive Director/ Interim Chair	6/7	2 Terms +1year +1year	31 Dec 2020
Gil Black	Non-Executive Director	4/4	2 Terms +2 months	15 Jan 2019
Debbie Francis	Non-Executive Director	5/6	1 Term	Resigned – 29 March 2019
Mark Baker	Non-Executive Director	5/7	1 Term	31 Oct 2019
David Teale	Non-Executive Director	6/7	1 Term	31 Jan 2020
Mark Tattersall	Non-Executive Director	3/3	1 Term	30 Nov 2021
Geoff Broadhead	Associate Non-Executive Director	1/3	1 Year	30 Nov 2019
Ann Farrar	Interim Chief Executive	4/4		Left 2018
Liz Bishop	Chief Executive	3/3		
Sheila Lloyd	Director of Nursing & Quality	7/7		
Sheena Khanduri	Medical Director	7/7		
Heather Bebbington	Director of Workforce & OD	4/4		Left 2018

Name	Role	Meetings attended as at 31 March 2019	Term of office	End of current term
Jayne Shaw	Director of Workforce and OD	2/3		
Barney Schofield	Director of Operations	7/7		Left 2019
John Andrews	Interim Director of Finance	4/5		
James Thomson	Director of Finance	2/2		

Audit Committee

Gil Black	Chair of the Committee/ Non-Executive Director	3/4		Left 2019
Mark Tattersall	Non-Executive Director/ Chair of the Committee	2/2		
Debbie Francis	Non-Executive Director	6/6		Left 2019
Alison Hastings	Non-Executive Director	3/4		
Geoff Broadhead	Associate Non-Executive Director	1/2		
John Andrews	Interim Director of Finance	4/5		
James Thomson	Director of Finance	1/1		
Sheila Lloyd	Director of Nursing and Quality	5/6		

Quality Committee

Mark Baker	Chair of the Committee/ Non-Executive Director	4/5		
David Teale	Non-Executive Director	4/5		
Debbie Francis	Non-Executive Director	3/5		
Sheila Lloyd	Director of Nursing and Quality	4/5		
Sheena Khanduri	Medical Director	2/5		
Heather Bebbington	Director of Workforce & OD	3/3		
Jayne Shaw	Director of Workforce & OD	2/2		

Finance and Business Development /Performance Committee

David Teale	Chair of the Committee/ Non-Executive Director	5/5
Debbie Francis	Non-Executive Director	4/5
Mark Tattersall	Non-Executive Director	2/2
Gil Black	Non-Executive Director	3/4
John Andrews	Interim Director of Finance	3/4
James Thomson	Director of Finance	1/1
Sheila Lloyd	Director of Nursing & Quality	1/2
Barney Schofield	Director of Operations	5/5

Governors Report

The Council of Governors has a number of regulatory and statutory responsibilities that are set out within the Trust Constitution. In accordance with the Health and Social Care Act 2012, they have a responsibility to hold the Non-Executive Directors to account for their performance in addition to representing the interests of the members of the Trust.

In addition to Council meetings, the Governors hold a number of sub-committees:

- Patient Experience Committee
- Membership and Communications Committee

During the year, the Council of Governors has worked with the Board on the development of the Strategy and will receive the annual report and accounts. In addition, Non-Executive Directors attend the Council of Governors to provide an overview of the work carried out by the Committees they Chair; this has been particularly well received by the Council of Governors. Governors are invited to, and have attended joint Executive/Non-Executive Walk rounds in order to strengthen the Board to Floor process.

The Council of Governors appointed a Lead Governor, Mr Stephen Sanderson who has regular one to one meetings with the Chair and the Chief Executive to allow for any exchange of information to take place. The Lead Governor is also supported by the Associate Director of Corporate Governance.

Composition of the Council of Governors

The Council of Governors is made up of 28 Governors representing the public, staff and nominated organisations. Each Governor serves a three year term and is eligible for re-election/re-appointment to serve a maximum of nine years.

The Electoral Reform Services manages the provision of the elections for the Trust and one round of elections took place in accordance with the Model Rules for Elections.

Attendance at Council of Governors (as at 31 March 2019)

Name	Constituency	9th July 2018	29th October 2018	13th February 2019	18th March 2019	Notes
Angela Cross	Wirral and Rest of England					Resigned May 18
Dave Steele	Wirral and Rest of England					Resigned June 18
John Field	Wirral and Rest of England	A	✓	✓	✓	
Andrew Waller	Wirral and Rest of England		✓	X	A	New Gov Sept 18
Christine Littler	Wirral and Rest of England		✓	✓	✓	New Gov Sept 18
Ian Boycott-Samuels	Sefton	✓	✓	✓	✓	
Carla Thomas	Sefton	✓	A	✓	A	
John Roberts	Liverpool	✓	X	✓	A	
Yvonne Tsao	Liverpool	✓	A			End of term Sept 18
Millie Blankstone	Liverpool		A	X	X	Now Gov Sept 18
Stephen Sanderson	St Helens & Knowsley	✓	✓	✓	✓	
Brian Bawden	St Helens & Knowsley		✓	A	A	New Gov Sept 18
Vacancy	Warrington & Halton					
Trish Marren	Warrington & Halton	✓	A	A	A	
Jane Wilkinson	Wales	✓	✓	✓	✓	
Matthew Duffy	Cheshire West & Chester	A	✓	X	X	
Brian Blundell	Cheshire West & Chester		✓	✓	✓	New Gov Sept 18
Andrea Chambers	Nominated	A	A	A	✓	
Andrew Bibby	Nominated	✓	X	X	X	

Name	Constituency	9th July 2018	29th October 2018	13th February 2019	18th March 2019	Notes
Andrew Pettitt	Nominated		X	X	✓	
Kate Cannon	Nominated			X	X	Appointed Oct 18
Mike Sullivan	Nominated	A				Resigned Oct 18
Ray Murphy	Nominated	✓	✓	✓	✓	
Shaun Jackson	Nominated	✓	A	X	A	
Sonia Holdsworth	Nominated	✓	A	X	A	
Burhan Zavery	Staff	✓	A	X	A	
Douglas Errington	Staff	A				End of term Sept 18
Samantha Wilde	Staff		A	✓	✓	New Gov Sept 18
Laura Jane Brown	Staff		✓	✓	✓	New Gov Sept 18
John Archer	Staff	✓	✓	✓	✓	
Luke Millward-Browning	Staff	A				End of term Sept 18
Deborah Spearing	Staff	A	A	A	✓	
Amit Patel	Staff		✓	X	✓	New Gov Sept 18
Pauline Pilkington	Staff	✓				End of term Sept 18

Key

✓ Attended

A Apologies

X non attendance and no apologies received

Strengthening the links between the Governors and the Board

The Board has a strong commitment to strengthening the existing partnership working with the Governors. The Council of Governors is chaired by the Trust's Chair, Mrs Kathy Doran with the Deputy Chair being Mr Stephen Sanderson, Lead Governor. Both Executive and Non-Executive Directors are committed to attending the Council in order to update the Governors on events within the Trust in addition to providing an opportunity for Non-Executive Directors to present their updates on relevant committee activity.

Attendance by Directors at the Council of Governors

Name	Meetings Held	Meetings Attended
Executive Directors		
Ann Farrar	2	2
Liz Bishop	2	2
Sheila Lloyd	4	4
Barney Schofield	4	2
Sheena Khanduri	4	2
John Andrews	2	2
James Thomson	2	2
Jayne Shaw	2	1
Non - Executive Directors		
Phil Edgington	2	2
Gil Black	4	1
Alison Hastings	4	2
Debbie Francis	4	0
David Teale	4	1
Mark Baker	4	0
Mark Tattersall	2	1
Geoff Broadhead	2	1

Membership Report

The Trust is accountable to the population it serves and membership of the Trust is open to any individual over the age of 16 years who are entitled to be a member of one of the public constituencies or staff constituencies, having completed the relevant application form.

Our staff membership operates on an 'opt out' basis. As with staff, all volunteers (with service longer than 12 months) are automatically members unless they chose to 'opt out'.

Membership overview as of 31 March 2019

The Trust had a total of 6,578 at 31 March 2019 as follows:

Constituency	Number of members
Staff	
Doctor	63
Nurse	304
Non Clinical	460
Other Clinical Professional	242
Radiographer	169
Non staff	192
Public Constituencies	
Wirral and the rest of England	1305
Liverpool	1172
Sefton	1052
Warrington and Halton	410
St Helens and Knowlsey	580
Cheshire West and Chester	440
Wales	189

Statement as to disclosure to auditors (s418)

So far as the directors are aware, there is no relevant audit information of which The Clatterbridge Cancer Centre NHS Foundation Trust's auditors are unaware and the directors have taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditors are aware of that information.

Goods and Services

The Trust's income from the provision of goods and services for the purpose of the health service in England has exceeded its income from the provision of goods and services for any other purposes.

3.3 Remuneration Report

Salary and Allowances (subject to audit)

	2018/19							2017/18					
Name and title	**Salary and Fees (bands of £5,000) £000**	**Taxable Benefits (bands of £100) £00**	**Annual Performance Bonus (bands of £5,000) £000**	**Long term Performance Bonus (bands of £5,000) £000**	**Increase in Pension Related Benefits (bands of £2,500) £000**	**Total (bands of £5,000) £000**		**Salary and Fees (bands of £5,000) £000**	**Taxable Benefits (bands of £100) £00**	**Annual Performance Bonus (bands of £5,000) £000**	**Long term Performance Bonus (bands of £5,000) £000**	**Increase in Pension Related Benefits (bands of £2,500) £000**	**Total £000**
Executive Directors													
A Cannell - Chief Executive	**30-35**				**0**	**30-35**		**145-150**				**80-82.5**	**230-235**
Y Bottomley - Director of Finance / Deputy Chief Executive	**20-25**				**45-47.5**	**70-75**		**125-130**				**40.42.5**	**165-170**
E Bishop - Chief Executive	**55-60**				**15-17.5**	**70-75**							
J Thomson - Director of Finance	**15-20**				**40-42.5**	**60-65**							
S Lloyd - Director of Nursing & Quality	**110-115**				**47.5-50**	**155-160**							
B Schofield - Director of Transformation & Innovation	**115-120**				**57.5-60**	**175-180**		**105-110**				**27.5-30**	**135-140**
S Khanduri- Medical Director*	**170-175**				**15-17.5**	**185-190**		**55-60**				**22.5-25**	**80-85**
A Farrar - Interim Chief Executive	**165-170**				**0**	**165-170**							
J Andrews - Acting Director of Finance	**95-100**				**122.5-125**	**205-210**		**5-10**				**22.5-25**	**30-35**
Non Executive Directors													
A Hastings - Interim Chair	**20-25**					**20-25**							
P Edgington - Interim Chair	**30-35**					**30-35**		**20-25**					**20-25**
G Black - Non Executive Director	**10-15**					**10-15**		**15-20**					**15-20**
D Teale - Non Executive Director	**10-15**					**10-15**		**10-15**					**10-15**
M Baker - Non Executive Director	**10-15**					**10-15**		**10-15**					**10-15**
D Francis - Non Executive Director	**10-15**					**10-15**		**5-10**					**5-10**
M Tattersall - Non Executive Director	**5-10**					**5-10**							
Banded remuneration of the highest paid director and the ratio between this and the median remuneration of the Trusts staff													
Band of the Highest Paid Directors Total						**165-170**		**145-150**					
Median Total Remuneration						**29,659**		**29,517**					
Ratio						**5.73**		**5.08**					

* The medical director salary includes £79k that relates to their clinical role within the Trust.

The Trust are required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the Trust's workforce.
In the financial year 2018/19 the highest paid director was in the banding £165k-£170k (2017/18 £145k-150k). This was 5.73 times (2017/18 5.08 times) the median remuneration of the workforce.

The aggregate amount of remuneration and other benefits received by Directors during the financial year was £935,957 (2017/18 £784,278). There is no performance related pay or bonuses paid to Directors.

Employer contributions to a pension scheme in respect of Directors was £80,899 (2017/18 £82,931).

Expenses	2018-19 £00s	2017-18 £00s
Total number of directors in office	18	17
Number of directors receiving expenses	9	11
Aggregate sum of expenses paid to directors	**155**	**158**

1) All Board members are appointed by the Board on permanent contracts.

2) All Non Executive Board members are appointed by the Council of Governors for an initial period of 3 years which is renewable subject to satisfactory performance.

3) The following changes have occurred to the Board members with voting rights since 1st April 2018:
- a) E Bishop appointed Chief Executive from 26.11.18
- b) S Lloyd appointed Director of Nursing from 01.04.18
- c) J Thomson appointed Director of Finance from 01.02.19
- d) J.Andrews left the Board as Acting Director of Finance from 31.01.19
- e) A Hastings appointed Interim Chair from 01.01.19
- f) M Tattersall appointed Non Executive Director from 02.12.18
- g) P Edgington left the Board as Interim Chair on 31.12.18
- h) G Black left the Board as Non Executive Director on 15.01.19
- i) D Francis left the Board as Non Executive Director on 18.03.19
- j) A Farrar appointed Interim Chief Executive between 03.04.18 and 30.11.18
- k) A Cannell left the Board as Chief Executive on 22.05.18
- l) Y Bottomley left the Board as Director of Finance / Deputy Chief Executive on 24.05.18

Off-payroll engagements

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months	
Number of existing engagements as of 31 March 2019, of which …	0
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	1
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four years or more at time of reporting	0

For all new off-payroll engagements,or those that reached six months in duration, between 1 April and 31 March 2019, for more than £245 per day and that last for longer than six months	
Number of new engagements,or those that that reached six months in duration between 1 April 2018 and 31 March 2019.	0
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and national insurance obligations	0
Number for whom assurance has been requested of which,	0
Number for whom assurance has been requested and received.	0
Number for whom assurance has been requested but not received	0
Number that have been terminated as a result of assurance not being received.	0

3.4 Staff exit packages

Exit package cost band	Number of compulsory redundancies Number	Cost of compulsory redundancies £000s
£0 - £50,000	0	0
£50,000 - £100,000	0	0
Total	**4**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the contractual arrangements under Agenda for Change.

3.5 Pension entitlements

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2019 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2019 £000	Cash Equivalent Transfer Value at 1 April 2018 £000	Real increase in Cash Equivalent Transfer Value at 31 March 2019 £000	Employer's contribution to stakeholder pension £000
E Bishop - Chief Executive	0-2.5	0	60-65	155-160	1,260	1,096	131	0
B Schofield - Director of Transformation & Innovation	2.5-5	5-7.5	35-40	85-90	617	476	126	0
S Khanduri - Medical Director	0-2.5	0	25-30	60-65	479	391	76	0
S Lloyd - Director of Nursing & Quality	2.5-5	2.5-5	40-45	105-110	820	664	135	0
J Thomson - Director of Finance	0-2.5	0-2.5	25-30	55-60	397	310	77	0
J Andrews - Acting Director of Finance	5-7.5	12.5-15	30-35	80-85	646	461	171	0
A Cannell - Chief Executive	0-2.5	0	60-65	185-190	1,451	1,292	119	0
Y Bottomley - Deputy Chief Executive / Director of Finance	0-2.5	0	15-20	0	277	209	62	0

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.CETVs are calculated in accordance with SI 2008 no.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV
This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end the period.

3.6 Remuneration Committee and Terms of Service

The Remuneration Committee is made up of the Chairman and Non-Executive Directors only. Acting in accordance with Department of Health Guidelines, the committee determines the remuneration of Senior Managers and Executive Directors. The Chief Executive of the Trust joins the Committee when the remuneration of other Executive Directors is being reviewed.

The Chief Executive and Executive Directors are employed under permanent contracts of employment and they have been recruited under national advertisements. The employment of Senior Managers and Executive Directors may be terminated with six months notice as a result of a disciplinary process, if the Trust is dissolved as a statutory body, or if they choose to resign. None have contracts of service, and none has a contract that is subject to any performance conditions.The position of Chair and Non-Executive Directors are recruited through national advertisements. Appointments are made on fixed term contracts (normally for three years), which can be renewed on expiry. Terms of appointment and remuneration for Non-Executive Directors are set by the Council of Governors.

Details of the remaining terms of the Chair and Non-Executive Directors are as follows:

Name	First Appointed	To	Extended To
Gil Black	01.12.2012	30.11.2015	15.01.2019
Phil Edgington	01.08.2014	31.07.2017	31.12.2018
Alison Hastings	01.01.2012	31.12.2014	01.04.2019
Mark Baker	01.11.2016	31.10.2019	
Deborah Francis	01.08.2017	18.03.2019	
David Teale	01.02.2017	31.01.2020	
Mark Tattersall	02.12.2018	01.12.2021	

The Remuneration Committee will be responsible for agreeing remuneration and terms of employment for the Chief Executive and other Directors in accordance with:

1) Legal requirements
2) The principles of probity
3) Good people management practice
4) Proper corporate governance

Signed …… Chief Executive
Dr Liz Bishop

Date……28 May 2019……

Staff Report

Report 1

Analysis of staff numbers by employee definitions analysis by permanent and other

Staff Group	Permanent Contract (Average FTE)	Other Contract (Average FTE)	Average FTE 2018/2019
Additional Professional Scientific and Technical	59	4	63
Additional Clinical Services	121	9	130
Administration and Clerical	368	50	418
Allied Health Professionals	168	5	173
Healthcare Scientists	33	0	33
Medical and Dental	56	9	66
Nursing, Midwifery and Health Visiting	277	7	283
Agency and contract staff			
Total	**1082**	**84**	**1166**

Staff Group	Headcount (total number of agency and contract workers 2018/19)
Agency and contract staff	36

Report 2

Gender Breakdown – Directors as at 31st March 2019

Directors	Count of Assignment Number	Headcount
Female	5	5
Male	6	6
Total	**11**	**11**

Report 3

Gender Breakdown – Employees as at 31st March 2019

Gender	Count of Assignment Number	% of Workforce	Sum of FTE
Female	1084	82	962
Male	223	18	227
Total	**1,317**	**100%**	**1,189**

Report 4

Sickness absence

The Workforce and Organisational Development Team continue to work closely with line managers to help support staff in maintaining their health and well-being and managing any sickness absences appropriately. This year's sickness rates have marginally improved in comparison to the previous year. This coincides with the embedding of a new Attendance Management Policy and further management training. The sickness absence rates for 2018/19 are as follows:

Yearly Quarter	2018/2019
Q1 (April - Jun)	3.51%
Q2 (Jul - Sept)	4.13%
Q3 (Oct - Dec)	4.39%
Q4 (Jan - Mar)	4.55%
Total for the year	4.15%

The Trust continues to work to reduce sickness to below its key performance indicator of 3.5% and particular focus over the last 12 months has been on reducing staff absence for stress reasons whether on a work or personal basis. Interventions have included the procuring of additional counselling services by the Trust for staff along with the launch of an Employee Assistance Programme with access to telephone counselling 24 hours a day, 7 days a week, 365 days a year.

Human Resources (HR) Policies and Procedures

The Trust continues to regularly review all its policies and procedures in partnership with staff side colleagues with the aim of ensuring they remain effective, meet the needs to the Trust and are beneficial for staff and the organisation.

The Trust has committed to being a Disability Confident Committed Employer under the government scheme which aims to ensure that our recruitment process is inclusive and accessible and that we support disabled people in being able to work with suitable adjustments. The Trust's policies such as the Recruitment and Selection Policy, Attendance Management Policy and Procedure and Equality, Diversity and Human Rights Policy support our approach to equal treatment of all staff.

Internal communication with our staff is vital to sharing our vision for the future. During the year the Trust held a number of "Honest Conversation" events to share plans and strategies with staff and receive feedback regarding what is important to them. There is also regular communication via weekly e-bulletins and monthly team briefs and recently introduced town hall events, in order to ensure staff are kept informed and involved in new developments.

Occupational Health services for the Trust are provided through a service level agreement with Wirral University Hospitals NHS Trust. This is a comprehensive service covering pre-employment screenings, employment health assessments and the management of sharps and contamination incidents. Specialist counselling support services are also provided to the Trust through a services level agreement with Cheshire and Wirral Partnership NHS Trust.

Working in Partnership

Partnership working is well embedded within The Clatterbridge Cancer Centre and is underpinned with a Partnership and Recognition Agreement. Our management, staff and trade union organisations within the Trust work together to achieve a shared vision, common understanding and joint communication to best meet the needs of the service and provide the best possible patient care through effective joint working. We are committed to the Trusts Partnership forum arrangements which provide a two-way channel of communication and involvement between staff and members of the Trust Board. The Partnership forum receives and considers strategic matters relating to performance, developments in service provision and matters of organisational change. Its forms the platform for collective bargaining and negotiation of local agreements, employment policies and general terms and conditions of employment.

We are committed to providing a workplace that is free from bullying and harassment in all its forms and will take the steps which are needed in partnership with our Trade Union colleagues to achieve this. In response to the NHS National Staff Survey results and a series of focus groups with staff we have developed a new 'Respect for Each Other' toolkit. It is designed to provide information, advice and solutions to dealing with workplace bullying and harassment, and other forms of unacceptable behaviour. The Trust has a number of dedicated 'Respect for Each Other' Champions who are trained and able to support our staff should they feel they are being bullied or harassed.

Trade Union Facility Time

The data provided within the following tables 1 to 4 cover the time period 1st April 2018 to 31st March 2019 as per statutory regulations. Updated reporting covering the period 1st April 2018 to 31st March 2019 will be published on the Trusts website by 31st July 2019 as per statutory requirements

Table 1

Relevant Union Officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
11	11 (all full time)

Table 2

Percentage of time spent on facility time

Percentage of Time	Number of Employees
0% 1-50% 51-99% 100%	11

Table 3

Percentage of pay bill spent on facility time

First Column	Figures
Provide the total cost of facility time	£264,169.77
Provide the total pay bill	£52,754,000.00
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time / total pay bill) x 100	0.5%

Table 4

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period / total paid facility time hours) x 100	25.25%

Equality, Diversity and Inclusion

The Trust is committed to eliminating discrimination and encouraging equality, diversity and inclusion amongst our workforce. We aim to have a workforce that is truly representative of all sections of society and where each employee feels respected and able to give their best. The Trust is committed to reducing health inequalities, promoting equality, diversity and inclusion within its decision making, workforce and services. We have policies and processes in place to ensure equality, diversity and inclusion is incorporated into all aspects of our work and that it informs our values and behaviours.

The Trust set it's 2018/19 Equality, Diversity and Inclusion Objectives aligned to the Equality, Delivery System 2.

Equality Objective 1.	Better health outcomes for all
Equality Objective 2.	Improved patient access and experience
Equality Objective 3.	A represented and supported workforce
Equality Objective 4.	Inclusive leadership at all levels

Our continued aim is to embed the above equality objectives into the day to day practices across the organisation, provide equal access to services for all groups, reduce health inequalities, safeguard employees across the protected characteristics and commit to advance equality of opportunity across the organisation.

During 2018/19, the Trust maintained and adhered to NHS Mandated Equality Standards, meeting deadlines for the submission of the Gender Pay Gap and the Workforce Race Equality Standard.

We have:

- Improved data collection and equality profiles for all staff members by introducing a personal profile self-recording communications. This has enabled the Trust to monitor personal profile data on the Electronic Staff Recording (ESR) system to understand the equality, diversity and inclusion of our workforce and hold accurate information that will help support and inform our NHS Mandatory Standard Reports

- Published its second Gender Pay Gap Report

- Integrated the Workforce Race Equality Standard (WRES) into workforce planning

- Monitored staff retention on a monthly basis

- Developed a recruitment and retention strategy

During the last 12 months progress has been made around equality, diversity and inclusion principles, developing and building on existing relationships with groups and individuals who share and represent the interests of the protected characteristics, however we recognise there is always more we can do, and we will continually strive to improve and ensure our employment practices are accessible and fair.

Key workforce recommendations for 2019/20

- Develop the equality, diversity and inclusion profiles to reflect the local population in which the Trust provides services, including a planned approach to our new hospital in Liverpool
- Achieve the successful implementation of the Workforce Disability Equality Standard (WDES) which will support career progression and make reasonable adjustments to enable all staff to achieve their full potential regardless of disability or any other protected characteristic
- Establish staff equality networks to provide capacity for all staff who wants to become involved within the equality, diversity and inclusion domain, to provide feedback and advice to the Trust with regards to policies, functions, services, equality objective setting and equality analysis
- Through training and communication channels raise awareness with all staff regarding the meaning of discrimination, it's impact and consequences on the health and wellbeing of all those exposed to discrimination

2018 Staff Survey Results

Summary of Performance

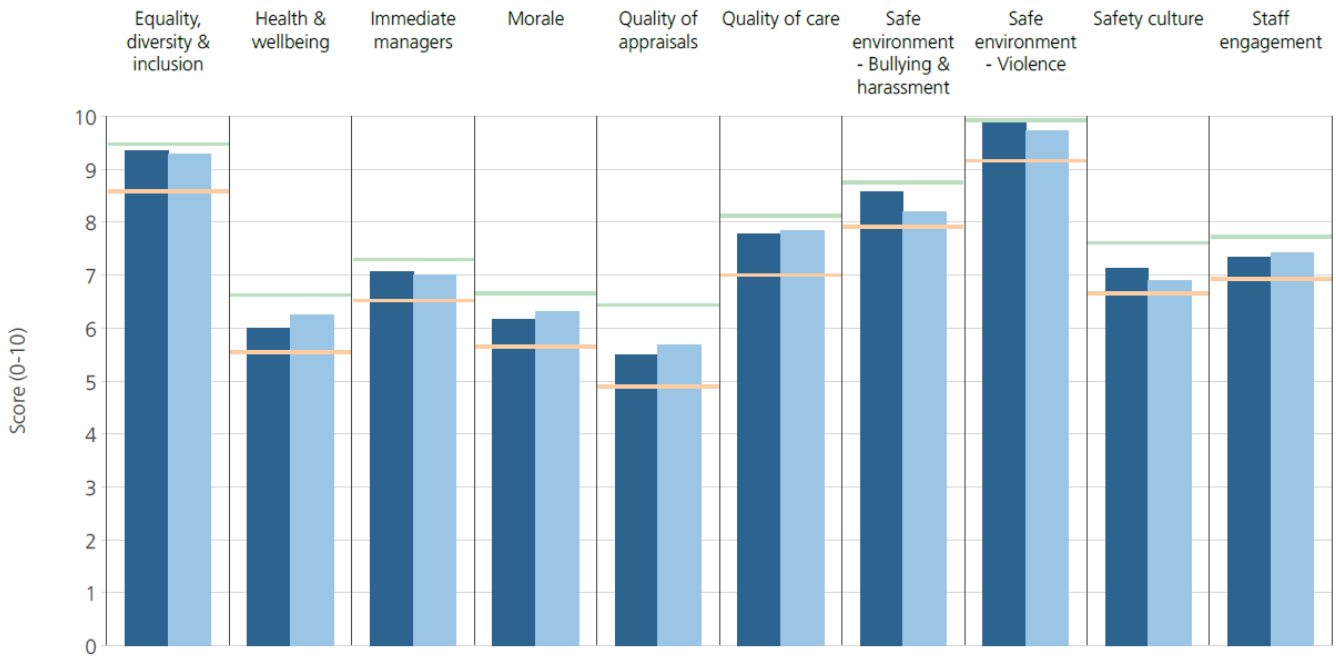
A total of 761 staff out of 1,234 completed the 2018 NHS Staff Survey which represents a response rate of 62%, the same as the 2017 response rate yet significantly higher than the national response rate of 46% and the national sector response rate of 53% for Acute Specialist Trusts. As last year, a mixed method of distribution was used for the 2018 survey with 70% of staff completing on line. The Trust engaged with Departmental Survey Champions, nominated as part of the survey process in 2017 that supported the Trust to actively promote the survey within their departments during the survey window.

	2017 Survey		2018 Survey		Trust improvement/ deterioration
Response rate	Trust	National Average	Trust	National Average	
	62%	45%	62%	46%	0% increase

Survey Highlights

Overall our results are similar to our comparator group and there are no significant changes from the 2017 survey. For the 2018 survey, there have been changes to how the results are reported in that key findings have been replaced with ten themes, scored on a 0 to 10 point scale, the higher the score the better. The table below shows the Trust's performance against the ten key themes, indicated by 'Your org' compared to the best, average and worst scores within the national sector (Acute Specialist Trusts).

Overview of Theme Scores



Best	9.5	6.6	7.3	6.7	6.4	8.1	8.8	9.9	7.6	7.7
Your org	9.4	6.0	7.1	6.2	5.5	7.8	8.6	9.9	7.1	7.3
Average	9.3	6.3	7.0	6.3	5.7	7.8	8.2	9.7	6.9	7.4
Worst	8.6	5.6	6.5	5.6	4.9	7.0	7.9	9.2	6.7	6.9
Responses	748	757	752	739	700	595	748	750	753	756

The Table below shows our ranked theme scores with a comparison to the National Sector Scores and equivalent scores for 2017.

Ranked Theme Scores

Theme No.	Theme Name	Trust Score 2017	Trust Score 2018	Sector Score 2018
8	Safe Environment – Violence	9.9	9.9	9.7
1	Equality, Diversity & Inclusion	9.5	9.4	9.3
3	Safe Environment – Bullying & Harassment	8.5	8.6	8.2
4	Quality of Care	7.6	7.8	7.8
5	Staff Engagement	7.4	7.3	7.4
6	Safety Culture	7.1	7.1	6.9
7	Immediate Managers	6.9	7.1	7.0
8	Morale	-	6.2	6.3
9	Health & Wellbeing	6.2	6.0	6.3
10	Quality of Appraisals	5.1	5.5	5.7

Our overall engagement score is 7.3, slightly lower than the equivalent scores in 2017 (7.4) and 2016 and also the national sector score. Staff engagement is measured across three sub sections Advocacy, Motivation and Involvement.

The survey results indicate that

68% of CCC staff would recommend CCC as a place to work

89% of staff agreed they would be happy with the standard of care provided by CCC

85% of staff agreed that the care of patients is the Trust's top priority

30% of staff agreed that they often think about leaving the organisation

The overall theme for safe environment – violence is better than the sector score.

Comparison of 2018 Survey Scores to 2017

At question level compared to the 2017 results, 10 questions have shown a significant improvement, 5 questions have shown a decline and 67 questions have shown no significant movements.

Improved Scores Compared to 2017

Question	2017	2018	Diff
There are enough staff at this organisation for me to do my job properly	33%	40%	+6.78%
Satisfaction with recognition for good work	51%	56%	+5.13%
Satisfaction with the quality of care given to patients	82%	87%	+4.89%
I am able to deliver the care I aspire to	68%	75%	+6.64%
My immediate manager asks for my opinion before making decisions that affect my work	56%	61%	+5.33%
My immediate manager takes a positive interest in my health and wellbeing	68%	73%	+4.82%
We are given feedback about changes made in response to reported errors, near misses and incidents	61%	71%	+9.80%
In the last 12 months, have you had an appraisal?	91%	94%	+3.13%
Did it (the appraisal) leave you feeling that your work is valued by the organisation?	73%	79%	+5.77%
Were the values of your organisation discussed as part of the appraisal process	76%	87%	+11.36%

All of the Trust's scores relating to immediate managers have shown improvement since 2017. Staff reporting that they had an appraisal in the last 12 months is in the top 20% of sector and is an improvement from 2017. There has also been an improvement in two scores relating to the quality of appraisals in that the appraisal discussion left staff feeling valued and that our Trust values were discussed as part of it. All questions relating to the quality of care have improved since 2017. With regards to a safety culture there has been an improvement in staff agreeing that they are given feedback about changes made in response to reported incidents.

Scores Declined Compared to 2017

Question	2017	2018	Diff
In the last 12 months have you experienced musculoskeletal problems as a result of work activities?	17%	21%	+4.19%
Care of patients/service users is my organisation's top priority	89%	85%	-4.21%
My organisation acts on concerns raised by patients/service users	84%	79%	-4.44%
I would recommend my organisation as a place to work	73%	68%	-5.45%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	92%	89%	-3.47%

The overall score for health and wellbeing is in line with sector however the number of staff responding positivity that the Trust takes positive action is below sector score. Percentage of staff reporting feeling unwell due to work related stress is slightly worse than sector. Scores relating to satisfaction with resourcing and support are low. Although only 40% of staff agrees that they can meet the conflicting demands of their time at work, this has improved from 2017 (41%). There has also been a decline in staff agreeing that they have the right equipment to do their jobs. Scores relating to senior managers communication and involvement are lower than the rest of the sector.

Areas Highlighted for Improvement & Progress

Following the 2017 Staff Survey results the following were identified as the Trust's top three areas of focus for improvement for 2018/2019.

- Improving the health and wellbeing of our staff - Staff workload and reducing the experience of work related stress
- Staff engagement and involvement in change – our staff highly recommend the Trust as a place of work, look forward to coming to work and are highly motivated to deliver compassionate care
- The quality of appraisals including career development and succession planning – Ensuring our staff feel part of our vision for the future and feel valued

The table below summarises progress made in these areas

Areas Highlighted for Improvement	Progress to Date
Improving the health and wellbeing of our staff	• Health and wellbeing is a key element of the Workforce and Organisational Development strategies developed in 2018 • Review of the Trust's Stress Management Policy and established a Mental Health & Wellbeing Task & Finish Group • Trained staff members to be Mental First Aiders as part of a Mental Health First Aid programme to provide early interventions and offer support for staff who may be experiencing a mental health issues. Mental health and mental wellbeing training is being developed and will be rolled out across the Trust in 2019/20 • Launched Vivup, a benefits programme aimed to improve health and wellbeing which includes an Employee Assistance provision • Continued focus on embedding of our Trust Values and behaviours and as part of this launched the 'Respect for Each Other' campaign in September 2018 which includes a toolkit to provide information, advice and solutions to dealing **with workplace bullying and harassment and other forms of unacceptable behaviour. Respect for Each Other Champions have been appointed and bullying and Harassment Awareness training is being rolled out across the Trust** • **Implemented an internal Leadership development programme to enhance leadership capability and management effectiveness and also rolled out attendance management training for managers**

Areas Highlighted for Improvement	Progress to Date
Improving the health and wellbeing of our staff	• A number of initiatives are on-going to help address issues relating to staff work load and staffing including: ► The Trust's workforce planning process which continuously identifies and reviews resourcing requirements and implementation plans to meet our future service needs ► Departmental staff survey action plans and addressing staff concerns raised
Staff engagement and involvement in change	• Throughout 2017 and 2018 carried out a series of honest conversations and focus groups with key staff groups to involve staff in our vision for the future and various initiatives of our transformation programme to better understand what information and support staff need • Established a Staff Engagement Steering Group and a bi monthly Senior Leaders Forum with the aim of engaging more effectively with our staff and providing an opportunity for involvement and feedback • Staff engagement is a key element of the Organisational Development Strategy which was developed in 2018, implementation plans are currently in progress in conjunction with the development of a Communication, Engagement and Marketing Strategy to inform priority areas for development and focus for 2019/20
The quality of appraisals including career development opportunities	• Continued to focus on driving the Performance, Appraisal and Development Review (PADR) compliance across the Trust seeing improvements in Trust compliance rates and also improvements in staff survey scores relating to appraisals in 2018 • In 2018 we enhanced the PADR process by incorporating a Career Development Section into the main PADR documentation and we are currently developing an 'on line' PADR Process for 2019 that will help embed a performance management and development focused culture • Created a talent management tool for managers to use to capture summaries of the career development discussions with their staff and to help create succession plans, inform workforce and development plans • Developing a Trust Wide Education Strategy which will include the development of career pathways demonstrating the required knowledge, skills, experience and job requirements for each position within the Trust, this will support staff with career development planning

Future Priorities

The Trust will continue to focus on the key areas identified above for improvement following the 2017 survey results and is currently reviewing and refreshing action plans to align to initiatives and drive real improvements throughout 2019/20. In addition we will work with managers and staff to better understand how we can continue to improve the support offered by immediate managers and how this group of staff can have a positive impact on the culture of the Trust which will be particularly important as we plan to mobilise our workforce and open the new hospital in Liverpool in 2020. The 2018 results, both at Trust and departmental level are currently being communicated across the Trust and Departmental managers are tasked with working with their teams to develop, review and refresh action plans to bring about improvements in 2019. The progress of action plans will be reported via the Workforce, Education and OD Committee reporting up to the Quality Committee to Trust Board.

Disclosures set out in the NHS Foundation Trust Code of Governance

The Clatterbridge Cancer Centre NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Trust will seek to comply with the code and review and monitor compliance via the Audit Committee. With the exception of the provision within this disclosure, the Board considers itself compliant with the NHS Code of Governance and has made the required disclosures within the Annual Report.

Provision B1.2 states that “at least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent”

Explanation: The Board is reviewed by the Nominations Committee. Currently, the Board consists of six executive directors, including the Chief Executive and six non-executive directors, including the Chair and a non-voting Associate non-executive director. Paragraph 3.3.5.1 of the Trust’s Standing Orders ensures that where a vote is taken at a Board of Directors meeting, the Chair of the meeting will have a second and casting vote in case of inequality of votes.

The Trust has set out within the Annual Report how the code principles have been complied with.

NHS Improvement’s Single Oversight Framework

NHS Improvement’s Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where ‘4’ reflects providers receiving the most support, and ‘1’ reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

Following review by NHS Improvement, the Trust has been placed in Segment 1.

Finance and Use of Resources

The finance and use of resources theme is based on the scoring of the five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2018/19 scores				2017/18 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	1	2	1	1	1	1	1	1
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	I&E margin	1	1	1	1	1	1	1	1
Financial controls	Distance from financial plan	1	1	1	1	1	1	1	1
	Agency spend	2	1	1	1	1	1	1	1
Overall scoring		1	1	1	1	1	1	1	1

Statement of the Chief Executive's Responsibilities as the Accounting Officer at The Clatterbridge Cancer Centre

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- Value for money is achieved from the resources available to the Trust;
- The expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- Effective and sound financial management systems are in place; and
- Annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as a the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer

Dr Liz Bishop
Chief Executive
Date: 23 May 2019

Annual Governance Statement

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of The Clatterbridge Cancer Center NHS foundation Trust's polices, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that The Clatterbridge Cancer Centre NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accountable Officer Memorandum.*

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather that to eliminate all risk failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritize the risks to the achievement of the policies, aims and objectives of The Clatterbridge Cancer Centre NHS Foundation Trust, to evaluate the likelihood of those risks being realized and the impact should they be realized, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Clatterbridge Cancer Centre NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership
As Accountable Officer, I have overall accountability for risk management within the Trust, ensuring that the organisational structure is in place to ensure this occurs. Senior leadership is delegated through the Executive Directors and operationally through Directorates, Departments and Committee Structure. Following review by the new Executive Team the Committee structure was revised early January 2019 in order to provide clarity of reporting which in turn will provide additional assurance to the Board. The revised structure incorporates the introduction of a higher level Risk Management Committee, chaired by the Chief Executive which will provide assurance and challenge to the Trust's risk management processes.

The sub-committees of the Board are all chaired by a Non-Executive Director which in itself enables and enhances independent scrutiny and challenge. In addition, the Audit Committee's role is to scrutinise and seek assurance that risk is managed effectively within the Trust; this role is further supported by Board committees that oversee specific aspects of the risk portfolio. In addition, each committee has a standing agenda item relating to the review of risks that have been allocated to that particular committee.

Our systems are further supported by the evaluation of the effectiveness of risk management and control systems in addition to the implementation of recommendations from external assessments which in turn promote organisational learning and dissemination of good practice within the Trust.

The Trust has a Risk Management Strategy clearly setting out the accountability and reporting arrangements to the Board which will be updated to reflect the recent changes to the committee structure.

Training and guidance on the management of risk
Risk management training is mandatory for all staff including senior managers and Board members. Expert advice and assistance is provided by the Clinical Governance Team in addition to the availability of a number of policies which describe the roles and responsibilities around the identification, management and control of risk. Following feedback from our recent CQC Inspection, additional training will be scoped in relation to risk description, management and escalation.

The risk and control framework

Key elements of the Risk Management Strategy are to manage and control all identified risks including clinical, non-clinical and financial. This is achieved through an organisational framework which promotes early identification of risk, the co-ordination of risk management activity, the provision of a safe environment for patients and staff in addition to the effective use of financial resources. It ensures that staff are aware of their roles and responsibilities and outlines structures and processes through which risk is assessed, controlled and managed. Risks are identified through a variety of sources including formal risk assessment, the assurance framework, incident reporting, audit data, complaints, litigation, patient and public feedback, stakeholder/partnership feedback and internal/external assessment.

The identification of risk, assessment, control and action planning is the same throughout all levels of the Trust. All risks are quantified based on the risk management standard ISO 31000:2009 which measures risk using a combination of consequences (which can also be described as severity or impact) and the likelihood (or probability) of an event occurring. The Trust uses the 5x5 risk matrix, whereby both consequence and the likelihood of a risk materialising are given a score that this multiplied to provide an overall risk score. Risks are identified through risk assessment in addition to analysis from other sources such as incidents, claims, complaints, serious incidents or clinical audits.

Directorate risks scoring 15 and above are escalated to the Corporate risk register and the Trust uses the Datix system to support its risk management and risk register processes.

The Board approved the new revised governance structure which was implemented in shadow form from February 2019; this will continue to strengthen our governance practice and oversight. The Board will continue to review compliance with the NHSI Single Oversight Framework including performance against all best practice areas.

The Trust has embedded a Board Assurance Framework which provides a mechanism for Board oversight and the mechanism for the proactive assessment of risk and control which further supports the annual governance statement. The Board Assurance Framework identifies those risks deemed as strategically significant to the achievement of the Trust's objectives. The Board carried out a focused review of the Board Assurance Framework, followed by quarterly reviews at Board level. Further development work is underway in relation to the Board Assurance Framework which is delegated to the Associate Director of Corporate Governance which ensures impartiality from the operational management of the Trust.

Major risks for the Trust
The Board identified a number of high level risks in year which are reflected in the Board Assurance Framework and as at 31 March 2019, the following risks had been categorized:

- Ensuring delivery of high quality patient services (safety, experience and outcomes)
- Ensuring the Trust has the appropriate, motivated and engaged workforce in place to deliver its strategy
- Ensuring financial sustainability and delivery of the financial plan
- Ensuring regulatory compliance with, CQC, NHSI, and other relevant legislation
- Ensuring strong leadership within the Trust and external to the Trust
- Ensuring capability and capacity to deliver major strategic change
- Ensuring adequate infrastructure e.g., estates and IT
- Ensuring robust external relationships and responding to changes in the external environment
- Ensuring responsiveness to technical challenges and development to deliver cancer treatments

The Trust Board recognised and considered a number of strategic challenges as part of its ambition to contribute fully to the Cheshire and Merseyside system leadership in addition to fulfilling the Trust's objective to extend our provision of groundbreaking cancer care in the heart of Liverpool. The challenges comprised the following:

- **Changes to the Board leadership** relating to new Director of Nursing and Quality, Chief Executive, Chair, Director of Finance, Director of Workforce and OD, in addition to one new Non-Executive Director and one Associate Non-Executive Director.
- **Regulatory compliance:** Although the Trust is fully compliant with the registration requirements of the CQC, we are required to maintain ongoing compliance with the CQC standards of safety and quality for all its regulated activities across all locations. The Trust achieved an overall rating of 'Good' following the inspection process carried out during December 2018 and January 2019.

In response, the Trust developed a programme of work to address each of the regulated 'Must do' requirements. In addition, a programme of work has continued to address the 'Should do' requirements The Trust responded to the issues raised by the CQC through the immediate implementation of a comprehensive action plan with focus on the priority areas relating to the Fit and Proper Person requirement, mandatory training and staffing. Leadership around delivery of the action plan is provided by the Executive Directors with progress overseen by the Quality Committee and the Trust Board.

- **Challenges in organisational performance and developments in the local health economy to drive forward the Cancer Plan:** The Trust is a major contributor to the success of the Cancer Alliance and recognizes the enhanced leadership role in the future delivery of the Cancer Alliance Strategy. As Chief Executive, I have taken on role as Chair of the Cancer Alliance.
- **Cyber security, information governance risks and associated reportable incidents to the Information Commissioner:** The Trust continues to maintain a robust action plan for Cyber Security which is monitored via the Digital Board with exception reports to the Trust Board. To ensure we continue to deliver the best cancer care possible, we have commenced an ambitious transformation change programme that aims to expand and improve cancer care across our region. To support our digital journey, we are proud to be part of the NHS England's Global Digital Exemplar Programme. Thorough our newly acquired Global Digital Exemplar (GDE) Fast Follower status we have, as a Trust committed to Cyber Security as a key priority.

All areas of delivery and risk are assessed and any identified risks are included within the Trust's Board Assurance Framework and risk register.

Compliance with NHS Foundation Trust condition 4 (FT governance)
The Board considers the corporate governance statement on an annual basis prior to confirming compliance. All statements were confirmed in the review during May 2019 with no unmitigated risk compliance identified and the Trust believes that effective systems and processes are in place to maintain and monitor the following:

• Effectiveness of governance structures
• Responsibilities of the directors and sub-committees of the Board
• Accountability and reporting lines between the Board, sub-committees and the executive team
• Degree of rigor of oversight the Board has in relation to the performance of the Trust

The Trust has reviewed it's compliance with the NHS Foundation Trust condition 4 (FT Governance) and recognizes there are areas that require strengthening and it is expected that the new governance process will provide further assurance to the Board. The new committee structure and revised terms of references provide additional clarity in relation to the responsibilities of the committees.

The Board receives and reviews monthly integrated performance reports including the financial report ensuring the Board is appraised of the Trusts performance and is able to challenge and scrutinize the performance. Development work has begun on enhancing the performance report to incorporate scorecards and key performance indicators which will further enhance the ability for scrutiny and challenge around performance.

Incident reporting arrangements are embedded with the organisation, The Trust encourages of culture of identifying the causes of incidents, learning lessons from them and providing feedback and support for staff involved in incidents.

Safer staffing reports are provided to the Board twice a year with monthly safer staffing dashboard reported to the Quality Committee.

The Trust is fully compliant with the registration requirements of the Care Quality Commission and its current registration status is unconditional.

In line with the ongoing work relating to the register of interests policy and associated register, the Trust will be extending that work to publish an up-to-date register of interests for decision-making staff as required by the Managing Conflicts of Interest in the NHS guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust will be undertaking further work relating to risk assessments around our sustainable development management plan, taking into account of the UK Climate Projections 2018 (UKCP18). This will include collating and reviewing assurance that the Trust complies with its obligations under the Climate Change Act and the Adaption Reporting requirements.

Review of economy, efficiency and effectiveness of the use of resources
As the Accounting Officer, I am responsible for ensuring that the organisation has arrangements in place to secure value for money in the use of resources. The Trust achieves this through the following systems:

- Setting and monitoring the delivery of strategic and operational objectives
- Monitoring and review of organisational performance
- Delivery of efficiency savings
- Workforce review

Annually, the Trust produces an operational plan which incorporates a supporting financial plan for approval by the Board of Directors. The approved plan informs the detailed annual financial and performance plans and forecasts which are monitored monthly via the performance review meetings.

External audit provide an independent opinion on the Trust's financial statements and may review, and report on, aspects of the arrangements put in place to ensure the proper conduct of the Trust's financial affairs and performance and use of resources.

Reports on specific issues relating to economy, efficiency and effectiveness are commissioned by the Audit Committee from the Trust's Internal Auditors and it also receives reports from the External Auditors as required. The Audit Committee monitors closely the implementation of Audit recommendations and effective performance has been demonstrated through the achievement of all the key NHS targets and allocation of segment 1 (NHSI).

Information Governance
The Trust has in place robust and effective systems, procedures and practices to identify manage and control information risks. In addition we have retained significant assurance in our submission relating to the Data Protection and Security Toolkit. The Trust was not involved in any incidents that required reporting to the Information Commissioner.

Annual Quality Report
The directors are required under the Health Act 2009 and the National Health service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Trust has an established process in place for the preparation of the Quality Report. The following steps have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of the data:

- The Director of Nursing and Quality is responsible for the Quality Strategy and the Quality Report. The Board receives a quality report that is built on the structure of the annual Quality Report to ensure progress against priorities and monitoring of performance measures are reviewed throughout the year to ensure the Quality Report is balanced

- The Quality Report includes information on both good performance and areas for improvements which provides a balanced picture of the Trust's performance

- As part of the Board approval process, the two clinical staff on the Trust Board (Medical Director and Director of Nursing and Quality) approves the data included in the Quality Report

- The Trust has in place policies, strategies and standards to ensure the provision of high quality care which are subject to regular review and audit to ensure compliance with any standards set

- Systems and processes are in place for the collection, recording, analysis and reporting of data which are being strengthened to ensure we can focus on securing data which are accurate, valid, reliable, timely, relevant and complete

- The draft Quality Report is provided to external stakeholder groups; Healthwatch Wirral welcomed the Trust's ongoing commitment to continuous improvement and our vison to provide the best cancer care to our patients

In addition, our external auditors have reviewed the Quality Report and have provided an independent opinion

Review of Effectiveness
As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within The Clatterbridge Cancer Centre NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors reviews performance across a range of indicators which include both corporate and national objectives and those measures of performance are included in the Quality Report.

The work of the Audit Committee, Quality Committee and Performance Committee are described on pages 38-40 of this report. The Board receives monthly Chair's reports from the aforementioned Committees in addition to commissioned reports on areas of concern where additional information and assurance is required. The external assurance audit undertaken by our external auditors as a part of the process of completing the Quality Report will provide the Board and the Council of Governors additional assurance.

My review has also been informed by internal audit providing Substantial Assurance overall across a range of individual opinion; this highlights there are good systems of internal control designed to meet the organisation's objectives and that controls are generally being applied consistently. In addition, following review of the Assurance Framework, internal audit opinion stated that the organisation's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board.

During the reporting period, thirteen reviews were undertaken with one receiving high assurance, five substantial assurances and three moderate assurances. None of the reviews received 'no assurance' but I have received limited assurance opinions in relation to the following:

- Complaints and PALs
- Consultant Job Planning (report in draft at the time of reporting)
- TCC Programme Management
- Service Review – Integrated Care

Actions identified as part of the above reviews are monitored through the governance structure, with an Executive Lead assigned to each action and signed off at the relevant sub-committee of the Board. Improvement will be demonstrated and monitored through the Audit Tracker at the Audit Committee. Thereafter progress against the actions are presented to the Audit Committee.

Conclusion
As Accounting Officer, and based on the review process detailed above, I am assured that there are no significant internal control issues.

Dr Liz Bishop
Chief Executive
23 May 2019

Statement of Director's Responsibilities in Respect of the Accounts

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognized gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- Apply on a consistent basis accounting policies laid down by the Secretary of state with the approval of the Treasury;
- Make judgements and estimates which are reasonable and prudent;
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with the requirements outlined in the above mentioned direction by the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The Directors confirm that the annual report and accounts, taken as a whole, is fair, balance and understandable and provides the information necessary for patients, regulators and stakeholders to assess The Clatterbridge Cancer Centre NHS Foundation Trust's performance, business model and strategy.

By order of the Board

23 May 2019  **Chief Executive**

23 May 2019  **Director of Finance**

Quality Report

Our Vision: To Provide The Best Cancer Care To The People We Serve

2018 / 2019

Contents

Part 1: Statement on Quality from the Chief Executive

High quality care is at the heart of what our staff aim to achieve for patients in our care. I would like to thank our staff and volunteers for the professionalism, expertise and commitment which has ensured that we are able to deliver a high quality service.

Our Vision is to provide the best cancer care to the people we serve. To deliver our vision we have made it our Mission to improve health and well-being through compassionate, safe and effective cancer care. We constantly strive to continuously improve the quality of service we provide to our patients.

Our values, developed with our staff, demonstrate our commitment to how we work:

- Passionate about what we do
- Putting people first
- Achieving excellence
- Looking to the future
- Always improving our care

In 2018/19 we were inspected by the Care Quality Commission. The Trust achieved an overall rating of good and outstanding in care.

The Trust Board continues to ensure that Quality and Safety is a key priority and this is reflected in the new governance arrangements and structures introduced in 2018/19. The Trust Board continues to oversee the delivery of the Trust's quality priorities and initiatives.

As a Foundation Trust we work closely with our Council of Governors in shaping the Quality Strategy. The Governors are kept appraised of progress in the delivery of the plans it contains. The Governors also receive the quarterly Quality Committee Performance Report.

We continue to work with our staff and our key stakeholders to continue to improve the quality of our services. This year has seen a number of key developments and challenges for the Trust including:

• A key part of our Trust strategy and Transforming Cancer Care initiative continues to be realised in the building of a new cancer centre in Liverpool due to open 2020. We are committed to working in partnership with our patients and the Royal Liverpool and Broadgreen University Hospital Trust.(RLBUHT)

• The continued integration of our Haemato-oncology service based at RLBUHT, acquired July 2017.

• The opening of a Clinical Decisions Unit in 2018 to provide streamlined quality care for our patients

• I am particularly pleased to be able to report again that we have achieved against our clostridium difficile and MRSA targets. Whilst we had 12 cases of clostridium difficile (C.diff), only 2 cases were attributable against a maximum of 4 cases, post infection reviews identified no lapses in care at time of reporting.

• By 31st March 2019, it has been 7 years and 275 days since our last case of MRSA bacteraemia attributable to the Trust.

• We achieved consistently high scores in the Patient Care Quality Commission surveys and National Cancer Patient Experience Survey (published September 18). The average rating given by the Trust respondents when asked to rate their care on a scale of zero (very poor) to 10 (very good) was 8.9.

• In the 2018 NHS Staff Survey we saw an improvement in scores relating to the key theme, Quality of care, and scored above the national sector score. Whilst all of the questions in these surveys are important one particular staff survey question provides me with assurance of the quality of care. When staff were asked 'if a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust' 89% replied yes. 87% agreed that they are satisfied with the quality of care that they give to patients and 91% responded 'Yes' to feeling that their role makes a difference to patients.

• Our annual PLACE (Patient Led Assessment of the Care Environment) was undertaken in May 2018. The actions from this assessment have been regularly reviewed throughout the year to ensure we continue to improve our patient experience.

• We continue to support our healthcare staff in the completion of the Care Certificate. As agreed at Trust level, this includes all band 4 staff and below, existing and newly qualified).As at March 2019, of the 160 staff required to complete, 72 staff have achieved the care certification with 21 in progress

As Chief Executive I am confident that the Trust provides a high quality service and that this Quality Account demonstrate this. To the best of my knowledge the information in this report is accurate.

In summary, The Clatterbridge Cancer Centre NHS Foundation Trust (CCC) has a solid track record in the delivery of high quality services and outstanding care for our patients. We will continue to deliver against the objectives we have set and will continue to improve quality in the challenging times ahead.

I would like to thank the staff of The Clatterbridge Cancer Centre for their exceptional commitment and professionalism, which ensures that we can continue to work as a leading cancer centre.

Dr Liz Bishop Chief Executive
Date:23 May 2019

During the last year in our cancer centre:

We cared for 8019 in- patients	We saw 11,916 new out-patients
We delivered 92,179 outpatient radiotherapy treatments	We delivered 57,720 outpatient chemotherapy treatments

During the last year we had:

0 cases of MRSA	2 cases of attributable Clostridium difficile
17 formal complaints	28 attributable pressure ulcers (1 lapse in care)

Introduction

The Quality Report provides an overview of performance in key priorities set for improving the quality of care provided to patients and to achieve our vision to provide the best cancer care to the people we serve. It outlines our future priorities for continuous quality improvement and reports on key quality measures.

Over the coming years the Trust will continue to keep a strong focus on improving the quality of the service it provides. This is primarily achieved through the delivery of the Quality Strategy. This strategy is being refreshed in 2019, with a clear focus on defining the quality objectives that take us towards 'Transforming Cancer Care' which is our key strategic objective culminating in the build of a new state of the art cancer centre in Liverpool.

The strategy aims to improve:
- Patient Safety: *Always safe, always effective*
- Patient Experience: *Striving for excellent patient satisfaction*
- Outcomes / Effectiveness: *Efficient, effective, personalised care*

Part of our Quality Strategy is the ongoing review and monitoring of our local and national quality standards. We are also committed to ensuring transparency and we publish this information on our website 'High Quality and Safe Care'. We publish information in relation to the Care Quality Commission's (CQC) '5 key questions'.

Are We Safe includes:
- Open and Honest Care
- NHS Safety Thermometer- an improvement tool for measuring, monitoring & analysing patient harms & 'harm free' care in 4 key areas: Pressure Ulcers, Falls, Urinary infection (in patients with a catheter), Treatment for Venous Thromboembolism

- Medicines Thermometer- a measurement tool for improvement that focuses on: medication reconciliation, allergy status, medication omission, and identifying harm from high risk medicines.
- Healthcare associated infections
- Patient Led Assessment of the Care Environment (PLACE)
- Incident reports

Are we Effective includes:
- Compliance with patient risk assessments
- 30 day mortality post treatment

Are we Caring includes:
- Ward nursing staff levels
- Patient feedback

Are we Responsive includes:
- Compliance with cancer waiting times

Are we Well Led includes:
- Integrated performance report
- Staff feedback
- Nursing care indicators
- Quality accounts

https://www.clatterbridgecc.nhs.uk/about- centre/our-expertise/our-standards

Throughout the year we actively engage with our staff, governors (as elected representatives of our members), our Patient's Council and members of local Healthwatch and Overview and Scrutiny Committees. A public governor is a member of our Quality Board Committee which is the main forum for oversight of the delivery of the Quality Strategy and a governor also sits on the Trust Board. A Council of Governors Patient Experience Committee actively reviews patient experience measures and reports including detailed analysis of all patient complaints.

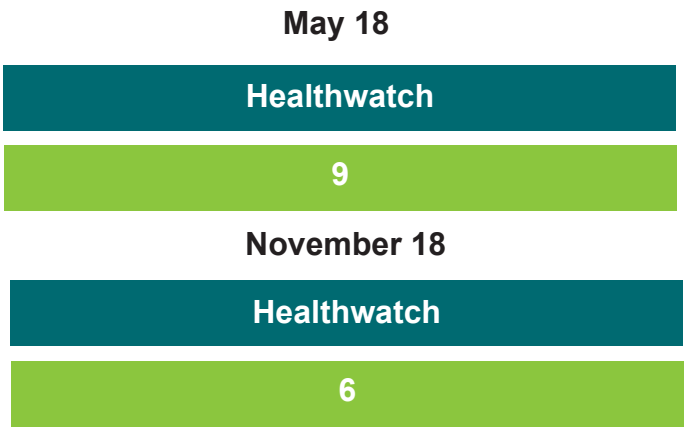
Part 2: Priorities for Improvement and Statements of Assurance from the Board

The three main Quality priorities have been developed through an ongoing programme of engagement with the Trust Board, Council of Governors, Commissioners and local Healthwatch as well as our staff through ongoing engagement processes throughout the year.

Due to the size of the population served, the Trust has endeavoured to engage with all Healthwatch and Overview and Scrutiny Committees (OSC) in developing the Quality Report and key priorities.

In May and November 2018 the Trust held two engagement events to which it invited Healthwatch and OSC representatives from across Merseyside and Cheshire. At these events the Trust presented information and progress on the delivery against its 2017/18 key priorities. An engagement event is planned in June 2019 to further discuss the priorities for 2018/19. The Trust will continue to use these engagement events to continue to improve engagement with Healthwatch over the coming year.

Representation from Healthwatch and OSC:



The Trust continued to monitor performance against its Quality Strategy through its Quality Committee.

2.1 18/19 Report: Priorities for Improvement

Priority 1: Safety

Patient Safety: *Always safe, always effective*

Patient safety:
Developing enhanced management and care of the deteriorating patient

Why have we chosen this priority?

In December 2018 the Trust launched a digital pathway to record and escalate a patient's clinical condition and the need for escalation of care. The NEWS2 track and trigger tool is a national tool used to identify the deteriorating patient and support clinical staff in appropriate action. The trust also launched a digital sepsis pathway at the same time. This has helped to highlight and identify patients with potential sepsis and ensure they receive the right treatment according to national guidelines. Education was provided at the time of the launch to patient facing staff in use of the digital tools and an on-going E- Learning module is in place for NEWS2 training. Further enhanced training is proposed for key clinical staff around sepsis and a train the trainer system for sepsis management will be implemented for the deteriorating patient and resus team (DaRT) Nurse Practitioners.

This is linked to the Advancing Quality Alliance (AQUA) programme and audit tool for the management of sepsis. The Clinical Director and Integrated Care Directorate (ICD) Matron are leading on this piece of work with the clinical teams. A deteriorating patient steering group has been set up to support the clinical objectives around the care and management of the deteriorating patient and will also support any future developments. This group will feed into the Mortality and Morbidity Group and Integrated Governance Committee.

As a Cancer Trust, it is essential that the care of patient with potential sepsis is managed efficiently and effectively:-

- To prevent patient harm
- Ensure standardised quality pathways across all clinical services
- Prevent avoidable deaths
- Standardise clinical tool to identify the deteriorating patient

How will we monitor and measure progress of this priority

Monitoring and measuring of progress will be through the Quality Committee of the Board who will have oversight of delivery of:

- Monthly audit of management of the septic patient in line with sepsis 6 guidance
- Daily NEWS2 and Sepsis pathway compliance
- Review of all deaths linked to sepsis in mortality & morbidity meeting
- Education for key staff in sepsis awareness
- Development of the deteriorating patient and resus team
- Interface work with the RLBUHT to agree clinical pathway with critical care and outreach services for 2020.

Priority 2: Experience:

Patient Experience: *Striving for excellent patient satisfaction*

Patient Experience:
Delivering a Nursing and Allied Healthcare Professionals model of Shared Governance

Why have we chosen this priority?

The national critical shortage of registered nurses and AHP's is a worrying theme in healthcare. In response to this situation, more organisations are turning to a shared governance model. This model enables shared decision making based on the principles of partnership, equity and ownership and empowers all members of the healthcare workforce to have a voice in decision making which directly influences safe patient care and experience. At the CCC a shared governance framework is being developed to ensure Allied Healthcare Professionals (AHPs)and nursing staff are empowered as leaders to be involved with, and to assist, in shaping organisational clinical decision making. This is evident as part of "business as usual" as well as within the Transforming Cancer Care Agenda. Strong clinical leadership is vital to ensure the Nursing/AHP voice is heard from floor to Board. Nursing has a strong leadership and governance model within the trust and is represented at board level by Director of Nursing & Quality (DoN&Q). Matrons and Ward Leaders work closely with the DoN&Q and Deputy Director of Nursing regarding decision making aligned to the Quality Agenda as well as the Matrons being part of the "triumvirate" within directorate senior leadership teams. Nursing leadership development is a priority area for the Trust as well as pushing the boundaries in developing clinical practice. CCC has a professional nurses forum and this is attended by a number of registered nurses across the organisation and is where National, Regional and local updates are shared and discussed. A similar forum for the non- registered nursing workforce is also being explored.

The senior AHP leaders within the Trust are working with colleagues and the national AHP leaders (providing external advice and support), to develop the first Trust AHP strategy and a more robust AHP reporting structure within the organisation. This will inform, shape and define the structure and development of AHP leadership, AHP clinical practice and AHP clinical developments within the organisation. Through an improved reporting structure and the promotion of innovations, AHP work will be able to more closely align, support and influence the organisational clinical decision making. An

AHP forum will be developed for all AHPs across the Trust and this will feed into the already formed AHP senior leader team for effective monitoring and promotion of their objectives.

How will we monitor and measure progress of this priority

Progress with be monitored through the Quality Committee of the Board against the Trust Objectives for 2019/20:

- Introduction of a refreshed Nursing Forum, led by Matrons, that supports the professional development of all registered nurses and is where National, Regional and local updates are shared and discussed.
- Introduction of a refreshed AHP Forum, led by senior AHPs, that supports the professional development of all AHP groups and is where national, regional and local updates are shared and discussed.
- Q4 implementation of a shared multi- professional forum, decided by consensus, with agreed collaboration to promote mutual core objectives, development and learning.
- Delivery of the Patient & Public Involvement & Engagement Strategy
  19-21 milestones to enhance patient care, improve services and patient experience.

Priority 3: Effective:

Outcomes / Effectiveness: *Efficient, effective, personalised care*

Patient Outcomes/effectiveness:

Delivering outstanding Patient Experience through achievement of the Patient & Public Involvement & Engagement Strategy 19-21

Why have we chosen this priority?

The vision of The Clatterbridge Cancer Centre NHS FT is to provide the best cancer care to the people we serve. This Patient and Public Involvement and Engagement Strategy 2019-2021 aims to support this vision, by ensuring patient and public experience and feedback is used to enhance the care and services we provide and to ensure, in line with our values, that we always improve our care by listening to our patients and those whose lives we touch. The seven key pledges of the strategy will ensure our patients continue to receive the safest care possible, and in an environment where all complaints raised are listened to, and used, for improving the quality of care by the Trust, as a truly learning organisation.

Patient and public feedback, involvement and engagement is essential in helping us to shape our future model of care and in supporting us on our exciting cancer care transformation journey, allowing us to continue to deliver outstanding care for our patients

How will we monitor and measure progress of this priority

Monitoring and measuring of progress will be through the Quality Committee of the Board who will have oversight of delivery against the key milestones of the 7 pledges of the strategy.

How we did last year: Progress made since publication of the 2017/18 report:

In our Quality Report last year (2017/18) we identified the following priorities:

Priority 1: Safety:

Implement a Human Factors (HF) Programme

Why did we choose this priority?

Human factors is about enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings.

Human Factors is an established scientific discipline used in many other safety critical industries. Human Factors approaches underpin current patient safety and quality improvement science, offering an integrated, evidenced and coherent approach to patient safety, quality improvement and clinical excellence.

How we did last year –some key implementation examples:

- Human Factors (HF) awareness and training delivered to key staff groups and integrated into leadership training for staff
- Use of fishbone model for investigations/Serious Untoward Incidents

- Re design of incident investigation with focus on HF
- Introduction of Serious Incident Learning Reviews
- Promotion safety culture and use of SBAR tool (Situation, Background, Assessment, Recommendation)
- HF approach embedded into Quality and Safety agenda: Quality & Safety Data Packs
- Shared Learning Briefing and Newsletter launched
- Mortality Review Meetings -forum for HF
- Executive/ Non-Executive and Governor support HF focused leadership walk- rounds
- Re modelling of Policies/Standard Operating Procedures

Progress has been monitored through the Board Quality Committee. Progress is measured against evidence to include staff training, incident review process and evidence of learning.

Priority 2: Experience:

Implement Reminiscence Therapy (RITA) for dementia patients supported by volunteers.

Why did we choose this priority?

Cancer is often described as a disease of older age. Many of our in-patients have

many co-morbidities including dementia which can increase risk of harm such as falls.

Reminiscence therapy is defined by the American Psychological Association as “the use of life histories – written, oral, or both – to improve psychological well-being. The therapy is often used with older people.”

How we did last year

RITA is now established and freely available on the inpatient wards. The device has not only been used for those patients with dementia, the AHP teams have utilised the device to supplement their care using software/games to enhance hand eye coordination. One patient was able to spend some time using the karaoke function which was a favourite of his. The device also has an interpretation function which has been invaluable to improve communication and assisting with patient assessments.

Reminiscence therapy is now a work stream within the Dementia Strategy and will build on the work already implemented such as ‘John’s Campaign’ (visiting rights for family carers of patients with dementia in hospitals in the UK)

Progress of the programme is monitored through the Board Quality Committee.
Progress is measured against evidence to include patient and carer feedback, reduction in falls/incidents and complaints.

Priority 3: Effective:

The development of an outcomes dashboard and KPI’s (Key Process Indicators) aligned with Site Reference Groups (SRG’s)

Why did we choose this priority?

This is a quality metric for our patients and supports clinical leadership during transformation, improving the quality of care. The development of a digital outcomes dashboard will drive improvements in the quality of patient care.

How we did last year

Outcomes dashboards and KPI’s aligned with Site Reference Groups (SRG’s) completed include head and neck, upper GI, Lung, Breast, Skin and Palliative care. Additional dashboards are Gynaecology, Colorectal, Urology, CNS and Acute Oncology/ unknown primary. Work is now ongoing to produce these dashboards from the Trust Data Warehouse to further support the new clinical model introduced in 2018/19 and the Trusts mortality and outcomes programme
Progress has been monitored through the Board Quality Committee and measured against dashboard development, improved outcomes and performance against key performance indicators.

Other key Quality focus Priorities

Safeguarding

In addition to the three priorities identified above the Trust committed in 17/18 to the strengthening and improving of its safeguarding policies and processes. Underpinned by a robust safeguarding improvement action plan delivered in August 2018, the Trust has strengthened its safeguarding team and employed a Head of Safeguarding and Named Nurse for safeguarding. The team continues to support the Trust and its patients by driving this agenda forward and provide expert knowledge and training to all staff

Falls

The Trust has a comprehensive falls prevention action plan. The green wrist bands were launched on the inpatient wards January 2018, patients will be allocated one to wear if they have had a history of falling or if they fall whilst an inpatient at CCC. The green wrist band is in addition to the white ID one provided on

admission and is only to provide a visual alert that the patient is at risk of falling. The ‘call don’t fall’ signs are now in place across the trust in bathrooms/en-suites as a prompt for patients.

Ramblegard falls monitors are now well established on both Conway and Mersey wards.

During 18/19 we have continued to address falls prevention, launching a number of initiatives to help reduce the risk of patients falling. All patients admitted to the trust will now have a lying and a standing blood pressure reading performed, any deficit in this reading is report immediately to the medical team.

Ward pharmacists now perform a medication review on all inpatients with added emphasis on those medications that may increase a patient's risk of falling.

To ensure that patients are supervised appropriately when they are mobilising, the physiotherapy team label all inpatient mobility aids using a RAG rated system. Green for those patients who have been assessed as being able to mobilise independently, amber for those patients who require the assistance of one member of staff and red labels for those patients who need two members of staff to mobilise.

At the start of the year the trust invested in new beds for the Wirral based inpatients, the beds have the ability to be lowered nearer to the floor and also house night lights underneath that can enhance patients orientation if they are mobilising during the night.

All inpatient falls are discussed at the harms collaborative meeting in order that we can learn lessons for the future. One issue highlighted during a review was the bathroom/en-suite lights being energy saving bulbs. This means that there is a short delay in them being bright enough for some patients to see clearly, especially during the night. The Quality Improvement Manager liaised with Prop care who have now applied for and have been awarded a grant to upgrade the current lights to LED, work will begin soon on this.

The trust has also joined the newly formed Cheshire and Merseyside Falls Prevention steering group, collaborating with regional trusts on a number of work streams to reduce the number fall regionally.

In Patient Falls: How we did

Year	Number inpatient falls	Inpatient falls per 1000 admissions
2018/19	122	15.2
2017/18	110*	15.1
2016/17	92	24.7

** from July 2017 the figures shown include the haemato oncology service which was transferred from Royal Liverpool and Broadgreen University Hospital Trust (RLBUHT).*

Falls prevention will remain a Trust priority and continue to be monitored and assessed, acknowledging increasing levels of Trust patient acuity.

Mortality

The Trust's Council of Governors have selected the mortality indicator: 30 days post radical chemotherapy, expanded to include the Haemato-oncology service in 19/20, to deliver a comprehensive Trust- wide mortality review. As a specialist Trust The Clatterbridge Cancer Centre NHS FT is not eligible to utilise SHMI or HSMR as a mortality review tool.

The Trust continues to regularly evaluate, modify and improve the quality of its comprehensive mortality review processes. The Mortality Surveillance Group (MSG) maintains an effective strategic lead in the monitoring and promotion of mortality reduction, having oversight of all Trust related deaths, to include weekend deaths, via the Trust developed mortality dashboard. The MSG takes the lead in reviewing all high risk mortality areas, and

reviews hard and soft intelligence in this regard, as well as internal and external clinical audit feedback. In-depth statistical analysis of chemotherapy and radiotherapy related deaths continues, providing a platform for the interrogation of individual Consultant performance, and continuous monitoring of chemotherapy regimens toxicities and variations in clinical practice.

Trust -wide monthly feedback and dissemination of learning from deaths from Mortality Review Meetings is in place. Structured Judgment Review methodology has been successfully introduced, with all Consultants expected to engage in such reviews, to highlight areas of good practice as well as identify any sub optimal care provision and avoidable deaths. All Trust deaths in care are subject to one or more of five levels of scrutiny, to include a documented specialist Site Reference Group Review or Specialist Committee Review response to a mortality alert investigation process. The Trust continues to share this learning widely with external healthcare providers to include other hospital Trusts, GPs and Coroners.

The adoption of new national mortality guidance and policy has seen the Trust's closer liaison with national and regional partners and external agencies, to include CDOP (Child Death Overview Panel) and LeDER (NHSE Learning Disabilities Mortality Review Programme). Also a focused emphasis on the early involvement of families, and continued open and honest communication with families and carers, in the event of Serious Untoward Incident investigations. In line with new statutory guidance in relation to the management of child (0-18yrs) deaths, the Trust now has an identified Key Worker for any families affected by the death of a child.
The Trust is committed to improving mortality review and review of serious incidents as a driver for improved quality and patient safety.

The Trust Mortality Review Meetings have resulted in a number of changes to clinical

care such as changes to clinical practice, documentation and education and training.

Mortality performance and progress is monitored at the Mortality Surveillance Group and reported to the Board via the Quality Committee.

Oversight of Trust mortality data summary is included in the annual Trust's Quality Accounts.

2.2 Statements of Assurance from the Board

During 2018/19 The Clatterbridge Cancer Centre NHS Foundation Trust provided and/or sub-contracted three relevant NHS services.

The Clatterbridge Cancer Centre NHS Foundation Trust has reviewed all the data available to them on the quality of care in three of these NHS services.

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by The Clatterbridge Cancer Centre NHS Foundation Trust for 2018/19.

In 2018/19 the Trust received £1.600m (£1.457m 2017/18) for achieving quality improvement and innovation goals.

Information on participation in clinical audits and national confidential enquiries

During 2018/19, 18 national clinical audits and 2 national confidential enquiry were relevant to the health services provided by The Clatterbridge Cancer Centre NHS Foundation Trust.

During that period The Clatterbridge Cancer Centre NHS Foundation Trust participated in 18 (100%) of national

clinical audits and 2 (100%) of national confidential enquiries of the national clinical audits and national confidential enquiries for which it was eligible to participate.

The national clinical audits and national confidential enquiries that The Clatterbridge Cancer Centre NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry are contained in the following table.

- National Bowel Cancer Audit
- National Oesophago-Gastric Cancer Audit
- National Head and Neck audit (HANA)
- Female Genital Mutilation
- NCEPOD – Cancer in Children, Teens and Young Adults
- NCEPOD – Pulmonary Embolism
- RCR National Prostate Cancer Audit - Radiotherapy Data
- National Study of Late Effects after Hodgkin Lymphoma
- National Audit of Care at the End of Life (NACEL)
- Acute Kidney Injury
- RCR National audit of the use of radiotherapy in the treatment of vulval cancer
- RCP National Mesothelioma Audit
- Deferred SACT at outpatient clinics
- HCC Sorafinib Outcomes
- 100 day mortality post allogeneic stem cell transplantation
- BSBMT long-term outcomes audit with UK benchmarking, 2004-2016, 9th report published 2018
- NHSE dashboard: outcomes audit with UK benchmarking
- Cancer Outcomes and Services Dataset (COSD)
- National Audit of Breast Cancer in Older patients
- National Lung Cancer Audit

Table 1a: Audits: cases submitted

National Clinical Audit and NCEPOD eligible studies	Cases submitted
National Bowel Cancer Audit	Deadline is June 2019, currently 189/946 (20%) treatment records submitted by CCC (as data has not been uploaded by the referring hospitals to enable CCC treatment data to be submitted)
National Oesophago- Gastric Cancer Audit	Deadline is 24th May 2019, 197/284 (69%) treatment records submitted by CCC (as data has not been uploaded by the referring secondary hospitals to enable CCC treatment data to be submitted. This is being reviewed and managed by the Clinical Audit and Registries Management Service)
National Head and Neck audit (HANA)	9 files uploaded containing 408 patient records (100%) and 436 treatment records (100%)
Acute Kidney Injury	Data provided within agreed deadline
RCR National audit of the use of radiotherapy in the treatment of vulval cancer	5/5 records completed (100%)
Female Genital Mutilation	Zero return for 2018-19
NCEPOD – Cancer in Children, Teens and Young Adults	1/1 In-patient clinician questionnaire completed (100%). 4/4 SACT case clinician questionnaires completed (100%). 1/1 organisational questionnaire completed (100%). 5/5 case note extracts returned to NCEPOD (100%)
NCEPOD –Pulmonary Embolism	3/3 Clinical Questionnaires completed (100%) 3/3 case note extracts returned to NCEPOD (100%)
RCP National Mesothelioma Audit	12/12 (100%) files uploaded successfully
Deferred SACT at outpatient clinics	Local audit expanded to collate data with other Trusts Nationally (for the British Oncology Pharmacy Association)
HCC Sorafinib Outcomes	66 patients identified. SpR undertaking casenote review (Joint project with University College London)
100 day mortality post allogeneic stem cell transplantation	Total Number of Allogeneic Transplants Oct17-Sept 18 = 34 Total Number who died within 100 Days of Transplant = 2 patient
NHSE dashboard: outcomes audit with UK benchmarking	Total Number of autologous Transplants Oct 17 – Sept 18 = 68 Total Number of patients alive 1 year after transplant = 63
RCR National Prostate Cancer Audit - Radiotherapy Data	807 patients records were submitted
BSBMT long-term outcomes audit with UK benchmarking, 2004-2016, 9th report published 2018	1839 patients records were submitted
National Study of Late Effects after Hodgkins Lymphoma	213/237 records completed (90%) remaining 24 records was unmatchable patient or casenotes could not be found (Patients dating back as early as diagnosis in 1954)
National Audit of Care at the end of life (NACEL)	5/5 HO records completed (100%) plus 5/5 data reliability records completed. 23/23 CCC Wirral records completed (100%) plus 5/5 data reliability records completed

Cancer Outcomes and Services Dataset (COSD)	12/12 (100%) files uploaded successfully
National Audit of Breast Cancer in Older patients	12/12 (100%) files uploaded successfully
National Lung Cancer Audit	12/12 (100%) files uploaded successfully

The reports of four national clinical audits were reviewed by the provider in 2018/19 and The Clatterbridge Cancer Centre NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Table 1a: Audits: cases submitted

National Clinical Audit and NCEPOD eligible studies	Actions to improve quality of care
NBOCAP (Bowel Cancer)	The annual report and recommendations were reviewed by the SRG* Chair and will continue to support the audit and submit data for 2019- 20 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
NOGCA (Oesophago- Gastric Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2019- 20 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
NPCA (Prostate Cancer)	The annual report and recommendations were reviewed by the SRG Chair and will continue to support the audit and submit data for 2019- 20 SRG members reviewing action plan outlining requirements for ensuring provision of data required and continued compliance.
NCEPOD – Cancer in Children, Teens and Young Adults	14/15 recommendations are compliant with 1 action plan in place to develop a bespoke dashboard encompassing side effects and outcomes of SACT. This dashboard enables Specialist the SRG to discuss performance and set improvement goals with findings reported at Board level.

**SRG – Site Reference Group*

Table 1c: Local Audits/Quality Improvement Projects

The reports of 43 local clinical audits were reviewed by the provider in 2018/19 (compared to 33 in 2017-18), of which 28 provided assurance (compared to 17 in 2017-18) and 15 made improvements through action plans to improve the quality of healthcare provided (compared to 16 in 2017-18).

Title	Actions to improve quality of care/ Assurance Provided	Outcome	Presented
1516-37 Jaw tracking to reduce dose to organs at risk for early stage non-small cell lung treated using Volumetric Arc Therapy (VMAT)	In response to these results, CCC have been using jaw tracking clinically for some time – initially used for SABR lung on the Edge machines but has been used for all sites treated with VMAT since January 17.	Significant improvement made in care	SABR Consortium Annual Conference
1617-25 Quality Improvement Project on Junior Doctor's Meditech Training	Introduction of a video showing a clinician demonstrating the use of Meditech for the clinical tasks i-iii (above) with the aim of avoiding the need for a clinician to attend every trainee IT induction. The format of IT training was amended to more closely map the practical needs of the trainees. It was also agreed that this new training should be tested initially as a joint presentation by a clinician and an IT technician.	Significant improvement made in care	National Acute Oncology Conference Acute Oncology Flow Conference
1617-33 Pilot evaluation of pre-appointment phone Follow-up upper GI	Objective of the project was "To reduce face to face consultations in outpatient". Conclusion of report states "Patients with upper GI tumours avoided an unnecessary visit to outpatient clinic when reporting progressive symptoms & concerns during the pre-appointment telephone consultation, Patients with stable symptoms avoided unnecessary visits to the outpatient clinic. Patient experience questionnaires show overall satisfaction with the pre-appointment physician associate led telephone consultation". Action plan drawn up for two issues specifically expansion of the project and clinic disposal – both of which have been addressed	Significant improvement made in care	General Audit Presentation Event
1617-44 Intra Fraction Motion Bio Optimised RT Prostate	Objective of Audit was "To assess the intrafraction motion of the prostate and whether real time motion management is essential". Lead reports "The study is complete and showed our standard imaging is optimum and the future of soft tissue CBCT pre and post would be the gold standard particularly for those patients with consistently large post image displacements"	Provided Assurance	Poster for Liverpool University School of Science
1516-14 Neutropenic sepsis in Ewings and Rhabdomyosarc oma	Objective of the audit was "The aim of this study was to assess the incidence of neutropenic sepsis in patients who had received aggressive chemotherapy regimens for sarcomas, and assess the point in the chemotherapeutic cycle that patients develop neutropenic sepsis."	Improved knowledge	

Title	Actions to improve quality of care/ Assurance Provided	Outcome	Presented
	This concluded that although "Based on several published studies, the use of G-CSF for primary prophylaxis with chemotherapy regimens can reduce the risk of neutropenic sepsis, however this study concludes it can still occur in up to 50% of patients. Neutropenic sepsis is most likely to occur on day 10 of the cycle of chemotherapy for sarcoma patients and if it is going to occur, is more likely after cycles one or two. Further research in a larger population is needed to confirm these observations."		
1516-06 Efficacy and safety of Ipilimumab in metastatic ocular melanoma	• Ipilimumab, as a single agent for the treatment of metastatic ocular melanoma, has shown overall disappointing results with best response being SD and 1-year OS of 40%. • The treatment has significant immunological toxicity, with occasional fatal outcome. Overall immunological toxicity is seen in 60%, being grade 3 or 4 in 26% cases. • Recommended to explore if new regimens of combined immunotherapies have better outcome and different toxicity profile	Improved knowledge	Skin SRG
1617-45 Rate of uterine perforation before and after the introduction of ultra sound guided brachytherapy for cervical cancer	This procedure is recommended for proper placement of intracavitary applicator as it reduces the rate of uterine perforation and suboptimal placement of uterine applicator. It is fairly accurate, easily available and cost effective.	Provided Assurance	The International Gynaecologic al Cancer Society (IGCS), Japan
1718-43 Post-Operative Cavity Irradiation for brain metastases	• Post-operative fSRS 30Gy in five fractions for surgically resected brain metastases was well tolerated and achieved good local control • Intracranial Relapse Free Survival. Median time to relapse 4.21 months • Median target volume: 18.5 cc [2.31-45.47] • Mean equivalent sphere diameter: 3.1 cm [1.6- 4.4] • No reports of radionecrosis or severe (>grade 2) toxicity	Provided Assurance	BNOS Conference
1718-01 Efficacy of Abiraterone with low-dose Dexamethasone in castration- resistant prostate cancer	• Steroid switch is effective in controlling PSA in 63% of cases • The known baseline factors are not predictive of response to steroid switch • Effect of steroid switch is not possible to predict • Given this data, it is difficult to approve to continue low-dose dexamethasone on PSA rise after steroid switch • Recommendation from this audit to consider steroid switch on PSA rise on the treatment with abiraterone/prednisone.	Significant improvement made in care	Urology SRG8

Title	Actions to improve quality of care/ Assurance Provided	Outcome	Presented
	• Recommendation from this audit to continue low-dose dexamethasone is not substantiated by this data.		
1617-46 Dose intensity and clinical efficacy of Afatinib in EGFR mutant NSCLC: a multicentre retrospective study	• Results suggest that neither dose intensity nor dose reductions down to 20mg/day are deleterious to clinical outcomes. • Indicates that in mutation-driven cancers using clinical markers of efficacy instead of MTD in early phase studies may contribute to optimise the clinical benefit/toxicity balance of targeted agents. • Using afatinib in first line with optimal dose reductions remains an attractive option to control patient disease for those presenting with brain metastasis, whilst keeping open the possibility of second line osimertinib.	Provided Assurance	ESMO
1718-09 Determination of appropriate CBCT imaging doses for H&N daily imaging protocol	• Results are indicative that the lower dose imaging protocols do produce comparable quality images in comparison to the default manufacturer settings. • The roll out of daily imaging for head and neck patients and CNS patients.	Significant improvement made in care	
1617-05 Patients experience with PICCS in CCC	• 99% of patients said their PICC was the best way to get their treatment • 57% rated the PICC insertion experience as 10 out of 10, 22% 9 out of 10 & 11% 8 out of 10	Provided Assurance	Study day hosted by PICC team
1819-07 Evaluation of the addition of GCSF Prophylaxis to the FLOT Chemotherapy regimen	• After the introduction of filgrastim prophylaxis from day 5 of each cycle of the FLOT regimen, the incidence of neutropenia fell from 61.6% to 3.1%.	Significant improvement made in care	Liverpool University (Poster) Circulated to Upper GI SRG General audit meeting
1819-09 What do multi- disciplinary staff members at The Clatterbridge Cancer Centre know about the MHRA Yellow Card Scheme?	Results showed knowledge of “Yellow Card Scheme” across the Trust was lacking with the exception of Pharmacy department. Therefore the following actions were introduced: • Screen saver on all site computers reminding staff of “Yellow Card Scheme” • Desktop icon on Trust computers and IOS devices which takes you directly to the Yellow Card reporting website • Yellow Card Posters in all staff areas increasing awareness of the scheme • Teaching sessions at staff meetings	Improved Knowledge	Liverpool University (Poster) General audit meeting case note

Title	Actions to improve quality of care/ Assurance Provided	Outcome	Presented
1819-09 Advanced Ovarian Cancer update Merseyside /Cheshire	• Sustained significant improvement in overall survival for advanced ovarian cancer (compared to 2006-2009 data) • No significant survival difference between 12-13, 13-14 and 15 cohorts • Similar patient demographics • Ongoing analysis of practice and outcomes will hopefully show ongoing improvement as new therapies are introduced to practice	Provided Assurance	Gynae Audit Presentation Event
1617-42 A report on patients' information survey before consenting for contact X-ray brachytherapy (Papillon).	The result from our patients' survey suggested that the majority of the patients were satisfied with our process of consenting and that they do not wish to have more time to consider about this before their treatment. The majority of our patients do not wish to come back on a different day for their treatment.	Provided Assurance	
1819-06 Assessing the Value of the Neuro CNS team	100% positive feedback for all questions, bar one "Did you feel your questions were answered by the specialist nurse" which was 97%.	Provided Assurance	CNS SRG Meeting
1718-38 Sorafenib for hepatocellular carcinoma	• Survival in HCC depends on interplay of disease stage, liver function and patient performance status which need to be considered when making treatment decisions. • The BCLC staging provides a good prognostic stratification of overall survival in patients diagnosed with HCC and a similar trend would be seen in patients treated in a tertiary transplant unit.	Provided Assurance	2 posters presented at British Association for the Study of the Liver conference (BASL)
0910-36 HDR Cervix 3 insertions	• Cervical cancer patients treated at CCC in 2009 to 2010 have a better OS than previously • There are more patients receiving concurrent Cisplatin chemotherapy • Toxicity during treatment has not increased • Long term toxicity has not increased since the brachytherapy dose increased	Provided Assurance	Gynae SRG audit day
1718-15 Assessment of adequacy of contrast enhancement in CTPA (CT pulmonary angiogram)	• Training: To correct the technique of the bolus tracking and optimal position of the ROI • Introduce saline chaser if possible • Omit patient's deep inspiration: either STOP breathing or no instructions of breathing • Reduced the FOV • Use >20G cannulas or PICC lines (>4F, CT- ready) and flow >4 mL/	Significant improvement made in care	Presented to Radiological Department
1718-27 1st line use of Palbociclib and AI in ER+ metastatic breast cancer: Toxicities and benefits in the real world	• In the context of a real world population there does not appear to be any major issues in delivering Palbociclib. • There was a clear and sustained reduction in white cell count and neutrophil count on Palbociclib, this is not seen with other haematological parameters. • Initial progression free survival data is consistent with the data within PALOMA-2.	Provided Assurance	San Antonio Breast Cancer Symposium (SABCS) / Breast SRG Away Day

Title	Actions to improve quality of care/ Assurance Provided	Outcome	Presented
1718-48 "What are the barriers to facilitating conversations about erectile- dysfunction for men having hormone-radiotherapy for prostate cancer?"	It is recognised that erectile dysfunction is a common complication of hormone-radiotherapy for prostate cancer. Results showed all clinicians were able to engage patients to discuss this subject and refer to specialists when clinically indicated. Results also showed patients were more concerned with treatment options and it's side-effects.	Provided Assurance	Urology SRG
1819-28 Re-Audit Pressure Ulcer Compliance at CCC	Six monthly audit, May 2018 and October 2018 • Acknowledged previous actions have been complete. • Action was to reinforce to all staff the requirement to complete risk assessments within 6 hours	Significant improvement made in care	Ward Huddle & Directorate Quality and Safety Meeting
1718-45 Real world assessment of the efficacy of neoadjuvant Trastuzumab and Pertuzumab for HER2 positive early breast cancer	• Real world efficacy of neoadjuvant Trastuzumab/Pertuzumab reflective of trial data • Significant number of LN+ patients become LN- following NA treatment and measures to avoid ANC are needed • Docetaxel toxicity frequently results in switching to weekly paclitaxel: a safe option that may be associated with a higher pCR • Diarrhoea rates reflect the literature	Provided Assurance	ASCO / Breast SRG Away Day
1617-11 Real world data regarding the efficacy of neoadjuvant Carboplatin- Paclitaxel followed by dose-dense Adriamycin-Cyclophosphami de for triple negative early breast cancer	• pCR rates with Carbo-Pac-ddAC are consistent with current literature. • These results support the use of platinum based chemotherapy in the neoadjuvant management of TNBC. • No all patients <50 appear to have been tested for germ line susceptibility	Provided Assurance	ASCO / Breast SRG Away Day
1718-33 A retrospective audit on treatment outcomes for patients with high grade neuroendocrine colorectal carcinoma	• We have demonstrated that response rates to chemotherapy are low at 33.3% to first line and 0% to second line. Therefore, better systemic treatments are needed and as such patients with colorectal-NEC should preferably be treated on clinical trials	Improved Knowledge	ESMO GI
1819-26 Folfirinox	• As fewer than 10% of patients are not able to have more than 1 cycle of Folfirinox an in-depth review of patient selection may be justified. • Deferral rate should be investigated to see if there is a correlation to cycle number • Well tolerated treatment considering the number of agents • Successes have been found with this treatment allowing patients to have adjuvant surgeries and curing disease but this should be measured carefully with the toxicities that this treatment may cause	Improved Knowledge	Drugs & Therapeutics Committee

Title	Actions to improve quality of care/ Assurance Provided	Outcome	Presented
18-19/11 Melanoma brain metastases: management and outcomes	Brain metastases carries a poor prognosis in Metastatic Malignant Melanoma. This cohort illustrates that patients continue to have a varied treatment regime and poor survival. With earlier, asymptomatic detection and robust, multi- professionally agreed treatment algorithms the outcomes for this patient group may be improved.	Improved Knowledge	General Audit Meeting
17-18/47 A Critical Appraisal of the Impact of my Leadership on the Patient Safety Culture at the Clatterbridge Cancer Centre	Overall, the findings demonstrate that diversity within healthcare often infers the requirement for multiple solutions to individual challenges, in this case that of fostering a positive patient safety culture. Indeed, this is how modern healthcare leaders need to respond, particularly when working in multidisciplinary, integrated formats	Provided Assurance	NHS Leadership Academy
17-18/50 Audit of the Palliative Radiotherapy Service	• In order to improve the prioritisation of patients for treatment, there was a need to increase communication from referring hospitals regarding patient condition, escort & medication 24hr prior to Palliative Radiotherapy Clinic (PRC) • Appointment of Consultant Radiographer in Palliative Radiotherapy, Support Clinical Oncologist Lead • Introduction of PRC at CCC Aintree to reduce travel time	Significant improvement made in care	BIR Annual Congress
16-17/29 Monitoring patients during treatment with Trabectedin	• Work with pharmacy and IT to embed the serological monitoring into Meditech	Significant improvement made in care	British Sarcoma Group Conference General audit meeting
18-19/14 GDE Programme Patient Baseline Survey	Majority of patients state they would utilise self- check in kiosks (>85%)	Provided Assurance	GDE Digital Board
17-18/18 RCA Pressure Ulcer Service Evaluation	The RCA is fit for purpose. It is efficient and it enables the identification of root causes. There is the potential for some minor modification and for the incorporation of trust specific items, and for it to be available for completion on-line	Provided Assurance	Edge Hill University CCG
15-16/16 HNA for high risk uveal melanoma patients undergoing regular liver surveillance	89% of patients showed emotional concerns at baseline which declines then peaks again around 4.5 years which is in line with length between follow-up appointments increasing at the 5 year mark.	Provided Assurance	Venice European Nursing General Audit Presentation Event

Title	Actions to improve quality of care/ Assurance Provided	Outcome	Presented
16-17/14 Secondary Breast Cancer Pledge	Increased access to services including named clinical nurse specialist for advanced breast patients. Enhanced Supportive Care initiative expanded to this cohort of patients	Significant improvement made in care	Breast SRG Away Day
18-19/19 Ovarian Survival Analysis update	Sustained significant improvement in overall survival for advanced ovarian cancer (compared to 2006- 2009 data) No significant survival difference between 2012- 2013, 2013-2014 and 2015 cohorts Similar patient demographics	Improved Knowledge	Gynae SRG meeting
18-19/01 Outcomes audit of Lung cancer patient from Isle of Man service	There has been an increase in 1yr OS which acts as a surrogate for treatment effect from 38 to 44%. The one year survival is comparable with other centres	Provided Assurance	
16-17/40 Compliance of Docetaxel in treating breast cancer patients in adjuvant setting using FEC-T	The protocols for adjuvant/neoadjuvant management of breast cancer have been amended such that the standard of care for patients 60 years or older with ER positive early breast cancer (and all patients with triple negative breast cancer) have been changed from Docetaxel to Paclitaxel in response to audit findings.	Significant improvement made in care	Breast SRG Away Day

Information on participation in clinical research 2018/19

The number of patients that were recruited during 2018/19 to participate in research approved by a Research Ethics Committee was 846.
57 Studies opened in 18/19 with a fully diversified portfolio enabling the highest levels of recruitment recorded by CCC

2018/19 Recruitment to Clinical Trials

	Q1	Q2	Q3	Q4	Total
Clatterbridge Cancer Centre	129	145	239	333	**846**

Research and Innovation

This has been a seminal year for the Research and Innovation Department at CCC. The Trust has recognised research as core business and provided significant investment of £1.8 million over the next three years to support research. This has underpinned the new Research Strategy approved by the Board in July 2018 which holds the mission and values of CCC at its heart and which has taken CCC research to the next level where we will make each patient's experience count. We have long been recognised as a tertiary cancer centre with strength in the delivery of complex trials of novel agents, however, the new Research Strategy provided ample opportunity to build on this strength and to deliver a wider ranging, diverse, patient focused portfolio of research giving tangible patient benefit and enabling increased patient access to research studies. We appreciate that we are part of a wider health economy and are developing and refreshing relationships with key stakeholders, partners and providing leadership of the cancer agenda across the region that we serve. The Transformation of Cancer Care programme

and expansion into the new CCC Centre of Excellence in the Knowledge Quarter gives us a unique opportunity for research expansion, staff development and system change.

Key Drivers for the Research Strategy

The key drivers for research are:

- Continue to embed research as core business throughout the Trust to become a recognised research active hospital.
- Provide patient centred research and increase recruitment into research studies.
- Ensure our patients have equitable access to research through our hubs and sectors
- Build a dynamic research portfolio based on our strengths in interventional studies and novel agents.
- Diversifying the portfolio to support real world studies, qualitative studies and supporting translational research to identity mechanisms of cancer, biomarkers and understanding toxicities.
- System change across the region to support cancer research.
- Continuing the support of the Liverpool Experimental Cancer Medicine Centre as the NHS partner.
- Increasing the visibility of CCC research.
- Raising the profile of CCC nationally.

Notable Achievements

We have delivered on the goals and milestones of the new Research Strategy at pace.

- Achieved the highest level of recruitment of participants to research attributable to CCC, with 846 patients recruited overall and of those 588 to NIHR portfolio studies to this report date.
- Achieved a number of 'First UK patient' recruited to studies where CCC has been a participating site (see table below). We are also in the top 3 sites for recruitment in many interventional studies across our portfolio.
- Diversified the research portfolio by increasing the number of non- interventional, observational and qualitative studies.
- Invested in new posts to support the diversified portfolio.
- Invested in infrastructure support for research facing staff in service department and supported staff Programmed Activities (PA) time for research.
- Supported our research fellows programme.
- Led systems change in bespoke working with partner Trusts, developing Service Level Agreements (SLAs) to speed timelines for opening studies, increasing patient access to cancer trials across the region and partnering in new ways of mutual support and working. We are continuing to work with our University partners particularly the University of Liverpool in driving the cancer research agenda.
- Continue to be an active and committed partner in the establishment of the Liverpool Health Partners Joint Research Service, providing delivery and business intelligence expertise. As nationally recognised leaders in the use of the Edge system, CCC has led the development and implementation of this crucial part of the Joint Research Service (JRS) and will continue to work with the Edge Team and North West Coast Cancer Research Network (NWC CRN) stakeholders in building this novel system for the JRS.
- We have extended our reach in participants from across the UK and Ireland taking part in our studies.
- We continue to support CCC-led research where CCC acts as Sponsor, with studies in Lung, Cervical Cancer, Head and Neck Hepatobiliary, Haemato-oncology and Prostate studies open or in pipeline development.

- The CCC Biobank continues to collect samples to support fundamental research into the mechanisms of cancer, biomarker development and target collections to support our research fellows.
- We have refreshed the Trust research website, making it more user-friendly patient focused and accessible. We are continuing to work on this and upgrade as we move forward.

Therefore we have in this year, re- energised research at CCC. This has resulted in refreshed research facing staff, the highest ever recruitment to NIHR portfolio and non-portfolio studies, increased partnership working, increased patient benefit and care through research.

First UK patient' recruited to studies where CCC has been a participating site

Project Acronym	Project Full title	Principal Investigator	Disease Group
5512 EPIZYME	An Open-Label, Single Center, Two-Part, Phase 1 Study to Characterize the Pharmacokinetics of a Single Intravenous Micro-Dose of Tazemetostat (EPZ-6438) and the Absorption, Distribution, Metabolism and Elimination of a Single Oral [C] Labelled Dose of Tazemetostat in Subjects with Advanced Solid Tumours or With Lymphomas	Palmer, Prof Daniel Pettitt, Prof Andrew	Upper GI Haematological
PRAN-16-52	Phase III, Double-Blind, Placebo-Controlled, Multicenter, Randomized Study Of Pracinostat In Combination With Azacitidine In Patients ≥18 Years With Newly Diagnosed Acute Myeloid Leukemia Unfit For Standard Induction Chemotherapy	Patel, Dr Amit	Haematological
FORT-1	A randomized, open label, multicenter Phase 2/3 study to evaluate the efficacy and safety of rogaratinib (BAY 1163877) compared to chemotherapy in patients with FGFR-positive locally advanced or metastatic urothelial carcinoma who have received prior platinum-containing chemotherapy	Syndikus, Dr Isabel	Bladder
AGIOS AG120- C-005	A Phase 3, Multicenter, Randomized, Double-Blind, Placebo-controlled Study of AG-120 in Previously-treated Subjects with Nonresectable or Metastatic Cholangiocarcinoma with an IDH1 Mutation	Palmer, Prof Daniel	Upper GI
RSV-L	A double blind, placebo-controlled study to assess the antiviral effect, safety and tolerability of inhaled PC786 for the treatment of acute respiratory syncytial virus (RSV) infection in adult hematopoietic stem cell transplant recipients	Patel, Dr Amit	Haematological
CHECKMATE 9DX	A Phase 3, Randomized, Double-blind Study of Adjuvant Nivolumab versus Placebo for Participants with Hepatocellular Carcinoma Who Are at High Risk of Recurrence after Curative Hepatic Resection or Ablation	Faluyi, Dr Olusola	Upper GI
PIVOTALboost	A phase III randomised controlled trial of prostate and pelvis versus prostate alone radiotherapy with or without prostate boost	Syndikus, Dr Isabel	Prostate

CQUINS:

A proportion of The Clatterbridge Cancer Centre NHS Foundation Trust's income (2018/19) was conditional on achieving quality improvement and innovation goals agreed between The Clatterbridge Cancer Centre NHS Foundation Trust and its commissioners, through the Commissioning for Quality and Innovation payment framework.
Whilst the Trust did not meet all requirements, we are proud of CQUIN related developments including the expansion of the Enhanced Supportive Care team and the introduction of a network of Cancer Support Workers, both of which have delivered better patient experience. For future CQUINS we have revised processes to ensure achieved.

Information relating to registration with the Care Quality Commission and periodic/special reviews

The Clatterbridge Cancer Centre NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions for the treatment of disease, disorder or injury and for diagnostic and screening procedures.
The Care Quality Commission has not taken enforcement action against The Clatterbridge Cancer Centre NHS Foundation Trust during 2018/19. The Trust was under enhanced monitoring and required to strengthen its safeguarding service in February 2018. An agreed 6 month action plan was successfully delivered by the Trust in August 2018, and new safeguarding leads appointed. Further detail has been provided in the Safeguarding section of this report.

Information on the quality of data

The Clatterbridge Cancer Centre NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published

data. The percentage of records in the published data:

- Which included the patient's valid NHS Number was:99.9% for admitted patient care and 99.9% for out patient care. The Trust does not provide accident and emergency care.

- Which included the patient's valid General Practitioner Registration Code was: 99.8% for admitted patient car and 99.7% for outpatient care. The Trust does not provide accident and emergency care.

The above figures are in line with the SUS data quality dashboard methodology:

- Where there is an NHS number this is classed as valid.

- The General Practitioner Registration Code figures include the default not known/not applicable codes as valid.

- The General Practitioner Registration Code figures class any GP Practice that was closed prior to the beginning of the financial year as invalid.

In The Clatterbridge Cancer Centre NHS Foundation Trust Information Governance Assessment for 2018/19 the Trust achieved compliance against all 40 mandatory standards of the new NHS Digital Data Protection and Security Toolkit.

Data Quality Improvement Plans

Good quality information that is accurate, valid, reliable, timely, relevant and complete is vital to enable the Trust and our staff to evidence that high quality, safe and effective care is delivered.

Good quality information also supports the Trust to manage service planning, performance management and commissioning processes.

The Trust has a Data Quality Policy in place which outlines expected standards around data recording. The Trust has an active data quality group which oversees an annual audit programme that reports into Information Governance Committee for Toolkit requirements including the annual audit of nationally submitted data sets.

During 2019/20 the Trust is replacing the existing Data Quality group with a new Data Management group which will be chaired at Executive level and will meet monthly with a clear focus on data quality. This group will ratify a new Kite Marking policy and will review the existing data quality policy.

The importance of Data Quality is also highlighted in Electronic Patient Record (EPR) System training along with the importance of Good Record Keeping.

The Trust continues to review its Business Intelligence function and has recently recruited to a new post of Head of Business Intelligence to lead a new service within the Trust.

Implementation of the Clinical Standards for Seven Day Hospital Standards

The Trust has made significant progress in the Implementation of the Priority Clinical Standards for Seven Day services. The Consultant of the week rota is now well embedded and has enabled the Trust to meet the 14 hour target of 90% in the last two consecutive months.

We are also consistently compliant in the delivery of the following standards;

Standard 1- Information gathered via our FFT, In Patient surveys and the patient experience group indicate we are compliant with this measure.

Standard 3 - All emergency admissions are assessed for complex and/or on-going needs via the MDT ward round, as per the Transfer and Discharge policy. All ward rounds are led by a consultant.

Standard 4 - Handovers occur at 9am and 4pm daily in a designated location, handover is led by a Consultant and attended by all the junior doctors, consultants on call x2, registrar on call, spinal cord compression coordinator, ward managers, palliative care nurse, critical care outreach nurse, physician associates and a representative from medical staffing All clinical data is recorded on an Electronic Patient Record system.

Standard 7 - Urgent psychiatric and psychological support is available from the Psychological Medicine team at WUTH for solid tumour in patients on our Wirral site and RLBUHT for our Haemato Oncology patients at the Liverpool site.

Standard 10 - The Trust Integrated Performance report is shared with the Board monthly; this includes performance data relating to quality improvement and patient outcomes. The management and supervision of junior trainees is delivered by an identified education lead for each professional group, this includes Practice Education Facilitators, Medical Education Team, Radiographer Lead and the Head of Physics.

The Trust has made great progress towards achieving compliance against **Standard 9**, there is a Pharmacy service, Physiotherapy service and access to transport services 7 days per week, however, as the Trust delivers services to patients living across a very wide geographical area, the availability of support services, in primary and community health settings are not always available 7 days per week. To improve access to these services CCC has introduced a designated Discharge Coordinator and Patient Flow Team. This Team proactively identify patients that may require additional support within the community following discharge and coordinate individual care packages for this patient group. The Trust is confident that it will be fully compliant against standard 9 during 2019.

Learning from Deaths

During 2018/19 89 patients died as an inpatient at The Clatterbridge Cancer Centre NHSFT, 65 patients died at CCC Wirral & 24 patients died at CCC HO Liverpool. This comprised the following number of deaths which occurred in each quarter of that reporting period: 30 in the first quarter; 24 in the second quarter; 18 in the third quarter; 17 in the fourth quarter.

2018-19	No. of Inpatient Deaths
Q1	30
Q2	24
Q3	18
Q4	17
Total	**89**

As of 8th April 2019, 70 case reviews have completed phase I*, out of which 63 were further investigated at phase II** and 22 were further selected for discussion at phase III*** the Trusts formal Mortality Review Meeting.

* Consultant case record review of own case
** Multi-disciplinary case selection panel
*** Trust – wide formal multi-disciplinary mortality & learning from deaths review meetings)

19 cases require phase I review and will be completed during 2019-20.
26 cases require phase II review and will be completed during Q1 2019-20.

Out of the 22 cases discussed at the formal mortality review meeting, the number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 0 in the first quarter;
- 4 in the second quarter;
- 11 in the third quarter;
- 4 in the fourth quarter.

3 cases awaiting phase III review will be discussed during Q1 2019-20.

63 out 70 cases (90%) had a Structured Judgement Review (SJR) completed, 1 out of 63 was deemed to have had a slight evidence of avoidability (score 5) and 62/63 were scored 6
i.e. definitely not avoidable.

7 (10%) cases require a SJR which will be completed during Q1 2019-20 to ensure 100% completion of SJR for all inpatient deaths.

Estimated Death more likely than not to have been due to problems in care provided

	Definitely Avoidable (1)	Strong Evidence of Avoidability (2)	Probably avoidable (more than 50:50) (3)	Possibly avoidable but not very likely (less than 50:50) (4)	Slight evidence of avoidability (5)	Definitely not avoidable (6)	SJR Completed	% patient deaths are judged more likely to have been due to problem in care provided
QTR 1	0	0	0	0	0	26	26	0%
QTR 2	0	0	0	0	1	20	21	4.7%
QTR 3	0	0	0	0	0	11	11	0%
QTR 4 (Jan & Feb Only)	0	0	0	0	0	5	5	0%

Outpatient Deaths

In addition to reviewing all inpatient deaths, The Clatterbridge Cancer Centre NHSFT is also committed to reviewing outpatient deaths for patients within our care who meet the mortality review criteria; deaths within 30 days of chemotherapy or radiotherapy treatment, and within 90 days of radical radiotherapy treatment. Radiotherapy for spinal cord compression and bone metastases cases do not require review, on the condition that the dose and fractionation given was as per Trust protocol. Therefore the corresponding figures for the outpatient deaths during the period are as follows;

During April 2018 – February 2019 499 of The Clatterbridge Cancer Centre NHSFT patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period: 146 in the first quarter; 113 in the second quarter; 152 in the third quarter; 88 in the fourth quarter*.

2018-19	No. of Outpatient Deaths
Q1	146
Q2	113
Q3	152
Q4 (January & February 2019)	88
Total	**499**

**Death data only available for January & February 2019.*

Of the 499 deaths, 388 cases required a review following the above aforementioned criteria. By 8th April 2019 338 case reviews have completed phase I, out of which 235 were further investigated at phase II and 34 were further selected for discussion at phase III the Trusts formal Mortality Review Meeting out of which 20 were discussed during the period.

2018-19	No. of Outpatient Deaths Reviewed
Phase I	338
Phase II	235
Phase III	34

50 cases require phase I review and will be completed during 2019-20.
153 cases require phase II review and will be completed during Q1 2019-20.
14 cases awaiting phase III review will be discussed during Q1&Q2 2019-20.

Out of the 20 cases discussed at the formal mortality review meeting, the number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 1 in the first quarter;
- 6 in the second quarter;
- 3 in the third quarter;
- 10 in the fourth quarter.

Learning from SUI investigations

Incident	Key learning
Triage call received regarding a patient who was feeling unwell, assessed using UKONS and attended for further assessment. On arrival MET call raised as patient collapsed in car. The Serious Incident learning meeting concluded that the staff acted appropriately and followed due process and were commended for their efforts, especially in the challenging environment.	• Communication on the use of the Hotline service to other departments to ensure staff aren't taken away from hotline duties. • Medical Director has highlighted the importance of timely and thorough documentation by medical staff. • An audit of hotline service to be completed. • Review of the UKONS tool has been undertaken and it was agreed that this is the most appropriate tool to assess each individual patient
Patient became unwell after undergoing a radiotherapy planning scan with oral and IV contrast. MET call raised which was quickly escalated to CRASH call but the patient deteriorated rapidly and attempts to resuscitate were unsuccessful. Coroner confirmed the cause of death as anaphylactic shock due to a reaction to the IV contrast medium.	• To enable faster IV access in case of emergency the post scanning protocol has been amended so that the cannula now remains in situ for 30 minutes after the scan is complete for all Radiation Services patients who have received IV contrast • Intraosseous drill purchased for CRASH trolley to be used in cases where intravenous access cannot be obtained • Planning staff have received training in in anaphylaxis reactions and administering IM adrenalin • Planning staff to be linked with Medical Emergency Team on rotation to enhance decision making for acutely unwell patients

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

Case	Background	Action	CCC Lesson learned
1	There was a contraindication between Pazopanib and the patient's current medication, although the contraindication did not affect the patient's outcome. In order to minimise contraindication to Pazopanib, it is necessarily to have a current medication list for patients who are on Pazopanib	Addition to current process, pharmacy will ring Pazopanib patients to gain consent to contact GP for current medication list	Acquiring the latest medication list from the patients GP will minimise this risk as consequences can be fatal if there is a contraindication
2	Sub optimal dose of Dexamethaone was prescribed for a patient's condition in the palliative care emergency setting Dexamethaone prescribing and dosage is not only a local issue, it is also an issue in the wider community	Ensure there is junior doctor education in palliative care emergencies Introduce 3 day Dexamethasone review and update SACT protocol Disseminate Dexamethasone guidelines out to the clinical pharmacist network and acute oncology team Produce guidance for CNS and air way obstruction in relation to Dexamethasone management for triage	Increased and frequent education is essential to ensure junior doctors are confident and capable in dealing with palliative care emergencies Ensuring that the SACT protocol contains thorough instructions enables a safe and consistent approach to patient care Sharing of guidelines enables a safe and consistent approach to patient care
3	A patient who lived alone was discharged home when it was unclear whether requested community support was in place before discharge	• Conway Ward Manager to review/revise discharge process for patients living alone • The patient flow team fully established Jan 2019 • Development of a discharge assessment in Meditech which the patient flow team will lead on. • Implemented daily ward rounds across the 2 wards Feb 2019 • Ward based education regarding safe discharge/documentation • Introduction of 24 hr discharge follow up calls for complex discharges	The introduction of designated team to provide follow up service to a specific patient group at 24/48hours post discharge will enable us to provide timely intervention if required

Case	Background	Action	CCC Lesson learned
4	A fit neoadjuvant patient passed away from surgical complications after receiving pre-op chemotherapy, followed by chemoradiation as standard of care. It was queried whether a conservative “watch and wait” surveillance policy would have sufficed as a complete response after chemoradiation was achieved.	Upper GI SRG to consider an audit of patient survival following Pre-Op ChemoRT in oesophageal cancer	It is good clinical practice to follow established treatment protocol. Protocol should be periodically reviewed / audited to confirm best practice/outcomes.
5	Patient had a very rare catastrophic event. It was felt that Cabozantinib may have led to necrosis in a previously irradiated area	Include potential fatal risk in consent process. SRG agreed that consent form should cover adverse events including death Yellow card completed	It is important to inform patients of rare side effects that could occur in this patient group during the consent process. MHRA monitor the safety of all healthcare products in the UK and ensure they are safe for patients taking the medicines and for clinical staff administering them
6	It was unclear to clinicians when and who should instigate the amber care bundle when clinicians have concerns that patient may have a few months left to live	Clarity of who initiates amber care bundle	Amber Care Bundle is currently not implemented in the Trust. The group agreed this patient would have benefitted from the amber care bundle. Plan is to form a working group, led by palliative care team and re-launch Amber Care Bundle.
7.	Patient’s performance status deteriorated between time of consent and start of Pembrolizumab.	Lung SRG to review the Pembrolizumab protocol in light of patients with declining PS prior to treatment commencement after consent	For patient safety it is important that the consultant is informed of a declining performance status before deciding whether to go ahead with treatment as planned
8.	Communication issues with patients who present with learning disability. End of life planning presented challenges with patient and carers.	Investigate Learning Disabilities Mortality Review (LeDeR) requirements	Occasionally patients with a learning disability may require addition support to ensure information is understood fully and work with patient family to provide best possible care/support to the patient. Promote safeguarding across the Trust.

Case	Background	Action	CCC Lesson learned
9	Inaccurate performance status was recorded by chemotherapy nurses however this did not affect the eligibility for this patient to receive chemotherapy	Performance Status definition training for chemotherapy nurses	Performance status (PS) definition can be subjective. Standardising its definition across the nursing team enables the accurate recording of PS as interpretation can lead to stopping treatment as well as continuation of treatment if appropriate.
10	There was no evidence that the care after death documentation was completed	Investigate if care after death documentation was completed	Secondary checks have been introduced to ensure that all relevant documentation is completed
11	An ultrasound showed a renal mass after radiotherapy and brachytherapy to the pelvic region, it was queried if the renal mass was present before the radiotherapy treatment	Gynae SRG chair reviewed the care with North Wales Colleagues, concluded that there is no identifiable cause of renal failure and we do not feel this was related to the recent pelvic radiotherapy and more likely a consequence of other pre-existing comorbidities. There are no issues with her care whilst attending Clatterbridge	Having a complete patient journey available can be useful in some cases whereby there have been transfers to and from acute hospital Trusts when reviewing mortality cases. Shared learning between Trusts is beneficial to strengthening partnership working
12.	Patient became unwell after completing chemoradiation, declined review by a GP or attendance at local A&E as per UKONS guidance.	Confirmed that the Upper GI CNS had completed daily notes in Meditech post triage call until day of death	Excellent service provided by Upper GI CNS in relation to this case
13.	Appropriateness of transfer was discussed for a patient was in a lot of pain	Transfer policy reviewed	The process of ward transfers has now changed, as patients are moved to tumour group specific wards from CDU and then wouldn't be transferred again between the wards. The discharge and transfer policy has been rewritten to reflect this.
14.	Patient's deterioration was likely due to immunotherapy treatment that exacerbated existing comorbidities	Lung SRG to review consent process for Pembrolizumab in light of quarterly 30 day chemotherapy mortality data	It is important for site reference groups to review their consent processes in the context of 30 day mortality for high risk regimes

Case	Background	Action	CCC Lesson learned
15.	Chemotherapy was given on admission at external hospital. The named surgeon was unaware of admission. An interventional procedure was planned when DNACPR in place but subsequently abandoned. There is no record of involvement with the palliative care team. Urine output was not visibly documented. Management plan not clearly documented.	Contacted external hospital involved in care clinical team to review the care of this case in light of concerns	Shared learning between Trusts is beneficial to strengthening partnership working
16.	Lack of communication with patient's family after acute deterioration. The patient's family were not present when patient died and were informed of the patient's death over the telephone. 25% HER2 positive breast patient would develop brain met. If scan HER2 patient at diagnosis of brain met, there is a possibility for resection when they are small, enhancing patient's QOL.	Amber care bundle tool to be implemented. Discuss potential benefits of scanning HER2 + breast cancer patients at diagnosis of metastasis for brain metastases at the next Breast SRG	The use of a structured tool on the wards can help start and guide discussions in end of life care planning. There is a potential benefit of scanning to investigate whether HER2+ breast cancer patients have brain metastases at diagnosis of other metastases, as early diagnosis can result in survival benefits and increased quality of life in these patients
17.	This patient has multiple cancer diagnosis making it unclear as to which pathway should be followed and by whom	Head & Neck and Skin SRG to develop pathway for St Helens & Knowsley patients	It is very important that patients do not fall into a grey areas within different pathways and instead have a personalised pathway
18.	Clinician requested for patient's Apixaban treatment for DVT to be switched to Low Molecular Weight Heparin in preparation for chemotherapy treatment to start. However, the District nurse referral alluded a prophylactic dose of Apixaban of 5000 rather than a therapeutic dose.	Inform external hospital involved in the care and check whether patient was on therapeutic dose prior to treatment of ascites. Risk & Patient safety manager at LWH has been tasked with responding accordingly	Shared learning between Trusts is beneficial to strengthening partnership working
19.	Patient had an abdominal x- ray suggesting a possible bowel perforation, however there was no documented surgical review until 4 days later	Request external hospital involved in the care investigate the care of this patient	Shared learning between Trusts is beneficial to strengthening partnership working
20.	Patient collapsed at home and taken to a local A&E via ambulance 14 days post cycle 1 chemotherapy, Neuts were 0.1 but no documentation of antibiotic administration until 4 hours post arrival	Request external hospital involved in the care investigate the care of this patient (including time to antibiotic administration)	Shared learning between Trusts is beneficial to strengthening partnership working

Case	Background	Action	CCC Lesson learned
21.	The choice of radiotherapy protocol given was questioned in a patient with metastatic disease1 chemotherapy, Neuts were 0.1 but no documentation of antibiotic administration until 4 hours post arrival	Any off protocol treatment to be discussed within the peer group and documented in Meditech. Message to be conveyed to Site Reference Group Chairs	Documentation of discussions using structured tool within Meditech will strengthen the mortality review process and provide assurance and evidence of peer review

Estimated Death more likely than not to have been due to problems in care provided

Following the national review across the NHS into Whistleblowing, The Clatterbridge Cancer Centre fully embraced the recommendations to foster a culture of safety and learning in which all staff feel safe to raise a concern. The Trust reviewed the Raising Concerns Whistleblowing Policy and the process for speaking up and in-line with the new national guidance, the reviewed policy has been renamed Freedom to Speak Up (raising concerns in the workplace). The Trust appointed FTSU Executive and Non-Executive Leads, a FTSU Guardian Lead plus five Local Freedom to Speak Up Guardians and launched our Freedom to Speak Up campaign in 2018.

Freedom to Speak Up Guardians work alongside Trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely. Furthermore, the Trust Policy is clear that those who raise concerns are protected from detriment or suffering any form of reprisal and anyone responsible for such detriment will be subject to disciplinary action.

The Trust hopes that all members of staff feel comfortable in raising any concerns openly however, we also appreciate that some staff may wish to raise concerns confidentially.
Therefore, unless required to do so by law, the Trust will keep the individuals identity confidential.

The Trust Board is committed to listening to our staff, learning lessons and improving patient care and supporting an open and honest culture where staff feel comfortable and safe to speak up.

The communications to support the campaign are as follows:

- A Trust wide Screen Saver
- E Bulletin – regular updates are included in the Trusts electronic communication bulletin
- An Extranet page is available to all staff which provides
    - Introduction and Trust Values & Behaviours
    - Clarity around who can raise a concern
    - What type of concern can be raised
    - How to raise a concern.
    - Guidelines for anyone to whom a concern has been raised
    - Where to get advice and support.
- Information leaflets have been distributed to all members of staff.
- A dedicated Freedom to Speak Up notice board displays a poster of all the guardians with contact details
- Monthly FTSU meetings have been formalised and are chaired by the FTSU Guardian Lead.
- A confidential email address for staff has been introduced and can only be accessed by the FTSU Guardians.

Oversight of FTSU is ultimately through the Trust Board via quarterly and annual reports.

Raising a Concern

Staff can raise concerns in confidence with any of the people listed below in person, by phone or in writing (including email).

- Directorate, Departmental and Line Manager
- The Workforce and Organisational Development Team (WOD)
- Freedom to Speak Up Local Staff Guardians
- Trade Union Representatives or Professional Organisations (TU)

• Health & Safety Team
• Local Security Management Specialist
• Occupational Health Team
• Safeguarding Team
• Chaplaincy

Staff can visit, telephone or write in confidence to one of the FTSU Guardians or by using the confidential email address.

FTSU Guardians are a point of contact for all staff to raise concerns and act on them by:

• Escalation to the appropriate level (Line Manager, General Manager, Head of Department, Director of Workforce and Organisational Development or The Executive Team including direct access to the Chief Executive if necessary)
• Signposting to the appropriate person or service for further advice and support for example Occupational Health or where issues raised as part of this process clearly relate to employee relations, that they are signposted to Workforce and Organisational Development and Trade Union Representatives.
• Recording and monitoring of concerns raised, providing timely feedback where possible
• Monitoring any trends and themes arising, providing reports as detailed in section.

Investigation:
Once a concern has been escalated to the appropriate Manager, an investigation is conducted by 1 trained investigator and 1 trained Trade Union Investigator who have no regular contact with the individuals involved and who work in a different area.

Outcome following investigation:
The person, who has raised the concern, will be invited to a meeting to discuss the outcome of the investigation and the decision following the investigation report. The Trust will, throughout this process respect the confidentiality of others.

Learning from raising concerns:
The focus of any discussion/investigation will be on improvement. Where it identifies improvements that can be made, the Trust will monitor them via the appropriate governance committee to ensure that any necessary changes are made and furthermore they are embedded within the organisation. Any lessons will be shared with teams across the organisation, or more widely, as appropriate.

There were 5 concerns raised in 2018/19 with no patient safety issues raised. All concerns will be monitored on a regular basis by the FTSU Guardians in conjunction with the Workforce and Organisational Development team and Trade Union representatives, whereby any trends or themes will be monitored and appropriate actions taken as necessary. Update reports will be provided to the Trust Board and appropriate committees on a regular and ongoing basis.

Rota gaps and the plan for improvement to reduce these gaps' re doctors and dentists in training

The Clatterbridge Cancer Centre NHS Foundation Trust does not facilitate Dentists in training, but does provide training to Specialist Registrars and Junior Doctors who are assigned by the Lead Employer St Helen's & Knowsley Teaching Hospital NHS Trust. The funded establishment for the training posts at The Clatterbridge Cancer Centre NHS Foundation Trust are as follows:

Specialist Registrars

Speciality	Number	Type of post	Number of posts funded by Trust
Clinical Oncology	13	Training post	2
Medical Oncology	6	Training post	1

Junior Doctors

Type of Trainee	Number of Whole time equivalent	Lead Employer
Foundation Year 2 (FY2)	3	Wirral University Teaching Hospital NHS Foundation Trust
Core Medical Trainees (CMT's)	3	St Helen's & Knowsley Teaching Hospital NHS Trust
GP Specialist Trainees (GPST)	3	St Helen's & Knowsley Teaching Hospital NHS Trust

Rotations for FY2 and CMT run for 4 months in Aug-Dec; Dec-Apr; Apr- Aug
Foundation Year 2 – Rotate to the Trust in August for 4 months and leave in December to continue their training.
Core Medical Trainees – Rotate to the Trust in August for 4 months and leave in December to continue their training.
GP Specialist Trainees – Rotate to the Trust in August for 6 months and leave in February to continue their training (Aug-Feb; Feb-Aug.)
Specialist Registrars – ST3 and above rotate to the Trust every August and remain for the full training programme until they qualify as a Consultant.

For 2018/2019 the Trust was allocated 21 Specialist Registrars (funded establishment was 19 wte), with 5 trainees being out of programme (2 of which were on maternity leave). The Trust also had 2 further trainees on maternity leave. Therefore, the rota that was established was based on a head count of 14 and any identified gaps were covered internally or by the trainees who were out of programme.

The Junior Doctor funded establishment for 2018/2019 was 9 wte. For the first rotation in August, 8.6 wte was allocated by the Lead Employer. As there was a training gap of 0.4 wte, the Trust recruited 2 Clinical Fellows (1.4 wte), with 1 wte being funded by the Trust. As this was over the funded establishment a 1:11 rota was implemented.

The Foundation Year 2's (3) and the Core Medical Trainees (3) left the Trust in December 2018 for their next rotation (6 wte). From December 2018, the Trust had been allocated 3 wte Foundation Year 2 and 2 wte Core Medical Trainees (5 wte). With the recruited Clinical Fellows, there were no identified training gaps. The Trust implemented a 1:11 rota. In November 2018 one of the Clinical Fellows left; in the interim, the shifts were filled internally/agency locum until the vacancy was recruited to in February 2019.

The 3 GP Specialist Trainees (2.6 wte) completed their rotation in February 2019 and the Trust was allocated 2 GP Specialist Trainees (2 wte). From February 2019 until April 2019, the Trust utilised agency locums and reviewed the rota establishment adjusting this accordingly.

The 3 GP Specialist Trainees (2.6 wte) completed their rotation in February 2019 and the Trust was allocated 2 GP Specialist Trainees (2 wte), therefore, leaving a training gap of 1 wte. This gap was temporary until April 2019, and the Trust utilised agency locums.

Planning for the future, a business case has been submitted to increase the establishment at Foundations Year 2, Core Medical Trainees and GP Specialist Trainees at an additional cost to the Trust in order to ensure compliance with new training requirements to increase clinic experience for trainees. In May 2019, the Trust will be notified by the Lead Employer of the number of Specialist Registrars, Foundation Year 2, Core Medical Trainees and GP Specialist Trainees who have been allocated from August for the year. Any gaps which are identified at Specialist Registrar level will now be advertised as a Senior Clinical Fellow or a Locum Appointed for Service (LAS) and recruited to for a period of 12 months. In tandem with these changes, allied health professional roles are being developed to support the work previously undertaken by the Junior Doctor workforce.

2.3 Reporting Against Core Indicators

See web link to NHS Digital where this data is provided
https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts

In July 2017 the Trust took over the management of the haemato-oncology service from the Royal Liverpool and Broadgreen NHS Trust. Where the information below contains data after this period it will include the haemato-oncology patients and staff which impacts on the ability to compare with previous year's performance. Commentary provided on all relevant domains to the Trust as below.

Domain 4: Ensuring that people have a positive experience of care – responsiveness to inpatients' personal needs.

The Trust's responsiveness to the personal needs of its patients during the reporting period.

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
2018/19	Data not yet available			
2017/18	83.7	68.6	60.5	85.0
2016/17	84.9	68.1	60.0	85.2
2015/16	86.3	77.2	70.6	88.0
2014/15	85.9	76.6	67.4	88.2

Data source: NHS Digital

- The Clatterbridge Cancer Centre NHS Foundation Trust considers that this data is as described for the following reasons:
    - o It is consistent with our previous performance
    - o It is consistent with our internal real time patient survey program
    - o The data source is governed by a standard national definition and results are reported from a statistical data set on the Health and Social Care website.

- The Clatterbridge Cancer Centre NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:
    - o Developing an action plan to address any issues identified in the patient survey results
    - o Continual monitoring of our internal real time survey results and the Friends and Family results
    - o Enhancing our understanding of the 'patient story' through patient attendance at Board to talk to our Board members about their experience of our services.

Domain 4: Ensuring that people have a positive experience of care:

If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (agree or strongly agree).

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
2018	90%	89%	77%	94%
2017	93%	89%	79%	93%
2016	92%	89%	76%	93%
2015	91%	89%	82%	93%

Data source: NHS Digital Comparator group: Acute Specialist organisations

- The Clatterbridge Cancer Centre NHS Foundation Trust considers that this data is as described for the following reasons:
    - o It is consistent with our previous performance
    - o The data source is governed by a standard national definition and results are reported from a statistical data set on the Health and Social Care website.

• The Clatterbridge Cancer Centre NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:
    - o Continual monitoring of our internal quality indicators
    - o Ensuring staff views are heard directly by the Board through Patient Safety and Quality Leadership Walk Rounds
    - o The data source is governed by a standard national definition and results are reported from a statistical data set on the Health and Social Care website.
    - o Developing an action plan to address any issues identified in the staff survey results.

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm:

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
Q3 18/19	92.96%	95.37%	54.86%	100%
Q2 18/19	94.86%	95.37%	68.67%	100%
Q1 18/19	92.39%	95.42%	75.84%	100%
Q4 17/18	80.96%	94.87%	67.04%	100%
Q3 17/18	94.14%	95.25%	76.08%	100%
Q2 17/18	96.36%	95.19%	71.88%	100%
Q1 17/18	97.25%	95.09%	51.38%	100%
Q4 16/17	97.10%	95.54%	63.02%	100%
Q3 16/17	90.67%	95.7%	76.48%	100%
Q2 16/17	96.64%	95.65%	72.14%	100%
Q1 16/17	98.33%	96.01%	80.61%	100%
Q4 15/16	96.26%	95.87%	78.06%	100%
Q3 15/16	98.1%	95.8%	61.5%	100%
Q2 15/16	98%	96.2%	75%	100%
Q1 15/16	97.8%	96.04%	86.1%	100%
Q4 14/15	99.08%	96.31%	79.23%	100%
Q3 14/15	98%	96%	81%	100%
Q2 14/15	98.1%	96%	86.4%	100%
Q1 14/15	98.2%	96%	87.2%	100%

Data source: NHS Digital

• The Clatterbridge Cancer Centre NHS Foundation Trust considers that this data is as described for the following reasons:

    - o It is consistent with our internal audit program
    - o It is consistent with our Safety Thermometer results.
    - o The data source is governed by a standard national definition and results are reported from a statistical data set on the Health and Social Care website.

• The Clatterbridge Cancer Centre NHS Foundation Trust recognises the % performance figure has been influenced by both changes in reporting and responsibilities for risk assessment completion since 2014/15. The Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

    - o Ongoing clinical audit including management of the whole VTE pathway
    - o Daily review of compliance with all clinical risk assessments

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm:

The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
April 2017 to March 2018	78.6	38.3	0	157.5
April 2016 to March 2017	39.9	35.9	0	147.5
April 2015 to March 2016	30.5	40.1	0	111.1
April 2014 to March 2015	6.1	15.1	0	62.2
April 2013 to March 2014	11.6	39	0	85.5

Data source: NHS Digital Comparator group: Acute Specialist (including acute specialist (children)) organisations

- The Clatterbridge Cancer Centre NHS Foundation Trust considers that this data is as described for the following reasons:
    - o It is consistent with our internal reporting
    - o The data source is governed by a standard national definition and results are reported from a statistical data set on the Health and Social Care website.

- The Clatterbridge Cancer Centre NHS Foundation Trust is a specialist cancer Trust and therefore recognises the complexity of performance comparisons to national cases. In acknowledging that the Trust acuity levels have risen, new treatment regimens can be aggressive, and that the Trust now supports haemato-oncology and immunotherapy treatments for patients, the Trust has taken the following actions to improve this rate and so the quality of its services, by:
    - o Continuing to improve our infection control practices and case reviews of all incidences of Clostridium Difficile

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm:

The number of patient safety incidents reported within the Trust during the reporting period (acute specialist).

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
October 17 – March 18	941	1454	287	3582
April 17 – September 17	903	1448	294	2814
October 16 to March 17	771	1444	295	3872
April 16 to September 16	1342	1357	286	2527
October 15 to March 16	1217	1312	334	2666
April 15 to September 15	916	1138	347	2137
October 14 to March 15	849	1114	300	2672
April 14 to September 14	776	993	85	2619

Data source: NHS Digital Comparator group: Acute Specialist (including acute specialist (children)) organisations

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm:

The rate (per 100 admissions) of patient safety incidents reported within the Trust during the reporting period (acute specialist)

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
October 17 – March 18	69.9	52.2	17.6	158.3
April 17 – September 17	95.7	56.0	14.8	174.6
October 16 to March 17	85.3	51.6	13.7	149.7
April 16 to September 16	150.6	59.5	16.3	150.6
October 15 to March 16	141.9	56.7	16.1	141.9
April 15 to September 15	117	48.5	15.9	117
October 14 to March 15	108.5	43.3	3.6	170.8
April 14 to September 14	94.8	40.2	17.6	94.8

Data source: NHS Digital Comparator group: Acute Specialist (including acute specialist (children)) organisations

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm:

The number that resulted in severe harm or death (acute specialist)

Period	Trust Performance	National Average	National Range (lowest)	National Range (Highest)
October 17 – March 18	2	3	0	15
April 17 –September 17	3	3	0	11
October 16 to March 17	0	3	0	11
April 16 to September 16	0	2	0	7
October 15 to March 16	0	2	0	9
April 15 to September 15	0	2	0	9

Data source: NHS Digital Comparator group: Acute Specialist (including acute specialist (children)) organisations

The Clatterbridge Cancer Centre NHS Foundation Trust considers that this data is as described for the following reasons:

- It is consistent with our internal reporting processes
- The Clatterbridge Cancer Centre NHS Foundation Trust has taken the following actions to improve the quality of its services (the rate of severe harm incidents is 0 and therefore cannot be improved on.)
- Continued delivery against our Risk Management Strategy
- Continued delivery against our Quality Strategy
- Continued monitoring of our incident reporting levels via the NRLS (National Reporting and Learning System)
- Improved feedback to staff who report incidents
- Improved Organisational shared learning through the introduction of Quality & Safety meetings, a Shared Learning Bulletin and Newsletter

NB: Our rate of incidents reported is at the highest level. According to the NRLS / National Patient Safety Agency organisations that report more incidents usually have a better and a more effective safety culture. You can't learn and improve if you don't know what the problems are.

We will therefore continue to encourage staff to report all incidents and near misses as we see this as indicative of a proactive risk management and patient safety culture.

2.4 The Friends and Family Test

The goal of The Friends and Family Test is to improve the experience of patients. It aims to provide timely feedback from patients about their experience. All NHS Trusts have a requirement to ask every inpatient the following question:

How likely are you to recommend our ward to friends and family if they needed similar care or treatment?

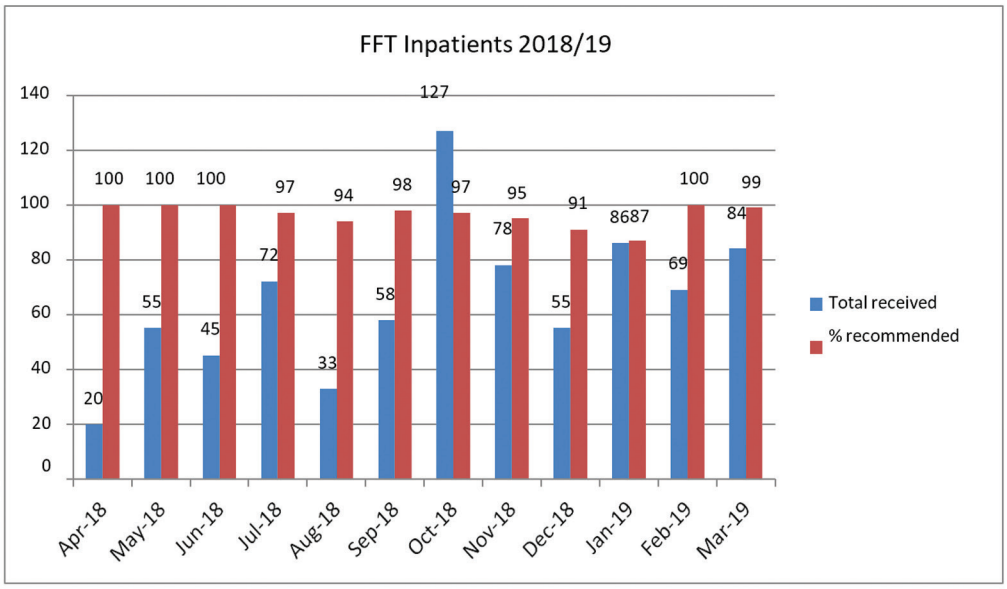
- Extremely likely
- Likely
- Neither likely or unlikely
- Unlikely
- Extremely unlikely
- Don't know

The following graphs show the percentage of patients that would recommend our services to the Friends and Family. The number of responses received for each month is also indicated.

The Trust recognises that the Friends and Family response rate is lower than desired due to a number of circumstances to include the disease status of the patient population and timing of distribution of the response cards. To address this matter the Trust has invested in digital software in 2018 to facilitate ease of response.

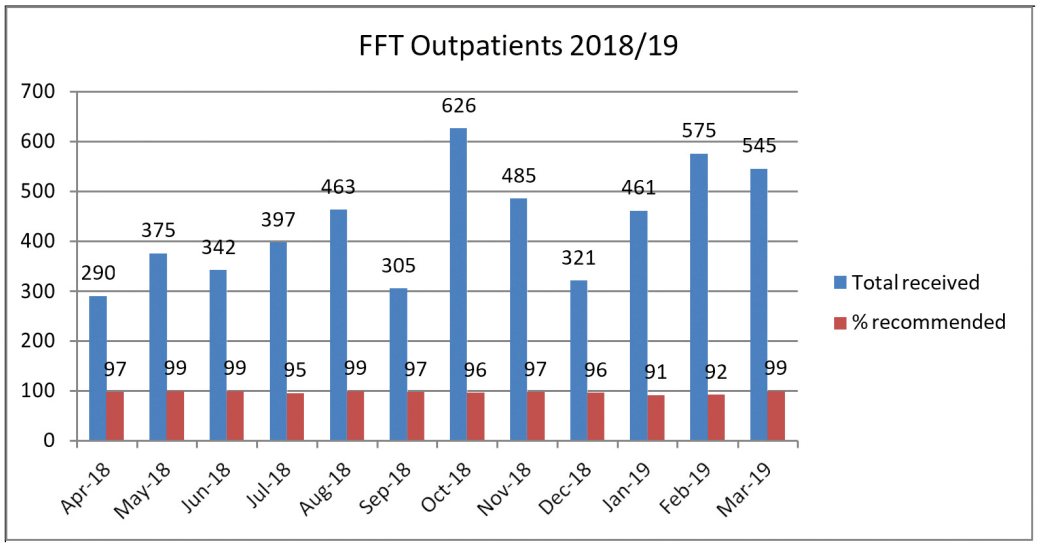
Inpatient Friends and Family Test

Inpatients for 2018/19 total responses received 782 of which 96% would recommend our services.



Outpatient Friends and Family Test

Outpatients for 2018/19 total responses received 5185 of which 96% would recommend our services.



We also asked patients 'what would have made your visit better'.

If there were no delays in transport

Nothing - made a bad experience so much easier to cope with

If parking were free and if the spaces were nearer to the hospital

Better access to tea and coffee

Would be better if I saw the same doctor every day on the ward

Nothing - I cannot fault my care

If appointments were on time. delays really need addressing

If scan results had been ready in time for appointment

Better conditions in waiting room. Could be brighter and airier with more chairs

Trust response-what are we doing to improve?:

- A Receptionist service is now in place to manage transport requirements and reduce delays
- Patient car parking in Liverpool forms a key part of the Transformation work stream for the new build. Car parking at CCCW is free and accessible for patients
- Medical staff work in teams to reduce reliance on individual doctors and decisions are effectively communicated and discussed through the electronic patient record and at multidisciplinary meetings.
- New vending machines have been purchased and installed. Volunteers provide patients and carers with free tea and coffee outside of mealtimes.
- The new cancer hospital opening in 2020 will provide state of the art facilities for our patients
- We aim to minimise delays where possible and to schedule appointments to avoid unnecessary waits. A patient pager system is in place and we aim to keep patients fully informed at all times of any unavoidable delays

2.5 Implementation of the Duty of candour

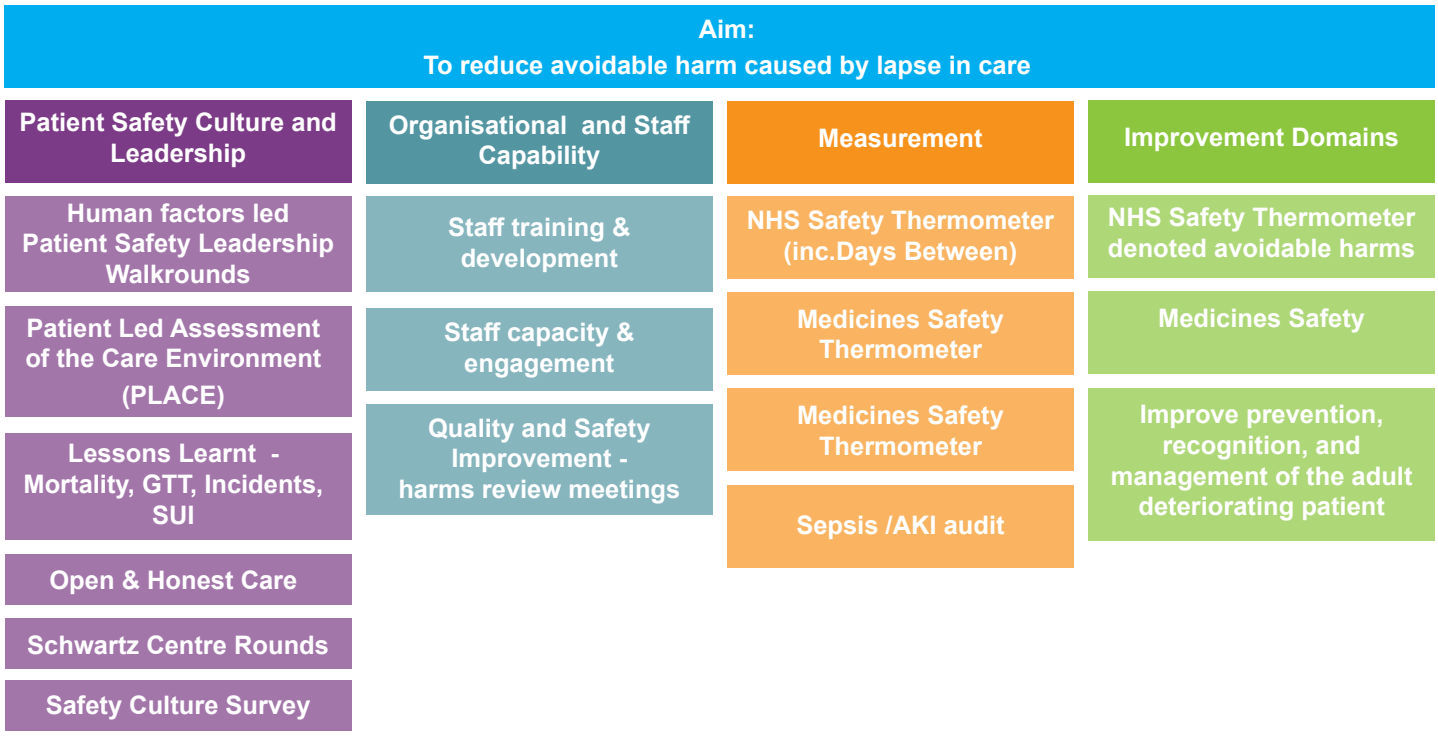
The Trust has in place a Guide to Incident Reporting & Being Open/Duty of Candour: Communicating Patient Safety Incidents with Patients and their Carers policy. This policy provides the information and framework to all staff to ensure a culture of openness where communication with the patient, their family or carers and the healthcare team is open, honest and occurs as soon as possible following a patient safety incident. The policy is audited annually and the 2018 audit involved reviewing all incidents that caused moderate harm or above and all serious incidents held from 1/1/18-31/12/18. It also involved reviewing all complaints and claims to ensure that the Being Open policy/principles were followed.

The audit has confirmed that the principles of being open have been undertaken where appropriate.

Duty of Candour is included in the Risk Management Training for all staff which is an e- learning workbook to be completed every 2 years.

2.6 Sign up to Safety Campaign

The Trust is an active participant in the Sign up to Safety Campaign, supporting NHS England's vision to create the conditions for making care safer. Sign up to Safety comes to an end in March 2019. However as a Trust the work developed either as a direct or indirect consequence of the NHSE Sign Up to Safety campaign continues as "business as usual" within the Trust as shown in below driver diagram.



2.7 The Clatterbridge Cancer Centre NHS Staff Survey Results: Workforce Race Equality Standard (WRES)

			2018	Average (median) for acute specialist trusts 2018	2017	Change	Ranking compared with all acute specialist trusts in 2018
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	23%	25%	24%	1%	Better than average
		BME	20%	27%	16%	4%	Better than average
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	86%	88%	89%	4%	Below average
		BME	81%	76%	96%	15%	Better than average

2.8 CQC Ratings Grid

The Clatterbridge Cancer Centre NHS Foundation Trust underwent an inspection of a number of core services and a Well Led inspection in Dec 2018/Jan 2019. The overall rating for the Trust was 'Good'. A comprehensive action plan, with weekly performance management meetings, is in place to address the 'must do' and 'should do' issues raised within the inspection report published on 16th April 2019. The ratings grid and must do actions are described below:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Mar 2019	Good →← Mar 2019	Outstanding →← Mar 2019	Good Mar 2019	Requires improvement ↓ Mar 2019	Good →← Mar 2019
End of life care	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Outpatients	Good Mar 2019	Not rated	Outstanding Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Diagnostic imaging	Requires improvement Mar 2019	Not rated	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Chemotherapy	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Radiotherapy	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Overall*	Good ↑ Mar 2019	Good →← Mar 2019	Outstanding →← Mar 2019	Good →← Mar 2019	Good ↓ Mar 2019	Good ↓ Mar 2019

** The Rating Grid above was published incorrectly by CQC and the overall rating for 'Well-Led' should be 'Requires Improvement'.

How the Trust plans to address 'must do' areas that require improvement

Action	Progress	Monitoring
Fit and Proper Person's Process Regulation 5 – The trust must ensure that people who have director level responsibility for the quality and safety of care and for meeting the fundamental standards are fit and proper to carry out this important role.	The gaps highlighted at the inspection have been rectified and files are complete Full review of the existing Fit and Proper Persons Framework culminating in development of new Policy.	The gaps highlighted at the inspection have been rectified and files are complete Full review of the existing Fit and Proper Persons Framework culminating in development of new Policy.
Safe Care and Treatment Regulation 12 – The trust must ensure that relevant identification and safety checks are completed prior to initiating exposure to radiation	The work instruction reviewed and updated to indicate explicitly clear roles and responsibilities. Update communicated to all staff. The pause and check process was audited in January 2019 and the report presented to the Quality and Safety committee. The result of this audit was 100%. Trust policy for the identification of the patient reviewed and updated.	A cycle of audits in place next audit due the first week in June 2019.
Good Governance Regulation 17- The Trust must ensure that it has systems and processes in place to enable oversight, audit and assessment of services.	Full review of the governance structure commenced in January 2019. New committee meeting schedule devised. Review of the Terms of Reference for all committees Revised templates for Chair reports and 'Triple A' reports introduced	The governance structure will be audited by internal audit and has been included on the annual work plan for 2019/2020.
Staffing Regulation 18- The Trust must ensure that there is always enough suitably qualified , competent and experienced staff with relevant levels of life support training deployed within the service at all times.	Increased the number of training sessions available Rosters allow staff protected time to attend their allotted session. There has been a significant improvement in compliance levels at end of April All directorates are above the trust's 90% target	Monthly audits are conducted in each clinical area and are reported to directorate quality and safety meetings and escalated through the weekly Improvement Plan Assurance Group.

Part 3: Other information

3.1 An overview of the quality of care offered by the Trust

The Board in consultation with stakeholders has determined a number of metrics against which it can measure performance in relation to the quality of care it provides. The Trust has chosen metrics which are relevant to its speciality i.e. non-surgical oncology and which are identified as important to the public. However, this does mean that data is predominantly internally generated and may not be subject to benchmarking at this stage.

Safety indicators

	2018/19	2017/18	2016/17	2015/16	2014/15
Attributable grade 2 or above pressure ulcers/1,000 bed days	0.04	0.92	0.99	0.87	1.03
MRSA bacteraemia cases/10,000 days	0	0	0	0	0
C Diff cases / 1,000 bed days	0.09	0.38	0.28	0.18	0.06
'Never Events' that occur within the Trust	0	0	0	0	0
Chemotherapy errors (number of errors per 1,000 doses):	1.31	1.3	0.57		
Radiotherapy treatment errors (number of errors per 1,000 fractions)	1.35	1.07	1.2	1.5	1.4
Falls / injuries / 1,000 inpatient admissions	15.2	15.07	24.7	29.7	12.6
Number of patient safety incidents	2352	2121	2773	2534	1901
Percentage of patient safety incidents that resulted in severe harm* or death.	2*	0.24%	0	0.04%	0

* 2 incidents resulted in death, however not due to harm or lapse in care.

All indicators:

- Data source: CCC
- The expansion of our services to now include the Haemato-oncology services from the Royal Liverpool & Broadgreen University Hospital Trust in July 2017.

***Severe Harm:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care. (National Patient Safety Agency)

According to the NRLS / National Patient Safety Agency organisations that report more incidents usually have a better and a more effective safety culture. You can't learn and improve if you don't know what the problems are.

We will therefore continue to encourage staff to report all incidents and near misses as we see this as indicative of a proactive risk management and patient safety culture.

Clinical Effectiveness Indicators

	2018/19	2017/18	2016/17	2015/16	2014/15
30 day mortality rate (radical chemotherapy)	0.7% (Apr 18 – March 19)	0.67% (Apr 17 – Mar 18)	0.6% (Apr 16-Mar 17)	1.05% (Apr 14-Mar 15)	0.66% (Apr 14-Mar 15)
30 day mortality rate (palliative chemotherapy)	7.4% (Apr 18 – March 19)	6.1% (Apr 17 – Mar 18)	5.7% (Apr 16-Mar 17)	7.5% (Apr 14-Mar 15)	6.7% (Apr 14-Mar 15)
30 day mortality rate (haemato-oncology)	5.2% (Apr 18 – March 19)	4.1% (July 17 – Mar 18)			
30 day mortality rate (radical radiotherapy)	3.9% (Apr-March 19)	3.5% (Apr-Mar18)	*4.3% (Apr16-Mar17)	0.76% (Apr 14-Mar 15)	0.70% (Apr 14-Mar 15)
30 day mortality rate (palliative radiotherapy)				12.8% (Apr 14-Mar 15)	10.0% (Apr 14-Mar 15)
SHMI: *Unfortunately as a Specialist Trust we are not included in the Summary Hospital Mortality Indicator (SHMI) so this data is unavailable.					

Mortality rate:

- Data definition: unadjusted mortality rate as a percentage of all cases treated in that category.
- Data source: CCC
- *Radiotherapy intent is not recorded against appointment in Meditech system, a different data source will need to be explored (i.e. Aria system) for mortality reporting in future.

Patient Experience Indicators

Patients rate as 'always' in the local patient survey programme.

	2018/19	2017/18	2016/17	2015/16	2014/15
'I was treated with courtesy and respect'	91%	98%	96%	98%	98%
'Was the ward / department clean'	99%	96%	94%	96%	96%
'I never had to wait'	76%	41%	36%	35%	29%
'I was included in discussions about my care'	95%	93%	92%	93%	93%
'Did the staff wash their hands'	99%	90%	95%	95%	95%

Patient survey:

- Data source: data collected from in-house survey
- Survey questions based on annual Care Quality Commission In-patient survey
- Target for compliance agreed by the Trust Board as part of our Quality Strategy

3.2 Performance against relevant indicators and thresholds in the Risk Assessment Framework and the Single Oversight Framework

	2018/19	2017/18	2016/17	2015/16	2014/15
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	98% (target 92%)	96.33% (target 92%)	96.2% (target 92%)	98.0% (target 92%)	97.3% (target 92%)
All cancers: 62-day wait for first treatment from: urgent GP referral for suspected cancer	84.6% post reallocation (target 85%).	79% post reallocation, against revised NHSE rules (target 85%). The target was achieved in all but 1 month in Q3 and Q4.	89.1% post reallocation (target classic 85%)	90.9% post reallocation (target classic 85%)	88.2% post reallocation (target classic 85%)
All cancers: 62-day wait for first treatment from: NHS Cancer Screening Service referral	64.5% of screening patients (post allocation) were treated within 62 days against a target of 90%. 9 patients breached in this period; CCC was fully responsible for 1 breach and partly responsible (with another Trust) for 8.	93.3% post reallocation (target 90%).	92.6% post reallocation (target screening 90%)	100% post reallocation (target screening 90%)	100% post reallocation (target screening 90%)
Clostridium difficile – meeting the C. difficile objective: variance from plan	2 attributable (annual target of no more than 4). 1 case remains under review to determine if there was a lapse in care.	6 attributable (annual target of no more than 5). The target increased when the Trust acquired the Haemato – oncology service on 1st July 2017).	4 attributable (target no more than 1). All cases agreed as no lapse in care.	3 attributable (target no more than 1). 2 cases agreed as no lapse in care.	1 (target no more than 2)
Maximum 6-week wait for diagnostic procedures	100% waiting fewer than 6 weeks	100% waiting fewer than 6 weeks			
Venous thromboembolism (VTE) risk assessment	94% (target 95%)	93%			

Abbreviations

AHP	Allied Health Professional
ANP	Advanced Nurse Practitioner
AO	Acute Oncology
AONP	Acute Oncology Nurse Practitioner
AQuA	Advancing Quality Alliance
BSBMT	British Society Of Blood And Marrow Transplantation
C&M	Cheshire and Merseyside
CAS	Central Alerting System
CCC	Clatterbridge Cancer Centre
CCCL	Clatterbridge Cancer Centre Liverpool
CCG	Clinical Commissioning Group
CDS	Cancer data Set
CEO	Chief Executive Officer
CET	Clinical Effectiveness Team
CGST	Clinical Governance and Support Team
CNS	Clinical Nurse Specialist
CoG	Council of Governors
COSD	Cancer Outcomes and Services Dataset
CQC	Care Quality Commission
CQUINS	Commissioning for Quality and Innovation
CSAN	Clinical Specialist Additional Needs
CUP	Cancer of Unknown Primary
DaRT	deteriorating patient and resus team
DDoN	Deputy Director of Nursing
DIPC	Director of Prevention Control
DoN&Q	Director of Nursing & Quality
EPR	Electronic Patient Record
ESC	Enhanced Supportive Care
FFT	Friends and family Test
FT	Foundation Trust
FTSU	Freedom to Speak Up
G-CSF	Granulocyte-colony stimulating factor
GI	Gastro-intestinal
GTT	Global Trigger Tool
HAP	Hepatoma arterial-embolisation prognostic
HCC	hepatocellular carcinoma
HF	Human Factors
HO	Haemato Oncology
HSMR	hospital standardised mortality ratio
HWB	Health & Well Being
IC	department Integrated Care Department
ID	identification
IG	Information Governance
JRS	Joint Research Service
KPI	Key Performance Indicator
L&D	Learning and Development
LD	Learning Disabilities
LWH	Liverpool Women's Hospital
MDT	Multi-Disciplinary Team
MHRA	The Medicines and Healthcare products Regulatory Agency
MRM	Mortality Review Meeting
MRSA	methicillin-resistant Staphylococcus aureus
NCEPOD	National Confidential Enquiry into Patient Outcome & Death
NCS	National Cancer Survey
NED	Non-Executive Director
NEWS2	National Early Warning Score
NHSE	NHS England
OSC	Overview and Scrutiny Committee
PALs	Patient Advocacy and Liaison Service
pCR	Polymerase chain reaction
PICC	Peripherally Inserted Central Catheter

Abbreviations

PLACE	Patient Led Assessment of the Care Environment
PSA	prostate specific antigen
Q&S	Quality & Safety
QA	Quality Assurance
QoL	Quality of Life
R&D	Research & Development
R&I	Research and Innovation
RAG	Red Amber Green
RCA	Root Cause Analysis
RCR	Royal College of Radiologists
RITA	Reminiscence Interactive Therapy Activities
RLBUHT	Royal Liverpool & Broadgreen University Hospital Trust
SABR	Stereotactic body radiation therapy
SACT	Systemic Anti-Cancer Therapy
SBAR	Situation-Background-Assessment-Recommendation
SHMI	Summary Hospital-level Mortality Indicator
SLA	Service Level Agreement
SOP	Standard Operating Procedure
SpPCT	Specialist Palliative Care Team
SpR	Specialist Registrar
SRG	Site Reference Group
SUI	Serious Untoward Incident
SUS	Secondary Uses Service
ToR	Terms of Reference
UKONS	United Kingdom Oncology Nursing Society
VMAT	Volumetric Arc Therapy
VTE	Venous Thromboembolism
WOD	Workforce and Organisational Development
WRES	Workforce Race Equality Standard
WUTH	Wirral University Teaching Hospital
XML	eXtensible Markup Language

Annex 1

Statement from Commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Quality Account Commentary
for Clatterbridge Cancer Centre NHS Foundation Trust provided by Healthwatch Wirral CIC
May 2019

Healthwatch Wirral would like to thank Clatterbridge Cancer Centre for the opportunity to comment on the Quality Account for 2018/19.

Over the last year Clatterbridge Cancer Centre has welcomed Healthwatch Wirral's input on improving patient experience.

Members of the Healthwatch Wirral Working Group met during May 2019 to discuss the Trust's Quality Account and produce the following commentary.

Priorities for Improvement

The account detailed the priorities and outlined the Trust's commitment to them.
The three priorities noted were recorded under the following headings: - Patient Safety, Patient Experience and Effective/Patient Outcomes.

Priority 1 - Healthwatch would appreciate a quarterly performance update on the digital pathway for the management of the deteriorating patient introduced in December 2018.

Priority 2 – Introducing a Nursing Allied Healthcare Professional Model of Shared Governance. The Quality Account lacked clarity on how this initiative would directly lead to improved shared decision making.

Priority 3 – Patient Involvement Strategy – Healthwatch would appreciate details of what the key milestones are for the 7 pledges that the Trust will monitor.

Healthwatch look forward to hearing what will be the measures and indicators of success for these priorities along with updates on their progress throughout the year.

Progress made since the publication of the 2017/18 report.

The account set out their outcomes and achievements.

Healthwatch would welcome any information on the impact of the introduction of RITA (Reminiscence Interactive Therapy Activities) and what difference it has made.

Improving the Quality of Mortality Review and Serious Incident Investigation.

Healthwatch Wirral have noted that the Trust continues to evaluate and improve these processes.

CQINS

It was disappointing to see that the Trust did not meet all requirements but it was interesting to see that CQUIN related developments resulted in better patient experience.

Research and Innovation

Healthwatch Wirral welcomed the significant investment over the next 3 years to support research and to ensure that patients have equitable access to research through the Trusts hubs and sectors.

Safeguarding

The Trust should be commended for strengthening and improving its safeguarding policies and procedures including the recruitment of a Head of Safeguarding and Named Nurse.

Falls

Reassuringly, the Trust has a comprehensive falls prevention and management plan and they continue to address falls prevention.
Although Healthwatch Wirral welcomed the number of initiatives that have been launched to reduce the risk of patients falling, there were concerns that the incidence of falls continue to increase.

Friends and Family Test

The Friends and Family test responses recorded that, of those who responded, 96% of inpatients and 96% of outpatients would recommend the service to family and friends.
These findings mirror positive public feedback that Healthwatch Wirral received in relation to the Trust.
However, the Trust response rate was lower than desired due to a number of circumstances but it was reassuring that the Trust is addressing this by introducing digital software to facilitate ease of response

Staff Surveys

It was concerning that 43% of staff reported to have experienced harassment, bullying or abuse from other staff in the last 12 months.

Healthwatch would like to be updated on whether the newly launched Freedom to Speak Up Campaign will make a difference to future statistics.

Reporting Against Core Indicators

Healthwatch noted the Trust's performance and look forward to receiving updates when the most recent data is available.

Overall, the Quality Account was comprehensive.

Healthwatch Wirral welcome the Trust's ongoing commitment to continuous improvement and its vision to provide the best cancer care to their patients.

Karen Prior

Chief Officer - Healthwatch Wirral
On behalf of Healthwatch Wirral

NHS Liverpool Clinical Commissioning Group

NHS England

Clatterbridge Cancer Centre – Quality Account 2018/19

NHS England Specialised Commissioning Team and Liverpool Clinical Commissioning Group would like to thank The Clatterbridge Cancer Centre for the opportunity to comment on their Quality Account for 2018/19. The account reflects the performance for the organisation during 2018/19.

The Quality Account clearly sets out the outcomes and achievements for 2018/19 and details the priority areas and rationale for the coming year. The priority areas demonstrate patient's engagement and a commitment to improving quality for patients in the coming year.

Clatterbridge's values have been developed by staff and demonstrate a focus on improvement of care and commitment. Commissioners are keen to see the revised governance arrangements, structures and Quality Strategy following the new Board appointments and are looking forward to working with the Trust during the move to their new cancer centre in Liverpool City Centre.

The trust should be commended on meeting their mandated targets and the maintenance of zero tolerance to MRSA as again there have been no cases of MRSA. The trust has not exceeded its Clostridium Difficile (CDiff) threshold, with 2 cases of hospital attributable CDiff reported in the last year against a maximum of 4. Commissioners are keen to see further integration of Haemato-oncology services at the Royal Liverpool site into the organisation. Achievements against last year's priority areas are clearly stated and have resulted in positive changes to practice. Work on the digital sepsis pathway should be noted and it will be good to see the impact this has on patient outcomes and care.

The account shows how future priority areas will be measured, monitored and reported within the Trust. Commissioners will also monitor progress through regular Quality and Performance meetings. It is evident that there is a focus on patient and public involvement which is of particular importance this year in the run up to the new cancer centre opening in 2020.

The Trust have demonstrated a transparent learning culture in serious incident monitoring and have a robust system in place working with Commissioners to review serious incidents and ensure lessons learnt are shared. One of the mechanisms for sharing is via the Trust newsletter. The account also reports learning from deaths and there is evidence of changes in practice as a result of reviewing deaths.

Safeguarding procedures have been improved over the last year with investment in new posts to ensure safeguarding is embedded into practice and that there is Board oversight.

The Quality Account shows commitment to National and Local audits and research. There is a demonstrable focus on improving patient safety and improving quality outcomes and experience. A recent CQC inspection has rated the Trust as 'Good', Commissioners will be working with the Trust to ensure improvements are made in the coming year and monitoring against the action plan.

The Clatterbridge Cancer Centre provides quality assurance throughout the year to commissioners via regular Quality, Performance and Contracting meetings and we look forward to working in partnership in 2019/20 to further improve quality and experience for patients.

ANDREW BIBBY
Director of Specialised Commissioning Health and Justice North West

Liverpool CCG

Jan Ledward
Chief Officer
Date: 20th May 2019

The Clatterbridge Cancer Centre NHS Foundation Trust Quality Account 2018/19

Statement from Wirral Metropolitan Borough Council

The Adult Care and Health Overview & Scrutiny Committee are responsible for the discharge of the health scrutiny function at Wirral Council. The Committee established a task and finish group in May 2019 in order to review the Quality Account of the Clatterbridge Cancer Centre NHS Foundation Trust for 2018/19 and were grateful for the opportunity to comment on the draft report.

Members are satisfied that the Trust has delivered on its targets for the last year within the quality indicators of patient safety, patient experience and clinical effectiveness. In particular, the implementation of reminiscence therapy (RITA) for dementia patients is welcomed as an innovative approach to dealing with inpatient co-morbidity. It is particularly encouraging to see the individualisation of patient care through use of personal life stories, as well as an extensive timetable of weekly activities. Members look forward to receiving updates on this initiative.

Members are particularly pleased with the Trust's sustained record of infection control, with achievements against both clostridium difficile and MRSA targets. In addition, it is noted that the Trust operates a comprehensive mortality programme, with investigation taking place around avoidability and learning from case record reviews fully documented. The focus on implementation of the Duty of Candour further contributes to a culture of openness and transparency around incident reporting.

Early in 2019, Members were disappointed to learn that the Trust's CQC rating had fallen from 'Outstanding' to 'Good' following inspection, and were particularly concerned with the CQC report's comments around the 'well-led' inspection area. Members have been made aware that this is an area of focus for the Trust and steps have already been taken to strengthen the senior management structure, with a number of executive roles recruited to. Members have also been adequately assured that work is ongoing to guarantee robust processes are in place and that governance arrangements are stable. It is expected that these developments will contribute to the permanency of the organisation in the coming year.
The Trust's strong record of participation in audits, research and academic oncology is commended, along with its commitment to digital innovation. The introduction of the outcomes dashboard is welcomed as a key development in order to provide an oversight of performance indicators in different delivery areas. Members also welcome the Trust's encouraging results in the Friends & Family Test – with a score of 96% satisfaction for both inpatients and outpatients.

There is concern amongst Members around the increasing number of falls at the Trust, with an increase of 30 inpatient falls since 2016/17, although it is appreciated that there has been a focus on incident reporting and implementation of a series of initiatives to combat this; such as thorough blood pressure checks on admission and upgraded lighting.

Members welcome the Trust's key priorities for 2019/20; in particular the planned delivery of a shared governance framework for nurses and allied healthcare professionals in response to the national shortage of healthcare staff. This collaborative approach to clinical decision making is noted by Members as an area of good practice and allows for a fully engaged workforce. Members also look forward to the anticipated expansion of services and the opening of the new Cancer Centre facility in Liverpool in 2020.

The Adult Care and Health Overview & Scrutiny Committee look forward to continued partnership working with the Trust during the forthcoming year and note its priorities for 2019/20.

Julie McManus

Councillor Julie McManus
Chair, Adult Care and Health Overview & Scrutiny Committee Wirral Borough Council

Annex 2

Statement of Directors' Responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance;

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

    - o Board minutes and papers for the period April 2018 to May 2019
    - o Papers relating to Quality reported to the Board over the period April 2018 to May 2019
    - o Feedback from the commissioners dated May 2019
    - o Feedback from governors dated April 2018 to June 2019
    - o Feedback from Local Healthwatch organisations dated May 2019
    - o Feedback from Overview and Scrutiny committee dated May 2019
    - o The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019
    - o The latest National Patient Survey 2018
    - o The latest National Staff Survey 2018
    - o The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2019
    - o CQC Inspection Report dated April 2019

- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;

- the performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Signed

Alison Hastings
Vice Chair Date: 23 May 2019

Signed

Dr Liz Bishop
Chief Executive Date: 23 May 2019

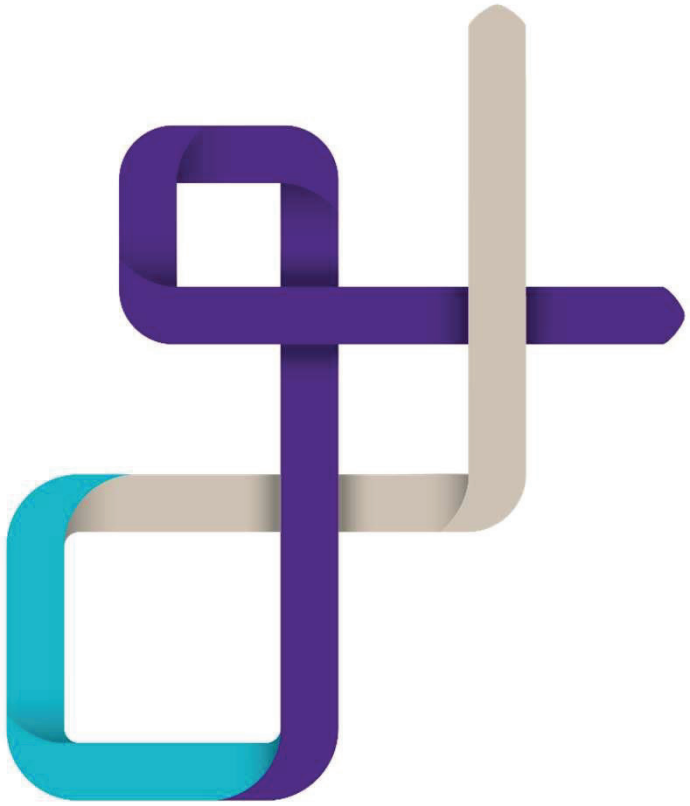
Grant Thornton

Report to the Governors on the Quality Report

Year ending 31 March 2019

The Clatterbridge Cancer Centre NHS Foundation Trust

24 May 2019



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Headlines

The Quality Report

The Quality Report is a mandatory part of a foundation trust's Annual Report. Its specific aim is to encourage and improve the foundation trust's public accountability for the quality of the care it provides. It allows leaders, clinicians, governors and staff to show their commitment to continuous, evidence-based quality improvement, and to explain progress to the public.

Purpose of this report

This report to governors summarises the results of our independent assurance engagement on your Quality Report. It is issued in conjunction with our signed limited assurance report, which is published within the Quality Report section of the Trust's Annual Report for the year ended 31 March 2019.

In addition, this report provides the findings of our work on the indicator you selected for us to perform additional substantive testing on to support your governance responsibilities.

In performing this work, we followed NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19' ('Guidance').

The output from our work is a limited assurance opinion on whether anything has come to our attention which leads us to believe that:

- the Quality Report is not prepared, in all material respects, in line with the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent, in all material respects, with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report have not been reasonably stated, in all material respects, in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

Conclusion

Our work on your Quality Report is substantially complete although we are finalising our procedures in respect of:

- finalising documentation of work done and final review
- checking the final version of the Quality Report
- reviewing feedback from stakeholders to ensure that it is reflected in the final version of the Quality Report
- obtaining a letter of representation from management

Subject to this, we are proposing to issue unqualified opinion on your Quality Report.

The text of our proposed limited assurance report can be found at Appendix C.

Key messages

- We confirm that the Quality Report has been prepared in all material respects in line with the requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.
- We confirm that the Quality Report is not materially inconsistent with the sources specified in NHS Improvement's Guidance.
- Our testing of two indicators included in the Quality Report found no evidence that these two indicators were not reasonably stated, in all material respects, in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.
- Our testing of the indicator selected by the governors found no evidence that this indicator was not reasonably stated, in all material respects, in accordance with relevant guidelines on calculation. In line with NHS Improvement's Guidance, we do not express any assurance in respect of this indicator.

We have not made any recommendations as a result of our work. Progress made against the recommendations we made in 2017/18 can be found at Appendix B.

Acknowledgements

We would like to thank the Trust staff for their co-operation in completing this engagement.

Compliance with regulations

We checked that the Quality Report had been prepared in line with the requirements set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

Requirement	Work performed	Conclusion
Compliance with regulations	We reviewed the content of the Quality Report against the requirements of the 'NHS foundation trust annual reporting manual 2018/19' and the supporting guidance 'Detailed requirements for quality reports for foundation trusts 2018/19'.	Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019, the Quality Report is not prepared, in all material respects, in line with the criteria set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance.

Consistency of information

We checked that the Quality Report had been prepared in line with the requirements set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

Requirement	Work performed	Conclusion
Consistency with other sources of information	We reviewed the content of the Quality Report for consistency with specified documentation, set out in the auditor's guidance provided by NHS Improvement. This includes the board minutes and papers for the year, feedback received on the Quality Report, survey results from staff and patients and the Head of Internal Audit opinion.	Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019, the Quality Report is not consistent, in all material respects, with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'.
Other checks	We also checked the Quality Report to ensure that the Trust's process for identifying and engaging stakeholders in the preparation of the Quality Report has resulted in appropriate consultation with patients, governors, commissioners, regulators and any other key stakeholders.	Overall, we concluded that the process has resulted in appropriate consultation.

Data quality of reported performance indicators

We undertook substantive testing on certain indicators in the Quality Report.

Selecting performance indicators for review

The Trust is required to obtain assurance from its auditors over three indicators.

NHS Improvement requires that we select two indicators in a prescribed order of preference from the list of four mandated indicators that are relevant to this Trust. Two of the four indicators were not applicable to the Trust. These were percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge and Summary Hospital-level Mortality Indicator.

These two indicators are subject to a limited assurance opinion in line with the requirements set by NHS Improvement. We have to report on whether there is evidence to suggest that they have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

In line with the auditor guidance, we have reviewed the following indicators:

Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway: selected as the first priority from the subset of mandated indicators

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers: selected as the second priority from the subset of mandated indicators

In 2018/19, NHS foundation trusts also need to obtain assurance through substantive sample testing over one additional local indicator included in the Quality Report, selected by the governors of the Trust. Although the Trust's external auditors are required to undertake the work, this indicator does not form part of the limited assurance report.

In line with the auditor guidance, we have reviewed the following local indicator:

- 30 day mortality rate (radical chemotherapy). This was selected by the Council of Governors at their March 2019 meeting.

Data quality of reported performance indicators – Indicators subject to limited assurance report

Indicator & Definition	Indicator outcome	Work performed	Conclusion
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway The accurate recording and reporting of referral to treatment (RTT) waiting times information is extremely important. Patients can and do use this information to inform their choice of where to be referred and also to understand how long they might expect to wait before starting their treatment. Once a referral to treatment (RTT) waiting time clock has started it continues to tick until: • the patient starts first definitive treatment • a clinical decision is made that stops the clock. Trusts should ensure that all clock stops without treatment are made in the best clinical interest of the patient and are not influenced by the impact on incomplete pathway waiting time performance	98% (target 92%)	We documented and walked through the process used by the Trust to collect data for the indicator. We checked that the indicator presented in the Quality Report reconciled to the underlying data. We then tested a sample of 25 items in order to ascertain the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation of the indicator was in accordance with the definition. Our audit procedures included; confirming that the clock start date was correct to the source referral, that the patient had a valid clock stop event and that the patient was correctly recorded as incomplete for the month selected for testing. We found no errors in the sample tested.	Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019, the indicator has not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

Data quality of reported performance indicators – Indicators subject to limited assurance report (continued)

Indicator & Definition	Indicator outcome	Work performed	Conclusion
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers This indicator relates to the percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer. The current operational target, as set by NHSI, is for 85% of patients to wait no more than 62 days for first treatment. Additional guidelines are in place which detail how patient pathways are allocated between referring providers and treating providers. Within this indicator the deadline for inter-provider transfers is day 38. Transfers after this date cannot result in a 50% share of any breach between providers as the referring provider must recognise 100% of the breached pathway.	86% post reallocation (target 85%)	We documented and walked through the process used by the Trust to collect data for the indicator. We checked that the indicator presented in the Quality Report reconciled to the underlying data. We then tested a sample of 25 items in order to ascertain the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation of the indicator was in accordance with the definition. Our audit procedures included gaining assurance over the date of the urgent GP referral, the date the patient was referred to the Trust, the date of first treatment and that the patient was recorded in the correct period. We also tested patients who were referred through Cancer Screening/ Pathways upgrades to confirm that they were correctly excluded from the indicator. No issues were identified.	Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019, the indicator has not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

Data quality of reported performance indicators – Local indicator not subject to limited assurance report

Indicator, Definition & Scope	Indicator outcome	Work performed	Conclusion
30 day mortality rate (radical chemotherapy) Most hospitals use the Summary Hospital-level Mortality Indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. Specialist trusts are not included in this methodology. The Trust reports and reviews all deaths within 30 days of chemotherapy and radiotherapy treatment. These are divided between radical (potentially curative) and palliative (treatment to relieve or delay the onset of symptoms. In line with the requirements of NHS Improvement's guidance, this indicator is not subject to a limited assurance opinion. We do not provide the governors with any formal assurance in relation to whether this indicator is fairly stated.	0.7% (Apr 18 – Mar 19)	We documented and walked through the process used by the Trust to collect data for the indicator. We checked that the indicator presented in the Quality Report agreed to the value reported by NHS Digital. We then tested a sample of 25 items in order to ascertain the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation of the indicator was in accordance with the definition. Our audit procedures involved gaining assurance that the start date of the cycle of radical chemotherapy was correct, that the intent was radical in nature and not palliative, the date of death if applicable and that the patient was recorded in the correct period. We found no issues within the sample tested.	Based on the results of our procedures we did not identify any material issues in relation to the calculation of this indicator or the six dimensions of data quality.

Fees

Fees for our work on the Quality Report

We confirm below our final fees charged for this work.

	Proposed fee	Final fee
Assurance on your Quality Report	£4,000	£4,000
Total fee (excluding VAT)	£4,000	£4,000

Follow up of prior year recommendations

We identified the following issue in our work on the Trust's 2017/18 Quality Report, which resulted in one recommendation being reported in our 2017/18 Report to the Governors. We have followed up on the implementation of our recommendation and note that it is still to be completed.

	Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
□	X	During our testing of the Referral to Treatment indicator we had difficulty obtaining the patient records relating to the Haemato-oncology service patients who form part of the service transferred to the Trust during 2017/18. We found that these patients are not validated by the same waiting times team as the rest of the indicator population due to being held in a different patient administration system. If the Haemato-oncology service patients are not validated in the same way as other patients, there is a risk that the data quality may be affected.	There remains a planned approach to the RTT data capture which involves the HO service being transferred into the Trust EPR. Due to the unforeseen changes regarding the changes to the opening timescale of the Royal Liverpool hospital, CCC's plans have been amended accordingly and full transfer of HO onto the Trust EPR is now planned for autumn 2019 in preparation for the opening of the new CCC hospital in Liverpool. The HO RTT validation processes have improved during 2018/19 through increased utilisation of the CCC Cancer waiting times online dashboard.

Assessment
□ Action completed
X Not yet addressed

Annual Accounts

2018 / 2019

Contents

FOREWORD TO THE ACCOUNTS

THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST

The Group accounts for the 12 months ended 31 March 2019 that have been prepared by The Clatterbridge Cancer Centre NHS Foundation Trust are in line with IAS1 paragraph 51 and in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Services Act 2006 are in the form which NHS Improvement has, with the approval of the Treasury, directed.

Signed..... Date 23 May 2019

Dr Liz Bishop,
Chief Executive

Independent auditor's report to the Council of Governors of The Clatterbridge Cancer Centre NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of The Clatterbridge Cancer Centre NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'group') for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Service Act 2006, the NHS foundation trust annual reporting manual 2018/19 and the Department of Health and Social Care group accounting manual 2018/19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2019 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018-19; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you were:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Overview of our audit approach

Financial statements audit

- Overall materiality: £2,397,330, which represents 1.54% of the group's gross operating costs (consisting of operating expenses and finance expenses);

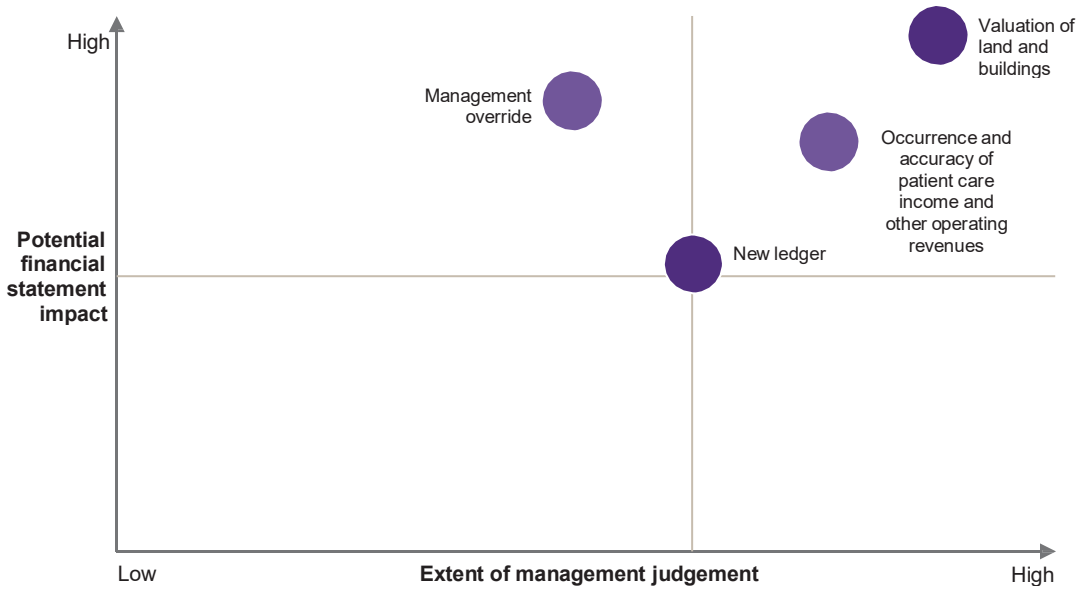
- Key audit matters were identified as:
  - Occurrence and accuracy of patient care income and other operating revenues
  - Valuation of land and buildings
  - Completeness and accuracy of the financial information transferred to the new general ledger
- We performed a full scope audit of The Clatterbridge Cancer Centre NHS Foundation Trust, targeted audit procedures on Clatterbridge Propcare Services Limited ('Propcare'), The Clatterbridge Pharmacy Limited and The Clatterbridge Cancer Charity and analytical audit procedures on Clatterbridge Private Clinic LLP, which is a non-significant component of the group.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

- We identified one significant risk in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources in relation to financial sustainability (see report on other legal and regulatory requirements section). The significant risk was related to financial sustainability and resilience.

Key audit matters

The graph below depicts the financial statement audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit

of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key Audit Matter – Group and Trust	How the matter was addressed in the audit – Group
Risk 1 – Occurrence and accuracy of patient care income and other operating revenues • Trusts are facing significant external pressure to restrain budget overspends and meet externally set financial targets, coupled with increasing patient demand and cost pressures. In this environment, we have considered the rebuttable presumed risk under ISA (UK) 240 that revenue may be misstated due to the improper recognition of revenue. • We have rebutted this presumed risk for the revenue streams of the group and Trust that are principally derived from contracts that are agreed in advance at a fixed price. We have determined these to be income from: • Block contract income element of patient care revenues • Block contract income element of education & training contracts • We have not deemed it appropriate to rebut this presumed risk for all other material streams of patient care income and other operating revenue. • We have therefore identified the occurrence and accuracy of these income streams of the group and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement and a key audit matter.	Our audit work included, but was not restricted to: • evaluating the group's accounting policy for recognition of income from patient care activities and other operating revenue for appropriateness and compliance with the DHSC Group Accounting Manual 2018/19 • updating our understanding of the group's system for accounting for income from patient care and other operating revenue, and evaluating the design of the associated controls <u>Patient Care Income</u> • using the DHSC mismatch report, we have investigated unmatched revenue and receivable balances over the NAO £0.3m threshold, corroborating the unmatched balances used by the group to supporting evidence; • agreeing, on a sample basis, income from contract variations and year end receivables to signed contract variations, invoices or other supporting evidence such as correspondence from the group's commissioners • evaluating the group's estimates and the judgments made by management on contract income variations with regard to corroborating evidence in order to arrive at the total income from contract variations recorded in the financial statements. <u>Other Operating Revenue</u> • agreeing, on a sample basis, income and year end receivables from other operating revenue to invoices and cash payment or other supporting evidence • Agreeing PSF income recognised in Q1 – Q3 to NHS Improvement notifications and obtain supporting evidence that confirms the Trust has met NHS Improvement requirements for recognising Q4 income; • Testing, on a sample basis, additions to deferred research and development income in the current year to ensure the accuracy of deferring the income. The group's accounting policy on **revenue recognition** is shown in note 1.4 to the financial statements and related disclosures are included in note 2. **Key observations** We obtained sufficient audit evidence to conclude that: • The group's accounting policy for recognition of income from patient care activities and other operating revenue is in compliance with the DHSC Group Accounting Manual 2018/19; • Patient care income and other operating

Key Audit Matter – Group and Trust	How the matter was addressed in the audit – Group
	revenue have been fairly stated.
Risk 2 - Valuation of land and buildings The Trust re-values its land and buildings annually to ensure that the current value is not materially different from fair value This represents a significant estimate by management in the financial statements. In valuing the Trust's estate, management have made the assumption that the main hospital site and satellite radiotherapy clinic, if needed to be replaced, would be rebuilt to modern conditions. The Trust plans to commission a valuer to value the Trust's estate at 31 March 2019 on a desktop basis. We therefore identified the valuation of land and buildings, in particular revaluations of the main hospital site and satellite clinic, as a significant risk, which was one of the most significant assessed risks of material misstatement, and a key audit matter. We therefore identified valuation of PPE as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • evaluating management's processes and assumptions for the calculation of the estimate, the instructions issued to the valuation experts and the scope of their work • evaluating the competence, capabilities and objectivity of the valuation expert • discussing with the valuer the basis on which the valuations were carried out and challenging the key assumptions applied • testing the information used by the valuer to ensure it is complete and consistent with our understanding • testing, on a sample basis, revaluations made during the year to ensure they have been input correctly into the Trust's asset register • evaluating the assumptions made by management for any assets not revalued during the year and how management has satisfied themselves that these are not materially different to current value. The group's accounting policy on valuation of PPE is shown in note 1.7 to the financial statements and related disclosures are included in note 8.1. **Key observations** As a result of our work, we have noted that our recommendation to implement a review process of the valuer's report and challenging assumptions applied within the valuation has not yet been adopted.
Risk 3 Management override of controls • Under ISA (UK) 240 there is a non-rebuttable presumed risk that the risk of management over-ride of controls is present in all entities. The Trust faces external pressures to meet agreed targets, and this could potentially place management under undue pressure in terms of how they report performance. • We therefore identified management override of control, in particular journals, management estimates and transactions outside the course of business as a significant risk, which was one of the most significant assessed risks of material misstatement. We therefore identified management override of controls as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • Evaluation of the design effectiveness of management controls over journals • analysing the journals listing and determining the criteria for selecting high risk unusual journals • testing unusual journals made during the year and after the draft accounts stage for appropriateness and corroboration • gaining an understanding of the accounting estimates and critical judgements applied made by management and consider their reasonableness • evaluating the rationale for any changes in accounting policies, estimates or significant unusual transactions. The group's accounting policy on management override of controls is shown in note 1.2 to the financial statements. **Key observations** Our journals testing has not identified any incidents of management overriding internal controls.
Risk 4 Incomplete or inaccurate financial	We have: • completed an information technology (IT)

Key Audit Matter – Group and Trust	How the matter was addressed in the audit – Group
information transferred to the new general ledger In February 2019, the Trust implemented a new cloud based general ledger system for the 2018/19 financial year. When implementing a new significant accounting system, it is important to ensure that sufficient controls have been designed and operate to ensure the integrity of the data. There is also a risk over the completeness and accuracy of the data transfer from the previous ledger system. We therefore identified the completeness and accuracy of the transfer of financial information to the new general ledger system as a significant risk, which was one of the most significant assessed risks of material misstatement and a key audit matter.	environment review to document, evaluate and test the IT controls operating within the new general ledger system; and • mapped the closing balances from the 2017/18 general ledger to the opening balance position in the new ledger for 2018/19 to ensure accuracy and completeness of the financial information. **Key observations** Our work has not identified any errors in the information transfer between the two ledgers.

Our application of materiality

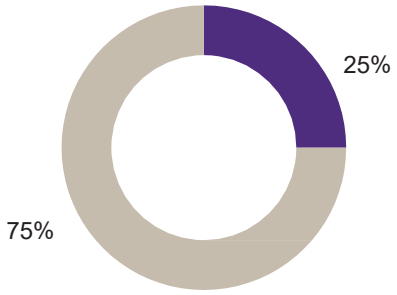
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

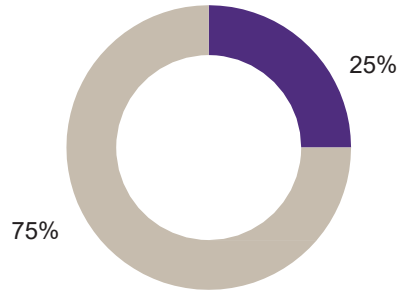
Materiality Measure	Group	Trust
Financial statements as a whole	£2,397,330 which is 1.54% of the group's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the group has expended its revenue and other funding. Materiality for the current year is at the same percentage level of gross operating costs as we determined for the year ended 31 March 2018 as we did not identify any significant changes in the group or the environment in which it operates.	£2,373,357 which is 1.48% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust has expended its revenue and other funding. Materiality for the current year is at the same percentage level of gross operating costs as we determined for the year ended 31 March 2018 as we did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality	75% of financial statement materiality
Specific materiality		Disclosure of senior managers' remuneration in the Remuneration Report £15,000 based on 2% of the total senior managers' remuneration.
Communication of misstatements to the Audit Committee	£119,867 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.	£118,668 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.

Overall materiality – Group



Overall materiality – Trust



■ Tolerance for potential uncorrected mis-statements ■ Performance materiality

An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the group's business, its environment and risk profile and in particular included:

- Evaluation of identified components to assess the significance of each component and to determine the planned audit response based on a measure of materiality and significance of the component as a percentage of the group's total income, assets and liabilities. A full scope, targeted or analytical approach was taken for each component based on their relative materiality to the group and our assessment of audit risk;
- Full scope audit procedures on The Clatterbridge Cancer Centre NHS Foundation Trust. The Trust's transactions represent 98.33% of the group's income, 71.04% of its total expenditure, and 94.03% of its total assets. Our work involved obtaining evidence about the amounts and disclosures in the financial statements to give us reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. The scope of our audit of The Clatterbridge Cancer Centre NHS Foundation Trust included:
  - obtaining an understanding of and evaluating the Trust's overall control environment relevant to the preparation of the financial statements, including its IT systems,
  - completion of walk through tests of the Trust's controls operating in key financial systems where we consider that there is a risk of material misstatement to the financial statements;
  - performing interim testing, on a sample basis of operating expenditure and income.
  - performing year-end testing on the Trust's financial statements, which focused on gaining assurance around the Trust's material income streams and operating costs, testing the Trust's employee remuneration costs and the notes to the accounts to ensure that they were compliant with the Department of Health and Social Care's Group Accounting Manual for 2017/18.
  - testing, on a sample basis of all of the Trust's material income streams, covering 100% of the Trust's income; operating expenses, covering 100% of the Trust's expenditure; current and non-current assets, covering 98% of Trust's total assets; and current and non-current liabilities, covering 99% of the Trust's total liabilities.
- Targeted audit procedures on the assets and the income and expenditure of Clatterbridge Propcare Services Limited.
- Performing analytical procedures on the trial balance and management accounts of The Clatterbridge Private Clinic LLP.
- Performing analytical procedures on the trial balance and management accounts of The Clatterbridge Cancer Charity.
- Targeted audit procedures on the assets and the income and expenditure of The Clatterbridge Pharmacy Limited.
- Together, the subsidiaries represent 1.67% of the group's income, 28.96% of its expenditure, and 5.97% of its total assets.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report[1], other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the group and Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- Audit committee reporting in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit committee does not appropriately address matters communicated by us to the Audit committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2018/19 or is misleading or inconsistent with the information of which we are aware from our audit.. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2018/19 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2018/19, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of the Trust's services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We have nothing to report in respect of the above matter.

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our

view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

Significant risks	How the matter was addressed in the audit
Risk 1 - Financial sustainability and resilience Whilst the Trust delivered a surplus in 2017-18 and 2018-19, and is forecasting further surpluses going forward, a number of complex accounting and operational arrangements have occurred over the last couple of years. The setting up of the Propcare subsidiary and the transfer of the haemato-oncology service have led to increased complexity operationally and in the accounting treatments. There has also been an increase in borrowings required as a result of these projects. The collapse of Carillion and the issues with the building of the new Royal Hospital has also had an impact upon the building of the Trust's new hospital site in Liverpool.	Our audit work included, but was not restricted to: • Monitoring the Trust's financial position and consider the year end outturn position to secure PSF funding. Considering the adequacy of cash resources and level of borrowing in the context of the 2019-20 budget position. • Reviewing the Trust's project and financial management and reporting arrangements relating to the construction of the new hospital. This included monitoring and controls to ensure project costs are properly managed and reported against the agreed contract price. **Key findings** The key observations are: • The Trust's 3 year operational plan forecasts surplus position for each of the next 3 years. • The Trust's cash position is forecast to be healthy over the next 3 years, despite significant cash outlay is completing the capital projects. • The building work at Royal Liverpool is slightly behind, and there is a risk of not meeting the planned completion date, which would impact planned service delivery. However, the Trust is acting to mitigate these, which should lessen the impact. • The additional works required following the Carillion collapse also has some impact on the capital resource requirements, however, the Trust has quantified this and is actively seeking recourse to minimise the impact on the Trust.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place

proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of The Clatterbridge Cancer Centre NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Andrew Smith

Andrew Smith, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Manchester

29 May 2019

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 2018/19

	NOTE	Group		FT	
		2018/19	2017/18	**2018/19**	2017/18
		£000	£000	**£000**	£000
Income from patient care activities		**143,785**	126,121	**143,785**	126,121
Other operating income	2	**19,835**	17,544	**19,902**	17,203
Operating Income from continuing operations		**163,620**	143,665	**163,688**	143,324
Operating Expenses from continuing operations	3	**(151,922)**	(133,185)	**(154,429)**	(134,956)
OPERATING SURPLUS / (DEFICIT)		**11,698**	10,480	**9,259**	8,368
Finance costs					
Finance income	5	**417**	201	**1,896**	410
Finance expense - financial liabilities	6.1	**(254)**	(151)	**(1,983)**	(421)
PDC dividends payable		**(3,667)**	(3,180)	**(3,667)**	(3,180)
Net Finance costs		**(3,504)**	(3,130)	**(3,754)**	(3,191)
Share of Profit/(Loss) of Associates accounted for using the equity method	9	**502**	569	**502**	569
Corporation Tax		**(360)**	(252)	**0**	0
Surplus / (deficit) from continuing operations		**8,336**	7,667	**6,007**	5,746
Other Comprehensive Income:					
Impairments		**0**	0	**0**	0
Revaluations		**922**	1,079	**922**	1,079
FV gains/(losses) on Available For Sale (AFS) financial assets		**45**	(2)	**0**	0
Total other comprehensive income/(expenditure) for the year		**967**	1,077	**922**	1,079
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**9,303**	**8,744**	**6,929**	6,825

The notes on page 159 to 177 form part of these accounts.

The results of the group are attributable to the parent.

STATEMENT OF FINANCIAL POSITION AS AT 31MARCH 2019

	NOTE	Group 31 March 2019 £000	Group 31 March 2018 £000	FT 31 March 2019 £000	FT 31 March 2018 £000
Non-current assets					
Intangible assets	7	**1,673**	717	**1,673**	717
Property, plant and equipment	8.1	**157,905**	89,191	**158,340**	89,306
Investments in associates	9	**1,174**	672	**1,174**	672
Other investments		**1,236**	1,191	**0**	0
Other financial assets	13.0	**0**	0	**78,815**	18,715
Trade and other receivables	11.1	**1,667**	4,563	**1,667**	4,563
Total non-current assets		**163,655**	96,333	**241,669**	113,972
Current Assets					
Inventories	10.1	**2,263**	1,872	**1,263**	1,161
Trade and other receivables	11.1	**34,098**	30,402	**34,431**	30,686
Cash and cash equivalents	18	**84,260**	65,175	**72,963**	55,368
Total current assets		**120,621**	97,449	**108,657**	87,215
Current liabilities					
Trade and other payables	12	**(42,422)**	(30,149)	**(35,938)**	(26,455)
Borrowings	14	**(1,985)**	(301)	**(1,985)**	(301)
Provisions	16	**(350)**	(489)	**(267)**	(461)
Other liabilities	13	**(2,402)**	(2,462)	**(2,402)**	(2,307)
Total current liabilities		**(47,159)**	(33,402)	**(40,592)**	(29,525)
Total assets less current liabilities		**237,117**	160,379	**309,734**	171,663
Non-current liabilities					
Trade and other payables	12	(1,162)	(301)	0	0
Borrowings	14	(37,336)	(2,859)	**(37,336)**	(2,859)
Other liabilities	13	0	0	**(84,723)**	(20,152)
Total non-current liabilities		**(38,498)**	(3,160)	**(122,059)**	(23,011)
Total assets employed		**198,619**	157,219	**187,675**	148,652
Financed by taxpayers' equity					
Public Dividend Capital		**55,364**	23,267	55,364	23,267
Revaluation reserve	17.1	**8,493**	7,839	8,493	7,839
Income and expenditure reserve		**123,384**	117,546	123,818	117,546
Financed by others' equity					
Charitable fund reserves	17.2	**8,295**	6,786	**0**	0
Pharmacy subsidiary reserves		**2,018**	1,595	**0**	0
PropCare subsidiary reserves		**1,064**	186	**0**	0
Total taxpayers' and others' equity		**198,619**	157,219	**187,675**	148,652

Signed: ..... Chief Executive

Date: 23 May 2019.

STATEMENT OF CHANGES IN TAXPAYERS EQUITY

	Total £000	Others' Equity: Charitable Funds £000	Taxpayers' Equity: Public Dividend Capital £000	Taxpayers' Equity: Revaluation Reserve £000	Taxpayers' Equity: Income & Expenditure Reserve £000
Equity at 1 April 2018	**157,219**	6,786	23,267	7,839	119,327
Surplus/(deficit) for the year	**8,336**	1,464	0	0	6,872
Transfers between reserves	**0**	0	0	(267)	267
Revaluations - property, plant and equipment	**922**	0	0	922	0
Fair value gains/(losses) on available-for-sale financial investments	**45**	45	0	0	0
Public dividend capital received	**32,097**	0	32,097	0	0
Equity at 31 March 2019	**198,619**	**8,295**	**55,364**	**8,493**	**126,466**

	Total £000	Others' Equity: Charitable Funds £000	Taxpayers' Equity: Public Dividend Capital £000	Taxpayers' Equity: Revaluation Reserve £000	Taxpayers' Equity: Income & Expenditure Reserve £000
Equity at 1 April 2017	**143,990**	5,452	22,197	3,584	112,757
Prior period adjustment	**3,416**	0	0	3,416	0
Equity at 1 April 2017 (restated)	**147,406**	5,452	22,197	7,000	112,757
Surplus/(deficit) for the year	**7,666**	1,335	0	0	6,331
Transfers between reserves	**0**	0	0	(240)	240
Revaluations - property, plant and equipment	**1,079**	0	0	1,079	0
Fair value gains/(losses) on available-for-sale financial investments	**(2)**	(2)	0	0	0
Public dividend capital received	**1,070**	0	1,070	0	0
Equity at 31 March 2018	**157,219**	**6,786**	**23,267**	**7,839**	**119,327**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 2018/19

Prepared using the indirect method

	Group		FT	
	2018/19	2017/18	**2018/19**	2017/18
	£000	£000	**£000**	£000
Cash flows from operating activities				
Operating surplus/(deficit)	**11,698**	10,480	**9,259**	8,368
Non-cash income and expense				
Depreciation and amortisation	**4,493**	4,471	**4,493**	4,471
(Increase)/Decrease in Trade and Other Receivables	**(785)**	(11,426)	**669**	(9,891)
(Increase)/Decrease in Other Assets	**0**	0	**(60,100)**	(18,715)
(Increase)/Decrease in Inventories	**(391)**	(423)	**(102)**	(264)
Increase/(Decrease) in Trade and Other Payables	**5,723**	13,822	**7,968**	11,849
Increase/(Decrease) in Other Liabilities	**95**	(824)	**64,664**	19,328
Increase/(Decrease) in Provisions	**(139)**	429	**(195)**	401
Tax (paid) / received	**(90)**	(190)	**0**	0
NHS Charitable Funds	**14**	2	**0**	0
Net cash generated from/(used in) operations	**20,618**	16,341	**26,656**	15,548
Cash flow from investing activities				
Interest received	**387**	166	**377**	166
Purchase of intangible assets	**(1,059)**	(115)	**(1,059)**	(115)
Purchase of Property, Plant and Equipment	**(65,191)**	(18,804)	**(72,513)**	(21,431)
Cash movement from disposals of business units and subsidiaries	**0**	792	**0**	792
NHS Charitable Funds	**0**	35	**0**	0
Net cash generated from/(used in) investing activities	**(65,863)**	(17,927)	**(73,195)**	(20,588)
Cash flows from financing activities				
Public dividend capital received	**32,097**	1,070	**32,097**	1,070
Loans received to the Foundation Trust Financing Facility	**37,000**	0	**37,000**	0
Loans repaid to the Foundation Trust Financing Facility	**(990)**	(250)	**(990)**	(250)
Capital element of finance lease rental payments	**(51)**	(49)	**(51)**	(49)
Interest paid	**(52)**	(141)	**(248)**	(141)
Interest element of finance lease	**(7)**	(9)	**(7)**	(9)
PDC dividend paid	**(3,667)**	(3,043)	**(3,667)**	(3,043)
Net cash generated from/(used in) financing activities	**64,330**	(2,423)	**64,134**	(2,423)
Increase/(decrease) in cash and cash equivalents	**19,085**	(4,008)	**17,595**	(7,463)
Cash and cash equivalents at 1 April	**65,174**	69,183	**55,368**	62,830
Cash and cash equivalents at 31 March	**84,260**	65,175	**72,963**	55,368

1. Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1.2 Going concern

These accounts have been prepared on a going concern basis. There is no reason to suggest that the NHS Foundation Trust does not have adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.2 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Deferred income
Income in respect of services provided is recognised when, and to the extent that, performance occurs and/or the foundation trust becomes entitled to it, and is measured at the fair value of the consideration receivable.

Assessment of leases
Leases are assessed under IFRS as being operating or finance leases, which determines their accounting treatment. The criteria for assessment are to a certain extent subjective, but a consistent approach has been taken through use of a standard template which sets out the relevant criteria. Further information is in section 1.12 of the accounting policies.

Clatterbridge Propcare Services Limited - VAT Recovery & Asset Valuation
The Trust applied to HMRC to request formal clearance for provision of a fully operated and managed healthcare facility under HMRC contracted-out services heading 45 – “Operation of hospitals, healthcare establishments and healthcare facilities and the provision of any related services” by its wholly owned subsidiary company Clatterbridge Propcare Services Limited. The Trust board have considered the risks under heading 45 and agreed that Propcare should proceed with the build, recovering VAT as costs are incurred. The implication for the accounts is that the value of the asset under construction is calculated on the cost of construction excluding VAT.

Clatterbridge Propcare Services Limited - Accounting for the Financial Asset/Liability
Management has determined that Clatterbridge Propcare Services Limited is acting as principal in the provision of a service consisting of the design, construction, operation and management of a fully managed and operated healthcare facility to the Trust under **the 25** year agreement. As a result, as at 31 March 2019, the Trust has measured the liability with Clatterbridge Propcare Services Limited in respect of construction costs for the new cancer centre in accordance with IAS 17 – Leases. Accordingly, Clatterbridge Propcare Services Limited have recognised a financial asset in their individual financial statements.

Financial Assets
In line with DHSC guidance the Trust has adopted IFRS 9 – Financial Assets, replacing IAS 39. The Trust has made a loan to PropCare Limited, and this is considered a financial asset. The Trust’s approach is that this is accounted for on an amortised cost basis, with a 12 month expected loss value. This will be reviewed annually.

1.2.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Provisions
Provisions held within the Statement of Financial Position contain estimates for future contractual liabilities.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which The Clatterbridge Cancer Centre NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims.

Estimation of remaining economic lives of assets
Assets are depreciated on a straight-line basis over their remaining estimated economic life.

Impairment review
An impairment review is carried out using a professional valuer to determine non-current asset values at least every three years. Further information on impairments is in section 1.7 of the accounting policies.

1.3 Consolidation

NHS Charitable Fund

The NHS Foundation Trust is the corporate trustee to the Clatterbridge Cancer Charity NHS charitable fund. The trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Other subsidiaries

The Group has two wholly owned subsidiaries, The Clatterbridge Pharmacy Limited which was established in 2013, and Clatterbridge Propcare Services Limited which was established in 2016. Both subsidiaries have been consolidated in the group financial statements

Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position.

Associates

The Group has an associate, Clatterbridge Private Clinic LLP, which was established in 2013 with the healthcare company Mater Private and the FT owns a 49% share.

Associate entities are those over which the trust has the power to exercise a significant influence. Associate entities are recognised in the trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, e.g., share dividends are received by the trust from the associate.

1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.4.3 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales.

The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, plant and equipment

1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust;
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably and
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.7.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Excess depreciation

The trust applies excess deprecation to the I&E reserve.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses;
and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
    - management are committed to a plan to sell the asset;
    - an active programme has begun to find a buyer and complete the sale;
    - the asset is being actively marketed at a reasonable price;
    - the same is expected to be completed within 12 months of the data of classification as 'Held for Sale'; and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not quality for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.7.4 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items or property, plant and equipment.

1.8 Intangible assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. .

Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment.

An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First out (FIFO) method.

1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.11 Financial instruments and financial liabilities

1.11.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

1.11.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost

Financial liabilities classified as subsequently measured at amortised cost

In line with DHSC guidance the Trust has adopted IFRS 9 – Financial Assets, replacing IAS 39. The Trust has made a loan to PropCare Limited, and this is considered a financial asset. The Trust's approach is that this is accounted for on an amortised cost basis, with a 12 month expected loss value. This will be reviewed annually.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets).

The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.11.3 De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Financial Guarantees

Financial guarantees issued by the Trust on behalf of its subsidiaries are recognised as financial liabilities at the date the guarantee is issued. Liabilities arising from financial guarantee contracts are initially recognised at fair value and subsequently at the higher of the amount determined in accordance with the Group's provisions accounting policy (please refer to 1.13) and the amount initially recognised less cumulative amortization.

The fair value of the financial guarantee is determined by way of calculating the present value of the difference in net cash flows between the contractual payments under the debt instrument and the payments that would be required without the guarantee, or the estimated amount that would be payable to a third party for assuming the obligation.

Where guarantees in relation to loans or other payables of subsidiaries or associates are provided for no compensation, the fair values are accounted for as contributions and recognised as part of the cost of the investment in the financial statements of the Trust.

1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.12.1 The trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income.
The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.13 Provisions

The trust recognises a provision where is has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 16 but is not recognised in the trust's accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated assets (including lottery funded assets),

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and

(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.16 Value Added Tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 Corporation Tax

The Clatterbridge Cancer Centre NHS Foundation Trust is a Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains tax within categories covered by this. There is a power by the treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities, which are not related to, or ancillary to, the provision of healthcare, and where the profits therefrom exceed £50,000 per annum.

1.18 Foreign exchange

The Foundation Trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the foundation trust's Statement of Comprehensive Income in the period in which they arise.

1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since The Clatterbridge Cancer Centre NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are changed to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

1.23 Accounting standards issued but not yet effective or adopted

HM treasury, via the FReM, applies EU-adopted IFRS with adaptations and interpretations. DHSC group bodies must apply IFRS and adopted by HM Treasury in the FReM, except where additional departures and interpretations have been agreed by DHSC, as specified in DHSC GAM.

European Union (EU) adoption is always subsequent to the publication of IFRS by the IASB. Where a new standard or interpretation has been issued by the IASB, but has not yet been implemented, IAS 8 Accounting Policies, changes in Accounting Estimates and Errors requires disclosure in the accounts of this fact, and the known or reasonably-estimated impact that application will have in the period of initial applications.

In each case below, the new standards have not been adopted by the EU for financial years up to and including 2018/19. Therefore, they are not yet adopted in the FReM (and therefore DHSC GAM). In each case, the financial year in which the change is expected to become effective in the Trust's accounts is disclosed after the standard's name.

IFRS 14 Regulatory Deferral Accounts (new standard) – this standard is not applicable to DHSC group bodies.

IFRS 16 Leases: (new standard) (2020/21) – this standard replaces IAS 17 Leases and IFRIC 4 Determining whether an Arrangement contains a Lease, and is expected to have a significant impact on accounting by lessees. The standard will re-specify the recognition, measurement, presentation and disclose of leases. Rather than applying a distinction between operating leases ('off balance sheet (SOFP)') and finance leases ('on SOFP'), lessees will be required to recognise a lease liability reflecting future lease payments and a 'right-of-use asset' ('on SOFP') for virtually all lease arrangements, excepting small-value contracts or those with a lease term not exceeding 12 months. Reliable quantitative estimates of the financial impact of application of the standard are not possible as full and final application instructions through DHSC GAM 20-21 and subsidiary guidance is neither issued nor definitive.

IFRS 17 Insurance contracts: (new standard) (2021/22) – This standard is not expected to affect the Trust's accounts as it does not issue insurance contracts.

IFRIC 23 Uncertainty over income Tax Treatments: (2019/20) – this interpretation will have no impact on the Trust's accounts

In addition, the IASB has issued a revised Conceptual Framework for Financial Reporting. Whilst early adoption is permissible under the FReM, for consistency, all DHSC group bodies will continue to apply the current Conceptual Framework, issued in 2010, until the 2020/21 financial year. This is unlikely to significantly affect the Trust's accounts.

IASB – International Accounting Standards Board – the independent, accounting standard-setting body of the IFRS Foundation.
IFRS – International Financial Reporting Standard.

2. Operating segments

The business activities of the Group can be summarised as that of 'healthcare'. The chief operating decision maker for Clatterbridge Cancer Centre NHS Foundation Trust is the FT Board. Key decisions are agreed at monthly Board meetings and sub-committee meetings of the Board, following scrutiny of performance and resource allocation. The FT Board review and make decisions on activity and performance of the FT as a whole entity, not for its separate business activities.

The activities of the subsidiary companies, The Clatterbridge Cancer Charity, The Clatterbridge Pharmacy Limited and Clatterbridge PropCare Services Limited, are not considered sufficiently material to require separate disclosure.

The Clatterbridge Cancer Charity is a registered charity that supports cancer care in the NHS. The Board of the FT is the Corporate Trustee of the Charity.

The Clatterbridge Pharmacy Limited provides dispensing services and drug procurement to the FT. The FT is the sole shareholder of the company.

Clatterbridge PropCare Services Limited is overseeing construction of the new hospital in Liverpool and redesign of the Wirral site, and manages the FT's property, estates and facilities on its behalf.

2.1 Income from Activities

Income from activities comprises:

	Group / FT	
	2018/19	2017/18
	£000	£000
Elective income	**3,990**	3,512
Non-elective income	**5,044**	4,965
First outpatient income	**2,730**	2,525
Follow up outpatient income	**17,469**	15,046
High cost drugs income from commissioners	**58,595**	47,780
Other NHS clinical income*	**46,446**	45,500
NHS Income from Activities	**134,274**	119,330
Private patients	**2,392**	1,777
North Wales	**3,468**	2,886
Rest of Wales	**131**	167
Scotland	**218**	338
Ireland	**86**	62
Other non-protected clinical income	**3,216**	1,561
	143,785	126,121

*Other NHS clinical income comprises of drugs (£1m), chemotherapy activity (£20m), radiotherapy activity (£17m), block income (£1m), diagnostic imaging (£1m) and bone marrow transplants (£4m).

The figures quoted for both years above are based upon income received in respect of actual activity undertaken within each category. The Terms of Authorisation set out the mandatory goods and services that the FT is required to provide protected services. All of the income from activities shown above is derived from the provision of protected services.

2.2 Income from patient care activities

	Group / FT	
	2018/19	2017/18
	£000	£000
NHS Foundation Trusts	**282**	313
NHS Trusts	**0**	301
CCGs and NHS England	**134,606**	118,623
Non NHS Private patients	**2,392**	1,777
Non NHS: Other	**6,505**	5,106
	143,785	126,121

2.3 Other Operating Income

	Group		FT	
	2018/19	2017/18	**2018/19**	2017/18
	£000	£000	**£000**	£000
Research and Development	**3,149**	2,924	**3,149**	2,924
Education and Training	**1,289**	1,270	**1,289**	1,270
Non-patient care services to other bodies	**5,667**	4,739	**5,667**	4,739
Sustainability and Transformation Fund income	**4,011**	2,442	**4,011**	2,442
Other	**3,018**	3,677	**5,786**	5,827
NHS Charitable Funds: Incoming Resources excluding investment income	**2,700**	2,492	**0**	0
	19,835	17,544	**19,902**	17,203

3. Operating Expenses

3.1 Operating expenses comprise:

	Group		FT	
	2018/19	2017/18	**2018/19**	2017/18
	£000	£000	**£000**	£000
Purchase of healthcare from NHS and DHSC bodies	**10,397**	9,414	**10,397**	9,414
Purchase of healthcare from non-NHS and non-DHSC bodies	**458**	197	**458**	206
Staff and executive directors costs	**58,225**	52,473	**57,207**	51,592
Non Executive Directors' costs	**159**	161	**128**	134
Supplies and services - clinical (excluding drug costs)	**3,018**	4,257	**4,693**	4,270
Supplies and services - general	**2,229**	3,307	**2,216**	2,060
Drugs costs	**57,521**	47,610	**58,271**	47,691
Consultancy	**363**	411	**343**	429
Establishment	**1,702**	1,508	**1,753**	1,498
Premises - business rates collected by local authorities	**178**	171	**178**	171
Premises - other	**6,256**	2,862	**7,928**	6,832
Transport (business travel only)	**87**	65	**85**	65
Transport - other (including patient travel)	**118**	96	**120**	96
Depreciation on property, plant and equipment	**4,391**	4,391	**4,391**	4,391
Amortisation on intangible assets	**103**	80	**103**	80
Increase / (decrease) in provision for impairment of receivables	**57**	58	**57**	58
Provisions arising / released in year	**(22)**	401	**(22)**	401
Audit services- statutory audit*	**83**	83	**48**	48
Other auditor remuneration (external auditor only)	**9**	5	**9**	5
Internal audit costs	**118**	103	**98**	88
Clinical negligence	**194**	149	**194**	149
Legal fees	**205**	169	**205**	163
Insurance	**155**	133	**136**	119
Research and development	**307**	139	**307**	139
Education and training	**1,394**	1,256	**1,384**	1,244
Operating lease expenditure	**543**	368	**543**	368
Redundancy costs	**0**	281	**0**	281
Car parking & Security	**0**	(0)	**0**	(0)
Hospitality	**13**	14	**13**	14
Other **	**3,605**	2,962	**3,186**	2,949
NHS Charitable funds: Other resources expended	**57**	60	**0**	0
	151,922	133,185	**154,429**	134,956

*Group statutory audit fees include £5k for the charity, £15k for PharmaC and £23k for PropCare. Audit fees are inclusive of VAT for the FT and charity, and exclusive of VAT for PharmaC and PropCare.
** Other operating expenditure contains £3.2m of expenditure relating to Haemato Oncology.

3.2 Arrangements containing an operating lease

	Group / FT	
	2018/19	2017/18
	£000	£000
Future minimum lease payments due:		
Not later than one year	**456**	321
Later than one year and not later than five years	**300**	302
Later than five years	**8,475**	8,475
	9,231	9,098

These leases are for land at Aintree, IT equipment, and portakabins.

4.1 Staff costs

	Group		FT	
	2018/19	2017/18	**2018/19**	2017/18
	£000	£000	**£000**	£000
Salaries and wages	**47,085**	43,239	**46,186**	42,489
Social Security costs	**4,299**	3,900	**4,210**	3,827
Apprenticeship levy	**193**	188	**193**	188
Pension cost - employer contributions to NHS pension scheme	**5,228**	4,720	**5,228**	4,720
Pension cost - other	**37**	56	**6**	3
Agency and contract staff	**1,384**	651	**1,384**	646
	58,225	52,754	**57,207**	51,873

4.2 Average number of WTE persons employed

	Group		FT	
	2018/19	2017/18	**2018/19**	2017/18
	WTE	WTE	**WTE**	WTE
Medical and dental	**96**	90	**96**	90
Administration and estates	**459**	417	**447**	409
Healthcare assistants and other support staff	**96**	96	**96**	96
Nursing, midwifery and health visiting staff	**268**	241	**268**	241
Scientific, therapeutic and technical staff	**279**	262	**265**	247
	1,199	1106	**1,173**	1083

4.3 Retirements due to ill-health

This note discloses the number and additional costs for individuals who retired early on ill-health grounds during the year. There was one retirement at an additional cost of £113k in 2018-19 (2017-18 - three retirements at an additional cost of £228k). This information has been supplied by the NHS Business Services Authority.

4.4 Retirement benefits

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The expected employer's contributions to the NHS pension scheme for 2018-19 is £5.3m.

5. Finance Income

	Group		FT	
	2018/19	2017/18	**2018/19**	2017/18
	£000	£000	**£000**	£000
Interest on other investments / financial assets	**387**	166	**1,896**	410
NHS Charitable funds: investment income	**30**	35	**0**	0
	417	201	**1,896**	410

6.1 Finance Costs - Interest expense

	Group		FT	
	2018/19	2017/18	**2018/19**	2017/18
	£000	£000	**£000**	£000
Loans from the Foundation Trust Financing Facility	**247**	141	**247**	141
Interest on other loans	**0**	0	**1,729**	270
Interest on finance lease obligations	**7**	9	**7**	9
	254	151	**1,983**	421

6.2 Better Payment Practice Code

	Group/FT			
	2018/19		2017/18	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**8,585**	**82,926**	8,312	70,564
Total Non NHS trade invoices paid within target	**6,928**	**76,267**	7,289	67,044
Percentage of Non-NHS trade invoices paid within target	**80.7%**	**92.0%**	87.7%	95.0%
Total NHS trade invoices paid in the year	**1,419**	**27,361**	1,219	16,831
Total NHS trade invoices paid within target	**712**	**18,787**	898	13,121
Percentage of NHS trade invoices paid within target	**50.2%**	**68.7%**	73.7%	78.0%

The Better Payment Practice Code requires the FT to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

6.3 The late payment of commercial debts (interest) Act 1998:

No interest or compensation has been paid under the Late Payment of Commercial Debts (Interest) Act 1998 during 2017-18 or 2018-19.

7. 1 Intangible assets 2018/19

	Group / FT	
	Software licences £000	TOTAL £000
Cost / valuation at 1 April 2018	891	**891**
Additions – purchased	1,059	**1,059**
Cost / valuation at 31 March 2019	**1,950**	**1,950**
Accumulated amortisation at 1 April 2018	174	**174**
Provided during the year	103	**103**
Accumulated depreciation at 31 March 2019	**277**	**277**
Net book value at 31 March 2018		
Purchased	717	**717**
Total at 31 March 2018	**717**	**717**
Net book value at 31 March 2019		
Purchased	1,673	**1,673**
Total at 31 March 2019	**1,673**	**1,673**

7. 2 Intangible assets 2017/18

	Group / FT	
	Software licences £000	TOTAL £000
Cost / valuation at 1 April 2017	776	**776**
Additions – purchased	115	**115**
Cost / valuation at 31 March 2018	**891**	**891**
Accumulated amortisation at 1 April 2017	95	**95**
Provided during the year	80	**80**
Accumulated depreciation at 31 March 2018	**174**	**174**
Net book value at 31 March 2017		
Purchased	682	**682**
Total at 31 March 2017	**682**	**682**
Net book value at 31 March 2018		
Purchased	717	**717**
Total at 31 March 2018	**717**	**717**

8.1 Property, plant and equipment 2018/19

	Group / FT							
	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	TOTAL
	£000	£000	£000	£000	£000	£000	£000	£000
Cost / valuation at 1 April 2018	871	36,989	32,177	23,659	25	8,399	171	**102,291**
Prior period adjustment	0	0	0	0	0	0	0	**0**
Cost / valuation at 1 April 2019 (restated)	871	36,989	32,177	23,659	25	8,399	171	**102,291**
Additions – purchased	0	224	64,381	3,687	0	3,892	0	**72,183**
Revaluations	0	177	0	0	0	0	0	**177**
Disposals/derecognition	0	0	0	(2,184)	0	0	0	**(2,184)**
Cost / valuation at 31 March 2019	**871**	**37,390**	**96,558**	**25,162**	**25**	**12,291**	**171**	**172,467**
Accumulated depreciation at 1 April 2018	0	0	0	10,426	16	2,572	86	**13,100**
Provided during the year	0	745	0	2,347	4	1,278	17	**4,391**
Revaluations	0	(745)	0	0	0	0	0	**(745)**
Disposals/derecognition	0	0	0	(2,184)	0	0	0	**(2,184)**
Accumulated depreciation at 31 March 2019	**0**	**0**	**0**	**10,590**	**20**	**3,850**	**103**	**14,562**
Net book value at 31 March 2018								
Purchased	871	33,408	32,290	12,130	0	5,407	84	**84,190**
Finance leased	0	0	0	0	0	421	0	**421**
Donated	0	3,582	0	1,104	9	0	0	**4,695**
Total at 31 March 2018	**871**	**36,990**	**32,290**	**13,234**	**9**	**5,828**	**84**	**89,306**
Net book value at 31 March 2019								
Purchased	871	33,760	96,558	13,793	0	8,174	67	**153,223**
Finance leased	0	0	0	0	0	268	0	**268**
Donated	0	3,629	0	780	5	0	0	**4,414**
NBV at 31 March 2019 for Group	**871**	**37,390**	**96,558**	**14,573**	**6**	**8,442**	**67**	**157,905**
Add: PURP adjustment*	0	0	435	0	0	0	0	**435**
NBV at 31 March 2019 for FT	**871**	**37,390**	**96,993**	**14,573**	**6**	**8,442**	**67**	**158,340**

*The PURP (provision for unrealised profits) relates to the adjustment required to eliminate the profit element recognised by PropCare on the new build hospital costs charged to the FT.

8.2 Property, plant and equipment 2017/18

	Group / FT							
	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	TOTAL
	£000	£000	£000	£000	£000	£000	£000	£000
Cost / valuation at 1 April 2017	350	36,871	13,237	44,108	73	10,830	247	**105,715**
Prior period adjustment	0	3,416	0	0	0	0	0	**3,416**
Cost / valuation at 1 April 2017 (restated)	350	40,287	13,237	44,108	73	10,830	247	**109,131**
Additions – purchased	0	165	19,054	720	0	1,421	0	**21,360**
Revaluations	521	(3,462)	0	0	0	0	0	**(2,941)**
Disposals/derecognition	0	0	0	(21,169)	(48)	(3,852)	(76)	**(25,145)**
Cost / valuation at 31 March 2018	**871**	**36,989**	**32,291**	**23,659**	**25**	**8,399**	**171**	**102,405**
Accumulated depreciation at 1 April 2017	0	3,322	0	29,222	60	5,123	146	**37,873**
Provided during the year	0	698	0	2,372	4	1,301	17	**4,391**
Revaluations	0	(4,020)	0	0	0	0	0	**(4,020)**
Disposals/derecognition	0	0	0	(21,168)	(48)	(3,852)	(77)	**(25,145)**
Accumulated depreciation at 31 March 2018	**0**	**0**	**0**	**10,426**	**16**	**2,572**	**86**	**13,100**
Net book value at 31 March 2017								
Purchased	350	31,117	13,237	13,458	0	5,133	101	**63,397**
Finance leased	0	0	0	0	0	574	0	**574**
Donated	0	2,432	0	1,428	12	0	0	**3,872**
Total at 31 March 2017	**350**	**33,548**	**13,237**	**14,886**	**12**	**5,707**	**101**	**67,842**
Net book value at 31 March 2018								
Purchased	871	33,408	32,291	12,130	0	5,407	84	**84,190**
Finance leased	0	0	0	0	0	421	0	**421**
Donated	0	3,582	0	1,104	9	0	0	**4,694**
NBV at 31 March 2018 for FT	**871**	**36,989**	**32,291**	**13,234**	**9**	**5,827**	**84**	**89,306**
Less: PURP adjustment*	0	0	(115)	0	0	0	0	**(115)**
NBV at 31 March 2018 for Group	**871**	**36,989**	**32,177**	**13,234**	**9**	**5,827**	**84**	**89,191**

*The PURP (provision for unrealised profits) relates to the adjustment required to eliminate the profit element recognised by PropCare on the new build hospital costs
Disposals relate to fully depreciated assets that have been removed from the accounts in year.

8.3 Assets for commissioner requested services

All assets on the fixed asset register are used for commissioner requested services.

8.4 Economic life of Property, plant and equipment and Intangibles

	Minimum Years	Maximum Years
Land	Infinite	Infinite
Buildings excluding dwellings	5	85
Plant & Machinery	5	15
Transport Equipment	3	7
Information Technology	3	10
Furniture & Fittings	3	10
Licences	5	10

There have been no significant changes in useful lives or estimation methods from the previous period.

8.5 Property Valuations:

The last full site valuation of all the FT's property was undertaken in 2014-15 by a professional valuer, Cushman & Wakefield, on the Modern Equivalent Asset basis. They also carried out a desktop valuation in 2018-19. Further details of the valuation approach are included under note 1.7 (Accounting policies).

9. Investments in associates

	Group / FT	
	Investments in associates 2018/19 £000	Investments in associates 2017/18 £000
Carrying value at 01 April	**672**	895
Share of profit/(loss)	**502**	569
Disposals	**0**	(792)
Carrying value at 31 March	**1,174**	672

This relates to the FT's associate company, the Clatterbridge Clinic LLP, which provides a service for private patients.

10.1 Inventories

	Group		FT	
	31 March 2019 £000	31 March 2018 £000	**31 March 2019 £000**	31 March 2018 £000
Drugs	**2,263**	1,872	**1,263**	1,161
	2,263	1,872	**1,263**	1,161

10.2 Inventories recognised in expenses

The value of inventories recognised in expenses was £57.52m (2017-18 £47.61m) for the Group and £58.27m (2017-18 £47.69m) for the FT.

11.1 Trade and other receivables

	Group		FT	
	31 March 2019 £000	31 March 2018 £000	**31 March 2019 £000**	31 March 2018 £000
Contract Receivables 1	**8,210**		**8,351**	
Trade receivables 1		16,977		17,029
Accrued income 1	**15,468**	4,409	**19,075**	6,371
Allowance for impaired contract receivables 1	**(186)**		**(187)**	
Allowance for other impaired receivables		(134)		(134)
Prepayments	**6,836**	7,167	**6,833**	7,154
PDC dividend receivable	**0**	0	**0**	0
VAT receivable	**3,742**	1,967	**360**	267
Other receivables	**(1)**	0	**0**	0
NHS Charitable funds: Trade and other receivables	**30**	16	**0**	0
Total current trade and other receivables	**34,098**	30,402	**34,431**	30,686
Prepayments*	**1,667**	4,563	**1,667**	4,563
Total non-current trade and other receivables	**1,667**	4,563	**1,667**	4,563

*Prepayments include a balance of £3.14m relating to the transfer of Haemato-Oncology services to the FT.

1. Following the application of IFRS 15 from 1 April 2018, the Trust's entitlement to consideration for work performed under contracts with customers is shown separately under contracts receivables. This replaces the previous analysis into Trade receivables and Accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

11.2 Allowance for credit losses - 2018-19

	Group / FT 2018/19 £000
Allowances at 1 April 2018	**134**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018.	**0**
New allowances arising	**57**
Changes in existing allowance	**(5)**
Reversals of allowances	**0**
Utilisation of allowances (write offs)	**0**
Allowance at 31 March 2019	**186**

The allowance for credit losses relates to the Trust's non-government trade debt.

11.3 Allowance for credit losses - 2017-18

	Group / FT 2017/18 £000
Allowances at 1 April 2017	76
Increase in provision	58
Amounts utilised	0
Unused amounts reversed	0
Allowances at 31 March 2018	134

IFRS 9 and IFRS 15 are adopted without restatement. This analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption.

12. Trade and other payables

	Group		FT	
	31 March 2019 £000	31 March 2018 £000	**31 March 2019 £000**	31 March 2018 £000
Trade payables	**9,810**	13,588	**10,494**	11,642
Receipts in advance	**5,066**	4,795	**5,066**	4,795
Capital payables	**8,449**	2,317	**97**	107
Social Security costs payable	**619**	586	**1,093**	586
Other taxes payable	**849**	545	**1,077**	442
Accrued interest on DHSC loans 1 *	**0**	6	**0**	6
Accrued interest on other loans 1 *	**0**	0	**1,999**	270
Other payables	**2,615**	2,928	**807**	2,881
Accruals	**15,009**	5,378	**15,306**	5,726
NHS Charitable funds: Trade and other payables	**6**	6	**0**	0
Total current trade and other payables	**42,422**	30,149	**35,938**	26,455
Capital payables	**1,162**	301	**0**	0
Total non-current trade and other payables	**1,162**	301	**0**	0

* 'Following adoption of IFRS 9 on 1 April 2018, the Trust's loans are measured at amortised cost rather than being carried at historical cost net of repayments. Any accrued interest is now included in the carrying value of the relevant loan.IFRS 9 is applied without restatement and therefore comparatives have not been restated.

The Better Payment Practice code (BPPC) gives NHS organisations a target of paying 95% of undisputed invoices within 30 calendar days of receipt of either goods or a valid invoice (whichever is later), unless other payment terms have been agreed. Information regarding the Trust's BPPC performance is within the Annual report.

The carrying amounts of Trade and other payables approximate to fair value.

13. Other liabilities (and other financial assets)

	Group		FT	
	31 March 2019 £000	31 March 2018 £000	**31 March 2019 £000**	31 March 2018 £000
Deferred income	**2,402**	2,307	**2,402**	2,307
Total current other liabilities	**2,402**	2,307	**2,402**	2,307
Deferred income	**0**	0	**1,156**	1,156
PropCare liability	**0**	0	**83,567**	18,996
Total non-current other liabilities	**0**	0	**84,723**	20,152

Included within deferred income are specific allocations relating to hosted services, research and development and post graduate medical education. Funding is received annually for these services. Deferred income brought forward from the previous year is utilised in year and the annual incomes received for the services are deferred if not required during the current year. The majority of the remaining balance at 31st March 2019 relates to earmarked funding to contribute to the "Building for the Future" project. The majority of this income was released in 2015-16.

The PropCare liability is offset by the loan receivable within Other Financial Assets of £78,815k. The non-current deferred income of £1,156k relates to an arrangement fee with PropCare. Both entries are eliminated on consolidation.

Loan commitments

The Trust has made loan commitments to Clatterbridge Propcare Services Limited totaling £118 million. As at 31 March 2019, Clatterbridge Propcare Services Limited has drawn down £83.6 million in loans from the Trust. The receipt of loans from the Trust are intended to cover the capital cost of the new cancer centre and the refurbishment of the existing estate. Clatterbridge Propcare Services Limited will be responsible for repaying the loans plus a fixed rate of interest from the income received via the unitary charge under the 25 year agreement.

The Trust measures the loan commitments in accordance with IAS 37. As at 31 March 2019, management does not believe that the loan commitment is onerous as Clatterbridge Propcare Services Limited's credit risk is low and therefore the probability of a default event is remote. Therefore, the Trust does not expect any credit losses arising from the loan commitment it has made to Clatterbridge Propcare Services Limited. Accordingly, the Trust has not recognised a provision in its accounts as at 31 March 2019

Financial guarantee

The Trust has provided a financial guarantee to Laing O'Rourke on behalf of Clatterbridge Propcare Services Limited. In the event that Clatterbridge Propcare Services Limited is unable to meet its financial obligations to Laing O'Rourke, the Trust is liable to pay the outstanding trade creditor. In accordance with IAS 39, this financial guarantee needs to be recognised at fair value. As there is no active market for this type of guarantee, the Trust needs to estimate the fair value. The Trust has calculated the expected losses under the guarantee, i.e. the probability-weighted outcome. Using this estimation technique, management believes that as at 31 March 2019 the fair value of the financial guarantee is nil. This is based on the judgement that Clatterbridge Propcare Services Limited is a going concern and the probability of a credit default event is very remote.

14. Borrowings

	CURRENT		NON-CURRENT	
	Group / FT		**Group / FT**	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£000	£000	**£000**	£000
Loans from Foundation Trust Financing Facility	**1,932**	250	**37,280**	2,750
Obligations under finance leases	**53**	51	**56**	109
	1,985	301	**37,336**	2,859

On 1st March 2010, the FT took out a loan in the sum of £5 million from the Department of Health Foundation Trust Financing Facility for the specific purpose of funding expenditure on the new radiotherapy treatment centre at Aintree which became operational in February 2011.

On 3 September 2019, the FT took out a further of £37 million from the Department of Health Foundation Trust Financing Facility for the specific purpose of funding the new Cancer Centre in Liverpool.

15. Finance lease obligations

	Group / FT	
	31 March 2019 £000	31 March 2018 £000
Gross lease obligations		
- Not later than one year	**53**	51
- later than one year and not later than 5 years	**56**	109
- later than 5 years	**0**	0
	109	160
Net lease liabilities		
- Not later than one year	**53**	51
- later than one year and not later than 5 years	**56**	109
- later than 5 years	**0**	0
	109	160

These finance leases relate to IM&T equipment purchased in 2015-16 for the EPR project.

16. Provisions for liabilities and charges

	Group		FT	
	31 March 2019 £000	31 March 2018 £000	**31 March 2019 £000**	31 March 2018 £000
Legal claims	**263**	458	**263**	458
Redundancy	**0**	0	**0**	0
Other	**87**	31	**4**	3
Total current provisions	**350**	489	**267**	461

	Group 2018/19			FT 2018/19		
	Legal claims £000	**Other £000**	**Total £000**	**Legal claims £000**	**Other £000**	**Total £000**
At start of period	**458**	**31**	**489**	**458**	**3**	**461**
Arising during the year	**17**	**84**	**101**	**17**	**1**	**18**
Utilised during the year	**(117)**	**0**	**(117)**	**(117)**	**0**	**(117)**
Reversed unused	**(95)**	**(28)**	**(123)**	**(95)**	**0**	**(95)**
At end of period	**263**	**87**	**350**	**263**	**4**	**267**
Expected timing of cashflows:						
Within 1 year	263	87	350	263	4	267

Legal claims consist of amounts due as a result of third party and employee liability claims. The values are based on information provided by NHS Resolution and estimates made by the FT. The FT is a member of the NHS Resolution clinical negligence scheme. All clinical negligence claims are therefore recognised in the accounts of NHS Resolution, consequently the FT will have no provision for such claims. NHS Resolution is carrying provisions as at 31st March 2019 in relation to ELS of £nil (2017-18 £nil) and in relation to CNST of £1,813k (2017-18 £523k) making a total of £1,813k (2017-18 £523k).

17.1 Revaluation Reserve

	Group / FT	
	2018/19	2017/18
	Property, Plant & Equipment	Property, Plant & Equipment
	£000	£000
Revaluation reserve at 1 April	**7,839**	3,584
Prior period adjustment	**0**	3,416
Revaluation reserve at 1 April (restated)	**7,839**	7,000
Revaluations	**922**	1,079
Transfers to other reserves	**(267)**	(240)
Revaluation reserve at 31 March	**8,494**	7,839

17.2 Charitable Funds Reserve

	Group	
	31 March 2019	31 March 2018
	£000	£000
Restricted Funds	**824**	518
Unrestricted Funds	**7,472**	6,268
	8,296	6,786

The restricted funds have arisen as they are donations which the donor has specified the income to be used for a particular purpose.

18. Cash and cash equivalents

	Group	FT
	2018/19	
	£000	**£000**
Balance at 1 April	**65,175**	55,368
Net change in year	**19,086**	17,595
Balance at 31 March	**84,260**	72,963
Broken down into:		
Commercial banks and cash in hand	**7,866**	3
Cash with Government Banking Service	**41,394**	37,960
Deposits with the National Loan Fund	**35,000**	35,000
	84,260	72,963

19. Related Party Transactions

The Clatterbridge Cancer Centre NHS Foundation Trust is a public interest body authorised by NHS Improvement, the independent regulator for NHS Foundation Trusts. It is part of a Group along with the Clatterbridge Cancer Charity, the Clatterbridge Pharmacy Limited, and Clatterbridge PropCare Services Limited. The FT has transactions with each of its subsidiary companies.

During the year none of the Board Members or members of the key management staff, or parties related to them, have undertaken any material transactions with the Group.

The Register of Interests for the Board of Governors for 2018-19 has been compiled in accordance with the requirements of the Constitution of The Clatterbridge Cancer Centre NHS Foundation Trust.

In 2012-13, Liverpool Health Partners Ltd, a company limited by guarantee, was set up between the University of Liverpool, Aintree University Hospital NHS FT, Alder Hey Children's NHS FT, The Clatterbridge Cancer Centre NHS FT, Royal Liverpool and Broadgreen University Hospitals NHS Trust, Liverpool Women's NHS FT, The Walton Centre NHS FT, Liverpool Heart and Chest NHS FT and Liverpool School of Tropical Medicine. The objects of the company are to advance education, health, learning and research by facilitating world class research among the partners. Each organisation has a single share in the company and the Chief Executives are ex-officio directors of the company.

The Department of Health is the parent department of the Clatterbridge Cancer Centre NHS Foundation Trust. The main entities within the public sector with which the body has had dealings are NHS England, Royal Liverpool and Broadgreen University Hospitals NHS Trust, Liverpool CCG, Wirral CCG, HMRC, NHS Pensions Scheme and National Loans Fund.

Related party transactions:

	Group / FT			
	2018/19		2017/18	
	Revenue	**Expenditure**	Revenue	Expenditure
	£000	**£000**	£000	£000
Non-consolidated associates	**2,239**	**217**	1,770	76
Total transactions with related parties	**2,239**	**217**	1,770	76

	Group / FT			
	31 March 2019		31 March 2018	
	Assets	**Liabilities**	Assets	Liabilities
	£000	**£000**	£000	£000
Non-consolidated associates	**813**	**198**	556	76
Total balances with related parties	**813**	**198**	556	76

Clatterbridge Propcare Services Limited (Propcare) is a wholly owned subsidiary of the Trust. Propcare will provide a fully managed suite of healthcare facilities, including the new cancer centre in Liverpool, for use by the Trust in return for a unitary charge payment. Propcare provides value to the Trust through its specific estates focus and through its ability to manage construction and operational risk for Trust, enabling the Trust board to focus on clinical matters. Whilst ownership of the buildings and fixed equipment will remain with the Trust, Propcare occupies the sites in order to construct and operate the facilities under a non-exclusive licence. Propcare is funded by loans and share capital from the Trust, which are intended to cover the capital cost of the new cancer centre and refurbishment of the existing facilities. Propcare will be responsible for repaying the loans from the income received via the unitary charge as well as distributing returns to the Trust through dividends. The Trust has provided a financial guarantee to Laing O'Rourke on behalf of Propcare in relation to the construction contract for the new cancer centre.

The Clatterbridge Phamacy Limited (CPL) is a wholly owned subsidiary of the Trust. CPL is registered as a pharmacy with the General Pharmaceutical Council and offers a range of over-the-counter medicines as well as other healthcare products. In addition to these traditional pharmacy services, CPL provides specialist cancer dispensing services to help patients manage their healthcare and medicines in one place. CPL provides value to the Trust by delivering a more personalised and efficient experience for our patients. The main related party transactions between the Trust and CPL relate to the purchase and sale of drug consumables.

20.1 Financial assets

IFRS 9 financial instruments is applied retrospectively from 1 April 2018 without restatement of SOPF comparitives.Therefore, comparative disclosures have been prepared under the previous standard (IAS 39 financial instruments: recognition and measurement) and the measurement categories differ to those in the current year analysis.

	Group	FT	Group	FT	Group	FT
	Financial instruments at amortised cost		Investments in equity instruments designated at fair value through OCI		Total	
	£000	£000	£000	£000	£000	£000
Financial assets held at amortised cost under IFRS 9						
Trade and other receivables - with NHS and DH bodies	**19,659**	**17,747**	**0**	**0**	**19,659**	**17,747**
Trade and other receivables - with other bodies	**3,831**	**9,491**	**0**	**0**	**3,831**	**9,491**
Other investments / financial assets	**1,174**	**1,174**	**0**	**0**	**1,174**	**1,174**
Cash and cash equivalents	**76,692**	**72,963**	**0**	**0**	**76,692**	**72,963**
NHS Charitable funds: financial assets	**7,598**	**0**	**1,236**	**0**	**8,834**	**0**
Total at 31 March 2019	**108,954**	**101,375**	**1,236**	**0**	**110,190**	**101,375**
Loans and receivables under IAS 39						
Trade and other receivables - with NHS and DH bodies	17,479	17,479	0	0	17,479	17,479
Trade and other receivables - with other bodies	2,326	4,339	0	0	2,326	4,339
Other investments / financial assets	672	672	0	0	672	672
Cash and cash equivalents	59,244	55,368	0	0	59,244	55,368
NHS Charitable funds: financial assets	5,946	0	1,191	0	7,136	0
Total at 31 March 2018	85,667	77,858	1,191	0	86,857	77,858

20.2 Financial liabilities

	Group	FT
	Other Financial Liabilities	
	£000	£000
Financial liabilities held at amortised cost under IFRS 9		
DHSC loans	**39,212**	**39,212**
Obligations under finance leases	**109**	**109**
Trade and other payables - with NHS and DH bodies	**15,231**	**14,997**
Trade and other payables - with other bodies	**21,814**	**11,707**
NHS Charitable funds: financial liabilities	**6**	**0**
Total at 31 March 2019	**76,372**	**66,025**
Other financial liabilities under IAS 39		
Borrowings excluding finance leases	3,000	3,000
Obligations under finance leases	160	160
Trade and other payables - with NHS and DH bodies	13,927	13,927
Trade and other payables - with other bodies	10,759	6,358
NHS Charitable funds: financial liabilities	6	0
Total at 31 March 2018	27,852	23,445

20.3 Fair Values

Set out below is a comparison, by category, of book values and fair values of the Group's non-current financial assets and liabilities. Fair values have been calculated using the Treasury discount rate of 3.7% over the repayment of the loan.

There has been no impairment of financial assets, other than bad debt expense shown in note 11.2. Other investments all relate to the Charity.

	Group				FT			
	31 March 2019		31 March 2018		**31 March 2019**		31 March 2018	
	Book value	**Fair value**	Book value	Fair value	**Book value**	**Fair value**	Book value	Fair value
	£000	**£000**	£000	£000	**£000**	**£000**	£000	£000
Financial assets								
Other Investments	**1,236**	**1,236**	1,191	1,191	**0**	**0**	0	0
Other Financial assets	**0**	**0**	0	0	**78,815**	**52,499**	18,715	15,636
	1,236	**1,236**	1,191	1,191	**78,815**	**52,499**	18,715	15,636

	Group				FT			
	31 March 2019		31 March 2018		**31 March 2019**		31 March 2018	
	Book value	**Fair value**	Book value	Fair value	**Book value**	**Fair value**	Book value	Fair value
	£000	**£000**	£000	£000	**£000**	**£000**	£000	£000
Financial liabilities								
Loan 1	**2,750**	**2,750**	2,750	2,750	**2,750**	**2,750**	2,750	2,750
Loan 2	**36,260**	**36,260**	0	0	**36,260**	**36,260**	0	0
Other liabilities	**0**	**0**	0	0	**84,723**	**55,395**	20,152	16,728
	39,010	**39,010**	2,750	2,750	**123,733**	**94,405**	22,902	19,478

21. Losses and Special Payments

	Group / FT			
	2018/19		2017/18	
	Number	**£000**	Number	£000
Losses of cash	**8**	**55**	1	0
Fruitless payments and constructive losses	**0**	**0**	0	0
Bad debts and claims abandoned in relation to:				
other	**0**	**0**	0	0
Damage to buildings, property etc. due to:				
theft, fraud etc	**0**	**0**	2	1
stores losses	**0**	**0**	1	0
other	**0**	**0**	1	2
Ex gratia payments in respect of:				
personal injury with advice	**1**	**3**	1	3
	9	**58**	6	5

The FT's losses and special payments are on an accruals basis and do not include any provisions for future losses.

22. Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the DHSC GAM has been applied by the Trust from 1 April 2018.The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 Financial instruments Recognition and Measurement. The main effects on the accounts of the Trust are the standard's revised approach to the classification and measurement of financial assets and financial liabilities (note 20) and a new forward-looking 'expected loss impairment model' (note 11)

Under IFRS 9, borrowings from DHSC, which were previously held at historic cost, are measured on an amortised cost basis.

The calculation of the new allowance for credit losses under the 'expected loss model' resulted in a £57k increase in the carrying value of receivables.

23. Initial application of IFRS 15

IFRS15 introduces a new model for income recognition, replacing IAS 18 Revenue,IAS 11 Construction Contracts and related interpretations. The core principle of IFRS 15 is that an entity recognises income when it satisfies performance obligations through the transfer of promised goods or services to customers, at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the DHSC GAM, the Trust has applied the practical expedient offered in IFRS 15 which removes the need to retrospectively restate any contract modifications that occurred before 1 April 2018.There have been no significant changes to the Trust's accounts in applying this standard.

24 (i) Liquidity risk

The FT's income is negotiated under agency purchase contracts with NHS England, which is financed from resources voted annually by Parliament. The FT receives such contract income in accordance with Payment by Results (PBR), which is intended to match the income received in year to the activity delivered in that year by reference to a National / Local Tariff unit cost.

For 2018-19, the FT has negotiated a one year block contract with its main commissioner for activity delivered. The FT receives cash each month on the agreed level of the contract value. This has allowed the FT to minimise the risk to its main source of income.

The FT presently finances most of its capital expenditure from internally generated funds. In 2009/10 the FT borrowed £5 million from the Department of Health Financing Facility specifically to finance part of the construction of the new Radiotherapy Centre at Aintree. In 2018/19 the FT borrowed a further £37 million from the Department of Health Financing facility to part fund the new Cancer Centre build in Liverpool.

There have not been any material changes to the FT or Group risk on the previous year.

(ii) Market risk

This is not applicable to the FT or Group.

(iii) Interest rate risk

The only asset or liability subject to fluctuation of interest rates are cash holdings at the Government banking service and at a UK High street bank. The £5 million loan in 2009/10 and the £37 million loan taken out in 2018/19 from the Department of Health Financing Facility has been taken on a fixed rate basis to avoid any risk from interest rate fluctuations. The FT is not, therefore, exposed to significant interest rate risk.

(iv) Foreign currency risk

The FT has negligible foreign currency income, expenditure, assets or liabilities.

(v) Credit Risk

The FT has considered credit risk under IFRS 7, and concluded that this note is not applicable to the FT. There is no material monetary impact on the financial statements from any of the risks.

25. Auditors Liability

The auditor's liability for losses in connection with the external audit is limited to £2,000,000.

26. Third Party Assets

The FT did not hold any money on behalf of patients in either 2018-19 or 2017-18.

Cash and cash equivalents in the group are available for use with the exception of any cash and cash equivalents ring-fenced in the charity accounts as restricted funds.

27. Retirement benefits

The FT is a member of a defined benefit scheme.

28. Events after reporting period.

There are no post balance sheet events.

29. Contingent Assets and Liabilities

There are six contingent liabilities with a total value of £16k (2017-18 seven contingent liabilities with a total value of £347k).

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

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